

NHS PLYMOUTH

**PHARMACEUTICAL NEEDS
ASSESSMENT**

Document Information

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative.

On receipt of a new version, please destroy all previous versions

Date of Issue: 31.1.2011	Next Review Date: 1.2.2014
Version: 3	Last Review Date: 31.1.2011
Author: James Glanville	
Directorate: Development	
Approval Route: The NHS Plymouth Board	
Approved By: The NHS Plymouth Board	Date Approved: 27th January 2011
Links or overlaps with other policies: Links to: Plymouths Joint Strategic Needs Assesement and NHS Plymouth Strategic Framework	

Amendment History

Issue	Status	Date	Reason for Change	Authorised
0.1	Draft	October 2010	Initial Draft	J Glanville
0.2	Final Draft	12 th January 2011	Following consultation period and approval from PEC	J.Glanville
0.3	Final	31 st January 2011	Following approval from NHS Plymouth Board	J.Glanville

Contents

1. Executive Summary
2. Introduction and Context of the PNA
3. Process followed for the development of the Pharmaceutical Needs Assessment (PNA)
4. NHS Plymouth's Strategic Priorities
5. Overview of the area – Identifying health needs
6. Localities – definition and description
7. Local Health Needs
8. Current Service Provision
9. Exempt applications
10. Outcomes of the consultation process
11. Future Development
12. NHS Plymouth's vision for pharmaceutical services
13. Conclusions
14. References
15. Glossary
16. Appendices
 - A. Terms of reference for working group
 - B. Pharmacy questionnaire
 - C. Summary of questionnaire responses
 - D. Consultation questionnaire
 - E. Consultation report
 - F. Specification of all essential services
 - G. Specification of advanced services
 - H. Specification of NHS Plymouth enhanced services
 - I. Map showing locations of pharmacies in Plymouth
 - J. Map showing locations of GP practices in Plymouth
 - K. Maps showing drive times to pharmacies
 - L. Pharmacy opening hours
 - M. List of enhanced and advanced services provided by pharmacy

List of tables & statistics

- Table 1 - Resident population by locality, Plymouth, October 2009
- Table 2 - MOSAIC group composition of the resident population, Plymouth, October 2008
- Table 3 - Births by locality, Plymouth, 2004 to 2008
- Table 4 - Low birth weight births (%) by locality, Plymouth 2004 to 2008
- Table 5 - Life expectancy by locality, Plymouth 2002-04 to 2006-08
- Table 6 - Breastfeeding at 6-8 week check by locality, Plymouth 2007 to 2009
- Table 7 - Percentage of vulnerable families by locality, Plymouth, 2002 to 2008
- Table 8 - Dental health of children, Plymouth, 2000 and 2009
- Table 9 - Childhood obesity (%), Plymouth 2005/06 to 2008/09
- Table 10 - Elective hospital admission rates by locality, Plymouth 2005/06 to 2009/10
- Table 11 - Emergency hospital admission rates by locality, Plymouth 2005/06 to 2009/10
- Table 12 - Circulatory disease mortality rates by locality, persons aged less than 75 years, Plymouth 2004 to 2008
- Table 13 - Mortality rates by locality, Plymouth 2004 to 2008
- Table 14 - Indicator values for the most recent year from table 3 to 13
- Table 15 - Indicator rankings for the most recent year from table 3 to 13
- Table 16 - Public Health Priorities 'Choosing Health through Pharmacy'
- Table 17 - Teenage conception rate for population aged 15 – 17 years, Plymouth 2005 to 2009
- Table 18 - Mothers who smoke in pregnancy, percentage all mothers, Plymouth 2005/06 to 2008/09
- Table 19 - Parents who smoke, percentage Plymouth 2002 to 2008
- Table 20 - A&E attendance rates due to accidents, Plymouth 2005/06 to 2009/10
- Table 21 - Substance misuse clients, percent by locality Plymouth 2006/07 to 2008/09
- Table 22 - Parents misuse drugs, percentage Plymouth 2002 to 2008
- Table 23 - Households with parents who are depressed/mentally ill, Plymouth 2002 to 2008
- Table 24 - Households with parents who are depressed/mentally ill, Plymouth 2002 to 2008
- Table 25 - Emergency hospital admissions for circulatory disease, residents aged under 75 years, Plymouth 2005/06 to 2009/10
- Table 26 - Cancer mortality, persons aged under 75 years, Plymouth 2004 to 2008
- Table 27 - Summary of indicators and localities. Indicator values for the most recent year from table 16 to 25
- Table 28 - This table shows the indicator rankings for the most recent year from table 16 to 25
- Table 29 - Table of Enhanced and Advanced Services

1. Executive Summary

- 1.1 The NHS Plymouth Pharmaceutical Needs Assessment (PNA) is a document that will enable us to undertake a number of commissioning and regulatory functions in relation to the provision of high quality and accessible pharmaceutical services for the population of Plymouth. It will be used to prioritise the commissioning of pharmacy services, and inform the consideration of applications for market entry. The PNA will enable external stakeholders to understand the need of the local population and the requirements for pharmaceutical services to meet those needs. Providers will be able to use the PNA to inform their applications to provide pharmaceutical services. This PNA replaces the Plymouth tPCT Community Pharmacy Needs Assessment published in March 2005 and will become effective on 1st February 2011.
- 1.2 The NHS Plymouth Pharmaceutical Needs Assessment presents a picture of community pharmacy need and provision in Plymouth; the document links to the Pharmacy White Paper, World Class Commissioning, Primary Care & Community Services: Improving Pharmaceutical Service paper, the Joint Strategic Needs Assessment and NHS Plymouth Strategic Framework. It was developed in partnership with NHS Devon, Torbay Care Trust, Devon Local Pharmaceutical Committee, Devon Local Medical Committee. Stakeholders involved in development included individual community pharmacy contractors (through completion of a questionnaire) and key staff from across NHS Plymouth. Consultation with interested parties will inform the final version of the document.
- 1.3 The geographical area of the PCT has been divided into its six established localities which are outlined in section 6 for the purpose of the PNA. They are:
- Central & North East
 - North West
 - Plympton
 - Plymstock
 - South East
 - South West
- 1.4 The core NHS service offered by community pharmacies is the supply of medicines; in addition a number of locally commissioned enhanced services are offered, the main thrust comprising supervised consumption of methadone and sexual health services such as emergency hormonal contraception and Chlamydia screening and treatment. Other services include needle and syringe exchange and drop bins for Chlamydia testing for 16 to 25 year olds. In addition a new voucher scheme for the provision of Nicotine Replacement Therapy (NRT) from community pharmacies is due to start in February 2011. The majority of pharmacies in Plymouth offer 'Medicine Use Reviews' as an advanced service and we have worked hard in this area to improve quality and provision of this service. Enhanced services have been commissioned in Plymouth to meet the local needs of the population. Scope to increase provision of existing services and to provide new enhanced services is limited

given current financial constraints; should resources be available then priority will be given to developments which are in line with the NHS Plymouth strategic priorities and Quality Innovation Productivity & Prevention (QIPP) programme which is outlined in the PNA.

- 1.5 Access to community pharmacies is generally good in Plymouth with 51 community pharmacies spread across the City. 18 pharmacies in the City offer hours beyond 6pm during weekdays including Plymouth's two 100 hours a week pharmacies and a pharmacy that is routinely open until midnight 6 day per week. 42 pharmacies are open on Saturdays and seven on Sundays; this ensures patients have access to pharmaceutical services at a wide range of times to suit more of the population. No household in Plymouth is more than 5 minutes drive from a community pharmacy at off peak times and no more than 8 minutes during peak times.
- 1.6 Current pharmacy provision per head of population is close to the UK average, and we do not anticipate the need for further pharmacies to support the population of Plymouth. The UK average number of pharmacies is 20 per 100,000 head of population; in Plymouth that figure is 19 although that figure could soon rise to 20 with two new pharmacy applications recently approved by NHS Plymouth. It is worth noting that Plymouth has an urban, dense population and the UK average includes rural populations.
- 1.7 NHS Plymouth oversees clinical governance for community pharmacy as part of the monitoring of the contractual framework. We work with pharmacies to develop their knowledge and skills on specifically targeted areas such as safeguarding children and adults, the development of the clinical governance leads in pharmacies, Controlled Drugs Management and encouraging the reporting of, and sharing the learning from, significant events. We will continue to administer effective and robust monitoring processes to ensure high quality services. By undertaking monitoring visits and annual self-assessments we can monitor how the pharmacy contract is being implemented and target areas for improvement.
- 1.8 NHS Plymouth's vision for improving pharmaceutical services, which all providers of services should aspire to achieving and which it would expect all providers of new enhanced services to achieve as a prerequisite, is outlined in section 12 of the document, it includes the patient offer which states the range of services that should be available and what patients can expect to be provided at their local pharmacy as well as a statement about equality and diversity, quality, the range of services available, leadership, workforce and information technology.
- 1.9 The NHS is undergoing a thorough and significant programme of review redesign and change, largely under the umbrella of QIPP. Commissioning and provision of community pharmacy needs to be fully engaged in this programme and existing investment as well as potential future investment needs to be carefully revived and prioritised. This will ensure that NHS resources are used to their best effect on evidence based provision of services to patients which deliver value for money.

- 1.10 The Healthy Lives, Healthy People: Our strategy for public health in England. Department of Health, paper published on 30th November 2010 shapes the future of public health in England and recognises the important role of community pharmacy. The strategy describes a new public health service, Public Health England, which will in the future significantly influence the development of the community pharmacy contractual framework, through the new National Health Commissioning Boards (NHSCB). New Health and Wellbeing Boards will become responsible for producing pharmaceutical needs assessments, which will inform decisions about the commissioning of community pharmacy services by the NHSCB and other local public health commissioning decisions.
- 1.11 Section 13 sets out NHS Plymouth conclusions on the range of information set out in this PNA. It shows that community pharmacies are well placed to make a very strong positive contribution to the significant agenda for improving health, reducing health inequalities and financial health of the health economy in Plymouth.

2. Introduction/Context of the PNA

- 2.1 This Pharmaceutical Needs Assessment (PNA) is published by NHS Plymouth (Plymouth Teaching Primary Care Trust) to fulfil the requirements of Section 128A of the NHS Act 2006. A copy of this document is available on the PCT website at www.plymouthpct.nhs.uk
- 2.2 The pharmacy white paper *Pharmacy in England: Building on strengths - delivering the future* was published in April 2008 by the Department of Health (DH). It sets out the Government's programme for a 21st century pharmaceutical service and identified practical, achievable ways in which pharmacists and their teams can contribute to improving patient care through delivering personalised pharmaceutical services in the coming years.
- 2.3 Following consultation, two clauses were proposed for the Health Bill 2009 from the white paper: to require PCTs to develop and publish pharmaceutical needs assessments (PNAs); and then to use PNAs as the basis for determining market entry to NHS pharmaceutical services provision.
- 2.4 In April 2010, guidance from the Department of Health on the production of PNAs was issued to PCTs "*Pharmacy in England: Building on strengths – delivering the future –Regulations under the Health Act 2009: Pharmaceutical Needs Assessments Information for Primary Care Trusts*". This guidance was accompanied by the regulations themselves which came into force on 24th May and required all PCTs to produce, consult on and publish a PNA by 1st February 2011.
- 2.5 The preparation and consultation of PNAs takes account of Joint Strategic Needs Assessments (JSNAs) and effective PNAs should build on JSNAs. In addition, they should help PCTs to demonstrate progress against one or more World Class Commissioning competencies. The most relevant competencies to the PNA are:
- Competency 2 – Work collaboratively with community partners to commission services that optimise health gains and reduce health inequities
 - Competency 4 – Lead continuous and meaningful engagement of all clinicians to inform strategy and drive quality service design and resource utilisation
 - Competency 5 – Manage knowledge and undertake robust and regular needs assessment that establish a full understanding of current and future needs and requirements.
 - Competency 7 – Effectively stimulate the market to meet the demands and secure required clinical, and health and wellbeing outcomes.

- 2.6 The PNA also takes account of Healthy Lives, Healthy People: Our strategy for public health in England. Department of Health, paper published on 30th November 2010. The implications for community pharmacy in the paper are as follows:
1. Pharmacists are explicitly recognised in the white paper as part of a wider public health professional network
 2. Community pharmacies are acknowledged in the white paper as a valuable and trusted public health resource: “With millions of contacts with the public each day, community pharmacy teams could be used more effectively to improve health and reduce health inequalities”.
 3. A new public health service, Public Health England, will influence development of the community pharmacy contractual framework through the NHSCB.
 4. Health and Wellbeing Boards will produce pharmaceutical needs assessments, which will inform:
 - a. Commissioning of community pharmacy services by the NHSCB
 - b. Local public health commissioning decisions.
- 2.7 The PNA will enable NHS Plymouth to undertake a number of Commissioning and regulatory functions in relation to the provision of high quality pharmaceutical services for the population of Plymouth. It will be used to prioritise the commissioning of pharmacy services, and inform the consideration of applications for market entry. The PNA will enable external stakeholders to understand the need of the local population and the requirements for pharmaceutical services to meet those needs. Providers will be able to use the PNA to inform their applications to inform their applications to provide pharmaceutical services.
- 2.8 NHS Plymouth will use the PNA to prioritise investment according to local needs, service requirements and where necessary stimulate the market to meet the demand to secure required clinical and health and well-being outcomes.
- 2.9 This PNA does not dictate the future of pharmaceutical developments to the extent that it is separate from the wider NHS agenda; rather it sets out the intended direction but with the explicit statement that this direction, subject to the appropriate decision making process, may change in order that community pharmacy in Plymouth is at all time making its optimal contribution in Plymouth.

3 Process followed for development of the PNA

3.1 This Pharmaceutical Needs Assessment has been devised by the Pharmaceutical Needs Assessment Steering Group for NHS Devon, NHS Plymouth and Torbay Care Trust. The core membership of the group that met monthly from May 2010 until the completion of the PNA included:

- Non Executive Director (Chair)
- Primary Care Contracts (Commissioning)
- Medicines Management Lead
- Public Health Representative
- Local Medical Committee
- Local Pharmaceutical Committee
- Devon Local Involvement Network (LINK)
- Others co-opted as necessary

3.2 Additional stakeholder engagement included the issue of a questionnaire to all community pharmacies in the Trust and discussion with the Strategic Improvement Priority (SIP) leads.

3.3 Consultation was undertaken using the Department of Health template consultation form. The following interested parties were consulted with:

- Devon Local Medical Committee
- All GP practices in Plymouth
- Devon Local Pharmaceutical Committee
- Community pharmacies
- Appliance contractors
- Dispensing doctors
- The Local Involvement Network (LINK)
- Health Overview and Scrutiny Committee
- Equality and Diversity Group
- Plymouth City Council
- NHS Plymouth Strategic Improvement and Priorities Leads (SIP)
- NHS Plymouth Public Health Department
- Sentinel Healthcare Southwest CIC
- NHS Devon
- Cornwall and Isles of Scilly PCT
- Plymouth Drug And Alcohol Team (DAAT)
- Harbour Drug and Alcohol Services

3.4 Consultation ran for 60 days from 7th October 2010 to 7th December 2010 and the consultation report is included in section 10 of the PNA. The final version of the PNA will be approved by the NHS Plymouth board in January 2011 for publication on 1st February 2011.

4. NHS Plymouth's Strategic Priorities

- 4.1 NHS Plymouth recently published its 'Strategic Framework for improving health in Plymouth 2010/11 – 2014/15'. It outlines the vision and ambitions for improving the health of the people of Plymouth and how NHS Plymouth will work in partnership to develop the nine identified health programmes to deliver that vision.

The strategic framework identifies our strategic improvement priorities which were chosen following a review of the Joint Strategic Needs Assessment, benchmarking activity and performance data, comparative programme costs. We also took into account the views of the public and our partners. As a result nine areas of business have emerged as being the most in need of significant change. These are areas that we will tackle first and should have the most impact on the delivery of our strategy.

The nine identified areas are:

- Improve clinical and cost effectiveness within planned care
- Reduce the use of A&E and unscheduled hospital based care. Focus on choice and access to community based options for non elective care and converting unplanned care into interventions
- Reduce avoidable hospital attendances for children and young people
- Improve quality and value for money in mental health services
- Reduce health inequalities for people with learning disabilities
- Improve satisfaction with cost and effectiveness of out of hospital services for adults and in particular older people
- Improve efficiency and effectiveness of continuing care
- Helping people to stay healthy. Focus on sexual health alcohol, smoking, breast feeding, substance misuse, obesity and mental health promotion
- Long-term conditions. Improve the way we address the projected demand from people living with long-term conditions. Focus on coronary heart disease, chronic obstructive pulmonary disease.

In order to measure success against these priorities NHS Plymouth chose the following 10 outcome measures from the World Class Commissioning outcomes:

- Health inequalities (male/female)
- Life expectancy at birth (male/female)
- Women smoking at time of delivery
- Infants breastfed
- Hospital admissions for alcohol related harm
- Hospital admissions caused by unintended and deliberate injuries
- Coronary Heart Disease mortality
- Teenage conception rates
- Acute delayed transfers per hospital bed
- Self reported experience of patients

NHS Plymouth's strategic ambitions are being delivered through Strategic Improvement Priorities (SIPs) work streams. The progress of SIPs are regularly monitored and the subject of review at each annual strategic framework fresh, giving the opportunity to change them as areas are successfully delivered and new challenges arise.

4.2 **Quality, Innovation, Productivity and Prevention (QIPP)**

In Plymouth we refer to the QIPP programme as our quality care best value programme. Over recent years, there has been a continued increase in investment in the NHS and this has significantly improved the overall quality of services, improved people's access to these services, reduced waiting times and helped us to improve the buildings, wards and clinics in which care is delivered. This investment has helped to keep the NHS as a universal service that is free at the point of delivery.

However, the cost of delivering care is growing at a rate that means that this investment is not sustainable. The main reasons for this are:

- The rising expectations of the general public, carers and patients
- Our increasing ability to treat illness and extend life through the availability of new drugs, treatments and technology
- The increasing numbers of elderly people in the population
- Changes in the population's lifestyles

Because of this, the NHS needs to review and where appropriate change the way it delivers services and the way it works with other organizations to improve efficiency and effectiveness that will in turn slow or stop the unsustainable trend of continuous growth.

To support this process the Department of Health has provided NHS organisation with a framework to support local work which is known as QIPP (Quality, Innovation, Productivity and Prevention), in Plymouth we refer to the QIPP programme as our quality care best value programme

QIPP is about creating an environment in which improvement and change can flourish; where a culture of innovation is fostered and where staff are provided with the tools, techniques and support they need to take ownership of improvement the quality of care provided.

NHS South West has identified 10 'prescriptions' that it believes will result in improved service provision that meets the QIPP principles. For each of these prescriptions, we at NHS Plymouth have identified were well developed already and based on local priorities and areas where we know service delivery can be improved and funding better used. The other initiatives are based on national information, good practice and clinical evidence.

NHS Plymouth's approach to meeting the QIPP challenge involves the continued development of a 'Plymouth Healthy System' in which health and social care organisations, patients and the public and the community and voluntary sector work together to commission and/or to provide the services Plymouth people need and to:

- Plan services and service changes
- Delivery them together where this adds value
- Identify those areas where expertise, functions and facilities can be shared.

Slowing or stopping growth and creating a quality and effective service will be achieved best by us focusing on keeping people healthy.

Patients, staff, clinicians, local political leaders and the public will be involved in the decisions about the changes to the way health and social care in Plymouth is provided in the future.

Community pharmacy has an important role within this agenda.

4.3 Equality and Diversity

NHS Plymouth acknowledges that the population of Plymouth is becoming more and more diverse and wants to ensure that its services are inclusive, accessible and meet the needs of the local population regardless of their characteristics. To help us achieve this we have in place an Equality Scheme which is a public commitment of how we plan to meet our statutory duties set out in equality legislation.

5 Overview of the area – Identifying Health Needs

5.1 Introduction

Plymouth's coastal location, its undulating topography and compact nature facilitates physical exercise above that ordinarily found in the national population and ensures a clean air environment for most of its inhabitants. The City does not have a preponderance of heavy industries whose processes endanger public health whilst its residents are in general not significantly different in their dietary or social habits from the national population.

5.2 Population

The usually resident population of the City is believed to be growing and was estimated by the Office of National Statistics (ONS) to have reached 256,700 people by mid-2009. The resident population is however likely to be higher than this ONS estimate. According to the GP population register, the population of the city was 265,733 in October 2009. ONS have estimated that the city's population will grow by 7.2% to reach 272,400 by 2018. Local aspirations expressed within the 'Mackay Vision for Plymouth' seek a further expansion of the city's population to 300,000 by the year 2020. Population growth to reach this level would need to be at a higher rate than that experienced over the past two decades.

The population of the city also changes during the course of the year with the arrival of up to 16,000 students undertaking studies with the University of Plymouth and further education colleges. This is supplemented by military personnel and summer visitors to the city. Therefore Plymouth is thought to have a 'Summer-high' population of approximately 270,000 (based on estimates calculated for Devon & Cornwall Constabulary, 2007).

Overall, the demographic profile of the city is similar to that of England as a whole with the population comprising slightly more females (51%) than males. The city's population is slowly ageing but also becoming more age-polarised. The GP population register recorded a three percent fall in the under 19 age group and a slight increase in the 65+ and 75+ age groups to 2008. The city is also experiencing an increase in births with the number of children aged under one year increasing year-on-year from 2,172 in 2001 to 3,100 in 2008 - a 46% increase over the period.

There is however a marked difference in the 20-24 years age group compared with England. This is most likely due to the expansion of the University Campus from 2000 to 2008 and the recent influx of economic migrants of this age during the period 2005 to 2008.

Table 1- Resident population by locality, Plymouth, October 2009

	Central & North East	North West	South West	South East	Plymstock	Plympton	Plymouth
Population 2009	61,891	46,810	54,643	46,546	25,172	30,671	265,733
% of total	23.3%	17.6%	20.5%	17.5%	9.5%	11.5%	
Population 2008	61,756	46,848	54,075	46,033	25,012	30,594	264,318
% change 2008 - 2009	+0.21%	-0.08%	+1.05%	+1.11%	+0.63%	+0.25%	+0.53%

Source: PHDU, using GP Population register, October 2009 download

The population growth envisaged under the McKay Vision is expected to be accommodated mainly in the Eastern (Plymstock locality) and North Eastern neighbourhoods (Central & North East locality) with further intensification of residential densities in the neighbourhoods in the South West locality. Details of potential future developments are in section 10 of the PNA.

5.3 Demographic of the city's population

5.3.1 Mosaic classification of the city's population

Mosaic is a company that provide detailed understanding and analysis of consumers, markets and economics, both past and present. Using information provided by 'Mosaic' it is possible to classify Plymouth's residents (based on their postcodes) into one of a number of categories. This shows that Plymouth is, in fact, a diverse city. The Mosaic distribution of the population is shown in table 2.

Table 2 - MOSAIC group composition of the resident population, October 2008

MOSAIC Public Sector Group	% of city
D: Close-knit, inner city and manufacturing town communities	20%
C: Older families living in suburbia	15%
H: Upwardly mobile families living in homes bought from social landlords	15%
B: Younger families living in newer homes	12%
E: Educated, young, single people living in areas of transient populations	11%
G: Low income families living in estate based social housing	10%
F: People living in social housing with uncertain employment in deprived areas	7%
J: Independent older people with relatively active lifestyles	5%
A: Career professionals living in sought after locations	3%
I: Older people living in social housing with high care needs	2%
K: People living in rural areas far from urbanisation	0%

Source: PHDU, using data supplied by Experian Ltd

The MOSAIC groups are unevenly distributed across the city with those requiring a higher degree of social housing and welfare benefit support tending to be located in the South West, South East and North West localities, and those requiring less welfare support living in the eastern localities (Plymstock and Plympton).

5.3.2 Ethnicity

According to the 2001 census, 98% of Plymouth's population was of White British origin; this is more than seven percentage points higher than the national average. However, Plymouth's 'black and minority ethnic' (BME) population is believed to have grown to around 6% by mid-2006 (ONS mid-year estimate, 2008), particularly from the EU Accession Eight (A8) countries.

Overseas migrants, especially from the A8 countries account for the vast majority of inward migration into the city, although not as significant as that experienced in other major population centres in the country. The influx of economic migrants witnessed between 2006 and 2008 is now thought to have reversed with the onset of the economic recession such that it no longer represents a significant demographic issue.

The largest ethnic minorities in Plymouth are the Chinese (just over 1,800 people) and the Polish, although they each account for less than half of one percent of the population. The city's Asian and Black communities are very small, with each making up less than 0.2% of the total population. In 2007/08 a total of 2,270 national insurance numbers were issued to foreign nationals in Plymouth. This was a rise of just 10 compared to 2006/07. Plymouth has been a dispersal area for asylum seekers since 2000 and has about 427 Asylum Seekers supported by the UK Borders Agency in the city at any given time including unaccompanied asylum seeking children.

Schools are required to complete an annual census of their pupils. One of the data items collected is the ethnic group of the children. Of the 36,621 children and young people in Plymouth schools in 2007/08, 32,194 (87.9%) were classified as White British, and 2,400 (6.6%) as other ethnic groups. This information suggests that the proportion of the ethnic population in the city may be higher than official estimates suggest.

Further evidence of a higher degree of diversity in the ethnic mix of the resident population is provided through an examination of the ethnic origin of surnames of residents of the city in 2008. Utilising MOSAIC's 'ethnic origins' tool for a 10% sample of surnames revealed 122 different countries of origin for surnames of city residents, with 73.0% originating in England, 6.7% in Wales, 6.2% in Scotland and 4.7% in Ireland – a total of 90.7%.

The ethnic mix of the city population is expected to become more diverse but with no major immigration influx expected for the foreseeable future the overall impact on the public health services of the city should remain small.

5.3.3 Material deprivation

Deprivation has been defined as "a state of observable and demonstrable disadvantage relative to the local community or the wider society or nation to which an individual, family or group belongs" (Townsend, 1987). People can be deprived of adequate education, adequate housing, employment, sufficient income, good health, and opportunities for enjoyment. A deprived area is conventionally understood to be a place in which people tend to be relatively poor and are relatively likely to suffer from misfortunes such as ill-health. Deprivation measures attempt to identify communities where the need for healthcare is greater, material resources are less and as such the capacity to cope with the consequences of ill-health are less.

In practice, disadvantaged areas in Britain tend to be identified using measures constructed wholly or partially from census data; this is even the case with the current official measure of deprivation (the index of multiple deprivation 2007). The deprivation measures result from the combination of a number of variables which have often also been statistically transformed in a number of ways.

The index of multiple deprivation 2007 (IMD2007) the current official measure of deprivation. It is a measure of multiple deprivation at the small area level. The model of multiple deprivation which underpins the IMD2007 is based on the idea of distinct dimensions of deprivation which can be recognised and measured separately. These are experienced by individuals living in an area. The IMD2007 contains seven domains which relate to income deprivation, employment deprivation, health deprivation and disability, education skills and training deprivation, barriers to housing and services, living environment deprivation, and crime. There are also two supplementary indices ('income deprivation affecting children' and 'income deprivation affecting older people').

Figure 1 - IMD 2007 by neighbourhood and LSOA within Plymouth

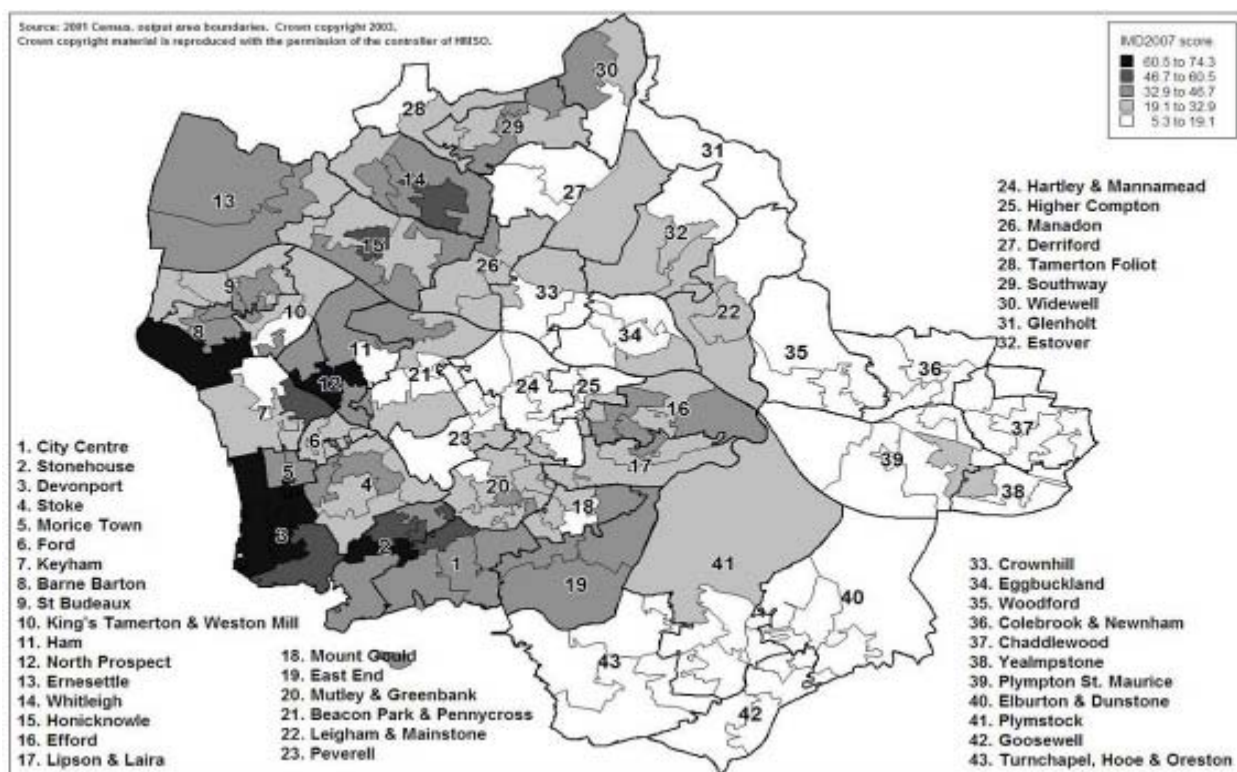
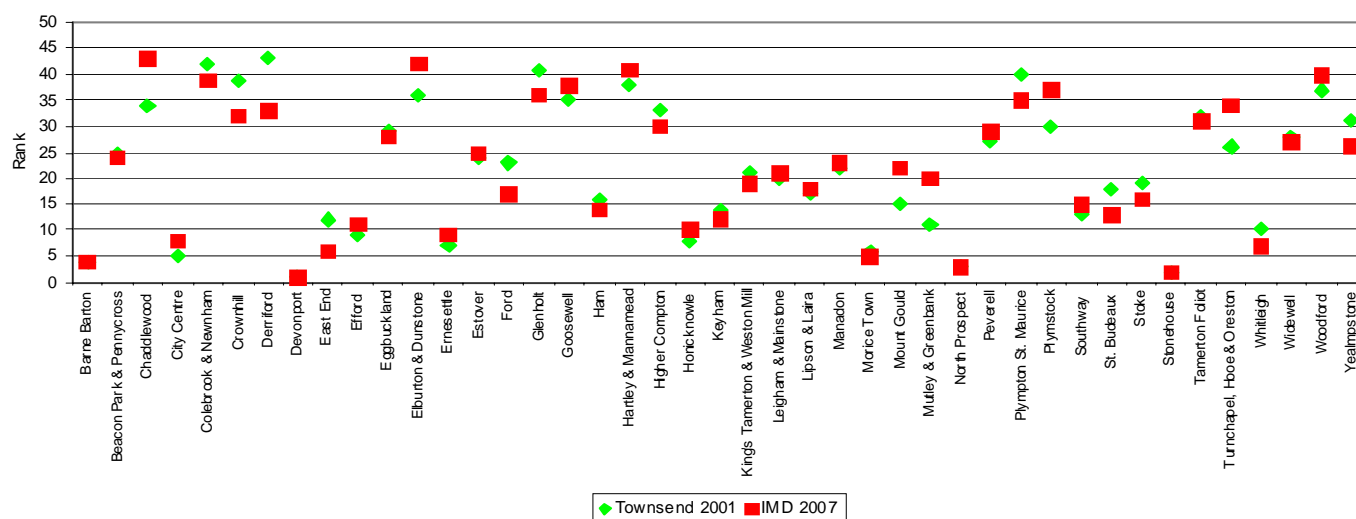


Figure 1 shows the IMD2007 values for the 160 LSOAs in Plymouth with the boundaries of the 43 Plymouth neighbourhoods overlain. Although it is useful to see the data presented in this way, it does not show a composite neighbourhood score (for each of the 43 Plymouth neighbourhoods) that can be used to identify, for example, the most or least deprived neighbourhoods in the city. Therefore separate analysis has been carried out by NHS Plymouth's Public Health Team to produce IMD2007 scores for each of the city's 43 neighbourhoods. The results of this analysis are shown in figure 2 which, as well as showing the rankings of the Plymouth neighbourhoods according to the IMD2007, also shows their rankings according to another measure of deprivation - the Townsend (Material Deprivation) Score. The Townsend Score was developed in an attempt to identify materially deprived areas and uses four 2001 census variables to assess the following: general lack of material resources and insecurity, income, wealth and material living conditions (overcrowding). As the Townsend Score is now considerably out of date (given its total reliance on census data), it is seldom used; the majority of resource allocation decisions being made using the IMD2007.

On the basis of the IMD2007 analysis carried out by the Public Health Team, the 20% (eight) most deprived neighbourhoods in Plymouth are: Devonport (highest IMD2007 ranking), Stonehouse, North Prospect, Barne Barton, Morice Town, East End, Whiteleigh, and City Centre. The 20% least deprived neighbourhoods are: Glenholt, Plymstock, Goosewell, Colebrook & Newnham, Woodford, Hartley & Mannamead, Elburton & Dunstone, and Chaddlewood (lowest IMD2007 ranking).

Figure 2 – The rankings of the Plymouth neighbourhoods by deprivation measure



5.4 Overview of health in Plymouth

Despite the natural advantages afforded to the city population by virtue of geography and topography, a selection of health indicators monitored by the Association for Public Health Observatories (APHO) suggests that the health of people in Plymouth is generally worse than the England average.

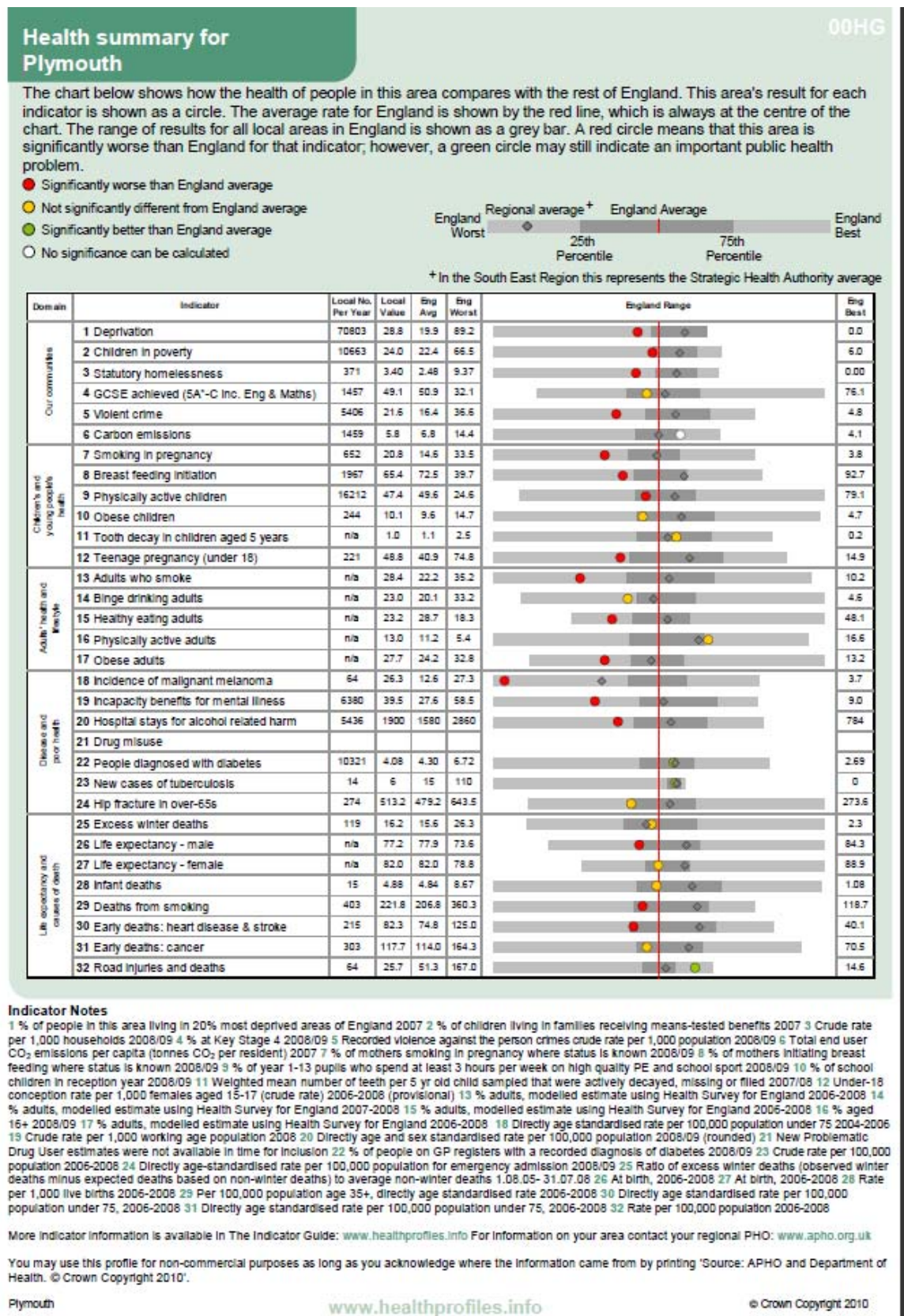
Levels of deprivation are higher than the England average. Rates of teenage pregnancy, violent crime and hospital stays for alcohol related harm are all higher than the England average. Men living in the least deprived areas can expect to live 7 years longer than men in the most deprived areas. The equivalent difference for women is nearly 3 years. Early death rates from cancer and from heart disease and stroke have fallen over the last 10 years. Estimated rates of smoking, healthy eating and obesity in adults are worse than the England average, while the estimated physical activity rate is similar to England. The rate of new cases of malignant melanoma skin cancer is among the highest in England. The percentage of women smoking in pregnancy and the percentage of mothers initiating breastfeeding are worse than the England average. The proportion of children classified as obese in Reception year is similar to the England average. The rate of tooth decay in children aged 5 years is similar to England. However, health in Plymouth continues to improve year-on-year. Partnership work is going on across the city to improve health by specifically addressing its determinants, targeted at communities with the greatest health need.

5.5 Community pharmacy can make a greater contribution to the current health challenges faced in Plymouth. The pharmacy white paper 'Pharmacy in England: building on strengths - delivering the future' (2008) gives a vision of community pharmacies becoming healthy living centres with a greater

emphasis on health and wellbeing and supporting self-care. Examples of the contribution that providers of pharmaceutical services can make such as maintaining health weight and lifestyle, smoking, sexual health, alcohol use, the ageing population, long term conditions, mental health and drug use are all outlined in the pharmacy white paper.

- 5.6 NHS Plymouth is working successfully with representatives from GP practices, pharmacies, care homes and the local authority to improve the strategic management of medication for patients in care homes. Multidisciplinary discussions have allowed real progress on appreciating medication issues from all perspectives and engender an understanding and willingness to work together to improve medicines management for this vulnerable group of patients. The group has introduced the NHS Plymouth significant event reporting system (already in use by pharmacies and GP practices) to care homes. This has allowed learning to be shared and used to highlight areas for prioritisation. We have introduced best practice guidelines endorsed across all groups. An early success has been the agreement of GPs to confirm changes to medication in writing to ensure a clear message is given to the care home and pharmacy at this particularly vulnerable step in the medicines pathway.

Figure 3 - Health Profile for Plymouth, 2010



6 Localities - definition and description

6.1 The Plymouth neighbourhoods

The Plymouth neighbourhoods were officially approved by Plymouth's Local Strategic Partnership ('Plymouth 2020') in January 2003 and define 43 distinctive areas within the city and have been adopted for the NHS Plymouth PNA. The development of the Plymouth neighbourhoods stemmed from a recognition by partners within the city that the geographic boundaries traditionally used for service planning and delivery (i.e. the electoral wards) may not always be appropriate. All too often, deprived neighbourhoods were either 'hidden' within the larger electoral wards, or crossed the boundaries of two or more electoral wards. In either case, these areas never stood out in official statistics.

Equally important was the fact that in recent years Government initiatives aimed at improving social and economic conditions (known as 'Area-Based Initiatives') have tended to be targeted at neighbourhood areas rather than at electoral wards. There was therefore a need to develop a geography that all partners could adopt and use for planning, service delivery, monitoring, and evaluation.

In recognition of these factors a group drawn from the statutory, voluntary and community sectors within Plymouth met over a number of months to devise a neighbourhood map of the city. The following factors were taken into account:

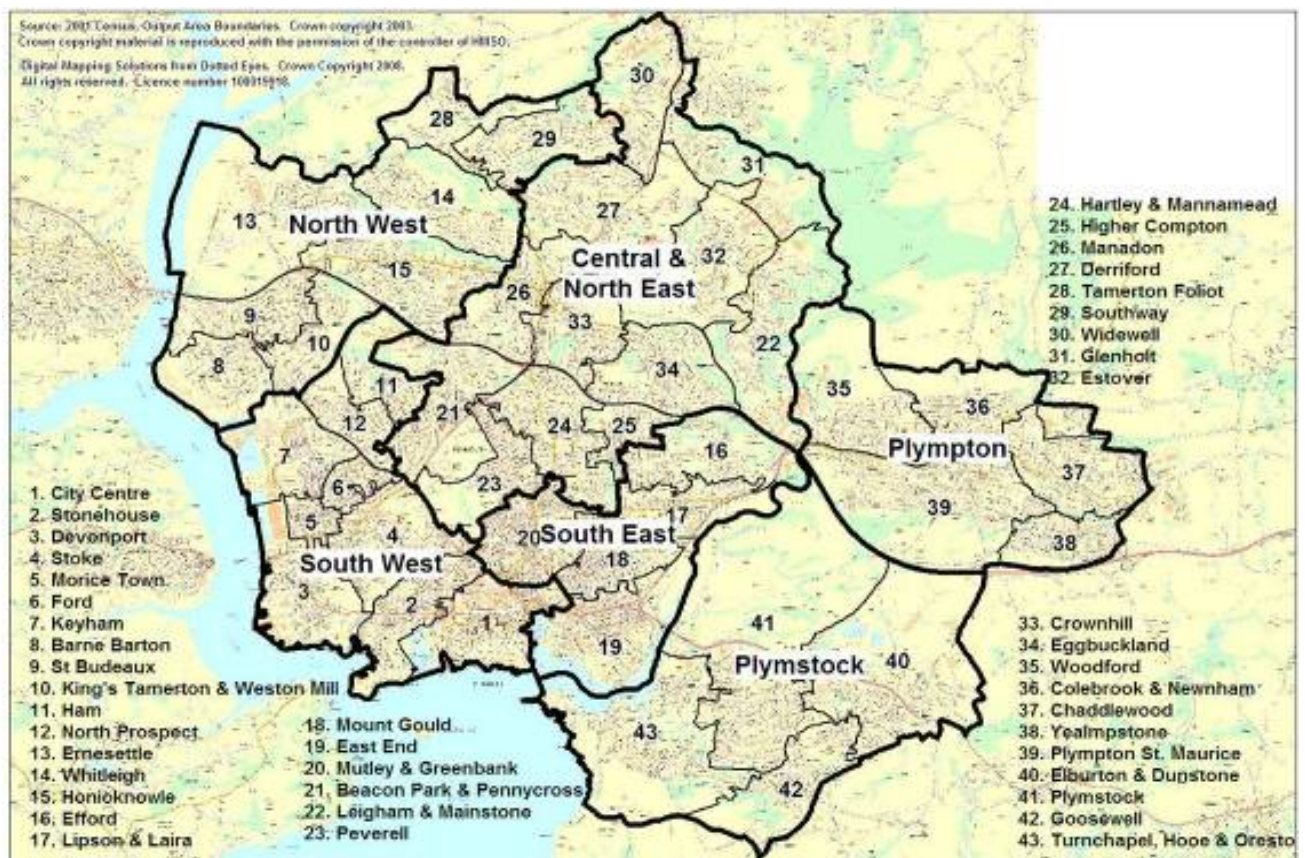
- i) natural boundaries i.e. the location of existing natural boundaries such as roads, parks, railways and rivers.
- ii) population size – the ideal was regarded as an area large enough to support project delivery, but small enough to differentiate local problems and opportunities. On this basis, the neighbourhoods needed to be smaller than electoral wards and comprise approximately 2,500 households, or a population of approximately 5,500 people.
- iii) existing area-based initiatives – the geographical areas covered by these initiatives (e.g. Surestart and New Deal for Communities) for which individual neighbourhoods had already been identified as the unit of delivery.

Once agreed within the group, the proposed map was subject to extensive consultation throughout the city. People's local knowledge was invaluable in helping to shape the boundaries of the neighbourhoods. The neighbourhoods are not intended to replace existing boundaries in the city, nor are they intended for political purposes. The 43 neighbourhoods were officially adopted by Plymouth 2020 in January 2003 and define 'real' areas with which people can identify as 'natural' neighbourhoods. They vary in size, with an average population of approximately 5,600 people. The distribution of the Plymouth neighbourhoods is shown in figure 1.

6.2 The Plymouth localities

As well as existing in their own right, the 43 Plymouth neighbourhoods have been grouped together to form six localities (figure 4). These localities were originally produced to support NHS Plymouth's 'practice-based commissioning' (PBC) which allows the GP practices in each sub-locality to work together to commission (buy) specific services on behalf of their patients. In August 2008, these boundaries were adopted by Plymouth's Local Strategic Partnership as the single set of locality boundaries to be used by partner organisations in Plymouth and they have been adopted for the NHS Plymouth PNA.

Figure 4 – Plymouth by neighbourhood and locality



6.3 Neighbours

In terms of Neighbouring PCTs NHS Plymouth has borders with:

- NHS Devon
- Cornwall & Isles of Scilly PCT

6.4 NHS Plymouth uses the 6 defined localities to identify the local needs of each area. The information gathered on a locality basis informs commissioning decisions relating to community pharmacy services and services delivered by alternative providers. This is to ensure the distribution of services across the City meets the needs of local communities.

7 Local Health Needs

7.1 General health indicators

7.1.1 Births

From 2004 to 2008 there has been a year-on-year increase in the number of births in the city resulting in a 13.5% increase overall from 2004 to 2008. The number of births is not evenly distributed across the city. From 2004 to 2008 the largest number of births was in the South West locality, which also recorded the highest percentage increase (+21.2%) over the period. The lowest percentage increase was recorded in the North West locality (+7.5%).

Table 3 - Births by locality, 2004 to 2008

	2004	2005	2006	2007	2008	Percentage change
Central & North East	622	617	596	688	677	8.1%
North West	614	595	658	664	664	7.5%
Plympton	298	308	337	325	328	9.1%
Plymstock	197	230	230	238	242	18.6%
South East	425	421	483	515	511	16.8%
South West	634	663	718	767	805	21.2%
Plymouth City	2,790	2,834	3,022	3,197	3,227	13.5%

Source: PHDU, using public health births extracts

7.1.2 Low birth weight births

From 2004 to 2008 the percentage of low birth weight (<2,500 grams) births in Plymouth has varied between 6.9% and 7.8%. The distribution of low birth weight births is unevenly spread across the localities with the highest percentages tending to be found in the North West locality, and the lowest tending to be found in the Plymstock locality.

Table 4 - Low birth weight births (%) by locality, Plymouth 2004 to 2008

	2004	2005	2006	2007	2008	Change in percent
Central & North East	6.1	8.1	6.0	5.1	4.9	-1.2
North West	8.6	7.7	7.0	8.6	9.5	0.9
Plympton	5.7	6.5	6.2	6.2	5.2	-0.5
Plymstock	3.6	7.0	4.3	4.6	3.7	0.2
South East	6.6	9.0	6.4	9.9	7.2	0.7
South West	7.7	7.7	6.3	9.3	9.7	2.0
Plymouth City	6.9	7.8	6.3	7.7	7.3	0.5

Source: PHDU, using public health births extracts

7.1.3 Life expectancy

Life expectancy in the period 1991-93 was 73.3 years for males and 79.0 years for females (a 5.7 year differential). By 2006-08 life expectancy of males in the city had increased to 77.2 years (+4.1) whilst that for females had increased to 82.0 years (+3.0). The result of this is a convergence in the life expectancy differential between males and females in the city to 4.8 years by 2008.

Life expectancy varies by locality in Plymouth with, in general, the highest life expectancy found in the Plymstock locality (82.5 years in 2006-08) and the lowest life expectancy in the South West locality (76.6 years in 2006-08). Although life expectancy has risen in all localities the gap between the best and worst performing localities has been slowly widening, reaching 5.9 years in the period 2006-08.

Table 5 - Life expectancy by locality, Plymouth 2002-04 to 2006-08

	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	Change
Central & North East	80.6	80.3	81.0	80.9	81.1	0.5
North West	77.7	78.2	79.0	79.2	78.9	1.2
Plympton	80.4	80.3	80.2	80.2	80.6	0.2
Plymstock	80.8	80.5	81.3	82.4	82.5	1.7
South East	77.6	78.3	79.1	80.0	79.4	1.8
South West	75.6	75.6	76.4	76.4	76.6	1.0
Plymouth City	78.6	78.7	79.4	79.6	79.6	1.0

Source: PHDU, using public health birth and mortality extracts

7.1.4 Breastfeeding

The percentage of all children being breastfed at 6-8 weeks was 35.3% in 2009. Rates are highest in the Plymstock locality (48.3% in 2009), where there has been a 22.3 percentage points increase from 2007 to 2009. Rates are lowest in the North West locality (23.1% in 2009), where there has only been an 8.0 percentage points increase from 2007-08.

Table 6 - Breastfeeding at 6-8 week check by locality, Plymouth 2007 to 2009

	2007	2008	2009	Change in percent
Central & North East	24.2	26.6	36.9	12.7
North West	15.1	18.6	23.1	8.0
Plympton	19.2	15.5	40.8	21.6
Plymstock	26.0	30.1	48.3	22.3
South East	23.8	28.2	44.2	20.4
South West	21.5	23.9	32.7	11.2
Plymouth City	21.2	23.7	35.3	14.1

Source: PDDU, using data from Child Health Information Team

7.1.5 Vulnerable families

Plymouth Health Visitors have completed a health needs form for every family on their caseloads every two years since 2002. Information on 31 health needs factors is recorded. Families who experience four or more of a specific sub-set of 26 of the indicators are classified as 'vulnerable'. Table 7 shows how the percentage of vulnerable families has changed from 2002-2008.

The percentage of vulnerable families in the city has declined from 25.0% in 2002 to 16.9% in 2008. The distribution of vulnerable families is uneven across the city with the highest percentage consistently recorded in the South West locality (27.2% in 2008). However, the South West locality has also recorded the largest fall in the percentage of vulnerable families, by 15.1 percentage points from 2002 to 2008.

Table 7 - Percentage of vulnerable families by locality, Plymouth, 2002 to 2008

	2002	2004	2006	2008	Change in percent
Central & North East	14.0	13.9	10.3	8.4	-5.6
North West	31.9	32.2	28.6	22.3	-9.6
Plympton	11.2	10.4	7.4	8.2	-3.0
Plymstock	8.4	9.6	7.1	6.0	-2.4
South East	29.2	29.9	25.9	18.5	-10.7
South West	42.3	40.0	31.7	27.2	-15.1
Plymouth City	25.0	24.8	20.5	16.9	-8.1

Source: PDDU, using data from the Health Visitor caseload surveys 2002 to 2008

7.1.6 Dental health of children aged 5 years

There have been two surveys of the dental health of children aged five years in Plymouth undertaken in 2000 and in 2009 respectively. It is therefore possible to examine changes in oral health (and oral health inequalities) in this population group over a nine year period. In studies of dental decay, examiners count the number of sound teeth in each individual and the numbers of teeth that are decayed, missing and filled. The addition of the **decayed, missing and filled** components into a single score is the most commonly used mechanism for assessing the dental health status of the individual, giving rise to an individual '**dmft score**' (lower case is used to denote 'primary' teeth). This score along with the prevalence (i.e. the proportions of children with disease experience) gives a good picture of the dental health status of populations.

Table 8 shows average number of decayed, missing or filled teeth per five year old child in 2009 and the percentage of children with decay in 2009. It also shows the changes in these variables from 2000 to 2009. Overall average dmft has reduced by 0.7, to stand at 0.9 in 2009. The percentage of children with decay has reduced by 12.6 percentage points to stand at 29.1% in 2009. Children in the South West locality have the highest average dmft (1.4 teeth)

whereas the prevalence of dental disease is highest in the North West locality (43.7%).

Table 8 - Dental health of children, Plymouth, 2000 and 2009

	dmft	Change in dmft	%dmft>0	Change in %dmft>0
Central & North East	0.7	0.5	20.6	15.1
North West	1.2	0.7	43.7	4.5
Plympton	0.6	0.4	19.3	12.4
Plymstock	0.3	0.6	15.8	15.6
South East	1.3	0.6	31.1	17.4
South West	1.4	0.6	38.1	9.1
Plymouth City	0.9	0.7	29.1	12.6

Source: PHDU, using data from dental epidemiological surveys

7.1.7 Childhood obesity

Children in Year R and Year 6 are weighed and measured on an annual basis as part of the National Child Measurement Programme (NCMP). Children whose BMI for their age and sex place them equal to or above the 95% centile are classified as obese.

Levels of childhood obesity have increased from 12.1% in 2005/06 to 14.2% in 2008/09. The South East locality had the highest level of childhood obesity in 2008/09 (16.9%) and the Central & North East locality had the lowest level (11.4%). From 2005/06 to 2008/09 the largest increase has been in the South East locality (5.7 percentage points), compared to the South West locality where the level of obesity reduced by 0.8 percentage points.

Table 9 - Childhood obesity (%), Plymouth 2005/06 to 2008/09

	2005/06	2007/08	2008/09	Change in percent
Central & North East	12.0	12.5	11.4	-0.6
North West	11.2	14.7	16.7	5.5
Plympton	10.2	11.9	11.8	1.6
Plymstock	10.3	11.1	13.9	3.6
South East	11.2	14.4	16.9	5.7
South West	16.1	14.9	15.3	-0.8
Plymouth City	12.1	13.4	14.2	2.1

Source: PHDU, using data from the NCMP

7.1.8 Hospital admissions – elective

The directly age standardised rate (DASR) of elective hospital admissions for persons of all ages has risen from 2005/06 to 2009/10 to reach a rate of 10,014.1/100,000 population in 2009/10. Elective admission rates are fairly evenly distributed across the localities of the city, the highest rate being recorded in the North West locality in 2009/10 (10,549.3/100,000). The lowest

rate in 2009/10 was in the Plympton locality (9,704.9/100,000). All localities recorded an increase in rates from 2005/06 to 2009/10, the largest being in the Plymstock locality (2,010.3).

Table 10 - Elective hospital admission rates by locality, Plymouth 2005/06 to 2009/10

	2005/ 06	2006/ 07	2007/ 08	2008/ 09	2009/ 10	Change in rate
Central & North East	9,047.8	9,787.6	10,205.6	10,066.3	10,215.5	1,167.7
North West	9,497.8	10,023.6	11,005.3	10,829.5	10,549.3	1,051.5
Plympton	8,833.6	9,930.2	9,888.3	10,171.9	9,704.9	871.3
Plymstock	8,037.7	8,913.2	9,659.3	9,741.5	10,048.0	2,010.3
South East	8,367.6	8,860.1	9,488.0	9,605.4	9,786.0	1,418.4
South West	9,366.6	9,890.8	10,594.3	10,728.1	10,077.8	711.2
Plymouth City	8,912.1	9,583.4	10,176.0	10,171.9	10,014.1	1,102.0

Source: PHDU, using data from Plymouth Hospitals Trust

7.1.9 Hospital admissions – emergency

The directly age standardised rate (DASR) of emergency hospital admissions for persons of all ages has risen from 2005/06 to 2009/10 to reach a rate of 12,661.0/100,000 population in 2009/10. Emergency admission rates are unevenly distributed across the localities of the city, the highest rate being recorded in the North West locality in 2009/10 (15,676.3/100,000). The lowest rate in 2009/10 was in the South East locality (11,785.4 per 100,000). All localities recorded an increase in rates from 2005/06 to 2009/10, the largest being in the North West locality (1,531.3).

Table 11 - Emergency hospital admission rates by locality, Plymouth 2005/06 to 2009/10

	2005/06	2006/07	2007/08	2008/09	2009/10	Change in rate
Central & North East	10,872.0	10,335.3	10,292.2	10,541.2	11,630.0	758.0
North West	14,145.0	13,830.8	13,110.7	13,923.1	15,676.3	1,531.3
Plympton	11,379.0	10,333.1	9,941.2	11,125.8	11,971.2	592.2
Plymstock	10,951.8	10,380.7	10,246.9	11,745.9	11,898.5	946.7
South East	11,015.3	10,266.4	10,323.2	10,400.0	11,785.4	770.1
South West	13,707.0	13,361.1	13,059.8	12,918.8	14,400.4	693.4
Plymouth City	11,864.4	11,315.2	11,089.6	11,448.8	12,661.0	796.6

Source: PHDU, using data from Plymouth Hospitals Trust

7.1.10 Circulatory disease mortality (under 75s)

The directly age-standardised rate (DASR) of mortality from circulatory diseases per 100,000 persons aged less than 75 years has decreased from 2004 to 2008 and stood at 83.0/100,000 in 2008. Mortality from circulatory diseases (<75s) is unevenly distributed across the city with the highest rates being consistently recorded in the South West locality over the period 2004 to 2008. Rates of circulatory disease mortality (<75s) have increased in the North West and Central & North East localities, compared to the Plymstock locality where the rate has decreased by 48.8 points.

Table 12 - Circulatory disease mortality rates by locality, persons aged less than 75 years, Plymouth 2004 to 2008

	2004	2005	2006	2007	2008	Change In rate
Central & North East	54.8	58.1	69.1	53.8	58.8	4.0
North West	96.5	116.2	64.5	104.7	106.6	10.1
Plympton	74.1	84.0	55.0	35.4	31.0	-43.1
Plymstock	84.8	63.0	48.1	50.4	36.0	-48.8
South East	137.4	94.9	105.2	85.2	113.4	-24.0
South West	151.6	139.3	139.8	110.1	142.1	-9.5
Plymouth City	95.7	92.0	80.4	74.6	83.0	-12.7

Source: PHDU, using data from public health mortality extracts

7.1.11 Mortality All Ages All Causes

The directly age-standardised rate (DASR) of mortality from all causes for persons of all ages (per 100,000 population) has generally fallen over the period 2004 to 2008 to reach a rate of 579.6 per 100,000 population in 2008. Over the period 2004 to 2008, the annualised DASR for the city fell by 63.9 points. Mortality rates are unevenly distributed across the localities of the city with the highest mortality rate being consistently recorded for the South West locality over the period 2004 to 2008. Conversely, the lowest DASR is generally recorded for the Plymstock locality although, in 2008, the lowest rate was recorded for Plympton locality (468.5/100,000).

Table 13 - Mortality rates by locality, Plymouth 2004 to 2008

	2004	2005	2006	2007	2008	Change in rate
Central & North East	520.4	528.1	551.1	548.5	489.5	-30.9
North West	666.0	636.2	614.7	655.9	626.8	-39.2
Plympton	599.2	589.0	581.1	586.5	468.5	-130.7
Plymstock	562.6	580.0	448.4	439.2	528.7	-33.9
South East	719.4	600.3	598.1	589.4	659.3	-60.1
South West	824.2	802.3	764.9	787.0	712.6	-111.6
Plymouth City	643.5	619.1	597.0	609.1	579.6	-63.9

Source: PHDU, using data from public health mortality extracts

7.1.12 Summary of indicators and localities

Table 14 - Indicator values for the most recent year from table 3 to 13

	Central & North East	North West	Plympton	Plymstock	South East	South West	Plymouth
Births	677	664	328	242	511	805	3,227
Low birth weight births	4.9	9.5	5.2	3.7	7.2	9.7	7.3
Life expectancy	81.1	78.9	80.6	82.5	79.4	76.6	79.6
Breastfeeding at 6-8 weeks	36.9	23.1	40.8	48.3	44.2	32.7	35.3
Vulnerable families	8.4	22.3	8.2	6.0	18.5	27.2	16.9
Dental Health (prevalence)	20.6	43.7	19.3	15.8	31.1	38.1	29.1
Childhood obesity	11.4	16.7	11.8	13.9	16.9	15.3	14.2
Elective admissions	10,215.5	10,549.3	9,704.9	10,048.0	9,786.0	10,077.8	10,014.1
Emergency admissions	11,630.0	15,676.3	11,971.2	11,898.5	11,785.4	14,400.4	12,661.0
Circulatory disease mortality (<75s)	58.8	106.6	31.0	36.0	113.4	142.1	83.0
Mortality all ages all causes	489.5	626.8	468.5	528.7	659.3	712.6	579.6

Table 15 - Indicator rankings for the most recent year from table 3 to 13

	Central & North East	North West	Plympton	Plymstock	South East	South West	Plymouth
Births	2	3	5	6	4	1	n/a
Low birth weight births	5	2	4	6	3	1	n/a
Life expectancy	5	2	4	6	3	1	n/a
Breastfeeding at 6-8 weeks	3	1	4	6	5	2	n/a
Vulnerable families	4	2	5	6	3	1	n/a
Dental Health (prevalence)	4	1	5	6	3	2	n/a
Childhood obesity	6	2	5	4	1	3	n/a
Elective admissions	2	1	6	4	5	3	n/a
Emergency admissions	6	1	3	4	5	2	n/a
Circulatory disease mortality (<75s)	4	3	6	5	2	1	n/a
Mortality all ages all causes	5	3	6	4	2	1	n/a

Note: 1=highest or worst value, 6=lowest or best value.

7.2 Public Health Priorities for pharmacy

The Department of Health publication 'Choosing Health through Pharmacy; A Programme for Pharmaceutical Public Health 2005-2015' sets out a vision for the role of pharmacy in achieving public health objectives.

Table 16 below taken from the 'choosing health through pharmacy' document sets out in order of potential public health impact, the priorities for pharmacy. The table estimates the potential population health impact of pharmacy interventions from the importance of the identified health problem, and the strength of the available evidence for the intervention.

Table 16
Public Health Priorities from Pharmacy

Overall Priority	National PSA target	Pharmacy Contribution	Population health impact
1 REDUCING SMOKING			
	Reduce adult smoking rates to 21% or less by 2010, & to 26% in 'routine' & 'manual' groups	Opportunistic brief advice No-smoking campaigns Specialist NHS Stop Smoking Service, including nicotine replacement therapy (NRT) etc.	****
2 HEART DISEASE, STOKES AND CANCER			
	Reduce mortality rates by 2010 from heart disease and stroke by at least 40% in people under 75, with a 40% reduction in the inequalities gap Reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a 6% reduction in the inequalities gap	Information & advice on healthy lifestyle (smoking, diet, physical activity, etc.) Campaigns – national or local Secondary prevention/risk factor monitoring and advice, etc.	***
	Skin cancer prevention	Information and advice	**
3 UNDER-18 CONCEPTION RATE			
	Reduce the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health	Emergency hormonal contraception under Patient Group Directions (PGD) Supply of condoms Signposting to other sources of advice and support Sexual health advice and screening as part of integrated system	***
4 OBESITY AMONG CHILDREN			
	Halt the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole	Targeted information & advice on diet and physical activity Weight reduction programmes including supply of anti-obesity medicines	**
5 REDUCE HEALTH INEQUALITIES			
	Reduce health inequalities by 10% by 2010 as measured by infant mortality & life expectancy at birth (& see priority 2 above)	Signposting to services to: improve housing, improve income among the poorest, support to families with young children, health literacy Target services to reduce smoking, improve diet, coronary heart disease (CHD) risk, etc., on disadvantaged groups PCT investment in pharmacies in areas with the worst health indicators Community action & advocacy; provide floor space for community groups, etc.	**

Overall Priority	National PSA target	Pharmacy Contribution	Population health impact
6 LONG-TERM CONDITIONS			
	Improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and improve care in primary care and community settings	Providing support to patients & other professionals in the effective use of medicines. Promotion of healthy lifestyles Support for self care Disease-specific care management Work with case managers	**
7 SUICIDE AND UNDETERMINED INJURY			
	Reduce mortality rates from suicide and undetermined injury by 20% by 2010	Provide information & advice Signpost or refer to appropriate local services	*
8 OTHER INTERVENTIONS TO IMPROVE HEALTH AND REDUCE HEALTH INEQUALITIES			
	Safe and effective use of medicines	Opportunistic advice Medicines – use reviews and prescription intervention service. Reporting of adverse drug reactions Helping to reduce medication errors	***
	Services for substance misuses	Supervised consumption of methadone and other medicines Needle and syringe exchange schemes, plus information & advice	***
	Immunisation services	Identifying and referring clients Offering floor space to other professionals Administering the immunisation	***
	Management of asthma	Opportunistic advice	**
	Children & young people	Involvement/lead in asthma care pathway Effective use of medicines Signposting Child Health Promotion Programme, Healthy Start, Extended Schools	**
	Men's health	Information & advice	**
	Reduction of harm from alcohol	Opportunistic advice Brief interventions Offering floor space to other professionals	* *

Estimated the potential population health impact of pharmacy interventions from the importance of the identified health problem and the strength of the available evidence for the intervention.

- **** = major impact
- *** = considerable impact
- ** = moderate impact
- * = some impact

7.3 Public Health Indicators related to community pharmacy

The following public health indicators have been chosen for inclusion in the PNA as they are areas where pharmaceutical services can have an impact.

7.3.1 Teenage Pregnancy

The conception rate per 1,000 women aged 15-17 years for Plymouth in 2009 was 52.6. The conception rate varies considerably between the city's localities and until 2009 was highest in the South West locality. However in 2009, the rate was highest in the North West locality (81.5/1,000). The lowest rate in 2009 was in the Plympton locality (20.1/1,000). From 2005 to 2009 the rate has increased by 28.2 points in the North West locality, compared with a 6.7 point decrease in the Plympton locality.

Table 17 - Teenage conception rate for population aged 15 – 17 years, Plymouth 2005 to 2009

	2005	2006	2007	2008	2009	Change in rate
Central & North East	22.7	40.0	36.4	33.6	26.8	4.1
North West	53.3	72.9	65.1	62.1	81.5	28.2
Plympton	26.8	42.4	31.6	12.2	20.1	-6.7
Plymstock	22.9	31.9	21.9	26.1	39.7	16.9
South East	59.8	59.6	73.5	76.0	58.7	-1.0
South West	78.3	91.6	92.1	106.8	80.0	1.7
Plymouth City	45.3	58.6	55.5	56.0	52.6	7.3

Source: PHDU, using data supplied by Plymouth Hospitals Trust

7.3.2 Smoking in Pregnancy

On average, just over a fifth (20.5%) of Plymouth mothers smoked in pregnancy in 2008/09. This represents a reduction of 3.4 percentage points from 2005/06. The distribution of mothers who smoke in pregnancy is unevenly distributed across the city with the highest rates found in the North West (29.5%) and South West (27.8%) in 2008/09. The lowest rates were found in the Central & North East and Plympton localities in 2008/09 (both 10.4%). Rates have fallen in all localities apart from Plymstock where they increased by 4.8 percentage points from 2005/06 to 2008/09.

Table 18 - Mothers who smoke in pregnancy, percentage all mothers, Plymouth 2005/06 to 2008/09

	2005/06	2006/07	2007/08	2008/09	Change in percent
Central & North East	14.3	13.1	10.2	10.4	-3.9
North West	33.6	32.8	29.0	29.5	-4.1
Plympton	11.3	10.9	10.1	10.4	-0.8
Plymstock	7.9	14.2	9.5	12.7	4.8
South East	23.6	20.7	19.4	21.5	-2.1
South West	36.1	32.4	29.0	27.8	-8.3
Plymouth City	23.9	23.0	20.0	20.5	-3.4

Source: PHDU, using data collected in the survey of health visitor caseloads

7.3.3 Parents who smoke

According to the 2008 survey of health visitor caseloads, 28.5% of parents with children aged less than five years currently smoke. This represents a 6.3 percentage points decrease since 2002. The distribution of parents who smoke is uneven across the city with (in 2008) higher percentages found in the South West (40.0%) and North West (36.1%) localities than elsewhere. Percentages in these localities are twice that found in the Central & North East, Plympton and Plymstock localities.

The pattern of change from 2002 to 2008 is likewise uneven with those localities recording the highest percentages of parents who smoke also recording the highest percentage point falls. Thus the South West and North West localities recorded notable declines in the percentage of parents who smoke, as did the South East locality. In contrast, the percentage in the Plymstock locality rose to reach 20.6% in 2008.

Table 19 - Parents who smoke, percentage Plymouth 2002 to 2008

	2002	2004	2006	2008	Change in percent
Central & North East	20.9	23.0	20.1	17.2	-3.7
North West	44.4	44.8	40.3	36.1	-8.3
Plympton	19.7	18.4	16.8	14.7	-4.9
Plymstock	18.8	23.9	17.8	20.6	1.7
South East	40.4	36.8	30.4	31.3	-9.2
South West	51.4	45.0	36.3	40.0	-11.5
Plymouth City	34.7	33.8	28.8	28.5	-6.3

Source: PHDU, using data collected in the survey of health visitor caseloads

7.3.4 Accident and emergency attendances (accidents)

The directly age-standardised rate of A&E attendances for accidents in Plymouth was 9,732.6/100,000 in 2009/10. The city-wide rate has varied little from 2005/06 to 2009/10, ranging from 9,595.6/100,000 in 2008/09 to 10,443.2 in 2005/06 with only a small overall decline by 2009/10. The pattern of A&E attendances for accidents is uneven across the city with the North West locality consistently recording the highest Directly Age Standardised Rate (DASR) in each financial year. In contrast, Plymstock locality consistently recorded the lowest attendance rate across the period

The pattern of change is likewise unevenly distributed across the city with the locality consistently recording the highest DASR, the North West, also recording the highest rate of increase between 2005/06 and 2009/10 (702.2). Three localities recorded a decline in their rate of A&E admissions, the biggest fall being recorded for the South West locality (-883.3).

Table 20 - A&E attendance rates due to accidents, Plymouth 2005/06 to 2009/10

	2005/06	2006/07	2007/08	2008/09	2009/10	Change in rate
Central & North East	10,800.0	11,002.4	10,167.7	9,910.7	10,106.9	357.4
North West	12,476.4	12,847.6	12,099.9	12,175.5	12,227.2	702.2
Plympton	9,190.0	9,539.6	9,085.6	8,692.6	8,847.9	-230.0
Plymstock	8,640.3	8,552.7	8,109.7	8,166.4	8,773.5	282.1
South East	9,656.8	9,812.3	9,346.9	8,868.2	8,867.8	-716.4
South West	10,696.4	10,757.5	9,478.0	9,272.4	9,238.2	-883.3
Plymouth City	10,443.2	10,603.0	9,846.8	9,595.6	9,732.6	-173.4

Source: PHDU using data supplied by Plymouth Hospitals NHS Trust

7.3.5 Substance misuse

The misuse of substances by Plymouth residents is recorded by agencies commissioned by the NHS Plymouth's Drug and Alcohol Action team. From 2006/07 to 2008/08 the number of clients in receipt of treatment for substance misuse increased from 1,820 to 2,373 (an increase of 553 (+30.3%)). The distribution of substance misuse was unevenly distributed across the city with the highest proportion resident in the South West locality (42.3%) and the lowest proportion resident within Plymstock locality (2.5%).

Table 21 - Substance misuse clients, percent by locality Plymouth 2006/07 to 2008/09

	2006/07	2007/08	2008/09	Change In percent
Central & North East	11.3	11.1	10.5	-0.8
North West	18.7	18.0	18.7	0.0
Plympton	4.3	3.7	4.3	0.0
Plymstock	2.9	2.9	2.5	-0.4
South East	21.4	20.0	21.4	0.0
South West	41.4	43.9	42.3	0.9
Plymouth City clients	1,820	2,153	2,373	553

Source: PHDU, using data provided by the HALO system

7.3.6 Parent who misuse drugs

The survey of Health Visitor caseloads suggests that a small percentage of parents with young children misuse drugs and that this percentage has fallen over the period 2002 to 2008. In 2008 1.9% of city families with young children misused drugs. The distribution of parents who misuse drugs is uneven across the city with higher percentages found in the South West (2.9%), North West (2.9%) and South East (2.8%) localities than elsewhere. Percentages in these localities are considerably higher than found in the Plympton (0.5%) and Central & North East (0.6%) localities which have the lowest percentages. The pattern of change from 2002 to 2008 is likewise uneven with those localities recording the highest percentages also recording the highest percentage point falls. Thus the South West locality recorded the largest percentage fall (-1.9 percentage point) but there was no change in the North West over the period 2002 to 2008. In contrast the percentage of parents who misuse drugs rose in Plymstock to reach 1.0% in 2008.

Table 22 - Parents misuse drugs, percentage Plymouth 2002 to 2008

	2002	2004	2006	2008	Change in percent
Central/North East	0.9	1.3	0.9	0.6	-0.3
North West	2.9	3.4	3.6	2.9	0.0
Plympton	0.6	0.5	0.5	0.5	-0.1
Plymstock	0.4	0.5	0.6	1.0	0.6
South East	2.7	2.8	2.9	2.8	0.1
South West	4.8	4.6	3.5	2.9	-1.9
Plymouth City	2.3	2.5	2.2	1.9	-0.4

Source: PHDU, using data collected in the survey of health visitor caseloads

7.3.7 Depressed/mentally ill parents

The survey of Health Visitors caseloads suggests that 13.4% of parents with young children were considered to be depressed/mentally ill in 2008. This figure has reduced by 2.7 percentage points since 2002. The distribution of depressed/mentally ill parents is uneven across the city with higher percentages found in the North West (16.4% of parents are depressed/mentally ill) and South West (15.6% of parents are depressed/mentally ill) localities in 2008. Percentages in these localities are twice that found in the Plymstock locality (8.2%) which consistently records the lowest percentage. The pattern of change from 2002 to 2008 is likewise uneven. All but one locality recorded a fall in the percentage of households containing depressed/mentally ill parents with the biggest fall being recorded by the locality (South West) with the biggest percentage of these parents (in 2002). In contrast the Plympton locality recorded the sole increase, a 5.3 percentage points rise over the period 2002 to 2008 to reach a percentage of 14.9% in 2008 – the third worst ranked locality whereas in 2002 it was the second best ranked locality.

Table 23 - Households with parents who are depressed/mentally ill, Plymouth 2002 to 2008

	2002	2004	2006	2008	Change In percent
Central & North East	13.7	15.1	13.2	10.1	-3.6
North West	17.6	20.9	19.3	16.4	-1.2
Plympton	9.6	13.3	11.1	14.9	5.3
Plymstock	8.6	10.3	11.0	8.2	-0.4
South East	15.2	16.2	17.5	12.2	-3.0
South West	24.8	24.4	19.8	15.6	-9.2
Plymouth City	16.1	17.9	16.1	13.4	-2.7

Source: PHDU, using data collected in the survey of health visitor caseloads

7.3.8 Social isolation

Social isolation has been shown repeatedly to prospectively predict mortality and serious morbidity both in general population samples and in individuals with established morbidity, especially coronary heart disease. The survey of Health Visitor caseloads suggests that 6.1% of parents with young children were

considered to be socially isolated in 2008. The distribution of socially isolated parents in 2008 is uneven across the city with the highest percentage found in the South West (9.1%) and lowest in Plympton (1.5%). The pattern of change from 2002 to 2008 is likewise uneven. Three localities recorded a fall in the percentage of households containing socially isolated parents and three recorded an increase. The Plympton locality recorded an increase in socially isolated parents of 0.8 percentage points, whilst the Central & North East locality recorded a fall of nearly 2%.

Table 24 - Households with parents who are depressed/mentally ill, Plymouth 2002 to 2008

	2002	2004	2006	2008	Change in percent
Central & North East	n/a	7.1	5.0	5.1	-1.9
North West	n/a	7.9	6.7	8.5	0.6
Plympton	n/a	1.4	1.1	2.2	0.8
Plymstock	n/a	2.6	2.1	1.5	-1.1
South East	n/a	5.2	7.2	4.7	-0.5
South West	n/a	8.6	9.5	9.1	0.5
Plymouth City	n/a	6.3	6.0	6.1	-0.2

Source: PHDU, using data collected in the survey of health visitor caseloads

7.3.9 Emergency admissions for circulatory diseases (under 75s)

The directly age standardised rate of emergency admissions for residents aged under 75 years has risen from 478.5/100,000 population in 2005/06 to 495.1/100,000 population in 2009/10. This represents an increase of 16.6 points. The pattern of admissions is unevenly distributed across the city with the highest rate found in the North West locality (625.1/100,000) in 2009/10 and the lowest rate found in Plympton (391.4/100,000). There have however been important changes amongst the localities over the period 2005/06 to 2009/10 marked by a considerable increase in the rate for residents aged under 75 years in the North West locality, particularly between 2008/09 and 2009/10, such that it recorded the highest rate for this age group in 2009/10 (625.1). In contrast, the South West locality recorded a slight decrease in its emergency admission rate from circulatory diseases from 2005/06 to 2009/10.

Table 25 - Emergency hospital admissions for circulatory disease, residents aged under 75 years, Plymouth 2005/06 to 2009/10

	2005/06	2006/07	2007/08	2008/09	2009/10	Change in rate
Central & North East	432.4	380.4	364.7	398.6	438.4	6
North West	514.6	479.9	458.2	489.8	625.1	110.5
Plympton	368.1	267.2	355.5	381.1	391.4	23.3
Plymstock	407.0	327.7	442.9	374.5	397.7	-9.3
South East	531.1	525.7	479.4	566.7	523.6	-7.5
South West	601.1	650.2	553.4	529.4	575.1	-26
Plymouth City	478.5	444.2	438.2	455.7	495.1	16.6

Source: PHDU, using data provided by Plymouth Hospitals Trust

7.3.10 Cancer mortality (under 75s)

The directly age standardised rate of cancer mortality for persons aged less than 75 years has decreased from 122.0/100,000 population in 2004 to 108.3/100,000 population in 2008. This represents a 13.7 point decrease. The highest rate in 2008 was in the South West locality (145.2/100,000 population). This compares with the Plympton locality where the rate was 80.3/100,000) in 2008. All but one locality - the South East - recorded a fall in under 75s cancer mortality rates from 2004 to 2008.

Table 26 - Cancer mortality, persons aged under 75 years, Plymouth 2004 to 2008

	2004	2005	2006	2007	2008	Change In rate
Central & North East	113.1	103.7	128.6	116.4	81.7	-31.4
North West	146.2	159.0	130.5	110.6	124.2	-22.0
Plympton	101.3	116.7	92.3	108.8	80.3	-21.0
Plymstock	110.1	118.9	102.9	80.6	98.4	-11.7
South East	103.8	84.2	100.5	95.1	131.7	27.9
South West	147.1	132.1	134.0	143.7	145.2	-1.9
Plymouth City	122.0	118.9	118.5	111.8	108.3	-13.7

Source: PHDU, using public health mortality extracts

7.3.11 Summary of indicators and localities

The below tables give a summary of all the above indicators and rank them by locality:

Table 27 - Indicator values for the most recent year from table 16 to 25

	Central & North East	North West	Plympton	Plymstock	South East	South West	Plymouth
Teenage pregnancy	26.8	81.5	20.1	39.7	58.7	80.0	52.6
Smoking in pregnancy	10.4	29.5	10.4	12.7	21.5	27.8	20.5
Parents smoke	17.2	36.1	14.7	20.6	31.3	40.0	28.5
A&E attendances (accidents)	10,106.9	12,227.2	8,847.9	8,773.5	8,867.8	9,238.2	9,732.6
Substance misuse	10.5	18.7	4.3	2.5	21.4	42.3	n.a.
Parents misuse drugs	0.6	2.9	0.5	1.0	2.8	2.9	1.9
Depressed/mentally ill parents	10.1	16.4	14.9	8.2	12.2	15.6	13.4
Social isolation	5.1	8.5	2.2	1.5	4.7	9.1	6.1
Emergency circ. dis. admits (<75s)	438.4	625.1	391.4	397.7	523.6	575.1	495.1
Cancer mortality (<75s)	81.7	124.2	80.3	98.4	131.7	145.2	108.3
Childhood Obesity	11.4	16.7	11.8	13.9	16.9	15.3	14.2

Table 28 – This table shows the indicator rankings for the most recent year from table 16 to 25

	Central & North East	North West	Plympton	Plymstock	South East	South West
Teenage pregnancy	5	1	6	4	3	2
Smoking in pregnancy	5	1	6	4	3	2
Parents smoke	5	2	6	4	3	1
A&E attendances (accidents)	2	1	5	6	4	3
Substance misuse	4	3	5	6	2	1
Parents misuse drugs	5	2	6	4	3	1
Depressed/mentally ill parents	5	1	3	6	4	2
Social isolation	3	2	5	6	4	1
Emergency circ. dis. admits (<75s)	4	1	6	5	3	2
Cancer mortality (<75s)	5	3	6	4	2	1
Childhood Obesity	6	2	5	4	1	3

Note: 1=highest or worst value, 6=lowest or best value

7.4 Section 7 of the PNA highlights in detail the key public health indicators which show the local needs of the population and outlines which localities are the most deprived. In addition to this, table 16 taken from the Department of Health publication 'Choosing Health through Pharmacy; A Programme for Pharmaceutical Public Health 2005-2015' on pages 27 and 28 of the PNA, sets out a vision for the role of pharmacy in achieving some of the key public health objectives of NHS Plymouth and the country as a whole. NHS Plymouth pharmacies already deliver some of the services mentioned in the table such as support for self care, signposting, engagement in public health campaigns and a number of locally enhanced services including supervised consumption, needle exchange, emergency hormonal contraception and Chlamydia screening, but the table gives us a clear picture of how pharmacy in terms of services can be further developed help to deliver some of our key strategic priorities.

8 Current Service Provision

8.1 Overall, Plymouth is well provided with pharmaceutical services with a total of **51** pharmacies. **37** of these are national multiples, **4** are Supermarket pharmacies **7** are independent chains with **2** single premise independents; **2** pharmacies in Plymouth provide 100 hour a week pharmacy services.

8.2 In addition to the current 51 pharmacies NHS Plymouth recently granted **2** preliminary consent applications for new pharmacies in the City. The first was an exempt 100 hour per week pharmacy located in the Marsh Mills Retail Park (approved July 2010) and the second for a new pharmacy in Barne Barton (approved April 2010). In September 2010 NHS Plymouth also granted **1** exempt application for a wholly Internet/Mail order pharmacy. A map with the location of pharmacies in Plymouth is at appendix **I**

8.3 Access to community pharmacy in Plymouth is good, with no household more than 5 minutes drive (the vast majority are within 3 minutes drive) from a community pharmacy at off peak time and no more than 8 minutes drive (the vast majority are within 5 minutes drive) during peak times. Maps showing the drive times to a pharmacies during peak and off peak time and the drive times to 100 hour pharmacies are at appendix **K**.

8.4 Opening Hours

Appendix **I** details the opening hours of community pharmacies in Plymouth. We are confident that access to community pharmacy is sufficient, and that there are currently no gaps in service provision.

8.5 In order to ensure adequate access to pharmacy services on bank holidays NHS Plymouth can ask pharmacies to open in order to secure adequate services are available for the population, this through our Out of Hours (Access to Medicines) locally enhanced service (see appendix **H**)

8.6 There is a dispensary located at Derriford Hospital which can be used for hospital out patient prescriptions.

8.7 GP Practices

There are a total of 42 GP practices and 12 Branch Surgeries across the City. A map of GP practices in the City is at appendix **J**. The average distance between a GP practice and a pharmacy is 0.18 of a mile (figures taken from NHS choices)

8.8 There is one dispensing practice located in Wotter, which is located outside of the Plymouth boundaries but which is a branch surgery of The Ridgeway Practice in Plympton. Dispensing doctors provide a valuable service in providing dispensing services in rural areas where a pharmacy may not sustain sufficient commercial business to be viable. However, dispensing doctors cannot supply over the counter medicines to patients as there may be a perceived conflict of interest.

8.9 Community Pharmacy Services

The contract for community pharmacy services was implemented on 1st April 2005. The Pharmacy contract focuses on improving the range and quality of services provided by community pharmacies. Payment by the NHS is no longer almost entirely based on volume of prescriptions dispensed.

The community pharmacy contract incorporates three levels of service (Full details of which are listed at appendix's **F,G** and **H**) They are:

• **Essential Services** – These services must be provided by all contractors and are part of the national contractual framework. Services include:

- Dispensing
- Repeat Dispensing
- Disposal of unwanted medicines
- Promotion of healthy lifestyles
- Signposting
- Support for self-care
- Clinical Governance

• **Advanced Services** – Medicines Usage Reviews. This service is part of the national contractual framework but pharmacists will need to be accredited locally to provide them and pharmacy premises will need to meet specified national standards.

Accredited pharmacies may offer patients a Medicines Use Review (MUR). The aim of this service is to improve the patient's knowledge, concordance and use of their medicines. NHS Plymouth issues guidance to pharmacists on the groups of patients that would particularly benefit from an MUR and these groups are reviewed annually. NHS Plymouth has introduced a locally "targeted MUR" for patients who have recently been discharged from hospital; patients are offered a modified MUR to improve safety and the understanding of their medication after being discharged from hospital.

• **Enhanced Services** – These services will be commissioned locally by Primary Care Trusts (PCT). Nationally agreed service specifications and benchmark prices have been developed but there is room for local negotiation. NHS Plymouth reviews and monitors all its enhanced services on a 3-year rolling process and currently commissions:

- Supervised consumption
- Needle and syringe exchange
- Emergency Hormonal Contraception (EHC)
- Out of Hours (Access to medicines)
- Chlamydia screening
- Chlamydia treatment
- Chlamydia drop bins

NHS Plymouth is also intending to commission an NRT voucher scheme which will be offered to all community pharmacies in Plymouth in February 2011.

All enhanced pharmaceutical services are reviewed on a 3-year rolling programme to ensure they are in line with the NHS Plymouth priorities and the needs of patients. NHS Plymouth will normally look to commission enhanced services from any willing provider able to meet the requirements of the relevant service specifications. If a lack of provision of an enhanced services is identified in an area of the city this does not mean there is a gap in a pharmaceutical service requiring an additional pharmacy contract; priority will always be to work with existing contractors to improve the coverage of services rather than dilute the market with additional contract

8.10 Table of Enhanced and Advanced Services

The current enhanced and advanced services provided by locality are summarised in the table below:

Table 29

	Number of pharmacies	MUR	Needle Exchange	EHC	Chlamydia Screening	*Chlamydia Treatment	*Chlamydia Drop Bins	Supervised Consumption
Central/North East	9	7	3	1	1	0	0	9
South West	16	12	7	5	5	2	2	15
South East	8	8	1	1	1	0	0	7
North West	9	7	3	1	1	0	0	9
Plymstock	4	3	1	1	1	1	1	4
Plympton	5	5	0	1	1	1	1	5
TOTALS	51	42	15	10	10	4	4	50

* Four pharmacies were specifically chosen by NHS Plymouth to provide Chlamydia treatment and Chlamydia drop bins due to their location and high numbers of Emergency Hormonal Contraception patients seen.

8.11 Provision in each locality

8.11.1 There are nine pharmacies in the Central/North East locality and nine GP practices. Seven pharmacies provide advanced services. All pharmacies provide supervised consumption, three provide needle exchange, one provides EHC and Chlamydia screening. A further pharmacy has agreed to provide EHC and Chlamydia screening and are currently being accredited to do so. Seven pharmacies are open beyond 18.00 on weekdays; nine are open on Saturdays and three on Sundays.

8.11.2 There are sixteen pharmacies in the South West locality and ten GP practices. Twelve pharmacies provide advanced services. All pharmacies provide supervised consumption, seven provide needle exchange, five provide EHC and Chlamydia screening, two provide Chlamydia treatment and Chlamydia screening drop bins. A further two pharmacies have agreed to provide EHC and Chlamydia screening and

are currently being accredited to do so. There are no pharmacies open beyond 18.00 on weekdays; eleven are open on Saturdays and none on a Sunday.

- 8.11.3 There are eight pharmacies in the South East locality and nine GP practices. All pharmacies provide advanced services. Seven pharmacies provide supervised consumption, one pharmacy provides needle exchange, one provides EHC and Chlamydia services in this locality. One pharmacy in the area has been chosen provide EHC and Chlamydia screening and is currently being accredited to do so. Five pharmacies are open beyond 18.00 on weekdays; twelve are open on a Saturdays and two on Sundays.
- 8.11.4 There are nine pharmacies in the North West locality and seven GP practices. Seven pharmacies provide advanced services. All pharmacies provide supervised consumption, three provide needle exchange, one pharmacy provides EHC and Chlamydia services from this area although five pharmacies have agreed to provide EHC and Chlamydia screening and are currently being accredited to do so. Two pharmacies are open beyond 18.00 on weekdays and five are open on Saturdays and one on Sundays.
- 8.11.5 There are four pharmacies in the Plymstock locality and three GP practices. Three pharmacies provide advanced services. All pharmacies in the locality provide supervised consumption, one provides needle exchange, one pharmacy provides EHC; Chlamydia screening and Chlamydia treatment are provided by one pharmacy. Further pharmacies have agreed to provide EHC and Chlamydia screening and is currently being accredited to do so. Two pharmacies are open beyond 18.00 on weekdays; three are open on Saturdays and one on Sundays
- 8.11.6 There are five pharmacies in the Plympton locality and four GP practices. All pharmacies provide advanced services. All pharmacies in the locality also provide supervised consumption, one pharmacy provides EHC; Chlamydia screening and Chlamydia treatment is provided by one pharmacy. There are no needle exchange pharmacies in the locality. Two pharmacies are open beyond 18.00 on weekdays and three are open on Saturdays. There are no pharmacies on Sundays

8.12 **Clinical Governance**

NHS Plymouth has developed a clinical governance plan for community pharmacy which is reviewed annually.

Areas include National Patient Safety Authority (NPSA) alerts, National Institute for Clinical Excellence (NICE) guidance, and information governance.

9 Exempt applications

9.1 NHS Plymouth has determined that the following enhanced services are directed for exempt applications:

- Supervised consumption
- Needle Exchange
- Emergency Hormonal Contraception
- Chlamydia Screening
- Chlamydia treatment
- Chlamydia drop-bins
- Paid additional hours.

As and when further enhanced services are commissioned NHS Plymouth will amend and publish this list accordingly.

9.2 For 100 hours per week pharmacies all essential services are to be provided for the full 100 hours per week. Advanced services (Medicines Use Reviews) are to be provided for no less than 75 hours per week and these services must be available on Saturdays and Sundays.

10. Outcomes of consultation process

10.1 NHS Plymouth undertook a wide consultation of the Pharmaceutical Needs Assessment between October and December 2010

There were **15** responses to the consultation of as follows:

- **1** from the Devon LPC
- **3** from pharmacy companies with contracts in the area
- **10** from pharmacy contractors in Plymouth
- **1** from a GP practice in Plymouth
- **1** from Plymouth LINKs

Of the above, **12** pharmacies completed the NHS Plymouth consultation reply form, the other **3** respondents replied via either letter or e-mail and their responses have been incorporated into the consultation assessment. A full copy of the consultation report is at appendix **E**.

11. Future Developments

11.1 Future Developments Planned to Increase the Population in Plymouth

Plymouth City Council has published its Local Development Framework (LDF) which contains the Core Strategy detailing potential developments in the city up until 2021.

Development has slowed due to adverse market conditions, but the Council is implementing Market Recovery Measures to incentivise and support development. This strategy will be reviewed in March 2011.

11.2 Brief Overview of Significant Developments Currently Being Planned:

Barne Barton – Planning permission for additional housing has been granted on two sites to date, with the possibility of others to follow. The population increase planned so far will be approximately 500, but could rise to 2,000 when other schemes come online. Housing on the first two sites is in progress and the other developments could potentially be underway by 2015.

Devonport – Some development has already been completed, but further housing should restart in the near future due to Kickstart housing development funding being provided by the Government. Total increase in the area by 2015 is estimated at 2,000

Millbay – Some development has already been completed, but further housing should restart in the near future due to Kickstart funding being provided by the Government. Total increase in the area by 2015 is estimated at 2,000

Further details are available at the Plymouth City Council Website:

www.plymouth.gov.uk/planningonline

11.3 Current pharmacy provision per head of population in Plymouth is close to the UK average; therefore we do not anticipate the need for further pharmacies to support the population. We will review the PNA to take account of any significant developments but only when they are confirmed and work is underway.

12. NHS Plymouth vision for pharmaceutical services

12.1 NHS Plymouth has a vision for improving pharmaceutical services in Plymouth over the next 3 years. All providers of community pharmacy services in Plymouth should aspire to achieving this standards set for pharmacies in this vision. NHS Plymouth would expect all providers of new enhanced services to achieve the standards set in this vision as a prerequisite. The vision is described in the sections below.

12.1.1 The Patient Offer

World Class Commissioning 'Improving pharmaceutical services' guidance requires Primary Care Trusts (PCTs) to outline the 'patient offer' which should clearly state the range of services available and what patients can expect to be provided at their local pharmacy. The patient offer should include minimum standards that a patient should expect from their community pharmacy. The patient offer which has been adopted by NHS Plymouth is:

You can expect all pharmacies in Plymouth to provide you with a wide range of high quality, accessible and cost effective, evidence based services. These include accurate and timely dispensing of medicines including repeatable NHS prescriptions, disposal of unwanted medicines, support and advice for self care and healthy lifestyles, and signposting where necessary to other health and social care providers. This is underpinned by a robust clinical governance structure to ensure patient safety. Most pharmacies will also provide you with a confidential consultation to help you get the best out the medicines you are taking.

You can expect your pharmacy to meet the following standards: to be open at least 40 hours a week - most pharmacies in Plymouth are open longer; to clearly show their opening hours and, when closed, to clearly show the location and times of alternative pharmacies; to have information available in an easily accessible format on the services provided in the form of a practice leaflet; to, at least once a year,

12.1.2 Aligning the development of community pharmacy within the wider strategic priorities for Plymouth

Developments for community pharmacy will be prioritised and considered in line with the strategic priorities set by NHS Plymouth and other strategic ambitions or requirements as may change from time to time. Chapter 4 in this PNA refers.

12.1.3 Ensuring services provided by community pharmacies in Plymouth are aligned with the identified health needs in the city

People in Plymouth have significant and widely ranging health needs. Services provided by community pharmacies must be aligned with these health needs in order that community pharmacy makes its optimum contribution towards improving health, and reducing health inequalities, in the City. Chapters 5 and 7 in this PNA refer.

12.1.4 Planning services on a locality basis

Community pharmacy services will be planned and developed on a locality basis. Chapters 6 and 8 in this PNA refer.

12.1.5 Ensuring people have appropriate access to, and choice of, community pharmacy (and applications for new pharmacies)

There is good access to community pharmacy services across the City but NHS Plymouth will commission or allow further provision, if a need is identified. Change back

NHS Plymouth will take consideration of choice of provider of NHS pharmaceutical services, as well as access, when determining applications for additional pharmacies.

Should the availability of NHS pharmaceutical services reduce then NHS Plymouth would reassess the need and commission further services accordingly. This would involve appropriate consultation.

We will ensure opening hours offered by community pharmacies continue to meet the needs of patients. Consultation and analysing ad hoc feedback from patients and the public through organisations such as the LINK will contribute to this.

Chapter 8 in this PNA refers:

12.1.6 Equality and diversity

NHS Plymouth will ensure services are provided with due regard to equality and diversity and the full range of disability issues.

12.1.7 Ensuring community pharmacy services are of high quality

NHS Plymouth will continue to administer effective and robust monitoring processes to ensure high quality services are delivered. We do this by undertaking monitoring visits and self assessments to assess how the pharmacy contract is being implemented and target areas for improvement.

NHS Plymouth will continue to work with pharmacies to help develop their knowledge and skills on specifically targeted areas such as safeguarding children and adults, the development of the clinical governance leads in pharmacies, Controlled Drugs management and encouraging reporting of, and sharing the learning from, significant Incidents.

NHS Plymouth will set clear minimum standards that all community pharmacies in Plymouth will be expected to adhere to.

12.1.8 Clinical Governance

Pharmacies are to take part in individual practice based and PCT led multi-disciplinary clinical audits, increase the reporting of significant incidents and share the results and learning across the healthcare community. They must have clear procedures and evidence for acting on and implementing all aspects of the requirements of new and existing regulations and guidance.

12.1.9 Community Information and Advice Centres

Community pharmacies are to strengthen their functions and reputations as sources of high quality and accessible information, support and advice for healthy living and health improvement. Work to ensure community pharmacies have a greater emphasis and alignment with public health needs to be undertaken. It is clear that community pharmacy can have a real impact in supporting self care in area such as maintaining weight, alcohol use, long-term conditions

12.1.10 Range of services

NHS Plymouth will continue to encourage community pharmacies to provide Additional and Enhanced Services, as well as Essential Services, to best suit their populations.

NHS Plymouth aims to increase the targeting of Medicines Usage Reviews (MURs) as an Additional Service to meet local health needs and promote and facilitate referrals for MURs from other healthcare professionals; it is clear that the development of MUR services could have a real impact in improving the health of patients in Plymouth.

There are some gaps in the provision of existing enhanced services which NHS Plymouth will seek to address:

- There are no pharmacies providing needle exchange in the Plympton locality;
- Chlamydia services are not readily available in the Central/North East, South East, North West or South East localities, although a further ten pharmacies in areas which are known as 'hot spot' in need of sexual health services, have been chosen to provide EHC and Chlamydia screening and are currently undergoing accreditation to provide these services.
- In addition a new voucher scheme for the provision of Nicotine Replacement Therapy (NRT) from community pharmacies is due to start in the autumn of 2010, this service will be offered to all pharmacies in the City.

Regarding Enhanced Services NHS Plymouth will always look to work with existing providers to improve quality and coverage of services before looking to secure additional contracts for NHS pharmaceutical services. It should be noted that resources at present are very limited for the expansion of existing services so the cost benefit of expanding any services would need to be carefully considered. Equally all existing investment must be reviewed to ensure the value for money and appropriateness (ensuring services are evidence based, safe and effective) of services delivered by community pharmacy.

Pharmacists and their teams in Plymouth are to be further recognised for their clinical skills and contribution to improving health in the City, by providing a range of services to meet the needs of their communities and by being considered for the provision of services that extend their current role but contribute to the efficiency and effectiveness of the wider health economy and health and health inequalities.

12.1.11 Leadership

Pharmacists in Plymouth should strengthen their role as community leaders, providing positive action to tackle the causes of ill health and health inequalities.

12.1.12 Workforce

Due to its location Plymouth faces specific difficulties in the recruitment of pharmacists. Locum pharmacists from outside the region are used which can present problems especially in pharmacies providing locally enhanced services. Locum pharmacists working in the city are often not accredited to provide locally commissioned services meaning the pharmacy are unable to offer the full range of commissioned services. NHS Plymouth strongly supports and is keen to help with the work being undertaken by the Strategic Health

Authority around the harmonisation of accredited services in community pharmacy; this work will have a positive impact in resolving this issue.

The contracted workforce should provide a trusted and professional service with a friendly, welcoming and competent approach. Staff must have a good knowledge and skills base with relevant qualification, registration with the appropriate governing bodies, appraisal and continuing professional development.

NHS Plymouth will develop corporate knowledge of workforce issues for effective development of the community pharmacy agenda in Plymouth and will report or share this knowledge with other bodies as appropriate in order to address potential or real issues.

12.1.13 Information Technology

NHS Plymouth will ensure all providers of NHS pharmaceutical services have appropriate systems in place to allow for electronic access, distribution of patient information and access to patient care records.

Pharmacy computer systems should have the ability to link with standard NHS systems and be able to communicate with NHS Plymouth via NHS mail.

NHS Plymouth will work with community pharmacies as it prepares for the implementation of EPS release 2 (and beyond, dependent on national and local agendas and priorities), ensuring that patient safety and choice is maintained throughout this process.

12.1.14 Premises

Pharmacy premises should project an image which complements the professionalism of Pharmaceutical providers; they should be safe, welcoming, easily accessible and comply with the Disability Discrimination Act 2005.

NHS Plymouth wishes to encourage all community pharmacies to have an accredited consultation room to enable the appropriate provision of Advanced and Enhanced services

13. Conclusions

- 13.1 There is a real challenge to continue to improve the health of people in Plymouth; there is an ageing population, percentages of women smoking in pregnancy and the percentage of mothers initiating breastfeeding are worse than the England average. The prevalence of mental health conditions, teenage pregnancy rates and hospital stays for alcohol-related harm are all also above the national average and there is a 12 year gap between the neighbourhoods with the highest and lowest life expectancy.
- 13.2 NHS Plymouth's Strategic Framework shows that we are committed to delivering a more strategic and long-term approach to commissioning services with a clear focus on delivering our targets and improving health outcomes for patients. Value for money principals mean that funding will be targeted at the areas of greatest need and through services that are proven to have the greatest impact for the investment made.
- 13.3 Community pharmacies are well placed to make very strong positive contributions to the significant agenda for improving health, reducing health inequalities and financial health of the health economy in Plymouth. By better utilising the range skills offered in pharmacies, by introducing services such as Minor Ailments schemes, it will help free up time in other areas of both secondary and primary care.
- 13.4 Based on numbers, Plymouth is well provided with pharmacies and as such there is no apparent need for additional pharmacies. No household is more than 5 minutes drive from a community pharmacy at off peak time and no more than 8 minutes during peak times. Current pharmacy provision per head of population is close to the UK average, and we do not anticipate the need for further pharmacies to support the population of Plymouth. The UK average is 20 pharmacies per 100,000 head of population, in Plymouth that figure is currently 19 and could rise to 20 with two new pharmacy applications recently approved by NHS Plymouth.
- 13.4 Plymouth currently has two 100 hour a week pharmacies which ensure patients have access to pharmaceutical services at a wide range of time to suit more of the population; we believe that any reduction in the opening hours of those pharmacies would create a gap in service provision.
- 13.5 NHS Plymouth will however consider new applications and new information on needs and developments that may change the adequacy of access and choice of NHS pharmaceutical services for the City's population.

- 13.6 Community pharmacy can and should play a greater role in pathway development. Further services could be developed and commissioned from community pharmacies to meet the key needs shown in this PNA but they would in all likelihood need to lead to savings in other areas in line with the QIPP program in order to be given serious consideration.
- 13.7 Community pharmacies need to have a greater emphasis and alignment with public health, it is clear that community pharmacy can have a real impact in supporting self care in area such as maintaining weight, alcohol use, long-term conditions.
- 13.8 NHS Plymouth is proud of the services provided by community pharmacy in Plymouth and it is pleased to have an effective and trusting relationship with the Local Pharmaceutical Committee, helping to further develop the services in Plymouth. NHS Plymouth will continue to work hard to strengthen links between community pharmacy and the wider health economy (commissioners and providers) and looks forward to the further development of pharmacies as community leaders and promoters of excellent public health.
- 13.9 NHS Plymouth sees a very positive future for community pharmacy in Plymouth.

14. References

- Plymouth Joint Strategic Needs Assessment (2009)
- Pharmacy in England: building on strengths - delivering the future(2008)
- World Class Commissioning, Primary Care & Community Services: Improving Pharmaceutical Service 'Choosing Health through pharmacy; A Programme for pharmaceutical Public Health 2005-2015'
- Community pharmacy Contractual Framework : DH
- *Healthy Lives, Healthy People: Our strategy for public health in England.* Department of Health, 30 November 2010.

15. Glossary

A&E	Accident & Emergency
APHO	Association of Public Health Observations
BME	Black & Minority Ethnic
BMI	Body Mass Index
CHD	Coronary Heart Disease
CSP	Chlamydia Screening Programme
DASR	Directly Age Standardised Rate
DH	Department of Health
EHC	Emergency Hormonal Contraception
EPS	Electronic Prescription Service
EU (A8)	European Union Accession Eight Countries
IMD2007	Index of Multiple Deprivation 2007
JSNA	Joint Strategic Needs Assessment
LDF	Local Development Framework
LES	Local Enhanced Service
LINK	Local Involvement Network
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LSOA	Lower Layer Super Output Area
MUR	Medicines Use Review
NCMP	National Child Measurement Programme
NCSP	National Chlamydia Screening Programme
NHSCB	National Health Commissioning Boards
NICE	National Institute for Health & Clinical Excellence
NPSA	National Patient Safety Agency
NRT	Nicotine Replacement Therapy

ONS	Office of National Statistics
PBC	Practice Based Commissioning
PCO	Primary Care Organisation
PCT	Primary Care Trust
PGD	Patient Group Directions
PHDU	Public Health Development Unit
PNA	Pharmaceutical Needs Assessment
QIPP	Quality Innovation Productivity & Prevention
SIP	Strategic Improvement Plan
STI	Sexually Transmitted Infections
TPCT	teaching Primary Care Trust