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# Health and Wellbeing Board

**Wednesday, 28th January, 2015**
**at 5.30 pm**

# Conference Room 3 - Civic Centre

This meeting is open to the public

**Members**

Councillor Shields (Chair)
Councillor Jeffery
Councillor Baillie
Councillor Lewzey
Councillor Chamberlain

Rob Kurn – Health Watch
Alison Elliott – Director, People
Dr A Mortimore – Director of Public Health
Dr S Townsend – Clinical Commissioning Group (Vice Chair)
Dr S Ward – NHS England Wessex Local Area Team

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## BACKGROUND AND RELEVANT INFORMATION

**Purpose of the Board**

The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities;
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

**Responsibilities**

The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
- Testing the local framework for commissioning for:
    - Health care
    - Social care
    - Public health services
    - Ensuring safety in improving health and wellbeing outcomes

**Smoking policy** – The Council operates a no-smoking policy in all civic buildings.

**Mobile Telephones:-** Please switch your mobile telephones to silent whilst in the meeting

**Southampton City Council's Priorities:**

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

**Use of Social Media:-** The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting.

**Fire Procedure** – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take

**Access** – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

**Dates of Meetings: Municipal Year 2014/15**

| 2014 | 2015 |
|---|---|
| 14 May | 28 January |
| 30 July | 25 March |
| 1 October | |
| 3 December | |

## CONDUCT OF MEETING

**BUSINESS TO BE DISCUSSED**
Only those items listed on the attached agenda may be considered at this meeting.

**PROCEDURE / PUBLIC REPRESENTATIONS**
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

**RULES OF PROCEDURE**
The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

**QUORUM**
The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

## DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

## DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class

## Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

## Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

# AGENDA

**Agendas and papers are now available via the Council's Website**

## 1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Board made in accordance with Council Procedure Rule 4.3.

## 2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

## 3 STATEMENT FROM THE CHAIR

## 4 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the Minutes of the Meeting held on 3rd December 2014 and to deal with any matters arising, attached.

## STRATEGIC DEVELOPMENTS

## 5 PHARMACEUTICAL NEEDS ASSESSMENT (PNA)

Report of the Director of Public Health requesting approval of the Pharmaceutical Needs Assessment (PNA) Consultation Report, attached.

## BOARD UPDATES AND INFORMATION

## 6 SOUTHAMPTON LOCAL PLAN FOR THE BETTER CARE FUND : POOLED FUND DEVELOPMENT

Report of the Director of Quality and Integration, Integration Commissioning Unit providing details of the Southampton Local Plan Better Care Fund : Pooled Fund Development, attached.

## 7 FEEDBACK FROM THE MENTAL HEALTH MATTERS ROUND TABLE EVENT, 4TH DECEMBER 2014

Report of the Senior Commissioner for Mental Health Services providing an overview of the first Mental Health Matters Event held on 4th December 2014, attached.

## 8 HEALTHY SOUTHAMPTON BRANDING

Report of the Director of Public Health providing details of the Healthy Southampton Branding, attached.

## 9 IMPROVING ACCESS TO GENERAL PRACTICE AND INNOVATION IN PRIMARY CARE - THE PRIME MINISTER'S CHALLENGE FUND

Report of the Chair, Southampton City Clinical Commissioning Group (CCG) providing details of a bid made by a federation of Southampton GP practices seeking funding from the Prime Minister's Challenge Fund for improving access to General Practice and stimulating innovative ways of providing Primary Care, attached.

## 10 MONITORING PROGRESS OF THE JOINT HEALTH AND WELLBEING STRATEGY

Report of the Director of Public Health providing details of arrangements for monitoring the current Joint Health and Wellbeing Strategy and making reference to initial thoughts for refreshing the Strategy in 2016, attached.

TUESDAY, 20 JANUARY 2015 HEAD OF LEGAL AND DEMOCRATIC SERVICES

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 3 DECEMBER 2014

Present: Councillors Baillie, Lewzey, Shields (Chair), Jeffery and Chamberlain Andrew Mortimore, Dr Steve Townsend (Vice-Chair), Dr Stuart Ward and Rob Kurn

Apologies: Alison Elliott

Also in attendance: Sue Leamon, Vice-Chair-Southampton Connect, Councillor Stevens, Chair of Health Overview and Scrutiny Panel, Stephanie Ramsey, Director of Quality and Integration

22. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

Councillor Shields declared a personal interest in that he was a Council appointed representative of Solent NHS Trust and remained in the meeting and took part in the consideration and determination of items on the agenda.

Councillor Lewzey declared a personal interest in that he was a Council appointed representative of Southern Health NHS Foundation Trust and remained in the meeting and took part in the consideration and determination of items on the agenda.

23. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

**RESOLVED** that the Minutes of the Meeting held on 1 October 2014 be approved and signed as a correct record.

24. **HEALTH OVERVIEW AND SCRUTINY PANEL INQUIRY REPORT: THE IMPACT OF HOUSING AND HOMELESSNESS ON THE HEALTH OF SINGLE PEOPLE**

The Board considered the report of the Director of Public Health providing details of the Health Overview and Scrutiny Panel (HOSP) Inquiry into the “Impact of Homelessness on the Health of Single People”.

Councillor Stevens, Chair of the Health Overview and Scrutiny Panel was present and with the consent of the Chair, addressed the meeting.

It was acknowledged that the impact of housing and homelessness had a direct link on the health of single people and that the following issues should be considered a priority for long-term, sustainable improvements for single homeless people in the City:-

- the quality and availability of single units and shared accommodation for single people in the system should be maximised through the Housing Strategy as well as working with landlords of private housing;
- continued transformation through early help and improved outcomes for children who were looked after;
- Mental Health Support and Services be reviewed to ensure early intervention and smooth transition into adult services;

- consideration of “invest to save” opportunities including a “dry” hostel option and a “Housing First” model; and
- increased awareness of homelessness and expansion of the Homelessness Partnership.

The Board noted that further information and feedback would be provided by officers in relation to the following recommendations:-

- Recommendation 10
  consideration of the outcomes from the Southampton Healthwatch Review of General Practitioner (GP) Registration with specific emphasis on working with GP’s to improve access and integration to support homeless clients to move away from Homeless Health Care to Primary Care Services;
  Recommendation 15
  Commissioners of Homelessness Services should consider the option of providing a “dry” environment within the Homelessness Prevention Model in the City, to support those who wanted to become sober or stay sober; and
- Recommendation 25
  Homelessness Commissioners should undertake a City-wide review of services which might come under threat due to lack of funding, with immediate consideration being given to determining the value of these services to the City’s Homelessness Model and health outcomes for individuals at The Two Saints Day Centre, the Breathing Space Project and the Vulnerable Adult Support Team in the University Hospital Southampton NHS Trust’s Emergency Department.

**RESOLVED**:-

(i) that the Health Overview and Scrutiny Inquiry Report on “The Impact of Housing and Homelessness on the Health of Single People” be noted; and
(ii) that officers be requested to provide further feedback to the Executive, prior to the 20th January 2015 Cabinet Meeting on Recommendations 10, 15 and 25 in Appendix 2 to the Report.

25. **HEALTH INEQUALITIES IN SOUTHAMPTON**

The Board considered the report and received a presentation from the Director of Public Health providing details of the health inequalities that existed in the City.

The Board noted:-

- that the Marmot Review highlighted the fact that social and economic status affected people’s health;
- that people in deprived areas were twice as likely to die before reaching 75 years old, twice as likely to die from heart disease or a stroke and early deaths from cancer and lung disease were also more prevalent; and these inequalities were not being reduced;
- that smoking was the primary reason for the difference in life expectancy between the different classes in Southampton, followed by obesity and alcohol;
- that early intervention with children at a very young age was key to the problem; and

- that an engagement exercise should be undertaken to identify the challenges and key strands that would have the most impact covering the following:-
  - understanding the levels and the consequences of health inequalities;
  - how the plans and strategies of other Partnerships and Agencies could be linked with the work of the Health and Wellbeing Board to reduce health inequalities within the City and the City region;
  - how the Health and Wellbeing Board could effectively engage with other sectors and communities not represented on the Board to discuss health inequalities; and
  - what additional support was required from the Health and Care Community to address these issues;

**RESOLVED**:-

(i) that health inequalities could be addressed by engagement with a wider range of organisations; and

(ii) that a working party to identify and investigate specific health inequality issues be established and its findings be reported back to the Health and Wellbeing Board at a future meeting.

26. **BETTER CARE SOUTHAMPTON UPDATE**

The Board considered the report of the Director of Quality and Integration, Integrated Commissioning Unit providing an update on the progress towards the implementation of Better Care Southampton.

The Board noted the following:-

- that on 29th October 2014 NHS England had confirmed that the Southampton Better Care Fund (BCF) local plan had been "Approved with Support";
- that work was currently underway to develop a Section 75 Pooled Fund Agreement with the legal and financial expertise of both the Local Authority and Health, which was being overseen by the Integrated Commissioning Board;
- that a joint meeting of General Practitioners was scheduled to be arranged to discuss the details of the Better Care Fund, to which members of the Health and Wellbeing Board and the Health Overview and Scrutiny Panel would be invited; and
- that when received, feedback from the Cabinet Office, analysing Southampton's progress on Southampton's Better Care Plan would be circulated to Board Members.

**RESOLVED**:-

(i) that approval of Southampton's Better Care Plan, following the Nationally Consistent Assurance Review (NCAR) process be noted;

(ii) that the progress made towards the implementation of Better Care Southampton be noted; and

(iii) that following the Cabinet decision on 20th January 2015 to approve Southampton's Local Plan for the Better Care Fund, the Section 75 Pooled Fund Agreement, which required to be in place by 1 April 2015 be endorsed

by the Health and Wellbeing Board at the meeting scheduled for 28th January 2015.

27. **CARE ACT 2014**

The Board received a presentation from the Director of Quality and Integration, Integrated Commissioning Unit providing details of the 2014 Care Act.

The Board noted the following:-

- that the majority of provisions of the 2014 Care Act would come into force in April 2015, with those relating to funding reform from April 2016 and this would have a major impact on Local Authorities in relation to Adult Social Care responsibilities;
- that there would be implications for the whole Care System and the specific duties and responsibilities that would impact on Southampton City Council from April 2015 were:-
  - a new power to delegate assessment and other functions to external organisations;
  - a new eligibility framework for carers and a duty to support carers with eligible needs;
  - a new integrated charging system;
  - the extension of the Universal Deferred Payment Scheme; and
  - a requirement to provide an Information and Advice Service ensuring that independent financial advice was available and that independent advocates were provided where appropriate.
- that the presentation on the 2014 Care Act would be circulated electronically to Board Members; and
- that all Councillors would be invited to attend a briefing on the 2014 Care Act in the near future.

| | | | | |
|---|---|---|---|---|
| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | PHARMACEUTICAL NEEDS ASSESSMENT (PNA) | | |
| **DATE OF DECISION:** | | 28th JANUARY 2015 | | |
| **REPORT OF:** | | DIRECTOR OF PUBLIC HEALTH | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR**: | **Name:** | **Dan King** | **Tel:** | **023 80 832493** |
| | **E-mail:** | **dan.king@southampton.gov.uk** | | |
| **Director** | **Name:** | **Andrew Mortimore** | **Tel:** | **023 80 833738** |
| | **E-mail:** | **andrew.mortimore@southampton.gov.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None | | | | |

**BRIEF SUMMARY**

The Southampton Health & Wellbeing Board has an obligation to produce a Pharmaceutical Needs Assessment (PNA) for the city by 1st April 2015. A draft PNA was presented to the board at its previous meeting on 1st October 2014, where it was approved for public consultation. The statutory 60 day consultation on the draft PNA commenced on 16th October and closed on 18th December. A consultation report has been written and responses taken into account in drafting the post consultation PNA, which are now presented to the Health and Wellbeing Board for final approval prior to publication.

**RECOMMENDATIONS:**

(i) That the consultation report be approved and the responses recommended by the PNA Steering Group to points raised in the consultation be endorsed by the Board.

(ii) That the post consultation Pharmaceutical Needs Assessment be approved and adopted by the Board ready for publication on 1st April 2015.

(iii) That authority be delegated to the Director of Public Health following consultation with the Chair and Vice-Chair of the Board, to make any drafting or other changes necessary, including any amendments recommended by the Health and Wellbeing Board.

(iv) That authority be delegated to the Director of Public Health to publish any supplementary statements to the PNA, required by the NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations (2013), to reflect any minor changes to the availability of pharmaceutical services in the city following the publication of the PNA.

## REASONS FOR REPORT RECOMMENDATIONS

1. To enable the publication of a Pharmaceutical Needs Assessment for Southampton by 1st April 2015 as stipulated in the NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations 2013.

## ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2 None. It is a statutory requirement to publish a PNA for the city by 1st April 2015 that secures the pharmaceutical needs of the citizens of Southampton.

## DETAIL (Including consultation carried out)

3. At its meeting on 30th July the Health and Wellbeing Board approved a process to ensure that a Pharmaceutical Needs Assessment would be in place by 1st April 2015, as required by the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. As previous reports stated, the PNA is a tool for control of market entry and should only include those pharmaceutical services commissioned by NHS England. As the purpose of a PNA is to support market entry decisions, the document will not deal directly with the provision of public health activity within pharmacies but will link to relevant strategies and needs assessments.

4. The draft PNA has been developed by the consultants, Primary Care Commissioning (PCC), who secured the contract to undertake the work to produce the PNA, and concluded that there was adequate provision of pharmaceutical services in the city. The draft was reviewed by the PNA steering group and approved by the Health and Wellbeing Board at its meeting on 1st October ready for a statutory extensive 60 day engagement and consultation process to establish if the pharmaceutical providers and services supporting the population of Southampton are accurately reflected in the PNA.

5. The consultation ran from 16th October until 18th December and consulted those parties identified under Regulation 8 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) 2013, which included the Local Pharmaceutical Committee (LPC), Healthwatch, NHS Trusts, neighbouring Health & Wellbeing Board areas and pharmaceutical contractors. In addition, other local stakeholders were invited to consult on the draft. These included patient groups and commissioners such as local CCGs. Each consultee was contacted via a letter inviting them to respond to the consultation. In addition, e-mail reminders were sent a month into the consultation period to those consultees for which the steering group had a valid e-mail address.

6. Seven responses were received to the formal consultation. Overall, the majority of responses received were supportive of the draft PNA and the limited comments offered provided no reason to alter the conclusions for the final published PNA, although a number of minor changes were made as outlined below. A full consultation report has been prepared by PCC (see appendix 1) which outlines the consultation process, responses received and actions taken. PCC will be in attendance at the meeting and will summarise the process and contents to the Board.

7. Although the number of responses to the formal consultation was lower than expected, additional engagement with patients and contractors was undertaken through online questionnaires. The interim results from this engagement process were included in the draft PNA. However, as stated in the previous report to the Health and Wellbeing Board, the steering group felt it important to give the maximum amount of time for patients and contractors to respond and so the questionnaires remained open for four weeks into the formal consultation period. Overall 16 responses were received to the contractor questionnaire, whilst 327 responses to the patient questionnaire were received from the public which is considered to be a very good response rate.

8. Following the completion of the patient and contractor engagement and conclusion of the formal consultation, the steering group have considered the results and a final version of the PNA has been prepared by PCC (presented in appendix 2). A summary of the changes made are provided below:

- DRAFT watermark removed and report header changed.
- Minor typographical errors and clarification points raised by the LPC corrected.
- Executive summary changed to reflect the completion of the consultation.
- Sections 3.3.7 and 3.3.10 from the draft PNA combined into one section on tobacco, alcohol and other substance misuse, to avoid duplication (3.3.7 in the final PNA).
- Countess Mountbatten Hospice (CMH) removed from section 6.1 following clarification.
- Updated final patient survey results in sections 1.6.3 (summary) and 5.6 (patient access themes).
- Updated final contractor questionnaire results in sections 1.6.4 (summary) and 5.7 (results).
- Changes made to section 6.6 to reflect the fact that the Clinical Commissioning Group (CCG) now commissions a Minor Ailments Service.
- Contents page updated as a result of the above changes.
- Appendix M updated to reflect the relocation of one pharmacy.
- No changes were made to the conclusions.

9. The PNA steering group present the consultation report (appendix 1) and the updated PNA (appendix 2) to the Health and Wellbeing board for approval. The Health and Wellbeing Board are asked to delegate authority to the Director of Public Health, in consultation with the Chair and Vice-Chair, to make any final changes necessary to publish the PNA by 1st April 2015.

10. The Health and Wellbeing Board is required to publish a refreshed PNA within three years of its previous publication. However, it must also make a revised assessment as soon as reasonably practicable after identifying

changes since the previous assessment, which are of significant extent, to the need for pharmaceutical services in the city. If this is deemed to be a disproportionate response to these changes, the Health and Wellbeing Board may publish a supplementary statement explaining changes to the availability of pharmaceutical services since the publication of its PNA. The PNA Steering Group have agreed a process for the notification of any changes to pharmaceutical services in the city and for the publication of any necessary supplementary statements that may be necessary as a result. The Health and Wellbeing Board are asked to delegate authority to the Director of Public Health to publish any necessary supplementary statements reflecting minor changes to services. Any changes which are deemed to require a full revised assessment will be notified to the Board.

**RESOURCE IMPLICATIONS**

**Capital/Revenue**

11. The costs for procuring the services of a private provider to conduct the PNA are being met from the 2014/15 Public Health budget. There are also resource implications in terms of staff time to manage the contract and collate some data. The stakeholder consultation has resource implications for the Public Health team, other SCC departments and for partner organisations.

**Property/Other**

12. None

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

13. The requirements for a PNA are set out in the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

**Other Legal Implications:**

14. None

**POLICY FRAMEWORK IMPLICATIONS**

15. None

**KEY DECISION?** N/A

**WARDS/COMMUNITIES AFFECTED:**

The PNA covers the whole city but areas of disadvantage and their access to pharmaceutical services will be a major consideration.

## SUPPORTING DOCUMENTATION

**Appendices**

| | |
|---|---|
| 1. | Appendix K – Southampton PNA Consultation Report |
| 2. | Southampton Post Consultation PNA |

**Documents In Members' Rooms**

| | |
|---|---|
| 1. | None |

**Equality Impact Assessment**

| | |
|---|---|
| Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out. | Yes |

**Other Background Documents**

**Equality Impact Assessment and Other Background documents available for inspection at:**

| | Title of Background Paper(s) | Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable) |
|---|---|---|
| 1. | None. | |

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**Appendix K**

## Consultation Report

### Introduction

As part of the PNA process there is a statutory provision that requires consultation of at least 60 days to take place to establish if the pharmaceutical providers and services supporting the population in the Health and Wellbeing Board (HWB) area are accurately reflected in the final PNA document, which is to be published by 1st April 2015. This report outlines the considerations and responses to the consultation and describes the overall process of how the consultation was undertaken.

### Consultation Process

In order to complete this process the HWB has consulted with those parties identified under Regulation 8 of the NHS (Pharmaceutical and Local Pharmaceutical Services Regulations) 2013, to establish if the draft PNA addresses issues that they considered relevant to the provision of pharmaceutical services. Examples of consulted parties include: the LPC, LMC, Healthwatch, NHS Trusts, neighbouring HWB areas and those on the pharmaceutical lists.

In addition, other local stakeholders were invited to consult on the draft. These included patient groups and commissioners such as local CCGs. A list of organisations consulted is provided in the attached list.

Each consultee was contacted via a letter explaining the purpose of the PNA and that as a statutory party; the HWB welcomed their opinion on whether they agreed with the content of the proposed draft. They were directed to the Southampton City Council website to access the document and accompanying appendices, and offered the option of a hard copy if they wanted one.

Consultees were given the opportunity to respond by completing a set of questions and/or submitting additional comments. This was undertaken by completing the questions online, via a link or alternatively email, post or paper copy.

The questions were designed to assess the current provision of pharmaceutical services, have regard to any specified future circumstance where the current position may materially change and identify any current and future gaps in pharmaceutical services.

The consultation ran from 16th October 2014 until 18th December 2014.

### Results

The online consultation received a total of 7 responses, which identified themselves as the following:

| Answer Options | Response Percent | Response Count |
|---|---|---|
| On behalf of a pharmacy/dispensing appliance contractor | 16.7% | 1 |
| On behalf of an organisation | 83.3% | 5 |
| A personal response | 0.0% | 0 |
| *answered question* | | 6 |
| *skipped question* | | 1 |

This report outlines the considerations and responses to the consultation. It should be noted that participants in the consultation were not required to complete every question. As a result percentages are derived from the number of responses to the questions rather than the number of overall respondents.

**Summary of Online Questions, Responses and HWB Considerations**

In asking the following questions:

> **"Has the purpose of the PNA been explained sufficiently"**;
>
> "**Has the scope of the PNA been explained sufficiently**";
>
> "**Are localities clearly defined throughout the draft PNA**";
>
> "**Does the PNA reflect the current provision of pharmaceutical services within Southampton City Council**";
>
> "**Has the PNA provided adequate information to inform market entry decisions**";
>
> "**Has the PNA provided adequate information to inform how services may be commissioned in the future**";

the HWB appreciated the respondents' wholly positive confirmation.

In asking "**Are there any gaps in the service provision; i.e. when, where and which services are available that have not been identified in the PNA**", the HWB noted the majority of respondents confirmed there were no gaps in service provision. The remaining reply did not offer an explanation to what the gaps maybe.

In asking "**Does the draft PNA reflect the needs of the Southampton population**", the HWB noted the majority (83.3%) of the respondents agreed the needs of the population were addressed. However, two comments were received and considered by the HWB, as shown below:

| Comment: | Suggested HWB response |
|---|---|
| It would have been useful to have understood the provision of pharmaceutical services in relation to students and where the main areas of their accommodation are within Southampton as this is such a large group of people who potentially would access those services relating to smoking, sexual health etc. | The HWB confirmed that the student population formed part of the overall consideration. However, the comment does not identify a need not provided by the current provision identified within the PNA. |
| There are, however, additional services that could be commissioned to enhance service provision beyond need alone e.g palliative Care Service, Minor Ailments etc. | The HWB are mindful that such services are regularly reviewed however the comment does not identify a specific gap in service not currently met. However those identified services are commissioned from the CCG as shown in section 6.5 of the published PNA. |

In asking "**Has the PNA provided enough information to inform future service provision and plans for pharmacies and dispensing appliance contractors**", the HWB noted the majority of respondents' positive confirmation however, one comment was received and considered by the HWB, as shown below:

| Comment: | Suggested HWB response |
|---|---|
| However, the PNA is a document written to ensure that regulatory requirements are met. It does not talk about innovation, enhancement of service provision beyond need or reflect the pilots of service that organisations such as the AHSN are supporting | The HWB noted the comment concurred that the regulatory requirement was met. The other matters are not within the scope of the PNA. |

In asking "**Are there any services that could be provided in the community pharmacy setting in the future that have not been highlighted**", the HWB noted the majority of respondents confirmed there was not, however one comment was received and considered by the HWB as shown below:

| Comment: | Suggested HWB response |
|---|---|
| Amongst others, the following could be provided:<br>Brief Alcohol Intervention<br>COPD; Atrial Fibrillation;<br>Signposting to third sector & social services;<br>Extend the number of Healthy Living Pharmacies providing a broad range of public health & wellness services & advice;<br>Dementia support; Palliative care services;<br>Minor (common) Ailment scheme;<br>Repeat dispensing service;<br>Anticoagulation services. | The HWB are mindful that such services are regularly reviewed and some are currently provided. However the comment does not identify a specific gap in service not currently met. |

In seeking to establish whether the respondents agreed with the conclusions of the PNA, the HWB noted the majority (83.3%) concurred with no reasons as to why not given by those not in agreement. Respondents were asked if they had any further comments in addition to the questions asked, but no further comments were made.

**Comments Received By Post and Email**

In addition to the on-line responses, the HWB received and considered the following responses:

By email, the Hampshire Health and Wellbeing Board expressed the view that the draft PNA "*needs to describe the services outside of Southampton that residents may use in Hampshire and how this affects access to services. In particular Section 5.2.1 describes the services outside of Southampton that a resident may use, this would benefit from some more detail. It would be beneficial to clarify that for some residents the nearest pharmacy will be outside of Southampton and located in the county of Hampshire"*:

In the HWB's view, while appreciative of the comment, there is no further detail available other than potentially naming each pharmacy used in the Hampshire area, which will not add to the conclusions of the PNA.

**Amendments**

During the consultation, the HWB received notification from NHS England of a relocation of the Lloyds pharmacy shown as index 42 on appendix M to the PNA. This was not considered significant and hence no changes to the conclusions of the draft PNA were required, other than amending appendix M accordingly as below:

| | |
|---|---|
| Lloyds Pharmacy Ltd<br>1 Market Buildings<br>Stoneham Lane<br>Swaythling<br>Southampton<br>SO16 2HW | Lloyds Pharmacy Ltd<br>Health Centre<br>Southampton City Gateway<br>Parkville Road<br>Swaythling<br>Southampton<br>SO16 2JA |

The Clinical Commissioning Group commenced the commissioning of a Minor Ailments scheme with effect from 19th January 2015, which is reflected in section 6.6 of the published PNA.

The email response from the Hampshire Health and Wellbeing Board pointed out that at section 6.1 in incorrect in that *"Countess Mountbatten Hospital is located in Hampshire (outside of Southampton) not Southampton."* The HWB amended the paragraph accordingly for the published PNA.

In addition to completing the online questionnaire, the LPC provided minor observations on the draft PNA for completeness. The HWB are grateful for the LPC's time and considered their comments amending the PNA where relevant.

**Summary Conclusions**

The HWB concluded that the majority of the responses were supportive of the draft PNA and the limited comments offered provided no reason to alter the conclusions for the final published PNA, albeit minor amendments were made as outlined in this consultation report.

## List of Consultees:

| Consultee | Type |
|---|---|
| Southampton pharmacy contractors (see appendix M) | Statutory consultee |
| Local Pharmaceutical Committee (LPC) | Statutory consultee |
| Local Medical Committee (LMC) | Statutory consultee |
| Southampton Healthwatch | Statutory consultee |
| University Hospital Southampton NHS Trust | Statutory consultee |
| Solent NHS Trust | Statutory consultee |
| Southern Health NHS Foundation Trust | Statutory consultee |
| NHS England | Statutory consultee |
| Hampshire Health & Wellbeing Board | Statutory consultee |
| Portsmouth Health & Wellbeing Board | Statutory consultee |
| Wiltshire Health & Wellbeing Board | Statutory consultee |
| NHS Southampton Clinical Commissioning Group (CCG) | Statutory consultee |
| Age UK (Southampton) | Patient Group |
| Arthritis Care Southampton Group | Patient Group |
| Carers Together (Southampton) | Patient Group |
| Choices Advocacy | Patient Group |
| Chrysalis | Patient Group |
| Diabetes UK Southampton Group | Patient Group |
| EU Welcome | Patient Group |
| Expert Patients Programme | Patient Group |
| Hampshire Autistic Society | Patient Group |
| Keeping Pace with Pain | Patient Group |
| Macmillan Cancer support | Patient Group |
| MORPH | Patient Group |
| No Limits | Patient Group |
| Options Counselling | Patient Group |
| Parent Support Link | Patient Group |
| Society of St James | Patient Group |
| Solent Mind | Patient Group |
| Sonus | Patient Group |
| Southampton Learning Disability Partnership board | Patient Group |
| Southampton Mencap | Patient Group |
| Southampton Sight | Patient Group |
| Southern Health NHS Foundation Trust | Patient Group |
| Spectrumcil | Patient Group |
| The Rose Road Association | Patient Group |
| Thornhill Health and Wellbeing Network (THAWN) | Patient Group |
| Two Saints | Patient Group |

# Southampton Pharmaceutical Needs Assessment

## Primary Care Commissioning (PCC)
## March 2015

# Contents

# Executive summary

From 1 April 2013, every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up-to-date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment' (PNA).

The PNA will be used by NHS England in its determination as to whether to approve applications to join the pharmaceutical list under The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. The relevant NHS England Area Team will then review the application and decide if there is a need for a new pharmacy in the proposed location. When making the decision NHS England is required to refer to the local PNA.

This PNA describes the needs for the population of Southampton.

This PNA considers current provision of pharmaceutical services across Southampton. The PNA aims to identify whether current pharmaceutical service provision meets the needs of the population. The PNA considers whether there are any gaps to service delivery.

The PNA may be used to inform commissioners such as Clinical Commissioning Groups (CCGs) and Local Authority Public Health, of the current provision of pharmaceutical services and where there are any gaps in relation to the local health priorities. Where such gaps are not met by NHS England, these gaps may then be considered by those organisations.

The PNA includes information on:

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

In order to inform the draft PNA, the HWB established a steering group. The group undertook a public survey and sought information from pharmacies as well as NHS England. The local authority and clinical commissioning group also provided information.

The draft PNA having regard to the totality of information available, the HWB consider the location, number, distribution and choice of pharmacies covering the whole conurbation of Southampton providing pharmaceutical services during the available hours to meet the needs of the population. The HWB has not received any significant information to conclude otherwise currently or of any future specified circumstance that would alter that conclusion.

The draft PNA concluded that no gaps in pharmaceutical services had been established. A 60 day statutory consultation was undertaken and the responses used to inform the final conclusions published. The HWB considered those responses and determined to adopt the draft conclusions.

# 1 Introduction

Glossary and acronyms are provided at the end of this PNA.

## 1.1 Purpose of a PNA

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

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

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

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

## 1.2 HWB duties in respect of the PNA

Further information on the HWB's specific duties in relation to PNAs and the policy background to PNAs can be found in appendix A, however in summary the HWB must:

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

## 1.3 Pharmaceutical services

The services that a PNA must include are defined within both the NHS Act 2006 and the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended (the 2013 regulations).

Pharmaceutical services may be provided by:

- A pharmacy contractor who is included in the pharmaceutical list for the area of the HWB;
- A pharmacy contractor who is included in the local pharmaceutical services (LPS) list for the area of the HWB;
- A DAC who is included in the pharmaceutical list held for the area of the HWB; and
- A doctor who is included in a dispensing doctor list held for the area of the HWB.

NHS England is responsible for preparing, maintaining and publishing these lists. It should be noted, however, that for Southampton HWB there is no dispensing doctor list as there are no dispensing doctors within the HWB's area. Similarly there is also no LPS list as there are no contractors within the HWB's area that hold a LPS contract with NHS England.

Contractors may operate as either a sole trader, partnership or a body corporate. The Medicines Act 1968 governs who can be a pharmacy contractor, but there is no restriction on who can operate as a DAC.

**1.3.1 Pharmaceutical services provided by pharmacy contractors**

Unlike for GPs, dentists and optometrists, NHS England does not hold contracts with pharmacy contractors. Instead they provide services under a contractual framework, details of which (their terms of service) are set out in schedule 4 of the 2013 regulations and also in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 (the 2013 directions).

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

- Essential services – all pharmacies must provide these services
    - Dispensing of prescriptions (both electronic and non-electronic), including urgent supply of a drug or appliance without a prescription
    - Dispensing of repeatable prescriptions
    - Disposal of unwanted drugs
    - Promotion of healthy lifestyles
    - Signposting
    - Support for self-care

- Advanced services – pharmacies may choose whether to provide these services or not. If they choose to provide one or more of the advanced services they must meet certain requirements and must be fully compliant with the essential services and clinical governance requirements.
    - Medicine use review and prescription intervention services (more commonly referred to as the medicine use review or MUR service)
    - New medicine service (Note post-consultation - a funding settlement agreed in November 2014 means NMS will continue)
    - Stoma appliance customisation
    - Appliance use review

- Enhanced services – service specifications for this type of service are developed by NHS England and then commissioned to meet specific health needs.
    - Anticoagulation monitoring
    - Care home service
    - Disease specific medicines management service
    - Gluten free food supply service
    - Independent prescribing service

- Home delivery service
- Language access service
- Medication review service
- Medicines assessment and compliance support service
- Minor ailment scheme
- Needle and syringe exchange*
- On demand availability of specialist drugs service
- Out of hours service
- Patient group direction service*
- Prescriber support service
- Schools service
- Screening service*
- Stop smoking service*
- Supervised administration service*
- Supplementary prescribing service

It should be noted that since 1 April 2013 those enhanced services marked with an asterisk are commissioned by Southampton City Council.

Further information on the essential, advanced and enhanced services requirements can be found in appendices B, C and D respectively.

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

- A patient and public involvement programme
- A clinical audit programme
- A risk management programme
- A clinical effectiveness programme
- A staffing and staff programme
- An information governance programme
- A premises standards programme.

Pharmacies are required to open for 40 hours per week, and these are referred to as core opening hours, but many choose to open for longer and these hours are referred to as supplementary opening hours. Between April 2005 and August 2012, some contractors successfully applied to open new premises on the basis of being open for 100 core opening hours per week (referred to as 100 hour pharmacies), which means that they are required to be open for 100 hours per week, 52 weeks of the year (with the exception of weeks which contain a bank or public holiday, or Easter Sunday). These 100 hour pharmacies remain under an obligation to be open for 100 hours per week. In addition these pharmacies may open for longer hours.

The proposed opening hours for each pharmacy are set out in the initial application, and if the application is granted and the pharmacy subsequently opens then these form the pharmacy's contracted opening hours. The contractor can subsequently apply to change their core opening hours. NHS England will assess the application against the needs of the population of the HWB area as set out in the PNA to determine whether to agree to the change in core hours or not. If a contractor wishes to change their supplementary opening hours they simply notify NHS England of the change, giving at least three months' notice.

Whilst the majority of pharmacies provide services on a face-to-face basis e.g. people attend the pharmacy to ask for a prescription to be dispensed, or to receive health advice, there is one type of

pharmacy that is restricted from providing services in this way. They are referred to in the 2013 regulations as distance selling premises (previously called wholly mail order or internet pharmacies).

Distance selling pharmacies are required to provide essential services and participate in the clinical governance system in the same way as other pharmacies; however they must provide these services remotely. For example a patient posts their prescription to a distance selling premises and the contractor dispenses the item and then delivers it to the patient's address. Distance selling pharmacies therefore interact with their customers via the telephone, email or a website and will deliver dispensed items to the customer's preferred address. Such pharmacies are required to provide services to people who request them wherever they may live in England.

**1.3.2 Pharmaceutical services provided by DACs**

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

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

- Dispensing of prescriptions (both electronic and non-electronic), including urgent supply without a prescription
- Dispensing of repeatable prescriptions
- Home delivery service
- Supply of appropriate supplementary items (e.g. disposable wipes and disposal bags)
- Provision of expert clinical advice regarding the appliances
- Signposting

Further information on the requirements for these services can be found in appendix E.

All DACs must provide the above services.

- Advanced services – DACs may choose whether to provide these services or not. If they do choose to provide them then they must meet certain requirements and must be fully compliant with their terms of service and the clinical governance requirements.
    - Stoma appliance customisation
    - Appliance use review

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

- A patient and public involvement programme
- A clinical audit programme
- A risk management programme
- A clinical effectiveness programme
- A staffing and staff programme
- An information governance programme.

DACs are required to open at least 30 hours per week and these are referred to as core opening hours. They may choose to open for longer and these hours are referred to as supplementary opening hours.

The proposed opening hours for each DAC are set out in the initial application, and if the application is granted and the DAC subsequently opens then these form the DAC's contracted opening hours.

The contractor can subsequently apply to change their core opening hours. NHS England will assess the application against the needs of the population of the HWB area as set out in the PNA to determine whether to agree to the change in core hours or not. If a contractor wishes to change their supplementary opening hours they simply notify NHS England of the change, giving at least three months' notice.

#### 1.3.3 Pharmaceutical services provided by doctors

The 2013 regulations allow doctors to dispense to eligible patients in certain circumstances. As there are no dispensing doctors within the HWB's area this route of provision is not included in this document.

#### 1.3.4 Local pharmaceutical services

Local pharmaceutical services (LPS) contracts allow NHS England to commission services, from a pharmacy, which are tailored to specific local requirements. LPS complements the national contractual arrangements but is an important local commissioning tool in its own right. LPS provides flexibility to include within a contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national contractual arrangements. For the purposes of the PNA the definition of pharmaceutical services includes LPS. There are, however, no LPS contracts within the HWB's area and NHS England does not have plans to commission such contracts within the lifetime of this PNA.

## 1.4 Locally commissioned services

Southampton city council and Southampton CCG may also commission services from pharmacies and DACs, however these services fall outside the definition of pharmaceutical services. For the purposes of this document they are referred to as locally commissioned services and examples include the sexual health services commissioned by Southampton city council:

- Chlamydia screening
- Emergency hormonal contraception (the 'morning after pill')
- Needle exchange
- Supervised consumption of methadone and buprenorphine

Locally commissioned services are included within this assessment where they affect the need for pharmaceutical services, or where the further provision of these services would secure improvements or better access to pharmaceutical services.

## 1.5 Other NHS services

Other services which are commissioned or provided by NHS England, Southampton city council, Southampton CCG and University Hospital Southampton NHS Foundation Trust (UHS), which affect the need for pharmaceutical services, are also included within the PNA.

## 1.6 How the assessment was undertaken

#### 1.6.1 PNA steering group

The HWB has overall responsibility for the publication of the PNA, and the director of public health is the HWB member who is accountable for its development. The HWB has established a PNA steering group whose purpose is to ensure that the HWB develops a robust PNA that complies with the 2013

regulations and the needs of the local population. The membership of the steering group ensured all the main stakeholders were represented. The membership of the group can be found in appendix F.

Following a competitive tender process PCC was appointed to draft the PNA on behalf of the HWB, working closely with the steering group.

### 1.6.2 PNA localities

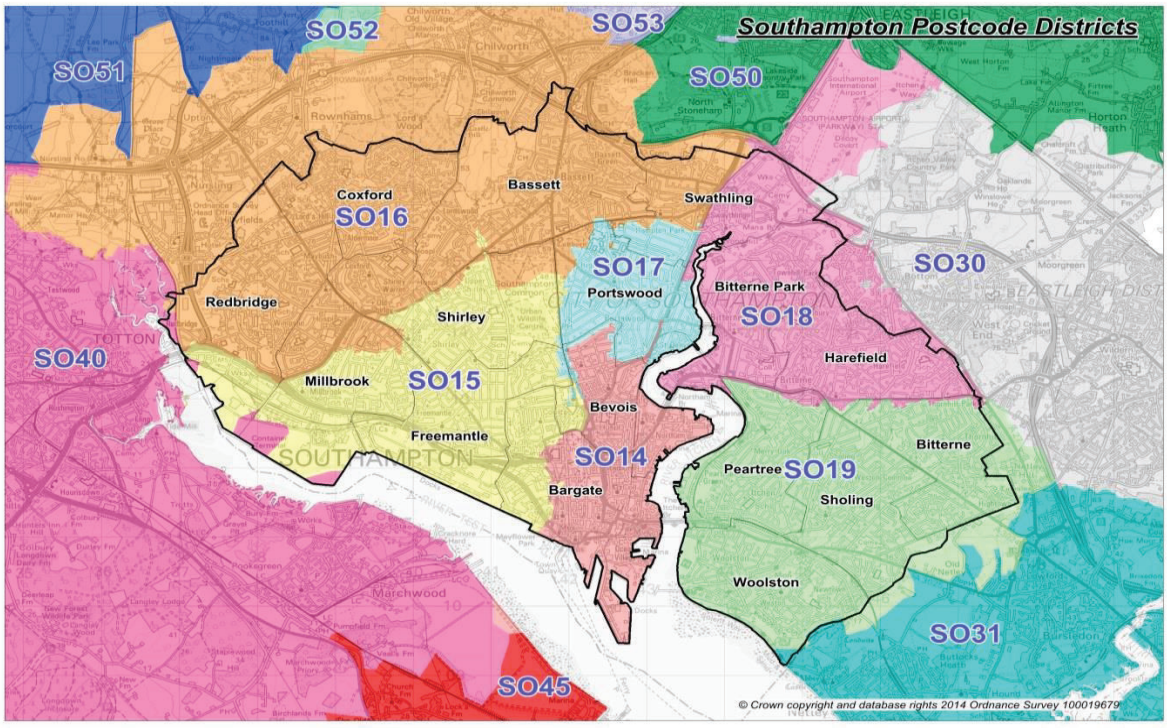
At its initial meeting the steering group agreed there was not a need to have more than one locality due to the characteristics of the population living within the HWB area. However within the PNA the different needs of people living within the area and sharing a protected characteristic are identified and addressed as well as the needs of other patient groups.

### 1.6.3 Patient and public engagement

In order to gain the views of patients and the public on pharmaceutical services, a questionnaire was developed and made available on the council's public health and consultation webpages on 14th August 2014, closing during the statutory consultation period on 5th November 2014. As well as promoting on the council's website, the questionnaire was publicised through 'Stay Connected' e-alerts, the council member's bulletin and social media channels (Twitter and Facebook). The questionnaire was also promoted by Healthwatch through their various networks. A copy of the survey, which shows the questions asked, can be found in appendix G.

The public survey received 327 responses, albeit not all responded to each question with 298 being completed fully. The table and map below illustrate which postcode districts respondents came from. All areas of the city were represented, although SO14 and SO17 had the lowest number of respondents; areas characterised by higher numbers of students and ethnic minority groups.

| SO14 | SO15 | SO16 | SO17 | SO18 | SO19 | 0ther |
|---|---|---|---|---|---|---|
| 20 | 72 | 97 | 18 | 30 | 67 | 10 |



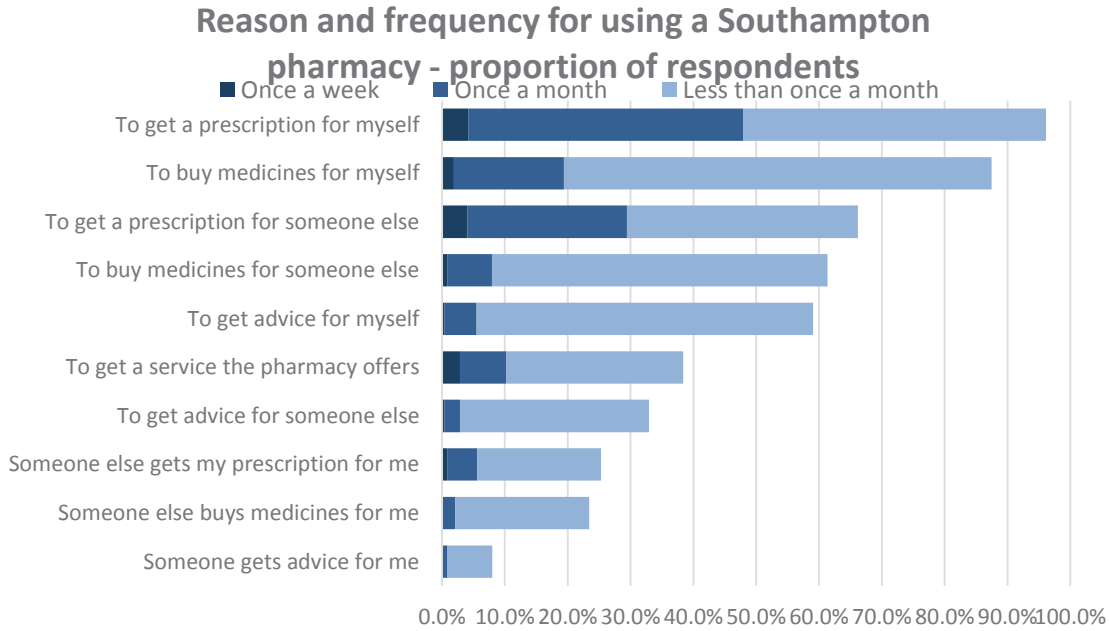
The percentage of respondents increased with age, as identified in the table below. 42% of respondents described themselves as retired, whilst 90% identified themselves as White British.

| Answer Choices | Responses | |
|---|---|---|
| Under 16 | **0.00%** | 0 |
| 16 to 25 | **0.66%** | 2 |
| 26 to 35 | **11.18%** | 34 |
| 36 to 45 | **12.83%** | 39 |
| 46 to 55 | **17.11%** | 52 |
| 56 to 65 | **28.29%** | 86 |
| Over 66 | **29.93%** | 91 |
| **Total** | | **304** |

Other respondent information included:

- 4 people (1.34%) describing themselves as housebound
- 121 (39.67%) pay prescription charges
- 294 respondents (97.67%) have access to the internet
- Over 99% are able to communicate in English, with one person preferring another language
- The majority of those who responded were female (62.38%), with 1% identifying themselves as transgender or would rather not say.

The reason and frequency given for using a pharmacy is shown in the chart below. 96.1% said they used a pharmacy to get a prescription for themselves, with approximately half of those visiting a pharmacy at least once a month. 66.2% of respondents reported using a pharmacy for getting a prescription for someone else, 59.1% reported using a pharmacy to get advice and 38.4% reported using a pharmacy for another offered service.



In addition to closed quantitative questions, respondents were given an opportunity to answer some questions in free text form, which the HWB have considered. There were both positive and negative comments on some local pharmacies. However, these are operational matters such as politeness, waiting times and other matters that while important, are not issues that may be dealt with in this PNA. Each pharmacy will undertake its own patient survey on a regular basis to inform such considerations. The main themes informing this PNA were with regard to opening times and services provided, which are reflected in section 5.6 of this PNA.

**1.6.4 Contractor engagement**

At the same time as the initial patient and public engagement survey, an online contractor questionnaire was undertaken using PharmOutcomes. The contractor questionnaire provided an opportunity to validate the information provided by NHS England in respect of the hours and services provided. Where information provided by the contractor differed to that held by NHS England this was offered to NHS England for resolution.

The questionnaire asked a number of questions outside the scope of the PNA, but that also provided commissioners with valuable information related to governance and IT. A copy is provided in Appendix H.

The questionnaire ran from 7th August 2014 until 5th November 2014, overlapping with the formal consultation period. The relevant results are summarised in section 5.7 of this published PNA.

**1.6.5 Other sources of information**

Information was gathered from NHS England, Southampton CCG and Southampton city council regarding:

- Services provided to residents of the HWB's area, whether provided from within or outside of the HWB's area
- Changes to current service provision
- Future commissioning intentions
- Known housing developments within the lifetime of the PNA
- Any other developments which may affect the need for pharmaceutical services

The JSNA and the 2013 public health report for Southampton city council, and Southampton's joint health and wellbeing strategy provided background information on the health needs of the population.

**1.6.6 Equality and safety impact assessment**

The council recognises that the effects of discrimination and inequality are many and will be experienced differently by different groups of people. It also recognises the multiplicity of disadvantage – so that some people experience many different forms of inequality at the same time.

Therefore the council has adopted this statement as an example of discrimination, although it is not intended to be absolutely definitive:

"Unfair or unequal treatment of people on the basis of race, colour, national and ethnic origin, culture or faith, gender, sex, sexual orientation, gender reassignment or gender identity, marital or civil partnership status, pregnancy and maternity, disability, physical, sensory or learning impairments, mental health problems, HIV status, income or age."

Southampton City Council uses equality and safety impact assessments (ESIA) to ensure that all the protected characteristics are considered when key decisions are made. The ESIA for the PNA can be found in appendix J.

**1.6.7 Consultation**

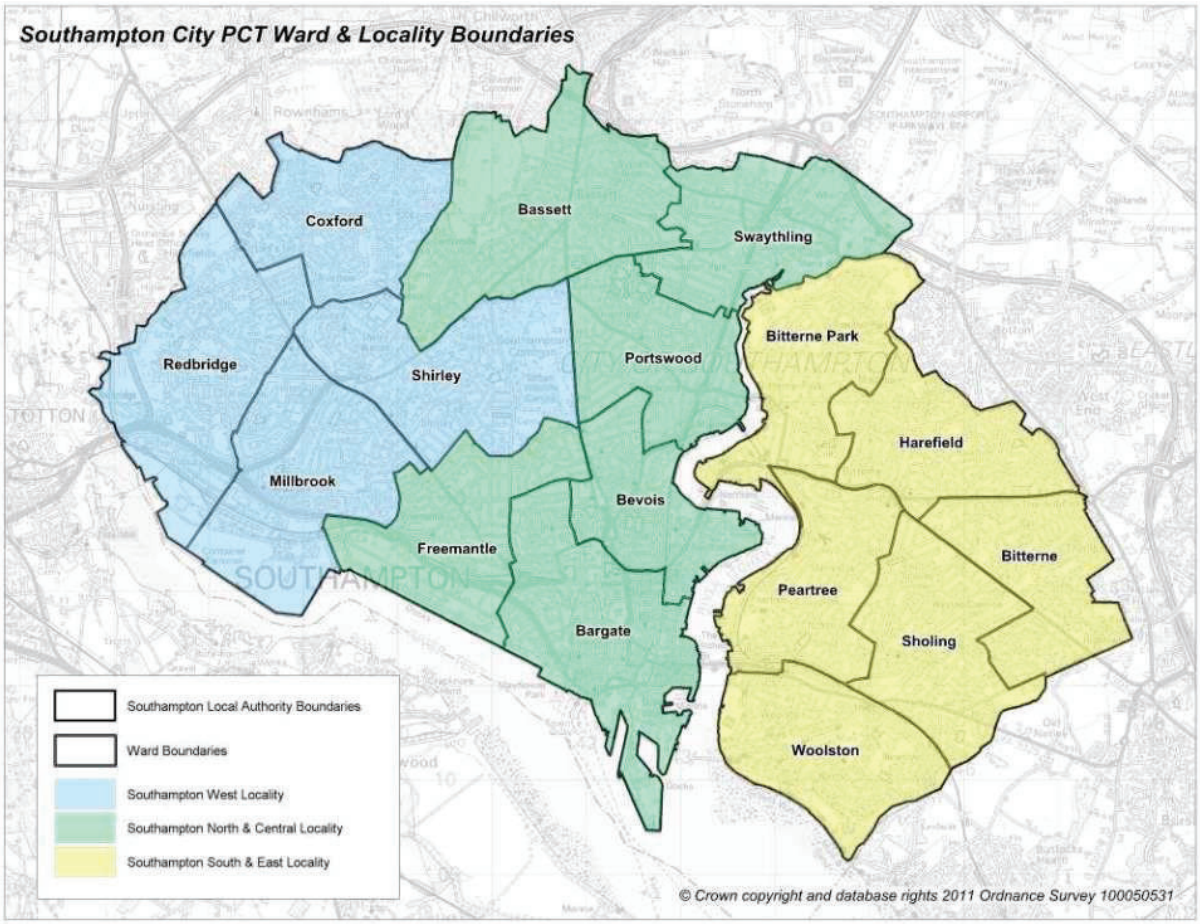
The patient and public engagement and contractor questionnaire informed the draft PNA consulted upon and remained open at the commencement of the statutory consultation in order to allow respondents additional time. The final responses to these inform the final PNA.

On 16/10/2014 the HWB consulted on the draft PNA in accordance with the 2013 Regulations for a period of 60 days, closing on 18/12/2014. The statutory consultees were written to regarding the consultation, provided a link to the council's web site where the draft PNA was published and invited to respond online. Paper copies were made available to those unable to access online.

A report of the consultation including any changes to the PNA was produced before the final PNA was published and is included at appendix K.

# 2 The Southampton locality

Until the abolition of the Southampton City Primary Care Trust in March 2013, the city was divided into areas based upon groups of GP practices that worked together in 'localities' to manage and commission services relevant to their area. These are no longer used in the CCG, but are still referred to in the JSNA as a way of segmenting the city. The below historic map is illustrative of that former division and included here for reference purposes. This PNA has not divided the city into localities but considered Southampton as a whole for the purpose of pharmaceutical services.




## 2.1 Introduction

Southampton is the largest city in the south east, outside of London, with a population of 236,900[1] which is set to grow to 246,263 by 2018[2]. The city is ranked as one of the top five performing cities in England for employment, population growth and skills and is also a major retail centre[3]. The city has a working age population of 167,701 and a current workforce of 117,000, across a variety of sectors with particular strengths in banking, finance and insurance as well as public administration, education and health sectors[4].

[1] Population data, Southampton JSNA. September 2014
[2] Public health Southampton data compendium to the JSNA. September 2014. http://www.publichealth.southampton.gov.uk/healthintelligence/jsna/data.aspx
[3] NHS Southampton PNA, December 2010
[4] Solent Local Enterprise Partnership (2011) Regional Growth Fund Bid Submission

Southampton's city centre is undergoing a significant and ambitious transformation. The council's 2012 City Centre Master Plan will see £3 billion of investment into the city by 2030. It will improve the city for residents, businesses and visitors alike, creating a vibrant and eclectic city centre.

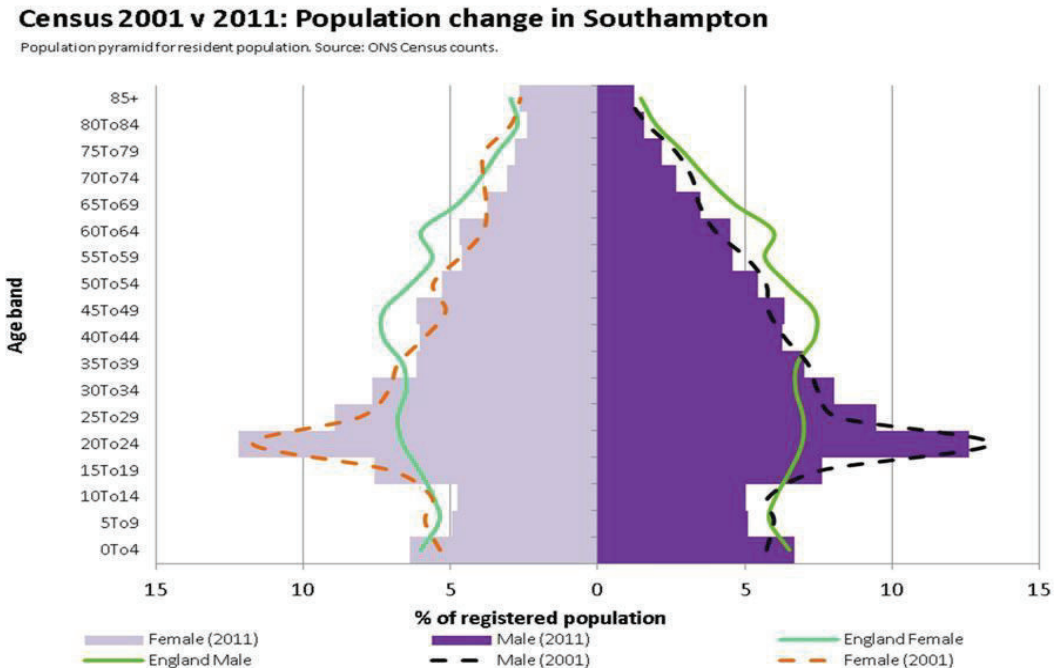
The city is home to two strong universities with complementary specialisms in engineering and maritime science, and the arts and humanities. There are over 40,000 students studying in the city.

In addition the port is a dynamic international transport hub that operates 24 hours a day and 365 days a year. It handles one fifth of the United Kingdom's (UK) trade with non-European Union countries by value and is the UK's premier international maritime gateway. In 2008, the latest available national statistics, the port handled 41 million tonnes of cargo, making it one of the largest ports in the UK by tonnage. Key trades of national significance handled by the port include containers, cars, passenger cruise and petrochemicals. In 2008 almost one million cruise passengers passed through the port[5].

Surprisingly therefore, deprivation is a significant issue in Southampton with the city being ranked as the fifth most deprived local authority in the south east and 81st out of the 326 local authorities in England according to the index of multiple deprivation (IMD) 2010. In addition, Southampton has a significantly lower healthy life expectancy than the national average for men (61.1 years compared with 63.2 years).

## 2.2 Population

The profile of the city's population differs from the national average because of the large number of students; 20% of Southampton's population is aged between 15 and 24 years compared to just 13% nationally (see chart below)[6].




Map 4 (appendix L) identifies pharmaceutical premises in relation to the density of population.

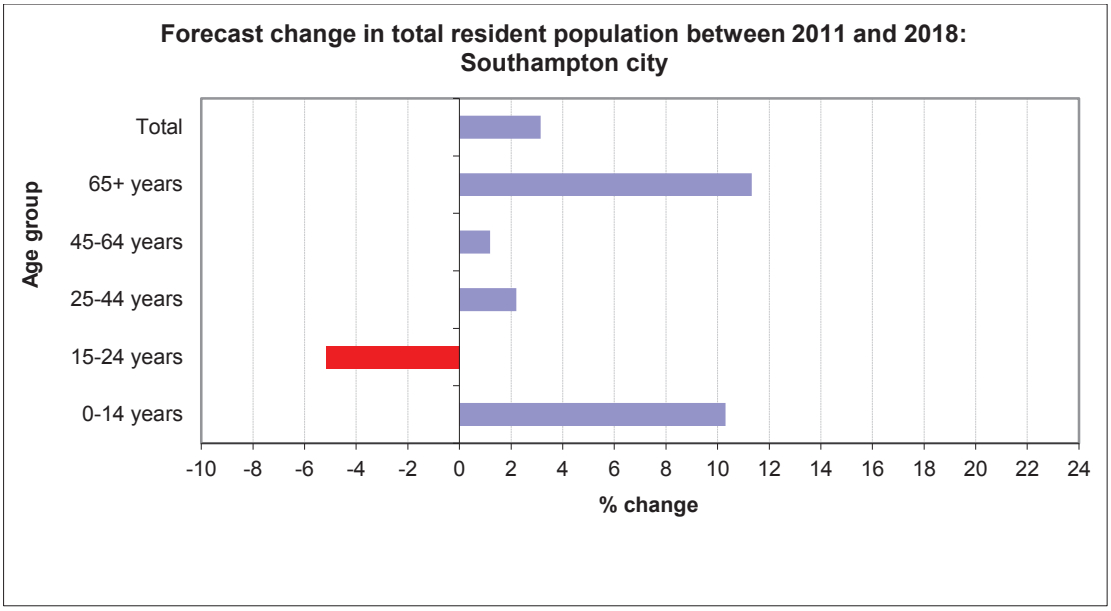
[5] Port of Southampton Master Plan 2009-2030.
http://www.southamptonvts.co.uk/Port_Information/Commercial/Southampton_Master_Plan/
[6] Southampton JSNA. September 2014

## 2.3 Population forecasts

There are many uncertainties around current and future population numbers. The Southampton JSNA currently uses data produced by Hampshire county council (HCC) but this does not yet incorporate the results of the 2011 Census (an update was expected in Spring 2013 and the Southampton JSNA will be updated accordingly). These forecasts are based on the planned completions of residential dwellings in the city and they predict an increase in dwellings of 4.8% between 2011 and 2018. Bargate and Woolston are the wards set to see the biggest increases in dwellings.

In Southampton, as nationally, average life expectancy is increasing and as a consequence more people are living longer. The fastest growing sector of the population is that aged 65 years and over. Forecasts made using known residential development plans predict the over 65s will rise by 11% between 2011 and 2018 whilst the number of people over 85 years is forecast to grow from 5,300 to 6,000, an increase of 13%. Longer term projections, based on past trends, predict a 42% increase in over 65s in Southampton between 2010 and 2035 with the number of residents in the city aged over 85 reaching 10,000 by 2035.

The chart below shows how the age of population is expected to change up to 2018[7].




In 2011 there were 3,520 maternities to Southampton females resulting in 3,550 live births.

In 2011/12 47.2% of babies were being fully or partially breastfed at their 6-8 week check.

According to the HCC forecasts, the number of births will increase by 3.1% over the period 2011 to 2018. However, local monitoring of births at Southampton University Trust (SUHT) reveals that since 2004 births have actually been increasing at 3.5% a year on average. This suggests that, despite improvements in the HCC methodology and the use of local fertility assumptions, HCC may still be underestimating the very significant increases in fertility in the city. Between 2003 and 2011 general fertility rates in the city have increased from 49.3 to 63.4 per 1000 females aged 15-44. In 2010 Bitterne ward had the highest fertility rates in the city at 106.9 per 1000.

[7] Hampshire County Environment Department's 2011-based alternative Southampton Small Area Population Forecasts

## 2.4 Sexual orientation

Data from the ONS Integrated Household Survey in 2010/11 found 1% of adults surveyed identified themselves as gay or lesbian and a further 0.5% identified themselves as bisexual. In Southampton this would equate to 1,970 gay or lesbian adults and 990 bisexual adults. The survey found a larger proportion of men stating they were gay (1.3%) compared to women (0.6%).

## 2.5 Gender re-assignment

There are no official statistics nationally or regionally regarding transgender populations, however, the Gender Identity Research and Education Society (GIRES) estimated that, in 2007, the prevalence of people who had sought medical care for gender variance was 20 per 100,000. This equates to an estimated 50 people in Southampton.

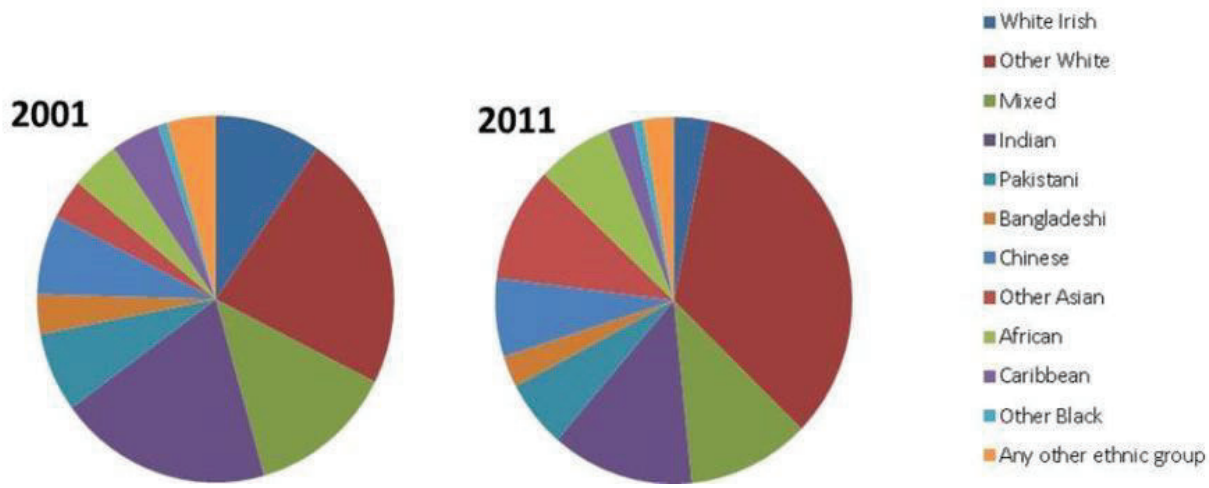
According to GIRES, 60% of those presenting with gender dysphoria actually underwent transition; of these 80% were assigned as boys at birth (now trans women) and 20% as girls (now trans men).

Gender variant people present for treatment at any age. The median age is 42.

The adults who present emerge from a large, mainly invisible, reservoir of people, who experience some degree of gender variance. GIRES estimate a prevalence of 600 per 100,000 which would equate to 1,440 people in Southampton.

## 2.6 Ethnicity and language

Southampton is a diverse city; in the 2011 census 77.7% of residents recorded their ethnicity as white-British, a considerable decrease from 2001 when 88.7% of residents put themselves in this category. The pie charts below show that since the 2001 census the biggest change has been in the 'Other white' population (which includes migrants from Europe); this has increased in last 10 years by over 200% (from 5,519 to 17,461).




Within Southampton there is much variation in diversity; in Bevois ward over half of residents (55.4%) are from an ethnic group other than white-British compared to 7.6% in Sholing. The annual school census in the city in 2012 revealed that 29.4% of pupils were from an ethnic group other than white-British.

Southampton has a higher proportion of households where no-one has English as their main language (7.7% compared to 4.4% nationally). There are 7,522 households in the city that fall into this category. The school census in 2012 found that 14.1% of school pupils had a first language other than English; a rise from 8.4% in 2007. In 2007 there were 427 pupils whose first language was Polish but by 2012 this had risen to 1,282[8].

Map 6 (appendix L) shows Black & Minority Ethnic levels (BME) and maps pharmaceutical premises.

## 2.7 Religion

The following statistics for Southampton residents are taken from the 2011 Census.

| Religion | Number | Percentage |
|---|---|---|
| **Christian** | 122,018 | 51.5 |
| **No religion** | 79,379 | 33.5 |
| **Religion not stated** | 16,710 | 7.1 |
| **Muslim** | 9,903 | 4.2 |
| **Sikh** | 3,476 | 1.5 |
| **Hindu** | 2,482 | 1.0 |
| **Buddhist** | 1,331 | 0.6 |
| **Other religions** | 1,329 | 0.6 |
| **Jewish** | 254 | 0.1 |

## 2.8 Household composition

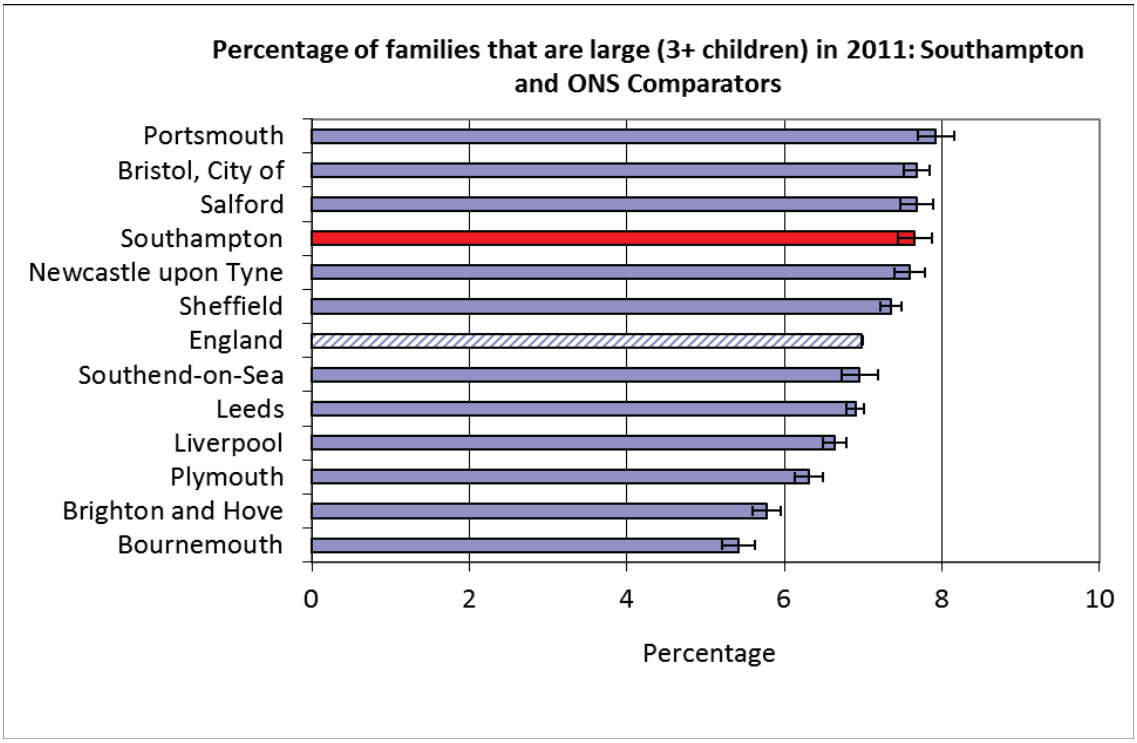
The 2011 census revealed much about the way people live in Southampton. As expected from the large student population, the city has a higher proportion of single (never married) residents than nationally (45.3% compared with 34.6%). There were 11,283 households in the city consisting older people living alone.

In 2011 there were 6,918 lone parent families in Southampton with dependent children; of these, 46.8% were not in employment (compared to 40.5% nationally) and the vast majority were female (over 91%).

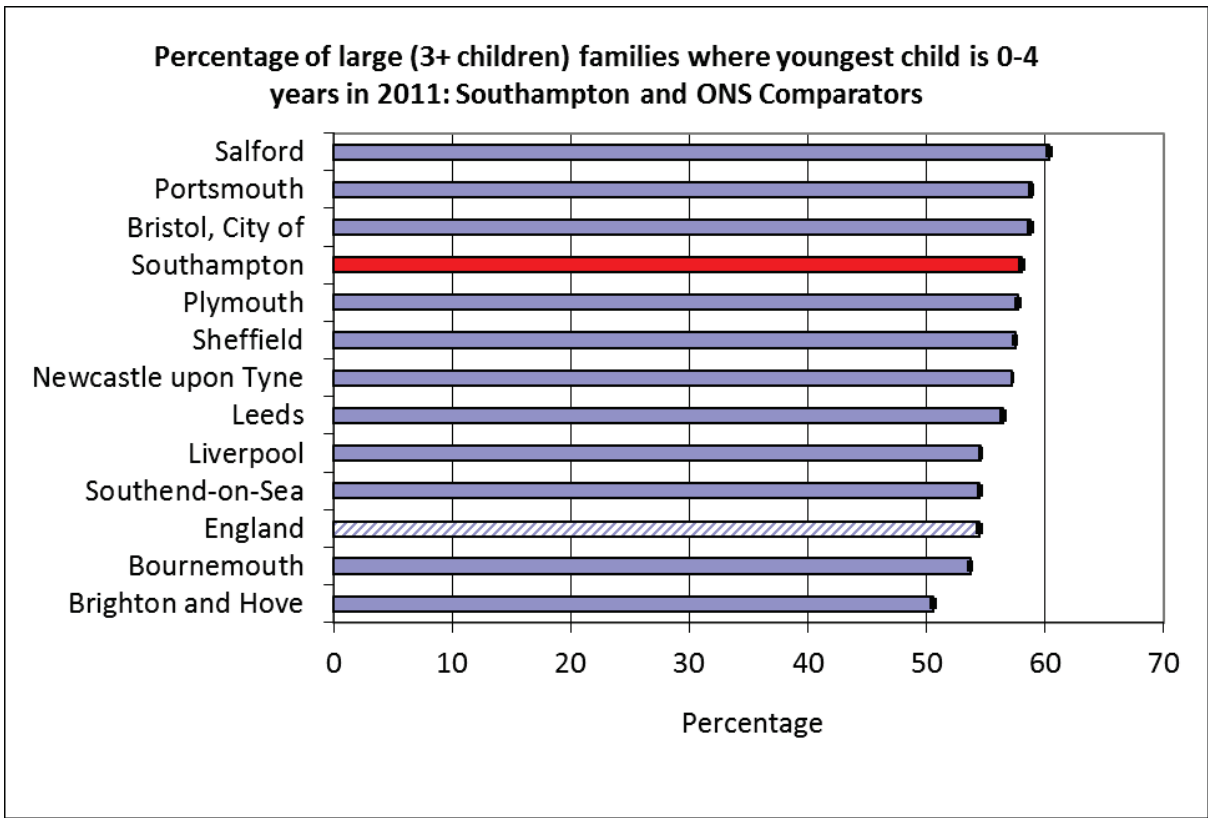
| Marital status for Southampton residents | Number | Percentage |
|---|---|---|
| Single (never married or never registered a same-sex civil partnership) | 88,491 | 45.3 |
| Married | 72,324 | 37.0 |
| In a registered same-sex civil partnership | 416 | 0.2 |
| Separated (but still legally married or still legally in a same-sex civil partnership) | 5,141 | 2.6 |
| Divorced or formerly in a same-sex civil partnership which is now legally dissolved | 17,827 | 9.1 |
| Widowed or surviving partner from a same-sex civil partnership | 11,335 | 5.8 |

[8] Southampton JSNA. September 2014

The 2011 Census data shows Southampton has a higher proportion of families that are large (3+ children) than the national average.




Compared to its statistical neighbours, Southampton has high proportions of families that are large, and large families where the youngest child is aged 0-4years, with only Portsmouth, Bristol and Salford being higher.



## 2.9 Housing

There are an estimated 98,400 homes in Southampton, the details of which are shown in the table below:

| Tenure | Number | Percentage of total (Southampton) | Percentage of total (National) |
|---|---|---|---|
| Owner occupied | 52,000 | 53% | 71% |
| Privately rented | 23,400 | 24% | 11% |
| Social housing (council and housing associations) | 23,000 | 23% | 18% |
| Total (all housing) | 98,400 | 100% | 100% |

The Southampton city council private sector stock condition survey (2008) revealed that Southampton's private housing is exceptional because of the size of the private rented sector (over twice the national average).

The council was on track to ensure that all of the homes that it lets (over 18,000 properties) meet the Decent Homes Standard by December 2010. However, 28,400 private homes are non-decent (37.7% of all homes). An estimated 8,490 of these are occupied by vulnerable people (defined by the Government for this purpose as receiving a means tested benefit) and an estimated 16,000 fail to meet the basic level of insulation required in the Decent Homes Standard. 5,600 of these private homes are considered to have a severe excess cold hazard.

In 2008 the council estimated that 357 households living in council and housing association homes needed a larger home. In addition, it is estimated that between 3,000 and 3,600 households are living in overcrowded privately owned and rented homes. In 2006 12% of all households consider that they live in accommodation that is unsuitable for their needs. As at 1 April 2010, there were 16,042 households on the housing waiting list and with a typical wait of five to seven years for a one bedroom flat and six to seven years for a three bedroom house.

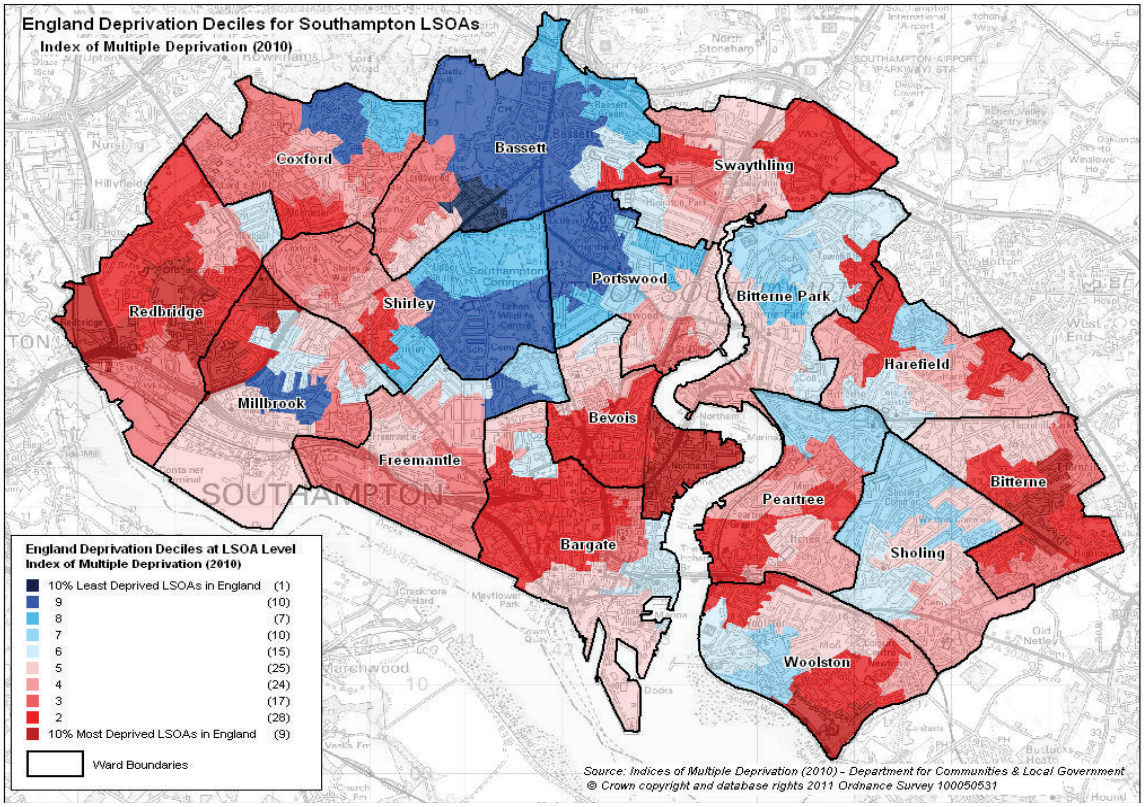
## 2.10 Homelessness

In Southampton city, the statutory homelessness rate was 1.89 per 1,000 households (2011/12), an increase from 1.76 per 1,000 households the previous year. This compares to a rate of 2.29 per 1,000 households in England in 2011/12 (with the previous year's rate of 2.03 per 1,000). Southampton's statutory homeless rate is ranked 7th within our 11 ONS peers.

Southampton's homelessness prevention strategy 2013/18 highlights that the impact of the recession on homelessness has not yet been fully realised in Southampton, partly due to the relatively low local house values and low interest rates. It notes a significant decline in homelessness applications and acceptances from 2003-2009 as a result of increased homelessness prevention and improved housing options for people at risk. It also describes the impact of homelessness rise since 2009 on households with dependent children. There has been a 68% increase in the number of households with dependent children accepted as homeless since that time. The figures for other priority need groups have either remained static or continued to fall since 2009.

## 2.11 Deprivation

As noted at the beginning of this section, deprivation is a significant issue in Southampton and is a wider determinant of health outcomes. The map below shows how the lower super output areas (LSOA) in Southampton score on the index of multiple deprivation (IMD) scale[9]. Better health outcomes are expected in those areas shaded in blue (the darker the blue, the better the outcomes), and poorer health outcomes are expected in those areas shaded in red, with the worst outcomes expected in those areas shaded in the darkest red.




Map 5 (appendix L) similarly shows the IMD and maps pharmaceutical premises

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[9] Department for Communities and Local Government, Indices of Deprivation 2010

# 3 General health needs of Southampton

In Southampton the JSNA is a comprehensive online resource. It aims to identify the 'big picture' for health and wellbeing through analysis of a wide range of data sets and through stakeholder and public engagement.

Maintaining a needs assessment is a dynamic iterative process rather than a product and builds on the first JSNA, published in 2008. The local data compendium lies at the heart of that process. The data will be used to inform future commissioning decisions and spending priorities. The data compendium will be regularly updated with current data during the lifetime of this second JSNA as new data sets and analysis become available. The JSNA also integrates the six key recommendations from Sir Michael Marmot's report *Fair Society Healthy Lives*[10], probably the most important evidence based commentary on health for a generation.

All references to the JSNA within this document are to the version that was available on the Public Health Southampton website as of 3 September 2014.

The JSNA is arranged around 9 key themes for a healthier population. The PNA reflects these and identifies where the provision of pharmaceutical services can contribute towards them.

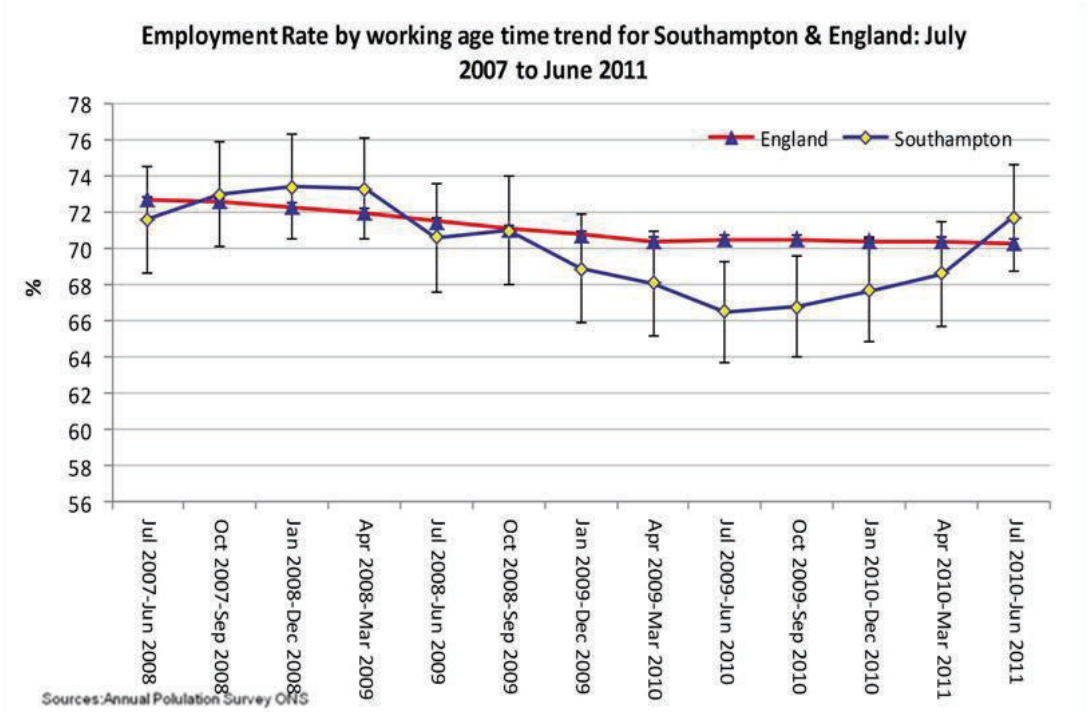
## 3.1 Theme 1 – improving economic wellbeing

An estimated 2000 households in the city do not have a bank account and around 16,000 households have no home contents insurance[11]. Around 6,500 households are without affordable credit[12] and approximately 1,800 people use loan sharks[13].

The economic recession has had a marked impact on Southampton and its residents. In November 2010, there were a total of 18,790 claimants of out of work benefits in the city, 11.2% of the working age population[14]. This compares with a rate of 8.6% for the south east region.

The chart below shows that over the period from July 2009 to June 2010 the employment rate in Southampton fell significantly below the England average[15].

[10] February 2010 http://www.marmotreview.org/
[11] Estimated from Family Resources Survey 2007/2008
http://research.dwp.gov.uk/asd/frs/2007_08/frs_2007_08_report.pdf
[12] 'Mapping the demand for, and supply of, third sector affordable credit' (Experian 2007)
http://webarchive.nationalarchives.gov.uk/+/http://www.hm-treasury.gov.uk/d/research.pdf
[13] Research & Information Southampton City Council 2010.
[14] https://www.nomisweb.co.uk
[15] Analysis of Worklessness in Southampton Final Report 2010, CLREA, University of Portsmouth report for Southampton City Council and SITES




In 2010 the average weekly gross earnings for a full-time employee in Southampton were estimated at £452.20. This compares poorly to Portsmouth and Hampshire, where the average earnings are £480.20 and £540.70 respectively[16].

There are currently 5,627 people claiming jobseekers allowance in the city. This translates to over 19 unemployed people chasing a job in Southampton[17].

The average house price in Southampton is nearly 8 times the average annual salary for residents[18].

## 3.2 Theme 2 – improving mental health

One in six of the adult population experiences mental ill health at any one time. Anxiety and depression are common conditions which can affect all age groups. Mental health conditions are poorly understood by the wider community and are often associated with fear and stigma and many people feel excluded from their communities and lack confidence in accessing mainstream resources.

Within this theme the JSNA focuses on three population groups:

- Children/young people
- Adults
- Older people.

[16] Nomis – Annual Survey of hours and earnings 2010
[17] Nomis –Job Seekers Allowance claimants and notified job vacancies as at May 2011 Southampton.
[18] This is based on house price data from Land Registry for England and Wales as at December 2010, and Annual Survey of Hours and Earnings (ONS, July 2010).

### 3.2.1 Children and young people

Based on national prevalence rates by gender, and local population estimates, the JSNA identifies that there are nearly 5,500 (10.6%) children and young people with mental health problems in Southampton. The relative child deprivation in Southampton compared to England means this crude estimate is likely to underestimate the actual level of local need.

The JSNA states that the estimated number of children and young people with mental health problems will increase by 231 or 4.3% between 2012 and 2018. It anticipates that the greatest pressure will come from the 5 to 10 year old age range with an estimated 221 or 19.8% increase within that time period.

### 3.2.2 Adults

According to the JSNA within Southampton there are:

- 2,758 people registered with their GP as having a severe and enduring mental illness (schizophrenia, bipolar disorder and other psychosis). This gives a crude prevalence rate of 1% which is significantly above the England rate of 0.8%.
- 13,800 people registered with their GP as having depression (with a diagnosis since 2006). This gives a crude prevalence rate of 6.6% which is slightly higher than the figure for England (5.8%).

Not everyone who has a mental health problem is registered with a GP or has a diagnosis so the true figure is likely to be significantly higher.

The JSNA states that it is estimated that the number of 18 to 64 year olds in the city with a common mental health disorder will rise from 26,562 in 2010 to 30,233 by 2030.

### 3.2.3 Older people

Evidence suggests that less than half of people with dementia have a formal diagnosis; so in Southampton we may expect the true number of dementia suffers to be 2,386 rather than the 1,376 recorded by GPs in 2012/13. A tool for estimating true prevalence and resources for improving diagnosis rates[19] calculates that of the estimated 2,386 people living with dementia in the city:

- 1,308 have mild dementia
- 778 have moderate dementia
- 300 have severe dementia

According to the JSNA it is estimated that there will be a 19% increase in the number of older people with dementia in Southampton between 2012 and 2020.

## 3.3 Theme 3 – early years and parenting

### 3.3.1 Low birth weight

Low birth weight among infants is strongly linked to poorer outcomes for children as they get older. There has been a fall in the percentage of live births classified as 'low birth weight' (below 2,500grams) from 7.1% in the 2003/04 to 2005/06 period to 6.1% in the 2008/09 to 2010/11 period,

[19] Originally developed by NHS South of England and now available at www.dementiapartnerships.org.uk

but because of the small number of events these rates are based on this change is not statistically significant.

The decline in low birth weight has been more rapid in those parts of the city with the highest levels of economic deprivation where case-loading midwifery teams are based. The rate has declined significantly in these areas from 9.0% to 6.6% over the same period and a narrowing of the gap compared to the rest of the city from 2.8 percentage points to 0.8 percentage points. In 2009 the Southampton low birth weight rate of 7.3% was lower than the national average of 7.5% and ranked 6th lowest out of our eleven statistical neighbours. This indicates that current provision is successfully reducing this problem.

**3.3.2 Levels of caesarean versus normal births**

Variations in the level of caesarean births relate more to the effective use of resources than need. The proportion of total births that were normal deliveries in 2010/11 was 60.5%. The proportion that were caesarean section was 22.7%, which is an increase of 2.3 percentage points on the previous year (SUHT) births and bookings data).To ensure good use of resources there is a drive to reduce unnecessarily high levels of caesarean assisted deliveries.

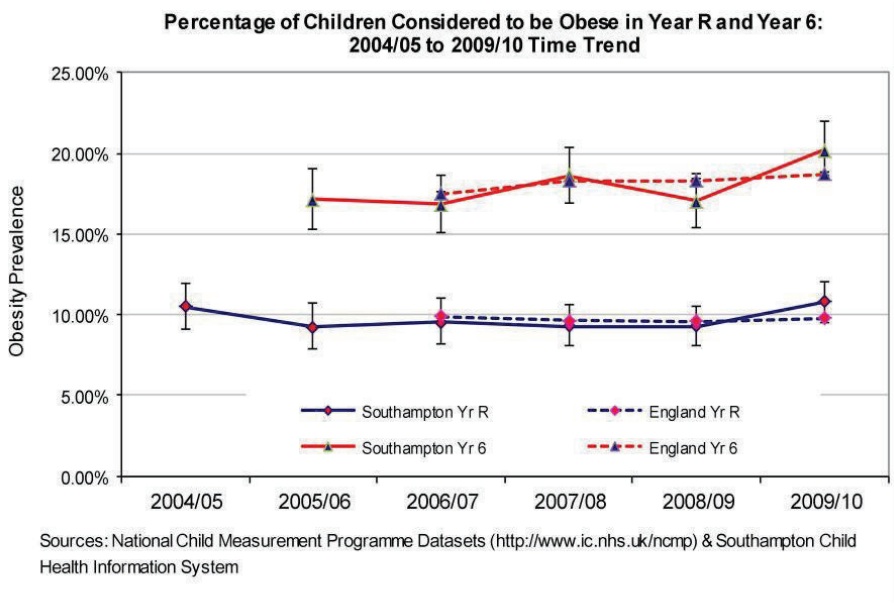
Caesarean birth rates are significantly lower within the most deprived areas compared to the rest of the city, although the gap is narrowing.

**3.3.3 Breastfeeding initiation and maintenance**

Year on year there has been a steady increase in the number of mothers initiating breastfeeding from 70.8% in the 2003/04 to 2005/06 period to 75.3% in the 2008/09 to 2010/11 period, with the greatest success in the areas of high deprivation, leading to a significant reduction in the health inequalities gap. The challenge is now to maintain breastfeeding after the neonatal period so that more women continue to breastfeed at 6-8 weeks and beyond.

**3.3.4 Smoking during pregnancy**

Smoking during pregnancy is strongly associated with a number of health problems for new born children. There is evidence to suggest that the number of mothers smoking at midwifery booking has reduced a little from 24.3% in the 2003/04 to 2005/06 period to 19.8% in the 2008/09 to 2010/11 period. There are differences between different ethnic communities, with "White British" mothers having smoking rates significantly higher than the city average. Sure Start data shows that in the 2008/09 to 2010/11 period, 8.0% of mothers who smoked at the time of midwifery booking had a premature baby, which is significantly higher than 4.3% who did not smoke. 8.7% of mothers who smoked at the time of midwifery booking had a low birth weight baby, which is significantly higher than 3.8% of births to non-smoking mothers. Low birth weight often results in more intensive medical care, higher morbidity and delayed development in childhood.




### 3.3.5 Childhood obesity

Obesity in childhood is closely linked to obesity in adulthood and a wide range of poor long term physical and mental health outcomes related to poor diet and low levels of physical activity. According to a city-wide survey during the Autumn of 2009, 11% of children in reception classes are overweight and a further 9% obese; this increases to almost 13% overweight by year 6 with 17% obese (i.e. 30% above normal weight). The prevalence of obesity for Year 6 children has reduced from 18.62% in 2007-08 to 17.03% in 2008-09, but has not reached the target of 16.51% set in the Local Area Agreement.

### 3.3.6 Health education and exercise

The link between lack of physical activity and poor health outcomes is well documented. 2008-10 has seen a significant increase in the percentage of schools achieving and maintaining the Healthy Schools Standards. The majority (90%) of children and young people are offered two hours of high-quality PE and sport a week, and all Southampton schools have travel plans that encourage and promote active travel to and from school, which are increasing the percentage of children not travelling to school by car. Plans to extend the measurement from two hours of PE and sport within the curriculum to include an additional three hours of physical activity accessed through extended school and community provision are in progress.

### 3.3.7 Misuse of tobacco, alcohol and other substances by young people

Modelling has found that key groups of vulnerable young people who typically demonstrate higher levels of risk-taking behaviour are under-represented in treatment services e.g. young offenders, children looked after, young people with emotional and mental health issues, young people not attending school. Consultation with providers and service users found that services working with these young people lack the skills to be able to identify, assess and screen young people around their substance misuse. Partnership working to effectively support young people needs further development.

In the 2009 TellUs4 survey young people in Southampton self-reported drug and alcohol use above that of their counterparts nationally (10.7% of school-age young people compared with 9.8% nationally). Young people in Southampton are demonstrating problematic substance use at age 15

and until 2009/10 too few young people had received support through young people's substance misuse treatment services. Alcohol specific admissions to accident and emergency (A&E) for under 18s in Southampton are high compared to the national average and to most of the city's ONS peers.

At the end of 2010/11 the outcomes for young people in specialist substance misuse treatment continued to improve:-

- 106 young people were engaged in treatment in 2010/11, and
- 89% of these young people completed treatment in an agreed and planned way (the highest in the South East region)

The Health Related Behaviour Questionnaire reports 9% of year 6 students and 30% of year 10 students drinking alcohol in the last 7 days.

The Get Smart survey of sixth form students found that 87% of students had drunk alcohol in their life time. Of these, 46% were drinking at levels which suggest early signs of hazardous and harmful drinking. Spirits were favoured and increasingly so with age. 81% mostly drink with friends, drinking at parties with friends and family (59%), in friends' houses (50%) and/or at home (44%). For those under 18, alcohol was mainly acquired from friends and family (40%).

**3.3.8 Teenage pregnancy**

Southampton's 2009 under 18s conception rate was 49.2 per 1,000 females aged 15-17 years old. This equates to approximately 4.9% of the under 18 female population conceiving within 2009 (188 young women). The Southampton rate of teenage pregnancy has been consistently higher than the regional and national rates since the 1998-2000 baseline. However, by 2007-2009 the rates in Southampton had declined by 15.3% compared to a 10.7% decrease nationally.

Within Southampton there are seven wards with under 18 conception rates significantly higher than the national average but none of these are significantly higher than the city average. In the period 2006-08 there were 124 conceptions amongst girls aged less than 16. This is important in demonstrating that many of these conceptions were both unplanned and unwanted, and therefore might have been prevented through effective sex and relationships education support and access to contraception and sexual health provision.

Southampton's under 16 conception rate remains significantly higher than national and regional comparators (11.2 per 1,000 compared with 7.9 England average).

Secondary outcomes for teenage mothers under the age of 19 are monitored closely, and experience fluctuation given the small numbers of parents involved. SUHT births and bookings data shows however, there have been improvements within the past year in:

- breastfeeding rates
- smoking rates
- previous live births

These improvements must be maintained to impact upon not only the mother's health outcomes but those of her child.

### 3.3.9 Child dental/oral health

Dental health has been shown to be important in relation to other outcomes for children. Dental decay is a largely preventable disease and prevention would help ensure that children get the best start in life and facilitate the most effective use of NHS resources. Rates of children's dental health are poor compared to other areas in the country. In the 2006 dental survey of 5 year olds, 42% of over 2000 Southampton children surveyed had decayed, missing or filled teeth (DMFT) compared to 38% in England. There has been a significant change since 2006 in the way that dental surveys are conducted. Previously, a process of negative consent was used where children could be examined as long as the parent or guardian did not specifically object. Positive consent is now required so any child who does not return a consent form signed by a parent or guardian cannot be examined. In the most recent survey of 5-yr-olds in 2007, many children across the country, including Southampton, who were known to have high levels of dental decay did not return a signed consent form, thereby excluding them from the survey. The information collected locally and nationally was therefore unrepresentative of the population. This highlights the need for a better consent process to enable the collection of useful information.

Another more consistent indicator of children's dental health over the last few years is the number of children requiring dental extractions under a general anaesthetic. This has not changed, indicating that there has been no reduction in severe dental caries in the city's children.

### 3.3.10 Emotional well-being

Emotional well-being is important in minimising the risk of children and young people making poor choices in relation to their long term well-being. The percentage of children who enjoy good relationships with their family and friends in Southampton is lower than the national average (53% compared to 56%), and below all of our statistical neighbours. The emotional well-being of children in care is also lower than the national average (as calculated through the strengths and difficulties questionnaire). The assessment of the effectiveness of local Children and Adolescent Mental Health Services (CAMHS) resulted in them achieving the maximum score in 2010/11 (based on having a full range of services, age appropriate provision, 24 hour care and full range of early intervention support).

## 3.4 Theme 4 – taking responsibility for health

### 3.4.1 Smoking

Although smoking prevalence has decreased nationally, a wide disparity still exists across regions and Southampton compares less favourably both to the region and the country as a whole, making smoking a public health priority. The prevalence of smoking in the city is 22.6% compared to the national average of 20%. 16.6% of pregnant women in the city smoke at the time of delivery compared to the national average of 13.2%, putting both their own health, and the health of their baby, at risk. In addition, smoking rates are higher among the city's routine and manual workers with rates of 30.3% in Southampton compared to 29.7% nationally.

Men living in Southampton have significantly lower healthy life expectancy than the national average (61.1 years compared with 63.2 years), and smoking is one of the main causes for this. More people die from smoking related deaths in Southampton than the national average (236 per 100,000, compared to 210.6 in England). Deaths from lung cancer and chronic obstructive pulmonary disease are also higher than the national average, and more people are admitted to our hospitals with smoking related illnesses.

Smoking causes a considerable burden for our health services, impacting on primary care and also increasing the number of hospital admissions, especially in the winter months. 1,746 per 100,000 admissions to hospital in 2010-2011 were directly attributable to smoking. The cost to the local health economy is estimated by Action on Smoking and Health (ASH) to be £1.48m. The cost of treating children who are affected by smoking within the home is estimated to be £10 million, while hospital admissions cost a further £13.6 million. To try to reduce the significant economic burden of smoking on local NHS services, there is local investment in the improving fitness for surgery programme, which is an initiative that provides help to people to stop smoking for 4 weeks before having non-urgent (elective) surgery. There is also a need to ensure that smoking cessation is integrated into clinical pathways. A high level commitment is required within acute and mental health trusts to support the tobacco cessation agenda in order to realise the potential of the fitness for surgery Initiative to reduce bed days and post-operative complications.

### 3.4.2 Obesity

Levels of obesity in both reception and Year 6 children were 9.6% and 20.4% in 2012/13 respectively; these figures are higher than the England average (9.3% and 18.9% respectively). The prevalence of both overweight and obesity amongst reception pupils is 22.3%, and amongst Year 6 pupils is 34.5% in 2012/13, both again higher than the England average ( 22.2% and 33.3% respectively).

For Year 6 children, those children living in the most deprived groups have a significantly higher prevalence (21.9%) compared to those living in the least deprived groups (12.7%).

In Southampton 64.8% of adults are estimated to be overweight or obese which is not significantly different from the national average of 63.8%. However, the proportion of adults recorded as obese on GP registers in the city is 9.5% which is significantly lower than the England average of 10.7%. However physical activity amongst adults in Southampton is at higher levels than the national average and higher than most of the city's Office of National Statistics (ONS) peers.

### 3.4.3 Sexual health

#### 3.4.3.1 Sexually transmitted infections (STIs)

In 2012, a total of 2,475 acute STIs were diagnosed in Southampton residents, with the distribution varying considerably across the city. The most commonly diagnosed STI was chlamydia, followed by anogenital warts and herpes.

Of the 2,475 acute STIs diagnosed in Southampton in 2012:

- 59% were in people aged 15-24 years
- 7% were in Black/Black British people (compared to 2% of population)
- 19% were in people born overseas
- 13% for cases in men where sexual orientation recorded were among men who have sex with men (MSM)

In Southampton, an estimated 10.8% (9.6% nationally) of women and 12.3% (12% nationally) of men presenting with an acute STI at a genitourinary medicine (GUM) clinic became re-infected with an acute STI within twelve months.

Southampton does not perform well when compared against other areas in England; it is ranked 43 out of 326 local authorities, where 1 has the highest rates. In 2012, the rate of acute STIs for Southampton was 1,049 per 100,000 residents compared to 804 per 100,000 for England.

The highest rate of STI diagnoses in Southampton is in the 15 to 24 age group. This is likely to reflect not only a greater burden of infections in this age group due to more frequent unprotected sex but also higher ascertainment due to targeted testing of young people.

In 2012, Southampton performed poorly on chlamydia diagnostic rates compared to its national comparators. Although the rate has increased in 2013, achieving the target of 2,300 diagnoses per 100,000 remains a significant challenge for Southampton.

In Southampton 20% of the population is aged between 15 and 24 years, compared to 13% in England. Forecasting tools predict that by 2018, the size of the 20 to 24 age group will decrease by up to 10% in Southampton, but even so, this group will still represent the largest proportion of the population. As this younger age group is most susceptible to STIs, strategic planning must take population projections into account.

#### 3.4.3.2 Human immunodeficiency virus (HIV)

In Southampton, 308 (1.95 per 1,000) residents aged 15 to 59 are accessing HIV care. An estimated 22% of people with HIV are not diagnosed; therefore the total number of people with HIV is likely to be closer to 400. In 2012, 144 more individuals were accessing HIV care compared to 2005, an increase of 89%.

Late diagnosis of HIV is associated with a ten-fold increase in risk of death in the first year of diagnosis compared to those diagnosed early. Of those Southampton residents diagnosed with HIV, 47.4% had a late diagnosis, this is compared to 52.3% nationally and the city is ranked third out of its comparators (where 1 is best outcome).

#### 3.4.3.3 Teenage pregnancy

Under 18 conception rates have declined significantly in Southampton from a peak of 63.7 (2001-03) to 48.6 (2009-11) per 1,000 females aged 15 to 17. However, Southampton has significantly higher rates compared to England. In 2011 there were 170 conceptions to under 18 females in Southampton.

In the city 41.2% of under 18 conceptions led to an abortion in 2011, this is compared to 49.3% nationally and has been consistently lower than the England average for the last few years.

Teenage conception rates are significantly higher than the England average in the following wards:

- Redbridge
- Millbrook
- Freemantle
- Woolston
- Bitterne

In the past three years, smoking (37.3% compared to 18.8%) and breastfeeding (54.5% compared to 75.9%) rates for teenage mothers in Southampton are significantly worse for teenage mothers compared to the rest of the city.

#### 3.4.3.4 Termination of pregnancy

In Southampton 939 abortions were carried out in 2012, this is a crude rate of 15.5 per 1,000. This rate is lower than the England average but not significantly so.

In the city, 79.3% of NHS abortions are performed under 10 weeks gestation, this is a significantly higher proportion compared to the England average of 77.5%.

Southampton has a lower rate of repeat abortions compared to England for all ages (25.2% compared to the national average of 36.9%).

## 3.5 Theme 5 - living with long term conditions and maximising the quality of life

In Southampton disability free life expectancy is lower than the national average at 60.9 years for men and 63.4 years for women, compared with 61.7 years and 64.2 years respectively. Disability free life expectancy highlights inequality in the average number of years a person could expect to live free of an illness or health problem that limits their daily activities.

Many long term health conditions increase markedly with age; consequently the effect of the aging population on the prevalence of these diseases in Southampton is significant.

### 3.5.1 Levels of disability among children and young people

There are an estimated 1,900 children and young people (4.3%) living in Southampton with moderate or severe disabilities. These disabilities are generally chronic and limiting and include:

- Learning disabilities,
- Physical disability,
- Autistic spectrum disorders and
- Sensory disorders.

The most common is moderate learning disabilities (33% of all recorded disabilities). The majority of children and young people recognised as having learning difficulties are of school age and attend mainstream schools (80% with moderate or severe disabilities).

Data on disability living allowance claimants amongst the under 16s shows that rates in Southampton have not changed significantly over the past few years. In 2002 rates in Southampton were significantly higher than the national rates but since then the national rates have increased and there is now no significant difference.

### 3.5.2 Levels of disability among adults

The number of adults aged 18 to 64 with physical disabilities receiving services in 2008 was 1,235. Estimates and projections of the number of disabled people in the city have been produced using national prevalence rates applied to local population data; these suggest there may be around 11,000 working-age adults with a moderate physical disability and a further 3,000 with a serious physical disability living in Southampton. By 2030 there are projected to be over 16,000 adults of working age with a moderate or serious physical disability in Southampton.

### 3.5.3 Coronary heart disease (CHD)

In 2009/10 there were 7,242 people on CHD registers in Southampton giving a crude prevalence rate of 2.8%. The modelled estimate of CHD is higher at 9,822 giving a crude rate of 3.9%. Both sources of data suggest Southampton has lower rates of CHD than many of its ONS peers but these rates take no account of differences in age profile. Looking at locality rates is misleading because of this

fact. For example, the North and Central locality has significantly lower rates than elsewhere in the city but this will be partly due to the large number of students living here. Over the 2004/05 to 2009/10 period there has been a very slight downward trend in CHD prevalence both nationally and locally.

### 3.5.4 Atrial fibrillation (AF)

AF is recognised as a key risk factor for stroke and is the most common form of cardiac arrhythmia which is more prevalent in older age. Early detection of AF with treatment reduces the likelihood and severity of stroke. In March 2011 GP quality and outcomes framework (QOF) data showed 3,011 people registered with AF which equates to a raw prevalence rate of 0.012% against a national raw prevalence rate of 0.014%.

### 3.5.5 Stroke

Stroke accounts for around 165 deaths a year (9% of total deaths) in Southampton and causes a disproportionate amount of disability. Many strokes are preventable, with primary prevention offering the greatest potential for achieving benefits in value for money.

In March 2011 GP QOF data showed 3,721 people being cared for with stroke or transient ischaemic attacks.

### 3.5.6 Hypertension

Hypertension or high blood pressure contributes to cardiovascular disease (CVD), strokes, renal disease, vascular disease including aortic aneurysms, and yet shows few, if any symptoms until the disease is advanced. In March 2011 there were 26,606 people on hypertension registers in Southampton, giving a raw prevalence of 0.11%. However, the modelled estimate of hypertension predicts that there are 54,907 sufferers across the city.

### 3.5.7 Kidney disease

In March 2011 GP QOF data showed 7,140 people on GP disease registers with chronic kidney disease (CKD). The prevalence of diagnosed CKD amongst people aged 18 years and over in Southampton is 3.3% (compared to 4.2% in the ONS comparator group) although this varies from 0.2% to 8.2% by Southampton GP practices. This variation between practices will include differences in underlying risk factors including practice population and thresholds for CKD testing. In general CKD increases markedly with age, with the most common risk factors are cardiovascular disease, hypertension and diabetes. These often coexist with other factors such as obesity, coming from a lower socioeconomic group and from a minority ethnic group, particularly Black and Asian.

### 3.5.8 Diabetes

In 2009/10 there were 9,970 people on GP diabetes registers in Southampton which gives a crude prevalence rate of 3.8%, significantly lower than the England rate of 4.3%. Much diabetes is undiagnosed and modelled estimates of the true underlying prevalence put the total burden in the city at nearly 14,000 people (a crude rate of 6.4%).

Applying current national prevalence rates to Southampton's population projections results in a forecast increase in the number of people aged 65+ with diabetes from 3,852 in 2010 to 5,214 in 2030 as a result of changing demography alone. This takes no account of the fact that the actual prevalence rates of diabetes are also set to increase.

### 3.5.9 Chronic obstructive pulmonary disease (COPD)

In March 2010 there were 4,573 people on QOF COPD registers in Southampton. This represents a crude prevalence rate of 1.7% which is significantly higher than the England rate and about average compared to Southampton's ONS peers.

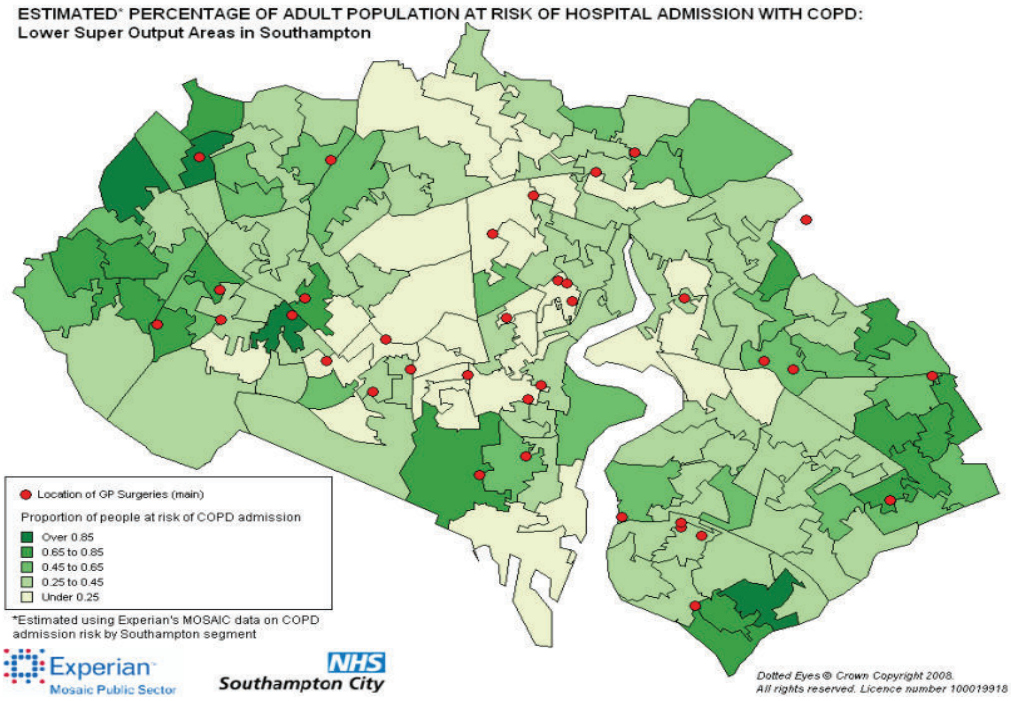
However, there is a disparity between disease prevalence estimates from large surveys, in particular the Health Survey for England, and the number of patients diagnosed and registered in QOF. In response to this disparity, the Eastern Region Public Health Observatory has developed a model to estimate COPD prevalence down to GP practice level. For Southampton city as a whole this model estimates there are 8,723 people with COPD which gives a crude prevalence of 3.5%.

It should however be noted that the model is supplied with various caveats about the assumptions that have gone into it. For example for practices with a population that significantly differs from a 'typical' population the assumptions of the model may not apply and discrepancies may occur.

For the city as a whole, the ratio between the estimated prevalence of COPD using the ERPHO model and the QOF registered prevalence is1.9. North and Central locality has the highest ratio at 2.38 indicating that the estimated prevalence is higher than the registered prevalence. This is, however, probably related to the skewed demography of this area as a large number of students live here.

The British Lung Foundation used MOSAIC population segmentation data to predict which lifestyle types are most at risk of future hospital admission with COPD. They then used this information to pinpoint which primary care trusts have the highest proportions of predicted COPD admissions. Through this work Southampton was identified as one of the COPD 'hot spots'.

Public Health Southampton has replicated this work locally using Southampton-specific MOSAIC data; the map below shows which areas of Southampton are estimated to have the highest proportions of people at risk of hospital admission due to COPD.



### 3.5.10 Asthma

In 2009/10 there were 15,725 people on GP asthma registers in Southampton giving a crude prevalence rate of 6.0% which is not significantly different from the national average of 5.9%. However, in previous years rates in Southampton were slightly higher than nationally and, it is only since 2007/08 that the gap has closed. Within the city, crude asthma prevalence rates are significantly higher in the West locality, whilst they are significantly lower than the city average in the North & Central locality.

### 3.5.11 Neurological conditions

In England 8 million people are estimated to have a neurological condition, and over half a million people are newly diagnosed with neurological conditions each year.

The national prevalence of Parkinson's disease is 200 per 100,000 and for multiple sclerosis its 100-120 per 100,000. Applying these rates to Southampton's population would give 470 people with Parkinson's and 260 people with multiple sclerosis in the City. Robust local data is currently not available.

Dementia is one of the main causes of disability in later life ahead of cancer, CVD and stroke. Data from GP QOF registers shows that in March 2011 there were 1250 people with diagnosed dementia, although the actual number of sufferers is likely to be higher. Applying national prevalence rates to the local population gives an estimated 2,490 dementia suffers in the over 65 age group. This is projected to rise to nearly 3,700 by 2030.

The number of people with neurological conditions is likely to grow sharply in the next two decades due to improved survival rates, improved general health care and infection control, increased longevity and improved diagnostic techniques.

### 3.5.12 Sight loss

Sight impaired (SI) and severe sight impairment (SSI) replace the terms partially sighted and blind for registration purposes. The GP registered population in 2009/10 identified 875 people with severe sight impairment, equating to 0.33% of patients registered with a GP in the city. There were 638 registered blind people (SSI) and 730 registered partially sighted (SI) people known to the city council on 31 March 2010, making a grand total of 1,368 people. This represents a 5.5 % increase in two years.

### 3.5.13 Hearing loss and deafness

Infants in Southampton have their hearing checked within hours of birth through the newborn infant screening programme. In March 2011 there were around 177 children aged a few months to 17 years supported by speciality teachers of the deaf.

The number of adults registered as deaf in Southampton is 290, which gives a rate of 1.23 per capita, which is slightly higher than England at 1.09. The number of people registered as hard of hearing is 1,025, a rate of 4.33 per capita and slightly higher than the 3.02 average for England. However, city council figures suggest that the number of hearing impaired in Southampton is 1,333 as at 31 March 2010. Using Medical Research Council methodology based on prevalence by age group of an average hearing loss (in the better ear) of 35dB or greater we estimate that 19,273 people would benefit from a hearing aid in our GP registered population.

### 3.5.14 Cancer

In 2009 there were 1,963 deaths in Southampton and 29% of these were caused by cancer. New cases of cancer are measured using an age standardised incidence rate (per 100,000 population). The rate of incidence of all cancers in England is 374 per 100,000 but in Southampton it is significantly higher still at 417. In the under 75 age group the figures for England and Southampton are 296 and 329 per 100,000 respectively. Rates of breast, prostate and colorectal cancer in Southampton are not significantly different from the England average, although lung cancer rates are significantly higher. In March 2011 there were 2,924 people diagnosed and on GP disease registers living with cancer in Southampton.

Lung cancer continues to be one of the most common cancers in Southampton. In 2009 there were 488 deaths from cancer amongst city residents and of these 125 were caused by lung cancer.

Bowel cancer is the second most common cause of cancer death following lung cancer. In 2009 there were 52 deaths in the city from colorectal cancer. In 2008 the Bowel Cancer Screening Programme was introduced for 60 to 69 year olds in the City and extended to include people up to 74 years of age in 2010. This programme offers screening every two years to men and women within this age group. In March 2011 around 60% had taken up this offer, but uptake varies between 30% and 100% across GP practice populations. Work is being undertaken to encourage those elements of the population to take up this screening offer to enable earlier diagnosis and treatment. 9 out of 10 people will survive bowel cancer if caught early enough.

In Southampton the overall uptake rate for breast cancer screening as at March 2009 was 71.9%, which was significantly lower than the national average.

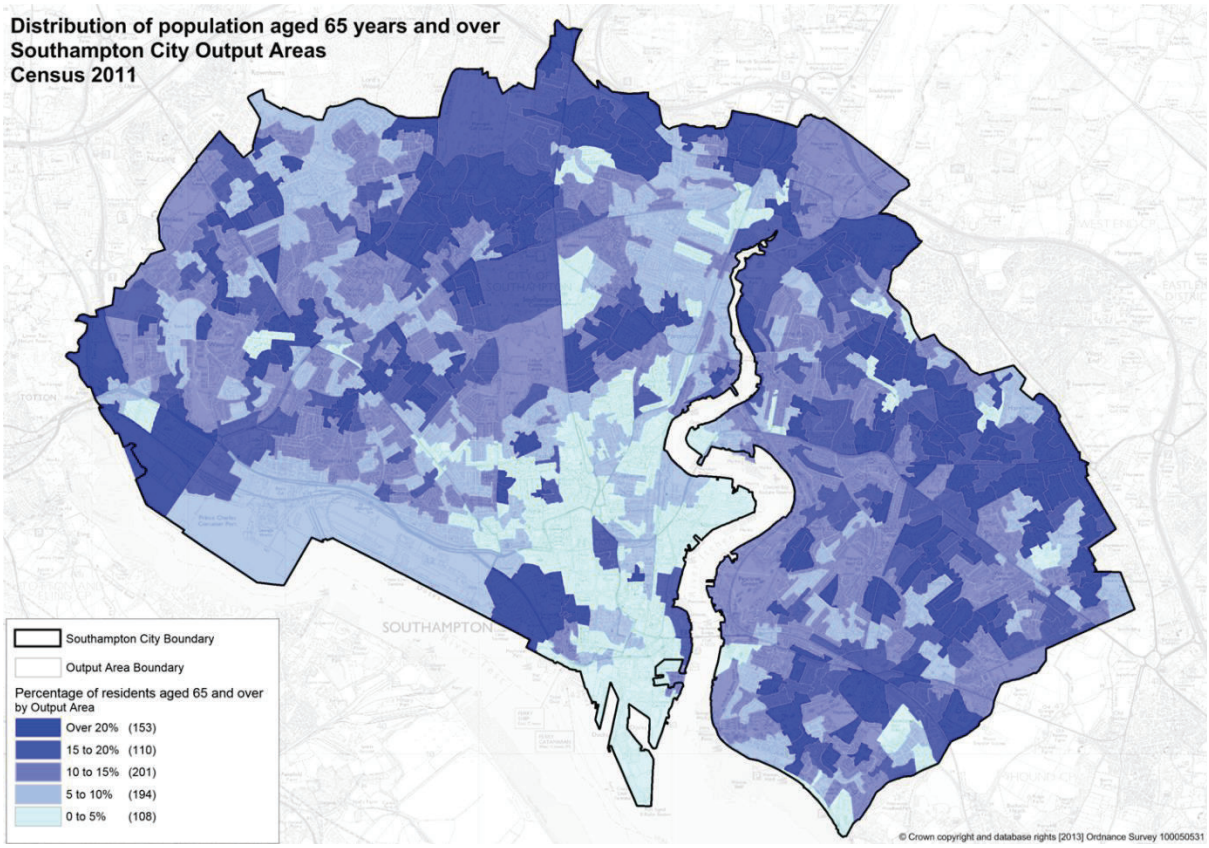
Every year, 2,000 women are diagnosed with cervical cancer in the UK and sadly, approximately 800 die. It is a disease that often affects women in the middle years of life. Infection with human papilloma virus is responsible for 70% of cases. The introduction in 2008 of a vaccine against human papilloma virus (HPV) for teenage girls promises to markedly reduce the incidence of this disease in the future.

The uptake of this vaccine in the City has been good. 93% of Year 8 girls received the first vaccination and 88.8% their third vaccination and completed this programme. A catch up programme for girls and young women up to age 18 years has been completed. Vaccinations take place in educational establishments by school nurses. This vaccination programme will not however eliminate the necessity of cervical screening for which the uptake in the city is below that for England and its ONS peers. In the future when women have their cervical screen the smear will be tested for HPV as part of a national addition to this programme.

Worryingly the incidence of malignant melanoma is increasing in Southampton and exposure to ultraviolet radiation, including that from tanning beds and lamps, is the single most important avoidable cause.

## 3.6 Theme 6 - more years, better lives and end of life care

The 2011 Census recorded 30,800 residents in Southampton aged over 65 years. The map below shows the distribution of these older people across the city. The proportions are lower in the central areas of the city where there is a large student population.

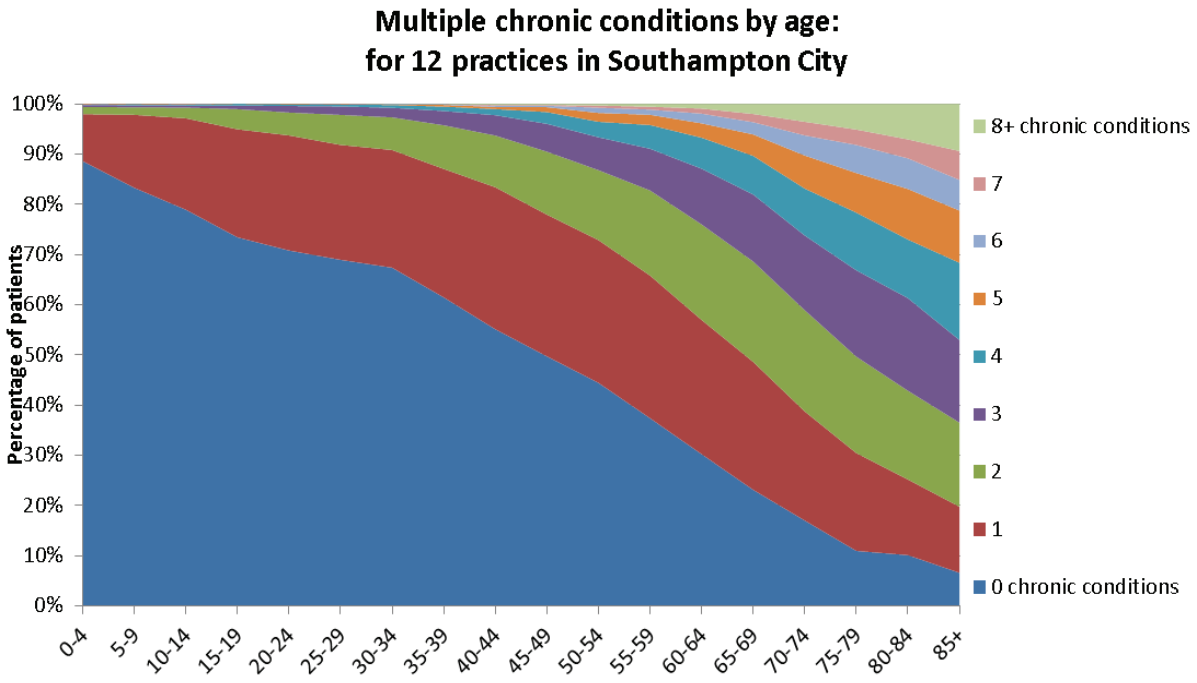



The demand for joint replacements due to disease and/or injury is rising. Over the period 2006/07 to 2011/12 there was a 47% increase in the rate of admissions for hip replacement in Southampton.

The Older People's Atlas produced by the West Midlands Public Health Observatory[20] provides a useful snap shot of indicators at local authority level. It shows that older people in Southampton are having worse than average outcomes for several key indicators, particularly around falls.
Long term conditions in later life tend to become more frequent and complex, requiring more reactive and proactive health and social care although it is recognised that many long term conditions can be self-managed with the right telehealth care provision.

Data from 12 practices in Southampton have been analysed to investigate how the number of chronic conditions increases with age. As the chart below shows, 85% of people aged over 65 have at least one chronic condition and 30% of them have more than four; among the over 85s the equivalent figures are 93% and 47%.

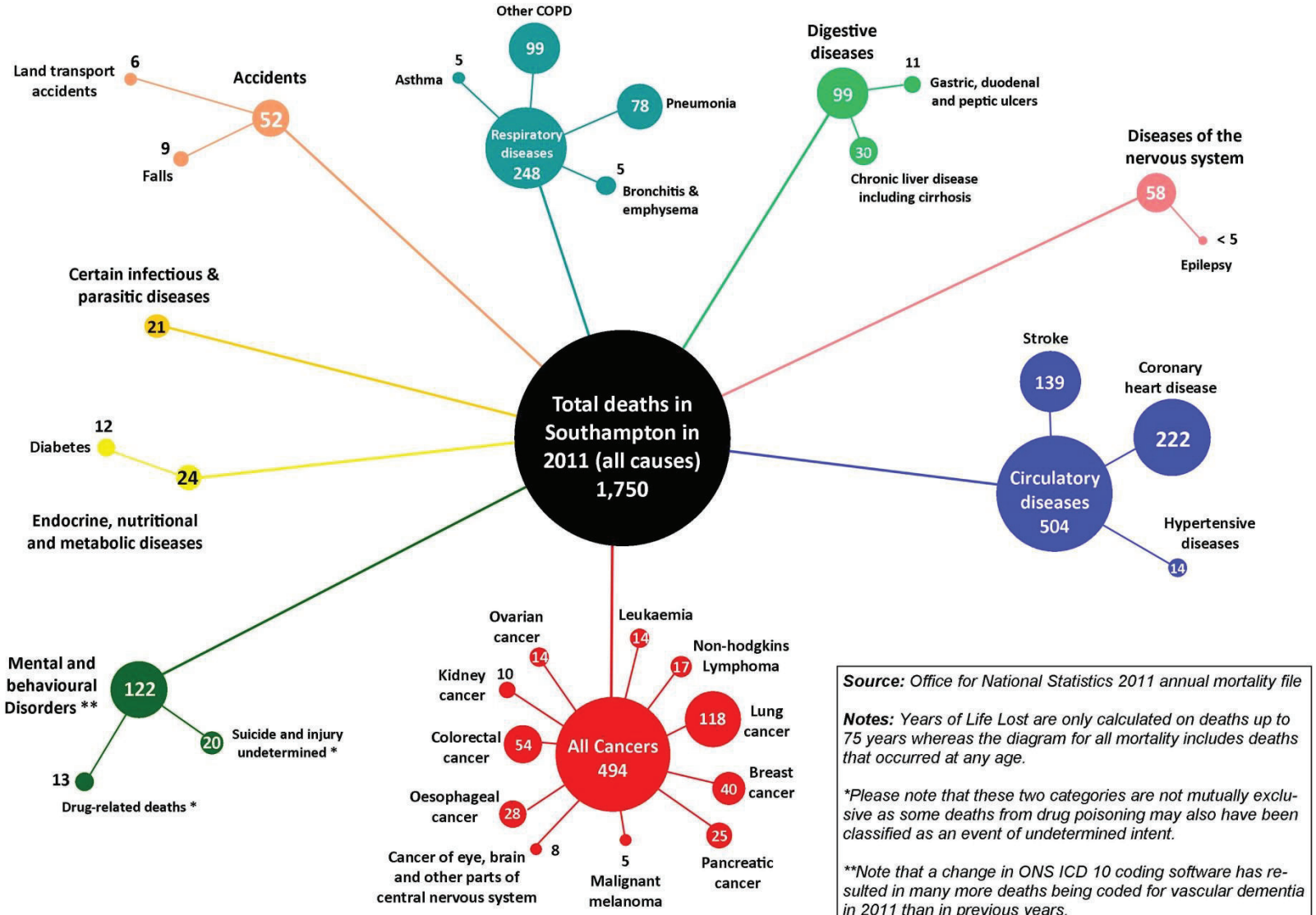
[20] http://www.wmpho.org.uk/olderpeopleatlas/




Source: ACG Tool extract September 2012

In 2011 there were 1,750 deaths registered in Southampton's resident population and of these cancer was responsible for 28.2%, coronary heart disease 12.7% and other circulatory diseases 16.2%. Around 55.4% of these deaths occurred in an acute hospital setting, 12.9% in a nursing/care home and 25.7% in the individuals own home.

The diagram below illustrates the main causes of death for Southampton residents as defined by the International Classification of Diseases v10 (ICD-10).




***Source:*** *Office for National Statistics 2011 annual mortality file*

***Notes:*** *Years of Life Lost are only calculated on deaths up to 75 years whereas the diagram for all mortality includes deaths that occurred at any age.*

**Please note that these two categories are not mutually exclusive as some deaths from drug poisoning may also have been classified as an event of undetermined intent.*

***Note that a change in ONS ICD 10 coding software has resulted in many more deaths being coded for vascular dementia in 2011 than in previous years.*

Carers are a critical, and often under-recognised and under-valued resource in caring for vulnerable people. The 2011 Census revealed that in Southampton, 8.6% (or 1 in 12) of the population provides some form of unpaid care, ranging from 1 hour per week to over 50 hours per week. This represents 20,263 people in the city. There is no significant difference in the proportion of people providing unpaid care in 2011 compared to 2001. The proportion of the population who are carers was lower in Southampton than in all its ONS peers, apart from Portsmouth.

Of those who provide care in Southampton, most provide 1-19 hours per week. Almost a quarter of carers provide 50 hours of care or more each week. The number of people providing 50 hours or more of care has increased marginally, but significantly, in Southampton since 2001 from 1.9% of the population to 2%. This is equivalent to 4,802 people.

## 3.7 Theme 7 – creating a healthier environment

Prior to the mid-1980s asbestos was widely used in the ship-building industry. Exposure to asbestos is the leading cause of a cancer called mesothelioma which can affect the tissues covering the lungs or the abdomen. Southampton's ship-building heritage means that we need to be aware of this possible risk even though mesothelioma is a relatively rare cancer. Over the period 2009-11 there were an average of 12 deaths per year to Southampton residents from mesothelioma.

Nationally mortality from mesothelioma is expected to peak in 2016 and then to decline rapidly. Rates in Southampton will be monitored by the public health team.

Active transport has benefits for health in terms of reducing the risk of chronic disease such as coronary heart disease or stroke and improving mental health and well-being. However, the 2011 census showed that 61.0% of employed residents in Southampton were travelling to work by car or van (either as driver or passenger). This is an increase from the 2001 rate of 59.8% but is a lower rate than the England figure of 62.0% and average compared to Southampton's ONS peers. In 2011 only 4.7% of Southampton residents used a bicycle as their main method of travelling to work but the proportion that walked had increased to 16.5% from 13.3% in 2001.

**Main method of travel to work by Southampton residents: 2001 and 2011[21]**

| Method of travel to work | % of residents aged 16-74 who were in work | |
|---|---|---|
| | 2001 | 2011 |
| **Work mainly at or from home** | 6.6 | 3.3 |
| **Underground, metro, light rail, tram** | 0.1 | 0.1 |
| **Train** | 2.0 | 2.9 |
| **Bus, minibus, coach** | 11.4 | 9.3 |
| **Taxi** | 0.4 | 0.5 |
| **Motorcycle, scooter or moped** | 1.5 | 1.1 |
| **Driving a car or van** | 52.9 | 54.3 |
| **Passenger in a car or van** | 6.9 | 6.7 |
| **Bicycle** | 4.3 | 4.7 |
| **On foot** | 13.3 | 16.5 |
| **Other method of travel to work** | 0.5 | 0.8 |

[21] 2001 and 2011 Censuses, ONS

## 3.8 Theme 8 - improving safeguarding for children and vulnerable adults

Thresholds and referral processes have been thoroughly reviewed and improved to ensure that more referrals are appropriate and that timely interventions are made. However, the levels of children and young people who are subject to safeguarding support either as children in need, children and young people in care, or subject to a Child Protection Plan have risen sharply since 2008, more quickly than either nationally or among most comparable areas. Numbers of Child Protection Investigations (Section 47 enquiries) have risen from a baseline of 30 per month in September 2008 to 113 per month in September 2011, with an average level per month of just under 136 over the six months May 2011 to October 2011. In relation to racially motivated harassment of children and young people at Southampton schools, there has also been an improvement from 209 reported incidents in schools in 2007/08 to 155 in the academic year 2008/09, though there has been a reported increase of 33% in Special Schools over the same period.

Abuse of older people is a hidden and often ignored problem in society, and many older people are too frightened to report its presence or may be unaware that it is happening. In 2004 it was estimated at least half a million older people were experiencing abuse at any one time. However, the actual prevalence remains difficult to identify. Locally, the reporting of abuse against older people and other vulnerable adults has increased significantly in the last few years. It is likely that this is the result of increased awareness amongst both professionals and the public, but it is not known whether prevalence is increasing simultaneously.

Certainly as the population lives longer therefore the numbers of people living with complex health and social care needs increases, unless there are significant changes in society, the potential for increased need for safeguarding adult's services exists. Safeguarding Adults must be considered as everybody's business and the education and raising of awareness must continue.

## 3.9 Theme 9 - protecting people from threats to health

Health protection includes (but is not confined to) communicable disease, environmental health hazards/contamination and extreme weather conditions. As Southampton is a port city there are particular threats to health posed by the large scale movements of goods and people through the port.

### 3.9.1 Tuberculosis (TB)

Cases of TB in Southampton are rising. In 2010, the rate per 100,000 population of new TB notifications in Southampton was 12.1, under the national average. This figure rose to 23.4 per 100,000 in 2011, mainly due to the existence of a large and growing cluster of cases.

In 2011, there were 51 cases resident in Southampton recorded onto the enhanced TB surveillance system. This represents an approximate 63% increase in cases since 2010. In 2011, 33 cases completed treatment, of whom, less than five were known to misuse alcohol or to be homeless. Five or fewer are recorded as having received directly observed therapy, all of whom have completed treatment. At the time of writing the JSNA there were two clusters of TB in Southampton, both of which have genetic links to cases across the country.

### 3.9.2 Hepatitis C

Public Health England has produced a tool for estimating the prevalence of Hepatitis C in a local population based on national rates[22]. Using this tool, there are an estimated 553 people living in Southampton with Hepatitis C virus.

Locally there are two other sources of direct measures of Hepatitis C prevalence amongst the local population of drugs users. One source is a local audit of around 95 shared care patients who are drug clients who are stable and no longer injecting. The audit was completed in 2013 and found a 20% prevalence of Hepatitis C.

The other local source of data is the unlinked anonymous monitoring survey of people who inject drugs. In 2011/12 this found a higher prevalence of Hepatitis C at 48.5% as would be expected amongst a higher risk group.

### 3.9.3 Healthcare associated infections (HCAI)

Between April 2008 and March 2012 there were less than 5 cases of meticillin-resistant *staphylococcus aureusis* (MRSA) each quarter amongst the population registered with GPs in Southampton.

During April 2012 to April 2013 there were, on average, 6 cases of *clostridium difficile* per month amongst people registered with Southampton GPs.

### 3.9.4 Vaccine preventable disease

Between April 2010 and March 2013 there were 294 possible and confirmed cases of Mumps amongst Southampton residents. Young adults are particularly affected with 75% of cases being in the 15-29 age group. Mumps is commonly seen amongst University students. The reasons for this are manifold. University students mainly comprise the cohort of children who were born prior to the introduction of 2 doses of measles, mumps and rubella (MMR) vaccines in the national schedule. Additionally, over time vaccine immunity wanes and the opportunities for social interaction provided by University student life provides a good environment for mumps virus to spread.

There were just 9 cases of suspected Rubella infections reported in Southampton city residents between April 2010 and March 2013 – none of which were confirmed and a majority of which tested negative.

In Southampton the number of confirmed and suspected pertussis cases was only around 5 per year in 2010 and 2011 rising to 46 in 2012. With the introduction of pertussis vaccine for pregnant women, and the associated awareness increasing, numbers appear to be falling again in 2013.

Although there have been no confirmed cases of Measles in Southampton city residents since March 2010, a drop in coverage rates for MMR vaccine nationally and locally in the late 1990s and early 2000s (when concern around the discredited link between autism and the vaccine was widespread) means the potential for cases and consequently outbreaks is currently at its highest.

### 3.9.5 Pandemic flu

The UK is planning for the worst case scenario in terms of pandemic flu, which would see a clinical attack rate of 50% amongst the population. Of those affected 2.5% of the population may die as a

[22] http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HepatitisC/EpidemiologicalData/

result. Extrapolating these figures to Southampton's population would mean an estimated 118,450 people could become symptomatic and 2,961 people could die.

**3.9.6 Port health**

As noted earlier the port handled 41 million tonnes of cargo and almost one million cruise passengers in 2008. Food and people now travel over far greater distances than ever before, creating the conditions necessary for widespread and rapidly occurring outbreaks of disease. Infectious diseases such as cholera persist and return, and recent decades have shown an unprecedented rate of emergence of new zoonoses within the UK.

It is anticipated that container volumes and shipping movements will continue to grow but accurate projections are somewhat difficult in the current economic climate. It is also anticipated that the number and details of intervention will also increase in line with the effects of climate change, food fraud and adulteration which have clear implications for food production, food security and food safety.

Southampton city council continually assesses resource threats and requirements and delivery outcomes.

# 4 Identified patient groups – particular health issues

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

- Those sharing one of more of the following Equality Act 2010 protected characteristics,
  - Age;
  - Disability which is defined as a physical or mental impairment, that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities;
  - Gender reassignment;
  - Marriage and civil partnership;
  - Pregnancy and maternity;
  - Race which includes colour, nationality, ethnic or national origins;
  - religion (including a lack of religion) or belief (any religious or philosophical belief)
  - Sex;
  - Sexual orientation.
- University students
- Port workers and visitors
- Veterans
- Homeless

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

## 4.1 Age

- Health issues tend to be greater amongst the very young and the very old
- The number of chronic conditions increases with age: data from 12 GP practices in Southampton was analysed showing that 85% of people aged 65+ have at least one chronic condition and 30% of them have more than four (amongst the over 85's the equivalent figures are 93% and 47%).
- A higher proportion of older people in Southampton rely on input from social services than is the case nationally (5.2% compared with 3.8%).

## 4.2 Disability

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

## 4.3 Gender re-assignment

- A survey of 889 people who had personal experience of transgender healthcare found that rates of mental ill health were high.
- Transgender individuals can face discrimination and harassment; they may be possible targets for hate crime

## 4.4 Marriage and civil partnership

- Domestic violence (mainly against women) is an issue in Southampton. In the last two years 450 referrals have been made to Multi Agency Risk Assessment Conferences because victims are at high risk of serious injury or death.

## 4.5 Pregnancy and maternity

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

## 4.6 Race

- Ethnic differences in health are most marked in the areas of mental wellbeing, cancer, heart disease, HIV, TB and diabetes1.
- An increase in the number of older BME people is likely to lead to a greater need for provision of culturally sensitive social care and palliative care.
- BME populations may face discrimination and harassment and may be possible targets for hate crime

## 4.7 Religion and belief

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

## 4.8 Sex

- Male healthy life expectancy in Southampton is 61.1 years which is significantly lower than the national average of 63.2 years.
- Inequalities in health are also greater for men in the city; there is a difference in life expectancy of 9.4 years for men from the most deprived 10% compared to those from the least deprived (the gap for women is 5.8 years).
- Domestic violence (mainly against women) is an issue in Southampton. In the last two years 450 referrals have been made to Multi Agency Risk Assessment Conferences because victims are at high risk of serious injury or death.

## 4.9 Sexual orientation

- Gay or lesbian individuals may be possible targets for hate crime
- Certain sexual health issues may be more prevalent in gay and lesbian populations e.g. gay men are in a higher risk group for HIV.
- Research suggests that gay and lesbian people may be less likely to be screened for certain conditions meaning problems are not picked up as early as they could be.

- Mental illness, such as depression and anxiety, is more common amongst lesbian, gay and bisexual people.
- Research has shown that lesbian women tend to drink more alcohol than straight women and gay men and lesbians generally take more drugs and are more likely to smoke than heterosexuals.

## 4.10 University students

- Mumps
- Chlamydia testing
- Meningitis
- Contraception, including EHC provision
- Mental health problems are more common among students than the general population

## 4.11 Port workers and visitors

- Infectious diseases

## 4.12 Veterans

In common with other areas of the country, routinely collected local data for veterans in Southampton are extremely limited. Consequently for the Southampton veterans' health needs assessment[23] national data was used. The following data are taken from the veterans' health needs assessment dated September 2012.

Applying estimates of the national veteran population obtained from survey data from the Royal British Legion (RBL) and the ONS gives an estimated 18,433 to 21,277 veterans living in the city. Most veterans are estimated to be in the older age groups, with 26 to 30% aged 65-74 years old, and 30 to 35% aged 75+ years.

The RBL suggests that between 2005 and 2020, the UK veteran population will reduce by 35% nationally. Although the overall number of veterans is projected to decline, the proportion of veterans aged 85 years and over is projected to increase. This is likely to be a reflection of the last veterans of the National Service cohort moving through the age profile, as well as increasing longer life expectancy within the UK population as a whole. However, there are increased proportions in age groups 16-24 years and 25-34 years due to the majority of personnel leaving the Armed Forces each year being in the younger age groups. There is also an unquantified impact of reductions in overall Service numbers (put in place after the RBL and ONS surveys) which may lead to personnel leaving sooner than expected. The health needs of younger veterans are likely to differ significantly from those in older age groups.

Between 2007 and 2027, ONS predicts a 50.4% reduction in the size of the veteran population in England. Much of this reduction results from declines in the oldest age groups with a disproportionate number of deaths in these age groups compared to the in-flow of new veterans each year. Once again, this has implications for the age profile of veterans in future, although the average age of the national veteran population is likely to remain older than that of the general population.

The Hampshire Health Record identifies 1,013 ex-service personnel in the 21 Southampton practices that link to it – a prevalence of just 0.65% amongst the 16+ years population.

In July 2011, 890 people were in receipt of an occupational pension under the Armed Forces Pension Scheme. The largest proportions of these veterans live in SO16 and SO19 which are the postcode districts covering the West and East/South localities in Southampton. These localities include some

[23] http://www.publichealth.southampton.gov.uk/Images/Veterans'%20Needs%20Assessment%20May'12.pdf

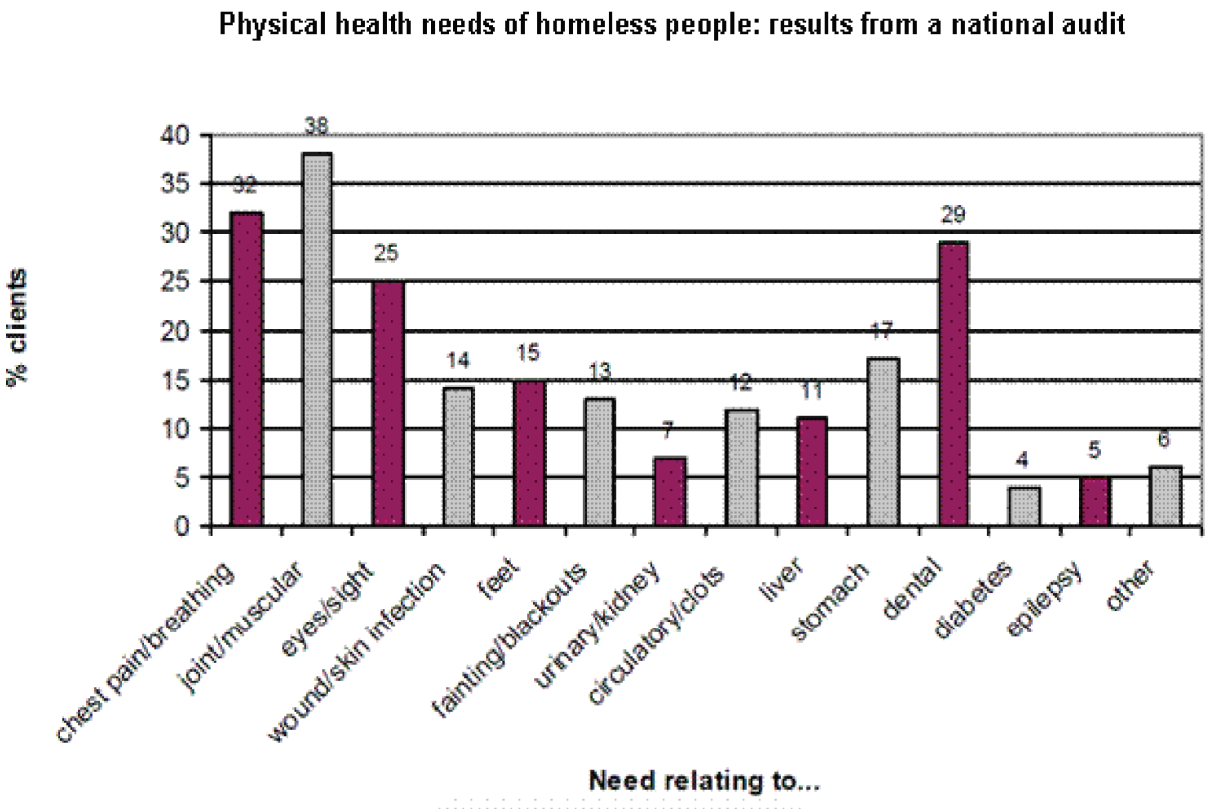
of the city's most deprived areas. These two postcode districts also contained the majority of the 390 people in receipt of a war disablement pension (115 and 110 respectively).

A recent review of health and social factors affecting veterans suggest that overall the health of the veteran population is comparable to that of the UK's general population[24]. A study by the RBL in 2005 includes self-reported health information from veterans and the wider ex-service community (including dependents). With this caveat, when compared to the UK general population, significantly higher prevalence was reported for the ex-service community for the following conditions:

- Musculo-skeletal
- Cardiovascular
- Respiratory
- Mental health, particularly depression, anxiety and alcohol abuse
- Sight
- Hearing

## 4.13 Homeless

Homeless Link completed a nationwide study of the health needs of homeless people which showed that 82% of homeless people have the physical health needs set out in the chart below[25]. Of these, 56% were long term health needs which compares to 29% in the rest of the population.




[24] Fear N, Wood D, Wessely S for the Department of Health. *Health and social outcomes and health services experiences of UK military veterans - a summary of the evidence.* London: November 2009. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113749.pdf

[25] The Health And Wellbeing Of People Who Are Homeless: Evidence From A National Audit (2010)

Other key findings of this audit included:

- 72% reported one or more mental health needs – a rate almost two and a half times as great.
- 77% smoke compared to 21% of the general population. Only half of smokers in the audit (55%) had been offered smoking cessation advice.
- 52% indicated they used one or more type of illegal drug.
- 4% indicated they currently inject drugs.
- 75% consume alcohol, and around half of these indicated this was weekly consumption or less frequent. However 20% of clients said they drank more than 4 times per week (the frequency considered harmful by DH). A third of these clients said they consume 10 or more units each time they drink, which suggests very harmful levels of alcohol consumption.

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

# 5 Provision of pharmaceutical services

Necessary services, for the purposes of this PNA, are defined as:

- access to essential services provided at all premises on the pharmaceutical list,
- essential services provided by pharmacies and DACs during standard 40 core hours in line with their terms of service as set out in the 2013 regulations, and
- advanced services

## 5.1 Necessary services: current provision within the HWB's area

There are 44 pharmacies included in the pharmaceutical list for the area of the HWB, operated by 19 different contractors. Of these, 31.8% are owned by independent contractors (defined as owning five or less pharmacies within England) and 68.2% by multiple contractors (those owning six or more pharmacies).

Over the last four years there has been a 2% increase in the number of pharmacies owned by independent contractors. This differs from the national picture where since 2006-07 the proportion of pharmacies in England owned by multiple contractors has increased from 58.9% to 61.4%.

Of these 44 pharmacy premises, forty operate standard 40 core hours. [Supplementary hours and the 4 premises providing services for 100 core hours are considered in section 5.3]. There are no distance selling premises within the HWB's area.

There is one DAC within the area of the HWB.

There is a statutory requirement to provide a map of the premises providing pharmaceutical services. In addition, the HWB commissioned a suite of maps to inform the PNA. These can be found at appendix L. Any reference to a Map by number throughout this PNA is a reference to a map in that appendix. Appendix M provides a numbered index table to mapped premises.

Map 1 shows the location of the pharmacy and DAC premises within the HWB's area. It should be noted that due to the proximity of some pharmacies some icons may reflect the location of two contractors.

In 2013/14 93.38% of items[26] prescribed for Southampton residents were dispensed by contractors within the HWB's area.

As can be seen from the table below the number of pharmacies within the HWB's area has remained relatively static since 2010/11 with just one new pharmacy opening since 1 March 2010. This indicates that up to September 2012 applicants were unable to demonstrate that new premises were either necessary or expedient. The preceding PNA did not identify the need for new premises and since September 2012 no applicant has successfully demonstrated that there would be unforeseen benefits in approving an application for new premises.

[26] The number of items dispensed differs from the number of prescription forms as a prescription form may contain more than one item.

| Year | Number of community pharmacies | Prescription items dispensed per month (000)s | Population (000)s Mid 2007 | Pharmacies per 100,000 population |
|---|---|---|---|---|
| 2007-8 | 40 | 243 | 231 | 17 |
| 2008-9 | 40 | 254 | 235 | 17 |
| 2009-10 | 40 | 266 | 235 | 17 |
| 2010-11 | 43 | 274 | 237 | 18 |
| 2011-12 | 43 | 283 | 236 | 18 |
| 2012-13 | 44 | 290 | 236 | 19 |

There has been a small increase in the number of items dispensed per month (approximately 3% per annum since 2010/11) which has been absorbed by the existing contractors.

**5.1.1 Access to premises**

Map 2 shows that the majority (99%) of Southampton residents live within 1.6km, in a straight line, of a pharmacy.

However, very few people will ever travel in a straight line from their home to a pharmacy. A more useful measure therefore is how long it takes for people to access a pharmacy by foot, car and public transport.

Map 7 analyses the average drive times to pharmacies. As can be seen from the map, 98.6% of residents can access a pharmacy by car within 5 minutes and everyone can access a pharmacy within 10 minutes. This position doesn't change during peak times as can be seen from Map 9.

Access to a pharmacy out of peak times improves such that everyone can access a pharmacy within 5 minutes, by car. Map 8 refers.

According to 2011 census data, car ownership within Southampton is as follows:

- 28,996 households do not have a car or van (29.5%)
- 43,938 have one car or van
- 20,099 have two cars or vans
- 3,969 have three cars or vans
- 1,252 have four cars or vans

For those households where there is no car available during the day it is necessary to look at how easy it is to access a pharmacy by public transport and on foot.

Two maps look at the how long it takes to get to a pharmacy using public transport; Map 10 between 9am and 1pm, and Map 11 between 2 and 5pm on a typical weekday. Both maps show that 99.2% of the population is able to access a pharmacy within 20 minutes using public transport.

There will be a cohort of the population who do not have access to a car or van and are unable to afford public transport. Map 12 analyses how long it takes to walk to a pharmacy.

From the map it can be seen that 99.2% of the population is able to walk to their nearest pharmacy within 30 minutes.

The public survey received 281 responses with 63% being from females and 36% males. The percentage of respondents increased with age, 60% being 56 or ever.provided the following insights into accessing pharmaceutical services:

- 39% use the same pharmacy while 51% use different premises but visit one most often
- people use a pharmacy because it close to home 70%, close to the doctor 56% or shops 23%
- people usually get to a pharmacy by walking (57%) or by car (43%)
- access takes less than 5 minutes (40%) or 5 to 15 minutes for 55% or the respondents
- 78% rated access as easy with 20% rating it as OK
- Typically, during the week 75% found access convenient during the day rising to 85% before 9am and 94% in the evening. Saturday was typically 65% during the day with Sunday 40%.

**5.1.2 Access to services**

Whilst the majority of people will visit a pharmacy during the 8.30am to 6pm period, Monday to Friday, following a visit to their GP, there will be times when people will need to access a pharmacy outside of those times. This may be to have a prescription dispensed after being seen by the out of hours GP service, or it may be to access one of the other services provided by a pharmacy outside of a person's normal working day.

Map 3 shows when pharmacies and the DAC are open based on their core and supplementary opening hours[27]. Appendix N provides a numbered index table and the opening times of mapped premises.

In summary there are:

- Seven pharmacies open seven days a week (includes the four 100 hour pharmacies)
- 15 pharmacies open Monday through to Saturday
- 18 pharmacies open Monday through to Friday, and part of Saturday
- Four pharmacies that open Monday to Friday.

The DAC is open Monday to Friday and part of Saturday.

Map 13 identifies pharmaceutical premises with Southampton ward boundaries and complements the historic map at the beginning of section 2.

Whilst the normal working hours that a GP practice is obliged to be available to patients is 08:00 until 18:30 Monday to Friday, a number of practices offer extended hours both before and after these times including on a Saturday morning. In summary, for 2014/15 there are the following extended hours for primary medical provision:

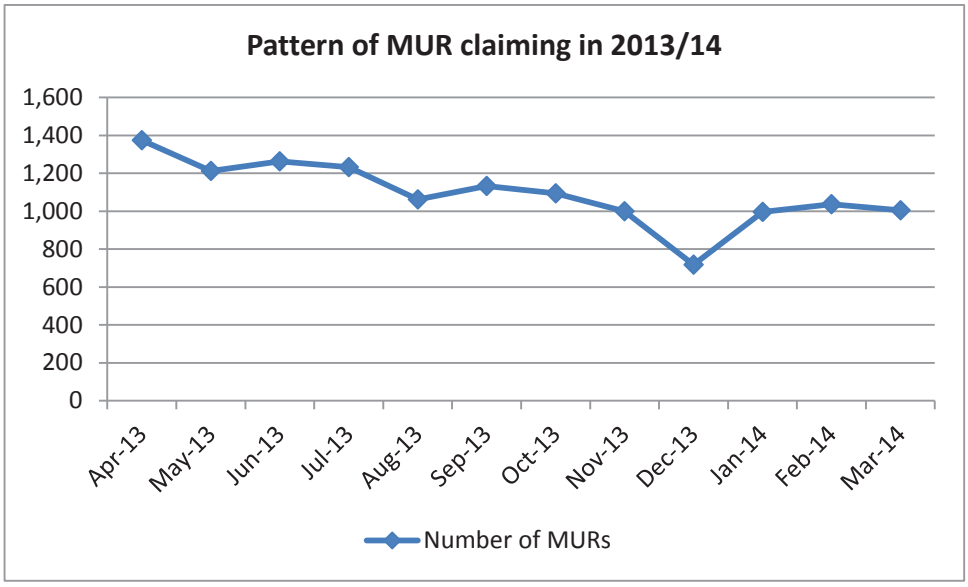
- Monday to Friday there are a small number of GP practices open in the morning typically 07:30 until 08:00;
- Monday to Thursday there are evening clinics provide by a number of GP practices on some evenings with Monday providing the highest provision:
- On Saturday morning there are clinics provided by a number of GP practices at varying hours between 08:00 and 13:00.

[27] As at 23 July 2014.

### 5.1.3 Access to MURs

Appendix N provides a numbered index table of mapped premises and indicates those providing Advanced Services.

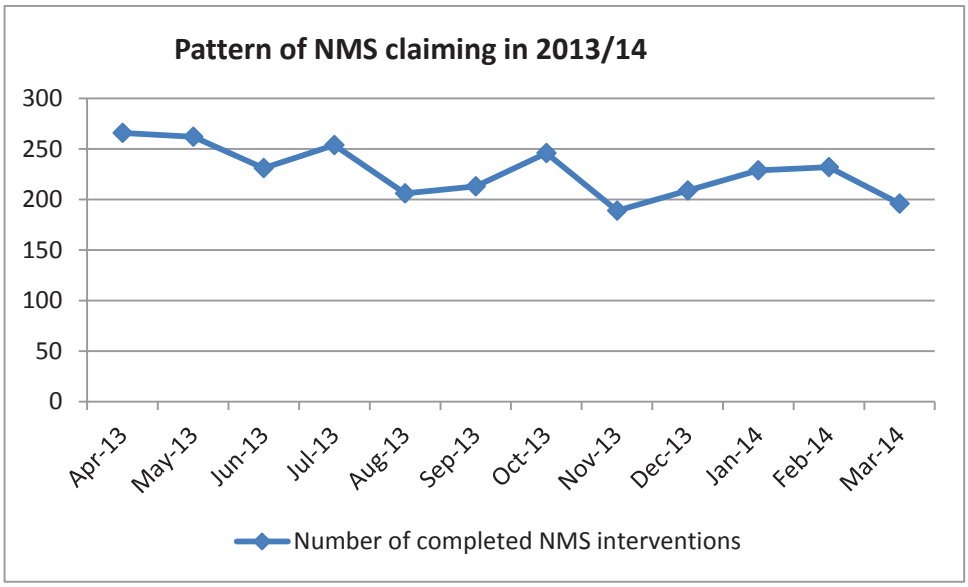
In 2013/14 a total of 13,523 MURs were provided by 41 of the pharmacies with only four pharmacies claiming for the maximum number of MURs. The graph below shows the pattern of claiming throughout the year for all pharmacies.




Up to 400 MURs can be provided at each pharmacy, giving an overall maximum number of 17,600 per annum. However with three pharmacies not providing the service the actual number of MURs that could have been undertaken is 16,400.

### 5.1.4 Access to NMS

In 2013/14 a total of 2,733 NMS interventions were provided by 38 pharmacies. The graph below shows the pattern of claiming throughout the year.



Unlike for MURs there is no nationally set maximum number of NMS interventions that may be provided in a year. However the service is limited to a specific range of drugs and can only be provided in certain circumstances and this therefore limits the total numbers of eligible patients.

Over the year there was a gradual reduction in the provision of this service but this may reflect the uncertainty of the future of this service. It is currently due to come to an end on 31 March 2015; however this may change following discussions between NHS England and the Pharmaceutical Services Negotiating Committee (PSNC).

#### 5.1.5 Access to stoma appliance customisation

Ten of the pharmacies in the area customised just over 400 stoma appliances in 2013/14[28]. This low level of activity reflects the specialist nature of the provision of appliances and it would be expected that this service is provided by DACs specialising in the provision of stoma appliances. The only DAC in the area did not provide this service in 2013/14; however this is because they do not provide stoma appliances.

#### 5.1.6 Access to AURs

No pharmacy within the area provided this service in 2013/14 and neither did the DAC.

#### 5.1.7 Access to enhanced services

At the time of writing this PNA NHS England only commissioned one enhanced service from pharmacies in 2014/15 – provision of flu vaccinations. It was not known which pharmacies will provide this service nor whether it will continue beyond this year's flu season.

The HWB recognises that this position may be mitigated by locally commissioned services and the public survey identified access and familiarity with services offered by pharmacists. For example, respondents were aware pharmacies offered stop smoking services (73%), alcohol advice (35%), treatment for minor ailments (45%), flu vaccination (45%), various health checks (typically 35% to 50%) and various contraception (typically 50% to 75%). People were less familiar with Chlamydia tests (18%) and Anticoagulation checks (13%).

#### 5.1.8 Access to pharmaceutical services on public and bank holidays

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

### 5.2 Necessary services: current provision outside the HWB's area

#### 5.2.1 Access to essential services and DAC equivalent services

The map in the section above shows the location of the pharmacies around the border of the HWB's area.

[28] This figure will not be accurate as once a contractor starts to provide this service they are paid for each customisable appliance that they dispense, irrespective of whether or not they did customise it. This is recognised in the level of fee that is paid.

Patients have a choice of where they access pharmaceutical services; this may be close to their GP practice, their home, their place of work or where they go for shopping, recreational or other reasons. Consequently not all the prescriptions written for residents of Southampton were dispensed by the pharmacies within the city. As noted in the previous section, the vast majority of items were dispensed by contractors within the HWB's area. However, 242,102 items (6.61%) were dispensed outside of the HWB's area by a total of 2,494 different contractors. An analysis of these contractors indicates that:

- 2,072 dispensed 10 items or less
- 322 dispensed between 11 and 100 items
- 138 dispensed between 101 and 1,000 items
- 34 dispensed 1,001 items or more

As may be expected of the 34 contractors that dispensed 1,001 items or more, 26 are located in Hampshire. The remaining contractors were spread throughout England.

It should be noted that although there is a DAC within the HWB's area the vast majority of items dispensed by DACs was done outside of the area. This reflects the specialist nature of DACs who generally focus on a specific range of appliances and provide a nation-wide delivery service.

#### 5.2.2 Access to advanced services

Information on the type of advanced services provided by pharmacies and DACs outside the HWB's area to residents of Southampton is not available. When claiming for advanced services contractors merely claim for the total number provided for each service. The exception to this is the stoma appliance customisation service where payment is made based on the information contained on the prescription. However even with this service just the total number of relevant appliance items is noted for payment purposes.

It can be assumed however that residents of the HWB's area will be able to access the advanced services from contractors outside of Southampton.

#### 5.2.3 Access to enhanced services

It is not possible to identify the number of Southampton residents who access enhanced services from pharmacies outside of the HWB's area. This is due to the way that pharmacies are paid. However residents of the HWB's area may access the flu vaccination enhanced services from contractors outside of Southampton.

### 5.3 Other relevant services: current provision

Other relevant services are pharmaceutical services there are not defined as necessary, see section 5.1, but have secured improvement or better access to pharmaceutical services.

Other relevant services, for the purposes of this PNA, are defined as:

- essential services provided at times by pharmacies beyond the standard 40 core hours (known as supplementary hours) in line with their terms of service as set out in the 2013 regulations,
- essential services provided during core hours by pharmacies obliged to open at least 100 core hours in line with their terms of service as set out in the 2013 regulations, and
- Enhanced services

#### 5.3.1 Other relevant services within the HWB's area

There are 4 pharmacies providing a minimum of 100 core hours.

There are supplementary hours provided by those obliged to provide 40 core hours.

The totality of these hours covers evenings, Saturday and Sunday. The data on opening hours provided by NHS England is shown in appendix N and mapped at Map 3.

#### 5.3.2 Other relevant services provided outside the HWB's area

Whilst there are pharmacies outside of the HWB's area providing pharmaceutical services during hours that may be regarded as providing improvement or better access, it is a choice of individuals whether to access these as part of their normal lives. None are specifically commissioned to provide services to the population of Southampton.

#### 5.3.3 Other relevant services

Whilst the HWB consider Enhanced Services as providing an improvement or better access to pharmaceutical services, none are commissioned by NHS England. The HWB is mindful of local commissioned services as described in section 6.

## 5.4 Choice with regard to obtaining pharmaceutical services

As can be seen from sections 5.1, 5.2 and 5.3, the residents of the HWB's area currently exercise their choice of where to access pharmaceutical services to a considerable degree. Within the HWB's area they have a choice of 44 pharmacies, operated by 19 different contractors, and one DAC. Outside of the HWB's area residents chose to access a further 2,494 pharmacies, although only 34 of those appear to be on a regular basis. In addition they chose to use three DACs.

## 5.5 Future provision – necessary and other relevant services

#### 5.5.1 Housing and development

Any planned new residential developments are dispersed across the existing urban area and minimal in scale. There are no known future developments that are likely to significantly alter demand for pharmaceutical services.

#### 5.5.2 Primary Care developments

There are no planned primary care developments that will impact on pharmaceutical service provision.

## 5.6 Themes on access and services from the public

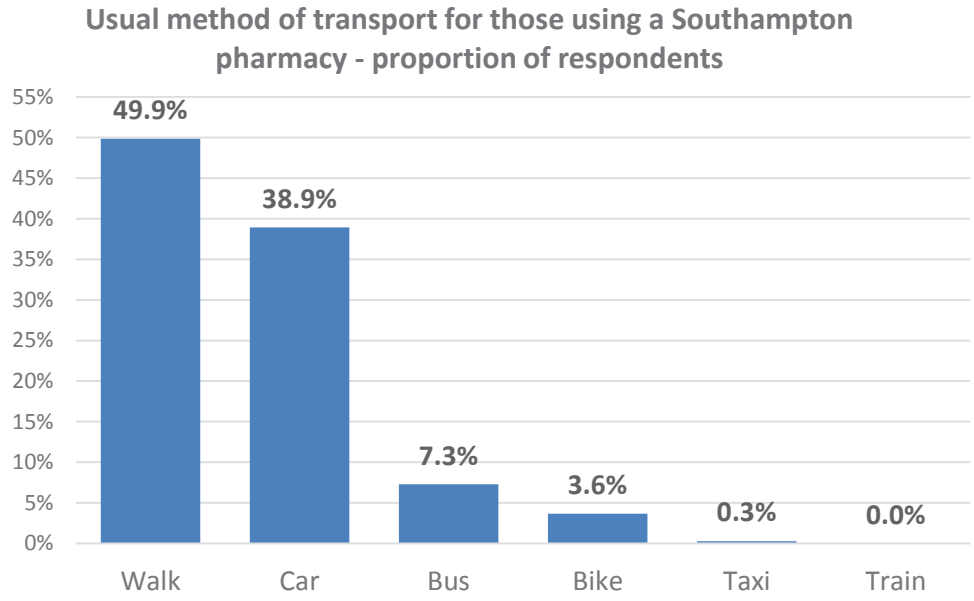
The public and patient engagement referred to in section 1.6.3 sought to gain information on access to pharmaceutical services. There is a general theme that most people use the same pharmacy all or most of the time, with the proximity to home or the doctors being the main reason cited (see table below). There are other reasons relating to the specific pharmacy that include, amongst others, easy access, customer service and a feeling of trust that the customer is looked after.

| Answer Choices: | Responses: | |
|---|---|---|
| Use different pharmacies but visit one most often | 52.48% | 169 |
| Use the same pharmacy all of the time | 38.51% | 124 |
| Use different pharmacies and none more frequently than any other | 9.01% | 29 |
| Total Respondents: | | 322 |

When asked if there is a more convenient or closer pharmacy that for some reason they didn't use, 30% of the respondents said 'Yes', citing the following as reasons for not doing so:

| Answer Choices: | Responses: | |
|---|---|---|
| The service is too slow | 44.12% | 30 |
| I have had a bad experience in the past | 41.18% | 28 |
| They don't have what I need in stock | 27.94% | 19 |
| It is not easy to park | 22.06% | 15 |
| It's not open when I need it | 17.65% | 12 |
| There is not enough privacy | 16.18% | 11 |
| It's not wheelchair/baby buggy friendly | 2.94% | 2 |
| Multiple option responses totalling: | | 117 |

When accessing the pharmacy themselves, 41% said it took less than five minutes with only 5% indicating more than 15 minutes. Overall, getting to a pharmacy was deemed easy (77.60%), OK (21.14%) and difficult (1.26%) by those who responded. Their mode of access is shown in the graph below:




In providing free text comments, the theme of access times was frequently mentioned, with the following requested:

- Better opening hours
- Longer opening hours
- 24 hour opening alongside supermarket 24 hour opening
- Stay open over lunch hour
- Before 9 a.m. opening hours during the week
- Each shopping area should have a pharmacist and one or two open all night.

The most convenient time for the 307 respondents to use a pharmacy is during the morning and afternoon periods, where historically GP surgeries are open. However, the evening period until 8pm is popular with a lesser number of people identifying late evening and early morning (before 9am) as convenient. Responders could choose more than one period as shown in the table below:

| | Normal weekday | Saturday | Sunday | Total Respondents |
|---|---|---|---|---|
| Before 9am | **84.38%** 54 | **46.88%** 30 | **32.81%** 21 | 64 |
| Between 9am and noon | **75.11%** 178 | **72.15%** 171 | **40.51%** 96 | 237 |
| Between noon and 2pm | **73.33%** 121 | **67.88%** 112 | **46.67%** 77 | 165 |
| Between 2pm and 5pm | **75.92%** 145 | **62.83%** 120 | **43.46%** 83 | 191 |
| Between 5pm and 8pm | **94.23%** 147 | **50.00%** 78 | **34.62%** 54 | 156 |
| After 8pm | **93.55%** 58 | **56.45%** 35 | **41.94%** 26 | 62 |

When three-quarters of respondents could not access their usual pharmacy they went to another. The majority of the remainder waited until that pharmacy was open. In order to access information on the pharmacy, such as opening times and services, searching the internet was the most common answer (67.6%) with some form of direct communication still rating highly.

The table below shows summarises respondents knowledge and use of additional NHS services offered by pharmacies and those discussed with the pharmacist. The majority responded that they had not received advice from pharmacies on smoking (90.5%), alcohol (96.2%), their weight (83.1%) or heart disease (82.9%) but didn't feel they needed it.

| | Yes, and the advice was welcome | Yes, but I wasn't interested | No, and I would like some advice | No, and I don't need advice | I can't remember | Total |
|---|---|---|---|---|---|---|
| Smoking | **5.10%** 15 | **2.04%** 6 | **1.36%** 4 | **90.48%** 266 | **1.02%** 3 | 294 |
| Alcohol | **0.34%** 1 | **0.69%** 2 | **1.72%** 5 | **96.22%** 280 | **1.03%** 3 | 291 |
| Your weight | **3.39%** 10 | **1.36%** 4 | **9.15%** 27 | **83.05%** 245 | **3.05%** 9 | 295 |
| Heart disease | **4.79%** 14 | **0.34%** 1 | **7.88%** 23 | **82.88%** 242 | **4.11%** 12 | 292 |

In providing free text comments, the theme of offering additional services more generally was frequently requested:

- Treat very minor injuries
- Short counselling service
- Free cholesterol testing
- Free body fat measurements
- Hearing and Sight testing
- Over-the-counter asthma inhalers
- Ordering prescription by computer for home delivery
- Internet orders for repeat prescriptions with home delivery.

The knowledge of respondents in respect of free NHS services varied indicating that some services may need to be more widely promoted. However, only a small percentage had found need to use the various services available as shown in the table below:

| | I know they offer this service | I didn't know this service was on offer | I have used this service | Total |
|---|---|---|---|---|
| Stop smoking help | **73.36%** 201 | **25.18%** 69 | **1.46%** 4 | 274 |
| Alcohol advice | **35.97%** 91 | **63.64%** 161 | **0.40%** 1 | 253 |
| Help watching your weight | **41.38%** 108 | **57.85%** 151 | **0.77%** 2 | 261 |
| Heart health check ups | **35.00%** 91 | **64.62%** 168 | **0.38%** 1 | 260 |
| Cholesterol check ups | **40.60%** 108 | **58.65%** 156 | **0.75%** 2 | 266 |
| Blood pressure check ups | **46.67%** 126 | **52.22%** 141 | **1.11%** 3 | 270 |
| Morning after pill | **54.03%** 134 | **44.35%** 110 | **1.61%** 4 | 248 |
| Anticoagulation (blood thinners) checks | **14.17%** 34 | **85.42%** 205 | **0.42%** 1 | 240 |
| Gluten free foods | **34.01%** 84 | **65.18%** 161 | **0.81%** 2 | 247 |
| Medicine reviews | **40.82%** 109 | **47.57%** 127 | **11.61%** 31 | 267 |
| Chlamydia tests and treatment | **19.23%** 45 | **80.34%** 188 | **0.43%** 1 | 234 |
| Treatment for minor ailments | **45.59%** 119 | **49.04%** 128 | **5.36%** 14 | 261 |
| Disposal of injecting equipment | **42.34%** 105 | **56.45%** 140 | **1.21%** 3 | 248 |
| Flu vaccination | **46.25%** 117 | **51.38%** 130 | **2.37%** 6 | 253 |
| Diabetes check ups | **39.69%** 102 | **58.75%** 151 | **1.56%** 4 | 257 |
| Home delivery | **72.22%** 195 | **22.96%** 62 | **4.81%** 13 | 270 |
| Head lice treatment | **53.20%** 133 | **44.80%** 112 | **2.00%** 5 | 250 |
| Contraception supply | **68.70%** 169 | **28.05%** 69 | **3.25%** 8 | 246 |
| Condoms | **75.10%** 184 | **22.86%** 56 | **2.04%** 5 | 245 |
| Pregnancy testing | **62.04%** 152 | **36.33%** 89 | **1.63%** 4 | 245 |

## 5.7 Contractor questionnaire results

The contractor questionnaire was issued to all 44 pharmacies and one DAC in Southampton HWB area. This resulted in 16 responses (36%), with all responding they dispense all types of appliances.

In addition, the respondents identified whether they were regarded as a healthy living pharmacy as below:

| Healthy living pharmacy | Total |
|---|---|
| Yes | 5 (31.3%) |
| Currently working towards HLP status | 7 (43.8%) |
| No | 4 (25%) |

**Premises**: When asked if the pharmacy premises included a consultation area, all responded that they did (see table below). All had an enclosed room for this purpose.

| On site consultation | Total |
|---|---|
| Available (including wheelchair access) on the premises | 15 (93.8%) |
| Available (without wheelchair access) on premises | 1 (6.3%) |

**Advanced services**: Pharmacies confirmed which services they currently provide or if they intended to provide them in the near future. The majority of pharmacies either provide, or soon will be able to provide, the MUR and NMS services. Stoma customisation services and AURs are also provided, but to a lesser extent given the specialised nature of these services. The table below summarises the responses.

| Advanced service | MUR | NMS | AUR | Stoma |
|---|---|---|---|---|
| Yes | 16 (100%) | 16 (100%) | 3 (18.8%) | 5 (31.3%) |
| Soon | | | 3 (18.8%) | 3 (18.8%) |
| No | | | 10 (62.5%) | 8 (50%) |

**Enhanced and locally commissioned services**: Pharmacies confirmed which services they currently provide and gave expressions of interest in providing new services.

The following services were identified as being provided or willing to be provided as either enhanced services (commissioned by NHS England) or locally commissioned services (Local Authority or CCG) by the number of pharmacies indicated:

| Service | Providing | Willing to Provide |
|---|---|---|
| Supervised Administration | 12 | 4 |
| Needle and Syringe Exchange Service | 8 | 8 |
| Sharps disposal service | 7 | 7 |
| minor ailments scheme | 7 | 9 |
| supplementary prescribing | 7 | 3 |
| anti-coagulant monitoring | 7 | 7 |
| Gluten free food supplies | 8 | 8 |
| On Demand Availability of Specialist Drugs Service | 8 | 7 |
| Smoking Cessation Counselling Service | 12 | 4 |
| Chronic heart disease (CHD) | 7 | 8 |
| Cholesterol service | 6 | 8 |
| NRT voucher service | 8 | 8 |
| NHS Health Checks | 8 | 7 |
| Independent prescribing service | 6 | 7 |
| Medicines Assessment & Compliance Support Service | 9 | 6 |
| Parkinson's disease service | 7 | 6 |
| Dementia/ Alzheimer service | 7 | 7 |
| Depression | 7 | 6 |
| Epilepsy service | 7 | 7 |
| Allergy testing | 7 | 8 |
| Hypertension | 6 | 8 |
| HIV service | 6 | 6 |
| HPV service | 6 | 10 |
| Heart failure service | 7 | 7 |
| Diabetes service | 7 | 8 |
| anti-viral distribution service | 7 | 8 |
| Asthma & COPD | 7 | 7 |
| Care Home Service | 7 | 7 |
| Obesity management (adults and children) | 7 | 8 |
| Medication Review Service | 8 | 7 |
| MUR Plus/Medicines Optimisation Service | 7 | 8 |
| Phlebotomy service | 7 | 5 |
| Out of hours services | 5 | 5 |
| Emergency Hormonal Contraception Service | 10 | 6 |
| Contraceptive Service | 8 | 7 |
| Chlamydia testing service | 9 | 7 |
| Chlamydia treatment service | 7 | 9 |
| Hepatitis service | 6 | 7 |
| Gonorrhoea | 5 | 7 |
| H. pylori | 6 | 7 |
| HbA1C | 6 | 6 |
| Seasonal Influenza Vaccination Service | 12 | 4 |
| Childhood vaccinations | 6 | 9 |
| Alcohol service | 5 | 8 |
| Schools service | 7 | 7 |
| Prescriber support service | 7 | 7 |
| Patient Group Direction Service | 8 | 5 |
| Home delivery service | 9 | 5 |
| Travel vaccines | 6 | 8 |
| Language access service | 7 | 8 |

**Non-NHS services**

Of the pharmacies that completed the questionnaire:

- All provide a prescription collection service
- 93% provide a free delivery service (criteria may apply)
- One has a chargeable delivery service

Pharmacies have staff that speak a number of languages, other than English, these include: Afrikaans, Arabic, Bulgarian, Chinese, Congolese, Dutch, French, Hindi, Italian, Pashtu, Polish, Punjabi, Romanian, Somalian, Spanish and Urdu.

**IT facilities**

IT facilities available to staff are variable; however all have full or restricted access to the internet. The majority are able to use documents in Word, Excel or PDF formatted documents.

The following responses were received in seeking to establish whether the pharmacy was electronic prescription service (EPS) enabled:

| EPS 2 enabled | Total |
|---|---|
| Release 1 enabled | 10 (62.5%) |
| Release 2 enabled | 15 (93.8%) |
| Intending to become release 1 enabled within the next 12 months | 0 (0%) |
| Intending to become release 2 enabled within the next 12 months | 1 (6.2%) |
| No plans for EPS at present | 0 (0%) |

# 6 Other NHS services

The following NHS services are deemed, by the HWB, to affect the need for pharmaceutical services within its area:

- Hospital pharmacies – reduce the demand for the dispensing essential service as prescriptions written in the hospital are dispensed by the hospital pharmacy service.
- Personal administration of items by GPs – as above this also reduces the demand for the dispensing essential service. Items are sourced and personally administered by GPs and/or practice nurses thus saving patients having to take a prescription to a pharmacy, for example for a vaccination, in order to then return with the vaccine to the practice so that it may be administered.
- GP out of hours service.
- Services commissioned by Southampton city council – all of these services remove the need for sexual health enhanced services to be commissioned by NHS England from pharmacies.
- Sexual health services provided by a variety of organisations - all of these services remove the need for sexual health enhanced services to be commissioned by NHS England from pharmacies.
- Access to palliative drugs commissioned by Southampton CCG – this service removes the need for this enhanced service to be commissioned by NHS England from pharmacies.
- Other services commissioned by Southampton CCG – these community based services require a number of prescriptions to be dispensed by pharmacies.

## 6.1 Hospital pharmacies

There are four hospitals in Southampton:

- Southampton General Hospital (SGH)
- Princess Anne Hospital (PAH)
- Southampton Children's Hospital (SCH)
- The Royal South Hants Hospital (RSH)

Patients attending these, on either an inpatient or outpatient basis, may require prescriptions to be dispensed.

Three hospital pharmacies provide services between them to the five sites. Two pharmacies are located at SGH:

- The main hospital pharmacy services inpatients from SGH, PAH and SCH. The pharmacy is operated by UHS for its patients.
- University Hospital Pharmacy Limited (UPL) is a wholly owned subsidiary company of UHS. It provides services to hospital outpatients only, including all the above hospitals.

The third pharmacy is located at RSH. It is operated by UHS and whilst it does some dispensing for UHS outpatient clinics held on the RSH site, it mainly provides services, under contract, to Solent and Southern Health Trust inpatients and outpatients located at the RSH site and other units run by Solent and Southern Health. It also provides services to UHS patients at CMH.

Should services be moved out of the hospitals and into the primary care setting then it is likely that this would lead to more prescriptions needing to be dispensed by pharmacies in primary care.

However Southampton CCG has confirmed that, within the lifetime of this PNA, it does not have plans to move any services out of the hospitals and into primary care.

## 6.2 Personal administration of items by GPs

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

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

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

In 2013/14 73,761 items were personally administered by the GP practices in Southampton.

## 6.3 GP out of hours service

Beyond the normal working hours GP practices open, there is an out of hours service operated as an initial telephone consultation where the doctor may attend the patients home or request the patient access one of the clinics. The clinics and travelling doctors have a stock of medicines and depending on the patient and their requirement they may be given medicines from stock or a prescription issued for dispensing at a pharmacy. Whilst patients may attend further afield, the clinic located in Southampton is at the Royal South Hants Hospital, which has a number of pharmacies within a mile including Asda and Boots open until 23:00 and mid-night respectively, and Sunday.

## 6.4 Locally commissioned services – Southampton city council

Since 1st April 2013 Southampton city council has been responsible for the commissioning of some public health services and this has impacted on the need for pharmaceutical services.

Southampton city council commissions the following public health services from pharmacies:

- Emergency hormonal contraception
- Chlamydia screening
- Needle exchange
- Smoking cessation
- Supervised consumption of methadone and buprenorphine

As at the beginning of September 2014:

- 19 pharmacies provide the emergency hormonal contraception service
- 19 pharmacies provide chlamydia screening
- 6 pharmacies provide a needle exchange service
- 33 pharmacies provide the smoking cessation service
- 12 pharmacies supervise the consumption of methadone.

## 6.5 Sexual health services

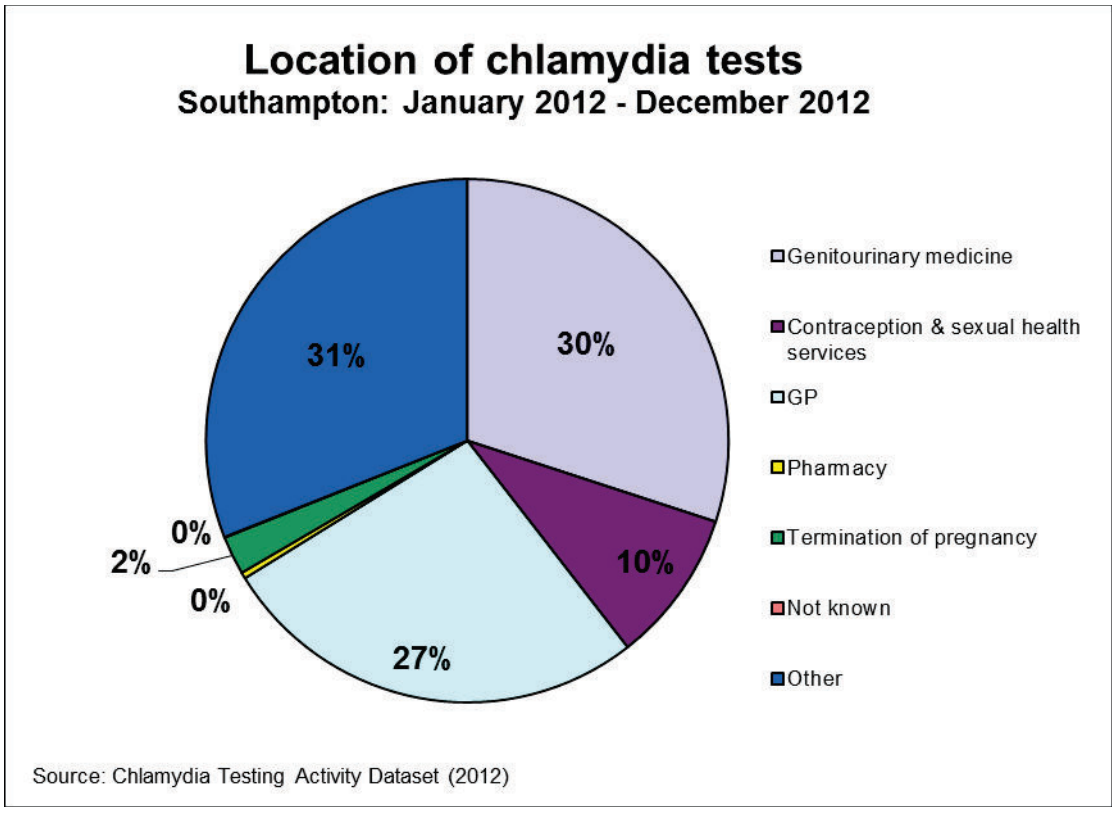
Integrated Sexual Health services are provided by Solent NHS Trust on a 'hub and spoke' model. Services providing contraception, STI testing and specialist sexual health services, for example unplanned pregnancy services, are provided centrally at the Royal South Hants Hospital (the hub), with additional services in Weston, Bitterne and Millbrook (spokes) and by sexual health outreach nurses at a number of college and school settings across the city.

Voluntary services working with young people (for example No Limits) provide access to free condoms, pregnancy testing and chlamydia testing as well as support to young people around their sexual health and relationships.

Additionally, some GP practices provide long acting reversible contraception provision, chlamydia testing and HIV screening.

Solent NHS Trust is commissioned to provide a sexual health promotion service in Southampton. The service provides training for professional groups, outreach to at-risk communities including MSM, BME groups and commercial sex workers, one to one brief interventions and sex and relationship education in some schools/colleges.

The pie chart below shows the location of chlamydia tests undertaken in 2012.




Chlamydia testing takes place in a variety of settings across the city, the greatest proportion being the 'other' category which comprises community testing by the chlamydia screening programme. A significant proportion of testing also takes place in GP practices, although the great majority of this activity is from one practice which serves the student population.

Schools and colleges play an important role in sexual health support for young people; not only as a venue for sexual health outreach services but also through the sex and relationship education they provide and their more holistic aims of increasing self-esteem and ambition amongst their pupils.

EHC can be prescribed within 72 hours after unprotected sex to help prevent pregnancy. As can be seen from the table below, the majority (65.6%) is provided by pharmacies under the locally commissioned service.

| Location[29] | Number of tests | % of total |
|---|---|---|
| **Pharmacies (SO14-19)** | 3,175 | 65.6% |
| **GP practices** | 807 | 16.7% |
| **Solent integrated sexual health service** | 466 | 9.6% |
| **Walk in centre/minor injuries unit** | 394 | 8.1% |
| **Total** | 4,842 | 100% |

## 6.6 Locally commissioned services – Southampton CCG

Southampton CCG commissioned two services from pharmacies in 2014/15 – access to palliative care drugs (7 pharmacies) and Pharmacy First Minor Ailments Service from 19th January 2015 (12 pharmacies).

## 6.7 Other services commissioned by Southampton CCG

The following community services are currently commissioned by Southampton CCG and lead to the need for prescriptions to be dispensed by pharmacies:

- Community dermatology clinic, Canute surgery
- Community ophthalmology service, RSH
- Community ENT service, Adelaide health centre
- Community ENT service, RSH
- Community ENT service Weston Lane centre for healthy living
- Southampton treatment centre
- RSH minor injury unit

At the time of drafting the PNA most of these services were undergoing a re-tendering process. Should these services terminate during the lifetime of the PNA the work will return to a hospital setting and prescriptions issued will be dispensed by one of the hospital pharmacies.

[29] GP practices and the walk in centre/minor injuries unit data is based on people registered with a Southampton CCG practice, for pharmacies it is those with a postcode starting SO14-19, and for the Solent integrated sexual health service it is residents of the HWB's area.

# 7 Health needs that can be met by pharmaceutical services

## 7.1 Need for drugs and appliances

Everyone will at some stage require prescriptions to be dispensed irrespective of whether or not they are in one of the groups identified in section 6. This may be for a one off course of antibiotics or for medication that they will need to take, or an appliance that they will need to use, for the rest of their life in order to manage a long term condition. This health need can only be met within primary care by the provision of pharmaceutical services be that by pharmacies, DACs or dispensing doctors, and is applicable to all nine of the JSNA themes.

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

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

Deprivation is a significant issue in Southampton and is a wider determinant of health outcomes. The economic recession is having a marked impact and the average weekly wages are low compared to the rest of the South East. Section 3.1 outlines some of the key issues affecting the economic wellbeing of the population. Whilst none of the recommendations within theme 1 of the JSNA relate to the provision of pharmaceutical services, the provision of essential and advanced services is key to ensuring that people are able to have their prescriptions dispensed (free to eligible people) and are able to benefit from a range of associated services as part of the NHS.

## 7.2 Improving mental health

In addition to ensuring that people with mental health problems have access to drugs and medicines, pharmacies can contribute to the following recommendation from this JSNA theme:

- Provide accessible and comprehensive information and advice to carers about what help and support is available to them

Section 5 of this document outlines the essential services that pharmacies must provide, and one of these is signposting. Ensuring that pharmacies have information on the help and support that is available will enable them to signpost carers accordingly.

## 7.3 Early years and parenting

Pharmacies can contribute to many of the public health issues contained within this theme in the JSNA as part of the essential services they provide:

- Where a person presents a prescription the pharmacy is required to give appropriate advice with the aim of increasing their knowledge and understanding of the health issues which are relevant to that person's circumstances.

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England.
- Signposting people using the pharmacy to other providers of services or support.

## 7.4 Taking responsibility for health - smoking

As noted in section 6, smoking cessation is commissioned by Southampton city council as a locally commissioned service and pharmacies are just one of several providers of this service. Two recommendations of the JSNA are:

- Sustain the availability and access to smoking cessation support across the city through the Quitters Service, primary care and community pharmacies
- Target smoking cessation support to those neighbourhoods with highest prevalence

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

## 7.5 Taking responsibility for health – obesity

Three elements of the essential services will address this health need:

- Where a person presents a prescription, and they are overweight, the pharmacy is required to give appropriate advice with the aim of increasing their knowledge and understanding of the health issues which are relevant to that person's circumstances.
- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England.
- Signposting people using the pharmacy to other providers of services or support.

## 7.6 Taking responsibility for health – STIs

As chlamydia screening is commissioned by the council, it is not envisaged that within the lifetime of this PNA there is or will be a need for it to be commissioned as part of pharmaceutical services.

However there are elements of essential service provision which will help address this health need:

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England.
- Where the pharmacy does not provide the locally commissioned service for chlamydia screening, signposting people using the pharmacy to other providers of this service.

## 7.7 Taking responsibility for health – teenage pregnancy

As EHC provision is commissioned by the council, it is not envisaged that within the lifetime of this PNA there is or will be a need for it to be commissioned as part of pharmaceutical services.

However there are elements of essential service provision which will help address this health need:

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England.
- Where the pharmacy does not provide the locally commissioned service of EHC provision, signposting people using the pharmacy to other providers of the service.

## 7.8 Taking responsibility for health – alcohol and drugs

As needle exchange and the supervised consumption of methadone and buprenorphine are commissioned by the council, it is not envisaged that within the lifetime of this PNA there is or will be a need for either service to be commissioned as part of pharmaceutical services.

However there are elements of essential service provision which will help address this health need:

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England.
- Where the pharmacy does not provide the locally commissioned services of needle exchange and the supervised consumption of methadone and buprenorphine, signposting people using the pharmacy to other providers of the services.

## 7.9 Living with long term conditions and maximising the quality of life

In addition to dispensing prescriptions, pharmacies can contribute to many of the public health issues contained within this theme in the JSNA as part of the essential services they provide:

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

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

## 7.10 More years, better lives and end of life care

In addition to dispensing prescriptions, pharmacies can contribute to many of the public health issues contained within this theme in the JSNA as part of the essential services they provide:

- Where a person presents a prescription, and they appear to have diabetes, be at risk of coronary heart disease (especially those with high blood pressure), smoke or are overweight, the pharmacy is required to give appropriate advice with the aim of increasing their knowledge and understanding of the health issues which are relevant to that person's circumstances.

- Pharmacies are required to participate in up to six public health campaigns each calendar year by promoting public health messages to users. The topics for these campaigns are selected by NHS England.
- Signposting people using the pharmacy to other providers of services or support.

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

## 7.11 Improving safeguarding for children and vulnerable adults

All the pharmacies are required, as part of their system of clinical governance, to have appropriate safeguarding procedures for service users. Contractors are responsible for ensuring that relevant staff who provide pharmaceutical services to children and vulnerable adults are aware of the safeguarding guidance and the local safeguarding arrangements. This includes the reporting of concerns and being alert to and acting on indications that a child or vulnerable adult may be being abused, or at risk of abuse or neglect.

## 7.12 Protecting people from threats to health

The participation of pharmacies in the six annual public health campaigns and the signposting of people to other services will contribute to health risks set out in this section of the JSNA.

At the time of drafting the PNA, NHS England was in the process of commissioning a flu vaccination enhanced service from pharmacies for 2014/15 to evaluate whether vaccinations by pharmacies could contribute towards improving uptake of the vaccination in the target groups. By the time the statutory consultation period on the draft PNA had ended, this service was being delivered with approximately 5000 vaccinations across Wessex to 'at risk' patients & pregnant women.

# 8 Necessary services: gaps in provision of pharmaceutical services

Necessary services, for the purposes of this PNA, are defined as:

- access to essential services provided at all premises on the pharmaceutical list,
- essential services provided by pharmacies and DACs during standard 40 core hours in line with their terms of service as set out in the 2013 regulations, and
- advanced services

The HWB consider it is those services provided within the standard pharmacy providing 40 core hours and the single DAC that should be regarded as necessary. There are 40 such pharmacies, with access to a further 4 premises. The opening times, including the core hours are provided in an index table accompanying the mapped locations.

The HWB are mindful of the national picture as expressed in the 2008 White Paper Pharmacy in England: Building on strengths – delivering the future which states that it is strength of the current system that community pharmacies are easily accessible. The HWB consider that the population of Southampton currently enjoy a similar position.

In particular, the HWB had regard to the following drawn from the mapped provision of and access to pharmacies:

- The map showing the 1.6km buffers around pharmacies indicate that 99% of Southampton‘s population is within 1.6km of a pharmacy.
- The population density per square km by Census 2011 Output Area and the relative location of pharmacy premises.
- The Index of Multiple Deprivation and deprivation ranges compared to the relative location of pharmacy premises.
- The Black & Minority Ethnic levels by electoral ward compared to the relative location of pharmacy premises.
- The walking times to pharmacies indicate 91.1% of Southampton residents are within 20 minutes walking time of a pharmacy.
- The average drive times to pharmacies (private vehicle) indicate that 98.6% of Southampton residents are within 5 minutes average drive time of a pharmacy (during weekday daytime). For off peak times (during weekday daytime), that figure rises to show 100% of Southampton residents within 5 minutes of a pharmacy.
- Using public transport, 82.4% of Southampton residents are within 10 minutes of a pharmacy during the morning (Tuesday, 9am to 1pm) and 81.1% within 10 minutes of a pharmacy during the afternoon (Tuesday, 1pm to 5pm).

Taking into account the totality of information available, the HWB consider the location, number, distribution and choice of pharmacies covering the whole conurbation of Southampton providing essential and advanced services during the standard core hours to meet the needs of the population. The HWB has not received any significant information to conclude otherwise currently or of any future specified circumstance that would alter that conclusion.

# 9 Improvements and better access: gaps in provision of pharmaceutical services

The HWB consider it is those services and the times at which those services are provided in addition to those considered necessary for the purpose of this PNA that should reasonably be regarded as providing either an improvement or better access to pharmaceutical provision.

The HWB recognises that any addition of pharmaceutical services by location, provider, hours or services may be regarded by some as pertinent to this consideration. However, the HWB consider the duty be one of proportionate consideration overall.

The location of premises and choice of provider is not as extensive beyond the standard 40 core hours as described under the previous consideration of what is necessary. However, there are 4 pharmacies obliged to provide a minimum of 100 core hours. There are pharmacies open beyond what may be regarded as normal hours in that they provide pharmaceutical services during supplementary hours in the evening, on Saturday and Sunday.

Taking into account the totality of information available, the HWB consider the location, number, distribution and choice of pharmacies covering the whole conurbation of Southampton providing essential and advanced services during the evening, on Saturday and Sunday to provide an improvement and better access that meet the requirements of the population.

Whilst the HWB recognise some respondents to the patient survey expressed a view to the effect that increased opening hours should reflect extended GP surgery hours or retail provision, the HWB did not consider this amounted to significant information in order to conclude there is a gap in the current provision of these hours. At present, the same conclusion was reached in considering whether there is any future specified circumstance that would give rise to the conclusion that there is a gap in pharmaceutical provision at certain times. Nonetheless, the HWB will be considering the response by pharmacy contractors to the changing expectations of the public to reflect the times at which pharmaceutical services are provided more closely with such changes during the life of this PNA.

With regard to enhanced services, the HWB is mindful that only those services commissioned by NHS England are regarded as pharmaceutical services. However, since 1 April 2013, there has been a shift in commissioning arrangements for some services that would otherwise be defined as enhanced services. Therefore, the absence of a particular service being commissioned by NHS England is mitigated by commissioning through the local Clinical Commissioning Group and Southampton City Council. This PNA identifies those locally commissioned services.

Whether commissioned as enhanced or locally commissioned services, the HWB consider these to provide both an improvement and better access to such services for the population of Southampton where such a requirement has been identified and verified at a local level. At the time of writing this PNA, the HWB has not identified either itself or through consultation any requirement to provide either further those services already commissioned or to commence the provision of enhanced pharmaceutical services not currently commissioned.

Taking into account the totality of information available, the HWB consider the location, number, distribution and choice of pharmacies covering the whole conurbation of Southampton providing enhanced services, including the mitigation by the provision of local commissioned services, to provide an improvement and better access for population. The HWB has not received any significant information to conclude otherwise currently or of any local future specified circumstance that would alter that conclusion.

# 10 Conclusions – [for the purpose of Schedule 1 to the 2013 Regulations]

## 10.1 Current provision – necessary and other relevant services

As described in particular in sections 5.1, 5.2 and 5.3 and required by paragraphs 1 and 3 of schedule 1 to the Regulations, Southampton HWB has had regard to the pharmaceutical services referred to in this PNA in seeking to identify those that are necessary, have secured improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the HWB.

**Southampton HWB has determined that while not all provision was necessary to meet the need for pharmaceutical services, the majority of the current provision was likely to be necessary as described in section 8 with that identified in section 9 as providing improvement or better access without the need to differentiate in any further detail.**

## 10.2 Necessary services – gaps in provision

As described in particular in section 8 and required by paragraph 2 of schedule 1 to the Regulations, Southampton HWB has had regard to the following in seeking to identify whether there are any gaps in necessary services in the area of the HWB.

### 10.2.1 Access to essential services

In order to assess the provision of essential services against the needs of our population we consider access (travelling times and opening hours) as the most important factor in determining the extent to which the current provision of essential services meets the needs of the population.

#### 10.2.1.1 Access to essential services during normal working hours

Southampton HWB has determined that the travel times as identified in section 8 to access essential services are reasonable in all the circumstances.

**Based on the information available at the time of developing this PNA no current gaps in the need for provision of essential services during normal working hours have been identified.**

#### 10.2.1.2 Access to essential services outside normal working hours

In Southampton there is good access to essential services outside normal working hours due to the four 100 hour pharmacies and the supplementary opening hours offered by the other pharmacies. It is not expected that any of the current pharmacies will reduce the number of core opening hours, indeed 100 hour pharmacies are unable to, and NHS England foresees no reason to agree a reduction of core opening hours for any service provider except on an ad hoc basis to cover extenuating circumstances.

**Based on the information available at the time of developing this PNA no current gaps in the provision of essential services outside normal working hours have been identified.**

### 10.2.2 Access to advanced and enhanced services

Insofar as only NHS England may commission these services, sections 5.1 and 5.2 of this PNA identify access to enhanced and advanced services.

**Based on the information available at the time of developing this PNA no current gaps in the provision of advanced and enhanced services have been identified.**

#### 10.2.3 Future provision of necessary services

Southampton HWB has not identified any pharmaceutical services that are not currently provided but that will, in specified future circumstances, need to be provided in order to meet a need for pharmaceutical services.

**Based on the information available at the time of developing this PNA no gaps in the need for pharmaceutical services in specified future circumstances have been identified.**

## 10.3 Improvements and better access – gaps in provision [paragraph 4]

As described in particular in section 9 and required by paragraph 4 of schedule 1 to the 2013 Regulations, Southampton HWB has had regard to the following in seeking to identify whether there are any gaps in other relevant services in the area of the HWB.

#### 10.3.1 Access to essential services – present and future circumstances

Southampton HWB considered the conclusion in respect of current provision as set out at 10.1 above and the information in respect of essential services as it had done at 10.2. While it had not been possible to determine which current provision of essential service by location or standard hours provided improvement or better access, the HWB was satisfied that some current provision did so. Southampton HWB has not identified services that would, if provided either now or in future specified circumstances, secure improvements to or better access to essential services.

**Based on the information available at the time of developing this PNA no gaps have been identified in essential services that if provided either now or in the future would secure improvements, or better access, to essential services.**

#### 10.3.2 Current and future access to advanced services

Not all pharmacies are currently offering MURs or NMS, however these services are not commissioned by NHS England but provided by the pharmacy should it choose to do so.

In 2013-14 three pharmacies did not provide MURs. NHS England will encourage these pharmacies to become eligible to deliver MURs and to encourage all pharmacies to complete the maximum number of MURs allowed to ensure more eligible patients are able to access and benefit from this service.

In 2013-14 six pharmacies did not provide the NMS, and a further 22 provided less than one complete intervention a week. At the time of writing it is not known whether this service will continue from 1 April 2015. If it does, then NHS England will encourage pharmacies and pharmacists to become eligible to deliver the service so that more eligible patients are able to access and benefit from this service.

Demand for the appliance advanced services (stoma appliance customisation and appliance use reviews) is lower than for the other two advanced services due to the much smaller proportion of the population that may require the services. Pharmacies and DACs may choose which appliances they

provide and may also choose whether or not to provide the two related advanced services. NHS England will encourage those contractors in the area that do provide appliances to become eligible to deliver these advanced services where appropriate.

**Based on the information available at the time of developing this PNA no gaps have been identified in the need for advanced services that if provided either now or in the future would secure improvements, or better access, to advanced services.**

#### 10.3.3 Current and future access to enhanced services

NHS England commissioned just one enhanced service (flu vaccination) from pharmacies in 2014/15 and the future of this service is unknown at the time of writing this PNA. It also commissions this service from other non-pharmacy providers, principally GP practices.

Many of the enhanced services listed in the 2013 directions are now commissioned by Southampton city council (public health services) or Southampton CCG (access to palliative care drugs) and so fall outside of the definition of both enhanced services and pharmaceutical services.

**Based on the information available at the time of developing this PNA no gaps in respect of securing improvements, or better access, to enhanced services either now or in specified future circumstances have been identified.**

## 10.4 Other NHS Services

As required by paragraph 5 of schedule 1 to the 2013 Regulations, Southampton HWB has had regard in particular to section 6 in considering any other NHS Services that may affect the determination in respect of pharmaceutical services in the area of the HWB.

## 10.5 How the assessment was carried out

As required by paragraph 6 of schedule 1 to the 2013 Regulations:

In respect of how the HWB considered whether to determine localities in its area for the purpose of this PNA, see section 1.6.2.

In respect of how the HWB took into account the different needs in its area, including those who share a protected characteristic, see sections 3 and 7,

In respect of the consultation undertaken by the HWB, see appendix K.

## 10.6 Map of provision

As required by paragraph 7 of schedule 1 to the 2013 Regulations, the HWB has published a map of premises providing pharmaceutical services at Map 1 of appendix L, which also includes links to additional mapping to that required by regulation.

# Appendix A – policy context and background papers

Between the 1980s and 2012 the ability for a new pharmacy or DAC premises to open was largely determined by the regulatory system that became known as 'control of entry'. Broadly speaking an application to open new premises was only successful if a primary care trust (PCT) or a preceding organisation considered it was either necessary or expedient to grant the application in order to ensure that people could access pharmaceutical services.

The control of entry system was reviewed and amended over the years, and in 2005 exemptions to the 'necessary or expedient' test were introduced – namely 100 hour pharmacies, wholly mail order or internet pharmacies, out of town retail area pharmacies and one-stop primary care centre pharmacies.

In January 2007 a review of the system was published by the government[30], and found that although the exemptions had had an impact, this had not been even across the country. At the time access to pharmaceutical services was very good (99% of the population could get to a pharmacy within 20 minutes, including in deprived areas[31]), however the system was complex to administer and was largely driven by providers who decided where they wished to open premises rather than by a robust commissioning process.

PCTs believed that they did not have sufficient influence to commission pharmaceutical services that reflected the health needs of their population. This was at odds with the thrust of the then NHS reforms which aimed to give PCTs more responsibility to secure effective commissioning of adequate services to address local priorities.

When the government published the outcomes of this review, it also launched a review of the contractual arrangements underpinning the provision of pharmaceutical services[32]. One of the recommendations of this second review was that PCTs should undertake a more rigorous assessment of local pharmaceutical needs to provide an objective framework for future contractual arrangements and control of entry, setting out the requirements for all potential providers to meet, but flexible enough to allow PCTs to contract for a minimum service to ensure prompt access to medicines and to the supply of appliances.

The government responded to the outcomes of both reviews, as well as a report by the All-Party Pharmacy Group following an inquiry into pharmacy services, in its pharmacy White Paper "Pharmacy in England. Building on strengths – delivering the future" published in April 2008. The White Paper proposed that commissioning of pharmaceutical services should meet local needs and link to practice-based commissioning. However it was recognised that at the time there was considerable variation in the scope, depth and breadth of pharmaceutical needs assessments (PNAs). Some PCTs had begun to revise their PNAs (first produced in 2004) in light of the 2006 re-organisations, whereas others had yet to start the process. The White Paper confirmed that the government considered that the structure of and data requirements for PCT PNAs required further review and strengthening to ensure they were an effective and robust commissioning tool which supported PCT decisions.

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[30] Review of progress on reforms in England to the "Control of Entry" system for NHS pharmaceutical contractors. DH 2007
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063460

[31] Pharmacy in England. Building on strengths – delivering the future. DH 2008
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228858/7341.pdf

[32] Review of NHS pharmaceutical contractual arrangements. Anne Galbraith 2007
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083871.pdf

Following consultation on the proposals contained within the White Paper, the Department of Health (DH) established an advisory group with representation from the main stakeholders. The terms of reference for the group were:

"Subject to Parliamentary approval of proposals in the Health Bill 2009, to consider and advise on, and to help the Department devise, regulations to implement a duty on NHS primary care trusts to develop and to publish pharmaceutical needs assessments and on subsequent regulations required to use such assessments as the basis for determining the provision of NHS pharmaceutical services".

As a result of the work of this group, regulations setting out the minimum requirements for PNAs were laid in Parliament and took effect from 1 April 2010. They placed an obligation on all PCTs to produce their first PNA which complied with the requirement of the regulations on or before 1 February 2011, with an ongoing requirement to produce a second PNA no later than three years after the publication of the first PNA. The group also drafted regulations on how PNAs would be used to determine applications for new pharmacy and DAC premises (referred to as the 'market entry' system) and these regulations took effect from 1 September 2012.

The re-organisation of the NHS from 1 April 2013 came about as the result of the Health and Social Care Act 2012. This Act established health and well-being boards (HWBs) and transferred responsibility to develop and update PNAs from PCTs to HWBs. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

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

**Section 128A Pharmaceutical needs assessments**

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

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

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

The regulations referred to in the NHS Act 2006 are the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013[33], as amended, in particular Part 2 and Schedule 1.

The overarching provisions for PNAs and the duties on HWBs are set out in Section 128A of the NHS Act 2006 (see appendix 1 for further information). These provisions are then expanded upon in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended, in particular Part 2 and Schedule 1.

In summary the regulations set out the:

- Services that are to be covered by the PNA;
- Information that must be included in the PNA (it should be noted that HWBs are free to include any other information that they feel is relevant);
- Date by which HWBs must publish their first PNA;
- Requirement on HWBs to publish further PNAs on a three yearly basis;
- Requirement to publish a revised assessment sooner than on a three yearly basis in certain circumstances;
- Requirement to publish supplementary statements in certain circumstances;
- Requirement to consult with certain people and organisations at least once during the production of the PNA, for at least 60 days; and
- Matters the HWB is to have regard to when producing its PNA.

Each HWB is under a duty to publish its first PNA by 1 April 2015. In the meantime the PNA produced by the preceding PCT remains in existence and is used by NHS England to determine whether or not to grant applications for new pharmacy or DAC premises.

Once a HWB has published its first PNA it is required to produce a revised PNA within 3 years or sooner if it identifies changes to the need for pharmaceutical services which are of a significant extent. The only exception to this is where the HWB is satisfied that producing a revised PNA would be a disproportionate response to those changes.

In addition a HWB may publish a supplementary statement. The regulations set out two situations where the publication of a supplementary statement would be appropriate:

1. The HWB identifies changes to the availability of pharmaceutical services which are relevant to the granting of applications for new pharmacy or DAC premises, and it is satisfied that producing a revised assessment would be a disproportionate response to those changes; and
2. The HWB identifies changes to the availability of pharmaceutical services which are relevant to the granting of applications for new pharmacy or DAC premises, and is in the course of making a revised assessment and is satisfied that it needs to immediately modify its current PNA in order to prevent significant detriment to the provision of pharmaceutical services in its area.

Supplementary statements are therefore merely statements of a change to the availability of a pharmaceutical services or services. They are not assessments of need.

[33] http://www.legislation.gov.uk/uksi/2013/349/contents/made

# Appendix B – essential services

## 1. Dispensing of prescriptions

**Service description**

The supply of medicines and appliances ordered on NHS prescriptions, together with information and advice, to enable safe and effective use by patients and carers, and maintenance of appropriate records.

**Aims and intended outcomes**

To ensure patients receive ordered medicines and appliances safely and appropriately by the pharmacy:

- performing appropriate legal, clinical and accuracy checks
- having safe systems of operation, in line with clinical governance requirements
- having systems in place to guarantee the integrity of products supplied
- maintaining a record of all medicines and appliances supplied which can be used to assist future patient care
- maintaining a record of advice given, and interventions and referrals made, where the pharmacist judges it to be clinically appropriate.

To ensure patients are able to use their medicines and appliances effectively by pharmacy staff:

- providing information and advice to the patient or carer on the safe use of their medicine or appliance
- providing when appropriate broader advice to the patient on the medicine, for example its possible side effects and significant interactions with other substances.

## 2. Dispensing of repeatable presciptions

**Service description**

The management and dispensing of repeatable NHS prescriptions for medicines and appliances in partnership with the patient and the prescriber.

This service specification covers the requirements additional to those for dispensing, such that the pharmacist ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.

**Aims and intended outcomes**

- To increase patient choice and convenience, by allowing them to obtain their regular prescribed medicines and appliances directly from a community pharmacy for a period agreed by the prescriber
- To minimise wastage by reducing the number of medicines and appliances dispensed which are not required by the patient
- To reduce the workload of general medical practices, by lowering the burden of managing repeat prescriptions.

## 3. Disposal of unwanted drugs

**Service description**

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

**Aims and intended outcomes**

- To ensure the public has an easy method of safely disposing of unwanted medicines
- To reduce the volume of stored unwanted medicines in people's homes by providing a route for disposal thus reducing the risk of accidental poisonings in the home and diversion of medicines to other people not authorised to possess them
- To reduce the risk of exposing the public to unwanted medicines which have been disposed of by non-secure methods
- To reduce environmental damage caused by the inappropriate disposal methods for unwanted medicines.

## 4. Promotion of healthy lifestyles

**Service description**

The provision of opportunistic healthy lifestyle and public health advice to patients receiving prescriptions who appear to:

- have diabetes; or
- be at risk of coronary heart disease, especially those with high blood pressure; or
- who smoke; or
- are overweight,

and pro-active participation in national/local campaigns, to promote public health messages to general pharmacy visitors during specific targeted campaign periods

**Aims and intended outcomes**

- To increase patient and public knowledge and understanding of key healthy lifestyle and public health messages so they are empowered to take actions which will improve their health.
- To target the 'hard to reach' sectors of the population who are not frequently exposed to health promotion activities in other parts of the health or social care sector.

## 5. Signposting

**Service description**

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

**Aims and intended outcomes**

- To inform or advise people who require assistance, which cannot be provided by the pharmacy, of other appropriate health and social care providers or support organisations
- To enable people to contact and/or access further care and support appropriate to their needs
- To minimise inappropriate use of health and social care services.

## 6. Support for self-care

**Service description**

The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

**Aims and intended outcomes**

- To enhance access and choice for people who wish to care for themselves or their families
- People, including carers, are provided with appropriate advice to help them self-manage a self-limiting or long-term condition, including advice on the selection and use of any appropriate medicines
- People, including carers, are opportunistically provided with health promotion advice when appropriate, in line with the advice provided in essential service – promotion of healthy lifestyles service
- People, including carers, are better able to care for themselves or manage a condition both immediately and in the future, by being more knowledgeable about the treatment options they have, including non-pharmacological ones
- To minimise inappropriate use of health and social care services.

# Appendix C – advanced services

## 1. Medicines use review and prescription intervention service

**Service description**

This service includes medicines use reviews undertaken periodically, as well as those arising in response to the need to make a significant prescription intervention during the dispensing process. A medicines use review is about helping patients use their medicines more effectively.

Recommendations made to prescribers may also relate to the clinical or cost effectiveness of treatment.

**Aims and intended outcomes**

To improve patient knowledge, concordance and use of medicines by:

- establishing the patient's actual use, understanding and experience of taking their medicines;
- identifying, discussing and assisting in resolving poor or ineffective use of their medicines;
- identifying side effects and drug interactions that may affect patient compliance;
- improving the clinical and cost effectiveness of prescribed medicines and reducing medicine wastage.

## 2. New medicine service

**Service description**

The new medicine service (NMS) is provided to patients who have been prescribed for the first time, a medicine for a specified long term condition, to improve adherence. The NMS involves three stages, recruitment into the service, an intervention about one or two weeks later, and a follow up after a two or three weeks.

**Aims and intended outcomes**

The underlying purpose of the service is to promote the health and wellbeing of patients who are prescribed a new medicine or medicines for certain long term conditions, in order—

(a) as regards the long term condition—
(i) to help reduce symptoms and long term complications, and
(ii) in particular by intervention post dispensing, to help identification of problems with management of the condition and the need for further information or support; and

(b) to help the patients—
(i) make informed choices about their care,
(ii) self-manage their long term conditions,
(iii) adhere to agreed treatment programmes, and
(iv) make appropriate lifestyle changes.

## 3. Stoma appliance customisation

**Service description**

Stoma appliance customisation is the customisation of a quantity of more than one stoma appliance, where:

- the stoma appliance to be customised is listed in Part IXC of the Drug Tariff;
- the customisation involves modification to the same specification of multiple identical parts for use with an appliance; and
- modification is based on the patient's measurement or record of those measurements and if applicable, a template.

**Aims and intended outcomes**

The underlying purpose of the service is to:

- ensure the proper use and comfortable fitting of the stoma appliance by a patient; and
- improve the duration of usage of the appliance, thereby reducing wastage of such appliances.

## 4. Appliance use review

**Service description**

An appliance use review (AUR) is about helping patients use their appliances more effectively. Recommendations made to prescribers may also relate to the clinical or cost effectiveness of treatment.

**Aims and intended outcomes**

The underlying purpose of the service is, with the patient's agreement, to improve the patient's knowledge and use of any specified appliance by:

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

# Appendix D – enhanced services

1. An anticoagulant monitoring service, the underlying purpose of which is for the pharmacy contractor to test the patient's blood clotting time, review the results and adjust (or recommend adjustment to) the anticoagulant dose accordingly.

2. A care home service, the underlying purpose of which is for the pharmacy contractor to provide advice and support to residents and staff in a care home relating to—

   (i) the proper and effective ordering of drugs and appliances for the benefit of residents in the care home,
   (ii) the clinical and cost effective use of drugs,
   (iii) the proper and effective administration of drugs and appliances in the care home,
   (iv) the safe and appropriate storage and handling of drugs and appliances, and
   (v) the recording of drugs and appliances ordered, handled, administered, stored or disposed of.

3. A disease specific medicines management service, the underlying purpose of which is for a registered pharmacist to advise on, support and monitor the treatment of patients with specified conditions, and where appropriate to refer the patient to another health care professional.

4. A gluten free food supply service, the underlying purpose of which is for the pharmacy contractor to supply gluten free foods to patients.

5. An independent prescribing service, the underlying purpose of which is to provide a framework within which pharmacist independent prescribers may act as such under arrangements to provide additional pharmaceutical services with NHS England.

6. A home delivery service, the underlying purpose of which is for the pharmacy contractor to deliver to the patient's home—

   (i) drugs, and
   (ii) appliances other than specified appliances;

7. A language access service, the underlying purpose of which is for a registered pharmacist to provide, either orally or in writing, advice and support to patients in a language understood by them relating to—

   (i) drugs which they are using,
   (ii) their health, and
   (iii) general health matters relevant to them,

   and where appropriate referral to another health care professional.

8. A medication review service, the underlying purpose of which is for a registered pharmacist—

   (i) to conduct a review of the drugs used by a patient, including on the basis of information and test results included in the patient's care record held by the provider of primary medical services that holds the registered patient list on which the patient is a registered patient, with the objective of considering the continued appropriateness and effectiveness of the drugs for the patient,
   (ii) to advise and support the patient regarding their use of drugs, including encouraging the active participation of the patient in decision making relating to their use of drugs, and

(iii) where appropriate, to refer the patient to another health care professional.

9. A medicines assessment and compliance support service, the underlying purpose of which is for the pharmacy contractor —

(i) to assess the knowledge of drugs, the use of drugs by and the compliance with drug regimens of vulnerable patients and patients with special needs, and
(ii) to offer advice, support and assistance to vulnerable patients and patients with special needs regarding the use of drugs, with a view to improving their knowledge and use of the drugs, and their compliance with drug regimens.

10. A minor ailment scheme, the underlying purpose of which is for the pharmacy contractor to provide advice and support to eligible patients presenting with a minor ailment, and where appropriate to supply drugs to the patient for the treatment of the minor ailment.

11. A needle and syringe exchange service, the underlying purpose of which is for a registered pharmacist—

(i) to provide sterile needles, syringes and associated materials to drug misusers,
(ii) to receive from drug misusers used needles, syringes and associated materials, and
(iii) to offer advice to drug misusers and where appropriate refer them to another health care professional or a specialist drug treatment centre;

12. An on demand availability of specialist drugs service, the underlying purpose of which is for the pharmacy contractor to ensure that patients or health care professionals have prompt access to specialist drugs.

13. Out of hours services, the underlying purpose of which is for the pharmacy contractor to dispense drugs and appliances in the out of hours period (whether or not for the whole of the out of hours period).

14. A patient group direction service, the underlying purpose of which is for the pharmacy contractor to supply or administer prescription only medicines to patients under patient group directions.

15. A prescriber support service, the underlying purpose of which is for the pharmacy contractor to support health care professionals who prescribe drugs, and in particular to offer advice on—

(i) the clinical and cost effective use of drugs,
(ii) prescribing policies and guidelines, and
(iii) repeat prescribing.

16. A schools service, the underlying purpose of which is for the pharmacy contractor to provide advice and support to children and staff in schools relating to—

(i) the clinical and cost effective use of drugs in the school,
(ii) the proper and effective administration and use of drugs and appliances in the school,
(iii) the safe and appropriate storage and handling of drugs and appliances, and
(iv) the recording of drugs and appliances ordered, handled, administered, stored or disposed of.

17. A screening service, the underlying purpose of which is for a registered pharmacist—

(i) to identify patients at risk of developing a specified disease or condition,

(ii) to offer advice regarding testing for a specified disease or condition,
(iii) to carry out such a test with the patient's consent, and
(iv) to offer advice following a test and refer to another health care professional as appropriate.

18. A stop smoking service, the underlying purpose of which is for the pharmacy contractor —

(i) to advise and support patients wishing to give up smoking, and
(ii) where appropriate, to supply appropriate drugs and aids.

19. A supervised administration service, the underlying purpose of which is for a registered pharmacist to supervise the administration of prescribed medicines at the pharmacy contractor's premises.

20. A supplementary prescribing service, the underlying purpose of which is for a registered pharmacist who—

(i) is a supplementary prescriber, and
(ii) with a doctor or a dentist is party to a clinical management plan,

to implement that plan, with the patient's agreement.

# Appendix E – terms of service for DACs

## 1. Dispensing of prescriptions

**Service description**

The supply of appliances ordered on NHS prescriptions, together with information and advice and appropriate referral arrangements in the event of a supply being unable to be made, to enable safe and effective use by patients and carers, and maintenance of appropriate records.

**Aims and intended outcomes**

To ensure patients receive ordered appliances safely and appropriately by the DAC:

- Performing appropriate legal, clinical and accuracy checks
- Having safe systems of operation, in line with clinical governance requirements
- Having systems in place to guarantee the integrity of products supplied
- Maintaining a record of all appliances supplied which can be used to assist future patient care
- Maintaining a record of advice given, and interventions and referrals made, where the DAC judges it to be clinically appropriate
- Providing the appropriate additional items such as disposable bags and wipes
- Delivering the appropriate items if required to do so in a timely manner and in suitable packaging that is discreet.

To ensure patients are able to use their appliances effectively by staff providing information and advice to the patient or carer on the safe use of their appliance(s).

## 2. Dispensing of repeatable prescriptions

**Service description**

The management and dispensing of repeatable NHS prescriptions appliances in partnership with the patient and the prescriber.

This service specification covers the requirements additional to those for dispensing, such that the DAC ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.

**Aims and intended outcomes**

- To increase patient choice and convenience, by allowing them to obtain their regular prescribed appliances directly from a DAC for a period agreed by the prescriber.
- To minimise wastage by reducing the number of appliances dispensed which are not required by the patient.
- To reduce the workload of GP practices, by lowering the burden of managing repeat prescriptions.

## 3. Home delivery service

**Service description**

The delivery of certain appliances to the patient's home.

**Aims and intended outcomes**

To preserve the dignity of patients by ensuring that certain appliances are delivered:

- With reasonable promptness, at a time agree with the patient;
- In a package that displays no writing or other markings which could indicate its content; and
- In such a way that it is not possible to identify the type of appliance that is being delivered.

## 4. Supply of appropriate supplementary items

**Service description**

The provision of additional items such as disposable wipes and disposal bags in connection with certain appliances.

**Aims and intended outcomes**

To ensure that patients have a sufficient supply of wipes for use with their appliance, and are able to dispose of them in a safe and hygienic way.

## 5. Provide expert clinical advice regarding the appliances

**Service description**

The provision of expert clinical advice from a suitably trained person who has relevant experience in respect of certain appliances.

**Aims and intended outcomes**

To ensure that patients are able to seek appropriate advice on their appliance to increase their confidence in choosing an appliance that suits their needs as well as gaining confidence to adjust to the changes in their life and learning to manage an appliance.

## 6. Where a telephone care line is provided, during the period when the DAC is closed advice is either to be provided via the care line or callers are directed to other providers who can provide advice

**Service description**

Provision of advice on certain appliances via a telephone care line outside of the DAC's contracted opening hours. The DAC is not required to staff the care line all day, every day, but when it is not callers must be given a telephone number or website contact details for other providers of NHS services who may be consulted for advice.

**Aims and intended outcomes**

Callers to the telephone care line are able to access advice 24 hours a day, seven days a week on certain appliances in order to manage their appliance.

## 7. Signposting

**Service description**

Where a patient presents a prescription for an appliance which the DAC does not supply the prescription is either:

- with the consent of the patient, passed to another provider of appliances, or
- if the patient does not consent, they are given contact details for at least two other contractors who are able to dispense it.

**Aims and intended outcomes**

To ensure that patients are able to have their prescription dispensed.

# Appendix F – steering group membership

Southampton PNA Steering Group:

| Name | Role |
|---|---|
| Debbie Chase | Consultant in public health, Southampton City Council (SCC) |
| Dan King | Acting head of public health intelligence, Southampton City Council (SCC) |
| Rob Kurn | Healthwatch Southampton Manager |
| Julia Booth | Contracts manager (pharmacy and optometry), NHS England |
| Sue Lawton | Locality lead pharmacist for West/community pharmacy development manager, Southampton Clinical Commissioning Group (CCG) |
| Jessica North | Senior communications officer, Southampton City Council (CCG) |
| Joanne Bertelsen | PA to Director of Public Health, Southampton City Council (SCC) |
| Debby Crockford | Chair of Hampshire & IOW Local Pharmaceutical Council (LPC) |
| Paul Bennett * | Hampshire & IOW Local Pharmaceutical Committee (LPC) Chief Officer *(replaced Sarah Billington)* |

Advice and support provided by Primary Care Commissioning.

## Appendix G – patient and public engagement survey

Appendix published separately electronically

## Appendix H – contractor questionnaire

Appendix published separately electronically

## Appendix J – ESIA

Appendix published separately electronically

# Appendix K – Consultation report

## Introduction

As part of the PNA process there is a statutory provision that requires consultation of at least 60 days to take place to establish if the pharmaceutical providers and services supporting the population in the Health and Wellbeing Board (HWB) area are accurately reflected in the final PNA document, which is to be published by 1st April 2015. This report outlines the considerations and responses to the consultation and describes the overall process of how the consultation was undertaken.

## Consultation Process

In order to complete this process the HWB has consulted with those parties identified under Regulation 8 of the NHS (Pharmaceutical and Local Pharmaceutical Services Regulations) 2013, to establish if the draft PNA addresses issues that they considered relevant to the provision of pharmaceutical services. Examples of consulted parties include: the LPC; LMC; Healthwatch; NHS Trusts, neighbouring HWB areas and those on the pharmaceutical lists.

In addition, other local stakeholders were invited to consult on the draft. These included patient groups and commissioners such as local CCGs. A list of organisations consulted is provided in the attached list.

Each consultee was contacted via a letter explaining the purpose of the PNA and that as a statutory party; the HWB welcomed their opinion on whether they agreed with the content of the proposed draft. They were directed to the Southampton City Council website to access the document and accompanying appendices, and offered the option of a hard copy if they wanted one.

Consultees were given the opportunity to respond by completing a set of questions and/or submitting additional comments. This was undertaken by completing the questions online, via a link or alternatively email, post or paper copy.

The questions were designed to assess the current provision of pharmaceutical services, have regard to any specified future circumstance where the current position may materially change and identify any current and future gaps in pharmaceutical services.

The consultation ran from 16th October 2014 until 18th December 2014.

## Results

The online consultation received a total of 7 responses, which identified themselves as the following:

| Answer Options | Response Percent | Response Count |
|---|---|---|
| On behalf of a pharmacy/dispensing appliance contractor | 16.7% | 1 |
| On behalf of an organisation | 83.3% | 5 |
| A personal response | 0.0% | 0 |
| *answered question* | | 6 |
| *skipped question* | | 1 |

This report outlines the considerations and responses to the consultation. It should be noted that participants in the consultation were not required to complete every question. As a result percentages are derived from the number of responses to the questions rather than the number of overall respondents.

**Summary of Online Questions, Responses and HWB Considerations**

In asking the following questions:

> **"Has the purpose of the PNA been explained sufficiently"**;
>
> "**Has the scope of the PNA been explained sufficiently**";
>
> "**Are localities clearly defined throughout the draft PNA**";
>
> "**Does the PNA reflect the current provision of pharmaceutical services within Southampton City Council**";
>
> "**Has the PNA provided adequate information to inform market entry decisions**";
>
> "**Has the PNA provided adequate information to inform how services may be commissioned in the future**";

the HWB appreciated the respondents' wholly positive confirmation.

In asking "**Are there any gaps in the service provision; i.e. when, where and which services are available that have not been identified in the PNA**", the HWB noted the majority of respondents confirmed there were no gaps in service provision. The remaining reply did not offer an explanation to what the gaps maybe.

In asking "**Does the draft PNA reflect the needs of the Southampton population**", the HWB noted the majority (83.3%) of the respondents agreed the needs of the population were addressed. However, two comments were received and considered by the HWB, as shown below:

| Comment: | HWB response |
|---|---|
| It would have been useful to have understood the provision of pharmaceutical services in relation to students and where the main areas of their accommodation are within Southampton as this is such a large group of people who potentially would access those services relating to smoking, sexual health etc. | The HWB confirmed that the student population formed part of the overall consideration. However, the comment does not identify a need not provided by the current provision identified within the PNA. |
| There are, however, additional services that could be commissioned to enhance service provision beyond need alone e.g. palliative Care Service, Minor Ailments etc. | The HWB are mindful that such services are regularly reviewed however the comment does not identify a specific gap in service not currently met. However those identified services are commissioned from the CCG as shown in section 6.5 of the published PNA. |

In asking "**Has the PNA provided enough information to inform future service provision and plans for pharmacies and dispensing appliance contractors**", the HWB noted the majority of respondents' positive confirmation however, one comment was received and considered by the HWB, as shown below:

| Comment: | HWB response |
|---|---|
| However, the PNA is a document written to ensure that regulatory requirements are met. It does not talk about innovation, enhancement of service provision beyond need or reflect the pilots of service that organisations such as the AHSN are supporting | The HWB noted the comment concurred that the regulatory requirement was met. The other matters are not within the scope of the PNA. |

In asking "**Are there any services that could be provided in the community pharmacy setting in the future that have not been highlighted**", the HWB noted the majority of respondents confirmed there was not, however one comment was received and considered by the HWB as shown below:

| Comment: | HWB response |
|---|---|
| Amongst others, the following could be provided:<br>Brief Alcohol Intervention<br>COPD; Atrial Fibrillation;<br>Signposting to third sector & social services;<br>Extend the number of Healthy Living Pharmacies providing a broad range of public health & wellness services & advice;<br>Dementia support; Palliative care services;<br>Minor (common) Ailment scheme;<br>Repeat dispensing service;<br>Anticoagulation services. | The HWB are mindful that such services are regularly reviewed and some are currently provided. However the comment does not identify a specific gap in service not currently met. |

In seeking to establish whether the respondents agreed with the conclusions of the PNA, the HWB noted the majority (83.3%) concurred with no reasons as to why not given by those not in agreement. Respondents were asked if they had any further comments in addition to the questions asked, but no further comments were made.

**Comments Received By Post and Email**

In addition to the on-line responses, the HWB received and considered the following responses:

By email, the Hampshire Health and Wellbeing Board expressed the view that the draft PNA "*needs to describe the services outside of Southampton that residents may use in Hampshire and how this affects access to services. In particular Section 5.2.1 describes the services outside of Southampton that a resident may use, this would benefit from some more detail. It would be beneficial to clarify that for some residents the nearest pharmacy will be outside of Southampton and located in the county of Hampshire"*:

In the HWB's view, while appreciative of the comment, there is no further detail available other than potentially naming each pharmacy used in the Hampshire area, which will not add to the conclusions of the PNA.

**Amendments**

During the consultation, the HWB received notification from NHS England of a relocation of the Lloyds pharmacy shown as index 42 on appendix M to the PNA. This was not considered significant and hence no changes to the conclusions of the draft PNA were required, other than amending appendix M accordingly as below:

| | |
|---|---|
| Lloyds Pharmacy Ltd<br>1 Market Buildings<br>Stoneham Lane<br>Swaythling<br>Southampton<br>SO16 2HW | Lloyds Pharmacy Ltd<br>Health Centre<br>Southampton City Gateway<br>Parkville Road<br>Swaythling<br>Southampton<br>SO16 2JA |

The Clinical Commissioning Group commenced the commissioning of a Minor Ailments scheme with effect from 19th January 2015, which is reflected in section 6.6 of the published PNA

The email response from the Hampshire Health and Wellbeing Board pointed out that at section 6.1 in incorrect in that *"Countess Mountbatten Hospital is located in Hampshire (outside of Southampton) not Southampton."* The HWB amended the paragraph accordingly for the published PNA.

In addition to completing the online questionnaire, the LPC provided minor observations on the draft PNA for completeness. The HWB are grateful for the LPC's time and considered their comments amending the PNA where relevant.

**Summary Conclusions**

The HWB concluded that the majority of the responses were supportive of the draft PNA and the limited comments offered provided no reason to alter the conclusions for the final published PNA, albeit minor amendments were made as outlined in this consultation report.

## Appendix L - Index of GIS maps for Southampton Pharmaceutical Needs Assessment.

## The maps listed below are provided separately electronically

| Filename | Version | Latest date | File type | Comments/description |
|---|---|---|---|---|
| Map1_Southampton_PNA2014_Pharmacies | 1 | 08/08/14 | PDF | Pharmacy locations with labels.<br>Different symbols are used for each of the pharmacy categories – community, 100 hour and non-standard (DAC). Pharmacies surrounding Southampton are also shown. Southampton pharmacies are labelled by trading name and index number. |
| Map2_Southampton_PNA2014_1.6kmBuffers | 1 | 08/08/14 | PDF | 1.6km buffers around Community and 100 hour pharmacies. 99% of Southampton's population is within 1.6km of a community or 100 hour pharmacy. |
| Map3_Southampton_PNA2014_OpeningHours | 1 | 08/08/14 | PDF | Community Pharmacy Opening Hours.<br>Opening times are shown as a combination of symbol style (weekday) and colour (weekend).<br>Note: 100 hour, non-standard and nearby pharmacies are included for information. |
| Map4_Southampton_PNA2014_Pop | 1 | 08/08/14 | PDF | Pharmacies and Population Density by Output Area.<br>Population density per square km by Census 2011 Output Area. Population density ranges (shades of brown) are based on Southampton-wide values grouped as quintiles (divided into fifths). Data source: ONS, Census 2011. |
| Map5_Southampton_PNA2014_IMD | 1 | 08/08/14 | PDF | Pharmacies and Index of Multiple Deprivation by LSOA.<br>Index of Multiple Deprivation 2010 by Census Lower Super Output Area. Deprivation ranges (shades of green) are based on England-wide deprivation scores grouped as quintiles. Data source: Dept. for Communities & Local Government. |
| Map6_Southampton_PNA2014_BME | 1 | 08/08/14 | PDF | Pharmacies and Black & Minority Ethnic levels (BME) by Ward.<br>Black & Minority Ethnic levels by electoral ward. BME ranges (shades of turquoise) are based on Southampton-wide percentages |

| | | | | |
|---|---|---|---|---|
| | | | | grouped as quintiles. Data source: ONS, 2011 Census. |
| Map7_Southampton_PNA2014_Drive_Avg | 1 | 08/08/14 | PDF | Average drive times to pharmacies.<br>Drive times (private vehicle) are shown as 5 minute zones, up to 30 minutes. The population summary gives the number of residents within cumulative travel zones. 98.6% of Southampton residents are within 5 minutes average drive time of a pharmacy (during weekday daytime). Note that the population data is calculated using LSOA centroids and therefore is only a rough approximation. Data source: ONS, Mid-Year Estimate 2012 |
| Map8_Southampton_PNA2014_Drive_Off_Peak | 1 | 08/08/14 | PDF | Off peak drive times to pharmacies.<br>Drive times (private vehicle) are shown as 5 minute zones, up to 30 minutes. The population summary gives the number of residents within cumulative travel zones. 100% of Southampton residents are within 5 minutes off peak drive time of a pharmacy (during weekday daytime). Note that the population data is calculated using LSOA centroids and therefore is only a rough approximation. Data source: ONS, Mid-Year Estimate 2012 |
| Map9_Southampton_PNA2014_Drive_Peak | 1 | 08/08/14 | PDF | Peak drive times to pharmacies.<br>Drive times (private vehicle) are shown as 5 minute zones, up to 30 minutes. The population summary gives the number of residents within cumulative travel zones. 98.6% of Southampton residents are within 5 minutes peak drive time of a pharmacy, while the remaining 1.4% are with 5-10 minutes (during weekday daytime). Note that the population data is calculated using LSOA centroids and therefore is only a rough approximation. Data source: ONS, Mid-Year Estimate 2012 |
| Map10_Southampton_PNA2014_PT_AM | 1 | 08/08/14 | PDF | Public Transport times to pharmacies (Tuesday, 9am to 1pm)<br>Times represent the best case scenario for journeys by bus and train on a Tuesday between 9am and 1pm. Travel times are shown as 5 minute zones, up to 30 minutes. The population summary gives the number of Southampton residents within cumulative travel zones. 82.4% of Southampton residents are within 10 minutes of a pharmacy. Note: Due to the frequency of services |

| | | | | |
|---|---|---|---|---|
| | | | | remaining constant throughout the day there is very little difference between the AM and PM maps (10 and 11) |
| Map11_Southampton_PNA2014_PT_PM | 1 | 08/08/14 | PDF | Public Transport times to pharmacies (Tuesday, 1pm to 5pm) Times represent the best case scenario for journeys by bus and train on a Tuesday between 1pm and 5pm. Travel times are shown as 5 minute zones, up to 30 minutes. The population summary gives the number of Southampton residents within cumulative travel zones. 81.1% of Southampton residents are within 10 minutes of a pharmacy. Note: Due to the frequency of services remaining constant throughout the day there is very little difference between the AM and PM maps (10 and 11) |
| Map12_Southampton_PNA2014_Walking | 1 | 08/08/14 | PDF | Walking times to pharmacies. Walking times (based on 2.5mph/4kph) are shown as 5 minute zones, up to 30 minutes. The population summary gives the number of Southampton residents within cumulative travel zones. 91.1% of Southampton residents are within 20 minutes walking time of a pharmacy. |
| Map13_Southampton_PNA2014_Wards | 1 | 08/08/14 | PDF | Pharmacy locations with Southampton ward boundaries. Southampton pharmacies are labelled by index number. |

This index and maps provided by South West Commissioning Support Unit.

## Appendix M – pharmaceutical list premises index

| MAP INDEX | PHARMACY NAME | TRADING NAME | ADDRESS 1 | ADDRESS 2 | ADDRESS 3 | ADDRESS 4 | POSTCODE |
|---|---|---|---|---|---|---|---|
| 1 | Pillbox Chemists Limited | Spiralstone Pharmacy | 122, Brintons Road | | Southampton | | SO14 0DB |
| 2 | Boots UK Ltd | Boots The Chemists | 233 Portswood Road | Portswood | Southampton | | SO17 2NF |
| 3 | Sunak Ltd | Sunak Pharmacy | 19 Burgess Road | Bassett | Southampton | Hampshire | SO16 7AP |
| 4 | Boots UK Ltd | Boots The Chemists | 9 Victoria Road | Woolston | Southampton | | SO19 9DY |
| 5 | Superdrug Stores Plc | Superdrug Pharmacy | 15 - 17 Victoria Road | Woolston | Southampton | Hampshire | SO19 9DY |
| 6 | Sangha Pharmacy Ltd | Sangha Pharmacy | 48 Thornhill Park Road | Thornhill Park | Southampton | Hampshire | SO18 5TQ |
| 7 | Lloyds Pharmacy Ltd | Lloyds pharmacy | 2 Shirley Shopping Precinct | Shirley | High Street | Southampton, Hampshire | SO15 5LL |
| 8 | Bassil Ltd | Bassil Chemist | 55a Bedford Place | Southampton | Hampshire | | SO15 2DT |
| 9 | Boots UK Ltd | Boots The Chemists | Unit 3 | West Quay Retail Park | Southampton | Hampshire | SO15 1BA |
| 10 | Lloyds Pharmacy Ltd | Lloyds pharmacy | 9 St. James Road | Shirley | Southampton | Hampshire | SO15 5FB |
| 11 | Boots UK Ltd | Your Local Boots Pharmacy | Unit 4 | 12 West End Road | Bitterne | Southampton, Hampshire | SO18 6TG |
| 12 | Lloyds Pharmacy Ltd | Lloyds pharmacy | 10a Dean Road | Bitterne | Southampton | Hampshire | SO18 6AP |
| 13 | Boots UK Ltd | Boots The Chemists | 19 - 29 Above Bar Street | Southampton | Hampshire | | SO14 7DX |
| 14 | Boots UK Ltd | Your Local Boots Pharmacy | 2 Midanbury Broadway | Witts Hill | Southampton | Hampshire | SO18 4QD |
| 15 | Lloyds Pharmacy Ltd | Lloyds pharmacy | 16 - 17 Lordshill District Centre | Lordshill | Southampton | Hampshire | SO16 8HY |
| 16 | Arun Sharma Chemists Ltd | Pharmacy Direct | 18 Commercial Street | Bitterne | Southampton | Hampshire | SO18 6LW |
| 17 | Boots UK Ltd | Boots The Chemists | 9 - 11 High Street | Shirley | Southampton | | SO15 3NJ |
| 18 | Lloyds Pharmacy Ltd | Lloyds pharmacy | 66b Portsmouth Road | Woolston | Southampton | Hampshire | SO19 9AL |
| 19 | Day Lewis Plc | Day Lewis Pharmacy | 241 Portswood Road | Portswood | Southampton | Hampshire | SO17 2NG |
| 20 | Medicine Clinic Ltd | Highfield Pharmacy | 29 University Road | | Southampton | | SO17 1TL |
| 21 | Lloyds Pharmacy Ltd | Lloyds pharmacy | 49 Portsmouth Road | Woolston | Southampton | Hampshire | SO19 9BD |
| 22 | Arun Sharma Chemists Ltd | Pharmacy Direct | The Weston Healthy Living Centre | Weston Lane | Southampton | Hampshire | SO19 9GH |
| 23 | Sangha Pharmacy Ltd | Bitterne Pharmacy | 62a, West End Road | | Southampton | | SO18 6TG |
| 24 | Tesco Stores Ltd | Tesco Instore Pharmacy | Tesco Superstore | Tebourba Way | Millbrook | Southampton, Hampshire | SO16 4QE |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 25 | Day Lewis Plc | Day Lewis Pharmacy | One Stop Store | 398 Coxford Road | Lordswood | Southampton | SO16 5LL |
| 26 | Superdrug Stores Plc | Superdrug Pharmacy | 401 - 403 Bitterne Road | Bitterne | Southampton | Hampshire | SO18 5RR |
| 27 | Pillbox Chemists Ltd | Millbrook Pharmacy | 168 Windermere Avenue | Millbrook | Southampton | Hampshire | SO16 9GA |
| 28 | E H Casey Chemist Ltd | Regents Park Pharmacy | 61 Regents Park Road | Shirley | Southampton | Hampshire | SO15 8PF |
| 29 | Arun Sharma Chemists Ltd | Pharmacy Direct | 93 Gordon Avenue | Portswood | Southampton | Hampshire | SO14 6WB |
| 30 | Boots UK Ltd | Your Local Boots Pharmacy | 357a Burgess Road | Bassett | Southampton | Hampshire | SO16 3BD |
| 31 | National Co-operative Chemists Ltd | The Co-operative Pharmacy | 326 Hinkler Road | Thornhill | Southampton | Hampshire | SO19 6DF |
| 32 | Day Lewis Plc | Day Lewis Pharmacy | 195 Portswood Road | Portswood | Southampton | Hampshire | SO17 2NF |
| 33 | Boots UK Ltd | Your Local Boots Pharmacy | Bitterne Park Medical Centre | Thorold Road | Bitterne Park | Southampton | SO18 1JB |
| 34 | Asda Stores Ltd | Asda Pharmacy | Asda Stores Ltd | Portland Terrace | Southampton | | SO14 7EG |
| 35 | S & K Nam Ltd | S & K Nam Pharmacy | 99 Rownhams Road | Maybush | Southampton | Hampshire | SO16 5EB |
| 36 | Arun Sharma Chemists Ltd | Pharmacy Direct | 202 Shirley Road | Shirley | Southampton | | SO15 3FL |
| 37 | Sainsbury's Supermarkets Ltd | Sainsbury's Pharmacy | Pharmacy Dept West End Road | Bitterne | Southampton | Hampshire | SO18 6TG |
| 38 | S K Roy Late Night Dispensing Chemists | S K Roy Dispensing Chemists | 44 - 45 St Marys Road | St Mary's | Southampton | Hampshire | SO14 0BG |
| 39 | Day Lewis Plc | Day Lewis Pharmacy | Chessel Practice | Sullivan Road | Sholing | Southampton | SO19 0HS |
| 40 | Pharmalpha Ltd | Adelaide Pharmacy | The Adelaide Health Centre | William Macleod Way | Southampton | | SO16 4XE |
| 41 | Lloyds Pharmacy Ltd | Lloyds pharmacy | 76 St Marys Street | Southampton | Hampshire | | SO14 1NY |
| 42 | Lloyds Pharmacy Ltd | Lloyds pharmacy<br>*relocated from*: | Health Centre, Southampton City Gateway<br>*1 Market Buildings* | Parkville Road<br>*Stoneham Lane* | Swaythling<br>*Swaythling* | Southampton<br>*Southampton* | SO16 2JA<br>*SO16 2HW* |
| 43 | Telephone House Ltd | Telephone House Pharmacy | Telephone House | 71 High Street | Southampton | | SO14 2NW |
| 44 | Lloyds Pharmacy Ltd | Lloyds pharmacy | 17 Grove Road | Shirley | Southampton | Hampshire | SO15 3HH |

Dispensing Appliance Contractor.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 45 | G E Bridge & Co Ltd | G E Bridge & Co | 226-228 Burgess Road | Bassett | Southampton | Hampshire | SO16 3AY |

*Premises, opening hours and Advanced Services data provided by NHS England.*

## Appendix N – pharmaceutical list opening hours and advanced services

| MAP INDEX | TRADING NAME | TYPE | Hours | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday | MUR | NMS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Spiralstone Pharmacy | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-19:00 | 09:00-13:00; 14:00-19:00 | 09:00-13:00; 14:00-19:00 | 09:00-13:00; 14:00-19:00 | 09:00-13:00; 14:00-19:00 | 09:00-13:00; 14:00-18:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | |
| 2 | Boots The Chemists | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | | Yes | Yes |
| | | | Core Hours | 10:00-13:00; 14:00-17:30 | 10:00-13:00; 14:00-17:30 | 10:00-13:00; 14:00-17:30 | 10:00-13:00; 14:00-17:30 | 09:30-13:00; 14:00-17:30 | 09:30-13:00; 14:00-17:30 | | | |
| 3 | Sunak Pharmacy | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-11:30 | | | |
| 4 | Boots The Chemists | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-11:30 | | | |
| 5 | Superdrug Pharmacy | Standard 40 Hour | Opening Hours | 09:00-14:30; 15:00-17:30 | 09:00-14:30; 15:00-17:30 | 09:00-14:30; 15:00-17:30 | 09:00-14:30; 15:00-17:30 | 09:00-14:30; 15:00-17:30 | 09:00-13:00; 15:00-17:30 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 15:00-17:30 | 09:00-13:00; 15:00-17:30 | 09:00-13:00; 15:00-17:30 | 09:00-13:00; 15:00-17:30 | 09:00-13:00; 15:00-17:30 | 09:00-13:30; 14:30-17:30 | | | |
| 6 | Sangha Pharmacy | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-17:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00 | | | |
| 7 | Lloydspharmacy | Standard 40 Hour | Opening Hours | 09:00-19:00 | 09:00-19:00 | 09:00-19:00 | 09:00-19:00 | 09:00-19:00 | 09:00-17:00 | | Yes | Yes |
| | | | Core Hours | 09:00-12:00; 15:00-19:00 | 09:00-12:00; 15:00-19:00 | 09:00-12:00; 15:00-19:00 | 09:00-12:00; 15:00-19:00 | 09:00-12:00; 15:00-19:00 | 09:00-11:00; 14:00-17:00 | | | |
| 8 | Bassil Chemist | Standard 40 Hour | Opening Hours | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-15:00 | | Yes | Yes |
| | | | Core Hours | 10:00-17:00 | 10:00-17:00 | 10:00-17:00 | 10:00-17:00 | 10:00-17:00 | 09:00-14:00 | | | |
| 9 | Boots The Chemists | 100 Hour | Opening Hours | 08:30-24:00 | 08:30-24:00 | 08:30-24:00 | 08:30-24:00 | 08:30-24:00 | 08:00-24:00 | 11:00-17:00 | Yes | Yes |
| | | | Core Hours | 08:30-24:00 | 08:30-24:00 | 08:30-24:00 | 08:30-24:00 | 08:30-24:00 | 08:00-24:00 | 10:00-16:00 | | |
| 10 | Lloydspharmacy | Standard 40 Hour | Opening Hours | 09:00-19:00 | 09:00-19:00 | 09:00-19:00 | 09:00-19:00 | 09:00-19:00 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 10:00-14:30; 16:00-19:00 | 10:00-14:30; 16:00-19:00 | 10:00-14:30; 16:00-19:00 | 10:00-14:30; 16:00-19:00 | 10:00-14:30; 16:00-19:00 | 09:30-12:00 | | | |
| 11 | Your Local Boots Pharmacy | Standard 40 Hour | Opening Hours | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-11:30 | | | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | Lloydspharmacy | Standard 40 Hour | Opening Hours | 09:00-19:00 | 09:00-19:00 | 09:00-19:00 | 09:00-19:00 | 09:00-19:00 | 09:00-17:00 | | Yes | Yes |
| | | | Core Hours | 09:00-11:30; 14:30-19:00 | 09:00-11:30; 14:30-19:00 | 09:00-11:30; 14:30-19:00 | 09:00-11:30; 14:30-19:00 | 09:00-11:30; 14:30-19:00 | 09:00-11:00; 14:00-17:00 | | | |
| 13 | Boots The Chemists | Standard 40 Hour | Opening Hours | 08:30-18:15 | 08:30-18:15 | 08:30-18:15 | 08:30-19:30 | 08:30-18:15 | 08:30-18:15 | 10:30-16:30 | Yes | Yes |
| | | | Core Hours | 10:00-14:00; 15:00-17:00 | 10:00-14:00; 15:00-17:00 | 10:00-14:00; 15:00-17:00 | 10:00-14:00; 15:00-17:00 | 10:00-14:00; 15:00-17:00 | 10:00-14:00; 15:00-17:00 | 11:00-13:00; 14:00-16:00 | | |
| 14 | Your Local Boots Pharmacy | Standard 40 Hour | Opening Hours | 09:00-12:30; 13:00-18:00 | 09:00-12:30; 13:00-18:00 | 09:00-12:30; 13:00-18:00 | 09:00-12:30; 13:00-18:00 | 09:00-12:30; 13:00-18:00 | 09:00-12:30; 13:00-17:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |
| 15 | Lloydspharmacy | Standard 40 Hour | Opening Hours | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-17:00 | | Yes | Yes |
| | | | Core Hours | 09:00-12:00; 14:00-18:00 | 09:00-12:00; 14:00-18:00 | 09:00-12:00; 14:00-18:00 | 09:00-12:00; 14:00-18:00 | 09:00-12:00; 14:00-18:00 | 09:00-11:00; 14:00-17:00 | | | |
| 16 | Pharmacy Direct | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | Yes | No |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |
| 17 | Boots The Chemists | Standard 40 Hour | Opening Hours | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | | Yes | Yes |
| | | | Core Hours | 10:00-13:00; 14:00-17:30 | 10:00-13:00; 14:00-17:30 | 10:00-13:00; 14:00-17:30 | 10:00-13:00; 14:00-17:30 | 10:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | | | |
| 18 | Lloydspharmacy | Standard 40 Hour | Opening Hours | 08:30-19:00 | 08:30-19:00 | 08:30-19:00 | 08:30-19:00 | 08:30-19:00 | 09:00-12:00 | | Yes | Yes |
| | | | Core Hours | 08:30-12:30; 15:00-19:00 | 08:30-12:30; 15:00-19:00 | 08:30-12:30; 15:00-19:00 | 08:30-12:30; 15:00-19:00 | 08:30-12:30; 15:00-19:00 | | | | |
| 19 | Day Lewis Pharmacy | Standard 40 Hour | Opening Hours | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | | | Yes | Yes |
| | | | Core Hours | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | | | | |
| 20 | Highfield Pharmacy | Standard 40 Hour | Opening Hours | 09:00-18:30 | 09:00-18:30 | 09:00-18:30 | 09:00-18:30 | 09:00-18:30 | 09:00-13:30 | | Yes | Yes |
| | | | Core Hours | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:00-13:30; 14:30-17:30 | 09:30-12:00 | | | |
| 21 | Lloydspharmacy | Standard 40 Hour | Opening Hours | 08:30-18:30 | 08:30-18:30 | 08:30-18:30 | 08:30-18:30 | 08:30-18:30 | 09:00-12:00 | | Yes | Yes |
| | | | Core Hours | 08:30-16:30 | 08:30-16:30 | 08:30-16:30 | 08:30-16:30 | 08:30-16:30 | | | | |
| 22 | Pharmacy Direct | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |
| 23 | Bitterne Pharmacy | 100 Hour | Opening Hours | 07:00-22:30 | 07:00-22:30 | 07:00-22:30 | 07:00-22:30 | 07:00-22:30 | 07:00-22:30 | 10:00-17:00 | Yes | No |
| | | | Core Hours | 07:00-22:30 | 07:00-22:30 | 07:00-22:30 | 07:00-22:30 | 07:00-22:30 | 07:00-22:30 | 10:00-17:00 | | |
| 24 | Tesco Instore Pharmacy | Standard 40 Hour | Opening Hours | 08:30-13:00; 14:00-20:30 | 08:30-13:00; 14:00-20:30 | 08:30-13:00; 14:00-20:30 | 08:30-13:00; 14:00-20:30 | 08:30-13:00; 14:00-20:30 | 09:00-13:00; 14:00-20:30 | 10:00-16:00 | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-17:00 | | | |
| 25 | Day Lewis Pharmacy | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 26 | Superdrug Pharmacy | Standard 40 Hour | Opening Hours | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 15:00-17:30 | 09:00-13:00; 15:00-17:30 | 09:00-13:00; 15:00-17:30 | 09:00-13:00; 15:00-17:30 | 09:00-13:00; 15:00-17:30 | 09:00-13:30; 14:30-17:30 | | | |
| 27 | Millbrook Pharmacy | Standard 40 Hour | Opening Hours | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-13:00 | | | |
| 28 | Regents Park Pharmacy | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:15-17:30 | 09:00-13:00; 14:15-17:30 | 09:00-13:00; 14:15-17:30 | 09:00-13:00; 14:15-17:30 | 09:00-13:00; 14:15-17:30 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:15-17:30 | 09:00-13:00; 14:15-17:30 | 09:00-13:00; 14:15-17:30 | 09:00-13:00; 14:15-17:30 | 09:00-13:00; 14:15-17:30 | 09:00-12:45 | | | |
| 29 | Pharmacy Direct | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |
| 30 | Your Local Boots Pharmacy | Standard 40 Hour | Opening Hours | 08:45-13:00; 14:00-18:00 | 08:45-13:00; 14:00-18:00 | 08:45-13:00; 14:00-18:00 | 08:45-13:00; 14:00-18:00 | 08:45-13:00; 14:00-18:00 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |
| 31 | The Co-operative Pharmacy | Standard 40 Hour | Opening Hours | 08:30-18:00 | 08:30-18:00 | 08:30-18:00 | 08:30-18:00 | 08:30-18:00 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |
| 32 | Day Lewis Pharmacy | Standard 40 Hour | Opening Hours | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-17:30 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |
| 33 | Your Local Boots Pharmacy | Standard 40 Hour | Opening Hours | 08:45-13:00; 14:00-18:30 | 08:45-13:00; 14:00-18:30 | 08:45-13:00; 14:00-18:30 | 08:45-13:00; 14:00-18:30 | 08:45-13:00; 14:00-18:30 | | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |
| 34 | Asda Pharmacy | 100 Hour | Opening Hours | 08:00-23:00 | 07:00-23:00 | 07:00-23:00 | 07:00-23:00 | 07:00-23:00 | 07:00-22:00 | 11:00-17:00 | Yes | No |
| | | | Core Hours | 08:00-23:00 | 07:00-23:00 | 07:00-23:00 | 07:00-23:00 | 07:00-23:00 | 07:00-22:00 | 11:00-17:00 | | |
| 56 | S & K Nam Pharmacy | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 15:15-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00 | | No | No |
| | | | Core Hours | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 15:15-17:15 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00 | | | |
| 36 | Pharmacy Direct | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |
| 37 | Sainsbury's Pharmacy | Standard 40 Hour | Opening Hours | 08:00-19:00 | 08:00-19:00 | 08:00-19:00 | 08:00-19:00 | 08:00-19:00 | 08:00-19:00 | 10:00-16:00 | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-17:00 | 09:00-13:00; 14:00-15:00 | | | |
| 38 | S K Roy Dispensing Chemists | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-18:30 | 09:00-13:00; 14:00-18:30 | 09:00-13:00; 14:00-18:30 | 09:00-13:00; 14:00-18:30 | 09:00-13:00; 14:00-18:30 | 09:00-13:00; 14:00-17:00 | | No | No |
| | | | Core Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 39 | Day Lewis Pharmacy | Standard 40 Hour | Opening Hours | 08:30-18:30 | 08:30-18:30 | 08:30-18:30 | 08:30-18:30 | 08:30-18:30 | 08:30-11:30 | | Yes | Yes |
| | | | Core Hours | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | | | | |
| 40 | Adelaide Pharmacy | 100 Hour | Opening Hours | 07:30-22:30 | 07:30-22:30 | 07:30-22:30 | 07:30-22:30 | 07:30-22:30 | 07:30-22:30 | 09:00-19:00 | Yes | No |
| | | | Core Hours | 07:30-22:30 | 07:30-22:30 | 07:30-22:30 | 07:30-22:30 | 07:30-22:30 | 07:30-22:30 | 09:00-19:00 | | |
| 41 | Lloydspharmacy | Standard 40 Hour | Opening Hours | 08:30-18:30 | 08:30-18:30 | 08:30-18:30 | 08:30-18:30 | 08:30-18:30 | 09:00-12:00 | | Yes | Yes |
| | | | Core Hours | 08:30-14:00; 16:30-18:30 | 08:30-14:00; 16:30-18:30 | 08:30-14:00; 16:30-18:30 | 08:30-14:00; 16:30-18:30 | 08:30-14:00; 16:30-18:30 | 09:30-12:00 | | | |
| 42 | Lloydspharmacy | Standard 40 Hour | Opening Hours | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-12:00 | | Yes | Yes |
| | | | Core Hours | 09:00-12:30; 14:00-18:00 | 09:00-12:30; 14:00-18:00 | 09:00-12:30; 14:00-18:00 | 09:00-12:30; 14:00-18:00 | 09:00-12:30; 14:00-18:00 | 09:30-12:00 | | | |
| 43 | Telephone House Pharmacy | Standard 40 Hour | Opening Hours | 08:45-18:30 | 08:45-18:30 | 08:45-18:30 | 08:45-18:30 | 08:45-18:30 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-11:30 | | | |
| 44 | Lloydspharmacy | Standard 40 Hour | Opening Hours | 08:30-19:00 | 08:30-19:00 | 08:30-19:00 | 08:30-19:00 | 08:30-19:00 | 09:00-13:00 | | Yes | Yes |
| | | | Core Hours | 08:30-12:30; 15:00-19:00 | 08:30-12:30; 15:00-19:00 | 08:30-12:30; 15:00-19:00 | 08:30-12:30; 15:00-19:00 | 08:30-12:30; 15:00-19:00 | | | | |

**Dispensing Appliance Contractor**

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 45 | G E Bridge & Co | DAC | Opening Hours | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | 09:00-14:00 | | N/A | N/A |
| | | | Core Hours | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | 09:00-17:00 | | | | |

*Premises, opening hours and Advanced Services data provided by NHS England.*

## Glossary and acronyms

A&E – accident and emergency
AF – atrial fibrillation
ASH - action on smoking and health
BME - black and minority ethnic
CAMHS - child and adolescent mental health service
CCG – clinical commissioning group
CHD – coronary heart disease
CKD – chronic kidney disease
CMH - Countess Mountbatten Hospice
COPD – chronic obstructive pulmonary disease
CVD – cardio-vascular disease
DAC – dispensing appliance contractor
DH – Department of Health
DMFT – decayed, missing, filled teeth
ESIA - equality and safety impact assessment
GIRES - Gender Identity Research and Education Society
GUM - genito-urinary medicine
HCAI - healthcare-associated infections
HCC – Hampshire county council
HIV – human immunodeficiency virus
HPV - human papilloma virus
HWB – health and well-being board
IMD – index of multiple deprivation
JSNA – joint strategic needs assessment
LPS – local pharmaceutical services
LSOA – lower super output area
MRSA - meticillin-resistant *staphylococcus aureusis*
MSM – men who have sex with men
MUR – medicines use review
NMS – new medicines service
ONS – Office for national statistics
PAH - Princess Anne Hospital
PCT – primary care trust
PNA – pharmaceutical needs assessment
PSNC – Pharmaceutical Services Negotiating Committee
QOF – quality and outcomes framework
RBL – Royal British Legion
RSH - The Royal South Hants Hospital
SCH - Southampton Children's Hospital
SGH - Southampton General Hospital
SI – sight impaired
SSI – severe sight impairment
STI – sexually transmitted infection
TB - tuberculosis
The 2013 directions – The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013
The 2013 regulations – The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended
UHS- University Hospital Southampton NHS Foundation Trust
UK – United Kingdom

| | | | | |
|---|---|---|---|---|
| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | SOUTHAMPTON LOCAL PLAN FOR THE BETTER CARE FUND : POOLED FUND DEVELOPMENT | | |
| **DATE OF DECISION:** | | 28TH JANUARY 2015 | | |
| **REPORT OF:** | | DIRECTOR OF QUALITY AND INTEGRATION, INTEGRATED COMMISSIONING UNIT | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR:** | **Name:** | **Donna Chapman** | **Tel:** | **023 80296004** |
| | **E-mail:** | **Donna.chapman@southamptoncityccg.nhs.uk** | | |
| **Director** | **Name:** | **Alison Elliott**<br>**John Richards** | **Tel:** | **023 80 832602**<br>**023 80 296923** |
| | **E-mail:** | **alison.elliott@southampton.gov.uk**<br>**john.richards@southamptoncityccg.nhs.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None | | | | |

**BRIEF SUMMARY**

In the statement on the next comprehensive spending review made in summer of 2013 the Chancellor of the Exchequer announced that nationally a sum of £3.8 billion would be set aside for 2015/16 to ensure closer integration between health and social care. This funding was described as “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and Local Authorities”. Local Authorities and the Clinical Commissioning Groups (CCGs) operating in their area were required to submit a plan setting out how the pooled funding will be used to improve outcomes for patients, drive closer integration and identify the ways in which the national and local targets will be met.

Over the last 12 months extensive work has been undertaken by the City Council working in partnership with Southampton City CCG and other stakeholders to develop Southampton's Better Care Plan, under the leadership of the Health and Wellbeing Board. The final plan was signed off by the Health and Wellbeing Board, Chief Executive of the City Council and Chief Operating Officer of the CCG on 19 September 2014 and submitted to Ministers. This has been recently approved following the Nationally Consistent Assurance Review which identified no areas of high risk within the plan and means that Southampton can now progress its plan with establishment of a Better Care pooled fund by 1 April 2015.

Southampton is one of ten authorities nationally with the ambition to integrate and pool resources at scale to significantly transform its health and care services. The Better Care Fund (BCF) requires a minimum contribution of £15.325m revenue funds plus £1.526m capital to a pooled fund. Southampton City's plan is to go far beyond this and pool over £132m, nearly 9 times more than the minimum requirement. The split between the forecast contributions is currently 57% CCG and 43% City Council.

**RECOMMENDATIONS :**

(i) To support the request that the Council and CCG Governing Body approve entering into a S75 of the National Health Service Act 2006 Partnership Agreement pooled fund, noting the minimum statutory requirement to pool £15.325m revenue and £1.526m capital.

(ii) To support the request that the Council and CCG Governing Body approve exceeding the minimum requirement to pool up to the total value of the first 3 schemes identified in Section 13 of this report (Cluster development, Supporting carers and Integrated discharge, reablement and rehabilitation) from 1 April 2015, noting Southampton's ambition to achieve integration at scale at a total cost of approximately £61m.

(iii) To support the request that the Council and CCG Governing Body approve the addition of the remaining budgets included within Section 13 of this report into the pooled fund as and when appropriate, bringing the total value to approximately £132m.

**REASONS FOR REPORT RECOMMENDATIONS**

1. From 1 April 2015 Local Authorities and CCGs are required to establish a pooled fund under Section 75 of the NHS Act 2006 for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authority. For Southampton City the minimum value of the pooled fund is £15.325m revenue and £1.526m capital.

2. Southampton City has taken a more holistic approach to health and social care and proposes to fund and commission it in that way. The ambition is to encompass all services that fit within the scope of the Better Care model, bringing together approximately £132m into the pooled fund.

**ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

3. Not to establish a pooled fund - this is not an option as Local Authorities and CCGs are required to establish a pooled fund for the minimum £15.325m revenue and £1.526m capital by 1 April 2015

4. To pool only the minimum - this has been rejected on the basis that Southampton's Better Care Plan, which has been signed off by the Health and Wellbeing Board, seeks to achieve a fully integrated model of health and social care. In order to achieve this ambitious transformation, it is considered necessary to bring together all of those health and social care resources associated with this vision and commission services in a fully integrated way, which is focussed on people's outcomes and needs in their entirety, as opposed to their health or social care in isolation.

5. To pool all of the health and social care resources for those services within the scope of the Better Care model from 1 April 2015 - this has been rejected in favour of a more gradual progression towards this aim which allows each scheme to be fully scoped and tested before adding it to the pooled fund. Three of the five schemes have been worked up in significant detail and are ready for inclusion from 1 April 2015.

**DETAIL (Including consultation carried out)**

6. The Southampton Better Care Plan is attached at **Appendix 1**. The details of the plan are not re-iterated in this covering report, as the plan is a detailed stand-alone document.

7. **Summary of Plan**

Southampton's vision for Better Care is to completely transform the delivery of care in Southampton so that it is better integrated across health and social care, delivered as locally as possible and person centred. People will be at the heart of their care, fully engaged and supported where necessary by high quality integrated local and connected communities of services to maintain or retain their independence, health and wellbeing. Neighbourhoods and local communities will have a recognised and valued role in supporting people and there will be a much stronger focus on prevention and early intervention.

The overall aims are:

- Putting people at the centre of their care, meeting needs in a holistic way.
- Providing the right care, in the right place at the right time, and enabling people to stay in their own homes for as long as possible.
- Making optimum use of the health and care resources available in the community, reducing duplication and closing gaps, doing things once wherever appropriate.
- Intervening earlier in order to secure better outcomes by providing more coordinated, proactive services.

Underpinning these aims are the following national conditions:

- Protecting social care services.
- Seven day services to support discharge from hospital.
- Data sharing.
- Joint assessment and accountable lead professional for high risk populations.

8. Southampton's plan has the following main schemes:

1. Local person centred coordinated care (clusters) - integrated multidisciplinary cluster teams providing integrated risk stratification, care coordination, planning, 7 day working.
2. Integrated discharge, reablement and rehabilitation service, including greater use of telecare/telehealth. This scheme is aimed at helping people to maintain their independence at home, in the community, intervening quickly where required to prevent deterioration, as well as supporting people's recovery and reablement following a period of illness
3. Community solutions and prevention - this scheme is aimed at building on and developing local community assets and supporting people and families to find their own solutions.
4. Supporting carers – this scheme recognises the important role that carers have in supporting older people and those with multiple long term conditions in the community and supports the overall model and ambitions of local person centred coordinated care.
5. Developing the market for placements and packages and further integrating approaches – this includes work to develop the market to

provide greater opportunity and choice, encourage a recovery/ reablement focus and support people to remain as independent as they can be in their own homes.

9. Southampton's Better Care Plan has been designed to achieve the following key targets:

- To reduce unplanned hospital admissions - by 2% year on year over the next 5 years (2014 – 2019).
- To reduce permanent admissions to residential and nursing homes - by 12.3% in per capita terms over 2014/15 and sustain and improve on this in subsequent years, bringing Southampton in line first with its statistical neighbours and then the national average.
- To reduce readmissions by increasing the percentage of older people still at home 91 days post discharge into reablement services - to achieve 90% in 2015/16.
- To reduce delayed transfers of care and therefore excess bed days - by 3 per day in 15/16 which equates to an approximate 10% reduction.
- To reduce injuries due to falls - by 12.5% by the end of 2014/15 and sustain and improve on this in subsequent years.

10. **Consultation**

Engagement with local providers has been an important aspect of the Local plan development. Providers, along with community, voluntary sector and public representatives have contributed to the shared view of the future shape of services.

Three large stakeholder workshops were held on 16 November 2013, 12 December 2013 and 17 January 2014 and involved a wide range of stakeholders from all of the local health providers, primary care, voluntary sector groups, local councillors and City Council housing and social care. Since then the Integrated Care Board which brings together senior operational and clinical leaders from the CCG, City Council, provider NHS Trusts and voluntary sector has been overseeing the development of the plan, with regular updates to the Health and Wellbeing Board. There has been ongoing engagement and consultation in cluster areas.

Extensive engagement with patients/service users and the public has also taken place and included:

- A range of service user focus groups including the CCG Patients Forum, Older Persons Forum focus group, Pensioners Forum
- Equality Reference group
- Healthwatch
- Carers Strategic group

11. **Development of the pooled fund - core principles**
**What is a pooled fund?**

Section 75 of the NHS Act (2006) allows the pooling of funds where payments may be made towards expenditure incurred in the exercise of any NHS or 'health-related' local authority functions. Section 75 also allows for one partner to take the lead in commissioning services on behalf of the other (lead commissioning) and for partners to combine resources, staff and management structures to help integrate service provision (integrated management or provision), commonly known as 'Health Act flexibilities'.

A pooled budget (or fund) is an arrangement where two or more partners make financial contributions to a single fund to achieve specified and mutually agreed aims. It is a single budget, managed by a single host organisation with a formal partnership or joint funding agreement that sets out aims, accountabilities, responsibilities, governance and technical aspects including financial reporting, management of risks, exit strategy, and treatment of overspends. Detailed guidance is attached at **Appendix 2.**

**Benefits of a pooled fund**

Southampton City's Better Care Fund Plan seeks to pool all budgets associated with health and social care services for older people and those with long term conditions to deliver a fully integrated provision centres on the needs of individuals. Pooling these budgets at scale will:

- Minimise overlap/gaps in service delivery, increase efficiency, improve value for money and ensure that services are designed to meet the needs of service users.
- Enable faster shared decision making, effective use of resources and economies scale.
- Enable radical redesign of services around the user regardless of whether their needs are mainly social or health.
- Enable greater transparency of spend – governance of a pooled fund requires all budgets to be clearly identified and monitored by both partners.
- Provide greater flexibility to move resources quickly to where they are required to meet need.

The Integrated Commissioning Board (ICB) of the City Council and CCG which oversees all integrated commissioning arrangements between the two organisations has been overseeing the development of the pooled fund, in consultation with City Council and CCG legal representatives and finance. The Board comprises the Cabinet Member for Adult Health and Social Care/Chair of the HWB Board, the Clinical Chair of the CCG, the Chief Executive of the City Council, the Chief Operating Officer of the CCG, the Director of Public Health, the Director of People, Chief Finance Officer of the CCG, Chief Finance Officer of the City Council and the Director of Integrated Commissioning and Quality. The Board have established the following core principles for the pooled fund:

1. To break the total pooled fund down into a number of smaller pooled funds each with their own hosting arrangements and specifications, but sitting under the overall Section 75 Partnership Agreement.
2. The host organisation which holds the budget for each pooled fund /

scheme will be the partner who contributes the majority of the funding to that pool, unless there are stronger reasons for this not to be the case. The main exception will be where the statutory functions associated with the specific scheme sit primarily with the other partner.

3. A phased approach will be adopted, whereby pooled funds are established within the S75 Partnership Agreement as and when schemes have been fully worked up. A gateway process will ensure sign off by both CCG and City Council through the ICB of each pooled fund scheme prior to it being placed within the Partnership Agreement.
4. It is proposed that the overarching Partnership Agreement has duration of 3 years with a 3 month notice period for variation, unless otherwise agreed by the ICB.
5. There will be an annual review of the whole agreement and each of the schemes within it.

12. **Governance**

It is proposed that the ICB will oversee the effective management and performance of the overall Partnership Agreement and each of the individual Schemes within it on behalf of the CCG and City Council. The Integrated Commissioning Unit (ICU) will support the ICB in this function, managing each of the Schemes and their associated contracts. A lead commissioner from the ICU will be identified to manage each Scheme and will ensure that quarterly monitoring reports are produced for each of the Schemes and contracts, detailing financial performance and performance against key outcomes and indicators.

13. Based on the above principles, the following is recommended:

| Scheme | Approximate Value | Host | Rationale |
|---|---|---|---|
| ***From 1 April 2015*** | | | |
| Clusters (Local person centred coordinated care | £30m (CCG £29.8m; SCC £0.2m) | CCG | CCG contributing greatest share; enables alignment of primary care funding under co-commissioning arrangements. |
| Supporting carers | £1.4m (CCG £1.2m; SCC £0.2m) | SCC | Although CCG contributing greater share, statutory functions sit with SCC |
| Integrated discharge, reablement and rehabilitation | £29m (CCG £24m; SCC £5m) | CCG, (within this scheme there will be 2 subpools that will be hosted by SCC – Joint Equipment Store and both Capital schemes) | CCG contributing greatest share |
| TOTAL | £61m | | |

| *Funds to be varied into the Partnership Agreement at a later date* | | | |
|---|---|---|---|
| Placements and packages | £60m<br><br>(CCG £25m<br>SCC £35m) | TBA | Clarification needed around which budgets to include and the benefits |
| Community solutions and prevention | £11.7m<br><br>(CCG £200k<br>SCC £11.5m) | SCC | Clarification needed around which budgets to include and the benefits |
| Total | £72m | | |
| **GRAND TOTAL** | **£132m** | | |

It should be noted that all figures in this report are based on 2014/15 budgeted levels for both the Council and CCG. The equivalent budgets for 2015/16, except for the minimum BCF provision, may vary subject to the relevant budget approvals for each organisation.

## RESOURCE IMPLICATIONS

### Capital/Revenue

14 The minimum requirement for the Better Care Fund in 2015/16 is £15.325M Revenue and £1.526M Capital. The table below outlines the funding sources for the minimum required level for the Southampton Better Care Fund in 2015/16.

| **Funding Source** | **£000** |
|---|---|
| Existing NHS Resource | |
| Care Act Implementation | 600 |
| Other | 7,828 |
| Re-ablement | 1,212 |
| Social Care Transfer | 5,085 |
| Carers | 600 |
| **Total Revenue** | **15,325** |
| | |
| Capital | |
| Disabled Facilities Grant | 908 |
| Personal Social Services Capital Grant | 618 |
| **Total Capital** | **1,526** |
| | |
| **Total Minimum BCF** | **16,851** |

15. All of the above are existing funding sources included within either the Council or CCG 2014/15 budget. This funding is not new to the Health and Social Care system. However, under the conditions of the Better Care Fund, additional funding of £600,000 from within the pool will be provided to help meet the new responsibilities of the Council required by the Care Act 2014. This funding will

come from the existing NHS resource and will therefore be a pressure to the CCG.

16. The Council currently receive the Social Care Transfer funding of £5.085m from the NHS Commissioning Board and £1.2m from the CCG in respect of re-ablement. Although this funding will form part of the Better Care Fund from 2015/16 this will still be utilised to support Social Care. There will not be a negative impact on the Council's budget.

17. As outlined in the report it is planned to place three of the five schemes into the pool from 1st April 2015. These schemes will incorporate approximately a further £45m of funding from the Council and the CCG bringing the total planned pool for 2015/16 to £61m. Currently £3.4m of the additional £45m is within an existing joint funding arrangement between SCC and SCCCG under a S75, S76 or S256 agreement. The funding for the first three schemes entering into a pooled fund arrangement will be Council £5.3m, (9%) and CCG £55.5m (91%).

18. It is proposed that beyond April 2015 the remaining two schemes, (Placement and Packages and Community Solutions and Prevention) at the point they have been fully developed, will be varied into the pooled fund achieving a pool total of approximately £132m. These schemes total funding of approximately £71m, split Council £46.4m, (65%) and CCG £24.9m (35%). This proposed expansion beyond the minimum required BCF includes other CCG and Council budgets associated with the services within the Better Care model. These will be primarily services for older people and adults with long term conditions.

19. Children's Services are currently not within the scope of the pooled fund but could be considered for inclusion in future to reflect the development of more integrated services in this area also.

20. All financial totals included within this report are based on 2014/15 budgeted levels for both the Council and CCG. The equivalent budgets for 2015/16, except for the minimum BCF provision, may vary subject to the relevant budget approvals for each organisation. In respect of the Council there may be reductions in funding should the proposed savings be accepted at Full Council in February. All figures are indicative only at this stage.

21. As outlined in this report there are significant risks and opportunities associated with a proposed pooled budget of this magnitude. The work to mitigate these risks and maximise the opportunities within the contractual arrangement is currently under the consideration of the Legal Services team and the ICB.

22. It should be noted that it is the commissioning budgets for services that are being pooled and that the services themselves and the associated staff will remain managed and employed as they are currently. Therefore the recommendations in this report have no TUPE implications.

23. **FINANCIAL RISKS**

The following risks will be mitigated as far as possible through the terms and conditions of the Section 75 Partnership Agreement which is being developed by City Council and CCG legal teams.

1. Overspends - As a general rule, it is proposed that overspends are handled at an individual pool level and are shared proportionately on the

basis of each partner's contribution.

2. Potential loss of each organisation's budget flexibility - careful consideration has been given to the budgets for inclusion in the pooled fund and the terms and conditions of the Agreement will include arrangements for either organisation to vary its contributions or achieve savings, without adversely affecting the other partner.
3. Equally there are risks that the Better Care fund programme does not achieve the targets outlined in Section 9 or indeed activity increases in these areas in spite of the Better Care fund and there is an increase in expenditure outside of the pooled fund. A risk mitigation plan has been developed to address this and is overseen by the Integrated Care Board.

**Property/Other**

24. The proposal should not have any property implications as it relates to commissioning functions. Any changes made to any service funded through the pooled fund which may have property implications will be subject to a separate report.

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

25. Section 75 of the National Health Service Act 2006

    The pooled fund agreement will cover governance and technical aspects including accountability, financial reporting and the handling of overspends, underspends and savings requirements.

**Other Legal Implications:**

26. The Health and Social Care Act 2012 places a duty on Health and Wellbeing Boards to encourage and support integrated working.

**POLICY FRAMEWORK IMPLICATIONS**

27. The decision sought is wholly consistent with the Council's Health and Wellbeing Strategy and other policy framework strategies and plans.

**KEY DECISION?** No

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | All |

**SUPPORTING DOCUMENTATION**

**Appendices**

| | |
|---|---|
| 1. | Southampton City Better Care Plan |
| 2. | Pooled budgets and the Better Care Fund Guidance, October 2014 (The Chartered Institute of Public Finance and Accountancy) |

**Documents In Members' Rooms**

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|---|---|
| 1. | None |

**Equality Impact Assessment**

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|---|---|
| Do the implications/subject of the report require an Equality Impact | Yes |

| | |
|---|---|
| Assessment (EIA) to be carried out. | |

**Other Background Documents**

**Equality Impact Assessment and Other Background documents available for inspection at:**

| Title of Background Paper(s) | | Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable) |
|---|---|---|
| 1. | None | |

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|---|---|---|---|---|
| DECISION-MAKER: | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | FEEDBACK FROM MENTAL HEALTH MATTERS ROUND TABLE EVENT, 4TH DECEMBER 2014 | | |
| **DATE OF DECISION:** | | 28TH JANUARY 2015 | | |
| **REPORT OF:** | | SENIOR COMMISSIONER FOR MENTAL HEALTH SERVICES | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR:** | **Name:** | **Katy Bartolomeo** | **Tel:** | **023 8083 416** |
| | **E-mail:** | **Katy.bartolomeo@southampton.gov.uk** | | |
| **Director** | **Name:** | **Stephanie Ramsey** | **Tel:** | **023 8029 6923** |
| | **E-mail:** | **stephanie.ramsey@southamptoncityccg.nhs.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None. | | | | |

**BRIEF SUMMARY**

This Paper provides an overview of the first Mental Health Matters round table event which took place on 4th December 2014, along with a summary of the main themes from the event and planned next steps.

**RECOMMENDATIONS:**

(i) That the report be noted;

(ii) That a Health and Wellbeing Board Champion for mental health be identified; and

(iii) That the Health and Wellbeing Board acknowledges and welcomes Southampton Connect's contribution in championing the issue of mental health and ensuring that it develops into a cross cutting theme in the City Plan.

**REASONS FOR REPORT RECOMMENDATIONS**

1. To inform the Health and Wellbeing Board of the key outcomes from the Mental Health Matters event in December 2014.

**ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

2. None.

**DETAIL (Including consultation carried out)**

3. On the 4th December 2014 the Health and Wellbeing Board held Southampton's first 'Mental Health Matters' round table event. The event aimed to highlight key issues and challenges facing service users, commissioners and providers of mental health services and explore the future of mental health in the City.

4. The event was attended by 84 people with representation from NHS and voluntary sector providers, service users, carers and ICU/Public Health Commissioners. The day consisted of key note talks on topics such as the service user perspective, parity of esteem, local and national needs analysis, excluded populations and governance within commissioning along with a number of small group exercises to gather the views and experiences of the

wide variety of individuals who attended the event across all ages.

5. The key themes from the feedback that was captured on the day include:

What is working well?

- Peer support
- Operation serenity (mental health workers within Police call centres)
- Steps2Wellbeing service
- Specialist employment support and recovery college
- Mental health support for schools including headstart and mental health nurse at Itchen college

What is not working well?

- Acute care pathway
- Dual diagnosis needs not met within one service
- Physical and mental health needs not being met
- Heavy reliance on medical model
- Voluntary sector not always feeling valued
- People not knowing what support and services are out there
- Lack of co-ordination of/between services
- Lack of service user network
- Need to focus on younger people and early intervention

Parity of esteem

- Work as a city to reduce stigma
- Integration of physical and mental health services
- Primary care to increase understanding and skills
- Improve the building environments in mental health services
- Co-production
- Work with schools and universities to educate people
- Embed mental health in generic health consultations and consider how general services should be adapted for people with mental health problems
- Include ‘reasonable adjustments’ within contracts
- Focus on Time to Change and Mindful Employers

Priorities for change – key themes

- Crisis care – out of hours provision, out of hours hub, prevention and early intervention and local beds.
- Housing – increase in step down beds and services, helping people to maintain tenancies to reduce high cost placements, better quality and affordable housing.
- Carers and service users – support and resources for service user network, listening to carers and service users, person centred care and support planning, peer development.

- Integration – more spending for mental health services, commission as a city, health and wellbeing centres, primary mental health for CAMHS, co-location of services.
- Health and social care – start with a blank sheet and budget and design a new service from scratch, early diagnosis, plan the solution and support around the service user's needs.
- Stigma – city wide/multiagency approach to anti stigma, telling real stories in ad campaigns, maximise publicity – learning from dementia initiatives.
- Education – school education on mental health.
- Employment – education for businesses to understand mental health, early intervention and education around barriers to employment.

6. The first Mental Health Matters event served as a good starting point for what needs to be a process of continued engagement with stakeholders across Southampton.

   Despite representation from service users, and the Southampton Service User Network at the event, more needs to be done to engage with these individuals in ways and environments that are conducive to their involvement. This will be taking place over the coming months.

7. Action plan and next steps:

   - A survey monkey questionnaire is in the final stages of development which will be used to gather feedback from attendees of the event but will also be sent to a wider range of individuals across the city that were not able to attend the event. This will focus on gathering feedback along the same themes as the event:
     1. What is working well within the city?
     2. What is not working well?
     3. How do we achieve parity of esteem so that our mental health services enable us to maintain both our physical and mental health needs and that mental health is valued equally to physical health in other services?
     4. What should our priorities be within the city to improve our services?
   - Use the initial feedback to help shape commissioning priorities for 2014/15, to be developed further with increased engagement
   - Analyse further feedback gathered via survey monkey and service user/carer engagement
   - Follow up focus groups with stakeholders, including separate session for service users, to further develop feedback into ideas and solutions for how mental health services across the city can be improved and re-designed.
   - Refining and using the information gathered to date to redesign provision, services and priorities where appropriate.

**RESOURCE IMPLICATIONS**

**Capital/Revenue**

8. None.

**Property/Other**

9. None

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

10. Health and Social Care Act 2012.

**Other Legal Implications:**

11. None.

**POLICY FRAMEWORK IMPLICATIONS**

None.

**KEY DECISION?** No

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | All. |

## SUPPORTING DOCUMENTATION

**Appendices**

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|---|---|
| 1. | None. |

**Documents In Members' Rooms**

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|---|---|
| 1. | None. |

**Equality Impact Assessment**

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|---|---|
| Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out. | Yes/No |

**Other Background Documents**

**Equality Impact Assessment and Other Background documents available for inspection at:**

| | Title of Background Paper(s) | Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable) |
|---|---|---|
| 1. | None. | |

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|---|---|---|---|---|
| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | HEALTHY SOUTHAMPTON BRANDING | | |
| **DATE OF DECISION:** | | 28TH JANUARY 2015 | | |
| **REPORT OF:** | | DIRECTOR OF PUBLIC HEALTH | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR**: | **Name:** | **Martin Day** | **Tel:** | **023 80917831** |
| | **E-mail:** | **Martin.day@southampton.gov.uk** | | |
| **Director** | **Name:** | **Dr Andrew Mortimore** | **Tel:** | **023 80833204** |
| | **E-mail:** | **Andrew.mortimore@southampton.gov.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None | | | | |

**BRIEF SUMMARY**

This report informs the Health and Wellbeing Board of the Healthy Southampton branding.

**RECOMMENDATION:**

(i) That the Healthy Southampton branding as presented to the Board be adopted for use in Health and Wellbeing Board publications and activities.

**REASONS FOR REPORT RECOMMENDATIONS**

1. To encourage the use of the Healthy Southampton brand.

**ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

2. None.

**DETAIL (Including consultation carried out)**

3. Unlike a number of other cities, Southampton has not previously developed a brand to promote good health and healthy lifestyles. Development work was undertaken in 2014 to develop a "Healthy Southampton" brand. This was to be an outward facing brand, designed to be recognised by the public and communities of interest. To help link it to recognisable national brands, permission was obtained from the Public Health England to incorporate some of the styling from the Change4Life into the Healthy Southampton branding. Based around the wording Healthy Southampton, a blue heart symbol represents health and vitality. Slides showing the brand will be presented at the Board meeting.

4. Taking the World Health Organisation definition of health as, "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity." the brand can provide a means of identifying work that supports this wide definition of health.

Ultimately the brand would be applied to:

- Publications
- Presentations
- Websites
- Pop-up banners
- Social media
- The Director of Public Health's annual report

5. Healthy Southampton encompasses the aspirations of the Health and Wellbeing Board, and the logo could act as a visual anchor for the public facing work the Board will be pursuing in the future.

6. It has been used in a limited manner by Southampton City Council, Southampton City Clinical Commissioning group, and Southampton Connect. In the longer-term it is to be hoped providers will want to use it promote their activities in the City.

7. It is important to maintain control of the Healthy Southampton brand, and it would be appropriate for the Health and Wellbeing Board to be the gatekeeper, maintaining parameters for its use.

**RESOURCE IMPLICATIONS**

**Capital/Revenue**

8. None.

**Property/Other**

9. None.

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

10. N/A

**Other Legal Implications:**

11. N/A

**POLICY FRAMEWORK IMPLICATIONS**

12. None

**KEY DECISION?** No

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | All |

**SUPPORTING DOCUMENTATION**

**Appendices**

| | |
|---|---|
| 1. | None |

**Documents In Members' Rooms**

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|---|---|
| 1. | None |

**Equality Impact Assessment**

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|---|---|
| Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out. | No |

**Other Background Documents**

**Equality Impact Assessment and Other Background documents available for inspection at:**

| | Title of Background Paper(s) | Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable) |
|---|---|---|
| 1. | None | |

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| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | IMPROVING ACCESS TO GENERAL PRACTICE AND INNOVATION IN PRIMARY CARE – THE PRIME MINISTER'S CHALLENGE FUND | | |
| **DATE OF DECISION:** | | 28TH JANUARY 2015 | | |
| **REPORT OF:** | | CHAIR, SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR**: | **Name:** | **Dr Steve Townsend** | **Tel:** | **023 8029 6958** |
| | **E-mail:** | **steve.townsend@nhs.net** | | |
| **Director** | **Name:** | **Dr Steve Townsend** | **Tel:** | **023 8029 6958** |
| | **E-mail:** | **Steve.townsend@nhs.net** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None. | | | | |

**BRIEF SUMMARY**

The report informs the Health and Wellbeing Board of a bid made by a federation of Southampton GP practices seeking funding from the Prime Minister's Challenge Fund for improving access to general practice and stimulating innovative ways of providing primary care.

**RECOMMENDATION:**

(i) That the report be noted.

**REASONS FOR REPORT RECOMMENDATIONS**

1. To inform the Health and Wellbeing Board of a further application made seeking funding from the Prime Minister's Challenge Fund.

**ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

2. None.

**DETAIL (Including consultation carried out)**

3. The Prime Minister's Challenge Fund was set up in 2013 to help improve access to general practice and stimulate innovative ways of providing primary care. The first tranche of £50 million was awarded last year, and a group of six Southampton practices submitted a bid which reached the national shortlist but was unfortunately ultimately unsuccessful. The 20 schemes that were successful were almost all on a very much larger scale than Southampton's.

4. Last year a federation was set up including most of the Southampton practices, Southampton Primary Care Ltd. A second tranche of £100 million was announced in October, and bids were invited. Building on our previous experience, the federation has developed a proposal which is much more

ambitious, providing extended hours care for all patients registered with a Southampton practice, particularly those who have long term conditions. This has been supported by the Clinical Commissioning Group.

5. The closing date for applications was 16th January 2014, and we anticipate hearing whether the bid has been successful during February. If it has, the Board may wish to invite representatives of the federation to a meeting to learn more about what is proposed and comment on it.

**RESOURCE IMPLICATIONS**

**Capital/Revenue**

6. None.

**Property/Other**

7. None

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

8. Health and Social Care Act 2012

**Other Legal Implications:**

9. None.

**POLICY FRAMEWORK IMPLICATIONS**

10. None.

**KEY DECISION?** No

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | |

**SUPPORTING DOCUMENTATION**

**Appendices**

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|---|---|
| 1. | None |

**Documents In Members' Rooms**

| | |
|---|---|
| 1. | None |

**Equality Impact Assessment**

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|---|---|
| Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out. | No |

**Other Background Documents**

**Equality Impact Assessment and Other Background documents available for inspection at:**

| | Title of Background Paper(s) | Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable) |
|---|---|---|
| 1. | None | |

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| **DECISION-MAKER:** | | HEALTH AND WELLBEING BOARD | | |
| **SUBJECT:** | | MONITORING PROGRESS OF THE JOINT HEALTH AND WELLBEING STRATEGY | | |
| **DATE OF DECISION:** | | 28TH JANUARY 2015 | | |
| **REPORT OF:** | | DIRECTOR OF PUBLIC HEALTH | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR**: | **Name:** | **Martin Day** | **Tel:** | **023 80917831** |
| | **E-mail:** | **Martin.day@southampton.gov.uk** | | |
| **Director** | **Name:** | **Dr Andrew Mortimore** | **Tel:** | **023 80832304** |
| | **E-mail:** | **Andrew.mortimore@southampton.gov.uk** | | |
| **STATEMENT OF CONFIDENTIALITY** | | | | |
| None | | | | |

**BRIEF SUMMARY**

This report informs the Health and Wellbeing Board of arrangements for monitoring the current Joint Health and Wellbeing Strategy, and makes reference to initial thoughts for refreshing the strategy in 2016.

**RECOMMENDATION:**

(i) That the report be noted.

**REASONS FOR REPORT RECOMMENDATIONS**

1. To notify the Health and Wellbeing board of arrangements for monitoring the current Joint Health and Wellbeing Strategy, and setting out initial thoughts for refreshing the strategy in 2016

**ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

2. None.

**DETAIL (Including consultation carried out)**

3. The work programme for 2014/15 indicated that a report would be coming to this meeting updating the Board on the progress made in delivering the Joint Health and Wellbeing Strategy 2013-16. However staff illness has meant this is not possible, and the information will now be presented to the next meeting in March 2015.

4. It would be appropriate, however, to place on record that Health and Wellbeing Board members have had informal conversations about refreshing the Joint Health and Wellbeing Strategy. The view that emerged was that strategy should not be refreshed until the intentions of the government in office following general elections in May 2015 were known. It is likely that details of the intentions for health and care will be fleshed out in late 2015/early 2016, so there would be no sense or benefit in attempting to undertake this work prior to 2016.

The Board members were also of the view that the second Joint Health and Wellbeing Strategy should attempt to address some of the health inequalities that have shown little movement over the past decade.

**RESOURCE IMPLICATIONS**

**Capital/Revenue**

5. None.

**Property/Other**

6. None

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

7. Health and Social Care Act 2012

**Other Legal Implications:**

8. None.

**POLICY FRAMEWORK IMPLICATIONS**

9. None.

**KEY DECISION?** No

| | |
|---|---|
| **WARDS/COMMUNITIES AFFECTED:** | All |

## SUPPORTING DOCUMENTATION

**Appendices**

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|---|---|
| 1. | None |

**Documents In Members' Rooms**

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|---|---|
| 1. | None |

**Equality Impact Assessment**

| | |
|---|---|
| Do the implications/subject of the report require an Equality Impact Assessment (EIA) to be carried out. | No |

**Other Background Documents**

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| | Title of Background Paper(s) | Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable) |
|---|---|---|
| 1. | None. | |