# HEALTH AND WELLBEING BOARD

## MONDAY 4 DECEMBER 2017
## 1.00 PM

### Bourges/Viersen Room - Town Hall
**Contact – paulina.ford@peterborough.gov.uk, 01733 452508**

## AGENDA



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|---|---|
| **11. Annual Report Of The Peterborough Safeguarding Children Board 2016-17 and Annual Report Of The Peterborough Safeguarding Adults Board 2016-17** | **207 - 272** |
| **12. Quarterly Health & Wellbeing Strategy Performance Report** | **273 - 348** |
| **13. Adult Social Care, Better Care Fund (BCF) 2017-19 Update** | **349 - 352** |
| **14. Schedule of Future Meetings and Draft Agenda Programme** | **353 - 354** |

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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http://democracy.peterborough.gov.uk/documents/s21850/Protocol%20on%20the%20use%20of%20Recording.pdf

Board Members:

Cllr J Holdich (Chairman), Cllr D Lamb, Cllr W Fitzgerald, Cllr R Ferris, G Smith, H Daniels, C Mitchell, Dr Laliwala, Dr Howsam, (Vice Chairman), W Ogle-Welbourn, Dr Robin, A Chapman and S Evans Evans

Co-opted Members: Russell Wate and Claire Higgins

Further information about this meeting can be obtained from Paulina Ford on telephone 01733 452508 or by email – paulina.ford@peterborough.gov.uk

PETERBOROUGH CITY COUNCIL

# MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD AT 1PM, ON 11 SEPTEMBER 2017 BOURGES/VIERSEN ROOM, TOWN HALL, PETERBOROUGH

**Committee Members Present:** Dr Gary Howsam, Clinical Commissioning Group (Vice-Chair)
Councillor Ferris
Councillor Fitzgerald, Deputy Leader, Cabinet Member for Integrated Adult Social Care and Health
Councillor Lamb, Cabinet Member for Public Health
Dr Liz Robin, Director for Public Health
Wendi Ogle-Welbourn, Executive Director People and Communities
Catherine Mitchell, Director of Community Services and Integration
Joanne Proctor, Head of Service, Adult and Children's Safeguarding Boards
Gordon Smith, Healthwatch
Hilary Daniels, South Lincolnshire CCG
Simon Evans-Evans, Locality Director Cambridgeshire and Norfolk, NHS
Sarah Ferguson, Assistant Director Housing, Communities and Youth

**Officers Present:** Daniel Kalley, Senior Democratic Services Officer

**Also Present:** Helen Gregg, Partnership Manager, Peterborough and Cambridgeshire Councils
Aidan Fallon, Head of Communities & Engagement Cambridgeshire & Peterborough STP
Caroline Townsend, Better Care Fund Lead
Katie Johnson, Specialty Registrar in Public Health
Keith Reynolds, Assistant Director of Strategy at North West Anglia NHS Foundation Trust

## 11. APPOINTMENT OF VICE-CHAIRMAN

The Senior Democratic Services Officer informed the Committee that Dr Mistry was no longer the Vice-Chairman of the Health and Wellbeing Board. A nomination was proposed and seconded that Dr Gary Howsam be appointed the Vice-Chairman of the Health and Wellbeing Board for the remaining meetings of the municipal year.

**RESOLVED:**

That Dr Gary Howsam be appointed Vice-Chairman of the Health and Wellbeing Board for the remainder of the municipal year.

At this point the Vice-Chairman took up the position of the Chairman in the absence of the regular Chairman

## 12. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Holdich, Dr Laliwala, Claire Higgins, Russell Wate, Andrew Pike and Adrian Chapman. Sarah Fergusan was in attendance as substitute for Adrian Chapman, Simon Evans-Evans was in attendance as substitute for Andrew Pike, Joanne Proctor was in attendance as substitute for Russell Wate.

## 13. DECLARATIONS OF INTEREST

Agenda Item 5 – Adult Social Care, Better Care Fund (BCF) 2017-19 Plan Approval

Dr Gary Howsam declared that he was a part of the Clinical Commissioning Group as mentioned in the report.

## 14. MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 12 JUNE 2017

The minutes of the meeting held on 12 June 2017 were agreed as a true and accurate record.

## 15. ADULT SOCIAL CARE, BETTER CARE FUND (BCF) 2017-19 PLAN APPROVAL

The Health and Wellbeing Board received a report in relation to the Better Care Fund (BCF) approval for 2017-2019.

The purpose of the report was to seek approval from the Health and Wellbeing Board for the BCF 2017-2019 submission.

The Better Care Fund Lead introduced the report and stated that Peterborough was required to submit a new, jointly agreed BCF Plan, covering a two year period to NHS England on 11 September 2017. The Board were informed that the 2017-2019 submission built on plans agreed previously. One of the key priorities was to pool monies into the BCF Section 75 budget between Peterborough City Council and Cambridgeshire City Council and that these monies must be used to meet Adult Social care needs, reducing pressures on the NHS once people discharged and ensuring the local social care provider market is supported.

The Committee were informed that housing options for vulnerable people was a key priority and this had been enhanced with a joint contribution with the local STP.

The debated the report and in summary, key points raised and responses to questions included:

- There was recognition that a large number of people had significant needs when it came to housing. It was important that work was carried out with local housing providers, especially for those with the most sever needs. It was envisaged that those who were able to self-manage in their own homes would have a better quality of life.
- It was noted that in order to support the delivery of the 3.5% national DTOC target there would need to be a significant recruitment drive,

- It was a challenging target to get buy-in. It was therefore essential to work closely with local partners and to identify the reasons for any delays.
- The investment in re-enablement was significant and it was anticipated that this would be done via the local STP.

The Health and Wellbeing Board considered the report and **RESOLVED** to approve the Better Care Fund (BCF) submission.

## 16. UPDATE ON THE HINCHINGBROOKE HEALTHCARE NHS TRUST AND PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST MERGER

The Health and Wellbeing Board received a report in relation to Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust Merger.

The purpose of the report was brief the Board on the outcome of the merger and to look at the key issues identified in the approved business case for the merger.

The Assistant Director of Strategy at North West Anglia NHS Foundation Trust introduced the report and commented that the merger was to provide greater integration across Peterborough and South Lincolnshire. The merger was completed on 1 April 2017 and corporate structures were now fully in place.

Consultation and final structures for clinical services had been delayed, however these had now started. The focus going forward was to look at those services that faced the biggest challenges. Cardiology services provided for the local area were not the full range, however this was being looked at in depth.

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- Although there were a number of challenges, the due diligence process carried out enabled the senior management team to identify those areas that were most in need of attention.
- NHS England and Improve had been a great source of support and had enhanced relationships between parties.
- CCG were fully aware of the issues surrounding the cardiology facilities and were looking at a full needs assessment.

The Health and Wellbeing Board considered the report and **RESOLVED** to:

1. Note the progress with the formation of North West Anglia NHS Foundation Trust
2. Note those services identified during the merger as fragile and needing support
3. Support the resolution of these services for the local population

## 17. PETERBOROUGH ANNUAL PUBLIC HEALTH REPORT 2017

The Health and Wellbeing Board received a report in relation to the Peterborough Annual Public Health Report 2017

The purpose of the report was to provide information to the Board about statistics and trends on the health of the Peterborough population.

The Director of Public Health introduced the report and commented that the Annual Health Report reviewed the determinants of health, education and employment. The

report included maps of Peterborough which show how the determinants of health varied across the authority. The second section of the report focused at the main lifestyle behaviours which impacted on individual health and wellbeing and compared this against other local authorities.

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- The trends around infant mortality and childhood obesity were key indicators that had improved
- Life expectancy had improved, although this was still below national average.
- Most of the information contained in the report had a work programme that was being worked on to improve key issues.
- The report was to be distributed as widely as possible.
- The focus going forward was to look at what individual boards did in terms of tackling health
- One of the biggest areas of concern was housing, however there was a programme board in place to look at this issue.

The Health and Wellbeing Board considered the report and **RESOLVED** to:

1. Note the information outlined in the Annual Public Health report
2. Consider any recommendations the Health and Wellbeing Board make.

## 18. PETERBOROUGH PHARMACEUTICAL NEEDS ASSESSMENT

The Health and Wellbeing Board received a report in relation to the Peterborough Pharmaceutical Needs Assessment.

The purpose of the report was to provide the Health and Wellbeing Board with a summary of the statutory requirements for the Board to complete a Pharmaceutical Needs Assessment (PNA) every three years. In addition the Health and Wellbeing Board were being asked to delegate authority to the Chairman and Vice-Chairman in discussion with the Director of Public Health for approval of the draft PNA report being published for public consultation.

The Specialty Registrar in Public Health introduced the report and informed the board that since 1 April 2015 every health and wellbeing board had a statutory responsibility to publish and keep an up to date statement of the needs for pharmaceutical services for the population in its local area.

The board were informed that the draft PNA report would be published for a formal 60 day public consultation from mid-October to mid-December 2017. Members of the public and stakeholders would be able to complete a questionnaire in order to give their views.

The Health and Wellbeing Board considered the report and **RESOLVED** to:

1. Delegate authority to the Chairman and Vice-Chairman, in discussion with the Director of Public Health, for approval of a draft pharmaceutical needs assessment being published for public consultation

## 19. NEW GOVERNANCE ARRANGEMENTS AND SUSTAINABLE TRANSFORMATION PROGRAMME

The Health and Wellbeing Board received a report in relation to new Governance arrangements and sustainable transformation programme.

The purpose of the report was to inform the Health and Wellbeing Board on the review of the Sustainability and Transformation Partnership (STP) leadership. This was to also include the proposed changes to governance arrangements.

The Head of Communities and Engagement Cambridgeshire and Peterborough STP introduced the report and commented that there had been universal support from the NHS partner chairs and the Health and Care Executive (HCE) for the formation of an STP Board. The first meeting of the board was scheduled to take place on Thursday 14 September. It was envisaged that the first meeting would discuss the stakeholder group and would seek to gather the views of a number of these stakeholders including Health and Wellbeing Boards.

The revised structure needed to be approved by all individual boards, this was hoped to be completed by October 2017. The Health and Wellbeing Board were informed that STP would be broadly responsible for setting medium and long term STP strategy. In terms of the leadership of the STP, Tracy Dowling, the current Accountable Officer for the STP was to continue in the role for now. In addition Catherine Pollard had been appointed as Executive Programme Director and was to replace Scott Haldine.

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- Peterborough was in the process of seeking legal advice as to who would represent Peterborough City Council
- The STP Board would look into internal arrangements and not duplicate the work of the HCE Executive Board.
- A further update report would be useful for the Board to consider at the next meeting.

The Health and Wellbeing Board considered the report and **RESOLVED** to note:

1. The proposed changes to STP leadership including the establishment of the STP Board
2. That Local Authority colleagues are currently considering appropriate elected representation to sit on the STP Board
3. That ToR's, the STP Governance Framework and other governance documentation can be made available to the Board

**ACTIONS AGREED:**

1. That the Health and Wellbeing Board receive an update report at the next meeting in December.

## 20. JOINT STRATEGIC NEEDS ASSESSMENT CORE DATASET 2017

The Health and Wellbeing Board received a report in relation to the Joint Strategic Needs Assessment Core Dataset 2017.

The purpose of the report was to provide the board with the most recently updated Joint Strategic Needs Assessment (JSNA) dataset.

The Director of Public Health introduced the report and stated that the Health and Wellbeing Board had a statutory duty to prepare a JSNA for Peterborough. In addition the board were informed that this document provided a useful tool for experts and service managers in being able to access detailed information for their particular field.

The JSNA highlighted to the CCG, STP and Combined Authority those areas that needed urgent addressing, showing inequalities in certain sectors.

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- There would need to be careful planning of communications strategy and the key areas relevant to different organisations before the document was circulated more widely. In practice this would enable those core organisations to target areas of inequality and issues that may arise.

The Health and Wellbeing Board considered the report and **RESOLVED** to:

1. Note the content of the updated Peterborough Joint Strategic Needs Assessment Core Dataset 2017
2. Approve the publication of the Peterborough Joint Strategic Needs Assessment Core Dataset 2017 on the Peterborough City Council Website

## 21. LOCAL TRANSFORMATION PLAN

The Health and Wellbeing Board received a report on the Local Transformation Plan.

The purpose of the report was to inform the Board of the planned refresh of the Local Transformation Plan (LTP) for children and young people's emotional and mental health. In addition it enabled the Board to provide delegated sign-off of the plan once amendments had been made with wider stakeholders.

The Director of Community Services and Engagement introduced the report and commented that this was the third refresh of the LTP. The report was being brought to the Committee in order to agree delegated sign off to the Executive Director People and Communities in order to ensure that the plan was signed off within the relevant timeframe.

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- The LTP would draw on recent evidence around self-harming amongst 10-24 year olds.
- It was agreed that the plan could be discussed at a number of executive boards.

The Health and Wellbeing Board considered the report and **RESOLVED** to:

1. Note the refresh of the Local Transformation Plan for children and young people's emotional and mental health which was due by 31 October 2017
2. Provide delegated sign off for the plan prior to publication deadline 31 October 2017

## 22. JOINT DEVELOPMENT PLAN

The Health and Wellbeing Board received a report on a joint development session with colleagues from the Cambridge Health and Wellbeing Board.

The purpose of the report was to outline a possible development session with the LGA in January 2018, involving members of both Peterborough and Cambridge Health and Wellbeing Boards.

The Partnership Manager, Peterborough and Cambridgeshire Councils introduced the report and informed the Board that a joint development session was planned for January 2018.

The Health and Wellbeing Board considered the report and **RESOLVED** to:

1. Agree to a joint development session with Cambridge Health and Wellbeing Board in January 2018.

## INFORMATION AND OTHER ITEMS

## 23. QUARTERLY HEALTH AND WELLBEING STRATEGY PERFORMANCE UPDATE

The Health and Wellbeing Board received a quarterly update report on the Health and Wellbeing Strategy.

The Partnership Manager, Peterborough and Cambridgeshire Councils introduced the report and informed the Board that the report tried to summarise progress against future plans outlined in the Health and Wellbeing Strategy 2016-2019.

The Health and Wellbeing Board debated the report and in summary, key points raised and responses to questions included:

- The report was clear and helped a number of organisations see what was happening across Peterborough and identify areas to build on.
- There were a number of outreach programmes taking place across Peterborough to try and engage with a number of different communities.

The Health and Wellbeing Board considered the report and **RESOLVED** to note the content of the performance progress.

**ACTIONS:**

1. To circulate scrutiny report showing how Peterborough was meeting targets for engagement.

## 24. SCHEDULE OF FUTURE MEETINGS AND DRAFT AGENDA PROGRAMME

The Health and Wellbeing Board received a report of the work programme and future dates of the Health and Wellbeing Board.

The Board agreed to look at adding an item on the Woodland Trust and Self-Harm and suicide figures. In addition a further update report on the STP Governance Arrangements would come to the meeting in December.

The Health and Wellbeing Board considered the report and **RESOLVED** to note the work programme and future dates of the Health and Wellbeing Board.

Chairman
1pm – 2.17pm
11 September 2017

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 4 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

| Report of: | Wendi Ogle-Welbourn, Executive Director of People and Communities Cambridgeshire and Peterborough Councils | |
|---|---|---|
| Contact Officer(s): | Daniel Kalley/Paulina Ford, Senior Democratic Services Officer | Tel. 01733 296334 / 452508 |

# AMENDED HEALTH AND WELLBEING BOARD MEMBERSHIP AND TERMS OF REFERENCE

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Wendi Ogle-Welbourn, Executive Director of People and Communities Cambridgeshire and Peterborough Councils | **Deadline date:** *N/A* |
| It is recommended that the Health and Wellbeing Board note and agree the amended terms of reference as attached at Appendix A. | |

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following the resignation of Dr Harshad Mistry from his role on the Peterborough Local Clinical Commissioning Group.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to seek the agreement of the Health and Wellbeing Board on the revised terms of reference of the Board. Namely the reduction from two to one member of the Peterborough Local Clinical Commissioning Group. Paragraph 2.7.4.1. of Appendix A identifies the amendment.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No.2.8.4.2: *The membership will be kept under review periodically.*

## 3. TIMESCALES

| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | N/A |
|---|---|---|---|

## 4. BACKGROUND AND KEY ISSUES

4.1 At its meeting held on 11 September 2017 the Health and Wellbeing Board agreed to appoint Dr Gary Howsam as the Vice-Chairman of the Board following the resignation of Dr Harshad Mistry.

Following further consultation there are no other suitable personnel to sit as the second representative of the Peterborough Local Clinical Commissioning Group. The Health and Social Care Act 2012 mandates a minimum membership of:

- one local elected representative;
- a representative of local Healthwatch organisation;
- a representative of each local clinical commissioning group;
- the local authority director for adult social services;
- the local authority director for children's services; and
- the director of public health for the local authority.

Therefore the Health and Wellbeing Board is still able to continue with Dr Laliwala as the sole representative of the Peterborough Local Clinical Commissioning Group.

4.2 Local boards are free to expand their membership beyond this to include a greater number of elected representatives. It is for the Executive Leader of the local authority to make nominations to the Health and Wellbeing Board for approval under the Health and Social Care Act 2012.

## 5. CONSULTATION

5.1 Consultation has taken place with the Director of Community Services and Integration, to ascertain whether there was a suitable second representative of the Peterborough Local Clinical Commissioning Group.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 That the Health and Wellbeing Board agree to the amended terms of reference and the reduction from two to one representative from the Peterborough Local Clinical Commissioning Group.

## 7. REASON FOR THE RECOMMENDATION

7.1 Under the Health and Social Care Act 2012 there needs to be a minimum of one representative from the Local Clinical Commissioning Group.

7.2 Due to the Peterborough Health and Wellbeing Board still adhering to the legislation there is no need at this stage to seek a further representative from the Peterborough Local Clinical Commissioning Group.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 To keep the position open, however this leaves a vacancy that is unlikely to be filled in the near future.

## 9. IMPLICATIONS

### Financial Implications

9.1 There are none.

### Legal Implications

9.2 There are none. The legislation under the Health and Social Care Act 2012 is still adhered too.

### Equalities Implications

9.3 There are none.

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1
- Health and Social Care Act 2012
- Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

- Local Government Association 'Health and Wellbeing Boards: A Practical Guide to Governance and Constitutional Issues'

## 11. APPENDICES

11.1 **Appendix A -** Revised Health and Wellbeing Board Terms of Reference

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## 2.7 Peterborough Health and Wellbeing Board

**Purpose and Terms of Reference**

### 2.7.1. Background and context:

The Peterborough Health and Wellbeing Board has been established to provide a strategic leadership forum focussed on securing and improving the health and wellbeing of Peterborough residents.

### 2.7.2. The aims are:

2.7.2.1 To bring together the leaders of health and social care commissioners to develop common and shared approaches to improving the health and wellbeing of the community.

2.7.2.2 To actively promote partnership working across health and social care in order to further improve health and wellbeing of residents.

2.7.2.3 To influence commissioning strategies based on the evidence of the Joint Strategic Needs Assessment.

### 2.7.3. Its functions are:

2.7.3.1 To develop a Health and Wellbeing Strategy for the city which informs and influences the commissioning plans of partner agencies.

2.7.3.2 To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health & Wellbeing Strategy.

2.7.3.3 To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities.

2.7.3.4 To consider the recommendations of the Director of Public Health in their Annual Public Health report.

2.7.3.5 To consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Peterborough to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.

2.7.3.6 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.

2.7.3.7 By establishing sub groups as appropriate give consideration to areas of joint health and social care commissioning, including but not restricted to services for people with learning disabilities.

2.7.3.8 To oversee the development of Local HealthWatch for Peterborough and to ensure that they can operate effectively to support health and wellbeing on behalf of users of health and social care services.

2.7.3.9 To keep under consideration, the financial and organisational implications of joint and integrated working across health and social care services, and to make recommendations for ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.

2.7.3.10 To ensure effective working between the Board and the Greater Peterborough Partnership ensuring added value and an avoidance of duplication.

**2.7.4 Membership**

2.7.4.1 Membership of the Health and Wellbeing Board will be composed of the following:

Peterborough City Council:
The Leader of the Council / Deputy Leader – Chairman of the Board
Cabinet Member Adults & Health Integration
Cabinet Member Public Health
An Opposition Councillor
Executive Director People and Communities Cambridgeshire and Peterborough Councils
Service Director ~~Adults and~~ Communities and Safety
The Director of Public Health

Cambridgeshire and Peterborough Clinical Commissioning Group
Local Chief Officer for Peterborough City and Borderline LCG
~~2~~ 1 GP member representing Peterborough City Local Commissioning Group ~~- Vice Chairman of the Board~~
– 1 GP member representing Borderline Local Commissioning Group - Vice Chairman of the Board

Lincolnshire
1 GP representing South Lincolnshire CCG

National Commissioning Board
1 representative of the NCB Local Area Team

Peterborough Healthwatch
1 member

The Board will also include as co-opted members the following:
Independent Chair of Local Safeguarding Children's Board and Peterborough Safeguarding Adults Board
The Chair of the Safer Peterborough Partnership (Claire Higgins)

2.7.4.2 The membership will be kept under review periodically.

2.7.4.3 The Board shall co-opt other such representatives or persons in a non-voting capacity as it sees relevant in assisting it to undertake its functions effectively.

### 2.7.5 Meetings

2.7.5.1 The meetings of the Board and its decision-making will be subject to the provisions of the City Council's Constitution including the Council Procedure Rules and the Access to Information Rules, insofar as these are applicable to the Board in its shadow form.

2.7.5.2 The Board will meet in public.

2.7.5.3 The minimum quorum for the Board shall be 5 members which should include at least one elected member, one statutory director (DCS/DASS/DPH) and a CCG/LCG member.

2.7.5.4 The Board shall meet periodically and at least quarterly. Additional meetings shall be called at the discretion of the Chairman where business needs require.

2.7.5.5 Administrative arrangements to support meetings of the Board shall be provided through the City Council's Governance team.

### 2.7.6 Governance and Approach

2.7.6.1 The Board will function at a strategic level, with priorities being delivered and key issues taken forward through the work of the partnership organisations.

2.7.6.2 Decisions taken and work progressed will be subject to scrutiny of the City Council's Scrutiny Commission for Health Issues.

### 2.7.7 Wider Engagement

2.7.7.1 The Health and Wellbeing Board will develop and implement a communications engagement strategy for the work of the Board, including how the work of the Board will be influenced by stakeholders and the public.

2.7.7.2 The Board will ensure that its decisions and the priorities it sets take account of the needs of all of Peterborough's communities and groups are communicated widely.

### 2.7.8 Review

2.7.8.1 These Terms of Reference will be reviewed periodically.

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| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 5 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

| Report of: | Woodland Trust | |
|---|---|---|
| Contact Officer(s): | Victoria Banks Price, Planning Adviser, Government Affairs Team | Tel. 0343 770 5798 |

# THE HEALTH BENEFITS OF TREES AND WOODLAND

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Woodland Trust | **Deadline date:** *N/A* |

It is recommended that the Health and Wellbeing Board:

1. Recognise the importance of trees and woods in helping with delivery of health outcomes and requests that the Director of Public Health work with departments across the City Council and with external partners to promote these benefits.

2. Look for opportunities to work with the City Council and partners to make better use of woodland and natural greenspace in the Peterborough City Council area for activities aimed at improving the health and wellbeing of local people.

3. Work with the City Council and other partners such as the Woodland Trust and Peterborough Environment City Trust to identify areas of land within the district for creation of new woodland and opportunities for planting of street trees and trees in other locations such as parks or housing areas. This will help to address air quality issues and can also have benefits near the hospital, by reducing the average length of stay.

4. That the Board request the Director of Public Health examine whether it is possible for some of the City Council's public health funding to be used to support the initiatives proposed under items 2 and 3 above.

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board by the Woodland Trust following a request from Councillor Ferris.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to set out how woods and trees can help contribute to the delivery of the 5 markers set out in the Peterborough Health and Wellbeing Strategy. Whilst woods and trees cannot deliver all the answers they can contribute to a holistic city-wide approach to health and wellbeing.

The report is being presented to the Board to:

(a) Provide a briefing on how woodland and trees can help improve health and wellbeing in Peterborough.

(b) Suggest opportunities to work in partnership with other groups to achieve health outcomes.

## 3. TIMESCALES

| | | | |
|---|---|---|---|
| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | N/A |

## 4. BACKGROUND AND KEY ISSUES

4.1 Headings taken from the 5 priorities set out on the Peterborough Health and Wellbeing Strategy website.

**Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes**

Air quality is the fundamental starting point for ensuring equality in health outcomes. Trees and woodland improve air quality by adsorbing pollutants such as sulphur dioxide and ozone, intercepting harmful particulates from vehicle emission, smoke, pollen and dust and of course release oxygen through photosynthesis. This helps to reduce the occurrence of the problems caused by chronic respiratory disease. The British Lung Foundation suggests that one in every five people in the UK is affected by lung disease, more than 12 million people.

Research[i] on the impact of installing a kerbside line of young birch trees demonstrated more than 50% reductions in measured Particulate Matter (PM) levels inside those houses screened by the temporary tree line. Electron microscopy analyses showed that leaf-captured PM is concentrated in agglomerations around leaf hairs and within the leaf microtopography. Furthermore, iron-rich, ultrafine, spherical particles, probably combustion-derived, were abundant on the leaf, noted these as a particular hazard to health. The researchers concluded that "the efficacy of roadside trees for mitigation of PM health hazard might be seriously underestimated in some current atmospheric models."

Trees will have a proportionately greater benefit in urban areas, where they are close to sources of pollution and nearer to people who might be affected.

**Ensure that children and young people have the best opportunities in life to enable them to become healthy adults and make the best of their life chances**

Woods and trees provide multiple benefits for children and young people from helping them learn through play to helping them learn healthy lifelong behaviours by providing a green environment that encourages active travel choices. There are also many physical benefits, for example, research shows that asthma rates among children aged four and five fell by a quarter for every additional 343 trees per square kilometre (one in every garden on an average street).

Studies also show that natural surroundings have a positive impact on children with Attention Deficit Hyperactivity Disorder.

**Enable older people to stay independent and safe and to enjoy the best possible quality of life**

The Woodland Trust and Dementia Adventure carried out a pilot project to consider the value of woodland visits for older people living with dementia. Getting people out into woods showed that nature is potentially a significant non-pharmacological treatment which is accessible and readily available for all people living with dementia. The project found that there were multiple social and economic benefits. The potential cost-benefits are huge, primarily in helping to dramatically reduce use of anti-psychotic medication and reducing the frequency and severity of anxiety, apathy, anger and depression which all too commonly predominate in long term care settings.

These can occur with less frequency out in nature, and after exposure to nature. This can also reduce the number of unnecessary hospital admissions.

**Enable good child and adult mental health through effective, accessible health promotion and early intervention services**

Trees and woods can play a part in a holistic approach to mental health; both through limiting the onset of mental health problems and through having a restorative and therapeutic effect on the mind. Studies have found that woods and trees can be an antidote to stress, providing an opportunity to escape modern urban life.

**Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs.**

Trees can pay a key role in the Patient recovery rates improve when they can view trees from their hospital window. The evidence is so strong that the NHS is developing the NHS Forest to green their estate. The Woodland Trust can help identify opportunities for tree planting on suitable land.

Research shows that if just 1% of the 2.5 million people on incapacity benefit in Britain adopted healthier lifestyles it would have significant cost savings. The current cost to the Exchequer is around £13 billion and to industry £11 billion a year. Over a third of people are on benefits because of mental health problems or muscular or skeletal disorders – both of which can respond to tailored physical activity programmes. If just one per cent of people on incapacity benefit could be helped back into the workplace through active lifestyles, it could save the country £67 million a year. Woods and trees offer opportunities to encourage people to engage more actively in their surroundings.

Examples of partnerships work undertaken by the Woodland Trust:

(a) Tree Packs for community groups - Group can apply for up to 420 trees in each planting season.

(b) Use of our local woods for community activities and events for example our woods are used for activities such as green gyms, parkrun and 'boot camp' fitness; in particular activities aimed at physically inactive adults. They are also used for educational projects such as forest schools which have associate health and wellbeing benefits.

(c) Use of our woods to enable social prescriptions.

## 5. CONSULTATION

N/A

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The Health and Wellbeing Board to work with others to achieve:

- Better air quality through the planting of street trees. This has been shown to reduce childhood asthma rates.

- Identify opportunities for planting around the hospital – which will help to reduce the length of hospital stays.

- Identify opportunities for use of woodlands by the community (to help address physical and mental health issues).

- Consider the anticipated outcome of consideration of this report. For example, it may be that a new major policy or statutory plan is being developed to improve service delivery for a particular group of the population; or a review of existing policy is expected to streamline current processes. This section will assist the Board in scheduling items into its work programme for further work or determining whether this is a one-off item which can be resolved quickly.

## 7. REASON FOR THE RECOMMENDATION

7.1 *N/A*

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 *NONE*

## 9. IMPLICATIONS

### Financial Implications

9.1 *N/A*

### Legal Implications

9.2 *N/A*

### Equalities Implications

9.3 *N/A*

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 Barbara A. Maher , Imad A. M. Ahmed , Brian Davison , Vassil Karloukovski , and Robert Clarke Centre for Environmental Magnetism & Palaeomagnetism, Lancaster Environment Centre, Lancaster University; *Impact of Roadside Tree Lines on Indoor Concentrations of Traffic-Derived Particulate Matter*; http://pubs.acs.org/doi/pdf/10.1021/es404363m

Trees in residential developments:
https://www.woodlandtrust.org.uk/publications/2015/07/residential-developments-and-trees/

Space for People report:
https://www.woodlandtrust.org.uk/publications/2017/06/space-for-people-2017/

## 11. APPENDICES

11.1 None

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 6 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Wendi Ogle-Welbourn, Executive Director People and Communities Cambridgeshire and Peterborough Councils | |
| Cabinet Member(s) responsible: | Cllr Irene Walsh, Cabinet Member for Communities | |
| Contact Officer(s): | Adrian Chapman, Service Director Communities and Safety | Tel. 07920 160441 |

# CAMBRIDGESHIRE AND PETERBOROUGH SENIOR OFFICERS COMMUNITIES NETWORK

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Executive Director People and Communities Cambridgeshire and Peterborough Councils | **Deadline date:** *N/A* |

It is recommended that the Health and Wellbeing Board:

1. Consider the purpose and remit of the Cambridgeshire and Peterborough Senior Officers Communities Network, and;
2. Consider how the Health and Wellbeing Board can support and benefit from current and future work programmes.

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request made by the Cambridgeshire and Peterborough Senior Officers Communities Network.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform the Board of the Cambridgeshire and Peterborough Senior Officers Communities Network, outlining the reasons for the network, its membership and work it is engaged in, in order that the Board can influence its priorities and gain maximum benefit from the Network's outcomes.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.7.2.1:

*To bring together the leaders of health and social care commissioners to develop common and shared approaches to improving the health and wellbeing of the community.*

## 3. TIMESCALES

| | | | |
|---|---|---|---|
| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | N/A |

## 4. BACKGROUND AND KEY ISSUES

### 4.1 Main Purpose

The Cambridgeshire and Peterborough Senior Officer Communities Network was formed to bring together key partners across Peterborough and Cambridgeshire at a strategic level, to deliver against our shared ambition to build stronger, self-sustaining communities.

### 4.2 Background

Building community capacity is a shared goal across the public sector. In addition to often delivering better outcomes, it is an underpinning driver to manage demand away from more costly services. Many public sector organisations across the statutory, discretionary and voluntary sector are already doing a huge amount to support and encourage community-based work which is making an impact, particularly at a local level. However, more could be done through an alignment of planning and resources at a citywide and countywide level, and this becomes ever more pressing as resources shrink.

The Cambridgeshire and Peterborough Senior Officers Communities network creates a forum where this activity can be understood and shared across partners, and where activity can be commissioned & delivered to best meet need.

### 4.3 Community Resilience

Community Resilience forms a core part of a system wide approach to demand management, and is the foundation on which the Devolution deal will be delivered, providing the springboard to deliver on health and well-being, economic growth and community safety. It is intended that, as the new arrangements for the Combined Authority come into place, the Communities Network will form part of its wider governance arrangements, defining a set of clear priorities on which the public sector across Cambridgeshire and Peterborough want to make an impact through communities. The work programme for the Communities Network will in particular support the delivery of public services reform and tackling deprivation in this context, much of which will need to be led and delivered at a local level.

### 4.4 Communities Network Objectives

The objectives of the network are that they will :

- Share plans and proposals for community resilience or capacity-building activity, including the development of local community hubs, employment and skills strategies, and pilots and test beds such as Neighbourhood Cares and social prescribing
- Share, learn from and extend successful new approaches adopted elsewhere or at very local levels
- Decide on joint investment/delivery in prevention within communities to manage demand for high cost services
- Determine how to work together to equip local people with the information, tools and capacity they need to help themselves and each other

The Network will define and jointly commission or deliver against an agreed set of priorities, in agreed locations with agreed target groups.

### 4.5 Work Programme

The work programme for the Network will evolve as the Network becomes more embedded. Its initial focus however will be on examining and trialling new ways of working collaboratively to:

- tackle isolation and loneliness
- tackle deprivation and reduce poverty
- improve community safety and resilience

The Network will also work closely with the Combined Authority to ensure future devolution deals are aligned to the needs of and potential provided by communities

### 4.6 Governance

This is not a formal board and therefore there is no statutory requirement to be accountable, other than members of the network reporting into their own governance structures. However due to the

nature of the Network's work, reporting into governance structures linked to the new Combined Authority for Cambridgeshire and Peterborough is likely to be developed.

## 5. CONSULTATION

5.1 Not applicable, although it is important to note that membership of the Network is drawn from across a wide range of partners and organisations – the terms of reference at appendix 1 refer.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The positive impact of the Network will result in improved outcomes for our communities through shared plans and proposals, joint development of improvement activity including that relating to employment and skills and social prescribing.

Joint investment and delivery within communities will help to collectively better manage the demand for high cost services and will provide a joined up, 'one-team' approach with organisations and members of the Network making good use of collective resources, working together to equip local people to help themselves and each other.

## 7. REASON FOR THE RECOMMENDATION

7.1 Officers are keen to ensure the Network plays a key role in helping ensure communities are empowered, that demand for statutory services is managed more effectively, and that outcomes for citizens are improved.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The alternative is for organisations to work more in isolation, each with limited resources and more likelihood of duplication of effort and points of contact with communities.

## 9. IMPLICATIONS

### Financial Implications

9.1 At this stage there are no additional costs associated with the Network. It is anticipated that the Network will directly support demand management and therefore help reduce costs across statutory services. Some investment to enable this to happen may therefore become necessary, but this will be subject to a case by case business plan.

### Legal Implications

9.2 Not applicable.

### Equalities Implications

9.3 It is anticipated that the work of the Network will directly contribute to addressing inequalities through, for example, its work to tackle deprivation, isolation and poverty.

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 Not applicable.

## 11. APPENDICES

11.1 Appendix 1 : Communities Network Terms of Reference

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**CAMBRIDGESHIRE AND PETERBOROUGH**
**Senior Officer COMMUNITIES Network**

**DRAFT TERMS OF REFERENCE**

## Purpose of Board

To bring together key partners across Peterborough and Cambridgeshire at a strategic level to deliver against our shared ambition to build stronger self-sustaining communities. The Board will maximise opportunities to collaborate, seeking countywide and local opportunities to jointly commission & deliver where it makes sense to do so, aligning resources and expertise around an agreed set of outcomes in order to make the most of public sector funds. The network will oversee the delivery of a joint delivery plan, and will also be the forum for each Partner to share their plans and proposals for community resilience or capacity-building activity, seeking synergies and input from network member organisations. The network will provide opportunities to share, learn from and extend successful new approaches adopted elsewhere or at very local levels. The network will support the Devolution Deal for the Combined Authority.

## Background and context

Building community capacity is a shared goal across the public sector. In addition to often delivering better outcomes, it is an underpinning driver to manage demand into more costly services. Many public sector organisations across the statutory, discretionary and voluntary sector are already doing a huge amount to support and encourage community based work which is making an impact, particularly at a District/ City level. However, more could be done through an alignment of planning and resources at a local and Countywide level, and this becomes ever more pressing as resources shrink. The Communities network creates a forum where this activity can be understood and shared across partners, and where activity can be commissioned & delivered to best meet need.

Community Resilience forms a core part of a system wide approach to demand management, and is the foundation on which the Devolution deal will be delivered, providing the spring board to deliver on health and well-being, economic growth and community safety. As the new arrangements for the Combined Authority come into place, the Community Resilience network will form part of its wider governance arrangements, defining a set of clear priorities on which the public sector across Cambridgeshire and Peterborough want to make an impact through communities. The work programme for the Communities network will in particular support the delivery of public services reform and tackling deprivation in this context, much of which will need to be led and delivered at a local level.

## Reporting to

This is not a formal board and therefore there is no statutory requirement to be accountable, other than members of the network reporting into their own governance structures. However due to the nature of the networks work, reporting into governance

structures linked to the new Combined Authority for Cambridgeshire and Peterborough would make sense.

**Objectives**

The network will :

- Share plans and proposals for community resilience or capacity-building activity, including the development of local community hubs, employment and skills strategies, and pilots and test beds such as Neighbourhood Cares and social prescribing
- Share, learn from and extend successful new approaches adopted elsewhere or at very local levels
- Decide on joint investment/delivery in prevention within communities to manage demand for high cost services
- Determine how to work together to equip local people with the information, tools and capacity they need to help themselves and each other

The network will define and jointly commission or deliver against an agreed set of priorities, in agreed locations with agreed target groups. The work programme will focus around elements of the devolution deal for the Combined Authority as they evolve, but will have a particular interface with Public Services Reform, Community Safety and Tackling Deprivation. A sample work programme is attached as Appendix 1.

**Chairing arrangements**

The Board will be Chaired by the Shared Cambridgeshire and Peterborough DAS/DCS who will ensure appropriate administration and programme support. This arrangement will be reviewed in 12 months and the network will elect a chair for the following 12 months.

**Membership and responsibility of members**

The network Members will be at a senior enough level to be able to make financial or operational decisions and/ or recommendations on behalf of their organisations. Members are expected to attend each meeting or to send a substitute with the authority to act. Members will be responsible for proposing membership of the workstreams outlined in the work programme. Membership will include the following:

| Name | Job role | Organisation |
|---|---|---|
| Wendi Ogle-Welbourn | Peterborough and Cambridgeshire DAS/ DCS | Cambridgeshire County Council Peterborough City Council |
| Helen Gregg | Partnership Manager | PCC / CCC |
| Will Patten | Director for Transformation | PCC / CCC |
| Antoinette Jackson/ delegate | Chief Executive | Cambridge City Council |
| Suzanne McBride | Strategic Director | Cambridge City Council |
| John Hill/ delegate | Chief Executive | East Cambs District Council |
| Jo Brooks | Director | East Cambs District Council |
| Paul Medd/ delegate | Chief Executive | Fenland District Council |
| Richard Cassidy | Director | Fenland District Council |
| Dan Horn | Head of Housing and Community Support | Fenland District Council |
| Jo Lancaster/ delegate | Chief Executive | Huntingdonshire District Council |
| Chris Stopford | Director | Huntingdonshire District Council |
| Alex Colyer/ delegate | Chief Executive | South Cambs District Council |
| Mike Hill | Director | South Cambs District Council |
| Cath Mitchell | Director of Integration | Clinical Commissioning Group/LA |
| Dorothy Gregson/ delegate | Chief Executive | Office of the Police and Crime Commissioner |
| Adrian Chapman | Director | Peterborough City Council |
| Sarah Ferguson | Director | Cambridgeshire County Council |
| Sue Grace | Director | Cambridgeshire County Council |
| Christine May | Director | CCC |
| Pat Carrington | Assistant Director | PCC |
| Lynsi Hayward-Smith | Head of Service, Adult Learning and Skills | Cambridgeshire County Council |
| Rick Hylton | Assistant Chief Officer | Fire and Rescue Service |
| Liz Robin | Director | Public Health |
| Julie Farrow | Chief Executive Officer | Support Cambridgeshire |
| Chris Mead | Chief Inspector | Cambridgeshire Constabulary |
| Nav Malik | Assistant Chief Constable | Cambridgeshire Constabulary |
| Charlotte Black | Director | Cambridgeshire County Council |
| Matthew Winn | Chief Executive | Cambridgeshire Community Services NHS Trust |
| Aidan Thomas | Chief Executive | Cambridgeshire and Peterborough NHS Foundation Trust |

**Frequency of meetings**

The Board will meet quarterly

**APPENDIX ONE** **Sample Work programme – year 1**

| Strategic aim | Communities | Vulnerable people | Objective | Action |
|---|---|---|---|---|
| **PUBLIC SECTOR REFORM/ TACKLING DEPRIVATION** | | | Oversee the delivery of shared community-facing facilities where there is an appetite to do so | |
| | | | Develop partnership District/ City based plans to develop further work with Parish Councils/ City Fora | |
| | | | Deliver on a cross-Partner volunteering strategy | |
| | | | Jointly develop or commission resources for local communities which provide excellent advice, signposting and support to local community groups wanting to do more themselves, with a shared narrative across the network | |
| | | | Jointly consider our community-focussed voluntary sector commissioning<br>Support the delivery of community-based innovation through the identification of resources to fuel a good idea which can prevent or reduce the need for public sector services | |
| | | | Align resources further at a District or local level which can support the delivery of community development work | |
| | | | Deliver on a shared workforce development plan to build the capacity of front line staff to work in a strengths-based, community facing way. | |

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 7 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

| Report of: | Dr Liz Robin, Director for Public Health | |
|---|---|---|
| Cabinet Member(s) responsible: | Councillor Diane Lamb, Cabinet Member for Public Health | |
| Contact Officer(s): | Stuart Keeble, Consultant in Public Health | Tel. 07816597855 |

# HEALTH AND TRANSPORT JSNA DATA SET

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

It is recommended that the Health and Wellbeing Board:

1. Note the content of the Health and Transport JSNA Dataset document
2. Considers any recommendations they may want to make to address issues outlined in the Report.

## 1. ORIGIN OF REPORT

1.1 The report is submitted to the Health and Wellbeing Board following a request from the Director of Public Health.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

- Provide the Health and Wellbeing board with a local resource outlining evidence on the link between transport and health including active travel, air quality and access to transport.
- Provide evidence to inform the Cambridge and Peterborough Local Transport Plan and the Peterborough Sports strategy.
- Support broader partnership working through the provision of a single evidence base.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No.

2.7.2.3 - To influence commissioning strategies based on the evidence of the Joint Strategic Needs Assessment.

2.3 This report links to the following commitments in the Children in Care Pledge: help encourage you to be healthy.

## 3. TIMESCALES

| | | | |
|---|---|---|---|
| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | N/A |

## 4. BACKGROUND AND KEY ISSUES

4.1 The 2016-19 Peterborough Health and Wellbeing Strategy identifies Health and Transport Planning as a priority with a specific action of:

- Collecting further joint strategic needs assessment (JSNA) information on transport and health for Peterborough, using locally developed methodologies.

As a response, the report in appendix A was produced to provide background evidence on the link between health and transport and makes use of local data to provide a Peterborough perspective. The report is divided into three sections.

- The first section focuses on active travel (walking or cycling as an alternative to motorised transport for the purpose of making every day journeys), the opportunities it offers to improving health, current levels of walking and cycling and an assessment of infrastructure in Peterborough.
- The second section considers air quality and describes the impact of air quality on health, its link with transport and currents situation in Peterborough.
- The third section briefly discusses the links between access to transport and health and provides information on access time to health services in Peterborough.

The key findings of the report are summarised below:

4.2 **Active travel**

'Active travel' means walking or cycling as an alternative to motorised transport (notably cars, motorbikes/mopeds etc.) for the purpose of making every day journeys. Public transport can also contribute to levels of physical activity, as people who take public transport are likely to walk further than car users – for example, by walking to and from bus stops.

Active travel has an important role to play in improving the health and wellbeing of Peterborough residents by maintaining levels of physical activity. For most people the easiest and most acceptable forms of physical activity are those that can be built into everyday life such as walking and cycling.

Studies show that people who cycle for travel purposes are four times as likely to meet physical activity guidelines as those who do not and that active commuting confers around a 10% reduction in the risk of developing heart disease and stroke. Further, individuals who commute by bike have half the level of sickness absence (1 day less) per year compared to those who do not cycle. At a city level, only a marginal change in the levels of active commuting can have a significant impact. For example, across a town of 150,000 people, if everyone walked an extra 10 minutes a day, an estimated 30 lives would be saved each year.

There is a clear relationship between the amount of physical activity people do and health. While increasing the activity levels of all adults who are not meeting physical activity recommendations is important, targeting those adults who are significantly inactive i.e. engaging in less than 30 minutes of activity per week, will produce the greatest reduction in chronic disease.

Research indicates that a combination of distance, perceived safety of walking/cycling routes and individual characteristics such as age, gender and access to a car are the most important influences on walking and cycling behaviour.

Peterborough has higher levels of cycling for utility (commuting) and leisure compared to similar local authorities and England.

The 2011 census showed that for journeys of less than 2km (deemed walkable), Peterborough residents were twice as likely to cycle compared to England (11% compared to 5%) and less likely to walk (33% compared to 42%). The proportion of people who drove or were a passenger in a car or van was higher in Peterborough compared to England (48% compared to 43%).

For journeys less than 5km (considered achievable by bicycle) Peterborough residents were again more likely to cycle compared to England (9% compared to 5%) and were less likely to walk (16% compared to 24%). The proportion of people who drove or were a passenger in a car or van was again higher in Peterborough compared to England (63% compared to 56%).

Cycling rates for utility in Peterborough are relatively consistent across all age bands at around 5% whereas for England the rate declines after the age of 40. Asian/Asian British residents were less likely to cycle to work (2.1%) compared to the Peterborough average and Irish and White British residents were more likely to cycle. Asian/Asian British residents and residents from other ethnic groups were more likely to travel on foot compared to the Peterborough average (8.5%) while residents from 'white other' ethnic groups were less likely to walk.

The size and layout of Peterborough provides the potential foundations for an 'active' city as at the last census 16000 or 18% of working age residents lived within 2km of their work place (higher than for England) and 40,000 or 45% lived within 5km of their work place (35% nationally).

With new town status in 1967 the city benefitted from new highway infrastructure including the Parkways, which has led to some of the fastest commuting speeds in the country. Although a benefit to Peterborough residents from a commuting and economic perspective, this may also contribute to physical inactivity through greater use of less active forms of travel.

Over the last 3 years the authority has invested in walking and cycling infrastructure with an additional 12 miles of cycle routes. However, the Peterborough Council Local Sustainable Transport Fund (LSTF) Monitoring Report (2016) identifies further physical barriers to walking and cycling modes across Peterborough including:

- Approximately one third of all walking routes assessed deemed to be poor. The three with the poorest score were Fengate, A15 between Thorpe Road and Bishop's Road and St John's Street;
- Only one cycle route in the city listed as excellent – London Road between Fletton Parkway and Cook Avenue; and
- Several cycle routes are listed as poor – Thorpe Road, Fengate and Lincoln Road.

It should be noted that many other cities would score similarly.

**Air quality**

4.3 As recently as the Nineties it was felt that air pollution was no longer a major health issue in the United Kingdom as legislation had made the great smog's of the Fifties a thing of the past. However, pollutants such as Particulate Matter (PM) and Nitrogen Dioxide (NO2) are still at levels which can harm health.

Stationary road transport including lorries, buses and cars/vans are the primary source of NO2 (especially emissions from diesel light duty vehicles) and PM (engine emissions, tyre and brake wear) in urban areas across the UK.

The National Air Quality Strategy sets air quality objectives or levels for pollutants such as NO2 on the basis of scientific and medical evidence on the health effects of each pollutant, and according to practicability of meeting the standards. There is no statutory requirement to review and assess fine Particulate Matter (PM2.5) as it is recognised there are no absolute safe levels of exposure. As such any improvement in air quality will have positive health consequences.

Nitrogen Dioxide is monitored across a number site across Peterborough through diffusion tubes, with locations chosen on a risk based approach. Levels of NO2 are within prescribed levels which is likely due to the lower levels of traffic congestion in Peterborough compared to many other

cities.

Modelled estimates of PM2.5 levels suggest that long term exposure to PM2.5 in Peterborough contributed to approximately 5% of deaths in 2015, this is similar to England and comparator authorities. It should be noted that in general air pollution contributes a small amount to the cause of death of a large number of exposed individuals, who also have other risk factors (heart disease, lung disease etc), rather than being the main cause of death.

The health effects of air pollution are generally distributed unequally across the population, with the heaviest burden borne by those with greatest vulnerability and/or exposure. The elderly, children and those with cardiovascular and/or respiratory disease are at greater risk from the health effects of air pollution.

Health modelling shows that interventions to increase active travel can result in significantly greater benefits from increased physical activity, compared to direct interventions targeting air quality overall – so greater health benefits will be achieved by people switching to walking and cycling than by switching to electric cars.

4.4 **Access to transport**

Access to transport is an important determinant of health and wellbeing as it is a fundamental enabler to access services and social opportunities.

There are multiple forms of access barriers, or issues that make it more difficult to reach and use health and other key services. The Governments 2003 Social Exclusion Unit report, identified five main barriers in accessing services:

1. The availability and physical accessibility of transport.
2. Cost of transport.
3. Services and activities located in inaccessible places.
4. Safety and security.
5. Travel horizons

Local data focuses mainly on journey times to health services. Analysis undertaken by the Department for Transport (using public transport timetables from 2015) found that the:

1) Average travel time to access a GP by walking or public transport for Peterborough was 8 minutes (range – 5 to 20 minutes). The wards with the highest average travel times were Barnack, Northborough and Bretton South which all had average travel times of just over 20 minutes.
2) Average travel time to access a Hospital by walking or public transport for Peterborough was 40 minutes. This ranged from 12 minute (Bretton North) to 65 minutes (Eye and Thorney).

It should be noted that public transport routes may have changed since this analysis was undertaken.

Local modelling using road traffic data (average travel times) found that the vast majority of Peterborough population could access a pharmacy within a 20 minute car journey. A local survey of 35 pharmacies in Peterborough found that (95%) provided home delivery services, enabling those without a car or unable to use public transport access to services.

## 5. CONSULTATION

5.1 The document has been shared with the Peterborough City Council transport team.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The anticipated outcome of this Report is that the information provided will be used to inform the development of the new local transport plan which is being produced on behalf of the Cambridgeshire and Peterborough Combined Authority, inform the development of the Peterborough sports strategy and facilitate closer working with Peterborough transport team.

## 7. REASON FOR THE RECOMMENDATION

7.1 The Health and Wellbeing Strategy identifies the need to further information on transport and health in Peterborough. The reports provide a resource to support this.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The alternative option would have been to provide a summary of the national evidence linking health and transport without the inclusion of local data. This would have left a gap in our knowledge when informing and influencing the development of the new local transport plan for Cambridgeshire and Peterborough and may have left Peterborough at a potential disadvantage.

## 9. IMPLICATIONS

### Financial Implications

9.1 *None*

### Legal Implications

9.2 *None*

### Equalities Implications

9.3 The transport and health JSNA dataset provides, where available, information on health and transport for protected characteristics.

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 References and sources are provided within the Health and Transport JSNA Dataset report.

## 11. APPENDICES

11.1 Appendix A - Health and Transport JSNA Dataset

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# Appendix A - Transport and health JSNA dataset - Peterborough

# 1 Executive Summary

The 2016-19 Peterborough Health and Wellbeing Strategy identifies Health and Transport Planning as a priority with a specific action of:

- Collecting further joint strategic needs assessment (JSNA) information on transport and health for Peterborough, using locally developed methodologies.

As a response, this report provides background evidence on the link between health and transport and makes use of local data to provide a Peterborough perspective. The report is divided into three sections.

- The first section focuses on active travel (walking or cycling as an alternative to motorised transport for the purpose of making every day journeys), the opportunities it offers to improving health, current levels of walking and cycling and an assessment of infrastructure in Peterborough.
- The second section considers air quality and describes the impact of air quality on health, its link with transport and currents situation in Peterborough.
- The third section briefly discusses the links between access to transport and health and provides information on access time to health services in Peterborough.

The key findings of the report are summarised below:

### Active travel

'Active travel' means walking or cycling as an alternative to motorised transport (notably cars, motorbikes/mopeds etc.) for the purpose of making every day journeys. Public transport can also contribute to levels of physical activity, as people who take public transport are likely to walk further than car users – for example, by walking to and from bus stops.

Active travel has an important role to play in improving the health and wellbeing of Peterborough residents by maintaining levels of physical activity. For most people the easiest and most acceptable forms of physical activity are those that can be built into everyday life such as walking and cycling.

Studies show that people who cycle for travel purposes (as opposed to leisure purposes) are four times as likely to meet physical activity guidelines as those who do not and that active commuting confers around a 10% reduction in the risk of developing heart disease and stroke. Further, individuals who commute by bike have half the level of sickness absence (1 day less) per year compared to those who do not cycle. At a city level, only a marginal change in the levels of active commuting can have a significant impact. For example, across a town of 150,000 people, if everyone walked an extra 10 minutes a day, an estimated 30 lives would be saved each year.

There is a clear relationship between the amount of physical activity people do and health. While increasing the activity levels of all adults who are not meeting physical activity recommendations is important, targeting those adults who are significantly inactive i.e. engaging in less than 30 minutes of activity per week, will produce the greatest reduction in chronic disease.

Research indicates that a combination of distance, perceived safety of walking/cycling routes and individual characteristics such as age, gender and access to a car are the most important influences on walking and cycling behaviour.

Peterborough has higher levels of cycling for utility (commuting) and leisure compared to similar local authorities and England.

The 2011 census showed that for journeys of less than 2km (considered achievable by walking), Peterborough residents were twice as likely to cycle compared to England (11% compared to 5%) and less likely to walk (33% compared to 42%). The proportion of people who drove or were a passenger in a car or van was higher in Peterborough compared to England (48% compared to 43%).

For journeys less than 5km (considered achievable by bicycle) Peterborough residents were again more likely to cycle compared to England (9% compared to 5%) and were less likely to walk (16% compared to 24%). The proportion of people who drove or were a passenger in a car or van was again higher in Peterborough compared to England (63% compared to 56%).

Cycling rates for utility purposes in Peterborough are relatively consistent across all age bands at around 5% whereas for England the rate declines after the age of 40. Asian/Asian British residents were less likely to cycle to work (2.1%) compared to the Peterborough average and Irish and White British residents were more likely to cycle. Asian/Asian British residents and residents from other ethnic groups were more likely to travel on foot compared to the Peterborough average (8.5%) while residents from 'white other' ethnic groups were less likely to walk.

The size and layout of Peterborough provides the potential foundations for an 'active' city as at the last census 16000 or 18% of working age residents lived within 2km of their work place (higher than for England) and 40,000 or 45% lived within 5km of their work place (35% nationally).

With new town status in 1967 the city benefitted from new highway infrastructure including the Parkways, which has led to some of the fastest commuting speeds in the country. Although a benefit to Peterborough residents from a commuting and economic perspective, this may also contribute to physical inactivity through greater use of less active forms of travel.

Over the last 3 years the authority has invested in walking and cycling infrastructure with an additional 12 miles of cycle routes. However, the Peterborough City Council Local Sustainable Transport Fund (LSTF) Monitoring Report (2016) identifies further physical barriers to walking and cycling modes across Peterborough including:

- Approximately one third of all walking routes assessed were deemed to be poor. The three with the poorest scores were Fengate, A15 between Thorpe Road and Bishop's Road and St John's Street;
- Only one cycle route in the city was listed as excellent – London Road between Fletton Parkway and Cook Avenue; and
- Several cycle routes are listed as poor – Thorpe Road, Fengate and Lincoln Road.

It should be noted that many other cities would score similarly.

## Air quality

As recently as the Nineties it was felt that air pollution was no longer a major health issue in the United Kingdom as legislation had made the great smog's of the Fifties a thing of the past. However, pollutants such as Particulate Matter (PM) and Nitrogen Dioxide (NO2) are still at levels which can harm health.

Stationary road transport including lorries, buses and cars/vans are the primary source of NO2 (especially emissions from diesel light duty vehicles) and PM (engine emissions, tyre and brake wear) in urban areas across the UK.

The National Air Quality Strategy sets air quality objectives or levels for pollutants such as NO2 on the basis of scientific and medical evidence on the health effects of each pollutant, and according to practicability of meeting the standards. There is no statutory requirement to review and assess fine

Particulate Matter (PM2.5) as it is recognised there are no absolute safe levels of exposure. As such any improvement in air quality will have positive health consequences.
Nitrogen Dioxide is monitored across a number site across Peterborough through diffusion tubes, with locations chosen on a risk based approach. Levels of NO2 are within prescribed levels which is likely due to the lower levels of traffic congestion in Peterborough compared to many other cities.

Modelled estimates of PM2.5 levels suggest that long term exposure to PM2.5 in Peterborough contributed to approximately 5% of deaths in 2015, this is similar to England and comparator authorities. It should be noted that in general air pollution contributes a small amount to the cause of death of a large number of exposed individuals, who also have other risk factors (heart disease, lung disease etc), rather than being the main cause of death.

The health effects of air pollution are generally distributed unequally across the population, with the heaviest burden borne by those with greatest vulnerability and/or exposure. The elderly, children and those with cardiovascular and/or respiratory disease are at greater risk from the health effects of air pollution.

Health modelling shows that interventions to increase active travel can result in significantly greater benefits from increased physical activity, compared to direct interventions targeting air quality overall – so greater health benefits will be achieved by people switching to walking and cycling than by switching to electric cars.

## Access to transport

Access to transport is an important determinant of health and wellbeing as it is a fundamental enabler to access services and social opportunities.
There are multiple forms of access barriers, or issues that make it more difficult to reach and use health and other key services. The Governments 2003 Social Exclusion Unit report, identified five main barriers in accessing services:

1. The availability and physical accessibility of transport.
2. Cost of transport.
3. Services and activities located in inaccessible places.
4. Safety and security.
5. Travel horizons

Local data focuses mainly on journey times to health services. Analysis undertaken by the Department for Transport (using public transport timetables from 2015) found that the:

1. Average travel time to access a GP by walking or public transport for Peterborough was 8 minutes (range – 5 to 20 minutes). The wards with the highest average travel times were Barnack, Northborough and Bretton South which all had average travel times of just over 20 minutes.
2. Average travel time to access a Hospital by walking or public transport for Peterborough was 40 minutes. This ranged from 12 minute (Bretton North) to 65 minutes (Eye and Thorney).

It should be noted that public transport routes may have changed since this analysis was undertaken.

Local modelling using road traffic data, based on average travel times, found the majority of Peterborough population could access a pharmacy within a 20 minute car journey. A local survey of

35 pharmacies in Peterborough found that (95%) provided home delivery services, enabling those without a car or unable to use public transport access to services.

# 2 Active travel

## 2.1 What is Active travel?

'Active travel' (or active transportation or mobility) means walking or cycling as an alternative to motorised transport (notably cars, motorbikes/mopeds etc.) for the purpose of making everyday journeys[1]. Public transport can also contribute to levels of physical activity, as people who take public transport are likely to walk further than car users – for example, by walking to and from bus stops.

## 2.2 Why should we prioritise active travel?

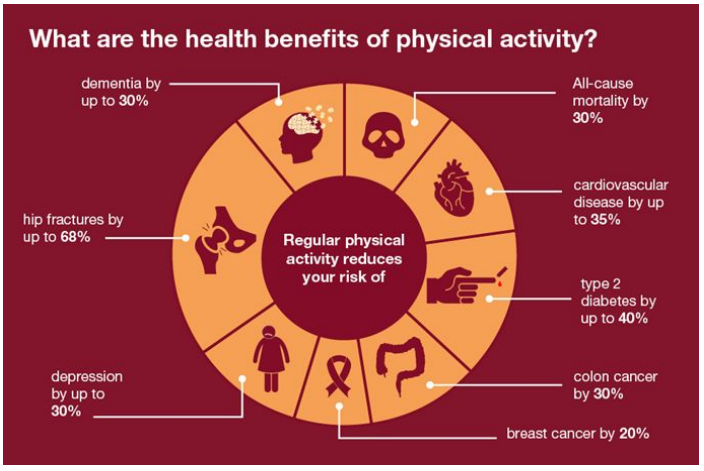
Active transport has an important role to play in improving the health and wellbeing of Peterborough residents by maintaining levels of physical activity. as for most people the easiest and most acceptable forms of physical activity are those that can be built into everyday life such as cycling and walking.

Recent analysis of data from the Active People Survey has shown that people who cycle for travel purposes (i.e. rather than simply for recreation) are four times as likely to meet physical activity guidelines as those who do not[2]

The link between physical inactivity and obesity is well established. With more than half of adults in England currently overweight or obese, everyone can benefit from being more active every day. It is important that physical activity is not, however, framed as just an option for combating obesity. Low physical activity is one of the top 10 causes of disease and disability in England.

Regular physical activity can help to prevent and manage over 20 chronic conditions and diseases, many of which are on the rise and affecting people at an earlier age; 1 in 3 of the working age population have at least 1 long term condition and 1 in 7 have more than one.

**Figure 1: Summary of impact of physical activity on the risk of common disease**




1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/523460/Working_Together_to_Promote_Active_Travel_A_briefing_for_local_authorities.pdf

2 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/523460/Working_Together_to_Promote_Active_Travel_A_briefing_for_local_authorities.pdf

https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day/health-matters-getting-every-adult-active-every-day

## 2.3 Benefits of cycling and walking to health

A wealth of evidence shows walking and cycling to be excellent forms of exercise – free, convenient and beneficial to both physical and mental health.

Active commuting confers around a 10% reduction in the risk of developing heart disease and stroke[3] and people who are at least 'moderately' active have a 30%-40% lower risk of type 2 diabetes[4]. Regular physical activity also reduces the risk of depression and has positive benefits for mental health including reduced anxiety, enhanced mood and higher self-esteem[5]. Walking and cycling are also carbon-neutral methods of transport.

Analysis of the effects of different methods of transport on health conclude that:

- Each additional hour spent travelling in a car per day is associated within a 6% increase in the likelihood of becoming obese[6]
- Each additional kilometre walked per day is associated with a 4.8% reduction in the likelihood of becoming obese.[7]
- Switching from private motor transport to active travel or public transport is associated with a significant reduction in body mass index (BMI)[8]
- Those people who maintain commuting by bike have half the level of sickness absence (1 day less) per year compared to those who did not

Studies[9] examining the relationship between cycling/walking and mortality overtime show that individuals who:

- Walk 168 minutes per week (17 mins twice per day for 5 days) are 11% less likely to die compared to non-walkers.
- Cycle 100 minutes per week (10 minutes twice per day for 5 days) are 10% less likely to die compared to non-cyclists.

If the residents double the level of walking or cycling this increases the protective benefit accordingly e.g. 20 minutes twice per day reduces your risk of dying compared to non-cyclists by 20%.

**What is the potential impact on health of increasing active travel at a city level?**

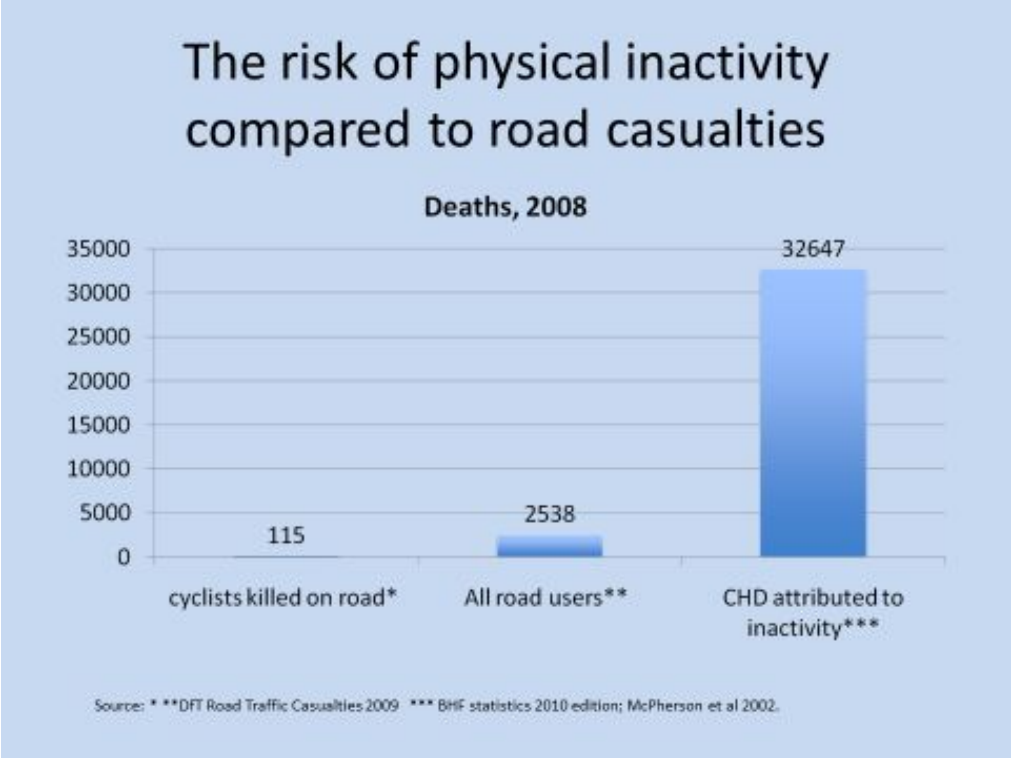
Therefore, at a city level only a marginal change in the levels of active commuting can have a significant impact. For example, across a town of 150,000 people, if everyone walked an extra 10 minutes a day, an estimated 31 lives would be saved each year.

[3] Hamer, M., & Chida, Y, *Active commuting and cardiovascular risk: a meta-analytic review*. Preventative Medicine, 2008;46(1):9-13.
[4] Department of Health, Start Active, Stay Active. 2011. Available at https://www.gov.uk/government/publications/start-active-stay-active-a-report-on-physical-activity-from-the-four-home-countries-chief-medical-officers
[5] Pucher, J., et al, *Walking and Cycling to Health: A Comparative Analysis of City, State, and International Data,* American Journal of Public Health, 2013; 100(10): 1986–1992
[6] 'Start active, stay active: a report on physical activity from the four home countries', Chief Medical Officers (2011), Department of Health.
[7] Frank LD, Andresen MA, Schmid TL Obesity relationships with community design, physical activity, and time spent in cars. (2004) Am J Prev Med 27(2):87–96
[8] Martin A, et al. Impact of changes in mode of travel to work on changes in body mass index: evidence from the British Household Panel Survey. (2015) J Epidemiol Community Health 0:1–9. doi:10.1136/jech-2014-205211
[9] http://www.euro.who.int/__data/assets/pdf_file/0010/256168/ECONOMIC-ASSESSMENT-OF-TRANSPORT-INFRASTRUCTURE-AND-POLICIES.pdf?ua=1

## 2.4 Risk and perception of risk from active travel

Safety is relevant to the uptake of active transport. The safety of cycling routes and perceived safety of walking/cycling routes have been positively associated with the uptake of active transport, especially in the provision of children cycling to school. In particular, vehicle speed and its effect on perceived safety of walking/cycling routes have been investigated. The actual risk of deaths from cycle related accidents is very small and in fact the benefits outweigh the risks by a ratio of at approx. 10 to 1[10]. The chart below shows the greatest risk by far, relates to heart disease due to inactivity.

Figure 2: Deaths attributable to physical inactivity and road casualties, 2008



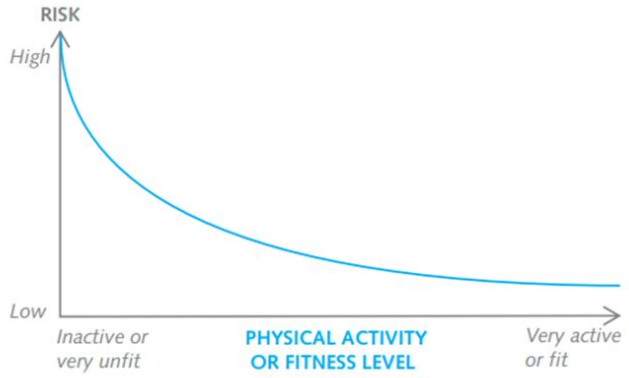

## 2.5 Groups that benefit the most from increased physical activity levels

**Most inactive**

There is a clear causal relationship between the amount of physical activity people do and health. While increasing the activity levels of all adults who are not meeting the recommendations is important, targeting those adults who are significantly inactive (i.e. engaging in less than 30 minutes of activity per week) will produce the greatest reduction in chronic disease[11].

[10] Increasing walking and cycling A briefing for Local Authority Directors of Public Health, PHE
[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf

Figure 3: Correlation between levels of physical activity and levels of fitness




Source: Department of Health (2004) *At least five a week: Evidence on the impact of physical activity and its relationship to health*. A report from the Chief Medical Officer

Persuading inactive people (those doing less than 30 minutes per week) to become more active could prevent one in ten cases of stroke and heart disease in the UK and one in six deaths from any cause. In fact it's often said that if physical activity was a drug it would be classed as a wonder drug[12].

In addition to those that are most inactive, the following groups also benefit the most from being more active.

**Those living in areas of high deprivation**: areas with higher levels of deprivation tend to have lower levels of general physical activity[13]. Cycling proficiency is also linked to where people live, with those in more deprived neighbourhoods less likely to report being able to cycle[14]. It is, therefore, important that opportunities to be physically active are provided in disadvantaged areas which are safe and free or low cost[15].

However, it is worth noting that those households in the lowest quintile for income walk the most, perhaps due to lower access to more expensive forms of travel such as a car.

**Groups without a culture of active transport:** white adults are more likely than those from black and minority ethnic groups to say that they can cycle[16].

**Older people:** walking levels tend to decrease in older age groups with levels falling after the age of 40. Increased activity amongst this group has the most immediate benefits in terms of health and well-being, as well as aiding healthy ageing, lessening the risk of trips and falls, and increasing the likelihood of independent living, bringing potential benefits to the NHS and social care provision.

[12] https://www.nhs.uk/Livewell/fitness/Pages/whybeactive.aspx 'if exercise were a pill, it would be one of the most cost-effective drugs ever invented'
[13] UKActive, *Turning the Tide of Inactivity*. 2014. Available at http://www.ukactive.com/turningthetide/
[14] Department for Culture, Media and Sport, *Taking part 2011/12 quarter 3: statistical release*, 2012. Available at https://www.gov.uk/government/statistics/taking-part-2011-12-quarter-3-statistical-release
[15] Department of Health, *Health Survey for England*, 2004. Available at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publishedsurvey/healthsurveyforengland/healthsurveyresults/index.htm
[16] Department for Culture, Media and Sport, *Taking part 2011/12 quarter 3: statistical release*, 2012. Available at https://www.gov.uk/government/statistics/taking-part-2011-12-quarter-3-statistical-release

Engaging in physical activity carries very low health and safety risks for older adults[17]. In contrast, the risk of poor health as a result of inactivity is very high[18].

## 2.6 What factors affect walking and cycling levels?

Travel choices are often influenced by behaviour and the environment, with home location often limiting available travel choices.

**Environmental factors**

Evidence shows that distance was the most consistent environmental influence on walking behaviour[19] with a similar effect for cycling[20]. Compact communities with easy access to local shops, services, and public transport stops and better street connectivity help adult residents walk more for transport[21]. This has been echoed in recent research where walking for transport was associated with a supportive infrastructure, availability of local amenities and general environment quality whereas cycling for transport was associated with street connectivity[22].

Van Dyck et al (2012)[23] produced a 'cyclability' index which examined environmental factors such as: proximity to destinations, good cycling facilities, perceiving difficulties in parking near local shopping areas, and perceived aesthetics on transport-related cycling across metropolitan areas in the USA, Australia and Belgium. The study found a consistent, positive correlation between transport-related cycling and the cyclability index with an increase of approximately 11% in transport-related cycling per unit increase.

**Commute of children to school**

Whether children actively commute to school may be determined by parents' perception of safety of the mode of transport, lack of time in the morning and social factors such as no other children to walk with[24]. Furthermore 'walk to school' interventions involving educational lessons and goal setting tasks aimed at eight to nine year olds have not shown to increase walking to school[25], highlighting the importance in influencing parents' behaviour and perceptions.

In summary, research indicates that the combination of distance, perceived and actual safety concerns, individual characteristics such as age, gender were the most important consistent influences on walking and cycling behaviour.

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[17] Hamer M., et al, *Taking Up Physical Activity in Later Life and Healthy Ageing: the English Longitudinal study of Ageing'*. British Journal of Sports Medicine, 2013; **48**:239-243 doi:10.1136/bjsports-2013-092993.

[18] British Heart Foundation National Centre for Physical Activity and Health. *Physical activity for older adults (65 + years) Evidence Briefing,* 2012. Available at http://www.bhfactive.org.uk/older-adults/index.html

[19] Saelens B, Handy S, *Built Environment Correlates of Walking: A Review*. Medicine and Science in Sports and Exercise. 2008;40(7S):S550-S66.

[20] Panter, J.R, Jones, A.P., van Sluijs, E.M. Griffin, S.J, *Attitudes, social support and environmental perceptions as predictors of active commuting behaviour in schoolchildren*. Journal of Epidemiology and Community Health, 2010;***64:****41-48*.

[21] T Sugiyama, E Leslie, B Giles-Corti, N Owen, *Associations of neighbourhood greenness with physical and mental health: do walking, social coherence and local social interaction explain the relationships? J Epidemiol Community Health,* 2008;**62**:e9 doi:10.1136/jech.2007.064287.

[22] Adams, E, J., et al, *Correlates of walking and cycling for transport and recreation: factor structure, reliability and behavioural associations of the perceptions of the environment in the neighbourhood scale (PENS*), *International Journal of Behavioral Nutrition and Physical Activity,* 2013, 10:87 doi:10.1186/1479-5868-10-87.

[23] Van Dyck et al, *Perceived neighborhood environmental attributes associated with adults' transport-related walking and cycling: Findings from the USA, Australia and Belgium*, *International Journal of Behavioral Nutrition and Physical Activity,* 2012, **9**:70 doi:10.1186/1479-5868-9-70.

[24] Jo Salmon, Louisa Salmon, David A. Crawford, Clare Hume, and Anna Timperio, *Associations Among Individual, Social, and Environmental Barriers and Children's Walking or Cycling to School*. American Journal of Health Promotion, 2007: November/December 2007, Vol. 22, No. 2, pp. 107-113.

[25] David McMinn et al, *Predicting active school travel: The role of planned behavior and habit strength*, International Journal of Behavioural Nutrition and Physical Activity, 2012;2012; 9: 65.

## 2.7 Local Data: what do we know about levels of physical activity and active travel in Peterborough?

### 2.7.1 Why do we need to increase the level of active travel in Peterborough

Increased levels of active travel and commuting in Peterborough would have a significant impact on health because of the poor health outcomes in the area, including the:

- Higher rate of early deaths (under 75) due to heart disease and stroke.
- Gap of 8.4 years in life expectancy for males between Peterborough's most deprived areas and least deprived; for females, this gap is 6.1 years.
- Higher rates of excess weight (overweight and obese) amongst adults.

### 2.7.2 General physical activity in Peterborough

Sixty percent of adult Peterborough residents in 16/17 achieved the recommended 150+ minutes of moderate intensity exercise or equivalent per week, which is similar to England and 4th highest out of comparator (similar) local authorities. Just over a quarter (26%) of all adults were deemed to be inactive (< 30 moderate intensity equivalent minutes per week) which is similar to the England average.

**Figure 4: Peterborough Physical Activity Profile – Key Indicators**

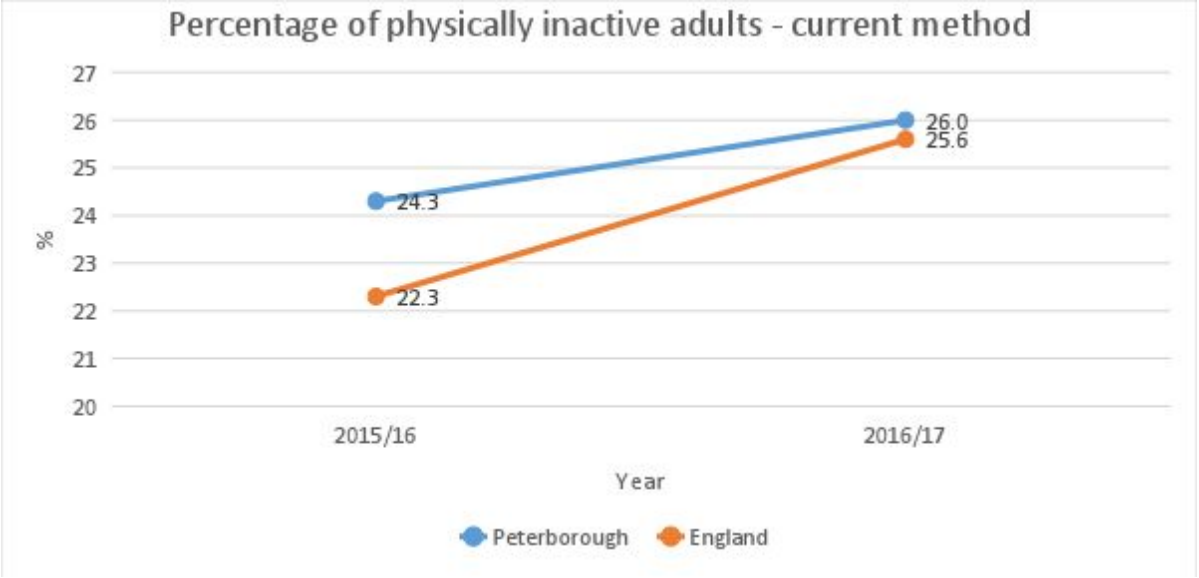
| Indicator | Time Period | Peterborough Value | England Value | Peterborough Status | Peterborough Trend | Peterborough CIPFA Ranking (1=Best, 16=Worst) |
|---|---|---|---|---|---|---|
| Percentage of physically active adults (150+ moderate intensity equivalent minutes per week) | May 2016 - Apr 2017 | 59.9 | 60.6 | Statistically similar to England | ▼ | 4 |
| Percentage of physically inactive adults (< 30 moderate intensity equivalent minutes per week) | May 2016 - Apr 2017 | 26.0 | 25.6 | Statistically similar to England | ▲ | 2 |
| Percentage of 15 year olds physically active for at least one hour per day, seven days per week | 2014-15 | 12.7 | 13.9 | Statistically similar to England | First data point | 10 |
| Percentage of 15 year olds with a mean daily sedentary time in the last week of over 7 hours per day | 2014-15 | 71.3 | 70.1 | Statistically similar to England | First data point | 9 |

**Source: Public Health Outcomes Framework Physical Activity Profiles & Active Lives Survey, Sport England**

**Key:**


In 2015/16 the percentage of inactive adults in Peterborough was statistically significantly higher (24.3%) compared to England and although it increased further in 2016/17 to 26.0%, the increase in the national rate from 22.3% to 25.6%, meant the rate is now similar to the England average (see figure 5).

**Figure 5: Percentage of adults achieving less than 30 minutes of physical activity per week, Peterborough, 2015/16 – 2016/17**




**Source: Public Health Outcomes Framework Physical Activity Profiles & Active Lives Survey, Sport England**

National data show that the rate of inactivity among adults (undertaking less than 30 minutes of physical activity per week) is higher in Black & Ethnic Minority (BME) groups than in the 'white' ethnicity group. 17.5% of the Peterborough population self-identified as being of BME ethnicity in the 2011 Census, statistically significantly higher than the England percentage of 14.6%.

**Figure 6: Percentage of adults achieving less than 30 minutes of physical activity per week, England, 2015/16, split by Ethnicity**


**Source: Public Health Outcomes Framework Physical Activity Profiles, URL:**
https://fingertips.phe.org.uk/profile/physical-activity/data#page/0

### 2.7.3 Levels of cycling and walking in Peterborough (all reasons for exercise)

In 2014/15 Peterborough had the highest percentages of adults who undertook any cycling once per month, once per week, three times per week or five times per week among its nearest socio-economic neighbours (similar local authorities) and was statistically significantly better than England for all of these indicators.

The rate of walking was lower compared to some of our comparator authorities and statistically similar to England average.

**Figure 7: Cycling & Walking for any reason, Peterborough & Nearest Socio-Economic Neighbours**

| | Area | | | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator (All Reasons for Cycling/Walking)** | Peterborough | Thurrock | Swindon | Milton Keynes | Coventry | Bolton | England |
| Percentage of adults cycling at least once per week, 2014/15 | 15.2 | 6.8 | 11.3 | 9.0 | 8.2 | 6.5 | 9.5 |
| Percentage of adults cycling at least three times per week, 2014/15 | 8.6 | 1.2 | 5.4 | 4.2 | 3.7 | 3.1 | 4.4 |
| Percentage adults cycling at least five times per week, 2014/15 | 5.1 | 0.7 | 3.7 | 2.0 | 3.6 | 1.1 | 2.6 |
| Percentage of adults cycling at least once per month, 2014/15 | 25.1 | 13.0 | 16.7 | 15.4 | 12.9 | 10.7 | 14.7 |
| Percentages of adults walking at least once per week, 2014/15 | 77.7 | 77.5 | 76.8 | 79.4 | 83.3 | 77.4 | 80.6 |
| Percentages of adults walking at least three times per week, 2014/15 | 59.5 | 58.0 | 55.0 | 61.4 | 67.4 | 61.0 | 61.8 |
| Percentages of adults walking at least five times per week, 2014/15 | 48.8 | 48.8 | 43.1 | 47.7 | 58.0 | 50.1 | 50.6 |
| Percentages of adults walking at least once per month, 2014/15 | 84.1 | 82.8 | 84.3 | 82.9 | 88.4 | 83.5 | 86.3 |

**Source: Active people survey**

### 2.7.4 Levels of cycling and walking for utility (commuting)

In 2014/15 Peterborough also had some of the highest percentages of adults cycling for utility (commuting) once per month, once per week, three times per week or five times among its its nearest socio-economic neighbours (similar local authorities) and was statistically significantly better than England for all of these indicators.

The rate of walking for utility was again lower compared to some our similar authorities and statistically similar to England average.

**Figure 8: Cycling & Walking for utility only, Peterborough & Nearest Socio-Economic Neighbours**

| | Area | | | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator (Cycling/Walking for Utility Only)** | Peterborough | Thurrock | Swindon | Milton Keynes | Coventry | Bolton | England |
| Percentage of residents aged 16+ cycling at least once per week, 2014/15 | 7.4 | 2.6 | 5.0 | 4.1 | 4.2 | 1.9 | 4.5 |
| Percentage of residents aged 16+ cycling at least three times per week, 2014/15 | 5.2 | 1.2 | 4.3 | 2.3 | 3.2 | 1.0 | 2.6 |
| Percentage of residents aged 16+ cycling at least five times per week, 2014/15 | 2.9 | 0.7 | 2.5 | 1.7 | 2.0 | 0.4 | 1.5 |
| Percentage of residents aged 16+ cycling at least once per month, 2014/15 | 12.6 | 5.2 | 7.5 | 6.3 | 8.8 | 2.5 | 6.5 |
| Percentages of residents aged 16+ walking at least once per week, 2014/15 | 48.3 | 51.6 | 47.1 | 50.4 | 55.9 | 46.4 | 53.2 |
| Percentages of residents aged 16+ walking at least three times per week, 2014/15 | 35.4 | 38.8 | 30.6 | 35.2 | 41.7 | 32.5 | 36.4 |
| Percentages of residents aged 16+ walking at least five times per week, 2014/15 | 25.9 | 28.5 | 20.4 | 19.8 | 32.0 | 23.2 | 24.6 |
| Percentages of residents aged 16+ walking at least once per month, 2014/15 | 55.8 | 57.6 | 56.8 | 56.5 | 62.9 | 52.9 | 60.4 |

**Source: Active people survey**

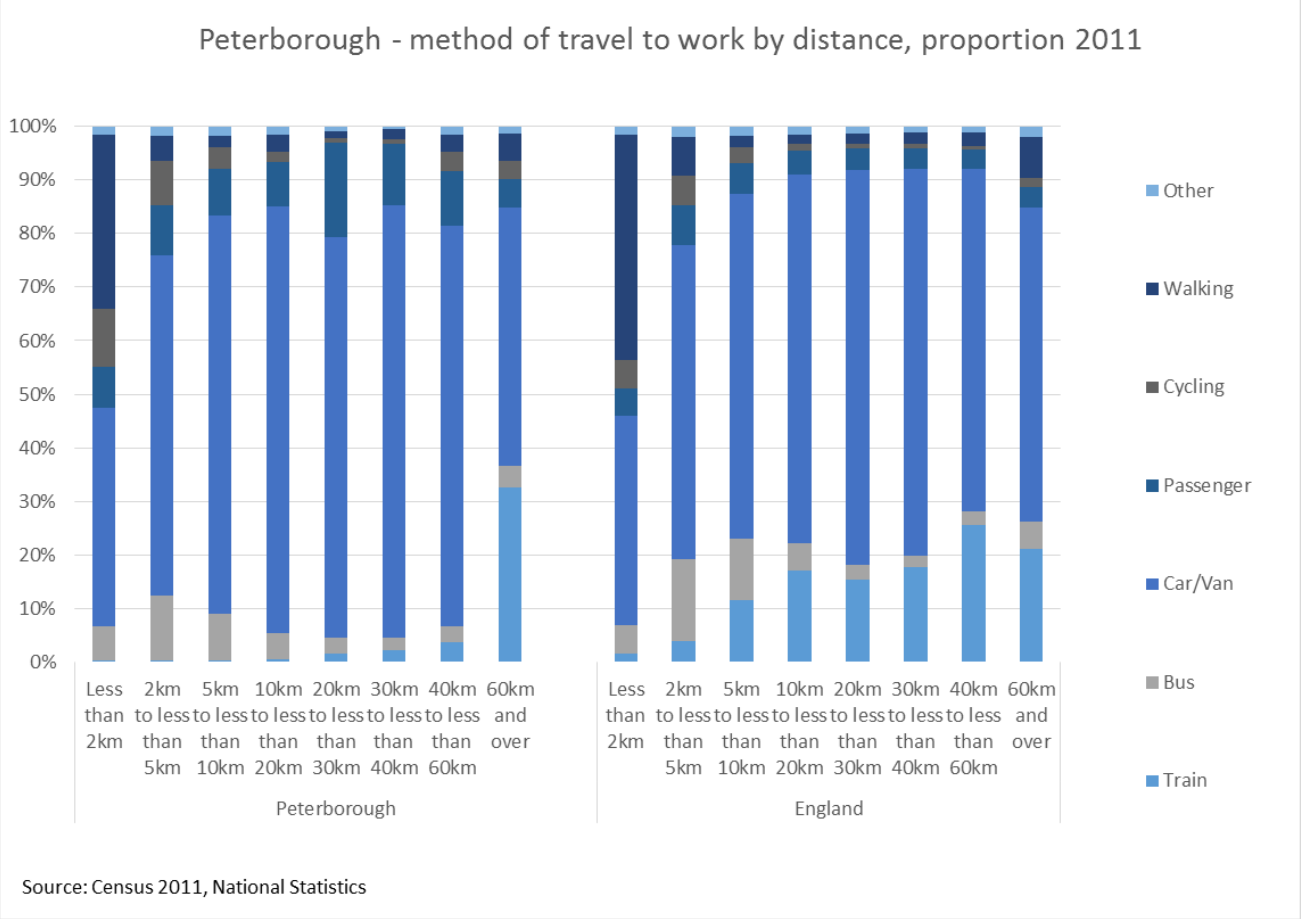
### 2.7.5 2011 Census – Travel to work

Travel to work data from the 2011 census provides a more detailed picture of active travel in Peterborough and takes into account the distance residents travel to work. Journeys of <2km are considered walkable (about 20 minutes at 5km per hour) while journeys up to 5km (20min at 15 km per hour) are considered achievable by bicycle.

For journeys less than 2km Peterborough residents were twice as likely to cycle compared to England (11% compared to 5%) and were less likely to walk (33% compared to 42%). The proportion of people driving or a passenger in a car or van was higher in Peterborough compared to England (48% compared to 43%).

For journeys less than 5km Peterborough residents were again more likely to cycle compared to England (9% compared to 5%) and were less likely to walk (16% compared to 24%). The proportion of people driving or a passenger in a car or van was again higher in Peterborough compared to England (63% compared to 56%).

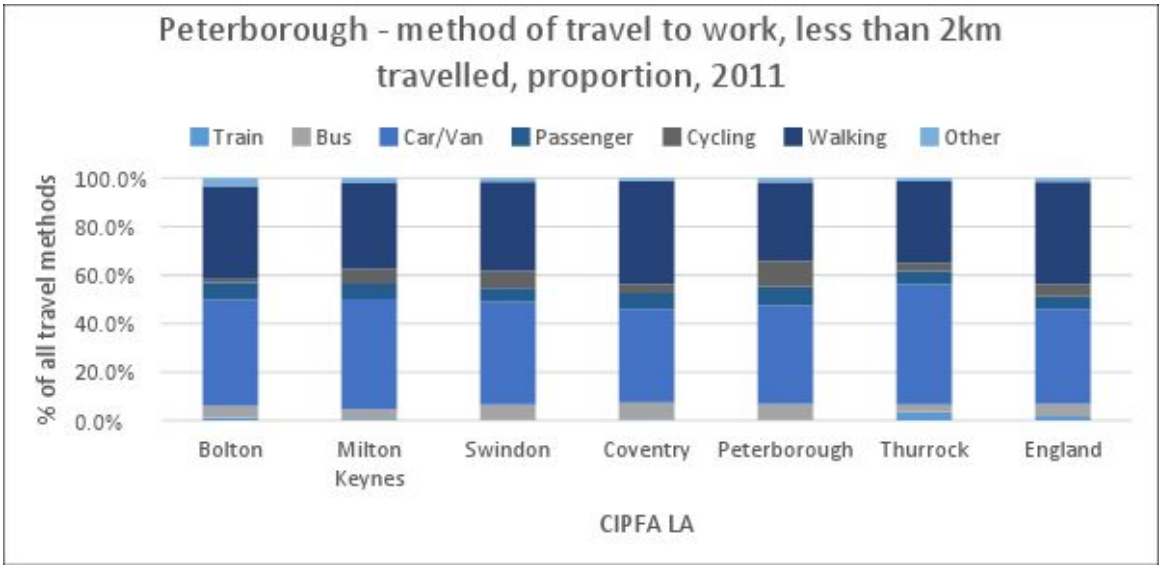
**Figure 9: Peterborough – Method of Travel to Work by Distance, 2011**




Source: Census 2011, National Statistics

When benchmarking against comparator authorities Peterborough had higher rates of commuting by bicycle and lower levels of walking

**Figure 10: Peterborough – Method of Travel to Work, <2km, 2011**




If you take all forms of travel which incorporate active element e.g. walking, cycling and public transport (this includes walking to and from stations and bus stops) then Peterborough has lower total levels of active commuting compared to England for journeys <2km (50% compared to 54%) and < 5km (35% compared to 43%).

Achieving the same levels of non-car travel as England (based on 2011 census) would lead to:

- Journeys <2km – 690 less people driving to work.
- Journeys <5km – 1770 less people driving to work.

**Figure 11: Methods of Travel to Work for journeys <2km**

| Area | Train, underground, metro, light rail or tram | Bus, minibus or coach | Driving a car or van | Passenger in a car or van | Bicycle | On foot | All other methods of travel to work | *All active forms of travel |
|---|---|---|---|---|---|---|---|---|
| Peterborough | 0.3% | 6.4% | 40.7% | 7.7% | 10.7% | 32.5 % | 1.6% | 50.0% |
| England | 1.5% | 5.2% | 39.2% | 5.1% | 5.2% | 42.2 % | 1.4% | 54.2% |

Source: 2011 Census

*Bus, train, Bicycle and on foot

**Figure 12: Method of Travel to Work for journeys <5km**

| Area | Train, underground, metro, light rail or tram | Bus, minibus or coach | Driving a car or van | Passenger in a car or van | Bicycle | On foot | All other methods of travel to work | *All active forms of travel |
|---|---|---|---|---|---|---|---|---|
| Peterborough | 0.3% | 9.7% | 54.4% | 8.7% | 9.3% | 15.8% | 1.8% | 35.1% |
| England | 2.8% | 10.5% | 49.4% | 6.4% | 5.4% | 23.8% | 1.7% | 42.5% |

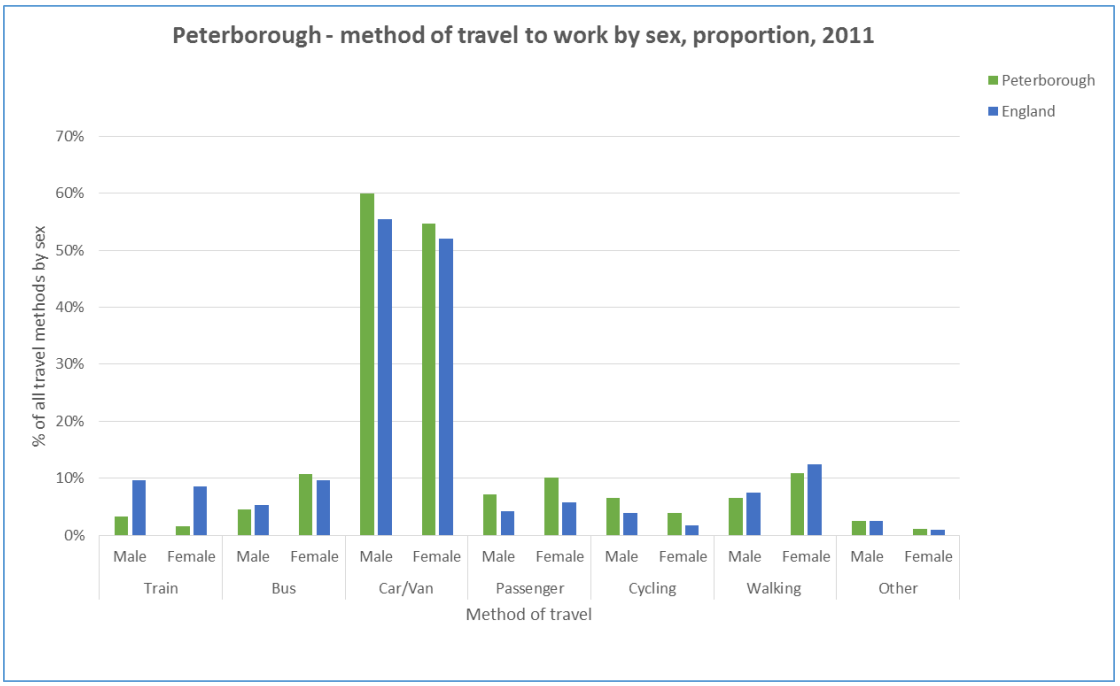
Source: 2011 Census

* Bicycle, walking and public transport

### Gender

A greater percentage of females (11%) undertake journeys to work by walking in comparison to men (7%) in Peterborough, which is similar to the pattern observed nationally (12% females compared to 7% males). Whilst the percentage of males cycling is higher than for females.

**Figure 13: Peterborough – Method of Travel to Work by Sex, 2011**

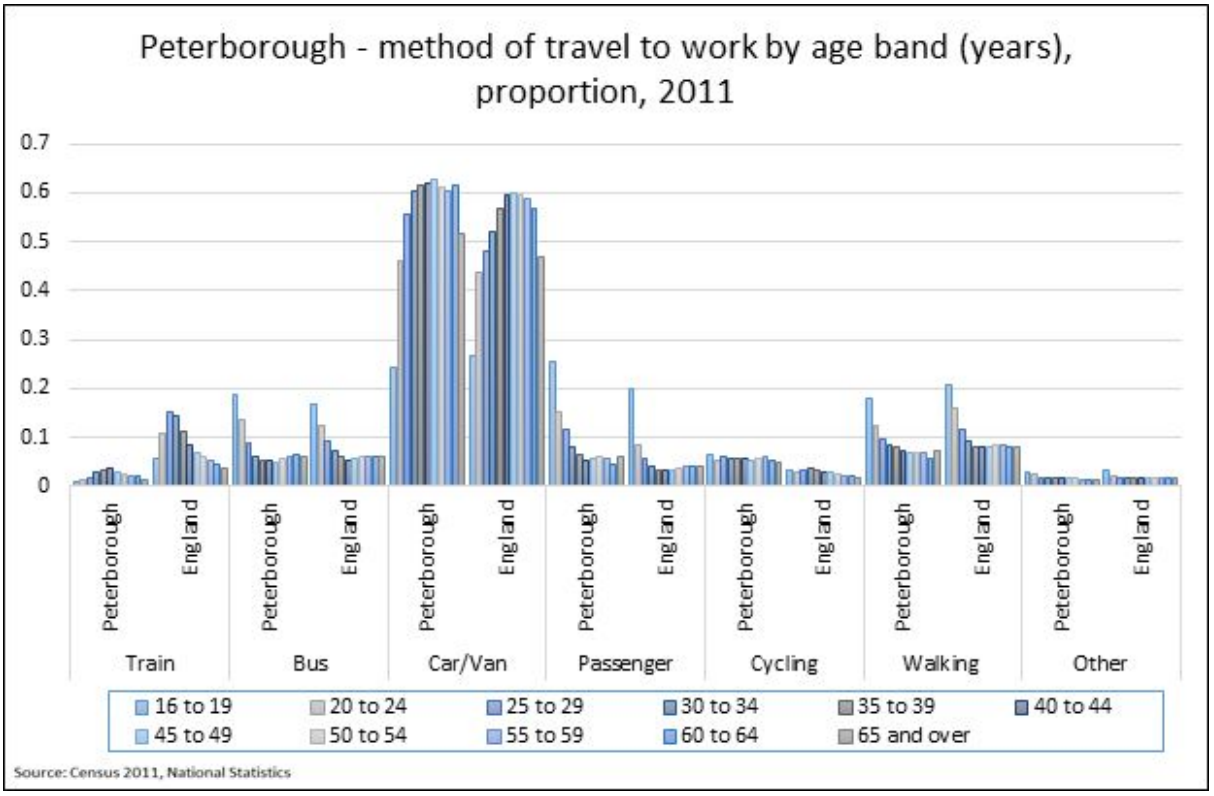



Source: Census, 2011

### Age

The proportion of people that walk to work decreases between the ages of 16 and 40 years and then stays relatively stable for both Peterborough and nationally. Cycling rates in Peterborough are relatively consistent across all age bands at around 5%. However, cycling rates for England show a decline after the age of 40. Car usage increases with age, with a notable increase between 16-19 and 20-24 years, which ties in with the legal age limit for driving. Bus usage decreases with age but increases again in people aged 50 years onwards. There is an apparent pattern of young people aged 16-19 years being passengers to get to work.

**Figure 14: Peterborough – Method of Travel to Work by Age Band (Years), 2011**




**Ethnicity**

The ethnic group with the largest percentage of residents travelling less than 5km to work was Asian/Asian British (52.0%) whilst the ethnic group with the largest percentage of residents travel 10km or more to get to work was 'Other White' which includes Estonian, Latvian, Lithuanian and Polish residents (28.5%).

**Figure 15: Distance travelled to work by ethnicity, percentages, Peterborough, Census 2011**

| | Distance Travelled (Observed Numbers) | | | | | | |
|---|---|---|---|---|---|---|---|
| Ethnic Group | Less than 2km | 2km to less than 5km | 5km - 10km | >10km | Mainly Work From Home | Other | Total |
| English/Welsh/Scottish/Northern Irish/British | 17.3% | 28.0% | 19.2% | 19.9% | 8.8% | 6.7% | 100.0% |
| Other White | 19.3% | 23.9% | 12.7% | 28.5% | 4.6% | 10.9% | 100.0% |
| Asian/Asian British | 26.2% | 25.8% | 11.8% | 19.4% | 8.7% | 8.2% | 100.0% |
| Black/African/Caribbean/Black British | 15.9% | 26.9% | 14.3% | 25.7% | 8.3% | 8.9% | 100.0% |
| Mixed/multiple ethnic group | 19.0% | 26.3% | 17.3% | 21.8% | 7.6% | 8.1% | 100.0% |
| Other ethnic group | 21.2% | 22.9% | 9.2% | 28.4% | 6.7% | 11.6% | 100.0% |
| Irish | 16.7% | 27.2% | 14.3% | 19.5% | 12.4% | 9.9% | 100.0% |
| Total | 18.4% | 27.2% | 17.4% | 21.3% | 8.2% | 7.5% | 100.0% |

**Source: Nomis/Census 2011, LC7202EW- Distance travelled to work by ethnic group**

There was considerable differences in travel mode by ethnic group which may reflect the distance travelled to work.

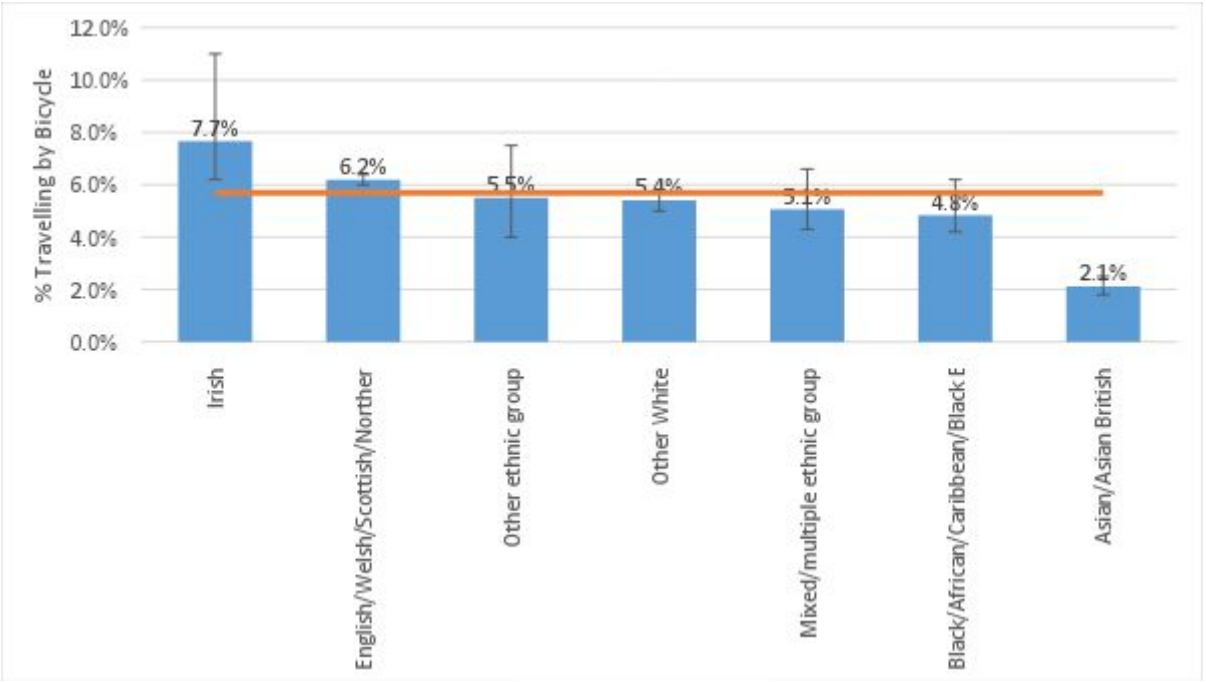
**Figure 16: Method of travel to work by ethnicity, percentages, Peterborough, Census 2011**

| | Method of Travel to Work (Percentages) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Ethnicity** | **Driving a car or van** | **On foot** | **Passenger in a car or van** | **Work mainly at or from home** | **Bus, minibus or coach** | **Bicycle** | **Train, underground, metro, light rail or tram** | **All other methods of travel to work** | **Total** |
| English/Welsh/Scottish/Northern Irish/British | 60.8% | 8.1% | 6.1% | 8.8% | 6.0% | 6.2% | 2.5% | 1.5% | 100.0% |
| Other White | 46.1% | 7.7% | 20.2% | 4.6% | 13.1% | 5.4% | 1.1% | 1.6% | 100.0% |
| Asian/Asian British | 52.3% | 12.6% | 10.5% | 8.7% | 6.4% | 2.1% | 2.9% | 4.4% | 100.0% |
| Black/African/Caribbean/Black British | 52.4% | 8.0% | 6.0% | 8.3% | 13.4% | 4.8% | 5.9% | 1.2% | 100.0% |
| Mixed/multiple ethnic group | 47.7% | 10.1% | 12.0% | 7.6% | 14.0% | 5.1% | 2.0% | 1.7% | 100.0% |
| Other ethnic group | 53.9% | 11.1% | 8.6% | 6.7% | 8.2% | 5.5% | 3.1% | 2.8% | 100.0% |
| Irish | 50.2% | 10.8% | 6.3% | 12.4% | 7.0% | 7.7% | 4.7% | 1.0% | 100.0% |
| **Peterborough Total** | **57.5%** | **8.5%** | **8.5%** | **8.2%** | **7.3%** | **5.7%** | **2.5%** | **1.8%** | **100.0%** |

**Source: Nomis/Census 2011, DC7201EW- Method of travel to work by ethnic group**

Asian/Asian British residents were less likely to cycle to work (2.1%) compared to the Peterborough average whilst Irish and White British residents were more likely to cycle.

**Figure 17: Percentages of residents travelling to work via bicycle by ethnicity, Peterborough, Census 2011**

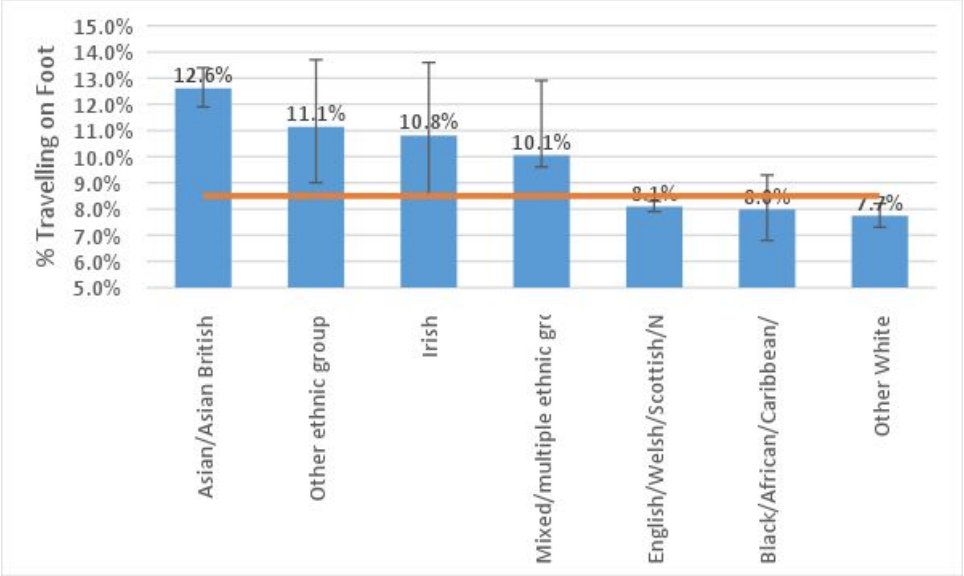



**Source: Nomis/Census 2011, DC7201EW- Method of travel to work by ethnic group**

**Orange line = Peterborough average**

Asian/Asian British residents and residents from other ethnic groups were more likely to travel on foot compared to the Peterborough average (8.5%). Conversely, residents from a white other ethnic group were less likely to travel on foot.

**Figure 18: Percentage of residents travelling to work on foot by ethnicity, Peterborough, Census 2011**




**Source: Nomis/Census 2011, DC7201EW- Method of travel to work by ethnic group**

## 2.8 Road Safety

Peterborough has lower rates of Killed and seriously Injured*[26] per 100 million vehicle km travelled than Great Britain, although Peterborough has a markedly higher rate of 'slight' injuries than observed nationally which contributes towards a higher overall rate of 42.5/100 million km travelled compared to 36.5/100 million km travelled across all of Great Britain (figure 19 below).

**Figure 19: Casualties per 100 million Vehicle km Travelled, 2015, Peterborough, Cambridgeshire & Great Britain**

| Area | KSI | Slight | Total (may not sum due to rounding) |
|---|---|---|---|
| Peterborough | 3.6 | 39.0 | 42.5 |
| Cambridgeshire | 3.7 | 20.4 | 24.1 |
| Great Britain | 4.7 | 31.9 | 36.5 |

**Source: Cambridgeshire & Peterborough Road Safety Partnership, Annual Statistics Summary 2015**

Data are available up to 2015 for the vehicle type involved in Peterborough KSI and 'slight' injury incidents. The strong majority (68%) of all incidents involved slight injuries within a car, with a further 13% attributable to slight injuries where the vehicle type was pedal cycle (figure 20 below). Twenty percent of KSIs were among cyclists and pedestrians.

[26] The definition of 'killed' within this context is 'a human casualty who dies within 30 days after collision due to injuries received in the crash' whereas the definition of 'seriously injured' in the UK covers injury resulting in a person being detained in hospital as an in-patient, as well as all injuries causing fractures, concussion, internal injuries, crushing, burns, severe cuts, and severe general shock. 'Slight injury' refers to sprains (including neck whiplash injuries), bruising, minor cuts and mild shock requiring roadside assistance.

**Figure 20: KSI & Slight Injury Observed Incidents in Peterborough by Vehicle Type, 2015**

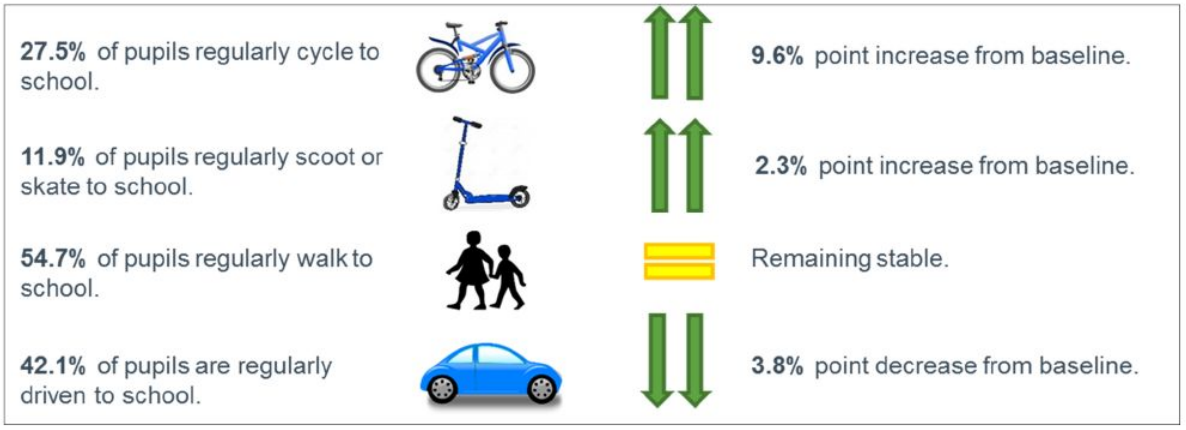
| Vehicle Type | Fatal | Serious | Slight | Total | % of Total |
|---|---|---|---|---|---|
| Pedal Cycle | 1 | 12 | 86 | 99 | 13% |
| Car | 3 | 27 | 506 | 536 | 68% |
| Motorcycle | 0 | 12 | 38 | 50 | 6% |
| Goods Vehicle | 0 | 1 | 27 | 28 | 4% |
| Pedestrian | 0 | 7 | 45 | 52 | 7% |
| Other | 0 | 3 | 19 | 22 | 3% |
| Total | 4 | 62 | 721 | 787 | 100% |

**Source: Cambridgeshire & Peterborough Road Safety Partnership, Annual Statistics Summary 2015**

## 2.9 Travel to School

Peterborough City Council has been operating the Bike It Programme for schools which works alongside schools to increase the number of young people travelling to school actively and / or sustainably with an emphasis on increasing cycling levels, reducing car travel and creating a culture of active travel within school which can be sustained. Between 2014 and 2015, the Bike It officers in Peterborough have delivered approximately 200 activities across all schools in the city, resulting in them engaging with 14,907 attendees. Figure 21 below shows the key outcomes of the Bike It programme.

**Figure 21: Key Outcomes of PCC Bike It Programme**




Data from a number of schools which submitted Travel Plans to PCC between 2006 and 2015 has also been analysed to obtain average mode share change across schools in the city. The results of this analysis are presented in figure 22.

**Figure 22: School Travel Plan Mode Data**

| Mode | Average Mode Share Change (%) |
|---|---|
| Cycling | 7.5 |
| Walking | -10.8 |
| Scoot / Skate | 7.7 |
| Park & Stride | 4.5 |
| Bus | -1.0 |
| Train | 0.1 |
| Car | -7.6 |

**Source: LSTF Data Monitoring Report, Peterborough City Council, 24 February 2016**

## 2.10 Travel to work

Feedback from workplace travel surveys indicates a prevalent perception that active travel and other sustainable transport alternatives are intimidating, impractical or inconvenient. Previous experience shows that, by addressing these concerns, travel behaviour change programmes have the potential to inspire people to use sustainable transport and create measurable change in local transport patterns, as illustrated during our 2014/15 programme, where specific bespoke workplace interventions were deployed (e.g. my Personal Travel Plan (myPTP)) and as a result employees reduced their overall single occupancy vehicle (SOV) car mode share by nearly 6%, yielding a Benefit Cost Ratio (BCR) of 9.87. This has also potentially helped to reduce the overall mortality rate by 2% attributed to increased cycling and an 11% reduced risk of mortality for walker's vs non-walker's, calculated using the WHO HEAT assessment tool.

Peterborough has been delivering a programme to encourage smarter travel choices for over 10 years. In 2004, as one of three Sustainable Travel Demonstration Towns, Peterborough was awarded £5m to fund measures to encourage behavioural change towards sustainable modes of travel. Over a five year period, the Travelchoice project achieved:

- 9% reduction in car journeys
- 12% increase in cycling
- 35% increase in public transport
- 14% increase in walking

## 2.11 Peterborough walking and cycling environment

### 2.11.1 Size of city and proximity to workplace

The size of Peterborough means there is substantial potential for active travel as at the last census (2011):

- 16,000 or 18% of working age residents lived within 2km of their work place, which is higher than for England (16.6%).
- 40,000 people or 45% of working age residents lived within 5km of their work place compared to 35% nationally.

This provides the basic building blocks for creating a city where active forms of transport could be the default.

### 2.11.2 The environment

Peterborough was ranked by the Campaign for Better Transport's 2014 'Car Dependency Scorecard 2014' (the most recent such analysis) as the most car-dependent city in the UK[27]. This likely reflects the fact that In 1967 Peterborough was declared a new town which benefitted with highways infrastructure including the Parkway. As a result, Peterborough is recognised as having some of the fastest commuting speeds in the country.

As noted in Figure 23 below, Peterborough scored poorly for all four assessed criteria; accessibility and planning (ranked 27th/29), cycling and walking as alternatives to driving (28th/29), bus/train quality and uptake (28th/29) and driving and car use (28th/29).

**Figure 23: Car Dependency Analysis, Campaign for Better Transport, 2014**


**Source: 'Car Dependency Scorecard 2014', Campaign for Better Transport, 2014, URL:**
**http://www.bettertransport.org.uk/sites/default/files/pdfs/Car_Dep_Scorecard_2014_LOW_RES.pdf**

[27] http://www.bettertransport.org.uk/sites/default/files/pdfs/Car_Dep_Scorecard_2014_LOW_RES.pdf

**Barriers to increasing levels of walking and cycling in Peterborough**

There are a number of potential barriers to active travel in Peterborough that prevent individuals from travelling sustainably. The Peterborough Council Local Sustainable Transport Fund (LSTF) Monitoring Report (2016) focuses on the barriers which need to be overcome in order to promote sustainable travel. Walk and Cycle friendly mapping outputs were analysed to assess the quality of on-road cycling and walking routes in Peterborough, as shown in Figure 24 & Figure 25. The Walk and Cycle friendly projects were carried out to consider specifically the level of service quality along key commuting corridors into and out of the city. The studies evaluated particular physical barriers to walking and cycling modes and developed practical action plans to prioritise future capital spending on infrastructure.

In summary the outputs showed that:

- Approximately one third of all walking routes assessed are deemed to be poor. The three with the poorest score are Fengate, A15 between Thorpe Road and Bishop's Road and St John's Street;
- Only one cycle route in the city is listed as excellent – London Road between Fletton Parkway and Cook Avenue; and
- Several are listed as poor – Thorpe Road, Fengate and Lincoln Road.
- Although it should be noted that many other cities would score similarly.

The areas with the most barriers from this analysis broadly correlate with PCC's areas for investment for Travel choice programmes. These include Fengate where extensive business travel planning was recently undertaken and future plans for Lynchwood.

Barriers to travel that could be alleviated in the future were also included in PCC's Draft Local Plan 4. There are barriers impacting all modes of travel walking, cycling, public transport and cars. The key barriers in Peterborough are;

- Walking – physical features restricting the permeability of the walking routes in Peterborough, individuals face health related problems due to inactivity restricting their mobility;
- Cycling – cycling network has some missing links and focused on radial routes, individuals face health related problems due to inactivity restricting their mobility;
- Challenges with public transport information, interchanges and integration between different modes of public transport, some issues with bus punctuality and frequency, congestion at times impacting on bus reliability; and Car Use – congestion impacting on journey times and reliability, air pollution and noise issues, safety concerns, parkway reaching capacity, growth agenda will further accelerate traffic growth into the city.

**Figure 24: Walk friendly Mapping Output**

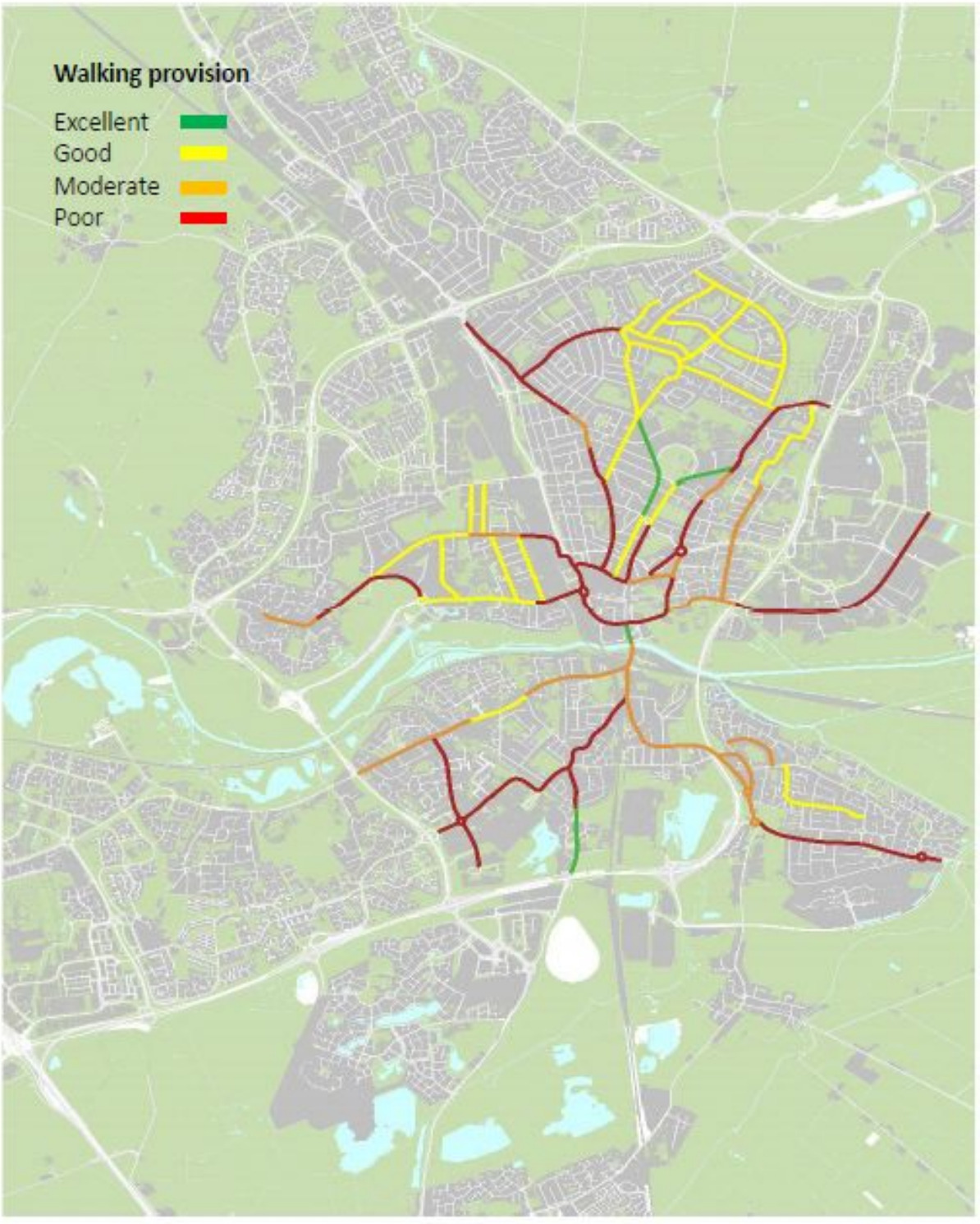
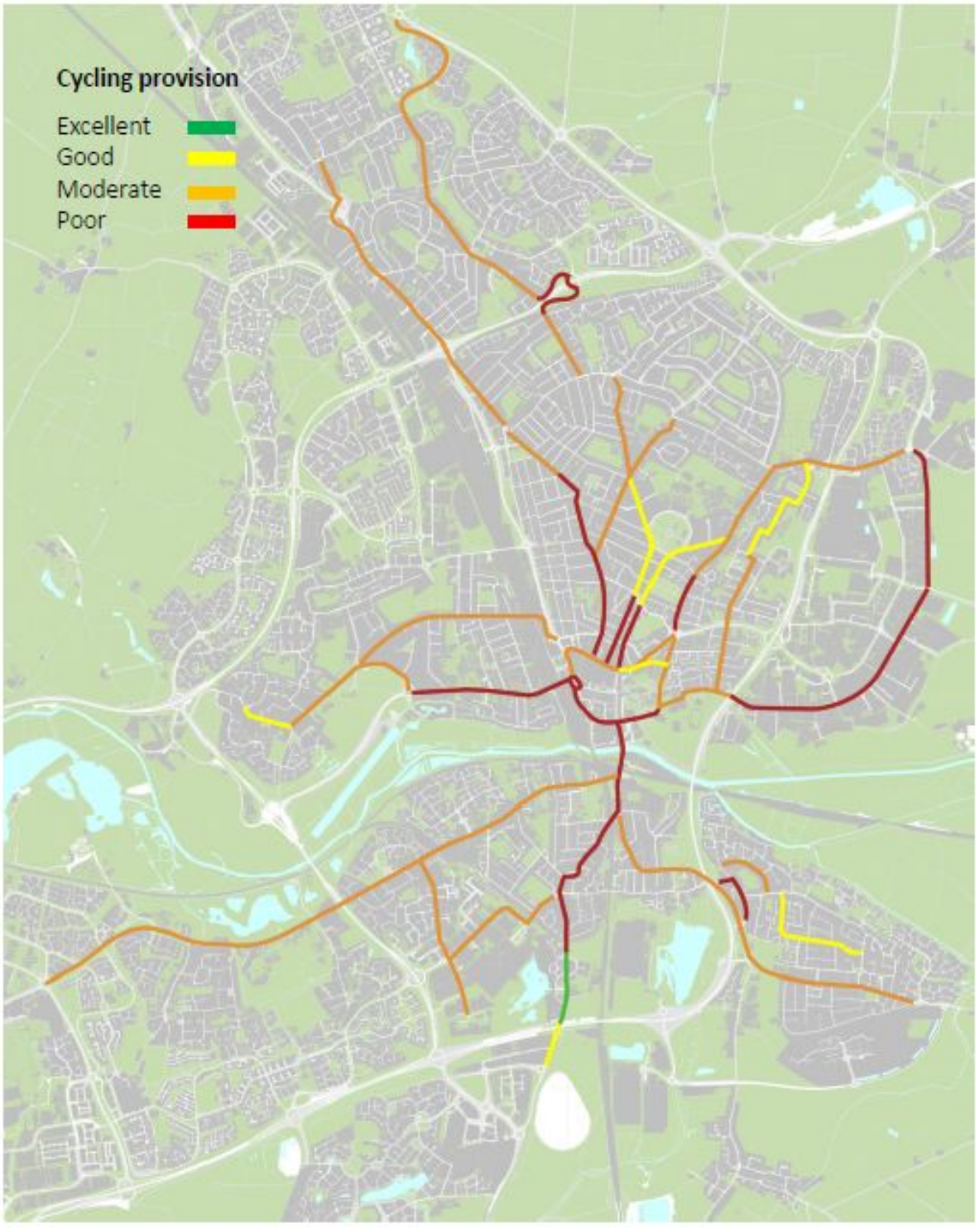


**Figure 25: Cycle friendly Mapping Output**



# 3 Air pollution

## 3.1 Why is air pollution important?

As recently as the Nineties it was felt that air pollution was no longer a major health issue in the United Kingdom as legislation had made the great smog's of the Fifties a thing of the past.

However, evidence started to emerge that small particles emitted to the air from various sources, such as road transport, industry, agriculture and domestic fires, were still having a considerable effect on health. This type of air pollution is so small that it can't be seen by the naked eye, but can get into our respiratory system[28].

Other air pollutants, such as nitrogen dioxide and ozone, can also affect our health. Nitrogen dioxide is produced by burning fuel, whilst ozone is formed by chemical reactions in the air.

It is estimated that long term exposure to particulate matter alone has an effect equivalent to 25,000 deaths a year in England by increasing the risk of diseases such as heart disease, stroke, respiratory disease and cancers[29] and was one of the 20 leading risk factors to health in 2013[30].

## 3.2 What is air pollution?

Air pollutants are generated by a mixture of natural and man-made processes (see below) and are released into the air, often reacting with other chemicals. The distribution of these pollutants will depend on the size of the molecule and weather patterns, with some pollutants being mainly deposited locally and some affecting sites in other world regions eg ozone.

There are many pollutants that impact health and the UK Air Quality Standards Regulations 2000[31] which sets standards for:

- Particulate matter ($PM_{10}$ and $PM_{2.5}$)
- Nitrogen dioxide ($NO_2$)
- Ozone ($O_3$)
- Sulphur dioxide ($SO_2$)
- Lead
- Benzene and Benzo(a)pyrene
- Carbon monoxide (CO)

The majority of air pollutants have declined over time in the UK but particulates, nitrogen dioxide and ozone are still at levels that can harm health. Ozone is not deemed to be a local pollutant, as formation takes place over some time, and may be a result of emissions from thousands of kilometres away.

[28] Air Quality A Briefing for Directors of Public Health March 2017
[29] https://publichealthmatters.blog.gov.uk/2017/06/15/clean-air-day-taking-steps-to-reduce-air-pollution/
[30] https://vizhub.healthdata.org/gbd-compare/england/
[31] Statutory Instruments, *2010 No 1001, Environmental Protection, The Air Quality Standards Regulations 2010*

http://www.legislation.gov.uk/uksi/2010/1001/pdfs/uksi_20101001_en.pdf

### 3.2.1 Particulate matter (PM)

PM has three sizes that are commonly used as indicators PM10, PM2.5 and PM0.1. PM is made up of a wide range of materials and arise from a variety of sources including.

- Primary particles emitted directly into the atmosphere from combustion sources, and
- Secondary particles formed by chemical reactions in the air.

Road transport gives rise to primary particles from engine emissions, tyre and brake wear and other non-exhaust emissions and make a significant (about 30-50%) contribution to the urban background levels. Other primary sources include quarrying, construction and non-road mobile sources[32].

Secondary particles dominate urban background PM2.5 in the UK, accounting for some 30-50% of the PM2.5 in urban areas. A significant proportion of secondary PM2.5 is imported into the UK, having been formed from precursor emissions in continental Europe.

Due to much of the ambient (outdoor) $PM_{2.5}$ coming from non-local sources in order to achieve a reduction of 15% (1.5 - 2µg/m3) of the total urban background concentration PM2.5, using local measures, would require a very challenging reduction of local sources of 25-67% or a reduction of secondary sources of 25-50%[33].

### 3.2.2 Nitrogen Dioxide

The gaseous pollutant nitrogen dioxide (NO2) is a gas produced along with nitric oxide (NO) by combustion processes and together they are often referred to as oxides of nitrogen (NOx). On average around 80% of oxides of nitrogen (NOx) emissions in areas where the UK is exceeding NO2 limit values is due to transport, although urban and regional background non-transport sources are still considerable. The largest source is emissions from diesel light duty vehicles (cars and vans) and there has been significant growth in these vehicle numbers over the last ten years in the UK.

## 3.3 National and local policies to lower emissions

The UK Air Quality Strategy[34] established objectives for eight key air pollutants, based on the best available medical and scientific understanding of their effects on health. These Air Quality Objectives are at least as stringent as the limit values of the relevant EU Directives – in some cases, more so.

The current Government policy framework, and the legislative requirement to meet EU air quality limit values everywhere in the UK, tends to direct attention to localised hotspot areas of pollution (where the objectives are not met). Monitoring of Nitrogen Dioxide by screening using diffusion tubes has been happening in Peterborough since 1994. With respect to Particulate Matter (PM) it is recognised that there are no absolute safe levels of exposure. As such any improvement in air quality will have positive health consequences, although $PM_{2.5}$ is still not incorporated into the LAQM Regulations, and therefore there is no statutory requirement to review and assess $PM_{2.5}$ for LAQM purposes.

Local Authority Air Quality Management Areas are declared when the local authority review and assessment process identifies an exceedance of an Air Quality Strategy objective. The local authority

[32] http://www.aqconsultants.co.uk/AQC/media/Reports/SNIFFER-PM25-Rept-Final-201210.pdf
[33] http://www.aqconsultants.co.uk/AQC/media/Reports/SNIFFER-PM25-Rept-Final-201210.pdf
[34] Department for Environment, Food and Rural Affairs (Defra*), The air quality strategy for England, Scotland, Wales and Northern Ireland*, 2011. Available at https://www.gov.uk/government/publications/the-air-quality-strategy-for-england-scotland-wales-and-northern-ireland-volume-1

must declare an 'Air Quality Management Area' (AQMA) and develop an Action Plan to tackle problems in the affected areas. Peterborough City has not declared any AQMAs, however Hanson Building Products Limited carry out monitoring of their Whittlesey brickworks in relation to the Air Quality Management Area.

## 3.4 What impact does air pollution have on health?

Numerous studies have found an association between air pollution and a wide range of adverse health effects in the general population; the effects can range from subtle subclinical effects to early death[35]. When talking about the contribution of air pollution to deaths it is most appropriate to speak in terms of lives shortened, rather than deaths caused; as while a car crash can be said to be the exclusive cause of an individual's death, nobody is dying purely as a result of air pollution[36]. Pollutants such as particulates could well have had a significant impact on somebody who died from heart disease, but it's likely that other factors, such as diet or exercise, played a part too. Instead, the toxic pollutants in our air affect everybody a little bit, and some people – the young, elderly and those with respiratory and cardiac conditions – significantly more.

### 3.4.1 Health impact PM2.5

PM2.5 has the strongest link to health outcomes and at this size the particles can be inhaled deep into the lungs. The very smallest particles, ultrafine PM0.1 are thought, once inhaled, to be able to pass directly into the bloodstream[37].

Long-term exposure to $PM_{2.5}$ is the key air pollution contributor to excess deaths. The relative risk of death attributable to PM2.5 is 6.6% per 10µg/$m^3$ increase in $PM_{2.5}$[38], in other words if there was no PM2.5 there would be 6.6% less mortality). It also increases mortality for cardiovascular and respiratory diseases such as stroke, ischaemic heart disease, lung disease and lung cancer.

Short-term exposure to $PM_{2.5}$ is also associated with small increases in hospital admissions for cardiovascular and respiratory conditions and reduction in activity levels - resulting in days of missed work, absences from school and other more minor reductions in daily activity.

### 3.4.2 Health impact of $PM_{10}$

Larger $PM_{10}$ particles tends to have a more direct, short-term impact on people's respiratory symptoms and health as they are more likely to be deposited in the upper airways and normally cleared rapidly through mucus and other mechanisms. A review of the evidence produced by the WHO[39] summarised evidence on the link between $PM_{10}$ and health (see opposite). Due to variability in the underlying studies, there is uncertainty surrounding the precise estimates.

PM10 increases:

- Post neonatal (1- 12 months) all-cause infant mortality (long-term exposure).
- Prevalence of bronchitis in children 6-12 years (long-term exposure).
- Incidence of chronic bronchitis in adults (long-term exposure).
- Incidence of asthma symptoms in children with asthma (short-term exposure).

### 3.4.3 Health impact of $NO_2$

Unlike particulates, $NO_2$ is a gas and therefore disperses differently from traffic sources and can be inhaled deep into the lungs. In recent years the evidence[40] associating $NO_2$ with health effects has

[35] Health-risk-assessment-air-pollution-General-principles-en
[36] http://energydesk.greenpeace.org/2017/03/06/air-pollution-cause-40000-deaths-every-year-fact-check-linked/
[37] Air Quality A Briefing for Directors of Public Health March 2017
[38] http://www.euro.who.int/__data/assets/pdf_file/0010/263629/WHO-Expert-Meeting-Methods-and-tools-for-assessing-the-health-risks-of-air-pollution-at-local,-national-and-international-level.pdf?ua=1
[39] HRAPIE
[40] Committee on the Medical Effects of Air Pollutants (COMEAP), *Statement on the evidence for the effects of nitrogen dioxide on health*, March 2015. Available at https://www.gov.uk/government/publications/nitrogen-dioxide-health-effects-of-exposure

strengthened substantially with scientist believing that $NO_2$ itself is responsible for some of the health impact found to be associated with it in epidemiological studies.

A Department of Health[41] study found that a 10µg/$m^3$ increase in 24 hour average $NO_2$ was associated with increases in:

- Mortality
    - All age, all-cause mortality: 0.71%
    - Cardiovascular mortality: 0.94%
    - Respiratory mortality: 1.09%
- Hospital admissions
    - Respiratory: 0.57%
    - Cardiovascular disease: 0.66%
- Incidence of asthma in children – 6% based on 18 studies.

However, although epidemiological evidence associates exposure to $NO_2$ with adverse effects on health, there is some discussion as to whether $NO_2$ is just a marker for other toxic elements of vehicle pollution with potential overlap with PM 2.5.

## 3.5 Who is most impacted by air pollution and when?

The health effects of air pollution are distributed unequally across the population, with the heaviest burden borne by those with greatest vulnerability and/or exposure. The elderly, children and those with cardiovascular and/or respiratory disease are at greater risk from the health effects of air pollution.

Those who spend more time in highly polluted locations will be affected more. Since air pollution levels are typically as high within vehicles as just outside, this is likely to include not only those who live and work near busy roads, but also those who drive for a living.

Deprived communities are more likely to be situated near polluted busy roads, and are more likely to experience adverse health impacts. Analysis of environmental quality and social deprivation carried out for the Environment Agency (2003) looked at the social distribution of the wards with the highest pollutant concentrations, and concluded that more than half of the most exposed 5% of the population (2.5 million people) were resident in the 20% most deprived wards.

For $PM_{2.5}$, the particle is so small that 40-70% of it can penetrate into indoor spaces where people are working, and provides much of the exposure to particulate matter[5]. Active urban adults in Europe spend an average of 85-90% of their time indoors, 7-9% in traffic and only 2-5% outdoors, with very vulnerable groups, such as infants and the elderly, spending nearly all their time indoors. Therefore, due to time, exposures indoors dominate overall air pollution exposures[5].

## 3.6 What do we know about air pollution levels in Peterborough?

### 3.6.1 Peterborough infrastructure

In 1967 Peterborough was declared a new town. This benefitted the City with highways infrastructure including the Parkway and cycleway systems. As a result, Peterborough is recognised as having some of the fastest commuting speeds in the country. However as one of the fastest growing cities in the country the greater volumes of traffic will place increased pressures on the road

[41] Department of Health, Policy Research Programme, *Systematic review and qualitative meta-analysis of the evidence for associations between chronic and short-term exposure to outdoor air pollutants and health*, January 2012 Available at http://www.prp-ccf.org.uk/PRPFiles/SFR_April_2011/0020037%20SFR_Atkinson.pdf

system and potentially reduce speeds. This could lead to increased levels of transport related air pollution in the future.

**Fig 27: Nitrogen dioxide monitoring sites across Peterborough**


### 3.6.2 Local monitoring

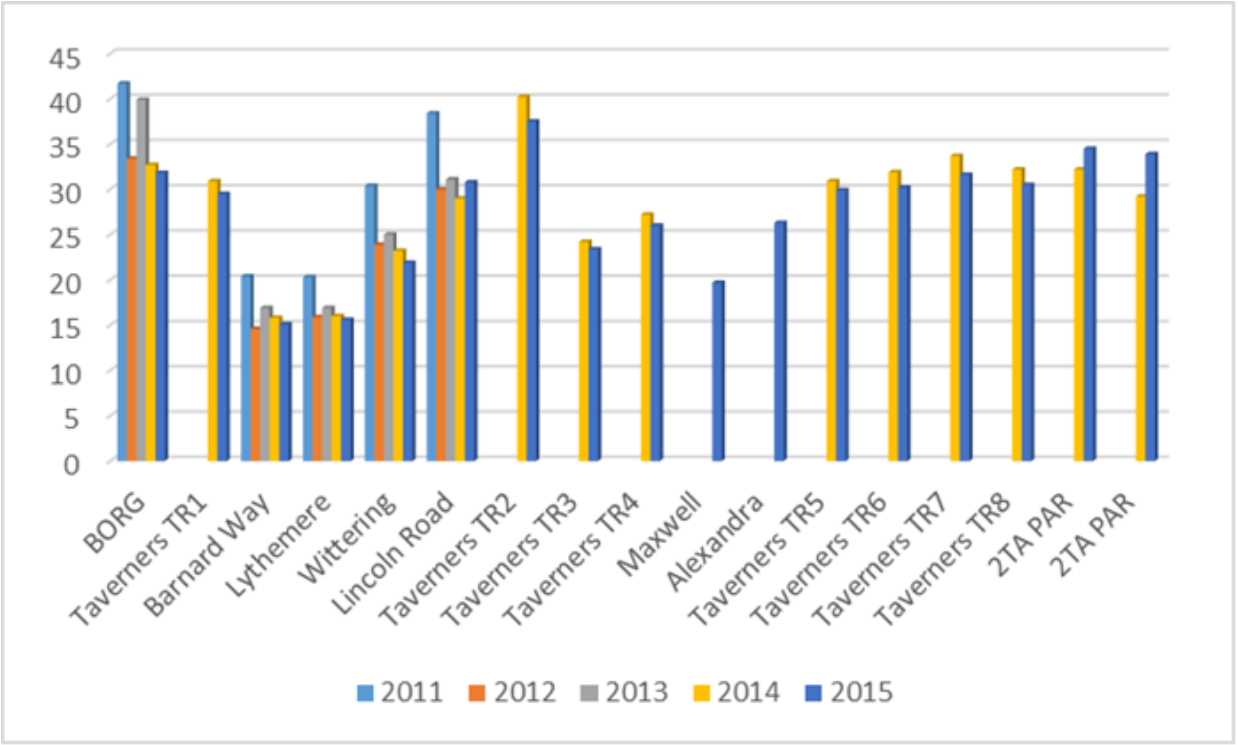
Peterborough City Council undertook monitoring of $NO_2$ at 16 sites within the Local Authority Area during 2015. These sites are a mixture of urban background, roadside and kerbside. The map opposite shows the site of the NO2 monitors.

Other sites have been monitored around Peterborough in previous years, however monitoring at these sites ceased following the completion of planned monitoring programmes for these locations.

### 3.6.3 NO2

There are no Air Quality Management Areas (AQMA) for N02 in Peterborough. The results of monitoring for sites across Peterborough are presented below. They show that no areas in the last couple of years have exceeded air quality objectives for NO2 of 40µg/m3.

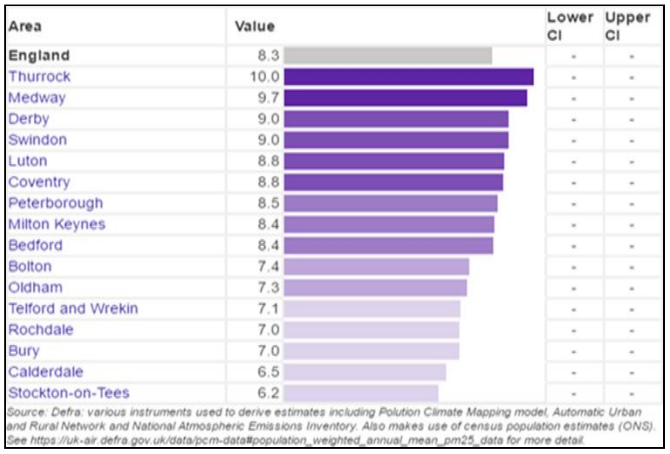
**Fig 26: Trends in Annual Mean Nitrogen Dioxide Concentrations Measured at Diffusion Tube Monitoring Sites**



### 3.6.4 PM2.5

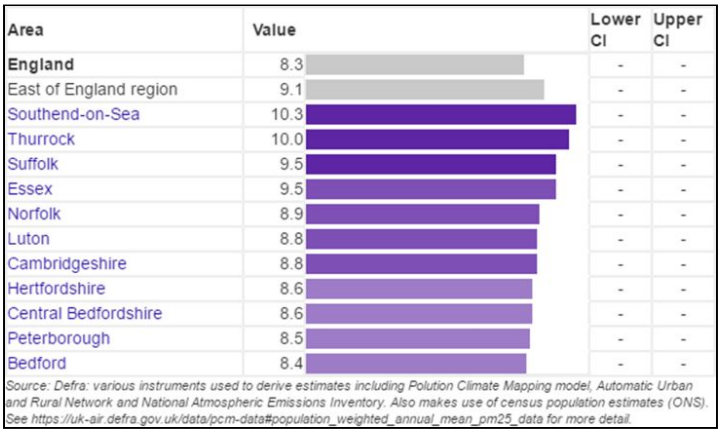
Local data on PM2.5 is modelled and comes from the pollution climate mapping (PCM) model[42]. The charts below show that in 2015 the estimated background level of manmade PM2.5 across Peterborough was 8.5ugm3 which is below the Air Quality Objectives. However, as noted previously, we now know that significant harm to health results from exposure to current concentrations of particulate air pollution, even though target and limit values are being met. The level is slightly higher than the England average, similar to our statistical neighbours and lower compared to East of England authorities. This is likely due to authorities further east receiving a larger contribution of particulate pollution from mainland Europe.

**Figure 28: Estimated background rate of PM2.5 compared to statistical neighbours and EOE LA's**



| Area | Value | Lower CI | Upper CI |
|---|---|---|---|
| England | 8.3 | - | - |
| Thurrock | 10.0 | - | - |
| Medway | 9.7 | - | - |
| Derby | 9.0 | - | - |
| Swindon | 9.0 | - | - |
| Luton | 8.8 | - | - |
| Coventry | 8.8 | - | - |
| Peterborough | 8.5 | - | - |
| Milton Keynes | 8.4 | - | - |
| Bedford | 8.4 | - | - |
| Bolton | 7.4 | - | - |
| Oldham | 7.3 | - | - |
| Telford and Wrekin | 7.1 | - | - |
| Rochdale | 7.0 | - | - |
| Bury | 7.0 | - | - |
| Calderdale | 6.5 | - | - |
| Stockton-on-Tees | 6.2 | - | - |

Source: Defra: various instruments used to derive estimates including Polution Climate Mapping model, Automatic Urban and Rural Network and National Atmospheric Emissions Inventory. Also makes use of census population estimates (ONS). See https://uk-air.defra.gov.uk/data/pcm-data#population_weighted_annual_mean_pm25_data for more detail.

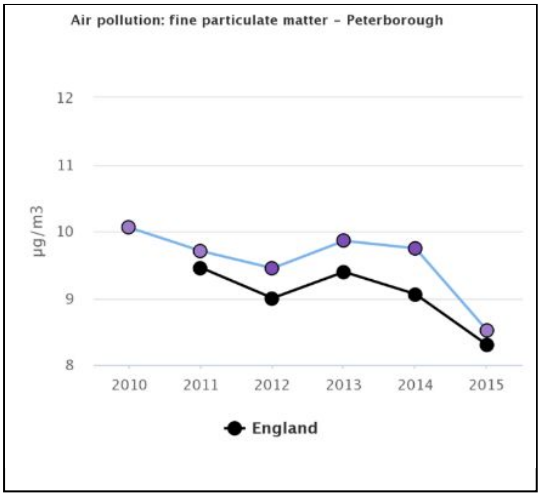


| Area | Value | Lower CI | Upper CI |
|---|---|---|---|
| England | 8.3 | - | - |
| East of England region | 9.1 | - | - |
| Southend-on-Sea | 10.3 | - | - |
| Thurrock | 10.0 | - | - |
| Suffolk | 9.5 | - | - |
| Essex | 9.5 | - | - |
| Norfolk | 8.9 | - | - |
| Luton | 8.8 | - | - |
| Cambridgeshire | 8.8 | - | - |
| Hertfordshire | 8.6 | - | - |
| Central Bedfordshire | 8.6 | - | - |
| Peterborough | 8.5 | - | - |
| Bedford | 8.4 | - | - |

Source: Defra: various instruments used to derive estimates including Polution Climate Mapping model, Automatic Urban and Rural Network and National Atmospheric Emissions Inventory. Also makes use of census population estimates (ONS). See https://uk-air.defra.gov.uk/data/pcm-data#population_weighted_annual_mean_pm25_data for more detail.

**Fig 29: Trend in modelled PM 2.5 for Peterborough**

The modelled PM 2.5 levels in Peterborough have been decreasing at a similar rate to England. Trends in modelled data need to be treated with caution as data is modelled and changes in assumptions can change estimated levels, further pollution levels can be heavily influenced by weather.




### 3.6.5 Sulphur Dioxide ($SO_2$)

Sulphur Dioxide is not monitored at any location by Peterborough City Council, however, Hanson Building Products Limited carry out monitoring of their Whittlesey brickworks in relation to the Air Quality Management Area.

[42] Estimated local mortality burdens associated with particulate air pollution – PHE

## 3.7 Impact of air quality on the health of Peterborough residents

### 3.7.1 Mortality

As long term exposure to air pollution is considered a contributory factor to deaths e.g. unlikely to be sole cause of death and not on death certificates[43], it is necessary to estimate mortality attributable to air pollution using modelled background levels of pollutants and estimates of mortality from the academic literature.

With long term exposure to PM2.5 associated with an increase in deaths of 6.6% for every 10Ug/m3 increase in PM2.5[44] and modelled background levels of PM2.5 in Peterborough of 8.5 Ug/m3 particulate matter was estimated to contribute to 5.3% of all deaths in 2015.

The rate of deaths attributable to PM2.5 in Peterborough's is comparable to our similar local authorities and lower compared to other LAs in the East of England (reflecting patterns of background rates).

In 2010 Public Health England estimated that long term exposure to PM2.5 in Peterborough accounted for 829 years of life lost due to PM2.5. Recognising that air pollution is not a direct cause of death this could mean that:

- 9948 people lived 1 month less,
- 1658 people lived 6 months less life or
- 41 people died 20 years early etc.

**Figure 30: Rate of attributable mortality in Peterborough compared to compared to statistical neighbours and EOE LA's**

| Area | Value | Lower CI | Upper CI |
|---|---|---|---|
| England | 4.7 | - | - |
| East of England region | 5.1 | - | - |
| Southend-on-Sea | 5.8 | - | - |
| Thurrock | 5.6 | - | - |
| Suffolk | 5.4 | - | - |
| Essex | 5.4 | - | - |
| Norfolk | 5.0 | - | - |
| Luton | 5.0 | - | - |
| Cambridgeshire | 5.0 | - | - |
| Hertfordshire | 4.9 | - | - |
| Central Bedfordshire | 4.9 | - | - |
| Peterborough | 4.8 | - | - |
| Bedford | 4.8 | - | - |

| Area | Value | Lower CI | Upper CI |
|---|---|---|---|
| England | 4.7 | - | - |
| Thurrock | 5.6 | - | - |
| Medway | 5.5 | - | - |
| Derby | 5.1 | - | - |
| Swindon | 5.1 | - | - |
| Luton | 5.0 | - | - |
| Coventry | 5.0 | - | - |
| Peterborough | 4.8 | - | - |
| Milton Keynes | 4.8 | - | - |
| Bedford | 4.8 | - | - |
| Bolton | 4.2 | - | - |
| Oldham | 4.2 | - | - |
| Telford and Wrekin | 4.0 | - | - |
| Rochdale | 4.0 | - | - |
| Bury | 4.0 | - | - |
| Calderdale | 3.7 | - | - |
| Stockton-on-Tees | 3.5 | - | - |

### 3.7.2 Impact on disease prevalence and health care utilisation

At present, Peterborough does not have specific estimates for the impact of air pollution on disease prevalence and health care utilisation. Therefore, the health impact on hospital admissions for respiratory and cardiovascular admissions needs to be based on the general estimates[45].

[43] Estimating the local mortality burden associated with particulate air pollution PHE 2014

[44] http://www.euro.who.int/__data/assets/pdf_file/0010/263629/WHO-Expert-Meeting-Methods-and-tools-for-assessing-the-health-risks-of-air-pollution-at-local,-national-and-international-level.pdf?ua=1

[45] World Health Organisation, 2013. Review of Evidence on Health Aspects of Air Pollution – REVIHAAP Project – Technical Report [online] Available At: http://www.euro.who.int/__data/assets/pdf_file/0004/193108/REVIHAAP-Final-technical-report-final-version.pdf?ua=1

## 3.8 Susceptible populations in Peterborough

Individuals with conditions such as lung disease, heart disease and stroke are at greater risk of worsening symptoms due to air pollution compared to the rest of the population.

Hospital activity data suggests Peterborough already has higher rates of susceptible individuals as there are:

- higher rates of emergency hospital admissions due to COPD and Asthma (under 19s).
- higher rates of hospital admissions and premature deaths due to heart disease and stroke.

This is not suggesting the higher rates of admission are due to poor air quality but rather Peterborough residents could be at greater risk if air pollution increased in the future.

# 4 Access to transport

## 4.1 Transport links as a wider determinant of health

Access to transport is an important determinant of health and wellbeing as it is a fundamental enabler to access services and social opportunities. Nonetheless, even when transport is available and accessible, there may be other important access barriers that limit travel and mobility, and limit social participation.

**Figure 31: Model of Wider Determinants of Health and Wellbeing**

## 4.2 What factors make people vulnerable to transport barriers?

There are multiple forms of access barriers, or issues that make it more difficult to reach and use health and other key services. The Governments 2003 Social Exclusion Unit report,[46] identified five main barriers in accessing services:

1. The availability and physical accessibility of transport.
2. Cost of transport.
3. Services and activities located in inaccessible places.
4. Safety and security.
5. Travel horizons.

### 4.2.1 Rurality

There are particular challenges to transport provision in rural areas due to the dispersed population and the reduced cost effectiveness of public transport options. Although car ownership levels are higher in rural areas, there are a significant proportion of households without access to a car. Those living in rural areas without a car face particularly acute problems because the high level of car use means, demand for public transport services has declined.[47]

The report on Rural Communities from the UK Government Environment, Food and Rural Affairs Committee, published in July 2013 addressed rural transport[48], noting that:

- People living in villages and dispersed areas travel 10,000 miles per year on average, compared to 6,400 miles per year in urban areas.
- On average, expenditure on transport accounts for 17.7% of total expenditure for rural residents compared with 14.5% for urban residents.

The number of households with good transport access to key services or work has declined for town/fringe areas from 86% of households in 2007 to 83% in 2011; over the same period the figures for villages decreased from 52% to 27% and for hamlet/isolated dwellings decreased from 41% to 29%.[49]

Community transport has expanded in recent years for a number of reasons including cutbacks in mainstream public transport because of budget reductions in local government, a reduced commitment by the Health Service to provide non-emergency transport, an increased recognition of the role community transport can play, and changing demographics.

### 4.2.2 Car Dependency and Driving Cessation

Car and van ownership offer significant opportunity and flexibility for travel for individuals and households across England. The National Travel Survey for 2016 found that 62% of all trips in England were made by car (as a driver or passenger).

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[46] Social Exclusion Unit: Office of the Deputy Prime Minister, *Making the connections: final report on Transport and Social Exclusion*, 2003.

[47] Social Exclusion Unit: Office of the Deputy Prime Minister, *Making the connections: final report on Transport and Social Exclusion*, 2003.

[48] House of Commons Environment, Food and Rural Affairs Committee. *Rural Communities*, Sixth Report of Session 2013–14. Available at: http://www.publications.parliament.uk/pa/cm201314/cmselect/cmenvfru/602/602.pdf

[49] Department for Transport, *Households with good transport access to key services or work*, *England,* 2013. Cited in House of Commons Environment, Food and Rural Affairs Committee. *Rural Communities*, Sixth Report of Session 2013–14

There are increasing numbers of older drivers due to ageing of existing licence holders rather than large numbers of newly qualified drivers in older age groups.[50] It is acknowledged that for the majority of older drivers, driving cessation is a process, with an element of self-regulation including reducing distance travelled and driving journeys undertaken in adverse conditions or in the dark, before complete cessation.

The UK Driving and Vehicle Licensing Authority issue medical standards of fitness to drive, most recently updated in November 2014.[51] DVLA requires confirmation at the age of 70 that no medical disability is present, and thereafter licences are granted for three years. Some health conditions or change in health status may result in a driving licence being suddenly revoked. For example, a person must not drive for one month following a transient ischaemic attack (TIA).[52]

Conditions that may preclude people of all ages from driving include:

- Neurological disorders
- Cardiovascular disorders
- Diabetes Mellitus
- Psychiatric Disorders
- Drug and Alcohol misuse and dependence
- Visual disorders
- Renal and Respiratory disorders

There is research evidence that those who anticipate, plan and give-up driving on a gradual basis experience less negative transitional effects than those who have to be told to give-up driving or do so on the spur of the moment. This transition will necessitate learning alternative ways of travelling. Expert opinion suggests that support for life beyond the car is needed at a younger age (while older people are driving) to help build solutions and confidence in transport use beyond the car and should involve emotional support, as well as practical support.[53]

The evidence from driving cessation indicates that some journeys eg those that allow engagement in social activities, and with social networks, are potentially affected differently and more detrimentally by transportation barriers than travel to access key services[5455].

### 4.2.3 Transport knowledge and skills

Making use of public and community transport infrastructure requires knowledge and skills of finding information about the services that are available, and how to access and use them. Particular vulnerable groups have been identified by the Department for Transport who may benefit from 'travel training': training that aims to help people travel independently and without fear to work, to education, to other key services, or simply for leisure:

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50 Department for Transport. *National Travel Survey Statistical Release*, July 2013. Available at: https://www.gov.uk/government/statistics/national-travel-survey-2013

51 DVLA Medical Standards of fitness to drive, 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390134/aagv1.pdf

52 Details on current medical guidelines are available for a range of conditions at: https://www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals-conditions-s-to-u#stroketia

53 Travelwest evidence briefing drawing from: 1 Musselwhite, C. and Haddad, H. *Mobility, accessibility and quality of later life.* Quality in Ageing and Older Adults, 2010. 11(1), 25-37. Musselwhite, C. *The importance of driving for older people and how the pain of driving cessation can be reduced*. Signpost: Journal of Dementia and Mental Health Care of Older People, 2011. 15 (3). 22-26.

54 Davey, J.A., *Older people and transport: Coping without a Car.* Ageing & Society. 2007. 27:49-65

55 Azad N., et al. *A survey of the impact of driving cessation on older drivers.* Geriatrics Today. 2002. 5/4: 170-174.

- People with learning difficulties of all ages, requiring individualised training appropriate to their situation for specific journeys or the whole network.
- People with disabilities, ranging from physical or cognitive disabilities to mental impairments, reduced sensorial abilities, again people of all ages.
- Children and young adults with Special Educational Needs (SEN).
- Children (often at/or approaching transitional stages).
- People who do not know how to and/or do not feel safe or confident using public transport.
- Older people who find themselves without the use of a car for the first time in many years, either through their own deteriorating health or the death of a spouse/partner that drove them.
- Ethnic minority groups, particularly when English is not the first language.
- Unemployed people who might not, for a number of reasons, be able to access and/or remain in employment.
- People who have started to use specialist transport services such as dial-a-ride.

By contrast, taxis offer a higher level of convenience and flexibility. However, those in lower socioeconomic groups use taxis more frequently, and spend a higher proportion of their budget on taxi journeys.[56]

As noted in the known transport barriers above, 'travel horizons' or willingness to travel is also a component of access. There is evidence that narrower travel horizons may limit social and employment opportunities, due to a lack of information or confidence about travelling a further distance, even where the services are available and affordable.[57]

One of the proposed solutions to supporting individuals with their transport needs is providing information, support and the opportunity to make arrangements online.

These examples both require sufficient digital literacy to benefit from the opportunities. Local residents will need to have access to appropriate equipment such as a smart phone, tablet, or computer, and have the skills and confidence to benefit from them. There is, therefore, a risk that those who are most vulnerable do not benefit from these approaches.

## 4.3 What are the health impacts of transport barriers to health services?

### 4.3.1 Impacts of transport barriers on quality of life for patients and carers

Transport barriers may have a detrimental impact on quality of life for patients and carers, and wider wellbeing indicators for a range of reasons, including:

- Time and stress involved in arranging transport.
- Time and stress involved in making the journey.
- Cost implications of travel as a proportion of the household budget.
- Impact of transport barriers on wider wellbeing including as a factor in social isolation.

[56] Social Exclusion Unit: Office of the Deputy Prime Minister, *Making the connections: final report on Transport and Social Exclusion*, 2003.
[57] Social Exclusion Unit: Office of the Deputy Prime Minister, *Making the connections: final report on Transport and Social Exclusion*, 2003.

A Centre for Health Economics study from 2010 considered hospital car parking and the impact of access costs.[58] Travel costs (including parking charges) for a course of treatment ranged from £60 to £400. Although there was a variety of methodologies in estimating time costs, four to five hours was often cited as the overall time involved in attending an outpatient appointment. The highest costs were incurred by those attending regularly for courses of treatment, and those living furthest from the health care setting. For patients with chronic conditions that affected their ability to work, their reduced income amplified the burden of access costs. Of note, is the burden of stress and anxiety that was associated with using the hospital car park. Difficulties with parking – time spent queuing for a space, finding the correct change – were commonly cited as stressful and negative events for patients. The study concluded that the stress caused by hospital parking is largely avoidable.

## 4.4 Local data

### 4.4.1 Distance to key health services by public transport and car

The Department for Transport provides estimates of travel time to key services by public transport and walking. The statistics are based on the calculation of theoretical journey times, they are not based on real journeys. They are, however, based on actual public transport times, and average traffic speeds on the road network. It should be noted that public transport routes may have changed over time.

The most recent statistics are based on a snapshop of public transport timetable for 2015 and shows the average length of time to access a GP by walking or public transport for Peterborough was 8 minutes (range - 5 minute to 20 minutes). The wards with the highest average travel times were Barnack, Northborough and Bretton South which all experienced average travel times over just over 20 minutes (see figure 33).

The average length of time to access a Hospital by walking or public transport for Peterborough was 40 minutes with journeys ranging from 12 minute (Bretton North) to 65 minutes (Eye and Thorney); see figure 34.

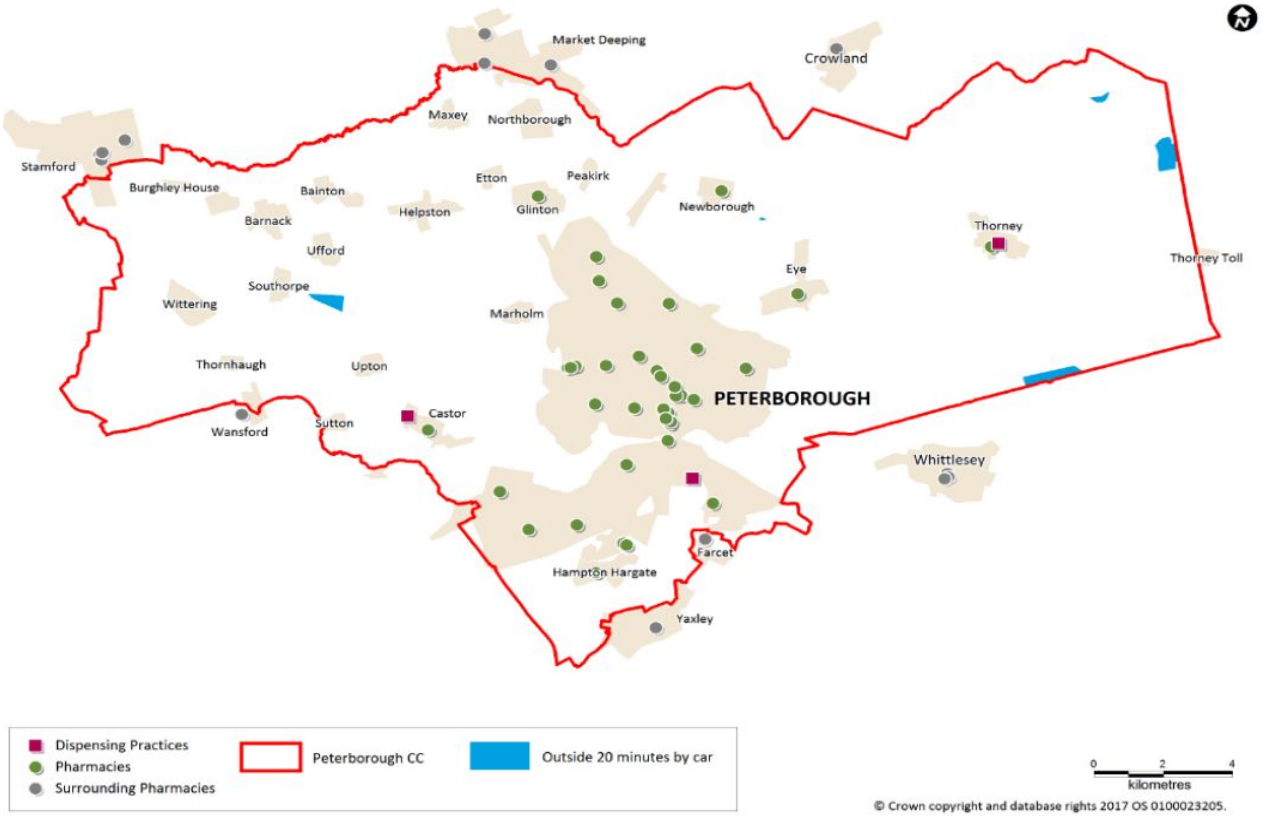
[58] Mason, A. *Hospital Car Parking: The Impact of Access Costs.* CHE Research Paper 59, Centre for Health Economics, the University of York. 2010.

### 4.4.2 Access to pharmacies

The 2008 White Paper 'Pharmacy in England: Building on Strengths, Delivering the Future' states that it is a strength of the current system that community pharmacies are easily accessible and that 99% of the population – even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport. 31

Figure 34 was created to identify which areas in Peterborough were within and which were not within a 20 minute driving distance of either a pharmacy or a dispensing practice as of July 2017. For this map, pharmacies and dispensing practices could be located either within the boundaries of Peterborough Unitary Authority or outside of the boundaries. Road speed assumptions were made dependent on road type and ranged up to 65mph (for motorways) but down to 20mph in urban areas. The map shows that the vast majority of the Peterborough population can access a Pharmacy within 20 minutes.

**Fig 32: Access to Pharmacies and Dispensing GPs within 20 min**




Home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport. Of the pharmaceutical providers who completed a survey questionnaire in 2017, 35 out of 37 pharmacies (95%) and 1 of 1 dispensing GP practices (100%) reported that they provide free delivery services to their patients. In addition, some providers deliver to specific patient groups and/or specific regions, some for free and others for a charge. Pharmaceutical services are also available from internet pharmacies (located inside or outside of Peterborough) that could make deliveries to individual homes. Finally, in addition to delivery services, community transport schemes (e.g. car clubs, minibuses) can potentially improve access to both pharmaceutical services and other services.

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 8 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

| Report of: | Adrian Chapman, Service Director for Communities and Safety | |
|---|---|---|
| Cabinet Member(s) responsible: | Councillor Peter Hiller, Cabinet Member for Growth, Planning, Housing and Economic Development | |
| Contact Officer(s): | Sean Evans, Housing Needs Manager | Tel.01733 864083 |

# HOMELESSNESS PREVENTION

| R E C O M M E N D A T I O N S | |
|---|---|
| **FROM:** Service Director for Communities and Safety | **Deadline date: n/a** |

It is recommended that the Health and Wellbeing Board:

1. Consider the report on housing pressures within the city and the work that is being undertaken on prevention and provide scrutiny and any comment, particularly in relation to the health and wellbeing implications of homelessness..

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request at a previous meeting of the Board.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an overview of the current levels of homelessness in Peterborough, including previous and forecast trends, to enable additional interventions that might mitigate the health and wellbeing implications of homelessness to be introduced.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No.2.7.2.2:

*To actively promote partnership working across health and social care in order to further improve health and wellbeing of residents.*

## 3. TIMESCALES

| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | n/a |
|---|---|---|---|

## 4. BACKGROUND AND KEY ISSUES

4.1 As set out in the council's phase one budget proposals for 2018/19, there has been a 200 per cent rise in the number of homeless families requiring temporary accommodation in just the last two years. As of the end of September 2017, the city council was supporting 328 households in temporary accommodation. The situation Peterborough faces is the same for councils across the

country because of a national shortage of social housing, changes to the way benefits are paid and private landlords supporting fewer tenants on benefits. The impact on the council's budget is huge as the council has a legal duty to provide housing for all those who meet the criteria for support. So far this financial year the cost of this is £1.6million.

4.2 It is highly likely that the city will continue to see an increase in the number of households presenting to us for assistance. Reasons for this include:

- Universal Credit - being rolled out in Peterborough in November 2017 and pilot areas are reporting a 12 per cent increase in eviction action due to rent arrears. We have reflected this impact in our forecasting from January 2018

- Homelessness Reduction Act 2017 - anyone accepted by the council as being threatened with homelessness within 56 days (rather than the current 28 days) will be owed the new prevention duty which could include placing them into temporary accommodation at an earlier point in the process than is presently required. Government forecasts expect the Act, which becomes law on 1 April 2018, will increase demand by a further 26 per cent. Again, we have reflected this impact in our forecasting from April 2018

4.3 Depending on an individual's circumstances, the council may have a duty to provide temporary accommodation until permanent accommodation can be allocated. Traditionally, the council used hostel accommodation for homeless households while investigations were ongoing and until suitable permanent accommodation could be secured. Where hostel accommodation was fully occupied B&B type accommodation would be used as a short term emergency placement until a hostel vacancy could be secured. B&B type accommodation is only meant as a short term option, but as the numbers of households presenting to the council has been increasing, use of this type of accommodation has increased as no alternative accommodation options were available.

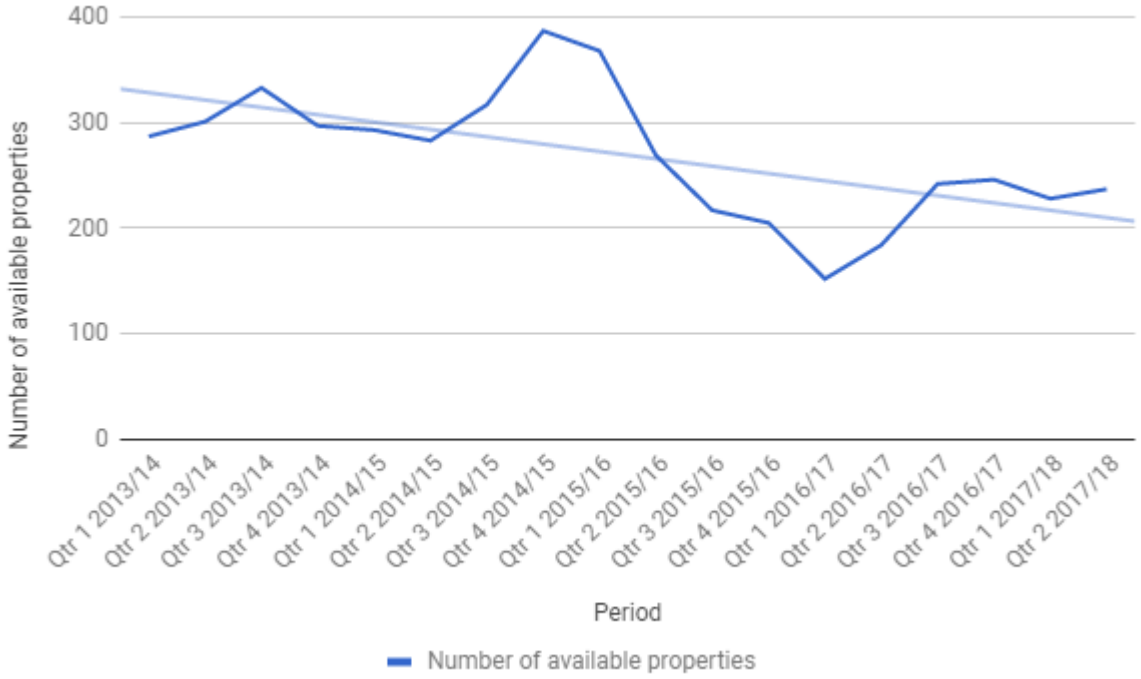
4.4 In recognition of the increases in demand, the council has taken steps to reduce the use of B&B type accommodation by securing use of alternative self-contained temporary accommodation options at St Michael's Gate (leased accommodation from a private accommodation provider) and bringing Elizabeth Court back into use in partnership with Cross Keys Homes. Along with the hostel accommodation owned and managed by Cross Keys Homes, when fully available, this increases the contracted provision to 216 units of available temporary accommodation

**Availability of Social Housing**

4.5 Generally, those households to whom the council accepts a full housing duty will be allocated accommodation with a social landlord. The council has arrangements with 10 housing associations in the city to allocate its vacant properties through the Peterborough Homes Choice Based Lettings scheme. The Common Allocations Policy was developed to ensure that households who are accepted as homeless and therefore owed a full housing duty are given high priority in order to assist them with a prompt move into suitable permanent accommodation.

4.6 In addition to the Housing Register the Localism Act 2011 gave local authorities the power to discharge their full housing duty by securing suitable accommodation in the private sector. Previously the combination of these two options has been more than sufficient in meeting both the demand from households who have presented to the council as homeless and those living in unsuitable housing allocated through the Housing Register.

4.7 Unfortunately while the demand from households requiring assistance has been increasing the availability of permanent accommodation options has been decreasing. The graph below shows the number of properties which have been made available for allocation from our partner housing associations through the choice based lettings scheme:




**Homelessness Reduction Act**

4.8 The new Act places more emphasis on prevention activities by placing new legal duties on local authorities to provide meaningful support to everyone who is homeless or at risk of homelessness, regardless of whether they are in priority need or 'intentionally homeless', as long as they are eligible. The Act comes into effect from 1 April 2018 and will require local authorities to carry out duties on a range of areas including:

- doubling the length of time (from 28 to 56 days) in which the council must support someone who is threatened with homelessness
- a more robust approach to advisory services with the need to provide information and advice to prevent homelessness
- providing targeted support to groups who are at greater risk of homelessness such as care leavers, prison leavers, people leaving the armed forces, domestic abuse victims etc.
- a personalised plan, setting out steps for the applicant and the council to take to ensure accommodation is secured and/or retained
- a duty to help all eligible homeless applicants to secure accommodation for a period of at least 6 months, regardless of whether they are 'intentionally homeless' or in priority need. Those in priority need will be provided with interim accommodation whilst steps are taking place to secure future accommodation.
- Public Authority Duty to Refer - under the Homelessness Reduction Act 2017, "specified public authorities" (e.g. NHS services) will be required to refer details of people who they consider as being homeless or threatened with homelessness to their local authority (if the person agrees to the notification being made). The council will then need to make contact with this individual for assessment.

**UNIVERSAL CREDIT FULL SERVICE (UC)**

4.9 In November 2017, Universal Credit Full Service will be rolled out in Peterborough to include all new benefit claimants and those currently in receipt of benefits who have a change in circumstances (such as birth of a child, family separation, move from being sick to employment or vice versa). This will affect all claimants, including families, for the first time.

4.10 There are a number of changes which will affect claimants and could cause some challenges, at least in the short term. Whilst some aspects of UC are undoubtedly positive, particularly around making it easier for claimants to take on additional employment and simplifying a complex benefits system, there are nevertheless a number of issues and risks. The key points of UC are:

- Integration of six core benefits (including housing benefit) and tax credits into a single, monthly payment. This will apply to claimants both in and out of work
- Claimants will not receive any payment for a minimum of 42 days from the point of claim - although a limited advanced payment loan can be applied for
- A shift away from a mix of weekly, fortnightly, four-weekly and monthly payments to a standard monthly payment. Claimants will need to have budgeting skills to ensure that their money can last for a longer period and that debts and bills are prioritised
- All Universal Credit applications must be applied for and subsequently managed online. For claimants with limited digital skills and access, this may present a challenge
- Claimants enter into a Claimant Commitment with the Job Centre to demonstrate what they are doing to either enter work or increase their hours. Failure to comply with the commitment will see claimants sanctioned and benefits reduced or suspended
- One of the objectives of Universal Credit is that claimants are responsible for their finances and rent. In most cases, housing benefit payments will now be made to the claimant, rather than the landlord. Many claimants will be unfamiliar with and unaware of their rent obligations and will need to ensure that their rent is paid from their Universal Credit payment. In addition, claimants will need to have an up to date tenancy agreement in order to claim housing benefit
- Introduction of a single recipient model where the award is paid into one bank account. For couples and families, this will see one person in control of all Universal Credit payments

4.11 Experience from other areas which have already gone live with Universal Credit Full Service is that debt and rent arrears will increase, at least in the short term (although many clients will already be facing some form of debt and arrears). This can lead to increased evictions and further pressures on temporary accommodation and/or homelessness.

**PROPOSED ACTIONS**

4.12 Given the significant challenges outlined above, the council are exploring a number of potential solutions.

**Homelessness Prevention & Homelessness Trailblazer**

4.13 The council continues to be proactive in the prevention of homelessness where the opportunity arises and officers in the housing needs team adopt a problem solving approach when presented with households at risk of homelessness. The primary aim of all preventative work is to support households to remain in their current accommodation or to find alternative accommodation prior to them having to leave the address they had been residing at. Work is underway to ensure there is a renewed and resourced focus on prevention as part of the core business of the Housing Needs team.

4.14 Recently the council in partnership with the other Cambridgeshire housing authorities were successful in a bid for trailblazer funding to the DCLG who were providing £20 million of grant funding nationally across 2016/17, 2017/18 and 2018/19. Local authorities were invited to bid either singularly or in collaboration in order to provide the resources to ramp up prevention activities and take new approaches to reduce homelessness.

**Prevention Toolkit**

4.15 With affordability in the private sector becoming more of an issue when trying to prevent households from becoming homeless there is a need to improve the tools that officers have available to them to support their attempts to prevent homelessness.

4.16 This being the case officers have to focus more on keeping people in their current homes. The following prevention tools could potentially be used to help support people at risk of

homelessness, and these ideas will be developed into detailed business cases over the coming weeks.

***Amended Discretionary Housing Payments (DHP) Policy***

4.17 Currently the DHP policy is limited in the support it can offer to households to meet the financial shortfall between an applicant's benefit entitlement and their full rent. The DHP fund also allows the council to pay a landlord in order to secure an alternative property for a household in order to prevent homelessness. This is increasingly more difficult as some landlords are no longer willing to accept applicants who will be receiving benefits.

4.18 Officers will review the DHP policy to allow the council to make a payment to the current landlord in order to clear an amount of rent arrears in order to prevent the landlord from having to seek possession of his property. Applicants would still have to be a current Housing Benefit or Universal Credit claimant in order to be eligible.

***Use of the Homelessness Prevention Fund***

4.19 The DHP fund is only accessible to applicants who are currently in receipt of Housing Benefits or Universal Credit. There is also a need for working households not in receipt of housing benefit to receive support where required. Officers will therefore review ways in which the Homelessness Prevention Fund could be used for supporting households where the DHP policy does not allow.

***Mortgage Rescue Fund***

4.20 The Government's Mortgage Rescue Fund was brought to a close 3 years ago. Peterborough was very successful in supporting households who were at risk of losing their homes as they were at risk of possession action from their landlords. The Mortgage Rescue Scheme had 2 benefits in that not only did it allow the householder to remain in their home and not become homeless, the property was also then brought into the ownership of the social sector.

Officers will therefore explore the possibility of establishing a similar scheme.

***Landlord Incentives Scheme***

4.21 Many landlords are reporting significant concern about benefit changes, and in some cases are refusing to accept tenants who are likely to be in receipt of Housing Benefit or Universal Credit. They report they are concerned about the introductory period of 42 days under Universal Credit. Officers are exploring ways in which landlords might be incentivised to continue to accept tenants in receipt of benefits, for example where the council makes an initial payment to cover any period where the tenant is unable to pay rent due to delays in receiving their benefit payment.

4.22 Any payments under the scheme could be in exchange for the landlord offering a longer fixed term of, for example, 12 months to applicants and notifying us of any issues with rent payments at the earliest stage in order for us to intervene in an attempt to prevent a repeat homelessness situation.

**The Peterborough Homes Housing Allocations Policy**

4.23 It is proposed to amend the Housing Allocations policy in order to increase the chances of families in temporary accommodation being offered permanent accommodation. This recommendation is now making its way through the Council's governance process.

**Increased housing supply**

4.24 The Council is exploring buying and/or adapting a number of properties throughout the city in order to reduce the pressures on temporary accommodation and/or move more people into permanent accommodation. A number of sites are being reviewed for suitability and affordability and further details regarding the numbers of properties and their locations will be presented in the new year.

4.25 Financial modelling will be be completed to ensure that the capital purchase is cost effective when taking into account the rental income that could be achieved, the cost of borrowing and the alternative cost of placements into private sector temporary accommodation.

## 5. CONSULTATION

5.1 Phase one budget proposal consultation is underway and ends on 30th November. This includes significant information about the homelessness challenges the city faces.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The additional services, support and investment will significantly improve the homelessness position within Peterborough over the coming months, although it will take time before new homes identified are available for use to house families or individuals.

Providing good quality accommodation will help to improve physical and mental wellbeing for people currently in temporary accommodation, many of whom may well be living in crowded conditions.

## 7. REASON FOR THE RECOMMENDATION

7.1 This report provides the Board with an update on the work that is being delivered to help address the growing problems of homelessness within Peterborough. The Board's scrutiny and recommendations on the work being developed is welcomed.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Doing nothing will see an already problematic area further worsen. This will have significant implications for the council and partner budgets and negative outcomes for family health, education and employment prospects.

## 9. IMPLICATIONS

### Financial Implications

9.1 Capital resource to increase housing supply in the city may be required in due course, and this will be subject to a separate decision making process.

Investment to increase staff resources within the Housing Needs Team has previously been agreed. This is a temporary and time limited investment in order to meet the demand pressures faced.

The financial implications of any of the other measures set out in this report will be subject to separate scrutiny as the individual business cases are brought forward.

### Legal Implications

9.2 Full legal advice will be sought prior to implementing any key actions or policy changes.

### Equalities Implications

9.3 None

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 None

## 11. APPENDICES

11.1 None

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 9 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

| Report of: Dr Liz Robin | Director for Public Health | |
|---|---|---|
| Cabinet Member(s) responsible: | Councillor Diane Lamb, Cabinet Member for Public Health | |
| Contact Officer(s): | Katharine Hartley - Consultant in Public Health | Tel. 01733 207175 |

# DRAFT SUICIDE PREVENTION STRATEGY 2017- 2020

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Consultant in Public Health | **Deadline date:** *N/A* |
| It is recommended that the Health and Wellbeing Board approve the Draft Suicide Prevention Strategy 2017 - 2020 attached at Appendix 1 | |

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following presentation to the Health Scrutiny Committee on 6th November 2017.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to :

(a) Ensure continuation of suicide prevention work to 2020 through the refresh of the joint Cambridgeshire and Peterborough Suicide Prevention Strategy
(b) Review the progress to date from the Suicide Prevention Strategy, 2014 - 2017

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.7.3.3: *To keep under review the delivery of the designated public health functions and their contribution to improving health and wellbeing and tackling health inequalities.*

2.3 The work of the suicide prevention implementation group will help support the Children in Care Pledge to ensure that the children are brought up in a supportive and safe environment. In particular, the strategy includes *'assessing pathways for support for children who are at risk of self-harm, recognising that children in care are at higher risk'.*

## 3. TIMESCALES

| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | N/A |
|---|---|---|---|

## 4. BACKGROUND AND KEY ISSUES

4.1 *S*uicide is a major public health issue as it marks the ultimate loss of hope, meaning and purpose to life and has a wide ranging impact on families, communities and society. Suicide is the leading cause of death for younger adults. However, the National Suicide Prevention Strategy – Preventing Suicide in England, states that suicides are not inevitable and many can be prevented, thus supporting a call for action to reduce suicide and the impact of suicide both at national and local level.

This report proposes a refresh of the joint Peterborough and Cambridgeshire Suicide Prevention strategy (2017-2020) - see Appendix 1. and includes updates on national and local suicide statistics, initiatives, evidence and forward planning. Incorporated as a main thread throughout the strategy is an ambition towards ZERO Suicide, as agreed through the multi-partner suicide prevention implementation board in 2017. The strategy builds on and supports the National Suicide Prevention Strategy – 'Preventing suicide in England', Dept. of Health 2012.

The key purpose is to ensure that there is co-ordinated and integrated multi-agency agreement on the delivery of suicide prevention services that is tailored appropriately to local need and is driven by the involvement and feedback from service users. With a focus on Zero suicide, the strategy emphasises the requirement for senior level engagement with all relevant organisations to ensure quality improvement across the pathways of care for suicide prevention.

The six priority areas for suicide prevention in Cambridgeshire and Peterborough with recommendations for actions are set out in the Suicide Prevention Action Plan, developed by the Joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group – comprising a partnership of multiple organisations involved in mental health care see Appendix 2.

Key points of progress seen since the launch of the 2014 - 2017 suicide prevention implementation plan:

- The suicide rate in Peterborough has decreased steadily since 2010-2012 when the rate was significantly above both the England and East of England rates and is now similar to the England average.
- Development and roll-out of 'STOP Suicide' across Peterborough and Cambridgeshire, including a local suicide prevention website, pledge, training in suicide prevention and campaigns to increase awareness of mental health issues and how to access support.
- Implementation of a 111(2) mental health crisis telephone triage and First Response Service (FRS) that includes a Peterborough 'sanctuary' as a place to feel safe and supported during mental health crisis.
- The construction of safety barriers on Peterborough car parks to prevent suicide
- Community based youth 'face to face' counselling services including a 'drop in' service for young people in Peterborough. The Kooth online counselling service for young people was commissioned in September 2016 to broaden the mental health support available for young people.

Key new initiatives to enhance suicide prevention from 2017:

- GP Training in suicide prevention - Funding has been secured through the Sustainability and Transformation Plan (STP) for training of GPs across Cambridgeshire and Peterborough in suicide prevention, which will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care.
- Bereavement support for people affected by suicide - STP funding to set up a reactive support service for people who have been bereaved as a result of suicide. The service will be managed by a family liaison officer who will offer support to families in the first weeks after bereavement. They will also signpost people to follow-up services and peer support groups. Part of this work will be to set-up SOBS (Survivors of bereavement due to suicide) or similar groups in Cambridge and Peterborough and connect with CRUSE bereavement counselling services.
- Zero suicide initiative - This is the overarching ambition for suicide prevention locally and aims to bring all partners together to support the development of a learning culture to drive up quality so that suicide prevention is a priority for each organisation, across the system.

## 5. CONSULTATION

5.1 The original Suicide Prevention Strategy (2014-2017) was consulted upon widely with stakeholders and the public in 2014. To date, the draft refresh of the strategy and action plan has been shared with key partners who participate in the suicide prevention implementation board, including CPFT and has been scrutinised by Health Scrutiny at Peterborough City Council 0n 6th November 2017 and the Health Committee at Cambridgeshire County Council on 7th September 2017.

Wider partnership stakeholder engagement and consultation has been conducted through the multi-partnership suicide prevention implementation group and by engagement with CPFT and their network of stakeholders.

Workshop style consultations with Service Users and people with lived experience of mental health crisis and suicide ideation are planned for Peterborough and Cambridge in the coming weeks and will support development of the action plan to deliver the Strategy.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Consideration by the Health and Wellbeing Board of the refresh of the suicide prevention strategy will enhance partnership working and knowledge of the initiatives that will facilitate their implementation to better effect locally. Feedback from the board will aid the fine-tuning of the initiatives presented.

## 7. REASON FOR THE RECOMMENDATION

7.1 HM Government requires each local area to have a Suicide Prevention Strategy and Action Plan with Public Health leading the co-ordination of a wider partnership group to oversee implementation of the plan.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The Suicide Prevention Strategy could have been extended to cover a longer period without a updating. However this would not reflect the reality that progress has been made and new areas have been identified that require further work.

The Suicide Prevention Strategy could have been allowed to lapse. However this would not meet central government guidance as outlined under 7.1.

## 9. IMPLICATIONS

### Financial Implications

9.1 Peterborough City Council contribute £9,919 per annum to aid the continuing roll-out of ‘STOP Suicide’.

### Legal Implications

9.2 There is a legal requirement to keep any person identifiable information confidential and therefore, when data is received about suicide, this is held securely by Public Health.

### Equalities Implications

9.3 The work of the suicide prevention implementation group will be all inclusive for the benefit of the community but will focus on groups at higher risk of suicide. This will take account of equality and diversity issues as it identifies the most vulnerable groups in society.

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 *1. National Strategy: Preventing Suicide in England, 2012: http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-crossgovernment-outcomes-strategy-to-save-lives.pdf*
*2. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives: https://www.gov.uk/government/publications/suicide-prevention-thirdannual-report*
*3. Cambridgeshire and Peterborough Clinical Commissioning Group Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016 http://www.cpft.nhs.uk/Downloads/rod%20files/2013_0816_CCG_Adult_MH_Commissioning_Strategy_2013_FINAL.pdf*
*4. JSNA Cambridgeshire – health and wellbeing strategy see: http://www.cambridgeshire.gov.uk/info/20116/health_and_wellbeing_board*
*5. JSNA Peterborough Mental Health http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Mental%20Health.pdf*
*6. Suicide Prevention Strategy CPFT 2013-2016 (closed document ) – for details please contact author or CPFT*
*7. Emotional well-being and mental health strategy for children and young people 2014- 2016 (draft strategy)*
*8. Suicides in students http://www.ons.gov.uk/ons/about-ons/what-we-do/publicationscheme/published-ad-hoc-data/health-and-social-care/november-2012/index.html*
*9. National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2013 http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf*
*10. Samaritans report –men suicide and society: http://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf*
*11. No health without mental health: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf*
*12. Public Health Outcomes Framework https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf*
*13. Mental Health Crisis Concordat – Improving outcomes for people experiencing mental 14 health crisis, February 2014. Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf*
*14. Annual Report of the Chief Medical officer 2013 – Public Mental Health Priorities: Investing in the Evidence https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf*
*15. Saving Lives: Our Healthier Nation; Department of Health, 1999: https://www.gov.uk/government/publications/saving-lives-our-healthier-nation*
*16. Detroit model for suicide prevention: http://zerosuicide.actionallianceforsuicideprevention.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/PerfectDepressionCarearticles.pdf*
*17. ASIST suicide prevention training: http://www.chooselife.net/Training/asist.aspx*
*18. Mental Health First Aid training England: http://mhfaengland.org/*
*19. Suicide in primary care in England 2002-201118 http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/SuicideinPrimaryCare2014.pdf*
*20. Knapp et al 2011, Mental health promotion and prevention: The economic case. http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf*
*21. The Use and Impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation Social research: The Scottish Government, http://www.chooselife.net/uploads/documents/19-ASISTEvaluationFullReport.pdf*

*22. Bickley, H et al 2013; Suicide within two weeks of discharge from psychiatric inpatient care. A case control study Psychiatric Services 2013*
*http://ps.psychiatryonline.org/article.aspx?articleID=1673604*
*23. Cox et al 2013; Interventions to reduce suicides at suicide hotspots: a systematic review BMC Public Health 2013, 13:214*
*http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3606606/pdf/1471-2458-13-214.pdf*
*24. Mann et al, 2005 Suicide Prevention Strategies: A systematic Review. JAMA. 2005;294(16):2064-2074*
*25. Support after a suicide: A guide to providing local services*
*https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providinglocal-services*
*26. We are in your corner – Samaritans: http://www.samaritans.org/media-centre/ourcampaigns/were-your-corner*
*27. MHRA – Best practice for the sale of medicines for pain relief - http://www.mhra.gov.uk/home/groups/pl-p/documents/websiteresources/con065560.pdf*
*28. Hawton K, Bergen H, Simkin S et al (2010) Toxicity of antidepressants: rates of suicide relative to prescribing and non-fatal overdose. British Journal of Psychiatry 196: 354-358*
*29. 'Help is at hand' a resource for people bereaved by suicide and other sudden, traumatic death http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf*
*30. Preventing Suicide - A Resource for Media Professionals: A resource guide produced by the Department of Mental Health at the World Health Organization in 2000. http://www.who.int/mental_health/media/en/426.pdf*
*31. Media guidelines for reporting suicide – Samaritans: http://www.samaritans.org/sites/default/files/kcfinder/files/press/Samaritans%20Media%20Guidelines%202013%20UK.pdf*
*32. NHS England and Public Health England 'A call for Action: Commissioning for Prevention' November 2013. Available at: www.england.nhs.uk WHO For which strategies of suicide prevention is there evidence of effectiveness*
*http://www.euro.who.int/__data/assets/pdf_file/0010/74692/E83583.pdf*

## 11. APPENDICES

11.1 Appendix 1 – Draft Suicide Prevention Strategy 2017 - 2020

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Appendix 1

# DRAFT Joint Cambridgeshire and Peterborough Suicide Prevention Strategy

# 2017-2020

Main Author: Katharine Hartley

Consultant in Public Health

Peterborough City Council

**ORGANISATIONAL SIGNATORIES**

**To be added**

**ACKNOWLEDGEMENTS**

The joint Cambridgeshire and Peterborough suicide prevention strategy is the result of discussions between partner organisations and individuals. We are grateful for the continuing support and input from the following:

**ACRONYMS AND ABBREVIATIONS**

| | |
|---|---|
| ARC | Advice and Resource Centre |
| ASIST | Applied Suicide Intervention Skills Training |
| CAB | Citizens Advice Bureau |
| CAF | Clinical Assessment Framework |
| CCG | Clinical Commissioning Group |
| CEC | Clinical Executive Committee |
| CMO | Chief Medical Officer |
| CO | Carbon monoxide |
| CPFT | Cambridgeshire & Peterborough Foundation Trust |
| CR/HT | Crisis Resolution/Home Treatment |
| CREDS | Cambridgeshire Race Equality and Diversity Service |
| GPs | General Practitioners |
| ICD10 | International Classification of Diseases version 10 |
| LAC | Local Area Coordination |
| MHFA | Mental Health First Aid |
| MHRA | Medicines and Healthcare products Regulatory Authority |
| NICE | National Institute for Health & Clinical Excellence |
| ONS | Office for National Statistics |
| PCAS | Peterborough Community Assistance Scheme |
| QALY | Quality Adjusted Life Year |
| SCN<br>STP | Strategic Clinical Network<br>Sustainability and Transformation Plans |
| SUN | Service User Network |

**CONTENTS – TO BE EDITED FOR FINAL COPY**

***'Keep your face always to the sunshine and shadows will fall behind you'***
***Walt Whitman***

## 1. EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

The Cambridgeshire and Peterborough suicide prevention strategy 2017-2020 is a refresh of the 2014-2017 strategy with updates on national and local suicide statistics, initiatives, evidence and forward planning. Incorporated as a main thread throughout the strategy is an ambition towards ZERO suicide, as agreed through the multi-partner suicide prevention implementation board in 2017. This enhances the work already underway to prevent suicide locally, including 'STOP Suicide' and the 111(2) First Response Service (FRS) for mental health crisis.

The strategy builds on and supports the National suicide prevention strategy – 'Preventing suicide in England, Dept. of Health 2012'[1] but also includes a drive to aim for ZERO suicide, based on the National Zero Suicide Alliance. The key purpose is to ensure that there is co-ordinated and integrated multi-agency agreement on the delivery of suicide prevention services that is tailored appropriately to local need and is driven by the involvement and feedback from service users. With a focus on Zero suicide, the strategy emphasises the requirement for senior level engagement with all relevant organisations to ensure quality improvement across the pathways of care for suicide prevention.

Six priority areas for suicide prevention in Cambridgeshire and Peterborough with recommendations for actions are set out in sections 9-14 and accompanying action plan. A summary of the recommendations is provided below.

**Table 1 – Summary of suicide prevention priority areas and recommendations for actions**

| **Priority area 1 – Reduce the risk of suicide in high risk groups** |
|---|
| **Recommendations**<br><br>**1.1** Continue to implement suicide prevention training (STOP suicide and ASIST) to professionals, organisations and individuals in contact with people at risk of suicide. Develop and implement suicide prevention training for GPs<br><br>**1.2** Continue to develop and tailor suicide prevention resources for professionals, agencies and vulnerable groups<br><br>**1.3** Continue to raise awareness of STOP suicide and suicide prevention in community settings and to high risk groups<br><br>**1.4** Ensure access to resources to aid self-help in those at risk of suicide<br><br>**1.5** Continue to develop integrated, appropriate and responsive services for those at risk of suicide – including pathways for vulnerable groups such as those with co-occurring drug and alcohol and mental health problems.<br><br>**1.6** Reassess pathways for young people and adults known by mental health services at risk of suicide<br><br>**1.7** Improve pathways and support for people taken into custody and newly released from custody at risk of suicide |

**Priority area 2 – Tailor approaches to improve mental health in specific groups**

**Recommendations**

**2.1 Continue to** work with partners who are delivering the 'Emotional wellbeing and mental health strategy for children and young people' to

- Raise awareness and campaigning around self-harm
- provide access to self-help resources that focus on building resilience in young people
- Raise awareness on preventing bullying
- Assess pathways for support for children who are at risk of self-harm , particularly in vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems
- Support initiatives that work with families to address children and young people's mental health

**2.3** Promote early interventions to aid prevention of mental health problems that could lead to suicide in particular risk groups.

**2.4** Promote training in mental health awareness, particularly with professional groups such as GPs to recognise mental health issues and risk of suicide

**Priority area 3 – Reduce access to the means of suicide**

**Recommendations**

**3.1** In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings

**3.2** Continue to reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car-parks and bridges

**3.3** Continue work to reduce the risk of suicide on railway lines

**3.4** Work with Medicines Management teams at the CCG to ensure safe prescribing of some toxic drugs

**3.5** Work with health and care professionals to establish and reinforce safety plans for individuals with mental health problems

**Priority area 4 – Provide better information and support to those bereaved or affected by suicide**

**Recommendations**

**4.1** Ensure bereavement information and access to support is available to those bereaved by suicide

**4.2** Implement a bereavement support service and pathway for those affected by suicide

**Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior**

**Recommendations**

**5.1** Encourage appropriate and sensitive reporting of suicide

- Continue to provide information to professionals on the sensitive reporting of suicide
- Continue to work with local media to encourage reference to and use of guidelines for the reporting

| |
|---|
| of suicide |
| **Priority area 6 - Support research, data collection and monitoring** |
| **6.1** Monitor real-time information on suspected suicides as they occur. Link this information to suicide data provided on a quarterly basis by Cambridgeshire and Peterborough coroners. Include data from the Police on suicides and near suicides.<br><br>**6.2** Continue to conduct an annual audit of local suicides<br><br>**6.3** Continue to disseminate current evidence on suicide prevention to all partner organisations<br><br>**6.4** Evaluate and report on the suicide prevention implementation plan |

### 1.1 Zero Suicide

The ambition towards Zero suicide as the 'backbone' of the strategy requires commitment by organisations and individuals to create a cultural change in suicide prevention as summarised below.

**Table 2 – Outline of the zero suicide ambition**

| **Zero Suicide Ambition** |
|---|
| Top level (Chief executive) engagement and commitment towards zero suicide for the main organisations involved – CCG, CPFT, PCC, CCC, Police |
| Improve quality - Create a learning culture not a blaming culture that will review both suicide information and information from people with lived experience to learn lessons and implement good practice. |
| Review and improve information sharing across agencies involved in the pathway of care of individuals with mental health problems |
| Strengthen the suicide prevention implementation plan with a stronger emphasis on training, campaigns and initiatives that raise awareness, educate and promote mental health across the population, but with a focus on young people |

## 2. PURPOSE

This document sets out the strategic priorities and recommendations to prevent suicide in Cambridgeshire and Peterborough between 2017 and 2020. Accompanying the strategy is an action plan that is updated from the previous suicide prevention strategy. The action plan is intended to be used as a framework by key stakeholders for implementing the recommendations and for measuring and evaluating suicide prevention outcomes.

Suicide is a major public health issue as it marks the ultimate loss of hope, meaning and purpose to life and has a wide ranging impact on families, communities and society. Suicide is the leading cause of death for younger adults. However, the National Suicide Prevention Strategy – Preventing Suicide in England[1] states that suicides are not inevitable and many can be prevented, thus supporting a call for action to reduce suicide and the impact of suicide both at national and local level.

In line with national guidelines on preventing suicide, and to oversee the implementation of the local strategy, a multi-agency suicide prevention implementation group meets on a quarterly basis with input and membership from many organisations across public, charitable and voluntary sectors, including:

- Cambridgeshire County Council
- Peterborough City Council
- Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) - including CCG GP leads for mental health and commissioning support
- Police
- Coroners
- Cambridgeshire and Peterborough Foundation Trust
- MIND
- Lifecraft
- Service User Engagement Network (SUN)
- MindEd Trust
- Youth Offender service
- Rethink Carers
- Prison and probation service
- Samaritans
- Individuals with lived experience

The strategy is refreshed as a result of the following key considerations:

Nationally

- The National drive to prevent suicide – highlighted by the report "Preventing suicide in England - a cross-government outcomes strategy to save lives HM Government September 2012"[1] with progress reports including the most recent publication 'Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives'[2]
- Public Health England's guidance on 'Local suicide prevention planning - a practice resource'
- National momentum to aim for Zero suicide as described by the Zero Suicide Alliance
- Government commitment to improve mental health - a comprehensive package of measures to transform mental health support in schools, workplaces and communities – as announced in January 2017
- Public Health England Guidelines to develop bereavement support services for those affected by suicide: 'Support after a suicide: a guide to providing local services'

- The findings from the National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

Locally

- Suicide prevention is specified in the STP improvement plan within the Primary Care and Integrated Neighbourhoods (PCIN) delivery group, Mental Health Prevention and promotion of mental wellness priority. This stipulates the continued implementation of the suicide prevention strategy and findings of suicide audit.
- The five year forward view on mental health states within the key priorities for investment and focussed work 2016/17 and 2017/18 (primary prevention section): A local focus on 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.
- The Peterborough Health and Wellbeing Strategy identified five priorities to improve the health and wellbeing of everyone in Peterborough including 'to enable good child and adult mental health through effective, accessible health promotion and early intervention services'. The suicide prevention strategy includes areas that focus on mental health promotion and early intervention. The findings of the Peterborough JSNA on the mental health and mental illness of adults – 2015/2016 are also considered and help to focus the suicide prevention action plan.
- The development and implementation of a local Mental Health Crisis Concordat Declaration and Action Plan. This work is being led by the Police, but is supported by members across the partnership of organisations including the suicide prevention implementation group. The suicide prevention strategy includes recommendations that link directly to the work developed in the Crisis Concordat Action Plan.
- Feedback consistently received from individuals affected by suicide and local agencies that there is a need for:
    - better support for those bereaved or affected by suicide
    - clearer guidance where to seek help and advice for people who are worried that someone they know might be at risk of suicide, or are presented with somebody threatening suicide
    - improved information sharing across the pathway of care for people at risk of suicide
    - improvements to training for GPs and other health professionals to identify and manage those at risk of suicide

In developing recommendations and action plans for each priority area within the strategy, evidence and information is drawn from national guidance and publications on what is effective in preventing suicide. An emphasis is placed on local needs assessments and intelligence gathered from coroner data. Consultation is made with service users and other organisations or groups including British Transport Police, Probation services, Drug and Alcohol services, Public Health England and Cambridge University Student welfare officers to identify groups at higher risk of suicide and gaps in service provision.

Implementation of the recommendations and action plan are managed by a joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. Multi-agency working across all sectors, from NHS and mental health professionals to voluntary organisations, will be encouraged in order to utilise expertise from these organisations to implement the proposed initiatives. Continuing engagement with service users and their carers is expected for the successful development, implementation and delivery of initiatives in each priority area. It is envisaged that working groups will be established to address priority areas or particular recommendations and these will report to the joint implementation group. The joint implementation group will be accountable for delivering the strategy and will report progress on a regular basis as part of governance procedures to the Joint Safeguarding Executive and the Health and Wellbeing Boards in Peterborough and Cambridgeshire.

**2.1 Outcomes of the implementation of the suicide prevention strategy 2014-2017**

The table below lists the progress made to date as a result of the suicide prevention strategy, implementation plan and partnership working since 2014.

**Table 3 – Summary of progress of the suicide prevention strategy 2014-2017**

**Priority area 1 – Reduce the risk of suicide in high risk groups**

**Suicide Prevention Training**

**Applied Suicide Intervention Skills Training (ASIST) Training**

- Three ASIST trainers trained
- ASIST Courses delivered across Cambridgeshire and Peterborough targeting 'Gate Keeper' roles including those working with migrant communities and bereavement support workers.
- An ASIST course was funded and delivered to peer support workers in Peterborough prison.
- 258 people trained in ASIST between October 2015 and January 2017

**Bespoke stop suicide training -** Locally developed ½ day STOP suicide course has been developed and delivered. 21 STOP suicide workshops have been delivered reaching 236 people (From Oct 2015 to Jan 2017). These have included sessions with the following:

- CAB
- Three Homeless Charities
- Oasis Community Centre (East European migrants)
- NCS Programme (Peterborough)
- UNISON
- Junior Drs
- Carers Trust
- Cruse
- Colleges (Impington, Homerton, Huntingdon, Ely, Peterborough)

Courses are also offered to the **emergency services** as part of MIND's **Blue Light Activity**.

**GP Training in suicide prevention**

Funding has been secured through the STP for training of GPs across Cambridgeshire and Peterborough in suicide prevention, which will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care. Training will be implemented from the Autumn 2017

**Suicide prevention resources**

Since October 2015 the STOP suicide Campaign Makers, partners and other local organisations have helped us to distribute resources to at least 70 different locations across Fenland, Peterborough, Melbourn, Cambridge i.e. pubs, leisure/sport centres, community centres, local shops.

The Blue Light Programme team have also been giving out leaflets to emergency services across Cambs and Peterborough.

In addition, Great Northern agreed to display STOP Suicide resources at its key railway stations from end of July 2016 onwards

A website aimed at promoting mental health in children and young people has been developed – 'Keep Your Head' www.keep-your-head.com This includes a page designed with, and for, GPs. Crisis information and suicide and self-harm information. Wide promotion of this resource has taken place and is continuing.

A directory of Services App (MyHealth App) for the public and a professional directory of services App (Midos) are being developed. These will be available along with the directory of services produced by Lifecraft via 'Keep Your Head'.

The development of an adult version of the 'Keep Your Head' website has been agreed with funding secured from the 'Better Care Fund'. This will be developed from September 2017 with partner organisations and the Service User Network working together to create content.

**Awareness raising in suicide prevention**

**Stop suicide website and pledge**

As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. In addition, STOP Suicide had 1,343 twitter followers and 394 facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Approximately **3000** one to one conversations with individuals around the subjects of mental health and suicide since September 2015. The campaign has recruited a total of **10** new Campaign Makers - four in Peterborough, five in Cambridge and one in St Neots.

**Promoting suicide prevention across the county:**

- 'No Shame In Talking' video on **ITV News Anglia** – Fixers, 5 October 2016 http://www.fixers.org.uk/index.php?module_instance_id=11312&core_alternate_io_han

dler=view_fixer_news_video&data_ref_id=14785&news_data_ref_id=14784&video_no=1 – talk about STOP Suicide

- 'Health Secretary Jeremy Hunt visits Cambridge's 'groundbreaking' mental health services' – **Cambridge News**, 28 October 2016 http://www.cambridge-news.co.uk/news/health/health-secretary-jeremy-hunt-visits-12095230
- **CRC radio** interview – talk about current campaigns, 2 December 2016
- 'Cambridgeshire dad welcomes Theresa May's pledge to 'transform' attitudes to mental health' – **Cambridge News**, 10 January 2017 http://www.cambridge-news.co.uk/news/cambridge-news/cambridgeshire-dad-welcomes-theresa-mays-12431838
- 'Crisis cafes and community clinics among plans to improve mental health services in Cambridgeshire' – **Ely Standard**, 11 Jan 2017 http://www.cambstimes.co.uk/news/crisis_cafes_and_community_clinics_among_plans_to_improve_mental_health_services_in_cambridgeshire_1_4844482
- **Promotion of suicide prevention awareness to coincide with suicide prevention day on September 10th 2016 via a discussion hosted by radio Cambridgeshire**

**Develop Integrated services for those at risk of suicide**

Vanguard/Crisis Care Concordat work has been successful at creating an integrated mental health team with mental health nurses based in the police control room.

A First Response service (FRS)with crisis telephone number (111 option 2) was established in September 2016 to help prevent people with mental health crisis going to A&E and being admitted or sectioned under section 136 of the mental health act. In addition non health places of safety (sanctuaries) have been established in Peterborough, Cambridge and Huntingdon for people in mental health crisis to access via the FRS. This service has been shortlisted for the Positive Practice in Mental Health Awards in the 'Crisis and Acute Services' category. In addition, the FRS and Sanctuaries have been evaluated by the 'Service User Network' (SUN) against it's 'five values' of Empathy, Honesty, Inclusion, Personalisation and Working Together and have awarded the FRS 3 stars (good rating) and Sanctuaries 4 stars (outstanding).

**Data sharing** - Information Sharing Agreements are in place across organisations to support the Frequent Attenders CQUIN, in addition to MH and Acute Trusts this includes 111, ambulance service, substance misuse, primary care (Work carried out through the Crisis Care Concordat).

**PRISM** (enhanced primary care) service for people with mental health problems is in place for many areas across Cambridgeshire. This provides access to support and care for people struggling with mental illness through referral via the GP or through 'step down' from secondary care. The PRISM service is proving effective at reducing referrals to secondary care as people are managed in the community.

**Lifeline –** continues to offer a free, confidential and anonymous telephone helpline service that is available from 7.00pm – 11.00pm 365 days of the year for Cambridgeshire residents. The

Line provides listening support and information to someone experiencing mental distress or to those supporting someone in distress. Lifeline is hosted by Lifecraft in Cambridge.

**Priority area 2 – Tailor approaches to improve mental health in specific groups**

**Anti-stigma work and mental health promotion targeting specific groups at higher risk**

Funding to deliver courses to bar staff in Fenland as well as scoping work to assess feasibility of training barbers/hair dressers. A need for mental health awareness and suicide prevention for men working in the construction industry has been identified (through national data and suicide surveillance) and will be a focus for the anti-stigma/suicide prevention work commissioned from CPSL MIND

Other public engagement events through the 'anti-stigma work:

- Mental Health crisis support for young people event, Cambourne – 22 Sept
- Shelf Help launch, Huntingdon library – 28 Sept
- World Mental Health Day stand at South Cambs Council – 10 Oct
- CCG Development Day stand – 13 October 2016
- HRC Freshers' Fair – 20 October 2016
- Meeting a group of potential Campaign Makers, Wilbrahams Memorial Hall – 1 November
- Hunts Forum AGM stand – 10 November 2016
- Young people's follow up event, Cambourne – 23 November 2016
- Meeting with Cambs Football Association – 12 Jan 2017
- TASC meeting, London – 13 Jan 2017

**Children young people anti stigma/bullying in schools**

Between October 2015 and January 2017 CPSL Mind have engaged approximately 555 young people via workshops at Hills Road Sixth Form College, Kimbolton School, College of West Anglia, Milton, Oliver Cromwell College, Chatteris, Thomas Clarkson Academy, Wisbech and Ramsey College. Centre 33 have also been delivering mental health awareness sessions in schools. Between September 2016 - March 2017 mental health awareness sessions had taken place in 11 with sessions booked for a further 7 other schools. Across the 11 schools a total of 821 students engaged in the workshops. These sessions aim to challenge stigma and build understanding of mental health.

The Stress LESS campaign launched in April 2016, aiming to support young people to manage stress through the exam period. A range of resources were produced with over 6,500 being downloaded and 2,695 website page views. Over 130 Stress LESS Action plans were made to encourage people to 'Take 5' when revising.

Alongside the campaign a range of workshops are being run to enable school staff to deliver 'Stress LESS' sessions within their schools with pupils. As of Spring 2017 over 21 schools had been involved in this training and a further 90 individuals were being trained over the summer term. These workshops have been expanded to include information on how to respond to a young person in distress (including discussion around self-harm and suicide).

Within schools that engage in the Stress LESS workshops, small grants are available to pupils who have ideas they would like to develop to support the wellbeing of other students. These ideas are taken forward by 'Stress LESS' champions in schools.

A range of training is provided by CPFT to upskill the children and young people's workforce, this includes specific training courses on areas such as responding to self-harm as well as a 14 day CAMH foundation course. There is also tailored training for schools which includes the whole school briefing which offers an introduction to mental health with a focus on the ethos and culture around mental health in schools. Since 2015 there have been 49 schools that have held a whole school briefing, which equates to 1,616 staff.

**Tackling self-harm in young people**

A self-harm conference was held in 2015 in Cambridgeshire for professionals and locally a guide to 'understanding and responding to self-harm' has been produced and is freely available (download via the Keep Your Head website http://www.keep-your-head.com/CP-MHS/need-help-now/suicide-and-self-harm-support). A self-harm support group for parents has been run by PinPoint with support from local authority teams.

A range of training is provided by CPFT aimed at upskilling the children and young people's workforce in terms of mental health. Self-harm is covered within a number of courses, including specific training on responding to self-harm. This training is free to access for many professionals.

Community based youth counselling services are run across Cambridgeshire and Peterborough, with a bereavement service offered in Cambridgeshire also. These services offer face-to-face counselling and support to young people. The Kooth online counselling service for young people was commissioned in September 2016 to broaden the mental health support available for young people.

**Early interventions to prevent suicide**

**GP training**

Funding obtained through STP for suicide prevention training for GPs. Funding is supplemented by CCC Public mental health budget. A bespoke GP training package will be designed and implemented hoping to cover 20-30% of GPs or practices within the next twelve months (from September 2017) – see priority area 1. The training will help to improve GP recognition and management of mental illness and use early intervention techniques to prevent escalation to mental health crisis.

**Money management/debt advice** - debt prevention work is being funded with care leavers to improve money management skills and ensure vulnerable young people know where to access support if in financial trouble. A contract has also been awarded to support debt prevention and money management support to those with a severe mental illnesses in Cambridgeshire. Both of these pilot projects will be evaluated with a view to expanding provision in the future if successful.

**Preventative work in schools** (please see priority 2 for further details of training for school staff and mental health awareness sessions with pupils).

In 2017/18 training is being offered to schools staff to develop peer mediation skills. This work aims to support anti-bullying work locally. In addition a range of anti-bullying resources have been developed locally by the PSHE service working together with schools in Cambridgeshire. http://www5.cambridgeshire.gov.uk/learntogether/homepage/352/anti_bullying/

Drop in services for young people in Huntingdon and Peterborough and Cambridge as part of Centre 33 and local authority partnerships. Delivering broad support as well as counselling.

**Priority area 3 – Reduce access to the means of suicide**

**Car park barriers**

The 2014-2017 strategy identified a need to reduce access to the means of suicide in Peterborough carparks. There had been a number of suicides from Queensgate car park and incidences of suicide at Northminster car park, both close to the city centre. There is strong evidence for reducing access to the means of suicide in preventing suicide, particularly barriers at sights where suicide has been frequent.

The suicide prevention implementation group along with other parties including the coroner in Peterborough were successful in working with the owners of the Queensgate car parks to reach a decision to erect barriers on all the car parks they operate in the city centre.

Car park barrier construction began in 2015 and was completed in 2017. Following this, barriers have been erected at Northminster car park in Peterborough. There have been no suicides from car parks in Peterborough since the start of the barrier construction.

**Suicide prevention on Railways**

A range of work is being undertaken nationally as part of the railway Suicide Prevention plan – Samaritans, Network Rail and British Transport Police.

-Samaritans/Network Rail campaign on the railway including printed messages on tickets and posters at stations.

Some local stations are also displaying STOP Suicide resources.

-Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally).

-Rail505 app – enables other passengers/anybody to report someone they are worried about or to seek help themselves on the railway. https://www.rail505.com/

**Safer medicines management**

Following Child Death Overview Panel reports there was a communication to GPs regarding safe prescribing to young people, this was also re-circulated.

**Priority area 4 – Provide better information and support to those bereaved or affected by suicide**

**Bereavement support - access to the 'help is at hand' leaflet for people bereaved as a result of suicide:**

- Help is at hand booklet shared with Coroners Office (Feb15) and electronically shared with Funeral directors. Information on 'help is at hand' circulated via the GP bulletin in 2015 and 2017.
- Help is at Hand booklets circulated to all GP practices in Cambridgeshire and Peterborough with instructions on how to re-order them.

**Establishing a bereavement support service for people affected by suicide**

STP Funding was granted in July 2017 to set up a reactive support service for people who have been bereaved as a result of suicide. The service will be managed by a family liaison officer who will offer support to families in the first weeks after bereavement. They will also signpost people to follow-up services and peer support groups. Part of this work will be to set-up SOBS (Survivors of bereavement due to suicide) groups in Cambridge and Peterborough and connect with CRUSE counselling services.

**Bereavement support resources**

Bereavement support resources are promoted via the Stop Suicide Pledge website and Keep Your Head website. These resources include specific sites for young people who are bereaved.

**Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior**

Communication with Cambridge News on the responsible reporting of suicide, including information advice created by The Samaritans – this was initiated after a suspected suicide incident was poorly reported by the Cambridge News. CCC Coms team have been involved in this work.

Two visits were made to Radio Cambridgeshire to promote the responsible reporting of suicides. Guidelines on suicide reporting were provided to the editor.

**Support research, data collection and monitoring**

**Surveillance: suicide audit**

An annual suicide audit was undertaken in 2015 (of deaths in 2014) and 2016 (of deaths in 2015) The audits have helped to shape targeting of local work. The audit will continue to be undertaken annually, with a detailed case review of a sample of files.

Work has been carried out together with the Coroner's Office to improve the standardised regular information received on deaths throughout the year. The quality of the information received has improved.

**Surveillance from British Transport Police**

Data is received from BTP through an annual report and a warning system (national system).

**Local, real-time surveillance system**

A local real-time surveillance system has been established – This shares information from Police/Coroner to Public health on suspected suicides as they occur. This information is essential to establish a bereavement support service

The Coroner flags any notable patterns with the group or public health. The surveillance system will also help to identify any concerns in terms of geographic/temporal patterns/clusters.

**Suicide rates C&P**

The suicide audit for 2014 showed 65 deaths as a result of suicide or unexplained deaths in Cambridgeshire and Peterborough. A similar audit of suicides for 2015 showed there were 66 deaths.

## 3. NATIONAL CONTEXT

This section reviews and reflects upon nationally available data on suicides in order to place local information on suicides in context. With national reference points that include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide prevention can be developed. This section summarises key findings from national data on suicides and is intended to be used as a guide to draw comparisons with local data and information presented in section 5.

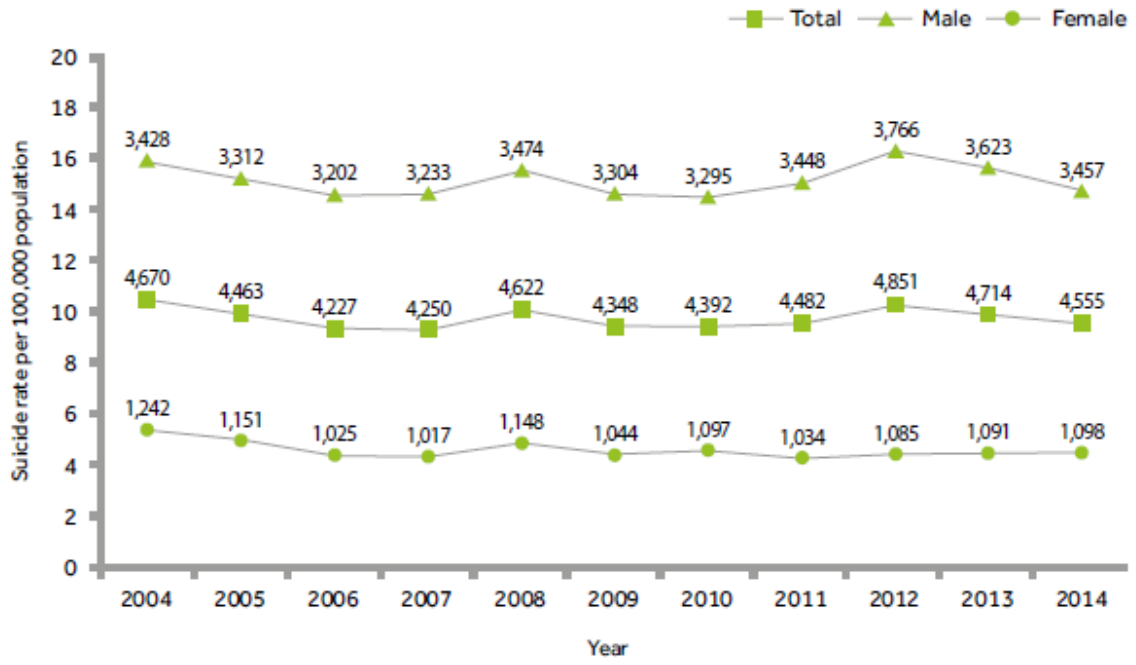
Suicide is defined in England and Wales as a death with an underlying cause of intentional self-Harm and/or an injury/poisoning of undetermined intent (ICD10 codes X60-X84 - all ages and Y10-Y34 – for ages over 15 years). It is assumed that most injuries or poisonings of undetermined intent are self-inflicted, but there is insufficient evidence to prove that the person intended to take their own life. This assumption however cannot be applied to children due to the possibility that these deaths were caused by other situations – neglect or abuse for example. For this reason, data on suicides in England only include persons aged 15 years and over for deaths from injury of undetermined intent and may under-report deaths as a result of suicide in children.

### 3.1 Suicide rates and Trends

Data from the Office for National Statistics (ONS) The pattern of suicide since 2004 is a continued fall from previous years, reaching a historical low in 2006 and 2007, a rise in 2008 and 2012, with intervening years being lower, influenced by under-recording of “narrative” verdicts. Suicide rates

have reduced since the peak in 2012. Suicide rates are volatile from year to year and are influenced by and reflect social and economic circumstances. Periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide.

**Figure 1 – Rates of suicide in the general population in England, by gender.**
Number of suicides included on the figure



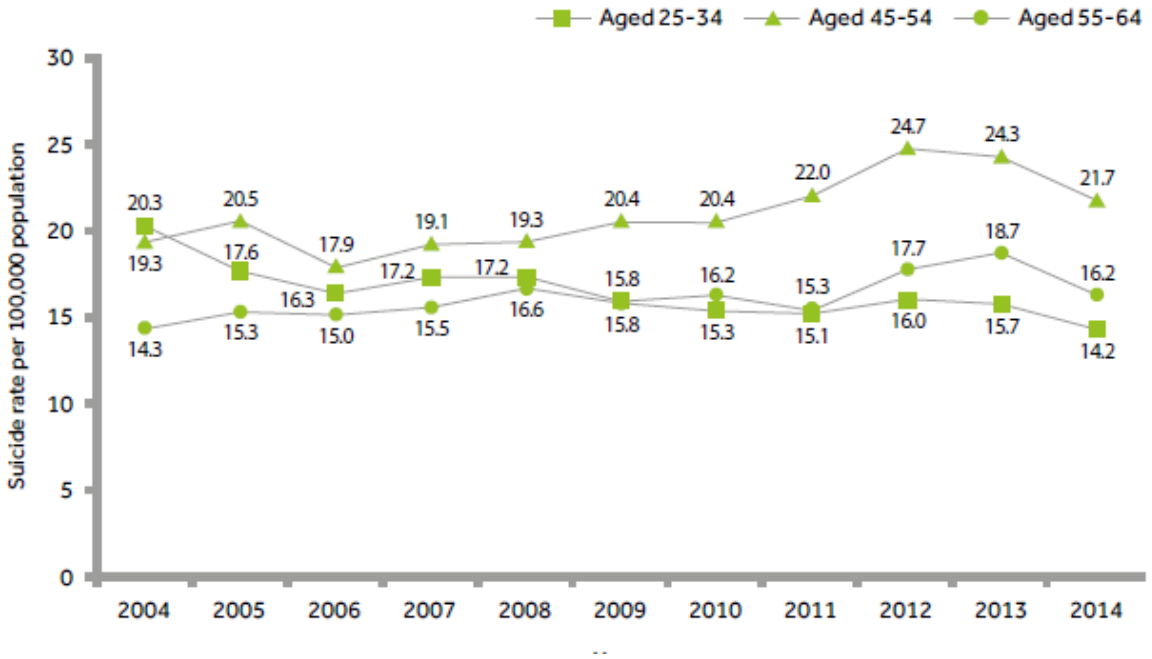

Source: National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

### 3.2 Suicides by sex and age

Suicide in males is currently about three times the rate of suicide in females across all ages in England. Of the total number of suicides in 2014, 3,457 were males and 1,098 were females.

Suicide occurs at all ages, however since 2006 the suicide rate was highest in men between the ages of 45 and 54 years and has increased by 27%. In contrast, the suicide rate in younger men, aged 25-34 has fallen since 2004 by 30% (figure 2). Middle-aged men are recognised as a one of the high-risk groups and should be a focus for suicide prevention strategies. Suicide rates fell in women aged 25-34 and rose in women aged 55-64 years.

**Figure 2 – Male suicide rates in the general population in England in those aged 25-34, 45-54 and 55-64**




Source: National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

### 3.3 Methods of suicide

National data from the 'National Confidential Inquiry into Suicide and homicide by people with Mental Illness" – Annual report 2016[8] on methods of suicide over the last decade show that the most common methods of suicide were hanging/strangulation, followed by self-poisoning (overdose) and jumping/multiple injuries - mainly jumping from a height or being struck by a train.

Less frequent methods were drowning, carbon monoxide (CO) poisoning, firearms, and cutting/stabbing.

Between 2001 and 2011, there were changes in method of suicide. Suicide deaths by hanging increased, whilst those by self-poisoning and jumping decreased. Of the less common methods, deaths by drowning, carbon monoxide poisoning, and firearms decreased.

### 3.4 Suicide Risk factors

Preventing Suicide in England, 2012[1] identifies groups of people at higher risk of suicide as follows:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- Physically disabling or painful illnesses including chronic pain
- Alcohol and drug misuse
- Stressful life events:
    - Loss of a job
    - Debt
    - Living alone, or becoming socially excluded or isolated
    - Bereavement
    - Family breakdown and conflict including divorce and family mental health problems
    - Imprisonment
- Specific occupational groups, Low skilled male labourers, particularly construction workers, building and finishing trades - plasterers and painters and decorators. Artistic, media and literary occupations presented higher risk, particularly in females. Health professionals and carers were at increased risk as were primary and nursery school teachers

Middle-aged men are identified as one of the high-risk groups and a priority for suicide prevention. A recent report by the Samaritans suggested that middle-aged men, especially those from poorer socio-economic backgrounds are particularly at risk of suicide due to a combination of factors. These include social and cultural changes (for example, rising female employment and greater solo living) that have particularly impacted on the lives of the cohort of men who are now in mid-life[9]

However, the greatest risk of suicide is found in people known to mental health services and particularly in people during the four week period following discharge from psychiatric hospital care[8,21]. It is important that the strategy focuses on identifying weaknesses in the system of care for people with mental health problems and works towards reducing risk in these groups – See section 9 and 9.9 for details.

## 4. LOCAL CONTEXT

### 4.1 Local suicide rates

Analysis of suicide rates at a local level for national purposes, uses pooled data on suicides over three year periods to provide a more consistent format to analyse suicide rates and trends when small numbers are given annually. Standardised rates are used in order to make comparisons with other regions.

### 4.2 Local suicide rates as measured by Public Health Indicator 4.10

The Public Health Outcomes Framework – 2013-2016[11] sets out the opportunities to improve and protect health across the life course and to reduce inequalities in health. The Outcomes Framework includes the Public Health Indicator 4.10 'Suicide Rate' and reflects the importance to keep the

suicide rate at or below current levels.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf

A baseline suicide rate (deaths by suicide and injury of undetermined intent) is set for the period 2009-2011 using pooled three year average data. It is expected that each area will report and compare the suicide rate on a yearly basis based upon pooled three year data.

**4.3 Trends in local suicide rates**

Data on pooled three-year rates for suicide are published on the Public Health Outcomes Framework website: http://www.phoutcomes.info/ and show current indicators as measured against England rates as well as recent trends in suicide rates. . The suicide rate in Peterborough has decreased steadily since 2010-2012 when the rate was significantly above both the England and East of England rates and is now similar to the England average. The suicide rate in Cambridgeshire has remained similar to or slightly below the England average for the last five time periods. When the data for Cambridgeshire is broken down to smaller local authority areas, all districts have recently had rates of suicide which are similar to the England average, although in the past Cambridge City and Fenland have both had periods of statistically higher suicide rates than average. No data is shown for East Cambridgeshire due to small numbers.

**Figure 3 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for PETERBOROUGH compared with England**

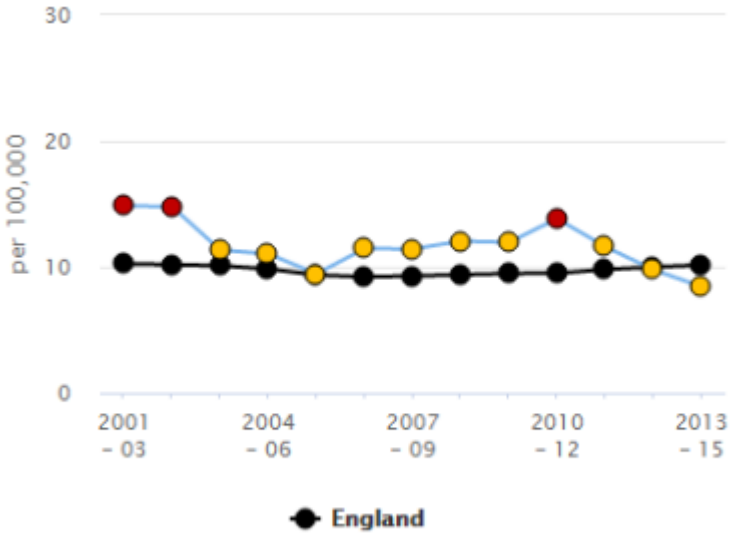


**Figure 4 - Peterborough suicide rates (2013 -2015) with nearest CIPFA comparators**

**4.10 - Suicide rate (Persons)** 2013 - 15 — Directly standardised rate - per 100,000

| Area | Recent Trend | Neighbour Rank | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|---|
| England | – | - | 14,429 | 10.1 | 10.0 | 10.3 |
| Bedford | – | 12 | 32 | 7.5 | 5.1 | 10.6 |
| Luton | – | 10 | 40 | 7.7 | 5.4 | 10.6 |
| Peterborough | – | - | 42 | 8.4 | 6.0 | 11.5 |
| Milton Keynes | – | 3 | 54 | 8.6 | 6.3 | 11.3 |
| Swindon | – | 2 | 53 | 9.3 | 6.9 | 12.2 |
| Coventry | – | 4 | 83 | 10.0 | 7.9 | 12.5 |
| Derby | – | 6 | 65 | 10.2 | 7.8 | 13.0 |
| Bolton | – | 5 | 78 | 10.7 | 8.4 | 13.4 |
| Telford and Wrekin | – | 7 | 50 | 11.0 | 8.1 | 14.5 |
| Oldham | – | 11 | 63 | 11.0 | 8.4 | 14.1 |
| Rochdale | – | 8 | 62 | 11.2 | 8.6 | 14.4 |
| Thurrock | – | 1 | 47 | 11.3 | 8.3 | 15.1 |
| Medway | – | 9 | 83 | 11.7 | 9.3 | 14.5 |
| Bury | – | 15 | 58 | 12.0 | 9.1 | 15.6 |
| Calderdale | – | 13 | 71 | 12.9 | 10.1 | 16.3 |
| Stockton-on-Tees | – | 14 | 68 | 13.6 | 10.5 | 17.3 |

Although not significantly lower than the England rates, Peterborough has lower suicide rates than most of the CIPFA comparators for the latest data collection time period (2013-2015). Comparators are chosen as nearest and most similar local authority areas in terms of demographics and socio-economic information.

**Figure 5 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for CAMBRIDGESHIRE compared with England**

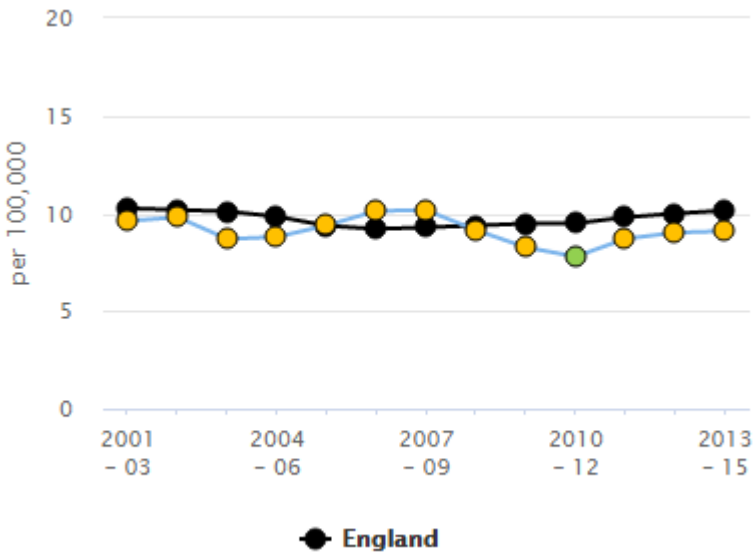


**Figure 6 -Cambridgeshire suicide rates with nearest CIPFA comparators**

**4.10 - Suicide rate (Persons)** 2013 - 15 — Directly standardised rate - per 100,000

| Area | Recent Trend | Neighbour Rank | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|---|
| England | – | - | 14,429 | 10.1 | 10.0 | 10.3 |
| Hertfordshire | – | 14 | 197 | 6.6 | 5.7 | 7.6 |
| Buckinghamshire | – | 7 | 113 | 8.5 | 7.0 | 10.2 |
| Hampshire | – | 8 | 313 | 8.7 | 7.7 | 9.7 |
| Cambridgeshire | – | - | 155 | 9.1 | 7.7 | 10.6 |
| Suffolk | – | 5 | 181 | 9.3 | 8.0 | 10.8 |
| Leicestershire | – | 4 | 164 | 9.3 | 7.9 | 10.9 |
| Oxfordshire | – | 1 | 164 | 9.4 | 8.0 | 10.9 |
| North Yorkshire | – | 13 | 164 | 10.0 | 8.5 | 11.6 |
| West Sussex | – | 15 | 220 | 10.1 | 8.8 | 11.5 |
| Worcestershire | – | 6 | 152 | 10.1 | 8.5 | 11.8 |
| Staffordshire | – | 11 | 240 | 10.4 | 9.1 | 11.8 |
| Essex | – | 12 | 394 | 10.4 | 9.4 | 11.5 |
| Gloucestershire | – | 3 | 171 | 10.6 | 9.0 | 12.3 |
| Northamptonshire | – | 9 | 197 | 10.6 | 9.2 | 12.2 |
| Somerset | – | 10 | 165 | 11.6 | 9.9 | 13.5 |
| Warwickshire | – | 2 | 175 | 11.8 | 10.2 | 13.7 |

*Source: Public Health England (based on ONS source data)*

Although not significantly lower than the England rates, Cambridgeshire has lower suicide rates than most of the CIPFA comparators for the latest data collection time period (2013-2015). Comparators are chosen as nearest and most similar local authority areas in terms of demographics and socio-economic information.

**Figure 7 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for CAMBRIDGE CITY compared with England**

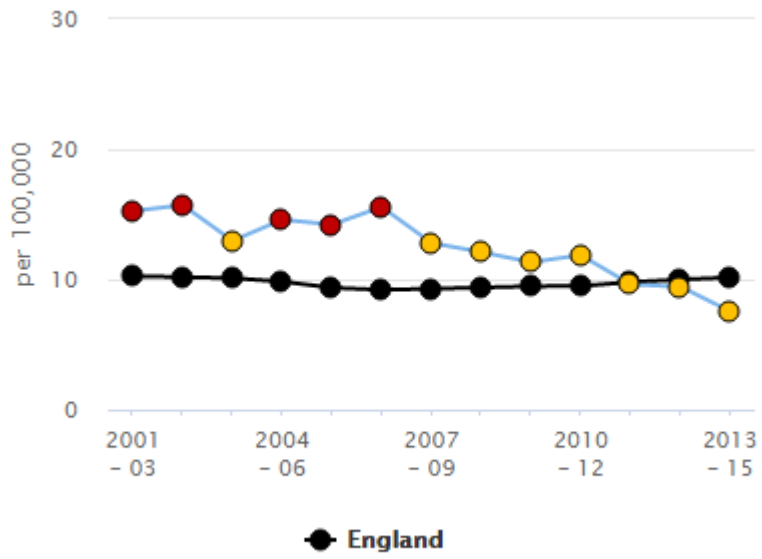


**Figure 8 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for FENLAND compared with England**

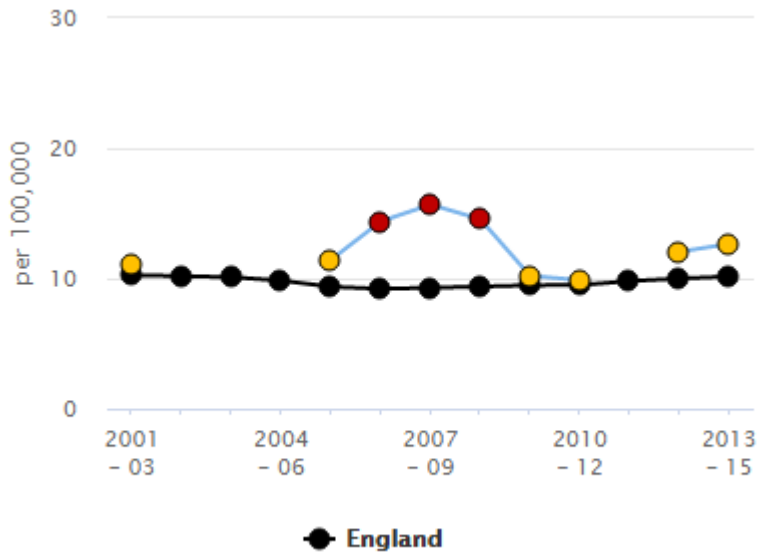



**Figure 9 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for HUNTINGDONSHIRE compared with England**

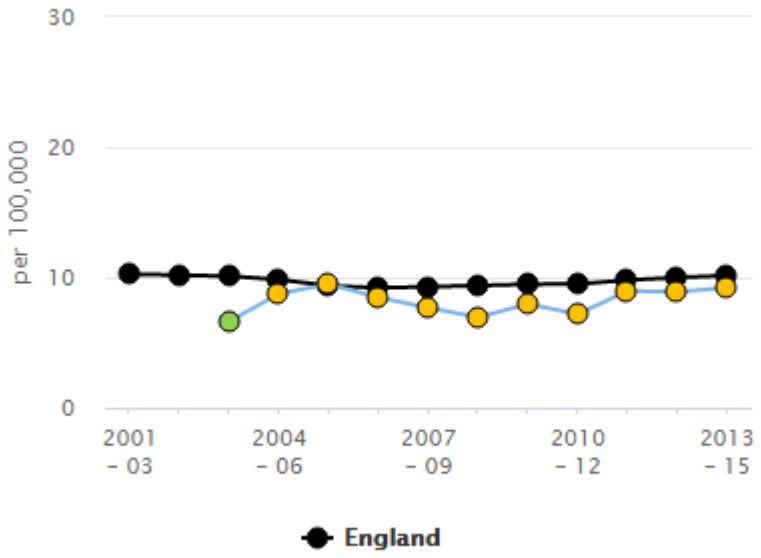
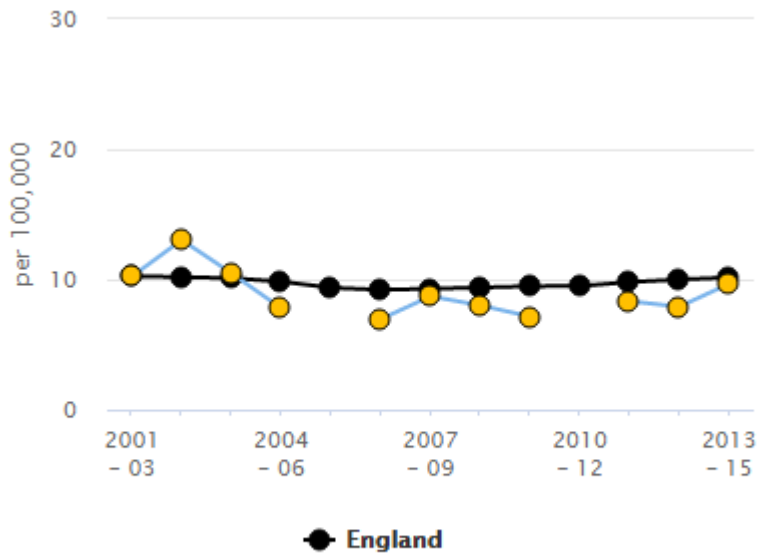


**Figure 10 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for SOUTH CAMBRIDGESHIRE compared with England**




Source: Figure 10 data is taken from The Public Health Outcomes Framework information on indicator 4.10 – suicide rate. Rates are based upon pooled data for the three year periods shown.

Rates are age- standardised and show the number of deaths per 100,000 population from suicide and injury undetermined - ICD10 codes X60-X84 (all ages) and Y10-Y34 (for ages 15 and over) registered in the respective calendar years, aggregated into quinary age bands (0-4, 5-9,…, 85-89, 90+). Counts of deaths for years up to and including 2010 have been adjusted where needed to take account of the ICD-10 coding change introduced in 2011. The detailed guidance on the implementation is available at http://www.apho.org.uk/resource/item.aspx?RID=126245.

**4.4 Local annual suicide audit**

A recommendation in the 2014-2017 strategy was to conduct a local suicide audit annually for monitoring purposes and to inform the suicide prevention implementation group of any information about concerns, or risk factors that could help focus the prevention work. Two full local suicide audits have taken place so far – for 2014 and 2015 and an audit of suicides for 2016 is expected to be initiated early in 2018. It is important that the annual audit continues, particularly as interventions are focused as a result of audit findings. This will allow data to be gathered to understand effectiveness of interventions and where gaps and need may present. With 'zero suicide' as an overall ambition, the suicide audit will become embedded in the learning culture as case notes are examined for lessons to be learned on a regular basis.

The local suicide audit for 2014 and 2015 showed there were 65 and 66 suicides and unexplained deaths, respectively for these years in Cambridgeshire and Peterborough.

The main findings from the 2014 and 2015 Suicide audits are summarised below. Due to the sensitive nature of the information, details cannot be published.

In Peterborough there were 19 deaths in 2014 and 18 deaths in 2015 classified as suicide or unexplained. The majority of suicides or unexplained deaths were by males ( 67%). 63% (2014) and 42% (2015) had current or previous contact with mental health services and 30% in 2015 had contact within six months of death with mental health services.

In 2015, there was a noticeably high number of deaths in under 30 year olds in Peterborough and Eastern European populations were overrepresented.

The 2015 audit results for Cambridgeshire & Peterborough showed:

- In males the highest number of deaths was in under 25 year olds and 50-59 year olds.
- In females the age pattern was more mixed, with highest numbers in 30-39 year olds and 70-74 year olds.
- The highest rate locally was in Peterborough, but Fenland and South Cambridgeshire also have high rates compared to the Cambridgeshire and Peterborough average. None of the areas were statistically significantly above that of Cambridgeshire and Peterborough as a whole though.
- Around 30% had been in contact with mental health services within the 6 months prior to death.
- Where a mental illness diagnosis was recorded in the audit records, almost three-quarters mentioned depression, as well as 29% with recorded anxiety.
- Two thirds of people had been in touch with primary care in 2015 or within a maximum of 6 months prior to death.
- 19 people were found to have physical health problems, including 12 with long term conditions (such as diabetes).
- Alcohol misuse was noted in 9 records and 7 mentioned drugs, such as cannabis, cocaine, amphetamine and crystal meth.
- Bereavement was noted in 10 records.

### 4.5 CPFT Suicide Audit report 2013/14 and 2014/15 data

In 2015, a comprehensive audit on all suicides and possible suicides reported by the CPFT 'Datix' system during the period 2013/14 and 2014/15 was completed by the Trust. This covered suicides and possible suicides of people who have been in contact with care of secondary mental health within twelve months prior to death.

The audit identified 29 deaths in 13/14 with a 3:1 ratio of men to women. 32 deaths were identified in 14/15 with a 1:1 ratio of men to women. Nationally, there is a 3:1 ration of men to women who have died due to suicide, known to mental health services and therefore the 14/15 CPFT data shows a divergence from the national trend.

For men the highest risk factors in both years were being single, unemployed, living alone and experiencing relationship problems. For women, the highest risk factors were being unemployed,

and/or experiencing relationship problems. Behavioural risk factors included a history of self-harm and previous suicide attempts.

31% (13/14 data) and 25% (14/15 data) had had contact with CPFT within seven days prior to death. In both years, the majority of suicides were *nCPA* (Care Programme Approach) patients (55% in 2013/14 and 59% in 2014/15).

In 2013/14 14% had been referred to CPFT and were awaiting assessment at the time of death, another 14% had been assessed as not requiring CPFT services, and another 14% had been assessed and refused CPFT services. In 2014/15, the proportion was smaller for those who had been referred to CPFT and were awaiting assessment at the time of death or had been assessed as not requiring CPFT services. However, in 2014/15, 41% had been discharged from CPFT at the time of death.

National data has shown an increase in suicides from CRHT services and as of 2013 there were three times as many suicides in CRHT services as in inpatient care in England. CPFT audit data also reflects this national information.

## 5. NATIONAL AND LOCAL PUBLICATIONS AND GUIDANCE RELEVANT TO SUICIDE PREVENTION

The local suicide prevention strategy must reflect the latest national information, evidence and guidance on improving mental health and preventing suicide for the population. In addition, the suicide prevention strategy must reflect, support and build upon other local strategies that support mental health. This section summarises the latest national and local publications that underpin the suicide prevention strategy.

### 5.1 No health without Mental Health

Suicide prevention starts with a better understanding of mental health and improving the mental health of populations, particularly those at high risk of mental health problems. No *health without mental health*, published in 2011[10], is the government's mental health strategy. Published alongside this is an implementation framework to set out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported.

### 5.2 Cambridgeshire and Peterborough CCG Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2]

Our local Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age provides detailed information on the commissioning intentions and objectives for the next three years. Four key priority areas are identified and within these, priority objectives are listed. Many of the objectives are relevant to suicide prevention in our local area and are listed in table 2 below – extracted from the Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2].

**Table 4 – Extract from 'the Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016' showing key priority areas and objectives that are relevant to suicide prevention**

| Key Commissioning Priority Area | Objectives relevant to suicide prevention |
|---|---|
| **1. Prompt Access to Effective Help** | • Introduce a **single-point of access** Advice and Resource Centre (ARC) to local mental health services for referrers, carers and service users CCG-wide.<br>• Seek to expand the range of treatment options available – including self-help, online resources, counselling, etc. for people experiencing **mild-to-moderate** mental health problems that could be effectively helped without the need to access specialist mental health services;<br>• Improve the help and support offered throughout the CCG to **offenders** with mental health problems<br>• Ensure more equal access to voluntary sector services throughout the CCG. |
| **2. The "Recovery" Model.** | • Improve support for **Carers** and engagement in care planning of loved ones.<br>• Robust **discharge planning** processes<br>• Ensuring there is access to a specialist community-based **forensic** mental health service for former offenders throughout the CCG.<br>• Improved partnership working between primary care, secondary services, and voluntary organisations to strengthen the local response to people who may be at risk of **suicide**<br>• Ensure that there is appropriate **training** in mental health for key stakeholders such as GPs |
| **3. The Inter-Relationship between Physical Health and Mental Health** | • Support the introduction of **Liaison Psychiatry** Services at Hinchingbrooke and Peterborough hospitals.<br>• Ensure people with **Dual Diagnosis** promptly receive the help they need for both their mental health and substance misuse problems |
| **4. Improve Our Commissioning Processes** | • Ensure that the services we commission are safe, effective and value-for-money |

### 5.3 Preventing suicide in England[1]

*Preventing suicide in England* is the national strategy intended to reduce the suicide rate and improve support for those affected by suicide. The strategy builds on the successes of the earlier strategy published in 2002. The overall objective of the strategy is to reduce the suicide rate in the general population in England and to better support for those bereaved or affected by suicide. It sets out key areas for action and brings together knowledge about groups at higher risk as well as effective interventions and resources to support local action.

The main changes from the previous national suicide prevention strategy are the greater prominence of measures to support families - those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.

The Six key areas for actions to prevent suicide are listed as follows:

- Reduce risk of suicide in key high risk groups
- Improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

The strategy outlines a range of evidence based local approaches and good practice examples are included to support local implementation. National actions to support these local approaches are also detailed for each of the six areas for action.

The inclusion of suicide as an indicator within the Public Health Outcomes Framework - 4.10[11] will help to track national and local progress against the overall objective to reduce the suicide rate.

### 5.4 Key findings for England from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]:

This report analyses data on deaths by suicide and undetermined cause in people known to mental health services. Data is compared with that obtained for the general population. Factors leading to or contributing to suicide are analysed and recommendations for service improvements are made as a result of these findings.

The main findings on suicides by people known to mental health services are:

- During 2004-14, 18,172 deaths (28% of suicides in the UK general population) were by people under mental health care
- In the UK in 2014, around 460 patient suicides were recorded - in acute care settings – in-patient and post-discharge care and crisis teams.

[1] http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

- In-patient suicides have continued to fall with a decrease of around 60% during 2004-14. This fall is partly attributed to the removal of ligature points to prevent deaths by hanging but there has been a reduction in suicides on and off the ward by all methods. However, despite this success, there were 62 suicides by in-patients in the England in 2014.
- There are three times as many suicides by patients under the care of the Crisis Resolution Home Treatment service CHRT - in the community, as there are in in-patients.
- Of the patients who died by suicide who were under the care of CRHT services, a third were known by the service for less than one week and a third had recently been discharged from hospital. 43% of those who died by suicide lived alone. The report suggests that CRHT may not be a suitable setting for their care and raise concerns that CRHT has become the default option for acute mental health care because of pressure on other services, particularly beds.
- Suicide risk is high in the first three months post discharge with highest risk during the first two weeks. Deaths are associated with preceding short term admissions and lack of care planning. However, there has been a fall in post-discharge deaths occurring before first service contact, and this points to a recognition of the need for early follow-up.
- Of the patients who died by suicide, over 50% had a history of alcohol or drug misuse.
- Hanging, followed by self poisoning were the most common methods used for suicide in patients. However, jumping from a height or in front of a train was the third most common method . Suicide prevention initiatives by mental health services should consider how to address the physical safety of their local environment
- Economic challenges were seen to have an impact on patient suicide as 13% of patients who died by suicide had experienced serious financial difficulties in the previous 3 months.
- New migrant status is noted in 5% of patient suicides - people who had been living in the UK for less than five years. 20 deaths over a four year period were recorded in people who were seeking permission to stay in the UK

**Recommendations made by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]**

The following table is taken from the National Confidential Inquiry report and lists recommendations for safer patient care to avoid suicide:

**Table 5 – Recommendations by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]**

**Key elements of safer care in mental health services:**

1. Safer wards
   - — Removal of ligature points
   - — Reduced absconding
   - — Skilled in-patient observation
2. Care planning and early follow-up on discharge from hospital to community
3. No 'out of area' admissions for acutely ill patients
4. 24 hour crisis resolution/home treatment teams
5. Community outreach teams to support patients who may lose contact with conventional services
6. Specialised services for alcohol and drug misuse and "dual diagnosis"
7. Multidisciplinary review of patient suicides, with input from family
8. Implementing NICE guidance on depression and self-harm
9. Personalised risk management, without routine checklists
10. Low turnover of non-medical staff

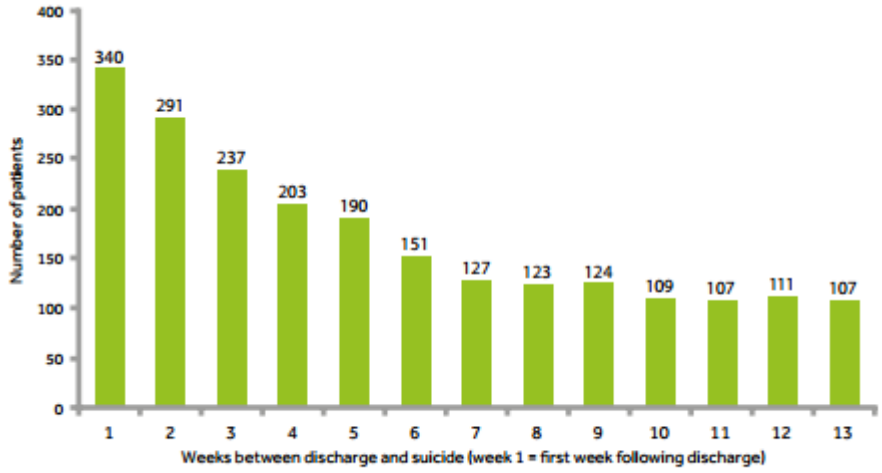
**Key elements of safer care in the wider health system:**

1. Psychosocial assessment of self-harm patients
2. Safer prescribing of opiates and antidepressants
3. Diagnosis and treatment of mental health problems especially depression in primary care
4. Additional measures for men with mental ill-health, including services online and in non-clinical settings

Source: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

The findings above are used to strengthen recommendations for local interventions as part of the action plan that accompanies this strategy.

**Figure 11 - Number of patient suicides by week following discharge, England?, 2004-2014**




Source: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

### 5.5 Cambridgeshire and Peterborough Emotional well-being and mental health draft strategy for children and young people 2014-2016[6]

The suicide prevention strategy takes account of recommendations made in the Cambridgeshire and Peterborough CCG 'Emotional well-being and mental health strategy for children and young people 2014-2016'. This document recognises that the mental health and wellbeing of children and young

people is everybody's business and by partnership working, more efficient use of resources to provide the right intervention at the right time to the right people will result.

The specific areas for action listed in this draft strategy are:

1. The commissioning of mental health services will be outcome-focussed, maximising the capacity of statutory and voluntary sector organisations
2. Mental health support will be everyone's business, all partners will understand the role they can play and support will be co-ordinated, integrated, evidence based and cost effective.
3. There will be clear pathways of care across agencies, with the right level of expertise and a shared professional knowledge
4. Services will be available for all levels of need, maximising the opportunities for early intervention and prevention, whilst also providing for those with severe and enduring mental health problems
5. Ensure that children and young people's mental health needs are identified early and support is easy to access and prevents problems getting worse
6. Standardised principles of practice will be adopted across all organisations

**5.6 Mental Health Crisis Concordat – Improving outcomes for people experiencing mental health crisis – February 2014[12]**

The Mental Health Crisis Care Concordat is a national agreement between 22 national bodies involved in the care and support of people in crisis and includes health, policing, social care, housing, local government and the third sector. The concordat sets out how partners will work together to ensure that people receive the help they need when they are in mental health crisis.

The Concordat focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can access help 24 hours a day and are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by ensuring that people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. This strategy includes and reflects some of the key messages and recommendations from the concordat, aiming to reinforce a commitment by partners to work together in preventing and managing crises. To this end, members of the suicide prevention strategic group will support the development of the mental health crisis care concordat declaration and action plan to ensure a joined-up approach to effective crisis management and prevention.

**5.7 Annual Report of the Chief Medical Officer 2013 – Public Mental Health Priorities: Investing in the Evidence**

The report from the Chief Medical officer focuses on epidemiology and the quality of the evidence base for public mental health and includes a chapter on suicide prevention[13]. The report highlights the recent increase in both the suicide and self-harm rates (since 2006/7), and suggests that the economic recession is the most likely cause for the increase. The risk of suicide in the year following self-harm is much greater than that of the general population. In addition, risk of suicide is high in people who are admitted for psychiatric treatment and remains high in the immediate post-discharge period. However, around three quarters of suicides occur in people not known to psychiatric services.

Suicide prevention should be based on evidence of what is effective. To improve safety of mental health services, access to 24 hour crisis services, policies for patients with dual diagnoses (drug/alcohol problems in combination with mental illness) and multidisciplinary reviews after suicide are effective strategies. Suicide prevention in the general population should focus on restricting of access to means of suicide, population approaches to reduce depression and improvements in detecting and managing psychiatric disorders with increased voluntary sector and internet based support. It is also recommended that work is carried out with media and internet providers to ensure responsible reporting of suicide. Self-harm should be followed up with a psychosocial assessment and access to psychological therapy upon discharge and screening for dual diagnoses. Importantly, it is recommended that surveillance should be in place to ensure that information about changes and trends in suicides are identified to enable public health action.

This strategy learns from the recommendations made in the CMO report, and this is reflected in the details contained within the accompanying action plan.

## 6. LOCAL ACTIVITY TO PREVENT SUICIDE - MAPPING SUICIDE PREVENTION SERVICES PROVIDED IN CAMBRIDGESHIRE AND PETERBOROUGH

It is important to understand the current services and pathways with regard to suicide prevention in order to form a map of available interventions with which to identify any gaps and weaknesses in the system. A summary of the available services is provided in the following sections:

### 6.1 Services for people with mental health problems

NHS Cambridgeshire and Peterborough CCG currently commissions services for people with mental health problems on a pathway basis from the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). In addition, NHS Cambridgeshire and Peterborough CCG along with Cambridgeshire County Council and Peterborough City Council commission mental health services from a range of local independent and voluntary sector organisations. Some mental health services are commissioned as part of the mental health Crisis care work that includes Police. In addition, there are voluntary sector organisations that provide mental health support in Cambridgeshire and Peterborough with funding outside the statutory sector.

- Cambridgeshire and Peterborough Foundation Trust (CPFT) Locality Teams; Psychosis, Affective Disorders, Assertive Outreach

- **Improving Access to Psychological Therapies (IAPT)** services (through CPFT) – providing psychological or talking therapies for people experiencing common mental health problems. **Group Therapy Centre** (http://www.grouptherapycambridge.org.uk/) in Cambridge and **Oakdale** in Peterborough - commissioned by Cambridge & Peterborough NHS to provide therapy groups for local people experiencing emotional and mental health worries.
- Acute Care Pathway (including crisis resolution and home treatment (CRHT) and Psychiatric Intensive Care Pathway). The acute pathway may include contact with liaison psychiatry services
- **111 (option 2)** mental health crisis telephone line with First Response Service (FRS) support into the community.
- Community **Sanctuaries** (in Cambridge, Peterborough and Huntingdon) for people to be referred to by the FRS if in mental health crisis
- **CAMEO** (NHS service that provides specialised assessment, care and support to young people experiencing a first episode of psychosis)
- **Lifecraft** – a user-led organisation for adults in the Cambridge area who have experience of mental health difficulties in their lives. Lifecraft offers a wide range of free services to help and support its' Members in their wellbeing and recovery. Lifecraft have produced a Mental Health Handbook that serves as a directory of services for people with mental health problems
- **Lifeline** is provided for people in Cambridgeshire and offers telephone support to people experiencing mental health crisis
- Cambridgeshire, Peterborough and South Lincolnshire Mind (**CPSL MIND) -** provide a wide range of services across the county to support those recovering from mental health challenges, promote positive mental health and tackle mental health-related stigma and discrimination within our communities. CPSL MIND also hosts the STOP Suicide campaign and website
- **Talking therapies** are available through 3Ts to 11-17 year olds. This will shortly be changing (1st January 2018) and the service will be expanding to include provision for under 11s in Peterborough. In Peterborough the service will cater for up to 18 year olds, in Cambridgeshire the service will go up to 25 year olds.
- Drop in counselling sessions for children and young people run by **Centre 33**. This is provided on Saturdays 11am -1pm in Cambridge, on Thursdays 2pm-5pm in Wisbech, on Monday 4pm -6pm and Thursday 4pm – 7pm in Ely, on Thursday, 4pm-7pm in Huntingdon and 'Here Now' Drop-in on Fridays, 2-5pm at Central Library, Peterborough
- **Kooth** (www.kooth.com) - an online counselling and emotional well-being platform for children and young people (aged 11-25), accessible through mobile, tablet and desktop. Kooth users have access to trained counsellors available until 10pm, 365 days a year, peer-to-peer support through moderated forums, and a range of self-help materials
- **Keep Your Head website** for children and young people - http://www.keep-your-head.com/ - provides information on mental health and wellbeing, including services that are available as well as self-help guides and professional resources
- **Centre 33** offers a range of support for young people (up to the age of 25) in Cambridgeshire. They can help with a range of issues from housing, to family problems and bullying.

### 6.2 Independent and Voluntary Sector Services

Voluntary sector organisations play a significant role in local mental health service provision, often for people who may struggle to access the "mainstream" services

- **Cambridge and Peterborough Samaritans** - provide confidential emotional support to people in distress or despair in the local area. Support is provided over the telephone or by email. Cambridge Samaritans in Emmanuel St takes callers at the door from 10am until 10.30pm. Peterborough Samaritans in Lincoln Rd, Millfield takes callers at the door on Mondays (10am - 4pm) and all other days from 7am – 4pm.
- **PINPOINT** (https://www.pinpoint-cambs.org.uk/) offers parent-to-parent support for children with additional needs including mental health problems, particularly around self-harm
- **Choices** in Cambridge - Offers a confidential counselling service in Cambridge and surrounding areas for women and men whose lives are affected by childhood sexual abuse. - https://www.choicescounselling.co.uk/
- **Relate** relationship counselling
- **The Richmond Fellowship -** a specialist employment service providing support for people recovering from mental health problems to find paid employment, voluntary work, education and training or to retain their current employment
- **Rethink Carers -** The Cambridge and the Peterborough and Fenland Groups help the carers of those with severe and enduring psychotic illnesses including schizophrenia
- **Bereavement services – CRUSE bereavement** - provide bereavement support to anyone who needs it. This includes a Cambridge based group specifically for people affected by suicide.

### 6.2 Gap analysis in suicide prevention service provision – information from the 2014-2017 strategy

Service user feedback is crucial in determining where the gaps in service provision lie for suicide prevention across Cambridgeshire and Peterborough

NHS Cambridgeshire and Peterborough CCG Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2] consulted with service users, carers, HealthWatch, GPs and the Patient Experience Team to identify gaps in service provision relevant to suicide prevention as follows:

- Raising awareness and mental health promotion to ensure better access to services, and linking between physical and mental health services. Make the best use of existing campaigns to raise awareness
- Improved information and services for carers
- Improved crisis support
- Prompt access to appropriate services
- Prompt and appropriate response by services – particularly in crisis
- acknowledge the role of carers in supporting people with severe and enduring mental illness

- Commissioners and providers review practice to ensure recipients of mental health support services always have details of who they can contact when in distress 24 hours a day.
- greater emphasis throughout services upon prevention, early intervention, support and self-management
- prompt access for GPs to obtain advice and effective help for patients presenting at surgeries in distress or "crisis"
- partnership working across local service providers (including the voluntary sector) in order that patients receive an integrated and seamless service across all interfaces

These issues were used to inform the suicide prevention implementation plan 2014-2017. Some of the needs are being addressed through workplans initiated in the last few years and details can be found in the implementation plan and summary of suicide prevention work to date. However, many of the needs are still relevant and additional needs are identified through consultation work through the suicide prevention implementation group

- Access to sanctuaries during mental health crisis in all areas of Cambridgeshire, including an unmet need in Fenland
- Better working relationships between and across the statutory services and third sector agencies to ensure sharing of information and timely and appropriate response to those requiring mental health support and crisis resolution
- Faster access to therapy, particularly for those with depression.
- Support for drug and alcohol users with mental health problems who do not meet the threshold for treatment under the dual diagnosis pathway
- Walk in centres – there is a lack of walk in voluntary centres that offer support and help to people at risk of suicide. Cambridge has Lifecraft and Centre 33 (for people aged below 25 years). No similar walk in centres exist in Fenland, Peterborough or Huntingdon.
- Bereavement support services for people bereaved as a result of suicide
- Mental health promotion targeted to men at higher risk of suicide
- Online information for adults with mental health problems – self-help resources and services that are available (similar to the children and Young people's Keep Your Head site)

## 7. A STRATEGIC LOCAL PARTNERSHIP APPROACH TO SUICIDE PREVENTION IN PETERBOROUGH AND CAMBRIDGESHIRE

In line with National guidelines on preventing suicide, and in recognition that an effective local public health approach is fundamental to suicide prevention**,** a multi-agency local suicide prevention group was established to provide input and recommendations to develop and refresh this strategy. The group is formed from partner organisations and stakeholders and includes representatives from the NHS – GPs and clinical commissioners, public health, mental health trusts, police, coroners and charitable organisations –such as The Samaritans, Lifecraft and CPSL MIND (see section 2 for details). An important aspect to developing a local strategy for suicide prevention will be engagement with 'service users' – those who have been affected by suicide or at risk of suicide. With service user input

and feedback, the strategy should reflect what is needed and what would work to minimise suicide risk in the population.

*Note: service user and stakeholder consultations on this strategy and action plan are scheduled for December 2017 and January 2018*

## 8. THE ZERO SUICIDE AMBITION

There has been national and local interest to embrace what is termed as a 'zero suicide initiative'. Zero suicide was conceived through the 'Detroit model' for suicide prevention[15], which has been successful in America - creating a cultural shift in how patients with mental health problems are cared for with the emphasis on an ambition to achieve a zero rate of suicides as a core responsibility of the 'caring' organisations. The core principles and values of the 'Detroit model' are based on six dimensions and ten rules for perfect care:

**Table 6 – Six dimensions and ten rules of perfect care according to the 'Detroit Model'**

| **Six Dimensions of Perfect Care** | **Ten rules of perfect care** |
|---|---|
| 1. Safe<br>2. Effective<br>3. Patient Centred<br>4. Timely<br>5. Efficient<br>6. Equitable | 1. Care is relationships<br>2. Care is customised<br>3. Care is Patient centred<br>4. Share knowledge<br>5. Manage by Fact<br>6. Make safety a system priority<br>7. Embrace transparency<br>8. Anticipate patient needs<br>9. Continually reduce waste<br>10. Professionals Cooperate |

Nationally, the Zero Suicide Alliance (http://zerosuicidealliance.com/) was launched in November 2017. This focuses on improving support for people contemplating suicide by raising awareness of and promoting FREE suicide prevention training which is accessible to all.

The suicide prevention group has also agreed to endorse the Detroit principle to aim to work towards zero suicides in our local area. This will form the overarching principle for all suicide prevention as outlined in this strategy. Zero suicide requires high level commitment by all partner organisations and support by individuals to drive through the cultural change required to make this a success.

A Workshop in July 2017 consulted key stakeholders on the zero suicide ambition and what this means locally to support the suicide prevention implementation plan. The themes that emerged are presented in the box below.

As Cambridgeshire and Peterborough have already established the 'STOP suicide campaign' , which is now recognised widely across the county and has the support of all major organisations involved

in mental health care, the ambition towards 'zero suicide' will not be viewed as a new initiative but embedded as the core principle for the local strategy and STOP suicide campaign. In addition, the Cambridgeshire and Peterborough suicide prevention implementation group will endorse and promote the national Zero Suicide Alliance initiative through the partnership.

**Table 7 – Local goals for the zero suicide ambition**

| **Zero Suicide Ambition – Main goals for implementation locally** |
|---|
| Top level (Chief executive) engagement and commitment towards zero suicide for the main organisations involved – CCG, CPFT, PCC, CCC, Police |
| Improve quality at the organisational level- Engagement with organisational workforce to create a learning culture not a blaming culture. Part of this process will involve reviewing both suicide information and information from people with lived experience to learn lessons and implement good practice. |
| Improve quality at the individual level – win over 'hearts and minds' for zero suicide so it is at the forefront of peoples' minds during day to day organisational business and becomes part of life. |
| Review and improve information sharing across agencies involved in the pathway of care of individuals with mental health problems |
| Strengthen the local STOP suicide campaign and suicide prevention implementation plan with a stronger emphasis on campaigns and initiatives that raise awareness, educate and promote mental health across the population, but with a focus on young people |
| Promote the Zero Suicide Alliance resources and information including free online training in suicide prevention |

## 9. SUICIDE PREVENTION PLAN

The zero suicide ambition will provide the main thread for suicide prevention and its work will be embedded in all areas within the plan. The suicide prevention plan is divided into six priority areas based upon the national guidance 'Preventing suicide in England, 2012[1]:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behavior
6. Support research, data collection and monitoring.

In tackling each priority area, evidence and information is taken from national guidance and publications on what is effective in preventing suicide, but an emphasis is placed on local needs and information gathered from the suicide audit and stakeholders that identify groups at higher risk of suicide and gaps in service provision. In all areas there will be encouragement of multi-partnership working across all sectors from NHS and mental health professionals to voluntary organisations that

will utilise expertise from these organisations to implement the proposed initiatives. Continuing engagement between the dedicated members of the Cambridgeshire and Peterborough suicide prevention group and service users and their carers is essential for the successful design, development, implementation and delivery of initiatives in each priority area.

The plan includes recommendations from the CPFT zero suicide strategy and cross reference to the Trust's strategy and action plan will be made to ensure a joined up and comprehensive approach to suicide prevention locally.

Each priority area is discussed in detail and recommendations for action are made in the following sections of this strategy document.

## 10. PRIORITY 1 - REDUCE THE RISK OF SUICIDE IN KEY HIGH-RISK GROUPS

Data presented in 'Preventing suicide in England[1]' identified particular groups at higher risk of suicide – see section 3.4. It is important to compare and contrast the high risk groups identified nationally with local data on suicides as well as local information based upon health and wellbeing needs assessment in order to focus suicide prevention resources appropriately to those in greatest local need.

### 10.1 Identifying People at higher risk of suicide

The suicide prevention strategic group includes Peterborough and Cambridgeshire coroners who are providing comprehensive local suicide data to the group on a regular basis. Analysis of the local data on suicides has enabled the identification of local suicide risk factors and emerging issues. In particular, men from Eastern European migrant populations – Polish and Lithuanian nationals residing in Peterborough and Fenland regions are emerging as a high risk group for suicide. In addition, unemployment, bereavement, drug or alcohol use are factors that have been recognised through the local suicide audits as potential risk factors. Groups of people, such as middle aged men (particularly those working in building and construction or IT), people in custody, gypsies and travellers and homeless are also identified as at increased risk of mental health issues and suicide.

Cambridge has a higher proportion of students in the population compared with similar sized cities as it is home to both the university of Cambridge and Anglia Ruskin University. Although the risk of suicide in the Cambridge student population has not been established, ONS data has shown a substantial increases in both male and female suicides in the student population from 2007-2011[7]

Based upon the evidence above of people at high risk of suicide both nationally and locally, the following groups of people will form the basis for targeted interventions (table 3):

**Table 8 - Groups at high risk of suicide – Cambridgeshire and Peterborough**

- New migrants – Polish and Lithuanian people
- People in contact with mental health services – including people recently discharged from psychiatric hospital care
- Unemployed people and those in financial difficulties
- Students
- Middle-aged men
- Gypsies and travellers
- Young offenders
- People in custody
- People who self-harm and have had a history of self-harm
- Alcohol/drug users
- Bereaved people and those bereaved by suicide
- Veterans
- Gay, lesbian, transsexual people
- Children with mental health problems at risk of self-harm

The strategy recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the group will be vulnerable to suicide. Other risk factors, such as loneliness, social circumstances and physical illness, must also be considered within the wider context or risk *Preventing suicide in England, Department of Health, 2012*[1]

**10.2 Creating tools and resources to aid suicide prevention in high risk groups**

The evidence base for suicide prevention highlights particular interventions that have been shown as effective in reducing risk or raising awareness of suicide. The best suicide prevention strategies use a combination of tools and interventions.

Based on the evidence of what is effective in preventing suicide, the following tips have been developed to aid the development of the suicide prevention strategy:

- Emphasise self-help and provide solutions for self-help
- Emphasise that suicide is preventable - there are preventative actions individuals can take if they are having thoughts of suicide or know others who are at risk of suicide.
- The impact of mental illness and substance abuse as risk factors for suicide can be reduced by access to effective treatments and strengthened social support.
- Don't glorify or romanticize suicide or people who have died by suicide. Vulnerable people, especially young people, may identify with the attention and sympathy garnered by someone who has died by suicide.
- Teach people how to tell if they or someone they know may be thinking of harming themselves and how to protect them from this harm.

### 10.3 Recommendations to prevent suicide in high risk groups

This strategy reflects what is known from the evidence base on suicide prevention and uses knowledge of local gaps in service provision to make the following recommendations for actions in preventing suicide in high risk groups:

1. Suicide prevention training – for professionals and other front-line workers in contact with vulnerable groups at risk of suicide
2. Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help
3. Promote awareness raising campaigns to prevent suicide
4. Ensure integrated, appropriate and responsive services to those at risk of suicide
5. Reassess pathways for people known by mental health services at risk of suicide – ensure follow-up provision of care upon discharge from services.
6. Improve pathways and support for offenders and people taken into custody at risk of suicide.

Each of these recommendations for action is discussed in detail below, highlighting how they will reach out to the target groups at high risk of suicide across Cambridgeshire and Peterborough

### 10.4 Recommendation 1.1 - Suicide Prevention Training

The recommendation is to enable mental health and suicide prevention training throughout Cambridgeshire and Peterborough for professional groups and third sector organisations in regular contact with adults who are at risk of suicide. The training will equip people in recognising the signs and symptoms of mental health problems and suicidal behaviour in people they encounter through the work they do. Moreover, it will give them the skills and confidence to respond appropriately to affected individuals – to support and refer them appropriately.

From 2017 -2020 suicide prevention training will continue after initial funding in 2014 from the Strategic Clinical Network. This helped to set-up the local STOP suicide initiative, that included training. From 2015, funding for suicide prevention training was provided by Cambridgeshire County Council (CCC) with support funding from Peterborough City Council (PCC) to continue the work of the STOP Suicide initiative. MIND in Peterborough and Cambridgeshire with support from Lifecraft in Cambridge deliver the suicide prevention training on behalf of the partnership.

Training in suicide prevention aims to reach beyond “traditional” models of suicide prevention by engaging with a much wider range of agencies, including voluntary organisations and faith groups who are likely to come into contact with the two thirds of suicides who are not in contact with mainstream mental health services.

Suicide prevention training is provided from a recognised and evidence-based source such as ‘Applied Suicide Intervention Skills Training’ **(**ASIST )[16]. ASIST is a two-day suicide prevention course that aims to help both professionals and lay people to become more willing, ready and able to recognise and help persons at risk of suicide. ASIST is intended as ‘suicide first-aid’ training, and is focused on teaching participants to recognise risk and learn how to intervene effectively to reduce the immediate risk of suicide. A study by the London School of Economics estimated the cost-

effectiveness of implementing ASIST training to GPs and concluded that the cost per QALY (Quality Adjusted Life Year) saved was £1,573 – extremely cost effective in terms of medical interventions

A bespoke, half day 'STOP suicide' suicide prevention training course has been developed by MIND and Lifecraft and is offered as an alternative to the two day ASIST training.

In addition, Cambridgeshire County Council continues to support Mental Health First Aid (MHFA)[17] training, in order to promote general mental health awareness in professional groups and organisations likely to be in contact with people with a broad range of mental health needs is recommended.

CPFT also offer suicide prevention training as do Samaritans and free online suicide prevention training is available through the Zero Suicide Alliance.

Suicide prevention training will be targeted to individuals and organisations who are most likely to encounter people at risk of suicide, with priorities given to people working with those with recognised risk locally, for example, Eastern European migrants or men working in the building/construction industry.

In order to create a culture that encourages an understanding and appreciation of the roles and responsibilities of other agencies, suicide prevention training, where possible will be offered to mixed groups of professionals. This would promote partnership working between agencies and deliver consistent messages on suicide prevention across the professional groups. Mixed groups will also facilitate a better understanding of each other's roles and responsibilities when dealing with people in crisis.

**GP Training in suicide prevention**

Funding has been secured through the STP with some support from CCC and PCC for training of GPs across Cambridgeshire and Peterborough in suicide prevention. GPs are most likely to have contact with people at risk of suicide in many of the 'high risk' categories listed in Table 3.The 2015 audit of suicides and deaths from undetermined intent for Cambridgeshire and Peterborough found that two thirds of people had been in touch with primary care in 2015 or within a maximum of 6 months prior to death. Suicide prevention training for GPs can potentially enable greater identification of those at risk, and earlier referral to evidence based treatment services (Suicide in primary care in England 2002-2011[18]. Training will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care. Training will be implemented from late 2017.

### 10.5 Recommendation 1.2 - Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help

Different professional groups and organisations with direct contact with people at risk of suicide will have differing responsibilities towards these people. Often there is a lack of clarity or understanding about what is appropriate in terms of responding to a person who may be suicidal or in signposting that person to sources of self-help. In order to bridge this gap, it is recommended that resources be developed for professional groups and organisations that will act as protocols and provide signposting information in any circumstances where professionals are in contact with people at risk

of suicide. Resources will help to empower organisations with information to help vulnerable people in mental health crisis. Examples of suicide prevention protocols for GPs and for people working for MIND are provided in Appendix 1

A variety of resources and information was developed and collated as a result of the 2014-2017 suicide prevention implementation plan. These included the development and promotion of the STOP suicide initiative, including the STOP suicide website: http://www.stopsuicidepledge.org/. The development of the local 'Keep Your Head' website with resources and information aimed at young people, their carers and professionals: http://www.keep-your-head.com/CP-MHS. Wide promotion of the Crisis (111/2) service has been undertaken by the partnership. The suicide bereavement support leaflet has been distributed via GPs, police, coroners and will be promoted on a regular basis.

There has been support and agreement by partners involved in suicide prevention work to create an adult version of the 'keep your head' website, which will contain information, resources and self-help guides for people experiencing mental health problems or suicidal thoughts. This work will be initiated in the Autumn of 2017, with funding in place to support (through the Better Care Fund).

A directory of services has been produced by Lifecraft in Cambridge and a professional and service user App (MiDos and MyHealth), are being created to contain information about mental health support and services with funding through the Mental Health Delivery Board. These will be promoted through the various websites mentioned above.

An opportunity exists to work with professionals to develop care plans for people known by mental health organisations to ensure up-to-date self-help resources and contact information is included to help prevent escalation of mental health problems into crisis. This can be facilitated through the proposed GP training.

### 10.6 Recommendation 1.3 – Awareness-raising campaigns and the Cambridgeshire and Peterborough Pledge to reduce suicide

The 2014-2017 suicide prevention strategy recommended the development of a range of awareness raising initiatives and campaigns in collaboration with service users through focus group feedback. Service users representing particular high-risk or hard to reach groups should be sought to ensure resources and advocacy services are developed appropriately. Resources will need to be translated into other languages, including Polish and Lithuanian and be culturally appropriate if they are to reach out to all vulnerable groups.

In addition the development of the 'Cambridgeshire and Peterborough STOP suicide Pledge' to reduce suicide was recommended. The pledge is intended to raise awareness in individuals and organisations about responding to the risk of suicide by encouraging self-help and helping others. Development and roll-out of the 'Peterborough and Cambridgeshire Pledge' to reduce suicide was initially supported by funding from the SCN Pathfinder programme and is now receives continuing support and funding from CCC and PCC.

As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. In addition, STOP Suicide had 1,343 twitter followers and 394 facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Approximately 3000 one to one conversations with individuals around the subjects of mental health and suicide since September 2015. The campaign has recruited a total of 10 new Campaign Makers - four in Peterborough, five in Cambridge and one in St Neots.

The Samaritans run a national campaign 'We're in your corner' that raises awareness of the issue of men and suicide and encourages these men to seek help – see https://www.samaritans.org/media-centre/our-campaigns/were-your-corner. It would be beneficial for local campaigns targeted at reducing suicide in men (such as STOP suicide) work with the Samaritans to share idea and resources in order to maximise benefits.

Continuing support for campaign work and promotion of the STOP suicide pledge is recommended.

It is recommended that awareness-raising will be supported by promotion of 'World Suicide Prevention Day' each year on September 10th and world 'mental health awareness day on October 10th in addition to local initiatives throughout the year.

### 10.7 Recommendation 1.4 – Aspire to develop integrated, appropriate and responsive services to those at risk of suicide

This work is the backbone to suicide prevention with an aspiration to create a seamless pathway of care that has no cracks for people to fall between. Service improvement and driving up quality of care is the key theme behind the zero suicide ambition. A first step to achieving this is to create a culture of learning across the system. Learning from case reviews of suicides is recommended as a pilot but also learning from people with 'lived experience' to determine what works as well as what has gone wrong.

The last year has seen the implementation of initiatives to improve the pathway of care for people in mental health crisis (through the work of the Crisis Care Concordat partnership). The suicide prevention strategy endorses and continues to support this work:

- Continue support for Integrated Mental Health teams – Mental health nurses in police control rooms
- Continue support for Crisis 111(2), First Response Service and the continuing roll-out of sanctuaries or places of safety in the community for people in mental health crisis to use.
- Ensure suicide prevention initiatives link to Crisis Concordat work and include pathways of care for people pre crisis, during crisis and post crisis
- Develop and expand data sharing agreements and protocols (see recommendation 1.6 below)

A recent audit of drug and alcohol related deaths highlighted the high rate of mental health problems in people who have died as a result of drug and/or alcohol abuse. Likewise, the suicide audit highlighted drug and/or alcohol problems in a proportion of deaths. It is clear that there are gaps in services that do not cater sufficiently for people who do not meet the thresholds for a 'dual diagnosis' of concurrent drug/alcohol abuse and severe mental illness. These may be people who are substance or alcohol users with common mental health disorders such as depression. They may be

treated for their substance use but their mental health needs are overlooked. A recommendation in this strategy is to encourage and facilitate systems that allow engagement with other services where appropriate – particularly with drug and alcohol teams.

Other recommendations in this section include:

- The development of guidance for GPs and primary care – resources, sign posting and self-referral as well as safety plans and links with PRISM
- Develop bereavement support services for those affected by suicide – see Recommendation 4.1
- Improve data sharing between agencies– The Vanguard and Concordat work has required data sharing protocols. Data flow following a bereavement is being reviewed.
- Continue work to map and update pathways and ensure all partners are aware of contacts and resources for self-help as well as pathways and how they operate
- Encourage professionals and organisations to work together in identifying gaps and opportunities in pathways to prevent suicide – particularly at points where services meet when a person is transferred from one service to another

### 10.8 Recommendation 1. 6 - Reassess pathways for people known by mental health services at risk of suicide

Approximately 30% of people who die as a result of suicide are known to the mental health services. People recently discharged from psychiatric care are the group with the highest risk of suicide, particularly within the first two weeks post discharge[8]. A retrospective case control study showed that 55% of suicides by people known by psychiatric services, died within a week of discharge from a psychiatric unit[21]. The study concluded that factors associated with increased suicide risk during this period included hospitalization of less than 1 week, recent adverse events, older age, and comorbid psychiatric disorders. Factors associated with decreased risk included patients receiving enhanced aftercare. Based on these findings, work should be conducted in partnership with CPFT to identify gaps or weaknesses and areas for improving the care of people upon discharge from psychiatric care.

To assess and improve pathways of care for people known to mental health services, it will be important to work in partnership with CPFT, through the CPFT zero suicide strategy group and the Mental Health Crisis Care Concordat Working group. To this end, the following are recommended:

- Ensure Crisis Concordat work aligns with this priority area. Pathways of care to be assessed include those pre crisis, during crisis and post crisis. Explore models for strong community and joined-up support at locality level for people pre and post crisis as part of the 'Neighbourhood model'.
- Assess pathways to ensure that information is shared across agencies in the patient's best interest
- Assessment of pathways for people who are discharged from psychiatric care. This would include ensuring that careful and effective careplans and follow-up arrangements are in place. Link with PRISM as a 'step down' or 'step up' process in community settings. Ensure that carers, families and significant others are always involved in care planning, including the identification and mitigation of risk.

- Ensure that every CPFT patient has a comprehensive flexible risk management strategy that results from a specific risk focused conversation and that the strategy is consulted, considered and reviewed at every contact.
- Ensure that CPFT patients who's mental state is deteriorating are picked up early and offered objective review and increased support
- Engage with Rethink Carers group – for carers of people with mental health illnesses – understand concerns about pathways of care and provide information to carers in order to support them in their care role for someone at risk of suicide
- Engage with service users to establish the strengths and weaknesses in pathways of care in response to crisis – including a review of the use of Police section 136 and the use of places of safety
- Encourage development of pathways that are comprehensive and organised around the patient – particularly where organisations meet during transition points – acute sector transition into the community, for example
- Enable ongoing support for people with mental health issues and for those people in the community who do not meet the threshold for secondary mental health services – through links with PRISM. CPFT will ensure that it has a pathway for the care of patients with drug and alcohol problems that explicitly manages their risk of suicide and provides them with more not less active treatment

### 10.9 Recommendation 1.7 - Improve pathways and support for people taken into custody and newly released from custody at risk of suicide.

Prisoners and people taken into custody have been identified as a group with specific requirements due to the nature of the crisis that has increased their risk of suicide. To this end, the following is proposed:

- Liaise with NHS England and Public Health England to work with probation, prison and police staff to understand the screening risk assessment procedure at court and upon reception of prisoners and people taken into custody to include risk of suicide/self-harm.
- In partnership with NHS England, liaise with prison managers to promote the use of prison listeners to prevent suicide.
- Assess pathways of care for people in police custody and working with NHS England, assess pathways of care for people in prisons at risk of suicide. Review self-help advice and information, screening and risk assessment upon reception into custody
- Promote access to the Samaritans in custody suites.
- Continue to support suicide prevention training of prison staff and prison listeners (section 9.4).
- Promote access to support from drug and alcohol services for people in custody with mental health and drug/alcohol problems.
- Assess discharge pathways for people who have been in custody, including a review of care plans for people with mental health problems. Recognise the need to promote joined-up services with an understanding of the roles and responsibilities of other organisations including the probation service.

## 11 PRIORITY 2 - TAILOR APPROACHES TO IMPROVE MENTAL HEALTH IN SPECIFIC GROUPS

The Preventing Suicide in England strategy identified specific groups of people for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system
- survivors of abuse or violence, including sexual abuse
- veterans
- people living with long-term physical health conditions
- people with untreated depression;
- people with autism or Asperger's spectrum disorders
- people who are especially vulnerable due to social and economic circumstances
- people who misuse drugs or alcohol
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

The Cambridgeshire and Peterborough CCG Commissioning Strategy for Mental Health and Well-being of Adults of Working Age 2013-2016[2] sets out an implementation plan with four themes as follows:

Theme 1 – Easier and prompt access to effective help

This includes a section on addressing the barriers to access to 'main stream' services for marginalised groups

Theme 2 – The Recovery Model

Theme 3 – The inter-relationship between physical health and mental health

Theme 4 – Improve our commissioning processes

The National publication 'No health without mental health' 2011 set out six mental health objectives:

- More people will have good mental health – this included a statement to continue to work to reduce the national suicide rate
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm – includes fewer people self-harming and safeguarding children and young people and vulnerable adults
- Fewer people will experience stigma and discrimination

### 11.1 Recommendations to improve mental health in specific groups

**Recommendation 2.1 Assess pathways of care for children and adults who self-harm**

Emergency admissions for self-harm in young people remains a concern in Cambridgeshire and Peterborough with data showing rates of admission above those for England and the East of England. It will be important to work in partnership highlight strengths, gaps and weaknesses within the pathways of care for children and adults who self-harm and identify areas for improvement, particularly with respect to follow-up care for people discharged from services.

- Monitor admissions to the Accident and Emergency departments for self-harm to assess any impact on service developments. Repeat admissions of people who self-harm would be particularly useful to monitor as the strategy should focus on the best interventions to prevent repeat episodes of self-harm
- assess pathways for support for children who are at risk of self-harm , particularly in vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems
- Promote the 'Keep Your Head' website for children and young people to professionals including liaison psychiatry to highlight resources and directory of services for self-help and signposting
- Develop an adult version of the 'Keep Your Head'website to contain information about resources, services and self-help guidance for people with mental health problems
- Ensure follow-up care plans are robust for people discharged from services
- Assess plans for people who self-harm if mental health services are not involved. Link this work to the PRISM service (Enhanced primary care service for people with mental health issues).

**11.2 Recommendation 2.2 Work with partners who are developing the 'Emotional wellbeing and mental health strategy for children and young people' to promote the following:**

- Continue to raise awareness and campaigning around self-harm
- Continue to provide access to self-help resources that focus on building resilience in young people, including the 'Keep Your Head' website
- Continue work that raises awareness and develops resources aimed at preventing bullying and promoting mental wellbeing in schools and colleges- see 'beat bullying' teaching resources – www.beatbullying.org/dox/resources.html
- Support and promote the projects that work with families to address self-harm, for example Pinpoint.
- Develop a 24 hour crisis response for children.

**11.3 Recommendation 2.3 – Promote early interventions to aid prevention of mental health problems that could lead to suicide**

Prevention interventions to promote good mental health and avoid decline towards suicidal tendencies are essential to this strategy:

- Review access to support in the community before crisis situations arise.
- Work with communities and community liaison teams to raise awareness of sources of help, for example, debt management, relationship counselling, housing organisations parent/children centres

- Promote Information and provide training to health professionals including GPs and health visitors to encourage use of signposting, advice and self-help resources (through the Keep Your Head websites, for example
- Engage with service users and public to understand gaps in service provision and focus efforts on improving the system to support individuals where appropriate
- Review the potential to provide a tangible presence of a mental health drop-in facility in Peterborough city centre

### 11.4 Recommendation 2.4 - Promote training in Mental Health Awareness

For detailed information – see section 9.4. Continue to roll-out training that promotes mental health awareness and prevention of mental health problems that could lead to suicide. Implementation of bespoke training packages in mental health awareness and suicide prevention began in 2014. This work is continuing to be funded as well as additional training in suicide prevention aimed at GPs. Training for General Practice staff should include awareness around risk assessment for mental health issues by assessing patient histories, particularly around a past history of self-harm.

## 12 PRIORITY 3 - REDUCE ACCESS TO THE MEANS OF SUICIDE

The 2014-2017 strategy reported that the most common method for suicide was hanging but there was considerable concern about information on deaths as a result of multiple injuries associated with falling from height from car parks in both Peterborough and Cambridge. The strategy made clear recommendations to help address these issues but vigilance is still required and more work can be done as follows:

### 12.1 Recommendation 3.1 – In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings

Most suicides are the result of hanging. It is therefore important to remove potential ligature points in places likely to have people at high risk of suicide – including places of custody, prisons and hospitals in line with national regulations and guidance -
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117555/safer-detention-guidance-2012.pdf
http://www.rcpsych.ac.uk/pdf/AIMS-PICU%20Standards%20-%20Second%20Edition%20-%20FINAL%20new%20template.pdf

Regular audit of potential ligature points should continue as good practice in places of safety including psychiatric hospitals and places of custody taking into account recommendations made by coroners.

### 12.2 Recommendation 3.2 Reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car parks

Preventing access to the means of suicide by physical barriers in locations where people may choose to jump is one of the most effective mechanisms for preventing suicide[22,23]. There is no evidence to suggest that people will find an alternative mechanism for suicide if one method is made inaccessible[23]

The suicide prevention implementation group fully endorses the erection of barriers at all multi-

storey car parks in Cambridge and Peterborough to ensure safety by preventing access to any area with a sheer drop that could lead to a suicide attempt. This would make a clear statement and showcase Peterborough and Cambridge as places that take positive steps to prevent suicide.

The suicide prevention implementation group is delighted with progress to date; barriers have been erected on all the Queensgate shopping centre car parks in Peterborough. No deaths have been reported as a result of jumping from car parks since the work began to construct the barriers. In Cambridge, the Queen Anne car park in Cambridge should to be reviewed in terms of protective measures to prevent people from jumping from the building.

Training in suicide prevention has been provided to staff working at both Peterborough and Cambridge shopping centres by the Samaritans. Similar training should be considered for all staff working in the multi-storey car parks in Peterborough and Cambridge.

**12.3 Recommendation 3.3 – Reduce the risk of suicide on railway lines**

A range of work is being undertaken nationally as part of the railway Suicide Prevention plan – involving Samaritans, Network Rail and British Transport Police. There have also been local initiatives to support this work:

- Samaritans/Network Rail campaign on the railway includes printed messages on tickets and posters at stations. Some local stations are also displaying Stop Suicide resources.
- Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally).
- The Rail505 app – enables other passengers/anybody to report someone they are worried about or to seek help themselves on the railway. https://www.rail505.com/

Continuing implementation of these initiatives is supported by this strategy

In addition, the annual suicide audit will be used to assess whether there are any 'black spots' for suicide on railway lines locally. An assessment of any requirements for physical barriers should be made at any location with heightened risk of suicide.

**12.4 Recommendation 3.4 – Work with Medicines Management team at the CCG to ensure safe prescribing of some toxic drugs**

Self-poisoning accounts for about a quarter of deaths by suicide in England and is the second most common method for suicide in men and women. Safe prescribing regulations were introduced in 1998 to limit the size of packs of paracetamol, salicyates and their compounds sold over the counter, supported by guidance on best practice in the sale of pain relief medication (MHRA, 2009[25]).

The National Institute for Health and Clinical Excellence (NICE) will be developing a quality standard on safe prescribing, as part of a library of approximately 170 NHS Quality Standards covering a wide range of diseases and conditions.

The suicide prevention implementation group should work with the CCG Medicines Management team chief pharmacist to ensure that there is a focus on suicide prevention as part of implementation of forthcoming NICE guidance – quality standard on safe prescribing. Further

consideration needs to be given to the prescribing of some toxic drugs, where safer alternative medicines are available[26]

Promotion of suicide prevention through pharmacies and with pharmacists is recommended to raise awareness of suicide risk due to some forms of prescription medication.

### 12.5 Recommendation 3.5 - Whenever possible, medical professionals should be reinforcing safety plans for individuals with mental health problems

Promote the adoption of personal safety plans for people with mental health illness, or who have previously suffered from mental illness and/or are at risk of suicide as identified by GPs and other health professionals. This includes those who have never been in Secondary Care services.

Personal safety plans are essential as part of the process of care and need to cross over organisational boundaries and be person held. There is an opportunity to promote the use of safety plans with GPs and other health professionals through the suicide prevention training from the autumn of 2017 (funded with STP money). Included in the safety plan is an assessment of access to means of suicide and dialogue should be promoted between the health professional and patient about how to eliminate access to the means of suicide. This should include exploring and adopting best models for reducing hanging in the community.

Educational resources and information for GPs will continue to be disseminated by engagement with GP leads and clinical networks through the CCG.

## 13 PRIORITY 4 - PROVIDE BETTER INFORMATION AND SUPPORT TO THOSE BEREAVED OR AFFECTED BY SUICIDE

It was recognized in the 2012 Preventing Suicide in England strategy that bereavement by suicide was an area poorly covered by previous suicide prevention strategies.

Public Health England have published a suite of recent guidelines on supporting people after suicide. These highlight the need for change to ensure all suicide prevention strategies include postvention (activities for people bereaved by suicide to support their recovery and prevent adverse outcomes). The guidelines include several case studies of reactive approaches to postvention support as well as information on how to implement and evaluate similar initiatives.
https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providinglocal-services
Locally, no specific bereavement support service exists for people and families who have been affected by suicide. Bereavement is in itself a risk factor for suicide and a conservative estimate is that 10 people are directly affected by each suicide death. Friends and relatives of people who die by suicide have a 1 in 10 risk of making a suicide attempt after their loss. When compared with people bereaved through other causes, those bereaved by suicide are also at an increased risk of psychiatric admission and depression.

There are several bereavement charities and organisations, some of which specialize in helping

those affected by suicide.

- CRUSE – a charity dealing with bereavement in general – supported by the CCG
- Survivors of bereavement by suicide
- Compassionate Friends – a charity dedicated to helping families of children who have died

In addition, The 'Help is at hand' booklet produced by the Department of health[27] is designed for people affected by the loss of a loved one through suicide.

### 13.1 Recommendations to support those who are bereaved and bereaved as a result of suicide

**Recommendation 4.1 Ensure bereavement information and access to support is available to those bereaved by suicide**

Funding has been approved through the Systems Transformation Programme (STP) to implement a local, county wide suicide bereavement support service (approved in July 2017). A pathway will be developed so that bereaved individuals will be asked whether they would like to be contacted by a support officer upon initial contact (usually by a police informing the family of the death by suicide of a loved one). If they consent to be contacted, this information will be passed to the family support officer and they will make contact with the family or bereaved individual within the first week after bereavement to offer support and signposting to services (such as CRUSE a charity to help bereaved people) and self-help resources. It may be important to ascertain whether there are any other individuals outside the family context (friends, colleagues for example) who may be affected by the suicide.

The bereavement support service will also help facilitate the setting up of local 'Survivors of Bereavement due to Suicide (SOBS) groups, that will be run as friendship or 'peer support' groups for people affected by suicide.

Information for those bereaved as a result of suicide will continue to be made available through professionals and other organisations in first contact with bereaved people (Police Officers, coroners, GPs, death registration professionals and funeral directors).

- Continue to distribute 'help is at hand' leaflets to these professionals.
- Provide details of local bereavement charities if not included in 'help is at hand' leaflet. A local bereavement support leaflet should be developed to signpost people to locally available services and resources for self-help. This should be provided to individuals who have been affected by suicide.

The families of people who have died as a result of suicide who are known to mental health services may be particularly vulnerable after bereavement. It will be important to review and map the processes in place to ensure that appropriate support is available to families and close contacts after bereavement. Any gaps in the services should be highlighted and recommendations made to improve outcomes.

## 14 PRIORITY 5 - SUPPORT THE MEDIA IN DELIVERING SENSITIVE APPROACHES TO SUICIDE AND SUICIDAL BEHAVIOR

It is known that the reporting of suicides by the media can promote other suicides – particularly using the same method or at the same location and that responsible reporting of suicide or reduced reporting can decrease suicides at 'hotspot' locations[28].

There are media guidelines on the reporting of suicide from 'The Samaritans'[29] that set out clear instructions and recommendations on what an article should contain when it reports a death by suicide.

### 14.1 Recommendation 5.1 – Encourage the appropriate and sensitive reporting of suicide

- Ensure all professionals in contact with the media are aware of guidelines for reporting suicide. Some professionals such as coroners and police may be contacted by journalists after a suicide in order to obtain details for an article to report the suicide.
- Continue to work with local media to encourage reference to and use of guidelines for the reporting of suicide. Work with Communications teams within the local authorities to encourage responsible reporting of suicide by the local newspapers.
  Highlight the following:
    - Media guidelines produced by Samaritans
    - Encourage a positive report on the deceased person
    - Do not sensationalise the suicide or suicide method
    - Protect bereaved families from intrusion – press complaints commission
    - Use of language by the media - Avoid referring to suicide in the headline of a story – it is more sensitively reported in the body of the story.
    - Avoid terms such as "successful", "unsuccessful", or "failed".

## 15 PRIORITY 6 - SUPPORT RESEARCH, DATA COLLECTION AND MONITORING

Suicide prevention relies on information about local suicides to determine who is at risk of suicide and where and how suicides happen locally. This data is important in order to focus resources. It is also important to monitor local suicides and reports of self-harm by assessing up-to-date information. This will enable appropriate response to any changes in rates of suicides and self-harm and will help to understand the impact of implementing the recommendations set out in this strategy.

To this end, the following recommendations are made:

### 15.1 Recommendation 6.1 Continue to collect detailed suicide data on a quarterly basis and carry out an annual audit of local suicides

Data should continue to be collected from Cambridgeshire and Peterborough coroners and include information on age, sex, nationality, occupation, marital status, contact with mental health services, contact with primary care services and in particular services in two weeks prior to death, place of death, resident address, method of suicide.

A suicide audit will be conducted on an annual basis and used to inform development of initiatives targeted to people at risk locally. The information contained in the audit will also be used as part of the evaluation process for this strategy.

Real-time suicide surveillance has been implemented that sends information on suspected suicides as they occur from police to public health. This enables the suicide prevention implementation group to react if necessary to any concerns, for example linked suicides, or suicide in young people that may affect other young people at school or colleges.

In addition, and as part of the Zero suicide ambition, it is proposed that a sample of suicide case files be reviewed on a quarterly basis to learn lessons and identify preventative actions that could be implemented locally.

All data is held securely by public health analysts as part of the suicide prevention partnership.

In addition to the above, CPFT will ensure they have a comprehensive, clinically rich, searchable data set collating every suicide of a patient in contact with the trust. The data from this database will be freely available to staff, patients and carers and actively used to educate staff patients and carers.

### 15.2 Recommendation 6.2 Disseminate current evidence on suicide prevention to all partner organisations

As evidence emerges on the best practice interventions and measures to reduce the risk of suicide, there should be a mechanism for ensuring that this is disseminated to all partner organisations working to prevent suicide. This may be facilitated through the suicide prevention group meetings with an assigned person responsible for checking the evidence base on a regular interval.

### 15.3 Recommendation 6.3 Coroners should notify the Suicide Prevention Strategic Group about inquest evidence that suggests patterns and suicide trends and evidence for service development to prevent future suicides

Coroners are best placed to review and assess evidence during the year as inquests to suicides occur. This may provide opportunities to identify concerns about local suicides – patterns or trends, for which action may be required. In addition, coroners may highlight concerns about services or opportunities to improve services where failings have occurred.

## 16 EVALUATION – HOW WILL WE KNOW WE ARE MAKING PROGRESS? Recommendation 6.4 - Evaluate and report on the suicide prevention implementation plan

Evaluation is an important component to this strategy and will provide essential information and evidence on what is effective in suicide prevention and what areas require more work or are ineffective.

A set of Key Performance Indicators will be developed to monitor the progress against the strategy and aligned with the suicide prevention implementation plan 2017 - 2020.

Public health outcome indicator 4.10[11] expects suicide rates to be reported annually based on three year rolling average rates for local populations. A baseline has been set as the average rate of

suicides for the period 2009-2011 and this should be used to compare future statistics and the impact of implementing this strategy.

Evaluation should also include surveys of various groups for effectiveness of particular actions or interventions.

- Survey of GPs
- Survey of mental health professionals
- Survey of people trained in suicide prevention
- Survey of service users

Soft data should be used as part of the evaluation – data collected by each implementation sub-group. For example; actions taken, resources disseminated or used and numbers of people reached by the initiative.

### 16.1 RESOURCES FOR IMPLEMENTING INITIATIVES TO PREVENT SUICIDE AND SUSTAINABILITY

The implementation of the strategy will require a mixture of input and work from partner organisations, cultural and organisational change and funding for the delivery of specific initiatives.

Implementation of the recommendations and action plan will be managed by a joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. Multi-agency working across all sectors, from NHS and mental health professionals to voluntary organisations, will be encouraged in order to utilise expertise from these organisations to implement the proposed initiatives.

Continuing engagement with service users and their carers is expected for the successful development, implementation and delivery of initiatives in each priority area.

## 17 REFERENCES


1. National Strategy: Preventing Suicide in England, 2012: http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf
2. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives https://www.gov.uk/government/publications/suicide-prevention-third-annual-report

   Support after a suicide: A guide to providing local services https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providing-local-services
3. Cambridgeshire and Peterborough Clinical Commissioning Group Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016 http://www.cpft.nhs.uk/Downloads/rod%20files/2013_0816_CCG_Adult_MH_Commissioning_Strategy_2013_FINAL.pdf
4. JSNA Cambridgeshire – health and wellbeing strategy see: http://www.cambridgeshire.gov.uk/info/20116/health_and_wellbeing_board

5. JSNA Peterborough Mental Health http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Mental%20Health.pdf
6. Suicide Prevention Strategy CPFT 2013-2016 (closed document ) – for details please contact author or CPFT
7. Emotional well-being and mental health strategy for children and young people 2014-2016 (draft strategy)
8. Suicides in students http://www.ons.gov.uk/ons/about-ons/what-we-do/publication-scheme/published-ad-hoc-data/health-and-social-care/november-2012/index.html
9. National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2013 http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf
10. Samaritans report –men suicide and society: http://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf
11. No health without mental health: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf
12. Public Health Outcomes Framework https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf
13. Mental Health Crisis Concordat – Improving outcomes for people experiencing mental health crisis, February 2014. Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
14. Annual Report of the Chief Medical officer 2013 – Public Mental Health Priorities: Investing in the Evidence https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf
15. Saving Lives: Our Healthier Nation; Department of Health, 1999: https://www.gov.uk/government/publications/saving-lives-our-healthier-nation
16. Detroit model for suicide prevention: http://zerosuicide.actionallianceforsuicideprevention.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/PerfectDepressionCarearticles.pdf
17. ASIST suicide prevention training: http://www.chooselife.net/Training/asist.aspx
18. Mental Health First Aid training England: http://mhfaengland.org/
19. Suicide in primary care in England 2002-2011[18] http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/SuicideinPrimaryCare2014.pdf
20. Knapp et al 2011, Mental health promotion and prevention: The economic case. http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf
21. The Use and Impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation Social research: The Scottish Government, http://www.chooselife.net/uploads/documents/19-ASISTEvaluationFullReport.pdf
22. Bickley, H et al 2013; Suicide within two weeks of discharge from psychiatric inpatient care. A case control study Psychiatric Services 2013 http://ps.psychiatryonline.org/article.aspx?articleID=1673604
23. Cox et al 2013; Interventions to reduce suicides at suicide hotspots: a systematic review BMC Public Health 2013, 13:214 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3606606/pdf/1471-2458-13-214.pdf

24. Mann et al, 2005 Suicide Prevention Strategies: A systematic Review. *JAMA.* 2005;294(16):2064-2074
25. We are in your corner – Samaritans: http://www.samaritans.org/media-centre/our-campaigns/were-your-corner
26. MHRA – Best practice for the sale of medicines for pain relief - http://www.mhra.gov.uk/home/groups/pl-p/documents/websiteresources/con065560.pdf
27. Hawton K, Bergen H, Simkin S et al (2010) Toxicity of antidepressants: rates of suicide relative to prescribing and non-fatal overdose. *British Journal of Psychiatry* 196: 354-358
28. 'Help is at hand' a resource for people bereaved by suicide and other sudden, traumatic death http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
29. Preventing Suicide - A Resource for Media Professionals: A resource guide produced by the Department of Mental Health at the World Health Organization in 2000. http://www.who.int/mental_health/media/en/426.pdf
30. Media guidelines for reporting suicide – Samaritans: http://www.samaritans.org/sites/default/files/kcfinder/files/press/Samaritans%20Media%20Guidelines%202013%20UK.pdf
31. NHS England and Public Health England 'A call for Action: Commissioning for Prevention' November 2013. Available at: www.england.nhs.uk
32. WHO For which strategies of suicide prevention is there evidence of effectiveness http://www.euro.who.int/__data/assets/pdf_file/0010/74692/E83583.pdf

**APPENDIX 1**

**Examples of Suicide Prevention Protocols for specific professional groups**

1. **Suicide Prevention Pathway developed by Peterborough MIND -**Peterborough and Fenland Mind Suicide Protocol

mind for better mental health | Peterborough and Fenland

**Who should you call is you are faced with a Suicidal Person (SP)?**

Rarely a SP may behave out of control on in a way suggesting harm to themselves or others. If this is the case you should call the Police on 999. See *point 1* if this is the case.

Normally the SP will speak of thoughts or plans of suicide alone and appear distressed. If this is the case see *point 2* for the key questions you need to ask.

Point 1
The police are able to detain someone under the Section 136 of the Mental Health Act if they believe the SP to have a 'mental disorder' and are in need of immediate need of care and control.

They will first remove the SP to a place of safety, preferably a hospital or police station where they will be held until approved by an Approved Mental Health Professional. One or two doctors will also assess the SP for up to 72 hours.

Point 2
If you feel the person is distressed and can be spoken through what they are experiencing you should stay calm, show interest and concern, not show judgement or shock. You should be positive that the right help they can feel better.

You should then encourage them to see their GP as a matter of priority whilst still addressing non-medical concerns. The agreed response you need here is for the person to let you contact their GP. The SP may suggest this is pointless but nevertheless it should be the first port of call unless consent is firmly withheld. If you are given consent see point 4, if you are not see point 3.

Point 3
If the SP refuses for you to get in contact with their GP then you must respect their request for confidentially. You should then offer the SP a 'Feeling on the Edge' leaflet and tell them they can return to you if they decide they want help from the service to access their GP. The expectations to this strict rule are (a) Imminent threat of self- harm, then call the police (b) Vulnerable Adult such as Dementia, Learning Disability or Abused Domestic Violence when a SOVA approach is required.

Point 4
If you are given consent you should then ring the GP and explain to the receptionist who you are, who the SP is and why you are calling. They should use a password (perhaps a Suicide Prevention Alert) and ask to speak to the Duty GP.
The GP will speak to you and they should use their professional judgement and personal knowledge to decide on the best pathway which will often result to a same day appointment. If the GP cannot speak to you immediately then you are to ask for a ring back and an urgent same day appointment for the SP.

If the surgery is uncooperative or unresponsive and you feel they are still carrying the risk then they should log the experience and feedback to the Administrators as a possible Quality Issue and also ring ARC for assistance.

Appendix 1

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| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 10 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Wendi Ogle-Welbourn, Executive Director People and Communities Cambridgeshire and Peterborough Councils and Dr Liz Robin, Director of Public Health | |
| Cabinet Member(s) responsible: | Cllr Wayne Fitzgerald | |
| Contact Officer(s): | Helen Gregg, Partnership Manager, Peterborough and Cambridgeshire Councils | Tel. 863618 |

# CQC AREA REVIEW BRIEFING

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Executive Director People and Communities Cambridgeshire and Peterborough Councils and Director of Public Health | **Deadline date: N/A** |
| The Health and Wellbeing Board is asked to note the report for information only | |

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board at the request of the Executive Director for People and Communities Cambridgeshire and Peterborough Councils and the Director of Public Health.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this briefing is to provide the Health and Wellbeing Board with information on the CQC Area Reviews.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference Numbers: 2.8.3.1.:

*To keep under consideration, the financial and organisational implications of joint and integrated working across health and social care services, and to make recommendations for ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.*

## 3. TIMESCALES

| | | | |
|---|---|---|---|
| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | N/A |

## 4. BACKGROUND AND KEY ISSUES

4.1 Following the budget announcement of additional funding for adult social care, CQC has been requested by the Secretary of State for Health to undertake a programme of targeted reviews in local authority areas. These reviews will be focussed on the interface of health and social care.

Reviews will look at the quality of the interface between health and social care and the arrangements and commitments in place to use the Better Care Fund to reduce delays in transfer of care. This will be a system-wide review, not just social care.

The reviews will look specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. The findings will be reported to the Health & Wellbeing Board.

The reviews will also consider pressure points such as

- Maintenance of peoples health and well-being in their usual place of residence
- Multiple confusing points to navigate in the system
- Varied access to GP/Urgent Care centres/Community health services/social care
- Varied access to alternative hospital admission
- Ambulance interface
- Voluntary sector interface
- Discharge planning delays and varied access to ongoing health and social care
- Varied access to reablement and Intermediate Care Tier services
- Transfer from reablement and Intermediate Care Tier services

They will make an assessment of the governance in place for the management of resources and scrutiny of local authorities plans for use of better care fund money.

20 “challenged” areas in total will be reviewed by the CQC. These reviews will predominantly focus on areas that have been deemed to be underperforming by Government based upon published Local Authority Performance Metrics which are weighted in order to make Delayed Transfers of Care the main focus.

The first tranche of reviews (Oxfordshire, Birmingham, East Sussex, York, Coventry, Plymouth, Hartlepool, Bracknell Forest, Manchester, Halton, Trafford, Stoke-on-Trent), are expected to be completed by December 2017. The remaining 8 areas, which have yet to be announced, are scheduled to be completed by April 2018. It is possible that Cambridgeshire and/or Peterborough will be one of the remaining 8 areas. Halton was one of the first areas to be reviewed and a copy of the published report is included as Appendix 2.

The reviews will be used to inform decisions about future Government social care grants to councils and how to plan for handling winter pressures. Poor performance will be highlighted and findings will be reported to the Health and Wellbeing board. “Support” for improvement will be provided where needed along with possible financial sanctions for authorities which don’t improve.

The team of reviewers would be approximately 12. Meetings with groups of service users and other local partners would take place between notification and a fortnight before the review week itself. The usual dip sampling case tracking and “well-led” interviews would take place during the review week and a report would be published by 14 weeks after the notification date.

It is likely that if a review is conducted, members of the Health and Wellbeing Board will be interviewed and involved in workshops and focus groups.

The reviews would look at partnership working, and views in the NHS as to whether they are confident the money given to social care will have the required impact on reducing DTOC, whether there is an explicit agreement from social care to use funding for this purpose and whether all NHS partners have been included in discussions. These focus areas are surmised

from the headlines in the recent Winter Warnings report which raises NHS concerns about plans to deal with winter pressures.

In order to prepare for a potential review, a countywide steering group (Peterborough and Cambridgeshire) has been set up which will meet monthly to cover key preparations to include the local system overview information request, relational audit (survey), data metrics, collating supporting evidence documentation, pulling together the onsite programme, case studies, case auditing etc. (NB: preparations would be complementary to any other CQC inspections of NHS providers). Membership of the group includes senior management staff from both Cambridgeshire and Peterborough local authorities, Cambridgeshire & Peterborough CCG, North West Anglia NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust, Sustainable Transformation Programme, Cambridgeshire and Peterborough Foundation Trust.

## 5. CONSULTATION

5.1 The Integrated Commissioning Board is the governing board that would monitor the preparations. Briefing presentations would be made to the A&E Delivery Board and NWAFT as well as a programme of communications to prepare staff from across the various organisations as well as service users/patients, providers and GPs.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The Board is asked to note the report for information only.

## 7. REASON FOR THE RECOMMENDATION

7.1 To ensure the Health and Wellbeing Board members are briefed on a possible CQC Area Review in Peterborough.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 N/A

## 9. IMPLICATIONS

### Financial Implications

9.1 There are no financial implications associated with this report.

### Legal Implications

9.2 There are no legal implications associated with this report.

### Equalities Implications

9.3 There are no equality implications associated with this report.

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 N/A

## 11. APPENDICES

11.1 Appendix 1 CQC Area Review Presentation
Appendix 2 Halton Report

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# Local System Reviews

# Version 16

**2017/07/19 Board update**

# Introduction

- Introduction
- Scope
- Review methodology
- Review approach
- Data

# Introduction: CQC Local System Reviews

- Following the budget announcement of additional funding for adult social care, the Department of Health has asked CQC to undertake a programme of targeted reviews in local authority areas.

- Each review will answer the question:

  ***How well do people move through the health and social care system, with a particular focus on the interface between the two, and what improvements could be made?***

- We want to answer:

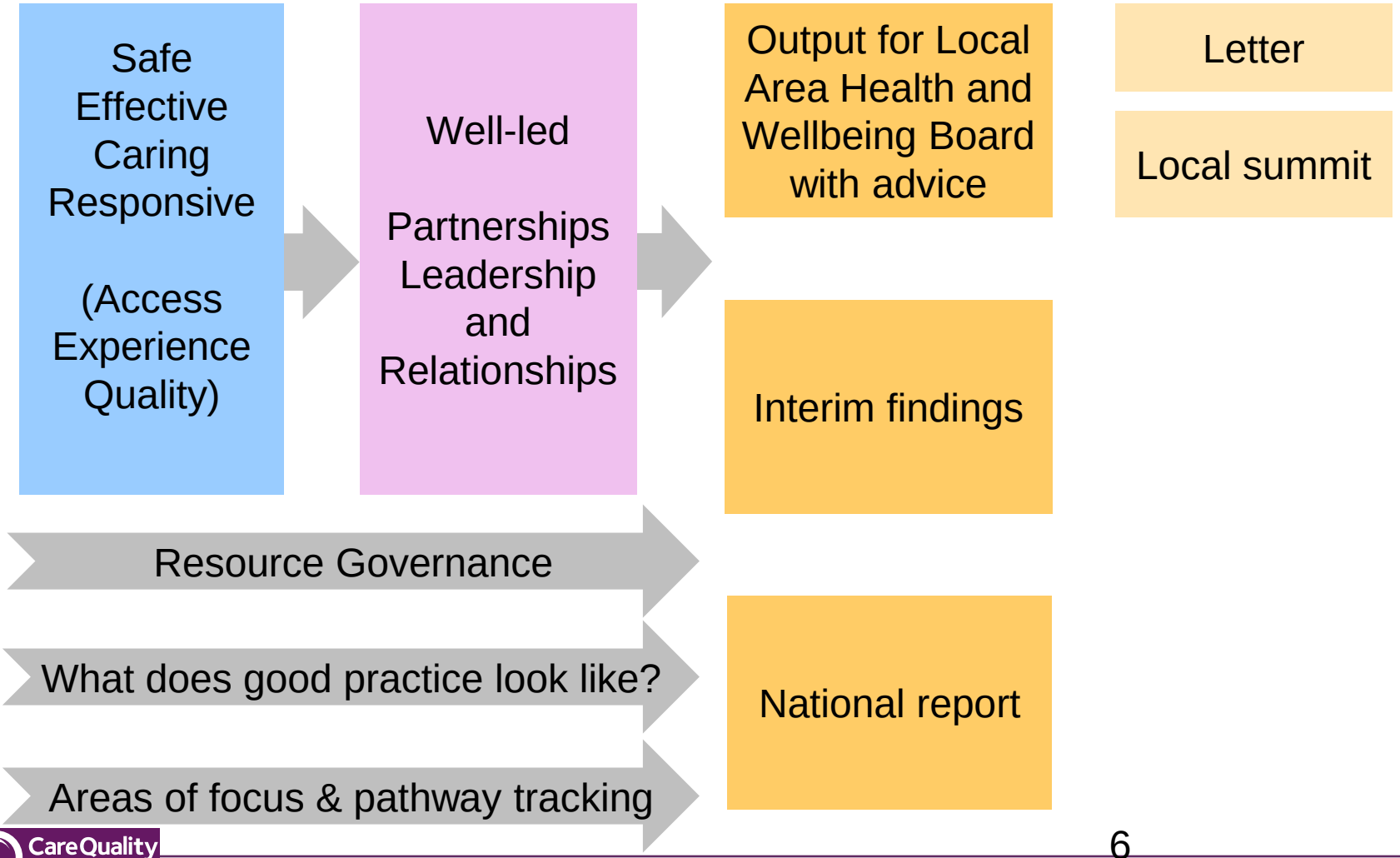
  - What is currently happening and what are the outcomes for people who move through the system?
  - What is the maturity of the local area to manage the interface between health and social care moving forward?
  - What else needs to happen?

# Review methodology

# Methodology

- We have developed the methodology using::
- CQC tools:
    - Provider inspection findings and reports
    - Quality in a Place Framework (year 1)
    - Quality in a Place Frameworks (year 2 – Cornwall/Sutton)
    - Integrated Care for Older People
    - Tools from thematic reviews
- Wide range of external documents and tools developed
- Co-production across professionals and people who use services, their cares and families
- Walk through with Hertfordshire County Council which added a further focus on well-led, workforce, the relationship audit and the system overview document.

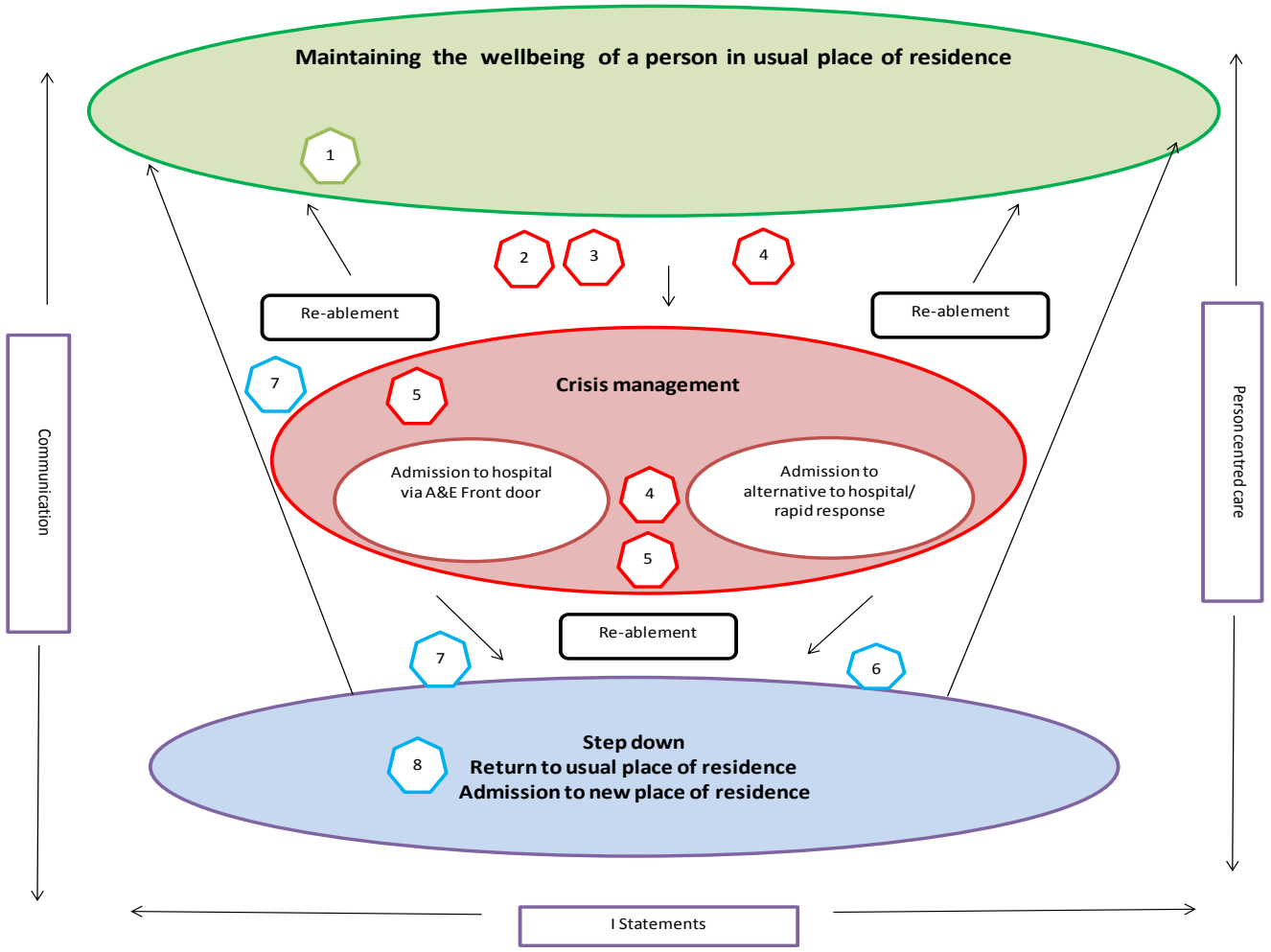
# Areas of focus: KLOES



# Pressure points

## Pressure Points:

1. Maintenance of peoples health and well being in their usual place of residence
2. Multiple confusing points to navigate in the system
3. Varied access to GP/ Urgent Care centres/ Community care/ social care
4. Varied access to alternative hospital admission
5. Ambulance interface
6. Discharge planning delays and varied access to ongoing health and social care
7. Varied access to re-ablement
8. Transfer from re-ablement



# Areas of Focus to underpin KLOEs : Key system pressure points

**Pressure Points:**

1. Maintenance of peoples health and well being in their usual place of residence
2. Multiple confusing points to navigate in the system
3. Varied access to GP/ Urgent Care centres/ Community care
4. Varied access to alternative hospital admission
5. Ambulance interface
6. Discharge planning delays and varied access to ongoing health and social care
7. Varied access to re-enablement
8. Transfer from re-enablement

- Maintaining wellbeing
- Crisis episode
- Discharge, step down, re-ablement

**I statements - Person centred coordinated care**

***"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."***

# Methodology Key Lines of Enquiry

Overarching questions?

***How well do people move through the health and social care system, with a particular focus on the interface and intraface, and what improvements could be made?***

**Safe**

KLOE 1: Are people using services supported to move safely across health and social care to prevent avoidable harm?

**Effective**

KLOE1: How effectively are the services commissioned and delivered across the interface between health and social care in improving health and wellbeing and maximising independence?

# Methodology

## Caring

KLOE 1:Do people experience a compassionate, high quality and seamless service across the system which leaves them feeling supported and involved in maximising their wellbeing?

## Responsive

KLOE 1:To what extent are services across the interface between health and social care responsive to people's individual needs?

# Methodology

**Well led**

KLOE 1:Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

KLOE 2: What impact is governance of the health and social care interface having on quality of care across the system?

KLOE 3: Is commissioning of care across the health and social care interface well led, demonstrating a whole system approach and evidence based?

KLOE 4: To what extent is the system working together to develop its health and social care workforce to meet the needs of its population

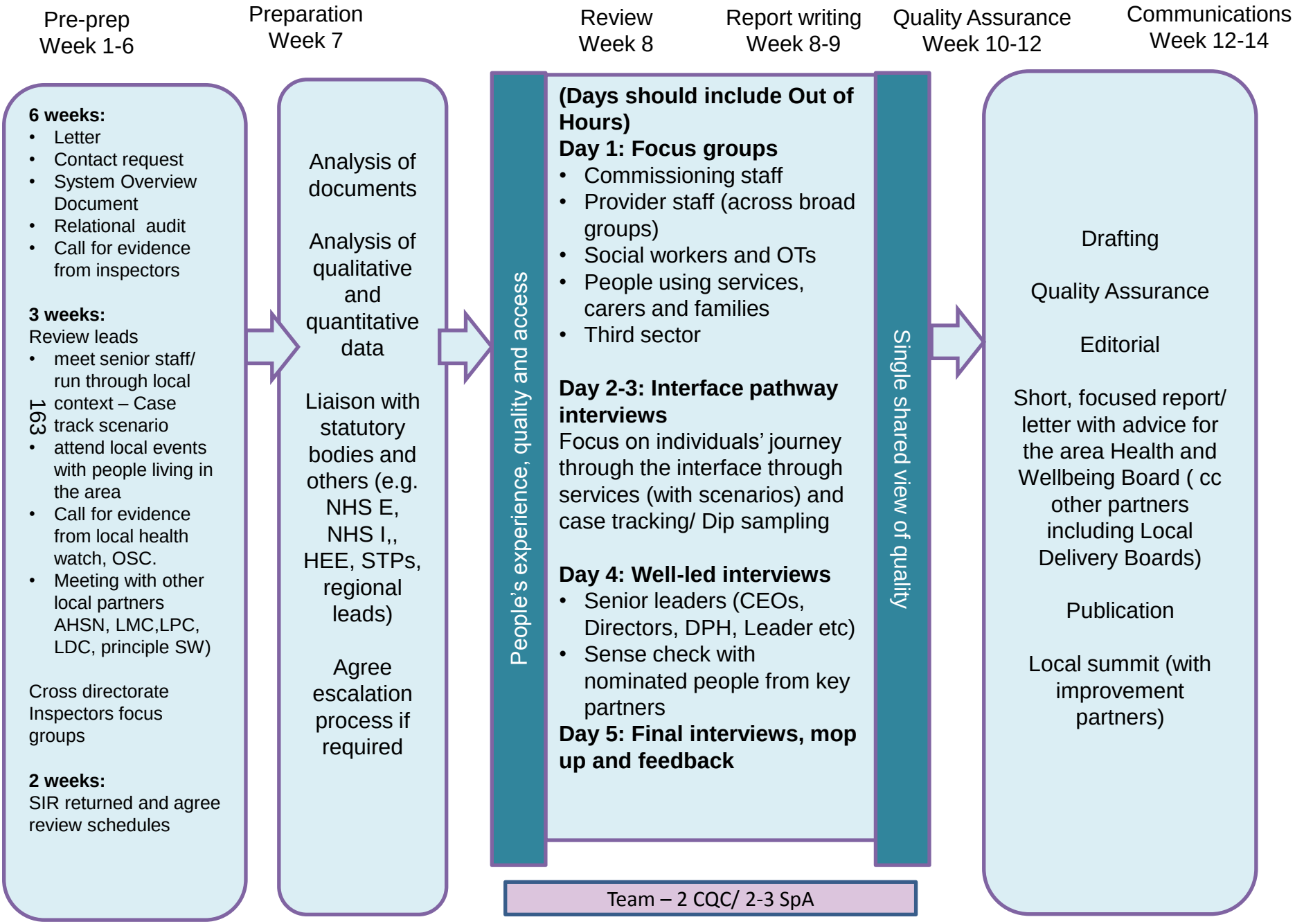
**Resource Governance**

KLOE1 : How is the system managing its resources to achieve sustainable high quality care and promoting peoples independence?

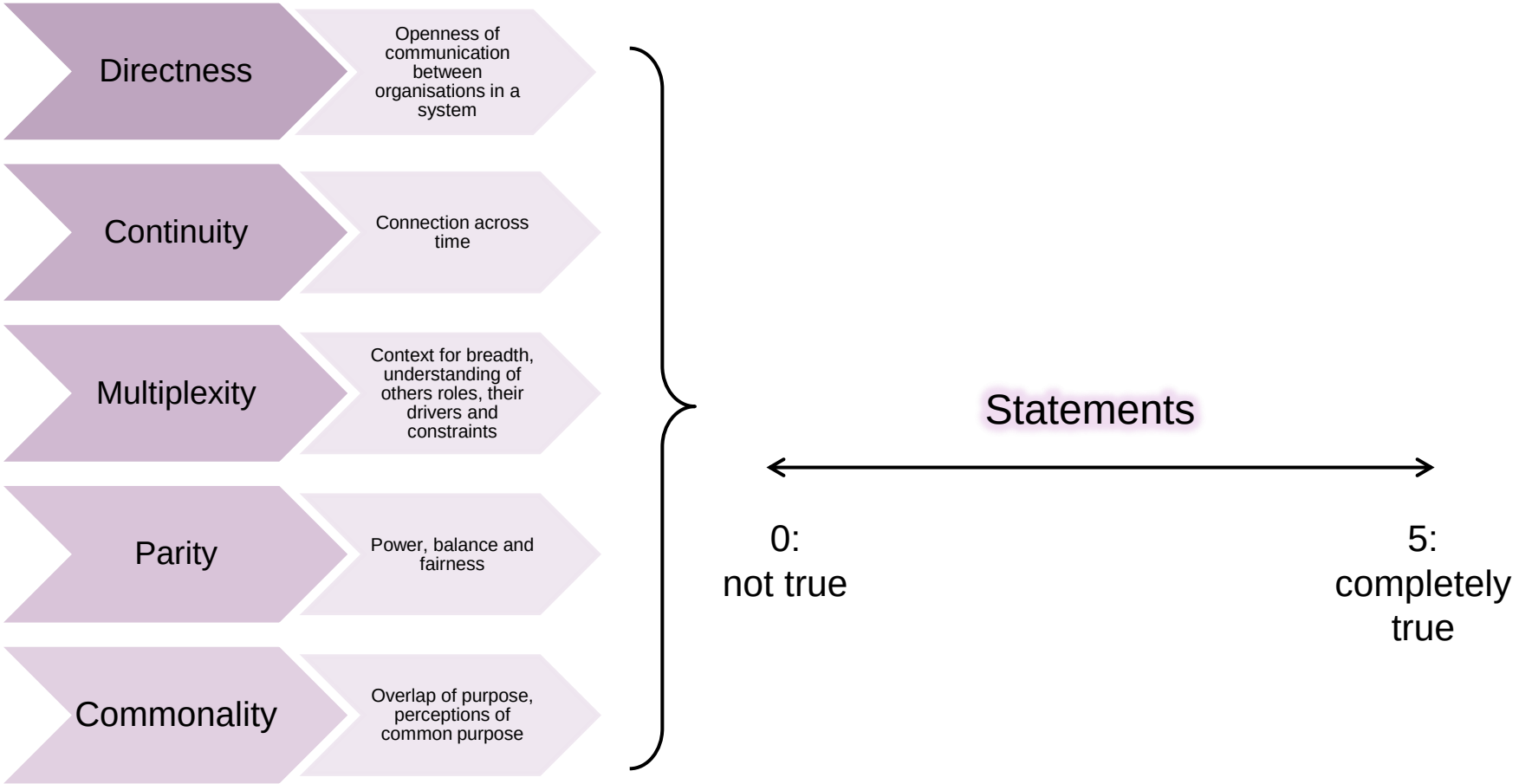
# Review approach

- Review approach
- Relational Audit

# Provisional review methodology



# Relational Audit



# Appendix

- Data

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# Data Profiles

- To support the review, (as well as longer-term ‘Place’-based fieldwork and BAU cross-sector working), Intelligence is developing area-level data profiles containing cross-sector analysis.

- Data profiles will feature analysis of a range of quantitative metrics. Qualitative information gathered via the System Information Return will be appended to the profiles.

- The analysis included with the profiles will reflect and build on the analysis DH undertakes to select the areas for the review. Our analytical approach will align with DH’s to ensure we reflect a consistent view of system performance. CQC has been involved in discussions with DH to advise on the measures and analytical approach. The final list of measures and detailed analytical methodology will be supplied by DH shortly.

- Data profiles will be developed iteratively, with profiles for the earlier local authorities focused around a list of high-priority measures. Profiles for later local authorities will include additional analysis

# Data Profiles – High Priority Metrics

| Demographic Context | Quality of Service | Activity/Flow through System |
|---|---|---|
| • % Population aged 65+<br>• % Population White British<br>• IMD quintile | • CQC Area Ratings Score<br>• Overall Provider Ratings by Sector<br>• Change in ratings by Sector | • A&E 4 hour waits<br>• Emergency admissions per 1000 18+ (*DH metric*) and 65+ and from care home postcodes<br>• % admissions with LOS >7days (18+, 65+ and from care home postcodes)<br>• Percentiles LOS for emergency admissions (*DH metric*)<br>• Total DTOC days per 100,000 (*DH metric*)<br>• DTOC days attributable to NHS/ASC/Both and DTOC by reason for delay<br>• Emergency readmissions 65+ (*DH metric*) and from care home postcodes<br>• Proportion of discharges which occur at the weekend vs weekday<br>• Proportion of 65+ discharged from hospital into reablement/rehabilitation services, and those that were still at home 91 days after discharge (*DH metric*)<br>• Key Ambulance System Performance Indicators |

# Data Profiles – High Priority Metrics

## System Provision /Capacity

- Acute Hospital Bed Occupancy
- Capacity per 100,000 pop (aged 65+) of Residential, Nursing and Community (DCA) ASC Services
- ASC Entries and Exits (% increase/decrease in Residential and Nursing home beds and DCA services over last 2 years)
- Patients per FTE GP & Nurse
- NHSE Primary care access: Extended access to GP services on a weekend and evening (*DH metric*)

## Staffing

- Services that are missing a registered manager
- Turnover of registered managers
- The professional and caring staff vacancy and turnover rate within ASC services

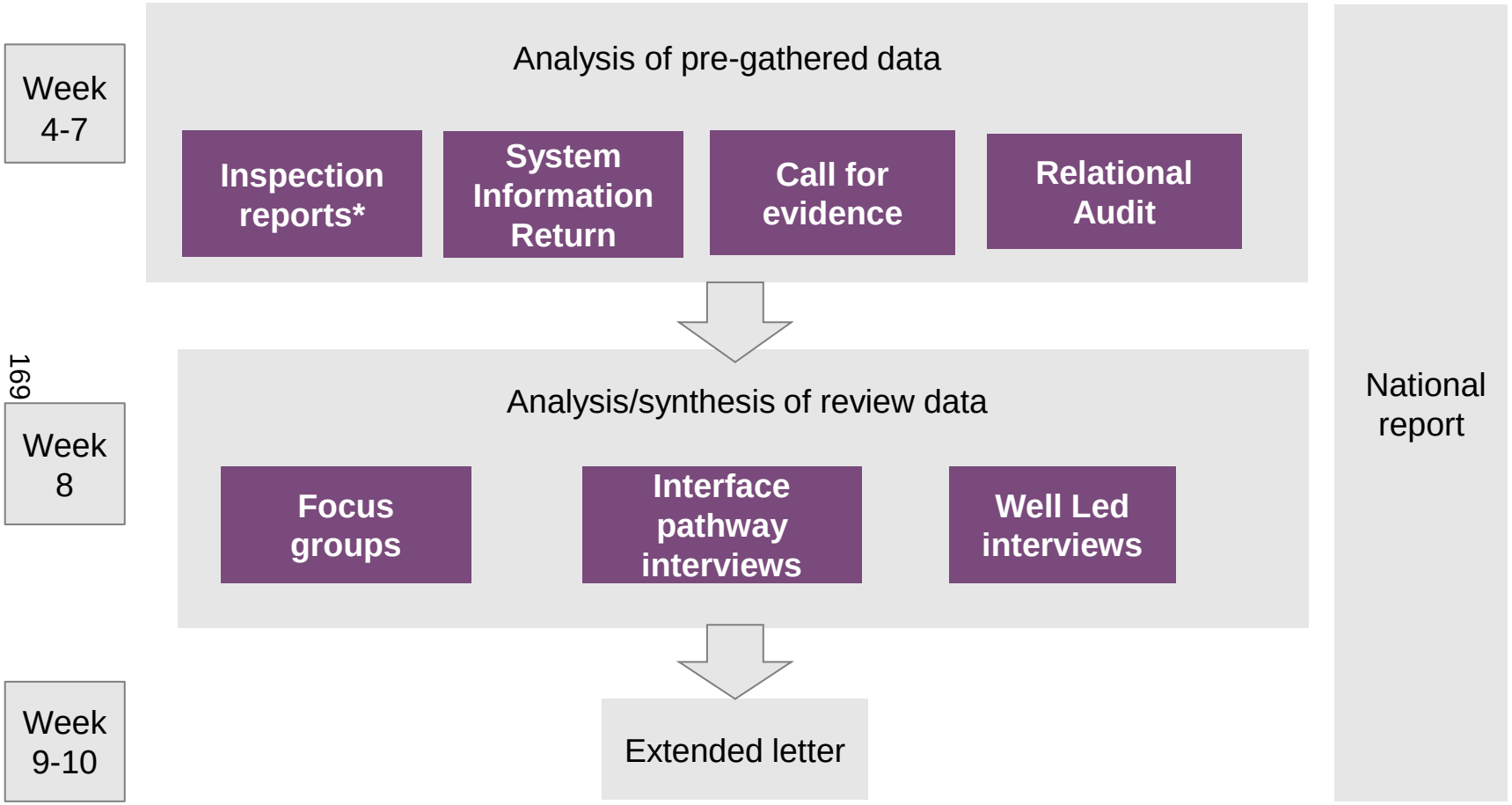
## Funding

- % of ASC services that are fully self-funded vs % of services that are LA funded.
- Surplus /deficit by NHS hospital provider
- Average GP pounds per patient

## Service User Experience

- Health-related quality of life for people with long-term conditions
- Proportion of people feeling supporting to manage their long-term condition (*DH metric*)
- Social care-related quality of life score (*DH metric*)

# Qualitative data analysis






* The feasibility of analysing inspection reports as part of the preparation stage is currently being scoped

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# Halton

## Local system review report

## Health and Wellbeing Board

Date of review:
21-25 August 2017

## Background and scope of the local system review

This review has been carried out following a request from the Secretaries of State for Health and Communities and Local Government to undertake a programme of 20 targeted reviews of local authority areas. The purpose of this review is to understand how people move through the health and social care system with a focus on the interfaces between services.

This review has been carried out under Section 48 of the Health and Social Care Act 2008. This gives CQC the ability to explore issues that are wider than the regulations that underpin our regular inspection activity. By exploring local area commissioning arrangements and how organisations are working together to develop person-centred, coordinated care for people who use services, their families and carers, we are able to understand people's experience of care across the local area, and how improvements can be made.

This report is one of 20 local area reports produced as part of the local system reviews programme and will be followed by a national report for government that brings together key findings from across the 20 local system reviews.

## The review team

Our review team was led by:
**Delivery Lead:** Ann Ford, CQC
**Lead Reviewer:** Wendy Dixon, CQC

The team also included:

- Members of the executive team
- Three CQC reviewers,
- Two CQC strategy leads,
- One CQC analyst,
- One CQC Expert by Experience; and
- Three specialist advisors (two former local government directors of social service and one Clinical Commissioning Group board member).

## How we carried out the review

The Local System Review considered system performance along a number of **'pressure points'** on a typical pathway of care with a focus **on older people aged over 65.**

We also focussed on the interface between social care, general medical practice, acute and community health services, and delayed transfers of care from acute hospital settings.

Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across three key areas:

1. Maintaining the wellbeing of a person in usual place of residence
2. Crisis management
3. Step down, return to usual place of residence and/ or admission to a new place of residence

Across these three areas, detailed in the report, we have asked the questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?

We have then looked across the system to ask:

- Is it well led?

Prior to visiting the local area we developed a local data profile containing analysis of a range of information available from national data collections as well as CQC's own data. We requested the local area provide an overview of their health and social care system in a bespoke System Overview Information Return (SOIR) and asked a range of other local stakeholder organisations for information. We also developed two online feedback tools; a relational audit to gather views on how relationships across the system were working, and an information flow audit to gather feedback on the flow of information when older people are discharged from secondary care services into adult social care[1].

During our visit to the local area we sought feedback from a range of people involved in shaping and leading the system, those responsible for directly delivering care as well as those who use services, their families and carers. The people we spoke with included:

- Staff members including social workers, GPs, discharge coordinators, therapists and nurses
- Senior leaders and managers in the local authority, the Clinical Commissioning Group (CCG), Warrington and Halton Hospitals NHS Foundation Trust, St Helen's and Knowsley Teaching Hospitals NHS Trust, Bridgewater Community Healthcare NHS foundation Trust, the North West Ambulance Service and North West Boroughs

- Local Healthwatch, voluntary and community sector (VCS) services
- Local Residents attending the Halton Direct Link service (the local authority's walk in advisory service)
- Service users in the acute hospitals in both A&E and the discharge lounges

We reviewed 26 care and treatment records and visited nine services in the local area including acute hospitals, intermediate care facilities, a hospice, a care home, a nursing home and 2 GP practices.

# The Halton context

**Demographics**

- 15% of the population is aged 65 and over.
- 98% of the population is categorised as White.
- Halton is in the most deprived 20% of local authorities in England.

**Adult Social Care**

- 18 active residential care home locations:
  - 17 rated good
  - 1 rated requires improvement
- 8 active nursing care home locations:
  - 5 rated good
  - 3 rated requires improvement
- 5 active domiciliary care agencies:
  - 4 rated good
  - 1 rated requires improvement

**GP Practices**

- 12 GP practices rated good
- 1 GP practice rated outstanding
- 2 are currently unrated

**Acute and community Healthcare**

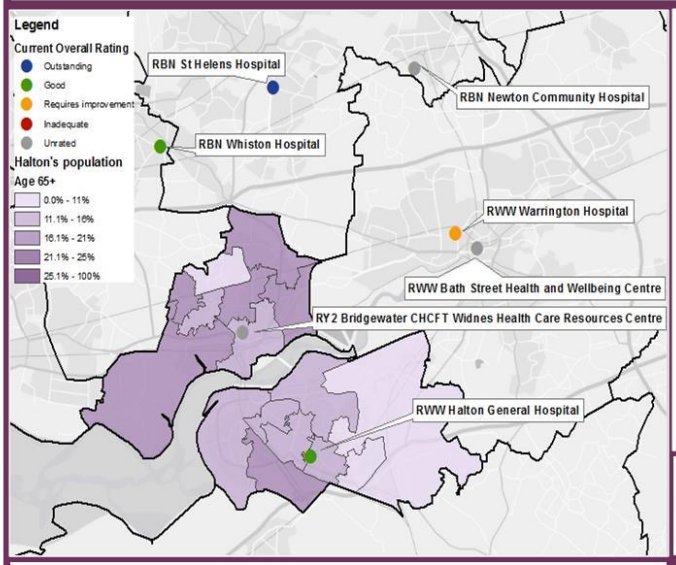
Hospital admissions (elective and non-elective) from Halton are largely split between two NHS acute hospital trusts:

- Warrington and Halton Hospitals NHS Foundation Trust (RWW)
  - Receives 49% of Halton's admissions
  - Admissions from Halton make up 25% of the trust's admissions
  - Currently rated Requires Improvement overall
- St Helens and Knowsley Teaching Hospitals NHS Trust (RBN)
  - Receives 43% of Halton's admissions
  - Admissions from Halton make up 16% of the trust's admissions
  - Currently rated Good overall

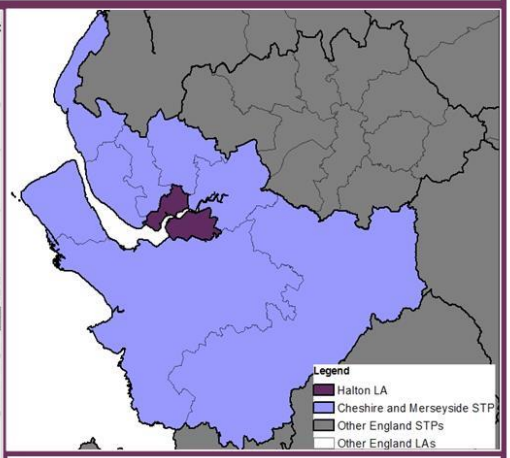
Community services are provided by:

- Bridgewater Community Healthcare NHS Foundation Trust (RY2) - currently rated requires improvement overall.

*Acute and Community hospital locations as at 29/09/2017; ASC and PMS locations as at 29/09/2017*
*Admissions percentages from 2015/16 Hospital Episode Statistics.*




Map 1: Population of Halton aged 65+ and location and current rating of acute and community healthcare organisations serving Halton.




Map 2: Location of Halton LA within Cheshire and Merseyside STP. Halton CCG and the HWB cover an almost identical footprint.

## Summary of findings

**Is there a clear shared and agreed purpose, vision and strategy for health and social care?**

- Overall, there was a strong commitment from the local authority (LA) and the clinical commissioning group (CCG) to serve the people of Halton well.
- The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by their staff at a managerial and operational level. There were also well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority underpinned by a high level of trust.
- Local NHS acute trusts, although not located in the borough, participated in the wider system planning.
- As there was not yet a cohesive interface or alignment between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and a developing accountable care system, there were opportunities for system partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the system footprint.
- Work was required to develop a wider system vision for the STP footprint and develop a common framework for prioritising actions, and for specifying accountabilities and shared governance arrangements.
- This was recognised by the system leaders who were working towards a more robust approach to alignment at the time of our review.
- There was agreement across partners to develop an accountable care system (ACS) in the future, however this agreement had not yet manifested into detailed plans and actions. Discussions were ongoing at the time of our review.

**Is there a clear framework for interagency collaboration?**

- There were well established, positive relationships across the health and social care system with a shared dialogue between the CCG and the local authority, underpinned by a high level of trust.
- The Joint Strategic Needs Assessment (JSNA) was well thought out and had underpinned operational delivery plans and desired outcomes .All partners were sighted on what was important to older people and carers when moving through the interface of health and social care. There was a specific JSNA for older people and there was good evidence of partners meeting individuals'

needs in terms of health and wellbeing, social inclusion, social prescribing and transport. However, a joint commissioning strategy for older people's service provision had not yet been fully developed.

- There was evidence of robust analysis of need to support resource allocation and the setting of priorities within the local authority and the CCG. The local authority had a strong track record of financial management and delivering services for older people based on quality outcomes within budget.

- Joint preventative approaches were well thought through and embedded. There was a wide range of effective initiatives that were supporting people to remain socially included, maintain their own health and manage their long term conditions.

- There were some excellent examples of shared approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person-centred way.

- The seven-day Rapid Access Re-ablement Service (RARS) and the five- day Rapid Clinical Assessment Team (RCAT) had been developed to reduce avoidable hospital admissions, which in 2016/17 had been above the comparator average. Similarly the numbers of delayed transfers of care were higher than the comparator average for the same period. System leaders were confident that the recently implemented RARS and RCAT teams' approach, coupled with the implementation of elements of the high impact change model, would secure improved performance in respect of avoidable admissions and further reductions in the numbers of delayed transfers of care.

- It was evident from the range of joint initiatives from the local authority and the CCG that there was a shared understanding and collective responsibility for meeting the needs of the local population. There was a strong commitment from partners to work collaboratively and efficiently for the benefit of local people.

- We found that the Health and Wellbeing board provided senior officers with high levels of support. However, as a forum to challenge and support the system's joint strategic approach, the Health and Wellbeing Board lacked rigour and required improvement to support and challenge the local system's transformation agenda and monitor progress more robustly.

- We found examples of poor monitoring of commissioned services which were having an impact on the quality of service provision, such as the intermediate care service provided at Warrington and Halton NHS Foundation Trust.

- Initiatives were not always connected and joined up to inform whole system performance. For example, GP practices were not always aligned with the system wellbeing strategies for example the enhanced care home model was not fully embedded with all GP practices

- Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population,

below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support and maintain further reduction. Some people with complex needs were experiencing considerable delays.

- The local authority and CCGs had transformation plans for domiciliary care and care home provision in Halton. Both these elements of provision were challenged in terms of their capacity to meet demand

**How are interagency processes delivered?**

- The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach by the STP.

- There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.

**What are the experiences of front line staff?**

- Senior leaders were visible, accessible and approachable.

- Staff felt supported by their line managers and were encouraged to influence the design and delivery of services.

- There were systems and processes in place to support staff development and professional competence.

- There was work planned with staff in the independent sector in terms of promoting peoples safety and injury prevention.

- There was good support available to staff underpinned by regular training to manage adult safeguarding issues including issues of abuse and neglect.

- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support interagency and multi-disciplinary working and encourage staff to work in cohesive teams.

- We found a range of support services that encouraged staff to work across organisational boundaries to better provide holistic care to people requiring services

## What are the experiences of people receiving services

- The experiences of people receiving services in Halton varied.
- We found a very positive approach to maintaining people's health and wellbeing in their own homes and services designed for older people to keep them socially included, active and able to manage their long term conditions.
- There were some excellent examples of social prescribing that helped people deal with bereavement, loneliness and concerns about their safety at home.
- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person-centred assessments, including those for people experiencing memory loss. Clinical, social and cultural information was included in assessments which covered all aspects of what was important in people's lives. Care plans were developed with the inclusion of the person, their families and carers.
- Halton had a high uptake of personal health budgets and direct payments for all adults compared to the England average and Cheshire and Merseyside regional average. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments.
- The local authority provided good support to carers with input from the carer's centre that supported approximately 5000 carers, including 528 carers supporting people living with dementia.
- However, some older people from the Halton area had less satisfactory experiences when they were admitted to hospital; they were often experiencing long waits in A&E before being admitted to a ward.
- Once ready for discharge, some older people were subject to delays in their transfer home or to a new place of residence. In some cases people had suffered avoidable harm or detriment as a result of the delays, such as the development of a pressure sore. In the main, delays were attributed to the lack of provision of care packages in the community or the availability of long term care placements.
- In response there were a number of new initiatives planned to improve the experience of older people and at the time of our review performance in delayed transfers of care was improving. Nevertheless further work was required to maintain this improvement and ensure that delays did not increase as a result of winter pressures.
- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget that had been established for a number of years. Securing CHC funding was not considered to be a primary cause of delayed transfers of care. The NHS CHC figures for all adults showed that in Q1 2017/18 both the referral conversion rate (% of newly eligible cases of total referrals completed) and assessment conversion rate (% newly eligible cases of total cases assessed) were higher than the

England and Cheshire and Merseyside regional averages. This indicated that Halton's processes for identifying people eligible for CHC were working well. However, there were delays in completing the process as the data for all adults in Q1 2017/18 also showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.

## Are services in Halton well led?

### Is there a shared clear vision and credible strategy which is understood across health and social care interface to deliver high quality care and support?

*As part of this review we looked at the strategic approach to delivery of care across the interface of health and social care. This included strategic alignment across the system, joint working, inter-agency and multi-disciplinary working and the involvement of people who use services, their families and carers.*

*We did not find a cohesive interface between the local authority' and CCG vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and the emergent accountable care system (ACS).*

*The local authority and CCG had a clear vision for the borough that had been shared with its strategic partners and was well understood by its staff at a managerial and operational level. There was a strong commitment to joint working across the health and social care system. Leaders were visible and accessible, staff felt engaged and included in planning for the future. They were well supported by leaders in the development and design of services.*

**Strategy, Vision and partnership working**

- We did not find a cohesive interface between the local authority's and CCGs vision for the borough, the Local Delivery System (LDS), the Sustainability and Transformation Plan (STP), and the emerging plans for an accountable care system (ACS).

- There were opportunities for partners to think more widely and include the Local Delivery System (LDS) and the Sustainability and Transformation Plan (STP) in the overall system strategy to strengthen the position of the Halton community and give local partners a stronger voice within the wider system.

- There were a range of plans across different organisations that were targeted at achieving the strategic aims in addition to the action plan within the wellbeing strategy.

- The local authority and CCGs had a clear vision for the borough. System leaders were working to promote a wider shared vision but there was a lack of clarity on the wider system interface; some leaders referred to the vision for the borough, others to the LDS and the STP.

- Interviews with system leaders indicated that partnerships and relationships at a local level were strong, particularly between the local authority and the CCG. Primary care engagement had previously been challenging but was seen to be improving, facilitated by the GP Federations. However, improvement was needed across the system in terms of understanding the role and potential of the federations.

- A review of the minutes of the Health and Wellbeing Board and discussions with senior leaders indicated that the function of the Health and Wellbeing Board could be improved as a forum to challenge and support the system's joint strategic approach and drive changes in practice.

- There was further work to be done to strengthen the HWB Board's challenge function to ensure the change agenda is developed and implemented in a timely way.

- Capacity and demand within the hospital system was overseen at an LDS and A&E Delivery Board level. This involved predictive modelling of activity, links to the A&E work streams and the wider out of hospital demand management work within the Local Alliance. The Local Delivery System (LDS) is the system that will deliver the Sustainability and transformation plans (STPs) developed for the area of Halton and make them operational.

- Planning for winter pressures was aligned with the North West boroughs and local plans had started via the A&E Delivery Board in the weeks prior to our visit. The local authority's divisional manager was also the urgent care lead for the local authority and the CCG, and was an active member of the Mid Mersey A&E Delivery Board, representing both organisations. This appointment was well received at an operational level and the divisional manager was seen as visible and supportive across the CCG, local authority and local NHS Trusts. There was an opportunity to replicate these joint posts at a more strategic level to better support the alignment of plans and the integration of services as well as establish joint governance and performance management arrangements.

- Winter planning was underway in all partner organisations however though we found a winter plan was being developed at a strategic level we found no evidence of this begin shared to system partners

- Winter plans across different organisations were collated at the A&E Delivery Board, however, operational staff in services felt that overarching plans were not fed back to them and consequently they were only aware of their own operational plans and not the wider support for winter pressures planned across the system.

**Involvement of service users, families and carers in the development of strategy**

- Halton OPEN (Older People's Empowerment Network) was a network of over 1000 older people that was established in 2001 and had become the collective voice of people aged 50 and over who live and work in Halton. The network was designed to support older people to influence and

encourage the development of services that can help to improve the quality of life and wellbeing of all older people in Halton.

- Halton OPEN members were engaged in new approaches and represented on boards for frailty pathway; Older People's Delivery Board and GP patient participation group boards. The network was also engaged in the process for transforming domiciliary care and will also have representation on the forthcoming Domiciliary Care Board.

- Halton OPEN has been engaged in discussions about health and wellbeing, finances, public transport, information provision, and reducing social isolation. The Director of Adult Social Services (DASS) met with the group regularly.
- Halton Carers Centre was used to gather carers' views and has fed into work such as the development of Halton's dementia strategy and associated implementation plan.

- Halton People's Health Forum was a key group supporting local engagement and involvement in service redesign. They have supported the development of the urgent care centres and aspects of enhancing healthcare in care homes, particularly with regard to GP realignment.

- The local authority started work on the development of an end-to end-pathway of care for frail older people, as part of the 'One Halton' approach.

- Older people have been involved in the development in the needs gap analysis for the older people's pathway, 'Living and Aging Well in Halton'.

- The Bridgewater Community NHS FT that serves the Halton area had undertaken engagement activities with local populations and staff on the future of community health services, which included a 'Big Conversation' event.

- North West Boroughs Healthcare NHS Foundation Trust undertook an engagement exercise in respect of changes to the bed provision for people with dementia. Plans were changed as a result of this engagement, ensuring better travel arrangements, improved community services as well as a more flexible approach to bed based service provision for older people.

- The information gathered as part of the consultation on 'Living and Aging Well in Halton', along with national best practice guidance was used to underpin the development of an overarching integrated 'Older People's Pathway'. This outlined the expected interventions, standards and aims to the approach for supporting older people across the whole system.

- It was evident that system partners understood the importance of including and involving people who use services, their families and carers in developing their strategic approach to managing the quality of the interface of health and social care.

**Promoting a culture of inter-agency and multi-disciplinary working**

- From interviews with system leaders and operational staff it was evident that leaders across respective agencies were working together to implement systems to support inter-agency and multi-disciplinary working.

  The framework for interagency working was supported by separate organisational strategies; however we did not find evidence of this being co-ordinated into a system wide approach. There were shared performance metrics between the local authority and the CCG which were scrutinised at the Executive Partnership Board. However these were not aligned with all system partners.
- We found a range of support services that encouraged staff to work across organisational boundaries. Examples included:

  ⇒ A new contract from the CCG that will see all GP practices aligned to individual care homes – every care home will now have a designated GP practice.

  ⇒ Social workers embedded within GP practices.

  ⇒ The continued development of the multi-disciplinary team (MDT) approach at primary care level offered a medical, nursing and a social care service as well as a multi-disciplinary prevention and wellbeing approach.

  ⇒ District nurses working together with local pharmacies to support effective medicines management and mitigate risk to safety to enable people to be maintained in their usual place of residence.

**Learning and improvement across the system**

- The CCG and the local authority are engaged with the STP and LDS and the Liverpool City Region Combined Authority which enabled them to transfer and apply learning from outside their local area.

- There was some evidence of learning being shared across agencies to improve quality and safety of care, for example, the CCG has worked with operational staff in hospices and hospitals to improve the quality of discharge information.
- We found evidence of learning at an organisational level regarding lessons learned however it was less apparent that this learning was being shared across organisations within the local area.

## What impact is governance of the health and social care interface having on quality of care across the system?

*We looked at the governance arrangements with the system, focusing on collaborative governance, information governance and effective risk sharing.*

*We found governance arrangements had been developed across the system to support partners to*

*collaboratively drive and support quality of care across the health and social care interface.*

*The overarching forum for system leaders to jointly plan how best to meet local health and care needs, and to commission services accordingly was the Health and Wellbeing Board (HWB). However there was little evidence of shared success criteria between the local authority and CCG commissioners and providers, underpinned by shared key performance metrics outside of the BCF*

**Overarching governance arrangements**

- Governance arrangements had been developed across the system to support partners to collaboratively drive and support quality of care across the health and social care interface. Governance for the local authority and CCG's Section 75 partnership agreement was through a shared Executive Partnership Board (EPB) with an Operational Commissioning Committee (OCC) undertaking the detailed work of the agreement**.**

- The Health and Wellbeing Board was described as the overarching forum for system leaders to jointly to plan how best to meet local health and care needs, and to commission services accordingly. Partners were already engaged in system wide dialogue regarding the development of an accountable care system however these discussions had not yet manifested into detailed planning arrangements. Partners were committed to moving this work forward over the coming months

- Individual organisational governance arrangements were supported by well-developed committee structures in each of the system partner organisations. Strategic objectives were linked appropriately to organisational priorities. Organisational performance dashboards were shared and understood across partners and focussed on service quality and delivery.

- System partners acknowledged that pathways of care across organisational boundaries continued to challenge the system and required additional work regarding governance arrangements as well as future contracting and commissioning arrangements to ensure a truly collaborative and shared approach.

- There was a good process for agreeing Better Care Fund (BCF) allocations and responsibilities were agreed, shared and understood across the local authority and the CCG, and this was built on a pooled budget. However, the NHS trusts were not fully engaged

- There was not a collective governance framework that culminated in a series of agreed or shared performance metrics that were robustly monitored at the Health and Wellbeing Board. From the minutes of its meetings, and from our discussions with senior leaders, we found that the Health and Wellbeing Board had extensive membership and good rates of attendance. However the minutes indicated positive stakeholder engagement rather than a forum for strategic leadership and robust governance. There was a lack of challenge around performance for the system through the Health and Wellbeing Board.

- There was a history of joint working across health and social care, with some joint posts established, for example, the local authority's divisional manager is also the urgent care lead for the local authority and the CCG, and is an active member of the Mid Mersey A&E Delivery Board, representing both organisations. This appointment was well received at an operational level and the divisional manager was seen as visible and supportive across the CCG, local authority and local NHS Trusts. There was an opportunity to replicate these posts at a more strategic level to better support alignment and the integration of services as well as establish joint governance and performance management arrangements.

- In addition there was an agreement for a single executive lead for the development and delivery of older people's services supported by the chief nurse.

The governance of data collection systems were not always aligned to inform performance, which meant that information could not be effectively monitored across the system. For example, information from the discharge lounge at Warrington Hospital was not being used to improve the effectiveness of discharge lounge processes.

**Information governance arrangements across the system**

- Better Care Fund returns for 2016/17 indicated that the area was meeting the national conditions around data sharing. This included confirmation that they are using NHS numbers as the consistent identifier for health and care services. The local authority and the CCG are pursuing interoperable Application Programming Interfaces (APIs) – systems that can exchange and make use of information – with the necessary security and controls, ensuring appropriate information governance controls for information sharing, in line with national guidance. This approach supports people having clarity about how their data is used, who may have access to it, and how they can exercise their legal rights.

- The system has agreed to undertake work to improve information sharing and is transferring urgent care centres and community services onto 'EMIS Web' which will allow access to shared records with out of hospital services. This approach (due to be fully implemented in 2020) aims to promote seamless transfer of information across the system and reduce duplication of effort.

- All organisations within the system had robust policies regarding personal information and a person's right to confidentiality and privacy.

**Risk sharing**

- Work is required at a system level to articulate and mitigate wider system risks; this process was not yet fully developed across the STP and LDS or the emerging ACS

- We found no evidence (either during on site activities or through reviewing minutes from Health and Wellbeing Board meetings) of risk management arrangements across the system, however these were in place at an organisational level.

- All partners in the system were experiencing complex financial challenges. Partners were transparent and open with each other in sharing information about their own risks as to the impact this was having on decision making in respect of resource allocation and the setting of priorities.

- There was a shared understanding regarding risk mitigation in respect of the new approach to domiciliary care provision between the local authority and the preferred provider.

## To what extent is the system working together to develop its health and social care workforce to meet the needs of its population?

*We looked at how the system is working together to develop its health and social care workforce, including the strategic direction and efficient use of the workforce resource. In Halton we found system leaders acknowledged a number of workforce issues across the health and social care system. Workforce challenges in the NHS were most prevalent in the availability of medical staff in hospitals, general practice and urgent care. In adult social care the biggest challenge was in the recruitments and retention of domiciliary care staff. Robust actions had been taken by each organisation to address vacancies however this had not yet resulted in a system-wide workforce strategy that supported the system to determine joint investment in a future workforce.*

**Workforce planning and development**

- With the exception of the acute trusts we met with system leaders responsible for workforce planning. All participants indicated that there were strong personal relationships across the system and a shared understanding that workforce issues were a risk to high quality, timely service delivery. Most partners had an organisational workforce strategy however; we found little evidence of a cross sector analysis of workforce challenges or joint plans to address them.
- Individual partners in the system had an organisational workforce strategy. However, there was not a joint workforce strategy for the Halton footprint that was shared and governed across the health and social care system.

- System leaders acknowledged a number of workforce issues across the health and social care system. Workforce challenges in the NHS were most prevalent in the availability of medical staff in hospitals, general practice and urgent care.

- Actions had been taken by each NHS acute trust to address hospital-based nursing vacancies; however this remained an ongoing challenge and there were rolling programmes in place to secure nursing staff and manage turnover.

- Within social care, analysis of Skills for Care data from 2013-14 to 2015-16 indicated that staff turnover and vacancies in Halton were below national and comparator group averages. During our visit we found there were no social worker vacancies, the greatest challenges related to the recruitment and retention of domiciliary care workers.

- The increased skill expectation of care and nursing staff in the independent care sector was having an impact on capacity, demand and the delivery of high quality care. These matters also had an impact on the ability of community services to respond to the changing pattern of demand and the desire to deliver older peoples' care closer to and in their own home.

- The local authority and in some areas the CCG, had started work to support care and nursing staff in the independent sector through the transformation of domiciliary care and the support to care homes projects. This involved initiatives such as apprenticeships, and training and development programs to support staff development and retention in these areas.

- We found that there was a collaborative agreement across the whole system, including Health Education England, to work with the developing Health Academy to help address staffing challenges within health and social care and to adopt a more collegiate and strategic approach to manage workforce across the local authority footprint.

- Work was also underway to develop the skills of the existing workforce to help manage gaps. Partners were looking at ways to increase the numbers of advanced nurse practitioners and nurse prescribers to support timely interventions and improved access in both primary and secondary care.

- We found little evidence of a cross sector analysis of need regarding the workforce and no joint strategic action plan to support the anticipated increased demand as winter approached.

- However, there were positive steps being taken at an organisational level to support the maximisation of the existing workforce through work-related wellness campaigns and immunisation projects that included staff in the independent sector who were involved in direct care.

**Is commissioning of care across the health and social care interface, demonstrating a whole system approach based on the needs of the local population? How do leaders ensure effective partnership and joint working across the system to plan and deliver services?**

*We looked at the strategic approach to commissioning and how commissioners are providing a diverse and sustainable market in commissioning of health and social care services*.

*There was evidence that the local authority and the CCG worked positively together to develop the JSNA over a number of years. Commissioning strategies were underpinned by the JSNA and were regularly reviewed and evaluated.*

*There was a specific JSNA for older people and good evidence of partners meeting people's needs in terms of health and wellbeing, social inclusion, social prescribing and transport; however a joint*

*commissioning strategy for older people's service provision had not yet been fully developed.*

*There was acknowledgement, particularly by the local authority, that work was needed to strengthen and diversify the range and nature of support services particularly domiciliary and care home provision to meet the needs of older people.*

**Strategic approach to commissioning**

- Commissioners in the local authority and the CCG had carried out a comprehensive needs assessment and had used this to determine commissioning priorities at the interface of health and social care.

- To secure improved outcomes for older people commissioners had initiated several large-scale, long-term commissioning initiatives that were in the early stages of development and implementation. For example the 'Healthy New Town' project that aimed to improve peoples' experience by providing housing with health and wellbeing services that were easily accessible and co-located. This initiative also aimed to address staffing shortages in health and social care.

- A JSNA for older people had been completed however a joint commissioning strategy for Older People had not yet been formalised at the time of our review.

- There was evidence of consultation and inclusion of older people in the assessment process.

- One of the issues raised by users was they often felt unprepared for discharge from hospital and that the discharge process was not always well managed, especially for those older people who lived alone.

- Partners had responded positively to improving older people's experiences in this regard; this was one of the main areas identified to shape future service commissioning

- The local authority acknowledged that patients being able to exercise a choice regarding which care home to move to was leading to delays, patients were given the full range of care homes in the borough and not just a list of those care homes with vacancies. This meant that if a patient chose a home without vacancies their transfer of care could be delayed. The rationale for this was that the local authority wanted to provide information on all care homes within the area to ensure people in the borough received their care in a place of their choice. However there was a choice policy in place at Warrington and Halton NHS FT intermediate care unit that would have mitigated this issue, by a service user choosing there long term home but waiting in the interim in another care home however, we did not see evidence this was being implemented

- There were joint commissioning initiatives for older people based on robust analysis and evidence-based commissioning principles to keep people well and when they experienced a crisis, focussed on recovery. These were not yet fully implemented and embedded at the time of our review but included:

- ⇒ The development of multi-agency guidance regarding the early recognition of frailty across health and social care sectors
- ⇒ Rapid assessment 'close to home' and at hospital including management of frailty and improved discharge processes
- ⇒ Review of capacity, demand and models in intermediate care provision
- ⇒ Outcome-based domiciliary care commissioning and contracting
- ⇒ Strengthening of the existing primary and secondary falls prevention work

- There was one A&E Delivery Board for covering both St Helens and Knowsley NHS Trust and Warrington and Halton NHS Foundation Trust. The A&E Delivery Board met regularly and supported system resilience planning across the system including capacity planning and out-of-hours planning, however joint winter plans were still being developed at the time of the review. Pooled budgets had been in place since 2013, for example the continuing healthcare budget. Other initiatives included the use of embedded Social Care in Practice (SCIP) workers who worked across the primary care and social care interface.

- The joint commissioning of new services and the implementation of some key initiatives was already underway, for example the development of a frailty pathway.

- Changes to domiciliary care provision proposed by the local authority were agreed and due for full implementation by November 2017.

**Market shaping**

Our analysis showed that, per population aged 65+, there are fewer residential and nursing care home beds in Halton compared to comparator areas and the England average. Furthermore, our analysis identified that the number of residential care home beds had decreased by 9% since April 2015, meanwhile nursing home beds had decreased by 13%. However the vacancy rates in care homes was below the England average and that of comparator areas.

- There was an acknowledgement, particularly by the local authority, that work was needed to strengthen and diversify the range and nature of support services *particularly domiciliary and care home provision* to meet the needs of older people. Partners had an understanding of the changing environment of the adult social care provision and a subsequent risk assessment has been used to inform the 'Transforming Domiciliary Care' project.

- Commissioners were using long term contracts and risk sharing to address the challenges in the market. For example, through the Transforming Domiciliary Care project a long term contract was offered to a sole provider. The contract had an associated risk mitigation process, allowing the provider to sub-contract to meet identified and anticipated increased need, if required.

- The local authority had agreed to expand its in-house service provision by recommissioning long-term care beds for the provision of intermediate care.

- LDS partners had worked together to agree the key characteristics of a high performing out-of-hospital system, undertaking a baseline assessment and identifying the areas for improvement. Implementation of the following would commence in September 2017:

  ⇒ Halton's GP Forward View and the local strategy for primary care. These outlined the plans to manage the increasing demand for local medical services and primary care through service redesign.

  ⇒ Work to strengthen the domiciliary care and care home sector as part of Halton's BCF plan.

  ⇒ A single contract for care home provision was developed by the local authority and the CCG as part a Section 75 agreement, following a consultation on the cost of care.

  ⇒ The transformation of domiciliary care and the re-procurement of domiciliary care which sought to strengthen the market and plan for future demand. This would be done through using long term contracts, more efficient care delivery, and greater utilisation of the third sector to support older people in their own homes.

  ⇒ Developing existing multi-disciplinary teams, wrapped around primary care and supporting better self-care through technology.

- Developing an ACS will go some way to managing competitive elements with the health and social care system, however at the time of our review this work was in its very early stages.

**Do commissioners have the right range of support services in place to enable them to improve interface between health and social care?**

- An assistive technology program (telemedicine) was well established in Halton with approximately 3,000 people currently using the service that included a 24-hour response service.

- Community wardens responded to calls within approximately 30 minutes and were actively involved in the falls prevention programme.

- There was evidence emerging locally that the falls reduction programme was having a positive impact in reducing the number of domestic admissions to hospital as a result of falls.

- There was a single team approach in the falls team with good communication and support between teams and single senior management oversight of operational provision of this valued service.

- Halton Direct Link services, supported by partners in the voluntary sector, provided two centres in Widnes and Runcorn for people to access or be signposted to services that supported health and wellbeing and avoid medical intervention. Support was also available for people to access an appropriate assessment of need. People also had access to social prescribing and productive activities to maintain the wider determinants of health such as housing and social isolation.

- In addition, a member of the wellbeing service team was based at each GP practice; people could be referred directly to wellbeing services at the point of GP contact. Feedback from service users was very positive about these services and they felt valued and included as a result. Feedback from GPs indicated that this service was successful at preventing older people becoming lonely, demotivated and suffering from related conditions such as depression and anxiety.

**Contract oversight**

- The local authority had systems and processes in place to review the impact and quality of service provision through close working with the CCG in respect of contract renewal. This was particularly evident in the recent work regarding the transformation of domiciliary care and care home provision in the borough.

- More widely, all service commissioners had systems in place to review contractual arrangements as part of a rolling programme. However we found that some quality monitoring arrangements relating to commissioning contracts would benefit from a more proactive approach, for example in primary care and the performance of the intermediate care services provided by Warrington and Halton Hospitals NHS FT.

## How do system partners assure themselves that resources are being used to achieve sustainable high quality care and promoting peoples' independence?

*We looked at resource governance and how systems assure themselves that resources are being used to achieve sustainable high quality care and promote peoples' independence.*
*We found that the assurance and governance process across the system would benefit from the addition of agreed performance metrics underpinned by a continuing challenge and scrutiny function from the HWB. Partners met regularly to share information, discuss key issues and adopt a problem solving approach. However not all partners felt fully involved in determining how resources were allocated, primarily the NHS trusts, and in particular with regards to the resource allocation for the Better Care Fund. We found performance dashboards in place to monitor resource capacity and predict demand. Performance metrics were shared and a problem solving approached adopted, particularly by the local authority and the CCG.*

- The Health and Wellbeing Board had ultimate oversight of the work of the Operational Commissioning Committee, the forum undertaking the detailed work of the pooled budget agreement which included the BCF. Governance of this was through a shared Executive Partnership Board (EPB). However, not all partners felt fully engaged in this process, particularly the NHS Trusts.

- The assurance and governance process across the system would benefit from the addition of agreed performance metrics underpinned by a continuing challenge and scrutiny function from the HWB.

- The CCG and the local authority held monthly joint meetings of the Executive Board of the Council

and the Executive Management Team of the CCG, to share information and discuss key issues.

- There were a number of joint management team meetings that included the local authority, CCG and NHS Trusts that supported an open culture and problem solving approach.

- There were performance dashboards in place to monitor resource capacity and predict demand. Resource allocation and effective financial management was scrutinised through an embedded committee structure that called senior officers to account in their respective organisations.

- In respect of the BCF, joint consideration had been given and agreed by the local authority and the CCG as to where the investment of the fund would have the biggest impact on improving the care for older people and reducing DTOC.

- Work was planned and underway in respect of:
  - ⇒ Investment in re-ablement as the first approach on discharge from hospital, rather than a reliance long-term domiciliary care
  - ⇒ Investment in the transforming domiciliary care project
  - ⇒ The development of improved technology such as telecare
  - ⇒ The development of a social care Trusted Assessor model
  - ⇒ Improved information systems within the hospital to support discharge choices/ pathways
  - ⇒ Enhancing health in care homes, working with providers to develop an alternative commissioning and delivery model

- Expected outcomes were to:
  - ⇒ Meet adult social care needs in a timely way
  - ⇒ Reduce pressures on the NHS. There is an expectation that additional funding will reduce DTOC in accordance with national expectations
  - ⇒ Stabilise the social care provider market to support a wider range of support in the community

- Associated action plans had been developed to ensure that these initiatives would be implemented during 2017/18. A review of the outcomes and financial impact achieved was scheduled for completion at the end of 2017/18, and would form the basis of recommendations for further initiatives/developments for 2018/19 and 2019/20.

- The local authority worked with the CCG to complete the Urgent & Emergency Care Milestone Tracker that indicated positive progress in relation to the implementation of the high impact change model. However, the trusted assessor element of the model had yet to be implemented.

- We saw evidence of where resources were not being managed effectively. For example, some people being cared for in hospital were also being funded for a residential care home bed, when it

was apparent their needs had changed and they would require more intensive support ,for example a nursing home placement and consequently would not be eligible to return to their usual place of residence.

- Halton had one of the highest costs per patient with regards prescriptions in the country. To reduce the costs and optimise medication use in the system, the CCG medicine team were beginning to review cases where older people were prescribed large numbers of medicines in care homes. However this work needed a more system wide approach as the team were struggling to reach all GPs to identify cases for review.

## Do services work together to keep people well and maintain them in their usual place of residence?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: maintaining the wellbeing of a person in usual place of residence**

### Are services in Halton Safe?

*Strategies and initiatives have been developed and put in place to prevent avoidable harm.*

- Each GP practice held monthly MDT meetings targeted at people with complex needs and those at risk of deterioration. These meetings were attended by a range of health and social care professionals to develop a person centred approach to case management.

- Systems were in place across the health and social care interface to safeguard people from avoidable harm, abuse or neglect. Halton's Safeguarding Adults Board was well established and was supported by its member agencies including the local authority, Halton CCG, North West Ambulance Service (NWAS), the local acute trusts, NHS England, Cheshire Probation Service, Halton Housing Trust and Cheshire Fire and Rescue.

- Providers were supported to identify people who were frail and with complex needs. A frailty pathway had been developed with input from all partners in the system. This included assessments being developed and rolled out across health and social care teams to facilitate the early identification of frailty, and timely access to support and interventions.

- Systems were in place to support the management of medicines. Pharmacy support was provided to reduce polypharmacy related risks, including falls prevention. The CCG medicines management team were working with the falls team to proactively address medication prescription and polypharmacy issues to support falls prevention for people living in care homes.

- Domiciliary care providers were working with their commissioners to assess risk to people using their services. Risk assessments were in place for each service user that could be reviewed on a regular basis. The domiciliary care provider proactively raised concerns to the local authority where there were mental capacity concerns that had not been communicated by the Acute Trust. In these instances a Mental Capacity Act assessment was subsequently completed, however we were told this could sometimes be delayed.

**Are services in Halton Effective?**

*Halton had a high rate of attendance at A&E for older people. Joint initiatives had been developed across the health and social care system to maintain people in their usual place of residence. However these were not always fully coordinated and evaluated, meaning they might not always be used to their maximum benefit.*

- Our analysis showed that Halton had a significantly higher rate of attendance at A&E of people aged 65+ than the England average and their comparator areas.[2] Analysis also showed a comparatively high number of hospital admissions from care homes, with a diagnosis associated with accidents and injury[3].

  A high number of falls in Halton had been identified as a challenge by the system, and a joint strategy involving public health, the CCG and the fire service had been put in place to prevent falls. There was multi-agency working to prevent falls including the falls team working with care homes to train staff, and the fire service conducting falls risk assessments in domestic premises. The system reported that the number of admissions to hospital as a result of falls has since reduced.
- The planned enhanced care home model, involving the CCG, local authority and GPs, will support care home staff to have the skills and confidence to make care decisions that avoid hospital admission. However this initiative will not be embedded to support the anticipated increase in service demand over this winter.

- An Older Peoples' Pathway had been jointly developed across the system with an emphasis on reducing the dependency culture for older people and supporting them to remain independent. The pathway had nine elements, including staying healthy, living well and rapid support to avoid admissions.

- We found that many older people had access to a range of services to help them remain healthy and socially included. Service user satisfaction rates remained high with over 90% of older people who responded to the local authority satisfaction survey saying the services were effective.

- Rapid and out of hours support in Halton included the Rapid Clinical Assessment team (RCAT) and

[2] Hospital Episode Statistics April 2015-March 2016.
[3] Hospital Episode Statistics October 2015- September 2016. Analysis based on attendances from postcodes containing a registered care home. Data could pertain to other addresses within the postcode. Postcodes containing more than one care home have been excluded from analysis.

Rapid Access Rehabilitation Service (RARS) services. Across stakeholders, the RCAT service was regarded as an effective and valued service; an unpublished exploratory study conducted locally identified that RCAT successfully avoided admissions for 85% of cases referred to it.

- However, the RCAT service was underutilised due to low referral numbers (196 in 2016/17). A recent (June 2017) report commissioned by the local authority identified the reasons for this as being gaps in GPs' knowledge of the service, inadequate communication between system partners, and a lack of shared understanding as to the capacity of the service and its availability out of hours. The recommendations made following the report were yet to be agreed and implemented by partners. The number of referrals to RCAT was being monitored as part of shared BCF Key Performance Indicators.

- In the RARs service there was historical evidence of a formal commissioning process and agreed performance criteria. However operational staff were unable to articulate this when asked

**Are services in Halton Caring?**

*People and their carers are supported and involved in the planning and delivery of their care. There was good evidence of support services for carers that met their individual needs and preferences; however the assessment process for carers was duplicated.*

- We observed a number of assessments carried out by different teams during the course of the review. We saw good examples of person centred assessments, including for people experiencing memory loss. Clinical, social and cultural information was included in assessments which provided all aspects of what was important in people's lives.

- Halton CCG had a high uptake of personal health budgets and direct payments. Cumulative activity through Q1 2017/18 showed their rate of personal health budgets for all adults was 27.7 per 50k, compared to the England average of 5.82 and the average across Cheshire and Merseyside of 7.44. Their number of direct payments for all adults was 11.18 per 50k, compared to the England average of 3.63 and Cheshire and Merseyside region average of 3.79. The Halton Disability Partnership delivered a service to support people through the process of accessing and using direct payments. Direct payments can empower people to make decisions about their future care and manage their health and wellbeing.

- Carers were well supported in Halton, with input from the Carer's Centre that reached approximately 5000 carers, including 528 carers supporting people with dementia. The centre had a carers support group specifically for people living with dementia which had 20 members. The centre considered the wishes and aspirations of carers and held a well-attended quarterly forum to seek feedback to ensure that they were meeting carers' needs.

- However, there was some duplication of assessments for service users between system partners and the local authority. There was an opportunity to streamline the assessment processes and reduce the number of times service users have to tell their story in order to receive support.

## Are services in Halton Responsive?

*People are assessed and receive care and treatment at the right place and the right time to maintain them in their usual place of residence. However, data showed that there were challenges in Halton in avoiding admission and readmission to A&E.*

- Work was being undertaken to reduce A&E attendance by increasing the capacity within care homes to be more responsive to the needs of residents. The care home support team, and mental health care home liaison team supported care homes to prevent hospital admissions and improve the quality of care. There were plans to link each care home to a named GP, due to begin in September 2017 and be completed by December 2017.

- People in Halton could contact the local authority Contact Centre or attend the Direct Link services which were available to signpost and support people to make decisions about their care. Direct Link hosted health improvement and prevention programmes to keep people well, such as stop smoking groups and diet and nutritional advice.

- Direct Link could refer people to the local authority Contact Centre for pendant alert system services and blue badge applications, the Citizens Advice Bureau, and the Sure Start to Later Life service (offering information and activities for people over 55) . However, staff at Direct Link felt that by taking a greater role in referral process they could be more responsive to people's needs. Staff at the Direct Link centre had not received dementia training, meaning that there was a risk that people with dementia were not having their needs identified.

- Halton had a range of services designed to enable people to receive the right care in the right place at the right time to maintain them in their usual place of residence. This included:
  - ⇒ The 24-hour assistive technology service
  - ⇒ Community wardens working to a 30 minute response from referral time
  - ⇒ The Initial Assessment Team, RCAT and RARs services working to a same day response from referral target
  - ⇒ Community equipment provided within five days and emergency equipment available for teams as needed
  - ⇒ Strong and bespoke support for carers.

## Do services work together to manage people effectively at a time of crisis?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: crisis management**

### Are services in Halton Safe?

*Partners were working together to implement initiatives to assess risk and reduce avoidable harm, however there are still challenges in meeting the needs of older people at a time of crisis, particularly in relation to patients moving to intermediate care.*

- There were systems and processes in place across the system to safeguard people from avoidable harm at a time of crisis. For example, NWAS had worked with the CCGs to reduce the number of A&E admissions from people who call the emergency services. NWAS deployed a 'falls care' process to incidents where an older person had fallen to give specific care and support to prevent a direct A&E admission.

- Our analysis of waiting times in A&E from 2014/15 to 2016/17 showed that both trusts were performing below the national expectation. In Whiston Hospital (St Helen and Knowsley Teaching Hospitals NHS Trust) an increasing percentage of people arriving at A&E had to wait longer than four hours year-on-year, with only 85% seen within four hours in 2016/17. At the two hospitals in Warrington and Halton Hospitals NHS Foundation Trust, 90% were seen within four hours in 2016/17.

- Risk assessments and escalation pathways were in place to mitigate avoidable harm for people who use services during a crisis. These included pressure area management and falls prevention. However, due to the extended waits for some patients to access intermediate care at Warrington and Halton Hospitals NHS FT we found evidence of avoidable harm to people.

- The CCG and local trusts had shared key performance indicators around quality, safety and experience of care, these look at recurrent trends for incidents and falls. Incidents were reported and discussed at the Quality Surveillance Group (QSG).

- Staff in A&E departments displayed an awareness of how to identify and manage safeguarding concerns, however further training in safeguarding awareness was identified as a need. Halton Adult Social Care was recognised in the system as providing high quality safeguarding training, and had been requested to deliver training to NHS staff.

- At Whiston Hospital GP streaming had been in place since June 2017 WHFT was due to have front door clinical screening provided by GPs in place by October 2017, this would allow the emergency departments to focus on caring for people with the highest needs, including older people.

**Are services in Halton Effective?**

*We found evidence that the urgent care system was effectively managing the flow of people at a time of crisis, including through effective joint working in the emergency departments.*

- There were good examples of effective system working at the Urgent Care Centres (UCCs) in Widnes and Runcorn. The UCCs were aligned in their approach, using a shared care pathway to deliver a consistently high standard of care across both sites.

- Systems were in place to support the effective collaboration and information sharing between professionals and organisations to meet the needs of the people who used services. Both UCCs had access to a record sharing system that included a summary care record, information about allergies, medications, and risk management.

- Diagnostic testing such as scans and blood tests could be carried out in the centres and the person's care and treatment plan was sent to their GP by 8am the following morning. Multi-disciplinary assessments were carried out by the appropriate professionals, as therapy staff were co-located at the centres. Referrals could be made to community services, district nurses, or when appropriate local safeguarding teams.

**Are services in Halton Caring?**

*People and their carers are involved in their care and supported to make informed choices during a time of crisis. However people indicated that the discharge process could be more informative.*

- In the discharge lounge people told us they had been given information about their care and treatment options and that the process had been explained in a way that they could fully understand. There was a wide range of information available in the departments for people to take away regarding the management of their condition and discharge options. However, there were also some people who indicated that the discharge process could be more informative.

- A survey carried out by the discharge teams at WHFT in 2016/17 was generally positive and people felt assessment and discharge was a smooth process, however, 10% of people and their carers who took part in the survey felt they weren't given enough time to prepare for the change in care arrangements.

**Are services in Halton Responsive?**

*Services have been developed and planned in consultation with the local population. People are managed well through their admission and assessment in acute settings. However some people remain in acute care longer than necessary while waiting for intermediate and re-ablement services.*

- Operational and management staff acknowledged that there was a challenge around delayed discharge due to a lack of care home placement and domiciliary care packages. During our site visit to Warrington hospital we saw examples of people who had been assessed as no longer requiring an acute bed remaining in hospital because an enablement /intermediate care bed was not available. There was evidence to suggest that one patient had suffered avoidable harm because of this.

- Data for 2016/17 showed an improvement in reaching the four hour treatment expectation at Warrington and Halton Hospitals NHS FT; however performance was still below the national expectation, and at St Helen and Knowsley Teaching Hospitals NHS Trust performance had been declining each year and in 2016/17 was below the expectation and the national average. The system attributes the improvement at Warrington and Halton Hospitals NHS FT to the RCAT and RARs services.

- At Q4 2016/17, 95.4% of the 718 available overnight beds at St Helens and Knowsley Hospital NHS Trust were occupied and throughout 2016/17 occupancy had remained above 90% at the trust. Although optimum occupancy rates for hospital beds may vary according to type of services offered, hospitals with average bed-occupancy levels above 85% are likely to face regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. At Warrington and Halton Hospitals NHS Foundation Trust, 86.9% of the 613 available overnight beds were occupied in Q4 2016/17 and occupancy had stayed close to the optimal 85% level throughout the year.

- We found positive examples of effective discharge planning when we sampled records in Whiston hospital and Warrington hospital A&E and discharge lounges. There was evidence of people progressing through the system with a multi-disciplinary focus on assessment and discharge planning.

- There was a challenge around the sharing of relevant service user information in a timely way across organisations with different IT systems. This was identified as causing delays to the process, duplication of effort, and impacting effective decision making.

- Halton operated a borough based urgent care system review using daily information on capacity and demand in hospitals, intermediate care, and care home and domiciliary care provision. This information supported operational teams to identify gaps and direct existing resources (finance and staffing) accordingly. This also fed into longer term trend analysis used for the commissioning of additional capacity and alternative forms of care as well as for seasonal planning.

## Do services work together to effectively return people to their usual place of residence, or a new place that meets their needs?

**Using specially developed key lines of enquiry, we reviewed how the local system is functioning within and across the key area: step down, return to usual place of residence and/ or admission to a new place of residence**

### Are services in Halton Safe?

*There was a shared view of risk management across staff, however there were sometimes difficulties with joined up working between health and social care when people are returned to their usual place of residence, or a new setting.*

- Our analysis of emergency readmissions within 30 days of discharge during 2015/16 showed that Halton was in line with the England and comparator averages. However, the rate of emergency readmissions from care homes was significantly higher in Halton than the England average (28% in Q1 2016/2017 compared to 20%) and was also higher than the comparator group average (22%).

- A lack of communication between hospital social work teams and domiciliary care agencies during the discharge process was sometimes leading to people being discharged to their usual place of residence without all aspects of packages of care in place. The system in place for the domiciliary care provider to contact the social work team to address any issues was not always effective.

- There was an agreed view on risk across professions within the intermediate care team; that people should be facilitated to take ownership over their risk management plans. From a number of years of health and social care services working together a shared understanding of risk management had developed, this was well embedded and GPs trusted the system and used it to inform decisions as to whether a hospital re-admission was necessary.

### Are services in Halton Effective?

*There were a number of discharge pathways and plans in place involving partners across the system to effectively enable people to return to their usual place of residence. However these were not always able to be carried out effectively due to a lack of social care availability and poor information flow.*

- We observed people experiencing delayed discharges on the review: one person waiting for a care home placement, one person waiting for intermediate care and another waiting for a domiciliary package of care. We saw the negative impact of delayed discharge; one person developed a pressure ulcer and another experienced an increase in clinical symptoms.

- Both our analysis and the analysis conducted by the Department of Health indicated that Halton

had comparatively longer length of stay in acute hospitals for older people. Across Halton's comparators, 90% of people aged 65+ who were admitted as an emergency were discharged within 19 days, however in Halton this figure was 23 days.

- At the time of our review the length of stay at the intermediate care unit at Warrington hospital was more than 50 days. The reasons cited by senior leaders and operational managers for these delays were the challenges in the care home and domiciliary care market including volume and capacity and quality issues.

- Analysis of Adult Social Care Outcome Framework (ASCOF) reablement measures for 2015/16 showed that Halton had a significantly lower percentage of people aged 65+ still at home 91 days after discharge from hospital into a reablement service (63.3%) compared to the England average (82.7%) and comparator areas (81%). Analysis of the longer term trend between 2011/12 to 2015/16 showed that the proportion had been consistently lower in Halton relative to the national and comparator averages and had decreased over that period. The rationale for this of the Local Authority was to respect people's choice if they wanted to return to their usual place of residence, sometimes against professional advice. This resulted in a higher percentage of people being transferred to a more suitable care environment.

- The quality of discharge summaries was raised as a concern across professional groups. Poor quality discharge summaries sometimes impacted on providers' ability to meet the needs of people when they return to their usual place of residence or a new setting. This was a particular issue with regard to quality of information around medications. It was acknowledged at a senior level that there was a lack of understanding about the importance of the quality of discharge information and actions were in place to help address the issue. These included the introduction of compulsory fields on electronic discharge forms.

- Our analysis showed there were fewer care home beds available in Halton compared to similar areas and recent care home closures had contributed to this. The local authority had worked with an external consultancy firm to assess the reasons for closures and develop early warning indicators before services closed. This had been fed into the care homes transformation programme and the local authority was also in the processes of purchasing a care home at risk of closure to secure these placements.

- Although both the domiciliary care and care home transformation plans appeared robust they were not in place at the time of the review. At the time of the review was that there were no new domiciliary care placements available and people had to stay in hospital until capacity became available. This meant that people were having extended length of stays in intermediate care. We also saw examples of people waiting in acute hospital beds to go into intermediate care.

- It was acknowledged across the system that there was a shortage of care home placements for people living with dementia. This was being addressed through the care home transformation programme, however this was not due to fully implement until 2018. It was not possible to assess if either of these programmes would be effective in dealing with the increased demand over winter.

## Are services in Halton Caring?

*People using serves, their families and carers felt included and involved in care planning. However the co –ordination of care and content of needs assessment was not always consistent across services*

- Feedback from people in the Halton Borough Council satisfaction survey who had received a service (approximately 4,500) was positive overall with 58% of people responding:
  - ⇒ 96% of people said that they felt that staff treated them with respect and dignity all of the time.
  - ⇒ 100% of people outlined that they fully understood the information given to them about their care.
  - ⇒ .
  - ⇒ 96% of the people said they were either likely/extremely likely to recommend the service to a friend.
  - ⇒ 100% of people were either satisfied/very satisfied with the care they received.

- We reviewed eight assessments and discharge plans at Whiston, Warrington and Halton hospitals and found they varied in content and quality. There was evidence of people progressing through the system with a MDT approach to discharge planning. However in records reviewed at Halton hospital we found no evidence of involvement from people, their family or carers in terms of discharge planning and preferred place for discharge.

- In our review of case notes we saw examples of repeated assessments; in one case a person had received five assessments by different professionals in two weeks. The person had some cognitive impairment and had become distressed at the number of questions they were being asked and the number of people visiting them. This had also led to duplication of effort across professionals. The reoccurrence of such situations may be reduced by the planned implementation of the trusted assessor component of the high impact change model; however this had not been implemented at the time of our review.

- Case note review and dip sampling showed that people who used services and their relatives were involved in the development of care plans and discharge arrangements. We also saw evidence that GPs had discussion post admission with families about their choices and future planning, for example around further hospital admissions.

- However, involvement of people who use services, their families and carers was not consistent across Halton, and in some records we saw no evidence of their involvement in terms of discharge planning and preferred place of discharge. This was more significant in records reviewed from Warrington and Halton hospitals.

**Are services in Halton Responsive?**

*Partners are working together to enable people to be discharged at the right time and to the right place, however, there are significant challenges with delayed transfers of care that had a negative impact on people.*

- The capacity challenges in the care home, nursing home and domiciliary care market was widely recognised at operational and management levels at both hospitals as a key contributor to delayed transfers of care.

- The length of stay at the Warrington and Halton Hospitals NHS FT intermediate care unit (HICU/ B1) was at an average of 48 days for 2016/17, on the day we visited this had risen to 67 days. Staff dealing with discharges did not routinely attend the length of stay weekly meetings at Warrington hospital in person and any delayed transfers of care would be reported by phone.

- When reviewing six sets of case notes, the most common reasons for delayed discharge were people waiting for care packages, either domiciliary care provision or a care home placement.

- Senior leaders in the local authority and CCG had instigated the plans to transform provision in both domiciliary and care home settings, however these plans were untested and therefore the impact could not be measured as to see how they would increase capacity in the system and address the increased pressures during winter

- Analysis of DTOC figures from April 2015 to April 2017 showed that the rate of delays had been increasing within Halton and after October 2016 had remained higher than both national and comparator area averages. Although recent DTOC figures were improving (figures for June 2017 indicate that the average daily rate of delayed transfers of care in Halton had dropped to 8.8 delayed days per 100,000 population, below the England figure of 13.8 and below Halton's comparator average of 10.80), there were a number of challenges in the timely provision of appropriate rehabilitation services and intermediate care to support this reduction. Patients with complex needs were experiencing some considerable delays.

- Our analysis of delayed transfers of care showed that one of the main reasons reported for delayed discharges was 'patient or family choice', accounting for 35% of delays in the area. We were informed at the Warrington and Halton NHS FT intermediate care unit that people awaiting discharge to a care home were provided with information about all homes within the area, even those that did not have availability. This could result in delays if people and their families chose to wait for a bed in their preferred home. There was a choice policy in place at Warrington and Halton NHS FT intermediate care unit, we did not see evidence this was being implemented. The local authority acknowledged that people choice was leading to delays; however they wanted to provide the information to enable people to choose the right provision for them.

- Halton has comparatively longer lengths of stay in hospital for older people than the England average and that of its comparators. Analysis produced by the Department of Health showed that

across Halton's comparators, 90% of people aged 65+ who were admitted as an emergency were discharged within 19 days, however in Halton this figure was 23 days[4]. Additionally, our analysis showed that during 2015/16 33% of people aged 65+ who were admitted stayed in hospital for over a week, compared to the national average of 32% and comparator average of 30%.

- We held discussion with members of staff who dealt with discharges from the two acute hospitals and the intermediate care units. Staff from Whiston hospital had a good overview of how many delayed transfers of care they were managing that week. However staff covering Warrington and Halton were less clear because of a lack of robust managerial oversight.

- Continuing Healthcare (CHC) was provided through a joint local authority and CCG budget which had been established for a number of years. Staff did not recognise CHC as being a primary cause of delays. However, NHS CHC figures for all adults (NHS England) for Q1 2017/18 showed that for Halton CCG 25% of referrals for standard CHC were completed within 28 days, lower than the England average of 57% and the Cheshire and Merseyside regional average of 73%.

- The same data (NHS CHC figures for all adults for Q1 2017/18) showed that Halton CCG had a standard NHS CHC referral conversion rate (% of newly eligible cases of total referrals completed) of 43%. This was high compared to the England and Cheshire and Merseyside regional averages of 25%. Their assessment conversion rate (% newly eligible cases of total cases assessed) was also higher. This indicates that Halton's processes for identifying people eligible for CHC are working well and a lower proportion of people and their families entered the CHC process to be then denied CHC funding.

[4] Department of Health analysis of Hospital Episode Statistics - March 2016 – February 2017

# Maturity of the system

**What is the maturity of the system to secure improvement for the people of Halton?**

- Relationships were strong with a high level of mutual trust and a culture of openness and transparency. There was a shared understanding of system challenges and a willingness to work together to achieve a solution, coupled with a strong commitment to serve the people of Halton well.
- Partners in the Halton system had a longstanding history of working together effectively for the benefit of the people living in the borough.
- There were some excellent examples of shared preventative approaches and local agreements that supported local people in having timely access to services and support that met their needs in a person centred way.
- However, there was still work required in relation to developing a wider system vision for the STP and ACS footprint and the development of a common framework for prioritizing actions, accountabilities and governance arrangements.
- Although managed well at a local level, the system had work to do to develop a strategic approach to workforce planning and development.
- In addition, the allocation of resources within a financially challenging environment and managing system wide performance would benefit from a more robust approach to risk sharing and shared success criteria.
- Work was underway to allow access to shared records with out of hospital services. This approach (due to be fully implemented in 2020) aims to promote seamless transfer of information across the system and reduce duplication of effort.
- This approach to records and information sharing should be part of a wider IT strategy that supports compatibility across partner IT systems to ensure that all parties have access to a full range of a person's record.
- Strengthening these key elements of system wide working would support the area to understand its future priorities and direction of travel more comprehensively and support improved outcomes for local people in a timely and effective way.

## Areas for improvement

- The Health and Wellbeing Board would benefit from increased vigour in calling system leaders to account to ensure that agreed plans and service improvements are delivered at pace.
- A cohesive interface and robust alignment between the local authority's and CCGs vision for the borough, the Local Delivery System, the STP and planned ACS should be developed. This alignment should be underpinned by shared success criteria, key performance metrics and formal joint governance arrangements so that the all partners have a voice and appropriate recognition in wider system planning.
- While the local authority and the CCG work effectively together as commissioners in the borough, commissioning activity would benefit from increased care provider engagement including local NHS trusts and the GP Federations.
- The implementation of local strategies and plans to reduce avoidable admissions to hospital and improve delayed transfers of care should continue at pace.
- Plans to meet winter pressures should be aligned and coordinated at a system level to ensure that actions between key partners, staff, and people are effective and communications with the public to deter hospital attendance are clear, helpful and consistent.
- Further oversight and monitoring of commissioned services, particularly the intermediate care service provided at Warrington and Halton NHS FT should be put in place by both the service provider and the service commissioner so that poor performance is actively managed and patient experience improved.
- Data collection in different assessment processes across the system should be reviewed to avoid duplication this was particularly evident in assessment of people living with dementia and in the carer's assessment process.
- Now that strategic plans have been developed, strategic leaders should focus on delivery at the front line to improve outcomes for people in Halton.

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| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 11 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Peterborough Safeguarding Children Board and Peterborough Safeguarding Adults Board | |
| Cabinet Member(s) responsible: | Cabinet Member for Children's Services, Councillor Sam Smith<br>Deputy Leader & Cabinet Member for Integrated Adult Social Care and Health, Councillor Wayne Fitzgerald | |
| Contact Officer(s): | Joanne Procter<br>Head of Cambridge & Peterborough Adult's & Children Safeguarding Boards | Tel.01733 863765 |

# ANNUAL REPORT OF THE PETERBOROUGH SAFEGUARDING CHILDREN BOARD 2016-17
# ANNUAL REPORT OF THE PETERBOROUGH SAFEGUARDING ADULTS BOARD 2016-17

| RECOMMENDATIONS | |
|---|---|
| **FROM: Dr Russell Wate QPM<br>Chair of the Cambridge & Peterborough Adults & Children Safeguarding Boards** | **Deadline date: N/A** |

It is recommended that the Health and Wellbeing Board:

1. Note the content of the Peterborough Safeguarding Children Board Annual Report 2016-17 and Peterborough Safeguarding Adults Board Annual Report 2016-17

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following sign off and publication of the Peterborough Safeguarding Children Board Annual Report 2016-17 and Peterborough Safeguarding Adults Board Annual Report 2016-17 in July 2017.

## 2. PURPOSE AND REASON FOR REPORT

2.1 There is a statutory requirement under Section 14a of the Children Act 2004 and Schedule 2 of the Care Act 2014 that Safeguarding Boards publish an annual report detailing the work of the Boards.

The purpose of the reports being brought to the Health and Wellbeing Board is to ensure members are fully aware of the work and progress of the Peterborough Safeguarding Children Board and Safeguarding Adults Board.

The reports cover the period from April 2016 – March 2017 and were published in July 2017.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.7.2.2:

*To actively promote partnership working across health and social care in order to further improve health and wellbeing of residents.*

2.3 The report links into the Children in care Pledge as there is a specific section in the Safeguarding Children Board annual report that addresses children in care.

## 3. TIMESCALES

| | | | |
|---|---|---|---|
| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | N/A |

## 4. BACKGROUND AND KEY ISSUES

4.1 The annual reports include information on the work that has been undertaken by the Peterborough Safeguarding Children Board and Safeguarding Adults Board in the period April 2016- March 2017. Members are requested to note the contents of the reports.

## 5. CONSULTATION

5.1 Partner agencies including Peterborough City Council, contributed to the information contained within the annual reports.

The annual reports were approved by the Safeguarding Children Board and Safeguarding Adults Board in July 2017 and were subsequently published on the Boards website (www.safeguardingpeterborough.org.uk) and shared on social media.

The Boards have also produced a young person's version of the Safeguarding Children Board annual report and an easy read version of the Safeguarding Adults Board annual report. Both of these can both be found on the board's website.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The annual reports highlight the significant events during the last year. They summarise the work of the safeguarding boards and their sub committees. They highlight areas of good practice and present statistical information regarding safeguarding performance.

The reports have been brought to the Health and Wellbeing Board for information purposes.

## 7. REASON FOR THE RECOMMENDATION

7.1 There are no recommendations for the Board to consider – the reports are for information only.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 There were no alternative options- it is a statutory responsibility of the Boards to produce and publish an annual report.

## 9. IMPLICATIONS

### Financial Implications

9.1 There are no financial implications

### Legal Implications

9.2 There are no legal implications

### Equalities Implications

9.3 There are no equalities implications

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 The majority of the statistics contained within the annual reports are from the Safeguarding Boards dataset.

Partners provided information from their agencies which was used to formulate the annual reports.

## 11. APPENDICES

11.1 Appendix 1 – Annual Report of Peterborough Safeguarding Children Board 2016-17
Appendix 2 – Annual Report of Peterborough Safeguarding Adults Board 2016 -17

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# Peterborough Safeguarding Children Board

## Annual Report 2016/17

# Foreword

BY DR RUSSELL WATE QPM, INDEPENDENT CHAIR PETERBOROUGH SAFEGUARDING CHILDREN BOARD

It gives me great pleasure to present to you Peterborough's Safeguarding Children Board annual report for the period April 2016 – March 2017. The report outlines both the activity and contribution of the Board and its partners that has taken place during the last year. The year has been as always a very challenging one for all agencies. I would like to thank all of the Board members (in particular the Lay Members) and their organisations, especially the frontline staff, for the hard work they have carried out to keep children and young people safe from harm in Peterborough.

Our overarching objectives through Working Together 2015 are to:

1. *Co-ordinate what is being done by each person or body represented on the board to safeguard and promote the welfare of children in Peterborough and*
2. *Ensure the effectiveness of what is done by each such person or body for those purposes.*

You will see in the report that we have worked well through our priorities for the year and, as a result of these being correctly identified, we are now continuing with them for another year. Some of these priorities we share with our partner boards, for example the priority of ensuring children and young people receive early help in Peterborough. This is achieved in conjunction with other boards working in Peterborough and evidences clear joint agency working arrangements in Peterborough.

We published this year (June 2016) the Serious Case Review (SCR) that looked at learning from the investigation (Operation Erle) in the city into child sexual exploitation. We must pay tribute to the victims and the frontline staff that helped us to capture this learning. The Board and its partners received national recognition for this work.

The Children and Social Work Act 2017 has meant that we have to think how we do things differently when Safeguarding boards, in about two years, change to be called multi-agency partnerships. I am pleased to say that the board and its partners are already putting plans in place for these changes, for example working a lot closer with our colleagues in Cambridgeshire.

In the last year a lot of activity was focussed on a refresh of our threshold strategy and also producing and implementing a partnership neglect strategy. Our challenge now is to make sure these are embedded in our frontline practitioners' daily work.

We, as a Board, feel the next year is an exciting one for us with lots of opportunities for the partnership to continue our work and to move to be a very good, if not outstanding, Safeguarding Board.

Finally I would like to thank Jo Procter and all of her team for their unstinting commitment to the work of the Board and keeping children in the City safe.

Dr Russell Wate QPM

# Table of Contents

# Glossary of Terms

| | |
|---|---|
| CAFCASS | Children & Family Court Advisory & Support Service |
| CAMHS | Child & Adolescent Mental Health Service |
| CCG | Clinical Commissioning Group |
| CHISVA | Children and Young People's Sexual Violence Advocate |
| CDOP | Child Death Overview Panel |
| CP | Child Protection |
| CPFT | Cambridgeshire & Peterborough Foundation Trust |
| CPIN | Child Protection Information Network (Education) |
| CQC | Care Quality Commission |
| CSE | Child Sexual Exploitation |
| CSM | Complex Strategy Meeting |
| DfE | Department for Education |
| EHA | Early Help Assessment |
| GP | General Practitioner |
| HMP | Her Majesty's Prison |
| HWB | Health and Wellbeing Board |
| JASP | Joint Access to Support Panel |
| LADO | Local Authority Designated Officer |
| LSCB | Local Safeguarding Children Board |
| LAC | Looked After Child |
| MAPP | Multi-Agency Public Protection Board |
| MARAC | Multi-Agency Risk Assessment Conference |
| MASG | Multi-Agency Support Group |
| MASH | Multi-Agency Safeguarding Hub |
| NHS | National Health Service |
| NSPCC | National Society for the Prevention of cruelty to children |
| PACE | Parents against child exploitation |
| PASP | Peterborough Access to Support Panel |
| PWA | Peterborough Women's Aid |
| PSCB | Peterborough Safeguarding Children Board |
| QEG | Quality and Effectiveness Group |
| RAG | Red, Amber, Green |
| SAB | Safeguarding Adults Board |
| SASP | Specialist Abuse Services - Peterborough |
| SCR | Serious Case Review |
| TAC | Team Around the Child |
| ABH | Actual Bodily Harm |
| BME | Black Minority Ethnic |
| CSC | Children Social Care |
| ICPC | Initial Child Protection Conference |
| RCPC | Review Child Protection Conference |
| DBS | Disclosure and Barring Service |
| FGM | Female Genital Mutilation |
| FRT | First Response Team |
| IRO | Independent Reviewing Officer |
| MAPPA | Multi-agency Public Protection Arrangements |
| MASE | Multi-agency Sexual Exploitation |
| OFSTED | Office for Standards in Education, Children's Services and Skills |
| PSHE | Personal, Social and Health Education |
| UASC | Unaccompanied Asylum Seeking Children |

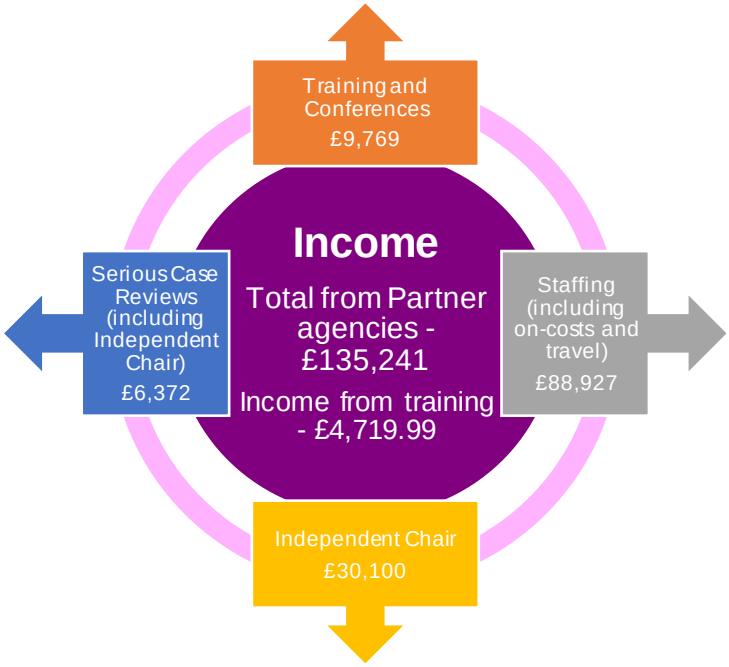
# The Board

The Peterborough Safeguarding Children Board (PSCB) is the statutory body that oversees the multi-agency child safeguarding arrangements across the City of Peterborough as set out in statutory guidance **Working Together to Safeguard Children 2015** [1] and the **Local Safeguarding Children Board (LSCB) Regulations 2006**[2], the PSCB is composed of senior representatives nominated by each of its member agencies and professional groups. It has two basic objectives defined within the Children Act 2004;

- to co-ordinate what is done by each person or body represented on the board to safeguard and promote the welfare of children
- to ensure the effectiveness of what is done for those purposes.

## Financial Arrangements

Partner agencies have continued to provide financial contribution towards the PSCB's budget for 2016/17. Agency contributions totalled £135,241.00, with an additional £36,919 from Peterborough City Council paid directly to Serco PLC for Business Support Services. This income ensured that the overall cost of running the PSCB were met in 2016-17.




## Key Roles and Relationships

Dr Russell Wate QPM has been the Independent Chair of the PSCB since 2013. He is tasked with leading the Board and ensuring it fulfils its statutory objectives and functions.

The Chair is accountable to the **Chief Executive of Peterborough City Council** and they met frequently during 2016/17. **The Corporate Director of People and Communities** for the City also continued to work closely with the Chair on related safeguarding challenges.

**The Lead Member for Children's Services** in Peterborough is a "participating observer" of the PSCB; engaging in discussions but not part of the decision making process which provides the Lead Member with the independence to challenge the Local Authority when necessary.

[1] **Working Together to Safeguard Children (2015)** https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[2] **Local Safeguarding Children Board Regulations 2006** http://www.legislation.gov.uk/uksi/2006/90/regulation/5/made

## Designated Professionals

The Designated Doctor and Nurse take a strategic and professional lead on all aspects of the health service contribution to safeguarding children. Designated professionals are a vital source of professional advice. Across the range of PSCB activities, these designated roles have continued to demonstrate their value during 2016/17.

## The PSCB Business Unit

The Peterborough Safeguarding Children Board Business Unit supports both the Adult and Children's Safeguarding Boards and is made up of the following members of staff;

- Head of Service
- Exploitation Coordinator
- Safeguarding Board Officers – Children's Lead
- Safeguarding Board Officer – Adult's Lead
- Safeguarding Board Coordinator (Communication and E-safety Lead)
- Business Support Officer - Full-time
- Business Support Officer - Part-time

## Board Membership & Attendance

The Board met six times during 2016/17 with good attendance from both statutory and non-statutory partners. Each member of the Board is responsible for ensuring a two-way communication between their agency and the Board by disseminating information between the Peterborough Safeguarding Children Board and their agency/professional body. They are also responsible for identifying any appropriate actions and highlight any issues with partners that have been identified by their agency which will lead to challenge by the Board.

| | Attendance | Number of seats per organisation |
|---|---|---|
| **Independent Chair** | 100% | |
| **Peterborough City Council (Including Youth Offending Service)** | 100% | |
| **Cambridgeshire Constabulary** | 100% | |
| **Cambridgeshire and Peterborough Clinical Commissioning Group (including Designated Doctor and Designated Nurse)** | 100% | |
| **Peterborough and Stamford Hospital Foundation Trust** | 100% | |
| **Cambridgeshire and Peterborough Foundation Trust** | 83% | |
| **Cambridgeshire Community Services** | 67% | |
| **East of England Ambulance Service** | 83% | |
| **Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company** | 100% | |
| **National Probation Service** | 83% | |
| **CAFCASS** | 83% | |
| **Cambridgeshire Fire and Rescue** | 50% | |
| **Healthwatch** | 83% | |
| **NSPCC** | 50% | |
| **Primary School Representative** | 83% | |
| **Secondary School Representative** | 50% | |
| **Further Education** | 83% | |
| **Lay Member** | 100% | |
| **Lead Member for Children Services** | 83% | |

## Relationship with other Boards

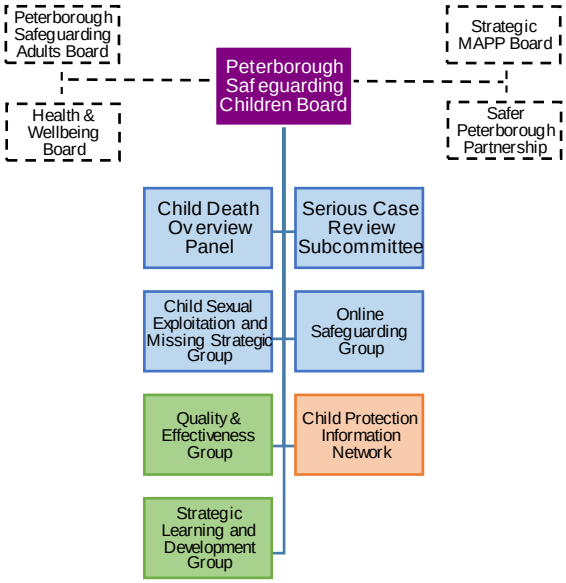
For the Board to be influential in coordinating and ensuring the effectiveness of safeguarding arrangements, it is important that it has strong links with other groups and boards who impact on child services. An Inter Board Protocol has been developed and implemented in the last year to formalise the governance and reporting arrangements between the statutory boards. The Board also has an integral role in being part of the planning and commissioning of services delivered to children in Peterborough.

The Independent Chair of the Peterborough Safeguarding Children Board is also the Chair of Peterborough Safeguarding Adults Board, Cambridgeshire Safeguarding Children Board and Cambridgeshire Safeguarding Adults Board which provides consistency of services for children and adults across Cambridgeshire and Peterborough. He is also a member of other strategic and statutory partnerships within Peterborough which include the Health and Wellbeing Board, the Safer Peterborough Partnership and the Strategic MAPP Board. Key members of the Peterborough Safeguarding Children Board also sit on the Safer Peterborough Partnership and Domestic Abuse Governance Board. In addition, the Head of Service is a member of the Domestic Abuse Governance Board and the Children and Families Joint Commissioning Board.

These links mean that safeguarding children remains on the agenda of these groups and is a continuing consideration for all members, widening the influence of the Peterborough Safeguarding Children Board across all services and activities in Peterborough.

There are strong historical links between Cambridgeshire and Peterborough and a number of partner agencies deliver services across the two areas and are members of both LSCB's. To ensure consistency and efficiency for all partner agencies, where possible, both Boards have sought to co-work across the two authorities. The primary purpose has been to reduce duplication of work, ensure consistent expectations are placed on partner agencies and increase the efficiency of meetings. As a result of the co-working arrangements, there has been some savings in LSCB resources which has allowed other work to be progressed.

For some years there has been a significant level of cooperation across the two Boards in relation to training. The Boards work to the same validation process and deliver a number of joint training courses across the County.




## Sub-Group Structure

Each sub-group has its own terms of reference and reporting expectations. They are chaired by an agency representative and supported by the Peterborough Safeguarding Children Board Business Unit.

## Child Death Overview Panel (CDOP)

The primary function of the Cambridgeshire and Peterborough Child Death Overview Panel (CDOP) is to review all child deaths in the area. It does this through two inter related multi-agency processes; a paper based review of all deaths of children under the age of 18 years by the CDOP and a rapid response service, led jointly by health and police personnel, which looks in greater detail at the deaths of all children who die unexpectedly.

This is a statutory process, the requirements of which are set out in chapter 5 of 'Working Together to Safeguard Children 2015'. The CDOP is chaired by the Independent Chair of the LSCB and the CDOP Annual Report for 2016/17 can be found on the PSCB website. The information in the summary below relates **only to Peterborough children.**

### Numbers of child deaths reported and reviewed

During the period of this report, 24 children's deaths were reported in Peterborough, which is six deaths more than the previous year. Of those children who died, 58% were less than a year old, the majority of whom never left hospital.

### Modifiable Factors

It is the purpose of the Child Death Overview Panel to identify any 'modifiable' factors for each death, that is, any factor which, with hindsight, might have prevented that death and might prevent future deaths.

There were two sudden and unexpected deaths in Peterborough where a modifiable factor was identified.

## The Serious Case Review Group

The overall purpose of the group is to consider cases and determine whether a Serious Case Review should be undertaken and ensure that key learning is effectively disseminated. Serious Case Reviews are undertaken where:

a) abuse or neglect of a child is known or suspected; and

b) either –

   i. the child has died; or

   ii. the child has been seriously harmed and there is cause for concern to the way in which the authority, their Board partners or relevant persons have worked together to safeguard the child.

In line with Working Together to Safeguard Children (2015), all reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter, the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs.

The Serious Case Review Sub-Group is held bimonthly with six meetings being held. The group has finalised and published one Serious Case Review into CSE, considered one case which did not meet the criteria for an SCR, undertook two agency de-briefs and commenced one serious case review into child sexual abuse.

## Summary of Published Serious Case Reviews in 2016/17

### An Overview of CSE in Peterborough – published June 2016

The serious case review focused on the learning from Operation Erle which was the operational name of a multi-agency partnership investigation into child sexual exploitation in the City which spanned 2013 to 2015.

Operation Erle has received national recognition as a model of good practice for identifying and investigating child sexual exploitation.

Undoubtedly, there has been significant progress in understanding and analysing active and potential cases of child sexual exploitation by Cambridgeshire Constabulary, Children's Social Care, Health, Education and several agencies across the voluntary sector. This progress has

primarily been achieved through the relentless commitment of a spectrum of dedicated professional staff.

The report outlines the lessons learnt specifically from Operation Erle and details each agency's response to the issue of child sexual exploitation since then, including the CSE Co-ordinator role, CSE leads in all secondary schools, a specific Police team to tackle CSE aligned with the Missing Persons Investigation Unit, Independent Return Interviews being offered by Barnardos and the embedding of NICE guidance on transitions across the health economy.

## Quality and Effectiveness Group

The aim of the Quality and Effectiveness Group (QEG) is to monitor the individual and collective effectiveness of the Peterborough Safeguarding Children Board members as they carry out their duties to safeguard and promote the welfare of children in Peterborough. The group also advises and supports the Peterborough Safeguarding Children Board in achieving the highest standards in safeguarding and promoting the welfare of children in Peterborough by evaluation and continuous improvement. Five meetings of the group were held in the timeframe covered by this report.

The PSCB has a strong quality assurance function and regularly undertakes quality assurance activity. This includes a range of activity including audits, focus groups and surveys.

The Peterborough Safeguarding Children Board has developed and implemented an annual themed audit programme which includes both single and multi-agency audits. All multi-agency audits are linked to the Peterborough Safeguarding Children Board Business Priorities.

During the 12 months covered by this report, the Peterborough Safeguarding Children Board has undertaken 10 multi- agency audits/ dip samples. These focussed on a range of subjects. Areas of practice that have been reviewed include Thresholds, Domestic Abuse, CSE contacts, cse risk management tools, return interviews and elective home education. All of the audits have resulted in action plans and learning for practice.

In addition to the audits the QEG had developed a multi agency performance data set. This is based on the PSCB priorities and provides the Board with a further process to scrutinise practice. In the last 12 months the Board has worked closely with public health to strengthen the PSCB dataset to include information about neglect (including low birth weight, immunisations, obesity, and repeat accidental injuries). Whilst this data is in place work is taking place to further refine the data and make it more meaningful.

## Training Sub-Group

The Strategic Learning and Development Group has continued to ensure that the Peterborough Safeguarding Children Board Training Strategy has been effectively implemented. The aim of the strategy is for all workers in Peterborough in contact with children/young people and/or their parents and carers to receive appropriate and relevant training in safeguarding children.

The group was also responsible for agreeing effective quality assurance processes in order to ensure that the safeguarding children training provided by all member agencies meets agreed standards. It made changes in the light of any identified gaps in training or resulting from national and local findings of serious case reviews/case reviews, research, new or revised legislation and guidance.

The work undertaken by the Training Group during 2016/17 included:

- Oversight of the Peterborough Safeguarding Children Board Multi-agency Workforce Development Programme of which 867 professionals from across the city attended.
- Developing training and a resource pack to support practitioners with the launch of the revised threshold document and neglect strategy

- Updates to the CSE Resource Pack and FGM Resource Pack. The aim of these resources is to aid agencies in delivering single agency briefings to ensure basic awareness raising is delivered in as many agencies as possible.
- Organising and delivering a conference on Adolescents and risk taking behaviour, jointly with Cambridgeshire LSCB colleagues.
- Considering the impact of training delivered by the Peterborough Safeguarding Children Board: details can also be found later in this report.
- Validation of single agency safeguarding training.

The work of the group continues to be informed by the Peterborough Safeguarding Children Board business priorities and in response to learning arising from serious case reviews and other national and local concerns.

## Cambridgeshire and Peterborough Child Sexual Exploitation Group


Ensuring that children and young people are fully protected from CSE has, once again, remained a business priority for the Peterborough Safeguarding Children Board and activity and awareness raising has continued throughout this period.

- In August 2015 the Joint CSE Risk Management Tool was launched for all agencies across the county with guidance on the intended function of the tool. In the past12 months dip samples have been undertaken to ensure that the risk management tool have been properly embedded.
- Work under the communication strategy continues and is a continuing agenda item for discussion at each meeting of the group.
- Leaflets for businesses on their duties to safeguard children and young people from sexual exploitation have been updated and translated into 7 additional languages.
- Leaflets for parents and carers providing advice on what to do when their child goes missing was created in collaboration with Cambridgeshire Constabulary and Cambridgeshire LSCB and translated into various languages and is available from our website.
- An updated CSE Strategy which reconfigured the membership of the Strategic Group was approved by both Peterborough and Cambridgeshire Boards.

More information can be found under the Board's priority "Children are fully protected from Child Sexual Exploitation" later in this report.

## Cambridgeshire and Peterborough Online Safeguarding Group


The joint Cambridgeshire and Peterborough LSCB Online Safeguarding Group continues to be a focus for the Board.

Over the last year, the group has

- reviewed the section 11 returns regarding E-safety,
- revised the E-safety incident flowchart,
- developed leaflets and resources for both professionals and the public
- undertook a survey regarding E-safety training within agencies
- participated in a police led awareness campaign around online safety
- started updating the e-safety strategy.

In addition to the above the PSCB developed and launched an online safety survey aimed at seven to sixteen year olds. This took place between November 2016 and March 2017. The Board received over 2000 responses to the survey from children and young people across the City. This provided the Board with extensive insight into what young people across Peterborough are doing "on line". The findings from the survey will form the basis for the ongoing work of the sub group. Further details relating to the survey can be found in the "voice of the child" section of the report.

## Child Protection Information Network (CPIN)

The Child Protection Information Network is an education sub group of the Board. Meetings are held on a termly basis and members of the education community are invited to attend.

Attendance remained good, with representation from sectors from Early Years through to Further Education. The group appreciates continued support from both the PSCB and from police (Safer Schools). Sgt Susie Tinsley has kept the group up to date on all relevant police matters, including issues around Prevent.

Information updates have ensured safeguarding leads are aware of the latest statutory guidance, and of any local and national resources to support their role and to protect children in their care. Changes to the statutory guidance *Keeping Children Safe in Education* have seen a substantial shift towards information to be shared with the wider workforce.

Presentations by senior staff from CSC and from Early Help provided a deeper understanding of the MASH and expectations of the Early Help process. A presentation on the impact of domestic abuse on children and young people was extremely helpful and some of the examples shared have been incorporated into training sessions to extend awareness. The Youth Offending Service presented on harmful sexualised behaviour. Again, attendees found this extremely interesting and beneficial, both in terms of their own understanding of the subject matter and of pathways to support.

The increased involvement of education professionals in strategy meetings is identified as a positive move and welcomed by the Safeguarding Leads.

# Safeguarding in Peterborough 2016/17 Snapshot

Approximately **52000** children live in the city

**27%** of the total population of the City

**153** languages are spoken in schools

**23.1%** of children are living in poverty

**1195** Total number of Violent or sexual offences against under 18s

**10261** Total number of contacts to Children's Social Care for April 2016 - March 2017

**2013** contacts to Children's Social Care with the reason of domestic abuse/DV

**1976** Total number of Domestic Abuse incidents where children were present

**133** Total number of Repeat Domestic Abuse incidents where children were present

**449** Cases / **147** repeat cases discussed at MARAC

**2188** contacts and referrals to Children's Social Care with an outcome of Early Help

**1842** Total number of Early Help Assessments completed during the year

**2513** Total Number of single assessments completed

**1188** Number of open Children in Need cases (as of March 2017)

**236** Number of children on a CP Plan (as of March 2017)

**363** Number of looked after children (as of March 2017)

**173** Madrassa and Supplementary Schools members have been trained in Safeguarding Children and Young People

**417** Children reported missing from Home or Care

**110** Children and young people missing from Home or Care for two days or more

**40** Children identified as being at risk of Child Sexual Exploitation

**208** Allegations against staff who work or volunteer with Children and young people

**6** Children Privately Fostered

# Local Context

Peterborough is noted in the 2017 Centre for Cities report 'Cities Outlook 2017' to be the fourth-fastest growing city in the UK, behind only Exeter, Coventry and Cambridge City[3].

Population density is highest in Peterborough among the urban, relatively deprived areas towards the centre of the Local Authority, although Peterborough also has some rural areas towards its outer boundaries, which tend to be more sparsely population and less deprived.

Approximately 52,000 children and young people under the age of 19 live in Peterborough, which is 27% of the total population in the area. There are year-on year increases in the numbers of children and young people attending Peterborough schools; the number of pupils increased by 4% between October 2013 and October 2014.

Peterborough has an increasingly diverse population where 153 languages are spoken in Peterborough schools. There is a growing number of children and families moving to the city from Central and Eastern Europe.

School children and young people from minority ethnic groups account for 44.8% of all children living in the area, compared with 28.9% in the country as a whole. The largest minority ethnic group of pupils is still Asian Pakistani, reflecting earlier patterns of migration. However, this group as a proportion of the school population is now relatively stable, whilst the population of Polish and Lithuanian children in Peterborough schools increased by 19% and 13% respectively between October 2013 and October 2014.

37% of children and young people in primary schools and 28% in secondary schools have English as an additional language compared with the national averages of 19% and 14% respectively.

**The child population in this area**

| | | Local | Region | England |
|---|---|---|---|---|
| Live births (2015) | | 3,170 | 72,505 | 664,399 |
| Children aged 0 to 4 years (2015) | | 15,900<br>8.2% | 378,300<br>6.2% | 3,434,700<br>6.3% |
| Children aged 0 to 19 years (2015) | | 52,100<br>26.9% | 1,437,000<br>23.6% | 13,005,700<br>23.7% |
| Children aged 0 to 19 years in 2025 (projected) | | 57,600<br>27.2% | 1,572,100<br>23.8% | 14,002,600<br>23.8% |
| School children from minority ethnic groups (2016) | | 14,372<br>46.4% | 178,543<br>23.3% | 2,032,064<br>30.0% |
| Children living in poverty aged under 16 years (2014) | | 23.1% | 16.5% | 20.1% |
| Life expectancy at birth (2013-2015) | Boys | 78.6 | 80.3 | 79.5 |
| | Girls | 82.4 | 83.7 | 83.1 |

**Source: Public Health England Child Profiles 2017**

This rapidly increasing and changing population is likely to place additional pressures on services over the coming years. An increasing population of children implies that, all things being equal, there will be increasing numbers of children who are in need, including those who are in need of protection and/or looking after. The Peterborough Safeguarding Children Board will need to ensure that it has an awareness of safeguarding issues in all sectors of Peterborough's communities. This in itself will be a challenge for the Board.

### Child and Family Poverty in Peterborough

Peterborough remains a local authority with relatively high levels of deprivation, as measured by the Income Deprivation Affecting Children Index (IDACI), which forms part of the Index of Multiple Deprivation (IMD).

Deprivation affecting children, as measured by IDACI, fell slightly between 2010 and 2015, with Peterborough's IDACI score falling from 0.27 to 0.25, reflecting a reduction in children living in poverty of approximately 2%.

Among Peterborough's CIPFA (Chartered Institute of Public Finance and Accountancy) comparator group of 15 socio-economic neighbours, Peterborough has moved from being the fifth-most deprived local authority to the fourth-most deprived.

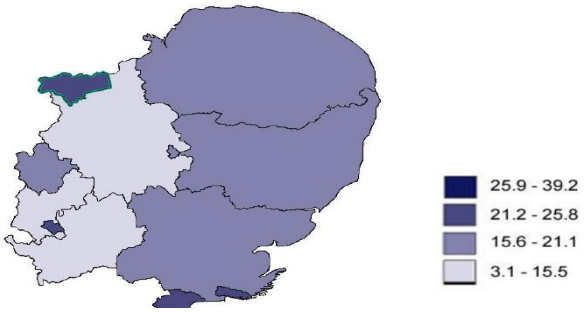
[3] http://www.centreforcities.org/wp-content/uploads/2017/01/Cities-Outlook-2017-Web.pdf

Levels of deprivation are particularly high in areas near the centre of Peterborough and there is a higher concentration of relatively deprived areas towards the south of the geographical area that comprises Peterborough. Deprivation, as measured by the Income Deprivation Affecting Children Index, is markedly less prevalent in Peterborough's more affluent, rural wards.

The health and wellbeing of children in Peterborough is generally worse than the England average. The Public Health England Child Health Profile[4] provides the following key findings relating to the health of children in the City. Poverty is evidenced to be a key factor in health outcomes.

**Children living in poverty**

Map of the East of England, with Peterborough outlined, showing the relative levels of children living in poverty.




The overarching Child Poverty measure found within the Child Health Profile indicates that the percentage of children living in poverty in Peterborough was 23.1% in 2014, higher than the national average of 20.1%. Peterborough also has lower life expectancy at birth than England for both boys (78.6 years compared to 79.5 years) and girls (82.4 years compared to 83.1 years) for the period 2013-15. The rate of family homelessness in Peterborough is also worse than the England average.

**Children in Low Income Families (Under 16s), East of England Region, 2014**[5]

| Area | Count | Value |
|---|---|---|
| England | 2,003,060 | 20.1 |
| East of England region | 181,560 | 16.5 |
| Luton | 12,215 | 24.5 |
| Peterborough | 10,360 | 23.1 |
| Southend-on-Sea | 7,315 | 22.1 |
| Thurrock | 7,600 | 21.2 |
| Bedford | 6,015 | 18.4 |
| Norfolk | 25,510 | 17.9 |
| Essex | 42,365 | 16.4 |
| Suffolk | 19,995 | 16.0 |
| Hertfordshire | 29,335 | 13.3 |
| Central Bedfordshire | 6,695 | 13.3 |
| Cambridgeshire | 14,155 | 12.9 |

## The Peterborough Safeguarding Children Board Business Priorities - 2016/17

Partner agencies were in agreement that the business priorities from 2015/16 remained relevant and, as they were based upon the views of agencies and children and young people, it was decided that they remain the same for 2016/17. These were:

1. Early help and preventative measures are effective.
2. Children at risk of significant harm are effectively identified and protected.
3. Everyone makes a significant and meaningful contribution to safeguarding children.
4. Workforce has the right skills/knowledge and capacity to safeguard children.
5. Understand the needs of all sectors of our community.
6. Children are fully protected from the effects of domestic abuse (domestic violence) and neglect.
7. Children are fully protected from child sexual exploitation.

[4] Child Health Profile – March 2017 https://www.gov.uk/government/statistics/2017-child-health-profiles

[5] **Source:** HM Revenue & Customs, Personal Tax Credits, Related Statistics – Child Poverty Statistics,

It is the aim of the Peterborough Safeguarding Children Board that these priorities will primarily be achieved and monitored by undertaking the following:

- Monitoring and evaluating the effectiveness of safeguarding activities by partner agencies individually and collectively and advising and supporting them to make improvements.
- Undertaking reviews of serious cases and disseminating identified learning to partner agencies.
- Collecting and analysing information about all child deaths across Cambridgeshire and Peterborough to increase the learning opportunities.
- Developing and updating policies and procedures to ensure consistency and transparency between partner agencies.
- Communicating the need to safeguard and promote the welfare of children amongst professionals, parents and carers and children and young people, raising awareness of how this can best be done and encouraging it to happen.
- Publishing an Annual Report on the effectiveness of safeguarding arrangements for services for children in Peterborough.

## Early help and preventative measures are effective

*Some families need help – this may be help in relation to housing, how to parent, behaviour/ anger management, how to budget and attendance at school. By helping these families it is hoped that the situation will improve and the family/ children will not need to have intervention by children's social care.*

## Thresholds

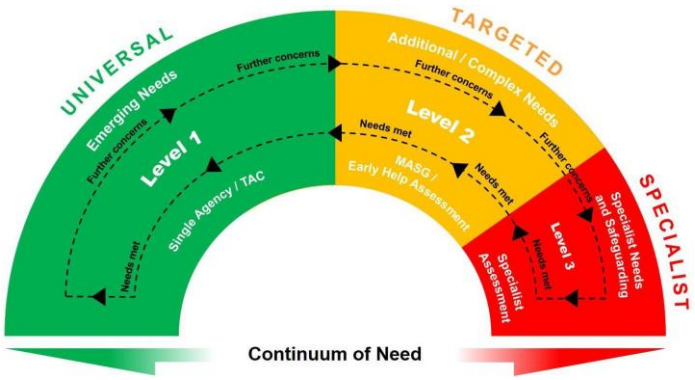
Working Together 2015 states:

The LSCB should publish a threshold document that includes:

- the process for the early help assessment and the type and level of early help services to be provided;
- the criteria, including the level of need, for when a case should be referred to local authority children's social care for assessment and for statutory services
- clear procedures and processes for cases relating to the sexual exploitation of children and young people.

The Peterborough Threshold Document which sets out how Peterborough agencies approaches the task of keeping children and young people safe and protected from harm was updated and published in September 2016.

At its heart is the continuum of need, a model that emphasises that the assessment of a child's needs, and meeting those needs, is never a static process. Situations change and as a result so does the level of need and risk.




The guidance, which covers the threshold of need and intervention, is a vital tool that underpins the local vision to provide targeted support services at the earliest opportunity right through to specialist and statutory interventions when it is needed. The aim is to promote the welfare and safety of vulnerable children and young people.

It offers a clear framework and a common understanding of thresholds of need for practitioners within all agencies, to help to promote a shared awareness of the different interventions required to effectively support children, young people and their families or carer.

The Document provides information, advice and guidance that equips any practitioner working with children to know when additional services

may be required, including when there is a risk of harm, and how to access those services.

## Early Help

In Peterborough, we believe that Early Help is about ensuring that children and families receive the support they need at the right time. We aim to provide help for children and families when problems start to emerge or when there is a strong likelihood that problems will emerge in the future. This means providing support early in life or early in the identification and development of a problem.

Services in Peterborough also recognise that some families will require additional help at various times of their lives and may need to access targeted services periodically to help rebuild their resilience and capacity to manage. Support is also provided within the arena of Early Help when families have received specialist support and need a reduced level of support to sustain and continue the progress made.

### The Peterborough model

Early Help delivery in Peterborough is based primarily on a commissioning model. There is a small Local Authority Early Help team whose role it is to support practitioners and professionals in the field. The majority of Early Help services are commissioned and delivered by a wide range of partners. The Local Authority Early Help Service currently provides the following functions:

- Strategic direction and oversight of Early Help in Peterborough including access to support
- Development and maintenance of positive working relationships with partner agencies to ensure engagement and accountability
- Direct support to professionals working with families in the arena of Early Help, including supporting professionals to complete good quality Early Help Assessments, engaging professionals in the Peterborough Early Help Process including Team Around the Child meetings, Family Actions Plans and Early Help panels to gain additional support
- Early Help support in the Peterborough MASH
- Strategic and Operational management of three locality based Multi-agency Support Group (MASG) panels
- Direct support to the operational functioning of other Early Help panels (Early Support Pathway; Behaviour Panel)
- Delivery of the National Troubled Families agenda in Peterborough overseen by the Department for Communities and Local Government. Known locally in Peterborough as 'Connecting Families'.
- Strategic and operational management of all Evidenced-Based Parenting Programmes in the City, including the training and development of training providers to support the implementation of the neurodevelopmental pathway
- Maintenance and oversight of the Liquid Logic case management Early Help Module system accessed by all partners
- Monitoring of performance and outcomes, and quality assurance.

### Early Help Assessments

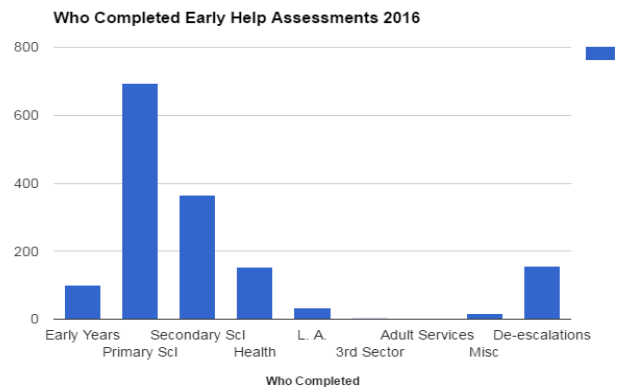
Peterborough promotes the use of the Early Help Assessment (previously known as a CAF) as the tool for recording the family's unmet needs. The document should be a holistic assessment that captures the family's strengths. It should ask what is going really well? What is not going so well and causing some concern or worry? What do the family and those working with them think needs to happen, and what are the next steps to help that happen? The Early Help Assessment is single assessment that is created with the family. It should reflect their views, wishes and feelings and what they want to change. It is shared when appropriate [and where there is consent] with other professionals who are working in a co-ordinated way to support the family.

In Peterborough, Early Help Assessments are completed by any professional or partner agency who comes into direct contact with families, and who has identified more than one unmet need that would benefit from a multi-agency support

approach. They are not initiated by members of the Early Help Team. Where professionals working with the family are lacking skills and experience in Early Help and how to complete a holistic assessment, a member of Early Help staff from the LA will work with professionals and partner agencies - often by modelling good practice - to upskill the workforce and ensure good quality assessments are produced. Early Help Assessments are initiated on an electronic case management system known as the Early Help Module as part of our Liquid Logic suite of products. Training is provided for all professionals from the Early Help Team who might need to complete an Early Help Assessment with a family or contribute to one that another professional has started.

### Completion of Early Help Assessments January 2016 to December 2016 inclusive

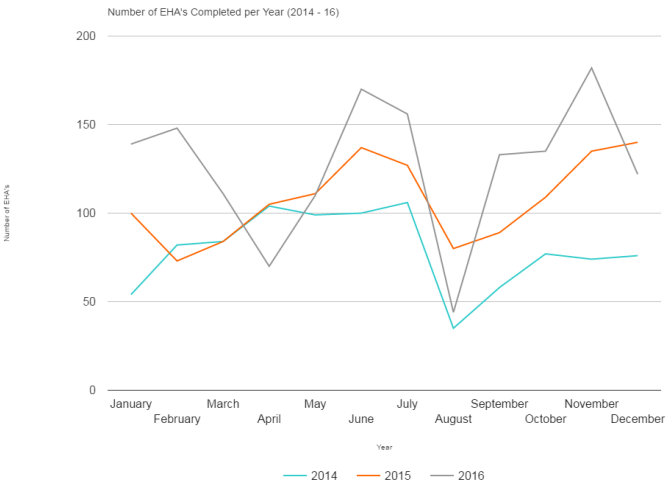
The following chart indicates the number of Early Help Assessments initiated by partner agencies. The greatest number of assessments continues to be completed by Primary Schools, with a small increase in the number of assessments from health colleagues which now includes assessments completed by physiotherapists and CAMHS colleagues. Only three Early Help Assessments were completed by third sector organisations and none from adult services. In the main, third sector organisations provide support and interventions to families where an Early Help Assessment has already been completed.




### Early Help Assessment completion 2014-16

The following graph shows the completion of Early Help Assessments 2014 to 2016 inclusive. The number of Early Help Assessments has continued to rise year on year with the same peaks and troughs appearing which in the main are affected by the school academic year. The graphs now show a marked reduction in the completion of Early Help Assessments at Easter, in August and a slight reduction in December. As a service we need to be aware and alert to the unavailability of partner agencies during these periods in the year and consider alternative methods of support where this cannot wait until the start of the new term

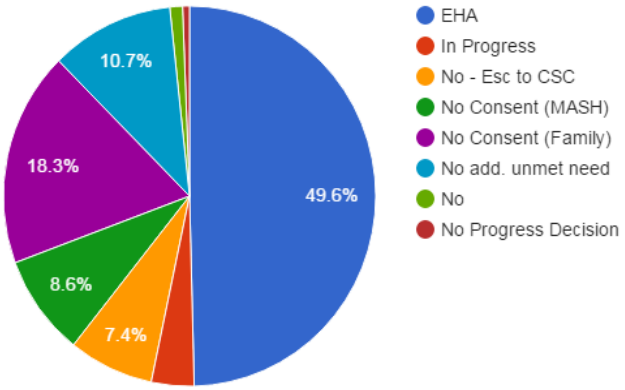
### Graph showing number of Early Help Assessment completed 2014-2016




### Contacts into Children's Social Care with recommended outcome of Early Help

During 2016 there has been a steady increase with 2188 contacts and referrals with a recommended outcome of Early Help. When these cases are picked up by the Early Help Service, our priority is to try and identify a Lead Professional from our partner agencies to work with the family and engage them in the Early Help Assessment process. Negotiating this with potential Lead Professionals can be quite challenging, as can engaging some of our families. The Early Help Service aim to achieve a conversion rate of contact to completed Early

Help Assessment with an agreed family plan of 50% on all contacts passed to the service from Children's Social Care with a recommended outcome of early help. The following pie chart confirms that in 2016, 49.6% with a further 3.7% of assessments in progress takes the total to 53.3% therefore demonstrating the target has been met.




**Involvement and role of Early Help in the neurodevelopmental pathway**

Due to high demands for specialist child and adolescent mental health services for ASD / ADHD assessments, waiting lists were temporarily closed in spring 2015. In response to this increasing demand, a new pathway was developed through the Joint Commissioning Unit. The route to access a specialist assessment is now through the Early Help Assessment. The assessment enables access to support, including Evidence Based Parenting Programmes (EBPP). The waiting list reopened on 15th December, adopting the new pathways. Transformation funding was allocated to support the purchase of EBPP as well as developing the infrastructure to support the services.

A range of activity has supported the roll out and delivery of the ASD/ADHD pathways to support families whose children are exhibiting challenging behaviours. These have included;

- A series of evidence based parenting programmes were directly commissioned from voluntary sector providers. Practitioners have been trained to deliver individual programmes and are supporting families on an individual level.
- In Peterborough, a strategy to support schools to directly deliver EBPP has been rolled out. Training was therefore organised for both primary and secondary school, in the delivery of Webster Stratton and Triple P Teens respectively.
- A total of **195 parents** have benefited from the delivery of the Evidence Based Parenting Programmes, directly funded from the transformation funds.
- The EBPP have been developed to provide early support for parents struggling to manage a child's behaviour, enable collection of appropriate information to support referral into more specialist services if required, and to reduce inappropriate referrals.

Evaluation from the EBPP does provide evidence of positive results for parents.

**Workforce Development**

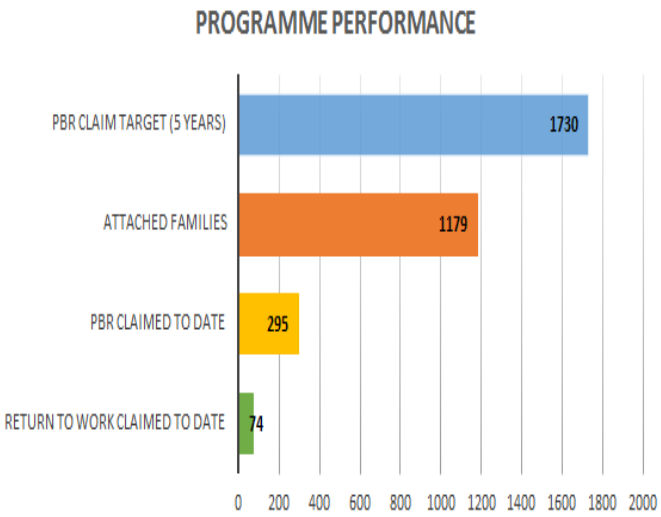
In addition to offering practitioners the opportunity to engage in one of the train the trainer Evidenced Based Parenting Programmes, we have continued to review the effectiveness and volume of other early help training. In addition to the Liquid Logic Early Help Module face to face training we have purchased and are still in the development stage of an eLearning package to enable more practitioners to engage in training with greater flexibility. We are hoping to pilot the eLearning modules with partners in July.

The Early Help Service continue to offer Outcome Star training which remains very popular with greater demand than we have capacity to deliver. We are also hoping later in the year to introduce a new training to accompany the Outcome Star training that will focus specifically on good action planning

Following an analysis of a number of Early Help Assessments that indicated a lack of basic understanding and knowledge in respect of when to complete an Early Help Assessment and what

makes a good Early Help Assessment we have designed a new training programme called 'Back to Basics'. We have delivered one per month since February, as well as four bespoke sessions to individual organisations. Practitioners have reported this to be very helpful both for new practitioners and as a refresher for those working in the field for some time.

**Connecting Families Progress**




The national Troubled Families Programme, referred to locally as Connecting Families which is being drive through Early Help is making good progress to date. The total number of families for which a Payment by Result has been claimed is currently 295 - 17.05% of our 5 year target. 74 of these families have been claimed on the basis of an adult achieving continuous employment.

1,179 families have been attached to the programme, consisting of 884 active, qualified families and the 295 families for whom a PbR has already been claimed. The target number of families to be attached by March 2018 is 1,313.

Unsatisfactory school attendance has surpassed worklessness as the leading individual indicator present within the Connecting Families cohort, being present 651 times. The prevalence of worklessness as an indicator has reduced slightly from 493 to 480.

The Early Help Service have completed an analysis of the claim to help us shape our future provision and delivery and to stand us in good stead for increased numbers of potential claims as the programme progresses.

**New case tracking process**

The Early Help Service have conducted a full review of the tracking and monitoring of all Early Help cases that will enable us to demonstrate the impact of Early Help on improving outcomes for children and families. We aim to communicate more regularly with Lead Professionals and intervene earlier when cases are not making the expected progress.

**Emotional Health and Well-being**

Over the last year, Peterborough Early Help Service have worked with colleagues from Cambridgeshire County Council, Public Health and CPFT in developing a range of support for practitioners supporting children and young people with emotional health and wellbeing. This has included the production and launch of a public health hosted website called 'Keep Your Head'[6] which has information for children and young people, parents and carers as well as professionals pages. This website also plays host to the Kooth online counselling service for 11-25 year olds, and provides access to a new emotional health and wellbeing toolkit for practitioners produced through funding from Health Education England

[6] http://www.keep-your-head.com/CP-MHS

## Children at risk of significant harm are effectively identified and protected

*Significant harm within this priority means children who are the victims of child abuse. This could be emotional abuse, physical abuse, neglect or sexual abuse (including child sexual exploitation).*

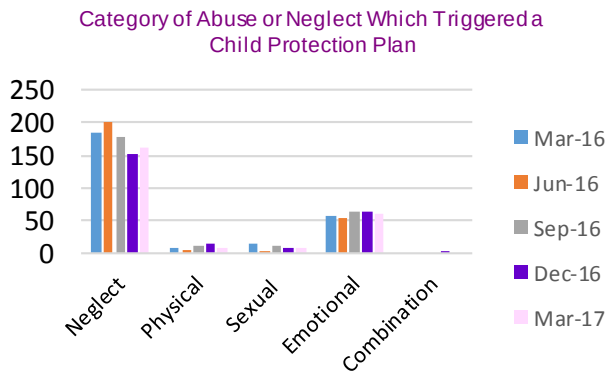
### Child Protection Plans

All children at risk of significant harm or abuse will be the subject of a Child Protection Plan. A child protection plan is a working tool that should enable the family and professionals to understand what is expected of them and what they can expect of others. The aims of the plan are:

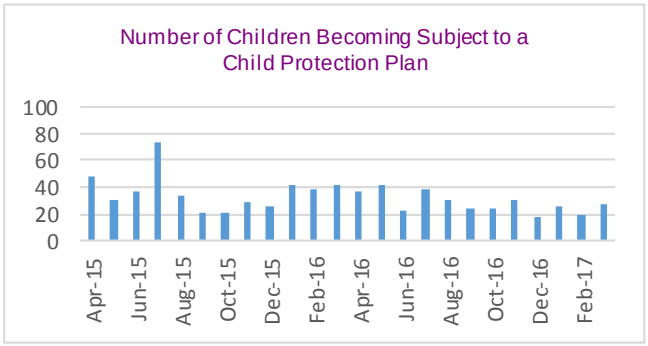
- To keep the child safe
- To promote their welfare
- To support their wider family to care for them, if it can be done safely.

The table and charts show the number of Peterborough children on a Child Protection Plan.

| | Mar 16 | Jun 16 | Sep 16 | Dec 16 | Mar 17 |
|---|---|---|---|---|---|
| Child Protection | 265 | 264 | 262 | 244 | 236 |

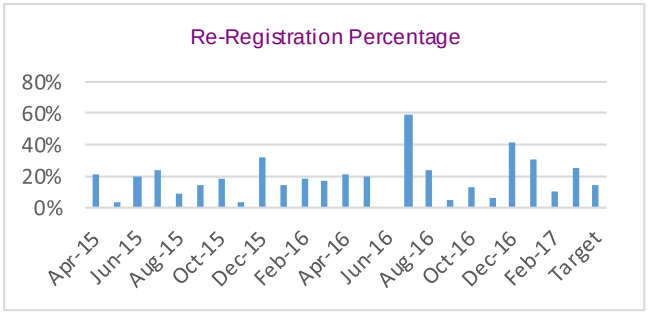



The majority of children and young people who are the subject of Child Protection Plans in Peterborough are registered under the category of Neglect (69%). The Peterborough Safeguarding Children Board has recognised this and accordingly, Neglect will remain as a business priority for the Board in 2017/18 and further work around the issue of Neglect will take place.



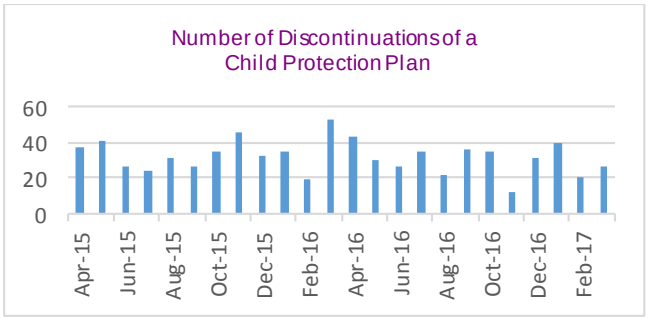

There were 338 children who became subject to a Child Protection Plan during 2016/17. This equates to a rate per 10,000 of 70.8 against the target rate of 53.4.

**The number who became subject to a CP plan for second or subsequent time:**



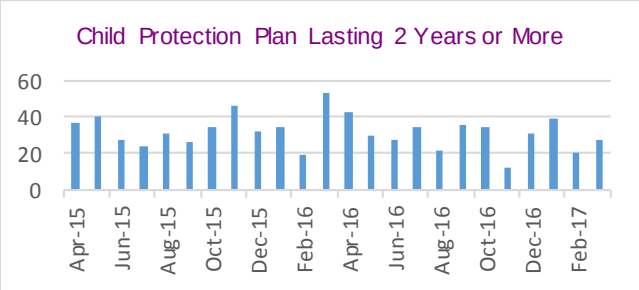

Of the 338 children who became subject to a Child Protection Plan during 2016/17, 76 (22.5%) of them had previously had a Child Protection Plan in Peterborough.

**The number of discontinuations of a Child Protection Plan per 10,000 of the local population under 18:**




There were 358 children who ceased to be subject to a Child Protection Plan during 2016/17. This

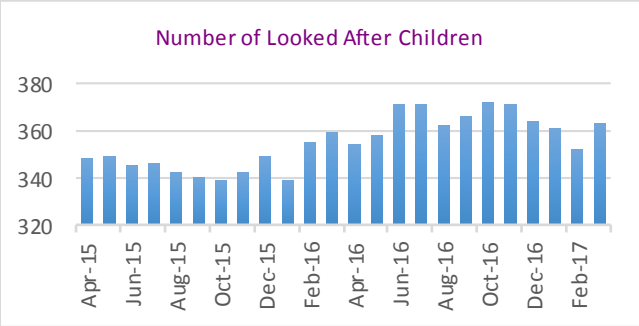
equates to a rate per 10,000 of 75.0 against the target rate of 63.0.




Of the 358 children who ceased to be subject to a Child Protection Plan during 2016/2017, 5 (1.4%) of them had been subject to a Child Protection Plan for more than two years. This is 1.4% against a target rate of 2.5%.

## Looked After Children

The looked after children population in Peterborough has varied between 352 and 372 over the last year, showing a small end of year increase of four in the number of children and young people in care in March 2017, compared with the end of year figure in March 2016. The biggest age band within this population is the 10-15 year olds, which represents over 38% of the total number of looked after children.




During the last year between April 2016 and March 2017, the following arrangements, amongst others, have continued to ensure the identification and protection of children at risk of significant harm:

1. The Peterborough Access to Support Panel (PASP) has continued to oversee the decisions for children to come into care, which are made at Assistant Director level or above. This Panel also reviews all care packages regularly, especially for those children placed out of area or in independent placements.
2. The Joint Access to Support Panel (JASP), chaired by the Director for Children's Services has continued to determine and review the needs and placements of children with additional needs.
3. Decisions to place children at a distance from the local authority are based on thorough assessments of need and require senior manager approval. They are only made in the most complex cases involving children who need significant additional support. The local authority applies rigorous quality assurance in the procurement and monitoring of independent sector placements.
4. Prior to considering a potential placement, the Access to Resources Team secures local information from the host authority, requires a copy of the home's Local Area Assessment, liaises with the Head of the Virtual School to determine education provision and ensures that where appropriate, parents' views of the provision are taken into account.
5. Complaints are taken seriously and are investigated quickly and sensitively. Themes from complaints are reviewed at quarterly service improvement meetings chaired by the Assistant Director, to enable learning and inform any need for changes in practice or guidance.
6. Children and young people benefit from a high quality advocacy service commissioned through a voluntary organisation. They are actively supported to participate in looked after children reviews, either in person or through a report, so that the children's voices are heard and can be acted upon.
7. Independent visiting services are provided by a voluntary organisation. Currently, 17 looked after children have access to an Independent Visitor (IV). There are 4 young people waiting to be matched with an IV at this current time.

**Developments in 2016-17**

1. With support of the Corporate Parenting Committee Chair Cllr Ray Bisby the CIC (Children in Care Council) have co-produced a Z-Card Children in Care Go 2 Guide to be sent to every young person in care aged 8-18 that includes the updated Children in Care Pledge and useful contact information for young people.
2. A Youth Club session for young people 8-13yrs old which held its first session in May with 5 young people attending and lots of interest from young people and carers about future sessions was also launched.
3. In addition to the formal structure of the Children in Care Council a summer activity programme has been developed to encourage participation from a wider range of young people. Last summer (2016) saw engagement from 92 young people, with 308 attendances over 16 sessions.
4. With regard to Care leavers a monthly drop in has been run for the last 12 months with an average attendance of 7 young people per month. Working closely with Rights Resolution, who have secured funding to make the drop in a weekly activity, may support increase attendance.
5. A Post 16 Education Coordinator is now in post and liaises with the NEET team, Leaving Care Service and Local providers to ensure collaborative working to improve outcomes. A Post 16 PEP process will be develop and clarity with social workers where Young People are placed will ensure that education data is accurate on the Local Authority data base.

**Developments for 2017-18**

It is recognised by the Local Authority that there remain areas for improvement in certain areas and the following are plans for development in the coming year:

1. The introduction of a Parents Report for Review Conference is to be launched
2. The introduction of a Professionals Feedback Form for Conferences to enable agencies to share their opinions of how they feel the conferences are run and that plans are clear and outcome focussed for the families we work with.
3. Child Protection Conference Participation Leaflets have been devised, aimed at the children and young people, to explain what a Child Protection Conference is in age appropriate language.
4. Regular auditing of actions and whether records can evidence the completion and impact of the action concerned.

## Children Missing from Home and Care

When a child goes missing, it can be a clear sign of problems in their life. Some of the potential reasons children go missing include domestic abuse, neglect, exploitation, mental health issues and substance misuse. Once away from home they are vulnerable to many risks including child sexual exploitation, gang exploitation, becoming involved in crime or becoming a victim of crime.[7] Failing to recognise missing as a serious safeguarding issue can lead to significant gaps in agencies awareness and the effectiveness of their responses. In contrast, early intervention with a missing child can reduce the harm they experience and help them change behaviour before it gets embedded: a sexually exploited 15 year old who frequently goes missing is likely to need significantly more safeguarding

[7] Missing Children and Adults, A cross government strategy, 2011, the Home Office; Still Running 3, 2011, The Children's Society

interventions and support than a child who goes missing once.

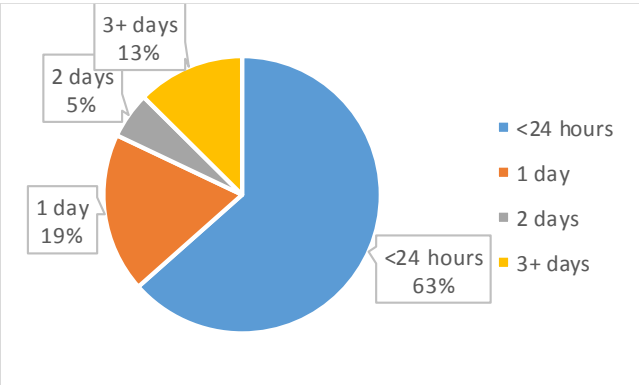
In Peterborough the Local Authority are alerted to missing incidents in the following ways:

- for children living in Peterborough who go missing (either from home or from a care placement), the contact service receive a missing alert from the police
- for Peterborough children in care who are placed outside of the LA boundary, the contact service and often the allocated social worker are alerted by the care provider.

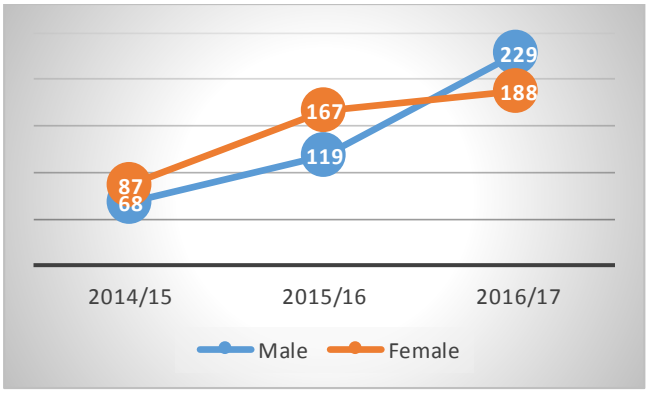
Since July 2015, the police removed the absent category for missing and now consider all those under 18 to be "missing".

During 2016/17 there have been a total of 417 children and young people under 18 who had gone missing on 613 separate occasions. This number has increased from 286 children and young people having gone missing on 466 separate occasions during 2015/16. This means that there were 147 more episodes of missing involving 131 more children than the previous financial year.

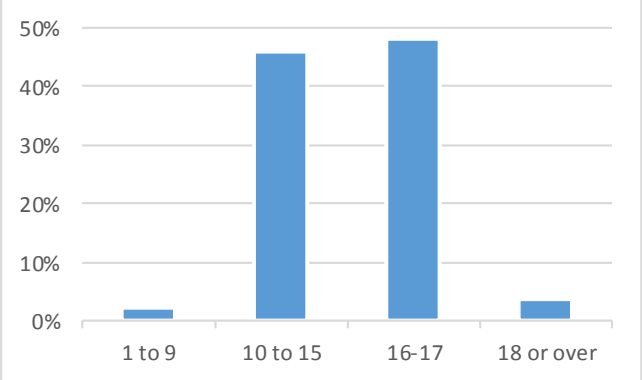
Out of 613 missing incidents, 63% were reported missing and found on the same day.




Of the 417 individual children who went missing during 2016/17, we can see that 55% were male and 45% were female. Previous year's data suggests that missing incidents are higher amongst females.




The age split shows that 48% of individuals who went missing were from the 16-17 year group with 45% from the 10-15 age group.




In terms of ethnicity, it is clear to see that the majority of children going missing are from a white British background (63%), 12% are white European, 10% Asian and 8% Mixed.

## Private Fostering


A private fostering arrangement is one that is made privately (without the involvement of a local authority) for the care of a child under the age of 16 years (under 18 if disabled) by someone other than a parent or close relative of the child, in their own home, with the intention that it should last for 28 days or more. It should not be confused with fostering placements provided by Independent Fostering Agencies run by private companies.

A private foster carer may be a friend of the family or the child's friend's parents. However, a private foster carer is sometimes someone who is not previously known to the family, but who is willing to foster the child privately.

Examples of private fostering arrangements are:

- Children sent from abroad to stay with another family, usually to improve their English or for educational opportunities.
- Asylum seeking and refugee children.
- Teenagers who, having broken ties with their parents, are staying in short-term arrangements with friends or other non-relatives.
- Children living with host families, arranged by language schools or other organisations.
- Children living with members of the extended family, e.g. Great aunt.

The Children Act 1989 requires parents and private foster carers to give the Local Authority advance notice of a private fostering arrangement. It also places specific duties on local authorities with responsibilities for children's services. The legislation made what was considered a private arrangement into a public matter by giving Local Authorities a role in ensuring that children are safeguarded.

The Board's role in Private Fostering is to have an overview of the numbers of cases being notified and that those cases are being dealt with within the guidance.

To ensure that the Board is fully aware of Private Fostering arrangements within the city, the Board receives regular updates reports from Children's Social Care as to numbers etc. In addition, the Board has played a role in ensuring that agencies are aware of Private Fostering and the implications for practice.

There were six private fostering notifications received during the period of this report, two down on the previous year.

The low numbers of notified cases could be a concern and therefore, the Peterborough Safeguarding Children Board takes the role of ensuring that all partners are aware of what Private Fostering is and their responsibility to notify the Local Authority when they become aware of this sort of arrangement.

## Allegations Management

*"Working Together To Safeguard Children – a guide to inter agency working to safeguard and promote the welfare of children 2006"* introduced the concept of the Local Authority Designated Officer (LADO) who has the responsibility to have oversight of all allegations against a professional who volunteers or works with children or young people. This was updated in 2015 where it stipulates that Local Authorities must have in place a 'Designated Officer' to handle all allegations against adults who work with children and young people.

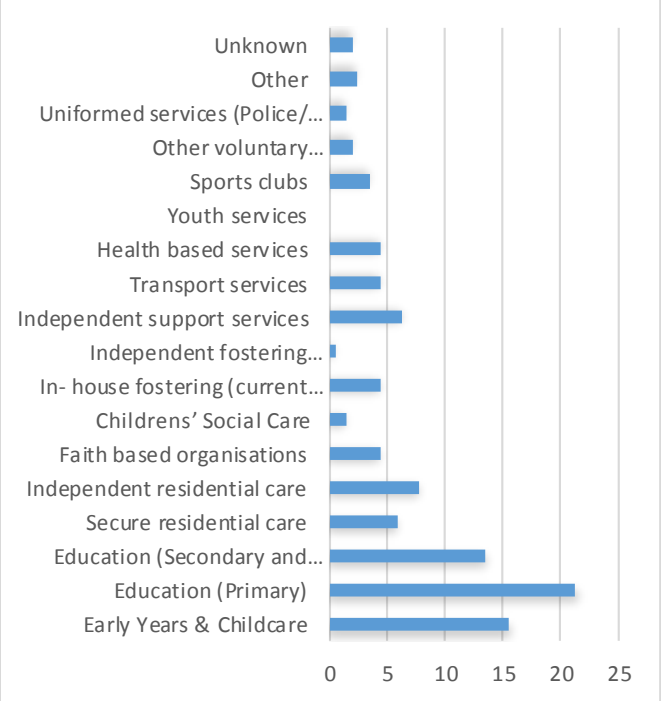
Although this practice must continue, the guidance no longer refers to them as LADOs only 'Designated Officers' or teams. However through participation at regional and national LADO meetings it has become clear that there has been some confusion with the new term 'Designated Officer' and therefore, most authorities continue to refer to the role as the LADO.

The LADO is responsible for:-

- Providing information, advice and guidance to employers and voluntary organisations regarding allegations management and concerns relating to paid and unpaid workers.
- Managing and overseeing individual cases from all partner agencies.
- Ensuring the child's view is heard and they/other children are safeguarded.
- Ensuring there is a consistent and thorough process for all adults working with children against whom an allegation is made.
- Monitoring the progress of cases to ensure they are dealt with as quickly as possible.
- Recommending when full referrals are needed and arranging and chairing complex strategy meetings where the allegation requires investigation by police and/or social

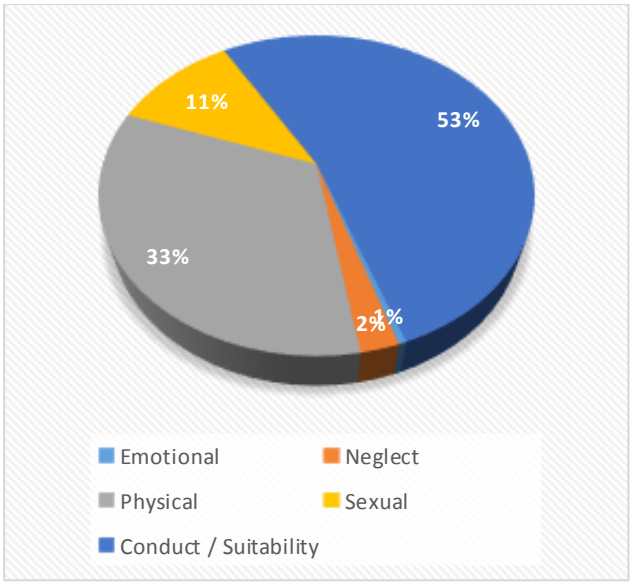
care.

The level of referrals has continued to rise during this year with an 11% increase in referrals compared to last year. This has been the pattern year on year since 2013. However, the number of referrals that required a Complex Strategy Meeting (CSM) has remained broadly consistent within the past three years which shows that thresholds are being applied consistently.

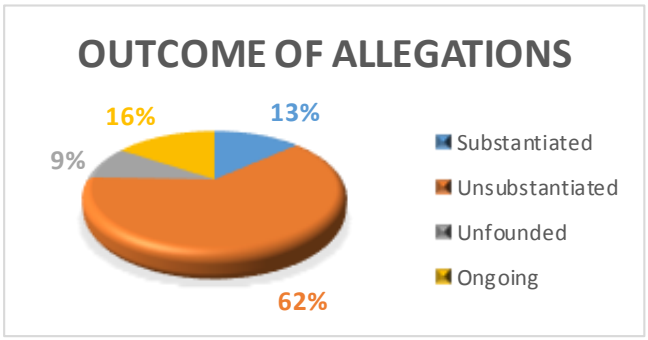



There have been three high profile cases in the last year which have received local and national media interest. Such cases increase the amount of LADO work on each case due to the increased level of communication needed and additional meetings required to manage the allegations and impact on local communities. This is hard to capture in statistics.

The chart below shows the Primary Category of Abuse in relation to allegations received in the period of this report.




Where an allegation has been made that a person who works or volunteers with children has harmed their **own** child, or been involved in an offence outside of the workplace and this may affect their suitability to work with children, this has been recorded as a conduct or suitability issue.




There have been a significant drop in the number of allegations that could be substantiated. There are no definitive reasons apparent for this, it is highly dependent upon the level and quality of evidence available. All disclosures by children are taken very seriously by the LADO and Police and must be thoroughly investigated. When an allegation cannot be substantiated, the employer then has to carry out an internal investigation.

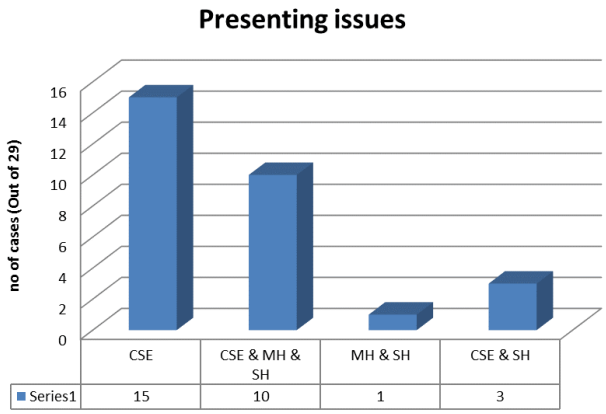
During this year there were no 'false' or 'deliberately invented or malicious' allegations.

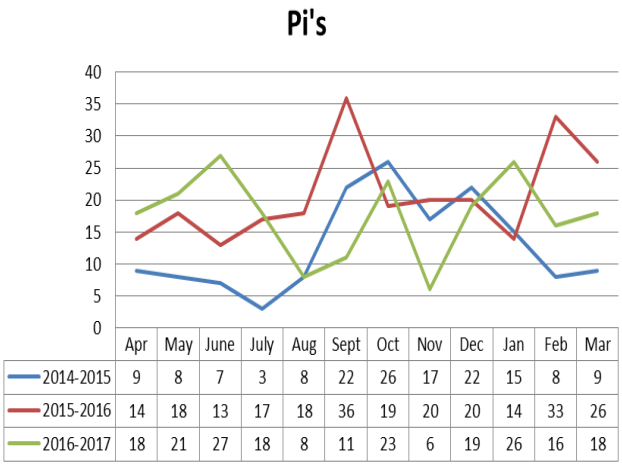
## The use of restraint in Secure Settings

Clare Lodge is a 16 bed all female, all welfare unit. Since 1 October 2016 there have been 12 discharges and 12 admissions. Most of these young people were from different local authorities. The trend on referrals for complex young people with mental health needs and experience of child sexual exploitation with the added dimension of aggression and violence. Of the group nine were from the South, thirteen were from the North, one from Wales and one from the East Anglia region. Three were from the same local authority. One was a readmission. One of the discharges went to a Tier 4 mental health bed; one went to another secure unit in Scotland after we gave notice. One young person went home. The majority of the other young people left to open children's homes.

The difficulty with local authority sourcing placements continues especially for the most complex and challenging of young people. We are finding that the quality of transitions depends on the individual Local authorities. Of those discharged the average length of stay was 181 days this was an increase on the previous six months which was 159 days. Average age has risen to 15 from 14.

See below graphs for presenting issues and levels of physical intervention. We continue to have high numbers of girls who experience child sexual exploitation this leads to a number or trauma related complexities. Physical interventions have peaked at times for the particular young person. Other than this physical intervention figures have been fairly consistent. Many staff have received refreshers in safeguarding training. There is now better communication between the secure unit and the LADO with arranged visits on a quarterly basis.




| | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2014-2015 | 9 | 8 | 7 | 3 | 8 | 22 | 26 | 17 | 22 | 15 | 8 | 9 |
| 2015-2016 | 14 | 18 | 13 | 17 | 18 | 36 | 19 | 20 | 20 | 14 | 33 | 26 |
| 2016-2017 | 18 | 21 | 27 | 18 | 8 | 11 | 23 | 6 | 19 | 26 | 16 | 18 |

## Everyone makes a significant and meaningful contribution to safeguarding children

*Legislation states that everyone has a role to play in safeguarding children. Part of the role of the Peterborough Safeguarding Children Board is to ensure that all agencies (including Police, Children's Social Care, Education, Probation, Youth Offending Service, Health and the Voluntary Sector) are properly completing their role in safeguarding. We do this through case reviews, audits, training and listening to children, young people, carers and professionals. Where we consider that an agency could improve their safeguarding activities the Peterborough Safeguarding Children Board holds the agency to account.*

This priority is primarily measured via the indicators within the PSCB dataset. As mentioned previously in the report the dataset has been

strengthened over the past year but further work is ongoing to further refine the data.

Section 11 of the Children Act 2004 imposes a statutory duty on partner agencies to safeguard children and young people. The Board scrutinises agencies compliance with this duty by undertaking a S11 audit. These audits are carried out every two years .The last Section 11 audit was completed in 2015/16 and the next S11 will commence in May 2017. Findings from this audit will be shared in the 2017/18 Annual Report.

As previously mentioned, attendance at meetings of Peterborough Safeguarding Children Board by all of the wide range of agencies is good and all members have made contributions towards the campaigns run in the last year. In addition, those agencies who support the Learning and Development Programme by delivering multi-agency training include:

- Police
- Children's Social Care
- Health
- The voluntary sector

## Workforce has the right skills / knowledge and capacity to safeguard children

*'Local Safeguarding Children Boards (LSCBs) should use data and, as a minimum monitor and evaluate the effectiveness of training, including multi-agency training to safeguard and promote the welfare of children".Working Together to Safeguard Children 2015*

During April 2016 and March 2017 the PSCB offered over 40 different safeguarding courses (14 of which form the core programme) with 90 individual training sessions being offered, this does not include the Annual Conference, training undertaken by the Exploitation Coordinator to groups of young people or the training undertaken with the Mosques and Madrassahs.

The courses varied in both subject field and course level but all courses were delivered to a multi-agency audience. The subjects discussed during the 12 months included:-

- Child Sexual Exploitation (CSE)
- Neglect (including specific training on neglect assessment tools)
- Gang exploitation and safeguarding
- Domestic Abuse
- Honour Based Violence
- Children displaying sexually harmful behaviour

Although 90 sessions were offered only 76 training sessions went ahead. The majority of course cancellations were due to either trainer sickness/annual leave or low enrolment figures.

914 training course places were allocated to delegates and of these 867 delegates attended. This equates to a 5% non-attendance rate. This is 1% higher than last year but considerably lower than previous years (2013/14).

Out of the 867 delegates, 42% were from the local authority, 17% from various health organisations, 16% from Education and 12% were from the voluntary sector. Attendance from Probation and Police continues to be substantially lower than other agencies and can partially be explained by these agencies accessing training through the Cambridgeshire Local Safeguarding Children Board.

Out of 867 delegates, 85% completed evaluation forms which found their knowledge of the subject had increased substantially.


It is clearly evidenced that delegates felt that the training they have attended was both relevant to

their day to day role and their knowledge had sufficiently increased on completion of the course. It is also important to highlight that training attendance had a positive impact in terms of confidence growth when dealing with safeguarding issues.

The Annual Conference was also a success and had good attendance levels from a multi-agency audience across the County. The evaluation forms evidence that delegates felt the conference increased their knowledge of risk taking behaviour in adolescents and neglect.

Further details can be found in the PSCB Training Annual Report which can be found on our website www.safeguardingpeterborough.org.uk

## Understand the needs of all sectors of our community

*Peterborough is a multi-cultural City with lots of different communities. It is very important that the Peterborough Safeguarding Children Board understands the cultural and religious beliefs of all sectors of its communities and how they may impact on safeguarding issues.*

The Peterborough City Council Community Cohesion team has played a central role in developing the safeguarding programme in partnership the PSCB and the local Muslim community, Muslim Council of Peterborough (MCP).

The Board worked in partnership with the MCP and community cohesion team to develop and produce safeguarding guidance and policies that were tailored to the needs of the community.

The PSCB developed a train the trainer safeguarding programme which was delivered to the community by the PSCB in conjunction with the Education Safeguarding Lead and the LADO.

Through this Safeguarding programme, the Muslim Council of Peterborough has been empowered to deliver an Introduction to Safeguarding Children and Young People safeguarding course to Mosque madrassa employees and volunteers, Non-Mosque Madrassa employees and volunteers and 5 Eastern European Complimentary School staff members. To date 173 people have been trained.

The Norfolk Safeguarding Children Board have visited Peterborough to view the MCP Safeguarding Policies, they have been visibly impressed and have shown an interest in replicating the work in Norfolk.

Through the sustained efforts of the Community Cohesion team, the Muslim Community have understood the need for safeguarding within their communities. The mosque members have recognised its importance and have set it as a priority for their organisation.

Mosque members affiliated to the Muslim Council of Peterborough are taking a keen interest in the training sessions and new updates.

The non-mosque madrassas which have previously been very hard to reach are now opening up and engaging with the safeguarding work.

The Eastern European communities have been accessed through the MCP Safeguarding work, they too are keen to further work to update their organisations. It is hoped that this work will be progressed over the next year.

In addition to the above, in March 2017 the Board held a safeguarding awareness month. Members of the Business Unit manned stalls in a number of public areas (including shopping centres, hospital foyers) to promote information about safeguarding and neglect. Leaflets were disseminated to members of the public and it was an opportunity for people to ask questions or raise concerns

## Children are fully protected from the effects of neglect

The Board developed and launched a neglect strategy in September 2016 to coincide with the launch of the threshold document. To assure the Board that the strategy had been appropriately

embedded into practice a multi agency audit was scheduled to take place in May 2017.

In the interim period the Board scrutinised performance through the dataset and escalations. The PSCB has worked with public health to strengthen the PSCB dataset to include information about low birth weight, immunisations, obesity, repeat accidental injuries. Whilst this data is in place work is taking place to further refine the data and make it more meaningful.

In May 2017 the Board will undertake a neglect audit to check compliance with the neglect strategy across agencies.

In addition to the neglect audit the PSCB will use the S11 audit as a further opportunity to monitor and scrutinise practice around neglect.

The Board offers basic and intermediate training on neglect. This is regularly accessed by practitioners from all agencies. In addition training is available on:

- Quality of Care tool
- Completing the Quality of Care Tool
- Outcome Star
- Early help
- Supporting vulnerable children and families in the early years.

In March 2017 the Board hosted a conference (Adolescent perception of risk: Understanding and preventing high risk behaviour). 110 people attended the conference from a range of agencies. A key note speaker gave a presentation about mental health and neglect and there was a specific workshop "Thrive to survive" that looked at issues of neglect in adolescents.

In addition to the training the PSCB has developed a neglect resource pack for practitioners. This contains PowerPoint presentations, leaflets, guidance and additional information on neglect. The resource has been shared with agencies and is available on the PSCB website

## Children are fully protected from Child Sexual Exploitation

Throughout 2016-17, the Board has continued its proactive response to CSE through continued awareness raising and extensive partnership working.

Since April 2016, Peterborough Safeguarding Boards has delivered a significant amount of multi-agency and single agency training, including: four half-day sessions on child sexual exploitation to multi-agency professionals, one half-day session specifically for foster carers, newly-qualified social workers and family support workers and three separate bespoke sessions for youth work staff, first response Social Workers and education settings across Cambridgeshire. These workshops were tailored to the audience to ensure relevant materials and messages were shared. Most recently, a workshop was offered as part of the Safeguarding Board's annual conference titled 'CSE in 2017', which aimed to consider the perception of CSE and how this might have changed since the first reports and court cases on the topic surfaced around 2009. This workshop was both well attended and well received.

A significant area of activity at the beginning of the period was community awareness raising on child sexual exploitation focussed on hotels in the city, evidenced by local information gained under Operation Makesafe. Extensive contact was made with hotels across the city and six sessions of bespoke training were delivered to five different hotels in partnership with Constabulary staff from the Safer Peterborough Partnership. This activity was linked into regional activity which saw the delivery of test purchasing in hotels across the Cambridgeshire area. In addition, Licensing Officers delivered CSE messages during a week of action in May 2016 using materials produced by the Safeguarding Board. Operation Makesafe continues to consider this area of awareness raising and partnership building across the night-

time economy a priority, and activity will continue in 2017-18.

In 2015-16, the Board recognised that boys are under reported as potential victims of CSE nationally and so offered specific workshops to raise awareness of the warning signs for boys and young men. This year, this work was developed to reach a wider audience than that which might be able to access face to face training, by launching a resource pack focussed on the topic of boys and young men as potential victims of CSE. This pack includes links to videos for professionals with associated training materials, case studies and worksheets and materials for use in working with children and young people, including those from the LGBTQ community. These resource packs were launched on National CSE Awareness Day free of charge to professionals across the city.

In addition, a similar resource pack was launched on the same day which covered the topic of child sexual exploitation and learning disabilities. Significant specialist support and advice was provided in the development of this pack by the Counselling Psychologist in the Youth Offending Team. This pack also contained research, training materials and worksheets for use with young people. The aim of both packs is to empower professionals to introduce potentially difficult conversations with young people they are concerned about and raise their awareness of potentially dangerous or harmful relationships and situations. Both packs will be updated as new material becomes available. An update of the main resource pack to include worksheets and other materials is underway following the release of the updated definition of CSE by the Department for Education.

In June 2016, a report was published by the Board into the city's multi-agency response to child sexual exploitation by independent author Ceryl Davies. The report is a positive reflection of the proactive response by agencies to the issue and a number of recommendations were made which were placed into an Action Plan, monitored by the Safeguarding Board's Serious Case Review sub-group. To date all of the actions within the Action Plan have either been achieved or marked as ongoing: for example continued intelligence gathering from partner agencies to support Operation Makesafe.

Two specific actions within this Action plan were an audit into the use of the Joint Child Sexual Exploitation Risk Management Tool and a dip sample exercise looking at return interviews (completed when children and young people go missing from home or care).

Both of these exercises were completed by the Sexual Exploitation Co-ordinator.

In September 2016 the powerful play 'Chelsea's Choice' returned to Peterborough's secondary schools, commissioned by the Board. 11 secondary schools in the city received performances which were delivered to children in years 8 or 9, depending on the school. Two of the city's special schools also agreed to performances for their students. In total the play was seen by around 1800 students, and all of the schools expressed positive feedback about the impact the play had had on their students and the work they had completed afterwards.

In addition to the school based performances, the Board also commissioned an evening performance for members of the local community including parents and carers. This performance was attended by over 80 people and again, received excellent feedback.

Finally, this year has seen the development of partnership information sharing and intelligence gathering through the following activities:

The development of an Information Sharing protocol between Cambridgeshire Constabulary, PSCB, Cambridgeshire Local Safeguarding Board, Lincolnshire Constabulary and Lincolnshire Local Safeguarding Children Board.

The development of links between Rutland Safeguarding Children Board and PSCB

Continued support from PSCB to the Police led Operation Makesafe, and the associated information sharing and governance, and finally continued support and challenge to the local Peterborough based Operational Group which considers those children at the highest risk of going missing or at risk of harm from child sexual exploitation.

Planned activity for the next year will include: cross-county updates to the joint CSE Risk Management Tool following changes in Cambridgeshire affecting the consideration of children at risk of child sexual exploitation, updated to the CSE Strategy and Action Plan, continued awareness raising with the night time economy and alignment of training on Child Sexual Exploitation and children who go missing across Peterborough and Cambridgeshire.

## The Voice of Children, Young People and Families

The Board and their partners are very aware of the need to engage with families, children and young people in a meaningful way to understand and act on their views and concerns.

The PSCB has worked hard to capture the views and opinions of young people across the City and ensure that they are used to improve agencies practice. Over the last 12 months the Board has undertaken 3 surveys with young people across the City and had an overwhelming response. Whilst none of the surveys were explicitly around the subject of neglect they all involved subject areas that research indicates are intrinsically linked to those children who are the subject of neglect.

In February – April 2016 the Board ran a survey on Domestic abuse and sexual violence (healthy relationships). We produced two surveys, one aimed at school years 4-7 and one aimed at school 8-11. Questions included what makes a health relationship, what things are ok/ not ok in a relationship, who they would talk to if they had a concern in a relationship. There were also specific questions around whether they had seen/heard violence at home, the frequency with which it occurred and who they would talk to about it. We received a total of 1946 responses from across the City which provided the Board with a good insight into the lives of young people across the City. The findings from the survey have been used to inform the work of the DA/SV strategic Board. The findings have also been used by the Safer Peterborough Partnership (CSP) to their work around DA and were also used to inform the Countywide JSNA on VAWG.

In February/ March 2017 the PSCB undertook a survey around "gangs" with secondary school students across the City. The questions included their perception of gangs, had they been a member of a gang, names of local gangs. We received 669 responses to the survey and the results were used to inform the PSCB Gang workshops that are currently being delivered across the County. The work has also been shared with the Safer Peterborough Partnership (CSP) to help inform their work around Gang related activity.

The Board undertook a further survey in November 2016 -March 2017. This survey examined the issues of e safety, sexting and on line bullying.

The survey was issued to all schools across the city to ascertain the views and experiences of children and young people with regards to their online safety. Two surveys were developed, one aimed at 7-10 year olds and the other aimed at 11-16 year olds. In total, there were over **2,011** responses from **49** schools across Peterborough which were completed anonymously.

The findings from the survey included;

- 64% of 7 to 10 year olds and 87% of 11 to 17 year olds has a social networking profile with the most popular sites being Snapchat, WhatsApp, Facebook and Instagram.
- 79% of 7 to 10 year olds and 68% of 11 to17 year olds play games online. The most

popular games included Minecraft, Call of Duty, Grand Theft Auto, Pokémon and ROBLOX.

- 23% of 7 to 10 year olds and 26% of 11 to 17 year olds have met with someone they only knew online.
- 28% of 7 to 10 year olds and 48% of 11 to 17 year olds do not always follow online safety advice they have been given.
- 56% of 7 to 10 year olds and 25% of 11 to 17 year olds do not use privacy settings on their social networking accounts
- 4% of 10 to 17 year olds have shared inappropriate images of themselves.

There needs to be an emphasis to children and young people that not everyone online may be who they appear to be, and children and young people who use social networking sites should be reminded about the importance of setting privacy settings and to only make friends with people they know and trust and to remind them of online stranger danger.

Despite the low number of young people admitting to sharing intimate or inappropriate images, young people need to be aware of the possible dangers by sending these images both to themselves now and in the future.

The learning from the survey has been used to shape the work plan of the E safety sub group. The findings have also been shared with schools across the City, governors, and parents. The Internet Watch Foundation have also used the findings as part of their research information.

## Scrutiny and Challenge

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

b) to ensure the effectiveness of what is done by each such person or body for those purposes.

### Scrutiny

In the period covered by this report, the Board has provided scrutiny to agencies through reports and discussion at the bi-monthly Board meetings on the following issues:

- LADO Annual Report
- Parental Consultation around the Child Protection Conference Process Feedback Report
- Analysis of Multi-agency Attendance at Child Protection Conferences Report
- Children in Need Update
- Unaccompanied Asylum Seeking Children
- Safeguarding Children Quarterly Reports
- Police Problem Profile – Child Sexual Exploitation in Cambridgeshire and Peterborough
- Elective Home Education
- Clare Lodge Performance Quarterly Performance Report
- Annual Report 2015-16 (CDOP)

### Challenge

As well as evaluating and analysing operational issue within Board meetings, the Peterborough Safeguarding Children Board has also been active in the last year, challenging practice through individual case escalation. This can result in the Peterborough Safeguarding Children Board facilitating meetings around practice or speaking directly to senior managers about the issue. The Peterborough Safeguarding Children Board does not keep a record of every concern or challenge that it has participated in but it does keep a 'Challenge Log' of examples of concerns or challenges it has been involved in.

The log evidences that, within the 12 months of this report, the Peterborough Safeguarding Children Board (through either the Chair or Board Manager) has facilitated inter-agency meetings involving challenges to practice. In addition there has also been cases where the Peterborough Safeguarding Children Board Manager has raised

escalation concerns directly with the appropriate Board Member regarding frontline practice.

The challenge log demonstrates that the Board has a good oversight of practice across agencies.

## Conclusion

The Peterborough Safeguarding Children Board continues to be a strong partnership which has worked well together to coordinate activity and hold partner agencies to account for their activity to provide the best outcomes for children and young people in the city. The good work the Board has completed in the last year can be seen in the strengthening of its engagement with young people. The aim has been to gain knowledge of their wishes, feelings and opinions, ensuring that the work of the Board is relevant and informed by the voices of local children. This work has been greatly supported by better relationships with the schools, secondary and primary, via the Education Safeguarding Lead who has contributed directly to ensuring the profile of the Board has been raised amongst children and young people in the city.

The Board offered a good, proactive response to neglect and e safety, including some excellent community engagement work. This work is ongoing and it is the aim that community engagement work with a range of safeguarding activities and awareness raising more generally, will benefit from the lessons learnt and good practice demonstrated in the Board's response to CSE.

Work with the faith communities in Peterborough has continued to be a particular area of good practice in the last year. The Muslim Council of Peterborough, via the Communities and Cohesion Manager for Peterborough City Council and again the Education Safeguarding Lead have supported some excellent awareness raising and engagement work.

Lastly, there has been some excellent partnership work across the county of Cambridgeshire this year through joint work with Cambridgeshire Local Safeguarding Board and it is the aim that this work will not only continue but develop further to strengthen this partnership through 2017/18.

### The Boards' Business Priorities 2017-18

It was agreed by the group to retain the priorities in place in 2016/17 for an additional year. These are:

- Early help and preventative measures are effective.
- Children at risk of significant harm are effectively identified and protected.
- Everyone makes a significant and meaningful contribution to safeguarding children.
- Workforce has the right skills/knowledge and capacity to safeguard children.
- Understand the needs of all sectors of our community.
- Children are fully protected from the effects of neglect.
- Children are fully protected from Child Sexual Exploitation.

### Future developments

- Strengthening the multi-agency dataset to reflect safeguarding activity across the city and to provide the Peterborough Safeguarding Children Board with a clear picture of agencies' performance,
- Development of audit activity across the county, as well as across the children's and adult's safeguarding workforce.
- Scrutiny of the implementation of the neglect strategy
- Continued activity to ensure neglect continues to be a priority for safeguarding agencies.
- Increased engagement with front line practitioners.
- Closer working with Cambridgeshire LSCB

This report has been compiled on behalf of the Peterborough Safeguarding Children Board by the Peterborough Safeguarding Boards (Adult and Children) Business Unit.

The content is drawn from the work of the Peterborough Safeguarding Children Board and its sub-groups including; reports presented to those groups; records of meetings; multi-agency audit findings and the findings from Serious Case Reviews.

The report will be published in July 2017 and will be a public document and available from the Peterborough Safeguarding Children Board website.

In line with statutory requirements and best practice, the Annual Report 2016/17 has been sent to the following:

- Peterborough City Council Chief Executive
- Leader of the Council
- Cambridgeshire and Peterborough Police and Crime Commissioner
- Chair of the Peterborough Health and Wellbeing Board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# Peterborough Safeguarding Adults Board Annual Report 2016-17

***Safety, Enablement, Empowerment and Prevention, at the centre of everything we do***

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## FOREWORD

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

In September 2016 The Local Government Agency (LGA) carried out a peer review of Safeguarding Adults in Peterborough. They found that the Board was working well with strong board activity promoting issues like Making Safeguarding Personal, and working on collobrative projects. It was really pleasing to all of us to receive this National positive endorsement of the work we are doing. The frontline staff and their managers from local agencies need particular mention for their commitment to safeguarding adults in Peterborough.

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

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

There are still many challenges and the boards are striving hard to work on improving how we do this, through writing policies and guidance, and improving frontline practice, with a full and challenging training programme. This year the board ran a "A Domestic Abuse and Adults Safeguarding" conference, with over 110 delegates, many providing good feedback.

This annual report provides a background to adult safeguarding work in Peterborough and a summary of the work undertaken by the Safeguarding Adults Board (SAB), the sub groups, the Adult Safeguarding Team and partners with insight into local issues. It showcases the developments and initiatives pertaining to safeguarding that have taken place during April 2016 to March 2017. In doing so, it aims to provide a level of assurance that the organisation is fulfilling its statutory duties and responsibilities for safeguarding adults in Peterborough.

I realise there is much more to be done, and we must strive to work with all of the organisations and providers of adult care in Peterborough to make this a safe city to be a resident of, in particular when you are vulnerable and in need of care and protection. The underpinning message however remains the same, that safeguarding is everyone's business, irrespective of role or position. It is everyone's responsibility to safeguard and protect the most vulnerable adults in our society. The adult at risk must remain at the centre of all our actions.

Dr Russell Wate QPM - Independent Chair

## BACKGROUND

The implementation of the 2014 Care Act set out a statutory framework for safeguarding (using the 2011 Law Commission Adult Safeguarding report as its backdrop). Peterborough already had a Safeguarding Adult's Board in place before it became a statutory requirement.

**The role of The Board is to work as a multi-agency group:**

1. To ensure the safeguarding of adults at risk of abuse in Peterborough and to prevent abuse and neglect happening within the community and in service settings by providing effective strategic governance at senior management level across partner organisations.
2. To provide independent governance and audit of safeguarding practices and to promote the safeguarding interests of adults at risk to enable their wellbeing and safety.
3. To promote, inform and support the work to safeguard adults in Peterborough, across all the partnership agencies, and to inform and support cross boundary safeguarding arrangements.
4. To develop Peterborough's strategic safeguarding policies, and ensure the inclusion of these polices in all agencies strategy documents and plans.
5. To address poor practice and robustly act to ensure the principles are maintained.
6. To seek independent legal advice as appropriate.

**The key elements of the 2014 Care Act are:**

- Safeguarding Adults Boards (SABs) placed on a statutory basis
- Core membership must consist of the Local Authority, NHS and Police
- Partners have a duty to co-operate
- The SAB must have a Strategic Plan, written after consultation with the local Healthwatch and the local community, and it must be published

**The SAB must publish an annual report, which must include:**

- what the SAB, and its members, have done to carry out and deliver its objectives
- information about any Safeguarding Adult Reviews (SAR's) that are ongoing or have been reported in the year. This must include what the SAB has done to act on the findings of any completed SARs, or where it has decided not to act on a finding, why not
- how the SAB is monitoring progress against its policies and intentions to deliver its strategic plan

## OUR VISION

*"Safety, Enablement, Empowerment and Prevention will be at the centre of everything we do"*

We implement this vision using the firm foundation the Board has developed, where our shared values and beliefs are manifested through close partnership working, commitment and our mutual accountability.

Working within the **six principles** for adult safeguarding is key to delivering our vision – these principles are an aid to understanding the action that need to be taken to protect people and are agreed within the Care Act 2014:


## MAKING SAFEGUARDING PERSONAL

The Care Act 2014 defines safeguarding adults as protecting an adult's right to live in safety, free from abuse and neglect. Making Safeguarding Personal (MSP) aims to make safeguarding person-centred and outcomes focussed and moves away from process-driven approaches to safeguarding.


The SAB continues to have MSP as a central theme in its priorities, it is a regular discussion item at the Board and sub-groups and members are challenged on how they are delivering in this area.

## THE LOCAL PICTURE

.

Demand for adult social care continues to increase as older people, people with learning disabilities and younger people with physical disabilities are all generally living longer.

Peterborough has greater areas of deprivation than the England average.

Peterborough's estimated population is 193,980, of which 53% are over 25, 14.3% over 65

In 2016-17 Peterborough City Council supported 2112 older people (65+) and 1031 adults (18-64) with long term packages of care and support

Although life expectancy has been improving 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.

1 in 17 people over 65 are living with Dementia, which is 1,500 people in Peterborough.

Suicide rates in Peterborough are currently similar to the national average, but admissions to hospital for mental health causes are higher than average.

A growing number of vulnerable people are independently funding their own care but turning to social services to enable funding when their own funds expire.

Information taken from: ONS 2015 midyear figure, Peterborough's multiple deprivations core and the Joint Strategic Needs Assessment Core Dataset Refresh 2016

# SAFEGUARDING FACTS AND FIGURES

**How much abuse was reported?**

The Adult Social Care Team dealt with 1825 new safeguarding concerns (cases that progressed as far as triage) and 294 new enquiries.

Most commonly reported abuse was:

Neglect – **36%**

Physical – **19%**

Financial – **18%**

**Who reported the abuse?**

Primary/secondary health care staff raised **21%** of concerns

Social worker/care manager - **18%**

Police – **12%**

**What about the risks?**

Of the original risks identified 6% remained at the end of investigation – the majority of these occurred where the risk was from contact with someone known to the individual

Of risks posed by service providers **56%** occurred within a care home setting, **28%** within the adult's own home

Of all risks posed to individuals **42%** were by people that were known to them a further **52%** were posed by a service provider

**Who was abused?**

Of the individuals involved in new safeguarding concerns:

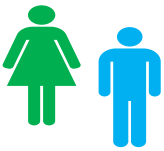
**59%** were aged 65+

**31%** were aged 85+

Of the individuals involved in new safeguarding concerns:

**61%** were women

**39%** were men



**What were the conclusions?**

At the end of the investigation, the conclusions were that:

**37%** of alleged abuse was evidenced as having happened

**55.5%** of the alleged abuse was evidenced or partially evidenced

**35%** of the allegations were unfounded or not evidenced

Of the individuals involved in new safeguarding concerns:

**51%** had a physical support need

**29%** a mental health need

**Where were they abused? 4o%** of abuse took place in the adults own home. **33%** in care homes

**What about the outcome?**

**63%** of those adults who stated a desired outcome for the safeguarding investigation thought that this had been fully achieved. (compared with 47% the previous year)

Information from the Safeguarding Adults Collection (SAC) 2016-17

## HOW THE BOARD OPERATES

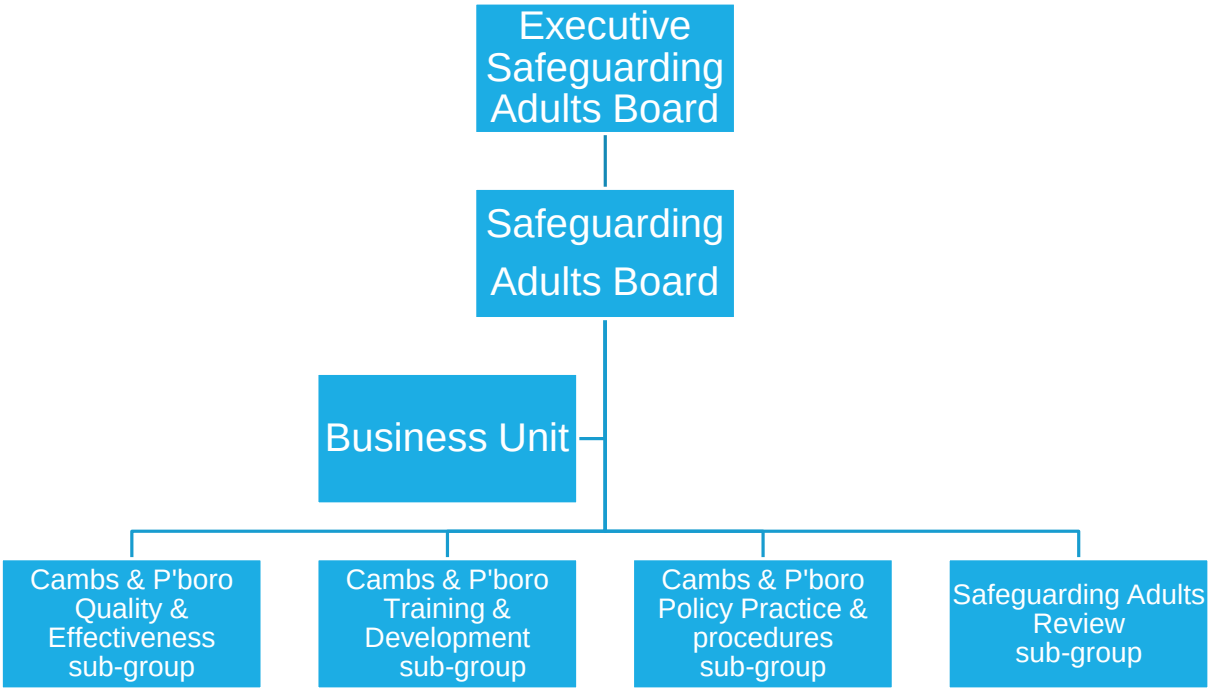
The Board meets 4 times a year and has an Independent Chair, Dr Russell Wate, who has been in post since June 2014. Russell also chairs the Peterborough Safeguarding Children Board (a statutory requirement for a number of years) and this has provided a level of shared understanding across the two boards.

In September 2016 he also became Chair of the Cambridgeshire Local Safeguarding Children Board, and in November, the Cambridgeshire Safeguarding Adults Board. This allows for better partnership working, better use of resources and a consistent approach to Safeguarding across the county. In light of this it was decided in 2016 that some of the work of the Boards should be combined or mirrored across the two Boards, to ensure consistency of practice and policies, and efficient service delivery.

To enable this joint work, the Business Unit which supports the work of all the Boards is being reconfigured to form a combined Adult and Children's, Peterborough and Cambridgeshire Safeguarding Board Business Unit, managed by Jo Procter as Head of Service. This process will complete in July 2017.

A further step towards better joint working was the establishment of the Executive Safeguarding Adults Board (ESAB) in January 2017. The ESAB will meet 3 times a year and is made up of the senior statutory members from Peterborough and Cambridgeshire and together they set the strategic agenda for both SABs.

The Board has to ensure it delivers on its statutory requirements and hold agencies in Peterborough to account for their adult safeguarding responsibilities. This includes the establishment of a multi-agency training programme, policies and procedures and the implementation of a quality assurance programme. To help with this, the work of the Board is progressed via its sub-groups who are tasked with specific responsibilities in line with the Board's priorities:



## THE SUB-GROUPS

There are 4 sub-groups, all of which include members from Peterborough and Cambridgeshire:

**Policy, Practice and Procedures sub-group**

The overarching purpose of the group is to develop and maintain a harmonised policy and procedural framework for Cambridgeshire & Peterborough Safeguarding Adults Boards.

**Quality & Effectiveness sub-group (QEG):**

To assure adult safeguarding processes in Peterborough and Cambridgeshire are safe, effective and provide a positive customer experience. To commission specific quality and performance analysis work, to report the findings and make recommendations to the SAB's

**Training and Development sub-group:**

To oversee and commission training which further strengthens the awareness of safeguarding and to ensure that those who respond to and investigate safeguarding concerns have the necessary skills to do so effectively. To look at how training across the county can be better aligned and map what training is already been delivered and to develop a competency framework.

**Safeguarding Adults Review (SAR) sub-group**


The Care Act 2014 statutory guidance says that a SAB must arrange a SAR when the following criteria is met:

1) when an adult in its area **dies** as a result of abuse or neglect, whether known or suspected, **and** there is concern that partner agencies could have worked more effectively to protect the adult.

2) if an adult in its area **has not died**, but the SAB knows or suspects that the adult **has experienced serious abuse or neglect**.

The SAB delegates this function to the SAR sub-group.

The purpose of a SAR is not to reinvestigate or to apportion blame, it is:

- to establish whether there are lessons to be learnt from the circumstances of the case and the way in which local professionals and agencies work together to safeguard vulnerable adults;
- to review the effectiveness of procedures;
- to inform and improve local inter-agency practice and
- to improve practice by acting on learning (developing best practice)

The sub-group regularly reports to the SAB, and all SAR reports are shared with the SAB before final approval.

In 2016/17 the sub-group met 6 times and during this period no new referrals were received. The sub-group has continued to progress work on two cases that started in 2015:

**a.** The case of an elderly lady who died and neglect of her health needs was suspected
**b.** The case of a middle aged lady who committed suicide while her mental health needs were known but not met (words taken from the Coroners verdict)

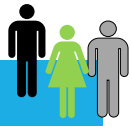
The first of these two cases, **a,** is near completion, the recommendations are being discussed and it is hoped the report will be finalised in the summer of 2017. The recommendations will form an action plan, which will be monitored by the SAB.

The second case, **b,** was completed in March 2017. 7 recommendations were made as part of the review, and work has started on the implementation of these, and several areas have been identified for learning. A leaflet and PowerPoint presentation have been prepared and are available for agencies to use as learning resources. This particular case also involved Children's Services.

The key themes were:

- It is hard for professionals to have a complete picture of what is happening in a person's life when the subject does not want to share information - agencies need robust strategies in place to deal with this
- Supervision could have been better used to discuss risks
- There is a need to challenge the myth that patients will not get a bed, or appropriate treatment if they attend the hospital Emergency Department as a result of a mental health crisis.
- Family/Friends/Carers should not be over relied on to support those with a mental illness
- Children's Services need to have greater awareness of the impact of child safeguarding issues on parental mental health, and the action to take when there is an adverse effect

## WHO IS REPRESENTED ON THE SAB



As well as the as the statutory members, other agencies, who represent the services delivering care and support to adults at risk in Peterborough are also members:

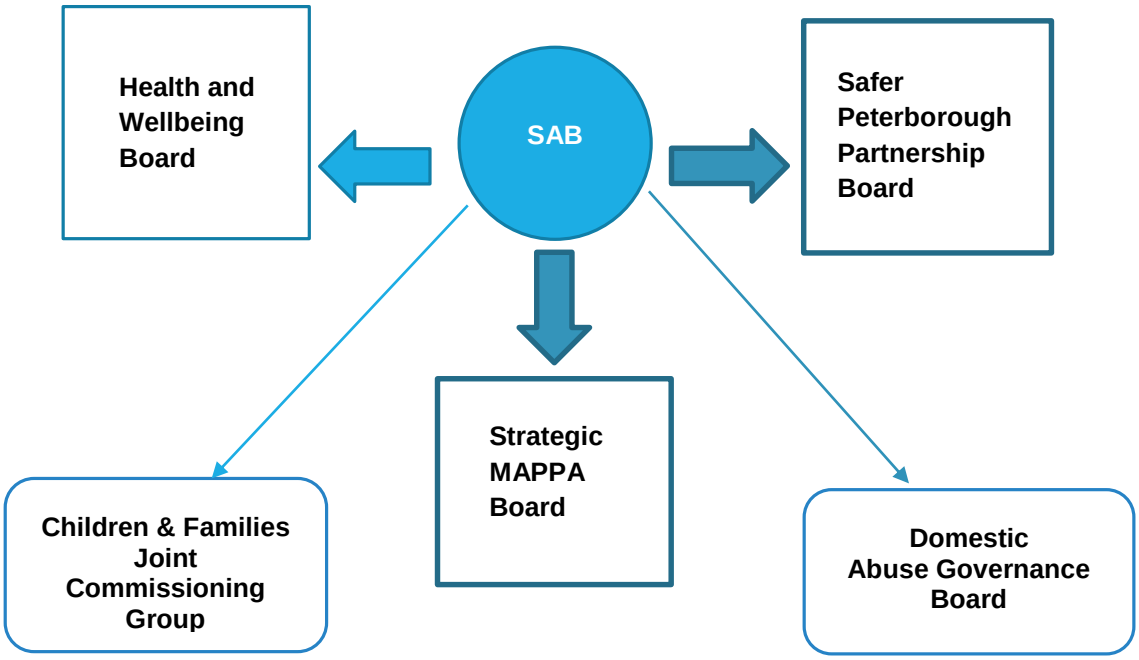
| Agency | Name |
|---|---|
| Age UK Peterborough (Voluntary Sector Rep) | Chief Executive Officer |
| Axiom Housing (Housing Sector Rep) | Operations Director |
| **Cambridgeshire Constabulary (Statutory Member)** | Detective Superintendent, Public Protection |
| BeNCH (Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire Community Rehabilitation Company) | CRC Deputy Director & Head of Cambs Local Delivery Unit |
| Cambridgeshire Fire & Rescue Service | Community Safety Advisor & Safeguarding Manager- |
| Cambs & Peterborough NHS Foundation Trust | Director of Nursing |
| **Cambs Clinical Commissioning Group (Statutory Member)** | Deputy Director Of Patient Quality and Safety |
| **Cambs Clinical Commissioning Group (Statutory Member)** | Designated Nurse – Adult Safeguarding |
| City College Peterborough | Vice Principle |
| Peterborough Healthwatch | Chief Executive Officer |
| HMP Peterborough | Deputy Director |
| National Probation | Assistant Director |
| **Peterborough City Council (Statutory Member)** | Director for People & Communities |
| Peterborough City Council | Service Director, Adult Services and Communities |
| Peterborough City Council | Assistant Director, Adult Operations and Housing |
| Peterborough City Council | Head of Social Care Commissioning |
| Peterborough City Council | Safeguarding and Quality Assurance Manager |
| Peterborough City Council | (Cllr) Cabinet Member |
| Peterborough & Stamford Hospitals NHS Foundation Trust | Deputy Chief Nurse |
| Peterborough Regional College | Executive Director (students) |
| Provider Forum Representative | 2 members |

Representatives from partner agencies are of sufficient seniority to make decisions on behalf of their agency and are responsible for disseminating information between the SAB and their agency. The Cabinet Member for Adult Services attends as a participating observer, and can challenge the Board and its members as necessary.

## LINKS WITH OTHER BOARDS

The SAB has strong links with other boards who impact on adult services and those involved in the planning and commissioning of services delivered to adults in Peterborough.

The Chair is a member of the Peterborough Health and Wellbeing Board, the Safer Peterborough Partnership and the Strategic MAPPA Board.




Key members of the SAB also sit on the Safer Peterborough Partnership and Domestic Abuse Governance Boards. In addition, the Head of Service is a member of the Domestic Abuse Governance Board and the Children and Families Joint Commissioning Board.

These links mean that adult safeguarding remains on the agenda of these groups and is a continuing consideration for all members, widening the influence of the SAB across all services and activities in Peterborough. This was further enhanced by the introduction of the Inter-board protocol in January 2017, ensuring these boards work better together.

## BUSINESS PRIORITES

In March 2016 the SAB met and agreed the following priorities for 2016-17:

**Priority 1**: To work in partnership with all agencies to safeguard adults at risk of abuse and neglect, while following the principles of Making Safeguarding Personal – person-led and outcome focused; allowing involvement, choice and control.

**Priority 2**: To deliver policy and procedures based on collaborative best practice and consultation.

**Priority 3**: To ensure the workforce has the right skills/knowledge and capacity to recognise and safeguard adults at risk of abuse and neglect.

**Priority 4**: To seek assurance that adults at risk of abuse and neglect are effectively identified and safeguarded.

As well as these priorities it was recognised that there needs to be focus on:

- Embedding the new Multi-Agency Safeguarding Adults Policy and Procedures
- Community/Service User engagement
- Domestic Abuse, Human Trafficking and Modern Slavery – including upskilling workers in these areas
- Multi-Agency Audits
- Evaluation and mapping of training across the partnership

**What have we done to meet these priorities?**

Priority 1: To work in partnership with all agencies to safeguard adults at risk of abuse and neglect, while following the principles of Making Safeguarding Personal – person-led and outcome focused; allowing involvement, choice and control.

The SAB has continued to build and maintain strong relationships with partners across Peterborough and Cambridgeshire through the following:

- Executive Safeguarding Adults Board – with cross county membership
- Joint sub-subs are established
- plans are in place for a joint business unit
- first joint conference in March 2016
- shared Safeguarding Adults Review procedures
- joint procedures are being developed
- Inter-board protocol developed to enable better working across other boards

All of this has been done within the principles of Making Safeguarding Personal and members have been challenged over their practice in this area.

**Priority 2: To deliver policy and procedures based on collaborative best practice and consultation.**

The Peterborough Multi-Agency Safeguarding Adult Procedures were formally adopted in September 2016. Following this, work began almost immediately to develop joint procedures with Cambridgeshire and it is hoped these will be launched in July 2017. Joint guidance for self-neglect and hoarding have also been developed.

**Priority 3: To ensure the workforce has the right skills/knowledge and capacity to recognise and safeguard adults at risk of abuse and neglect.**

New training and awareness events were introduced to raise understanding in areas identified by staff as where they lacked knowledge, these included:

- advanced awareness training to broaden understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards – aimed at Lead Practitioners and registered managers.
- workshops to introduce the Self-Neglect resource pack, followed by training sessions using newly developed materials.
- Domestic Abuse and Adult Safeguarding conference

The Training sub-group has also started work to develop a competency framework which should be introduced later in 2017.

**Priority 4: To seek assurance that adults at risk of abuse and neglect are effectively identified and safeguarded.**

Throughout the year the SAB has invited partner agencies to share their work and learning, to provide assurance and be challenged by members. Presentations have included:

- Coercion and Control
- The Victim Hub
- Peterborough Night Shelter
- Winter Pressures
- Quality Improvement Team
- Integrated Mental Health Services

The Chair has also written to local providers of private healthcare, seeking assurance of their practice and procedures.

## What about the areas identified as needing focus?

- **Embedding the new Multi-Agency Policy and Procedures** – Procedures are now embedded and used across all agencies
- **Community/Service User engagement** – The First Peterborough Safeguarding Awareness Month took place in March, with over 100 new contacts made, 11 agencies visited and 8 events attended.
- **Domestic Abuse, Human Trafficking and Modern Slavery – including upskilling workers in these areas** – A Domestic Abuse conference took place in March 2017
- **Multi-Agency Audits** – The Quality and Effectiveness sub-group is progressing this work
- **Evaluation and mapping of training across the partnership** – The Training sub-group is progressing this work
- **Sexual Exploitation** – Working in partnership working with the Safer Peterborough Partnership Board (SPPB) has continued, with Street Sex Workers Case Management Meetings, held six-weekly. The SAB supported with the development of an information sharing protocol for members of this group and has challenged as appropriate. The most significant piece of work delivered in this year has been the community awareness raising on sexual exploitation focussed on hotels in the city.

Extensive contact was made with hotels across the city and six sessions of bespoke training were delivered to five different hotels in partnership with the Operation Pheasant Team from the SPPB. These sessions focussed on spotting the signs that an adult or child might be being sexually exploited, and trigger plans for establishments to implement when they have concerns. This area of awareness raising and partnership building across the night-time economy continues to be considered as a priority, and activity will continue in 2017-18. Links continue with HMP Peterborough.

"*I had a good understanding of DA before the course but today I have learned lots of new information about perpetrators and elder abuse. The research and case studies were really interesting"*

## OUR ACHIEVEMENTS

Here are some of the highlights:

**Training**

Over 400 people attended multi-agency training – excellent feedback received

Self-Neglect

New guidance on self-neglect and hoarding, new training, Workshops and resource pack

**Domestic Abuse Conference**

*"This was a really valuable event, it could have gone on for days"*

Inter-Board Protocol

Ensures Boards work better together

Cross-county working

Joint sub-groups, Shared Chair, joint procedures in development

**Raising Awareness**

Safeguarding Awareness month – attended 8 events, met over 100 people, visited 11 agencies

LGA Peer Review

*"SAB is working well with good attendance from partners and strategic focus"*

**County wide Executive SAB set up**

Setting the strategic direction for the SABs across the county

Communications

New leaflets & posters, including easy read, quarterly newsletter & a range of resources available on our website

## COMMUNICATION AND SOCIAL ENGAGEMENT

The SAB has its own website which links with the LSCB website, making it more accessible for those working in both adult and children's services and for the general public. The website can be found at: www.safeguardingpeterborough.org.uk.

The SAB newsletter, **"*SAB News*"** is produced quarterly and is sent out via email to a wide range of partners and interested parties, and is also available on the SAB website. It is aimed at anyone who has an interest in safeguarding adults at risk. The newsletter aims to be an important means to keep practitioners and professionals up to date, and to share good practice and important information, it includes updates on local and national policies and developments in Safeguarding, learning from Safeguarding Adult Reviews and upcoming multi-agency training events. Contributions to the newsletter are received from various partner agencies and some information is sourced from national publications and organisations (ADASS, LGA etc.).

A new easy read leaflet ***"Keeping Adults Safe from Abuse and Neglect*** " was introduced and in November 2016 a new Self-Neglect resource pack was introduced which included a leaflet for professions and one for members of the public and a poster.

These leaflets and the poster are available on the website.

In March members of the SAB Business Unit took part in a number of community events, as part of the first Peterborough ***Safeguarding Awareness month***, aimed at raising awareness about the work of the Board and safeguarding in general. These events included:

- 4 days at the Disability and Community awareness event at Serpentine Green
- Age UK Peterborough annual general meeting
- Empowering Women – an event organised by the Police and Crime Commissioner
- Visits to a number of volunteer groups
- The Business Unit also took part in an awareness session to learn more about Dementia and are now proud to be Dementia Friends.


*"I never knew people were working together to help the old and vulnerable"*

## SAFEGUARDING TRAINING

Section 14.110 of the Care and Support Statutory guidance issued under the Care Act 2014 states that each Safeguarding Adults Board should promote multi agency training and consider any specialist training that may be required. On behalf of the Board, the Peterborough City Council Workforce Development Team (Adults) delivered the Safeguarding Adults multi-agency training. The Workforce Development Team is endorsed by Skills for Care as a Recognised provider of training.

Section 14.47 of the Care and Support Statutory guidance states: Mental Capacity is frequently raised in relation to adult safeguarding. The requirement to apply the Mental Capacity Act in adult safeguarding enquiries challenges many professionals and requires utmost care, particularly when it appears an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected. Therefore training on the Mental Capacity Act and Deprivation of Liberty Safeguards are also included in the training offer.

Training provided:

| Course | Number Attended |
|---|---|
| Safeguarding Adults Awareness | 65 |
| Safeguarding Adults Refresher | 34 |
| Mental Capacity Act and Deprivation of Liberty Advanced Awareness | 25 |
| Self-Neglect Workshop | 38 |
| Self-Neglect training for professionals who work with people who self-neglect | 14 |
| Deprivation of Liberty Awareness | 23 |
| Deprivation of Liberty Level 2 | 20 |
| Mental Capacity Act Awareness | 38 |
| Mental Capacity Act and Deprivation of Liberty Refresher | 23 |
| Mental Capacity Act Level 2 | 27 |
| Leading Safeguarding Enquiries (2-Day Course) | 33 |
| Mental Capacity Act and Deprivation of Liberty Awareness | 60 |
| Total | **400** |

There are also a range of other courses available to, and attended by, the multi-agency workforce, delivered and commissioned by the Peterborough Safeguarding Childrens Board (PSCB), which are relevant to those involved in Adult Safeguarding – the attendance figures for these are reported in the PSCB annual report, they include, but are not limited to:

Honour Based Violence, Female Genital Mutilation, Drug and Alcohol Awareness, Introduction to the Effects of Domestic Abuse, Understanding the Freedom Programme and What is Prevent.

## WHAT HAVE THE STATUTORY MEMBERS DONE

The statutory members were asked to consider the following questions when outlining what they have done:

1. What has your agency done to meet the embrace and embed the Safeguarding Principles:
2. What has your agency done to improve the safeguarding and welfare of adults in Peterborough?
3. How does your agency evaluate its Safeguarding effectiveness and what evidence do you have?
4. How has your agency challenged itself and others to improve safeguarding arrangements? What were the risks and impact of your challenge?

### CAMBRIDGESHIRE CONSTABULARY

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

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

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

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

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

In 2016-2017 we have

- Continued the development of the MASH, firmly establishing Domestic Abuse and Adult Abuse as priority themes.

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

## Detective Superintendent Lorraine Parker - Head of Public Protection

### CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP (CAPCCG)

**What has the CCG done to embrace and embed the safeguarding principles?**

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) are committed to working with partner agencies to identify all forms of abuse and mistreatment, ensuring that safeguarding is everyone's business.

The safeguarding of adults is firmly embedded within the wider statutory duties of the CCG in order to promote well-being, prevent harm and respond effectively if concerns are raised. The safeguarding principles (as expressed in the Care Act[1] and Care and Support Statutory guidance[2]) are clearly articulated in the CCG Safeguarding Adults Policy[3] and staff training.

Services commissioned by the CCG are expected to comply with the Care Act 2014[4], Care and Support Statutory Guidance[5] and Care Quality Commission (CQC) regulations[6], as well as meeting the requirements of the NHS Contract[7].

- **Empowerment** – *People being supported to and encouraged to make their own decisions and informed consent.* The broad principles of 'Making Safeguarding Personal[8]' are mirrored in the NHS Constitution[9] and it is therefore an expectation that all NHS organisations' work to these principles. Similarly, NHS staff are required to address the requirements within the Mental Capacity Act 2005[10] which aims to empower people to make decisions for themselves as much as possible and to protect people who may not be able to take some decisions.

[1] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
[2] https://www.gov.uk/guidance/care-and-support-statutory-guidance
[3] http://www.cambridgeshireandpeterboroughccg.nhs.uk/search for safeguarding adults policy
[4] See 1.
[5] See 2.
[6] http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-13-safeguarding-service-users-abuse-improper
[7] https://www.england.nhs.uk/wp-content/uploads/2016/11/2-service-conditions-fl.pdf
[8] http://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp
[9] https://www.gov.uk/government/publications/the-nhs-constitution-for-england
[10] http://www.legislation.gov.uk/ukpga/2005/9/contents

- **Prevention** – *It is better to take action before harm occurs.* The CCG fully supports a proactive approach to the avoidance of harm. Learning from past incidents via SAB processes (e.g. Safeguarding Adult Reviews) is key for both the CCG and commissioned Providers. Lessons learned as a result of Serious Incidents (Sis) which have safeguarding implications are shared across the local Health economy. The CCG also takes a system leadership role about Fatal Fire Reviews[11] and Domestic Homicide Reviews[12] to contribute towards the prevention of future harm. Responses to 'Whistle blowing' and complaints that have a safeguarding context equally provide an opportunity for learning.
- **Proportionality** – *The least intrusive response appropriate to the risk presented.* There is an expectation that CCG staff and commissioned Providers will apply the principles of the Mental Capacity Act[13]to acknowledge the notion of 'unwise' decision making, whilst remaining alert to the need to intervene under certain circumstances.
- **Protection** – *support and representation for those in greatest need.* The CCG and commissioned Providers have adopted 'Safer' recruitment practices in line with standard NHS requirements to reduce the likelihood of unsuitable staff being recruited. Mindful of the need for support and representation Advocacy is flagged in CCG staff training and we would expect commissioned Providers to do likewise.
- **Partnership** – *Local solutions through services working with their communities.* The CCG takes its responsibilities to partnership working in the safeguarding adults' arena seriously; the CCG actively participates in the work of the Safeguarding Adult Board, including membership of the Executive Board, Leadership of the Health Executive Quality Network, and engagement with all sub-groups.
- **Accountability** – *Accountability and transparency in delivering safeguarding*. There are Safeguarding Adult requirements specified by NHS England which apply to all NHS organisations[14]. Commissioned Providers are required to demonstrate measures around accountability and transparency in the Quality Schedule of the NHS Contract and compliance with these by NHS funded Health Providers is monitored via the Clinical and Contract Quality Review (CCQR) process. As markers of good professional practice around safeguarding adults it is both an expectation and requirement that these principles are adhered to.

**What has the CCG done to improve the safeguarding and welfare of adults in Peterborough?**

The CCG is robust in holding commissioned health care Providers to account for their performance around Safeguarding Adults. This in turn contributes to raising awareness and

[11] A fatal fire review considers all community safety information gathered regarding the person who died in the fire and the circumstances of the fire, in order to identify organisational learning points that can be implemented.

[12] https://www.gov.uk/government/collections/domestic-homicide-review

[13] See 10.

[14]

promoting excellent practice by staff, contributing to improving the safeguarding and welfare of adults at risk locally.

**How does the CCG evaluate its Safeguarding effectiveness and what evidence do you have?**

The CCG completed the Safeguarding Commissioning Toolkit recently, and participates in multi-agency audit as required. In 17-18 the CCG will be part of a regional pilot led by NHS England of a Safeguarding Assurance Tool.

**How has the CCG challenged itself and others to improve safeguarding arrangements?**

See above.

**Carol Davies - Designated Nurse for Safeguarding Adults and Serious Incidents**

## PETERBOROUGH CITY COUNCIL (PCC)

**What has PCC done to embrace and embed the Safeguarding Principles:** We have reviewed and updated our operational procedures and supporting documents for safeguarding concerns and enquiries to support front line social workers to embed Making Safeguarding Personal and the Safeguarding principles? The key points below have been noted through ongoing audit and the Peer Review.

- **Empowerment** – *People being supported to and encouraged to make their own decisions and informed consent.* The adult at risk is central to the safeguarding enquiry and their wishes are taken into account at all times. At the start of an enquiry and throughout the enquiry there are clear sections on the forms for capturing the person's (or their appropriate representative) consent, views and outcomes.
- **Prevention** – *It is better to take action before harm occurs.* The Social Work teams work closely with the Quality Improvement Team to monitor any concerns in respect of providers to ensure appropriate support is given to providers to prevent more serious safeguarding concerns. Heads of Service attend the CQC and Adult Social Care Information Sharing meeting with other key partners (CCG/Police/Healthwatch/) to discuss and share information/concerns and agree where support and closer monitoring is required.
- **Proportionality** – *The least intrusive response appropriate to the risk presented* The MASH has dedicated Lead Practitioners who have developed their skills and knowledge resulting in a high number of safeguarding concerns not progressing to section 42 enquiries. This is achieved by robust triage/risk assessment and face to face visits where required and taking into account the wishes of the AAR - early resolution. 18 out of 20 safeguarding enquiries selected for audit were deemed to be proportionate.
- **Protection** – *support and representation for those in greatest need.* Robust risk assessment and use of safeguarding plans to record protective factors and ongoing monitoring through review for those in greatest need.

- **Partnership** – *Local solutions through services working with their communities. E*ngagement with key multi agency partners is evidenced through audit and formal/informal feedback. Engagement with local providers has improved significantly through an open and transparent approach to safeguarding, ensuring providers are notified at the earliest opportunity where concerns have been raised and the relevant information is shared to enable them to contribute to the enquiry.
- **Accountability** – *Accountability and transparency in delivering safeguarding.* Good management support and oversight evidenced during enquiries and upon conclusion. Appropriate feedback via Social Workers/Lead Practitioners to the AAR, family, representative, and referrer and where relevant providers, evidenced through audit by the Quality Assurance Team, Heads of Service and Directors.

**What has PCC done to improve the safeguarding and welfare of adults in Peterborough?**

- skilled and knowledgeable Lead Practitioners ensure a consistent approach to safeguarding referrals and ensures relevant agencies are involved at the earliest opportunity.
- development of multi agency self neglect and hoarding policies to support front line social workers/managers.
- ensuring staff/managers are aware in relation to any learning from audits - briefing sheets are shared with all staff. Senior Manager Audits have commenced with the allocated worker to support reflective practice.
- mandatory training including refresher training relevant to role/responsibility/accountability.

**1. 3. How does PCC evaluate its Safeguarding effectiveness and what evidence do you have?**

- audit/ Best Practice Forum (case discussion/reflective practice) led by Head of Service,
- learning shared in relation to SAR's,
- feedback from key partners (informal),
- performance data/dashboard.

**How has PCC challenged itself and others to improve safeguarding arrangements?**

- Action plans developed to address areas identified as requiring improvement following the Peer Review (details below) and Audits.
- Working with key partners to develop agreed multi agency procedures (neglect/hoarding) and the SAB Multi Agency Policy and Procedures.
- Development of the LSE procedure to support frontline staff/managers and key partners/partners to understand process/roles/accountability.

We requested a Peer Review via the Local Government Association in September 2016 to review our adults safeguarding and commissioning processes. The review focused on three key areas:

**(i) Delivery of outcomes from frontline staff**

**(ii) The quality of strategic leadership and governance**

**(iii) The robustness and effectiveness of commissioning and quality assurance/ improvement mechanisms**

The team were on-site for four days and included activities designed to enable members of the team to meet and talk to a range of internal and external stakeholders. Alongside council officers and councillors, the review team engaged with key partners from health, the voluntary and community sector, independent care providers, Peterborough Safeguarding Adult Board members, Police and Healthwatch.

Following completion of the review, a number of strengths and areas for development were identified. These are included within the main report attached. The areas for development have been captured in a delivery plan and this is monitoring by the Corporate Director's management team on a quarterly basis and the SAB on a 6 monthly basis.

**Debbie McQuade, Assistant Director – Adult Operations**

## LOOKING FORWARD

In May 2017 the ESAB met and agreed the following priorities for 2017-18:

- **Domestic Abuse** - To ensure that adults at risk of abuse and neglect are protected from all types of Domestic Abuse; and when victims are identified they are provided with appropriate support to recover and are safeguarded in line with the principles of Making Safeguarding Personal. In this priority there will be a particular focus on **elder abuse** (over 65)

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

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

## WHO WILL RECEIVE A COPY OF THIS REPORT?

In accordance with the requirements of the Care Act 2014, copies of this report will be sent to:

- the chief executive and leader of the local authority which established the SAB
- the police and crime commissioner and the chief Constable
- the local Healthwatch organisation
- the chair of the local health and wellbeing board

The report will also be available on our website.

## FOR FURTHER INFORMATION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peterboroughsafeguardingboardsadmin@peterborough.gov.uk
www.safeguardingpeterborough.org.uk

01733 863744

# GLOSSARY

| | |
|---|---|
| **adass** | Association of Directors of Adult Social Services |
| **Adults Board**<br><br>**(SAB**<br>**PSAB**<br>**CSAB**<br>**ESAB)** | The Local Safeguarding Adults Board (SAB) brings together local statutory and independent sector agencies working with adults at risk of abuse. The SAB is responsible for ensuring the Multi-Agency Safeguarding Adults Procedures are effective and preventing adults from experiencing significant harm. Peterborough Safeguarding Adults Board/Cambridgeshire Safeguarding Adults Board. The Executive Safeguarding Adults Board is made up of the Statutory members, and drives the strategic agenda across the county. - |
| **Care Act 2014** | The Care Act 2014 introduces major reforms to the legal framework for adult social care, to the funding system and to the duties of local authorities and rights of those in need of social care |
| **Childrens Board**<br>**PSCB** | Peterborough Safeguarding Childrens Board |
| **Enquiry** | Previously a safeguarding investigation, A S42 enquiry is the action taken or instigated by the local authority in response to concern that abuse or neglect may be taking place |
| **LGA** | Local Government Association |
| **Making Safeguarding Personal (MSP)** | A guiding principle for safeguarding which is about engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realised at the end. |
| **MAPPA** | Multi Agency Public Protection Arrangements |
| **MASH** | Multi-Agency Safeguarding Hub |
| **SAR** | Safeguarding Adults Review - previously known as a Serious Case Review. |
| **Statutory Members** | The Care Act states that the SAB must have representation from the Local Authority, the Police and the local Clinical Commissioning Group. |


Cambridgeshire
& Peterborough
age UK


PETERBOROUGH
Safeguarding
Adults Board


NHS
North West Anglia
NHS Foundation Trust


Axiom


PETERBOROUGH
CITY COUNCIL


CAMBRIDGESHIRE
FIRE & RESCUE SERVICE


NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group


Bedfordshire
Northamptonshire
Cambridgeshire
& Hertfordshire
Community Rehabilitation Company
PROBATION


healthwatch
Peterborough


HM Prison &
Probation Service


CAMBRIDGESHIRE CONSTABULARY
Creating a safer
Cambridgeshire


Cambridgeshire and Peterborough NHS
Foundation Trust


City College
Peterborough
Working together, learning together


Peterborough
Regional College

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 12 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Wendi Ogle-Welbourn, Executive Director People and Communities Cambridgeshire and Peterborough Councils and Dr Liz Robin, Director of Public Health | |
| Cabinet Member(s) responsible: | Cllr Wayne Fitzgerald | |
| Contact Officer(s): | Helen Gregg, Partnership Manager, Peterborough and Cambridgeshire Councils | Tel. 863618 |

# QUARTERLY HEALTH & WELLBEING STRATEGY PERFORMANCE REPORT

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Executive Director People and Communities Cambridgeshire and Peterborough Councils and Director of Public Health | **Deadline date: N/A** |
| It is recommended that the Health and Wellbeing Board consider the content of the performance progress report and raise any questions. | |

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board at the request of the Executive Director for People and Communities Cambridgeshire and Peterborough Councils and the Director of Public Health.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Health and Wellbeing Board with a summary of progress against the Future Plans identified for each of the focus areas outlined in the Health & Wellbeing Strategy 2016-2019.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference Numbers:

*2.7.3.1 To develop a Health and Wellbeing Strategy for the city which informs and influences the commissioning plans of partner agencies*

*2.7.3.2 To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health and Wellbeing Strategy*

## 3. TIMESCALES.

| | | | |
|---|---|---|---|
| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | N/A |

## 4. BACKGROUND AND KEY ISSUES

4.1 The Health & Wellbeing Strategy 2016-19 identified key focus areas. A performance report for each focus area is contained within **Appendix 2**. A full set of reports was presented to the HWB/SPP Partnership Delivery Group on 8 November.

In addition to the performance headlines listed below, the delivery group would also like to highlight activity in the following areas:

### The Campaign to End Loneliness Conference, Kingsgate, December 2017

The Campaign is a network of national, regional and local organisations and people working together through community action, good practice, research and policy ensuring that loneliness is acted upon as a public health priority at national and local levels.

Aim of the Event

- The Campaign for Loneliness is due to be launched nationally during November and December to highlight the plight of social isolation during the **festive season**.
- Social Isolation is a key priority for both the government and local authorities currently as this can often lead to health issues adding pressure to our already overloaded health and social care system.

Key messages

- A call out action to tackle isolation amongst the elderly population in Peterborough during Christmas and New Year.
- The Campaign to End Loneliness believes that nobody who wants company should be without it.
- The Campaign also want to target voluntary/community organisations that involve young people to gain their involvement in tackling isolation. The Campaign want to make this happen by ensuring that:
- People most at risk of loneliness are reached and supported
- Services and activities are more effective at addressing loneliness
- A wider range of loneliness services and activities are developed

### Health and Wellbeing Strategy Outcome Metrics

- The HWB/SPP Partnership Delivery Group asked pupils from the City College to create a poster that illustrated the key headlines listed in the Health and Wellbeing Strategy Outcome Metrics report brought to the HWB Board earlier this year. The group have asked the pupils to deliver a presentation to the main Health & Wellbeing Board. Date to be confirmed

### Universal Credit Support

- Foodbanks have offered to support anyone awaiting for their Universal Credit payment by providing additional food parcels. This is an increase of the usual offer of up to 3 food parcels per year for people in need. The offer is subject to sufficient provision of food donations available.
- Energy cards - PCAS can provide energy card top ups of £15 per utility. Where clients are in crisis and awaiting Universal Credit, we will look to offer more than one instance
- Explore with Public Health options for supporting vulnerable people who are in energy debt. A meeting will take place before the end of November to take this forwards.

### English as a Second / Other Language (ESOL) courses

- The Getting to Know You' project, funded under DCLG Controlling Migration funding for 2 years, is designed to teach people with no / low English skills in Peterborough to navigate public services such as health, education and housing, thus reducing the burden on services themselves as well as existing established communities. As well as this, the project will improve participants' English language skills as there is huge unmet demand

for classes in the city.

- The classes are being delivered by trained volunteers using lessons and resources developed by ESOL specialists at City College. Responses from volunteers has been overwhelming, with 70 people of all ages, backgrounds and ethnicities applying to volunteer. In year one, we aim to deliver the courses to 350 learners in a range of venues in the community.

### Supported Housing Provision

The Government has announced details of proposed funding arrangements for supported housing provision, which are subject to a public consultation which closes in January. The proposals provide clarity on the approach Government wish to take to encourage the development of new provision for people in vulnerable groups including older people, people with mental health issues, care leavers and people with disabilities

### Selective Licensing

Selective Licensing schemes in Peterborough are continuing to positively impact on the conditions across the private rented sector housing market. For example 938 Gas Safe certificates were issued in November 2016, just before the formal scheme began, suggesting that these landlords didn't have one in place and they had been done so their applications could be submitted. Almost 1 year on:

- We have carried out over 1700 initial property inspections, these determine if there are any serious risks we need to deal with urgently, and to identify any category one hazards that need housing enforcement officer intervention.
- The visits are also used to advise owners of any defects found that they need to attend to and to risk assess when a full inspection should be carried out within the lifetime of the scheme, the aim being to tackle the worst first.
- Those c.1700 inspections have resulted in us finding 557 properties having at least one category one hazard that needed enforcement action.
- The housing enforcement officers are working through these and 64 notices have been issued so far.
- We are finding a higher rate of compliance from landlords and many more disrepair issues are being resolved informally reducing the need for formal notices, works in default and prosecutions.
- Six cases have been brought before the courts for not licensing, all have been found guilty and fined. We are currently working towards the introduction of civil penalties which will move these offences away from the court system and will allow us to set more appropriate fines, and recover the money through debt recovery to be used for housing enforcement work.
- Some enforcement action has been carried out to find unlicensed properties. 110 investigations have been undertaken which have resulted in 24 landlords applying for their licences at first contact, 6 resulted in prosecution and the remainder are still ongoing investigations.

Key Headlines from the performance reports:

**Children and Young People**

- Mental Health & Wellbeing Services Conference is being held on 30 November. The conference will celebrate and focus on the new and improved services across Cambridgeshire and Peterborough for children and young people's mental health and wellbeing
- A new pathway has been developed for children with suspected ADHD/ASD
- A procurement process has recently been completed for the provision of counselling services and mental health promotion services jointly with CCC and C&P CCG and additional investment has gone into this. The new provider CHUMS, will start delivering the service from 1st January 2018

**Ageing Well**

- The Older People Mental Health Delivery Board is bringing together agencies across the health and social care system to develop an integrated plan to improve outcomes for

people living with dementia across Cambridgeshire and Peterborough
- Implementation of the CCG-wide falls prevention business case has now commenced. The aim of the project is to implement a comprehensive, standardised and integrated falls prevention pathway across the CCG area of Cambridgeshire and Peterborough
- Social isolation has been determined a priority by the Ageing Well Strategy Board, alongside other priorities including falls prevention and dementia
- A falls prevention pathway has been co-produced and is being implemented by colleagues from Public Health, CPFT and the CCG. Funding has been secured from Better Care Fund, the STP and public health

**Growth, Health and the Local Plan**

- Consultation on the Proposed Submission version of the emerging Local Plan is now due to commence in Jan 2018 for a six week period. It includes a proposed Health and Wellbeing policy
- The Public Health team are working with colleagues from strategic planning, development planning, community safety and environmental health to investigate options for improving the food environment in Peterborough. A review of local food environment was undertaken to better understand:
    - The number and distribution of different food outlets e.g. fast food, local grocery shops across Peterborough, their location and growth over time
    - National evidence on what can be done to improve choice and create a food environment which encourages as default more healthy options
- A report was taken to the Public Health Board in October and following this Public Health, Planning Policy and Development Management teams will meet in November to explore the feasibility of developing a Supplementary Planning Document as a means of influencing the development of fast food outlets in the city

**Health and Transport Planning**

- The Council has applied for sustainable travel funding from the Combined Authority following a unsuccessful application to Department for Transport, a decision should be taken at their board meeting on 25 October
- £20,000 has been awarded to the Cambridgeshire and Peterborough Road Safety Partnership Delivery Group from the OPCC to deliver various road safety activities
- Toolkits are being developed which cover the fatal four (speed, seatbelts, mobile phones and drink drug driving). Toolkits will be available to community, voluntary groups, CSPs across the county to allow for a coordinated message.
- Focus has continued on young drivers officers have delivered events at RAF Wittering around drink/drug driving and attended the Freshers Fayre at Peterborough Regional College
- The Council was successful in it's application for funding from department for transport to enhance its cycling and walking plans and provide staff training on current best practices
- The Road safety partnership is currently experiencing problems with casualty data and the new CRASH system. This is currently being investigate and solutions being developed

**Health and Wellbeing of Diverse Communities**

- National Controlling Migration Fund. Five Peterborough projects have been funded to date, these are:

| CMF Project | Lead Officer | DCLG Grant Awarded (Total) | 17-18 | 18-19 | 19-20 |
|---|---|---|---|---|---|
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Getting to Know You | Janet Bristow - City College | £281,573 | £138,706 | £142,867 | N/A |
| Alcohol Misuse | Joseph Keegan / Julian Base - Public Health | £283,347 | £135,120 | £148,227 | N/A |
| Rough Sleeper Support Services | Sean Evans - PCC | £250,436 | £99,401 | £151,036 | N/A |
| Shared Vision | Keith Jones - CAB | £288,350 | £105,344 | £145,852 | £37,154 |
| Social Media Resources | Kathy Hartley - Public Health | £94,200 | £48,900 | £45,300 | N/A |
| | | **£1,197,906** | **£527,471** | **£633,282** | **£37,154** |

- The projects help to address many of the issues identified in the JSNA for Diverse Ethnic Communities
- The mental health Crisis 'First Response Service' (FRS) and 'Sanctuaries' - implemented as part of a partnership 'crisis care concordat programme' is being promoted as a programme of work to Minority Ethnic communities throughout Peterborough
- NHS Health Checks are now being delivered within local community settings, complementing existing delivery through local GP practices

**Health Behaviours and Lifestyles**

- Solutions4Health are delivering one to one clinics and group programmes to assess and address lifestyle factors including alcohol, diet and nutrition, physical inactivity and smoking, with 380 people setting a personal health plan since April.
- The workplace programme is a joint commission across Cambridgeshire and Peterborough that supports the wider networking of local employers. The programme is also closely aligned with both healthy lifestyle services across the area to ensure employers have full access to support services.
- A Tobacco Control Plan is being co-produced with a variety of partners from the local authority, health sector, voluntary groups and patient groups. Each partner is directly committed to lead specific interventions and work collaboratively towards the achievement of shared outcomes
- The Staying Well Campaign is being actively promoted through digital, print, media and publication platforms between 23 October through to 17 December. Key messages are around flu jabs and how cold weather can affect your health. A copy of a poster is attached as Appendix 3. The aim of the campaign is to ensure that people who are most at risk of preventable emergency admission to hospital are aware of and, where possible, are motivated to take actions that may avoid admission this winter.

**Housing and Health**

- 1,077 aids & adaptations were completed in 2016/2017 and so far this year 667 have been completed
- 3,427 Handyperson requests were completed in 2016/2017 and so far this year 1,228 have been completed
- 8 Housing Related Support providers are currently funded, which includes support in accommodation settings, drop in support and some specialist floating support. Overall numbers of Homelessness Prevention as a direct result of this support are slightly up on same period last year

- Discussions are now taking place to jointly commission a generic Floating Support Service with Cambridgeshire County Council from July 2018 onwards. This will provide support to vulnerable residents in both hostel settings and within their homes. The aim is for the support to move with them through different types of accommodation and at different levels to achieve full independent living.
- The Cross Keys Homes Extra Care scheme of 54 units completed and was handed over to CKH's Housing Related Support team on 5th September. An open day has taken place and 14 units, accommodating 20 people are now occupied within the scheme
- The Vulnerable Housing G has now met twice resulting in positive discussions on how we gear ourselves up for the provision for vulnerable people (older people, people suffering from mental health issues, domestic abuse victims, young people leaving care)
- The Housing Board for the Combined Authority has agreed in principle to include vulnerable peoples housing needs as a sub-group
- The levels of homelessness in the city remain high, with a number of households temporarily housed in bed and breakfast-type accommodation. To address this, the council is actively working to increase the availability of housing to accommodate homeless households; this is being achieved through the conversion of existing buildings and the acquisition of additional housing off the open market.

**Mental Health for Adults of Working Age**

- The Draft Joint Cambridgeshire and Peterborough Suicide Prevention Strategy was presented to Health Scrutiny on 6 November. The strategy outlines 6 priorities: Priority area 1 – Reduce the risk of suicide in high risk groups, Priority area 2 – Tailor approaches to improve mental health in specific groups, Priority area 3 – Reduce access to the means of suicide, Priority area 4 – Provide better information and support to those bereaved or affected by suicide, Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behaviour and Priority area 6 - Support research, data collection and monitoring
- Suicide Prevention - a number of new workstreams have been established e.g. bereavement support for people bereaved by suicide following investment by the STP. Funding has been provided to set up a reactive support service for people who have been bereaved as a result of suicide
- Zero suicide initiative - This is the overarching ambition for suicide prevention locally and aims to bring all partners together to support the development of a learning culture to drive up quality so that suicide prevention is a priority for each organisation, across the system
- GP Training in suicide prevention - Funding has been secured through the STP for training of GPs across Cambridgeshire and Peterborough in suicide prevention, which will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care.
- Stronger links between commissioners - two multi-agency groups that include service user and carer representation now oversee the delivery and improvement of mental health services: i) The MH Delivery Board (the Cambridgeshire and Peterborough Crisis Care Concordat group) which oversees crisis acute care ii) the Community MH Services Delivery Board which oversees statutory and voluntary sector provision in the community and primary and secondary care.
- The Right Support, the First Time, at the Right Place, by the Right People - the enhanced primary care mental health pathway to be delivered through the PRISM has been implemented across Peterborough. This will help to ensure that the Care Act responsibilities of CPFT, including as required in of social care through the Section 75 Partnership Agreement, are discharged
- Improvement in the identification of carers of people with mental needs is a key priority 2017/18. This is being addressed directly with CPFT and with The Carers Trusts as well as being addressed within the joint Council and CCG review of the Cambridgeshire and Peterborough Carers Strategy

**Protecting Health**

- Good progress continues to be made in Peterborough on Latent TB (LTBI) screening in certain at risk groups, which has been the focus of the TB commissioning Group led by

the CCG in the past 18 months. Additional GP practices have now been recruited to the programme to ensure a high level of coverage

- Health Protection Steering Group (HPSG) Screening Updates
- Low uptake for all three cancer screening programmes:
    - Bowel Cancer screening uptake – range 55.4% – 59.9% (acceptable 52%, achievable >70%)
    - Breast screening uptake – range 69.87% - 75.8% (acceptable >70%, achievable >80%)
    - Cervical cancer screening – range 63.3% - 66.1% (acceptable >80%, achievable >95%)
- Immunisations – causing concern is the second dose of MMR vaccine – there is good uptake now of the first dose but at age 5 years under 90% of children have been received the second dose of the vaccine that is needed to give a high level of immunity
- Current focus on flu vaccination as winter approaches. Reports from Australia show that their flu season that has just ended was more severe than previous years and usually the flu strains that have been predominant in the Southern hemisphere tend to be those that affect us in our following flu season so we are expecting a more severe flu season this year. Encouraging flu vaccination was the focus of the November Healthy Peterborough campaign.

**Health and Wellbeing of People with Disability and/or Sensory Impairment**

- Peterborough Physical Disability Board - The first meeting of the refreshed Peterborough Physical Disability Board met in May 2017. The Board is Chaired by an independent person and the membership includes officers from the Council and others from the voluntary sector (and other interested parties). It has a Forward plan that includes Transport, Health, Employment and Leisure
- Peterborough Sensory Disability Board - A pre-meeting to develop the Peterborough Sensory Disability Board took place at the beginning in Oct 2017 and a Terms of Reference was agreed to be taken to the first ever board in December 2017
- The results of the 2016/17 Carers Survey has been analysed and an action plan devised. The results were very positive with 72.6% of carers stating that they were extremely to quite satisfied with the support and services they receive against an England average of 70.8%.
- The Care and Support Directory for 2017/18 which is a useful information source for people with disabilities and sensory impairment was distributed to council offices, the hospital, Age UK, Carers Trust and GP practices in August 2017 and can be viewed on the council website
- Future arrangements for Learning Disability **-** A joint review is underway between both LAs and the CCG about future arrangements for learning disability

**Geographical Health Inequalities**

- Can Do Regeneration Programme - An Executive Board has been established to oversee the 2-year programme and governance terms agreed that reflect the vital participation of the community
- Public and voluntary sector partners will work in collaboration with the community to develop improvement plans for the parks and open spaces in the area. It is anticipated that this group will submit a funding bid to the National Lottery's new £4.5m Place Based Social Action Fund to support this work
- Community Serve - Community Hubs supported by the City College are located within Gladstone and Orton Malborne. Cross Keys Homes support a community led hub in Westwood. As a result of attending the Hub and participating in a range of courses including ESOL, students have gained valuable life changing skills; for the first time, they can communicate at an effective level with Doctors and Teachers. This is a major achievement as it eliminates the isolation factor and it allows students to integrate within the community
- Community Meet and Eat events attracting a total of 543 local people and improving social cohesion and isolation. Partners attending include Public Health, the National Literacy Trust and College staff to promote learning and volunteering opportunities. The meet and eat gatherings have proved to be incredibly successful and go a long way to

reduce isolation, increase social relationships, tackling health and well-being and providing volunteering skills and development in the local community
- Public Health are beginning a programme of cross cutting analytical work on health inequalities across Peterborough and Cambridgeshire and how this is linked to socioeconomic outcomes and pressures on health and care services. The work will help partners better understand how outcomes differ across the area, how they are changing and the areas with greatest need

**Long Term Conditions and Premature Mortality**
- Recent data shows that the overall cardiovascular mortality for adults under the age of 75 in Peterborough has fallen to similar to that of the national average, having been above average since 2005/07. There are still inequalities between different areas in Peterborough
- Implementation of the STP/BCF programme to identify and treat people with atrial fibrillation to reduce their risk of stroke is progressing, with good engagement of local GP practices.

**Future Plans RAG Ratings and Risk Register (Appendix 2)**
There have been a number of improvements to the RAG ratings (all from AMBER to GREEN) as listed below:

Long Term Conditions and Premature Mortality
- Develop and implement a joint strategy to address CVD in Peterborough

People with Disability and/or Sensory Impairment
- Work with users of St George's hydrotherapy pool to explore future options for sustainability

Ageing Well
- The HWB has commissioned an 'Older People: Primary Prevention of Ill Health' JSNA for Peterborough, which is due for completion during 2016

Protecting Health
- Develop a joint strategy to address poor uptake of immunisation including improved communication with communities and individuals

Health & Transport Planning
- Collect further JSNA information on transport and health for Peterborough, using locally developed methodologies

BCF / STP
- Greater alignment of Peterborough and Cambridgeshire BCF Plans
- A single commissioning board for Peterborough and Cambridgeshire

## 5. CONSULTATION

5.1 The progress reports were reviewed at the Health & Wellbeing and SPP Partnership Delivery Group on 8 November 2017.

5.2 The Partnership Delivery Group will be focussing on a review of the integrated front door and 106 agreements.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The Board is expected to review the information contained within this report and respond / provide feedback accordingly.

## 7. REASON FOR THE RECOMMENDATION

7.1 To ensure the Health and Wellbeing Board members are kept regularly informed of progress and any barriers/challenges that may be preventing progress so that members may assist in unblocking these.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The Board must be kept informed of progress against the identified focus areas within the current Health & Wellbeing Strategy.

## 9. IMPLICATIONS

### Financial Implications

9.1 There are no financial implications associated with this report.

### Legal Implications

9.2 There are no legal implications associated with this report.

### Equalities Implications

9.3 There are no equality implications associated with this report.

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1 N/A

## 11. APPENDICES

11.1 Appendix 1 Future Plans RAG Ratings and Risk Register
Appendix 2 Focus Areas Performance Reports
Appendix 3 Staying Well Poster

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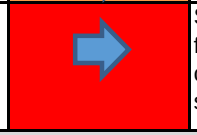
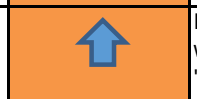
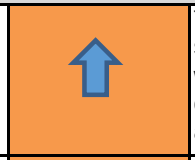
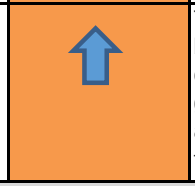
# HWB Strategy Progress Risk Register - March 2017

| Ref | Description of risk, i.e. what is the threat or | Raised on Date | Impact (1-5) | Probability (1-5) | RAG Rating | Action or | Owner | Status |
|---|---|---|---|---|---|---|---|---|
| **Children and Young People's Health** | | | | | | | | |
| 1 | Lack of embedding of Neglect strategies in community and specialist services | 01 March 2017 | 3 | 3 | | The LSCB monitors performance and outcomes | Lou Williams | Open |
| **Health Behaviours and Lifestyles** | | | | | | | | |
| 2 | Delay in mobilisation of tier 3 weight management services sub-contracted from the new integrated healthy lifestyle service | 01 March 2017 | 3 | 2 | | Delay occurred but implementation is now back on track | Liz Robin | Open |
| **Long Term Conditions and Premature Mortality** | | | | | | | | |
| 3 | Ability to recruit skilled workforce in the local area | 01 March 2017 | 4 | 3 | | Workforce Review taking place in STP Business Cases / considering Secondments from Secondary Care | Cath Mitchell | Open |
| 4 | Lack of capacity in primary care to deliver AF programme | 02 August 2017 | 4 | 2 | | Support to GPs through incentives, training and clinical support | Cath Mitchell | Open |
| **Mental Health for Adults of Working Age** | | | | | | | | |
| 5 | Insufficient resource across the health and social care system to support all the developments identified as being required to improve access to services and outcomes by the various workstreams | 01 March 2017 | 3 | 3 | | Minimise inefficiencies and improve promotion including effective information, advice and signposting | Wendi Ogle-Welbourn | Open |
| 6 | Complexities and time needed to meet the internal governance requirements of each organisation slows progress and sufficiently slows delivery of the potential benefits of working collaboratively | 01 March 2017 | 3 | 2 | | Progress the proposed exploration of models of joint commissioning for mental health | Wendi Ogle-Welbourn | Open |
| **H&WB of People with Disability / Sensory Impairment** | | | | | | | | |
| 7 | Managing demand from service users | 01 March 2017 | 3 | 3 | | Work with key stakeholders and organisations to develop local solutions | Adrian Chapman | Open |
| **Ageing Well** | | | | | | | | |
| 8 | LDR investment will not be available for NHS Digital until April 2017 | 01 March 2017 | 3 | 5 | | | Adrian Chapman | Open |
| 9 | BCF planning will not incorporate plans for achieving health and social care integration by 2020 | 01 March 2017 | 3 | 3 | | A multi agency strategic framework is being developed | Adrian Chapman | Open |
| **Protecting Health** | | | | | | | | |
| 10 | Continued availability of funding for strategy implementation especially LTBI screening | 01 March 2017 | 2 | 4 | | | Liz Robin | Open |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Growth, Health and the Local Plan** | | | | | | | | |
| **11** | H&WB amendments to the Local Plan not incorporated into the next draft of the Plan | 01 March 2017 | **3** | **3** |  | | Simon Machen | Open |
| **12** | Significant objections to the H&WB policies in the Local Plan result in the policies being removed or changed at the examination in public stage of the Local Plan | 01 March 2017 | **3** | **2** |  | | Simon Machen | Open |
| **Health and Transport Planning** | | | | | | | | |
| **13** | Lack of capacity to compile Transport and Health data | 01 March 2017 | **3** | **1** |  | PH resources currently producing data and information | Simon Machen | Open |
| **14** | Reduction in active travel activities due to loss of funding from the Dept for Transport sustainable travel funding | 02 August 2017 | **3** | **4** |  | Submit bids for further pots of funding. Applied to the combined authority for fund to support some active travel work | Simon Machen | Open |
| **Housing and Health** | | | | | | | | |
| **15** | Once the funding for Supported Housing changes from the current model, there may be a risk of ensuring that the full rent level on these units are met through the proposed top up funding. | 01 March 2017 | **3** | **3** |  | Government proposals are currently at the consultation stage | Adrian Chapman | Open |
| **16** | Shortage of housing stock - improve the join up of people and places | 01 August 2017 | **4** | **2** |  | Paper to be taken to CMT to review short, medium and long term housing options | Adrian Chapman | Open |
| **Geographical Health Inequalities** | | | | | | | | |
| **17** | Lack of agreement on how to use the proposed £7.5m investment into the Can Do Area | 01 March 2017 | **3** | **3** |  | | Adrian Chapman | Open |
| **18** | Limited take up of projects to tackle social cohesion | 01 March 2017 | **3** | **3** |  | | Adrian Chapman | Open |
| **19** | Too great a focus on the Can Do area | 01 March 2017 | **3** | **2** |  | | Adrian Chapman | Open |
| **Health and Wellbeing of Diverse Communities** | | | | | | | | |
| **20** | Communities will not engage with the services on offer and they will therefore be less effective | 01 March 2017 | **4** | **2** |  | Health messages being delivered by Salaam Radio | Adrian Chapman | Open |
| **21** | Public perception of significant investment targeted to non-UK national communities | 01 March 2017 | **4** | **3** |  | Effective publicity campaign with a greater focus on the 'Healthy Peterborough' campaign | Adrian Chapman | Open |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Sustainable Transformation 5 Year Plan (STP)** | | | | | | | | |
| **22** | Local 2017/18 BCF plan - planning guidance and policy is further delayed | 01 March 2017 | **3** | **4** |  | The plan has now been submitted to NHSE on 21/9 and we are awaiting the approval outcome following the assurance process | Will Patten | Open |
| **23** | STP governance is currently being reviewed by SDU for greater clarity on board roles and alignment with BCF governance | 01 March 2017 | **3** | **3** |  | The review has been completed by the SDU. However, there is a current review of the DTOC governance arrangements across the system to ensure it is fit for purpose. | Will Patten | Open |
| **OTHER** | | | | | | | | |
| **24** | Impact of universal credit implementation in November | 01 August 2017 | **4** | **3** |  | Report to be taken to CMT to discuss plans / contingencies | Adrian Chapman | Open |

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**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** CHILDREN AND YOUNG PEOPLE'S HEALTH
**LEAD:** LOU WILLIAMS

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>● Managing the transition of commissioning arrangements for health visiting from NHS England to the Local Authority;<br>● Developing a healthy child programme that ensures that emerging needs for support are identified early and are acted upon effectively in partnership with children and families;<br>● Reviewing the Child and Adolescent Mental Health (CAMH) offer across the area, including overseeing action related to reducing waiting list for specialist CAMH services and remodelling support for children and young people with emotional health and wellbeing needs to make the best use of additional funding from Central Government. | |
|---|---|
| **Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)** | - Health Visiting service is now commissioned through a section 75 agreement with CPFT<br>- Outcomes framework, service specification and key performance indicators for the Healthy Child Programme have been developed and embedded. Quarterly performance monitoring meeting are held with the Provider CPFT. The health visiting service is required to carry out 5 mandated visits, from the ante natal period to the 2year check on the child. Of these:<br>o 268 families received an antenatal visit<br>o 98% of all new mothers received a new birth check, 92% of which was within the first 14 days of birth<br>o 95% of mothers received a 6 - 8 week check, 88% within the 6 to 8 week period<br>o 95% of mothers/families had a 12 month check by 15 months.<br>o 81% of children had a two year development check<br>- New pathway developed for children with suspected ADHD/ASD. Following consultation with parents the name of the pathway has been re launched as the Emotional and Social Development Pathway. Parents are offered early help, via Webster Stratton or Triple P evidence-based parenting programmes, prior to referral to specialist CAMH services. On on |

| | |
|---|---|
| | line Triple P programme is also being piloted at the moment in Peterborough and Cambridgeshire. Feedback from CPFT indicates that the early help is supporting in the reduction of the waiting lists for assessment. For both ASD and ADHD, assessment waiting times have been reduced to less than 12 weeks. For ADHD, the waiting time is within 6 weeks for the majority of referrals.<br>- Recently a procurement process has been completed for the provision of counselling services and mental health promotion services jointly with CCC and C&P CCG and additional investment has gone into this. The new provider CHUMS, will start delivering the service from 1st January 2018. |
| **Narrative update on workstreams** | The Joint Commissioning Unit, which is made up of commissioners from Peterborough City Council, Cambridgeshire County Council and Cambridgeshire and Peterborough Clinical Commissioning Group, continues to work jointly to develop an integrated 0 - 19 service. The JCU have overseen a number of areas of work:<br>● The redesign of the Speech and Language Therapy Service to offer a consistent model of delivery across Peterborough and Cambridgeshire - focusing on early support and prevention. Recruitment to the remodeled service is underway and a launch event will be held in January 18.<br>● The redesign of the Occupational Therapy and Physiotherapy Service has begun, including a full needs assessment and engagement with partners.<br>● Options for future delivery of the 0 - 19 services is being considered by the JCU<br><br>Joint work is being done with the Local Maternity System (LMS) to deliver the Better Births Strategy. There is a national drive to improve local maternity services. The Cambridgeshire and Peterborough LMS has written a Better Births Strategy and Plan. One workstream identified is a focus on the development of "Community Hubs", which has been set up to deliver a more integrated way of working with other services in the community. A workshop has been held with key partners to look at the services that could be delivered in the community. to improve outcomes for families. |
| **Examples of partnership working (services, projects, co-production/design etc)** | A workshop was help with range of partners and key stakeholders, to consider the community hub model, as part of the Better Births Strategy. The workshop included midwifery services, children's |

| | |
|---|---|
| | centre providers, voluntary sector providers, health visiting teams, parent representation and local authority representatives. |
| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>● Develop a CAMH pathway that better meets need and manages demand so that pressures on specialist services are minimised<br>● Continuing a pilot approach where additional CPN capacity is aligned with schools to enable better support to be offered to C&YP with emerging emotional and mental health difficulties<br>● Working with the PSCB to develop a more effective multi-agency response to neglect, focused particularly on addressing early indications of neglectful parenting and offering support to prevent patterns becoming established<br>● Renew the Child Poverty Strategy in 2016<br>● Develop a joint strategy to address high rates of teenage pregnancy<br>● Jointly review the commissioning and delivery of services for C&YP with SEND, from age 0-25<br>● Consideration of the needs of single parent families in these workstreams | |
| **Future Plans: Progress against key milestones and local indicators/trends** | ● In order to reduce pressures on specialist CAMH services, a new counselling service with additional investment from the CCG is due to start from January 2018. Procurement completed and mobilisation ongoing.<br>● Following the JTAI inspection, multi-agency action plans have been developed to address neglect.<br>● A needs analysis for SEND has been completed by Public Health in order to inform a 10 year SEND strategy across Cambridgeshire and Peterborough. |
| **Risks** | ● Risks involved with mobilisation of a new service (CHUMS counselling service) are being managed through a mobilisation board. |
| **Key considerations** | |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Current Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 1.1a | CAMH - Number of Children & Young People commencing treatment in NHS-funded community services | - | Indicator only currently available at national/regional level | - | - | - | - | CAMH - Number of Children & Young People commencing treatment in NHS-funded community services |
| 1.1b | CAMH - Proportion of Children & Young People with an eating disorder receiving treatment within 4 weeks (routine) and 1 week (urgent) | - | Indicator only currently available at national/regional level | - | - | - | - | CAMH - Proportion of Children & Young People with an eating disorder receiving treatment within 4 weeks (routine) and 1 week (urgent) |
| 1.1c | CAMH - Proportion of Children & Young People showing reliable improvement in outcomes following treatment | - | Indicator only currently available at national/regional level | - | - | - | - | CAMH - Proportion of Children & Young People showing reliable improvement in outcomes following treatment |
| 1.1d | CAMH - Total bed days in CAMHS tier 4 per CYP population/total CYP in adult in-patient wards/paediatric wards | - | Indicator only currently available at national/regional level | - | - | - | - | CAMH - Total bed days in CAMHS tier 4 per CYP population/total CYP in adult in-patient wards/paediatric wards |
| 1.2 | Prevalence of obesity - reception year (proportion, %) | ▼ | Statistically similar to England | 2015-16 | 259 | 9.3% | 9.3% | Prevalence of obesity - reception year (proportion, %) |
| 1.3 | Prevalence of obesity - year 6 (proportion, %) | ▲ | Statistically similar to England | 2015-16 | 460 | 19.8% | 19.8% | Prevalence of obesity - year 6 (proportion, %) |
| 1.4 | Number of young people Not in Education, Employment or Training (NEET) (Proportion, %) | ▼ | Peterborough higher (worse) than England. Statistical significance unavailable | 2016 | - | 5.0% | 4.2% | Number of young people Not in Education, Employment or Training (NEET) (Proportion, %) |
| 1.5 | Successful implementation of a multi-agency neglect strategy resulting in increased early intervention to prevent such patterns becoming entrenched | - | Strategy launched by Peterborough Safeguarding Children Board 13/09/2016 | - | - | - | - | Successful implementation of a multi-agency neglect strategy resulting in increased early intervention to prevent such patterns becoming entrenched |
| 1.6 | Under 18 conceptions (crude rate per 1,000) | ▼ | Statistically significantly worse than England | 2015 | 95 | 28.3 | 20.8 | Under 18 conceptions (crude rate per 1,000) |
| 1.7 | Under 16 conceptions (crude rate per 1,000) | ▼ | Statistically similar to England | 2015 | 8 | 2.4 | 3.7 | Under 16 conceptions (crude rate per 1,000) |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** AGEING WELL
**LEAD:** CHARLOTTE BLACK

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:<br><br>• A service model has been developed by local NHS commissioners and community service providers, local Councils and voluntary organisations to enable people to age well and to live the life they want to lead by:<br>  ○ Providing high quality, responsive care and support<br>  ○ Integrated working across health, social care and third sector services in Peterborough to ensure that care is joined-up around the needs of individuals within local communities, and avoidable admissions to hospital and care can be prevented<br>  ○ This is supported by jointly agreed plans for the BCF</td></tr>
<tr><td>Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)</td><td>Indicators currently showing green:<br>• Health checks: the total number of health checks delivered to over 40s remains significantly above the England average.<br>• Feeling safe: The proportion of people who use services who say that those services have made them feel safe and secure is statistically significantly better than England.<br><br>Indicators currently showing red:<br>• Falls: The rate of injuries due to falls in people aged 65 and over is still statistically significantly worse than England. However, there is a positive trend over time with the rate of falls decreasing. This issue is being addressed by the CCG-wide falls prevention programme.<br>• Feeling safe: The proportion of people who use services who feel safe is statistically significantly worse than England. However, there is a positive trend over time with the proportion of people feeling safe increasing. It is important to note that the proportion of people who use services who say that the services have made them feel safe and secure is still significantly better than England.</td></tr>
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| | • **Social isolation:** the proportion of carers who have as much social contact as they would like is significantly worse than England. This has been identified as a priority area by the Cambridgeshire and Peterborough Ageing Well Strategy Board (see below for further details). |
| **Narrative update on workstreams** | **Dementia:** The Older People Mental Health Delivery Board is bringing together agencies across the health and social care system to develop an integrated plan to improve outcomes for people living with dementia across Cambridgeshire and Peterborough. A multi-agency strategy that reflects local need and responds with current evidence-based practice to inform future provision and support is being developed. The strategy uses the following Well Pathway for Dementia domains: (i) Preventing Well (ii) Diagnosing Well (iii) Supporting Well (iv) Living Well (v) Dying Well. A system-wide dementia business case has been approved by the STP; this includes investment for a Dementia Nurse Consultant leadership post, development of the Dementia Intensive Support Services (DIST), education and training, carer support and end of life preparation.<br><br>**Falls prevention:** Implementation of the CCG-wide falls prevention business case has now commenced. The aim of the project is to implement a comprehensive, standardised and integrated falls prevention pathway across the CCG area of Cambridgeshire and Peterborough. This will include:<br>- Increased provision and improved quality of evidence-based targeted interventions e.g. strength and balance classes, future development of fracture liaison services.<br>- Proactive identification of those at risk of falls.<br>- Comprehensive multifactorial assessment offered to those at risk of falling with appropriate intervention plan to address risk identified.<br>- Strengthened system-wide integration and co-ordination.<br><br>Implementation is being overseen by a small, multi-agency group with strategic oversight from the Cambridgeshire and Peterborough Falls Preventions Working Groups and the Ageing Well Strategy Board.<br><br>**Social isolation:** Social isolation has been determined a priority by the Ageing Well Strategy Board, alongside other priorities including falls prevention and dementia. This reflects the need described in the 'red' performance indicator and feedback from stakeholders, including at the Ageing Well Prioritisation Event which took place in May 2017. The Campaign to End Loneliness has received funding to work intensively in Cambridgeshire and Peterborough with the aim of reducing loneliness in |

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| | older people. The first stages of the work are underway including a mapping and consultation exercise to establish agreed solutions locally.<br><br>**Integrated Commissioning and the Better Care Fund (BCF):** A new Cambridgeshire and Peterborough Integrated Commissioning Board has been set up to agree opportunities for a common approach to commissioning, develop strategies, deliver sustainable transformation and provide oversight of the BCF plans and pooled budgets. Due to delays in the publication of the national guidance, the 2017/18 plans for the Cambridgeshire and Peterborough Better Care Funds are currently being drafted.<br><br> **Older People: Primary Prevention of Ill Health JSNA**: the JSNA has been completed and signed off by the Health and Wellbeing Board. Work has now commenced to communicate the findings of the JSNA and implement key recommendations. |
| **Examples of partnership working (services, projects, co-production/design etc)** | The dementia strategy is being co-produced by the multi-agency Older People Mental Health Delivery Board, with representation from adult services, public health, health service commissioners and providers, and the voluntary sector.<br><br>The falls prevention pathway has been co-produced and is being implemented by colleagues from public health, CPFT and the CCG. Funding has been secured from both public health and the STP. |

| HWB STRATEGY 2016/19: FUTURE PLANS | |
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| • The HWB has commissioned an 'Older People: Primary Prevention of Ill Health' JSNA for Peterborough, which is due for completion during 2016<br>• Develop a joint 'Healthy Ageing and Prevention Agenda' to ensure that preventative action is integrated and responsible to best support people to age well, live independently and contribute to their communities for as long as possible, including isolation and loneliness<br>• Review and refresh the joint dementia strategy for Peterborough<br>• A specific programme of work, in collaboration with older residents, will explore the main health and care issues faced by this group to inform future commissioning of services across the system and how stronger communities can empower people to self-manage with minimal support<br>• Recognise that some older people prefer face to face communication rather than digital, through community hubs which are part of the Council's wider strategy for communicating with the public | |
| **Future Plans: Progress against key milestones and local indicators/trends** | **Milestone 1: Falls Prevention**<br>Implementation of the business case is underway using learning from a pilot in St. Ives, which completed recently (see above for further details).<br><br>**Milestone 2: Mental Health and Dementia**<br>The joint dementia strategy is under development and the business case for investment from the STP has been approved (see above for further details).<br><br>**Milestone 3: Continence and UTIs**<br>Further development of gaps and priorities is being undertaken.<br><br>**Milestone 4: Community VCS** |
| **Risks** | As below |
| **Key considerations** | Previous considerations:<br>• STP governance is currently being reviewed by SDU for greater clarify on board roles and alignment with BCF governance.<br>• LDR investment will not be available from NHS Digital until April 2017.<br>• Better Care Fund planning for 2017/18 will need to incorporate plans for achieving health and social care integration by 2020 and future initiatives, e.g. devolution, will need to be factored into those plans. |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 6.1a | Injuries due to falls in people aged 65 and over (Persons, Directly Standardised rate per 100,000) | ▼ | Statistically significantly worse than England | 2015-16 | 663 | 2,348 | 2,169 | Match or exceed England performance |
| 6.1b | Numbers of over 40s taking up NHS health check offers | ▲ | Total of health checks delivered remains significantly above England average | 2016-17 | 5,232 | 10.4% | 8.5% | Match or exceed England performance |
| 6.1c | Report on take up of any preventative service commissioned directly as part of STP in the future | - | TBC | - | - | - | - | - |
| 6.2 | Reducing avoidable emergency admissions (BCF), (crude rate per 100,000) | ▼ | Statistically similar to England | Mar-13 | 328 | 176.0 | 178.9 | Match or exceed England performance |
| 6.3a | The proportion of people who use services who feel safe (proportion, %) | ▲ | Statistically significantly worse than England | 2015-16 | - | 65.0% | 69.2% | Exceed England performance in order to reach statistical similarity |
| 6.3b | The proportion of people who use services who say that those services have made them feel safe and secure (proportion, %) | ▼ | Statistically significantly better than England | 2015-16 | - | 88.3% | 85.4% | Match or exceed England performance |
| 6.4 | Using an Outcomes Framework - covering several key priority areas for older people in relation to their NHS care and the Social Care Outcomes Framework | - | Will be expanded as part of on-going work with Clinical Commissioning Group on Sustainability & Transformation (STP) Plans | - | - | - | - | - |
| 6.5 | Social Isolation: % of adults carers who have as much social contact as they would like (proportion, %) | ▼ | Statistically significantly worse than England | 2014-15 | - | 29.7% | 38.5% | Match or exceed England performance |
| 6.6 | Carer-reported quality of life score for people caring for someone with dementia | - | Indicator provided for the first time in 2014-15. Peterborough has a lower score than England | 2014-15 | - | 6.7% | 7.7% | Match or exceed England performance |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** GROWTH, HEALTH AND THE LOCAL PLAN
**LEAD:** SIMON MACHEN

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:** | |
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| 1. The Environment Action Plan describes the following actions:<br>a. Secure funding to increase the number of Green Flag awards to 6<br>b. Nene Park Trust will continually raise the quality of its facilities and improve the participation and engagement of visitors<br>c. Seek funding to carry out a feasibility study into local, sustainable food production<br>d. Achieve Fairtrade city status<br>e. Develop planning guidance to support local food<br>2. The health of residents is being specifically considered in the new Local Plan, consideration will be given to the access needs of vulnerable and marginalised groups<br>3. Public Health outcomes and/or objectives will be added to the Plan<br>4. Public Health advice will be embedded into the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of land use planning on health | |
| **Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)** | There have been no changes to the national indicators since the August report |
| **Narrative update on workstreams** | **Activity 1 – Environment Action Plan**<br>No update since last report<br><br>**Activities 2 and 3 - Local Plan**<br>Consultation on the Proposed Submission version of the emerging Local Plan is now due to commence in Jan 2018 for a six week period. This version of the plan will then be submitted to central government who will appoint an independent planning Inspector to carry out a public examination into the document. It is anticipated that the new Plan will be adopted by end of 2018.<br><br>**Activity 4 –** Public health continue to work with Growth and Regeneration Directorate |

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| **Examples of partnership working (services, projects, co-production/design etc)** | PH team are working with colleagues from strategic planning, development planning, community safety and environmental health to investigate options for improving the food environment in Peterborough |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• Strategic planning to undertake training with Development Management officers on Health Impact Assessment (HIA) and develop guidance for planners and developers on optimising health and wellbeing for smaller residential schemes.<br>• Strategic planning to attend a Developers Forum meeting to brief them on the Health policy.<br>• Public Health to look at available data around fast food outlets in Peterborough and consider options around possible guidance on their future location | |
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| **Future Plans: Progress against key milestones and local indicators/trends** | **Milestone 1**: Strategic planners are in discussion with development planners about the use of HIA as part of the new local plan. Public Health will be reviewing best practice, learning and identifying resources from elsewhere to support HIA training and the development of simple/ pragmatic resources to support planners and developers optimise health for smaller residential schemes.<br><br>**Update** – Concerns raised about the workload implication of the proposed HIA policy and how outputs from HIA will be used. Considerations are being made to increase the threshold level e.g. size of the development at which an HIA is required.<br><br>**Milestone 2**: Meeting to be scheduled with housing development forum before the release of the final plan.<br>**Update –** There has been a short pause in the Local plan process<br><br>**Milestone 3**: Review of local data on fast food premises and related health conditions in Peterborough and national evidence on what can be done will begin in September.<br>**Update**<br>A review of local food environment was undertaken to better understand:<br>• The number and distribution of different food outlets e.g. fast food, local grocery shops across Peterborough, their location and growth over time<br>• national evidence on what can be done to improve choice and create a food environment which encourages as default more healthy options |

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| | The report was taken to the Public Health Board in October and following this Public Health, Planning Policy and Development Management teams will meet in November to explore the feasibility of developing a Supplementary Planning Document as a means of influencing the development of fast food outlets in the city.<br><br>A second work stream is running in tandem, which includes colleagues from PH and environmental health to look at evidence based interventions to influence the quality of food being offered. |
| **Risks** | At the stage of the examination of the Local Plan, objections to the Health policy (or any of the health and wellbeing cross cutting themes within other policies) could result in directions for amendments to the Plan that are outside the control of the authority<br><br>Lack of understanding or buy in from officers and/or developers may mean that the Health policy is not fully implemented once adopted. |
| **Key considerations** | |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 8.1 | Excess weight in 4-5 year olds (% of all pupils) | ▲ | Statistically similar to England | 2015-16 | 632 | 22.8% | 22.1% | 8.1 |
| 8.2 | Excess weight in 10-11 year olds (% of all pupils) | ▲ | Statistically similar to England | 2015-16 | 794 | 34.2% | 34.2% | 8.2 |
| 8.3 | The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more during the day time (proportion, %) | ▼ | Statistical significance not calculated - Peterborough percentage is now below England | 2011 | 5,020 | 2.7% | 5.2% | 8.3 |
| 8.4 | The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more during the night time (proportion, %) | ▼ | Statistical significance not calculated - Peterborough percentage is now below England | 2011 | 8,190 | 4.5% | 12.8% | 8.4 |
| 8.5 | Utilisation of outdoor space for exercise/health reasons (proportion, %) | ▼ | Statistically similar to England | 2015-16 | - | 17.8% | 17.9% | 8.5 |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** HEALTH AND TRANSPORT PLANNING
**LEAD:** ADRIAN CHAPMAN / SIMON MACHEN

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>• The City Council's Travelchoice initiative encourages people to walk, cycle, use public transport and car share, as well as the uptake of low emission vehicles<br>• Increase the number of pupils receiving Bikeability training from 951 to 1,300 annually<br>• The Cambridgeshire and Peterborough Road Safety Partnership (CPRSP) works with a number of organisations to look at the causes of road accidents, understands current data and intelligence regarding the County's roads and develop multi-agency solutions to help prevent future accidents and reduce collisions<br>• Addenbrooke's Regional Trauma Network is a key partner in the CPRSP, and through various data sources to allow the serious accident data to be broken down into more detail to gain a clear understanding on the impact of severe collisions to the NHS and longer term social care and other partners<br>• The fourth Local Transport Plan (2016-2020) emphasises the role transport can play in the health of Peterborough residents | |
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| **Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)** | There have been no update to indicators since the last August Performance Report.<br><br>Discussion to take place between Public health and Transport team to agree further performance measures moving forward which can be used in next quarter performance report. |
| **Narrative update on workstreams** | The Council has applied for sustainable travel funding from the Combined Authority following a unsuccessful application to Department for Transport, a decision should be taken at their board meeting on 25 October. This will enable the continuation of projects focused on increasing active travel through the targeting of communities and businesses.<br><br>£20,000 has been awarded to the Cambridgeshire and Peterborough Road Safety Partnership Delivery Group from the OPCC to deliver various road safety activities. This has funded the following over the last 3 months: |

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| | • Officers from different partner agencies have attended various nationally recognised road safety training courses. By attending these courses has allowed officers from the different agencies to develop new road safety interventions which can be targeted at specific identified groups and fully.<br>• Toolkits are being developed which cover the fatal four (speed, seatbelts, mobile phones and drink drug driving). Toolkits will be available to community, voluntary groups, CSPs across the county to allow for a coordinated message.<br>• Focus has continued on young drivers officers have delivered events at RAF Wittering around drink/drug driving and attended the Freshers Fayre at Peterborough Regional College. Drive IQ was also launched, this new interactive road safety package is available free of charge to all schools across Peterborough. www.cambsdriveiq.co.uk |
| **Examples of partnership working (services, projects, co-production/design etc)** | |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• Collect further JSNA information on transport and health for Peterborough, using locally developed methodologies<br>• Permanently embed public health advice in to the City Council's Growth and Regeneration Directorate, through a post which will work with local land use and transport planners to consider the impact of transport planning on health and health inequalities | |
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| **Future Plans: Progress against key milestones and local indicators/trends** | The Council was successful in it's application for funding from department for transport to enhance its cycling and walking plans and provide staff training on current best practices. Eight days of free consultancy time have been agreed. A Dept for Transport introductory meeting is scheduled for late October.<br><br>A paper on transport and health will be taken to the HWB in December, this will outline the importance of active travel in increasing physical activity across Peterborough and improving the overall health of the residents. |

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| | A transport model has recently been developed with Cranfield University that allows us to test different scenarios to enable the City to achieve it's Sustainable Transport aspiration of creating 'A pedestrian, public transport and cycle first city and 90% of all journeys will be zero emission' by 2050. The model allows us to test the effect of changes such as more electric vehicles, improved infrastructure, behavioural change campaigns etc. Further work will now take place to ensure the scenarios are suitably evidenced based. |
| **Risks** | The loss of funding from the Dept for Transport sustainable travel funding means there is a shortfall in funding of £500k (compared to 2016/17). This could curtail activities around supporting/enabling active travel.<br><br>Responsibility for developing the local transport plan has moved to the Combined Authority, the recently completed Peterborough transport plan, strongly supported active and sustainable travel. It is unclear where active travel fits within future priorities of the combined authority at this point.<br><br>The Road safety partnership is currently experiencing problems with casualty data and the new CRASH system. This is currently being investigate and solutions being developed. Currently a risk as 6 months into 2017 and only have verified casualty data for January 2017. |
| **Key considerations** | |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 9.1 | The number of businesses with travel plans | - | 48 business in Peterborough have travel plans | 2016 | 48 | - | - | 9.1 |
| 9.2 | To further develop a robust monitoring network to enable in depth transport model data to be measured | - | In progress | | | | | 9.2 |
| 9.3 | Measures of air quality | - | Peterborough currently has 1 Air Quality Assessment Area | 2015 | 1 | - | - | 9.3 |
| 9.4 | The numbers of adults and children killed or seriously injured in road traffic accidents (crude rate per 100,000) | ▼ | Statistically similar to England | 2013-15 | 229 | 40.1 | 38.5 | 9.4 |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** HEALTH AND WELLBEING OF DIVERSE COMMUNITIES
**LEAD:** ADRIAN CHAPMAN

**HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**

- The HWB has commissioned a JSNA on the health and wellbeing needs of migrants
- Eastern European 'community connectors' employed by the City Council are working closely with the local NHS on issues such as promotion of screening and immunisations

**Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)**

The proportion of health checks completed that recorded a South Asian ethnicity was 7.2%. This is below the 12% proportion of people of south Asian ethnicity in the general Peterborough population. In total, 376 health checks were completed in people with South Asian ethnicity in the year 2016/17.

Data is being collected to determine ethnicity of people using mental health crisis services (First Response Service -FRS, and Sanctuaries)

Suicides in Peterborough by people with Eastern European ethnicity is a concern. It is difficult to report this data for confidentiality reasons as the numbers are small.

**Narrative update on workstreams**

**Controlling Migration Fund projects**

Peterborough and Cambridgeshire councils have been successful in a number of bids to DCLG's

Controlling Migration Fund. Five Peterborough projects have been funded to date, these are:

| CMF Project | Lead Officer | DCLG Grant Awarded (Total) | 17-18 | 18-19 | 19-20 |
|---|---|---|---|---|---|
| Getting to Know You | Janet Bristow - City College | £281,573 | £138,706 | £142,867 | N/A |
| Alcohol Misuse | Joseph Keegan - Cambs Council / Julian Base - PCC | £283,347 | £135,120 | £148,227 | N/A |

| | | | | | |
|---|---|---|---|---|---|
| Rough Sleeper Support Services | Sean Evans - PCC | £250,436 | £99,401 | £151,036 | N/A |
| Shared Vision | Keith Jones - CAB | £288,350 | £105,344 | £145,852 | £37,154 |
| Social Media Resources | Kathy Hartley - Public Health | £94,200 | £48,900 | £45,300 | N/A |
| | | **£1,197,906** | **£527,471** | **£633,282** | **£37,154** |

The projects help to address many of the issues identified in the JSNA for Diverse Ethnic Communities.

Funding has been received and the projects are beginning to be implemented or their roll-out is being planned.

Getting to Know You will see increased ESOL provision within Peterborough over the next 2 years. The project is led by City College and will involve both GLADCA and PARCA in community based delivery.

ESOL classes will be thematically based and will focus on participants gaining confidence in accessing and using a range of public services. A call for volunteers to deliver the ESOL classes met a good response. The programme of lessons has been planned and resources are being developed.

Tackling Alcohol Misuse is being led by Public Health and delivered in both Wisbech and Peterborough.

This will see additional outreach and engagement to migrant communities to help tackle street drinking and support migrants to access treatment services.

Information Pack of Social Media is also being led by Public Health and will see a range of videos created in a variety of languages explaining how to access and use public and other services e.g. education, housing, health, employment etc. This project has a steering group and project support from public health. Implementation is being planned with the involvement of Peterborough City Council Comms team, linking with the 'Healthy Peterborough' initiative

The Citizens' Advice Peterborough project to deliver targeted IAG from community locations and Boroughbury Medical Centre is in the planning stage.

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| | Of note is the intention to link the projects listed above together, in order to help with design and implementation, particularly around sharing information resources.<br><br>**Community engagement support**<br><br>Community connectors have been involved in the following:<br><br>● connecting with faith communities and other communities to support and encourage completion of survey forms in understanding the health needs of South Asian Communities in the city.<br>● promoting the health MOT checks that have been arranged by Solutions 4 Health during the summer when several hundred people have benefited.<br>● Taken part in the initial preparatory work to organise an awareness event around sexual health for the targeted community groups being proposed in early 2018 and other campaigns work that is currently being run by Public Health Team |
| **Examples of partnership working (services, projects, co-production/design etc)** | The mental health Crisis 'First Response Service' (FRS) and 'Sanctuaries' - implemented as part of a partnership 'crisis care concordat programme' is being promoted as a programme of work to Minority Ethnic communities throughout Peterborough. This is being achieved by the FRS visiting community groups to talk about the service, promotion of the mental health crisis video, translated into Urdu, Punjabi, Lithuanian and Polish.<br><br>Training of the FRS team is also planned to increase their knowledge and understanding of cultural attitudes. |

| HWB STRATEGY 2016/19: FUTURE PLANS<br><br>● The benefits of tailoring preventive programmes, working with South Asian communities to prevent diabetes and CVD, are increasingly recognised nationally. The CCG and the City Council will work together to assess the feasibility of local schemes | |
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| **Future Plans: Progress against key milestones and local indicators/trends** | NHS Health Checks - designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia among adults aged 40 - 74 years old - are now being delivered within local community settings, complementing existing delivery through local GP practices. In addition to increasing the delivery of NHS Health Checks the delivery of Health MOT's for younger age groups has also begun, with a specific focus on target populations. Target populations include local south Asian* communities who have a higher risk of developing diabetes and higher rates of coronary heart disease.<br><br>A South Asian health and wellbeing survey is being implemented, which will assess the local need as well as access to services. The survey aims to assess health and wellbeing risks and concerns and will be used to help tailor and design appropriate services including preventative programmes. The survey is expected to be completed by the end of January 2018. The results of the survey and any recommendations that are drawn from them will be made available within a supplement to the diverse ethnic communities JSNA that will focus on the needs of South Asian communities. |
| **Risks** | The main risk for both the health check programme and the health and wellbeing survey is ability to engage with the S Asian population to ensure a good return (for the survey). There is also the risk that the reach for both these programmes is not comprehensive – ability to engage women or traditionally hard to reach communities. Engagement is important for the survey as we would require a good return in order for the responses to be representative of the needs of the community. |
| **Key considerations** | |

## Performance Indicators:

| Indicator Ref | Indicator | Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 12.1 | We will work with local health services to improve data collection on ethnicity, both generally and to assess the success of targeted interventions<br><br>Ethnicity broken down further than 'white other' when collecting data | - | To follow via Peterborough City Council policy team in collaboration with Public Health Intelligence | - | - | - | - | 12.1 |
| 12.2 | Proportion of health checks completed where ethnicity is given as British Asian | - | Proportion is below proposed target | - | - | - | - | target to be in line with the proportion of S. Asian in the population aged 40-70<br><br>12.2 |
| 12.3 | The proportion of BME people detained under Section 136 of the mental health act | | | | | | | 12.3 |

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|---|---|---|---|---|---|---|---|---|
| 12.4 | suicides by people with Eastern European ethnicities | | | | | | | |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** HEALTH BEHAVIOURS AND LIFESTYLES
**LEAD:** LIZ ROBIN

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>• Develop a joint 'Prevention Strategy' to ensure that supporting people to improve and maintain their own health is a key part of managing demand on local NHS services<br>• Commissioning a joint Drug and Alcohol Service through the Clinical Commissioning Group and Peterborough City Council, which reaches into the Hospital.<br>• Improve support for local employers to promote healthy workplaces through a new contract with 'Business in the Community' | |
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| **Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)** | A Health System Prevention Strategy has been produced in recognition of the impact of preventable ill health has locally. GP practices continue to deliver the key prevention programme, NHS health checks while this is now also being delivered by the local lifestyle provider, Solutions4Health, who delivered over 120 health checks since July 2017. Solutions4Health are also delivering one to one clinics and group programmes to assess and address lifestyle factors including alcohol, diet and nutrition, physical inactivity and smoking, with 380 people setting a personal health plan since April.<br><br>A range of weight management and physical activity programme for children and adults are also being delivered with over 100 adults referred to programmes since April and nine local schools expressing an interest in hosting child programmes. Schools also remain engaged in the local Health Champion initiative and the associated health awareness training programme with over 300 children and young people supported in schools since April.<br><br>The integrated drug and alcohol treatment service (Aspire) went live on 1st April 2016 and is now half way through it's second year. Year 1 saw a dip in performance due to the complex system change involved in the retender. However, performance has subsequently recovered to national average levels. During Year 1 and 2 the service has significantly increased the number of clients with alcohol and non-opiate issues engaged into treatment compared to the previous two separate drug and alcohol treatment providers. |

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| | The current Healthy Workplace programme continues to be delivered with a focus on supporting those workplaces that predominantly employ routine and manual workers. The programme has supported an additional 11 new workplaces during last quarter and held 8 training and network event to support local workplaces. |
| **Narrative update on workstreams** | The lifestyle services are being embedded in an increased number of locations across the City and at increased time to improve access. At a strategic level during the last quarter there has been a focus on tobacco control as part of the prevention work being undertaken. Following the publication of the national Tobacco Control Plan in July 2017 partners have been working to establish a refreshed local Tobacco Control partnership and associated local plan and workstreams.<br><br>Implementation of the Migrant Impact programme following a successful bid to DCLG is progressing. The workstream focused on addressing the impact of alcohol misuse among migrant population on the wider community is underway. A coordinated approach across both Fenland and Peterborough is being established through the appointment of specialist alcohol outreach workers, across both areas and a Community Connector and Healthy lifestyle advisor for Peterborough.<br><br>Year 2 objectives for the integrated drug and alcohol treatment service (Aspire) service include continued performance improvement to reach top quartile, to reduce the proportion of clients in long term treatment and development of early intervention provision for alcohol.<br><br>A strategic partnership approach is needed to increase the number of GPs engaging in Shared Care and to develop a strategic response to the nationally identified issue of addiction to prescribed medicines and over the counter medicines<br><br>The contract for the current Healthy Workplace programme is due to finish on 31 March 2018. A proposal to undertake a procurement exercise for a new programme has been approved by the Joint Commissioning Board. The new programme will include accreditation framework to recognise progress made in supported workplaces and a requirement on the new provider to ensure increased sustainability of health and wellbeing activities within supported workplaces after the initial intervention. |

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| **Examples of partnership working (services, projects, co-production/design etc)** | The workplace programme is a joint commission across Cambridgeshire and Peterborough that supports the wider networking of local employers. The programme is also closely aligned with both healthy lifestyle services across the area to ensure employers have full access to support services.<br><br>The Tobacco Control Plan is being co-produced with a variety of partners from the local authority, health sector, voluntary groups and patient groups. Each partner is directly committed to lead specific interventions and work collaboratively towards the achievement of shared outcomes.<br><br>The drug and alcohol retender embedded two key strategic joint commissioning arrangements. The first relates to the Hospital Alcohol Liaison Project, jointly commissioned with the CCG to provide extended brief interventions to patients admitted due to alcohol and or drugs and engage them with structured treatment where needed.<br><br>The second is the Integrated Recovery Offender Programme (IROP) jointly commissioned with the Police & Crime Commissioner. IROP is piloting innovative ways to support frequent custody attenders with drug, alcohol and mental health issues. The Project is in its second year and has recently commissioned a mental health nurse from the Liaison and Diversion Service in CPFT to work within the team. |

| HWB STRATEGY 2016/19: FUTURE PLANS | |
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| • Commission an integrated healthy lifestyle service with the aim that people can access one service for help and support with stopping smoking, healthy eating, physical activity, weight management and mental wellbeing, linked with services for people with mental and physical health, disability and ageing issues<br>• Improve our communication with local residents on health issues and to develop local campaigns and access to health information sources in a range of settings, which can be trusted to provide reliable advice on healthy lifestyles<br>• Recognise the vital role schools play in supporting the health and wellbeing of children and young people through a Healthy Schools Peterborough programme<br>• Reduce the number of local people developing Type 2 Diabetes | |
| **Future Plans: Progress against key milestones and local indicators/trends** | The integrated healthy lifestyle service has been commissioned by Peterborough City Council in partnership with the Clinical Commissioning Group and began delivery on 01 April 2017. The service is delivering clinics from the majority of GP practices and a range of community settings across Peterborough. Services are being provided on a one to one basis and through group interventions to help local people address health risks such as smoking, inactivity and excess weight.<br><br>The Healthy Peterborough campaign programme has been established with monthly campaigns delivered on specific health issues, aligned to associated national campaigns to maximise exposure. Since March 2016 the campaign programme has focused on issues such as Ageing Well, Physical Activity, Smoking, Mental Health and Cancer. Data from the Healthy Peterborough website has demonstrated that campaigns have been viewed in excess of 10,000 times and in some cases over 30,000 times when a campaign has run over a two month period.<br><br>The Healthy Schools Peterborough programme was established during the 2016/17 academic year and has engaged primary, secondary and special schools. An accreditation process covering Bronze, Silver and Gold awards for schools has been developed. The Programme Board is now established and is directing the development and delivery of the programme this academic year.<br><br>The Healthier You: NHS Diabetes Prevention Programme service has been established across Cambridgeshire and Peterborough to support people at risk of developing Type 2 diabetes. The local |

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| | programme is being delivered by ICS Health and Wellbeing in local settings and are working with Solutions4Health. |
| **Risks** | The weight management element of the integrated healthy lifestyle service remains a has been a risk. A proposal for Solutions4Health to sub-contract the Obesity Service at Cambridge University Hospitals to deliver Tier 3 weight management services has been agreed and is being progressed. Delivery of the service will still be based in Peterborough. |
| **Key considerations** | |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 2.1 | Smoking Prevalence - All (proportion, %) | Decreasing - getter better | Statistically similar to England | 2016 | - | 17.6% | 2.1 | Reduce disparity between Peterborough and England |
| 2.2 | Smoking Prevalence - Routine & Manual Occupations (proportion, %) | Increasing - getting worse | Statistically similar to England | 2016 | - | 27.9% | 2.2 | Match or exceed England performance |
| 2.3 | Excess weight in adults (proportion, %) | Increasing - getting worse | Statistically significantly worse than England | 2013-15 | - | 70.8% | 2.3 | Reduce disparity between Peterborough and England |
| 2.4a | Physically active adults (proportion, %) | Increasing - getter better | Statistically similar to England | 2015 | - | 54.7% | 2.4a | Reduce disparity between Peterborough and England |
| 2.4b | Physically inactive adults (proportion, %) | Increasing - getting worse | Statistically significantly worse than England | 2015 | - | 34.3% | 2.4b | Reduce disparity between Peterborough and England |
| 2.5 | The numbers of attendances to sport and physical activities provided by Vivacity (observed numbers) | Increasing - getter better | 5.7% increase between 15/16 and 16/17 | 2015-16 | 1,388,710 | - | 2.5 | Increase of year-on-year number |
| 2.6 | Admission episodes for alcohol-related conditions - Persons (directly standardised rate per 100,000) | Increasing - getting worse | Statistically significantly worse than England | 2015-16 | 1,245 | 708 | 2.6 | Reduction in DSR of 1.0% per year |
| 2.7 | Admission episodes for alcohol-related conditions - Males (directly standardised rate per 100,000) | Increasing - getting worse | Statistically significantly worse than England | 2015-16 | 800 | 939 | 2.7 | Reduction in DSR of 1.0% per year |
| 2.8 | Admission episodes for alcohol-related conditions - Females (directly standardised rate per 100,000) | Increasing - getting worse | Statistically similar to England | 2015-16 | 445 | 491 | 2.8 | Reduction in DSR of 1.0% per year |
| 2.9 | The annual incidence of newly diagnosed type 2 diabetes (observed numbers) | - | Awaiting provision from CCG | - | - | - | - | TBC - Awaiting data from CCG |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** HOUSING AND HEALTH
**LEAD:** ADRIAN CHAPMAN

<table>
<tr><td colspan="2">HWB STRATEGY 2016/19: CURRENT ACTIVITIES:<br><br>● Housing related support funds support to a variety of providers and settings to ensure their clients are supported into move on accommodation, can maintain tenancies and therefore prevent them from becoming homeless<br>● The Peterborough Older Persons Accommodation Strategy identified that over 90% of people wished to remain at home to be supported to do through the provision of aids and adaptations and a demand for extra care accommodation. To date 262 additional units of extra care accommodation have been provided in partnership with registered providers. A further scheme of 54 dwellings is under construction<br>● Care and Repair provides a handyperson (HP) scheme to help aged and vulnerable people with small scale works. The minor aids and adaptations installations the HP assist hospital discharge and enable health services to be delivered in people's homes. The agency provides advice and has a network of contacts for onward referral and works with other voluntary sector groups on winter warmth initiatives<br>● The City Council's Cabinet has approved introducing selective licensing in 5 areas of the city covering privately rented properties. This would help raise the standard of private rented accommodation and therefore improve the health and wellbeing of those residents. Since its launch in December 2016 over 6,000 applications for a licence have been received.</td></tr>
<tr><td>Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)</td><td>● 1,077 aids & adaptations were completed in 2016/2017 and so far this year 667 have been completed. 258 Disabled Facility Grant funded adaptations were completed in 2016/2017. 103 Disabled Facility Grant funded adaptations have been completed so far this year.<br>● 3,427 Handyperson requests were completed in 2016/2017 and so far this year 1,228 have been completed. Handyperson requests often identify other issues within the property which can be addressed by other available assistance and funding streams<br>● The Local Energy Advice Programme (LEAP) funded through the Warm Homes Discount provides energy advice, energy & tariff switching, simple energy efficiency measures, income maximisation, debt advice and onward referrals for further assistance to fuel poor households and households at risk of falling into fuel poverty. This programme is now in its second year</td></tr>
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| | and so far 192 referrals have been made against a target of 650. 126 Home energy visits have been completed and 967 simple measures installed resulting in total bill savings of £10,530. The Incomemax service has resulted in an estimated £45,000 yearly increased income and the energy advice given has resulted in an estimated £171.00 unit bill saving with an estimated £21,546.00 lifetime bill saving. Information about the LEAP Scheme will be included in the 6,000 Stay Warm, Stay Well packs as part of this year's Public Health campaign |
| **Narrative update on workstreams** | ● 8 Housing Related Support providers are currently funded, which includes support in accommodation settings, drop in support and some specialist floating support. Overall numbers of Homelessness Prevention as a direct result of this support are slightly up on same period last year (173 Q1 2016/17 vs 185 Q1 2017/18) Discussions are now taking place to jointly commission a generic Floating Support Service with Cambridgeshire County Council from July 2018 onwards. This will provide support to vulnerable residents in both hostel settings and within their homes. The aim is for the support to move with them through different types of accommodation and at different levels to achieve full independent living.<br>● The Cross Keys Homes Extra Care scheme of 54 units completed and was handed over to CKH's Housing Related Support team on 5th September. An open day has taken place and 14 units, accommodating 20 people are now occupied within the scheme. Other units have now been reserved resulting in a total of 50% of the units now being allocated.<br>● We continue to work with Housing providers and Health Investment Organisation's to ensure we get the right accommodation to meet the needs of each person, including bespoke requirements. |
| **Examples of partnership working (services, projects, co-production/design etc)** | Partnering with AgilityEco on the LEAP project. |

| **HWB STRATEGY 2016/19: FUTURE PLANS** | |
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| • Peterborough City Council is working in partnership with registered providers to provide new supported housing schemes including accommodation for people with learning disabilities and mental health disorders to enable them to live independently with a live-in carer where necessary or floating support<br>• A Vulnerable People's Housing Sub-Group has been established, which will review how local housing needs for vulnerable people, including people with disabilities, should be addressed<br>• The Peterborough Market Position Statement has identified a significant shortfall of nursing and residential care accommodation and it will be a priority to increase this provision for the ageing population<br>• A task and finish group including housing managers and hospital managers is reviewing complex cases causing hospital discharge delays, and how use of disabled facility grants could address this | |
| **Future Plans: Progress against key milestones and local indicators/trends** | **Milestone 1 -** Adult Social Care achieved the development of 22 units since April 2017 slightly below our initial target. We would expect to achieve a further 16 units by early 2018.<br><br>**Milestone 2** The Vulnerable Persons Housing Sub Group - the group relaunched on 1st November (after the time of writing this report and so a verbal update will be provided at the meeting).<br><br>**Milestone 4 -** Discretionary DFGs have been introduced to support health priorities. Pathways are being developed with the DTOC Teams at the City Hospital and the Transfer of Care Team where discharge is being delayed due to housing inaccessibility or poor condition. This discretionary grant (max £6,000) can be used to carry out urgent work in people's homes to facilitate discharge from hospital, interim beds, re-ablement or a care setting ensuring the property is warm and safe. Further identified work can be carried out at the property at a later date under DFG or Repairs Assistance funding.<br><br>We have been working in partnership with the NHS on developing our Housing and Accommodation Strategy to support our most complex and challenging clients to be discharged from inappropriate inpatient services. Providing the right accommodation and support for these clients forms part of our commitment to the NHS England transforming care programme for people with a learning disability". |

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| **Risks** | |
| **Key considerations** | |

**Performance Indicators:**

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 10.1 | Excess winter deaths index (3 years, all ages, Persons, Ratio) | Increasing - getting worse | Statistically similar to England | Aug 2012 - Jul 2015 | 268 | 19.6 | 19.6 | Match or exceed England performance |
| 10.2 | Excess winter deaths index (3 years, all ages Males, Ratio) | Increasing - getting worse | Statistically similar to England | Aug 2012 - Jul 2015 | 81 | 11.8 | 16.6 | Match or exceed England performance |
| 10.3 | Excess winter deaths index (3 years, all ages Females, Ratio) | Increasing - getting worse | Statistically similar to England | Aug 2012 - Jul 2015 | 187 | 27.3 | 22.4 | Match or exceed England performance |
| 10.4 | Reduction in unintentional injuries in the home in under 15 year olds | Decreasing - getter better | Statistically similar to England | 2015-16 | 464 | 113.5 | 104.2 | Match or exceed England performance to improve to statistically similar to England |
| 10.5 | Reduction in delayed discharges from hospital related to housing issues (observed numbers) | Decreasing - getter better | Has reduced, statistical significance unavailable | 2015-16 | 694 | - | - | Reduction in observed numbers |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** MENTAL HEALTH FOR ADULTS OF WORKING AGE
**LEAD:** WENDI OGLE-WELBOURN

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:** | |
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| • The Joint Suicide Prevention Strategy and implementation plan for Cambridgeshire and Peterborough is being delivered<br>• The local 'Crisis Care Concordat' implementation plan aimed at reducing the incidence of mental health crisis and the use of Section 136 of the Mental Health Act is being delivered within the agreed time frames. Improvements include a new mental health crisis care telephone helpline through the 111 service (option 2), that connects with a community First Response Service (FRS). A community place of safety or 'sanctuary' has been set up to offer support to people in mental health crisis. This service has been nominated for a Positive Practice Award.<br>• Implementation of the Joint Peterborough Mental Health Commissioning Strategy includes redesign of the mental health accommodation pathway, increased choice of housing options, a placement model of employment support, stronger links between commissioners and clear focus on the right support, the first time, at the right place, by the right people | |
| **Current Activities: Performance narrative and statistics. (Please refer to relevant performance measures of success).** | **1. Suicide Prevention**<br>***Metrics: Suicide Rates:*** *Persons/Males/Females: Standardised rate per 100,000 population*<br>***Performance: 2013-1015 three year average 'rolling' data:*** *All persons: 8.4% Decreasing, getting better and better than the England value (10.1%)*<br>*Males: 11.5% Decreasing, getting better; better than the England value (15.8%)*<br>*Females: Data redacted due to low numbers (not statistically significant) (New data not yet available – therefore no change)*<br>*An annual suicide audit has been carried out for Peterborough and Cambridgeshire since 2014. Early indications suggest that the total number of suicides in Peterborough reduced duriing 2016.*<br><br>**2. Crisis Prevention**<br>***Metric:*** *Rates of use of Section 136 under the Mental Health Act*<br>***Performance:*** *Instances of use of Section 136 under the Mental Health Act in Peterborough decreased during 2016/17 and continue to reduce. Figures are currently being audited. The final outturn 2016/17 and in-year figures will be included in the next report.* |

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| | **3. Mental Health Housing and Accommodation**<br>***Metric:*** *Adults in contact with mental health services in settled accommodation*<br>***Performance:*** *Increasing (80% at April 2017) – getting better and statistically better than England (58.5%) (31% previously reported; this is likely to be an under reporting of the actual values)*<br><br>**4. Employment**<br>***Metric:*** *Adults in contact with mh services in employment*<br>***Performance:*** *10.5% at April 2017): Increasing – getting better although and statistically better than England (8.8%) (4.6% previously reported; this is likely to be an under reporting of the actual values)*<br><br>**5. Stronger Links Between Commissioners**<br>***Performance:*** *Performance is improving in 5 out of the 6 areas with meaningful measures*<br>***Metrics:*** *Improvement in performance against the prioritised metrics;*<br><br>**6. The Right Support, the First Time, at the Right Place, by the Right People**<br>***Performance:*** *Performance is improving in respect of the items for which there is full and robust data In the future it will be possible to track progress as anomalies in the approach to data collection have now been addressed.* ***Metrics:*** *Improvement in performance against the prioritised metrics*<br><br>*Note: an overarching report against the outcome metrics in the HWB Strategy will be prepared annually, co-ordinated by the Public Health Intelligence team.* |
| **Current Activities: narrative update on workstreams** | **1. Suicide Prevention**<br>i) The suicide prevention strategy has been updated by members of the Suicide Implementation Group.<br>ii) A number of new workstreams have been established e.g. bereavement support for people bereaved by suicide following investment by the STP.<br>iii) A Zero Suicide Ambition now underpins the Suicide Prevention Strategy and a proposal that delivery of this ambition and the Suicide Prevention Strategy should be governed by the Cambridgeshire and Peterborough Safeguarding Executive will be considered at the January meeting of that Group. This will give both initiatives senior support and guidance. A proposal to hold 2 launch events in February/March 2018 – one in each of Cambridgeshire and Peterborough - will also be considered by the Executive. These events will be co-produced with people with lived experience of mental health problems and carers. |

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| | iv) Key organizations directly involved in Suicide Prevention or with people with lived experience of mental health problems will be asked to sign up to the National Suicide Alliance at these events. A target will be set to secure sign up from organizations in the wider community by 2019/20 will also be set.<br><br>**2. Crisis Prevention**<br>i) Excellent progress is being made with implementation of the Crisis Concordat Action Plan with progress being to or ahead of time on most of the 17 priorities.<br>ii) The focus of activity is ensuring that the new requirements arising from the Police and Crime Act will be met across the health and care system. Action to address potential gaps was initiated late in June 2017. The Board will be alerted to any areas of concern in the next report. This will allow the Board to consider areas that may need more focussed and senior attention to resolve.<br><br>**3. Mental Health Housing and Accommodation**<br>i) It is likely that the figures previously reported were inaccurate with performance being under reported. The next report will start to show the ongoing trend in performance.<br>ii) Housing and accommodation has been prioritised by Peterborough commissioners. Mental health is included within the work being undertaken. Significant work is being undertaken with providers to develop the market to increase both the range and choice of accommodation and the capacity available. This includes increasing capacity in the accommodation available for people stepping down from forensic/secure services.<br><br>**4. Employment**<br>i) It is likely that the figures previously reported were inaccurate with performance being under reported. The next report will show the ongoing trend in performance.<br>ii) Improvement of employment outcomes has been prioritised by PCC, CCC and the CCG which are working increasingly collaboratively.<br>iii) Following the 29.06.17 workshop, a multi-agency Steering Group has been established. 3 priorities have been identified: i) Co-production of the mental health employment strategy in order to ensure that it truly reflects the needs and wishes of local people with mental health needs ii) alignment with the DWP employment pathway and the Devolution agenda/work of the Combined Authority in relation to employment across Cambridgeshire and Peterborough iii) developing a multi-agency bid for investment in an Individual Placement Service, the evidence based model of choice for people with |

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| | mental health problems on the Care Programme Approach specified in the 5 Year Forward View for Mental Health. This is led by the CCG and CPFT as funding is available from NHS England through the CCG.<br>iv) The service currently commissioned for Peterborough residents from Richmond Fellowship which was not delivering against the targets and specification has been decommissioned. A decision regarding what is needed in Peterborough to support people into employment will be made through the work on the Mental Health Employment Strategy.<br><br>**5. Stronger Links Between Commissioners**<br>i) Work to establish a Mental Health Joint Commissioning Unit continues. A decision about the most effective governance, structure and arrangements will be made at the December Joint Commissioning Board. The expectation is that this will confirm the arrangements that have been established during the year.<br>ii) Two multi-agency groups that include service user and carer representation now oversee the delivery and improvement of mental health services: i) The MH Delivery Board (the Cambridgeshire and Peterborough Crisis Care Concordat group) which oversees crisis acute care ii) the Community MH Services Delivery Board which oversees statutory and voluntary sector provision in the community and primary and secondary care.<br><br>**6. The Right Support, the First Time, at the Right Place, by the Right People**<br>i) The enhanced primary care mental health pathway to be delivered through the PRISM has been implemented across Peterborough. This will help to ensure that the Care Act responsibilities of CPFT, including as required in of social care through the Section 75 Partnership Agreement, are discharged.<br>iii) The focus of both commissioners and providers remains to improve outcomes across the mental health pathway including prevention and suicide prevention. |

| **HWB STRATEGY 2016/19: FUTURE PLANS** | |
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| • Bring together findings from the Peterborough Mental Health JSNA (2015) and refresh the Mental Health Commissioning Strategy in 2016, to tailor implementation plans to address unmet mental health need<br>• A new recovery coach service to support people after discharge from secondary care and during transitions by connecting between third sector, local authority and mental health services<br>• An enhanced Primary Care Mental Health Service is planned to support people with greater needs upon discharge from secondary care. This will operate through community based teams<br>• The new Mental Health Commissioning and Delivery Partnership Board which includes representatives of carers and the voluntary sector, will ensure that the needs of carers are considered in joint planning of services<br>• Service user representation will also be invited to the Partnership Board | |
| **Future Plans: Progress against key milestones** | **Milestone 1**: **Bring together findings from the Peterborough Mental Health JSNA (2015) and refresh the Mental Health Commissioning Strategy in 2016, to tailor implementation plans to address unmet mental health need**<br><br>i) The HWB can now be assured that Engagement on the MH Strategy is robust and complete. The work requested by the CCC HWB to ensure that there is clarity about the outcomes/impact of the strategy is also complete.<br><br>**Milestone 2: A new recovery coach service to support people after discharge from secondary care and during transitions by connecting between third sector, local authority and mental health services**<br>i) The Recovery Coach service continues to deliver strong outcomes. Council and CCG commissioners are considering ways to build on the impact they have had within the mental health commissioning strategy going forwards.<br><br>**Milestone 3: An enhanced Primary Care Mental Health Service is planned to support people with greater needs upon discharge from secondary care. This will operate through community based teams**.<br>See 6 ii) above.<br><br>**Milestone 4: The new Mental Health Commissioning and Delivery Partnership Board which includes representatives of carers and the voluntary sector, will ensure that the needs of carers are considered in joint planning of services** |

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| | i) Improvement in the identification of carers of people with mental needs is a key priority 2017/18. This is being addressed directly with CPFT and with The Carers Trusts as well as being addressed within the joint Council and CCG review of the Cambridgeshire and Peterborough Carers Strategy.<br>ii) Work to improve outcomes and experience of carers in contact with CPFT is continuing and will be captured in the new Carers Schedule within the revised Mental Health Section 75 Partnership Agreement to be implemented from 01.04.18.<br>iii) Council and CCG commissioners meet jointly with Rethink Carers Support and Healthwatch on a quarterly basis to discuss concerns with mental health care and services.<br>iv) The Peterborough and Cambridgeshire MH Stakeholder Group meets quarterly to provide a forum for engagement with the wider mental health stakeholder group, including carers.<br><br>**Milestone 5: Service user representation will also be invited to the Partnership Board**<br>i) The Peterborough MH Stakeholder Group now includes Cambridgeshire with the first joint meeting being held on met on The next meeting of the group is arranged for 31.01.18. The operation of the group as a Partnership Board will be considered as part of the paper on mental health governance that will be considered at the MH Joint Commissioning Group meeting on 05.12.17. This will ensure that the role of the group is clear. |
| **Risks** | i) That there is insufficient resource, despite efficiencies being achieved by addressing duplication and improving joint working and synergies, across the health and social care system to support all the developments identified as being required to improve access to services and outcomes by the various adult mental health workstreams. Mitigation: i) to minimise inefficiencies e.g. duplication and overly complicated processes and pathways; ii) to improve promotion/prevention and early intervention including effective information, advice and signposting; to minimise duplication and maximise integration/seamlessness of pathways and services commissioned by the Councils and CCG – through the Mental Health Joint Commissioning Unit.<br>ii) That the complexities and time needed to meet the internal governance requirements of each organization slows progress and significantly slows delivery of the potential benefits of working collaboratively. Mitigation: Establish joint commissioning for adult mental health. |
| **Key considerations** | i) The work to identify and interrogate opportunities to work jointly across the whole system requires support from the senior managers and others within the key organizations involved to maximise the benefit of the opportunities.<br>ii) Reporting and governance within the 3 organizations can be time consuming and slow progress. Exploration of models to establish joint commissioning for mental health will help to address this. |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 4.1 | Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years, crude rate per 10,000) | ▲ | Statistically significantly worse than England | 2015-16 | 431 | 189.5 | 134.1 | - |
| 4.2 | Rates of use of section 136 under the mental health act | - | Instances of S136 use in Peterborough have fallen but this is partly attributable to closing of Cavell Centre. Constabulary suggest target should be based around avoiding use of police stations as place of safety | 2015-16 | 20 | - | - | - |
| 4.3 | Suicide Rate - Persons (directly standardised rate per 100,000) | ▼ | Statistically similar to England | 2013-15 | 42 | 8.4 | 10.1 | - |
| 4.4 | Suicide Rate - Males (directly standardised rate per 100,000) | ▼ | Statistically similar to England | 2013-15 | 29 | 11.5 | 15.8 | - |
| 4.5 | Suicide Rate - Females (directly standardised rate per 100,000) | - | Data redacted due to low numbers | 2013-15 | - | - | - | - |
| 4.6 | Hospital readmission rates for mental health problems | - | Awaiting provision from CPFT | - | - | - | - | - |
| 4.7a | Adults in contact with mental health services in settled accommodation | ▲ | Statistically significantly worse than England | 2012-13 | 410 | 30.7% | 58.5% | - |
| 4.7b | Adults in contact with mental health services in employment | ▲ | Statistically significantly worse than England | 2012-13 | 65 | 4.8% | 8.8% | - |
| 4.8 | Carers for people with mental health problems receiving services advice or information | Increasing - getter better | Remains below England (statistical significance not calculated | 2013-14 | 5 | 2.9% | 19.5% | - |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** PROTECTING HEALTH
**LEAD:** DR LIZ ROBIN



| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:** | |
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| • Cambridgeshire and Peterborough CCG has convened a joint TB commissioning group, to develop a plan to commission accessible and responsive services. The first task has been to develop a plan for implementation of Latent TB (LTBI) screening in line with the national TB strategy and a successful bid for pilot funding was submitted to Public Health England<br>• The Health Protection Steering Group, which involves the City Council, local NHS and Public Health England, has oversight of immunisation and screening uptake, task and finish groups to look at uptake issues for immunisation and screening have completed reports and implementation groups are due to take forward the recommendations<br>• A multi-agency sexual health strategy group is due to commence work shortly, convened by Peterborough City Council, to look at a range of sexual health issues, not just communicable diseases | |
| **Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)** | **TB**<br>Good progress continues to be made in Peterborough on Latent TB (LTBI) screening in certain at risk groups, which has been the focus of the TB commissioning Group led by the CCG in the past 18 months. Additional GP practices have now been recruited to the programme to ensure a high level of coverage.<br><br>The eligibility criteria for the service are any new patient registering with a practice or retrospectively identified by the practice as being:<br>• Born or spent > 6 month in a country of high TB incidence<br>• Entered the UK within the last 5 years<br>• Aged 16-35 years<br>• No history of TB either treated or untreated<br>• Never screened for TB in the UK<br><br>GP practices with a crude annual rate of active TB ≥ 20 cases/100,000 were initially prioritised<br>The project commenced in March 2016 and was very successful in its pilot year. |

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| | Data to end of May 2017 showed that 385 people were screened, 307 negative, 48 positive, 8 borderline negative, 10 borderline positive, 5 indeterminate<br><br>Work also continues on workforce planning for specialist TB clinical staff in local NHS provider trusts. A revised hospital discharge protocol is being developed that combines Adult Social Care and Housing. TB patients will be incorporated into this.<br><br>**Health Protection Steering Group (HPSG)**<br>This group meets quarterly to review performance for Screening and Immunisation, current communicable disease activity, healthcare associated infection and work to improve anti-microbial stewardship and reduce the development of antibiotic resistance and to receive reports of health protection issues dealt with by environmental health teams.<br><br>Updates<br>Low uptake for all three cancer screening programmes:<br>Bowel Cancer screening uptake – range 55.4% – 59.9% (acceptable 52%, achievable >70%)<br>Breast screening uptake – range 69.87% - 75.8% (acceptable >70%, achievable >80%)<br>Cervical cancer screening – range 63.3% - 66.1% (acceptable >80%, achievable >95%)<br><br>Immunisations – uptake for most vaccines is fairly steady, and, while not above the 95% her immunity target, they are at an acceptable level but HPV vaccination uptake has dropped and at 86% is now below the target of 90%. The other vaccination that is causing concern is the second dose of MMR vaccine – there is good uptake now of the first dose but at age 5 years under 90% of children have been received the second dose of the vaccine that is needed to give a high level of immunity.<br><br>Neonatal BCG – all trust are now reporting uptake routinely with a very high level of uptake in excess of 90%.<br><br>**Sexual health strategy**<br>The Sexual Health Board is working on an action plan that has absorbed the actions from the sexual health strategy for Peterborough. Emergency Hormonal Contraception has now been commissioned from a number of local pharmacies and work is in hand to extend this cover to more pharmacies. |

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| | Priorities for the delivery board are prevention of teenage pregnancy, reduction of late diagnosis of HIV, development of clinical pathways and reduction in Chlamydia infection<br>Under 18 conception rate in 2015 in Peterborough was 28.3 / 1000, compared with national rate of 20.<br>Chlamydia detection rate (15 – 24 year olds) in 2016 in Peterborough was 2862. While this is seen to be a good rate as it indicates a reasonable level of screening uptake, it also indicates a high rate of infection. |
| **Narrative update on workstreams** | **TB**<br>Delivering the detailed TB commissioning action plan, including:<br>Expanding the LTBI screening programme;<br>Specialist Workforce planning;<br>Discharge planning<br><br>**HPSG**<br>Current focus on flu vaccination as winter approaches. Reports from Australia show that their flu season that has just ended was more severe than previous years and usually the flu strains that have been predominant in the Southern hemisphere tend to be those that affect us in our following flu season so we are expecting a more severe flu season this year.<br><br>We also hope to do some targeted communications in the new year to encourage uptake of the Human Papilloma Virus (HPV) vaccine by teenage girls – this vaccine prevents infection with the Human Papilloma Virus that is associated with Cervical Cancer. Uptake of the vaccine has fallen recently, not just in Peterborough, mostly associated with unfounded adverse publicity in neighbouring countries and counties.<br><br>**Sexual Health**<br>Delivering the detailed sexual health action plan, including:<br>Tackling teenage pregnancy through - a holistic schools based programme to provide them with information, skills and services; and Improving access to information and services in schools and colleges;<br>Decreasing the rate of late HIV diagnosis;<br>Decreasing the prevalence of chlamydia in the 15-24 year olds in Peterborough;<br>Increasing uptake of the new Community Pharmacy Emergency Contraception Service in Peterborough; |

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| | Increasing access to appropriate reproductive and sexual health services |
| **Examples of partnership working (services, projects, co-production/design etc)** | All of the work described above is done in partnership with Public Health England, NHS England, the CCGs, Provider organisations and the voluntary sector and includes involvement of the public. |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• Develop a TB commissioning plan for Cambridgeshire and Peterborough<br>• Develop a joint strategy to address poor uptake of screening including improved communication with communities and individuals<br>• Develop a joint strategy to address poor uptake of immunisation including improved communication with communities and individuals<br>• Develop a Peterborough Joint Sexual Health Strategy, covering a range of issues | |
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| **Future Plans: Progress against key milestones and local indicators/trends** | Milestone 1: TB commissioning plan: Latent TB screening implementation, second wave GP practices recruited. Workforce mapping for TB management is complete.<br>Milestone 2: Strategy to improve screening uptake: A task group led by NHS England has been set up including voluntary sector organisations: Strategy to improve communications. Promotional materials for cervical screening have been used in a range of PCC and partner venues. 'Healthy Peterborough' focussed on cancer prevention and screening in February 2017. Focus group work with diverse communities is being conducted. A new multi-agency stakeholder group is being established to take forward the action plan for screening, due to meet on 29 November.<br>Milestone 3 Strategy to improve immunisation uptake: The recommendations of the Immunisations task group led by NHS England are being taken forward and work has included: training local health connectors on immunisations; dispelling the myths; targeting practices with child immunisation waiting lists.; developing a pilot flag system for practices to identify children missing immunisations; and encouraging practices to run more open access immunisation clinics which have been demonstrated to improve access and increase uptake.<br>Milestone 4: Develop a Peterborough joint sexual health strategy: The local multi-agency Contraceptive and Sexual Health Strategic Group has agreed a strategy and action plan. The strategy continues to focus on four key overall themes for Peterborough:<br><br>• Increase sexual and contraceptive health awareness amongst local population; |

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| | ● Increase detection of Sexually transmitted infections amongst the local population;<br>● Reduce the number of unplanned pregnancies; and<br>● Improve early HIV detection within the city to reduce high rate of late diagnosis.<br>A sexual health needs assessment for vulnerable groups is close to completion. Peterborough and Cambridgeshire multi agency strategic groups will align in the future and we are waiting for the finalisation of this. |
| **Risks** | All organisations involved in this work face serious financial pressures that could impact this work in the future. |
| **Key considerations** | The priorities outlined the narrative sections of this report are our key considerations for the future |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 7.1 | Percentage of eligible people screened for latent TB infection | - | Denominator data currently unavailable - 325 patients screened May 2016 - January 2017 | - | - | - | - | - |
| 7.2 | Percentage of eligible newborn babies given BCG vaccination (aim 90%+) | - | Denominator data currently unavailable - Apr 17 - Jun 17 data show 175 patients vaccinated prior to discharge, 13 OPD vaccination by 4 weeks and 7 patients declined at Peterborough City Hospital | April to June 2017 | >90% | - | - | - |
| 7.3 | Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months (proportion, %) | ▲ | Statistically similar to England | 2014 | 35 | 85.4% | 84.4% | Match or exceed England performance |
| 7.4 | Evidence of increasing uptake of screening and immunisation | - | Peterborough currently amber or green for 8/10 chosen indicators | 2015-16 | 8/10 | - | - | • Achieve 95% performance for years 2016/17, 2017/18 and 2018/19 where this is already being achieved or close to being achieved (Dtap/IPV/Hib (1 year old and 2 years old), MMR for one dose (5 years old)<br>• Improve MMR for two doses (5 years old) to national benchmark goal of 90% by 2018/19<br>• For all other indicators, maintain 90% performance for years 2016/17 and 2017/18 and improve to 95% for 2018/19 |
| 7.5 | HIV late diagnosis (proportion, %) | ▲ | Remains above benchmark goal of 50.0% | 2013-15 | 23 | 60.5% | 40.3% | Return to 25% to 50% (PHOF Amber 'Rag') by 2017-19 |
| 7.6a | Chlamydia- proportion aged 15-24 screened (proportion, %) | ▲ | Statistically significantly better than England | 2016 | 5,689 | 25.0% | 20.7% | Increase to at least previous best of 24.7% (requires increase of 2.05% per year) |
| 7.6b | Increase in chlamydia detection rate (proportion, %) | ▲ | Remains above benchmark goal of 2,300/100,000 | 2016 | 651 | 2,862 | 1,882 | Benchmark goal already reached - maintain and improve by 1% per year |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** HEALTH AND WELLBEING OF PEOPLE WITH DISABILITY AND/OR SENSORY IMPAIRMENT
**LEAD:** CHARLOTTE BLACK

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:**<br><br>• The Council and CCG have agreed a strategy for supporting older people and adults with long term conditions within the BCF plan, working together to support people with disabilities through data sharing, 7 day working, person centred system, information / communication / advice, ageing healthily and prevention<br>• The Learning Disability Partnership maintains an overview of needs and services for people with a learning disability in Peterborough<br>• A Vulnerable People's Housing Sub-Group has been established, which will review how local housing needs for vulnerable people, including people with disabilities, should be addressed | |
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| **Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)** | Performance reporting requirements to be set. |
| **Narrative update on workstreams** | Peterborough Physical Disability Board - The first meeting of the refreshed Peterborough Physical Disability Board met in May 2017. The Board is Chaired by an independent person and the membership includes officers from the Council and others from the voluntary sector (and other interested parties). It has a Forward plan that includes Transport, Health, Employment and Leisure. The last Partnership Board meeting discussed Transport with specific reference to rail travel - and Virgin EC were in attendance.<br><br>Peterborough Sensory Disability Board - A pre-meeting to develop the Peterborough Sensory Disability Board took place at the beginning in Oct 2017 and a Terms of Reference was agreed to be taken to the first ever board in December 2017. The membership currently includes - Guidedogs for the Blind, Deafblind, Cambridgeshire Deaf Association, Peterborough Association for the Blind and the Royal National Institute for the Blind. The first meeting will be chaired by Gary Jones, Head of Adults |

Commissioning, Peterborough Council - but this will pass to an independent person ounce that person is identified.

**Local Offer**

Considerable work has been undertaken on the development of the Local Offer which is a website and database of information for children and young people up to the age of 25 who have special educational needs and/or disabilities. The Local Offer has been amalgamated with the Families Information Service and has been co-produced with Family Voice, the Youth Access Champions and partners from health. The website includes a wealth of information for young people with disabilities and sensory impairment including links to other websites and downloadable leaflets and brochures. Easy Read brochures for the Local Offer and Preparing for Adulthood have been co-produced and uploaded.

**2016/17 Carers Survey**

The results of the 2016/17 Carers Survey has been analysed and an action plan devised. The results were very positive with 72.6% of carers stating that they were extremely to quite satisfied with the support and services they receive against an England average of 70.8%. A public report on the survey can be viewed on the council website. Work continues with Carers Trust Cambridgeshire and Peterborough, including sending a regular magazine to all carers.

**Care and Support Directory 2017/18**

The Care and Support Directory for 2017/18 which is a useful information source for people with disabilities and sensory impairment was distributed to council offices, the hospital, Age UK, Carers Trust and GP practices in August 2017 and can be viewed on the council website. Copies can be requested from the council by calling 01733 747474.

**Adult Social Care User Survey 2016/17**

The results of the 2016/17 Adult Social Care Service User Survey are currently being analysed. The results are extremely positive with Peterborough receiving better than England average results on most questions. We achieved a 51% response rate on the survey which is very high for a postal survey and 65.5% of respondents were extremely or very satisfied with the support they received. This is better than the England average of 64.7%. When asked about whether they had enough choice over care and support services. 74.6% said yes, compared to an England average of only 67.6%. In relation to finding it

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| | very or fairly easy to find information and advice about support, services or benefits, Peterborough's result was 78.6% against an England average of 73.5%.<br><br>**Future arrangements for Learning Disability**<br>A joint review is underway between both LAs and the CCG about future arrangements for learning disability |
| **Examples of partnership working (services, projects, co-production/design etc)** | Adult Social Care is working closely with partners to develop an integrated response and pathway to all adults who may need support. Work is also in hand to develop the early help response and identify effective ways of intervening early and reducing escalation of need. This work is taking place across al partner organisations. |

| **HWB STRATEGY 2016/19: FUTURE PLANS**<br><br>• Implementation of strategy for supporting older people and adults with long term conditions<br>• Work with users of St George's hydrotherapy pool to explore future options for sustainability | |
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| **Future Plans: Progress against key milestones and local indicators/trends** | Future plans related to people with physical disability and sensory needs will form part of an adult social care programme across PCC and CCC. Work being undertaken by Impower in PCC and Capgemini consortium in CCC |
| **Risks** | |
| **Key considerations** | |

## Performance Indicators:

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 5.1a | Adults with learning disabilities in employment (proportion, %) | Increasing - getter better | Statistically similar to England | 2013-14 | 55 | 8.4% | 6.7% | Match or exceed England performance |
| 5.1b | ASCOF - Percentage of adults known to Adult Social Care in employment (to increase) (proportion, %) | Increasing - getter better | Statistically significantly worse than England | 2012-13 | 65 | 4.8% | 8.8% | Match or exceed England performance |
| 5.2a | Adults with learning disabilities in settled accommodation (proportion, %) | Decreasing - getting worse | Statistically similar to England | 2013-14 | 475 | 72.5% | 74.9% | Improve by 0.5% per year |
| 5.2b | Adults in contact with mental health services in settled accommodation (proportion, %) | Increasing - getter better | Statistically significantly worse than England | 2012-13 | 410 | 30.7% | 58.5% | Improve at greater rate than national average |
| 5.3 | ASCOF - Permanent residential admissions of adults to residential care (to decrease) (65+, proportion, %) | Increasing - getting worse | Statistically similar to England | 2013-14 | 20 | 17.3% | 14.4% | 1% decrease per year |
| 5.4 | Numbers of adults in receipt of assistive technology | Increasing - getter better | Green RAG status to reflect consistent increase in recipients | Feb-17 | 5,131 (predicted end of year) | - | - | Year-on-year increase |
| 5.5a | Adult Social Care service user survey quality of life measure - carer-reported quality of life | Decreasing - getting worse | Statistically similar to England | 2014-15 | - | 7.3 | 7.9 | Improve each year |
| 5.5b | Adult Social Care service user survey quality of life measure - social care-related quality of life | Increasing - getter better | Statistical significance not calculated - Peterborough value has fallen between 2012-13 and 2013-14 and is now below that of England | 2015-16 | - | 19.1% | 19.1% | Year-on-year increase |
| 5.6 | Number of adults with social care needs receiving short term services to increase independence | Increasing - getter better | Green RAG status to reflect consistent increase in recipients | Feb-17 | 1,498 (Predicted end of year) | - | - | Year-on-year increase |
| 5.7 | Number of adults with social care needs requesting support, advice or guidance | Increasing - getter better | Rate per 100,000 is 490.8, currently below target rate of 658/100,000 | Sep-16 | - | 490.8 | - | 658.0/100,000 |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** GEOGRAPHICAL HEALTH INEQUALITIES
**LEAD:** ADRIAN CHAPMAN

| **HWB STRATEGY 2016/19: CURRENT ACTIVITIES:** | |
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| ● The city council has a focus on economic development and regeneration in the city, together with improving educational attainment. In the long term these measures should improve both socio-economic circumstances and health.<br>● City Council children's centres work closely with health visitors and are located to ensure focus on the areas of the city with the highest levels of need. Every child development, which children's centres help to support, is important for future health & wellbeing<br>● The City Council has identified the CAN Do Area around Lincoln Road, which includes parts of Central, Park & North wards. The CAN Do Programme focuses on supporting environment and service improvements for the area. The City Council has recently secured £7.5m capital funding for improvements in the area. | |
| **Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)** | |
| **Narrative update on workstreams** | **CAN Do Regeneration Programme**<br>● An Executive Board has been established to oversee the 2-year programme and governance terms agreed that reflect the vital participation of the community.<br>● Scoping is underway within the 3 themes - assets, parks and open spaces, public realm - and design options are also being prepared in relation to the public realm works.<br>● The programme engages with the Community Serve Local Action Group as a consultative forum and members have been asked to map out the community led activities within the area to |

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| | inform and influence the design requirements for a potential new community facility that can address the needs and gaps in health and wellbeing services in the area.<br>● Recruitment is shortly to complete for the Programme's part time Project Manager<br>● Public and voluntary sector partners will work in collaboration with the community to develop improvement plans for the parks and open spaces in the area. It is anticipated that this group will submit a funding bid to the National Lottery's new £4.5m Place Based Social Action Fund to support this work. This group have also submitted an expression of interest for the Innovation Litter Fund (made available from DCLG in line with the new National Litter Strategy). Both of these initiatives aim to ensure direct participation and ownership within the community for sustainably improved open spaces<br><br>**Community Serve**<br><br>● Community Hubs supported by the City College are located within Gladstone and Orton Malborne. Cross Keys Homes support a community led hub in Westwood.<br>● Solution4Health offer health & wellbeing activities in both the Gladstone Park Community Centre and the Millfield Community Centre.<br>● Recruited 2 hub apprentices to support Coordinators<br>● Undertaken initial demographic mapping of each hub area with more detailed mapping to follow<br>● Run 19 Community Meet and Eat events attracting a total of 543 local people and improving social cohesion and isolation. Partners attending include Public Health, the National Literacy Trust and College staff to promote learning and volunteering opportunities<br>● Run a total of 11 free courses to improve skills, employability or health and wellbeing and reduce isolation<br>● Engaged 5 partners (NHS, Solutions4Health, Age UK, Carers Trust, Dementia UK) to offer Health & Wellbeing information and advice sessions to local residents and attend Meet and Eat events. |

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| | ● Engaged 3 businesses to encourage their CSR responsibilities, increase Apprenticeship take up, local volunteering and participate in the time banking rewards scheme initiative<br>● Engaged 1,228 residents:<br>1. 211 have attended drop- in information and advice sessions<br>2. 543 have attended a community Meet and Eat.<br>3. 20 have taken up an Apprenticeship<br>4. 454 have attended a community course e.g. IT, employability ESOL, healthy eating, self-employment.<br>● Facilitated engagement of residents, stakeholders and partners by organizing meetings of the Can do Local Action Group.<br>**Community Serve Outcomes**<br>Feedback from members of the community confirms appreciation of having a community Hub on their doorstep to learn valuable, life changing skills, which can improve employability or a change in direction by gaining promotion.<br>As a result of attending the Hub and participating in a range of courses including ESOL, students have gained valuable life changing skills; for the first time, they can communicate at an effective level with Doctors and Teachers. This is a major achievement as it eliminates the isolation factor and it allows students to integrate within the community.<br>The CommUNITY meet and eat gatherings have proved to be incredibly successful and go a long way to reduce isolation, increase social relationships, tackling health and well-being and providing volunteering skills and development in the local community. Over 500 People have come together to enjoy a three- course meal for £2.50 in community venues across the three areas in which we operate. Other partners also attend these events to support public health, children's literacy and well- |

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| | being. The aim of the CommUNITY meet and eats is to provide the food and initial skills and then encourage volunteers to take on the running for sustainability.<br><br>We are now working on a stronger, more evidence-based tool to demonstrate the impact of Community Serve, especially in relation to reducing demand in statutory services, improving outcomes for vulnerable people, and supporting communities to do more to help themselves. |
| **Examples of partnership working (services, projects, co-production/design etc)** | All of the activity in this theme is being delivered in partnership with a wide range of agencies from across all sectors. |

| HWB STRATEGY 2016/19: FUTURE PLANS | |
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| **Future Plans: Progress against key milestones and local indicators/trends** | Public Health are beginning a programme of work on health inequalities across Peterborough and Cambridgeshire and how this is linked to socioeconomic outcomes.<br><br>The work will help partners better understand how outcomes differ across the area, how they are changing and the areas with greatest need. The output will support:<br><br>● the CCG in its statutory duty to reduce health inequalities and to carry out health inequalities impact assessments of any significant services changes<br>● targeting of preventive public health initiatives and services so that they focus more on areas of the city with the greatest health and wellbeing needs.<br><br>This work will be completed by March 18. |
| **Risks** | ● Housing shortages continue, resulting in increased levels of overcrowding, poor standards and households being accommodated in temporary accommodation |
| **Key considerations** | |

**Performance Indicators:**

| Indicator Ref | Indicator | Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Agreed Target |
|---|---|---|---|---|---|---|---|---|
| 12.1 | We will work with local health services to improve data collection on ethnicity, both generally and to assess the success of targeted interventions | - | To follow via Peterborough City Council policy team in collaboration with Public Health Intelligence | - | - | - | - | 12.1 |
| 12.2 | Outcome measures for health and wellbeing of migrants will be developed following completion of the JSNA | - | To follow via Peterborough City Council policy team in collaboration with Public Health Intelligence | - | - | - | - | 12.2 |

**HEALTH & WELLBEING AND SPP PROGRAMME DELIVERY BOARD**
**PERFORMANCE REPORT**
**DATE:** NOVEMBER 2017
**SUBJECT:** SUSTAINABLE TRANSFORMATION 5 YEAR PLAN (INCLUDING BCF)
**LEAD:** WILL PATTEN (AUTHOR: CAROLINE TOWNSEND)

**KEY PRIORITIES**

- Health system transformation planning
- Customer experience strategy

**Performance narrative and statistics (please include updates on local indicators / trends, key outcomes achieved and updates on those national indicators currently showing red)**

The 2017/18 metrics for the Better Care Fund have been agreed. The below table provides an overview of targets and performance to date:

| Metric | 2017/18 Planned Target | Summary Performance to date |
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| **Non-elective admissions to hospital** | 18,128 non elective admissions | Full Q2 performance was not available at time of writing. Q1 performance underperformed against the threshold target (4.545) with 4,988 actual non-elective admissions. Performance in July and August indicates a decrease in non-elective admissions for the start of Q2. |
| **Delayed Transfers of Care (DTOCs) from hospital** | 3.5% Occupied Bed Days | The system continues to report high levels of DTOC and we have experienced an increase in DTOCs throughout Q1. There is a clear DTOC trajectory and plan in place to support delivery of the 3.5% target by the end of October, we hope to see significant improvements against this metric in Q3. |
| **Admissions to long-term residential and nursing homes in over 65 year olds** | 154 | At the end of Quarter 2 there were a total of 54 care home admissions year to date and we are forecast to deliver within our threshold target. |
| **Effectiveness of re-ablement services** | 83% | At the end of Q2 performance was at 80.8%. This was impacted by reduced performance due to capacity issues in the care market and winter pressures. |

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| **Narrative update on work-streams** | Our approach to integration over 2017-19 was submitted as part of our local Better Care Fund plan to NHS England on 11th September 2017.<br><br>There will be a continued focus on building on the work undertaken to date. The following provides an update on key priority areas:<br><br>**Prevention and Early Intervention:** including a county wide falls prevention programme, further work to ensure a comprehensive approach to equipment and assistive technology, and development of joint VCS commissioning opportunities. Falls prevention implementation is underway with a focus on disseminating learning from the St Ives pilot review event in October, to support the roll out of initiatives. Stroke prevention Atrial Fibrillation is currently focusing on the roll out of ECG equipment to identify patients in flu clinics. SLAs have been signed by 22 GP practices.<br><br>**Community Services (MDT Working):** including wider roll out and embedding of case management, to include data sharing to support risk stratification and pro-active identification of service users. Additional CPFT staff recruitment is being finalised to support the enhanced case management service roll out. Agreement that Datalytix will support risk stratification data sharing for 12 months from go live. First run of data is being gathered from GPs to support case finding.<br><br>**Enablers:** continued development of consistent, accurate and reliable information and advice to support the concept of 'no wrong front door'. Further work to progress the LGA funded proof of concept has been progressed and a test proof of concept has been developed. An evaluation workshop was held on the 16th October, which will inform a review of next steps.<br><br>**High Impact Changes for Discharge:** A new national BCF condition, requires the local system to implement the high impact change (HIC) model for managing transfers of care. The HIC areas are: early discharge planning; systems to monitor patient flow; MDT/multi-agency discharge teams; home first / discharge to assess; 7 day services; trusted assessor; focus on choice; and enhancing care in care homes. Good progress is being made implementing the High Impact Changes for Discharge and the below provides an update on key initiatives that are progressing in this area:<br><br>**Reablement:** recruitment is progressing well to support a 20% increase in reablement capacity. A number of appointments have been made, with further recruitment initiatives planned. Additional reablement step down bed capacity is being commissioned for the winter months. Options for low level reablement provision are being explored with VCS providers. |

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| | **Moving and Handling Coordinator:** this post is now based with the Transfer of Care Team with a view to support embedding integrated approaches to equipment and assistive technology to support discharge and this post was in place from the 16th October.<br><br>**Transfer of Care:** two new social worker posts have been based in the acute from 23rd October (Admissions Avoidance Social Worker and Social Care Strategic Discharge Lead). A new Continuing Healthcare pathway (4Qs) 3 month pilot was launched in NWAFT during October and additional social worker and discharge planning nurse capacity to support this is being recruited to.<br><br>**Trusted Assessor:** a care home trusted assessor pilot is being implemented with South Lincolnshire County Council and LINCA. Communications have been undertaken with the local care homes to ensure appetite and buy in.<br><br>**Home Care:** a weekly meeting with home care providers is now fully operational to support joint working and capacity building. Alternative options to increase home care capacity are also being explored. |
| **Examples of partnership working (services, projects, co-production/design etc)** | The Better Care Fund 2017-19 Plan is based on the following agreed principles:<br>● Greater alignment across Cambridgeshire and Peterborough<br>● A single commissioning board (the ICB)<br>● Greater alignment with the STP and local authority transformation plans<br>● Using the BCF to 'get the basics right' and coordinate our approach, focusing on a smaller number of system-wide changes. |

| **FUTURE PLANS** |
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| **Future Plans: Progress against key milestones and local indicators/trends** | **BCF Planning 2017/18**<br><br>The BCF 2017-19 plan was submitted to NHS England on the 11th September 2017. Final approval status is expected shortly following the regional assurance process. The Q2 submission to the Department of Communities and Local Government (DCLG) in relation to the Improved Better Care Fund (iBCF) was also submitted on the 29th October 2017.<br><br>**Alignment with STP**<br><br>A single BCF implementation plan is in development. Further work to develop a BCF reporting/metrics dashboard is also being undertaken, ensuring alignment with appropriate STP metrics to prevent duplication. This will provide a clear overview of scope and milestones, including progress to date on an ongoing basis. |
| **Risks** | ● NHS Digital national funding is less than expected and Local Digital Roadmap projects will need to be prioritised accordingly.<br>● DTOC targets for the system are ambitious to meet 3.5% national target.<br>● iBCF Spring Budget funding is non-recurrent, gradually decreasing over the next 3 years. |
| **Key considerations** | ● DTOC governance is currently being reviewed by the SDU for greater clarity and system wide oversight. |

Public Health England

NHS

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Cheril Sowell, Nurse

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| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 13 |
|---|---|
| **4 DECEMBER 2017** | PUBLIC REPORT |

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| Report of: | Wendi Ogle-Welbourn, Executive Director, People and Communities Cambridgeshire and Peterborough Councils | |
| Cabinet Member(s) responsible: | Councillor Wayne Fitzgerald | |
| Contact Officer(s): | Will Patten, Director of Transformation, Peterborough City Council | Tel. 07919 365883 |

# ADULT SOCIAL CARE, BETTER CARE FUND (BCF) 2017-19 UPDATE

| RECOMMENDATIONS | |
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| **FROM:** Wendi Ogle-Welbourn | **Deadline date:** N/A |
| The Health and Wellbeing Board are requested to:<br>1. Note the update of BCF delivery and planning for BCF 2017/19 submission | |

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board at the request of the Executive Director for People and Communities Cambridgeshire and Peterborough Councils.

## 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 and planning approach for the BCF 2017/18 submission.

2.2 This report is for the Board to consider under its Terms of Reference No. 2.7.3.6:

*'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. TIMESCALES

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|---|---|---|---|
| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | N/A |

## 4. BACKGROUND AND KEY ISSUES

4.1 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 2017/18 £16.8 million budget is largely 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. It includes funding for the Disabled Facilities Grant, which supports housing adaptations and Improved Better Care Fund (iBCF) monies.

MONITORING:

4.2 Due to the delays in the BCF Policy Framework and Planning Guidance and the subsequent submission timelines, there were no BCF reporting requirements to NHS England for Q1. Q2 reporting templates have been issued by NHS England and are due for submission by 17th November 2017.

BCF PLANNING SUBMISSION 2017-19

4.3 The Better Care Fund 2017-19 plan was fully approved and submitted to NHS England on 11th September 2017. Following the regional assurance process we were 'approved with a minor condition' with a requirement to resubmit further clarification around the risks associated with the closer integration of Peterborough and Cambridgeshire plans. The plan was resubmitted to NHS England on 4th November 2017 and final approval status is due to be notified to us by the end of November 2017.

PROGRESS OF DELIVERY

4.4 Our approach to integration over 2017-19 was submitted as part of our local Better Care Fund plan to NHS England on 11th September 2017. There will be a continued focus on building on the work undertaken to date. The following provides an update on key priority areas:

**Prevention and Early Intervention:** including a county wide falls prevention programme, further work to ensure a comprehensive approach to equipment and assistive technology, and development of joint VCS commissioning opportunities. Falls prevention implementation is underway with a focus on disseminating learning from the St Ives pilot review event in October, to support the roll out of initiatives. Stroke prevention Atrial Fibrillation is currently focusing on the roll out of ECG equipment to identify patients in flu clinics. Service Level Agreements have been signed by 22 GP practices.

**Community Services (MDT Working):** including wider roll out and embedding of case management, to include data sharing to support risk stratification and pro-active identification of service users. Additional CPFT staff recruitment is being finalised to support the enhanced case management service roll out. The first run of data is being gathered from GPs to support case finding.

**Enablers:** continued development of consistent, accurate and reliable information and advice to support the concept of 'no wrong front door'. Further work to progress the LGA funded proof of concept has been progressed and a test proof of concept with MiDOS has been developed. An evaluation workshop was held on the 16th October, which will inform a review of next steps.

**High Impact Changes for Discharge:** A new national BCF condition, requires the local system to implement the high impact change (HIC) model for managing transfers of care. The HIC areas are: early discharge planning; systems to monitor patient flow; MDT/multi-agency discharge teams; home first / discharge to assess; 7 day services; trusted assessor; focus on choice; and enhancing care in care homes.

The Local Authority worked collaboratively with health partners to develop and agree a costed plan to support delivery of the 3.5% national DTOC target. This built on the gaps identified as part of the High Impact Changes self-assessments and workshops which were held late July to agree the system priorities. Investment requirements were also reviewed to support winter planning initiatives and there was significant investment from the iBCF to support key initiatives. Good progress is being made implementing these plans and the below provides an update on key initiatives that are progressing in this area:

**Reablement:** recruitment is progressing well to support a 20% increase in reablement capacity. A number of appointments have been made, with further recruitment initiatives planned. Additional reablement step down bed capacity is being commissioned for the winter months. Options for low level reablement provision are being explored with VCS providers.

**Moving and Handling Coordinator:** this post is now based with the Transfer of Care Team with a view to support embedding integrated approaches to equipment and assistive technology to support discharge and this post was in place from the 16th October. In addition a falls response service is being piloted with Cross Keys Homes from November 2017 reduce unnecessary ambulance conveyances associated with falls.

**Transfer of Care:** two new social worker posts have been based in the acute from 23rd October (Admissions Avoidance Social Worker and Social Care Strategic Discharge Lead). A new Continuing Healthcare pathway (4Qs) 3 month pilot was launched in NWAFT during November and additional social worker and discharge planning nurse capacity to support this is being recruited to.

**Trusted Assessor:** a care home trusted assessor pilot is being implemented with South Lincolnshire County Council and LINCA. Communications have been undertaken with the local care homes to ensure appetite and buy in.

**Home Care:** a weekly meeting with home care providers is now fully operational to support joint working and capacity building. Alternative options to increase home care capacity are also being explored.

**Discharge to Assess:** there has been good progress implementing phase 1 of the system wide discharge 2 assess pathway, with further refinement ongoing to support phase 2 implementation in March 2018. A review of the Continuing Health Care Hospital discharge process with a new process (4Qs) being piloted for 3 months from November 2017.

## 5. CONSULTATION

5.1 As previously reported, in the developing and drafting of the BCF Plan there were detailed discussions and workshops with partners, including discussion at the A&E Delivery Board and appropriate STP governance boards. The Joint Cambridgeshire and Peterborough Integrated Commissioning Board, which has system wide health and care representation, has overseen the development of the plan In line with national requirements, local system partners have approved and are signatories to the 2017-19 BCF Plan. Joint working across Cambridgeshire and Peterborough continues and regular monitoring activities have been solidified to ensure clear and standardised reporting mechanisms.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Not applicable. The contents of this report provide an update for the Health and Wellbeing Board to note.

## 7. REASON FOR THE RECOMMENDATION

7.1 The report is for information to the Board.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Not applicable.

## 9. IMPLICATIONS

### Financial Implications

9.1 Delivery assurance through the Board will enable the Council and the CCG to continue to meet NHS England's conditions for receiving BCF monies.

The BCF funding is in line with the Council's Medium Term Financial Strategy (MTFS).

**Legal Implications**

9.2 There are no legal implications related to this report.

**Equalities Implications**

9.3 There are no equalities implications related to this report.

## 10. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

10.1

i) BCF Quarterly Data Collection Template Q1 16-17 Peterborough (final)
ii) BCF Quarterly Data Collection Template Q2 16-17 Peterborough (final)
iii) BCF Quarterly Data Collection Template Q3 16-17 Peterborough (final)
iv) BCF Quarterly Data Collection Template Q4 16-17 Peterborough (final)

## 11. APPENDICES

11.1 None

Updated on: 14 NOVEMBER 2017

**HEALTH AND WELLBEING BOARD**
**AGENDA PLAN 2017/2018**

| MEETING DATE | ITEM | CONTACT OFFICER |
|---|---|---|
| **Monday 12 June 2017** | • Annual Health and Wellbeing Strategy Performance Report<br>• Adult Social Care Better Care Fund (BCF) Update<br>• Increased 7 Day GP Access<br>• Motor Neurone Disease Charter – Focus Group Update<br>• Older People's Primary Prevention – Joint Strategic Needs Assessment<br>• Cambridgeshire & Peterborough Sustainability and Transformation Plan (STP) Update<br><br>**For information**: | Dr Robin / Ryan O'Neill<br>Will Patten<br>Mustafa Malik<br>Cathy Mitchell<br>Dr Liz Robin / Dr Angelique Mavrodaris<br><br>Aidan Fallon / Scott Haldane |
| **Monday 11 September 2017** | • Better Care Fund sign off<br>• North West Anglia NHS Foundation Trust Update on the Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation merger.<br>• Public Health Annual Report<br>• Pharmaceutical Needs Assessment<br>• New governance arrangements Sustainable Transformation Programme<br>• JSNA Core Data Set<br>• Developmental Session paper<br>• Local Transformation Plan<br><br>**For Information**:<br>Quarterly Health & Wellbeing Strategy Performance Update | Will Patten/Caroline Townsend<br>Stephen Graves<br><br>Dr Liz Robin<br>Dr Robin/Katie Johnson<br>Aiden Fallon/Scott Haldane<br><br>Ryan O'Neil<br>Helen Gregg<br>Kathyrn Goose, CCG<br><br>Helen Gregg |

Updated on: 14 NOVEMBER 2017

| MEETING DATE | ITEM | CONTACT OFFICER |
|---|---|---|
| **Monday 4 December 2017** | • Health and Wellbeing Board Terms of Reference<br>• The Health Benefits of Trees and Woodlands<br>• Cambridgeshire And Peterborough Senior Officers Communities Network<br>• Health And Transport JSNA Data Set<br>• Homelessness Prevention<br>• Draft Suicide Prevention Strategy 2017- 2020<br><br>**For Information**:<br>Adults and Children's Local Safeguarding Board Annual Reports 2016/17<br>Better Care Fund Update<br>Quarterly Health & Wellbeing Strategy Performance Update<br>CQC Area Review Briefing | Wendi Ogle-Welbourn<br>Woodland Trust<br>Elaine Matthews<br><br>Stuart Keeble<br>Adrian Chapman<br>Katherine Hartley<br><br>Russell Wate<br><br>Will Pattern<br>Helen Gregg<br>Helen Gregg |
| **Monday 19 March 2018** | • Pharmaceutical Needs Assessment<br>• Diverse Ethnic Communities JSNA supplement<br>• Annual Health Protection Plan<br>• Updates on PHCU, MOU, Children's, etc<br>• Poverty Strategy<br>• Healthwatch – Priorities, Ways of working across Cambridgeshire and Peterborough<br>• Adult Social Care Survey<br>• STP Governance process<br><br>**For Information**:<br>Better Care Fund Update<br>Sustainable Transformation Programme Update<br>Quarterly Health & Wellbeing Strategy Performance Update | Dr Robin<br><br>Dr Robin<br><br>Val Moore, Chair of Healthwatch Cambridgeshire and Peterborough<br><br>Jacqui Cozens<br>Aidan Fallon<br><br>Will Patten<br>Aiden Fallon<br>Helen Gregg |