CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Thursday, 06 July 2017

Democratic and Members' Services
Quentin Baker
LGSS Director: Lawand Governance

10:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Kreis Viersen Room
Shire Hall, Castle Hill, Cambridge, CB3 0AP

AGENDA

Open to Public and Press

1	**Notification of the Appointment of the Chairman**	
2	**Election of the Vice Chairman/ Vice Chairwoman** The Vice Chairman or Vice Chairwoman is elected annually from the Clinical Commissioning Group representatives on the Board.	
3	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code*	
4	**Minutes of the Meeting on 30 March 2017 and the Extraordinary Meeting on 27 April 2017**	**5 - 20**
5	**Action Log**	**21 - 24**
6	**Person's Story**	

The Cambridgeshire Health and Wellbeing Board will meet next on Thursday 21 September 2017 at 10.00am, venue to be confirmed.

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Lynda Harford (Chairwoman)

Councillor Margery Abbott Jessica Bawden Councillor Mike Cornwell Councillor Angie Dickinson Tracy Dowling Councillor Sue Ellington Stephen Graves Chris Malyon Val Moore Wendi Ogle-Welbourn Dr Sripat Pai Stephen Posey Liz Robin Councillor Joshua Schumann Vivienne Stimpson Aidan Thomas and Matthew Winn Councillor Anna Bailey Councillor Simon Bywater Councillor Claire Richards and Councillor Susan van de Ven

For more information about this meeting, including access arrangements and facilities for people with disabilities, please contact

Clerk Name: Richenda Greenhill

Clerk Telephone: 01223 699171

Clerk Email: Richenda.Greenhill@cambridgeshire.gov.uk

The County Council is committed to open government and members of the public are welcome to attend Committee meetings. It supports the principle of transparency and encourages filming, recording and taking photographs at meetings that are open to the public. It also welcomes the use of social networking and micro-blogging websites (such as Twitter and Facebook) to communicate with people about what is happening, as it happens. These arrangements operate in accordance with a protocol agreed by the Chairman of the Council and political Group Leaders which can be accessed via the following link or made available on request: http://tinyurl.com/ccc-film-record.

Public speaking on the agenda items above is encouraged. Speakers must register their intention to speak by contacting the Democratic Services Officer no later than 12.00 noon three working days before the meeting. Full details of arrangements for public speaking are set out in Part 4, Part 4.4 of the Council's Constitutionhttps://tinyurl.com/CCCprocedure.

The Council does not guarantee the provision of car parking on the Shire Hall site and you will need to use nearby public car parks http://tinyurl.com/ccc-carpark or public transport

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: 30 March 2017

Time: 9.15am-11.20am

Venue: The Swansley Room, South Cambridgeshire Hall, Cambourne CB23 6EA

Present:

Cambridgeshire County Council (CCC)
Councillors T Orgee (Chairman), D Jenkins and P Topping
Dr L Robin, Director of Public Health (PH)
C Black, Service Director for Older People and Mental Health (substituting for W Ogle-Welbourn)

City and District Councils
Councillors M Abbott (Cambridge City), S Ellington (South Cambridgeshire) and J Palmer (Huntingdonshire)

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
T Dowling, Chief Officer (Vice-Chairwoman)

Healthwatch
J Wells (substituting for Val Moore)

NHS Providers
D Cohen, Cambridgeshire and Peterborough NHS Foundation Trust, (substituting for A Thomas) and M Winn, Cambridgeshire Community Services NHS Trust

District Council officer advisor (non-voting)
M Hill

Also in attendance:
V Thomas, Consultant in Public Health, CCC
G Hinkins, Transformation Manager, CCC
G Kelly, Interim Head of Communities & Integration, CCG
S Haldane, Executive Programme Director, Sustainability and Transformation Programme (STP)
A Fallon, Senior Communications and Engagement Manager, Sustainability and Transformation Programme System Delivery Unit
J Bawden, Director of Corporate Affairs, CCG
K Parker, Head of Public Health Programmes, CCC
R Greenhill, Democratic Services Officer, CCC

Apologies:
Cllr M Cornwell, Fenland District Council
Cllr J Schumann, East Cambridgeshire District Council
C Malyon, Chief Finance Officer and Deputy Chief Executive, CCC
L McCarthy, Hinchingbrooke Healthcare NHS Trust
W Ogle-Welbourn, Interim Executive Director for Children Families and Adults, CCC (substituted by C Black)
A Thomas, Cambridgeshire and Peterborough NHS Foundation Trust (substituted by D Cohen)
V Moore, Healthwatch (substituted by J Wells)

Dr S Pai, CCG
V Stimpson, NHS Commissioning Board
S Posey, Papworth Hospital NHS Foundation Trust
J Farrow, Hunts Forum

263. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

The Board noted apologies for absence as recorded above. Cllr Ellington declared a non-statutory interest in Item 6 - Review of the Better Care Fund as a Trustee of the Care Network.

264. MINUTES OF THE MEETING ON 19 JANUARY 2017

The minutes of the meeting on 19 January 2017 were agreed as an accurate record, subject to the correction of Minute 256, paragraph 6 to read 'the HWB did not have a specific responsibility for the STP, but did have a duty to promote the integration of healthcare and ~~healthcare~~ *social care* commissioning…'. The Chairman signed the corrected minutes.

265. ACTION LOG

The Board reviewed and noted the Action Log.

266. A PERSON'S STORY

The Consultant in Public Health shared two stories as context to the following item on the dual diagnosis of mental health and substance misuse issues.

'Sarah's story' was provided by the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). Sarah had first self-medicated at the age of three and was diagnosed with hyperactivity at around the same age. She became interested in street drugs as a teenager and cannabis was used widely within her social circle. Within months of using cannabis she moved on to using increasingly harmful drugs. By the time she went to university she was experiencing significant mood swings, but she did not recognise this as an issue at the time. She gave up university after a year as her life became more focused on drug use and this brought her into contact with criminal elements. She experienced her first psychosis at the age of 25 and was diagnosed as bi-polar five years later. Sarah questioned whether she would have experienced mental health issues if she had not taken street drugs.

Person A's story was provided by Inclusion, the organisation contracted to provide drug and alcohol treatment services across Cambridgeshire. Person A had been engaging with Inclusion since December 2015. He was a crack and cocaine user and demonstrated impulsive behaviour and difficulties with anger management. At the request of Inclusion his GP had requested a mental health assessment. This was carried out by CPFT and Person A was referred to the Psychological Wellbeing Service. However, he was not offered further support by that service because he was already accessing support from Inclusion.

The Board noted the personal stories as context to the next item on the agenda.

267. DUAL DIAGNOSIS OF MENTAL HEALTH AND SUBSTANCE MISUSE ISSUES

The Board received a report by the Consultant in Public Health setting out current issues and concerns relating to the dual diagnosis of substance misuse (which for the purpose of this report was taken to refer to drugs and alcohol) and mental health conditions. A similar report and recommendations had been submitted to the Peterborough Health and Wellbeing Board.

A range of work and initiatives had been undertaken on dual diagnosis strategy and protocols, but there was concern that the needs of certain clients and patients were still not being met. There was strong evidence of better outcomes when drugs and alcohol issues were treated concurrently, but there remained a dissonance between pathways and their accessibility to patients. The differing needs and experiences of individual clients made it difficult to identify an optimum service delivery model, but it should be possible to align care pathways more effectively through strategic joint commissioning approaches and improved data sharing.

The following points arose in discussion of the report and in response to members' questions:

- There was already a lot of good work happening in relation to clients with low levels of substance misuse and high levels of mental health needs, including the alignment of commissioning. However, it appeared that the targets and standards included in the Improving Access to Psychological Therapies (IAPT) programme could lead to some clients with low levels of mental health need and high levels of substance misuse being excluded from treatment. The experience of Person A (minute 266 refers) was noted in this context. It would be helpful to look at this further with a view to raising the issue with NHS England if appropriate;
(**Action:** Consultant in Public Health)

- An officer group had been looking at current practice relating to dual diagnosis and it was at their request that the issue had been elevated to both the Cambridgeshire and Peterborough Health and Wellbeing Boards for consideration;

- The Service Director for Older People and Mental Health stated that a lot of work on data sharing had been done in conjunction with the Clinical Commissioning Group (CCG) in the context of the Better Care Fund (BCF), within the constraints of the Data Protection Act and Caldicott guidance. She would discuss this further with colleagues in the Public Health team outside of the meeting and submit a report to a future meeting of the Board;
(**Action:** Service Director for Older People and Mental Health)

- Paragraph 3.6: A member commented that, if it was accepted that the threshold for accessing services was currently set too high, it was reasonable to assume that lowering the threshold would increase the number of people accessing services. This did not mean that it should not be done, but it was important that the resource implications were recognised. The Consultant in Public Health stated that modifying the service access thresholds would require a better understanding of the prevalence of conditions and it had not yet been possible to obtain all of the necessary information due to data sharing issues. However, addressing

needs more efficiently should mean better outcomes for clients and a reduction in their need for on-going support which would lessen the demand on resources over time.

Summing up, the Chairman said that the issue of data sharing between service providers had been an area of concern for some time. It was imperative that full and accurate information was shared within the recognised statutory constraints to enable both need and provision to be considered holistically. This would ensure the most efficient and effective delivery of services and the best possible outcomes for individual service users.

It was resolved to:

a) Comment on the issues raised in the report;

b) Endorse the recommendations for taking forward the alignment of commissioning strategies to strengthen and develop services for those with mental health and substance misuse problems.

268. REVIEW OF THE BETTER CARE FUND

The Board received a report from the Transformation Manager inviting comments on a draft report on progress in the delivery of the Better Care Fund (BCF) during its first two years of operation. The report had been submitted late because the performance data was incomplete at the time the meeting documents were published, but had been accepted by the Chairman on the grounds of urgency to allow members' comments to inform planning for the BCF for 2017-19. The guidance and policy framework for the BCF for the period April 2017 to March 2019 had not yet been issued and an extraordinary meeting of the Board had been called for Thursday 27 April to review and approve the Plan.

The Interim Head of Communities & Integration (CCG) apologised for the delay in providing health data for inclusion in the draft report and provided a verbal update. Key points included:

- An encouraging decline in emergency department attendance between October 2016 and February 2017. Whilst it was too early to infer that this would be a sustained trend it reflected the positive impact of recent initiatives such as the new Joint Emergency Teams (JET teams), Neighbourhood Teams and work with local care home providers in reducing emergency department attendance;

- An increase in the number of non-elective admissions since April 2015. A number of BCF investments had targeted this area and a challenging target set to cut the number of avoidable admissions, but it was noted that many of these admissions were appropriate and unavoidable;

- Delated transfers of care (where a patient was medically fit for discharge, but their discharge was delayed because the required health or social care support systems were not in place) remained an area of challenge. A positive decline in numbers since December 2016 was noted.

The following points arose in discussion of the report and in response to members' questions:

- The majority of BCF investments in Cambridgeshire to date related to core social care and community health services;

- The National Audit Office (NAO) had published a summary of progress in health and social care integration in February 2017 which indicated that the challenges being experienced in Cambridgeshire were in line with those being reported nationally. The report acknowledged the positive work which the BCF had achieved, but was critical of the bureaucracy associated with it;

- The first meeting of the single commissioning board for Cambridgeshire and Peterborough had taken place the previous week and had been positive. The Service Director for Older People and Mental Health stated that the commissioning board was keen to ensure that it got district council representation right and that she was happy to discuss this further with district council representatives outside of the meeting;

- The representative of Healthwatch urged caution in assuming that a reduction in the number of people accessing social care necessarily reflected a reduction in need. Healthwatch continued to hear from people receiving less social care support than they felt they needed;

- The Service Director for Older People and Mental Health reported that the Adult Early Help Team was succeeding in meeting short term need more effectively, but its impact in the longer term was not yet known;

- It was understood that local authorities would in future be able to apply to 'graduate' from the BCF, whereby the requirement to submit a BCF plan would be removed. Officers would offer further advice on this when more was known;

- The CCG Finance Committee had discussed the possibility of joint work on the BCF being reflected in the Sustainability and Transformation process;

- The Vice Chairwoman highlighted delayed transfers of care as a key issue with around 10% of the county's transfers being delayed compared to a national rate of 3.1%, although this figure was reducing with a notable improvement had been seen recently at Hinchingbrooke Hospital. The CCG was jointly funding a piece of work to look in detail at this issue and how it should be addressed going forward. This would look across the whole system and not focus solely on acute care;

- Non-elective admissions at Hinchingbrooke Hospital showed an overall reduction year on year which was felt to be due in large part to the assessment and admissions process in place. This trend was less evident at Addenbrooke's Hospital, but good joint work was now taking place. A member noted a lack of consistency and variability in practice between providers and highlighted the need to work out why learning was not always being shared;

- The Vice Chairwoman reported a significant improvement in Accident and Emergency Department performance during the previous three weeks and noted that Addenbrooke's Hospital had been the best performing hospital in the country the previous week. This reflected the practical benefits to patients of good processes which were implemented rigorously.

Summing up, the Chairman highlighted the importance of digging into the headline figures to identify variations in performance and the reasons behind these. It would be useful to review these figures in six months' time to assess the evolving picture. (**Action:** Transformation Manager/ Interim Head of Communities & Integration (CCG))

The Chairman noted the Board's significant concern at the delay in issuing guidance for the BCF for 2017-19 and questioned how the Board could be expected to plan properly without this guidance or notification of the sums involved. Members had also expressed concern that the timing of the BCF cycle did not correspond with the NHS financial planning round which ended in December. This did not represent the coherent and joined up approach to public sector working which the public should expect.

It was resolved:

a) To comment on the review of the Better Care Fund (BCF) contained in the appendix to the report and to make recommendations to inform future planning;

b) That the Chairman should write to the Department for Communities and Local Government on behalf of the Board to set out members' concerns about the delay in issuing guidance on the 2017-19 BCF and the importance of aligning the BCF timeframe with other relevant financial planning considerations. (**Action:** Transformation Manager)

269. REPORT FROM THE PUBLIC HEALTH REFERENCE GROUP

The Board received a report from the Director of Public Health which set out the work and outcomes achieved by the Cambridgeshire Public Health Reference Group during 2016/17. The Group met quarterly and provided whole system leadership and multi-agency co-ordination for public health initiatives in Cambridgeshire, with a focus on improving outcomes for residents and reducing health inequalities. The Group was co-chaired by the Director of Public Health and the Chief Executive of Fenland District Council.

The Group's work had focused on the Cambridgeshire Healthy Weight Strategy and community engagement and had encompassed both short-term initiatives designed to achieve 'quick wins' together with longer term, more strategic planning. The valuable input received from District and City Councils and Val Thomas, Consultant in Public Health was noted.

The following points arose in discussion of the report and in response to members' questions:

- Paragraph 3.1 - Implementation and Evaluation of Diet and Physical Activity Pilots.

i. Evidence suggested both that nurseries and early years groups were more receptive to engaging with these initiatives than schools and that the benefits were greater;
ii. The Group would in future review those initiatives which it was hoped would become self-sustaining to see whether they were still in operation.

- Paragraph 3.2 – Cambridgeshire Healthy Weight Strategy. Achieving a healthy weight for the population of Cambridgeshire remained a major public health challenge. Public consultation on the draft strategy had lasted from August to November 2016 and a final draft strategy and action plan would be submitted to the County Council Health Committee;

- Paragraph 3.3 – Developing a Locality Delivery Model to Increase Physical Activity Levels Across Cambridgeshire. The County Council Health Committee had approved expenditure of £513k over two years to support the development of a collaborative district-based physical activity programme;

- Paragraph 3.4 – Joint Working between District Councils and Public Health. This area was one of the County Council's transformation priorities;

- Paragraph 3.5 – Promoting Academic Links. A bid to the Wellcome Trust to create a Translational Centre for Global Ageing had reached the short-list stage and, although unsuccessful, officers had been encouraged to submit a revised bid;

- Paragraph 3.6 – Other issues. Development of a joint 'Be Well in Cambridgeshire' communications strategy, phone app and webpage in collaboration with District and City Councils. Members noted that public health differed from other aspects of Council business in its focus on changing behaviour rather than delivering a service. 'The 'Be Well in Cambridgeshire' strategy had been designed as a stand-alone initiative to provide local residents with a trusted source for health information. Work had focused initially on the development of a mobile phone app as 60% of users accessing the County Council's online information services currently did so by phone. It was agreed that it would be useful to include a link to the new 'My Health' app which had been launched recently by the CCG which would provide information on local health services in a number of languages.
(**Action:** Director of Public Health/ Director of Corporate Affairs (CCG) to progress)

It was resolved to:

a) Note and comment on the Public Health Reference Group report of activity in 2017/17.

270. SUSTAINABILITY AND TRANSFORMATION PLAN

The Board received a report by the Executive Programme Director for the Sustainability and Transformation Plan (STP) which provided an update on the Cambridgeshire and Peterborough STP.

The reference to developing the beneficial behaviours of an Accountable Care Organisation (ACO) in paragraph 2.3 was clarified to make clear that a decision on whether to commit to becoming an ACO had not yet been taken. Further consideration of the implications of this for system-wide accountability and individual sovereignty would take place before a formal decision was taken in April 2017.

The STP was designed to facilitate a joined-up whole system approach to health, working in co-operation with other public sector services and organisations, and to address the significant financial challenges being faced. This would include looking at new health initiatives and delivery models and considering these against clear published criteria. A number of significant investments had already been made including the decision to extend the Joint Emergency Team (JET) programme. Workforce issues were recognised as the greatest area of challenge as the success of the Plan was dependent on having the right people in place to deliver the services required. This was a national issue and it was imperative to make working in the health sector in Cambridgeshire as attractive as possible to attract and retain the calibre of professionals required to make the transformation a success.

A positive meeting had taken place the previous day between services and providers to discuss digital delivery. The need to make a step change in the use of digital technology to enable individuals to access the information they needed to enable them to look after their health was recognised and a number of promising initiatives had been identified.

The STP System Delivery Unit was leading on communication and engagement on the STP. Officers were working proactively with local people and service users to ensure their involvement in service design at all stages and reacting to the intense interest in the STP, including by regularly attending meetings of the County Council Health Committee and the Health and Wellbeing Board. Officers within the Unit had a clear understanding of their statutory responsibilities and best practice in relation to public engagement and were committed to meeting these. An important part of this process was establishing a productive two-way dialogue with service users and the local community at the outset of the process and to look at the implications of proposals in real terms. Part of this would look at how to make the best use of social media to engage. There was a clear understanding that change was more likely to happen in a positive way when public engagement and consultation formed an integral part of the process from the outset. In Cambridgeshire it was proposed to customise engagement on each element of the STP rather than considering it in its entirety.

The following points arose in discussion of the report and in response to members' questions:

- The Healthwatch representative welcomed the commitment to ensuring public involvement from the outset of the process. He highlighted the key role played by carers in complementing the health and social care services provided by statutory organisations and their wish to see this role recognised;

- A member questioned the omission from the STP of reference to the role of GP's. The Executive Programme Director for the STP stated that this reflected a move away from talking about the role of GPs in isolation from a wider discussion about primary care. This did not mean that questions about GPs' role and capacity would not be addressed and there was already significant

engagement with GP practices and confederations about their evolving role in healthcare delivery;

- A member noted that some areas had chosen to consult with the public on their STPs as a whole in order to consider the proposals holistically, but that this did not seem to be proposed in Cambridgeshire. Representatives of the CCG acknowledged that consulting on the STP as a whole would raise awareness of the full range of issues involved, but as a high level document its focus was on the what and why of what it was hoped to achieve. Although not ruling out the possibility of consultation on the whole document it was felt at present that public input would be most valuable when work started on looking at how individual areas of delivery should be addressed;

- A member emphasised the importance of making the public aware now of the need to save £504m over the next four years so that the conversation could begin about how this challenge would be met. This would provide context for the decisions to be made and attempt to avoid the polarised opinions which could form when individual proposals were considered on a piecemeal basis rather than in the context of the wider financial picture;

- A member stated that buildings seemed to be a fundamental issue and that some smaller GP surgeries would not have the scope to provide a wider range of services due to lack of space. The Executive Programme Director for the STP stated that there was a workstream which was looking at the NHS estate within the community and more widely at the public sector estate to look for opportunities to co-locate services. The example of the co-location of a Neighbourhood Team at Histon Police Station demonstrated how this model supported greater partnership working between the organisations concerned as well as delivering financial savings.

It was resolved to:

a) Note and comment on the report.

271. FORWARD AGENDA PLAN

It was resolved to note the Forward Agenda Plan, subject to the following amendments:

i. To move consideration of the Safeguarding Adults Board Annual Report for 2016/17 forward from the September 2017 meeting to the July 2017 meeting;
ii. To add a report on Data Sharing by the Service Director for Older People and Mental Health;
iii. To add an update on the Better Care Fund Health Data in six months' time.

(**Action:** Democratic Services Officer)

272. DATE OF NEXT MEETING

An extraordinary meeting of the Board had been called for Thursday 27 April 2017 at 11.30am in the Kreis Viersen Room, Shire Hall, Cambridge CB3 0AP to consider the Better Care Fund Plan for 2017-19.

Chairman

EXTRAORDINARY MEETING OF THE CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: 27 April 2017

Time: 11.30am-12.40pm

Venue: Kreis Viersen Room, Shire Hall, Cambridge

Present: Cambridgeshire County Council (CCC)
Councillors T Orgee (Chairman), D Jenkins and J Whitehead
Dr L Robin, Director of Public Health (PH)
C Black, Service Director – Older People's Services and Mental Health (substituting for Wendi Ogle-Welbourn)
T Kelly, Strategic Finance Manager (substituting for C Malyon, Deputy Chief Executive and Chief Finance Officer)

City and District Councils
Councillors M Abbott (Cambridge City) and S Ellington (South Cambridgeshire)

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
J Bawden, Director of Corporate Affairs (substituting for Tracy Dowling) and Dr S Pai

Healthwatch
V Moore, Chair

NHS Providers
None present

Voluntary and Community Sector (co-opted)
J Farrow, Chief Executive Officer, Hunts Forum of Voluntary Organisations

Also in attendance:
G Hinkins, Transformation Manager, CCC
R Greenhill, Democratic Services Officer, CCC

Apologies:

T Dowling, Chief Officer, CCG (substituted by J Bawden); J Farrow, Hunts Forum (co-opted member); C Malyon, Deputy Chief Executive and Chief Finance Officer (CCC) (substituted by Tom Kelly); W Ogle-Welbourn, Interim Executive Director, Children Families and Adults (CCC) (substituted by C Black); Cllr J Palmer, Huntingdonshire District Council; S Posey, Papworth Hospital NHS Foundation Trust; Cllr J Schumann, East Cambridgeshire District Council and M Winn, Cambridgeshire Community Services NHS Trust

273. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Apologies were noted as recorded above. Cllr Whitehead asked that her belated apologies for the meeting on 30 March 2017 should also be noted as she had been unable to attend due to ill health. Cllr Ellington declared a non-statutory interest in Item 2: Cambridgeshire Better Care Fund Planning as a Trustee of the Care Network.

274. CAMBRIDGESHIRE BETTER CARE FUND PLANNING 2017-19

The Board received a report and presentation from the Transformation Manager, Cambridgeshire County Council which set out the work which had been completed to date on the Better Care Fund (BCF) plan. It had been intended to circulate further detailed information to members in advance of the meeting once planning guidance and funding allocation information for 2017-19 had been received, but this had not yet been issued by central government. Given that it was now clear that there would be the opportunity for the Board to meet again prior to final sign-off of the plan the proposal to delegate authority for the sign-off to the Director of Public Health had been withdrawn. Instead, members were invited to review the performance of the BCF to date and offer an initial steer on the way forward in the light of the policy framework guidance which was currently available.

The BCF was designed to improve integration between services with a particular focus on health and social care. During 2016-17 BCF expenditure had totalled £48,464k. This sum was drawn from existing funds and did not represent new money coming into the area. The majority of expenditure had remained within front-line health (£25,803k) and social care (£17,430k) services, but £3,480k had been allocated to the Disabled Facilities Grant (DFG) and £1,702k to transformation projects which focused on delivering better outcomes to those receiving services.

Evaluation of the BCF in 2016-17 showed some performance improvements, particularly in long-term care, but challenges remained in areas such as non-elective admissions and managing transfers of care. Similarly, some transformation investments had proved effective, but others had struggled to progress due to issues elsewhere within the system. On balance, the BCF was felt to have been helpful in articulating a shared vision for the integration of services. However, it was recognised that it could not operate in isolation from the initiatives and challenges existing within the wider context of health and social care delivery, including the local Sustainability and Transformation (STP) Plan.

In the course of discussion, Board members noted:

- Officers' advice that Cambridgeshire was not yet ready to apply to apply to 'graduate' from the Better Care Fund and be given greater freedom by central Government to manage its own integration plan, but that the position would be kept under review;

- Budgetary flexibility within the BCF remained limited;

- Greater alignment in the commissioning and delivery of services across Cambridgeshire and Peterborough offered improved efficiency and economies of scale. It was hoped to keep as close as possible to a narrative plan across the two areas, although the two areas' BCFs would remain separate;

- A clear recognition of the need to avoid as far as possible duplication of work being undertaken as part of the STP process;

- Some of the most significant progress had been made in areas which had received little or no additional funding, but which had benefitted from closer collaborative working. These included the Disabled Facilities

Grant review, Cambridgeshire Fire and Rescue partnership and the falls pathway re-design;

- Possible areas for focus going forward included neighbourhood team working, co-ordinating early intervention and prevention initiatives across the county, district and city councils and the Clinical Commissioning Group (CCG) and greater co-ordination of intermediate care and re-ablement services across health and social care;

- Some progress in relation to data sharing. The CCG had asked all GP practices to sign up to an information sharing protocol;

- The difficulty in recruiting community care staff in some areas. A member suggested developing a training programme or using 'taster days' which emphasised the importance of interaction and communication in carers' roles in addition to the practical aspects of care to encourage potential applicants to look again at careers within care delivery. It was noted that workforce planning was a major element of the STP and there was now the wider question of how this might be considered within the context of devolution;

- Officers had concentrated on issues which required joint working across multiple partner organisations rather than discrete projects which could be progressed by individual organisations or those already being addressed through other forums. There was also real recognition of the need to identify and address underlying causes to issues rather than provide short-term fixes;

- In response to a question from the Healthwatch representative, officers advised that there had been quite a lot of public engagement on specific issues by individual organisations, but said that it would be a helpful challenge going forward to see how this information could be pulled together;

- Members noted that the additional £8.3m Improved BCF funding for Cambridgeshire in 2017/18 represented a one-off sum and as such could not be used to fund recurring costs. Officers noted the Board's wish that this sum should be used as productively as possible, but emphasised that this additional funding was being provided to protect existing services and to reduce pressures on the NHS;

- Members discussed the need for intermediate levels of care between hospital at home and measures to support the independence and improve quality for life of residents. The Chairman stated that this was a recognised issue within health and social care services;

- One member stated that they found the whole idea of the BCF opaque and that they would like more information on numbers and to articulate exactly what the Board wanted the Fund to achieve. It should also acknowledge the role played by district, city, town and parish councils in achieving healthier communities and the importance of early intervention and support. The success of the Adult Early Help Team established in 2016 was noted and the Service Director for Older People's Services and

Mental Health stated that officers would be discussing with health service colleagues how this work might be further enhanced;

- Members discussed the role now being played by the Joint Emergency Teams (JET Teams);

- The Director of Public Health stated the importance of ensuring that services worked for users by properly understanding their needs and priorities and avoiding duplication and delay;

- Members discussed the importance of creating an appropriate environment to support healthy ageing. This required an holistic approach which recognised the importance of factors such as an accessible environment, housing needs, access to lifelong learning and the opportunity to continue to contribute to the community as well as more widely recognised factors such as health and social care needs;

- A member reported the difficulty and delay experienced by some patients in returning equipment provided by the health service. They felt that this created a perception that the equipment was not valued. The Service Director for Older People's Services and Mental Health stated that recycling targets were set in relation to collecting equipment and offered to put someone in touch to discuss this further;
(**Action: Service Director – Older People's Services and Mental Health**)

- A member reported that a change in personnel on a ward at Addenbrookes Hospital had resulted in a noticeable change in onward referral rates. The Director of Corporate Affairs (CCG) offered to follow this up outside of the meeting;
(**Action: Director of Corporate Affairs (CCG)**)

- A member reported a positive personal experience of re-ablement support.

It was resolved to:

a) Comment on the proposals for the Better Care Fund plan 2017-19.

275. VOTE OF THANKS

Councillor Ellington noted that this would be the Chairman's last meeting as he was stepping down as a county councillor at the forthcoming elections. She expressed her gratitude to Councillor Orgee for his excellent chairmanship of the Board, commenting that he had acted with sincerity, integrity and fairness. The Director of Public Health endorsed these comments and offered her personal thanks to Councillor Orgee for his support during the transfer of responsibility for Public Health to the local authority and for consistently and actively fostering collaboration and constructive working across the Board's member organisations and beyond.

It was resolved to:

a) Record a vote of thanks to Councillor Orgee for his contribution as chairman of the Cambridgeshire Health and Wellbeing Board.

276. DATE OF NEXT MEETING

The Board is scheduled to meet next on Thursday 1 June at 10.00am in the Council Chamber, Shire Hall, Cambridge CB3 0AP. *(Clerk's note: The meeting on 1 June 2017 was subsequently cancelled. The Board will meet next on 6 July 2017 at 10.00am in the Kreis Viersen Room, Shire Hall, Cambridge).*

Chairman

HEALTH & WELLBEING BOARD ACTION LOG: JULY 2017

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
Meeting Date: 15.09.16		
235. Safeguarding Adults Board Annual Report 2015-16	To share with the Board any recommendations arising from the review of the increase in reported cases of abuse and/ or neglect in care homes in 2015-16 compared to the previous year when this information was available. **UPDATE 15.06.17**: An update emailed to all members of the Board advising that the proposed review of the dataset of information that allows effective monitoring of safeguarding activity and outcomes by doing in depth data and trend analysis, which would have included the number of cases of abuse in care homes, was postponed until 2017/18 to allow the data from the Multi Agency Safeguarding Hub (MASH) and the new recording requirements introduced by the Care Act around the person's desired outcomes to be fully considered in this work **Action: C Bruin**	**Completed**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
Meeting Date: 17 November 2016		
244. Health and Care System Sustainability and Transformation Programme - MOU	The Voluntary and Community Sector representative would provide feedback on where she felt the voluntary sector could contribute via the Chief Executive of the Cambridgeshire and Peterborough NHS Foundation Trust. **UPDATE 18.04.17**: The Voluntary Sector is happy to support the STP and as a stakeholder is already involved in some areas. The mechanism for involving the voluntary sector is not yet consistent across all hospitals, but the voluntary sector are very happy to work towards achieving this alongside health sector colleagues and to flag up any areas of difficulty should they arise. **Action: J Farrow/ A Thomas**	**Completed**
Meeting Date: 30 March 2017		
267. Dual Diagnosis of Mental Health and Substance Misuse Issues	To consider further the extent to which targets and standards included in the Improving Access to Psychological Therapies (IAPT) programme could lead to some clients with low levels of mental health needs and high levels of substance misuse being excluded from treatment, with a view to raising the issue with NHS England if appropriate. **Action: V Thomas** **UPDATE 26.06.17**: A Working Group has planned and agreed with the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) to undertake an audit of IAPT services to identify the numbers of patients that present with a Dual Diagnosis. Secondly, to review the service delivery models to identify whether its scope could address the needs of this cohort of these patients.	**Completed**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
	To submit a report to a future meeting of the Health and Wellbeing Board on Data Sharing. **UPDATE 06.04.17**: Provisionally added to the HWB agenda for 6 July 2017, subject to confirmation by Charlotte. **UPDATE 01.06.17**: Added to the agenda for 21 September 2017. **Action: C Black**	**Completed**
268. Review of the Better Care Fund (BCF)	To provide a follow-up report in six months (September 2017) containing updated health data. **UPDATE 01.06.17**: Added to the agenda for the meeting on 21 September 2017. **Action: G Hinkins & G Kelly, CCG**	**Completed**
	To provide a draft letter for the Chairman's signature to the Department for Communities and Local Government setting out the Board's concerns about the delay in issuing guidance on the 2017-19 Better Care Fund and the importance of aligning the BCF timeframe with other relevant financial planning considerations. **UPDATE 03.05.17**: The Chairman wrote to the Right Hon Jeremy Hunt MP, Secretary of State for Health on 3 May 2017, side-copied to the Right Hon Sajid Javid MP, Secretary of State for Communities and Local Government. **UPDATE 06.06.17**: A response received from the Private Secretary to the Parliamentary Under Secretary of State for Health advising that the future of the Better Care Fund will be a matter for the next Government. Should the Board wish to write again following the General Election the Department will be happy to respond in full. The Chairman has asked that the Board consider this when it next receives a report on the BCF (September 2017). **Action: G Hinkins**	**On-going**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
269. Report from the Public Health Reference Group (PHRG)	To arrange for a link to the CCG 'My Health' app to be included on the 'Be Well in Cambridgeshire' phone app and webpage. **UPDATE 24.04.17:** The CCG "My Health" app has been included in the links that will appear on the 'Be Well in Cambridgeshire' website. **Action: V Thomas**	**Completed**
271. Forward Agenda Plan	To incorporate the items identified in the course of the meeting into the Forward Agenda Plan. **Action: R Greenhill**	**Completed**

Meeting Date: 27 April 2017 (Extraordinary Meeting)		
274. Cambridgeshire Better Care Fund Planning 2017-19	To put Cllr Ellington in touch with someone to discuss the timely collection of health service equipment which was no longer required. **Action: C Black** **UPDATE 26.06.17**: The Service Development Manager at Cambridgeshire County Council will contact Cllr Ellington direct.	**Completed**
274. Cambridgeshire Better Care Fund Planning 2017-19	To follow up with Cllr Ellington her observation that a change in personnel on a ward at Addenbrookes Hospital had resulted in a noticeable change in onward referral rates. **Action: J Bawden** **UPDATE 02.06.17**: Cllr Ellington's feedback passed on to the CCG Urgent Care Team who sent it to Cambridge University Hospitals NHS Foundation Trust.	**Completed**

Agenda Item No: 7

SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT 2016/17

To: **Health and Wellbeing Board**

Date: **6th July 2017**

From: **Russell Wate, Independent Chair**

Recommendation: **The Health and Wellbeing Board is invited to:**

1. **Comment on the content of the covering report and the Cambridgeshire Safeguarding Adults Board Annual Report 2016/17;**

2. **Ask the Independent Chair to present the next Annual Report (for 2017/18) at a Health and Wellbeing Board meeting in 2018.**

	Officer contact:
Name:	Claire Bruin
Post:	Service Director Adult Social Care
Email:	Claire.Bruin@cambridgeshire.gov.uk
Tel:	01223 715665

1.0 PURPOSE

1.1 To present the Cambridgeshire Safeguarding Adults Board Annual Report for 2016/17.

2.0 BACKGROUND

2.1 The Care Act 2014 (enacted in April 2015) introduced the statutory duty on Local Authorities, Clinical Commissioning Groups and the Constabulary to operate a Safeguarding Adults Board (SAB) to promote and oversee the protection of adults with care and support needs from abuse and/or neglect.
Cambridgeshire has a well-established SAB with strong commitment from the Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG) and police and other key partners and we have continued to build on this collaborative approach during 2016/17.

2.2 The Draft Annual Report (Appendix A) provides a background to adult safeguarding work in Cambridgeshire and a summary of the work undertaken by the Safeguarding Adults Board (SAB), Adult Safeguarding Team and partners. N.B. The Draft Annual Report will be presented to the SAB for approval on 27 June 2017. Confirmation of that approval will be provided verbally at the Health and Wellbeing Board (HWB) Board meeting on 6 July 2016.

3.0 PROGRESS ON PRIORITIES IN 2016/17

3.1 The report to the Health and Wellbeing Board in September 2016 identified a number of priority areas of work for the SAB in 2016/17. An update on each of these priorities is provided below.

3.2 *Embedding the practice of Making Safeguarding Personal (MSP) across all organisations involved in safeguarding. Use feedback from a "Temperature Check" commissioned by Association of Directors of Adult Social Services (ADASS) and due out in the Autumn 2016 to focus further development of MSP practice.*

3.2.1 For information, MSP is an initiative developed by ADASS and the Local Government Association prior to the Care Act 2014 to promote a person centred approach to safeguarding. MSP is referred to in the Department of Health guidance for the Care Act 2014 (link below). The guidance recognises that safeguarding arrangements are there to protect individuals and that people "…..all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised." The guidance goes on to say that "Making Safeguarding Personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in

a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety." https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

3.3 Building on experience since the implementation of the Care Act in April 2015, all safeguarding courses delivered by the Cambridgeshire County Council Safeguarding Adults Team were updated in 2016/17 to strengthen compliance with the Care Act 2014, and in particular, the focus on MSP. This work informed a new Training Programme that was launched on March 2017, with MSP Training being the prerequisite to all other safeguarding training courses.

3.4 Following the feedback from the national "Temperature Check", the Eastern Region of ADASS agreed to commission a regional report to provide more detailed feedback and recommendations for action. This report and the recommendations will be considered fully at the SAB meeting in June 2017 and will inform the work required to continue to embed the practice of MSP across Cambridgeshire.

3.5 *Embedding the Multi-agency Safeguarding Hub (MASH) arrangements and understanding the impact on numbers of safeguarding referrals being passed to locality teams. Explore why cases that are not safeguarding are passed to the MASH and provide guidance as necessary to other organisations.*

3.6 The adults' team in the MASH has been operating since April 2016, providing a consistent approach to all safeguarding adult concerns, liaising with the Police and other agencies as necessary, and advising the next steps in responding to the concerns.

3.7 Data collected from April 2016 to January 2017 showed that 30% of cases were referred to long-term care teams for general case work and a further 12% of cases being passed to teams to carry out a Section 42 enquiry, as required under the Care Act 2014. Approximately 60% of the concerns coming into the Adults MASH were being handled by the MASH team rather than being dealt with within the long-term care teams freeing up capacity in these teams to focus on the more complex safeguarding cases and assessment and review work for people who require support from the long-term care teams.

3.8 *Confirm the appointment of an independent chair for the SAB. Review the operation of the SAB with the new chair.*

3.9 Russell Wate was confirmed as the Independent Chair for the Cambridgeshire SAB in September 2016. Russell's appointment has brought together the chairmanship of the SABs for Cambridgeshire and

Peterborough and the Local Safeguarding Children's Boards for both local authority areas. This arrangement supports closer collaboration across the Cambridgeshire and Peterborough locality which mirrors the area covered by key partners including the Constabulary and Cambridgeshire and Peterborough Clinical Commissioning Group. A joint business unit is being established to support Russell in the work of all four boards.

3.10 *Develop the joint working arrangements across SAB subgroups with Peterborough colleagues, including agreement on joint procedures.*

3.11 Joint arrangements were established across SAB subgroups with Peterborough colleagues during 2016/17 and work has progressed on developing joint procedures. The development of the joint business unit will support the collaborative work of subgroups going forward.

3.12 *Review dataset of information that allows effective monitoring of safeguarding activity and outcomes, doing in depth data and trend analysis.*

3.13 This work was been postponed until 2017/18 to allow the data from the MASH and the new recording requirements introduced by the Care Act around the person's desired outcomes to be fully considered in this work.

4.0 Safeguarding Activity in 2016/17

4.1 The Annual Report provides information and commentary on the safeguarding activity relating to 21016/17. The headlines are provided below.

4.2 The number of incidents referred to the Council has reduced this year from 1499 in 2015/6 to 1272 in 2016/17.

4.3 The most commonly reported type of abuse continues to be physical abuse (33%) although this has reduced from 42% of referrals in 2015/16.

4.4 Neglect, which has been given greater prominence through the Care Act 2014 has increased from 24% in 2015/16 to 30%.

4.5 New reporting has been introduced regarding alleged perpetrator that shows that most abuse/neglect occurs by people known to the adult, followed by service provider. The category of "known to individual" would include situations between residents in care homes that cater for people who present behaviours that can challenge, specifically people with

dementia, mental health issues and learning disabilities. This group was the most prevalent in the way that information was collected in previous years.

4.6 The Care Act 2014 changed the reporting regarding the outcome of safeguarding enquiries, so rather than collect whether a safeguarding allegation has been substantiated or not, we record whether the actions taken in response to the allegation has led to the following:
• Risk reduced
• Risk remains
• Risk removed
• No action taken under safeguarding
In the majority of cases (58%), the risk was reduced, with a smaller numbers where the risk was removed (17%) or where the risk still remains (10%). This emphasises the importance of working with the person to agree the personal outcome that they want from the safeguarding intervention and the follow up that will be required to minimise the impact of remaining or reduced risks.

5.0 Priorities for 2017/18

5.1 The following priorities have been identified for 2017/18.

5.1.1 *Domestic Abuse [including Sexual Violence (SV), Female Genital Mutilation (FGM), Honour based violence (HBV), Forced Marriage (M), across all genders] – To ensure that adults at risk of abuse and neglect are protected from all types of Domestic Abuse; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.*

5.1.2 *Neglect (including self-neglect and hoarding) – To ensure that adults, at risk of abuse and neglect, in all settings, are protected from neglect; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.*

5.1.3 *Adults living with mental illness - To ensure that adults at risk of abuse and neglect are protected, and that practitioners are skilled and trained appropriately to recognise changes in symptoms and behaviours that may indicate a deterioration in their mental health and that a change in care management/planning is required; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.*

5.2 In support of these priorities, work on embedding the practice of MSP across all organisations involved in safeguarding, will need to be informed by the report and recommendations from the “Temperature Check” commissioned by Eastern Region ADASS.

6.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

6.1 The work on safeguarding adults from abuse and neglect supports the implementation of the following priorities in the Cambridgeshire Health and Wellbeing Strategy:
Priority 2: Support older people to be independent, safe and well.
Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
Priority 6: Work together effectively

7.0 Sources

Source Documents	Location
The Care Act 2014	http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Cambridgeshire Safeguarding Adults Board

making a difference together

Annual Report

April 2016 – March 2017

Section		Page
	Index	2
1	Welcome from the Chair	3
2	Members of the Cambridgeshire Safeguarding Adults Board	4
3	Safeguarding Nationally	5
4	Analysis of Adult Safeguarding Referrals	7
5	Quality Assurance	15
6	Progress on priorities in 2015/16	18
7	Safeguarding Adults Team Training and Development	21
8	Deprivation of Liberty Safeguards (DoLS)	28
9	A word from some of our Partners	30
10	Further information	45

1. Welcome from the Chair

It is my pleasure to introduce the Cambridgesghire Safeguarding Adults Board's Annual report. The aim of the report is to capture the difference we made in 2016/17, set against the priorities we had identified in our business plan.

I am delighted to be the Board's first Independent Chair and would like to place formal thanks to both Adrian Loades and Claire Bruin from Cambridgeshire County Council for the great work that they have done in chairing and leading this board prior to myself. They were also incredibly ably supported by Caroline Webb.

The biggest challenge the board has had to face is dealing with the requirements, from the 1 April 2015, of the Care Act 2014. The guidance that the Government sent out has been tested during this time and as a result updated guidance was also issued in 2016, which has involved during this reporting year further changes to working practices in safeguarding.

As well as this, once again, our work over the year took place in an environment of organisational change and resource constraint across the whole partnership, in particular with the continuing reconfiguring of the Local Authority, health system and probation system.

Nevertheless, I think that we have made some considerable progress again this year, particularly around our monitoring and oversight of the quality of care within Cambridgeshire.

This year the board ran a "Domestic Abuse and Adult Safeguarding" conference, which over 120 delegates attended and there was good feedback from those that attended.

I realise there is much more to be done and we must strive to work with all of the organisations and providers of adult care in Cambridgeshire to make this a safe county to be a resident of, in particular when you are vulnerable and in need of care and protection.

We have maintained close links with both the Peterborough Safeguarding Adult Board and the Cambridgeshire Safeguarding Children Board in recognition of those organisations that deliver services to both children and adults and across the local authority boundaries. Both the Adult Boards now have a Joint Executive Board and this will set and monitor the business priorities going forward in 2017-18. A number of the sub-groups are now joint one's as well.

There are many challenges to do this and the board are striving hard to work on improving how we do this, through writing policies, guidance and improving frontline practice, with a full and challenging training programme.

The frontline staff and their managers from local agencies need particular mention for their commitment to safeguarding adults in Cambridgeshire.

This annual report provides a background to adult safeguarding work in Cambridgeshire and a summary of the work undertaken by the Safeguarding Adults Board (SAB), the sub groups, the Adult Safeguarding Team and partners with insight into local issues. It showcases the developments and initiatives pertaining to safeguarding that have taken place during April 2016 to March 2017.

In doing so, it aims to provide a level of assurance that the organisation is fulfilling its statutory duties and responsibilities for safeguarding adults in Cambridgeshire.

The underpinning message however remains the same in that safeguarding is everyone's business irrespective of role or position. It is everyone's responsibility to safeguard and protect the most vulnerable adults in our society. The adult at risk must remain at the centre of all our actions.

Dr Russell Wate QPM
Independent Chair

2. Members of the Cambridgeshire Safeguarding Adults Board

Chairperson: Russell Wate – Independent Chair

Representatives from:

Addenbrookes Hospital, Cambridge University Hospital NHS Foundation Trust

Adult Safeguarding Team, Cambridgeshire County Council (CCC)

Adult Social Care, CCC

Age UK Cambridgeshire

Cambridge Regional College

Cambridgeshire and Peterborough NHS Foundation Trust

Cambridgeshire Community Services NHS Trust

Cambridgeshire Constabulary

Cambridgeshire Fire & Rescue Service

Care Quality Commission

Children Safeguarding and Standards Unit, CCC

Community Network Representatives

County Councillor, CCC

Healthwatch Cambridgeshire

Hinchingbrooke Health Care NHS Trust

Mental Capacity/Deprivation of Liberty Safeguards Team, CCC

National Probation Service - Cambridgeshire

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

Papworth Hospital NHS Foundation Trust

South Cambridgeshire District Council representing District Councils across Cambridgeshire

3. Safeguarding Nationally

During 2016/17 there was a strong focus by the Association of Directors of Social Services (ADASS) on understanding how well Making Safeguarding Personal (MSP) was being embedded in practice within local authorities and the organisations that they work with to safeguard people. The principles underpinning safeguarding in the Care Act 2014 (set out below) support MSP which was an initiative developed by ADASS and the Local Government Association prior to the Care Act 2014.

Empowerment: People being supported and encouraged to make their own decisions and informed consent. *"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."*

Prevention: It is better to take action before harm occurs. *"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."*

Proportionality: The least intrusive response appropriate to the risk presented. *"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."*

Protection: Support and representation for those in greatest need. *"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."*

Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. *"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."*

Accountability: Accountability and transparency in delivering safeguarding. *"I understand the role of everyone involved in my life and so do they."*

MSP, which is referred to in the Department of Health guidance for the Care Act 2014, (link below) recognises that safeguarding arrangements are there to protect individuals and that people "…..all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised." The guidance goes on to say that "Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety."

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

In developing the MSP approach, ADASS and the Local Government Association (LGA) developed a range of resources to support implementation that can be found at https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/making-safeguarding-personal

To understand the progress in implementing MSP, ADASS commissioned a 'temperature check' across 76% of local authorities. Through interviews with Safeguarding Leads in each authority, this work covered the impact on people experiencing safeguarding, staff and practice; recording systems, evaluation of outcomes and performance monitoring; strengths and good practice; barriers to implementation and what is needed to overcome them; and level of partner organisations' commitment to MSP.

The results indicated that the majority of local authorities had completed the first steps to implementing MSP i.e. staff were trained in the approach and systems modified and were progressing with embedding person centred work in their practice and culture. There was less progress in engaging partner organisations beyond gaining agreement that MSP was a good approach.

The report provided a set of recommendations at national, regional and local level to support local authorities on the journey to make safeguarding truly person centred and can be found at the link below.

https://www.adass.org.uk/making-safeguarding-personal-temperature-check-2016

Following this report, the local ADASS Eastern Region Group commissioned a further report to bring together the 'temperature check' information for all 11 local authorities in the Region. This report has provided a comprehensive set of recommendations that the Cambridgeshire Safeguarding Adults Board will be considering in June 2017 and using to guide current and future work to fully embed MSP as our approach to safeguarding adults.

The ADASS Safeguarding Adults Policy Network with membership from each Region is continuing to prioritise the implementation of MSP in its work for 2017/18, with further resources being developed to support local authorities and Safeguarding Adult Boards in this work.

The Policy Network will also be working on three other key areas:

- prevention and safeguarding with a focus on social isolation and how addressing this can contribute to keeping people safe from harm
- quality and safeguarding, focusing on quality of care and support delivered by providers and how to recognise and respond to quality issues early, that might otherwise lead to safeguarding issues
- support the development of a library for Safeguarding Adult Reviews (SARs) being led by SCIE (Social Care Institute for Excellence)and RiPfA (Research into Practice for Adults) that will offer a way for Safeguarding Adult Boards and local authorities and partner organisations to search SARs for specific themes and take the learning from these.

The Cambridgeshire Safeguarding Adults Board will be able to benefit from the work of the ADASS Safeguarding Adults Policy Network and any linked worked undertaken through the Eastern Region ADASS Safeguarding Network through representation at these groups.

4. Analysis of Adult Safeguarding Referrals

Table 1: Number of incidents received per year

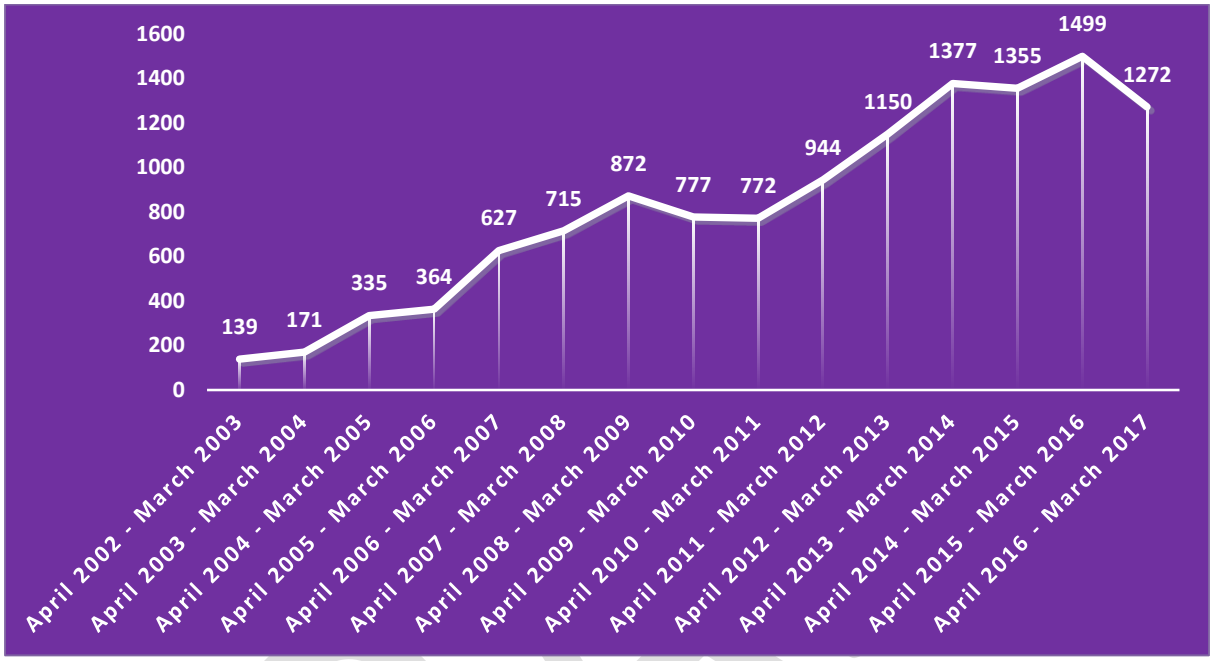


Table 1 indicates the number of safeguarding referrals made in Cambridgeshire from April 2002 through to March 2017.

Despite the rise in referrals the previous year, the number of incidents received between April 2016 and March 2017 has showed a decrease of 227 referrals, equating to a 15% decrease from the previous year.

Since April 2016 all adult safeguarding referrals, excluding adult mental health referrals, have been through the Multi-Agency Safeguarding Hub (MASH) and the reduction is likely to be as a result of a consistent approach to concerns received and appropriate signposting where a Section 42 enquiry is not the most appropriate option.

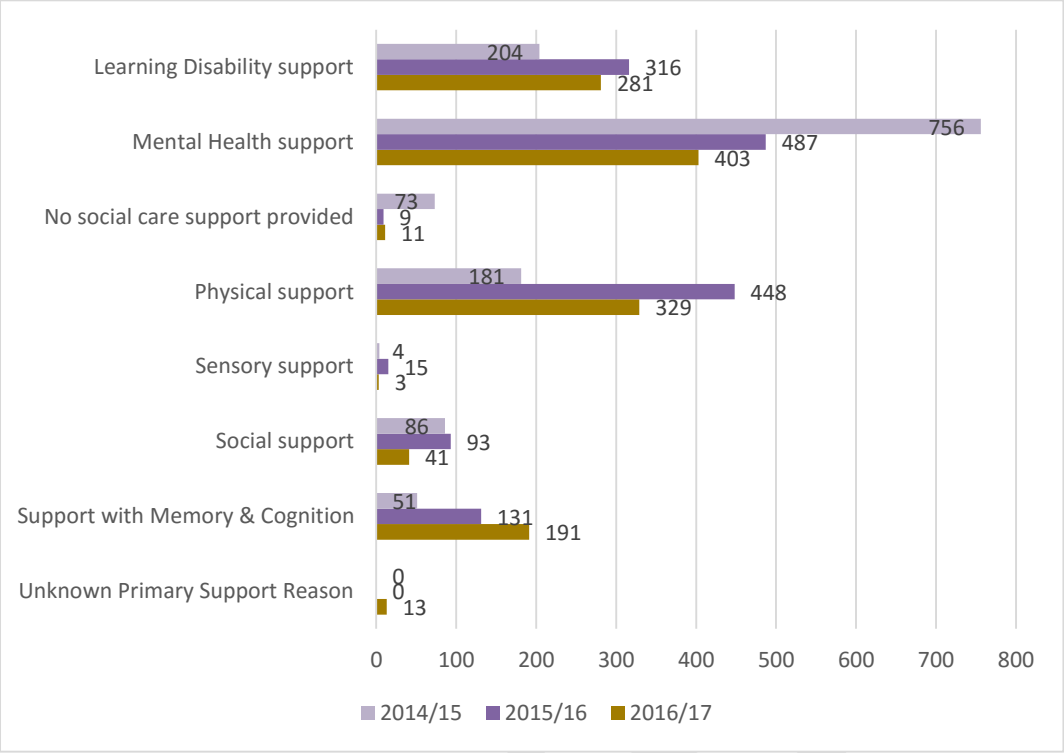
Table 2: Types of Abuse

	2014-2015	2015-2016	2016-17	Trend
Discriminatory Abuse	0%	0%	1%	
Domestic Violence	-	6%	6%	
Emotional/ Psychological Abuse	13%	10%	8%	
Financial Abuse	9%	9%	12%	
Neglect and/or Acts of Omission	22%	24%	30%	
Modern Slavery	-	0%	0% (1 case)	
Organisational Abuse	2%	2%	3%	
Physical Abuse	48%	42%	33%	
Self Neglect	-	3%	2%	
Sexual Abuse	6%	4%	5%	
Sexual Exploitation	-	0% (5 cases)	0% (6 cases)	

The most commonly reported type of abuse continues to be physical abuse at 33% although this has showed a downward trend over the past two years with a significant decrease since 2014-2015 when physical abuse was nearly 50% of all the types of abuse that was reported. There is no clear rationale for this although domestic violence is now recorded as a separate category of abuse and many of the previous physical abuse cases will now be reported under domestic violence. Self-neglect is also a category that was not used in 2014-2015 although it is not clear that this would impact on the physical abuse category.

Domestic violence is at 6%, this is a category that has only been monitored as a category in its own right since 2015 and it is possible that these are under reported and domestic abuse may continue to be categorised by the workforce as physical abuse, neglect or emotional/psychological abuse. There is a risk that the 6% does not accurately capture the level of domestic abuse in Adults at Risk and work is required to ensure this is captured correctly.

Table 3: Client category

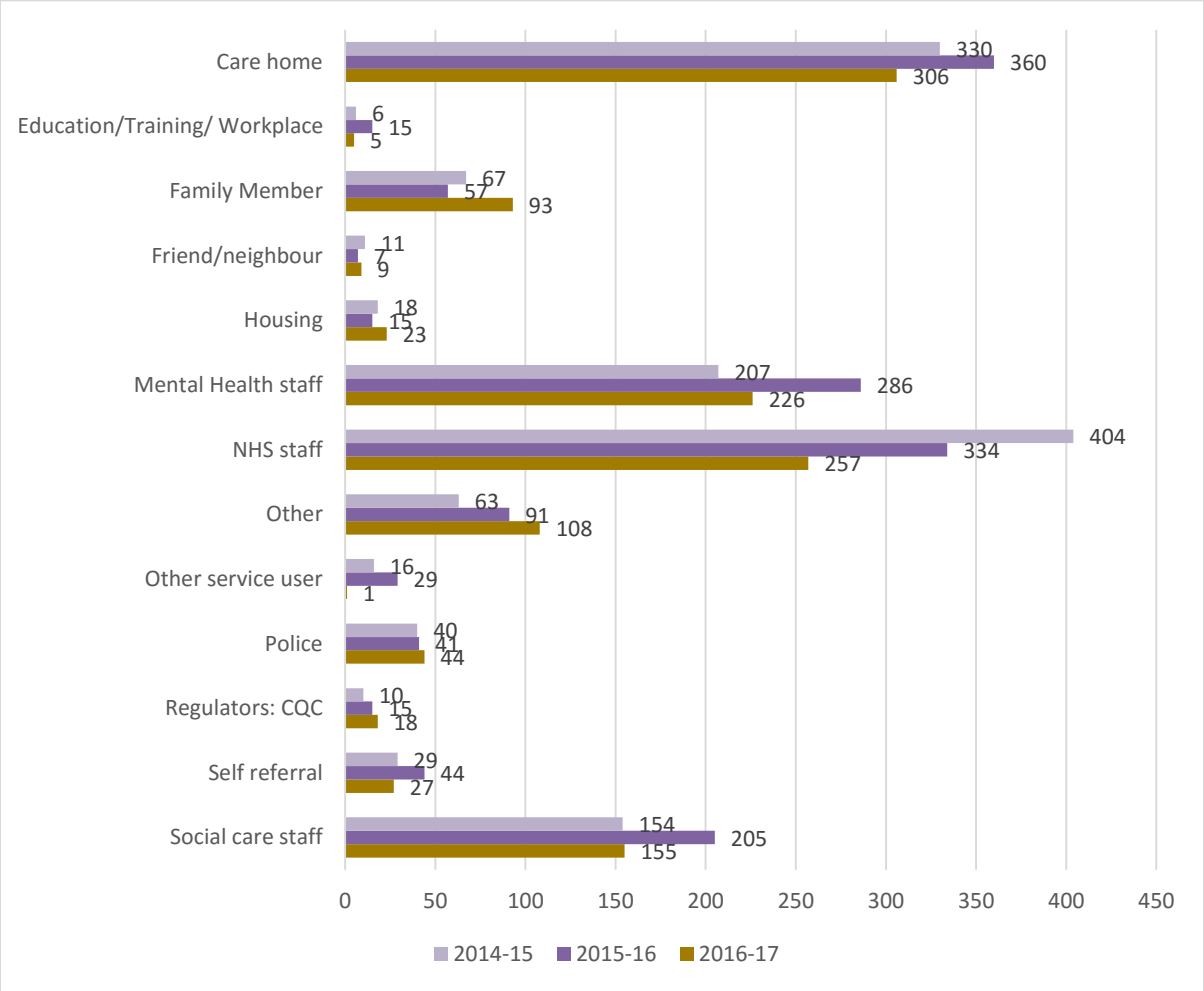


This table shows the 'client category' where there has been a Section 42 enquiry.

This data shows a further decline in Section 42 enquiries for adults who receive mental health support, a decline of 33.5%. There is no clear rationale for this and a piece of work should be completed to ensure that where adults are in need of mental health support, abuse is recognised and reported in the same way as other adults at risk. Currently this group of people are the only group not going through the MASH and action needs to be taken to ensure a consistent approach across all client groups.

Whilst adults who require support due to a memory or cognitive condition has risen over the past 3 years there is still a considerable lower number of Section 42 enquiries than for adults who require support due to a physical condition. It is important to understand whether there is any risk that adults who have cognitive difficulties are less able to report and therefore is there a gap?

Table 4: Source of referral

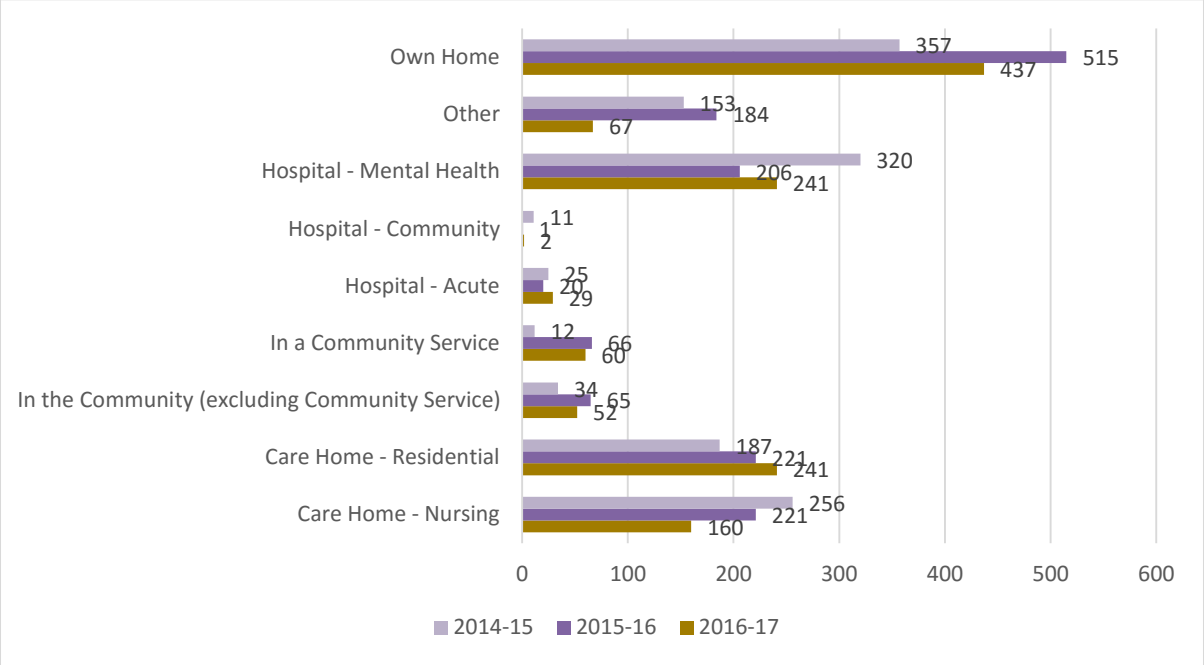


The number of care homes who are referring through for a safeguarding enquiry has reduced over the past 12 months. This may be attributable to the MASH and a consistent message being delivered to care homes about what constitutes a safeguarding concern.

There is also the possibility that with the implementation of Making Safeguarding Personal, adults at risk are requesting that other routes are taken to address concerns rather than the formal safeguarding process. It is essential that providers are clear on the Making Safeguarding Personal Principles and how the outcome of the adult is heard whilst ensuring that others are not at risk and safeguarding referrals are still made.

There has been a decrease of referrals from NHS staff from 404 to 257 in the past 3 years, equating to 36.4% and there is no obvious rationale for this. On the surface this would appear concerning and raise questions about whether referrals are being missed, however, unless this information is broken down further it is difficult to make assumptions about this and clarify whether there is a concern or where anything needs to be done.

Table 5: Number of incidents at each location

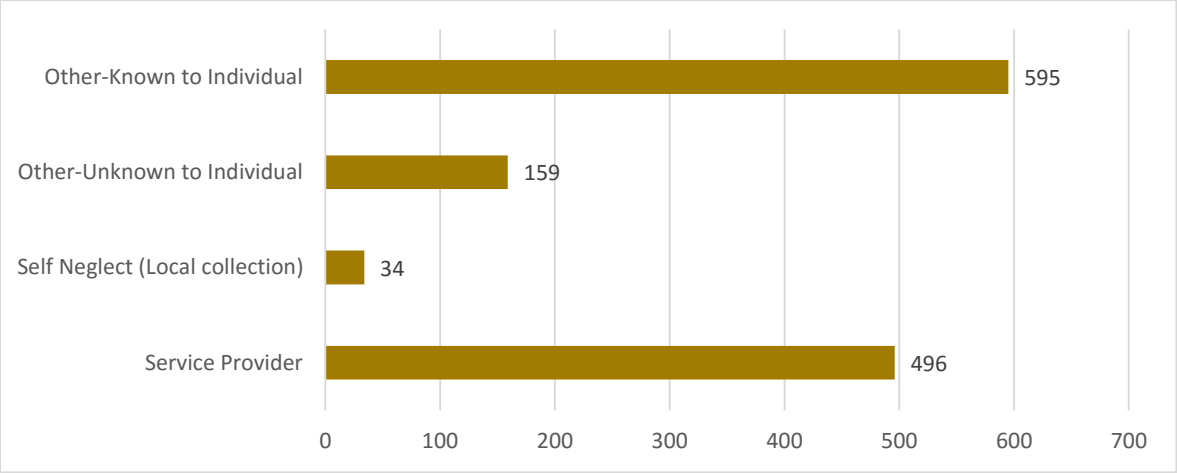


The number of safeguarding incidents within an acute hospital setting in the past three years is less than 30 each year. Within Cambridgeshire there are 2 acute hospitals, with a total of 1223 beds, therefore less than 30 Section 42 enquiries seems relatively low. However, the bigger hospital carries out specialist work for patients from outside of Cambridgeshire and therefore any safeguarding work for those patients would not be captured within this report.

It would be helpful to understand this data further and explore with acute hospital colleagues if there is a need for further training for staff particularly in the context of the recognition of domestic violence, coercive control, female genital mutilation and modern slavery within safeguarding under the Care Act 2014. Hospital staff may be well placed to identify signs of these types of abuse.

Incidents within care homes have increased consistently over the past three years and this may be as a result of a greater awareness of reporting, however the number of incidents increasing does not reconcile with the reduction in the number of care home referrals. Further work would need to be completed to understand this.

Table 6: Alleged perpetrators – 2016-2017



Due to a change in the way that safeguarding information is being collected in the "alleged perpetrators" category we are only able to show one years' worth of data, the preceding years are below.

The alleged perpetrator information indicates that more abuse occurs by people known to the adult rather than unknown. However it is not clear where the perpetrator is known to the adult what the relationship is, friends and family, people who access the same services or potentially other social contacts.

It would be helpful to understand the alleged perpetrator group in correlation with the abuse type in order to look at whether there are gaps in the market for services that may reduce risks. For example, you would assume that where the alleged perpetrator is the Service Provider the majority of this would fall into "neglect/acts of omission", whereas when the perpetrator is known to the individual it is more likely to be associated with domestic abuse. This further analysis may be useful when considering services to perpetrators and also highlighting training needs across the County.

7: Alleged perpetrators – 2015-2016

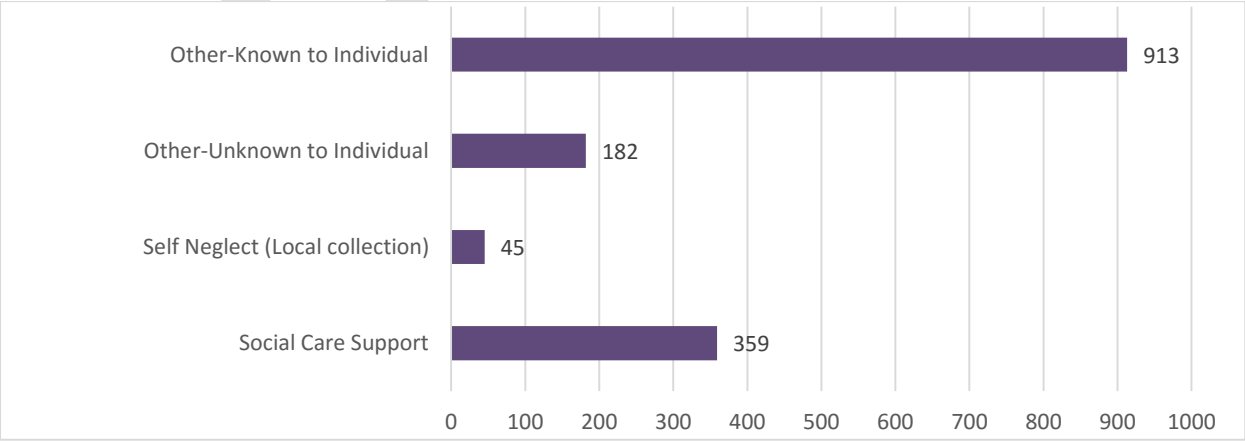
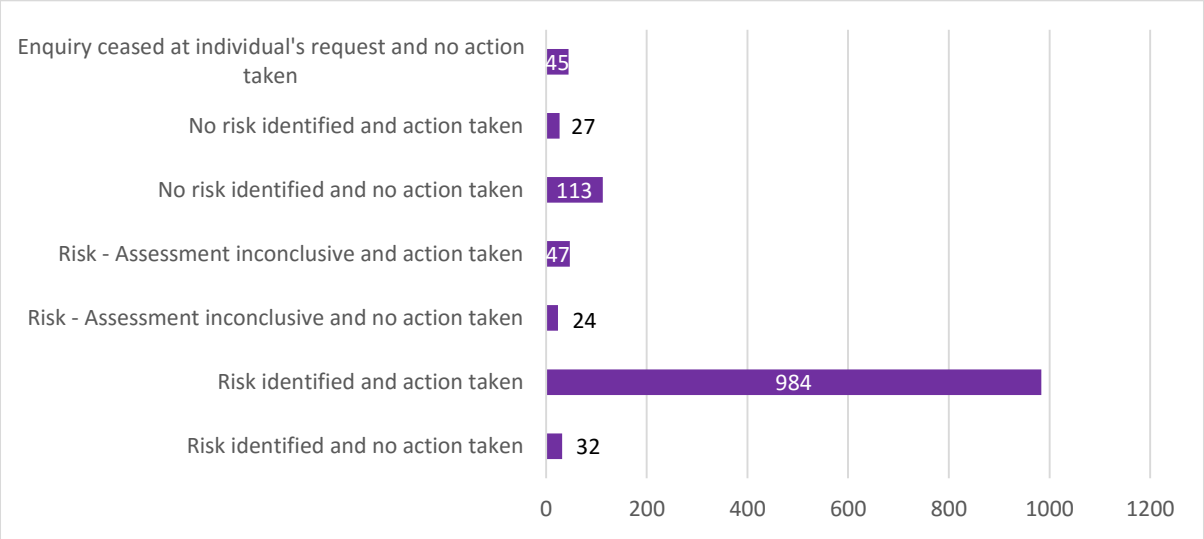


Table 8: Outcomes for victims, action taken

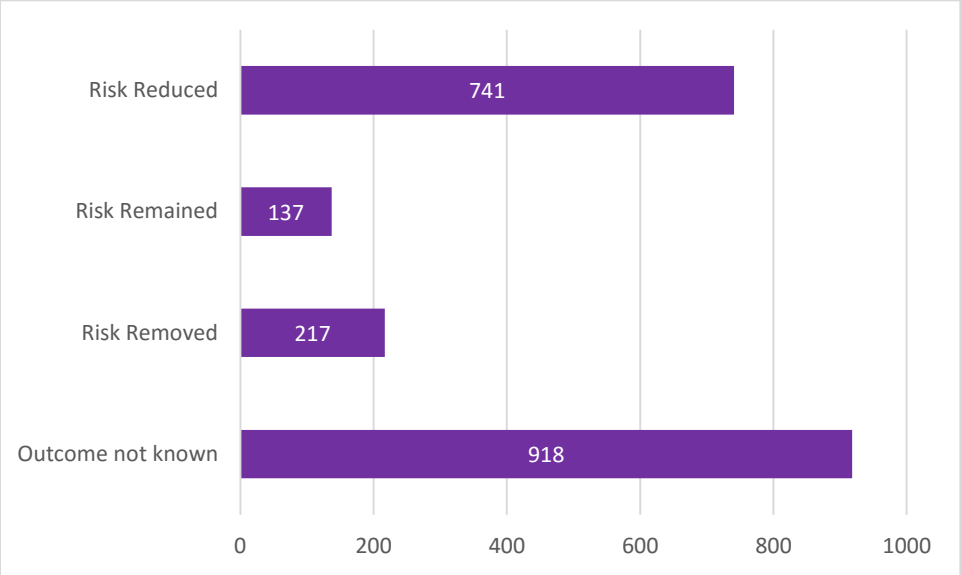


2016-2017 is the first year that the outcomes for victims has been recorded in this way and therefore it is not possible or helpful to compare with previous years as the information is different.

However, what can be seen from this data is that out of 1272 Section 42 enquiries only 113 were identified as no risk identified indicating that 91.12% of referrals taken to Section 42 enquiries were appropriate.

5% of cases were identified risks but no action taken, it could be assumed that the majority of these cases are because the adult at risk has capacity and has made a choice for no further action to be taken, in line with the Making Safeguarding Personal Principles. It is not clear if the no further action is also due to the perpetrator no longer being a risk.

Table 9: Outcomes for victims regarding ongoing Risks



918 cases were recorded as Outcome not known, it is essential that further training is carried out with the workforce to drastically reduce this number and establish what the outcome was regarding risk.

Out of 1272 safeguarding adult enquiries, this information shows that in 58% of enquiries the risk was reduced and in 10% of cases the full risk remained. It was only in 17% of cases that the risk was totally removed.

Safeguarding adults is complex and whilst there are now statutory duties to carry out enquiries there are still no powers for Adult Social Care to take action. Adults live complex lives. The disparity between the criminal threshold of "beyond reasonable doubt" and the safeguarding threshold of "the balance of probability" continues to be a cause of tension when trying to take action where abuse is occurring. Adults also have rights to make their own decisions and there are often very complex relationships involved between the perpetrator and the adult at risk.

Whilst the law has gone someway to try to support safeguarding over recent years the only way to truly reduce risks to adults at risk is to work with them in a way that empowers them to take action themselves. The knowledge and skills that professionals have around Systems Theory, Attachment Theory and carrying out some Solution Focussed work should not be underestimated and with an increase in this practice and working across agencies maybe then the risk removed data will increase and be higher than 17%.

5. Quality Assurance

Monitoring quality in practice in safeguarding adults was a key priority for the Board in 2015-16. Safeguarding practice has been included on the framework shaping our future: A Quality Assurance framework for Adult Social Care Practice.

The framework was developed in 2015-2016 and auditing to assure CCC social work practice began in a consistent way in April 2016 with Safeguarding being one of the 6 areas of practice which will be consistently audited. The 6 practice areas which are audited are:

- Assessment
- Care and Support
- Review
- Safeguarding
- Mental Capacity Assessments
- Case Recording

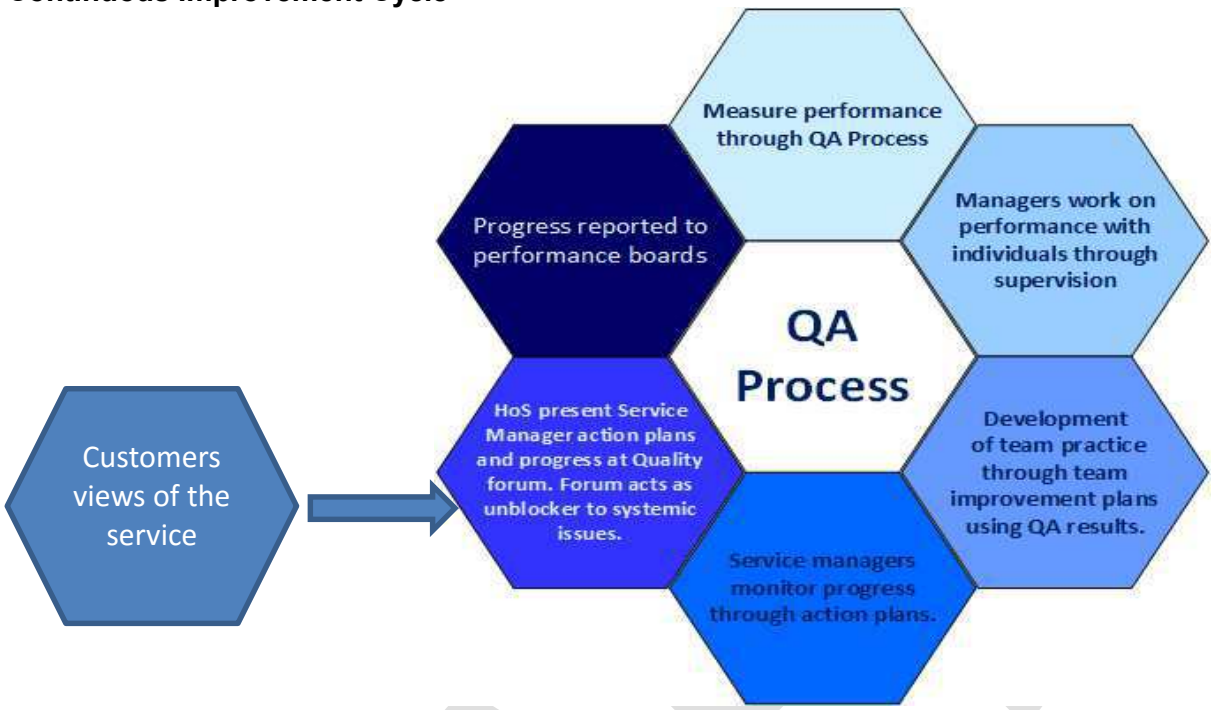
The expected standards of practice for each of the 6 areas are set out in the Quality Assurance (QA) case file audit toolkit as prompts for practitioners and managers. The toolkit was developed with practitioners and specialist teams within Adult Social Care (ASC). The safeguarding standards of practice were written by the Safeguarding Team ensuring we meet our legal duties and the experience of people who use the service is of a standard we would expect. Making Safeguarding Personal is at the heart of the practice expected and measured in the case file audit.

The Process

The QA practice audit has now been implemented across ASC including mental health social work within Cambridgeshire & Peterborough NHS Foundation Trust. The following process is consistently applied across all social work teams and includes the work of Adult Support Coordinators.

- Case file reviews are carried out by supervising managers.
- Each practitioner has their practice audited once every three months.
- Measurement is by grading which reflects the Care Quality Commission (CQC) grading of quality these are *outstanding,* good, requires improvement and inadequate.
- Monthly reporting of the results of the audits is broken down by team and reported through the Performance Management portal which is presented to the Older People Mental Health Performance Board, ASC Performance Board, CPFT Integrated Service Committee and Adults Committee and Safeguarding Board.
- The results and analysis of performance inform the continuous improvement cycle as illustrated below. The areas of practice which are identified as requiring improvement are presented to the newly formed Transforming Lives and Practice Governance Project TLQGP (referred to below as the Quality Forum) where the actions to be taken are agreed and monitored. The TLQGP is chaired by Claire Bruin (Director for Adult Social Care) and take place on a monthly basis.
- The Continuous Improvement Cycle as detailed below shows how the information from the audit process is used ensuring we have the mechanism to improve practice and answer the “so what” question from the collection of the results.

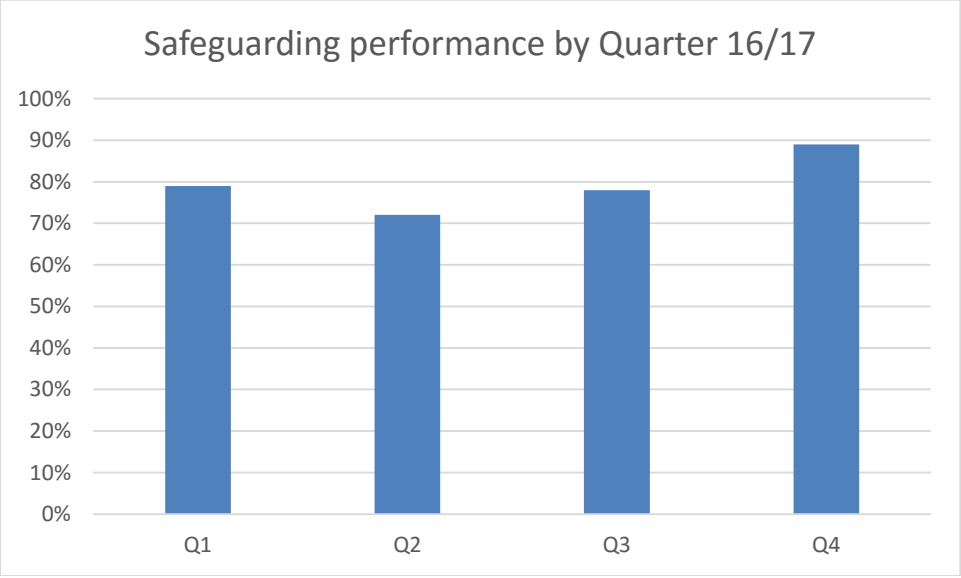
Continuous Improvement Cycle



Results of safeguarding audits

Safeguarding practice has improved as illustrated in the chart below from 79% in quarter 1 to 89% in quarter 4.

The figures represent audits graded as good or outstanding.



It is important to note the numbers of case file audits focusing on safeguarding was 63 cases in total over the year. This will increase as we target this practice area for case file audit over the year 17/18.

There is a clear divide between practitioners who produce excellent practice in this area and those where improvement is required. It maybe that practitioners who do not frequently undertake safeguarding work do not retain the learning in practice.

There is good evidence of Making Safeguarding Personal in the documentation seen by auditors. The challenge remains in evidencing what actions have been taken when a case is transferred from Multi Agency Safeguarding Hub (MASH) to the locality team for a Section 42 investigation.

MASH team are now carrying out case file audits.

Recommendations and Actions

- Practitioners Pathway has been revised to ensure practitioners are competent in all areas of practice including safeguarding. This work is led by work force development and has been informed by the results of the QA case file audit.

- Through a coaching approach to learning areas of excellent practice are shared within teams to improve practice across the team.

- Safeguarding practice is an area of priority for improvement for the TLPGP. The QA results are scrutinised by the project group. Each Head of Service is responsible for the action plans for improvement in their area supported by WFD and Quality Governance and Practice Development Teams.

- Individual practitioner's performance is managed by team managers where they are not meeting the required standard with individual improvement plans.

Next Steps – Thematic review
Safeguarding practice is an area of priority to quality assure through the thematic audit process and will be included in a themed audit this coming year.

Section 42 Enquiry practice is scheduled for an audit in July 2017 which will look at:

- Triage within the MASH process.
- Transfer to Long Term teams for Section 42 enquiry.
- Evidence of actions recorded as taken by the receiving team.
- Experience of the individual.

6. Progress on priorities in 2016/17

The report to the Health and Wellbeing Board in September 2016 identified a number of priority areas of work for the SAB in 2016/17. An update on each of these priorities is provided below.

Embedding the practice of MSP across all organisations involved in safeguarding. Use feedback from a "Temperature Check" commissioned by ADASS and due out in the Autumn 2016 to focus further development of MSP practice.

Building on experience since the implementation of the Care Act in April 2015, all safeguarding courses delivered by the CCC Safeguarding Adults Team were updated in 2016/17 to strengthen compliance with the Care Act 2014, and in particular, the focus on MSP. This work informed a new Training Programme that was launched on March 2017, with MSP Training being the prerequisite to all other safeguarding training courses.

Following the feedback from the national "Temperature Check", the Eastern Region of ADASS agreed to commission a regional report to provide more detailed feedback and recommendations for action. This report and the recommendations will be considered fully at the SAB meeting in June 2017 and will inform the work required to continue to embed the practice of MSP across Cambridgeshire.

Headline recommendations from the national "Temperature Check" for SABs are set out below, with comments about progress:

- Local organisations should improve ways of managing the increase in safeguarding alerts and referrals by considering integration of front doors either through MASH or a jointly staffed Single Point of Access.
    - MASH established in April 2016.
- Local organisations (Safeguarding Adults Boards) should develop a means of gaining a picture of what happens to safeguarding alerts that do not progress to a Section 42 enquiry.
    - Data collected in the MASH includes alerts that do not progress to a Section 42 enquiry.
- Directors of Adult Social Services should take stock of where their service stands on the road to full implementation of MSP and then reflect on their current plans using the evidence in this temperature check.
    - A stocktake across Cambridgeshire and Peterborough has collected information on the implementation of MSP.
- Adult Social Care departments should consider how they can get greater corporate council buy-in to MSP and ensure local authority councillors are aware of MSP and are supportive of the changes required to implement it, particularly the need to promote personal empowerment and positive risk management.
    - The principles of MSP have been included in formal reports to the CCC Adults Committee, linked to the development of the MASH.

- Local training commissioners should ensure that staff training providers review their materials to modify and update them according to evidence of effective practice and blockages in shifting the culture to embed MSP values.
    - Training provided by CCC Safeguarding Adults Team has been updated.
- All organisations and SABs need to do more to meaningfully engage service users in planning and shaping safeguarding services.
    - The Community Network Representatives on the SAB are involved in sub group work and have developed public material to raise awareness of abuse and actions that people can take.
- Statutory organisations should enhance prevention of abuse by building a pathway from alerts and referrals into voluntary and community assets for lower levels of safeguarding intervention.
    - The MASH has close links with the Adult Early Help Team that can signpost people to voluntary and community resources.
- Local adult social care and health commissioners need to work more closely with independent care providers to link and embed MSP into good service quality.
    - Training offered to independent care providers focuses on MSP.

Embedding the MASH arrangements and understanding the impact on numbers of safeguarding referrals being passed to locality teams. Explore why cases that are not safeguarding are passed to the MASH and provide guidance as necessary to other organisations.

The adults' team in the Multi-agency Safeguarding Hub (MASH) has been operating since April 2016, providing a consistent approach to all safeguarding adult concerns, liaising with the Police and other agencies as necessary, and advising the next steps in responding to the concerns.

Data collected from April 2016 to January 2017 showed that 30% of cases were referred to long-term care teams for general case work and a further 12% of cases being passed to teams to carry out a Section 42 enquiry, as required under the Care Act 2014. Approximately 60% of the concerns coming into the Adults MASH were being handled by the MASH team rather than being dealt with within the long-term care teams freeing up capacity in these teams to focus on the more complex safeguarding cases and assessment and review work for people who require support from the long-term care teams.

Confirm the appointment of an independent chair for the SAB. Review the operation of the SAB with the new chair.

Russell Wate was confirmed as the Independent Chair for the Cambridgeshire SAB in September 2016. Russell's appointment has brought together the chairmanship of the SABs for Cambridgeshire and Peterborough and the Local Safeguarding Children's Boards for both local authority areas. This arrangement supports closer collaboration across the Cambridgeshire and Peterborough locality which mirrors the area covered by key partners including the Constabulary and Cambridgeshire and Peterborough Clinical Commissioning

Group. A joint business unit is being established to support Russell in the work of all four boards.

Develop the joint working arrangements across SAB subgroups with Peterborough colleagues, including agreement on joint procedures.

Joint arrangements were established across SAB subgroups with Peterborough colleagues during 2016/17 and work has progressed on developing joint procedures. The development of the joint business unit will support the collaborative work of subgroups going forward.

Review dataset of information that allows effective monitoring of safeguarding activity and outcomes, doing in depth data and trend analysis.

This work has been postponed until 2017/18 to allow the data from the MASH and the new recording requirements introduced by the Care Act around the person's desired outcomes to be fully considered in this work.

Priorities for 2017/18

The following priorities have been identified for 2017/18.

- **Domestic Abuse** (including SV, FGM, HBV, FM, across all genders) – To ensure that adults at risk of abuse and neglect are protected from all types of Domestic Abuse; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.
- **Neglect** (including self-neglect and hoarding) – To ensure that adults, at risk of abuse and neglect, in all settings, are protected from neglect; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.
- **Adults living with mental illness** - To ensure that adults at risk of abuse and neglect are protected, and that practitioners are skilled and trained appropriately to recognise changes in symptoms and behaviours that may indicate a deterioration in their mental health and that a change in care management/planning is required; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal.

In support of these priorities, work on embedding the practice of MSP across all organisations involved in safeguarding, will need to be informed by the report and recommendations from the "Temperature Check" commissioned by Eastern Region ADASS.

7. Safeguarding Adults Team Training and Development

Introduction
The County Council's Safeguarding Adults Training Team offers training to our statutory partners and independent, private, voluntary and charitable organisations across Cambridgeshire.

A commitment towards improving the lives of adults at risk remains central to the work of the team, which is reflected in the changes that have been made during the past year and are planned for the coming year.

Staffing
The Safeguarding Adults Specialist Training Team is currently made up of two part-time trainers and a part time manager, supported by 1.5 administrators.

During the year the training manager and two training organisers left the team, resulting in a period of seven months from September to March 2017 with one part time trainer acting up as manager/trainer and one part time trainer (seconded). Since March 2017, one new part-time trainer has been recruited and the seconded part time trainer has now accepted a permanent part time post.

Work completed during 2016 – 2017
Core objectives for the team for the year have built on the targets set in the Training Teams Care Act Action Plan, June 2015. The Action Plan was updated June 2016 to have a clear definition of tasks required, which included a complete review and redesign of the range of courses and content of all courses, to ensure compliance with The Care Act 2014 and Cambridgeshire County Council Safeguarding Adults Procedures.

To be able to take a systematic approach to updating courses, as identified in the action plan, a framework, with SMART targets, was used by the team, whereby, every course was scrutinised and either radically updated or removed.

Main drivers for training courses from this year was to build on and meet the requirements of the Care Act and to keep in line with any updates identified by this legislation by providing practical guidance relating to the different types of abuse (including domestic abuse, self-neglect and modern slavery) and guidance on how to respond to concerns and how to evidence decisions made – with a central theme of Making Safeguarding Personal – the adult at risk is central throughout and involved in any safeguarding activity or decisions made. All course outcomes are aimed at meeting the learning needs of course attendees and ultimately appropriate responses for adults who may be at risk.

The joint training programme between the Safeguarding Adults Team and the Education Child Protection Service, which was developed last year, continued to be successful. There has been an increase in requests for bespoke Making Safeguarding Personal (MSP) training from other areas within the Education Sector e.g. Homerton/Cambridge University.

Partnership working continued with Anglia Ruskin University delivering the adult safeguarding modules within the BA/Masters Social Work programme.

An effective working relationship has continued with the Diocesan of Ely Safeguarding Officer to review their training and contribute towards updating knowledge of internal trainers on adult safeguarding. Similar work has now started with the Head of Safeguarding, Cambridgeshire Fire and Rescue.

Adult safeguarding training sessions have now been developed for informal or unpaid carers and volunteers.

The team continued to deliver a tailored adult safeguarding training service to specialist organisations such as the housing and homeless sector and responded to support requests from Section 42 Safeguarding Meetings, Care Quality Commission (CQC) and Contracts.

Course and Resource Development during 2016 to 2017
All safeguarding adults courses have been updated and are compliant with the Care Act and Making Safeguarding Personal. The new Training Programme was launched in March 2017, with Making Safeguarding Personal training being the prerequisite to all other training courses.

Due to the reduction in team members and current training taking priority, the development of the Modern Slavery and Discrimination course, Making Safeguarding Personal Advanced for the Independent Sector and Management Responsibilities for Safeguarding Lead Managers has been temporarily suspended. This development will continue once the team is back to full capacity.

A joint training programme has been developed with Workforce Development to provide both adults and children's safeguarding training. This is mandatory training aimed at all staff within the Children's, Families and Adults Social Care Directorate.

Bespoke training sessions for specific groups of people are constantly being developed to meet the needs of their client group. The Framework used to monitor the development and delivery of the training is still being used to maintain the quality and momentum of work required. There has been an increase in bespoke training requests in relation to last year.

An information guidance card is being developed to support the shortened adult safeguarding/MCA/DoLS training for GP Practices.

In conjunction with the Network Community Group, an Adult Safeguarding Newsletter and poster has been developed and launched.

This year has been a very busy one for the whole training team, with every team member being involved in updating materials and courses and in the organisation and delivery of courses, with constant reviewing, to ensure learning outcomes have been met.

Training Figures

- We have had an increase of 15% in attendees for all courses since 2015-2016, Training 2495 staff during 2016-2017.
- All courses directly link to the Training Strategy 2015-2018 and directly to the core principle of Making Safeguarding Personal.
- 10 different programmed courses are now provided via the Safeguarding Adults Training Programme, this does not include courses that are provided on a 'bespoke' basis for services. The courses can be found in the Safeguarding Training Programme launched in March 2017.
- In 72 separate sessions, 885 people from 22 Independent Sector providers, have received training via a bespoke in-house course. This was mainly for Making Safeguarding Personal Training.
- Taking into consideration all the development work during the past year and lack of staff in the team, this year has proved productive and positive for the team.
- GP Practice training was a shortened, summary version of the Making Safeguarding Personal course, mainly delivered by MCA and DoLS trainers. This has been provided to 268 health professionals across 16 different surgeries.

The team administrators also support the Mental Capacity Act and Deprivation of Liberty Safeguards Team with their training programme. These figures are not included in these statistics.

Table 1: People Attended All Courses

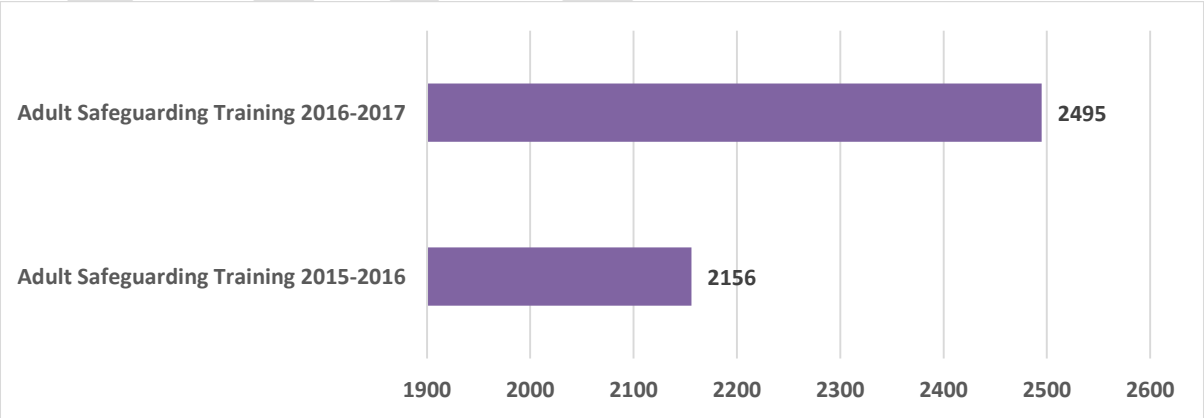


Table 2: Service/Sector Attendance (All Courses)

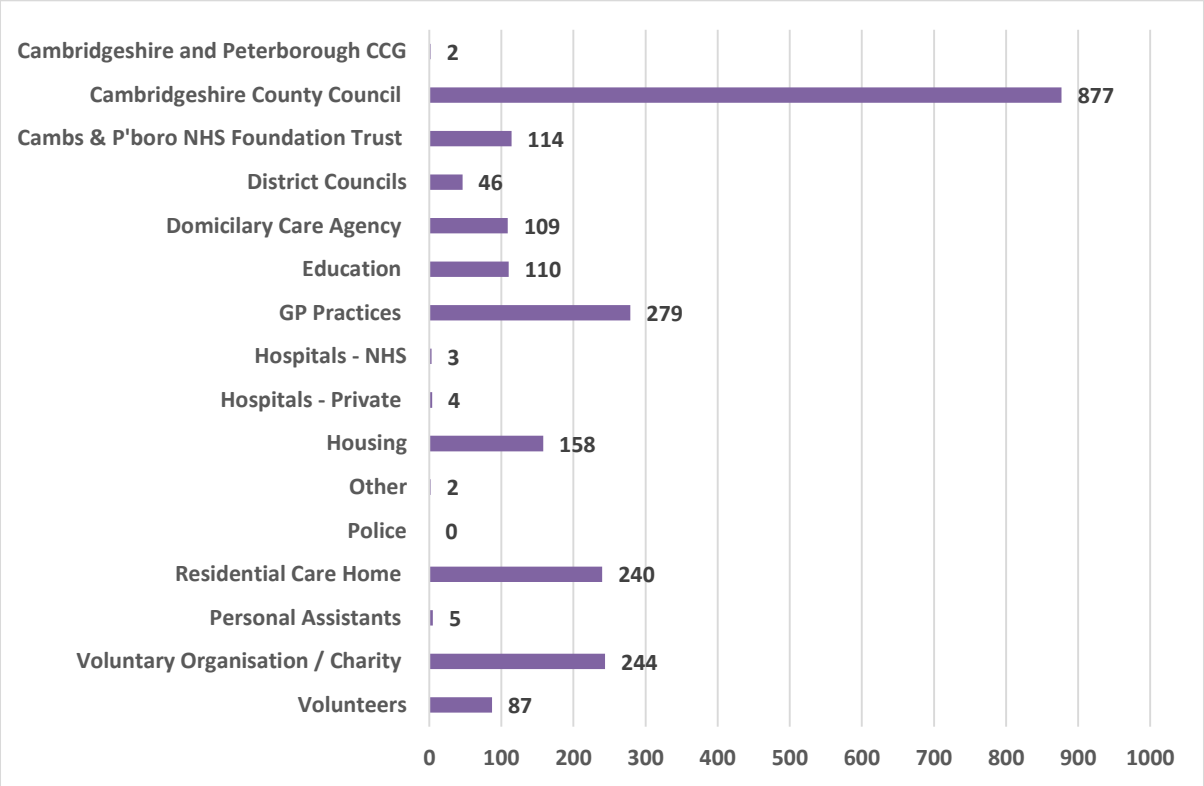


Table 3: Making Safeguarding Personal Sector Attendance

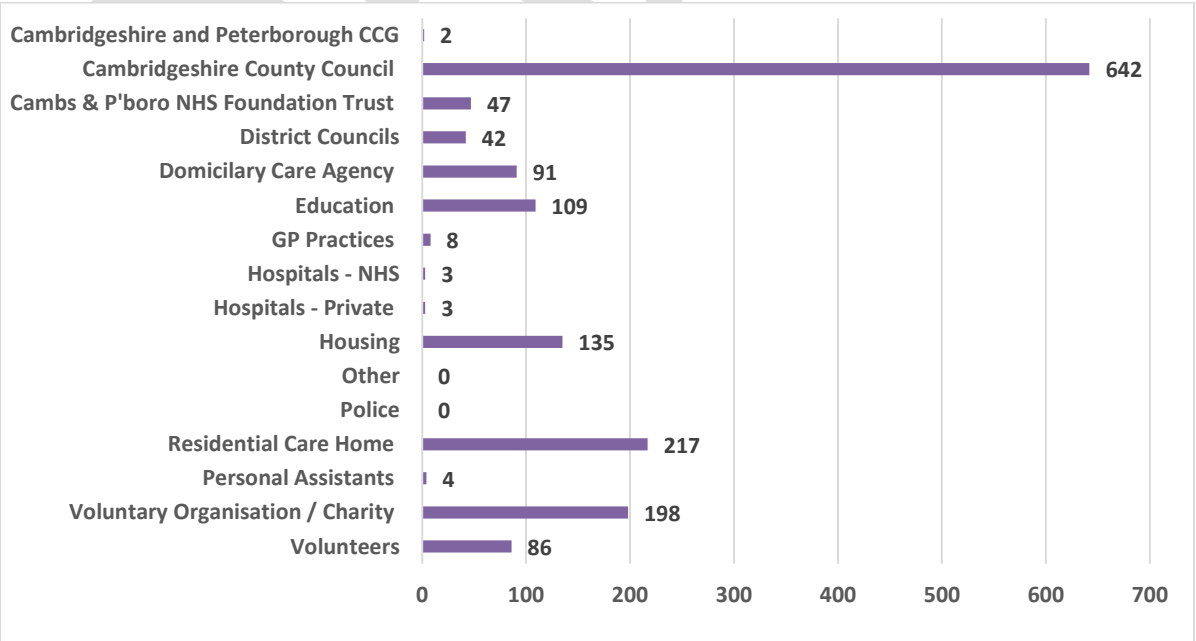


Table 4: Course Attendance by Course and Sector

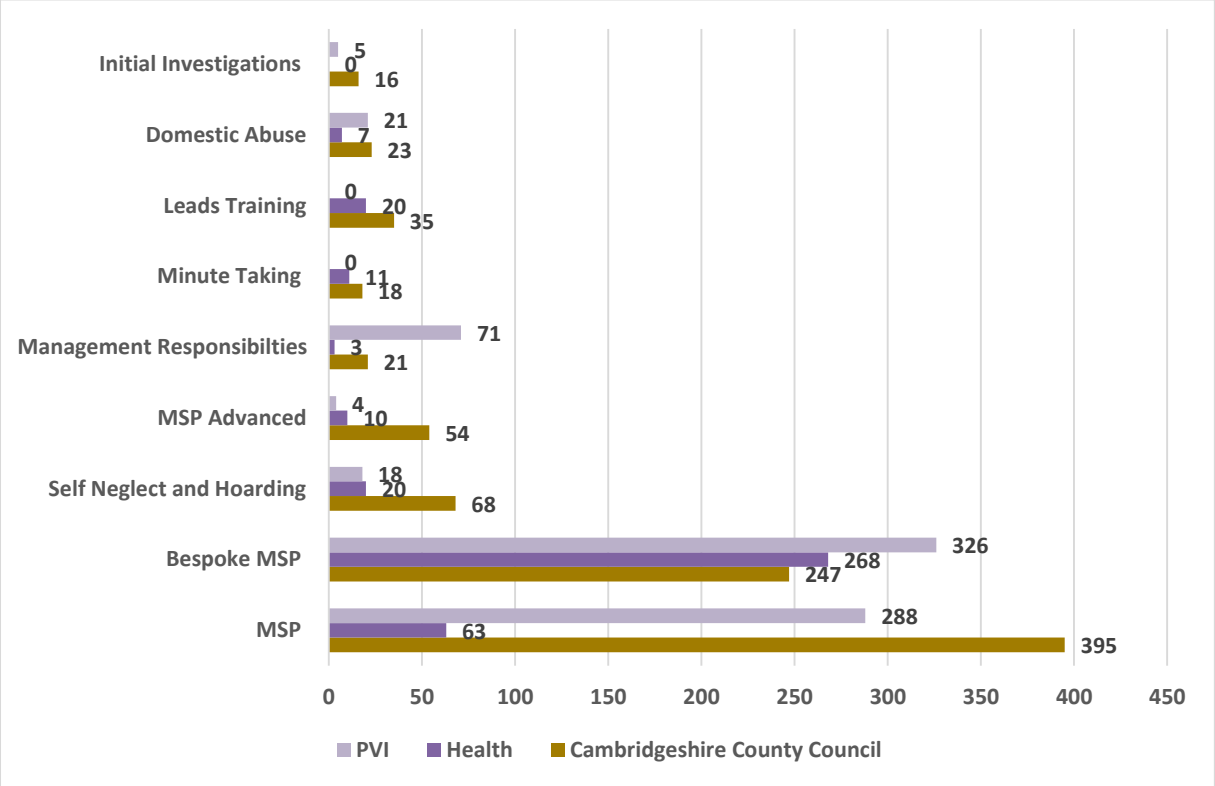
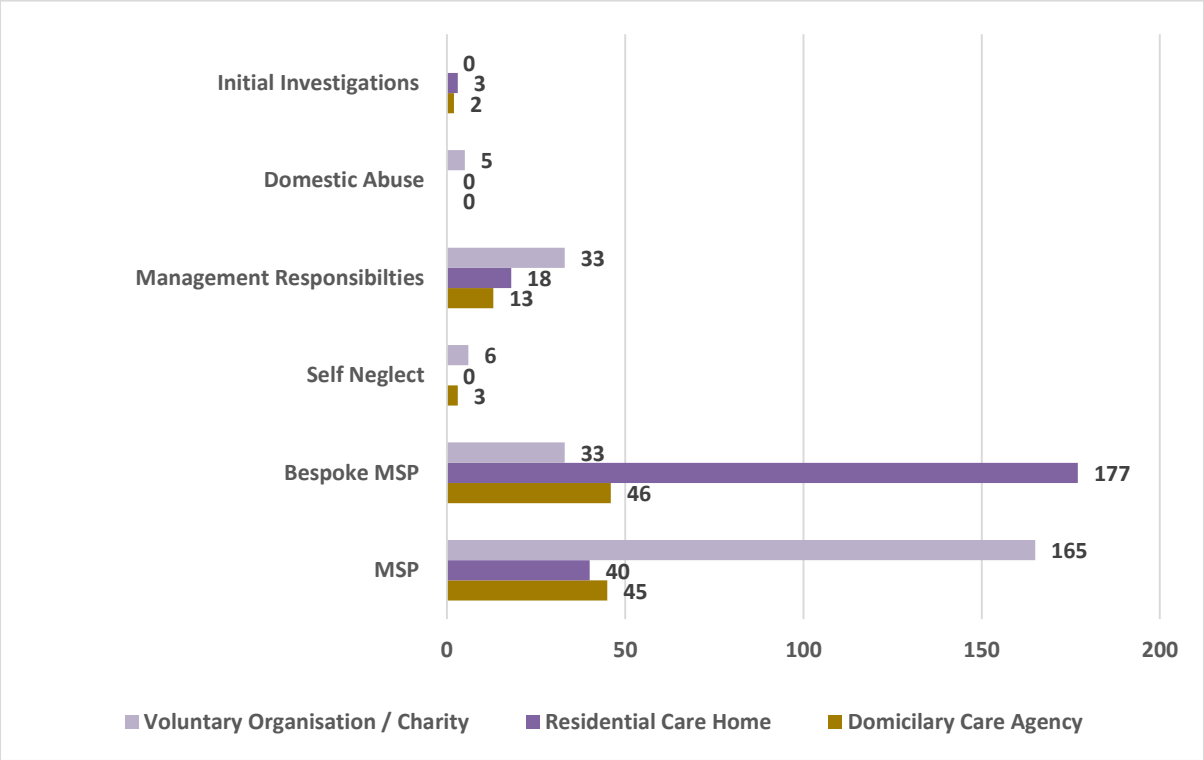


Table 5: Course Attendance for PVI Sector



Training evaluation comments

"Would recommend course and would like to attend further training facilitated by Christine. Great subject knowledge"
Management Responsibilities
12 December 2016

"Looking at how you put the person at the centre of safeguarding and it becoming less of a policy lead activity"

"I wasn't sure that this would be a relevant course but I found it very useful – particularly in re-examining what constitutes abuse"
Making Safeguarding Personal
15 December 2016

"Really enjoyed/understood training. Good mix of visual and group interaction"
Making Safeguarding Personal
Bespoke for Anglian Ruskin University – 27 October 2016

"Really enjoy my safeguarding courses. They are very comprehensive and upbeat. Thank you. A great team.
Self-Neglect and Hoarding
13 July 2016

"Most useful training course that I've done for a long time, really relevant and useful, huge confidence in Christine's knowledge, Thank you"
Management Responsibilities
11 October 2016

"I wish I could offer some help to promote this and bring it more to the public domain, as it's so important. I have learnt so much as well as having existing knowledge re-enforced. Thank you"
Domestic Abuse - 18 April 2016

Future work plan

- Referring to the Training Strategy, the Adult Safeguarding Training Team and the Safeguarding Adults Board Community Network Sub Group have developed two separate sessions specifically for service users and carers. These are now available and will be provided directly for adults with care and support needs and/or who may be at risk; and for informal carers of people who have needs for care and support. It is planned to run these with a member of the Adult Safeguarding Training Team with support from a member of the SAB Community Network Sub Group.
- To continue with the development of the Modern Slavery and Discrimination course, Making Safeguarding Personal Advanced for the Independent Sector and Management Responsibilities for Safeguarding Lead Managers.
- To continue to develop and deliver the Safeguarding Leads training and Development Days. To develop a competency framework to support and enable effective supervision of S42 Enquiry work for Safeguarding Leads.
- Bespoke in-service training has increased over the last year and is set to rise with requests being received. Bespoke training is adapted to meet the needs of particular services, or roles, to enhance practice with service users.
- To ensure continuity of the Safeguarding Adults Newsletter - the Community Network Sub Group are involved in its development and circulation.
- Core objectives for the team for the next year include providing all courses as described in the Training Strategy, to respond to the increased requests for in-service bespoke training and a review of attendance and outcomes.

In the coming year:

- All courses will be reviewed and updated as a collective, to ensure they meet the learning needs of attendees.
- All courses will be reviewed and updated to link to the updated joint Cambridgeshire and Peterborough SAB Safeguarding Adults Procedures and updated with any national guidance.
- To link and align the current training strategy with the updated procedures and national guidance and to develop a competency framework.
- To develop a Making Safeguarding Personal e-learning package in line with the updated procedures.
- To continue to develop the information guidance card to support the shortened adult safeguarding/MCA/DoLS training for GP practices.

8. Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguard (DoLS) is a statutory practice and administrative arrangement managed by Cambridgeshire County Council in its capacity as the Supervisory Body and through which a person can be lawfully deprived of his or her liberty when all six requirements are met.

As with most other Local Authorities in the country, we are continuing to face the challenge to manage the more than tenfold increase in applications for Standard Authorisations for DoLS following the Supreme Court's ruling back in March 2014.

The Policing and Crime Act 2017 (PCA 2017) makes a significant change to coroners' investigations into deaths in deprivation of liberty cases in that an inquest is no longer needed and we welcome this change.

We are also continuing with all of the actions as listed in last year's report and in particular, we will be updating our Action Plan in relation to administrative processes in managing referrals and signing off authorisations.

DoLS' activity April 2016 to March 2017

Month	Total No. of Applications	Assessment Completed and Withdrawn	Outstanding Waiting list
April 2015 to March 2016	**2078**	**684**	**1394**
Apr-16	116	85	1425
May-16	100	225	1300
Jun-16	113	210	1203
Jul-16	94	76	1221
Aug-16	107	115	1213
Sep-16	125	91	1247
Oct-16	115	103	1259
Nov-16	150	120	1289
Dec-16	134	114	1309
Jan-17	149	128	1330
Feb-17	160	101	1389
Mar-17	161	121	**1429**
Total	**1524**	**1489**	

Looking forward

In March this year, the Law Commission published their Draft Bill to change the legislation relating to Deprivation of Liberty with a name change to Liberty Protection Safeguards. With the sudden call for a General Election, we now await a response from the next government as to whether it will be introduced into Parliament for debates or not. However, it is important to note that with the current demand for Parliamentary time relating to BREXIT, it will be difficult to forecast when the legislation for DoLS be changed and we may need to contend with a few more years to come with the current legislation.

MCA Training and other developments

Over the past year the MCA and DoLS' Training and Development Team in collaboration with the Quality Governance and Practice Development team and the MCA/DoLS Operational Manager have delivered the following projects to improve practice in our Social Care workforce:

- New Practitioner Factsheets on the MCA DoLS for our Social Workers and Adult Support Co-ordinators to use as they apply the Care Act to their day to day practice.
- A quality assessment toolkit to evaluate how well the MCA & DoLS is being applied in practice in our Locality Teams.
- Updated the Supported Decision/Capacity Assessment Form ASC 1708 – and delivered bespoke training sessions to our workforce to learn how to use the assessment tool in practice.
- Agreement sought from the Transforming Lives/Care Act Project Board that all Adult Social Care Locality Teams to access a 1 day in house training session every year covering both the MCA and DoLS. The aim is to ensure all Social Workers, Locality Team Managers, Adult Support Coordinators and other registered professionals who work within Children, Families and Adults Services (CFA) remain up-to-date with the changing legal landscape of the MCA and DoLS and that practice will be improved in these areas of law. However, the take up of this training and mentoring opportunity which offered a more tailored & blended approach to learning has been slower than anticipated with many staff still attending our community courses which do not offer the opportunity to discuss and work through practice dilemmas. This will be addressed thorughout 2017/18.
- We have continued to deliver Re. X training to our workforce (applications to the Court of Protection for DoLS in the community).

Beyond our CCC social care workforce we have been as always delivering our community based training sessions for commissioned services. However, we are beginning to see an increase from Commissioned Services purchasing our training in house (often for senior & management staff) as they realise the benefits of the tailored and blended approach to learning and appreciate the time and effort our team take beyond the training day to offer mentoring and advice to help them apply the law to day to day practice.

The training and work we do across primary health in Cambridgeshire and Peterborough continues to grow, with many GP Practices having talks in their practice from our team on a yearly basis. We are also in the process of moving into phase 2 of training for the physical health workforce in CPFT, which will support community based therapists and nurses to apply the MCA to their day to day practice. In this sector we also this year had the launch of our online learning for Health Professionals which was supported by Medical Protection Society and endorsed by NHS England. Since the launch of our online learning, we have now received accreditation from the Royal College of GP's and we are in the process of getting accreditation from the Royal College of Nursing.

9. A word from some of our Partners

Addenbrooke's Hospital, Cambridge University Hospital NHS Foundation Trust

Addenbrooke's Hospital, part of Cambridge University Hospitals NHS Foundation Trust (CUH) has continued over the course of the last twelve months to implement our Trust Improvement Plan, devised following the Care Quality Commission inspection of 2015. Developed in collaboration with CUH staff from across the Trust, the plan has brought together a number of work streams designed to improve delivery and efficiency of services across selected priority areas.

Following the resignation of the Chairman to the Board of Directors in 2016, the Vice-Chair Dr Mike More stepped into the role as an interim measure before becoming the substantive post-holder in April 2017.

Completion of the new Papworth Hospital is now scheduled for less than a year's time. Moving into a purpose-built hospital will provide Papworth with the bespoke facilities required to continue the delivery of patient care at the forefront of heart and lung medicine. Whilst remaining clinically and organisationally autonomous, Papworth Foundation Trust will benefit from co-location with research and development facilities as well as the opportunity to work alongside health partners such as the School of Medicine, Addenbrooke's and the Rosie.

Governance and Accountability
The recent CQC inspection in September gave the Trust an overall rating of 'good' and again rated care as "outstanding". The report referred to an improvement in quality and safety and also referred to the revised governance systems now in place and ensuring that the CUH senior team has robust information upon which to make decisions.

As part of the overall review of internal governance mechanisms, the Trust's Serious Incident strategy has undergone revision. Measures have been taken to provide further clarity with regard to the definition of roles and responsibilities within investigations and have included the provision of standardised Root Cause Analysis training across the Trust to key senior staff. The Internal Adult Safeguarding Process is acknowledged and incorporated as an integral part of the SI process and the new Quality and Safety reporting system forms an effective communication tool both in support of investigations and the dissemination of learning from incidents.

Mental Capacity Act/Deprivation of Liberty Safeguards
The Trust continues to respond to national developments in this continuously evolving landscape of legislation. One recent change with an impact on all acute hospitals has been the Coroner's duty with regard to patients subject to the Deprivation of Liberty Safeguards (DoLS). Since April 2017 it has no longer been necessary for Coroners to undertake an inquest for all patients who die whilst subject to DoLS authorisation.

Local Authorities have generally been more able over the last year to collaborate with the Trust in order to identify and prioritise DoLS applications. This has led to an increase in the number of supervisory bodies providing timely reviews to support patients with complex capacity issues.

Case law continues to illustrate legal challenge to the DoLS framework. The Law Commission has prepared a document detailing recommended changes to legislation and some recent cases have held interest for the acute provider. The Trust currently adheres to the 'acid test' and the ruling from Cheshire West. Of recent significance to acute Trusts is the ruling of the Court of Appeal in January 2017 in the case of Ferreira v. Coroner of Inner South London. However, as this case is likely to go back later in the year for review by the Supreme Court, our current practice remains consistent with the earlier rulings.

Staff training for MCA/DoLS is incorporated into Level 2 Adult Safeguarding across the Trust, and is mandatory for all staff members in patient-facing roles. The training material is accessed via an 'e-learning' package and compliancy rates have consistently exceeded the target of 90% agreed with commissioning. In January 2017 the CQC reported that staff they had questioned across the Trust were familiar with adult safeguarding recognition and reporting and also had an understanding of the Mental Capacity Act, of the need for consent and of the criteria for DoLS.

Face-to-face training and support continues for clinical areas and specialist teams involved in cases where complex capacity issues are regularly encountered. Individual cases are also followed where capacity and consent issues are of particular significance and Best Interests meetings are promoted as good practice and facilitated by the Named Nurse for Adult Safeguarding where required.

Partnership Working
All adult safeguarding concerns are considered and investigated in collaboration with the Local Authority relevant to the patient. This has always been the process within our own locality, but the Trust's status as a tertiary facility has sometimes made management of patients from further afield more challenging. Improvement has been seen over the past year with regard to this issue – increased understanding about information-sharing and the 'making safeguarding personal' agenda has led to an improvement in liaison and willingness to share. This is a vital issue for Acute Trusts, impacting directly on length of stay and safe discharge.

A number of concerns related to perceived poor discharge processes levied against the Trust by community partners have led to the implementation of the monthly Discharge Assurance Panel. Senior staff members with responsibility for complex discharge are joined by representatives from community services including the local authority and district nursing. Each concern is investigated by the treating team and presented for discussion at the panel meeting. The resultant learning is relayed along governance routes and trends and themes are then considered by a steering group led by the Assistant Director of Nursing for Patient Experience. The process has been well received. Approximately 50% of concerns are upheld and have led to the identification of changes in Trust practice with an ultimate benefit to the efficiency of the discharge process.

CUH Safeguarding Service
Over the course of the year, the wider Trust Safeguarding Team (Children, Adult and Maternity) has relocated to a central 'hub.' Sharing offices has promoted collaborative practice and the exchange of information and also facilitates the development of joint management plans for patients with needs that meet a wider range of overlapping safeguarding requirements.

Implementation of local authority Multi-Agency Safeguarding Hubs across part of the region has the potential to increase the shared approach to adult safeguarding enquiries.

Safeguarding work at CUH is conducted against a background of development and change within the wider 'safeguarding family'. The Adult Safeguarding Intercollegiate Guidelines are to be published shortly, and will inform the activities of our commissioning colleagues and further define our training needs analysis. There have also been recent reforms to the local Adult Safeguarding Boards (SAB). Historically we have had two local SABs, one for Peterborough and one for Cambridge. The appointment of an independent chairman across both has been part of a move to consolidate and decrease parallel working. In future there will be a county wide board executive team and a single business unit serving all of the boards, adult and children. Whilst the boards remain separate, a number of the subgroups are now combined. Further developments when considered alongside the demographics of the regional acute hospital providers will be of considerable interest to CUH.

Cambridgeshire Constabulary

Cambridgeshire Constabulary have continued to work hard with partners to develop systems, processes, expertise and experience to better safeguard adults at risk. Referrals are made into the Multi Agency Safeguarding Hub (MASH) where assessments are made, information is shared and onward referral for joint investigations, single agency responses or other early intervention options offered. The MASH Governance Board has been re-invigorated and there is agreement that the adults' side of the MASH will be developed with vigour across Cambridgeshire and Peterborough over the next twelve months.

The Constabulary continue to operate Domestic Abuse Investigation and Safeguarding Units (DAISU) which investigate cases of domestic abuse, supporting victims and those close to them through positive action and bringing offenders to justice. The DAISU have achieved successful outcomes on Coercive Control cases involving adults at risk of harm. The Partnership have introduced daily Multi Agency Risk Assessment Conference (MARAC)s which are chaired by managers from the Constabulary and consider cases where a high risk of harm exists.

The Adult Abuse Investigation and Safeguarding Unit (AAISU) continue to undertake investigations into cases of adult abuse, including those in a health or care setting. These investigations include physical, sexual and financial abuse as well as neglect.

The Constabulary are working with the Board to examine the training offers on this topic from both the Board and the Constabulary. The intention is to develop a training offer which compliments that already delivered by the Constabulary to its own workforce and ensure what is delivered is quality assured against Safeguarding Board standards and that the offer by the board is accessible to this hard to reach workforce.

The Constabulary will be delivering Safe Lives Domestic Abuse training to 500 staff which will enhance the knowledge of the workforce in particular regarding coercive control.

In 2016-2017 we have:

- Continued the development of the MASH, firmly establishing Domestic Abuse and Adult Abuse as priority themes.
- Continued to work in partnership with Peterborough and Cambridgeshire Safeguarding Adult Leads.
- Continued to carry out investigations into cases of Domestic Abuse, safeguarding victims, in particular those that are at risk and bringing offenders to justice.
- Continued to train and prosecute the new Coercive/Control Legislation.
- Continued to investigate those who offend against the elderly, disabled and vulnerable and bring offenders to justice.

Cambridgeshire & Peterborough Domestic Abuse and Sexual Violence Partnership (DASVP)

Cambridgeshire DASVP continues to work closely with the Adult Safeguarding Team on awareness raising around adults at risk and both services work collaboratively on areas where domestic abuse and sexual violence overlaps with adult safeguarding. The monthly newsletter produced by the DASVP includes details of adult safeguarding training and our website also signposts professionals to the Adult Safeguarding Team.

Domestic Abuse Update

The Domestic Abuse and Adult Safeguarding Action Plan was implemented in 2013 and all actions have now been delivered. The DASV Partnership Officer has met with the Cambridgeshire Safeguarding Adults Board (SAB) to discuss new actions going forward and these will be signed off in Spring 2017.

The Partnership Officer now sits on the SAB Training Sub Group and attends the SAB Quality and Effectiveness Group meetings.

Peterborough SAB organised a conference around adult safeguarding and domestic abuse in March 2017 and the DASV Partnership Officer sourced speakers and provided materials for presentations at the event. Formal feedback is awaited but the event was well attended by a range of senior managers and front line staff.

Data around the number of adult safeguarding cases with a domestic abuse or sexual violence element is now being provided by the Adult Safeguarding Team located at the MASH.

The Care Act came into force in April 2015, setting out for the first time legislation around adult safeguarding. Domestic abuse is now a national category of abuse for adults at risk from harm (the new term for vulnerable adults). Whilst this legislation is welcomed, it has meant that some cases of domestic abuse or sexual violence involving people who were previously classed as 'vulnerable' now do not meet the threshold for adult safeguarding. Work is ongoing with the SAB and the Adult Safeguarding Team at the MASH to ensure appropriate signposting and services are in place. Furthermore, the DASV Delivery Group will be commissioning an audit of Safeguarding Adults cases where domestic abuse or sexual violence is a factor to be carried out during 2017 with the aim of ensuring responses from all services are appropriate and are meeting the needs of victims.

The Cambridgeshire IDVA team received training around domestic abuse and people with Disabilities from specialist support organisation Stay Safe East in November 2016. Following the training, an action plan was developed to ensure IDVA services are responding positively to victims with disabilities.

Cambridgeshire Fire and Rescue Service (CFRS)

Our vision is for:

A safe community where there are no preventable deaths or injuries in fires or other emergencies.

To achieve this we need to strive for operational and community safety excellence, demonstrating value for money and by putting people at the centre of everything we do - that's people in the community in terms of their safety and diverse needs and our own staff in terms of training, development and health and safety.

We continue with our prevention work regarding multi-agency de-briefs should a fire death occur. Agencies who had previously been involved with the individual work in partnership to ascertain if together we could have intervened to prevent this fire from occurring, as well as identifying any similarities in individuals' life style choices with incidents of a similar nature.

As a direct result of two deaths early in 2016 and this multi-agency way of working the service has instigated a programme of activity (Olive branch) working directly with agencies who have staff visiting residents.

This ranges from voluntary British Red Cross practitioners, NHS employees (Train the trainer events) to Care Support workers. The service has been and will continue to educate employees on recognising risk for themselves and the resident they are visiting and as importantly what to do should they identify a risk, particularly in relation to fire and safety.

Over 200 front line staff in 2016 have benefited from the training with 98% stating they would now recognise fire hazards and 99% stating they know where to report their concerns to for assistance.

Do you have staff that need this training? Please contact **firefire@cambsfire.gov.uk** or Freephone 0800 917 9994 quoting "Olive Branch training".

CFRS has recognised by tackling the issues that make individuals a high risk of fire we can reduce their risk of dying as a result of fire.

Safeguarding and its broader agenda continues to be a high priority and to support this we have widened our on line learning tools for front line staff that can be monitored and reported on.

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

Statement of Purpose
Cambridgeshire and Peterborough NHS Foundation Trust is committed to the working with partner agencies to ensure the safeguarding of adults at risk of abuse and neglect.

Governance and Accountability
Safeguarding matters are reported to the Board via the Quality Safety and Governance Committee. The Director of Nursing is the Executive Director with Board responsibility for safeguarding adults; the Head of Adult Safeguarding is the lead officer for adult safeguarding with responsibility for developing policy and procedures within the Trust.

2016-17 Achievements

- Training
  At April 2017, 97% of CPFT staff had trained in adult safeguarding. MCA training stood at 76% and 97% of staff had received PREVENT training.
- Staff Supervision
  Safeguarding Leads are supported by the programme of peer supervision meetings where safeguarding staff visit the wards and teams in CPFT to discuss cases, issues and developments.
- Healthcare Services
  Safeguarding referrals from CPFT community health services showed a significant increase over the previous year which is likely to reflect greater awareness.
- Policy and Procedures
  The CPFT have contributed to the development of joint Cambridgeshire and Peterborough SAB adult safeguarding policy and procedures and self neglect and hoarding protocols.
- Partnership Working
  A Multi Agency Safeguarding Hub (MASH) has been developed within Cambridgeshire as a single point for referrals and triage of all adult safeguarding matters. CPFT has an Advanced Practitioner post embedded within the MASH although the retirement of the post holder has meant that the development of the MASH for CPFT has been delayed.

Priorities for 2017-18

- Ensure all staff receive appropriate training and are able to identify and respond to safeguarding issues and that the target of 90% for staff training in adult safeguarding continues to be met.
- Ensure compliance with attendance at Mandatory MCA & PREVENT training.
- Ensure CPFT has a sufficient number of trained Safeguarding Leads.
- Work with partners (including Local Authorities & Police) to further develop the working of the Multi-Agency Safeguarding Hub (MASH).
- Revise CPFT policy & procedures in line with the SAB documents.

Cambridgeshire and Peterborough Clinical Commissioning Group (CAPCCG)

Cambridgeshire and Peterborough Clinical Commissioning Group (CAPCCG, 'the CCG') is one of the largest CCGs in England (by patient population), with 105 GP practices as members. They cover all GP practices in Cambridgeshire and Peterborough, as well as three practices in North Hertfordshire (Royston) and two in Northamptonshire (Oundle and Wansford). We are responsible for planning and buying local NHS services, such as the care you receive at hospital and in the community, as well as ensuring they deliver the best possible care and treatment for patients.

Our main Providers are:

- Cambridge University Hospitals NHS Foundation Trust (CUHFT - encompassing Addenbrookes and Rosie hospitals)
- Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT)
- Hinchingbrooke Health Care Trust (HHCT)
- Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Cambridgeshire Community Services (CCS)
- Papworth Hospital NHS Foundation Trust - specialist cardiothoracic hospital

There are also a range of other key Providers such as GP Out of Hours services, NHS 111, East of England Ambulance Trust and many other smaller specialised service Providers.

The monitoring of Providers compliance with the safeguarding adult's requirements in the quality schedule of the NHS contract was undertaken by the CCG on a quarterly basis as part of the Clinical Quality Review processes (CQRs). Specific metrics outlined in the CCG's quality dashboard were reviewed with no major shortcomings noted. Additional funding from NHS England has continued to facilitate organisations' ability to address issues with compliance with training requirements in relation to MCA/DoLS.
Attendance at CQC/Local Authority information sharing meetings also supports the CCG in maintaining a soft intelligence database which helpfully provides an overview, useful for quality surveillance and identification of systemic issues, particularly in relation to care homes and domiciliary care agencies.

Partnership working

CCG staff attend multiagency meetings in order to achieve partnership working. There has been regular attendance at the Cambridgeshire Safeguarding Adult Board (CSAB) meeting and its subgroups, as well the Domestic Abuse Governance Board, the MASH Governance Board and the Prevent Delivery Board.

Health Executive Safeguarding Board

The Health Executive Safeguarding Board (HESB) is a subgroup of the SABs, reporting to both Peterborough and Cambridgeshire SABs. HESB is chaired by CAPCCG Director of Nursing and Quality. The membership largely comprises Directors of Nursing from NHS Provider organisations across Cambridgeshire who work collaboratively taking a strategic 'Health' view in relation to safeguarding adults' issues.

Safeguarding Adults Health Sub Group

The Safeguarding Adults Health Subgroup (HSG) reports to the HESG and has membership of Health Providers across Peterborough and Cambridgeshire reviewing operational issues, receiving direction from HESB as required.

CAPCCG has strived to maintain a high profile around the importance of safeguarding adults to the health and well-being of our population and continues to promote a culture of Making Safeguarding Personal. Prevention is vital and staff training around safeguarding adults to raise awareness is both promoted and monitored closely by the CCG. The responsibility of all staff to recognise and respond to safeguarding concerns is emphasised in the training delivered to staff by Provider Safeguarding Adult Leads.

Priorities and challenges for 2016 -2017

- Review the recommendations from the Safeguarding Adults Reviews published and ensure these are being considered within CCG commissioned services.
- To respond to the forthcoming 'NHS England Roles and Competencies for Healthcare staff' document and consider the implications for the learning and development needs of NHS staff locally.
- Consider the impact of increasingly constrained resources upon both the CCG and Providers, while still striving to maintain a robust response to meeting safeguarding adults responsibilities.

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. We will develop our approach to inspection so we can respond to new models of care and new models of service which will develop over the next few years. We are clear that regulation will not act as a barrier to innovation.

Our role is to monitor, inspect and regulate services to ensure they meet fundamental standards of quality and safety and to publish what we find, including performance ratings to help people choose care.

CQC's four underpinning priorities are to:

- Encourage improvement, innovation and sustainability in care
- Deliver an intelligence-driven approach to regulation
- Promote a single shared view of quality
- Improve our efficiency and effectiveness

Care that fails to meet the expected national standards of quality and safety against which we regulate will not be tolerated. We will use our enforcement powers necessary to stamp out poor practice wherever we find it. Any form of abuse, harm or neglect is unacceptable and should not be tolerated by the provider, its staff, the regulators or by members of the public who become aware of such incidents. Safeguarding is everybody's business and CQC is aware of the role it can play in striving to reduce the risk of abuse from occurring.

Safeguarding is a key priority that reflects both our focus on human rights and the requirement within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to have regard to the need to protect and promote the rights of people who use health and social care services.

As the regulator of health and adult social care services, our primary role is to make sure that providers have appropriate systems in place to safeguard people who use the service and that those systems are implemented and followed in practice to ensure good outcomes for people who use the service. We will monitor how these roles are fulfilled through our regulatory processes by assessing how providers are meeting the national standards of quality and safety.

The CQC consists of three main inspection directorates of Hospitals, Adult Social Care (ASC) and Primary Medical Services (PMS). We now consider our inspection findings under the safe domain to seek assurance that people are safeguarded where we will always ask: Is the service safe?

We will continue to implement and improve the new approach to regulation. The CQC has introduced safeguarding leads who champion this subject through all three directorates supported by the Deputy Chief Inspector, PMS and Integrated Care. All CQC staff are expected to follow the CQC's Safeguarding Handbook which gives guidance and also all the statutory requirements that inspection and registration staff need to be mindful of. This handbook is also available to members of the public.

Community Network Sub Group

The three public representatives who make up the Community Network Sub Group have experience of using services as carers and patients and link into other networks in health and social care. They are supported by Healthwatch Cambridgeshire.

The representatives have been involved in various activities which have helped the Board better understand the patient and public perspective:

- Attending professional training courses and giving feedback – this has been enormously helpful to the training team to ensure the courses remain focused on the person rather than processes.
- Helping design public material – the group has worked with the training team to design and develop a poster and newsletter to raise public awareness of abuse and what actions people can take. The Group has helped to distribute the posters through the different networks they are involved in. The Safeguarding Adults Newsletter will be produced on a quarterlly basis and seeks to have a person-centred ethos.
- Attending Safeguarding Adults Board meetings, contributing a service-user perspective e.g. questioning the jargon used. The Group has noticed a signficant shift in language and tone within these meetings.
- Being involved in the interviewing process for appointing to senior positions.

The Community Network Representatives are very pleased to do this work and help make adult safeguarding more meaningful to people. The other Board Members always welcome comments. It is very rewarding to have our efforts appreciated.

Healthwatch Cambridgeshire

Safeguarding is a key priority for Healthwatch Cambridgeshire and we are delighted to be a member of the Cambridgeshire Safeguarding Adults Board. We welcome the commitment that the Board has made to the Making Safeguarding Personal agenda and are pleased to have worked closely with the County Council on improving the public understanding of safeguarding. The language used in safeguarding is highly jargonised and means little to the general public. By making the language used more understandable, the aim is that we raise awareness of the general public of safety and risk and appropriate ways to respond. By hearing the views of service users and the public organisations can learn from people's experiences; thereby improving their understanding of what helps people stay safe.

Healthwatch Cambridgeshire supports the Board's Community Safeguarding Network and the three representatives that attend the Board meetings. These meeting tend to feature very dry data and processes, the representatives have been vocal in their questioning of the purpose and meaning of these. This has been welcomed by the Board. We have undoubtedly seen an increase in the Board's awareness of how complex safeguarding processes are and the benefits of making safeguarding more meaningful to people.

Healthwatch Cambridgeshire continues to work closely with the Care Quality Commission and the County Council to ensure that there is a robust system for reporting safeguarding concerns and sharing intelligence. All Healthwatch Cambridgeshire staff and volunteers undertake safeguarding training, the CEO is the Safeguarding Lead and there is also a Safeguarding Adults Champion to make sure that safeguarding policies and procedures are current, practical and effective.

National Probation Service (NPS)

The National Probation Service (NPS) is committed to reducing re-offending, preventing victims and protecting the public. The NPS engages in partnership working to safeguard adults with the aim of preventing abuse and harm to adults and preventing victims. The NPS acts to safeguard adults by engaging in several forms of partnership working including:

- Operational: Making a referral to the local authority where NPS staff have concerns that an adult is experiencing or is at risk of experiencing abuse or neglect, including financial abuse, and is unable to protect oneself from that abuse or neglect.
- Strategic: Attending and engaging in local Safeguarding Adults Boards (SABs) and relevant sub-groups of the SAB. Through attendance, take advantage of training opportunities and share lessons learnt from Safeguarding Adult Reviews and other serious case reviews.

In 2016, NPS published its new strategic partnership framework outlining the ways in which we work, attend and engage in local Safeguarding Adult Boards (SABs). The NPS works closely with partner agencies to safeguard adults.

The six safeguarding principles that underpin our work are:

- Empowerment: People being supported and encouraged to make their own decisions and informed consent.
- Prevention: It is better to take action before harm occurs.
- Proportionality: The least intrusive response appropriate to the risk presented.
- Protection: Support and representation for those in greatest need.
- Partnership: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability: Accountability and transparency in safeguarding practice.

Much of our work relates to assessing and managing offenders who are registered sexual offenders and offenders with a pattern of serious violent offending. Some of this work involves NPS working with other agencies under Multi-Agency Public Protection Arrangements (MAPPA) and in Multi-Agency Risk Assessment Conferences (MARAC). There are also NPS staff working in the local Multi-Agency Safeguarding Hubs (MASHs) to help protect some of the more vulnerable members of our community.

In terms of adult safeguarding, NPS contributes to multi-agency work to protect and support victims of abuse and neglect and adults at risk of abuse and neglect. This includes victims of domestic abuse.

Adult safeguarding is a developing area for work for NPS and progress has been made in the following ways:-

- delivery of adult safeguarding mandatory training for all staff
- appointment of a NPS senior manager to lead on adult safeguarding in Cambridgeshire at a strategic level and who attends the Board on a regular basis
- starting discussions with partner agencies on developing a strategy for managing offenders who pose a serious risk to vulnerable groups but who themselves have acute health and other needs
- roll out of briefings to front line staff on the Care Act.

Papworth Hospital NHS Foundation Trust

Papworth Hospital NHS Foundation Trust is one of the largest specialist cardiothoracic (heart and lung) hospitals in Europe and includes the country's main heart and lung transplant centre. Over the last three years, it has performed the highest number of heart surgery procedures in the UK whilst achieving the country's lowest cardiac surgery mortality rate.

Governance and Accountability
The Director of Nursing is the Executive Director with Board responsibility for Safeguarding. Safeguarding matters are reported through the Trust's quarterly Joint Safeguarding Committee, which is chaired by the Deputy Director of Nursing. The Trust Board receives annual reports on safeguarding via the Quality and Risk Committee. In addition there is a monthly meeting of operational leads.

The trust has a named professional for safeguarding adults and a strong commitment to the safeguarding agenda.

Attendance at the Health Executive Safeguarding Board run by the CCG is prioritised. The Adult Safeguarding Lead attends the health sub group of SAB.

2016-17 Achievements

- Delivery of safeguarding training 2016/17 – see below:

	Safeguarding People L1	Safeguarding People L2	Safeguarding People L3	Safeguarding People L4
Add Prof Scientific and Technic	100%	95%		100%
Additional Clinical Services	96%	97%		
Administrative and Clerical	87%	64%		
Allied Health Professionals	80%	98%		
Estates and Ancillary	95%	92%		
Healthcare Scientists	93%	98%		
Medical and Dental	100%	99%		100%
Nursing and Midwifery Registered	60%	100%	87%	50%
Grand Total	89%	98%	87%	75%

- Safeguarding Adults Policy is care act compliant and in date. Review planned 2018
- update for VIP policy completed
- Audit to look at safeguarding referrals and whether they embody the principles of Care Act – Making Safeguarding Personal MSP – due to be reported end of May 2017

- Safeguarding link nurses training planned to focus on needs of patients with Learning Disabilities and Dementia and their carers (24/5/17).
- Safeguarding APP on front page of intranet to give staff an easily identifiable reference and thresholds for safeguarding. This is also embedded in the Datix reporting system.
- First safeguarding newsletter to be published May 2017.
- Learning from SUI published re falls.
- Falls policy/procedure and on call system to be looked at as result of this learning.
- Fatal Fire self-assessment completed.

2017-8 Action Focus

- Audit numbers of patients with dementia and learning difficulties and review if and what reasonable adjustments have been made
- New EPR system to be introduced which should give more robust information regarding quarterly reporting on dementia and learning disability activity
- Safeguarding training to mirror NHS England's stated developments for 2017/18 – focus on Modern Slavery and Trafficking; Impact of MCA and DoLS legislative review; Reform of child safeguarding; Domestic Abuse and looked after children see below:

Year	Adults	Children	Joint areas
2016/17	Care Act - Modern Slavery and Self Neglect Learning Disabilities and DoLS	Chaperoning	Prevent Safeguarding App
2017/18	MCA Consent and Capacity	CSE and on line safety Looked after children	Prevent
2018/19	Domestic Abuse	Complicated Matters [1]	FGM

- We also await the publication of Best Practice Guidance regarding standards for training – currently embargoed until after general election.

[1] Domestic and sexual violence, substance use and mental ill-health are three issues which often co-exist. And when they do, things can become complicated. The Toolkit is designed to 'uncomplicate' matters by raising awareness about how the three issues intersect and offer effective ways to engage with individuals and families who are affected by these issues.

10. Further information

If you are worried about an adult who is being abused or who is at risk of abuse you should contact the following numbers:

Customer services

For reporting adult safeguarding or urgent contacts between

8am - 6pm Monday to Friday & between 9am - 1pm on Saturday
Telephone: 0345 045 5202
Fax: 01480 498066
Email: referral.centre-adults@cambridgeshire.gov.uk
Minicom: 01480 376743
Text: 07765 898732

If you urgently need to make contact outside of the above hours call **01733 234724**

Cambridgeshire Constabulary	
Non-Emergency Contact Centre	**101**
Cambridgeshire and Peterborough NHS Foundation Trust	
Huntingdon and Fenland	**01480 415177**
Cambridge and Ely	**01223 218695**
Action on Elder Abuse Response Line	**0808 808 8141**
Age UK Cambridgeshire	**0300 666 9860**

For copies of this annual report or if you would like a copy of this annual report on audio cassette, CD, DVD or in Braille, large print or other languages, please call 0345 045 5202. Or write to Cambridgeshire County Council, Box No. SH1211, Shire Hall, Cambridge, CB3 0AP

We would like to thank everyone who has contributed to this annual report.

You can find out more information about safeguarding adults in Cambridgeshire on our website: www.cambridgeshire.gov.uk/safeguardingmca

Agenda Item No: 8

CAMBRIDGESHIRE PHARMACEUTICAL NEEDS ASSESSMENT 2017

To: **Health and Wellbeing Board**

Meeting Date: **6 July 2017**

From: **Dr. Liz Robin, Director of Public Health**
Katie Johnson, Specialty Registrar in Public Health

Recommendations: **The Health and Wellbeing Board is asked:**

1. **To note the findings of the Cambridgeshire Pharmaceutical Needs Assessment (PNA) 2017 and approve the final PNA report submitted by the multi-agency PNA Steering Group.**

2. **To approve the monitoring protocol for keeping the PNA up to date between now and July 2020, including the delegated authority for approval of supplementary statements to the Director of Public Health, in discussion with the Chair or Vice-Chair of the Board.**

	Officer contact:
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1. PURPOSE

1.1 To present the final update of the Cambridgeshire Pharmaceutical Needs Assessment (PNA) 2017 for approval by the Health and Wellbeing Board. The full report is attached, including an executive summary on pages 6-12. The report of the public consultation on the draft PNA is presented in appendix 6. The response to consultation and a summary of changes made to the PNA are presented in appendix 7. The monitoring protocol for keeping the PNA up to date between now and July 2020, when the PNA is next due to be updated, is also presented for approval.

2 BACKGROUND

2.1 Since 1 April 2015, every Health and Wellbeing Board in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services for the population in its area (the PNA). This PNA updates the 2014 Cambridgeshire PNA and describes the pharmaceutical needs for the population of Cambridgeshire.

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

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

3. MAIN ISSUES

3.1 Process

- As in 2014, the specific legislative requirements in relation to development of PNAs were duly considered and adhered to. The final PNA report and monitoring protocol have been reviewed by the LGSS legal team and are compliant with the regulations.

- The development of the revised PNA for 2017 was overseen by a multi-agency steering group, with representation from the County Council, the Clinical Commissioning Group, Healthwatch, the Local Medical Committee (a corresponding member), the Local Pharmaceutical Committee and NHS England. In the process of undertaking the PNA, the Cambridgeshire Health and Wellbeing Board sought the views of a wide range of stakeholders to identify issues that affect the commissioning of pharmaceutical services and to meet local health needs and priorities.

- Information from the Joint Strategic Needs Assessment (JSNA) and Public Health sources were used to describe pharmaceutical provision throughout

the county and local health needs that may be addressed through pharmaceutical services. All pharmacies and dispensing GP practices in Cambridgeshire were asked to complete a questionnaire describing their service provision. 93 of 110 (85%) community pharmacies and 34 of 43 (79%) dispensing GP practices in Cambridgeshire responded to the questionnaire.

- A public consultation was undertaken from 30 January to 30 April 2017 to seek the views of members of the public and other stakeholders, on whether they agreed with the contents of the draft PNA and whether it addressed issues that they considered relevant to the provision of pharmaceutical services. A good response was received to the public consultation, with 354 responses to the survey from individuals or groups. The feedback gathered in the consultation is described in the Consultation report (see Appendix 6 of the PNA) and a summary of how the draft PNA was amended to produce the final PNA in response to the feedback received is included as Appendix 7 of the PNA.

3.2 Key findings:

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

- Cambridgeshire has one pharmaceutical service provider per 4,258 people, equivalent to 23 pharmaceutical service providers per 100,000 resident population. This is the same as the national average and slightly lower than the East of England average (24 providers per 100,000 resident population).

- All community pharmacy and GP dispensing practices who responded to the questionnaire considered local provision to be ‘adequate’ or better, with 30% of pharmacies and 56% of dispensing GP practices reporting provision as ‘excellent’ and 55% of pharmacies and 41% of dispensing GP practices as ‘good’.

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

- Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services in Cambridgeshire. 91% of respondents to the public consultation thought that pharmacy services are available at convenient locations and opening hours.

- 86% of respondents to the public consultation felt that the draft PNA adequately described current pharmaceutical services in Cambridgeshire. 83% agreed with the key findings about pharmaceutical services in Cambridgeshire as outlined in the PNA.

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

3.3 Future population changes and housing growth

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

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

- A monitoring protocol for keeping the Cambridgeshire PNA up to date has been produced by the multi-agency PNA steering group. It describes how the steering group will monitor, assess and respond to changes in pharmaceutical needs in Cambridgeshire until July 2020, when the next PNA update is due to be published.

4 RECOMMENDATIONS

4.1 The Health and Wellbeing Board is asked:

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

2. To approve the monitoring protocol for keeping the PNA up to date between now and July 2020, including the delegated authority for approval of supplementary statements to the Director of Public Health, in discussion with the Chair or Vice-Chair of the Board.

5 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

5.1 The PNA is relevant to all six priorities of the Health and Wellbeing Strategy:

- Priority1: Ensure a positive start to life for children, young people and their families.
- Priority 2: Support older people to be independent, safe and well.
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
- Priority 6: Work together effectively.

6 IMPLICATIONS

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

6.2 This PNA has been produced by a multi-agency steering group on behalf of the Health and Wellbeing Board, and the specific legislative requirements, as described in the *NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013,* in relation to the development of PNAs were duly considered and adhered to. The final PNA report and monitoring protocol have been reviewed by the LGSS legal team and are compliant with the regulations.

Source Documents	**Location**
The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.	http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Cambridgeshire
County Council

Cambridgeshire

Pharmaceutical Needs Assessment 2017

FINAL REPORT WITH APPENDICES

Contents

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KEY: CCC, Cambridgeshire County Council. CPCCG, Cambridgeshire and Peterborough Clinical Commissioning Group.

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

Executive summary

1. Introduction

Since 1 April 2015, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment' (PNA). This PNA updates the 2014 Cambridgeshire PNA and describes the pharmaceutical needs for the population of Cambridgeshire, including Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire. A separate PNA is produced by the Peterborough Health and Wellbeing Board.

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

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

2. Process

As in 2014, the specific legislative requirements in relation to development of PNAs[1] were duly considered and adhered to. The development of the revised PNA for 2017 was overseen by a multi-agency steering group.

Information from the Joint Strategic Needs Assessment (JSNA) and Public Health sources were used to describe pharmaceutical provision throughout the county and local health needs that may be addressed through pharmaceutical services. All pharmacies and dispensing GP practices in Cambridgeshire were asked to complete a questionnaire describing their service provision. 93 of 110 (85%) community pharmacies and 34 of 43 (79%) dispensing GP practices in Cambridgeshire responded to the questionnaire.

In the process of undertaking the PNA, the Cambridgeshire HWB sought the views of a wide range of key stakeholders to identify issues that affect the commissioning of pharmaceutical services and to meet local health needs and priorities.

A public consultation was undertaken from 30 January to 30 April 2017 to seek the views of members of the public and other stakeholders, on whether they agreed with the contents of this PNA and whether it addressed issues that they considered relevant to the provision of pharmaceutical services. A good response was received to the public consultation, with 354 responses to the survey from individuals or groups.

323 of 354 respondents (91%) felt that the purpose of the PNA was explained sufficiently and 304 of 354 respondents (86%) felt that the draft PNA adequately described current

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

pharmaceutical services in Cambridgeshire. 293 of 354 respondents (83%) agreed with the key findings about pharmaceutical services in Cambridgeshire as outlined in the PNA. The feedback gathered in the consultation is described in the Consultation report (see Appendix 6) and a summary of how the draft PNA was amended to produce this final report in response to the feedback received is included as Appendix 7.

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

3. Understanding local health needs

Cambridgeshire is a predominantly rural county with few urban settlements, which can create challenges for local transport and access to services. The health of the Cambridgeshire population is generally similar to or better than the England average, but important local variations exist within the county.

The PNA should be viewed in conjunction with the Cambridgeshire Joint Strategic Needs Assessments which describe the health and wellbeing needs of the local population, and with national and local health data sources available through www.cambridgeshireinsight.org.uk. The PNA and the role of pharmacies should also be considered alongside the Cambridgeshire Health and Wellbeing Strategy, the Cambridgeshire & Peterborough System Transformation Plan and the Health System Prevention Strategy for Cambridgeshire and Peterborough.

The local population is forecast to increase substantially in the coming years, with the biggest increases seen in the age group of over 65 years. There are also several major housing developments underway across Cambridgeshire. The impact of this population growth on pharmaceutical needs is discussed in Section 6 of the PNA.

4. Current provision of local pharmaceutical services

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

Cambridgeshire has one pharmaceutical service provider per 4,258 people, equivalent to 23 pharmaceutical service providers per 100,000 resident population in Cambridgeshire. This is the same as the national average of 23 per 100,000 resident population and slightly lower than the East of England average of 24 pharmaceutical providers per 100,000 resident population. Estimates of the average number of people per pharmaceutical service provider across Cambridgeshire have remained relatively stable since 2011.

As of July 2016 there were:

- 110 pharmacies in Cambridgeshire (only slightly more than 109 in July 2013 and 101 in January 2011).
- 43 dispensing GP practices in Cambridgeshire (unchanged from July 2013 and January 2011).
- One Dispensing Appliance Contractor (unchanged since 2011).

Taking into account current information from stakeholders including community pharmacies and dispensing GP practices, the number and distribution of pharmaceutical service provision in Cambridgeshire is sufficient. The distribution of pharmacies and dispensing GP practices appears to cover the county well with few gaps and some concentrations. Some geographical gaps appear to exist in some of the less populated areas in the north and southern fringes of the county but these localities are served by suppliers from outside the county. In terms of postal addresses, across all of Cambridgeshire, there are only 67 postal addresses registered as a residential property that are located more than 20 minutes away by car from a pharmacy or dispensing surgery.

Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services in Cambridgeshire. There appears to be good coverage in terms of opening hours across the county. Overall, out of 110 community pharmacies, 45 (41%) are open after 6pm and 26 (24%) are open after 7pm on weekdays; 90 (82%) open on Saturdays; and 22 (20%) open on Sundays. The out of hours service, Hertfordshire Urgent Care is required to arrange for the provision of a full course of treatment, if clinically necessary, before a community pharmacy is open.

Home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport. Of the pharmaceutical providers who completed the questionnaire, 89 pharmacies (95.7%) and 21 dispensing GP practices (61.8%) have some form of delivery service in operation, which is more than in 2013.

The proportion of providers reporting that they have wheelchair access to consultation facilities has increased since 2013 from 80.4% to 93% of community pharmacies and from 86.8% to 88.2% of dispensing GP practices.

All community pharmacy and GP dispensing practices who responded to the questionnaire considered local provision to be ‘adequate’ or better, with 39% of pharmacies and 56% of dispensing GP practices reporting provision as ‘excellent’ and 55% of pharmacies and 41% of dispensing GP practices as ‘good’.

5 The role of pharmacy in addressing health needs

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

Medicines advice and support

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

Medication errors in care homes for older people can also be reduced by reviewing the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. Cambridgeshire and Peterborough

Clinical Commissioning Group (C&P CCG) employ a small team of CCG pharmacists and pharmacy technicians to work collaboratively with GP practices and care homes to rationalise prescribing, optimise medicines usage and reduce medicines waste.

Services and support to encourage healthy lifestyle behaviours

Providers of pharmaceutical services also have an important role to play in improving the health and wellbeing of local people beyond providing and supporting the safe use of medicines. The NHS Community Pharmacy Contractual Framework requires community pharmacies to contribute to the health needs of the population they serve and the recent changes to the 2017/2018 pharmacy contract have included quality payments to pharmacies who are accredited as 'Healthy Living Pharmacies'. Community pharmacies can contribute to the health and wellbeing of the local population in a number of ways, including direct service provision, for example Emergency Hormonal Contraception, along with providing ongoing support for lifestyle behaviour change through motivational interviewing, providing information and brief advice, and signposting to other services.

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

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

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

Pharmacy staff can play a role in promoting awareness of good mental health, for example signposting to information about local support networks, mental health help lines etc. Pharmacy providers are also involved in part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and C difficile.

The following local services are currently commissioned from community pharmacies:

- *Smoking Cessation 'CAMQUIT'* (commissioned by Cambridgeshire County Council (CCC))

The Community Pharmacy Smoking Cessation Service in Cambridgeshire illustrates how community pharmacies can improve population health through smoking cessation services, as evaluated by NICE. Smoking cessation services are commissioned from some community pharmacies in Cambridgeshire but this has decreased in the past two years. The contribution of pharmacies towards quit levels has also decreased from 12% in 2013/2014 to 6% in 2015/2016 and the lost to follow up rates have increased. Community pharmacies remain well placed to ensure services are accessible to the smoking population and evidence suggests community pharmacies can improve quit rates. The provision of commissioned smoking cessation services in pharmacies is currently under review to address service provision and quality concerns.

- *Chlamydia Screening and Treatment* (commissioned by CCC)
  Community pharmacies are easily accessible for young people and are crucial for offering treatment of chlamydia infections. Only 26 pharmacies have signed up to the Cambridgeshire chlamydia screening programme and only 0.9% of chlamydia tests performed in Cambridgeshire were collected from pharmacies. Although there is some opportunity to expand, this is limited by the number of pharmacies that do not have the appropriate facilities to offer screening. There is also potential for offering advice on barrier contraception methods for both males and females and for raising awareness of HIV, chlamydia and other STIs.

- *Emergency Hormonal Contraception (commissioned by CCC)*
  Pharmacies in Cambridgeshire are offered the opportunity to receive training and a contract to provide Emergency Hormonal Contraception (EHC), which is available as a locally commissioned service in some community pharmacies. The EHC Service is currently being delivered by 28 pharmacies across Cambridgeshire, as part of the overall contraception service offered by sexual health, contraception clinics and GP practices across Cambridgeshire, and there are opportunities to expand. It is advised to offer chlamydia screening when Emergency Hormonal Contraception is provided, since those requiring such contraception may also be at risk of infection. The extent to which local services signpost to services or carry out testing when EHC is provided is regularly examined in an audit, as recommended in the 2014 PNA.

- *Needle and Syringe Exchange Service* (Drug & Alcohol Action Team (DAAT), CCC)
  The Cambridgeshire Drug and Alcohol Action Team (DAAT) commission services to provide specialist drug and alcohol treatment across Cambridgeshire. Currently Adult drug and alcohol services are provided by 'Inclusion' and Young People services are provided by the Cambridgeshire Child and Adolescent Substance Use Service (CASUS). Further information can be found at: www.cambsdaat.org. A 'Drug and Alcohol JSNA' was published in September 2016 which provides an overview of legal and illicit drug and alcohol misuse needs for the Cambridgeshire population.
  People who use illicit drugs are often not in contact with health care services and their only contact with the NHS may be through a needle exchange service within a community pharmacy. At a minimum, the pharmacy can provide advice on safer injecting and harm reduction measures. In addition, community pharmacies can provide information and signposting to treatment services, together with information and support on health issues other than those that are specifically related to the client's addiction. 34 community pharmacies across Cambridgeshire are sub-contracted by the DAAT commissioned provider *Inclusion* to provide access to sterile needles and syringes, and sharps containers for return of used equipment.

- *Supervised Administration Service* (DAAT, CCC)
  Once clients are being treated within the NHS, community pharmacies can provide supervised administration of drug therapies and instalment dispensing. Clients often need support to prevent them stopping treatment. 34 community pharmacies across Cambridgeshire are sub-contracted by the DAAT commissioned provider *Inclusion* to provide a Supervised Administration Service, which requires the pharmacist to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient.

- *Outreach NHS Health checks service (pilot) (CCC)*
  In summer 2016, Cambridgeshire County Council trained 11 Pharmacies in the Wisbech area, Fenland, to deliver outreach NHS Health Checks as part of a 6 month pilot, which has since been extended to one year. The NHS Health Check is a health check-up designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia, in adults in England aged 40-74 without a pre-existing condition. The rural, market town of Wisbech was chosen for the pilot as it has a high prevalence of cardiovascular disease, a high number of local residents unable to attend their GP practice, and a number of proactive community pharmacies in the area.

- *Directly observed therapy (DOT) service for Tuberculosis (TB) patients (C&PCCG/ CCC)*
  The CCG in conjunction with public health and local respiratory clinics are exploring commissioning a Directly Observed Therapy (DOT) service for tuberculosis (TB) patients from a limited number of community pharmacies across the geography of the CCG. This will provide care closer to home for non-infectious patients who require support in adherence with their prescribed TB medication.

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

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

6 Pharmaceutical needs associated with Future Population Changes and Housing Growth

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

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

1 Introduction

1.1 Pharmaceutical Needs Assessments – description and background

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

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

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

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

As PNAs are central to decision-making regarding commissioned services and new pharmacy openings, it is essential that they comply with the requirements of the regulations, that due process is followed in their development and they are kept up to date. Section 2 describes the process for this PNA.

1.2 Overview of NHS pharmaceutical services

Section 126 of the NHS Act 2006 places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons. This section of the Act also describes the types of healthcare

[2] Primary Care Commissioning. 'Pharmaceutical needs assessments.' March 2013. Available at: http://www.pcc-cic.org.uk/

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

professionals who are authorised to order drugs, medicines and listed appliances on an NHS prescription.

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

The following can be included in the pharmaceutical list:

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

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

NHS legislation provides that in certain rural areas classified as 'controlled localities' general practitioners may apply to dispense NHS prescriptions as 'dispensing doctors'. The provisions to allow GPs to dispense were introduced to provide patients access to dispensing services in rural communities not having reasonable access to a community pharmacy. Since 2005, a practice can only apply to be a dispensing practice if it is located in a 'controlled locality' and the total of all patient lists for the area within a 1.6km (1 mile) radius of the premises is fewer than 2,750.[4] In the majority of cases, patients eligible to use the dispensing practice will therefore be located more than 1.6km away from the nearest pharmacy. Further information about this process and how areas of new growth may affect dispensing doctors' practices is described in Section 6.5.2. Dispensing GP practices can make a valuable contribution to dispensing services although they do not offer the full range of pharmaceutical services offered at community pharmacies.

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

[4] Pharmaceutical Services Negotiating Committee briefing on 'Rurality, controlled localities and the provision of pharmaceutical services by doctors'. Available at: http://psnc.org.uk/contract-it/market-entry-regulations/rural-issues/

[5] National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Available at: http://www.legislation.gov.uk/uksi/2013/349/contents/made

- Essential services which every community pharmacy providing NHS pharmaceutical services must provide (as described in Schedule 4, Part 2 of the Regulations). These include: the dispensing of medicines and appliances; clinical governance; repeat prescriptions; disposal of unwanted medicines; promotion of healthy lifestyles; signposting to other services or information; and support for self-care.
- Advanced services which community pharmacy contractors and dispensing appliance contracts can provide subject to accreditation. These include: Medicines Use Reviews (MUR); the New Medicines Service from community pharmacists; Appliance Use Reviews; the NHS Seasonal Flu Vaccination Programme; and the Stoma Customisation Service which can be provided by dispensing appliance contracts and community pharmacies.
- Enhanced services are commissioned directly by NHS England. These could include anti-coagulation monitoring; the provision of advice and support to residents and staff in care homes in connection with drugs and appliances; on demand availability of specialist drugs; and out-of-hours services.

Further information about these services in Cambridgeshire is described in Sections 5.1-5.3.

1.3 Local Pharmacy Services

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

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

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

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

2 Process

Key messages:

As in 2014, the specific legislative requirements in relation to development of PNAs[6] were duly considered and adhered to. The development of the revised PNA for 2017 was overseen by a multi-agency steering group.

Information from the Joint Strategic Needs Assessment (JSNA) and Public Health sources were used to describe pharmaceutical provision throughout the county and local health needs that may be addressed through pharmaceutical services. All pharmacies and dispensing GP practices in Cambridgeshire were asked to complete a questionnaire describing their service provision. 93 of 110 (85%) community pharmacies and 34 of 43 (79%) dispensing GP practices in Cambridgeshire responded to the questionnaire.

In the process of undertaking the PNA, the Cambridgeshire HWB sought the views of a wide range of key stakeholders to identify issues that affect the commissioning of pharmaceutical services and to meet local health needs and priorities.

A public consultation was undertaken from 30 January to 30 April 2017 to seek the views of members of the public and other stakeholders, on whether they agreed with the contents of this PNA and whether it addressed issues that they considered relevant to the provision of pharmaceutical services. A good response was received to the public consultation, with 354 responses to the survey from individuals or groups.

323 of 354 respondents (91%) felt that the purpose of the PNA was explained sufficiently and 304 of 354 respondents (86%) felt that the draft PNA adequately described current pharmaceutical services in Cambridgeshire. 293 of 354 respondents (83%) agreed with the key findings about pharmaceutical services in Cambridgeshire as outlined in the PNA. The feedback gathered in the consultation is described in the Consultation report (see Appendix 6) and a summary of how the draft PNA was amended to produce this final report in response to the feedback received is included as Appendix 7.

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

2.1 Summary of the process followed in developing the PNA

In 2014 the Cambridgeshire Health and Wellbeing Board updated the 2011 PNA produced by the Primary Care Trust, NHS Cambridgeshire, to publish its first PNA, in line with the 2013 regulations[7] (An extract of part of these regulations can be found in Appendix 1).

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

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

The Cambridgeshire PNA 2014 remains available online at: http://cambridgeshireinsight.org.uk/other-assessments/pharmacy-needs-assessment.

The development of the 2014 PNA was overseen by a multi-agency Steering group, representing a wide range of stakeholders. The PNA steering group was re-convened with continued membership from the original 2014 steering group to oversee the process and content of the PNA (see Acknowledgements for list of steering group members). Details of the activities undertaken to update the 2014 PNA and a timeline are outlined in Appendix 4 which describes the document control of this report.

The legal regulations state that each PNA should have a maximum lifetime of three years. The full PNA process was therefore re-initiated in 2016, with the final PNA finalised and published in 2017. It includes updated information from the 2014 PNA and has engaged key stakeholders in identifying any new relevant issues.

As in 2014, the specific legislative requirements in relation to the development of PNAs[8] were duly considered and adhered to.

2.2 Methods

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

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

In developing the PNA for Cambridgeshire, information from the JSNA and Public Health sources were used to describe pharmaceutical provision throughout the county and local health needs that may be addressed through pharmaceutical services.

All pharmacies and dispensing GP practices in Cambridgeshire were also asked to complete a questionnaire describing their service provision (see Appendix 3). 93 of 110 (85%) community pharmacies and 34 of 43 (79%) dispensing GP practices in Cambridgeshire responded to the 2016 PNA questionnaire. This is slightly lower than the 2013 questionnaire which had response rates of 89% for community pharmacies and 88% of dispensing GP practices. The information received is described throughout Sections 4, 5 and 6.

Assessing need for pharmaceutical services is a complex process. In addition to taking account of all views submitted from stakeholders, the PNA considers a number of factors, including:[9]

- The size and demography of the population across Cambridgeshire.

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

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

2.3 Stakeholders involved in the development of the PNA

The process of developing the PNA has taken into account the requirement to involve and consult people about changes to health services. In revising the PNA, key partners were consulted to seek their views and initial feedback on the findings set out in the draft PNA 2017. In line with the 2013 Regulations,[10] this PNA process including the public consultation involved consulting with:

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

Views on the PNA draft findings were sought from the wider public in Cambridgeshire and other interested parties through a formal consultation running from 30 January 2017 to 30 April 2017. The feedback gathered in the consultation is described in a Consultation Report (Appendix 6) and a summary of how the draft PNA was amended to produce this final report in response to the feedback received is included as Appendix 7.

A good response was received to the public consultation, with 354 responses to the survey from individuals or groups. 323 of 354 respondents (91%) felt that the purpose of the PNA was explained sufficiently and 304 of 354 respondents (86%) felt that the draft PNA adequately described current pharmaceutical services in Cambridgeshire. 293 of 354 respondents (83%) agreed with the key findings about pharmaceutical services in Cambridgeshire as outlined in the PNA.

2.4 Future PNAs and supplementary statements

The PNA will continue to be updated every three years and supplementary statements may be published before this if deemed necessary by the HWB. HWBs are required to publish a

[10] Ibid.

revised assessment when significant changes to the need for pharmaceutical services are identified, unless this is considered a disproportionate response.[11] The Cambridgeshire PNA Steering Group will continue to identify changes to the need for pharmaceutical services within their area and assess whether the changes are significant.

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

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

On 20th October 2016 the Government imposed a two-year funding package on a community pharmacy, with a £113 million reduction in funding in 2016/17.[12] This is a reduction of 4% compared with 2015/16, and will be followed by a further 3.4% reduction in 2017/18.[13] Key changes were also made to the national pharmacy contract with the aim of creating a more efficient service which is better "*integrated with the wider health and social care system."*[14]

Full details of the final Community Pharmacy proposals can be found in the Department of Health (DoH) report "*Community pharmacy in 2016/2017 and beyond: final package*"[15]. Appendix 5 provides a summary of the proposed changes to the pharmacy contracts and the potential impact of these as assessed by the DoH and the national Pharmaceutical Services Negotiating Committee (PSNC) who represent all community pharmacies providing NHS services in England.

The changes also include a new 'Pharmacy Access Scheme' which aims to ensure that populations have access to a pharmacy, especially where pharmacies are sparsely spread and patients depend on them most. Qualifying pharmacies will receive an additional payment, meaning those pharmacies will be protected from the full effect of the reduction in funding from December 2016. Nationally 1,356 pharmacies have qualified for the scheme. In Cambridgeshire, 30 pharmacies have been identified which is 27% of all current pharmacies as at October 2016 (see Appendix 5 and **Map 15)**.

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

The Cambridgeshire Local Pharmaceutical Committee will focus on supporting local pharmacies by keeping them up to date with changes/details, to meet the quality agenda, and to take up and deliver locally commissioned services more effectively. The PNA steering

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

group will continue to monitor any potential closures or mergers of local pharmacies and issue appropriate statements of fact as necessary in line with PNA requirements.

Of particular relevance to this PNA at this point in time, is that amendments were also made to the pharmacy *National Health Service (Pharmaceutical Services, Charges and Prescribing) Regulations 2013* in December 2016.[16] One key change was a new regulation which describes the potential consolidation of two or more pharmacies onto one existing site. A new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes which would protect two pharmacies that choose to consolidate on a single existing site – where this does not create a gap in provision.

> "*Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means in general terms they will not be assessed against … the pharmaceutical needs assessment ("PNA") produced by the HWB. Instead, they will follow a simpler procedure, the key to which is whether or not a gap in pharmaceutical service provision would be created by the consolidation….. If the NHSCB is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application. The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought (regulations 12 and 13). If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement published alongside its pharmaceutical needs assessment recording its view (regulation 3).*"[17]

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

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

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

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

3 Understanding local health needs

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

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

3.1 Cambridgeshire Joint Strategic Needs Assessments

A JSNA is the means by which partners in the Health and Wellbeing Board describe the health, care and wellbeing needs of the local populations and seeks to identify a strategic direction of service delivery to meet those needs.[18]

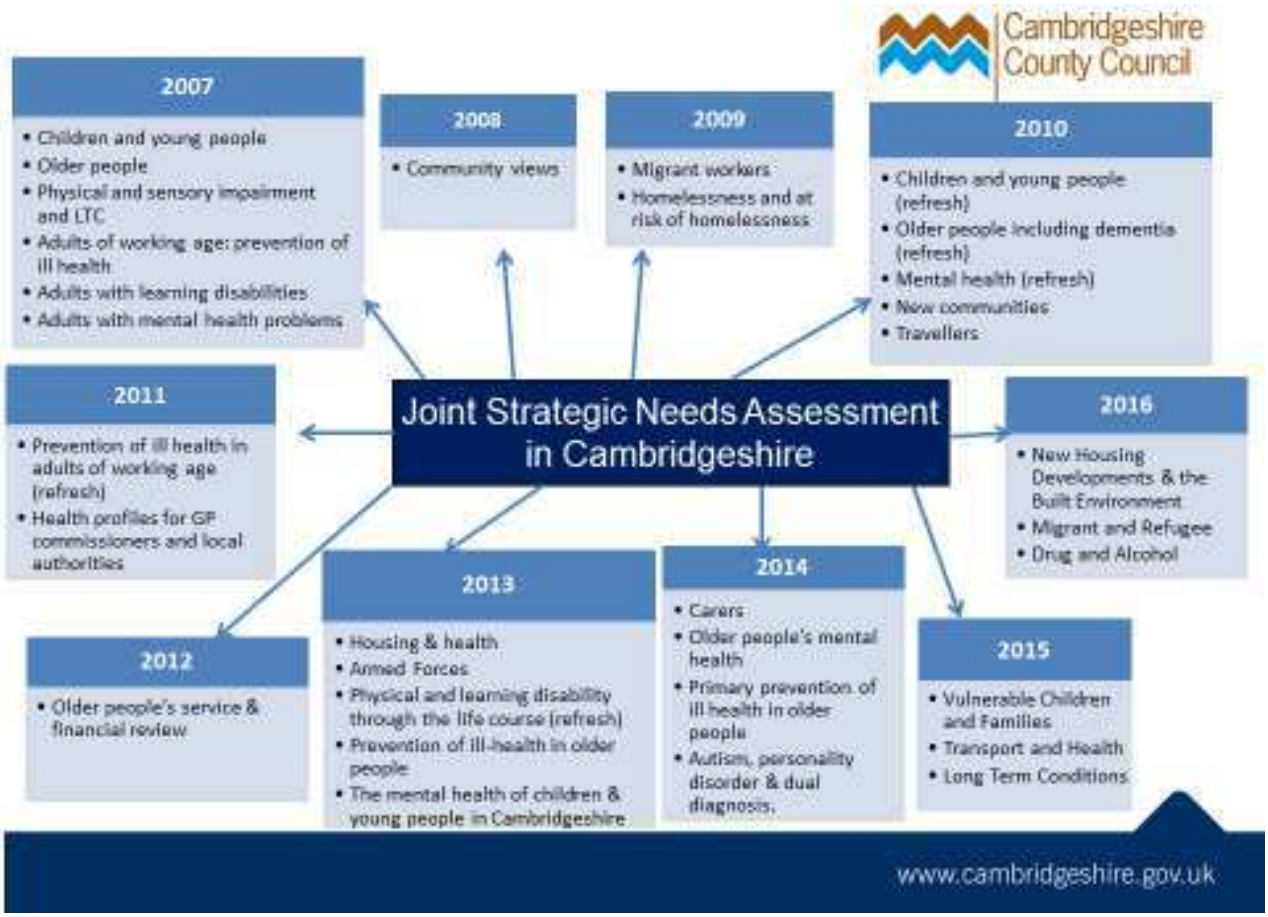
The aim of a joint strategic needs assessment is to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities. This includes:

- Providing analyses of data to show the health and wellbeing status of local communities.
- Defining where inequalities exist.
- Providing information on local community views and evidence of effectiveness of existing interventions which will help to shape future plans for services.
- Highlighting key findings based on the information and evidence collected.[19]

The Cambridgeshire Insight website www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment publishes all the local JSNA reports and supporting documentation, including additional data and specific topic area reports for the local area. The JSNAs developed for Cambridgeshire are shown in **Figure 1**.

[18] Cambridgeshire JSNA. 'What is the joint strategic needs assessment?'
Available at: http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/what-jsna
[19] Ibid.

Figure 1. Joint Strategic Needs Assessments developed for Cambridgeshire



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

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

The data that underpins the JSNA have been updated and include a county and district health atlas www.cambridgeshireinsight.org.uk/interactive-maps. A local Public Health Outcomes Framework document containing district data and profiles for the Clinical Commissioning Group (CCG) and Local Commissioning Groups (LCGs) can also be found at www.cambridgeshireinsight.org.uk/health.

The Annual Public Health Report for Cambridgeshire 2015-2016 looks at health issues at a local level, providing a series of 'health maps' of the county broken down into individual electoral wards. It also provides brief case studies of what can be done at community level to support healthy lifestyles and wellbeing. The Annual Public Health Report for Cambridgeshire 2014-2015 looked at changes and trends in public health outcomes over recent years. Understanding which outcomes are improving and which are deteriorating helps to identify emerging problems and target resources to address them. These reports are available at: http://cambridgeshireinsight.org.uk/health/aphr.

3.2 Cambridgeshire Health and Wellbeing Board

The Cambridgeshire Health and Wellbeing Board and Network brings together leaders from local organisations which have a strong influence on health and wellbeing, including the commissioning of health, social care and public health services. The HWB focuses on planning the right services for Cambridgeshire and securing the best possible health and wellbeing outcomes for the local community.[20]

The work of the Board is guided by the Cambridgeshire Health and Wellbeing Strategy 2012-17. The Strategy sets out the priorities the HWB and Network feel are most important for local people, based on the JSNA and other relevant sources of information.

The strategy includes the following six key priorities:[21]

1. Ensure a positive start to life for children, young people and their families.
2. Support older people to be independent, safe and well.
3. Encourage healthy lifestyles and behaviours in all actions and activities whilst respecting people's personal choices.
4. Create a safe environment and help to build strong communities, wellbeing and mental health.
5. Create a sustainable environment in which communities can flourish.
6. Work together effectively.

Further details about the Cambridgeshire Health and Wellbeing Strategy and the work of the Cambridgeshire Health and Wellbeing Board and Network can be found at: http://cambridgeshireinsight.org.uk/health/hwb.

3.3 Cambridgeshire and Peterborough Clinical Commissioning Group

The Cambridgeshire and Peterborough CCG is the clinical commissioning body for the county of Cambridgeshire and the Unitary Authority of Peterborough. In addition, the CCG also includes some GP practices in Hertfordshire and Northamptonshire. The 'boundary' for the CCG is illustrated in **Map 1**. It should be noted that the boundary for the CCG is not the same boundary as for the Cambridgeshire Health and Wellbeing Board and therefore this PNA relates only to Cambridgeshire. Peterborough Health and Wellbeing Board are responsible for assessing pharmaceutical needs for Peterborough and produces a separate Pharmaceutical Needs Assessment, available at: https://www.peterborough.gov.uk/healthcare/public-health/pharmaceutical-needs-assessment/.

The CCG is responsible for designing and buying health services for around 933,000 people across Cambridgeshire, Peterborough, Hertfordshire and Northamptonshire. Clinicians are involved at every level of decision-making. Further information about the role of Cambridgeshire and Peterborough CCG is available on their website: www.cambridgeshireandpeterboroughccg.nhs.uk.

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

- improve the quality of the services provided;
- encourage and support people to take action to maintain their own health and wellbeing;

[20] Cambridgeshire Health and Wellbeing Board. Available at: http://cambridgeshireinsight.org.uk/health/hwb
[21] Ibid.

- ensure that health and care services are financially sustainable and that commissioners make best use of the money allocated to the local population;
- align NHS and local authority plans.

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

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

3.4 National Outcomes Frameworks

In addition to local priorities there are national priority areas for improvement in health and wellbeing. The Department of Health has published outcomes frameworks for the NHS, CCGs, Social Care, and Public Health which offer a way of measuring progress towards achieving these aims. The Public Health Outcomes Framework (PHOF) for England, 2013-2016 sets out desired outcomes for public health, focussing on two high-level outcomes:

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

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

3.5 National policy context

An independent '*Community Pharmacy Clinical Services Review'* ('the Murray report')[22] was commissioned by the Chief Pharmaceutical Officer and published by the Kings Fund in December 2016. The report provides a useful summary of national policy reports over the past eight years which have described opportunities for expanding the role of community pharmacy and pharmacists. However, the report highlights the fact that there remains significant untapped potential for better utilising the clinical skills and expertise of the community pharmacy team.

The *2008 White Paper*[23] set out a vision for expansion of the pharmacy role from simply dispensing and supplying medicines to additional clinical services e.g. treating common minor ailments; providing public health services such as smoking cessation support and sexual health services; supporting those with long term conditions; delivering some clinical services such as blood tests and screening programmes; and involvement in clinical

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

[23] Department of Health. 'Pharmacy in England Building on strengths – delivering the future'. (2008). Available at: https://www.gov.uk/government/publications/pharmacy-in-england-building-on-strengths-delivering-the-future

pathways that support integrated care.[24] In 2013, the Royal Pharmaceutical Society published a report '*Now or Never*'[25] which proposed that the skills of pharmacists were greatly under-utilised and outlined areas where pharmacists could contribute to, in particular, the management of long-term conditions and urgent care pathways. A Nuffield Trust report published in 2014[26] found that "*pharmacists at a local level continue to persuade some local commissioners to fund innovative services to support health and social care, but such progress remains patchy and lacks scale. At a national level, there has been disappointingly little progress over the last year in shifting the balance of funding and commissioning away from the dispensing and supply of medicines toward the delivery of direct patient services*".

The Murray report proposes that pharmacy needs to be a 'core part of the integrated, convenient services that people need', although the report identifies that this has proven difficult to achieve thus far. NHS England's *Five Year Forward View* (October 2014)[27] and the *General Practice Forward View* (April 2016)[28] set out proposals for the future of the NHS based around new models of care, and offer a strategic opportunity to review and revisit the role of community pharmacy in the health and care system. The Murray report recommends that pharmacy needs to be fully integrated into the new models of care developed by the Vanguard programme, particularly into the following four of the five groups:

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

(The role of pharmacy in the 5th group relating to acute care collaboration may be more relevant to hospital than community pharmacy).

Sustainability and Transformation programmes (STPs) across 44 'footprint' areas in England aim to bring together health and care stakeholders to develop local plans for how local services will evolve and become sustainable over the next five years. The Murray report recommends that efforts are made to ensure that community pharmacy are involved in this work: "*Community pharmacy can provide a wide range of services that provide value for money at the same time as providing a new way to meet patient demand and indeed contribute to reducing demand through better public health*". [29]

There is a need in the medium-term to "*ensure that community pharmacy is integrated into the evolving new models of care alongside primary care professional. This will include enhancing the support they provide to people with long-term conditions and public health,*

[24] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 4. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf
[25] Royal Pharmaceutical Society. 'Now or never: shaping pharmacy for the future'. (November 2013). Available at: https://www.rpharms.com/resources/reports/now-or-never-shaping-pharmacy-for-the-future.
[26] The Nuffield Trust. 'Now more than ever: why pharmacy needs to act' (December 2014). Available at: https://www.nuffieldtrust.org.uk/research/now-more-than-ever-why-pharmacy-needs-to-act
[27] NHS England. 'Five Year Forward View' (October 2014). Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[28] NHS England 'General Practice Forward View' (April 2016) Available at: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
[29] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016). Page 13. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf

but should not be limited to these."[30] At a national level, the Murray report calls for NHS England and national partners to consider how best to support STPs in integrating community pharmacy into plans and overcoming barriers in the complexities of the commissioning landscape. At a local level, the Health and Wellbeing Board could encourage the involvement of pharmacies and pharmacy teams in developing local plans and systems of integrated working and the incorporation of best practice and evidence as it becomes available.

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

- integrating community pharmacists and their teams into care pathways for long-term conditions;
- involving community pharmacists and their teams in case finding programmes for certain conditions e.g. hypertension;
- developing contractual mechanisms for incentivising more rapid uptake of independent prescribing and utilising clinical skills of pharmacists as groups and individuals.

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

3.6 Characteristics of the population in Cambridgeshire

Cambridgeshire is a predominantly rural county with few urban settlements, which can create challenges for local transport and access to services. There are five district councils in Cambridgeshire: Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire. These districts can be more locally described by electoral wards or Middle Super Output Areas (MSOAs) (see **Map 2)**.

Close to the county borders of Cambridgeshire there are three large settlements, Wisbech, Whittlesey and St Neots. Eight areas border Cambridgeshire – Norfolk, Suffolk, Peterborough, Northamptonshire, Bedfordshire, Hertfordshire, Essex and Lincolnshire.

3.6.1 Demography

The mid 2016 population of Cambridgeshire was approximately 663,700 people.[31] The age composition of the population varies by district, with a higher proportion of people aged 65 years or older living in Fenland compared to other areas in the county (see **Map 3)**.

The population is forecast to increase substantially in the coming years, with the biggest increases seen in the age group of over 65 years. There are also several major housing developments underway across Cambridgeshire. The impact of this population growth on pharmaceutical needs is discussed in Section 6 of the PNA.

3.6.2 Deprivation

Pockets of deprivation are found in Cambridge City, Huntingdonshire, and Fenland (see **Map 4**).

[30] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 18. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf

[31] 2013-based population forecasts, Cambridgeshire Research Group

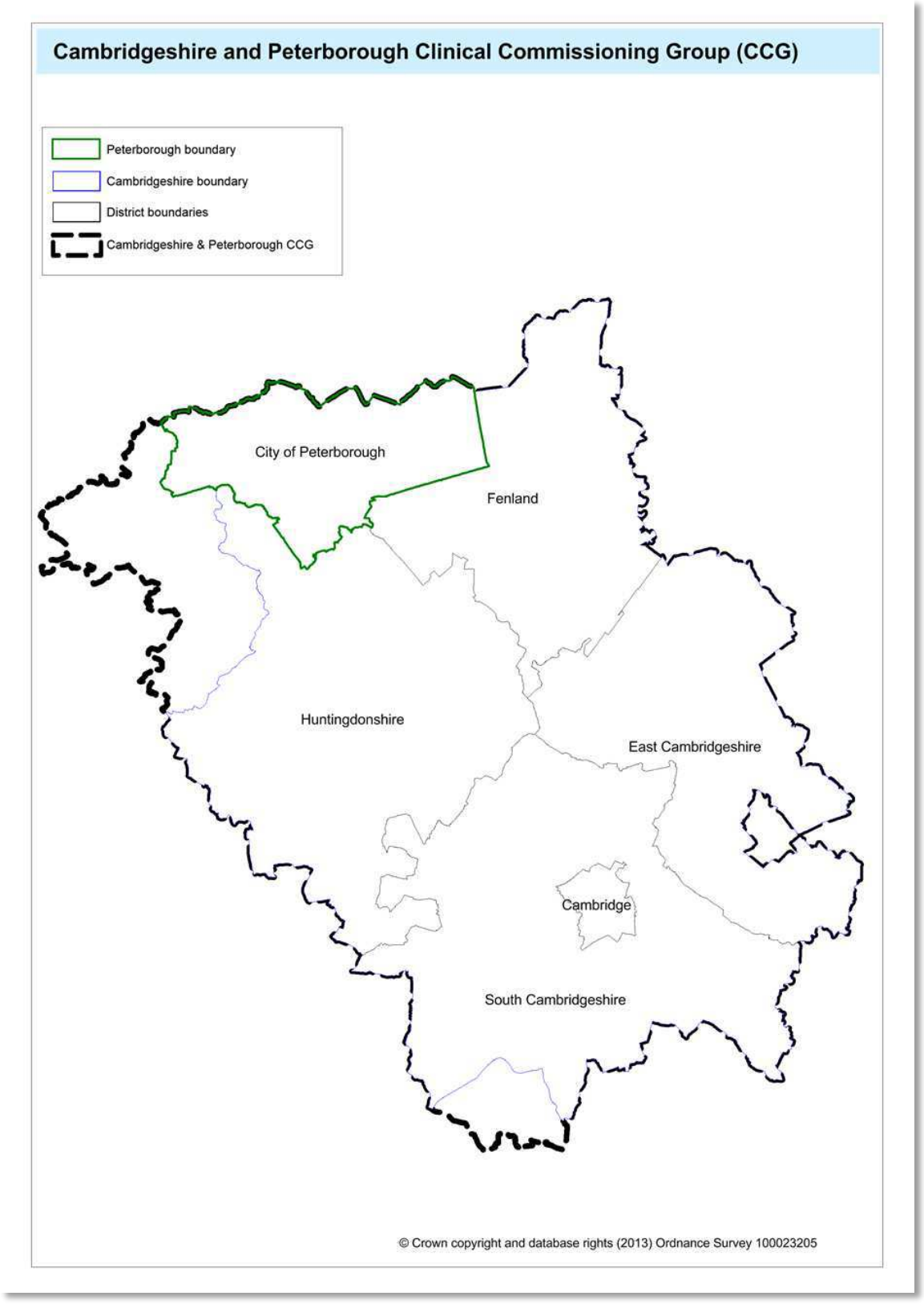
3.6.3 Ethnicity

Data from the 2011 Census indicates that the number of foreign-born individuals living in Cambridgeshire increased from 48,556 to 85,698 people during 1995-2010, an increase of 77%. Around 1% of the foreign-born population in England reside in Cambridgeshire.[32] Considerable populations of travellers and migrant workers also reside in Cambridgeshire.

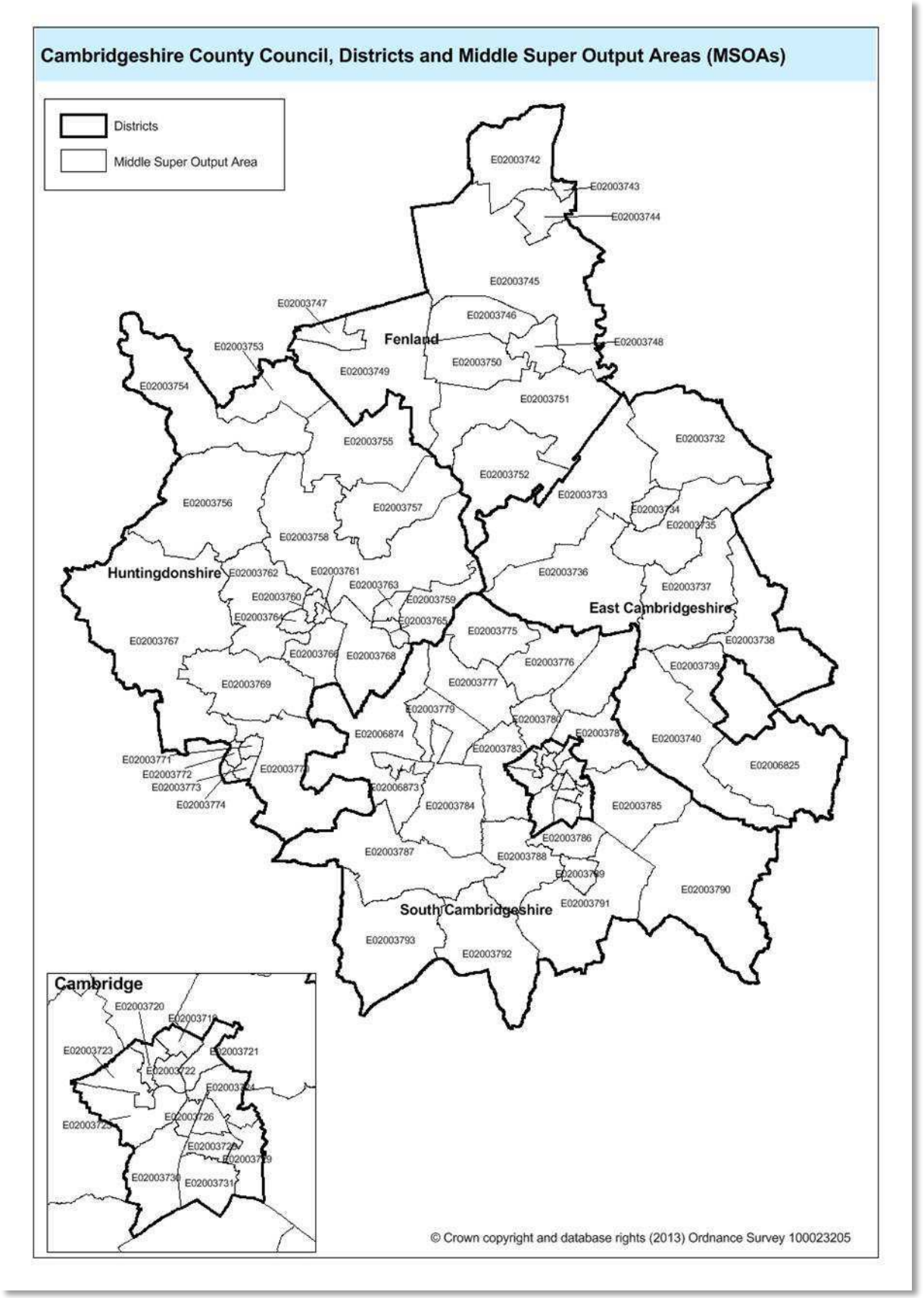
For further information on health needs, please refer to the Migrant and Refugee Joint Strategic Needs Assessment Report 2016 (available at: http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/migrant-and-refugee-2016).

[32] http://www.migrationobservatory.ox.ac.uk/sites/files/migobs/Migrants%20in%20the%20UK-Overview_0.pdf (Accessed 1st October 2013).

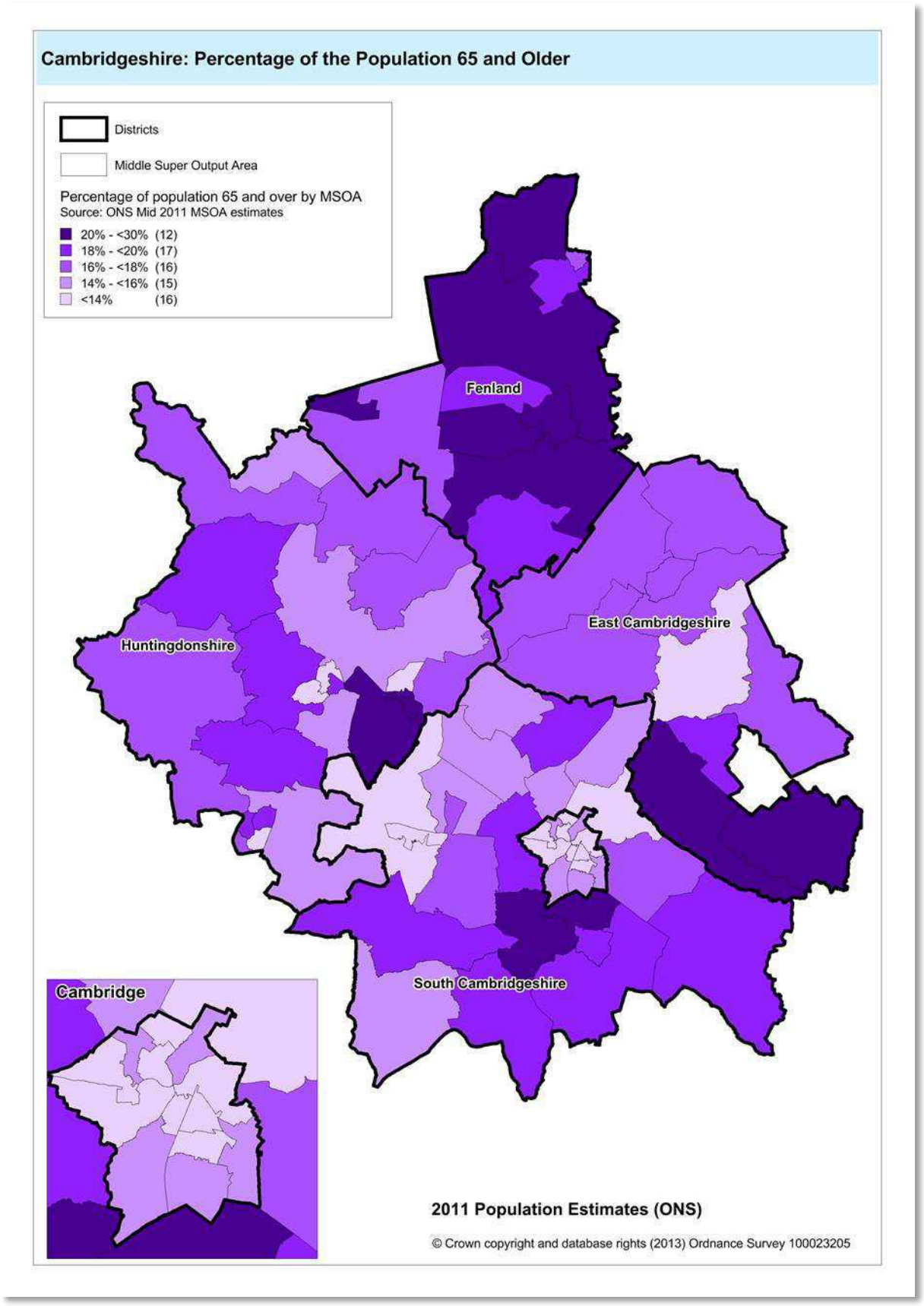
Map 1. Boundary of Cambridgeshire and Peterborough Clinical Commissioning Group



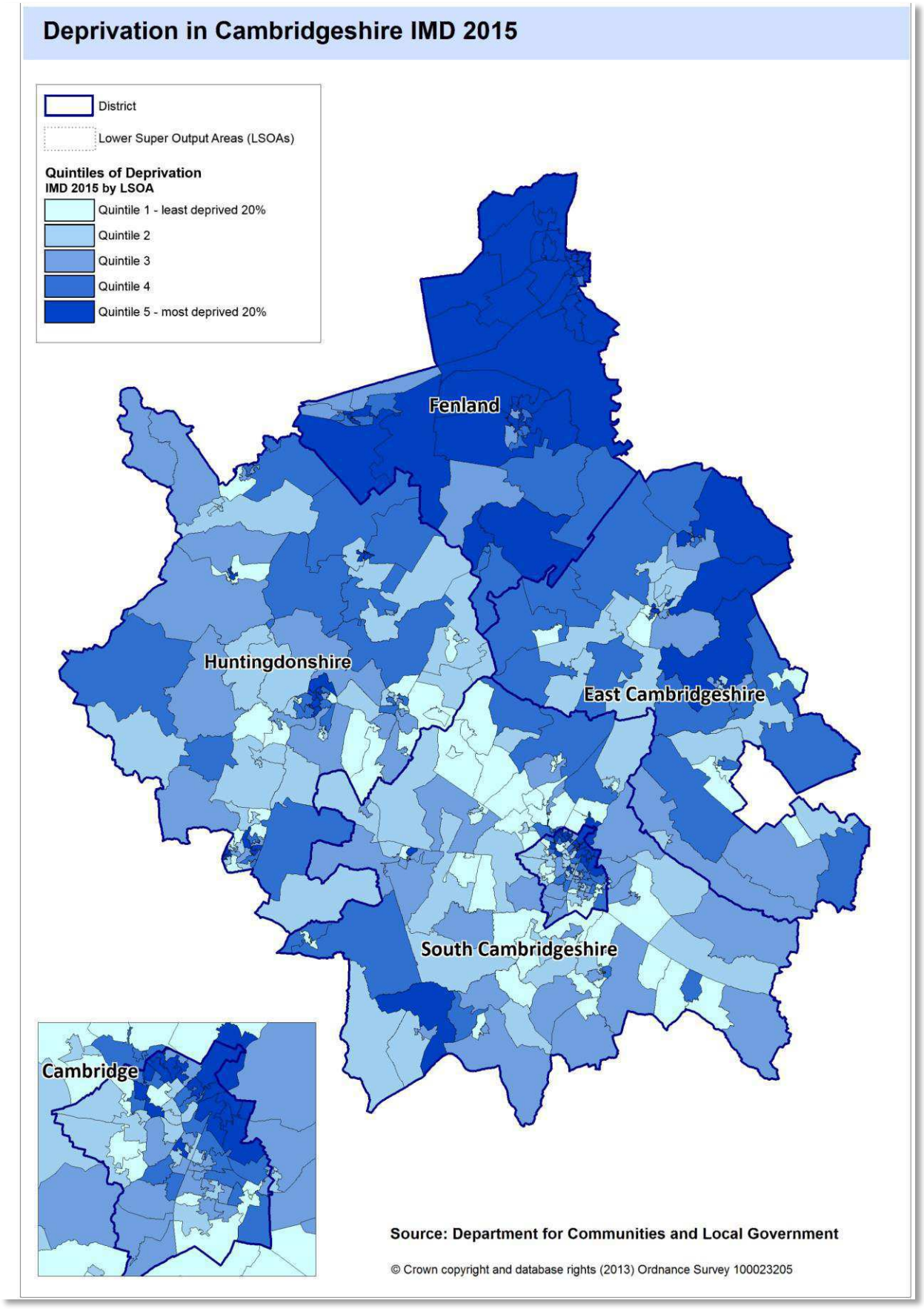
Map 2. Middle layer Super Output Areas (MSOAs) in Cambridgeshire



Map 3. Percentage of the population in Cambridgeshire aged 65 years or older



Map 4. Deprivation in Cambridgeshire



3.6 General health across Cambridgeshire

The health of the Cambridge population is generally similar to or better than the England average, but important local variations exist within the county. An interactive map of key demographic and health-related data has been created that illustrates the latest available data by local authority district for a number of key indicators relating to the health of the local population.[33]

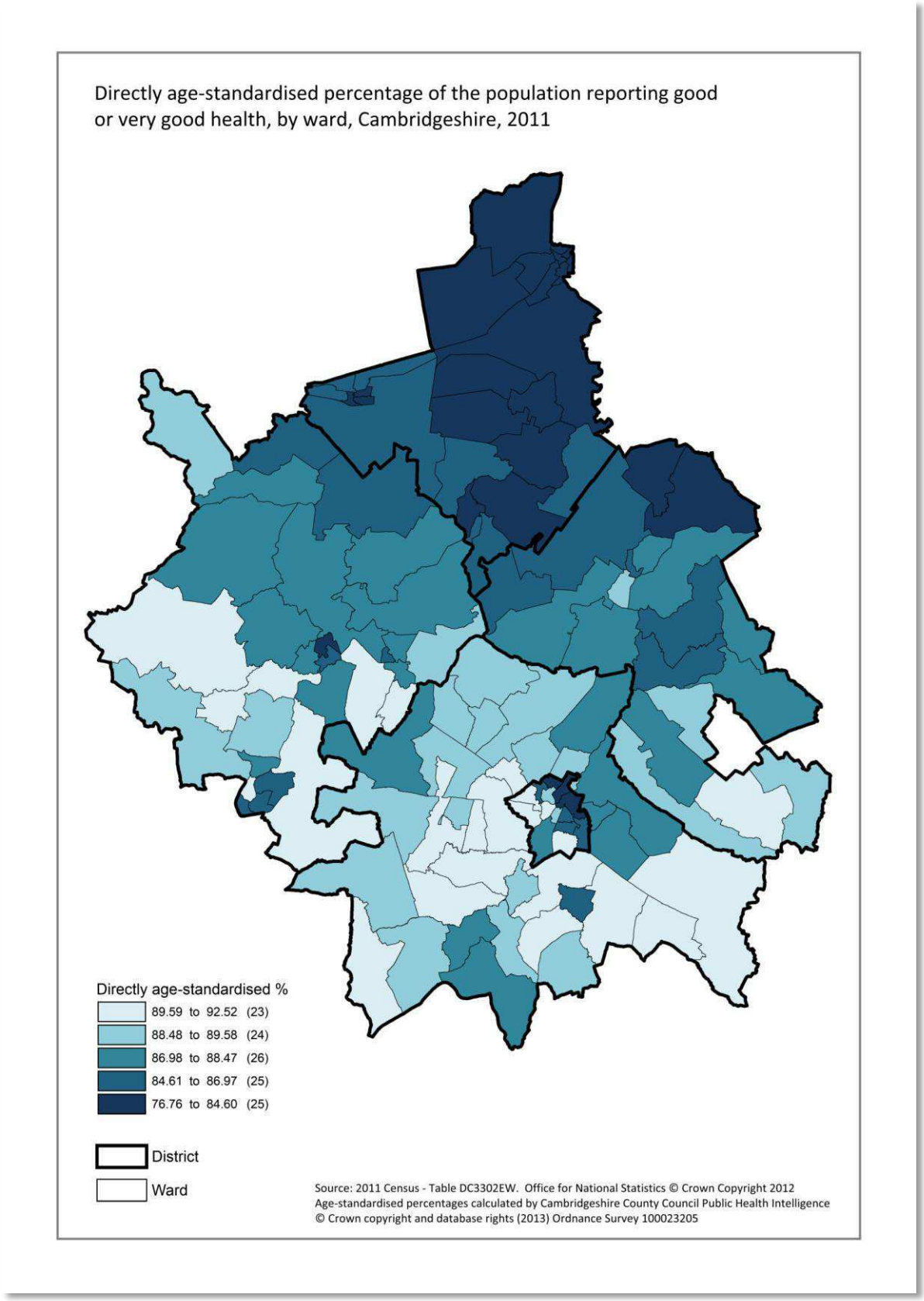
Overall, Cambridgeshire has a favourable health profile but, compared to the national average, substantial local variation exists within the county. There are important differences in health across Cambridgeshire, as illustrated in **Map 5**. Map 5 uses data from the 2011 Census to illustrate the proportion of the population in different areas of Cambridgeshire who report being in good or very good health. Broadly, the map shows darker shades in the northern areas of the county which means fewer people who report being in good or very good health. The data in the map have been age standardised, which means that the differences in self-reported health are not due to differences in age.

A local health briefing giving health information for each district council area is available on the Cambridgeshire Insight website.[34] This local summary can help to highlight sub-county inequalities and monitor progress. More information about the Public Health Outcomes Framework (PHOF) in Cambridgeshire and other areas can be found at: http://cambridgeshireinsight.org.uk/health/phof and http://healthierlives.phe.org.uk/topic/mortality

Comparing the prevalence of common conditions of the practices within the CCG with the England average gives an indication of the health of the local population. A more convenient way of viewing individual practices are the practice profiles at https://fingertips.phe.org.uk/profile/general-practice. Some insight into the health needs at GP practice population level can also be gained from the Quality and Outcomes Framework data of the local GPs. Entering a postcode at http://www.qof.ic.nhs.uk/search.asp returns a list of GPs in the proximity of the postcode.

[33] Available at: http://www.cambridgeshireinsight.org.uk/interactive-maps/health.
[34] Available at: http://www.cambridgeshireinsight.org.uk/health

Map 5. Directly age-standardised percentage of the population reporting good or very good health, by ward, Cambridgeshire 2011



4 Current Provision of NHS Pharmaceutical Services

This section describes the current provision of NHS pharmaceutical services, in order to assess the adequacy of provision of such services. Also included is a description of the number and locations of community pharmacies, dispensing GP practices and national Dispensing Appliance Contractors (DACs) premises. Information was collected up until 31 July 2016. Up-to-date information on community pharmacies (including opening hours) is available on the NHS website: www.nhs.uk/servicedirectories/Pages/ServiceSearch.aspx.

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

4.1 Summary of key findings

Key message: There is currently sufficient pharmaceutical service provision across Cambridgeshire. No need for additional pharmaceutical service providers is identified at present in this PNA.

Cambridgeshire has one pharmaceutical service provider per 4,258 people, equivalent to 23 pharmaceutical service providers per 100,000 resident population in Cambridgeshire. This is the same as the national average of 23 per 100,000 resident population and slightly lower than the East of England average of 24 pharmaceutical providers per 100,000 resident population. Estimates of the average number of people per pharmaceutical service provider across Cambridgeshire have remained relatively stable since 2011.

As of July 2016 there were:

- **110 pharmacies in Cambridgeshire (only slightly more than 109 in July 2013 and 101 in January 2011).**
- **43 dispensing GP practices in Cambridgeshire (unchanged from July 2013 and January 2011).**
- **One Dispensing Appliance Contractor (unchanged since 2011).**

Taking into account current information from stakeholders including community pharmacies and dispensing GP practices, the number and distribution of pharmaceutical service provision in Cambridgeshire is sufficient. The distribution of pharmacies and dispensing GP practices appears to cover the county well with few gaps and some concentrations. Some geographical gaps appear to exist in some of the less populated areas in the north and southern fringes of the county but these localities are served by suppliers from outside the county. In terms of postal addresses, across all of Cambridgeshire, there are only 67 postal addresses registered as a residential property that are located more than 20 minutes away by car from a pharmacy or dispensing surgery.

Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services in Cambridgeshire. There appears to be good coverage in terms of opening hours across the county. Overall, out of 110 community pharmacies, 45 (41%) are open after 6pm and 26 (24%) are open after 7pm on weekdays; 90 (82%) open on Saturdays; and 22 (20%) open on Sundays. The out of hours service, Hertfordshire Urgent Care is required to arrange for the provision of a full course of treatment, if clinically necessary, before a community pharmacy is open.

Home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport. Of the pharmaceutical providers who completed the questionnaire, 89 pharmacies (95.7%) and 21 dispensing GP practices (61.8%) have some form of delivery service in operation, more than in 2013.

The proportion of providers reporting that they have wheelchair access to consultation facilities has increased since 2013 from 80.4% to 93% of community pharmacies and from 86.8% to 88.2% of dispensing GP practices.

All community pharmacy and GP dispensing practices who responded to the questionnaire considered local provision to be 'adequate' or better, with 39% of pharmacies and 56% of dispensing GP practices reporting provision as 'excellent' and 55% of pharmacies and 41% of dispensing GP practices as 'good'.

4.2 Service Providers – numbers and geographical distribution

4.2.1 Community pharmacies

There were a total of 110 community pharmacies within Cambridgeshire as of 31 July 2016. This represents a small increase from 109 in July 2013 and 101 in January 2011. The names of the community pharmacies within Cambridgeshire are listed in Appendix 2 and their locations shown in **Map 6**.

4.2.2 Dispensing GP practices

The rurality of parts of Cambridgeshire has led to relatively high numbers of dispensing GP practices. There were 43 dispensing GP practices within Cambridgeshire as of 31st July 2016. This is unchanged from 2013. The names of the dispensing GP practices within Cambridgeshire are listed in Appendix 2 and their locations shown in **Map 7**.

Out of 691,180 people registered with a GP in Cambridgeshire, 129,576 people (19.1%) were registered as dispensing patients with a dispensing GP practice as at September 2015.[35] It should be noted that some of these patients may have an address outside Cambridgeshire, and similarly some patients with an address in Cambridgeshire could be registered with a practice in another county.

Access to GPs in general (not only dispensing practices) appears to be good in Cambridgeshire compared to the East of England and England. Cambridgeshire has more full time GPs per 100,000 registered population than both the regional and England average (see **Table 1**). For locations of GP practices across the CCG area, see **Map 8**.

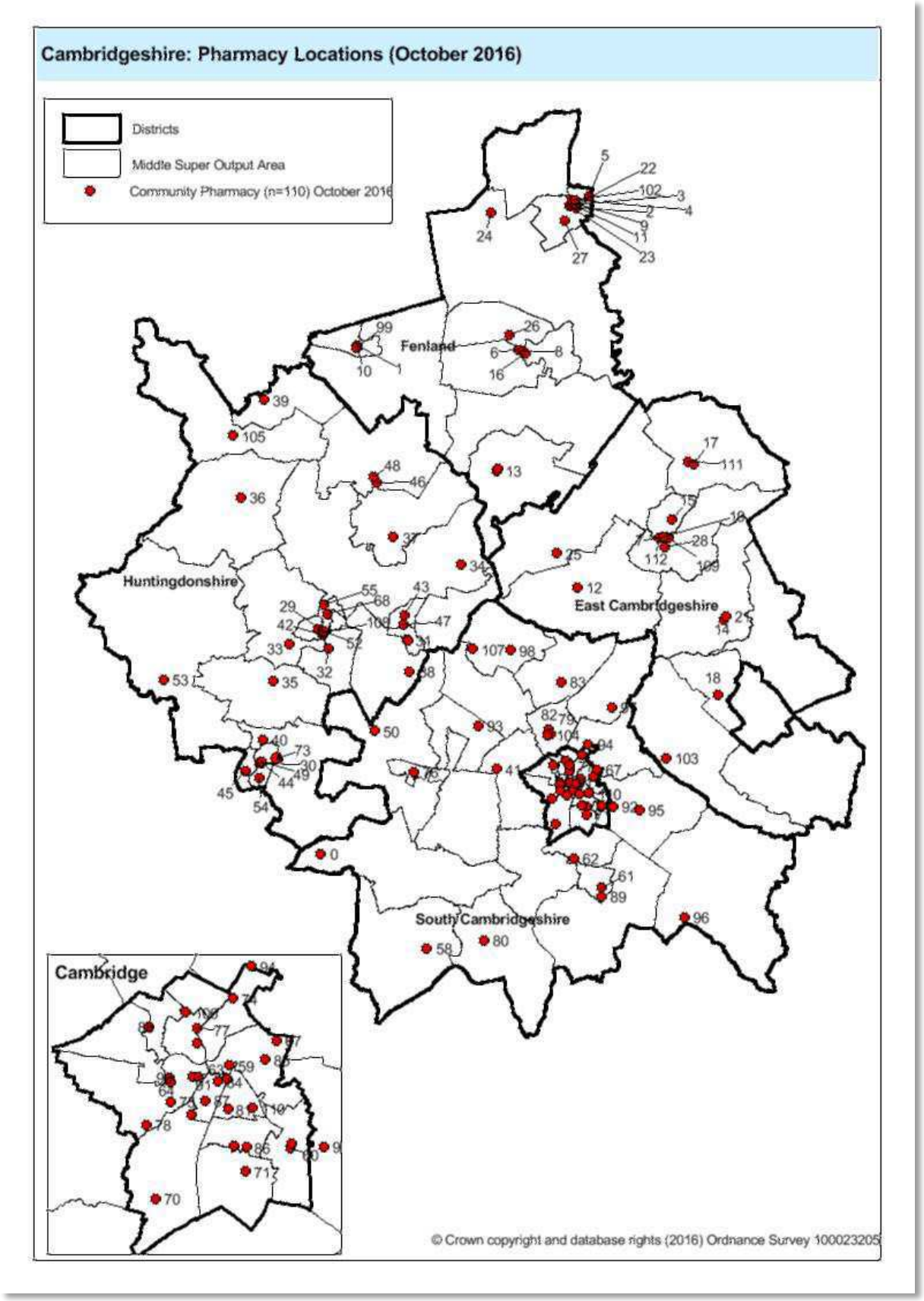
Table 1. Average numbers of full time equivalent GPs per 100,000 registered population, 2015/16

Cambridgeshire	East of England	England
56.2	49.4	48.7

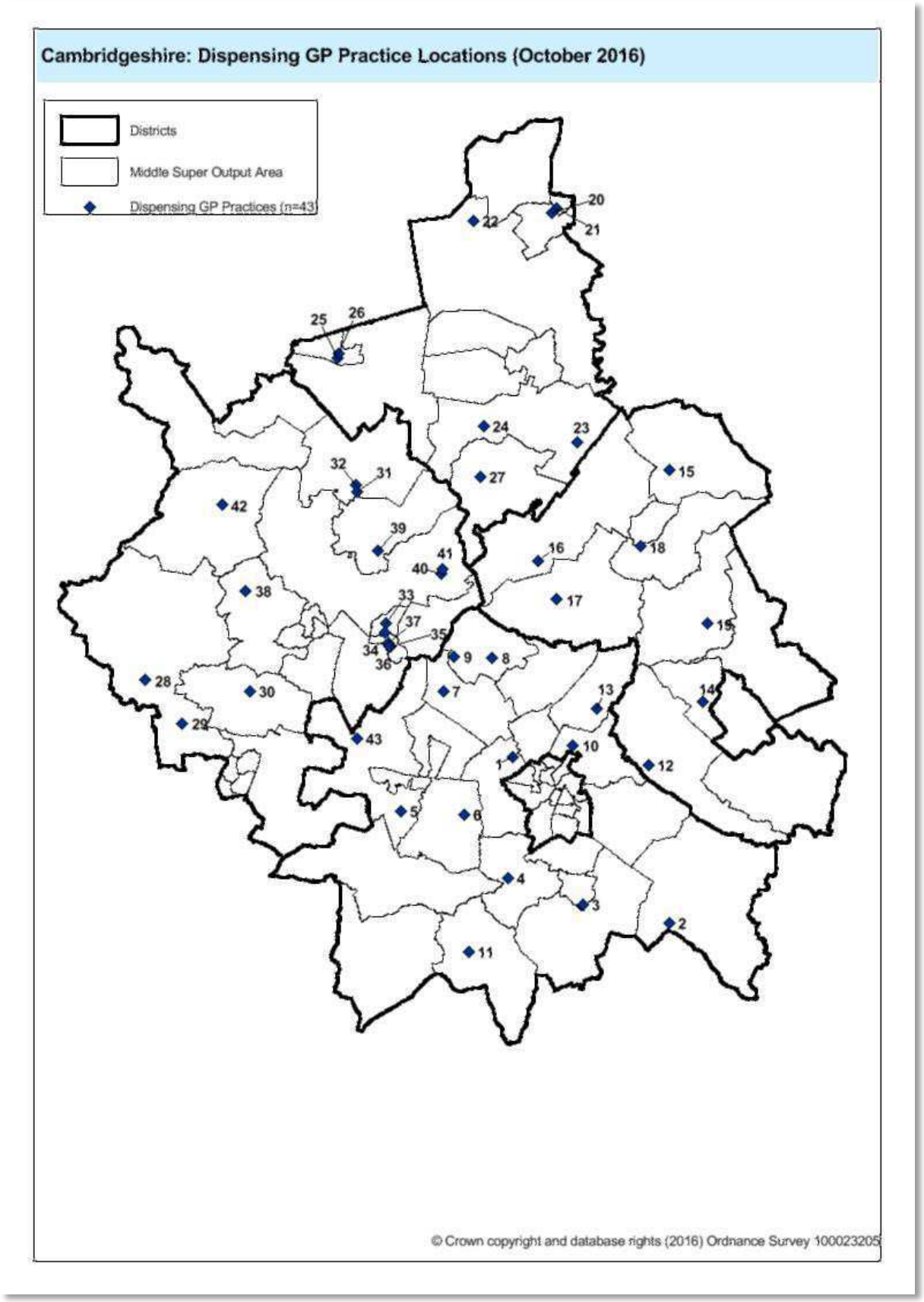
Source: NHS Digital. NHS Staff Workforce Census
Available at: http://content.digital.nhs.uk/catalogue/PUB20503

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

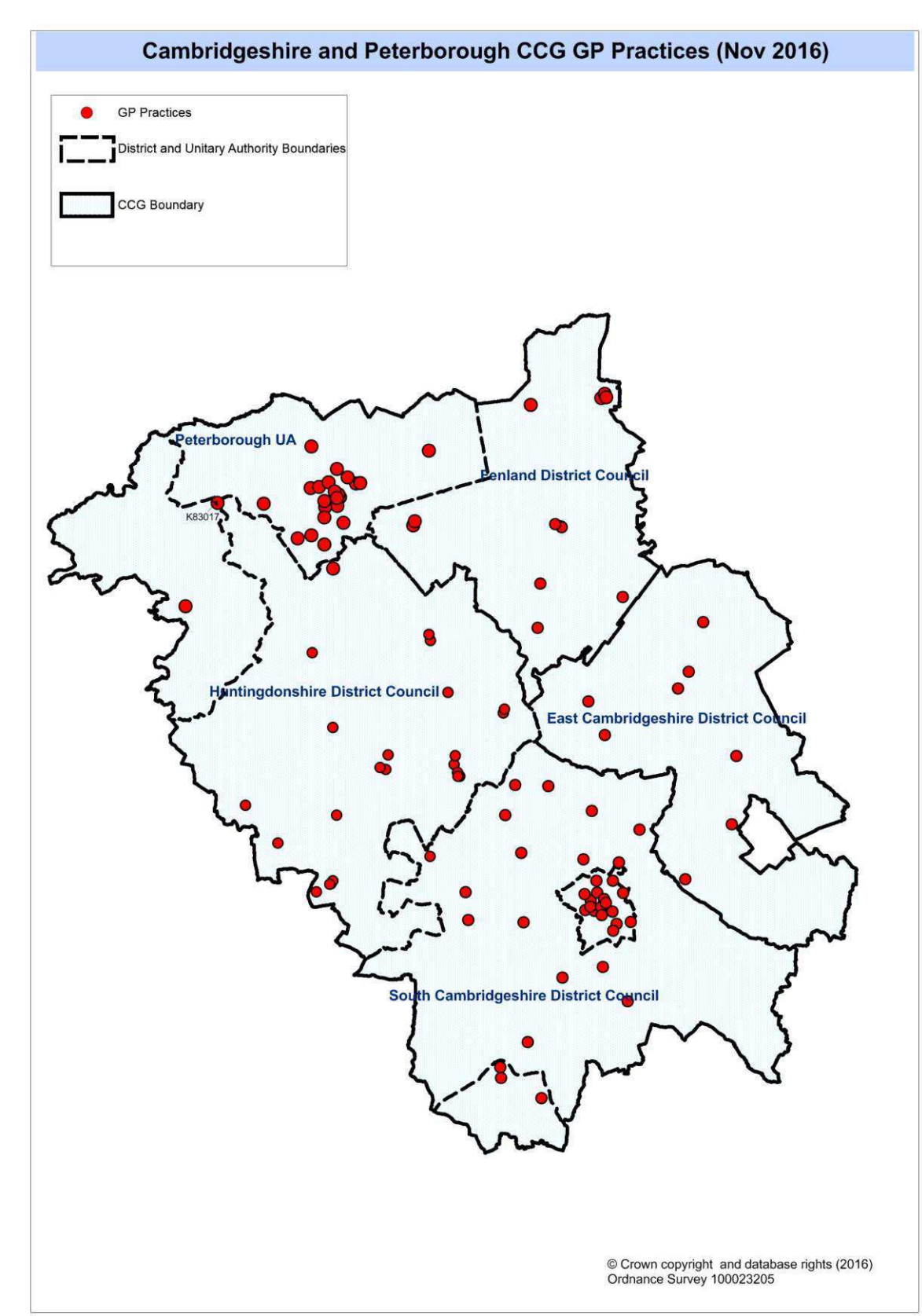
Map 6. Pharmacy Locations (for key code see list of pharmacies in Appendix 2)



Map 7. Dispensing GP Practice Locations (for key codes see list in Appendix 2)



Map 8. Locations of GP practices in Cambridgeshire & Peterborough CCG



4.2.3 Distance selling pharmacies

There was one mail order/wholly internet pharmacy within Cambridgeshire as of 31st July 2016. Three other such pharmacies have existed in the county but two closed in 2013 and the third closed in January 2016.

Patients have the right to access pharmaceutical services from any community pharmacy including mail order/wholly internet pharmacy of their choice and therefore can access any of the many internet pharmacies available nationwide.

4.2.4 Dispensing Appliance Contractors

There is currently one Dispensing Appliance Contractor (DAC) within Cambridgeshire (who supplies appliances alone but cannot supply medicines): Fittleworth Medical, Histon. Appliances are also available from community pharmacies, dispensing GP practices and other DACs from outside the county.

From the questionnaires sent out to Cambridgeshire pharmaceutical service providers, 83 of the 93 pharmacies that responded (89%) reported that they provided all types of appliances. In addition, some pharmacies provide certain types of appliances. 15 of 34 (41%) dispensing GP practices who returned the questionnaire reported providing all types of appliances. In addition, several such practices provided certain types of appliances. Further detail regarding which types of appliances are provided can be found in the results from the Community Pharmacy and Dispensing Practice questionnaire reported in Appendix 3.

4.2.5 Hospital pharmacies

There are four hospital pharmacies providing services to the Cambridgeshire population:

- Addenbrooke's;
- Papworth;
- Hinchingbrooke;
- Cambridgeshire and Peterborough Mental Health Trust.

In addition, pharmacy services are provided to community hospitals run by Cambridgeshire and Peterborough Foundation Trust (CPFT).

4.2.6 Pharmacy services in prisons

There are pharmacy services provided to HMP Whitemoor and HMP/YOI Littlehey.

4.2.7 Comparison with pharmaceutical service provision elsewhere

Assuming a resident population of 653,400 people[36] in Cambridgeshire and 153 providers of pharmaceutical services (including 110 community pharmacies and 43 dispensing GP practices), there is on average one service provider per 4,258 people. Stated in a different way, there are 23 pharmaceutical service providers per 100,000 people in Cambridgeshire. This is the same as the national average of 23 pharmaceutical providers per 100,000 and only slightly lower than the East of England average of 24 pharmaceutical providers per 100,000 (see Table 2).

[36] Calculations based on ONS resident population figures as per Table 2.

Table 2. Average numbers of pharmaceutical providers (community pharmacies and dispensing GP practices) per 100,000 resident population, 2015/16

Cambridgeshire	East of England	England
23	24	23

Source: NHS Prescription Services of the NHS Business Services Authority, Population data - Office for National Statistics. Dispensing Practices in England from NHS Prescription Authority.

Information about pharmaceutical providers in other areas in England is shown in **Table 3**.

In terms of *community pharmacies alone*, there were 22 pharmacies per 100,000 population in England in 2015/16, a slight increase from 21 per 100,000 in 2011/12. The number of *community pharmacies* per 100,000 population ranged from 18 per 100,000 population in South Central to 26 community pharmacies per 100,000 population in two areas in the North of England. In the East of England the average was 19 per 100,000 (unchanged from 2011/12).

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

Table 3. Community Pharmacies and Dispensing GPs by NHS Regions, 2015/16

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

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

Source: NHS Prescription Services of the NHS Business Services Authority, Population data - Office for National Statistics. http://content.digital.nhs.uk/phs1 Dispensing Practices in England from NHS Prescription Authority.[37]

[37] Note this table is combined data from NHS Digital and NHS Prescription Authority. Dispensing practices downloaded and assigned to NHSE Region using organisational codes in order to display pharmaceutical providers – both community pharmacies and dispensing practices. https://apps.nhsbsa.nhs.uk/infosystems/report/viewReportList.do?reportMenuItemId=207

4.2.8 Considerations of service providers available

The distribution of pharmacies and dispensing GP practices appears to cover the county well with few gaps and some concentrations. Some geographical gaps appear to exist in some of the less populated areas in the north and southern fringes of the county (see **Maps 6 and 7**) but these localities are served by suppliers from outside the county (see **Map 10**). Access to services in these areas will be further discussed in Section 4.3.

4.2.9 Results of questionnaires sent to pharmacies and dispensing GP practices

93 of 110 (85%) community pharmacies and 34 of 43 (79%) dispensing GP practices in Cambridgeshire responded to the 2016 PNA questionnaire. This is slightly lower than the 2013 questionnaire which had response rates of 89% for community pharmacies and 88% of dispensing GP practices.

Results from the questionnaires showed that responders considered provision to be 'excellent' (39% of pharmacies and 56% of dispensing GP practices), 'good' (55% of pharmacies and 41% of dispensing GP practices) or 'adequate' (7% of pharmacies and 3% of dispensing GP practices). No responder considered provision to be 'poor'. Overall, more community pharmacies and dispensing GP practices rated the current level of provision in their locality as 'good' than 'excellent' in 2013 (see Table 4 below).

Table 4: Summary of how community pharmacies and dispensing GP practices responded in 2013 and 2016 to the question: '*Do you feel there is a need for more pharmaceutical service providers in your locality?'*

Survey year	Community pharmacies		Dispensing GP practices	
Number of respondents to question and (% of respondents)	*2013 responders (n=82)*	*2016 responders (n=93)*	*2013 responders (n=34)*	*2016 responders (n=34)*
considered provision to be 'excellent'	42 (51.2%)	36 (38.7%)	24 (70.6%)	19 (55.8%)
considered provision to be 'good	36 (43.9%)	51 (54.8%)	7 (20.6%)	14 (41.1%)
considered provision to be 'average'	4 (4.9%)	6 (6.5%)	3 (8.8%)	1 (2.9%)
considered provision to be 'poor'	0	0	0	0

Similarly, most responders (95% of pharmacies and 94% of dispensing GP practices) responded 'no' to the question '*Do you feel there is a need for more pharmaceutical service providers in your locality*?' One community pharmacy and two dispensing practices who felt there may be increased need referred in their free text comments to the need to consider the growth sites across Cambridgeshire and what new services may be needed for expanding populations in these areas. This is considered in further detail in Section 6.

4.2.10 Stakeholder feedback in 2014

In 2014, the majority of respondents to the public consultation (88%) felt that the needs for pharmacy services for the population of Cambridgeshire were adequately identified in the PNA report. 82% (179 out of 218) agreed that at that time no more pharmacies were needed in Cambridgeshire; only 5% (13 individuals) suggested that additional pharmacies were required.

In summary, taking into account current information from stakeholders including community pharmacies and dispensing GP practices, the number and distribution of pharmaceutical service provision in Cambridgeshire is sufficient. There is no current need identified for more pharmaceutical providers at this time.

4.3 Accessibility

4.3.1 Distance and travel times

The 2008 White Paper *Pharmacy in England: Building on strengths – delivering the future* states that it is a strength of the current system that community pharmacies are easily accessible, and that 99% of the population – even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport.[38]

Map 9 shows the locations of both pharmacies and dispensing practices in Cambridgeshire, together with the major roads in the county.

Map 10 was created to identify which areas in Cambridgeshire were within and which were not within a 20 minute driving distance of either a pharmacy or a dispensing practice as of 31st July 2013 (and pharmacy locations have remained unchanged save for one additional pharmacy). For this map pharmacies and dispensing practices could be located either within the county or outside of the county. Road speed assumptions were made dependent on road type, and ranged up to 65mph (for motorways) but down to 20mph in urban areas, and just 15mph in Cambridge City.

Map 10 indicates that there are some pockets in Cambridgeshire where it is necessary to drive more than 20 minutes by car to access a pharmacy or dispensing surgery. However, these areas are to a large extent uninhabited. In terms of postal addresses, across all of Cambridgeshire, there are only 67 postal addresses registered as a residential property that are located more than 20 minutes away by car from a pharmacy or dispensing surgery.

Therefore, assuming that the numbers of people who live at the mentioned postal addresses are equal to the average for Cambridgeshire, it would be expected that there are only around 146 people in the county who need to drive more than 20 minutes by car to access a pharmacy or dispensing GP practice (146 people corresponds to 0.02% of 653,400 people, the estimated population size for Cambridgeshire). This can be considered as an indication of good coverage in terms of the locations of pharmaceutical services across the county.

However, it is recognised that not everyone has access to a car, and that those unable to access a car may be among the more vulnerable in society. The Steering Group considered creating maps to illustrate access through public transport, but found that this information could not easily be presented due to the complexity and constantly changing nature of public transport routes and service times.

4.3.2 Home delivery services

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

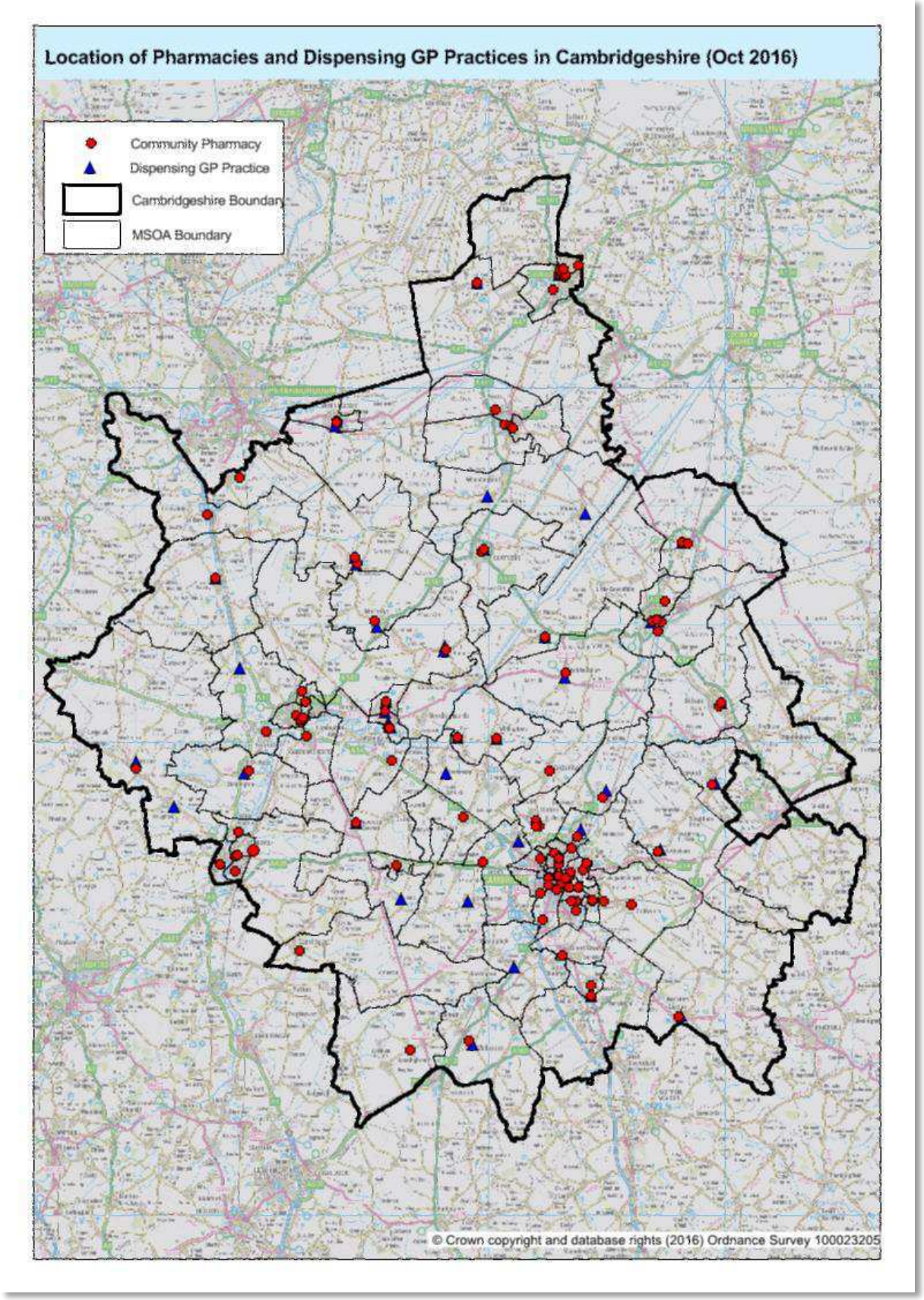
Of the pharmaceutical providers who completed the questionnaire in 2016, 83 out of 93 pharmacies (89.2%) and 17 out of 34 dispensing GP practices (50%) reported that they

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

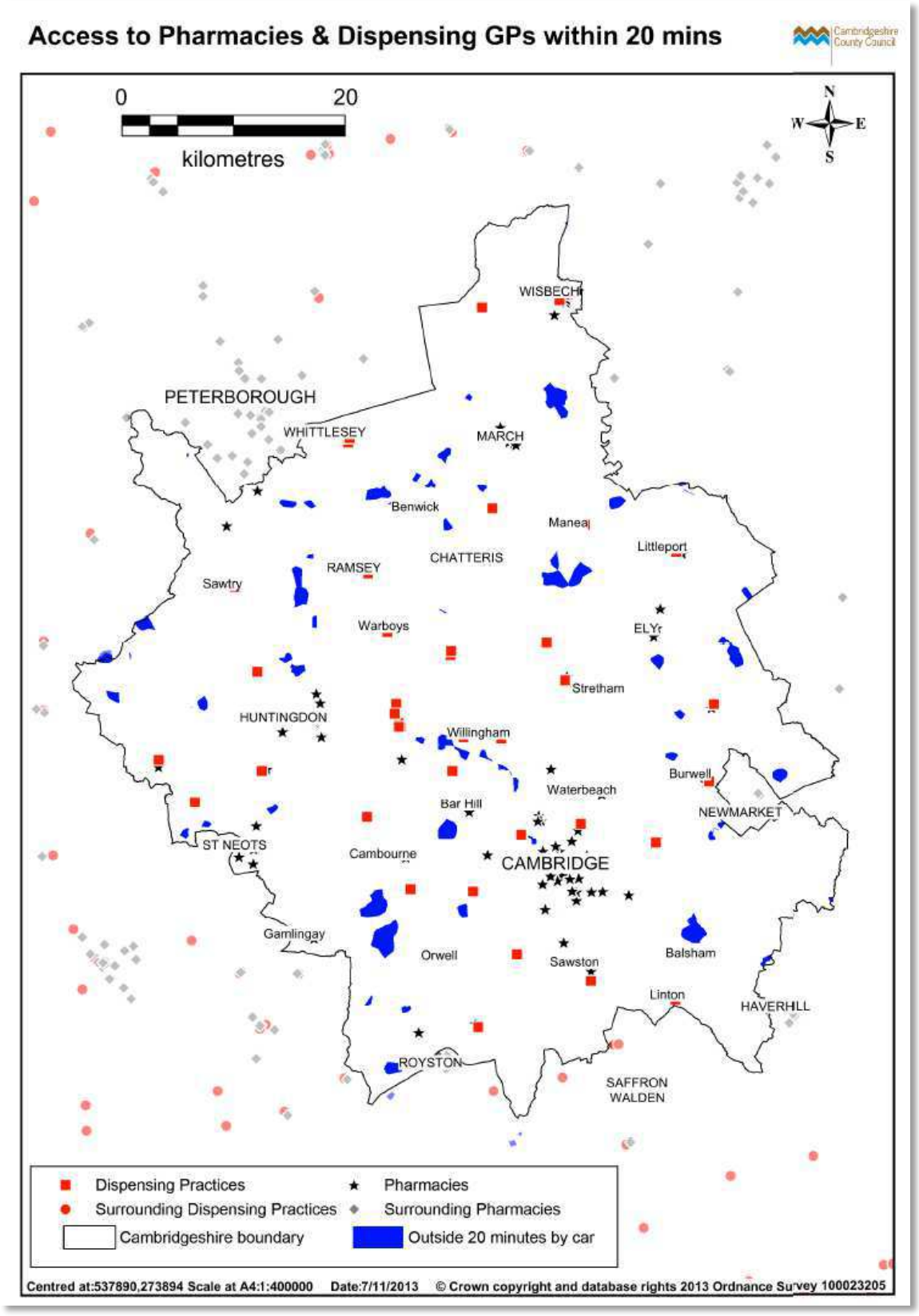
provide free delivery services to their patients. This represents an increase in the percentage of providers offering home delivery services as reported in 2013 (64% of community pharmacies and 34% of dispensing GP practices). In addition, some providers deliver to specific patient groups and/or specific regions, some for free and others for a charge. Of those who responded to the questionnaire, 89 pharmacies (95.7%) and 21 dispensing GP practices (61.8%) have some form of delivery service in operation.

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

Map 9. Pharmacies, dispensing practices and major roads in Cambridgeshire



Map 10. Access to Pharmacies and Dispensing Practices: 20 minutes by car



Note: While there are pockets in Cambridgeshire more than 20 minutes away from a pharmacy or dispensing surgery by car, these are mainly uninhabited areas. It is estimated that only around 0.02% of the population in Cambridgeshire are more than 20 minutes away from a pharmacy or dispensing surgery by car.

4.3.3 Border areas

There are nine other HWBs with borders close to Cambridgeshire. These areas have pharmacies that are accessible to the residents who live near the borders of the county.

Within Cambridgeshire there are three large settlements close to the county border: Wisbech, Whittlesey and St Neots. They have pharmacies that serve their town and the surrounding areas in Cambridgeshire and beyond. Just over the border of Cambridgeshire the towns of Peterborough, Royston, Saffron Walden, Haverhill and Newmarket all have pharmacies that provide services to Cambridgeshire residents.

The rest of the border areas are more sparsely populated with few settlements of a size that would support a pharmacy. However, there are many pharmacies in surrounding counties that are located in smaller settlements near the Cambridgeshire border (see **Map 10**). These pharmacies provide services to people whether they reside in Cambridgeshire or a neighbouring county. Dispensing GP practices also offer pharmaceutical services in these areas.

4.3.4 Access for people with disabilities

The questionnaire sent to pharmacies and dispensing GP practices included a question asking if any consultation facilities existed on site and if they included wheelchair access. The results showed that 87 of 94 community pharmacies who completed the questionnaire (93%) report they have consultation areas with wheelchair access. Similarly, 30 out of 34 dispensing GP practices who completed the questionnaire (88.2%) report they have consultation areas with wheelchair access. This represents an increase from the percentages reported in 2014: 80.4% of community pharmacies and 86.8% of dispensing GP practices.

4.4. Opening hours

4.4.1 Opening hours: community pharmacies

There are currently 13 '100 hour' pharmacies in Cambridgeshire, this is unchanged since 2014. These are included in the pharmaceutical list under regulation 13(1)(b) of the *National Health Service (Pharmaceutical Services) Regulations 2005*; premises which the applicant is contracted to open for at least 100 hours per week for the provision of pharmaceutical services.

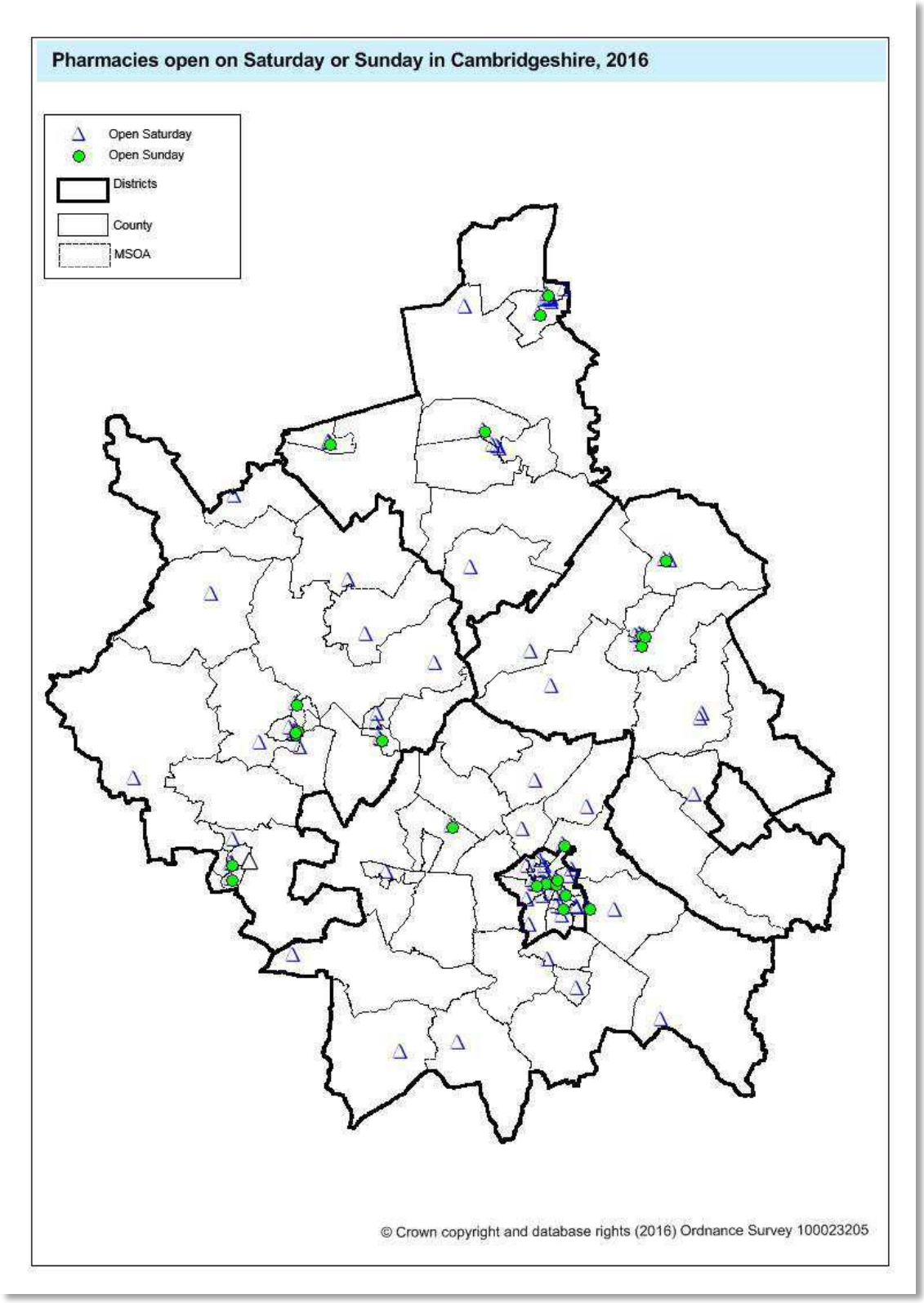
These 100 hour pharmacies are:

- Numark Pharmacy, Perne Road, Cambridge
- Sainsbury's Pharmacy, Brookes Rd, Cambridge
- Tesco Pharmacy, Fulbourn, Cambridge
- Sainsbury's Pharmacy, Ely
- St. Mary's Pharmacy, Ely
- Tesco In-store Pharmacy, Angel Drove, Ely
- Priory Fields Pharmacy, Huntingdon
- St George's Pharmacy, Littleport
- Tesco In-store Pharmacy, March
- Asda Pharmacy, Wisbech
- North Brink Pharmacy, Wisbech
- Tesco Pharmacy, Wisbech
- Whittlesey Pharmacy, Whittlesey

There is also night pharmaceutical service provision at a pharmacy in Boots, Newmarket Road, Cambridge, which is open until midnight Monday to Saturday (not including bank holidays).

Overall, out of 110 community pharmacies, 45 (41%) are open after 6pm and 26 (24%) are open after 7pm on weekdays; 90 (82%) open on Saturdays; and 22 (20%) open on Sundays. These findings are similar to those in the 2014 PNA. The locations of pharmacies currently open on a Saturday or a Sunday are illustrated in **Map 11**.

Map 11. Pharmacies open on a Saturday or Sunday in Cambridgeshire, 2016



Note: The map does not include dispensing GP practices in Cambridgeshire, and also does not include pharmacies or dispensing GP practices in neighbouring counties.

Further community pharmacy opening hours on weekdays can be summarised as:

- During the week two pharmacies are open until midnight; these are located in Cambridge City and Whittlesey.
- St Mary's pharmacy in Ely opens from midnight through to 6.30 pm the following day Monday to Friday (not including bank holidays). Elsewhere in the county, five pharmacies are open at 6 am or 6.30 am; these pharmacies are found in Whittlesey, March, Ely, and Wisbech. By 7 am a further five pharmacies are open across the county.

Community pharmacy opening hours on weekends can be summarised as:

- Of 90 pharmacies open on a Saturday, 12 (13%) pharmacies distributed across the county are open by 8.00 am. Nine pharmacies across the county are open until 10 pm and one pharmacy in Cambridge City is open until midnight.
- On a Sunday, of 22 pharmacies that open, 21 pharmacies (96%) open at 10 am and one at 8 am and 19 (86%) close at 4 pm. One pharmacy in Littleport remains open until 9 pm.

The out of hours service, Hertfordshire Urgent Care, is required to arrange for the provision of a full course of treatment, if clinically necessary, before a community pharmacy is open. It is recognised that the provision of a prescription for dispensing at a pharmacy during the evenings and at weekends is preferable to the out-of-hours service stocking and supplying the medication.

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

The consultation for the 2014 PNA showed that 201 out of 225 respondents (89%) agreed that pharmacy services are currently available at convenient locations and opening times. In addition, 14 responders gave feedback on opening hours including a desire to extend opening hours on weekdays (six respondents), around weekend openings (five respondents) and around closings at lunch time (four respondents).

For the 2011 PNA, focus groups expressed a feeling that whilst 24/7 opening would be ideal realistically they felt this would be an expensive and underused option. The general consensus was, therefore, that pharmacy provision addressed the needs of most people. The results of the consultation for the 2011 PNA indicated that a vast majority (93%) of respondents agree, it is necessary for *some* pharmacies to open late at night and at weekends.

Currently 13 pharmacies are contractually obliged to open for 100 hours per week due to the conditions on their application. This inevitably means that they are open until late at night and at the weekend. There is a risk that if the regulations for these contracts were to change that they may reduce their hours. This could significantly reduce the county network of late night and weekend pharmacies.

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

Since the introduction of the pharmaceutical contractual framework in 2005 community pharmacies do not need to participate in rota provision to provide access for weekends or during the evening. The need for such a service has been greatly reduced by the increased opening hours of a number of pharmacies including the 100 hours pharmacies.

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

4.4.2 Opening hours: dispensing GP practices

To consider opening hours for dispensing GP practices the opening hours for general practices were identified using the NHS Direct website. The dispensaries at the dispensing GP surgeries were assumed to be open at the same hours as the rest of the practice. Out of 43 dispensing GP practices, all surgeries (including dispensary) are closed on a Saturday and Sunday.

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

89% (201 out of 225) of respondents to the public consultation in 2014 agreed that pharmacy services are currently available at convenient locations and opening times.

The extended opening hours of some community pharmacies are valued and these extended hours should be maintained. Many pharmacies and dispensing surgeries have wheelchair access and home delivery services, which can help to provide medications to those who do not have access to a car or who are unable to use public transport.

4.5. Priorities for local community pharmacies and dispensing GP practices

The top five features identified by community pharmacies as being important were availability of information and advice about medicines and how to use them (83/93, 89%), the availability of consultation facilities (65/93, 70%), the availability of prescription only items (57/93, 61%), qualified staff (56/93, 60%) and the availability of non-prescription medicines (50/93, 54%) (see Figure 2)

The top five features identified by Dispensing Practices as being important were location (27/34, 79%), qualified staff (24/34, 71%), access and facilities for disabled people (24/34, 71%), car parking (20/34, 59%) and the availability of consultation facilities (15/34, 44%) (see Figure 3).

Figure 2. Features identified by local Community Pharmacies as important in the questionnaire
(Question: Please tick 5 of the following features which you would identify as being most important)

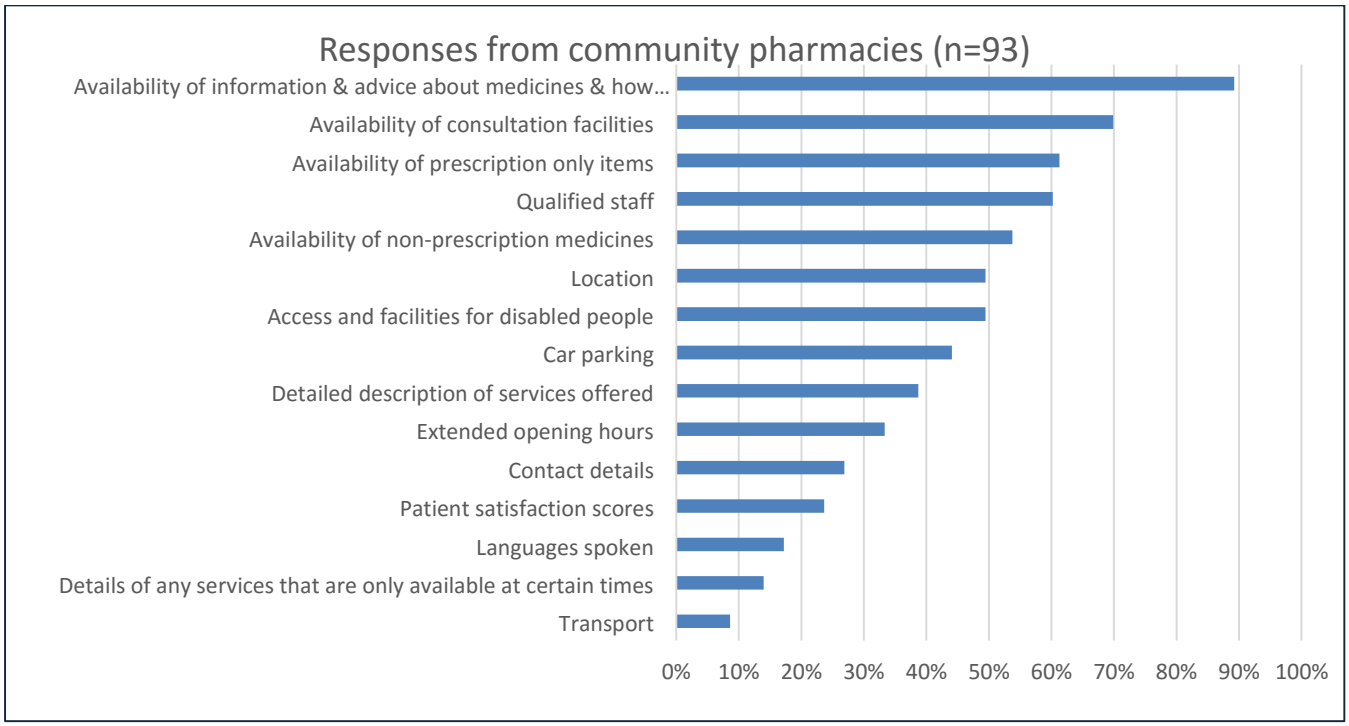
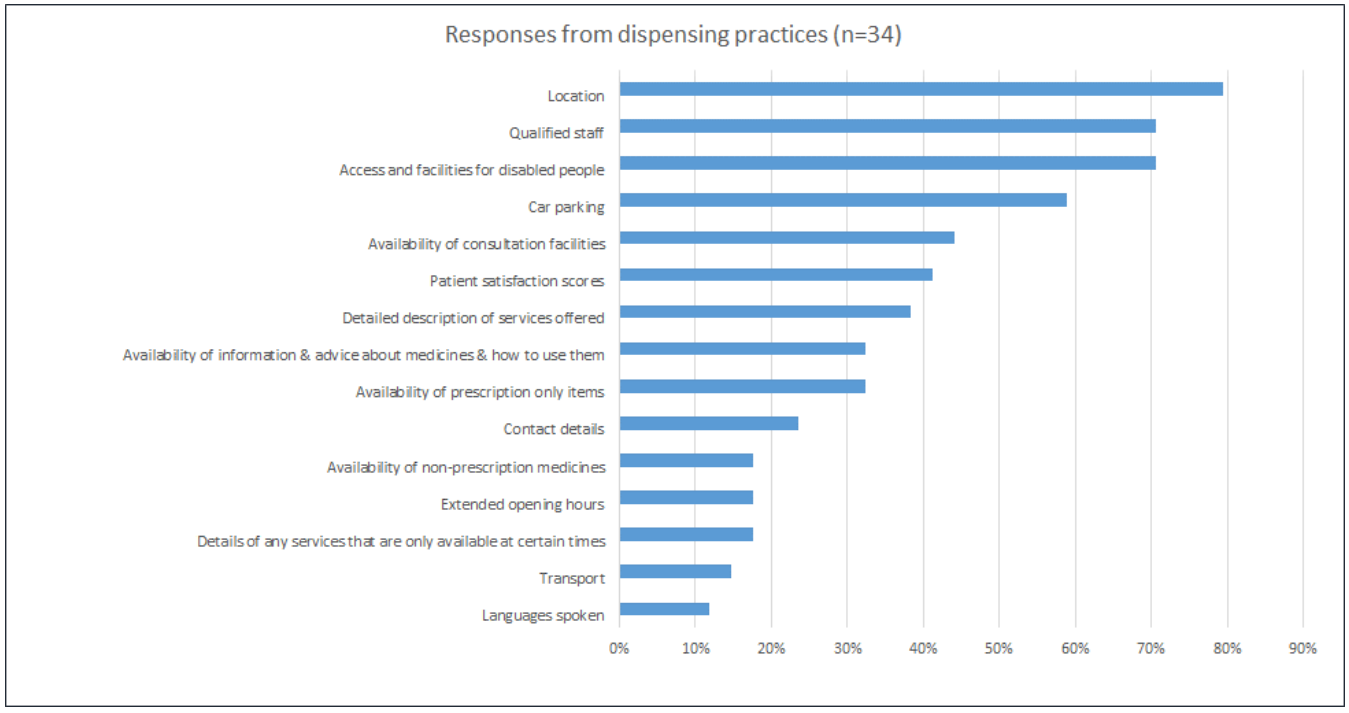


Figure 3. Features identified by local dispensing GP practices as important in the questionnaire
(Question: Please tick 5 of the following features which you would identify as being most important)



5 The role of pharmaceutical providers in addressing health needs

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

Key messages:

Medicines advice and support

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

Medication errors in care homes for older people can also be reduced by reviewing the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. C&P CCG employ a small team of CCG pharmacists and pharmacy technicians to work collaboratively with GP practices and care homes to rationalise prescribing, optimise medicines usage and reduce medicines waste.

Services and support to encourage healthy lifestyle behaviours

Providers of pharmaceutical services also have an important role to play in improving the health and wellbeing of local people beyond providing and supporting the safe use of medicines. The NHS Community Pharmacy Contractual Framework requires community pharmacies to contribute to the health needs of the population they serve and the recent changes to the 2017/2018 pharmacy contract have included quality payments to pharmacies who are accredited as 'Healthy Living Pharmacies'. Community pharmacies can contribute to the health and wellbeing of the local population in a number of ways, including direct service provision, for example Emergency Hormonal Contraception, along with providing ongoing support for lifestyle behaviour change through motivational interviewing, providing information and brief advice, and signposting to other services.

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

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

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

Pharmacy staff can play a role in promoting awareness of good mental health, for example, signposting to information about local support networks, mental health help lines etc. Pharmacy providers are also involved in part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and C difficile.

The following local services are currently commissioned from community pharmacies:

- ***Smoking Cessation 'CAMQUIT'*** **(commissioned by Cambridgeshire County Council (CCC))**
  The Community Pharmacy Smoking Cessation Service in Cambridgeshire illustrates how community pharmacies can improve population health through smoking cessation services, as evaluated by NICE. Smoking cessation services are commissioned from some community pharmacies in Cambridgeshire but this has decreased in the past two years. The contribution of pharmacies towards quit levels has also decreased from 12% in 2013/2014 to 6% in 2015/2016 and the lost to follow up rates have increased. Community pharmacies remain well placed to ensure services are accessible to the smoking population and evidence suggests community pharmacies can improve quit rates. The provision of commissioned smoking cessation services in pharmacies is currently under review to address service provision and quality concerns.

- ***Chlamydia Screening and Treatment*** **(commissioned by CCC)**
  Community pharmacies are easily accessible for young people and are crucial for offering treatment of chlamydia infections. Only 26 pharmacies have signed up to the Cambridgeshire chlamydia screening programme and only 0.9% of chlamydia tests performed in Cambridgeshire were collected from pharmacies. Although there is some opportunity to expand, this is limited by the number of pharmacies that do not have the appropriate facilities to offer screening. There is also potential

for offering advice on barrier contraception methods for both males and females and for raising awareness of HIV, chlamydia and other STIs.

- ***Emergency Hormonal Contraception (commissioned by CCC)***
  Pharmacies in Cambridgeshire are offered the opportunity to receive training and contract to provide Emergency Hormonal Contraception (EHC), which is available as a locally commissioned service in some community pharmacies. The EHC Service is currently being delivered by 28 pharmacies across Cambridgeshire, as part of the overall contraception service offered by sexual health, contraception clinics and GP practices across Cambridgeshire, with opportunities to expand. It is advised to offer chlamydia screening when Emergency Hormonal Contraception is provided, since those requiring such contraception may also be at risk of infection. The extent to which local services signpost to services or carry out testing when EHC is provided is regularly examined in an audit, as recommended in the 2014 PNA.

- ***Needle and Syringe Exchange Service*** **(DAAT, CCC)**
  The Cambridgeshire Drug and Alcohol Action Team (DAAT) commission services to provide specialist drug and alcohol treatment across Cambridgeshire. Currently Adult drug and alcohol services are provided by Inclusion and Young People services are provided by the Cambridgeshire Child and Adolescent Substance Use Service (CASUS). Further information can be found at: www.cambsdaat.org. A 'Drug and Alcohol JSNA' was published in September 2016 which provides an overview of legal and illicit drug and alcohol misuse needs for the Cambridgeshire population.

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

  34 community pharmacies across Cambridgeshire are sub-contracted by the DAAT commissioned provider Inclusion to provide access to sterile needles and syringes, and sharps containers for return of used equipment.

- ***Supervised Administration Service*** **(DAAT, CCC)**
  Once clients are being treated within the NHS, community pharmacies can provide supervised administration of drug therapies and instalment dispensing. Clients often need support to prevent them stopping treatment. 34 community pharmacies across Cambridgeshire are sub-contracted by the DAAT commissioned provider *Inclusion* to provide a Supervised Administration Service, which requires the pharmacist to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient.

- ***Outreach NHS Health checks service (pilot) (CCC)***

In summer 2016, Cambridgeshire County Council trained 11 Pharmacies in the Wisbech area, Fenland, to deliver outreach NHS Health Checks as part of a six month pilot. The NHS Health Check is a health check-up designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia, in adults in England aged 40-74 without a pre-existing condition. The rural, market town of Wisbech was chosen for the pilot as it has a high prevalence of cardiovascular disease, a high number of local residents unable to attend their GP practice, and a number of proactive community pharmacies in the area.

- ***Directly observed therapy (DOT) service for Tuberculosis (TB) patients (C&PCCG/ CCC)***
  The CCG in conjunction with public health and local respiratory clinics are exploring commissioning a Directly Observed Therapy (DOT) service for tuberculosis (TB) patients from a limited number of community pharmacies across the geography of the CCG. This will provide care closer to home for non-infectious patients who require support in adherence with their prescribed TB medication.

In addition to commissioned services, our questionnaire found that community pharmacies provide a number of additional services.

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

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

5.1 Community Pharmacy Essential Services

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

- Essential Services – services all pharmacies are required to provide;
- Advanced Services – services to support patients with safe use of medicines;

- Enhanced Services – services that can be commissioned locally by NHS England.

These types of services are defined in the *NHS Regulations*[39] and are briefly described below.

The essential services offered by all pharmacy contractors are specified by a national contractual framework that was agreed in 2005. The following description of these services is an excerpt from a briefing summary on NHS Community Pharmacy services by the Pharmaceutical Services Negotiating Committee:[40]

- ***Dispensing*** – the safe supply of medicines or appliances. Advice is given to the patient about the medicines being dispensed and how to use them. Records are kept of all medicines dispensed and significant advice provided, referrals and interventions made.
- ***Repeat dispensing*** – the management of repeat medication for up to one year, in partnership with the patient and prescriber. The patient will return to the pharmacy for repeat supplies, without first having to visit the GP surgery. Before each supply the pharmacy will ascertain the patient's need for a repeat supply of a particular medicine.
- ***Disposal of unwanted medicines*** – pharmacies accept unwanted medicines from individuals. The medicines are then safely disposed of by a waste contractor engaged by NHS England.
- ***Promotion of Healthy Lifestyles (Public health) (see section 6.4.2)*** – opportunistic one to one advice is given on healthy lifestyle topics, such as stopping smoking, to certain patient groups who present prescriptions for dispensing. Pharmacies will also get involved in six local campaigns a year, organised by NHS England. Campaign examples may include promotion of flu vaccination uptake or advice on increasing physical activity.
- ***Signposting patients to other healthcare providers*** – pharmacists and staff will refer patients to other healthcare professionals or care providers when appropriate. The service also includes referral on to other sources of help such as local or national patient support groups.
- ***Support for self-care*** – the provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families. The main focus is on self-limiting illness, but support for people with long-term conditions is also a feature of the service.
- ***Clinical governance*** – pharmacies must have a system of clinical governance to support the provision of excellent care; requirements include:
    - provision of a practice leaflet for patients;
    - use of standard operating procedures;

[39] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Available at: http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf (Last accessed 1 Dec 2016)
[40] Pharmaceutical Services Negotiating Committee Summary of NHS Community Pharmacy services. Available at: http://psnc.org.uk/wp-content/uploads/2015/06/CPCF-summary-June-2015.pdf

- patient safety incident reporting to the National Reporting and Learning Service (NRLS);
- conducting clinical audits and patient satisfaction surveys
- having complaints and whistle-blowing policies;
- acting upon drug alerts and product recalls to minimise patient harm;
- having cleanliness and infection control measures in place.

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

5.2 Advanced Services

In addition to essential services, the community pharmacy contractual framework allows pharmacies to opt to provide any of four advanced services to support patients with the safe use of medicine, which currently include: Medicines Use Reviews (MUR); Appliance Use Reviews (AUR); New Medicines Service (NMS); the Stoma Customisation Service (SCS). The NHS Seasonal Flu Vaccination Programme is also currently commissioned from pharmacies as an advanced service (see Section 5.2.5) although NHS England currently has limited powers to monitor or direct this service to local need.

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

Through the provision of MURs, DRUMs, clinical screening of prescriptions and identification of adverse drug events dispensing staff work with patients to help them understand their medicines. This also ensures that medicines are not omitted unnecessarily and that medication allergies and dose changes are clearly documented and communicated.

The Community Pharmacy questionnaire indicates that all community pharmacies who responded currently provide MURs and a Stoma Customisation service. 28% of those who responded provide AURs or intend to within the next 12 months. 93.5% of those who responded provide seasonal flu vaccinations under the NHS programme or intend to within the next 12 months. In addition, of the GP dispensing practices who responded to the questionnaire, 4/34 (11.8%) provide AURs or intend to within the next 12 months and 3/34 (8.8%) provide a Stoma customisation service or are intending to within the next 12 months.

Table 5: Community pharmacies providing advanced services 2016

Advanced service	Does the community pharmacy provide the following Advanced services? (respondents n=93)		
	Provided	Intending to within next 12 months	No, not intending to
Medicines Use Reviews (MUR)	93 (100%)	-	-
Appliance Use Reviews (AUR)	7 (7.5%)	19 (20.4%)	67 (72%)

New Medicines Service (NMS)	22 (23.7%)	13 (14%)	58 (62.4%)
Stoma Customisation Service (SCS)	93 (100%)	-	-
NHS Seasonal Flu Vaccination Programme.	78 (83.9%)	9 (9.7%)	6 (6.5%)

5.2.1 Medicines Use Reviews (MURs)

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

An MUR is a way to: improve patients' understanding of their medicines; highlight problematic side effects and propose solutions where appropriate; improve adherence; and reduce medicines wastage, usually by encouraging the patient only to order the medicines they require. An MUR is not: a full clinical review; an agreement about changes to medicines; a discussion about the medical condition beyond that which is needed to achieve the above objectives; or a discussion on the effectiveness of treatment based on test results."[41]

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

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

- patients taking high risk medicines;
- patients recently discharged from hospital who had changes made to their medicines while they were in hospital;
- patients with respiratory disease; and
- patients at risk of or diagnosed with cardiovascular disease and regularly being prescribed at least four medicines.

All patients who receive an MUR should experience the same level of service regardless of their condition, i.e. MURs cover all the patient's medicines not just those that fall within a target group.

The pharmacy provides a quarterly summary report to NHS England of MUR consultations conducted. Each pharmacy is limited in the numbers of each Medicines Use Reviews (MURs) that they may undertake. In the year 2015/2016, 109 pharmacies in Cambridgeshire were able to provide up to 400 MURs each financial year to provide a potential total of 43,600 MURs (which includes one distance selling pharmacy that technically could deliver MURs). In total 31,404 MURs were completed over the year 2015/16. This compares with 26,911 MURs that were completed in 2012/13. Pharmacies are

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

now undertaking approximately 73% of the reviews that could have been undertaken if all pharmacies had completed their maximum entitlement. There is the potential for an increased delivery of MURs across the county to support patients with their medicines. There are also opportunities to increase the uptake of MURs and in the future to target pharmaceutical care towards complex cases.

The '*Community Pharmacy Clinical Services Review'* (The 'Murray report', 2016) recommends that "the MURs element of the pharmacy contract should be re-designed to include on-going monitoring and regular follow-up with patients as an element of care pathways". [42] The report proposes that MURs evolve into full clinical medication reviews for patients with long term conditions and/or multiple morbidities.

5.2.2. Appliance Use Reviews (AURs)

Appliance Use Review (AUR) is the second Advanced Service to be introduced into the English Community Pharmacy Contractual Framework (CPCF). 'This service is similar to the MUR service, but it aims to help patients better understand and use their prescribed appliances (e.g. stoma appliances) rather than their medicines by:

- establishing the way the patient uses the appliance and the patient's experience of such use;
- identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient;
- advising the patient on the safe and appropriate storage of the appliance; and proper disposal of the appliances that are used or unwanted.'[43]

5.2.3 New medicines service (NMS)

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

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

The Department of Health (DH) commissioned researchers at the University of Nottingham to lead an academic evaluation of the service, investigating both the clinical and economic benefits of the service. The findings from the evaluation[44] were published in August 2014 and were overwhelmingly positive, with the researchers concluding that as the NMS delivered better patient outcomes for a reduced cost to the NHS, it should be continued. This was the basis for NHS England's decision to continue commissioning the service.

Since the introduction of the NMS in October 2011, more than 90% of community pharmacies in England have provided it to their patients. The pharmacy provides a quarterly summary

[42] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 18. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf

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

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

report to NHS England of NMS consultations conducted. This supports monitoring of the service to determine its effectiveness and value to the NHS.

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

A final consultation (typically 21-28 days after starting the medicine) will be held to discuss the medicine and whether any issues or concerns identified during the previous consultation have been resolved. If the patient is having a significant problem with their new medicine the pharmacist may need to refer the patient to their GP.'[45]

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

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

5.2.4 Stoma Appliance Customisation Service (SAC)

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

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

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

From 2015/16 NHS England also commissioned a new Advanced Service from all community pharmacies who can vaccinate patients in at-risk groups against flu. In May 2016, NHS England announced the Community Pharmacy Seasonal Influenza Vaccination programme would be re-commissioned for the 2016/17 flu season. This service sits alongside the nationally commissioned GP vaccination service, giving patients another

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

choice of venue for their vaccination and helping commissioners to meet their local NHS vaccination targets.

The aims of the national programme are:[46]

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

In the pharmacy questionnaire, 93.5% of community pharmacies who responded reported that they provide seasonal flu vaccinations under the NHS programme or intend to within the next 12 months. As of January 2017, community pharmacies across Cambridgeshire have delivered over 11,000 seasonal flu vaccinations. A number of pharmacies also reported that they provide private seasonal flu vaccinations (at a cost) to those who are not in the NHS at risk groups.

5.2.6 NHS Urgent Medicine Supply Advanced Service Pilot

In 2016, NHS England has commissioned a national NHS Urgent Medicine Supply Advanced Service (NUMSAS) pilot, in order to reduce the burden on urgent and emergency care services of handling urgent medication requests, whilst ensuring patients have access to the medicines or appliances they need.

Under this NUMSAS service, in an emergency and at the request of a patient via NHS 111 telephone service, a pharmacist can supply a prescription only medicine (POM) without a prescription to a patient who has previously been prescribed the requested POM.[47]

The pilot programme commenced locally on 23rd December 2016; at the end of February 2017, nine pharmacies across Cambridgeshire were participating in the pilot. The service will be evaluated in due course.

5.3 Enhanced Services

The third tier of Pharmaceutical Service that can be provided from pharmacies are the Enhanced Services. These are services that can be commissioned locally from pharmacies by NHS England. Examples of enhanced services include:

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

[46] NHS England. 'Community Pharmacy Seasonal Influenza Vaccination Advanced Service Service Specification.' October 2016. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/08/serv-spec-seasnl-flu-16-17-v1.pdf.

[47] NHS England. 'NHS Urgent Medicine Supply Advanced Service Pilot Community Pharmacy Service Specification'. (November 2016) Available at: https://www.england.nhs.uk/wp-content/uploads/2016/11/numsas-service-specification.pdf

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

These services can only be referred to as Enhanced Services if they are commissioned by NHS England. If local services are commissioned by CCGs or local authorities, they are referred to as locally commissioned services. At present no enhanced services are commissioned in Cambridgeshire.

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

The NHS Community Pharmacy Contractual Framework requires community pharmacies to contribute to the health needs of the population they serve. Children, adults and the elderly are all vulnerable to the risk factors that contribute to preventable non-communicable diseases, whether from unhealthy diets, physical inactivity, exposure to tobacco smoke or the effects of the harmful use of alcohol.[48]

Cambridgeshire Health and Wellbeing Board consider community pharmacies to be a key public health resource and recognise that they offer potential opportunities to commission health improvement initiatives and work closely with partners to promote health and wellbeing, as recommended by the Local Government Association (LGA)[49] and Public Health England[50].

Local commissioning organisations should continue to consider pharmacies among potential providers when they are looking at the unmet pharmaceutical needs and health needs of the local population, including when considering options for delivering integrated care. Commissioners are recommended to commission service initiatives in pharmacies around the best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation.

In Cambridgeshire in 2016, there were 118,700 people aged 65 or over. People in Cambridgeshire are living longer and the number of people over 65 is set to grow by approximately 15% in the next five years and 30% in the next ten years. Lifestyle related diseases such as diabetes are increasing. An ageing population with a range of health issues will also put pressure on health and social services. As described earlier in section 3.5, the Murray report proposes that pharmacy needs to be a 'core part of the integrated, convenient services that people need', although the report identifies that this has proven difficult to achieve thus far. NHS England's *Five Year Forward View* (October 2014)[51] and

[48] World Health Organization. (March 2013) Fact sheet: Noncommunicable diseases. Available at: http://www.who.int/mediacentre/factsheets/fs355/en/ (Last accessed 20 Nov 2013)
[49] Local Government Association (2016). 'The community pharmacy offer for improving the public's health.' Available at: http://www.local.gov.uk/sites/default/files/documents/community-pharmacy-offer--9b3.pdf
[50] Public Health England Public Health Matters blog. Prof Fenton K. 'Putting pharmacy on the public health map' (March 2015). Available at: https://publichealthmatters.blog.gov.uk/2015/03/24/putting-pharmacy-on-the-public-health-map/
[51] NHS England. 'Five Year Forward View' (October 2014). Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

the *General Practice Forward View* (April 2016)[52] set out proposals for the future of the NHS based around new models of care, and offer a strategic opportunity to review and revisit the role of community pharmacy in the health and care system.

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

Further information regarding the health and wellbeing of older people can be found in the JSNA on Primary Prevention of Ill Health in Older People (2014), JSNA for the Prevention of Ill Health in Older People (2013) and JSNA for Older People (including Dementia) (2010) all available at www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports.

The HWB and its partners also recognise the importance of improving awareness of the risks associated with Long Term Conditions (LTC). In 2015 the Cambridgeshire JSNA on Long Term Conditions across the Lifecourse was published (www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports). This highlighted the importance of, and value placed by patients particularly those on multiple medications, of local pharmacies in managing their conditions.

Patients with Long Term Conditions (LTCs) are likely to be taking medication, often several medications. These patients have a particular need to understand the role medicines play in managing their condition in order to gain maximum benefit and reduce the potential for harm. Health campaigns aimed at improving medicines-related care for people with LTC, and therefore reducing emergency admissions, could also be provided through community pharmacies. Community pharmacists could be involved in monitoring the use of, for example: statins, blood pressure regulating medication and supplementary prescribing, making adjustments to the treatment being received by the patient. In addition, pharmacists and their staff already provide a signposting service to other sources of information, advice or treatment. The recent evidence review published in the Murray report found there is evidence supporting a wider role for pharmacy in supporting patients with long-term conditions and one of its key recommendations is integrating community pharmacists and their teams into long-term condition management pathways.[53]

Evidence shows that deprived populations often experience poor health outcomes including low life expectancy.[54] The prevalence of lifestyle related conditions as well as long term conditions are more prevalent in more deprived populations. Community pharmacies are easily accessible and can offer a valuable opportunity for reaching people who may not otherwise access health services. Pharmacy support for the public health and prevention agenda could therefore be especially valuable in more deprived communities or for vulnerable groups who have a variety of poorer health outcomes (e.g. migrant workers; traveller communities; ethnic minorities; older people). Community pharmacies can be

[52] NHS England 'General Practice Forward View' (April 2016) Available at: https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
[53] Murray R. 'Community Pharmacy Clinical Services Review' The Kings Fund. (December 2016) Page 19. Available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/12/community-pharm-clncl-serv-rev.pdf
[54] Marmot, M et al. 'The Marmot report- Fair society, healthy lives'. Feb 2010. University College London (Accessed November 2016). Available at: http://www.instituteofhealthequity.org/

involved in addressing health inequalities and targeting initiatives and resources to improve the health of the poorest fastest.

5.4.1 Promoting healthier lifestyles

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

Across England, over 2,100 pharmacies were accredited or en route to be accredited as 'Healthy Living Pharmacies' in January 2016. The 'Healthy Living Pharmacy (HLP)' framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. Evaluations[55],[56] of Healthy Living Pharmacies (HLP) have demonstrated an increase in successful smoking quits, extensive delivery of alcohol brief interventions and advice, emergency contraception, targeted seasonal flu vaccinations, common ailments, NHS Health Checks, healthy diet, physical activity, healthy weight and pharmaceutical care services.

Achieving HLP level 1 (self-assessment) is also now a quality payment criterion for the Quality Payments Scheme 2017/18, introduced by the DoH as part of the Community Pharmacy Contractual Framework in 2017/18.[57] This will involve payments being made to community pharmacy contractors that meet certain quality criteria. The inclusion of the HLP accreditation emphasises the national expectation of pharmacies to take an active role in public health and the promotion of healthy lifestyles.

The HLP framework is underpinned by three enablers[58]:

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

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

[55] University of Bradford. 'Evaluation of the West Yorkshire Healthy Living Pharmacy Programme' (Jan 2016). Available at: http://www.cpwy.org/doc/973.pdf
[56] Mohan L, McNaughton R & Shucksmith J. Teeside University. 'An Evaluation of the Tees Healthy Living Pharmacy Pilot Scheme' (2013) Available at: https://www.networks.nhs.uk/nhs-networks/hlp-pathfinder-sites/messageboard/hlp-forum/358672516/600199395/healthy-living-pharmacy-electronic-3-pdf
[57] Public Health England. 'Healthy Living Pharmacy Level 1 Quality Criteria Assessment of Compliance Healthy Living Pharmacy (HLP) Level 1' (2016). Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/538638/HLP-quality-criteria-and-self-assessement-process.pdf
[58] PSNC Website. 'Healthy Living Pharmacies" Available at: http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/

health and wellbeing ethos, team leadership, communication, community engagement and having a health promoting environment."[59]

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

5.4.2 Public health campaigns

At the request of NHS England, as part of essential service provision, NHS pharmacists are required to participate in up to six campaigns each year to promote public health messages to their users.[60] Where requested to do so by NHS England the NHS pharmacist records the number of people to whom they have provided information as part of one of those campaigns. 87 of the 93 community pharmacies in Cambridgeshire (93.5%) that responded to the Community Pharmacy questionnaire reported that they participate in the contracted annual six Public Health campaigns. Six pharmacies reported they did not.

Public health campaigns in Cambridgeshire that have been carried out or are planned for 2016/17 include the following themes: Move More (March), Dementia Awareness (May), Alcohol Awareness (June), Change for Life - physical activity (July), Stoptober (October), Stay Well (November/December) and One You (March).

Previous pharmacy campaigns have included the following themes:

2015/16: July/Aug – Change4Life (physical activity); Sept – Sexual Health Week; October – Stoptober; November – Winter Warmth / Flu; January – Stop Smoking; February – Cervical Cancer Prevention; March – Sexual Health.

2014/15: April/May – Be Clear on Cancer (Lung); July – Change for life (magic moves); September – Sexual Health; October – Stoptober; November - Winter Warmth/Flu; February – Alcohol Awareness.

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

Pharmacists are also involved in the early detection of some cancers, for example, through the provision of advice on skin care and sunbathing, and participating in the national Be Clear on Cancer campaign,[61] which aims to improve early diagnosis of cancer by raising awareness of symptoms and making it easier for people to discuss them with their GP.

5.4.3 Promotion of healthy lifestyle and supportive services (non-commissioned)

Between 80-99% of community pharmacies who responded to the questionnaire indicated that they provide:

[59] PSNC Briefing. 'Healthy Living Pharmacies: Information for Local Authorities' (May 2015) Available at: http://psnc.org.uk/wp-content/uploads/2013/08/LA_HLP_briefing_May2015.pdf
[60] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 No. 349 Schedule 4. http://www.legislation.gov.uk/uksi/2013/349/schedule/4/made (Last accessed 27 Nov 2013)
[61] More information on Be Clear on Cancer homepage, available at: http://www.cancerresearchuk.org/cancer-info/spotcancerearly/naedi/beclearoncancer/.

- Brief advice on lifestyles e.g. stop smoking, weight management, etc (98.9% of community pharmacies);
- Signposting to lifestyles services e.g. Stop smoking service, weight management, exercise etc. (97.8% of community pharmacies);
- Referral to lifestyles services e.g. Stop smoking service, weight management, exercise etc. (80.6% of community pharmacies).

87 community pharmacies (93.5% of respondents) indicated that they would like more information about local lifestyle services.

At present, 35 community pharmacies (37.6% of 93 respondents) report that they provide brief advice and provision of suitable health promotion materials specifically regarding healthy weight management to adults over 18, and 18 (19.4% of respondents) offer this to children 17 and under. All community pharmacies who stated that they did not currently provide this service indicated a willingness to do so if training were provided. 20 (21.5% of respondents) currently offer to determine BMI in children and adults; 21 (22.6% of respondents) refer individuals to the GP for weight management support and seven (7.5% of respondents) report that they provide follow-up consultation for support and motivation and to record progress outcomes. Similarly, all pharmacies who responded who did not currently offer these interventions indicated a willingness to do so if training were provided (see Appendix 3 for questionnaire responses).

The questionnaire also indicated a willingness by a number of community pharmacies who responded to the questionnaire to consider providing screening services for various health conditions if they were to be commissioned, including: alcohol use; cholesterol; diabetes; gonorrhoea; H. pylori; HbA1C , hepatitis and HIV (see Appendix 3).

5.5 Locally commissioned services: public health services

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

Broadly, across England the following specific public health services are commissioned from community pharmacies by local authorities[62],[63]:

- ***Stop smoking services***: proactive promotion of smoking cessation through to provision of full NHS stop smoking programmes.
- ***Sexual health services***: emergency hormonal contraception services; condom distribution; pregnancy testing and advice; Chlamydia screening and treatment; other sexual health screening, including syphilis, HIV and gonorrhoea; contraception advice and supply (including oral and long acting reversible contraception).
- ***Substance misuse services***: needle and syringe services; supervised consumption of medicines to treat addiction, e.g. methadone; Hepatitis testing and Hepatitis B and C vaccination; HIV testing; provision of naloxone to drug users for use in emergency overdose situations.

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

- ***NHS Health Checks for people aged 40-74 years***: carrying out a full vascular risk assessment and providing advice and support to help reduce the risk of heart disease, strokes, diabetes and obesity.
- ***Weight management services***: promoting healthy eating and physical activity through to provision of weight management services for adults who are overweight or obese.
- ***Alcohol misuse services***: providing proactive brief interventions and advice on alcohol with referral to specialist services for problem drinkers.
- ***Pandemic and Seasonal 'Flu services***: providing continuity of dispensing of essential medicines, provision of antiviral medicines; 'flu vaccination services.

The following local services are currently commissioned in Cambridgeshire:

- Smoking Cessation (CAMQUIT, commissioned by CCC)
- Chlamydia Screening and Treatment (commissioned by CCC)
- Emergency Hormonal Contraception (commissioned by CCC)
- Needle and Syringe Exchange Service (DAAT, CCC)
- Supervised Administration Service (DAAT, CCC)
- Pilot for NHS Health Checks (in Wisbech) Treatment (commissioned by CCC)

Table 6 shows the number of pharmacies commissioned to provide smoking cessations services, emergency hormonal contraception, and chlamydia screening and treatment. Table 7 shows how these are delivered according to district.

Table 6: 2016/2017 CCC Public Health Pharmacy contracts offered and taken up by pharmacies

Service	Offered	Contracted
Smoking - Full Service	109	20
Smoking - Voucher Scheme	109	8
Emergency Hormonal Contraception (EHC)	109	28
Chlamydia screening & treatment	109	24
Health Checks (pilot in Wisbech)	12	9

Table 7: 2016/17 CCC Public Health Pharmacy contracts offered and taken up by pharmacies, by district

District	Offered	Contracted				
		Smoking - Full Service	Smoking - Vouchers	EHC	Chlamydia	Health Checks
Cambs City	26	5	3	9	8	-
East Cambridgeshire	12	2	1	3	3	-
Fenland	20	4	0	4	2	9
Huntingdonshire	32	3	2	4	3	-
South Cambridgeshire	19	6	2	8	8	
Total	109	20	8	28	24	9

The range of services commissioned by CCC from community pharmacies varies due to several factors, including: availability of accredited pharmacists, capacity issues in the

pharmacy, changes to service level agreements and the need for a service (for example, in response to pandemic flu).

There is an apparent discrepancy between what services pharmacies in the PNA questionnaire reported that they provide and agreed contractual arrangements described in tables 6 and 7 – more pharmacies than are commissioned by CCC report providing these services. There are opportunities to develop the contribution of community pharmacies to these services. Pharmacies are able and should be encouraged to bid for locally commissioned health improvement programmes, along with other non-pharmacy providers.

Currently no services are commissioned from pharmacies to support health weight management or alcohol misuse services. In the community pharmacy questionnaire, providers were given an opportunity to indicate if they would be willing to provide specific services if they were commissioned, and could specify whether they would need training and/or facilities adjustment. For example, 22 pharmacies reported that they would be willing to provide obesity management services if commissioned, and 59 reported they were willing but would need training or facilities adjustment.

5.5.1 Smoking cessation services in Cambridgeshire pharmacies

- Around 5,140 deaths occur in Cambridgeshire each year,[64] with around 755 being attributable to smoking.[65]
- Smoking prevalence in Cambridgeshire is statistically similar to the England average, with 16.4% of over 18 year olds estimated to smoke (Table 8). This equates to just over 84,000 smokers in the county.
- The prevalence of smoking varies by district, with statistically significantly higher than national average rates of smoking in Fenland (26.4%) – see Table 8.
- District-level estimates of smoking prevalence can mask small areas of high prevalence. It is known from GP-level analysis completed for the Cambridgeshire & Peterborough Clinical Commissioning Group that higher rates of smoking are seen in areas of Cambridge, St Neots, Huntingdon, Littleport and Soham, as well as towns and villages of Fenland (see Map 12).

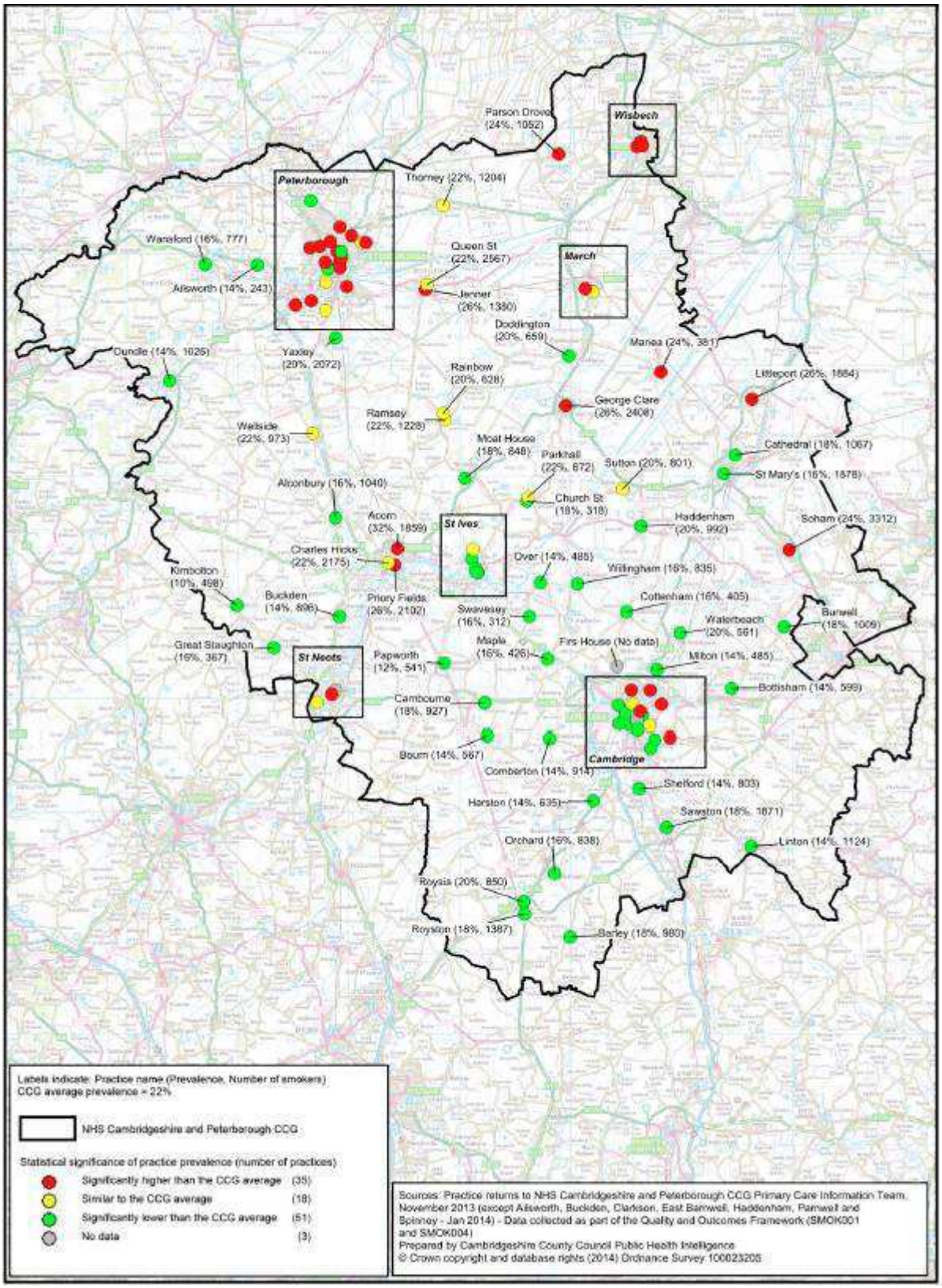
Table 8 Estimated smoking prevalence and number of smokers aged 18 years and over, Cambridgeshire, 2015

[64] Average annual deaths, 2013-15. NHS Digital Primary Care Mortality Database (Office for National Statistics death registrations).
[65] Average annual deaths attributable to smoking, 2012-14. Public Health England Local Tobacco Control Profiles.

Local authority	2015		
	Prevalence (%)	95% CI	Estimated number of smokers*
Cambridge	17.7	12.6 to 22.8	19,166
East Cambridgeshire	14.4	9.4 to 19.4	9,776
Fenland	26.4	19.8 to 33.1	20,965
Huntingdonshire	13.0	10.2 to 17.5	17,958
South Cambridgeshire	12.8	9.3 to 16.3	15,422
Cambridgeshire	16.4	14.4 to 18.5	84,329
England	16.9	16.7 to 17.1	7,285,332

* Number of smokers estimated by applying the point estimate of prevalence to local population estimates
CI - confidence interval
Sources: Public Health England - Public Health Outcomes Framework (Annual Population Survey data - 2015), Office for National Statistics mid-2015 population estimates

Map 12: Recorded smoking prevalence and number of smokers by practice, Cambridgeshire and Peterborough Clinical Commissioning Group, November 2013



Full resolution version of map, including inset maps for major towns/cities, available on request.

The primary care based Stop Smoking Service in Cambridgeshire can improve population health through smoking cessation services, as evaluated by NICE.[66] Evidence for the effectiveness of pharmacies in contributing to smoking cessation has also led to a recommendation in the '*Community Pharmacy Clinical Services Review'* (the Murray report, 2016) [67] for smoking cessation services to be considered an element of the national contract.

All GP surgeries within Cambridgeshire deliver a stop smoking service and during 2015/16 there were also 36 active pharmacies across the county. Pharmacies in Cambridgeshire are offered the opportunity to have a contract with CCC to provide evidence-based stop smoking services. By signing up to the contract, designated personnel within the pharmacy receive training (at both brief intervention – Level 1 and intensive interventions – Level 2 standards), mentoring and ongoing support from the co-ordinating service (CAMQUIT) to help them deliver the National Standard Treatment Programme. The Level 2 service consists of one to one advice and behavioural support for smokers over the age of 12 years who live or work in Cambridgeshire. The programme lasts 12 weeks and the behavioural support is used alongside medication treatments via NHS prescription, with outcomes measured four weeks after setting a 'quit date'.

The community pharmacy can also choose to sign the contract but to deliver the 'Nicotine Replacement Therapy (NRT) voucher scheme' only. This scheme enables the team of community-based CAMQUIT advisors to complete a voucher for Nicotine Replacement Therapy for the client to take to the participating pharmacy to have the chosen NRT dispensed under an NHS prescription.

Over recent years there has been a gradual decline in the number of community pharmacies actively delivering stop smoking interventions from 57 active in 2013/14 to 36 in 2015/16 and 28 in 2016/2017 (see Table 9) below. In conflict with this commissioning activity data, 46 community pharmacies self-reported in the questionnaire that they are currently providing a commissioned stop smoking service, with 58 reporting that they offer the stop smoking vouchers (see Appendix 3).

In addition, the contribution of pharmacies towards quit targets has also decreased from 12% in 2013/14 to 6% in 2015/16. Quality has been a concern with some of the national benchmarks not being achieved, e.g. lost to follow up rates (clients who have set a quit date but not been followed up after four weeks) should be lower than 20%, however in 2014/15 the rate for community pharmacy was 41% and in 2015/16 was 26.4%.

Table 9. Stop Smoking Service activity – number of quit attempts by provider, Cambridgeshire, 2008/09 – 2015/16

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
GP	4,109	4,968	4,529	4,872	4,817	4,008	3,024	2,821
Stop Smoking Services	1,259	1,425	1,744	2,178	1,930	1,534	1,232	1,273
Community Pharmacy	375	519	852	1,231	977	767	418	267
Prison			85	134	77	76	99	74

Source: CAMQUIT

[66] https://www.nice.org.uk/guidance/pH10

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

In 2015/16, 84.7% of quitters in Cambridgeshire quit through a general practice setting, higher than the national average of 35.9% (Table 10). The percentage quitting through a pharmacy in Cambridgeshire was 5.6% compared with 17.9% across England.

47.2% of Cambridgeshire people setting a quit date through a pharmacy successfully quit, compared to a 50.4% quit rate across all settings; this pattern is very similar to that seen for England.

Table 10. Smoking quits by intervention setting, Cambridgeshire and England, 2015/16

Intervention setting	Cambridgeshire				England	
	Number setting a quit date	Number of successful quitters	Quit rate (%)	Percentage of quitters	Quit rate (%)	Percentage of quitters
Children's centre	29	23	79.3	1.0	41.5	0.3
Community	115	59	51.3	2.6	56.1	31.4
Community psychiatric	0	0	-	0.0	43.6	0.1
Dental	0	0	-	0.0	47.9	0.0
General practice	3842	1899	49.4	84.7	49.1	35.9
Hospital	68	58	85.3	2.6	57.8	3.3
Maternity	12	10	83.3	0.4	41.9	0.7
Military base	0	0	-	0.0	49.8	0.2
Pharmacy	267	126	47.2	5.6	46.2	17.9
Prison	74	37	50.0	1.6	45.5	2.2
Psychiatric hospital	0	0	-	0.0	36.6	0.1
School	2	1	50.0	0.0	57.1	0.7
Workplace	1	1	100.0	0.0	57.5	0.8
Other	40	29	72.5	1.3	57.6	5.7
All intervention settings	4450	2243	50.4	100.0	51.0	100

Intervention setting does not necessarily reflect the service provider.
Source: NHS Digital. Statistics on NHS Stop Smoking Services

Community pharmacies remain well placed to ensure the services are accessible to the smoking population, particularly with many offering extended opening hours. Despite the recent decline in the contributions of pharmacies to smoking cessation, there have been some examples of good practice in each of the districts across the county. In addition, in the community pharmacy questionnaire, 40 community pharmacies indicated they would be willing to provide the stop smoking service if commissioned, although many would need training and adjustment of facilities (see Appendix 3).

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

5.5.2 Sexual health services in Cambridgeshire pharmacies

- Genital *chlamydia trachomatis* infection is the Sexually Transmitted Infection (STI) most frequently diagnosed in Genitourinary Medicine (GUM) clinics in England. Untreated infection can have serious long-term consequences, particularly for women, in whom it can lead to Pelvic Inflammatory Disease (PID), ectopic pregnancy and tubal factor

infertility. Since many infections are asymptomatic, a large proportion of cases remain undiagnosed, although infection can be diagnosed easily and effectively treated.

- It is difficult to assess changes in local chlamydia occurrence over the last decade for several reasons. The diagnostic definitions have changed during this period. More importantly, in the past two years the focus of the programme has changed from the absolute numbers being diagnosed to diagnostic rates. Public Health England recommends that local areas should be working towards achieving a diagnosis rate of at least 2,300 per 100,000 15-24 year old resident population annually. This target can be challenging to reach in Cambridgeshire given the relatively low occurrence of chlamydia infections in the county. Quarterly data is available on the National Chlamydia Screening Programme Website: http://www.chlamydiascreening.nhs.uk/ps/data.asp

- The number of people living with HIV/AIDS in Cambridgeshire has increased by 24% from 2010 to 2014.[68] This increase could reflect either that more people are being diagnosed, or that fewer people die from HIV/AIDS because drug therapies have become more effective.

- Data from Public Health England indicate that between 2010 and 2015 there has been an increase in diagnoses of gonorrhoea and syphilis (small numbers), whilst diagnoses of warts and herpes have shown a downward trend.[69]

Community pharmacies are easily accessible for young people and are crucial for offering treatment of chlamydia infections. In some cases, it can be challenging to offer testing in the pharmacy setting as not all pharmacies have the facilities required to enable patients to provide a sample for diagnostic testing on site. There is a potential for offering advice on barrier contraception methods for both males and females and for raising awareness of HIV, chlamydia and other STIs.

Screening uses first-void urine samples or self-taken vulva-vaginal swabs. Samples can be sent in the post to a laboratory for analysis and the results are returned to the chlamydia screening office; all patients are then informed of their result and contact tracing is conducted in people with positive results and treatment is offered to them and their partners. Young people can request a self-administered postal kit by visiting www.dontpassiton.co.uk.

The Cambridgeshire Chlamydia Screening Programme targets 15-24 year olds and was introduced in 2006. From 2008 community pharmacies joined other agencies in providing Chlamydia Screening and Treatment service to support screening and treatment offered across Cambridgeshire.

The Cambridgeshire Chlamydia Screening Programme recognises that pharmacies play an important role in the treatment of chlamydia positive patients and their partners. Treatment can only be provided by accredited pharmacists. All pharmacies in Cambridgeshire are offered the opportunity to receive training and contracts to provide chlamydia screening. Staff in pharmacies can participate in the National Chlamydia Screening Programme by distributing kits or signposting young people to the text or website request system. Compulsory training is provided for pharmacists and pharmacy assistants to support the screening service.

[68] Health Protection Agency. The Survey of Prevalent HIV Infections Diagnosed (SOPHID).
[69] Sexual and Reproductive Health Profiles, Fingertips, Public Health England

Table 11 summarises the local Chlamydia screening activity in Cambridgeshire in 2015/16. Of the 12,418 tests performed in Cambridgeshire in 2015/16, 111 were collected from pharmacies (0.9%). In pharmacies where testing is offered, diagnostic rates can be expected to be high due to the involvement in testing contacts of infected patients.

Table 11. Local Chlamydia screening activity, Cambridgeshire, 15-24 year olds, 2015/16

	Total completed screens, numbers	Positive, %
Contraception and sexual health service (CASH)	2,661	7.6%
GP	3,488	7.0%
Pharmacy	111	18.0%
Termination of pregnancy (TOP)	80	5.0%
Internet	751	9.0%
Outreach and other community work	5,327	4.0%

Source: CCS Chlamydia Screening Team

All pharmacies were offered the opportunity to deliver Community Pharmacy Chlamydia Screening and Treatment service when the service was introduced. In 2016/17 only 24 pharmacies are signed up to the chlamydia screening programme with the Public Health department. Despite this, 31 community pharmacies reported in the pharmacy questionnaire that they are currently providing chlamydia testing. To improve access the chlamydia screening programme would encourage more pharmacies to offer this service. The role of pharmacies in chlamydia is invaluable, especially for treatment where they can access quickly. It is recognised that although there is opportunity to expand the service to more pharmacies, this is limited by the number of pharmacies that do not have the appropriate facilities to offer screening. However, 54 of the community pharmacies who responded to the pharmacy questionnaire indicated that they would be willing to provide chlamydia testing if commissioned, although 41 report they would need training and four would need adjustment of facilities (see Appendix 3).

5.5.3 Emergency hormonal contraception

- Reducing the teenage conception rate and increasing the number of teenage parents who can access and sustain places in education, employment or training are important to improve outcomes for young people and their babies.[70]
- Studies indicate that making emergency hormonal contraception (EHC) available over the counter has not led to an increase in its use, to an increase in unprotected sex, or to a decrease in the use of more reliable methods of contraception.[71]
- Cambridgeshire has a teenage conception rate that is below the national rate, with Cambridge City and Fenland districts having rates that are higher, but not significantly higher, than the England average (2014).[72]

EHC may only be supplied by an accredited pharmacist. In order to achieve accreditation, the pharmacist(s) must have satisfactorily completed the Centre for Pharmacy Postgraduate Education (CPPE) Emergency Hormonal Contraception distance learning package.

[70] Cambridgeshire JSNA Children & Young People (2010). Page 45. Available at http://www.cambridgeshireinsight.org.uk/currentreports/children-and-young-people (Last accessed 20 Nov 2013).
[71] Marston C. (2005) 'Impact on contraceptive practice of making emergency hormonal contraception available over the counter in Great Britain: repeated cross sectional surveys.' *BMJ* 331: 271.
[72] Teenage Conceptions, Sexual and Reproductive Health Profiles

Medicine counter staff must be trained to refer each request for EHC to the pharmacist(s). It is the responsibility of the pharmacy to ensure that all pharmacists and locums supplying EHC are accredited. The pharmacy must be able to supply EHC during opening hours of the pharmacy on at least four days of the week, one of which will preferably be a Saturday. Anyone accessing the service will need to check with the pharmacy that they have an accredited pharmacist available.

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

The Emergency Hormonal Contraception Service (EHC) is currently being delivered by 28 pharmacies across Cambridgeshire (see Table 6) with opportunities to expand. In 2015/16 Pharmacies administered 3,613 Levonelle (EHC) treatments to the women of Cambridgeshire.

65 community pharmacies reported in the pharmacy questionnaire that they are currently providing an emergency hormonal contraception service and a further 24 would be willing to do so but they would need training or adjustment of facilities (see Appendix 3). This service is part of the overall contraception service offered by sexual health, contraception clinics and GP practices across Cambridgeshire.

It is advised to offer chlamydia screening at the time of EHC provision because those who require EHC contraception are highly likely to be at risk of infection. In 2015/16 pharmacies provided 364 chlamydia screening kits to people aged 15 to 24 years old when they administered EHC. The extent to which local services offer signposting to services or carry out testing when EHC is provided is routinely examined in an audit, as recommended in the 2014 PNA. There is a rolling programme of pharmacy audits in place which focuses on the use of the patient group directions for EHC and chlamydia treatment, overall governance process and safeguarding. These audits are currently undertaken by a community pharmacist.

5.5.4 Services for drug misuse related harm

- Illicit drug use contributes to the disease burden both globally and in Cambridgeshire. Efficient strategies to reduce disease burden of opioid dependence and injecting drug use, such as the delivery of opioid substitution treatment and needle and syringe programmes, are needed to reduce this burden at a population scale.[73]
- A 'Drug and Alcohol JSNA' was published in September 2016 which provides an overview of legal and illicit drug and alcohol misuse needs for the Cambridgeshire population. The full report is available at: http://cambridgeshireinsight.org.uk/JSNA/Drugs-and-Alcohol-2015.
- Based on national prevalence estimates, in 2014 32,190 people in Cambridgeshire aged 16-59 had used illicit drugs in the last year (8.6% of the population) (Table 12). Nearly half (47%, 14,603) were young adults aged 16-24 (19.4% of the population). There were 8,235 frequent drug users, of which 3,839 were young adults.

[73] Degenhart L et al. 'Global burden of disease attributable to illicit drug use and dependence: findings from the Global Burden of Disease Study 2010'. *Lancet* 2013; e-pub 29 Aug. Available at: http://www.sciencedirect.com/science/article/pii/S0140673613615305 (Last accessed 19 Nov 2013)

- In 2014, there were 29 drug-related deaths in Cambridgeshire; provisional data for 2015 indicate 27 deaths. The annual number and crude rate of drug-related deaths has stayed relatively stable over the past ten years.
- The age-standardised rate of drug-related deaths in Cambridgeshire varies with deprivation, with statistically significantly higher than county average rates in the most deprived 20% of wards (Figure 4).

Table 12: Estimated numbers using illicit drugs*, Cambridgeshire, 2014

Local Authority	Used in the last year		Using more than once a month	
	16-24 years	16-59 years	16-24 years	16-59 year
Cambridgeshire	14,603	32,190	3,839	8,235
NN - Oxfordshire	16,174	34,091	4,252	8,721

* As defined by the Misuse of Drugs Act

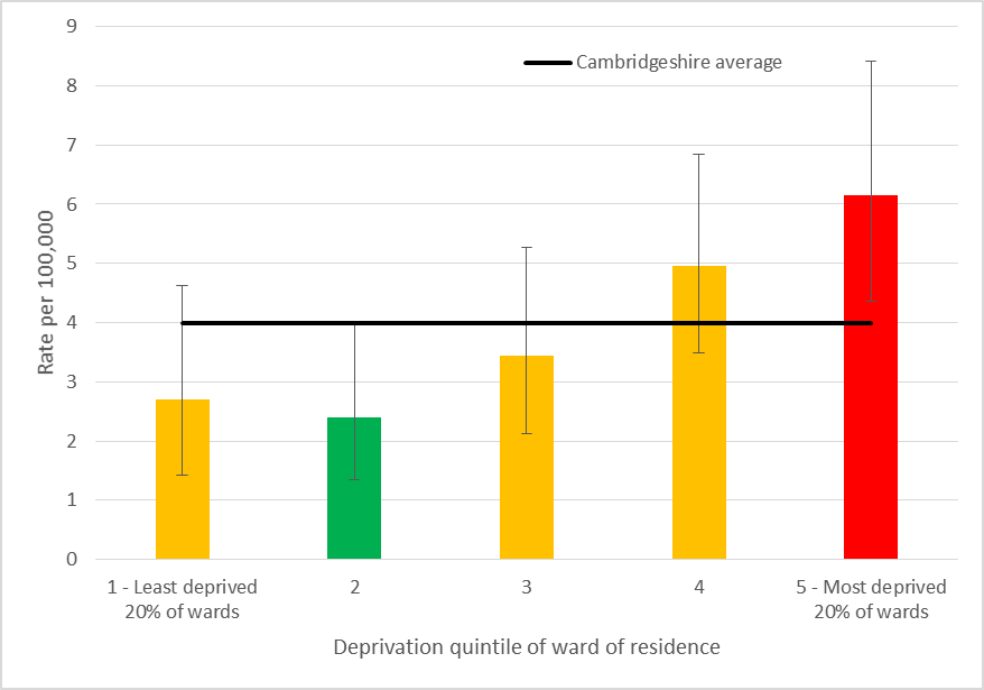
NN - CIPFA nearest neighbour for Cambridgeshire

These numbers are estimated based on prevalence estimates for England and Wales 2014/15 applied to the mid-2014 population:

Using in the last year	16-24 year olds: 19.4%
	16-59 year olds: 8.6%
Frequent drug use	16-24 year olds: 5.1%
	16-59 year olds: 2.2%

Sources: Crime Survey for England 2014/15, Office for National Statistics mid-year population estimates

Figure 4: Drug-related mortality by deprivation quintile of ward of residence (directly age-standardised rates), Cambridgeshire, 2011-15



Error bars represent 95% confidence intervals

Source: Health and Social Care Information Centre Primary Care Mortality Database, Office for National Statistics mid-year population estimates, Communities and Local Government Index of Multiple Deprivation 2010

The Cambridgeshire Drug and Alcohol Action Team (DAAT) commission services to provide specialist drug and alcohol treatment across Cambridgeshire. Currently adult drug and alcohol services are provided by 'Inclusion' and Young People services are provided by the Cambridgeshire Child and Adolescent Substance Use Service (CASUS). Further information can be found at: www.cambsdaat.org.

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

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

- *Needle exchange programmes offered in pharmacies across the county*

34 community pharmacies across Cambridgeshire are sub-contracted by the DAAT commissioned provider *Inclusion* to provide access to sterile needles and syringes, and sharps containers for return of used equipment. Where agreed locally, associated materials will be provided (for example condoms, citric acid and swabs) to promote safe injecting practice and reduce transmission of infections by substance misusers.

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

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

Usage of needle exchange services can be difficult to capture as users tend to provide little information which can be recorded and this has to be manually counted, which the service does not do as a norm.

- *Community pharmacy supervised administration service across Cambridgeshire*

The same 34 community pharmacies offering needle exchange also provide 'supervised administration'. This service requires the pharmacist to supervise the consumption of prescribed medicines at the point of dispensing in the pharmacy, ensuring that the dose has been administered to the patient. Contracted pharmacies aim to offer a user-friendly, non-judgmental, client-centred and confidential service. They provide support and advice to the patient, including referral to primary care or specialist centres where appropriate.

Examples of medicines which may have consumption supervised include: methadone, other medicines used for the management of opiate dependence and medicines used for the management of mental health conditions or tuberculosis.
Terms of agreement are set up between the prescriber, pharmacist, patient, and patient's key worker (a four-way agreement) to agree how the service will operate, what constitutes acceptable behaviour by the client and what action will be taken by the Specialist Drug Treatment Service and pharmacist if the user does not comply with the agreement.

The pharmacy contractor has a duty to ensure that pharmacists and staff involved in the provision of the service have relevant knowledge and are appropriately trained in the operation of the service and are aware of and operate within local protocols. The pharmacy contractor must maintain appropriate records to ensure effective on-going service delivery and audit and share relevant information with other health care professionals and agencies, in line with locally determined confidentiality arrangements.

In 2015/2016 there were a total of 817 individuals (565 males and 252 females) who were on supervised consumption for at least one point during the year.

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

5.5.5 Outreach NHS Health checks service (pilot)

In summer 2016, Cambridgeshire County Council trained 11 Pharmacies in the Wisbech area, Fenland, to deliver outreach NHS Health Checks as part of a six month pilot, which has since been extended to one year. The NHS Health Check is a health check-up for adults in England aged 40-74 without a pre-existing condition. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia, and calculates a cardiovascular disease risk score over the next 10 years. An NHS Health Check helps to identify ways to lower this risk.

The rural, market town of Wisbech was chosen for the pilot as it has a high prevalence of cardiovascular disease, a high number of local residents unable to attend their GP practice, and a number of proactive community pharmacies in the area. Once an eligible patient check was complete, the result was sent securely to their GP Practice to be entered onto the patient's clinical record and for any appropriate follow-up.

Eligibility, patient forms, all relevant resources, and all promotional materials were supplied by Cambridgeshire County Council. Clinical training and ongoing support for the delivery of an NHS Health Check was provided by a clinical lead nurse on secondment from Cambridgeshire & Peterborough Foundation Trust, whilst Point of Care blood testing equipment and training was supplied by Alere.

Eight Pharmacies actively took part delivering outreach NHS Health Checks, aiming to reach patients who are unable to attend their GP Practice. Data are collected and payments are made on a quarterly basis, in line with the local authority's GP Practice programme.

More information on the national programme is available at: www.nhs.uk/Conditions/nhs-health-check/Pages/NHS-Health-Check.aspx.

5.6 Locally commissioned services commissioned by Cambridgeshire & Peterborough CCG

5.6.1 Community Pharmacy Not Dispensed Scheme

The National Audit Office in 2007 found that drugs wastage is a significant cost for the NHS: at least £100 million a year, and perhaps considerably more.[74] One objective marker of waste in prescribing that is easily measurable, is the production of prescriptions bearing items that the patient does not require. This may be caused by a misunderstanding on the part of any or all of the parties involved in the ordering and production of the repeat prescription.

The Not Dispensed Scheme highlights items that are not required by the patient and informs their GP's. Previously GPs did not get any feedback on medicines which had not been dispensed or were returned to the pharmacy unused. Out of 110 community pharmacies in Cambridgeshire there are currently 94 pharmacies (86.2%) signed up to the scheme. Not all pharmacies signed up submit claims to the medicines management team on a monthly basis. Pharmacies are entitled to a small fee for each item that is not dispensed. There are restrictions on items that may be claimed under the scheme.

5.6.2 Directly Observed Therapy (DOT) service for tuberculosis treatment

The CCG in conjunction with public health and local respiratory clinics are exploring commissioning a Directly Observed Therapy (DOT) service for tuberculosis (TB) patients from a limited number of community pharmacies across the geography of the CCG. This will provide care closer to home for non-infectious patients who require support in adherence with their prescribed TB medication.

5.6.3 Pharmacy support in care homes

Medication errors in care homes for older people can be reduced by reviewing the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. The CCG employ a small team of CCG pharmacists and pharmacy technicians to work collaboratively with GP practices and care homes to rationalise prescribing, optimise medicines usage and reduce medicines waste.

In the pharmacy questionnaire, 28 pharmacies reported that they currently supply medicines to care homes (see Appendix 3). 14 (15% of respondents) reported that they provide a care home service - a further 59 indicated that they would be willing to provide this as a commissioned service. 12 of the 34 dispensing GP practices who responded to the questionnaire (35%) reported that they supply medicines to care homes.

[74] National Audit Office (2007) 'Prescribing Costs in Primary Care.' Available at: http://www.nao.org.uk/wp-content/uploads/2007/05/0607454.pdf (Last accessed 21 Nov 2013)

5.6.4 Community Pharmacy Minor Ailments Service

A minor ailments service was commissioned across Cambridgeshire from 2009 to August 2016. This service was however stopped following a public consultation from March-May 2016.

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

There is now a national commitment that a minor ailments scheme should be commissioned locally across England by April 2018, although there is debate over whether this needs to be a nationally commissioned service by NHS England or commissioned locally by CCGs.[75]

5.7 Healthcare services commissioned by NHS England

There are opportunities for local service commissioning to build on the services provided as essential services to assist in proving effective, integrated healthcare services. A wide range of services are described in the Drug Tariff which are locally commissioned across England including:[76]

- minor ailments management
- palliative care services
- care home services
- head lice management services
- gluten free food supply services
- services to schools
- out of hours services
- supplementary and independent prescribing by pharmacists
- medicines assessment and compliance support.

5.7.1 Dispensing Review of Use of Medicines

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

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

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

5.8 Healthcare services commissioned by other organisations in primary and secondary care

5.8.1 Healthcare associated infections

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

Senior specialist antimicrobial pharmacists within hospitals, primary care trust pharmacists and microbiology/infectious diseases/infection control teams must work together to develop, implement and monitor antimicrobial guidelines across the local health economy. This will involve community pharmacists and GPs working together with hospital teams to align prescribing with the agreed local policy.

Within the secondary care setting, it is possible for pharmacists to lead on 'switching' policies to convert patients from intravenous therapy to oral drug therapy at the earliest appropriate opportunity.

Increasingly, patients are treated with intravenous antibiotics at home. The patient's regular community pharmacy, together with hospital pharmacy services, should be aware of and could be involved in their treatment.

Within primary care, dispensing staff are able to reinforce the message that antibiotics are not always necessary and explain the relationship between excessive use of antibiotics and Health Care Acquired Infections (HCAIs). In addition, they are able to inform other primary care practitioners when a prescribed item is not normally available in the community.

5.8.2 Anticoagulation monitoring

An example of a local service that can be commissioned from pharmacies is anticoagulation monitoring ('INR Clinics'). Currently this is provided in only one pharmacy in Cambridgeshire (Sainsbury's Cherry Hinton Branch, as an outreach service through Cambridge University Hospitals NHS Foundation Trust.

5.9 Other health advice and support services (non-commissioned)

In addition to commissioned services, our questionnaire found that community pharmacies provide a number of additional services as described in Table 13.

There is also potential to draw on experiences from areas where community pharmacies have worked innovatively to address key local public health challenges and benefit local communities. Possible examples include work around fuel poverty, falls prevention, supporting people at risk of domestic abuse, and behavioural change initiatives.

Table 13: Community pharmacy questionnaire – reported local services provided by community pharmacies, as reported in the questionnaire (from 93 respondents out of 110 community pharmacies)

23. Locally commissioned services (Locally commissioned services commissioned by either NHS England, local authorities or CCGs)

	Currently providing	Willing and able to provide if commissioned	Willing to provide if commissioned (need training)	Willing to provide if commissioned (need facilities adjustment)	Not able or willing to provide.	Response Total
Emergency Supply of Medicines (at NHS Expense)	38.7% (36)	24.7% (23)	33.3% (31)	1.1% (1)	2.2% (2)	93
Home Delivery Service (not appliances)	64.5% (60)	10.8% (10)	16.1% (15)	2.2% (2)	6.5% (6)	93
Gluten Free Food Supply Service (ie not via FP10)	10.8% (10)	33.3% (31)	34.4% (32)	3.2% (3)	18.3% (17)	93
Independent (Prescribing Service)	2.2% (2)	15.1% (14)	60.2% (56)	3.2% (3)	19.4% (18)	93
Language Access Service	1.1% (1)	18.3% (17)	52.7% (49)	2.2% (2)	25.8% (24)	93
Medicines Assessment and Compliance Support Service	6.5% (6)	21.5% (20)	55.9% (52)	4.3% (4)	11.8% (11)	93
On Demand Availability of Specialist Drugs Service	5.4% (5)	22.6% (21)	47.3% (44)	5.4% (5)	19.4% (18)	93
Medication review botomy Service	4.3% (4)	8.6% (8)	43.0% (40)	17.2% (16)	26.9% (25)	93
Refer to Pharmacy - allows hospital pharmacy to refer patients to their community pharmacy for a discharge medicines use review/new medicines service	9.7% (9)	31.2% (29)	43.0% (40)	4.3% (4)	11.8% (11)	93
Schools Service	2.2% (2)	20.4% (19)	49.5% (46)	4.3% (4)	23.7% (22)	93

5.9.1 Community Pharmacy Palliative Care Service

Palliative care is the care of any patient with an advanced, incurable disease. It involves the control of symptoms, such as pain, and aims to improve quality of life for both patients and their families. Drug treatment plays a major role in symptom control in palliative care. The aim is to ensure that appropriate palliative care drugs are available in the community at the point of need.

Designated community pharmacies hold essential palliative care drugs for easier access. The drugs that must be held in stock by pharmacies taking part in the scheme are listed in the essential list of palliative care drugs agreed with palliative care clinicians. When pharmacies are closed, the out of hours service, Hertfordshire Urgent Care are required to meet the needs of patients for provision of essential palliative care drugs.

5.9.2 Electronic prescriptions

Responses to the PNA public consultation in 2014 suggested that electronic prescriptions might be beneficial to providing a good service, and improve communication between GPs and pharmacies. The Electronic Prescription Service (EPS) allows the transfer of a prescription from the prescriber to pharmacy (or other dispensing contractor), by electronic means rather than the traditional paper form. The introduction and running of the EPS service is managed by an NHS department. The Murray report[77] recommends that electronic repeat dispensing should become the default for repeat prescribing and its use should be incentivised both for community pharmacies and for GPs.

In Cambridgeshire, all community pharmacies are enabled to receive electronic prescriptions. 15 (44% of the 34 dispensing practice respondents) reported that they are enabled to receive electronic prescriptions and a further six (18%) are intending to become enabled in the next 12 months.

5.9.3 Community Pharmacy Healthy Start Service

Healthy Start is the Department of Health's scheme to help pregnant women and children under four in low-income families eat healthily. Women who qualify for Healthy Start, including those on certain benefits and all pregnant women under the age of 18, receive free food and vitamin vouchers. Healthy start provides vitamin supplements through arrangements with local community pharmacies. Pharmacy coverage is voluntary and unpaid.

The scheme helps to support breastfeeding and offers nutrition support to pregnant women and young children, including eating 5-a-day and following a healthy diet with Healthy Start vitamins. Recipients receive weekly food vouchers to exchange for fresh and frozen fruit and vegetables, plain cow's milk and cow's milk based infant formula and vouchers every eight weeks for free vitamin supplements for children from six months until their fourth birthday, and free vitamin supplements for pregnant women and women with babies up to one year old. The scheme also has the advantage of encouraging earlier and closer contact between health professionals and families from disadvantaged groups.

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

5.9.4 Travel immunisation clinics

A number of community pharmacies reported in the questionnaire that they provide private travel clinics including vaccinations.

6 Future Population Changes and Housing Growth

Key messages:
Over the coming years the population in Cambridgeshire is expected to both age and grow substantially in numbers. An increase in population size is likely to generate an increased need for pharmaceutical services, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required, due to the range of other factors influencing local pharmaceutical needs. Several large-scale housing developments are in progress and considerations, when assessing needs for local pharmaceutical service providers, should be based on a range of local factors specific to each development site. These are further described in section 6.5.3 of the PNA report.

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

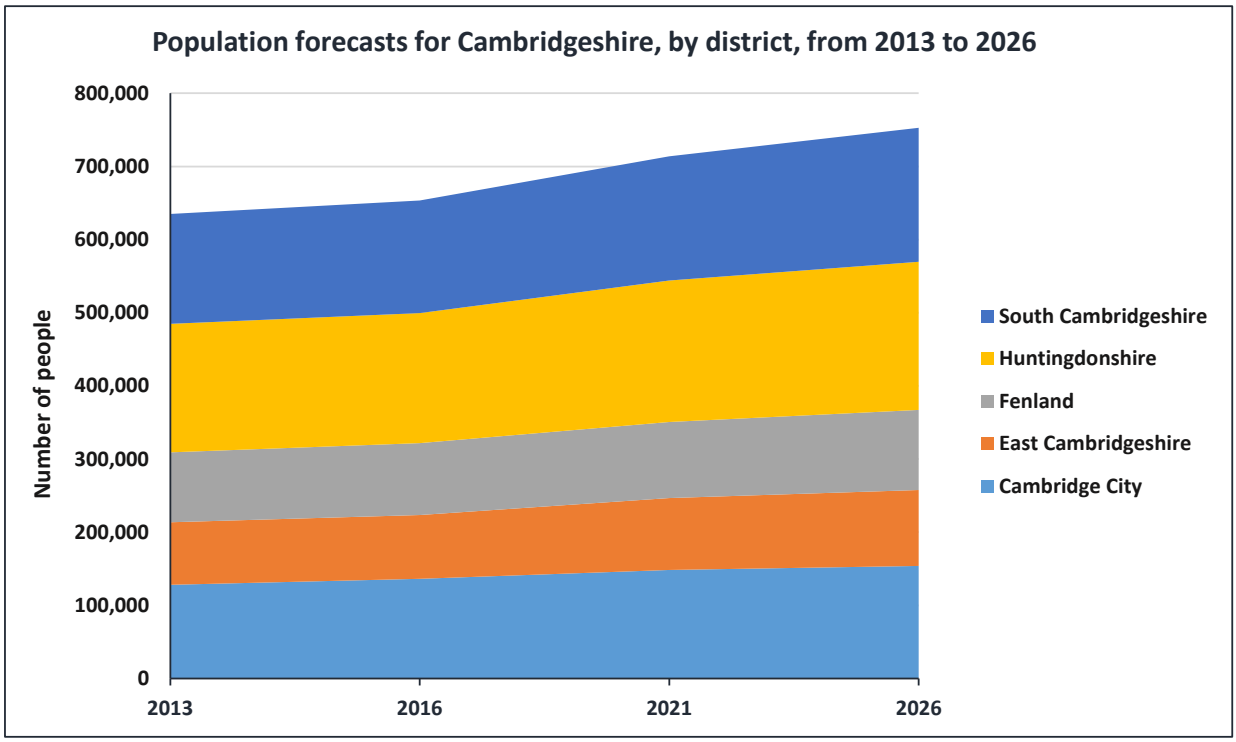
This section considers population changes and housing growth in Cambridgeshire. Particular emphasis is placed on expected housing completions during 2016 to 2019, which is the three-year period before the PNA will need to be updated.

6.1 Population changes in Cambridgeshire

The population of Cambridgeshire was 653,400 in 2016 and is expected to increase by approximately 60,400 (9.2%) to 752,800 by 2021.

An overview of the population growth in Cambridgeshire by district in the coming decades is shown in **Figure 5**. The largest increases in both absolute and relative terms are expected in Huntingdonshire and South Cambridgeshire, where a number of significant new housing developments are planned, including the new town of Northstowe.

Figure 5. Population forecasts for Cambridgeshire, by district, from 2013 to 2026



Source: Cambridgeshire Research Group 2013 base population forecasts

The population of 0 to19 year olds in Cambridgeshire is expected to increase by 9.4% overall between 2016 and 2021 (see **Table 14)**. East and South Cambridgeshire are forecast to have the largest increases, of 14% and 11% respectively.

Table 14. Current and Forecast Population aged 0-19 years

Local Authority	2016	2021	2026	% change 2016-2021	% change 2016-2026
Cambridge	35,000	37,800	38,900	8.0%	11.1%
East Cambridgeshire	20,350	23,200	24,150	14.0%	18.7%
Fenland	21,100	22,200	23,000	5.2%	9.0%
Huntingdonshire	40,400	44,100	45,750	9.2%	13.2%
South Cambridgeshire	36,100	40,050	42,900	10.9%	18.8%
Cambridgeshire	152,950	167,350	174,700	9.4%	14.2%

Source: Cambridgeshire Research Group 2013 base population forecasts

The adult working-age population (age 20 to 64) in Cambridgeshire is expected to increase by some 7.6% between 2016 and 2021 (see **Table 15)**. East Cambridgeshire is expected to have the largest increase at 11.6%.

Table 15. Current and Forecast Population aged 20-64 years

Local Authority	2016	2021	2026	% change 2016-2021	% change 2016-2026
Cambridge	84,900	92,100	94,000	8.5%	10.7%
East Cambridgeshire	49,750	55,500	57,350	11.6%	15.3%
Fenland	55,100	56,900	58,700	3.3%	6.5%
Huntingdonshire	103,500	109,900	111,650	6.2%	7.9%
South Cambridgeshire	88,200	95,850	101,600	8.7%	15.2%
Cambridgeshire	381,450	410,250	423,300	7.6%	11.0%

Source: Cambridgeshire Research Group 2013 base population forecasts

The number of people in Cambridgeshire aged over 65 years is expected to increase by 14.8% between 2016 and 2021 (see **Table 16)**. The highest growth in the older population is expected to be in East Cambridgeshire (16.6%) and in Huntingdonshire (16.6%).

Table 16. Current and Forecast Population aged 65 years and over

Local Authority	2016	2021	2026	% change 2016-2021	% change 2016-2026
Cambridge	16,200	18,500	20,900	14.2%	29.0%
East Cambridgeshire	16,900	19,700	22,300	16.6%	32.0%
Fenland	22,200	24,800	27,800	11.7%	25.2%
Huntingdonshire	33,800	39,400	45,200	16.6%	33.7%
South Cambridgeshire	29,600	33,900	38,700	14.5%	30.7%
Cambridgeshire	118,700	136,300	154,900	14.8%	30.5%

Source: Cambridgeshire Research Group 2013 base population forecasts

6.2 Housing growth

The county has been an area of growth for many years. In fact, Cambridgeshire was the fastest growing county between the 2001 and 2011 Census in terms of population growth. Emerging district council local plans continue to support future growth in their areas of the county to meet housing need and support economic growth.

The 2013 update of the Strategic Housing Market Assessment (SHMA) proposes a total of 75,000 new dwellings in the county from 2011 to 2031. The recession and current economic situation has caused a slowdown in house building and a delay in starting work on major new housing sites. During 2015/16, there were 2,540 new dwellings completed, which is less than the 2,812 completed in 2014/15 and 3,176 in 2013/14. District council planners had expected annual house completions to increase to pre-recession levels of over 4,000 completions a year from 2014/15, but this has not happened with levels still below the figure of 4,000 completions per year.

Table 17: Dwelling Completions (NET) in Cambridgeshire

	2013-2014	2014-2015	2015-2016
Cambridge City Council	1,325	713	884
East Cambridgeshire District Council	191	163	181
Fenland District Council	343	555	269
Huntingdonshire District Council	686	516	535
South Cambridgeshire District Council	631	865	671
Cambridgeshire	**3,176**	**2,812**	**2,540**

NET completions include all dwelling gains in monitoring year minus the losses (demolitions, etc)
Source: Cambridgeshire Research Group.

Table 18 describes dwelling commitments across Cambridgeshire as at 31 March 2015. Commitments include those with outline planning permission, full/reserved permissions, and allocated sites within the Local Plans.

Table 18. Dwelling Commitments in Cambridgeshire at 31 March 2015

Outline planning permission	Full / Reserved Matters permission, Under Construction	Full / Reserved Matters permission, Not Started	Total Permissions	Adopted Allocation with no Planning Permissions	Proposed Allocation included in Local Plans submitted March 2014	Total Commitments
14,423	2,723	5,859	23,005	26,668	15,437	65,110

Source: Cambridgeshire Research Group

6.3 Growth during 2017 – 2020

Several major developments are expected to progress significantly during 2017 to 2020. There are several developments which are underway and a number of other major developments are expected to begin during the period. Table 19 shows the major developments in Cambridgeshire between 2017 to 2020.

Table 19. Major developments in Cambridgeshire 2017 to 2020

Site	Area	Total units at completion	Estimated start date
Northstowe	South Cambridgeshire	10,000	Started
Bourn Airfield	South Cambridgeshire	3,000	TBC
Cambourne West	South Cambridgeshire	2,350	TBC
Waterbeach	South Cambridgeshire	10,000	TBC
Cottenham (various sites)	South Cambridgeshire	530-625	TBC
Alconbury Weald	Huntingdonshire	5,000	2015
Wyton	Huntingdonshire	4,500	TBC
RAF Brampton	Huntingdonshire	587	TBC
West March	Fenland	2,000	TBC
Chatteris	Fenland	1,000	TBC
St Neots East	St Neots	3,700*	2014
Ely North	Ely	3,000	2014
Cambridge North-West	Cambridge fringe	3,000	2014
Darwin Green 1&2	Cambridge fringe	2,700	2014
Clay Farm	Cambridge fringe	2,300	Started
Trumpington Meadows	Cambridge fringe	1,200	Started
Wing	Cambridge fringe	1,500	2015

* St Neots East includes two separate sites, Wintringham Park (2,800 units) and Loves Farm East (900 units with a possible potential for 1200 units). Source: Cambridgeshire Research Group

Map 13 shows growth sites of 200 or more commitments across Cambridgeshire together with community pharmacies and dispensing practices as at October 2016. **Map 14** shows growth sites of between 10 and 200 commitments against current pharmaceutical providers.

6.4 Growth after 2020

After 2020, there are likely to be additional sites that need to be taken account of in future PNAs.

6.5 Monitoring of housing developments and needs for pharmaceutical services

In addition to the growing and ageing population, the large-scale housing developments in progress can impact on the need for pharmaceutical services in their area in the future.

The new town of Northstowe is an NHS Healthy New Town Vanguard and the project is looking to provide new residents with the spectrum of health services from pharmacy and primary care in a new model of care. Residents will be advised when they move in on the most appropriate health service to access for their needs.

The HWB has considered ways of monitoring the progress of planned housing developments in relation to need for pharmaceutical services.

6.5.1 Monitoring of housing developments

Cambridgeshire Research Group publish a quarterly update on the status of major housing developments in Cambridgeshire.[78] This information will be used to inform monitoring of need for pharmaceutical services before the next PNA is published.

CCC also monitors, on behalf of the five Cambridgeshire district councils, the annual number of commitments, completions and units under construction. This information is available on an annual basis across the county.[79]

Each District in Cambridgeshire has a plan for community growth and development and these plans are under regular review.

In addition to monitoring individual housing sites, it may be necessary to monitor cumulative developments across several sites; i.e. if a number of smaller developments are built in an area then future completions may be worth monitoring by town/village/vicinity to pharmacies as well as just by individual housing developments. This might be particularly relevant where the ratio of pharmacies to people is already above or below average.

6.5.2 Effect of Growth on a Reserved Location

A reserved location is an area within a controlled locality where the total of all patient lists for the area within a radius of 1.6km (1 mile) of the proposed premises or location is fewer than 2,750.

Should the population reach or exceed 2,750 the pharmacy, if already open, can apply to NHS England for a re-determination of reserved location status. If this status is removed then, subject to the prejudice test, the normal one mile rule would apply (i.e. the doctors lose dispensing rights within a mile of the pharmacy).

[78] Ibid.
[79] Cambridgeshire County Council. 'Housing Development' webpage. Available at: http://cambridgeshireinsight.org.uk/interactive-maps/housing

6.5.3 Factors to consider in relation to needs for pharmaceutical services

In Cambridgeshire there is currently one pharmaceutical provider (defined as community pharmacy or dispensing GP practice) per 4,258 people. The lowest concentration of pharmacies in England is one pharmacy per 4,924 people (in Wessex) and the highest concentration is one pharmacy per 3,768 people (Cheshire and Merseyside).

According to the 2011 Census the average number of people per household in East of England is 2.3-2.4 (the average for England is 2.3). However, an analysis undertaken by Cambridgeshire Research Group, to forecast the population of new developments in Cambridgeshire, suggested that it is reasonable to assume an average household size of 2.5 people. Note that the average household size in the new developments tends to be larger than the standard multiplier used of 2.5, with Cambourne, Cromwell Park and Orchard Park seeing average household sizes of 2.8 (see Table 20). This has implications for service delivery in new developments (i.e. coping with an increase in population compared to predicted populations). The average household size was expected to be relatively consistent in different housing mix scenarios, so that the average would be between 2.25 and 2.75 people for most scenarios.

Table 20. Average household size of recent new developments

Development	Average Household Size
Bar Hill	2.3
Cambourne	2.8
Cromwell Park	2.8
Hampton	2.7
Loves Farm	2.6
Orchard Park	2.8
Stukeley Meadows	2.6

Source: Cambridgeshire Research Group and Census 2011 (ONS)

The HWB is not aware of any robust evidence to suggest a generic 'population trigger point' for when a housing development in a location might need a pharmaceutical service provider. The HWB is also not aware of any measure of the extent to which existing local pharmaceutical service providers can accommodate the increase in need for pharmaceutical services created by an increase in local population size.

An increase in population size is likely to generate an increased need for pharmaceutical services, but, on a local level, changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required to meet local pharmaceutical needs, due to the range of other factors influencing such needs.

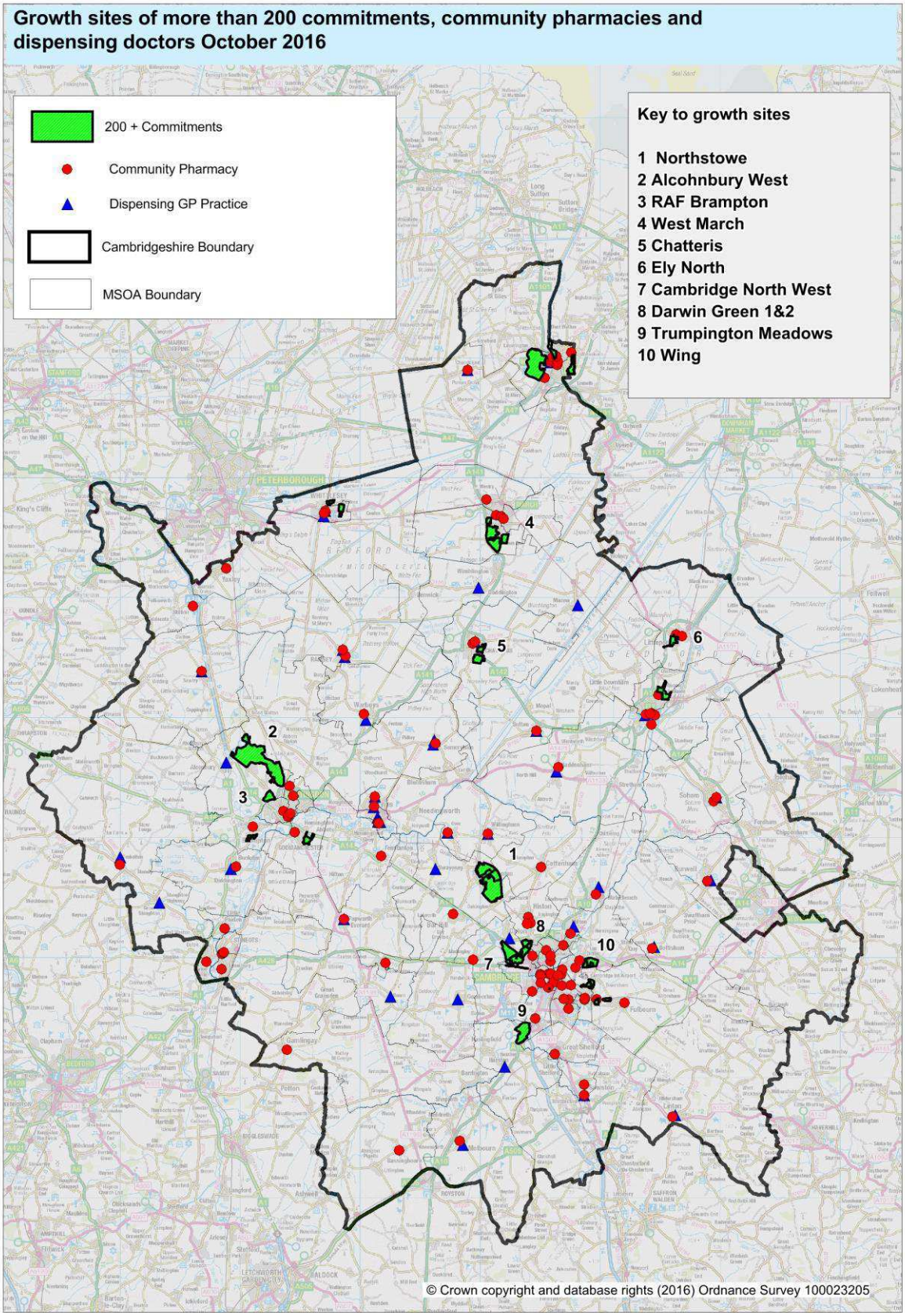
Considerations, when assessing needs for local pharmaceutical service providers, should be based on a range of local factors specific to each development site. Such factors may include:

- Average household size of new builds on the site.
- Demographics: People moving to new housing developments are often young and expanding families, but some housing developments are expected to have an older population with different needs for health and social care services.
- Tenure mix, ie the proportion of affordable housing at the development.

- Existing pharmaceutical service provision in nearby areas and elsewhere in the county and opportunities to optimise existing local pharmaceutical service provision;
- Access to delivery services, distance selling pharmacies, and Dispensing Appliance Contractors that can supply services.
- Developments in pharmaceutical supply models (eg delivery services, robotic dispensing, centralised hub dispensing and electronic transmission of prescriptions) that could affect the volume of services a pharmaceutical service provider can deliver.
- Skill mix. A pharmacy's capacity to dispense larger volumes of prescriptions and/or deliver other services is greatly influenced by the number of pharmacists working in the pharmacy and, increasingly more importantly, the number of support staff. There have been significant developments in the roles that support staff can now fulfil to support the pharmacy operation. Medicines Counter Assistants, Dispensers, Pharmacy Technicians and Accredited Checking Technicians all now make a significant contribution to the delivery of pharmacy services and their availability to support a pharmacist should be considered by commissioners when considering how services can be commissioned from pharmacies.
- Considerations of health inequalities and strategic priorities for Cambridgeshire.

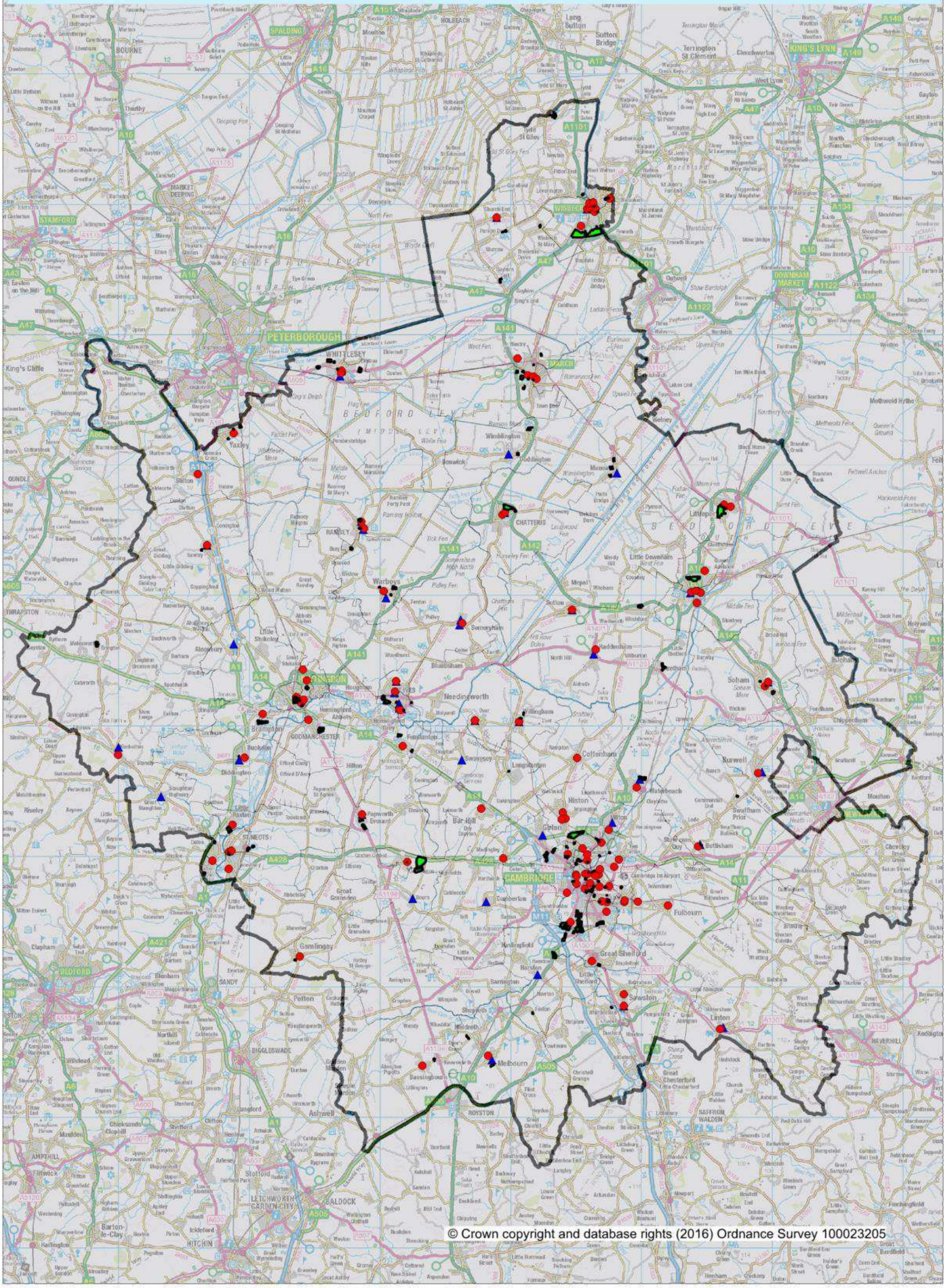
In conclusion, over the coming years, the population in Cambridgeshire is expected to both age and grow substantially in numbers. Several large-scale housing developments are in progress. The Cambridgeshire HWB will monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, to ensure that appropriate information is available to determine whether additional pharmaceutical services provision might be required.

Map 13: Growth sites of more than 200 commitments



Map 14: Growth sites of 10 to 200 commitments

Growth sites of 10 to 200 commitments, community pharmacies and dispensing doctors October 2016



Cambridgeshire

Pharmaceutical Needs Assessment 2017

Appendices 1 – 7

Appendix 1: Legal requirements for PNAs

This section contains an extract from The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Please note that the HWB takes no responsibility for the accuracy of the extract. The full text of the Regulations is available at: http://www.legislation.gov.uk/uksi/2013/349/contents/made

1. These regulations may be cited as the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and came into force on 1st April 2013.

2. Interpretation *(long – see website)*

3. The pharmaceutical services the PNA must cover are all the pharmaceutical services that may be provided under arrangements made by the NHSCB for:

a) *the provision of pharmaceutical services (including directed services) by a person on a pharmaceutical list;*
b) *the provision of local pharmaceutical services under an LPS scheme (but not LP services which are not local pharmaceutical services); or*
c) *the dispensing of drugs and appliances by a person on a dispensing doctors list (but not other NSH services that may be provided under arrangements made by the NHSCB with a dispensing doctor)*

4. Information to be contained in PNA

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

5. Date by which the first HWB PNAs are to be published

Each HWB must publish its first PNA by 1st April 2015.

6. Subsequent assessments

(1) *After it has published its first PNA, each HWB must publish a statement of its revised assessment within three years of its previous publication.*
(2) *A HWB must make a revised assessment as soon as is reasonably practicable after identifying changes since the previous assessment, which are of a significant extent, to the need for pharmaceutical services in its area, having regard in particular changes to –*
   a) *the number of people in its area who require pharmaceutical services;*
   b) *the demography of its area; and*
   c) *the risks to the health or wellbeing of people in its area,*

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

(3) *Pending the publication of a statement or a revised assessment, a HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services (..) where –*
   a) *the changes are relevant to the granting of applications referred to in section 129(2)(c)(i) or(ii) of the 2006 Act; and*
   b) *the HWB –*
      (i) *is satisfied that making its first or revised assessment would be a disproportionate response, or*
      (ii) *is in the course of making its first or revised assessment and is satisfied that immediate notification of its PNA is essential in order to prevent significant detriment to the provision of pharmaceutical services in its area.*

7. Temporary extension of PCT PNAs and access by the NHSCB and HWBs to PNAs

Before the publication by an HWB of the first PNA that it prepares for its area, the PNA that relates to any locality within that area is the PNA that relates to that locality of the PCT for that locality immediately before the appointed day, read with

a) *any supplementary statement published by the PCT (..)*
b) *any supplementary statement published by the HWB (..)*

Each HWB must ensure that the NHSCB has access to –

a) *the HWB's PNA (including any supplementary statements) (..)*
b) *any supplementary statement that the HWB publishes (..)*
c) *any PNA of a PCT that it holds, which is sufficient to enable the NHSCB to carry out its functions under these Regulations*

Each HWB must ensure that, as necessary, other HWBs have access to any PNAs of any PCT that it holds, which is sufficient to enable the other HWBs to carry out their functions under these Regulations.

8. Consultation on PNAs

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

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

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

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

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

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

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

(g) the NHSCB; and

(h) any neighbouring HWB.

(2) The persons mentioned in paragraph (1) must together be consulted at least once during the process of making the assessment on a draft of the proposed pharmaceutical needs assessment.

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

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

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

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

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

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

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

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

9. Matters for consideration when making assessments

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

(a) the demography of its area;

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

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

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

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

(e) any other NHS services provided in or outside its area (which are not covered by subparagraph

(d)) which affect—

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

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

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

(b) having regard to likely changes to—

> *(i) the number of people in its area who require pharmaceutical services,*
>
> *(ii) the demography of its area, and*
>
> *(iii) the risks to the health or wellbeing of people in its area.*

SCHEDULE 1 Regulation 4(1)

Information to be contained in pharmaceutical needs assessments

Necessary services: current provision

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

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

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

Necessary services: gaps in provision

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

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

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

Other relevant services: current provision

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

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

(b) outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;

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

Improvements and better access: gaps in provision

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

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

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

Other NHS services

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

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

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

How the assessment was carried out

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

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

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

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

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

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

Map of provision

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

Appendix 2: List of Pharmacies & Dispensing Practices in Cambridgeshire *(July 2016)*

ID	Pharmacy	Code
29	Acorn Pharmacy, Oaktree Drive, Huntingdon	FD696
57	Asda Pharmacy, Beehive Centre, Cambridge	FLM26
102	Asda Pharmacy, North End, Wisbech	FF184
58	Bassingbourn Pharmacy, Royston	FM614
30	Boots, (Boots UK Ltd) (Boots, (Boots UK Ltd) UK Ltd), High Street, St Neots, Huntingdon	FAC08
7	Boots, (Boots UK Ltd), Market Street, Ely	FD365
59	Boots, (Boots UK Ltd), Cambridge Retail Park, Cambridge	FFF41
63	Boots, (Boots UK Ltd), Grafton Centre, Cambridge	FJ710
32	Boots, (Boots UK Ltd), High Street, Huntingdon	FLX65
8	Boots, (Boots UK Ltd), Broad Street, March	FP164
31	Boots, (Boots UK Ltd), Sheep Market, St Ives, Huntingdon	FP179
64	Boots, (Boots UK Ltd), Petty Cury, Sidney St, Cambridge	FPA48
9	Boots, (Boots UK Ltd), Horsefair, Wisbech	FPK57
1	Boots, (Boots UK Ltd), Syers Lane, Whittlesey	FFR55
2	Boots, (Boots UK Ltd), Norfolk Street, Wisbech	FGX50
3	Boots, (Boots UK Ltd), Old Market, Wisbech	FL705
4	Boots, (Boots UK Ltd), De Havilland Road, Wisbech	FQH01
5	Boots, (Boots UK Ltd), Kirkgate Street, Walsoken, Wisbech	FFE75
60	Boots, (Boots UK Ltd), High Street, Cherry Hinton, Cambridge	FNC93
61	Boots, (Boots UK Ltd), High Street, Sawston, Cambridge	FNM28
62	Boots, (Boots UK Ltd), Woollards Lane, Gt Shelford, Cambridge	FXO39
6	Boots, (Boots UK Ltd), Marylebone Road, March	FAW48
10	Boots, (Boots UK Ltd), High Causeway, Whittlesey	FC181
33	Boots, (Boots UK Ltd), Sawtry, Huntingdon	FAE37
65	Boots, (Boots UK Ltd), Cherry Hinton Road, Cambridge	FM486
66	Boots, (Boots UK Ltd), Chesterton Road, Cambridge	FPQ39
103	Bottisham Pharmacy, High Street, Bottisham	FW128
34	Brampton Pharmacy, High Street, Brampton	FQJ32
35	Buckden Pharmacy, Hunts End, Buckden	FCF97
67	Ditton Pharmacy, Ditton Lane, Cambridge	FVP77
11	Fairbrother Pharmacy, Church Terrace, Wisbech	FRT66
36	Fenstanton Pharmacy, High Street, Fenstanton	FXE71
104	Fittleworth Medical, Histon	FJF97
75	Fitzwilliam Pharmacy, Trumpington Street, Cambridge	FPJ79
69	GFT Davies & Co, Hills Road, Cambridge	FRH66
68	Gamlingay Pharmacy, Church Street, Gamlingay	FKT41
70	JT and K Gregory Pharmacy & Opticians, Trumpington, Cambridge	FV636
12	Haddenham Pharmacy, Station Road, Haddenham	FDQ06
105	Halls the Chemist, Stilton	FWL28
37	JW Anderson Dispensing Chemist, Somersham, Huntingdon	FL284
38	JG Clifford Dispensing Chemist, 2-2A The Causeway. Godmanchester	FHM18
71	Kays Chemist, Wulfstan Way, Cambridge	FH400
72	Kumar Chemist, High Street, Cherry Hinton	FXP71
39	Rowlands Pharmacy, The Health Centre, Yaxley	FF148

ID	Pharmacy	Code
40	Little Paxton Pharmacy, St Neots	FWJ14
14	Lloyds Pharmacy, High Street, Soham, Ely	FJ667
73	Loves Farm Pharmacy, St Neots	FF149
13	Lloyds Pharmacy, High Street, Chatteris	FJ193
18	Lloyds Pharmacy, High Street, Burwell, Cambridge	FRK45
76	Lloyds Pharmacy, High Street, Cambourne	FWE48
41	Lloyds Pharmacy, Great Whyte, Ramsey, Huntingdon	FA042
47	Lloyds Pharmacy, Market Hill, St Ives, Huntingdon	FC219
42	Lloyds Pharmacy, Ermine St, Huntingdon	FDL32
43	Lloyds Pharmacy, Kings Hedges, St Ives, Huntingdon	FGT99
15	Lloyds Pharmacy, Princess of Wales, Ely	FJ828
16	Lloyds Pharmacy, Elwyn Roadd, March	FK813
44	Lloyds Pharmacy, Huntingdon Street, St Neots	FLF21
74	Lloyds Pharmacy, Nuffield Centre, Cambridge	FMQ30
45	Lloyds Pharmacy, Gt North Road, St Neots	FMR87
17	Lloyds Pharmacy, Main Street, Littleport	FPF47
19	St Mary's Pharmacy, Ely	FEJ14
20	Lloyds Pharmacy, Swan Drive, Chatteris	FYE36
46	Lloyds Pharmacy, Stockingfen Road, Ramsey	FQ079
21	Staploe Pharmacy	FXM99
77	Milton Road Pharmacy, Cambridge	FND78
106	Lloyds Pharmacy, Arbury Court, Cambridge	FA272
78	NK Jank Chemist, Newnham Road, Cambridge	FM044
23	Brink Medicines Ltd	FQN58
86	Numark Pharmacy, Perne Road, Cambridge	FG659
107	Over Healthcare Pharmacy, Drings Close, Cambridge	FW840
50	Papworth Pharmacy	FDV36
24	Parson Drove Pharmacy, Wisbech	FAK71
87	Waterbeach Pharmacy, Cambridge	FAN68
108	Priory Fields Pharmacy, Huntingdon	FW406
51	Rowlands Pharmacy, Lansdowne Road, Yaxley	FRR65
88	Rowlands Pharmacy, Histon, Cambridge	FX220
109	Sainsbury's Pharmacy, Ely	FDK60
110	Lloyds Pharmacy, Brooks Road, Cambridge (Sainsbury's In-store)	FQ463
52	Sainsburys Pharmacy, Nursery Road, Huntingdon	FMT88
89	Sawston Pharmacy, London Road, Sawston, Cambridge	FW739
111	St George's Pharmacy, Littleport	FRQ84
112	Lloyds Pharmacy, Ely	FT482
90	Superdrug Pharmacy, Sidney Street, Cambridge	FJE06
91	Superdrug Pharmacy, Fitzroy Street, Cambridge	FVE60
25	BK Kandola Ltd, High St, Sutton	FMF35
27	Tesco In-store Pharmacy, Sandown Road, Wisbech	FG548
53	Tesco In-store Pharmacy, Abbots Ripton Road, Huntingdon	FJ285
54	Tesco In-store Pharmacy, Eynesbury, St Neots, Huntingdon	FJ579
93	Tesco In-store Pharmacy, Bar Hill, Cambridge	FJM20
26	Tesco In-store Pharmacy, March	FJW80
28	Tesco In-store Pharmacy, Angel Drove, Ely	FTO42

ID	Pharmacy	Code
94	Tesco In-store Pharmacy, Cambridge Road, Milton, Cambridge	FV774
92	Tesco In-store Pharmacy, Yarrow Road, Fulbourn	FVR16
85	Well Pharmacy, Barnwell Road, Cambridge	FC248
79	Well Pharmacy, Station Road, Impington, Cambridge	FCH09
83	Well Pharmacy, High Street, Cottenham	FCJ05
48	Well Pharmacy, Constable Road, St Ives, Huntingdon	FD555
22	Well Pharmacy, Augustine's Road, Wisbech	FFJ83
49	Well Pharmacy, Huntingdon Street, St Neots	FM489
80	Well Pharmacy, High Street, Melbourn, Royston	FN376
84	Well Pharmacy, York Street, Cambridge	FNT86
81	Well Pharmacy, Unity House, Mill Rd, Cambridge	FQJ21
82	Well Pharmacy, Station Road, Histon, Cambridge	FT890
56	The Old Swan Pharmacy, Kimbolton, Huntingdon	FC095
95	The Village Pharmacy, Fulbourn, Cambridge	FM607
96	Village Pharmacy, Linton, Cambridge	FR918
55	JW Anderson Dispensing Chemis, Ramsey Road, Warboys	FLQ28
97	Waterbeach Pharmacy, Cambridge	FHK72
99	Whittlesey Pharmacy, Whittlesey	FGQ83
98	Willingham Health Care, Cambridge	FTA59

List of Dispensing Practices (Oct 2016)

Source: NHS England East Anglia Area Team.

Practice Code	Practice Name	Map ID
D81004	Alconbury & Brampton Surgeries	38
D81055	Bottisham Medical Practice	12
D81041	Bourn Surgery	5
D81045	Buckden Surgery	30
D81051	The Burwell Surgery	14
D81040	Church Street Medical Centre	40
D81011	Clarkson Surgery	21
D81035	Comberton & Eversden Surgery	6
D81030	Cromwell Place Surgery	35
D81071	Doddington Medical Centre	24
D81061	George Clare Surgery	27
D81081	Great Staughton Surgery	29
D81062	Haddenham Surgery	17
D81058	Harston Surgery	4
D81002	Girton Branch Surgery (Huntingdon Road Surgery)	1
D81039	Jenner Health Centre	25
D81038	Kimbolton Medical Centre	28
D81048	Linton Health Centre (now Granta Medical Practices)*	2
D81611	Manea Surgery	23
D81612	Milton Surgery	10
D81060	The Moat House Surgery	39
D81046	The New Queen Street Surgery	26
D81008	The North Brink Practice	20
D81074	Northcote House Surgery	37
D81623	The Old Telephone Exchange	36
D81018	Orchard Surgery, Melbourn	11
D81606	Orchard Surgery, St Ives	33
D81033	The Over Surgery	9
D81085	Papworth Surgery	43
D81619	Parkhall Surgery	41
D81015	Parson Drove Surgery	22
D81036	Priors Field Surgery	16
D81087	Rainbow Surgery	32
D81059	Ramsey Health Centre	31
D81043	Granta Medical Practices (formerly Sawston)	3
D81021	St Georges Medical Centre	15
D81034	St Mary's Surgery	18
D81607	Swavesey Surgery	7
D81049	The Spinney Partnership	34
D81014	The Staploe Medical Centre	19
D81042	Waterbeach Surgery	13
D81027	Wellside Surgery	42
D81084	Willingham Medical Practice	8

** Sawston Medical Practice and Linton Health Centre now merged to become Granta Medical Practice*

2.c Methods used to identify and map pharmaceutical service providers:

- A list of pharmacies within Cambridgeshire as of 30th June 2016 including postcodes and other information was obtained via Medicines Management in the CCG. This was checked against information from the Organisation Data Service (ODS) (as at June 2016). The 2016 list was compared with that from the previous PNA to identify pharmacies that opened and/or closed since the last PNA was published.

- Pharmacies in surrounding counties were obtained from the ODS. An alternative method for identifying out-of-area providers has also been described[80] but was not used for the current PNA as it was considered more resource intensive.

- Lists of dispensing practices were obtained from NHS England Area Team. The number of people registered with as a dispensing patient was obtained from NHS Digital.

- Maps showing the locations of premises providing pharmaceutical services were created in MapInfo.

- Maps showing access to pharmaceutical services by travel distance were created using *Rootfinder version 3.7.3*. Use of *AddressBase Premium* enabled identification of properties that are classified as residential. This map was not updated from 2013.

[80] NHS Primary Care Commissioning. 'Identifying out-of-area providers of pharmaceutical services' August 2010. Available at: http://www.pcc-cic.org.uk/sites/default/files/articles/attachments/identifying_out_of_area_providers_of_pharmaceutical_services.pdf

Appendix 3: Results of Community Pharmacy questionnaire 2016

A questionnaire was sent to all 110 Community Pharmacies in Cambridgeshire.
There were 93 returned questionnaires (85%)

Consultation Facilities

Question	Response
Are consultation facilities on site and do they include wheelchair access? Where there is a consultation area, is it a closed room?	Out of 93 returned questionnaires: 87 (94%) Have consult. areas w/ wheelchair access 5 (5%) Have consult. areas w/o wheelchair access 1 (1%) Has planned within next 12 months 93 (100%) Have the consult. area in a closed room
Have access to off-site consultation area? Willing to undertake consultations in patient's home, or other suitable site?	Out of 93 returned questionnaires: 2 (2%) have access to off-site consultation area 48 (52%) willing to undertake consult. in patient's home/other suitable site
During consultations are there hand washing facilities? Patients attending for consultations have access to toilet facilities	Out of 93 returned questionnaires: 65 (70%) Hand-washing facilities in cons. area 21 (23%) Hand-washing facilities near cons. area 7 (8%) No hand-washing facilities 44 (47%) have toilet facilities available for patients.

IT Facilities

Question	Response
Does the pharmacy have an nhs.net email address? If no, does the pharmacy intend to have an nhs.net address in the next 12 months?	Out of 93 returned questionnaires: 19 (20%) have an nhs.net address 74 (80%) do not have an nhs.net address 51/74 (69%) intend to have an nhs.net address in the next 12 months
Facilities for opening documents	Out of 93 returned questionnaires: Word 91 (98%) Access 55(59%) Excel 85 (91%) PDF 92(99%)

Essential Services

Does the pharmacy dispense appliances?	Out of 93 returned questionnaires: 83 (89%) Yes, all types 2 (2%) Yes, excluding stoma appliances 1 (1%) Yes, excluding incontinence appliances 2 (2%) Yes, excluding stoma and incontinence 3 (3%) Yes, just dressings 2 (2%) None

Advanced Services

Question	Response
Medicines Use Review	Out of 93 returned questionnaires: 93 (100%) Yes
Appliance Use Review	7 (8%) Yes 19 (20%) Intend to begin within 12 months 67 (72%) Not intending to provide
Stoma Appliance Customisation	22 (24%) Yes 13 (14%) Intend to begin within 12 months 58 (62%) Not intending to provide
New Medicines Service	93 (100%) Yes
NHS Seasonal Flu Vaccination	78 (84%) Yes 9 (10%) Intend to begin within 12 months 6 (7%) Not intending to provide

Locally Commissioned Services

Locally commissioned services commissioned by either NHS England, Local Authorities or CCGs

Anticoagulant monitoring service	Of 93 returned questionnaires: 0 (0%) Currently providing 15 (16%) Willing and able to provide if commissioned 55 (59%) As above (needs training) 10 (11%) As above (need facilities adjustment) 13 (14%) Not able or willing to provide
Anti-viral distribution service	(1%) Currently providing 16 (17%) Willing and able to provide if commissioned 49 (53%) As above (needs training) 8 (9%) As above (need facilities adjustment 19 (20%) Not able or willing to provide

Care Home Service	14 (15%) Currently providing 21 (23%) Willing and able to provide if commissioned 33 (36%) As above (needs training) 5 (5%) As above (need facilities adjustment) 20 (22%) Not able or willing to provide
Chlamydia testing service	31 (33%) Currently providing 9 (10%) Willing and able to provide if commissioned 41 (44%) As above (needs training) 4 (4%) As above (need facilities adjustment) 8 (9%) Not able or willing to provide
Emergency Hormonal Contraception Service	65 (70%) Currently providing 8 (9%) Willing and able to provide if commissioned 15 (16%) As above (needs training) 1 (1%) As above (need facilities adjustment) 4 (4%) Not able or willing to provide
Emergency Supply of Medicines (at NHS expense)	36 (38%) Currently providing 23 (25%) Willing and able to provide if commissioned 31 (33%) As above (needs training) 1 (1%) As above (need facilities adjustment) 2 (2%) Not able or willing to provide
Home Delivery Services (not applicances)	60 (65%) Currently providing 10 (11%) Willing and able to provide if commissioned 15 (16%) As above (needs training) 2 (2%) As above (need facilities adjustment) 6 (6%) Not able or willing to provide
Gluten Free Food Supply Service (ie not via FP10)	10 (11%) Currently providing 31 (33%) Willing and able to provide if commissioned 32 (34%) As above (needs training) 3 (3%) As above (need facilities adjustment) 17 (18%) Not able or willing to provide
Independent (Prescribing Service)	2 (2%) Currently providing 14 (15%) Willing and able to provide if commissioned 56 (60%) As above (needs training) 3 (3%) As above (need facilities adjustment) 18 (19%) Not able or willing to provide
Language Access Review	1 (1%) Currently providing 17 (18%) Willing and able to provide if commissioned 49 (53%) As above (needs training) 2 (2%) As above (need facilities adjustment) 24 (26%) Not able or willing to provide

Medication Review Service	53 (57%) Currently providing 8 (9%) Willing and able to provide if commissioned 29 (31%) As above (needs training) 0 (0%) As above (need facilities adjustment) 3 (3%) Not able or willing to provide
Medicines Assessment and Compliance Support	6 (7%) Currently providing 20 (22%) Willing and able to provide if commissioned 52 (56%) As above (needs training) 4 (4%) As above (need facilities adjustment) 11 (12%) Not able or willing to provide
MUR Plus Service	1 (1%) Currently providing 24 (26%) Willing and able to provide if commissioned 56 (60%) As above (needs training) 3 (3%) As above (need facilities adjustment) 9 (10%) Not able or willing to provide
Needle and Syringe Exchange Service	35 (38%) Currently providing 12 (13%) Willing and able to provide if commissioned 25 (26%) As above (needs training) 5 (5%) As above (need facilities adjustment) 16 (17%) Not able or willing to provide
Obesity Management (adults and children)	0 (0%) Currently providing 22 (24%) Willing and able to provide if commissioned 54 (58%) As above (needs training) 5 (5%) As above (need facilities adjustment) 12 (13%) Not able or willing to provide
On demand availability of specialist drugs service	5 (5%) Currently providing 21 (23%) Willing and able to provide if commissioned 44 (47%) As above (needs training) 5 (5%) As above (need facilities adjustment) 18 (19%) Not able or willing to provide
Oral Contraceptive Service	18 (19%) Currently providing 19 (20%) Willing and able to provide if commissioned 44 (47%) As above (needs training) 4 (4%) As above (need facilities adjustment) 8 (9%) Not able or willing to provide
Out of Hours Service	6 (7%) Currently providing 21 (23%) Willing and able to provide if commissioned 20 (22%) As above (needs training) 2 (2%) As above (need facilities adjustment)

Phlebotomy Service	4 (4%) Currently providing 8 (8%) Willing and able to provide if commissioned 40 (43%) As above (needs training) 16 (17%) As above (need facilities adjustment) 25 (27%) Not able or willing to provide
Prescriber Support Service	0 (0%) Currently providing 16 (17%) Willing and able to provide if commissioned 48 (52%) As above (needs training) 6 (7%) As above (need facilities adjustment) 23 (25%) Not able or willing to provide
Refer to Pharmacy *allows hospital pharmacy to refer patients to their community pharmacy for a discharge medicines use review/new medicines service	9 (10%) Currently providing 29 (31%) Willing and able to provide if commissioned 40 (43%) As above (needs training) 4 (4%) As above (need facilities adjustment) 11 (12%) Not able or willing to provide
Schools Service	2 (2%) Currently providing 19 (20%) Willing and able to provide if commissioned 46 (50%) As above (needs training) 4 (4%) As above (need facilities adjustment) 22 (24%) Not able or willing to provide
Sharps Disposal Service	22 (24%) Currently providing 20 (22%) Willing and able to provide if commissioned 27 (29%) As above (needs training) 9 (10%) As above (need facilities adjustment) 15 (16%) Not able or willing to provide
Stop Smoking Service (full service)	46 (50%) Currently providing 11 (12%) Willing and able to provide if commissioned 24 (26%) As above (needs training) 5 (5%) As above (need facilities adjustment) 7 (8%) Not able or willing to provide
Stop Smoking Service (voucher service)	58 (62%) Currently providing 12 (13%) Willing and able to provide if commissioned 14 (15%) As above (needs training) 4 (4%) As above (need facilities adjustment) 5 (5%) Not able or willing to provide
Supervised Administration Service	75 (81%) Currently providing 4 (4%) Willing and able to provide if commissioned 7 (8%) As above (needs training) 2 (2%) As above (need facilities adjustment) 5 (5%) Not able or willing to provide

Vascular Risk Assessment Service (NHS Health Check)	6 (7%) Currently providing 17 (18%) Willing and able to provide if commissioned 53 (57%) As above (needs training) 6 (7%) As above (need facilities adjustment) 11 (12%) Not able or willing to provide

Locally commissioned services – Disease Specific Management Service

Question	Response
Allergies	1 (1%) Currently providing 21 (23%) Willing and able to provide if commissioned 55 (59%) As above (needs training) 6 (7%) As above (need facilities adjustment) 10 (11%) Not able or willing to provide
Alzheimer's/Dementia	0 (0%) Currently providing 20 (22%) Willing and able to provide if commissioned 52 (56%) As above (needs training) 6 (7%) As above (need facilities adjustment) 15 (16%) Not able or willing to provide
Asthma	1 (1%) Currently providing 22 (24%) Willing and able to provide if commissioned 56 (60%) As above (needs training) 5 (5%) As above (need facilities adjustment) 9 (10%) Not able or willing to provide
CHD	1 (1%) Currently providing 21 (23%) Willing and able to provide if commissioned 50 (54%) As above (needs training) 6 (7%) As above (need facilities adjustment) 15 (16%) Not able or willing to provide
COPD	1 (1%) Currently providing 21 (23%) Willing and able to provide if commissioned 51 (55%) As above (needs training) 7 (8%) As above (need facilities adjustment) 13 (14%) Not able or willing to provide
Depression	1 (1%) Currently providing 20 (22%) Willing and able to provide if commissioned 52 (56%) As above (needs training) 5 (5%) As above (need facilities adjustment) 15 (16%) Not able or willing to provide

Diabetes type I	3 (3%) Currently providing 21(23%) Willing and able to provide if commissioned 52(56%) As above (needs training) 4 (4%) As above (need facilities adjustment) 13(14%) Not able or willing to provide
Diabetes type II	4 (4%) Currently providing 21 (23%) Willing and able to provide if commissioned 54 (56%) As above (needs training) 4 (4%) As above (need facilities adjustment) 10 (11%) Not able or willing to provide
Epilepsy	0 (0%) Currently providing 20 (22%) Willing and able to provide if commissioned 51 (55%) As above (needs training) 5 (5%) As above (need facilities adjustment) 17 (18%) Not able or willing to provide
Heart Failure	1 (1%) Currently providing 20 (22%) Willing and able to provide if commissioned 51 (55%) As above (needs training) 5 (5%) As above (need facilities adjustment) 16 (17%) Not able or willing to provide
Hypertension	2 (2%) Currently providing 22 (24%) Willing and able to provide if commissioned 53 (57%) As above (needs training) 4 (4%) As above (need facilities adjustment) 12 (13%) Not able or willing to provide
Parkinson's Disease	0 (0%) Currently providing 21 (23%) Willing and able to provide if commissioned 50 (54%) As above (needs training) 5 (5%) As above (need facilities adjustment) 17 (28%) Not able or willing to provide

Locally commissioned services – Screening Services

Alcohol	0 (0%) Currently providing 17 (18%) Willing and able to provide if commissioned 54 (58%) As above (needs training) 7 (8%) As above (need facilities adjustment) 15 (16%) Not able or willing to provide
Cholesterol	2 (2%) Currently providing 19 (20%) Willing and able to provide if commissioned 55 (59%) As above (needs training) 8 (9%) As above (need facilities adjustment) 9 (10%) Not able or willing to provide

Diabetes	11 (12%) Currently providing 18 (19%) Willing and able to provide if commissioned 54 (58%) As above (needs training) 6 (7%) As above (need facilities adjustment) 4 (4%) Not able or willing to provide
Gonorrhoea	0 (0%) Currently providing 17 (18%) Willing and able to provide if commissioned 48 (52%) As above (needs training) 8 (9%) As above (need facilities adjustment) 20 (22%) Not able or willing to provide
H. pylori	0 (0%) Currently providing 16 (17%) Willing and able to provide if commissioned 53 (57%) As above (needs training) 8 (9%) As above (need facilities adjustment) 16 (17%) Not able or willing to provide
HbA1C	0 (0%) Currently providing 18 (19%) Willing and able to provide if commissioned 52 (56%) As above (needs training) 8 (9%) As above (need facilities adjustment) 15 (16%) Not able or willing to provide
Hepatitis	0 (0%) Currently providing 16 (17%) Willing and able to provide if commissioned 45 (48%) As above (needs training) 8 (9%) As above (need facilities adjustment) 24 (26%) Not able or willing to provide
HIV	1 (1%) Currently providing 15 (16%) Willing and able to provide if commissioned 45 (48%) As above (needs training) 7 (8%) As above (need facilities adjustment) 25 (26%) Not able or willing to provide

Locally commissioned services – Other vaccinations

Childhood vaccinations	6 (7%) Currently providing 12 (13%) Willing and able to provide if commissioned 50 (54%) As above (needs training) 7 (8%) As above (need facilities adjustment) 18 (19%) Not able or willing to provide
Hepatitis (at risk workers or patients)	5 (5%) Currently providing 17 (18%) Willing and able to provide if commissioned 47 (51%) As above (needs training) 6 (7%) As above (need facilities adjustment) 18 (19%) Not able or willing to provide

HPV	6 (7%) Currently providing 14 (15%) Willing and able to provide if commissioned 49 (53%) As above (needs training) 6 (7%) As above (need facilities adjustment) 18 (19%) Not able or willing to provide
Travel vaccines	7 (8%) Currently providing 20 (22%) Willing and able to provide if commissioned 47 (51%) As above (needs training) 7 (8%) As above (need facilities adjustment) 12 (13%) Not able or willing to provide

Non NHS funded services – Does the Pharmacy provide any of the following?

Collection of prescriptions from surgeries	Out of 93 returned questionnaires 93 (100%) Yes
Delivery of dispensed medicines – free of charge on request	83 (89%) Yes 10 (11%) No
Delivery of dispensed medicines - chargeable	6 (7%) Yes 87 (93%) No

Does the pharmacy provide any of the following weight management interventions?

Weight management suitable for adults (18+) Brief advice and provision of suitable health promotion materials	Out of 93 returned questionnaires: 35 (38%) Currently providing 58 (62%) Willing to if training provided
Weight management for children (17 and under) with parents, Brief advice and provision of suitable health promotion material.	18 (19%) Currently providing 75 (81%) Willing to if training provided
Offer to determine BMI in children and/or BMI and waist measurement in adults	20 (22%) Currently providing 73 (79%) Willing to if training provided
Follow up consultations for support and motivation and to record progress outcomes	7 (8%) Currently providing 86 (92%) Willing to if training provided

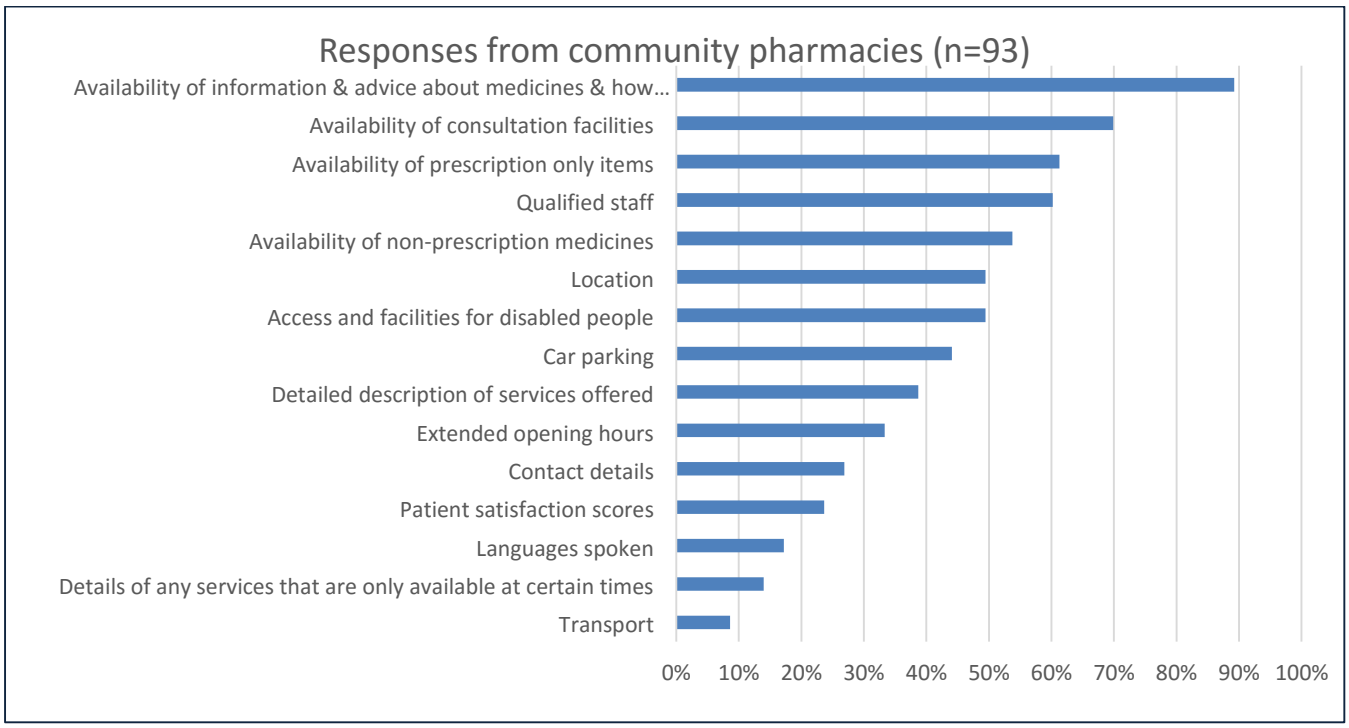
Referral to GP for weight management support	21 (23%) Currently providing 72 (77%) Willing to if training provided

Does the Pharmacy provide any of the following?

Brief advice on lifestyles eg stop smoking, weight management etc	Out of the 93 returned questionnaires: 92 (99%) Yes
Signposting to lifestyle services eg Stop Smoking, weight management, exercise etc	91 (98%) Yes
Referral to lifestyle services eg Stop smoking, weight management, exercise etc	75 (81%) Yes
Would the pharmacy like more information about local lifestyle services?	87 (94%) Yes
Does the Pharmacy participate in the contractual annual six Public Health Campaigns?	87 (94%) Yes
Does the Pharmacy do any extra promotional work?	55 (59%) Yes 38 (41%) No
Are there any other non NHS commissioned services that the pharmacy provides.	Examples include – blood pressure monitoring; local GP surgery warfarin clinic held on premises; asthma/copd inhaler user advice; male sexual health clinic; wellness checks at a cost, phlebotomy; travel health; opticians; Dosette trays; Repeat Prescription services;
Does your pharmacy supply medicines etc to care homes?	28 (30%) Yes 65 (%) No 10 (10.3%) Blank

Is the current provision of Dispensing Doctors and Community Pharmacies: Excellent, Good, Adequate, Poor	Out of 97 returned questionnaires: Excellent 36 (39%) Good 51 (55%) Adequate 6 (7%) Poor 0 (0%)
Do you feel there is a need for more pharmaceutical providers in your locality?	5 (6%) Yes 88 (95%) No

Which features from your Dispensing Doctors and Community Pharmacies would you identify as being important?



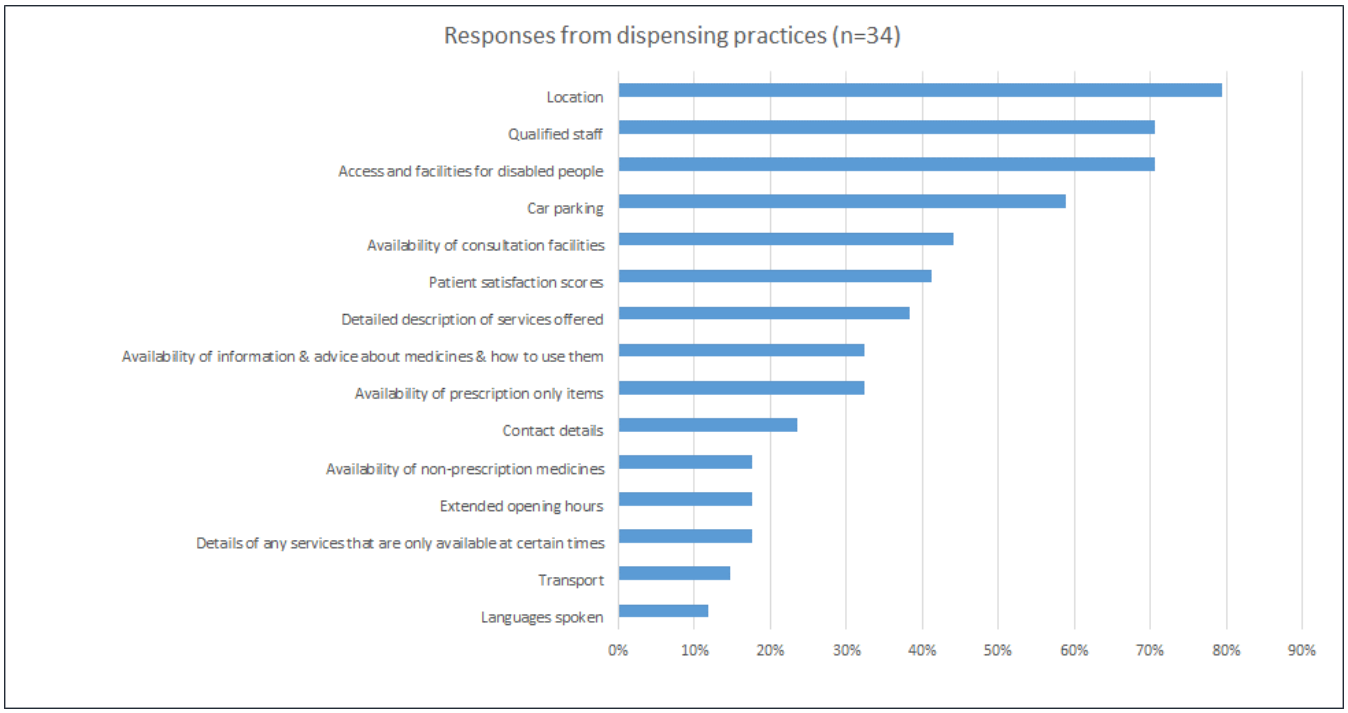
Results of the Dispensing Practice Questionnaire

A questionnaire was sent to all 43 Dispensing Practices in Cambridgeshire. There were 34 returned questionnaires giving a response rate of 79%.

	Question	Response
Consultation Facilities	Are consultation facilities on site and do they include wheelchair access? Where there is a consultation area, is it a closed room?	Out of 34 returned questionnaires: 30 (88%) Have wheelchair access 4 (12%) Have no consultation area 28 (83%) Have a closed room on site for consultation 6 (18%) No
IT Facilities	Electronic Prescription Service	Out of 34 returned questionnaires: 15 (44%) are Release 2 enabled 6 (18%) Intend to become Release 2 enabled 13 (38%) No plans for EPS at present
Services	Essential Does the pharmacy dispense appliances?	Out of 34 returned questionnaires: 15 (44%) Yes, all types 1 (3%) Yes, excluding stoma appliances 3 (9%) Yes, excluding incontinence appliances 2 (6%) Yes, excluding stoma and incontinence 7 (21%) Yes, just dressings 6 (18%) None
	Appliance Use Review	Out of 34 returned questionnaires: 3 (9%) Yes 1 (3%) Intend to begin within 12 months 30 (88%) Not intending to provide
	Stoma Appliance Customisation	Out of 34 returned questionnaires: 2 (6%) Yes 1 (3%) Intend to begin within 12 months 31 (91%) Not intending to provide
	Collection of prescriptions from surgeries	Out of 34 returned questionnaires: 10 (29%) Yes 24 (71%) No
	Delivery of dispensed medicines free of charge on request	Out of 34 returned questionnaires: 17 (50%) Yes 17 (50%) No
	Delivery of dispensed medicines - chargeable	Out of 34 returned questionnaires: 4 (12%) Yes 30 (88%) No
	Delivery of dispensed medicines selected patient groups	Out of 34 returned questionnaires: 4 responses indicating delivery of meds under disability discrimination act as needed; service to housebound, elderly, disabled or those isolated and unable to find he
	Supply of medicines to care homes	Out of 34 returned questionnaires: 12 (35%) Yes 22 (65%) No

	Current provision of pharmaceutical providers	Out of 34 returned questionnaires: Excellent 19 responders (56%) Good 14 responders (41%) Adequate 1 responders (3%) Poor 0 responders (0%)
	Are there any other services provided from your dispensary that you would like to be considered in the PNA?	Examples of responses: 1. DRUMS – Dispensary Review of Use of Medicines. 2. As a dispensing practice we fully integrate GP, nurse and dispensing services. 3. Remote delivery of prescriptions for the over 60s; internet and email access for ordering prescriptions. 4. Preparing Dosset boxes. 5. Reminders for overdue reviews and ability to book in patient at the time. 6. Staff trained to flag patients with memory problems. 7. Just in Case Bags. 8. GP led medication reviews; measuring and fitting of hosiery; flu vaccinations; minor illness consultations; prophylactic medication; travel advice and vaccinations; missed HPV vaccinations, smoking cessation; dermatology checks; erectile dysfunction medications; emergency and LARC contraception.
	Do you feel there is a need for more pharmaceutical service providers in your locality?	Out of 34 returned questionnaires: 2 (6%) Yes 32 (94%) No

Top Five Features identified as being important by Dispensing Practices



Appendix 4: Details of PNA process & document control

Date	***Action***	***Person***
16 June 2016	Planning meeting with chapter authors	KW, JE, SH, IG
14 July 2016	Steering group meeting – initial comments on PNA 2014 and recommendations for amendments for 2017 draft noted	Steering Group
August	Pharmacy questionnaire updated and sent out	JE, SH, RB, JW
July – Oct 2016	Updating all public health data sources including demography, health needs and maps	JE
Sept - Oct 2016	Health improvement team review and updating of local health needs section (Chapter 4)	VT & HI team
Oct – Nov 2016	Chapters 1,2, 3 & 4 edited and summarised to reduce word count	KW
Oct – Nov 2016	Planning chapter (Chapter 5) revised and reviewed, all data updated and additional information added re new sites	IG
Nov 2016	Pharmacy questionnaire data analysed and new data added to draft	JE, KW
Nov 2016	Addition of briefing on new Pharmacy Contract (in conjunction with LPC & CCG)	KW, RB, JW, JE
Dec – Jan 2017	Feedback from HWB Support Group including District Council representatives, Social Care, LMC,	KW collated
4 Jan 2017	Amendments to report according to feedback. Murray report reviewed and relevant recommendations added to the PNA. New regulations and amendments added to PNA report.	KW
5 Jan 2017	Draft 2017 PNA report approved by Steering group	Steering Group
19 Jan 2017	Draft 2017 report for public consultation presented to Cambridgeshire Health and Wellbeing Board	KW, RB, JW, SG
30 Jan 2017	Draft 2017 report published for 60 day public consultation (30 January 2017 to 30 April 2017)	
30 Jan 2017 – 30 April 2017	60 day public consultation	
May 2017	Consultation responses analysed and summary report produced. Response to consultation drafted and amendments to PNA made.	KJ, JE
25 May 2017	Steering group meeting – discussion and approval of consultation report, response to consultation and amendments to PNA.	Steering Group
May – June 2017	Review by Cambridgeshire County Council legal team.	CCC Legal Team
6 July 2017	Presentation of 2017 PNA to Cambridgeshire Health and Wellbeing Board for discussion and approval, followed by publication on Cambridgeshire Insight webpages.	

Appendix 5: Impact of the Pharmacy Contract Funding Changes (October 2016)

This section outlines the recent consultation and changes to the national Pharmacy contract. Of note, a national public consultation was held to seek views on the proposals in 2015/16 and the decisions have been taken at a national level by Department of Health (DoH). This section describes the national changes in order to assess the potential impact on Cambridgeshire pharmaceutical providers and the local population.

A5.1 Summary of the changes to the Pharmacy Contract

In December 2015, the Department of Health (DoH) launched a consultation with the Pharmaceutical Services Negotiation Committee (PSNC), pharmacy stakeholders and others on community pharmacy in 2016/17 and beyond.[81] The stated vision from the DoH was:

'for community pharmacy to be integrated with the wider health and social care system. This will aim to relieve pressure on GPs and Accident and Emergency Departments, ensure optimal use of medicines, and will mean better value and patient outcomes. It will support the promotion of healthy lifestyles and ill health prevention, as well as contributing to delivering seven day health and care services'.[82]

In the context of delivering £22 billion in efficiency savings by 2020/21, the review and consultation aimed to examine how community pharmacy could contribute to this financial challenge. The proposals state that:

'*efficiencies could be made without compromising the quality of services or public access to them because:*

- *There are more pharmacies than necessary to maintain good patient access;*
- *Most NHS funded pharmacies qualify for a complex range of fees, regardless of the quality of service and levels of efficiency of that provider;*
- *More efficient dispensing arrangements remain largely unavailable to pharmacy providers*.'[83]

Key proposals included[84]:

- Simplifying the NHS pharmacy remuneration system e.g. phasing out of the establishment payment received by all pharmacies dispensing 2,500 or more prescriptions per month, which incentives pharmacy business to open more NHS funded pharmacies;
- Helping pharmacies to become more efficient and innovative e.g. through more modern dispensing methods; including hub and spoke models to deliver more economies of scale in purchasing and dispensing and reducing operating costs;
- Encouraging longer prescription durations where clinically appropriate e.g. 90 day repeat periods instead of 28 days.

[81] Department of Health stakeholder briefing. 'Community pharmacy in 2016/2017 and beyond: proposals. (Dec 2015) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495774/Community_pharmacy_in_2016-17_and_beyond_A.pdf
[82] Ibid.
[83] Ibid.
[84] Ibid.

The results of the consultation and a final package of changes to the contractual framework were announced in October 2016. On 20th October 2016 the Government imposed a two-year funding package on community pharmacy, with a £113 million reduction in funding in 2016/17.[85] This will take total funding to £2.687 billion for 2016/17. This is a reduction of 4% compared with 2015/16, but it will mean that contractors will see their funding for December 2016 to March 2017 fall by an average of 12% compared with November 2016 levels. This will be followed by a further 3.4% reduction in 2017/18 to £2.592 billion for the financial year, which will see funding levels from April 2017 drop by around 7.5% compared with November 2016 levels.[86]

Full details of the final Community Pharmacy proposals can be found in the DoH report "Community pharmacy in 2016/2017 and beyond: final package" available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf

In addition to the overall reduction of funding, key changes to the regulations are outlined below:

A5.1.1 Changes to payment of fees

- A range of fees including the professional or 'dispensing' fee, practice payment, repeat dispensing payment and monthly electronic prescription payment service payment will be consolidated into a single activity fee.
- Community pharmacists currently receive an establishment payment as long as they dispense above a certain prescription volume – this will be gradually phased out over a number of years, starting with a 20% reduction in December 2016 and reduced by 40% on 1 April 2017.

A5.1.2 The Pharmacy Access Scheme (PhAS)

- A new Pharmacy Access Scheme will be introduced with the aim of creating efficiencies without compromising the quality of services or public access to them. The Pharmacy Access Scheme (PhAS) is designed to ensure populations have access to a pharmacy, especially where pharmacies are sparsely spread and patients depend on them most. A national formula will be used to identify those pharmacies that are geographically[87] important for patient access, taking into account isolation criteria based on travel times or distances, and also population sizes and needs.
- Qualifying pharmacies will receive an additional payment, meaning those pharmacies will be protected from the full effect of the reduction in funding from December 2016. A payment is made to pharmacies that are more than a mile away from another pharmacy (until March 2018).

[85] Department of Health. 'Community pharmacy in 2016/2017 and beyond: final package'. (Oct 2016) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf

[86] http://psnc.org.uk/funding-and-statistics/cpcf-funding-changes-201617-and-201718/

[87] Department of Health stakeholder briefing. 'Community pharmacy in 2016/2017 and beyond: proposals. (Dec 2015) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495774/Community_pharmacy_in_2016-17_and_beyond_A.pdf

A5.1.3 A new quality payments scheme

- Quality criteria have been introduced which, if achieved, will help to integrate community pharmacy into the wider NHS/Public Health agenda. The criteria includes[88]:
  - the need to have an NHS email account and ability for staff to send and receive NHS mail;
  - an up-to-date entry on NHS Choices; ongoing utilisation of the Electronic Prescription service; and
  - at least one specified advanced service e.g., Healthy Living pharmacy level 1 status, 80% of staff trained as Dementia Friends etc.

A5.1.4 Urgent medicines supply pilot

- NHS England have commissioned a new urgent medicines supply pilot as an advanced service, where people calling NHS 111 requiring urgent repeat medicines will be referred directly to community pharmacies. This pilot commenced on 23 December in Cambridgeshire with six local community pharmacies participating.

A5.1.5 Changes to regulations to allow pharmacy mergers

- '*On 5 December 2016, amendments to the 2013 Regulations come into force which facilitate pharmacy business consolidations from two or more sites on to a single existing site. Importantly, a new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes. This would protect two pharmacies that choose to consolidate on a single existing site – where this does not create a gap in provision*.'
- "*Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means in general terms they will not be assessed against … the pharmaceutical needs assessment ("PNA") produced by the HWB. Instead, they will follow a simpler procedure, the key to which is whether or not a gap in pharmaceutical service provision would be created by the consolidation….. If the NHSCB is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application. The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought (regulations 12 and 13). If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement published alongside its pharmaceutical needs assessment recording its view (regulation 3).*"[89]
- As such, in the event of a consolidation in future, in accordance with Paragraph 19 of Schedule 2 of the regulations the Cambridgeshire HWB will publish a supplementary statement which will become part of the PNA, explaining whether, in its view, the proposed removal of premises from its pharmaceutical list would or would not create a gap in pharmaceutical services provision that could be met by a routine application:
  (a) to meet a current or future need for pharmaceutical services; or
  (b) to secure improvements, or better access, to pharmaceutical services.

[88] http://psnc.org.uk/services-commissioning/essential-services/quality-payments/

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

A5.1.6 Pharmacy Integration Fund'

- In the Government's letter from 17th December 2015 entitled 'Community pharmacy in 2016/17 and beyond', the Department of Health (DoH) announced that it would consult on a 'Pharmacy Integration Fund' (PhIF) to help transform how pharmacists and community pharmacy will operate in the NHS.
- The Fund is the responsibility of NHS England and is separate to any negotiations related to the Community Pharmacy Contractual Framework (CPCF). It will be used to validate and inform any future reform of the CPCF going forward.[90]

A5.2 DoH National Health Impact assessment

The Department of Health has produced an impact assessment for the proposed changes, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561496/Community_pharmacy_impact_assessment_A.pdf.

This impact assessment focuses only on the impact on essential and advanced services. The Pharmaceuticals Services Negotiating Committee (PSNC) have produced an impact assessment on 'The Value of Community Pharmacies' from external consultants, which also looks at locally commissioned and non-essential services (see section A5.3).

Key findings of the DoH impact assessment are summarised below:

A5.2.1 Potential pharmacy closures

There is no reliable way of estimating the number of pharmacies that may close as a result of the policy and this may depend on a variety of complex factors, individual to each community pharmacy and their model of business. The DoH states that:

> *'it is not the Government's intention to reduce the number of community pharmacies…however, we cannot know for certain how the market will react and we recognise the potential for some pharmacies to take the decision to close as a result of the changes.'* [91]
>
> *'Reducing income would mean that community pharmacies must reduce their costs, change their business model of accept reduced profits, and in some circumstances this could mean pharmacies become economically unviable". It is also unclear whether if the viability of an individual business is threatened, whether these business will close or simply be taken over by other owners on the basis that they can be run more efficiently and remain viable business propositions…. there is also an important interdependency that, if a pharmacy closes, it is likely that the prescriptions that were dispensed by that pharmacy would be redistributed to pharmacies located nearby.*[92]

[90] http://psnc.org.uk/the-healthcare-landscape/the-pharmacy-integration-fund-phif/
[91] Department of Health. 'Community pharmacy in 2016/2017 and beyond: impact assessment' (Oct 2016). Paragraph 41, page 12. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561496/Community_pharmacy_impact_assessment_A.pdf.
[92] Ibid. Paragraph 51, page 14.

The quality payment scheme is expected to maintain or increase the quality of services provided by community pharmacies, although this potential benefit has not been explicitly estimated'.[93]

A5.2.2. Potential impact on patients

There may be potential increased travel time and consequent economic costs for patients who have to travel further if their nearest pharmacy closes.

In terms of impact on patients, the DoH impact assessment found that a potential reduction in community pharmacy numbers would be likely to '*mean that some patients have further to travel to access community pharmacy services, however the analysis shows that for hypothetical closure scenarios the increase is very small*'.[94] The modelling estimates provided suggest that with the provision of the PhAS, across England the average journey time after the removal of 100 community pharmacies at random was estimated at 12.86 minutes, an increase of 0.04 minutes per journey[95].

It is stated that

'even if there were closures as a result of the funding reductions, it is not considered that this would lead to any significant impacts on patient health. It is considered highly unlikely that any patient will be unable to receive their medicines and the potential increase in journey times estimated in the DoH model are relatively minor, and patients will have a number of means of ensuring they receive the medicines they need eg distance selling pharmacies'.[96]

Respondents to the consultation stated that, to mitigate the funding reductions, community pharmacies could choose to open only for their 'core' hours, or to withdraw non-NHS services, such as home delivery. In terms of quality of services, the impact assessment states that pharmacies will still need to compete to secure prescription volume and the competitive incentive to provide these services remains.[97]

Evidence shows that deprived areas (by the Index of Deprivation) tend to have more clustering of pharmacies, and it was considered whether deprived areas might therefore be adversely affected by the policy. The Pharmacy Access Scheme is intended to protect areas that may be at risk of reduced access, and takes into account isolation and need.

A5.2.3 Impact on other areas of the NHS

The public consultation revealed a concern that a reduction in the number of community pharmacies could lead some patients to seek health advice from GPs, other primary care providers, or acute services, thereby imposing additional costs on the NHS. However, the DoH states that:

'*even if there were closures, the magnitudes of impact on travel time are not considered sufficient to materially deter any significant number of patients from seeking this guidance from a community pharmacy. Those patients who would previously have found it most convenient to get such information from a community pharmacy are considered unlikely to change their decision and seek a different route*

[93] Ibid. Paragraph 43, page 13.
[94] Ibid. Paragraph 60, page 15.
[95] Ibid. Paragraph 69, page 16.
[96] Ibid. Paragraphs 81-82, page 18.
[97] Ibid. Paragraph 84, page 19.

of access to medical care, even if in some cases there are small increases in travel time.'

'*In addition, the overall package of measures contains steps to decrease pressure on other parts of the NHS, by embedding pharmacy into the urgent care pathway through an expansion of the services already provided by community pharmacies in England for those who need urgent repeat prescriptions and treatment for urgent minor ailments and common conditions.'* [98]

A5.2.4 Potential impact on local communities

Beyond their direct benefits in providing NHS pharmacy services to patients, community pharmacies may play a less tangible role in promoting welfare and social cohesion in local communities, and in supporting local commercial areas. The DoH impact assessment suggests that '*there would ordinarily be at least one remaining pharmacy in the vicinity" reducing the likelihood that closures would have a significant impact on local communities*'.[99]

A5.3 Views of the Pharmaceuticals Services Negotiating Committee

A5.3.1 Objections to the pharmacy contract changes

The Pharmaceuticals Services Negotiating Committee (PSNC) is the body recognised under section 65(1)(a) of the NHS Act 2006 as representing all community pharmacies providing NHS pharmaceutical services in England. The PSNC has published objections to the proposals, which can be viewed in full at: http://psnc.org.uk/our-news/psnc-demands-clarity-on-nhs-englands-long-term-plans/

In brief, the '*PSNC believes the proposals as set out create massive risks to the sustainability of an already fragile supply system*.'[100] The specific concerns outlined include:

- 'Concerns that the £170m funding reduction in 2016/17 runs counter to the Government's stated aim to develop a more clinically focused pharmacy service'.
- Refusal to accept that there are too many community pharmacies. Agreement that there is some clustering of pharmacies and they aim to work with the NHS and Government to facilitate voluntary mergers.
- Refusal to accept that the development of large warehouse supply operations, removing the need for local community pharmacies, is an acceptable alternative to the services currently provided by those pharmacies and would oppose models for hubs without those community pharmacy spokes. Any revised regulations must prevent misuse of collection point arrangements intended for rural locations as an inferior but expedient alternative.
- Rejection of proposals to transfer funds to CCGs to drive longer periods of treatment, and will insist on effective protection against GP direction of prescriptions.

[98] Ibid. Paragraph 86-88, page 19.
[99] Ibid. Paragraph 89-90, page 19.
[100] http://psnc.org.uk/psncs-work/communications-and-lobbying/community-pharmacy-in-201617-and-beyond/

A5.3.2 Report commissioned by the PSNC: "The Value of Community Pharmacies" (2016)

PricewaterhouseCoopers LLP (PwC) was commissioned by the PSNC to examine the contribution of community pharmacy in England in 2015.[101] The report analyses the value (net benefits) to the NHS, to patients and to wider society of 12 specific services provided by community pharmacy:

- Emergency hormonal contraception
- Needle and syringe programmes
- Supervised consumption
- Self-care support
- Minor ailments advice
- Medicines support
- Managing prescribing errors/clarifying prescriptions
- Medicines adjustments
- Delivering prescriptions
- Managing drug shortages
- Sustaining supply of medicines in emergencies
- Medicines Use Reviews (MUR)
- New Medicine Service (NMS)

The report found that in 2015 these 12 community pharmacy services in England contributed a net increase of £3.0 billion in value in that year, with a further £1.9 billion expected to accrue over the next 20 years. Further, 55% of in-year benefits and 91% of long run benefits (69% of total benefits) accrued outside the NHS. Other public sector bodies (e.g. local authorities) and wider society together received over £1 billion of benefits in 2015 as a result of the community pharmacy services covered. A further £1.7 billion is expected to accrue over the next 20 years.

In addition, the economic modelling suggested that patients experienced around £600 million of benefits, mainly in the form of reduced travel time to alternative NHS settings to seek a similar type of service as the ones provided by community pharmacy. The report notes that for many of these interventions the scale of value created is substantial and greatly exceeds the cost to the NHS of delivering them.

The findings in the report and associated potential impact are limited to just the 12 services reviewed. It excludes the economic value generated by community pharmacy through its central role, alongside pharmaceutical manufacturers and wholesalers/distributors, in the drug delivery system: specifically, it omits the value added that results from treating NHS patients using prescription drugs. It also does not look at other services beyond these core 12, and also does not take into account '*other elements of potential value, for example as a result of the important catalytic role that community pharmacies play in local communities, providing a valuable focal point for communities, especially as a point of contact for isolated people, and anchoring a parade of shops*.'[102]

[101] PWC. 'The value of community pharmacy: summary report' (Sept 2016). Available at: http://psnc.org.uk/our-news/pwc-report-quantifies-value-of-community-pharmacy/
[102] Ibid. page 7.

A5.4 Local impact of the new pharmacy contract

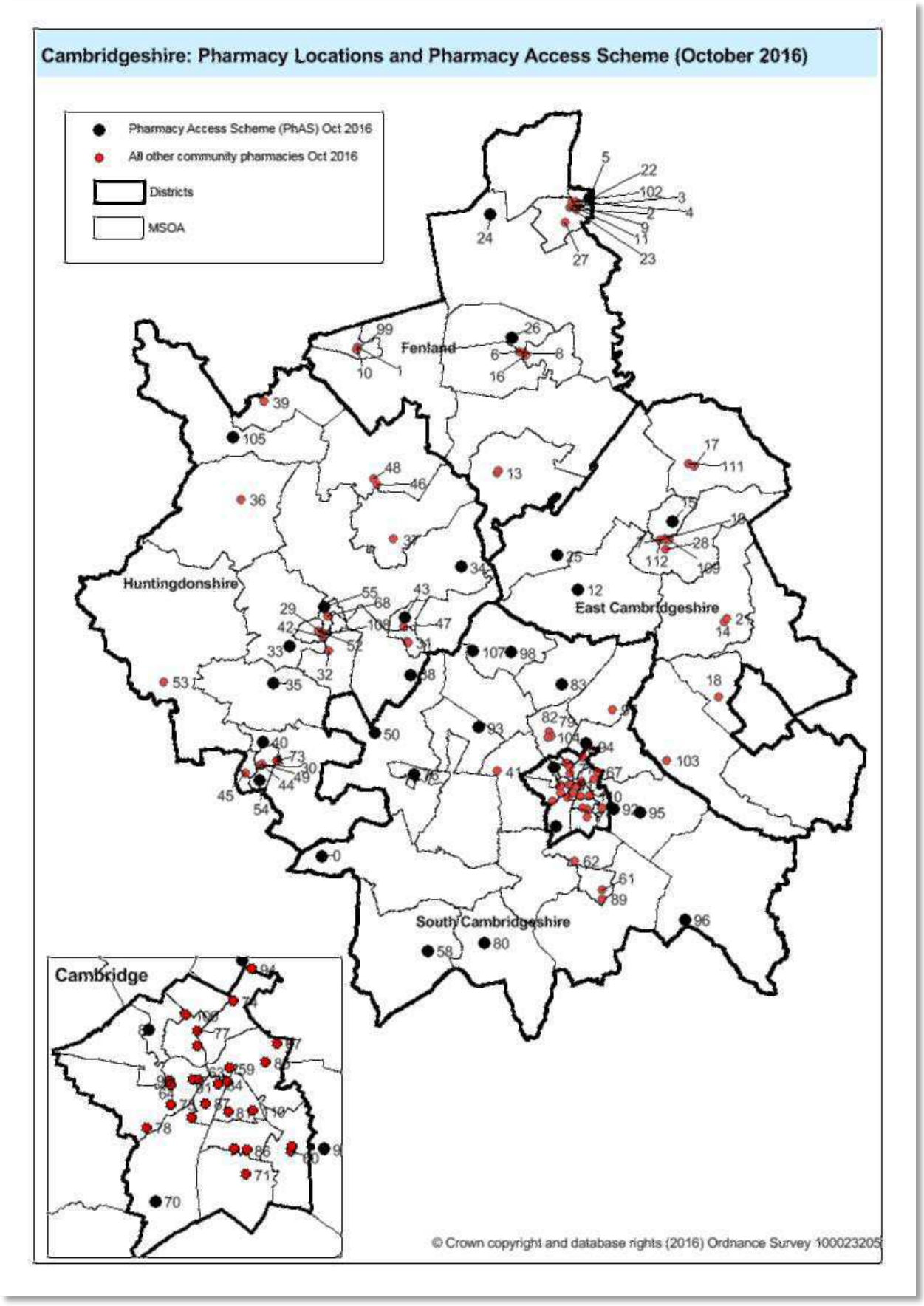
As stated in the DoH health impact assessment, it is complex to assess the impact of these changes on Cambridgeshire residents. There is no reliable way of estimating the number of pharmacies that may close as a result of the policy and this may depend on a variety of complex factors, individual to each community pharmacy and their model of business.

The Pharmacy Access Scheme aims to ensure populations have access to a pharmacy, especially where pharmacies are sparsely spread and patients depend on them most. Nationally 1,356 pharmacies have qualified for the scheme. In Cambridgeshire, 30 pharmacies have been identified which is 27% of all current pharmacies as at October 2016 (see **Map 15)**.

The Cambridgeshire Local Pharmaceutical Committee will focus on supporting local pharmacies by keeping them up to date with changes/details, to meet the quality agenda, and to take up and deliver locally commissioned services more effectively.

The PNA steering group will continue to monitor any closures of local pharmacies and issue appropriate statements of fact as necessary in line with PNA requirements.

Map 15: Pharmacy Locations and Pharmacy Access Scheme, October 2016



Appendix 6: Consultation report – results from the public consultation (30 January to 30 April 2017)

Introduction

Following the development of the draft PNA a formal public consultation was held, getting to know people's thoughts about the report and whether it covers what is important to their needs.

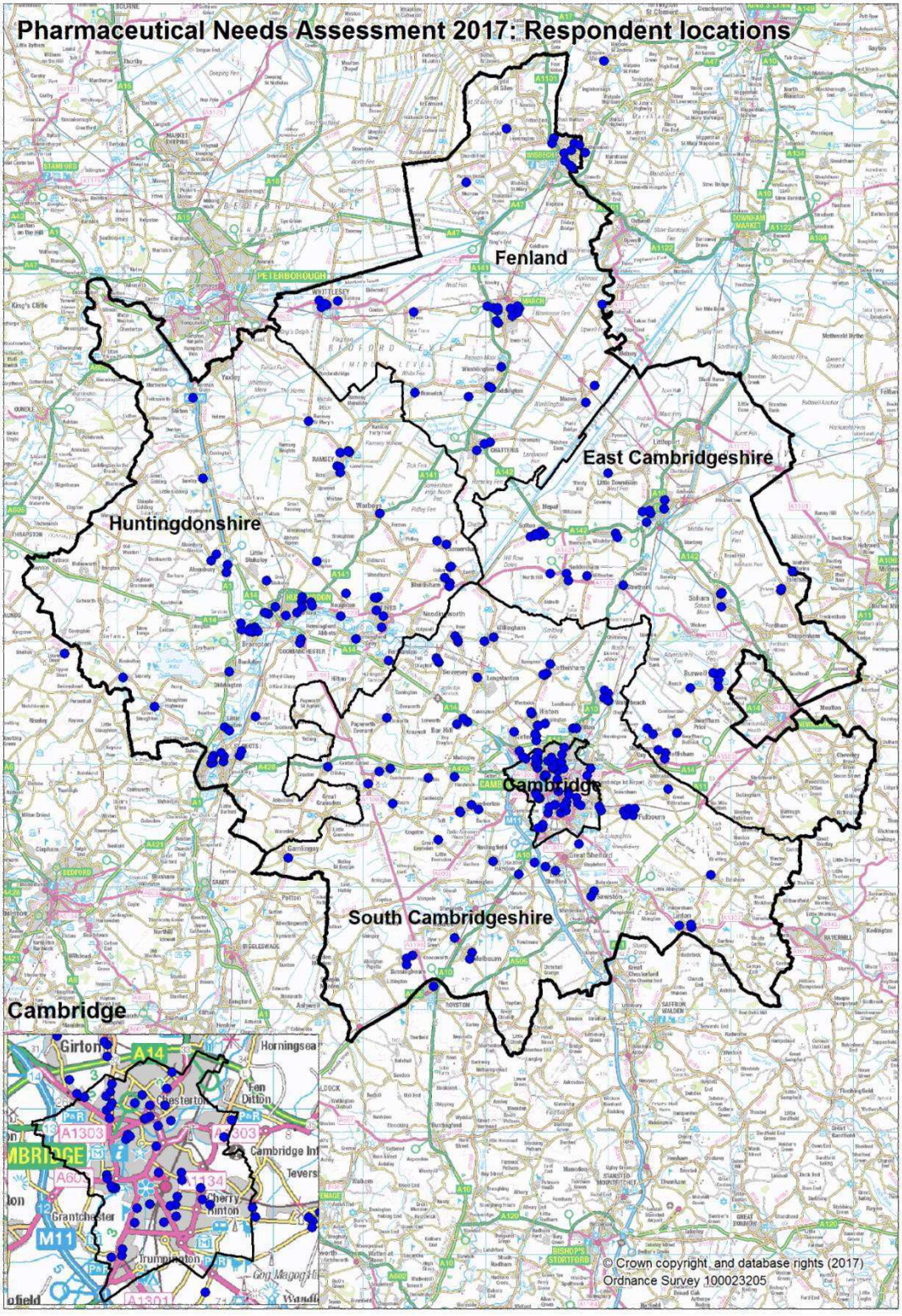
The consultation ran from the 30th January 2017 to the 30th April 2017, and received 354 responses. This report outlines the responses to the consultation. All percentages, unless otherwise specified, are rounded to the nearest whole number.

Section 1: Respondents

This section summarises the characteristics of the respondents to the consultation of the draft PNA.

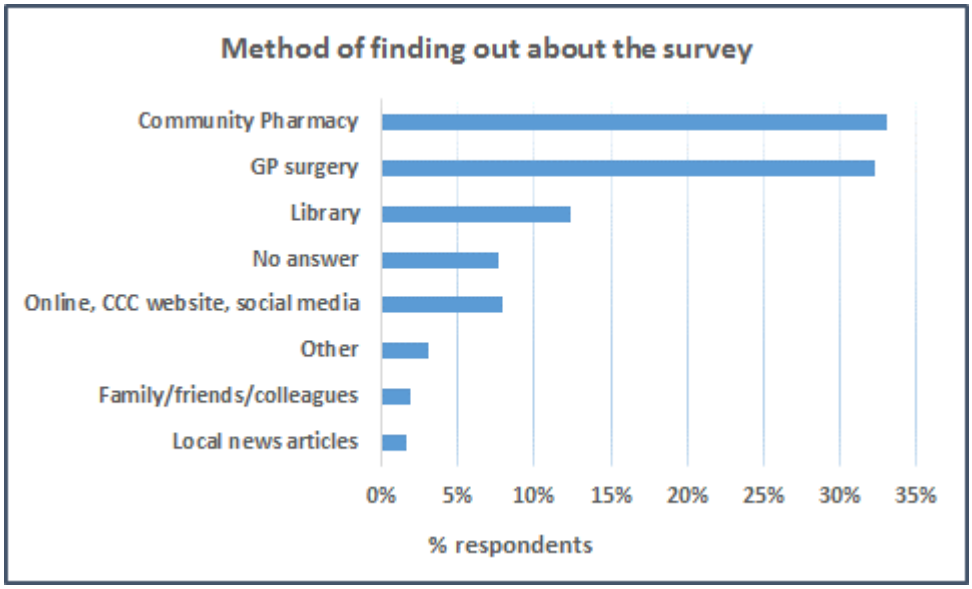
In total, 354 people responded to the consultation survey, of whom 27 responded online. 270 of these respondents left an accurate postcode – their locations have been mapped out in **Map 1.**

Map 1: Respondent locations



The ways in which respondents stated they found out about the survey is shown below in **Figure 1**. Most respondents indicated they had become aware of the survey via their GP or pharmacy (32% and 33% respectively).

Figure 1: Question: "*How did you find out about this survey?*" 354 respondents.



'Other' included via parish councils, local councillors and community magazines

The 354 responses to this consultation on the draft PNA is comparable to or higher than other surveys carried out using the same on-line methodology.

Most (92%) were responding as a member of the public (see Table 1). Some (5%) indicated they were a health or social care professional. A few respondents (2% in total) indicated they were a pharmacist/appliance contractor, or were responding on behalf of an organisation.

Table 1: Respondent Type. 354 respondents

Respondent type	Count of respondents	% of respondents
Member of the public	326	92%
A health or social care professional	16	5%
A Pharmacist or Appliance Contractor	4	1%
Respondent on behalf of an organisation	8	2%
Total responses received	354	100%

The majority of respondents were female (62%). When asked about ethnicity, 89% identified themselves as White British. The ethnic background of respondents compared to the Census 2011 is shown in **Table 2**. There are some differences when considered against the Census, with some groups being slightly under represented in the survey. Overall, although not perfect, the survey can be seen to be reasonably representative.

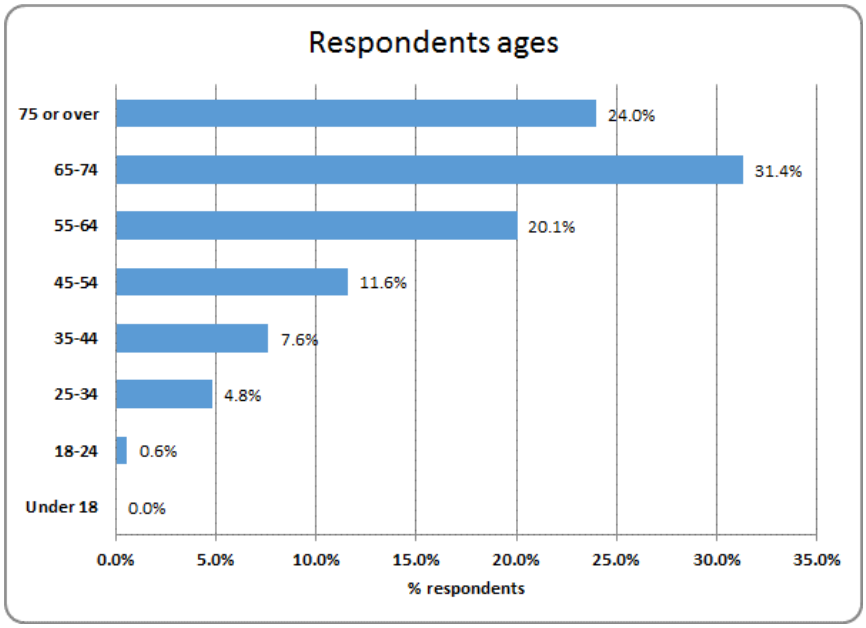
Table 2: Respondent Ethnicity. 354 respondents

Ethnicity	% respondents	**% Census 2011**
White British	88.9	84.5
White: Other	3.4	7.1
White: Irish	0.3	0.8
Eastern European	0.9	
Asian or Asian British: Indian	0.9	1.2
Prefer not to say	3.4	n/a
Mixed Race: White and Asian	0.6	0.6
Black or Blank British: Caribbean	0.3	1.1
Black or Black British: African	0.3	0.6
Total	100	96

Only ethnic backgrounds with at least one response are shown.

Figure 2 illustrates the percentage of responses by age group. The age group from 65 to 74 years had the highest percentage of respondents (31%). The groups most likely to use pharmacies regularly and to respond to surveys such as this are parents with young children (25 to 44 age groups) and older people living in the community (65 to 74 age group).

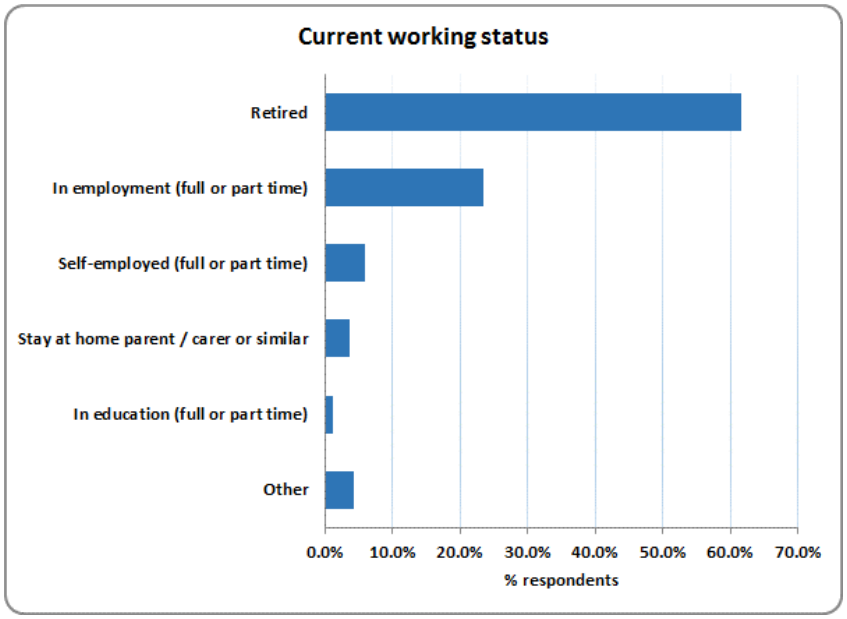
Figure 2: Respondent age group. 354 respondents.



Most respondents (81%) did not have a disability that impacted on the way they travelled.

Figure 3 summarises responses regarding current working status. The most common response (62%) was from people indicating they had fully retired from work.

Figure 3: Question "Which of these options best describes what you are doing at present?" 354 respondents.



Section 2: Service experience

This section summarises responses to the questions that were targeted only to those who indicated they were responding as members of the public. The aim of these questions was to gain information on how members of the public use the pharmaceutical services available, and their experiences with using these services. Most respondents (82%) indicated that they regularly use a Community Pharmacy. Almost four out of ten respondents (37%) indicated they made regular use of a dispensary at a GP pharmacy. When asked how often they used community pharmacies or dispensaries in Cambridgeshire, a high proportion stated they used them more than 12 times a year (51%). 40% indicated their use as being between three to 12 times a year, 7% less than three times, and 3% stated they never used pharmacies or dispensaries.

Respondents were also asked how often they used specific services provided by pharmacies / dispensaries and the responses to this question is summarised in **Table 4**. The services most commonly used included dispensing of prescriptions, buying non-prescription medicines, and getting a repeat prescription.

Table 4: Question: "*How often do you use each of the following services?" Responses by percentage*

Service	Never (%)	Less than three times a year (%)	3 to 12 times a year (%)	More than 12 times a year (%)
Dispensing of prescriptions (327)	23	14	34	28
Buying non-prescription medicines (327)	14	32	42	12
Getting a repeat prescription (331)	12	4	44	41
Disposing of old/unwanted medicines (327)	40	48	8	3
Seeking advice from your provider (Eg healthy lifestyle, medicines, advice etc) (327)	24	50	23	3
Using a dispensing Appliance Contractor (326)	94	3	2	1

Numbers at the end of each service indicate the number responding to each question

135 people made an additional comment of which 96 (72%) were positive about their local pharmacy or the services offered generally by pharmacists. The role of pharmacists in being able to offer advice was highly valued, as was the role played by pharmacies in the local community:

"Excellent both for prescription medicines and for advice"
"Essential for local community particularly the elderly and those with young children"

Other comments fell under the following broad headings:

- Repeat prescriptions (10 respondents)
- Disposal of medicines (5 respondents)
- Supplying non-prescription medicines at GP surgeries (3 respondents)
- Waiting times when collecting prescriptions (3 respondents)
- Access in rural areas (2 respondents)
- A mix of other comments (16 respondents)

Section 3: PNA Feedback

This section was targeted at all respondents. The questions specifically focused on the draft PNA document and asked people to ensure that the key messages and the draft PNA were reviewed and considered when responding. Responses were for the most part positive.

1: Do you feel that the purpose of the pharmaceutical needs assessment (PNA) has been explained sufficiently?

354 respondents answered this question. 323 respondents (91%) felt that the purpose of the PNA was explained sufficiently. Out of 31 respondents who did not

feel the purpose of the PNA was explained sufficiently, free text comments were provided by 19 respondents. The comments fell into the following categories:

- Insufficient detail in report (4 respondents)
- Respondents who felt unable to answer the question (4 respondents)
- Lack of clarity on specific topics (3 respondents)
- Omissions in the report (2 respondents)
- Concerns about the impact of population growth & increased demand (2 respondents)
- A mix of other comments (4 respondents)

2 *Do you agree with the key findings about pharmaceutical services in Cambridgeshire?*

354 respondents answered this question. 293 respondents (83%) agreed with the key findings about pharmaceutical services in Cambridgeshire as outlined in the PNA. Out of 61 respondents that did not agree, free text comments were provided by 34 respondents. These comments fell into the following broad categories:

- Concerns about the impact of population growth & increased demand (8 respondents)
- Respondents who felt unable to answer the question (6 respondents)
- Method of analysis (5 respondents)
- Access in rural areas (4 respondents)
- Importance of prevention of ill health & healthy lifestyles (3 respondents)
- Opening hours (3 respondents)
- A mix of other comments (5 respondents)

3 Do you feel the draft PNA adequately describes current pharmaceutical services in Cambridgeshire?

354 respondents answered this question. 304 respondents (86%) felt that the draft PNA did adequately describe current pharmaceutical services in Cambridgeshire. Out of 50 respondents that did not agree, free text comments were provided by 24 respondents. These comments fell into the following categories:

- Respondents who felt unable to answer the question (9 respondents)
- Method of analysis (6 respondents)
- Access and provision in rural areas (4 respondents)
- A mix of other comments (5 respondents)

4 Do you know of any pharmaceutical services that are not described in the PNA?

354 respondents answered this question. 88% of respondents stated that they did not know of any pharmaceutical services that were not described within the PNA. Out of 43 respondents that did not agree, free text comments were provided by 29 respondents and suggestions for one or more other services were provided by 20

respondents. These 20 respondents indicated that the following services had not been described in the PNA:

- Preventative services e.g. for blood pressure, cholesterol or weight management (4 respondents)
- Phlebotomy services (3 respondents)
- Minor ailment service (3 respondents)
- Better information about out of hours or emergency services (3 respondents)
- Medication reviews (2 respondents)
- Flu vaccinations (2 respondents)
- A mix of other comments (3 respondents)

5 Do you feel that the needs for pharmacy services for the population in Cambridgeshire have been adequately identified?

354 respondents answered this question. 264 respondents (75%) felt that the needs for pharmacy services for the population of Cambridgeshire had been adequately identified. Out of 90 respondents that did not agree, free text comments were provided by 50 respondents. These comments fell into the following categories:

- Concerns about the impact of population growth & increased demand (17 respondents)
- Respondents who felt unable to answer the question (11 respondents)
- Access in rural areas (7 respondents)
- Extended opening hours (2 respondents)
- A mix of other comments, including suggestions for improvement (13 respondents)

6 *Do you think that pharmacy services are available at convenient locations and opening times?*

326 respondents answered this question. 297 out of 326 respondents (91%) agreed that pharmacy services are currently available at convenient locations and opening times. Out of 29 respondents that did not agree, free text comments were provided by 24. These respondents fell into the following categories:

- Extended opening hours (13 respondents)
- Access in rural areas (4 respondents)
- A mix of other comments (7 respondents)

7. Do you have any difficulties in accessing your local pharmacy or dispensing doctor?

326 respondents answered this question. 293 of 326 respondents (90%) did not have difficulties in accessing their local pharmacy or dispensing doctor. Out of 33 respondents that did not agree, free text comments were provided by 29 respondents. These comments fell into the following categories:

- Opening hours (8 respondents)
- Access in rural areas (8 respondents)

- Access for people with disabilities (4 respondents)
- A mix of other comments (9 respondents)

A number of the other comments were about long waiting times to see their GP which suggests that the wording of the question could be improved.

8 Do you agree with our conclusion that we have enough pharmacies across Cambridgeshire and do not currently need any more?

354 respondents answered this question. 257 respondents (73%) agreed that currently we do not need more pharmacies in Cambridgeshire. Out of the 97 respondents that did not agree, free text comments were provided by 84. Their responses fell into the following broad categories:

- Concerns about the impact of population growth & increased demand (28 respondents)
- Respondents who felt unable to answer the question (21 respondents)
- Access in rural areas (13 respondents)
- Opening hours (4 respondents)
- Capacity issues in existing pharmacies (3 respondents)
- Method of analysis (2 respondents)
- A mix of other comments (13 respondents)

Many of the respondents who stated that they were unable to answer this question, stated that provision in their area was adequate but they could not answer for the rest of the county.

Additional feedback

Following on from these questions, respondents were invited to add any further comments or feedback on the PNA, and 87 respondents took up this opportunity.

There were some common themes under which comments fell, namely:

1. **Positive feedback about pharmacies (13 respondents):**

13 respondents used this question to provide positive feedback about their local pharmacy provision (both community pharmacies and dispensing practices) which included comments about the quality of the service, accessibility and extended opening hours.

2. **Concerns about the impact of population growth & increased demand (9 respondents)**

Nine respondents expressed concern about the impact of new developments and associated population growth in their local area on the demand for local pharmacy services.

3. **Respondents who felt unable to answer the survey (7 respondents):**

Seven respondents felt that they were unable to answer all the questions in the survey as they could only talk about their local area and not comment on the need for pharmacy services across the county.

4. **Method used to produce the PNA (7 respondents):**

These comments included specific suggestions for improvement for the survey and draft report, which will be used as learning for future consultations. One respondent commented that the report was not simply written and another gave thanks for the opportunity to comment.

5. **Dispensing practices (5 respondents):**

Five respondents used this question to make specific comments about dispensing practices, including the desire to maintain or expand these services. One respondent commented on dispensing delays at a specific practice.

6. **Suggestions for improvements to practice (4 respondents):**

Four respondents made suggestions for how pharmacy provision could be improved. These included health checks (such as blood pressure, diabetes and asthma) in pharmacies, more pharmacy staff, online functionality to ask pharmacists questions and check stock, home visits from pharmacists to explain medication and joining up pharmacy services with hearing and sight services.

7. **Home delivery (4 respondents):**

Four respondents commented on the benefits of the home delivery service provided by their local pharmacy.

8. **Access in rural areas (3 comments):**

These comments included a comment about the importance of the village pharmacy, a request for a pharmacy in a specific village and problems with reduced bus services.

9. **Repeat prescriptions (3 comments):**

Two respondents commented that they would like to receive medication for longer periods of time (e.g. two to three months) and one asked why they were no longer able to leave the prescription request with the pharmacy.

10. Prevention of ill health and healthy lifestyles (2 respondents):

One respondent made a positive comment about the increased role of healthy lifestyles, whilst another suggested that weight management should be expanded.

11. Impact of the changes to the pharmacy contract funding (2 respondents):

Two respondents expressed concern about any potential closures to pharmacies due to changes in government funding and highlighted the value of pharmacy services.

12. Too many pharmacies (2 respondents):

Two respondents commented that there were too many pharmacies, with one referencing Huntingdon town centre in particular.

Appendix 7: Consultation Response for the Cambridgeshire Pharmaceutical Needs Assessment, 2017

This appendix outlines the response from the Pharmaceutical Needs Assessment (PNA) Steering Group to the feedback obtained in the consultation on the PNA for Cambridgeshire, 2017.

The PNA consultation was undertaken from 30 January 2017 to 30 April 2017 and was made known to members of the public and key stakeholder organisations through advertisements online, in pharmacies, in GP surgeries, in libraries and targeted correspondence. People were encouraged to have their say on pharmaceutical services in Cambridgeshire by completing a standard consultation questionnaire, online or in print. The consultation was carried out in accordance with appropriate regulations, as described in the full PNA report.

There were 354 respondents to the consultation questionnaire, including some responses arriving via post after the consultation period had ended. In addition, three free-text responses were received via email during the consultation period, from one member of the public and two stakeholder organisations. A member of the public health team was invited to attend a local health partnership board meeting in person to discuss the report, and the minutes of this discussion have also been used as a consultation response. The feedback from all respondents has been summarised in a report prepared by the public health team at Cambridgeshire County Council (see appendix 6).

There are a number of key topics that were raised during the consultation; these have therefore been considered in-depth by the steering group and a summary response is provided in section 1 below. Section 2 sets out the response from the PNA Steering Group to each question. It is notable that most respondents were supportive of the methods used to undertake the PNA and the messages presented in the draft PNA.

The Cambridgeshire Health and Wellbeing Board value the feedback provided by respondents during the consultation exercise and will inform relevant stakeholders of the key findings of the consultation. This will include NHS England, the Clinical Commissioning Group, the Local Pharmaceutical Committee and all community pharmacies and dispensing practices.

The Cambridgeshire Health and Wellbeing Board wishes to thank all those who responded to the public consultation and the pharmacy questionnaire, as well as those who helped to develop the PNA.

Section 1 Response to key topics

1. **Population growth:**

A number of respondents raised concerns about the impact of population growth on the need for pharmaceutical services. This topic is addressed in section 6 of the PNA.

The PNA acknowledges that an increase in population size is likely to generate an increased need for pharmaceutical services, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required, due to the range of other factors influencing local pharmaceutical needs. The PNA considers forecasted population changes over the next three years, with particular reference to the significant housing developments that are due for completion during that time.

The PNA will be fully updated in 2020. The steering group has used the feedback from respondents to develop a monitoring protocol for keeping the PNA up-to-date in the interim period, with particular consideration to the impact of population growth. The Senior Public Health Manager for Environment and Planning will continue to monitor and assess pharmaceutical need across the county in relation to population growth. The steering group will meet every six months to review the latest data on housing development sites and population projections, and the potential implications for pharmaceutical provision. If changes to the need for pharmaceutical services are identified, the steering group will either issue a supplementary statement of fact which acts as an amendment to the PNA, or propose a revised assessment of need if the changes are significant.

It is useful to note that the purpose of the PNA is to provide a statement of pharmaceutical needs and is used by NHS England when assessing applications for the opening of new pharmacies. The Health and Wellbeing Board are not able to instruct the opening of a pharmacy which are independent contractors. However, if a need for a pharmacy is identified and is described in the PNA, an application from a business to open a pharmacy is more likely to be successful.

2. **Opening hours:**

The steering group is pleased to note that 91% of respondents thought that pharmacy services are available at convenient locations and opening hours.

Throughout the survey, a number of respondents raised the topic of extended opening hours of pharmacies, generally either providing positive feedback about the extending opening hours currently available in their area or expressing a wish for further extension of hours in their area.

Opening hours are considered in detail in section 4.4 of the PNA. The PNA concludes that overall there appears to be good coverage in terms of opening hours across the county, with 41% of community pharmacies being open after 6pm and 24% being open after 7pm on weekdays, 82% open on Saturdays and 20% open on Sundays. The steering group recognises that people may require medication outside of these hours and the out of hours general practice service, Hertfordshire Urgent Care, is required to arrange for the provision of a full course of treatment, if clinically necessary, before a community pharmacy is open.

Pharmacies are commissioned by NHS England and contracts include mention of core hours specifying when a pharmacy must be open. However, pharmacies are independent contractors and extension of opening hours or closure over lunch periods is decided by each pharmacy. Often, this is to ensure that pharmacists are able to take an appropriate break, as specified by professional regulations (pharmacies are required to have a pharmacist on site when open).

The PNA recognises that maintaining the current distribution of longer opening pharmacies is important to maintain out-of-hours access for the population of Cambridgeshire. Pharmacies are obliged to inform NHS England of alterations to their opening hours and any significant changes will be considered by the PNA steering group.

3. Accessibility for people with disabilities

A number of respondents note the importance of pharmacies being accessible to people with disabilities and providing information and services in a format appropriate to people's needs, such as braille, easy read leaflets and languages other than English.

This topic is addressed in section 4.3 of the PNA. It notes that the proportion of providers reporting that they have wheelchair access to consultation facilities has increased since 2013 from 80% to 93% of community pharmacies, and from 87% to 88% of dispensing practices.

The steering group recognises the importance of the accessibility of pharmaceutical services and will feedback the consultation response to all providers. All community pharmacies and dispensing practices must adhere to the Equality Act (2010) which states that reasonable adjustments must be made to help disabled people access services. The Cambridgeshire Local Pharmaceutical Committee, which represents all community pharmacies in the county, states that pharmacies provide information in alternative formats where available and appropriate. Pharmacies often employ people from the local community and therefore may speak languages other than English which are commonly spoken in the community.

4. Access in rural areas

The steering group are pleased to note that 91% of respondents thought that pharmacy services are available at convenient locations and opening hours and 90% of respondents do not have any difficulties in accessing their local pharmacy or dispensing doctor.

A number of respondents raised the issue of difficulties in accessing pharmacies in rural locations. This topic is addressed in section 4.3 of the PNA. The report concludes that the number and distribution of pharmaceutical service provision in Cambridgeshire is sufficient, with few gaps and some concentrations. The steering group recognises that Cambridgeshire is a predominantly rural county with few large urban settlements. Relatively wide areas are not densely populated and this can lead to potential challenges for residents with transport and access to services. While the spread of pharmaceutical service providers across the county is good, there is some clustering of pharmacies in small areas of the larger market towns.

Services available to help improve access to pharmaceutical services include:

- Dial-a-ride service;
- Community car schemes;
- Home delivery services;
- Prescription collection services;
- NHS repeat dispensing service; and
- Distance selling pharmacies.

5. Home delivery

A number of respondents commented on the usefulness of home delivery services, especially for those who are unable to visit a pharmacy in person. The steering group note the benefits of the home delivery services that many pharmacies provide. Further details on this topic are described in section 4.3 of the PNA.

6. Impact of the changes to the pharmacy contract funding

Some respondents raised concerns about the impact of the changes to the pharmacy contract funding. This topic is addressed in appendix 5 of the PNA. The steering group will continue to monitor any closures of local pharmacies and issue appropriate statements of fact as necessary in line with PNA requirements and the local monitoring protocol for keeping the PNA up to date.

7. Disposals of medicine

A small number of respondents raised concerns about the wastage of unnecessary medicine. Patients should be encouraged to only order medication they need and to take any unused medicine to a pharmacy for proper disposal. These wasted medicines will then be collected and incinerated.

8. Repeat prescriptions

A number of respondents raised concerns about the systems in place in their local area for repeat prescriptions. These included frustration that they are no longer able to make their request for medication directly from their local pharmacy, a change which has been put in place as a safety mechanism to prevent errors when transcribing the medication request. Potential solutions for this issue may include increased use of electronic repeat dispensing (eRD).

This topic is outside the scope of the PNA but has been fed back to the relevant stakeholders, including NHS England and the Clinical Commissioning Group.

9. The role of pharmacies in the prevention of ill health and healthy lifestyles

A small number of respondents made positive comments or suggestions about the role of community pharmacies in the prevention of ill health and promoting healthy lifestyles. The steering group recognises the wide range of opportunities for pharmacies to promote healthier lifestyles which could involve direct service provision, for example Emergency Hormonal Contraception, along with providing ongoing support for lifestyle behaviour change through motivational interviewing, providing information and brief advice, and signposting to other services. Current provision is described in detail in section 5 of the PNA.

The recent changes to the 2017/2018 pharmacy contract have included quality payments to pharmacies who are accredited as ‘Healthy Living Pharmacies’. The ‘Healthy Living Pharmacy (HLP)’ framework is a tiered commissioning framework aimed at achieving consistent delivery of a broad range of high quality services through community pharmacies to meet local need, improving the health and wellbeing of the local population and helping to reduce health inequalities. Evaluations of Healthy Living Pharmacies have demonstrated an increase in successful smoking quits, extensive delivery of alcohol brief interventions and advice, emergency contraception, targeted seasonal flu vaccinations, common ailments, NHS Health Checks, healthy diet, physical activity, healthy weight and pharmaceutical care services. The Healthy Living Pharmacies Framework is described in more detail in section 5.4.1 of the PNA.

10. Unable to comment

A number of respondents commented that they felt unable to answer the survey questions for the whole of the county. It is appreciated that it is difficult to judge pharmaceutical services for Cambridgeshire as a whole. We have sought views from the public across the county and a variety of stakeholders to help inform the PNA. It is recognised that people who respond to the consultation survey will primarily consider the services available in their locality. The aim is to collate these responses to represent the greater picture.

Section 2: Summary of feedback to the consultation and responses to this feedback including revisions to the final PNA report

Consultation question		Summary of feedback and free text comments	Response from the PNA Steering Group on behalf of the Cambridgeshire Health and Wellbeing Board
Service Experience			
	How often do you use each of the following?	The services most commonly used included dispensing of prescriptions, buying non-prescription medicines, and getting a repeat prescription (see table 4 in the consultation summary report). 135 people made an additional comment of which 96 (72%) were positive about their local pharmacy or the services offered generally by pharmacists. The role of pharmacists in being able to offer advice was highly valued, as was the role played by pharmacies in the local community: *"Excellent both for prescription medicines and for advice"* *"Essential for local community particularly the elderly and those with young children"*	• **It is noted that the majority of comments received were positive.** • The issues of repeat prescriptions, disposal of medicines, access in rural areas and the impact of population growth is addressed in section 1 of appendix 7. • <u>Supplying non-prescription medicines at dispensing practices:</u> Dispensing practices are not able to sell over-the-counter medication at their practices. • <u>Capacity issues:</u> The comments about the capacity and waiting times to collect prescriptions in a small number of pharmacies have been noted and shared with the Local Pharmaceutical Committee which represents community pharmacies in Cambridgeshire.

		Other comments fell under the following broad headings: • Repeat prescriptions (10 respondents) • Disposal of medicines (5 respondents) • Supplying non-prescription medicines at GP surgeries (3 respondents) • Waiting times when collecting prescriptions (3 respondents) • Access in rural areas (2 respondents) • A mix of other comments (16 respondents)	
PNA Feedback			
1.	Do you feel that the purpose of the pharmaceutical needs assessment (PNA) has been explained sufficiently?	354 respondents answered this question. 323 respondents (91%) felt that the purpose of the PNA was explained sufficiently. Out of 31 respondents who did not feel the purpose of the PNA was explained sufficiently, free text comments were provided by 19 respondents. The comments fell into the following categories: • Insufficient detail in report (4 respondents) • Respondents who felt unable to answer the question (4 respondents) • Lack of clarity on specific topics (3 respondents)	• **It is noted that the majority of respondents felt the purpose of the PNA was sufficiently explained.** • The issue of the impact of population growth is addressed in section 1 of appendix 7. • <u>Method:</u> A number of terms have been clarified in the PNA following this feedback, including a definition of community pharmacy.

		• Omissions in the report (2 respondents) • Concerns about the impact of population growth & increased demand (2 respondents) • A mix of other comments (4 respondents)	
2.	Do you agree with the key findings about pharmaceutical services in Cambridgeshire?	354 respondents answered this question. 293 respondents (83%) agreed with the key findings about pharmaceutical services in Cambridgeshire as outlined in the PNA. Out of 61 respondents that did not agree, free text comments were provided by 34 respondents. These comments fell into the following broad categories: • Concerns about the impact of population growth & increased demand (8 respondents) • Respondents who felt unable to answer the question (6 respondents) • Method of analysis (5 respondents) • Access in rural areas (4 respondents) • Importance of prevention of ill health & healthy lifestyles (3 respondents) • Opening hours (3 respondents)	• **It is noted that the majority of respondents agreed with the key findings about pharmaceutical services in Cambridgeshire.** • The issues of the impact of population growth, access in rural areas, opening hours and the role of pharmacies in prevention and healthy lifestyles are addressed in section 1 of appendix 7. • <u>Method:</u> One respondent commented that a small number of surveys were used to produce the report. The majority of community pharmacies and dispensing practices in Cambridgeshire responded to the questionnaire that was used to produce the PNA. [93 of 110 (85%) community pharmacies and 34 of 43 (79%) dispensing GP practices in Cambridgeshire responded to the 2016 PNA questionnaire.] One

		• A mix of other comments (5 respondents)	respondent commented on the timeliness of the data used. The PNA was produced using the most current data available at the time of production of the draft PNA.
3.	Do you feel that the draft PNA adequately describes current pharmaceutical services in Cambridgeshire?	354 respondents answered this question. 304 respondents (86%) felt that the draft PNA did adequately describe current pharmaceutical services in Cambridgeshire. Out of 50 respondents that did not agree, free text comments were provided by 24 respondents. These comments fell into the following categories: • Respondents who felt unable to answer the question (9 respondents) • Method of analysis (6 respondents) • Access and provision in rural areas (4 respondents) • A mix of other comments (5 respondents)	• **It is noted that the majority of respondents thought that the draft PNA adequately describes current pharmaceutical services in Cambridgeshire.** • The issue of access in rural areas is addressed in section 1 of appendix 7. • <u>Method:</u> It is noted that a small number of respondents commented on a lack of detail in the data that is presented in the PNA. The level of detail used in the report was agreed by the multi-agency steering group and reflects the availability of data and purpose of the PNA. The PNA presents and discusses the numbers and geographical distribution, accessibility and opening hours of pharmaceutical providers. This data is presented in text form and maps where appropriate. One respondent commented about the survey response rate – this point is addressed above.
4.	Do you know of any pharmaceutical services that are not described in the PNA that we should add?	354 respondents answered this question. 88% of respondents stated that they did not know of any pharmaceutical services that were not described within the PNA. Out of	• <u>Preventative services:</u> Current prevention and healthy lifestyle services delivered by pharmacies are described in section 5 of the PNA. The new Healthy Living Pharmacies

		43 respondents that did not agree, free text comments were provided by 29 respondents and suggestions for one or more other services were provided by 20 respondents. These 20 respondents indicated that the following services had not been described in the PNA: • Preventative services e.g. for blood pressure, cholesterol or weight management (4 respondents) • Phlebotomy services (3 respondents) • Minor ailment service (3 respondents) • Better information about out of hours or emergency services (3 respondents) • Medication reviews (2 respondents) • Flu vaccinations (2 respondents) • A mix of other comments (3 respondents)	commissioning framework provide a further mechanism for increasing the role of pharmacies in promoting healthy lifestyles. • Phlebotomy: The PNA states that 4 community pharmacies who responded to the questionnaire provide phlebotomy services (table 13 in the PNA). Due to the small number of pharmacies, these services have not been described in detail. • Minor ailment services: minor ailment services are described in section 5.6.4 of the PNA. • Out of hours/emergency services: The PNA states that the out of hours service, Hertfordshire Urgent Care, is required to arrange for the provision of a full course of treatment, if clinically necessary, before a community pharmacy is open. In addition, NHS England has commissioned a national NHS Urgent Medicine Supply Advanced Service (NUMSAS) pilot which is described in section 5.2.6 of the PNA. • Medication reviews: this service is described in section 5 of the PNA.

			• Flu vaccination: The PNA discusses flu vaccination services in pharmacies under Advanced Services (section 5.2.5).
5.	Do you feel that the needs for pharmacy services for the population in Cambridgeshire have been adequately identified?	354 respondents answered this question. 264 respondents (75%) felt that the needs for pharmacy services for the population of Cambridgeshire had been adequately identified. Out of 90 respondents that did not agree, free text comments were provided by 50 respondents. These comments fell into the following categories: • Concerns about the impact of population growth & increased demand (17 respondents) • Respondents who felt unable to answer the question (11 respondents) • Access in rural areas (7 respondents) • Extended opening hours (2 respondents) • A mix of other comments, including suggestions for improvement (13 respondents)	• **It is noted that the majority of respondents thought that the needs for pharmacy services for the population in Cambridgeshire have been adequately identified.** • The issues of the impact of population growth, access in rural areas and opening hours are addressed in section 1 of appendix 7. • Suggestions for improvement: One respondent made a suggestion that pharmacies should provide support for specific groups in the population and tests for early identification of chronic disease, such as diabetes. This links with the Healthy Living Pharmacies scheme which is described in section 5.4.1 of the PNA. One respondent made a suggestion that pharmacists should visit people in their homes to provide medication advice. The steering group recognises the potential value of such a service to those who are frail and housebound. Pharmacies are not contracted to provide this service. This feedback has been shared with the relevant stakeholders, including the Local Pharmaceutical Committee which

			represents all community pharmacies in Cambridgeshire.
6.	Do you think that pharmacy services are available at convenient locations an opening hours?	326 respondents answered this question. 297 out of 326 respondents (91%) agreed that pharmacy services are currently available at convenient locations and opening times. Out of 29 respondents that did not agree, free text comments were provided by 24. These respondents fell into the following categories: • Extended opening hours (13 respondents) • Access in rural areas (4 respondents) • A mix of other comments (7 respondents)	• **It is noted that most respondents agreed that pharmacy services are currently available at convenient locations and opening times.** • The issue of opening hours and access in rural areas is addressed in section 1 of appendix 7.
7.	Do you have any difficulties in accessing your local pharmacy or dispensing doctor?	326 respondents answered this question. 293 of 326 respondents (90%) did not have difficulties in accessing their local pharmacy or dispensing doctor. Out of 33 respondents that did not agree, free text comments were provided by 29 respondents. These comments fell into the following categories:	• **It is noted that most respondents did not have difficulties in accessing their local pharmacy or dispensing doctor.** • The issues of opening hours, access for people with disabilities and access in rural areas are addressed in section 1 of appendix 7.

		• Opening hours (8 respondents) • Access in rural areas (8 respondents) • Access for people with disabilities (4 respondents) • A mix of other comments (9 respondents) A number of the other comments were about long waiting times to see their GP which suggests that the wording of the question could be improved.	• <u>Questionnaire method:</u> The learning about the wording of the question causing confusion in the responses will be used to inform future questionnaires.
8.	Do you agree with our conclusion that we have enough pharmacies across Cambridgeshire and do not currently need any more?	354 respondents answered this question. 257 respondents (73%) agreed that currently we do not need more pharmacies in Cambridgeshire. Out of the 97 respondents that did not agree, free text comments were provided by 84. Their responses fell into the following broad categories:	• **It is noted that the majority of respondents agreed with the conclusion that we have enough pharmacies across Cambridgeshire and do not currently need any more.** • **A significant number of respondents responded no, but commented that they felt unable to answer this question as there was sufficient provision in their area but couldn't answer for the whole of the county.**

		• Concerns about the impact of population growth & increased demand (28 respondents) • Respondents who felt unable to answer the question (21 respondents) • Access in rural areas (13 respondents) • Opening hours (4 respondents) • Capacity issues in existing pharmacies (3 respondents) • Method of analysis (2 respondents) • A mix of other comments (13 respondents) Many of the respondents who stated that they were unable to answer this question, stated that provision in their area was adequate but they could not answer for the rest of the county.	• <u>Impact of population growth:</u> The majority of respondents were concerned about the impact of population growth and this issue is addressed in section 1 of appendix 7. • The issues of access in rural areas and opening hours are addressed in section 1 of appendix 7. • <u>Method:</u> Two respondents commented about a lack of detailed data – this is addressed in the response to question 3. • <u>Capacity issues:</u> The comments about the capacity and waiting times to collect prescriptions in a small number of pharmacies have been noted and shared with the Local Pharmaceutical Committee which represents community pharmacies in Cambridgeshire.
9.	Do you have any other comments?	Following on from these questions, respondents were invited to add any further comments or feedback on the PNA, and 87 respondents took up this opportunity.	• **It is noted that a significant number of respondents provided positive feedback about local pharmacy provision.** • The issues of the impact of population growth, home delivery, access in rural areas, repeat prescriptions, prevention and

		There were some common themes under which comments fell, namely: **13. Positive feedback about pharmacies (13 respondents):** Thirteen respondents used this question to provide positive feedback about their local pharmacy provision (both community pharmacies and dispensing practices) which included comments about the quality of the service, accessibility and extended opening hours. **14. Concerns about the impact of population growth & increased demand (9 respondents)** Nine respondents expressed concern about the impact of new developments and associated population growth in their local area on the demand for local pharmacy services. **15. Respondents who felt unable to answer the survey (7 respondents):** Seven respondents felt that they were unable to answer all the questions in the survey as they could only talk about their local area and not comment on the need for pharmacy services across the county.	healthy lifestyles, and the impact of the changes to the pharmacy contract funding are addressed in section 1 of appendix 7. • Method: The comments about the design of the survey will be used to improve the process in the future. • Suggestions for improvement: the suggestions for improvement have been fed back to the Local Pharmaceutical Committee, which represents all pharmacies in Cambridgeshire. • Dispensing practices: the feedback about dispensing GPs has been shared with the Clinical Commissioning Group and NHS England. • Surplus of pharmacies: the two comments about having too many pharmacies in the region have been noted. The majority of respondents agreed with the key findings of the PNA which concludes that there is sufficient pharmaceutical provision across Cambridgeshire. The number of providers per population is the same as the national average.

		16. **Method used to produce the PNA (7 respondents):** These comments included specific suggestions for improvement for the survey and draft report, which will be used as learning for future consultations. One respondent commented that the report was not simply written and another gave thanks for the opportunity to comment. **17. Dispensing practices (5 respondents):** Five respondents used this question to make comments about dispensing practices, including the desire to maintain or expand these services. One respondent commented on dispensing delays at a specific practice. **18. Suggestions for improvements to practice (4 respondents):** Four respondents made suggestions for how pharmacy provision could be improved. These included health checks (such as blood pressure, diabetes and asthma) in pharmacies, more pharmacy staff, online functionality to ask pharmacists questions and check stock, home visits from pharmacists to explain medication and	

		joining up pharmacy services with hearing and sight services. **19. Home delivery (4 respondents):** Four respondents commented on the benefits of the home delivery service provided by their local pharmacy. **20. Access in rural areas (3 comments):** These comments included a comment about the importance of the village pharmacy, a request for a pharmacy in a specific village and problems with reduced bus services. **21. Repeat prescriptions (3 comments):** Two respondents commented that they would like to receive medication for longer periods of time (e.g. two to three months) and one asked why they were no longer able to leave the prescription request with the pharmacy. **22. Prevention of ill health and healthy lifestyles (2 respondents):** One respondent made a positive comment about the increased role of healthy lifestyles, whilst another suggested that weight management should be expanded.	

		23. Impact of the changes to the pharmacy contract funding (2 respondents): Two respondents expressed concern about any potential closures to pharmacies due to changes in government funding and highlighted the value of pharmacy services. **24. Too many pharmacies (2 respondents):** Two respondents commented that there were too many pharmacies, with one referencing Huntingdon town centre in particular.	
Responses from stakeholder groups See section 2 for a full description of how stakeholders were engaged in the development of the PNA. In addition to this, some stakeholder groups provided feedback during the formal consultation:			
	Sandie Smith, CEO of Healthwatch Cambridgeshire & Peterborough (via email)	I have not responded to the survey as we do not have sufficient knowledge to give definitive answers on several of the questions. The survey does not have 'don't know' options nor allow questions to be left blank. The strategic issues we are concerned about are:	• The helpful feedback about the 'don't know' option in the survey will be used to inform future consultations. • Please see section 1 of appendix 7 for response to comments on population growth, access in rural areas, accessibility for people with disabilities and repeat prescriptions. • The steering group recognises the important role of pharmacies in the Sustainability and Transformation Plan (STP). This is being

		• Having sufficient pharmacy capacity in growth areas as they develop • Having appropriate pharmacy services for people living in rurally isolated areas without transport, or who cannot get to a pharmacy for other reasons • That the key role of pharmacies in the STP and integrated services is clearly articulated and embedded into development plans • That pharmacies make information available in other formats and are aware of different communities' communications needs Our feedback from the public tells us that people are concerned about changes in processes for getting repeat prescriptions.	taken forward by the Local Pharmaceutical Committee lead.
	Cambridgeshire Local Medical Committee (LMC) (letter via email)	Cambridgeshire Local Medical Committee is the independent statutory organisation that represents the views of the county's General Practitioners. Cambridgeshire LMC has considered your PNA consultation document and our comments are as follows:	• The steering group is pleased to note that the Local Medical Committee agrees with the key finding of the PNA. • The steering group has jointly produced a monitoring protocol for keeping the PNA up to date between now and 2020. This includes an agreed process for NHS England consulting with Cambridgeshire County Council Public Health team, on behalf of the Health and Wellbeing board,

		Pharmaceutical services Cambridgeshire LMC agrees with your key finding that there is currently sufficient pharmaceutical service provision across Cambridgeshire and notes that no need for additional pharmaceutical service providers has been identified. Concern The Committee is concerned that despite similar conclusions being stated in the 2014 PNA, there was a successful pharmacy application granted at appeal in Alconbury. The Committee is also concerned that neither Cambridgeshire County Council nor the Health and Wellbeing Board appear to have been made aware of, or asked to comment on this application. The Committee recommends that thought be given to finding a way to address this communication gap.	on receipt of applications for new pharmacies. This will enable public health to share any relevant knowledge, including current information about population growth and its impact on pharmaceutical services. • See section 1 of appendix 7 for a response to comments on population growth.

		Future reviews The Committee is aware of the new developments that are planned across the county and how this could impact on GP services. We agree that the Senior Public Health Manager for Environment and Planning should monitor and assess pharmaceutical need in these areas regularly with a view to publishing a supplementary statement to the PNA if necessary. The Committee would be happy to assist in any way with these reviews.	
	Cambridge City Local Health Partnership Board, Minutes of meeting 23/3/17.	The Partnership discussed the report and raised the following concerns: i. Partnership members had attended recent consultation events (to re-base the Out of Hours service) where it had been suggested that pharmacies would be encouraged to open for longer hours to compensate for the withdrawal of the service. KJ said she was not aware of this proposal. ii. Expressed the hope that predicted demographic changes and new settlements will be considered alongside existing needs in order to avoid future health inequalities. It was felt that services should be in place at an early point within new communities	• The changes to the Out of Hours services in Cambridge City are outside the scope of this PNA. If these changes were to impact the need or provision of pharmaceutical services in the City, this would be addressed via the standard processes for updating the PNA as specified in the monitoring protocol for keeping the PNA up to date. • See section 1 of appendix 7 for a response to comments on population growth and the impact of the changes to the pharmacy contract.

		before the demand for them was fully manifest, to help people settle. iii. Suggested that imposing a national contract on Pharmacies was unfair and appreciated it might be difficult to predict what the local consequences for provision might be, once it had been implemented. iv. Confirmed that the existing practice of providing an establishment fee for new pharmacies would be replaced by a contract offering higher payment per item, which might assist smaller pharmacies. v. Appreciated that the PNA would be revisited if some pharmacies become unviable and signal that they might close. The Partnership asked to be informed of any concerns about local provision. vi. SM confirmed that planners considered existing provision when new communities were planned. If there was no provision locally, additional support could be investigated to help a pharmacy until demand picked up with the growth of the community.	

Emails from members of the public During the consultation, members of the public were also able to email their comments on the PNA. One such email was received.			
	Member of the public (via email)	The commitments shown in Map 14: Growth sites of 10 to 200 commitments does not appear to show an allowance for an additional 30 dwellings off Spring Lane, Bassingbourn (ref.: South Cambridgeshire District Council Outline Planning Permission S/1745/16/OL) nor for the relocation of personnel from Burgoyne Barracks, Chilwell, Henlow and Wethersfield to Bassingbourn Barracks in 2019 onwards (ref.: A Better Defence Estate, Ministry of Defence, Nov. 2016). Both of these are likely to result in an additional load on ID58 Bassingbourn Pharmacy. The relocation of personnel to Bassingbourn Barracks will result in repopulation of Edinburgh Square and Oxford Close, Bassingbourn (together 131 dwellings). Whilst it is possible that the military personnel will be covered by Defence Medical Services, I suspect that there are also likely to be civilians who will need to use Bassingbourn Pharmacy.	• See section 1 of appendix 7 for a response to comments on population growth. • An additional 30 dwellings off Spring Lane and the relocation of personnel to Bassingbourn Barracks is unlikely to result in significant increased demand on the local pharmacy. Section 6 of the PNA describes the different factors that influence the needs for pharmaceutical services. We will continue to monitor the impact of population growth on the need for pharmaceutical services and will share this feedback with all pharmacies, including Bassingbourn Pharmacy.

Cambridgeshire Pharmaceutical Needs Assessment: Monitoring Protocol

A protocol for the monitoring, assessment and response to changes in pharmaceutical needs in Cambridgeshire (2017 – 2020)

Summary

To facilitate commissioning of pharmaceutical services responsive to population needs, the Health and Wellbeing Board (HWB) will, in accordance with regulations, update the Pharmaceutical Needs Assessment (PNA) every three years. Regulation 6 of the *National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013* describes the requirements of the HWB to respond to any significant changes to pharmaceutical provision or need within the three years before a revised assessment is next published.

The Cambridgeshire PNA Steering Group will, on behalf of the HWB, continue to identify changes to the need for pharmaceutical services within the area and assess the significance of any such changes. These changes may be due to population growth or the closure or merger of pharmaceutical sites. The HWB will publish supplementary statements or a revised PNA, where deemed appropriate in consideration of the national regulations.

This protocol describes the process that will be taken to monitor, assess and respond to any changes in the need for pharmaceutical services. It applies to the period from the publication of the Cambridgeshire PNA 2017 Final Report (July 2017) until a revised PNA is published, which is currently planned for July 2020. All members of the steering group have agreed to the delivery of this protocol.

1. Background:

1.1 Pharmaceutical needs assessments

Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up-to-date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment' (PNA). The 2014 PNA is currently being updated and is due for publication in July 2017. It will describe the pharmaceutical needs for the population of Cambridgeshire, which includes Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire, but not Peterborough. A separate PNA is produced by the Peterborough Health and Wellbeing Board.

The PNA will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. Of note, before a new pharmacy can dispense prescriptions issued under the National Health Service, it must be included in the pharmaceutical list relating to a Health and Wellbeing Board Area, and applications are made to NHS England, not by the HWB. As these decisions may be appealed and challenged via the courts, it is important that PNAs comply with regulations and that mechanisms are established to keep the PNA up-to-date.

The PNA will also inform decisions by local commissioning bodies, including local authorities (public health services from community pharmacies), NHS England and Clinical Commissioning Groups (CCGs), on which NHS funded services are provided

locally and where pharmacies may be able to deliver commissioned services (such as Stop Smoking and Sexual Health Services).

1.2 Legal requirements to keep the PNA up-to-date

HWBs are required to publish a revised PNA within three years of publication of their first assessment[i]. A revised Cambridgeshire PNA will therefore be due for publication in July 2020.

If, during the next three years (2017 – 2020), the HWB identifies relevant changes to the need for pharmaceutical services, it is responsible for either making a revised assessment or publishing a supplementary statement as soon as is reasonably practicable. Regulation 6 of the *National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013*[i] states that:

> *"(2) A HWB must make a revised assessment as soon as is reasonably practicable after identifying changes since the previous assessment, which are of a significant extent, to the need for pharmaceutical services in its area, having regard in particular to changes to—*
> *(a) the number of people in its area who require pharmaceutical services;*
> *(b) the demography of its area; and*
> *(c) the risks to the health or well-being of people in its area, unless it is satisfied that making a revised assessment would be a disproportionate response to those changes.*
>
> *(3) Pending the publication of a statement of a revised assessment, a HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of its or a Primary Care Trust's pharmaceutical needs assessment (and any such supplementary statement becomes part of that assessment), where—*
> *(a) the changes are relevant to the granting of applications referred to in section 129(2)(c)(i) or (ii) of the 2006 Act; and*
> *(b) the HWB—*
> *(i) is satisfied that making its first or a revised assessment would be a disproportionate response to those changes, or*
> *(ii) is in the course of making its first or a revised assessment and is satisfied that immediate modification of its pharmaceutical needs assessment is essential in order to prevent significant detriment to the provision of pharmaceutical services in its area."*

Amendments were made to the pharmacy *National Health Service (Pharmaceutical Services, Charges and Prescribing) Regulations* in December 2016[i]. One key change was a new regulation which describes the potential consolidation of two or more

pharmacies onto one existing site. A new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes which would protect two pharmacies that choose to consolidate on a single existing site – where this does not create a gap in provision.

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

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

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

2. Current context

There are a number of factors which may affect the likelihood of changes to the need for pharmaceutical services. These include the impact of the new national pharmacy contract and the future population changes and housing growth in Cambridgeshire.

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

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

Full details of the final Community Pharmacy proposals can be found in the Department of Health (DoH) report "*Community pharmacy in 2016/2017 and beyond: final package*"[ii]. Appendix 5 of the PNA 2017 provides a summary of the proposed changes to the

pharmacy contracts and the potential impact of these as assessed by the DoH and the national Pharmaceutical Services Negotiating Committee (PSNC) who represent all community pharmacies providing NHS services in England.

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

2.2 Future population changes and housing growth

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

3. Process

The following process has been agreed to by all members of the steering group and applies to the period from publication of the Cambridgeshire PNA 2017 Final Report (July 2017) until a revised PNA is published, which is currently planned for July 2020. Membership of the steering group is listed in the 2017 PNA Final Report.

3.1 Convening of the steering group:

The Cambridgeshire PNA Steering Group will meet every six months (actually or virtually) to assess any identified potential changes to the need for pharmaceutical provision.

The group will be provided with:

a) a summary report of the latest population growth data and potential implication for pharmaceutical provision (more details in section 3.2);
b) a summary of any closures or mergers of pharmacy sites, and the potential implications of these (section 3.3);
c) a summary of any applications for new pharmacy sites that have been considered by NHS England in the last six months (section 3.4);
d) a summary of any other changes to pharmaceutical provision, such as relocations or changes to opening hours (section 3.5); and
e) updated maps of pharmaceutical provision (section 3.6).

The group will use the available information to decide whether:

- A supplementary statement of fact should be published to explain any changes;
- A revised assessment is required if changes of a significant extent have been identified; or,
- No further action is required before July 2020.

The steering group will be guided by the legal requirements of the relevant regulations (see section 1.2) and the *Department of Health Information Pack on Pharmaceutical Needs Assessments for local authority Health and Wellbeing Boards*[iii]. The group will also identify and consider best practice from other areas where appropriate and available.

3.2 Monitoring of population growth:

Given the significant planned growth of new developments across Cambridgeshire, the Senior Public Health Manager for Environment and Planning will continue to monitor and assess pharmaceutical need in these areas. They will produce a report in advance of each steering group meeting using the information sources described in section 6 of the PNA, to update the steering group on the latest data on housing development sites and population projections, and the potential implications for pharmaceutical provision. Section 6 of the PNA also describes the factors that will be considered in relation to needs for pharmaceutical services.

The Senior Public Health Manager will link with any ongoing work that is happening in partnership with the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England (East) in relation to forecasting the impact of population growth on health services in general to ensure that pharmaceutical provision is considered alongside other health services.

3.3 Closures and mergers of pharmaceutical provision:

The relevant Contract Manager in NHS England (East) will inform and consult with the Lead Consultant in Public Health on any closures or mergers of pharmaceutical service providers, who will convene a steering group meeting (actually or virtually) to assess the potential impact of the closure or merger and produce a supplementary statement to the PNA.

3.4 Applications for new pharmaceutical provision:

The relevant Contract Manager in NHS England (East) will inform and consult with the Lead Consultant in Public Health on any application for new pharmaceutical provision. This will enable public health to share any relevant knowledge, including current information about population growth and its impact on pharmaceutical services. If an

application is approved, the Health and Wellbeing Board will issue a supplementary statement to update the current PNA.

3.5 Other changes to pharmaceutical provision:

The relevant Contract Manager in NHS England (East) will inform and consult with the Lead Consultant in Public Health, on behalf of the steering group, on any other changes to pharmaceutical provision in Cambridgeshire which may have an impact on local access to pharmaceutical services. This may include relocation of community pharmacies and changes to opening hours, such as significant changes to the opening hours of one pharmacy that plays a key role in providing pharmaceutical services out of hours, or smaller changes to a number of pharmacies in a local area.

3.6 Maps of pharmaceutical provision:

The Public Health Intelligence (PHI) team will be responsible for updating the maps of pharmaceutical provision as soon as possible following notification from NHS England of any closures, mergers or new pharmaceutical providers. The PHI team will review the maps in advance of the steering group meetings and provide the steering group with the latest version.

3.7 Role of the Cambridgeshire Health and Wellbeing Board:

The steering group will assess any changes in the need for pharmaceutical provision and produce supplementary statements or a revised assessment on behalf of the Cambridgeshire HWB. The steering group will write to the HWB to inform them of the identified change and the action the group has taken in advance of publishing any supplementary statements. It is proposed that the HWB delegates authority to the Director of Public Health, in discussion with the Chair or Vice-Chair of the HWB to note the information and approve any supplementary statements for publication. If a revised assessment is required, the steering group will inform the HWB and start the process for producing a revised PNA (as outlined in section 2 of the 2017 PNA report).

3.8 Publication:

Following endorsement by the HWB, any supplementary statements or revised assessments will be published on the Cambridgeshire Insight website www.cambridgeshireinsight.org.uk,, alongside the original 2017 PNA report. The steering group will write to all key stakeholders, who were involved in the development of the PNA, to inform them of the publication of any supplementary statements. Publication will be communicated to the public via the Cambridgeshire County Council website and social media accounts. Other members of the steering group will publicise the information via their websites and/or social media as they deem appropriate.

3.9 Review of protocol:

This protocol will be reviewed at each steering group meeting, at least every six months, to ensure it continues to be fit for purpose.

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

[ii] Department of Health. 'Community pharmacy in 2016/2017 and beyond: final package'. (Oct 2016) Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561495/Community_pharmacy_package_A.pdf

[iii] Department of Health. 'Pharmaceutical needs assessments – information pack for local authority Health and Wellbeing Boards. (May 2013). Available at: https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

Agenda Item No: 9

SUSTAINABILITY AND TRANSFORMATION PLAN (STP) UPDATE REPORT

To:	**Health and Wellbeing Board**
Meeting Date:	**6 July 2017**
From:	**Scott Haldane, Interim Executive Programme Director, Cambridgeshire & Peterborough System Delivery Unit**
	Report presented by:
	Joel Harrison, Finance, Analytics & Evaluation Director Cambridgeshire & Peterborough System Delivery Unit
	Aidan Fallon, Head of Communication & Engagement Cambridgeshire & Peterborough System Delivery Unit
	On behalf of:
	Scott Haldane, Interim Executive Programme Director, Cambridgeshire & Peterborough System Delivery Unit
Recommendations:	**The Health and Wellbeing Board is asked to comment upon and note this update report**

Officer contact:	
Name:	Aidan Fallon
Post:	Head of Communications & Engagement (C&P STP)
Email:	Aidan.fallon1@nhs.net
Tel:	07970 195351

1. PURPOSE

1.1 The purpose of this report is to update the Health & Wellbeing Board on progress relating to the Cambridgeshire & Peterborough Sustainability and Transformation Plan (STP).

2 BACKGROUND

2.1 The Cambridgeshire and Peterborough health system faces significant challenges due to:

- the health and care needs of our rapidly growing, increasingly elderly population;
- significant health inequalities, including the health and wellbeing challenges of diverse ethnic communities;
- workforce shortages including recruitment and retention in general practice;
- quality shortcomings and inconsistent operational performance; and
- financial challenges which exceed those of any other STP area in England on a per capita basis, such that by 2021 we expect our collective NHS deficit, if we do nothing, to be £504m.

2.2 In order to address these challenges, the NHS (including general practice) and local government came together in 2016 to develop a five-year Sustainability and Transformation Plan (STP) to improve the health and care of our local population and bring the system back into financial balance. The STP can be found at Cambridgeshire & Peterborough STP and, in essence, seeks to do the following:

- deliver a shift from reactive to proactive care, with a holistic approach to care planning, coordination, and delivery that empowers people to take as much control of their care as possible. This approach aims to manage the growth in demand for services through better prevention, self-management, re-enablement and intensive management of rising risk and high risk people;
- deliver care pathway changes, standardised care and reduced variation to maximise quality and minimise unit costs through, for example, improved clinical networks, reduced Length of Stay in hospital and staff skill mix;
- deliver knowledge sharing, breaking down organisational and setting boundaries;
- close the under-funding gap as quickly as possible and maximising income growth;
- reduce overheads within and across the health and care system by, for example, managing our Estate more effectively, maximising joint procurement across health and other public sector organisations, and integrating organisations and functions;
- use technology to improve modes of interaction/intervention; and
- mobilise collective efforts across the County's NHS and public sector bodies to leverage the 'Cambridge research' brand and the Cambridgeshire and Peterborough-wide education and business offer to attract investment and make new partnerships, in line with on-going devolution.

2.3 To enable us to deliver the best care we can, we have agreed a unifying ambition for health and care in Cambridgeshire and Peterborough. This is to

develop the beneficial behaviours of an 'Accountable Care System' by acting as one system, jointly accountable for improving our population's health and wellbeing, outcomes, and experience, within a defined financial envelope.

2.4 Through discussion with our staff, patients, carers, and partners, we have articulated four priorities for change and we have also developed a 10-point plan to deliver these priorities, as set out below and illustrated at Annex 1.

Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

2.5 The STP also addresses the system-wide financial challenge of £504m over the next four years. It estimates the need to invest £43m to improve services over these four years, which increases the total system-wide financial challenge to £547m.

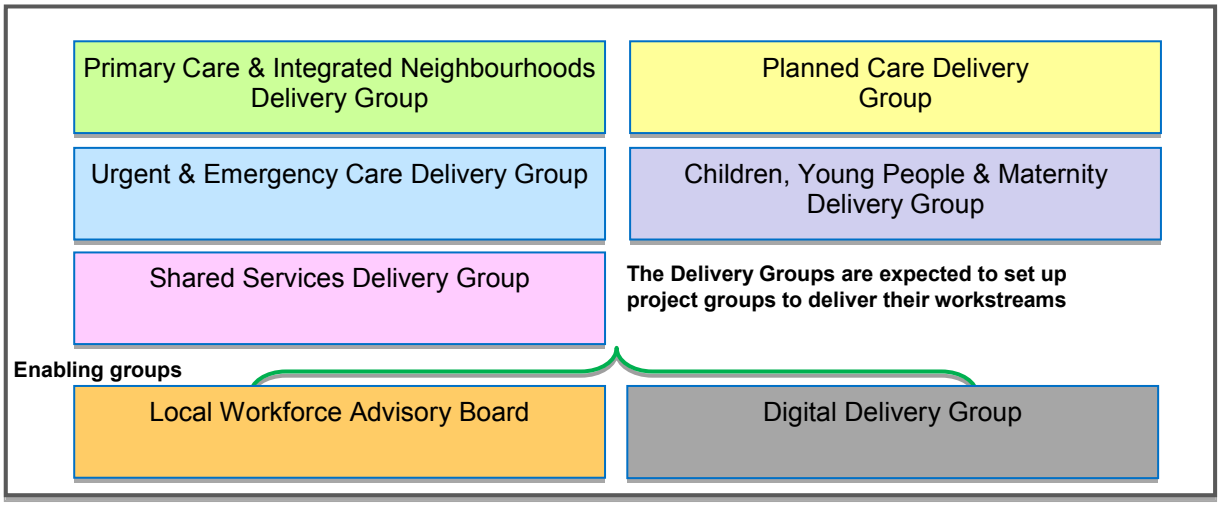
3.0 STP DELIVERY PROGRAMME

3.1 We have transitioned from STP development to delivery. We have put in place *Fit for the Future* (STP) programme arrangements, with a delivery governance structure to ensure effective implementation and this is illustrated at Annex 2, with an explanation of the purpose of each Group provided at Annex 3.

3.2 The Board is asked to note that the Programmes governance arrangements have undergone a recent review to ensure that they continue to be fit for purpose and a number of changes have been agreed but are still to be implemented, including the establishment of an STP Board and Stakeholder Group.

3.3 The programme has, at its core, seven Delivery Groups, each one responsible to Accountable Officers who are Chief Executive Officers from across the health and social care system, as set out below.

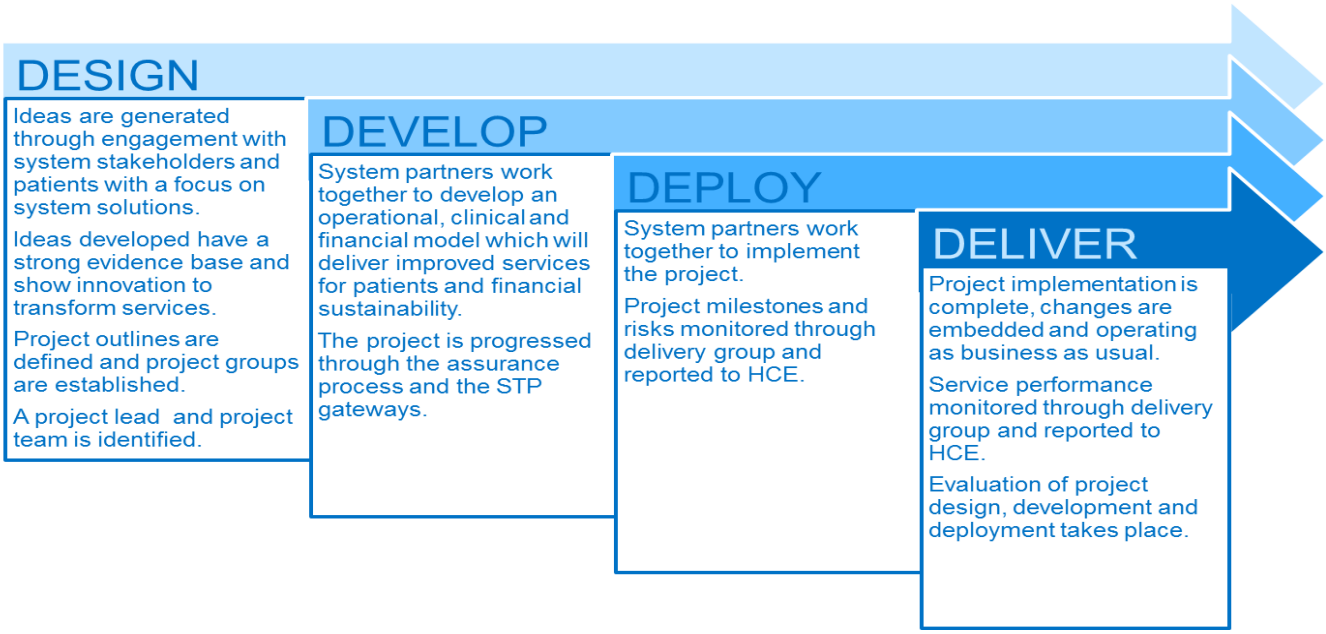
***Fit for the Future* (STP) Delivery Groups**



3.4 The Delivery Groups cover clinical services, workforce and support services and are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do. Membership includes clinicians from organisations across the system as well as patient and public representation.

3.5 Improvement Project Groups have been established within each Delivery Group to take forward specific aspects of work and, again, these groups include/will include clinical membership and patient and public representation.

3.6 We have established a clear and consistent structure to frame the various processes across the STP to ensure appropriate accountability across the 'lifecycle' of each STP Improvement Project, as set out below. Over 30 projects are currently 'live' across one or other of the four stages of the STP programme cycle.



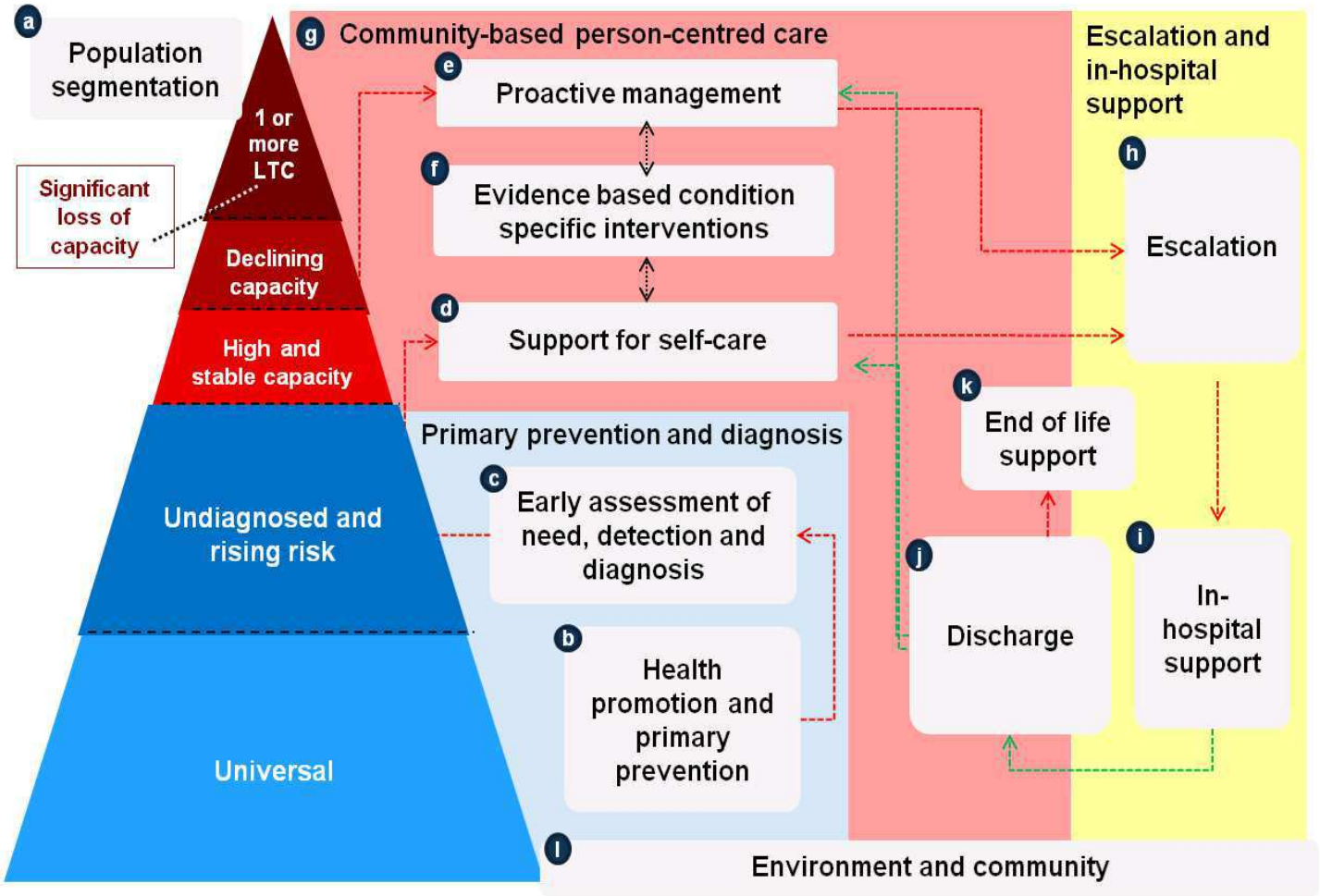
3.7 It is important to bear in mind that STP delivery will take place over several years and we are seeking to ensure a good balance of pace that will deliver real changes for people as quickly as possible but without overwhelming the health and care system's ability to process the changes.

4. MAIN ISSUES

4.1 This section summarises the current focus for implementation across the seven Delivery Groups within *Fit for the Future*.

4.2 Primary Care and Integrated Neighbourhoods

4.2.1 The purpose of this Delivery Group is to implement integrated health and care neighbourhood teams providing proactive care stratified by different levels of need, as determined by peoples medical and psychosocial conditions, and as illustrated in the diagram below. We have brought together previously disparate work on healthy ageing, long-term conditions management, and mental health for the first time in this delivery programme.



Key 2017/18 Interventions

- More specialist support for people with long term conditions such as ***diabetes, lung problems and heart disease***.
- Extra help for ***people who are at risk of falls*** by strengthening existing services. This will mean more staff in the community to help to prevent falls and help people recover if they do get injured.
- More case managers to identify patients who need the most ***support to remain at home*** and to ensure they get the help they need (this will be piloted in four neighbourhoods in the first instance and then expanded to other areas on the basis of the evidence from these pilots).
- Improving the ***prevention of stroke*** by identifying more patients with atrial fibrillation, a heart problem which is a significant risk factor, by giving them medication that will help earlier
- More support for ***people with dementia*** at all stages of the disease.

Key Achievements in 2017/18 to date

- £1m invested in respiratory, stroke prevention and falls prevention services
- £1.6m Diabetes funding awarded from national bid

4.3 **Urgent and Emergency Care**

4.3.1 This Delivery Group is seeking to manage demand for urgent and emergency care services which have seen significant increases over recent years resulting in clinical and financial challenges for the system. The increase in demand in Cambridgeshire & Peterborough is driven mainly by population growth and, in particular, by growth in the older frail population, as well as a lack of community based services to support vulnerable people.

Key 2017/18 Interventions

- ***Extended Joint Emergency Team (JET):*** This team intervenes to support vulnerable patients in their homes and/or the community. We will be expanding and enhancing this service to enable it to care for more patients.
- ***Stroke Early Supported Discharge (ESD):*** Establishing a service which will provide both intensive stroke discharge support and home based neuro rehabilitation.
- ***Discharge to Assess***
- Develop and deliver a ***mental health first response service*** to enable 24/7 access to mental health

Key Achievements in 2017/18 to date

- £1.9m invested in expanding the Joint Emergency Team with recruitment of additional staff and service expansion underway
- £0.5m invested in early supported discharge of Stroke patients
- £1.1m Psychiatric Liaison funding awarded from national bid for 2018/19 at Addenbrookes and Peterborough City Hospital

4.4 Planned Care

4.4.1 The focus for Planned Care is to define, design and implement shorter, faster, better and more cost-effective pathways of care for patients needing planned (or sometimes known as 'elective') care. This involves looking at every stage of the patient 'journey' from GP referral, outpatient appointment, procedure to follow up, ensuring that we are making the most effective use of clinical and financial resources.

Key 2017/18 Interventions

- Improve referral management
- Standardise high volume treatment pathways (orthopaedics, ophthalmology, ENT, cardiology)
- Reduced variation in diagnostic testing
- Improved cancer services

Key Achievements in 2017/18 to date

- Pathway reviews and re-design underway across several specialties.
- East of England Cancer Alliance awarded £9m national funding and Cambridgeshire & Peterborough awaiting confirmation of % share of this funding
- Appointed a Cancer Programme Manager for two years – by securing funding through the Cancer Alliance National Business Case. The role will be key in the overall delivery of the Cancer Priorities for 2017/18 and ensure they create sustainability for the future.

4.5 Children, Young People & Maternity Delivery Group

4.5.1 The Children, Young People and Maternity Services STP Delivery Group is leading seven projects over the next five years to improve services and outcomes for women and children.

Key Interventions

- Introducing 7-day-a-week paediatric community nursing
- Maternity developments such as implementing the national Better Births vision
- Improving the care models for children with asthma and children's continence services
- Developing an integrated children and family health and wellbeing service for 0-19 year olds
- Improving the emotional, mental health & wellbeing and specialist disabilities support for children and young people

4.6 Shared Services

4.6.1 This Delivery Group is focussed on ensuring that we optimise the use of our resources, assets and potential. This includes, for example, making best use of NHS buildings and land, sharing 'back office' functions such as Human Resources, and streamlining our procurement and purchasing processes.

Key 2017/18 Interventions

- Merger of Hinchingbrooke and Peterborough to enable shared service savings
- Explore back office consolidation across primary care
- Implement a single approach to procurement
- Develop a strategic estate plan - making best use of NHS buildings and land

Key Achievements in 2017/18 to date

- The merger of Hinchingbrooke Healthcare NHS Trust and Peterborough & Stamford Hospitals NHS Foundation Trust will ultimately make a significant contribution to shared service savings.

4.7 Local Workforce Advisory Board

4.7.1 In order to maximise the impact of new care models, the Local Workforce Advisory Board is working closely with clinical leads to ensure that workforce requirements can be met. Care models must take into account current workforce capacity and capability, and consider the change required to develop a workforce which is capable, competent, motivated, and supported to provide the best care for the population in future.

Key Interventions

- System-wide long-term workforce plan
- System-wide Organisational Development Plan
- Develop a system-wide Workforce Investment Plan, in which all providers commit to investment priorities in relation to Apprenticeships, Pre-Registration, Continued Professional Development (CPD) and wider workforce transformation

4.8 Digital Delivery

4.8.1 This Delivery Group is concerned with how best we can meet the opportunities and challenges of providing healthcare in a digital world where making the best use of technology is fundamental to supporting good care in areas such as tele-medicine, tele-monitoring, remote monitoring and paper free care delivery.

Key Interventions

- Deliver the Local Digital Roadmap
- Digital opportunities: tele-medicine, tele-monitoring, GS1, remote monitoring, internet of things, Paper-free care delivery

5 WORKING COLLABORATIVELY

5.1 Health, Cambridgeshire County Council and Peterborough City Council partners are working within the framework of the Memorandum of Understanding, agreed in 2016 to promote better joint accountability.

5.2 The STP Health and Care Executive also meets quarterly with the Cambridgeshire Public Services Board and has agreed a number of priority areas for collaborative action, including:

- Maximising the potential of **devolution**
- **Workforce** availability and development
- Better joint **procurement** practices
- Making best use of digital **technology**
- Maximising use of the public sector **estate**
- **Planning policy**

6 ENSURING EFFECTIVE PATIENT & OTHER STAKEHOLDER INVOLVEMENT IN STP IMPLEMENTATION

6.1 We are committed to ensuring that we effectively involve patients, service users and the public at every stage of STP implementation. To this end, we are taking the following steps in the short term:

- Establishing a Stakeholder Group (See section 3.2 above) to represent the views of the range of key stakeholders and advise the newly established STP Board. Although the membership has yet to be agreed, it is anticipated that the Stakeholder Group will include, for example, local government representation, NHS Governors, patient, carer and voluntary sector representation;

- Ensuring that there is patient, service user or voluntary sector representation on every *Fit for the Future* Delivery Group and 'live' Improvement Area Group;

- Putting in place training, guidance and support tools for colleagues involved in implementation;

- Ensuring that there is a communications specialist on every *Fit for the Future* Delivery Group and 'live' Improvement Area Group to advise and support best involvement practice as well as ensure that a Communication & Engagement Plan is developed and deployed;

- Working with Healthwatch who can advise on effective involvement and, in particular, facilitate access to specific and seldom heard groups; and

- When a Delivery Group/Improvement Area reaches a stage where PPI activity is required, ensuring that there is access to the extensive existing 'pools' of patients, service users and third/voluntary sector organisations who can be involved.

6.2 We recognise that we need to engage more widely than we have traditionally done and reach audiences that have not been heard to date. We will do this in a variety of ways, including:

- Exploiting the potential of social media to establish an on-going two-way dialogue with audiences that we would not routinely access e.g. teenagers and women aged between 30- 50;

- Use the facilitative input of organisations and groups that understand how to engage effectively with seldom heard groups e.g. Healthwatch and mental health charities;

- Promote the *Fit for the Future* website as the central point of contact with up-to-date information on activity and progress;

- Advertise opportunities for people to be involved; and

- Develop opportunities for individuals and groups to improve their involvement skills e.g. quality events, conference or guides.

7 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

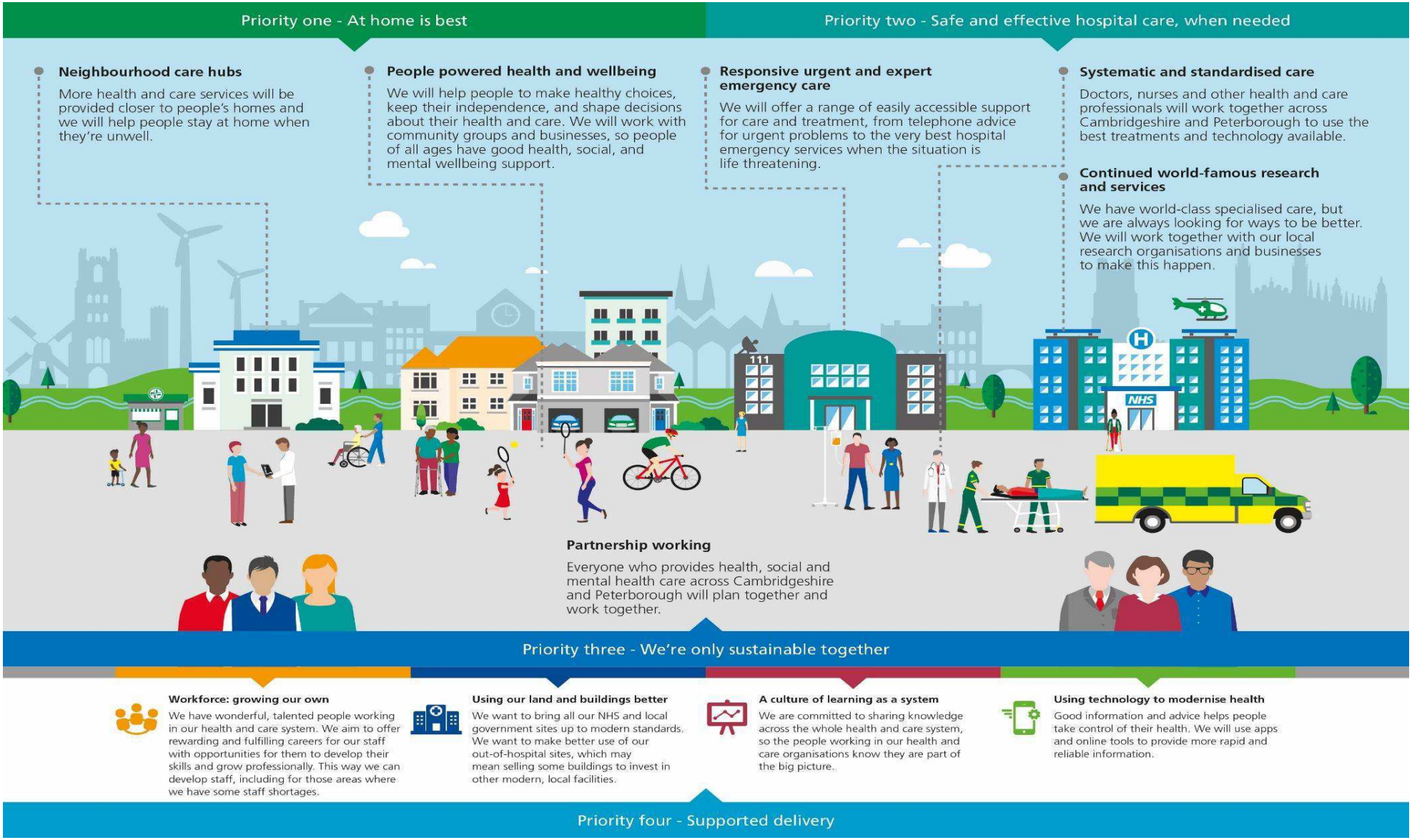
7.1 The STP is relevant to priorities 1, 2, 3, 4 and 6 of the Health and Wellbeing Strategy:

- Priority1: Ensure a positive start to life for children, young people and their families.
- Priority 2: Support older people to be independent, safe and well.
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.
- Priority 5: Create a sustainable environment in which communities can flourish.
- Priority 6: Work together effectively.

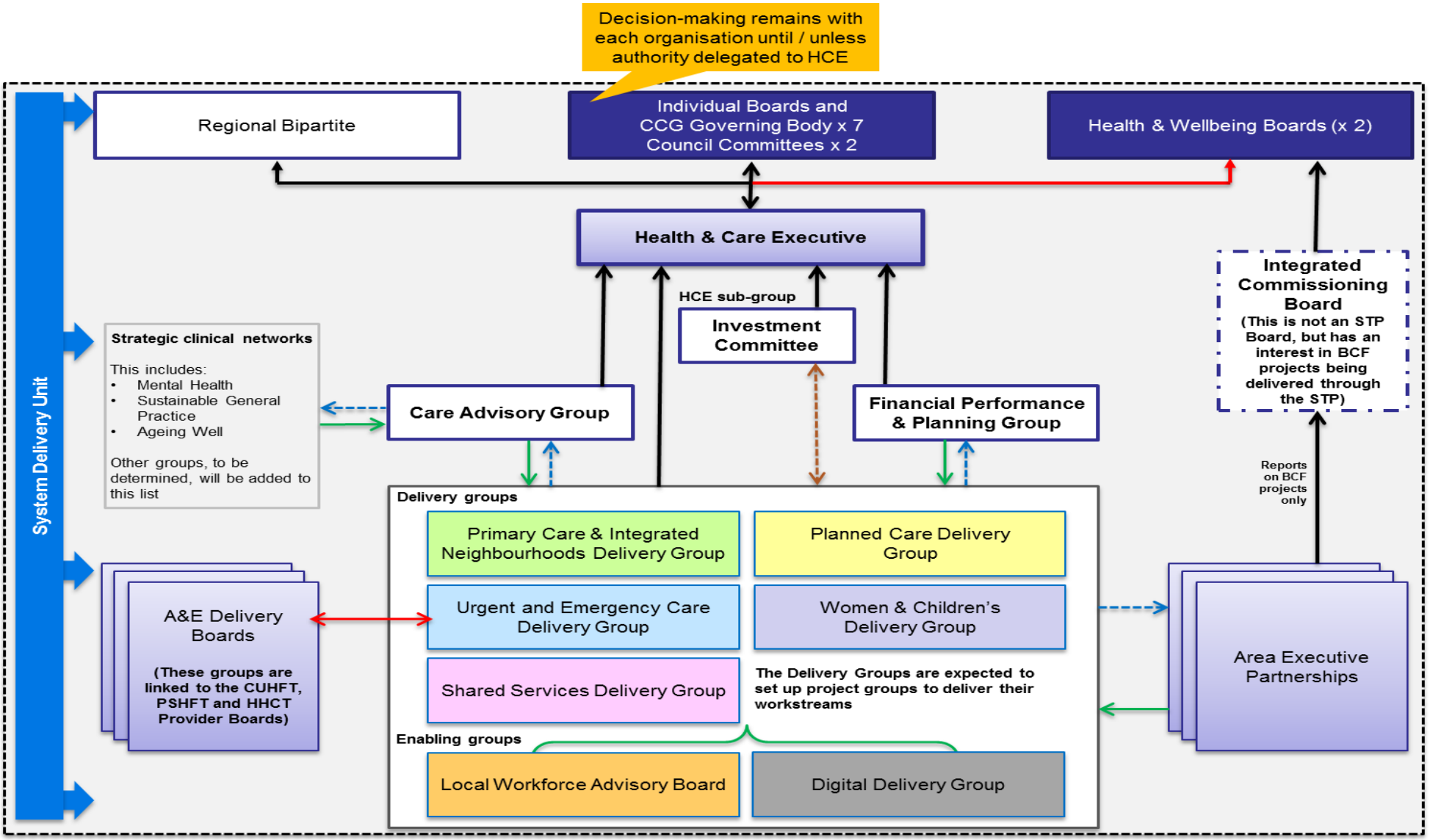
8 SOURCES

Source Documents	Location
Cambridgeshire & Peterborough STP	http://www.fitforfuture.org.uk/documents/cambridgeshire-peterborough-sustainability-transformation-plan-october-2016/
Cambridgeshire & Peterborough Local Digital Roadmap	http://www.fitforfuture.org.uk/documents/cambridgeshire-peterborough-local-digital-roadmap-january-2017/

ANNEX 1: Cambridgeshire & Peterborough *Fit for the Future* Priorities



ANNEX 2: *Fit for the Future* Delivery Governance Structure


Decision-making remains with each organisation until / unless authority delegated to HCE
System Delivery Unit
Regional Bipartite
Individual Boards and CCG Governing Body x 7 Council Committees x 2
Health & Wellbeing Boards (x 2)
Health & Care Executive
HCE sub-group
Investment Committee
Integrated Commissioning Board
(This is not an STP Board, but has an interest in BCF projects being delivered through the STP)
Strategic clinical networks
This includes:
• Mental Health
• Sustainable General Practice
• Ageing Well
Other groups, to be determined, will be added to this list
Care Advisory Group
Financial Performance & Planning Group
Reports on BCF projects only
Delivery groups
Primary Care & Integrated Neighbourhoods Delivery Group
Planned Care Delivery Group
Urgent and Emergency Care Delivery Group
Women & Children's Delivery Group
Shared Services Delivery Group
The Delivery Groups are expected to set up project groups to deliver their workstreams
Enabling groups
Local Workforce Advisory Board
Digital Delivery Group
A&E Delivery Boards
(These groups are linked to the CUHFT, PSHFT and HHCT Provider Boards)
Area Executive Partnerships

ANNEX 3: Purpose of each Group within the *Fit for the Future* Delivery Governance structure

1. Health and Care Executive (HCE)

Organisations from across the system have agreed to work together, taking joint responsibility for improving the population's health and wellbeing within a defined financial envelope. The Health and Care Executive (HCE) exists to provide strong, visible and collective leadership to this process.

The HCE's main purpose is to commission and oversee a programme of work that will deliver the *Fit for the Future* priorities:

Priorities for change	10 point plan
At home is best	People powered health and wellbeing Neighbourhood care hubs
Safe and effective hospital care, when needed	Responsive urgent and expert emergency care Systematic and standardised care Continued world-famous research and services
We're only sustainable together	Partnership working
Supported delivery	A culture of learning as a system Workforce: growing our own Using our land and buildings better Using technology to modernise health

2. Care Advisory Group (CAG)

The main purpose of the Care Advisory Group (CAG) is to contribute to the overall delivery of *Fit for the Future* objectives by reviewing care model design proposals, horizon scan for innovations, ensure that there is a robust evidence base behind decisions, and making recommendations to the HCE. Expertise and opinion will be represented and sought from the public, from health and care providers and from clinical experts. The CAG will prioritise clinical issues to be considered by HCE and make recommendations for their consideration.

3. Financial Performance and Planning Group (FPPG)

The main purpose of the FPPG is to contribute to the overall delivery of *Fit for the Future* objectives by promoting financial sustainability of health and care provision within the Cambridgeshire and Peterborough footprint.

The responsibilities of the FPPG are as follows:

- To ensure that proposals are affordable, efficient, and represent value for money;
- To ensure that investments reduce health inequalities;
- To ensure that financial incentives are aligned around minimising system costs; and
- To ensure that patient benefit is maximised.

4. Investment Committee (IC)

Organisations from across the system have agreed to work together, taking joint responsibility for improving the population's health and wellbeing within a defined financial envelope. In order to deliver this aim, a number of organisations in the system have committed to the creation and funding of an investment pot to fund some of the initiatives necessary to deliver the required change. The main purpose of the Investment Committee is to assess and evaluate Business Cases submitted for funding from this investment pot and, where supported, to recommend to the HCE for approval.

5. Delivery Groups

The structure includes the following Delivery Groups:

- Primary Care & Integrated Neighbourhoods;
- Urgent and Emergency Care;
- Planned Care;
- Women & Children's;
- Shared Services;
- Digital; and
- Local Workforce Advisory Board

The role of the Delivery Groups is to contribute to the overall delivery of *Fit for the Future* objectives by ensuring that the quality improvements and financial opportunities identified are realised. In particular, the delivery groups will be responsible for ensuring implementation (including savings realisation) of design projects, and delivery projects where implementation needs to happen consistently across the system.

6. Local Workforce Advisory Board (LWAB)

Critical to the successful delivery of *Fit for the Future* is the creation of an enabling workforce strategy for health and care. The Cambridgeshire and Peterborough Local Workforce Advisory Board (LWAB) has been established to create this strategy which will align and develop the local workforce to meet the priorities set out in *Fit for the Future*. The LWAB brings together health and care organisations and key stakeholders across a broad range of workforce issues, current and future, and its purpose is to ensure that the people elements of the 5 year service strategy can be identified and delivered.

7. Area Executive Partnerships (AEP)

Three Area Executive Partnerships have been established around the following areas: (1) Cambridge and Ely, (2) Huntingdon and Fenland and (3) Greater Peterborough. Their role is to contribute to the overall delivery of *Fit for the Future* objectives by providing strategic advice and local knowledge and expertise to the Delivery Groups within the structure. They have a key role to play in ensuring that the local context is factored into project design as well as a role to assist delivery by providing links to local groups, unblocking any issues related to the local context and helping the Delivery Groups to address local barriers to change. *[It should be noted that the role of AEPs and how they relate to District Council Local Health Partnerships has been reviewed to ensure that work is aligned and not duplicated]*

Each Area Executive Partnership:

- works with local communities (residents, patient groups, voluntary sector) and staff (primary care, NHS and local authorities) and develops an understanding of how to build capacity for proactively keeping people independent, well, and at home;
- provides a vehicle for strong and visible front-line clinical leadership and resident/ patient involvement; and
- promotes a culture of continuous quality improvement.

8. A&E Delivery Boards

Each A&E Delivery Board's main purpose is to:

- ensure urgent care needs are dealt with in the most appropriate setting by the most appropriate services (which in many cases should not be in A&E departments or acute hospital beds);
- provide a vehicle for strong and visible front-line clinical leadership and resident/ patient involvement; and
- promote a culture of continuous quality improvement

The A&E Delivery Boards are expected to oversee improvement projects that require locality tailoring for successful implementation. The over-arching guiding principle is that 'the same things are done differently' rather than 'different things are done' across Cambridgeshire and Peterborough.

Agenda Item No: 10

LOCAL AUTHORITIES AND HEALTH JOINT WORKING - UPDATE

To: **Health & Wellbeing Board**

Meeting Date: **6th July 2017**

From: **Mike Hill, Director, Health & Environmental Services, South Cambridgeshire District Council**

Recommendations: The Health & Wellbeing Board is recommended to:

a) Support the development of a "Living Well" Partnership Concordat to demonstrate commitment to "whole system" partnership working by all partner organisations involved in the delivery of Health & Wellbeing for Cambridgeshire residents, and so provide an alternative to signing the Sustainability & Transformation Plan Memorandum of Understanding;

b) Note progress to form joint "Area Delivery Partnerships" by merging Local Health Partnership and Area Executive Partnerships, as discussed at the Health & Wellbeing Board Development session in March 2017.

Officer contact:	
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Post:	Director, Health & Environmental Services, South Cambridgeshire District Council
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1.0 PURPOSE

1.1 To seek Health & Wellbeing Board support for the development of a "Living Well" Partnership Concordat to demonstrate commitment to "whole system" partnership working by all partner organisations involved in the delivery of Health & Wellbeing for Cambridgeshire residents

1.2 To note progress to form joint "Area Delivery Partnerships" by merging Local Health Partnership and Area Executive Partnership meetings, as discussed at the Health & Wellbeing Board Development session in March 2017.

2.0 BACKGROUND

2.1 To move towards a "whole system approach" to delivery of health and wellbeing of Cambridgeshire residents, the Cambridgeshire Public Service Board (PSB) and Health & Care Executive (HCE) have agreed to hold quarterly joint meetings to provide joined-up leadership and oversight of a range of projects and opportunities, including those under the Sustainability & Transformation Plan.

2.2 At its joint meeting on 25th May, and as part of the refresh of the Sustainability & Transformation Plan (STP) governance, the PSB & HCE agreed to develop a "Living Well" Partnership Concordat which all partner organisations could sign to demonstrate partnership commitment to a "whole system approach" to the delivery of health & wellbeing outcomes for Cambridgeshire residents.

2.3 For those partners yet to sign it, the "Living Well" Partnership Concordat would provide an alternative to the proposal to sign the STP Memorandum of Understanding (STP MoU), a matter which has previously been before the Health & Wellbeing Board. For clarity, the STP MoU remains in place for key partners who have chosen to sign it as it fulfils important financial and risk management purposes for the delivery of the STP.

2.4 A draft of a suggested "Living Well" Partnership Concordat will be developed by partners over the summer and presented to the Health & Wellbeing Board for comment in September 2017.

2.5 At its Development Day in March 2017, Health & Wellbeing Board discussed ideas to improve partnership working and reduce duplication and the number of meetings needed to deliver "whole system" health work. At its meeting on the 25th May, the PSB & HCE Chief Executives supported practical proposals to create 4 Area Delivery Boards (covering Peterborough, Huntingdonshire, East Cambridgeshire & Fenland, and Cambridge City & South Cambridgeshire) to oversee delivery of joint working by merging

(and ending) separate Local Health Partnership and STP Area Executive Partnership meetings and seek to align these better with Community Safety Partnership meetings. This will reduce the number of meetings from around 60 to 16. Terms of Reference and a Communications Plan for the new Area Delivery Partnerships are now being worked-up and it is anticipated that the new Area Delivery Boards will start work in September 2017.

2.6 There was general agreement amongst PSB & HCE Chief Executives that organisational structures and barriers need to be broken down to deliver what are clear, shared health and organisational outcomes and outputs. HCE & PSB agreed to focus a joint work programme on exploring ideas and opportunities for future Devolution deals, workforce & skills, procurement, estates and ICT. It was also agreed to map out all current partnership projects and shared outcomes to support improved joint programme management and delivery, to include more clinical / health improvement projects.

3.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

3.1 The proposals outlined will contribute to improved partnership working and delivery of Priority 6 “Work together effectively”.

4.0 IMPLICATIONS

4.1 The proposals outlined will reduce duplication and costs associated with Members and officers attending multiple meetings.

4.2 “Responsible Authorities” under the Crime & Disorder Act 1998 (as amended) will need to review their current arrangements for delivery of statutory Community Safety duties and how these may be impacted by the proposals outlined.

5.0 SOURCES

Source Documents	Location
Crime and Disorder Act 1998	http://www.legislation.gov.uk/ukpga/1998/37
Minutes of the Cambridgeshire Health and Wellbeing Board 19 January 2017	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/156/Committee/12/Default.aspx

RENEWING THE JOINT CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

To: **Health and Wellbeing Board**

Meeting Date: **06 July 2017**

From: **Dr Liz Robin, Director of Public Health**

Recommendations: **The Health and Wellbeing Board is asked to:**

a) **Approve the process and provisional timetable for renewing the Cambridgeshire Joint Health and Wellbeing Strategy as outlined in paragraph 4.1;**

b) **Approve the extension of the current Health and Wellbeing Strategy (2012-17) to May 31st 2018;**

c) **Provide any initial comments on the strategic approach and priorities which the HWB Board would wish to see in the new Joint HWB Strategy.**

Officer contact:	
Name:	Dr Liz Robin
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1. PURPOSE

1.1 The purpose of this report is to ask for the Health and Wellbeing Board's approval for the proposed process to renew the Cambridgeshire Joint Health and Wellbeing Strategy, and to receive an initial steer from the HWB Board on the approach to be taken and any key priorities.

2 BACKGROUND

2.1 The Cambridgeshire Health and Wellbeing Board has a statutory duty to prepare a Joint Strategic Needs Assessment of the health and wellbeing needs of the county's residents, and to prepare a Joint Health and Wellbeing Strategy to meet these needs.

2.2 The current HWB Strategy (attached at Appendix A) runs from 2012-2017 and therefore requires renewal this year. It was drafted as a high level strategy which identified priorities and areas of focus for health and wellbeing in the county, rather than specific strategic actions.

3.0 WIDER STRATEGIC LANDSCAPE

3.1 The strategic landscape has changed significantly since 2012 and there will be a number of issues for the HWB Board to consider when fulfilling its statutory duty to renew the HWB Strategy, in order for this activity to add value.

3.2 While health in Cambridgeshire remains better than the national average in terms of both life expectancy and healthy life expectancy, as would be expected from the county's relatively prosperous economy, there are several challenges to the health and care system:

- Meeting the health and care needs of a rapidly growing and ageing population
- Addressing significant health inequalities within the county
- Issues with recruitment and retention across health and social care
- Financial deficits in the local NHS and significant savings requirements across both local authorities and NHS organisations.

3.3 These challenges are being addressed through the Cambridgeshire and Peterborough Sustainable Transformation Partnership (STP) 'Fit for the Future' Plan, which runs for five years from 2016-21. A key consideration for renewing the Cambridgeshire HWB Strategy must be how this work will dovetail with and add value to STP planning and delivery.

3.4 Another major change has been the creation of a Combined Authority for Cambridgeshire and Peterborough. The current focus of the Combined Authority is on the Mayor's 100 Day Plan, which makes limited input to health and wellbeing issues. However, looking forward there is potential for devolution of powers to the Combined Authority to have a significant impact on strategies for health, wellbeing and care.

3.5 Finally there are a number of other strategies which could potentially dovetail with the Cambridgeshire HWB Strategy. These include Cambridgeshire and Peterborough wide strategies such as the Children and Young People's Emotional Health and Wellbeing Strategy; county-wide strategies such as the

draft multi-agency Healthy Weight strategy and the more local Health and Wellbeing Strategies led by District Councils.

3.6 Consideration of the role of the statutory Cambridgeshire Joint Health and Wellbeing Strategy in the context of the wider strategic landscape outlined above requires careful consideration before the process of renewing the HWB Strategy is started. This should ensure that the renewed HWB Strategy genuinely adds value and addresses HWB Board priorities, without duplicating other work.

4.0 PROPOSED PROCESS AND TIMETABLE

4.1 The proposed process for renewing the Cambridgeshire Joint Health and Wellbeing Strategy is outlined in the provisional timetable below. It starts with a development session for the HWB Board in early September, to ensure that the wider strategic landscape is considered and appropriate positioning for the HWB Strategy is defined by the Board.

Action	Date
Development session for HWB Board to discuss wider strategic landscape and positioning of the Cambridgeshire HWB Strategy, together with discussion of initial priorities.	Early September
Updated Summary of Cambridgeshire Joint Strategic Needs Assessment for health and wellbeing presented to HWB Board formal meeting.	September 21st (morning)
Wider Stakeholder Event to identify and test priorities for the HWB Strategy	September 21st (afternoon)
Presentation of consultation draft of HWB Strategy to HWB Board formal meeting.	November 23rd
Public and stakeholder consultation on the draft HWB Strategy	December 2017, January, February 2018
Final draft HWB Strategy (post-consultation) taken to organisational Boards and Committees for endorsement.	March, April 2018
Final draft HWB Strategy 2018-2021 approved by HWB Board formal meeting	31st May 2018

4.2 In order to follow the timetable outlined above, it will be necessary for the HWB Board to agree to extend the time period covered by the current Cambridgeshire Joint Health and Wellbeing Strategy 2012-2017 until May 31st 2018.

5 SOURCES

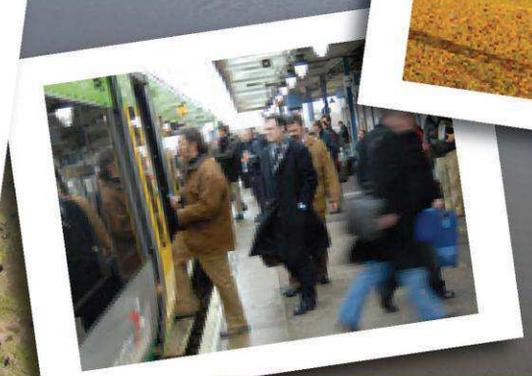
Source Documents	Location
Cambridgeshire & Peterborough Joint Health and Wellbeing Strategy 2012-17	Attached as Appendix A

Cambridgeshire County Council

Cambridgeshire Health & Wellbeing Strategy

2012–17

Updated May 2015



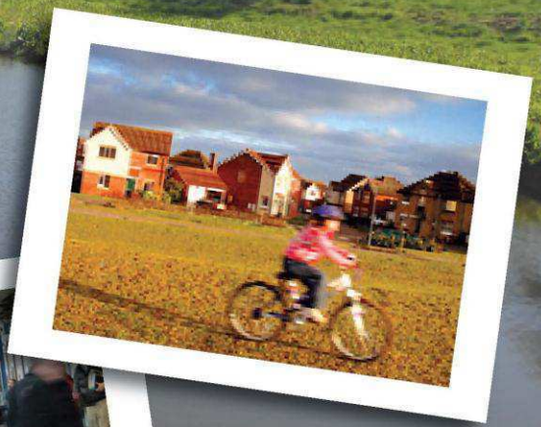


Table of Contents

For more information about the Cambridgeshire Health and Wellbeing Board please visit our webpages on the Cambridgeshire County Council website: **www.cambridgeshire.gov.uk**

Foreword

Good health and wellbeing is fundamental to enable us to live an active and fulfilled life and play a role in our local communities. In Cambridgeshire, we are fortunate to live in a part of the country where the health of local people is generally better than the England average. Whilst this is encouraging, it can mask some real challenges and marked differences between communities. We know that some local people experience significant disadvantage and inequalities in health, and our aim is to improve the health of the worst off fastest.

In our draft Health and Wellbeing Strategy published in June 2012, the Cambridgeshire Health and Wellbeing Board proposed five priorities where we can make the most difference to achieve better health and wellbeing outcomes for our communities. We carried out a public consultation from June to September 2012 to ask for your feedback and we received over 200 responses from individuals and groups throughout Cambridgeshire.

The overwhelming majority told us we have identified the right priorities for the Board and Network to work on over the next five years. This gives us confidence that this is a shared strategy and reflects what matters most to organisations and communities in Cambridgeshire.

In this revised strategy, we have stressed again the importance of supporting both physical and mental health for all residents – particularly for children and young people, the elderly and vulnerable individuals or groups. Throughout the strategy, links and synergies between each of the first five priorities are evident, as is the importance of prevention.

One strong theme from your feedback was that we need to find new ways to work together and to use resources in a different way, maximising the benefit for local people.In this time of financial constraint, we face significant challenges to manage public sector resources effectively while we continue to deliver the best outcomes for residents of Cambridgeshire. In response to this challenge and in recognition of your feedback, we have introduced a new sixth priority to the strategy: to work together more effectively and use resources differently.

Information about the health and wellbeing needs of Cambridgeshire has moved on since we first published this strategy in 2012, so we have updated some sections. These revised sections are all included in the refreshed Cambridgeshire Health and Wellbeing Strategy 2012-17, published in May 2015.

The Cambridgeshire Health & Wellbeing Board and Network have a unique and valuable role to play in addressing these priorities. We bring together leaders from key organisations to enable change, and are ideally placed to overcome barriers to working together, ensure services are joined up to help individuals and families, and deliver progress against these priorities.

This strategy is the first step in a bold vision to achieve change together. As we approach the end of the strategy's lifetime we will consider the impact the strategy has had and the progress against its six priorities. We will then turn our attention to the key health and wellbeing priorities for Cambridgeshire beyond 2017.

Councillor Tony Orgee
Chairman, Cambridgeshire Health & Wellbeing Board

1 Introduction

All aspects of our everyday life have an impact on our health and wellbeing: from health services through to our environment, housing, employment, education, transport and our involvement in local communities. This means that working to improve community health and wellbeing, whilst respecting people's personal lifestyle choices, is everybody's business and in everybody's interest.

Throughout Cambridgeshire each of our partner organisations have strategies and action plans to address specific health and wellbeing needs. We believe that the value of our role as a Health and Wellbeing Board and Network is in addressing issues we can influence the most **as a partnership**, for example:

- how we can identify and address the most important local needs, now and in the future;
- how we can build on the strengths in our communities and what is working well;
- how we can best protect or include the most vulnerable people in our communities;
- how we can work together at a time of public sector financial constraint to use our resources most efficiently;
- how working together can bring the most benefit to outcomes for Cambridgeshire residents.

Section 2 describes how we have developed this strategy and identified our key priorities. An important objective of the Health & Wellbeing Board is to communicate, listen and engage with the communities we serve. A public consultation was held on the draft strategy from June to September 2012 to seek feedback and views from across Cambridgeshire.

Section 3 describes our approach to physical and mental health and wellbeing. This strategy recognises the importance and interconnectedness of wider determinants on health and wellbeing and the importance of building public policy alongside local engagement with communities. We outline six cross-cutting principles which underpin the delivery of this strategy: we will strive to deliver equitable, preventative, evidence-based, cost-effective, empowering and sustainable solutions.

Section 4 describes key information about the health of our local population. We also recognise that there are variations across

Cambridgeshire and that different parts of the county will have different needs and priorities. This means that the immediate priorities and best solutions will often be derived through partnership working at a local level.

Section 5 sets out the six key priorities which the Health & Wellbeing Board and Network will focus on in the next five years and describes in more detail why each of these priorities is particularly relevant in Cambridgeshire.

Our next steps, outlined in **Section 6**, will be to identify what success in achieving these priorities will look like and how we will achieve this. We will define measurable outcomes, assess where we augment what is working well, help to unblock any barriers between agencies and identify collective actions and responsibilities to achieve these outcomes.

In May 2015 we published an updated version of the Cambridgeshire Health and Wellbeing Strategy 2012-17. This was to ensure the strategy still reflected the most important health and wellbeing priorities for the county. To do this we have included more up to date information and statistics about Cambridgeshire's communities and health needs, and we have identified a number of other strategies and action plans developed by our partners that are helping to address these needs.

2 How has the Health & Wellbeing Strategy been developed?

We have developed this strategy using:

a) National and local evidence of health needs as measured, analysed and reported in the Cambridgeshire Joint Strategic Needs Assessment

(http://www.cambridgeshireinsight.org.uk/jsna)

We used the Joint Strategic Needs Assessment (JSNA), which is an analysis of data, information, and intelligence from local and national sources, jointly produced by Cambridgeshire County Council and NHS Cambridgeshire and Peterborough Clinical Commissioning Group. The JSNA includes information about a wide range of health and wellbeing indicators, the views of the local people, and examples of effective practice along with identifying gaps and areas for development.

In this refreshed version of the Cambridgeshire Health and Wellbeing Strategy 2012-17, published in May 2015, we have also used information from JSNAs completed since this strategy was first published in 2012.

b) Existing local strategies and plans

We compiled a list of the strategies which are most relevant to health and wellbeing from county-wide or local partnerships, NHS organisations, and County and District councils.

In January 2015 the Health and Wellbeing Board agreed to adopt a number of our partners' strategies and action plans that help to address the needs identified in the most recent JSNAs. These 'delivery strategies' are an extension to the Cambridgeshire Health and Wellbeing Strategy 2012-17. The Health and Wellbeing Board will be kept informed of new delivery strategies that are developed which could help to address this strategy's priorities and will consider whether they should be adopted.
A list of strategies formally adopted as additions to this strategy are available to view on the Cambridgeshire Health and Wellbeing Board's webpages:
http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

c) Stakeholder event to identify the current priorities of local partnerships and organisations

We asked people from a range of different organisations and groups to use their local knowledge and expertise to identify key areas which are most important for health and wellbeing locally, and to think about what principles should guide decisions about priorities.

d) Public consultation

A public consultation on the draft strategy was held from June to September 2012, to find out whether we had identified the right priorities for the Health & Wellbeing Board to focus on. The methods of consultation included online and paper questionnaires and presentations to stakeholder groups.

Overall, most people (96%) were happy with the strategy and 81% felt this was the right vision for Cambridgeshire. A significant majority (over 92%) agreed that each of the 5 priorities proposed were appropriate for Cambridgeshire.

Over 70 specific comments are reflected in revisions to this final strategy and we received

over 130 suggestions for addressing these priorities which will help us at our implementation stage.

In response to public feedback, a sixth priority has been added to the final strategy, which commits the Health and Wellbeing Board and Network to working in new ways and using resources differently and innovatively in this time of financial constraint. Additional areas of focus have been added – recognising the importance of education to health and wellbeing in Priority 1, the importance of appropriate end of life care in Priority 2 and the prevention of mental health problems, as well as excess alcohol consumption in Priority 3.

For each priority it will be important to recognise the differing needs of specific groups such as military and ex-military personnel and their families and communities, prisoners and offenders, and those with physical or learning disabilities.

e) Community Impact Assessment

A Community Impact Assessment of this strategy has been conducted and is accessible on our Health & Wellbeing Board webpages on the Cambridgeshire County Council website. This is a process designed to evaluate the potential impacts on all individuals in Cambridgeshire and ensure that the strategy and associated actions do not discriminate against any disadvantaged or vulnerable people.

f) New information about our communities

We published an update to this strategy in May 2015 to reflect the changes in Cambridgeshire's communities and health needs since the strategy was first published, as well as to outline our approach of adopting relevant strategies and action plans developed in partnership that are helping to address these needs.

3 Our approach to improve health and wellbeing in Cambridgeshire

3.1 Our principles

Stakeholders from health and social care organisations, County and District Councils and local voluntary organisations agreed a number of principles which helped us to decide on the six priorities we will focus on in the next five years, and will inform how we work together and develop actions to achieve these priorities. These principles are:

1. **Reducing inequalities by improving the health of the worst off fastest**

Whilst working to improve everyone's health, we will strive to reduce inequalities in healthy life expectancy between communities by improving the health of the worst off fastest.

2. **Focusing on prevention**

Wherever possible we will take actions which support the prevention of poor health and wellbeing outcomes. This may be by encouraging and enabling healthy communities and lifestyles in general while respecting people's personal choices, or by supporting people with long term conditions, to prevent their health problems worsening.

3. **Using evidence-based practice and responding to local information**

We will use public health evidence and local information and views to make sure that we focus on the most significant health and wellbeing needs in Cambridgeshire and provide the best possible services and support. We will aim to build on what works and stop what isn't working.

4. **Developing cost-effective solutions and improving efficiency**

We will aim to use solutions which have the greatest impact for the most people, at the appropriate cost, taking account of the available resources and the constraints on public finances. We will try new approaches or ideas where there is a limited evidence base and support robust evaluation of services and programmes.

5. **Emphasising local action and responsibility**

Different age groups and communities will have different needs for information, prevention of poor health, and health and social care for the most vulnerable. This strategy recognises the importance of using local solutions. We will encourage individuals and communities to take responsibility for making healthy choices and identifying the services they need, and to build on existing strengths and resources in the community including local voluntary organisations. We will offer our residents choice, control and encourage their participation.

6. **Sustainability**

We will ensure that our services are sustainable, ensuring that changes are made which will create long term positive change, taking into account long term challenges.

3.2 Our model of health and wellbeing

Maintaining health and wellbeing is important for individuals to maximise their potential, enable them to lead active, fulfilled lives and participate fully in their local community. Physical and mental health are closely linked and both are important for wellbeing.

Figure 1 illustrates how lots of different aspects of our environment and community have a significant impact on our health and wellbeing and influence our behaviour. These include employment, education, housing, local community space or green areas, and transport. The health and behaviours of an individual are influenced more widely by the communities in which they live: their families or social networks, perception of safety and ability to contribute to the local neighbourhood. Our approach to health and wellbeing includes recognising that the best way to ensure participation, sustainability, and ownership of local initiatives is to work directly with local communities to enable them to develop local services and activities that are important to them and their community.

When people are experiencing problems with available to support people when they are their health or with caring for themselves, we needed. We will aim to ensure that these are will work together to ensure that appropriate integrated, and focussed on the needs of the local health and social care services are individual person.

Figure 1: Model of wider determinants of health & wellbeing

Source: Modified from Dahlgren & Whitehead's rainbow of determinants of health (G Dahlgren and M Whitehead, Policies and strategies to promote social equity in health, Institute of Futures Studies, Stockholm, 1991) and the LGA circle of social determinants (Available at: http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3511260/ARTICLE-TEMPLATE)

4 Information about Cambridgeshire

4.1 Who lives in Cambridgeshire?

Approximately 627,000 people live in Cambridgeshire. Of these, approximately 106,000 people are under 15 years of age, and 105,000 people are over the age of 65. Within the next five years, the population of Cambridgeshire is expected to grow further and by 2016 there are forecast to be another 28,000 people living in the county, with the largest increases expected in Cambridge City and South Cambridgeshire. We are expecting to see a significant rise in the population of older people across the whole county. Between 2016 and 2021 the number of people aged 65 and over in Cambridgeshire is predicted to increase by 13%.

Cambridgeshire County as a whole is among the 20% least socio-economically deprived top tier local authorities in England. At District Council level, there is variation; South Cambridgeshire and Huntingdonshire are both within the 20% least deprived second tier authorities nationally, while Fenland is in the 40% most deprived.

Most local authority areas in Cambridgeshire have a mainly white population. Cambridge City has higher proportions of minority ethnic groups than the England average, many of whom are students and professionals. Cambridgeshire is home to a number of military communities with specific health and wellbeing needs. Cambridgeshire also has a considerable number of Gypsies and Travellers and migrant workers within the county.

Some groups of people across the county are particularly vulnerable both to suffering from socio-economic deprivation and to the consequences of this deprivation. For example older people, people with disabilities, people who are on low incomes or unemployed, Gypsies and Travellers, homeless people and rural migrant workers.

4.2 How healthy are the people of Cambridgeshire?

In Cambridgeshire, overall health and life expectancy are well above the national average. Life expectancy at birth for men is 81.0 years and for women is 84.6 years. Death rates from all causes and early death rates from cancer, heart disease and stroke have fallen and are better than the England average. But these major diseases still have a considerable impact on health and wellbeing which could be reduced through healthier lifestyles and choices.

Within this picture, there are health inequalities across the county. These are closely linked with socio-economic circumstances and are more concentrated in Fenland, the north and east of Cambridge

City, North Huntingdon and the north of East Cambridgeshire, where lower levels of skills, income and greater health inequalities than the rest of Cambridgeshire are experienced. People in the more socioeconomically deprived areas of Cambridgeshire have a life expectancy which is 7.1 years lower for men and 5.0 years lower for women compared to people in the least deprived areas. Improving the health of the worst off fastest is a theme throughout this strategy.

More information about health in Cambridgeshire is available at www.cambridgeshireinsight.org.uk/jsna

4.3 How do we currently spend public money on health and social care in Cambridgeshire?

This Health and Wellbeing Strategy is being developed at a time of significant public sector financial restraint. A key aim of this strategy is to support public sector organisations to work and commission together so that their combined resources can be used to best effect to achieve outcomes for Cambridgeshire residents.

During the financial year 2013/14, NHS Cambridgeshire and Peterborough Clinical Commissioning Group spent £888 million on health services for Cambridgeshire and Peterborough patients. Over half of this spend was on hospital services (£495m, 56%), followed by primary care (£124m, 14%) which is mainly made up of the drugs prescribed by GPs. About a sixth of spend (£146m, 16%) was on community health services and a tenth (£93m, 10%) on mental health and learning disability services.

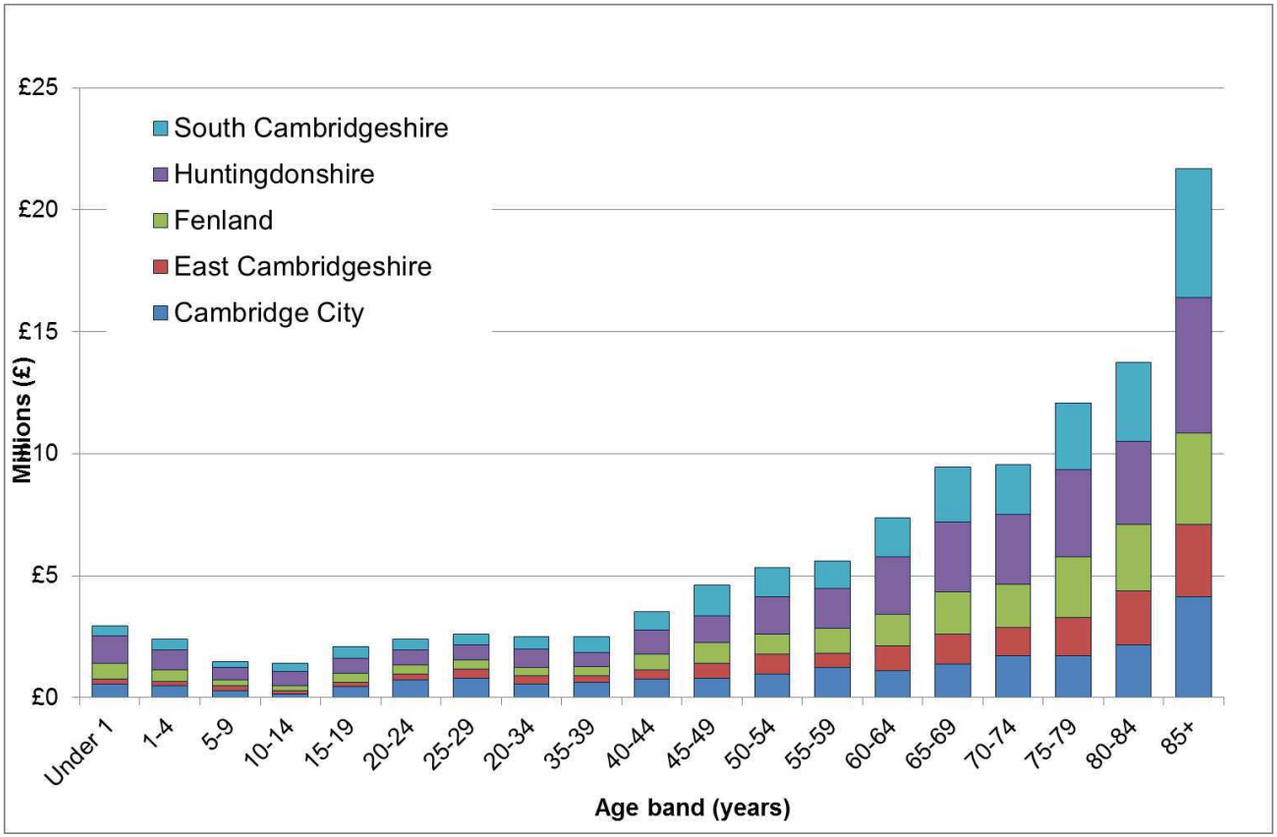


Figure 2: Unplanned (emergency) hospital admissions – total resource use by age group, 2013/14

Source: Admitted Patient Care Commissioning Data Set, Cambridgeshire and Peterborough CCG

The total adult social care budget for Cambridgeshire County Council for the financial year 2014/15 was £166 million. Of this, £74.6m (45%) was for social care for older people aged 65+ and over a third (£58m, 35%) was for social care for people with learning disabilities.

The budget allocation for Cambridgeshire County Council Children and Young People's Services for 2014/15 was £86 million, excluding direct spend on schools.

Over a tenth (£10.3m, 12%) was for looked after children, about a sixth (£14.4m, 17%) for other social care for children, including services for disabled children, and an eighth (£10.9m, 13%) was for locality teams, including children's centres and youth services, which provide preventive interventions for children, young people and their families.

In order to better understand how resources are currently used across different agencies and services to meet the needs of older people in Cambridgeshire, we carried out a JSNA Service and Financial Review, which gathered information from NHS services, adult social care, district councils and the voluntary sector. This showed that nearly half (45%) of resources used for NHS hospital care were for people aged 65+, which is to be expected as people are more likely to develop health problems and long term conditions with increased age. Further analysis showed that while resources used for planned hospital admissions were highest for people aged 60-74, resources used for unplanned hospital admissions (see Figure 2) and for placements in nursing and residential home care were highest for the very oldest age groups. This analysis raises the question of whether the needs of our most elderly and frail residents would be better met by shifting resources into more responsive and integrated health and social care services, based within communities.

5 Our priorities for health and wellbeing in Cambridgeshire

Priority 1

Ensure a positive start to life for children, young people and their families

- Strengthen our multi-agency approach to identifying children who are in poverty, who have physical or learning disabilities or mental health needs, or whose parents are experiencing physical or mental health problems.
- Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services.
- Support positive and resilient parenting, particularly for families in challenging situations, to develop emotional and social skills for children.
- Create and strengthen positive opportunities for young people to contribute to the community and raise their self esteem, and enable them to shape the programmes and services with which they engage.
- Recognise the impact of education on health and wellbeing and work to narrow local gaps in educational attainment.

Priority 2

Support older people to be independent, safe and well

- Promote preventative interventions which reduce unnecessary hospital admissions for people with long term conditions, enable them to live independently at home or in a community setting where appropriate and improve their health and wellbeing outcomes e.g. through falls prevention, stroke and cardiac rehabilitation, supporting voluntary organisations and informal carers.
- Integrate services for frail older people and ensure that we have strong community health, housing, voluntary support and social care services tailored to the individual needs of older people, which enable them to improve their quality of life and minimise the need for long stays in hospitals, care homes or other institutional care.
- Enhance services for the early prevention, intervention and treatment of mental health problems in older people, including timely diagnosis and joined up services for the care and support of older people with dementia and their carers.
- Ensure appropriate and person-centred end of life care for residents and their families and informal carers.

Priority 3

Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices

- Encourage individuals and communities to get involved and take more responsibility for their health and wellbeing.
- Increase participation in sport and physical activity, and encourage a healthy diet, to reduce the rate of development of long-term conditions, increase the proportion of older people who are active and retain their independence, and increase the proportion of adults and children with a healthy weight.
- Reduce the numbers of people who smoke.
- Promote individual and community mental health and wellbeing, prevent mental illness and reduce stigma and discrimination against those with mental health problems.
- Work with local partners to prevent hazardous and harmful alcohol consumption and drug misuse.
- Promote sexual health, reduce teenage pregnancy rates and improve outcomes for teenage parents and their children.

Priority 4

Create a safe environment and help to build strong communities, wellbeing and mental health

- Implement early interventions and accessible, appropriate services to support mental health, particularly for people in deprived areas and in vulnerable or marginalised groups.
- Work with partners to prevent domestic violence, raise public awareness especially amongst vulnerable groups, and provide appropriate support and services for victims of domestic abuse.
- Minimise the negative impacts of alcohol and illegal drugs and associated antisocial behaviour on individual and community health and wellbeing.
- Work with local partners to prevent and tackle homelessness and address the effects of changes in housing and welfare benefits on vulnerable groups.

Priority 5

Create a sustainable environment in which communities can flourish

- Develop and maintain effective, accessible and affordable transport links and networks, within and between communities, which ensure access to services and amenities and reduce road traffic accidents.
- Ensure that housing, land use planning and development strategies for new and existing communities consider the health and wellbeing impacts for residents in the short and long term.
- Encourage the use of green, open spaces including public rights of way, and activities such as walking and cycling.
- Seek the views of local people and build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion, and promote social inclusion of marginalised groups and individuals.

Priority 6

Work together effectively

- Commit to partnership working, joint commissioning and combining resources in new ways to maximise cost-effectiveness and health and wellbeing benefits for individuals and communities.
- Identify sustainable, long-term solutions to manage the increased demand on health and social care services.
- Encourage increased partnership working with research organisations to better inform the evidence base supporting the development and evaluation of future services.
- Encourage increased involvement of service user representatives and local groups in planning services and policies.
- Recognise the importance of the Voluntary and community sector and their valuable contribution to implementing the strategy.

Priority 1

5.1 Ensure a positive start to life for children, young people and their families

The Joint Strategic Needs Assessment (JSNA) for Children & Young People provides an overview of key issues and needs for children and young people currently living in Cambridgeshire. We know that the first few years of life have a significant impact on the health and wellbeing of children for the rest of their lives. It is therefore vitally important that we help to support the early development of healthy behaviours and foster a supportive community for parents and families, to give children the best opportunities in life. An essential component of this is positive and supportive parenting. This is particularly important for parents experiencing poor physical or mental health or in poverty. There is now a range of effective ways to support parents – from low-cost interventions for all parents, through to intensive programmes to support those families most in need.

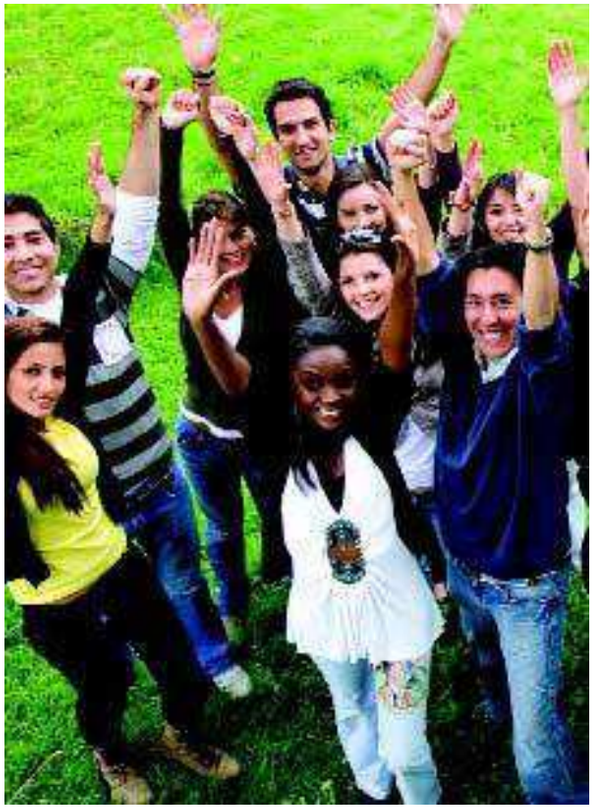
In Cambridgeshire, there are children growing up in poverty in every town and village. Despite the affluence of much of the population, there are pockets of real deprivation as well as disadvantaged families living within prosperous areas. Based on 2011 figures, 14,110 children (13.1% of the total) live in relative poverty (families whose income is at or below 60% of the national average) in Cambridgeshire[1]. This represents an increase from 12.5% in 2008. Children living in areas of deprivation are exposed to multiple social factors which adversely affect their health, educational attainment and life chances. Children from poorer families living in more prosperous areas are also at risk of poorer outcomes.

National evidence shows that children growing up in poverty are two and a half times more likely to suffer chronic illness and almost four times more likely to suffer mental health problems[2]. Looked-after children and young offenders are also particularly likely to have poor health outcomes[3].

Action to tackle poverty is a key strand within the Children's Trust programme and there are specific opportunities where the Health & Wellbeing Board and Network can encourage all partners to identify and reach families vulnerable to poverty or with high or complex needs. This includes both a concerted effort to identify children who are at risk of poverty or in challenging situations, tackling the challenges of worklessness, work poverty and poor housing, and working together to ensure these families can access effective, high-quality services and support.

The Mental Health of Children and Young People JSNA 2013 provides an overview of the key issues and needs relating to mental health for children and young people in Cambridgeshire.

[1] Cambridgeshire's Child Poverty Needs Assessment 2011. Available at: http://www.cambridgeshire.gov.uk/childrenandfamilies/providingchildrensservices/children/strategiesandplansforchildren/default.htm
[2] D.Hirsch and N. Spencer (2008), Unhealthy Lives: intergenerational links between child poverty and poor health in the UK
[3] JSNA Children & Young People. Available at: http://www.cambridgeshireinsight.org.uk/jsna



Mental health disorders in childhood can have high levels of persistence. Around 50% of lifetime mental illness starts before the age of 14 and continues to have a detrimental effect on an individual and their family for many years. Potentially, half of these problems are preventable.

Meeting the unmet mental health needs of children is important. In Cambridgeshire we will continue to strive to provide integrated multiagency services which address the physical and mental health and wellbeing needs of children, young people and their families through using tools such as the Common Assessment Framework. This also links closely to the importance of creating a safe and supportive environment and the positive effect on families of tackling drug and alcohol abuse and preventing abuse and neglect. In particular, domestic abuse can have a devastating impact on children and young people and is the most frequently reported reason for referrals to Children's services in Cambridgeshire.

These are specific areas of focus under Priority 4 which have a substantial effect on children, young people and their families. All of our partners are also committed to meeting their statutory requirements to ensure effective safeguarding of children and young people.

The Carers JSNA 2014 provides an overview of key issues and needs of carers, including young carers. According to the 2011 census, 4,208 young people under 25 years in Cambridgeshire provide unpaid care. 385 young people under 25 provide 50 or more hours care per week (including 92 under 16s). Young carers often take on practical and/or emotional caring responsibilities that would normally be expected of an adult. Joint working between services specifically working with young carers and mainstream preventive services for children and young people is needed to ensure that young carers are seen as a vulnerable group, their needs identified early and seen in the context of the whole family.

In Cambridgeshire, there are key inequalities in outcomes for children and young people, and these are demonstrated in a number of indicators, including attainment rates across all key stages of education, rates of unhealthy weight, childhood deaths and injuries3, and rates of young people becoming NEET (not in education, employment or training).

Cambridgeshire is experiencing rapid demographic growth and in parts of the county numbers of children are rising rapidly. The number of children with Special Educational Needs is also rising. It is not only an economic necessity, but critical to the best outcomes for these children that education, health and social care services work together to assess, plan and support these children and their families.

Tackling youth unemployment is important

if we are to grow the local economy, and increasing the participation of 16-18 year olds in education, work and training improves their life chances and makes a lasting difference.

Under 4% of 16- 19 year olds in Cambridgeshire are not in education, employment or training (NEET). For young people with learning difficulties and/or disabilities (LDD), this percentage rises to over 11%. Narrowing the Gap, Cambridgeshire's strategy to raise the attainment of vulnerable groups outlines key interventions to ensure all children achieve their potential.

[1]

Our focus will be to:

- Strengthen our multi-agency approach to identifying children who are in poverty, who have physical or learning disabilities or mental health needs, or whose parents are experiencing physical or mental health problems.
- Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services.
- Support positive and resilient parenting, particularly for families in challenging situations, to develop emotional and social skills for children.
- Create and strengthen positive opportunities for young people to contribute to the community and raise their self esteem, and enable them to shape the programmes and services with which they engage.
- Recognise the impact of education on health and wellbeing and work to narrow local gaps in educational attainment.

Priority 2

5.2 Support older people to be independent, safe and well

People in Cambridgeshire are living longer and the number of people over 65 is set to grow by approximately 37% in the next 10 years and 64% in the next 20 years. We know from the Joint Strategic Needs Assessment (JSNA) for Older People that most older people in Cambridgeshire are in good health, but over a lifetime can expect to spend longer in poor health and with disability than previous generations. This is because improved health over the years has allowed people to live longer too. Ageing is a success story although there are challenges associated with it.

The JSNA on Physical and Sensory Impairment and Long-Term Conditions provides local information on a variety of long term conditions, a large proportion of which affect people over 65 years. Although 40% of older people do not have a long term condition such as diabetes, hypertension, coronary heart disease or asthma, incidence of multiple long term conditions increases with increasing age. Many people live with a long term condition that limits their ability to cope with day to day activities. This is one of the main health challenges older people face: having to cope with more than one long-term condition. The Older People's Service and Financial Review analyses how different agencies use resources to meet the needs of our oldest residents and is described in 'Information about Cambridgeshire' (section 4.3 of this strategy). The report indicates that resources may need to be used differently to provide more responsive and integrated health and social care services, based in communities for our most elderly and frail residents.

We want to support older people in Cambridgeshire to live healthy lives, engaged and empowered to make decisions about their own health and wellbeing and play active roles within their local communities. In addition we want to continue providing services for older people that are effective, cost-effective and valued by service users and carers as the number of older people living in the county increases. This aim for the older population in Cambridgeshire drives two main themes:

- Prevention of ill health and promotion of good health (see also Priority 3);

- Reconfiguration and integration of services to support people to live safely and independently in a community setting as long as possible, avoid admission to hospital, and return to a community setting after discharge from hospital where appropriate.

We need to employ a whole system and life course approach to prevention, early intervention and cost-effective services to enable any individual requiring help to stay independent and well for as long as possible. One particular example is the prevention of falls. In the very elderly population (aged 85+), falls leading to hip fractures is the most common diagnosis for emergency admission to hospital. Compared to the East of England, Cambridgeshire has a higher number of falls amongst older people: around one third of people aged 65 and older, and one half of people aged 85 and older will fall once a year.

For frail older people with health and social care needs, we aim to integrate services across organisations to focus on the needs of the individual, ensuring that we have strong community health and social care services, which minimise the need for long stays in hospital or other institutional care and maximise the health and wellbeing of our older population. It is also important to ensure that support and multi-agency services are in place to provide appropriate end of life care.

Assuming prevalence rates remain the same as current rates, the Older People's Mental Health JSNA found that between 2012 and 2026, the number of older people with depression in Cambridgeshire is expected to rise by 12%, from approximately 11,900 to 13,360. The number of people over 65 years with dementia is expected to rise from 7,400 to 12,100; an increase of 64%. There is forecast to be a 43% increase in the number of older people with learning disability.

We know from the Carers JSNA that around 60% of carers are aged over 50. Carers over 65 are more likely to provide informal care for more than 50 hours per week than younger carers and are also more likely than other age groups to report their own health as 'bad' or 'very bad'. Carers are a valuable asset within our communities and need to be supported. This has been acknowledged by the Care Act 2014.

Older people in Cambridgeshire report that they are most concerned about income, transport and social inclusion, access to information on services and activities, housing and help in the home[4]. The role of communities is important. 85% of older people do not access social care services and most care and support provided to older people is unpaid and informal. The number of older people experiencing difficulty in managing alone at least one domestic task (for example shopping, jobs involving climbing, floor cleaning) is expected to almost double from 40,800 to 74,500 in the next 20 years. If current patterns of need and care are applied to the increasing numbers of older people, the provision of services will be unsustainable[5].

[4]JSNA Older People. Available at: http://cambridge.newcastlejsna.org.uk/webfm_send/143
[5]JSNA Older People. Available at: http://cambridge.newcastlejsna.org.uk/webfm_send/143

Older people make a valuable contribution to their local community. It is important that we capture contributions of older people and identify ways we can support, expand and utilise these assets in Cambridgeshire. Age should be celebrated.

This also links closely to ensuring a safe and accessible environment where older people can play an active role in community and local activities (closely linked to priorities 4 and 5).

Our focus will be to:

- Promote preventative interventions which reduce unnecessary hospital admissions for people with long term conditions, enable them to live independently at home or in a community setting where appropriate and improve their health and wellbeing outcomes e.g. through falls prevention, stroke and cardiac rehabilitation, supporting voluntary organisations and informal carers.
- Integrate services for frail older people and ensure that we have strong community health, housing, voluntary support and social care services tailored to the individual needs of older people, which enable them to improve their quality of life and minimise the need for long stays in hospitals, care homes or other institutional care.
- Enhance services for the early prevention, intervention and treatment of mental health problems in older people, including timely diagnosis and joined up services for the care and support of older people with dementia and their carers.
- Ensure appropriate and person-centred end of life care for residents and their families and informal carers.

Priority 3

5.3 Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices

There is good evidence of the links between lifestyle behaviours and health. Long term smoking causes a range of cancers and circulatory disease and reduces life expectancy by an average of ten years. Sedentary behaviour, poor diet and obesity are closely linked to the development of diabetes, heart disease, joint and back problems and depression. Use of alcohol above recommended limits leads to a range of longer term health problems including high blood pressure, liver disease and mental health issues, as well as often contributing to antisocial behaviour and crime in local communities.

We know from the Joint Strategic Needs Assessment (JSNA) on the Prevention of Ill Health in Adults of Working Age that a large number of people in Cambridgeshire have lifestyle factors which will adversely affect their health. Obesity both for children and adults, smoking rates, lack of physical activity and harm due to alcohol are all key areas where current levels are likely to have long term health consequences. InCambridgeshire about 14% of adults are smokers[6]: Fenland has the highest rates where 22% of the population is estimated to smoke. Alcohol-related admissions to hospital are high among residents of Cambridge and Fenland[7]. Estimates suggest that less than half of local adults eat more than five portions of fruit and vegetables per day and around 60% of adults have high levels of physical activity, with levels significantly lower in Fenland[8]. It is estimated that around 65% of adults are overweight or obese in Cambridgeshire[9], as well as 1 in 5 children aged 4-5 years and just under 1 in 3 children aged 10-11 years olds being overweight or obese[10].

Most of us know some of the everyday things we can do to improve our own health and life expectancy. Yet not everyone is able to make healthy decisions or adopt healthy behaviours. A number of factors can influence this from individual experiences to wider environmental factors which influence our behaviour such as the deprivation, the housing in which we live, transport that we can access, or community support we enjoy. These wider determinants of health are also closely linked to the gap in health between the rich and the poor. We know, for example, that as people become more affluent they are more likely to adopt healthy behaviours. Preventing ill health requires integrated approaches that bring together these wider determinants of health and how people choose to live their lives when healthy or when suffering from ill health.

A key aspect of prevention is taking pro-active steps to enable and encourage people in all age groups to have an active and healthy lifestyle, particularly those who are at a higher risk of ill health. The Primary Prevention of Ill Health in Older People JSNA found that there are health and wellbeing benefits to be experienced by older adults in Cambridgeshire through modifying health behaviours that affect lifestyles, with the key message being; it is never too late to make a positive change. A broad range of options and opportunities to promote a healthier lifestyle need to be available and accessible for all local communities.

[6]Source: Public Health England Public Health Outcomes Framework –Integrated Household Survey 2013
[7]Source: Public Health England Local Alcohol Profiles for England, 2014
[8]Source: Public Health England Public Health Outcomes Framework
[9] Source: Public Health England Public Health Outcomes Framework
[10]Source: Public Health England Public Health Outcomes Framework

This includes behavioural change approaches and changes in the environment or access opportunities, that make it easier for changes to be made by individuals and communities. It is also important that options are available for those with special circumstances, such as children and adults with physical or learning disabilities.

Regular physical activity can reduce the risk of many chronic conditions, including mental health problems. Sport and physical activity can also provide individual, family and community support and resilience, as well as development of personal and social skills and relationships. There are opportunities to promote physical activity through working with schools and local communities, through enabling transport networks and access to parks, green spaces or local countryside including public rights of way – this also links closely to Priority 5.

Encouraging healthy lifestyles and behaviours in children can have a big impact, as it is likely that these habits and activities will last a lifetime. Childhood obesity and teenage smoking are considerable challenges that can be met by schools, health services, social care services, environment teams and local communities working closely together, encouraging peer support and leadership from children and young people themselves.

Raising awareness of risks and early signs of disease so that early treatment can be given, can help to improve both physical and mental health. The way treatment or care is provided should enable people to have control over their own health and health care and to minimise the impact of ill health on their lives. People who already have health problems can benefit from support to help them make lifestyle changes such as increasing their physical activity which can slow or halt the rate at which these problems worsen.

Consumption of alcohol above the recommended safe limits causes a range of adverse impacts on health. Cambridge city has a higher rate of alcohol-specific hospital admissions for both adults and young people under the age of 18. The county also records a higher number of

alcohol-attributed recorded and violent crimes8. Priority 4 also considers alcohol and drug misuse and the impacts of these lifestyle choices not only on individual health, but on community health, safety and resilience.

The promotion of sexual health is especially important where there is a clear link with poverty and social exclusion. Promotion of sexual health also raises particular issues for vulnerable teenagers such as those with learning disabilities. Teenage pregnancy remains a priority for action, associated with health inequalities and poor social, economic and health outcomes for both mother and child. Despite the fact that teenage pregnancy rates in Cambridgeshire remain below the national average, there is still room to reduce them and opportunities to better support teenage parents and their children.

Our focus will be to:

- Encourage individuals and communities to get involved and take more responsibility for their health and wellbeing.
- Increase participation in sport and physical activity, and encourage a healthy diet, to reduce the rate of development of long-term conditions, increase the proportion of older people who are active and retain their independence, and increase the proportion of adults and children with a healthy weight.
- Reduce the numbers of people who smoke.
- Promote individual and community mental health and wellbeing, prevent mental illness and reduce stigma and discrimination against those with mental health problems.
- Work with local partners to prevent hazardous and harmful alcohol consumption and drug misuse.
- Promote sexual health, reduce teenage pregnancy rates and improve outcomes for teenage parents and their children.

Priority 4

5.4 Create a safe environment and help to build strong communities, wellbeing and mental health

As described in the Mental Health Joint Strategic Needs Assessment (JSNA), supporting good mental health and emotional wellbeing are fundamental to achieving good health, wellbeing and quality of life. Mental wellbeing impacts on how we think, feel, communicate and understand. It enables us to manage our lives successfully and live to our full potential. Mental health and physical health are strongly linked. Coping with a physical problem such as a long term condition can contribute significantly to mental health and wellbeing. Conversely, over two thirds of people with a persistent mental health problem also have a long-term physical complaint.

Actions to develop sustainable, cohesive and connected communities have an important role in promoting good mental health and wellbeing. For example, there is evidence that strong social networks help to protect people against physical and mental health stressors.

Promoting individual and community resilience to adversity is a key priority in preventing mental health problems, strongly linked with Priority 3. As well as stressing the importance of addressing wellbeing needs for the whole population, it is important to give attention to the wellbeing of people with serious mental health problems. Community support and local services are also important for the ongoing support and rehabilitation for people with lifelong mental health problems to prevent or minimise disability for them and their families or informal carers.

It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Gypsies and Travellers, migrant workers, prisoners, people with substance misuse problems and people with learning disabilities are at increased risk of mental ill health and may have difficulty accessing services and health promotion[11]. Migrant workers and black and minority ethnic communities are also vulnerable and may have barriers to accessing mental health services. Individuals in military or ex-military communities may be isolated or have difficulty accessing appropriate services.

Many of the risk factors for mental health and illness are linked to socioeconomic circumstances. There is more work to be done in mapping areas of deprivation and ensuring that mental health service provision is targeted appropriately. We also know that chronically excluded homeless people often have poor outcomes, poor physical and mental health, and drug, alcohol and social problems[12]. Making the transition out of

[11] JSNA Mental Health. Available at: http://cambridge.newcastlejsna.org.uk/webfm_send/58

homelessness can be an intensely difficult process and their complex needs require well-co-ordinated services and support from a variety of different organisations.

Many interventions can have a positive impact throughout the spectrum of mental health and wellbeing needs. Interventions to increase individual, family and community resilience against mental health problems include those which reduce inequalities, prevent violence, reduce homelessness, improve housing conditions, support debt management, and promote employment.

A persistent theme from both the data trends and the community consultation is that despite the generally positive wellbeing and health statistics for Cambridgeshire as a whole, the current economic climate has created some new areas of concern. Unemployment rates, benefits claims, and debt, all may impact on people's mental health and longer term physical health.

There is early evidence of an increase in levels of poor mental health amongst vulnerable parents for example. There is also a particular concern with the availability and affordability of housing, with increasing levels of fuel poverty, and the effects of changes to the benefits system. The Autism, Personality Disorders and Dual Diagnosis JSNA found that by 2026, there are expected to be about 2,000 people in the county with borderline personality disorder, about 1,600 with anti-social personality disorder and about 5,100 with autism spectrum conditions.

Part of maintaining resilience involves creating a safe environment for residents to participate in community activities and particularly for children to have safe places to play and access to positive activities[13]. Crime, particularly violent crime, is linked to mental health. They may have similar determinants such as drugs, alcohol and deprivation and victims of crime are more likely to suffer mental health problems such as depression. In addition to the impact alcohol can have on the health of an individual, alcohol misuse increases the risk of an individual becoming involved in crime, either as a victim or offender.

Antisocial behaviour has also been identified as an area of concern for local communities and can force some individuals or communities to live in fear and social isolation. We will work together with the police and criminal justice system in Cambridgeshire to address these issues and improve community safety.

Tackling this involves understanding why people (especially young people) commit crime or act antisocially and engaging with communities to encourage social responsibility.

Our focus will be to:

- Implement early interventions and accessible, appropriate services to support mental health, particularly for people in deprived areas and in vulnerable or marginalised groups.
- Work with partners to prevent domestic violence, raise public awareness especially amongst vulnerable groups, and provide appropriate support and services for victims of domestic abuse.
- Minimise the negative impacts of alcohol and illegal drugs and associated antisocial behaviour on individual and community health and wellbeing.
- Work with local partners to prevent and tackle homelessness and address the effects of changes in housing and welfare benefits on vulnerable groups.

[11] JSNA Mental Health. Available at: http://cambridgeshireinsight.org.uk/jsna
[12] JSNA for people who are homeless or at risk of becoming homeless. Available at: http://www.cambridgeshireinsight.org.uk/jsna
[13] The Big Plan 2: www.thebigplan2.co.uk

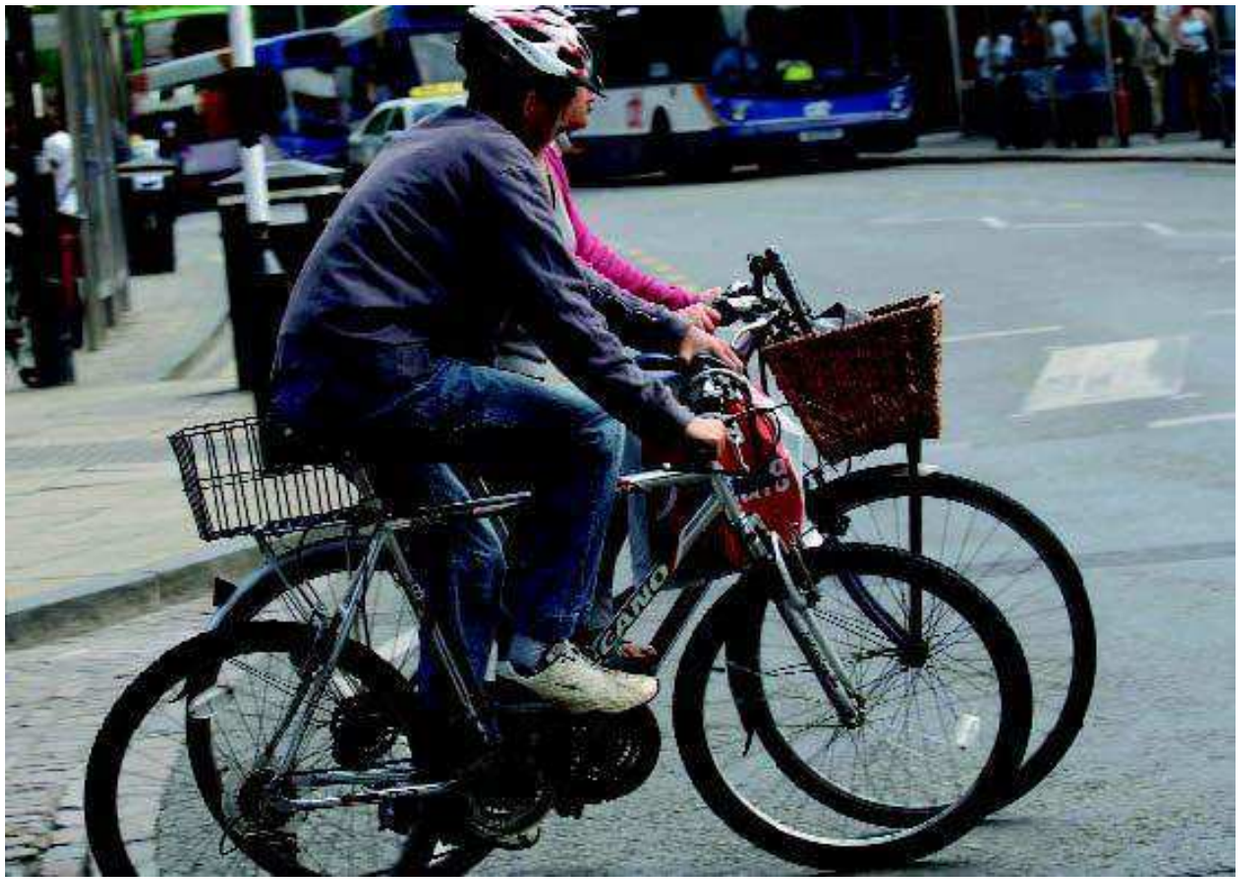
There are many types of abuse or neglect, but domestic abuse continues to be a particular problem. According to the Cambridgeshire Domestic Abuse Needs Assessment 2013, 7,620 incidents of domestic violence/abuse were reported to Cambridgeshire Constabulary. Domestic violence is the most common form of violence in rural areas and is the most frequently reported reason for referrals to Children's services in Cambridgeshire.

In November 2014 at an event hosted by the Police and Crime Commissioner, senior leaders from across the county signed the Cambridgeshire and Peterborough Mental Health Crisis Care Concordat Declaration. The declaration sets out how local agencies will work together to support people experiencing mental health crisis. Improved information sharing and partnership working, prevention and early intervention are just some of the commitments made in Cambridgeshire and Peterborough's Mental Health Crisis Care Concordat Declaration.

5.5 Create a sustainable environment in which communities can flourish

It is recognised that transport, green spaces and the built environment play a key role in determining our health and wellbeing. The importance of the wider local economy and the health benefits to individuals of being in employment are also well known. The New Communities Joint Strategic Needs Assessment (JSNA) describes how the quality of our communities' health and wellbeing is linked to the quality of their environment. For example:

- Good quality, affordable and accessible housing is important to people's health and wellbeing including adapting homes to meet the needs of people as they age or develop a disability;
- Exposure to green spaces is good for health, can improve mental wellbeing and may stimulate more social contact;
- Transport planning can enhance health by promoting active transport (such as cycling and walking), reducing road traffic accidents, facilitating social interaction, and improving access to green spaces, fresh food and other amenities and services that promote health and wellbeing;



- Building structures and transport systems that reduce or minimise air and noise pollution have clear health benefits in terms of respiratory illness and stress related conditions;
- It is critical to provide good community facilities for young families moving into new communities with lots of open play space, as this minimises the chances of isolation and depression;
- The provision of safe, continuous cycling and walking networks can also help to improve quality of life and wellbeing of vulnerable groups in the community such as young people and help them to access key services such as health care, leisure and recreational facilities.

The Housing and Health JSNA considered the relevance of health and wellbeing to each of the seven broad housing priorities for Cambridgeshire agreed by the Cambridge sub-regional housing board. These are to:

- Deliver new homes to support economic success.
- Enable better health and wellbeing through housing, affordable housing and housing-related support.
- Create mixed, balanced, sustainable and cohesive communities.
- Improve standards in existing homes and encourage best use of all housing stock.
- Extend housing choice and meet housing need.
- Prevent and tackle homelessness.
- Promote the benefits good partnership working can bring to housing- related issues.

The key findings of the JSNA focused heavily on partnership working, building networks, learning from each other, and sharing information, while addressing new challenges due to organisational change.

We will continue to work with District Councils and with housing providers including registered social landlords to consider the short and long term impacts of housing on the physical and mental health and wellbeing of residents. We will ensure that health and wellbeing is an integral part of our planning process for new communities or new environmental spaces. We will recognise the importance of lifetime homes on large scale housing developments so people are not excluded by design when they become older or frailer. We will recognise the importance of ensuring access to green spaces and support to develop community networks at an early stage.

Ability to access transport, particularly in rural areas, determines the extent to which individuals and families of all ages are able to access the facilities that enable them to have a good quality of life and contribute to and benefit from the local economy. This includes access to education, training, employment, health and social care services, recreation, and may also affect people's ability to access their social networks or activities, which are important for maintaining mental and physical health. Nearly one in five of Cambridgeshire's population do not have access to a car or van. The County Council's Local Transport Plan sets out the vision that no one in the county is unable to access the services and facilities they need to participate in community life, take advantage of life choices and to lead a healthy lifestyle because they do not have access to a car.

Our focus will be to:

- Develop and maintain effective, accessible and affordable transport links and networks, within and between communities, which ensure access to services and amenities and reduce road traffic accidents.
- Ensure that housing, land use planning and development strategies for new and existing communities consider the health and wellbeing impacts for residents in the short and long term.
- Encourage the use of green, open spaces including public rights of way, and activities such as walking and cycling.
- Seek the views of local people and build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion, and promote social inclusion of marginalised groups and individuals.

The Health and Wellbeing Board and Network recognises that partners need to work together to ensure services are provided in such a way that transport is not considered a barrier to accessing them.

Another important influence of transport on health and wellbeing is road safety. Although it has reduced, the number of people killed or seriously injured on Cambridgeshire roads remains statistically higher than the England and East of England average[14]. We will continue our efforts to reduce these unnecessary deaths.

We recognise that new communities do not develop in isolation from existing communities and the character of new communities is determined by much more than the physical infrastructure. Community development approaches enable people to work together to seek changes and solutions in their environment as part of a bottom up rather than top down approach. Sharing community resources and supporting systems that promote mutual support are crucial in developing this social capital (linked to Priority 4).

Stronger community networks play an essential role in supporting and encouraging vulnerable families and individuals. Good communications using existing networks and routes are central in promoting this type of community-based prevention linked to health and wellbeing matters within Community Plans.

[14]ERPHO Fingertips – Health & Wellbeing Indicators Profile for the East of England. Available at: http://fingertips.erpho.org.uk/key

Priority 6

5.6 Work together effectively

In many ways, priorities 1 – 5 are not new. Health and social care organisations have been striving to achieve these changes for a long time. What is new is the ambition of the Health and Wellbeing Board and Network to achieve some of these priorities through organisations working together in new ways or with fresh approaches. It is important that we continue to challenge our ways of working and understand whether we are using the right approach and how we can more effectively link together.

To improve health and wellbeing and improve the health of the worst off fastest we will need to think about the whole picture and how we can shape the services and support we provide to meet the needs of different communities. This strategy also emphasises the importance of building health and wellbeing into all public policies and services.

Many organisations that are not directly funded by the health sector make a considerable contribution to the health and wellbeing of local people, often by helping to prevent people becoming unwell. The County Council and local NHS will work closely with our partners in District Councils and Local Health Partnerships, Cambridgeshire Constabulary and Criminal Justice System, the voluntary sector and local community groups. This includes working closely with the different partnership groups and boards across Cambridgeshire which are relevant to health and wellbeing.

We will continue to engage and involve all partners and the local community in decision making and strive for open, honest conversations. We aim to maximise effective health networks across Cambridgeshire to ensure effective communication and better outcomes for local residents. We also recognise the importance of the voluntary and community sector and their valuable contribution to implementing the strategy.

This strategy is being developed during a period of public sector resource constraint. To make a difference we will need to change the way we use resources and re-think how we commission and deliver services across health and social care and other relevant services, in order to achieve better outcomes and effectively meet increasing levels of need. Managing the rising demand for health and social care to meet the needs of our ageing population (described in Section 4) is a significant challenge.

Our focus will be to:

- Commit to partnership working, joint commissioning and combining resources in new ways to maximise cost-effectiveness and health and wellbeing benefits for individuals and communities.
- Identify sustainable, long-term solutions to manage the increased demand on health and social care services.
- Encourage increased partnership working with research organisations to better inform the evidence base supporting the development and evaluation of future services.
- Encourage increased involvement of service user representatives and local groups in planning services and policies.
- Recognise the importance of the Voluntary and community sector and their valuable contribution to implementing the strategy.

In particular, focussing on prevention in a meaningful way requires investment. Although this is likely to lead to longer term improvement in health and wellbeing, alongside savings in health and social care, it may require difficult decisions to shift resources away from more acute care in the short term. We aim to find new ways of working with aligned or shared budgets and using our combined resources more effectively together, to get best value across the local public sector.

When considering commissioning of services from the community sector, where possible we will enter into joint funding arrangements with those statutory agencies already providing funding to add value and avoid duplication of monitoring and reporting.

6 Implementing the strategy: Next steps

This strategy is the first step towards seeing real results from the partnership of the Health and Wellbeing Board and Network. It forms the basis for guiding our focus as a Board and Network over the next five years. It will be reviewed and updated periodically to reflect progress and in light of new information.

Inclusion in the strategy will add impetus and support to effective work that is already underway, and lead to identification of gaps and issues which are currently blocking progress where this is relevant.

Through bringing together leaders from the local health and social care economy, the Health and Wellbeing Board and Network aims to enable and encourage more effective partnership working. The Board and Network will add most value where priorities benefit from more collaborative working across different organisations, and where resources could be used more efficiently through joint commissioning or other forms of partnership working.

The Health and Wellbeing Strategy will also help to inform the strategic and annual plans of the Cambridgeshire and Peterborough Clinical Commissioning Group. In this way, we can support clinical commissioning in the NHS to reflect the wider health needs of our community.

The broad priorities in this strategy will be supported by more detailed outcome measures against which we can compare our current situation and future progress. These measures will offer specific direction for each priority, which can be monitored over time.

Key to our success in delivering outcomes for local residents will be commitment from a range of organisations to clear and coherent joint action plans, including plans to align commissioning across organisations and use resources differently.

This strategy was updated in May 2015 to reflect new information about Cambridgeshire's communities and health needs. The Cambridgeshire Health and Wellbeing Board has adopted a number of its partners' strategies and plans that are taking action to address some of these recently identified health needs. These are in essence, additions and extensions to this strategy.

The Health and Wellbeing Board will be kept informed of new strategies and plans that are developed which could help to address this strategy's priorities and will consider whether they should be adopted.

A list of strategies formally adopted as additions to this strategy are available to view on the Cambridgeshire Health and Wellbeing Board's webpages: http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

Cambridgeshire Health & Wellbeing Board and Network will focus on these six priorities to improve the physical and mental health and wellbeing of Cambridgeshire residents. In particular, within each of these priorities, we will work to improve the health of the poorest fastest.

Priority 1

Ensure a positive start to life for children, young people and their families

- Strengthen our multi-agency approach to identifying children who are in poverty, who have physical or learning disabilities or mental health needs, or whose parents are experiencing physical or mental health problems.
- Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services.
- Support positive and resilient parenting, particularly for families in challenging situations, to develop emotional and social skills for children.
- Create and strengthen positive opportunities for young people to contribute to the community and raise their self esteem, and enable them to shape the programmes and services with which they engage.
- Recognise the impact of education on health and wellbeing and work to narrow local gaps in educational attainment.

Priority 2

Support older people to be independent, safe and well

- Promote preventative interventions which reduce unnecessary hospital admissions for people with long term conditions, enable them to live independently at home or in a community setting where appropriate and improve their health and wellbeing outcomes e.g. through falls prevention, stroke and cardiac rehabilitation, supporting voluntary organisations and informal carers.
- Integrate services for frail older people and ensure that we have strong community health, housing, voluntary support and social care services tailored to the individual needs of older people, which enable them to improve their quality of life and minimise the need for long stays in hospitals, care homes or other institutional care.
- Enhance services for the early prevention, intervention and treatment of mental health problems in older people, including timely diagnosis and joined up services for the care and support of older people with dementia and their carers.
- Ensure appropriate and person-centred end of life care for residents and their families and informal carers.

Priority 3

Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices

- Encourage individuals and communities to get involved and take more responsibility for their health and wellbeing.
- Increase participation in sport and physical activity, and encourage a healthy diet, to reduce the rate of development of long-term conditions, increase the proportion of older people who are active and retain their independence, and increase the proportion of adults and children with a healthy weight.
- Reduce the numbers of people who smoke.
- Promote individual and community mental health and wellbeing, prevent mental illness and reduce stigma and discrimination against those with mental health problems.
- Work with local partners to prevent hazardous and harmful alcohol consumption and drug misuse.
- Promote sexual health, reduce teenage pregnancy rates and improve outcomes for teenage parents and their children.

Priority 4

Create a safe environment and help to build strong communities, wellbeing and mental health

- Implement early interventions and accessible, appropriate services to support mental health, particularly for people in deprived areas and in vulnerable or marginalised groups.
- Work with partners to prevent domestic violence, raise public awareness especially amongst vulnerable groups, and provide appropriate support and services for victims of domestic abuse.
- Minimise the negative impacts of alcohol and illegal drugs and associated antisocial behaviour on individual and community health and wellbeing.
- Work with local partners to prevent and tackle homelessness and address the effects of changes in housing and welfare benefits on vulnerable groups.

Priority 5

Create a sustainable environment in which communities can flourish

- Develop and maintain effective, accessible and affordable transport links and networks, within and between communities, which ensure access to services and amenities and reduce road traffic accidents.
- Ensure that housing, land use planning and development strategies for new and existing communities consider the health and wellbeing impacts for residents in the short and long term.
- Encourage the use of green, open spaces including public rights of way, and activities such as walking and cycling.
- Seek the views of local people and build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion, and promote social inclusion of marginalised groups and individuals.

Priority 6

Work together effectively

- Commit to partnership working, joint commissioning and combining resources in new ways to maximise cost-effectiveness and health and wellbeing benefits for individuals and communities.
- Identify sustainable, long-term solutions to manage the increased demand on health and social care services.
- Encourage increased partnership working with research organisations to better inform the evidence base supporting the development and evaluation of future services.
- Encourage increased involvement of service user representatives and local groups in planning services and policies.
- Recognise the importance of the Voluntary and community sector and their valuable contribution to implementing the strategy.

Cross cutting principles: Equitable • Evidence-based • Cost-effective • Preventative • Empowering • Sustainable

CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD
FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	
6 July 2017 10.00am (Kreis Viersen Room, Shire Hall, Cambridge)	**Health and Wellbeing Board**		
	Notification of the Appointment of the Chairman	Oral (for noting only)	**Reports to Richenda Greenhill by Friday 23 June 2017**
	Election of Vice-Chairman/woman	Oral	
	Apologies for Absence and Declarations of Interest	Oral	
	Minutes of the Meeting on 30 March 2017 and the Extraordinary Meeting 27 April 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story: To provide context to the Cambridgeshire Safeguarding Adults Board Annual Report (*verbal report*)	Claire Bruin	
	Safeguarding Adults Board Annual Report for 2016-17	Russell Wate, Independent Chairman, Cambridgeshire Safeguarding Adults Board	
	Pharmaceutical Needs Assessment 2017	Katie Johnson	
	Sustainability and Transformation Plan: Update Report	Scott Haldane	
	Sustainability and Transformation Plan Memorandum of Understanding: Update	Mike Hill	
	Renewing the Joint Cambridgeshire Health and Wellbeing Strategy	Dr Liz Robin	

MEETING DATE	ITEM	REPORT AUTHOR	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting		
21 September 2017 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 8 September 2017**
	Minutes of the Meeting on 6 July 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story – Children's Emotional Health and Wellbeing	tbc	
	Local Safeguarding Children's Board Annual Report 2016-17	Andy Jarvis	
	Annual Public Health Report	Liz Robin	
	Data Sharing	Charlotte Black/ Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Better Care Fund Plan 2017-18	Geoff Hinkins	
	Better Care Fund: Six month Health Data Update	Gill Kelly, CCG	
	Core Joint Strategic Needs Assessment (JSNA) Strategy	tbc	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
23 November 2017 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 10 November 2017**
	Minutes of the Meeting on 21 September 2017	Richenda Greenhill	

MEETING DATE	ITEM	REPORT AUTHOR	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Health and Wellbeing Strategy 2018-22: Draft Consultation	Dr Liz Robin	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
1 February 2018 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 19 January 2017**
	Minutes of the Meeting on 23 November 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
22 March 2018 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 9 March 2018**
	Minutes of the Meeting on 1 February 2018	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		

MEETING DATE	ITEM	REPORT AUTHOR	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
31 May 2018 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 18 May 2018**
	Election of a Vice Chairman/ Chairwoman	Oral	
	Minutes of the Meeting on 22 March 2018	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Update	Scott Haldane	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		

Updated: 28.06.17