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PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

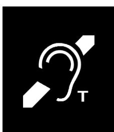
THURSDAY 22 SEPTEMBER 2016
1.00 PM

Bourges/Viersen Room - Town Hall
Contact – philippa.turvey@peterborough.gov.uk, 01733 452460

AGENDA

		Page No
1.	Apologies for Absence	
2.	Declarations of Interest	
3.	Minutes of the Previous Meeting	3 - 8
4.	Peterborough Cardiovascular Disease Strategy	9 - 26
5.	Diverse and Ethnic Communities Joint Strategic Needs Assessment for Peterborough	27 - 104
6.	Sustainable Transformation Programme Mental Health Strategy	105 - 148
7.	Mental Health Crisis Vanguard Project Update	149 - 152
8.	Sustainable Transformation Programme Update	153 - 168
	INFORMATION AND OTHER ITEMS	
9.	Adult Social Care, Better Care Fund (BCF) Update	169 - 172
10.	Revised Annual Public Health Report	173 - 198
11.	Schedule of Future Meetings and Draft Agenda Programme	199 - 200

To note the dates and agree future agenda items for the Board. To include frequency of reporting from other Boards, where appropriate, including Local Safeguarding Boards, Children's and Adults Commissioning Boards, LCG Commissioning Board. Also to consider how we will monitor progress against the Health and Wellbeing strategy.



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Board Members:

Cllr J Holdich (Chairman), Cllr D Lamb, Cllr W Fitzgerald, Cllr R Ferris, C Mitchell, Dr Laliwala, Dr Howsam, D Whiles, Dr Mistry (Vice Chairman), W Ogle-Welbourn, Dr Robin, A Chapman and A Pike

Co-opted Members: Russell Wate and Claire Higgins

Further information about this meeting can be obtained from on telephone 01733 452460 or by email – philippa.turvey@peterborough.gov.uk

PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 21 JULY 2015

Members Present:	Councillor Holdich, Leader and Cabinet Member for Education, Skills and University (Chairman) Councillor Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health Councillor Lamb, Cabinet Member for Public Health Wendi Ogle-Welbourn, Corporate Director People and Communities Adrian Chapman, Service Director Adult Services and Communities Julian Base, Head of Health Strategy Dr Gary Howsam, Clinical Commissioning Group David Whiles, Peterborough Healthwatch
Co-opted Members Present:	Jo Proctor, Local Safeguarding Children's Board and Peterborough Safeguarding Adults Board
Also Present:	Philippa Turvey, Senior Democratic Services Officer Sarah Shuttlewood, Director of Contracting Performance and Delivery, CCG Jessica Stokes, Public Health Registrar Bill Pickbourn, Programme Manager Rod Grant, Communities Directorate Tom Lydiate, Substance Misuse Service Manager

1. Apologies for Absence

Apologies for absence were received from Dr Mistry, Dr Laliwala, Councillor Ferris, Cath Mitchell, Claire Higgins, Russell Wate and Dr Liz Robin.

Julian Base and Jo Proctor were in attendance as substitutes for Dr Liz Robin and Russell Wate respectively.

2. Declarations of Interest

No declarations of interest were received.

3. Minutes of the Meeting Held on 24 March 2016

The minutes of the meeting held on 24 March 2016 were approved as a true and accurate record.

4. St George's Hydrotherapy Pool

The Director of Contracting Performance and Delivery, Clinical Commissioning Group (CCG), introduced the report regarding the use of St George's Hydrotherapy Pool. The Board was advised that the CCG would not commission further services from the Pool due mainly to financial restraints and the lack of definitive evidence on the clinical benefits of the service.

With the permission of the Chairman, Karen Oldale, spokesman for St George's Hydrotherapy Pool, addressed the Board and asked the CCG to reconsider the decision not to fund St George's. The key points raised by her included:

- Hydrotherapy was specifically for those who could not benefit from dry land physio-therapy and was invaluable to aid recovery.
- Hydrotherapy would now only be available for self-referral and self-funding, giving access only to those who could afford to pay for their treatment.
- Over 3,000 people with disabilities and long term health issues had used and benefited from the pool, illustrating the benefits from self-management.
- 234 users, 97% of the disabled service users, participated in discussions surrounding the benefits and future access to the pool.
- The use of hydrotherapy was efficient and cost effective, and an independent professional report had shown that every £1 invested at St George's resulted in a social value of £19 over the year.
- The funding concerned was £6,000 from CCG, whereas in Cambridgeshire the funding was £53,000 which is considered unfair.
- Patients were taking control of their disability and trying to improve themselves as per the remit from the CCG, and were saving money on their long term care.
- Costs to the CCG to send patients to NHS funded services rather than continue to use the St George's Pool would be greater. At the same time a less efficient service would be provided with an increase in disruption and therefore distress to patients.
- It was requested that the CCG discuss and reconsider its decision not to provide funding for St George's Pool in future.

The Board discussed the following:

- Evidence was requested on the claim that there was no benefit from hydrotherapy treatment.
- Members had personal experience of the benefits of the pool and had observed the benefit to others, particularly to those with mental health issues.
- It was considered that a contribution towards funding could be made if the full amount could not be met.
- The consultation had taken place in private. It was noted that if a policy was in place it would be necessary to hold a public consultation and have an open discussion.
- Using the lack of policy as a reason to withdraw funding was considered to be perverse.
- A request was made for a policy to be drafted and brought to a future meeting.
- Concern was raised in relation to the withdrawal of funding and the lean towards private funding.
- The number of sessions undertaken at Addenbrookes last year was 1,400 at a cost of £53,000.
- Patients self-funding was not considered to be a good reason to withdraw financial support for the service.
- It was accepted that this was an emotive topic and the purpose of the meeting was to provide comments back to CCG.

The Health and Wellbeing Board **RECOMMENDED** that the Clinical Commissioning Group draft a Hydrotherapy Policy to be brought back to the Board at its meeting in December 2016 for consideration.

5. Health and Care Executive Governance Framework

The Director of Contracting Performance and Delivery, CCG, introduced the report which outlined the health and care system in place within Peterborough and Cambridgeshire. It was advised that the Sustainable Transformation Programme as stipulated by NHS England and the NHS was particularly relevant, as the money spent exceeded that available. The report

requested the Board to review the implementation of the plan and to make members aware of the governance arrangements agreed.

Feedback and comments were invited from the Board, and key points highlighted and raised during discussion included:

- Expectations were high given the number of senior managers taking part.
- The timescale to reduce the £450 million deficit was discussed as well as the arising conflicts between this, providing an efficient service, and the clinical perspective. It was advised that the plan focused on care quality, which would drive efficiency. Therefore, an immediate deficit reduction would not be seen.
- Given the current footfall in GP surgeries and Accident and Emergency further education was needed to channel users toward the correct resources or self-care.
- The five year plan was to be implemented over the next five years, rather than being a plan for 2021.
- A review to assess progress would be required to measure the success of the plan. Some results would only be evident towards the end of the five year period. Urgent care pathway charges and changes to the 111 service would be in place in Autumn 2016. Improvements therefore in this area should be visible sooner resulting in a reduction in numbers in Accident and Emergency.
- Improvements were visible already within the area of mental health and it was suggested that successful strategies were reported.
- Politicians must make themselves aware of what was happening at ground level for them to pass this on to the public.
- The project was to ensure alignment and visibility across the system with different projects to ensure collaboration.
- There were no specific goals or an action plan contained within the report as this will follow in due course.
- Politicians needed to ensure the funding was received to drive this forward.
- Members of the public themselves must buy in to the plan, co-operate with changes introduced and use health services correctly both locally and nationally to ensure success.

The Health and Wellbeing Board **RESOLVED** to note the report.

6. Annual Director of Public Health Report

The Head of Health Strategy introduced the report, which was produced as a statutory duty of the Director of Public Health.

The key points raised by the Head of Health Strategy included:

- The report increased awareness of the condition of existing services, health challenges, and public health issues. The report would be available in both printed and electronic form to reach the widest audience across the city.
- The report addressed local health challenges such as the high proportion of premature death within the city, health inequalities, and the high mortality rates in central Peterborough, where there were overriding economic issues.
- Several important matters discussed within the report included:
    - Prevention of Cardio Vascular Disease and associated factors and conditions;
    - Smoking;
    - Physical activity;
    - Excess weight;
    - Education through schools; and
    - Engaging with more people within the community.

The Board considered the report, and key points highlighted and raised during discussion included:

- That the report didn't appear to contain any specific improvements and it was considered that any future successes should be published.
- The data could be presented in a manner to make it easier to understand, for example, reporting positive results and illustrating geographical and national comparisons.
- There had been a huge increase in population and an influx from overseas, which would have provided additional challenges and may have masked improvements. It was not obvious this has been accounted for.
- It was considered that the statistics needed to be measured within types of communities as well as geographically, as the Asian community was beginning to disperse from its traditional stronghold to be replaced by east European communities.
- It was not yet clear whether the health of the immigrating population would improve through the generations, or if the health issues experienced were an inherent part of their community.
- It was recommended that the report included trends in comparison to previous years.

The Health and Wellbeing Board **RESOLVED** to note the report.

7. Draft Peterborough Health and Wellbeing Strategy

The Public Health Registrar introduced the report on behalf of Dr Liz Robin. The Health and Wellbeing Strategy was a statutory function of the Health and Wellbeing Board and had been undertaken jointly with the NHS, the local authority and Healthwatch. The three month consultation resulted in over 100 replies across different groups and some changes were made in response.

Key points highlighted and raised during discussion included:

- Members commended the quality of the report.
- The objective was to work within existing strategies and to build on existing strategies rather than develop something new.
- Assurance had been given by the Health and Wellbeing Delivery Board that this was a deliverable strategy.
- Many areas covered by this board overlap with other committees, and it would be advantageous to have wider, cross committee involvement. This could be discussed in six months by a cross committee group.
- Vivacity were part of the working group looking at the programme, but were not part of the delivery process.
- Further integration with GP practices could involve Vivacity as part of a treatment plan, as well as delivering preventative measures, which would be desirable. These would not incur additional costs as the facilities were already open. It was considered that costs could be reduced by referrals directly to Vivacity services from a variety of sources as the health referral could come from anywhere, not necessarily a GP, although those on GP referrals do not have to pay to use the facilities.
- Access to those in deprived areas and social prescribing could be extended, funded by the community serve budget.
- Involvement with external bodies could be extended, such as the YMCA, who were currently in discussions with GP's regarding free gym membership.

The Health and Wellbeing Board **RESOLVED** to:

1. Note the feedback from the public and stakeholder consultation on the joint Health and Wellbeing Strategy and ways in which this feedback had been incorporated into the final draft of the Strategy;

2. Note the feedback from Peterborough City Council Cabinet and the Cambridgeshire and Peterborough Clinical Commissioning Group Governing Body, which had both discussed and endorsed the final draft Strategy at public meetings;

3. Note comments relayed verbally from the meeting of the Health Scrutiny Commission which considered the draft Strategy as part of a wider item on public health priorities for Peterborough; and

4. Approve the Peterborough Health and Wellbeing Strategy (2016/19) subject to inclusion of the amendment suggested by Peterborough City Council Cabinet i.e:
    - Inclusion of plans to address the needs of ex-military personnel including post traumatic stress disorder.

8. Adult Social Care, Integration of Health System Programmes Governance Structure

The Programme Manager introduced the report, which was a sub section of the Peterborough Health and Wellbeing Strategy, with a focus on local delivery. There were six or seven major programmes which all overlapped, and needed to be structured in an effective manner.

It was advised that separating the reporting of progress from the approval of progress would be more efficient, and would ensure interested parties were updated whilst the actual approval could be carried out in a more contained manner.

Key points highlighted and raised during discussion included:

- The Governance Arrangements proposals had been through a number of different boards for agreement and was included in the Health Executive Away Day as part of the System Transformation Plan.
- Efficiency and decision making had been simplified through the building of trust and good relationships and Members selected at the right level. This method was viewed as being successful and is under consideration by other authorities.

The Health and Wellbeing Board **RESOLVED** to approve the update to the Integration of Health Systems Programmes Governance Arrangements.

9. Update on the Implementation of the New Integrated Substance Misuse Service

Rod Grant, Communities Directorate, introduced the report, which provided an overview of the Council's re-tendering of the substance misuse services process last year. The new service commenced in April 2016. The new providers were CGL (previously CRI) who previously held the contract for adult drug services in Peterborough and now held the contract to supply all services. This provided greater flexibility between the various sectors and it was considered to be a preferable approach.

Key points highlighted and raised during discussion included:

- It was anticipated that a reduction in performance would be seen during the changeover.
- A recent informal first quarter review with CGL showed good results in areas that were new to their contract, including working with young people with alcohol problems and the Hospital Liaison Programme.
- The Safer Peterborough Partnership would be responsible for the deliverance of the programme and overseeing the performance of the contract.
- Tom Lydiate, Substance Misuse Service Manager, was recently appointed and was introduced to the board. Mr Lydiate was committed to delivering and working in partnership. He addressed the board and indicated he was impressed with the attitude and work being conducted here and intended to target all types of drug and alcohol misuse, and integrate users back into the community.
- The training given by staff at CGL to the Safeguarding Adults Board and Safeguarding Children's Board was appreciated and would now form part of the Multi Agency Training Suite.

The Health and Wellbeing Board **RESOLVED** to note the report on the implementation of the integrated substance misuse service.

10. Domestic Abuse and Sexual Violence Service Update

The Corporate Director People and Communities introduced the report which provided background information on domestic abuse and sexual violence services offered to Peterborough victims.

Key points highlighted and raised during discussion included:

- Services were provided by Peterborough Women's Aid and delivered across adults' and childrens' services.
- Waiting lists for children and young people were very long, however had been reduced upon receipt of additional funding from the CCG to employ an additional support worker.
- Further funding had been secured for the same support for 2016 / 2017.
- Additional funding had been received for the Ormiston Families to deliver an early intervention service for mothers and children who have experienced domestic violence.
- Peterborough City Council had joined forces with Cambridgeshire County Council in order to maximise the potential of working with partners who already work across both areas.
- It was considered that cross committee membership encouraged more efficient working.
- An audit into the repeat referrals to Women's Aid would be carried out with a view to improving the service.
- Training would now be the responsibility of the Joint Domestic Abuse and Sexual Violence Strategic Board. The number of staff attending the local children safeguarding board training was 185, not 2 as indicated in the report.
- Further training was being planned which would include working with offenders.
- Joint targeted investigations were due to be carried out and a mock review would be conducted in August / September ahead of the anticipated official review.

The Health and Wellbeing Board **RESOLVED** to note the content in the report.

INFORMATION ITEMS AND OTHER ITEMS

The remainder of the items on the agenda were for information only and the Health and Wellbeing Board **RESOLVED** to note them without comment.

11. Adult Social Care, Better Care Fund (BCF) Update

12. Schedule of Future Meetings and Draft Agenda Programme

The next meeting of The Health and Wellbeing Board will take place on 22 September 2016.

1.00pm – 3.25pm
Chairman

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 4
22 September 2016		PUBLIC REPORT
Contact Officer(s):	Jess Stokes, Public Health Registrar	Tel. 01733 452577

PETERBOROUGH CARDIOVASCULAR DISEASE STRATEGY, 2016-2021

R E C O M M E N D A T I O N S	
FROM : Director of Public Health	**Deadline date :** *N/A*

The Health and Wellbeing Board is asked to:

1. Consider and endorse the draft Peterborough Cardiovascular Disease Strategy; and
2. Consider comments from the Greater Peterborough Executive Partnership Board requesting a steer on how aggressive the strategy can be in encouraging healthy lifestyle choices in Peterborough.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board as the final part of the process to develop a Peterborough Cardiovascular Disease Strategy, which the Health and Wellbeing Board agreed should be the top priority for Peterborough.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to obtain the Board's views on and approval of the attached Cardiovascular Disease Strategy which has been developed in consultation with partner agencies.

2.2 This report is for Board to consider under its Terms of Reference No. 3.3 'To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities'.

3. BACKGROUND

3.1 Cardiovascular disease (CVD) is an overarching term that describes a family of diseases sharing a common set of risk factors, including heart disease, stroke and peripheral arterial disease. Although mortality from CVD has fallen over time, there is considerable variation in CVD mortality according to geography, ethnicity and social position. Peterborough is significantly worse than the national average for premature deaths from CVD.

3.2 A substantial programme of work already has and is being undertaken to improve CVD outcomes in Peterborough, including stakeholder events, a CVD Joint Strategic Needs Assessment and ongoing healthy lifestyle services. This strategy aims to bring this together and provide a framework to improve the cardiovascular disease health of people living in Peterborough. The specific objectives of the strategy are:

a. To reduce premature mortality from cardiovascular disease
b. To reduce inequalities in CVD outcomes between the most deprived and least deprived areas of Peterborough
c. To improve access to prevention and optimised management of CVD

3.3 The strategy has been developed around three thematic workstreams that had been identified previously by the Health and Wellbeing Programme Board. These are:

a. **Prevention and early intervention** – reducing risk factors for CVD through lifestyle modification, behaviour change and changes to the environment.
b. **Healthcare and rehabilitation/reablement** – including treatment and support for people with CVD to prevent or slow deterioration of their condition and enable recovery from episodes of poor health as far as possible.
c. **Continuing support** – including health and social care for people with chronic and long term impacts of CVD, providing effective treatment and promoting independence as far as possible.

3.4 Achieving improvements in CVD outcomes requires a joint approach across Local Authority and NHS services. A 'Peterborough CVD Programme Steering Group' of key stakeholders has been established to develop and monitor the implementation of the strategy.

3.5 It is important this strategy links to the wider work across Cambridgeshire and Peterborough as part of the System Transformation Plan. It builds on the CCG work on tackling inequalities in coronary heart disease and also takes account of the Cambridgeshire and Peterborough Health System Prevention Plan and national guidance.

3.6 Working groups have been established around each of the strategy workstreams to develop implementation plans and take forward specific projects. These groups will report to the Peterborough CVD Steering Group which will in turn report to the Greater Peterborough Executive Partnership Board Peterborough Health and Wellbeing Board as appropriate.

3.7 A Strategy launch event is planned for 2 November 2016.

4. CONSULTATION

4.1 A series of stakeholder events took place in 2015 and this strategy has taken account of the feedback from these events.

4.2 The draft strategy was considered and approved by the Greater Peterborough Executive Partnership Board – Commissioning on 19 August. The Executive Board asked for a steer from the Health and Wellbeing Board in terms of how aggressive the strategy could be in terms of creating a Healthy Peterborough environment, for example by encouraging healthy diet choices in public buildings.

5. ANTICIPATED OUTCOMES

5.1 The anticipated outcome is that the Health and Wellbeing Board will endorse the Peterborough CVD Strategy.

6. REASONS FOR RECOMMENDATIONS

6.1 The Health and Wellbeing Board have determined that cardiovascular disease should be the priority focus for Peterborough. The strategy provides a framework for taking this forward and monitoring progress.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 It was decided that the period covered by the strategy should be five years rather than a shorter time period in line with NICE guidance.

8. IMPLICATIONS

8.1 There is a resource implication in terms of ongoing co-ordination of the Peterborough CVD Steering Group and support for project implementation. There will also be financial implications for the plans and objectives outlined in the Strategy for the organisations

involved. The HWB Board is asked to endorse the CVD Strategy as an agreed strategic direction, rather than to make specific funding commitments at this point. The actions in the Strategy will then be subject to the business case development and prioritisation processes of the partner organistions involved.

Legal

8.2 The Council must ensure it complies with relevant Equalities and Human rights legislation.

9. BACKGROUND DOCUMENTS

9.1 Background documents used to prepare this report have all been previously published.

10. APPENDICES

- Appendix 1: Draft Peterborough Cardiovascular Disease Strategy, 2016-2021
- Appendix 2: Peterborough Cardiovascular Disease Programme Steering Group Terms of Reference

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Draft Peterborough Cardiovascular Disease Strategy 2016 - 2021

1. INTRODUCTION

This strategy has been developed to improve cardiovascular health for people living in Peterborough. It is concerned with preventing cardiovascular disease (CVD), improving the outcomes of people with CVD and reducing inequalities in outcomes across Peterborough.

Cardiovascular disease is an overarching term that describes a family of diseases sharing a common set of risk factors. The underlying cause is the build-up of fatty deposits lining the arteries (atheroma), which contribute to conditions such as heart disease (including heart attack, angina and heart failure), cerebrovascular disease (stroke and transient ischemic attack (TIA)) and peripheral arterial disease.

Circulatory diseases such as heart disease and stroke were the second broad cause of death (behind cancer) in 2014, accounting for just over a quarter (27%) of all deaths. Although mortality from CVD has fallen over time, there is considerable variation in CVD mortality according to geography, ethnicity and social position. Cardiovascular diseases, such as stroke, also have a serious impact on quality of life and can cause considerable disability.

Peterborough is significantly worse than the national average for premature deaths from CVD and CVD considered preventable and is ranked 122nd out of 150 local authorities for premature deaths from heart disease.

In more than 90% of cases the risk of first heart attack is related to nine modifiable risk factors; high blood cholesterol, smoking and tobacco use, overweight and obesity, high blood pressure, poor diet, insufficient physical activity, psychosocial stress, diabetes and excess alcohol consumption.[1] Evidence shows that these risk factors are often clustered in more disadvantaged population groups[2] and individuals will often have a number of these risk factors and may also have more than one clinical manifestation of CVD. However, patients often receive care from multiple different teams in different settings. There is a need for a more co-ordinated and integrated approach to care to improve outcomes.

It should also be noted that services for the prevention of CVD also contribute to the prevention of other non-communicable disease, including type II diabetes, chronic kidney disease, chronic obstructive pulmonary disease and some cancers.

Achieving improvements in CVD outcomes requires a joint approach across Local Authority and NHS services and this strategy has been developed in partnership between Peterborough City Council and Greater Peterborough Local Commissioning Group (LCG).

DRAFT

2. BACKGROUND

Cardiovascular Disease has been identified by Peterborough Health and Wellbeing Board as the top priority focus. Feedback from stakeholder events was that a population-based approach to prevention should be adopted which should be linked to existing strategies for targeting people at high risk of CVD, such as NHS Health Checks. A need to improve treatment pathways and outcomes for people with CVD was also identified, including acute interventions and reablement, for example in stroke. Three thematic workstreams were identified for the CVD programme in Peterborough;

- **Prevention and early intervention** – reducing risk factors for CVD through lifestyle modification, behaviour change and changes to the environment.
- **Healthcare and rehabilitation/reablement –** including treatment and support for people with CVD to prevent or slow deterioration of their condition and enable recovery from episodes of poor health as far as possible.
- **Continuing support –** including health and social care for people with chronic and long term impacts of CVD, providing effective treatment and promoting independence as far as possible.

The Peterborough Health and Wellbeing Board Strategy for 2016-2019 highlights that the following need to be addressed:

- Premature deaths (age under 75) from CVD are higher than average
- Preventable deaths from CVD are higher than average
- Emergency hospital admissions and premature deaths from heart disease are higher in deprived areas
- Diabetes and coronary heart disease are more common in South Asian communities

A number of programmes of work have been established to improve CVD outcomes across Cambridgeshire and Peterborough and it is important that this strategy complements and does not duplicate this work. Cambridgeshire and Peterborough CCG identified 'Tackling Health Inequalities in CHD' as a priority with a focus on NHS Health Checks, cardiac rehabilitation, primary care interventions and decreasing smoking prevalence. The programme was expanded for 2015-2017 to include CVD and incorporate Atrial Fibrillation and Stroke.

Cardiovascular disease is a working group of the Proactive Care and Prevention workstream of the Sustainability and Transformation Programme for Cambridgeshire and Peterborough and there is also an Elective (non-emergency) Cardiology workstream.

The Health System Prevention Strategy for Cambridgeshire and Peterborough[3] chapter on cardiovascular disease suggests that the strategic focus for short to medium term savings for the NHS should be on cardiac rehabilitation, and atrial fibrillation and hypertension diagnosis, management and prevention.

In developing this strategy relevant national documents and evidence based guidance has been used such as the Department of Health Cardiovascular Disease Outcome Strategy and NICE commissioning and public health guidance for CVD prevention.

DRAFT

3. KEY FINDINGS FROM THE PETERBOROUGH CVD JOINT STRATEGIC NEEDS ASSESSMENT

A **Cardiovascular Disease Joint Strategic Needs Assessment** (JSNA) was requested by the Health and Wellbeing Board to inform the development of the CVD workplan. The key findings from the JSNA[4] include:

- Peterborough has a relatively young and growing population with a relatively high proportion of black and minority ethnic (BME) residents compared to nationally.
- The prevalence of CVD rises with age and is also higher in more deprived populations. South Asian populations in the UK are known to have higher rates of premature coronary heart disease (CHD).
- Borderline & Peterborough practices comprise the majority (17/22, 77.3%) of practices in the most deprived quintile within the CCG. Within this quintile, prevalence is significantly higher than the CCG for CVD, CHD and diabetes despite a lower proportion of population being aged 65 or older.
- Although premature mortality rates from CVD have fallen substantially in recent years, Peterborough has significantly high mortality rates for CVD under the age of 75. There also appears to be a widening gap in premature CVD mortality for females in Peterborough.
- Circulatory diseases (including coronary heart disease and stroke) contribute a third of the gap in life expectancy between Peterborough and the national average for men, and half for women.
- In Peterborough, smoking prevalence was 34.7 % in people in routine and manual occupations, the highest in the East of England in 2013.
- Estimates based on the 2012 Active People Survey suggest the percentage of adults classified as obese in Peterborough is 24.1%, which is 2.5% higher than the estimate for Cambridgeshire (21.6%). The estimated percentage of adults classified as either overweight or obese in Peterborough is 65.5% whereas in Cambridgeshire it is 65.0%.
- CVD risk factors are relatively high in the relatively younger and more deprived population in Borderline and Peterborough LCGs, who may not be diagnosed with CVD yet, but are at high risk of developing disease and requiring services as they age.
- Hospital admissions and deaths data for circulatory diseases in Peterborough show a correlation with wards with a high proportion of BME groups. These wards are also the most deprived. Central, Park, Ravensthorpe, West, East, North and Dogsthorpe wards have higher % BME, % living in income deprived households, standardised mortality ratios for deaths from circulatory diseases and coronary heart disease (all ages) and higher standardised emergency admission ratios for coronary heart disease.

4. STRATEGY VISION AND OBJECTIVES

The vision is to improve the cardiovascular disease health of people living in Peterborough. This will be achieved by developing programmes and supporting individuals and communities to address those risk factors which influence CVD. This includes ensuring that there is equal access to CVD services and those individuals with CVD receive optimum care and are able to manage their condition. The three thematic workstreams form the strategy framework (prevention and early intervention, healthcare and rehabilitation, continuing support).

The objectives of the strategy are:

- To reduce premature mortality from cardiovascular disease
- To reduce inequalities in CVD outcomes between the most deprived and least deprived areas of Peterborough
- To improve access to prevention and optimised management of CVD

Improvements in CVD outcomes will be measured by the following overarching indicators. Additional indicators will be developed under the 3 thematic workstreams.

Under 75 mortality rate from cardiovascular disease, directly standardised rate per 100,000 (PHOF indicator)

Under 75 mortality rate from cardiovascular disease considered preventable, directly standardised rate per 100,000 (PHOF indicator)

Difference between the 20% most deprived wards in Peterborough and the remaining wards in under 75 mortality rate from cardiovascular disease (? Health and Wellbeing Strategy indicator)

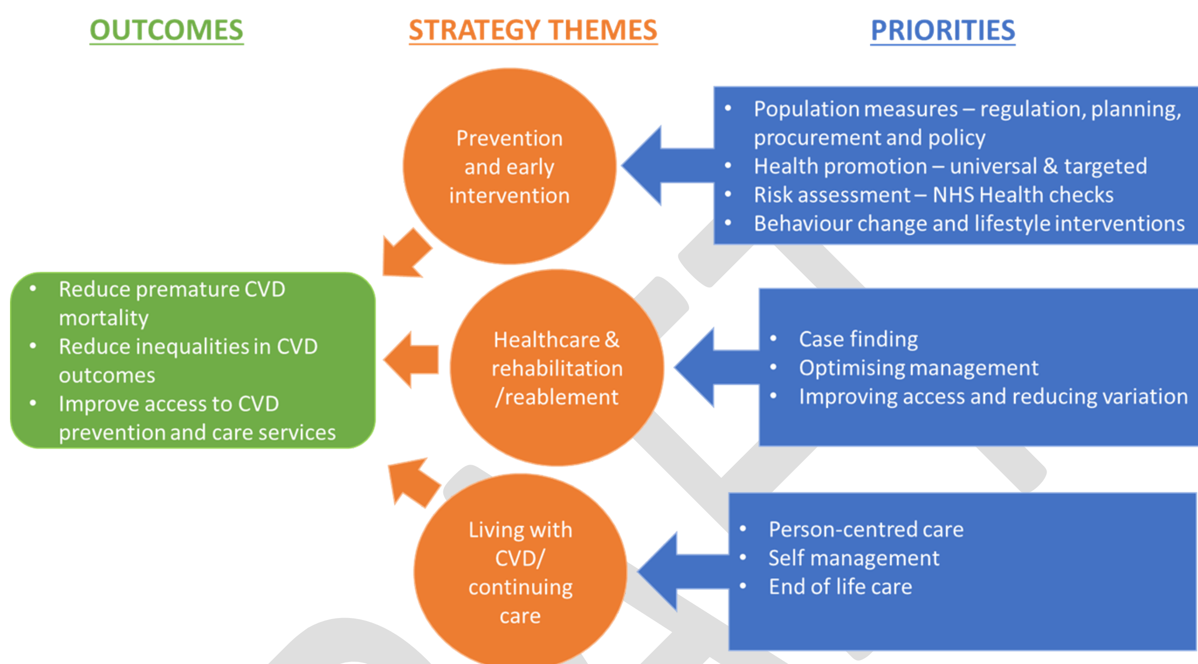
NICE public health guidance on CVD prevention[5] makes recommendations for developing a comprehensive regional and local CVD prevention programme which includes the following good practice principles:

- Ensure a CVD prevention programme comprises intense, multi-component interventions.
- Ensure it includes initiatives aimed at the whole population (such as local policy and regulatory initiatives) which complement existing programmes aimed at individuals at high risk of CVD.
- Ensure it is sustainable for a minimum of 5 years.
- Ensure appropriate time and resources are allocated for all stages, including planning and evaluation.

It is also important that a collaborative approach is taken with strong leadership for CVD prevention. Cardiovascular disease has been made a priority by the Peterborough Health and Wellbeing Board and the JSNA has provided an understanding of the prevalence of CVD and its risk factors in the community.

5. PRIORITIES FOR ACTION

A 'Peterborough CVD Programme Steering Group' of key stakeholders has been established to develop the strategy. The priorities for action have been considered for each of the workstreams and are detailed in this section and summarised in the figure below.



Workstream 1: Prevention and early intervention
Lead organisation: Peterborough City Council
Population measures: reducing population exposure to cardiovascular risk factors to create a healthy Peterborough environment and encouraging residents to make healthy life choices. This will involve regulatory services, planning and public procurement and policy. For example, encouraging healthy diet choices in public buildings by reducing the availability of foods that are high in fat, salt and sugar; regulating access to items that increase CVD risk such as tobacco and developing an environment that promotes physical activity. **Health promotion:** provision of information to inform and educate the public on cardiovascular disease and its risk factors. Health promotion activities should be at a universal level aimed at the whole population and also targeted at specific communities/groups with increased cardiovascular disease risk. The monthly 'Healthy Peterborough' campaign launched in 2016 has included heart disease and stroke as well as risk factors such as physical activity and smoking. Continuation of this campaign will help embed these messages. The South Asian population are at increased risk of cardiovascular disease and it will be important to work with community leaders to develop campaigns targeted at this community. Other areas that can be targeted are workplaces, particularly with routine and manual workers and schools.

Risk assessment: NHS Health Checks are a systematic programme for those aged 40 to 74 to assess a person's risk of heart disease, stroke, diabetes and kidney disease. In Peterborough NHS Health Checks are provided by GPs and work has been focused on improving the quality of health checks and supporting practices to invite those most at risk. In order to improve access to health checks, the procurement of Point of Care testing equipment is being considered to enable health checks to take place in community settings as well as in GP practices. This will enable key results to be communicated to patients immediately. Other groups at increased risk of CVD who are not eligible for a NHS Health Check should also be considered, such as the South Asian population aged 30 to 40, people with suspected familial hypercholesteraemia and people with severe mental illness, including schizophrenia and bipolar disorder.

Behaviour change and lifestyle interventions: There are a number of initiatives already in place in Peterborough, such as smoking cessation clinics, Let's Get Moving, Fit For Live and Morelife Family Clubs, Operation Smokestorm, Healthy Eating and Cooking Sessions as well as events and campaigns. The Public Health Team provide an Integrated Lifestyle service which includes six qualified Health Trainers whose clinics are being embedded within key locations including GP Practices and community settings. Procurement is underway for a new Integrated Lifestyle service, with a new provider starting delivery in April 2017. This will include extended smoking cessation activity as part of a wider Tobacco Control initiative, the Health Trainer programme, physical activity programmes for children, families and adults, outreach Health Checks and weight management interventions across Tier 1,2 and 3. There is a need to ensure that any behaviour change and lifestyle services are effectively coordinated and targeted and provided in culturally appropriate settings. Consideration should also be given to training appropriate Peterborough City Council staff on motivational interviewing so that they can use these skills with people at increased risk of CVD, for example using the Making Every Contact Count approach.

Key partners:

- Peterborough GPs and Practice Staff
- Greater Peterborough Executive Board
- Community Leaders
- Local businesses
- Schools

DRAFT

Workstream 2: Healthcare and Rehabilitation/Reablement

Lead organisation: Greater Peterborough Executive Board

Case finding: There is considerable variation between GP practices in the prevalence of conditions which contribute to cardiovascular disease, such as atrial fibrillation (AF) and hypertension. It is estimated that there are approximately 2,300 patients in Peterborough with AF who are undiagnosed. People with untreated AF have a 5 times higher risk of stroke and strokes caused by AF are often more severe. The Cambridgeshire and Peterborough Health System Prevention Strategy recommends that work on improving the diagnosis of AF and hypertension should initially focus on Peterborough. Case finding tools are available to identify those at high risk of CVD conditions. In addition, including pulse checks in blood pressure checks and as part of flu clinics may help identify new cases of AF. The NHS Health Check also offers an opportunity to diagnose and treat hypertension, including through lifestyle interventions.

Optimising management: There is again variation in terms of the management of CVD conditions across Peterborough. Less than half of people with known AF admitted to hospital with stroke are on anticoagulant treatment at the time of their stroke.[6] There are opportunities for improving the management of AF, hypertension, heart failure and coronary heart disease which should be maximised. Tools are available to be run on GP practice systems to help identify those patients who do not appear to be managed appropriately.

Improving access and reducing variation: Cardiac rehabilitation is a structured set of services that enables people with coronary heart disease (CHD) to have the best possible help (physical, psychological and social) to preserve or resume their optimal functioning in society.[7] Research suggests that achieving 65% uptake of cardiac rehabilitation would result in a 30% reduction in unplanned cardiac readmissions. Improvements should be made along the pathway to improve the numbers of people being referred for cardiac rehabilitation and uptake and completion rates. Through the Cardiology workstream of the Sustainability and Transformation Plan, work has started to review and standardise cardiology pathways across Cambridgeshire and Peterborough. There are currently variations in access to Specialist Heart Failure and AF Nurses across Peterborough.

Key partners:

- Peterborough GPs and Practice staff
- Peterborough and Stamford NHS Hospital Trust
- Peterborough City Council
- Cambridgeshire and Peterborough NHS Foundation Trust

DRAFT

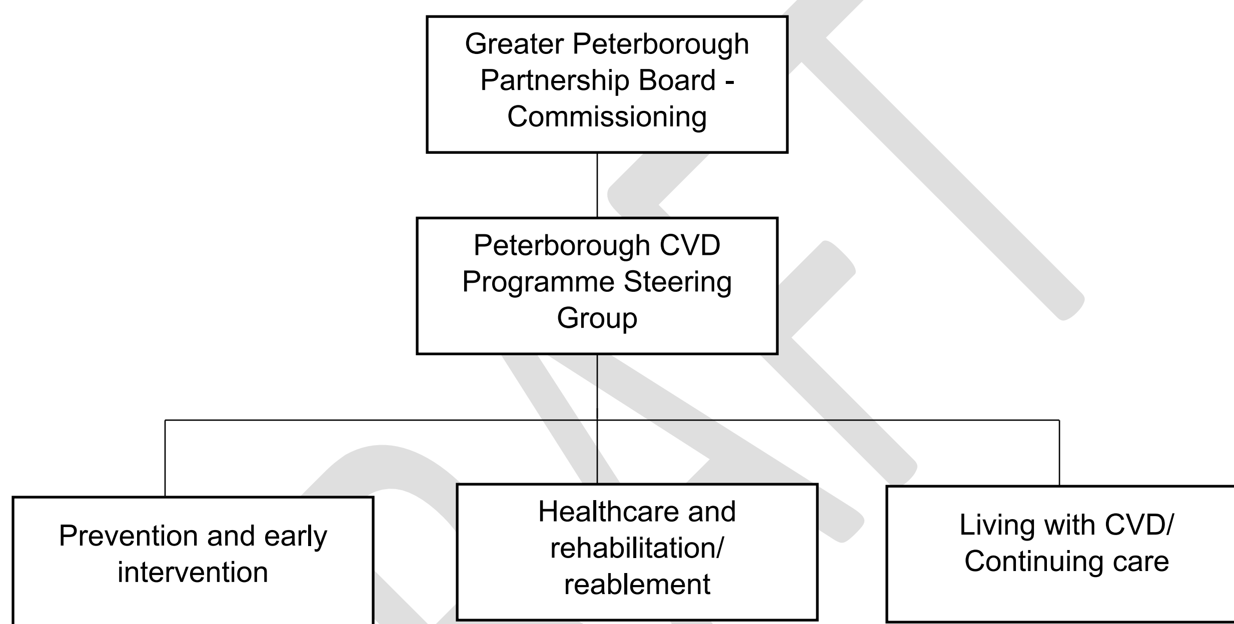
Workstream 3: Living with Cardiovascular Disease/Continuing Care
Lead organisation: Peterborough City Council/Greater Peterborough Executive Board
Person-centred care: People with CVD as with other long term conditions, should have a holistic assessment of their needs for rehabilitation and long-term support which should consider their physical, psychological and social care needs. A written care plan should be produced in partnership with the patient to meet the needs identified, involving carers and families where appropriate. For people living with long term conditions, care should be planned around the individual and their needs rather than separate conditions or where treatment is provided. This will allow for a more co-ordinated, integrated, personalised and person-centred approach which has been shown to improve experience of care. **Self-management:** Engaged, informed individuals and carers is one pillar of the House of Care[8] model to achieve person-centred care. Patients should know how to access the services they need when and where they need them. Electronic systems and tele-medicine solutions make it possible for patients to enter and view test results online and share them with professionals and carers and enable greater communication between patients and health professionals. These systems should be considered to promote independence and encourage self-management. **End of life care:** Many CVD patients receive suboptimal care at the end of life and are not dying in their place of choice.[2] There is a need for timely identification of people who are likely to be in their last year of life and planning their care with them. These care needs should be documented and coordination should take place across primary and secondary care to enable this.
Key partners: • All health and care professionals, patients and carers • Voluntary organisations

DRAFT

6. STRATEGY DELIVERY

In order to deliver the strategy and improve cardiovascular health in Peterborough, working groups have been developed around each strategy workstream. These working groups will develop implementation plans that will be monitored by the Peterborough CVD Programme Steering Group.

The Steering Group will report to the Greater Peterborough Executive Partnership Board – Commissioning and will also produce reports for the Peterborough Health and Wellbeing Board. The reporting arrangements are shown in the figure below.



DRAFT

7. REFERENCES

[1] Services for the prevention of cardiovascular disease: commissioning guide. June 2012. NICE.
[2] Cardiovascular Disease Outcomes Strategy. Department of Health.
[3] Health System Prevention Strategy for Cambridgeshire and Peterborough. December 2015.
[4] Cardiovascular Disease Joint Strategic Needs Assessment. Peterborough City Council.
[5] Cardiovascular Disease Prevention. Public Health Guidance. June 2010. NICE.
[6] CVD Primary Care Intelligence Packs: Stroke
[7] Cardiac rehabilitation services: commissioning guide. November 2013.
[8] The King's Fund (2013). Delivering better services for people with long-term conditions: Building the house of care. London: The King's Fund.

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Peterborough Cardiovascular Disease Programme Steering Group

Terms of Reference

1. Purpose

Cardiovascular Disease (CVD) has been agreed as the top priority focus area by Peterborough Health and Wellbeing Board and a CVD Joint Strategic Needs Assessment (JSNA) was carried out to inform the development of a CVD work plan. Furthermore it was agreed that a CVD Programme Steering Group be established to develop and take forward this plan of work. The overall aim of this work is to improve the cardiovascular health of all Peterborough residents whilst addressing the issues of inequality in risk, access and outcomes.

2. Objectives

The specific objectives of the CVD Programme Steering Group are:

- To lead the development of a strategy to improve the CVD outcomes of Peterborough residents and contribute to reduced inequalities in health.
- To direct the development of and monitor plans for the prevention, treatment and care of people with CVD across Peterborough
- To take an evidence based approach to develop the CVD programme, considering the findings of the Peterborough CVD JSNA and relevant national guidance
- To work in partnership with health, social care, voluntary organisations and local people to deliver improved CVD outcomes
- To consider CVD from across the lifecourse, for individuals and populations at different levels of prevention.

3. Membership

Membership includes representatives from the following organisations and individuals:

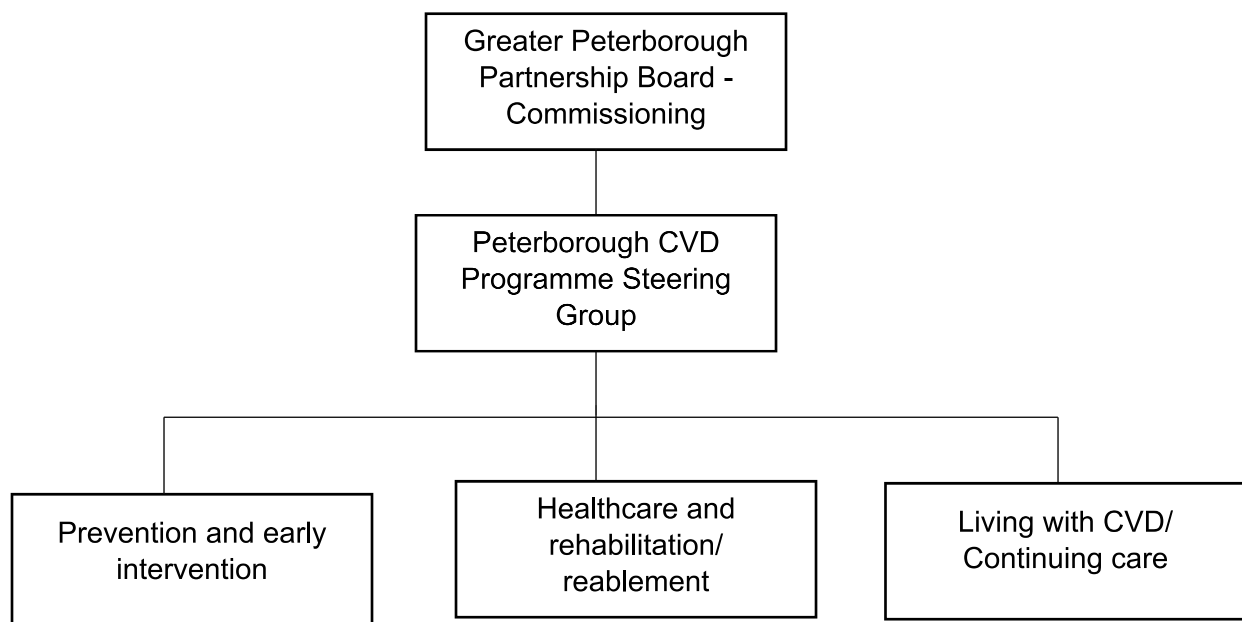
Peterborough City Council Public Health
Peterborough City Council Social Care
Greater Peterborough LCG
Cambridgeshire and Peterborough Clinical Commissioning Group
Peterborough and Stamford NHS Hospital Foundation Trust
Cambridgeshire and Peterborough NHS Foundation Trust
Primary Care CVD Lead
Lead Nurse NHS Health Checks
Patient representative
British Heart Foundation representative

The Steering Group will be chaired by Peterborough City Council Public Health.

4. Delivery and Accountability

Working groups/Task and finish groups will be established under the strategic themes of prevention and early intervention, healthcare and rehabilitation/reablement and living with CVD/continuing care to develop implementation plans for the strategy and project plans as appropriate. In developing these plans, these groups should pay attention to the Steering Group objectives. These groups may meet virtually and may include different members as appropriate, with an appropriate named lead who will report to the Steering Group on progress and delivery.

The CVD Programme Steering Group will report to the Greater Peterborough Executive Partnership Board – Commissioning. The reporting mechanisms are illustrated in the figure below.



5. Interdependencies

It is important this this steering group links with other work relating to cardiovascular disease that is taking place across Cambridgeshire and Peterborough. In particular the CVD working group of the Proactive care and prevention workstream and the Elective cardiology workstream of the Cambridgeshire and Peterborough Sustainability and Transformation Plan.

6. Meeting Arrangements

Quorum - Four representatives including the Chair and working group leads (or nominated deputy). In the event of a meeting not being quorate, items requiring decision may be actioned by written procedures.

Frequency - The Group shall meet on a quarterly basis and meetings will be timetabled for 2 hours.

Papers for the Board will be issued by email one week in advance of the meeting. Any papers relating to urgent business may be considered at the meeting subject to the Chair's

discretion. The Chair may add an item to the agenda less than one week before the meeting on request from a member of the Group. The Chair may also deal with appropriate business through written communication with the Group.

Minutes of each meeting will be circulated by email within 10 working days.

7. Review dates

The Terms of Reference will be reviewed at least annually or in line with any changes to the organisations or work programmes concerned.

August 2016

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5
22 SEPTEMBER 2016		PUBLIC REPORT
Contact Officer(s):	Liz Robin, Director of Public Health Katharine Hartley, Consultant in Public Health	Tel. 01733 207176

DIVERSE ETHNIC COMMUNITIES JOINT STRATEGIC NEEDS ASSESSMENT FOR PETERBOROUGH

R E C O M M E N D A T I O N S	
FROM : Director of Public Health	**Deadline date : N/A**
That the Health and Wellbeing Board to approve the Diverse Ethnic Communities Joint Strategic Needs Assessment.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board as part of the Joint Strategic Needs Assessment (JSNA) forward programme, developed by the Health and Wellbeing Board in 2014

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to enable the committee to review the findings and consider the recommendations in the Diverse Ethnic Communities JSNA.

3. KEY ISSUES

Background

3.1 It is important that Local Authorities understand the composition and needs of their local population, in order to be able to plan and deliver services effectively, as well as being able to respond to any issues relating to community cohesion or address health inequalities. This JSNA provides a framework for identifying and understanding the needs of diverse ethnic communities in Peterborough to help fulfil these obligations. Peterborough is a City with a growing economy which celebrates the diversity of its residents, and this JSNA will support public services to ensure effective delivery in this context.

Purpose

3.2 This JSNA provides detail on the determinants that affect the health of ethnic groups with the greatest representation in Peterborough.

Contents

3.3 Demographic information about the different ethnic communities in Peterborough and the patterns of migration of people born outside the UK, are provided in Chapter 3 of this JSNA. Chapter 4 includes data about the ethnic diversity of children in Peterborough and their educational attainment. Chapter 5 reviews health and healthcare needs. Data for Peterborough is often compared to other areas across Cambridgeshire or within the Eastern region or to England. Comparisons in this manner aim to highlight differences and therefore help to identify need that will help commissioners allocate resources

3.4 It's also important to understand the views and experiences of diverse communities, and of wider stakeholders which provide services, through methods such as local survey work, focus groups or stakeholder workshops. This has been piloted with communities of Eastern European residents and the results are included in Appendix A of this JSNA. Additional information about housing and employment of Eastern European migrants to Peterborough is also included in Appendix A. Similar work is recommended with other ethnic communities, to provide further Appendices for this JSNA going forward.

4. CONSULTATION

4.1 The pilot work on Appendix A was informed by stakeholder events and workshops in October 2015 and June 2016. These increased awareness of the JSNA and identified priorities and issues that stakeholders would like to see explored. It is recommended that similar work with stakeholders from other diverse ethnic communities in Peterborough should take place to inform further Appendices to the JSNA.

4.2 It is also proposed that consultation with communities and stakeholders should continue when implementing the recommendations of the JSNA and any resulting service developments should be co-produced.

5. ANTICIPATED OUTCOMES

5.1 To agree the next steps to ensure the findings and recommendations within the JSNA are taken forward

6. RECOMMENDATIONS

6.1 The Health and Wellbeing Board is asked to approve the Diverse Ethnic Communities JSNA and endorse the following recommendations:

a) The Cambridgeshire and Peterborough Clinical Commissioning Group, NHS England East, and local NHS providers should use the information in this JSNA when planning and delivering services. This will support the NHS duties to consider the needs of equalities groups and to reduce health inequalities.
b) Healthcare Providers should review the quality and completeness of their recording of ethnicity in order to ensure that information is available on service use in relation to needs.
c) Peterborough City Council should also use the information from the JSNA where relevant when planning and delivering services.
d) Further work to engage with a range of minority ethnic communities in Peterborough should take place, similar to the engagement work with Eastern European communities, and this should report back to the HWB Board.
e) Endorse the recommendations outlined in Appendix A relating to Eastern European communities in Peterborough

7. REASONS FOR RECOMMENDATIONS

7.1 The recommendations are made in response to the findings of the needs assessment for diverse ethnic communities.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The alternative option is to maintain the status quo

9. IMPLICATIONS

9.1 Implementation of the JSNA recommendations, which the HWB Board have been asked to endorse, would lead to a requirement for further development work. This would need to be prioritised within existing budgets and staff resources.

10. BACKGROUND DOCUMENTS

10.1 Diverse Ethnic Communities Joint Strategic Needs Assessment for Peterborough, 2016

11. APPENDICES

11.1 Appendix 1 - Diverse Ethnic Communities JSNA

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Diverse Ethnic Communities Joint Strategic Needs Assessment for Peterborough, 2016

Contents

Section Number	Section	Page Number
1	Contributors, Acknowledgement & Abbreviations	2
2	Introduction	5
3	Demography	6
4	Children & Education	18
5	Health	24
6	Recommendations	48
APPENDIX A	Pilot work: Eastern European migrant population	49
7.1	Introduction and overview	49
7.2	Children & Education	56
7.3	Employment	60
7.4	Housing	64
7.5	Specific Recommendations	68
Annex 1	Results of Community Health Survey	69
APPENDIX B	Peterborough City Council Electoral Ward Boundaries 2003-2016	71

1. Contributors, Acknowledgements & Abbreviations

1.1 Contributors

This Joint Strategic Needs Assessment has been developed and written by a working group in partnership with a range of local stakeholders across health and social care in Peterborough & Cambridgeshire. Working group members are listed below:

Name	Role
Dr Kathy Hartley	Consultant in Public Health Medicine, Peterborough City Council
Dr Fay Haffenden	Consultant in Public Health Medicine, Cambridgeshire County Council
David Lea	Assistant Director of Public Health Intelligence, Cambridgeshire County Council
Ryan O'Neill	Advanced Public Health Analyst, Peterborough City Council
Elizabeth Wakefield	Public Health Analyst, Cambridgeshire County Council & Peterborough City Council
Wendy Quarry	JSNA Programme Manager, Cambridgeshire County Council
Sue Hall	Senior Public Health Administrator, Cambridgeshire County Council
Shakeela Abid	Live Healthy Practitioner Specialist
Adrian McLean-Tooke	Senior Information Analyst, Cambridgeshire & Peterborough Clinical Commissioning Group

1.2 Acknowledgements

We are grateful for the full range of contributions from our local stakeholders. Organisations which have contributed to the JSNA include Peterborough City Council, Cambridgeshire County Council, Circle Housing Group, Cambridgeshire & Peterborough Clinical Commissioning Group, Fenland District Council, Public Health England, Cambridge Council for Voluntary Services, Rosmini Centre, Cambridgeshire Human rights and Equality Support Services, Gladstone Connect, Peterborough iCash, Healthwatch Cambridgeshire & Peterborough, and Cambridgeshire Constabulary.

1.3 Glossary of Abbreviations

A8 - The 8 member states that acceded to become part of the European Union on 01/05/2004 – Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia

A&E – Accident and Emergency

AIDS – acquired immune deficiency syndrome

ASB – anti-social behaviour

C&P – Cambridgeshire and Peterborough

CCG – Clinical Commissioning Group

CD4 count – A measure of the number of helper T cells per cubic millimeter of blood, used to analyze the prognosis of patients with HIV.

CHESS – Cambridgeshire Human rights and Equality Support Services

DAC – Dental Access Centre

DALYs – disability adjusted life years

DSR – Directly age-standardised rates

EU – European Union

FDC – Fenland District Council

GCSE – General Certificate of Secondary Education

GP – General Practitioner

GLA – Gangmaster Licensing Authority

HIV – human immune-deficiency virus

HMO – houses of multiple occupation

IAG - Information Advice & Guidance

iCaSH - integrated Contraception & Sexual Health

ICT – Information and communications technology

JSNA – Joint Strategic Needs Assessment

PHEC – Public Health England Centre

PHOF – Public Health Outcomes Framework

LCG – Local Commissioning Group

L4+ - Level 4 and above

LA – Local Authority

NICE – National Institute of Clinical Excellence

NINo – National Insurance Number

NHS – National Health Service

ONS – Office for National Statistics

TA – teacher assessment

TB – Tuberculosis

UASC – Unaccompanied Asylum-Seeking Child

VPRS – Vulnerable Persons Resettlement Scheme

WHO – World Health Organisation

2. Introduction

It is important that Local Authorities understand the composition and needs of their local population, in order to be able to plan and deliver services effectively, as well as being able to respond to any issues relating to community cohesion or address health inequalities. This JSNA provides a framework for identifying and understanding the needs of diverse ethnic communities in Peterborough to help fulfil these obligations. Peterborough is a City with a growing economy which celebrates the diversity of its residents, and this JSNA will support public services to ensure effective delivery in this context.

The demography, education and health sections of this JSNA use local and national quantitative (numerical) data, together with national research, to provide information on the likely health and wellbeing needs of a range of ethnic communities in Peterborough. The data available comes in two main categories. The first category is data related to people's self-reported ethnic group – for example from the national 2011 Census. The second category is data related to people's country of birth - for example National Insurance or GP registrations.

It's also important to understand the views and experiences of diverse communities, and of wider stakeholders which provide services, through methods such as local survey work, focus groups or stakeholder workshops. This has been piloted with communities of Eastern European origin and the results are included in Appendix A of this JSNA. Similar work will be carried out with other ethnic communities, to provide further Appendices for this JSNA going forward.

Demographic information about the different ethnic groups in Peterborough and about patterns of migration of people born outside the UK, are provided in Chapter 3 of this JSNA. Chapter 4 includes data about the ethnic diversity of children in Peterborough and their educational attainment. Chapter 5 reviews the health and healthcare needs of diverse ethnic communities. Data for Peterborough is often compared to other areas across Cambridgeshire or within the Eastern region or to England. Comparisons in this manner aim to highlight differences and therefore help to identify need that will help commissioners allocate resources.

3. Demography

Key Findings:

- At the time of the 2011 Census, 71% of the Peterborough population was classified as of 'white British' ethnicity. Of the remainder, 'Asian or Asian British' and 'white other' populations formed the largest communities at 12% and 11% respectively. Within the Asian communities, Asian Pakistani or British Pakistani made up the largest community at 7% of the total Peterborough population.
- The total black and minority ethnic (BME) population varied between Peterborough electoral wards from 2.3% to 58.2% of the ward population
- The overall population of Peterborough increased by 17.7% between 2001 and 2011. Within this population, the greatest increases in ethnic categories were seen in the 'white other' group and the Black British or Black African category. There was a slight decrease in the number of people recording their ethnicity as 'white British'.
- Non-UK born residents in the East of England were primarily adults of working age, with 43% aged 20-39 and 71% aged 20-59. In Peterborough 64% of non-UK born residents had one or more dependent children.
- In 2011, 4.86% of the population of Peterborough could not speak English or could not speak English well.
- Between Censuses, other sources of information are used by the Office of National Statistics to estimate changes in non-UK born populations. Within Cambridgeshire and Peterborough, ONS estimates for 2014 indicated that non-UK born populations were highest in Cambridge City and in Peterborough, at 307.1/1,000 residents and 206.3/1,000 residents respectively.
- Over the five years from 2009 to 2014, estimates of net international migration into Peterborough were highest in 2009/10, and lowest in 2011/12. In 2013/14, Cambridge City and Peterborough showed the highest local rates of net international migration at 16.3 and 9.7 (per 1,000) respectivly compared to 4.5 for England and 3.6 for the East of England.
- Information from school and GP registrations can also help to build the picture of demographic changes in Peterborough between Censuses, and these are described in the sections on Education and Health.

The diverse ethnic population of Peterborough

- The census data records information about people by how they describe their ethnicity, based on a choice of various ethnic groupings. This information does not necessarily reflect whether a person is born in the UK or not and therefore whether they are a migrant or not, it simply describes or assigns an ethnic origin to the person. Details of ethnicity within a population are useful to determine the proportion and number of ethnic minority groups. Comparisons between populations on the ethnic mix provides useful information to commissioners on where best to direct resources in order to address any need identified for particular ethnic communities. For the purpose of this JSNA, the census data is useful to identify black, Asian and minority ethnic (BME)and diverse communities within Peterborough and to assess how these populations are changing over recent time periods.

However, caution must be taken to account for the fact that Census data is only recorded every ten years and therefore may not represent a rapidly changing population several years after the last Census was recorded.

The figure below gives a breakdown of the population of Peterborough in terms of overall numbers of people and percentage of the total population, by ethnic origin, as described in the 2011 census.

Figure 1 – 2011 Census data for Peterborough Local Authority area showing population by ethnic categories

Peterbrough - all wards	All categories: Ethnic group	White	White: English/ Welsh/Scottish/Northern Irish/British	White: Irish	White: Any other ethnic group	Mixed/ multiple ethnic group	Asian or Asian British	Asian/Asian British: Indian or British Indian	Asian/Asian British: Pakistani or British Pakistani	Asian/Asian British: Chinese	Black/African/Caribbean/Black British	Black/African/Caribbean/ Black British: African	Black/African/Caribbean/Black British: Caribbean	Other ethnic group: any other ethnic group
Total Number	183631	151544	130232	1257	20055	4948	21492	4636	12078	872	4164	2480	1174	1483
Total %	100%	83%	71%	1%	11%	3%	12%	3%	7%	0%	2%	1%	1%	1%

It is clear that outside the white British population, 'Asian or Asian British' and 'white other' populations form the largest communities (12% and 11% respectively). Within the Asian community, Asian Pakistani or British Pakistani make up the largest community at 7% of the total population.

Population trends of ethnic communities in Peterborough

It is important to determine how populations change over time in order to understand where resources are required and may be needed in the future. By comparing Census data between 2001 and 2011, it is possible to show the ethnic categories within the population that are increasing most rapidly as well as those that may be decreasing (figure 2 below).

Figure 2 – Change in ethnic populations between the 2001 and 2011 Censuses

	All People	White - British	White - Other	Mixed multiple ethnic group	Asian or Asian British – Indian	Asian or Asian British - Pakistani	Black or Black British - Black Caribbean	Black or Black British - Black African	Chinese or other ethnic group - Chinese
2001	156,057	133,751	4,553	2,293	2,878	6,980	1,116	551	531
2011	183,631	130,232	20,055	4,948	4,636	12,078	1,174	2,480	872
% increase 2001-2011	17.7%	-2.6%	340%	115%	61%	73%	5.2%	350%	64.2%

The overall population of Peterborough increased by 17.7% between 2001 and 2011. Within this population, the greatest increases in ethnic categories were seen in the 'white other'

group and the Black British or Black African category (340% and 350% increases, respectively). There was a slight (2.6%) decrease in the 'white British' population.

BME population by Electoral ward in Peterborough (2011 Census data)

Black and minority ethnic (BME) populations usually describe all non-white categories of people in a given population.

The figure below shows how the total BME population varies between Peterborough wards from 58.2% of the population of Central ward to 2.3% of the population of Northborough ward.

Figure 3 – Proportion of the total population assigned to BME groups by electoral ward in Peterborough (2011) and deprivation score for each ward (2015)

Electoral Ward	BME Population (%, 2011)	IMD 2015 (Score, Higher Value = Greater deprivation)
Central	58.2	45.8
Park	35.8	26.0
Ravensthorpe	30.8	42.2
West	29.5	15.3
East	26.8	37.6
North	23.0	42.4
Dogsthorpe	18.4	40.7
Peterborough UA	17.5	27.7
Bretton South	14.8	27.7
Orton with Hampton	14.0	14.5
Bretton North	12.4	39.0
Fletton and Woodston	11.5	23.5
Orton Longueville	10.1	40.5
Paston	9.6	36.9
Stanground East	8.3	25.4
Walton	8.2	25.9
Werrington North	7.4	17.4
Orton Waterville	7.2	17.9
Stanground Central	6.9	24.0
Eye and Thorney	5.0	20.8
Werrington South	4.9	10.6
Newborough	4.7	17.2
Glinton and Wittering	2.8	10.1
Barnack	2.7	9.8
Northborough	2.3	10.1

Light blue indicates higher proportion of BME population than Peterborough average and dark blue indicates below Peterborough average. In general, wards with higher amounts of deprivation as measured by the IMD score have higher proportions of BME populations, although the correlation isn't strict and there are exceptions, for example West electoral ward, with 29.5% BME population and fifth lowest deprivation score.

Population defined by ethnicity in all electoral ward in Peterborough, 2011

The figure below shows the proportion of the population of each (pre-2016) electoral ward in peterborough in each ethnicity group. The data is ranked according to the proportion of the population described with Asian ethnicity. The first eight wards listed lie adjacent to each other, geographically and are in the city area of Peterborough. In contrast, the wards with the highest proportion of 'white British' residents are in wards located outside of Peterborough city – in more rural localities (see Appendix B for map of wards).

Figure 4 – proportion of the population of each electoral ward as defined by ethnicity groups in the 2011 census

Electoral Ward	All categories: Ethnic group	White	White: English/Welsh/Scottish/Northern Irish/British	White: Irish	White: Any other ethnic group	Mixed/multiple ethnic group	Asian or Asian British	Asian/Asian British: Indian or British Indian	Asian/Asian British: Pakistani or British Pakistani	Asian/Asian British: Chinese	Black/African/Caribbean/Black British	Black/African/Caribbean/Black British: African	Black/African/Caribbean/Black British: Caribbean	Other ethnic group: any other ethnic group
Central	100%	42%	17%	0%	24%	4%	49%	3%	39%	1%	3%	2%	0%	2%
Park	100%	64%	41%	1%	22%	3%	30%	3%	23%	1%	2%	1%	1%	1%
Ravensthorpe	100%	69%	55%	1%	14%	3%	22%	5%	10%	0%	4%	2%	1%	1%
West	100%	71%	62%	1%	7%	2%	25%	7%	14%	1%	2%	1%	0%	1%
East	100%	73%	52%	1%	20%	3%	19%	5%	9%	1%	3%	2%	1%	1%
North	100%	77%	57%	1%	19%	3%	16%	2%	11%	0%	2%	1%	1%	1%
Dogsthorpe	100%	82%	68%	1%	13%	4%	10%	3%	5%	0%	2%	1%	1%	2%
Bretton South	100%	85%	77%	1%	8%	3%	7%	4%	1%	0%	4%	3%	1%	1%
Orton with Hampton	100%	86%	77%	1%	9%	4%	6%	3%	2%	1%	3%	2%	1%	1%
Bretton North	100%	88%	76%	1%	10%	3%	6%	3%	2%	0%	3%	2%	1%	0%
Fletton and Woodston	100%	89%	74%	1%	14%	2%	5%	2%	1%	1%	3%	2%	1%	1%
Orton Longueville	100%	90%	80%	1%	9%	3%	3%	1%	1%	0%	3%	3%	1%	0%
Paston	100%	90%	81%	1%	8%	3%	4%	1%	0%	1%	3%	1%	1%	1%
Stanground East	100%	92%	85%	1%	6%	2%	4%	1%	1%	0%	2%	1%	0%	0%
Walton	100%	92%	85%	1%	6%	2%	4%	2%	1%	0%	2%	1%	1%	0%
Werrington North	100%	93%	88%	1%	5%	2%	3%	2%	1%	1%	2%	1%	1%	0%
Orton Waterville	100%	93%	86%	1%	5%	2%	3%	2%	0%	1%	2%	1%	1%	0%
Stanground Central	100%	93%	82%	1%	10%	2%	3%	2%	1%	0%	2%	1%	0%	0%
Eye and Thorney	100%	95%	92%	0%	2%	2%	2%	1%	0%	0%	1%	0%	0%	0%
Werrington South	100%	95%	92%	1%	3%	1%	2%	1%	1%	0%	1%	0%	0%	0%
Newborough	100%	95%	92%	0%	3%	2%	2%	1%	0%	0%	1%	1%	0%	1%
Glinton and Wittering	100%	97%	94%	1%	2%	1%	1%	0%	0%	0%	1%	0%	0%	0%
Barnack	100%	97%	95%	0%	2%	1%	1%	1%	0%	0%	0%	0%	0%	0%
Northborough	100%	98%	96%	0%	1%	1%	1%	1%	0%	0%	0%	0%	0%	0%
Total Number	100%	83%	71%	1%	11%	3%	12%	3%	7%	0%	2%	1%	1%	1%
Total %	100%	83%	71%	1%	11%	3%	12%	3%	7%	0%	2%	1%	1%	1%

Central ward has the highest proportion of Asian Pakistani/British Pakistani residents (39%), followed by Park and West wards, whereas West ward has the highest proportion of Asian Indian/British Indian residents (7%). The location of residents with Black African/Black British African or Black Caribbean/Black British Caribbean ethnicities shows a slightly different patterns to those residents with Asian ethnicies with more spread through the Peterborough City wards below. However, wards located in more rural locations still see an under-representation of these ethnic groups in the population.

<u>The 'White Any Other' population</u>

The 'white any other' ethnic group has been further broken down in this JSNA, into Eastern European and non-Eastern European, as Eastern European migration has been a particular feature of recent years. As shown in the table below, overall, 5.95% of the population of Peterborough in 2011 had an Eastern European ethnicity, with a range for all Peterborough wards of between 0% and 15.1%. . Central, Park, and East wards have the highest population of Eastern Europeans – 15.1%, 13.5% and 12.4% respectively. 4.97% of the Peterborough

population described themselves as of 'white other' ethnicity but were not from Eastern Europe.
Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

Figure 5: 2011 Census data for Peterborough wards ranked according to the proportion of White Eastern European population

Ethnic Group	White Eastern European	White any other ethnicity (not Eastern European)	Rank
Central	15.1%	8.9%	1
Park	13.5%	8.6%	2
East	12.4%	7.9%	3
North	10.9%	7.8%	4
Ravensthorpe	7.9%	5.8%	5
Dogsthorpe	7.4%	5.5%	6
Fletton and Woodston	6.5%	7.1%	7
Bretton North	5.2%	5.1%	8
Orton Longueville	5.1%	4.3%	9
Paston	4.4%	3.8%	10
Stanground Central	4.3%	5.8%	11
Orton with Hampton	4.3%	4.5%	12
Bretton South	3.7%	4.1%	13
West	3.7%	3.8%	14
Stanground East	3.3%	3.1%	15
Walton	3.2%	3.2%	16
Orton Waterville	2.4%	2.9%	17
Werrington North	2.2%	2.3%	18
Newborough	0.9%	1.9%	19
Werrington South	0.8%	1.8%	20
Eye and Thorney	0.7%	1.7%	21
Glinton and Wittering	0.4%	1.9%	22
Barnack	0.3%	1.7%	23
Northborough	0.0%	1.4%	24
Total %	5.95%	4.97%	

Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

Note: Categorisations of ethnicity are as follows:

Eastern European: Albanian, Baltic States (Estonia, Latvia & Lithuania), Bosnian, Russian, Croatian, Kosovan, Other Eastern European, Polish, Serbian

White any other: Afghan, Anglo Indian, Argentinian, Australian/New Zealander, Brazilian, British Asian, Burmese, Chilean, Colombian, Cuban, Cypriot, Ecuadorian, European Mixed, Filipino, Greek, Greek Cypriot, Iranian, Israeli, Italian, Japanese, Kashmiri, Kurdish, Latin/South/Central American, Malaysian, Mexican, Moroccan, Multi-ethnic islands, Nepalese, Nigerian, North

African, North American, Other Middle East, Other Western European, Peruvian, Polynesia/Micronesia/Melanesia, Somali, Somalilander, Tamil, Thai, Turkish, Turkish Cypriot, Venezuelan, Vietnamese, White African, White Caribbean, White any other ethnic group

English language skills

Peterborough has the second highest proportion of the population who cannot speak English or cannot speak English well of local authorities in the East of England (4.86% of the population). This data includes people of all nationalities and therefore does not specifically express the need for English language acquisition in any particular ethnic or diverse community.

Figure 6: % of people who cannot speak English/speak it well, 2011 Census

English Language skills: % of people who cannot speak English / speak it well — 2011 — Proportion - %

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Area	Value	Lower CI	Upper CI
England	1.65	1.65	1.66
East of England region	1.12	1.11	1.12
Luton	5.42	5.32	5.52
Peterborough	4.86	4.76	4.97
Bedford	3.11	3.03	3.20
Thurrock	1.14	1.09	1.20
Cambridgeshire	1.07	1.05	1.10
Southend-on-Sea	0.97	0.93	1.02
Hertfordshire	0.93	0.91	0.95
Norfolk	0.86	0.84	0.88
Suffolk	0.71	0.69	0.73
Central Bedfordshire	0.51	0.49	0.54
Essex	0.45	0.43	0.46

Source: Census (ONS)

Source: 2011 Census

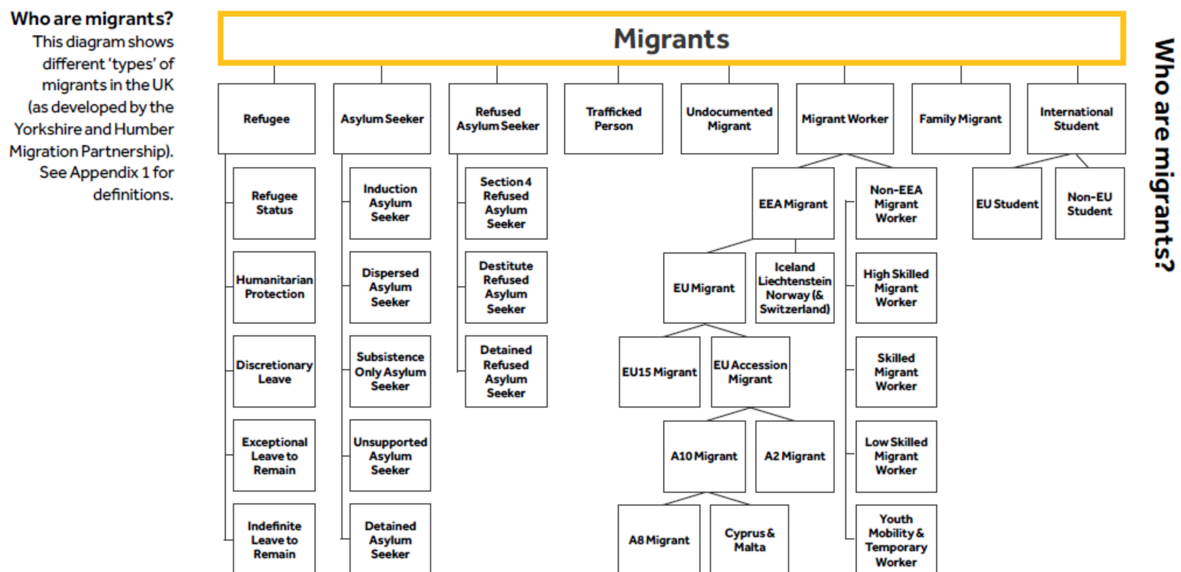
Non-UK born residents and migration

A long-term international migrant is defined as 'a person who moves to a country other than that of his or her usual residence for a period of at least 12 months, so that the country of destination effectively becomes his or her new country of usual residence. From the perspective of the country of departure, the person will be a long-term emigrant and from that of the country of arrival, the person will be a long-term immigrant[1].'

For the purposes of this JSNA, the term 'migrant' is used to describe a person who has moved to the UK who at the time of entry to the UK is not a British national. Migrants are not a homogeneous group, coming from all over the world and with different socio-economic backgrounds. Migrants can be grouped according to the primary reason why they have moved to the UK as shown in the diagram on the next page.

[1] http://www.ons.gov.uk/ons/guide-method/method-quality/specific/population-and-migration/population-projections/faq---population-projections/migration/index.html?format=print#1

Figure 7: Different categories of migrants based on the reason why they have moved to the UK



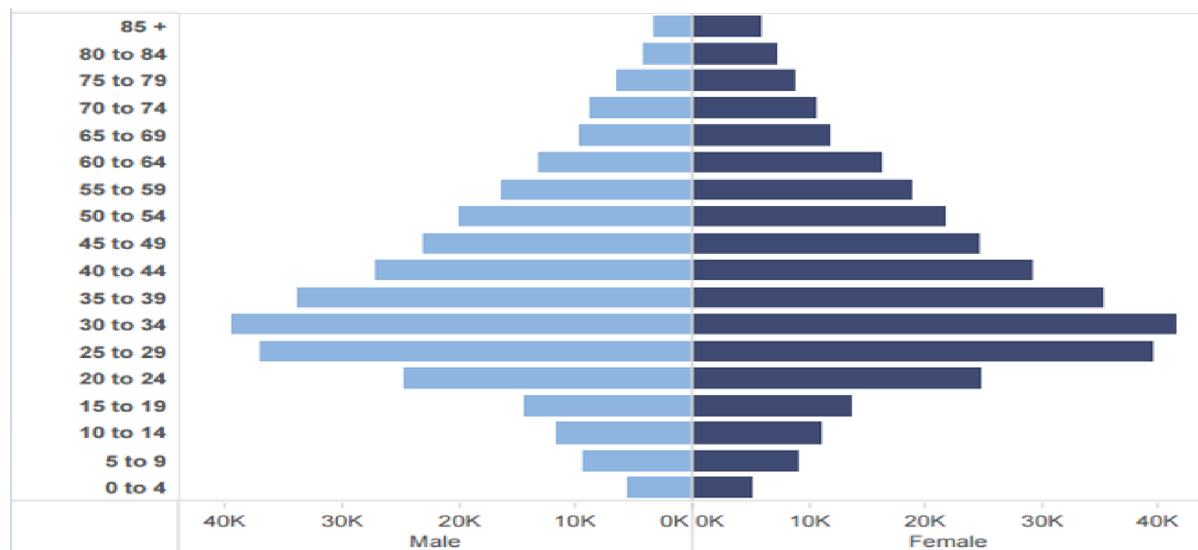
Source: Rose, N., Stirling, S., Ricketts, A., & Chappel, D. (2011). Including Migrant Populations in Joint Strategic Needs Assessment. A Guide.

In terms of data, Migrants can be defined in different ways: by place of birth (i.e. foreign-born), nationality (i.e. foreign citizens), and length of stay in the UK.

Characteristics of non-UK born residents in the East of England – age and sex

The figure below shows the age and sex distribution of people who are resident in the East of England but were not born in the UK.

Figure 8: East of England Migration Patterns, Non-UK born by age and sex, Population Pyramid 2011



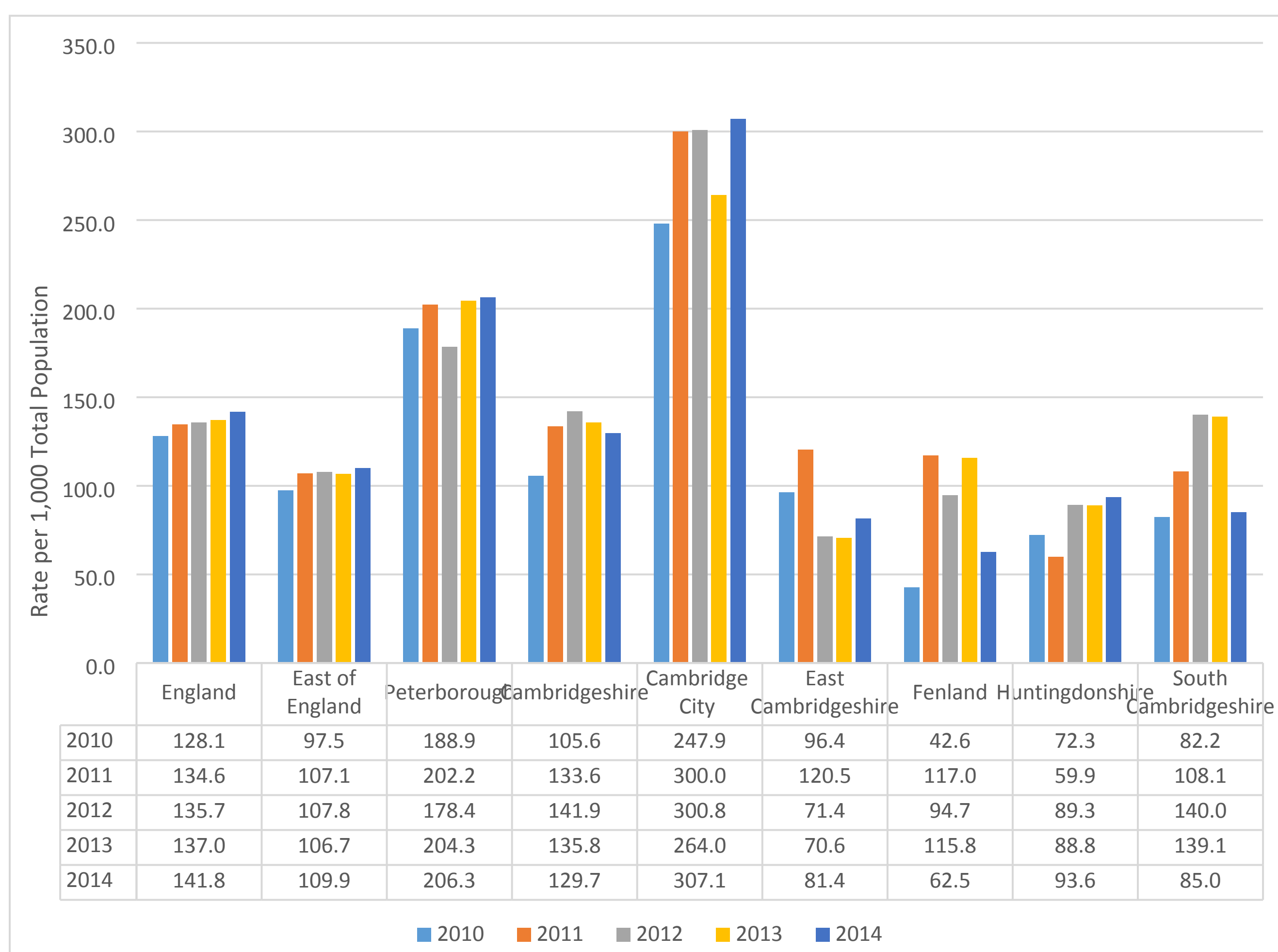
Source: Oxford Migration Observatory, 2015, http://www.migrationobservatory.ox.ac.uk/data-and-resources/maps/census-map-non-uk-born-population-increase-2001-v-2011-england-and-wales

48% of non-UK born residents in the East of England are males and 52% female. Non-UK born numbers are highest among adults of working age, with 43% aged 20-39 and 71% aged 20-59 years of age. The most common age groups for the non-UK born population of the East of England were 25-29 and 30-34, accounting for 12% and 13% of the non-UK born population respectively. In contrast, the general population of the Eastern region shows a more even spread of age categories up to the age of fifty, with the most common age group for people aged 45-50 (data not shown).

The non-UK born population across Peterborough and Cambridgeshire

The proportion of the population which is non-UK born is estimated for Peterborough and each Cambridgeshire district and compared with England and the East of England in the figure below for years 2010 -2014

Figure 9: Estimated rate of non-UK born population, crude rate per 1,000 total population, 2010-2014



	England	East of England	Peterborough	Cambridgeshire	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
2010	128.1	97.5	188.9	105.6	247.9	96.4	42.6	72.3	82.2
2011	134.6	107.1	202.2	133.6	300.0	120.5	117.0	59.9	108.1
2012	135.7	107.8	178.4	141.9	300.8	71.4	94.7	89.3	140.0
2013	137.0	106.7	204.3	135.8	264.0	70.6	115.8	88.8	139.1
2014	141.8	109.9	206.3	129.7	307.1	81.4	62.5	93.6	85.0

Source: Office for National Statistics, 2014, http://www.ons.gov.uk/ons/rel/migration1/migration-indicators-suite/2014/index.html

The proportion of non-UK born people in the population is higher in Peterborough and Cambridge City than those observed nationally.

Trends in non-UK born migration across Cambridgeshire

Data comparing the UK census results between 2001 and 2011 provides information on the rate of change of non-UK born residents over this period. This information is presented in the figure below for Peterborough and Cambridgeshire districts.

Figure 10: East of England Migration Patterns – Non-UK Born Population, 2001-2011

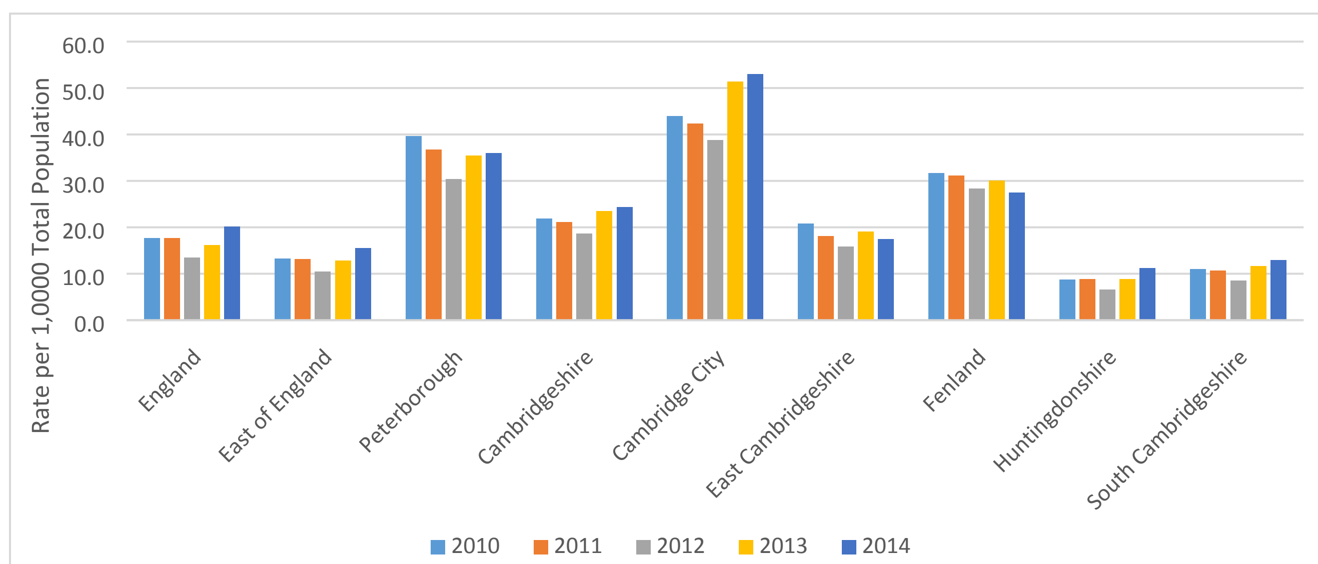
Area	2001 Non-UK Born Population	2011 Non-UK Born Population	Numerical Increase
Fenland	2,641	8,209	5,568
Peterborough	15,268	37,892	22,624
South Cambridgeshire	9,333	16,564	7,231
Cambridge City	20,851	36,381	15,530
East Cambridgeshire	4,973	8,242	3,269
Huntingdonshire	10,822	16,302	5,480

Source: Oxford Migration Observatory, 2015, http://www.migrationobservatory.ox.ac.uk/data-and-resources/maps/census-map-non-uk-born-population-increase-2001-v-2011-england-and-wales

New migration to Peterborough and Cambridgeshire districts

New or recent migration to an area for employment by non-UK born residents can be crudely assessed by data showing new national insurance registrations. For Peterborough and districts in Cambridgeshire, these data are presented in the figure below as a rate of the total population for years 2010 – 2014.

Figure 11: Non-UK born National Insurance Registrations, Crude Rate Per 1,000 Total Population, 2010 – 2014



Source: Office for National Statistics, 2014, http://www.ons.gov.uk/ons/rel/migration1/migration-indicators-suite/2014/index.html

Cambridge City and Peterborough have the highest rates of NINO registrations by migrants.

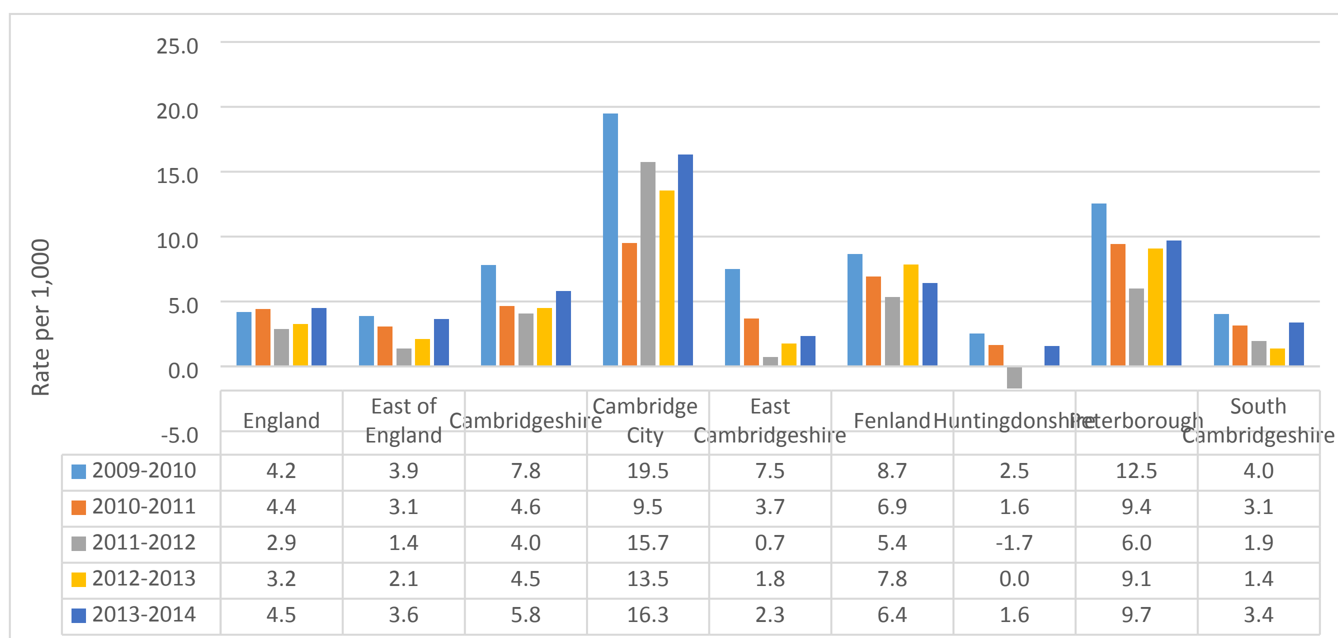
In terms of overall numbers, Peterborough recorded 4,360 NINO registrations in 2014.

Net migration – the difference between emigration and immigration rates across Peterborough and Cambridgeshire

With regards to migration, 'inflow' refers to immigration, 'outflow' refers to emigration and the difference between the two (e.g. the difference between population arriving and leaving) a country is 'net migration'. For example, in 2014, inflows to the UK were 641,000, outflows were 323,000 and net migration was therefore 318,000.

The figure below shows the net migration as a rate per 1,000 population for Peterborough and each Cambridgeshire district, compared with England and the East of England. The rate would be one of several factors that affect the overall population change over time. Both Cambridgeshire and Peterborough have higher rates of long-term international migration than England and the highest rate in the area is in Cambridge City.

Figure 12: Long-term international migration net rate, Crude Rate Per 1,000 Total Population, 2009-2010 to 2013-2014



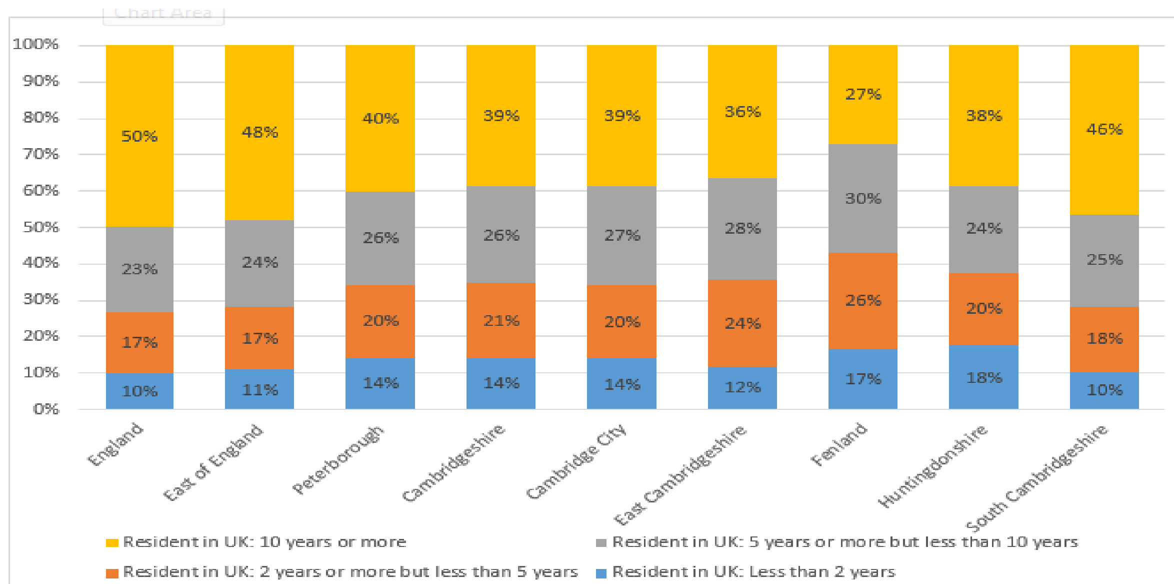
	England	East of England	Cambridgeshire	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	Peterborough	South Cambridgeshire
2009-2010	4.2	3.9	7.8	19.5	7.5	8.7	2.5	12.5	4.0
2010-2011	4.4	3.1	4.6	9.5	3.7	6.9	1.6	9.4	3.1
2011-2012	2.9	1.4	4.0	15.7	0.7	5.4	-1.7	6.0	1.9
2012-2013	3.2	2.1	4.5	13.5	1.8	7.8	0.0	9.1	1.4
2013-2014	4.5	3.6	5.8	16.3	2.3	6.4	1.6	9.7	3.4

Source: Office for National Statistics, 2014, http://www.ons.gov.uk/ons/rel/migration1/migration-indicators-suite/2014/index.html

Length of residence of non-UK born residents in Peterborough and Cambridgeshire

Information on the length of time the non-UK born population has resided in a location indicates how settled they are. The degree of 'settlement' will impact on needs and services in any area. The figure below shows the length of residence in non-UK born migrants in Peterborough and for each area in Cambridgeshire at the time of the 2011 Census.

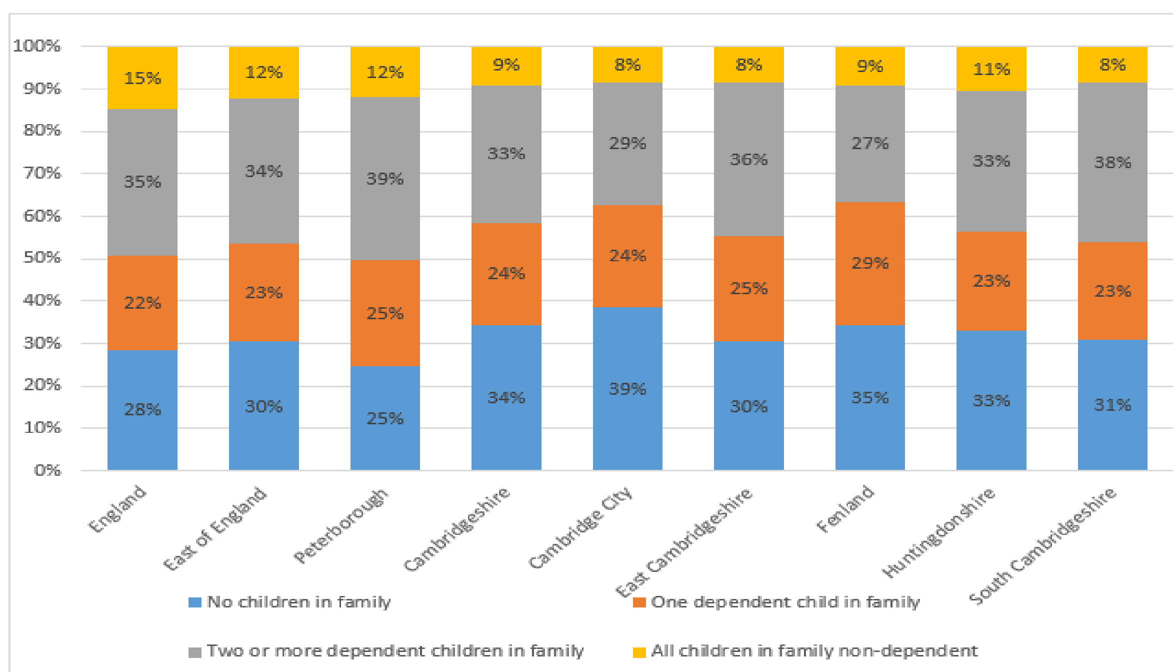
Figure 13: Length of Residence in UK – Non-UK born working population 2011



Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

Data show that in 2011 Peterborough had a higher percentage than England of migrants who have been resident in the UK for 5 years or less and conversely a lower percentage who had been in the UK for 10 years or more.

Figure 14: Number of children born to parents whose original country of residence is not the UK 2011



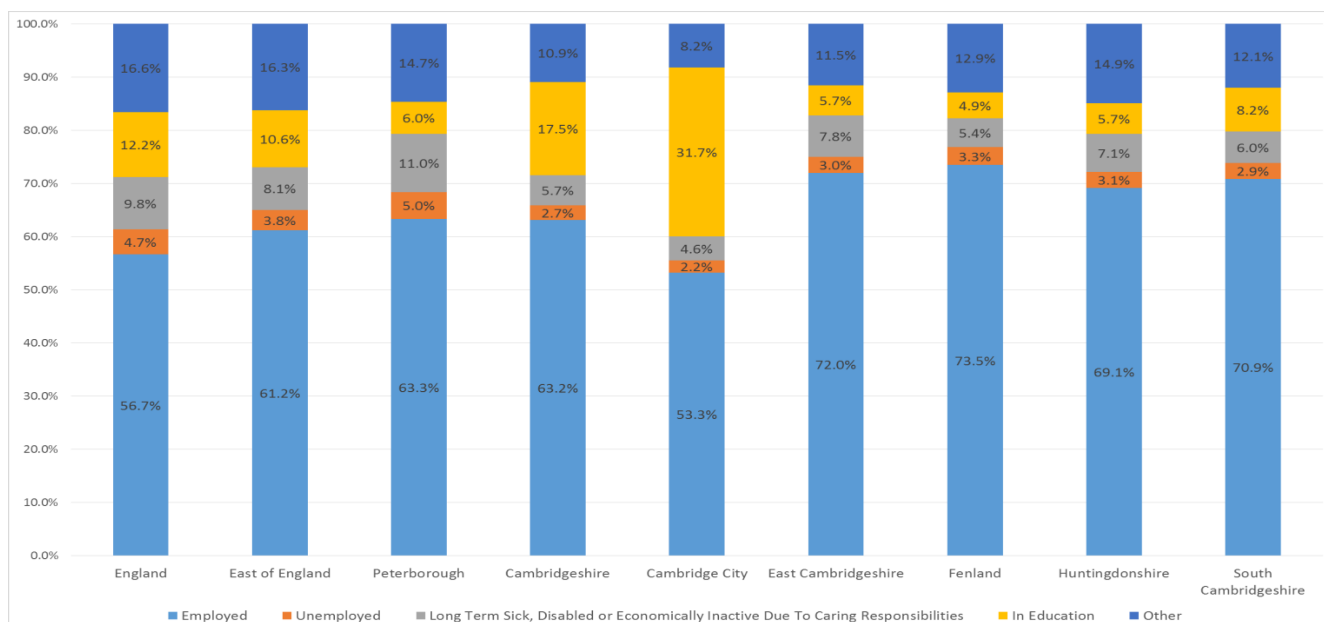
Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

In Peterborough in 2011, 64% of non-UK born residents had one or more dependant children, which is above the national average for non-UK born populations of 57%.

Economic Status of Non-UK Born Residents

The economic status of non-UK born residents provides an indication of the main reasons why migrants may settle in a particular area – for employment or education, for example. The figure below compares information taken from the 2011 census to determine the economic status of non-UK born residents across Peterborough and Cambridgeshire and compares this to England and the East of England.

Figure 15: Economic Status of Non-UK Born Residents, 2011



Source: Census, 2011, https://www.nomisweb.co.uk/census/2011/qs601ew

In 2011, Peterborough had a higher proportion of Non-UK born residents who were employed compared with both England and the East of England and proportionately fewer Non-UK born residents who were in education. This contrasts with Cambridge City where education was a key determining factor in the high rates of migration in Cambridge City, with 31.7% of non-UK born residents responding to the 2011 census stating they were in education[2]. 11.0% of non-UK born residents in Peterborough stated they were economically inactive due to caring responsibilities or to being long term sick or disabled.

[2] Poppleton, S. et al, Social and Public Service Impacts of International Migration at the Local Level, Home Office, July 2013, p. 20

4. Children & Education

Key Findings

- 45% of pupils in Peterborough have an ethnicity stated as 'not White British', (15,285 of 33,930 pupils).
- The most common ethnicities in the 2015 school census, other than 'White British', were 'Any Other White' (5,421 pupils – 16%), Pakistani (4,426 – 13%) and Indian (835 – 2.5%).
- 35.17% of pupils speak a language other than English. Panjabi and Polish are second and third most prevalent languages spoken by children after English.
- There is a wide range between different schools in the proportion of pupils who speak a language other than English at home, depending on the schools location and the communities which they serve.
- In general educational attainment is lower for pupils who speak a language other than English at home, and this is most marked for pupils who speak an Eastern European language. However the improvement in attainment between 2013 and 2015 has also been fastest for pupils speaking an Eastern European language at home.

Introduction

Schools have been identified as locations where 'community cohesion' can be fostered and encouraged,[3] as they are areas in which parents from different communities liaise and where children from differing backgrounds congregate to learn together. However, there remains debate about the levels to which schools should acknowledge diversity between pupils of differing backgrounds and this is an issue of particular significance in areas with fast-growing populations in which growth is partly attributable to relatively high levels of migration, such as Peterborough.

Ethnicity of school pupils across Peterborough

It is difficult to obtain data that directly states whether a pupil is part of the migrant population. Instead, details of a pupil's ethnicity and primary language spoken at home are recorded by the annual school census. This data does not describe whether pupils were born outside the UK or whether their parents are migrants to the UK. Information taken from the annual school census in 2015 is presented below for Peterborough and Cambridgeshire and its districts to compare proportions of pupils who are not 'white British'.

[3] https://www.sussex.ac.uk/webteam/gateway/file.php?name=mwp47.pdf&site=252

Figure 16: Total Pupils with a Stated Ethnicity

Area	Total Pupils	Total Pupils Not 'White British'	% Of Pupils Not 'White British'
Peterborough	33,930	15,285	45.0%
Cambridge City	11,862	5,016	42.3%
East Cambs	11,482	1,698	14.8%
Fenland	12,790	2,157	16.9%
Huntingdonshire	22,471	3,472	15.5%
South Cambs	19,844	3,614	18.2%
Cambridgeshire Districts Total	**78,449***	**15,957**	**20.3%**
Cambridgeshire & Peterborough Total	**112,379***	**31,242**	**27.8%**

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census

* 1,676 pupils in Cambridgeshire and 365 pupils in Peterborough fall within the categories 'information not recorded, information not obtained, refused to provide information'. Overall number of pupils including these categories is 80,125 for Cambridgeshire and 34,295 in Peterborough (114,420 pupils in total).

Peterborough has the largest percentage in the Cambridgeshire and Peterborough area of pupils with a stated ethnicity whose ethnicity is not 'White British', 45.0% (15,285 of 33,930 pupils), although Cambridge City has a similar proportion at 42.3%. The proportion of pupils with an ethnicity stated as not white Bristish is greater than the proportion of the general population that is not white British or white Irish from the 2011 Census data shown in section 1 (45% compared with 28.4%).

The figure on the next page presents a more detailed picture of the ethnic mix of school children in Peterborough, compared with Cambridgeshire districts.

Figure 17: Ethnicity Breakdown (Observed Numbers) of pupils at schools in Peterborough and Cambridgeshire

Area	Any Other Asian	Any Other Black	Any Other Ethnic Group	Any Other Mixed	Any Other White	Bangladeshi	Black African	Black Caribbean	Chinese	Gypsy/ Roma	Indian	Mixed White/Black African	Mixed White/ Black Caribbean	Pakistani	Traveller of Irish Heritage	White and Asian	White British	White Irish	Total
Peterborough	756	189	346	468	5,421	68	744	159	128	291	835	306	538	4,426	31	514	18,645	65	33,930
Cambridgeshire	991	177	608	1,339	6,503	624	534	138	527	507	871	472	712	481	128	1,079	62,492	266	78,449

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census

In Peterborough, the most common ethnicities (where an ethnicity was stated) in the 2015 school census, other than ‘White British’, were ‘Any Other White’ (5,421 pupils – 16%), Pakistani (4,426 – 13%) and Indian (835 – 2.5%).

Children who speak a language other than English at home

School census data 2015 records the number of pupils in each school who speak a language other than English at home.

For all schools in Peterborough (34295 pupils), 64.93% speak English at home. 35.17% of pupils speak a language other than English. The languages most frequently spoken by Peterborough school age children are shown in the table below. Panjabi is the second most prevalent language spoken by children after English (at 6.28% of all Peterborough school age children) followed by Polish (4.86%).

Figure 18 – Number and proportion of children who speak English and languages other than English at home – languages with over 2% prevalence are shown

Language	# of Speakers	% of all speakers
English	22269	64.93%
Panjabi	2153	6.28%
Polish	1667	4.86%
Urdu	1499	4.37%
Lithuanian	1184	3.45%
Portuguese	866	2.53%

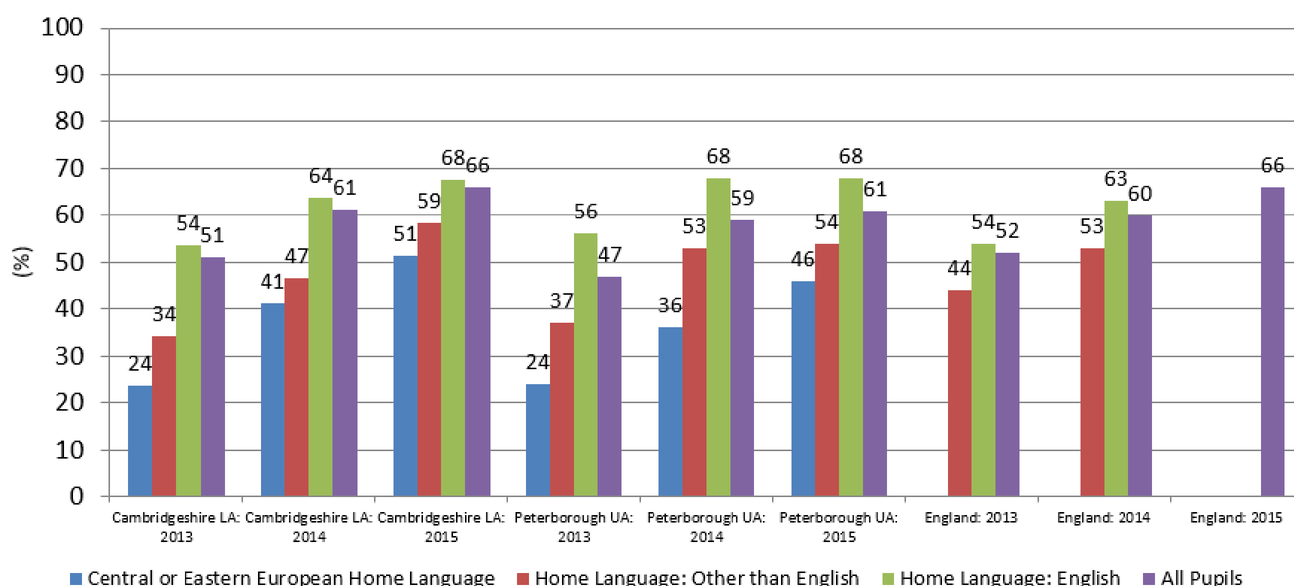
Source: School census data 2015

There is a wide variation between schools in Peterborough in the proportion of pupils who speak a language other than English at home, depending on their location and the communities they serve. Overall 38.6% of primary school pupils speak a language other than English at home, with the proportion attending individual schools varying from under 5% to over 90% of children. Similarly, 29.7% of secondary school pupils speak a language other than English at home, with the proportion attending individual schools ranging from under 5% to 65%.

Educational attainment of pupils assessed in relation to the primary language spoken at home

Data show that in both Peterborough and Cambridgeshire, the percentage of children who primarily speak a home language other than English achieving a good level of development in the early years foundation stage profile is lower than for children who primarily speak English; this is similar to the pattern observed nationally. This is most marked for pupils who speak a central or Eastern European language. In both Cambridgeshire and Peterborough there has been an increase in attainment level over the period shown (from 2013-2015) for pupils who either speak English at home or other languages, with the most marked improvement being for pupils who speak a central or Eastern European language.

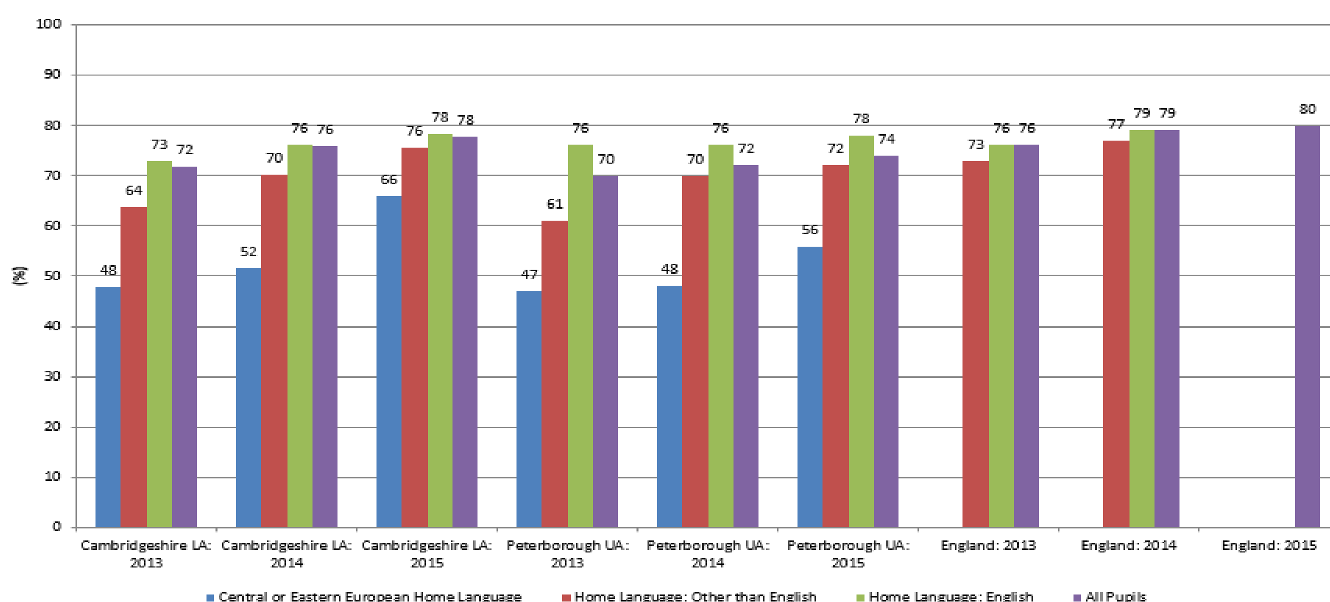
Figure 19: Proportion of Pupils Achieving a Good Level of Development in the Early Years Foundation Stage Profile by Primary Language Spoken at Home , 2013-15



Source: Department for Education, Statistical First Releases

Attainment at Level 4 and above, is lower in primary pupils in Peterborough who speak a central or Eastern European language at home compared with those who speak other languages at home, including English. Primary school pupils who speak other languages than English at home have a lower attainment at Level 4 and above in Key Stage 2 Reading, Writing TA & Mathematics than those who speak English and this is most marked for children who speak a central or Eastern European language. The gap has narrowed in recent years and attainment has increased for the period shown (2013 – 2015) with the greatest improvement seen in pupils who speak Central or Eastern European languages.

Figure 20: Proportion of Pupils Achieving L4+ in Key Stage 2 Reading, Writing TA & Mathematics, 2013-15

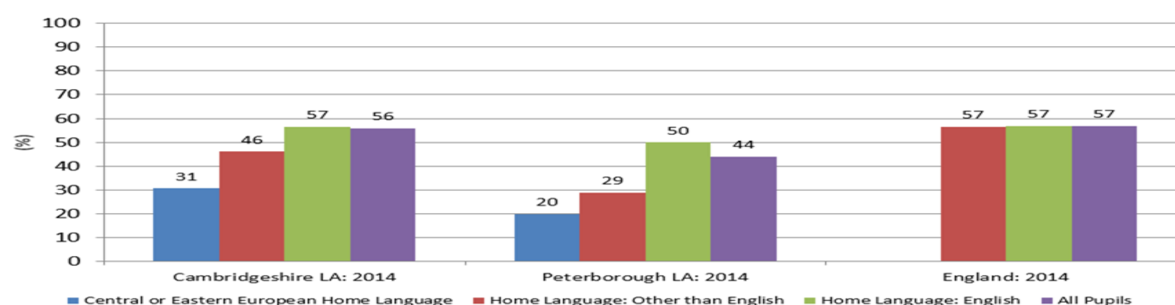


Source: Department for Education, Statistical First Releases

24

Attainment at the end of secondary school as measured by the proportion of pupils obtaining 5 or more GCSE grades A*-C is considerably lower in pupils in Peterborough who speak a Central or Eastern European language at home or a language other than English, compared with those whose home language is English. However the direct relationship between language spoken at home and educational attainment is difficult to assess, because schools with the highest proportion of pupils speaking a language other than English at home are in some of the most deprived areas and also experience higher levels of 'pupil turnover'. Socio-economic deprivation is independently associated with poorer educational performance.

Figure 21: Proportion of Pupils Achieving 5+ GCSE Grades A*-C, including English & Mathematics



Source: Department for Education, Statistical First Releases

Children in Need

A 'child in need' is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or the child is disabled.[4]

Figure 22: Peterborough Children in Need Referrals Jan 2012 – Aug 2015, 10 Most Common Languages Spoken at Home

Number	Language Spoken At Home	Referrals Number	Referrals % Of Total	Pupils Number	Pupils % Of Total
1	English	4,145	77.9%	22,269	65.1%
2	Lithuanian	233	4.4%	1,184	3.5%
3	Slovak	182	3.4%	442	1.3%
4	Portuguese	154	2.9%	866	2.5%
5	Polish	134	2.5%	1,667	4.9%
6	Latvian	97	1.8%	414	1.2%
7	Czech Republic	66	1.2%	299	0.9%
8	Panjabi	55	1.0%	2,153	6.3%
9	Urdu	45	0.8%	1,499	4.4%
10	Russia	29	0.5%	225	0.7%
-	Other	182	3.4%	3,169	9.3%
-	Total ('Blanks' are excluded)	5,322	100.0%	34,187	100.0%

Source: Peterborough City Council Children in Need Referral Data

4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

The table above shows the 10 primary languages spoken at home for which the highest number of children in need referrals in Peterborough were made between January 2012 and August 2015 and numbers of pupils attending Peterborough schools by language. Data show that, in Peterborough, 77.9% of children in need referrals were for primarily English-speaking pupils, whereas only 65.1% of pupils in the area speak English as a first language. This may be due to 'under-reporting' with regards to children who speak languages other than English; for example, pupils who primarily speak Panjabi represent 6.3% of the pupils in Peterborough but only 1% of referrals.

5. Health

Key Messages -

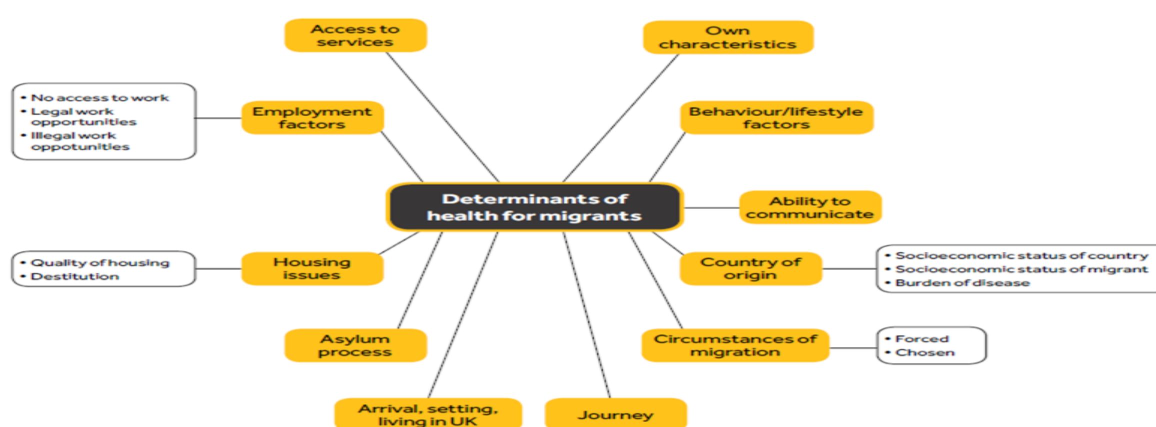
- Some ethnic communities are known through national and international research to have a higher risk of some health conditions and a lower risk of other health conditions than the average for the UK. There are also health risks associated with the relatively higher levels of socio-economic deprivation experienced by some local ethnic communities, and the challenges and stresses associated with being a recent migrant or a refugee.
- Electoral wards in Peterborough with greater proportions of people in BME groups generally have higher rates of overall mortality, and mortality from circulatory disease and coronary heart disease. However, In Peterborough, higher proportions of BME communities live in deprived areas. There is also a strong correlation by electoral ward between income deprivation and mortality rates and emergency hospital admission rates.
- People of Black Caribbean, Indian, Pakistani and Bangladeshi ethnicity have a higher prevalence of diabetes than the general population and black ethnic groups have a higher incidence of stroke for both sexes than the white ethnic groups in the UK
- Although there is no local data that examines the variation in cancer screening uptake by ethnicity, the research literature provides evidence that uptake for cancer screening is lower in some ethnic groups than the general population, including South Asian immigrants having lower rates of breast, cervical and colorectal cancer screening.
- Peterborough is among the areas with higher rates of tuberculosis within East Anglia & Essex. TB in the UK is higher among migrants from countries with high incidence of TB. The highest TB rates in the UK are seen in people with Indian and Pakistani ethnicities. There is also evidence that the highest rates of TB in migrants are in people who are recent arrivals in the UK.
- Sexual health is an area of concern in the migrant population and will need to be explored further to ensure access to services in hard to reach communities. The disparity between a late HIV diagnosis rate of 62% in Peterborough and 49% in Cambridgeshire is worthy of further investigation for its possible effect on the non-UK born population, which data show to be particularly susceptible to both late diagnosis of HIV and subsequent mortality within one year of diagnosis
- The percentage of births to non-UK born mothers was 43.6% of all births in Peterborough in 2014, although there is no further ethnic breakdown of this information. There is national research evidence that women from BME groups who were born outside the UK were later in booking antenatal care, received poorer information about antenatal care and may be less likely to be treated with respect by staff compared to White women born in the UK, although we do not have local research.

- There is a lack of systematically collected data that means our knowledge of ethnic minority and migrants' mental health remains limited. It would be worth investigating whether local NHS mental health are suitable and accessible to these populations.
- Suicide rates are higher in all of the EU A8 countries compared to England and there is some evidence that the suicide rate of Eastern European migrants living in Peterborough is also higher than would be expected.
- There are increasing indications that the prevalence of dementia in Black AfricanCaribbean and South Asian UK populations is greater than the white UK population and that the age of onset is lower for Black African-Caribbean groups than the white UK population
- Over the 10 years 2003/04 - 2013/14, new migrant GP registrations have risen by 37.6% in England. In Peterborough, the increase over this time period has been 71.6%.
- Peterborough has the second highest recorded rate of new migrant GP registrations across the Eastern region - over double the East of England rate and England rate

Introduction

The healthcare needs of non-UK born residents may be influenced by a range of factors - not only language and cultural differences but also the burden of disease and living conditions in their country of origin, experiences during migration, their circumstances in the UK and other factors relating to ethnicity and cultural practices. Recent studies have found that the majority of migrants are young and healthy on arrival, but their health – particularly their mental health – declines sharply after arrival in a new country, as a result of a range of factors that may include social exclusion, poverty and low standards of accommodation[5]. It is therefore important to consider the wider circumstances of migrants' lives in making sense of patterns of health and health care.

Figure 23: Health and wellbeing determinants of Migrants



Source: Rose, N., Stirling, S., Ricketts, A., & Chappel, D. (2011). Including Migrant Populations in Joint Strategic Needs Assessment. A Guide.

Health impacts relating to country of origin

[5] Collis, A. et al, Migrant Health Scoping Report, East of England Regional Assembly (2009), p. 7

Although migrants, being usually relatively young and in reasonable health, do not necessarily have a similar health profile to that of the population from which they have emigrated, analysis of mortality data in the countries of birth or origin represented by the main migrant and ethnic communities in Peterborough (figure 24 below) can be useful in assessing whether there are links between intrinsic factors, lifestyle behaviours and mortality outcomes which place some communities at higher risk. Mortality rates within a country will be influenced both by the likelihood that people develop an illness, and by the local availability and quality of healthcare for that illness.

Figure 24: Causes of Death – Directly Age-Standardised Rate per 100,000 population, All Ages, 2012

Country	Diabetes	Cardio-vascular disease	Liver cirrhosis (male mortality only)	Cancer	Respiratory disease	Suicide
Bangladesh	29.8	166.2	29.1	87.8	106.7	7.8
India	26.3	306.3	39.5	71.9	154.8	21.1
Pakistan	42.5	274.2	37.4	88.3	91.4	9.3
China	14.9	300	9.9	143.4	77.1	7.8
Jamaica	71.7	232.6	9.8	122.8	16.6	1.2
Nigeria	47	266.5	79.2	106.7	36.8	6.5
Portugal	17.6	113.1	20	130	22	8.2
Poland	9.4	253.4	28.8	149.7	20.8	16.6
Czech Republic	11.1	239	23.7	142.2	15.4	12.5
Hungary	12.3	293.3	57	184	27.2	19.1
Estonia	5.5	272.1	21.8	142.4	9.5	13.6
Latvia	20.8	361.1	29.1	157.2	8.8	16.2
Lithuania	4.7	322.5	53.9	143	11.8	28.2
Slovakia	6.7	305.9	39.3	139.6	13.2	10.1
Slovenia	3.6	141.2	41.9	150.7	11	12.4
UK	4.2	111.8	16	130.4	30.5	6.2

Source: World Health Organisation

Note: Nigeria was used as a reference for communities with Black African ethnicity and Jamaica was used as a reference for communities with Black Caribbean ethnicity. There is no specific data that determines the country of origin for the black ethnic communities and these were chosen as a result of research on historical migration to the UK.

Red cells in the table above represent a mortality rate at least double that of the UK. Green cells represent mortality rates below those of the UK.

Some main points from the table above:

- Diabetes in Pakistan causes age-standardised mortality rates ten times higher than the UK.
- Diabetes causes extremely high mortality rates in Jamaica and this may have an implication for communities with black Caribbean ethnicities.
- Mortality from cardio-vascular disease is higher in all countries listed than in the UK, with comparatively high rates in both Asian and Eastern European countries.

- Mortality from liver Cirrhosis in males is extremely high when compared with the UK, in Nigeria, Hungary and Lithuania
- Cancer mortality rates are lower in the south Asian countries, Nigeria, Jamaica and Portugal compared to the UK
- Mortality from respiratory disease is high in the Asian countries listed
- Mortality rates from suicide are higher in all countries listed compared to the UK, but are particularly high in Lithuania and India

Any link between ethnic origin or country of birth and risk of disease is explored further in the sections that follow.

Inequalities within Peterborough – mortality rates by electoral ward

The figure below shows the six Peterborough wards with the highest proportion in the population of BME ethnicities and compares overall mortality rates, mortality from circulatory disease and coronary heart disease. It also lists emergency and elective hospital admission rates for these wards.

It is clear, with the exception of West ward, that there is an association between higher rates of overall mortality, mortality from circulatory disease and coronary heart disease in wards with greater proportions of people in BME groups. It is also interesting that emergency hospital admissions are higher than the Peterborough average for these wards but elective (planned) admission rates are lower. This data does not directly link mortality risk and risk of emergency admission to ethnicity, but simply highlights the association in these wards. There is also a strong correlation between income deprivation and mortality rates and emergency hospital admission rates and these wards have high levels of deprivation (apart from West ward) – see Demography section. Deprivation is associated with risk factors for cardiovascular disease, including smoking prevalence, obesity and physical inactivity.

Figure 25 – Peterborough wards with the highest proportion of BME communities showing all cause mortality rates, mortality from circulatory disease, coronary heart disease and rates of emergency and elective hospital admissions

Electoral Ward	BME Population (%, 2011)	Deaths, U75, All Causes (SMR, 2008-2012)	Deaths, U75, Circulatory Disease (SMR, 2008-2012)	Deaths, U75, Coronary Heart Disease (SMR, 2008-2012)	Emergency Hospital Admissions for all Causes (SAR, 2008/09 - 2012/13)	Elective Hospital Admissions for all Causes (SAR, 2008/09 - 2012/13)
Central	58.2	150.6	172.1	229.9	127.5	89.9
Park	35.8	142.3	200.8	212.6	119.3	89.7
Ravensthorpe	30.8	159.2	224.5	262.0	123.1	95.8
West	29.5	87.7	86.5	62.3	92.8	89.1
East	26.8	142.9	181.2	188.9	114.4	92.3
North	23.0	129.5	137.4	161.5	117.4	98.5

Red indicates rates higher than Peterborough average and green indicates rates lower than Peterborough average.

Cardiovascular disease (CVD) and ethnicity

Peterborough CVD JSNA 2015 contains a section describing risk of cardio-vascular disease associated with ethnicity - Source: https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/CardiovascularDiseaseJSNA-November2015.pdf?inline=true

It refers to data from the British Heart Foundation that shows a disparity between ethnicities in prevalence of CVD and in associated risk factors. Black Caribbean, Indian, Pakistani and Bangladeshi men have a higher prevalence of diabetes than the general population and black ethnic groups have a higher incidence of stroke for both sexes than the white ethnic groups (British Heart Foundation, 2010[6]), while South Asian groups have a higher incidence of coronary heart disease.

Determining risk factors associated with ethnicity for cardiovascular disease is complicated as there are potentially many confounders including genetics, cultural and social practices and levels of obesity. There is however evidence that inequalities exists between ethnicities with regard to access to treatment, (Heart UK, 2013[7]) as well as behavioural factors such as smoking, diet and physical activity.

Hospital admissions data for Cardiovascular disease is available for Peterborough and broken down by ethnicity (Peterborough CVD JSNA 2015). This shows no increase incidence of admissions for CVD in the BME ethnicities compared with the white British community. However, there is a high proportion of ethnicity described as 'not known' in the data which is likely to make the results unreliable.

Diabetes and ethnicty

As stated in the CVD JSNA, 2015, ethnicity is a risk factor for diabetes. People with a South Asian ethnicity have a 50% higher lifetime risk of developing type 2 diabetes than white Europeans. Diabetes in these groups can often occur at a younger age and in people with a lower Body Mass Index (BMI). Obesity and diabetes guidelines take account of this, by recommending services for weight management to those with South Asian ethnicity and lower BMI, in order to help prevent the development of diabetes or to help reverse new onset diabetes (NICE Guidelines for Obesity Management, 2015[8]).

Deprivation is also associated with risk of developing diabetes as deprived communities have higher levels of obesity and physical inactivity, which in turn are risk factors for developing type 2 diabetes. In Peterborough, higher proportions of BME communities live in deprived areas.

Diabetes is also a strong risk factor for developing cardiovascular disease. Adults with diabetes are 2 to 4 times more likely to have heart disease or a stroke than people without diabetes.

Variation in Cancer incidence, survival and screening uptake in ethnic communities

Mortality from Cancer 2014.

The World Health Organisation (WHO) estimates that in 2012, about 8.2 million deaths, or 13% of all global deaths, were attributable to cancer. The UK recordend 163,200* deaths from Cancer in 2014 with equates to a crude mortality rate of 259.9 per 100,000 population. Of the counties with a high preveleance in Peterbough, Estonia, Slovenia and Latvia all had a higher crude rate of mortality from Cancer in they respective home counrties when compared to the UK.

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[6] https://www.bhf.org.uk/-/media/files/research/heart-statistics/hs2010fc_ethnic_differences_in_cardiovascular_disease-full-copy.pdf

[7] https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0ahUKEwjXnJ_SqevOAhXEDxoKHb2VAkYQFgg0MAM&url=https%3A%2F%2Fheartuk.org.uk%2Ffiles%2Fuploads%2FBridging_the_Gaps_Tackling_inequalities_in_cardiovascular_disease.pdf&usg=AFQjCNEKMGQdVk2HR_NRJ6eUMzhuJFQALA&bvm=bv.131286987,d.d2s

[8] https://www.nice.org.uk/guidance/Cg43

Variation in cancer incidence by ethnicity – evidence from the literature

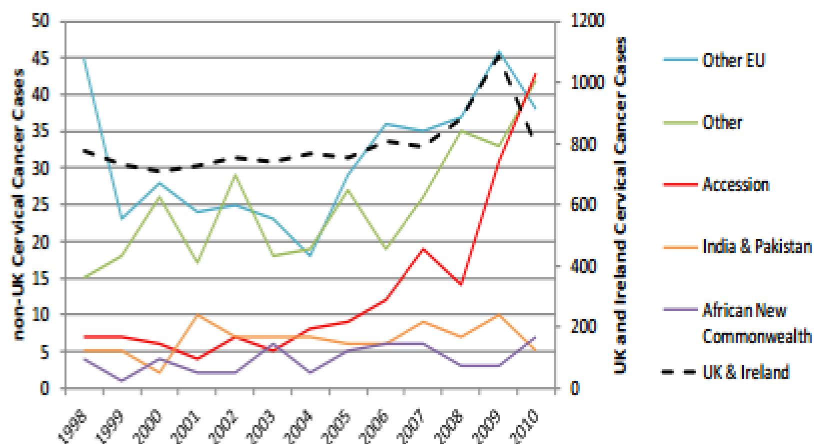
BME groups have lower risk of cancer in general than people of white ethnicity (Cancer Incidence and Survival By Major Ethnic Group, England, 2002-2006[9] & National Cancer Intelligence Network, 2015[10] Evidence shows that people of Asian, Chinese and mixed ethnic groups have significantly lower risk of cancer than those of white ethnicities if 'all malignancies combined' are analysed. Black females have a 10% - 40% lower risk of cancer than white females but the risk of cancer in Black males is similar to White males.

However, for specific cancers, the risk varied for different ethnic groups. The risk of liver cancer is 1.5 to 3 times greater for Asian ethnicities compared with White ethnicities. Cancer of the mouth was significantly increased for Asian females. The risk of cervical cancer is significantly higher in Asian and black females, for those aged 65 and over, but lower in Asian females below the age of 65, when compared with white females. Black males were more likely to have a diagnosis of prostate cancer than White males. Both males and females from the Black ethnic group also had higher rates of cancers of the stomach and liver as well as myeloma.

Asian and black ethnicity lowers the risk for breast, prostate, lung and colorectal cancer, and less common cancer types including cancers of the bladder, brain and CNS, kidney, oesophagus, ovary, pancreas and malignant melanoma of the skin.

The effect of new migration on incidence of cervical cancer in Engand is shown in the figure below. There has been a recent increase in cases of cervical cancer in people migrating to the UK from EU and Accession countries (including the A8 countries).

Figure 26 – Cervical cancer cases in non-UK born women by country of origin, England 1998-2010



Reference: Investigating the effect of immigration on trends in cervical cancer in young women, Rebecca Elleray, Jason Poole, Jack Hales PHE Knowledge & Intelligence Team (East Midlands)

Variation in cancer survival by ethnic group

Cancer survival by ethnicity was also analysed in this report and found that both Black and Asian women aged 15-64 years had reduced survival from breast cancer than women from the White ethnic group at three years (89% and 91%, respectively). In contrast, Asian people and males with lung cancer from the Black ethnic group aged over 65-99 had improved outcomes for lung cancer at both one and three years than White etnicities for all ages.

[9] http://publications.cancerresearchuk.org/downloads/Product/CS_REPORT_INCSURV_ETHNIC.pdf
[10] http://www.ncin.org.uk/cancer_type_and_topic_specific_work/topic_specific_work/equality

Cancer screening

Although there is no local data that examines the variation in cancer screening uptake by ethnicity, the research literature provides evidence that uptake for cancer screening is lower in some ethnic groups than the general population, with people born in South Asia having low rates of breast, cervical and colorectal cancer screening (Szczepura *et al*. 2008[11], Lee *et al*. 2010a[12], Lofters *et al*. 2010[13])

Research indicates that colorectal cancer screening uptake within the South Asian population in England is approximately half that of the general population (33 % vs 61 %), and varies by Muslim (31.9 %), Sikh (34.6 %) and Hindu (43.7 %) faith background. (BMC Public Health, 2015 [14] & Szczepura et al. 2003.[15]) It has also been shown that bowel and breast screening rates remain low for people of South Asian ethnicity, after adjusting for deprivation (Szczepura et al, 2008(1)[16]).

It has been recommended that local language broadcasts on ethnic media and face-to-face approaches within community and faith settings should be developed to increase awareness of colorectal cancer and screening, and address challenges posed by written materials (Szczepura et al, 2008(2)). This could be useful for enhancing bowel screening programmes locally that focus on hard to reach ethnic groups.

Cancer awareness in ethnic groups

There is evidence that awareness of cancer warning signs is low across all BME ethnic groups with lowest awareness in the African group. Women identified more emotional barriers and men more practical barriers to help seeking, with considerable ethnic variation (Waller, 2009[17]). The study suggests the need for culturally sensitive, community-based interventions to raise awareness and encourage early presentation.

Obesity and physical activity

Obesity, risk of obesity and obesity-related disease is different in different ethnic groups with some black and Asian populations showing increased risk for obesity and related disease compared with white British groups. (NOO Ethnicity and Obesity, 2011[18])

Research has shown that south Asian and black ethnicity is a predictor of obesity related behaviours among children in the UK and this cannot be explained by deprivation (Falconer et al, 2014[19])

There is consequently a need to develop culturally specific lifestyle interventions including assessments of dietary factors to reduce obesity-related health inequalities. This should be taken into account when designing lifestyle services to help tackle obesity in children and adults within Asian and black communities in Peterborough.

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[11] http://www.ncbi.nlm.nih.gov/pubmed/18831751
[12] http://onlinelibrary.wiley.com/doi/10.1111/hsc.12208/full#hsc12208-bib-0042
[13] http://onlinelibrary.wiley.com/doi/10.1111/hsc.12208/full#hsc12208-bib-0047
[14] http://www.ncbi.nlm.nih.gov/pubmed/26423750 , doi: 10.1186/s12889-015-2334-9
[15] http://wrap.warwick.ac.uk/133/1/WRAP_Szczepura_ethnicity-finalreport.pdf
[16] http://www.biomedcentral.com/qc/1471-2458/8/346
[17] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2790704/
[18] http://www.hscic.gov.uk/catalogue/PUB13219
[19] http://bmjopen.bmj.com/content/4/1/e003949.full

The increased risk of obesity-related disease in some ethnic groups is acknowledged in NICE guidance, (Obesity in children, young people and adults, 2014[20] & NICE guideline PH46, 2013[21]

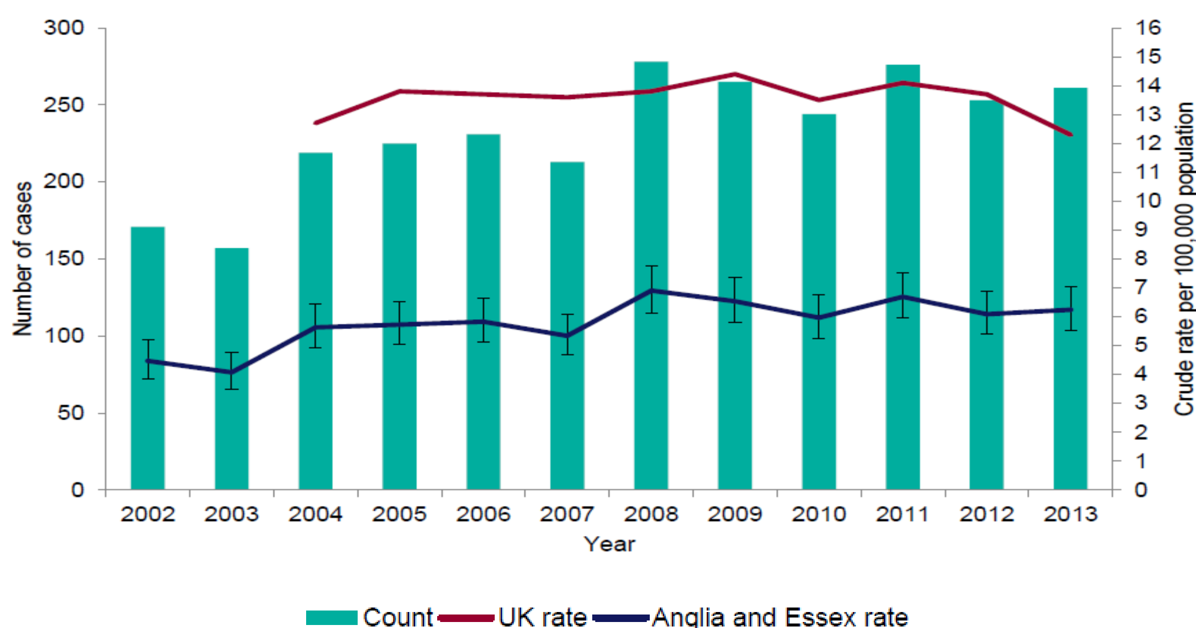
which recommend reducing the definition of obesity and the threshold for obesity services for people with a black, black Caribbean or south Asian ethnicity from BMI of 30 to BMI of 27.5. This would have an impact on weight management services in areas of Peterborough with higher proportions of people from these ethnic backgrounds. It will be important to ensure access to the relevant services for people from Asian and black ethnicities in general practices with higher proportions of people from these backgrounds.

Participation in physical activity has been shown to differ between ethnic groups, for example, Indian, Pakistani, Bangladeshi and Chinese women are all less likely than white women to meet recommended guidelines for physical activity. (Higgins et al, 2012)[22]

Communicable Diseases in the Migrant and ethnic population

Tuberculosis

Figure 27: Tuberculosis case reports and crude rates in Anglia and Essex Public Health England Centre, 2002-2013



Source: PHEC Anglia & Essex Tuberculosis Annual Report May 2015

In 2013, 261 cases of tuberculosis were reported among residents of East Anglia and Essex, a rate of 6.2/100,000 population which is approximately half of the UK rate of 12.3/100,000. 58 of these cases were within Peterborough. Data from the Health Protection Agency show that the majority of observed cases of tuberculosis reported in the UK in recent years were born abroad (74% of the total in 2010[23]). The highest rates of tuberculosis in the UK are in ethnic minority groups and of non-UK born cases diagnosed in 2010, 77% were diagnosed more than two years after arrival in the UK.

[20] https://www.nice.org.uk/guidance/cg189
[21] https://www.nice.org.uk/guidance/ph46/chapter/introduction-scope-and-purpose-of-this-guidance
[22] https://www.ukdataservice.ac.uk/use-data/data-in-use/case-study/?id=97
[23] Health Protection Services. Migrant Health: Infectious diseases in non-UK born populations in the United Kingdom. An update to the baseline report (2011) p.33

The figure below shows annual tuberculosis rates and trends by local authority area across Anglia and Essex. Peterborough is shown to have the highest rate of TB of local authority areas across Anglia and Essex.

Figure 28: Annual tuberculosis case rates by upper tier local authority, Anglia & Essex PHEC, 2002-2013

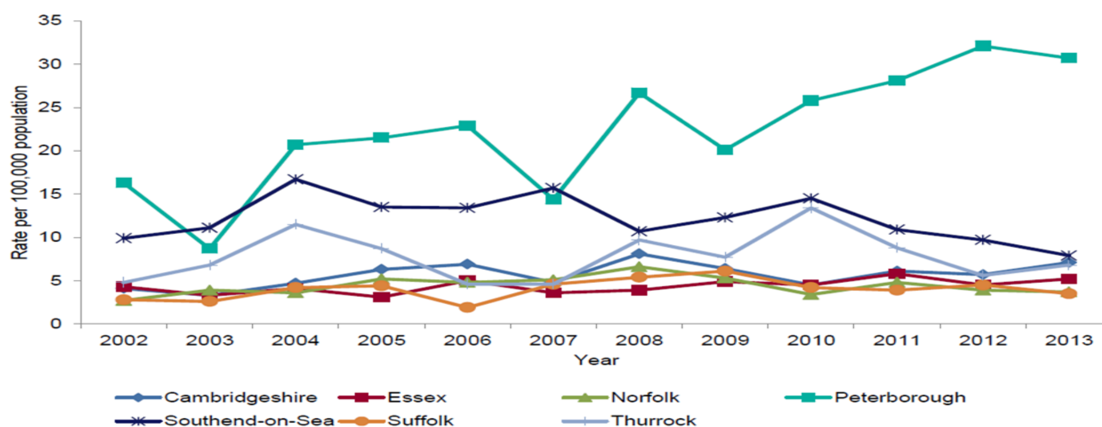
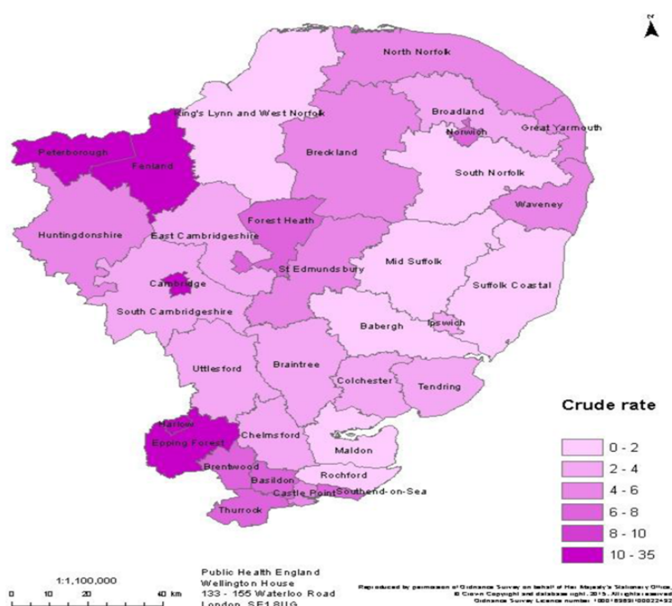


Figure 29: Tuberculosis case rate per 100,000 population for local authorities within Anglia and Essex PHEC, 2013



Source: PHEC Anglia & Essex Tuberculosis Annual Report May 2015

As of May 2012, the UK Home Office replaced the previously-enforced system of active TB case finding at ports of entry in to the UK with 'pre-entry TB screening' prior to migrants applying for a VISA to enter the UK. Everyone who applies for a UK via for more than 6 months and who is resident in a country where TB is common (over 40 incidences per 100,000 population) is now screened for pulmonary tuberculosis at one of the UK approved TB screening centres.[24] TB rates for countries with the highest prevalence are noted in the table below:

[24] https://www.gov.uk/guidance/tuberculosis-screening

Figure 30: Estimated Tuberculosis Rates per 100,000 Population, 2014, in countries with highest ethnic representations in Peterborough

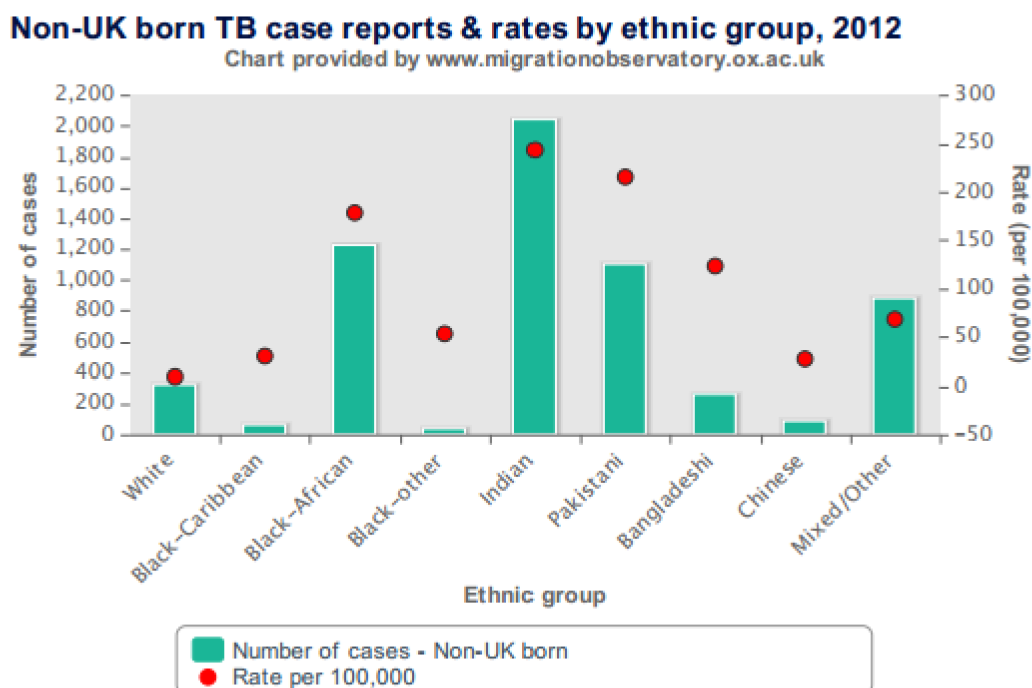
Country	Estimated TB rate per 100,000 population
Pakistan	270
India	167
Lithuania	62
Latvia	49
Portugal	25
Poland	21
Estonia	20
England	13.5
Hungary	12

Source: UK Government, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491527/WHO_estimates_of_tuberculosis_incidence_by_country__2014_v2.pdf

The figure below shows incidence and rates of Tuberculosis in the non-UK born population in the UK. The highest TB rates are seen in people with Indian and Pakistani ethnicities. There is also evidence that the highest rates of TB in migrants are in people who are recent arrivals in the UK, possibly reflecting prevalence rates in countries of origin. Reactivation of latent Tuberculosis contributes to the overall Tuberculosis numbers and this may be influenced by contributory factors, such as low income and poor living conditions experienced by new migrants in the UK (Robinson and Reeve 2006 – Neighbourhood Experiences of New Immigration: Reflections from the evidence base)[25].

[25] Robinson, D. & Reeve, K. (2006) Neighbourhood Experience of New Immigration – Reflections From the Evidence Base, Joseph Roundtree Foundation

Figure 31: Non-UK born TB Case Reports & Rates by Ethnic Group, 2012



Source : TB Section, Centre for Infectious Disease Surveillance and Control, Public Health England, Fig 1.5 p. 12

Screening for Tuberculosis in BME migrants in Peterborough

A recent Latent Tuberculosis plan for Peterborough and Cambridgeshire has been implemented and intends to screen 350 new migrants, prospectively through selected general practices. New migrants from countries with high incidence of Tuberculosis will be offered screening for latent Tuberculosis upon registration with a participating general practice.

In adition, an education programme targeted at GPs and communities will raise awareness of latent Tuberculosis in higher risk migrant groups.

Tuberculosis Treatment

Public Health England compares treatment services for tuberculosis across the Anglia and Essex region and gives an indication of numbers of patients completing treatment .Peterborough has the highest observed number of people with tuberculosis completing treatment as measured within the Anglia and Essex area for 2012. The percentage of people completing treatment in Peterborough (81.0%) is also higher than the collective percentage for Anglia and Essex (76.0%).

Sexual Health and HIV

New migrants are at higher risk of sexual health problems. Migration alone can result in the end of relationships, new relationships being formed and higher-risk sexual behaviour, increasing the risk of developing sexually transmitted diseases (Burns et al 2008[26], Burns et al 2011[27]). Alcohol is often a

[26] Burns, F. et al (2008) Increase attendances of people of Eastern European origin at sexual health services in London, Sex Transm Infect 2009; 85: 75-78 doi: 10.1136/sti.2007.029546

[27] Burns, F. et al (2011) Sexual and HIV risk behaviour in Central and Eastern European Migrants in London, Sex Transm Infect 2011 Jun: 87(4) 318-24 doi 10.1136/sti.2010.047209

factor in unsafe sex and therefore the spread of sexually transmitted diseases and unplanned pregnancy. Data from the Public Health England HIV and Aids New Diagnosis database shows that the national rate of new HIV diagnoses per 100,000 population was 13 whereas in Anglia and Essex the rate was statistically significantly lower than England at 9 per 100,000.[28] Nationally there are data available which indicate that between 2001 and 2010:

- 65% of new HIV diagnoses where country of birth is known were among those born abroad.
- Heterosexuals who were born outside of the UK were more likely to be diagnosed late compared to those born in the UK (63% compared to 50%).
- Sub-Saharan Africa was the predominant region of birth for HIV amongst heterosexuals. Europe was the most common world region of birth for HIV in homosexual men
- People receiving a 'late' diagnosis of HIV (CD4 count <350 cells/mm3 at time of diagnosis) have a ten-fold increased risk of death within one year of diagnosis compared to those diagnosed promptly.

Immunisation and Vaccine Preventable Diseases

Figure 32: Incidence rate of Measles & Rubella reporting per 1,000,000 population, By countries with highest representation in migrants to Peterborough, January – December 2014

Country	Incidence Rate Per 1,000,000 Population	
	Measles	Rubella
Czech Republic	20.8	-
Estonia	-	-
Hungary	-	-
Latvia	17.6	0.5
Lithuania	3.7	-
Poland	2.9	154.3
Portugal	-	0.7
Slovakia	-	-
Slovenia	25.1	-
UK	2.2	-
World	17.8	7.2

Source: World Health Organisation EpiData, http://www.euro.who.int/__data/assets/pdf_file/0004/276115/EpiData-No12-2014.pdf?ua=1

Data from the World Health Organisation suggest that the incidence rate of Measles is higher in the Czech Republic, Latvia, Poland and Slovenia than the UK and the incidence rate of Rubella is higher in Latvia, portugal and particularly in Poland than England. The data should be treated with a degree of caution due to the number of countries that have not reported an incidence rate.

Maternal health

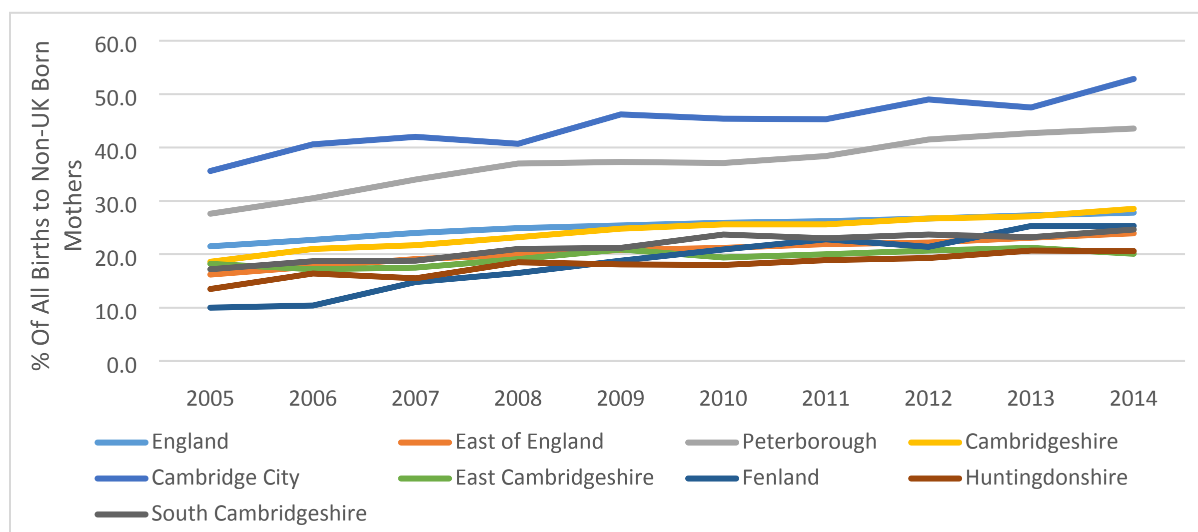
Births to non-UK born mothers

Non-UK-born residents tend to arrive in the UK as people of young working age (section 2) – a similar age group to people who will be having children in the general population. The percentage of

[28] Public Health England, Annual Epidemiological Spotlight on HIV in Anglia and Essex, 2013, URL: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/359662/Anglia_and_Essex_FES_STI_report_FINAL.pdf

births to non-UK born mothers (figure 33 below) is consequently higher than the proportion of non-UK born residents in the population. This needs to be reflected in the planning and delivery of maternity services.

Figure 33: % of All Births to Non-UK Born Mothers by Area, 2005-2014



Source: Office for National Statistics, Vital Statistics: Population & Health Reference Tables, URL: http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/vitalstatisticspopulationandhealthreferencetables

The percentage of all births to non-UK born mothers has risen in England between 2005 and 2014, from 21.5% of all births to 27.8%. In Peterborough, the percentage has risen from 27.6% in 2005 to 43.6% in 2014 across this time period. As seen in the table above, Peterborough has had a higher percentage of births to non-UK born mothers than England in all years 2005-2014. The data does not provide information to describe the proportion of births by country of origin, but provides an indication of the impact on maternity and children services by the non-UK born population as a whole.

Antenatal care in migrant and BME communities – evidence from national research

There is national evidence that women from BME groups who were born outside the UK were later in booking antenatal care, received poorer information about antenatal care and were less likely to be treated with respect by staff compared to White women born in the UK (Redshaw and Heikkila 2010[29]). Another study showed that 7.1% of non-UK born mothers had no antenatal care at all, compared to 2.4% of mothers born in the UK. The Confidential Enquiry into Maternal Deaths (2006 - 2008[30]) showed that Black African mothers, many of whom were recent migrants including refugees and asylum seekers, had a mortality rate nearly four times that of White women (Lewis 2011[31]). Key risk factors for maternal mortality included lack of antenatal care or late booking. There was also little or no English fluency among a fifth of mothers who died, and inadequate interpretation support from maternity services. There were particularly high proportions of mothers having no antenatal care among Pakistani and Bangladeshi migrant mothers.

[29] https://www.npeu.ox.ac.uk/downloads/files/.../Maternity-Survey-Report-**2010**.pdf
[30] https://www.npeu.ox.ac.uk/mbrrace-uk/reports
[31] Lewis, G., ed. "Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer 2006-2008." Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom (CEMACH), BJOG 118, supp. 1 (2011): 1-203

However, the risk of having no antenatal care is most strongly associated with socio-demographic factors such as younger age, lower educational level,occupational class and living in an electoral ward where at east 30% of the population were from BME communities. (Jayaweera and Quigley 2010[32]).

Mental Health

Mental health and migration

It is known that new migrants are at risk of poor mental health. Factors that increase risk of mental health problems include experiences in the migrants' home countries, stresses of immigration, settling and adaptation to a new country and culture, isolation, stress and poor living conditions (Tobi et all, 2010[33]). The diagram below summarises the range of factors and sub-factors that influence migrant mental wellbeing.

There is a lack of systematically collected data that means our knowledge of migrants' mental health remains limited. It would be worth further investigating whether local mental health services are suitable and accessible to the migrant population.

Figure 34: Factors and sub-factors that influence migrant mental wellbeing

Source: adapted from World Health Organisation, 2002 and Collis et al 'Workers on the Move 2' (Keystone Development Trust)

Mental health issues are likely to be more apparent among vulnerable migrant population groups such as asylum seekers, refugees and women and children who have suffered physical and/or sexual abuse. Evidence from both the UK and across Europe suggests that rates of depression and anxiety are higher among asylum seekers compared to the both the general population and other migrant categories; a rare quantitative study of women internally or internationally trafficked for sex work or

[32] http://www.ncbi.nlm.nih.gov/pubmed/20624665
[33] Tobi, P. et al (2010) Health and Social Care Needs Assessment of Eastern European (including Roma) individuals living in Barking and Dagenham, Institute for Health and Human Development

domestic service found that 70% had experienced both physical and sexual abuse during trafficking and the majority exhibited severe physical and mental health issues as a result[34].

Ethnicity and mental health

The table below provides a breakdown of rates of different mental disorders according to ethnicity and also gender and highlights groups at higher risk of certain mental health conditions. For example, South Asian women have higher rates of common mental health disorders (CMD) – that include depression and anxiety, than other ethnic groups. Black men have the highest rate of drug use whereas white men have the highest rate of alcohol dependence.

Figure 35 – Age standardised rates of different mental disorder according to ethnicity

	White		Black		South Asian		Other	
	Male	Female	Male	Female	Male	Female	Male	Female
Any CMD	12.0	19.3	12.9	21.0	10.3	34.3	20.2	20.6
PTSD	6.9	10.6	16.3	13.2	11.0	9.1	7.3	5.0
Suicidal thoughts	15.0	20.0	7.1	11.4	6.1	7.7	7.3	12.3
Suicide attempts	4.4	7.1	4.6	7.8	0.6	1.5	4.0	3.3
Self-harm	4.7	5.7	3.3	1.2	2.2	0.9	2.3	6.7
Psychotic disorder	0.2	0.5	3.1			0.6		
Alcohol dependence	9.6	3.7	3.0		1.0		3.5	1.4
Any drug use	12.4	6.8	21.8	5.6	3.5	0.8	9.2	11.5
Drug dependence	4.7	2.2	12.4	4.8	1.5	0.2	2.3	5.0

Source: Dept of Health – No Health Without Mental Health: A cross- Government mental health outcomes strategy for people of all ages Department of Health (2011)

Suicide

Figure 36 below shows suicide rates within a range of countries relevant to Peterborough's population. The suicide rate per 100,000 population is higher in all of the eight EU A8 countries than the UK rate of 7.2/100,000 and is highest in Lithuania (30.7/100,000). Rates are also relatively high in India, but similar to the UK in Pakistan. An annual audit of suicides conducted across both Cambridgeshire and Peterborough has also suggested that suicide rates are higher for people born in Eastern Europe in these localities than would be expected considering the percentage of the total population that these groups comprise as per the 2011 census. Between 2006 and 2015, 16% of suicides in Peterborough were by people born in Eastern Europe.

[34] Oxford Migration Observatory, 'Health of Migrants in the UK: What Do We Know?', 2014 http://www.migrationobservatory.ox.ac.uk/sites/files/migobs/Briefing%20-%20Health%20of%20Migrants%20in%20the%20UK_0.pdf

Figure 36: Suicide rate per 100,000 population 2012 By countries with highest representation in Peterborough

Country	Suicide rate 2012
Lithuania	30.7
Latvia	21.9
Slovenia	21.5
India	20.9
Estonia	18.3
Poland	16.7
Czech Rep	16
Romania	12.7
Portugal	12.5
Slovakia	11.5
Pakistan	7.5
UK	7.2

Source: extracted from World Health Organisation, 2012 Suicide mortality rate (per 100 000 population), by WHO region, by country, 2012, http://apps.who.int/gho/data/node.sdg.3-4-viz-2?lang=en

Higher rates of suicide in both EU A8 countries and among relevant populations that have migrated to England may be symptomatic of health and lifestyle behaviours that are known to be closely related to mental health issues including suicide. For example, evidence suggests a correlation between countries with higher rates of alcohol consumption and higher rates of suicide (Landberg 2008)[35]. Suicide rates are approximately three times higher in men than women in the UK and are also higher in men aged 35-44 as noted in the Cambridgeshire & Peterborough Suicide Prevention Strategy. As many economic migrants are aged between 25 and 39 this could also account for some of the difference in local suicide rates. Despite these possible explanations, the higher rate of suicide by people from Eastern European is of concern.

Dementia

There are increasing indications that the prevalence of dementia in Black African Caribbean and South Asian UK populations is greater than the white UK population (Turner et al, 2012[36]) and that the age of onset is lower for Black African-Caribbean groups than the white UK population. Since these groups are also more likely to experience high blood pressure, it is suggested that the

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[35] Landberg, J. (2008) Alcohol and suicide in Eastern Europe, Drug & Alcohol Review, 2008 Jul 27(4) 361-73
[36] Turner, D, Salway, S, Chowbey, P and Mir, G (2012) Mini Case Study Book Real world examples of using evidence to improve health services for minority ethnic people. http://clahrc-sy.nihr.ac.uk/images/health%20inequalities/resources/EEiC_mini_case_study_book.pdf

increased risk of vascular dementia contributes to increased prevalence (Adelman et al, 2009[37], Bhattacharyya, 2012[38]).

Factors affecting dementia awareness and diagnosis in BME groups

Information taken from Central and North West London NHS - David Truswell describing Black, Minority Ethnic and Refugee Communities and Dementia (Reflections from Implementing The National Dementia Strategy in London), suggests several factors that affect the prevalence and diagnosis of dementia in BME communities as follows:

1. Lack of awareness as well as social and cultural factors
2. An expectation of discrimination and/or lack of cultural competence from mental health services
3. Predisposing health factors e.g. South Asian and African Caribbean groups are at increased risk of developing vascular dementia - due to enhanced levels of diabetes and hypertension
4. Professionals' assumptions about lifestyle and care giving cultural norms may inhibit help-giving behaviour
5. Use of appropriately standardised diagnostic tools in assessments needs to be considered

Access to healthcare

The National Institute for Health and Care Excellence publication 'Improving Access to Health and Social Care Services for People Who Do Not Routinely Use Them'[39] states that key barriers to the access of services fall in to two broad categories:

- Structural and service characteristics, such as the structure, organisation and delivery of services and elements of delivery such as location and opening times.
- Population characteristics, including country of origin and cultural/attitudinal and lifestyle characteristics.

As with other themes included within this JSNA, barriers caused by language and cultural differences are considered a primary factor in the observed inequality regarding access to healthcare for some non-UK born populations in comparison to the wider population and resultant issues are likely to be exacerbated by any physical and/or mental health issues suffered by individuals. The East of England Regional Assembly Migrant Health Scoping Report[40] notes that many migrants fail to register with General Practices as a result of misunderstandings about how health services work and because of barriers faced when trying to do so, such as difficulty communicating without translation/interpreting.

GP services

[37] Adelman S (2009b) Prevalence and Recognition of Dementia in Primary care: A Comparison of Older African-Caribbean and White British Residents of Haringey. http://discovery.ucl.ac.uk/19622/1/19622.pdf
[38] Bhattacharyya, S & Benbow, S M (2012) Mental health services for black and minority ethnic elders in the United Kingdom: a systematic review of innovative practice with service provision and policy implications, International Psychogeriatrics
[39] NICE, Improving Access to Health and Social Care Services for People Who Do Not Routinely Use Them (2014), p.2
[40] Collis, A. et al, Migrant Health Scoping Report, East of England Regional Assembly (2009), p. 2

Ethnic mix of General Practices in Peterborough

Ethnicity of patients is recorded by general practices and this information can be analysed to compare ethnic mix between practices and across regions. Ethnicity is broken down into several categories, similar to those given in Census data (see chapter 3). The proportions of practice population registrants assigned to each ethnic category will be useful to commissioners and practice managers as they consider resources, initiatives and interventions that are appropriate for their population.

The general practices with the highest proportions of registered people with Asian Pakistani and Asian Indian ethnicities are shown in the next two figures. As expected, general practices in the more central Peterborough city areas have higher proportional registrations of people from the Asian communities, reflecting the Census data on where these communities reside.

Figure 37 - General Practices in the 'greater Peterborough' area with the greatest proportion of practice population registered as Asian/Pakistani by ethnic category (April 2015)

Practice name	Asian: Pakistani	White: British	Rank
Millfield Medical Centre, Peterborough	21.78	43.05	1
The Grange Medical Centre, Peterborough	17.54	54.83	2
Dogsthorpe Medical Centre, Peterborough	16.84	50.84	3
Thistlemoor Road, Peterborough	16.01	51.87	4
Welland Medical Practice, Peterborough	14.77	52.01	5
Huntly Grove, Peterborough	14.27	58.59	6
Westgate Surgery, Peterborough	13.69	54.66	7
Park Med Centre, Peterborough	11.07	59.78	8
63 Lincoln Road, Peterborough	10.00	65.09	9
Thomas Walker, Peterborough	9.84	64.62	10

Figure 38 - General Practices in the 'greater Peterborough' area with the greatest proportion of practice population registered as Asian/Indian by ethnic category

A different picture emerges for practices with higher proportions of registrations by people in the ethnic category Asian/Chinese. The practice with the greatest proportion of people registered with Chinese ethnicity is at Hampton Health (1.08%), which is located outside the city centre area of Peterborough (data not shown).

The proportion of patients registered as 'white other' with pratices in the Greater Peterborough system ranged from 1.79% (Jenner Health, Whittlesey) to 18.52% (Millfield practice). The general practices with 10% or more people registered as 'white other' are listed in the table below. The 'white other'category includes Eastern European ethnicities but also people from western Europe or the USA, for example.

Figure 39: General Practices in the 'greater Peterborough' area with over 10% of the practice population listed with ethnicity 'white other' (April 2015)

Practice name	% White: Other
Millfield Medical Centre, Peterborough	18.52
Parnwell Medical Centre, Peterborough	17.56
Thistlemoor Road, Peterborough	17.29
Welland Medical Practice, Peterborough	16.57
Dogsthorpe Medical Centre, Peterborough	16.08
Westgate Surgery, Peterborough	15.60
Park Med Centre, Peterborough	14.53
Huntly Grove, Peterborough	13.93
North St, Peterborough	12.65
Minster Practice, Peterborough	12.53
Thomas Walker, Peterborough	12.53
63 Lincoln Road, Peterborough	11.99
Westwood Clinic, Peterborough	11.39
The Grange Medical Centre, Peterborough	11.31
Old Fletton	11.06
Botolph Bridge, Peterborough	10.37

Source: Cambridgeshire & Peterborough Clinical Commissioning Group GP Statistics

Westwood clinic in central Peterborough has the highest proportion of people registered with Black Caribbean or black African ethnicities. However, there seems to be more dispersal of people with Black ethnicities registered to general practices across the Peterborough area, which reflects Census data on residential location of these communities.

Figure 40 - General Practices in the 'greater Peterborough' area with the greatest proportion of practice population registered as Black:African by ethnic category (April 2015)

Practice name	Black: African	White: British	Rank
Westwood Clinic, Peterborough	2.15	66.18	1
Nene Valley Medical Practice	2.15	80.48	2
Hampton Health	2.15	75.42	3
Orton Bushfield Medical Practice	1.91	81.53	4
Bretton Medical Practice	1.89	73.70	5
Parnwell Medical Centre, Peterborough	1.77	66.74	6
Botolph Bridge, Peterborough	1.77	76.52	7
Westgate Surgery, Peterborough	1.57	54.66	8
Welland Medical Practice, Peterborough	1.55	52.01	9
Millfield Medical Centre, Peterborough	1.48	43.05	10

Figure 41 - General Practices in the 'greater Peterborough' area with the greatest proportion of practice population registered as Black:Caribbean by ethnic category (April 2015)

Practice name	Black: Carribean	White: British	Rank
Westwood Clinic, Peterborough	0.98	66.18	1
Bretton Medical Practice	0.91	73.70	2
Parnwell Medical Centre, Peterborough	0.90	66.74	3
Paston	0.80	79.49	4
Hampton Health	0.76	75.42	5
Dogsthorpe Medical Centre, Peterborough	0.73	50.84	6
The Grange Medical Centre, Peterborough	0.73	54.83	7
Welland Medical Practice, Peterborough	0.73	52.01	8
Westgate Surgery, Peterborough	0.71	54.66	9
Park Med Centre, Peterborough	0.70	59.78	10

Changes in GP registrations of non-UK born residents

A measure of recent increases in needs for health services for non-UK born residents is gained from data recording new migrant GP registrations. The figure below shows new migrant GP registrations over a ten year period in Peterborough and across Cambridgeshire to assess trend. This information provides some insight into regions with faster growing migrant populations and the associated need for primary care services.

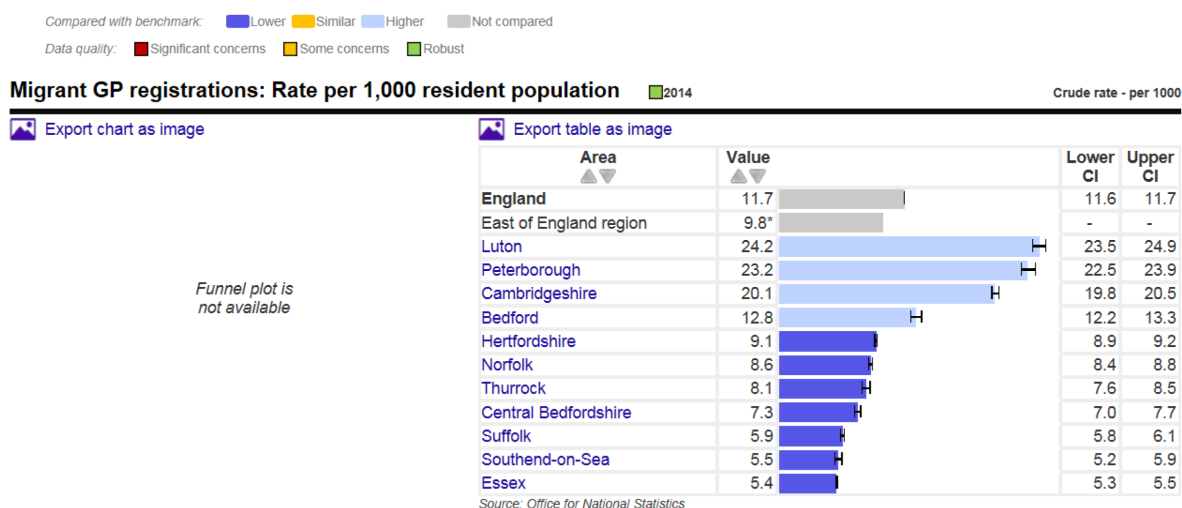
Figure 42: New Migrant GP Registrations, 2003/04 – 2014/15

Area	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
England	460,705	520,899	551,602	581,279	587,993	577,566	604,357	613,124	578,105	587,279	633,738
East of England	41,860	48,621	52,108	54,525	56,342	54,333	54,282	56,795	55,429	55,285	58,885
Peterborough	2,573	3,610	3,586	4,249	4,670	4,730	4,819	4,826	4,789	4,572	4,415
Cambridgeshire	8,270	9,301	9,653	9,711	11,229	10,837	11,222	11,683	11,474	11,889	12,868
Cambridge City	4,557	5,242	5,128	5,163	5,943	6,068	6,379	6,567	6,599	7,266	7,721
East Cambridgeshire	1,586	1,445	1,547	1,548	1,759	1,170	1,123	1,215	1,105	1,113	1,313
Fenland	585	627	1,086	999	1,324	1,291	1,405	1,538	1,464	1,374	1,249
Huntingdonshire	686	931	948	1,038	1,176	1,111	1,197	1,126	1,182	1,114	1,252
South Cambridgeshire	856	1,056	944	963	1,027	1,197	1,118	1,237	1,124	1,022	1,333

Source: Source: Office for National Statistics, Vital Statistics: Population & Health Reference Tables, URL: http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/vitalstatisticspopulationandhealthreferencetables

Data show that annual new migrant GP registrations have increased in Peterborough between 2003/04 and 2010/11 from 2,573 to 4,819. Since then they have shown a small decrease to 4415. When new migrant GP registrations are compared as a rate per 1,000 population across the eastern region, it is clear that Peterborough has the second highest recorded rate and Cambridgeshire third highest rate.

Figure 43: Migrant GP registrations as a rate comparing local authority areas across the Eastern region, 2014


Compared with benchmark: Lower Similar Higher Not compared
Data quality: Significant concerns Some concerns Robust

Migrant GP registrations: Rate per 1,000 resident population 2014 — Crude rate - per 1000

Area	Value	Lower CI	Upper CI
England	11.7	11.6	11.7
East of England region	9.8*	-	-
Luton	24.2	23.5	24.9
Peterborough	23.2	22.5	23.9
Cambridgeshire	20.1	19.8	20.5
Bedford	12.8	12.2	13.3
Hertfordshire	9.1	8.9	9.2
Norfolk	8.6	8.4	8.8
Thurrock	8.1	7.6	8.5
Central Bedfordshire	7.3	7.0	7.7
Suffolk	5.9	5.8	6.1
Southend-on-Sea	5.5	5.2	5.9
Essex	5.4	5.3	5.5

Source: Office for National Statistics

Source: Office for National Statistics

Although the rate of mew migrant GP registrations is lower overall in Cambridgeshire compared to Peterborough, Cambridge City has the highest rate within Cambridgeshire (almost three times the county average) – Figure 44 below.

Figure 44: New migrant GP registrations as a rate per 1,000 population, comparing Peterborough, Cambridgeshire and Cambridgeshire districts, 2014

District	Rate	Lower CI	Upper CI	Statistical Significance
Peterborough	23.2	22.5	23.9	High
Cambridgeshire	20.1	19.8	20.5	High
Cambridge City	60.1	58.8	61.4	High
East Cambridgeshire	15.2	14.3	16.0	High
Fenland	12.8	12.1	13.5	High
Huntingdonshire	7.2	6.8	7.6	Low
South Cambridgeshire	8.7	8.2	9.2	Low
England	11.7	11.6	11.7	-

Source: Office for National Statistics

Compared with benchmark Lower Similar Higher

New migrants who do not register with a GP

To describe the health needs of the non-UK born population, it is important to understand any unmet need in terms of the proportion of new migrants who do not register with a GP and may then either miss out on primary health care or use the health services inappropriately (George et al, 2011).[41]

It is problematic to obtain data to precisely reveal the proportion of new migrants who register with a GP and in most instances, the results of local surveys are used to this effect. A Cambridgeshire and Peterborough Eastern European migrant survey indicated that 93% of the 128 people who answered the question, said they were registered with a GP. However, this survey will not represent migrants

[41] George, A. et al (2011), Impact of migration on the consumption of education and children's services and thehe consumption of health services, social care and social services, National Institute of Economic and Social Research

from other diverse ethnic backgrounds. It also may not represent new migrants as 91.7% of the people who answered the survey had been living in the UK for more than one year. In addition, the survey results were heavily biased towards women migrants, who may be more likely to register with a GP. Research carried out in the South East found that registration rates were higher for females and those who had come with their spouse, children or parents. Furthermore, it was ascertained that young people (those aged under 25 years) and more recent migrants were least likely to register (Green, Owen, & Jones, 2008)[42].

Barriers to accessing primary care include language difficulties, differences in cultural norms and practical issues (Scullion and Morris, 2009, Humphries et al 2015)[43] [44]. Studies have also revealed that migrants who received accessible information were more likely to have registered with a GP (Humphries, 2015)[45]. In addition, migrant groups with the highest health needs are often the ones with the lowest proportion registered with primary care (Stagg et al, 2012)[46].

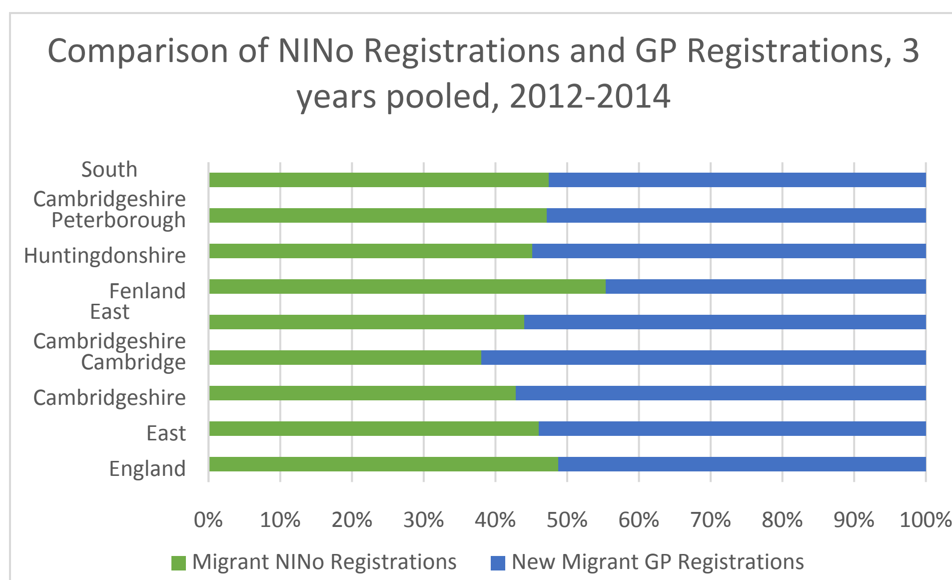
Comparing GP registrations to new National Insurance number registrations

It would be expected that every person registering for a national insurance number would also register with a GP and that the total number of new GP registrations by migrants will be greater than the total number of new national insurance number registrations, given that some migrants will have no need for a national insurance number – if they are children for example.

When the total number of new migrant GP registrations are comp[ared with the new National Insurance number registrations over a three year period, Peterborough showed a higher proportion of GP registrations compared with National Insurance registrations, as expected. (See fig 45 overleaf).

Figure 45 – Comparison of new migrant GP registrations with National Insurance number registrations, 2012 – 2014 for all Cambridgeshire districts and Peterborough

[42] Green, A. & Jones, P. (2008) Migrant Worker and Changing Economic Circumstances: Implications for Regional Labour Markets – The Case of the East Midlands in Recession, Institute for Employment Research, University of Warwick and Sheffield Hallam University
[43] Scullion, L. & Morris, G. (2009) A study of migrant workers in Peterborough, University of Salford
[44] Humphries, L. et al (2015) Migrant Workers Accessing Healthcare in Norfolk, Healthwatch Norfolk (1)
[45] Humphries, L. (2015) Migrant Workers Accessing Healthcare in Norfolk, Healthwatch Norfolk (2)
[46] Stagg, H. et al (2012) Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study, BMJ Open 2012, 2: e001453, doi: 10.1136/bmjopen-2012-001453



Source: Oxford Migration Observatory

Secondary care (hospital services)

With regards to secondary care use, there is evidence that the rate of admission to hospital among international migrants registering with a GP for the first time is only around half the overall national admission rate (with observed indirectly standardised admission ratios of between 56.0 and 57.0 compared to the England value of 100.0 over a three year period)[47]. As well as 'barriers to access', eincluding language and cultural factors, possible reasons for this difference in admission rates include a greater level of overall good health in international migrants than the general population (e.g. people travelling internationally for economic reasons are unlikely to have disabilities or serious illnesses and be relatively young) as well as the possibility that some international migrants might return to their country of origin for hospital treatment.

Irrespective of the reason(s) for this disparity, the data suggest that an increase in migrant population does not necessarily lead to an increase in burden on either primary or secondary healthcare services, although the aforementioned study does include caveats regarding the use of admission rates of economic migrants registered with a GP as an accurate barometer of true levels of demand. For example the registered population would not include migrants arriving at A&E departments without previously registering with a GP and reports of pregnant women who migrated for economic reasons presenting very late in pregnancy without having had a routine medical examination.

This perspective is further supported by the National Institute of Economic and Social Research (NIESR) which estimated that, despite the possibility of higher use of A&E by migrants, the overall annual expenditure on healthcare was £2,003 for British born and £1,602 for migrants in 2011 (George et al, 2011)[48].

[47] Steventon, A. & Bardsley, M., Journal of Health Services Research & Policy, Vol 16, 2, 90-94 (2011)
[48] George, A. et al (2011) Impact of migration on the consumption of education and children's services and the consumption of health services, social care and social services, UK Government

There are anecdotal descriptions of 'unnecessary' attendance at A&E by recent migrants, and this is explored further in Appendix A in relation to the Eastern European population. National research indicates that the picture may be complicated by confusion within GP practices themselves regarding what services they are obligated to deliver and to whom. The 2013 Department of Health paper 'Qualitative Assessment of Visitor and Migrant use of the NHS in England: Observations from the Front Line'[49] notes issues including confusion between primary and secondary providers with regards to the responsibility for treatment of economic migrants with pre-existing conditions such as diabetes resulting in referrals to A&E for inappropriate reasons, and a lack of consistency in approach between GPs.

The eradication of barriers to accessing appropriate healthhcare services for ethnic minority communities continue to be of kinterest to stakeholders across the health economy. An example of good practice In the London borough of Merton was a project between nurses, GPs and community workers, to develop a programme that supported ethnic minority and migrant communities, particularly in relation to their understanding of available healthcare. This was associated with a reduction in A&E attendances within the area of 15.6% between 2007/08 and 2011/12, from 84,537 to 71,374[50]. Although this fall cannot be attributed solely to reductions in A&E attendance among migrant/ethnic minority communities, one third of electoral wards had a majority ethnic minority population so it may be inferred that this targeted work contributed to a reduction in A&E attendance among the overall population.

Among migrants who registered with a GP, the Merton project found that lack of adequate translation and interpreting services can deny migrants access to the same quality of care as received by those who primarily speak English and this creates a risk around incorrect diagnosis and inappropriate care. Lack of informal support networks, mobility of migrant families and cultural differences are also observed as having an effect on both need and access to mental health and maternity services. The findings of the project are summarised in five 'key messages' for developing user friendly services for minority ethnic groups:

1. **Get to know your local communities:** Run workshops/collect survey data and apply findings to the modelling of service provision, tailoring need to meet the needs of minority ethnic communities.
2. **Work with others:** Efforts should be spread proportionally by need across social groups and geographical areas and partnerships should be developed across appropriate sectors to develop adequate support for people of all ages, across all communities.
3. **Build in time to develop trust:** Minority communities may have different beliefs and expectations about health and wellbeing services, including cultural differences developed by healthcare systems in their country of origin, such as experience of different financial models and perceived 'weakness' if admitting they are unwell. It may take time to help people understand the health services that are available to them and it is important to be realistic about expectations when setting up new services.
4. **Spread knowledge:** In Merton, it became apparent that people were using A&E services because they did not know what else was available. 51% of surveyed people were not aware of emergency out of hours services and the project emphasised the need to explain primary care, pharmacy and out-of-hours services at every contact and via translated posters and leaflets.

[49] Creative Research for the Department of Health, 'Qualitative Assessment of Visitor and Migrant use of the NHS in England: Observations from the Front Line (2013), p. 152

[50] Ford, A. et al, Cutting A&E Use and Health Inequalities, Nursing Times, Jun19-Jun 25, 109, 24 (2013)

5. **Look for 'quick wins':** Demonstrating how projects are making a difference to attitudes and behaviours is key to keep stakeholders motivated to take part, keep funders interested and build momentum.

Examples of good practice in primary care

There are some examples of good practice to encourage GP engagement with non-UK born residents:

- GP services having once a week drop in sessions with interpreters available – cost saving and effective. Improved access to community-based GPs and delivery of more appropriate care may lessen the impact on acute services (Hargreaves et al, 2006)[51]
- Marginalised and vulnerable adults service – Ipswich – provides initial GP appointments at double standard time as they appreciate language will be an issue – this is thought to prevent issues later in care

6. Recommendations

A number of recommendations are made to build on the findings of the Peterborough Diverse Ethnic Communities JSNA.

- The Cambridgeshire and Peterborough Clinical Commissioning Group, NHS England East, and local NHS providers should use the information about diverse ethnic communities in this JSNA when planning and delivering services. This will support the NHS duties to consider the needs of equalities groups and to reduce health inequalities.
- Healthcare Providers should review the quality and completeness of their recording of ethnicity in order to ensure that information is available on service use in relation to needs.
- Peterborough City Council should also use the information from the JSNA where relevant when planning and delivering services.
- Further work to engage with a range of minority ethnic communities in Peterborough should take place, similar to the engagement work with Eastern European communities for Appendix A of this report, and this should report back to the HWB Board.

APPENDIX A

Pilot work: Eastern European migrant population

7.1 Introduction & Overview

[51] Hargreaves, S. et al (2006) Impact on and use of health services by international migrants: questionnaire survey of inner city London A&E attenders

In recent years, there has been an increasing awareness of migrant workers coming to Peterborough, particularly since the enlargement of the EU in 2004 by the Treaty of Accession to the European Union to include an additional ten countries, eight of which are in Eastern Europe. These Eastern European countries - Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia are often referred to as the 'A8' countries and this term is used throughout the JSNA.

As part of the work on the Diverse Ethnic Communities JSNA - community and stakeholder surveys and a stakeholder event were held to further explore the views and needs of non-UK born residents from A8 countries on factors affecting their health and wellbeing. This has also been supplemented by some additional data analysis. This additional work has led to specific recommendations in relation to the health and wellbeing of A8 communities

It is intended to carry out similar community and stakeholder surveys/events events for other ethnic communities in Peterborough, in order to gain a better understanding of their views and health and wellbeing need. These will be brough to the Health and Wellbeing Board as additional appendices to this JSNA, with further tailored recommendations.

Health and health services

Key messages

- A higher rate of attendance at A&E at weekends by people of Eastern European origin than the general population has been described in Peterborough, although there are uncertainties in the data. The community survey results indicate a need to increase understanding of UK healthcare services, and explore mechanisms to adjust the GP offer for Eastern European migrants in some way.
- Anecdotal evidence highlights cultural differences in health beliefs of Eastern Europeans: There seems to be greater expectation for the medical and pharmaceutical management of minor health issues. There are concerns that it may be difficult to obtain referrals from GPs to a relevant specialist. There seems to be some stigma attached to mental health problems.
- Evidence suggests rates of smoking and excessive alcohol consumption are higher among some Eastern European communities, although rates of alcohol use amongst the individual respondents to the community survey were low. A8 migrants are utilising alcohol treatment services and smoking cessation services, but a lack of trust in health services may be a barrier for engagement as well as some perception that alcohol consumption is a 'way of life' and not a risk to health. Street drinking in the Eastern European population as part of social gatherings may create community tensions.
- Dental health is also an issue – some people from A8 countries present with high levels of untreated decay when they seek dental treatment.

Use of secondary care

Anecdotal evidence suggests that recent migrants – particularly Eastern European migrants, often use secondary care accident and Emergency services at higher rates than the non-migrant population or instead of accessing primary care services.

A project at Peterborough City Hospital placed a GP at the front entrance to the Emergency Department on Saturdays and Sundays between 09:00 – 21:00 to assess the needs of people using the service. This project recorded the ethnic background of people accessing the Emergency Dept. over a six month time period from November 2015 to April 2016.

The data was analysed in terms of the number and proportion of people with Eastern European (A8) backgrounds accessing the Emergency Department compared to all other ethnicities. Over the six month time period analysed, 196 out of a total of 1427, people (14%) who attended the A&E GP service at the weekend were of Eastern European (A8 countries) ethnic origin. This proportion is higher than that given for Eastern Europeans resident in the Peterborough area as provided by census data , although the census data is based on 2011 information. The figure is closer to the 12% of school children recorded as speaking an Eastern European language at home. The analysis therefore indicates there may be higher rate of attendance at A&E at weekends by people of Eastern European (A8) origin than the general population, although there are uncertainties in the data.

Use of primary care – stakeholder feedback

Anecdotal evidence from stakeholders included:

- Community: Health is very important for most of the A8 migrants, so they do register with GP as soon as they arrive in UK. The main concern around primary care is that the GP acts as a gatekeeper and it is very difficult to obtain referrals to a relevant specialist even with serious issues – there are difficulties in explaining the problems to the GP. Also there is an expectation to have blood tests if they have any concerns, but there is a feeling by A8 migrants that this it is not practiced in NHS system.
- Health professional: There are some different health beliefs are different in this population. There may be greater emphasis on use of prescriptions and antibiotics for minor illness. There seems to be a greater expectation for fast access to medical professionals by mothers with young children.

Community Survey

- 93.0% of respondents said they were registered with a GP practice, compared to only 60.6% registered with a local dental practice. 81.1% of people said they had visited a local hospital since arriving in England.
- Although 85.7% of respondents stated that their level of spoken English at least allowed them to participate in simple conversations and 87.1% said their level of written English allowed them to at least understand simple instructions, only 72.8% of respondents said that their understanding of UK healthcare services was 'reasonable' or 'good'. Respondents were asked to rate GP services on a scale of 1-5 (1 = very bad, 5 = very good) and for all categories, the average score provided was at least 3.1; when the same questions were asked about local hospitals, average scores were higher, ranging between 3.9 and 3.3. Respondents scored 'patient communication and respect' 3.1 for GPs and 3.9 for hospitals, suggesting a degree of variation with regards to this measure between GPs and hospitals. For maternity services, average scores were higher than for GPs and hospitals, ranging from 4.2 for accessibility and patient communication and respect to 3.8 for time effectiveness.

- 48.4% of survey respondents said they had not made any appointments for screening or immunisation with their local doctor/GP service (not all may have been due to have a screening test or immunisations) and 27.8% of applicable respondents (people aged 40-74) have had an NHS health check compared with 34.7% for the general Peterborough population.

Alcohol consumption

The World Health Organisation (WHO) estimates that in 2012, about 3.3 million deaths, or 5.9% of all global deaths, were attributable to alcohol consumption. In 2012 139 million DALYs (disability-adjusted life years), or 5.1% of the global burden of disease and injury, were attributable to alcohol consumption. There is also wide geographical variation in the proportion of alcohol-attributable deaths and DALYs, with the highest alcohol-attributable fractions reported in the WHO European Region. (http://www.who.int/mediacentre/factsheets/fs349/en/)

Figure 46: Comparisons of alcohol consumption between the UK and some Eastern European countries

Indicator	UK		Lithuania		Latvia		Poland	
	M	F	M	F	M	F	M	F
Total alcohol per capita (15+), drinkers only(in litres of pure alcohol)	18.9	8.5	33.3	13.5	26.5	10.1	31.5	14.0

Source: WHO country profiles, 2014: Latvia page 221; Lithuania p222; Poland p229; Romania p232; UK p246. http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_2.pdf?ua=1

It is clear from the table above that alcohol intake per capita is higher in Lithuania, Latvia and Poland than in the UK. There are potential knock-on consequences for health such as a higher risks of liver cirrhosis and road accidents. This data has potential implications for the health needs of the Eastern European migrant population of Peterborough which include people from Lithuania, Poland and Latvia.

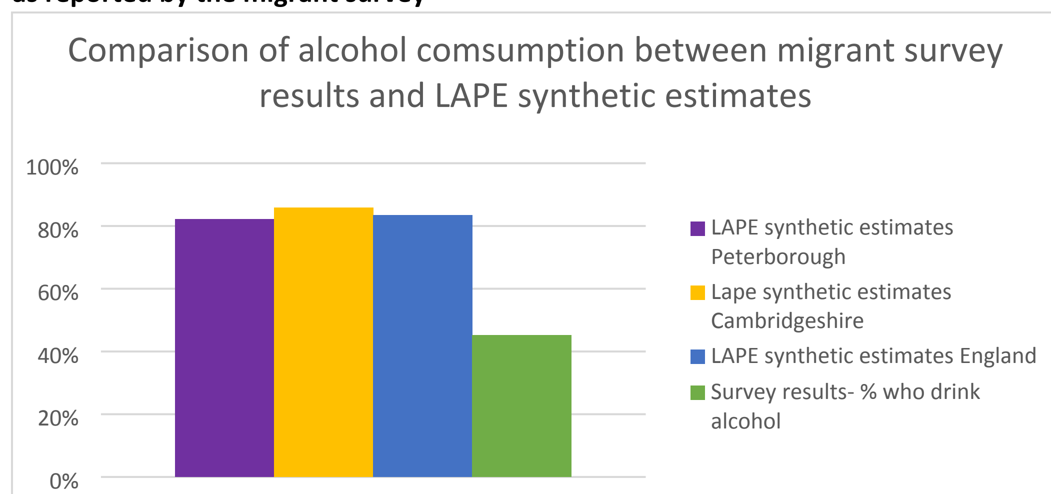
Community Survey

The Community Survey for migrants from A8 countries included the question :
'Do you drink alcohol? If so how often?'

Of the 126 people who answered this question, 54.8% declared that they do not drink alcohol and only 8.7% responding that they drink 3-5 times per week. The survey results show a lower percentage of people in the Eastern European migrant community drink alcohol than is estimated for the general population in Peterborough, Cambridgeshire and England (Figure 47 below).

This result contrasts with WHO data presented above and may indicate a more complicated picture of alcohol consumption in this population. It is important to note that 84% of respondents to the community survey were female, so the survey does not provide a clear picture of alcohol use among Eastern European males.

Figure 47 – Comparison of estimates of the proportion of people who drink in the general population of Peterborough, Cambridgeshire and England with the proportion who drink alcohol as reported by the migrant survey



Source: Mid-2009 synthetic estimates of prevalence taken from the Local Alcohol Profiles for England 2014 and applied to mid-2014 ONS population estimates

Fieldwork by voluntary sector organisation 'DrinkSense' in Peterborough in 2012/13 identified a number of key socio-cultural factors influencing drinking behaviour among young adults from Eastern European communities. The outdoor alcohol consumption perceived as 'street drinking' and usually associated by the British public with anti-social behaviour (ASB) is a common form of socialising unconnected with problematic street drinking in certain European countries, such as: Lithuania, Latvia, Portugal, Poland and Slovakia. These cultural differences lay at the foundation of perception of outdoor alcohol consumption, as this form of socialising is traditionally uncommon for the majority of the British public. As the WHO data also indicates, alcohol may play a significant role in these communities, especially in the consolidation of friendships during sessions of heavy drinking. This may be especially significant for a relatively young diaspora in the UK.

Use of health services for alcohol dependence

Until April 2016, DrinkSense provided an NHS funded community treatment service for people with alcohol problems, with routes to treatment including self-referral and referral from primary care (this has since been replaced by a new contract). Statistics from the DrinkSense alcohol treatment service 2014/15 showed that of 652 clients engaged in the service, 38 people (6%) were Eastern European. This proportion is similar to the proportion of the overall population referenced in the demography section of this paper but it should be acknowledged that individuals in contact with DrinkSense may have particularly extensive needs in relation to language and lack of understanding of UK health services that requires investment in engagement and liaison with relevant communities.

The hospital alcohol liaison service (HALP) places specialist alcohol workers in Peterborough City Hospital who engage patients admitted whose presenting problems may be alcohol related. The objective of this project is to reduce alcohol-related hospital admissions through early intervention. In 2015/16, 10.3% (85/823) of people seen by the HALP service in Peterborough City Hospital were from Eastern Europe. HALP data over the past five years has consistently shown around 10% of patients are European economic migrants This is a higher percentage than those self-referring into

community alcohol treatment services and may indicate that people from these communities are less likely to seek help from preventive services, before alcohol problems result in hospital attendance.

Smoking and tobacco

Fig 48 below shows that For European countries where data were collated, overall smoking prevalence was highest overall in Greece (31.8%), Bulgaria (29.2%) and Latvia (27.9%) and lowest in Slovenia (18.7%), Belgium (18.9%) and Malta (19.2%). In all countries, smoking prevalence was higher in males than in females and the gender difference with regards to consumption is highest in Latvia, where 46.0% of males consumed tobacco compared to only 13.0% of females. Unfortunately comparable statistics for the UK were not collected.

Figure 48: Smoking Prevalence, European Union Member States 2013-15* (Red = EU A8 Accession Countries)

Country	Total (%)	Male (%)	Female (%)	Gender Difference (% Points)
Slovenia	18.7	22.1	15.5	6.6
Belgium	18.9	21.1	17.0	4.1
Malta	19.2	23.8	15.1	8.7
Slovakia	19.3	26.9	12.3	14.6
Romania	20.5	32.7	9.1	23.6
Germany	22.8	25.5	20.3	5.2
Austria	22.9	26.8	19.3	7.5
Poland	23.8	30.9	17.9	13.0
Czech Republic	24.3	29.6	19.4	10.2
Spain	25.2	29.5	21.0	8.5
Estonia	25.9	39.5	15.1	24.4
Cyprus	25.9	37.9	14.3	23.6
Hungary	26.1	31.4	21.5	9.9
Latvia	27.9	46.0	13.0	33.0
Bulgaria	29.2	40.4	18.9	21.5
Greece	31.8	37.8	26.1	11.7

Source: Eurostat Tobacco Consumption Statistics, http://ec.europa.eu/eurostat/statistics-explained/index.php/Tobacco_consumption_statistics

Figure 49 shows smoking prevalence in Cambridgeshire and Peterborough in 2014. The national smoking prevalence is recorded as 18% but this may not be directly comparable with the European figures.

Figure 49: Smoking Prevalence, Public Health Outcomes Framework, 2014

Area	Smoking Prevalence
Peterborough	18.6
Cambridgeshire	15.5
Cambridge City	17.6
East Cambridgeshire	14.9
Fenland	21.2
Huntingdonshire	14.4
South Cambridgeshire	11.7
England	18.0

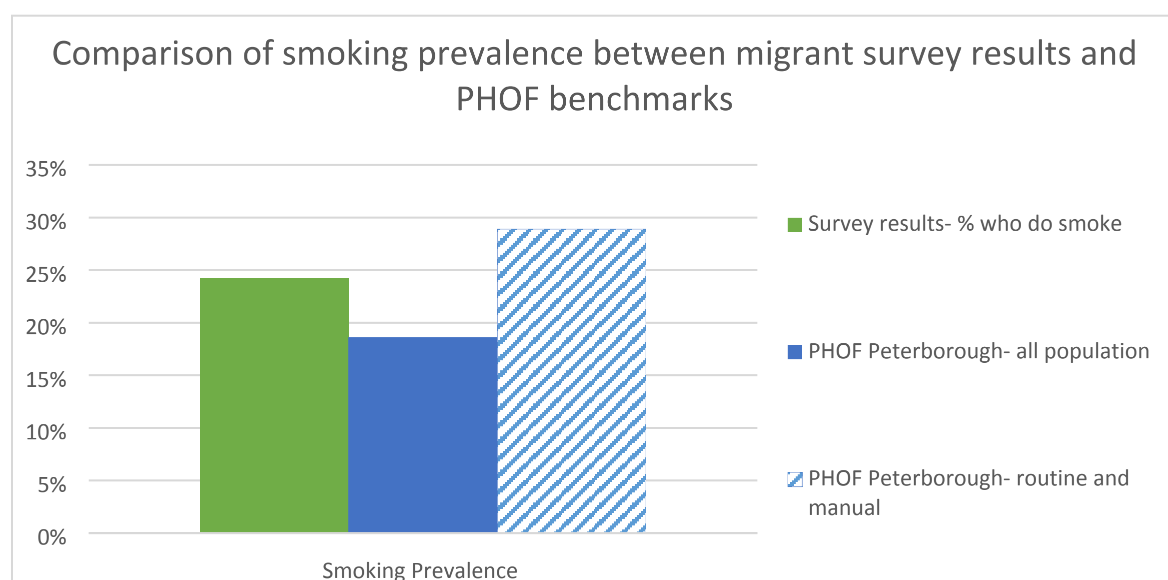
Source: Public Health Outcomes Framework, Indicator 2.14

Compared with benchmark: Better Similar Worse

Community Survey

The migrant survey for Cambridgeshire and Peterborough showed that 24.3 % of the respondents who answered the question – 'Do you smoke cigarettes?', said they smoked. This is higher than local overall smoking prevalence but similar to smoking prevalence in the local 'routine and manual' occupation groups for Cambridgeshire but lower than the 'routine and manual' group for Peterborough (Figure 50 below). Because 84% of the survey respondents were females, who usually have lower smoking rates in Eastern European countries, it is likely that actual smoking prevalence among Eastern Europeans in Peterborough is higher than 24.3%.

Figure 50: Comparison of smoking rates between the migrant survey results and PHOF benchmarks for Peterborough and Cambridgeshire



Source: Cambridgeshire & Peterborough Migrant Health Survey 2015/16 & Public Health Outcomes Framework

Residents of 'white other' ethnicity using the smoking cessation service in Peterborough

Peterborough smoking cessation service records information on the number of people classified as 'white other' who have used the service and 'set a quit date' or who have 'successfully quit'.

For the first three quarters of 2015/16, close to 20% of all 'quitters' (99 out of 488) were classified as 'white other' (any white ethnic group that isn't white Irish or white British), with similar numbers of men and women represented. This suggests that Eastern European migrants are engaging with the service, although caution should be applied as more detailed information on country of birth is not available.

It has also been reported by stakeholders that a high proportion of people attending the smoking cessation service from some GP practices are from migrant Eastern European backgrounds.

Oral Health

Across Europe, oral disease (disease involving the mouth and/or teeth) constitutes a major public health burden and significant oral health inequalities exist both within and between individual member states in terms of severity and prevalence. The burden is attributable principally to dental caries, periodontal disease and oral cancer.[52] Oral disease not only impacts on the individual by causing pain and discomfort as well as a broader impact on quality of life, but also increases need for relevant health services. [53] Despite a global decline in dental caries, the disease still remains a problem for many groups in Eastern Europe and for those from socioeconomically deprived groups in all European Union member states. Numbers of decayed, missing and filled teeth due to caries are higher for Central and Eastern Europe than the European average and significant proportions of children are in need of care.

Data from surveys carried out in Poland show that only 64% of school children brushed their teeth at least twice a day and 70% consumed sweets 'every day or several times a week'.[54] Several studies conducted in Eastern Europe have shown that school health education programmes can be instrumental in development of healthy lifestyles in oral health as well as general health.

It is estimated that over 50% of European populations may suffer from some form of periodontal disease and over 10% have severe periodontal disease; additionally, trends in oral cancer are now showing an increasing incidence in women and young adults.[55] Access to dental services in Eastern Europe is variable and the quality of dental services is inconsistent. Ensuring access to oral health care services remains a major health problem among vulnerable and low income groups, including migrant populations, for whom aforementioned barriers regarding language and culture as well as prohibitive cost may discourage attendance.

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[52] Patel R. September (2012). The state of oral health in Europe. Report commissioned by the Platform for Better Oral Health in Europe.

[53] Peterson P. (2003). World Health Organisation, Changing oral health profiles of children in Central and Eastern Europe, Challenges for 21st Century. URL: http;//www.who.int/oral_health/media/en/orh_eastern_europe.pdf p.2

[54] Peterson P. (2003). World Health Organisation, Changing oral health profiles of children in Central and Eastern Europe, Challenges for 21st Century. URL: http;//www.who.int/oral_health/media/en/orh_eastern_europe.pdf p.3

[55] Boyle P, Levin B. (2008). World cancer report. Lyon. International Agency for Research on Cancer

IARC International Agency for Research on Cancer GLOBOCAN (2008) (c) WHO

Community and Stakeholder Surveys

The Community Survey results show that 60.6% of respondents had registered with a dentist. A survey of dental staff working in Peterborough and Wisbech Dental Access Centres (DAC) outlines the following broad trends with regards to oral health of the local Eastern European migrant population:

- People tend to present with high levels of untreated decay and are often in high levels of pain and distress when they seek dental treatment.
- Levels of previous dental care often appear to be relatively poor and treatment issues are exacerbated by a lack of education and understanding regarding personal oral health
- Many patients report that they cannot find NHS dentists willing to accept them for treatment and that it is not possible for them to attend scheduled appointment times due to fear or loss of income or losing their jobs altogether. Anecdotal evidence suggests that appointments may be accepted but then not attended, primarily for the aforementioned reasons, which increases the 'Did Not Attend' rate of local Dental Practices.
- There is potential for the NHS payment system resulting in high needs patients being refused care as these patients are not seen to be 'financially viable'. Further research would be required to assess this issue, and the suggestion that dental appointments within standard working hours are difficult to attend for migrant workers.

7.2 Children & Education

Key Messages

- 12% (4,126 pupils) of all school pupils speak an Eastern European A8 language at home in Peterborough. This proportion is higher in primary schools (13.5%) compared with 9.9% in secondary schools.
- Three of the five primary schools with the highest percentage of pupils speaking an EU A8 language are located in the East electoral ward, with one school in Central and one in Bretton North.
- The most commonly spoken EU A8 language among pupils of school age is Polish (42.2%), followed by Lithuanian (27.7%) and Latvian (10.6%).
- Although academic attainment as measured by outcomes in the early years foundation stage profile, key stage 2 and at GCSE level has improved between 2013 and 2015 in Peterborough for pupils who primarily speak a Central or Eastern European language at home, attainment remains below that of pupils who primarily speak English.
- Communication with parents can be problematic due to poor English skills, and to parents not being clear who to speak to about issues or difficulties. Parents may work 'unsocial' hours and may not available to attend meetings at the school. Pupils may arrive to join a school throughout the school year, which can make it more difficult to address language needs.

Introduction

This section explores the demographics of schools across the region in terms of ethnicity of pupils and language spoken at home. Educational achievement is reviewed in terms of language spoken at home at key points in the educational system. The issues of pupils from Eastern European backgrounds are highlighted where information is available.

Demographics

The ethnic category 'any other white' includes Eastern European migrants. In Peterborough, 16% of school pupils are 'white other' compared with 10.6% of people of all ages recorded in the 2011 Census. This suggests that either the population of 'white other' has increased in Peterborough since 2011 or there are proportionately more school aged 'white other' people than there are in the general population.

Figure 51: Comparisons of the proportion of pupils classified as 'white other' across Cambridgeshire and Peterborough 2015 School Census & 2011 Census

Area	Any Other White (School Census 2015)	Any Other White (Census 2011)
Peterborough	16.0%	10.6%
Cambridgeshire	8.3%	7.1%
Cambridge City	14.9%	15.0%
East Cambridgeshire	6.9%	5.6%
Fenland	10.4%	5.9%
Huntingdonshire	5.7%	4.5%
South Cambridgeshire	6.7%	5.0%
Cambridgeshire & Peterborough	10.6%	7.9%

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census & Census 2011

Eastern European (A8) pupils in Peterborough

The school census data records information on the primary language spoken at home by pupils. This information has been analysed to identify the proportion of pupils in Peterborough and Cambridgeshire who speak an European Union A8 language at home – Czech, Estonian, Hungarian, Latvian, Lithuanian, Polish, Slovak or Slovenian.

Overall, 12% (4,126 pupils) of all school pupils speak an Eastern European A8 language at home in Peterborough. This proportion is three times higher than for the whole of Cambridgeshire. This proportion should be compared with the school Census information above that records 16% of Peterborough pupils as 'white other' in ethnicity, suggesting that the majority of the 'white other' pupils are from Eastern European countries. The proportion of pupils who sperak an Eastern European language at home are higher among primary school age pupils in comparison to secondary school age pupils, (13.5% in primary schools compared to 9.9% in secondary schools and 14.1% in 'other' schools). This suggests that the proportion within secondary schools will increase in coming years.

Figure 52: The proportion of school age pupils across Peterborough, Cambridgeshire and Cambridge districts who speak an Eastern European A8 language at home

Area	Number and Percentage of Pupils Speaking EU A8 Primary Language							
	Primary		Secondary		Other*		All Schools	
	Number	%	Number	%	Number	%	Number	%
Peterborough	2,422	13.5%	1,415	9.9%	289	14.1%	4,126	12.0%
Cambridgeshire	2,100	4.4%	879	2.8%	17	1.8%	2,996	3.8%
Cambridgeshire & Peterborough	4522	6.9%	2,294	5.1%	306	10.3%	7,122	6.3%

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census & Census 2011

*'Other' schools includes infant schools, junior schools, pupil referral services and special schools.

Primary school pupils in Peterborough who speak an Eastern European language

Analysis of data for each primary school in Peterborough showed a range of between 0% and 36.4% of pupils who speak an Eastern European language at home. Three of the five primary schools with the highest percentage of pupils speaking an EU A8 language (all over 30% of pupils) are located in the East electoral ward, with one school in Central and one in Bretton North.

Eastern European language spoken at home by school aged pupils

The figures below show the proportion of primary school children who speak each Eastern European A8 language. The most widely spoken Eastern European language spoken by primary pupils is Polish, followed by Lithuanian, Slovakian, Latvian and Czech

Figure 53: The language spoken at home by pupils who speak an Eastern European A8 language – Peterborough Primary Schools, School Census 2015

Percentages	Czech	Estonian	Hungarian	Latvian	Lithuanian	Polish	Slovakian	Slovenian	EU A8 Total	All Other	Total
Peterborough (In Comparison to All)	1.0%	0.0%	0.3%	1.4%	3.7%	5.7%	1.4%	0.0%	13.5%	86.5%	100.0%
Peterborough (In Comparison to other EU A8 Only)	7.1%	0.1%	1.9%	10.3%	27.6%	42.2%	10.5%	0.2%	100.0%	-	-

Source: Cambridgeshire County Council & Peterborough City Council Education Data, 2015 School Census

Educational attainment of pupils assessed in relation to the primary language spoken at home

- Educational attainment is covered in the main body of this JSNA which gives details of educational achievement of pupils who do not speak English at home from early years education through to GCSE performance. It shows that, in general, educational attainment at Foundation stage, Key stage 2 and GCSE is lower for pupils who speak a language other than English at home, and this is most marked for pupils who speak an Eastern European language. However the improvement in attainment between 2013 and 2015 has also been fastest for pupils speaking an Eastern European language at home.

Stakeholder Suvery - Eastern European (A8) pupils in secondary education in Peterborough

The specific needs of Eastern European pupils identified by a stakeholder survey of secondary schools in Peterborough include the following:

- Isolation – this concern reduces as the numbers of Eastern European pupils increase in a school. Immersion of new arrival students into the mainstream school helps to limit isolation
- English language acquisition – this occurs faster when pupils are integrated with other students
- Language barriers for Eastern European parents – communication with parents can be difficult. There is anecdotal evidence that Eastern European parents may not attend parent's evenings as much as the general population and this may be due to both language barriers and work commitments, with parents working 'unsocial' shifts and therefore not being available to attend parent's evenings.
- There may be difficulties engaging with Eastern European parents to discuss students with problems in school due to behaviour or attendance. Parents may not know where to go for help if their child is having difficulties or what services are available and how to access them.
- Some families do not acknowledge mental health as a problem and students may be embarrassed, ashamed or afraid to speak about mental health issues
- Domestic violence at home is mentioned anecdotally as an issue that arises for some pupils
- Attendance may sometimes be affected for Eastern European pupils due to visits to home countries
- Eastern European pupils may sometimes have low aspirations
- Cultural differences can create issues

There is evidence that the arrival of children of economic migrants at a time other than at the scheduled start of the school year (e.g. due to arrival in the country mid-term) creates difficulty for schools in meeting relevant language needs and can also lead to difficulties in maintaining records of a child's education progress if the economic necessity leads to the child moving from school to school throughout their education[56].

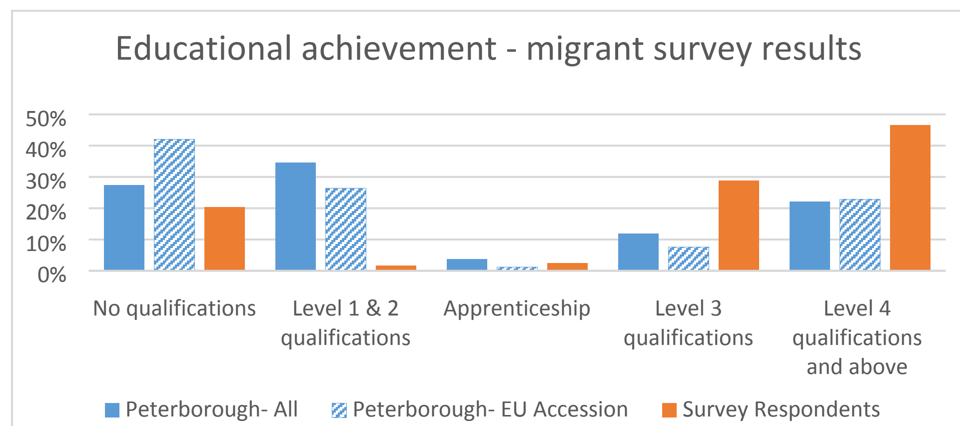
Community Survey

Educational attainment level in the migrant population – results from the migrant survey

The Community survey asked a question to determine the educational attainment level of respondents. The results are presented in the figure below and are compared with the general population and also people from EU accession countries living in Peterborough and Cambridgeshire (as recorded in the 2011 Census).

[56] George, A. et al, 'Impact of Migration on the Consumption of Education and Children's Services and the Consumption of Health Services, Social Care and Social Services, 2011 P.23

Figure 54 – Educational attainment level of migrants responding to the migrant survey compared with the general population and people from EU accession countries in Peterborough and Cambridgeshire



Source: Peterborough City Council/Cambridgeshire County Council Survey Data

This chart shows that whereas non-Uk residents born in EU accession countries were more likely than all Peterborough residents to have no qualifications according to the 2011 Census, respondents to the Community Survey are more likely to have a higher level of qualifications than average. Therefore the survey may not be fully representative.

7.3 Employment

Key Findings

- Peterborough has a higher proportion of Non-UK born residents who are employed compared with both England and the East of England (63.3%, compared with 56.7% and 61.2%, respectively).
- Evidence suggests that A8 migrants may often work in low-skilled, seasonal jobs that are low-paid and may be subject to zero-hours contract. The migrants are employed in these type of jobs because of poor English language skills, yet many migrant workers work below their skill level. Seasonal and shift work makes it difficult for migrant workers to make contact with services or seek help when needed. It also has an impact on social life and leads to isolation.
- Migrants can face financial challenges when work 'dries up' or if they cannot work due to sickness. Eviction from housing is often a consequence of financial difficulties and loss of work.
- Employment issues can arise due to low levels of understanding or lack of appropriate information about work entitlements, employment rights, holiday or sickness pay, access to benefits such as tax credits, or how the tax system works.
- The migrant survey showed that 21% of respondents said they have concerns about their safety at work on at least some days.

- Some community stakeholder feedback indicated that modern slavery and human trafficking is an issue, although being addressed by police and local authority.
- Language is a barrier to employment – the youth coming to UK have good knowledge of English, but the older migrants, especially those who work in factories/fields have less ability and struggle to find time to study. Certified ESOL provision can be expensive.

Legal rights of A8 nationals in the UK

A8 nationals currently have the same rights as any other workers from the EU and European Economic Area (EEA). These rights include:

- the general right to 'free movement' within the EU/EEA.
- the right to live in the UK for up to three months and longer if the person is able to support themselves financially
- the right to live in the UK as a student
- the right to seek work
- the right to work
- the right to enter self-employment or set up a business

Other rights depend on whether the EEA national is classified as a 'worker' as follows:

- currently employed
- temporarily unable to work because of sickness or an accident
- were working for at least one year and are now registered as a jobseeker
- were in work but are now in vocational training
- unable to work due to pregnancy or childbirth as long as there is an intention to return to work within a 'reasonable period', usually 52 weeks

EEA migrants cannot claim income-based Jobseeker's Allowance until they have been in the country for three months. Jobseeker's Allowance can only be claimed for a total of 91 days. All EEA nationals who are receiving Jobseekers Allowance are not able to access Housing Benefit. An EEA national who has lost their job and has worked for less than one year can be classified as 'a worker' for six months after losing their job, and claim Jobseeker's Allowance. An EEA national who has worked in the UK for more than a year before becoming involuntarily unemployed may be able to claim income-based jobseeker's allowance for longer than six months if they can provide 'compelling' evidence that they have a genuine chance of finding work.

Employment rates

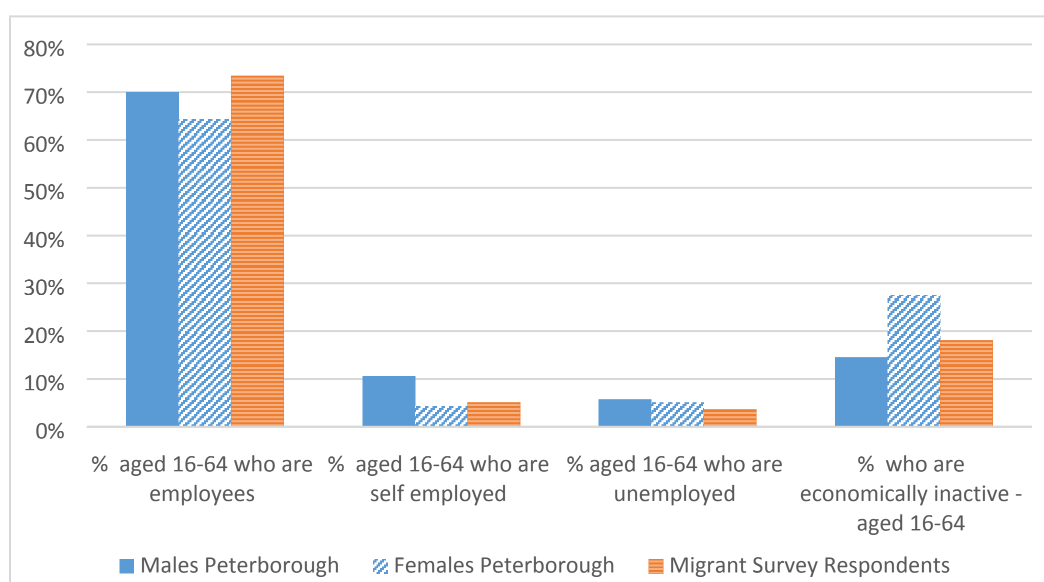
Data shown in Section 2 of this JSNA showed that a higher proportion of Peterborough's non-UK born residents are employed compared with both England and the East of England (63.3%, compared with 56.7% and 61.2%, respectively).

Community Survey Results – employment status

The Community survey included questions around employment status and the results are shown in the figure below, which compares the migrant survey result with the general population of Peterborough.

139 people answered the survey question about employment. The summary survey results are presented as an appendix at the end of this document.

Figure 55: Results of the migrant survey in relation to questions about employment status, comparing survey results with the general population of Peterborough



Source: Cambridgeshire & Peterborough Migrant Healthy Survey 2015/16

The Community survey results show a slightly higher proportion of migrants in employment as employees than the general population for both sexes. Unemployment is lower than the general population of Peterborough. The proportion of migrants describing themselves as 'economically inactive' is lower than Peterborough females and higher than males. The migrant survey respondents were predominantly female and this may explain the finding shown.

This data indicates that Eastern European migrants are predominantly settling in Peterborough for employment and are economically active.

Safety at work

An area of concern that arose from the migrant survey results was that of safety in the workplace. 21% of 105 respondents who answered a question about how safe they feel in their working environment said they have concerns about their safety on at least some days.

Issues identified in the Eastern European community in Fenland and Peterborough

Information on issues that arise in Eastern European migrants to Fenland was obtained from Cambridgeshire Human rights and Equality Support Services (CHESS) - an organisation that provides advice to migrants within the Fenland area on housing and Employment. In addition, the findings of a Peterborough migrant study in 2009 are included where consistent issues were identified[57].

- Often migrants work in low-skilled, low-paid jobs and may be subject to zero-hours contract. When the work is finished, the worker is left with no job and no money until the next job arises.
- There is a lack of understanding or lack of appropriate information (in an accessible form – translated into a range of Eastern European languages) about work entitlements, holiday or sickness pay.
- There is a lack of appropriate information on how to access benefits such as tax credits, child tax credits or how the tax system works – how to make tax payments, what the tax codes mean. Some people end up in financial difficulties as a result.
- There is a lack of information about employment rights including issues around discrimination, injury at work, disciplinary actions or dismissal
- Financial difficulties occur due to sickness or zero hours contracts. Eviction from housing is often a consequence of financial difficulties and loss of work.
- Shift work makes it difficult for migrant workers to make contact with services or seek help when needed.

In 2009, of the Eastern European migrants to Peterborough who were involved in the study, 69% were currently working within the Peterborough urban area. The others worked in surrounding counties or further afield - Lincolnshire, Cambridgeshire, Northamptonshire; Bedfordshire and Leicestershire. The majority of respondents worked in elementary occupations (77%). Around 70% of people had experienced a decrease in occupational level from their last job in their home country.

Stakeholder feedback about employment issues

Anecdotal information from a community stakeholder about employment for new migrants indicated that :

Newcomers usually start agency work, and mainly work in the fields. Most who come to work in seasonal employment over the summer, experience the worst working conditions. The migrants are employed in these type of jobs because of poor English language skills. Most agencies employ on zero hour contracts, which are temporary and not stable positions. This is convenient to the agencies as they can call any person to work when it suits them. This can have an impact on social life and can lead to isolation. People may be scared to take days off because of illness, as they fear that the agency will terminate their contract and they will lose their job.

Modern slavery and human trafficking is an issue, although this is 'in hand' by police and local authorities.

Language is a barrier to employment – youth coming to the UK have a good knowledge of English language, but the older generation, especially those who work in factories or in fields have less

[57] Ethnic & Racial Studies (2011), Journal Volume 34:12, December 2011

ability and time to learn English. The working hours may restrict their time to be able to study. ESOL courses can be expensive for migrants.

Information for Peterborough Eastern Europeans is obtained through social media, like Facebook. There is a Lithuanian magazine 'Svyturys', which is issued quarterly.

Anecdotal evidence from a health professional highlighted issues relating to sickness and work. There may be a requirement for a GP certificate in order to 'sign off' someone from work due to sickness. Without this, the migrant worker may not receive pay. In addition, long hours of physical work experienced by some migrants has lead to muscular-skeletal problems. Stress and problems achieving a good work/life balance have also been noted as potential issues related to long working hours in this population.

7.4 Housing

Key Findings

- The majority of respondents to the Community Survey live in rented accommodation, with 39% living in shared rented housing. This compares with 54% of the general population in Peterborough living in rented housing and only 2% living in shared rented accommodation.
- It is very difficult to access affordable housing for newly arrived migrants from EU countries. 17.2% of the current applications for social housing were made by people from A8 countries
- The numbers of Eastern European rough sleepers have sharply increased over the last 12 months and currently there are around 24 Eastern European rough sleepers on any night in Peterborough. These people may have multiple and complex needs including alcohol abuse.
- A selective licencing scheme has been approved locally for Peterborough within 22 Lower Super Output Areas. This will help to ensure greater enforcement of accommodation standards in relation to private rented accommodation and houses of multiple occupancy (frequently used by the Eastern European migrant population)

National research on migration and accommodation

Data from Oxford University's Migration Observatory[58] show that there are several observed key distinctions between migrant populations and UK-born populations in 2015:

- Only 43% of migrants own their own homes, compared to 68% of UK-born residents.

- The UK's migrant population is almost three times as likely to be in the private rental sector (39% of migrants were in this sector in quarter one 2015, compared to 14% among the UK-born population).

- Migrants who have been in the UK for five years or less are almost twice as likely to be renters compared to all migrants, with 74% of people within this group renting. Where

[58] Vargas-Silva, C., Migrants and Housing in the UK: Experience and Impacts, 2015

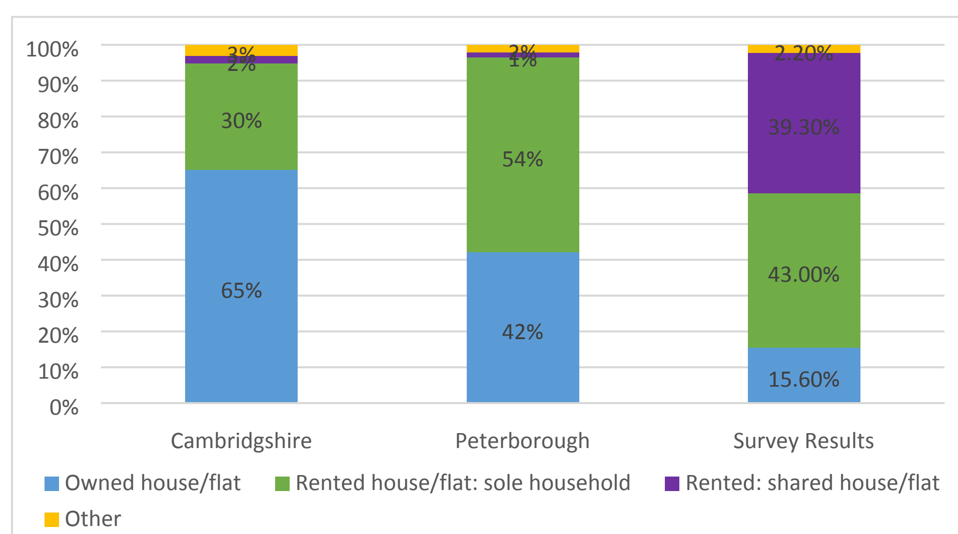
migrants have been in the UK longer than five years, patterns of ownership are relatively similar to that of the UK-born population.

- 17% of the UK-born population live in social housing, compared to 18% of the non-UK born population.

Accommodation used by Eastern European migrants locally

The Community survey asked a question about accommodation. The results are shown in the figure below and reinforce the key findings from Oxford University's Migration Observatory above. 82% of migrants who answered the survey question live in rented accommodation, with 39% living in shared rented housing.

Figure 56: Cambridgeshire and Peterborough Community survey results for accommodation type. Comparison between the proportions of migrants and the proportions of the general population in Cambridgeshire and Peterborough using different types of accommodation



Source: Cambridgeshire & Peterborough Migrant Healthy Survey 2015/16

The results also show that a much smaller proportion of migrants are owner occupiers compared to the general population.

Housing quality

Living conditions tend to be poorer in shared rented houses, particularly in houses of multiple occupation (HMO), where issues related to overcrowding may arise. HMOs of poor standard may present health hazards, for example problems with damp and mould can affect respiratory systems, problems with pests such as rats, mice or cockroaches can create unhygienic environments and spread diseases. A cold home that lacks effective heating and insulation could affect health, particularly in vulnerable people.

Safety hazards in the home may include fire risks, faulty wiring and the risk of carbon monoxide poisoning.

A Peterborough study on the local migrant population (2009) assessed the views and experiences of migrant workers in terms of a range of factors, including accommodation in predominant migrant groups to Peterborough in 2008/09 – Polish, Czech, Slovak, Portuguese and Lithuanian communities.

The research showed a dominance of the private rented sector amongst the migrant population of Peterborough - 51% of 278 migrant people interviewed were renting through private landlords. Almost half of these said they had no tenancy agreement.

There were 60 cases of bedrooms being shared by more than three people. Issues highlighted by the survey included problems with landlords, particularly in relation to conditions of properties. The condition of properties was also an issue creating tension between migrant communities and other local residents.

A recommendation that came from this research was the need to ensure greater enforcement of accommodation standards in relation to private rented accommodation.

Local Authority housing

Data from Peterborough City Council –housing showed that 17.2% of the current applications for Local Authority housing (all EEA countries including British) were made by people from A8 countries. 550 applications currently on the housing register were from residents from A8 countries out of a total of 3201 registrations for housing.

Homelessness in the Eastern European population

15.4% (20/130) of people who answered the local migrant survey said they had been at risk of homelessness. The Peterborough migrants study (2009) found that lower skilled migrants are more vulnerable to homelessness; however, anecdotal evidence also suggests that some people will opt for living in tents as a cheap means of accommodation.

In 2010, Peterborough recorded one of the highest rates of rough sleeping outside Westminster, with around 60 people sleeping on the streets at any one time, many of whom were Eastern Europeans. A response to this was formed in the development of the 'administrative removal project' between the City Council and UK Border Agency. This project facilitated the 'Administrative removal' of Eastern European rough sleepers who had refused other assistance. Alongside this project the City Council facilitated a 'reconnection project' which enabled those who were sleeping out to return to their home countries with dignity and respect. The running of these two projects saw a decrease in rough sleeping to approximately 15 people per night by 2015. However, the numbers of Eastern European rough sleepers has increased over the last 12 months and currently there are around 20 Eastern European rough sleepers on any night in Peterborough. This increase may be related to changes to welfare benefits for Eastern European nationals in 2014. Alcohol dependency is described as an issue for the majority of Eastern European people who are sleeping rough. The rough sleeper outreach service offers support and signposting to those who are eligible and rough sleeping to enable them to receive support in filling in forms, completing a C.V and helping to find employment. If they are unwilling to engage with services and are not eligible for assistance, they can be served with a notice by the Home Office through the administrative removal project.

Stakeholder feedback

Anecdotal community stakeholder feedback stated that social housing was perceived as cheaper, more secure and reliable than private rented accomodation. Problems for migrants occur when dealing with housing agencies including the requirement for guarantors, permanent contracts and

high application fees. It is difficult for new migrants to access affordable housing. One of the outcomes of this issue is homelessness.

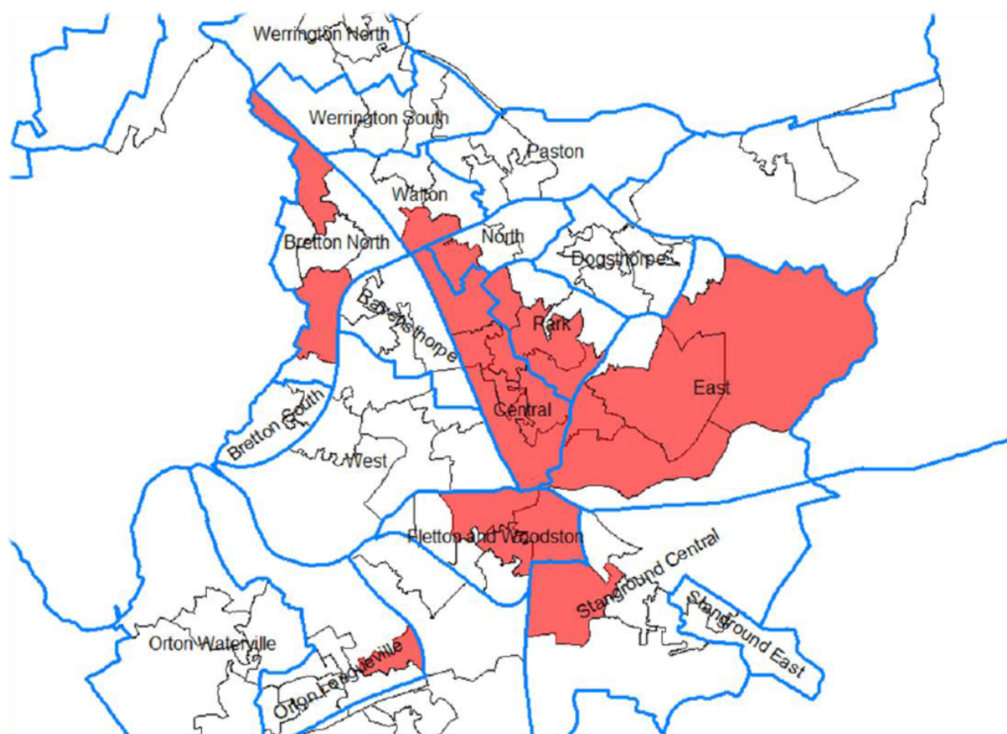
Selective Licencing

The Housing Act 2004[59] has given local authorities the power to introduce selective licensing of privately rented properties to improve conditions for tenants and the local community, if there is a high level of privately rented housing stock in the area and one or more of the following criteria are met:

a) The area is suffering from low housing demand
b) The area is experiencing a significant and persistent problem caused by anti-social behaviour
c) The area is suffering from poor property conditions
d) The area has high levels of migration
e) The area has high levels of deprivation
f) The area has high levels of crime

In Peterborough, the City Council Cabinet has approved selectively licensing within 22 Lower Super Output Areas (geographical areas with an average of 1,500 residents) in the Central, North, East, Park, Fletton, Bretton North, Stanground Central, Walton and Orton Longueville areas. These areas are known to have high proportions of Eastern European residents (data from census and school census). The scheme is proposed to cover 6,205 properties representing 4.8% of the city's geographic area and will initially last for five years.

Figure 57: Peterborough City Council – Proposed Selective Licensing Areas



Source: Peterborough City Council, Adult Services & Communities Directorate

[59] http://www.legislation.gov.uk/ukpga/2004/34/contents

Selective Licensing in Peterborough also needed national government approval from the Secretary of State to proceed, and this was granted in August 2016. Upon introduction, it will mean that all private landlords with residential property in designated areas will need to apply for a licence for each property. A landlord will need to meet a certain standard to become a licence holder and the licence will last for five years.

By introducing Selective Licensing, it is hoped that the quality, management and safety of all private rented properties in the designated areas will improve.

7.5 Specific Recommendations

In addition to the general recommendations made in Section 6 of the main Diverse Ethnic Communities JSNA (page 48), the following specific recommendations are made to support the health and wellbeing of Eastern European communities in Peterborough, based on the information in this Appendix. Some of these recommendations are similar to those made in a recent Migrant and Refugee JSNA for Cambridgeshire, so there may be scope for joint work across both Councils and the Cambridgeshire and Peterborough Clinical Commissioning Group to address them.

Recommendations for addressing need in the Eastern European migrant population in Peterborough

- Assess current information available to new migrants and create an up-to-date 'information' pack in appropriate languages that covers childcare, nurseries, school admissions, the health system, the tax system, housing, employment and benefit rights, and other useful local information. This 'pack' should be accessible online or through social media, potentially using video and the spoken word as well as written information. Dissemination and awareness raising of the information pack should be through public sector bodies including schools as well as through employment agencies and community forums for Eastern European residents. This recommendation is similar to one made in Cambridgeshire, giving scope for joint work. In Cambridgeshire the need of some local UK-born residents for clear verbal and simple written information on these issues was also highlighted – so it was agreed that the materials developed should be designed to be useful to new migrants and to other local residents.
- Continue the role of Peterborough City Council's 'community connectors' from Eastern European communities, to help disseminate information including the 'information packs' and build trust between communities.
- Improve appropriate use of primary care and the GP offer for A8 migrants – review primary care services for migrants taking into account issues around access, trust, communication difficulties and referral pathways. Further explore health beliefs of Eastern European migrants to understand cultural differences
- Improve opportunities for English language classes - Review current availability and funding to identify gaps and opportunities, taking into account the 'unsocial' hours many migrants work

Annex 1 - Results of Community Health Survey

The Public Health departments of Cambridgeshire & Peterborough ran an open survey in quarter 4 2015/16 to ask predominantly Eastern European migrant communities about their experiences of issues including housing, employment and public services in the UK. The survey was advertised via the Cambridgeshire County Council and Peterborough City Council websites, social media accounts and via local promotion through key stakeholders such as the Rosmini Centre in Wisbech and Community Connectors employed by Peterborough City Council. The survey was available electronically and in paper-based formats in English, Polish and Lithuanian and help with translation was made available to anyone who required it. Key findings and full results are presented below:

Key Findings:

- **The majority of survey respondents are originally from Lithuania (39.9%), Poland (22.9%) or Latvia (17.6%). 61.0% of respondents (94 people) are aged 31-45 and 84.3% (129 respondents) are female. Additionally, 46.6% respondents stated they had attended a university. 61.7% of respondents (82 people) live in Peterborough and 51 people (38.3% of respondents who answered the question) live in Cambridgeshire.**

- **Whilst interpreting these survey results, it should be acknowledged that the response data will, by definition, provide findings that relate only to people sufficiently engaged with local government/local services to wish to complete a survey of this nature and be sufficiently literate to do so in either English, Polish or Lithuanian. Paper copies were provided upon request so it is not necessarily the case that the results are biased towards the ICT-literate, although the survey was only publicised to the general population electronically, via Cambridgeshire County/Peterborough City Council websites and Facebook. For the aforementioned reasons, results may therefore not be representative of migrant populations with particularly high levels of aversion to involvement with government/local authorities, high levels of deprivation and/or low levels of literacy.**

- **93.0% of respondents said they were registered with a GP practice, compared to only 60.6% registered with a local dental practice. 81.1% of people said they had visited a local hospital since arriving in England.**

- **Although 85.7% of respondents stated that their level of spoken English at least allowed them to participate in simple conversations and 87.1% said their level of written English allowed them to at least understand simple instructions, only 72.8% of respondents said that their understanding of UK healthcare services was 'reasonable' or 'good'. Respondents were asked to rate GP services on a scale of 1-5 (1 = very bad, 5 = very good) and for all categories, the average score provided was at least 3.1/5; when the same questions were asked about local hospitals, average scores were higher, ranging between 3.9 and 3.3. Respondents scored 'patient communication and respect' 3.1/5 for GPs and 3.9/5 for hospitals, suggesting a degree of variation with regards to this measure between GPs and hospitals. For maternity services, average scores were higher than for GPs and hospitals, ranging from 4.2/5 for accessibility and patient communication and respect to 3.8/5 for time effectiveness.**

- **48.4% of survey respondents said they had not made any appointments for screening or immunisation with their local doctor/GP service and only 27.8% of applicable respondents (people aged 40-74) have had an NHS health check.**

- **75.7% of respondents said they did not smoke cigarettes and 54.8% said they did not drink any alcohol, which may be a reflection of the mainly relatively highly educated, female and young population that responded to the survey, as epidemiological evidence from Europe suggests that rates of alcohol and tobacco consumption, as well as associated disease prevalence, are higher in Eastern European countries than in England.**

- **73.4% of survey respondents said they were employed and, when asked to rate their working conditions on a scale of 1-5 (1 = very bad, 5 = very good), respondents scored 'treatment and respect' 3.8/5, working hours and working conditions 3.7/5 and opportunity for advancement and wage 3.4/5. 36.1% of respondents said they had obtained their current employment via an employment agency.**

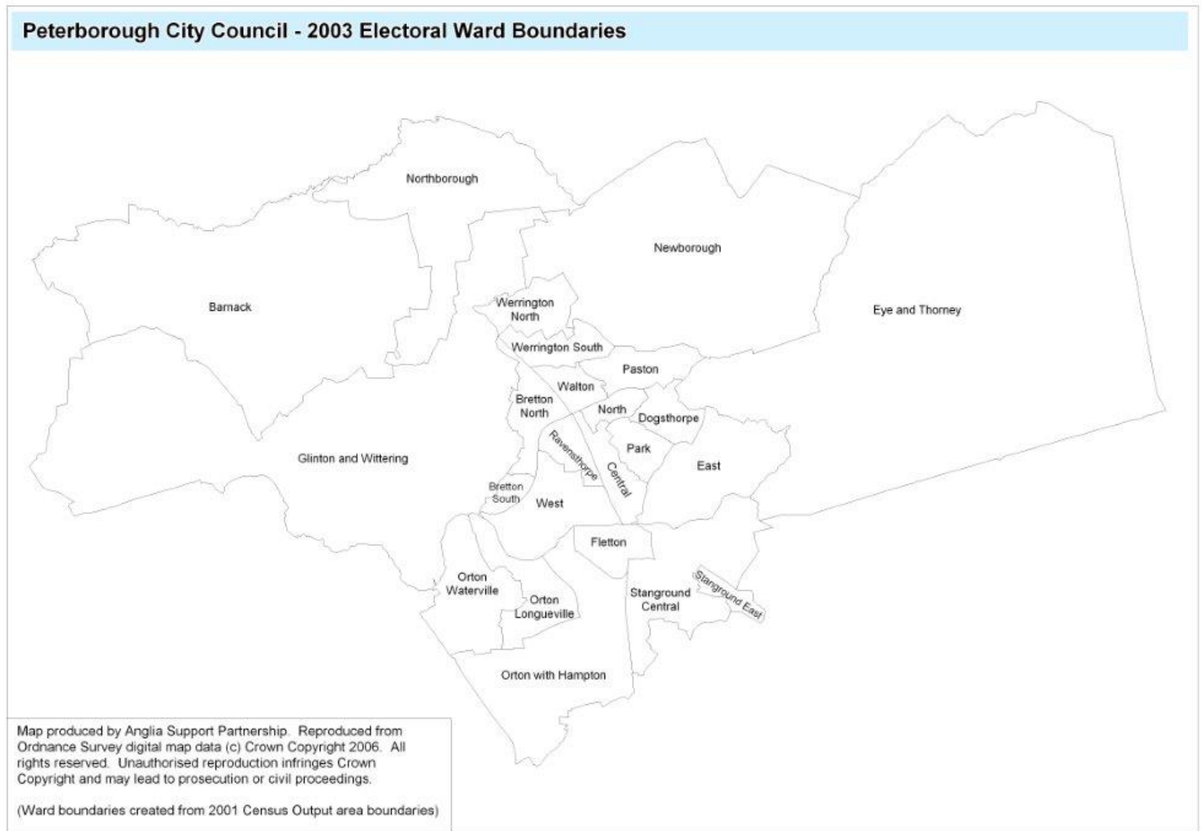
- **55.2% of people said they felt community services were accessible but only 49.5% said that the services provided are effective.**

- **61.9% of people said they had no worries about their safety at work, with 38.1% expressing at least some reservation about workplace safety. Conversely, 63.1% said they did worry about their safety at least 'sometimes' in their living environment, with only 36.9% saying they had no worries.**

- **Only 32.9% of respondents said they had used a translation service, but of those who had, the average response for overall service on a 1-5 scale (1= very bad, 5= very good) was 4.0/5.**

- **65.2% of respondents said they had been living in the UK for at least 5 years and 52.6% said they intended to reside in the UK permanently. Only 1.3% said they had conclusive plans to leave the UK within the next year. Only 15.6% of people said they owned the property within which they lived (either outright or with a mortgage), with the remaining 84.4% renting/room-sharing. 74.0% of respondents said they had lived in the current accommodation for at least one year.**

Appendix B - Peterborough City Council Electoral Ward Boundaries 2003-2016



Note: Data used in this JSNA uses electoral ward boundaries from 2003-2016 as illustrated on the above map.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6
22 SEPTEMBER 2016		PUBLIC REPORT
Contact Officer(s):	Dr Martin Stefan, Deputy Medical Director, CPFT	Tel. 01223 726762

SUSTAINABILITY AND TRANSFORMATION PROGRAMME MENTAL HEALTH STRATEGY: "WORKING TOGETHER FOR MENTAL HEALTH IN CAMBRIDGESHIRE AND PETERBOROUGH – A FRAMEWORK FOR THE NEXT FIVE YEARS"

R E C O M M E N D A T I O N S	
FROM : Cambridgeshire and Peterborough Sustainability and Transformation Programme (STP)	**Deadline date :** N/A
The Health and Wellbeing Board is asked to endorse the Mental Health Strategy, subject to any comments the Health and Wellbeing Board have.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from the Cambridgeshire and Peterborough Sustainability and Transformation Programme (STP). It describes the STP Mental Health Strategy document "Working together for Mental Health in Cambridgeshire and Peterborough", which has been discussed and endorsed by the STP Clinical Advisory Group (CAG) and is scheduled for discussion by the STP Health and Care Executive on 12 September 2016.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to bring to the Board's attention the Mental Health Strategy document "Working Together for Mental Health in Cambridgeshire and Peterborough – a framework for the next five years" which has been prepared by the Cambridgeshire and Peterborough Sustainability and Transformation Programme.

2.2 The need for such a document was identified by, among others, Councillor Tony Orgee, Chair of the Cambridgeshire Health and Wellbeing Board, who wrote in February 2015 that "there appeared to be no overall joint strategy for Mental Health" and questioned how a number of separate mental health strategies either existing or in development were to be brought together and progress made towards a joint strategic approach to adult mental health.

2.3 The Sustainability and Transformation Programme has prioritised the development of a coherent joint strategic document for Mental Health, and this has been underpinned by a number of national developments including the publication of the recommendations of the National Taskforce for Mental Health ("The Five Year Forward View for Mental Health").

2.4 Delivery of the strategy will be monitored through a MH Strategy Group as part of the STP Delivery programme.

2.5 This report is for Board to consider under its Terms of Reference No. 3.3.

3. BACKGROUND

3.1 The full report is appended as an Appendix to this paper.

3.2 Our strategic approach will focus on three areas:

- Prevention: promoting mental health and preventing mental illness.
- Community based care: developing an integrated approach to community based person centred care, focused on intervening early.
- Specialist care: timely acute, crisis and inpatient care when it's needed. Paying particular attention to admission and discharge processes, the management of interfaces between services and social services support.

3.3 The changes set out in the Five Year Forward View for Mental Health are being resourced through an anticipated £1bn additional national investment for mental health by 2020/21. We expect to receive a proportion of this investment locally. We estimate that our share of this additional investment should equate to approximately £12.8m by 2020/21 (based on the funding formula in use in June 2016) but it is important to note that our high level costing work suggests that this level of additional investment is unlikely to be sufficient by itself to achieve full implementation of the Five Year Forward View or all of the priorities set out in this strategy.

3.4 The national priorities for 2015/16 investment, IAPT, CAMH community eating disorder services, and early intervention in psychosis, have already received additional investment. We have also invested Vanguard funding in a community based first response service for mental health. Whilst we know there will continue to be national priorities for this investment, we also have local priorities which are key to ensuring that we create and maintain sustainable and effective mental health services in Cambridgeshire and Peterborough. There is work underway in the vast majority of these priority areas but often not at the scale needed.

3.5 Key local and national priorities for investment and further work are set out in the Report (see in particular Table 1 for priorities over the next two years).

3.6 This document does not currently encompass Learning Disabilities or Dual Diagnosis. However there is a clear recognition that these are areas of priority for further work, and Dual Diagnosis (ie concurrent substance misuse/mental health problems) in particular will be integral to the development of plans for enhanced primary care and crisis services and will be developed as a strand of the strategy. Work on dementia is being developed separately through a dementia strategy, and once available will also be incorporated.

4. CONSULTATION

4.1 Although this strategy document has been produced by a small working group, we have drawn on work which has been carried out by many people and organisations over the past few years, including a large number of discussions with service users, carers and representatives of partner organisations, as well as existing mental health strategies.

5. ANTICIPATED OUTCOMES

5.1 A joint outcomes framework for mental health across the health and social care system will be developed alongside specific, prioritised and fully costed investment cases for new developments.

6. REASONS FOR RECOMMENDATIONS

6.1 Mental Health problems represent the largest single case of disability in the UK. The cost to the economy is estimated at £105bn a year. Despite policy and strategic initiatives at national level to improve outcomes for people with mental health problems, challenges with system wide implementation and increases in demand have led to inadequate provision and worsening outcomes in recent years. Achieving parity of esteem for mental health,

improving outcomes, delivering national priorities and defining and prioritising local ones requires a coherent strategy implemented at local system level

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Continuing the separate development of mental health strategies, with the associated risk of a lack of coordination and integration between them.

8. IMPLICATIONS

8.1 A joint mental health strategy is now in existence. This will require further and detailed development, including the development of an outcomes framework and specific, prioritised and fully costed investment cases. A Mental Health Strategy Board, under the auspices of the STP, will be established.

9. BACKGROUND DOCUMENTS

9.1 The draft report, as submitted to the STP Health and Care Executive on 12 September 2016, is attached as an Annex and contains references to other relevant background documents.

10. APPENDICES

10.1 Appendix 1 – Working Together for Mental Health in Cambridgeshire and Peterborough – A Framework for the Next Five Years

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Working together for Mental Health in Cambridgeshire and Peterborough

A framework for the next five years

DRAFT 05.09.16

Emma de Zoete	Cambridgeshire County Council and Peterborough City Council Public Health
Martin Stefan	Cambridgeshire and Peterborough NHS Foundation Trust
Emma Tiffin	Cambridgeshire and Peterborough Clinical Commissioning Group
Marek Zamborsky	Cambridgeshire and Peterborough Clinical Commissioning Group

for the Cambridgeshire and Peterborough Sustainability and Transformation Programme

Contents

Working together for Mental Health in Cambridgeshire and Peterborough 3
A framework for the next five years 3
1. Where are we now? 6
  1.1. Local Mental Health strategies 6
  1.2. What people have told us about mental health services in our communities 6
  1.3. Main JSNA messages 7
2. Where do we want to be in five years' time? 9
  2.1. Our Vision for Mental Health 9
  2.2. The Main Building Blocks 9
  2.3. Our main priorities 13
    2.3.1. Our first local priority: promoting mental health and preventing mental illness... 19
    2.3.2. Our second local priority: developing community-based, person centred care including intervening early where possible 19
    2.3.3. Our third local priority: timely acute, crisis and inpatient care when it's needed. 22
  2.4. How will we deliver our vision? 23
  2.5. Principles of Collaboration and Logistics 24
    2.5.1. A common language 25
    2.5.2. Joint outcomes 25
    2.5.3. Information and data sharing 25
    2.5.4. Workforce development 25
    2.5.5. Property co-location 25
    2.5.6. Joint commissioning, including the voluntary and community sector 25
Annex A: Task Force Priorities 27
Annex B: Existing Links to Local Strategies 28
Annex C: Key local data 29
Annex D: Potential local implications of the Five Year Forward View for Mental Health: calculations and assumptions 35
Annex E: Further information on invest to save priorities 36

Working together for Mental Health in Cambridgeshire and Peterborough

A framework for the next five years

This document has been written as part of our Sustainability and Transformation Programme. It sets out the key priorities and next steps for our health and care system to achieve the aspirations of the Five Year Forward View for Mental Health, alongside our local Sustainability and Transformation Programme plans, and work to implement the Care Act.

Although it has been produced by a small group, we have drawn on work which has been carried out by many people and organisations over the past few years, including a large number of discussions with service users, carers and representatives of partner organisations, as well as existing mental health strategies.

Executive Summary: Headlines

There are three clear themes from strategy work to date:

- **Sustainability:** prevention, early intervention, and attention to the broader determinants of health (such as housing and jobs) are crucial for our system to be sustainable.
- **Integration** between physical and mental health care is not as good as it needs to be. Outcomes for people with physical and mental health problems are poor and there are cost-effective things we could be doing to improve this.
- **Capacity and Demand:** services for people with mental health problems are really stretched, and there are problems at the interfaces (for example between primary and secondary care; health, social care and other organisations; services for children and adults).

The Five Year Forward View for Mental Health, the Care Act 2014 and our local Sustainability and Transformation Plan set out clearly what needs to change. In delivering these changes our approach will focus on three areas:

- **Prevention:** promoting mental health and preventing mental illness.
- **Community based care:** developing an integrated approach to community based person centred care, focused on intervening early.
- **Specialist care:** timely acute, crisis and inpatient care when it's needed**.** Paying particular attention to admission and discharge processes, the management of interfaces between services and social services support.

The changes set out in the Five Year Forward View for Mental Health are being resourced through an anticipated £1bn additional national investment for mental health by 2020/21. We expect to receive a proportion of this investment locally. We estimate that our share of this **additional investment should equate to approximately £12.8m by 2020/21** (based on the funding formula in use in June 2016) but it is important to note that our high level costing work suggests that this level of additional investment is unlikely to be sufficient by itself to achieve full implementation of the Five Year Forward View or all of the priorities set out in this strategy. The national priorities for 2015/16 investment, IAPT, CAMH community eating disorder services, and early intervention in psychosis, have already received additional investment. We have also invested Vanguard funding in a community based first response service for mental health (see Box 3 for detail). Whilst we know there will continue to be national priorities for this investment, we also have local priorities which are key to ensuring that we create and maintain sustainable and effective mental health services in

Cambridgeshire and Peterborough. There is work underway in the vast majority of these priority areas but often not at the scale needed.

Our vision for mental health is:

'That health and care services for people living with long term conditions, mental health problems or advancing age are sustainable, designed with the people and communities who use them around their needs and support them to be resilient, independent and enabled.'

Key Priorities for 2016/17 and 2017/18

The key priorities for investment and focused work in 2016/17 and 2017/18 are set out below. The table combines nationally set priorities, as set out in the Five Year Forward View for Mental Health, and local priorities.

Table 1: Key priorities for investment and focused work 2016/17 and 2017/18

Pathway	2016/17	2017/18	Local focus	National aims**
Centrally led Task Force priorities*				
Perinatal mental health	X		Improved access through specialist service provision and community provision in line with NICE stepped provision. 2016/17 further work to baseline current service provision, allocate investment and commission new services. Taken forward through perinatal mental health network group as part of STP work on Children and Maternity.	By 2020/21, increase access to specialist perinatal mental health support in all areas in England, in the community or in-patient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence based treatment.
Crisis care	X		Plans in place for core/core 24 liaison psychiatry service standards (by 2020/21) in all acute trusts. Further implementation of our community based first response model to the whole CCG, subject to success of pilot and funding. Continued implementation of crisis concordat action plan.	By 2020/21, all acute hospitals will have all-age mental health liaison teams in place and at least 50% of those will meet the 'Core 24' service standard as minimum.
CAMH emergency, urgent, routine	X		Continued work on the development and implementation of the ithrive model. New children's mental health service model commissioned, including primary mental health support , counselling in localities, and crisis/liaison services in acute trusts. Developing a co-commissioning approach with NHS England.	By 2020/21 at least 70,000 additional children and young people each year will receive evidence-based treatment. Local transformation plans refreshed by Oct 2016, and annually.
Integrated mental and physical healthcare pathways	X	X	Focused prevention and screening initiatives amongst those with serious mental illness (SMI). Smoke free mental health facilities by 2018. Access to psychological therapies (including IAPT) for Long Term Conditions (LTCs) and Medically Unexplained Symptoms (MUS), psychosis, bipolar affective disorder, depression and personality disorder. Supporting self-care for those with LTCs to have mental health support embedded within it.	By 2020/21 25% of people with common mental health disorders will access services each year. Majority of services integrated with physical healthcare with 3,000 new mental health therapists co-located in primary care.

Primary Care				
Health trainer access for those with SMI	X	X	Improved access to health trainers for those with SMI. Initially investment made in 2016/17. Further work to align with other initiatives supporting self-care for LTCs.	By 2020/21 A reduction in premature mortality of people living with severe mental illness (SMI). 280,000 more people having full annual physical health check. Physical care interventions to cover 30% of population with SMI on the GP register in 2017/18, moving to 60% in 2018/19.
Social prescribing Medication management Peer experts/mentor and community health resilience building/navigators	X	X	Learn from pilot and scale up enhanced primary mental health care. This will provide additional mental health resource/capacity within primary care for managing those with mental health problems of moderate to high severity and disability but who are stable, and have risk levels that can be managed in a primary care based service, with support from recovery coaches for those stepping down from secondary care. We will also integrate and/or develop interface with newly expanded neighbourhood teams, who will support those with deteriorating SMI. Further work to link existing community health/navigators within these models, and supported self-care.	
Wider determinants				
Housing support Employment support Debt/benefit advice	X	X	Further work to scope potential for delivering improved services on housing, debt and employment services, and interface with enhanced primary care, supported self-care and neighbourhood teams.	A doubling in access to individual placement and support (IPS), enabling people with severe mental illness to find and retain employment.
Support for carers		X	Further work on supporting carers including well defined support pathways for carers.	
Primary Prevention				
Suicide prevention	X	X	Continued implementation of multi-agency suicide prevention strategy and findings of suicide audit (2016/17).	By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.
Anti stigma campaign work		X	Initial campaign work focused on young people, and suicide for 2016/17. Build further joint cross system campaigns for 2017/18.	
Staff wellbeing programmes (non-NHS & NHS)	X	X	Programmes commissioned, or underway. Further work and investment to scale these up, with mental health as part of wider staff wellbeing programmes.	Continued implementation of health initiatives for NHS staff.
Improved resilience for children and young people Mental health skills/knowledge of professionals and parents.	X	X	Further development of the 'thrive' element of the ithrive model. 2016/17 focus on redesign and commissioned model. Non-recurrent funding for 2016/17 focused on development areas.	

Key: *Adapted from p.36 'The five year forward view for mental health'. See Annex A for a full copy of the five year table.
**Taken from 'Implementing the five year forward view for mental health'. NHS July 2016.

Next Steps

Table 2 shows what this means for our local system, and Table 3 illustrates much of the work already underway to take forward these priorities. The purpose of this strategy is to describe our collective system wide priorities on mental health so we can track progress

against these. Overall progress in implementing this combined strategy will be reported through the STP. The principles of collaboration and logistics outlined in this document will underpin this work.

1. Where are we now?

1.1. Local Mental Health strategies

A number of documents about our local mental health strategy have been published, but they are not as joined up as they need to be.

We do not seek to duplicate or repeat in detail these previously published and agreed strategies. Links to them are at the end of this document. The purpose of this document is to place them in an overarching framework, and to describe how we will work together to implement our shared vision for Mental Health.

Across all the strategy work that our system has carried out in recent years, three common themes stand out:

- **Prevention:** early intervention and attention to the broader determinants of health (such as housing and jobs) are crucial for our system to be sustainable.
- **Integration:** between physical and mental health care is not as good as it needs to be. Outcomes for people with physical and mental health problems are poor and there are cost-effective things we could be doing to improve this.
- **Capacity and Demand:** services for people with mental health problems are really stretched, and there are problems at the interfaces (for example between primary and secondary care; health and social care; services for children and adults).

1.2. What people have told us about mental health services in our communities

Throughout our engagement with service users, carers, clinicians, commissioners and other partner organisations, a number of inequalities and gaps in the provision of mental health care have been identified, and a number of consistent themes have emerged, particularly around access and crisis.

In general, people have told us they are concerned about:

- A lack of linkage and coordination between services with the need to improve communication and better sharing of information.
- Variable access to different types of services (in general and during crisis).
- A lack of open access services.
- A gap between GP care and access to specialist services.
- Fear of a “cliff edge” when service users are discharged from specialist mental health services.
- Evidence of poor access to services, particularly when a crisis may be developing, creating an escalation of need.
- The need to join-up services which support individuals, such as benefits and housing advice, with overall provision.
- Recognition of the vital role of peer and carer support.

These service issues and views reflect how the entire health system delivers mental health services alongside its partners. It is clear that we cannot look at one part of the system without considering the whole. To radically improve access to mental health services, people have said that we need to remove the barriers between GPs and hospitals and physical and mental health, and that we need to think of healthcare alongside support for the wider factors which influence mental health including employment, housing, benefits and support for families and carers.

1.3. Main JSNA messages

- With a growing population, Cambridgeshire and Peterborough has growing numbers of people with mental illness. In 2016, it was estimated that over 88,000 adults (aged 18-64 years) in Cambridgeshire and Peterborough have a common mental health disorder – by 2021 this figure will be 95,200, and by 2026 it will be 97,500.

- Suicide rates have been consistently higher than England rates in Peterborough (although this was not always statistically significant) until a drop was seen in 2012/14, making Peterborough’s rates statistically similar to the England average.

- Hospital admissions rates for self-harm in those aged under 25 years are above the national average in both Cambridgeshire and Peterborough, with Peterborough the highest in the East of England.

- Patterns of service use suggest that acute ‘crisis’ services are being used more for mental health in Cambridgeshire, and particularly in Peterborough, when we compare with other areas. This is not explained by differences in population need.

- People with two or more long term conditions are seven times more likely to have depression.[1] Overall this means that locally there are an estimated 18,000 adults with two or more long term conditions with mental ill health and/or limitation, and a further 10,500 people aged 65 and over in these groups.

Further detail and references on key local data is provided at Annex C.

[1] The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.

2. Where do we want to be in five years' time?

2.1. Our Vision for Mental Health

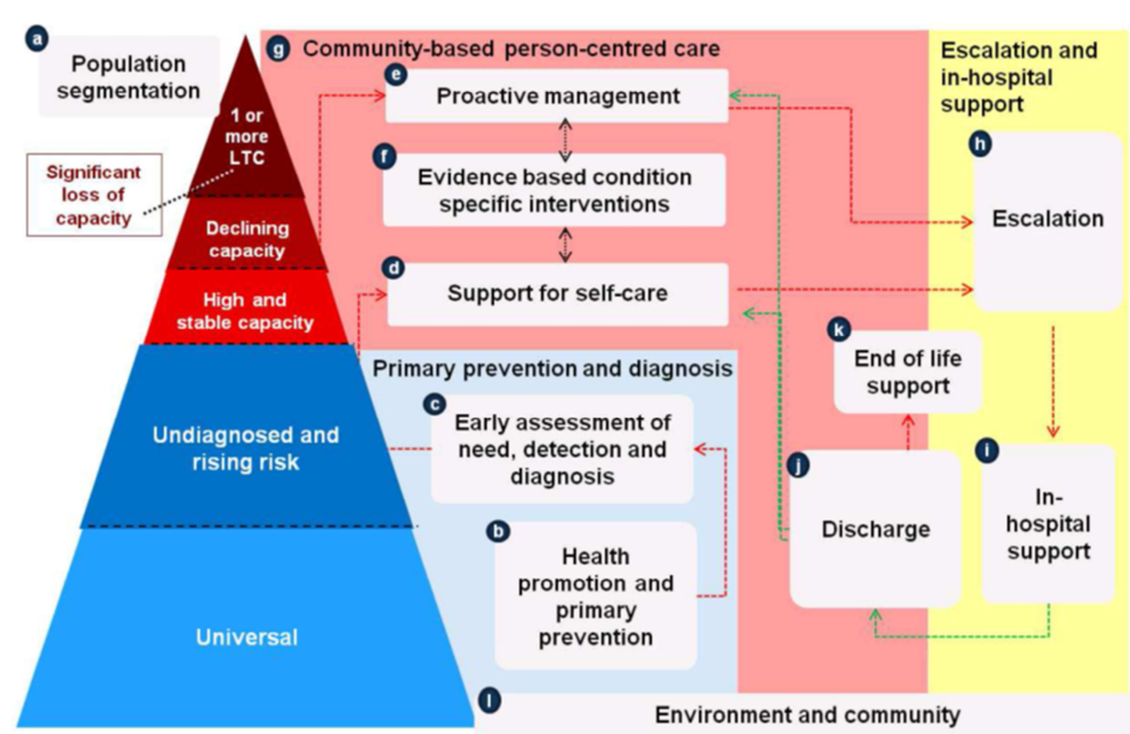
Our vision is that health and care services for people living with long term conditions, mental health problems or advancing age are sustainable, designed with the people and communities who use them around their needs and support them to be resilient, independent and enabled.

It is important to know that this vision has not been developed in isolation. We understand that many people live with multiple conditions, and it is often the psychological and social elements, including housing, employment, support from family and friends, and confidence to self-manage, as well as mental and physical illness, which determine what and how much support someone needs.

2.2. The Main Building Blocks

The main building blocks for our strategy include:

I. The Model of Care Developed by the Sustainability Transformation Programme



We have developed a model of care which places people at the centre of an integrated, community-focused approach; recognising the importance of the wider environment, prevention and early intervention; and that people frequently live with mental health problems alongside other long term conditions. The diagram above summarises how integrated health care neighbourhood teams can provide proactive care stratified by different levels of need, as determined by their medical and psychosocial conditions. This brings together work on healthy ageing, long-term conditions management and mental health.

II. The Five Year Forward View for Mental Health and the 2014 Care Act

A report from the independent Mental Health Taskforce to the NHS in England
February 2016

Care Act 2014

CHAPTER 23

Explanatory Notes have been produced to assist in the understanding of this Act and are available separately

Our objectives map closely on to those set out in the Five Year Forward View for Mental Health[2] - Prevention, Wellbeing, Delaying Needs, Good Quality Care, Information and Advice, Innovation and Research, Data, Commissioning - Market Shaping, Payments and Incentives, Leadership and Workforce. NHS England have published their implementation plan for the Five Year Forward View[3] and in Table 2 we describe what this means for our local health system.

Table 2: Local Implications of the Five Year Forward View for Mental Health

National commitment	Potential local implications
Physical care interventions to cover 30% of population with severe mental illness SMI on the GP register in 2017/18, moving to 60% in 2018/19.	2,100 people with SMI (30%) would have physical care interventions by 2017/18, moving to 4,200 (60%) in 2018/19
By 2020/21 25% of people with common mental health disorders will access services each year.	29,300 people with common mental health disorders would access services a year by 2020/21.
By 2020/21, increase access to specialist perinatal mental health support in all areas in England.	1,250 women would receive additional support for mental health problems during pregnancy and/or the postnatal period by 2020/21, with approximately 420 (or 4%) of this group having severe and complex needs.
At least 35% of CYP with a diagnosable mental health condition receive treatment from an NHS-funded community MH services by 2020/21.	6,755 (35%) children and young people with a diagnosable mental health condition would be receiving treatment from an NHS funded community mental health service a year by 2020/21.
By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.	There would be 6 fewer suicides a year (from 2015 levels) by 2020/21.

Please see Annex D for details of how these estimates have been calculated.

[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

The Care Act 2014 is the most significant change to adult social care in over 60 years. It modernises care and support so that the system is built around people's needs and what they want to achieve in their lives. It will give:

- Individuals and carers more control over their care and support.
- Clarification of what individuals and carers can expect from the care system.

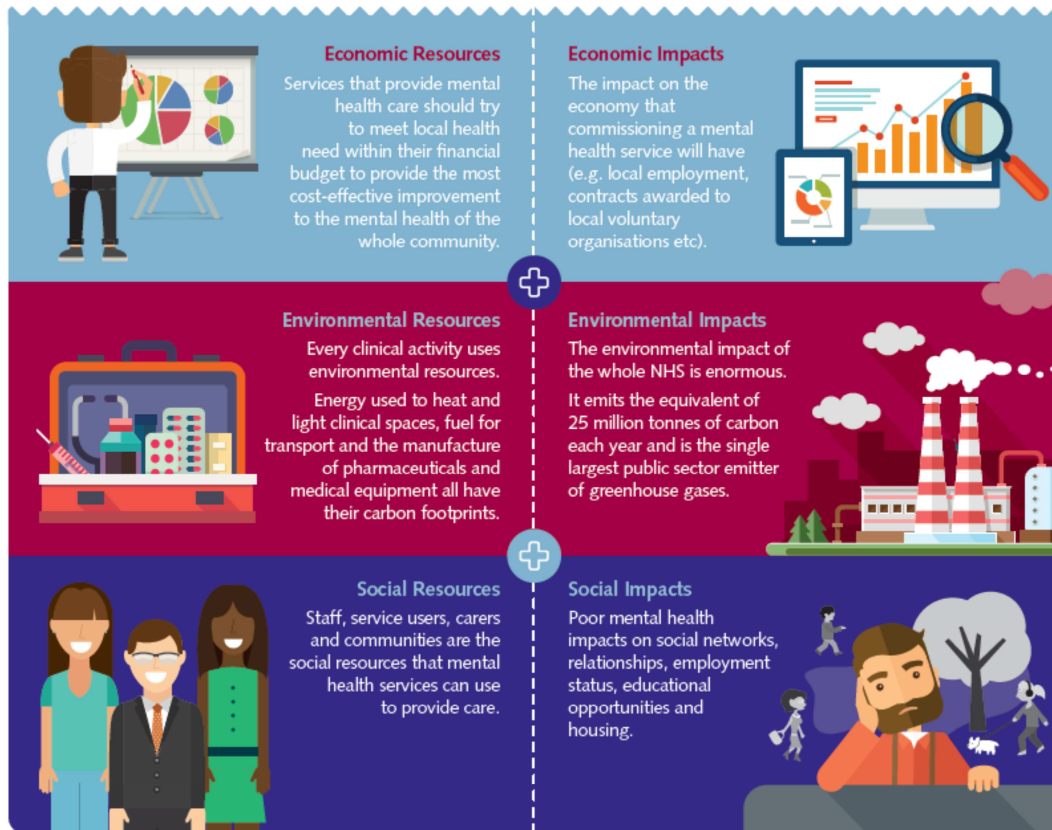
The introduction of the Care Act and its concept of 'Wellbeing' impacts upon how mental health social care services are delivered, because of the duties it places on the council to put more emphasis on responding to the needs of carers, placing more control in the hands of the individual over their care and providing better access to information.

Some of the main features of the Care Act include:

- A change to the way people are assessed – so that decisions about the help they receive will consider their wellbeing, what is important to them and their family, and help to plan for the future.
- New rights for carers and people who pay for their own care (called 'self-funders') to ask for an assessment of their needs and the council's help to access services and support to meet their eligible needs.
- Provision of information and advice to everyone who requires it, not just people using services.

One implication for Mental Health services is a need to realign social work resources away from working solely with secondary care to work across the pathway between secondary and primary care services. This would strengthen the early intervention and prevention capacity of the whole mental health system in line with emphasis on wellbeing

III. A commitment to sustainable commissioning



Our approach to commissioning must be sustainable: not just economically, but also environmentally and socially.[4]

What is sustainable commissioning?
Sustainable commissioning is about 'future-proofing' mental health care. This simply means ensuring better outcomes for patients both now and in the future, despite increasing resource constraints.

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[4] Source: JCPMH: Guidance for commissioners of financially, environmentally, and socially sustainable mental health services. Available at: http://www.jcpmh.info/resource/guidance-for-commissioners-of-financially-environmentally-and-socially-sustainable-mental-health-services/

Four Basic Principles for sustainable commissioning decision making.
These four principles are well known, but too rarely employed as a framework for decision-making among commissioners:

- **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).

- **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and service users are at the centre of decision making. It also requires supporting community projects that improve social networks, build new skills, support employment and ensure appropriate housing.

- **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

- **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care.

2.3. Our main priorities

Our main priorities, progress to date and next steps are summarised, and mapped against national priorities, in Table 3 below. The Executive Summary to this document provides a shortened version of this table highlighting the key priorities (Table 1).

Our proposed approach focuses on three areas:

- **Prevention:** promoting mental health and preventing mental illness.
- **Community based care:** developing an integrated approach to community based person centred care, focused on intervening early.
- **Specialist care:** timely acute, crisis and inpatient care when it's needed**.** Paying particular attention to admission and discharge processes, the management of interfaces between services, and social services support.

These headings draw together the themes of prevention, integration and capacity and demand alongside many of the other priorities identified both locally by our own service users and partners, and also nationally within the five Year Forward View for Mental Health. Importantly, they also build on and link in with each other, to provide a cohesive person-centred sustainable model of health and care.

This document does not currently encompass Learning Disabilities or Dual Diagnosis. Work on dementia is being developed separately through a dementia strategy, and once available will be incorporated here.

Table 3: Mental Health Five Year Forward View – *local requirements split by local priority areas*

Local and national aims: **A: Promoting Mental Health and Preventing Mental Illness**	**Progress to date**	**Next steps**
- *Focus on groups at risk of mental illness such as vulnerable children, as well as support for carers.* - *Access to employment, housing and debt support.* - *Tackling stigma through campaigns and mental health champions in communities.* - *Incentives for NHS employers relating to NHS staff health and wellbeing. Measures of staff awareness and confidence in dealing with mental health in staff surveys.* - *Parenting programmes as part of prevention work, particularly for vulnerable groups.* - *Improved resilience for children and young people, alongside mental health skills and knowledge of professionals and parents.* - *Implementation of a whole school approach to mental health and wellbeing.* - *Individuals and their families are enabled to achieve and sustain their wellbeing through links to strong and resilient communities.* - *Vulnerable people with mental health needs and their carers find the support and care system easy to navigate.* *(Suicide prevention see section C)*	- Some focus on at risk groups including vulnerable children. - Access available through commissioned voluntary sector services to employment support, housing and debt advice for some. - Anti-stigma campaigns such as ‘stress less’, ‘one you’ and mental health awareness week supported by public health. - School champions (teacher and young people) being piloted. - NHS staff wellbeing programmes, including mental health being developed in large NHS providers. - Parenting programmes considered as part of the mental health service redesign for Children and Young People. - Training for professionals and schools provided, alongside planning for whole school approach. - Development of training packages for employers and setting out standards for workplace health, and support for those with mental illness wanting to remain and/or return to work. - Pilot project on building mentally resilient communities and evaluation with MIND. - Improving the mental health awareness for a broad range of professionals.	- Further work to ensure prevention work is targeting at risk groups. - Further work with voluntary sector to scope potential for delivering improved services on housing, debt and employment services, and the interface with enhanced primary mental health care services, and neighbourhood teams. - Build further joint cross system campaigns for 2017/18. Further development of NHS wellbeing programmes for employees. - Further development of parenting programmes as element of the ithrive model. - Alignment of voluntary sector commissioning. - Further development of ‘thrive’ element of ithrive model focusing on school support, mental health knowledge and life skills, building resilience, staff and parents, and those most vulnerable to mental health problems. - Continued focus on reducing social isolation, and building community resilience. - Further work on supporting carers including robust assessments and ‘what if’ plans, as well as defined support pathways for carers.

B Developing community-based person centred care focused on intervening early	**Progress to date**	**Next steps**
- *By 2020/21 at least 60% of those experiencing a first episode of psychosis access to NICE approved care package within 2 weeks of referral.* - *Out of area placement for inpatient care eliminated by 2020/21.* - *Reduce Mental Health Act detention through earlier intervention and targeted work to reduce over-representation of BAME and other disadvantaged groups* - *Prevent avoidable admissions support recovery and 'step down' for SMI and significant risk/safety issues, least restrictive and close to home. Tackle inequalities in detentions and length of stays.* - *Expansion of 'navigator' roles.* - *Learning from SI's.* - *Social care practice is focused on supporting people to gain and retain their independence.* - *An effective re-ablement service is available in mental health.*	- Further investment in Early Intervention Psychosis (EIP) services in line with national guidance. EIP pathway development in place. - Enhanced Primary Care Pilot in place – looking at "step down/step up" management. - Development of a primary care wellbeing pathway integrating IAPT, the enhanced primary care pilot and recovery coach service (CQUIN). - Fully scoping activity data for Personality Disorder (PD) Pathway (CQUIN). - CCG have commissioned 'recovery coaches' to support patients post discharge. Local authority have piloted a mental health 'navigator' model based on an existing 'navigator' project. - Recovery College East provided collaborative educational opportunities for CPFT service users and staff. - Development of 'what if' plans for carers.	- Establish NICE compliant pathway (Year 3). - Learn from pilot and scale up enhanced primary mental health care. This will support GPs in identifying psychological needs and primary care led interventions, with support from recovery coaches for those stepping down from secondary care. Integrate and/or develop interface with newly expanded neighbourhood teams, who will support those with deteriorating SMI. Further work to link existing community health/navigators/Peer Support. Workers/Recovery College within these models, and supported self-care. - Consider how enhanced primary mental health care can support those not registered with GPs. - Further modify PD pathway as required (including strengthening involvement and support for friends/families). - Alignment of voluntary sector commissioning. - Improved recognition of depression in patients with LTC's, and in old age. - Re-focus social work practice so service users have more engagement with their communities as part of their care plans. - Develop a set of standards for the way in which voluntary sector services enable service users to engage with support existing in their community and build this role into the requirements of all relevant contracts. - Implement and evaluate the re-ablement pilot project in Huntingdon. - Maximise direct payments through staff training and making them more user friendly. - Implementation through strands of work from the Peterborough City Council 'People and Communities' Strategy'.

Integrated mental/physical health & access to psychological therapies - *Physical health checks for those with SMI.* - *Improved access to prevention and screening initiatives for those with mental illness.* - *All mental health inpatient facilities to be smoke free by 2018.* - *Access to psychological therapies (particularly for LTC's; psychosis, bipolar, PD and common mental health problems) Access to psychological therapies to meet 25% of need, and integrated into physical health pathways.* - *Improve offender services, including all age liaison and diversion schemes and forensic services.*	- Work underway to clarify responsibilities for annual checks with different groups of patients for GPs and CPFT. - Investment made in health trainers working within the enhanced primary care service. - Closer working between stop smoking and mental health services. - IAPT Access and recovery rates as per national targets. - IAPT already focusing on patients with LTCs.	- Clarity built into contracts, and provision monitored. Improve the proportion of SMI patients with a high quality annual health check. - Focused prevention and screening initiatives, and numbers accessing services amongst patients with SMI improved. Smoke free mental health facilities by 2018. - Improved access to health trainers for those with SMI. Initially investment made in 2016/17. Further work to align with other initiatives supporting self-care for LTCs. - Improve access to psychological therapies where this is of known benefit including for LTCs, MUS, psychosis, mood disorders including bipolar affective disorder and PD (improved). Impact analysed, financial flow adjusted between LTC and MH services. - Plans developed to implement smoke free inpatient facilities by 2018. - Supporting self-care for those with LTCs to have mental health support embedded within it. - Develop liaison psychiatry skills in primary care to reduce presentations to acute trusts and support them in moving services into the community
Perinatal, Children and Young people - *Improved access to evidence-based specialist mental health care including psychological therapies and specialist community or inpatient care* - *One in three children and young people with mental health needs to access Mental Health services by 2020*	- Perinatal mental health outcomes built into 0-19 contract for children's services (including health visiting, school nursing and children's centres). - Initial work on Children's mental health redesign to ithrive model underway. Service will: o Increase availability and accessibility of early interventions services through	- Continued work to recognise the impact of parental mental health on children and focus practice on responding to the needs of the whole family through whole family assessments and joint visits with other professionals wherever possible. - Improved perinatal access through specialist

	improved signposting, advice, guidance. o Movement of those CYP with mild needs to locality based support. o Effective early MH specific assessment to ensure access to correct interventions and support as early as possible. o Development of wellbeing lead roles to support, advise, guide professionals working with children and young people within the community. o Embedding the use of shared decision making and setting of outcomes and goals from first interaction with services (supported by a programme of training). o Reviewing model of delivery to ensure effective evidence based interventions are delivered and development of innovative workforce models with a range of people skilled to delivery these interventions.	service provision and community provision in line with NICE stepped provision. 2016/17 further work to baseline current service provision, allocate investment and commission new services. - Continued work on the development and implementation of the ithrive model. New children's mental health service model commissioned, including primary mental health support and counselling in localities. - Focused work to reduce transition issues between child and adult services. - Further development of co-located, jointly commissioned, fully integrated services for children including those with long term conditions. - By December 2016 developing a co-commissioning approach with NHS England focusing on alternatives to admission.
C Timely acute, crisis and inpatient care when it's needed	**Progress to date**	**Next steps**
- *By 2020/21 all acute hospitals to have all-age mental health liaison services in A&E and inpatient wards, and meeting core 24 service standards.* - *By 2020/21 24/7 community based mental health crisis response available. Including Crisis Resolution and Home Treatment Teams (CRHTTs) provision of intensive home treatment.* - *Equivalent model to adult model for children and young people.* - *Implement new duties to ban use of police cells as a "place of safety" for those under 18 years* - *Multi-agency suicide prevention plans in place by 2017, contributing to 10%*	- Implementation of phase 1 of UEC Vanguard for 24/7 mental health crisis in Cambridge. - Pilot of community based safe place with voluntary sector. - Mental health nurses in police control room as part of UEC Vanguard project provide early input and support to police and provide alternatives to use of Section 136. - Investment of £360k to improve psychiatric liaison services for children and young person including extending assessments to midnight and increasing capacity of Intensive Support Team - S136 Mental Health Based Places of Safety to meet national guidance.	- Plans in place for core/core 24 service standards (by 2020/21) in all acute trusts, subject to staffing limitations. Review Emergency Department Liaison Psychiatry provision, adjust as necessary. - Further implementation of our community based first response model to the whole CCG, subject to success of pilot and funding, to provide 24/7 self referral for mental health crisis with teletriage and mental health first responders available to provide urgent assessment when needed. - Develop multidisciplinary paediatric liaison services to acute trusts - Continued implementation of crisis concordat action plan (years 2-5).

reduction in suicide.	- Multi-agency suicide prevention plan and implementation group established. - Successful Stop Suicide Campaign and targeted training programme.	- Ensure there is a countywide Approved Mental Health Professional (AMHP) service with sufficient capacity and sufficient access to S12 approved medical practitioners. - Improved use and sharing of Crisis/Care Plans. - Develop pathways/processes to ensure ithrive and crisis redesign integration. - Continued implementation of suicide prevention strategy and findings of suicide audit (2016/17).

Sources: STP aide-mémoire: Mental Health and Dementia and Five Year Forward View for Mental Health. All relevant local strategies

2.3.1. Our first local priority: promoting mental health and preventing mental illness.

Preventing illness, promoting mental health and intervening early and effectively, when people become ill, are the foundations of our strategy.

The Five Year Forward View for Mental Health emphasises the importance of *promoting good mental health and preventing poor mental health – helping people lead better lives as equal citizens***,** and recognising that this his is not the remit of the NHS alone – it requires support for parents, good schools, decent housing and supportive communities. Our *Public Mental Health Strategy*[5] sets out the evidence for such an approach.

Our cross system prevention work will focus on:

- Building resilience, mental health knowledge and life skills in children and young people.
- Introducing a "whole school approach" to improving mental health and a similar approach in the early years environment.
- Supporting parents, particularly through evidence based parenting programmes.
- Engaging with communities to promote mental health and reduce stigma, including through anti-stigma campaigns.
- Mainstreaming mental health promotion within our healthy lifestyles work.
- Developing training packages for employers and setting out standards for workplace health, and support for those with mental illness wanting to remain and/or return to work.
- Improving the mental health awareness for a broad range of professionals who come into contact with those with mental illness but are not mental illness specialists.
- Work to address the factors that increase the risk of mental illness, such as improving access to employment support and debt advice.
- Work to improve the mental health of those with physical illness and the physical health of those with mental illness.
- Continued implementation of the Suicide Prevention Strategy.[6]

As described below much of the challenge with this work is ensuring that it takes place at a sufficient scale to have a significant impact.

2.3.2. Our second local priority: developing community-based, person centred care including intervening early where possible

At the heart of our vision is an integrated service, community based, which brings together physical and mental health care, alongside social care, the voluntary sector, and the many resources which exist within our communities. Considerable work is already underway, much of which is currently being tested in small geographical areas, but this needs further commitment and investment to be expanded across Cambridgeshire and Peterborough.

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[5] http://www.cambridgeshireinsight.org.uk/health/healthtopics/mh
[6] http://www.cambridgeshireinsight.org.uk/health/healthtopics/mh/suicide

One key area of activity in this area focuses on **improving access to and availability of mental health services**, including:

- Significantly more children and young people accessing high quality mental health care, including timely access to inpatient beds as close to home as possible when these are needed, alongside alternatives to admission where this is appropriate.
- Specialist perinatal mental health services available locally for all women who need them.
- Access to psychological therapies to meet 25% of need, integrated into physical health pathways.
- Expansion of rapid access for people experiencing their first episode of psychosis in line with NICE-approved care.
- Multi-agency action to reduce the suicide rate by 10%.

As part of our plan to achieve these goals, we will immediately set up a Cambridgeshire and Peterborough perinatal mental health network group; and we will also consider options for developing more specialist services for perinatal mental health, including exploring the option of establishing a regional Mother and Baby Unit, alongside the development of the whole perinatal pathway. We will expand our Long Term Conditions IAPT service, and take action to allow our early intervention in psychosis teams to increase their treatment pathways from two years to three, and to expand services for the assessment of individuals with at risk mental states.

Work on children and young people will build on the ‘ithrive’ work described below.

Box 1: ithrive redesign for children’s mental health

We are developing a new model for emotional health and wellbeing services based on the ITHRIVE framework. This will, we hope, reduce the demand we see later on in life for mental health, specialist health, and social care services. Thrive is a conceptual framework for delivering a need based model for CAMHS. Cambridgeshire and Peterborough is one of the national accelerator sites for implementing this approach. More detail on Thrive can be found at http://www.annafreud.org/service-improvement/service-improvement-resources/thrive/

The model supports self-resilience of CYP and families and supports them within their localities and in ways that meets their needs. The model supports the concept of increasing the availability and accessibility of early intervention and preventative activities and therefore ensuring that only children and young people whom would benefit from specialist mental health services need to be referred.

Key points of new model:

- Removal of tiers to a whole system approach.
- Needs based as opposed to diagnosis led.
- Outcome to be defined from beginning of interaction with services.
- Enhance preventative activities to support Thriving and build resilience.
- Increase in early intervention and provide interventions, advice, support earlier and not wait until crisis.
- Use of shared decision making to identify goals and outcomes to be achieved.
- Ensure use of evidence based or best practice interventions.
- Stop treatment if not achieving goals.
- Improvement in access.
- Access to advice and guidance from specialist services earlier through wellbeing lead.
- Improved training and knowledge of mental health across all sectors.

A second area for development focuses on providing people with community based holistic care, recognising their mental and physical health needs.

We know that we need to do more to bring together and co-ordinate services which can focus on the needs of the individual and understand them in their wider environment and work to address the factors contributing to their mental health problem. This means focusing on wider support such as housing, employment and benefits, alongside supporting family and/or carers.

We also recognise the need to expand support for people who are below the threshold for specialist services but who need more support than can be provided through GPs. Support for self-care and recovery, are central to this. Housing is a crucial part of this and there is a need tor review the sufficiency and spread across the County of specialist accommodation and access to general needs housing for those with severe and enduring mental health problems.

As part of our plan to achieve these goals, by 2017 we will have developed our Recovery Coach model to support discharge from secondary care, and our Enhanced Primary Care service for Mental Health will be developed to allow us to test out approaches to improve the effectiveness of our step up and step down pathways, and help address the “fear of a cliff edge” which causes many of our service users and carers concern when discharged from secondary Mental Health services. The Enhanced Primary Care mental health service will, along with all NHS services, support the physical care of patients with mental illness, and identify and address the psychological needs of those with long term conditions and is described in the box below. Our dementia strategy will be developed to continue to meet national targets for early diagnosis; and to improve the support (including crisis and end of life care) for people living with dementia and their carers.

Box 2: Enhanced primary care mental health services

The Model: The service will provide additional mental health resource/capacity within primary care to manage the defined patient group (see above) by supporting the GP with specialist Mental Health staff who have the knowledge, expertise and capacity to support the safe discharge/transfer of stable patients from Secondary to Primary Care and vice versa. Physical health monitoring and where appropriate physical and mental health interventions will be provided in collaboration with the wider MDT team. There will be three teams across the CCG consisting of: Band 6 nurse (mental health interventions and escalations to secondary care where needed); one Health Care Assistant for physical health interventions; and one Peer Support Worker to enable access to community resources.

Who is the service for?

The service will be for patients aged 17-65 years who have mental health problems of moderate to high severity and disability but who are stable, and have risk levels that can be managed in a primary care based service. This should reduce the pressure on primary care and reduce secondary care referrals, creating more capacity within the mental health system.

Next steps

The service specification and model have been agreed, with an initial proof of concept phase in the Fenland and Hunts area to better understand how the model will work in practise. Following an evaluation, the aim is to roll out the model CCG-wide from Autumn 2016.

2.3.3. Our third local priority: timely acute, crisis and inpatient care when it's needed

The Five Year Forward View for Mental Health emphasises the importance of a *seven day NHS which provides the right care at the right time and of the right quality.*

Within our local area the Crisis Care Concordat has provided a model of multi-agency collaboration to help develop and improve our crisis services. We will need to build on and develop this work. To make sure that the capacity of our acute and specialist mental health services can sustainably meet demand and achieve the best outcomes for patients, we also need to deliver effectively on our plans for prevention, early intervention and community-based care which we have described above.

We will continue to work to design integrated pathways between primary and secondary care and the voluntary sector, and to build teams that can respond quickly in a crisis and that will facilitate early discharge, with support from the right services, as soon as this is appropriate and safe. We will work to ensure that children and adolescents have timely access to crisis services that meet their needs in the community, as well as exploring new collaborative approaches to commissioning inpatient services when these are required.

We are developing and piloting a community-based mental health first response service as part of our Urgent and Emergency Care Vanguard programme, and this is described in the box below.

Box 3: Mental Health Vanguard: First Response Service

The mental health Vanguard programme aims to provide a universal, 24/7, mental health crisis care pathway, which can be accessed directly by patients and carers, alongside local NHS, social care and third sector colleagues.

The model: The new services include:

- A first response service run by Cambridgeshire and Peterborough Foundation Trust, supporting patients experiencing a mental health crisis in the community out-of-hours. The team will work alongside the existing crisis teams and will take referrals from emergency services.
- The Sanctuary, a safe place in the community, offering short-term support, run by the third sector, with referrals triaged by the First Response Service. It will provide practical and emotional support for people as an alternative to admission to statutory services. The service will run seven days a week between 6pm and 1am.
- A system-wide co-ordinator supporting calls from emergency services out-of-hours, and referring onto the new Sanctuary and First Response Service.
- Mental health practitioners in the Integrated Police Control Room providing advice to the police. This launched on 29 March and allows people in mental health crisis to be supported at the earliest opportunity, and provide police officers with advice and referral options. The team was part of the partnership response to the Crisis Care Concordat and is funded by the Cambridgeshire Police and Crime Commissioner and Peterborough City Council.
- The new model will also provide patients with the opportunity to self-refer into the services.

Phase one of the mental health Vanguard programme launched in April in Cambridge, to start to improve how we support people in mental health crisis out-of-hours. Once funding is confirmed the next stage of the programme will launch. We plan to roll out the new model of care in three phases over 2016. The phased rollout will enable us to look at mental health referrals into the emergency system and evaluate the benefits of the new service.

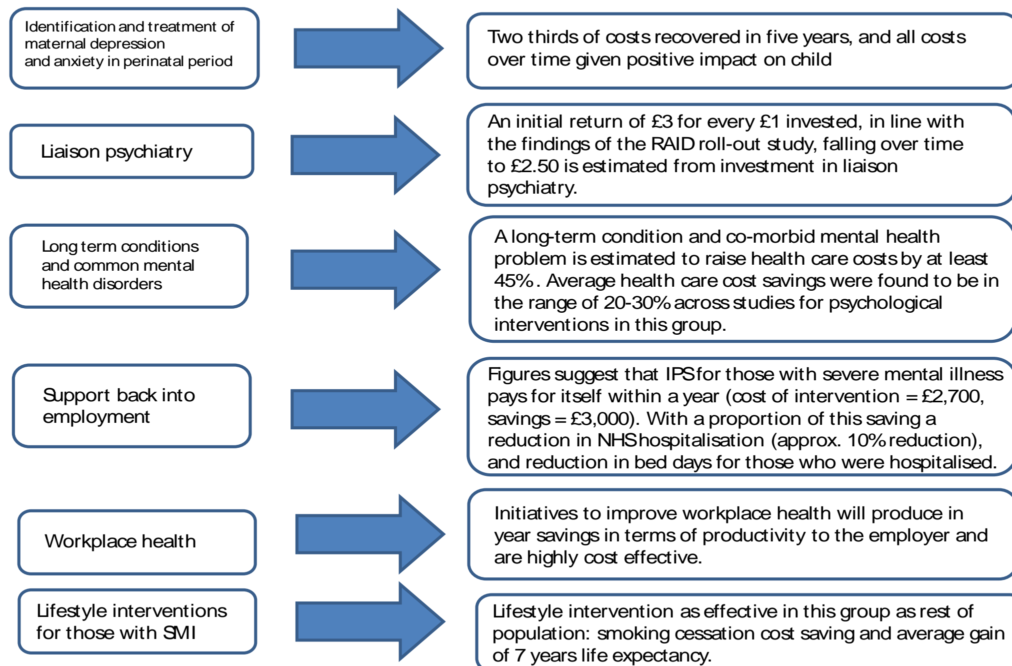
Within acute medical and surgical settings we will build on work which has already been carried out locally to develop liaison psychiatry; interventions for frequent attenders in the Emergency Department and those with medically unexplained symptoms; and building on existing and developed training to facilitate the provision of education and training opportunities for staff to adopt a holistic, integrated approach at the interface of physical and mental health.

2.4. How will we deliver our vision?

Delivering this strategy will require investment, and a detailed, costed programme plan for each element of implementation. The *Five Year Forward View for Mental Health* makes it clear that mental health services have been chronically underfunded, and estimates a requirement in England for an additional £1 billion investment by 2020/21 to help plug the gaps in the care that the NHS is currently unable to provide. We receive a proportion of this investment locally. We estimate that our share of this **additional investment will equate to £12.8m by 2020/21** (based on the funding formula in use in June 2016).

Additional investment is a fundamental requirement if we are to achieve parity of esteem between mental and physical health, but it is important to note that this strategy is not a detailed investment strategy, and there remains much work to be done to develop, cost and plan the key priorities highlighted here. It is clear from our high level costing work that the estimated additional investment of £12.8m is unlikely to be enough to achieve full implementation of the five year forward view or indeed this strategy by 2020/21. In particular this is the case as we have taken a system wide view of mental health, as we believe this is the best route to improved outcomes for patients, rather than only focusing on the Five year forward view priorities. Given the financial position of the CCG and both local authorities how we work together to maximise the value of any available investment is critical. We will be seeking to:

- Focus the additional investment to implement the Five Year Forward View for Mental Health on our key priorities.
- Maximise our opportunity to access any nationally available funding for specific mental health initiatives.
- Maximise our ‘invest to save’ opportunities, some of which are highlighted in the diagram below and at Annex D.
- Continue to ensure mental health provision is part of our core STP work on long term conditions, and primary and integrated neighbourhoods.
- Maximising our opportunities to improve quality within current services.
- Working together cross system to the principles of collaborations and logistics set out below.



As we develop our services and pathways, it is essential that we work to a set of principles to demonstrate that our proposals have been developed and implemented on the basis of consensus and collaboration, and with the best available evidence.

To achieve our goals, we will behave with transparency and openness, communicating clearly to develop collaborative consensus-based solutions, engaging widely, working as a system in the interests of the people and communities we serve.

We will work to the following principles and behaviours:

- We will put people and their families and carers at the heart of what we do, and ensure they are engaged in the design and planning of services.
- We will use evidence based solutions where possible, using data to drive and evaluate out progress. We will base our work on the best available knowledge and information.
- We will work to meet the diverse needs of the population, focusing on ensuring equity of access to care and support across our communities.
- We will focus on outcomes that are important for people and their families and carers, not on activity alone, and agree and align these with stakeholders and across agencies.
- We will seek where ever possible to embed consideration of mental health within physical health services.

2.5. Principles of Collaboration and Logistics

We will work together as partner organisations in Cambridgeshire and Peterborough to improve the system of care and support so that people are helped to help themselves live well, receive help when they need it for their mental health, and are supported in their recovery from mental health problems.

Next steps for our system cannot be delivered without collaboration across many organisations and individuals.

2.5.1. A common language

We will establish a common language that will give us the assurance we are able to work effectively and efficiently as a whole system. This will ensure that our pathways are well defined and can be navigated by any provider or user of the system, that we understand who staff working in our services are and what they do, and that we have a common framework for talking about risk.

2.5.2. Joint outcomes

We will establish a joint outcomes framework for mental health across the health and social care system.

2.5.3. Information and data sharing

Provision of the best quality and most appropriate services to children and adults in need of help and support can only be delivered if agencies have access to the correct information about service users' individual circumstances. Effective cross agency information quality and transparency is also key to ensuring an overall system that works for the population.

2.5.4. Workforce development

Greater integration means new ways of thinking, behaving and working across the whole system; and everyone working in all of our organisations will need to think differently about their role, with a clear expectation about how practice by all professionals will change to support a multi-disciplinary approach. Staff will need to develop new skills and work across traditional boundaries. Common approaches to training and development, as well as a common language across services, will be needed to achieve the full benefits of integration.

2.5.5. Property co-location

Where possible, we want staff from across the system to be co-located or able to share working space in a variety of settings. As partner organisations move towards more mobile working and reduced office space, there will need to be a better join up in relation to planning use of estates to achieve vertical or functional integration. In addition it will be important to make use of existing assets such as libraries and other community buildings to act as a point of information and advice. We will use technology to help us work more closely where we cannot be co-located and for such services as the single point of access this will be essential.

2.5.6. Joint commissioning by health and local councils working together

Service transformation is strengthened when the commissioning of services from both the statutory and voluntary and community sectors can be done jointly by the local NHS and Councils. This enables the commissioning of pathways and the delivery of coordinated services across sectors. This can be achieved through the pooling of commissioning budgets, use of the Better Care Fund pooled budget, and the encouragement of provider consortia and partnerships between the statutory and voluntary sectors. Such partnerships if properly constructed can provide greater security for third sector organisations in a difficult financial climate. The recent Vanguard First Response development was a jointly commissioned service – from a the local NHS Trust with a local voluntary sector provider. All commissioners will be looking to work more closely together, using this strategy as a roadmap , to promote

greater coordination of services and to remove duplication to the benefit of the whole health and wellbeing system.

Annex A: Task Force Priorities (p.36 The Five Year Forward View for Mental Health)

Proposed mental health pathway and infrastructure development programme

Proposed mental health pathway and infrastructure development programme

	Pathway	2015/16	2016/17	2017/18	2018/19	2019/20
Referral to treatment pathways	Psychological therapy for common mental health disorders (IAPT)					
	Early intervention in psychosis					
	CAMHS: community eating disorder services					
	Perinatal mental health					
	Crisis care					
	Dementia					
	CAMHS: emergency, urgent, routine					
	Acute mental health care					
	Integrated mental and physical healthcare pathways (IAPT / liaison / other integrated models)					
	Self harm					
	Personality disorder					
	CAMHS: school refusal					
	Attention deficit hyperactivity disorder					
	Eating disorders (adult mental health)					
	Bipolar affective disorder					
	Autistic spectrum disorder (jointly with learning disability)					
Recovery pathways	Secure care recovery (will include a range of condition specific pathways)					
	Secondary care recovery (will include a range of condition-specific pathways)					

Annex B: Existing Links to Local Strategies

Cambridgeshire and Peterborough Suicide Prevention Strategy
http://cambridgeshireinsight.org.uk/health/healthtopics/mh

Public Mental Health Strategy 2015-2018
http://cambridgeshireinsight.org.uk/health/healthtopics/mh

Cambridgeshire and Peterborough Crisis Care Concordat
http://www.crisiscareconcordat.org.uk/areas/cambridgeshire/

Social Care Strategy for Adults with Mental Health Needs 2015-18
http://www.cambridgeshire.gov.uk/info/20166/working_together/577/strategies_plans_and_policies

Peterborough People and Communities Strategy
https://www.peterborough.gov.uk/council/strategies-polices-and-plans/communities-strategies/people-and-communities-strategy/

Peterborough draft health and wellbeing strategy 2016-19
https://www.peterborough.gov.uk/healthcare/public-health/health-and-wellbeing-strategy/

Cambridgeshire Health and Wellbeing Strategy 2012-17

http://www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire_health_and_wellbeing_board

Annex C: Key local data

Mental Health – the current picture

Key points

- With a growing population Cambridgeshire and Peterborough has growing numbers of people with mental illness. In 2016 it estimated that over 88,000 adults (aged 18-64 years) in Cambridgeshire and Peterborough have a common mental health disorder – by 2021this figure will be 95,200, and by 2026 it will be 97,500.
- Suicide rates have been consistently higher than England rates in Peterborough (although this was not always statistically significant) until a drop was seen in 2012/14, making Peterborough's rates statistically similar to the England average.
- Hospital admissions rates for self-harm in those aged under 25 years are above the national average in both Cambridgeshire and Peterborough, with Peterborough the highest in the East of England.
- Patterns of service use suggest that acute 'crisis' services are being used more for mental health in Cambridgeshire and Peterborough when we compare with other areas. This is not explained by differences in population need.
- People with two or more long term conditions are seven times more likely to have depression.[7] Overall this means that locally there are an estimated 18,000 adults with two or more long term conditions with mental ill health and/or limitation, and a further 10,500 people aged 65 and over in these groups.

Prevalence levels

It is estimated that over 88,000 adults in Cambridgeshire and Peterborough aged 18-64 years have a common mental health disorder.

7% (50,417) of adults in Cambridgeshire and Peterborough were recorded by GP's as having depression in 2014/15.

There were 775 self-harm hospital admissions in people aged 10-24 years in 2014/15 in Cambridgeshire and Peterborough. Rates are significantly worse than the England average.

7,048 patients registered in Cambridgeshire and Peterborough have a serious mental illness.

In 2016 it estimated that over 88,000 adults (aged 18-64 years) in Cambridgeshire and Peterborough have a common mental health disorder – by 2021 this figure will be 95,200, and by 2026 it will be 97,500.

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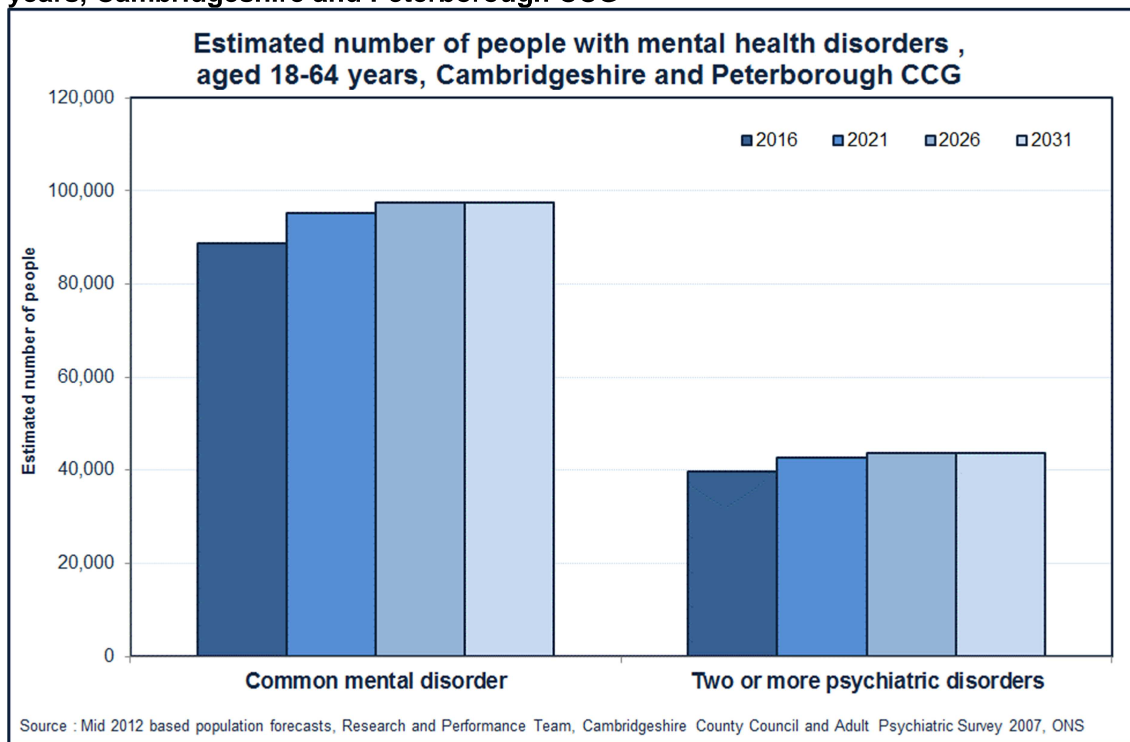
[7] The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.

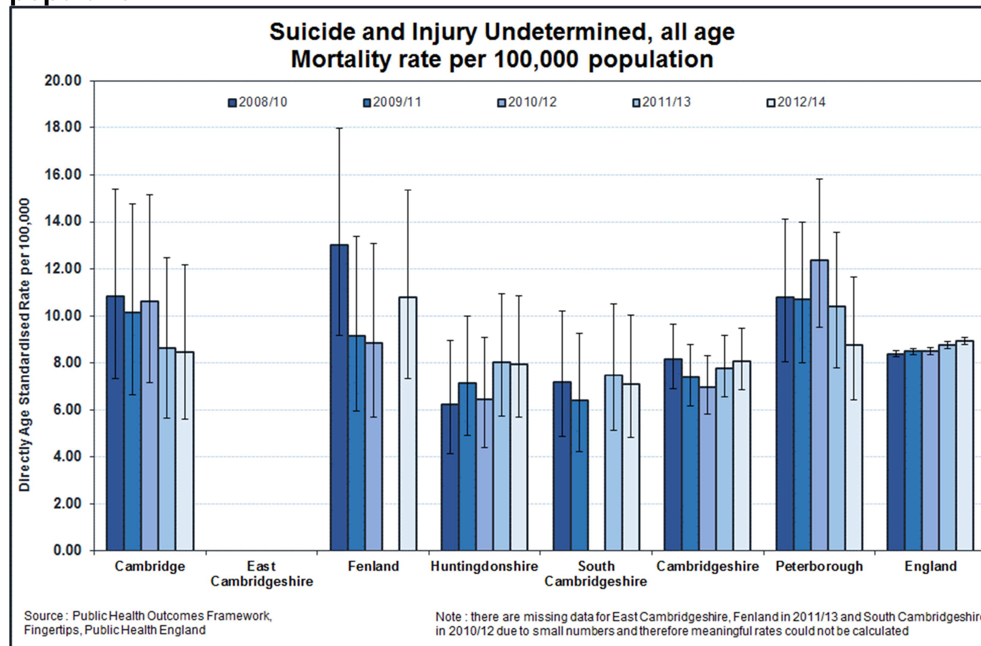
Figure 2: Estimated number of people with mental health disorders, aged 18-64 years, Cambridgeshire and Peterborough CCG



Suicide rates

Suicide rates have been consistently higher than England rates in Peterborough (although this was not always statistically significant) until a drop was seen in 2012/14. This recent improvement means that suicide rates in Peterborough are now statistically similar to the England average. Cambridgeshire rates are consistently below the England rate.

Figure 3: Suicide and Injury Undetermined, all age Mortality rate per 100,000 population



Self-harm in young people

Self-harm is understood as physical injury inflicted as a means to manage an extreme emotional state and is primarily a coping strategy.

In 2014/15 there were 775 admissions to hospital by young people (aged 10-24 years) as a result of self-harm – Cambridgeshire 567 admissions and Peterborough 208 admissions. Hospital admission rates for adult self-harm in 2013/14 for Peterborough (the latest data available) were highest in the East of England, at 40% above the average rate.

Figure 4: Hospital admissions as a result of self-harm (10-24 years)

Hospital admissions as a result of self-harm (10-24 years) 2014/15 — Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	39,563	398.8	394.9	402.7
East of England region	3,723	354.7	343.4	366.3
Bedford	125	422.6	351.6	503.7
Cambridgeshire	567	477.6	439.0	518.6
Central Bedfordshire	161	358.9	305.4	418.9
Essex	650	261.2	241.5	282.1
Hertfordshire	628	314.8	290.6	340.5
Luton	135	317.8	266.4	376.2
Norfolk	640	431.9	399.1	466.8
Peterborough	208	611.2	530.9	700.2
Southend-on-Sea	109	362.6	297.6	437.5
Suffolk	462	375.4	341.8	411.3
Thurrock	38	128.9	91.1	177.0

Source: Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

For the time period 2013-15 in children and young people aged under 18 years around 56% of self-harm admissions in Cambridgeshire and almost a half of admissions in Peterborough had a diagnosis of mental health recorded, with the majority for mood [affective] disorders (mania, bipolar or depression).

Admissions are higher from the 40% most deprived areas in Cambridgeshire and Peterborough compared to the rest of the areas.

Treatment

Across Cambridgeshire and Peterborough attendances at A&E for psychiatric disorder is higher than the England average and bed days per 100,000 population are lower.

In Peterborough:

- Referral rates to Crisis Resolution Home Treatment are higher than the rest of Cambridgeshire.
- Use of police powers to take a person in mental health crisis to a place of safety (Section 136) occurred at a much higher rate in Peterborough population than in the rest of Cambridgeshire.

This is part explained by Peterborough having a high prevalence of risk factors for mental health, such as, socio-economic deprivation, children in care, violent crime, drugs misuse, homelessness, relationship breakdown, lone parent households, overcrowding and vulnerable populations, such as migrants and asylum seekers. However, the patterns of acute service use in Peterborough are unlikely to be entirely due to additional need within the population.

Peterborough also has lower levels of recorded depression (a common mental health disorder) than would be expected and the depression prevalence data does not correlate with areas of deprivation as we would expect.

Long term conditions and mental health

Compared with the general population, people with diabetes, hypertension and coronary artery disease have double the rate of mental health problems, and those with chronic obstructive pulmonary disease, cerebrovascular disease and other chronic conditions have triple the rate. People with two or more long term conditions are seven times more likely to have depression.[8]

Those with LTCs are at a higher risk of developing a mental illness; Table 12 shows the proportion of the CCG population aged 18-64 years that have multiple longstanding illnesses with and without limitation and/or mental ill health. 3.4% (1,900 people) are estimated to have two or more LTCs and mental ill health, whereas 28.4% (16,100 people) are thought to have two or more LTCs, mental ill health and limitation.

[8] The King's Fund. (2012) Long-term conditions and mental health: The cost of co-morbidities.

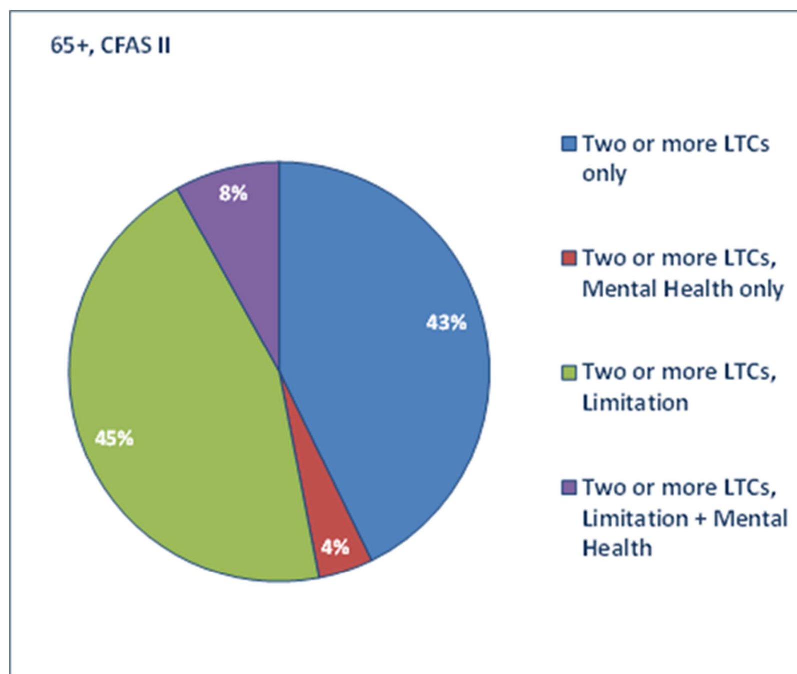
Table 3: Proportion of people aged 18-64 years with multiple (two or more) long standing illnesses with and without limitation and/or mental ill health (based on GHQ-12 score of four or more)

People aged 18-64 years with 2+ LTC	%	95% CI	Estimate of number of people in C&PCCG aged 18-64 years (2015) and range (95% CI)	
Two or more LTCs only	30.7	(26.7 - 34.9)	17,400	(15,200 - 19,800)
Two or more LTCs, mental ill health only	3.4	(2.1 - 5.3)	1,900	(1,200 - 3,000)
Two or more LTCs, limitation	37.6	(33.4 - 42.0)	21,300	(19,000 - 23,800)
Two or more LTCs, limitation + mental ill health	28.4	(24.6 - 32.5)	16,100	(1,400 - 18,400)
Total	100		56,700	

Source: Health Survey for England (2012) estimates applied to registered population. FHS Registration System (Exeter) April 2015.

Figure 5 shows data from a local study for over 65s with two or more LTCs. The data suggests that there are around 38,600 people aged 65 and over with two or more LTCs and limitation, an additional 3,600 people with mental ill health and an additional 6,900 with multiple LTCs, limitation and mental ill health (dementia, anxiety and depression). In total, it is estimated that 65,800 people aged 65 and over in C&P CCG have two or more LTCs.

Figure 5: Proportion of people aged 65 and over with multiple (two or more) LTCs with and without limitation and/or depression or anxiety (based on GMS AGECAT)



Source: MRC Cognitive Function and Ageing Study (CFAS II) (100% = people with two or more LTCs)

Overall this means that locally there are an estimated 18,000 adults with two or more long term conditions with mental ill health and/or limitation, and a further 10,500 people aged 65 and over in these groups. Prevalence of common mental health disorders is 16% in the adult population, and 10.6% in those aged 65-75 years.[9] Even at the population level of risk 3,993 people (2,880 adults and 1,113 older people) amongst this group will have common mental health disorder. Given that the risk of common mental health disorders in this group is a minimum of two of three times higher than the general population, these figures are likely to be much higher than this estimate.

[9] Psychiatric Morbidity Survey 2010.

Annex D: Potential local implications of the Five Year Forward View for Mental Health: calculations and assumptions

National commitment	Potential local implication
By 2020/21 A reduction in premature mortality of people living with severe mental illness (SMI). Physical care interventions to cover 30% of population with SMI on the GP register in 2017/18, moving to 60% in 2018/19.	Cambridge and Peterborough CCG in 2014/15 has 7,048 people with SMI (QOF data) on GP registers. Assuming levels remain the same as in 2017/18, this would mean 2,100 people with SMI (30%) will have physical care interventions, moving to 4,200 (60%) in 2018/19.
By 2020/21 25% of people with common mental health disorders will access services each year.	The Cambridgeshire and Peterborough CCG adult population (18+) is estimated to be 723,145 by 2021 (ONS population forecasts based on mid 2014). The prevalence of common mental health disorders is estimated to be 16.2% in the adult population (2007 Adult Psychiatric Morbidity Survey) or 117,150 people by 2021. 25% of this group is roughly 29,300 people with common mental health disorders.
By 2020/21, increase access to specialist perinatal mental health support in all areas in England, in the community or in-patient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence based treatment.	In Cambridgeshire and Peterborough in 2014 there were 10,431 still and live births. The estimated number of women who may require additional support and/or appropriate onward referral for mental health problems during pregnancy and and/or the postnatal period is based on the NICE benchmark rate of 12% of deliveries or 120 per 1000 deliveries. This includes 4% of deliveries to women with severe and/or complex needs and 8% of women who require and take up psychological therapies. https://www.nice.org.uk/guidance/cg192 This suggests that locally annually 1,250 women will need additional support for mental health problems during pregnancy and/or the postnatal period, with approximately 420 (or 4%) of this group having severe and complex needs.
By 2020/21 at least 70,000 additional children and young people each year will receive evidence-based treatment. At least 35% of CYP with a diagnosable mental health condition receive treatment from an NHS-funded community MH services.	By 2021 it is estimated that there will be 201,000 children and Young people aged under 18 in Cambridgeshire and Peterborough. Prevalence estimates (Mental health of children and young people in Great Britain, 2004,ONS) suggest approximately 9.6% of children aged 5-16 years will have a diagnosable mental health disorder. Applying these estimates to all those under the age of 18 this suggests there would be 19,300 children and young people in Cambridgeshire and Peterborough under age of 18 by 2021 with a diagnosable mental health condition. Therefore, 6,755 (35%) of these children and young people would be receiving treatment a year by 2021*.
By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.'	Using 2015 as the baseline year, by 2020/21 this would mean the number of people taking their own lives will be reduced by 10% to 54 deaths from 2015 levels. **

*This is based on the 2004 psychiatric morbidity study and this is current being revised.

**A three year rolling average is a more reliable measure of progress given the small numbers.

Annex E: Further information on invest to save priorities

The Priorities for Mental Health: Economic report for the NHS England mental health taskforce highlighted nine areas for investment as follows. Further detail from this report and other relevant reports is in the table below.

Prevention and early intervention

1. Identification and treatment of maternal depression and anxiety during the perinatal period, including as a preventive measure against the development of mental health problems in children.
2. Treatment of conduct disorder in children up to age 10.
3. Early intervention services for first-episode psychosis.

Physical health conditions

4. Expanded provision of liaison psychiatry services in acute hospitals, particularly in support of elderly inpatients.
5. Integrated physical and mental health care in the community for people with long-term conditions and co-morbid mental health problems.
6. Improved management of people with medically unexplained symptoms and related complex needs.

Improved services for people with severe mental illness

7. Expanded provision of evidence-based supported employment services.
8. Community-based alternatives to acute inpatient care at times of crisis.
9. Interventions to improve the physical health of people with severe mental illness.

Initiative	Evidence*
Perinatal mental health	Some 15-20% of women suffer from depression or anxiety during pregnancy or in the first year after childbirth, but about half of all these cases go undetected and untreated. This is damaging and costly, not only because of the adverse impact on the mother but also because maternal mental illness roughly doubles the risk of subsequent mental health problems in the child. According to one estimate, the long-term cost to society of a single case of perinatal depression is around £74,000, mostly because of adverse impacts on the child. The effective treatment of mothers offers the genuine prospect of primary prevention in relation to the development of mental health problems in children. The available evidence strongly supports the provision of psychological therapy as the most effective intervention, but this is currently available to only a small minority. Improving the identification of perinatal depression and anxiety (via more screening and assessment) and providing psychological therapy to all who would benefit in line with NICE waiting time standards it is estimate would lead to subsequent reductions in health service use by both mothers and children would more than cover this cost over time, with about two-thirds of costs being recovered within five years.
Liaison psychiatry	An initial return of £3 for every £1 invested, in line with the findings of the RAID roll-out study, falling over time to £2.50 is estimated from investment in liaison psychiatry. It is important that new - and indeed existing - services are targeted at those areas of activity which the evidence suggests will yield the greatest benefits. In terms of support for inpatients, this is particularly likely to mean a strong focus on elderly people. Similarly, in emergency departments, services should seek to work with those who make heavy use of A&E, keeping a register of frequent attenders combined with regular review of these patients and proactive case management. All the financial benefits of liaison support take the form of cost savings in those acute hospitals where liaison psychiatry is provided.
Early intervention psychosis	There is a strong case for in year savings. At a unit cost of £6,000 a year early intervention for psychosis has net cost savings of £2,510 per patient in **year one** and £6,728 per patient over three years. However, we have an good existing service, as Rightcare benchmarking information shows, that is already compliant to year 2 of NICE pathways.
Psychological interventions for those with Long Term Conditions	Common mental disorders (CMDs), which include depression and anxiety, are highly prevalent with long term conditions. Evidence consistently demonstrates that people with long term physical health conditions (LTCs) are two to three times more likely to experience mental health problems than the general population, with much of the evidence relating to common mental health disorders such as anxiety and depression. The additional impact of mental illness, which can exacerbate physical health problems, is estimated to raise the total health care costs by at least 45% for each person with a long-term condition and co-morbid mental health problem. Robust UK evidence establishing cost savings for psychological interventions and screening for those with long term conditions is not available. However, on the basis of studies undertaken outside of the UK it is evident that savings sufficient to cover the cost of the intervention are likely. From a large US meta-analytical study of psychological interventions for long term conditions, average

	health care cost savings were found to be in the range of 20-30% across studies.[10] Psychological interventions ranged from psycho-education treatments to those categorised as behavioural medicine interventions. Only a small proportion of studies reported that the costs of psychological treatment exceeded the cost savings. Most of the psychological interventions lead to reductions in health care costs, and these reductions were typically large enough to fully cover the costs of the psychological interventions themselves.
Parenting programmes for conduct disorder	Estimated public expenditure savings over the seven-year appraisal period amount to £3,758 per child, to be set against an intervention cost of £1,282. In other words, every £1 invested in the programme generates savings in public spending of £2.83. The breakdown of these savings is: NHS and social care £1,207 Education £2,215 Criminal justice £336 The largest savings thus accrue to the education sector, though the savings within health and social care are also almost enough to cover the full costs of the intervention on their own. Savings in the criminal justice system are small mainly because of the short time horizon of the appraisal, and over a longer period these would become the largest single item. Public sector savings over a five-year period, confined to health/social care and education, are roughly twice the cost of the intervention.
Medically Unexplained Symptoms (MUS)	The most costly 5% of patients with MUS cost the NHS around £3,500 a year, or £10,500 over three years. This compares with an intervention cost of around £1,350 per patient, again based on the PCPCS model. If the service reduces the use of health care by just 15% a year for three years, this would more than cover the full costs of intervention. Proportionate cost savings of this magnitude are well within the range suggested by the available literature.
Employment support **Individual Placement Support (IPS)**	Individual Placement and Support (for those with severe enduring mental health problems) participants are **twice as likely to gain employment compared** with traditional vocational rehabilitation alternatives. Figures suggest (from Centre for Mental Health) that **IPS pays for itself within a year** (cost of intervention = £2,700, savings = £3,000). With a proportion of this saving a reduction in NHS hospitalisation (approx. 10% reduction), and reduction in bed days for those who were hospitalised. Current CCG IPS provision supports only a small proportion of those suitable (current investment of approx. £0.5m). The commissioning for value packs show poor CCG performance in this area compared to others.
Debt advice	Debt advice – medium level evidence, debt management intervention has better outcomes and lower costs over a two-year period compared to no action. The investment in debt advice can reduce the risk of developing mental health problems, the vast majority of the savings are in reductions in lost productivity. Debt advice services are patchy across the CCG.
Suicide prevention	It is estimated that the average cost per completed suicide for those of working

[10] Chiles et al. (1999) The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review. American Psychological Association.

	age only in England is £1.67m (at 2009 prices).This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as lost output (both waged and unwaged), police time and funerals. The model looks at the economic case over 10 years for investing in GP suicide prevention education aimed at reducing suicide among the cohort of working age adults. Based on an earlier study,GPs who go on the suicide prevention training course will have a 20% greater chance of identifying those at risk of suicidal behaviour in the year following training.[vi] The model indicates that 603, 706 or 669 suicides would be avoided over the 1, 5and 10year time horizons, respectively. The analysis of costs/savings includes expenditure on health care, police/coroner activities, funerals, productivity and intangible costs. The additional treatment and support costs for individuals who do not complete suicide are to some extent offset by a reduction in the costs to the health care system of completed suicides and serious self harm events, but the intervention has significant net costs to the health care system of up to £19m over 10 years nationally. However, if the reductions in productivity losses are also included then the intervention is cost saving by a very large margin), and remains so even if the estimated impact on productivity is reduced to just 5% of the baseline case. Overall, net savings of £1.27bn arise over 10 years if intangible costs are also included. All results are sensitive to assumptions about the future risk of suicide.
Workforce health	The evidence shows that initiatives to improve workplace health will produce in year savings in terms of productivity to the employer. Some studies suggest that there is a return on investment of approximately £9 for every £1 spent in terms of improved productivity to the employer. ➢ The potential mental health productivity savings, assuming no current action in this area, amount to nearly £5.7m across the large NHS employers in Cambridgeshire and Peterborough. ➢ The evidence and modelling is clear that investing in workforce health will generate short term productivity savings to the NHS. These are estimated, with the package modelled here to be approximately £3.9m over three years, with an investment of £335k. ➢ NHS employers should see considerable productivity savings from investing in workplace health. In particular this needs to focus on improved management and awareness of mental health and illness.
Lifestyle interventions to improve the health of those with severe mental illness (SMI)	The prevalence of smoking is particularly high among mental health service users and interventions are just as effective in this group as in the rest of the population. Smoking cessation has been shown to be perhaps the single most effective and cost-effective intervention in the whole field of public health. Estimated savings are £100.8 million, spread over a number of years, due to reduced smoking-related NHS costs. More profoundly, those successfully quitting would on average gain an increase in life expectancy of around seven years.
Community-based alternatives to acute psychiatric inpatient care for people with severe mental health illness at times of crisis	There is growing evidence that when implemented as intended Crisis home resolution teams are effective in reducing admissions and reducing length of stay in hospital without any adverse impact on clinical outcomes. They are also preferred by patients. Initiatives, such as the mental health first response Vanguard service locally anticipate an impact on reducing attendances and admissions at A&E (10% - 30% reduction in avoidances overall in year as shown in other areas), aiming for 2-3 years to break even financially.

*adapted from Health System Prevention Strategy for Cambridgeshire and Peterborough (Jan 2016), and Priorities for Mental Health: Economic report for the NHS England mental health taskforce. Centre for Mental Health (Jan 2016). Mental health promotion and mental health prevention: the economic case. LSE/PRSSU April 2011.

Additional Key References:

Health System Prevention Strategy for Cambridgeshire and Peterborough January 2016
http://cambridgeshireinsight.org.uk/health/healthcare/prevention

Peterborough Mental Health and Mental Illness of Adults of Working Age
https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

Suicide Audit
http://cambridgeshireinsight.org.uk/health/healthtopics/mh

The Mental health of Children and Young People in Cambridgeshire 2013
http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/mental-health-children-and-young-people

Fingertips
http://fingertips.phe.org.uk/

Public Health Outcomes Framework
http://cambridgeshireinsight.org.uk/health/phof

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7
22 SEPTEMBER 2016		PUBLIC REPORT
Contact Officer(s):	Modestas Kavaliauskas, Mental Health Vanguard Project Manager	Tel. 01223219417

MENTAL HEALTH VANGUARD PROJECT UPDATE

R E C O M M E N D A T I O N S	
FROM : Mental Health Vanguard Team	**Deadline date :** N/A
The Health and Wellbeing Board are asked to note the contents of the report with regard to the most recent developments of the Mental Health Vanguard project.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Clinical Commissioning Group (CCG) Partnership

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the committee with the most recent developments of the Mental Health Vanguard project.

2.2 This report is for Board to consider under its Terms of Reference No. 3.3, 'To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities'.

3. BACKGROUND

3.1 In July 2015, Cambridgeshire and Peterborough CCG was awarded status to become one of eight national Urgent and Emergency Care Vanguard sites.

3.2 As part of a national NHS England programme, Vanguard sites are designed to test, evaluate and accelerate change, by piloting a range of new models of care.

3.3 The local Vanguard programme has been split into five workstreams, which are clinically-led and involve patients and their carers throughout their development and implementation.

3.4 The five workstreams are:

1. 111/out of hours clinical hub
2. Admission avoidance/community access
3. In-hospital emergency care
4. Post hospital discharge
5. **Urgent and emergency mental health care**

3.5 The CCG and CPFT partnership is leading on the Vanguard programme, which relates to urgent and emergency mental health care.

4. SIGNIFICANT IMPLICATIONS

4.1 Phase 1

Non-recurrent winter monies funds were used to fund a six month pilot, to support a limited component of a community-based Mental Health crisis service. This has and will inform the roll out of the proposed full vanguard service model CCG-wide by 19 September 2016.

Components of the phase 1 pilot currently in place:

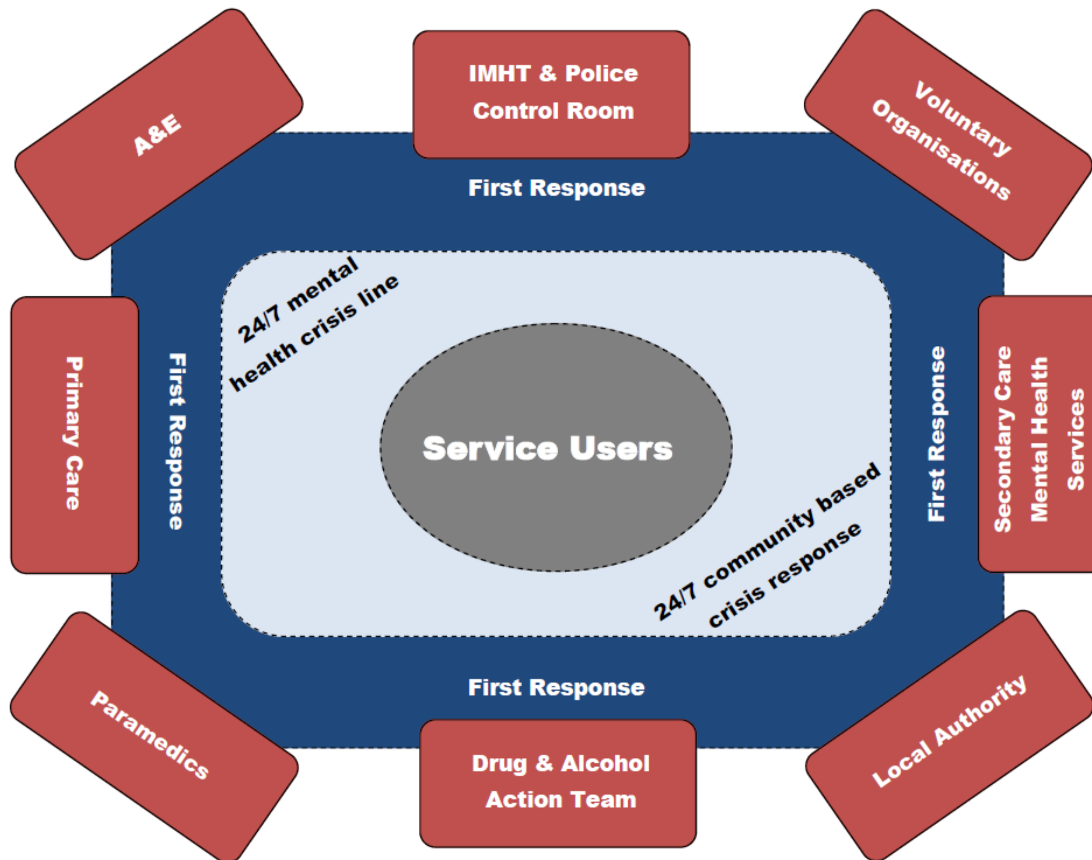
- First response service: With referrals triaged by the new system-wide co-ordinator, the first response service team dealt with 158 referrals in the first month of operation alone. Based in Cambridge, the team provide assessments in the community out-of-hours and respond to urgent referrals from emergency services.
- Sanctuary: The Sanctuary, based in Cambridge, opened on 4 April 2016 and allows people to get practical and emotional support during mental health crisis out of hours. Since opening feedback from patients and professionals has been very encouraging. Staffed by mental health charity Mind in Cambridgeshire, the Sanctuary can help patients link up with clinicians from CPFT's services or support from other organisations.
- MiDOS: MiDOS is a new mobile app that allows professionals to view a directory of services available locally and the service's live capacity. This will help professionals from different organisations better understand what is available, and then refer people on to the right service first time.
- A new integrated mental health team also launched on 29 March 2016 to provide mental health advice and support to the police. The team was part of the partnership response to the Crisis Care Concordat and is funded by the Cambridgeshire Police and Crime Commissioner and Peterborough City Council. In the first month they received 752 referrals from police across the county and were able to support the calls with advice or signposting to other services.

In summary, the phase 1 pilot was providing an urgent crisis response to mental health referrals in the emergency system by: coordinating the out of hours emergency response to mental health across the CCG, providing phone support out of hours for emergency referrals, and providing a full mental health response service within the Cambridge area.

4.2 Phase 2 – Mental Health Crisis Response Service, CCG-wide from 19 September, to includes the following:

- First Response Service will expand to cover the whole of Cambridgeshire and Peterborough 24/7. The service will aim to provide face-to-face assessment and crisis support within one hour, before diverting patients to a range of social, health and independent sector services, and urgent prescribing.
- A second Sanctuary, run by the third sector, will open in Peterborough to support people in the north of the county. There will also be an outreach service in Huntingdon, where people in crisis will be seen by the Sanctuary staff in a Huntingdon venue to work through their crisis and potentially be diverted from an unnecessary hospital attendance.
- Patients will be able to self-refer by telephone to urgent mental health services. Tele-coaches (experienced Psychological Wellbeing Coaches) will provide initial assessment and support via one point of telephone contact. They will then be able to signpost patients to the most appropriate service for them. They will be aided in this by the UK Mental Health Triage Scale – a new tool to assess over the telephone how quickly someone needs to receive mental health care. For more information please visit https://ukmentalhealthtriagescale.org/

It should be noted that the Mental Health Vanguard funding is non-recurrent but that any success within the programme could lead to these services being commissioned longer term.



4.3 CYP Mental Health Crisis pathway

- Online Counselling Service – KOOTH. It is expected that an online counselling support service will go live end Sept/early October, which will complement established face-to-face local counselling services. A practitioner will also work locally to promote the service in schools.

- Dedicated CYP practitioners within the Tele-triage. We propose to have dedicated CYP practitioners within the Tele-triage to ensure clinical safety, and appropriate levels of Clinical intervention to meet CYP needs, but the data of higher risk periods of the day would suggest this is not required 24hrs. The practitioner will have access to health and social care IT systems, with good liaison between the Crisis response, CAMHS, local authorities, schools and the voluntary sector.

- Discovery College – Based at Peterborough City College – proof of concept for CYP in Peterborough. It will provide an environment for young people to 'drop –in', it could also provide an appropriate environment for assessment if required. This Discovery college programme would be facilitated by the multiple agencies/ services and would allow CYP to present and self-refer in a crisis, or a service to be signposted too, if the crisis first came to attention through First response, schools or the online forum or website. The Discovery College would be a multi-agency environment with educational and mental health awareness training available. Given the diverseness of the population, the level of deprivation and the high rates of self-harm in Peterborough, the proof of concept would be initiated in this location.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8
22 SEPTEMBER 2016		PUBLIC REPORT
Contact Officer(s):	Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)	Tel. 01223 725400

SUSTAINABLE TRANSFORMATION PROGRAMME UPDATE

R E C O M M E N D A T I O N S	
FROM : Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)	**Deadline date :** N/A
The Health and Wellbeing Board is asked to note the direction and progress of the Sustainability and Transformation Plan.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board as an update to the Cambridgeshire and Peterborough Sustainability and Transformation Programme.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Board on the progress of the Sustainability Transformation programme and its next steps.

3. BACKGROUND

3.1 Cambridgeshire and Peterborough has been identified nationally as a 'challenged health economy'. In the local System Transformation Understanding Today, Designing Tomorrow change document, published in 2014, the health system's key challenges are identified as follows:

- the Cambridgeshire and Peterborough health system is not financially sustainable and if we continue as we are, we will face a financial gap of at least £250m by 2018/19
- the population of Cambridgeshire and Peterborough is increasing and there will be a greater proportion of older people in five years' time
- demand for health services continues to increase
- there are significant levels of deprivation and inequality, including between Cambridgeshire and Peterborough, that need to be addressed
- people are living longer and health outcomes are generally good but there are significant differences in people's health across the system.

3.2 All NHS organisations in the Cambridgeshire and Peterborough Health System have been asked to participate in a five year strategic plan – the Sustainable Transformation Plan (STP). Because local authority adult social care services and public health services are interdependent with NHS services, Cambridgeshire County Council and Peterborough City Council have also recognised the benefits of planning together with the NHS and aligning services with the NHS where appropriate. Local frontline staff are leading this work, supported by NHS England and NHS Improvement.

Cambridgeshire and Peterborough Sustainability and Transformation Plan

3.3 The first major output of the joint working to improve our populations' health and wellbeing was the draft Sustainability and Transformation Plan submission to NHS England and NHS Improvement on 30 June.

3.4 The draft Plan, known locally as *Fit for the Future*, sets out how each organisation in the system will need to work differently and increasingly together, in order to return the system to sustainability. The plan covers the period October 2016-March 2021.NHS England is currently reviewing all draft plans and has provided some feedback but local work continues in the meantime.

3.5 The views of patients and local people have already, and will continue to, shape key decisions and in developing *Fit for the Future*. For example the feedback received from public involvement assemblies over the past year and the needs identified in JSNAs have told us we need to address.

3.6 Implementing large scale change is difficult and there have been times in the past when the Cambridgeshire and Peterborough system has not succeeded in turning ideas into reality. It will be challenging to ensure that our STP is a success.

3.7 We are struggling today to meet the needs of our 900,000+ local residents. There is widespread variation in the health outcomes local people experience, largely due to socioeconomic factors, where increased partnership with local council and the voluntary sector is needed to address poor health proactively. A further contributor to our operational problems is that our capacity is not aligned to demand. These problems will worsen over the next few years when 100,000+ new homes are built and our population increases and ages.

3.8 We face key gaps that will widen if not tackled.

3.9 Health and wellbeing: Cambridgeshire and Peterborough is facing increasing demand for local health and care services. We have a rapidly growing population that will be 20% higher in 2031 than in 2013. Our elderly population is growing rapidly, increasing the number of people with long term conditions. We face growing levels of obesity, putting increasing demand on our health services. By 2018, 23.8% of our population will be obese.

Alongside this is an increasing mismatch in expectations. Some people are demanding more and faster access to healthcare but, at the same time, not taking responsibility for their own health and wellbeing by living healthy lifestyles.

The solutions we implement will need to be tailored to our diverse local populations. Life expectancy is generally higher than the national average in Cambridgeshire although there are variations within Cambridgeshire itself. However the reverse is true in Peterborough.
As a system, Cambridgeshire and Peterborough generally has lower disease prevalence than the UK average, however there are large differences in disease outcomes between areas. For example, age standardised mortality from CVD for those under 75 was 58.8 per 100,000 in Cambridgeshire in 2012-14 (statistically significantly better than the national average) but 89.6 per 100,000 in Peterborough (statistically significantly worse than the national average).

At times patients and carers feel that their views are not listened to by health care professionals. Those with long-term conditions report that they often experience a lack of coordination in the management of their multiple conditions and their multiple medications. We must address these concerns and do better for the people we serve.

3.10 Care and quality: Our staff also face challenges to the delivery of care. Our medical workforce has significant current and future capacity issues. These conditions have meant

the system has come to rely, too often, on overseas nursing recruitment. This is high cost and low yield in terms of return on investment with long-term retention unpredictable. The current model of general practice does not fit with the career aspirations of many of our younger doctors and nurses. New models of practice organisation, working at scale, networking, and provision for education and training need to be considered, along with any changes to skill mix. Our workforce problems have a direct impact on our ability to provide streamlined, efficient care to our patients.

Operationally we often struggle to meet demand. Overall, we have higher non-elective admissions than our peer group, driven by very high emergency bed-day usage by our south Cambridgeshire residents. The result is that we have long waiting lists for some specialties and we do not manage to meet either the 4-hour A&E target or the referral to treatment target consistently.

3.11 **Finance and efficiency:** We are more financially challenged than any other footprint. Our organisations have a combined deficit of 9% of turnover and our three general acute trusts all have severe financial problems. One reason for the significant deficit is historical underfunding in both health and social care. Whilst the recently updated CCG allocation formula and population growth allocations have partially addressed this, there remains a limited mismatch between financial allocations and population need.

3.12 **Partnership working:** Finally, we have not worked as well together as we might. Too often we have relied on contractual solutions when better relationships would have improved our collective ability to deal with the problems outlined above.

3.13 All of these reasons for change have been summarised in a number of public documents, and in particular the *Evidence for Change* document we published together in March 2016.

3.14 We have put in place what we believe to be the right building blocks including the strong, visible, collective leadership of our executives and frontline clinical, operational, and finance experts. We have designed a robust structure through which to drive the work. We are working on the Cambridgeshire and Peterborough system as a whole rather than on individual organisations or services. We have involved staff, patients, and the public in the design of our system solutions.

3.15 We have established a well-resourced programme of work, supported by NHS Improvement, through which we have sought to identify all opportunities to improve the effectiveness and efficiency of our system. It is through the work of voluntary organisations, councils and 200+ clinicians and patients who comprise the membership of the Clinical Working Groups, that our proposed solutions have been developed.

3.16 Our plan for the next five years aims to make significant strides. Our aim is for services to be delivered through joined-up health and social care that treats the ‘whole person’ and delivers a seamless service with minimal duplication of processes. This will require joined-up working across different groups of care givers from the different health and care organisations, as well as full involvement of patients, carers and, where appropriate, the voluntary sector.

10-point plan – Fit for the Future

3.17 Through discussion with our staff, patients, carers, and partners we have identified four priorities for change and developed a 10-point plan to deliver these priorities:

Priorities	10-Point Plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs

Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

3.18 Taken together, the 10-point plan identifies savings opportunities that will return the system to recurrent financial balance by 2021. This may require up-front financial support from national bodies to help us make investments in proactive community-based care that will lead to downstream savings and enable more people to be supported at home rather than in hospital.

Local Digital Roadmap

3.19 Digital transformation has been identified as an integral part of the delivery of future health services. To that end, each local community is required to describe how it will take forward this digital transformation. The document and process used to describe this is the Local Digital Roadmap (LDR) 2016-2020.

3.20 The CCG's LDR has to be linked to and reflect the STP ambitions for digital transformation. It also has to describe how local community will progress with achieving the national aspirations for Paper Free at Point of Care (by 2020), and more immediately deliver the Universal Capabilities by 2018. The CCG's LDR document follows a prescribed structure and was submitted to NHS England on 30 June 2016. It is anticipated that, following feedback, it will be agreed locally and published in autumn 2016.

4. NEXT STEPS

4.1 Our priority now is to translate our phased implementation plan into a series of delivery projects for 2016/17 and 17/18.

4.2 The Health and Care Executive (chief executives of the NHS organisations and the joint Chief Executive of Cambridgeshire County and Peterborough City councils) has agreed to:

- Establish an independent System Delivery Unit (SDU) and recruitment of the team has commenced for dedicated SDU posts.
- Bring together existing work programmes to deliver the STP into a single delivery plan. This included Better Care Funds projects and initiatives.
- Undertake a review of governance, including creating a Memorandum of Understanding (MOU) – which we hope will be signed off by HCE Sept 2016 and governing bodies/boards during October 2016. The MOU will underpin the Health & Care Executive which commits system leaders to working together to deliver the STP, and potentially, starts to delegate some decisions to the HCE. It will also simplify existing decision-making and partnership arrangements so they all align to the STP and are less administratively burdensome (with the benefit of more time being focused on 'doing').

4.3 We launched the Summary Sustainability and Transformation Plan to all staff on 19 July and key stakeholders and the public on 20 July. See Appendix 1.

4.4 The communications on this launch included staff briefings, email distribution, social media and a new partnership Fit for the Future website – www.fitforfuture.org.uk. The website includes:

- An overview of the programme
- Promotes our desire to involve them in designing and implementing changes, shaping care around local people's needs and empowering healthy behaviours
- Is supported by: conversational events / meetings, social media and videos to engage, a central source of information and updates on the website, and materials, including staff briefing slides, FAQs, leaflet, and posters.

5. BACKGROUND DOCUMENTS

5.1 Cambridgeshire and Peterborough Evidence for Change, March 2016 - here

5.2 NHS Shared Planning Guidance 2016/17 https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

6. APPENDICES

6.1 Appendix 1 – Summary Cambridgeshire and Peterborough Sustainability and Transformation Plan – 'How Health and Care services in Cambridgeshire and Peterborough are changing' - here

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APPENDIX 1

Fit for the Future

Working together to keep people well

How health and care services in Cambridgeshire and Peterborough are changing

@fitforfuturenhs
fitforfuturenhs
fitforfuture.org.uk

Cambridgeshire County Council
PETERBOROUGH CITY COUNCIL
NHS

1 Why do we need to change?

Our health and care services face challenges

The population of Cambridgeshire and Peterborough is growing rapidly. People are generally living longer, so we have an aging population, and more people have long term conditions or higher levels of obesity.

In addition, we are facing practical challenges:

- healthcare is not as good in some places as in others, and does not always meet the standards that it should
- recruiting and retaining staff is a challenge for all health and care services
- our health, local authority and other care services are not always joined-up, not always designed to meet people's individual needs, and do not always balance physical health with mental health and wellbeing
- overall, we spend too much of our time and resources treating illnesses which can be prevented or kept under control in better ways.

In Cambridgeshire and Peterborough we have a total budget of more than £1.7billion for NHS services, but we spend about £150million each year more than that. By 2021, this overspend is set to grow to about £250million if nothing changes.

This document tells you about our plan, both to meet your ambitions for health and care and to make services financially sustainable.

What you've told us so far

During 2015, we held listening events across Cambridgeshire and Peterborough to seek your views on the health and care system. We heard that:

- you want to be empowered to stay healthy
- you want easy access to information about health (you use Google and pharmacies)
- you want to understand how to use the right health and care service at the right time
- when you need care urgently, you would rather use a local service than be sent to A&E
- you want consistent access (e.g. opening hours for services) across Cambridgeshire and Peterborough
- you want care as close to home as possible
- children's services need to be co-ordinated better (they are currently too fragmented)
- you would be happy to be sent home from hospital sooner if you had visits from a nurse to support you
- you do not want to be sent home too early with no support – you are concerned about needing to be readmitted
- you need better communication and planning before you leave hospital
- you want the people who provide health and care services to collaborate and work more closely together.

2 Our five-year plan to make Cambridgeshire and Peterborough Fit for the Future

The NHS and local government officers have come together to develop a major new plan to keep Cambridgeshire and Peterborough Fit for the Future. Our plan aims to:

- improve the quality of the services we provide
- encourage and support people to take action to maintain their own health and wellbeing
- ensure that our health and care services are financially sustainable and that we make best use of the money allocated to us.
- align NHS and local authority plans.

It has been developed by our health and care organisations. We are working together and taking joint responsibility for improving our population's health and wellbeing, with effective treatments and consistently good experiences of care.

Local doctors and other clinicians are leading this work, supported by NHS England and NHS Improvement, the organisations that oversee our local NHS - ensuring that the views of patients and local people shape key decisions.

Fit for the Future sets out a single overall vision for health and care, including:

- supporting people to keep themselves healthy
- primary care (GP services)
- urgent and emergency care
- planned care for adults and children, including maternity services
- care and support for people with long term conditions or specialised needs, including mental ill health.

We know that we need to develop improved communication and stronger working relationships across our organisations. We also need a shared culture that means we can learn and make improvements together. We are committed to delivering the healthcare you need - working together as one system with one budget.

We are well placed to make the changes we need and have a lot to be proud of. Cambridgeshire and Peterborough has a committed and expert health and care workforce. We provide some excellent services to which people travel from other parts of the country. We host groundbreaking research and deliver excellent medical education and training. We have a resourceful voluntary sector, strong organisations, active local communities, and we work alongside research and technology industries which are world leaders in improving healthcare.

3 What are the priorities?

Through discussion with our staff, patients, carers, and partners we have identified four priorities for change and developed a 10-point plan to deliver these priorities.

Fit for the Future programme	
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

Priority one – At home is best

1 People powered health and wellbeing

We will help people to make healthy choices, keep their independence, and shape decisions about their health and care. We will work with community groups and businesses so people of all ages have good health, social, and mental wellbeing support.

Our first aim is to prevent illness and support people to take control of their own health and wellbeing. We will develop health services which work alongside patients and carers, social care, and housing providers, and help to build strong communities.

We want patients to become equal partners with those caring for them, make more decisions about their own treatment and, with advice and support, become increasingly confident to manage their own conditions, supported by technology.

2 Neighbourhood care hubs

More health and care services will be provided closer to people's homes and we will help people stay at home when they're unwell.

We aim to coordinate care better so it is tailored to the needs of the individual, paying close attention to the health and care services necessary to keep people living at home successfully - because we know this is the best way to keep people healthy and to maintain their independence.

When people become unwell, we will take every opportunity to spot warning signs, for example during regular health checks and visits to urgent care services, and focus local support to help people live with long-term health conditions.

We would like to see more joint working between local health and social care, with GPs playing a central role, supported by hospital clinical teams.

Patient story - future scenario

Better safe than sorry

When, on a Sunday morning outing, eight year old Olivia fell off her bike and banged her head, her mother Gemma didn't know what to do. She thought about driving to A&E or dialling 999 but remembered seeing posters saying that 111 was a better option for injuries that were not serious or life threatening.

She called 111 and they arranged for Olivia to see a GP later that morning. The GP, Martin, examined Olivia and advised Gemma about what to look out for following a head injury, and what to do if Olivia's condition changed. Martin directed Gemma to the NHS Choices website for further information.

In the afternoon, and using the information that she had been given, Gemma became concerned that Olivia was getting worse, not better. Following the advice that GP Martin had given her earlier she took Olivia to the hospital. The specialist children's team could access Olivia's notes and details of what had happened so Gemma didn't need to repeat her story. Olivia was observed for six hours and discharged fit, well, and keen to get back to playing with her friends.

Priority two – Safe and effective hospital care, when needed

3 Responsive urgent and expert emergency care

We will offer a range of easily accessible support for care and treatment, from telephone advice for urgent problems to the very best hospital emergency services when the situation is life threatening.

This will be supported by better coordination, for example referral through NHS 111, close working with the ambulance service, and clear information provided to patients about which services are available – and how to reach them - when they have an urgent health need.

We have made a commitment that all urgent and emergency care services must meet the recently revised national standards.

We expect that 24/7 urgent care services will remain on our main three sites: Addenbrooke's Hospital, Hinchingbrooke Hospital, and Peterborough City Hospital.

5 Continued world-famous research and services

We have world-class specialised care, but we are always looking for ways to be better. We will work together with our local research organisations and businesses to make this happen.

We believe we can achieve consistently better results for people with more serious needs, such as for heart and lung services, or complex surgery, in fewer, specialist units which make best use of the world-class expertise of our specialist consultants.

4 Systematic and standardised care

Doctors, nurses and other health and care professionals will work together across Cambridgeshire and Peterborough to use the best treatments and technology available.

We aim to make better use of research evidence – drawn from Cambridgeshire and Peterborough and beyond – to help us to use care and treatments systematically which are proven to be the most effective.

Where it is important to provide services from several sites across the area, we believe we can use our skills and expertise collectively to achieve better results through doctors and nurses working across more than one hospital site and sharing their expertise.

We expect that maternity services will also remain at The Rosie Hospital, Hinchingbrooke Hospital, and Peterborough City Hospital.

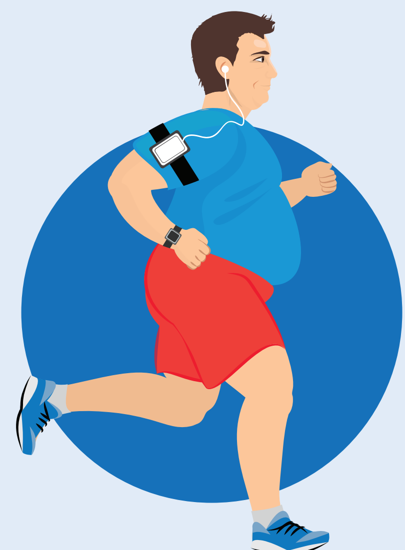
Patient story - future scenario

Looking forward – keeping active

Mark gave up playing rugby after a broken wrist and had become an armchair fan at the age of 39. He still enjoyed regular evenings out, and was ashamed to admit that his smoking had increased since he gave up sport. But Mark remained convinced he was still fit and healthy – with nothing to worry about.

Aisha, Mark's GP, was not so sure. Responding to an invitation for a regular check-up, Mark was told that he was significantly overweight, with warning signs suggesting he was at risk of developing diabetes. Aisha knew that persuading Mark to make the lifestyle changes he needed would require both a plan and support.

First, she connected him to the local smoking cessation service, which organised drop-in sessions Mark could easily get to, and put him in touch with a fitness coach who could recommend an exercise programme to suit him. She also realised that Mark's smartphone was his window on the world, and suggested some websites and a wellbeing app to help him plan and stick to his diet and fitness regime.



Priority three – We're only sustainable together

6 Partnership working

Everyone who provides health, social, and mental health care across Cambridgeshire and Peterborough will plan together and work together.

We believe we must work across boundaries: between NHS and local authority social care; GPs and hospital care; and physical health and mental health.

In addition, we aim to support our GPs to collaborate more, and work with them to develop sustainable services. We believe this will enable better access to resources through sharing and specialisation and closer working between GPs and their colleagues in hospitals. Development of the primary care workforce is an important part of this.

We also recognise that people are supported by a network of formal and informal care, and aim to work in partnership with local organisations such as faith groups and the voluntary sector.

Patient stories – future scenarios

Care shaped around the patient

After she turned 80, Doreen found her health deteriorating. Doreen has diagnoses of diabetes and emphysema (COPD), as well as early stage dementia. She lives with her husband, Roy, who is 82, who also has diabetes but is otherwise fit and cares for her.

Paul, her GP, invited Doreen for her annual assessment. Based on her increasing frailty, he accepted her onto the caseload for complex, case-managed patients who are supported by a multidisciplinary team in the community. Angela, a member of the community team, is her care coordinator.

Paul and Angela worked with Doreen and Roy to create two plans. The first was a care plan which summarised Doreen's health needs according to her preferences and priorities, and what she and Roy would want in the event of a crisis or deterioration in health. The second, a self-care plan, allowed Doreen to describe her goals and needs for caring for herself safely at home, and identified how she could be supported in doing so by Roy and the health system.

Living beyond psychosis

Jack was becoming increasingly isolated; he had stopped attending school and seeing his friends, and had complained of hearing voices. Following a comprehensive assessment at which he was considered to have developed an early onset psychosis, he was referred to the early intervention service. He began a three-year programme tailored to his needs. The service worked with Jack to deliver a holistic care plan.

Family therapy enabled Jack and his family to understand more about his experiences and to begin to resolve them.

Jack is now aware that he can choose to access a wealth of insight and to share experiences through social media. He is actively involved in monitoring his state of mind, has discussed in advance what he would like to happen in a crisis, and understands what to do if he becomes unwell again. His GP and the practice team are very involved with the care plan and can call on a range of support for Jack. Perhaps the most important connection was with an employment project which supported Jack through his college application. Now, in the second year of his course, Jack can see a much brighter future.

Priority four – Supported delivery

7 A culture of learning as a system

We are committed to sharing knowledge across the whole health and care system, so the people working in our health and care organisations know they are part of the big picture.

We want to develop a culture of learning. This means our staff developing a shared understanding of our services, priorities and challenges, a common approach to analysing opportunities and problems, and finding solutions together.

We believe we can share knowledge and expertise from the specialist services in Cambridgeshire and Peterborough, making the most of our world-class medical and healthcare education and training, and using research to drive improvement.

8 Workforce: growing our own

We have wonderful, talented people working in our health and care system. We aim to offer rewarding and fulfilling careers for our staff with opportunities for them to develop their skills and grow professionally. This way we can develop staff, including for those areas where we have some staff shortages.

We want staff to choose to work here and to see themselves as part of the whole health and care service in Cambridgeshire and Peterborough – not just the organisation which employs them, or their own clinical or professional groups. This will help us where we have services that have staffing shortages.

9 Using our land and buildings better

We want to bring all our NHS and local government sites up to modern standards. We want to make better use of our out-of-hospital sites, which may mean selling some buildings to invest in other modern, local facilities.

We want to explore how we can work together to get more value from our land and buildings, and bring all our sites up to modern standards.

There is a great deal of building development in Cambridgeshire and Peterborough, so we see opportunities for new strategic partnerships, such as the planned Hinchingbrooke Health Campus.

10 Using technology to modernise health

Good information and advice helps people take control of their health. We will use apps and online tools to provide more rapid and reliable information.

Shared information will help hospital clinicians, GP practices, community teams, and social care to work together more effectively.

Technology will help us to provide more rapid and reliable information for patients, and our clinicians will make sure technology is built in to new services.

Staff story – future scenario

Making the right call

Joanne supports several people with long term health conditions, enabling them to continue to live independently at home. She has built up a lot of knowledge about signs to look out for and urgent care options, and has always felt that she has valuable insight into how the emergency admission process works and whether it could provide a better experience for patients and carers.

Now working within a larger, multi-disciplinary team she can play a greater role. For example, she has received coaching from a local hospital consultant from whom she can also access immediate support and advice. This includes examples of symptoms which should raise concerns, so Joanne has the reassurance that she knows when it is right to call an ambulance and how she can help to prevent emergencies.

Staff stories – future scenarios

Joining up physical and mental health

Greg leads part of the liaison psychiatry service, which joins up mental health and physical health care when people need hospital treatment or urgent care. His team works in hospitals across Cambridgeshire and Peterborough, and is managed jointly by Cambridgeshire and Peterborough NHS Foundation Trust and Peterborough and Stamford Hospitals NHS Foundation Trust.

As well as helping to make sure that the NHS meets its commitment to give mental health the same priority as physical health, Greg believes that his service is based on principles which are fundamental to transforming care services in Cambridgeshire and Peterborough.

When people are admitted to hospital, the liaison psychiatry service focuses on helping them to recover and how they can be supported to return home. This requires a holistic approach - working across mental health and different hospital specialties, in partnership with the patient, and alongside carers, advocates, and social care providers - because keeping people well requires a team effort.

As a clinician, Greg wants to help shape new ways of working and sees his role as a great opportunity – both to help bring better outcomes for patients, and to develop his own professional skills.

Hospital care at home

Maqsood leads a newly-established team in St Neots. It helps to keep people living independently by providing intensive nursing input at home - so avoiding hospital admission or enabling earlier discharge.

Maqsood knows that the research evidence is clear. Too often, on admission to hospital the care and support networks on which older people depend fall away and with it their ability to live independently. He helped to co-design the service as part of the Fit for the Future programme and has worked hard to develop his team, which brings together professionals across several organisations and focuses on each individual patient's needs.

For example, Mrs Barlow was one of the team's first patients after she was discharged from hospital much sooner than she would have been before it was in place. She was able to recover at home, at first with high-level healthcare and daily contact with support workers, then stepping down to every other day contact with a nurse. She even received home visits from the pharmacist to make sure her medication was correct.

World-class hospital care – delivered closer to home

Visha, a Geriatrician, has always strived to provide the very best care available anywhere and, although they handle an enormous number of patients, she is proud of the outstanding results achieved by her hospital-based team.

Visha was recruited onto the transition team which managed the set up of a new service running satellite clinics. Working with Paul, one of the GP leads, she realised that this challenging change could mean even better treatment and an improved experience for patients. By setting up a buddying system, Visha's specialist expertise and Paul's broader experience were combined and Paul was supported to take on monitoring and care which would previously have required a hospital visit. Visha's team is now on rota to advise local GPs 24/7 via a hotline, so reducing the number of patients reaching them through A&E.

The practice at which Paul is based proved an ideal location for outpatient clinics. As a community 'hub', it is well-equipped and a new IT system enables Visha to access patient records and communicate with specialist colleagues - whether she is in the practice or on her ward.

4 What these changes mean for our finances

We have thoroughly reviewed our finances, including making comparisons with national figures, looking for opportunities to secure savings and ways to organise services more efficiently. We continue to look at the demands on services and our costs.

So far, if we deliver all the changes we have described our plan turns the currently projected £250million financial gap in to a small NHS system surplus by 2020/21.

We are committed to being as inclusive and open as possible. We will listen to all contributions and use these contributions to influence the decisions we make.

5 How you can get involved

There will be more opportunities for patients, carers, and local people to be involved about specific improvements we would like to make, and we will provide opportunities for staff and local people to help shape proposals for service change.

We also need a shared understanding about how best to use your valuable health and care services, and your priorities.

When we make changes, we aim to involve patients as early as possible - working alongside clinicians to help design services, as well as giving feedback.

You will be able to have a say in key decisions, including formal consultation.

And we want to help you look after yourself and take control of your own health and care.

Fit for the Future

Working together to keep people well

We will hold engagement events in the coming months and you can find the details on our website **www.fitforfuture.org.uk**

If you want to be part of the discussion and work with us to develop solutions, please contact us via email on **contact@fitforfuture.org.uk**

You can also register on our website **www.fitforfuture.org.uk**

Follow us on Twitter and Facebook for the latest news and developments.

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Produced by Cambridgeshire and Peterborough Sustainability and Transformation Programme.
July 2016

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HEALTH AND WELLBEING BOARD			AGENDA ITEM No. 9
22 SEPTEMBER 2016			PUBLIC REPORT
Contact Officer(s):	Will Patten, Director of Transformation, Peterborough City Council		Tel. 07919 365883

ADULT SOCIAL CARE, BETTER CARE FUND (BCF) UPDATE

R E C O M M E N D A T I O N S	
FROM : Will Patten, Director of Transformation,	**Deadline date :** N/A
Board members are requested to: 1. Note the update of BCF delivery and the BCF Section 75 Annual Report for 2015/16	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board at the request of the Corporate Director for People and Communities.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information for the Board; it sets out an update on the delivery of the BCF Programme.

2.2 This report is for the Board to consider under its Terms of Reference No. 3.6 *'To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.'*

3. BCF BACKGROUND

3.1 As previously reported, Peterborough's BCF has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the city. The BCF was announced in June 2013 and introduced in April 2015. The £12.6 million budget is not new money; it is a reorganisation of funding currently used predominantly by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and Peterborough City Council (PCC) to provide health and social care services in the city.

3.1.2 The BCF 2016/17 plan is now fully 'Approved' and written confirmation has been received by NHS England.

3.2 Governance

3.2.1 At a previous meeting, the Health and Wellbeing Board confirmed that the Joint Commissioning Forum, now the GPEPB, would oversee the delivery of the BCF Programme and management of the pooled budget on behalf of the Peterborough Health and Wellbeing Board.

3.2.2 Following approval by this Board in March 2015, the Section 75 Agreement between PCC and CCG was in place by 1 April 2015 when BCF funding began. The Section 75 Agreement has been reviewed to reflect changes for 2016/17 and contractual changes have been legally executed.

3.2.3 All necessary formal governance arrangements for the BCF were in place by April 2015.

3.3 Monitoring

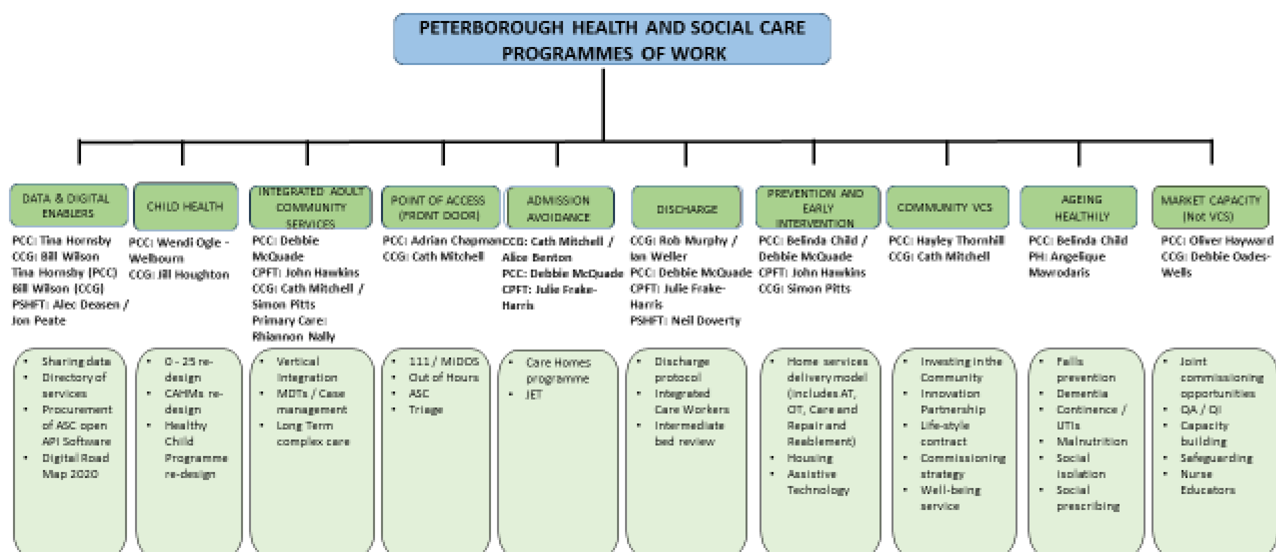
3.3.1 The Health and Wellbeing Board agreed to delegate responsibility for reporting to the GPEPB. The process and templates for reporting of local areas' BCF progress is defined by NHS England and the Local Government Association (LGA) arrangements.

3.4 The BCF Section 75 Annual Report was approved by the GPEPB on 22 April 2016. Key highlights include:

- 2015/16 spend was balanced at the end of the financial year and was invested in line with the budget plan.
- Large investments were made in OPACS, assistive technology, reablement, market development and quality improvement.
- The performance fund element of the budget was not released into the pooled fund, due to non-performance of non-elective admissions targets and was invested in acute provision.
- National conditions (e.g. protection of Adult Social Care provision, Care Act compliance and Disabled Facilities Grant investment) were met.
- Transformation projects progressed at varying speeds, with plans for 2016/17 building on the progress made to date.
- Key areas of learning have shaped the plans for 2016/17, including the need for stronger integration with other system programmes of work (e.g. STP, PCC Customer Experience Programme) and a shift to greater local delivery.

3.4 Workstream Updates

3.4.1 Recent analysis of Peterborough system plans, showed that there are a large number of programmes and initiatives across the local Health and Social Care System, including the BCF, CCG Sustainability and Transformation Plan and Vanguard programme. In the development of plans for 2016/17, the various programmes of work have been combined, wherever possible, to ensure efficient and effective deployment of resources, ensuring the focus is on delivering the changes and improvements. This approach has been shared with partners across the system and the below diagram outlines the agreed health and social care programme structure:



Data and Digital Enablers: The immediate focus is developing practical data sharing solutions to support multi-disciplinary working, including the review of approaches in line

with Caldicott recommendations. The decision was taken not to progress the UnitingCare 'OneView' system and the CCG is leading on exploring alternatives to support a single view of the patient record, linking with the Local Digital Road Map 2020 work.

Child Health: This incorporates the 0-25 re-design, CAMHS re-design and Healthy Child re-design projects. Work is underway to progress mapping, service design and implementation plans.

Integrated Adult Community Services: Vertical Integration plans to align PCC Adult Social Care with the Neighbourhood Teams are progressing. Trailblazer neighbourhood team sites to test the MDT coordination commenced on the 13th June. The need for MDT Coordinators has been confirmed. Trailblazer sites will continue for a further period, to allow further refinement of case finding and GP engagement before wider roll out. Case finding proof of concept pilot is currently being tested.

Point of Access (Front Door): Alignment of the PCC Adult Social Care Front Door with 111, including MiDOS is being progressed. A detailed model is now in development and benefits analysis has been undertaken. The LGA Digital Transformation Fund awarded £40k to support the development of a Local Information Platform (LIP) (previously referred to as the Information Hub), which will support the consistency, quality and accuracy of information.

Admission Avoidance: A&E Urgent Care Plan being developed. Mapping of intermediate care provision being undertaken to inform effective commissioning approach. 24/7 Mental Health crisis response service goes live in Peterborough on 19th September.

Discharge: Mapping of 7 Day Service community provision across Peterborough completed and priorities identified as care homes and voluntary sector. Pathway Coordinator pilot evaluation outcome report developed. Integrated Care Workers funding has been agreed and local implementation arrangements are being finalised.

Prevention and Early Intervention: PCC is undertaking further work to refine the Home Services Delivery Model to ensure integrated and strengthened intermediate care tier provision. This incorporates the integration of Care and Repair, Assistive Technology, Therapy Services and Reablement teams. PCC and CPFT are working closely to ensure integration is achieved across system-wide intermediate care provision. There is a continued focus on the expansion and embedding of Assistive Technology across social care and health.

Community VCS: The PCC Innovation Partnership is being progressed and discussions are underway with the CCG to understand the scope of integrating health commissioning with the model.

Ageing Healthily: Key objectives for this work include:

- Falls Prevention: District level leads group is looking at further development to support local implementation of the joint falls pathway.
- Primary Prevention: Further refinement of the scope of social prescribing work is being undertaken. The PCC Investment in the Community project focuses on building community resilience.
- Mental Health and Dementia: Key leads have been identified. The primary focus is the development of a joint strategy and pathway.
- Continence and UTIs: further development of gaps and priorities is being undertaken.

Market Capacity (not VCS): Care Home Educators have now been recruited by the CCG and further work to develop joint working with care homes is a priority. PCC is exploring joint commissioning opportunities to ensure efficiencies on an ongoing basis.

4. CONSULTATION

4.1 As previously reported, in the developing and drafting of the BCF Plan there were detailed discussions and workshops with partners. Joint working across Cambridgeshire and Peterborough continues and regular monitoring activities have been solidified to ensure clear and standardised reporting mechanisms.

5. IMPLICATIONS

Financial

5.1 Delivery assurance through the Board will enable the Council and the CCG to continue to meet NHS England's conditions for receiving £12.6m BCF.

Legal

5.2 The report is for noting and legal implications are covered within the body of the report.

5.3 The BCF funding is in line with the Council's Medium Term Financial Strategy (MTFS).

Human Resources

5.4 Some of the work-streams noted in 3.4 could have staffing implications such as changes to job descriptions or potential TUPE considerations. Where this is the case these will be considered and dealt with in accordance with the Council's HR policies.

6. BACKGROUND DOCUMENTS

i) BCF Quarterly Data Collection Template Q1 15-16 Peterborough (final)
ii) BCF Quarterly Data Collection template Q2 15-16 Peterborough (final)
iii) BCF Quarterly Data Collection Template Q3 15-16 Peterborough (final)
iv) BCF Quarterly Data Collection Template Q4 15-16 Peterborough (final)

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 10
22 SEPTEMBER 2016		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin Director of Public Health	Tel. 01733 207175

REVISED ANNUAL PUBLIC HEALTH REPORT 2016

R E C O M M E N D A T I O N S	
FROM : Director of Public Health	
The Health and Wellbeing Board is asked to note the revised Annual Public Health Report for Peterborough, which has additional pages on recent trends in health outcomes, as requested.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request from the July meeting of the Health and Wellbeing Board to provide additional information on key recent trends in health outcomes in the Annual Public Health Report (APHR) 2016.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Health and Wellbeing Board with the updated APHR 2016, for information.

2.2 This report is for Board to consider under its Terms of Reference no. 3.4, 'To consider the recommendations of the Director of Public Health in their Annual Public Health Report'.

3. MAIN BODY OF REPORT

3.1 At the Health and Wellbeing Board meeting in July, the HWB Board requested further information on trends, recent successes and comparisons with national and comparator authorities to be included in the APHR 2016.

3.2 The attached updated version of the APHR 2016 includes three additional pages outlining:

- Recent public health success stories in Peterborough
- Areas where we have made progress but further work is required
- Areas for change and improvement

3.3 The focus of the APHR on using straightforward and often pictorial information, which a wide range of readers can understand, has previously been welcomed by the HWB Board. But it does have limitations when communicating more complex information – for example the rate at which specific improvements in life expectancy or mortality rates are occurring in Peterborough, when compared with the national average and with similar local authorities. It is proposed that for next year's APHR (2017) – a technical appendix will be produced, which will provide the more detailed information which the HWB Board has requested, alongside a clear and easily read summary report.

3.4 A wealth of information on trends in public health outcomes in Peterborough, together with national, regional and local authority comparisons is also available online through the Public Health Outcomes Framework (PHOF) website http://www.phoutcomes.info/.

4. CONSULTATION

4.1 The APHR 2016 is the independent report of the Director of Public Health, and therefore public consultation on the content of the report is not required.

5. ANTICIPATED OUTCOMES

5.1 The addition of information on trends in public health outcomes, including recent public health successes and areas for improvement, adds to the picture of the health of the population in Peterborough, provided by the APHR 2016.

6. REASONS FOR RECOMMENDATIONS

6.1 The Health and Wellbeing Board is asked to note that additions to the APHR 2016 have been made as requested.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 The APHR 2016 could have been left unchanged, and comments noted for APHRs produced in future years. However the request from the HWB Board for further information in 2016 was clear feedback and was responded to promptly.

8. IMPLICATIONS

8.1 The APHR 2016 was presented to the HWB Board in July, and there are no additional implications.

9. BACKGROUND DOCUMENTS

9.1 Covering report titled ‘Annual Public Health Report 2016’ to the Peterborough Health and Wellbeing Board meeting on July 21 2016.

DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT 2016

PETERBOROUGH: CREATING A HEALTHY CITY

Contents

Introduction 3
Recent Public Health Success Stories in Peterborough
Areas Where We Have Made Progress – But Further Work Is Required
Areas for Change & Improvement

Our Population 7
Healthy Life Expectancy & Life Expectancy
Health Outcomes
Children & Young People
Older People

Our Lifestyle Choices 11
Cardiovascular Disease
Tobacco
Obesity
Alcohol & Drugs

Building A Healthy City 16
Healthy Places
Healthy Schools
Healthy Workplaces

Health Inequalities 20

Introduction

The annual Director of Public Health Report is an independent document focused on the health of the people of Peterborough. This year's report updates the health statistics used in the 2015 report and has a new section on health inequalities.

The Report provides information about public health successes and challenges in Peterborough. The plans to address these challenges are outlined in the Peterborough Health and Wellbeing Strategy, available on www.peterborough.gov.uk/healthcare/public-health/health-and-wellbeing-strategy

I'd like to thank all the people I've worked with over my first year as Director of Public Health in Peterborough for their enthusiasm, energy and practical support, and their commitment to improving outcomes for local residents.

Dr Liz Robin

Director of Public Health

Recent Public Health Success Stories in Peterborough

The percentage of adults in Peterborough who smoke has fallen from 20.7% to 18.1% over the period 2012 – 2015 and the percentage of workers in routine and manual occupations who smoke has fallen from 32.1% to 25.6% over the same time period.

Life expectancy at age 65 for males in Peterborough (18.5 years) is now similar to England (18.8 years), having been significantly worse in 8 of the past 13 years.

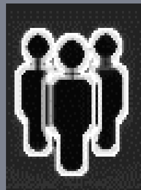
A significantly higher proportion of Peterborough residents aged 40-74 (34.7%) have received an NHS health check compared to England (27.4%).

Peterborough continues to meet national benchmark goals for a range of population vaccination indicators relating to children, including protection against diphtheria, tetanus, pneumonia, measles, mumps and rubella.

Peterborough has shown signfiicant improvements since 2012 in the success rate of treatment for people with drug misuse problems. The latest national benchmarking from 2014 indicates that success rates in Peterborough are better than the national average for both opiates and non-opiates treatment.

Significantly fewer households in Peterborough experience fuel poverty than the national average.

Areas Where We Have Made Progress – But Further Work is Required



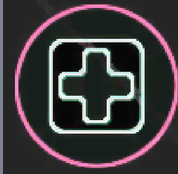
Over the last 10 years, life expectancy at birth has increased for both males (from 75.8 to 78.6 years) and females (80.4 to 82.4 years). But despite these increases, life expectancy remains significantly below England for both males and females.

The number of people under 75 who died from all cardiovascular diseases fell from 519 in 2001-03 to 352 in 2012-14, but Peterborough remains statistically significantly worse than England for both of these indicators.

The percentage of children living in poverty in Peterborough has fallen from 23.8% to 21.3% but remains significantly higher than England (18.0%).

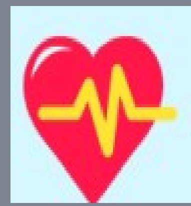
The rate of under 18 conceptions in Peterborough has fallen from 58/1,000 in 1998 to 30/1,000 in 2014, but this remains higher than England (23/1,000).

The recorded rate of diabetes in Peterborough (6.5% of the population) is similar to England (6.4%) but has risen in each of the last four years.



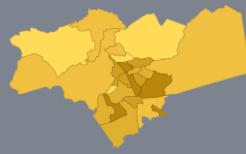
Numbers of people aged 65 and over suffering injuries due to falls are lower than in previous years but are significantly higher than England.

Areas for Change and Improvement



Although overall life expectancy has improved in Peterborough, healthy life expectancy (the average number of years a person can expect to live in self-reported good health) has not shown improvement in recent years for either males or females and remains below the national average.

The proportion of adults in Peterborough classified as physically “inactive” due to taking less than 30 minutes of moderate physical activity per week, rose from 30% to 34% between 2014 and 2015.



Significant health inequalities remain between communities in different parts of Peterborough. There are poorer health outcomes in communities towards the centre of the City associated with higher levels of socio-economic deprivation, while the best health outcomes are seen in rural areas west of the City.

Emergency hospital admissions for intentional self harm remained well above the national average between 2012/13 and 2014/15.

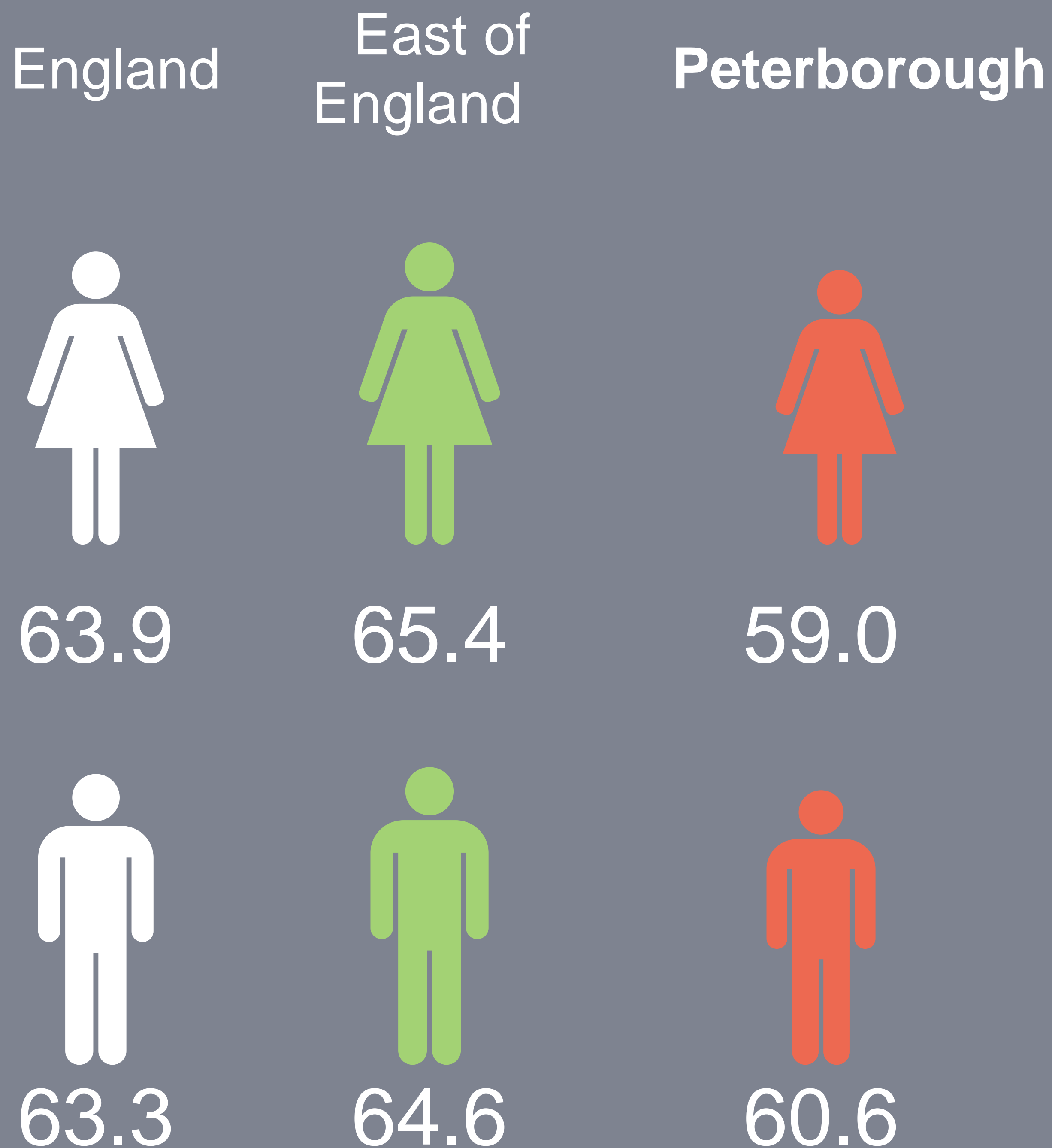
Breast cancer screening coverage in Peterborough fell from being significantly better than England in 2010 to significantly worse than England in 2015. Cervical cancer screening has been significantly lower than England for each of the six years 2010-2015,.

Our Population

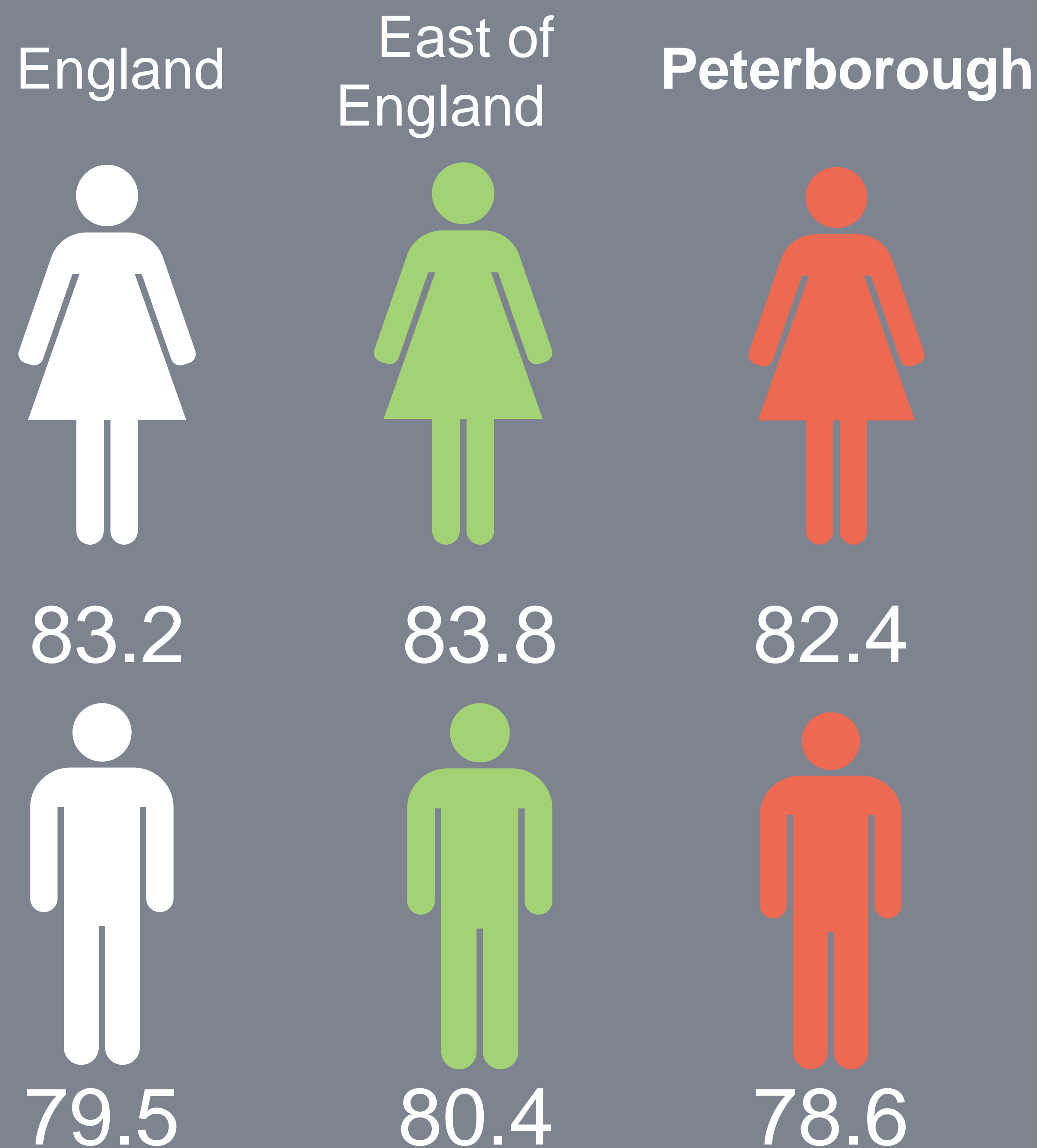
Peterborough

Although life expectancy has been improving over recent decades we are spending more years in poor health. A woman in Peterborough can expect to live to over 82 but will spend around 23 years in declining health. A man can expect to live to 79 having spent 18 years in poor health.

Healthy life expectancy



Life expectancy



Children and Young People

Peterborough is one of the fastest growing cities with an increasing younger population, yet some children in Peterborough continue to be disadvantaged in terms of health and factors that affect health and quality of life.

5 year old children receiving 2 doses of MMR is below the recommended 90% mark

480

Children (0-14) admitted to hospital in 2014/15 due to injuries.

27% Higher rates of hospital admissions for self-harm in 15-24 year olds than England

Similar rates of tooth decay in 5 year old children to England

72.9% of mothers breastfed in the first 48 hours after delivery but only 43.9% of mothers breastfeed after 6-8 weeks

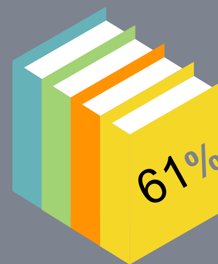
Peterborough's young population is growing

24% more 5-9 year olds by 2031

and

27% more 10-14 year olds by 2031

21.9% of children in Peterborough in low income families



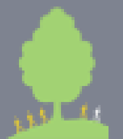
Over half of all children have achieved a good level of development at the end of reception

Lowest level of Year 1 pupils achieving the expected level in the phonics screening check in East of England

37.4%

Higher rate of teenage pregnancy in Peterborough compared with England

Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing, poor physical and mental health, and have lower rates of economic activity in adult life



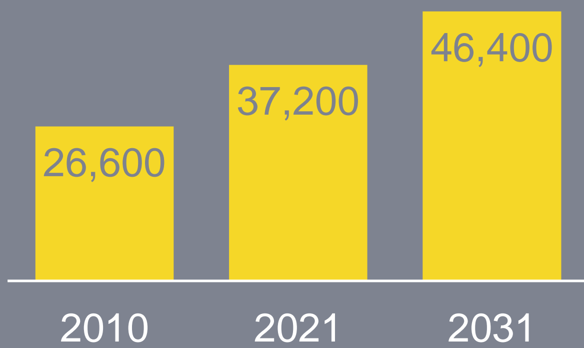
Older People

Older age often presents health challenges. The number of people aged over 65 in Peterborough is increasing and will continue to increase over the next 20 years. This will put pressure on health and social services. However, some simple measures can be taken to help prevent illness and disability and enable older people to live healthier longer lives and to live independently.

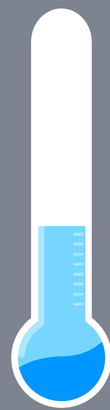
Our local challenges

74%

Increase in the number of people over the age of 65 by 2031 (compared with 2010)



2X more people aged over 80 in 2031 than 2010



In Peterborough, 50 more people aged over 85 died during winter months in 2011-14 than would be expected based on mortality rates at other times of year

69% of older people take up the offer of the flu immunisation

1 in 17 people aged over 65 are living with dementia, which is over 1,500 people in Peterborough

441 emergency hospital admissions for injuries from falls in persons aged 80 and over in Peterborough in 2014/15.

health and social care bill for hip fractures in Peterborough per year.

192 hip fractures in people aged over 65 in Peterborough in 2014/15

1 in 3 people who fracture their hip die within 12 months after the fracture

Our Lifestyle Choices

Reducing Deaths from Cardiovascular Disease

Cardiovascular disease includes stroke and heart disease: both involve damage to blood vessels and have common risk factors. Diabetes and chronic kidney disease are also included in the cardiovascular disease family as they have similar risk factors and increase the risk of cardiovascular disease. These risk factors include smoking, obesity, lack of physical activity, high blood lipids and high blood pressure.

Peterborough Health and Wellbeing Board has identified cardiovascular disease as a priority for action.

The challenge in Peterborough

352 deaths under the age of 75 in Peterborough between 2012-14 were caused by Cardiovascular Disease. 211 of these people died from heart disease and 50 from strokes.

Cardiovascular Disease deaths under the age 75 are preventable with current knowledge - but are the right people getting the care they need?

122nd out of 150

Peterborough ranked 122/150 local authorities for premature deaths from heart disease in 2012-14 (with 1 being the best ranking and 150 the worst).

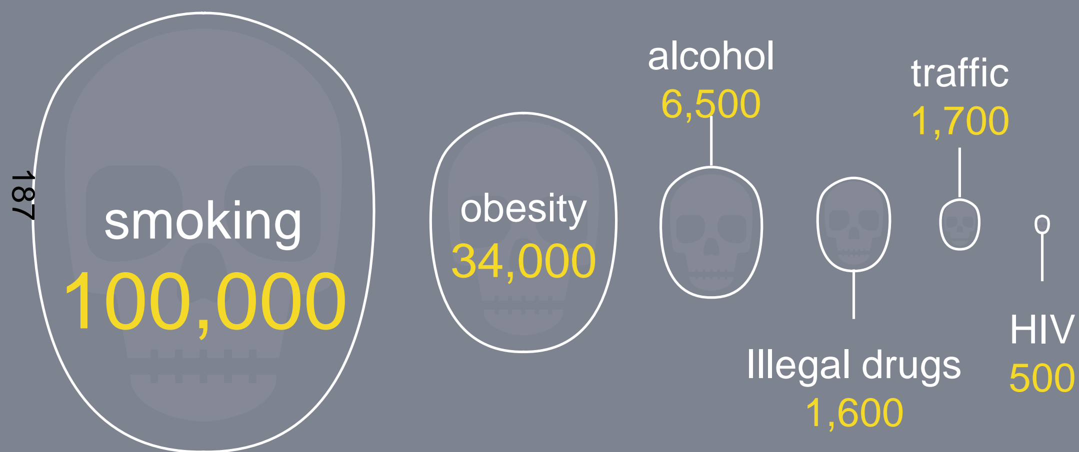
13th out of 15

Peterborough ranks 13/15 among local authorities with similar social and economic factors and similar deprivation levels for premature deaths from heart disease in 2012-14.

Reducing the harm caused by tobacco

Smoking kills half of all long term users. It is the main cause of preventable illness and premature death in the United Kingdom. It accounts for more preventable deaths than the following five preventable causes, **combined**.

Major annual causes of death in the United Kingdom



1out of 10

young people in Peterborough are regular smokers by the age of 15 years old

2 out of 3

smokers began smoking before they were 18

26%

of routine and manual workers in Peterborough smoke

4 out of 10

people with mental health issues smoke

Our challenges

30,000

smokers in Peterborough

£46 million
Total annual cost of tobacco to Peterborough

cost of smoking due to Ill health and care in later life

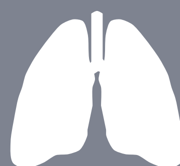
£10 million

over 2,000

people in Peterborough are admitted to hospital due to smoking every year

over 250

people in Peterborough die due to smoking every year



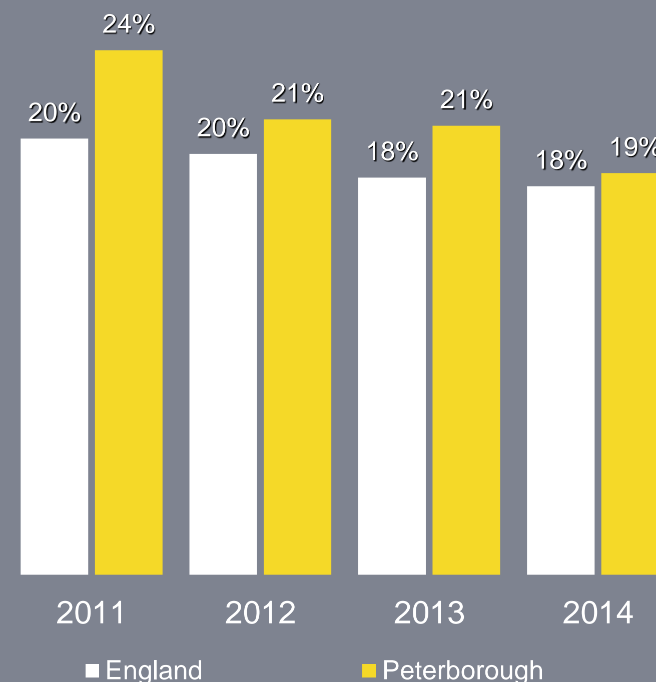
over 45

people in Peterborough die from lung cancer every year

Higher rates of smoking among
BME and migrant groups

Higher rates of smoking among
Pregnant women

Smoking prevalence among adults

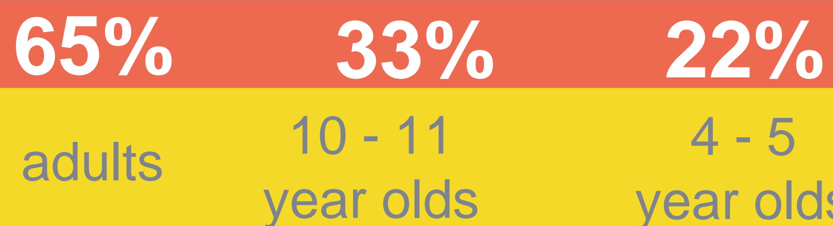


5 tonnes of cigarette waste produced every year

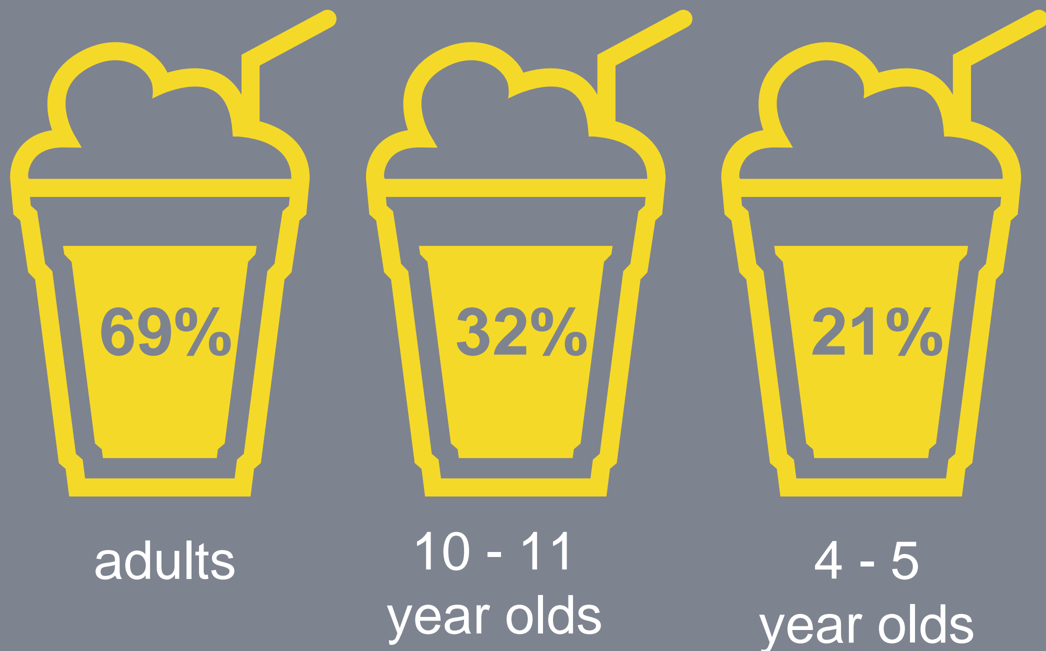
Unhealthy weight

a widespread threat to health and wellbeing

In England many people are overweight or obese



In Peterborough



Obesity develops when energy intake from food and drink is greater than the energy we use through exercise and to keep our body working. Obesity increases the risk of heart disease and some cancers.

Our approach

Bringing together a coalition of partners

Harnessing the reach of local government

Comprehensive support and intervention

Addressing attitudes, beliefs and behaviours towards diet

Action is needed at all stages of life, - from pre-conception through pregnancy, early years, childhood, and adolescence through to adulthood and preparing for older age – and in a variety of settings (school, workplace, community) **to encourage and support people to maintain a healthy weight.**

Local challenges

10 years

reduction in life expectancy for severely obese individuals

94th out of 150

local authorities for cancer deaths

122nd out of 150

local authorities for heart disease deaths

Alcohol and drugs

Drinking too much alcohol damages health and costs the NHS around £60 each day for each adult in Peterborough. About 16% of drinkers in Peterborough 'binge drink'- defined as drinking 8 or more units for a man and 6 or more units for a woman - in a session.

7,500

people in Peterborough drink heavily at levels which have, or risk, damaging their health

1 in 5

people in Peterborough (23,000 people) drink above the recommended levels

1,169

alcohol-related hospital admissions in Peterborough in 2014-15, the second-highest in the East of England

The cost to the local NHS system is £1.8 million a year or £244 per person for the 7,500 people in Peterborough who drink heavily

estimated opiate/cocaine users in Peterborough, though this probably underestimates the number of users

9,500

people in Peterborough estimated to have taken 'any drug' in the last year (the majority using cannabis)

20%

of 16-24 year olds nationally are estimated to have taken 'any drug'

Crimes related to drugs cost the UK £13.3 billion every year

Families suffer

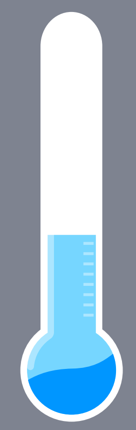
1 in 3 cases of domestic abuse is linked to alcohol

1 in 5 of all children live with a parent who drinks hazardously

Building A Healthy City

Creating Healthy Places

There is a clear relationship between health and where we live. A number of published studies have provided evidence that our local environments can have a positive affect on individual health and wellbeing as well enabling stronger communities.

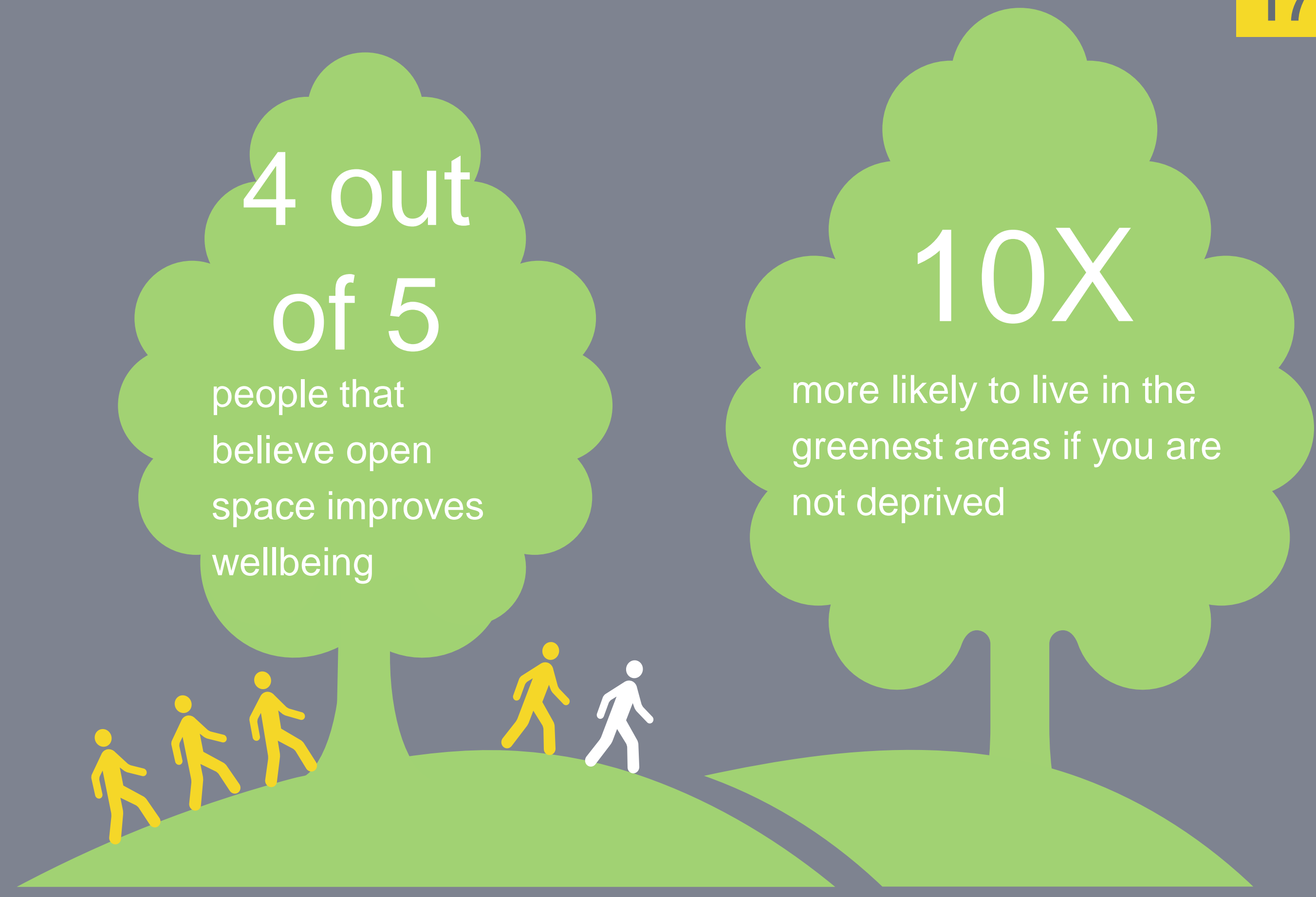


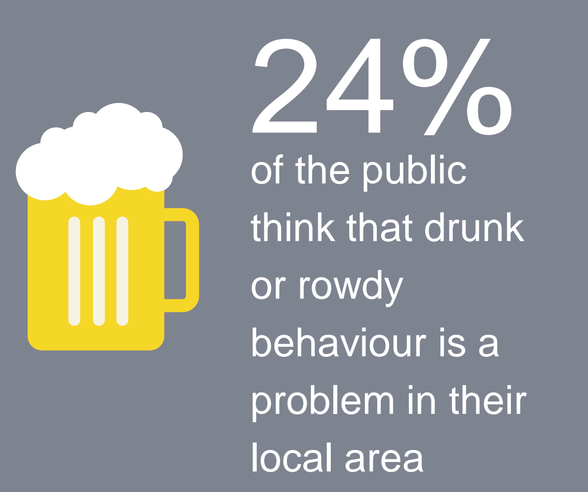
Living room temperature in winter

Under 16 C - Resistance to respiratory disease may be diminished

9 C - 12 C - exposure for more than two hours increases risk of cardiovascular disease

5 C - significant increase in the risk of hypothermia





Celebrating Healthy Schools

Schools play a vital role in nurturing the health and wellbeing of children and young people. Providing support and recognition of their role in enhancing emotional and physical health to improve long term health, increase social inclusion and raise achievement for all through a **Healthy Schools, Peterborough** programme is therefore be a local priority for implementation.

74%

of schools achieved Healthy School status as part the national programme that operated until 2011

Role of Healthy Schools programme identified through the national evaluation

Instigator: enabling changes to practice in schools

justification: providing reasons to change for management teams

Tool: acting as a tool to re-evaluate existing practice

Awareness: raising the profile of health and well being among staff

74%

of schools stated that the national programme had a positive impact on the emotional health and wellbeing of pupils

87%

of schools stated that the national programme had a positive impact on their schools' provision of PSHE (personal, social and health education)

impacts of healthy eating

improvement to pupil behaviour in school
increased take-up of school lunches
awareness of healthy food choices
increased healthy eating outside of school

72%

of schools stated that the national programme had a positive impact on their schools' physical activity provision

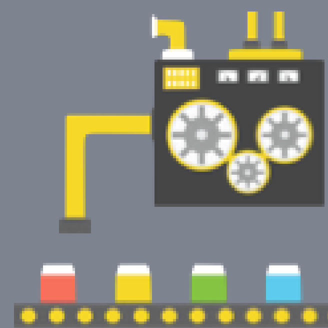
Encouraging

Healthy Workplaces

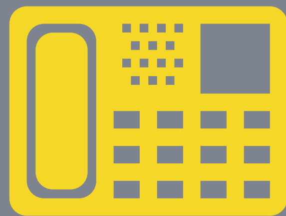
Reducing sickness absence, lowering staff turnover and increasing productivity are all outcomes of investing in a healthy workforce. The workplace provides an ideal place to promote healthy lifestyles to a large proportion of the local population. Improving the physical and mental wellbeing among our workforce will benefit individuals, organisations and Peterborough as a whole - after all **'health means wealth'**.

80%
chance of being off work for 5 years among those who have been off sick for 6 months or longer

Public Services
£889
average sickness absence cost per employee per year



Production and Manufacturing
£754
average sickness absence cost per employee per year

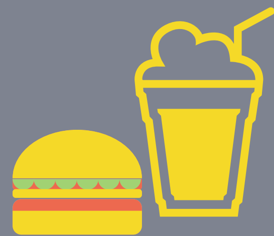


Call Centre
£940
average sickness absence cost per employee per year

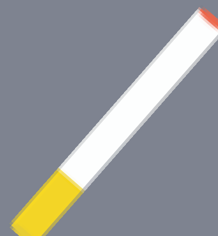
Professional Services
£904
average sickness absence cost per employee per year

27%
Fewer sick days taken by physically active workers

£835,355
estimated annual cost of mental ill health to an organisation with 1,000 employees. Prevention and early identification of problems in the workplace should enable employers to save at least 30% of this cost



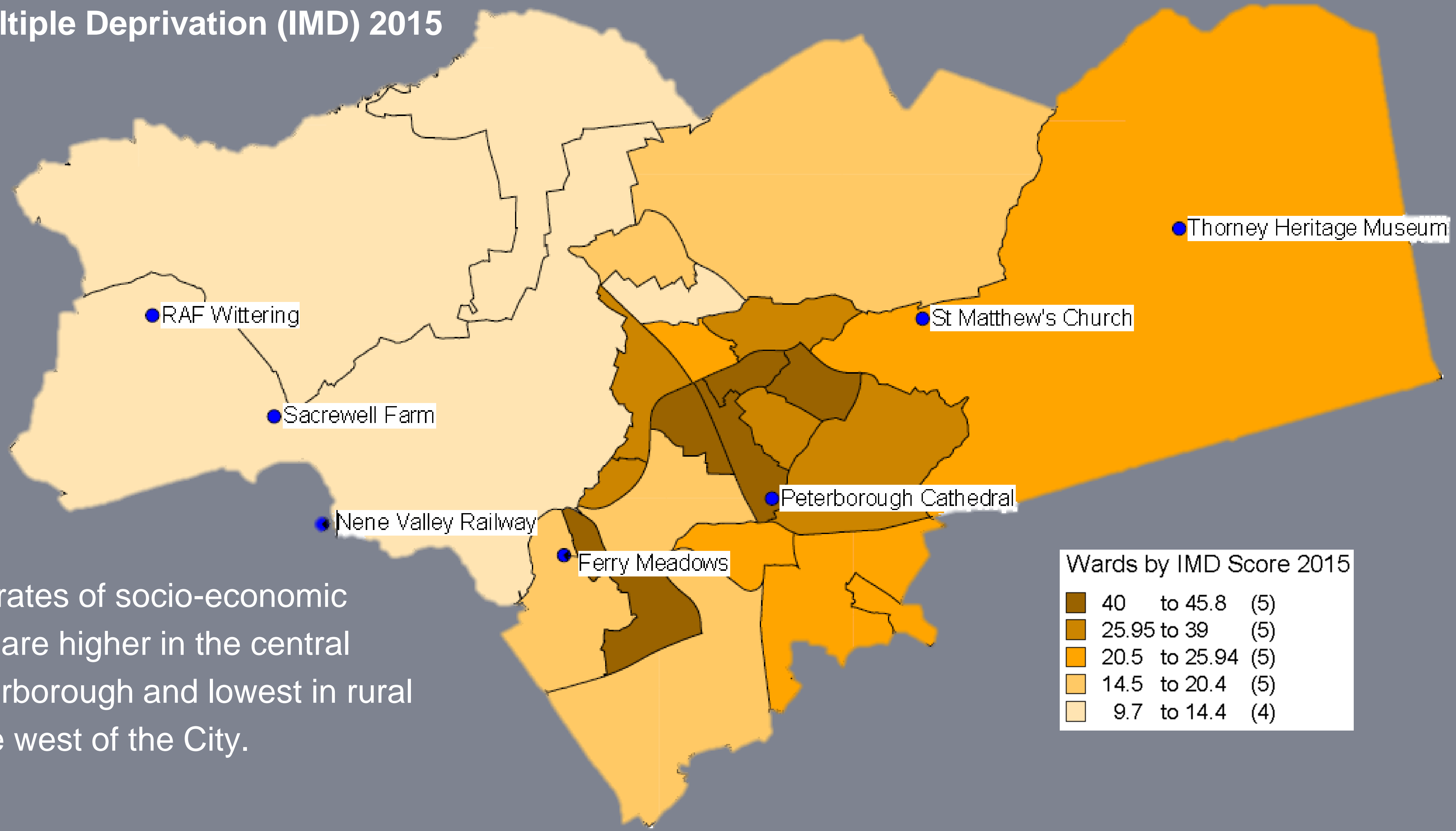
4
extra sick days, on average, taken by obese people each year



33
more hours off sick per year taken by a person who smokes than a non-smoker each year

Health inequalities

Socio-economic deprivation varies across Peterborough



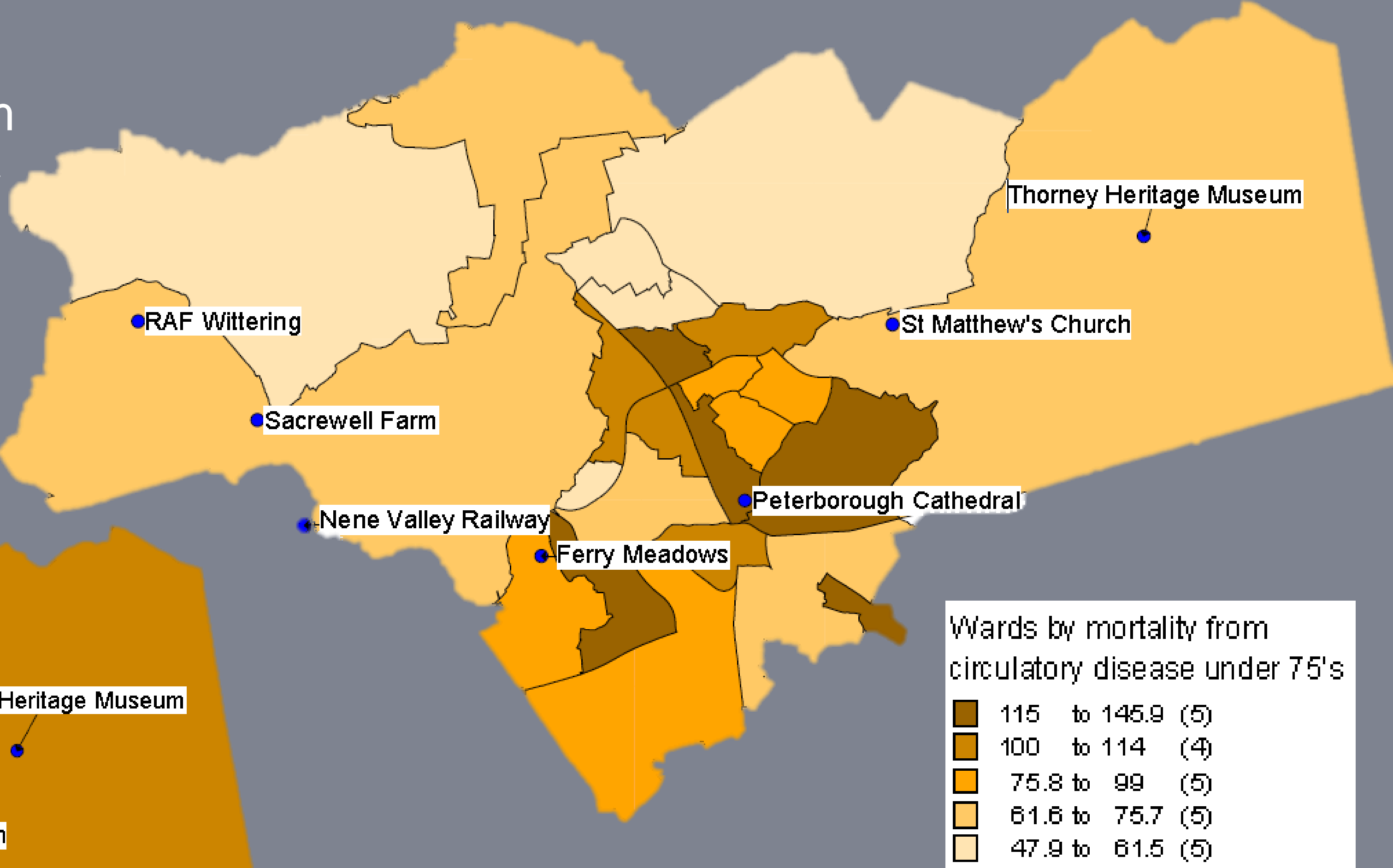
In general, rates of socio-economic deprivation are higher in the central part of Peterborough and lowest in rural areas to the west of the City.

Note: Darker colours indicate a high rate of deprivation

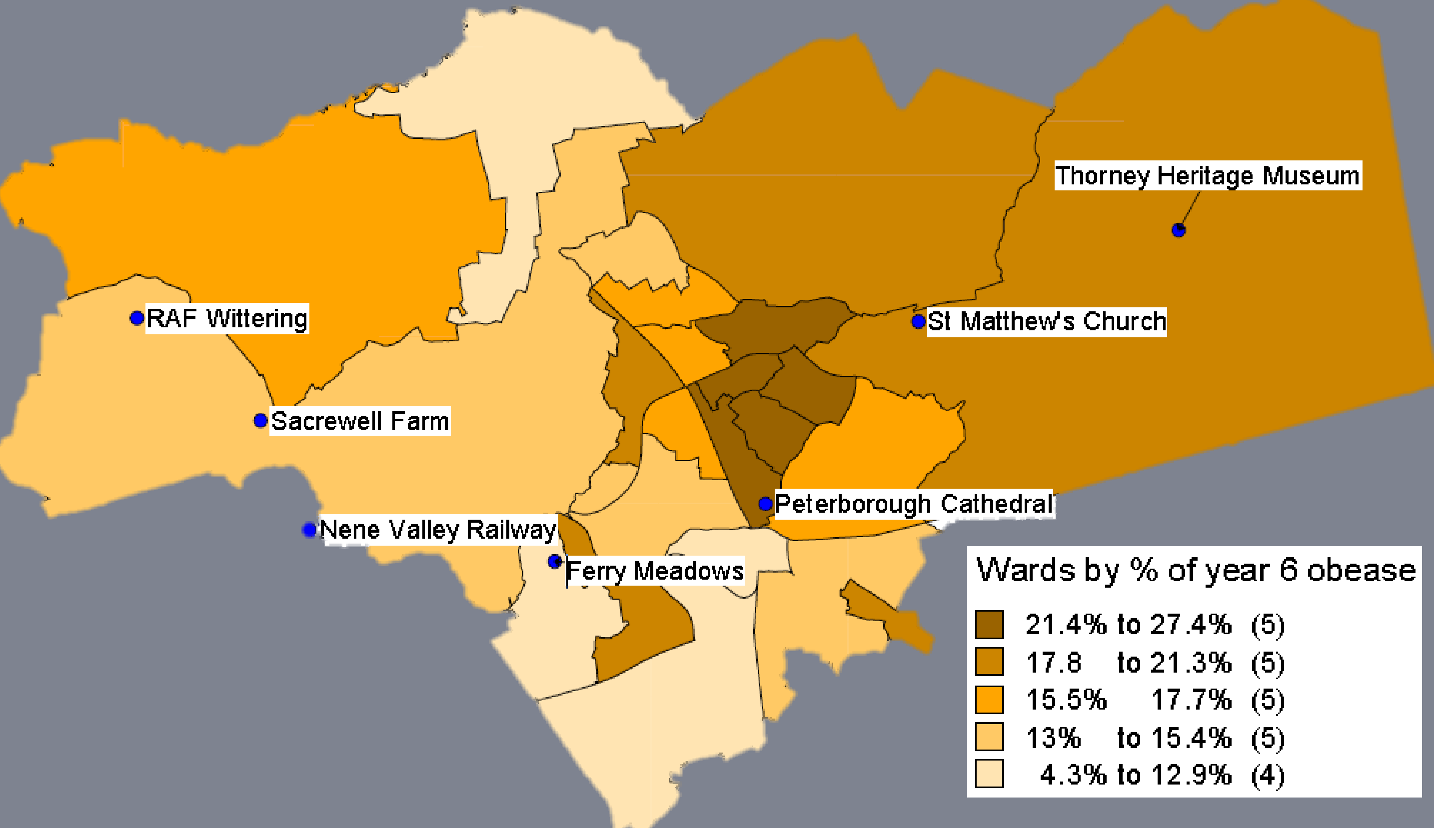
Poorer health outcomes are linked to areas of socio-economic deprivation

When comparing these maps with the map of socio-economic deprivation on page 17, it's easy to see that rates of premature deaths from heart disease and childhood obesity are higher in more deprived areas. Addressing this will need targeted action, working closely with local communities.

Premature deaths from circulatory Disease under age 75



Percentage of obese children age 10-11



Note: Darker colours indicate a high rate of either childhood obesity or heart disease mortality rates.

Acknowledgements:

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Infographics sourced from Freepik www.freepik.com

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UPDATED: 14 Sept 2016

HEALTH AND WELLBEING BOARD
PROPOSED AGENDA PLAN 2016/2017

MEETING DATE	ITEM	CONTACT OFFICER
21 July 2016	Greater Peterborough Partnership New Governance Framework Adult Social Care, Integration of Health System Programmes Governance Structure Domestic Abuse and Sexual Violence Update St Georges Hydrotherapy Pool Annual Director of Public Health Report Draft Peterborough Health and Wellbeing Strategy Health and Care Executive Governance Framework **For Information:** Adult Social Care, Better Care Fund Update	Will Patten Charlene Elliot Wendi Ogle-Welbourn Helen Gregg Cathy Mitchell Liz Robin Liz Robin Cathy Mitchell Will Patten (Caroline Hills)
22 September 2016	Peterborough Cardiovascular Disease Strategy Diverse and Ethnic Communities Joint Strategic Needs Assessment for Peterborough Sustainable Transformation Programme Mental Health Strategy Mental Health Crisis Vanguard Project Update Sustainable Transformation Programme Update **For Information:** Adult Social Care, Better Care Fund (BCF) Update Revised Annual Public Health Report	Liz Robin Liz Robin Aidan Thomas (CPFT) Wendi Ogle-Welbourn (Lee Miller / Elaine Young (CPFT)) Catherine Pollard – STP Lead Will Patten (Caroline Hills) Liz Robin
22 December 2016	Hydrotherapy Policy Health & Wellbeing and SPP Partnership Delivery Programme Board Update Report Healthwatch Priorities 2016/17 Recruitment & Retention – workforce development presentation CCG and PCC commissioning intentions 2017/18 Adult Safeguarding Peer Review – Outcomes and Recommendations Domestic Abuse Audit Report	**Sarah Shuttleworth/Gary Howsam (CCG)** **Helen Gregg** **Angela Burrows** **Ryan Hyman** **Cathy Mitchell / Will Patten** **Debbie McQuade** **Jo Procter**

MEETING DATE	ITEM	CONTACT OFFICER
	Devolution Update Adults and Childrens Local Safeguarding Board Annual Reports 2015/16 PRISM (Primary Care Service for Mental Health) (Requested by CCG/CPFT) **For Information:** Better Care Fund Update Sustainable Transformation Programme Update	**Kim Sawyer** **Jo Procter** **Andrea Bateman (andrea.batemen@cpft.nhs.uk)** **Will Patten (Caroline Hills)** **Catherine Pollard**
23 March 2017	Sexual Health Service Update Care Act Update VAWG Needs Assessment Sustainable Communities SPP Plan Health & Wellbeing Strategy 6 month progress update **For Information:** Better Care Fund Update Sustainable Transformation Programme Update	**Jo Melvin** **Debbie McQuade** **Helen Gregg** **Pat Carrington** **Adrian Chapman** **Liz Robin** **Will Patten (Caroline Hills)** **Catherine Pollard**