Lancashire County Council

Lancashire Health and Wellbeing Board

Thursday, 16th October, 2014 at 2.00 pm in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part 1 (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members of the Board are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the meeting held on the 1st September 2014**	(Pages 1 - 4)
4.	**NHSE Funding Transfer to Social Care**	(Pages 5 - 8)
5.	**Lancashire Safeguarding Children's Board Update**	(Pages 9 - 58)
6.	**Children and Young People's Emotional Health and Wellbeing**	(Pages 59 - 66)
7.	**Screening and Immunisation Programmes Update**	(Pages 67 - 104)
8.	**Update from the Joint Officer Group**	
	(a) Starting Well, Living Well and Ageing Well Progress Report	(Pages 105 - 164)
	(b) Six Shifts JSNA Update	(Pages 165 - 168)
	(c) Health Behaviours JSNA Update	(Pages 169 - 172)
	(d) Pharmaceutical Needs Assessment	(Pages 173 - 380)
9.	**Healthier Lancashire**	

Lancashire County Council

Oral report to be presented by Sam Nichols

10. Urgent Business

An item of Urgent Business may only be considered under this heading where, by reason of special circumstances to be recorded in the minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Members' intention to raise a matter under this heading.

11. Date of Next Meeting

The next scheduled meeting of the Board will be held at 2pm on 29th January 2015 in Cabinet Room C at County Hall, Preston.

I Young
County Secretary and Solicitor

County Hall
Preston

Lancashire Health and Wellbeing Board

Minutes of the Meeting held on Monday, 1st September, 2014 at 3.00 pm in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

Chair

County Councillor A Ali, Cabinet Member for Health And Wellbeing (LCC)

Committee Members

County Councillor T Martin, Cabinet Member for Adult and Community Services (LCC)
Mr S Gross, Executive Director for Adult Services, Health and Wellbeing (LCC)
Ms L Taylor, Interim Executive Director for Children and Young People (LCC)
Dr A Bowman, Greater Preston Clinical Commissioning Group (CCG)
Dr P Benett, Fylde and Wyre Clinical Commissioning Group (CCG)
Mrs G Stanley, Chairperson of Healthwatch
Councillor B Hilton, Central Lancashire District Councils
Councillor C Little, Fylde Coast District Councils
Ms L Norris, Lancashire District Councils (Preston City Council)

1. Apologies

Apologies for absence were received from County Councillor M Tomlinson, County Councillor D Whipp, Dr S Karunanithi, Dr G Bangi, Dr M Ions, Dr D Wrigley, Mr R Jones, Professor H Tierney-Moore and Canon Wedgeworth.

2. Disclosure of Pecuniary and Non-Pecuniary Interests

There were no disclosures of interest in relation to items appearing on the agenda.

3. Better Care Fund for Lancashire

A report was presented in relation to the revised process for submitting the Better Care Fund Plan (BCF) for Lancashire and the changes that had been made to the content of the Plan that had previously been approved and submitted in April 2014.

In presenting the report the Chair acknowledged concerns regarding the process and the short notice in relation to the arrangements for the meeting and explained that there was a limited timescale in which to revise the BCF Plan and take it through the necessary governance processes in order for it to be submitted before the 19th September 2014 deadline.

It was reported that the new guidance and templates represented a significant change from what had previously been approved. More detail was now required in a number of areas (as set out in the report) including how the activity shift away from acute activity

would be delivered, clarification of financial benefits and in relation to risk sharing and contingency arrangements.

The revised guidance had also removed the "pay for performance" (PFP) link to the existing metrics and had linked PFP to a single metric based around reducing non-elective admissions to hospital.

It was recognised that the County Council, CCGs and Lancashire Commissioning Support Unit (CSU) had worked to produce the information for the revised submission and agree a target for the new metric with advice and support from NHS England. The revised submission would be similar to a business plan and would enable partners to better articulate the changes and how they would be delivered with some elements of the submission being developed further in the future in the light of additional guidance.

With regard to the Section 75 agreement (which would address the question of the level of financial risk for which all parties would be jointly affected) it was noted that whilst the Agreement was referred to in the revised submission it would not be finalised before the deadline. As a result a report on the arrangements for the Section 75 agreement and governance was expected to be presented to the next meeting of the Board for consideration.

The meeting was informed that initial guidance had indicated an expectation that each Board would set a target of 3.5% reduction in non elective admissions. However, this position had subsequently changed as there had been an acknowledgement that local targets which differed from the 3.5% reduction may be acceptable if a strong local evidence based explanation was provided at the time of submission.

It was reported that the Lancashire submission was expected to contain a target that was less that 3.5% in line with the evidence of current performance and trend data in this area and aligned with the 5 year operation plans of the CCGs. Using the most recent data available the target in Lancashire was likely to be somewhere between 1.92% and 2.0%. Having considered this point the members of the Board agreed that the revised BCF submission for Lancashire should be made on the basis of a target of approximately a 2.0% reduction in non-elective admissions to hospital as this was felt to be a more realistic and achievable.

It was noted that as with the previous BCF submission the County Council, CCGs, and the Board would be required to sign-off the final document though their individual governance processes before the deadline on the 19th September 2014. In view of the timescale it was suggested that the Chair and Deputy Chair be given delegated authority to agree any final amendments to the Plan in order that it could be submitted to NHS England on time

Resolved:

1. To note the contents of the revised BCF submission as set out in the report and agree that the Lancashire submission be taken forward on the basis of a target of approximately a 2.0% reduction in non-elective admissions to hospital.

2. That in view of the timescales the revised BCF submission be approved under the Councils urgent business procedure.

3. That an update on the revised BCF submission be presented to the next meeting of the Board.

4. That the Chair write on behalf of the Board to the Secretary of State for Health in relation to concerns about the process and implementation of the revised BCF submission and to highlight the complexity of Lancashire in relation to health and care footprints compared with other areas.

5. That a Sub Group of the Board be established to consider further the delivery/governance structures and performance management framework with a view to proposals being submitted to the Board for consideration.

4. Urgent Business

The Chair referred to recent news reports in relation to safeguarding issues in Rotherham and informed the meeting that he had asked the Lancashire Safeguarding Children Board to examine the issue in relation to the County. He also suggested that a presentation on safeguarding in Lancashire be presented to the next meeting of the Board.

Resolved: That a presentation in relation to safeguarding across Lancashire be presented to the next meeting of the Board.

5. Date of Next Meeting

It was noted that the next scheduled meeting of the Board would be held at 2.00pm on the 16th October 2014 in Cabinet Room 'C' – the Duke of Lancashire Room at County Hall, Preston.

I Young
County Secretary and Solicitor

Lancashire County Council
County Hall
Preston

Lancashire Health and Wellbeing Board
Meeting to be held on 16 October 2014

Electoral Division affected: All

Funding Transfer from NHS England to Adult Social Care 2014/15

Contact for further information:
Steve Gross, 01772 534286, Adult Services Health & Wellbeing

Executive Summary

For 2014/15, the Department of Health has transferred funding to support adult social care to NHS England as part of the NHS Mandate.

This report provides information on the transfer to Lancashire County Council, how it will be made, and the allocations due to the County Council under Section 256 of the 2006 NHS Act.

Recommendation

The Health and Wellbeing Board is requested to agree the transfer of £25,291,529 from NHS England to Lancashire County Council as set out in this report.

Background

For the 2014/15 financial year, NHS England will transfer £1,100 million from the Mandate to local authorities. £200m of this total is the first part of the Better Care Fund, intended to help local authorities and clinical commissioning groups prepare for the implementation of the full Better Care Fund pooled budget in 2015/16. For the avoidance of doubt, the 2014/15 element of the Better Care Fund does not have to be held in a pooled budget.

The amount to be paid to Lancashire County Council from the Area Team is £25,291,529. This includes a payment in relation to integration of £4,598,000.

Legal basis for the transfer

The payment is to be made via an agreement under Section 256 of the 2006 NHS Act. NHS England will enter into an agreement with Lancashire County Council and this will be administered by the NHS England Area Team (and not Clinical Commissioning Groups). Funding from NHS England will only pass over to the Council once the Section 256 agreement has been signed by both parties.

Lancashire County Council

Use of the funding

In summary, before the agreement is made, certain conditions must be satisfied as set out below:

Better Care Fund (BCF)

As set out in the BCF Planning Guidance, each Health and Wellbeing Board must have agreed its Better Care Fund plan in order to have access to its share of the national £200m Better Care Fund allocated in 2014/15. For Lancashire, this amount is £4,598,000.

Remaining s256 transfer

The remaining national £900m will be subject to the same arrangements as the s256 transfer was in 2013/14. For Lancashire, the amount is £20,693,529. The key arrangements are summarised as follows.

The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.

The joint local leadership of Clinical Commissioning Groups and local authorities, through the Health and Wellbeing Board, is at the heart of the health and social care system. NHS England will require that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards are intended to be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.

In line with their responsibilities under the Health and Social Care Act, NHS England will make it a condition of the transfer that local authorities and CCGs have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.

NHS England will also make it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

The funding can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The funding can also support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

Recommendation

The Health and Wellbeing Board is requested to agree the transfer of £25,291,529 from NHS England to Lancashire County Council as set out in this report.

The CCGs and Lancashire County Council have developed plans for spending on social care services in 2015/16 as part of the BCF plans. The Council intends to spend the NHS England transfer to social care funding in 2014/15 under these same plans.

As required by NHS England, the 2014/15 expenditure plans have been categorised as follows:

Service Area	**£000**
Community equipment and adaptations	5,532
Integrated crisis and rapid response services	1,614
Maintaining eligibility criteria	5,204
Reablement services	5,200
Telecare	787
Carer Services	6,955
	25,292

Consultations

'N/A'

Implications:
As set out in the report

Risk management

You must include a paragraph which outlines the risk management implications of following or not following the proposals contained in the report

Legal

The transfer of this funding will be subject to an agreement made between the County Council and NHS England under the provision of s256 of the NHS Act 2006. Such agreement imposes certain obligations and conditions on the County Council as recipient of this funding.

Financial

The Council will be unable to meet its financial obligations in relation to the relevant contracts and services if the funding transfer is not agreed.

Health and Wellbeing Board
Meeting to be held on 16 October 2014

Electoral Division affected:
All

Lancashire Safeguarding Children Board update
(Appendices 1 and 2 refer)

Contact for further information:
Kathryn Grindrod, Board Manager, Lancashire Safeguarding Children Board, 01772 538 352 Kathryn.grindrod@lancashire.gov.uk

Jane Booth, Independent Chair, Lancashire Safeguarding Children Board, 01772 538 352 jane.booth@lancashire.gov.uk

Executive Summary

This report provides an update to the Lancashire Health & Wellbeing Board on the following issues:

- Statutory Guidance stipulates that the Health and Wellbeing Board (H&WBB) and Local Safeguarding Children Board (LSCB) must work together in the pursuit of safeguarding and promoting the welfare of children and young people. The H&WBB and LSCB recently agreed a protocol to ensure consideration and discussion of respective annual reports. This report presents the 2013-14 LSCB Annual Report and seeks a response from the H&WBB.(See Appendix 1)

- Concerns about equitable access to support for children and young people in respect of emotional health and well-being have been a recurrent subject of discussion at the LSCB. This dates back to the last Ofsted inspection and concerns have also arisen in more recent Serious Case Reviews and other audit processes. As a result the LSCB asked for assurance from the commissioners and providers of Child and Adolescent Mental Health Services (CAMHS) and received reports at its July 2014 meeting. These reports did not provide sufficient assurance and the LSCB has therefore referred this to the H&WBB with a challenge from the LSCB.

- Events in other parts of the country have led to an increased level of national concern about the way services respond to children and young people at risk of Child Sexual Exploitation. Lancashire has a strong record on CSE with multi-agency teams in place and working to an agreed LSCB Strategy to ensure appropriate responses. This is not a recent development and services have been embedded here for a number of years. The Annual Report details current arrangements and together with information provided to elected members during September 2014 provides assurance that a sufficient and comprehensive service is in place. (See Appendix 2)

Lancashire County Council

Recommendation

The Lancashire Health and Wellbeing Board is asked to:

i. consider the LSCB Annual Report and agree any areas that need to be taken forward by the H&WBB itself;
ii. specifically consider the concerns raised about provision for children and young people with emotional health and well being needs, and agree any action required by the H&WBB; and
iii. consider information about services to support children and young people at risk of sexual exploitation.

Background and Advice

The H&WBB has a responsibility to ensure that the safeguarding and welfare of children is a cross-cutting theme in all areas of work; from needs analysis through to commissioning of services and service development.

The LSCB has a responsibility to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area and must ensure the effectiveness of what is done by each such person or body for those purposes.

LSCB Annual Report

The LSCB has produced an Annual Report setting out the work undertaken to safeguard children in Lancashire for the 2013-14 financial year. The report is attached for information. It sets out key successes and also areas for development for all LSCB member agencies during the coming twelve months. Whilst the H&WBB is asked to consider all areas of the report that are of relevance, the LSCB specifically wishes to draw Board members' attention to two key issues. A copy of the report is at Appendix 1

Emotional Health and well-being of children and young people

The LSCB invites the H&WBB to consider issues relating to services in respect of the emotional health and wellbeing of children and young people in Lancashire. Since the beginning of the year the LSCB has become increasingly concerned about mental health issues and in particular arrangements for CAMHS involvement with children and young people.

Relevant issues brought to the attention of the LSCB, through reviews and other pieces of work, include concerns about support with police cases where there are clear mental health issues; concerns about the management of young people with mental health needs on general hospital wards; and a recent thematic inspection of services for children displaying sexually harmful behaviours highlighted issues around risk assessment for young people who may pose a risk to themselves.

In addition, child suicides continue to be a concern for our Child Death Overview Panel locally and nationally and local self harm rates are significantly higher than the England average.

These things taken together caused the LSCB to seek assurance about the robustness of local provision, and reports were presented to the July LSCB meeting. Rather than being provided with assurance the LSCB remains concerned about access to support and provision of services for children and young people with emotional or mental health needs.

Child Sexual Exploitation (CSE)

A separate brief has been prepared to provide members with key information (attached at Appendix 2).

Consultations

The LSCB has consulted with all partner organisations in the preparation for the Annual Report.

In addition, those organisations providing services for children with emotional and mental health needs were part of the discussions at the LSCB.

LSCB Partner agencies have contributed to the report re CSE.

Implications:

This item has the following implications, as indicated:

- There are no direct implications for finance or human resource management;

Risk management

- The H&WBB and LSCB need to continue to coordinate their work to ensure no duplication of activity or areas of omission
- Robust CAMHS and lower tier services are essential to ensure the emotional and mental health and wellbeing of children and young people in Lancashire
- Likewise, all partner agencies need to be fully engaged with services and support for children and young people at risk of sexual exploitation

Conclusion

The LSCB will continue to monitor the effectiveness of multi-agency arrangements of CSE service provision in Lancashire, to build on the positive work outlined today.

The LSCB continues to seek assurance about the efficacy of provision for children and young people with emotional and mental health needs.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

LANCASHIRE SAFEGUARDING CHILDREN BOARD

ANNUAL REPORT 2013/14

Published: September 2014

1. Foreword by Independent Chair

It was my privilege to take on the role of Independent Chair of the Lancashire Safeguarding Children Board in at the end of March 2014. Nigel Burke had fulfilled this role for the previous five years and I am indebted to him for the commitment he showed to the work of the Board and the strong and effective structure I inherited.

This report covers the period from April 2013 to the end of March 2014, a period prior to my appointment. It presents information about safeguarding of children across Lancashire. This is no easy task as this is not a single picture. In reality there is a diverse picture with clear links between the prevalence of safeguarding issues and deprivation. Ensuring a clear focus on distribution of need and equitable provision of services is a key challenge.

The information in the report highlights an increasing level of need with an upsurge of referrals to Children's Social Care Services, more children being made subject of a Child Protection Plan and more becoming "looked after" by the Local Authority; all this at a time of shrinking resources across the public sector and significant budget challenges.

This report identifies good practice but also areas for development. The Board recognises that, in a climate where there is little likelihood of new resources, development and improvement of services will have to be achieved by agencies working together more effectively. A particular challenge is to refocus resources on early help for children and families and we have seen a continuing increase in the numbers of children and families supported by a lead professional using the Common Assessment Framework. The report also reflects the work of the Board and its sub-groups. Agency engagement with the Board is strong, with membership at an appropriately senior level. The sub-groups involve a large number of professionals and these groups drive forward the business of the Board.

My thanks go to the staff in the Board Management Team who keep all this work on track and to the very many professionals and volunteers who work to safeguard children and support families across Lancashire. It has become a cliché to say that safeguarding is everyone's business but it is none-the less true. Acts of abuse and neglect blight a child's life and it is for each of us to use our energies and influence to ensure children in Lancashire are as safe as they can be.

Jane Booth
Independent Chair,
Lancashire Safeguarding Children Board

2. Contents

1. Executive Summary

It is recognised that Lancashire is a large and diverse county with complex demographics and significant local variation in deprivation and levels of need. This annual report has sought to provide a clear analysis of these trends and characteristics in relation to the safeguarding of children on a multi-agency basis. The LSCB and its partner agencies have made significant efforts to address these issues and continue to provide good services in the face of difficult financial challenges and subsequent organisational re-structuring. Throughout these organisational challenges the LSCB has continually sought assurance from agencies that any re-structuring of services does not negatively impact on the safeguarding of children.

The qualitative and quantitative evidence from the analysis of data, audits and reviews summarised in this annual report highlight a number of strengths and areas for development.

Key areas for development and further analysis exist around:

1. The application and understanding of thresholds and the continuum of need
2. Continued awareness raising and analysis of the risks presented through use of the internet and social media
3. Embedding the use of the refreshed CAF process and ensuring timely and appropriate early support services
4. The effectiveness of the Multi Agency Safeguarding Hub (MASH)
5. Domestic abuse data and evidence of the effectiveness of services on a countywide basis
6. Awareness of Private Fostering requirements and monitoring of number of cases
7. Engagement with private sector children's homes
8. Accurate monitoring of single agency training (quality and quantity)
9. The incidence of self harm and causal factors
10. Alcohol use by young people
11. The higher than average incidence of smoking during pregnancy and infant mortality
12. Ensuring assessments are multi-agency and holistic; especially regarding: voice of the child, the role of men/fathers, accurate and up to date information, professional challenge / scepticism, consideration of historical information
13. Ensuring services target resources to areas of need effectively
14. Accurate and regular performance data on a countywide basis from health agencies

The LSCB needs to be sighted on these areas throughout the current year and continue to seek evidence of effectiveness so it can scrutinise and challenge agencies to ensure children are safeguarded as affectively as possible.

Notwithstanding these areas for development, there have also been significant successes and strengths identified through this analysis. Most notably:

1. The supervision audit found that nearly all agencies had good arrangements in place
2. All agencies are largely compliant against the section 11 audit indicators with no inadequate ratings
3. Multi-agency practice inspections have identified a significant number of strengths, particularly around support for frontline staff, multi-agency practice generally and particularly in response to CSE
4. The Esafety Live conferences received extremely positive feedback from all attendees (of which there were over 200) examples of comments received include:
   "Extremely valuable session and delivered in a pacy and engaging manner."

"This was probably the best, most worthwhile 2 hours spent out of school. It was highly detailed, up-to-date, a little daunting but ESSENTIAL."

"This was an excellent session that has given some fantastic information out, including free resources. I am really pleased I attended."

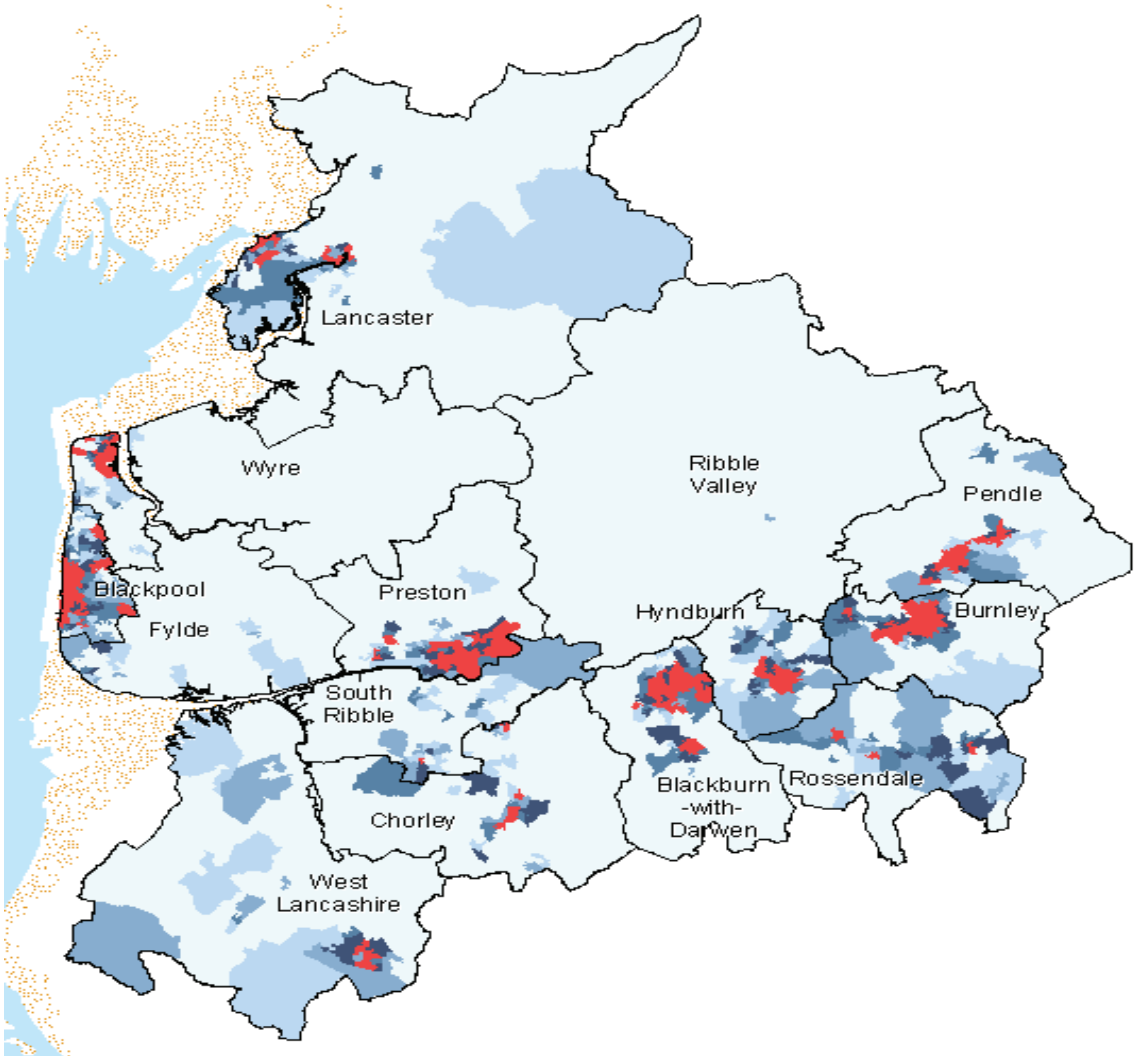
"Fabulous inspirational session. Lots of thoughts and plans to take forward."

5. UHMB have completed their action plan for improving safeguarding arrangements (though issues still remain for the trust in other areas)
6. 94% of attendees on LSCB training courses found them to be good / excellent
   Learners have stated that training provided them with:
   "A deeper understanding of the effect on children and young people who have suffered neglect"
   "Better understanding of DV relationships will help me recognise this as an issue and hopefully help with risk management/ strategy plans to address issues"
   "General knowledge gained from the course will help me to identify non-accidental injury sites and marks"
7. Ofsted's thematic inspection of neglect praised Lancashire's "whole-system approach to neglect" and was complimentary of the LSCB's Neglect Strategy
8. Lancashire Constabulary HMIC inspection of domestic abuse highlighted that:
   "*Police officers and staff provide a good service to victims of domestic abuse in all areas and help to keep them safe"* and *"staff demonstrated a high level of commitment and awareness and that they work well with partners"*
9. Practitioners feedback from SCR learning included the following comments:
   "I am more aware of multi-agency working and making sure that a full chronology is gathered on all aspects of the family"
   "It has reinforced a lot for me about not taking things at face value and being persistent"
10. The materials for the Safer Sleep Campaign have received some very positive feedback; for example the following quotes from parents:
    "Makes me want to pick it up and read it"
    "Love the bright colours – much less sombre and intimidating than the old one"
    "I like the way it is set out with 6 steps to follow and a lot more appealing with the images and colours. I also liked the sections on bed sharing and what baby should wear to sleep in"
11. The NSPCC delivered child abuse awareness raising sessions to children in 498 primary schools. Feedback indicated that 100% of schools would recommend the sessions to others and 80% of pupils could correctly identify abusive and non-abusive scenarios after the sessions.

2. Local Background and Context

Lancashire is a large and diverse Shire County with one County Council and 12 District Councils. Within the old county footprint there are two unitary authorities, Blackpool and Blackburn with Darwen who have separate administrations and separate Local Safeguarding Children Boards who provide their own Children Safeguarding Board Annual Report. The total population in Lancashire is approximately 1.9 million. Within Lancashire, there are pockets of severe social and economic deprivation. Four Lancashire Districts (Burnley, Hyndburn, Pendle and Preston) are in the "top 50" most deprived in England according to the Index of Multiple Deprivation 2010. There are also large areas of economic prosperity such as Ribble Valley and Fylde Borough. The map below shows the 'indices of multiple deprivation' across the county with dark and red areas identifying the most deprived places.

Figure 1

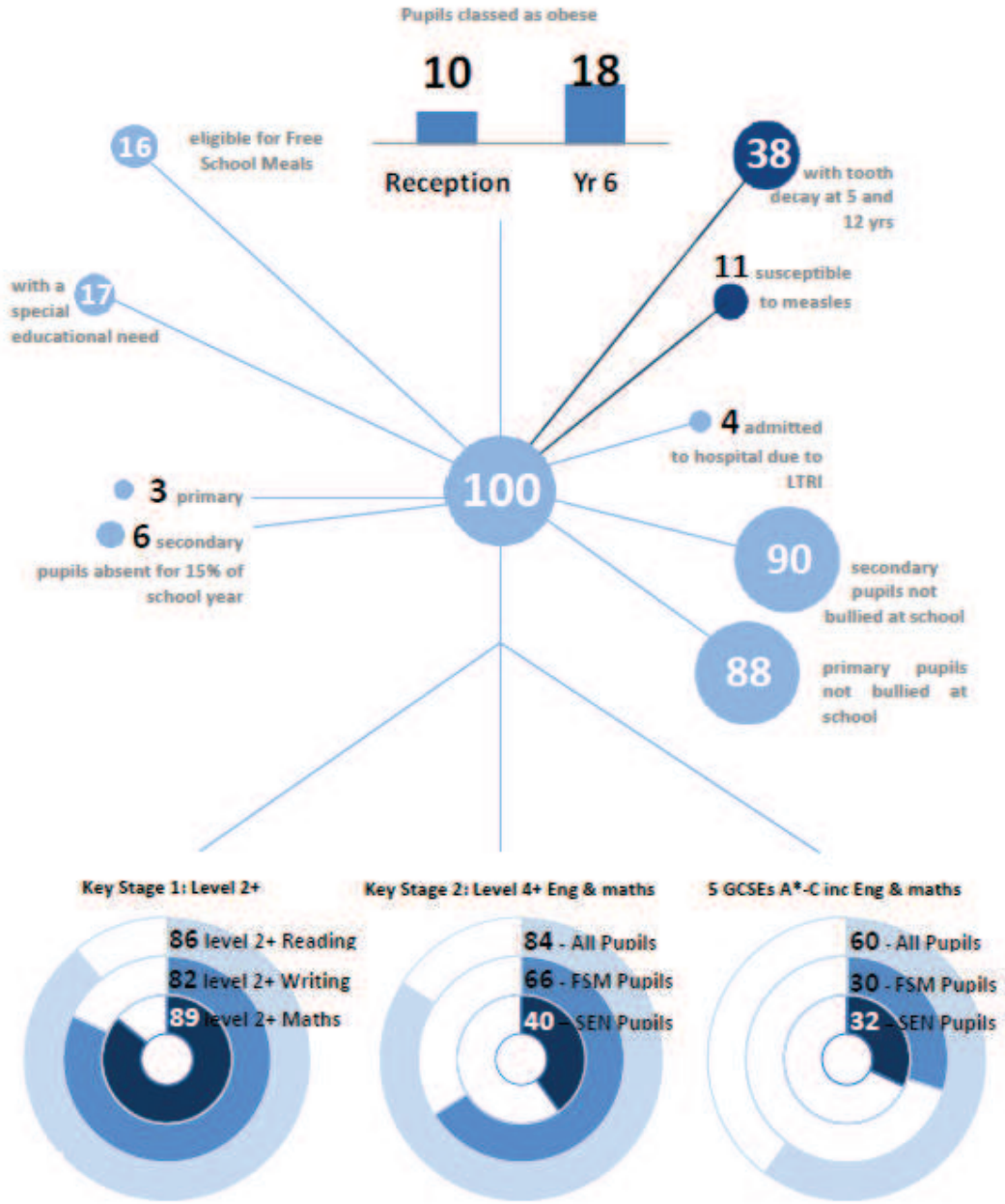


(Source – LCC JSNA 2013)

What do we know about Children in Lancashire?

Lancashire has a child population of around a quarter of a million and within this population. The Joint Strategic Needs Assessment identifies a diverse range of needs and demographic factors and has set these out diagrammatically:

If Lancashire was a Village of 100 children then:



(Source – LCC JSNA 2013) (LTRI – Lower Respiratory Tract Infection)

National comparator data shows that Lancashire is worse than the national average in:

- Tooth Decay rates
- Obesity rates (reception class)
- Teenage conception rates
- Educational Attainment rates (Key Stage 1)

And better in:

- Educational Attainment rates (key stage 2)
- Obesity rates (year 6)
- School Attendance rates
- Number of Pupils achieving 5+ GCSEs including Eng & Maths

What do we know about vulnerable children?

Safeguarding and related Health and Wellbeing indicators show a pattern of inequalities which closely correlate with indices of deprivation referred to above. Child mortality rates and educational attainment also closely correlate with these indices of deprivation.

The table below summarises key health and economic indices based on the most recent data available (2013)

Red = significantly worse, Green = significantly better, Amber = no significant difference

Indicator	Eng Average	Lancs Average
Low birth weight of term live births	2.8	2.7
Parental Smoking at time of delivery (SATOD)	12.7	18.8
Infant mortality (Rate per 1,000 live births)	4.1	4.8
Children aged 4-5 classified as overweight or obese	22.2	23.5
Children aged 10-11 classified as overweight or obese,	33.3	32.4
Children in poverty (all dependent children under 20)	20.1	17.8
Children in poverty	20.6	18.2
Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm	346.3	476.3
Rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years), per 10,000 resident population	103.8	138.8
Under 18s admitted to hospital with alcohol specific conditions: rate per 100,000 population	42.7	71.9
Accident and Emergency attendances for children aged 0-17 years (2010/11 – most recent data)	353.9	380.1

Self Harm rates give rise for concern as they are significantly above the national average. Further analysis into self harm data by Child and Maternal Health Intelligence (CHIMAT), 2011[1] gave a deeper insight into this issue, which is common to the North West Region. From their analysis the following key points emerge regionally:

- Rates for young females are 3.7 times higher than the rate for young males
- Emergency hospital admissions for self-harm increase as deprivation increases
- A&E attendances are highest between 10 p.m. and 1 a.m., between Saturday and Monday and in the first quarter of the year

Lancashire only analysis shows:

- Burnley General hospital has the highest rates, Royal Lancaster the lowest
- Lancashire's rate is slightly below the regional average

Additionally a research project conducted by the Lancashire Child Death Overview Panel looking at children who had died as a result of their own actions made the following key findings:

- 16 out of 21 cases were male

[1] Self-harm among children in the North West: accident and emergency attendances 2007–2009 and emergency hospital admissions 2007/08–2009/10

- Differential categorisation of deaths between coroners was evident
- Strong link with 'emotional distress' but not diagnosed mental health issues
- Inconsistency in support services for children with emotional distress across County

These recommendations have been taken forward by the CAMHS commissioning team in Lancashire County Council and used to inform commissioning arrangements.

It is therefore important that the issue of suicide and self harm remains a key strategic priority for the LSCB and partner agencies for the coming year and beyond.

Alcohol use among young people is also clearly an issue in Lancashire and this is reinforced by concerns expressed by young people in an LSCB survey in 2012 where alcohol was one of the issues they were most concerned about. Again the LSCB needs to consider how this features in its priorities and plans for the coming year and beyond.

Vulnerable Children

The table below provides a summary of the numbers of children / notifications under each category

Category	Number	Comparator	Comments
Privately Fostered Children	25	Not available	Previous years were 33, 25, 26
LADO Allegations / Investigations	715	Not available	A significant increase on previous years which were 652 in 2011-12 and 636 in 2012-13
IRO Caseloads	117	Not available	50-70 recommended caseload in national guidance (IRO Handbook)
Children Looked After[2] (CLA) (rate per 10k)	65.8	60 (Eng Avg)	Increase from previous year which was 60.9
Number of children identified as Children in Need	Not available	Not available	Data not available at present
Number of occasions on which children have been reported as "Missing From Home"	2,369	Not available	
Referrals regarding Honour Based Violence	28	Not available	
Referrals regarding potential Forced Marriage	16	Not available	
Percentage of Children with Special Educational Needs in Lancashire schools	17.2%	19.8% (Eng Avg)	
Young Carers	3,700 (est)	Not available	Youngest reported is 5 years old.
Children living in Private/Independent Children's Homes	97	N/A	Lancashire a net importer of CLA

Referrals to Children's Social Care

[2] A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours.

2014 saw an upsurge in child safeguarding activity. Rates of referrals to children's social care, core assessments, Section 47 enquiries, child protection plans and children being looked after all rose sharply.

NO/RATE	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Lancashire (average number/month)	1,659	1,470	1,389	1,175	1,370	1,677
Lancashire (rate per 10K)	778	724	606	548	726	827.2
England	**497**	**548**	**557**	**533**	**521**	**Awaiting**

Re-referrals

The proportion of re-referrals to children's social care in Lancashire had been fairly consistent for a number of years with some improvement between 2011 and 2013. However this trend has reversed in 2013-14 with a net 33% increase in this period. The Local Authority has examined reasons for this sharp increase and it would appear there have been some issues with how re-referrals are classified on the new ICT system and the process for 'contacts' being converted to 'referrals'. An audit conducted estimates that around a third of re-referrals were incorrectly categorized which would explain the sharp increase and bring the figure largely in line with previous year.

LANCASHIRE	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
%	24.6	25.8	25.4	23.2	20.5	30.7%

Referrals to Children's Social Care resulting in Initial Assessment

This indicator is a proxy for several issues: the appropriateness of referrals coming into social care, which can show whether local agencies are working well together; and the multi-agency understanding of thresholds which are being applied in children's social care at a local level.

Area	2007/0	2008/0	2009/1	2010/1	2011/1	2012/13	2013/14
Lancashire	39%	35%	48%	65%	74%	74%	64%
England	**59%**	**64%**	**66%**	**72%**	**79%**	**74%**	**Awaiting**

Number of Children subject to a Child Protection Plan (CPP) per 10k child population

Lancashire has experienced a rapid increase in CP cases and while the rate is still below the national average, it reflects a significantly higher demand for services. The current rate is more than 50% higher than in 2012-13.

AREA	2008-09	2009-10	2010-11	2011-12	2012-13	2013/14
Lancashire rate	26	27	27	23	36	44.4
England rate	**31**	**36**	**39**	**38**	**38**	**Awaiting**

The distribution of Child Protection Plans across the 12 districts of Lancashire varies significantly. Unfortunately data for 2013/14 is not available at present due to the Local Authority's new ICT system not being fully operational at the time of writing. Distribution charts will be published on the website once this information is available.

The vast majority of child protection plans in Lancashire arose from concerns about emotional abuse and neglect (46% of all plans). A minority of plans are put in place because of physical abuse (11%) and sexual abuse (8%). There are significant district variations in these figures.

Child Protection Plans Lasting Two Years or More

This measure provides in indication of whether children or young people and their families are receiving the services necessary to bring about the required changes on a timely basis – a long period on a CPP may reflect drift and lack of targeted support. This figure has risen since previous year but has consistently been lower than the national average.

Area	**2007/08**	**2008/0**	**2009/1**	**2010/11**	**2011/1**	**2012/13**	**2013/14**
Lancashire	5.0%	2.9%	3.8%	4.8%	4.4%	2.7%	3.7%
England	**5.3%**	**5.8%**	**5.9%**	**6.0%**	**6.0%**	**5.2%**	**Awaiting**

Children Looked After (CLA)

Lancashire's rate (per 10k) of CLA is now largely in line with national averages as illustrated below. This is as a result of a significant increase locally for the second year with an increase of 11% in 2012-13 and a further 10% in 2013-14.

Rate	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**
Lancashire	50	52	53	54	60.9	66.3
North West Rate	**71**	**76**	**77**	**76**	**79**	**Awaiting**
England Rate	**55**	**59**	**59**	**59**	**60**	**Awaiting**

There are significant variations in these rates across the County. Unfortunately data for 2013/14 is not available at present due to the new Local Authority ICT system not being fully operational at the time of writing. Distribution charts will be published on the website once this information is available.

The primary reason recorded for the child being looked after is illustrated in the table below:

	Abuse Or Neglect	**Family Dysfunction**	**Family In Acute Stress**	**Child Illness Or Disability**	**Absent Parenting**	**Parental Illness Or Disability**	**Socially Unacceptable Behaviour**	**Total**
Burnley	187	16	7	1	2	5	2	220
Chorley & S Ribble	123	21	7	0	2	3	0	156
Fylde & Wyre	125	12	7	1	2	1	0	148
Hyndburn & Ribble Valley	130	17	10	0	6	1	1	165
Lancaster	73	18	13	0	4	3	1	112
Pendle	142	20	7	0	0	7	1	177
Preston	129	20	14	1	6	0	0	170
Rossendale	63	13	8	2	1	1	0	88
West Lancs	89	18	5	1	0	4	0	117
Total	**1061**	**155**	**78**	**6**	**23**	**25**	**5**	**1353**

Abuse and neglect are clearly the most common reasons for children being looked after. As would be expected the more economically deprived districts have the highest rates.

Child Sexual Exploitation (CSE)

Lancashire has been collating data on the children referred to the Police or Children's Social Care for a number of years now. The table below shows the number of referrals made.

Division	April 2011 – Sept 2011	Oct 2011 - March 2012	April 2012 – Sept 2012	Oct 2012 – March 2013	April 2013 – Sept 2013	Oct 2013 – Mar 2014
West	260	218	156	141	214	272
South	219	160	164	136	146	121
East	306	328	338	372	362	313
HQ						2
Total	**785**	**706**	**658**	**649**	**722**	**708**

62% of referred young people were aged between 13 and 15 and 95% were white; similar to levels seen in previous reports. The majority of young people referred for CSE continue to be female. However, over the last 6 months of the year there has been a notable increase in the number of young males referred as potential victims of CSE. Boys now constitute 22% of referrals over the period compared to 8% previously and this will continue to be monitored to ascertain whether it is a longer term trend.

Children Missing from Home (MFH)

Breakdown of MFH Statistics October 2011 – March 2014

	Oct 2011 – Mar 2012	Apr – Sept 2012	Oct 2012 – Mar 2013	Apr – Sept 2013	Oct 2013 – Mar 2014
MFH episodes	3358	3269	2696	2779	2588
Number of individual children reported	1356	1453	1107	1203	1077
Mean missing episodes per month	2.48	2.25	2.44	2.31	2.40
Most frequent missing person	59 occasions	41 occasions	22 occasions	32 occasions	48 occasions
No of top 20 most frequent MFH cases also referred for CSE	18	17	9 (2 further intel) re potential CSE)	12	9

The number of children reported missing has fallen slightly compared to previous year's data. There is a relationship between CSE and MFH but this is not highly correlated with much of CSE occurring whilst not MFH. There has been a slight decline in the number of MFH referred for CSE compared to previous year.

Summary

Ensuring appropriate provision and equity of service access across the complex and diverse area that comprises Lancashire is a key challenge for all agencies providing services. There has recently been a clear increase in the demand for Children's Social Care services (which is also a national trend though the increase in Lancashire is largely above national averages on most indicators illustrated above) and the Local Authority and its partners are meeting this challenge effectively by largely maintaining performance levels and in some cases improving on previous years. Child sexual exploitation continues to be a priority for partner agencies in Lancashire and identification of young people at risk continues to be high. Lancashire has challenges around the use of alcohol by young people, self harm and smoking in pregnancy.

Engagement with private children's homes remains a challenge, especially in light of the number of establishments in Lancashire, and future activity will explore how the LSCB can engage with and hold them to account more effectively.

Case Studies

Child Protection Process

In this case there was disagreement between Children's Social Care and other agencies as to the need for an initial child protection conference, as opposed to continuing support under as part of a child in need plan. The IRO had discussions across agencies leading to the development and review of detailed chronologies to inform decision making. This led to an agreement that an initial conference would be convened; resulting in the development of a child protection plan, which by the first review was achieving a greater commitment from the parents and importantly improvements in the care afforded to the children.

Emotional Health and Well-being

The children and families team were asked to attend an initial case conference for a family that had recently moved into area, following mother fleeing her current partner who was abroad at the time. The family had suffered from a long standing history of domestic abuse, through various partners, including mother's current partner. The case was additionally complex as the family had moved to 22 different areas in the last 8 years.

Health agencies worked together across boundaries to provide historical information and records which brought to light CAMHS information regarding the oldest child, identifying that she was suffering from emotional ill health, self-harm and suicidal thoughts due to concerns with the relationship between Mother and her partner. This information was key in acknowledging the impact that the historical and current domestic abuse was having on the oldest child.

Following effective multi-agency planning through the CP process the children have been offered one to one appointments and their health assessments completed. This has enabled the children's physical and emotional health needs to be identified and addressed along with gaining details of previous names to aid the location of the children's full medical records. The children have been referred to CAMHS for support with identified emotional needs. The Children and Parenting Support Service are providing one to one support to the mother regarding the impact of domestic abuse, from these it was also identified that she has some issues with depression and low self-esteem and is now receiving treatment for depression along with counselling through the women's centre on the impact of domestic abuse and being aware of indicators for future relationships

CAF / TAF

At the beginning of the 2014 the family hit difficulties and were seeking support. One of the children in the family was showing signs of oppositional defiance disorder and ADHD although this had not been formerly diagnosed. Mum in turn was having difficulty managing this behaviour and understanding her actions. The older sister had moved out once reaching sixteen and there had been concerns surrounding her new partner. Dad had recently been made redundant and was unable to find work, causing financial hardship for the family. Mum was reaching the point where she did not know what else to do and was becoming extremely distressed.

Through the CAF and TAF process a number of needs were identified and the family have engaged well with a range of local services which has enabled the following outcomes to be achieved:

- Elearning courses have been identified for mum to improve her parenting skills and develop skills for employment
- Mum has been offered a place at college
- Dad has gained an HGV licence through support from the job centre
- Dad has received support with anger management and positive role modelling
- The families health needs have been reviewed and further support identified
- Improvements in the children's behaviour following parenting skills support
- The family have a TAF plan in place and feel things are improving

3. What do we know about the effectiveness of Local Services?

Services in Lancashire

A broad range of statutory and non-statutory services are available across Lancashire: Key services in terms of safeguarding are provided by the following agencies:

a) Lancashire Constabulary – direct policing and partnership services as part of the Child Sexual Exploitation teams, Multi-agency Safeguarding Hub, Multi-Agency Risk Assessment Conferences and Multi-agency Public Protection Arrangements. The HMIC conducted a thematic inspection of the Constabulary's arrangements for dealing with domestic abuse and violence in February 2014 which concluded in the following: *"The public in Lancashire can have confidence that police officers and staff provide a good service to victims of domestic abuse in all areas and help to keep them safe. Tackling domestic abuse is a priority for the constabulary which has invested in well-trained and specialist staff. HMIC found staff demonstrated a high level of commitment and awareness and that they work well with partners."*
(Pp6, Inspection Report, 2014)

b) Lancashire County Council – Support to vulnerable children through direct services from Children's Social Care, Care, Early Support Services, Children's Centres and Schools Services and specific support for children involved in the criminal justice system via the YOT. A range of other council services, including Adult Social Care also support families. The most recent inspection by OFSTED in respect of Safeguarding and Looked After Children in February 2012 where Lancashire was judged as being 'Good with outstanding features'. Not-withstanding this, a number of recommendations for improvements were made and a detailed action plan was developed by the Local Authority in collaboration with the LSCB. This action plan was overseen at the Quality Assurance Sub-group but was not fully signed of in 2013-14. Action continued to be monitored during 2013/14 and there have been a number of challenges made where progress has slipped or stalled. This has resulted in positive action to improve progress (but some actions remain outstanding in relation to: timeliness of health assessments for CLA, IRO Caseloads, equitability of sexual health services and CAMHS

c) Clinical Commissioning Groups x 6 – Clinical Commissioning Groups are responsible for ensuring that the healthcare services they plan, commission (buy) and deliver are safe, effective and of the highest quality. They are also responsible for making sure that these services are value for money. Services commissioned for patients include, planned hospital treatment; diagnostic tests and appointments; urgent or emergency care; community health services, such as specialist or district nurses, speech and language therapy or rehabilitation; mental health services; maternity and newborn services; children's healthcare services; services for people with learning disabilities. These organisations have only been established in 2013/14 and while they have not been inspected yet they all have been required to demonstrate effective safeguarding arrangements as part of their registration requirements

d) Acute Hospital Trusts x5 – Provide a range of community and acute services including: A&E, health visiting, school nursing, CLA nursing, neo/ante natal care, paediatric services and a range of specialist services

There are 5 acute hospital trusts that serve the Lancashire area as follows:

1. University Hospital Morecambe Bay
2. Southport and Ormskirk

3. Lancashire Teaching Hospitals
4. Blackpool Teaching Hospitals
5. East Lancashire

University Hospital Morecambe Bay (UHMB) has been subject to an improvement plan since their 2011/12 inspection found the organisation to be inadequate in a number of areas including safeguarding. The LSCB has maintained consistent oversight of these improvements and sought assurance through senior managers at the LSCB and the Local Safeguarding Group in the North of the County and through the section 11 audit process where it is evident improvements are progressing satisfactorily. Also during 2013/14 the LSCB has received detailed assurances, presentations and corresponding evidence from the UHMBT senior management team that these improvements are progressing well and at April 2014 were nearing completion. The LSCB has also provided a place on the Board for a UHMBT representative to further facilitate cooperation, scrutiny and challenge.

Southport and Ormskirk and Lancashire Teaching Hospitals Trust provide services through Preston Royal Hospital, Chorley & South Ribble Hospital, Ormskirk District General Hospital and Southport and Formby District General. Currently the CQC have not identified any concerns in relation to safeguarding at any of these services although there are some areas for improvement as identified in each inspection report. (See - http://www.cqc.org.uk/content/publications)

East Lancashire Hospital Trust (ELHT) and Blackpool Teaching Hospital Trust have both undergone CQC inspections during 2013/14. Although issues and improvements were identified at both trusts there were no concerns raised in relation to Safeguarding practice. There was an issue at ELHT with the number of A&E staff trained in safeguarding which has been addressed throughout the year and the Trust representative has provided assurance and evidence that these improvements are progressing as planned.

e) Lancashire Care Foundation Trust – Provider of children's (CAMHS) and adults' mental health services, Psychology Services and universal children and young people services such as health visiting and school nursing in East, Central and West Lancashire. LCFT were last inspected by the CQC as part of the Safeguarding and Looked After Children inspection where improvements were identified around access to CAMHS as referred to above.

f) NHS England – Commissioning of primary medical care, dental services (including secondary dental), community, pharmacy and primary optical services, some specific public health screening and immunisation services, some CAMHS services (especially tier 4)

g) Lancashire Probation Services – offender management services. Lancashire Probation Trust was last inspected in 2011 and judged to be 'Good'. There were no concerns identified in relation to safeguarding.

h) CAFCASS – court and legal support for children and families. CAFCASS were inspected in 2010 by Ofsted and found to be inadequate in a number of areas. The LSCB has had oversight of the improvement plan and been assured that the necessary improvements are progressing satisfactorily with regard to any safeguarding related issues. At the time of writing (July 2014) it is noted that CAFCASS has recently been re-inspected and judged to be 'Outstanding', further details in relation to this will be covered in next year's annual report.

i) Private/Independent Sector Providers – community drug and alcohol services, sexual health services, domestic abuse services

j) Housing providers – wide range of private providers, Registered Social Landlords, hospices and hostels, sheltered housing provision and local authority housing[3]

k) Voluntary Community and Faith Sector – over 100 different VCFS organisations providing a wide range of service on a commissioned and non-commissioned basis (Eg – carers support, advocacy, fostering agencies, lobbying, consultation)

l) Schools – over 600 schools including 30 special schools and 13 short stay schools
There are currently no Schools judged to be inadequate with regard to safeguarding

m) Over 100 children's homes with a high percentage of private providers and out of area placements (Lancashire is a net importer of CLA)[4]

n) 79 Children's Centres. There are currently no Children's Centres judged to be inadequate with regard to safeguarding. Indeed all are currently judged to be good or excellent

o) 909 child minders, 343 day nurseries and 161 pre-school play groups

Children and families are also supported by many of the smaller private and voluntary sector organisations who work on a local basis in response to local need. The larger organisations provide or commission a range of services on a countywide basis but given the size and diversity of Lancashire service equity is a significant challenge.

In addition to single service inspections Lancashire was selected as one of the Local Authority areas for a national thematic inspection of Neglect. Although the inspection did not provide an overall judgement for participating areas Lancashire was commended with a number of examples of good practice. Specific reference was made to the Local Authorities research highlighting the need for early intervention and the LSCB's Neglect Strategy, action plan and quality assurance activities.

The Board itself exercises challenge and scrutiny of agencies using a number of mechanisms for assessing the quality of local services and agencies commitment to safeguarding children. These include:

<u>Multi-Agency Practice Inspections</u>
2 Multi-Agency Safeguarding Practice Inspection's have been completed in 2013/14 in the districts of Pendle and Hyndburn and Ribble Valley. These involved a range of activities such including case audits, focus groups, data analysis, interviews with key officers and observation of practice. A multi-agency inspection team carried out these activities together with a group of 'Young Inspectors' who provided feedback from the perspective of children and young people. The inspections highlighted a number of areas of strength and areas for improvement. Some of the key findings are summarised below:
The Pendle inspection:

- significant evidence of good practice leading to improved outcomes for children and families;

[3] A scoping exercise carried out in 2012/13 concluded that RSLs and Local Authority providers generally had good safeguarding arrangements but that private landlords often may not

[4] The LSCB receives notification of any provider that is judged to be inadequate by Ofsted with regard to safeguarding

- good multi-agency working and learning; relatively stable work force; and
- staff well supported by management on the whole

Areas for improvement:

- improving links with District Children's Trusts:
- participation of children;
- the to address the challenges related to agency changes – particularly the restructure of the Health economy.

The Hyndburn & Ribble Valley inspection:

- good evidence of a committed workforce
- good multi-agency working practices especially in relation to CSE
- CSC case management and involvement of children/young people commended.

Areas for improvement:

- staff turnover
- analysis of need in relation to agency resources/ demands
- availability of accommodation
- understanding of thresholds
- use of CAF

The areas for improvement are being considered by the District Children's Trusts and action plans have been developed to address issues identified. The delivery of these is being by the LSCB Quality Assurance Sub-group.

Section 11 Audit Process:

Section 11 of the Children Act 2004 sets out agencies responsibilities in respect of safeguarding children and the LSCB conducts and annual audit in all member agencies. The section 11 audit tool and quality assurance process were updated in 2013-14 to ensure all agencies are rigorously assessed with regard to having the necessary arrangements in place as specified. Almost all agencies were able to provide evidence of full compliance. Agencies who were not fully compliant with all sections of the audit – most commonly recoded deficits around training and supervision arrangements where not all staff have been trained to the correct level or have access to specialist safeguarding reflective supervision. Where these issues were present assurance has been provided that improvements are progressing and this has been confirmed through the quality assurance and challenge process. There are no outstanding 'red' indicators for any of the agencies at present.

Themed Audits

A Supervision Audit was completed in August and found that all agencies (except 1) had effective arrangements in place but there was an issue of consistency and a lack of a common approach. It was felt this would be improved by a greater awareness of the LSCB guidance. The Board issued a reminder or all agencies of the importance of ensuring all staff were familiar with policy and required action plans where there was not evidence of compliance. The lack of arrangements at UHMBT was raised as an issue which has been taken forward as part of their improvement plan (see above).

An audit of Common Assessment Framework assessments was completed in November. The use of CAF in recognising and responding to the 'toxic trio' (combined effect of domestic abuse, parental mental ill-health and parental substance misuse) is very mixed with significant variation between the localities. Good practice was observed especially when a multi-agency approach was taken. Key issues were identified around: lack of analysis, incomplete information, unclear outcomes, lack of historical information and the voice of child not being present. The audit took place prior to the revision of the CAF

assessment process. The findings of the audit confirmed issues which had already been recognised with remedial action built into the refreshed procedures.

Multi-agency Performance Information

The LSCB has developed a performance scorecard to present relevant safeguarding data and performance information from all key agencies. This scorecard has been reviewed in 2013/14 to ensure the most relevant and timely information is included. There still remains a challenge in obtaining regular performance data from the Health economy on a countywide basis which will continue to be pursued in 2014/15.

The end of year position is as follows:

Measure		Performance			Comparators		
		12/13	13/14	Trend	Eng	North West	Stat Neigh
Local Authority (based on availability of data at time of writing)							
LA1	Rate of Referrals	638	827.2	↑	520.7	619.7	-
LA2	% of Re-referrals	20.5%	30.7%	↑	24.9	26.4	25.7
LA3	No CAFs completed	2,659 (3/12-2/13)	2,829* (3/13-2/14)	↑	-	-	-
LA4	% of Referrals leading to no further action	25.1%	35.8%	↑	14.5%	16.4%	15.7%
LA5	No. of Children with CPPs	878	1,120	↑	-	-	-
LA6	% of Children with 2nd CPPs	12.3%	14.4%	↑	14.9%	-	15.2%
LA7	% of Children with CPPs 2 years +	2.7%	3.7%	↑	3.2%	3.3%	2.2%
LA8	No. of First Time Entrants to YJS (rate per 100,000)	964 (11/12)	672 (12/13)	↓	537	542	548
LA9	% of YP re-offending	41.2% (Oct-Sep 10)	40.3% (Jan-Dec 11)	↓	35.9%	-	32.6%
LA10	No. of Children in the household with a MARAC (MG)	TBC	2,965	N/A	-	-	-
LA11	No. of contacts and referrals due to domestic violence	12,120	5,331	↓	-	-	-
LA12	Troubled Families: No of families 'turned around' as %	28%	35%	↑	-	-	-
LA13	No. of CLA	1,482	1,612	↑	-	-	-
LA14	Rate of CLA (per 10,000)	60.9	66.3	↑	60.0	79.0	67.6
LA15	No. of CLA in	610	642	↑	-	-	-
LA16	No. of CLA out	485	479	↓	-	-	-
LA17	% of CLA with up-to-date Health Assessment	85.1%	74.7%	↓	87.3%	91.4%	82.5%
LA18	Average SDQ score (emotional health of CLA)	13.1 (11/12)	13.2 (12/13)	↓↑	14.0	13.0	-
Health							
H1	Infant mortality rate (aged under 1 year)	5.4 (11/12)	5.4 (12/13)	↔	4.1	4.5	4.3
H2	Smoking at time of delivery	18.4%	17.8%	↓	12.0	16.2	-
H3	A&E admissions for self harm (10-24yrs, rate per 100,000)	N/A	476.3	N/A	346.3	433.0	-
H4	Hospital admissions as a result of unintentional & deliberate injuries (0-14 Year olds)	142.3 (11/12)	138.8 (12/13)	↓	103.8	133.9	-
H5	A&E Attendances, 0-17 years, rate per 1000 (2010/11)	359.4	380.1	↑	359.4	-	-
H6	Under 18s admitted to hospital with alcohol specific conditions per 100,000	84.6 (09 - 12)	71.9 (10 - 13)	↓	42.7	69.1	-
H7	Crude rate per 1,000 (age 0-4 years) of A&E attendances	503.8	545	↑	510.8		
Measure		**Performance**			**Comparators**		
		12/13	**13/14**	**Trend**	**Eng**	**North West**	**Stat Neigh**

Police/MASH							
P1	Number of DA/V referrals where a child is present (MASH)	13,960 (11/12)	16,997 (12/13)	↑	-	-	-
P2	Number of vulnerable child referrals to MASH	N/A	6,793	N/A	-	-	-
P3	Number of CSE referrals	1,497	1,086	↓	-	-	-
P4	Children reported missing to Police	N/A	2,369	N/A	-	-	-
P5	% Children reported missing to Police who were CLA	N/A	14.9%	N/A	-	-	-
Young People							
Y1	% of primary school children reporting they have been bullied at school	8.6%	11.5%	↑	-	-	-
Y2	% of secondary school children reporting they have been bullied at school	8.2%	7.6%	↓	-	-	-
Y3	% of primary school children reporting they feel safe in and around school	96.9%	94.6%	↓	-	-	-
Y4	% of secondary school children reporting they feel safe in and around school	92.5%	90.6%	↓	-	-	-
Board Indicators							
B1	Number of cases reviewed by the CDOP	124	105	↓			
B2	Attendance at LSCB meetings	79%	75%	↓			
B3	Referrals to SCR Group considered within statutory timescale	100%	100%	↔			

The key findings from this noted by the Board are:

- Substantial increases in rate of referrals and percentage of re-referrals to CSC
- Considerable rise in the number of CAFs completed
- Greater proportion of referrals leading to no further action
- Much larger number of children with CPPs
- Notable decrease in rate of first time entrants to YJS
- Significant reduction in DA/V contacts and referrals
- Notable increase in percentage of troubled families turned around
- Number and rate of CLA rising
- Timeliness of CLA health assessments getting worse
- Significant reduction in rate of young people admitted to hospital with alcohol specific conditions
- Vast rise in the number of referrals in relation to domestic violence or abuse where a child is present
- Notable drop in the number of Child Sexual Exploitation referrals
- Higher proportion of primary school children reporting being bullied at school

Annual Reports

The Board also receives annual reports regarding the functions of the IROs, in report of Private Fostering, the work of the LADO, the secure estate (regarding children in custody), counter-terrorism / radicalisation and in respect of Local Authority Complaints, Compliments. There has been a significant increase in the number of complaints received directly from children and young people who are in local authority care; in 2013-2014 there were 22 compared to the previous year's figure of 11. There were 5 complaints with regard to the Safeguarding Process compared to only 2 in 2012/13.

Views of Children, Young People and Families

The LSCB identified participation and engagement with young people as a priority for 2013/14 and has now established effective links with the local Children and Young People's Participation Officer who meets regularly with the LSCB Coordinator to identify where the LSCB can be involved in planned activity and vice versa. The LSCB has involved young people in a number of initiatives throughout 2013/14 as follows:

a) Engagement in national 'take over day' via Lancaster Young Advisors - a young person co-chaired the LSCB meeting which proved a rewarding and useful experience and challenged LSCB members to ensure dialogue is meaningful and accessible to young people
b) Involvement of the Young Inspectors in multi-agency practice inspections (see above)
c) Commissioning Lancaster Young Advisors to complete a schools engagement project aimed at improving awareness of eSafety issues through a programme of peer tutoring. This work is currently ongoing and a full report will be available for the next annual report
d) Establishment of a young people's panel as part of the recruitment process for a new LSCB Chair

In addition to this the LSCB has consulted families through the local women's refuge as part of the Toxic Trio quality assurance activities.

As part of the SCR process the LSCB routinely consults and seeks the views of family members in relation to the review and ensures their views are appropriately reflected.

Analysis of Child Deaths

The Child Death Overview Panel reviews every child death in the county and analyses any factors that may have lead to the death in order to identify themes and trends for preventative measures. A summary of the key findings for 2013/14 are as follows:

- 24% of Lancashire deaths had modifiable factors*
- Nationally 72% of cases are completed within 12 months; 79% of Lancashire deaths have been completed within 12 months of the death occurring
- 62% of Lancashire deaths reviewed are of children under 1 year of age, this is slightly below the national figure of 63%
- 60% of pan-Lancashire deaths were of male children and young people (56% national average)
- The largest categories of pan-Lancashire child deaths are perinatal/ neonatal event (34.2%), chromosomal, congenital and genetic abnormalities (24.5%) and sudden unexpected, unexplained deaths (8.7%)
- The largest category of death with modifiable factors in Lancashire is perinatal / neonatal event (23 %)
- The categories of death with the largest proportion of modifiable factors (pan-Lancashire) were Deliberately inflicted injury, abuse or neglect (89%), Trauma and other external factors (63%), Suicide or deliberate self-inflicted harm (52%), and Sudden unexpected, unexplained death (52%)
- The most common risk factors identified from the pan-Lancashire cases identified to have modifiable factors are:
    1. 35% service provision (including access to health care, prior medical intervention, communication and/or access to other services e.g. housing)
    2. 31% smoking (includes smoking in pregnancy and in the household by parent or carer)
    3. 31% alcohol/ substance misuse by parent, carer and/ or child

*Factors which could be modified to reduce the risk of future child deaths

4. Statutory and Legislative Context for LSCBs

Section 14 of the Children Act 2004 and Working Together to Safeguard Children 2013 sets out the statutory objectives and functions for an LSBC as follows:

1. To coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
2. To ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:
(i) the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;
(ii) training of persons who work with children or in services affecting the safety and welfare of children;
(iii) recruitment and supervision of persons who work with children;
(iv) investigation of allegations concerning persons who work with children;
(v) safety and welfare of children who are privately fostered;
(vi) cooperation with neighbouring children's services authorities and their Board partners;
(b) communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;
(c) monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;
(d) participating in the planning of services for children in the area of the authority; and
(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in chapter 4 of the guidance.
Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

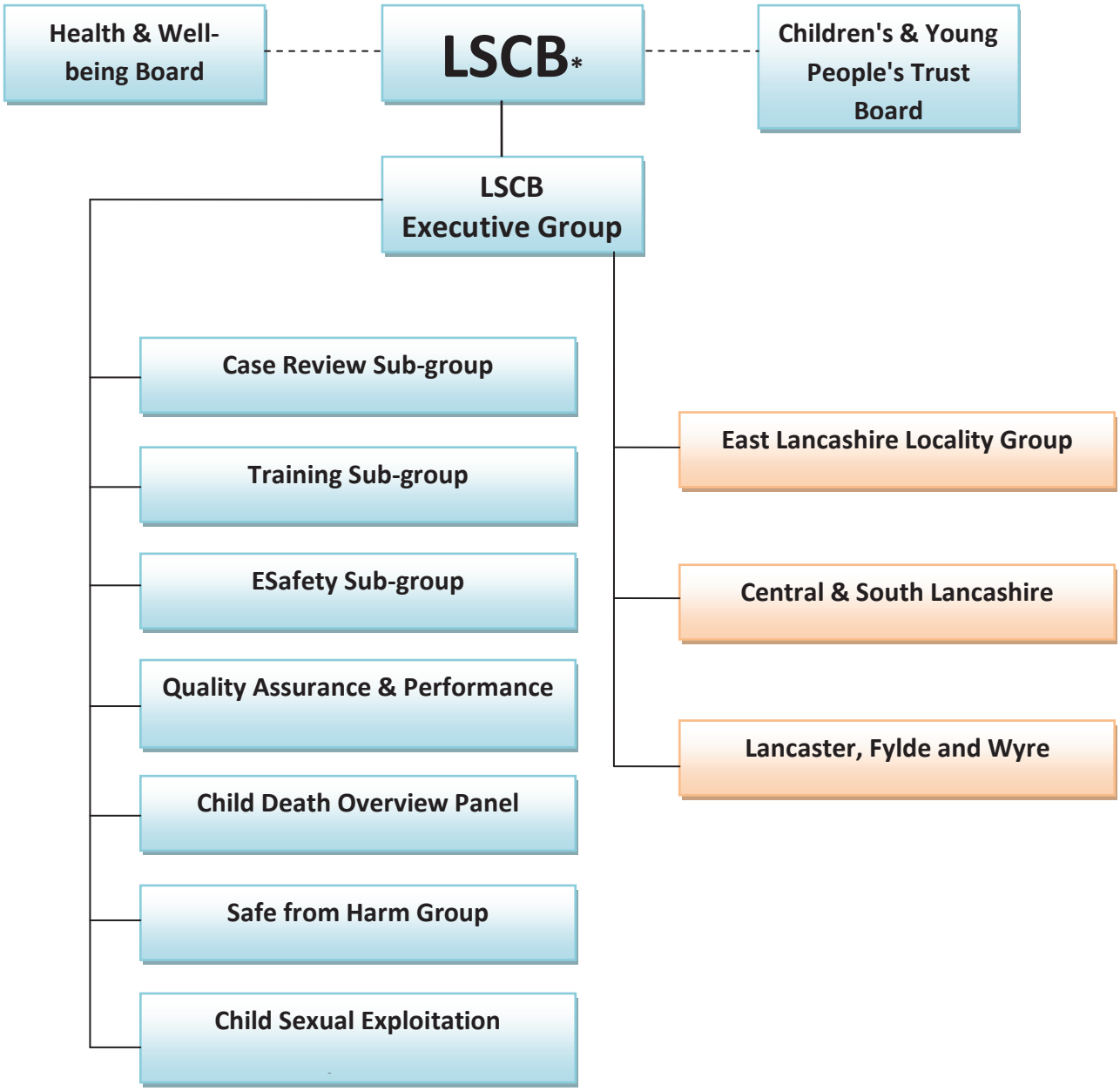
In order to fulfil its statutory function under regulation 5 an LSCB should use data and, as a minimum, should:

- assess the effectiveness of the help being provided to children and families, including early help;
- assess whether LSCB partners are fulfilling their statutory obligations set out in chapter 2 of this guidance;
- quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned; and
- monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children

5. Governance and accountability arrangements

The LSCB is now inspected as part of the local area Safeguarding and Looked After Children inspection carried out by Ofsted and according to the most recent guidance will receive a separate assessment and judgement. Previously it was assessed within the wider framework, as per the 2012 inspection in Lancashire where the LSCB was referred to positively. Lancashire was not inspected during 2013/14 so there is nothing to report in this respect, however, the LCSB has devoted a significant amount of resource to preparing for inspection and ensuring it can provide evidence against the key lines of enquiry outlined in the guidance.

The LSCB is structured as illustrated below. The chair is held to account by the Chief Executive of the Local Authority and its partners through a process of standardised appraisal. A challenge for the coming year will be embedding an effective relationship with the Corporate Parenting Board.



* Full Board membership can be seen at:
http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=3829&pageid=20792&e=e

The LSCB Executive Group continues to carry out the executive function and deals with the general business of the Board and has oversight of the Budget, Business Plan, performance information, risk register and any themed reports or annual reports required by the LSCB. The LSCB holds the Executive to account and ratifies / challenges any decisions made by the Executive where necessary.

Strategic Priorities

Partnerships in Lancashire such as the LSCB, Children and Young people's Trust, Health and Well Being Board and Community Safety Partnership all produce detailed strategic plans setting out the key outcomes to be achieved within a 3 year timescale. These plans are based on a detailed analysis of the needs, the aspirations of the Lancashire residents and the resources available to organisations to meet these needs and aspirations. The LSCB has arrangements in place to share its annual report with these key strategic groups and join up the business planning processes so priorities can be shared and reflected accordingly.

The LSCB Chair is also a member of the Children and Young Peoples Trust and a protocol is in place to define the relationship between the 2 groups and their chairs.
The LSCB's broad strategic priorities are currently as follows:

The Board will *ensure* that:

1. We improve the way we work by listening to and responding to the views and experiences of children and young people.
2. We make sure that services work well together, taking and sharing responsibility, to keep children and young people safe.
3. We make sure that the way we recruit, train and supervise those who work with children and young people will keep children and young people as safe as possible.
4. We make sure that everybody who works with children and young people knows that keeping them safe is an important part of their job.

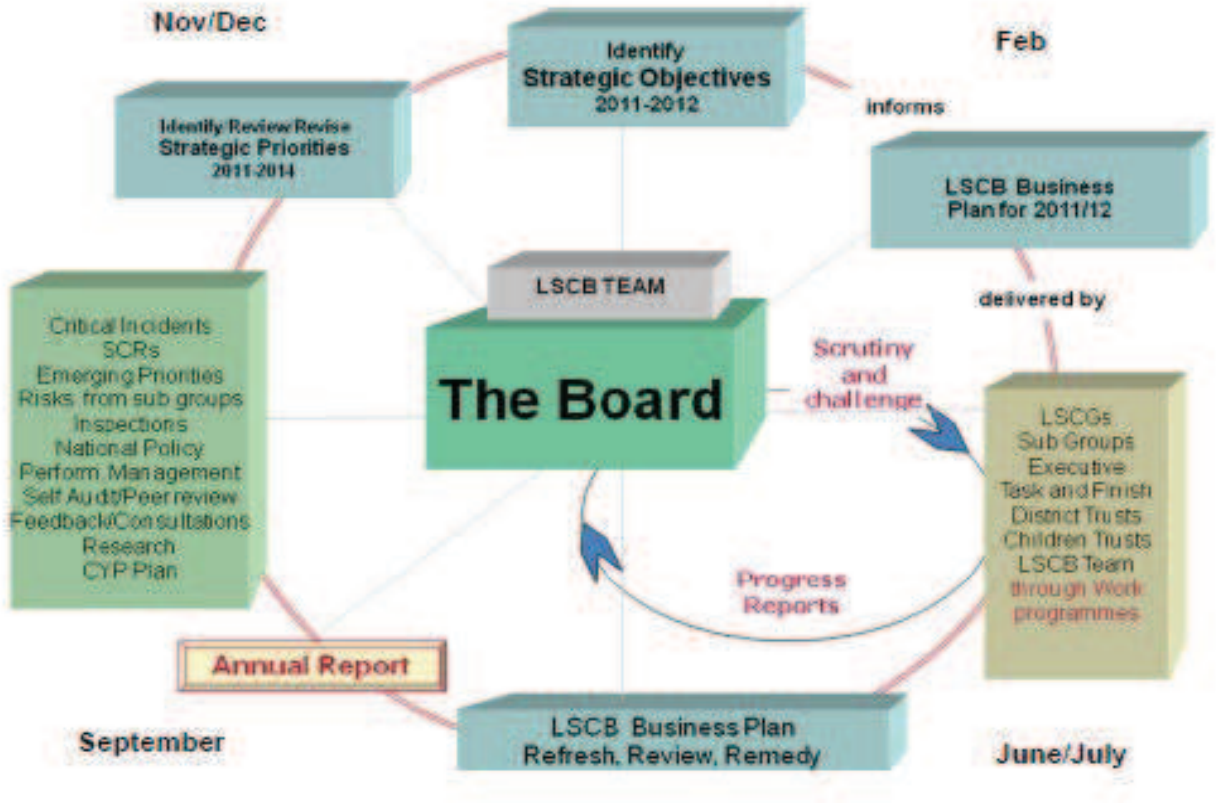
The Board will *take action* to:

5. Help children, young people, their families and communities keep themselves safe and know how to get help.
6. Monitor how well agencies safeguard and protect children and will challenge them when there are concerns about their performance.
7. Use Board resources effectively to give the best results for children and young people.
8. Implement necessary changes that come from research, serious case reviews and any national policy guidelines.

The following groups of children are recognised by the LSCB as potentially experiencing greater vulnerability:

- Children in Custody
- Children who are privately fostered
- Children experiencing neglect (see QA sub-group update)
- Children who are sexually exploited (see QA sub-group update)
- Children with disabilities
- Children Looked After, particularly those moving out of or into Lancashire
- Children of Travellers (especially educational outcomes, immunisations)

Based on these priorities the LSCB develops an annual business plan using the following planning cycle to ensure priorities and activity is up to date and reflects any changes in need or emerging issues:



The LSCB also has performance indicators which relate to the effectiveness of the LSCB, with the year end returns

Indicator	EoY 2013/13	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual	Target	Direction of Travel (at Q4)
Number of cases reviewed by CDOP	Not Available	25	30	23	28	26	Improved
SCRs referrals considered within timescale	100%	100%	100%	100%	100%	100%	Same
Attendance at LSCB Meetings	79%	80%	82%	71%	75%	80%	Improved
Percentage of Business Plan Actions completed within timescales	95%	90	90	90	95	90%	Improved

The LSCB also has in place; a risk management framework and risk register which is reviewed twice a year to ensure the appropriate controls are in place to mitigate against key risks to the delivery of LSCB business and the effectiveness of the partnership.

6. Key Achievements from LSCB Sub-groups

The work of the Board is delivered through a range of themed sub-groups as illustrated in the Board structure. Each sub-group has its own work plan which is drawn from the LSCB Business Plan which in turn is based around the Boards strategic priorities. The work plans have been reviewed for the year and key achievements are as follows:

Learning & Development

The principal purpose of LSCB learning & development sub-group is to promote learning and development.

1. 2152 professionals learned by attending LSCB training events, and 11291 completed e-learning (Level 1 6372, Level 2 2844, CSE 2006, CDOP 69), making a total of 13443 professionals who came through the LSCB learning programme
2. In 2013-14, L&D sub planned 90 training events. Of those, 85 ran, and 5 were cancelled. In addition, a number of other events were added throughout the year, meaning that 103 events were delivered, lasting 126.5 days.
3. Held SCR briefings, jointly with Blackburn with Darwen and Blackpool LSCBs, which were evaluated and found to provide excellent learning
4. Provided advice/consultancy to 65 organisations which approached the LSCB Training Unit
5. Successfully engaged the 12 District Councils in the safeguarding agenda, with the result that all now have a safeguarding policy and most have training for their staff
6. Delivery of the three Neglect Conferences which involved Children and Young people
7. Provided three System-based Critical Incident Reviews (now renamed), this has included training up three facilitators
8. Developed new ways of getting messages over, for example by bookmarks and 'best advice' cards
9. Unit costs for training are £52.61per place if e-learning is excluded, £8.42 per place if it is included.

Priorities for 2014/15

- Run a core training programme of approximately 75 events covering at least 20 topics, potentially adding further events required by the LSCB
- Audit the single agency safeguarding training
- Review the training needs of all agencies in respect of safeguarding training
- Maintain the e-learning programme
- Support the training pool
- Implement and embed on line sign up to LSCB training
- Support learning from other LSCB sub groups

Quality Assurance

To provide the LSCB with a qualitative and quantitative evidence base to demonstrate how effective multi-agency safeguarding practices and arrangements are.

The group has continued to progress the activities outlined in the Quality Assurance Framework (QAF) to ensure a strategic and planned approach to activities around agreed themes and issues.

1. Completed 2 multi-agency safeguarding practice inspections in the districts of Hyndburn & Ribble Valley & Pendle which identified strengths and areas for improvement in relation to multi-agency practice
2. Developed a new pan-Lancashire section 11 audit tool
3. Obtained section 11 audits from all statutory agencies in Lancashire

4. Completed peer reviews on 6 agencies with regard to their section 11 audit returns and agreed a number of improvements
5. Completed multi- agency audits of CAFs across the County to determine its effectiveness in respect to the early identification of Domestic Abuse; Substance Misuse and Mental Health in relation to neglect.
6. Maintained an oversight of the Children and Young People's Trusts Lancashire Improving Futures programme in relation to CAF/Continuum of Need, Workforce Development, integrated working, Working Together with Families and MASH developments
7. Maintained oversight of the SLAC inspection action plan and challenged agencies where improvements have not progressed as planned
8. Completed a multi agency supervision audit to determine whether effective arrangements are in place to enable practitioners to receive regular and reflective supervision
9. Reviewed the LSCB multi-agency performance scorecard and agreed a revised / improved version
10. Held multi-agency workshop briefings across Lancashire in respect of the Lancashire Assessment Framework and changes to child protection processes to improve child protection conferences

Priorities for 2014/15

- Completion of further multi-agency safeguarding practice inspections
- Completion of audits and focus groups around this year's QAF themes – Esafety and Thresholds
- Development of effective QA arrangements around Early Help and CAF
- Continued QA of section 11 audits through multi-agency site visits
- Maintain oversight of the SLAC action plan and challenge areas of outstanding activity

Case Review Group

To consider referrals for SCRs against the criteria, commission case reviews and monitor implementation of single and multi-agency learning from case reviews.

1. The completion of all relevant case reviews in a timely and thorough manner
2. Areas of work that need further review and examination by the LSCB have been identified through the process of reviewing cases
3. Improved procedures for transfer of case responsibility between agencies which will ensure children and families receive appropriate and timely services
4. Specific training courses have to help practitioners develop their skills in responding to particular issues for children and families
5. Improved procedures and guidance are helping practitioners in their work with children and families. An example includes promotion of information sharing guidance, to ensure that risks are fully identified and managed
6. Practitioner feedback providing evidence that involvement with reviews has changed their practice for the better. Some examples of this include:

i. I am more aware of multi-agency working and making sure that a full chronology is gathered on all aspects of the family
ii. It has reinforced a lot for me about not taking things at face value and being persistent

7. The identification of areas for development in agencies and with practitioners and the ongoing delivery of relevant briefings about case reviews (approximately two hundred people attended the general multi-agency SCR briefings alone – hundreds more attended other training events relevant to specific case review themes)

In the period 2013-2014 Lancashire LSCB published two Serious Case Reviews.

The first, child K, concerned a three year old child that died as a result of injuries caused by a blunt force trauma. The child's father was subsequently jailed for manslaughter and the child's mother was jailed for neglect of the child.

The review produced a number of findings and challenges for the LSCB. There has been a great deal of work completed about how we help practitioners to develop their understanding about their own cognitive frameworks and various methods of learning have been and continue to be trialled (such as group supervision, bite-sized briefings, traditional training courses, briefings, and so on).

The issue of information-sharing emerged as a theme and has been built into the various methods of training and developing practitioners. In addition, the way in which professionals and agencies share information has been incorporated into all quality assurance activity the LSCB undertakes. It is routinely examined during audit activity and addressed in Safeguarding Practice Inspections too.

Some specific development work about the understanding of cannabis use and also about the children of prisoners has followed from this review, with briefings and newsletters being delivered to several different forums and people.

The second serious case review published this year was about Baby E, a four month old child who died as a result of a heavy object falling on to him. His parents were both jailed for neglect as a result of the incident.

The actions following this review saw the roll-out of the single assessment framework, with findings from the review being incorporated into the development of the guidance and the assessment tool.

The Multi Agency Safeguarding Hub came into operation following this review and has shown to be making a difference to how cases are initially assessed and responded to on the basis of a fuller, multi-agency picture. In addition, the LSCB developed thresholds guidance for all practitioners that has been promoted and brought into operation.

The training and quality assurance work of the LSCB has taken all the findings from this review into account. Briefings sessions detail how practitioners can 'hypothesise' about what is happening for children, and healthy challenge and scepticism are promoted and encouraged.

The impact of all LSCB and single agency actions following all serious case reviews is monitored through s11 audits which are completed annually and all audit and QA activity. The lessons are built into all LSCB training and development activity.

Priorities for 2014/15

- Consider referrals against criteria for Serious Case Reviews
- Commission Serious Case Reviews as appropriate
- Commission multi-agency learning reviews as appropriate
- Complete Serious Case Reviews and multi-agency learning reviews and feedback learning to SCR Group and local agencies
- Continue to effectively monitor action plans and dissemination of learning from case reviews to ensure they make a difference
- SCR briefings to continue.
- Monitor agencies plans to disseminate information
- Newsletters to be published when new information is available
- Quarterly analysis of themes from SCRs to be shared widely, including with L and D sub and QA sub

- Survey of participants from reviews to be undertaken to evaluate the impact of involvement in reviews on their practice
- Leaflet to be produced to share with practitioners involved with future reviews

Child Death Overview Panel (CDOP)

Reviews all child deaths in Lancashire to identify themes and trends to inform preventative developments

1. Consistently the CDOP data highlights that more of the children and young people of pan-Lancashire die due to perinatal/ neonatal events than any other cause. As a result, Public Health undertook an in-depth analysis of some of these deaths and recommended an action plan be implemented, the recommendations of which are being monitored by the Pennine Lancashire Infant Mortality Group.
2. The Panel decided to continue to support the Safer Sleep Campaign, as many of the deaths in children under 1 year of age with modifiable risk factors were linked to inappropriate sleeping arrangements.
3. It was identified in the 2011/12 annual report that the SUDC protocol should be reviewed. Due to the national review of Working Together (2013) this was delayed by 1 year. The Protocol has now been reviewed to reflect changes in national guidance, changes in practice and learning from previous deaths with the aim of supporting families more effectively.
4. A function of the Panel is to disseminate learning. An e-learning package has now been developed which includes general information on CDOP, local procedures, the rapid response, themes and identified trends.

Priorities for 2014/15

- An analysis of the impact of service provision in areas of higher deprivation on child deaths
- In depth analysis of Category 3 deaths (trauma and other external factors)
- In depth analysis of Category 7 deaths (Chromosomal, congenital and genetic abnormalities)

Missing From Home (MFH)

Strategic multi-agency group to ensure a coordinated multi agency response to MFH.

1. Multi-agency review of the Pan-Lancashire Joint Protocol involving all relevant pan-Lancashire partners has provided a finalised document that is currently being submitted to each of the LSCB's.
2. Lancashire County Council Audit on a large number children MFH cases has enabled analysis of what is required in terms of data capture. This work is due to be formally released in the near future.
3. Joint Lancashire Constabulary/ LCC funding for The Children's Society 6 month pilot for Return Home Interviews, supported by the Missing From Home Co-ordinator for that area. Findings from this pilot will be published in the near future.
4. Single Point of Contact now in place for direct contact with OFSTED. Co-ordinated recording of requests for information are allocated to relevant co-ordinators and timely submissions of required data are returned to OFTSED to assist formal inspections.
5. Monthly downloads of information now routinely received from OFSTED in relation to the names and addresses of Care Homes in the county.

Priorities for 2014/15

- Implementation of the new guidance and responsibilities for agencies contained therein
- Embedding of the revised protocol pan-Lancashire

Child Sexual Exploitation

Strategic multi-agency group to ensure a coordinated multi agency response to CSE.

1. Increased work with all diverse communities regarding awareness of CSE and *c*onfidence in the service provided. The Children's Society continue to provide a service known as 'Respect U & Me' to assist young people in developing 'respectful and healthy relationships' targeting groups where concerns may have arisen
2. Further development of approach to targeted organised criminal groups/gangs committing CSE based on recommendations in the Office of the Children's Commissioner report "If Only Someone Had Listened" as detailed in the revised CSE plan
3. Delivery of a range of awareness raising initiatives including:
    a. A week long countywide CSE awareness campaign (in partnership with the Police and Crime Commissioner)
    b. A large CSE conference hosted by Lancashire Constabulary attended by over 200 professionals
    c. Engagement with a diverse range of communities to raise awareness about CSE and a focus on making sure the information is reached by young people
4. Production of a combined multi-agency action plan based on recommendations from a number of national reviews and strategies
5. Developed processes to obtain feedback from young people who have been exploited regarding the service they received in order to continually develop and improve services
6. Further development of local co-located teams to include statutory and third sector providers such as Brook, The Children's Society, PACE, and Barnardos
7. Intensive outreach workers, in the Children's Society's Street Safe Lancashire (SSL), provide valuable support to children and young people, at risk of or involved in sexual exploitation, from report through to the court process
8. Between April 2013 and March 2014, SSL supported 245 children and young people with interventions which raised awareness of grooming, CSE, healthy relationships and protective behaviours. These continued whilst they were needed by the victim and for varying periods from between 2-3 months and a few years, where young people struggled to cope and build resilience. They have also delivered a large number of group sessions in children's homes, schools, colleges and youth groups
9. SSL have employed a worker specifically for boys and young men who has engaged with 393 boys and young men over the 12 month period
10. There are now specialist teams within Early Break (voluntary provider service supporting young people) who are carrying out early intervention outreach work following a successful lottery fund bid being granted to East Lancashire CSE team
11. Parents Against Child Sexual Exploitation (PACE) parent support workers provide independent, non-judgmental and confidential support to parents
12. Review and Development of multi-agency training for all frontline professionals re awareness of CSE - The Children's Society and police continue to deliver a CSE training package on behalf of the LSCB to practitioners

Priorities for 2014/15

- Review and refresh of multi-agency action plan
- Repeat CSE awareness week including a multi-agency conference and range of partnership activities
- Build on and improve existing arrangements for prevention and responding to CSE

ESafeguarding

To raise awareness and support agencies in protecting young people from the risks associated with the use of the internet and social media.

The Group has achieved a number of key achievements during the year including:

1. Delivery of 2 large scale multi-agency awareness events in April 2013 and January 2014 each event was attended by over 200 practitioners and received very positive feedback
2. Identified as National supporter of Safer Internet Day 2014
3. Development and agreement of Pan-Lancashire eSafeguarding Strategy
4. Development of quantitative dataset for Lancashire (issues faced + support required)
5. Increased involvement across related agendas and priorities (e.g. Anti-Bullying, CSE)
6. Participation in media opportunities to raise awareness of Online Safety issues (e.g. BBC Radio Lancashire - Cyber bullying)
7. Continued representation on National eSafeguarding Group to highlight Lancashire issues (e.g. Ask FM) and feedback emerging threats / changes in trends (e.g. Sexting)

Priorities for 2014/15

- Repeat of the Esafety Live Conferences
- Roll out and embedding of refreshed strategy and action plan
- Support and oversight of the Young Advisors project in schools
- Continued sharing of information / alerts to agencies with regard to emerging risks and developments

Local Safeguarding Children Groups (LSCGs)

The LSCB has 3 LSCGs which cover the following districts of Lancashire

- Lancaster, Fylde and Wyre
- East Lancashire (Hyndburn, Rossendale, Burnley, Pendle and Ribble Valley)
- Central & South Lancashire (Preston, Chorley, West Lancashire and South Ribble)

These locality groups provide a greater locality focus to the work of the LSCB and ensure LSCB priorities are informed by local information as well as Countywide. Key achievements of the groups for 2013/14 include:

1. Establishment of local representation and oversight in relation to the refreshed CAF process and Early Support initiatives
2. Attendance at the sub-groups by all local District Children's Trust (DCT) chairs to improve connectivity and provide scrutiny and challenge of delivery plans
3. Regular scrutiny of local Child Protection and safeguarding data to identify local concerns which have informed service developments and improvements
4. Completion of Toxic Trio themed audits of CAFs
5. Consideration of learning from LSCB Case reviews
6. Discussion and resolution of local multi-agency issues
7. Effective forum for sharing information between agencies in relation to agency developments and changes in service

At the time of writing a review of local partnerships, including the LSCGs and District Children's Trusts, is being carried out with a plan to discontinue the LSCGs as of September 2014. 'Children's Partnership Boards' (on a similar locality footprint) are planned to replace these groups and the LSCB will engage with and challenge these groups to ensure safeguarding is effectively embedded in the commissioning and delivery of services at a local level.

7. Equality and Diversity

Children and young people in Lancashire are less ethnically diverse compared to the rest of the country with 12.7% being from black and minority ethnic groups (compared to 21% nationally). However there is wide district variation, with Burnley, Hyndburn, Pendle and Preston populations displaying the greatest ethnic diversity.

Recent migration patterns have created some challenges to local services especially in terms of language issues. The LSCB has looked into this more recently and this will be reported more fully in the next annual report.

The LSCB and it members recognise that Lancashire is a large and diverse county with huge local variation in need and the composition of local populations. The LSCB has a lay-member who has a BME background and all members are required to comply with equality requirements as laid out in statutory guidance and legislation. (Note: a second Lay Member has more recently been recruited).

Recognition of the diverse needs of different groups of children is central to all areas of LSCB business. Every effort is made to ensure the views of all groups are gathered to inform service developments and business planning.

8. Priority groups of children

The following groups of children are recognised by the LSCB as potentially experiencing greater vulnerability:

- Children in Custody
- Children who are privately fostered
- Children experiencing neglect (see QA sub-group update)
- Children who are at risk of sexual exploitation or sexually exploited
- Children with disabilities
- Children Looked After, particularly those moving out of or into Lancashire

The LSCB receives an annual report from the County Youth Justice manager to be assured that young people in custody are being effectively safeguarded. The report assured the LSCB that 100% of YOT assessments were completed within timescales for young people prior to detention, during and post release. The LSCB was also assured that effective arrangements were in place to identify and respond to any safeguarding issues within the secure estate.

The LSCB also receives an annual report from the Local Authority on privately fostered children. The following key points were noted:

- 100% of cases were managed in line with the regulations
- The number of arrangements rose from 35 to 64 from previous year
- New webpage's and eLearning in place to assist professionals
- New ICT system has hampered accuracy of data reporting for the period

With regard to children with disabilities (CWD), a multi-agency audit of cases and agency arrangements in relation to compliance with national guidance is progressing and scheduled for completion in September 2014. Key findings will be available in the next annual report.

In addition to these priority groups the LSCB receives an annual report from the Local Authority Designated Officer (LADO) with regard to the management of allegations against people working with children and young people. The report was presented to the LSCB in November 2013 and the following key points noted:

- Increase in number of notifications taken forward as allegations (from to 636 to 715)
- Increase in allegations of physical abuse, especially in relation to restraint / physical intervention
- Social Care remains the biggest source of allegations
- Completion of investigations within 1 month remains at 71%
- Increased awareness raising has resulted in increased demand for LADO services
- LADO now located in the MASH 2 days per week

Overall it was felt the service is effective and robust though the increased demand and pressure on the LADO was noted.

8. Engagement with and participation of children and young people

The LSCB identified participation and engagement with young people as a priority for 2013/14 and has now established effective links with the local Children and Young People's Participation Officer who meets regularly with the LSCB Coordinator to identify where the LSCB can be involved in planned activity and vice versa. The LSCB has involved young people in a number of initiatives throughout 2013/14 as follows:

Engagement in national 'take over day' via Lancaster Young Advisors - a young person co-chaired the LSCB meeting which proved a rewarding and useful experience and challenged LSCB members to ensure dialogue is meaningful and accessible to young people.

Commissioning of the Young Advisors to complete a commission in relation to eSafety and safer use of the internet and social networking. (Ongoing in 2014/15)

Participation of the Young Inspectors in Multi-agency Practice Inspections including interviews with key managers and agency representatives.

A panel of Young People interviewing candidates for the role of LSCB Chair and contribution to the decision to appoint.

9. LSCB Budget

The LSCB Budget position at April 2014 is summarised below

INCOME	
Contributions to Board	
Central Lancs	37,835
East Lancs	37,835
North Lancs	37,835
Police	43,938
Probation Service	13,488
CAFCAS	550
LCC - CYP Directorate Funding	112,000
CDOP Contributions	98,000
Other	9690
Total	**390,490**

EXPENDITURE	
LSCB General	140,598
CDOP	98,000
SCRs	61,202
Training	115,894
Total	**415,695**

RESERVES	
Combined Reserve	**268,418**

10. Contact details

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💻Website: http://www.lancashire.gov.uk/corporate/web/view.asp?siteid=3829&pageid=20739&e=e

11. Appendices

LSCB Attendance

Attendance by agency for all Board meetings in 2012/13 is shown below.

Red= 50% and below, Amber = 51-75, Green = Above 76%

Agency	% Atn by mem	Dep Att Y/N	No Att	Number to whichInvited
Cafcass	100		6	6
CDOP Chair	50		3	5
Council for Voluntary Services	33		2	6
Council for Voluntary Services	67		4	6
East Lancashire CCG	100		6	6
East Lancashire LSCG Chair	60		3	5
Independent Chair	100		6	6
Fylde & Wyre CCG	60		3	5
Lancashire Care NHS Foundation Trust	100		6	6
Lancashire County Council (Adult Safeguarding Board)	100		6	6
Lancashire County Council (Director of Children's Services)	100		6	6
Lancashire County Council (lead member - participant observer)	17		1	6
Lancashire Teaching Hospitals NHS Trust	67		4	6
Lancaster Fylde and Wyre LSCG Chair	83		5	6
Lay Member 1	75		3	4
Lay Member 2	67		4	6
Designated Doctor	83		5	6
NHS England	100		3	3
Police	100		6	6
Preston City Council	67		4	6
Preston, C&SR and West Lancs CCGs (Vice Chair & LSCG Chair)	67		4	6
Probation	83		5	6
Quality Assurance Sub-group Chair	67		4	6
Schools	50		1	2
Serious Case Review Sub-group Chair	100		6	6
University Hospitals Morecambe Bay NHS Trust	33		1	3
OVERALL	76			

Note – some members were only invited to the Board part way through the year due to ongoing decisions and reviews of membership

Author: Richard Matthews, LSCB Business Coordinator

Date of Publication: 24th September 2014

Approved by LSCB on: 17th September 2014

Missing from Home/Care, Child Sexual Exploitation and Human Trafficking.

Briefing for Health and Well-being Board
2 October 2014

Introduction

The following paper is a brief summary of arrangements to support children and young people who go missing and those at risk of, or who are currently being sexually exploited or being "trafficked".

National statutory guidance in respect of children and young people who go missing from home was updated in January 2014. It reflects the growing recognition of the vulnerability of these young people and confers a considerable increase in the obligations and expectations of both the police and local authority children social care services at a time of diminishing resources.

Child Sexual Exploitation has been a priority for the Lancashire Safeguarding Children Board and its Member agencies for some years and a Multi-Agency CSE Strategy is in place. It covers three areas: prevention, protection and prosecution.

1. Missing from Home

Government regulations require two active responses to children and young people who go missing from home and no longer distinguish between children who are 'looked after' and children who are not. When a missing incident is reported to the police a risk assessment is completed on the basis of the information provided which determines the urgency of response. Incidents relating to children and young people are never given a "low risk" classification and this ensures an effective response with close monitoring and re-evaluation of risk over time.

Once a child is found two checks take place. The first is a "Safe and Well" check which is carried out by the police and the second is an "Independent Return Interview". The reason for the "independent" element is to ensure that the child or young person has access to a professional who is not compromised by association with the environment from which the child has gone missing. For ‘looked after children’, these are carried out by a Local Authority social worker, while those who have gone missing from their own home are seen by a Children’s Society (CS) worker. This has been the case since 01/08/14.

This latter arrangement has a number of advantages. The CS workers are located within the CSE team enabling good communication in respect of historical intelligence, while their relationships with the families are less likely to be inhibited by any perceived stigma of social care involvement. CS refers children and families on to other services as appropriate and routinely thereafter follows up to come to a view as to how things are progressing.

Previously such interviews were only conducted after the third missing episode, whereupon it was not infrequently found that the child had in fact previously been missing six or seven times. That children are not always reported as missing from family homes has long been established as a significant concern.

The benefits of this recent development are becoming evident with children being referred to services that are able to address any issues at an earlier stage.

There are, based on the average of the last 3 years, in excess of 5000 reported incidents of children and young people going missing in Lancashire per year. Going missing from home is a key vulnerability in terms of risk of Child Sexual Exploitation.

2. Child Sexual Exploitation (CSE)

Lancashire has come to be seen as having developed some expertise and to have been innovative in this field. There is however no room for complacency. The LSCB coordinates multi-agency activity in response to CSE and takes responsibility for the establishment and delivery of the CSE Strategy.

Three specialist multi-agency teams are in place across the county to respond to CSE and trafficking. The LSCB recently received an updated profile re CSE and analysis of the information has led to a number of recommendations which are being implemented.

Rates of referrals in response to concern about potential CSE have remained constant across the county over the last three years with around 1400 referrals per annum. 62% of young people referred were between 13 and 15 years old and 95% were described as "white" with the majority being female. The number of referrals in respect of males has however risen with 22% of the 2013-14 referrals being in respect of boys.

"Looked after children" are disproportionately represented in CSE referrals.

The offender profile evidences that 92% of suspects are male and 93% described as "white".

In addition to single agency training, significant levels of multi-agency training are delivered by the LSCB. More than 2000 professionals have completed the LSCB level two CSE on-line training and demand for directly taught courses is high. While this may seem to be a high number there are an estimated 60000 professionals working with children and families who need the level of awareness that this training gives.

The recent enquiry by Alexis Jay following concerns about responses to CSE in Rotherham made fifteen recommendations, all of which are being considered by the LSCB CSE Strategy Group to ensure there are no gaps in Lancashire. Initial analysis suggests that many are met in full and all are at least partially met. The LSCB Strategy and action plan will be updated to ensure these are met in full.

Recommendation 1: ***Senior managers should ensure that there are up-to-date risk assessments on all children affected by CSE. These should be of consistently high quality and clearly recorded on the child's file.***

Senior managers do not routinely check all assessments but do have a general oversight; team managers for CSC and a police sergeant in the specialist CSE teams routinely approve risk assessments.

Recommendation 2: ***The numeric scoring tool should be kept under review. Professional judgements about risk should be clearly recorded where these are not adequately captured by the numeric tool.***

The new 'numeric scoring tool' is being used and reviewed. Practitioners are encouraged to use professional judgment and do not routinely and slavishly follow its results but instead use it as a kind of guide, open to interpretation;

Recommendation 3: ***Managers should develop a more strategic approach to protecting looked after children who are sexually exploited. This must include the use of out-of-area placements. The Borough should work with other authorities to minimise the risks of sexual exploitation to all children, including those living in placements where they may become exposed to CSE. The strategy should include improved arrangements for supporting children in out-of-area placements when they require leaving care services.***

This recommendation is complied with. If risk of CSE is identified a referral is made to the specialist team while in all CLA reviews the IRO will specifically enquire as to CSE and if there appears to be any evidence of its existence they must consider any assessment available and the level of risk. There exists a strategy whereby regular multi-agency CSE meetings are held to review the overall state of affairs and to plan whatever actions are required. There are only a few children placed outside Lancashire;

Recommendation 4: ***The Council should make every effort to make help reach out to victims of CSE who are not yet in touch with services. In particular, it should make every effort to restore open access and outreach work with children affected by CSE to the level previously provided by Risky Business.***

There is a pan-Lancashire approach to raising awareness of CSE. In 2012 and 2013 week-long events about this subject were held, publicised through national and local TV and radio, schools, football clubs, community and faith centres and such. This will continue annually so long as the problem persists: this year it is arranged for mid-November. In addition it is accepted that on-going awareness-raising is fundamental to the CSE teams and that early response to identified risks essential.

The services provided by the 'Risky Business' project in Rotherham are replicated in some of Lancashire's CSE teams. This needs to be the case throughout the County, North Lancashire and Chorley South Ribble are the least developed in this respect. Recruitment of workers to the dedicated teams is currently ongoing.

Recommendation 5: ***The remit and responsibilities of the joint CSE team should be urgently decided and communicated to all concerned in a way that leaves no room for doubt.***

There are three dedicated CSE teams in Lancashire (which also cover the two unitary authorities of Blackburn and Blackpool); pan Lancashire agreed responsibilities and core offer established and publicised.

Recommendation 6: ***Agencies should commit to introducing a single manager for the multi-agency CSE team. This should be implemented as quickly as possible.***

There are no managers specific to these teams: instead they come under their existing local management structure;

Recommendation 7: ***The Council, together with the Police, should review the social care resources available to the CSE team, and make sure these are consistent with the need and demand for services.***

There is a series of meetings planned to evaluate resources available to CSE in the context of, and taking into account, the contemporary reorganisation of both the constabulary and CSC;

Recommendation 8: ***Wider children's social care, the CSE team and integrated youth and support services should work better together to ensure that children affected by CSE are well supported and offered an appropriate range of preventive services.***

This work is on-going. YPS have accessed some CSE-awareness training but as yet do not have a presence in the CSE teams. There are established links, as is the case with the Youth Offending Teams;

Recommendation 9: ***All services should recognise that once a child is affected by CSE, he or she is likely to require support and therapeutic intervention for an extended period of time. Children should not be offered short-term intervention only, and cases should not be closed prematurely.***

This recommendation is accepted and there are examples of our funding of therapeutic support and of continuing long-term support being provided for victims and their families; there is recognition that siblings are often affected when there is a victim in the family and appropriate services for these have also been provided.

A number of films have been made featuring interviews with victims and their families which appear to have been particularly effective in illustrating the profound impact of CSE. They have proved to be an effective aid in therapy and in engaging those in training in this subject;

Recommendation 10: ***The Safeguarding Board, through the CSE Sub-group, should work with local agencies, including health, to secure the delivery of post-abuse support services.***

Intensive outreach workers, in the Children's Society's Street Safe Lancashire (SSL), provide valuable support to children and young people, at risk of or involved in

sexual exploitation, from report through to the court process. They provide support to victims as part of an integrated package of multi-agency intervention.

A recent Serious Case Review highlighted the need for counselling services to offer pre-trial counselling when needed and this has been reinforced through agency action and a newsletter that has been widely distributed across the network of partner agencies. The LSCB is seeking assurance from all large providers of counselling services that the guidelines about pre-trial counselling are understood and acted upon in the best interests of children and young people.

At the same time, the LSCB has concerns about the provision of emotional support for children and young people; either for mental health issues or emotional issues, including post incident support. The commissioning strategy for emotional health and wellbeing in Lancashire is complex. Schools and the voluntary sector, through external funding, contribute to the overall resource but Health continues to be the main commissioners of provision.

The LSCB understands that the draft joint commissioning plan is due to be agreed imminently and has asked that the Health and Wellbeing Board assure themselves of the adequacy and effectiveness of the strategy and provision;

Recommendation 11: ***All agencies should continue to resource, and strengthen, the quality assurance work currently underway under the auspices of the Safeguarding Board.***

The LSCB has a Quality Assurance Framework that all partner agencies have signed up to and engage with. Each year, two or three topics are chosen as key focus areas for QA activity. In 2012/13 one of those themes was CSE. A full programme of quality assurance around the work of agencies with children and young people at risk of or victims of CSE was completed.

This work provided assurance about quantitative, qualitative and outcome indicators examined over a period of twelve months. The findings from the work have been used to build on and improve the work of the CSE teams. This work is continuing through bi-monthly reporting of progress on the CSE action plan to the LSCB.

The intended outcomes which the plan will guide partners to achieve are set against the actions and in summary are as follows:

- greater awareness of CSE leading to greater management of risk and reassurance in communities;
- protection of vulnerable victims with a clear, proactive approach in protecting those at greatest risk;
- more perpetrators brought swiftly to justice with greater support for victims throughout their involvement with criminal justice services;
- greater collaboration amongst multi-agency teams to achieve the best outcomes for victims and those at risk of exploitation;
- good intelligence shared more widely to inform decisions on the targeting of perpetrators and protection of those at risk;

- strong, effective and well informed leadership within all partner organisations;
- a commitment to ongoing learning and development in a multi-agency environment where best practice is widely shared and consistently applied;

Recommendation 12: ***There should be more direct and more frequent engagement by the Council and also the Safeguarding Board with women and men from minority ethnic communities on the issue of CSE and other forms of abuse.***

This recommendation is currently only partially met and work will continue to develop effective community engagement in relation to CSE. The CSE sub group of the LSCB has been asked to consider all the recommendations in this report and develop a plan to address any issues that are not completed;

Recommendation 13: ***The Safeguarding Board should address the under-reporting of sexual exploitation and abuse in minority ethnic communities.***

This sensitive issue is being addressed as in recommendation 12.

Recommendation 14: ***The issue of race should be tackled as an absolute priority if it is a significant factor in the criminal activity of organised child sexual abuse in the Borough.***

This is being pursued and there is no discrimination being applied in respect of combatting this criminality. There are many examples of our intervention among minority communities;

Recommendation 15: ***We recommend to the Department of Education that the guiding principle on redactions in Serious Case Reviews must be that the welfare of any children involved is paramount.***

Not within our responsibilities.

3. Human Trafficking (HT)

The UK is believed to be in the top ten destinations globally in terms of human trafficking. It is not now true that this phenomenon is only present in countries with poor human rights. Evidence of trafficking within the UK for the purposes of labour and sexual exploitation is increasing as general awareness is raised.

All front line staff need to be aware of the nature of trafficking and to actively seek help for children and vulnerable adults. From April 2014 Lancashire has been part of a Home Office sponsored pilot study for the provision of independent guardians for trafficked children in the UK. There is to be support in respect of child advocacy from Barnardo's with the same for adults from The Salvation Army.

HT into and around the UK is known to have increased but precise figures as to the true extent are not easily obtainable. It is known that there has been a shift from the use of the larger UK airports and ports, to the smaller lesser known ones including

some in the North West, of which Blackpool airport is an example. There have been a number of children not born in the UK becoming looked after in Lancashire in the last five years. Invariably, these children have problematic backgrounds and only in retrospect has the likelihood of their having been trafficked been considered. In these cases there are indicators that the females have all displayed behaviours that could be evidence of the possibility of their having been victims of trafficking.

The designated workers within the CSE teams in Lancashire work with internally-trafficked children i.e. those being transported within the UK for the purposes of CSE. MASH, CART and CSE teams will become the designated front-line services providing the essential first response.

The regular LSCB and other multi-agency training sessions around CSE include input regarding Trafficking.

The third annual multi-agency week of action around CSE is in the final planning stage. Operation "Toledo", the name given to the CSE Awareness week activities which are scheduled for week commencing Monday 10th November 2014, will include events targeted at schools, other professionals, parents/carers and the general public. The programme for the week takes a particular theme each day, such as street grooming.

Conclusion

The CSE sub group of the LSCB reports on a bi-monthly basis about progress with their action plan and specific risks or concerns. They problem-profile on a continual basis and take reports from each area of Lancashire to ensure issues are identified and addressed promptly. In addition, the LSCB is planning an event for providers of children's homes that will include information about CSE and providers responsibilities. Operation Toledo will build on all this work to disseminate knowledge and learning on a wide scale.

Jane Booth

Lancashire LSCB Independent Chair

1 October 2014

Lancashire Health and Wellbeing Board
Meeting to be held on 16th October 2014

Electoral Division affected:
All

Children and Young People's Emotional Health and Wellbeing
(Appendix 1 refers)

Contact for further information:
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Executive Summary

In 2015, it is estimated that 45,101 children and young people in Lancashire will have an emotional health need which will require interventions from comprehensive Child and Adolescent Mental Health Services, Tiers 1- 4 (See Appendix 1). While it is evidenced nationally that 25%-50% of mental illness during adulthood could be prevented with effective intervention during this period, fewer than 25% of children and young people with mental health needs are in contact with appropriate services.

Evidence, along with national policy and guidance, suggests that in order to have an impact, improving the emotional health and wellbeing of children and young people needs to be everybody's business. Joint commissioning arrangements, therefore, which ensure clear roles and accountabilities across all partner agencies responsible for universal, targeted and specialist services are imperative, if we are to achieve positive outcomes for Children and Young People (CYP) in Lancashire.

In completing the 'understand' phase (needs analysis, consultation, review of evidence and provision mapping) to inform the development of a joint commissioning strategy going forward, a number of key issues and areas for improvement have been identified in relation to the current partnership and commissioning arrangements. These are detailed in the following report but in summary include:

- Limited strategic governance arrangements
- Lack of a coordinated approach around promotion and prevention (Tier 1) to capitalise on the role of universal services
- Inequity of provision/ lack of capacity in targeted and specialist services (Tiers 2,3, 4)
- Joint commissioning arrangements which are neither robust, nor sustainable due to funding pressures and procurement regulations.

Equally concerns have been raised by Lancashire Safeguarding Children's Board and from the findings of recent serious case reviews which support the case for change.

In response to the above, a number of joint outcomes, and proposals to meet them, have emerged, which when agreed could form the basis of a three year action plan. These are detailed in section 5.

It is also suggested that a whole system review of the current commissioning arrangements should be considered as part of the developed plan.

Recommendation:

In order to address the issues raised and subsequently have a positive impact on the emotional health and wellbeing of children and young people in Lancashire, members of the Health and Wellbeing Board are recommended to agree that:

1. The Health and Wellbeing Board strategically leads a joined up approach across partners and provides the mechanism for us to hold each other to account.
2. A task and finish group is established which:
    - Is sponsored and led by a member of the Board, with project management support provided by the local authority
    - Reviews current commissioned provision and develop future possible models for consideration by the Board in April 2015
    - Following agreement by the Board, work to jointly implement the chosen model by April 2016
    - In addition to the redesign, oversees the implementation of an action plan which captures all partnership actions to support the achievement of the eight outcomes detailed in the report.
    - Provides quarterly monitoring updates to the Board and biannual progress updates to the Overview and Scrutiny Committee.

Background and Advice

1. Context

The development of a robust joint commissioning approach for emotional health and wellbeing is essential for a number of reasons:

- Improving the emotional health and wellbeing of our children and young people in Lancashire is a priority in the Children and Young People's Plan, the Health and Wellbeing Strategy and our children and young people tell us time and time again that it is a priority for them.
- Nationally there is clear direction through the cross government's strategy 'No Health without Mental Health' that intervening in early childhood and adolescence is vital. This is supported by evidence which suggests that 25%-50% of mental illness during adulthood could be prevented with effective intervention during this period.
- Fewer than 25% of children and young people with mental health needs are in contact with appropriate services, so most mental disorder in children and adolescents remain undiagnosed and untreated.
- The commissioning responsibility for services across the 4 tiers of comprehensive CAMHS sits within a number of organisations and therefore a joint approach to ensure sufficiency and efficiency of provision at each tier is essential.

- A Child and Adolescent Mental Health Strategy is a requirement by Ofsted.
- The evidence suggests that to have an impact, improving emotional health should be seen as 'everyone's business', therefore the contribution of all services across the system needs to be understood and capitalised upon.

2. Prevalence

The report 'Treating Children Well' (Z. Kurtz, Mental Health Foundation, 1996) provides estimates of the number of children/ young people who may experience emotional wellbeing and mental health problems appropriate to a response from comprehensive CAMHS at Universal, Targeted, Specialist and Very Specialist Tiers (1-4).

Applying these rates to Lancashire's population indicates that in 2015, **45,101** children and young people will require an intervention at Tier 1, **20,751** at Tier 2, **5,188** at Tier 3 and **1,300** at Tier 4.

3. Current Joint Commissioning Arrangements

To inform the development of a strategy, the current commissioning arrangements and services were mapped to understand Lancashire's joint response across the tiers. This is summarised pictorially in appendix 1.

Overall Lancashire's Joint commissioning arrangements for comprehensive CAMHS at Tiers 1 to 4 are overseen by the Children and Young People's Commissioners Group.

Although schools and the voluntary sector, through external funding, also contribute to the overall resource, Health continue to be the main commissioners of provision. Responsibilities, however, are now split across the different organisations. The Children and Young Peoples Directorate also contributes financially at different tiers, which according to a recent Young Minds study is in line with other Local Authorities. (83% were continuing to fund CAMHS).

The strategy details all the commissioned services and their offer, but in short the arrangements for the main commissioned services are summarised below:

Tier 1: (Provided by professionals whose main role and training is not in mental health)

The Children and Young Peoples Directorate commissions the following services:

- Lancashire Early Support Core Offer, £239,000 is allocated to services to improve the emotional health and wellbeing of children and young people.
- Targeted Youth Support- £202,626 is allocated to VCSF services to support young people engaging in risk taking behaviour or dealing with emotional health and wellbeing issues.

Public Health, East and Wyre and Fylde CCG's also commission a mixture of emotional health projects in schools

Tier 2 (Provided by specialist trained mental health professionals working primarily on their own)

The children and young people's directorate commissions and provides **SCAYT+** at a cost of £441,000. This service provides targeted interventions for children and young people who are looked after (5 times more likely to have childhood mental health problems) or adopted and their carers.

The six Clinical Commissioning Group's commission Lancashire Care Foundation Trust to provide Clinical Psychology services for children and young people across Lancashire with varying levels of resource per CCG, but to a total of £2,073,949.

Other services provided include The Early Years Emotional Health Team (funded by Public Health), The Butterfly and Phoenix Projects (funded by Wyre and Fylde CCG), Improving Access to Psychological Therapies and targeted services for young people with the Youth Offending Team (funded directly or indirectly by the CCG's)

Tier 3 (Services are provided by a multi-disciplinary team who aim to see cyp with diagnosed complex mental health problems).

Commissioning for CAMHS tier 3 service is led by the 6 CCGs with Lancashire County Council identified as a named associate on the contracts to enable appropriate monitoring. LCFT provide in North and Central and East Lancashire Hospitals Trust provide in the East.

The financial contribution to CAMHS made by the six CCGs totals £8,100,531 (Average £31.31 per head of 0-18 population). This varies across the CCGs, however, with East Lancashire contributing the most per head of the population at £42.76 and Greater Preston contributing the least at £17.86 per head.

Lancashire County Council's contribution to CAMHS, which is for a step down to tier 2 service, is calculated using a population formula and totals £1,148,363 across the six CCGs (a contribution of £14,809 is made to Blackpool for children and young people living in the Cleveleys area with a GP that chose to be part of Blackpool CCG).

Tier 4 (Very specialised services in residential day patient or outpatient settings for children and adolescents).

Services are commissioned by NHS England and, in Lancashire, this is undertaken by the Cheshire, Warrington and Wirral Specialist Commissioning Area Team. The financial envelope at this Tier was not provided. However, the strategy reports that current provision of 14 inpatient beds falls well below the recommended provision of 20-40 inpatient beds for our population size. The NHS Area Team is currently reviewing the capacity issues identified as part of a national review and negotiations with LCFT to increase inpatient beds have begun.

4. Issues/ Gaps

In completing the understand stage of the commissioning cycle: needs analysis, review of evidence, consultation and service mapping against the 4 tiers, we have identified a number of issues, gaps and potential areas for improved action across the system. These include:

- Limited strategic governance arrangements/ negative partner feedback
  - Lack of a specific local multi agency board to inspire, lead, inform local efforts and hold each other to account to improve CYP mental health and psychological wellbeing.
  - Feedback from children and young people, parents/ carers and stakeholders across Lancashire, as well as findings from recent serious case reviews and our performance data, indicates that emotional health and wellbeing is a key issue and we aren't getting it right.
  - The Local Safeguarding Children's Board has raised concerns regarding CAMHS provision.

- Lack of a coordinated approach around promotion and prevention (Tier 1) to capitalise on the role of universal services
    - A necessity to intervene earlier to prevent escalation into higher cost provision which is already struggling to meet to need
    - Lack of guidance for universal settings in commissioning emotional health and wellbeing services
    - Work is needed to counter the stigma associated with mental illness and its consequences.
    - Strategies are needed for developing better use of social networking and other web based sites to promote messages to CYP

- Inequity of provision/ lack of capacity in targeted and specialist services (Tiers 2,3, 4)
    - Inequity of funding across the six CCGs both for Clinical Psychology (£3.37 (Chorley and South Ribble) - £14.49 (Lancashire North) per head) and CAMHS (£17.86- £42.76 per head)
    - Services and stakeholders report a lack of capacity at Tiers 2, 3 and 4 owing to an increase in the numbers and the complexity of needs at presentation
    - Waiting times between referral and assessment for clinical psychology services (longest is 49 weeks; the shortest is 12 weeks)
    - Staffing levels within CAMHS (ELCAS- 43% of expected capacity; Central Lancashire - 56% and North Lancashire - 32%).
    - Lack of inpatient beds locally leading to an increase in use of out of area Tier 4 beds and beds on adult wards.
    - The offer from specialist CAMHS to Tier 2 is inconsistent and owing to rises in demand, current capacity issues have necessitated a focus on Tier 3 provision.

- Joint commissioning activity is not robust, nor sustainable:
    - The current commissioning arrangements for LCC's contribution to Tier 2/3 CAMHS are not legally compliant with procurement regulations.
    - Commissioning roles and responsibilities for funding at the differing tiers are not clear and current arrangements are based on historic funding streams.
    - The local authorities efficiency targets necessitate a review of all areas of spend. This could lead to each of the current spending areas being reduced and result in a destabilisation of all services.
    - Difficulty in collating comparable performance information as the development of routine systems for collation was delayed in anticipation of the National CAMHS dataset

5. Emerging proposals

In response to identified gaps and issues, a number of joint outcomes and proposals to meet them have emerged, which potentially could form the basis of a three year action plan.

Proposals have been grouped into eight over-arching outcomes which focus on improving emotional health and wellbeing across the whole continuum of need.

- **Outcome 1:** Good emotional health and wellbeing of Lancashire's children and young people is ensured by strategic leadership and ownership and the belief that it is 'Everybody's business'.
- **Outcome 2:** Children and young people are equipped with the skills, knowledge and understanding required to support their good emotional health and wellbeing.
- **Outcome 3:** Parents/carers are equipped, feel confident in their ability and are supported, to nurture the good emotional health and wellbeing of their children.
- **Outcome 4:** The Children and Young People's Workforce is equipped, and feels confident in their ability, to promote and support the good emotional health and wellbeing of children, young people and their families.
- **Outcome 5:** Through improving the public's understanding of mental health negative attitudes and behaviours towards people with mental health problems will decrease.
- **Outcome 6:** The emotional health and wellbeing needs of children and young people are identified early and an effective, appropriate and timely service response is provided to meet need, which builds upon the assets of the family.
- **Outcome 7:** Vulnerable children and young people receive the targeted support they require to improve their emotional health and wellbeing.
- **Outcome 8:** Children and young people diagnosed with a mental health illness or learning disability are supported through targeted, evidence based interventions to improve their emotional health and wellbeing**.**

6. Next steps

To enable the above outcomes to be achieved, partnership action and the provision of services from prevention and early help right through to specialist support needs to be robust, effective and equitable across Lancashire. There is also a requirement to ensure that commissioning arrangements going forward are clear, compliant with procurement law, can evidence improved outcomes, and demonstrate value for money.

In order to achieve this it is recommended that:

1. The Health and Wellbeing Board strategically leads a joined up approach across partners and provides the mechanism for us to hold each other to account.
2. A task and finish group is established which:
    - is sponsored and lead by a member of the Board, with project management support provided by the local authority
    - reviews current commissioned provision and develops future possible models for consideration by the Board in April 2015
    - following agreement by the Board, works to jointly implement the chosen model by April 2016

- in addition to the redesign, oversees the implementation of an action plan which captures other partnership actions to support the achievement of the eight outcomes detailed above.
- provides quarterly monitoring updates to the Board and biannual progress to the Overview and Scrutiny Committee.

7. Consultations:

Consultation with commissioners and providers across all public sector and third sector as well as with children and young people, parents and carers has identified the above issues and informed the development of the proposed outcomes.

8. Risk management

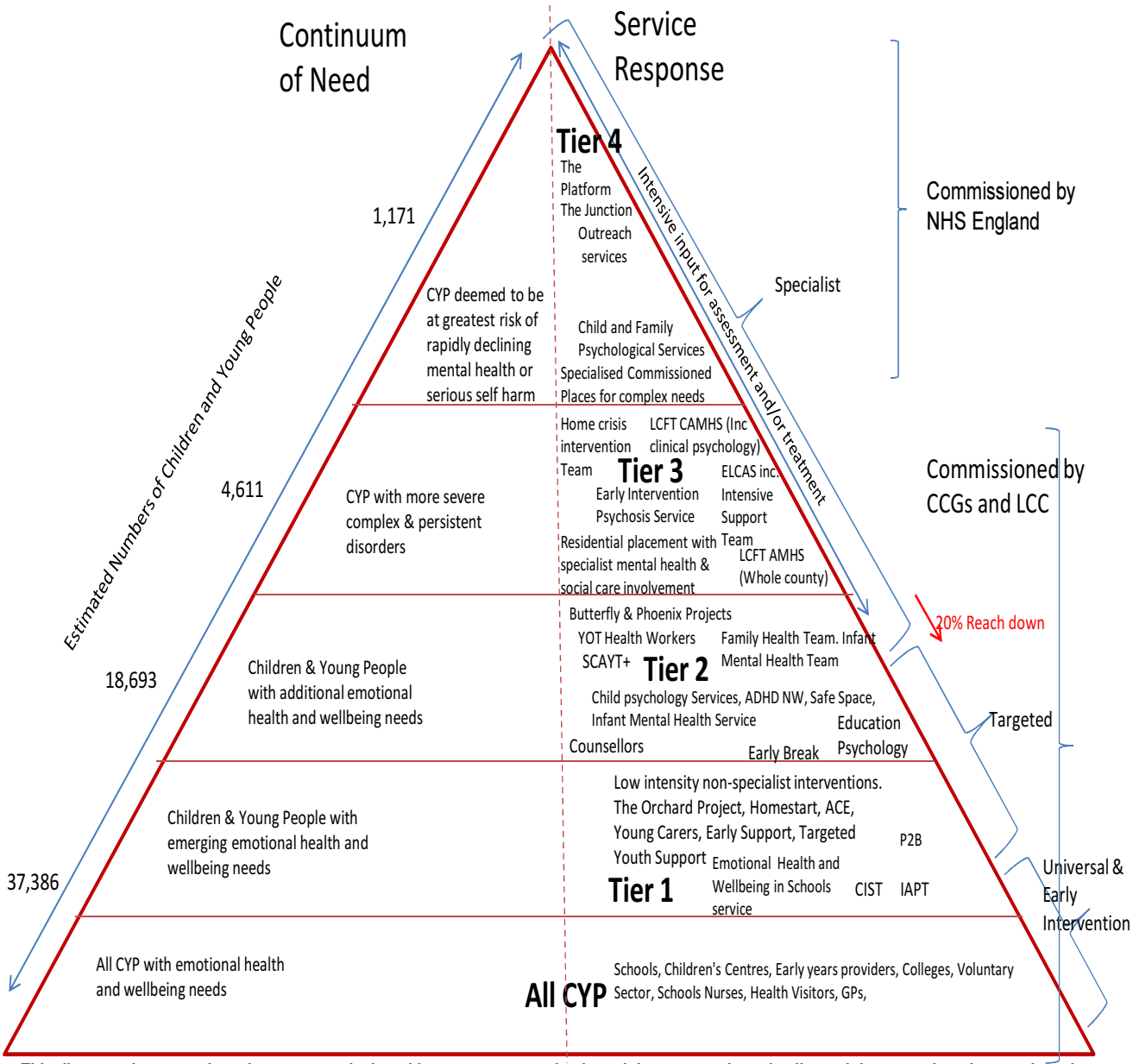
The risks of not supporting the above recommendations would result in the issues raised within the report not being addressed and subsequently children and young people in Lancashire having poorer emotional health and wellbeing outcomes. The Local Authority would also be at risk of breaking procurement law.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
	insert date	insert details

Reason for inclusion in Part II, if appropriate

N/A



This diagram shows services that are commissioned by statutory organisations. It is not an exhaustive list and there may be other services that exist. Whilst accepting that the service may spill over into other groups of emotional health and wellbeing intervention, services are placed into levels of need.

Lancashire Health & Wellbeing Board
Meeting to be held on 16th October 2014

Electoral Division affected:
All

Screening and Immunisation Programmes update
(Appendices 1 to 4 refer)

Contact for further information:
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Executive Summary

This report provides an initial overview of immunisation and screening programmes locally and proposes an assurance process for the Lancashire Health and Wellbeing Board.

Recommendations

The Lancashire Health and Wellbeing Board are asked to:

i. note the local arrangements in place to monitor the performance, quality and safety of screening and immunisation programmes.

ii. seek quarterly assurance from NHS England and Public Health England on the performance of all screening and immunisation programmes for its residents. The assurance report should include the following:
   a. information on uptake and coverage, highlighting particular issues of local relevance
   b. a summary of any serious incidents and their impact on the local population
   c. a programme of activities aimed at improving uptake and coverage locally

iii. seek an annual report from NHS England and Public Health England on the performance of all screening and immunisation programmes for its residents.

Background and Advice

Lancashire County Council

1. Issue for consideration

1.1. National immunisation and screening programmes exist to provide good protection against infectious diseases and promote early diagnosis of a number of serious conditions. Their effectiveness and cost effectiveness depends on the existence of a systematic approach, strict adherence to quality markers, and co-ordinated multidisciplinary working.

1.2. Effective delivery of screening and immunisation programmes will contribute to the stated goals with the Lancashire Health and Wellbeing Strategy, across Starting Well, Living Well and Ageing Well Programmes. It is therefore important for the Lancashire Health and Wellbeing Board to seek regular assurance on the local performance and safe delivery of these national programmes.

1.3. This report provides an initial overview of immunisation and screening programmes locally and proposes an assurance process for the Lancashire Health and Wellbeing Board.

2. NHS Screening Programmes

2.1. Eleven NHS screening programmes (figure 1) identify important diseases early enough to achieve better outcomes:

Figure 1. NHS SCREENING PROGRAMMES

NHS Breast Screening Programme
NHS Cervical Screening Programme
NHS Bowel cancer Screening Programme
NHS Abdominal Aortic Aneurysm Screening Proramme
NHS Diabetic Eye Screening Programme
NHS Newborn Hearing Screening Programme
NHS Newborn and Infant Physical Examination Programme
NHS Newborn Bloodspot Screening Programme
NHS Sickle Cell and Thalassaemia Screening Programme
NHS Infectious Diseases in Pregnancy Screening Programme
NHS Down's Syndrome and Fetal Anomaly Screening Programme

3. NHS Immunisation Programmes

3.1. Immunisation is one of the most effective public health measures to protect individuals and the community from serious infectious diseases (figure 2).

3.2. National programmes are targeted to specific groups such as newborn babies, children, pregnant women and frontline health and social care workers.

Figure 2. INFECTIOUS DISEASES FOR WHICH NHS IMMUNISATION IS AVAILABLE

Diptheria	Rubella
Tetanus	Seasonal influenza
Pertussis (whooping cough)	Human Papilloma Virus
Polio	Shingles
Haemophilus influenza type b	Hepatitis B
Pneumococcus	Tuberculosis
Rotavirus	Chicken pox
Meningitis C	Hepatitis A
Measles	Typhoid
Mumps	Cholera

3.3. The detailed immunisation schedule is available at:

http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-schedule-age-checklist.aspx

4. Commissioning responsibilities

4.1. Since April 1st 2013, NHS England has been responsible for the commissioning of immunisation and screening programmes. Locally, this responsibility is discharged through NHS England's Lancashire Area Team. Public Health England also plays a key role by employing expert teams of public health specialists who are 'embedded' into the Area Teams to support the delivery of screening and immunisation programmes.

4.2. Local authorities also have a role to play as they are responsible for ensuring plans are in place to protect the health of their population, improve health and reduce health inequalities[1]. The Director of Public Health must provide local leadership and liaise with local councillors, schools, communities, CCGs and primary care to ensure there is sufficient uptake of immunisation and screening programmes.

[1] http://www.local.gov.uk/publications/-/journal_content/56/10180/4068839/PUBLICATION

5. Delivery

5.1. The majority of immunisation programmes and the cervical screening programme are delivered in general practice. Community service providers (Lancashire Care NHS Foundation Trust and Blackpool Teaching Hospitals NHS Foundation Trust) employ immunisation teams to deliver school-based vaccination programmes (HPV, Meningitis C, the school-leavers' booster and seasonal influenza). Screening for bowel and breast cancer, diabetic retinopathy and abdominal aortic aneurysm are mostly delivered by NHS acute trusts while antenatal and newborn screening programmes are delivered by maternity service providers.

6. Performance monitoring and oversight

6.1. Information on immunisation and screening performance is collected nationally by NHS England from the various providers on a quarterly basis. Comparative data is then published in the following quarter.

6.2. The NHS England Lancashire Area Team has established a multi-agency Lancashire Screening and Immunisation Oversight Group. This reports to the Lancashire Quality Surveillance Group and has oversight of local Programme Boards for all screening and immunisation programmes. (Appendices 1a and 1b)

6.3. The Lancashire Screening and Immunisation Oversight Group meets quarterly to review and address issues relating to quality, performance, serious incidents and risks.

6.4. The latest performance reports for local immunisation and screening programmes are appended to this paper (Appendices 2 and 3). An update paper for DsPH (September 2014) summarising key issues for each group of programmes is also provided (Appendix 4).

7. Recommendations

7.1. The Lancashire Health and Wellbeing Board are asked to note the arrangements in place to monitor the performance, quality and safety of screening and immunisation programmes

7.2. It is recommended that the Lancashire Health and Wellbeing Board seek quarterly assurance from NHS England and Public Health England on the performance of all screening and immunisation programmes for its residents. The assurance report should include the following:

- information on uptake and coverage, highlighting particular issues of local relevance
- a summary of any serious incidents and their impact on the local population
- a programme of activities aimed at improving uptake and coverage locally

7.3. It is recommended that the Lancashire Health and Wellbeing Board seek an annual report from NHS England and Public Health England on the performance of all screening and immunisation programmes for its residents.

Consultations

N/A

Implications

This item has the following implications, as indicated:

The Lancashire Health and Wellbeing Board will receive regular assurance on the local performance and safe delivery of national screening and immunisation programmes.

Risk management

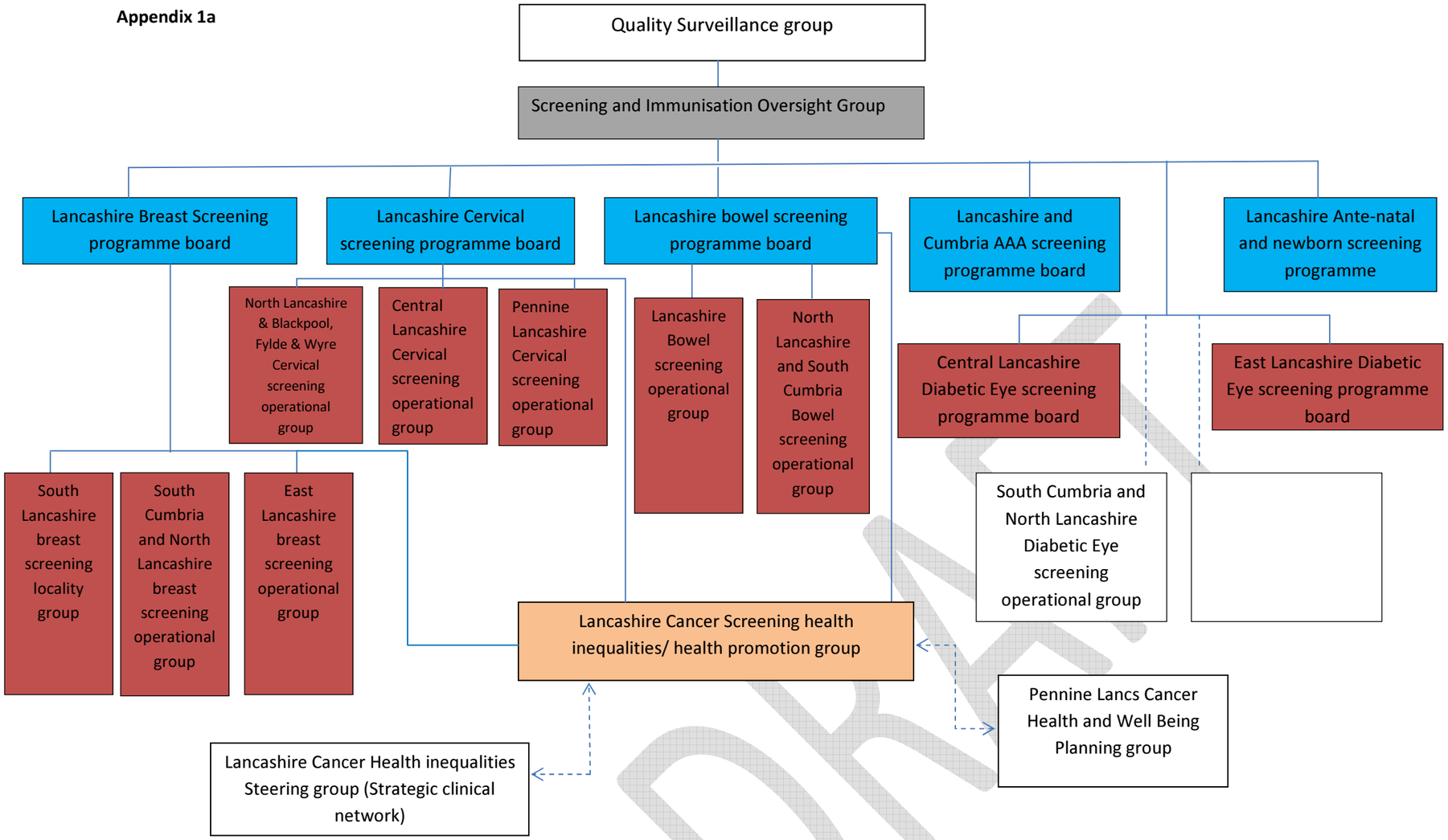
Effective delivery of screening and immunisation programmes is a key contribution to the delivery of the Lancashire Health and Wellbeing Strategy through preventing ill health, promoting healthy pregnancy, reducing infant mortality and reducing avoidable deaths. If the Lancashire Health and Wellbeing Board do not receive regular assurance on the local performance and safe delivery of national screening and immunisation programmes, they will not be able to oversee and monitor the delivery of the strategy.

List of Background Papers

Paper	Date	Contact/Directorate/Tel

Reason for inclusion in Part II, if appropriate

Appendix 1a



Membership to include as a minimum-

- CCG's
- Providers
- Patient rep
- Primary care rep (where appropriate)
- SIT

Membership to include as a minimum-

- CCGs
- Local Authority DPH
- PHE
- LAT- Nursing, Quality and public health

Membership to include as a minimum-

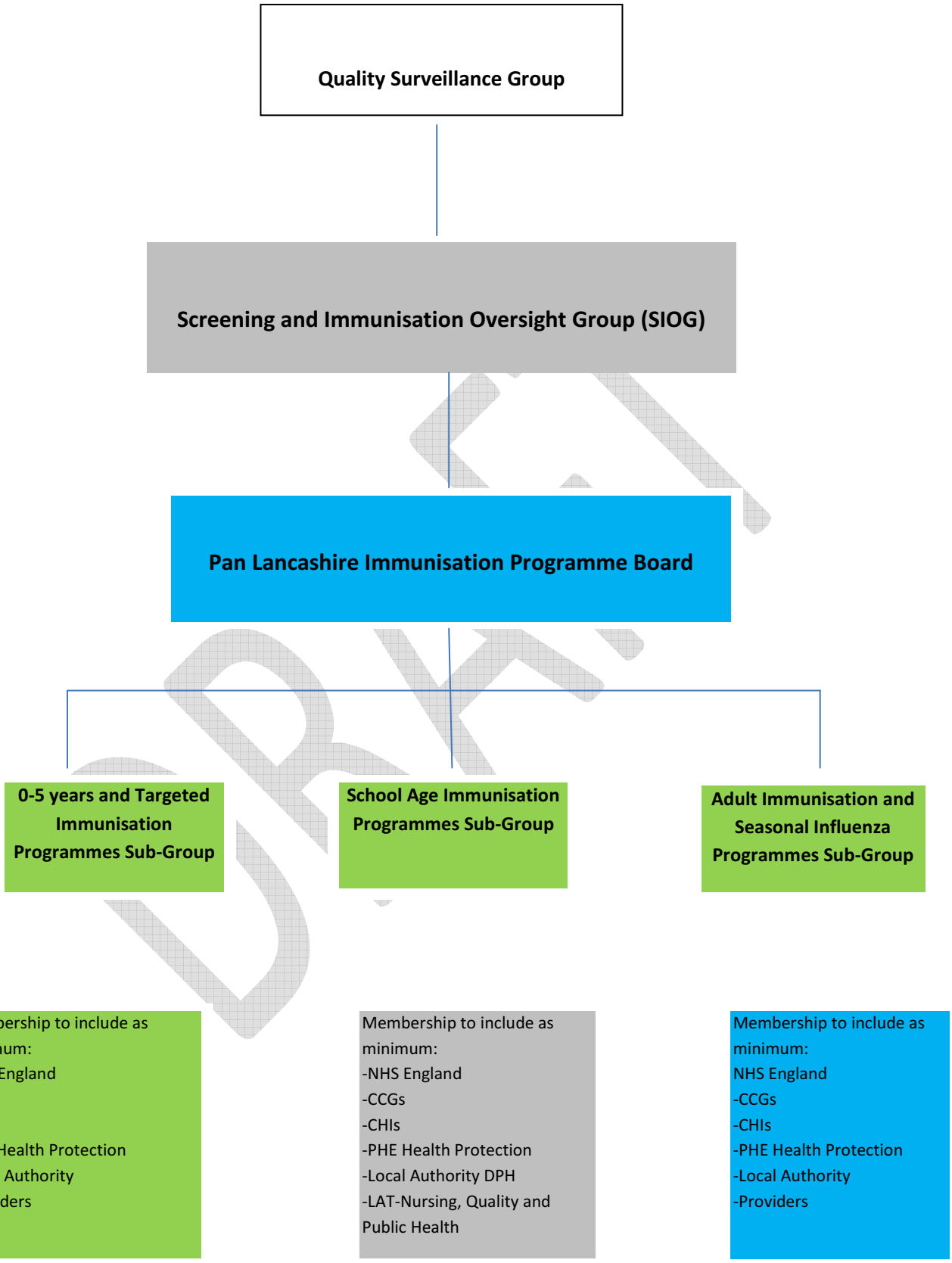
- Providers
- Clinical leads
- Programme managers (where appropriate)
- QA
- Patient rep
- SIT
- LAT (Public health)
- Local authority

Membership to include as a minimum-

- SIT
- Bowel cancer screening health promotion lead
- Local Authority
- 3rd sector organisations as appropriate
- Provider (e.g. LCFT)

Appendix 1b

IMMUNISATION GOVERNANCE STRUCTURE



Appendix 2

NHS England Lancashire Area Team

Immunisation Performance Report

September 2014

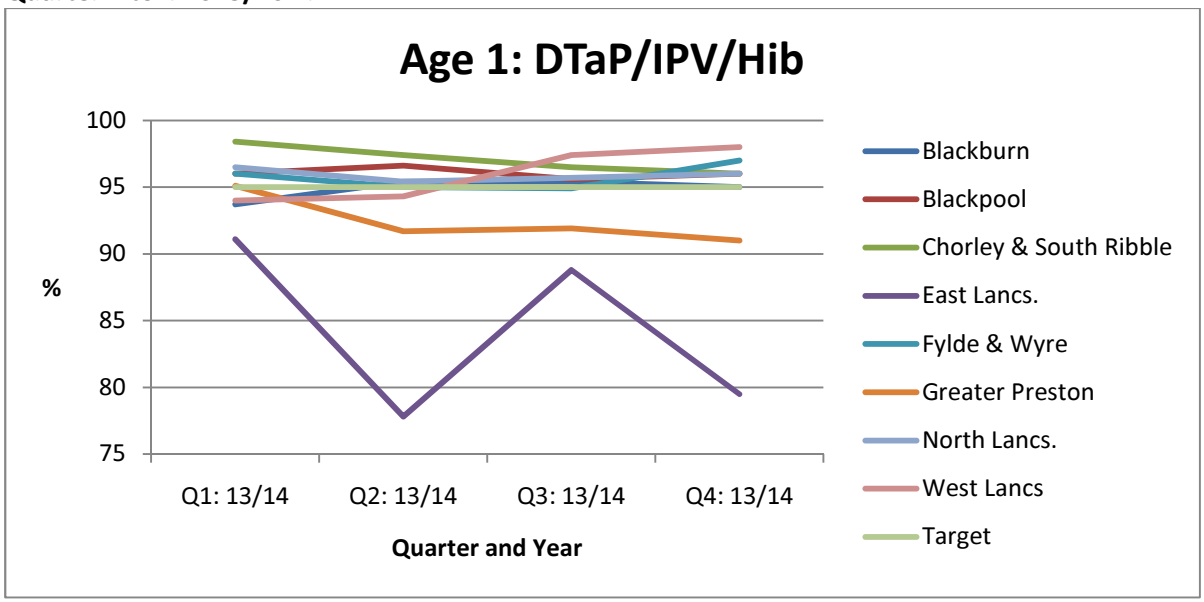
Martin Samangaya
Screening and Immunisation Manager

Introduction

This report will provide an over view of all the national immunisation programmes. The data presented is from Quarter 1 to 4 2013/2014. The 0-5 immunisation programme figures are based on the quarterly COVER (Coverage of Vaccine Evaluated Rapidly) data which is produced and published by Public Health England formally the Health Protection Agency.

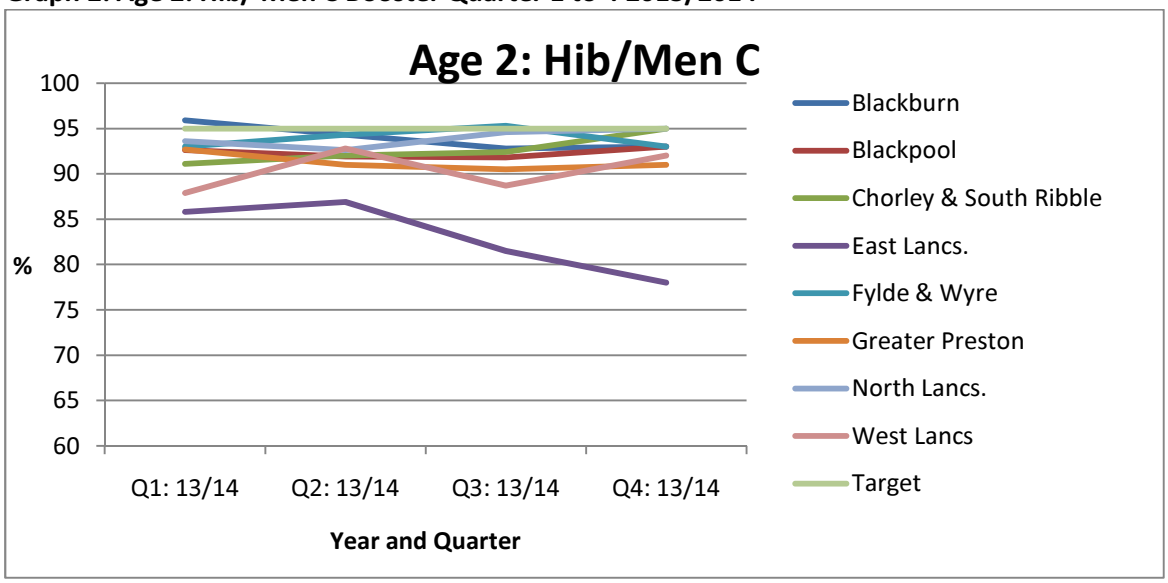
Childhood immunisation programmes

Graph 1: Age 1: Diphtheria, Tetanus, Polio, Pertussis, *Haemophilus influenzae* type b (Hib) Quarter 1 to 4 2013/2014



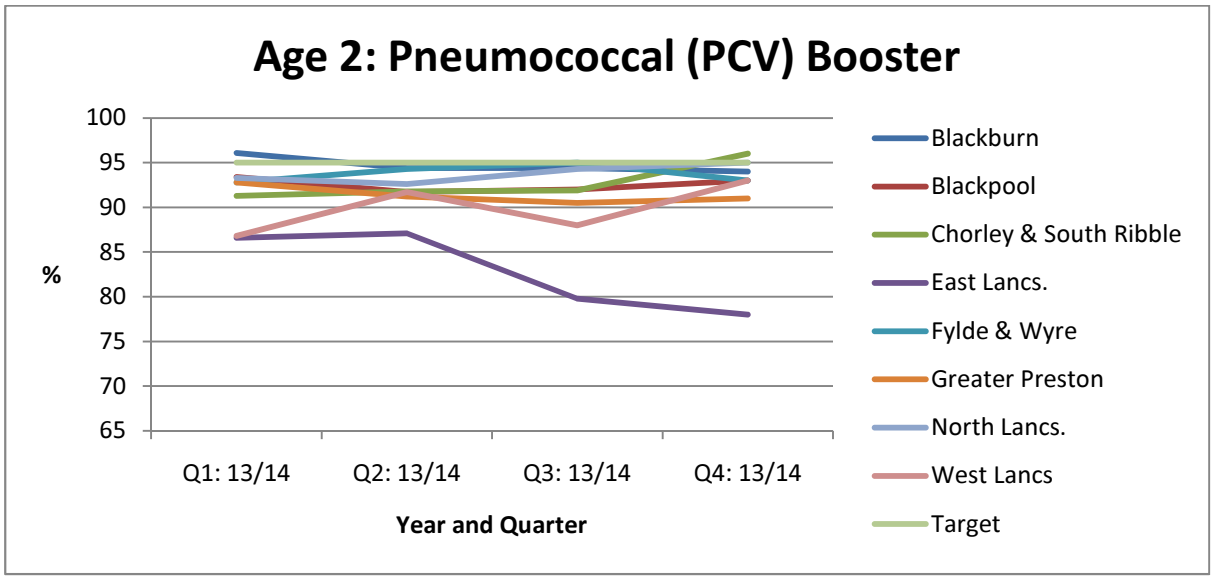
The above figures are for children who have received their third dose of diphtheria, tetanus, polio, pertussis and Haemophilus influenzae type b (Hib) by the age of 12 months.

Graph 2: Age 2: Hib/ Men C Booster Quarter 1 to 4 2013/2014



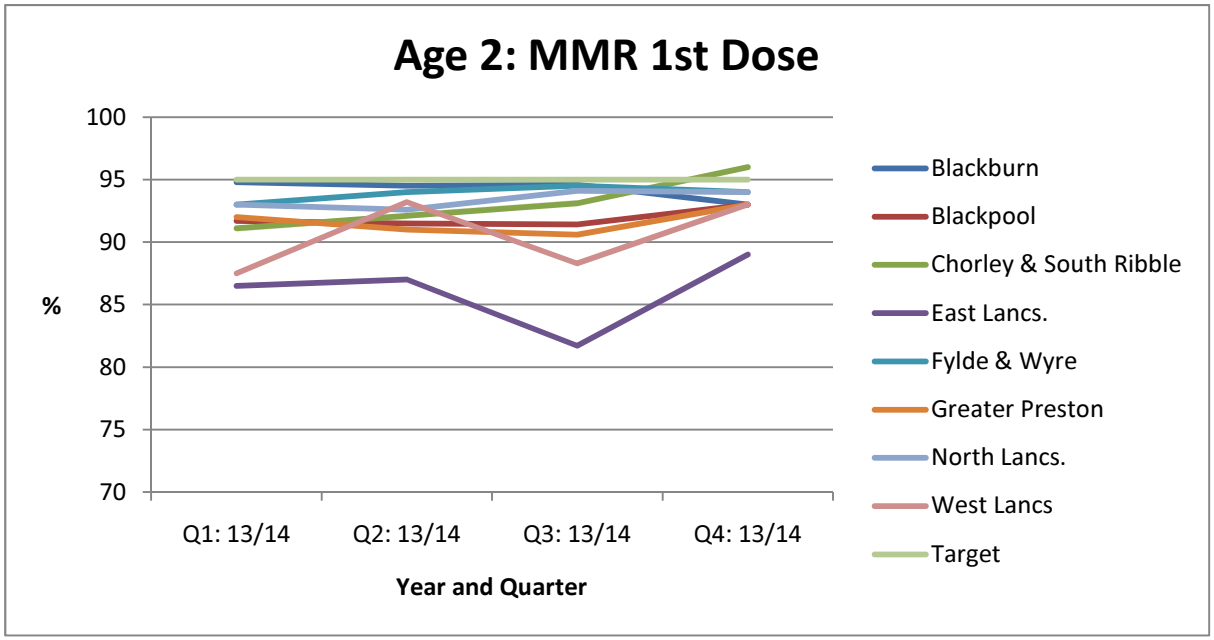
The graph above highlights the uptake figures of children who have received the Hib/Men C Booster by the age of 2 years old. The Hib/Men C booster is given when children are 12 months old.

Graph 3: Age 2: Pneumococcal (PCV) Booster Quarter 1 to 4 2013/2014



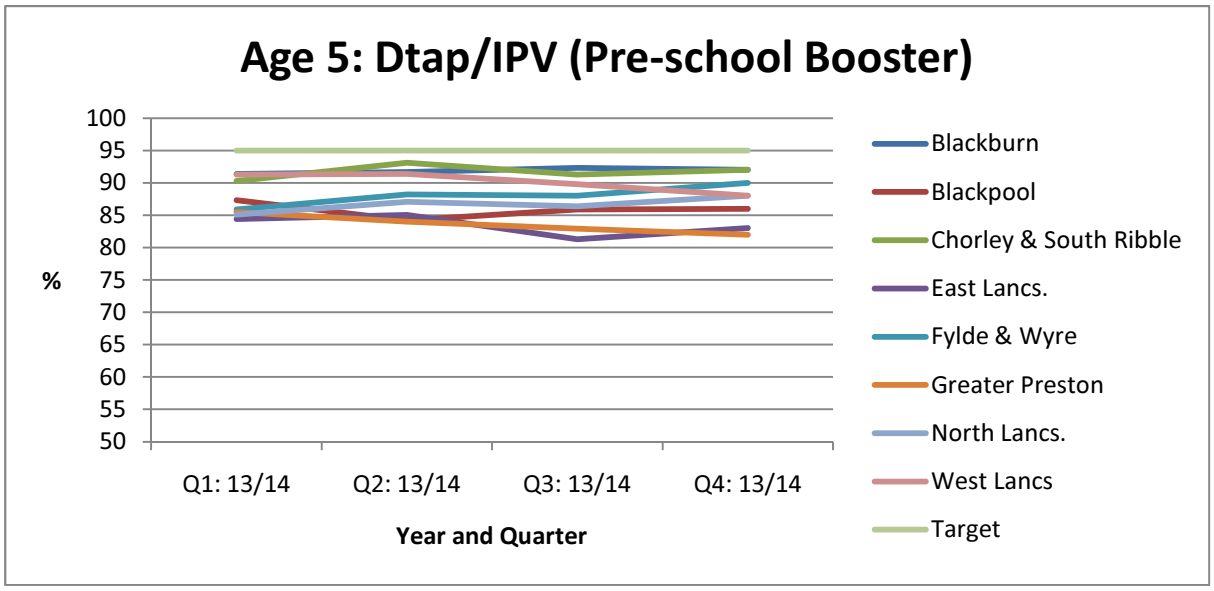
The graph above highlights the uptake figures of children who have received the Pneumococcal Booster (PCV) by the age of 2 years old. The PCV booster is given when children are 12 months old and can catch up until they are 18 months old.

Graph 4: Age 2: Measles, Mumps & Rubella (MMR) Quarter 1 to 4 2013/2014



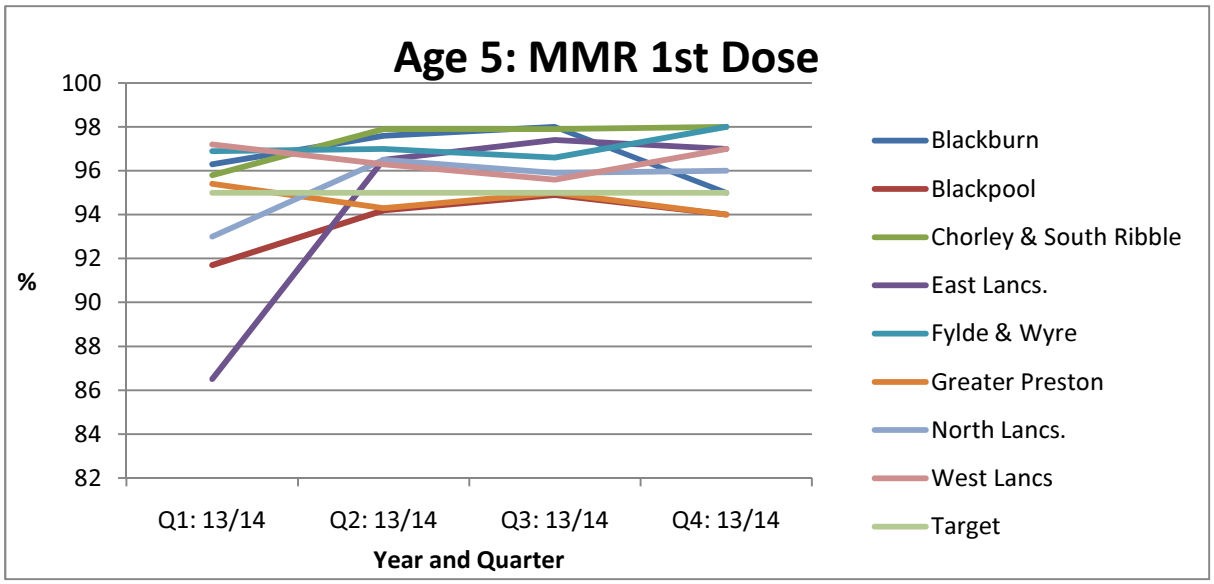
The above figures are for children who have received their first dose of measles, mumps and rubella (MMR) by the age of 2 years old. The first MMR dose according to the UK immunisation schedule is given at the age of 12 months, if missed it can be given at any time.

Graph 5: Age 5: Diphtheria, Tetanus, Polio Pertussis (Pre-school booster) Quarter 1 to 4 2013/2014



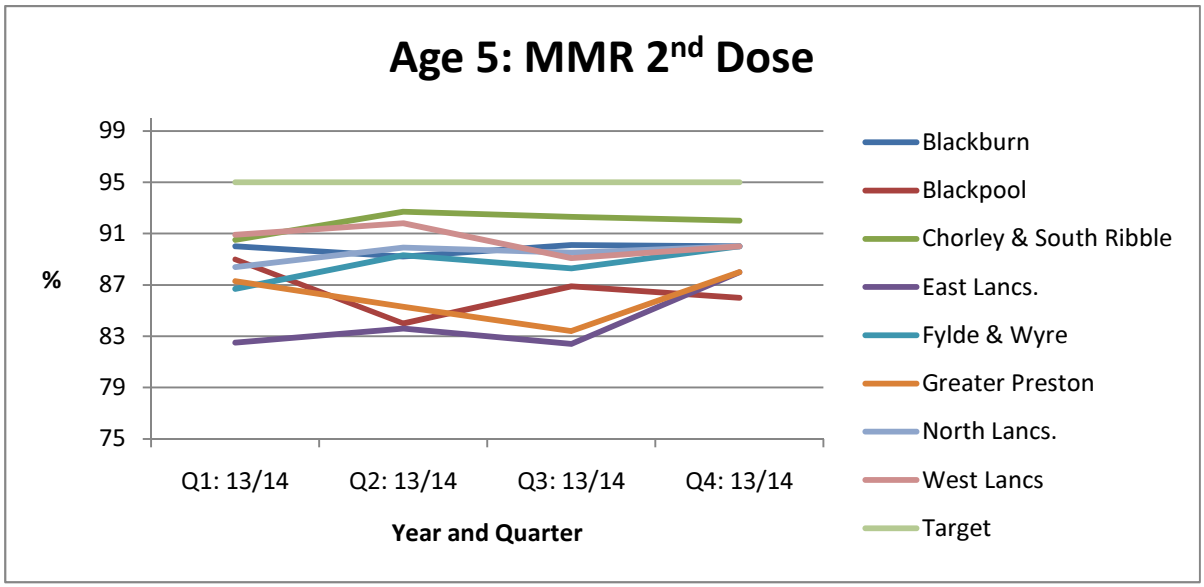
The graph above highlights the uptake figures of children who have received their diphtheria, tetanus, polio and pertussis booster doses which are given together with the second MMR dose.

Graph 6: Age 5: MMR 1st Dose Quarter 1 to 4 2013/2014



The above figures are for children who have received their first dose of measles, mumps and rubella (MMR) by the age of 5 years. In all the quarters although children are not getting their first dose of MMR by the age of 2 years old, the majority of them are getting their first dose after the age of 2 years and before the age of 5 years old.

Graph 7: Age 5: MMR 2nd Dose Quarter 1 to 4 2013/2014



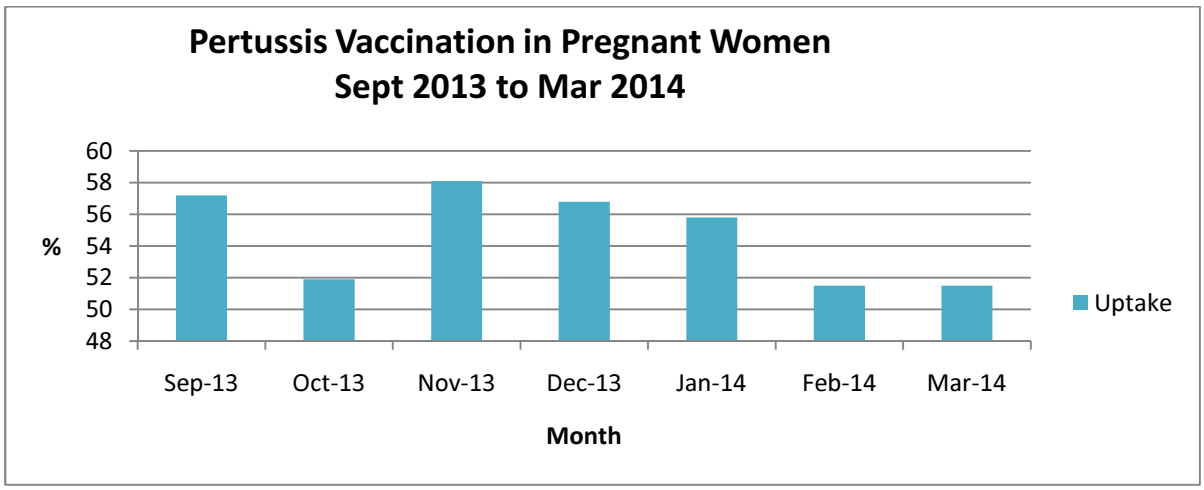
The above figures are for children who have received their second dose of measles, mumps and rubella (MMR) by the age of 5 years old. For children to be fully protected against measles, mumps and rubella they require two doses of MMR to cover them for life.

The uptake figures

- The 2013/2014 uptake figures were generally good across Pan Lancashire. As highlighted in previous reports there were on-going reporting and data issues in East Lancashire which is currently being addressed and a plan is now in place to rectify the issues.
- The pre-school booster and MMR uptake remains a concern across all the areas, which means there are a significant number of children starting primary school with incomplete immunisation status.
- The Screening and Immunisation Team has started doing practice visits to support and advice on how to improve immunisation uptake
- The three immunisation sub groups 0-5 Immunisation and targeted Programmes, School Aged Immunisation Programmes and Adult and Seasonal Influenza Immunisation Programmes are now in place and fully operational.

Pertussis (Whooping Cough) in pregnant women programme

Graph 8: Pertussis in pregnant women from April 2013 to March 2014



The programme was introduced in October 2012 after a national pertussis outbreak affecting babies under the age of two months not old enough to receive their primary immunisations. The programme has now been extended for an additional 5 years.

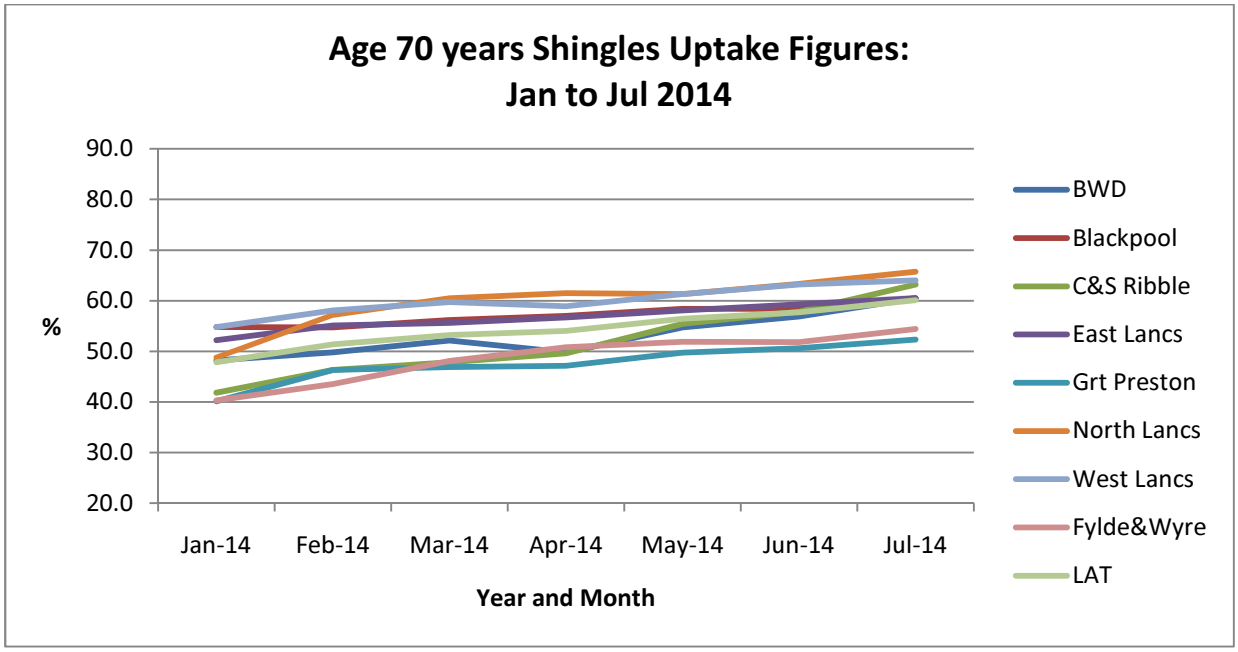
Points to note

- The uptake for this programme has been poor, this is partly due to how the data was collected
- In Lancashire the figures are based on the practices that uploaded the data just about 50% of practices
- As from April 2014 the figures are now collected on quarterly basis instead of monthly.
- In order to improve uptake the Area Team need to consider commissioning community pharmacies and maternity services to also deliver this programme

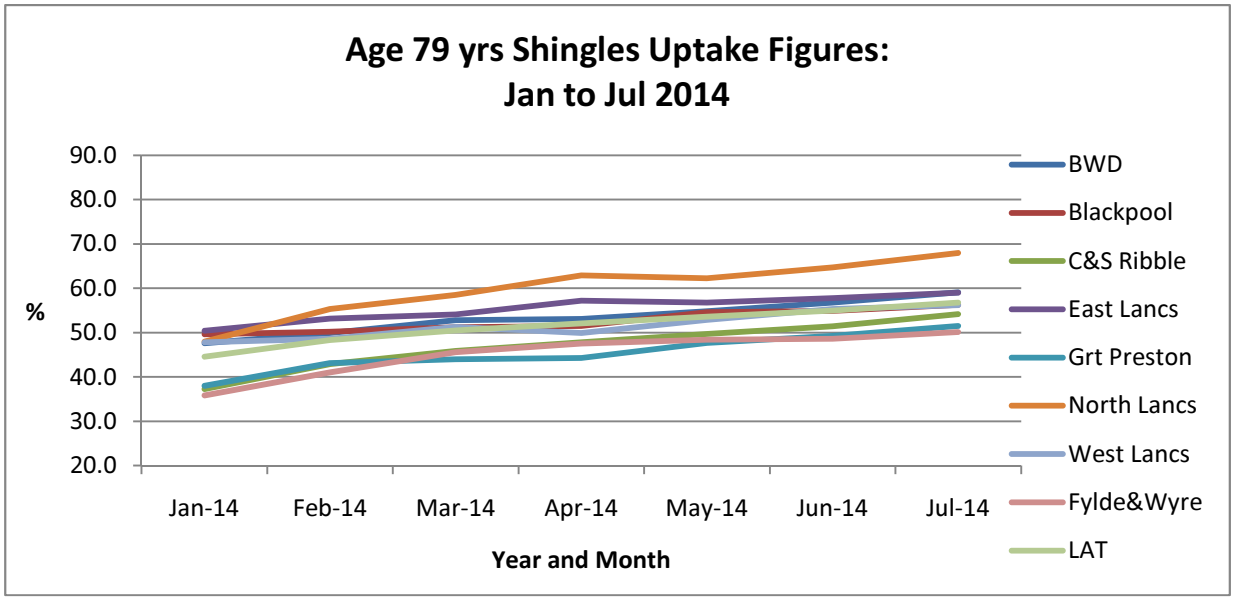
Shingles Programme

The programme was introduced in September 2013 and is offered to patients aged 70 years and 79 years old. The patients are offered a single dose of the vaccine and this is done in primary care.

Graph 9: Age 70 years old Cohort Shingles uptake



Graph 10: Age 79 years old Cohort Shingles uptake



Points to note

- The uptake figures are based on the Sentinel practices data uploaded from 223 out of 232 practices
- The uptake figures across Lancashire steadily increased since the programme began in September 2013
- This year the programme is been offered to patients aged 70, 78 and 79 years old.

Update on New Immunisation programmes

Men C Adolescent Programme

The Men C Adolescent programme was announced last year with the recommendation to offer the Men C adolescent booster dose in Year 9 or Year 10 together with the school leavers' booster

Points to note

- The programme was delivered in Blackpool and North Lancashire secondary schools in Year 10 during the 2013/2014 school year.
- This year in Blackpool and North Lancashire the programme is continuing and targeting the Year 10 cohort.
- In areas covered by the provider LCFT this year they are targeting Year 10 and Year 11

Human papillomavirus (HPV) Programme

- The HPV schedule will be changing from September 2014 reducing the programme from 3 doses to 2.
- The Department of Health recommendation is to offer a dose in Year 8 and then second dose in Year 9

- The HPV uptake figures across Lancashire have meet the national target of 90%.

Key issues

- Cohort denominator changes on a monthly basis and this cannot be changed on the ImmForm site until the final figures are received
- A real time reporting template is now in place and will be used by the providers to highlight the coverage across the Pan Lancashire area
- HPV immunisations are not recorded on open Exeter in some areas

Public Health England

NHS England

Appendix 3

Lancashire Area Team Screening Performance Review

September 2014

(This report is for discussion at the Screening and Immunisation Oversight group and should not be shared widely as Q4 data is currently unpublished)

Kerry Crooks
Screening and Immunisation Manager

Introduction

This quarterly screening performance report provides an overview of the national screening programmes in operation across Lancashire.

1. Bowel Screening

1.1 Bowel screening uptake (2013/14)

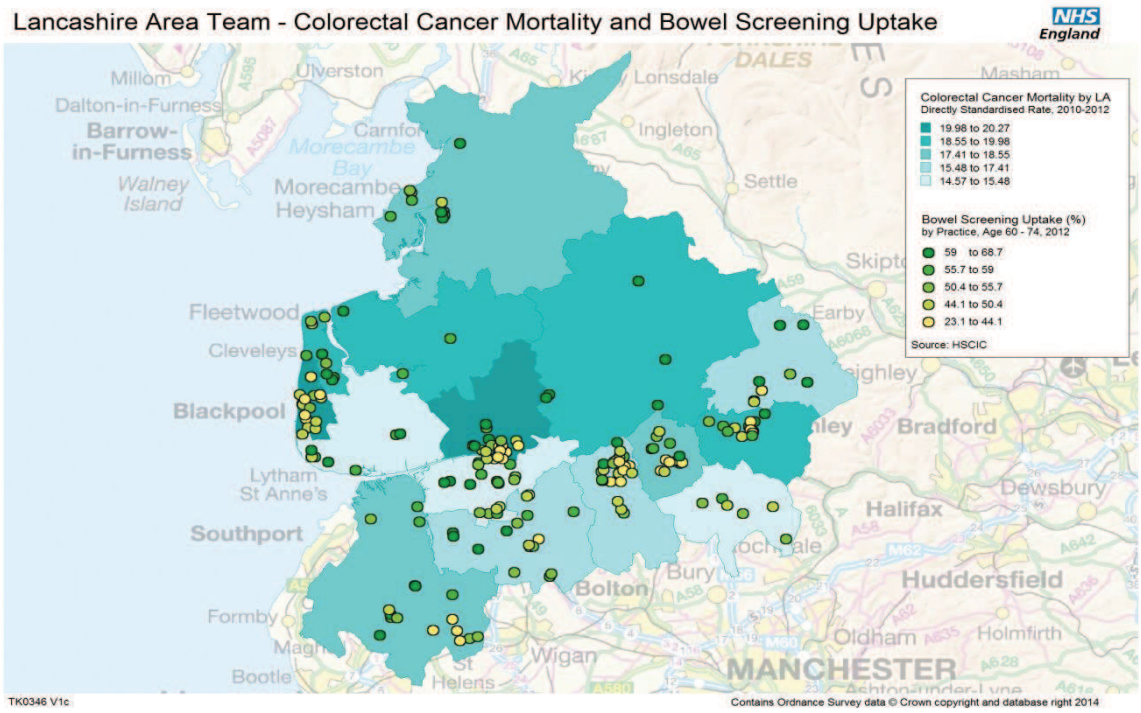
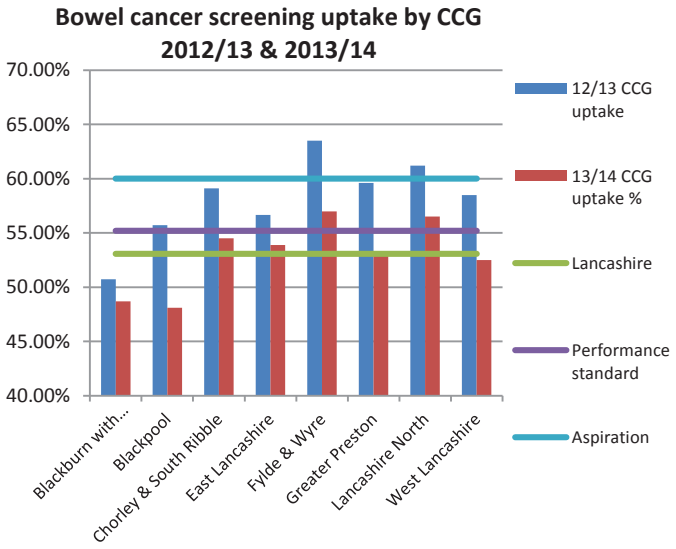


Figure 1 Bowel screening uptake (2012) source national bowel screening systems (OBIEE)



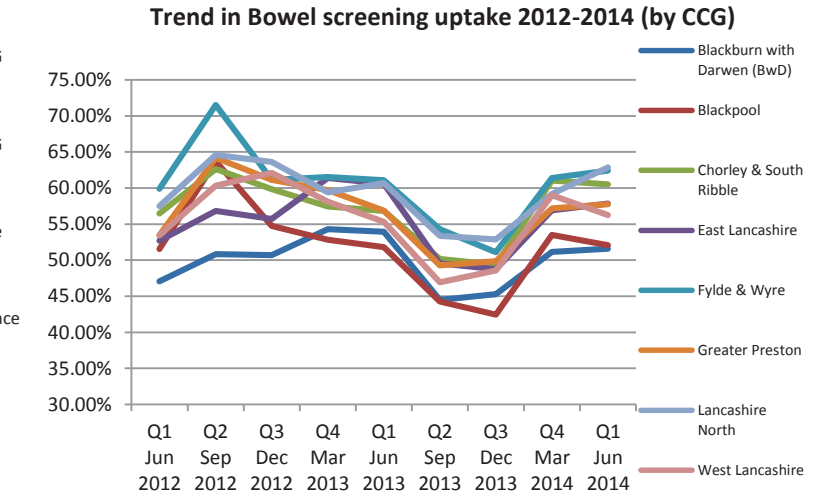


Fig 2: Bowel cancer screening uptake (2013)

Fig 3: Trend in uptake by Quarter 2012-2014

Points to note:

- Uptake has declined in most CCGs comparing 2012/13 with 2013/14.
- The map illustrates a large number of practices reaching 55%+. Many of the lower uptake practices are centered within the more deprived areas.

1.2 Bowel Scope programme

The Lancashire bowel scope programme commenced in December 2013 with the first scopes undertaken in Feb 2014. The data below shows some activity to date. The programme is currently rolling out in Blackpool with a phased roll out across Lancashire which will be completed in 2016.

Programme activity 01.01.2014- 05.09.2014

1.01.14 to 05.09.14	
Subjects	1448
Responded to invitation	514 (response rate 35%)
Rescheduled rate	36.7% (of those that responded)
Attended	322 (22% uptake rate)
Colonoscopies required	20 (17 attended)

Table 1: Programme activity 01.01.2014- 05.09.2014 Data source: Lancashire BCSP

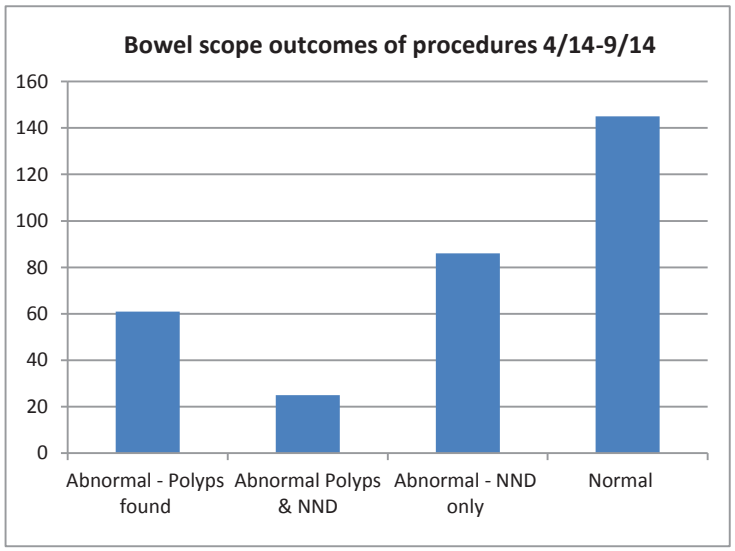


Fig 4: Outcomes of the bowel scope programme 01/14-09/14

The number awaiting histology is <5 therefore not reported in Fig 4

2.0 Breast Screening

2.1 Coverage

The coverage of the screening programme is the proportion of resident eligible women who have had a mammogram with a recorded result at least once in the previous 3 years.

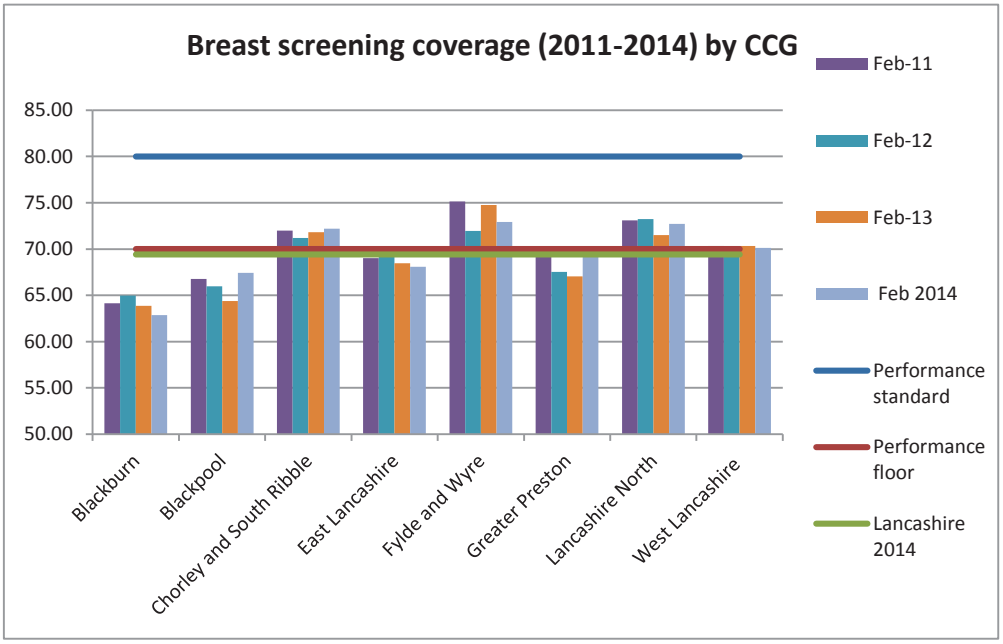


Figure 5 Breast screening coverage (September2013) Source: Primary care support services (PCSS)

Coverage is declining annually in all CCGs. Improving breast screening coverage is a priority for the Lancashire area team and the Screening and Immunisation team will be working with both the breast screening programmes and practices in the lower uptake areas.

2.2 Screen to assessment

All women with abnormal mammograms should be called to assessment within 3 weeks.

Screen to assessment- The percentage of women who attend an assessment centre within three weeks of attendance for their screening mammogram.								
	July to September 2013		**September to Dec 2013**		**Jan- March 2014**			
	≤ 3 weeks	**>3 weeks**	≤ 3 weeks	>3 weeks	≤ 3 weeks	>3 weeks	≤ 3 weeks	> 3 weeks
East Lancashire	99	1	97	3	98	2	95	5
North Lancashire	90	10	86	13	90	9	93	7
South Lancashire	89	10	83	16	79	20	1	99
Northwest	87.5	11.6	87.8	11.5	89.4	11.6	76.8	23.2
Minimum standard –≥ 90% Achievable- 100%								

Table 2: Screen to assessment **Data source: NW QA quarterly report**

Points of note:

- Screen to assessment- All programmes struggle with this KPI, but there has been good progress in East Lancashire and North Lancashire, South Lancashire is the only programme remaining below target. A recovery plan was put in place following the release of the Q4 figures and performance has been improving month and month and is now operating a screen to assessment for all women of 3 weeks or less.

3. Cervical Screening

3.1 Local Coverage

Coverage is the percentage of eligible women (25-64yrs) who have a recorded adequate test result within the last 5 years - national target 80%. The NW has seen a persistent downward trend for several years.

	25-49years (screened over the last 3 years)				50-64years old (screened over that last 5 years)			
	Coverage (%)	Additional screens per year to reach 80% (CCG)	Additional screens per month (CCG)	Estimated additional screens per practice per month	Coverage (%)	Additional screens per year to reach 80% (CCG)	Additional screens per month (CCG)	Estimated additional screens per practice per month
NHS Blackburn with Darwen CCG	60.4	1847	**153**	**6**	73.0	823	**68.5**	**2**
NHS Blackpool CCG	64.4	1372	**114**	**5**	71.4	1193	**94.9**	**4**
NHS Chorley and South Ribble CCG	70.1	954	**79**	**3**	76.9	458	**38**	**1**
NHS East Lancashire CCG	67.2	2529	**210**	**4**	76.5	1031	**86**	**1**
NHS Fylde and Wyre CCG	70.1	700	**59**	**3**	77.5	345	**29**	**1**
NHS Greater Preston CCG	64.4	1766	**147**	**5**	74.8	827	**69**	**2**
NHS Lancashire North CCG	66.5	1045	**87**	**7**	75.1	592	**49**	**4**
NHS West Lancashire CCG	67.9	670	**56**	**3**	75.9	388	**32**	**1**

Table 3: Cervical screening coverage by CCG Data source: PCSS (2014)

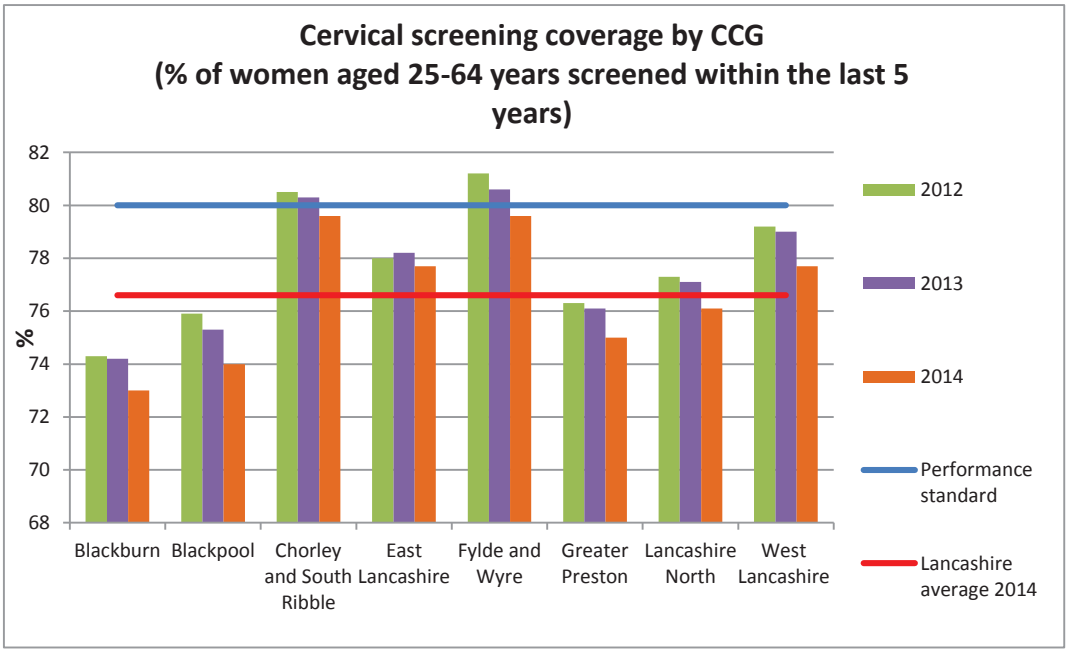


Fig 8: Cervical screening coverage (2014) **Source: Primary care support services (PCSS)**

Points to note:

- Coverage is declining annually in all CCGs and this is a similar picture nationally. Improving cervical screening coverage is another key priority for the Lancashire area team and the Screening and Immunisation team will be working with CCGs and practices to support practices in improving coverage especially in the younger age groups and target population groups.

4.0 Diabetic Eye Screening

4.1 Uptake and issuing of results

Uptake is the percentage of invited patients that attend for an annual screening. The marked variation in uptake between the programmes is likely to be due to issues with the programme software systems which are currently being updated by Digital healthcare.

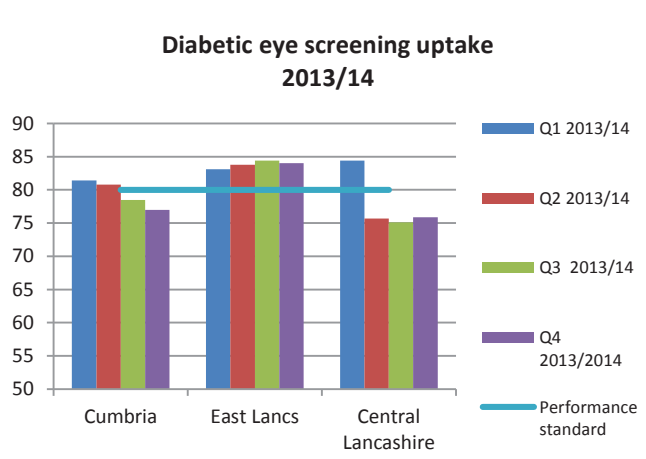


Fig 9: Diabetic eye screening uptake (2013/14)
Source of data- KPI returns

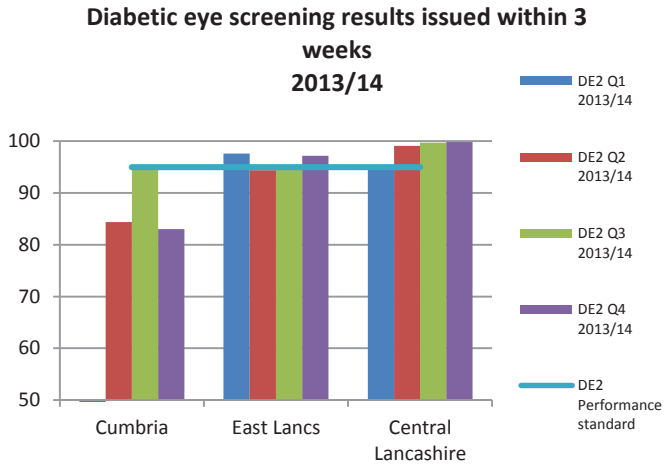


Fig 10: Diabetic eye screening issuing of results (2013/14)

5. Abdominal Aortic Aneurysm (AAA) Screening

5.1 Uptake

The definition of uptake is the percentage of those offered screening who accept the initial offer.

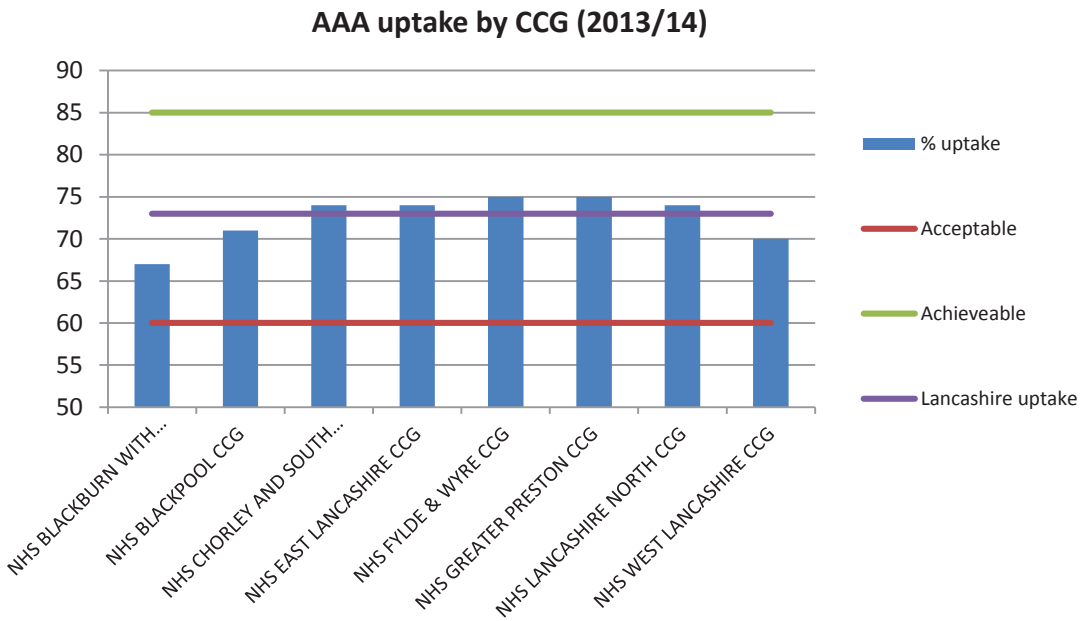


Fig 11: AAA Uptake by CCG (2013-14) Source- Screening programme data

Points to note:

- The programme has now been established for a full year, the acceptance rate is already over 60% in all CCGs.

5.2 Self referrals

	13/14	To date 14/15
Number of referrals	**389**	**455** June 166 July 86 August 48 (A publicity campaign took place in June)

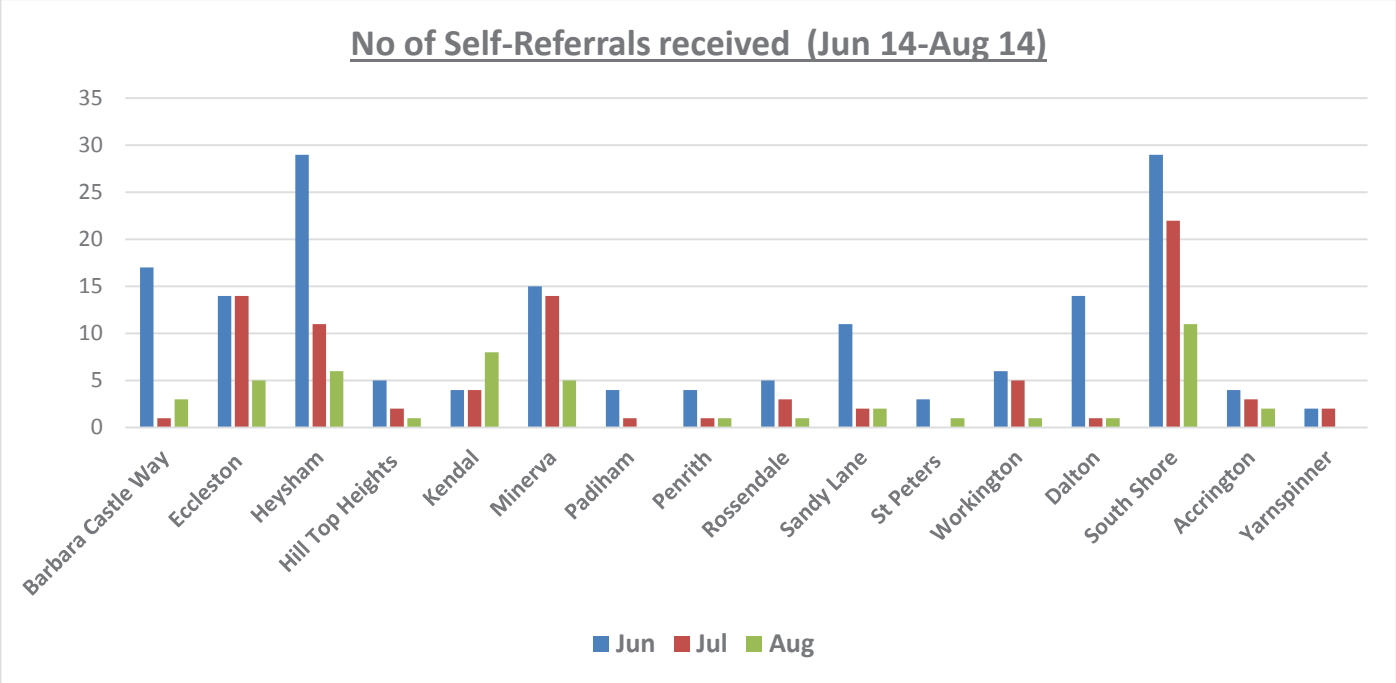


Fig. 12: Self referrals by site

5.3 Uptake within the local prison population

No of Self Referrals / No of men screened Dec 13 to Aug 14				
Clinics	**Self-Referrals**	**In Cohort**	**Consented for Scan**	**No of Clinics**
HMP Kirkham	6	0	6	2
HMP Wymott	13	7	20	2
HMP Garth	18	3	21	3
Total	**37**	**10**	**47**	**7**

5. Antenatal & Newborn Screening

6.1 Infectious Diseases in Pregnancy, Fetal anomaly and Down's syndrome, Sickle Cell and Thalassemia and Newborn blood spot and Newborn infant physical examination programmes

		ID1 ≥ 95%	ID2 (below standard ≤ 70%, acceptable between 70-89.9%, achievable ≥ 90%)	FA1 (below standard less than 97%, acceptable between 97% and 99.9%. Achievable 100%)	STI (below standard less than 95%, acceptable 95% and 98.9%. Achievable 99% and over)	ST2 (below standard less than 50%, acceptable 50-74%, achievable over 74%)	ST3 (below standard less than 90%, acceptable 90-94.9%, achievable over 95)	NB2 (below standard more than 2.0, acceptable 2.0-0.5, achievable less than 0.5) - also reported in some areas by PCT	NP1 (Below standard <95%, acceptable 95-99%, achievable 100%)	NP2 (Below standard <95%, acceptable 95-99%, achievable 100%)
Blackpool	Q1 13/14	96	100	100	95	60.2	98.6	1.6		
	Q2 13/14									
	Q3 13/14	Awaiting data	Awaiting data	Awaiting data	Awaiting data	Awaiting data	Awaiting data	Awaiting data		
	Q4 13/14	**Awaiting data**	**Awaiting data**	**Awaiting data**	**Awaiting data**	**Awaiting data**	**Awaiting data**	**Awaiting data**		
East Lancashire	Q1 13/14	96.6	66.7	95	95.5	59.1	100	1		
	Q2 13/14	96.9	66.7	95	97	63	100	0.8		
	Q3 13/14	**96.9**	**50**	**97.5**	**97.3**	**67.8**	**100**	**0.5**		
	Q4 13/14	**96.9**	**60**	**95**	**97.6**	**60**	**100**	**0.9**	**96.1**	
Lancashire Teaching Hospital	Q1 13/14	**99.2**	**no cases**	**98.4**	**99.1**	**56.9**	**99.2**	**0.8**		
	Q2 13/14	98.9		99.3	99.1	54.5	99	1.5		
	Q3 13/14	**98.9**	**100**	**98.8**	**98.9**	**50.3**	**99.3**	**2.1**	**90.3**	
	Q4 13/14	**99.4**	**50**	**99.7**	**99.5**	**40.5**	**97.7**	**2.2**	**91.7 (97 in well babies)**	**66.7**
Southport and Ormskirk	Q1 13/14	**97**	**no cases**	**100**	**96.30%**	**28.2**	**97.6**	**2.7**		
	Q2 13/14	99.4		96.7	98.5	15	97.2	2.4		
	Q3 13/14	**98.5**		**94.6**	**98.5**		**99**	**2.9**	**97.8**	**100%**
	Q4 13/14	**98.1**		**98.9**	**97.6**	**32**	**94.6**	**2.4**		
University Hospital of Morecambe Bay	Q1 13/14	99.4		84	100		100	3.0		
	Q2 13/14	100		94.2	100		99.3	2.3		
	Q3 13/14	**99.9**		**91.7**	**100**	**48.7**	**100**	1.2		
	Q4 13/14	**100**		**94.5**	**98**	**47.8**	**98**	2.1		

Table 4: Antenatal and Newborn screening KPI data submissions Date Source: Trust data

Definitions of the KPIs for all programmes are in appendix 1
Points to note:

- ID2- Timely referral of Hep B positive women- this indicator is affected by the small numbers involved and the fact that many women are already under the care of a consultant.
- FA1- Completion of laboratory request forms- Some trusts have made progress with this. This KPI will be discussed in depth at the next programme board to ascertain reasons from trusts for being unable to achieve the target.
- ST2- Timeliness of the test (less than 10 week's gestation) - to achieve this KPI work needs to be done to encourage women to book early for antenatal care.
- NB2-avoiadable repeats - Most maternity units have shown improvement in previous quarters however no trusts have met the KPIs this quarter. These issues will be raised at the next Antenatal and newborn meeting in October.
- NP1/ NP2- Maternity units are required to have systems in place to record NIPE outcomes by April 2015 all trusts have either implemented or have plans in place to implement SMART later this year.

6.2 Newborn blood spot (NB1)

This KPI measures the performance of the Newborn blood spot programme in testing babies and, where target conditions are detected, implementing treatment within an effective timeframe.

New born blood spot		NB1 (below standard less than 95%, acceptable 95% and 99.8%. Achievable 99.9% and over)	NB3 (acceptable 95% and 97.9%. Achievable 98% and over)
Blackpool PCT	Q1 13/14	99.10	99.7
	Q2 13/14	96.30	98.7
	Q3 13/14	87.90	99.8
	Q4 13/14	95.9	99.5
East Lancashire PCT	Q1 13/14	96.20	99.7
	Q2 13/14	95.20	99.7
	Q3 13/14	94.00	99.4
	Q4 13/14	95	99.9
Central Lancashire PCT	Q1 13/14	94.80	100
	Q2 13/14	96.70	90.5
	Q3 13/14	99.80	99.8
	Q4 13/14	96.7	99.7
Blackburn with Darwen	Q1 13/14	no data	no data
	Q2 13/14	96.60	94.3
	Q3 13/14	94.30	99.6
	Q4 13/14	95.8	99.4
North Lancashire PCT	Q1 13/14	95.40	99.6
	Q2 13/14	95.2	99.9
	Q3 13/14	91.6	100
	Q4 13/14	95.9	99.7

Table 4: Newborn bloodspot screening KPI data submissions Date Source: Trust data

6.3 Newborn hearing

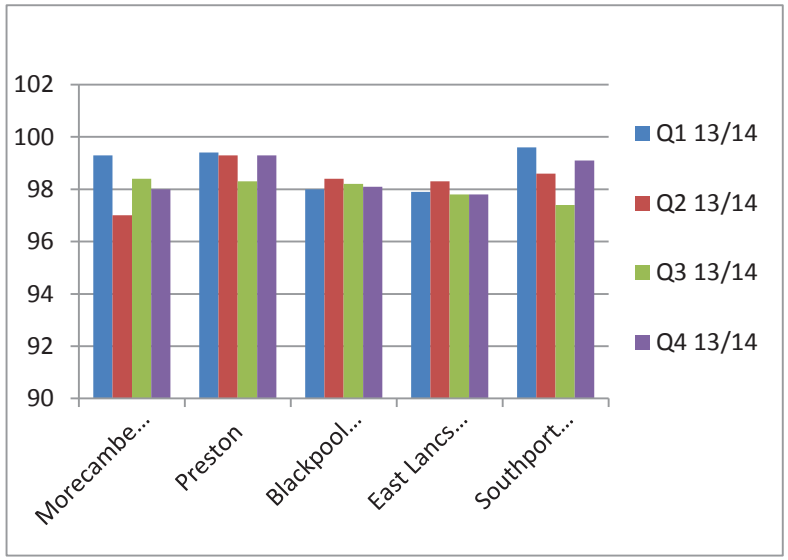


Fig 14: **Screens completed within 4wks (5wks in community) of birth**

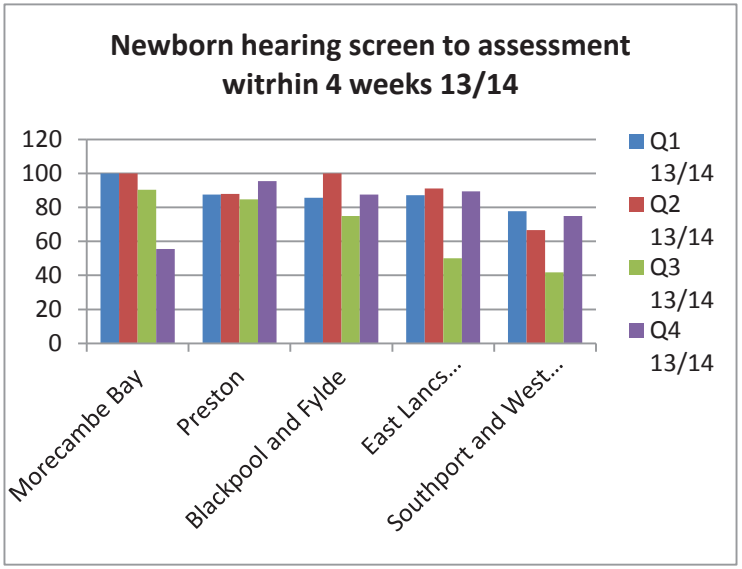


Fig 15: Screen Completion to Attended Assessment within 4 weeks

Data source- KPI submissions

Points to note:

- All centres are continuing to find it difficult to deliver NH2. Newborn hearing will be discussed in depth at the next Antenatal and Newborn meeting programme board to ascertain plans to improve performance. From Q1 2014/15 trusts will be required to report on breaches of NH2. There has been an improvement within some trusts for Q1 14/15 data and trusts are sharing best practice where they have managed to improve. A lot of the best practice involves joint working between maternity and health visitors.

Appendix 1 Antenatal and Newborn Screening KPI definitions

KPI ID1 Antenatal infectious disease screening – HIV coverage
Description: The proportion of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result. Numerator: tested women Denominator: eligible women

KPI ID2 Antenatal infectious disease screening – timely referral of hepatitis B positive women for specialist assessment
Description: The proportion of pregnant women who are hepatitis B positive who are referred and seen by an appropriate specialist within an effective timeframe (6 weeks from identification).
Numerator: women referred for hepatitis B
Denominator: pregnant women with hepatitis B

KPI FA1 Down's syndrome screening – completion of laboratory request forms
Description: The proportion of laboratory request forms including complete data prior to screening analysis, submitted to the laboratory within the recommended timeframe of 10+0 to 20+0 weeks' gestation.
Numerator: completed laboratory request forms Denominator: submitted laboratory request forms

KPI ST1 Antenatal sickle cell and thalassaemia screening – coverage
Description: The proportion of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report. Numerator: tested women
Denominator: eligible women

KPI ST2 Antenatal sickle cell and thalassaemia screening – timeliness of test
Description: The proportion of women having antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available by 10 weeks' gestation.
Numerator: women tested by 10 weeks gestation Denominator: women for whom sample received at laboratory

KPI ST3 Antenatal sickle cell and thalassaemia screening – completion of FOQ
Description: The proportion of antenatal sickle cell and thalassaemia samples submitted to the laboratory which is supported by a completed Family Origin Questionnaire (FOQ).
Numerator: laboratory requests with completed FOQ Denominator: laboratory requests

KPI NB1 Newborn blood spot screening – coverage (PCT responsibility at birth)
Description: The proportion of babies registered within the PCT both at birth and at the time of report who are eligible for newborn blood spot

screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe. For this KPI, PKU is used as a proxy for all tests and the test must be completed by 17 days of age.
Numerator: tested babies Denominator: eligible babies

KPI NB2 Newborn blood spot screening – avoidable repeat tests
Description: The percentage of babies from whom it is necessary to take a repeat blood sample due to an avoidable failure in the sampling process.
Numerator: avoidable repeats Denominator: initial blood samples

KPI NB3 Newborn blood spot screening – timeliness of result
Description: The proportion of newborn blood spot screening results which are screen negative for all five conditions, available for communication to parents within six weeks of birth.
Numerator: results available for communication by 6 weeks Denominator: babies screen negative for all 5 conditions

KPI NH1 Newborn Hearing Screening – coverage
Description: The proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks corrected age (hospital programmes-well babies, NICU babies) or by 5 weeks corrected age (community programmes-well babies).
Numerator: complete screens Denominator: eligible babies

KPI NH2 Newborn Hearing Screening – timely assessment for screen referrals
Description: The percentage of referred babies receiving audiological assessment within 4 weeks of the decision that referral for assessment is required or by 44 weeks gestational age.
Numerator: timely assessments
Denominator: assessment referrals indicated

KPI NP1 Newborn and Infant Physical Examination – coverage (newborn)
Description: The proportion of babies eligible for the newborn physical examination who were tested within 72 hours of birth.
Numerator: tested babies Denominator: eligible babies

KPI NP2 Newborn and Infant Physical Examination – timely assessment
Description: The proportion of babies who, as a result of possible abnormality of the hips being detected at the newborn physical examination, undergo assessment by ultrasound within two weeks of birth Numerator: timely assessments
Denominator: number of babies with assessment referrals indication.

Screening & Immunisation Programmes in Lancashire

Update for Directors of Public Health
September 2014

The Screening & Immunisation Oversight Group has met quarterly since March 2014. It is chaired by the Director of Commissioning, Lancashire Area Team, and has invited representation from all key stakeholders. The group was set up as a sub-group of the Lancashire Quality Surveillance Group and, as such, receives reports on performance and quality; areas of risk; and serious incidents affecting any of the programmes.

Key issues for each group of programmes are given below. The fuller reports referred to above are also available.

Screening Programmes

Bowel Cancer Screening

- 2013/14 uptake in Lancashire ranged from 48.17% (Blackpool) to 57.25 (Fylde & Wyre) .
- Highest positivity rates were seen in the two areas with lowest uptake: Blackpool and Blackburn with Darwen.
- 75% of cancers diagnosed by the programme in 2013 were early stage (Dukes stages A and B), with only 6% diagnosed as Duke D (palliative care).

Bowel Scope screening

- The Lancashire bowel scope programme started in December 2013 with the first scopes undertaken in Blackpool in February 2014. A phased roll out across Lancashire will be completed in 2016.

Breast screening

- Coverage is declining annually in most CCGs and addressing this is a priority for the Lancashire area team. Coverage is lowest in Blackburn with Darwen and Blackpool CCGs and highest in Lancashire North and Fylde & Wyre.

Cervical screening

- Coverage (25-64 yrs) is declining annually in most CCGs and none now achieve the national target of 80%. HSCIC information is still by PCT and ranged in 2012/13 from 74.3% in Blackburn with Darwen to 79.2% in North Lancashire PCT.
- Improving breast and cervical screening coverage is a key priority and the Area Team will be working with the programme providers, general practices and health inequalities group in the lower uptake areas to try to encourage more women to accept the screening offers.
- The screening & immunisation co-ordinators have recently begun a series of targeted visits to practices to offer support to those with poor performance against a range of KPIs.

Diabetic Eye Screening

- A lack of confidence in the ability of two programmes to provide assurance on pathway performance and/or affordability has led to a decision to re-procure diabetic eye screening services across East and Central Lancashire.

Antenatal & Newborn Screening Programmes

- Newborn Bloodspot test. Most maternity units have reduced the number of avoidable repeat tests over the past year and continue to monitor levels closely. The expansion of this programme (from 5 to 9 tests) will be rolled out nationally this year.
- Pulse oximetry testing on all newborns will be introduced in pilot areas in 2015.

Child Health Information System (CHIS)

- Lack of a fully functioning CHIS system is limiting the ability of the Area Team to ensure the accuracy of reporting on screening and immunisations for under 5s and school age children. It also provides an ineffective failsafe for newborn screening and primary immunisations.

Immunisation Programmes

0-5yrs

- 2013/2014 uptake figures were generally good across Lancashire.
- There are on-going data reporting and recording issues in East Lancashire CCG which are currently being addressed and an action plan is in place to rectify them.

Pre-school booster and MMR

- Uptake is a concern across all the areas of Lancashire with a significant number of children starting primary school with incomplete immunisations.

Antenatal Pertussis

- Building on its success in reducing neonatal deaths from pertussis, the antenatal pertussis programme has been extended for an additional 5 years.
- The reported uptake in Lancashire has been poor so far (approximately 50%), due to a mixture of problems in recording; confusion about the appropriate timeframe in which to give the vaccine and responsibility for administration. The Area Team will discuss ways to improve programme uptake by clarifying the roles of general practices, maternity services also possibly community pharmacies.

Shingles

- The uptake figures across Lancashire steadily increased since the programme began in September 2013 and are close to 70%
- In 2014/15 the programme is been offered to patients aged 70, 78 and 79 years old.

Adolescent Meningitis C

- From 2014/15 the Adolescent Meningitis C vaccine will be offered to children in school year 10 in all schools in Lancashire.
- The programme began in 2013/14 in Blackpool and North Lancashire schools.
- In 2014/15 schools in all other areas of Lancashire will also be offering a catch-up programme for children in year 11.

Human papillomavirus (HPV) Programme

- The HPV schedule will be changing from 3 to 2 doses from September 2014. It will be offered as one dose in Year 8 and a second dose in Year 9.
- HPV uptake figures across Lancashire currently meet the national target of 90%.

2014/2015 Seasonal Influenza Programme

Primary Care

- The majority of the seasonal influenza programme will be delivered in primary care
- As from September 2014 all children aged 2 to 4 years will be offered the nasal influenza vaccine
- The target groups will include people aged 65 years and over, those aged under 65 years old in clinical risk groups, carers and pregnant women.

Community Pharmacies

- The Area Team is commissioning community pharmacies to immunise those in the clinical risk groups (18yrs to<65yrs) and pregnant women from September to November 2014, and 18years and over and pregnant women from December 2014.
- Over 60 pharmacies have expressed interest in taking part

Pregnant women

- Coverage remains <50% with no appreciable improvement since 2011.
- A co-ordinated effort is required to target pregnant women by working closely with maternity services and community pharmacies across Lancashire

Childhood Flu pilot

- The Area Team is piloting the implementation of flu immunisation to school years 7 and 8 using different methods of delivery to inform best practice for the national roll out.
- Lancashire Care Trust will deliver the programme to 76 schools between October and December 2014

Incidents and Significant Events

34 incidents and significant events have been notified to and investigated by the Lancashire screening & immunisation team between April 2013 and July 2014. 10 of these incidents met the threshold for reporting on STEIS. A report on new and ongoing and recently closed incidents, is made to the Screening & Immunisation Oversight Group each quarter. Incident action plans are overseen by the relevant programme boards.

Dr Shelagh Garnett
Screening & Immunisation Lead
September 2014

Lancashire Health & Wellbeing Board
Meeting to be held on 16 October 2014

Electoral Division affected:
All

Starting Well, Living Well & Ageing Well progress report
(Appendices 1 to 2.7 refer)

Contact for further information:
Mike Leaf: mike.leaf@lancashire.gov.uk tel: 01772 534393

Executive Summary

This paper provides an update to the Health & Wellbeing Board of the progress of the actions in the 3 programmes of work within the Health & wellbeing Strategy. The actions were agreed and approved at the Board meeting on 16th July.
The 3 programmes are:

- Starting Well
- Living Well
- Ageing Well

This paper describes:

- A summary of progress provided by each Programme Lead
- Progress against each action in Appendix 1
- The outcomes framework dashboard in Appendix 2.1 – 2.7
- Key risks identified
- Next steps

Recommendations:
The Health & Wellbeing Board is asked to:

i. note the progress of each programme
ii. note the key risks identified by the programme leads
iii. note the outcomes framework dashboard for monitoring the implementation of health and wellbeing strategy
iv. Discuss and suggest which programme the Board would like to receive a detailed report on at the next meeting.

Background and Advice

On 16th July, the Board agreed the content of the three programmes of work in the Health & wellbeing Strategy.
The three programmes of work are:

- Starting Well
- Living Well

Lancashire County Council

- Ageing Well

Progress:

A high level summary of each of the three programme areas is available in appendix 1.
Generally, good progress is being made but, understandably, progress is more advanced in some areas compared to other areas. But, as this is a new piece of work and involves partnership working, then this is to be anticipated at this early stage.
A summary of progress for each programme is below and a more detailed progress update is available in Appendix 1.

Starting well:
Below is a summary of some key areas of focus:

Integrated Inspection Framework - the CYP Trust submitted a consultation response to proposals for new integrated inspection arrangements from April 2015 which will include the following inspectorates: Ofsted; CQC; Probation; Prisons; Constabulary. The response supported the principle of an integrated inspection but questioned some of the detail around implementation.
Workforce Development – the CYP Trust Board agreed a new framework on 25 September 2014 for the development of the children's workforce which will prioritise activity around three key strands – prevention, early help and maximising resources
Health Visiting and Family Nurse Partnerships – supporting the transition of commissioning responsibility from October 2015 of 0-5 services to public health and how this provision will support the delivery of a prevention and early help offer to families
Prevention and Early Help – continuing to embed district early help panel arrangements, respond to areas of improvement identified through the early help thematic inspection and develop our collective understanding of early help and the multi agency response
Child Sexual Exploitation – the LSCB is leading work to consider the Rotherham report and any implications for Lancashire
Children in Need – refining our understanding of Children in Need and the service offer available
Summer holiday activities – the CYP Trust co-ordinated a programme of activities in July and August. Tens of thousands of children and young people participated and the programme was specifically promoted to the most vulnerable families. A full evaluation will be available in October.
Special Educational Needs and Disability (SEND) Reforms – from 1 September as part of the Children and Families Act 2014, implementation includes new Education, Health and Care Plans and the development of a Lancashire Local Offer which provides information about support and service for children with SEND.

Living well:
Activity across this programme is ongoing, with some areas of work accelerated as other areas are completed.

Although HWB partners are working to maximise opportunities for workstart and apprenticeships, baseline and update data are not currently available in reportable format. Members of the Board are requested to identify a point of contact for this element of the workstream within the organisation(s) they represent.

Work to reduce premature hospital mortality is ongoing, supporting East Lancashire NHS services to improve integration and support discharge from hospital. Similarly work is being scoped with Fylde & Wyre CCG to audit hospital deaths from stroke, with a view to making recommendations for improving quality or care for stroke patients. There is also work ongoing with AQUA (Advancing Quality Alliance) to support a hospital mortality collaborative in the North West with a view to sharing learning and best practice for wider roll out.

Activity is ongoing to increase public awareness and uptake of health checks through community and workplace settings, primary care, and general practice, supported by a communications campaign.

Liason with housing authorities (district councils) to improve the quality of privately rented housing through selective licensing will be discussed at the next district officer Health Leads group, where learning and best practice can be shared with a view to progressing with individual authorities as appropriate.

Ageing well:
Overall all 3 Breakthrough Outcomes are progressing well. Neighbourhood working is continuing to develop across the county, which is leading to identifying more and more individuals most at risk. As the Better Care Fund working principles come into force, this activity will be strengthened and systematised. Support mechanisms for those at risk are in place across the county, and access/navigation/support to the asset based is now being structured into the system. This is a key element of the Health and Well-being Framework and is being structured into infrastructure of integrated neighbourhood working.

Dementia Friendly Lancashire work across the County is progressing well, with some very good examples and commitment to this particular issue. This work does however require a multi-agency input and support across the county. This will be developed with the Health & Wellbeing Partnerships.

It was disappointing that the Lancashire "loneliness in older people" Big Lottery bids were not successful. However, this has not deterred the efforts from partners across the county to continue the good work in this area. Again this work will be developed further with the Health & Wellbeing Partnerships.

Risks:
The key risks identified by the programme leads are:

Starting well:

- Embedding Liquidlogic Children's System – a new electronic social care monitoring, recording and reporting tool
- Performance of key children and young people's health measures and an ongoing concern around Child and Adolescent Mental Health Services

Living well:

- The potential of interventions are not realised due to capacity of partner organisations to progress. Control measure: activity undertaken needs to be targeted and proportionate.
- Commitment of partners to the areas of work may be variable. Control measure: members of the Board to act as champions for implementation of relevant actions within their organisations, and to identify key contacts

Ageing well:

- Not having a co-ordinated approach to the breakthrough outcomes and evaluating what works and doesn't work
- Not engaging with the Health & Wellbeing Partnerships when developing plans and initiatives

Outcomes Framework Dashboard:

In order to support the objectives of the Health and Wellbeing Board Strategy Delivery Plan a number of appropriate outcomes were selected from the Public Health Outcomes Framework, NHS Outcomes Framework and Adult and Social Care Outcomes Framework. These form the Health & Wellbeing Outcomes Dashboard. Alongside the Lead Officers progress reports, the Dashboard will enable the effectiveness of the proposed actions within the programmes be continually monitored and reviewed.

The dashboards are available at appendices 2.1 – 2.7

The dashboards are updated on a quarterly basis and the latest version will always be available via the following links:

Lancashire:
http://www.lancashire.gov.uk/corporate/health/index.asp?siteid=6715&pageid=40274&e=e (Strategy Outcomes in the panel on the right)

CCG/district:
http://www.lancashire.gov.uk/corporate/health/index.asp?siteid=6715&pageid=45247&e=e (Each individual CCG listed)

Next steps:

There is an intention, for future meetings, to present an in-depth report on one of the programmes alongside the higher-level (summary progress) reports of the other two programmes.
The Board may wish to decide which of the pros it wishes to see at the next meeting and the progress report officer will arrange for this to happen and will draw up a timetable with the programme leads.

Consultations

As part of the agreed process for producing the draft strategy, a wide range of partners have been consulted using the Board's governance structure. These partners include local authorities, CCGs, local health partnerships, Healthwatch, Public Health England, and NHS England.

Implications:

This item has the following implications, as indicated:

Financial

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
insert details	insert date	insert details

Reason for inclusion in Part II, if appropriate

Appendix 1

Health & Wellbeing Strategy Programme Update

Programme Name: Starting well		
Area of work / action	**Progress update**	**Programme Leads Notes**
Delivery of the Children and Young People's Plan	▪ Children and Young People's Plan Performance Scorecard(Appendix A) provides an overview of the key performance measures in the Children and Young People's Plan for quarter 1 ▪ There is good progress against Priority 2 (to do well) but a number of indicators in Priority 4 (to be healthy) have worsened ▪ There is no reporting against the priority 5 (to be listened to). This is a new priority and metrics, baselines and targets are in development	The Lancashire CYP Trust Board meets on 25 September 2014 and a key part of the agenda will be focussed on improving health outcomes for children and young people
Develop links between HWB Partnership and new local children's Partnership arrangements	▪ New arrangements have been agreed by the Lancs CYP Trust and the LSCB for the local delivery of the Children and Young People's Plan and the oversight of safeguarding practice and arrangements	12 District Trust and 3 Locality Safeguarding Children Groups have been disestablished 5 Children's Partnership Boards (CPBs) have been established and will meet for the first time in October Terms of Reference for the CPBs include a remit to formalise links with the local HWB Partnership
To provide clarity and develop coherence across those key strategic partnerships that improve outcomes for children, adults and families	▪ Proposals have been developed that will seek to improve understanding across key strategic partnerships ▪	These proposals will be shared, for agreement, across the governance structures of the strategic partnerships highlighted: ▪ Lancashire Children's Safeguarding Board ▪ Lancashire Adult Safeguarding Board ▪ Community Safety Strategy Group ▪ Health and wellbeing Board ▪ Lancashire Children and Young People's Trust ▪ Corporate Parenting

Programme Name: Starting well		
		Board

Programme Leads summary

Below is a summary of some key areas of focus:

Integrated Inspection Framework - the CYP Trust submitted a consultation response to proposals for new integrated inspection arrangements from April 2015 which will include the following inspectorates: Ofsted; CQC; Probation; Prisons; Constabulary. The response supported the principle of an integrated inspection but questioned some of the detail around implementation.

Workforce Development – the CYP Trust Board will agree a new framework on 25 September 2014 for the development of the children's workforce which will prioritise activity around three key strands – prevention, early help and maximising resources

Health Visiting and Family Nurse Partnerships – supporting the transition from October 2015 of 0-5 services to public health and how this provision will support the delivery of a prevention and early help offer to families

Prevention and Early Help – continuing to embed district early help panel arrangements, respond to areas of improvement identified through the early help thematic inspection and develop our collective understanding of early help and the multi agency response

Child Sexual Exploitation – the LSCB is leading work to consider the Rotherham report and any implications for Lancashire

Children in Need – refining our understanding of Children in Need and the service offer available

Summer holiday activities – the CYP Trust co-ordinated a programme of activities in July and August. Tens of thousands of children and young people participated and the programme was specifically promoted to the most vulnerable families. A full evaluation will be available in October.

Special Educational Needs and Disability (SEND) Reforms – from 1 September as part of the Children and Families Act 2014, implementation includes new Education, Health and Care Plans and the development of a Lancashire Local Offer which provides information about support and service for children with SEND.

Key risks

Embedding Liquidlogic Children's System – a new electronic social care monitoring, recording and reporting tool

Performance of key children and young people's health measures and an ongoing concern around Child and Adolescent Mental Health Services

In addition, there are a number of indicators that are considered as potential key lines of enquiry for any future safeguarding inspection:

- Re-referrals to children's social care within 12months of previous referral
- Rate of Initial Assessments per 10,000
- Care leavers in Suitable Accommodation
- Care leavers in Education, Employment and Training
- Children Looked After with 5 GCSEs A* - C inc Eng & Maths
- Children in Need – Persistent Absence
- Children in Need – Fixed Term Exclusions
- Children in Need – KS2 – 4: Expected Progress in Eng
- Average time from child entering care to moving in with adoptive family (days)
- Average time from local authority receiving court decision to place child and deciding on the match
- Children waiting less than 20 months between entering care and moving in with adoptive family
- Adoptive families matched to child who waited more than 3 months to being matched

Programme Name: Living Well		
Area of work / action	**Progress update**	**Programme Leads Notes**
Develop a work programme with registered social landlords to address health inequalities	Meeting with key stakeholders to scope main areas for collaboration and intervention planned for November 2014.	Event planned.
All partner organisations to maximise opportunities for workstart and apprenticeships	Baseline and update data not currently available across all organisations.	Need consensus from HWB members about how this information will be collected. Request that all members of the Board identify a point of contact for this element of the workstream within the organisation(s) they represent.
Develop a multi-agency work programme to address premature mortality	Hospital Mortality Work is ongoing to support East Lancashire CCG to undertake an audit of deaths which occur within 30 days of discharge from hospital, with a view to making wider recommendations for better integration of services to support discharge from hospital. Similarly work is under consideration with Fylde & Wyre CCG to audit hospital deaths from stroke, with a view to making recommendations for improving quality or care for stroke patients. There is also work ongoing with AQUA (Advancing Quality Alliance) to support a hospital mortality collaborative in the North West with a view to sharing learning and best practice. Learning shared with the QSG to spread good practice across other CCG areas. Screening and Immunisation A paper is being presented to the HWB recommending that it seeks regular assurance from NHS England and PH England on performance of all screening and immunisation programmes. Health Checks Increasing uptake through community and workplace settings - pilot ongoing, with full procurement planned; through primary care by commissioning of a local improvement service from community pharmacy; through general	Work is progressing well. A county wide lead for this element of the workstream will be identified, so that learning and best practice is disseminated.

Programme Name: Living Well		
	practice by CCG engagement, training and support with a specific focus on targeting high risk groups and areas of higher deprivation; through communications campaign to increase public awareness and uptake. Performance A monitoring system has been developed to measure local trends in premature mortality at county and district level. Work is also ongoing to capture health and wellbeing outcomes delivered through locally commissioned healthy lifestyle services, which are key to preventing ill health.	
Housing authorities (district councils) be requested to consider opportunities for the use of selective licensing arrangements to improve the quality of privately rented housing, working with the local health & wellbeing partnerships as appropriate	Once the draft minutes of the meeting are agreed, the programme lead to contact the housing authorities to advise them of the request, and also raise awareness of the local health and wellbeing partnerships of potential involvement. This is also an agenda item for the next district officer Health Leads group in November 2014.	Will be progressed after October meeting of HWB.
Programme Leads summary		
To date there has been activity across this programme although some areas of work require acceleration. Some further capacity has been identified as other areas of work are completed.		
Key risks		
Risk: The potential of interventions are not realised due to capacity of partner organisations to progress. Control measure: activity undertaken needs to be targeted and proportionate.		
Risk: Commitment of partners to the areas of work may be variable. Control measure: members of the Board to act as champions for implementation of relevant actions within their organisations, and to identify key contacts.		

Programme Name: Ageing Well		
Area of work / action	**Progress update**	**Programme Leads**

Programme Name: Ageing Well		
		Notes
Early identification: For partners to routinely come together at both a population, neighbourhood and GP practice level and by using a wide range of risk assessment tools (both in relation to health conditions and well-being indicators) to identify those people at current and future risk if adverse impacts on their health and well-being.	• Risk identification is a key element of the Better Care Fund Plans submitted 19 September 2014. • Neighbourhood team development is gathering pace in all areas of Lancashire as operational plans to reduce risk of admissions start to be implemented. • In Fylde & Wyre there is a programme of work in partnership with Blackpool to develop an 'Extensivist' model of support to those most at risk. The clinical blueprint for work to establish the team on a pilot basis in Lytham has just been agreed and so is at a very early stage. • In Lancaster there is joint work with the District Council to prepare a bid for an approach targeting those at risk in poor private tenancies. Data from the sector has been overlaid with health deprivation and social care data to potentially target those households at risk. • Healthier Lancashire Partners are awaiting the outcome of a Tech Fund bid to resource a web-based data-sharing platform that will allow key individual information to be shared. • In Preston, Chorley & South Ribble GP surgeries across this footprint have gone live on using risk stratification, Multi-Disciplinary neighbourhood team meetings, at a GP footprint, focus on citizens who are most at risk of admission and those who may be a future risk and can benefit from low level support and intervention, delivered through a form of local area coordination (Connect4Life), harnessing local community assets. The Local Area Coordination offer is established in each GP led integrated team.	Most of the development is currently at a neighbourhood level via the development of neighbourhood teams. Risk stratification tools are being utilised to identify the needs profile of the population to help inform the shape, make-up and focus of the neighbourhood teams. Increasingly there is a recognition that this needs to extend beyond clinical risk indicators to looking at social factors.

Programme Name: Ageing Well		
	• There is similar activity and outputs in West Lancashire, through the 'Care Closer to Home' transformation programme, which includes the Sefton ICO. Integrated neighbourhood teams are live in 12 of the 26 GP sites, with activity increasing month on month.	
Connectivity/Navigation: For all areas of Lancashire all older people should have robust access to people who can connect/navigate/support people to the information and advice, community networks, and voluntary, community and faith sector assets where they need this support. This is much more than "signposting", but allows the opportunity to build a relationship to get to know someone, explore the things that matter to someone and tailor makes a plan that achieves some personal goals. Although time limited, and designed to support rather than create dependence, the support would follow up and checks the differences made to enhanced quality of life.	• LCC is currently developing an Integrated Wellbeing Service (IWS) to support people to maintain health, wellbeing and independence, and to connect to the health and wellbeing assets that are in their community. This will align with the Health and Wellbeing Strategy across the life course particularly with regard to Living Well and Ageing Well. • In Preston, Chorley, South Ribble and West Lancashire a form of Local Area Coordination (Connect4Life) has been developed across GP practice and Neighbourhood team arrangements. Over 400 referrals in the past 4 months, reducing social isolation, linking and connecting people to sustainable activities and groups that help to keep them safe and well. • In the East the Building Resilience programme of work is focused on community asset development and linking people identified by other services, G.Ps and Wellbeing workers into their local community. The Job spec for GP link workers is just being developed and will compliment but not duplicate the IWS wellbeing workers, there is intended investment in time banking and connecting communities approaches.	The Better Care Fund plans across Lancashire recognise the need for more active support to connect those people at risk to the rich asset base in neighbourhoods. Whilst directories, self-serve information etc. is essential as part of the shift to "self-management" across the system, it needs to respond to those who are unlikely to engage with support.
To declare Lancashire as a Dementia Friendly	• Local health & Wellbeing Partnerships across Central locality	

Programme Name: Ageing Well		
County: Dementia-Friendly Communities (whether cities, towns, villages or streets) do as much as possible to remove the barriers to everyday living that people with dementia and their carers face. They also help people with dementia to make the most of their own capabilities, encouraging them and including them in what is going in the community.	have had presentations on Dementia Friends initiatives, with a view of incorporating this action within their local plans. • Presentations have been made to Elected Members • Health Advocate Training programme in April and in September 2014 • The South Asian Dementia Friendly capacity building and community awareness pilot programme for East Locality is being implemented, targeting both community and faith settings. Findings to be linked to proposed revision of locality strategy for 2015 • Central & West Lancashire have a new website and have launched 4 short films titled 'Life with dementia' to showcase and to provide information about the range of supports and services available. Please find the link to the website: www.lifewithdementia.org • In the North of Lancashire a number of Dementia Friends sessions coordinated and facilitated by LCC staff who are Dementia Champions have been organised • To date in excess of 130 staff have become Dementia Friends. In North Lancashire and Fylde and Wyre LCC staff are participating in and supporting the development of the creation of Dementia Friendly communities. Lancaster currently being led by Age UK, Wyre by Wyre Borough Council, Fylde by local MP and the Borough Council. • In Morecambe, with a significantly high older population the focus has been businesses, shops, community resources etc. signing up and participating	

Programme Name: Ageing Well		
To reduce social isolation/loneliness in Lancashire Communities.	• Unfortunately, the Big Lottery bids from Lancashire (East Lancs and Wyre) to address loneliness have been unsuccessful. However, a lot of work across the County is still progressing to address loneliness and isolation. The challenge is to identify those at risk and supporting them prior to the loneliness having an impact on their overall Health & Wellbeing. It is intended that the new Health & wellbeing Service mention above along with risk stratification will lead to those on the brink of isolation to be identified and supported effectively. Currently LCC is investing in a range of community based services and provision to support vulnerable people to develop their community networks to help reduce social isolation/loneliness and build community resilience, these include Help Direct, Connect for Life, the East Lancashire Befriending service and the East Lancashire Clinical Commissioning group funded building individual and community resilience programme	Social isolation is a key risk being discussed at GP level multi-disciplinary team meetings and is a key area that the asset-based approaches can address. As well as people living alone, risk stratification and data sharing can potentially highlight those people recently bereaved, retired or unemployed.

Programme Leads summary

Overall all 3 Breakthrough Outcomes are progressing well. Neighbourhood working is continuing to develop across the county, which is leading to identifying more and more individuals most at risk. .As the Better Care Fund working principles come into force, this activity will be strengthened and systematised. Support mechanisms for those at risk are in place across the county, and access/navigation/support to the asset based is now being structured into the system. This is a key element of the Health and Well-being Framework and is being structured into infrastructure of integrated neighbourhood working.

Dementia Friendly Lancashire work across the County is progressing well, with some very good examples and commitment to this particular issue. This work does however require a multi-agency input and support across the county. This will be developed with the Health & Wellbeing Partnerships.

It was disappointing that the Lancashire "loneliness in older people" Big Lottery bids were not

Programme Name: Ageing Well
successful. However, this has not deterred the efforts from partners across the county to continue the good work in this area. Again this work will be developed further with the Health & Wellbeing Partnerships.
Key risks
There is a high risk of duplication of effort and initiatives as localities seek implement the priorities. Work on directories, IT solutions, risk assessment tools and individual core data sets needs to be coordinated and communicated to people on the ground.
The benefits and impacts of the community assets in reducing isolation and improving well-being will not be realised if clear navigation capacity is not built into and funded as part of the neighbourhood infrastructure

Appendix 2.1 - Lancashire Health and Wellbeing Outcomes
Figures as at July 2014

The following outcomes were selected from the Public Health Outcomes Framework, NHS Outcomes Framework and Adult and Social Care Outcomes Framework in order to support the objectives of the Health and Wellbeing Board Strategy Delivery Plan at Lancashire level.

For CCG/district level information, please contact: tracy.pickens@lancashire.gov.uk

Significantly better | Significantly worse | Not significant | Significance not tested

OVERARCHING GOALS	England	LCC/LAT		LCC/LAT trend
REDUCING HEALTH INEQUALITIES				
Life expectancy (LE) at birth, 2010-12, Males	79.2	78.2		
Life expectancy (LE) at birth, 2010-12, Females	83.0	82.0		
Healthy life expectancy at birth, 2009-11, Males	63.2	62.8		-
Healthy life expectancy at birth, 2009-11, Females	64.2	63.3		-
Slope index of inequality in LE at birth based on national deprivation deciles within England:				
Slope index of inequality, 2010-12, Males (provisional)	9.2	-		-
Slope index of inequality, 2010-12, Females (provisional)	6.8	-		-
Slope index of inequality in LE at birth within English local authorities, based on local deprivation deciles within each area, (provisional):				
Slope index of inequality, 2010-12 Males	-	9.9		
Slope index of inequality, 2010-12, Females	-	7.6		
Gap in LE at birth between each local authority and England as a whole, 2010-12, Males	0.0	-1.0		-
Gap in LE at birth between each local authority and England as a whole, 2010-12, Females	0.0	-1.0		-
Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within each England:				
Slope index of inequality, 2009-11 Males	19.3	-		-
Slope index of inequality, 2009-11, Females	20.1	-		-
IMPROVING PATIENT EXPERIENCE				
Patient experience of GP out of hours service, (%), July 2012 to March 2013	70.2	73.7		
Patient experience of hospital care, (%), 2013-14	Provider	Provider		-
Overall satisfaction of carers with social services, (%), 2012-13	42.7	41.8		-
REDUCING ADMISSIONS/COSTS				
Emergency hospital admission for self-harm, (DSR per 100,000), 2012/13	188.0	247.3		
Alcohol-related admissions to hospital per 100,000 population, 2012/13	636.9	698.4		
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), 2012/13*	CCG	CCG		
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), 2012/13*	CCG	CCG		
STARTING WELL	**England**	**LCC/LAT**		**LCC/LAT trend**
PROMOTING HEALTHY PREGNANCY				
Low birthweight of term live births, (%), 2011	2.8	2.7		
Smoking at time of delivery (SATOD), 2013/14 - (CCG available on local dashboards)	12.0	16.8		
Smoking at time of delivery (SATOD), 2013/14 - Q4 - (CCG available on local dashboards)	*12.3*	*16.6*		-
REDUCING INFANT MORTALITY				
Infant mortality (Rate per 1,000 live births), 2010-12	4.1	4.8		
REDUCING CHILDHOOD OBESITY				
Children aged 4-5 classified as overweight or obese, (%), 2012/13	22.2	23.5		
Children aged 10-11 classified as overweight or obese, (%), 2012/13	33.3	32.4		
SUPPORTING CHILDREN WITH LONG TERM CONDITIONS				
Emergency admissions for children with LRTI, (DSR), 2012/13*	CCG	suppressed		-
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (DSR), 2012/13*	CCG	CCG		
SUPPORTING VULNERABLE FAMILIES AND CHILDREN				
Children in poverty (all dependent children under 20), (%), 2011	20.1	17.8		
Children in poverty, (under 16s), (%), 2011	20.6	18.2		

Appendix 2.1 - Lancashire Health and Wellbeing Outcomes
Figures as at July 2014

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For CCG/district level information, please contact: tracy.pickens@lancashire.gov.uk

Significantly better | Significantly worse | Not significant | Significance not tested

LIVING WELL	England	LCC/LAT		LCC/LAT trend
PROMOTING HEALTHY SETTINGS, HEALTHY WORKFORCE & ECONOMIC DEVELOPMENT				
Long-term unemployment, (crude rate), 2013	9.9	7.2		
Gap in the employment rate between the below and the overall employment rate:				
those with a long-term health condition and overall employment rate, 2012	7.1	8.7		-
those in contact with secondary mental health services, 2012/13	62.3	69.4		
PROMOTING MENTAL WELLBEING & HEALTHY LIFESTYLES				
Domestic abuse incidents reported to the police, (Rate per 1,000), 2012/13	18.8	26.5		
Statutory homelessness acceptances per 1,000 households, 2012/13	2.4	0.8		
Hospital admissions for violent crime (including sexual violence), (%), 2010/11-2012/13	57.6	66.9		
REDUCING AVOIDABLE DEATHS				
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Males	238.4	266.8		
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Females	140.6	164.4		
NHS Health Check offered, (%), to be updated soon	-	-		-
NHS Health Check uptake, (%), to be updated soon	-	-		-
IMPROVING OUTCOMES FOR PEOPLE WITH LEARNING DIFFICULTIES				
Adults with learning disabilities who live in their own home or with family, (%), 2012-13	73.5	86.6		
Gap in the employment rate between the below and the overall employment rate:				
those with a learning disability and the overall employment rate, 2011/12	63.2	67.2		-
AGEING WELL	**England**	**LCC/LAT**		**LCC/LAT trend**
PROMOTING INDEPENDENCE				
Percentage of older people still at home 91 days after discharge from hospital into reablement/rehabilitation service:				
Offered the service, 65+, 2012-13	3.2	1.3		
Effectiveness of the service, 65+, 2012-13	81.4	82.0		
REDUCING SOCIAL ISOLATION				
Adult social care users who have as much social contact as they would like, (%), 2012/13	43.2	46.3		
Lonliness and isolation in adult carers, (%), 2012/13	41.3	38.3		-
MANAGING LONG-TERM CONDITIONS AND DEMENTIA				
People who feel supported to manage their long-term condition, (%), Jul 2012 - Mar 2013	65.6	65.7		
Estimated diagnosis rate for people with dementia, 2012/13	48.7	-		-
REDUCING EMERGENCY ADMISSIONS & DIRECT ADMISSIONS TO RESIDENTIAL CARE				
Emergency readmisisons within 30 days of discharge - persons, (%), 2011/12	11.8	12.3		
Emergency readmisisons within 30 days of discharge - males, (%), 2011/12	12.1	12.7		
Emergency readmisisons within 30 days of discharge - females, (%), 2011/12	11.5	11.9		
Hip fractures in people aged 65-79, (Rate per 100,000), 2012/13	237.3	241.6		
Hip fractures in people aged 80+, (Rate per 100,000), 2012/13	1,527.6	1,486.5		
SUPPORTING CARERS AND FAMILIES				
Percentage satisfaction of people using services with their care & support, 2012-13	64.1	66.8		

*(and Jan 13 to Dec 13) available

Recent update

Infant mortality has changed to significantly worse than England from not significant

Emergency re-admissions within 30 days of discharge in females has changed to significantly worse from not significant

Hip fracture in the 65 to 79 year olds has changed to not significant from significantly worse

Appendix 2.2 - Lancashire Health and Wellbeing Outcomes - Greater Preston CCG & district

Figures as at July 2014

Definition: Significance (S) denotes if LCC figures are statistically significant against national value: green(significantly better), red(significantly worse), orange(not significant), grey(not tested)

Significance for districts shown by colour of figures, same colour key used as stated above.

England[1]/district figures - NHS Outcomes; England[2]/LAT/CCG figures - CCG Indicator Set

For further information please contact: tracy.pickens@lancashire.gov.uk

Opportunities for Improvement

Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year

OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Greater Preston CCG	Greater Preston	
REDUCING HEALTH INEQUALITIES										
Life expectancy (LE) at birth, 2010-12, Males	82.1	79.2	78.2			-	-	-	77.4	↑
Life expectancy (LE) at birth, 2010-12, Females	85.9	83.0	82.0			-	-	-	81.0	↔
Healthy life expectancy at birth, 2009-11, Males	70.3	63.2	62.8		-	-	-	-	-	
Healthy life expectancy at birth, 2009-11, Females	72.1	64.2	63.3		-	-	-	-	-	
Slope index of inequality in LE at birth based on national deprivation deciles within England:										
Slope index of inequality, 2010-12, Males (provisional)	-	9.2	-		-	-	-	-	-	
Slope index of inequality, 2010-12, Females (provisional)	-	6.8	-		-	-	-	-	-	
Slope index of inequality in LE at birth within English local authorities, based on local deprivation deciles within each area, (provisional):										
Slope index of inequality, 2010-12, Males	-	-	9.9			-	-	-	10.7	↑
Slope index of inequality, 2010-12, Females	-	-	7.6			-	-	-	6.7	↑
Gap in LE at birth between each local authority and England as a whole, 2010-12, Males	2.9	0.0	-1.0		-	-	-	-	-1.8	↓
Gap in LE at birth between each local authority and England as a whole, 2010-12, Females	2.9	0.0	-1.0		-	-	-	-	-2.0	↓
Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England										
Slope index of inequality, 2009-11, Males	-	19.3	-		-	-	-	-	-	
Slope index of inequality, 2009-11, Females	-	20.1	-		-	-	-	-	-	
IMPROVING PATIENT EXPERIENCE										
Patient experience of GP out of hours service, (%), July 2012 to March 2013	85.4	-	-			70.2	73.7	73.8	-	
Patient experience of hospital care, (%), 2013-14	87.0	76.9	74.6% - Lancashire Teaching Hospitals / 74.8% - Southport and Ormskirk Hospitals							
Overall satisfaction of carers with social services, (%), 2012-13	65.4	42.7	41.8		-	-	-	-	-	
REDUCING ADMISSIONS/COSTS										
Emergency hospital admission for self-harm, (DSR per 100,000), 2012/13	50.4	188.0	247.3			-	-	-	225.4	↓
Alcohol-related admissions to hospital per 100,000 population, 2012/13	365.0	636.9	698.4			-	-	-	741.8	↓
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), 2012/13	184.8	820.5	1001.8			802.8	1,056.1	982.6	1,112.7	↑
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), Jan 13 to Dec 13	-	-	-		-	*780.0*	*1,008.2*	*896.5*	-	
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), 2012/13	324.7	1204.3	1418.3			1,181.9	1,468.4	1,376.5	1,516.0	↑
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), Jan 13 to Dec 13	-	-	-		-	*1,174.2*	*1,469.2*	*1,339.0*	-	
STARTING WELL										
PROMOTING HEALTHY PREGNANCY										
Low birthweight of term live births, (%), 2011	1.6	2.8	2.7			-	-	-	3.1	↓
Smoking at time of delivery (SATOD), 2013/14	1.9	12.0	16.8			-	17.8	17.0	-	
Smoking at time of delivery (SATOD), 2013/14 - Q4	-	*12.3*	*16.6*		-	-	*17.6*	*17.2*	-	
REDUCING INFANT MORTALITY										
Infant mortality (Rate per 1,000 live births), 2010-12	1.1	4.1	4.8			-	-	-	5.7	↑
REDUCING CHILDHOOD OBESITY										
Children aged 4-5 classified as overweight or obese, (%), 2012/13	16.1	22.2	23.5			-	-	-	20.3	↓
Children aged 10-11 classified as overweight or obese, (%), 2012/13	24.1	33.3	32.4			-	-	-	30.6	↑
SUPPORTING CHILDREN WITH LONG TERM CONDITIONS										
Emergency admissions for children with LRTI, (DSR), 2012/13	73.3	371.2	suppressed		-	399.6	550.7	482.7	447.4	↓
Emergency admissions for children with LRTI, (DSR), Jan 13 to Dec 13	-	-	-		-	*375.8*	*506.8*	*529.8*	-	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), 2012/13	75.1	340.6	526.0			336.9	557.9	435.2	479.2	↓
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), Jan 13 to Dec 13	-	-	-		-	*309.0*	*494.2*	*364.8*	-	
SUPPORTING VULNERABLE FAMILIES AND CHILDREN										
Children in poverty (all dependent children under 20), (%), 2011	2.9	20.1	17.8			-	-	-	21.7	↑
Children in poverty, (under 16s), (%), 2011	2.8	20.6	18.2			-	-	-	21.9	↔

Appendix 2.2 - Lancashire Health and Wellbeing Outcomes - Greater Preston CCG & district

Figures as at July 2014

Definition: Significance (S) denotes if LCC figures are statistically significant against national value: green(significantly better), red(significantly worse), orange(not significant), grey(not tested)

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England[1]/district figures - NHS Outcomes; England[2]/LAT/CCG figures - CCG Indicator Set

For further information please contact: tracy.pickens@lancashire.gov.uk

Opportunities for Improvement

Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year

OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Greater Preston CCG	Greater Preston	
LIVING WELL										
PROMOTING HEALTHY SETTINGS, HEALTHY WORKFORCE & ECONOMIC DEVELOPMENT										
Long-term unemployment, (crude rate), 2013	2.3	9.9	7.2			-	-	-	9.2	↑
Gap in the employment rate between the below and the overall employment rate:										
those with a long-term health condition and overall employment rate, 2012	-5.3	7.1	8.7		-	-	-	-	18.2	
those in contact with secondary mental health services, 2012/13	53.1	62.3	69.4			-	-	-	-	
PROMOTING MENTAL WELLBEING & HEALTHY LIFESTYLES										
Domestic abuse incidents reported to the police, (Rate per 1,000), 2012/13	5.6	18.8	26.5			-	-	-	-	
Statutory homelessness acceptances per 1,000 households, 2012/13	0.2	2.4	0.8			-	-	-	0.9	↓
Hospital admissions for violent crime (including sexual violence), (%), 2010/11-2012/13	9.3	57.6	66.9			-	-	-	80.8	↓
REDUCING AVOIDABLE DEATHS										
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Males	164.9	238.4	266.8			-	-	-	299.5	↓
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Females	94.7	140.6	164.4			-	-	-	190.7	↓
NHS Health Check offered, (%) to be updated soon	-	-	-			-	-	-	-	
NHS Health Check uptake, (%) to be updated soon	-	-	-			-	-	-	-	
IMPROVING OUTCOMES FOR PEOPLE WITH LEARNING DIFFICULTIES										
Adults with learning disabilities who live in their own home or with family, (%), 2012-13	96.6	73.5	86.6			-	-	-	-	
Gap in the employment rate between the below and the overall employment rate:										
those with a learning disability and the overall employment rate, 2011/12	40.2	63.2	67.2		-	-	-	-	-	
AGEING WELL										
PROMOTING INDEPENDENCE										
Percentage of older people still at home 91 days after discharge from hospital into reablement/rehabilitation service:										
Offered the service, 65+, 2012-13	25.4	3.2	1.3			-	-	-	-	
Effectiveness of the service, 65+, 2012-13	98.1	81.4	82.0			-	-	-	-	
REDUCING SOCIAL ISOLATION										
Adult social care users who have as much social contact as they would like, (%), 2012/13	53.5	43.2	46.3			-	-	-	-	
Lonliness and isolation in adult carers, (%), 2012/13	23.9	41.3	38.3		-	-	-	-	-	
MANAGING LONG-TERM CONDITIONS AND DEMENTIA										
People who feel supported to manage their long-term condition, (DS %), Jul 2012 - Mar 2013	78.9	65.6	65.7			65.6	65.3	65.4	63.7	↓
Estimated diagnosis rate for people with dementia, 2012/13	-	48.7	-		-	-	-	-	-	
REDUCING EMERGENCY ADMISSIONS & DIRECT ADMISSIONS TO RESIDENTIAL CARE										
Emergency readmisisons within 30 days of discharge - persons, (%), 2011/12	7.9	11.8	12.3			-	-	-	13.1	↑
Emergency readmisisons within 30 days of discharge - males, (%), 2011/12	8.6	12.1	12.7			-	-	-	13.0	↔
Emergency readmisisons within 30 days of discharge - females, (%), 2011/12	7.2	11.5	11.9			-	-	-	13.2	↑
Hip fractures in people aged 65-79, (Rate per 100,000), 2012/13	121.8	237.3	241.6			-	-	-	301.5	↓
Hip fractures in people aged 80+, (Rate per 100,000), 2012/13	1108.0	1,527.6	1,486.5			-	-	-	1,738.0	↑
SUPPORTING CARERS AND FAMILIES										
Percentage satisfaction of people using services with their care & support, 2012-13	73.9	64.1	66.8			-	-	-	-	

Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

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REDUCING HEALTH INEQUALITIES												
Life expectancy (LE) at birth, 2010-12, Males	82.1	79.2	78.2			-	-	-	79.0	↑	80.1	↑
Life expectancy (LE) at birth, 2010-12, Females	85.9	83.0	82.0			-	-	-	81.9	↔	82.8	↓
Healthy life expectancy at birth, 2009-11, Males	70.3	63.2	62.8		-	-	-	-	-		-	
Healthy life expectancy at birth, 2009-11, Females	72.1	64.2	63.3		-	-	-	-	-		-	
Slope index of inequality in LE at birth based on national deprivation deciles within England:												
Slope index of inequality, 2010-12, Males (provisional)	-	9.2	-		-	-	-	-	-		-	
Slope index of inequality, 2010-12, Females (provisional)	-	6.8	-		-	-	-	-	-		-	
Slope index of inequality in LE at birth within English local authorities, based on local deprivation deciles within each area, (provisional)												
Slope index of inequality, 2010-12, Males	-	-	9.9			-	-	-	8.7	↑	8.9	↑
Slope index of inequality, 2010-12, Females	-	-	7.6			-	-	-	7.2	↑	6.5	↑
Gap in LE at birth between each local authority and England as a whole, 2010-12, Males	2.9	0.0	-1.0		-	-	-	-	-0.2	↑	0.9	↓
Gap in LE at birth between each local authority and England as a whole, 2010-12, Females	2.9	0.0	-1.0		-	-	-	-	-1.1	↓	-0.2	↓
Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England												
Slope index of inequality, 2009-11, Males	-	19.3	-		-	-	-	-	-		-	
Slope index of inequality, 2009-11, Females	-	20.1	-		-	-	-	-	-		-	
IMPROVING PATIENT EXPERIENCE												
Patient experience of GP out of hours service, (%), July 2012 to March 2013	85.4	-	-			70.2	73.7	84.8	-		-	
Patient experience of hospital care, (%), 2013-14	87.0	76.9	74.6% - Lancashire Teaching Hospitals									
Overall satisfaction of carers with social services, (%), 2012-13	65.4	42.7	41.8		-	-	-	-	-		-	
REDUCING ADMISSIONS/COSTS												
Emergency hospital admission for self-harm, (DSR per 100,000), 2012/13	50.4	188.0	247.3			-	-	-	218.5	↓	188.8	↓
Alcohol-related admissions to hospital per 100,000 population, 2012/13	365.0	636.9	698.4			-	-	-	656.4	↓	605.1	↓
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), 2012/13	184.8	820.5	1001.8			802.8	1,056.1	907.3	923.6	↓	839.1	↓
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), Jan 13 to Dec 13	-	-	-		-	*780.0*	*1,008.2*	*834.7*	-		-	
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), 2012/13	324.7	1204.3	1418.3			1,181.9	1,468.4	1,197.1	1,177.8	↓	1,165.1	↓
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), Jan 13 to Dec 13	-	-	-		-	*1,174.2*	*1,469.2*	*1,196.3*	-		-	
STARTING WELL												
PROMOTING HEALTHY PREGNANCY												
Low birthweight of term live births, (%), 2011	1.6	2.8	2.7			-	-	-	3.1	↑	2.6	↑
Smoking at time of delivery (SATOD), 2013/14	1.9	12.0	16.8			-	17.8	16.6	-		-	
Smoking at time of delivery (SATOD), 2013/14 - Q4	-	*12.3*	*16.6*		-	-	*17.6*	*15.6*	-		-	
REDUCING INFANT MORTALITY												
Infant mortality (Rate per 1,000 live births), 2010-12	1.1	4.1	4.8			-	-	-	4.6	↓	4.0	↑
REDUCING CHILDHOOD OBESITY												
Children aged 4-5 classified as overweight or obese, (%), 2012/13	16.1	22.2	23.5			-	-	-	22.0	↑	21.4	↓
Children aged 10-11 classified as overweight or obese, (%), 2012/13	24.1	33.3	32.4			-	-	-	30.4	↑	33.2	↑
SUPPORTING CHILDREN WITH LONG TERM CONDITIONS												
Emergency admissions for children with LRTI, (DSR), 2012/13	73.3	371.2	suppressed		-	399.6	550.7	382.7	suppressed	-	448.4	-
Emergency admissions for children with LRTI, (DSR), Jan 13 to Dec 13	-	-	-		-	*375.8*	*506.8*	*307.5*	-		-	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), 2012/13	75.1	340.6	526.0			336.9	557.9	353.2	289.7	↓	421.8	↑
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), Jan 13 to Dec 13	-	-	-		-	*309.0*	*494.2*	*279.4*	-		-	
SUPPORTING VULNERABLE FAMILIES AND CHILDREN												
Children in poverty (all dependent children under 20), (%), 2011	2.9	20.1	17.8			-	-	-	13.1	↑	12.1	↑
Children in poverty, (under 16s), (%), 2011	2.8	20.6	18.2			-	-	-	13.6	↔	12.5	↑

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LIVING WELL												
PROMOTING HEALTHY SETTINGS, HEALTHY WORKFORCE & ECONOMIC DEVELOPMENT												
Long-term unemployment, (crude rate), 2013	2.3	9.9	7.2			-	-	-	5.0	↑	3.9	↑
Gap in the employment rate between the below and the overall employment rate:												
those with a long-term health condition and overall employment rate, 2012	-5.3	7.1	8.7		-	-	-	-	7.8		4.3	
those in contact with secondary mental health services, 2012/13	53.1	62.3	69.4			-	-	-	-		-	
PROMOTING MENTAL WELLBEING & HEALTHY LIFESTYLES												
Domestic abuse incidents reported to the police, (Rate per 1,000), 2012/13	5.6	18.8	26.5			-	-	-	-		-	
Statutory homelessness acceptances per 1,000 households, 2012/13	0.2	2.4	0.8			-	-	-	0.5	↓	0.9	↓
Hospital admissions for violent crime (including sexual violence), (%), 2010/11-2012/13	9.3	57.6	66.9			-	-	-	44.6	↓	43.5	↓
REDUCING AVOIDABLE DEATHS												
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Males	164.9	238.4	266.8			-	-	-	230.7	↓	211.4	↓
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Females	94.7	140.6	164.4			-	-	-	147.6	↓	144.4	↑
NHS Health Check offered, (%) to be updated soon	-	-	-			-	-	-	-		-	
NHS Health Check uptake, (%) to be updated soon	-	-	-			-	-	-	-		-	
IMPROVING OUTCOMES FOR PEOPLE WITH LEARNING DIFFICULTIES												
Adults with learning disabilities who live in their own home or with family, (%), 2012-13	96.6	73.5	86.6			-	-	-	-		-	
Gap in the employment rate between the below and the overall employment rate:												
those with a learning disability and the overall employment rate, 2011/12	40.2	63.2	67.2		-	-	-	-	-		-	
AGEING WELL												
PROMOTING INDEPENDENCE												
Percentage of older people still at home 91 days after discharge from hospital into reablement/rehabilitation service:												
Offered the service, 65+, 2012-13	25.4	3.2	1.3			-	-	-	-		-	
Effectiveness of the service, 65+, 2012-13	98.1	81.4	82.0			-	-	-	-		-	
REDUCING SOCIAL ISOLATION												
Adult social care users who have as much social contact as they would like, (%), 2012/13	53.5	43.2	46.3			-	-	-	-		-	
Lonliness and isolation in adult carers, (%), 2012/13	23.9	41.3	38.3		-	-	-	-	-		-	
MANAGING LONG-TERM CONDITIONS AND DEMENTIA												
People who feel supported to manage their long-term condition, (DS %), Jul 2012 - Mar 2013	78.9	65.6	65.7			65.6	65.3	66..5	63.8	↓	67.4	↑
Estimated diagnosis rate for people with dementia, 2012/13	-	48.7	-		-	-	-	-	-		-	
REDUCING EMERGENCY ADMISSIONS & DIRECT ADMISSIONS TO RESIDENTIAL CARE												
Emergency readmisisons within 30 days of discharge - persons, (%), 2011/12	7.9	11.8	12.3			-	-	-	11.4	↑	12.1	↑
Emergency readmisisons within 30 days of discharge - males, (%), 2011/12	8.6	12.1	12.7			-	-	-	12.4	↑	11.8	↑
Emergency readmisisons within 30 days of discharge - females, (%), 2011/12	7.2	11.5	11.9			-	-	-	10.4	↓	12.3	↑
Hip fractures in people aged 65-79, (Rate per 100,000), 2012/13	121.8	237.3	241.6			-	-	-	181.9	↓	178.8	↓
Hip fractures in people aged 80+, (Rate per 100,000), 2012/13	1108.0	1,527.6	1,486.5			-	-	-	1,609.4	↓	1,673.7	↑
SUPPORTING CARERS AND FAMILIES												
Percentage satisfaction of people using services with their care & support, 2012-13	73.9	64.1	66.8			-	-	-	-		-	

Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

Figures as at July 2014

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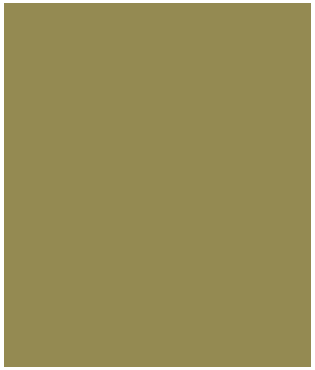

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OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Chorley & South Ribble CCG	Chorley	South Ribble

Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

Figures as at July 2014

Definition: Significance (S) denotes if LCC figures are statistically significant against national value: green(significantly better), red(significantly worse), orange(not significant), grey(not tested)

Significance for districts shown by colour of figures, same colour key used as stated above.

England[1]/district figures - NHS Outcomes; England[2]/LAT/CCG figures - CCG Indicator Set

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Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

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Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

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Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

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Opportunities for Improvement

Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year

OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Chorley & South Ribble CCG	Chorley	South Ribble

Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

Figures as at July 2014

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Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year

OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Chorley & South Ribble CCG	Chorley	South Ribble

Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

Figures as at July 2014

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Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

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OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Chorley & South Ribble CCG	Chorley	South Ribble

Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

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OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Chorley & South Ribble CCG	Chorley	South Ribble

Appendix 2.3 - Lancashire Health and Wellbeing Outcomes - Chorley and South Ribble CCG & districts

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Opportunities for Improvement

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OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Chorley & South Ribble CCG	Chorley	South Ribble

Appendix 2.4 - Lancashire Health and Wellbeing Outcomes - West Lancashire CCG & district

Figures as at July 2014

Definition: Significance (S) denotes if LCC figures are statistically significant against national value: green(significantly better), red(significantly worse), orange(not significant), grey(not tested)

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England[1]/district figures - NHS Outcomes; England[2]/LAT/CCG figures - CCG Indicator Set

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Opportunities for Improvement

Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year

OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	West Lancs CCG	West Lancashire	
REDUCING HEALTH INEQUALITIES										
Life expectancy (LE) at birth, 2010-12, Males	82.1	79.2	78.2			-	-	-	78.7	↑
Life expectancy (LE) at birth, 2010-12, Females	85.9	83.0	82.0			-	-	-	82.5	↑
Healthy life expectancy at birth, 2009-11, Males	70.3	63.2	62.8		-	-	-	-	-	
Healthy life expectancy at birth, 2009-11, Females	72.1	64.2	63.3		-	-	-	-	-	
Slope index of inequality in LE at birth based on national deprivation deciles within England:										
Slope index of inequality, 2010-12, Males (provisional)	-	9.2	-		-	-	-	-	-	
Slope index of inequality, 2010-12, Females (provisional)	-	6.8	-		-	-	-	-	-	
Slope index of inequality in LE at birth within English local authorities, based on local deprivation deciles within each area, (provisional):										
Slope index of inequality, 2010-12, Males	-	-	9.9			-	-	-	8.5	↑
Slope index of inequality, 2010-12, Females	-	-	7.6			-	-	-	6.5	↓
Gap in LE at birth between each local authority and England as a whole, 2010-12, Males	2.9	0.0	-1.0		-	-	-	-	-0.5	↓
Gap in LE at birth between each local authority and England as a whole, 2010-12, Females	2.9	0.0	-1.0		-	-	-	-	-0.5	↑
Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England										
Slope index of inequality, 2009-11, Males	-	19.3	-		-	-	-	-	-	
Slope index of inequality, 2009-11, Females	-	20.1	-		-	-	-	-	-	
IMPROVING PATIENT EXPERIENCE										
Patient experience of GP out of hours service, (%), July 2012 to March 2013	85.4	-	-			70.2	73.7	70.1	-	
Patient experience of hospital care, (%), 2013-14	87.0	76.9	74.6% - Lancashire Teaching Hospitals / 74.8% - Southport and Ormskirk Hospitals							
Overall satisfaction of carers with social services, (%), 2012-13	65.4	42.7	41.8		-	-	-	-	-	
REDUCING ADMISSIONS/COSTS										
Emergency hospital admission for self-harm, (DSR per 100,000), 2012/13	50.4	188.0	247.3			-	-	-	234.3	↓
Alcohol-related admissions to hospital per 100,000 population, 2012/13	365.0	636.9	698.4			-	-	-	612.9	↓
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), 2012/13	184.8	820.5	1001.8			802.8	1,056.1	1,042.0	1,020.5	↑
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), Jan 13 to Dec 13	-	-	-		-	*780.0*	*1,008.2*	*955.5*	-	
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), 2012/13	324.7	1204.3	1418.3			1,181.9	1,468.4	1,653.2	1,672.7	↑
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), Jan 13 to Dec 13	-	-	-		-	*1,174.2*	*1,469.2*	*1,616.7*	-	
STARTING WELL										
PROMOTING HEALTHY PREGNANCY										
Low birthweight of term live births, (%), 2011	1.6	2.8	2.7			-	-	-	2.4	↔
Smoking at time of delivery (SATOD), 2013/14	1.9	12.0	16.8			-	17.8	14.4	-	
Smoking at time of delivery (SATOD), 2013/14 - Q4	-	*12.3*	*16.6*		-	-	*17.6*	*11.9*	-	
REDUCING INFANT MORTALITY										
Infant mortality (Rate per 1,000 live births), 2010-12	1.1	4.1	4.8			-	-	-	4.9	↓
REDUCING CHILDHOOD OBESITY										
Children aged 4-5 classified as overweight or obese, (%), 2012/13	16.1	22.2	23.5			-	-	-	22.3	↓
Children aged 10-11 classified as overweight or obese, (%), 2012/13	24.1	33.3	32.4			-	-	-	36.9	↑
SUPPORTING CHILDREN WITH LONG TERM CONDITIONS										
Emergency admissions for children with LRTI, (DSR), 2012/13	73.3	371.2	suppressed		-	399.6	550.7	811.8	740.3	-
Emergency admissions for children with LRTI, (DSR), Jan 13 to Dec 13	-	-	-		-	*375.8*	*506.8*	*580.2*	-	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), 2012/13	75.1	340.6	526.0			336.9	557.9	567.8	533.8	↑
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), Jan 13 to Dec 13	-	-	-		-	*309.0*	*494.2*	*505.4*	-	
SUPPORTING VULNERABLE FAMILIES AND CHILDREN										
Children in poverty (all dependent children under 20), (%), 2011	2.9	20.1	17.8			-	-	-	17.4	↓
Children in poverty, (under 16s), (%), 2011	2.8	20.6	18.2			-	-	-	18.1	↓

Appendix 2.4 - Lancashire Health and Wellbeing Outcomes - West Lancashire CCG & district

Figures as at July 2014

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Opportunities for Improvement

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OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	West Lancs CCG	West Lancashire	
LIVING WELL										
PROMOTING HEALTHY SETTINGS, HEALTHY WORKFORCE & ECONOMIC DEVELOPMENT										
Long-term unemployment, (crude rate), 2013	2.3	9.9	7.2			-	-	-	6.6	↓
Gap in the employment rate between the below and the overall employment rate:										
those with a long-term health condition and overall employment rate, 2012	-5.3	7.1	8.7		-	-	-	-	15.5	
those in contact with secondary mental health services, 2012/13	53.1	62.3	69.4			-	-	-	-	
PROMOTING MENTAL WELLBEING & HEALTHY LIFESTYLES										
Domestic abuse incidents reported to the police, (Rate per 1,000), 2012/13	5.6	18.8	26.5			-	-	-	-	
Statutory homelessness acceptances per 1,000 households, 2012/13	0.2	2.4	0.8			-	-	-	1.4	↓
Hospital admissions for violent crime (including sexual violence), (%), 2010/11-2012/13	9.3	57.6	66.9			-	-	-	73.0	↓
REDUCING AVOIDABLE DEATHS										
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Males	164.9	238.4	266.8			-	-	-	240.7	↓
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Females	94.7	140.6	164.4			-	-	-	151.1	↓
NHS Health Check offered, (%), to be updated soon	-	-	-			-	-	-	-	
NHS Health Check uptake, (%), to be updated soon	-	-	-			-	-	-	-	
IMPROVING OUTCOMES FOR PEOPLE WITH LEARNING DIFFICULTIES										
Adults with learning disabilities who live in their own home or with family, (%), 2012-13	96.6	73.5	86.6			-	-	-	-	
Gap in the employment rate between the below and the overall employment rate:										
those with a learning disability and the overall employment rate, 2011/12	40.2	63.2	67.2		-	-	-	-	-	
AGEING WELL										
PROMOTING INDEPENDENCE										
Percentage of older people still at home 91 days after discharge from hospital into reablement/rehabilitation service:										
Offered the service, 65+, 2012-13	25.4	3.2	1.3			-	-	-	-	
Effectiveness of the service, 65+, 2012-13	98.1	81.4	82.0			-	-	-	-	
REDUCING SOCIAL ISOLATION										
Adult social care users who have as much social contact as they would like, (%), 2012/13	53.5	43.2	46.3			-	-	-	-	
Lonliness and isolation in adult carers, (%), 2012/13	23.9	41.3	38.3		-	-	-	-	-	
MANAGING LONG-TERM CONDITIONS AND DEMENTIA										
People who feel supported to manage their long-term condition, (DS %), Jul 2012 - Mar 2013	78.9	65.6	65.7			65.6	65.3	70.1	69.3	↑
Estimated diagnosis rate for people with dementia, 2012/13	-	48.7	-		-	-	-	-	-	
REDUCING EMERGENCY ADMISSIONS & DIRECT ADMISSIONS TO RESIDENTIAL CARE										
Emergency readmisisons within 30 days of discharge - persons, (%), 2011/12	7.9	11.8	12.3			-	-	-	11.8	↓
Emergency readmisisons within 30 days of discharge - males, (%), 2011/12	8.6	12.1	12.7			-	-	-	12.2	↑
Emergency readmisisons within 30 days of discharge - females, (%), 2011/12	7.2	11.5	11.9			-	-	-	11.4	↓
Hip fractures in people aged 65-79, (Rate per 100,000), 2012/13	121.8	237.3	241.6			-	-	-	259.1	↓
Hip fractures in people aged 80+, (Rate per 100,000), 2012/13	1108.0	1,527.6	1,486.5			-	-	-	1,540.8	↑
SUPPORTING CARERS AND FAMILIES										
Percentage satisfaction of people using services with their care & support, 2012-13	73.9	64.1	66.8			-	-	-	-	

Appendix 2.5 - Lancashire Health and Wellbeing Outcomes - East Lancashire CCG & districts

Figures as at July 2014

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									Opportunities for Improvement Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year									
OVERARCHING GOALS	**England best (County & UA)**	**England[1]**	**LCC**	**S**	**LCC Trend**	**England[2]**	**LAT**	**East Lancs CCG**	**Burnley**		**Hyndburn**		**Pendle**		**Ribble Valley**		**Rossendale**	
REDUCING HEALTH INEQUALITIES																		
Life expectancy (LE) at birth, 2010-12, Males	82.1	79.2	78.2			-	-	-	75.7	↑	76.5	↑	77.9	↑	80.5	↑	77.6	↑
Life expectancy (LE) at birth, 2010-12, Females	85.9	83.0	82.0			-	-	-	80.5	↓	81.0	↑	81.7	↑	84.0	↑	81.6	↑
Healthy life expectancy at birth, 2009-11, Males	70.3	63.2	62.8		-	-	-	-	-		-		-		-		-	
Healthy life expectancy at birth, 2009-11, Females	72.1	64.2	63.3		-	-	-	-	-		-		-		-		-	
Slope index of inequality in LE at birth based on national deprivation deciles within England:																		
Slope index of inequality, 2010-12, Males (provisional)	-	9.2	-		-	-	-	-	-		-		-		-		-	
Slope index of inequality, 2010-12, Females (provisional)	-	6.8	-		-	-	-	-	-		-		-		-		-	
Slope index of inequality in LE at birth within English local authorities, based on local deprivation deciles within each area, (provisional):																		
Slope index of inequality, 2010-12, Males	-	-	9.9			-	-	-	11.3	↑	11.4	↑	8.9	↓	2.3	↑	6.0	↑
Slope index of inequality, 2010-12, Females	-	-	7.6			-	-	-	3.3	↑	7.2	↓	9.4	↑	4.0	↓	7.0	↑
Gap in LE at birth between each local authority and England as a whole, 2010-12, Males	2.9	0.0	-1.0		-	-	-	-	-3.5	↓	-2.7	↑	-1.3	↓	1.3	↑	-1.6	↑
Gap in LE at birth between each local authority and England as a whole, 2010-12, Females	2.9	0.0	-1.0		-	-	-	-	-2.5	↓	-2.0	↑	-1.3	↑	1.0	↑	-1.4	↑
Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England																		
Slope index of inequality, 2009-11, Males	-	19.3	-		-	-	-	-	-		-		-		-		-	
Slope index of inequality, 2009-11, Females	-	20.1	-		-	-	-	-	-		-		-		-		-	
IMPROVING PATIENT EXPERIENCE																		
Patient experience of GP out of hours service, (%), July 2012 to March 2013	85.4	-	-			70.2	73.7	67.9	-		-		-		-		-	
Patient experience of hospital care, (%), 2013-14	87.0	76.9	73.9% - East Lancashire Hospitals NHS Trust															
Overall satisfaction of carers with social services, (%), 2012-13	65.4	42.7	41.8		-	-	-	-	-		-		-		-		-	
REDUCING ADMISSIONS/COSTS																		
Emergency hospital admission for self-harm, (DSR per 100,000), 2012/13	50.4	188.0	247.3			-	-	-	347.1	↓	318.5	↓	235.2	↓	154.5	↓	235.5	↓
Alcohol-related admissions to hospital per 100,000 population, 2012/13	365.0	636.9	698.4			-	-	-	895.8	↑	748.7	↓	675.8	↓	521.5	↓	697.4	↓
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), 2012/13	184.8	820.5	1001.8			802.8	1,056.1	1,197.9	1,469.5	↑	1,443.8	↑	1,175.5	↑	780.6	↑	1,040.4	↑
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), Jan 13 to Dec 13	-	-	-		-	*780.0*	*1,008.2*	*1,145.9*	-		-		-		-		-	
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), 2012/13	324.7	1204.3	1418.3			1,181.9	1,468.4	1,667.1	1,854.6	↑	1,957.3	↑	1,603.0	↑	1,156.7	↑	1,767.8	↑
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), Jan 13 to Dec 13	-	-	-		-	*1,174.2*	*1,469.2*	*1,626.9*	-		-		-		-		-	
STARTING WELL																		
PROMOTING HEALTHY PREGNANCY																		
Low birthweight of term live births, (%), 2011	1.6	2.8	2.7			-	-	-	3.5	↑	3.2	↓	2.4	↓	2.7	↑	3.2	↓
Smoking at time of delivery (SATOD), 2013/14	1.9	12.0	16.8			-	17.8	18.0	-		-		-		-		-	
Smoking at time of delivery (SATOD), 2013/14 - Q4	-	*12.3*	*16.6*		-	-	*17.6*	*18.6*	-		-		-		-		-	
REDUCING INFANT MORTALITY																		
Infant mortality (Rate per 1,000 live births), 2010-12	1.1	4.1	4.8			-	-	-	6.9	↔	4.4	↓	6.3	↓	0.7	↓	3.1	↓
REDUCING CHILDHOOD OBESITY																		
Children aged 4-5 classified as overweight or obese, (%), 2012/13	16.1	22.2	23.5			-	-	-	28.7	↑	26.1	↑	25.8	↑	22.3	↓	24.2	↑
Children aged 10-11 classified as overweight or obese, (%), 2012/13	24.1	33.3	32.4			-	-	-	33.0	↓	33.5	↔	35.2	↑	25.3	↓	35.1	↑
SUPPORTING CHILDREN WITH LONG TERM CONDITIONS																		
Emergency admissions for children with LRTI, (DSR), 2012/13	73.3	371.2	suppressed		-	399.6	550.7	638.8	735.5	-	663.3	-	476.5	-	suppressed	-	623.9	-
Emergency admissions for children with LRTI, (DSR), Jan 13 to Dec 13	-	-	-		-	*375.8*	*506.8*	*556.2*	-		-		-		-		-	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), 2012/13	75.1	340.6	526.0			336.9	557.9	659.3	892.8	↑	799.7	↑	557.1	↑	495.1	↑	538.2	↑
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), Jan 13 to Dec 13	-	-	-		-	*309.0*	*494.2*	*598.1*	-		-		-		-		-	
SUPPORTING VULNERABLE FAMILIES AND CHILDREN																		
Children in poverty (all dependent children under 20), (%), 2011	2.9	20.1	17.8			-	-	-	26.8	↓	22.5	↓	21.9	↓	6.5	↑	18.8	↑
Children in poverty, (under 16s), (%), 2011	2.8	20.6	18.2			-	-	-	26.9	↓	22.5	↓	21.3	↓	6.6	↑	19.4	↑

Appendix 2.5 - Lancashire Health and Wellbeing Outcomes - East Lancashire CCG & districts

Figures as at July 2014

Definition: Significance (S) (denotes if LCC figures are statistically significant against national value) green(significantly better), red(significantly worse), orange(not significant), grey(significance not tested)

Significance for districts shown by colour of figures, same colour key used as stated above.

England[1]/district figures - NHS Outcomes; England[2]/LAT/CCG figures - CCG Indicator Set

For further information please contact: tracy.pickens@lancashire.gov.uk

									Opportunities for Improvement Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year											
OVERARCHING GOALS	**England best (County & UA)**	**England[1]**	**LCC**	**S**	**LCC Trend**	**England[2]**	**LAT**	**East Lancs CCG**	**Burnley**		**Hyndburn**		**Pendle**		**Ribble Valley**		**Rossendale**	
LIVING WELL																		
PROMOTING HEALTHY SETTINGS, HEALTHY WORKFORCE & ECONOMIC DEVELOPMENT																		
Long-term unemployment, (crude rate), 2013	2.3	9.9	7.2			-	-	-	13.7	↑	7.6	↑	9.4	↑	1.9	↓	8.5	↑
Gap in the employment rate between the below and the overall employment rate:																		
those with a long-term health condition and overall employment rate, 2012	-5.3	7.1	8.7		-	-	-	-	2.0		16.3		5.1		13.2		15.9	
those in contact with secondary mental health services, 2012/13	53.1	62.3	69.4			-	-	-	-		-		-		-		-	
PROMOTING MENTAL WELLBEING & HEALTHY LIFESTYLES																		
Domestic abuse incidents reported to the police, (Rate per 1,000), 2012/13	5.6	18.8	26.5			-	-	-	-		-		-		-		-	
Statutory homelessness acceptances per 1,000 households, 2012/13	0.2	2.4	0.8			-	-	-	1.7	↓	0.2	↑	0.6	↓	0.6	↑	0.5	↓
Hospital admissions for violent crime (including sexual violence), (%), 2010/11-2012/13	9.3	57.6	66.9			-	-	-	125.3	↑	104.5	↓	77.0	↓	36.8	↑	61.9	↓
REDUCING AVOIDABLE DEATHS																		
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Males	164.9	238.4	266.8			-	-	-	365.3	↑	326.1	↑	268.1	↓	208.9	↓	275.6	↓
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Females	94.7	140.6	164.4			-	-	-	202.2	↓	204.4	↓	171.2	↓	130.5	↓	185.5	↓
NHS Health Check offered, (%) to be updated soon	-	-	-			-	-	-	-		-		-		-		-	
NHS Health Check uptake, (%) to be updated soon	-	-	-			-	-	-	-		-		-		-		-	
IMPROVING OUTCOMES FOR PEOPLE WITH LEARNING DIFFICULTIES																		
Adults with learning disabilities who live in their own home or with family, (%), 2012-13	96.6	73.5	86.6			-	-	-	-		-		-		-		-	
Gap in the employment rate between the below and the overall employment rate:																		
those with a learning disability and the overall employment rate, 2011/12	40.2	63.2	67.2		-	-	-	-	-		-		-		-		-	
AGEING WELL																		
PROMOTING INDEPENDENCE																		
Percentage of older people still at home 91 days after discharge from hospital into reablement/rehabilitation service:																		
Offered the service, 65+, 2012-13	25.4	3.2	1.3			-	-	-	-		-		-		-		-	
Effectiveness of the service, 65+, 2012-13	98.1	81.4	82.0			-	-	-	-		-		-		-		-	
REDUCING SOCIAL ISOLATION																		
Adult social care users who have as much social contact as they would like, (%), 2012/13	53.5	43.2	46.3			-	-	-	-		-		-		-		-	
Lonliness and isolation in adult carers, (%), 2012/13	23.9	41.3	38.3		-	-	-	-	-		-		-		-		-	
MANAGING LONG-TERM CONDITIONS AND DEMENTIA																		
People who feel supported to manage their long-term condition, (DS %), Jul 2012 - Mar 2013	78.9	65.6	65.7			65.6	65.3	65.7	66.4	↑	63.9	↓	67.6	↑	suppressed	-	61.7	↓
Estimated diagnosis rate for people with dementia, 2012/13	-	48.7	-		-	-	-	-	-		-		-		-		-	
REDUCING EMERGENCY ADMISSIONS & DIRECT ADMISSIONS TO RESIDENTIAL CARE																		
Emergency readmisisons within 30 days of discharge - persons, (%), 2011/12	7.9	11.8	12.3			-	-	-	13.1	↓	12.9	↓	11.8	↑	11.3	↑	12.9	↑
Emergency readmisisons within 30 days of discharge - males, (%), 2011/12	8.6	12.1	12.7			-	-	-	14.9	↑	13.2	↓	12.0	↑	10.9	↓	12.9	↑
Emergency readmisisons within 30 days of discharge - females, (%), 2011/12	7.2	11.5	11.9			-	-	-	11.5	↓	12.6	↓	11.6	↑	11.6	↑	12.9	↑
Hip fractures in people aged 65-79, (Rate per 100,000), 2012/13	121.8	237.3	241.6			-	-	-	181.3	↓	246.0	↑	300.9	↑	228.1	↓	286.7	↓
Hip fractures in people aged 80+, (Rate per 100,000), 2012/13	1108.0	1,527.6	1,486.5			-	-	-	1,496.6	↓	1,111.3	↓	1,552.4	↑	101.7	↓	1,733.9	↑
SUPPORTING CARERS AND FAMILIES																		
Percentage satisfaction of people using services with their care & support, 2012-13	73.9	64.1	66.8			-	-	-	-		-		-		-		-	

Appendix 2.6 - Lancashire Health and Wellbeing Outcomes - Lancashire North CCG & Lancaster district

Figures as at July 2014

Definition: Significance (S) denotes if LCC figures are statistically significant against national value: green(significantly better), red(significantly worse), orange(not significant), grey(not tested)

Significance for districts shown by colour of figures, same colour key used as stated above.

England[1]/district figures - NHS Outcomes; England[2]/LAT/CCG figures - CCG Indicator Set

For further information please contact: tracy.pickens@lancashire.gov.uk

Opportunities for Improvement

Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year

OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Lancashire North CCG	Lancaster	
REDUCING HEALTH INEQUALITIES										
Life expectancy (LE) at birth, 2010-12, Males	82.1	79.2	78.2			-	-	-	77.4	↓
Life expectancy (LE) at birth, 2010-12, Females	85.9	83.0	82.0			-	-	-	82.2	↑
Healthy life expectancy at birth, 2009-11, Males	70.3	63.2	62.8		-	-	-	-	-	
Healthy life expectancy at birth, 2009-11, Females	72.1	64.2	63.3		-	-	-	-	-	
Slope index of inequality in LE at birth based on national deprivation deciles within England:										
Slope index of inequality, 2010-12, Males (provisional)	-	9.2	-		-	-	-	-	-	
Slope index of inequality, 2010-12, Females (provisional)	-	6.8	-		-	-	-	-	-	
Slope index of inequality in LE at birth within English local authorities, based on local deprivation deciles within each area, (provisional):										
Slope index of inequality, 2010-12, Males	-	-	9.9			-	-	-	11.4	↓
Slope index of inequality, 2010-12, Females	-	-	7.6			-	-	-	9.6	↑
Gap in LE at birth between each local authority and England as a whole, 2010-12, Males	2.9	0.0	-1.0		-	-	-	-	-1.8	↓
Gap in LE at birth between each local authority and England as a whole, 2010-12, Females	2.9	0.0	-1.0		-	-	-	-	-0.8	↑
Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England										
Slope index of inequality, 2009-11, Males	-	19.3	-		-	-	-	-	-	
Slope index of inequality, 2009-11, Females	-	20.1	-		-	-	-	-	-	
IMPROVING PATIENT EXPERIENCE										
Patient experience of GP out of hours service, (%), July 2012 to March 2013	85.4	-	-			70.2	73.7	66.5	-	
Patient experience of hospital care, (%), 2013-14	87.0	76.9	78.6% - University Hospitals of Morecambe Bay NHS Foundation Trust							
Overall satisfaction of carers with social services, (%), 2012-13	65.4	42.7	41.8		-	-	-	-	-	
REDUCING ADMISSIONS/COSTS										
Emergency hospital admission for self-harm, (DSR per 100,000), 2012/3	50.4	188.0	247.3			-	-	-	314.8	↓
Alcohol-related admissions to hospital per 100,000 population, 2012/13	365.0	636.9	698.4			-	-	-	811.9	↑
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), 2012/13	184.8	820.5	1001.8			802.8	1,056.1	946.1	941.6	↓
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), Jan 13 to Dec 13	-	-	-		-	*780.0*	*1,008.2*	*937.0*	-	
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), 2012/13	324.7	1204.3	1418.3			1,181.9	1,468.4	1,407.2	1,375.9	↑
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), Jan 13 to Dec 13	-	-	-		-	*1,174.2*	*1,469.2*	*1,483.4*	-	
STARTING WELL										
PROMOTING HEALTHY PREGNANCY										
Low birthweight of term live births, (%), 2011	1.6	2.8	2.7			-	-	-	2.2	↑
Smoking at time of delivery (SATOD), 2013/14	1.9	12.0	16.8			-	17.8	16.2	-	
Smoking at time of delivery (SATOD), 2013/14 - Q4	-	*12.3*	*16.6*		-	-	*17.6*	*14.7*	-	
REDUCING INFANT MORTALITY										
Infant mortality (Rate per 1,000 live births), 2010-12	1.1	4.1	4.8			-	-	-	3.4	↓
REDUCING CHILDHOOD OBESITY										
Children aged 4-5 classified as overweight or obese, (%), 2012/13	16.1	22.2	23.5			-	-	-	24.4	↓
Children aged 10-11 classified as overweight or obese, (%), 2012/13	24.1	33.3	32.4			-	-	-	31.6	↑
SUPPORTING CHILDREN WITH LONG TERM CONDITIONS										
Emergency admissions for children with LRTI, (DSR), 2012/13	73.3	371.2	suppressed		-	399.6	550.7	616.7	543.7	↑
Emergency admissions for children with LRTI, (DSR), Jan 13 to Dec 13	-	-	-		-	*375.8*	*506.8*	*589.5*	-	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), 2012/13	75.1	340.6	526.0			336.9	557.9	543.7	543.5	↑
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), Jan 13 to Dec 13	-	-	-		-	*309.0*	*494.2*	*465.8*	-	
SUPPORTING VULNERABLE FAMILIES AND CHILDREN										
Children in poverty (all dependent children under 20), (%), 2011	2.9	20.1	17.8			-	-	-	17.7	↓
Children in poverty, (under 16s), (%), 2011	2.8	20.6	18.2			-	-	-	18.4	↓

Appendix 2.6 - Lancashire Health and Wellbeing Outcomes - Lancashire North CCG & Lancaster district

Figures as at July 2014

Definition: Significance (S) denotes if LCC figures are statistically significant against national value: green(significantly better), red(significantly worse), orange(not significant), grey(not tested)

Significance for districts shown by colour of figures, same colour key used as stated above.

England[1]/district figures - NHS Outcomes; England[2]/LAT/CCG figures - CCG Indicator Set

For further information please contact: tracy.pickens@lancashire.gov.uk

Opportunities for Improvement

Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year

OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Lancashire North CCG	Lancaster	
LIVING WELL										
PROMOTING HEALTHY SETTINGS, HEALTHY WORKFORCE & ECONOMIC DEVELOPMENT										
Long-term unemployment, (crude rate), 2013	2.3	9.9	7.2			-	-	-	7.3	↑
Gap in the employment rate between the below and the overall employment rate:										
those with a long-term health condition and overall employment rate, 2012	-5.3	7.1	8.7		-	-	-	-	7.9	
those in contact with secondary mental health services, 2012/13	53.1	62.3	69.4			-	-	-	-	
PROMOTING MENTAL WELLBEING & HEALTHY LIFESTYLES										
Domestic abuse incidents reported to the police, (Rate per 1,000), 2012/13	5.6	18.8	26.5			-	-	-	-	
Statutory homelessness acceptances per 1,000 households, 2012/13	0.2	2.4	0.8			-	-	-	1.0	↓
Hospital admissions for violent crime (including sexual violence), (%), 2010/11-2012/13	9.3	57.6	66.9			-	-	-	60.6	↓
REDUCING AVOIDABLE DEATHS										
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Males	164.9	238.4	266.8			-	-	-	313.4	↑
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Females	94.7	140.6	164.4			-	-	-	156.0	↓
NHS Health Check offered, (%) to be updated soon	-	-	-			-	-	-	-	
NHS Health Check uptake, (%) to be updated soon	-	-	-			-	-	-	-	
IMPROVING OUTCOMES FOR PEOPLE WITH LEARNING DIFFICULTIES										
Adults with learning disabilities who live in their own home or with family, (%), 2012-13	96.6	73.5	86.6			-	-	-	-	
Gap in the employment rate between the below and the overall employment rate:										
those with a learning disability and the overall employment rate, 2011/12	40.2	63.2	67.2		-	-	-	-	-	
AGEING WELL										
PROMOTING INDEPENDENCE										
Percentage of older people still at home 91 days after discharge from hospital into reablement/rehabilitation service:										
Offered the service, 65+, 2012-13	25.4	3.2	1.3			-	-	-	-	
Effectiveness of the service, 65+, 2012-13	98.1	81.4	82.0			-	-	-	-	
REDUCING SOCIAL ISOLATION										
Adult social care users who have as much social contact as they would like, (%), 2012/13	53.5	43.2	46.3			-	-	-	-	
Lonliness and isolation in adult carers, (%), 2012/13	23.9	41.3	38.3		-	-	-	-	-	
MANAGING LONG-TERM CONDITIONS AND DEMENTIA										
People who feel supported to manage their long-term condition, (DS %), Jul 2012 - Mar 2013	78.9	65.6	65.7			65.6	65.3	60.9	60.2	–
Estimated diagnosis rate for people with dementia, 2012/13	-	48.7	-		-	-	-	-	-	
REDUCING EMERGENCY ADMISSIONS & DIRECT ADMISSIONS TO RESIDENTIAL CARE										
Emergency readmisisons within 30 days of discharge - persons, (%), 2011/12	7.9	11.8	12.3			-	-	-	12.2	↓
Emergency readmisisons within 30 days of discharge - males, (%), 2011/12	8.6	12.1	12.7			-	-	-	12.3	↓
Emergency readmisisons within 30 days of discharge - females, (%), 2011/12	7.2	11.5	11.9			-	-	-	12.1	↔
Hip fractures in people aged 65-79, (Rate per 100,000), 2012/13	121.8	237.3	241.6			-	-	-	229.5	↓
Hip fractures in people aged 80+, (Rate per 100,000), 2012/13	1108.0	1,527.6	1,486.5			-	-	-	1,267.5	↓
SUPPORTING CARERS AND FAMILIES										
Percentage satisfaction of people using services with their care & support, 2012-13	73.9	64.1	66.8			-	-	-	-	

Appendix 2.7 - Lancashire Health and Wellbeing Outcomes - Fylde and Wyre CCG & districts

Figures as at July 2014

Definition: Significance (S) denotes if LCC figures are statistically significant against national value: green(significantly better), red(significantly worse), orange(not significant), grey(not tested)

Significance for districts shown by colour of figures, same colour key used as stated above.

England[1]/district figures - NHS Outcomes; England[2]/LAT/CCG figures - CCG Indicator Set

For further information please contact: tracy.pickens@lancashire.gov.uk

Opportunities for Improvement

Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year

OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Fylde & Wyre CCG	Fylde		Wyre	
REDUCING HEALTH INEQUALITIES												
Life expectancy (LE) at birth, 2010-12, Males	82.1	79.2	78.2			-	-	-	79.1	↑	78.2	↓
Life expectancy (LE) at birth, 2010-12, Females	85.9	83.0	82.0			-	-	-	82.8	↓	81.8	↓
Healthy life expectancy at birth, 2009-11, Males	70.3	63.2	62.8		-	-	-	-	-		-	
Healthy life expectancy at birth, 2009-11, Females	72.1	64.2	63.3		-	-	-	-	-		-	
Slope index of inequality in LE at birth based on national deprivation deciles within England:												
Slope index of inequality, 2010-12, Males (provisional)	-	9.2	-		-	-	-	-	-		-	
Slope index of inequality, 2010-12, Females (provisional)	-	6.8	-		-	-	-	-	-		-	
Slope index of inequality in LE at birth within English local authorities, based on local deprivation deciles within each area, (provisional)												
Slope index of inequality, 2010-12, Males	-	-	9.9			-	-	-	6.5	↑	9.7	↓
Slope index of inequality, 2010-12, Females	-	-	7.6			-	-	-	8.6	↑	9.8	↑
Gap in LE at birth between each local authority and England as a whole, 2010-12, Males	2.9	0.0	-1.0		-	-	-	-	-0.11	↓	-1.0	↓
Gap in LE at birth between each local authority and England as a whole, 2010-12, Females	2.9	0.0	-1.0		-	-	-	-	-0.2	↓	-1.2	↓
Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England												
Slope index of inequality, 2009-11, Males	-	19.3	-		-	-	-	-	-		-	
Slope index of inequality, 2009-11, Females	-	20.1	-		-	-	-	-	-		-	
IMPROVING PATIENT EXPERIENCE												
Patient experience of GP out of hours service, (%), July 2012 to March 2013	85.4	-	-			70.2	73.7	75.7	-		-	
Patient experience of hospital care, (%), 2013-14	87.0	76.9	74.6% - Lancashire Teaching Hospitals / 75.1% - Blackpool Teaching Hospitals									
Overall satisfaction of carers with social services, (%), 2012-13	65.4	42.7	41.8		-	-	-	-	-		-	
REDUCING ADMISSIONS/COSTS												
Emergency hospital admission for self-harm, (DSR per 100,000), 2012/13	50.4	188.0	247.3			-	-	-	268.5	↑	239.2	↓
Alcohol-related admissions to hospital per 100,000 population, 2012/13	365.0	636.9	698.4			-	-	-	636.8	↓	710.5	↑
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), 2012/13	184.8	820.5	1001.8			802.8	1,056.1	752.6	741.0	↑	761.9	↑
Unplanned hospitalisation for chronic ambulatory care sensitive conditions, (DSR), Jan 13 to Dec 13	-	-	-		-	*780.0*	*1,008.2*	*759.0*	-		-	
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), 2012/13	324.7	1204.3	1418.3			1,181.9	1,468.4	1,019.6	972.9	↑	1,016.2	↑
Emergency admissions for acute conditions that should not usually require hospital admission, (DSR), Jan 13 to Dec 13	-	-	-		-	*1,174.2*	*1,469.2*	*1,133.8*	-		-	
STARTING WELL												
PROMOTING HEALTHY PREGNANCY												
Low birthweight of term live births, (%), 2011	1.6	2.8	2.7			-	-	-	1.7	↓	2.2	↑
Smoking at time of delivery (SATOD), 2013/14	1.9	12.0	16.8			-	17.8	15.2	-		-	
Smoking at time of delivery (SATOD), 2013/14 - Q4	-	*12.3*	*16.6*		-	-	*17.6*	*15.4*	-		-	
REDUCING INFANT MORTALITY												
Infant mortality (Rate per 1,000 live births), 2010-12	1.1	4.1	4.8			-	-	-	5.8	↑	5.5	↑
REDUCING CHILDHOOD OBESITY												
Children aged 4-5 classified as overweight or obese, (%), 2012/13	16.1	22.2	23.5			-	-	-	22.8	↑	22.6	↑
Children aged 10-11 classified as overweight or obese, (%), 2012/13	24.1	33.3	32.4			-	-	-	26.9	↓	33.0	↑
SUPPORTING CHILDREN WITH LONG TERM CONDITIONS												
Emergency admissions for children with LRTI, (DSR), 2012/13	73.3	371.2	suppressed		-	399.6	550.7	359.0	368.8	↑	suppressed	-
Emergency admissions for children with LRTI, (DSR), Jan 13 to Dec 13	-	-	-		-	*375.8*	*506.8*	*334.3*	-		-	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), 2012/13	75.1	340.6	526.0			336.9	557.9	400.3	412.1	-	384.6	↑
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s, (ISR), Jan 13 to Dec 13	-	-	-		-	*309.0*	*494.2*	*382.7*	-		-	
SUPPORTING VULNERABLE FAMILIES AND CHILDREN												
Children in poverty (all dependent children under 20), (%), 2011	2.9	20.1	17.8			-	-	-	12.0	↓	15.8	↑
Children in poverty, (under 16s), (%), 2011	2.8	20.6	18.2			-	-	-	12.5	↓	16.3	↓

Appendix 2.7 - Lancashire Health and Wellbeing Outcomes - Fylde and Wyre CCG & districts

Figures as at July 2014

Definition: Significance (S) denotes if LCC figures are statistically significant against national value: green(significantly better), red(significantly worse), orange(not significant), grey(not tested)

Significance for districts shown by colour of figures, same colour key used as stated above.

England[1]/district figures - NHS Outcomes; England[2]/LAT/CCG figures - CCG Indicator Set

For further information please contact: tracy.pickens@lancashire.gov.uk

Opportunities for Improvement

Red figures denote significantly worse than national average, arrows denote positive/negative increase/decrease on figures from the previous year

OVERARCHING GOALS	England best (County & UA)	England[1]	LCC	S	LCC Trend	England[2]	LAT	Fylde & Wyre CCG	Fylde		Wyre	
LIVING WELL												
PROMOTING HEALTHY SETTINGS, HEALTHY WORKFORCE & ECONOMIC DEVELOPMENT												
Long-term unemployment, (crude rate), 2013	2.3	9.9	7.2			-	-	-	5.0	↑	5.9	↑
Gap in the employment rate between the below and the overall employment rate:												
those with a long-term health condition and overall employment rate, 2012	-5.3	7.1	8.7		-	-	-	-	-3.4		0.5	
those in contact with secondary mental health services, 2012/13	53.1	62.3	69.4			-	-	-	-		-	
PROMOTING MENTAL WELLBEING & HEALTHY LIFESTYLES												
Domestic abuse incidents reported to the police, (Rate per 1,000), 2012/13	5.6	18.8	26.5			-	-	-	-		-	
Statutory homelessness acceptances per 1,000 households, 2012/13	0.2	2.4	0.8			-	-	-	0.3	↓	0.2	↔
Hospital admissions for violent crime (including sexual violence), (%), 2010/11-2012/13	9.3	57.6	66.9			-	-	-	45.8	↓	50.1	↓
REDUCING AVOIDABLE DEATHS												
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Males	164.9	238.4	266.8			-	-	-	240.7	↑	237.5	↓
Mortality from causes considered preventable, (Rate per 100,000), 2010-12 - Females	94.7	140.6	164.4			-	-	-	136.9	↓	169.6	↑
NHS Health Check offered, (%) to be updated soon	-	-	-			-	-	-	-		-	
NHS Health Check uptake, (%) to be updated soon	-	-	-			-	-	-	-		-	
IMPROVING OUTCOMES FOR PEOPLE WITH LEARNING DIFFICULTIES												
Adults with learning disabilities who live in their own home or with family, (%), 2012-13	96.6	73.5	86.6			-	-	-	-		-	
Gap in the employment rate between the below and the overall employment rate:												
those with a learning disability and the overall employment rate, 2011/12	40.2	63.2	67.2		-	-	-	-	-		-	
AGEING WELL												
PROMOTING INDEPENDENCE												
Percentage of older people still at home 91 days after discharge from hospital into reablement/rehabilitation service:												
Offered the service, 65+, 2012-13	25.4	3.2	1.3			-	-	-	-		-	
Effectiveness of the service, 65+, 2012-13	98.1	81.4	82.0			-	-	-	-		-	
REDUCING SOCIAL ISOLATION												
Adult social care users who have as much social contact as they would like, (%), 2012/13	53.5	43.2	46.3			-	-	-	-		-	
Lonliness and isolation in adult carers, (%), 2012/13	23.9	41.3	38.3		-	-	-	-	-		-	
MANAGING LONG-TERM CONDITIONS AND DEMENTIA												
People who feel supported to manage their long-term condition, (DS %), Jul 2012 - Mar 2013	78.9	65.6	65.7			65.6	65.3	69.1	69.0	↓	69.8	↑
Estimated diagnosis rate for people with dementia, 2012/13	-	48.7	-		-	-	-	-	-		-	
REDUCING EMERGENCY ADMISSIONS & DIRECT ADMISSIONS TO RESIDENTIAL CARE												
Emergency readmisisons within 30 days of discharge - persons, (%), 2011/12	7.9	11.8	12.3			-	-	-	12.2	↑	12.1	↓
Emergency readmisisons within 30 days of discharge - males, (%), 2011/12	8.6	12.1	12.7			-	-	-	13.2	↓	12.3	↑
Emergency readmisisons within 30 days of discharge - females, (%), 2011/12	7.2	11.5	11.9			-	-	-	11.3	↑	12.0	↓
Hip fractures in people aged 65-79, (Rate per 100,000), 2012/13	121.8	237.3	241.6			-	-	-	252.6	↓	259.7	↑
Hip fractures in people aged 80+, (Rate per 100,000), 2012/13	1108.0	1,527.6	1,486.5			-	-	-	1,532.0	↑	1,401.9	↓
SUPPORTING CARERS AND FAMILIES												
Percentage satisfaction of people using services with their care & support, 2012-13	73.9	64.1	66.8			-	-	-	-		-	

Lancashire Health & Wellbeing Board
Meeting to be held on 16th October 2014

Electoral Division affected: ALL

Health & Wellbeing Strategy – Six Shifts JSNA Progress Report

Contact for further information:
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Executive Summary

This paper provides an update to the Health & Wellbeing Board of the production of a JSNA for the six shifts as identified in the Health & Wellbeing Strategy and compliments the update presented to the Board on July 16th.
In particular, this paper describes:

- The background
- The work undertaken thus far
- The position of lead officers for each of the six shifts
- Engagement events

Recommendations:
The Board is asked to:

- Note the progress of the production of the JSNA for the six shifts and initial findings
- Note the success of the engagement and consultation event for the Board on 15th September
- Note the second engagement and consultation event for the Board and third sector
- Identify a lead officer for the shift which currently has an acting lead.

Background and Advice

Work undertaken:

The Health & Wellbeing Board requested that a JSNA approach is used to work-up the Six Shifts as identified in the Health & Wellbeing Strategy.
A Scoping Group met on 5th February and started to identify:

- What success looks like
- What successful work is currently underway

The Scoping Group also established a project group.
The project group meets on a regular basis to share ideas, thoughts and support and to ensure that the project is progressing to the agreed timescales.

Lancashire County Council

A progress report was presented to the Board on July 16th where the board noted the process, governance structure and progress of the Six Shifts JSNA.

Engagement:

Each Shift lead is co-ordinating and undertaking its own consultation and engagement with its key stakeholders as part of the ongoing work of the shift.
Further to this, a large scale engagement and consultation event was held at Woodlands on September 15th to which the Board, JOG and district health lead officers were invited.
The event was very well attended and proved to be successful and provided the shift leads with some excellent material.
Unfortunately, the date was not suitable for a small number of members of the Board and so a second event is being organised. The event will take place towards the end of October and Board members who could not make the initial event will be invited, as will the key stakeholders from the third sector.

Current position:

Draft findings will be presented to JOG in October for discussion and comment and guidance.
Initial analysis suggests that, as well as specific actions which have been identified for each shift, there are a number of cross-cutting themes. These are:

- Leadership
- Relationship Building
- Partnership Working
- Communication
- Defining terms / language / vision

The JSNA will outline any eventual cross-cutting themes but the project lead is very keen to ensure that the shifts do not become homogenised and that each shift's findings are pertinent and relevant to that particular shift and are not unduly influenced by the initial findings.

Risk:

One key risk remains. At its meeting on September 16th, the Board agreed to identify and nominate a CCG officer lead for a shift which did not have a lead officer in place. The shift in question *is "Commit to delivering accessible services within communities; improving the experience of moving between primary, hospital and social care"*.
To date, no lead has been nominated.
To mitigate this risk, the project lead and the deputy project lead have acted as shift leads. However, this is a short-term solution and it is appropriate for the Board to nominate a lead officer at this point.

Next steps:

The project lead officer and the project team will continue to work to the agreed timescales and to engage with the Board and with other key stakeholders.
The project is on track to produce a JSNA which will be presented to the Board at its meeting on 29th January 2015.

Consultations

As part of the agreed process for producing the JSNA, a wide range of partners have been consulted using the Board's agreed governance structure. These partners include local authorities, CCGs, local health partnerships, Healthwatch, Public Health England, NHS England and the third sector.

Implications:

This item has the following implications, as indicated:

Risk management

Risks identified in the report.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
Lancashire's Health and Wellbeing Strategy	2014	Sakthi Karunanithi Public Health

Reason for inclusion in Part II, if appropriate

N/A

Lancashire Health and Wellbeing Board
Meeting to be held on 16 October 2014

Electoral Division affected:
All

Health Behaviours JSNA – progress report

Contact for further information:
Mike Leaf, 01772 534393, Adult Services, Health and Wellbeing,
mike.leaf@lancashire.gov.uk

Executive Summary

This paper provides a progress update on the Health Behaviours JSNA. The work forms part of the JSNA bespoke analyses work programme 2013/14 agreed by the Health and Wellbeing Board in October 2013. The project is on target with no concerns over delivery.

Recommendation

The Health and Wellbeing Board is asked to note this update report.

Background and Advice

Healthy behaviours such as sensible drinking of alcohol, being physically active, eating well and managing stress are known to prevent a wide range of health problems across the life course. Behaviours such as smoking tobacco, misusing drugs and alcohol and unsafe sex put people at particular risk of ill health.

In Lancashire we have very limited information about the prevalence of different health behaviours across population groups or the characteristics of people with different health behaviours. We don't know what assets there are in our communities that enable and support healthy behaviours. Neither do we know how many people participate in more than one risk-taking behaviour or the scale of the various combinations of unhealthy behaviours. The Health Behaviours JSNA has been designed to improve insight into these areas.

Progress

The project is on target with no concerns over delivery of the JSNA as planned.

As with all previous JSNAs, a small project group has been set up to direct the project, comprising research and intelligence experts along with commissioners from across the public, private and third sectors. The project group is the mechanism that

Lancashire County Council

drives the design and delivery of the survey, post-fieldwork analyses and the subsequent health behaviours JSNA.

A wider reference group met initially to frame the JSNA and to give the project group a better understand the topics the JSNA needs to tackle, and how the completed JSNA will influence strategic and commissioning decision-making.

Delivery has been split into four main sections comprising a literature review, secondary data analyses, public survey and reporting.

Literature review and secondary data analysis

A literature review and the secondary data analyses have both been completed. Work has been undertaken to ascertain the gaps in understanding from this work and this has fed into the refinement of the questionnaire topics. A combined report for this area of work is almost complete. It will provide a comprehensive picture of the data and literature surrounding the health behaviours covered in the survey. This will be used to underpin the final JSNA report and will be available on the health behaviours JSNA web page alongside all other supporting documents.

Public survey

The survey is currently out in the field, with fieldwork ending on 7 November. Early indications are that we have a strong response rate, which will provide a robust dataset that can be analysed by various demographic and behavioural characteristics, and lower-level geographies. Data processing is ongoing. A report from the survey will be produced.

Blackpool Council and Blackburn with Darwen Council were invited to take part in the JSNA. Blackpool Council is taking part in the survey and it is being run as a joint survey between the county council and Blackpool, with the county council providing the lead.

Analysis and reporting

Analysis and reporting will be completed once the survey report has been delivered. It will allow the various stands of the project to be brought together into a single understanding. The report will be a summary of health behaviours in Lancashire, with links to more in-depth analyses and resources, and with a set of draft recommendations and actions.

The reference group will be convened once the reporting has been completed and the recommendations are emerging. The reference group will be used to enable the recommendations and actions to be prioritised. A final report will then be submitted to the Health and Wellbeing Board, which will be 29 April 2015.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

The Health and Wellbeing Board is asked to note this update report.

Risk management

The project is on target with no concerns over delivery of the JSNA as planned.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
insert details	insert date	insert details

Reason for inclusion in Part II, if appropriate

insert the exemption number and extract from relevant Para 1-7 or 'N/A' as appropriate

Lancashire Health & Wellbeing Board
Meeting to be held on 16th of October 2014

Electoral Division affected:
All

Pharmaceutical Needs Assessment
(Appendices 1 and 2 refer)

Contact for further information Peter Lobmayer, 07876844095, Adult Services Health and Wellbeing, peter.lobmayer@lancashire.gov.uk

Executive Summary

The draft Lancashire Pharmaceutical Needs Assessment (PNA) outlines present and future needs of citizens for pharmacy services.
The main findings of the assessment as set out in the draft are:

- That there is adequate service provision of pharmacies for the residents of Lancashire
- That the PNA does not identify the need for any additional pharmacies in Lancashire

Recommendation

The Board is asked to

i. Consider the draft PNA and approve the draft document (subject to any amendments the Board may propose)
ii. Agree that the County Council should commence a statutory 60 days consultation of the draft Lancashire PNA beginning on 20th of October 2014
iii. Delegate responsibility to the HWB chair to approve the publishing of the PNA before 1st of April 2015, after amendments made based on the consultation.

Background and Advice
The purpose of this report is to update the Health and Wellbeing Board (HWB) on the work that is progressing locally in relation to the P NA and to invite the Board to comment on the draft attached to this report and approve the process for publishing a final version of the Lancashire PNA.

Background and rationale
Local Government took on a new role when Public Health transferred from the NHS in April 2013. The document “Community Pharmacy - Local Government’s new public health role" identifies the new roles and responsibilities that local Government took on including the production of a Pharmacy Needs Assessment.

The PNA is the key tool for identifying what is needed at a local level to ensure provision of high quality pharmaceutical services to local people. It is designed to identify gaps in service provision, support commissioning and/or decommissioning and ensure that the needs of the residents of Lancashire are met.

A steering group has been set up across Lancashire to produce the PNA. Although the process is Pan-Lancashire the products are localized and the present document relates to the area pharmacy needs of Lancashire County Council's citizens.

From the 1st April 2013 every Health and Wellbeing Board in England has had a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services for its local population. This is known as the Pharmacy Needs Assessment (PNA). It describes the needs for the population of Lancashire and enables commissioners to commission pharmaceutical services that are based on local priorities. A copy of the draft Pharmaceutical Needs Assessment is attached at Appendix 1 and the PNA 'Plan-on-a-page' is attached at Appendix 2

FORMAT
The draft PNA covers chapters on the following:

- Process followed when the PNA was constructed
- Background and context for the PNA
- Current provision of NHS Pharmaceutical Services
- Health needs and locally commissioned services
- Future population changes and housing growth

PROCESS AND DEADLINES
It is proposed that the HWB review and feedback comments and suggestions by 18th of October 2014. If necessary amendments will be made to the PNA and this will be followed by a 60 day public consultation commencing on the 20th of October involving key stakeholders. If necessary further amendments will be made after the public consultation. The final version of PNA will go to the Chair of HWB for final sign off subject to the Board's approval to this proposed process.

In order to promote the public consultation a stakeholder event will be arranged.

60 days further consultation will commence on the 20th of October 2014. The 2013 Regulations list those persons and organisations that the HWB must consult. This list includes:

- Any relevant local pharmaceutical committee (LPC) for the HWB area.
- Any local medical committee (LMC) for the HWB area.
- Any persons on the pharmaceutical lists and any dispensing GP practices in the HWB area.
- Any local Healthwatch organisation for the HWB area, and any other patient, consumer and community group which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area.
- Any NHS trust or NHS foundation trust in the HWB area.
- NHS England.
- Any neighbouring HWB.

Results of the consultation will be summarized and made part of the final Lancashire PNA.

Implications:

This item has the following implications, as indicated:

Risk management

The Health & Wellbeing Board is under a statutory duty to publish a PNA before the 1st of April 2015 l Failure to meet this requirement is likely to result in legal challenges and potential reputational damage.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel
Draft Lancashire PNA	16/10/2014	ASHW

Reason for inclusion in Part II, if appropriate

N/A

Lancashire Pharmaceutical Needs Assessment 2014

Lancashire County Council

www.lancashire.gov.uk

Contents

Acknowledgements

Special acknowledgement to Cambridgeshire County Council who kindly allowed us to use their PNA model for this process.

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In addition, a number of other individuals have submitted information used in the PNA.

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

Executive Summary

I. Introduction

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 of the population in its area, referred to as a pharmaceutical needs assessment (PNA).

Decisions on whether to open new pharmacies are not made by the HWB. Pharmacies must submit a formal application to NHS England. 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. As these decisions may be appealed and challenged via the courts, it is important that PNAs comply with regulations and that mechanisms are established to keep the PNA up-to-date. In accordance with these regulations, Lancashire County Council PNA will be updated every three years.

This PNA describes the needs for the population of Lancashire county.

The PNA includes information on:

- Pharmacies in Lancashire and the services they currently provide, including dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.
- Relevant maps relating to Lancashire and providers of pharmaceutical services in the area.
- Services in neighbouring HWB areas that might affect the need for services in Lancashire.
- Potential gaps in provision and likely future needs for the population of Lancashire.
- Potential opportunities relating to needs of the population.

II. Process

This PNA was undertaken in accordance with the requirements set out in regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

In the process of undertaking the PNA the pan Lancashire steering group sought the views of a wide range of key stakeholders to identify issues that affect the commissioning of pharmaceutical services and to meet local health needs and priorities. A stakeholder event was held in March 2014.

A 60 day public consultation will be undertaken from 20 October 2014 to seek the views of members of the public and other stakeholders, on whether they agree with the contents of this PNA and whether it addresses issues that they consider relevant to the provision of pharmaceutical services. The feedback gathered in the consultation will be reported and reflected in the final revised PNA report. Alongside the 60 day public consultation a further

stakeholder event will be held within Lancashire to promote the public consultation and identify views from key stakeholders.

III. Local context

The PNA for Lancashire is undertaken in the context of the needs of the local population. Health and wellbeing needs for the local population are described in the Lancashire Joint Strategic Needs Assessment. This PNA does not duplicate these detailed descriptions of health needs and should be read in conjunction with the JSNA (http://www.lancashire.gov.uk/corporate/web/?siteid=6101&pageid=35157&e=e).

Lancashire consists of urban and rural areas. The health of people in Lancashire is varied compared with the England average. Deprivation is higher than average and about 18.2% (38,700) children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 9.9 years lower for men and 7.6 years lower for women in the most deprived areas of Lancashire than in the least deprived areas.

IV. Key Findings

I. Provision of local pharmaceutical services

Lancashire is well provided for by pharmaceutical service providers. This PNA has not identified a current need for new NHS pharmaceutical service providers within Lancashire.

There are 295 pharmacies in Lancashire and the number of pharmaceutical service providers per population is higher than in the previous PNA in 2010. The number of pharmaceutical service providers per population has also grown during the same period. In 2 out of the 3 localities (Central and East) the number of pharmacies per 100,000 people has increased since the last PNA (Central Lancashire increased from 20 per 100,000 population to 24, East Lancashire from 20 per 100,000 to 27 while North Lancashire stayed the same at 24 per 100,000 population). In Lancashire the number of pharmacies per 100,000 people is 31 compared to the England average of 22 and the average for the North West being 26.

Approximately 64% of pharmacies responded to the PNA questionnaire about service provision.

Review of the locations, opening hours and access for people with disabilities suggest there is adequate access to NHS Pharmaceutical Services in Lancashire. There appears to be good coverage in terms of opening hours across the county. The extended opening hours of some community pharmacies are valued and these extended hours should be maintained. Many pharmacies and dispensing surgeries have wheelchair access and home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport.

ONS population projections do not show a substantial increase in Lancashire's population over the coming years, however, these projections do not take into account any future housing developments.

Lancashire's projected growth between 2014 and 2024 comes to approximately 2.8%, compared with a rise of 7.1% in England as a whole.

To ensure that pharmaceutical services are commissioned in line with population need, the Health and Wellbeing Board partners will monitor the development of major housing sites and if necessary provide supplementary statements in accordance with regulations.

II. The role of pharmacy in improving the health and wellbeing of the local population

Providers of pharmaceutical services have an important role to play in improving the health of local people. They are easily accessible and are often the first point of contact, including for those who might otherwise not access health services.

Community pharmacies can contribute to the health and wellbeing of the local population in a number of ways, including motivational interviewing, providing information and brief advice, providing on-going support for behaviour change and signposting to other services.

Commissioners are recommended to commission service initiatives in pharmacies around the best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation.

In Lancashire, commissioning of services from community pharmacy has been varied across the county and although work is on-going to try and standardise commissioned community pharmacy services, for some services inequalities do remain.

Three of the four Lancashire Stop Smoking Services (East, Central and West) have been using a pharmacy Nicotine Replacement Therapy (NRT) Voucher Scheme since 2009. The scheme has recently been extended to North Lancashire in 2014/15 and community pharmacies are currently being recruited to the scheme.

Of the pharmacies across Lancashire signed up to a local improvement service (LIS) agreements, 215 provide chlamydia testing and emergency hormonal contraception (EHC). It is advised to offer chlamydia screening when EHC is provided, since those requiring such contraception may also be at risk of infection.

Many pharmacies across the county provide dispensing for prescriptions issued for the management of substance misuse problems, supervised consumption of prescribed medication and needle and syringe exchange. Those pharmacies involved are contracted either by Lancashire County Council via the NHS Midlands & Lancashire Commissioning Support Unit (CSU) or by substance misuse treatment providers (depending on the locality).

A Lancashire Healthy Living pharmacy programme prospectus has been drawn up that local pharmacy contractors are invited to sign up to. Healthy Living pharmacy is an identified priority in the Local Professional Network (Pharmacy)(LPN) work plan and is accountable to the LPN for roll out and delivery of the plan.

In conclusion this Pharmacy Needs Assessment identifies that there is adequate service provision of pharmacies for the residents of Lancashire with a wide range of commissioned services available. This PNA does not identify any significant gaps in service provision. However, there may be potential opportunities relating to needs of the population.

1 Introduction

Key messages:

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 of the population in its area, referred to as a pharmaceutical needs assessment (PNA).

The PNA will help in the commissioning of pharmaceutical services in the context of local priorities, and will be used by NHS England when making decisions on applications to open new pharmacies. As these decisions may be appealed and challenged via the courts, it is important that PNAs comply with regulations and that mechanisms are established to keep the PNA up-to-date.

This PNA describes the needs for the population of Lancashire County.

The PNA includes information on:

- **Pharmacies in Lancashire and the services they currently provide, including dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.**
- **Relevant maps relating to Lancashire districts and providers of pharmaceutical services in the area.**
- **Services in neighbouring HWB areas that might affect the need for services in Lancashire.**
- **Potential gaps in provision and likely future needs for the population of Lancashire.**
- **Potential opportunities relating to needs of the population.**

1.1 What is a Pharmaceutical Needs Assessment?

The PNA is a structured approach to identifying unmet pharmaceutical need. It can be an effective tool to enable HWBs to identify the current and future commissioning of services required from pharmaceutical service providers. The Department of Health (DH) recently published an Information Pack to help HWBs undertake PNAs.[i]

1.2 What is the purpose of the PNA?

This PNA will serve several key purposes:[ii]

- It will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements.
- It will help the HWB to work with providers to target services to the areas where they are needed and limit duplication of services in areas where provision is adequate.
- It will inform interested parties of the pharmaceutical needs in Lancashire and enable work to plan, develop and deliver pharmaceutical services for the population.

- It will inform commissioning decisions by local commissioning bodies including local authorities (public health services from community pharmacies), NHS England and Clinical Commissioning Groups (CCGs).

1.3 Legislative background

Section 126 of the NHS Act 2006 placed an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons. This section of the Act also described the types of healthcare professionals who are authorised to order drugs, medicines and listed appliances on an NHS prescription. The first PNAs were published by NHS Primary Care Trusts (PCTs) in line with the requirements in the 2006 Act. NHS East, Central and North Lancashire Trusts produced their PNAs in 2010.[iii]

In 2012 the Health and Social Care Act was produced and superseded the NHS Act 2006. The 2012 Act established HWBs and transferred the responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, with effect from 1 April 2013. The requirements on how to develop and update PNAs are set out in Regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. [iv]

The 2012 Act also amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for HWBs in relation to Joint Strategic Needs Assessments (JSNAs). The preparation and consultation on the PNA should take account of the JSNA and other relevant local strategies in order to prevent duplication of work and multiple consultations with health groups, patients and the public. The development of PNAs is a separate duty to that of developing JSNAs. As a separate statutory requirement, PNAs cannot be subsumed as part of these other documents but can be annexed to them.

The PNA must be published by the HWB by April 2015, and will have a maximum lifetime of three years. As part of developing their first PNA, HWBs must undertake a consultation for a minimum of 60 days. The 2013 Regulations[iv] list those persons and organisations that the HWB must consult. This list includes:

- Any relevant local pharmaceutical committee (LPC) for the HWB area.
- Any local medical committee (LMC) for the HWB area.
- Any persons on the pharmaceutical lists and any dispensing GP practices in the HWB area.
- Any local Healthwatch organisation for the HWB area, and any other patient, consumer and community group which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area.
- Any NHS trust or NHS foundation trust in the HWB area.
- NHS England.
- Any neighbouring HWB.

The Health and Social Care Act 2012 also transferred responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list from PCTs to NHS England. The PNA will be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises; or applications from current pharmaceutical providers to change their existing regulatory requirements. Such decisions are appealable to the NHS Litigation Authority's Family Health Services Appeal Unit

(FHSAU), and decisions made on appeal can be challenged through the courts. PNAs will also inform the commissioning of enhanced services from pharmacies by NHS England, and the commissioning of services from pharmacies by the local authority and other local commissioners e.g., CCGs. It is extremely important that PNAs comply with the requirements of the regulations and are kept up to date by submitting supplementary statements when deemed necessary.

Primary Care Commissioning (PCC) has highlighted that failure to comply with the regulatory duties may lead to a legal challenge, for example where a party believes that they have been disadvantaged following refusal by NHS England of their application to open new premises. [v]

HWBs will also be required to publish a revised assessment when significant changes to the need for pharmaceutical services are identified, unless this is considered a disproportionate response. HWBs therefore need to establish systems that allow them to:[ii]

- Identify changes to the need for pharmaceutical services within their area.
- Assess whether the changes are significant.
- Decide whether producing a new PNA is a disproportionate response.

HWBs need to ensure they are aware of any changes to the commissioning of public health services by the local authority and the commissioning of services by CCGs as these may affect the need for pharmaceutical services. HWBs also need to ensure that NHS England and its Area Teams have access to their PNAs.

1.4 What are NHS pharmaceutical services?

Pharmaceutical services as defined in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 include:[iv]

- Essential services which every community pharmacy providing NHS pharmaceutical services must provide (as described in Schedule 4, Part 2 of the Regulations) which includes the dispensing of medicines, promotion of healthy lifestyles and support for self-care.
- Advanced services which community pharmacy contractors and dispensing appliance contracts can provide subject to accreditation. These are currently Medicines Use Reviews (MUR) and the New Medicines Service from community pharmacists and Appliance Use Reviews and the Stoma Customisation Service which can be provided by dispensing appliance contracts and community pharmacies.
- Enhanced services are commissioned directly by NHS England. These could include Seasonal Flu vaccination service, minor ailment services and palliative care / just in case services supporting end of life services.

1.5 Local pharmacy services

Local pharmacy services are services which are commissioned locally and fall outside of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

The 2013 regulations set out the enhanced services which may be commissioned from pharmacy contractors. It is important to note that the definition of 'Enhanced services' have changed, and the current commissioning arrangements can now be seen as more complex since pharmacy services previously commissioned by one organisation (PCTs) can now be

commissioned by at least three different organisations (CCGs, local authorities and NHS England) and the responsibility for commissioning some services is yet to be resolved.

1.5.1 *Public health services and enhanced services*

The changes to enhanced services are summarised in the following except from PCC8:

Public Health Services

The commissioning of the following enhanced services which were listed in the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2012 transferred from PCTs to local authorities with effect from 1 April 2013:

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

Where such services are commissioned by local authorities they no longer fall within the definition of enhanced services or pharmaceutical services as set out in legislation and therefore should not be referred to as enhanced services.

http://www.pcc-cic.org.uk/article/pharmacy-enhanced-services-1-april-2013

In Lancashire these are called Local Improvement Services (LIS).

However, the 2013 directions do make provision for NHS England to commission the above services from pharmacy contractors where asked to do so by a local authority. Where this is the case they are treated as enhanced services and fall within the definition of pharmaceutical services.

Enhanced services

The following enhanced services may be commissioned by NHS England from 1 April 2013 in line with pharmaceutical needs assessments (PNAs) produced by PCTs up to 31 March 2013 and by Health and Wellbeing Boards (HWBs) thereafter:

- Anticoagulation monitoring
- Care home service
- Disease specific medicines management service
- Gluten free food supply service
- Independent prescribing service
- Home delivery service
- Language access service
- Medication review service
- Medicines assessment and compliance support
- Minor ailment service
- On demand availability of specialist drugs
- Out of hours service

- Patient group direction service (not related to public health services)
- Prescriber support service
- Schools service
- Supplementary prescribing service.

1.5.2 *Clinical commissioning groups*

CCGs now have a role to commission most NHS services locally, aside from those commissioned by NHS England such as GP core contracts and specialised commissioned services. CCGs involve clinicians in their area to ensure commissioned services are responsive to local needs. CCGs will be able to commission services from pharmacies but similar to public health services these services will be known as local services and then fall outside the definition of enhanced services.

1.5.3 *Impact of Locally Commissioned Services by Local Authorities and CCGs*

It is important to identify those services that fall within the definition of pharmaceutical services and those that do not, in order to identify needs for, or improvements or better access to, pharmaceutical services.

Although the PNA is primarily concerned with pharmaceutical services, the PNA takes into account other NHS services which are provided or arranged by the local authority, NHS England, a clinical commissioning group (CCG), an NHS trust or an NHS foundation trust in order to provide as complete a description of relevant services as possible and to avoid erroneously identifying gaps in provision.

1.6 What are pharmaceutical lists?

If a person (a pharmacist, a dispenser of appliances or in some circumstances and, normally in rural areas, GPs) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled by NHS England. This is commonly known as the NHS 'market entry' system.

Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013, a person who wishes to provide NHS Pharmaceutical Services must apply to NHS England to be included on a relevant list by generally proving they are able to meet a pharmaceutical need as set out in the relevant PNA. There are exceptions to the applications to meet a need, such as applications for needs not foreseen in the PNA or to provide pharmaceutical service on a distance-selling (internet or mail order only) basis.

The following are included in a pharmaceutical list:

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

- Local pharmaceutical services (LPS) contractors also provide pharmaceutical services in some HWB areas.

1.7 What information will this PNA contain?

The information to be contained in the PNA is set out in Schedule 1 of The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013

This PNA includes information on:

- Pharmacies in Lancashire and the services they currently provide, including dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.
- Relevant maps relating to Lancashire and providers of pharmaceutical services in the area.
- Services in neighbouring HWB areas that might affect the need for services in Lancashire.
- Potential gaps in provision and likely future needs for the population of Lancashire.
- Potential overprovision of services.

2 Process

Key messages:

This PNA was undertaken in accordance with the requirements set out in regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.[iv]

In the process of undertaking the PNA the pan Lancashire steering group sought the views of a wide range of key stakeholders to identify issues that affect the commissioning of pharmaceutical services and to meet local health needs and priorities. A stakeholder event was held in March 2014.

A 60 day public consultation was undertaken from 20 October 2014 to 18 December 2014 to seek the views of members of the public and other stakeholders, on whether they agree with the contents of this PNA and whether it addresses issues that they consider relevant to the provision of pharmaceutical services. The feedback gathered in the consultation was reported and reflected on in the final PNA report. Alongside the 60 day public consultation a further stakeholder event was held within Lancashire to promote the public consultation and identifying views from key stakeholders.

2.1 Summary of the process followed in developing the PNA

In developing the PNA for Lancashire information from the JSNA and Public Health sources were used to explore the characteristics of areas within the town and local health needs that may be addressed through pharmaceutical services. The current provision of such services is described.

The process of developing the PNA has taken into account the requirement to involve and consult people about changes to health services. The specific legislative requirements in relation to development of PNAs were duly considered. An extract of part of these regulations can be found in Appendix 1.

2.2 Stakeholders involved in the development of the PNA

A pre-consultation exercise was carried out across Pan Lancashire in March 2014 to seek and take into account views from a range of key stakeholders to form the first draft of the PNA. Key partners were consulted to seek their views and get initial feedback for the proposals to be set out in the draft PNA.

The list of stakeholders consulted included the following groups:

- Lancashire Health and Wellbeing Board members
- The Local Pharmacy Professional Network (LPN)
- The Local Pharmaceutical Committee (LPC)
- The Local Medical Committee (LMC)
- Persons on the pharmaceutical list
- Healthwatch
- NHS trusts and NHS foundation trusts in the area.

- NHS England
- Commissioners of pharmaceutical services

2.3 How stakeholders were involved

A pan Lancashire steering group was convened and met on a monthly basis during the development of the PNA (see Acknowledgements for list of steering group members). The steering group held a pre consultation event and engaged with key stakeholders.

Questionnaires relating to service provision were sent out to all pharmacies in Lancashire. As part of the PNA process, Lancashire has worked with the two Lancashire unitary authorities (Blackburn with Darwen and Blackpool) to develop the PNA within Lancashire and we have informed all neighbouring HWBs that the PNA is in development. Lancashire HWB has the following neighbouring HWB who have been informed.

Sefton	Cumbria	Knowsley	St Helens
Wigan	Bury	Rochdale	Bolton
Calderdale	North Yorkshire	Blackpool	Blackburn with Darwen

Local Healthwatch in Lancashire (http://healthwatchlancashire.co.uk/) were commissioned to seek the views of the public and their experiences of using pharmaceutical services through a variety of engagement methods including focus groups, online surveys and questionnaires. The wider public in Lancashire and other interested parties are being informed of the PNA and their views on the PNA will be sought through a formal 60 day consultation running from 20 October to 18 December 2014. A stakeholder event will be held in October with a wide range of stakeholders to launch the consultation period of the draft PNA. At the stakeholder event people will be directed to the Lancashire HWB website to review the full PNA.

After the consultation period is completed, feedback gathered from members of the public and stakeholders will be reflected in a Consultation Report which will be an Appendix to the final PNA. The Consultation Report will also be made available on the Lancashire Health and Wellbeing Board website.

2.4 Localities used for considering pharmaceutical services

The PNA regulations requires the PNA to define 'localities' to use during this process.

For the purpose of the Lancashire PNA the county is considered in terms of its 12 districts and across 3 localities (Central, East and North) which were selected to support local decision making that takes into account the needs for the population in these areas; also see section 3.5. Characteristics of localities are further described in Appendix 2.

2.5 Methods used for identifying providers of pharmaceutical services

The methods used for identifying providers of pharmaceutical services and creation of maps are described in Appendix 3.

2.6 Assessment of need for pharmaceutical services

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

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

2.7 Future PNAs and supplementary statements

The HWB has a responsibility to keep the PNA up to date through publishing supplementary statements when appropriate as guided by the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

After the PNA is published, the HWB will publish a statement of any changes in the provision of pharmaceutical services in its localities by way of a supplementary statement, where appropriate. On behalf of the HWB the Director of Public Health will take the lead responsibility for PNAs and producing any supplementary statements. The PNA will be updated every three years.

3 Context for the Pharmaceutical Needs Assessment

Key Messages

The PNA for Lancashire is undertaken in the context of the needs of the local population. Health and wellbeing needs for the local population are described on the Lancashire Joint Strategic Needs Assessment pages on the Lancashire County Council website. This PNA does not duplicate these detailed descriptions of health needs and should be read in conjunction with the JSNA pages. (http://www.lancashire.gov.uk/corporate/web/?siteid=6101&pageid=35157&e=e)

Lancashire consists of urban and rural areas. The health of people in Lancashire is varied compared with the England average. Deprivation is higher than average and about 18.2% (38,700) children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 9.9 years lower for men and 7.6 years lower for women in the most deprived areas of Lancashire than in the least deprived areas.

3.1 Joint Strategic Needs Assessments

Lancashire's JSNA provides an online platform for intelligence to inform priority setting and commissioning for health and wellbeing which includes intelligence about indicators of health, wellbeing and social care, but also the determinants of health such as employment, the environment, community safety and social capital. [vi]The JSNA is integrated with Lancashire Profile and within the County Council's corporate research and intelligence function so there are good links across a wide partnership of intelligence professionals. Joint working arrangements are in place to maintain and develop the content of the web pages.

The JSNA team undertakes thematic analyses to identify strategic health needs to inform commissioning decisions. These analysis are determined by the annual programme of work set by the Health and Wellbeing Board's Joint Officer Group. Lancashire's JSNA is viewed as a process rather than a document so that the most up to date information is available as widely as possible to inform decision making.

The Lancashire County Council website publishes all the local JSNA reports and supporting documentation, including an annual JSNA summary and specific topic area reports for the local areas.
http://www.lancashire.gov.uk/corporate/web/?siteid=6101&pageid=35157&e=e

3.2 Lancashire Health and Wellbeing Board

The Lancashire Health and Wellbeing Board is a forum for key leaders from the health and care system in Lancashire to work together to improve the health and wellbeing of the local population and reduce health inequalities.[vii]

Board members work together to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and their local council in the future.

It is the responsibility of the Health and Wellbeing Board to:

- To identify the priority health and wellbeing needs in our area (using the Joint Strategic Needs Assessment)
- To set priorities based on information gathered from across Lancashire
- To promote integrated commissioning and provision of services by encouraging partnership working.

The work of the Board is guided by the Lancashire Health and Wellbeing strategy.

The strategy includes:

- Three goals the Board want to achieve by 2020
- Six changes to the way of work – the key shifts that will make a difference
- Three programmes of interventions to be delivered by April 2016 to start to achieve the Board's outcomes

The 3 goals of the strategy are by 2020 to deliver:

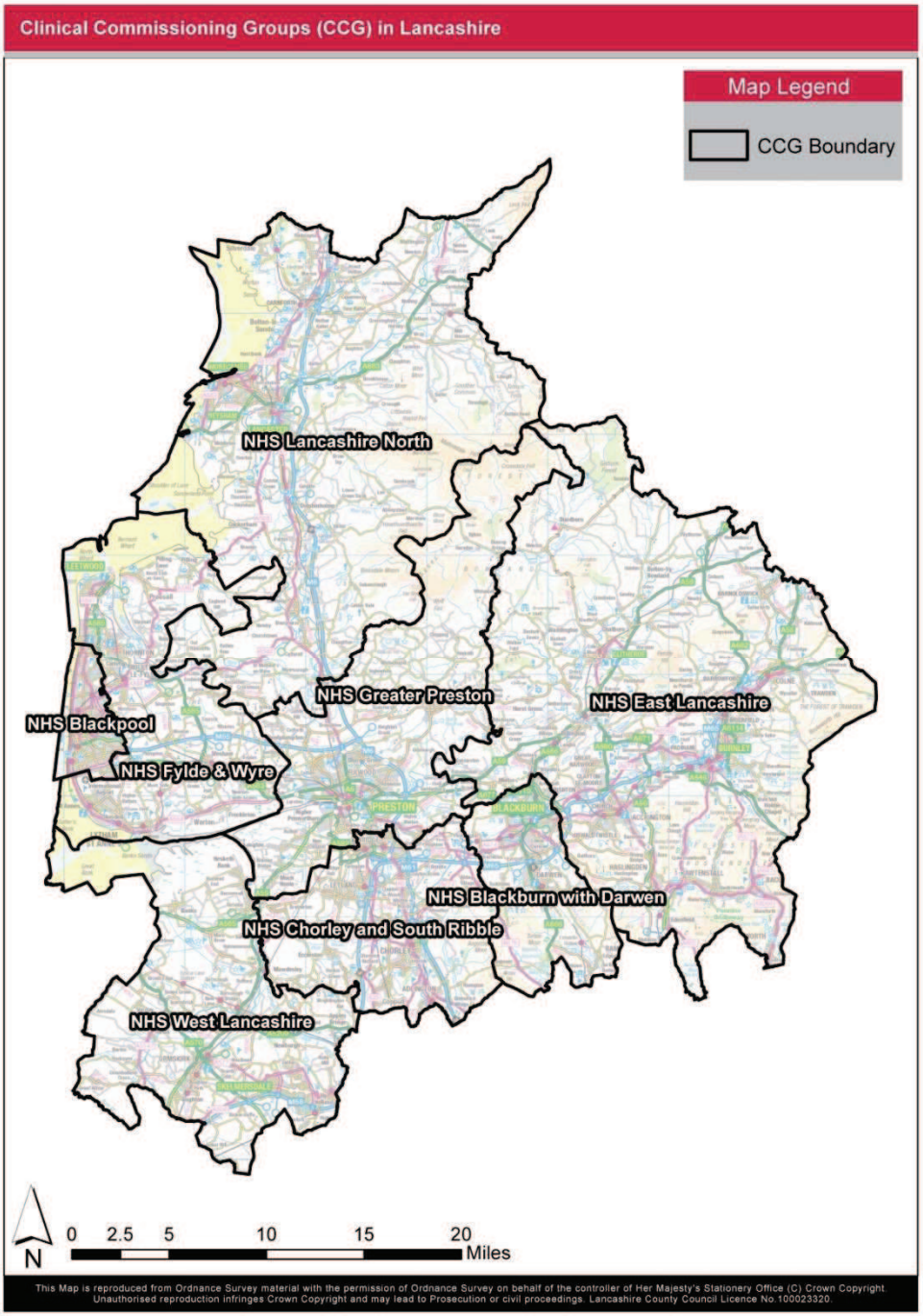
1. Better health – we will improve healthy life expectancy, and narrow the health gap
2. Better care – we will deliver measureable improvements in people's experience of health and social care services
3. Better value – we will reduce the cost of health and social care

3.3 Lancashire Clinical Commissioning Groups

Within Lancashire there are six Clinical Commissioning Groups (CCGs): NHS Chorley & South Ribble, NHS East Lancashire, NHS Fylde & Wyre, NHS Greater Preston, NHS Lancashire North and NHS West Lancashire; table 1 outlines their priorities. Map 1 shows the location of all the CCGs in Lancashire, including Blackburn with Darwen and Blackpool CCGs.

Table 1: Strategic priorities of the Lancashire CCGs				
Fylde & Wyre CCG	**West Lancashire CCG**	**Lancashire North CCG**	**East Lancashire CCG**	**Chorley & South Ribble CCG and Greater Preston CCG (joint priorities)**
Cancer Children & maternity End of life Learning disabilities Long term conditions Mental health & dementia Planned care Urgent care	Right care, right time, safely delivered • planned care • urgent care • end of life Preventing people from dying prematurely • cardiovascular disease • cancer Integrated working for better patient experience, safety and quality of life and reduced inequalities • diabetes • respiratory disease • dementia • mental health • alcohol • children, young people and families	Improve the health of our population and reduce inequalities in health Reduce premature deaths from a range of long term conditions with a specific focus on cancer and cardiovascular disease Develop care services closer to home Commission safe, sustainable and high quality hospital care Improve the capacity and capability of our primary care services to respond to the changing health needs of our population	Access to urgent care Developing primary care services Developing services to avoid unplanned admission to hospital Redesigning pathways of care in areas for services such as stroke and diabetes Work to improve access to mental health services Work to develop dementia care services	Heart disease and stroke Cancer Mental health Dementia Long term conditions (such as diabetes) End of life care
http://www.fyldeandwyreccg.nhs.uk/publication				
http://www.westlancashireccg.nhs.uk/what-we-do/our-priorities/				
http://www.lancashirenorthccg.nhs.uk/about-us/priorities/				
http://www.eastlancsccg.nhs.uk/about-us/mission-values-aims-priorities/				
http://www.chorleysouthribbleccg.nhs.uk/				
http://www.greaterprestonccg.nhs.uk/				

Map 1. CCGs in Lancashire



3.4 Outcomes Frameworks

In addition to local priorities there are national priority areas for improvement in health and wellbeing. The Department of Health has published outcomes frameworks for the NHS, CCGs, Social Care, and Public Health which offer a way of measuring progress towards

achieving these aims. The Public Health Outcomes Framework (PHOF) for England, 2013-2016 sets out desired outcomes for public health, focussing on two high-level outcomes:

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

To support these outcomes a set of public health indicators have been developed to monitor progress year on year. These indicators have been split into four domains:

- Improving the wider determinants of health
- Health improvement
- Health protection
- Healthcare public health and preventing premature mortality

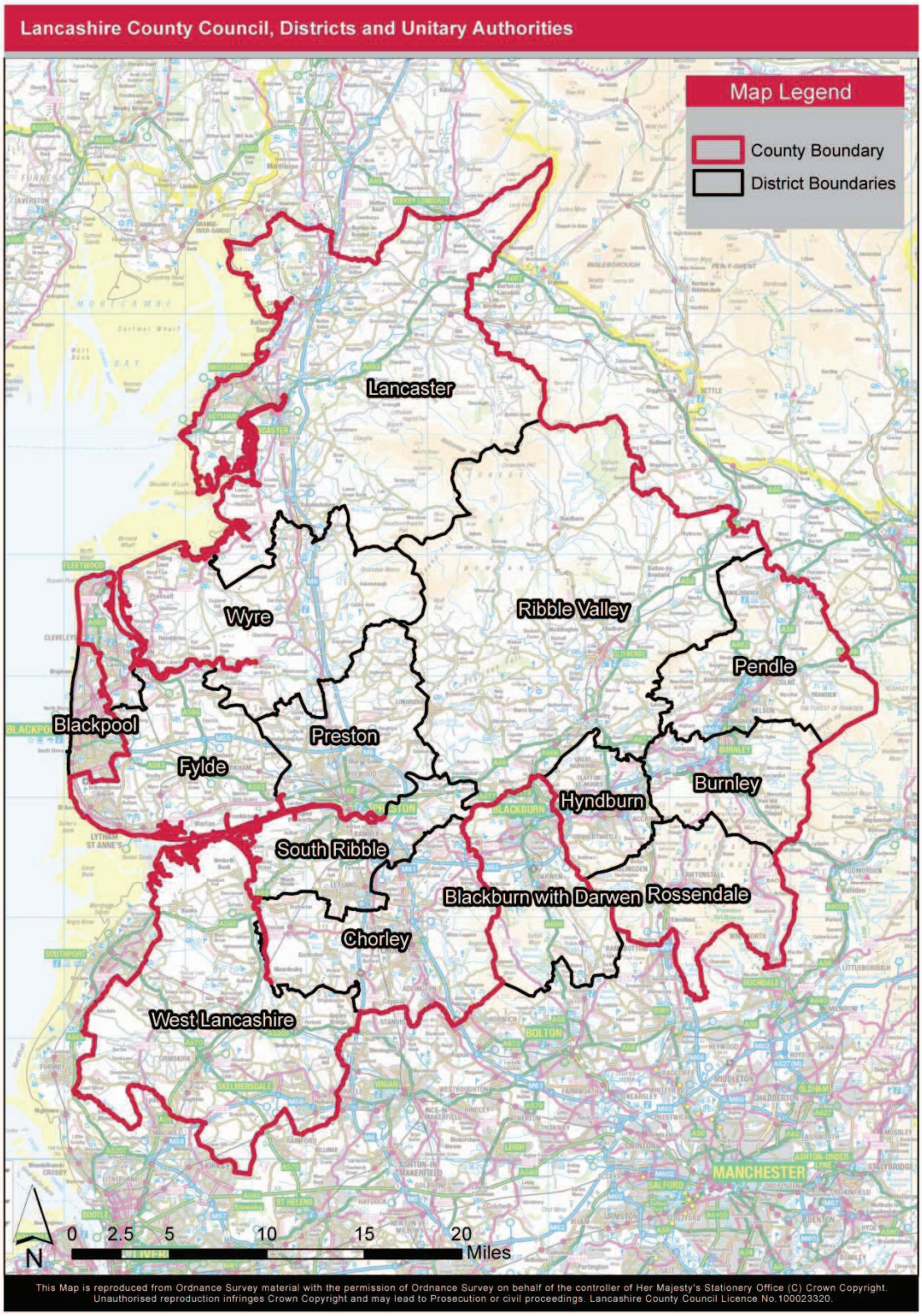
3.5 Locations in Lancashire

In Lancashire there are 12 district councils. Map 2 shows the 12 districts and the 2 unitary authorities. The districts in Lancashire are aligned to localities as follows:

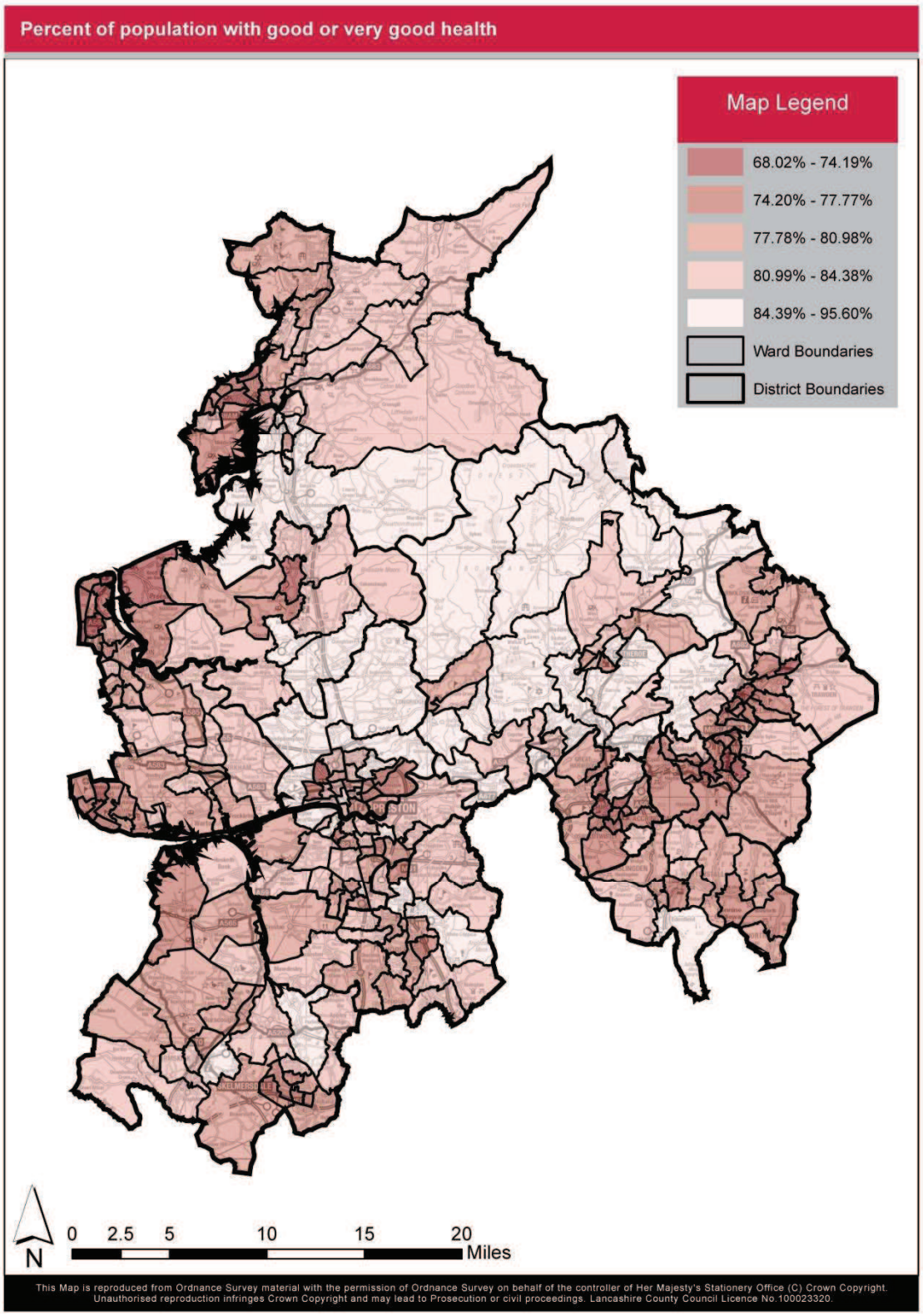
- **Central locality** – Districts of Chorley, Preston, South Ribble and West Lancashire
- **East locality** – Districts of Burnley, Hyndburn, Pendle, Rossendale and Ribble Valley
- **North locality** – Districts of Fylde, Lancaster and Wyre

The health of people in Lancashire is varied compared with the England average. Deprivation is higher than average and about 39,200 children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 10.3 years lower for men and 7.6 years lower for women in the most deprived areas of Lancashire than in the least deprived areas.[viii] There are differences in health care across Lancashire and, as one example, map 3 shows the proportion of the population in different parts of Lancashire who reported good or very good health in 2011 Census.

Map 2. Districts in Lancashire



Map 3. Percentage of population reporting good or very good health, by ward, 2011 Census



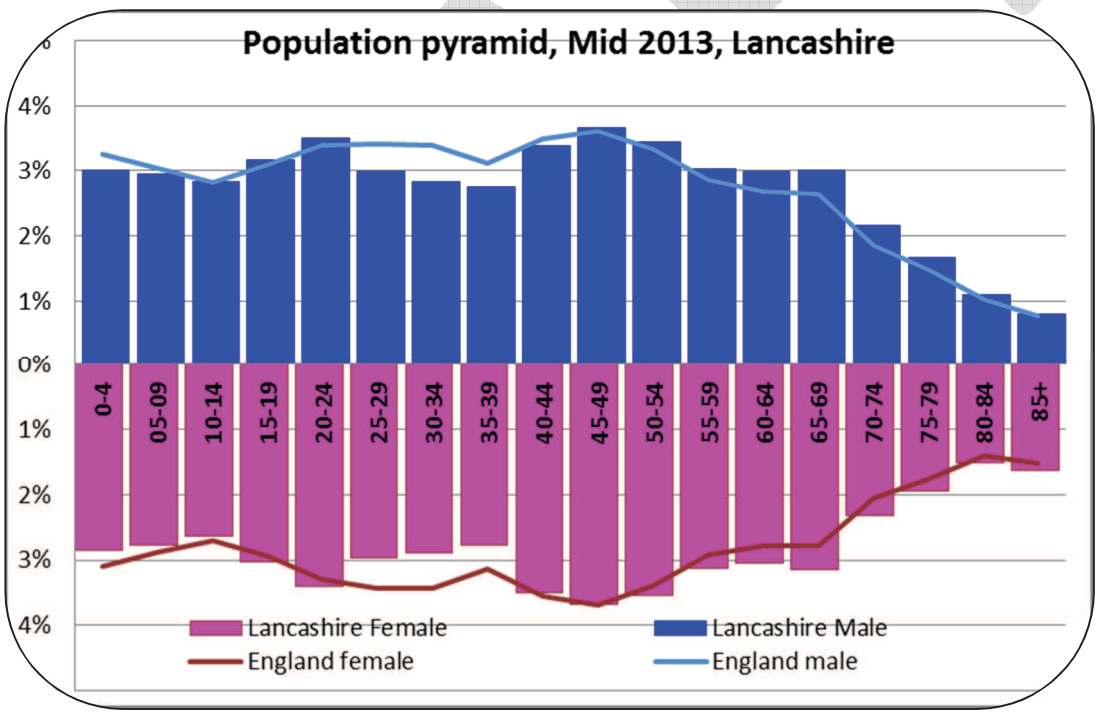
3.6 Characteristics of the population in Lancashire

3.6.1 *Demography*

The mid 2013 population estimate of Lancashire was approximately 1,180,076 people[ix], figure 1a shows the age and gender profile of the population of Lancashire. The age composition of the population varies by district, for example Wyre has more people aged 65 years or older compared to other areas in the county[ix] (map 4).

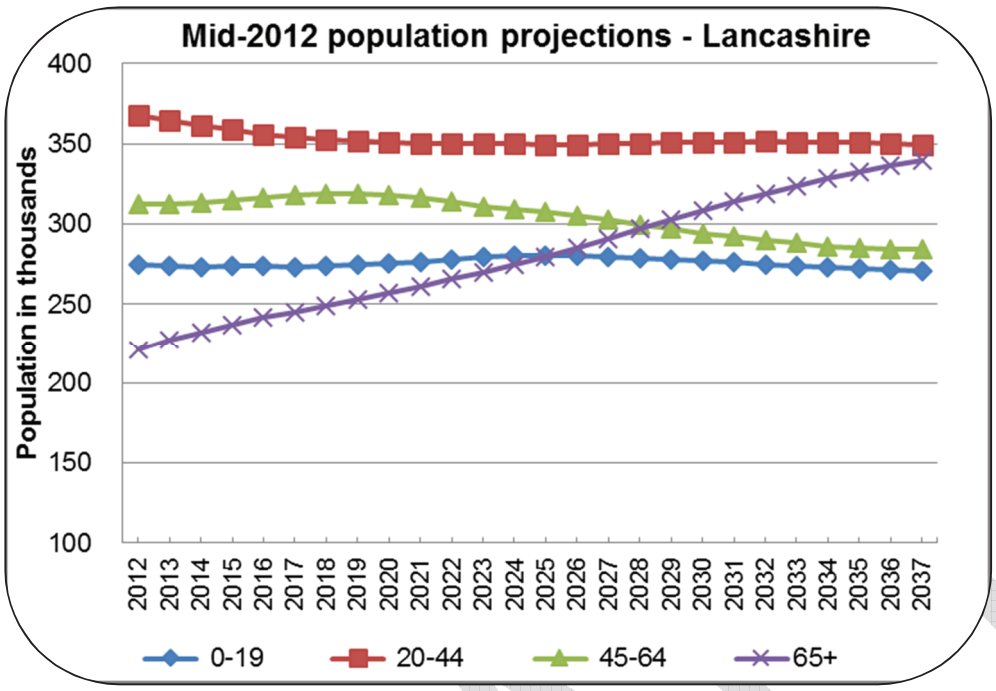
The population is not forecast to increase substantially in the coming years, with a projection of approximately 3% increase in the Lancashire population over the next ten years[x]. The biggest increases are seen in the age group of 65+ years, with a projection of a 18% increase over the next ten years and 41% increase over the next 20 shows the population projection in various age groups. There are also several major housing developments underway across Lancashire as part of the Preston, South Ribble and Lancashire City Deal. The impact of this population growth on pharmaceutical needs is discussed in Chapter 6 of the PNA.

Figure 1a. Population pyramid for Lancashire, mid 2013



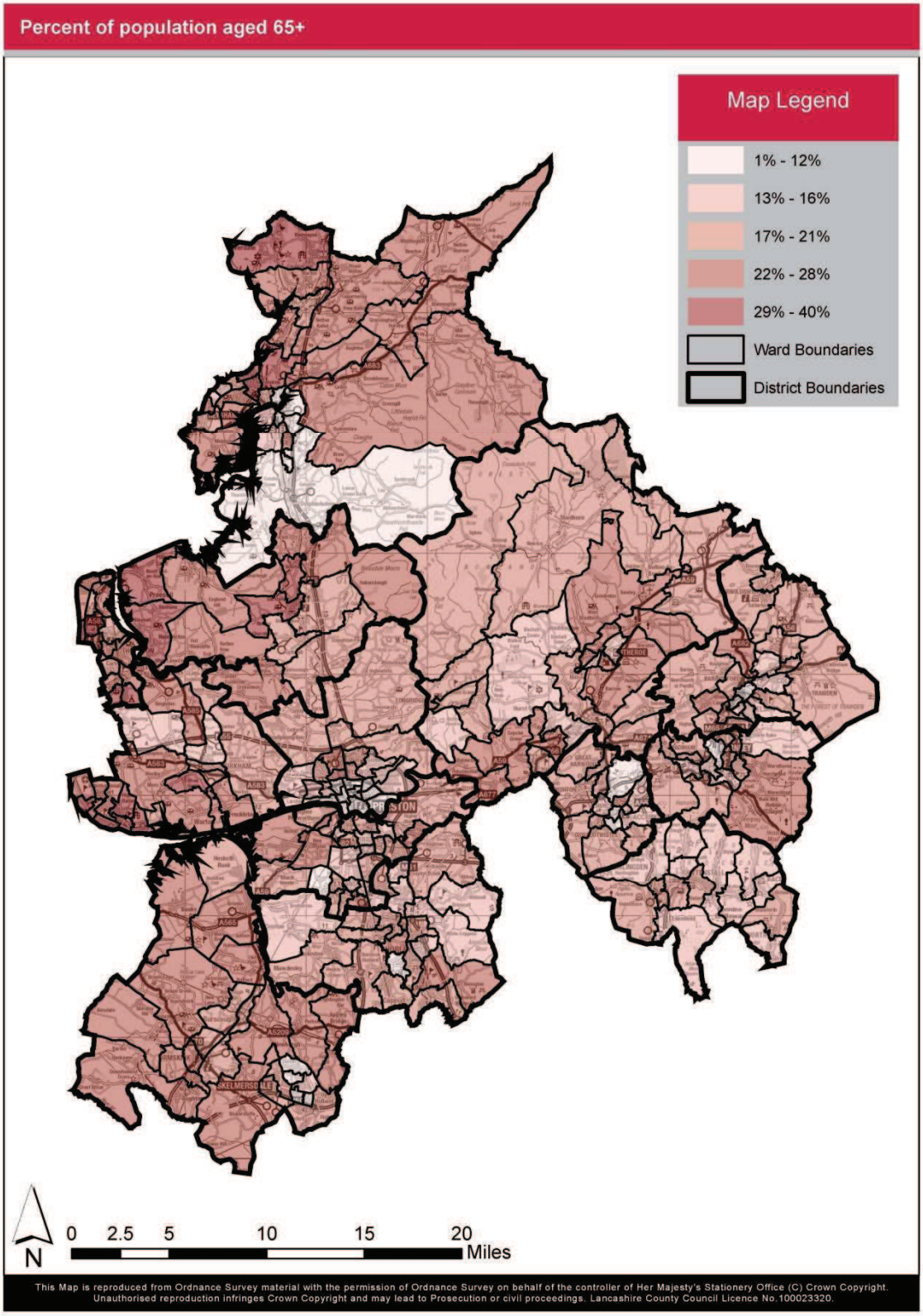
Source: ONS Mid 2013 population estimates, http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-322718

Figure 1b: Mid-2012 population projections by age group



Source: ONS Population Projections

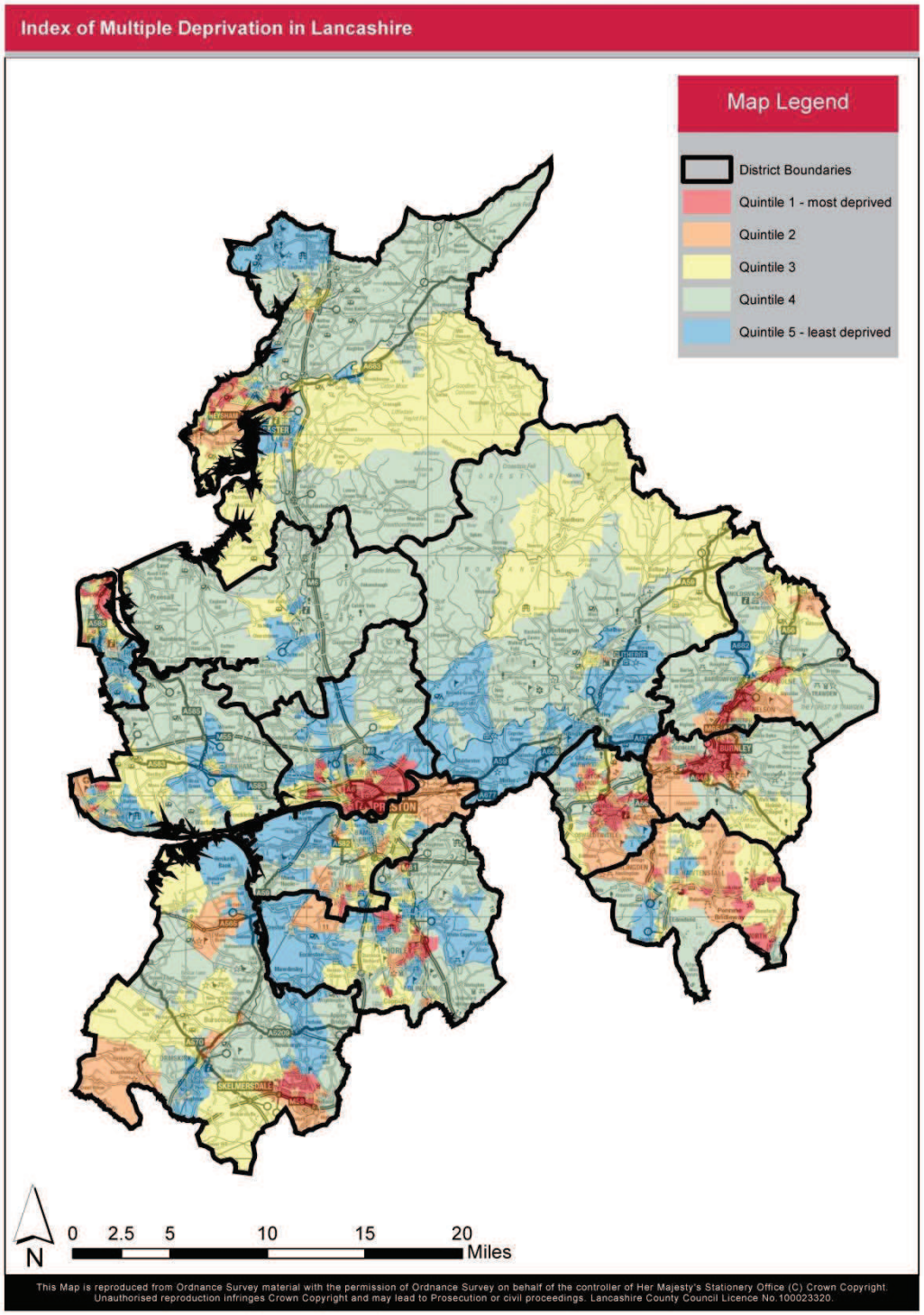
Map 4. Percentage of population aged 65 or above, by ward, 2011 Census



3.6.2 *Deprivation*

Pockets of deprivation are found in all the districts apart from Ribble Valley. Map 5 shows Lancashire's Lower Super Output Areas shaded according to the national quintile of deprivation they belong to.

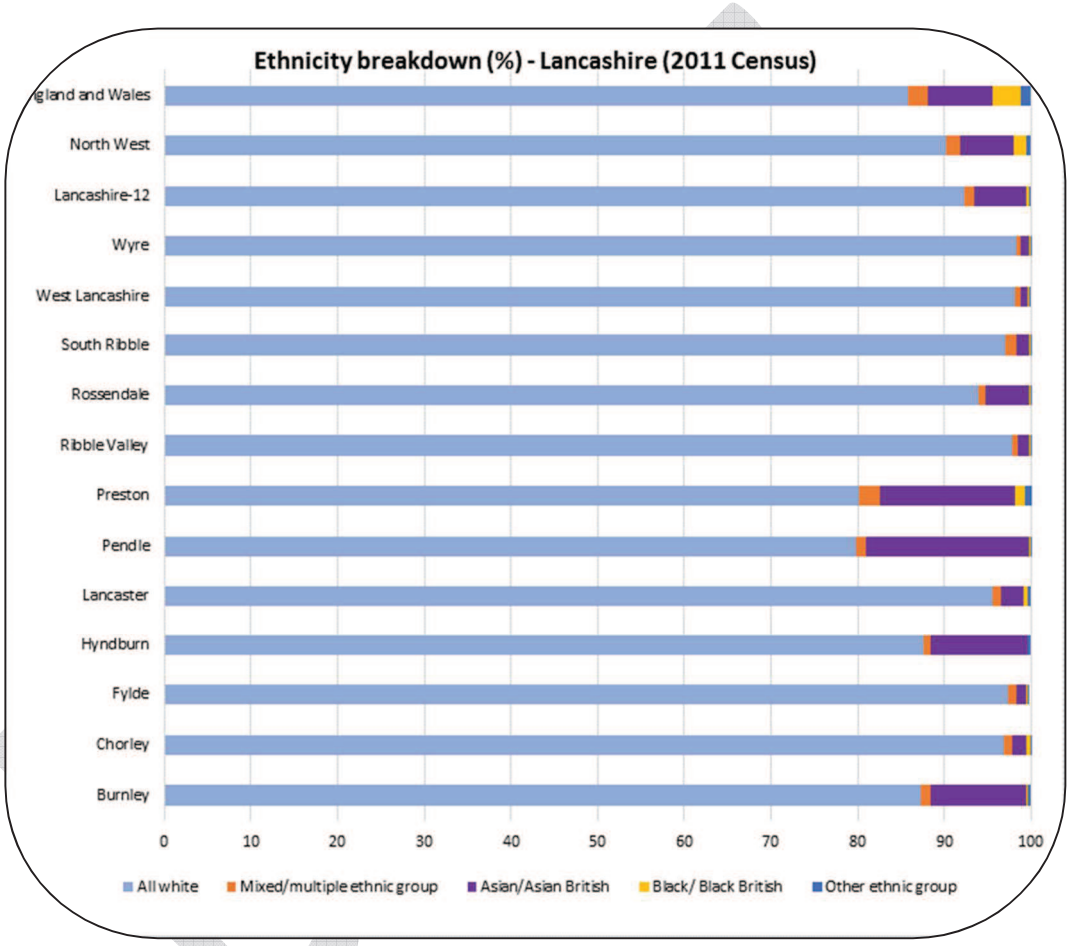
Map 5. Deprivation in Lancashire



3.6.3 *Ethnicity*

The largest ethnic group is white (92%). The black minority ethnic group makes up 7.7% of the population, the majority of this group are Asian/Asian British. Numerically, there are over 90,000 black minority ethnic people in the county. In 2001 the BME population was just over 5% of the population. Since then, the number of BME residents has increased by almost 30,000, a growth rate of around 50%. Pendle and Preston have the highest proportion of BME residents at around 20% of the population[xi].

Figure 2: Ethnic composition of Lancashire population (2011 Census)

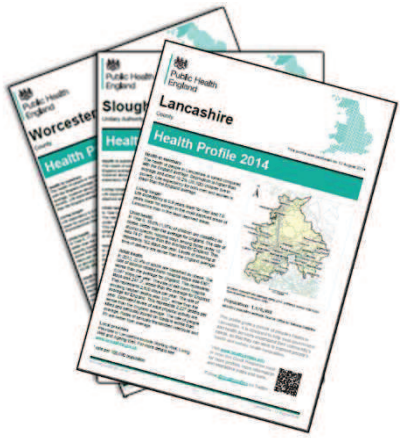


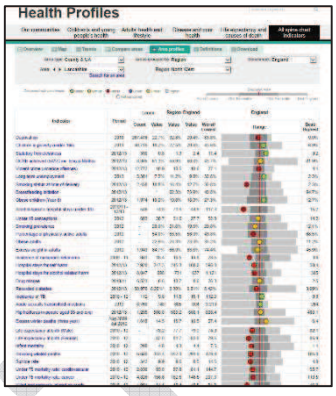
Source: ONS, 2011 Census

3.6.4 *Health*

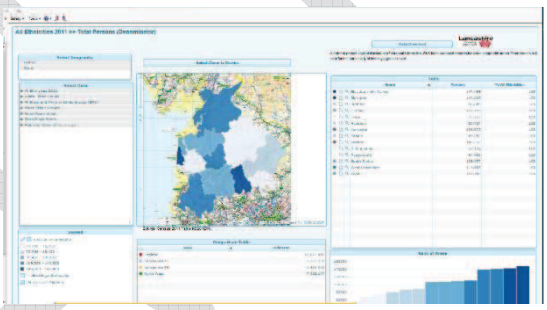
Public Health England's annual Health Profiles give a snapshot of the overall health of each local authority and district in England. The profiles present a set of important health indicators that show how each area compares to the national average in order to highlight potential problem areas. Lancashire's Health Profile 2014 highlights a number of areas where Lancashire is significantly worse than the national average, including premature mortality, smoking related deaths and alcohol related hospital admissions.[viii] The district profiles also highlight the differing health priorities there are across Lancashire and an interactive tool shows

comparisons across districts and by health topic (http://fingertips.phe.org.uk/profile/health-profiles)





An interactive map of key demographic data (2011 Census) is also available by local authority. [xii]



4 Current Provision of NHS Pharmaceutical Services

Key messages

Lancashire is well provided for by pharmaceutical service providers. This PNA has not identified a current need for new NHS pharmaceutical service providers in Lancashire. There are 295 pharmacies overall in Lancashire, representing almost a 9% growth in the number of providers, up from 271 since the last publication of the PNAs in 2011.

The previous PNAs covered separate areas:

- **Central Lancashire (117 pharmacies currently, from 106)**
- **East Lancashire (103 pharmacies currently, from 90)**
- **North Lancashire (75 pharmacies currently, the same as last time)**

Central Lancashire

The number of pharmaceutical service providers per population has grown during the same period. The last PNA showed that there were 20 pharmacies per 100,000 population, when the national figure for England was 20 and the average for the North West was 23. There are now 24 pharmaceutical service providers per 100,000 registered population in Lancashire, with the average in England being 22 and the average for the North West being 26.

East Lancashire

The number of pharmaceutical service providers per population has grown during the same period. The last PNA showed that there were 20 pharmacies per 100,000 population, when the national figure for England was 20 and the average for the North West was 23. There are now 27 pharmaceutical service providers per 100,000 registered population in Lancashire, with the average in England being 22 and the average for the North West being 26.

North Lancashire

The number of pharmaceutical service providers per population has remained the same during the same period. The last PNA showed that there were 24 pharmacies per 100,000 population, when the national figure for England was 20 and the average for the North West was 23. There are now 24 pharmaceutical service providers per 100,000 registered population in Lancashire, with the average in England being 22 and the average for the North West being 26.

Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS Pharmaceutical Services in Lancashire. There appears to be good coverage in terms of opening hours across the county. The extended opening hours of some community pharmacies are valued and these extended hours should be maintained. Many pharmacies and dispensing surgeries have wheelchair access and home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport.

Community pharmacies and pharmacists can have an impact on the health of the population by contributing to the safe and appropriate use of medicines.

This chapter describes the current provision of NHS pharmaceutical services, which were explained in Chapter 1: Introduction and are defined in the Pharmaceutical Regulations.[iv]

This chapter also includes a description of the number and locations of community pharmacies. The levels of provision of pharmaceutical services locally are compared with provision elsewhere.

4.1 Service Providers – numbers and geographical distribution

This PNA identifies and maps the current provision of pharmaceutical services in order to assess the adequacy of provision of such services. Information was collected up until June 2014. Up-to-date information on community pharmacies (including opening hours) is available on the NHS website: www.nhs.uk/servicedirectories/Pages/ServiceSearch.aspx

4.1.1 *Community pharmacies*

There were a total of 295 community pharmacies within Lancashire as of 01/06/14. The names of the community pharmacies within Lancashire are listed in Appendix 4 and their locations shown in maps 6 to 17.

Central Lancashire

There are 117 pharmacies across Central Lancashire, an increase from 106 in the previous PNA. These are broken down:

- 40 Hours Contract – 95
- 40 Hours Contract (ESPLPS) - 1
- 100 Hours Contracts – 17
- Distance-selling Contracts – 4

Maps 6 to 9 show community pharmacies and GP practices in the 4 Central Lancashire districts and over the border pharmacies within 2 mile buffer.

East Lancashire

There are 103 pharmacies across East Lancashire, an increase from 90 in the previous PNA. These are broken down:

- 40 Hours Contract – 79
- 40 Hours Contract (ESPLPS) - 1
- 100 Hours Contracts – 17
- Distance-selling Contracts – 6

Maps 10 to 14 show community pharmacies and GP practices in the 5 East Lancashire districts and over the border pharmacies within 2 mile buffer.

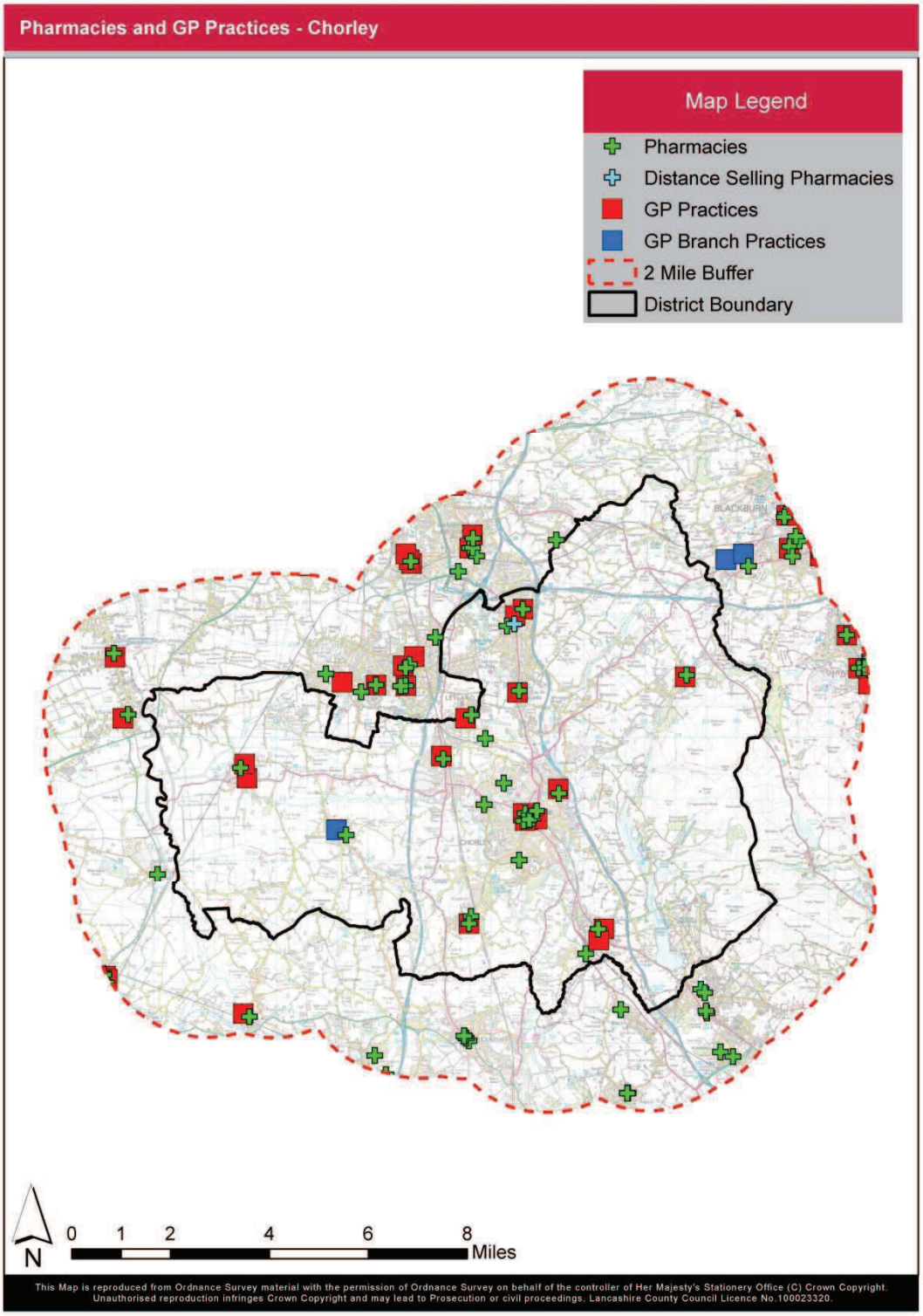
North Lancashire

There are 75 pharmacies across North Lancashire, the same number as in the previous PNA. These are broken down:

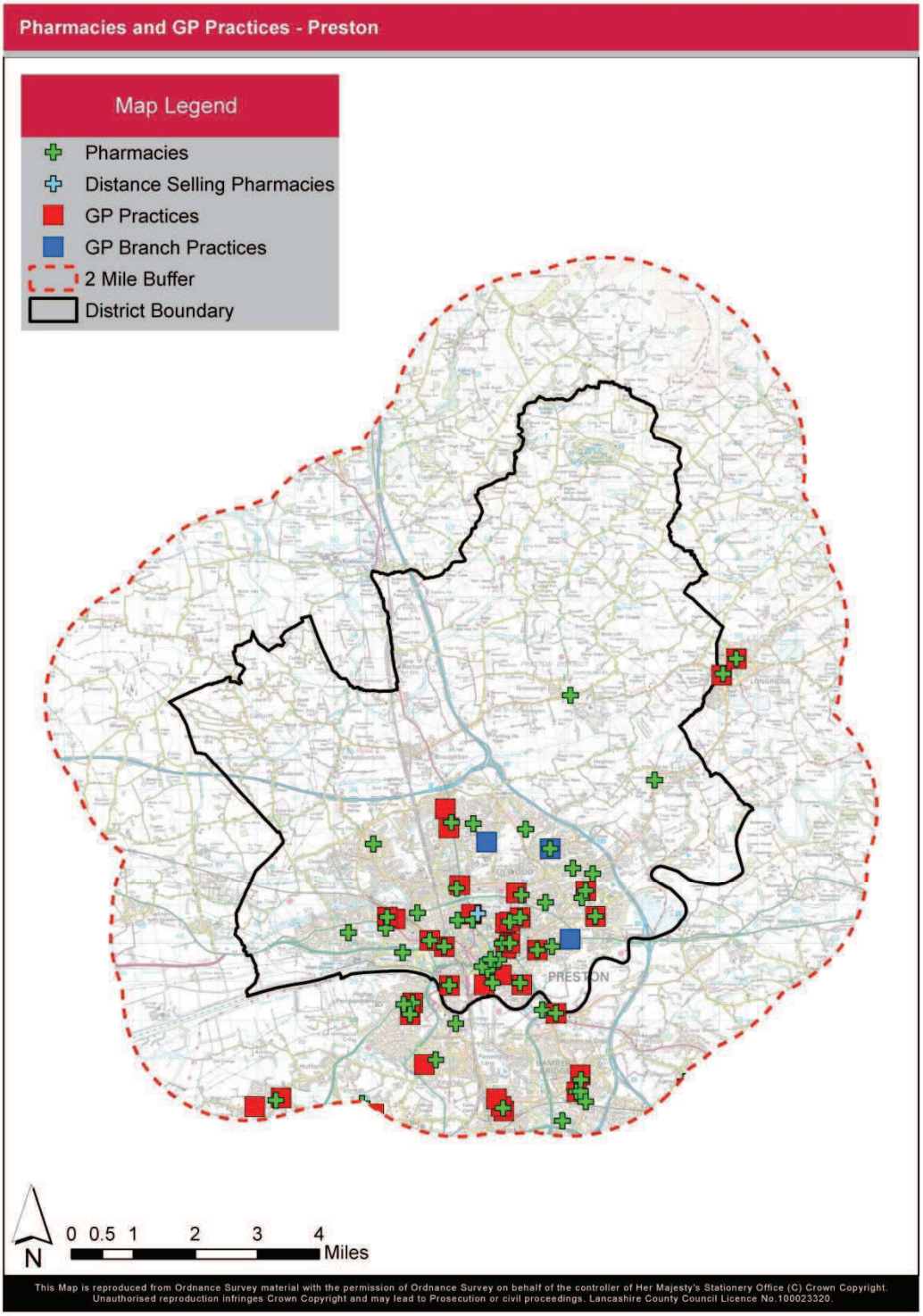
- 40 Hours Contract – 68
- 35 Hours Contract (ESPLPS) - 1
- 100 Hours Contracts – 6

Maps 15 to 17 show community pharmacies and GP practices in the 3 North Lancashire districts and over the border pharmacies within 2 mile buffer.

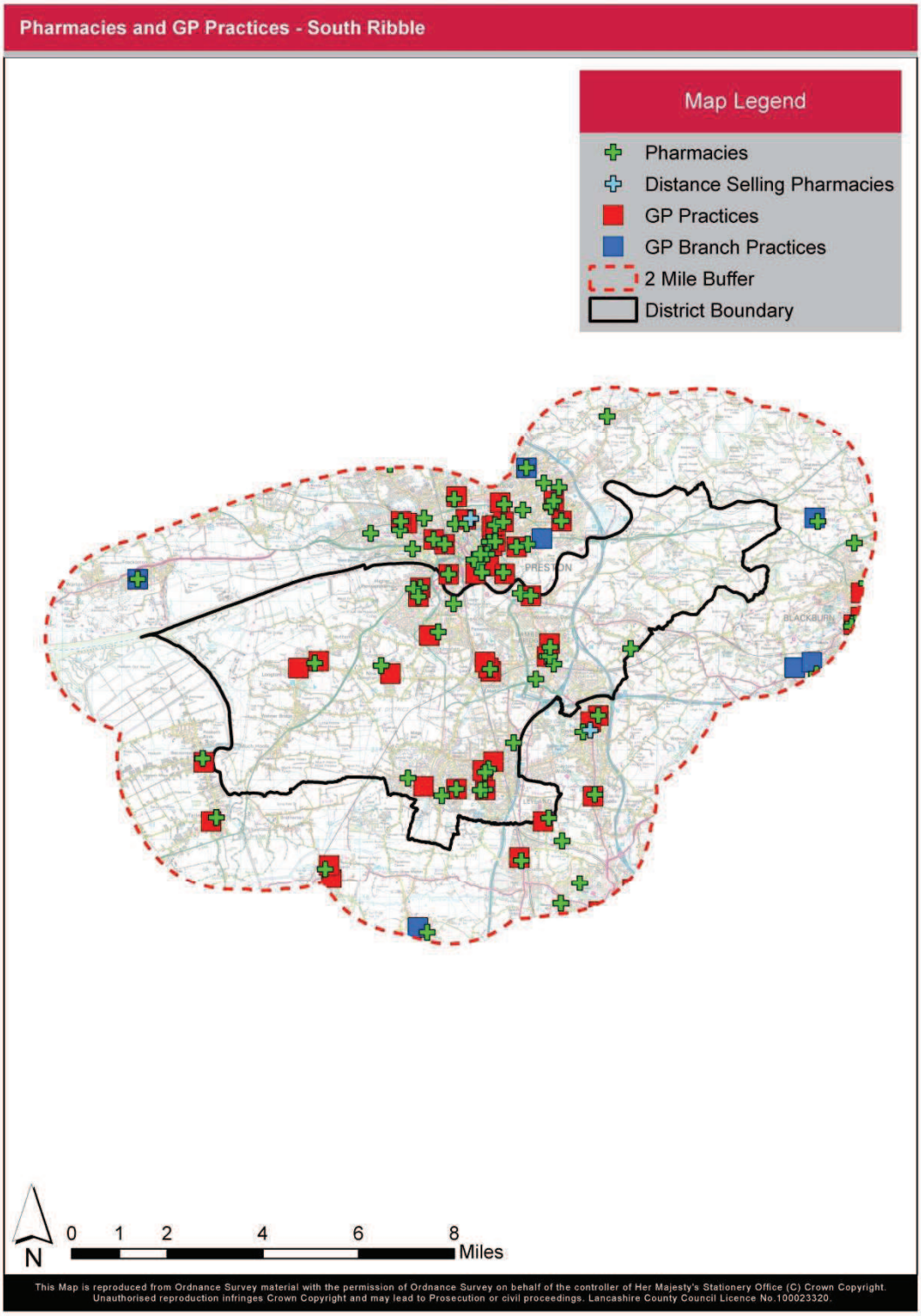
Map 6. Community pharmacies and GP practices in Chorley and over the border pharmacies within 2 mile buffer (Central locality)



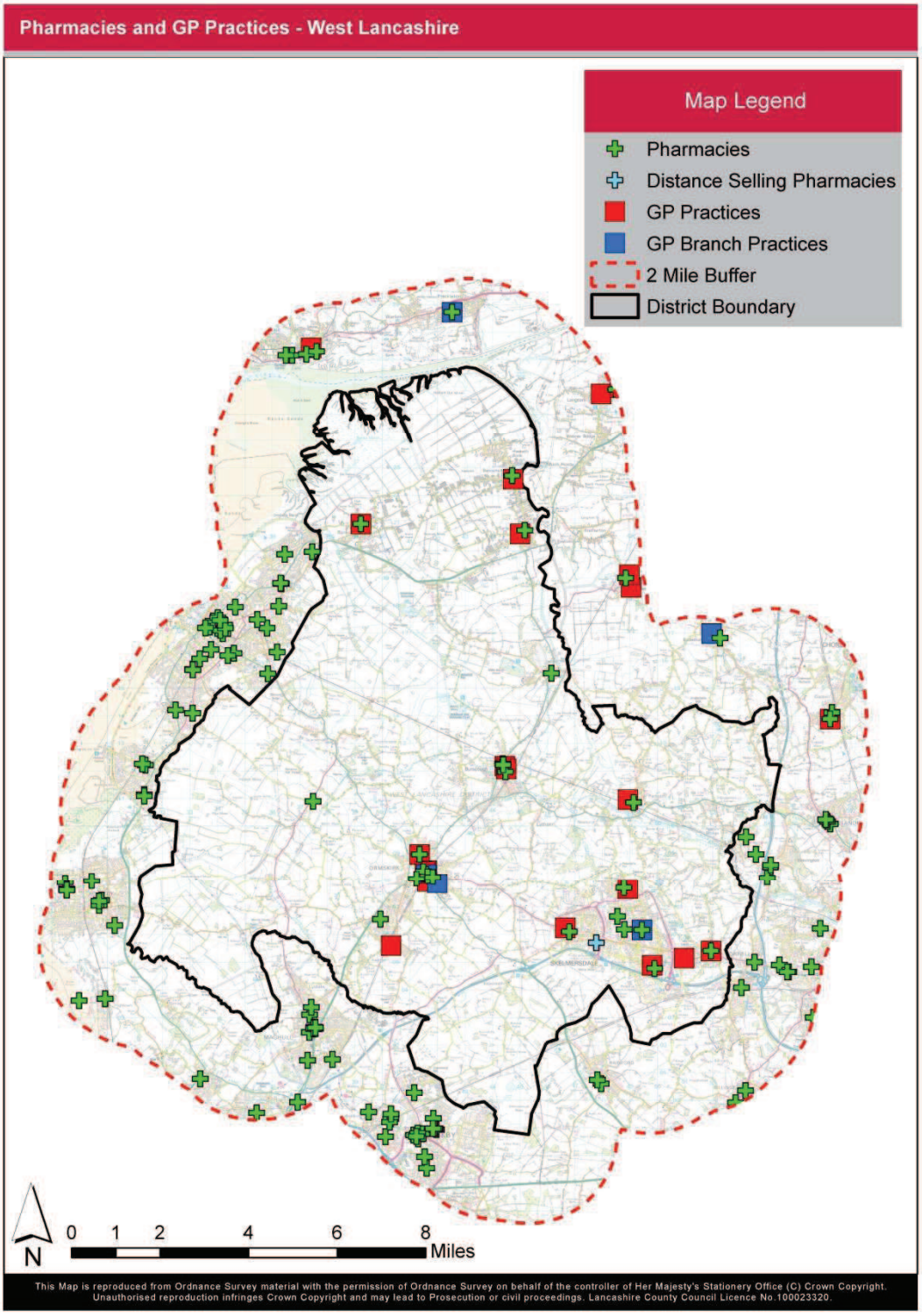
Map 7. Community pharmacies and GP practices in Preston and over the border pharmacies within 2 mile buffer (Central locality)



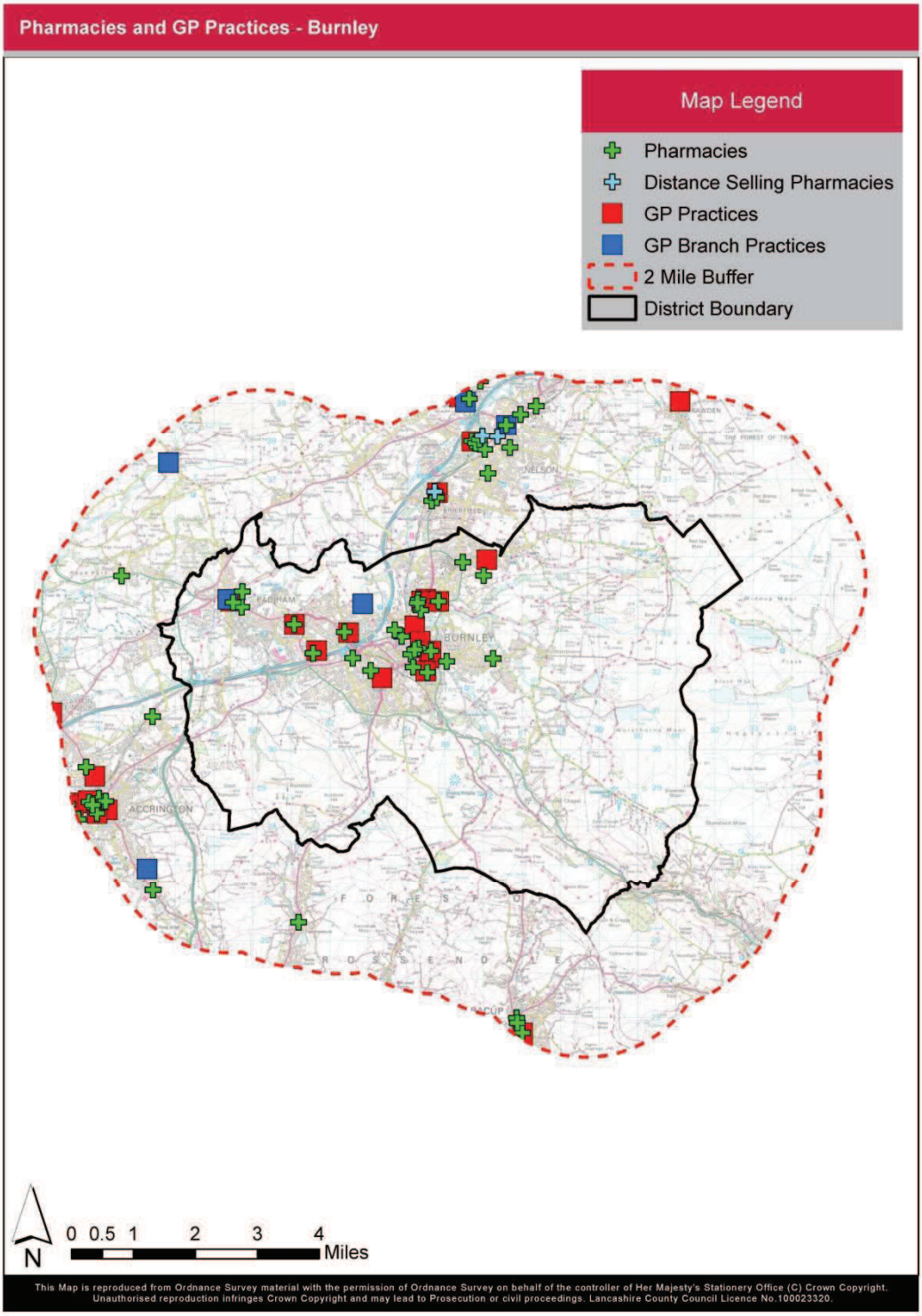
Map 8. Community pharmacies and GP practices in South Ribble and over the border pharmacies within 2 mile buffer (Central locality)



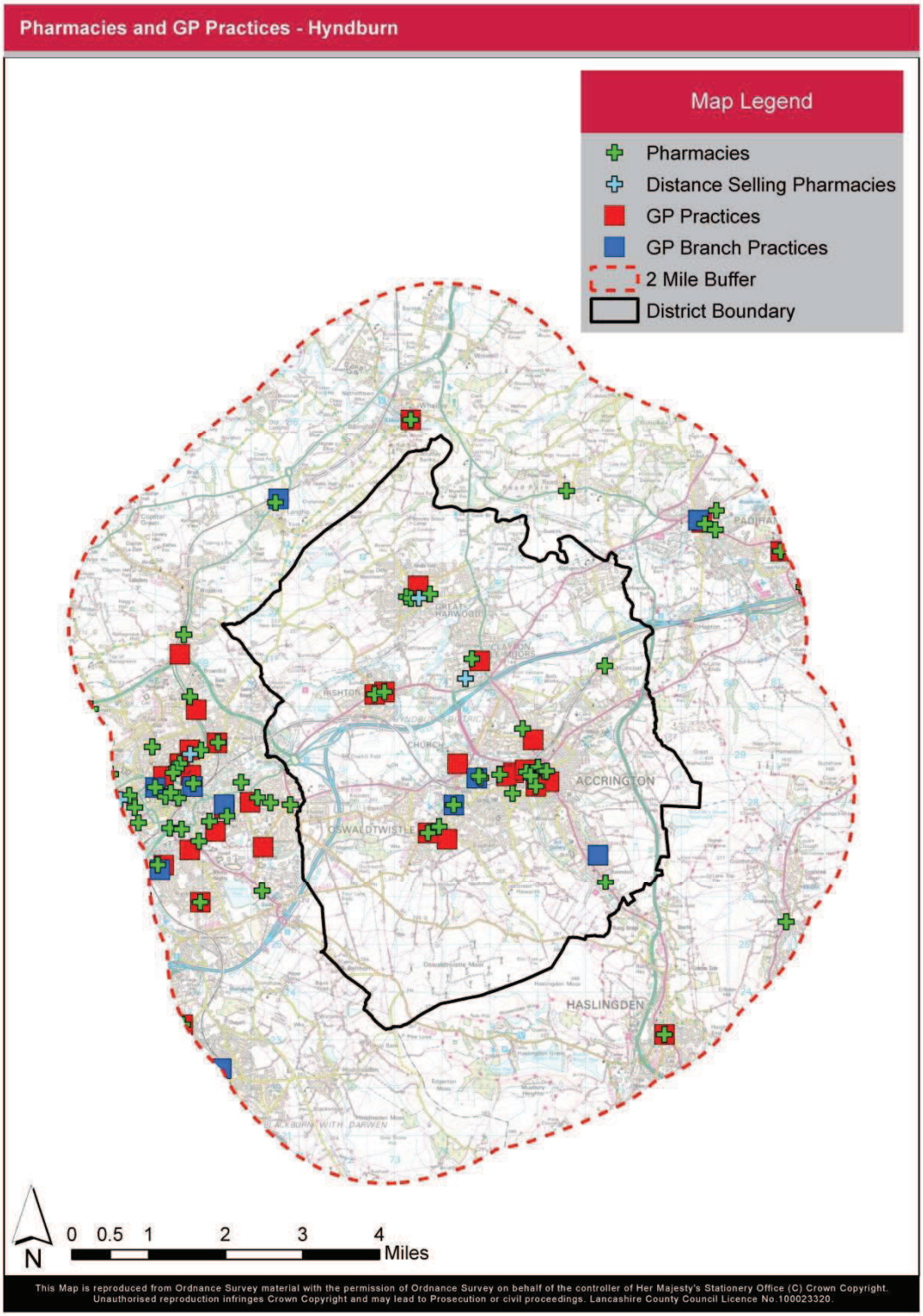
Map 9. Community pharmacies and GP practices in West Lancashire and over the border pharmacies within 2 mile buffer (Central locality)



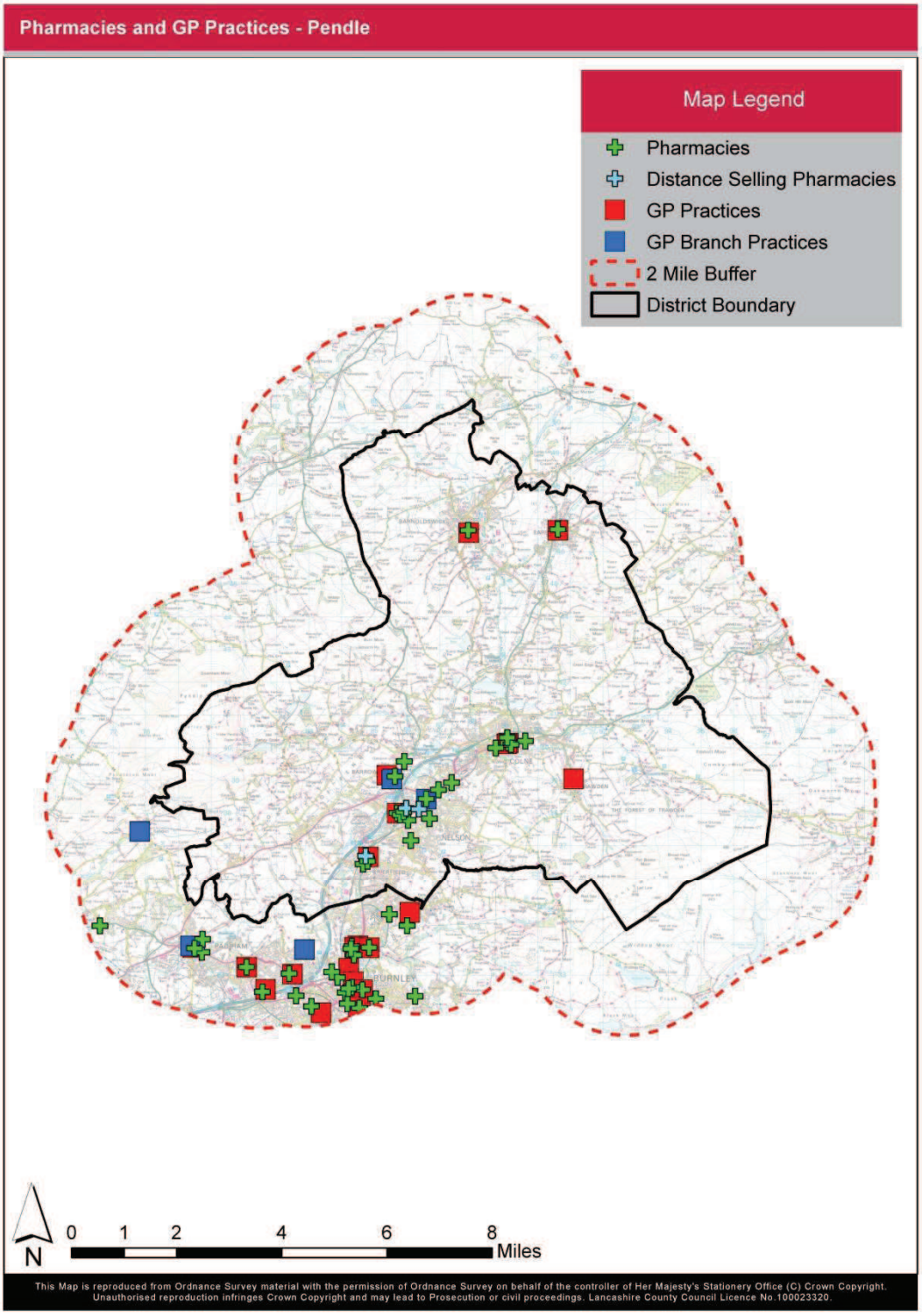
Map 10. Community pharmacies and GP practices in Burnley and over the border pharmacies within 2 mile buffer (East locality)



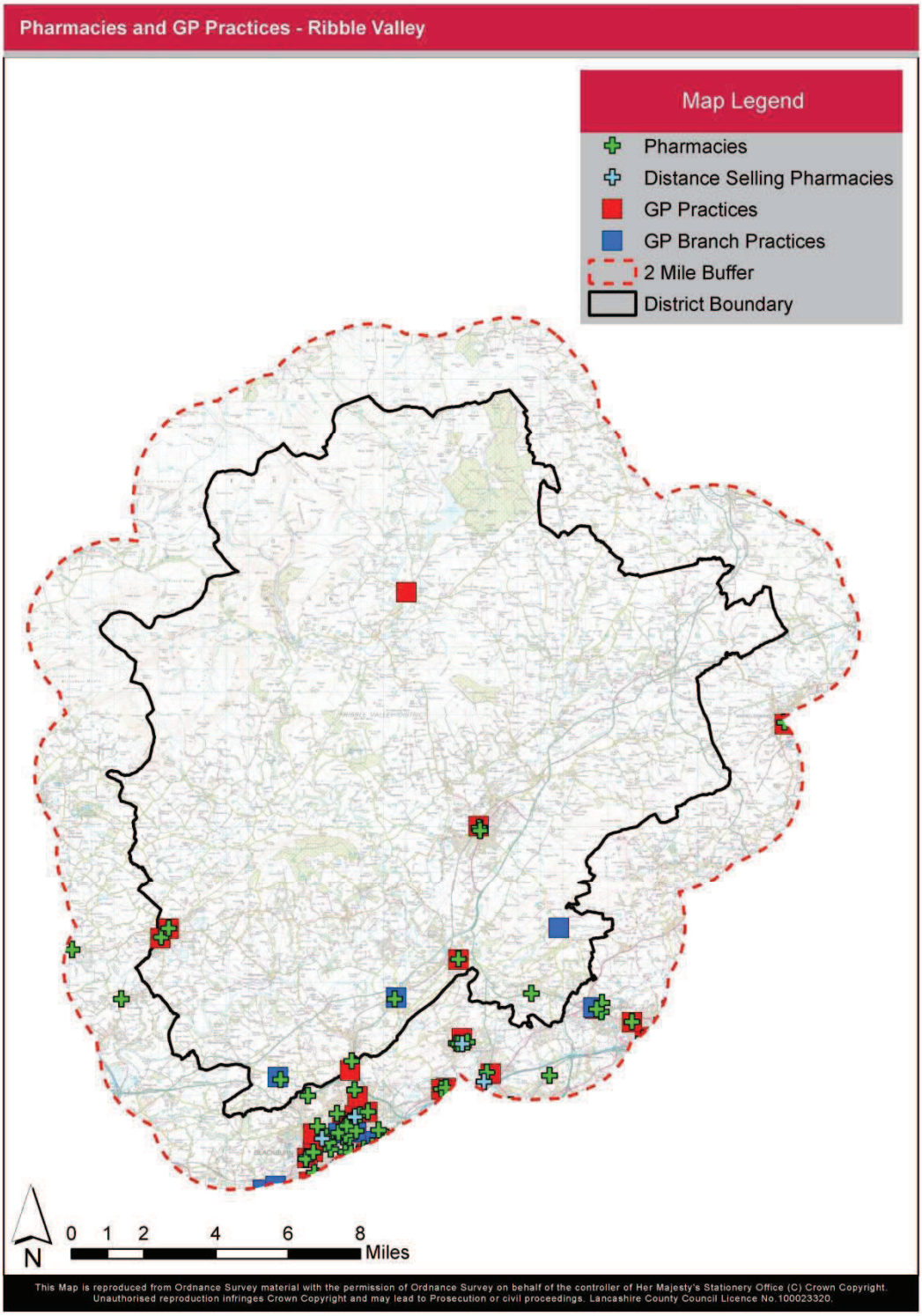
Map 11. Community pharmacies and GP practices in Hyndburn and over the border pharmacies within 2 mile buffer (East locality)



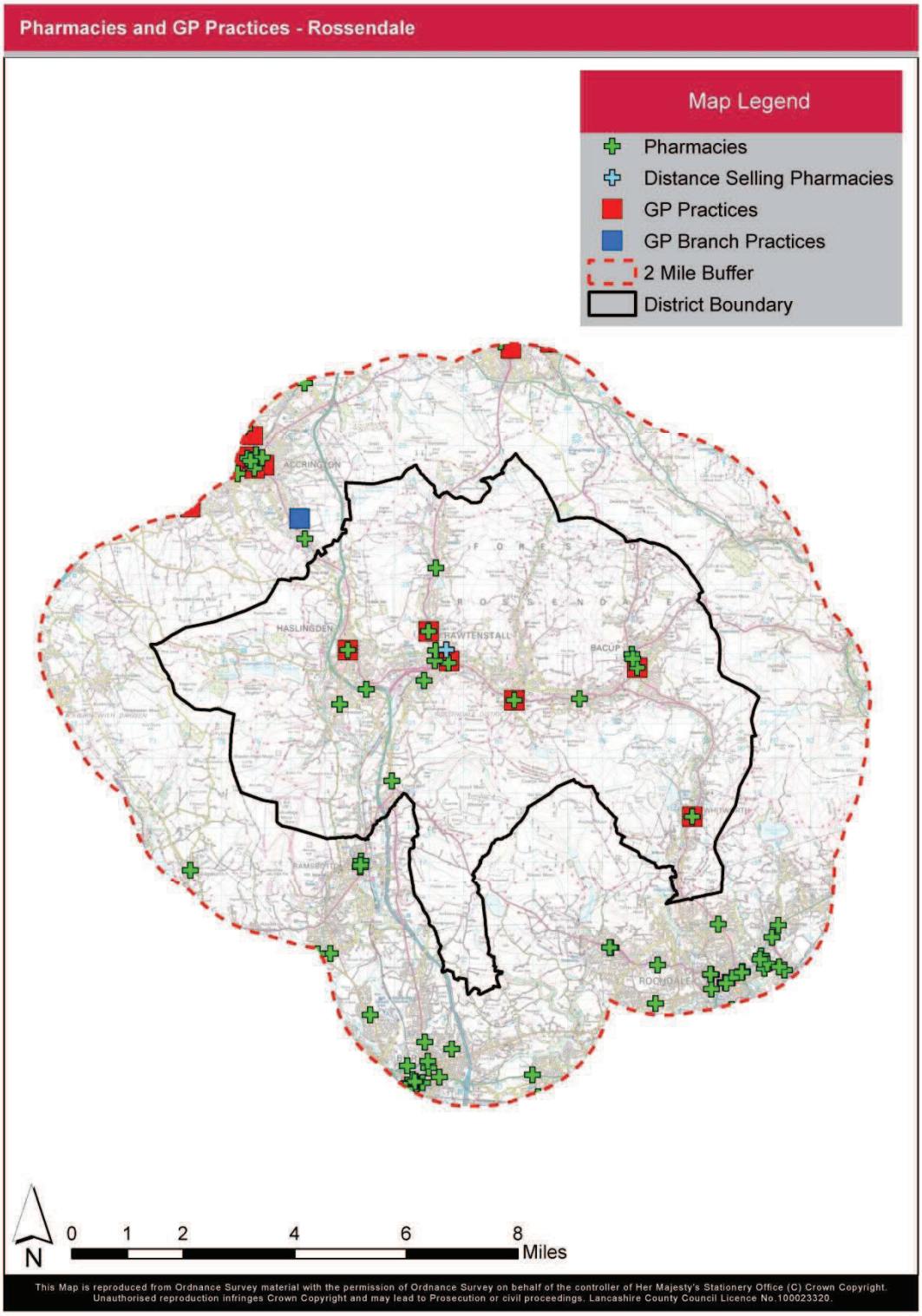
Map 12. Community pharmacies and GP practices in Pendle and over the border pharmacies within 2 mile buffer (East locality)



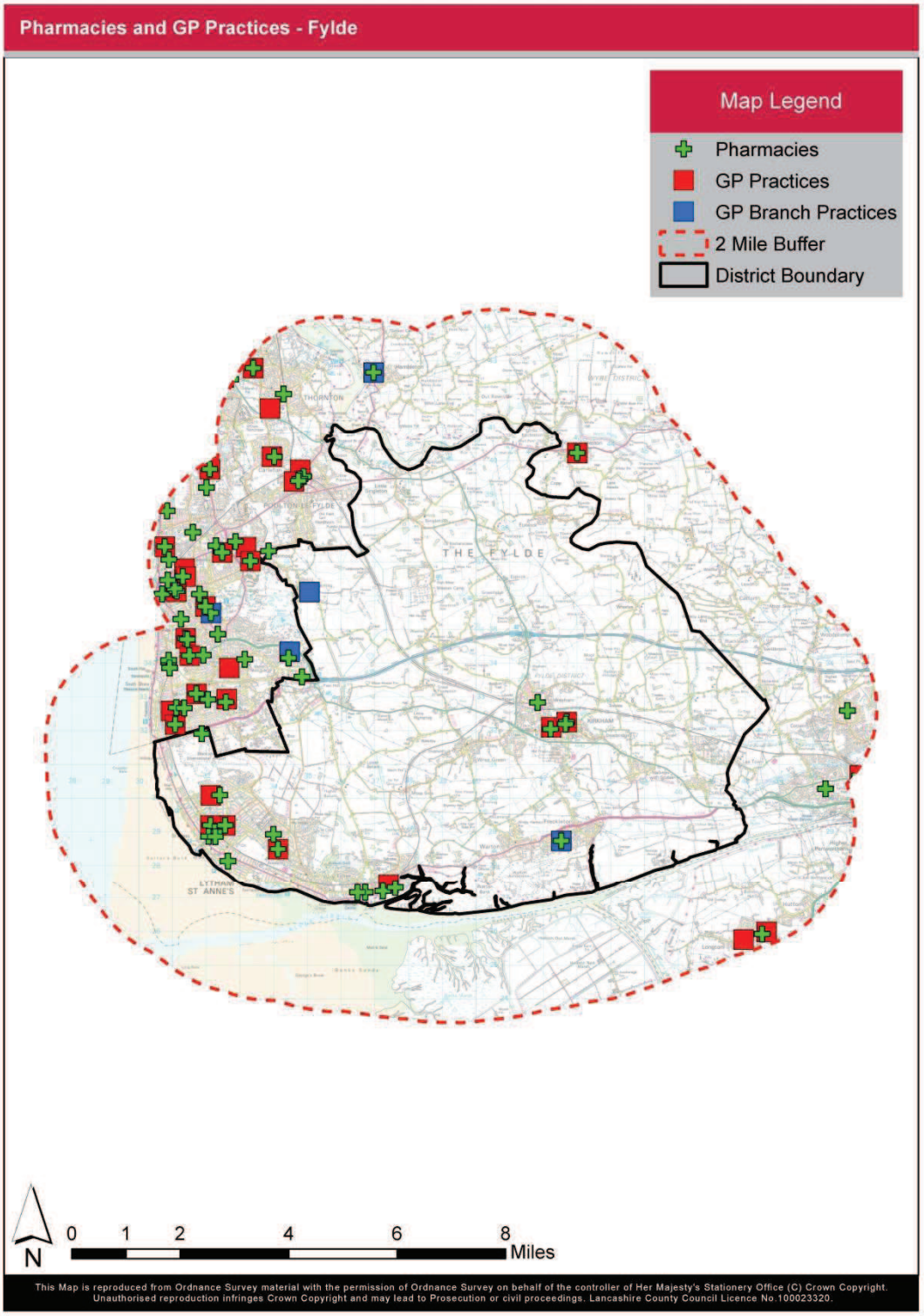
Map 13. Community pharmacies and GP practices in Ribble Valley and over the border pharmacies within 2 mile buffer (East locality)



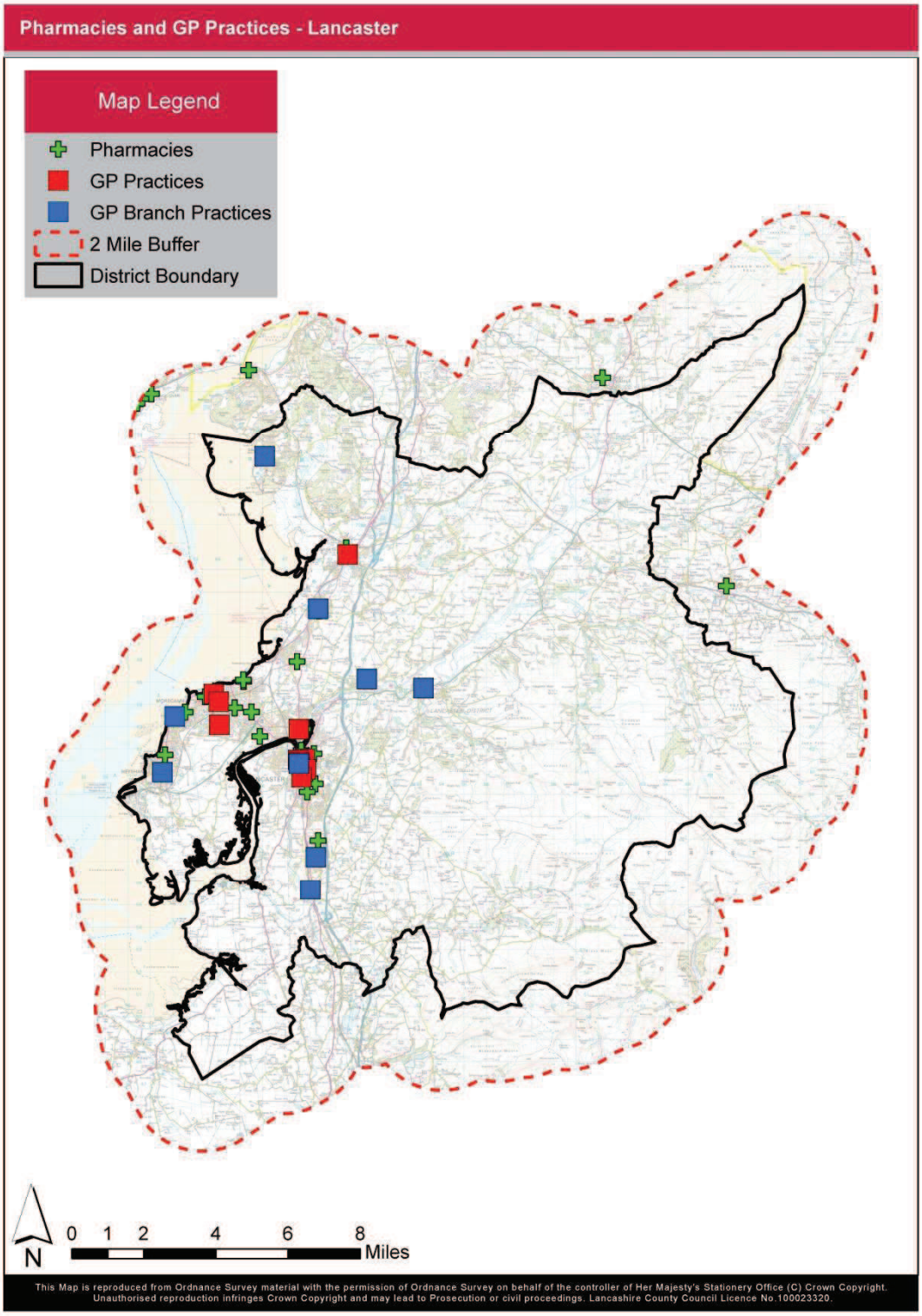
Map 14. Community pharmacies and GP practices in Rossendale and over the border pharmacies within 2 mile buffer (East locality)



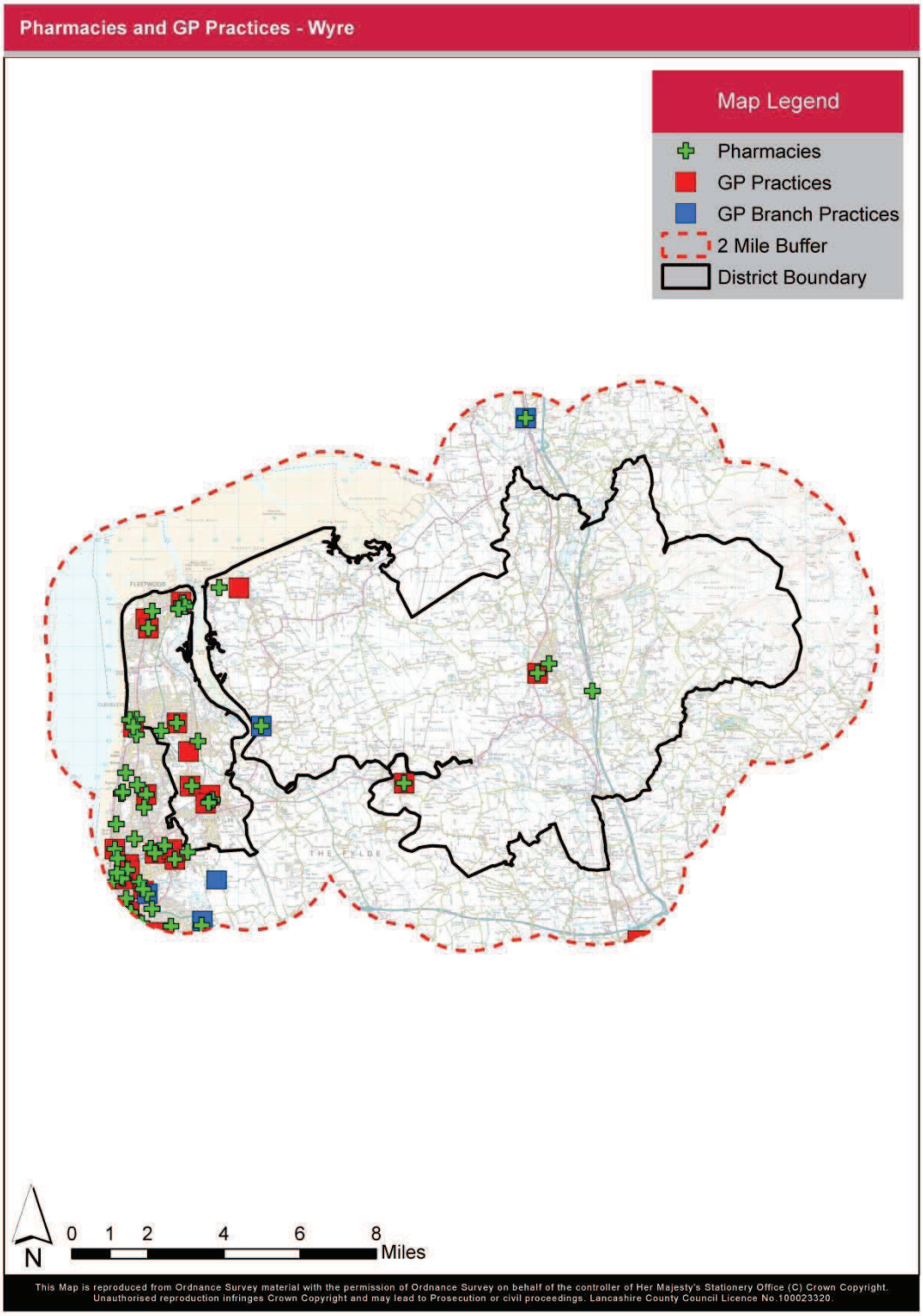
Map 15. Community pharmacies and GP practices in Fylde and over the border pharmacies within 2 mile buffer (North locality)



Map 16. Community pharmacies and GP practices in Lancaster and over the border pharmacies within 2 mile buffer (North locality)



Map 17. Community pharmacies and GP practices in Wyre and over the border pharmacies within 2 mile buffer (North locality)



4.1.2 *Dispensing GP practices*

The rurality in some areas leads to the existence of dispensing GP practices. Dispensing GP practices make a valuable contribution to dispensing services although they do not offer the full range of pharmaceutical services offered at community pharmacies.

There are 13 dispensing GP practices in Lancashire, unchanged from previous PNAs:

Central Lancashire – 2 (both in NHS Greater Preston CCG)
East Lancashire – 6
North Lancashire – 5 (4 in Lancashire North CCG and 1 in Fylde & Wyre CCG)

The names of the dispensing GP practices within Lancashire are listed in Appendix 5 and their locations shown in map 18.

Out of 1,181407 people registered with a GP in Lancashire, 114,376 people (10%) were registered with a dispensing GP practice as at April 2014. It should be noted that some of these patients may have an address outside Lancashire, and similarly some patients with an address in Lancashire could be registered with a practice in another county.

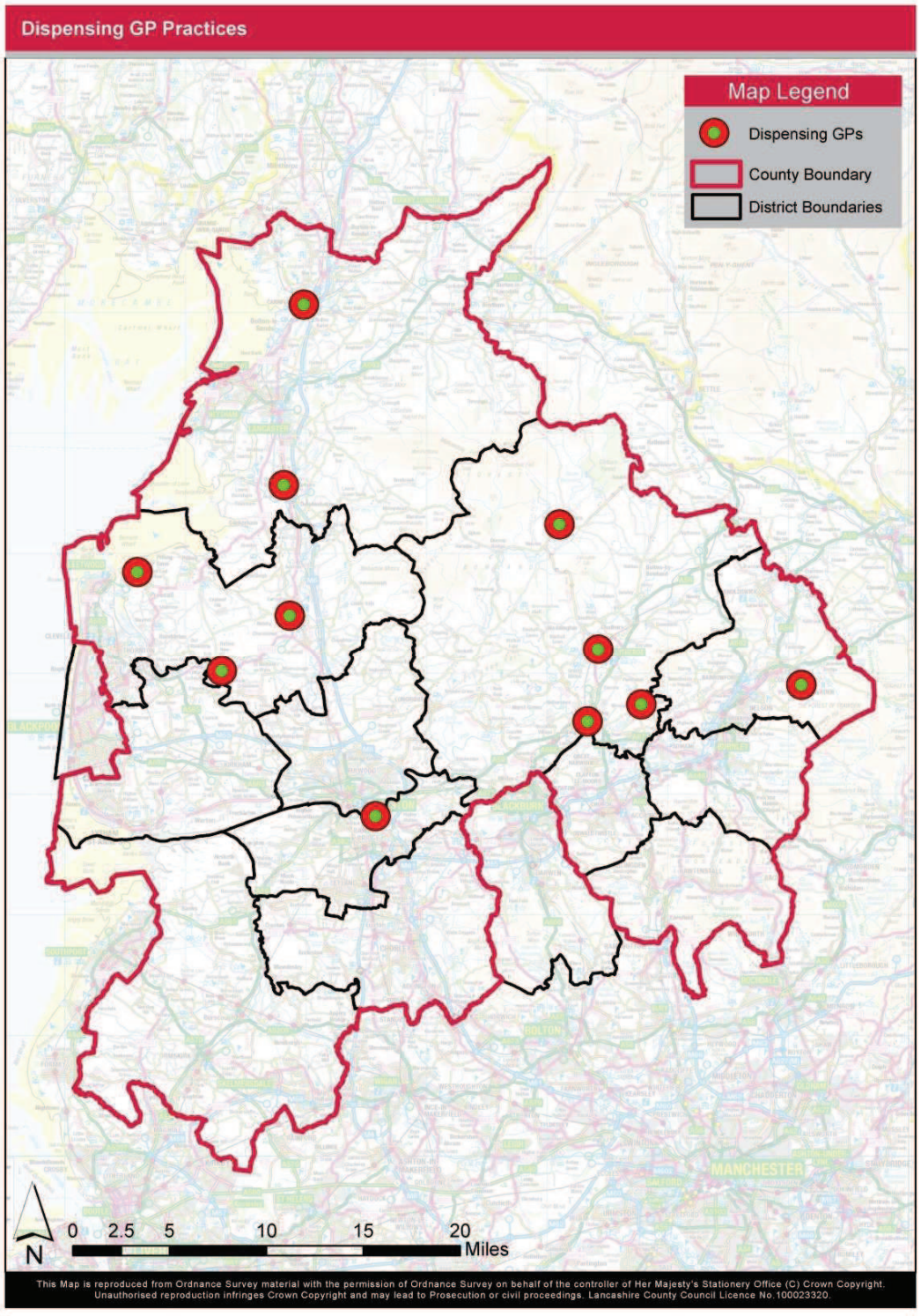
Access to GPs in general (not only dispensing practices) doesn't appear to be as good compared to England. Lancashire has less full time GPs per 100,000 registered population than the England average, 61.9 compared to 66.5. Only NHS Lancashire North CCG has more than average with 77. For locations of GP practices across Lancashire districts see maps 6 to 17.

Table 2: Average number of full time equivalent GPs per 100,000 registered population, 2013

	All FTE GPs	Average no. FTE GPs per 100,000 population
England	**32,075**	**66.5**
Lancashire-14	**848**	**61.9**
NHS Chorley and South Ribble	92	58.4
NHS East Lancashire	204	57.3
NHS Fylde & Wyre	86	56.3
NHS Greater Preston	109	57.9
NHS Lancashire North	108	77.0
NHS West Lancashire	56	55.9

Source: HSCIC, General and Personal Medical Services, England - As at 30 September 2013 (Table 11c)
http://www.hscic.gov.uk/searchcatalogue?productid=14458&topics=0%2fWorkforce&sort=Relevance&size=10&page=2#top

Map 18. Dispensing GP practices in Lancashire



NB The map only shows 11 locations as some practices share the same site.

4.1.3 *Distance selling pharmacies*

There were 10 mail order/wholly internet pharmacy within Lancashire as of 01/06/14:

Central Lancashire – 4 (1 in Chorley and South Ribble CCG, 1 in Greater Preston CCG and 2 in West Lancashire CCG)

East Lancashire – 6

North Lancashire – 0

It is important to acknowledge that the pharmaceutical regulations does not permit mail order/wholly internet pharmacy providers to see patients face to face.

Patients have the right to access pharmaceutical services from any community pharmacy including mail order/wholly internet pharmacy of their choice, provided it is not face to face and therefore can access any of the many internet pharmacies available nationwide.

4.1.4 *Dispensing Appliance Contractors*

Currently, there are 4 Dispensing Appliance Contractor (DAC) within Lancashire:

Central Lancashire – 1

East Lancashire – 1

North Lancashire - 2

Appliances are available from community pharmacies, dispensing GP practices and other DACs from outside the HWB.

From the questionnaires sent out to Lancashire pharmaceutical service providers, out of 188 pharmacies responding 166 (88.3%) reported that they provided all types of appliances. In addition, some pharmacies provide certain types of appliances.

4.1.5 *Hospital pharmacies*

There are seven hospitals within Lancashire which have a pharmacy on premises:

Central Lancashire

- Royal Preston Hospital
- Chorley and South Ribble Hospital
- Ormskirk and District General Hospital

East Lancashire

- Accrington Victoria Hospital
- Burnley Hospitals

North Lancashire

- Royal Lancaster Hospital
- Queen Victoria Hospital

4.1.6 *Pharmacy services in prisons*

There are five prisons in the area of Lancashire HWB and pharmacy services are available to all 5 prisons.

Central Lancashire

- HMP Preston
- HMP Garth
- HMP Wymott

East Lancashire

- None

North Lancashire

- HMP Kirkham
- HMYOI Lancaster Farms

4.1.7 *Essential Small Pharmacy Local Pharmaceutical Services (ESPLPS) scheme*

ESPLPS pharmacies offer the same essential, advanced and enhanced services as other community pharmacies but they dispense fewer than 26,400 items per year. The ESPLPS scheme, which involves giving extra support to some essential small pharmacies, is due to stop at 31 March 2015.

There are three Essential Small Pharmacy Local Pharmaceutical Services Schemes in Lancashire.

Central Lancashire

- Goosnargh Pharmacy, 859 Whittingham Lane, Goosnargh, Preston, PR3 2AU

East Lancashire

- Langho Pharmacy, 1a East View Terrace, Whalley Road, Langho, BB6 8BX

North Lancashire

- Lancaster University Pharmacy, Bailrigg House, Lancaster University, Lancaster, LA1 4YE

Should any of these pharmacies cease to exist this may lead to a gap in provision during core hours (9am–6pm, Mon-Fri).

4.1.8 *Comparison with findings in the 2011 PNA*

In 2011 a patient pharmacy questionnaire was developed for the PNA asking a range of questions. For this PNA we have engaged stakeholders in a variety of different ways and have asked varying questions. Therefore it is difficult to compare the responses.

As well as stakeholder and community engagement, questionnaires were sent out to community pharmacies. When the last PNA was carried out there was a higher return of questionnaires 85% as opposed to 64% this year.

The following changes to the numbers of providers were noted since the 2011 PNA:

- There were 271 pharmacies in Lancashire. This has increased to 295 pharmacies in June 2014.
- There were 13 dispensing GP practices within Lancashire. This was unchanged in June 2014.

As detailed above, in the introduction to this section, the number of pharmaceutical service providers per population is higher than in the previous PNA

- Central Lancashire (24 per 100,000 population from 20)
- East Lancashire (27 per 100,000 population from 20)
- North Lancashire (same - 24 per 100,000 population)

4.1.9 *Comparison with pharmaceutical service provision elsewhere*

Central Lancashire

In Central Lancashire there were 114 community pharmaceutical providers as at March 2014 which means there were 24 providers per 100,000 population (1 provider per 4,000 population). This is slightly lower than the overall Lancashire average of 25 per 100,000 but higher than the national average of 22 per 100,000 (table 3).

East Lancashire

In East Lancashire there were 104 community pharmaceutical providers as at March 2014 which means there are approximately 27 providers per 100,000 population (1 provider per 3,700 population). This is slightly higher than the overall Lancashire average of 25 per 100,000 and significantly higher than the national average of 22 per 100,000 (table 3).

North Lancashire

In North Lancashire there were 76 community pharmaceutical providers as at March 2014 which means there were approximately 24 providers per 100,000 population (1 provider per 4,100 population). This is slightly lower than the overall Lancashire average of 25 per 100,000 but higher than the national average of 22 per 100,000 (table 3)

Table 3. Average numbers of pharmaceutical providers (community pharmacies or dispensing GPs) per 100,000 registered population, 2012/13

	Average number of pharmaceutical providers (per 100,000 pop.)
England	22
North West	26
Lancashire	25
Central Lancashire	24
East Lancashire	27
North Lancashire	24

Significantly **HIGHER** / **LOWER** than the national average

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

Information about pharmaceutical providers in other areas in England is shown in Table 4. In terms of community pharmacies, there were 22 pharmacies per 100,000 population in England in 2012/13 and the North West of England average was 26 per 100,000. The number of community pharmacies per 100,000 population ranged from 26 community pharmacies per 100,000 population in the North West to 18 per 100,000 population in South Central.

Table 4: Community pharmacies on a PCT pharmaceutical list at 31 March, prescription items dispensed per month and population by SHA in England 2012-13

	Number of community pharmacies	*Prescription items dispensed per month (000)s*	*Population (000)s Mid 2011*	*Pharmacies per 100,000 population*
ENGLAND	**11,495**	**76,191**	**53,107**	**22**
North East	606	5,095	2,596	23
North West	1,812	12,334	7,056	26
Yorkshire and the Humber	1,206	8,557	5,288	23
East Midlands	919	6,476	4,537	20
West Midlands	1,297	8,247	5,609	23
East Of England	1,148	7,625	5,862	20
London	1,846	9,644	8,204	23
South East Coast	857	5,767	4,476	19
South Central	756	4,898	4,177	18
South West	1,048	7,546	5,301	20

Sources: NHS Prescription Services part of the NHS Business Services Authority, Population data - Office for National Statistics

Within the North West of England, the lowest level was 22 pharmacies per 100,000 population in Bury, Central & Eastern Cheshire, Cumbria and Warrington (table 5).

Lancashire has a significantly high number at 25 per 100,000 in (table 3) and this does not include the dispensing practices of which Lancashire has 13. Across Lancashire there were on average 1.96 million prescription items dispensed per month, approximately 1.7 per person which is slightly higher than the national average of 1.4 per person.

Table 5. Community pharmacies on a PCT pharmaceutical list at 31 March 2012/13

		Number of community pharmacies	Prescription items dispensed per month (000)s	Population (000)s Mid 2011 (1)	Pharmacies per 100,000 population
	ENGLAND	11,495	76,191	53,107	22
Q31	NORTH WEST	1,812	12,334	7,056	26
5HG	Ashton, Leigh and Wigan	73	523	318	23
TAP	Blackburn with Darwen Teaching	52	278	148	35
5HP	Blackpool	44	350	142	31
5HQ	Bolton	73	494	277	26
5JX	Bury	40	291	185	22
5NP	Central & Eastern Cheshire	101	737	463	22
5NG	Central Lancashire	114	738	467	24
5NE	Cumbria	111	765	500	22
5NH	East Lancashire	104	646	383	27
5NM	Halton and St Helens	82	579	301	27
5NQ	Heywood, Middleton & Rochdale PCT	51	374	212	24
5J4	Knowsley	37	299	146	25
5NL	Liverpool	136	866	466	29
5NT	Manchester	134	817	503	27
5NF	North Lancashire	76	577	322	24
5J5	Oldham	56	394	225	25
5F5	Salford Teaching	61	461	234	26
5NJ	Sefton	76	543	274	28
5F7	Stockport	70	504	283	25
5LH	Tameside and Glossop	64	455	253	25
5NR	Trafford	62	401	227	27
5J2	Warrington	45	316	203	22
5NN	Western Cheshire PCT	56	358	237	24
5NK	Wirral	94	570	320	29

Sources: NHS Prescription Services part of the NHS Business Services Authority, Population data - Office for National Statistics

It is clearly visible from Table 5 that all the neighbouring areas around Lancashire have the same as, or in some cases, a significantly higher proportion of pharmacies than the England average (per 100,000 population) and more than a third have higher than the North West average. This gives Lancashire adequate pharmacy provision should they need or wish to go to neighbouring areas.

4.1.10 *Results of questionnaires sent to pharmacies and dispensing GP practices*

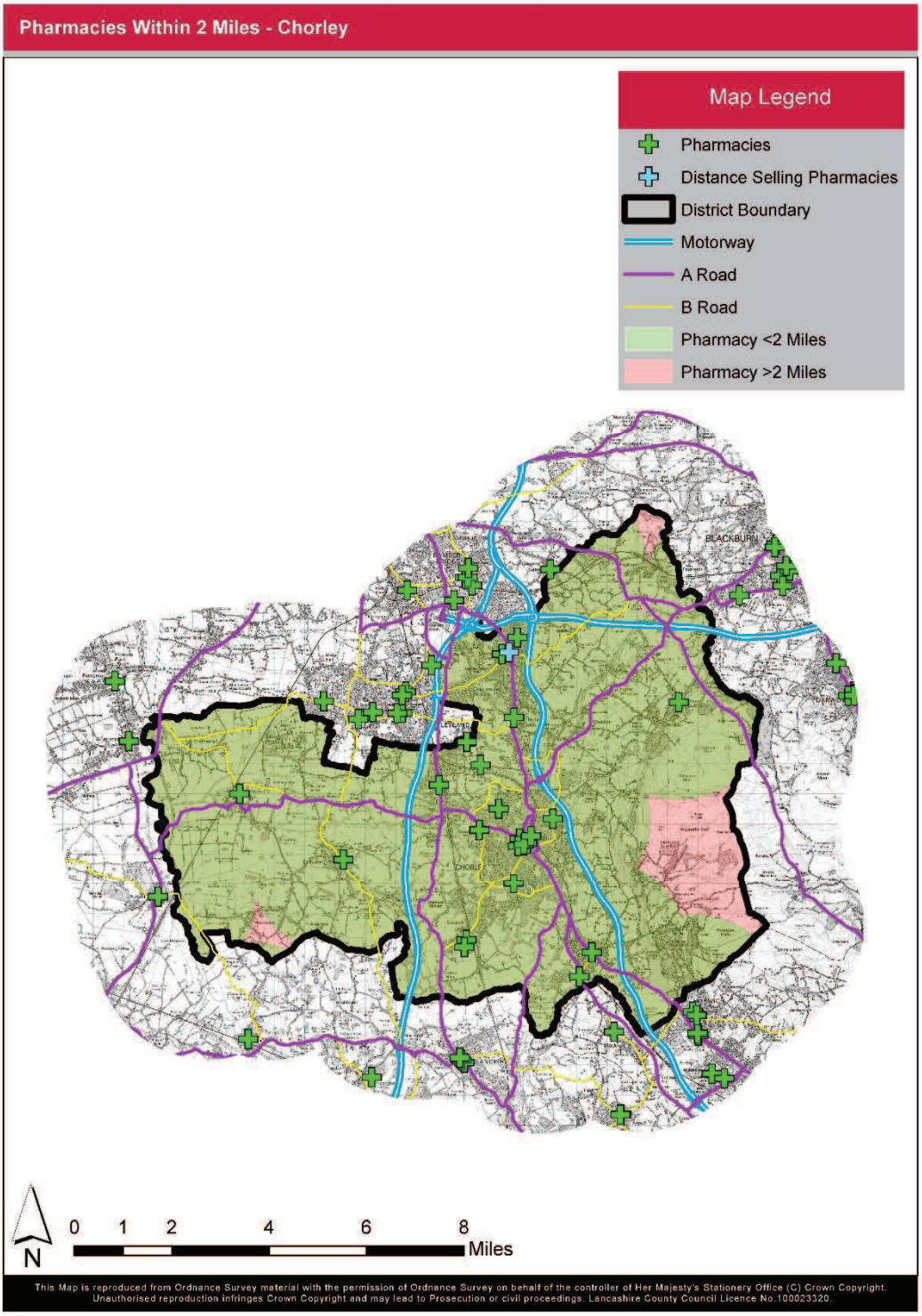
64.0% of community pharmacies and 77.0% of dispensing GP practices in Lancashire responded to the PNA questionnaire about service provision. The findings of the PNA questionnaire are presented in Appendix 6.

4.1.11 *Considerations of service providers available*

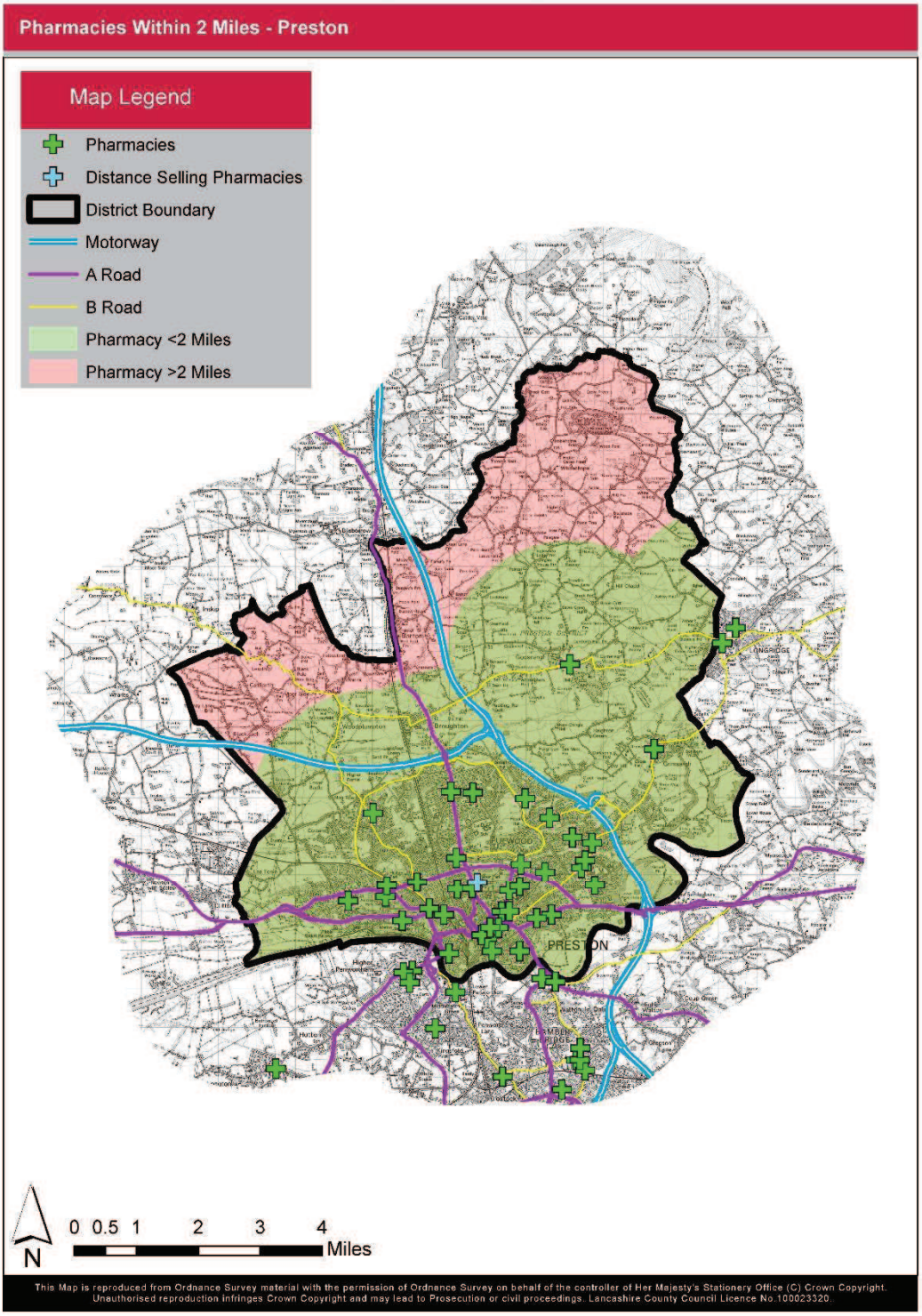
The distribution of pharmacies appears to cover the county well with pharmacies within every district of the county. Maps 19 to 30 show all areas within the Lancashire districts which are within 2 miles of a pharmacy; these include dispensing pharmacies. Access to services in these areas will be further discussed in section 4.2.

Taking into account information gathered for this PNA, pharmaceutical service provision in Lancashire appears to be adequate. There is no current need identified for more pharmaceutical providers at this time.

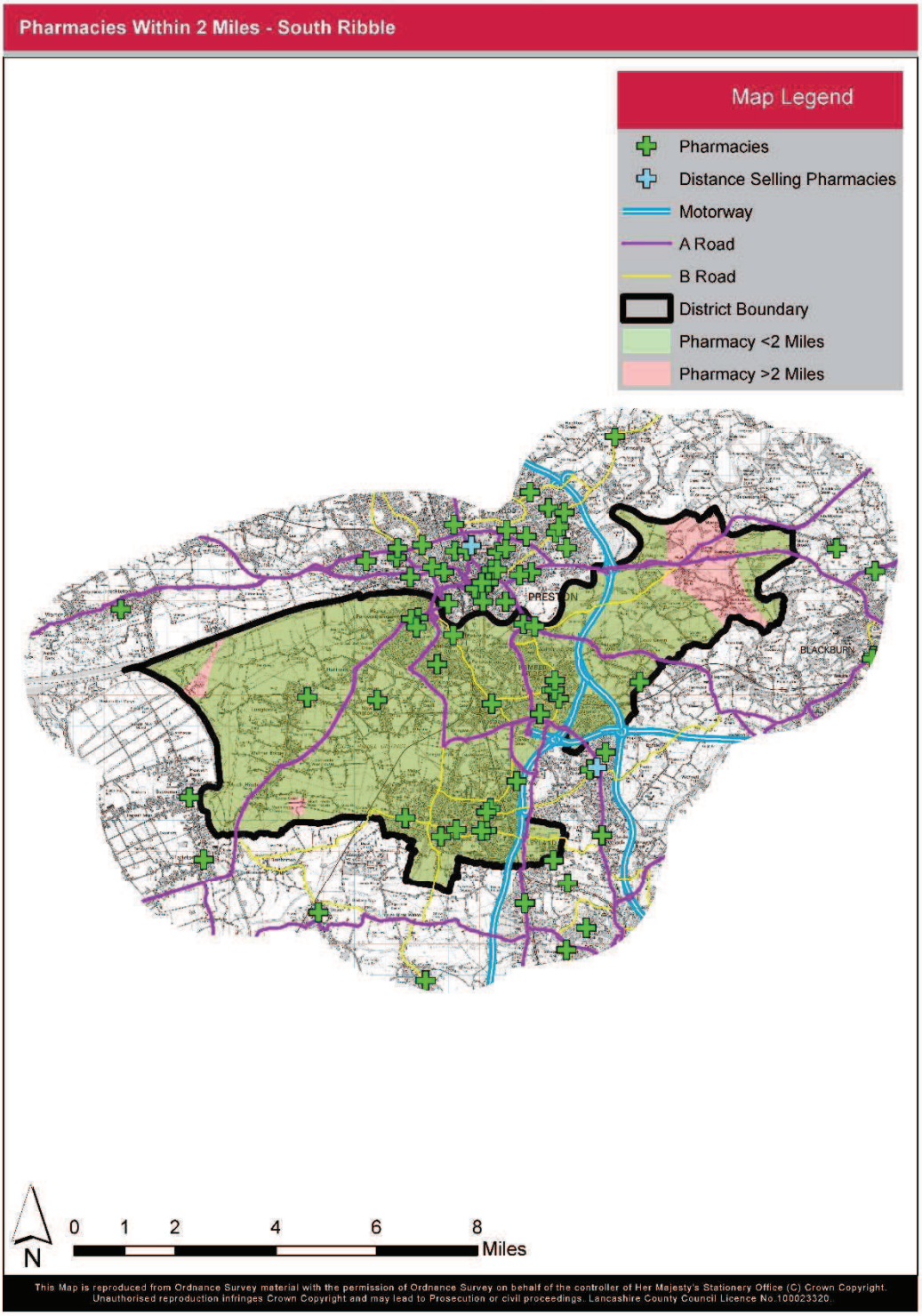
Map 19: Pharmacies within 2 miles of Chorley (Central locality)



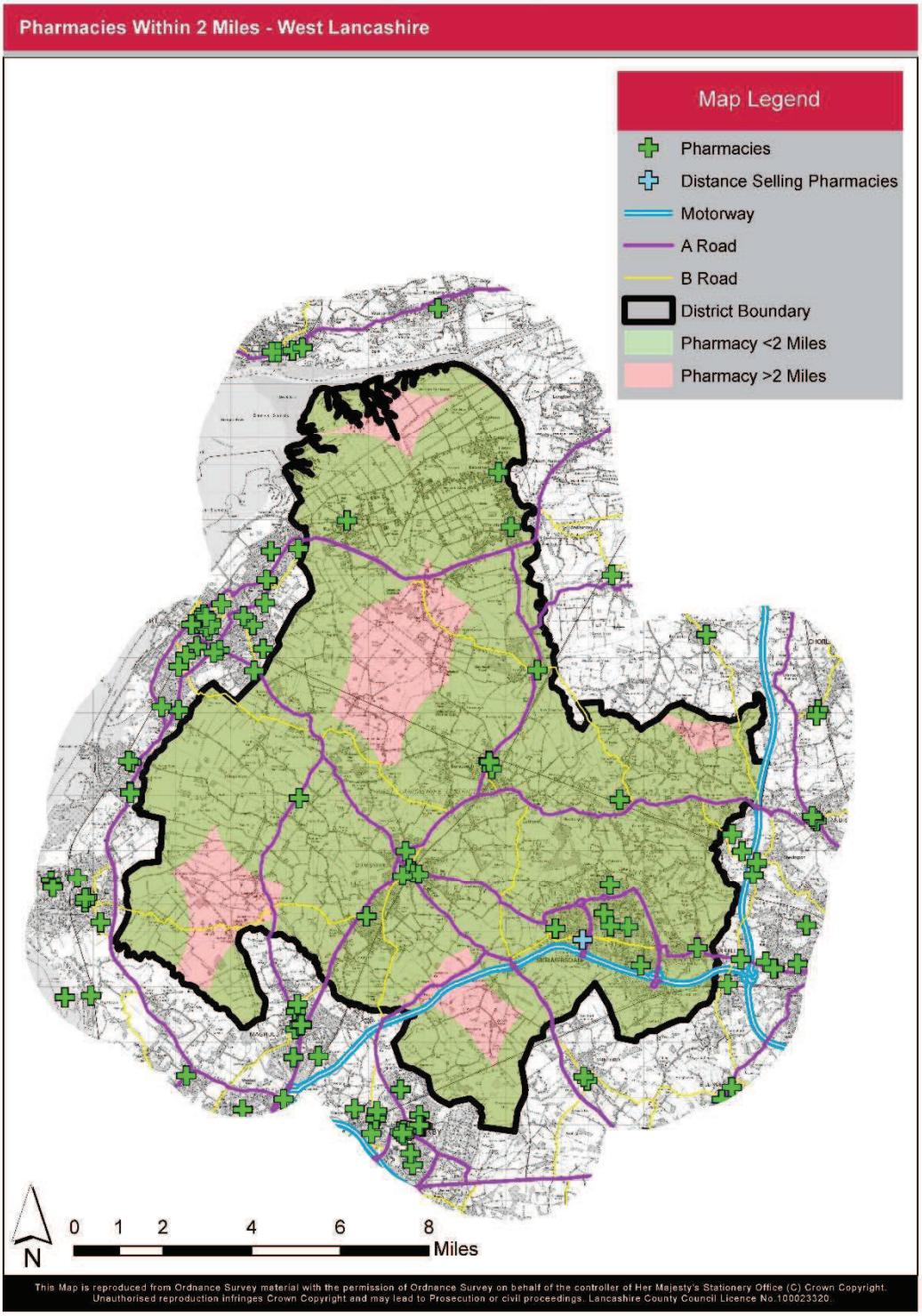
Map 20: Pharmacies within 2 miles of Preston (Central locality)



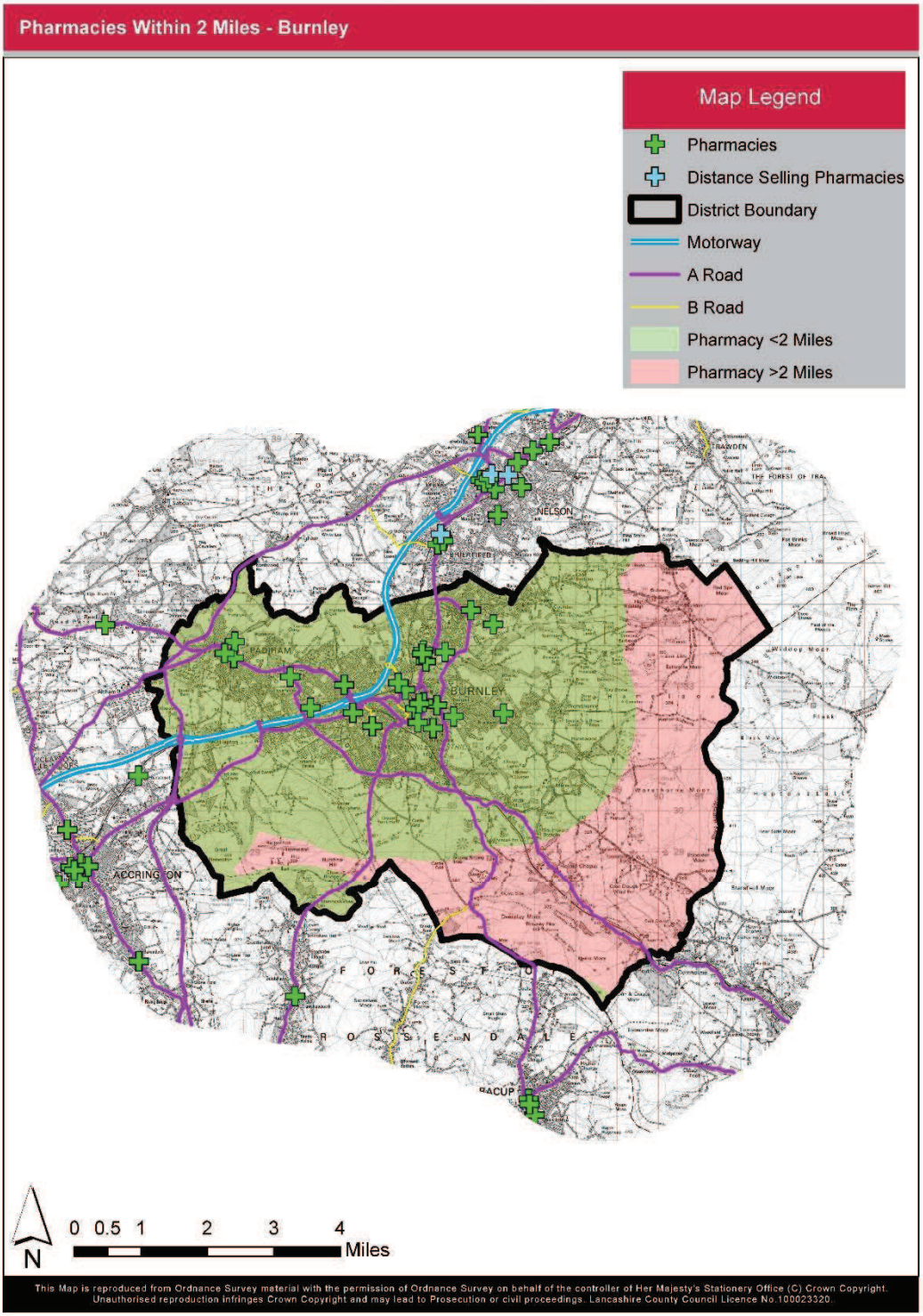
Map 21: Pharmacies within 2 miles of South Ribble (Central locality)



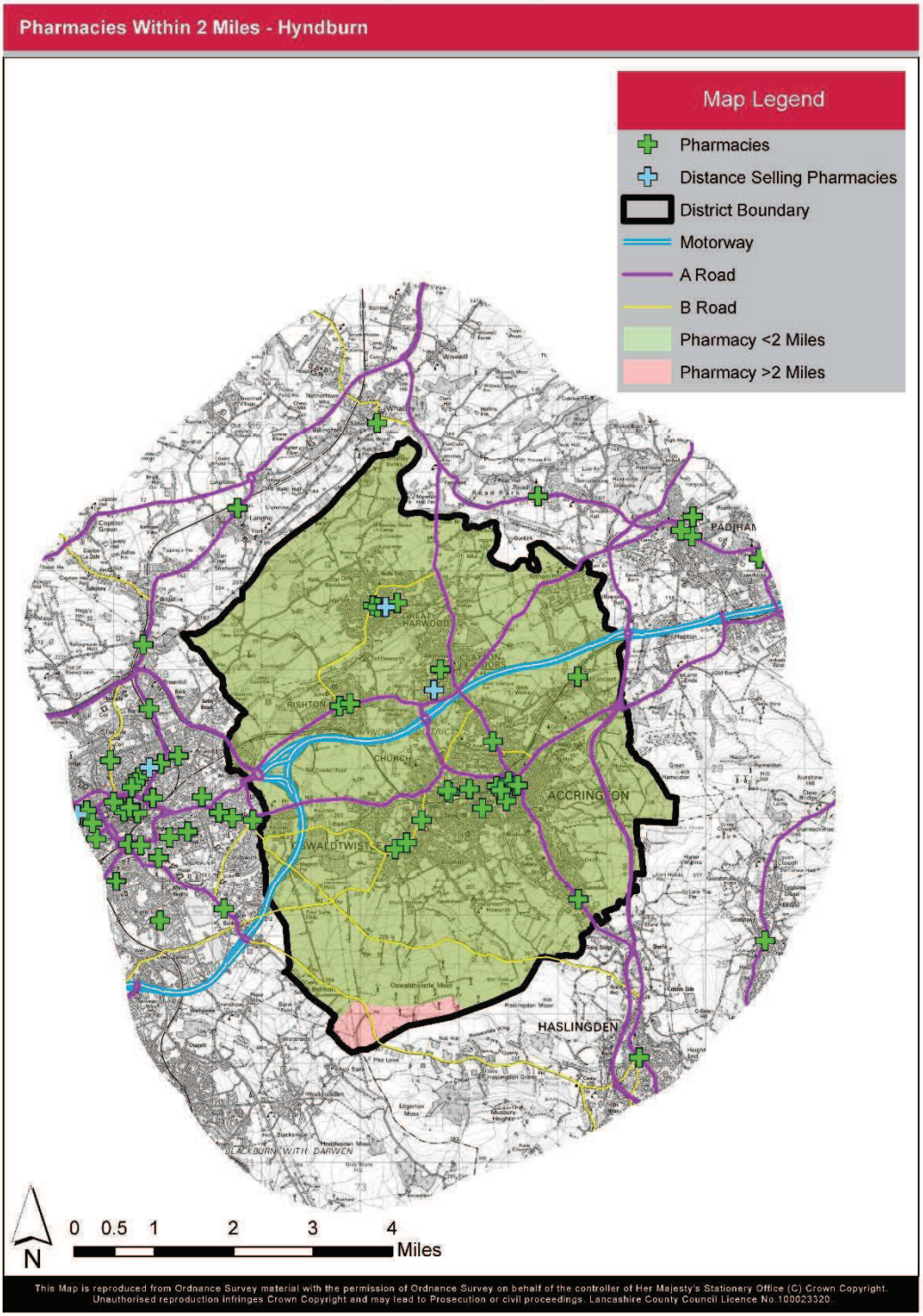
Map 22: Pharmacies within 2 miles of West Lancashire (Central locality)



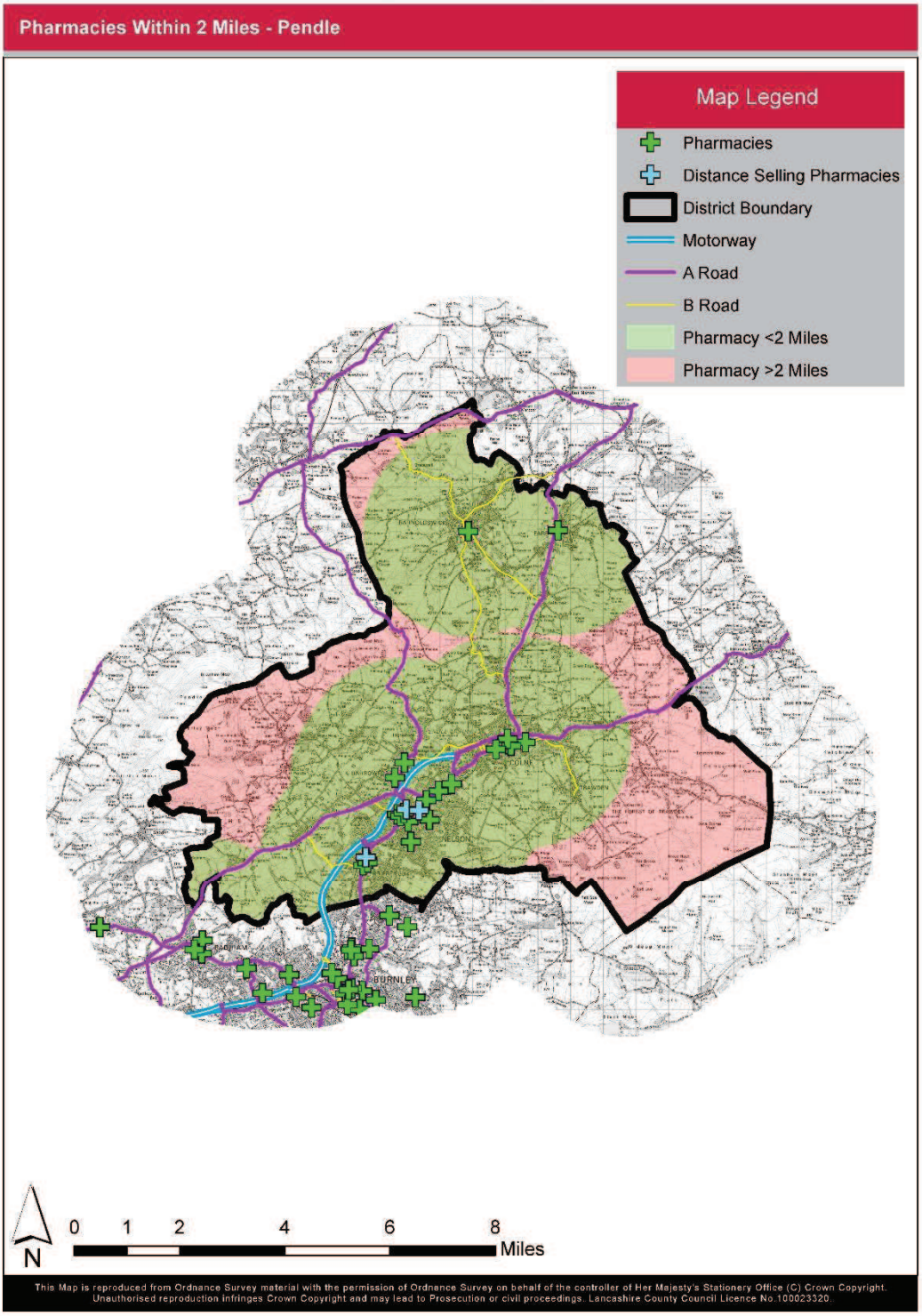
Map 23: Pharmacies within 2 miles of Burnley (East locality)



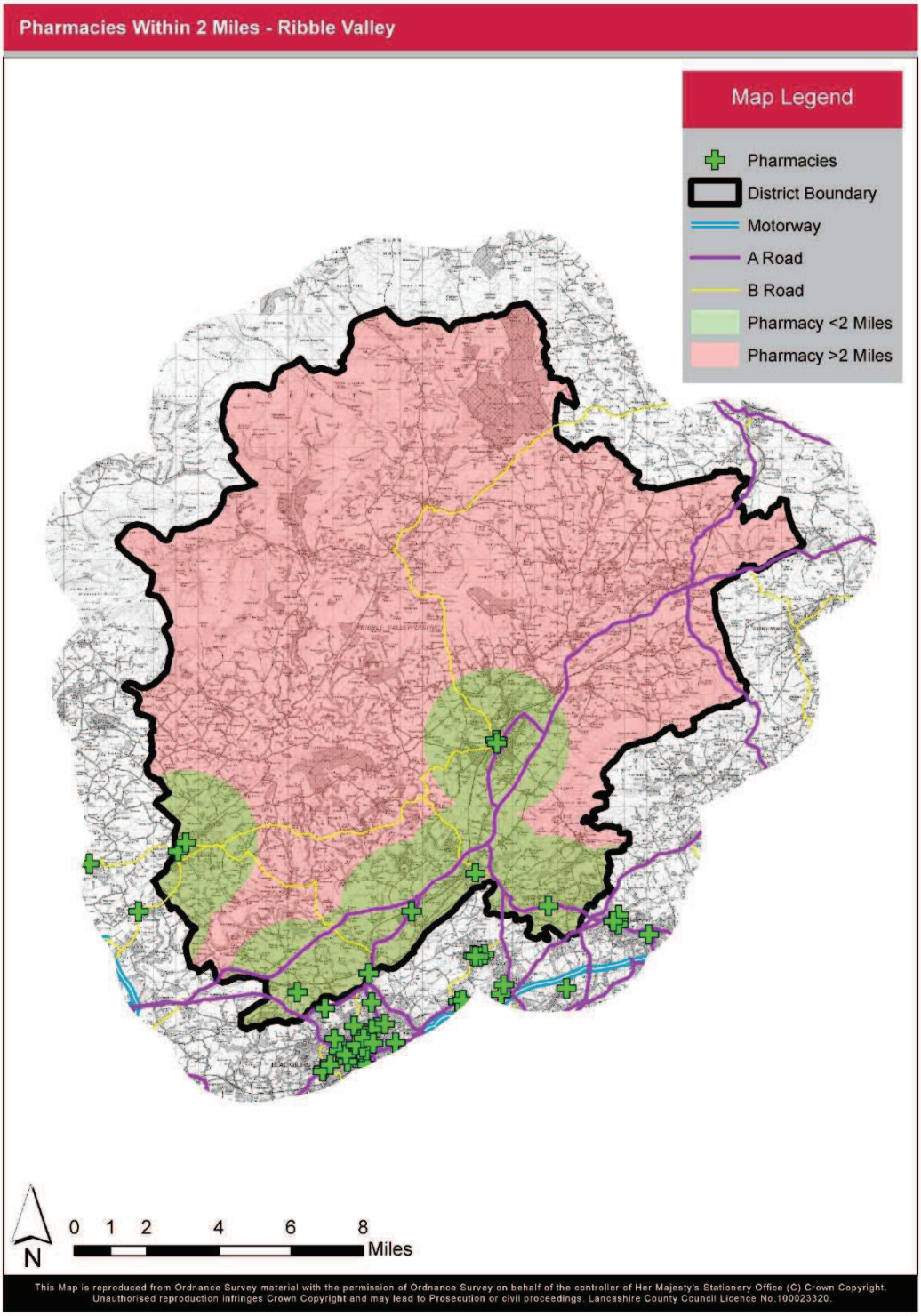
Map 24: Pharmacies within 2 miles of Hyndburn (East locality)



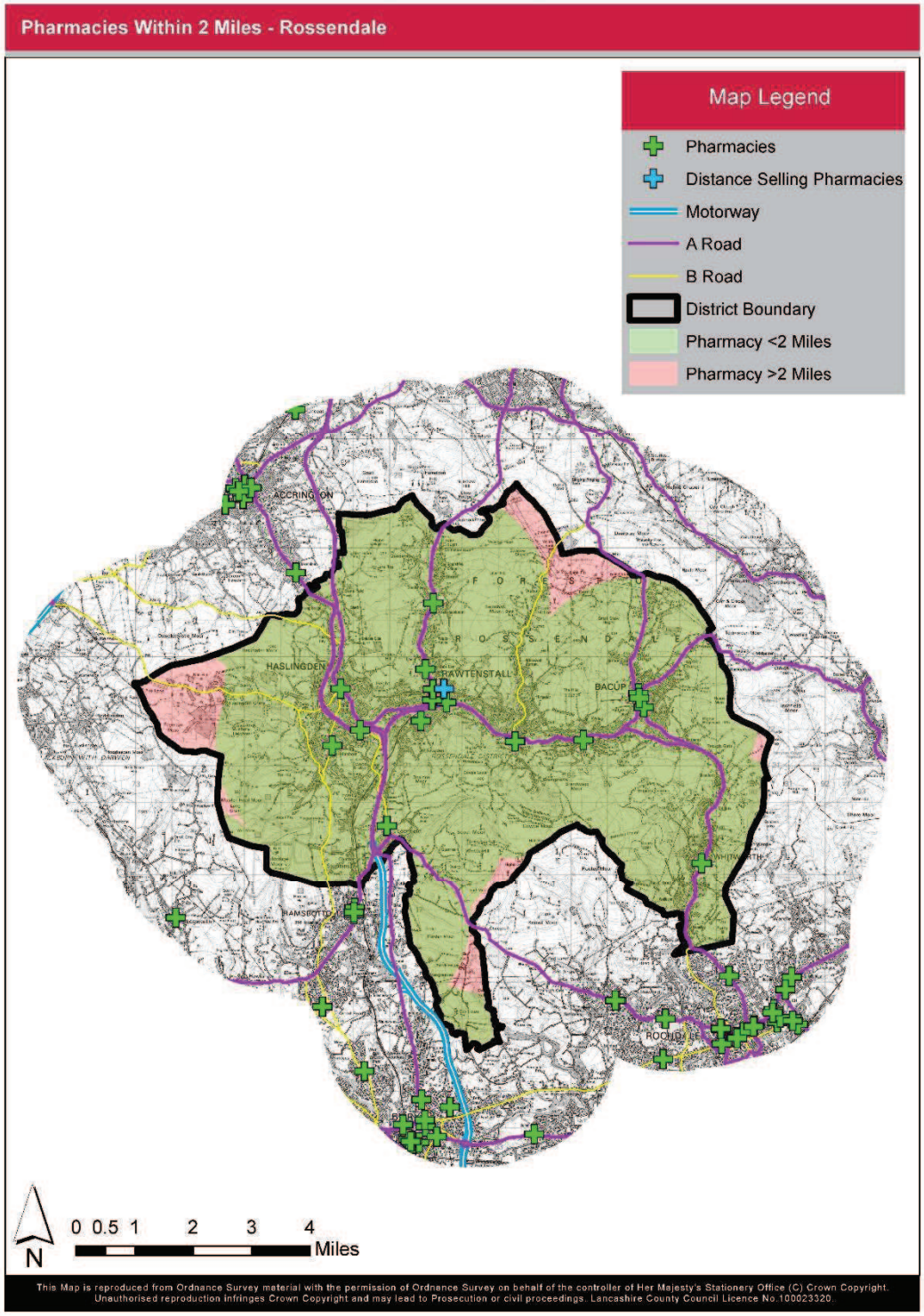
Map 25: Pharmacies within 2 miles of Pendle (East locality)



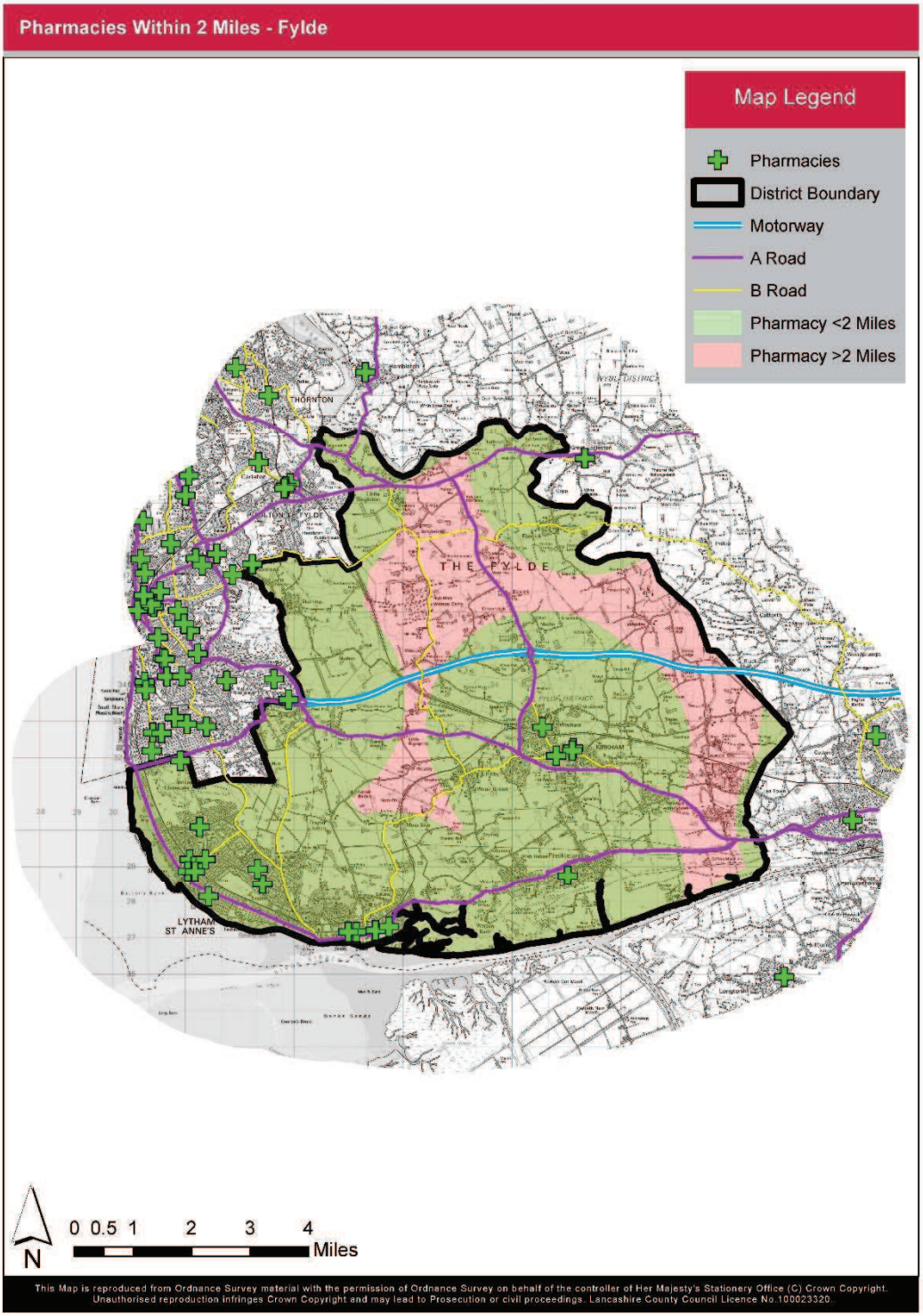
Map 26: Pharmacies within 2 miles of Ribble Valley (East locality)



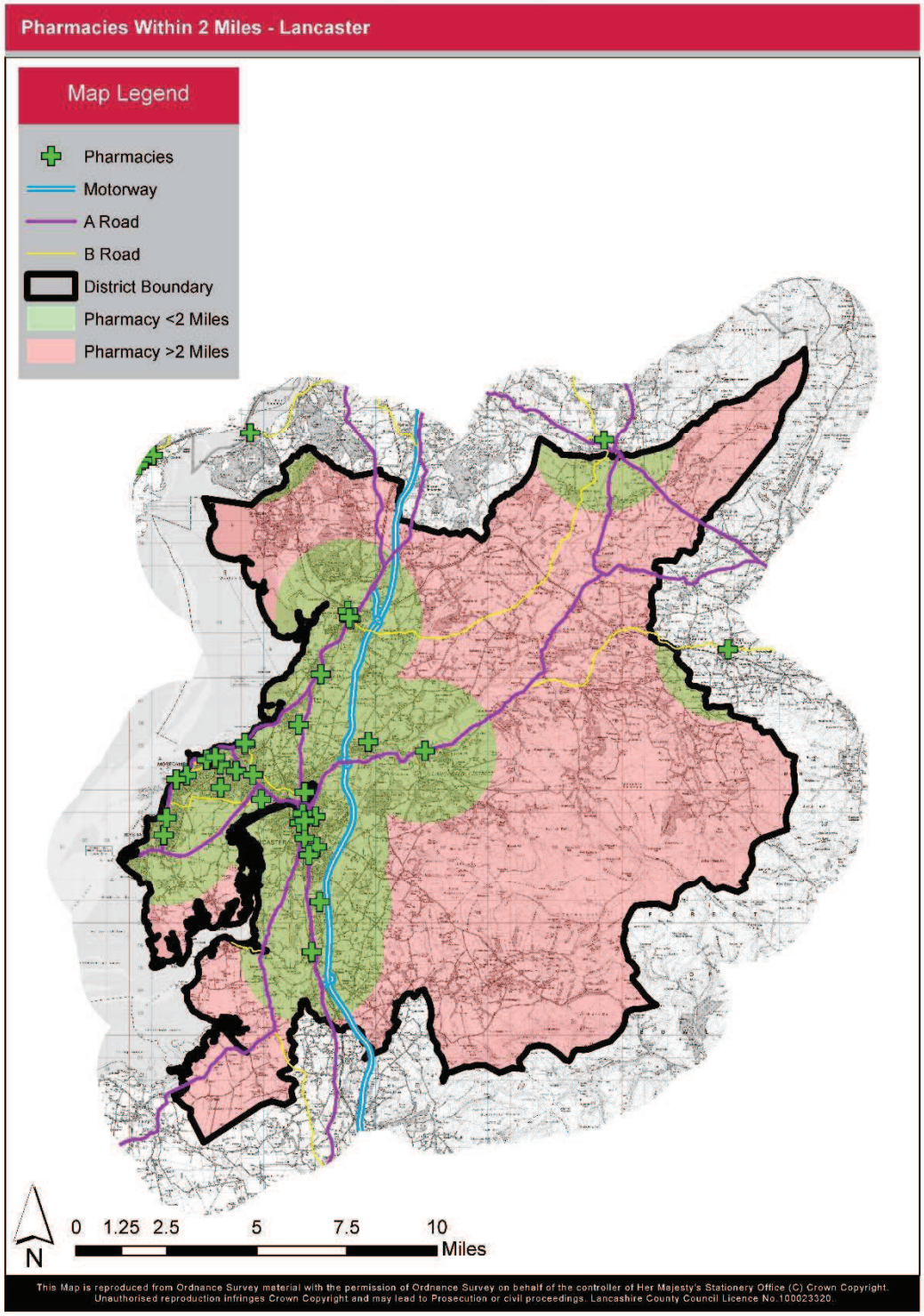
Map 27: Pharmacies within 2 miles of Rossendale (East locality)



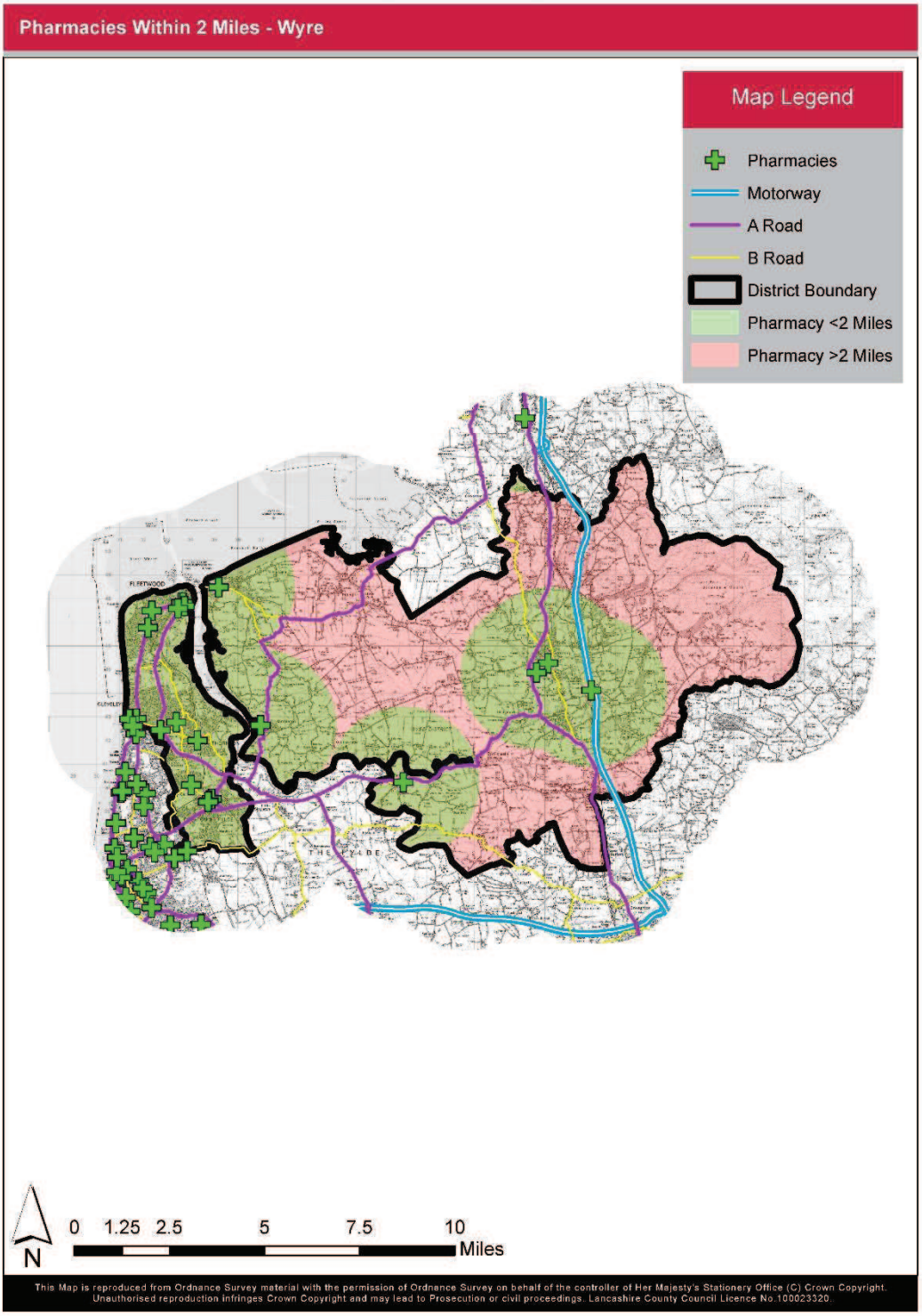
Map 28: Pharmacies within 2 miles of Fylde (North locality)



Map 29: Pharmacies within 2 miles of Lancaster (North locality)



Map 30: Pharmacies within 2 miles of Wyre (North locality)



4.2 Accessibility

Review of the accessibility of NHS Pharmaceutical Services in Lancashire in terms of locations, opening hours and access for people with disabilities, suggest there is adequate access. An Equality Impact Assessment has been carried out alongside this PNA (see appendix 6). Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS Pharmaceutical Services in Lancashire. There appears to be good coverage in terms of opening hours across the borough. The extended opening hours of some community pharmacies are valued and these extended hours should be maintained. Many pharmacies and dispensing surgeries have wheelchair access and home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport. Further information can be seen in Appendix 6.

4.2.1 Distance, travel times, and delivery services

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

Maps 31 to 42 (for each Lancashire district) were created to identify which areas (road networks) in Lancashire were within and which were not within a 20 minute driving time of a pharmacy. The maps present the locations of the pharmacies and road networks that are within 20 minutes' drive time (blue lines) of a pharmacy and are not within 20 minutes drive time (red lines) of a pharmacy. Road speed assumptions were made dependent on road type, and ranged from 67mph (for motorways) down to 22mph (for minor roads). Over the border pharmacies were included in the drive time analysis. As is clearly evident from the maps in the majority of the districts there are pharmacies within 20 minutes travelling time. This demonstrates that within the county there is good coverage of pharmacies across all districts.

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

There is the acknowledgment that not all individuals will have access to a car or be able to easily access public transport. To enable easy access for all individuals including those who can be deemed as the most vulnerable there is the option that pharmacies can provide home delivery services. Of the 188 pharmacies that responded to the patient questionnaires, all reported that they collected from GP Practices and 168 (89.4%) delivered dispensed medicines free of charge on request. Therefore, for those who may not be able to access the pharmacy there is the option of home delivery.

Pharmaceutical services are also available from internet pharmacies (located inside or outside of the county) that could make deliveries to individual homes. Finally, in addition to

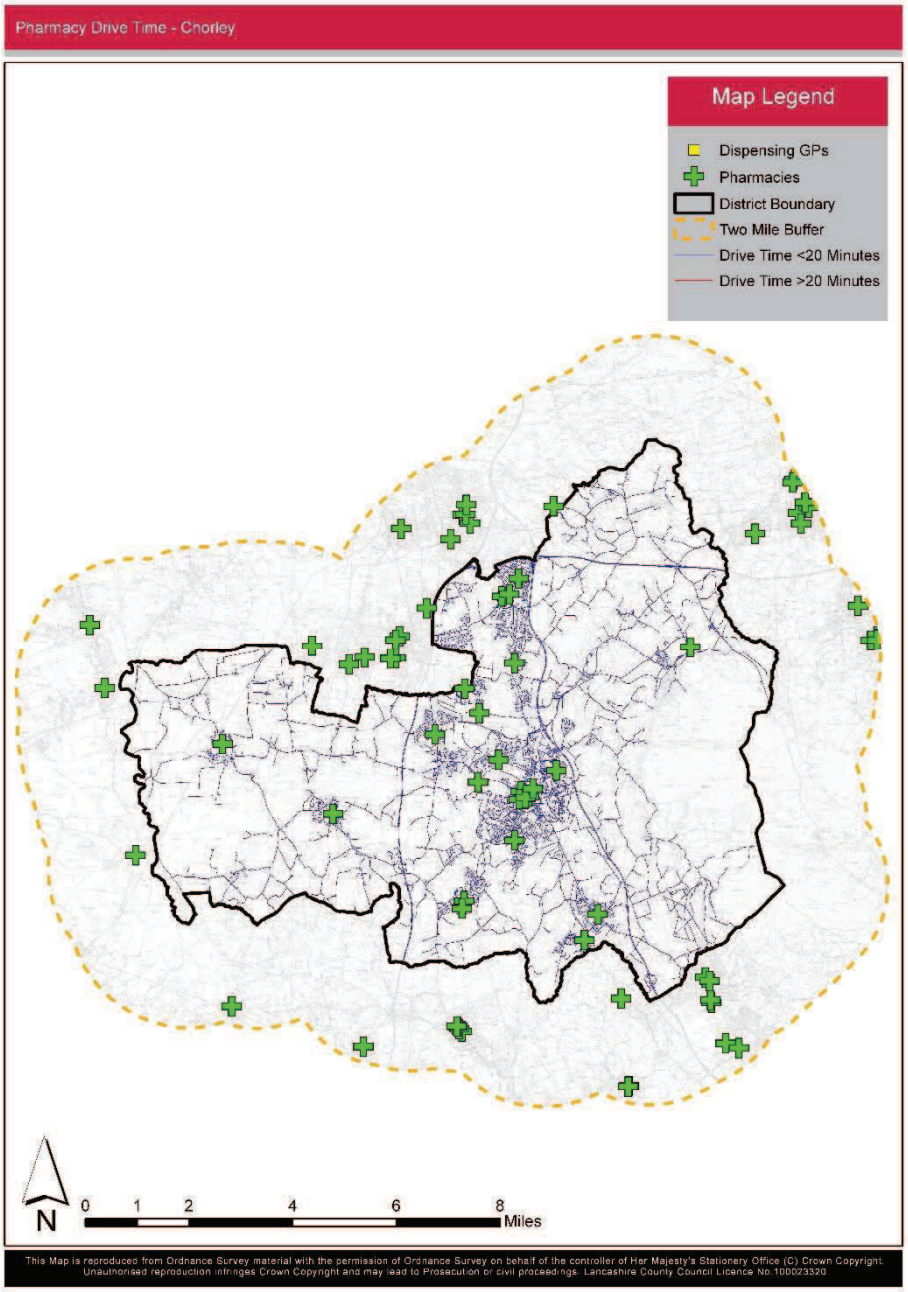
delivery services, community transport schemes (eg car clubs, minibuses) can potentially improve access to both pharmaceutical services and other services.

Central Lancashire

Chorley

As is clearly evident from the map all of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies.

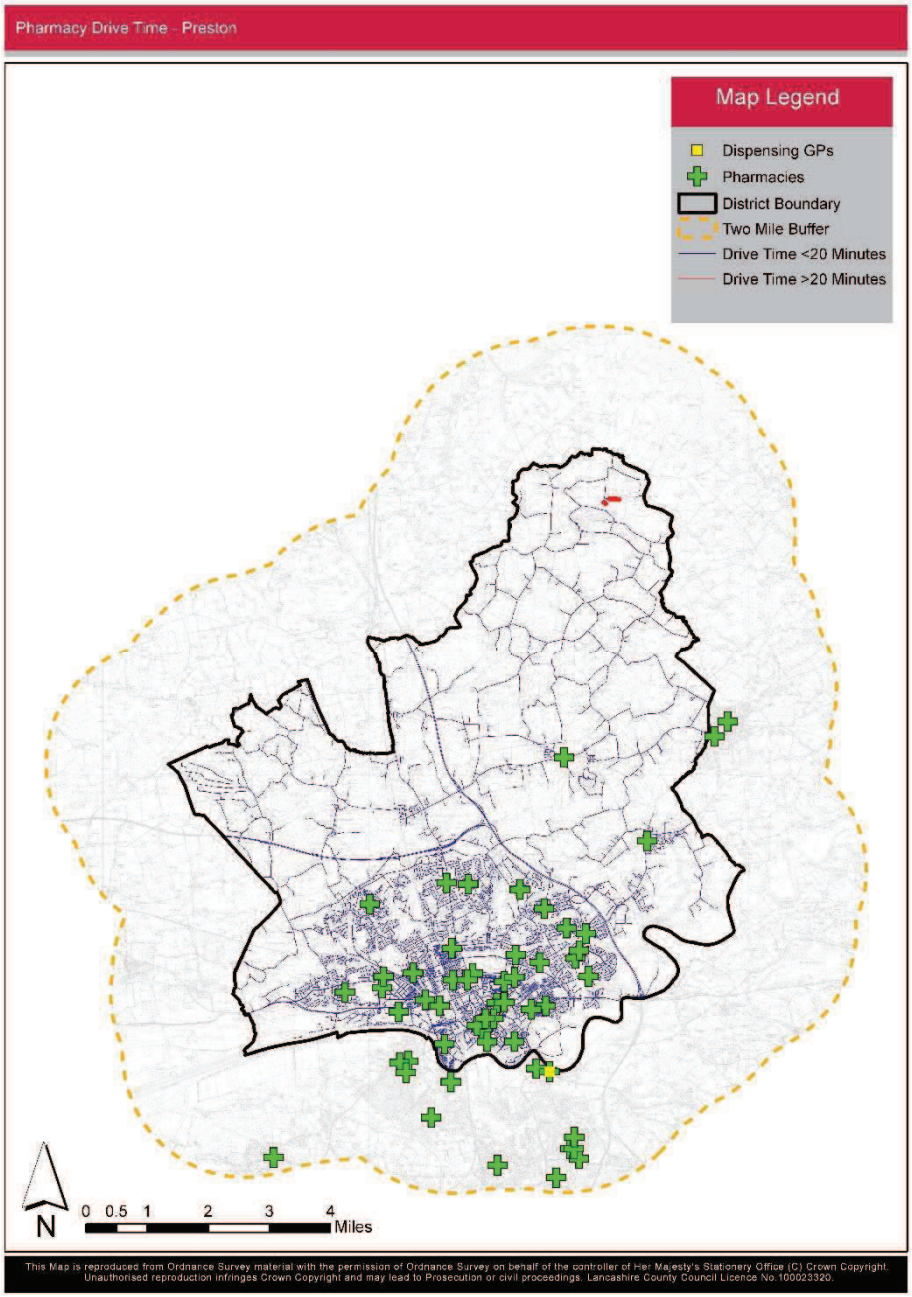
Map 31. Pharmacies within a 20 minute drive – Chorley



Preston

As is clearly evident from the map majority of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies. Note: While there is a small section of the road network more than 20 minutes away from a pharmacy or dispensing surgery by car, these are extreme rural areas and mainly uninhabited.

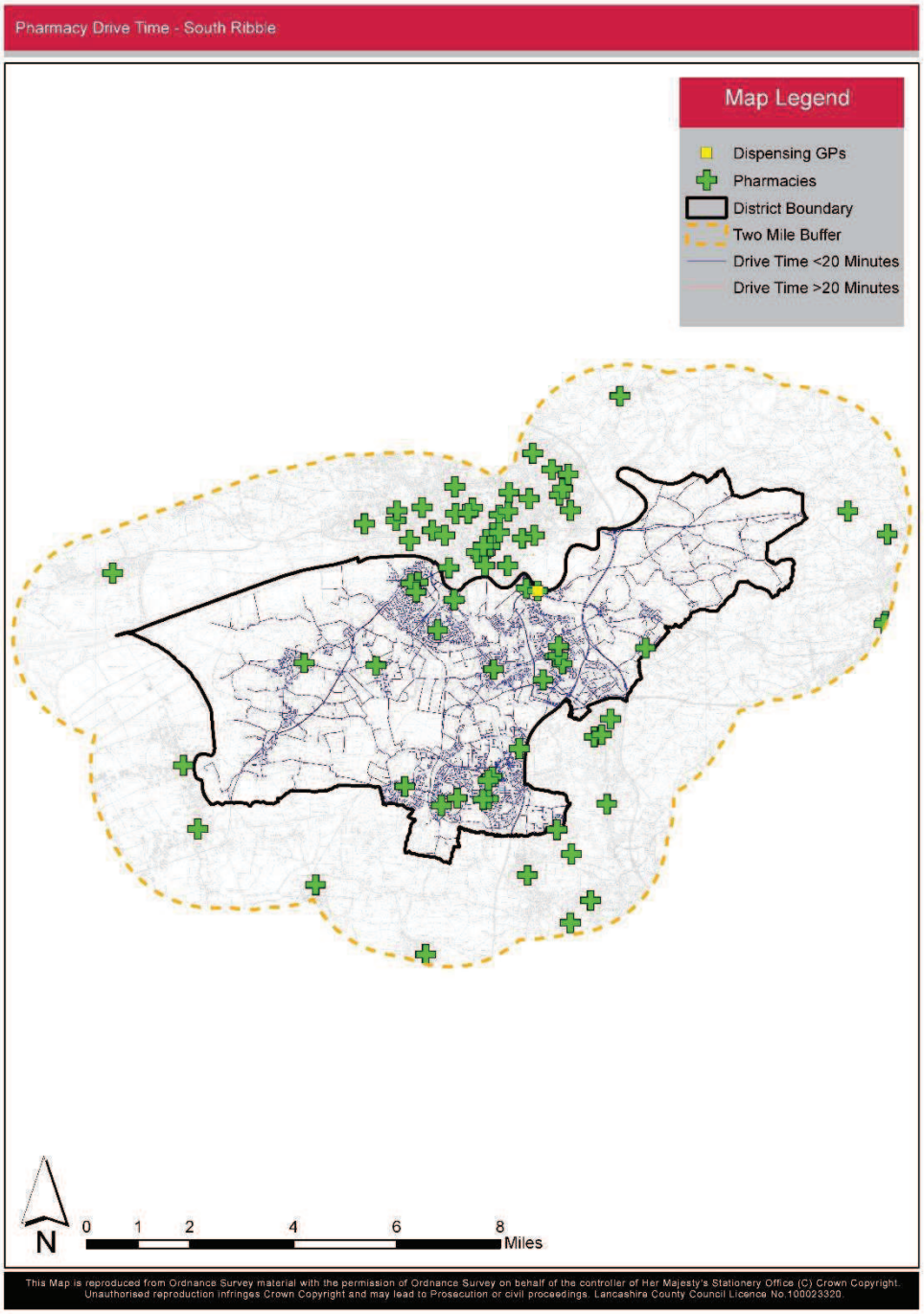
Map 32. Pharmacies within a 20 minute drive – Preston



South Ribble

As is clearly evident from the map all of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies

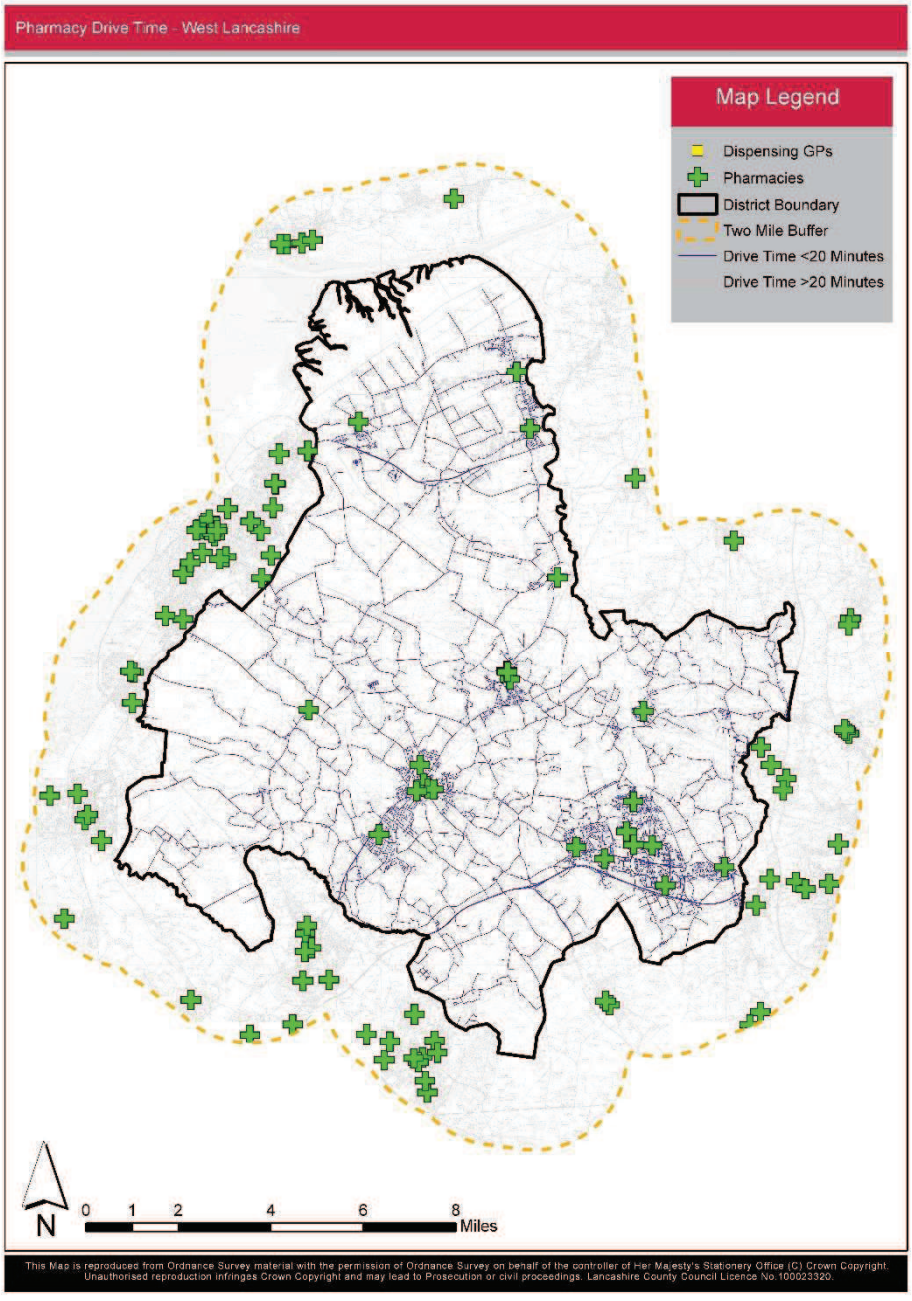
Map 33. Pharmacies within a 20 minute drive – South Ribble



West Lancashire

As is clearly evident from the map all of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies

Map 34. Pharmacies within a 20 minute drive – West Lancashire

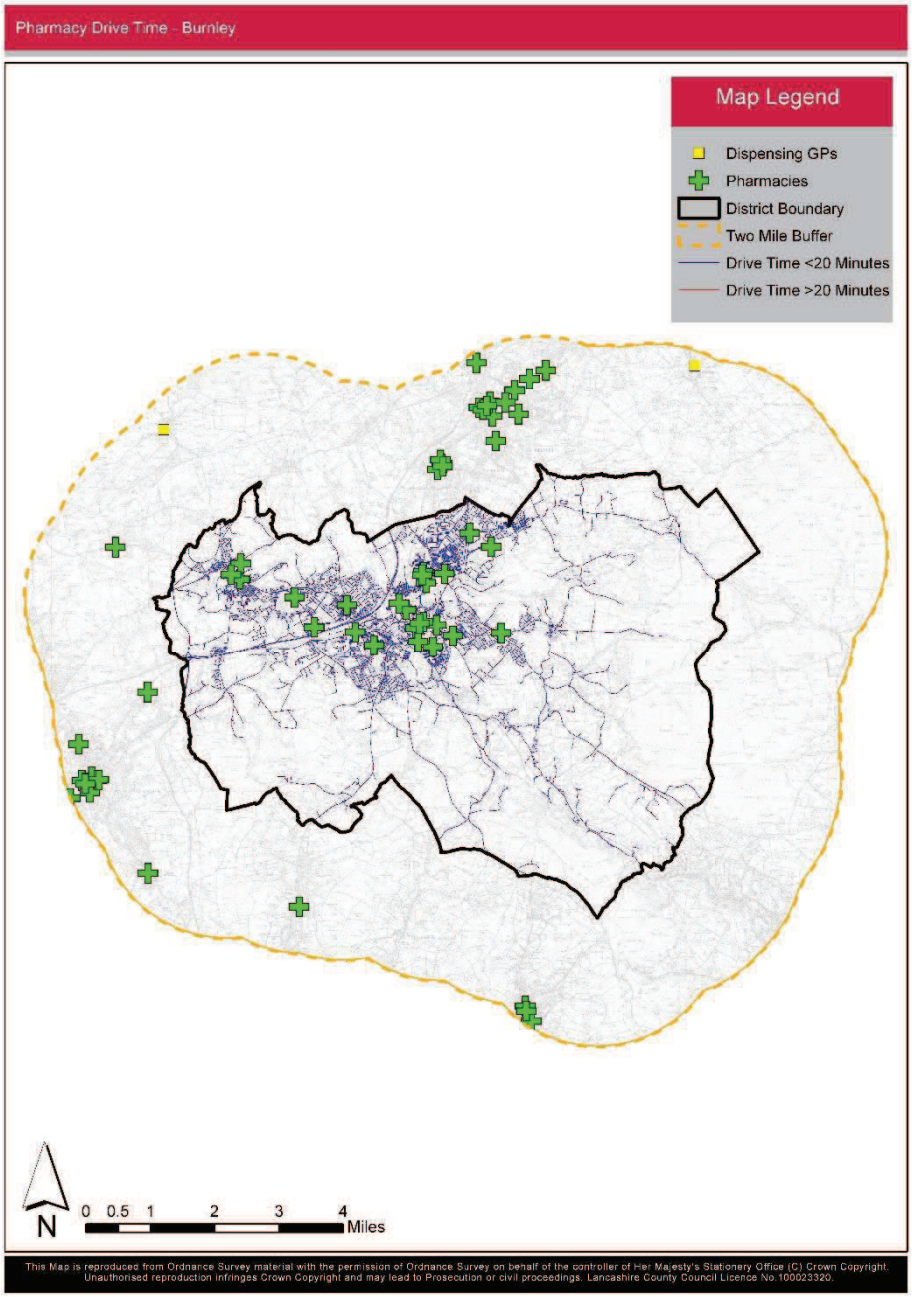


East Lancashire

Burnley

As is clearly evident from the map all of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies

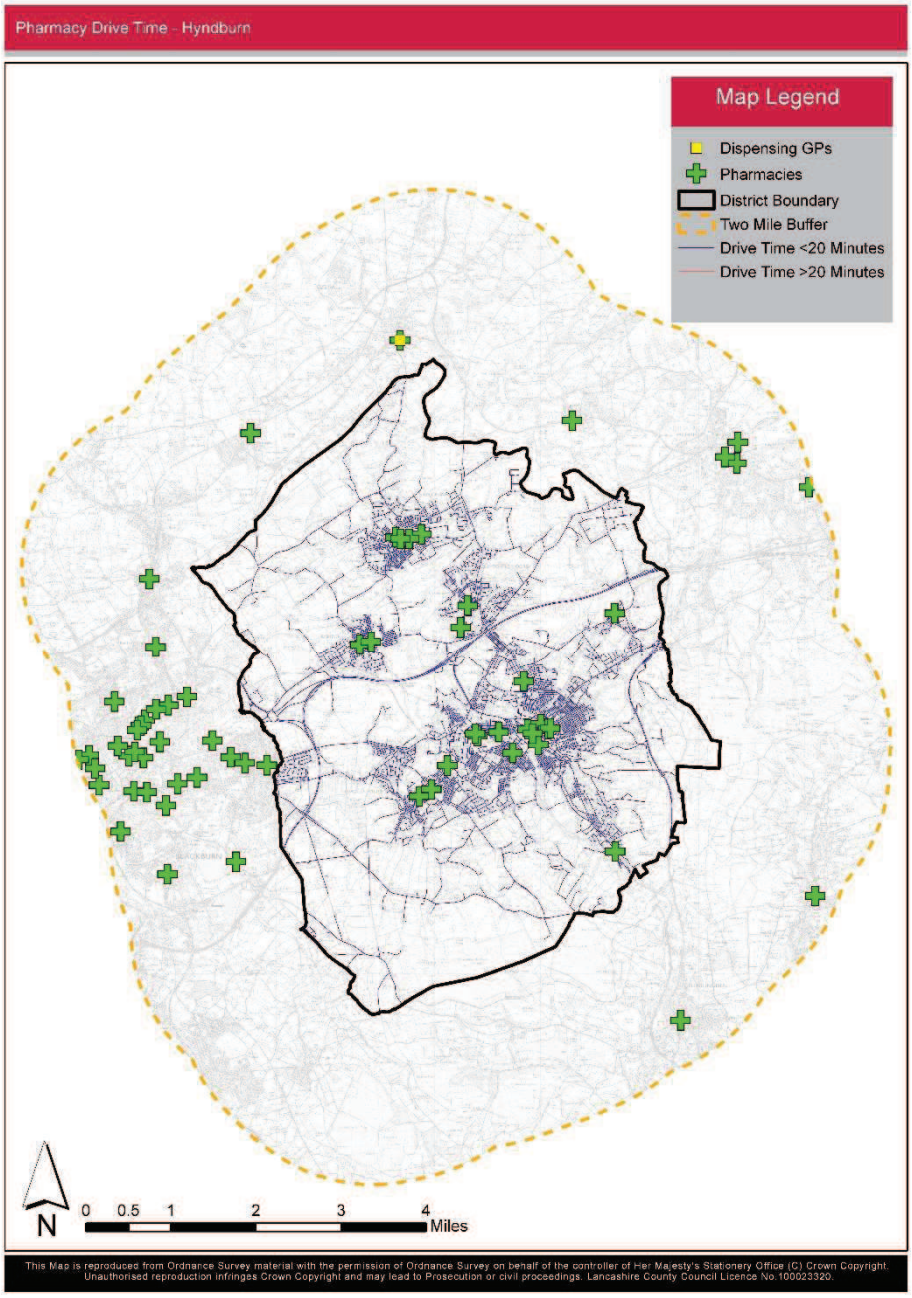
Map 35. Pharmacies within a 20 minute drive – Burnley



Hyndburn

As is clearly evident from the map all of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies

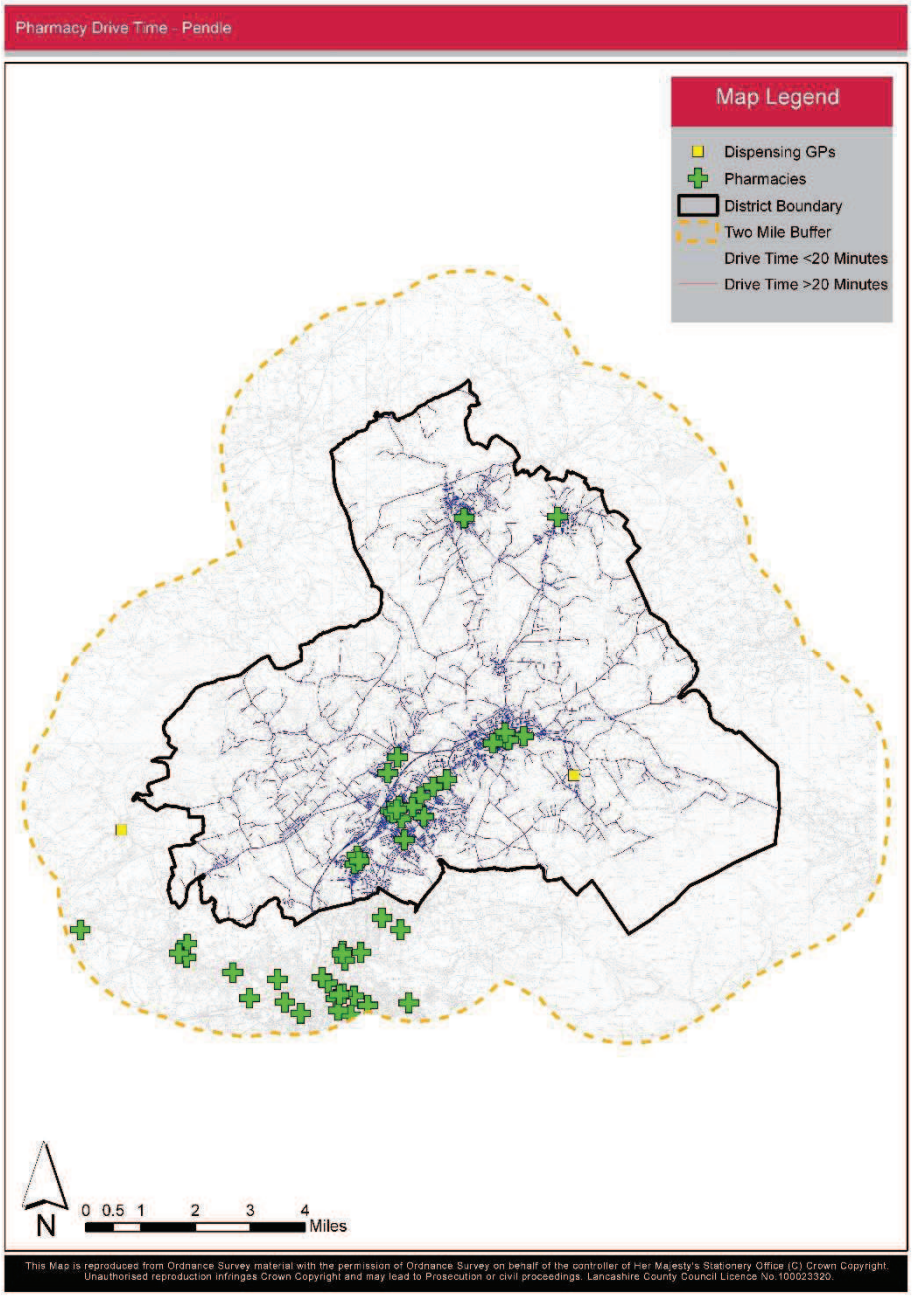
Map 36. Pharmacies within a 20 minute drive – Hyndburn



Pendle

As is clearly evident from the map all of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies.

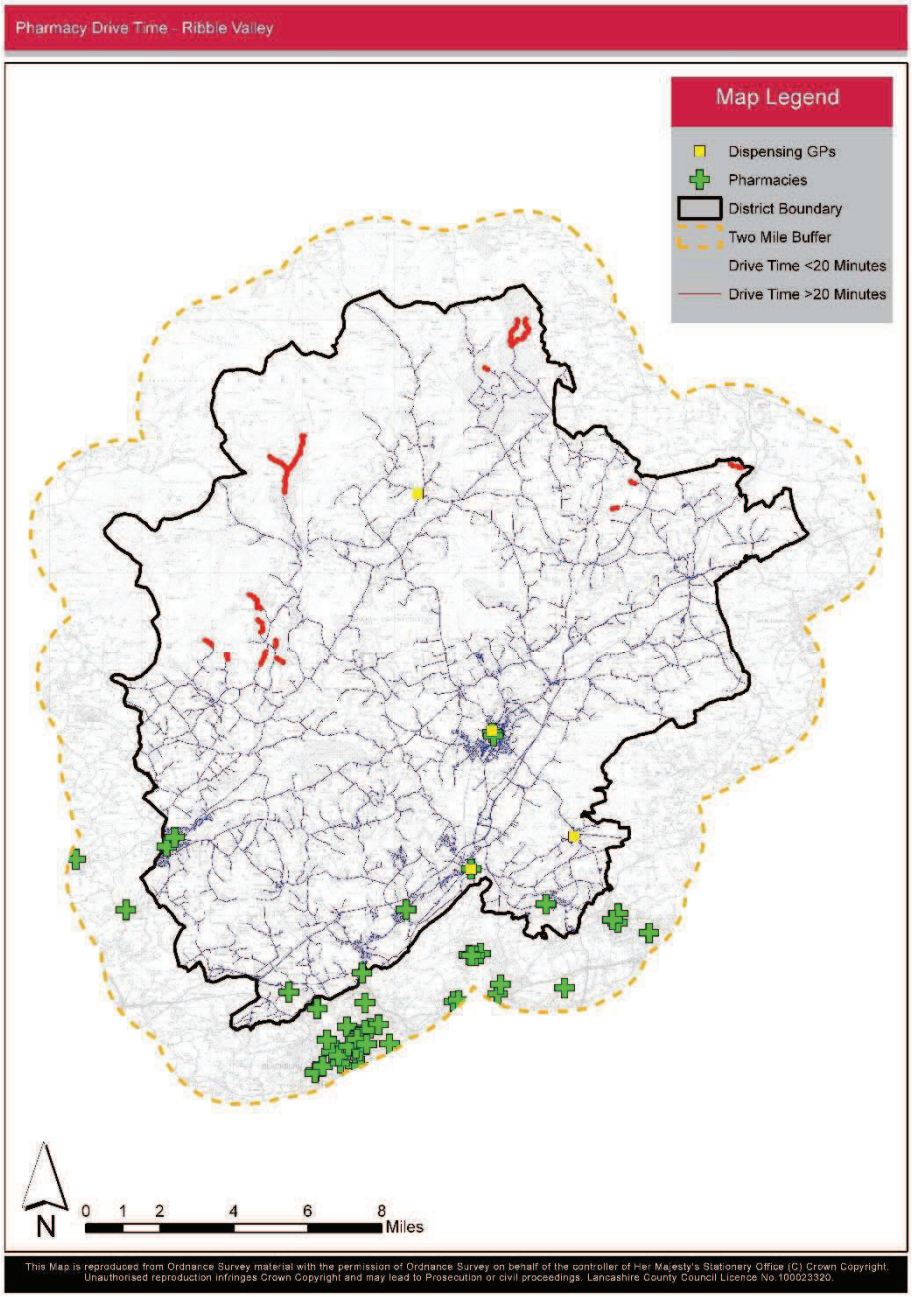
Map 37. Pharmacies within a 20 minute drive – Pendle



Ribble Valley

As is clearly evident from the map majority of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies. Note: While there are pockets of road networks more than 20 minutes away from a pharmacy or dispensing surgery by car, these are rural areas and mainly uninhabited.

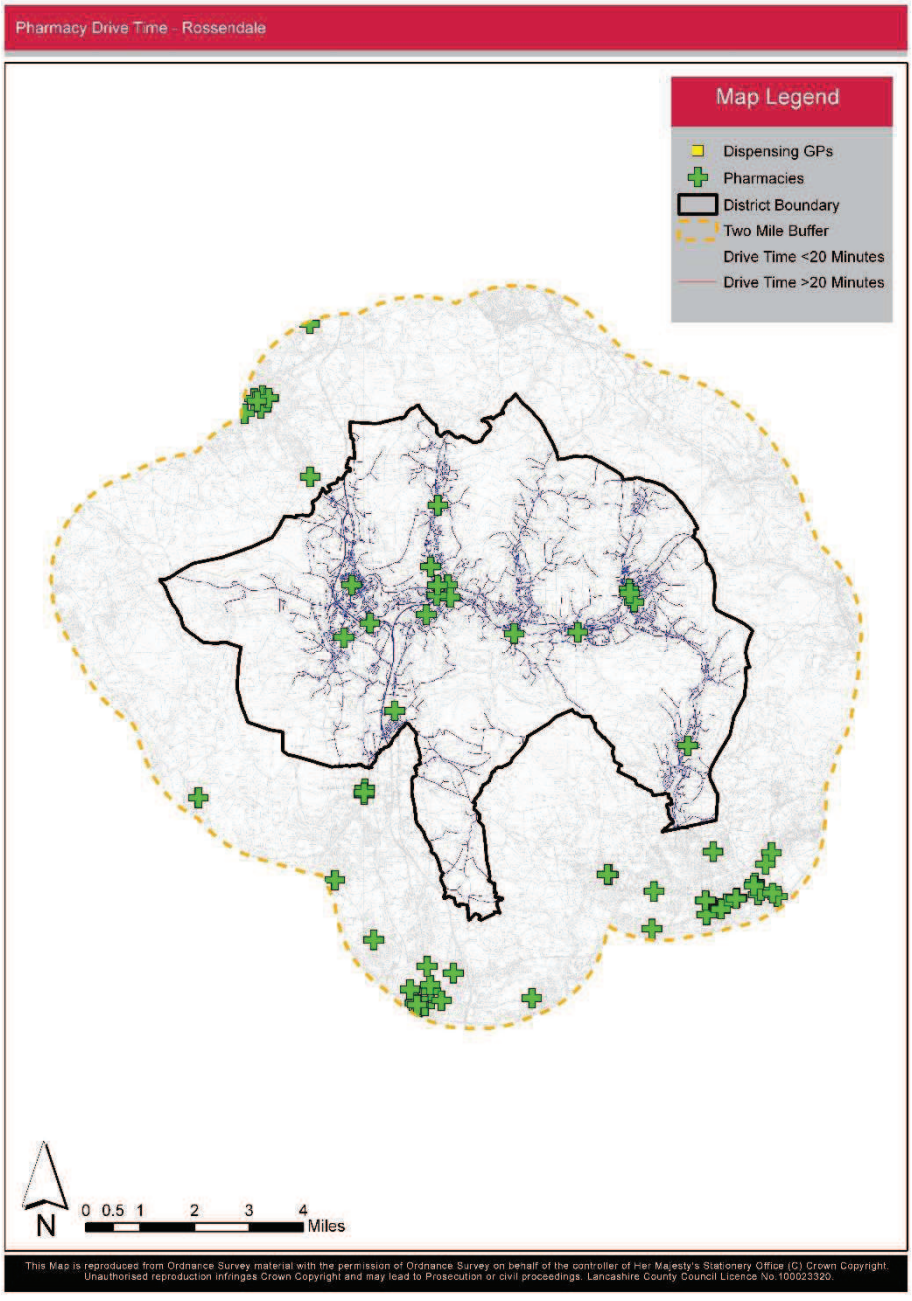
Map 38. Pharmacies within a 20 minute drive – Ribble Valley



Rossendale

As is clearly evident from the map all of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies

Map 39. Pharmacies within a 20 minute drive – Rossendale

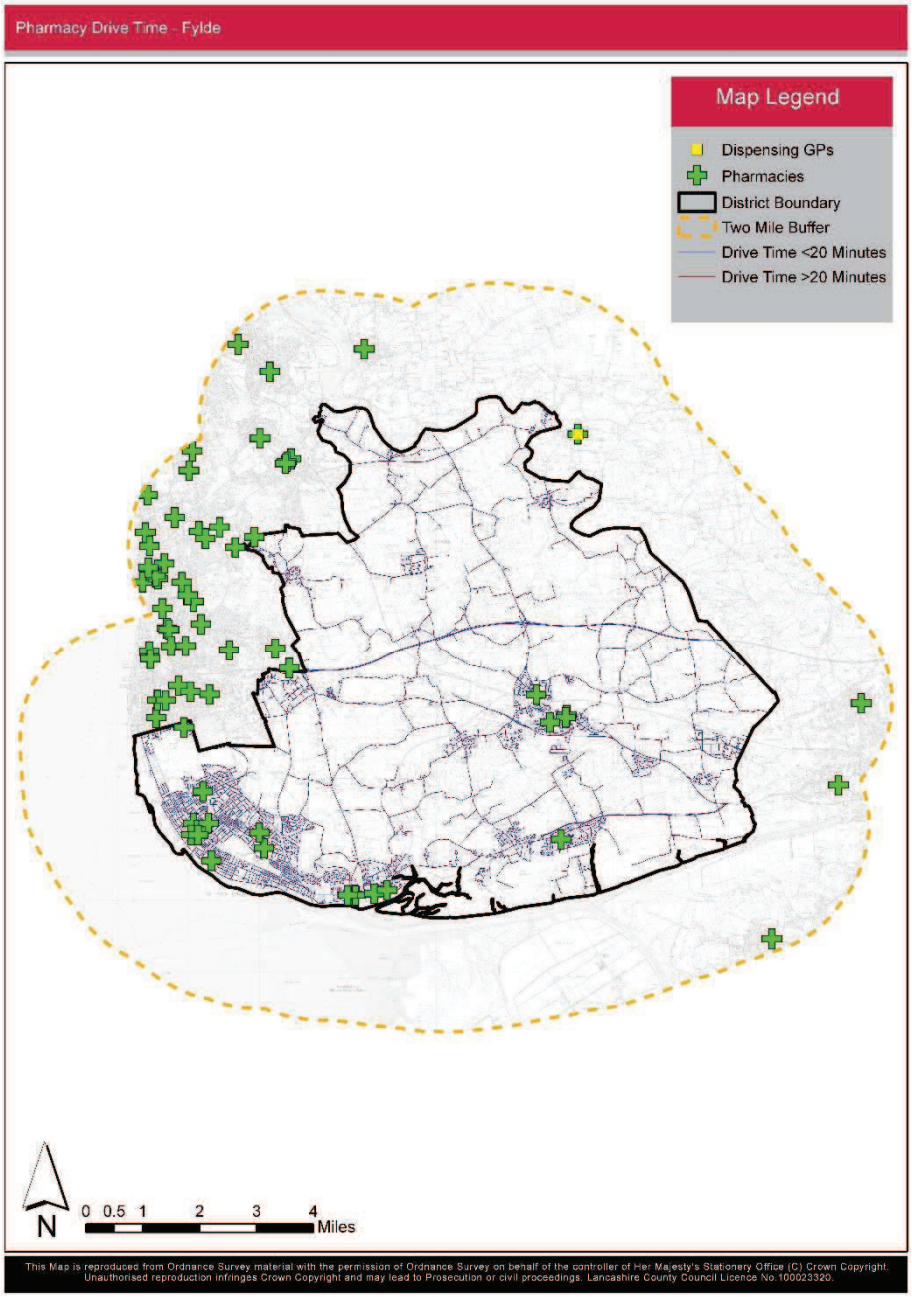


North Lancashire

Fylde

As is clearly evident from the map all of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies

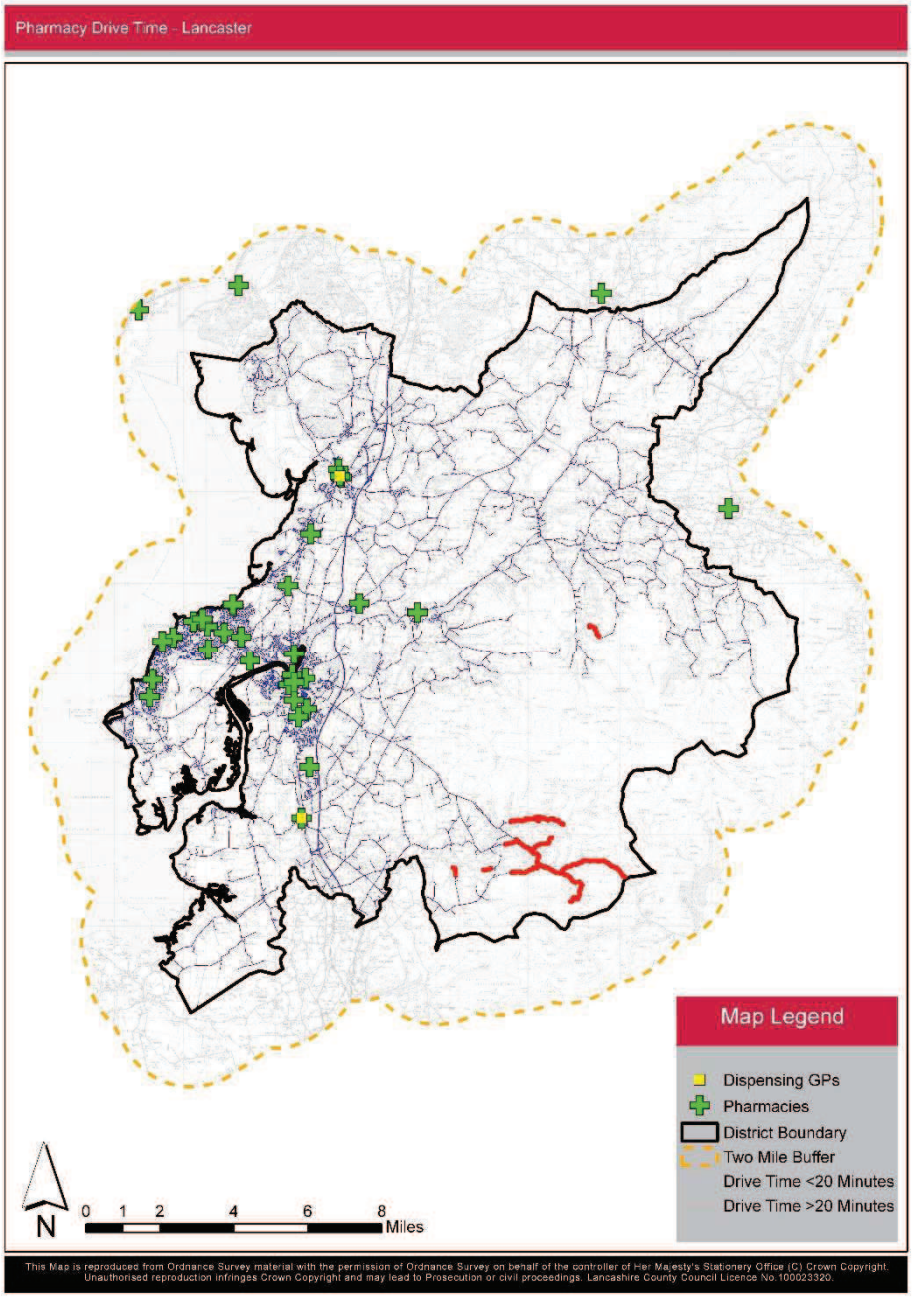
Map 40. Pharmacies within a 20 minute drive – Fylde



Lancaster

As is clearly evident from the map majority of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies. Note: While there are pockets of road networks more than 20 minutes away from a pharmacy or dispensing surgery by car, these are rural areas and mainly uninhabited.

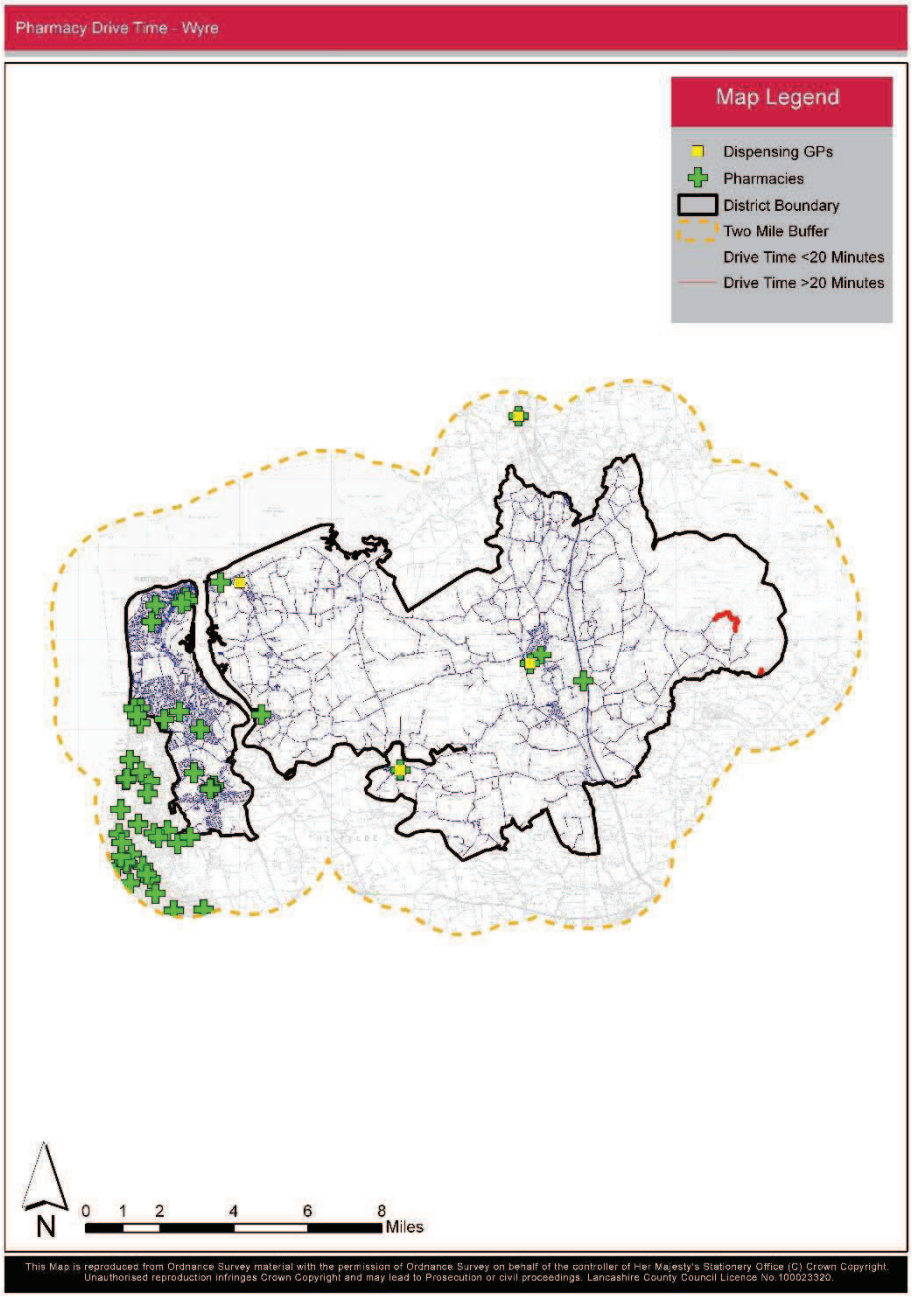
Map 41. Pharmacies within a 20 minute drive – Lancaster



Wyre

As is clearly evident from the map majority of the road networks are within 20 minutes travelling distance from a pharmacy. This demonstrates that within the district there is good coverage of pharmacies. Note: While there are pockets of road networks more than 20 minutes away from a pharmacy or dispensing surgery by car, these are rural areas and mainly uninhabited.

Map 42. Pharmacies within a 20 minute drive – Wyre



4.2.2 Border areas

There are 12 other HWBs with borders close to Lancashire. These areas have pharmacies that are accessible to the residents who live near the borders of the county.

Maps 6 to 17 show pharmacies which are over the border and within the 2 mile radius from East, Central and North Lancashire districts.

4.2.3 Opening hours: community pharmacies

Central Lancashire

There are currently 95 Pharmacies open for 40 hours, 17 '100 hour' pharmacies, one ESPLPS contracts and four distance-selling contracts in Lancashire. The 100 hours contracts are included in the pharmaceutical list under regulation 13(1)(b) of the National Health Service (Pharmaceutical Services) Regulations 2005;[iv] premises which the applicant is contracted to open for at least 100 hours per week for the provision of pharmaceutical services.

The 100 hour pharmacies are:

HBS Pharmacy	St Mary's Road	Bamber Bridge	Preston	PR5 6JD
HBS Pharmacy (Penwortham Healthcare Ltd)	St Fillans Medical Centre	1 Liverpool Road	Preston	PR1 0AD
Leyland Late Night Pharmacy	6 Hough Lane	Leyland	Lancs	PR25 2SD
MedicX	5 Acerswood Close	Coppull	Lancs	PR7 5EN
MedicX Pharmacy	13-17 Peel Street	Chorley	Lancashire	PR7 2EY
Sainsburys In-store Pharmacy	Cuerden Way	Bamber Bridge	Preston	PR5 6BJ
Tesco In-store Pharmacy	Tesco Extra	Ackhurst Industrial Estate, Foxhole Road	Chorley	PR7 1NW
Tesco In-store Pharmacy	Tesco Extra	Towngate, Leyland	Preston	PR25 2FN
Tesco stores Ltd	In store pharmacy, Ordnance Rd	Buckshaw Village	Chorley	PR7 7EL
Cottam Pharmacy	Cottam Lane Surgery	Ashton	Preston	PR2 1JR
HBS Pharmacy	Issa Medical Centre	St Gregory Road	Preston	PR1 6YA
M X Pharmacy	51-53 Longridge Road	Ribbleton	Preston	PR2 6RE
New Hall Lane Pharmacy	270 New Hall Lane		Preston	PR1 5XB
Ribble Village Pharmacy	200 Miller Road	Preston		PR2 6NH
Asda Pharmacy	Ingram	Skelmersdale		WN8 6LA
Aspire Pharmacy	9 Railway Road		Ormskirk	L39 2DN
Fishlocks Chemist	60 Liverpool Road North	Burscough	Ormskirk	L40 4BY

Overall, out of 117 community pharmacies, 49 (42%) are open after 6pm and 29 (25%) are open after 7pm on weekdays; 87 (74%) open on Saturdays; and 23 (21%) open on Sundays. These findings are similar to those in the previous PNA. The locations of pharmacies currently open on a Saturday or a Sunday are illustrated in Maps 43 to 46.

While we have adequate coverage of 100 hour pharmacies across Lancashire, it needs to be better advertised as patients may find it difficult to find this information.

East Lancashire

There are currently 79 Pharmacies open for 40 hours,17 '100 hour' pharmacies, one ESPLPS contracts and six distance-selling contracts in Lancashire. The 100 hours contracts are included in the pharmaceutical list under regulation 13(1)(b) of the National Health Service (Pharmaceutical Services) Regulations 2005,[iv] premises which the applicant is contracted to open for at least 100 hours per week for the provision of pharmaceutical services.

The 100 hour pharmacies are:

Accrington Late Night Pharmacy	188 Blackburn Road	Accrington		BB5 0AQ
Asda Pharmacy	Corporation Street	Colne		BB8 8LW
Asda Pharmacy	Hyndburn Road	Accrington		BB5 1QR
Asda Pharmacy	St Marys Way	Rawtenstall		BB4 8EL
Brierfield's Late Night Chemist	19A Chapel Street	Brierfield		BB9 5HJ
Burnley Late Night Pharmacy	36b Colne Road	Burnley		BB10 1LG
Nelson Pharmacy	41 Every Street	Nelson		BB9 7LU
Oswaldtwistle Pharmacy	300 Union Road	Oswaldtwistle	Accrington	BB5 3JD
Sainsbury's Pharmacy	Windy Bank	Colne		BB8 9HY
St Peters Pharmacy	St Peters Centre,	Church Street	Burnley	BB11 2DL
Tesco Instore Pharmacy	Queen Street	Great Harwood		BB6 7AU
Tesco Instore Pharmacy	Wyre Street	Padiham	Burnley	BB12 8DQ
Tesco Instore Pharmacy	Bury Road	Rawtenstall		BB4 6DD
Tesco Instore Pharmacy	2 Eagle Street	Accrington		BB5 1LN
Tesco Pharmacy	Haslingden Road	Haslingden		BB4 6LY
The Co-operative Pharmacy	13 Market Street	Colne		BB8 0LJ
The Co-operative Pharmacy	406 Blackburn Road	Accrington		BB5 1SA

Overall, out of 103 community pharmacies, 38 (37%) are open after 6pm and 21 (20%) are open after 7pm on weekdays; 73 (71%) open on Saturdays; and 22 (21%)

open on Sundays. These findings are similar to those in the previous PNA. The locations of pharmacies currently open on a Saturday or a Sunday are illustrated in Maps 47 to 51.

North Lancashire

There are currently 68 Pharmacies open for 40 hours, six '100 hour' pharmacies and one ESPLPS contract in Lancashire. The 100 hours contracts are included in the pharmaceutical list under regulation 13(1)(b) of the National Health Service (Pharmaceutical Services) Regulations 2005;[iv] premises which the applicant is contracted to open for at least 100 hours per week for the provision of pharmaceutical services.

The 100 hour pharmacies are:

Asda Pharmacy	Dock Street	Fleetwood	Lancashire	FY7 6NU
Kepple Lane Pharmacy	Kepple Lane	Garstang	Lancashire	PR3 1PB
Ash Trees Pharmacy	Market Street	Carnforth	Lancashire	LA5 9JU
Dalton Square Pharmacy	24 - 26 Great John Street	Lancaster	Lancashire	LA1 1NG
Sainsburys Pharmacy	Cable Street		Lancaster	LA1 1HH
Sainsburys Pharmacy	Christie Park	Morecambe	Lancashire	LA4 5TJ

Overall, out of 75 community pharmacies, 24 (32%) are open after 6pm and 9 (12%) are open after 7pm on weekdays; 48 (64%) open on Saturdays; and 14 (19%) open on Sundays. These findings are similar to those in the 2011 PNA. The locations of pharmacies currently open on a Saturday or a Sunday are illustrated in maps 52 to 54.

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

Currently 40 pharmacies are contractually obliged to open for 100 hours per week due to the conditions on their application. This inevitably means that they are open until late at night and at the weekend. There is a risk that if the regulations for these contracts were to change that they may reduce their hours. This could significantly reduce the availability of pharmacies within Lancashire that are available on late night and weekends.

Lancashire HWB has not identified needs that would require provision of a full pharmaceutical service for all time periods across the week. However, maintaining

the current distribution of 100 hour/longer opening pharmacies is important to maintain out of hours access for the population of the borough.

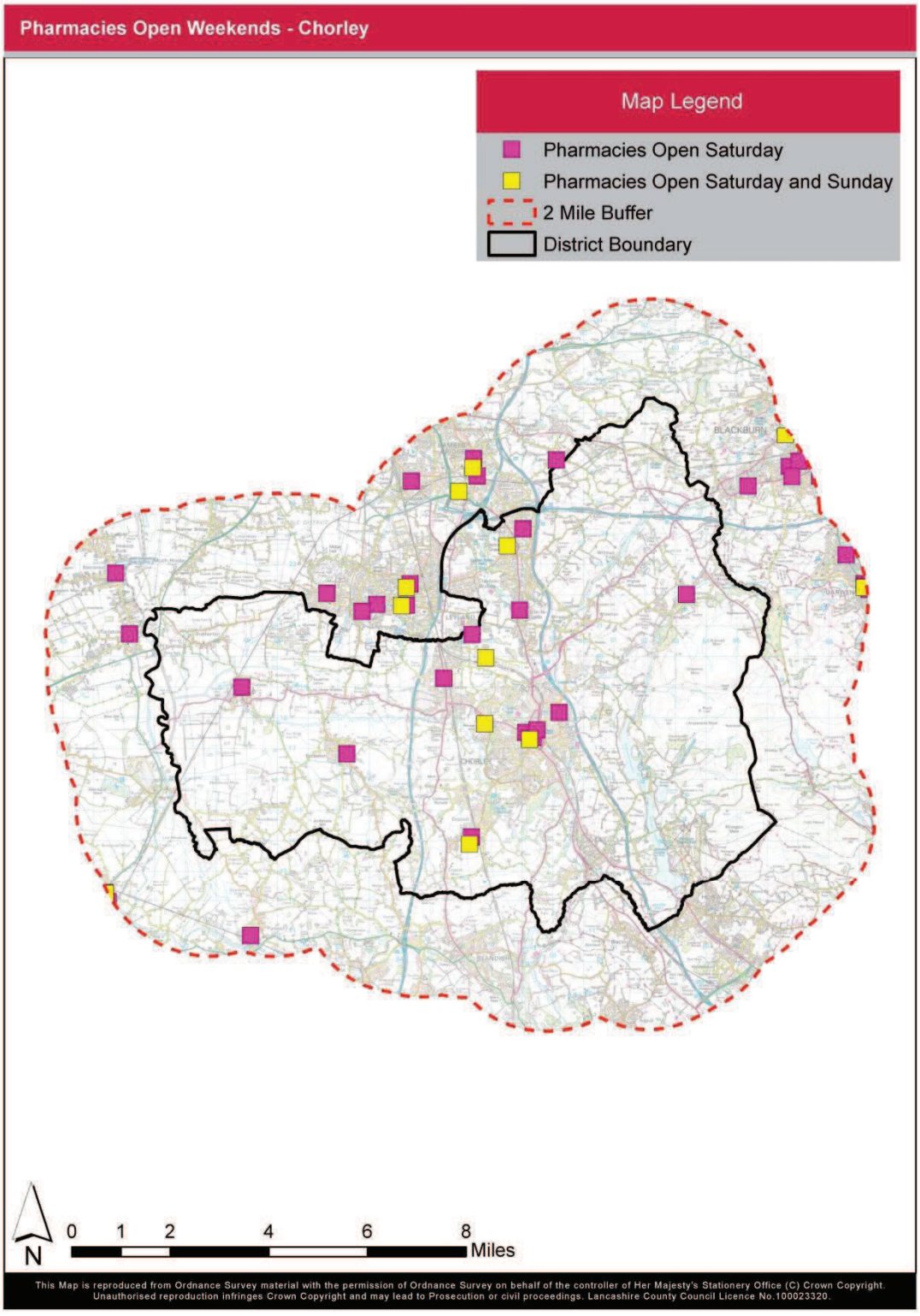
Since the introduction of the pharmaceutical contractual framework in 2005, community pharmacies do not need to participate in rota provision to provide access for weekends or during the evening. The need for such a service has been greatly reduced by the increased opening hours of a number of pharmacies including the 100 hours pharmacies. Despite this, there can still be a gap in contracted hours to cover statutory holidays.

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

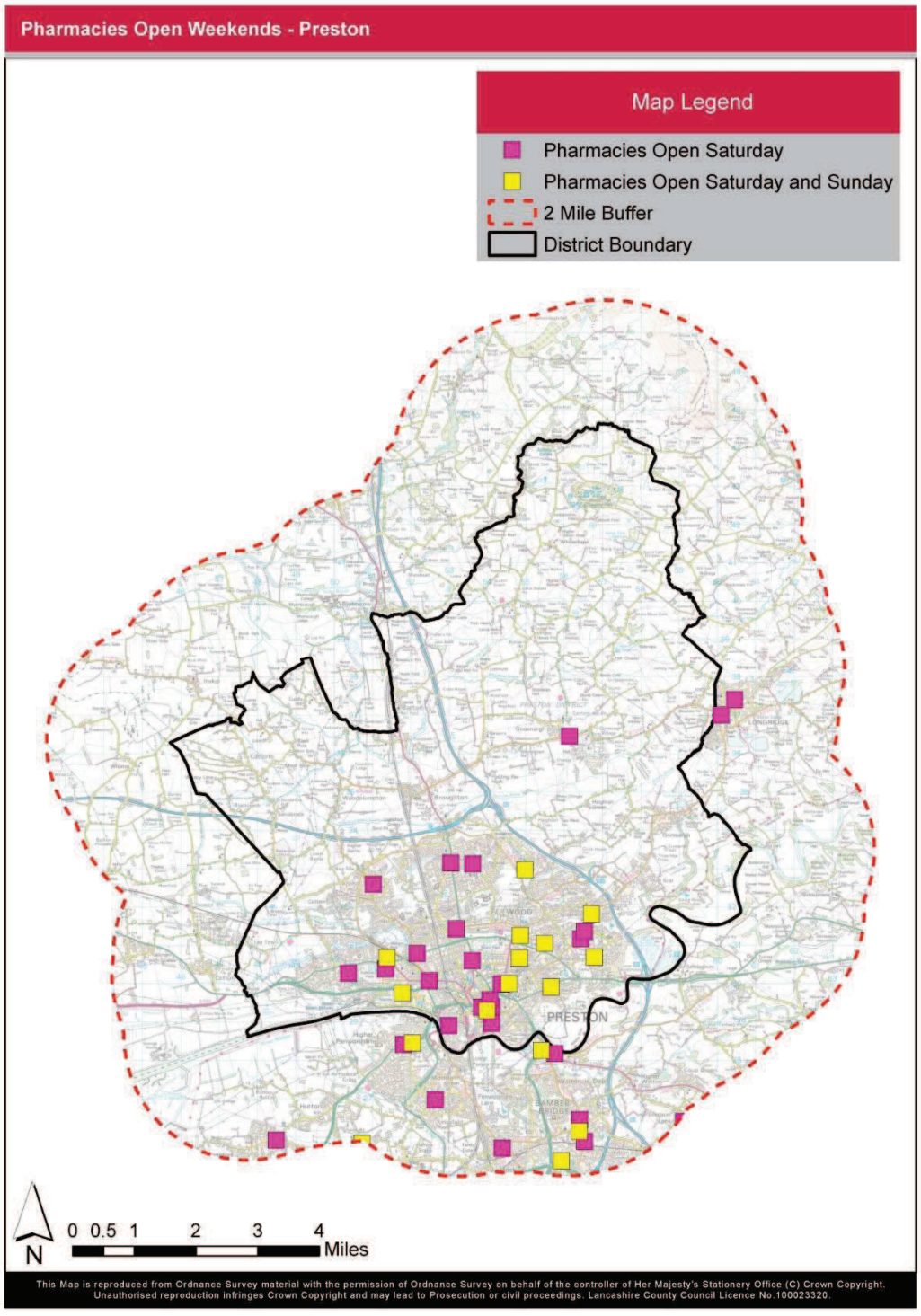
Maps 43 to 54 show the Saturday and Sunday opening times of pharmacies in the districts of the three localities.

- Map 43 to 46 show Saturday and Sunday opening times in the districts of East Lancashire
- Maps 47 to 51 show Saturday and Sunday opening times in the districts of Central Lancashire
- Maps 52 to 54 show Saturday and Sunday opening times in the districts of North Lancashire

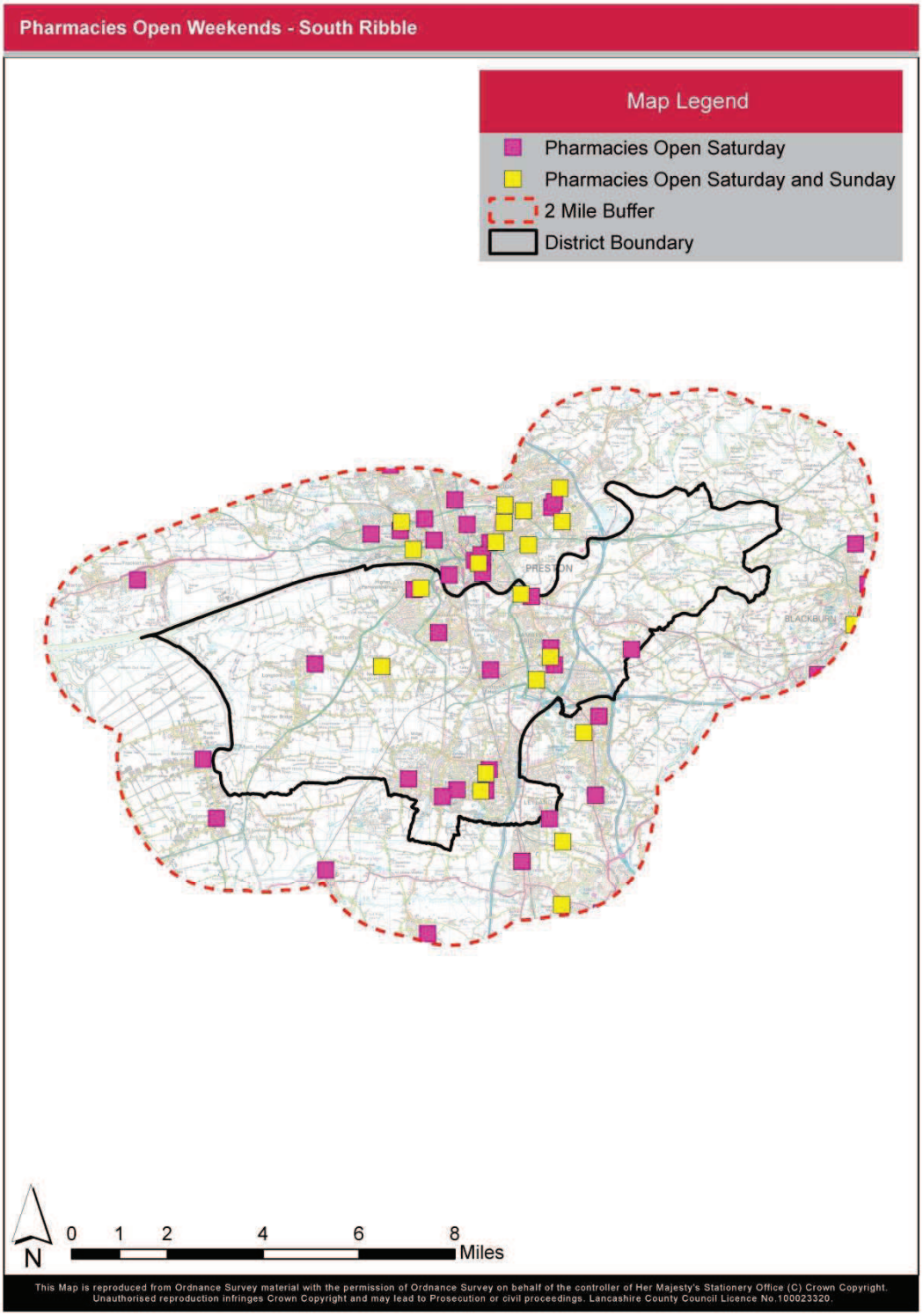
Map 43. Saturday and Sunday opening times of pharmacies located in Chorley



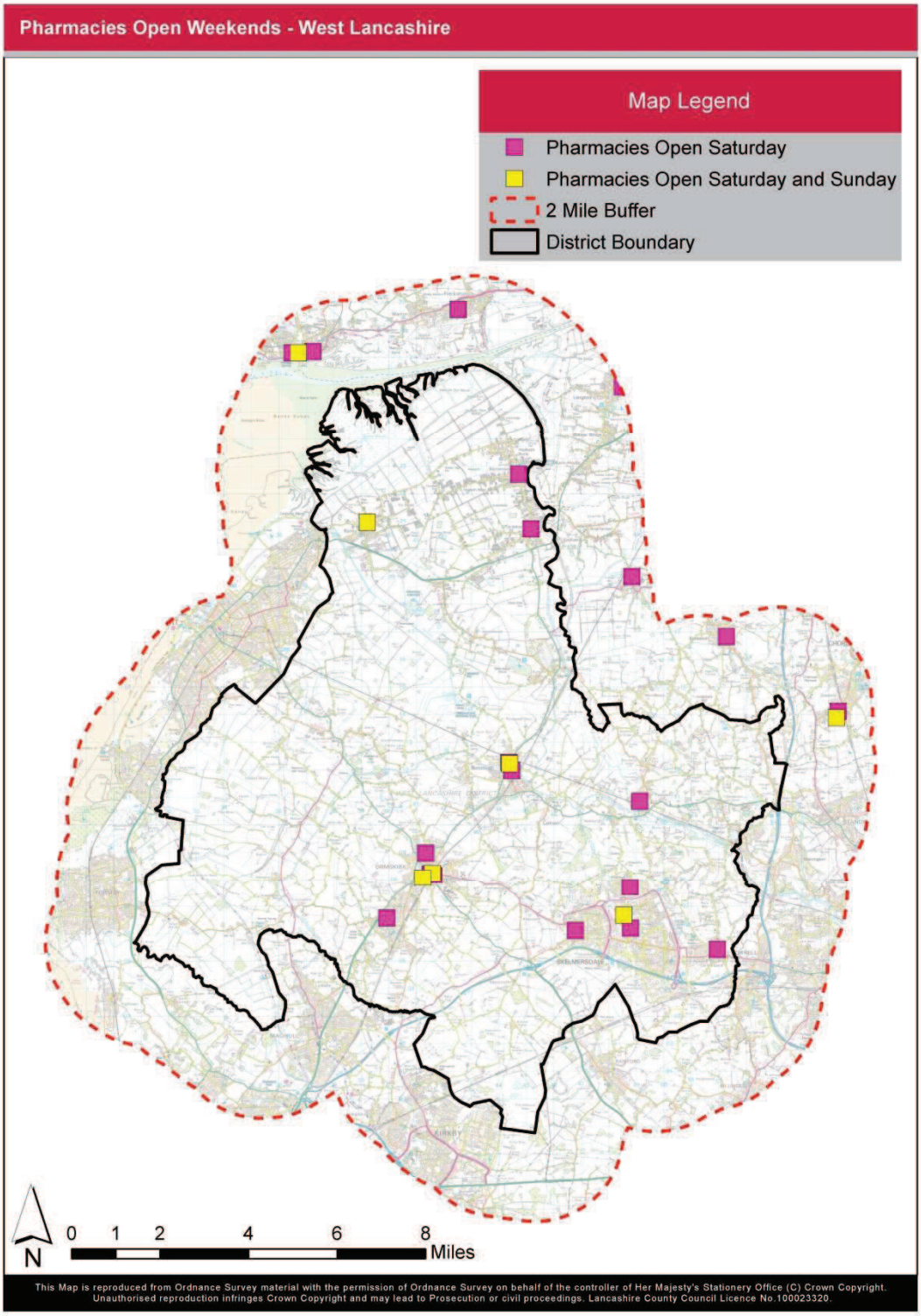
Map 44. Saturday and Sunday opening times of pharmacies located in Preston



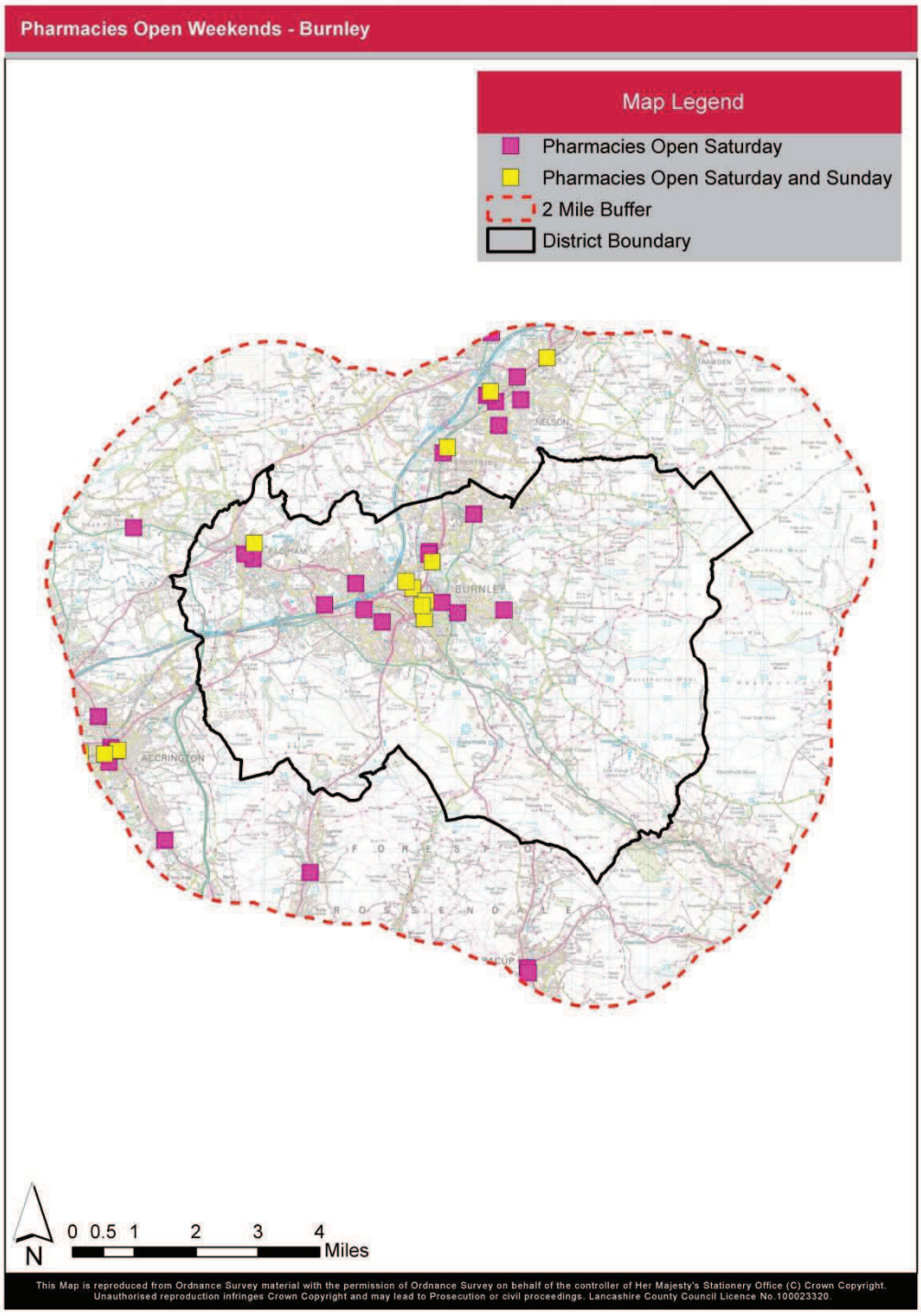
Map 45. Saturday and Sunday opening times of pharmacies located in South Ribble



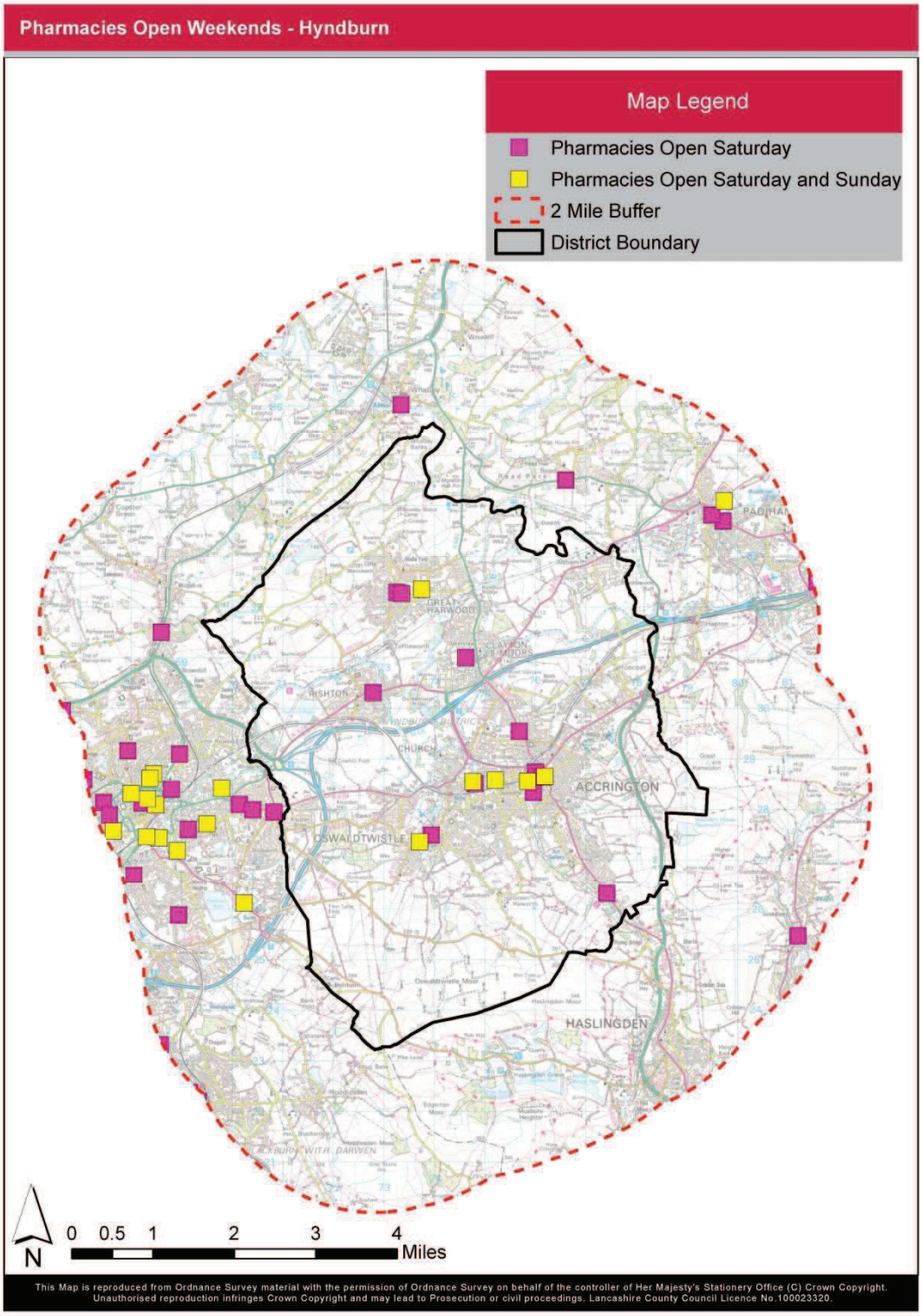
Map 46. Saturday and Sunday opening times of pharmacies located in West Lancashire



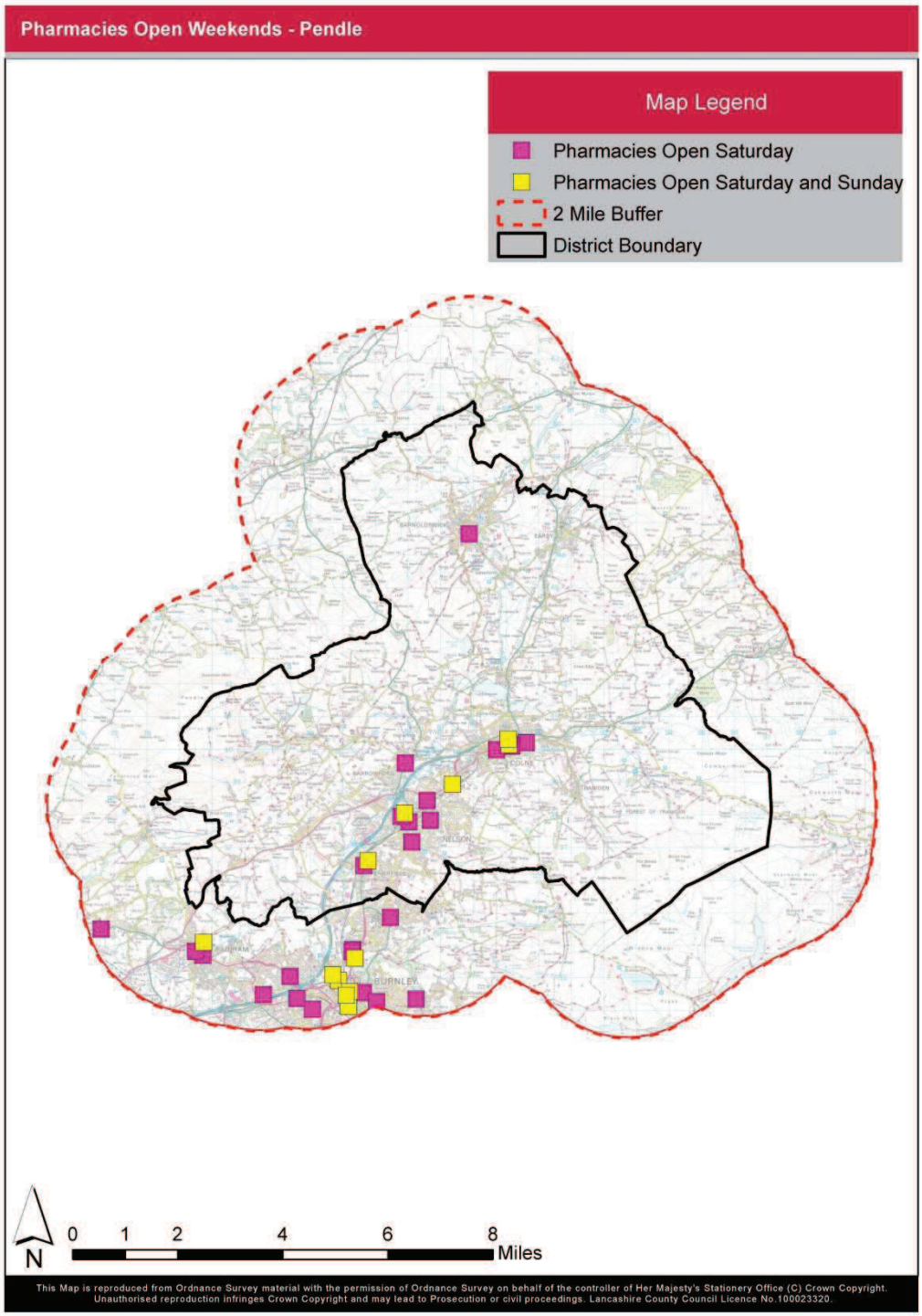
Map 47. Saturday and Sunday opening times of pharmacies located in Burnley



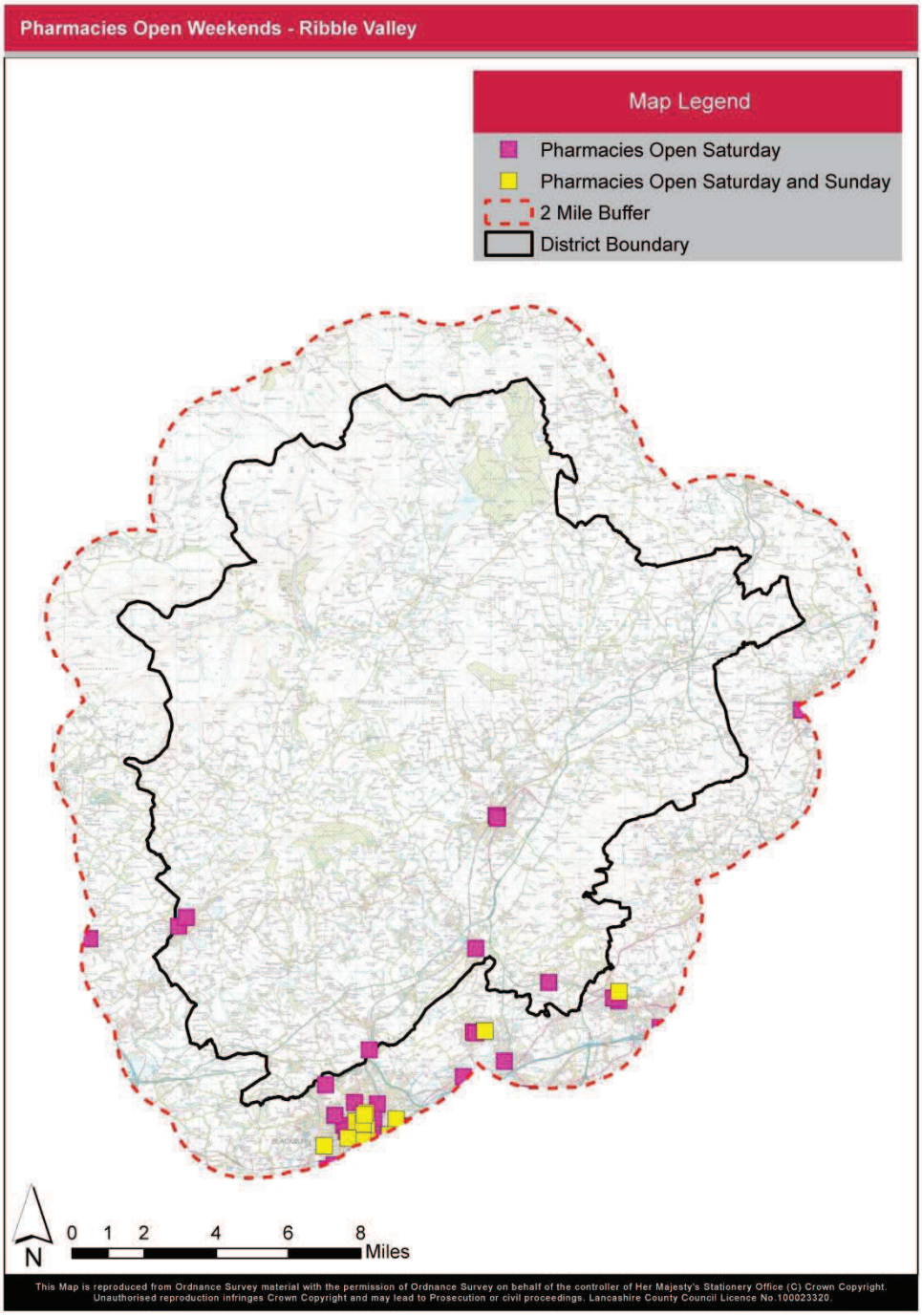
Map 48. Saturday and Sunday opening times of pharmacies located in Hyndburn



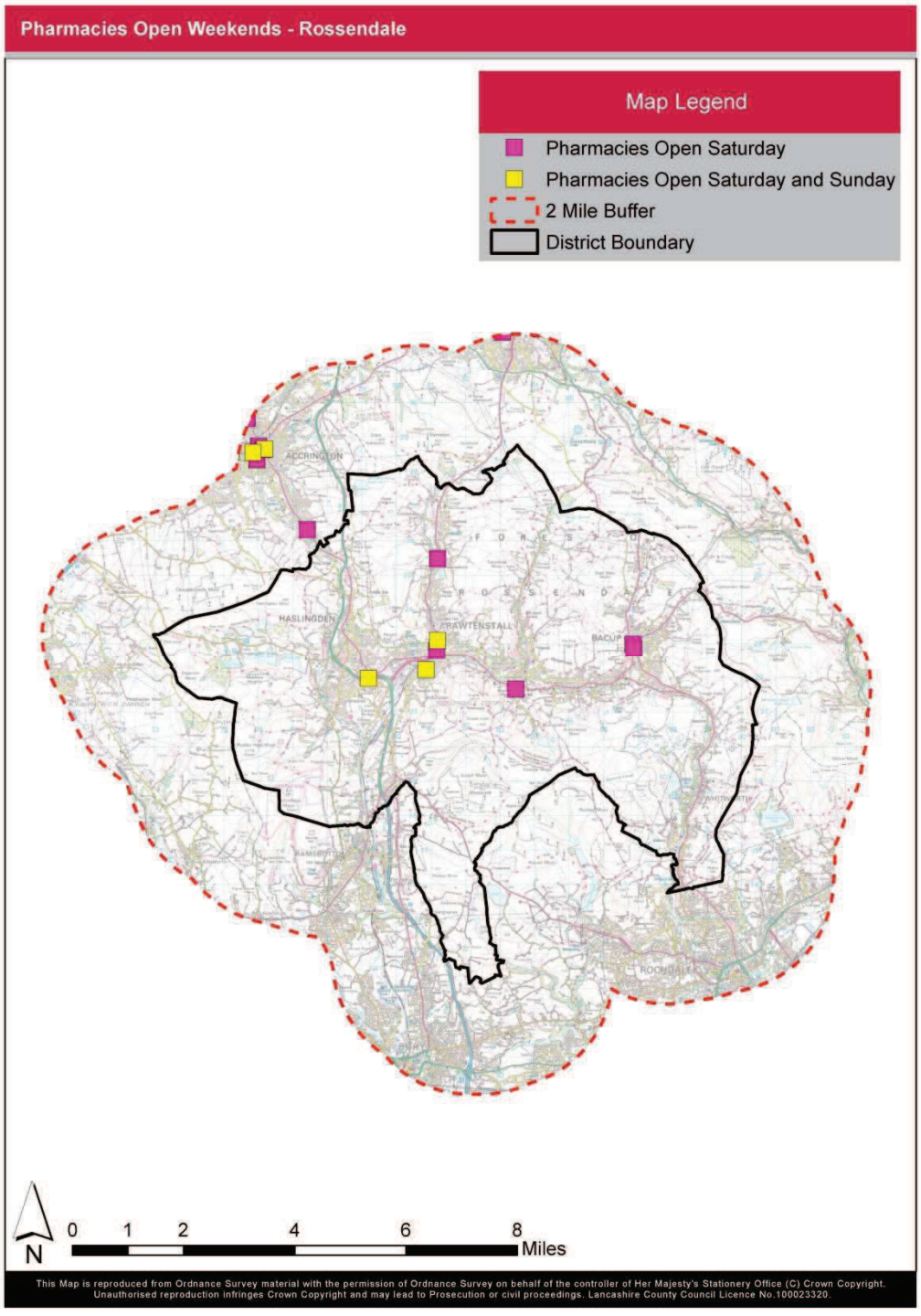
Map 49. Saturday and Sunday opening times of pharmacies located in Pendle



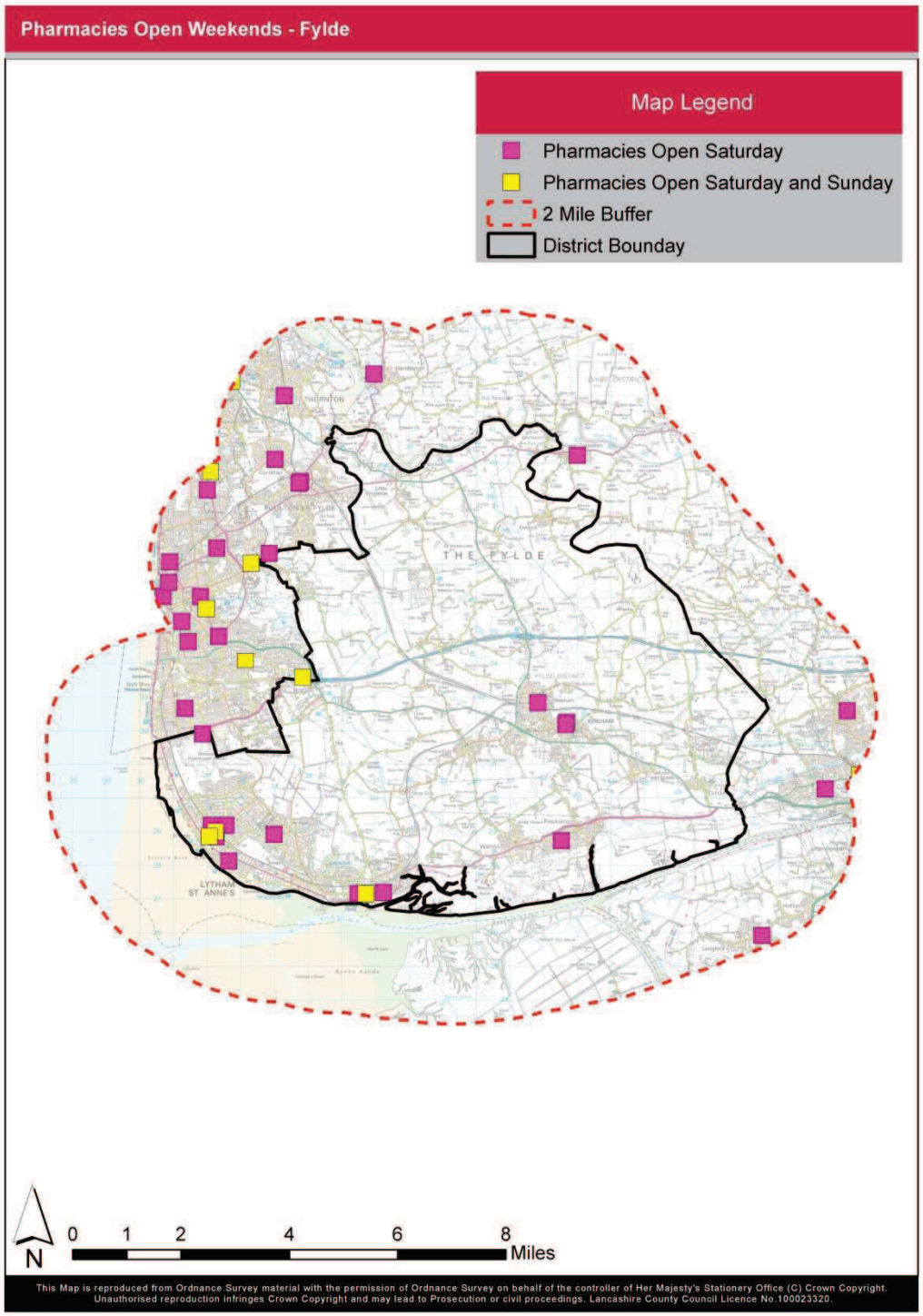
Map 50. Saturday and Sunday opening times of pharmacies located in Ribble Valley



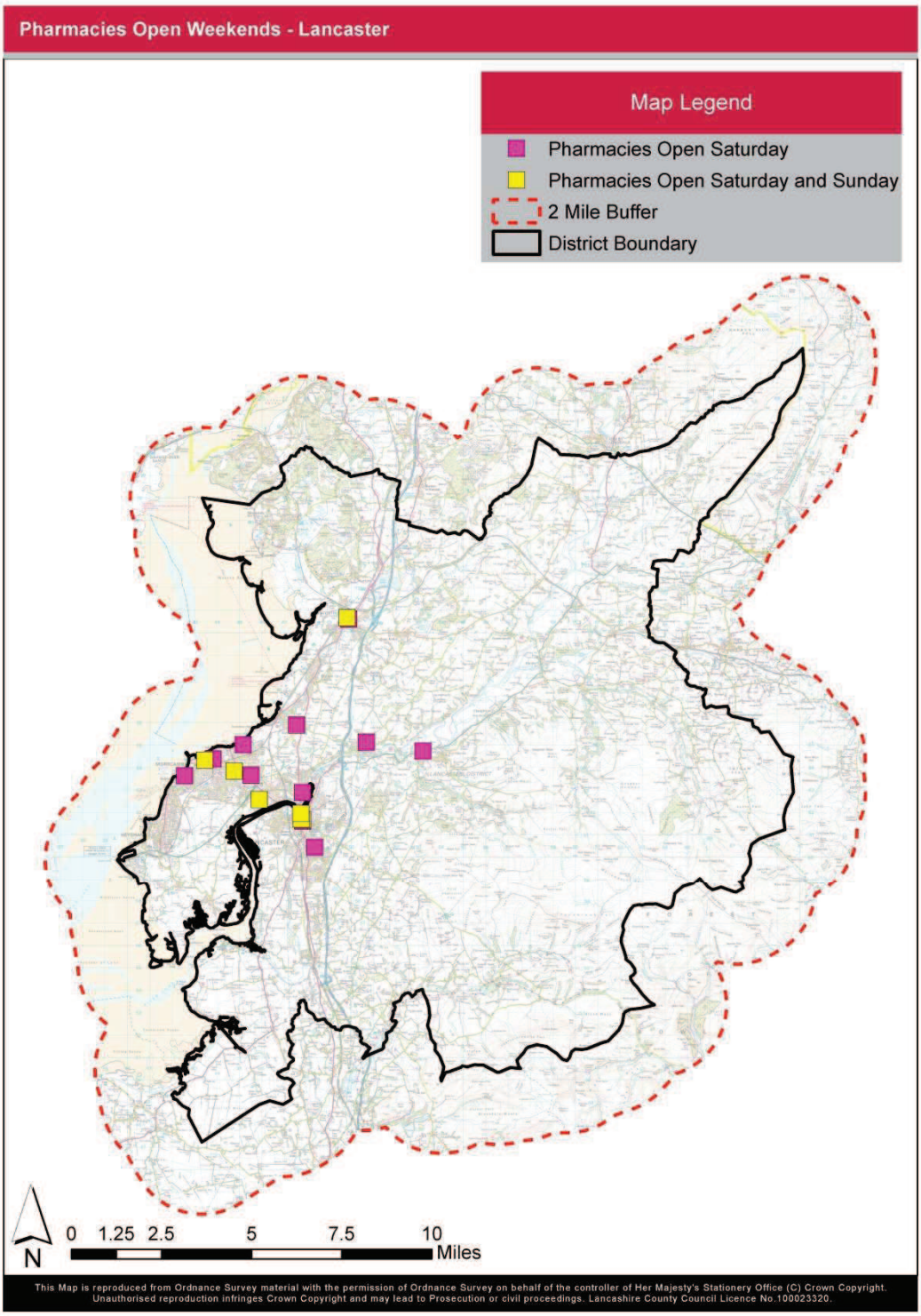
Map 51. Saturday and Sunday opening times of pharmacies located in Rossendale



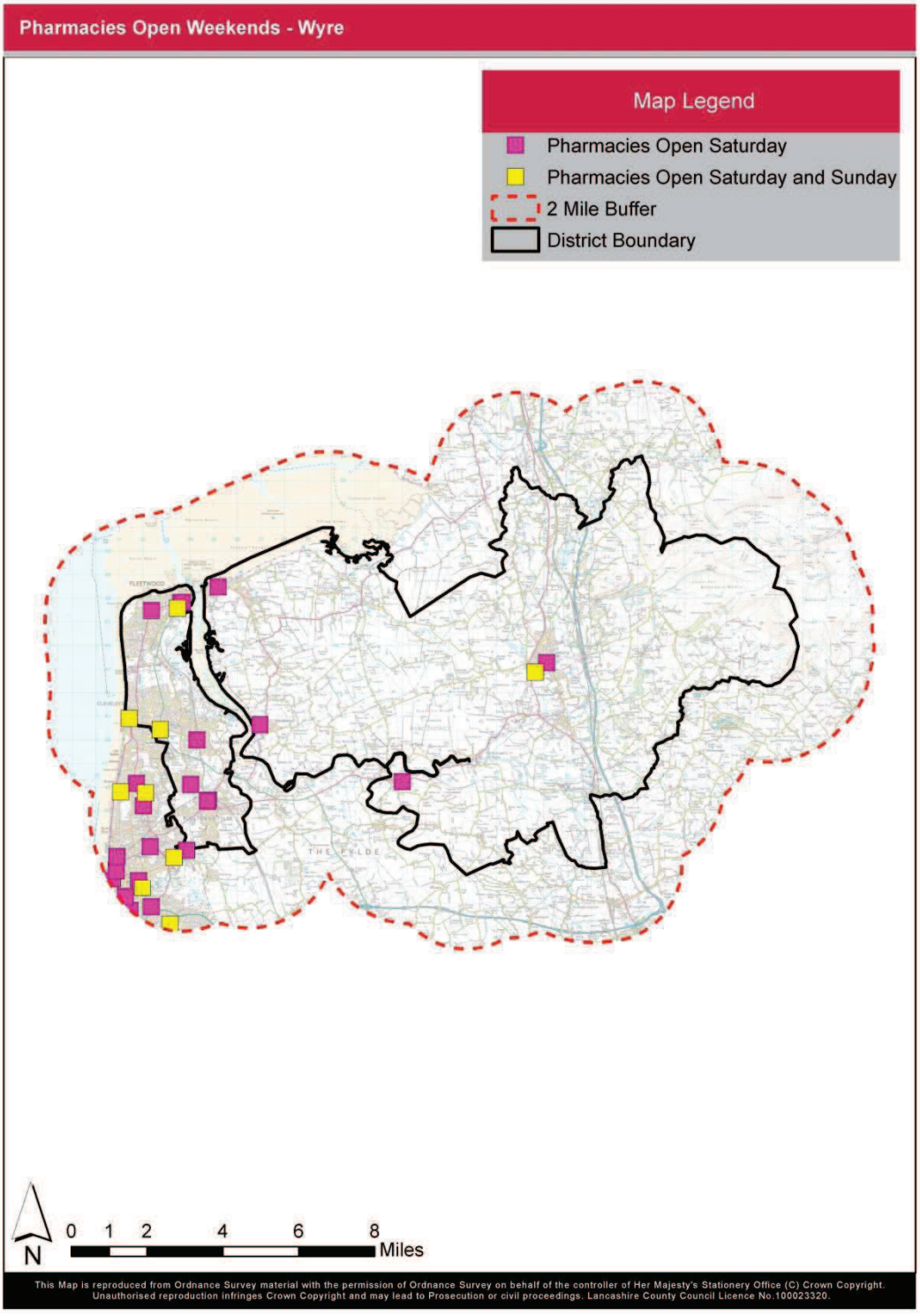
Map 52. Saturday and Sunday opening times of pharmacies located in Fylde



Map 53. Saturday and Sunday opening times of pharmacies located in Lancaster



Map 54. Saturday and Sunday opening times of pharmacies located in Wyre



4.2.4 Access for people with disabilities

The questionnaire sent to pharmacies included a question asking if any consultation facilities existed on site and if they included wheelchair access. The results showed that 155 of the 188 pharmacies (82.4%) have consultation areas with wheelchair access. 80 of the 188 (42.6%) stated they would be willing to undertake consultations in a patient's home or other suitable venue. 168 of the 188 (89.4%) stated they would deliver dispensed medicines free of charge on request.

4.3 Community Pharmacy Essential Services

Community Pharmacies provide three tiers of Pharmaceutical Services:

- Essential Services – services all pharmacies are required to provide.
- Advanced Services – services to support patients with safe use of medicines.
- Enhanced Services – services that can be commissioned locally by NHS England.

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

Essential services are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework.[xiv] Essential services include dispensing appliances, repeat dispensing, clinical governance, public health (promotion of healthy lifestyles), disposal of unwanted medicines, signposting and support for self-care.

The essential services are specified by a national contractual framework that was agreed in 2005. All community pharmacies are required to provide all the essential services. NHS England is responsible for ensuring that all pharmacies deliver all of the essential services as specified. Each pharmacy has to demonstrate compliance with the community pharmacy contractual framework by providing sufficient evidence for delivery of every service. This is monitored by NHS England.

All community pharmacies in Lancashire are currently compliant with the contract to date.

4.3.1 Public health campaigns

At the request of NHS England, NHS pharmacists are required to participate in up to six campaigns each year to promote public health messages to their users.[xv] Where requested to do so by NHS England the NHS pharmacist records the number of people to whom they have provided information as part of one of those campaigns.

The Community Pharmacy Contractual Framework identifies that pharmacies have to carry out 6 Public Health Campaigns over a 12 month period – this service provision is part of the overall pharmacy contract which is commissioned by NHS England. Historically the Public Health Campaigns delivered by community pharmacies were part of the contractual agreements with the Medicines Management Department supported by the Public Health Team in the Primary Care Trust.

To gain consistency, the 6 public health campaigns for 14/15 have been agreed across Pan Lancashire (Blackpool, Blackburn with Darwen and Lancashire County Council) as below:

- April-May – Lung Cancer awareness,
- June-July – Road Safety,
- Aug-Sep – Healthy Weight,
- Oct-Nov – Stoptober,
- Dec-Jan – Alcohol / Dry January,
- Feb-March – Mental Health /5 ways to Wellbeing

It is not stipulated that Public Health should provide the Pharmacies with the resources for each campaign. However for each campaign a briefing sheet of the key Public Health messages linked to pharmacies will be produced and links to where pharmacies can obtain posters and resources. For campaigns where we have resources available these will be distributed to the pharmacies.

It is expected that campaign material, either sourced by the contractor or provided by a commissioner should be displayed in a prominent area within the pharmacy. Pharmacists and pharmacy staff should actively take part in, and contribute to the campaigns for patients (and general pharmacy visitors) during the campaign period, including giving advice to people on the campaign issues.

4.4 Advanced Services

In addition to essential services the community pharmacy contractual framework allows for advanced services, which currently include Medicines Use Reviews (MUR), Appliance Use Reviews (AUR), New Medicines Service (NMS) and the Stoma Customisation Service (SCS). A pharmacy can choose to provide any of these services as long as they meet the requirements that are set out in the Secretary of State Directions. [xvi]

Further guidance has been issued to community pharmacists to conduct MURs on patients who are taking medications known to increase the risk of hospitalisation through complications with their medications, including: Non-steroidal Anti-Inflammatory drugs, Warfarin, Methotrexate and other Disease-Modifying Anti-Rheumatic Drugs (DMARDs), Insulin, Anti-Epileptics and Parkinson's drugs.

New Medicines Service Review was commissioned in 2011 and is currently being reviewed nationally to identify if it will continue in 2015.

Central Lancashire

In 2013-2014, of the 117 pharmacies in Central Lancashire, 113 contractors provided the Medicines Use Review Service with the mean average of MURs undertaken being 259 per contractor per year. The maximum number of MURs per contractor per year is 400.

In 2013-2014, of the 117 pharmacies in Central Lancashire, 102 contractors provided the New Medicines Service Review with the mean average of NMS Reviews undertaken being 60 per contractor per year.

East Lancashire

In 2013-2014, of the 103 pharmacies in East Lancashire, 94 contractors provided the Medicines Use Review Service with the mean average of MURs undertaken being 271 per contractor per year. The maximum number of MURs per contractor per year is 400.

In 2013-2014, of the 103 pharmacies in East Lancashire, 80 contractors provided the New Medicines Service Review with the mean average of NMS Reviews undertaken being 85 per contractor per year.

North Lancashire
In 2013-2014, of the 75 pharmacies in North Lancashire, 69 contractors provided the Medicines Use Review Service with the mean average of MURs undertaken being 277 per contractor per year. The maximum number of MURs per contractor per year is 400.

In 2013-2014, of the 75 pharmacies in North Lancashire, 62 contractors provided the New Medicines Service Review with the mean average of NMS Reviews undertaken being 84 per contractor per year.

4.5 Enhanced Services

Such services can only be referred to as Enhanced Services if they are commissioned by NHS England. If local services are commissioned by CCGs or local authorities, they are referred to as locally commissioned services or local improvement services.

The only pharmacy enhanced service commissioned from any willing pharmacy provider across the county, excluding distance selling pharmacies, is the seasonal flu vaccination service.

Central Lancashire
In 2013/14 21% (25) providers signed service level agreements to deliver the seasonal flu service. In total 682 patients were vaccinated from a total of 22 providers.

East Lancashire
In 2013/14 19% (20) providers signed service level agreements to deliver the seasonal flu service. In total 141 patients were vaccinated from a total of 18 providers.

North Lancashire
In 2013/14 15% (11) providers signed service level agreements to deliver the seasonal flu service. In total 116 patients were vaccinated from a total of 10 providers.

4.6 Local Improvement Services

In 2013/14 Public Health commission community pharmacies to deliver the following services;

- Needle exchange
- Supervised consumption
- Stop smoking service
- Nicotine replacement voucher scheme
- Emergency hormonal contraception

Not all pharmacies provide each service. Public Health commissioners provide service provision where there is the greatest of need.

These will be discussed in more detail in chapter 5.

5 Health Needs and Locally Commissioned Services

Key messages

Providers of pharmaceutical services have an important role to play in improving the health of local people. They are easily accessible and are often the first point of contact, including for those who might otherwise not access health services.

Community pharmacies can contribute to the health and wellbeing of the local population in a number of ways, including motivational interviewing, providing information and brief advice, providing on-going support for behaviour change and signposting to other services.

Commissioners are recommended to commission service initiatives in pharmacies around the best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation.

In Lancashire, commissioning from community pharmacy has been varied across the county and although work is on-going to try and standardise commissioned community pharmacy services across the county, for some services inequalities do remain.

Three of the four Lancashire Stop Smoking Services (East, Central and West) have been using a Pharmacy NRT Voucher Scheme since 2009. The scheme has recently been extended to North Lancashire in 2014/15 and community pharmacies are currently being recruited to the scheme.

Of the 295 pharmacies across Lancashire signed up to LIS agreements, 215 provide chlamydia testing and EHC.

Many pharmacies across the county provide dispensing for prescriptions issued for the management of substance misuse problems, supervised consumption of prescribed medication and needle and syringe exchange.

A Lancashire Healthy Living Pharmacy programme prospectus has been drawn up that local pharmacy contractors are invited to sign up to. Healthy Living Pharmacy is an identified priority in the Local Professional Network (Pharmacy)(LPN) work plan and is accountable to the LPN for roll out and delivery of the plan.

The Royal Pharmaceutical Society (RPS) recommends that pharmacists collaborate with each other and with other healthcare professions, to develop models of care which enable commissioners to deliver integrated patient pathways, and ensure patients have consistent access to support with medicines use as they move between care settings. This could be particularly relevant for frail older people and those with multiple conditions.

There may be potential opportunities for pharmacies relating to the needs of the health of the population. However, it should be recognised that there could be other non-pharmacy providers who can also provide these services.

5.1 A focus on the role of community pharmacy in improving public health

5.1.1 Local contributions to improving health and reducing inequalities

The NHS Community Pharmacy Contractual Framework requires community pharmacies to contribute to the health needs of the population they serve. There are opportunities for local service commissioning to build on the services provided as essential services. Pharmacies are able to bid for locally commissioned health improvement programmes, along with other non-pharmacy providers. Lancashire HWB considers community pharmacies a key public health resource and recognises that they offer potential opportunities to provide health improvement initiatives and work closely with partners to promote health and wellbeing, as recommended by the Local Government Association (LGA). [xvii]

The Public Health Strategy for England (2010) states that "Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities." [xviii]

LGA report Community Pharmacy: local government's new public health role states that community pharmacy and local government share several common purposes:

- Public health – e.g. promoting good sexual health and reducing substance misuse.
- Support for independent living – through healthy lifestyle advice and support with using medicines correctly.
- Making every contact count – through health promotion intervention and signposting.
- Core business – investment, employment and training in local communities.

The LGA report recommends that local commissioners consider the Healthy Living Pharmacy model and how it could be used to help improve health and reduce inequalities (see section HLP section 5.19).

5.1.2 Evidence based approach

The NHS Confederation report Health on the high street: *rethinking the role of community pharmacy*[xix] recommends that a strong evidence base underpins commissioning of public health services from community pharmacy. The Department of Health recently invited the submission of research proposals to determine and evaluate the role of Community Pharmacy in public health. This invitation stated that "whilst the evidence for pharmacy's contribution to public health is growing, there are gaps, and there is a clear requirement for good quality research to be carried out to determine and evaluate the contribution of a pharmacy where the evidence is missing or less strong. [xx]

5.1.3 Opportunities for integrated care

In the Royal Pharmaceutical Society (RPS) report *Now or never: shaping pharmacy for the future*[xxi] RPS recommends that pharmacists must collaborate with each other and with other healthcare professions, to develop models of care which enable commissioners to deliver integrated patient pathways, and ensure patients have consistent access to support with the use of medicines as they move between care settings. The NHS Confederation report Health on the high street: rethinking the role of community pharmacy also highlights the importance

of integrating the role of a community pharmacy with that of other elements of the health and public health system. The report emphasises the value of strong information flows between providers and commissioners. In developing commissioning and estate strategies, consideration could be given to how pharmacy services could be better integrated with health and social care and other public services, for example through co-location.[xxii]

5.1.4 Developing the workforce

The LGA report suggests that health and social care workforce strategy includes consideration of the pharmacy workforce and its training needs, including its role as a potential employer in deprived and rural communities. It proposes that there may be opportunities for greater integration and joint workforce training, for example of healthcare assistants and health champions. RPS is also developing Professional Standards for Public Health Practice for Pharmacy[xxiii] for pharmacy teams to promote the delivery of high quality public health services in pharmacy settings.

5.2 What will this chapter discuss?

This chapter considers local needs, local services and discusses the local services offered.

5.2.1 Local health needs

Children, adults and the elderly are all vulnerable to the risk factors that contribute to preventable non-communicable diseases, whether from unhealthy diets, physical inactivity, exposure to tobacco smoke or the effects of the harmful use of alcohol.

Overall Lancashire has a favourable health profile but, compared to the national average, substantial local variation exists within the county. Lifestyle related diseases such as diabetes are increasing. An ageing population with a range of health issues will also put pressure on health and social services. The JSNA describes specific health needs in detail.

Table 6 shows male and female life expectancy at birth compared to the national average. Although there is wide variation, most of the districts in Lancashire have significantly lower life expectancy than the national average. For males, seven of the districts have significantly lower life expectancy than average and for females, eight districts are worse than average. Only Ribble Valley has life expectancy significantly better than average for both males and females and South Ribble has better than average life expectancy for males. In the most deprived areas of Lancashire life expectancy is 9.9 years lower for men and 7.6 years lower for women[xxiv].

Table 6: Life expectancy at birth by district (2010-12)		
Significantly lower than England	Not significantly different from England	Significantly higher than England
Area	**Male**	**Female**
Burnley	75.7	80.5
Chorley	79.0	81.9
Fylde	79.1	82.8
Hyndburn	76.5	81.0
Lancaster	77.4	82.2
Pendle	77.9	81.7
Preston	77.4	81.0
Ribble Valley	80.5	84.0
Rossendale	77.6	81.6
South Ribble	80.1	82.8
West Lancashire	78.7	82.5
Wyre	78.2	81.8
Lancashire	78.2	82.0
England	**79.2**	**83.0**
Source: Life expectancy JSNA http://www.lancashire.gov.uk/corporate/web/?siteid=6117&pageid=35407&e=e		

5.2.2 Overview of local services

These are a number of local services commissioned from community pharmacies by public Health LCC and CCGs to support the local public health agenda. However, it is to note that ***commissioning from community pharmacy has been varied across the county*** and although work is on-going to try and standardise commissioned community pharmacy services across the county, for some services inequalities do remain. Community pharmacies are easily accessible and can offer a valuable opportunity for reaching people who may not otherwise access health services. Community pharmacies can contribute to the local public health agenda in a number of ways, including but not limited to:

- Motivational interviewing
- Providing education, information and brief advice
- Providing on-going support for behaviour change
- Signposting to other services or resources
- Long acting reversible contraception

A range of services are commissioned in Lancashire, including the following:

- NRT Voucher Scheme (commissioned by LCC)
- Chlamydia Screening and Treatment (commissioned by LCC)
- Emergency Hormonal Contraception (commissioned by LCC)
- Needle and Syringe Exchange Service (commissioned by LCC)
- Supervised Administration Service (commissioned by LCC)
- Minor Ailments Service (Chorley & South Ribble, East Lancashire, Greater Preston, West Lancashire CCG)

- Palliative care service (Chorley & South Ribble, East Lancashire, Fylde & Wyre, Greater Preston, West Lancashire CCG). East Lancashire CCG -stock holding & provision of specialists drugs in palliative care. Fylde & Wyre CCG - Just in Case Palliative Care Service.

  Appendix 4 shows list of pharmacies (as at June 2014).

Some local services are not commissioned but are provided on 'goodwill', see below and link to site:

- Healthy Start is a UK - wide government scheme to improve the health of low-income pregnant women and families on benefits and tax credits. http://www.healthystart.nhs.uk/for-health-professionals/

Community pharmacies are a provider of national NHS pharmaceutical services and must comply with the contractual framework introduced in 2005. The national contract for community pharmacy consists of 3 different levels of services: Essential services, advanced services and enhanced services.

All community pharmacies must provide essential services. Advanced services require pharmacists and their premises to be accredited in order for them to be able to provide the service and enhanced services are commissioned services in response to local population needs as part of an overall strategy to ensure, safe effective, fairer and more personalised care.

The range of services provided by community pharmacies varies due to several factors, including: availability of accredited pharmacists, capacity issues in the pharmacy, changes to service level agreements and the need for a service (for example, in response to pandemic flu).

5.3 Smoking

5.3.1 Local health needs

Smoking remains the single, greatest cause of preventable illness and death from respiratory disease, circulatory disease and cancer, responsible for 1,673 deaths each year in adults aged 35 years and over in Lancashire alone[xxv]. One in two lifelong users die prematurely as a result of smoking, half of these in middle age. On average, each smoker loses 16 years of life and experiences many more years of ill health than a non-smoker[xxvi].

Smoking rates remain higher in Lancashire than England as a whole in adults[xxvii] (21.2% compared to 20%), pregnant women[xxviii] (16.8% compared to 12.0%) and young people[xxix,xxx]. (16% compared to 11%). Within Lancashire smoking levels vary substantially across districts; from 13.4% in Fylde, to the highest, 30.1% in Hyndburn (see Table 7). In the districts of Burnley, Hyndburn, Lancaster, Pendle, Rossendale and West Lancashire, the rates of smoking are higher than the England average. the difference is only statistically significant for Hyndburn and Pendle. However, two-thirds of smokers (63%) want to quit and welcome support to do so[xxxi].

Table 7: Smoking status in adults in Lancashire and districts, 2012		
Significantly higher than England	Not significantly different from England	Significantly lower than England

Area	% adults smoking
England	19.5
Lancashire	20.6
Burnley	24.7
Chorley	14.2
Fylde	13.4
Hyndburn	30.1
Lancaster	22.4
Pendle	27.0
Preston	18.4
Ribble Valley	15.9
Rossendale	21.0
South Ribble	18.4
West Lancashire	22.5
Wyre	19.8

Source: PHE Public Health Outcomes Framework http://www.phoutcomes.info/

The Tobacco Control Plan for England[xxvi] reasserts the government's commitment to the provision of local Stop Smoking Services tailored to the needs of local communities, particularly groups which have high prevalence, as a contribution to reducing health inequalities in health. There is strong evidence, which demonstrates that Stop Smoking Services are highly effective both clinically and in terms of cost. Smokers are four times more likely to quit with support from a Stop Smoking Service than going it alone[xxxii]. Further to this, Department of Health guidance recommends that all smokers should be routinely offered advice to quit and a referral to the Stop Smoking Service[xxxii].

5.3.2 Local services

Stop smoking support in Lancashire is provided by four Specialist NHS Stop Smoking Services (North Lancashire, West Lancashire and Quit Squad in Central and East Lancashire). Each service provides comprehensive and consistent smoking cessation treatment for all smokers aged 12 years and above in Lancashire who wish to quit. However, specific focus is targeted to geographical areas of high deprivation and to priority groups (routine and manual workers, long-term unemployed, pregnant women and BME groups) in order to reduce health inequalities.

From April 2013 to March 2014, the stop smoking services assisted 11,849 people to set a quit date and 5,929 (50%) to successfully quit.

Three of the four Lancashire Stop Smoking Services (East, Central and West) have been using a **Pharmacy NRT Voucher Scheme** since 2009. The scheme has recently been extended to North Lancashire in 2014/15 and community pharmacies who are expressing an interest (EOI) are currently being recruited to the scheme.

Stop Smoking Advisors issue clients with a voucher to obtain NRT from a Community Pharmacy to enable them to receive NRT on the NHS without the need for a prescription. This provides holistic care to the client whilst reducing the need for unnecessary visits to primary care and GP consultations. Clients exempt from prescription charges may receive

NRT free from participating pharmacies, whilst those clients who are not exempt from prescription charges may also receive NRT at the same cost as a prescription. Each voucher covers between one and four week's supply of NRT and can be issued for up to 14 weeks (2 weeks reduction, 12 weeks quit) per cessation attempt.

Varenicline and Bupropion are not available through the pharmacy enhanced service NRT voucher scheme because these are Prescription Only Medicines and the patient's medical history is required to ensure there are no contra-indications. Therefore the pharmacological assessment, decision for treatment and prescribing of these products is undertaken by the individual's GP practice.

200 pharmacies are currently operating the enhanced service in the Central and East localities. Each one has to complete the 'Stop Smoking – very brief advice' e-package (NCSCT version) and the accredited Centre for Postgraduate Pharmaceutical Education Stop Smoking training to participate in the scheme. They are reimbursed with the Drug Tariff price of each NRT product, plus VAT and a professional fee of £2.62 per voucher from the NHS Staffordshire and Lancashire Commissioning Support Unit (CSU) who manage the contract on behalf of Lancashire County Council.

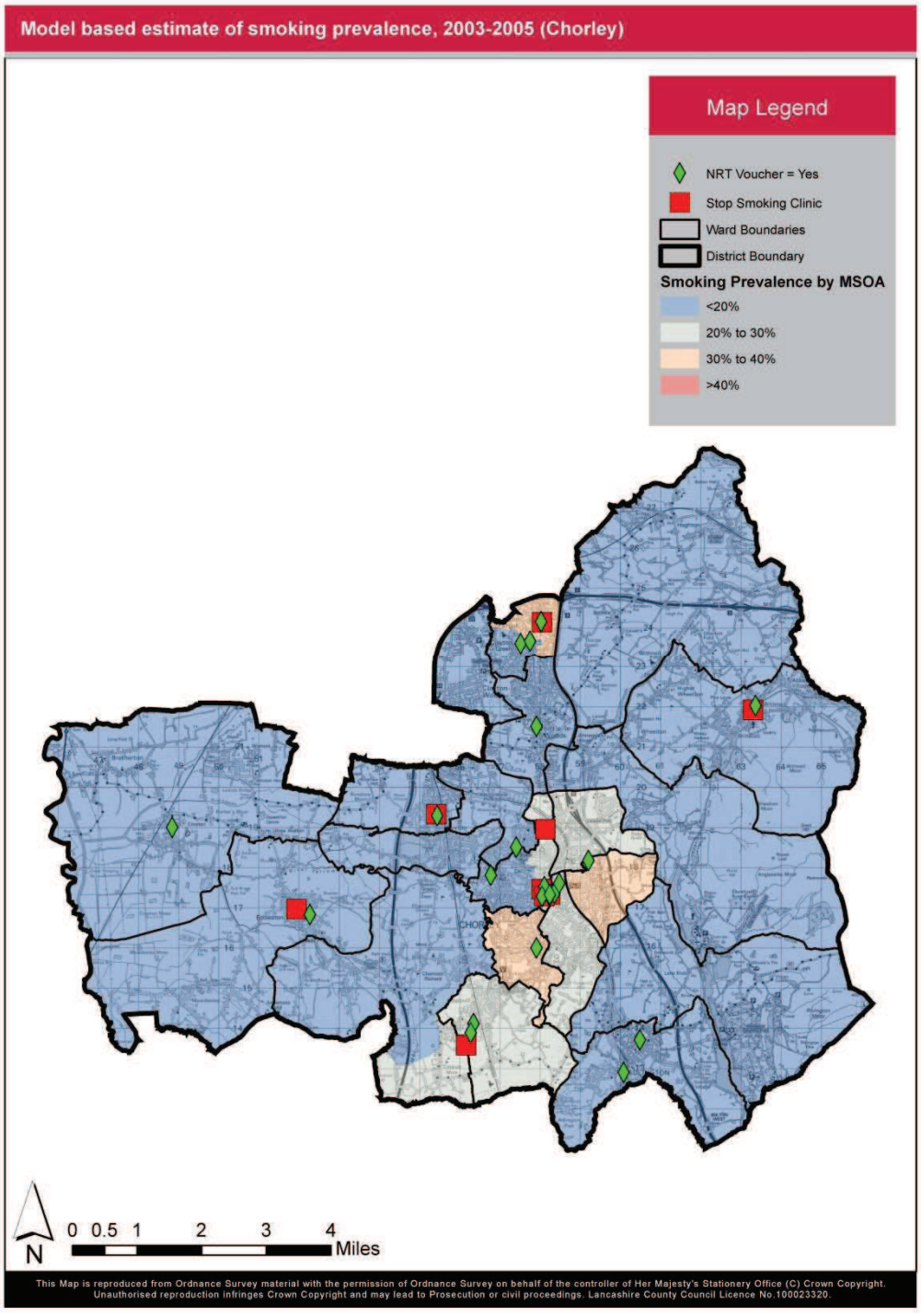
Maps 55 to 66 show the estimated prevalence of smoking, the location of the Stop Smoking Services and pharmacies which are providing or have expressed an interest to provide NRT voucher scheme.

Additionally some pharmacies in East Lancashire CCG are delivering smoking cessation support services. These are sub-contracted by the Specialist Stop Smoking Service, Lancashire Care Foundation Trust.

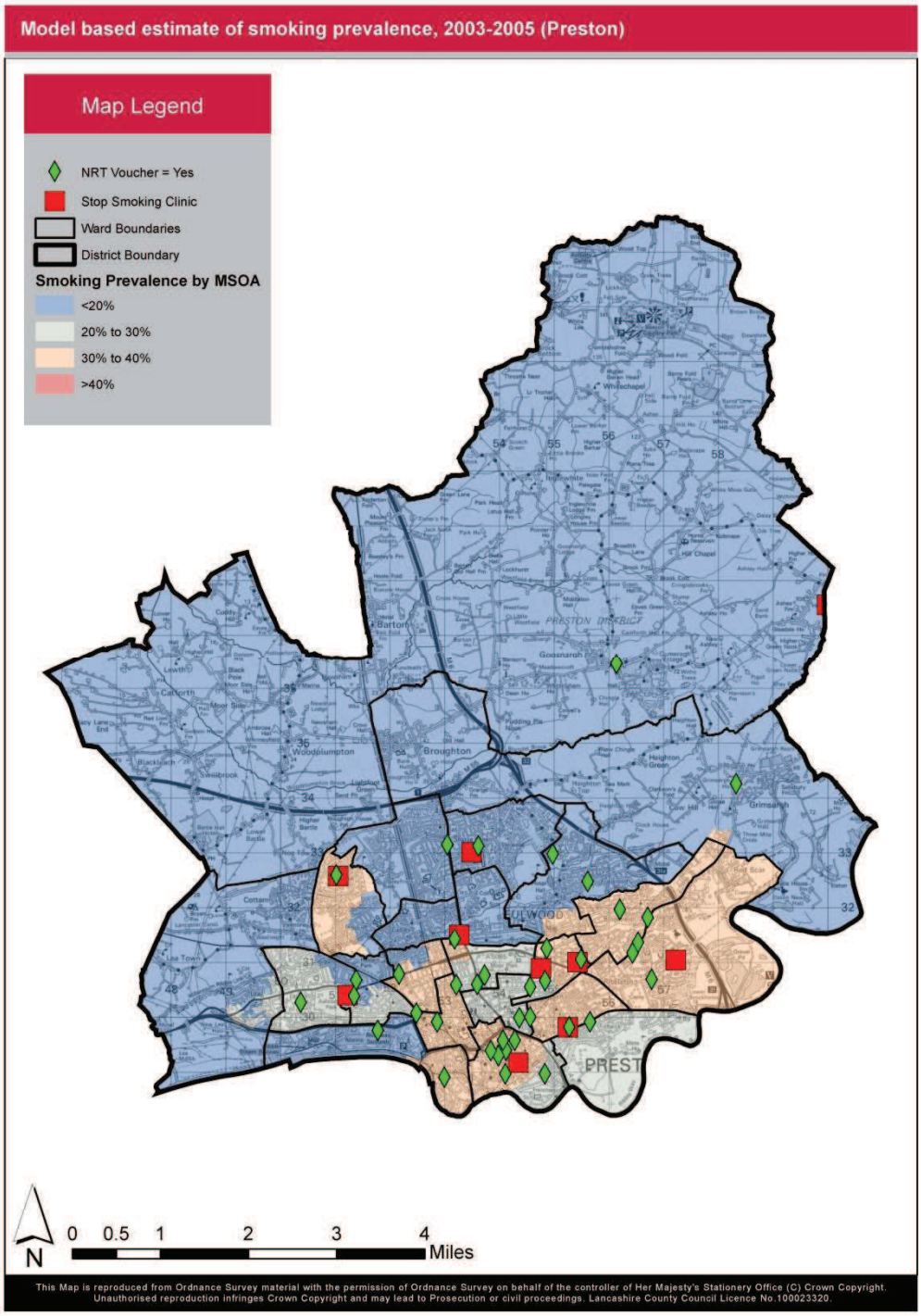
5.3.3 Consideration of services

Pharmacies are well placed to provide stop smoking services which are accessible and located in the community where people need them as part of a model of service which also includes provision in other settings within the community. The current priority for development of the Stop Smoking service is to continue to work with existing pharmacy providers in East Lancashire to market and deliver a high quality and accessible service through pharmacy settings. Other service development priorities over the next 12 months include extending the stop smoking service to pharmacies in Central Lancashire.

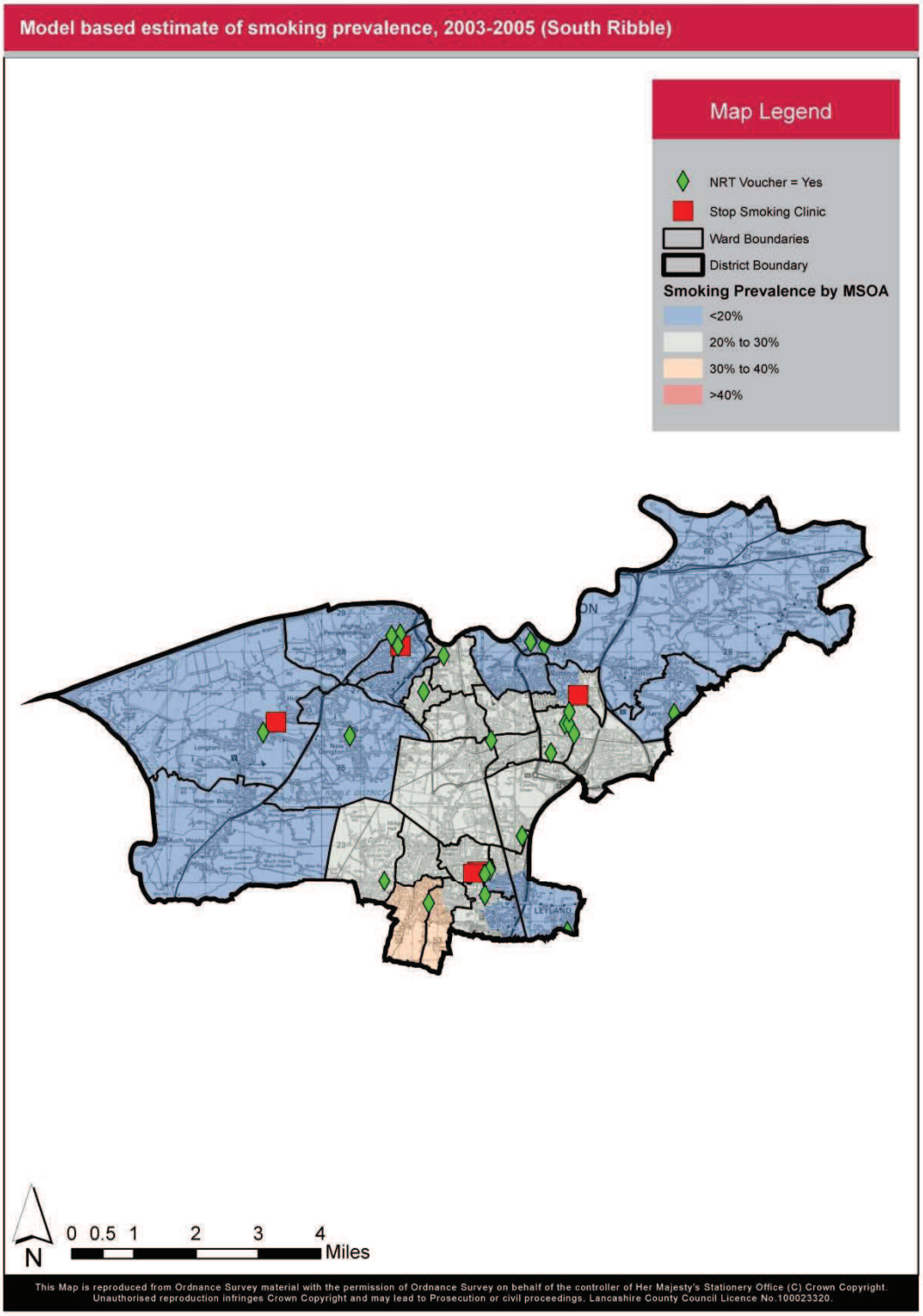
Map 55. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Chorley



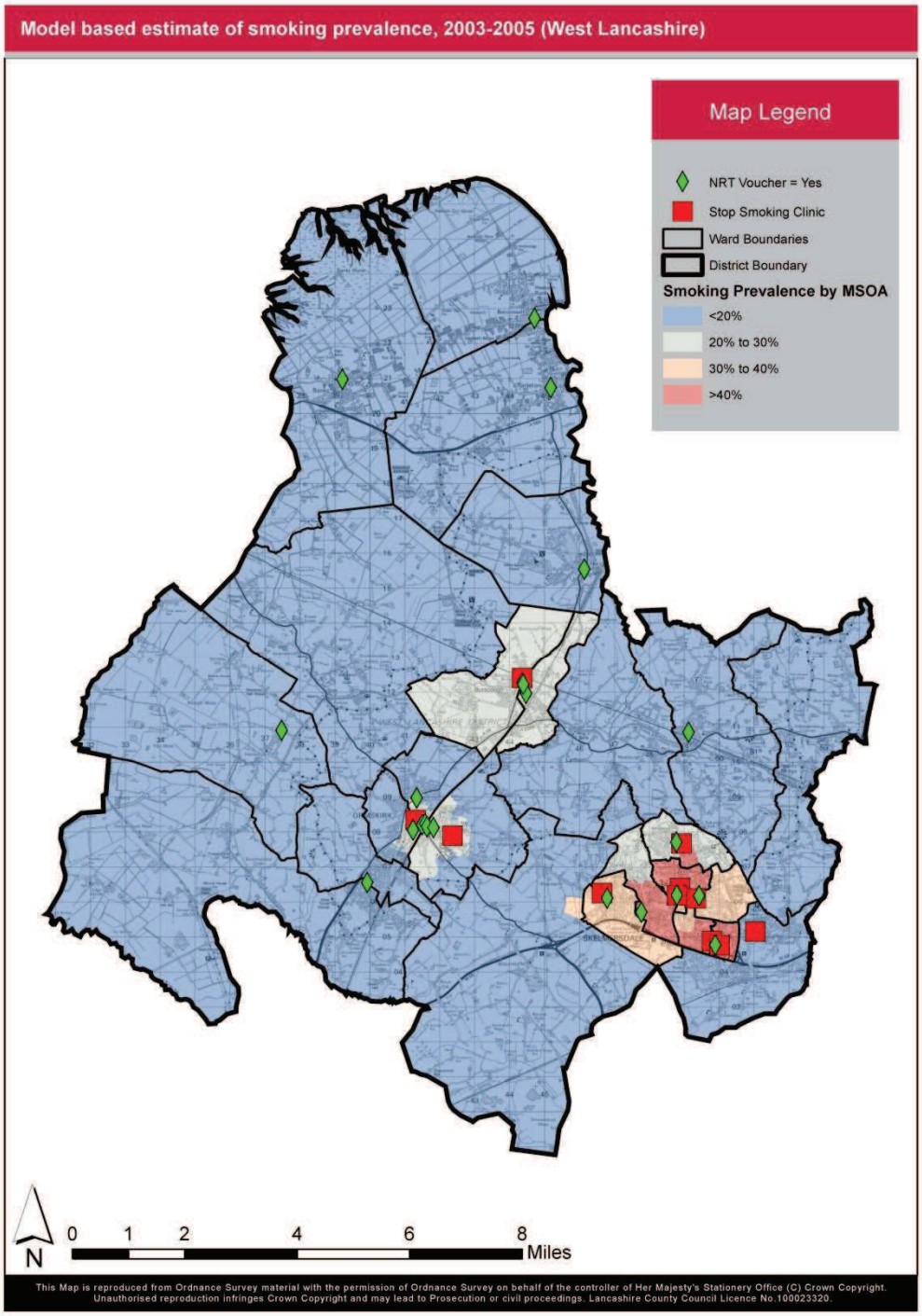
Map 56. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Preston



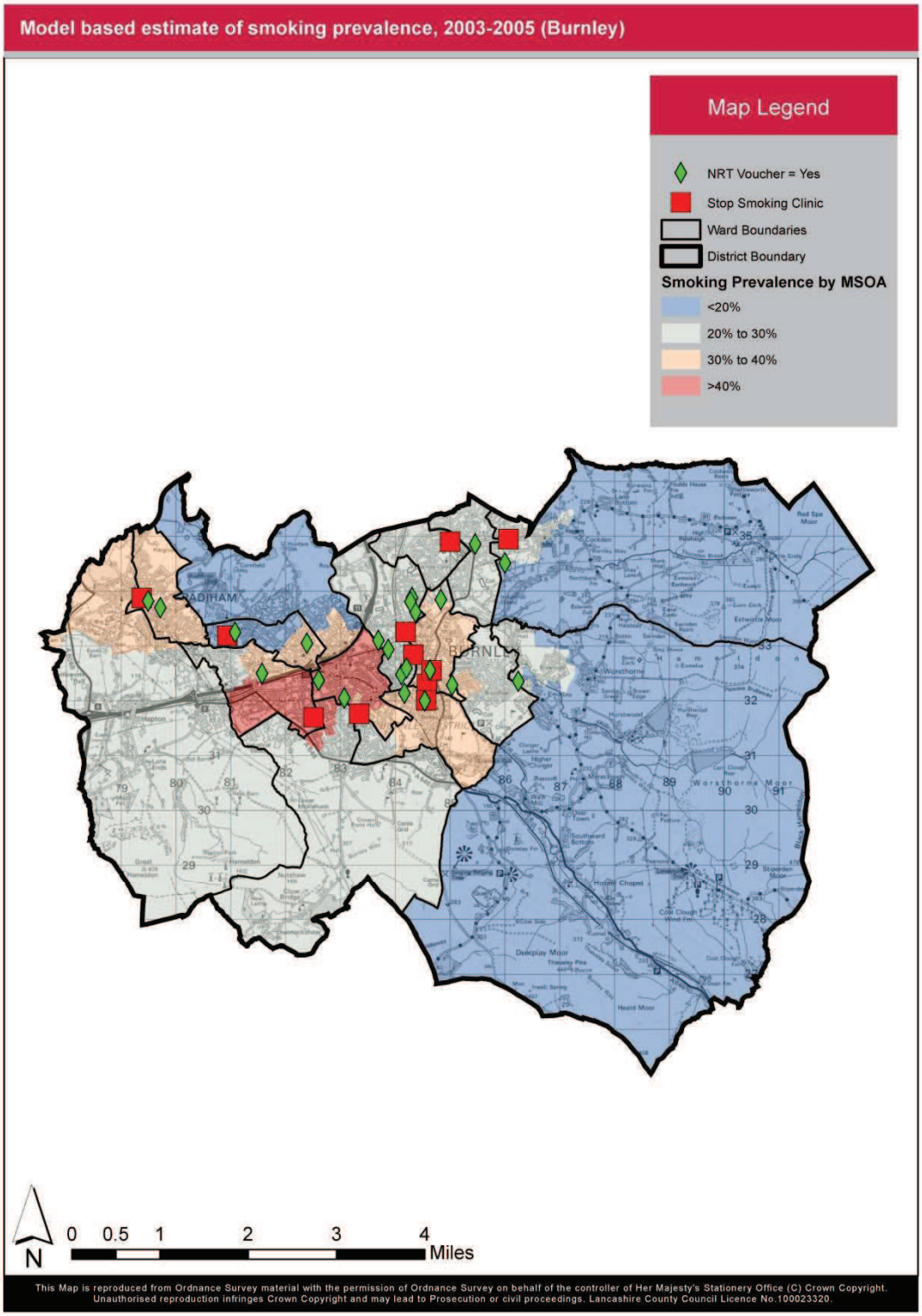
Map 57. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – South Ribble



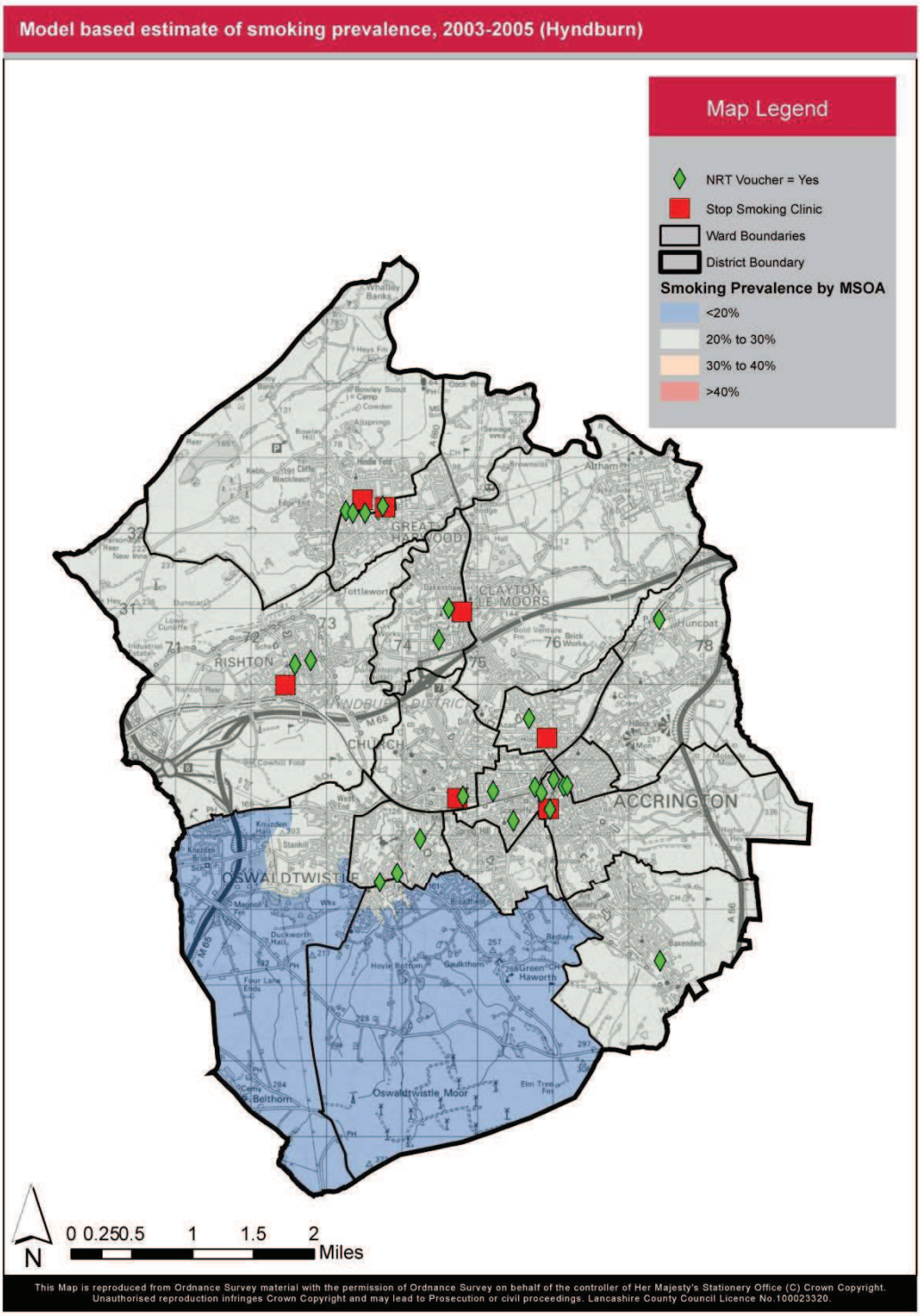
Map 58. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – West Lancashire



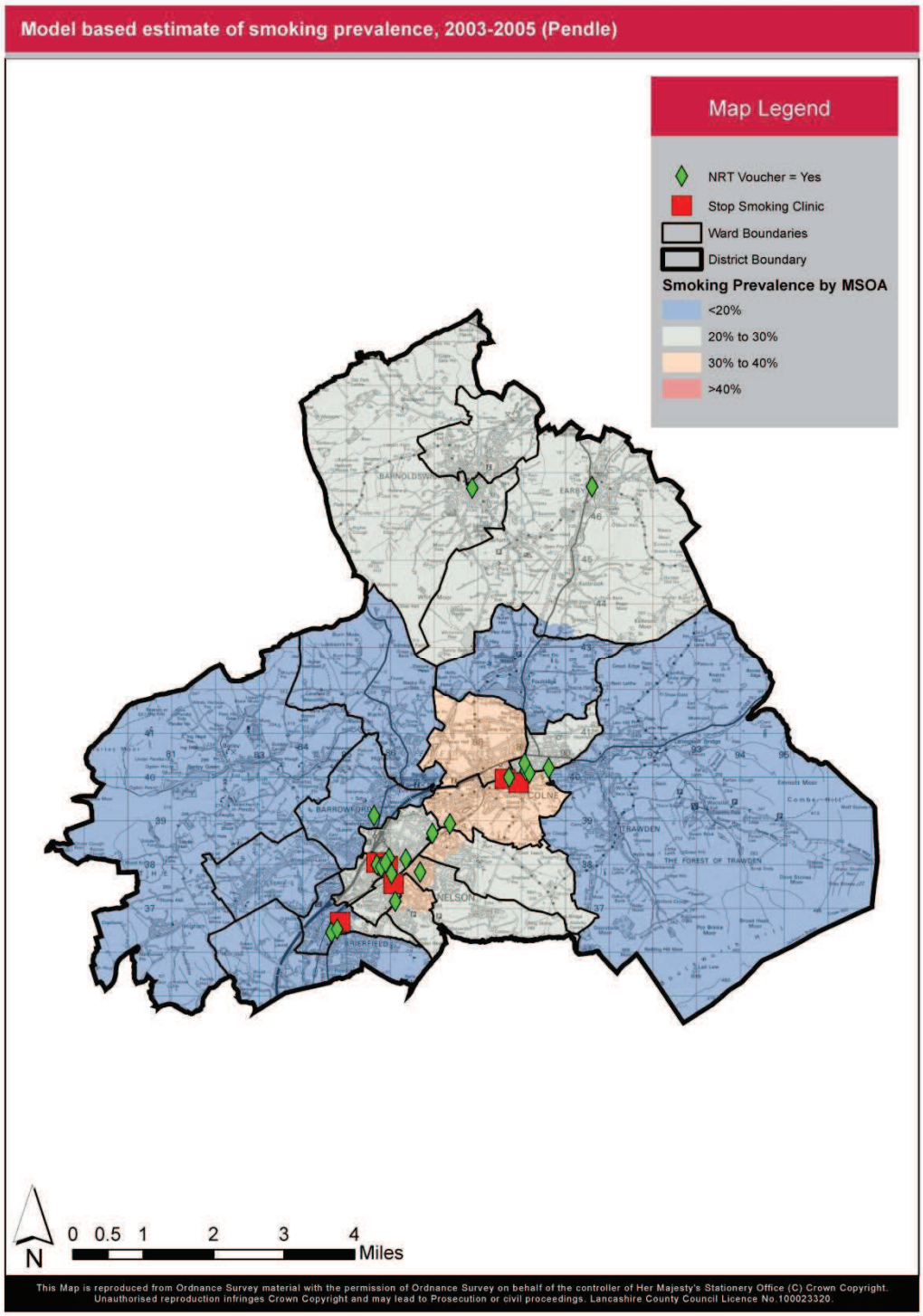
Map 59. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Burnley



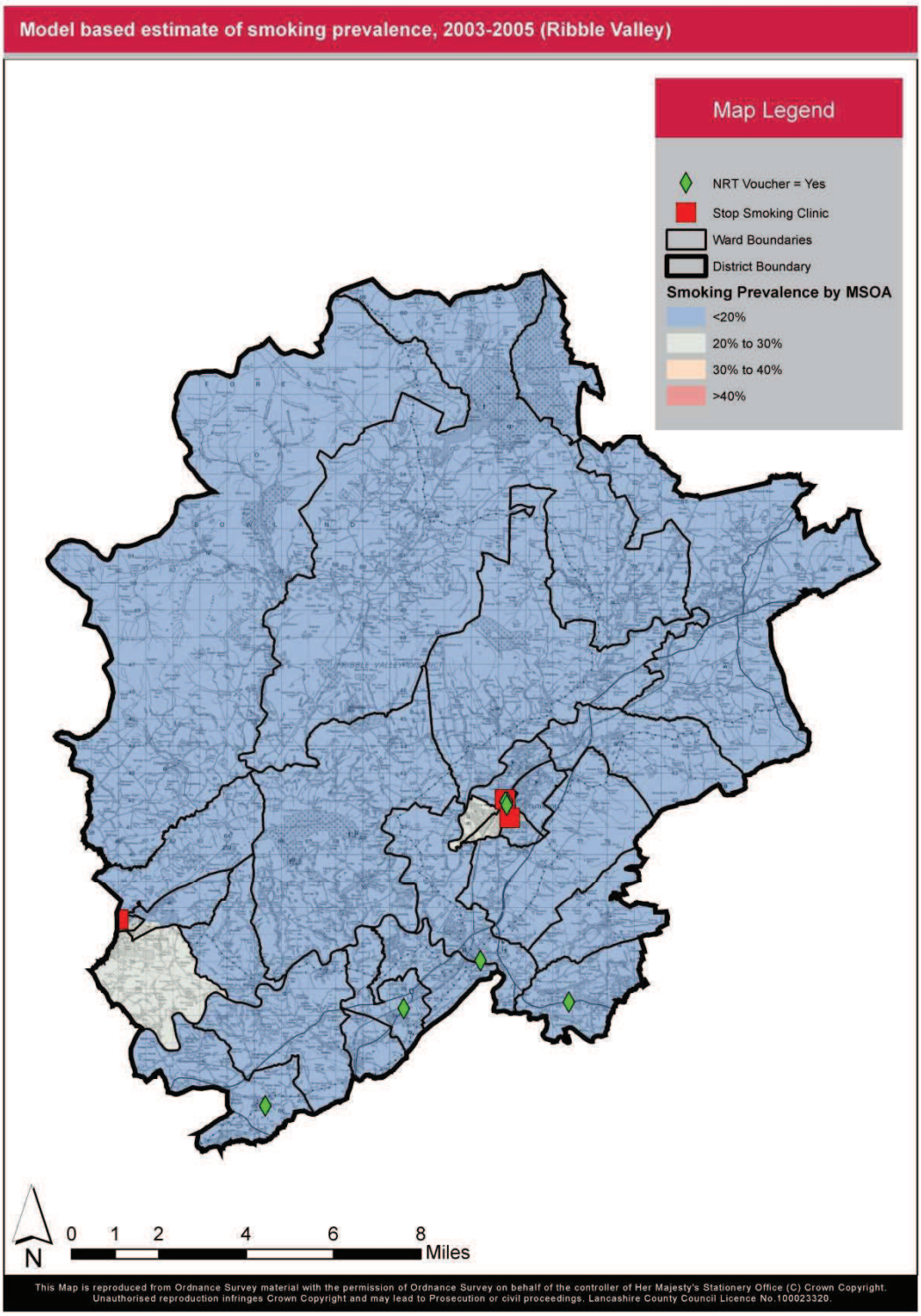
Map 60. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Hyndburn



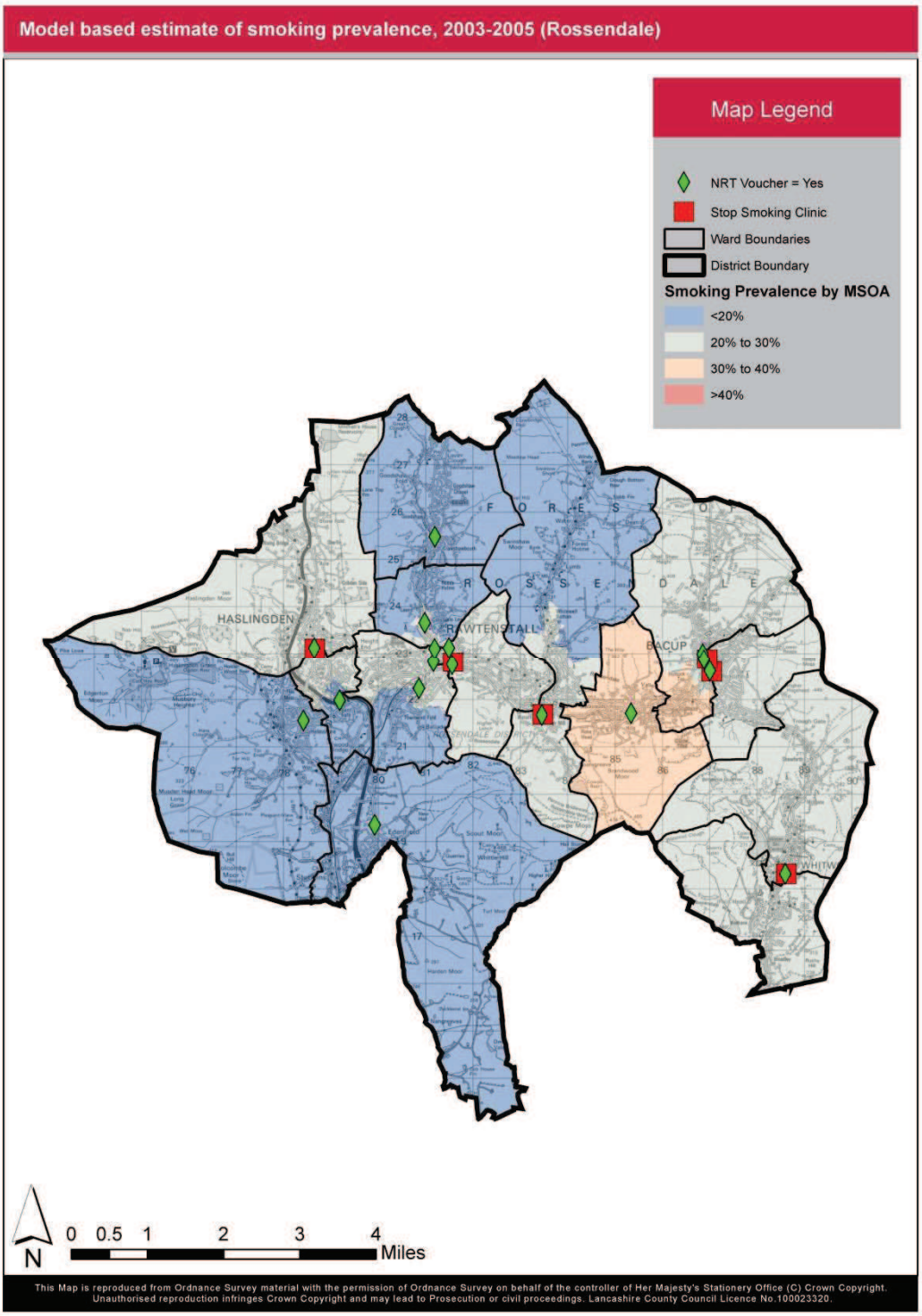
Map 61. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Pendle



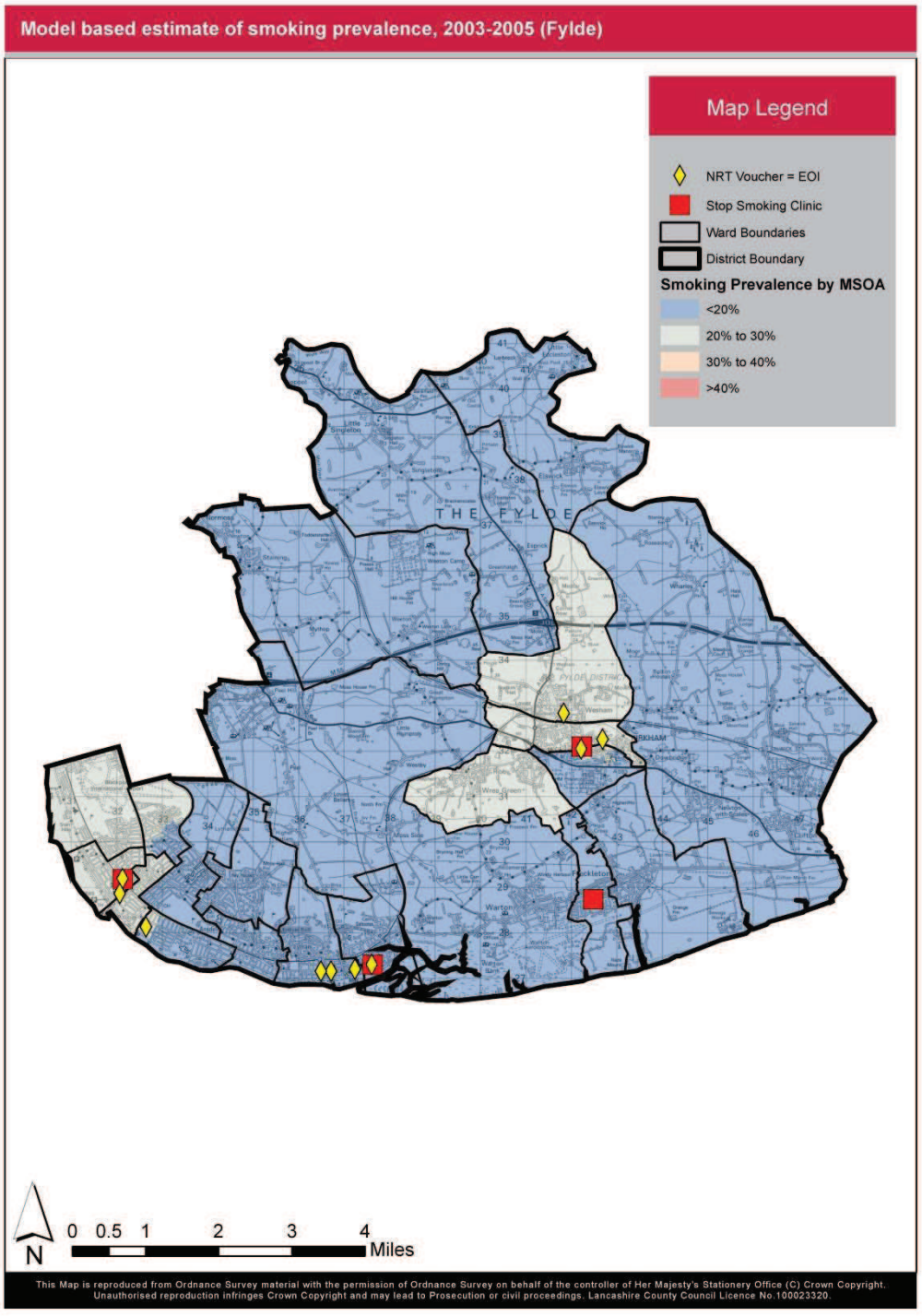
Map 62. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Ribble Valley



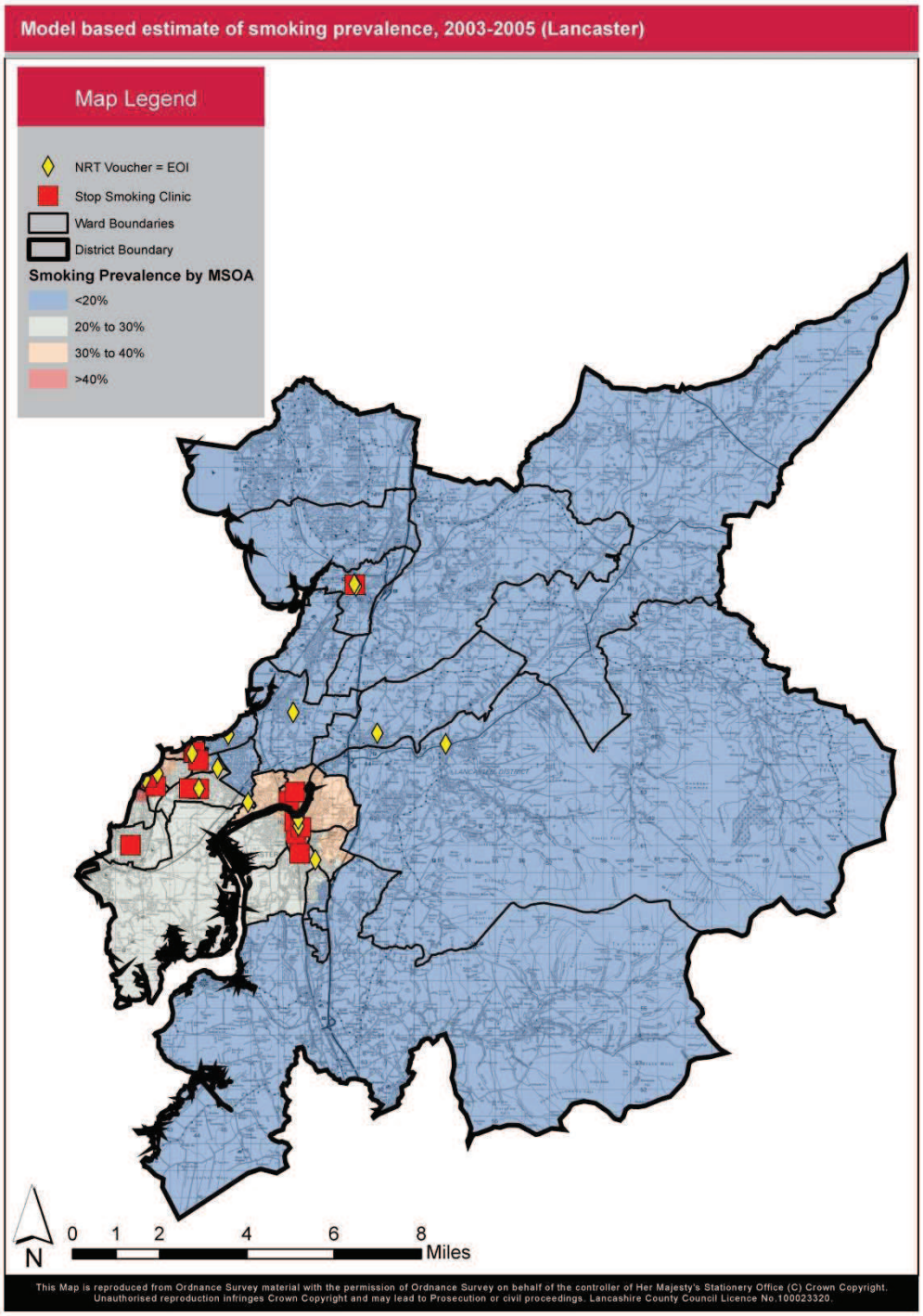
Map 63. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Rossendale



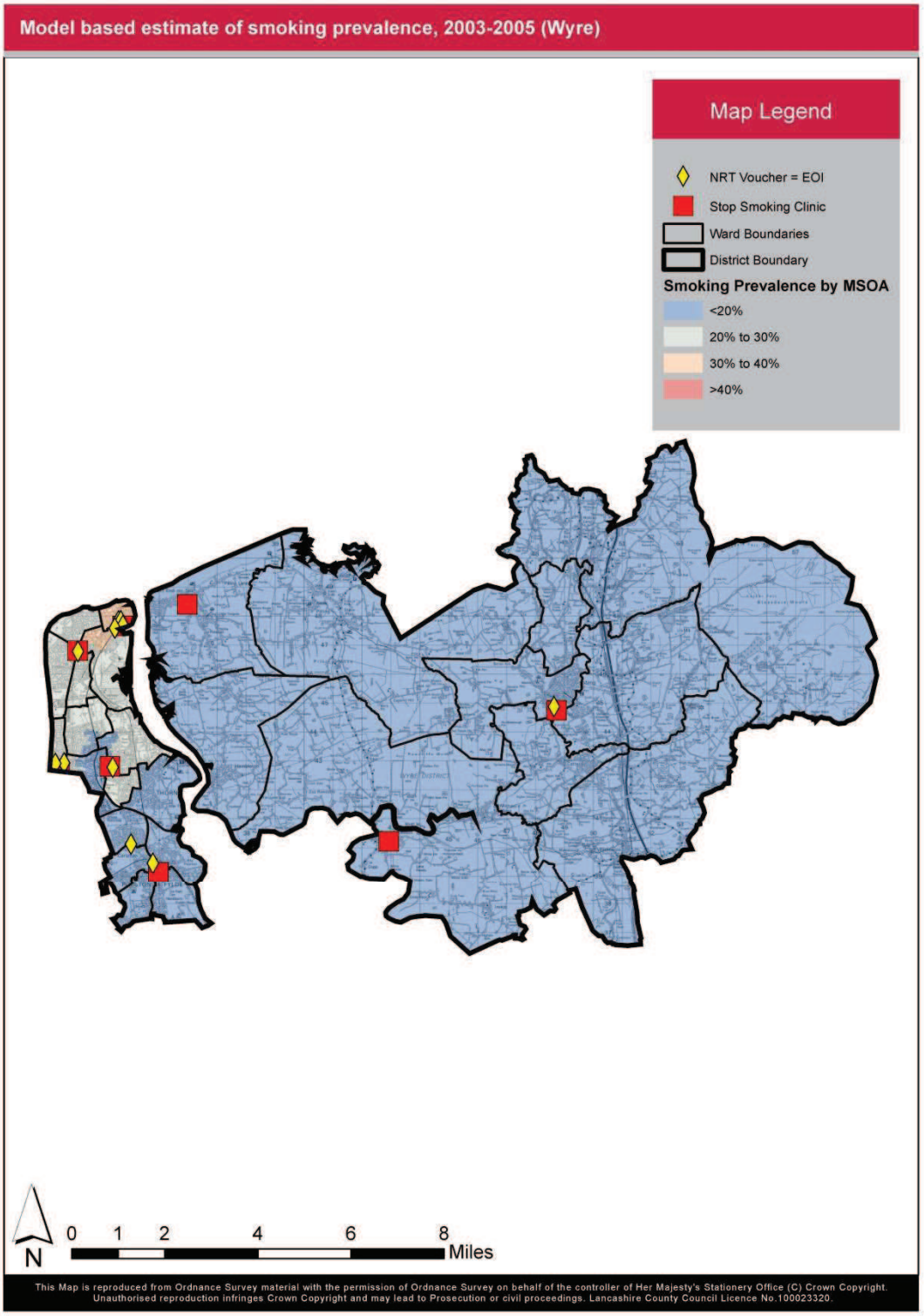
Map 64. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Fylde



Map 65. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Lancaster



Map 66. Smoking prevalence and location of pharmacies providing NRT Voucher Scheme and Stop Smoking Service locations – Wyre



5.4 Healthy weight

5.4.1 Local health needs

It is estimated that within Lancashire, Hyndburn district has the highest proportion of obese (defined as a body mass index above 30 kg/m2) adults, at 27.7% of the population. Six districts are higher than the national average of 23% but only Hyndburn and Wyre are statistically significantly higher. Lancaster (16.6%) and Ribble Valley (18.6%) have a significantly lower prevalence of obesity than the national average (see **Table 8**). These results, although encouraging, should be viewed against a background of generally increasing obesity rates both locally and nationally.

Table 8: Obesity prevalence in adults in Lancashire and districts, 2012

Significantly higher than England	Not significantly different from England	Significantly lower than England

Area	% Obese adults (BMI 30+)
England	23.0%
Lancashire	22.9%
Burnley	24.3%
Chorley	23.4%
Fylde	21.1%
Hyndburn	27.7%
Lancaster	16.6%
Pendle	25.3%
Preston	23.0%
Ribble Valley	18.6%
Rossendale	25.5%
South Ribble	21.9%
West Lancashire	22.5%
Wyre	27.5%

Source: Active People Survey 2012

5.4.2 Opportunities in local services

The causes of obesity are complex. Obesity is the consequence of interplay between a wide variety of variables and determinants related to individual biology, eating behaviours and physical activity, set within a social, cultural and environmental landscape. In order to tackle the 'obesity epidemic' these causes must be recognised and addressed. There is a need to prevent the ongoing rise in obesity levels but also to provide services to support individuals who have become overweight or obese to reduce their weight.

Several opportunities exist such as providing advice, signposting services and providing on-going support towards achieving behavioural change for example through monitoring of weight and other related measures. Opportunities for services to signpost to include:

- Exercise on Referral Programmes: supported physical activity interventions for people with moderate health conditions.
- Community Weight Management Programmes: there is provision throughout Central and East districts with provision currently being procured in the North of the County.

- Specialised services for specialist weight management and medical and surgical weight management interventions including bariatric surgery.
- NHS Health Checks: assess BMI and waist circumference in 40-75 years age.
- Whole population prevention activity: this includes a wide range of activity accessible to all the population and varies between districts e.g. chair-based exercise sessions, walking and cycling programmes, community food growing initiatives.
- Behaviour change support and advice through the national change for life website at http://www.nhs.uk/Change4Life/Pages/why-change-for-life.aspx

5.5 NHS Health Checks

The risk factors for vascular disease include diabetes, smoking, obesity, physical inactivity, high blood pressure and raised cholesterol levels. These risk factors can be identified and it is possible to try to manage them. The NHS Health Checks programme offers preventative checks to eligible individuals aged 40–74 years to assess their risk of vascular disease, followed by appropriate management and interventions. The Department of Health indicated that it would expect access to the NHS Health Checks Programme to be developed through a number of routes including community pharmacies and GP surgeries.

The NHS Health Checks programme in Lancashire is currently delivered by general practices. In Lancashire, 11.6% of eligible population aged 40-74 were offered an NHS Health Check in 2013/14. This is significantly lower than the England average (18.4%). There was a 52.7% take up rate by the people in Lancashire who were offered it; this is significantly higher than the England average (49%)[xxxiii].

Public Health Lancashire is developing a LIS with community pharmacy, it is not yet in place but is anticipated to be in place during 2014/15.

5.6 Sexual health

5.6.1 Local health needs: Chlamydia

Genital *chlamydia trachomatis* infection is the Sexually Transmitted Infection (STI) most frequently diagnosed in Genitourinary Medicine (GUM) clinics in England, particularly among young people under 25. It often has no symptoms, but if left untreated it may have longer-term consequences including pelvic pain, infertility and ectopic pregnancy. Testing for chlamydia is quick and easy, and it is simple to treat with antibiotics.

It is difficult to assess changes in local chlamydia occurrence over the last decade for several reasons. The diagnostic definitions have changed during this period. More importantly, in the past two years the focus of the programme has changed from the absolute numbers being screened to diagnostic rates.

The 2012 and 2013 screening rates now available from the NCSP site (http://www.chlamydiascreening.nhs.uk/ps/data.asp) with the 2012 data being the first to be based on a new data collection system known as CTAD (Chlamydia Testing Activity Dataset). The published 2013 diagnostic rate for Lancashire is 2,292 per 100,000, which is

very close to the target of 2,300, and appears, at first glance, to be a slight improvement on the 2012 rate of 2,250.

In 2013, the proportion of 15-24 year olds tested in Lancashire (25.8%) was higher than national rate (24.9%) and similar to North West of England rate (25.7%).

There is a wide variation in screening rates in Lancashire with the rates in Lancaster (43%) Wyre (32%) and Preston (30%) being more than double those in most other districts. This high coverage rate in Lancaster and Preston may be due to both these areas being university towns and having a large proportion of young people who access the service.

Despite many changes to service configuration during 2013, the overall diagnosis and testing coverage rates for England have remained stable, and the proportion of total tests that are positive has increased from 7.7% in 2012 to 8.1% in 2013, indicating successful implementation of NCSP guidance on testing policy. In Lancashire, the proportion of total tests that are positive has increased from 8.1% in 2012 to 8.9% in 2013. Within Lancashire, the percentages of positive tests were higher than that seen nationally (8.1%) with the districts of Rossendale (11.4%), Pendle (10.3%) and Chorley (10.0%) reporting the highest rates.
Quarterly data is available on the National Chlamydia Screening Programme Website: http://www.chlamydiascreening.nhs.uk/ps/data.asp

5.6.2 Local health needs: HIV/AIDS, gonorrhoea, syphilis and other conditions

The prevalence of diagnosed HIV infection in Lancashire has increased by 15% from 2010 to 2012[xxxiv]. This increase could reflect either that more people are being diagnosed, or that fewer people die from HIV/AIDS because drug therapies have become more effective.

Data from Public Health England indicate that between 2010 and 2012 there was an increase in diagnoses of gonorrhoea and syphilis (small numbers), while diagnoses of genital warts decreased.

5.6.3 Local services

Community pharmacies are easily accessible and are crucial for offering STI testing and can offer treatment of infections or signpost people to other sexual health services. Pharmacies are generally accessible via public transport links, available in rural areas and are possibly easier to access outside the hours of GP and sexual health services.

Increased HIV testing to prevent late diagnosis is one of the indicators within the Public Health Framework. This is essential as the earlier HIV is detected the better the outcome for the patient, early diagnosis and treatment will also prevent onward transmission. By providing HIV testing pharmacies could increase the rates of early diagnosis of HIV and other infections. If an individual knows they are infected they will benefit from treatment resulting in an improved prognosis.[xxxv] As from April 2013 the local authority became responsible for the testing of HIV and NHS England is currently responsible for the treatment and care of those living with HIV. If diagnosed early a person diagnosed at the age of 20 can expect to live on average to 65 when prescribed antiretroviral drugs.[xxxvi]

For chlamydia testing young people up to the age of 24 can request a self-administered postal kit via http://www.best2know.co.uk or by texting 82540 with their name, age and address. If their test is positive they are then offered advice and treatment which could be accessed at a local pharmacy, GP or sexual health service.

Pharmacies in Lancashire can provide free condoms and there is potential for pharmacies to offer advice on barrier contraception methods for both males and females and for raising awareness of HIV, chlamydia and other STIs. Currently some pharmacies in Lancashire advertise free condoms by displaying Best2Know posters on their premises and there are various condom distribution schemes across the county.

In addition, there are examples of pharmacies issuing on going contraception for those accessing EHC, so called 'bridging contraception'.

There are much greater opportunities for Pharmacies to provide additional sexual health services, providing there is a willingness from pharmacists to undertake additional education and training.

5.6.4 Consideration of services offered

In some cases it can be challenging to offer testing in the pharmacy setting as not all pharmacies have the facilities required to enable patients to provide a urine sample for diagnostic testing on site. In addition, there is a need for clear and direct pathways of care for those diagnosed with an STI, particularly HIV. Of the 295 pharmacies across Lancashire signed up to LIS agreements, 215 provide chlamydia testing and EHC.

5.7 Emergency hormonal contraception (EHC)

5.7.1 Local health needs

Lancashire has an under 18 conception rate that is statistically similar to the national rate (28.7 per 1,000 population in Lancashire compared to 27.7 nationally), but Burnley (50.1) and Hyndburn (38.5) districts have rates that are significantly higher than the national average (2012)[xxxvii]. Nearly all districts (apart from Ribble Valley) have seen their under 18 conception rates decrease from the previous year.
Maps 67 to 78 show Lancashire districts' wards with teenage conception rate (2009-11) higher than the National rate and location of pharmacies commissioned to provide EHC. Maps 55 to 59 show East Lancashire districts, maps 60 to 63 show Central Lancashire districts and maps 64 to 66 show North Lancashire districts.

5.7.2 Local services

EHC reduces the rate of unwanted pregnancies for women of all ages. The availability of EHC is also essential in reducing the teenage conception rate and also the number of unwanted pregnancies which result in abortion.

Studies indicate that making emergency hormonal contraception (EHC) available over the counter has not led to an increase in its use, to an increase in unprotected sex, or to a decrease in the use of more reliable methods of contraception.[xxxviii]

In Lancashire 215 pharmacies have agreed to LIS agreements and Patient Group Directives (PGDs) to provide EHC. Only accredited pharmacists can supply EHC and prescription counter staff must refer requests for EHC to the pharmacist. It is the responsibility of the pharmacy to ensure that all their pharmacists and locums are EHC accredited before supplying EHC. If the pharmacy does not provide EHC free to the patient they should refer to a pharmacy who has signed up to the EHC LIS agreement.

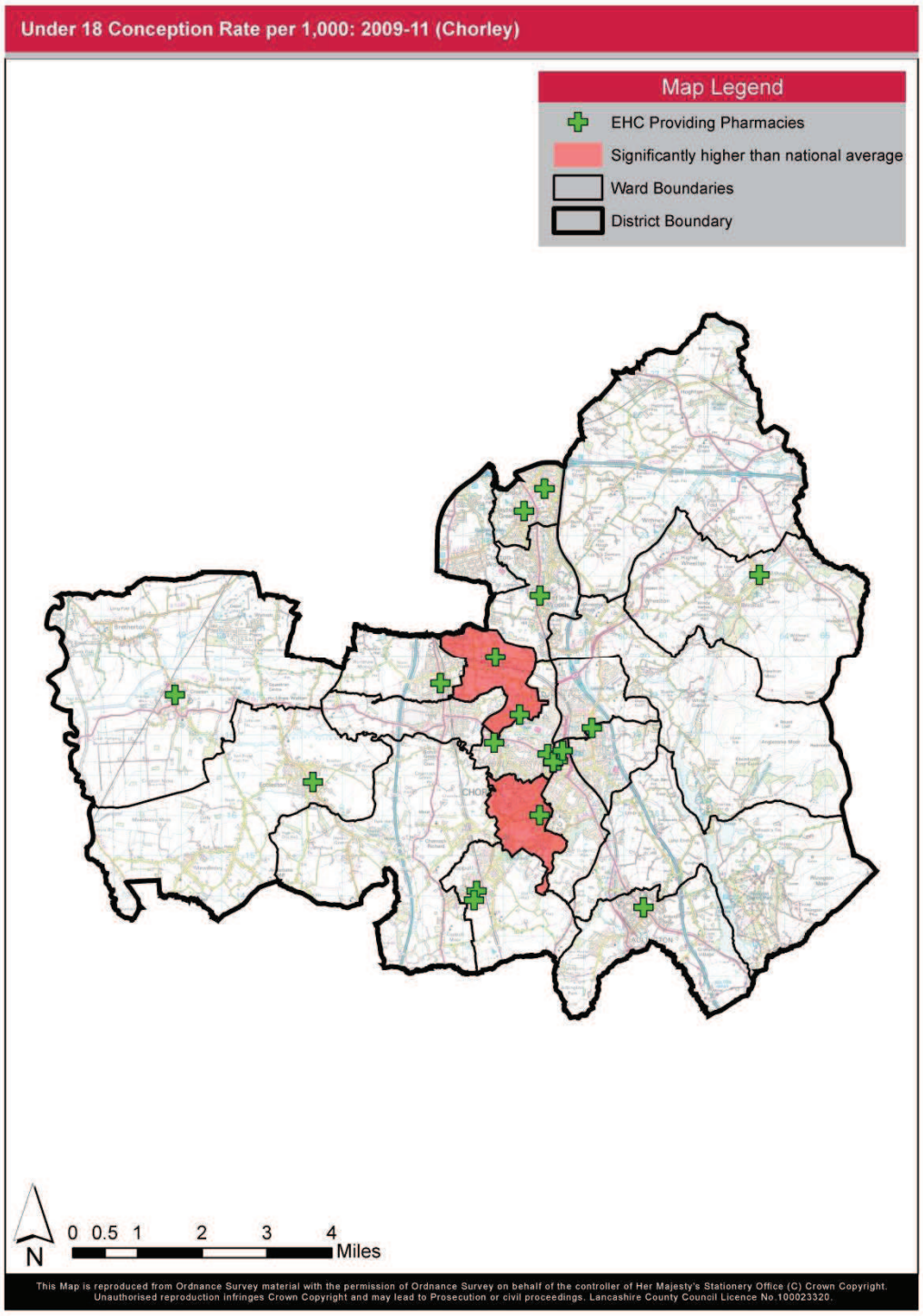
A list of pharmacies currently providing EHC across Lancashire is available via http://www.best2know.co.uk

5.7.3 Consideration of local services

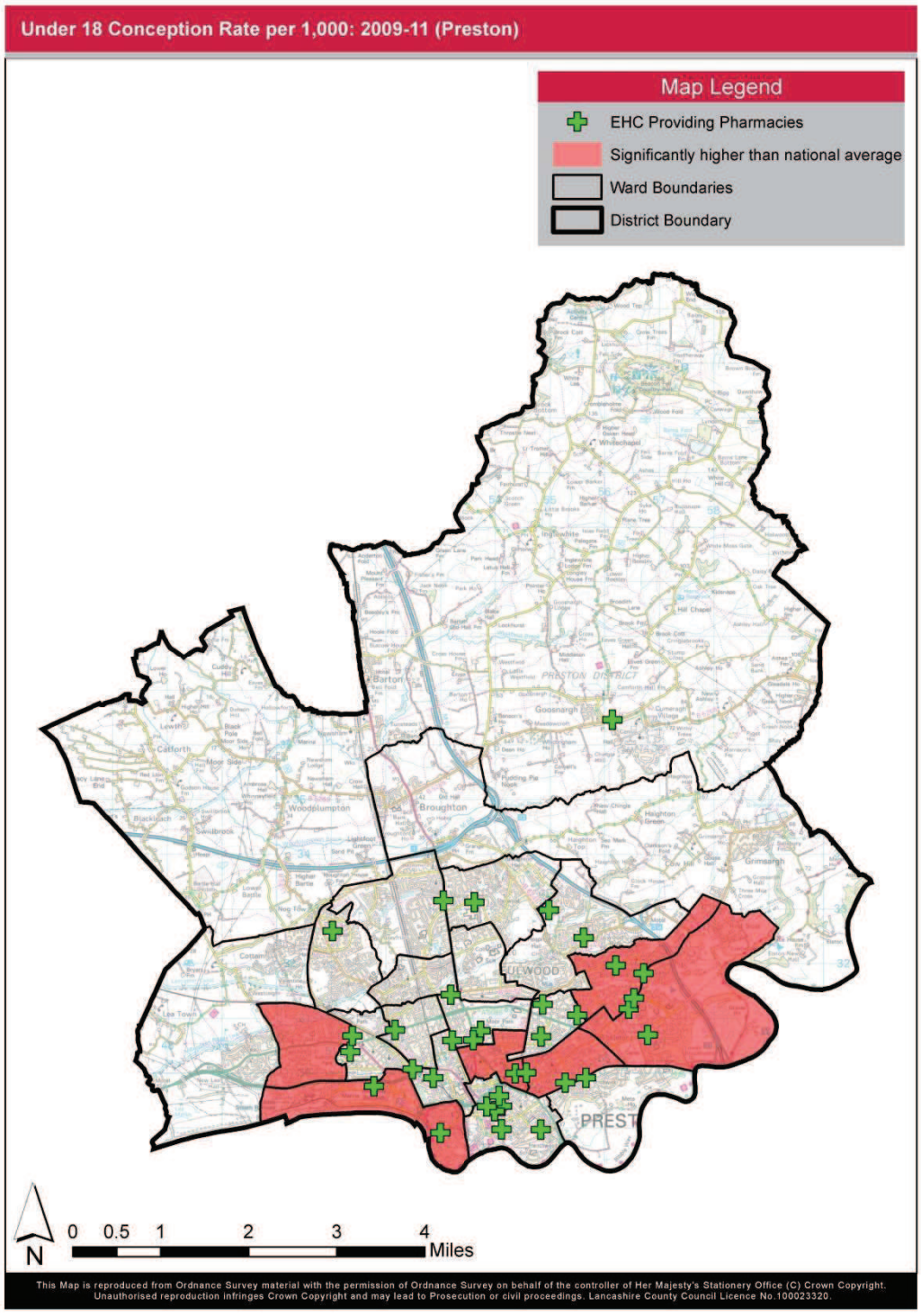
If a patient has requested EHC they should be tested for STIs as they are at increased risk of infection and therefore a further risk of onward transmission of the infection. It is important to note that due to incubation periods for infections, undertaking a test in conjunction with issuing EHC may not be appropriate.

Being unable to access EHC can result in unwanted pregnancies, abortion and repeat abortions. Pharmacies could offer contraception advice to reduce the need for future EHC and offer or signpost to a service providing Long Acting Reversible Contraception (LARC) again one of the indicators of the Sexual Health Outcomes Framework. In providing contraception pharmacies contribute towards the reduced rate of abortions resulting from unwanted pregnancies, whilst numbers since 2002 have reduced in women aged under 24, it has risen for those aged 28 and above.[xxxix]

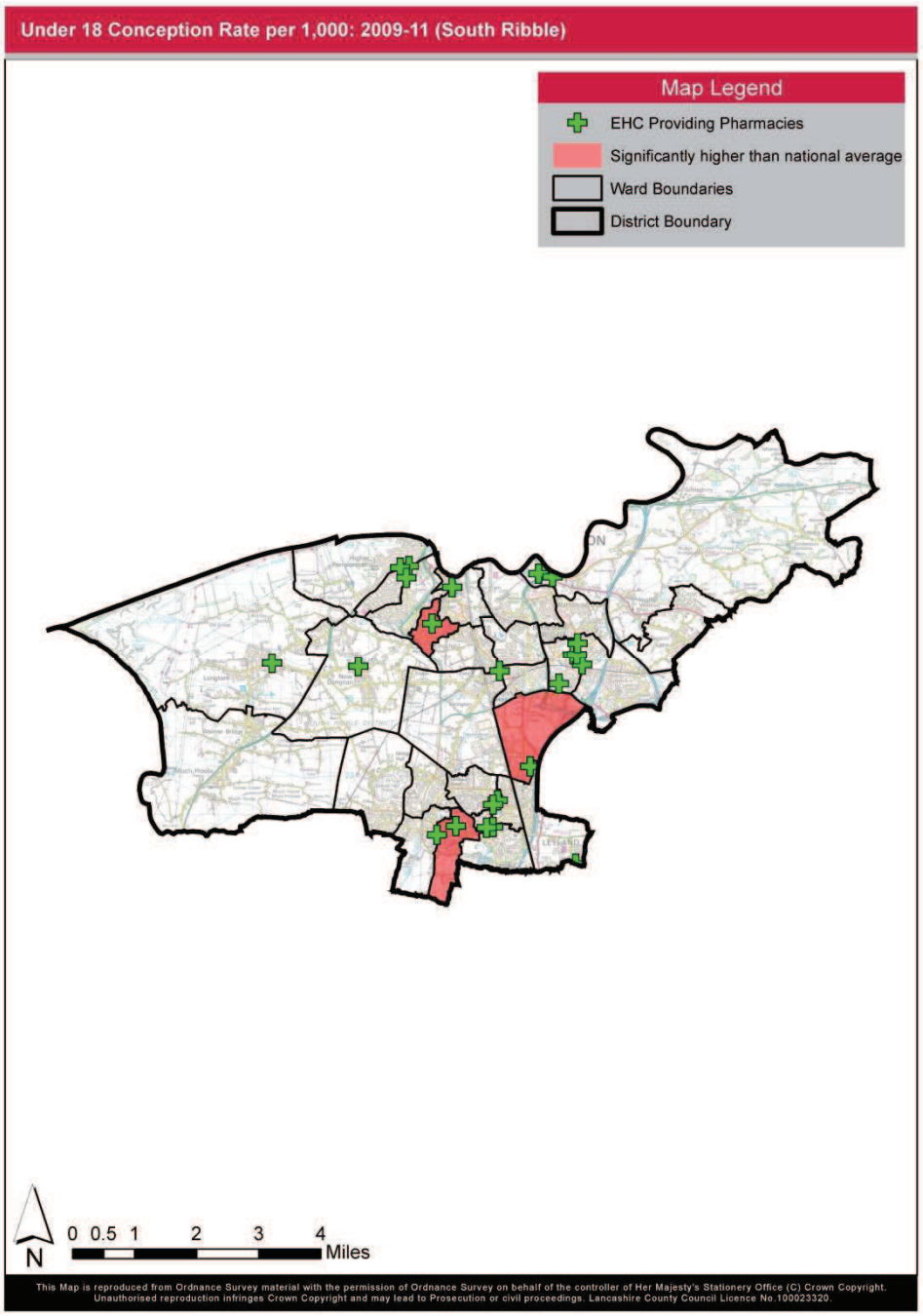
Map 67. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – Chorley



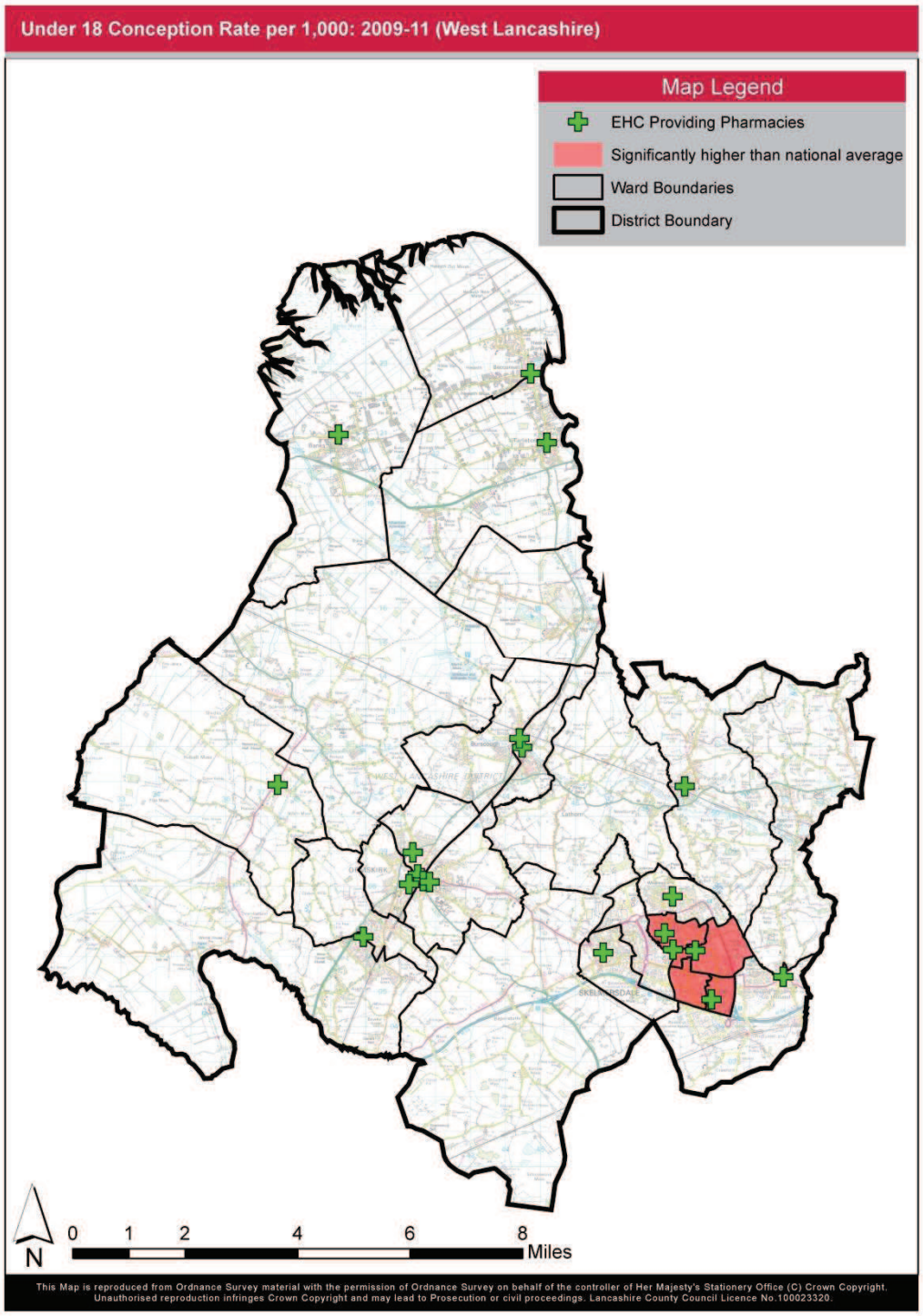
Map 68. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – Preston



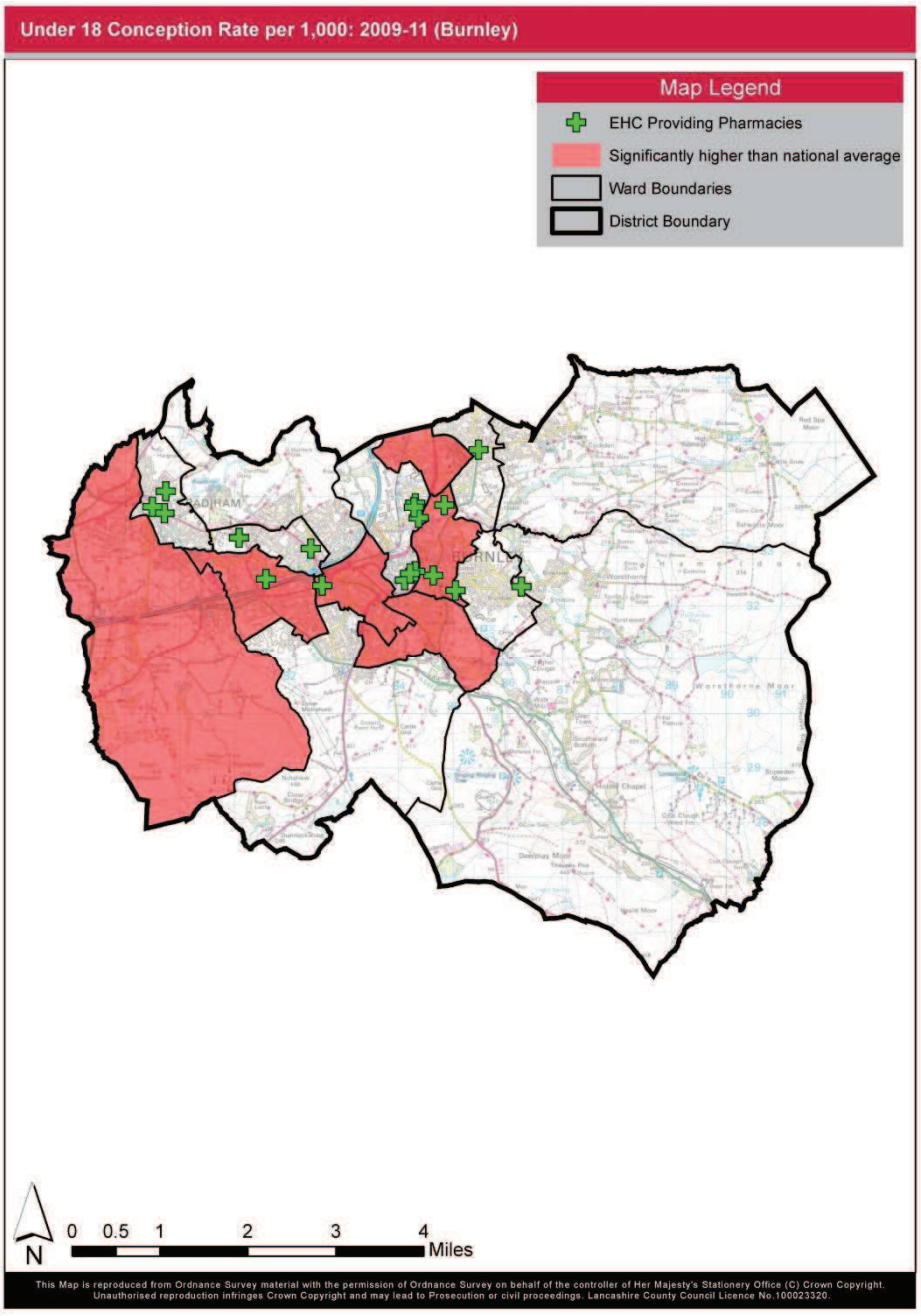
Map 69. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – South Ribble



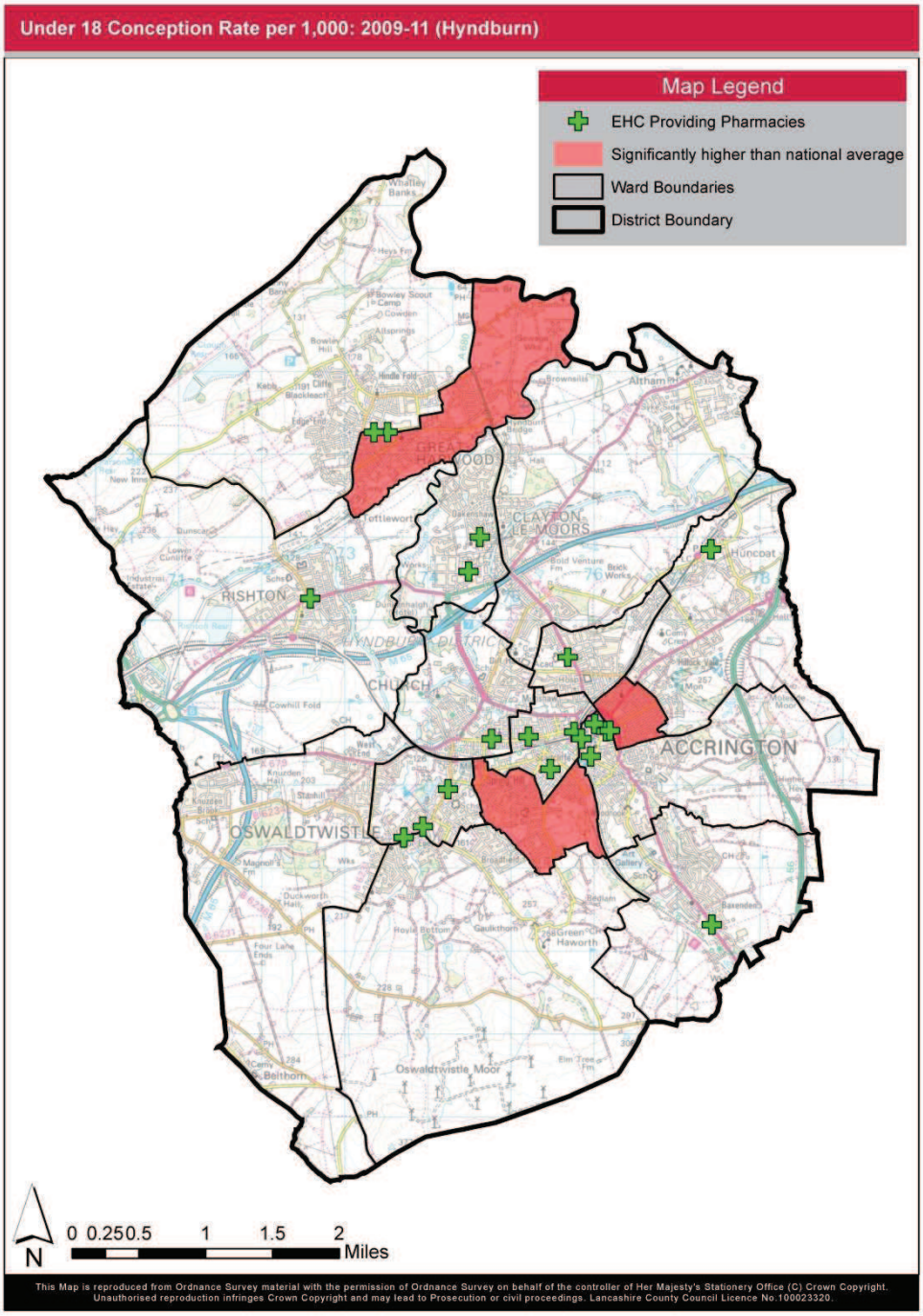
Map 70. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – West Lancashire



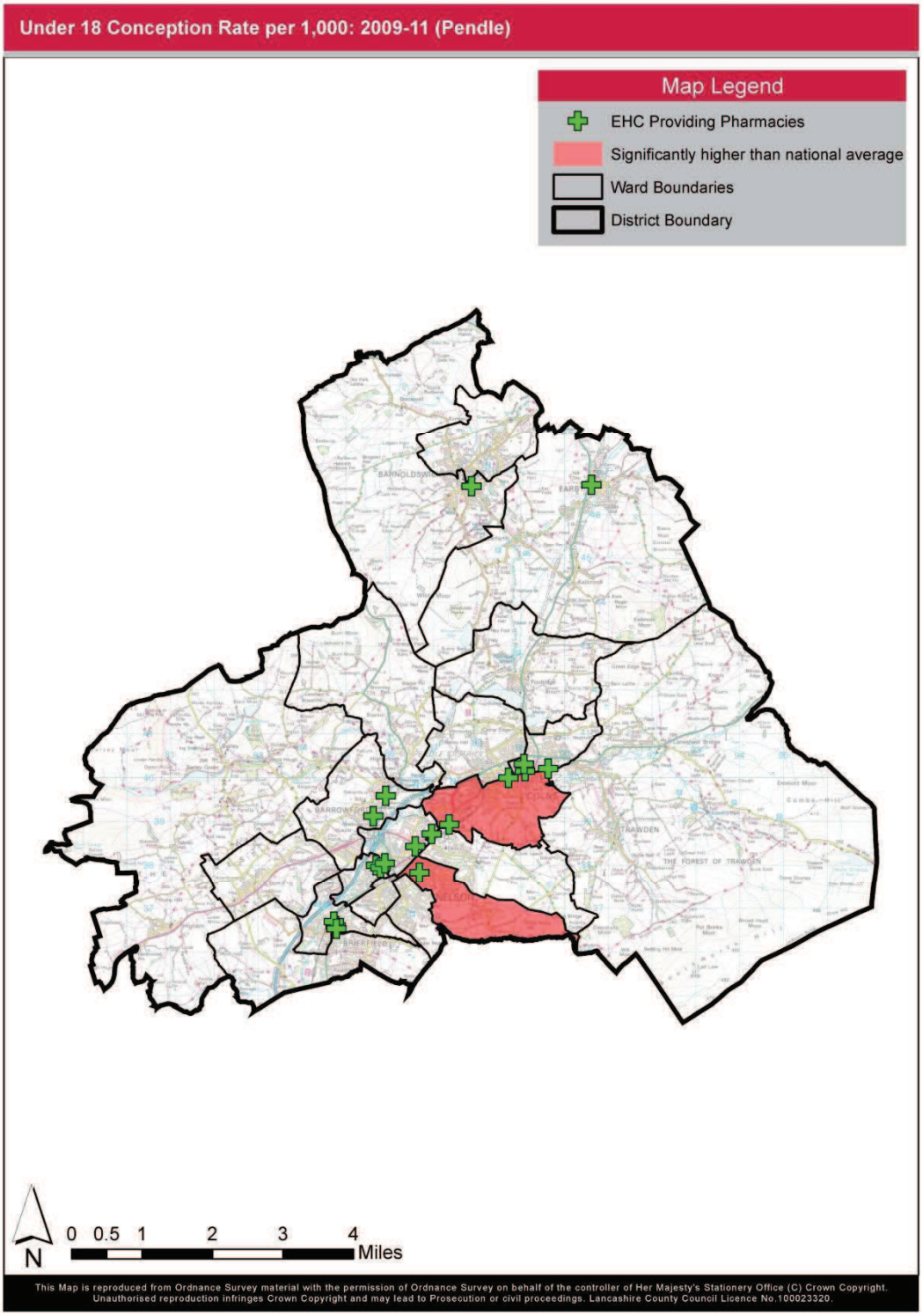
Map 71. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – Burnley



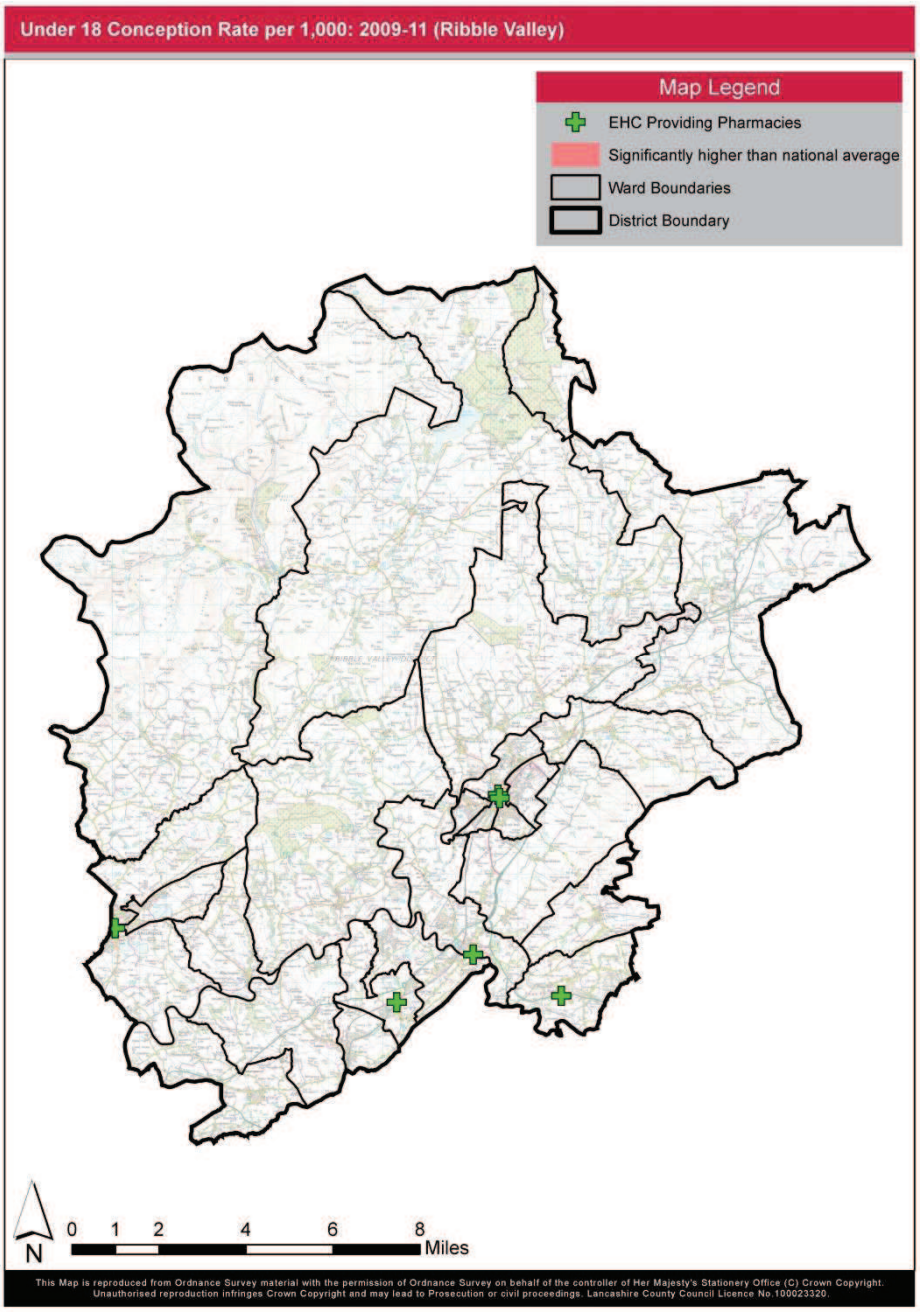
Map 72. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC –Hyndburn



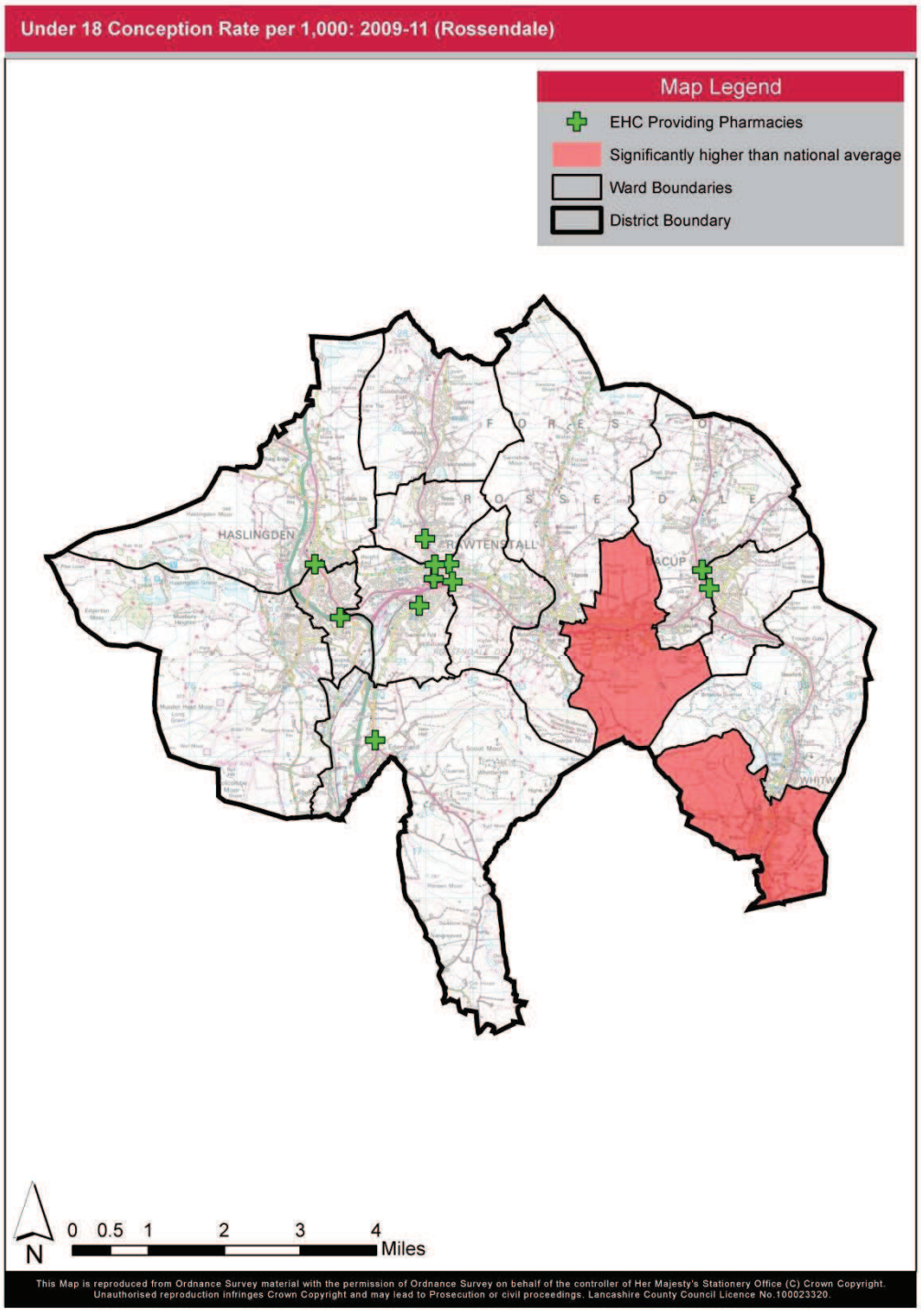
Map 73. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – Pendle



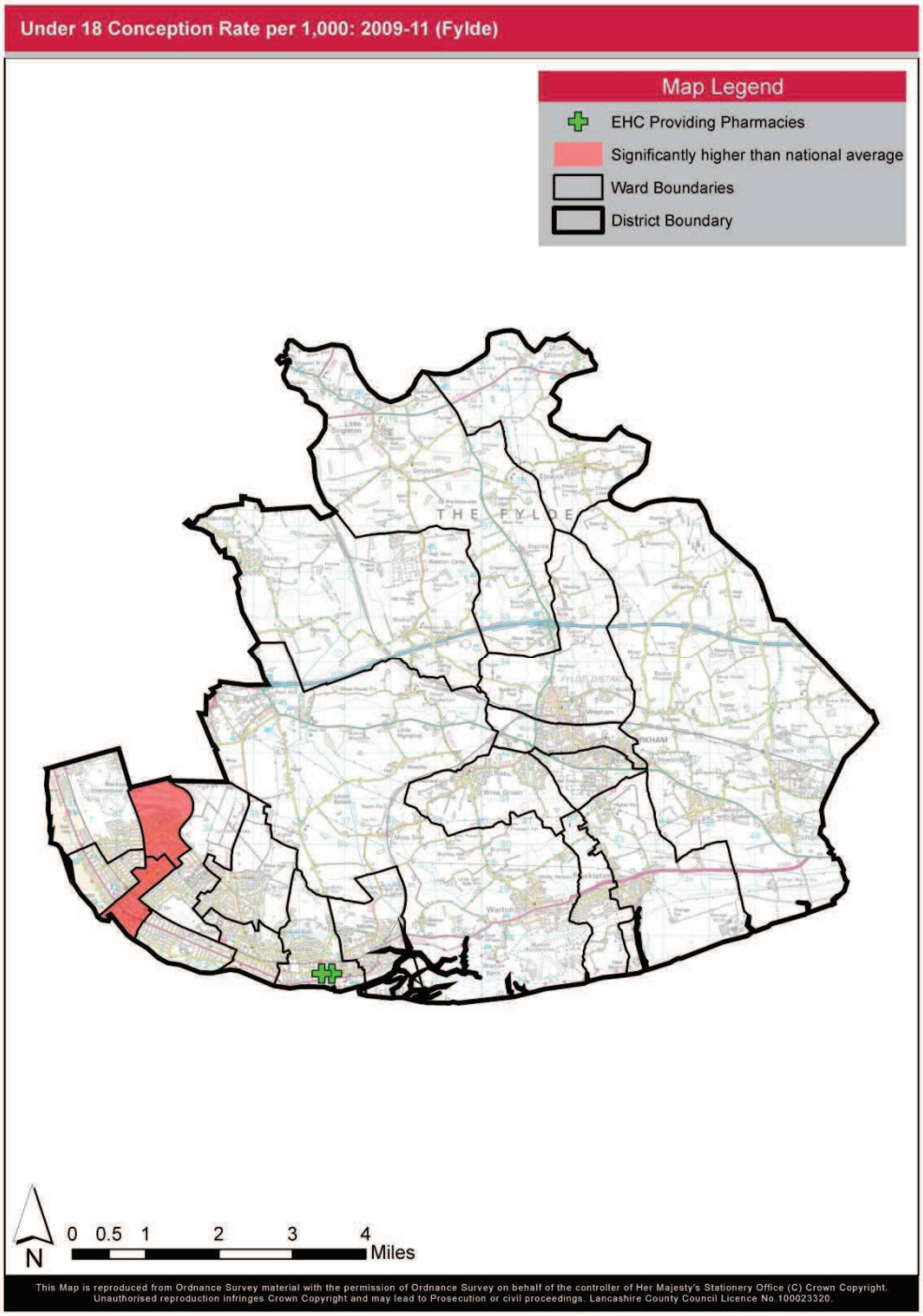
Map 74. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – Ribble Valley



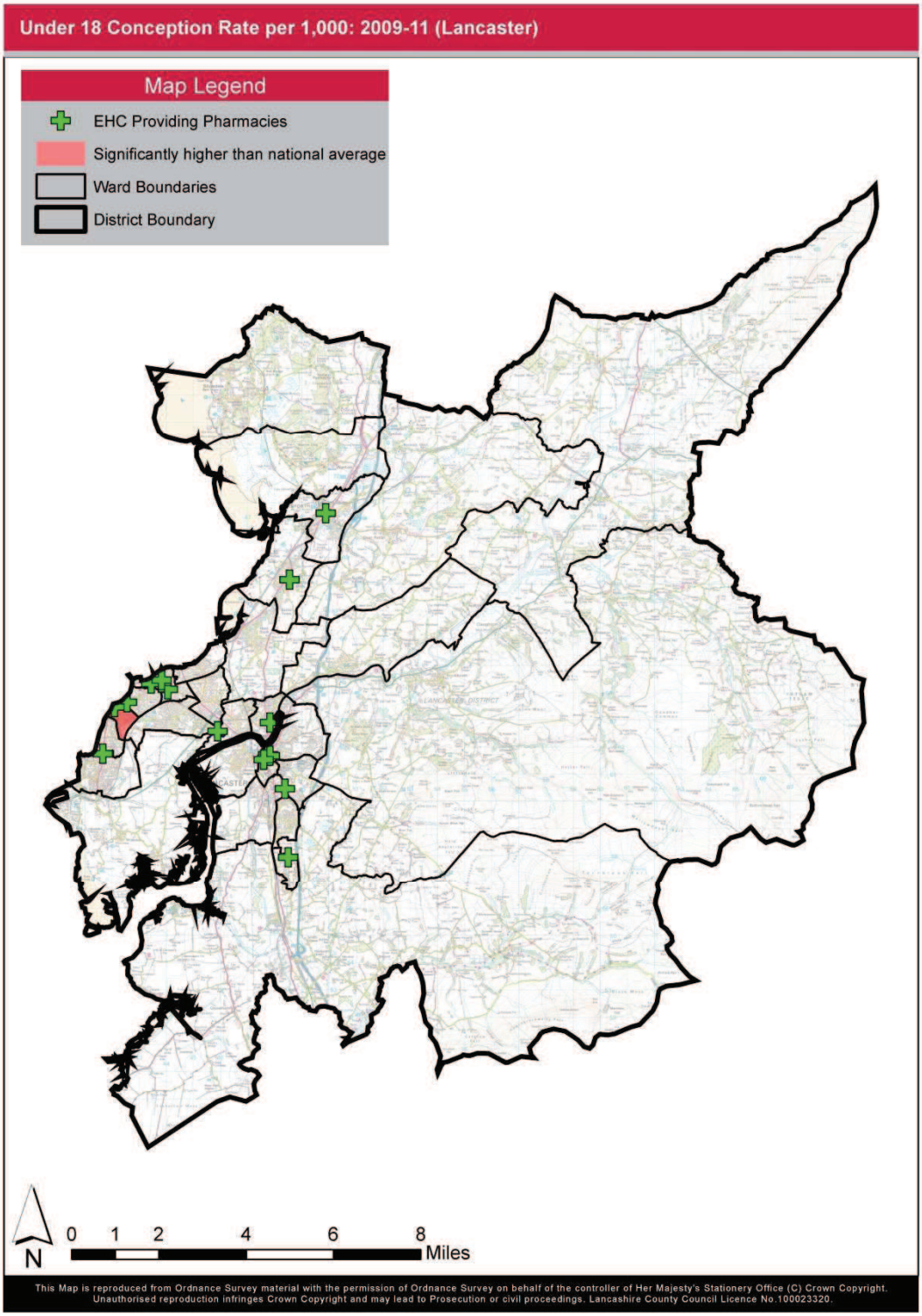
Map 75. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – Rossendale



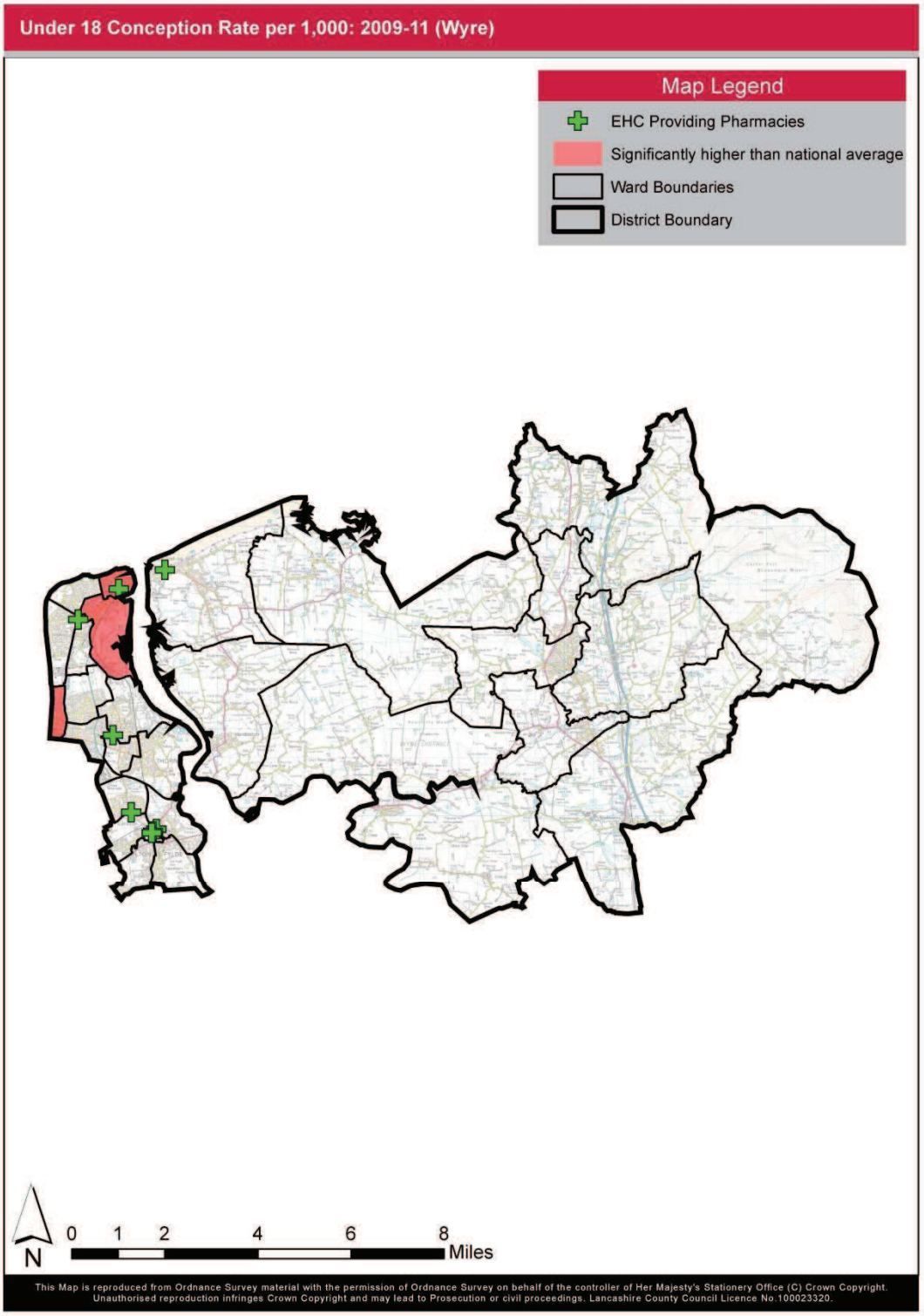
Map 76. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – Fylde



Map 77. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – Lancaster



Map 78. Teenage conception hotspot wards (2009-2011) and pharmacies commissioned to provide EHC – Wyre



5.8 Substance Misuse

Since April 2013 Lancashire County Council has been responsible for commissioning substance misuse (drug and alcohol) prevention and treatment services. [xl]. A wide range of services are commissioned in order to achieve this, generally as substance misuse services rather drug or alcohol; pharmacy specific services are described below.

Prior to April 2013 commissioning for substance misuse services led mainly by Lancashire Drug and Alcohol Action Team, with the three local Primary Care Trusts retaining responsibility for some areas of business.

5.8.1 Local health needs - Alcohol

Alcohol misuse has an impact on the whole community through crime, health and wellbeing, affecting families and the wellbeing of children, placing a strain on key health services and councils' resources.

The districts of Burnley, Hyndburn, Lancaster, Pendle, Preston, Rossendale and West Lancashire have a significantly higher, than national average, rate of alcohol-related hospital admissions (table 9). In Fylde, South Ribble and Wyre males the rate of alcohol-related hospital admissions is significantly lower rate than the national average. From **Figure 4**, it can be seen that rates are consistently lower in females than in males across all districts.

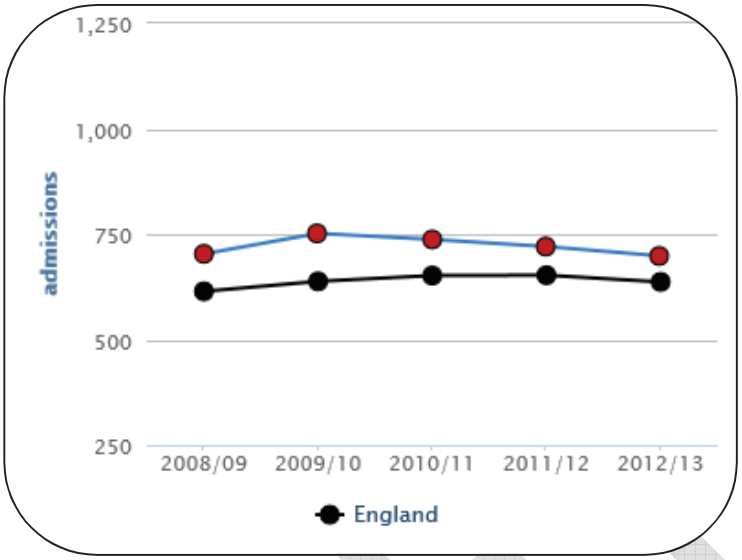
Table 9. Alcohol-related hospital admissions per 100,000 people in Lancashire, by district, 2012/13.

Significantly higher than England | Significantly lower than England | Not significantly different from England

Area	Male rate per 100,000	Female rate per 100,000
Burnley	2297.44	1202.01
Chorley	1689.96	869.10
Fylde	1466.47	814.79
Hyndburn	2302.78	1224.16
Lancaster	1868.15	962.95
Pendle	1889.33	1010.85
Preston	1842.14	991.35
Ribble Valley	1546.81	738.45
Rossendale	1946.93	1001.98
South Ribble	1485.51	837.51
West Lancashire	1913.15	930.78
Wyre	1524.12	829.44
England	**1676.33**	**831.84**

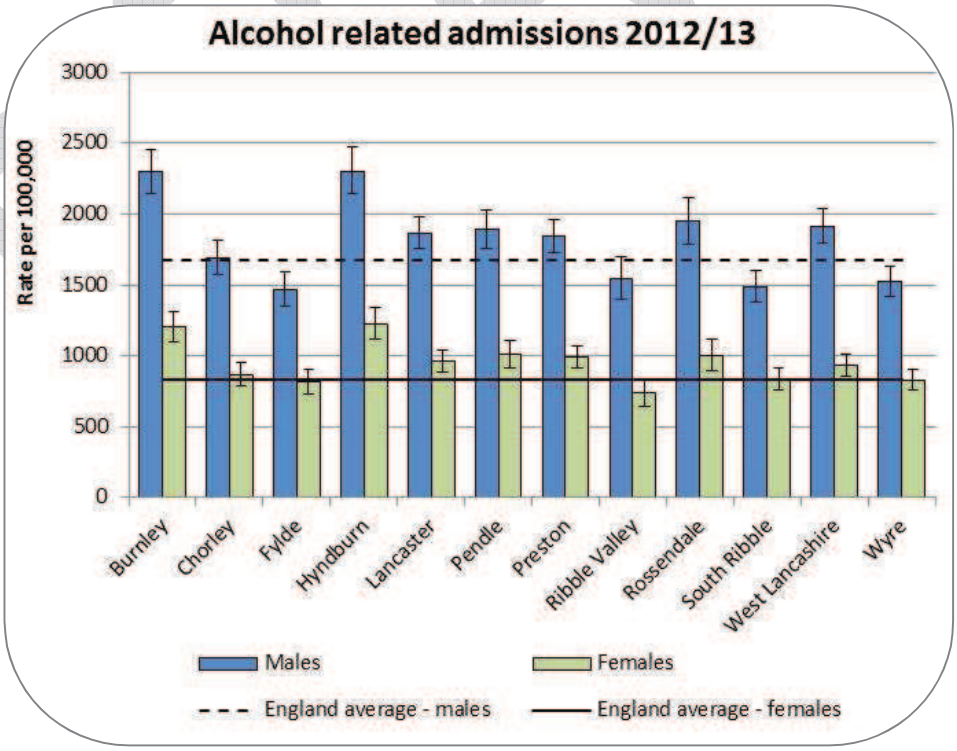
Source: PHE LAPE http://www.lape.org.uk/ 2012/13

Figure 3. Alcohol related admissions to hospital, Lancashire compared with England, 2008/09 – 2012/13



Source: PHOF http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/4/par/E12000002/are/E10000017

Figure 4. Alcohol-related hospital admissions per 100,000 people in Lancashire, by district and by gender 2012/13. Directly standardised rates.



Source: LAPE profiles http://www.lape.org.uk/

5.8.2 Local services – Alcohol

Local pharmacies are well connected to treatment services and are ideally placed to refer individuals disclosing harmful drinking to local treatment services.

Local pharmacies are involved in the dispensing of medications prescribed for the treatment of alcohol misuse in the community.

5.8.3 Local health needs - Drugs

Illicit drug use contributes to the disease burden both globally and in Lancashire. Efficient strategies to reduce disease burden of opioid dependence and injecting drug use, such as the delivery of opioid substitution treatment and needle and syringe programmes, are needed to reduce this burden at a population scale[xli].

Table 10. Drug Strategy cases in 2012 (16 years and over) – number and rate per 100,000 population

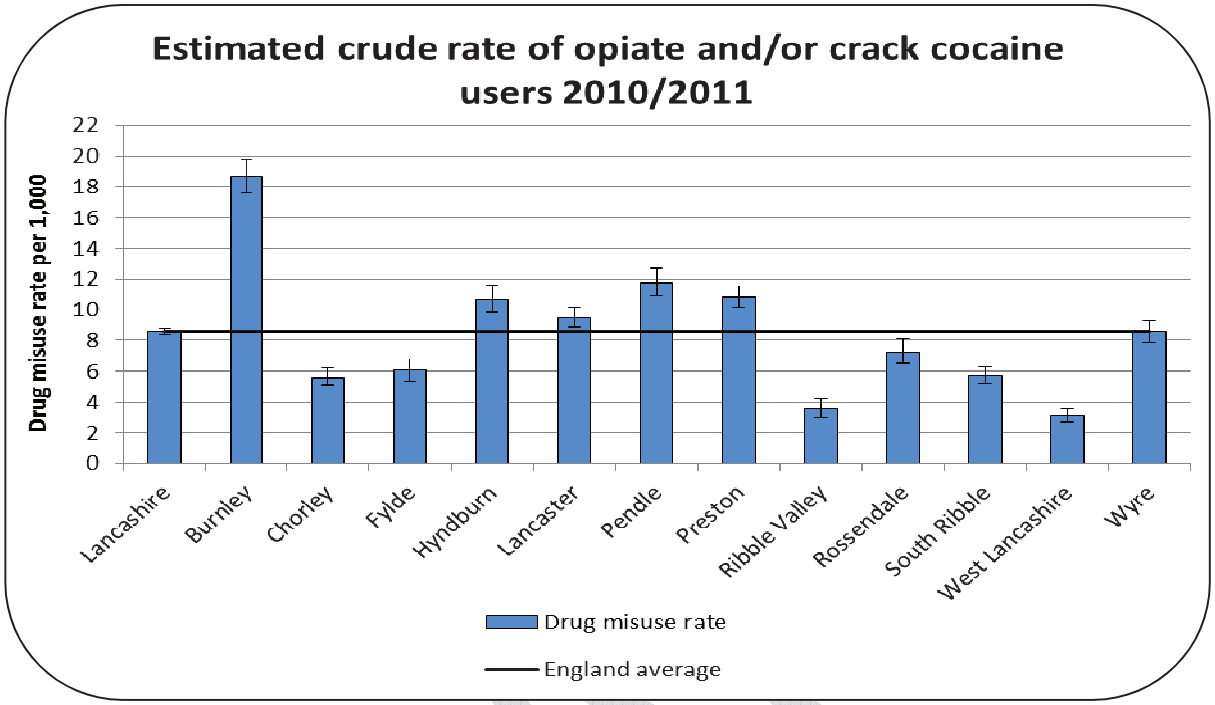
	Number and annual death rate per 100,000 population – usual area of residence		Number and annual death rate per 100,000 population – place of death	
	No.	Rate	No.	Rate
Lancashire	66	6.87	59	6.14

Source: Drug-related deaths in the UK: January-December 2012. http://www.sgul.ac.uk/research/projects/icdp/our-work-programmes/pdfs/drd_ar_2013.pdf

An overview of the current situation in the UK is given in the DH report *United Kingdom Drug Situation – 2012 Edition*[xlii]. Between 2006/07 and 2010/11 the estimated lifetime use of any drug amongst 16 to 59 year olds remained stable (35.4% and 35.6% respectively). Over the same time period, recent and current drug use decreased. In 2006/07, reported use of any drug within the last year was reported as 10.2%, this decreased to 8.8% in 2010/11. A similar pattern was seen for reported use of any drug within the last month, which decreased from 6.0% in 2006/07 to 4.8% in 2010/11.

The estimated rate of drug misuse in Lancashire is not significantly different from the national average (estimated crude rate of opiate and/or crack cocaine users, per 1,000 aged 15-64 for both Lancashire and England is 8.6). The highest rate of estimated drug misuse in the county is in Burnley (18.7 users per 1,000) and the 2nd highest is in Pendle (see Figure 5).

Figure 5. Estimated crude rate of opiate and/or crack cocaine users, per 1,000 aged 15-64, by district. 2010/11.



Source: PHE Health profiles 2013. http://www.apho.org.uk/resource/view.aspx?RID=126811

5.8.4 Local services - Drugs

Many pharmacies across the county provide:

- Dispensing for prescriptions issued for the management of substance misuse problems, including pharmacy services in each of the 5 prisons in Lancashire (HMP Preston, HMP Garth, HMP Wymott, HMP Kirkham and HMP Lancaster Farms – newly reclassified from HMYOI).
- Supervised consumption of prescribed medication and
- Needle and syringe exchange.

5.8.4.1 Local service: Dispensing services

Lancashire has one of the largest treatment systems in the UK with approximately 5000 people in drug treatment services in any one year. A significant number of these will be offered substitute prescribing interventions as part of a wider holistic treatment package. The dispensing by local pharmacies is a key element of this treatment delivery and is largely focussed on methadone and buprenorphine dispensing, though other medications will be used. Pharmacies also play a key role in liaising with treatment providers around missed collections and or how well individuals appear to be doing in treatment between service appointments.

5.8.4.2 Local service: Supervised consumption

Many service users are placed on supervised consumption in community pharmacies for periods during treatment either as a safety measure or relating to broader issues such as safeguarding. The substances that supervised consumption is used for are methadone and buprenorphine.

Those pharmacies involved are contracted either by LCC via the CSU or by substance misuse treatment providers (depending on the locality).

5.8.4.3 Local Service: Needle and syringe exchange

Needle and syringe exchange is a key harm reduction measure in the prevention of Blood Borne virus (BBV) transmission. Equipment, including related legal paraphernalia such as swabs etc. should be supplied to all injectors regardless of the substance being used (e.g. not restricted to opiate users, but may also include stimulant and steroid users for example). Pharmacies are supplied via the substance misuse treatment providers around the county with the equipment required and are trained and encouraged to engage Needle Exchange service users in discussion around their health and substance misuse and offer referral into local services.

Those pharmacies involved are contracted either by LCC via the CSU or by substance misuse treatment providers (depending on the locality).

5.8.5 Consideration of services offered – Alcohol & Drugs

Pharmacies play a key role in the delivery of substance misuse treatment interventions in Lancashire, however further developments could be made around the prevention and screening agenda.

Further work is currently on going to standardise the specifications for the delivery of supervised consumption and needle exchange across the county with plans in place to devolve commissioning responsibility to substance misuse treatment providers as part of their contractual obligations.

Local pharmacies are well placed to offer more services to the population around alcohol use and misuse. A key area for expansion would be alcohol information and brief advice. Initial discussions between Public Health (LCC) and the pharmacy network have already been held and there is interest on both sides, but no plans are currently in place to take this further.

5.9 The health of older people

5.9.1 Local health needs

In Lancashire in 2011, there were 211,193 people aged 65 or over. People in Lancashire are living longer and in the county, the number of people over 65 grew by 12% between 2001 and 2011. This is a slightly higher rate than the national growth of the 65+ age group at 11%[xliii]. In total, the over-65 population of Lancashire is projected to increase by 58% over

the next twenty years. This figure is in line with the national average (60%) but slightly above the regional (51%) projected increase. However, the over-85 population is estimated to grow considerably faster, with a 145% increase over the next 20 years. The Lancashire figure is above both the national (136%) and the regional (131%) projected increases[xliv].

Key stakeholders from across Lancashire put together priority topics for health and wellbeing issues in older people. The priority topics identified by the stakeholder group are:

1. Prevention and protection in a safe environment
2. Lifestyle
3. Mental health and wellbeing
4. Long term conditions and end of life care
5. Carers
6. Pathway of care and integration of services for older people

Further information regarding the health and wellbeing of older people can be found in the JSNA for older people in Lancashire (2013)[xlv] and JSNA for Dementia (2014).[xliv]

5.9.2 Local services

Support for people to ensure that they remain healthy for as long as possible through the provision of healthy lifestyle advice is important. Community pharmacies can support self - care where appropriate, as well as referring back to the GP service or signposting clients to other appropriate services.

Many patients receive a range of different medications and up to 50% of patients do not take their prescribed medicines as intended.[xlvi] Help with this, particularly for those who have complex medication regimens or have problems with taking their medication regularly, could be offered by a pharmacist working as part of a local clinical team whether in a pharmacy or doctors surgery, to give advice and support to the patients and their carers and to other healthcare professionals.

5.10 Long term conditions

Patients with Long Term Conditions (LTCs) are likely to be taking medication, often several medications. These patients have a particular need to understand the role medicines play in managing their condition in order to gain maximum benefit and reduce the potential for harm. Several types of interventions (e.g. reduced dosing demands as well as monitoring and feedback) may help in improving medication adherence[xlvii]. Self-monitoring of medication taking can also potentially be facilitated by new technologies (e.g. automatic pill dispensers and home blood pressure monitors) [xlviii]. It should be noted that, ideally, research in this field should consider not only patient adherence to medication but also patient outcomes.

Under NHS contractual arrangements community pharmacists already have the opportunity to carry out Medicines Use Reviews (MURs). As part of the Dispensing Services Quality Scheme (DSQS) dispensing staff are trained to discuss issues of concordance and compliance with patients during a Dispensing Review of Use of Medicines (DRUM). Any issues or concerns raised are then referred to the appropriate health care professional for follow up. Both pharmacy MURs and dispensary DRUMs are designed to improve the patient's understanding of the importance of the medicine in controlling their disease and the

reason for taking medicine appropriately. These can improve patient concordance and support and reinforce the advice given by the prescriber. There are opportunities to increase the uptake of MURs and in the future to target pharmaceutical care towards complex cases.

The HWB and its partners recognise the importance of improving awareness of the risks associated with LTCs. Health campaigns aimed at improving medicines-related care for people with LTC and therefore reducing emergency admissions could be provided through community pharmacies. In addition pharmacists and their staff already provide a signposting service to other sources of information, advice or treatment.

Community pharmacists could be involved in monitoring the use of, for example: statins, blood pressure regulating medication and supplementary prescribing, making adjustments to the treatment being received by the patient.
Pharmacists are also involved in the early detection of some cancers, for example, through the provision of advice on skin care and sunbathing, and participating in the Be Clear on Cancer campaign[xlix], which aims to improve early diagnosis of cancer by raising awareness of symptoms and making it easier for people to discuss them with their GP.

5.10.1 Long term conditions (LTCs) in Lancashire

The prevalence of several LTCs across all Lancashire CCGs are significantly higher than the national average e.g. coronary heart disease, chronic obstructive pulmonary disease, asthma and depression.

Table 11. Long-term conditions disease registers and prevalence, by CCG. 2012/13

Significantly higher than England | Significantly lower than England | Not significantly different from England

Long-term condition	Number/ %	Chorley & South Ribble CCG	East Lancs CCG	Greater Preston CCG	Lancs North CCG	West Lancs CCG	Fylde & Wyre CCG	England
Coronary Heart Disease	Number on register	7,095	15,467	7,914	7,579	6,491	4,399	**1,870,000**
	Prevalence (%)	4.1	4.2	5.2	3.6	4.0	3.9	**3.3**
Hypertension	Number on register	24,633	50,639	25,572	27,341	21,253	17,178	**7,660,000**
	Prevalence (%)	14.1	13.8	16.9	13.0	13.1	15.3	**13.7**
Diabetes Mellitus (ages 17+)	Number on register	8,879	18,574	10,065	7,628	5,611	8,222	**2,703,000**
	Prevalence (%)	6.3	6.4	6.0	5.8	6.2	6.5	**6.0**
Chronic Obstructive Pulmonary Disease	Number on register	3,567	8,777	3,639	4,116	3,490	2,379	**975,000**
	Prevalence (%)	2.0	2.4	2.4	2.0	2.2	2.1	**1.7**
Cancer Register	Number on register	3,664	7,522	4,284	3,731	3,374	2,483	**1,082,000**
	Prevalence (%)	2.1	2.0	2.8	1.8	2.1	2.2	**1.9**
Mental Health	Number on register	1,283	3,591	1,331	1,858	1,382	784	**471,000**
	Prevalence (%)	0.7	1.0	0.9	0.9	0.9	0.7	**0.8**
Asthma	Number on register	11,064	25,787	10,184	13,793	10,654	7,213	**3,359,000**
	Prevalence (%)	6.3	7.0	6.7	6.5	6.6	6.4	**6.0**
Dementia	Number on register	1,050	2,197	1,251	1,169	1,189	748	**319,000**
	Prevalence (%)	0.6	0.6	0.8	0.6	0.7	0.7	**0.6**
Depression (ages 18+)	Number on register	10,024	17,741	13,282	9,980	6,062	9,389	**2,582,000**
	Prevalence (%)	7.2	6.2	8.0	7.7	6.8	7.6	**5.8**

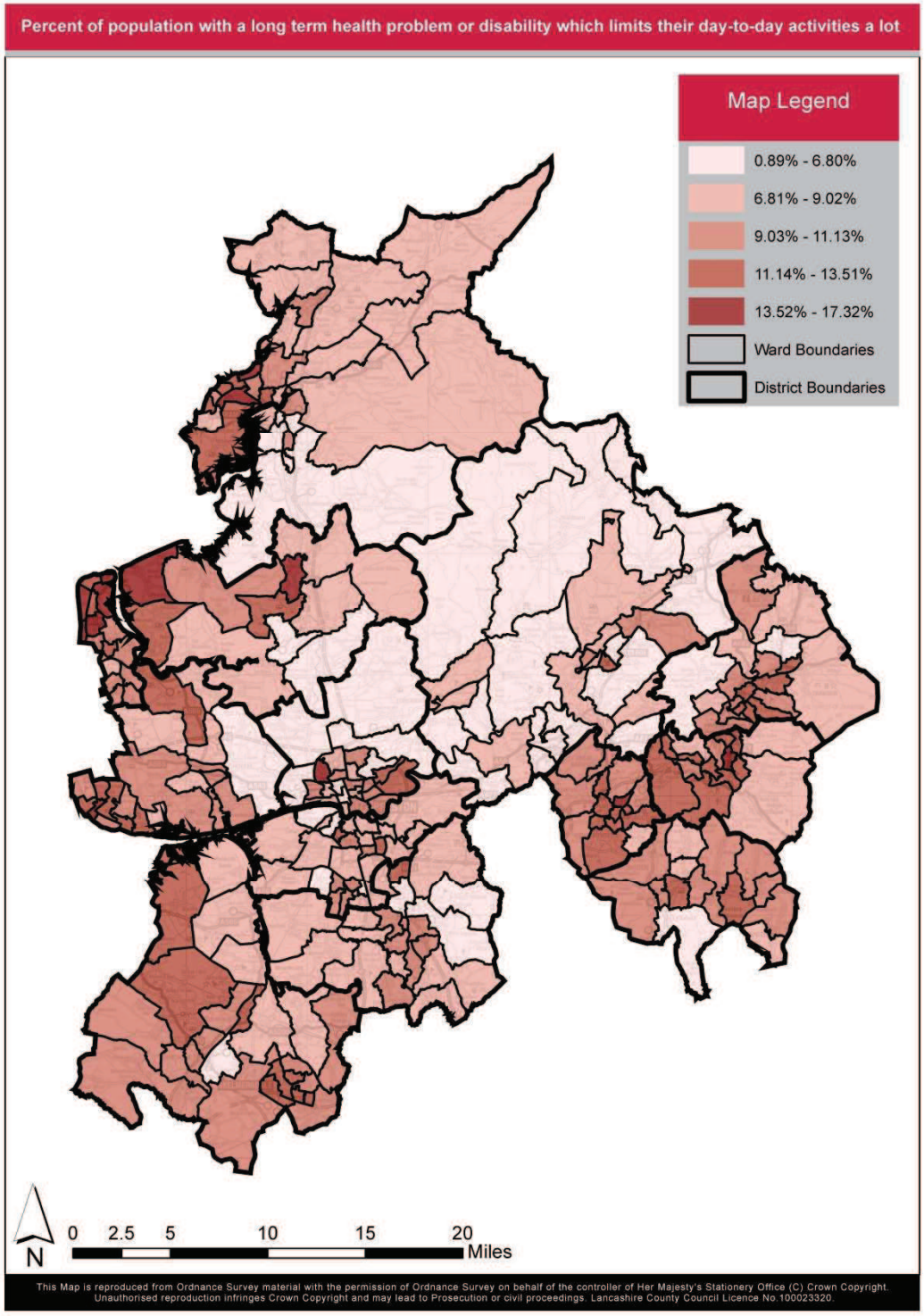
Source: Health and Social Care Information Centre. 2012/13

A bespoke JSNA for LTCs in Lancashire-14 has been completed [I] and focuses on the four main non-communicable disease groups identified by the World Health Organization in 2010:

- Cancer
- Cardiovascular disease
- Chronic respiratory diseases
- Diabetes

Map 79 shows the variation, across Lancashire, in the percentage of population reporting to have long-term health problem/disability which limits their day-to-day activities a lot, in 2011 Census.

Map 79. Percentage of population reporting long-term illness, by ward, 2011 Census



5.11.2 Consideration of services offered

Many patients with long term conditions receive a number of different medications for co-morbidities. Help with this, particularly for those with complex problems of concordance, could benefit from the intervention of a pharmacist working within a local clinical team, to give both them and other health professionals' advice and support.

Five priorities were identified in the Lancashire JSNA for long-term conditions. The priorities are listed in the table below along with, where applicable, the appropriate recommendations. A detailed report is available from the Lancashire JSNA website. [I] Not all of these priorities are relevant to pharmaceutical services.

Priority	Description	Recommendations
Intelligence	Intelligence for long-term conditions that is fit for purpose	Not applicable to pharmacies
Prevention	Greater emphasis on reducing the prevalence and impact of LTCs	• Health literacy should become integral to LTC, and developed throughout the whole population. This will ensure that people have the knowledge and power to make better health choices that could prevent or delay the onset of long-term conditions and prevent existing conditions from worsening or becoming a much larger burden on people's lives. • Policies concerned with wider determinants should be assessed for their impact on the development of LTCs e.g. urban planning and use of space and active transport (walking and cycling); housing renewal programmes; licensing; welfare advice. • Commissioners should focus on developing new models of delivery of effective and cost effective universal and targeted preventive interventions through collaborative approaches with all stakeholders. • Joint commissioning opportunities should be pursued between CCGs, local authorities, health and social care providers and the third sector to deliver value for money effective and cost effective health improvement interventions that are sensitive to the needs of different population groups. • Commissioners should ensure that service users are involved in the design, planning and evaluation of health promotion programmes. • Commissioned public health interventions targeted at children and young people should be recognised as part of a lifecourse approach to preventing the development of LTCs. • The evaluation of existing asset-based community projects associated with reducing risk factors for LTCs should focus on outcomes and identify key messages for future projects.
Urgent care	Improving the management of urgent care for people with chronic multiple conditions	• The high admission rates for chronic conditions and use of emergency bed days across Lancashire require further investigation. • Commissioners should focus on developing integrated approaches to managing urgent care that involve hospital, community, primary and ambulance services through joint service planning and sharing of clinical information through individualised care plans. • Commissioners should determine the patient and carer journey during urgent care episodes that encompass clinical pathways and patient flows in order to identify areas of inefficiency and ineffectiveness. • Healthcare staff in urgent care settings should be knowledgeable and competent in the required skills and attitudes for working with older people. Training should be provided where necessary to meet these requirements.
Long-term conditions model of care	Development of the LTC model of care	• Commissioners, working in partnership with all stakeholders, should seek to develop the LTC model of care locally in a way that builds on lessons learnt from those areas where development is already underway. • This LTC model of care requires providers to develop an integrated care response with the development of integrated neighbourhood teams based on a whole-person centred model of delivery.

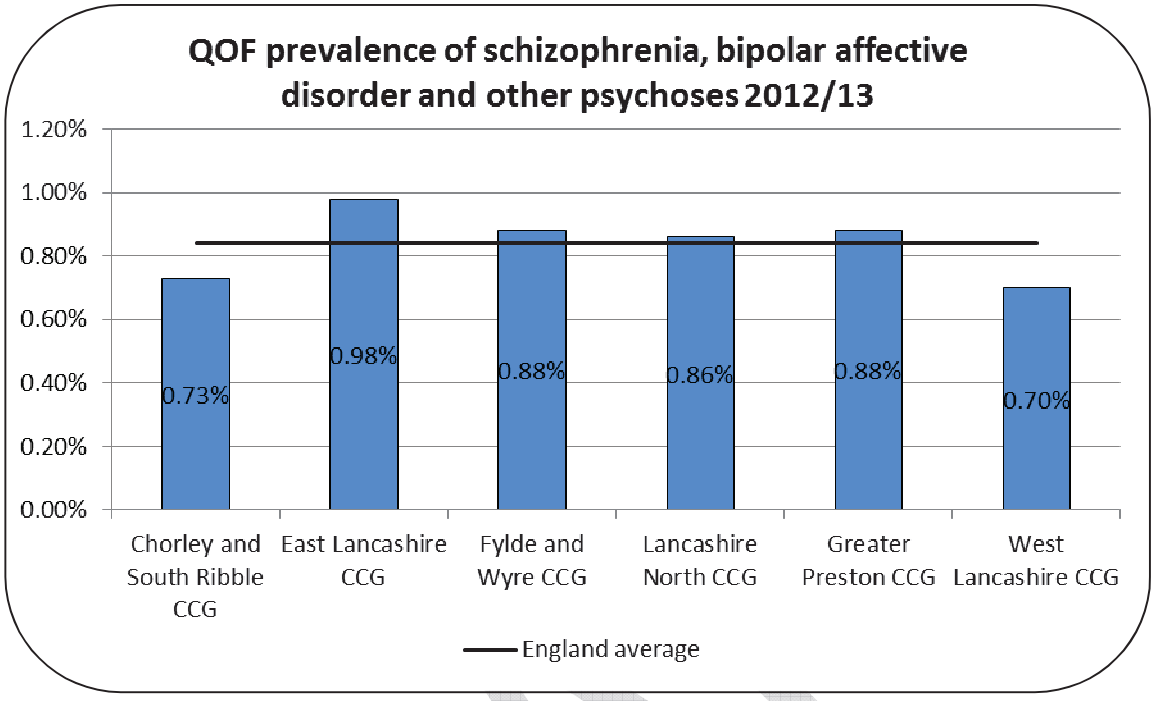
		• Development of the LTC model of care should occur within a whole systems framework that maximises opportunities for 'non–traditional' services to support self-management and shared decision-making. • The LTC model of care should encompass a single point of access underpinned with an individualised care plan that includes an emergency care plan. • Commissioners should take account of national developments surrounding the year of care currencies, and national pricing model and work with providers through the necessary contract processes to develop and implement a funding model that promotes a person-centred, self-care approach.
Empowerment	Empowerment of service users and carers	• Health literacy should become integral to LTC, and developed throughout the whole population. This will ensure that people with long-term conditions have the knowledge, health choices and power to better manage their own health and that of the people they care for. It will enable those who don't have long-term conditions to increase their resilience and to understand how their health behaviours can protect them from developing long-term conditions. • Commissioners should determine how self-management and shared decision-making link in with wider primary and secondary prevention structures and activities so that the 'whole system of prevention' sits within a broad strategic framework. • Working in partnership with stakeholders, commissioners should critically examine the balance of self-care delivery across traditional and other, non-traditional providers in order to determine the most optimal form of self-care provision. • Self-care should therefore be systematically coordinated through clearly determined pathways that can be delivered sensitively and appropriately, across and between a range of different organisations and groups. • Building on existing networks and partnerships with third sector bodies, local communities and other stakeholders commissioners should map available community assets for supporting self-care, particularly with vulnerable population groups. • Opportunities for service users and carers to use acceptable and accessible forms of technology and social media for education, condition management and/or support should be developed and their subsequent use evaluated. • The availability of MUR should be increased through community pharmacies particularly in those areas with a high prevalence of LTCs. • Any introduction of self-care should incorporate the necessary preparation and training for both health and social care professionals and service users.

5.12 Mental health

Pharmacy staff can play a role in promoting awareness of good mental health, for example signposting to information about local support networks, mental health help lines etc. Community pharmacists can also help by promoting simple mechanisms to help people understand and take their medicines as intended. If necessary the patient could receive medication by instalment dispensing or through supervised administration.

Lancashire CCGs have 10,229 patients on their mental health registers (QoF12/13). In Lancashire, the area with the highest prevalence of mental health patients is East Lancashire CCG (0.98%) (see Figure 6). West Lancashire (0.70%) has the lowest prevalence.

Figure 6. QOF prevalence of schizophrenia, bipolar affective disorder and other psychoses (%), by CCG. 2012/13.



Source: PHE general practice profiles.

5.12.1 Local Services

There is information on 5 ways to well-being and sign up to the website is encouraged – www.lancashirewellbeing.co.uk

Good levels of well-being in the population are in everyone's interest. People who report higher levels of wellbeing tend to be more involved in social and civic life, are more likely to behave in environmentally responsible ways, have better family and social relationships at home and are more productive at work. Lancashire County is encouraging individuals and organisations to adopt the five ways to improved wellbeing as identified by the New Economics Foundation:

- **Connect** with family, friends, colleagues and neighbours at home, work, school or in your local community
- **Be active** - discover a physical activity you enjoy and that suits your level of mobility and fitness
- **Take notice** - be aware of the world around you and what you are feeling
- **Keep learning** - learning new things will make you more confident as well as being fun
- **Give** - volunteering can be incredibly rewarding and creates connections with the people around you.

Social Prescribing

Social Prescribing is a mechanism for linking people experiencing, or at risk of experiencing, emotional health problems, with non-medical sources of support within the community – it

aims to look at the causes behind a person's distress and help them find solutions to address them.

A Social Prescribing programme provides an assessment and coordination function which identifies the needs and strengths of an individual and supports them to find their own solutions, linking them into and a range of community activities, such as: community groups focusing on self-management, skills development and building confidence and self-esteem; Computerised cognitive behavioural therapy; Arts and Health activity; promotion of physical activity; Bibliotherapy (self help books from participating libraries); supporting people to return to work, volunteering or vocational/further education; increasing social support and inclusion; Advice and information services (on finance, debt, housing etc.);

Social prescribing services currently sit within all the Help Direct services across Lancashire. To self-refer please contact the local service – details below:

Telephone: 0303 333 11 11 or email enquiries@helpdirect.org.uk

Or contact the local offices:

East Lancashire - http://www.helpdirect.org.uk/east-lancashire

Wyre and Fylde – No 3 Errigal House, Avroe Crescent, Blackpool, FY4 2DP - Open 9am - 5pm Monday to Friday

Can also be found throughout Fylde and Wyre at various outreach surgeries in the area - times dates and locations can be found on the What We Do page or contact for more details, email admin@fwhelpdirect.org

West Lancashire - The West Lancs team is based in Ormskirk and covers everywhere in West Lancashire. People can also drop in to their office on Moorgate, Ormskirk, L39 4RY (Opposite Happy Hippos).

Lancaster - The Help Direct Lancaster team is based at 7-11 Chapel Street, Lancaster which is the Age UK shop. Click here for directions.

Preston - 30 Cannon Street, Preston, PR1 3NS

Chorley - The Help Direct Chorley team is located in the Age UK building, 61-63 St Thomas Road, Chorley.

South Ribble - South Ribble within Roccoco Coffee Lounge, 41 - 45 Chapel Brow, Leyland PR25 3NH

Books on Prescription - http://www.booksonprescription.org.uk/

Cognitive behavioural therapy self-help books can provide very effective help and treatment for a range of common emotional and mental health problems such as depression, anxiety, phobias, low self-esteem, insomnia, panic and agoraphobia, obsessive compulsive disorder and eating disorders.
All of the books in the scheme are endorsed by health care professionals and have already helped thousands of people get better.

The above website features all 30 of the books in the Reading Well Books on Prescription scheme and *every library in Lancashire* has the full set of books available.

Improving Access to Psychological Therapy services (IAPT)

Self referral into IAPT services – Currently, only available in Blackburn and East Lancashire.

Lancashire Care NHS Foundation Trust (LCFT), Improving Access to Psychological Therapies (IAPT) Services.

Improving Access to Psychological Therapies (IAPT) is an initiative that aims to make psychological therapies (talking therapies) more accessible to people, especially those with stress, anxiety and depression. Lancashire IAPT Services offer a range of interventions such as:

- Groups
- Workshops
- Courses
- Computerised Cognitive Behavioural Therapy
- Supported Self-Help with a Psychological Wellbeing Practitioner
- Cognitive-Behavioural Therapy
- Counselling

For more information or to obtain a self-referral pack please contact your local IAPT Service:

IAPT East Lancashire: 01282 657116

IAPT Blackburn with Darwen: 01254 226037

IAPT Chorley and South Ribble: 01772 643168

IAPT Preston: 01772 773400

IAPT West Lancs: 01695 588254

IAPT Fylde and Wyre: 01253 655943

IAPT Lancaster and Morecambe: 01524 550550

5.12.2 Consideration of services offered

There are several ways that people can support their own mental; health, and self referral options for additional support as outlined above. Pharmacies can direct people to such forms of support and encourage uptake of self-help methods.

5.13 Healthcare associated infections

Pharmacy providers are involved in part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and C difficile.

Senior specialist antimicrobial pharmacists within hospitals, Medicines Management pharmacists within the CSU, Specialist Nurses Infection Prevention within Local Authority and microbiology must work together to develop, implement and monitor antimicrobial guidelines across the local health economy. This will involve community pharmacists and GPs working together with hospital teams to align prescribing with the agreed local policy. Within the secondary care setting it is possible for pharmacists to lead on 'switching' policies to convert patients from intravenous therapy to oral drug therapy at the earliest appropriate opportunity.

Increasingly patients are treated with intravenous antibiotics at home and the patient's regular community pharmacy, together with hospital pharmacy services, should be aware of, and could be involved in their treatment.

Within primary care, dispensing staff are able to reinforce the message that antibiotics are not always necessary and explain the relationship between excessive use of antibiotics and Health Care Associated Infections. In addition they are able to inform other primary care practitioners when an item prescribed is not normally available in the community.

5.14 Medication related harm

5.14.1 Local health needs

In their report *Safety in doses: improving the use of medicines in the NHS,* the National Patient Safety Agency reviewed medication incidents reported to the RLS in 2007[li]. The most serious incidents reported included 100 medication incident reports of death and severe harm. Most serious incidents were caused by errors in medicine administration (41%) and, to a lesser extent, prescribing (32%). Three incident types – unclear/wrong dose or frequency, wrong medicine and omitted/delayed medicines – accounted for 71% of fatal and serious harms from medication incidents.

A prospective study of a random sample of residents within a purposive sample of homes in three areas found that two-thirds of residents were exposed to one or more medication errors. The authors concluded that "the will to improve exists, but there is a lack of overall responsibility. Action is required from all concerned[lii]."

5.14.2 Local services

Community pharmacy can further contribute to improving health outcomes and reduce health inequalities for local people for example, through the concept of Healthy Living Centres promoting and supporting healthy living and self-care or providing targeted help with medicines to improve health through for example Medicines Use Reviews, New medicines Service. CCGs will continue to work with existing pharmacies to develop and improve pharmaceutical services throughout Lancashire for the benefit of local people.

In the community, pharmacists should work with GPs and nurse prescribers to ensure safe and rational prescribing of medication.

NHS England works with all pharmacies and other agencies to ensure that they are contributing to the system wide implementation of safety alerts – for instance NPSA alerts on: anticoagulant monitoring, methotrexate, lithium safety, cold chain integrity etc.

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

5.14.3 Consideration of services

The CSU Medicines Management Team on behalf of the CCG are responsible for working with primary medical care contractors, providers of pharmaceutical services and social care partners to determine how medication errors in care homes for older people can be reduced by reviewing the safety of local prescribing, dispensing, administration and monitoring arrangements in the provision of medication to older people in care homes. The team, consisting of Pharmacists and Technicians and working with local GP practices, attends nursing homes to carry out medication reviews to ensure patients are receiving the medications they should be and to reduce wastage.

5.15 Migration

5.15.1 Local needs

A JSNA for migration in Lancashire[liii] highlights that the reasons migrants come to the UK and to a particular area are varied. For some it will be to go to university; for others it will be because of the general availability of jobs or because work in a particular sector, such as tourism or agriculture, is available. Some may come to Lancashire because family or friends are already living here. They provide labour and skills for local business and public services. Many migrant workers are working below their skill level even if their skills are in areas where there are skill shortages.

The number of registrations in the county council area was 4,100 in 2009/10. This is a decrease of 1,740 on the number in 2008/09. This is the third annual decrease since figures were published and is similar to the decrease between 2007/08 and 2008/09 of 1,150[liv].

The wellbeing and integration of migrant workers is affected by their financial situation, access to adequate and affordable accommodation and access to English language courses designed to meet their needs. In 2009/10 there were 7,691 new GP registrations by international migrants within the county council area.

5.15.2 Consideration of services offered

From the local health data the populated areas where migrant workers reside have adequate provision of pharmacies and are easy accessible including pharmacies that speak a range of languages and have extended opening times.

There is a need to ensure the migrant worker population are aware of the services offered by primary care services, especially pharmacies, emphasising the health promotion and disease prevention elements and the provision of service given even if they are not registered with a GP Practice.

5.16 Community Pharmacy Minor Ailments Service

The White Paper *Pharmacy in England – Building on Strengths, Delivering the Future*[lv] set out the introduction of minor ailments services that promotes pharmacy as the first port of call for people with minor ailments and complements GP and out-of-hours medical provision.

The service aims to provide greater choice for patients and carers, and improved access to health care professionals by utilising the expertise of the pharmacists, so they become the first port of call for minor ailments. This can complement other medical services provisions and educate patients in self-care, thereby reducing the impact on GP consultations. The service aims to encourage patients to self-refer to their local community pharmacy where appropriate. The community pharmacist will provide advice on specified minor conditions and supply medicines, according to the local formulary, free of charge for patients exempt from prescriptions charges (this includes patients with a prepayment certificate).

To register for the service, a person must be registered with a GP practice. Patients who are exempt from prescription payment will receive medication supplied under this scheme free of charge, patients who pay for prescriptions may choose to purchase over the counter medicines rather than pay a prescription charge for a medicine supplied under the Minor Ailments Service.

Patients attending the pharmacy in person will receive a consultation and if appropriate a supply of medication, in the same way they would be required to attend a GP appointment for a prescription. Patients will be referred on to the GP/other healthcare professional when they present with symptoms formulary medicines are not suitable for an individual patient or the symptoms require referral or when the patient is requesting a medicines to treat a condition not covered by the scheme.

No treatment is provided for children of less than three months of age. In some CCGs, where minor ailment scheme is provided, the pharmacist provides the patient with a unique number on a registration card.

The following minor ailments are an example of what may be included in some schemes (***these vary in different CCGs***):

- Allergies, Bites and Stings
- Hayfever
- Colds and Flu, temperature and fever (children only)
- Cold sores
- Constipation
- Nasal congestion
- Conjunctivitis
- Cystitis
- Diarrhoea
- Pain relief (including backache, toothache and sore throat)
- Headlice, Sore Throat, Earache
- Indigestion / Heartburn
- Coughs, Temperature, Nasal Congestion
- Fungal Skin Infections
- Vaginal Thrush

Chorley & South Ribble, Greater Preston and West Lancashire CCG provide the following:

- Constipation
- Diarrhoea
- Head lice, Sore Throat, Earache
- Hay Fever, Conjunctivitis, Indigestion and Infant Gripes, Thread Worm
- Coughs, Temperature, Nasal Congestion
- Fungal Skin Infections, Athletes Foot, Dermatitis, insect bites & stings, scabies
- Thrush, Cold Sores, Nappy Rash, Headache, mouth ulcers
- Cystitis
- Teething
- Verrucas / warts

5.17 Community Pharmacy Palliative Care Service

Palliative care is the care of any patient with an advanced, incurable disease. It involves the control of symptoms, such as pain and aims to improve quality of life for both patients and their families. Drug treatment plays a major role in symptom control in palliative care. The aim is to ensure that appropriate palliative care drugs are available in the community at the point of need.

The demand for palliative care drugs can be urgent and unpredictable. A number of drugs used in palliative care are rarely used in other circumstances and are therefore often not readily available from community pharmacies.

Designated community pharmacies hold essential palliative care drugs for easier access. The drugs that must be held in stock by pharmacies taking part in the scheme are listed in the essential list of palliative care drugs agreed with palliative care clinicians. For some CCGs (Chorley and South Ribble and Greater Preston) the Out Of Hours (OOH) provider holds a number of the palliative care drugs and will dispense to patients out of pharmacy hours, they do not hold the full stock list as detailed in the palliative care service specification.

In East Lancashire CCG, a community pharmacy locally commissioned service for stockholding and provision of specialist drugs in palliative care provides increased availability of such drugs to patients. The objectives of the scheme is to improve access and continuity of supply for patients, carers and healthcare professionals and support them by providing up to date information, advice and referral where appropriate

5.17.1 "Just In Case" Palliative Care Service (Fylde & Wyre CCG only)

Designated community pharmacies hold, “Just In Case,” (JIC) palliative care drugs. JIC drugs are anticipatory and therefore prescribed in advance of the patient needing them and stored in the patient’s home. The purpose of this is that the patient has access to essential palliative care drugs in case of deterioration in condition which can immediately be accessed. Health care professionals can access these drugs in the patient’s home, out of hours, and therefore treat the patient in their own home.

5.18 Community Pharmacy Healthy Start Service

Healthy Start is the Department of Health's scheme to help pregnant women and children under four in low-income families eat healthily. Healthy Start replaces the welfare food scheme. It is active throughout Great Britain and Northern Ireland.

The scheme:

- Includes vouchers for fresh fruit and vegetables as well as milk and infant formula milk.
- removed
- Encourages earlier and closer contact between health professionals and families from disadvantaged groups.
- Provides coupons to swap for free vitamins suitable for:
    - pregnant women
    - breastfeeding women
    - children aged 6 months to 5 years old

Healthy Start vouchers aim to:

- Improve the nutrition of pregnant women
- Increase fruit and vegetable intake
- Initiate and maintain breastfeeding
- Introduce foods in addition to milk as part of a progressively varied diet when infants are six months old.

The scheme makes healthy start vitamin supplements available, and this is being achieved through arrangements with local community pharmacies. Pharmacy coverage is voluntary and unpaid.

5.19 Healthy Living pharmacies

Introduction

The political context for healthy living pharmacies (HLPs) was set out in the 2008 pharmacy white paper, 'Pharmacy in England: Building on Strengths, Delivering the Future'. [lvi]

This described how, in time, community pharmacies would become healthy living centres, which would promote and support healthy living by offering healthy lifestyle advice and support on self-care and a range of pressing public health concerns.

The public while fully aware of pharmacy's core role in the supply of prescription medicines and providing medicines over the counter, had little awareness of the broader role pharmacists and their teams could play in looking after their health and wellbeing. Research commissioned in 2008 by the Department of Health (DH) showed that, while around one in 10 people received health advice from their pharmacy, very few used pharmacy to access other health-related services, such as regular monitoring of current health conditions and screening for things such as diabetes and cholesterol. [lvii]

NHS Portsmouth were asked by Department of Health to develop a national framework for HLP in recognition of local innovation underway. A national reference group was formed and academic research and support commissioned.

The HLP framework developed involves a system-wide approach to support change across the profession and within the workplace, an organisational development tool, and a brand that unites community pharmacy while changing public perceptions about what community pharmacy can offer in supporting their health.

A national pathfinder commissioned to test whether the HLP framework developed in Portsmouth was transferable across demography and geography demonstrated similar positive results. Benefits have also been realised by commissioners, contractors and employees and significantly, the public welcomed the concept.

NHS Blackburn with Darwen and NHS East Lancashire were selected as a pathfinder site. That experience has proved very informative and beneficial in supporting the current HLP programme. Service outputs broadly by HLPs were increased compared to before the pharmacy became an HLP and in comparison to non-HLPs. This has now been extended to a Pan-Lancashire service.

In Lancashire the Healthy Living Pharmacy programme is co-ordinated by the HLP Strategic lead who chairs a steering group of senior Public Health leads and the Lancashire Local Pharmaceutical Committee. A Lancashire HLP prospectus has been drawn up that local pharmacy contractors are invited to sign up to. Healthy Living Pharmacy is an identified priority in the Local Professional Network (Pharmacy)(LPN) work plan and is accountable to the LPN for roll out and delivery of the plan.

What is a healthy living pharmacy?

Healthy living pharmacies put their local community's health and wellbeing at the core of everything they do. They consistently deliver a range of services to a high quality and are recognised with a HLP Quality Mark.

HLP enablers

Important HLP enablers to support delivery include:

- Workforce development
- Engagement with the community and other providers
- Premises that are fit for purpose and support health promotion.

All Lancashire HLPs have at least two health champions, usually members of the medicines counter team, who proactively engage with the public and create a health-promoting environment. The pharmacist or pharmacy manager will have undertaken leadership and change management training to support a team approach and lead a 'supply plus service' delivery model.

To achieve the HLP quality mark locally, pharmacies have to demonstrate that they:

- Consistently deliver a range of health and wellbeing services to a high quality
- Meet the HLP quality criteria requirements [lviii]
- Have a team that actively promotes health and wellbeing, proactively offers brief advice and signposts to relevant local and/or national support
- Have at least two trained health champions, who have achieved the Royal Society for Public Health's Understanding Health Improvement Level 2 Award

- Have a health-promoting environment with premises that are fit for purpose
- Proactively engage with the local community, and other health and social care providers and professionals
- Display the HLP logo

HLPs have a different skill mix and a team approach which enable staff to make every contact count.

Role of a pharmacy health champion

The accessibility and location of community pharmacies offer significant opportunities to make every contact count and provide individuals visiting the pharmacy with information, signposting them to the NHS and other local community services.

The health champion is an important member of the HLP team.

A pharmacy's health champion will undertake a number of activities including:

- Engaging proactively with individuals and the community on health and wellbeing issues, signposting them to relevant services within and outside the pharmacy
- Leading on health promotion activities
- Keeping the 'health promotion zone' up to date
- Supporting the delivery of local and national health promotion campaigns
- Working with the team to identify and implement community outreach activities
- Maintaining a signposting resource within the pharmacy
- Developing window displays to attract the public into the pharmacy to use its health and wellbeing services.

Other activities might include:

- Networking with other health champions to share ideas and see what works well
- Assist in the delivery of services such as stop smoking, weight management, chlamydia screening and other services not requiring the specific input of a pharmacist at every stage.

Within their HLP they may take a lead with their colleagues to ensure that the whole team is engaged in the concept.

Healthy Living Pharmacy and local priorities

Analysis of pathfinder reports indicated the value of HLPs for:

- Commissioners, showing that community pharmacies are able to deliver health and wellbeing services to meet local health needs.
- Public health teams who understood the potential for HLPs to deliver these types of health services effectively.
- Contractors - the results of the quantitative survey to assess the benefits of HLP status on contractors was positive for all contractor types and implementation of the HLP concept was seen as worthwhile for the business by over 70 per cent of contractors.

Healthy Living Pharmacy and commissioning intentions

Going forwards, the delivery of a pro-active approach and high quality services supports achievement of both Public Health England and NHS England outcomes. Identification of risk factors for life shortening diseases with appropriate signposting and/or referral helps prevent people dying prematurely; and targeted pharmaceutical support for patients with long term conditions provides enhanced quality of life.

The commissioning intentions for both Public Health England and NHS England would be to see as many HLPs as possible accredited throughout Lancashire, and to use these pharmacies as the platform from which to deliver high quality commissioned services within a setting where health and wellbeing information can be readily accessed. Initially that includes existing commissioned services but beyond that to develop, pilot and commission new services to improve capacity and extend access to healthcare within communities. All CCG areas have pharmacies working towards HLP accreditation.

Healthy Living Pharmacy has received widespread support from Ear Howe (minister for pharmacy), Professor Parish (PHE Advisory Board and former Chief Executive RSPH), Duncan Selbie (Chief Executive PHE), Professor Dame Sally Davies (Chief Medical Officer)

Text adapted from The Pharmacy Magazine CPD development programme Module 219 by Deborah Evans FRPharmS, pharmacy consultant, national HLP pathfinder work programme lead, and member of the Pharmacy and Public Health Forum. [lix]

5.20 Further opportunities

There is potential to draw on experiences from areas where community pharmacies have worked innovatively to address key local public health challenges and benefit local communities. Possible examples include work around fuel poverty, falls prevention (this will be built into screening pathway in Huntingdonshire), supporting people at risk of domestic abuse, and behavioural change initiatives.

6 Future Population Changes and Housing Growth

Key messages

Over the coming years, the population in Lancashire is expected to grow but not substantially. Several large-scale housing developments are in progress and a number of factors may influence the potential need for additional pharmaceutical service providers.

Lancashire's projected growth between 2014 and 2024 comes to approximately 2.8%, compared with a rise of 7.1% in England as a whole.

To ensure that pharmaceutical services are commissioned in line with population need, the Health and Wellbeing Board partners will monitor the development of major housing

sites and if necessary provide supplementary statements in accordance with regulations.

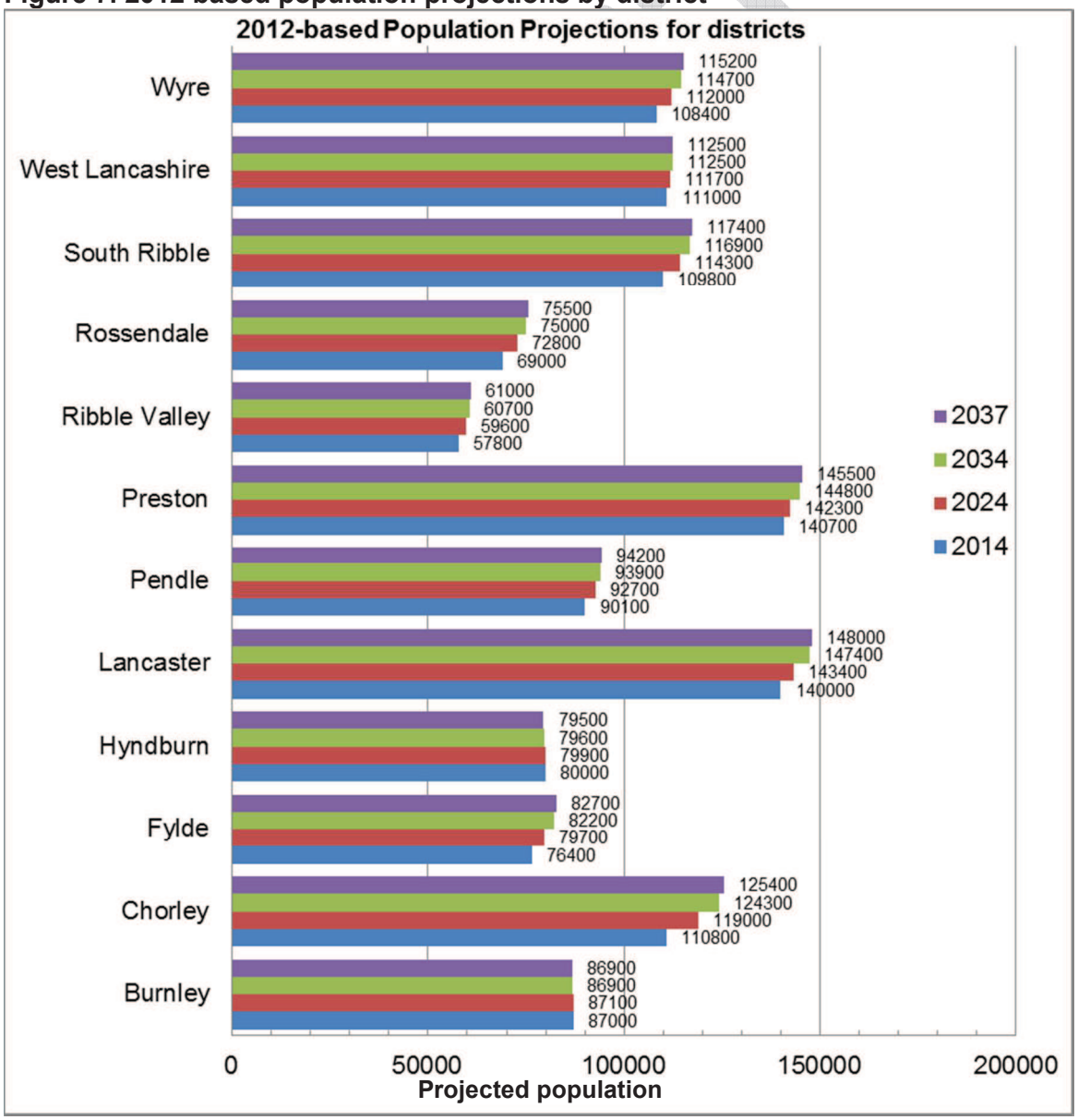
This section considers population changes and housing growth in Lancashire.

6.1 *Population changes in Lancashire*

The population of Lancashire was estimated 1,180,076 in 2013 and is expected to increase by approximately 34000 (3%) to 1,214,400 by 2024.

An overview of the population growth in Lancashire by district in the coming decades is shown in Figure 7.

Figure 7. 2012 based population projections by district



Source: http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/index.html

The percentage increase is projected to be at 3% by 2024. The estimated increases for Lancashire are noticeably below the projected national rate of change.

For the projected growth rates at the district level over the 10-year period (2014 to 2024), Hyndburn district is expected to record a population decrease of just -0.1%. This is the only projected decrease in the County, but the rate is so small that it shows that the district population is expected to remain fairly static. Other districts with rates of increase below 3% are Burnley (0.1%), Lancaster (2.4%), Pendle (2.9%), Preston (1.1%) and West Lancashire (0.6%). The highest population growth rates are predicted in Chorley (7.4%), Rossendale (5.5%), Fylde (4.3%) and South Ribble (4.1%).

Table 12. 2012 based population projections by district

Area	2014	2024	2034	2037	2014-2024 % change	2014-2037 % change
Burnley	87000	87100	86900	86900	0.1%	-0.1%
Chorley	110800	119000	124300	125400	7.4%	13.2%
Fylde	76400	79700	82200	82700	4.3%	8.2%
Hyndburn	80000	79900	79600	79500	-0.1%	-0.6%
Lancaster	140000	143400	147400	148000	2.4%	5.7%
Pendle	90100	92700	93900	94200	2.9%	4.6%
Preston	140700	142300	144800	145500	1.1%	3.4%
Ribble Valley	57800	59600	60700	61000	3.1%	5.5%
Rossendale	69000	72800	75000	75500	5.5%	9.4%
South Ribble	109800	114300	116900	117400	4.1%	6.9%
West Lancashire	111000	111700	112500	112500	0.6%	1.4%
Wyre	108400	112000	114700	115200	3.3%	6.3%
Lancashire	**1,181,000**	**1,214,400**	**1,238,900**	**1,243,800**	**2.8%**	**5.3%**
England	**54,227,900**	**58,072,600**	**61,315,100**	**62,166,000**	**7.1%**	**14.6%**

Source: http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/index.html

Table 13 details the population projections (both genders combined) by the available age-groups for the Lancashire County. Over the 10 year period, increases are projected in the 0-19 and 65+ years age group.

Table 13. 2012 projections by age group 2014-2037

Age group	2014	2024	2034	2037	% change between 2014 and 2024
0-19	273,500	280,000	272,800	270,400	2.4%
20-44	361,600	350,200	351,200	349,100	-3.2%
45-64	313,400	309,400	286,100	284,200	-1.3%
65+	232,500	274,800	328,700	339,900	18.2%

All ages	1,181,000	1,214,400	1,238,900	1,243,800	2.8%

Source: http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/index.html

6.2 Housing growth

Several major developments are expected to progress significantly during 2014 to 2026. There are developments in Central Lancashire which are underway and a number of other major developments are expected to begin.

6.3 Growth during 2014 – 2026

The information on house dwellings forecast in Lancashire has been compiled using a series of documents which have been adopted through the districts and are not the official figures. The series of documents, where the housing information has been extracted from, include local plans, strategic housing land availability assessments (SHLAAs), core strategies. These figures can change with time and any current information can be obtained from the district authorities' planning applications teams. Table 14 below shows a forecast of Lancashire's house dwellings, taken from the various documents.

Table 14: forecast of Lancashire's house dwellings

District	*2013 - 2014*	*2014 - 2015*	*2015 - 2016*	*2016 - 2017*	*2017 - 2018*	*2018 - 2019*	*2019 - 2020*	*2020 - 2021*	*2021 - 2022*	*2022 - 2023*	*2023 - 2024*	*2024 - 2025*	*2025 - 2026*
Burnley	130	130	130	130	130	130	130	130	130	130	130	130	130
Chorley	417	417	417	417	417	417	417	417	417	417	417	417	417
Fylde	408	408	408	408	408	408	408	408	408	408	408	408	408
Hyndburn	154	154	154	154	154	154	154	154	154	154	154	154	154
Lancaster	523	41	41	41	41	41	405	405	405	405	405	405	405
Pendle	170	170	170	170	250	250	250	250	250	250	250	250	250
Preston	507	507	507	507	507	507	507	507	507	507	507	507	507
Ribble Valley	75	75	75	75	75	75	75	75	75	75	75	75	75
Rossendale	247	247	247	247	247	247	247	247	247	247	247	247	247
South Ribble	417	417	417	417	417	417	417	417	417	417	417	417	417
West Lancashire	257	257	257	257	257	257	257	257	311	311	311	311	311
Wyre	225	225	225	225	225	225	225	225	225	225	225	225	225
Blackpool	235	235	235	235	235	235	235	235	235	235	235	235	235
Blackburn	530	530	625	625	625	625	625	625	720	720	720	720	720
Lancashire-12	3765	3283	3283	3283	3363	3363	3727	3727	3781	3781	3781	3781	3781

The following tables outline any large scale development (200 houses or more) till 2026 which have been identified in local plans and strategic housing land availability assessments

(SHLAA); the tables also state whether the particular site has passed the planning permission phase.

Chorley - Allocated

Site Name	District	Dwelling Capacity	Deliverable Completions 2011- 2016	Deliverable Completions 2016 - 2021	Deliverable Completions 2021 - 2026	Planning Permission
Land south of Cuerden Farm, Wigan Road, Chorley	Chorley	300	90	210	0	Yes
Land North Of Lancaster Lane Clayton-Le-Woods	Chorley	700	45	255	400	Yes
Outline application for the redevelopment of the former Camelot Theme Park	Chorley	420	Not mentioned in SHLAA or Local plan	Not mentioned in SHLAA or Local plan	Not mentioned in SHLAA or Local plan	No
Euxton Lane,Buckshaw Village	Chorley	761	120	312	329	No
Land of Moss Lane	Chorley	307	75	116	116	No

Chorley - Identified in SHLAA

Site Name	District	Dwelling Capacity	Deliverable Completions 2011- 2016	Deliverable Completions 2016 - 2021	Deliverable Completions 2021 - 2026	Planning Permission
Eaves Green, off Lower Burgh Way, Chorley	Chorley	304	0	152	152	No
Land at Sylvesters Farm, Euxton	Chorley	248	0	124	124	No

Fylde - Allocated

Site Name	District	Dwelling Capacity	Deliverable Completions 2011- 2016	Deliverable Completions 2016 - 2021	Deliverable Completions 2021 - 2026	Planning Permission
Land south of Queensway, Lytham, St Annes	Fylde	860	140	360	360	Yes
Pontins, Clifton Drive North, St Annes, Lytham	Fylde	275	200	75	0	Yes
Whyndyke Farm, Preston New Road,FY4 4XQ	Fylde	560	0	200	360	Yes
Land opposite Blackfield End Farm, Church Road, Bryning with Warton	Fylde	360	150	150	60	Yes
Former EDS, Heyhouses Lane, St Annes	Fylde	335	200	135	0	No
Former Marconi Factory, Lytham Road, Warton	Fylde	240	200	40	0	No
Total forecast dwellings in Fylde		6826	2391	2490	1945	

Fylde - Identified in SHLAA

No large enough sites identified in the Fylde SHLAA

Hyndburn - allocated

Site Name	District	Dwelling Capacity	Planning Permission
Central Huncoat	Hyndburn	391	No

Hyndburn – Identified in SHLAA

Site Name	District	Dwelling Capacity	Planning Permission
Land to north of Burnley Road, Huncoat	Hyndburn	470	No
Former Huncoat Colliery, Altham Lane, Huncoat	Hyndburn	223	No
Land at Moorside Farm, Altham	Hyndburn	693	No

Lancaster - Allocated

Site Name	District	Dwelling Capacity	Planning Permission
Lundsfield Quarry, Kellet Road	Lancaster	200	No
Luneside West	Lancaster	403	No
Land at Whinney Carr	Lancaster	900	No
Mossgate Park	Lancaster	395	Yes
Lancaster Moor Hospital	Lancaster	420	Yes

Lancaster - Identified in SHLAA

Site Name	District	Dwelling Capacity	Planning Permission
Brewers Barn, North Road, Carnforth	Lancaster	224	No
Land North East of Bailrigg Lane	Lancaster	750	No

Preston - Allocated

Site Name	District	Dwelling Capacity	Deliverable Completions 2011- 2016	Deliverable Completions 2016 - 2021	Deliverable Completions 2021 - 2026	Planning Permission
Former Whittingham Hospital	Preston	650	170	480	0	Yes
Haydock Grange, Hoyles Lane	Preston	450	300	150	0	Yes
Land at Lightfoot Lane	Preston	330	150	150	30	Yes
GOSS Graphics, Fylde Rd	Preston	358	0	0	358	Yes
Cottam (Hall & Former Brickworks)	Preston	1300	355	738	207	Yes
Avenham Car Park, Avenham Street	Preston	210	0	0	210	Yes
Land at Boyse's Farm & Eastway	Preston	460	300	160	0	No
Sandyforth Lane/Lightfoot Lane/Sandy Lane/M55	Preston	1400	450	400	550	No
Land off Whittingham Road, Longridge	Preston	280	50	230	0	Yes

Preston - Identified in SHLAA

Site Name	District	Dwelling Capacity	Deliverable Completions 2011- 2016	Deliverable Completions 2016 - 2021	Deliverable Completions 2021 - 2026	Planning Permission
LandChurch HouseFarm, Grimsargh	Preston	120	0	0	120	No
Land at Bank Hall Farm,Broughton	Preston	120	0	0	120	No
Bellway land to the East ofGoosnargh	Preston	120	0	0	120	No
West of Sandy Lane	Preston	350	0	0	350	No

Pendle - Allocated

Site Name	District	Dwelling Capacity	Planning Permission
Gib Hill, Nelson	Pendle	360	No
Knotts Lane, Colne	Pendle	230	No

Pendle- Identified in SHLAA

No large enough sites identified in the Pendle SHLAA

Ribble Valley - Allocated

Site Name	District	Dwelling Capacity	Planning Permission
Agricultural land of Henthorn Road, Clitheroe, BB7 2QF	Ribble Valley	270	Yes
Land to south-west of Barrow and West of Whalley Road Barrow Lancashire	Ribble Valley	504	Yes
Land at Higher Standen Farm and Part Littlemoor Farm	Ribble Valley	1040	Yes
Land to the east of Clitheroe Road, Lawsonsteads, Whalley	Ribble Valley	260	Yes

Ribble Valley - Identified in SHLAA

Site Name	District	Dwelling Capacity	Planning Permission
Pimlico Road, Ribble Valley	Ribble Valley	514	No
Woone Lane, Primrose Road	Ribble Valley	217	No
Land of Mitton Road / Broad Lane	Ribble Valley	247	No
Land adj - The Bungalow, Queen Street, Low Moor	Ribble Valley	298	No
Hammond Ground, Whalley Road	Ribble Valley	702	No
Land of Longsight Road	Ribble Valley	908	No

Rossendale - Allocated

No large enough sites identified in Local Plan or passed planning permission

Rossendale - Identified in SHLAA

Site Name	District	Dwelling Capacity	Planning Permission
Land off Hurst Lane, Hurst Lane, Rawtenstall	Rossendale	233	No
Tong Farm, Bacup	Rossendale	405	No
Land off Cowtoot Lane, Bacup	Rossendale	252	No
Hutch Bank Quarry, Hutch Bank Road, Haslingden	Rossendale	222	No
Pike Law, Haslingden	Rossendale	324	No
Cowpe Quarry and Cragg Quarry, Cowpe Moss	Rossendale	469	No
Land around Sheephouses Reservoir, Bacup	Rossendale	480	No
Land adj Laund Slack Farm, Haslingden	Rossendale	212	No
Land off Broadway and Greens Lane, Helmshore	Rossendale	586	No

South Ribble - Allocated

Site Name	District	Dwelling Capacity	Deliverable Completions 2011- 2016	Deliverable Completions 2016 - 2021	Deliverable Completions 2021 - 2026	Planning Permission
Access off Wesley Street	South Ribble	200	Timescale not mentioned in SHLAA or Local plan	Not mentioned in SHLAA or Local plan	Not mentioned in SHLAA or Local plan	Yes
Farington Business Park Wheelton Lane	South Ribble	234	Not mentioned in SHLAA or Local plan	Not mentioned in SHLAA or Local Plan	Not mentioned in SHLAA or Local Plan	Yes
Land of Croston Road	South Ribble	400	Not mentioned in SHLAA or Local plan	Not mentioned in SHLAA or Local plan	Not mentioned in SHLAA or Local plan	Yes
Land On The North Side Of Brindle Road Bamber Bridge Lancashire	South Ribble	315	0	150	165	Yes
Arla Dairies, School Lane	South Ribble	200	80	120	0	No
Vernon Carus Site, Factory Lane	South Ribble	450	50	175	250	No
Moss Side Test Track, Aston Way	South Ribble	850	80	325	425	No
Land between Altcar Lane/Shaw Brook, Road, Leyland	South Ribble	430	Not mentioned in SHLAA or Local plan	Not mentioned in SHLAA or Local plan	Not mentioned in SHLAA or Local plan	No
Pickering's Farm, Penwortham	South Ribble	1200	150	475	575	No

South Ribble - Identified in SHLAA

Site Name	District	Dwelling Capacity	Deliverable Completions 2011- 2016	Deliverable Completions 2016 - 2021	Deliverable Completions 2021 - 2026	Planning Permission
Land of eastern part ofChurch Lane	South Ribble	227	0	150	77	No
Safeguarded site - Flensburg Way	South Ribble	600	200	200	200	No
Safeguareded Leyland Lane	South Ribble	200	0	0	200	No

West Lancashire – Allocated

Site Name	District	Dwelling Capacity	Planning Permission
Skelmersdale Town Centre	West Lancs	730	No
Yew tree farm, Burscough	West Lancs	500	No
Grove farm, Ormskirk	West Lancs	300	No
Land at Firswood Road, Skelmersdale	West Lancs	400	No
Henry Alty Ltd, Station Road, Hesketh Bank	West Lancs	275	Yes
Land At Whalleys, Whalleys Road Skelmersdale Lancashire	West Lancs	630	Yes
Edge Hill University, St Helen Road, Ormskirk	West Lancs	624	Yes

West Lancashire - Identified in SHLAA

No large enough sites identified in the West Lancashire SHLAA

Wyre – Allocated

Site Name	District	Dwelling capacity	Planning Permission
Land Off Bourne Road, Thornton Cleveleys	Wyre	273	Yes
Land At Bourne Road, Thornton Cleveleys, Thornton (Former ICI Works)	Wyre	558	Yes
Land To The West Of The A6, Bounded By Nateby Crossing Lane & Croston Barn Lane, Nateby, Garstang , PR3 1DY	Wyre	320	Yes

Wyre - Identified in SHLAA

Site Name	District	Dwelling Capacity	Planning Permission
Land at Fleetwood Docks	Wyre	263	No
Land at Poolfoot Farm, Thornton	Wyre	219	No
Land east of Railway, Hillhouse site	Wyre	399	No
Land at Poolfoot Farm, Thornton	Wyre	219	No
Land between Lambs Rd/Raikes Rd, Thornton	Wyre	428	No
Land at Bourne Road	Wyre	436	No
Land between Raikes Rd/Stanah Rd/Underbank Rd,Thornton	Wyre	473	No
Land at Kepple Lane	Wyre	314	No
Site bounded by Cockerham Road, Nateby Crossing Lane, and Croston Barn Road, Garstang	Wyre	235	No
Land at Fouldrey Avenue	Wyre	317	No
Land south of Carr Head Primary School, Brockholdes	Wyre	367	No
Land east of Little Poulton Lane, Poulton	Wyre	951	No
Land north of Fairfield Road	Wyre	2121	No

6.4 *Monitoring of housing developments and needs for pharmaceutical services*

6.4.1 Monitoring of housing developments

Each District in Lancashire has a plan for community growth and development and these plans are under regular review.

In addition to monitoring individual housing sites it may be necessary to monitor cumulative developments across several sites; i.e. if a number of smaller developments are built in an area then future completions may be worth monitoring by town/village/vicinity to pharmacies as well as just by individual housing developments. This might be particularly relevant where the ratio of pharmacies to people is already above or below average.

6.4.2 Factors to consider in relation to needs for pharmaceutical services

The HWB is also not aware of any measure of the extent to which existing local pharmaceutical service providers can accommodate the increase in need for pharmaceutical services created by an increase in local population size. An increase in population size will likely generate an increased need for pharmaceutical services, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required to meet local pharmaceutical needs, due to the range of other factors influencing such needs.

Considerations when assessing needs for local pharmaceutical service providers should be based on a range of local factors specific to each development site. Such factors may include:

- Average household size of new builds on the site.
- Demographics: People moving to new housing developments are often young and expanding families, but some housing developments are expected to have an older population with different needs for health and social care services.
- Tenure mix, i.e. the proportion of affordable housing at the development.
- Existing pharmaceutical service provision in nearby areas and elsewhere in the county and opportunities to optimise existing local pharmaceutical service provision.
- Access to delivery services, distance selling pharmacies, and Dispensing Appliance Contractors that can supply services.
- Developments in pharmaceutical supply models (e.g. delivery services, robotic dispensing, and electronic transmission of prescriptions) that could affect the volume of services a pharmaceutical service provider can deliver.
- Skill mix and the number of pharmacists working in local pharmacies.
- Considerations of health inequalities and strategic priorities for Lancashire

In conclusion, over the coming years the population Lancashire is expected to both age and grow substantially in numbers. Several housing developments are in progress. The Lancashire HWB will monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, in accordance with regulations.

Appendix 1: Legal requirements for PNAs

This section contains an extract from The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Please note that the HWB takes no responsibility for the accuracy of the extract. The full text of the Regulations is available at: http://www.legislation.gov.uk/uksi/2013/349/contents/made

1. These regulations may be cited as the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and come into force on 1st April 2013.

2. Interpretation *(long – see website)*

3. The pharmaceutical services the PNA must cover are all the pharmaceutical services that may be provided under arrangements made by the NHSCB for:

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

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

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

4. Information to be contained in PNA

(1) Each PNA must contain the information set out in Schedule 1.

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

5. Date by which the first HWB PNAs are to be published

Each HWB must publish its first PNA by 1st April 2015.

6. Subsequent assessments

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

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

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

b) the demography of its area; and

c) the risks to the health or wellbeing of people in its area,

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

(3) Pending the publication of a statement or a revised assessment, a HWB may publish a supplementary statement explaining changes to the availability of pharmaceutical services (..) where –

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

b) the HWB –

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

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

7. Temporary extension of PCT PNAs and access by the NHSCB and HWBs to PNAs

Before the publication by an HWB of the first PNA that it prepares for its area, the PNA that relates to any locality within that area is the PNA that relates to that locality of the PCT for that locality immediately before the appointed day, read with

a) any supplementary statement published by the PCT (..)

b) any supplementary statement published by the HWB (..)

Each HWB must ensure that the NHSCB has access to –

a) the HWB's PNA (including any supplementary statements) (..)

b) any supplementary statement that the HWB publishes (..)

c) any PNA of a PCT that it holds, which is sufficient to enable the NHSCB to carry out its functions under these Regulations

Each HWB must ensure that, as necessary, other HWBs have access to any PNAs of any PCT that it holds, which is sufficient to enable the other HWBs to carry out their functions under these Regulations.

8. Consultation on PNAs

(1) When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB (HWB1) must consult the following about the contents of the assessment it is making—
(a) any Local Pharmaceutical Committee for its area (including any Local Pharmaceutical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);
(b) any Local Medical Committee for its area (including any Local Medical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);
(c) any persons on the pharmaceutical lists and any dispensing doctors list for its area;
(d) any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services;
(e) any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of HWB1 has an interest in the provision of pharmaceutical services in its area; and
(f) any NHS trust or NHS foundation trust in its area;
(g) the NHSCB; and
(h) any neighbouring HWB.
(2) The persons mentioned in paragraph (1) must together be consulted at least once during the process of making the assessment on a draft of the proposed pharmaceutical needs assessment.

(3) Where a HWB is consulted on a draft under paragraph (2), if there is a Local Pharmaceutical Committee or Local Medical Committee for its area or part of its area that is different to a Local Pharmaceutical Committee or Local Medical Committee consulted under paragraph (1)(a) or (b), that HWB—
(a) must consult that Committee before making its response to the consultation; and
(b) must have regard to any representations received from the Committee when making its response to the consultation.
(4) The persons consulted on the draft under paragraph (2) must be given a minimum period of 60 days for making their response to the consultation, beginning with the day by which all those persons have been served with the draft.
(5) For the purposes of paragraph (4), a person is to be treated as served with a draft if that person is notified by HWB1 of the address of a website on which the draft is available and is to remain available (except due to accident or unforeseen circumstances) throughout the period for making responses to the consultation.
(6) If a person consulted on a draft under paragraph (2)—
(a) is treated as served with the draft by virtue of paragraph (5); or
(b) has been served with copy of the draft in an electronic form, but requests a copy of the draft in hard copy form, HWB1 must as soon as is practicable and in any event within 14 days supply a hard copy of the draft to that person (free of charge).

9. Matters for consideration when making assessments
(1) When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB must have regard, in so far as it is practicable to do so, to the following matters—
(a) the demography of its area;
(b) whether in its area there is sufficient choice with regard to obtaining pharmaceutical services;
(c) any different needs of different localities within its area;
(d) the pharmaceutical services provided in the area of any neighbouring HWB which affect—
(i) the need for pharmaceutical services in its area, or
(ii) whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area; and
(e) any other NHS services provided in or outside its area (which are not covered by subparagraph (d)) which affect—
(i) the need for pharmaceutical services in its area, or
(ii) whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.

(2) When making an assessment for the purposes of publishing a pharmaceutical needs assessment, each HWB must take account of likely future needs—
(a) to the extent necessary to make a proper assessment of the matters mentioned in paragraphs 2 and 4 of Schedule 1; and
(b) having regard to likely changes to—
(i) the number of people in its area who require pharmaceutical services,
(ii) the demography of its area, and
(iii) the risks to the health or wellbeing of people in its area.

SCHEDULE 1 Regulation 4(1)
Information to be contained in pharmaceutical needs assessments

Necessary services: current provision
1. *A statement of the pharmaceutical services that the HWB has identified as services that are provided—*
(a) in the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area; and
(b) outside the area of the HWB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWB has identified such services).

Necessary services: gaps in provision
2. *A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied—*
(a) need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;
(b) will, in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.

Other relevant services: current provision
3. *A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided—*
(a) in the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;
(b) outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;

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

Improvements and better access: gaps in provision
4. *A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied—*
(a) would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area,
(b) would, if in specified future circumstances they were provided (whether or not they were located in the area of the HWB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.

Other NHS services
5. *A statement of any NHS services provided or arranged by a local authority, the NHSCB, a CCG, an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect—*
(a) the need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; or
(b) whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.

How the assessment was carried out
6. *An explanation of how the assessment has been carried out, and in particular—*
(a) how it has determined what are the localities in its area;
(b) how it has taken into account (where applicable)—
(i) the different needs of different localities in its area, and
(ii) the different needs of people in its area who share a protected characteristic; and
(c) a report on the consultation that it has undertaken.

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

Appendix 2: Characteristics of Localities

Defining localities

The PNA regulations requires the PNA to define 'localities' to use during this process. Twelve districts are commonly used by Lancashire to sub-divide the county.

In considering how to define localities within Lancashire, it was decided to use the 12 district council areas already aligned to three localities (East, Central and North Lancashire). These 3 localities are also aligned to the Clinical Commissioning Groups (CCGs).

The districts used in the PNA have an average population of 98,340 (range, 57,858 to 140,575) (ONS, 2013 population estimates).

The 12 district council areas in Lancashire are aligned to 3 localities, East, central and North.

- Central locality – districts of Chorley, Preston, South Ribble and West Lancashire
- East locality – districts of Burnley, Hyndburn, Pendle, Ribble Valley & Rossendale
- North locality - districts of Fylde, Lancaster and Wyre

There was also a practical decision to be made to ensure that the document remained manageable in terms of size. However it was recognised that the district level data could mask "need" in smaller areas. Therefore it was agreed that wherever possible data would be mapped to other small geographies to identify any pockets of need and inequalities.

As **Better Care** funds develop, localities may change as health economies change.

District council areas

District council areas are well understood by many people and enables comparison of routine data. In Lancashire the 12 districts are aligned to 3 localities, East, Central and North.

Clinical Commissioning Group (CCG)

There are 6 CCGs across Lancashire County and it is intended that the CCGs can use the PNA to inform their commissioning decisions.

Electoral wards

These are key building blocks of UK administrative geography. However, they have limited relevance to commissioning of pharmaceutical services, and are subject to change. The population size can vary from 100 to 30,000 residents.

Super Output Area (SOA)

This is a way of collecting and publishing small area statistics developed by the Office of National Statistics (ONS).[lx] They are of a more consistent size than electoral wards, which facilitates an assessment of needs for the local populations. They are not subject to frequent boundary change, so may be more suitable for comparisons over time. In addition, they will build on the existing availability of data for census output areas. SOA data are increasingly used for health needs assessment, health planning and assessing health inequalities.

SOAs come in two levels. Lower Layer Super Output Areas (LSOAs) have a minimum population size of 1,000 people and the average size is 1,500 people. Additionally, LSOAs can

be grouped into Middle Layer Super Output Areas (MSOA). The MSOAs population size is minimum 5,000 people and the average is 7,200 people. All MSOAs are contained within a local authority (LA) and do not cross LA boundaries.

Sources of data for small areas

A good source for a wide range of socio-economic data for small areas is the Office for National Statistics' Neighbourhood Statistics website (contains information on e.g. age structure, housing, long-term illness and deprivation and other data from 2011 Census): http://www.neighbourhood.statistics.gov.uk

Health profiles for the area can be found at: http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

Some insight into the health needs of the local population can be gained from the Quality and Outcomes Framework data of the local GPs. Entering a postcode at http://www.qof.ic.nhs.uk/search.asp returns a list of GPs in the proximity of the postcode.

Comparing the prevalence of common conditions of the practices within the CCG or England average gives an indication of the health of the local population. A more convenient way of viewing individual practices are the practice profiles at http://www.apho.org.uk/pracprof/

Appendix 3: Methods used to identify providers

This section outlines the methods used for identifying providers of pharmaceutical services.

1. Identification of pharmaceutical service providers

Pharmacies within Lancashire

A list of pharmacies as of 30/06/2014 including postcodes and other information was obtained from NHS England Local Area Team, who maintains the registration database of pharmacies in Lancashire.

Pharmacies outside of Cambridgeshire

Pharmacies in surrounding counties were obtained from the Health and Social Care Information Centre Organisation Data Service (ODS).

Dispensing doctors (GP) surgeries

NHS England Local Area Team confirmed that there are 13 dispensing doctors in Lancashire.

Distance selling pharmacies

A list of distance selling pharmacies was obtained from NHS England Local Area Team.

Dispensing appliance contractors

NHS England Local Area Team confirmed that there are 3 distanced Dispensing Appliance Contractors in Lancashire.

2. Creation of maps

The maps show the location of the pharmaceutical service providers in each of the 12 districts.

Maps indicating locations of premises providing pharmaceutical services

Maps showing the locations of premises providing pharmaceutical services were created in ArcGIS by the BTLS G.I.S. team.

Maps indicating travel distance

Maps showing access to pharmaceutical services by travel distance were created using ArcGIS by the BTLS G.I.S. team. ArcGIS Network Analyst was used to create drive time maps.

Appendix 4: List of pharmacies

Below is a list of the pharmacies in Lancashire as of June 2014. Source: NHS England LAT.

District	CCG	Pharmacy Code	Pharmacy Name	Postcode	Type
Burnley	East Lancashire	FH896	"your local Boots pharmacy"	BB11 3BT	40 Hr
Burnley	East Lancashire	FLJ29	"your local Boots pharmacy"	BB11 3ND	40 Hr
Burnley	East Lancashire	FQD43	Asda Pharmacy	BB12 0EQ	40 Hr
Burnley	East Lancashire	FFL68	Bailey & Garrett	BB12 6HX	40 Hr
Burnley	East Lancashire	FPK28	Bailey & Garrett	BB12 6LH	40 Hr
Burnley	East Lancashire	FXF47	Boots	BB11 1QL	40 Hr
Burnley	East Lancashire	FX858	Brunshaw Pharmacy	BB10 3JU	40 Hr
Burnley	East Lancashire	FLF27	Burnley Late Night Pharmacy	BB10 1LG	100 Hr
Burnley	East Lancashire	FA464	Cohens Chemist	BB11 5AL	40 Hr
Burnley	East Lancashire	FCE64	Cohens Chemist	BB11 4NW	40 Hr
Burnley	East Lancashire	FK190	Cohens Chemist	BB12 6PR	40 Hr
Burnley	East Lancashire	FRN38	Cohens Chemist	BB10 4DX	40 Hr
Burnley	East Lancashire	FXN00	Colne Road Pharmacy	BB10 1LG	40 Hr
Burnley	East Lancashire	FCT10	Ian G Todd	BB12 8BA	40 Hr
Burnley	East Lancashire	FVM08	Keirby Pharmacy	BB11 2DE	40 Hr
Burnley	East Lancashire	FYT29	Lloydspharmacy	BB12 8BL	40 Hr
Burnley	East Lancashire	FY454	Peak Pharmacy	BB10 1QR	40 Hr
Burnley	East Lancashire	FR451	Rowlands Pharmacy	BB10 2NZ	40 Hr
Burnley	East Lancashire	FEM21	Sainsbury's Pharmacy	BB11 1BS	40 Hr
Burnley	East Lancashire	FPH18	St Peters Pharmacy	BB11 2DL	100 Hr
Burnley	East Lancashire	FD131	Tesco Instore Pharmacy	BB12 8DQ	100 Hr
Burnley	East Lancashire	FRW31	Tesco Instore Pharmacy	BB11 2HE	40 Hr
Burnley	East Lancashire	FD070	The Co-operative Pharmacy	BB10 3BF	40 Hr
Burnley	East Lancashire	FQ161	Village Pharmacy	BB10 2HJ	40 Hr
Chorley	Chorley & South Ribble	FAW39	Asda Pharmacy	PR6 7JY	40 Hr
Chorley	Chorley & South Ribble	FKC77	Astley Village Pharmacy	PR7 1XA	40 Hr
Chorley	Chorley & South Ribble	FVM56	Bamfords Pharmacy	PR6 9LP	40 Hr
Chorley	Chorley & South Ribble	FY618	Boots Uk Limited	PR7 1DE	40 Hr
Chorley	Chorley & South Ribble	FLG75	Cohens Chemist	PR7 3QG	40 Hr
Chorley	Chorley & South Ribble	FA307	Cohens Pharmacy	PR7 2SQ	40 Hr
Chorley	Chorley & South Ribble	FX305	Croston Pharmacy	PR26 9RL	40 Hr
Chorley	Chorley & South Ribble	FJ369	Fishlocks Chemist	PR7 5SZ	40 Hr
Chorley	Chorley & South Ribble	FC827	Lloydspharmacy	PR7 5BY	40 Hr
Chorley	Chorley & South Ribble	FCX84	Lloydspharmacy	PR7 2BY	40 Hr
Chorley	Chorley & South Ribble	FKG45	Lloydspharmacy	PR7 2DJ	40 Hr
Chorley	Chorley & South Ribble	FRC14	Lloydspharmacy	PR7 2EE	40 Hr
Chorley	Chorley & South Ribble	FVK72	Lloydspharmacy	PR6 0ET	40 Hr
Chorley	Chorley & South Ribble	FCC14	MedicX	PR7 5EN	100 Hr
Chorley	Chorley & South Ribble	FEM48	MedicX (Rotherem Ltd)	PR7 2EY	100 Hr
Chorley	Chorley & South Ribble	FVW38	Pharmalogic	PR6 7EN	Internet
Chorley	Chorley & South Ribble	FV389	Rimmers	PR7 6JW	40 Hr
Chorley	Chorley & South Ribble	FWV78	Rowlands Pharmacy	PR7 4HE	40 Hr
Chorley	Chorley & South Ribble	FHL63	Tesco In-store Pharmacy	PR7 1NW	100 Hr
Chorley	Chorley & South Ribble	FCN66	Tesco stores Ltd	PR7 7EL	100 Hr
Chorley	Chorley & South Ribble	FFC49	Whittle Brook Pharmacy	PR5 8ES	40 Hr
Chorley	Chorley & South Ribble	FPH17	Whittle Brook Pharmacy	PR6 7HW	40 Hr
Chorley	Chorley & South Ribble	FAK76	Withnell Pharmacy	PR6 8RX	40 Hr

District	CCG	Pharmacy Code	Pharmacy Name	Postcode	Type
Blackpool	Fylde & Wyre	FVN33	Cleveleys Health Centre Pharmacy	FY5 3DZ	40 Hr
Fylde	Fylde & Wyre	FFG28	Alexandria Pharmacy	FY8 1JF	40 Hr
Fylde	Fylde & Wyre	FVC41	Ansdell Pharmacy	FY8 4GW	40 Hr
Fylde	Fylde & Wyre	FG789	Boots	FY8 5EW	40 Hr
Fylde	Fylde & Wyre	FN789	Boots	FY8 1SB	40 Hr
Fylde	Fylde & Wyre	FVV65	Cairns Pharmacy	PR4 2AU	40 Hr
Fylde	Fylde & Wyre	FVJ83	Cohens Chemist	FY8 2RW	40 Hr
Fylde	Fylde & Wyre	FDX51	Cohens Pharmacy	FY8 2EP	40 Hr
Fylde	Fylde & Wyre	FWE96	Medicx Pharmacy	FY8 5EE	40 Hr
Fylde	Fylde & Wyre	FYV63	Melling Pharmacy Ltd	FY8 3PU	40 Hr
Fylde	Fylde & Wyre	FX017	Rowlands Pharmacy	FY8 1QS	40 Hr
Fylde	Fylde & Wyre	FFK77	Sainsburys Pharmacy	FY8 2JE	40 Hr
Fylde	Fylde & Wyre	FR338	St. Annes Pharmacy	FY8 1UR	40 Hr
Fylde	Fylde & Wyre	FET66	The Co-operative Pharmacy	PR4 2AU	40 Hr
Fylde	Fylde & Wyre	FQ168	The Co-operative Pharmacy	PR4 2SD	40 Hr
Fylde	Fylde & Wyre	FTC77	The Co-operative Pharmacy	PR4 1RY	40 Hr
Fylde	Fylde & Wyre	FPH13	Tomlinsons Chemist	FY8 5LW	40 Hr
Fylde	Fylde & Wyre	FW538	Wesham Pharmacy	PR4 3AD	40 Hr
Fylde	Fylde & Wyre	FVR79	Whittle Pharmacy (Smiths Pharmacy)	FY8 5HA	40 Hr
Fylde	Fylde & Wyre	FC027	Whitworths Chemist	PR4 2SE	40 Hr
Hyndburn	East Lancashire	FWT37	"your local Boots pharmacy"	BB6 7QQ	40 Hr
Hyndburn	East Lancashire	FQE18	Accrington Late Night Pharmacy	BB5 0AQ	100 Hr
Hyndburn	East Lancashire	FXK55	Accrington Pharmacy	BB5 5AD	40 Hr
Hyndburn	East Lancashire	FRP19	Asda Pharmacy	BB5 1QR	100 Hr
Hyndburn	East Lancashire	FC783	Aston Pharmacy	BB5 1RP	40 Hr
Hyndburn	East Lancashire	FQX86	Baxenden Pharmacy	BB5 2RG	40 Hr
Hyndburn	East Lancashire	FCF32	Boots	BB5 1EX	40 Hr
Hyndburn	East Lancashire	FAF01	Cohens Chemist	BB1 4LD	40 Hr
Hyndburn	East Lancashire	FTG60	Cohens Chemist	BB5 3JD	40 Hr
Hyndburn	East Lancashire	FVW68	Cohens Chemist	BB5 3JD	40 Hr
Hyndburn	East Lancashire	FAT95	Dialachemist Ltd	BB5 5JB	Internet
Hyndburn	East Lancashire	FGQ96	Eccles Chemist	BB5 3DD	40 Hr
Hyndburn	East Lancashire	FW349	Holden E B Pharmacy	BB6 7QL	40 Hr
Hyndburn	East Lancashire	FTK15	Huncoat Pharmacy	BB5 6LS	40 Hr
Hyndburn	East Lancashire	FAR39	Lloydspharmacy	BB5 0AA	40 Hr
Hyndburn	East Lancashire	FKP72	Lloydspharmacy	BB5 1EA	40 Hr
Hyndburn	East Lancashire	FJL20	My Pharmacy	BB6 7AL	Internet
Hyndburn	East Lancashire	FC705	Oswaldtwistle Pharmacy	BB5 3JD	100 Hr
Hyndburn	East Lancashire	FF609	Paradise Street Pharmacy	BB5 2EJ	40 Hr
Hyndburn	East Lancashire	FV197	Rishton Pharmacy	BB1 4LA	40 Hr
Hyndburn	East Lancashire	FKD22	Superdrug Pharmacy	BB5 1EX	40 Hr
Hyndburn	East Lancashire	FCW00	Tesco Instore Pharmacy	BB6 7AU	100 Hr
Hyndburn	East Lancashire	FWQ17	Tesco Instore Pharmacy	BB5 1LN	100 Hr
Hyndburn	East Lancashire	FC859	The Co-operative Pharmacy	BB5 5NS	40 Hr
Hyndburn	East Lancashire	FER29	The Co-operative Pharmacy	BB5 0AQ	40 Hr
Hyndburn	East Lancashire	FVJ59	The Co-operative Pharmacy	BB5 1SA	100 Hr
Hyndburn	East Lancashire	FY047	The Co-operative Pharmacy	BB5 0RS	40 Hr

District	CCG	Pharmacy Code	Pharmacy Name	Postcode	Type
Lancaster	Lancashire North	FAJ19	"your local Boots pharmacy"	LA4 4UZ	40 Hr
Lancaster	Lancashire North	FV127	"your local Boots pharmacy"	LA2 9QW	40 Hr
Lancaster	Lancashire North	FAM03	Asda Pharmacy	LA1 5JR	40 Hr
Lancaster	Lancashire North	FVM37	Ash Trees Pharmacy	LA5 9JU	100 Hr
Lancaster	Lancashire North	FKF58	Bare Pharmacy	LA4 6BY	40 Hr
Lancaster	Lancashire North	FGA51	Boots	LA1 1NB	40 Hr
Lancaster	Lancashire North	FGT42	Boots	LA4 5DW	40 Hr
Lancaster	Lancashire North	FV089	Boots	LA5 9JX	40 Hr
Lancaster	Lancashire North	FPF67	Bowerham Pharmacy	LA14DS	40 Hr
Lancaster	Lancashire North	FA044	Cohens Chemist	LA3 1DA	40 Hr
Lancaster	Lancashire North	FCL21	Cohens Chemist	LA4 5TE	40 Hr
Lancaster	Lancashire North	FDT25	Cohens Chemist	LA1 3PS	40 Hr
Lancaster	Lancashire North	FHC75	Cohens Chemist	LA3 2LE	40 Hr
Lancaster	Lancashire North	FHM56	Cohens Chemist T/A Morecambe H/C Pharmacy	LA4 5LU	40 Hr
Lancaster	Lancashire North	FLC47	Dalton Square Pharmacy	LA1 1NG	100 Hr
Lancaster	Lancashire North	FLH34	Fox & Medcalfe	LA1 1RE	40 Hr
Lancaster	Lancashire North	FFH19	Halton Pharmacy	LA2 6PU	40 Hr
Lancaster	Lancashire North	FX944	Kings Chemist	LA4 6RL	40 Hr
Lancaster	Lancashire North	FNF05	Lancaster University Pharmacy	LA1 4YE	40 Hr
Lancaster	Lancashire North	FDT30	Lloyds Pharmacy	LA4 5LY	40 Hr
Lancaster	Lancashire North	FLA47	Lloyds Pharmacy	LA3 2BJ	40 Hr
Lancaster	Lancashire North	FG035	Morecambe Bay Chemist	LA3 1QN	40 Hr
Lancaster	Lancashire North	FJ938	Murray's Pharmacy	LA1 2BU	40 Hr
Lancaster	Lancashire North	FTC57	Rosebank Pharmacy	LA2 0NB	40 Hr
Lancaster	Lancashire North	FN335	Rowlands Pharmacy	LA1 4JT	40 Hr
Lancaster	Lancashire North	FT649	Rowlands Pharmacy	LA4 6BX	40 Hr
Lancaster	Lancashire North	FV563	Rowlands Pharmacy	LA1 1PL	40 Hr
Lancaster	Lancashire North	FW818	Rowlands Pharmacy	LA1 4ST	40 Hr
Lancaster	Lancashire North	FQD68	Sainsburys Pharmacy	LA1 1HH	100 Hr
Lancaster	Lancashire North	FLR12	Sainsburys Pharmacy	LA4 5TJ	100 Hr
Lancaster	Lancashire North	FME05	Slyne Pharmacy	LA2 6JY	40 Hr
Lancaster	Lancashire North	FGY83	Superdrug	LA1 1NB	40 Hr
Lancaster	Lancashire North	FD284	The Co-operative Pharmacy	LA5 9JX	40 Hr
Lancaster	Lancashire North	FFR06	The Co-operative Pharmacy	LA5 8DH	40 Hr
Lancaster	Lancashire North	FFT70	The Co-operative Pharmacy	LA1 1RE	40 Hr
Lancaster	Lancashire North	FM390	Westend Pharmacy	LA3 1DA	40 Hr
Pendle	East Lancashire	FGM92	Asda Pharmacy	BB8 8LW	100 Hr
Pendle	East Lancashire	FE218	Barkerhouse Pharmacy	BB9 9EU	40 Hr
Pendle	East Lancashire	FG310	Boots	BB9 9SA	40 Hr
Pendle	East Lancashire	FQ019	Boots	BB8 0HS	40 Hr
Pendle	East Lancashire	FFK28	Boundary Pharmacy	BB9 8RP	40 Hr
Pendle	East Lancashire	FM334	Brierfield Pharmacy	BB9 5NP	Internet
Pendle	East Lancashire	FGE39	Brierfield's Late Night Chemist	BB9 5HJ	100 Hr
Pendle	East Lancashire	FM816	Chapelhouse Pharmacy	BB9 0QW	40 Hr
Pendle	East Lancashire	FKR21	Colne H C Pharmacy	BB8 0LJ	40 Hr
Pendle	East Lancashire	FAN20	Direct2Chemist	BB9 7NB	Internet
Pendle	East Lancashire	FDY09	Leedams' Pharmacy	BB8 0QF	40 Hr

District	CCG	Pharmacy Code	Pharmacy Name	Postcode	Type
Pendle	East Lancashire	FFT88	Nelson HC Pharmacy	BB9 7SR	40 Hr
Pendle	East Lancashire	FW106	Nelson Pharmacy	BB9 7LU	100 Hr
Pendle	East Lancashire	FX511	Newbridge Pharmacy	BB9 8NT	40 Hr
Pendle	East Lancashire	FMG88	Pharmadrug Direct	BB9 9UA	Internet
Pendle	East Lancashire	FRH65	Rowlands Pharmacy	BB9 5SQ	40 Hr
Pendle	East Lancashire	FWD90	Rowlands Pharmacy	BB8 0RY	40 Hr
Pendle	East Lancashire	FWA37	Sainsbury's Pharmacy	BB8 9HY	100 Hr
Pendle	East Lancashire	FJL94	Taylors Chemist	BB9 8EH	40 Hr
Pendle	East Lancashire	FF644	The Co-operative Pharmacy	BB18 5DR	40 Hr
Pendle	East Lancashire	FGQ81	The Co-operative Pharmacy	BB9 5PH	40 Hr
Pendle	East Lancashire	FPN15	The Co-operative Pharmacy	BB8 0LJ	100 Hr
Pendle	East Lancashire	FFW12	Village Pharmacy	BB9 6EW	40 Hr
Pendle	East Lancashire	FAW09	Whitworth Chemists	BB18 6UN	40 Hr
Pendle	East Lancashire	FJR48	Whitworth Chemists	BB9 7LS	40 Hr
Pendle	East Lancashire	FXV04	Whitworth Chemists	BB18 5DR	40 Hr
Preston	Greater Preston	FQN23	Alliance Pharmacy	PR2 6NH	40 Hr
Preston	Greater Preston	FKV08	Asda Pharmacy	PR2 9NP	40 Hr
Preston	Greater Preston	FN226	Ashton Pharmacy	PR2 2PP	40 Hr
Preston	Greater Preston	FQT05	Avenham Pharmacy	PR1 3TS	40 Hr
Preston	Greater Preston	FMR67	Boots	PR2 1HN	40 Hr
Preston	Greater Preston	FEC01	Boots Uk Limited	PR1 3QA	40 Hr
Preston	Greater Preston	FJP66	Boots Uk Limited	PR1 6QY	40 Hr
Preston	Greater Preston	FTJ77	Boots Uk Limited	PR2 2LP	40 Hr
Preston	Greater Preston	FPK67	Broadway Pharmacy	PR2 9UP	40 Hr
Preston	Greater Preston	FME86	Cohens Chemist	PR2 6UE	40 Hr
Preston	Greater Preston	FWF05	Cottam Pharmacy	PR2 1JR	100 Hr
Preston	Greater Preston	FLM00	DDL Davies Ltd	PR1 7EN	40 Hr
Preston	Greater Preston	FK268	Frenchwood Pharmacy	PR1 4NA	40 Hr
Preston	Greater Preston	FG571	Goosnargh Pharmacy	PR3 2AU	40 Hr
Preston	Greater Preston	FNE92	Grimsargh Pharmacy	PR2 5JQ	40 Hr
Preston	Greater Preston	FDE38	HBS Pharmacy	PR1 6QB	40 Hr
Preston	Greater Preston	FJH26	HBS Pharmacy	PR1 6YA	100 Hr
Preston	Greater Preston	FKD99	HBS Pharmacy	PR1 6AS	Internet
Preston	Greater Preston	FXW27	Imann Pharmacy	PR1 1DD	40 Hr
Preston	Greater Preston	FJR29	Kadri Pharmacy Ltd	PR1 1TS	40 Hr
Preston	Greater Preston	FDH29	Lloyds Pharmacy	PR1 4ST	40 Hr
Preston	Greater Preston	FJ030	Lloyds Pharmacy	PR1 5NE	40 Hr
Preston	Greater Preston	FQ428	Lloyds Pharmacy	PR2 8JE	40 Hr
Preston	Greater Preston	FRE71	Lloyds Pharmacy	PR1 5AR	40 Hr
Preston	Greater Preston	FP556	M X Pharmacy	PR2 6RE	100 Hr
Preston	Greater Preston	FRN37	Moor Park Pharmacy	PR1 1LA	40 Hr
Preston	Greater Preston	FT104	Morrisons In-store Pharmacy	PR2 2YN	40 Hr
Preston	Greater Preston	FAL78	New Hall Lane Pharmacy	PR1 5XB	100 Hr
Preston	Greater Preston	FAJ46	Pomfret Pharmacy	PR1 1DA	40 Hr
Preston	Greater Preston	FRW79	Rainbow Healthcare	PR2 9PS	40 Hr
Preston	Greater Preston	FVJ04	Ribble Village Pharmacy	PR2 6NH	100 Hr

District	CCG	Pharmacy Code	Pharmacy Name	Postcode	Type
Preston	Greater Preston	FJE48	Ribbleton Pharmacy	PR2 6QN	40 Hr
Preston	Greater Preston	FC537	Rowlands Pharmacy	PR2 2RL	40 Hr
Preston	Greater Preston	FM831	Rowlands Pharmacy	PR2 6RD	40 Hr
Preston	Greater Preston	FQX15	Rowlands Pharmacy	PR2 7DS	40 Hr
Preston	Greater Preston	FWM31	Rowlands Pharmacy	PR2 1NT	40 Hr
Preston	Greater Preston	FMX25	Sainsburys In-store Pharmacy	PR1 6PJ	40 Hr
Preston	Greater Preston	FDK88	Sharoe Green Pharmacy	PR2 9HD	40 Hr
Preston	Greater Preston	FPV77	Smithson's Pharmacy	PR1 8DN	40 Hr
Preston	Greater Preston	FPV26	Superdrug Pharmacy	PR1 2NR	40 Hr
Ribble Valley	East Lancashire	FYQ04	Boots	BB7 2BT	40 Hr
Ribble Valley	East Lancashire	FKA00	Langho Pharmacy	BB6 8BX	40 Hr
Ribble Valley	East Lancashire	FEP07	Lloydspharmacy	BB7 9SL	40 Hr
Ribble Valley	East Lancashire	FFP28	Lloydspharmacy	BB7 2EU	40 Hr
Ribble Valley	East Lancashire	FJ612	Mellor Pharmacy	BB2 7ER	40 Hr
Ribble Valley	East Lancashire	FQY67	Peter Buckley Ltd	BB7 2EU	40 Hr
Ribble Valley	East Lancashire	FK895	Read & Simonstone Pharmacy	BB12 7PN	40 Hr
Ribble Valley	East Lancashire	FEQ95	The Clitheroe Pharmacy	BB7 1EU	40 Hr
Ribble Valley	Greater Preston	FXP51	Lloydspharmacy	PR3 3JJ	40 Hr
Ribble Valley	Greater Preston	FT428	The Co-operative Pharmacy	PR3 3AN	40 Hr
Rossendale	East Lancashire	FPA62	"your local Boots pharmacy"	BB4 7PL	40 Hr
Rossendale	East Lancashire	FAT09	A J Nuttall	OL12 8QS	40 Hr
Rossendale	East Lancashire	FTP61	Asda Pharmacy	BB4 8EL	100 Hr
Rossendale	East Lancashire	FM618	Boots	OL13 9NH	40 Hr
Rossendale	East Lancashire	FTM61	Boots	BB4 6QS	40 Hr
Rossendale	East Lancashire	FP156	Cohens Chemist	BB4 5SL	40 Hr
Rossendale	East Lancashire	FP211	Cohens Chemist	OL13 0UJ	40 Hr
Rossendale	East Lancashire	FJ067	Helmshore Pharmacy	BB4 4HD	40 Hr
Rossendale	East Lancashire	FLJ49	Lloydspharmacy	OL13 9NR	40 Hr
Rossendale	East Lancashire	FV079	Lloydspharmacy	OL13 0AD	40 Hr
Rossendale	East Lancashire	FL479	NHS Pharmacy	BB4 7QX	Internet
Rossendale	East Lancashire	FMR19	Rowlands Pharmacy	BB4 8HH	40 Hr
Rossendale	East Lancashire	FHL56	Strachan's Chemist	BL0 0JQ	40 Hr
Rossendale	East Lancashire	FH654	Tesco Instore Pharmacy	BB4 6DD	100 Hr
Rossendale	East Lancashire	FL635	Tesco Pharmacy	BB4 6LY	100 Hr
Rossendale	East Lancashire	FAJ76	The Co-operative Pharmacy	BB4 5SL	40 Hr
Rossendale	East Lancashire	FG858	The Co-operative Pharmacy	BB4 7DN	40 Hr
Rossendale	East Lancashire	FPK37	Theiam Chemists	BB4 8AJ	40 Hr
South Ribble	Chorley & South Ribble	FCK86	Boots Uk Limited	PR25 2SA	40 Hr
South Ribble	Chorley & South Ribble	FDP74	Boots Uk Limited	PR5 4AW	40 Hr
South Ribble	Chorley & South Ribble	FGD18	Boots Uk Limited	PR5 6LD	40 Hr
South Ribble	Chorley & South Ribble	FJ391	Clayfields Chemist	PR5 0AD	40 Hr
South Ribble	Chorley & South Ribble	FL817	Cohens Chemist	PR25 4YU	40 Hr
South Ribble	Chorley & South Ribble	FQK68	HBS Pharmacy	PR5 6JD	100 Hr
South Ribble	Chorley & South Ribble	FDG70	HBS Pharmacy (Penwortham Healthcare Ltd)	PR1 0AD	40 Hr
South Ribble	Chorley & South Ribble	FR111	Kingsfold Pharmacy	PR1 9BY	40 Hr
South Ribble	Chorley & South Ribble	FPE56	Leyland Late Night Pharmacy	PR25 2SD	100 Hr
South Ribble	Chorley & South Ribble	FD373	Lloydspharmacy	PR5 6TE	40 Hr

District	CCG	Pharmacy Code	Pharmacy Name	Postcode	Type
South Ribble	Chorley & South Ribble	FJG96	Longton Pharmacy	PR4 5PB	40 Hr
South Ribble	Chorley & South Ribble	FK888	Lostock Hall Pharmacy	PR5 5RU	40 Hr
South Ribble	Chorley & South Ribble	FKM84	MD Rimmer	PR7 7AR	40 Hr
South Ribble	Chorley & South Ribble	FWN77	Middleforth Pharmacy	PR1 9QJ	40 Hr
South Ribble	Chorley & South Ribble	FVK31	Peter Buckley Ltd	PR5 6QS	40 Hr
South Ribble	Chorley & South Ribble	FGV21	Pomfret Pharmacy	PR5 4AY	40 Hr
South Ribble	Chorley & South Ribble	FFX74	Rowlands Pharmacy	PR25 2FN	40 Hr
South Ribble	Chorley & South Ribble	FJ570	Rowlands Pharmacy	PR1 0DQ	40 Hr
South Ribble	Chorley & South Ribble	FJF38	Rowlands Pharmacy	PR25 1HR	40 Hr
South Ribble	Chorley & South Ribble	FR084	Rowlands Pharmacy	PR1 0SR	40 Hr
South Ribble	Chorley & South Ribble	FX445	Rowlands Pharmacy	PR25 1TB	40 Hr
South Ribble	Chorley & South Ribble	FT725	Sainsburys In-store Pharmacy	PR5 6BJ	100 Hr
South Ribble	Chorley & South Ribble	FMQ71	Tesco In-store Pharmacy	PR25 2FN	100 Hr
South Ribble	Chorley & South Ribble	FHT46	Village Pharmacy	PR4 4AA	40 Hr
South Ribble	Chorley & South Ribble	FFA80	Wise Pharmacy	PR5 3SN	40 Hr
West Lancashire	West Lancashire	FWP24	Asda Pharmacy	WN8 6LA	100 Hr
West Lancashire	West Lancashire	FHH39	Aspire Pharmacy	L39 2DN	100 Hr
West Lancashire	West Lancashire	FAL89	Banks Pharmacy	PR9 8ET	40 Hr
West Lancashire	West Lancashire	FH903	Boots Uk Limited	L39 2AA	40 Hr
West Lancashire	West Lancashire	FK531	Boots Uk Limited	WN8 6ND	40 Hr
West Lancashire	West Lancashire	FPQ59	Chemist-4-U	WN8 9SA	Internet
West Lancashire	West Lancashire	FHG54	Fishlocks Chemist	L40 4BY	100 Hr
West Lancashire	West Lancashire	FKL68	Greenhey Pharmacy Ltd	WN8 9SA	Internet
West Lancashire	West Lancashire	FJ533	Halsall Pharmacy	L39 8RW	40 Hr
West Lancashire	West Lancashire	FPG01	Hesketh Bank Pharmacy	PR4 6SN	40 Hr
West Lancashire	West Lancashire	FE703	J Halton	WN8 7HA	40 Hr
West Lancashire	West Lancashire	FTD78	Morrisons In-store Pharmacy	L39 3RB	40 Hr
West Lancashire	West Lancashire	FRQ00	Ormskirk Pharmacy	L39 2AU	40 Hr
West Lancashire	West Lancashire	FC861	Rowlands Pharmacy	WN8 6DS	40 Hr
West Lancashire	West Lancashire	FCT61	Rowlands Pharmacy	L39 1NL	40 Hr
West Lancashire	West Lancashire	FD431	Rowlands Pharmacy	L40 5TJ	40 Hr
West Lancashire	West Lancashire	FDF12	Rowlands Pharmacy	PR4 6TU	40 Hr
West Lancashire	West Lancashire	FDY91	Rowlands Pharmacy	L39 5DZ	40 Hr
West Lancashire	West Lancashire	FG210	Rowlands Pharmacy	L40 0SA	40 Hr
West Lancashire	West Lancashire	FHQ20	Rowlands Pharmacy	WN8 6UH	40 Hr
West Lancashire	West Lancashire	FLA57	Rowlands Pharmacy	L39 2ES	40 Hr
West Lancashire	West Lancashire	FQT26	Rowlands Pharmacy	L39 3BW	40 Hr
West Lancashire	West Lancashire	FR772	Rowlands Pharmacy	WN8 0EN	40 Hr
West Lancashire	West Lancashire	FT195	Rowlands Pharmacy	WN8 8LP	40 Hr
West Lancashire	West Lancashire	FXF02	Rowlands Pharmacy	WN8 9HR	40 Hr
West Lancashire	West Lancashire	FGL38	Rufford Pharmacy	L40 1SB	40 Hr
Wyre	Fylde & Wyre	FJM07	"your local Boots pharmacy"	FY5 1AS	40 Hr
Wyre	Fylde & Wyre	FY672	Albert Wilde Pharmacy	FY7 8GU	40 Hr
Wyre	Fylde & Wyre	FNV73	Asda Pharmacy	FY7 6NU	100 Hr
Wyre	Fylde & Wyre	FDA58	Boots	FY7 6DS	40 Hr
Wyre	Fylde & Wyre	FLP98	Boots	FY5 1BS	40 Hr
Wyre	Fylde & Wyre	FMH99	Carleton Pharmacy	FY6 7NH	40 Hr

District	CCG	Pharmacy Code	Pharmacy Name	Postcode	Type
Wyre	Fylde & Wyre	FN702	Fleetwood Health Centre Pharmacy	FY7 6HD	40 Hr
Wyre	Fylde & Wyre	FCD37	Hambleton Pharmacy	FY6 9AH	40 Hr
Wyre	Fylde & Wyre	FGD14	Johns Chemist	FY7 7LA	40 Hr
Wyre	Fylde & Wyre	FJD50	Kepple Lane Pharmacy	PR3 1PB	100 Hr
Wyre	Fylde & Wyre	FE908	Lloyds Pharmacy	FY6 7AA	40 Hr
Wyre	Fylde & Wyre	FEF13	Lloyds Pharmacy	FY6 OAE	40 Hr
Wyre	Fylde & Wyre	FJL19	Lloyds Pharmacy	FY5 5HT	40 Hr
Wyre	Fylde & Wyre	FT574	Lloyds Pharmacy	FY5 2TZ	40 Hr
Wyre	Fylde & Wyre	FTL58	Lloyds Pharmacy	FY6 7DF	40 Hr
Wyre	Fylde & Wyre	FAV22	The Co-operative Pharmacy	PR3 1EL	40 Hr
Wyre	Fylde & Wyre	FLD45	The Co-operative Pharmacy	FY6 7AP	40 Hr
Wyre	Fylde & Wyre	FCK08	Warburtons Pharmacy	FY7 6JZ	40 Hr
Wyre	Fylde & Wyre	FPE53	WM Morrisons Pharmacy	FY5 3TS	40 Hr
Wyre	Greater Preston	FTC27	Great Eccleston Health Centre	PR3 0ZA	40 Hr

Appendix 5: List of Dispensing Practices

Table 15: Dispensing practices as at June 2014

CCG	Practice code	Practice name	Location
East Lancashire	P81017	Sabden and Whalley Medical Centre	Whalley
East Lancashire	P81017	Sabden and Whalley Medical Centre	Sabden
East Lancashire	P81069	Pendleside Medical Practice	Clitheroe
East Lancashire	P81100	Castle Medical Group	Clitheroe
East Lancashire	P81620	Slaidburn Medical Centre	Slaidburn
East Lancashire	P81732	Harambee Surgery	Trawden
Fylde & Wyre	P81087	Over Wyre Medical Centre	Preesall
Greater Preston	P81059	Great Eccleston Health Centre	Great Eccleston
Greater Preston	P81185	Riverside Medical Centre	Walton-le-Dale
Lancashire North	P81006	The Windsor Road Surgery	Garstang
Lancashire North	P81029	Dr D H F Kopcke and Partners	Carnforth
Lancashire North	P81056	Dr R G Jackson & Partners	Lancaster
Lancashire North	P81190	The Landscape Surgery	Garstang

Source: NHS England, 2014

Appendix 6: Results of pre-consultation questionnaires

Results of the Community Pharmacy questionnaire

A questionnaire was sent to all 295 Community Pharmacies in Lancashire. There were 188 returned questionnaires (64%). In the table below 'Blank' denotes the number (percentage) who returned the questionnaire but did not respond to the specific question.

	Question	Response
Consultation facilities	Are consultation facilities on site and do they include wheelchair access?	Out of 188 returned questionnaires 155 (82.4%) Have consult. areas with wheelchair access 28 (14.9%) Have consult. areas w/o wheelchair access 4 (2.1%) No consultation rooms available 1 (0.5%) Blank
	Where there is a consultation area, is it a closed room?	Out of 188 returned questionnaires 179 (95.2%) Have the consult. area in a closed room 2 (1.1%) Don't have the consult. area in a closed room 7 (3.7) Stated NA
	Have access to off-site consultation area?	Out of 188 returned questionnaires 13 (6.9%) Don't have access to off-site consultation area 95 (50.5%) Stated that None apply
	Willing to undertake consultations in patients home, or other suitable site?	Out of 188 returned questionnaires 80 (42.6%) Willing to undertake consultations in Patient's home/ other suitable site
	During consultations are there hand washing facilities?	Out of 188 returned questionnaires

		124 (66.0%) Hand washing facilities in cons. area 30 (16.0%) Hand washing facilities close to cons. area 34 (18.1%) No hand-washing facilities
	Patients attending for consultations have access to toilet facilities	Out of 188 returned questionnaires 48 (25.5%) Have toilet facilities available for patients
IT facilities	Electronic Prescription Service: Release 1 enabled, or Release 2 enabled, or Intending to become Release 1 enabled within the next 12 months, or Intending to become Release 2 enabled within the next 12 months, or No plans for EPS at present	Out of 188 returned questionnaires: 6 (3.2%) No current plans to provide EPS R2 10 (5.3%) Planning to become EPS R2 enabled in the next 12 months 13 (6.9%) Release 1 Enabled 159 (84.6%) EPS R2 enabled
	Facilities for opening documents	Out of 188 returned questionnaires: 152 (80.9%) Word 140 (74.5%) Excel 0 (0%) Access 167 (88.8%) PDF 3 (1.6%) Unable to open or view any file formats 13 (6.9%) Blank
Services	Essential Does the pharmacy dispense appliances?	Out of 188 returned questionnaires: 166 (88.3%) Yes - All Types 7 (3.7%) Yes, just dressings 6 (3.2%) Yes, excluding stoma appliances 2 (1.1%) Yes, excluding incontinence appliances 3 (1.6%) Yes, excluding stoma and incontinence appliances

		1 (0.5%) Other: dressings and stoma and incontinence no space to measure and fit items 3 (1.6%) None
	Advanced Medicines Use Review	177 (94.1%) Yes 6 (3.2%) No 5 (2.7%) Soon
	New Medicine Service	173 (92.0%) Yes 6 (3.2%) No 9 (4.8%) Soon
	Appliance Use Review	151 (80.3%) No 18 (9.6%) Yes 19 (10.1%) Soon
	Stoma Appliance Customisation	134 (71.3%) No 38 (20.2%) Yes 16 (8.5%) Soon
Non NHS Funded Services	Collection of prescription from surgeries	Out of 188 returned questionnaires: All (100%) collect prescriptions from surgeries
	Delivery of dispensed medicines – free of charge on request	Out of 188 returned questionnaires: 168 (89.4%) deliver dispensed medicines free of charge on request 18 (9.6%) don't deliver dispensed medicines free of charge on request 2 (1.1%) blank)
	Delivery of dispensed medicines – selected patient groups	51 (27.1%) deliver to selected patient groups. Selected patient groups stated include: care homes, elderly, disabled or housebound and other patients specifically requesting the service.
	Delivery of dispensed medicines – selected areas	47 (25.0%) deliver to selected areas.

		Areas ranged from immediate and local to nationwide.
	Delivery of dispensed medicines – chargeable	9 (4.8%) deliver medicines – chargeable.
Other	Does your pharmacy supply medicines etc. to care homes?	Out of 188 returned questionnaires: 33 (17.6%) Currently providing 2 (1.1%) Willing to provide if commissioned but would need training and currently providing a private service 113 (60.1%) Willing to provide 40 (21.3%) Blank
	Home Delivery Service (not-appliances)	Out of 188 returned questionnaires: 107 (56.9%) Currently Providing NHS funded service 22 (11.7%) Currently providing private service 7 (3.7%) Willing to provide if commissioned but would need training 32 (17.0%) Willing and able to provide if commissioned 3 (1.6%) Willing to provide if commissioned but require facilities adjustment 17 (9.0%) Blank

Results of Dispensing Practice questionnaires

A questionnaire was sent to all 13 (Check with Mark) dispensing practices in Lancashire. There were 10 returned questionnaires (77%). In the table below 'Blank' denotes the number (percentage) who returned the questionnaire but did not respond to the specific question.

	Question	Response
Consultation facilities	Are consultation facilities on site and do they include wheelchair access?	Out of 10 returned questionnaires 9 (90.0%) Have consult. areas with wheelchair access 1 (10.0%) Blank
	Where there is a consultation area, is it a closed room?	Out of 10 returned questionnaires 8 (80.0%) Have the consult. area in a closed room 2 (20.0%) Blank
	Have access to off-site consultation area?	Out of 10 returned questionnaires 3 (30.0%) willing to undertake consultations in patient's home / other suitable site 4 (40.0%) blank 3 (30.0%) NA
IT facilities	Electronic Prescription Service: Release 1 enabled, or Release 2 enabled, or Intending to become Release 1 enabled within the next 12 months, or Intending to become Release 2 enabled within the next 12 months, or No plans for EPS at present	Out of 10 returned questionnaires: 2 (20.0%) Intending to become release 1 enabled within next 12 months 4 (40.0%) No plans for EPS at present 3 (30.0%) release 1 & 2 enabled 1 (10.0%) release 1 enabled
Services	Essential Does the pharmacy dispense appliances?	Out of 10 returned questionnaires: 6 (60.0%) yes 1 (10.0%) None

		3 (30.0%) Yes, excluding stoma appliances
	Advanced Medicines Use Review	3 (30.0%) DRUMs 2 (20.0%) No - not intending to provide 1 (10.0%) No not intending to provide 4 (40.0%) yes
	New Medicine Service	2 (20.0%) DRUMs 2 (20.0%) No - not intending to provide 2 (20.0%) No not intending to provide 1 (10.0%) Not Intending to Provide 1 (10.0%) Yes 2 (20.0% Blank
	Appliance Use Review	2 (20.0%) DRUMs 1 (10.0%) Intending to begin within next 12 months 2 (20.0%) No - not intending to provide 2 (20.0%) No not intending to provide 1 (10.0%) Not Intending to Provide 2 (20.0%) Blank
	Stoma Appliance Customisation	2 (20.0%) DRUMs 1 (10.0%) Intending to begin within next 12 months 2 (20.0%) No - not intending to provide 2 (20.0%) No not intending to provide 1 (10.0%) yes 2 (20.0%) Blank
	Delivery of dispensed medicines – free of charge on request	9 (90%) Yes 1 (10%) blank
	Delivery of dispensed medicines – selected patient groups	1 (10%) Over 60s 9 (90%) Blank

Appendix 7: Consultation report

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Pharmacy Needs Assessment summary on a page

Background

- From 1st April 2013 HWB have a legal responsibility to produce a Pharmacy Needs Assessment (PNA)
- A full pharmacy needs assessment has to be completed by 1st April 2015
- The PNA will help in commissioning of pharmaceutical services and will be used by NHS England when making decisions on applications to open new pharmacies
- Supplementary statements need to be produced every 6 months if necessary
- A PNA has to be produced every 3 years

Chapter coverage

Chapter 1: Introduction

- **What is a PNA**
- **Purpose Of PNA**
- **Legislative background**

Chapter 2: Process

- **Stakeholder involvement**
- **Assessment of need for pharmaceutical services**

Chapter 3: Context for the pharmaceutical needs assessment

- **Integrated Strategic Needs Assessment**
- **Lancashire HWB**
- **Characteristics of Lancashire**

Chapter 4: current provision of NHS pharmaceutical services

- **Service providers**
- **Accessibility**
- **Community pharmacy services**

Chapter 5: health needs and locally commissioned services

- **Focus on the role of community pharmacy in improving public health**
- **Key public health issues**

Chapter 6: future population changes and housing growth

- **Population changes in Lancashire**
- **Housing growth in Lancashire**

Next steps

HWB to review and feedback any comments by 18th of October

Once amendments have been made PNA will go out for a 60 day consultation on the 20th of October to the public and key stakeholders

Stakeholder event to be held to promote the public consultation

Amendments will be made after public consultation. Final version of PNA to go to Chair of HWB for final sign off or presented to HWB for sign off

Recommendations/considerations

- There is adequate service provision of pharmacies
- Pharmacies provide a wide range of commissioned services
- The PNA does not identify the need for any additional pharmacies