HEALTH AND WELLBEING BOARD

MONDAY 7 DECEMBER 2020
1.00 PM

Venue: Peterborough City Council's YouTube Page
Contact:: Paulina Ford, Senior Democratic Services Officer at paulina.ford@peterborough.gov.uk, or 01733 452508

AGENDA

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Board Members:

Cllr J Holdich (Chairman), Dr G Howsam (Vice Chairman), Charlotte Black, Alison Clarke
Cllr W Fitzgerald, , Louise Mitchell, V Moore, Cllr S Qayyum, Dr L Robin, Cllr I Walsh
W Ogle-Welbourn

Co-opted Members: Joanne Proctor and Claire Higgins

Substitutes: Dr Adnan Tariq (Sub for Dr Howsam), J Wells (sub for Val Moore)

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 1.00PM, ON
25 FEBRUARY 2020
COUNCIL CHAMBER, PETERBOROUGH

Committee Members Present: Councillor Holdich (Chairman) Leader of the Council
Dr Gary Howsam (Vice-Chairman), Chair of the Cambridgeshire and Peterborough CCG
Councillor Fitzgerald, Deputy Leader, Cabinet Member for Integrated Adult Social Care and Health
Councillor Walsh, Cabinet Member for Communities
Councillor Shabina Qayyum
Dr Liz Robin, Director for Public Health
Jonathan Wells, Director Cambridgeshire and Peterborough Healthwatch
Hilary Daniels, NHS South Lincolnshire CCG
Charlotte Black, Service Director Adults and Safeguarding

Officers Present: Helen Gregg, Partnership Manager
Sarah Ferguson, Assistant Director Housing, Community and Youth Services
Jane Coulson, Senior Engagement Manager

15. APOLOGIES FOR ABSENCE

Apologies for absence were received from Val Moore, Wendi-Ogle Welbourn, Zephen Trent and Jess Bawden. Jonathan Wells was in attendance as substitute for Val Moore.

16. DECLARATIONS OF INTEREST BY MEMBERS OF THE PETERBOROUGH HEALTH AND WELLBEING BOARD

There were no declarations of interest received.

17. MINUTES OF THE PETERBOROUGH HEALTH AND WELLBEING BOARD MEETING HELD ON 24 JUNE 2019

The minutes of the meeting held on 24 June 2019 were agreed as a true and accurate record.

18. UPDATED TERMS OF REFERENCE

The report was introduced by the Senior Democratic Services Officer. Members were informed that the terms of reference had been updated to now include the position of Director of Adult Social Services as a member of the Board going forward.

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

19. THINK COMMUNITIES PROGRESS REPORT

The Assistant Director, Housing Communities and Youth Services introduced the report and the Cabinet Member for Communities gave an overview to members. The purpose of the report was to provide the Board with progress made on the Think Communities approach. The Cabinet Member for Communities started that this was an important programme of work. There had been a number of achievements so far but more work was to be done. There are certain prototype areas that had been carried out so far.

The Board were informed that this was a large and ambitious transformation of work that was taking place. An update on the work across Peterborough and Cambridgeshire was laid out in the report. The ambition was to think of rewiring the public sector and organisations so that they were fit for the 21st century. In Peterborough there was a shift to a more think communities approach. Across the wider County there were groups looking at the issue of homelessness and how Think Communities could work around this.

One of the key highlights was the communication and engagement with the community and to try and seek ways to re-instate the relationship between community groups and its citizens. Data highlighted understanding the needs of the community in different ways and would assist with putting better governance procedures in place. There was a view to move away from reliance on statutory processes. It was critical to look at workforce reform to achieve transformation and make sure that it was at front line in changing the ways of working and engaging with people. One strand that was being worked on was bringing to life a place based approach to better understand the needs of citizens. Developing the health deal was an integral part of the strategy to protect and enable citizens.

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

- Work being carried out was essential to reduce demand on adult social care. Think Communities was crucial in this aspect and how it could benefit local neighbourhoods. There were good examples of maintaining independence in the community already.
- Public Health was supporting and encouraging this, empowering communities was key to making progress. The Marmot report is being published shortly. This was not about health service but rather about what services were available in the local community.
- Joint working was welcome and it was positive that this had been taking place. It was therefore more straightforward for the public to understand.
- There were questions on how this approach made sure outside commission teams were part of the process. The intention was the possibility to start in some pockets. This was part of workforce plans, the intention was to include the outside commissioned workforce teams.
- Staff were thinking differently about how they responded to the needs of people in the community, it was about making people feel more positive.
- There were encouraging signs people wanted to be more radical and people being more able to self-help.
- It might be useful to chart how this was going from a visual perspective, there had been neighbourhood team's setup in Lincolnshire already. People were not necessarily carrying a health problem when going into A&E. It was important to

look at outcomes and whether they were making a difference to the individual, these could be range of things outside of NHS services.

- The Questionnaire from Healthwatch was excellent and showed a number of areas to work on.
- A Local Parish Council chair had been proactive with a neighbourhood scheme, volunteers in the local area were helping people in their communities. It was crucial to investigate how we invest and enable these communities.
- One of the challenges around this was having a co-ordinator to take an overview of neighbourhood schemes.

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

1. Note and comment upon the progress being made towards delivery of the Think Communities approach.
2. Suggest further ideas for embedding the approach, particularly in relation to Health and Wellbeing Board priorities.

20. BIG CONVERSATION REPORT ON FEEDBACK

The report was introduced by the Senior Engagement Manager CCG. One of issues was to ask what was wrong and find solutions. Treating people was more than just to guidelines. GP's were under transformation at the moment and it was important to look at this in terms of the lives of people in their communities. When carrying out engagement the CCG normally relied on surveys, however there was less emphasis on having conversations with people about what was wrong. The Big Conversation was an important engagement activity, talking to the wider public and stakeholders to get views on how NHS resources were used. This activity was sent out via social media and made more easily accessible by read-text versions for example. There had been a high level of engagement.

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

- Healthwatch had compiled a report on big conversation, It was important not to miss the chance of going back to people and it shouldn't be a formal exercise.
- This had been a valuable steer from the public on decision making, using more social media platforms was beneficial and had been a great consultation exercise. The big conversation meant that there was opportunities to open up conversations going forward and keep these going it was also any opportunity to get feedback from a number of different groups
- It was a good piece of work and a refreshing way to do conversations with community group and was useful in identifying changes where there was a need to make them. There needed to be a balance on how digital media was used.
- This was a brilliant exercise with lots of feedback, there might be areas that some issues where larger proportions of population where split on what they wanted.
- GP communities wanted the Big Conversation and levels of engagement had been high on this.
- In terms of duplication of services, no decision on services were made as this wasn't a formal consultation.
- Consultation on the health and wellbeing strategy was going to be coming back and might have some similarities with the big conversation.

The Peterborough Health and Wellbeing Board **RESOLVED** to note and comment on the content of the HWBB Joint Development session update report.

21. LOCAL AREA SEND (LASEND) INSPECTION UPDATE REPORT

The Director of Public Health introduced the report the purpose of which was to present feedback on findings of the SEND local area inspection. The inspection had taken place Between 10 and 14 June 2019. The purpose was to inspect the effectiveness of SEND reforms carried out. The review outlined strengths and weaknesses and a written statement of action for improvements. The action plan was progressing well following this inspection.

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

- There had been lots of positive feedback on the work carried out in this area so far.

The Peterborough Health and Wellbeing Board **RESOLVED** to review the latest position regarding the findings of the SEND Local Area Inspection and the associated Written Statement of Action as attached in Appendix 1

22. PETERBOROUGH PUBLIC ANNUAL HEALTH REPORT

The report was introduced by the Director of Public Health. The report this year was more technical than in previous years. The Health and Wellbeing Strategy was ongoing and the focus needed to be on that piece of work. Members were informed that the report this year was more technical. The feedback from the voluntary sector was that organisations could get better funding from technical reports. In terms progress there had been a mixed success on the recommendations made from the previous year. There was good news in terms of teenage pregnancy rates which had now dropped in line with the national average, in addition rates had been falling in terms of smoking while pregnant. Finally the rates of children for school at five had nearly reached national levels.

The rates of smoking had not fallen as would have liked and one out of two deaths resulted from long term smoking. There were also concerns around high BMI which needed to be addressed. This was something people could control with support.

This year the report also focused on maps of Peterborough and areas of deprivation. This looked at access to housing and how this affected areas of Peterborough. The report also focused on lifestyle choices and localised challenges such as education, skills and crime. There had been a sharp fall in immunisations which might have been as a result of increased pressures on GP surgeries.

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

- There was good data that showed that even if over 60 and gave up smoking this could add three years to someone. People who changed their diets would also see health improvements.
- Clinicians found the statistics useful and could see in depth areas for patients to focus on. GP's were also keen to look at psychological data to keep an eye on people's wellbeing. It was important to note that it was never too late to make lifestyle changes.
- There had been a decrease in the uptake of cancer screenings, especially within ethnic minorities. There had been particularly low rates of uptake for bowel screenings. It was hoped that more funding would be made available from NHS England to do some work on screening.
- Some ethnic communities were not recognising mental health issues. Further work was needed around how information was disseminated in local communities.

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

1. The need to push for more public diversity figures from each community and continue to follow up from Public Health England and commissioners
2. Data around think communities and maps of data.
3. HWB strategy and improvements not being seen in smoking and dietary to take forward in the strategy.

23. SCHEDULE OF FUTURE MEETINGS AND DRAFT AGENDA PROGRAMME

Members were informed that the Lincolnshire CCG had come together from its different regions from 1 April 2020. They had therefore decided not to go forward on this Board. Members thanked Hilary Daniels for her contribution to the Board.

The Peterborough Health and Wellbeing Board **RESOVED** to note the schedule of future meetings and draft work programme.

Chairman

10:00am – 11.11am

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 5
7 DECEMBER 2020	PUBLIC REPORT

Report of:	Dr Fiona Head, Acting Medical Director NHS Cambridgeshire and Peterborough CCG	
Contact Officer(s):	Dr Fiona Head, Acting Medical Director Dr Olufunto Ogundapo, GP Registrar	Tel.01223 725400

NHS CAMBRIDGESHIRE AND PETERBOROUGH NHS HEALTH INEQUALITIES STRATEGY

RECOMMENDATIONS	
FROM: Dr Fiona Head, Acting Medical Director NHS Cambridgeshire and Peterborough CCG	**Deadline date: N/A**

It is recommended that Peterborough Health and Wellbeing Board Meeting:

1. Adopt the Health Inequalities Strategy and promote the awareness of the guiding principles within the strategy.

2. Continue to work in partnership across the system to address health inequalities in the delivering of services. With a focus on addressing health inequalities in the workforce and adopting a health inequalities impact assessment (HIIA) approach for all service changes.

1. ORIGIN OF REPORT

1.1 This report is submitted to Peterborough Health and Wellbeing Board Meeting following a request at the representatives meeting on 28 October 2020.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to present the Cambridgeshire and Peterborough NHS Health Inequalities Strategy and for adoption by the Peterborough Health and Wellbeing Board.

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

2.8.2.1 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

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

3. TIMESCALES

Is this a Major Policy Item/Statutory Plan?	**NO**

4. BACKGROUND AND KEY ISSUES

4.1 **Cambridgeshire and Peterborough NHS Health Inequalities Strategy**

The attached document is a Strategy for the NHS to address Health Inequalities.

It was written by a NHS system-wide health inequalities group and has been approved by the Sustainability Transformation Partnership (STP) Joint Clinical Group, STP Clinical Communities Forum and Clinical Commissioning Group (CCG) Governing Body.

In Cambridgeshire and Peterborough stark inequalities exist in the social determinants of health, risk factors, health care provision and clinical outcomes across socio-economic, disadvantaged and inclusion health groups. A 10-year life expectancy gap exists between men living in the poorest areas of Peterborough compared to the richest areas of Cambridge. The gap in life expectancy is driven by early deaths in cardiovascular disease, cancer, and respiratory conditions

The NHS System Health Inequalities Group, based on national and international recommendations, have developed seven “Guiding Principles”.

These are:

1. Explore the impact of decisions on health inequalities early in the decision-making process.
2. Value staff through parity of recruitment, promotion and employment.
3. Offer simple, hassle-free services.
4. Partner with other organisations to take a place-based approach to address social determinants of health.
5. Allocate health care resources proportionate to need.
6. Consider actions at different stages of life.
7. Harness the community benefits of the Social Value Act.

4.2 The Cambridgeshire and Peterborough NHS Health Inequalities Strategy recommends the following three priority areas for the STP:

Priority area 1 - Working across the system to reduce health inequalities

Recommendations are:

I. Establish a Health Care System Inequalities Group to monitor and drive action on health inequalities. There is now a system wide Health Inequalities Board that drives the actions on health inequalities.
II. Promote awareness of the Guiding Principles and embed them in commissioning and delivering of services across all STP partners.
III. Increase the use of Health Inequality Impact Assessment (HIIA). An officer is being recruited to support this work.
IV. Address inequalities in workforce distribution.

Priority area 2 - Addressing inequalities through Needs-Based Commissioning for Outcomes

Recommendations are:

I. Allocate discretionary funding proportionate to need. This is currently being trialled in diabetes funding.
II. Allocate elective care based on need.

Priority area 3 - Addressing inequalities in cardiovascular mortality through targeted action on hypertension and diabetes

Recommendations are:

I. Reduce inequalities in hypertension management in primary care.
II. Reduce inequalities in diabetes care in primary care.

4.3 **Regional Programme**

NHSE/I together with Public Health England have commenced a regional Health Inequalities and Equality, Diversity and Inclusion Programme.

Cambridgeshire and Peterborough NHS: Organisation of health inequalities work

The task and finish group that produced the strategy has evolved into an NHS system-wide Health Inequalities Board to which the Executive Health Inequalities Leads of each organisation have been invited. It is a collaborative group with membership from all organisations, Healthwatch and the Local Authority. This Board will report into both the Joint Clinical Group and Recovery Oversight Group.

The Health Inequalities Board is overseeing delivery of an action plan that combines the actions in the Cambridgeshire and Peterborough NHS Health Inequalities Strategy with the requirements of the national letter that was issued in July by NHS E/I to direct the third phase of the NHS recovery to covid.

4.4 **Progress in local work programme**

Resourcing health inequalities work and systematising inequalities impact assessment

The CCG is recruiting to a Health Inequalities Manager and Health Inequalities Impact Assessment Officer post. When this team is in place the pace of the NHS inequalities reduction work will increase.

As the NHS STP evolves into an Integrated Care System systematic, proportionate application of health inequality impact assessment processes will enable exploration of the impact of decisions on health inequalities early in the decision-making process (Health Inequality Strategy guiding principle 1).

Addressing inequalities in workforce availability

The Cambridgeshire and Peterborough NHS Health Inequalities Strategy highlights the inequality in workforce provision across the STP area for both primary and secondary care.

The reasons for this are complex and solutions are likely to be slow to enact. However anecdotally these inequalities are known to have existed for some time. Over the period of the COVID-19 pandemic there has been an increased realisation of system clinical risk that this produces. This has been particularly clearly seen in the area of respiratory care.

The Health Inequalities Board is therefore prioritising scoping this as an area of ongoing work. This is in line with guiding principle 5 of our Health Inequalities Strategy - allocate resources in proportion to need.

5. REASON FOR THE RECOMMENDATION

5.1 Persistent health inequalities exist across the Cambridgeshire and Peterborough STP footprint and the Strategy has NHS support to work to address the factors that are under NHS control.

6 APPENDICES

6.1 Appendix A: Cambridgeshire and Peterborough NHS Health and inequalities strategy PDF

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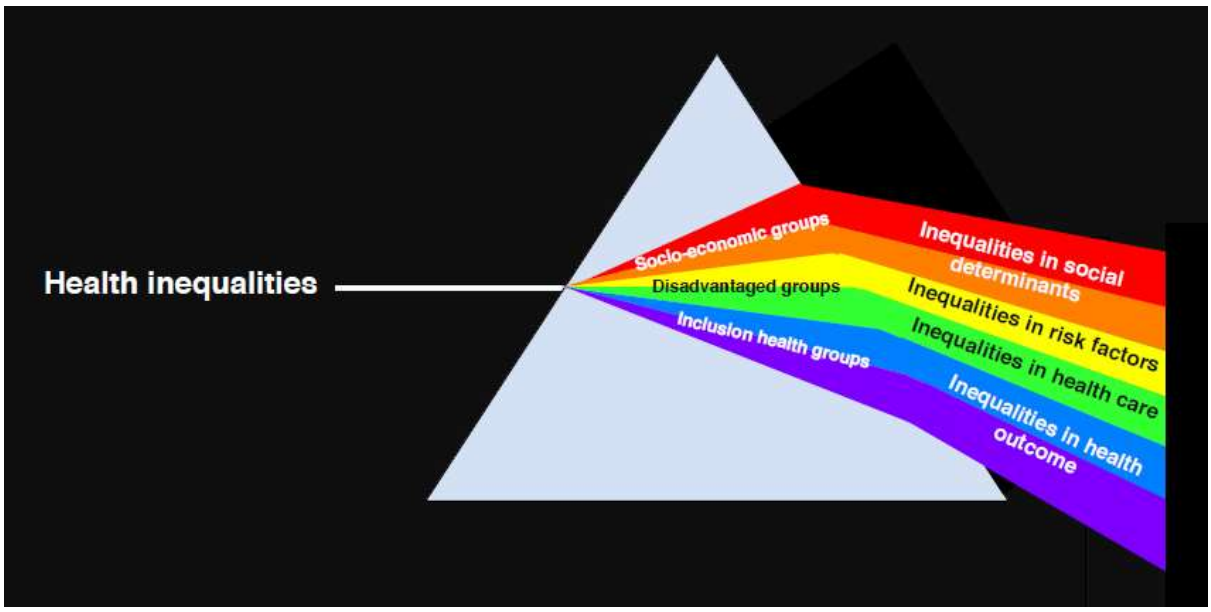
Cambridgeshire and Peterborough Health Inequalities Strategy



July 2020
Version 2.1

Executive summary

1. In Cambridgeshire and Peterborough stark inequalities exist in the social determinants of health, risk factors, health care provision and clinical outcomes across socio-economic, disadvantaged and inclusion health groups. A 10 year life expectancy gap exists between men living in the poorest areas of Peterborough compared to the richest areas of Cambridge. The gap in life expectancy is driven by early deaths in cardiovascular disease, cancer and respiratory conditions.

2. COVID-19 has increased the pre-existing inequalities with an extra 1,000 people dying across England in the most deprived decile compared to the least deprived between March and May 2020, and an extra 2,500 from all causes.

3. This strategy focuses on what the NHS can do and has three objectives.
   3.1. Develop Guiding Principles to support the NHS in tackling health inequalities
   3.2. Agree health inequality indicators
   3.3. Identify specific areas for priority action

4. Drawing on national and international recommendations we have developed seven Guiding Principles. These are:
   4.1. Explore the impact of decisions on health inequalities early in the decision-making process
   4.2. Value staff through parity of recruitment, promotion and employment
   4.3. Offer simple, hassle-free services
   4.4. Partner with other organisations to take a place-based approach to address social determinants of health
   4.5. Allocate health care resources proportionate to need
   4.6. Consider actions at different stages of life
   4.7. Harness the community benefits of the Social Value Act

5. We identified twenty health inequalities indicators, all of which had a socio-economic gradient, across five themes: risk factors; access to and use of services; diagnostics; treatment; and outcomes. Key examples of the inequality gap between most and least deprived quintile include:
   - 18.8% fewer mothers breast feeding
   - 6.5% fewer people with diabetes achieve all three targets
   - An extra 247 A+E attendances in 0-4 year olds per 100,000 per year
   - An extra 50 deaths from cardiovascular disease per 100,000 per year

6. We recommend the following three priority areas for the STP and CCG:
   6.1. Working across the system to reduce health inequalities
   - Establish a Health Care System Inequalities Group to monitor and drive action on health inequalities
   - Promote awareness of the Guiding Principles and embed them in commissioning and delivering of services across all STP partners
   - Increase the use of Health Inequality Impact Assessment (HIIA)
   - Address inequalities in workforce distribution

   6.2. Addressing inequalities through Needs-Based Commissioning for Outcomes
   - Allocate discretionary funding proportionate to need
   - Allocate elective care based on need

6.3. Addressing inequalities in cardiovascular mortality through targeted action on hypertension and diabetes

- Reduce inequalities in hypertension management in primary care
- Reduce inequalities in diabetes care in primary care

Lead author: John Ford, Clinical Lecturer in Public Health, Cambridgeshire and Peterborough CCG

Health Inequalities Task and Finish Group Membership

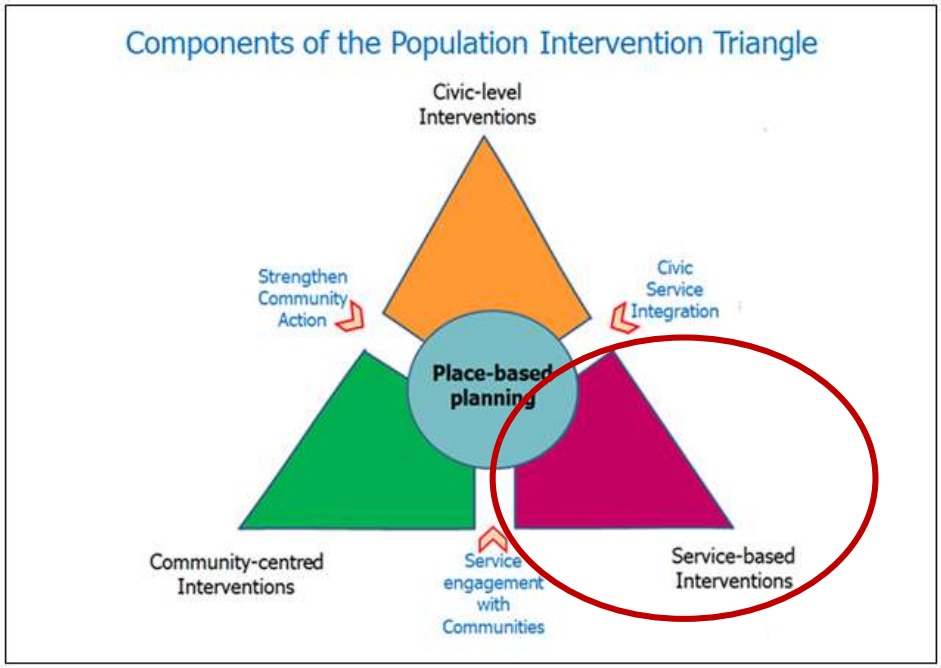
- Alex Gimson, Clinical Communities Forum and Cambridge University Hospital Trust
- David Lea, Public Health Intelligence, Cambridgeshire & Peterborough Public Health Intelligence
- Fiona Head, Cambridgeshire and Peterborough CCG
- Jeremy Lane, Cambridgeshire and Peterborough CCG
- Jessica, Randall-Carrick, STP & CCG Clinical Lead – Diabetes & Obesity and Thistlemoor Medical Centre
- Kanchan Rege, North West Anglia NHS Foundation Trust
- Marianne Monie, South Alliance and Cambridge University Hospital Trust
- Mark Brookes, Cambridgeshire and Peterborough CCG and Nuffield Road Medical Centre
- Rachel Harmer, East Barnwell Health Centre and Primary Care Network Clinical Director
- Ryan O'Neill, Public Health Intelligence, Cambridgeshire & Peterborough Public Health Intelligence
- Sire Mandeep, North Alliance and North Brink Practice
- Teresa Johnson, Cambridgeshire and Peterborough CCG
- Val Moore, Cambridgeshire and Peterborough HealthWatch

Contents

Scope of the strategy

This strategy originated from Cambridgeshire and Peterborough Clinical Commissioning Group and was jointly produced with the Clinical Communities Forum of the Cambridgeshire & Peterborough STP in response to the clear differences in health outcomes across our healthcare system. The strategy largely addresses inequalities in outcomes from a health perspective and is intended to be congruent with local Joint Strategic Needs Assessments, and Health and Wellbeing strategies within Public Health and local authorities

Health inequalities exist across a spectrum from prevention to illness and are driven by a complex interaction of factors. Public Health England have developed the Population Intervention Triangle to help local areas to address health inequalities[1]. Our strategy focuses largely on the "service-based interventions" part of this Population Intervention Triangle and in particular NHS services, with community-centred and civic-level aspects covered in the Health and Wellbeing Board Strategy.



Source: Public Health England Place-based approaches for reducing health inequalities: main report. 2019

The strategy has three objectives:

1) Develop a set of broad Guiding Principles which describe practical actions for the health care system to reduce health inequalities
2) Agree health inequality indicators to allow regular monitoring of health inequalities within the NHS.
3) Identify specific areas for priority action.

The strategy has been developed by a Task and Finish Group with representation from Cambridgeshire and Peterborough CCG, Cambridgeshire County Council, HealthWatch Cambridgeshire and Peterborough, Clinical Communities Forum, North and South Alliances and Primary Care Network Clinical Directors. The Public Health

Intelligence Team within Cambridgeshire County Council and Peterborough City Council analysed the data to develop the health inequalities indicators.

The strategy has been updated in June 2020 in light of the COVID-19 pandemic.

A supplementary action plan will outline the implementation of the strategy.

Setting the scene

What do we mean by health inequalities?

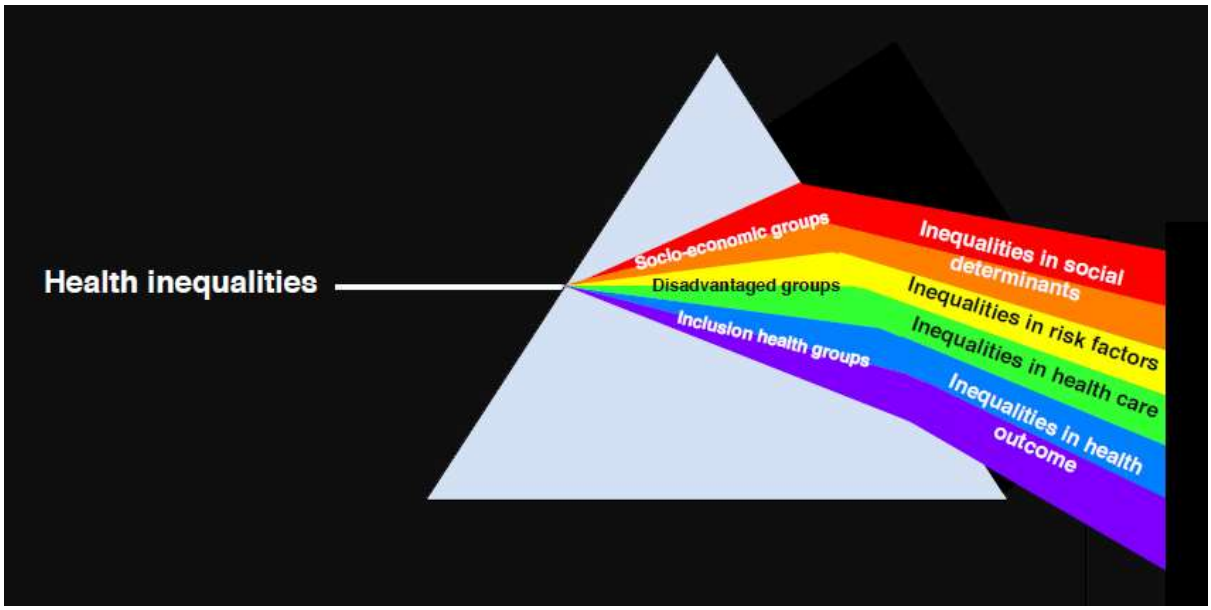
Health inequalities are systematic, avoidable and unfair differences in health outcomes between populations, between social groups within the same population or as a gradient across a population ranked by social position[2]. Inequalities in health outcomes arise from inequalities in social determinants of health, risk factors and health care access and provision.

We can think about the populations, social groups or gradients in which inequalities occur in three main categories:

1) The socio-economic gradient which describes increasing health inequalities according to socio-economic disadvantage, such as wealth, income, education and employment.
2) Disadvantaged groups who are not necessarily vulnerable but are at risk, such as minority ethnic communities, older people or those living in rural areas. Inequalities tend to arise in this group when multiple aspects of disadvantage coalesce, such as an older people, living alone in a rural area without transport.
3) Inclusion health groups who are by nature vulnerable, such as people who are homeless, have learning disabilities or asylum seekers.

Within each of these groups there are inequalities in the social determinants of health (e.g. income and employment), risk factors (e.g. smoking and obesity), health care (e.g. hypertension and diabetes treatment) and health outcomes (e.g. early death due to heart disease). Figure 1 below shows how we can think about the different aspects of health inequalities.

Figure 1: Conceptualising health inequalities



Health inequalities policy context

COVID-19 has significantly changed the health inequalities context. Health inequalities have already increased through twice as high COVID and non-COVID deaths in poorer areas. However, this is just the tip of the iceberg with health inequalities likely to worsen even more due to the impact on health care services, mental wellbeing and economic impact on employment, debt, housing, benefit payments and education. These social influences are key determinants of what makes people healthy or unwell and have been significant factors in peoples' exposure to and outcomes from COVID-19.

COVID-19 has also disproportionately minority ethnic groups. A Public Health England analysis found that people of Bangladeshi ethnicity were at twice the risk of death from COVID-19 and people of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity between 10 to 50% higher risk of death. A subsequent report which explores some of the reasons for this difference made a number of recommendations including better ethnicity data collection, regular equity audits, use of health impact assessments, integration of equality into quality systems, good representation of black and minority ethnic communities among staff at all levels, sustained workforce development and employment practices, trust-building dialogue with service users and development of culturally competent occupational risk assessment tools.

The Long Term Plan (LTP), published in January 2019, set out bold ambitions around health inequalities. Among several health inequality actions, it set an ambition for a "more concerted and systematic approach to reducing health inequalities" and to "set out specific, measurable goals for narrowing inequalities". The LTP also outlines additional services for several vulnerable groups, such as health checks for those with severe mental health problems, improved services for those with autism or a learning difficulty, outreach services for rough sleepers, improved primary care for carers, clinics for those with gambling problems and support for those in the justice system. As part of the Long Term Plan, Primary Care Networks (PCN) will be expected to develop plans to reduce health inequalities, although the exact details have not yet been published.

Health inequalities is a core component of the Cambridgeshire and Peterborough Health and Wellbeing Strategy 2019-24. The strategy sets out clear objectives to address the wider determinants of health and healthy lifestyles inequalities including:

- Preventing homelessness and improving pathways into housing for vulnerable people.
- Reducing inequalities in skills and economic outcomes across our area.
- Reducing inequalities in heart disease and smoking
- Acting as a system to reduce health inequalities

In 2019, NHS England published a Menu of Evidence Based Interventions and Approaches for Addressing and Reducing Health Inequalities[3]. The Menu provides a catalogue of interventions that local health care systems and commissioners, working with partners across the system, can draw on to act at the neighbourhood and system-level to reduce health inequalities.

Also in 2019, Public Health England published Place-Based Approaches for Reducing Health Inequalities (PBA) which aims to support local systems to take strategic and evidence-based action on health inequalities[1]. Key to the resource is focusing on place through civic-interventions, community-interventions and service-interventions. This holistic approach supports local areas to work together through evidence-based interventions. The main report is supported by four tools and a guide to using national and local data. The actions and tools included in the report build on a wealth of experience and information from the National Health Inequalities Support Team and consultation with stakeholders. The purpose of the resource is not to set out a one-size-fits-all approach to tackling health inequalities, but rather facilitate local systems to meaningfully engage with their own inequalities in a considered and evidence-based manner.

Why do we need a strategy?

Health inequality can be a nebulous topic, meaning different things to different people. For some, health inequalities are about the differences in mortality between the richest and poorest in society. For others, health inequality is about communities that face disadvantage, such as minority ethnic groups, or inclusion health groups, such as those who are homeless. Strategic leadership and local consensus is needed on how we think about health inequalities, how we measure them and what we can do about them. We need to build the local health inequalities infrastructure, in terms of resources, expertise and data monitoring, to make the most of current and future opportunities in a systematic and coherent manner.

Economic case

The cost to the NHS of health inequalities was estimated in 2011/12 to be at least £12.5 billion/year[4]. This was calculated by estimating the difference in NHS spend between the most and least disadvantaged fifth of the population. In Cambridgeshire and Peterborough CCG this would be equivalent to approximately £106 million/year, at 2011/12 costs. Whilst we do not know how much of this additional spend could be reduced through NHS actions, local data suggests that there are opportunities to save money through addressing inequalities. For example, RightCare data suggests avoidable admissions are about twice as high in the most deprived areas of the CCG compared to the least deprived[5].

Moral case

The place where children are born and grow up has a direct impact on their life chances and health in later life. Currently, a boy growing up in the poorest part of Peterborough has a life expectancy of 75.8 years, however a boy growing up in the richest part of Cambridge has a life expectancy of 85.2 years; a difference of 10 years. The gap has increased by 0.9 years between 2011-13 and 2015-17. This gap is likely to increase after COVID-19 deaths have been included. The NHS can reduce the gap through more equitable prevention, diagnosis and treatment since it has been estimated that health care contributes 15-43% to health outcomes[6].

Legislative case

The Health and Social Care Act 2012 sets out statutory responsibilities for Clinical Commissioning Groups to “have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved” (s.14T). Additional legal advice from NHS England states that this means “health inequalities must be properly and seriously taken into account when making decisions or exercising functions, including balancing that need against any countervailing factors”[7].

Current Health Inequalities in Cambridgeshire and Peterborough

People living in different parts of Cambridgeshire and Peterborough experience stark differences in health. There is a 10 year life expectancy gap between men living in the poorest areas of Peterborough compared to the richest areas of Cambridge. The gap in life expectancy is driven by early deaths due to cardiovascular disease, cancer and respiratory conditions. For example, 50 more people die early from cardiovascular disease per 100,000 population per year in the poorest areas compared to the richest.

An analysis by Lewer and colleagues estimates the excess mortality attributable to socio-economic inequalities based on IMD for both the conditions with the strongest link to socio-economic status and the conditions with the largest overall impact (see Appendix)[8]. Based on this data for Cambridgeshire and Peterborough, the five conditions which contribute most to excess deaths due to socio-economic inequalities are ischaemic heart disease, COPD, respiratory cancer, drugs, alcohol and accidental deaths and other cardiovascular.

COVID-19 has disproportionally affected poor areas with more 1,000 extra people died in the most deprived decile in England due to COVID-19 during March to May 2020 compared with the least deprived areas and 2,500 extra people from any cause of death during this period. There is a clear socio-economic trend in COVID deaths

Figure 2: Age-standardised death rate from COVID in England from March to May 2020

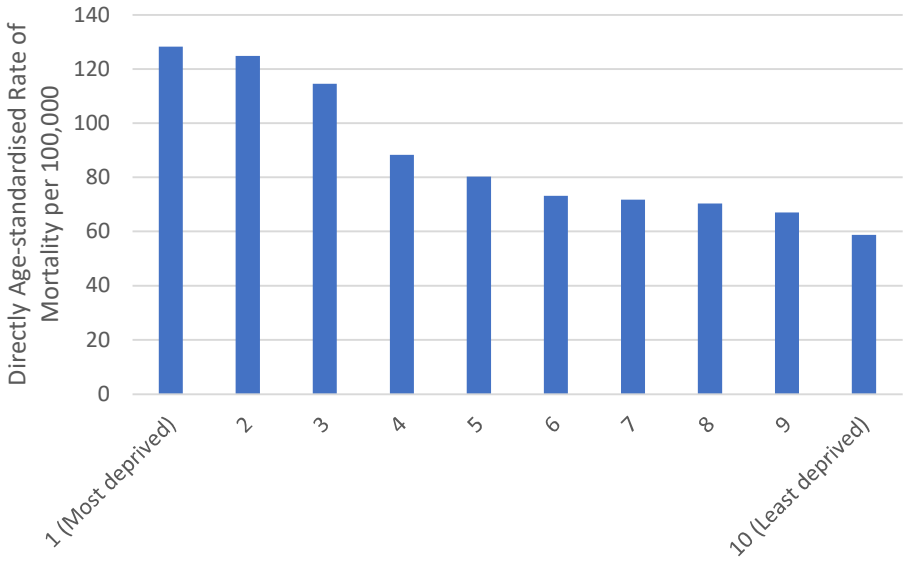
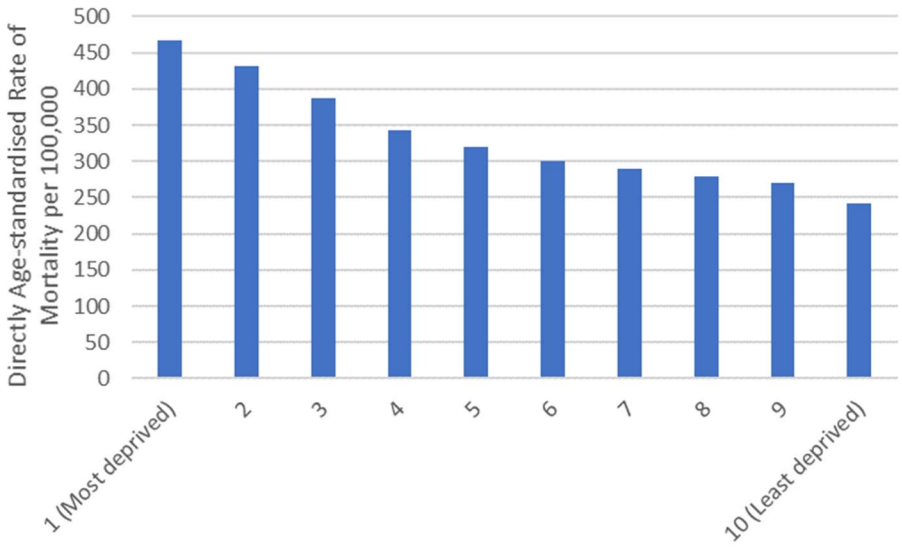


Figure 3: Age-standardised death rate in England from COVID and non-COVID deaths from March to May 2020



Inequalities in early deaths are caused by inequalities in social determinants of health, risk factors and health care that accumulate throughout a person's life.

- Social determinants
    - About half of the residents of Peterborough live in the bottom 30% most deprived areas in England, primarily reflecting low income and unemployment.
    - There is a 19% difference in breast feeding between those living in the poorest areas and the richest.
    - While local data does not exist on adverse childhood experiences (ACE), national data suggests that half of the population have experience of at least one ACE and 8% four or more.
- Risk factors
    - More children and adults are obese in the most deprived areas of Cambridgeshire and Peterborough, with 14% more children in Year 6 overweight or obese in Peterborough, compared to South Cambridgeshire, and 25% more adults overweight or obese in Fenland compared to Cambridge.
    - The inequality gap in smoking is 9% between South Cambridgeshire (10.4%) and Peterborough (19.5%).
- Health care
    - There is a relationship between satisfaction with general practice and deprivation, with satisfaction lower in the most deprived areas.
    - Achievement of diabetes targets is lower in Cambridgeshire and Peterborough compared to the rest of the country; achievement is even worse in the most deprived areas (6.5% inequality gap in meeting all three diabetes targets between richest and poorest areas)

Inequalities have a knock-on effect on the health service with the rate of avoidable admissions in the poorest areas double that of the richest areas. For children aged

0-4, there are an additional 247 A+E attendances per 1000 population per year for those living in the poorest quintile compared to the richest and an additional 85 emergency admissions.

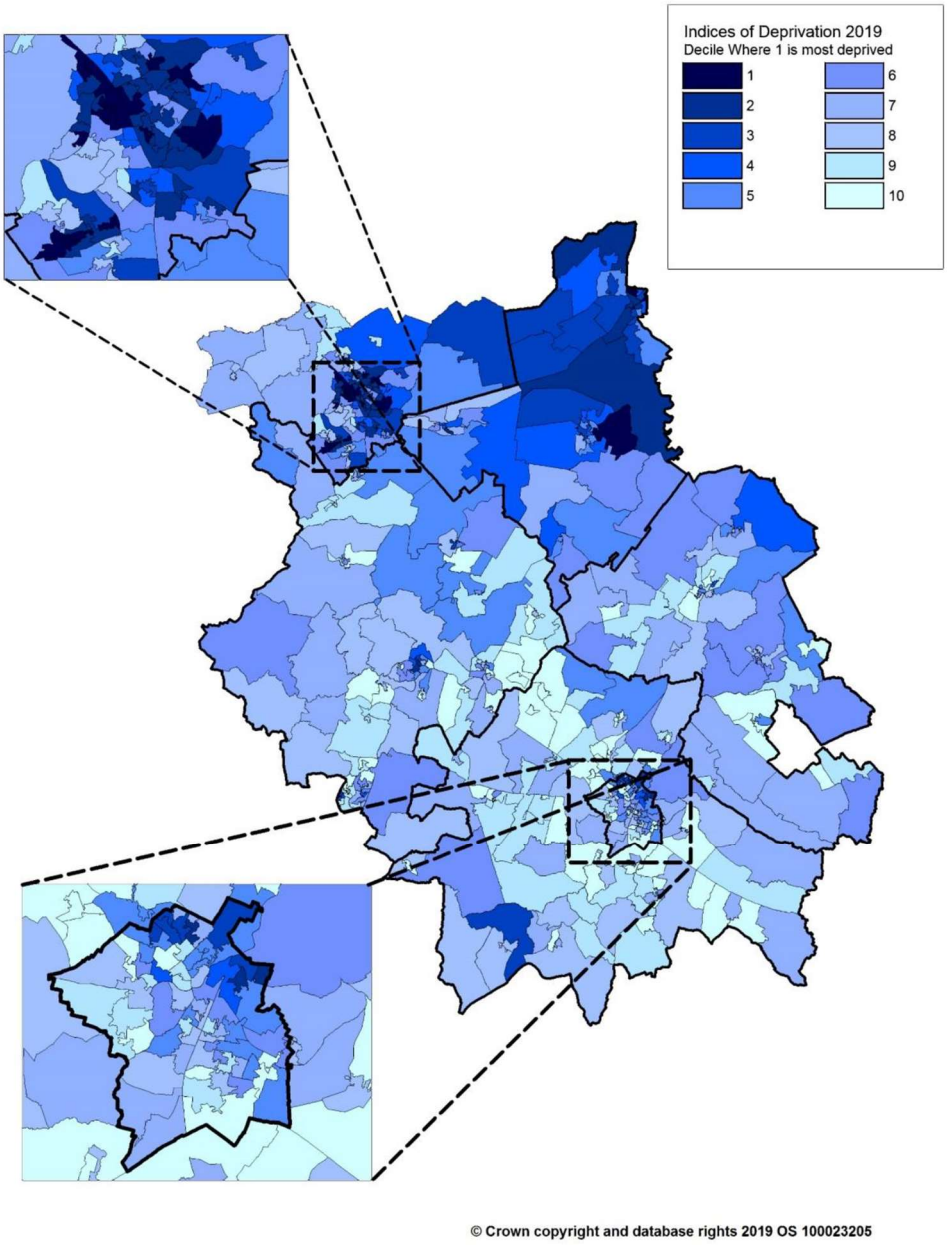
Inequalities do not just cross rich and poor areas, but also in disadvantaged communities (e.g. minority ethnic communities) and ‘inclusion health’ groups (e.g. street-based sex workers). Local health data for these groups is limited, but it is likely that people who are part of an inclusion health group or experience multiple disadvantages suffer the worst health outcomes in the area.

Examining the facts: 12 headline statistics on socio-economic and geographic Inequalities

FACT 1: Peterborough and Fenland are the most deprived areas across the CCG

Drawing on the latest Index of Multiple Deprivation data (2019), Peterborough and Fenland remain the most deprived areas in Cambridgeshire and Peterborough.

Figure 4:Indices of Multiple Deprivation 2019: National Decile for Overall Deprivation by Lower Super Output Area (LSOA)

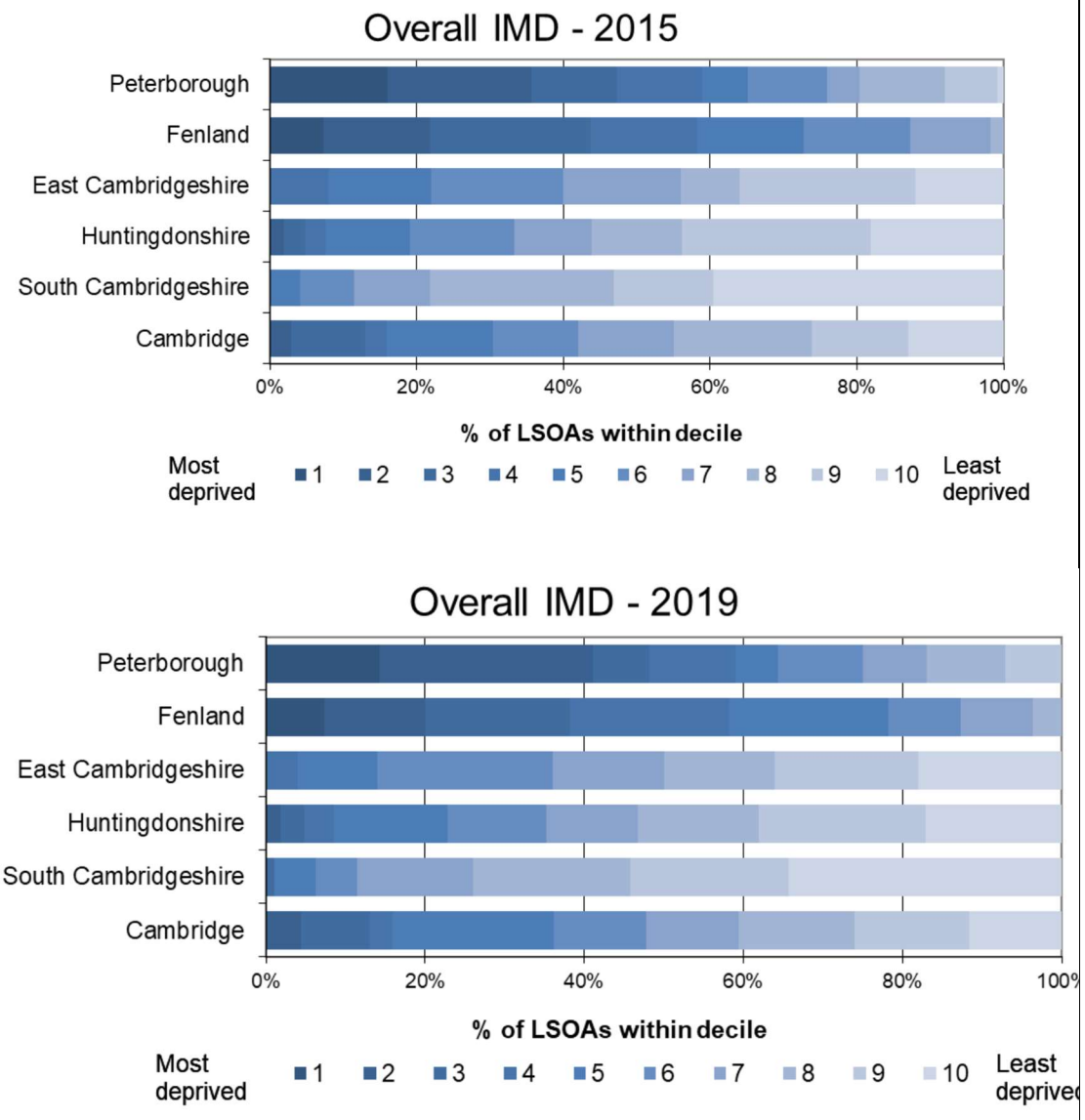


Source: Cambridge Insight 2019

FACT 2: Cambridge, South Cambridgeshire, Huntingdonshire and Peterborough are more relatively deprived now than 2015

Based on a comparison of 2015 and 2019 data Cambridge, South Cambridgeshire, Huntingdonshire and Peterborough rank as more relatively deprived. East Cambridgeshire ranks as less relatively deprived. Fenland has not changed rank.

Figure 5: A DNA chart showing the percentage of LSOAs per district within each of the 10 national deciles between 2015 and 2019



Source: Cambridgeshire Research Group

FACT 3: Fenland has 25% more people classified as overweight or obese compared to Cambridge (absolute difference)

Figure 6: Percentage of adults (aged 18+) classified as overweight or obese 2017/18

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	62.0	61.7	62
CA-Cambs and Peterborough	–	-	61.1	59.4	62
Fenland	–	-	68.5	64.1	72
Peterborough	–	-	68.3	63.7	72
Huntingdonshire	–	-	65.1	60.7	69
East Cambridgeshire	–	-	60.0	55.4	64
South Cambridgeshire	–	-	58.1	53.2	62
Cambridge	–	-	43.4	39.7	47

Source: Public Health Outcomes Framework

FACT 4: There is an additional 1 in 10 people who smoke in Peterborough compared to South Cambridgeshire

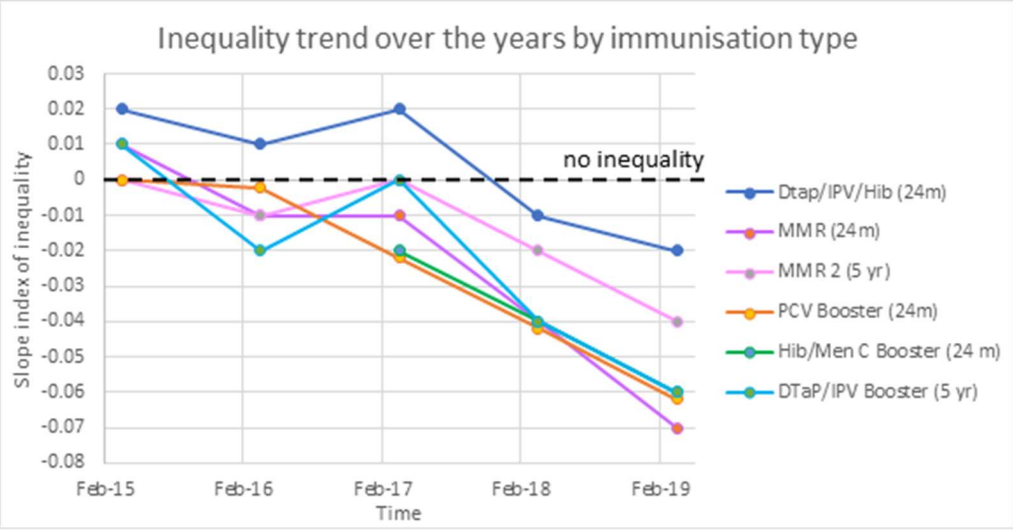
Figure 7: Smoking Prevalence in adults (18+) - current smokers (APS) 2018 Percentage

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	6,360,957	14.4	14.2	14
CA-Cambs and Peterborough	–	178,234	15.1	12.9	17
Peterborough	–	29,207	19.5	16.2	22
Fenland	–	15,728	19.4	11.3	27
Huntingdonshire	–	20,323	14.4	8.9	20
Cambridge	–	14,399	14.1	7.1	21
East Cambridgeshire	–	7,525	10.8	5.3	16
South Cambridgeshire	–	12,668	10.4	6.0	14

Source: Public Health Outcomes Framework

FACT 5: Inequalities in immunisations have been widening over time

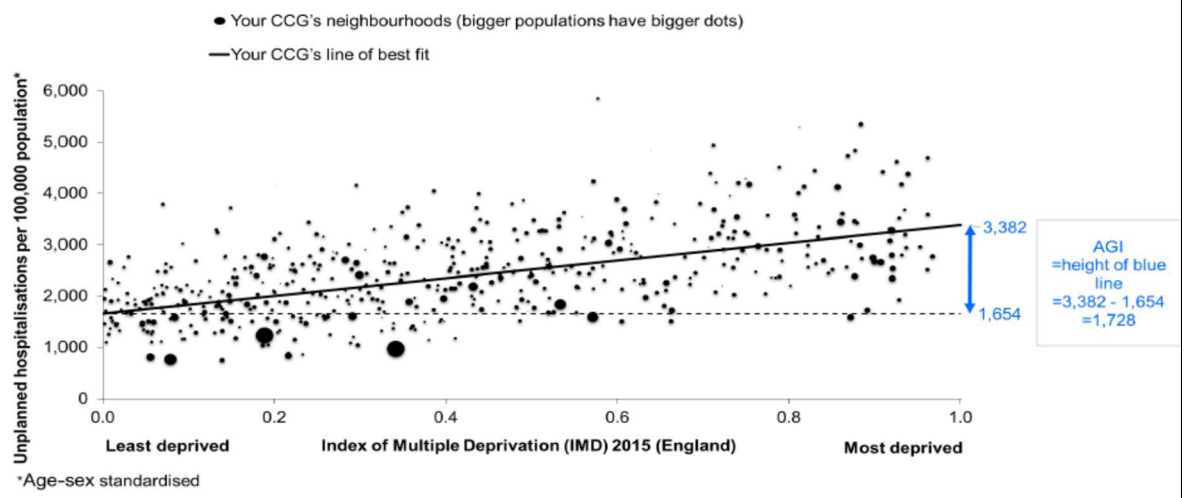
Figure 8: Inequalities in immunisations over time



FACT 6: Avoidable admissions are twice as high in the most deprived areas compared to the least deprived areas

The rate of unplanned hospitalisations per 100,000 is 1,654 in the most affluent areas compared to 3,382 in the most deprived areas of Cambridgeshire and Peterborough CCG

Figure 9: Absolute Gradient of Inequalities for avoidable unplanned admissions

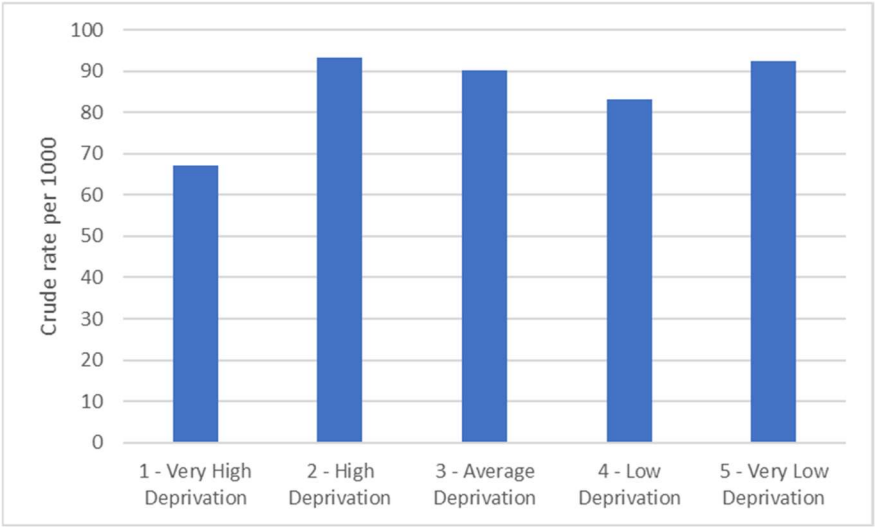


Sources: Unplanned hospitalisations: 2016-17 Secondary User Service (SUS), NHS Digital. Population data: CCG registered population for October 2016, NHS Digital.
Note: Numbers less than 6 have been suppressed when plotting neighbourhoods but have been included in overall calculations.

Source: NHS England Health Inequalities RightCare pack for Cambridgeshire and Peterborough

FACT 7: People living in the least deprived areas have 37% more elective procedures than the most deprived.

Figure 10: All elective admissions (inc day cases) across Cambridgeshire and Peterborough CCG for all specialities April 2019 to Dec 2019



Source: HES inpatient data

FACT 8: Practices in the most deprived areas have few doctors, but more nurses than the least deprived areas and there are more secondary care staff in the south of the area than the north.

Figure 11: Primary care GP and nurse inequalities in Cambridgeshire and Peterborough December 2019

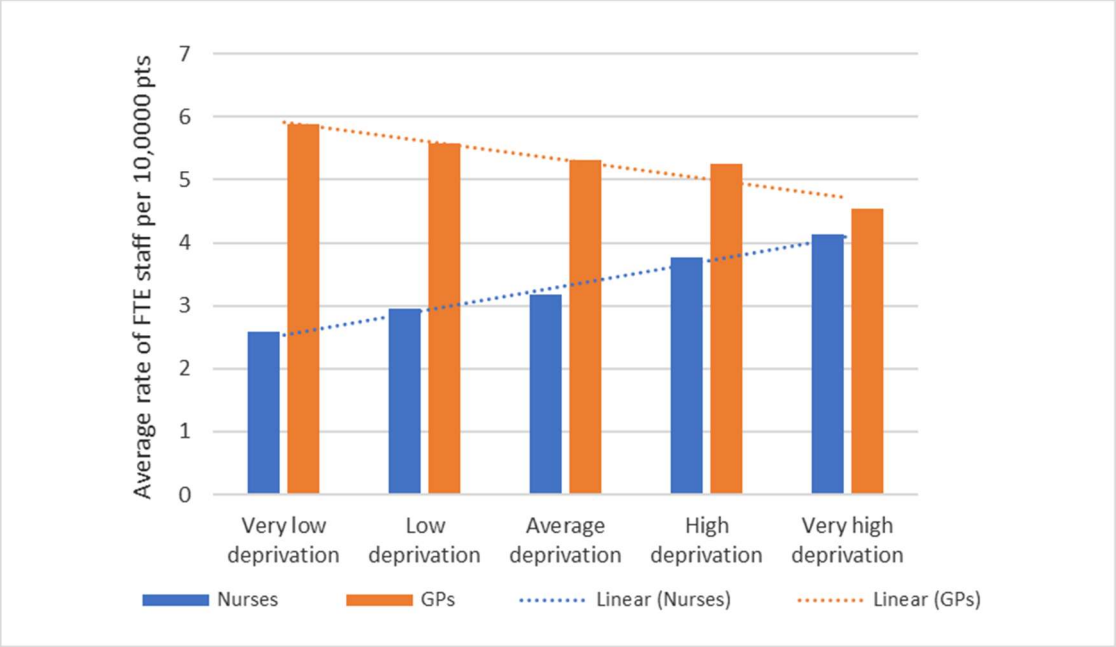
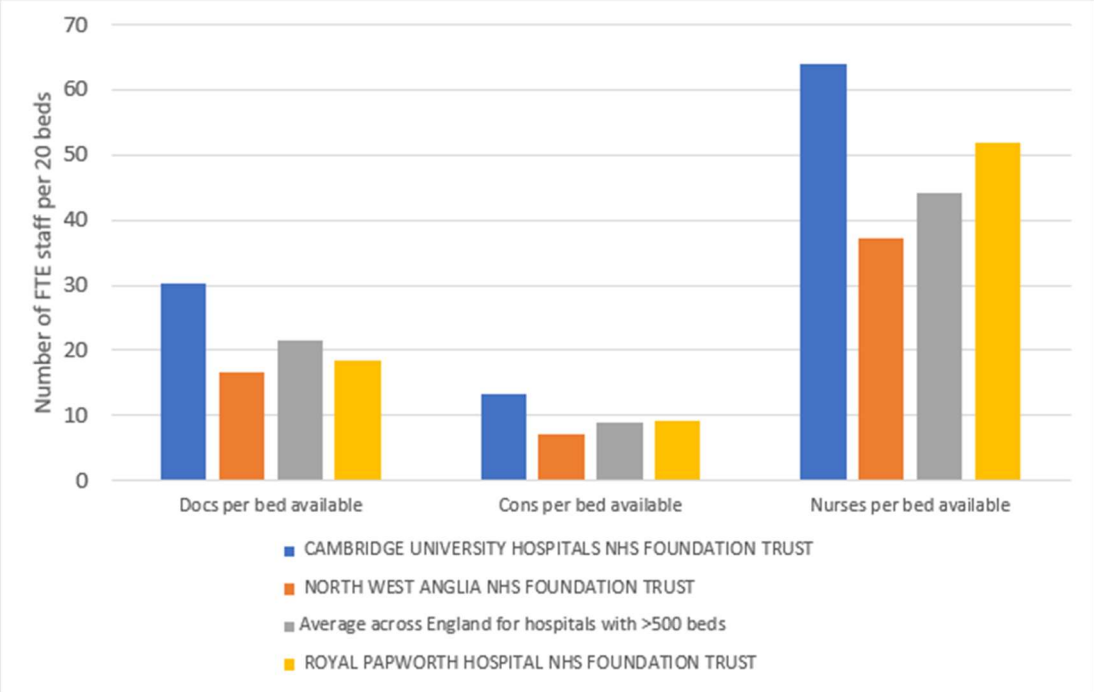


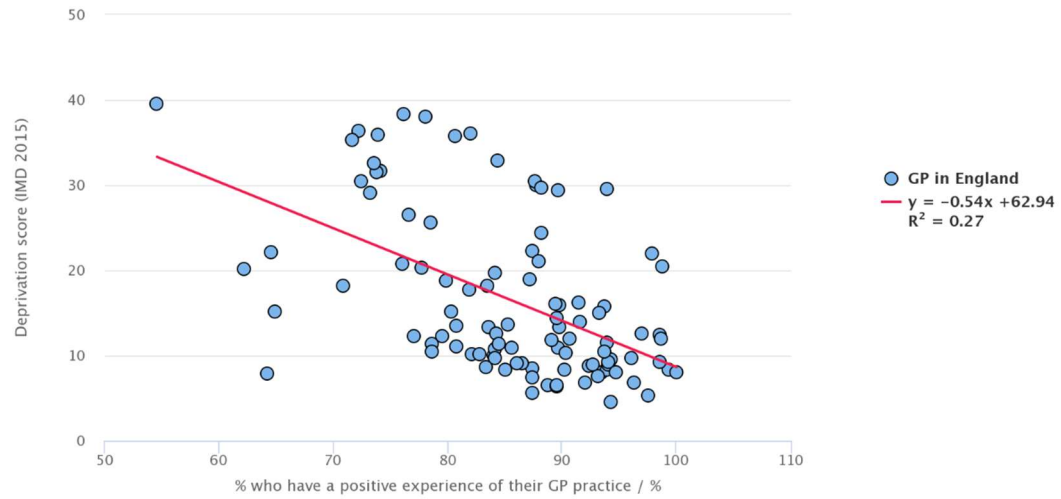
Figure 12:Workforce inequalities across CUH, NWAFT and Papworth compared to national average



Source: NHS digital workforce data (Jan 2020) and NHS Digital bed availability data (Q3 2019/20)

FACT 9: Generally, the more deprived the area that a practice is in, the higher the proportion of patients who report having a negative experience

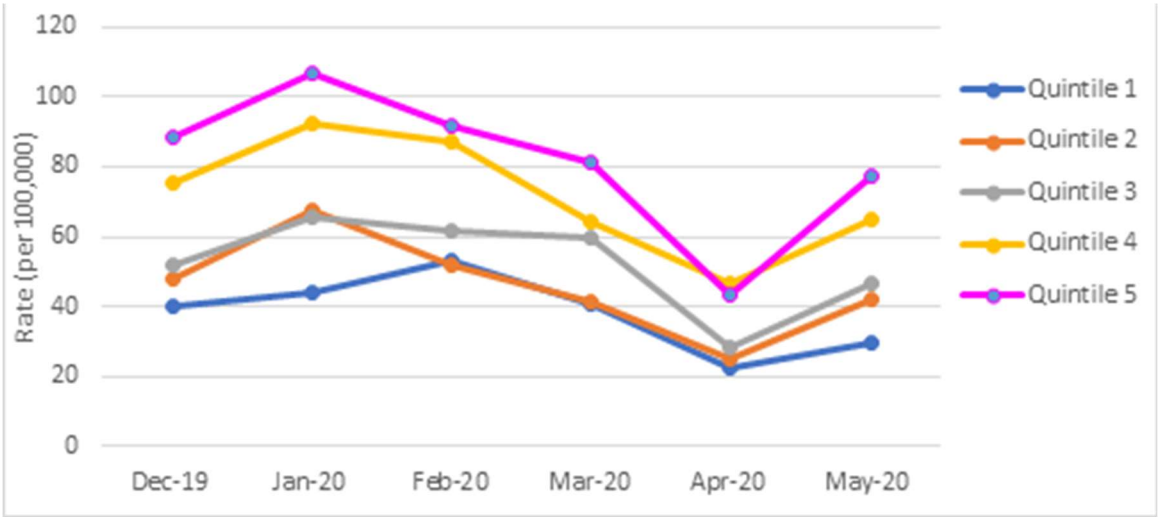
Figure 13: Positive experience of GP practice compared with deprivation score of practice



Source: PHE Fingertips

FACT 10: People living in the most deprived areas are 2.6 times more likely to attend A&E with a mental health problem than people living in the least deprived areas

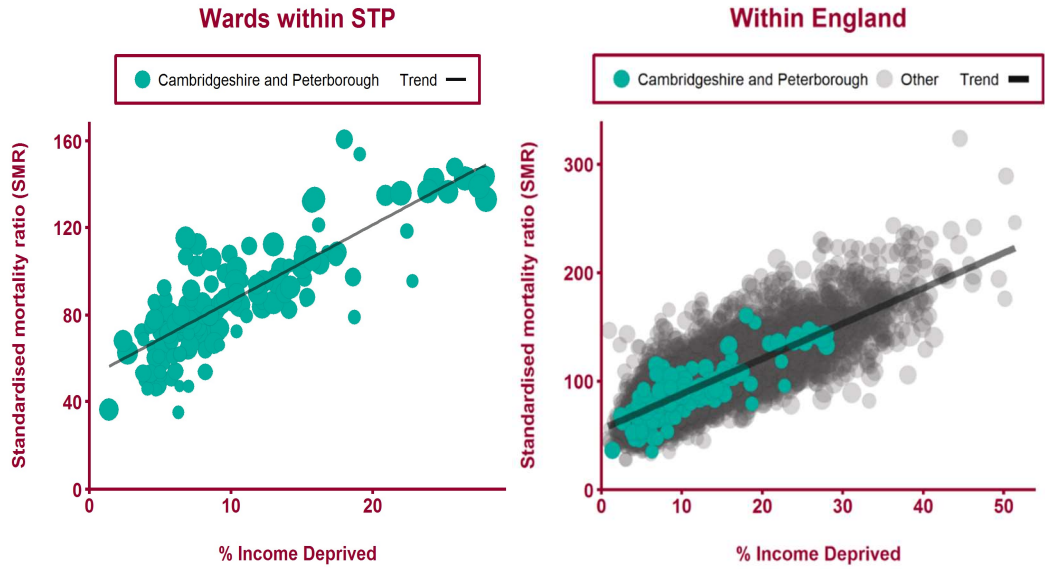
Figure 14:Rate of mental health presentations in A&E in Cambridgeshire and Peterborough by deprivation



FACT 11: Life expectancy of a man living in the poorest part of Peterborough is just 75.8 years compared to 85.2 years for a man living in the richest part of Cambridge

There is a clear socio-economic gradient between mortality and income deprivation in Cambridgeshire and Peterborough reflecting a national trend

Figure 15: Premature mortality from all causes, under 75 years for Cambridgeshire and Peterborough wards by % income deprived (2011-2015)

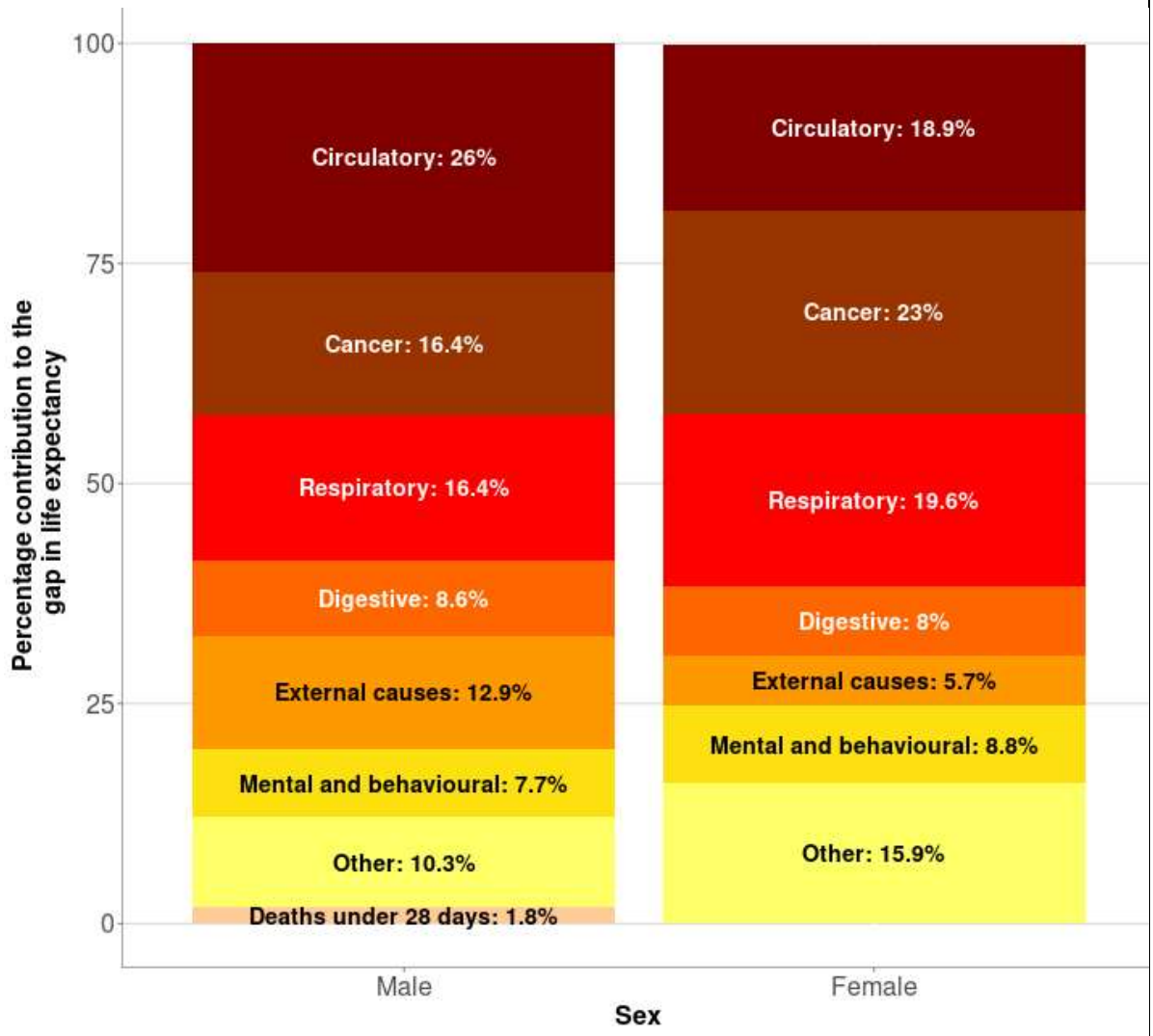


Source: Public health England STP Health Inequalities data pack

FACT 12: About 60% of the gap in life expectancy between the most deprived and least deprived quintile is due to circulatory conditions, cancer and respiratory conditions

In Peterborough, 42% of the gap in life expectancy in men is due to circulatory conditions. 40-54% of the gap in life expectancy is driven by the 60-79 year age group.

Figure 16: Scarf chart showing the breakdown of the gap in life expectancy between most and least deprived quintile of, 2015-17 for Cambridgeshire and Peterborough CCG



Source: Public Health England: Segment Tool

Disadvantaged groups

People with certain shared experiences or characteristics can face disadvantages leading to poor health. Whilst these experiences or characteristics of disadvantage may not lead to poor health for everyone, they lead to illness and early death in many and need specific consideration. Health data for these groups is significantly limited.

Six key disadvantaged groups in Cambridgeshire and Peterborough are:

1. People who suffer Adverse Childhood Experiences (ACEs)
    - Adverse childhood experiences are linked with risky health behaviours, chronic health conditions and poorer health later in their life. Children with four ACEs, compared to children with no ACEs, are 66% more likely to use heroin/crack cocaine, 35% more likely to be a high-risk drinker and 24% more likely to smoke[9]. Peterborough ranks 13th out of 14 similar local authorities for 'best start in life' outcomes[10].
2. People who belong to minority ethnic groups
    - In Cambridgeshire and Peterborough there are about 150,000 people who belong to a minority ethnic group[11]. While people who belong to a minority ethnic group are at risk of poorer health, there is considerable variation. For example, prostate cancer makes up over 40% of Black men's cancer compared with around 15% among Chinese men and 25% among all men[12]. There are large differences in infant mortality by ethnicity with rates highest among Pakistani, Black Caribbean and Black African groups
3. Those who are Lesbian, Gay, Bisexual and Transgender plus (LGBT+)
    - Research has shown that LGBT+ people are often less healthy than the wider population and tend to receive poorer quality of care than non-LGBT+ people. A Select Committee report found that too often health care professionals focus on sexual health rather than broader health needs a when supporting LGBT+ people[13].
4. Older adults, particularly those living in rural areas who rely on public transport
    - Socio-economic, ethnic and sexual minority inequalities persist into later life. These inequalities are compounded for those who experience other aspects of disadvantaged, such as those living in rural isolated areas without access to a car and on a low income[14].
5. Those with current or prior justice system involvement
    - In 2016 there were 7659 unique offenders known to Cambridgeshire Constabulary and 3775 managed by a probation service. There is a high health care need in this populations with national estimates that up to 70% of individuals in touch with the criminal justice system suffer with mental health issues[15].
6. Those who spent time in care as a child
    - A third of young people leaving care report problems with drugs or alcohol a year later. Young women leaving care are particularly susceptible to problematic substance use and a quarter of young women leaving care are pregnant, and nearly half become pregnant within 18 to 24 months[16].

Inclusion health groups

People who belong to inclusion health groups face marginalisation or social exclusion, and subsequently poor health, directly because of a certain characteristic or experience. People who belong to these groups tend to be vulnerable because of their current position.

There is no agreed categorisation of inclusion health groups, however the main groups are:

1. Those sleeping rough or housing insecure
    - In Peterborough, the count of family homelessness has increased from 180 families in 2011/12 (rate of 2.5 per 1000) to 632 families in 2017/18 (rate of 7.9 per 1000)[17].
2. Those belonging to the Gypsy Roma and Traveller community
    - In 2006 a study estimated that there was a Gypsy/Traveller population (including those in housing) of about 6500-7000 in the Cambridgeshire area. A survey of 40 individuals belong to a Gypsy or traveller community found high levels of racism from neighbours, feelings of isolation and loss of identity, feeling 'closed in' and drug abuse[18].
3. People who are transgender
    - Almost 14% of adult trans people have attempted to commit suicide more than twice, and 34.4% having attempted suicide at least once as an adult[19].
4. Asylum seekers, refugees and undocumented migrants
    - According to a recent Cambridgeshire and Peterborough Health Needs Assessment there has been an increase of 55.6% between 2003/04 - 2013/14 and the rise has been most substantial in percentage terms in Fenland (a 113.5% increase in migrant registrations)[20]. The rate of smoking and excessive alcohol consumption is higher among Eastern European communities. Fenland and Cambridge City are among the areas with the highest unadjusted rate of tuberculosis (TB) within the Anglia & Essex area. TB in the UK is higher among migrants from countries with high incidence of TB and these include Lithuania and Latvia.
5. Those who do not speak English
    - 1.9% of the population in Cambridgeshire and Peterborough have low English proficiency[17]. According to ONS data only two-thirds (65%) of people who could not speak English well or at all ('non-proficient)' were in good health, compared with nearly 9 in 10 (88%) who could speak English very well or well ('proficient)'[21].
6. Street-based sex workers
    - There is a widespread substance misuse problem among this street-based sex workers with 86 per cent of street-based sex workers reporting crack cocaine use, 40 per cent using heroin, and 5 per cent are HIV positive[22].
7. Those with a severe mental illness
    - Over 2000 people living in Cambridgeshire and Peterborough have been diagnosed with a severe mental illness, such as psychosis and

bipolar disorder[23]. People with these diagnoses have a life expectancy of up to 20 years shorter than the general population[24].

8. Those with a learning difficulty
    - In Cambridgeshire and Peterborough there are 3,955 people on the learning disability Quality Outcomes Framework register[25]. Learning disabilities affect health in different ways. A review of the literature found higher levels of epilepsy, coronary heart disease, respiratory disease, diabetes, chronic pain, visual and hearing impairments and mental health problems in those with learning difficulties[26].

Guiding Principles to reduce health inequalities

There is no silver bullet to reduce health inequalities, but there is much that the NHS can do. Key to this is acting together as a whole system to tackle inequalities. Making small changes to services during the design and implementation process, often with minimal cost, can help to ensure that services do not increase inequalities while supporting those in greatest need.

There are several national and international resources which outline ways in which the health care system can address health inequalities[1,3,27,28,29]. Drawing upon these guidelines, we have developed a set of seven Guiding Principles to help staff across the health care system take action to reduce health inequalities.

The seven principles are:

1. ***Explore the impact of decisions on health inequalities early in the decision-making process***

2. ***Value staff through parity of recruitment, promotion and employment***

3. ***Offer simple, hassle-free services***

4. ***Partner with other organisations to take a place-based approach to address social determinants of health***

5. ***Allocate health care resources proportionate to need***

6. ***Consider actions at different stages of life***

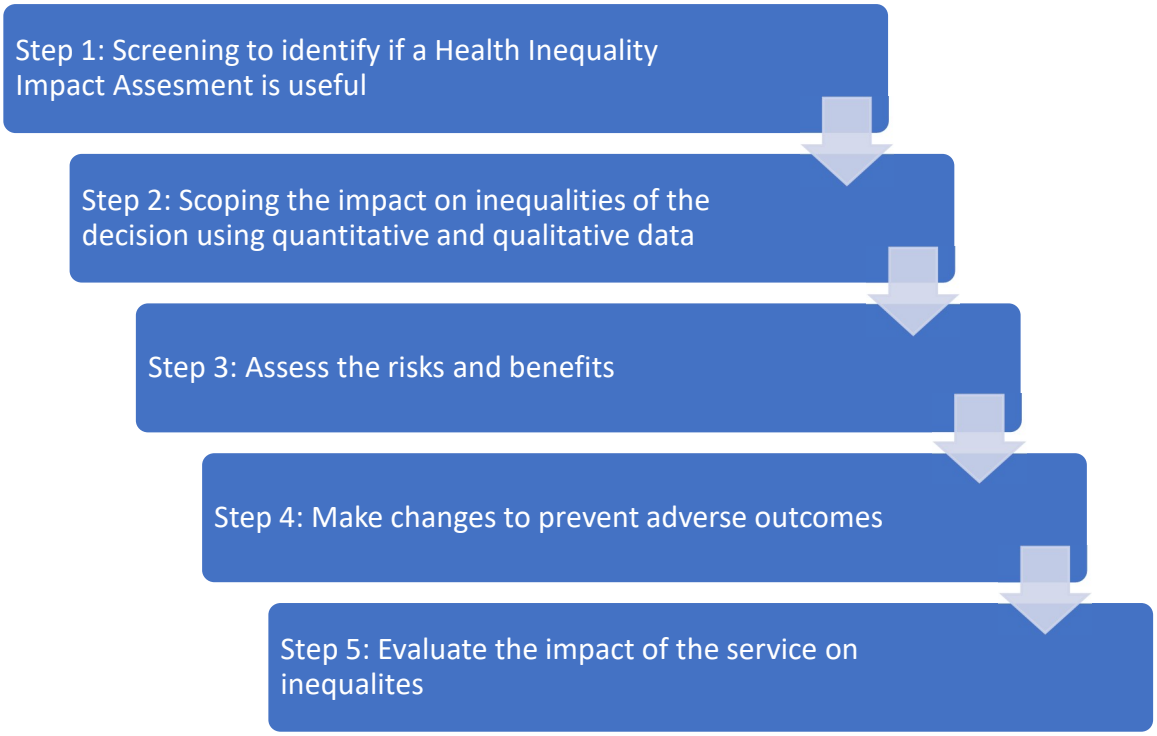
7. ***Harness the community benefits of the Social Value Act***

Principle 1: Explore the impact of decisions on health inequalities early in the decision-making process

Some health care interventions can inadvertently increase inequalities. For example, a non-targeted cancer screening campaign may increase inequalities because we know that white middle class people are more likely to respond to screening invitations. Therefore, anyone involved in re-designing services needs to think through how the design of the service may increase inequalities or disproportionally disadvantage one community.

Health Inequalities Impact Assessment (HIIA) is a key process for exploring the impact of decision making on disadvantaged and inclusion health groups. The Institute of Health Equity report on reducing inequalities through new models of care recommend undertaking a Health Inequalities Impact Assessment during service re-design. Whilst there are multiple names for HIIA, assessments all follow a similar structure.

Figure 17: Process for undertaking a Health Inequality Impact Assessment



Importantly, a HIIA is a process, not a form. The process should involve several team members brainstorming the possible impacts that the service may have on inequalities and then looking at quantitative data and/or speaking to community groups to understand the impact. It is important to consider the impact across the socio-economic gradient and across inclusion health and disadvantaged populations.

Principle 2: Value staff through parity of recruitment, promotion and employment

The NHS is the fifth largest employer in the world, employing about 1.3 million staff in the UK. In Cambridgeshire and Peterborough CCG the NHS employs about 25,000 staff in its hospitals, community trust and general practices (not including allied health professionals such as community pharmacists and ambulance staff)[i]. That means that about 1 in every 26 working age people work for the NHS (or 3.8% of the working age population)[ii]. Additionally, there are non-NHS organisations that are commissioned by the NHS or are dependent on the NHS as a part of the supply chain. Many of these jobs within, or associated with, the NHS are low paid.

Public Health England and the Institute of Health Equity published a report describing the ways in which good working conditions can improve health[30]:

- adequate pay;
- protection from physical hazards;
- job security and skills training with potential for progression;
- a good work-life balance; and
- the ability for workers to participate in organisational decision-making.

In a separate report the Institute of Health Equity published a report describing the role of health professionals in reducing health inequalities[31]. The report called on NHS organisations to ensure good quality of work that increases control, respect and rewards efforts, and provides services such as occupational health.

The NHS does not just have a role in good working conditions, but also supporting people who are not in employment, education or training (NEETs). For example, The Prince's Trust supported by Health Education England has launched a three-year pre-employment programme to give 10,000 people who may not have had the opportunity to work in the NHS the basic skills and experience needed.

The current National Living Wage is £8.21 per hour for those 25 and over, however the Living Wage Foundation estimate that £9.30 per hour is required to cover the cost of living based on a basket of household goods and services[32]. The Foundation argue that this should be applied to everyone over 18 years old whereas current the National Living Wage for 18-20 year olds is £6.15 and for 21-24 year olds is £7.70.

[i] This comes from Addenbrookes (~9800), CPFT (~4000), NWFT (~6100) Papworth (1918), GP practices (2850) and CCG (310)

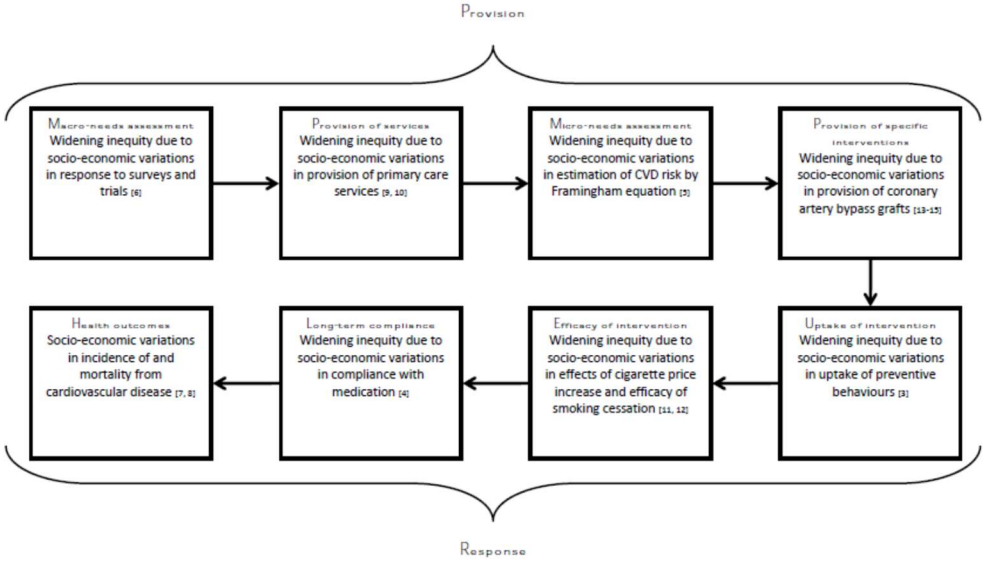
[ii] Based on General Practice registered population for Cambridgeshire and Peterborough CCG from National General Practice Database

Principle 3: Offer simple, hassle-free services

Services which require patients to jump through numerous hoops to benefit tend to increase inequalities. This has been described as a staircase effect, where each step represents a step in the patient pathway[33]. Only patients who can navigate the system benefit, disadvantaging certain patients, such as those with financial or employment challenges, poor health literacy, limited transport options or lack of an advocate or disempowerment. To reduce inequalities, we should design services which are simple and hassle-free and do not require patients to navigate complex systems.

Previous research has described the extent to which individuals have to use their own resources to benefit from an intervention or service as agency[34]. Interventions which require high agency (e.g. individuals have to use considerable personal resources to benefit) tend to be favoured by governments but are more likely to lead to inequalities, whereas low agency interventions (e.g. individuals only need to use a small amount of effort to benefit) are more likely to reduce inequalities.

White and colleagues give the following example: an intervention may be efficacious in 50% of those to whom it is delivered appropriately, but the condition for which it is efficacious is only diagnosed in 80% of those with the condition, only 60% of those diagnosed gain access to the intervention, only 90% of providers deliver the intervention as intended, and only 70% of consumers adhere to the intervention as intended. Its overall community effectiveness will thus be the product of the efficacy, multiplied by each of these modifiers (i.e. 0.5 x 0.8 x 0.6 x 0.9 x 0.7 = 0.15). In other words, the intervention would have an overall community effectiveness in 15% of the target population. Furthermore, if the magnitude of any of these five modifiers of the efficacy of the intervention varied by socio-economic position, then a socio-economic gradient of effectiveness would be observed[35]. Using cardiovascular disease as an example, White and colleagues also describe how inequalities occur from evidence to implementation to outcomes.

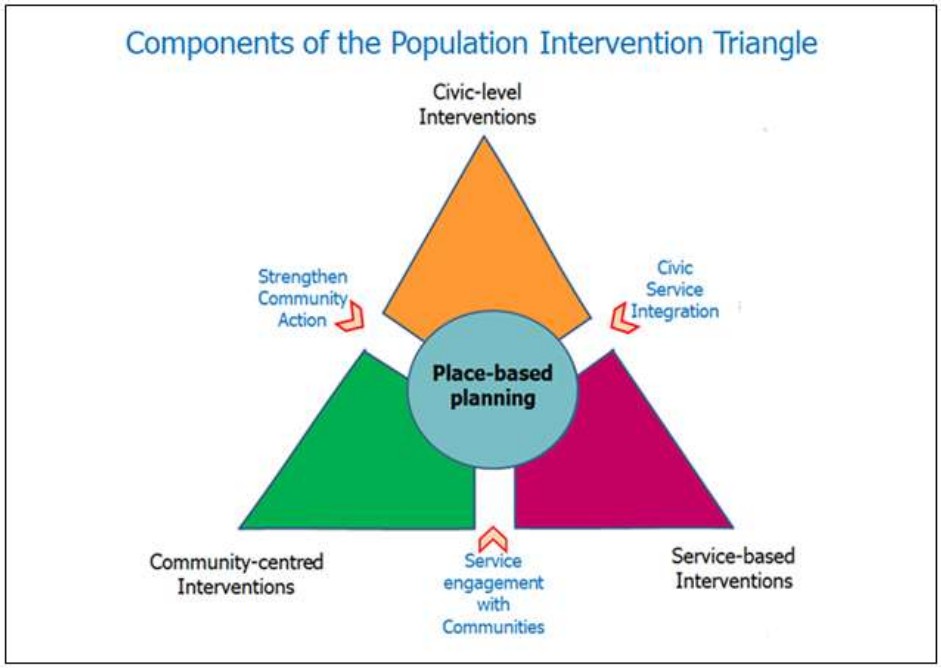


Source: White M, Adams J, Heywood P. How and why do interventions that increase health overall widen inequalities within populations? In Babones S (Ed.). *Health, inequality and society.* Bristol: Policy Press (*2009*).

Principle 4: Partner with other organisations to take a place-based approach to address social determinants of health

Addressing health inequalities requires the actions of multiple organisations working together. This may include partnering with organisations within the health care systems, such as general practices and community services, other public bodies, such as local authorities, voluntary sector organisations and communities themselves. The Institute of Health Equity recommends that partnerships within the health sector should be consistent, broad and focussed on the social determinants of health[31].

Public Health England in their recently publication on Place-based approaches for reducing inequalities[1] advocating an approach that treats the 'place', not just individual problems or issues. This requires partnership working in local neighbourhoods. The guidance recommends partnership working across the Population Intervention Triangle, as shown below.



Source: Public Health England Place-based approaches for reducing health inequalities: main report. 2019

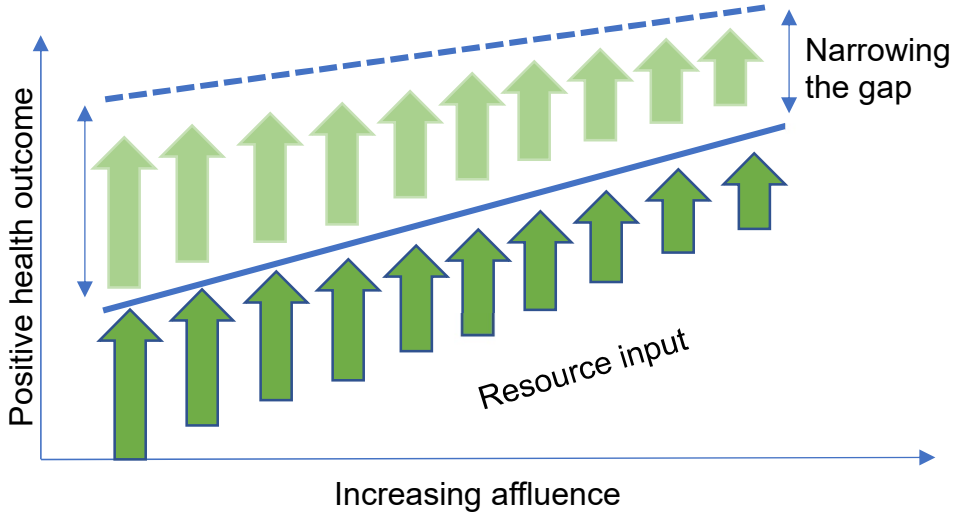
Civic-Level Interventions include the various tiers of local authority, regulation, licencing, healthy public policy and planning, and campaigns. Community-Level Interventions building on local assets such as leadership, infrastructures and community champions.

For service-based interventions the guidance provides a diagnostic tool called the Population Outcomes Through Services Framework. This tool provides a practical, systematic approach to addressing service-level intervention issues in a coherent way.

Principle 5: Allocate health care resources proportionate to need

Allocating resources according to need will ensure that the most disadvantaged and vulnerable people get the support that they need. This will help close the inequality gap between the most and least deprived. The Marmot report published in 2010 recommends something called "proportionate universalism", which states that services should be accessible to all, but the intensity of the service should be proportionate to need with the most disadvantaged receiving more resource[36]. The approach enables everyone in the population to access services whilst also looking across the socio-economic gradient. It does not only have to be about funding, it might be that rolling out services first in the most disadvantaged areas means that those areas have more time to benefit from new services. It could also apply to workforce or where services are located.

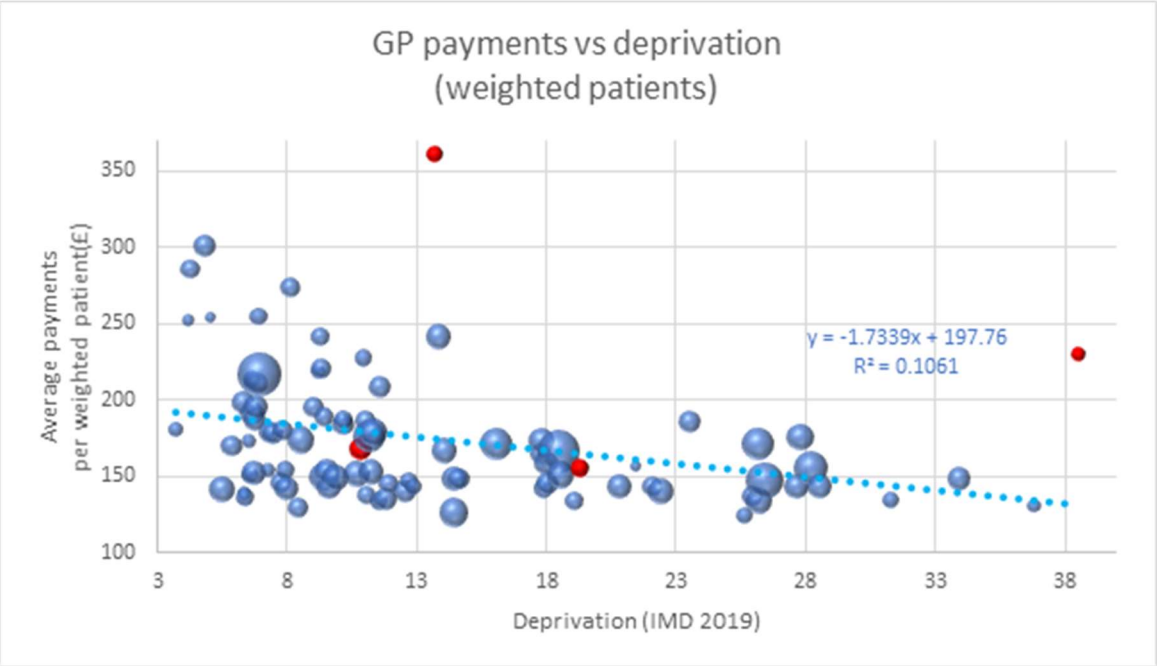
The concept is shown below.



This approach also means that health outcomes for the whole population increase whilst also reducing the inequalities gap.

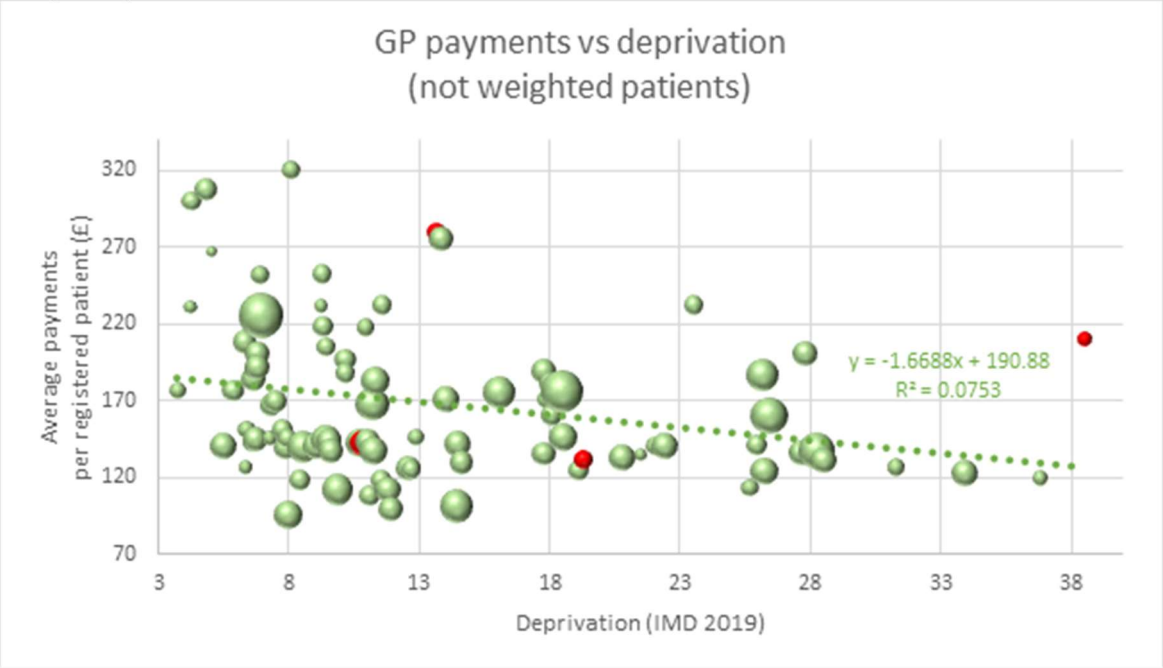
In Cambridgeshire and Peterborough, practices in more deprived areas receive less funding than those in the least deprived areas. The inequality gap in funding per weighted head of population in general practice between practices in the highest and lowest deprivation decile is £57. Figure 18 and Figure 19 show how general practice income is inversely proportionate to need.

Figure 18: Relationship between deprivation and average payments per weighted patient.



Note: Deprivation (IMD 2019) is plotted against the Average payments per weighted patient for GP practices in Cambridgeshire and Peterborough. Higher IMD scores represent higher deprivation. Bubble sizes are proportional to the size of the average number of weighted patients. Weights are calculated based on age and gender, patient need (morbidity and mortality), list turnover, market forces, rurality and patients in nursing or residential homes. For comparison non-weighted data are shown below.

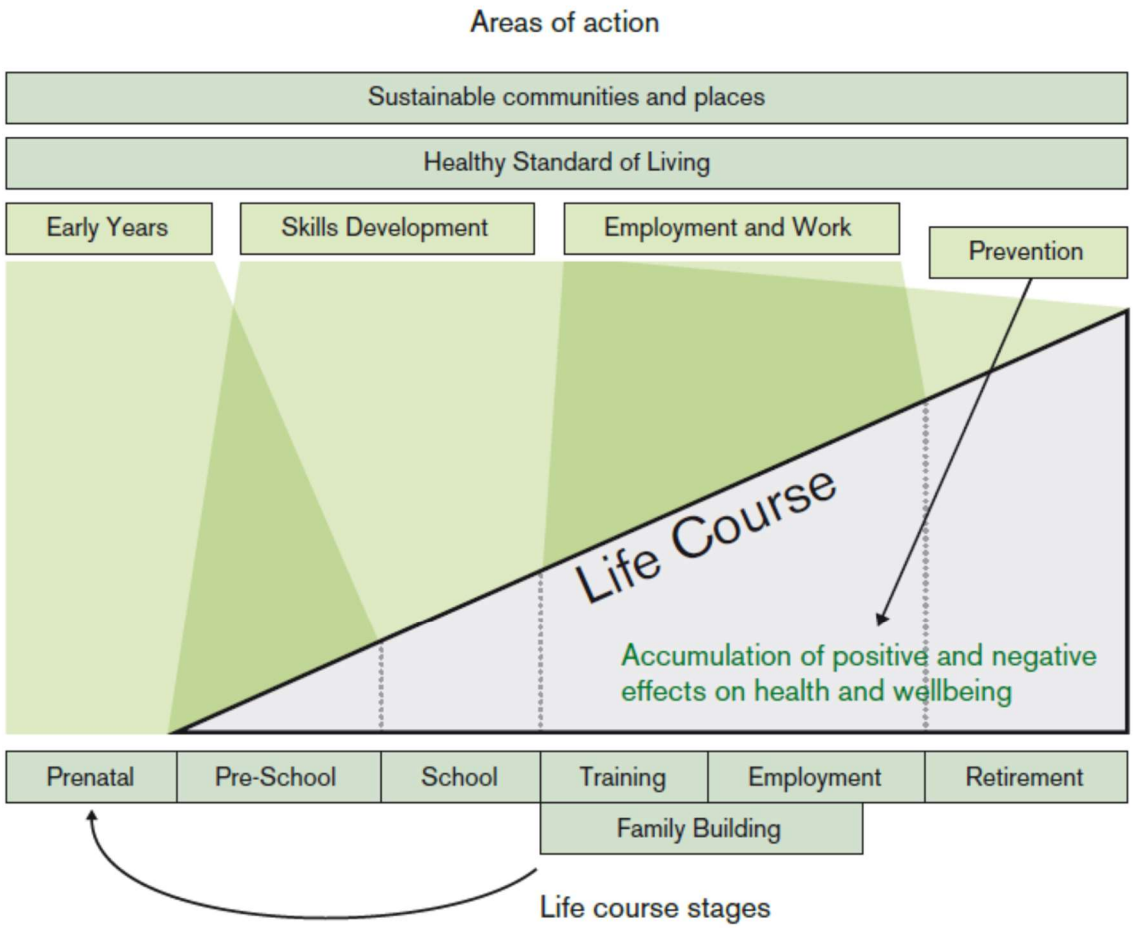
Figure 19: Relationship between deprivation and average payments per patient (non-weighted)



Principle 6: Consider actions at different stages of life

Disadvantage accumulates over the course of a person's life leading to inequalities later in life. This may start before birth if a pregnant mother smokes or uses illicit drugs. Adverse childhood experiences are associated with a number of poor outcomes in later life, such as alcohol abuse, unplanned teenage pregnancy, poor diet and incarceration[9].

The Marmot Review recommends action across the life course to address health inequalities[36]. Specifically, the report's highest priority recommendation is to give every child the best start in life. The action areas across the life course are shown below.



Source: Marmot, M. Fair society, healthy lives: the Marmot Review : strategic review of health inequalities in England post-2010. 2010

The health service can influence several of these stages through direct action (such as improving antenatal care), partnerships (such as improving immunisation coverage in school and pre-school children) and advocacy (such as making the case for increased early years funding).

Principle 7: Harness the community benefits of the Social Value Act

The Social Value Act (2013) requires public sector commissioners, including health sector bodies, to consider the economic, social and environmental wellbeing in procurement of services contracts. The ambition of the act is to get the most value for money from public spending. Creating social value can reduce health inequalities through action on the social determinants of health – for example, by improving employment and housing. Public Health England have described in detail in their report potential areas where public bodies could use the Social Value Act[37].

Actions include employing local residents or target groups such as young unemployed people, building local supply chains, procuring with the voluntary, community and social enterprise (VCSE) sector, working with schools and young people, requiring contractors to pay a living wage and minimising negative environmental impact.

In Cheshire and Merseyside NHS Providers, Local Authorities, Clinical Commissioning Groups (CCGs) and Voluntary, Community, Faith and Social Enterprise sector (VCFSE) organisations have all signed up to a Social Value Charter[38]. The Charter outlines the local vision and principles for maximising the potential of Social Value, including embedding social value across the whole commissioning cycle. In addition to this Cheshire & Merseyside Health & Care Partnership have been successful being one of a group of Social Value Accelerator Sites across the UK. This has included the development of social value champions and networks, increased use of social value measurement tools, such as the National TOMS Frameworks and Social Value Calculator, delivery of Social Value Training and development of Social Value Award/Kite Mark for Anchor Institutions[39].

Monitoring health inequalities

Developing the indicator list

Establishing “health inequalities indicators” is key as we seek to take a systematic, data-driven approach to decision making through benchmarking, monitoring and evaluation. A robust set of indicators will allow the health care system to identify the key inequalities and develop plans to close the inequality gap. A breadth of indicators is important to cover different conditions, service areas and timescales. For example, life expectancy is an important long-term indicator but is affected by many different factors within and outwith the health care system, whereas hypertension treatment is a short-term indicator which would in turn effect long-term indicators, such as early deaths from cardiovascular.

There are numerous socio-economic indicators which could be constructed using the Index of Multiple Deprivation and routinely collected data. The latest Index of Multiple Deprivation data published for 2019 is produced independently by the Ministry of Housing Communities & Local Government and reflects seven different domains of place-based deprivation: income, employment, education, health, crime, barriers to housing and services and living environment. Income and employment make up almost half of the index.

There are various choices to be made when developing local health inequalities indicators and we have made the following decisions:

1. Identification of the main causes of pre-mature mortality and morbidity from the Global Burden of Disease project and mapped possible indicators across five areas: risk factors, access to and use of services, diagnostics, treatment and outcomes.
2. Focus first on socio-economic inequalities using the Index of Multiple Deprivation 2019, with data on disadvantaged and inclusion health groups to follow later
3. Consider WITHIN CCG inequalities, rather than comparing local CCG data with national averages
4. Report indicators, where possible, at the level of action, e.g. diabetes treatment targets would be reported at general practice and Primary Care Network level.
5. For each indicator we would primarily report the inequality gap between the most and least deprived quintile because this would be easier to interpret rather than the slope index of inequalities. However, before reporting the inequality gap we would ensure that each indicator has a socio-economic gradient.

Where possible, we have age-standardised the data to take account of difference in the age structure between practice, but this has not been possible for some of the indicators.

List of health inequality indicators

The following metrics are reported as a within CCG inequality gap between the most and least deprived quintile.

Risk factors

1. Obesity Prevalence (%), 18+ only
2. National Child Measurement Programme, Prevalence of Excess Weight, 2015/16 - 17/18 Average Reception Year
3. National Child Measurement Programme, Prevalence of Excess Weight, 2015/16 - 17/18 Average Year 6
4. Breastfeeding Prevalence (%)

Access to and use of services

1. Directly age-standardised rate of avoidable hospital admissions per 1,000 registered population, all ages
2. Directly age-standardised rate of emergency hospital admissions per 1,000 registered population, 0-4 years only
3. Directly age-standardised rate of emergency department attendances per 100,000 registered population0-4 years only
4. Directly age-standardised rate of emergency hospital admissions per 1,000 registered population, all ages
5. Proportion describing GP Experience as 'Very Good' or 'Fairly Good' in GP Patient Survey, all ages
6. Proportion describing GP Booking Experience as 'Very Good' or 'Fairly Good' in GP Patient Survey, all ages

Diagnostics

1. Directly age-standardised rate of angiography hospital admissions per 100,000 registered population, all ages

Treatment

1. Percentage of patients with type 2 diabetes who meet all 3 National Diabetes Audit treatment targets, all ages
2. Percentage of patients with hypertension in whom last blood pressure reading (in preceding 12 months) is 150/90 mmHg or less, all ages

Outcomes

1. Male Life Expectancy
2. Female Life Expectancy
3. Directly age-standardised rate of mortality from causes considered preventable per 100,000 registered population, all ages
4. Directly age-standardised rate of mortality from causes amenable to healthcare per 100,000 registered population, all ages

5. Directly age-standardised rate of mortality from cardiovascular disease per 100,000 registered population, under 75 years only
6. Directly age-standardised rate of mortality from cancer per 100,000 registered population, under 75 years only
7. Directly age-standardised rate of mortality from respiratory disease per 100,000 registered population, under 75 years only

The inequality gap in Cambridgeshire and Peterborough

Table 1 shows the inequality gap between Cambridgeshire and Peterborough for the basket of health inequalities indicators. The socio-economic gradient is clear for all indicators with people living in more deprived areas having consistently poorer health outcomes across risk factors (obesity), service use (hospital admissions and attendances), satisfaction with general practice, diagnostics (angiography rates), treatment (diabetes and hypertension), pre-mature mortality and life expectancy. Indicators broken down by Primary Care Network are presented in the Appendix.

If we compared a town of 10,000 people who were in the bottom deprivation quintile to a similar town in the top quintile there would be stark differences:

- Of the 125 new mothers each year, 23 fewer would breast feed their babies
- Of the 120 children in reception, 7 more would be overweight and of the 120 children in Year 6, 15 more would be overweight
- 480 more people would be obese
- There would be 75 more avoidable admissions per year and 279 more emergency admissions per year
- Of the 500 children in the town aged 0-4 there would be 43 more emergency admissions and 123 attendances at A+E per year
- 880 fewer people would describe the their GP experience as 'Very Good' or 'Fairly Good' and 1,000 more would describe their GP Booking Experience as 'Very Good' or 'Fairly Good'
- Three fewer people having angiography per year
- Of the 600 people with diabetes, 36 fewer people would be meeting all three diabetes targets per year
- Of the 1200 people with hypertension 42 fewer people would be meeting their blood pressure target per year
- Life expectance would be 4.2 years less in men and 3.6 years less in women
- Every year five extra people would die prematurely from cardiovascular disease, 4 from cancer and 3 from respiratory disease.

Table 1: Inequality gap across Cambridgeshire and Peterborough

Indicator	Deprivation quintiles	Data	Gap	Corr coef	Notes
Obesity	Quintile 1 (Most deprived)	11.4	4.8	0.47	Percentage 18+ only
	Quintile 2	9.6			
	Quintile 3	7.0			
	Quintile 4	8.0			
	Quintile 5 (Least deprived)	6.6			
Excess weight in reception	Quintile 1 (Most deprived)	22.1	6.0	0.54	National Child Measurement Programme, Prevalence of Excess Weight, 2015/16 - 17/18 Average Reception Year
	Quintile 2	20.7			
	Quintile 3	17.4			
	Quintile 4	18.5			
	Quintile 5 (Least deprived)	16.1			
Excess weight in Year 6	Quintile 1 (Most deprived)	36.3	12.4	0.69	National Child Measurement Programme, Prevalence of Excess Weight, 2015/16 - 17/18 Average Year 6
	Quintile 2	31.5			
	Quintile 3	27.5			
	Quintile 4	25.8			
	Quintile 5 (Least deprived)	23.9			
Breast feeding	Quintile 1 (Most deprived)	34.9	18.8	-0.73	Percentage
	Quintile 2	41.9			
	Quintile 3	47.9			
	Quintile 4	53.4			
	Quintile 5 (Least deprived)	53.7			
Avoidable admissions	Quintile 1 (Most deprived)	101.0	7.5	0.65	Directly age-standardised rate of avoidable hospital admissions per 1,000 registered population, all ages
	Quintile 2	96.1			
	Quintile 3	84.7			
	Quintile 4	79.9			
	Quintile 5 (Least deprived)	73.0			
Emergency admissions	Quintile 1 (Most deprived)	101.0	27.9	0.42	Directly age-standardised rate of emergency hospital admissions per 1,000 registered population, all ages
	Quintile 2	96.1			
	Quintile 3	84.7			
	Quintile 4	79.9			
	Quintile 5 (Least deprived)	73.0			
0-4 year old emergency admissions	Quintile 1 (Most deprived)	197.3	85.3	0.38	Directly age-standardised rate of emergency hospital admissions per 1,000 registered population, 0-4 years only
	Quintile 2	172.1			
	Quintile 3	152.8			
	Quintile 4	113.4			
	Quintile 5 (Least deprived)	112.0			
	Quintile 1 (Most deprived)	658.0	247.4	0.73	Directly age-standardised rate of emergency

0-4 year old emergency attendances	Quintile 2	534.0			department attendances per 1,000 registered population, 0-4 years only
	Quintile 3	437.6			
	Quintile 4	460.5			
	Quintile 5 (Least deprived)	410.6			

	Better than CCG C&P average		Worse than CCG C&P average		No different from CCG C&P average

Corr Coef = correlation coefficient. As values approach 1 there is a positive correlation (as deprivation increases, the indicator increases) and as values approach -1 there is a negative correlation (as deprivation increases, the indicator value decreases).

Table 1 (continued)

Indicator	Deprivation quintiles	Data	Gap	Corr coef	Notes
Good GP experience	Quintile 1 (Most deprived)	79.8	8.8	-0.52	Proportion describing GP Experience as 'Very Good' or 'Fairly Good' in GP Patient Survey, all ages
	Quintile 2	80.4			
	Quintile 3	85.7			
	Quintile 4	88.3			
	Quintile 5 (Least deprived)	88.6			
Good GP booking experience	Quintile 1 (Most deprived)	67.6	10.0	-0.39	Proportion describing GP Booking Experience as 'Very Good' or 'Fairly Good' in GP Patient Survey, all ages
	Quintile 2	67.7			
	Quintile 3	75.2			
	Quintile 4	76.3			
	Quintile 5 (Least deprived)	77.6			
Angiography	Quintile 1 (Most deprived)	193.6	28.8	0.21	Directly age-standardised rate of angiography hospital admissions per 100,000 registered population, all ages
	Quintile 2	179.8			
	Quintile 3	165.5			
	Quintile 4	195.1			
	Quintile 5 (Least deprived)	164.8			
Meeting all three diabetes targets	Quintile 1 (Most deprived)	32.5	6.5	-0.25	Percentage of patients with type 2 diabetes who meet all 3 National Diabetes Audit treatment targets, all ages
	Quintile 2	35.1			
	Quintile 3	37.0			
	Quintile 4	35.0			
	Quintile 5 (Least deprived)	39.0			
Hypertensive patients meeting BP target	Quintile 1 (Most deprived)	76.1	5.1	-0.30	% of patients with hypertension in whom last blood pressure reading (in preceding 12mths) is ≤ 150/90 mmHg, all ages
	Quintile 2	77.0			
	Quintile 3	79.0			
	Quintile 4	80.8			
	Quintile 5 (Least deprived)	81.2			

Male Life Expectancy	Quintile 1 (Most deprived)	79.1	4.2	-0.59	Years
	Quintile 2	79.9			
	Quintile 3	82.3			
	Quintile 4	82.5			
	Quintile 5 (Least deprived)	83.3			
Female Life Expectancy	Quintile 1 (Most deprived)	82.9	3.6	-0.55	Years
	Quintile 2	82.7			
	Quintile 3	85.2			
	Quintile 4	84.8			
	Quintile 5 (Least deprived)	86.5			
Premature cardiovascular mortality	Quintile 1 (Most deprived)	86.4	49.8	0.51	Directly age-standardised rate of mortality from cardiovascular disease per 100,000 registered population, < 75 years
	Quintile 2	69.2			
	Quintile 3	51.8			
	Quintile 4	56.3			
	Quintile 5 (Least deprived)	36.6			

	Better than CCG C&P average		Worse than CCG C&P average		No different from CCG C&P average

Corr Coef = correlation coefficient. As values approach 1 there is a positive correlation (as deprivation increases, the indicator increases) and as values approach -1 there is a negative correlation (as deprivation increases, the indicator value decreases).

Table 1 (continued)

Indicator	Deprivation quintiles	Data	Gap	Corr coef	Notes
Premature cancer mortality	Quintile 1 (Most deprived)	139.3	38.5	0.53	Directly age-standardised rate of mortality from cancer per 100,000 registered population, under 75 years only
	Quintile 2	121.1			
	Quintile 3	112.6			
	Quintile 4	106.4			
	Quintile 5 (Least deprived)	100.8			
Premature respiratory mortality	Quintile 1 (Most deprived)	41.7	25.0	0.50	Directly age-standardised rate of mortality from respiratory disease per 100,000 registered population, < 75 years
	Quintile 2	32.1			
	Quintile 3	26.6			
	Quintile 4	18.3			
	Quintile 5 (Least deprived)	16.6			
Preventable mortality	Quintile 1 (Most deprived)	198.1	91.6	0.28	Directly age-standardised rate of mortality from causes considered preventable per 100,000 registered population, all ages
	Quintile 2	166.2			
	Quintile 3	133.9			
	Quintile 4	133.5			

	Quintile 5 (Least deprived)	106.5			
Mortality amenable to health care	Quintile 1 (Most deprived)	138.7	79.9	0.57	Directly age-standardised rate of mortality from causes amenable to healthcare per 100,000 registered population, all ages
	Quintile 2	106.7			
	Quintile 3	89.0			
	Quintile 4	87.4			
	Quintile 5 (Least deprived)	58.8			

	Better than CCG C&P average		Worse than CCG C&P average		No different from CCG C&P average

Corr Coef = correlation coefficient. As values approach 1 there is a positive correlation (as deprivation increases, the indicator increases) and as values approach -1 there is a negative correlation (as deprivation increases, the indicator value decreases).

Future indicators

There are several indicators that we wanted to include but were unable to for data availability reasons. Our hope is that these will be included in future health inequalities monitoring.

- Total number of COVID deaths in the community
- Unplanned hospital admissions for stroke per 100,000 per month
- Number of inpatient, day-case and outpatient elective procedures per 100,000 population per week compared to same time last year
- Patients screened for breast cancer in last 36 months, aged 50-70
- Patients attending a cervical screening within target period
- Patients aged 60-74 screened for bowel cancer in last 30 months
- Last stage cancer diagnosis
- Physical health check delivery, where individual has severe mental illness
- Smoking status at time of delivery
- Smokers that have successfully quit at 4 weeks
- Emergency admissions as a result of fatty liver disease
- School readiness
- Percentage of 5 year olds with tooth decay
- Health checks delivered where individual CVD risk score was 20%+
- Premature deaths from all causes at age 75 or under

Furthermore tuberculosis, opioid use, HIV, psychoactive drug use and viral hepatitis are particularly associated with the greatest socio-economic inequality in pre-mature mortality[40]. These conditions are intrinsically linked with deprivation and should be considered in future inequalities monitoring.

At present we do not have inequality gap for disadvantaged and inclusion health group, primarily because of data availability issues. We also do not have inequality indicators related to end of life care and only limited data on mental health. These should be considered in future health inequalities indicator lists.

Priority areas of recommendation for the STP and CCG

Based on a review of national guidance and local data, and congruent with local authority Joint Strategic Needs Assessment and the Health and Wellbeing Board Strategy, we recommend the following three areas for priority action.

1. Working across the system to reduce health inequalities

A whole health care systems approach to address health inequalities is needed. Through the collective efforts of everyone across all organisations and work programmes we can move towards an equity-focussed health care system. To achieve this, we propose three key actions:

a. Establish a Health Care System Inequalities Group to monitor and drive action on health inequalities

Considerable progress has been made across the system to address health inequalities. There is a need to galvanise the momentum and drive forward to ambitions of this strategy

.

- We recommend that a system-wide group is established to monitor health inequalities data, promote the use of the Guiding Principles and deliver the implementation plan. The group could report to the Joint Clinical Group. The group would also be able to further develop the health inequalities indicators, respond to emerging evidence and develop recommendations, especially around BAME inequalities and mental health impacts.

b. Promote awareness of the Guiding Principles and embed them in commissioning and delivering of services across all STP partners

The Guiding Principles are based on national and international recommendations on how health care systems can address health inequalities. They clearly show what the NHS can do to reduce health inequalities and have implications for every part of the health care system.

- We recommend the endorsement of the 7 Guiding Principles within the STP and a widespread communications and publicity campaign to raise awareness across health care commissioners and decision makers. The Guiding Principles would also be useful to scrutinise, and where necessary modify, local health care plans and decisions to reduce inequalities.

c. Increase the use of Health Inequality Impact Assessment (HIIA)

In their NHSE-commissioned report on Reducing Health Inequalities through New Models of Care, the Institute of Health Equity recommend that HIIAs are undertaken as an integral part of policy development and decision making to reduce health inequalities. The process includes screening to identify if HIIA is appropriate, scoping

the impact on inequalities, assessing the risks and benefits, developing recommendations and evaluation. HIIA should be undertaken in a meaningful way for all major commissioning and health care decisions, complemented by the Guiding Principles. The process should then be proportionate to the decision being made.

- We recommend that HIIA are embedded across the health care system and all organisations, including assessing the impact on BAME[iii] groups. We recommend that commissioners and health care staff undertake a HIIA screening for all business plans and commissioning plans that affect patient care. A draft SOP[iv] is shown in the appendix.
- We recommend that the disadvantaged and inclusion health groups are prioritised in light of COVID-19 and actions taken to ensure that they have access to health care and adopting actions, such as the Safe Surgery initiative.

d. Address inequalities in workforce distribution

To deal fairly with the backlog of NHS care and ensure that inequalities are not exacerbated, there needs to be a more equal distribution of the workforce across Cambridgeshire and Peterborough. Currently for a 20 bedded-ward in CUH there would be 30 doctors, 13 consultants and 64 nurses, whereas in NWAFT there would be only 17 doctors, 7 consultants and 37 nurses. While some of this disparity may be explained by academic clinical staff and research nurses and out-patient and day case activity, there is likely to be a substantial inequality, especially since academic staff have been increasing their clinical time. In primary care there is a socio-economic gradient in GPs, with the most deprived practices having on average 1.5 fewer FTE GPs per 10,000 patients than the least deprived (Figure 6). However, this is compensated in part by more nurses where practices in deprived areas have about 1.5 more FTE nurses than less deprived areas. Inequalities in the distribution of the workforce will lead to inequalities in the number of procedures, quality of care and clinical outcomes.

- We therefore recommend a system-wide workforce plan should be expedited, with recommendations for addressing geographic workforce imbalances. Further consideration of joint appointments between CUHFT, RPHFT, CPFT and NWAFT should be actively pursued.

2. Addressing inequalities through needs-based commissioning for outcomes

Financial leverage is a key factor in addressing health inequalities. A recent study found that allocating NHS funding proportionate to need over a seven year period reduced inequalities in amendable mortality[41]. Currently general practices income is inversely proportionate to need, with the practices in the most deprived areas receiving less income than those in the least deprived. This makes it much harder for these practices to improve services and treatment targets.

[iii] Black, Asian, and Minority Ethnic
[iv] Standard Operating Procedure

a. Allocate discretionary funding proportionate to need

To help close the health gap between the most affluent and disadvantaged areas of the CCG, there is a need to allocate greater resources to those areas with greatest need. Arguable this is a fairer distribution of resources, rather than allocating per head of population which does not take into account population need. Allocating based on need is in line with one of the six recommendations of the Marmot review which states that services should be accessible to all but the intensity of the service should be proportionate to need with the most disadvantaged receiving more resource. The Index of Multiple Deprivation is an objective, independent measure of deprivation and should be used, where appropriate, to allocate resources.

- We recommend allocating funding and resources based weighted for deprivation, such as the Index of Multiple Deprivation. This approach has already been used for the Diabetes Locally Enhanced Service and should be rolled out further.

b. Allocate elective care based on need

The lockdown has created a large backlog of elective procedures. During the period from 23rd March to 5th May last year, there were 31,341 elective procedures of which, 25,740 were day case procedures. Assuming there is a similar number of procedures this year, there could be a backlog of about 25,000 day elective procedures and 6,000 inpatient elective admissions. Based on last year's data from across Cambridgeshire and Peterborough, we know that there is a substantial inequality in elective procedures. There is a risk that as elective services resume inequalities are further increased if patients in the south of the patch have better access to elective procedures.

- We recommend that the provision of elective care should be considered from a health system level, based on clinical need using objective prioritisation criteria

3. Addressing inequalities in cardiovascular disease through targeted action on hypertension and diabetes

To prioritise health outcome inequalities, we recommend using the modelling by Lewer and colleagues published in the Lancet Public Health in 2019[v]. The authors estimate the excess mortality attributable to socio-economic inequalities based on Index of Multiple Deprivation for both the conditions with the strongest link to socio-economic status and the conditions with the largest overall impact. Based on this data for Cambridgeshire and Peterborough, the condition contributing most to inequalities is ischemic heart disease (Appendix 3).

Circulatory disease causes 42% of the inequality gap in life expectancy in Peterborough in men – our emphasis should start there. The inequality gap for cardiovascular disease premature mortality is greater than for any other major

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[1] Lewer, Dan et al. Premature mortality attributable to socioeconomic inequality in England between 2003 and 2018: an observational study The Lancet Public Health, Volume 5, Issue 1, e33 - e41

condition. This gap is driven by risk factors, such as smoking, hypertension and diabetes. In the Global Burden of Disease Study[42] hypertension was the cause of 11% of all years of life lost and second only to smoking.

a. Reduce inequalities in hypertension management in primary care

The cost to NHS in England from conditions attributable to high blood pressure has been estimated to be £2 billion[43]. In Cambridgeshire and Peterborough STP, it is estimated that optimising treatment of patients with hypertension would prevent 150 heart attacks and 230 strokes over 3 years, with a combined health and care saving of £4.5 million over that period. The Cambridgeshire and Peterborough Prevention Strategy prioritises identifying the number of people with hypertension and improving their care and the CCG Hypertension Case for Change includes working with clinical pharmacists to carry out quality improvement projects, increased use of the CCG's new medicine service, promotion of patient self-monitoring, and also to work with the local 'Know Your Numbers' campaign and increase referrals to healthy lifestyle service providers.

- We recommend that in those five Early Adopter PCNs target identification of hypertension and other cardiovascular risk factors using ECLIPSE data with the aim of reducing the inequality gap in hypertension control by 50%; equivalent to an improvement from 76.1% to 78.6% in the most deprived practices.
- We recommend the use of primary care equity audits using ECLIPSE to identify the key health care inequalities in cardiovascular disease management for inequalities relating to socio-economic status and minority ethnic groups.

b. Reduce inequalities in diabetes care in primary care

The Cambridgeshire and Peterborough STP Diabetes and Obesity Strategy identified addressing health inequalities as a key target. Early Adopter PCNs have been identified, with clinical leaders, and an introduction of Eclipse data with a management plan for call/recall of cases not achieving their three treatment targets.

- We recommend that the Diabetes Early Adopter sites are combined with cardiovascular initiatives to reduce the inequality gap in achievement of the diabetes three treatment targets by 50% whilst also improving the performance across the patch; this would mean supporting practices in the least deprived areas to increase achievement by 1.1% (from 39.0% to 40.1%) and practices in the most deprived areas by 4.4% (from 32.5% to 36.9%). The actions set out in the Diabetes and Obesity Strategy are targeted to reduce the inequality gap. Such support would require resource re-distribution for practices in more deprived areas. An example methodology of how such investment could be allocated according to deprivation is in Appendix 4.
- We recommend the use of primary care equity audits using ECLIPSE to identify the key health care inequalities in diabetes management for inequalities relating to socio-economic status and minority ethnic groups and inclusion groups that address the differences in their health outcomes

We have a moral, legal and economic imperative to address health inequalities across Cambridgeshire and Peterborough. Concerted action across the whole health care system is needed to help us improve the health of everyone while also reducing the inequality gaps that persist.

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Appendix 1: Excess mortality due to socio-economic inequalities by major condition from 2003 -2018 for Cambridgeshire and Peterborough

Condition	Expected deaths based on socio-economic profile	Observed deaths	Proportion of deaths due to inequalities	Number of deaths due to inequalities
Ischaemic heart disease	2685	4060	34%	1375
COPD	662	1450	54%	789
Cancers: respiratory	1844	2803	34%	959
Drugs, alcohol and other or vehicle accidents	764	1312	42%	548
Other cardiovascular	867	1384	37%	517
Other external causes	793	1118	29%	325
Nervous system	1009	1320	24%	311
Other forms of heart disease	529	786	33%	258
Other digestive diseases	540	787	31%	247
Liver disease	646	899	28%	253
Other respiratory	387	593	35%	206
Flu & pneumonia	413	631	35%	219
Stroke	994	1247	20%	253
Neonatal	298	427	30%	129
Cancers: other	3460	3767	8%	307
Cancers: breast	1180	1059	-11%	-121
Cancers: digestive	3228	3479	7%	251
Cancers: lympoid/haematopoietic	999	1090	8%	92
Cancers: female genital	671	713	6%	42
Other	1407	2380	41%	973

Source; Lewer, Dan et al. Premature mortality attributable to socioeconomic inequality in England between 2003 and 2018: an observational study The Lancet Public Health, Volume 5, Issue 1, e33 - e41 and online tool here https://public.tableau.com/profile/rob.aldridge#!/vizhome/MATI_19_11_25/MATI_dashboard

Appendix 2: Health inequalities metrics at PCN level

Primary care network name	IMD Score 2019	Male Life Expectancy 2015-2017	Female Life Expectancy 2015-2017	Mortality rate from preventable causes per 100,000 2016-2018*	Mortality rate from healthcare amenable causes per 100,000 2016 - 2018*	Cardiovascular mortality rate per 100,000, 2016-2018, under 75 years only*	Cancer mortality rate per 100,000, 2016-2018, under 75 years only*	Respiratory disease mortality rate per 100,000, 2016-2018, under 75 years only*	Rate of avoidable hospital admissions per 1,000, 2018-2019*	Rate of emergency hospital admissions per 1,000, 2018-2019, 0-4 years only*	Rate of emergency hospital admissions per 1,000, 2018 – 2019*	Rate of angiography hospital admissions per 100,000, 2016 – 2019*	Rate of emergency attendances per 100,000, 2018- 2019, 0-4 years only*
Central & Thistlemoor	35.0	79.9	84.0	187.6	123.7	101.0	123.8	26.3	21.3	169.3	92.8	248.9	618.9
Octagon Wisbech	32.1	78.2	82.8	217.6	155.0	87.3	150.0	47.9	27.6	206.3	125.6	146.1	615.7
BMC Paston	29.8	79.8	83.0	205.0	144.4	93.2	142.7	36.8	20.9	206.6	99.1	191.8	694.8
Octagon North	28.0	78.9	82.4	184.5	129.1	80.9	128.0	40.1	18.4	195.3	87.5	200.6	644.0
Peterborough Partnerships	27.9	79.5	82.9	182.9	125.7	87.8	158.3	38.2	20.6	183.4	94.9	193.0	768.6
Fenland	22.1	79.8	82.8	178.8	126.7	71.4	135.5	49.6	25.4	289.7	118.5	184.0	566.1
Cambridge City	19.9	78.3	81.7	183.7	118.9	77.4	119.1	24.7	21.3	67.3	99.4	222.5	470.1
South Peterborough	16.9	82.1	85.3	139.0	83.9	55.5	116.3	24.6	16.0	198.5	82.4	189.2	551.7
South Fenland	16.7	80.9	83.2	168.1	104.6	67.3	130.7	24.9	20.2	236.7	98.9	184.8	500.0
Huntingdon	15.9	79.7	82.6	163.8	106.6	69.5	123.5	42.5	23.1	262.4	107.6	138.3	425.0
Ely North	12.6	82.8	85.8	145.2	95.2	61.2	109.7	21.6	16.6	67.7	84.6	214.4	525.0
Cantab	12.5	83.9	86.1	104.4	73.2	45.4	71.9	18.0	13.4	56.7	63.2	156.6	417.0
Ely South	12.0	82.5	86.3	154.5	104.2	75.3	100.9	20.7	16.0	96.8	78.0	209.8	479.3
Cambridge City 4	11.8	81.3	83.5	151.9	101.0	51.9	135.2	23.2	17.1	76.5	81.7	225.8	487.4
St Neots	11.7	81.5	84.6	146.1	92.4	55.2	132.7	32.4	19.8	182.4	96.8	133.9	373.3
Cam Medical	11.3	84.4	87.4	98.5	62.2	35.3	98.6	17.3	12.3	68.7	96.8	135.3	474.9
A1 Network	10.4	82.6	85.7	114.1	63.9	39.5	96.1	15.3	16.7	231.4	60.1	123.8	374.1
St Ives	10.0	83.7	86.6	103.2	58.4	39.6	92.3	15.1	18.8	223.8	90.2	122.8	370.3
Meridian	8.4	83.7	86.3	111.0	58.8	39.6	97.7	17.6	14.4	72.4	75.2	192.6	402.1
Granta	8.3	83.1	86.6	115.9	72.2	35.6	97.8	18.0	13.5	62.5	67.7	197.8	451.6
Cambs Northern Villages	7.9	82.6	85.6	109.2	73.3	45.4	103.4	23.0	14.9	83.9	78.1	188.9	454.9

*Directly age standardised rate

Primary care network name	IMD Score 2019	Obesity Prevalence (%), 2018-19, 18+ only	Patients with type 2 diabetes who meet all 3 treatment targets, 2018-19 (%)	Patients with hypertension in whom last blood pressure reading (in preceding 12 months) is 150/90 mmHg or less, 2018-19 (%)	Proportion describing GP Experience as 'Very Good' or 'Fairly Good' in National GP Survey 2019	Proportion describing GP Booking Experience as 'Very Good' or 'Fairly Good' in National GP Survey 2019
Central & Thistlemoor	35.0	8.4	42.1	82.9	82.5	79.1
Octagon Wisbech	32.1	12.2	31.1	79.2	83.0	69.4
BMC Paston	29.8	15.6	32.5	81.7	77.9	61.4
Octagon North	28.0	10.3	30.6	80.9	76.0	63.0
Peterborough Partnerships	27.9	8.9	32.7	79.4	73.3	65.7
Fenland	22.1	13.8	37.2	82.2	82.3	67.4
Cambridge City	19.9	7.4	36.4	80.3	84.3	72.1
South Peterborough	16.9	9.5	35.8	80.3	81.8	63.3
South Fenland	16.7	13.8	34.6	78.4	80.7	71.0
Huntingdon	15.9	9.9	33.4	89.5	86.7	73.9
Ely North	12.6	10.3	37.5	86.2	91.4	77.8
Cantab	12.5	3.3	37.3	86.4	84.9	75.8
Ely South	12.0	9.7	39.7	83.2	87.0	76.7
Cambridge City 4	11.8	5.3	39.8	80.5	82.1	72.5
St Neots	11.7	8.1	32.2	82.3	80.6	64.8
Cam Medical	11.3	2.7	37.4	84.5	86.5	88.8
A1 Network	10.4	8.3	32.6	85.9	92.0	84.5
St Ives	10.0	8.2	33.0	82.1	90.0	79.9
Meridian	8.4	6.6	40.4	84.7	90.6	77.3
Granta	8.3	8.8	39.4	81.6	85.6	64.4
Cambs Northern Villages	7.9	7.1	39.7	84.3	88.3	75.8

Appendix 3: Excess mortality due to socio-economic inequalities by major condition from 2003 -2018 for Cambridgeshire and Peterborough

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Cancers: female genital	671	713	6%	42
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Source; Lewer, Dan et al. Premature mortality attributable to socioeconomic inequality in England between 2003 and 2018: an observational study The Lancet Public Health, Volume 5, Issue 1, e33 - e41 and online tool here https://public.tableau.com/profile/rob.aldridge#!/vizhome/MATI_19_11_25/MATI_dashboard

Appendix 4: Allocating proportionate to need

3. How to measure need – Index of Multiple Deprivation 2019

- There are several different ways of measuring "need", such as disease burden or health care use. However, these can miss undiagnosed disease or reflect health system behaviour rather than the underlying need. The latest Index of Multiple Deprivation (IMD) data published for 2019 is produced independently by the Ministry of Housing Communities & Local Government and reflects seven different domains of place-based deprivation.
- The IMD is published every 4-5 years, with the latest version published in 2019. The seven domains are income, employment, education, health, crime, barriers to housing and services and living environment. Income and employment make up 45% of the index, with health 13.5%.
- The health domain is made of four indicators:
    - Years of potential life lost: An age and sex standardised measure of premature death defined as death before the age of 75 from any cause (27.1% contribution)
    - Comparative illness and disability ratio: An age and sex standardised morbidity/disability ratio based on those receiving benefits due to inability to work through ill health (30% contribution)
    - Acute morbidity: An age and sex standardised rate of emergency admission to hospital (25.6% contribution)
    - Mood and anxiety disorders: A composite based on the rate of adults suffering from mood and anxiety disorders, derived from hospital episodes data, prescribing data and suicide mortality data (17.2% contribution)
- A score and rank are given to each Lower Super Output Area in England (geographic areas of about 1,500 population).

4. How to allocate proportionate to need

There are three key discussion points on how to allocate funding to PCNs:

- Should funding be weighted by PCN population size or not?
    - Each PCN could be allocated the same funding irrespective of size or we could give larger PCNs proportionally more and smaller PCNs less. The smallest PCN is about 30,000 and the largest about 94,000 therefore weighting based on population size makes a considerable difference.
    - If population size is not considered, the difference per head of population varies by over £1 between the largest and smallest PCN (from £0.51 per head in the largest PCN to £1.57 in the smallest)

- Should total IMD or just the health domain be used?
    - There are arguments for both; total IMD takes into account the factors which drive health and health inequalities such as the employment, education and living environment, but the health domain more accurately reflects the health needs of the population. Here we propose

that the total IMD score is used because there is only a small variation in health domain scores across PCNs meaning that, if we use health domain alone, any allocation is mostly driven by PCN size rather than need.
    - The difference between using only PCN size and PCN size with health domain scores results in only an additional £4.5k for the most deprived PCN and £4k less for the most affluent PCN.
    - We should note that one issue with the IMD score is that two areas can have a similar IMD score, but deprivation may look different. For example, a rural and urban area with the same deprivation score may have a different deprivation profile. This may in turn effect issues such as recruitment of health care staff in rural deprived areas, compared to urban deprived areas.

- Should individual scores or ranks be used?
    - Scores are more sensitives than ranks because small differences in scores can result in big differences in ranks.
    - For example, the difference in IMD score between Meridian and Granta PCNs is 0.1 and they are ranked 1 place apart. However, the IMD score difference between Peterborough Partnerships and Fenland PCNs is 5.8, but are also ranked 1 place apart.

The calculation is as follows using IMD score weighted by population as an example.

- First, each individual patient in their respective PCN is allocated a score based on the IMD for that PCN.
- These are then totalled across all patients from all PCNs to give the total burden for all patients.
- Then to calculate the proportion of available resource to allocate to a certain PCN, an IMD score is once again allocated to each individual in a given PCN, added together to give a total burden for each PCN and this is divided by the total burden for all PCNs to give a proportion.
- The PCN is then allocated this proportion of funding from the total available.
- This can also be expressed in the following formula

$$a = \frac{b_z \times c_z}{\sum(a_i \times b_i)} \times d$$

a = allocation for PCN ‘z’
b_z = population for PCN ‘z’
c_z= IMD score for PCN ‘z’

$\sum(a_i \times b_i)$ = sum of all PCN populations multiplied by their IMD scores
d = total funding available

5. Example of how allocating proportionate to need would impact on a hypothetical £1million fund

Here we use a **hypothetical** total fund of £1million to illustrate the differences.

- Based on the above, the best option appears to weight according to PCN population size (decision 1), use the total IMD rather than health domain (decision 2) and use score rather than the rank (decision 3).
- The table shows the difference between using this method and what we do currently which is allocating funds weighted by population size with a total resource allocation of £1million.

Table 2: Allocation by PCN according to deprivation using different indices to weight the allocation

PCN Name	Total Registered Population Apr'19	Index of Multiple Deprivation 2019 Score	Health domain of IMD 2019*	CURRENT Allocation just weighted on PCN size		PROPOSED Allocation based on IMD score and population	
				Total	Per head	Total	Per head
Central and Thistlemoor	38,286	35.0	10.6	£38,924	£1.02	£77,832	£2.03
Octagon Wisbech	50,424	32.1	10.7	£51,265	£1.02	£94,093	£1.87
BMC Paston	39,588	29.8	10.5	£40,248	£1.02	£68,569	£1.73
Octagon North	94,011	28.0	10.4	£95,579	£1.02	£153,227	£1.63
Peterborough Partnerships	40,356	27.9	10.4	£41,029	£1.02	£65,349	£1.62
Fenland	30,444	22.1	10.4	£30,952	£1.02	£39,040	£1.28
Cambridge City	50,456	19.9	9.9	£51,297	£1.02	£58,265	£1.15
South Peterborough	67,343	16.9	9.8	£68,466	£1.02	£66,153	£0.98
South Fenland	30,355	16.7	9.9	£30,861	£1.02	£29,394	£0.97
Huntingdon	43,760	15.9	9.7	£44,490	£1.02	£40,344	£0.92
Ely North	37,855	12.6	9.1	£38,486	£1.02	£27,783	£0.73
Cantab	49,998	12.5	9.4	£50,832	£1.02	£36,231	£0.72
Ely South	36,634	12.0	9.1	£37,245	£1.02	£25,504	£0.70
Cambridge City 4	56,400	11.8	9.4	£57,341	£1.02	£38,616	£0.68
St. Neots	53,511	11.7	9.3	£54,403	£1.02	£36,371	£0.68
Cam Medical	46,457	11.3	8.9	£47,232	£1.02	£30,407	£0.65
A1 Network	33,329	10.4	9.2	£33,885	£1.02	£20,198	£0.61
St. Ives	46,191	10.0	9.2	£46,961	£1.02	£26,740	£0.58
Meridian	48,323	8.4	8.9	£49,129	£1.02	£23,624	£0.49
Granta	43,001	8.3	8.8	£43,718	£1.02	£20,629	£0.48
Cambs Northern Villages	46,875	7.9	8.9	£47,657	£1.02	£21,628	£0.46

Appendix 4

Health Equity in England. The Marmot Report 10 years on

https://www.health.org.uk/sites/default/files/upload/publications/2020/Health%20Equity%20in%20England_The%20Marmot%20Review%2010%20Years%20On_full%20report.pdf

Summary of recommendations

Recommendations for Giving Every Child the Best Start in Life:

- Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.
- Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
- Improve availability and quality of early years services, including Children's Centres, in all regions of England.
- Increase pay and qualification requirements for the childcare workforce.

Recommendations for Enabling all Children, Young People and Adults to Maximise their Capabilities and Have Control over their Lives

- Put equity at the heart of national decisions about education policy and funding.
- Increase attainment to match the best in Europe by reducing inequalities in attainment.
- Invest in preventative services to reduce exclusions and support schools to stop off-rolling pupils.
- Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).

Recommendations for Creating Fair Employment and Good Work for All

- Invest in good quality active labour market policies and reduce conditionalities and sanctions in benefit entitlement, particularly for those with children.
- Reduce in-work poverty by increasing the National Living Wage, achieving a minimum income for healthy living for those in work.
- Increase the number of post-school apprenticeships and support in-work training throughout the life course.
- Reduce the high levels of poor quality work and precarious employment.

Recommendations for Ensuring a Healthy Standard of Living for All

- Ensure everyone has a minimum income for healthy living through increases to the National Living Wage and redesign of Universal Credit.
- Remove sanctions and reduce conditionalities in welfare payments.

• Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy.

• Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.

• Review the taxation and benefit system to ensure it achieves greater equity and ensure effective tax rates are not regressive.

Recommendations to Create Healthy and Sustainable Places and Communities

• Invest in the development of economic, social and cultural resources in the most deprived communities

• 100 percent of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector

• Aim for net zero carbon emissions by 2030 ensuring inequalities do not widen as a result

Recommendations for taking action

• Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health.

• Ensure proportionate universal allocation of resources and implementation of policies.

• Early intervention to prevent health inequalities.

• Develop the social determinants of health workforce.

• Engage the public.

• Develop whole systems monitoring and strengthen accountability for health inequalities

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 6
7 DECEMBER 2020	PUBLIC REPORT

Report of:	Wendi Ogle-Welbourn, Executive Director, People and Communities	
Cabinet Member(s) responsible:	Cllr Irene Walsh, Cabinet Member for Communities	
Contact Officer(s):	Adrian Chapman, Service Director, Adults and Communities	07920 160441

PETERBOROUGH COMMUNITY RESILIENCE GROUP (CRG) HUB AND OUTBREAK MANAGEMENT UPDATE

RECOMMENDATIONS	
FROM: Executive Director, People and Communities	**Deadline date: N/A**
It is recommended that Health and Wellbeing Board members note and comment on the progress of the Peterborough Hub and Outbreak Management activity.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request from Wendi Ogle-Welbourn, Executive Director, People and Communities.

2. PURPOSE AND REASON FOR REPORT

2.1 This report is being presented to update Health and Wellbeing Board members on key activity of the Peterborough Hub and Outbreak Management response.

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

2.8.2.1 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**

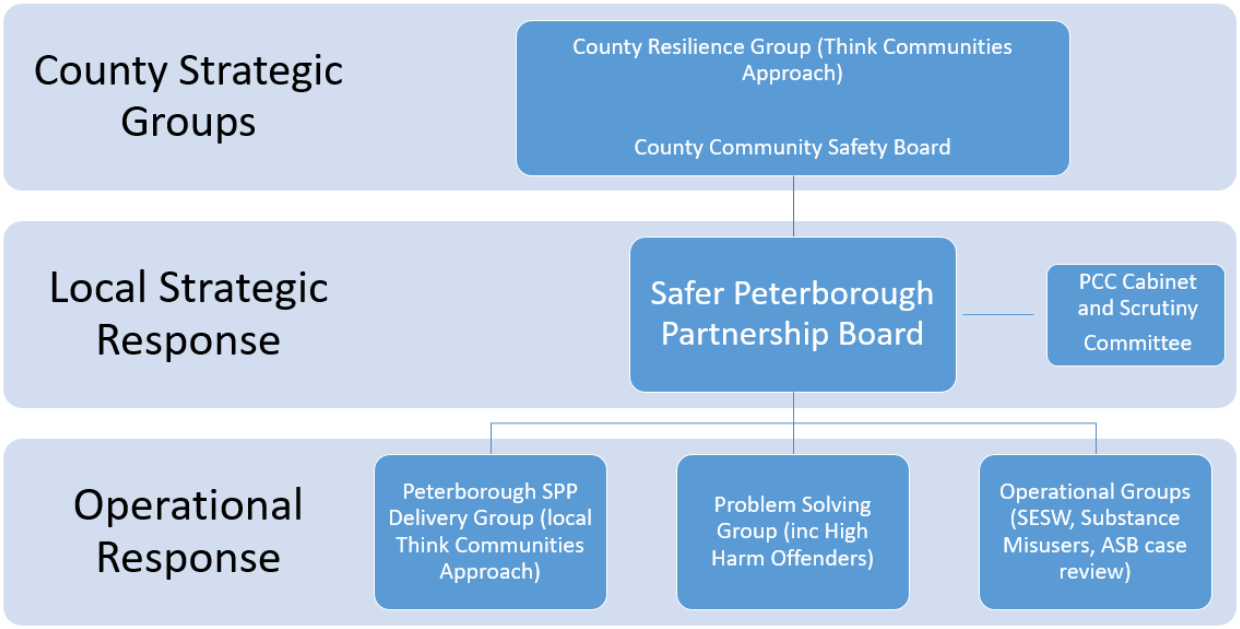
4. BACKGROUND AND KEY ISSUES

4.1 **PETERBOROUGH COMMUNITY RESILIENCE GROUP (CRG) HUB**

4.1.1 As part of the response to the COVID-19 emergency, the Government instructed every Local Resilience Forum (LRF) area to establish local hubs. Hubs are required to provide targeted support for those people who require support in dealing with COVID-19.

4.1.2 The Peterborough Local CRG, which coordinates the local hub, comprises representatives from the public, private, voluntary, independent and faith sectors involved in the response to the COVID-19 public health emergency.

4.1.3 The Safer Peterborough Partnership (SPP) leads the community response to COVID-19 in Peterborough, supported by the SPP Delivery Group which drives delivery of support, advice, guidance and information. The governance structure is as follows:



4.1.4 The County CRG manages the county response to need, particularly in respect of supporting those identified as Clinically Extremely Vulnerable (CEV), and leads overall on the community response to outbreak management.

4.1.5 The Peterborough Local CRG's responsibilities are to:

- Work closely with the COVID-19 Place co-ordinators
- Work closely with the Countywide Community Resilience Group
- Oversee implementation of actions arising from the County CRG
- Ensure consistent community messaging
- Support local community groups and social action, identifying further support where needed
- Understand and respond to local demand at an individual and community level
- Ensure that information provided to and within communities, as well as the response from communities, is properly co-ordinated
- Ensure that we are making the best use possible of all available resources to minimise anxiety, to co-ordinate social action, and to ensure those most vulnerable are benefitting from appropriate community support
- Identify community-based risks and concerns, and aim to resolve them locally or escalate to the county CRG

4.1.6 In practical terms, the work of the Peterborough CRG is delivered by the local Hub, which offers advice and information, and facilitates access to or directly delivers support such as:

- Food supplies/shopping and medication deliveries
- Financial / debt advice
- Low level support to domestic abuse victims
- Family support
- Befriending including friendly calls
- Emotional wellbeing support
- Support with house maintenance and domestic tasks
- Economic hardship advice and information

- Transport to appointments
- Volunteer matching with local support organisations

4.1.7 Some of the key headlines to date from the work of the Peterborough Hub include the following:

- The Hub launched on 2 April 2020 and has received over 2,100 contacts to date
- Supported by over 90 local voluntary and community organisations, parish councils, City Council services, Cross Keys Homes linking with other Registered Social Landlords, our faith communities, Light Project Peterborough, the City Leadership Forum, and City College Peterborough. This has resulted in a strong support offer to vulnerable residents
- A digital celebration event was held in September to thank these organisations and volunteers for their support, and was attended by over 50 people
- The Hub is currently preparing for an anticipated increase in demand throughout Winter and over the Christmas period, especially in relation to financial management / debt advice, access to the food bank / food parcels, self-isolation / loneliness and accessing supplies, e.g. medication
- The Hub will also respond to any local support needed for those identified as Clinically Extremely Vulnerable (CEV) as well as managing applications to the hardship fund, which has been set up to support those low-income residents who have to self-isolate due to having been in contact with people who have tested positive for COVID-19
- There is also a bank of volunteers who support the hub and local organisations
- A comprehensive communications plan was established and includes regular newsletters, radio interviews, press releases/publication articles and a leaflet was sent to all Peterborough households. The aim of these communication channels is to promote the Hub and Peterborough Information Network, so residents are aware of how and where they can get support, when they need it.

4.1.8 Contact into the Hub is via telephone on 01733 747474, or the dedicated information pages at www.peterborough.gov.uk/coronavirus

4.1.9 Peterborough Hub: The Future

The Hub will continue to develop and evolve in response to the pandemic, with key priorities including:

- Creating a sustainable local support system – Creating a Unified Approach
- Joining the dots where help is needed including working with adults and children's social care
- Continuing and enhancing relationships with local support organisations
- Working with local businesses to create opportunities for those affected by COVID-19 (including young people and those with No Recourse to Public Funds) and financial advice / support

4.2 **OUTBREAK MANAGEMENT**

4.2.1 PCC was removed from the national 'watch list' as an Area of Concern on Friday 25 September.

4.2.2 As part of the Government's national strategy to manage and control the pandemic, every area in England was required to develop its own Local Outbreak Control Plan for COVID-19. Peterborough's plan, published in August and revised since, builds on tried and tested existing plans for controlling other infectious diseases like tuberculosis. It relies on working closely with local communities to reduce the risk of people contracting the disease in the first place by following clear public health messages. Link

4.2.3 The plan is supported by a standard operating procedure, which describes in detail the ways in which we will respond to outbreaks and support people who have tested positive for COVID-19 and/or traced by the NHS Test and Trace service.

4.2.4 Oversight of the outbreak control measures is the responsibility of the multi-agency Health Protection Board which has been established as part of the response phase to the pandemic.

4.2.5 To provide political ownership and public engagement and reassurance on local outbreak control plans and their implementation across Cambridgeshire and Peterborough, a Member-led Engagement Board has been established, as referenced below.

4.2.6 **Governance Structure**

The following governance arrangements are in place to ensure adherence to the agreed plan:

- Cambridgeshire and Peterborough Local Outbreak Engagement Board, co-chaired by the HWB Board Chairs, meets monthly and provides political leadership.
- Multi-agency Cambridgeshire and Peterborough Health Protection Board, chaired by the Director of Public Health, meets weekly, supported by a Programme Delivery Group for strategic focus on delivering the Local Outbreak Control Plan.
- Cambridgeshire and Peterborough Strategic Co-ordinating Group Executive, co-chaired by the CCC/PCC and CCG Chief Executives, meets three times each week to cover wider system working and mobilisation.
- Internal Cambridgeshire and Peterborough Test and Trace Gold meets three times every week. Membership includes the Chief Executive, Director of Public Health, Service Director for Communities and Partnerships, Head of Communications, to drive activities.
- Daily rhythm of Surveillance Cell and Outbreak Management Team meetings co-ordinating action of LOCP 'cells' and the Rapid Response Team.
- The Rapid Response team meets regularly to monitor data on numbers of positive tests, areas where there have been particular increases and launch targeted communications, set up accessible test centres, as well as working with event organisers to review upcoming events.

4.2.7 **Shielding Delivery Plan**

A recent MHCLG workshop has highlighted that shielding will only be reintroduced as a last resort. Therefore, the Cambridgeshire and Peterborough delivery plan is being framed around how we will support anyone that is clinically extremely vulnerable (CEV) regardless of whether or not shielding is formally reintroduced. The delivery plan has four key principles:

- **Supporting people to be independent** – our offer will give people the information and resources they need to help themselves
- **Local is best** – individuals are linked into local support in their area, finding sustainable offers of support
- **Building on existing relationships** – how can we work with and recognise the trusted relationships that already exist for CEV people?
- **Data and Intelligence led** – how can we use our data, with our partners, to understand our shielded population and better tailor our offer of support?

Shielding has NOT been reintroduced during the current lockdown, however, all CEV residents have been written to by Government with enhanced advice about what they should do during this period. The countywide hub has held discussions with each of our district council partners and with Peterborough to develop the delivery and support model.

4.2.8 **Testing and Vaccination updates**

The County Hub continues to provide marshalling support at test sites in the North and South of the county which are available for key workers, run in collaboration with the CCG.

4.2.9 **Support for Self Isolation**

Each district and city has now gone live with the National Self-Isolation Support Scheme, supporting individuals who need to self-isolate either because they test positive or are contact traced and are likely to struggle financially. In addition, a local support scheme has been established that wraps around the national offer, providing financial support where appropriate and where the national scheme cannot help, but also other forms of support that prevents someone that must self-isolate from not being able to. A countywide working group continues to meet every 2 weeks to review requests coming through, share learning and identify any gaps that can be met locally (ie the Peterborough Hub for Peterborough residents).

Key actions in the past month:

4.2.10 **Routine surveillance and Outbreak Management**

- Ongoing daily Surveillance Cell, Outbreak Management Team and Outbreak Cell meetings to ensure local issues and outbreaks are managed appropriately.
- Review of capacity requirements and skill mix of the Outbreak Management structures, to cover increasing workload.

4.2.11 **Local Incident Management Teams**

- Peterborough Incident Management Team meets weekly to review the latest epidemiology and Public Health advice feeding into the twice weekly Peterborough Rapid Response Team meetings, to take local action working with communities.

4.2.12 **Schools**

- The Education Cell is providing advice and support for schools across Peterborough. A new Department for Education helpline has also been introduced.
- The Service Director of Education and Director of Public Health held a recent briefing with Head teachers across the city which was well attended and received positive feedback.
- **Remote Learning** – the DfE has published a temporary continuity direction which places a duty on schools to provide remote education for state-funded, school-age children unable to attend school due to coronavirus (COVID-19). This came into effect on 22 October 2020 and will run to the end of the academic year.
- **DFE Public Health Hotline** - In response to a rise in cases and Public Health England struggling to deal with demand, the Department for Education set up a helpline for schools to deal with confirmed cases. In Cambridgeshire and Peterborough our local system was working well but the new DfE approach caused confusion, and so from the 19th October, we have taken back this role and schools and settings are getting quick responses.
- **Elective Home Education** – the government has issued new guidance to LA's and schools on ensuring parents are informed on selecting EHE. A meeting will be required between schools, the Local Authority and parents before a child is taken off role.
- **Lockdown opening guidance** – the DfE sent out updated guidance for education settings on opening Wednesday 4 November in readiness for the November lockdown. The key elements for education were the expectation around Clinically Extremely Vulnerable pupils and staff not being in school. There was also a requirement for after school activities being limited to supporting working parents. However, an earlier section gives schools flexibility on providing sports and wellbeing activities after school. Ahead of this guidance we developed a FAQ for schools.
- We continue to monitor the weekly local public health data reporting to help inform schools and early years providers of the position around COVID-19 including pillar 2 testing. The test and trace process continues to operate well and we are working well with Public Health to provide advice and guidance to schools.
- Early years settings continue to open but attendance is currently running at around 75% of previous year's attendance as parents remained concerned about COVID-19.
- Free School Meals – there has been a significant increase in free school meals claims since January. The increase in numbers will mean around £18m of additional funding over 6 years – Peterborough has 620 new claims.
- Supporting families with food during half term – information was sent to parents via schools about the hub arrangements across Cambridgeshire and Peterborough. The number of requests made for Peterborough were 42 (111 children).
- During the last month we have provided advice to schools on Relationships and Sex Education, flu vaccinations, the application of the rule of six in schools, QR codes, complaint processes, young carers, changes to the DBS process, COVID-19 symptoms, ventilation and attendance coding. We also provide a weekly data update on COVID-19 infection rates across Peterborough.

4.2.13 **Care Homes**

- Ongoing implementation and updating of the Care Home Support Plan, with renewed training on infection control and PPE use.

4.2.14 **Workplaces**

- Ongoing support to workplaces experiencing cases or outbreaks.

4.2.15 **Events and Openings**

- The Rapid Response Team meets twice weekly to discuss forthcoming events. A team works with event organisers to ensure they are aware of good practice in organising COVID-19 safe events.

4.2.16 **Peterborough Communities**

- A Peterborough Leaders' Summit was held on 2 October to recognise the excellent work done by local communities and services to keep COVID-19 rates stable in Peterborough and to ask what actions we all need to take next.
- A Joint strategy agreed by Peterborough City Council and Cambridgeshire Constabulary to engage, explain, encourage and enforce COVID-19 legislation is being delivered in central Peterborough.

4.2.17 **Local enhanced contract tracing in Peterborough**

- Ongoing high success rates with approximately 90% of cases handed on by national Test and Trace system, successfully contacted.
- Ongoing challenges with national testing capacity impacting locally. Higher numbers of children have been using the testing system.
- A local testing centre has been set up for essential key workers (including school staff).
- A permanent, local Testing Centre opened in central Peterborough (Gladstone Park) in October, which provides access for walk-in clients.

4.2.18 **Planning for a winter surge**

- The Health Protection Board review planning for a winter surge and are identifying key priorities, including a focus on capacity and business continuity, communicating with communities, ensuring local preparedness, access to testing and promoting flu vaccination for eligible groups.
- Locally, winter/Christmas planning is discussed at the SPP Board and SPP Delivery Groups for members to talk through how they can work together to support the elderly, those struggling with loneliness and the vulnerable during this period.

For the latest Public Health COVID-19 data, please click on the following link:
https://cambridgeshireinsight.org.uk/coronavirus_cambridgeshire/cambridgeshire-and-peterborough-public-health-covid-19-reports/

5. CONSULTATION

5.1 Please refer to the governance structure within section 4.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The Health and Wellbeing Board is expected to review the information contained within this report and respond / provide feedback accordingly.

7. REASON FOR THE RECOMMENDATION

7.1 Health and Wellbeing Board members to feel assured that appropriate progress is being made to support Peterborough residents during the pandemic.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Health and Wellbeing Board members must be kept informed of progress and key activity.

9. IMPLICATIONS

Financial Implications

9.1 There are no significant implications within this category.

Legal Implications

9.2 There are no significant implications within this category.

Equalities Implications

9.3 There are no significant implications within this category.

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 N/A

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 7
7 DECEMBER 2020	PUBLIC REPORT

Report of:	Dr Liz Robin, Director of Public Health	
Cabinet Member(s) responsible:	Councillor Wayne Fitzgerald, Deputy Leader and Cabinet Member for Adult Social Care, Health and Public Health.	
Contact Officer(s):	Dr Tony Jewell, Consultant in Public Health	Tel. 01733 747474

REPORT OF THE COVID-19 HEALTH INEQUALITIES RECOVERY WORKING GROUP

RECOMMENDATIONS	
FROM: Director of Public Health	**Deadline date:** N/A

It is recommended that the Health and Wellbeing Board:

1. Notes and comments on the report attached at appendix 2
2. Suggests interventions or examples of good practice to be explored that may help to address the inequalities identified
3. Endorses the approach for driving this work forwards via the Community Resilience Group

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request from the Chairman.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to enable the review of a focussed piece of work undertaken as part of the COVID-19 recovery framework, examining the impact of the pandemic on health inequalities.

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

2.8.2.1 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

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

3. 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 A series of recovery groups have been established as part of our approach to managing the impacts and consequences of the COVID-19 pandemic. One of these groups has provided a focus on recovery from a Public Health and Prevention perspective.

4.2 The Public Health and Prevention Recovery Group focussed on five core themes, namely:

- Health inequalities
- Screening, vaccinations and immunisations
- Health behaviours
- Mental health
- Housing

The work under each theme was driven forward by small working groups.

4.3 Each working group has produced an initial report of its findings, and these have been brought together as a suite of reports via an executive summary. A copy of the executive summary is attached at appendix 1.

4.4 Attached at appendix 2 of this report is the initial report from the working group that focussed on health inequalities. The report sets out the context within which the theme has been examined and incorporates a range of evidence to demonstrate both the baseline position and some of the anticipated consequences on health inequalities caused by the pandemic.

4.5 Critically, it is now vitally important that the findings of this group to date are converted into positive action, to address the impacts suggested, and to identify, develop and deliver long term and permanent solutions to address the health and associated inequalities that some communities are facing. To drive this forward, the work is now being led via the Cambridgeshire and Peterborough Community Resilience Group (CRG). The CRG was set up at the start of the pandemic as a formal part of the Local Resilience Forum command structure. It brings together a large and diverse group of public and civil society sector partners on a fortnightly basis to jointly problem-solve and collectively ensure that communities are at the core of our COVID-19 responses. Such is the impact the CRG is having, members have agreed to commit long term to the approach, beyond the pandemic, making it the ideal forum for driving delivery of actions and interventions that address health and other inequalities.

5. CONSULTATION

5.1 The report at appendix 2 was developed in collaboration with partners within the NHS, and it has been discussed at the system-wide Recovery Cell. The actions that will emerge from the report will be taken forward in close collaboration with the CRG.

6. ANTICIPATED OUTCOMES OR IMPACT

6.1 It is anticipated that the Health and Wellbeing Board recognises the significance of the work carried out to date, and that there is now a unique opportunity to develop and deliver innovative and practical interventions that make a lasting difference.

7. REASON FOR THE RECOMMENDATION

7.1 Agreement to endorse the report and the approach being taken will ensure clear accountability to address health and other inequalities.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Work to address health inequalities could continue in the ways it was being delivered prior to the pandemic. However, COVID-19 has impacted significantly on many individuals and communities, drawing the issue of health inequality into sharper focus, and so continuing without review and reset is not considered to be appropriate.

9. IMPLICATIONS

Financial Implications

9.1 None at this stage.

Legal Implications

9.2 None.

Equalities Implications

9.3 At the heart of this report is the theme of addressing health inequalities.

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 Appendix 1: Public Health and Prevention Recovery Group Executive Summary
Appendix 2: Health Inequalities Working Group Report

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Appendix 1

Executive Summary to the Interim report of the Public Health and Prevention Sub Group of the LRF Recovery Group.

1.0 Introduction

This interim report has been produced for the C&P LRF Recovery Group by the Public Health and Prevention Sub Group. Our Sub Group is made up of representatives of C&P Upper Tier Local Authorities, City and District Councils, the NHS and Patient and Community Groups (see Annex 1 for Membership). The Sub Group has been Chaired by Dr Tony Jewell (CPH) on behalf of Dr Liz Robin (DPH). We are a sub Group of the LRF Recovery Group and the Chair participates in these meetings. We have uploaded our Health Impact Assessment, Action Plans and Minutes on the LRF Huddle.

The COVID-19 pandemic is global and is a UK wide public health emergency. We are aware therefore of the responsibility of our group to provide a strategic overview of the public health implications for C&P across all sectors and the need to provide focus on prevention, assessing the population health impact of the pandemic and key public health priorities going forward. The public health impact of the pandemic reaches across all sectors so we have participated in most other sub group's work for example the Vulnerable People and Environment sub groups of the LRF. There is also a Health (NHS) link between the LRF Recovery work and the NHSE Recovery and Restoration Planning which is important. Our Sub Group has taken the lead for the NHS (STP/CCG) on reporting on Screening and Vaccination and Immunisation (V&I) as well as health inequalities arising from the social determinants of health. We have collaborated with the local NHS (CCG) who have produced some detailed work on pre-Coronavirus health service inequalities, the impact of the pandemic where data is available and a strategy going forwards. It is important that links are made between socio-economic and cultural drivers of inequity with the specific needs of vulnerable populations and how the NHS and other services can inadvertently make these inequalities worse or mitigate them.

We have used five work streams to cover the breadth of public health impacts – Health Inequalities, Screening and V&I, Health Behaviours, Mental Health and Housing and Health. We published our Health Impact Assessment (HIA) in these five domains and the emerging Action Plans. This interim report provides more background information on each of these policy areas for LRF partners to comment on and draw them into the overall LRF Recovery Plan. For ease of access we present each work-stream report as a separate document attachment.

In drafting these plans we have chosen to frame the topics with reference to the pre-COVID period (2019), assess the impact of the first wave of the pandemic (March-June 2020) and to look forward while aware of the serious implication of a substantial second and other waves of the pandemic infection.

In drafting our response we have referred to the corporate LRF needs assessment which has been produced and have kept within the mandated strategic goals of the Four Grand Challenges and the draft Health and Wellbeing Strategy for C&P.

2.1 Health Inequalities

The report draws on routinely produced JSNAs and the draft Health and Wellbeing Strategy. It identifies pre-existing health inequalities between different population groups and local authorities many of which are long standing and relate to socio-economic factors centred in the urban areas of Cambridge and Peterborough and in rural Fenland.

The COVID pandemic has shone a harsh light on these inequalities and shown that deprivation is a major risk factor for getting severe illness and dying from the complications of the viral infection. The BAME populations also are at greater risk and while this is complicated by the co-existence of relative poverty, poor housing and occupational/environmental exposure there remain concerns about the impact of structural determinants. Age is also a key determinant and we note how older men in particular are at greatest risk and settings such as domiciliary care, residential and care homes need support to reduce these risks going forwards.

The sub group take a life-course approach to recommendations which look at the importance of pregnancy and early years, schooling, younger people, the workplace and ageing well. This fits well within the strategic aims of the 4 Grand Challenges and a reminder that greater equity is a benefit to everyone and the economy as well.

2.2 Screening and V&I

The local NHS (STP/CCG) asked C&P CCs to contribute to their Recovery Planning by reviewing prevention, the social determinants of health inequalities and in particular the impact of the pandemic on V&I and Screening programmes.

This report builds on an analysis undertaken within the CCG looking at uptake of V&I programmes for infants, children and adults. The report has shown that in some groups, such as neonates and infants the NHS has achieve impressive equity in maintaining uptake despite the pandemic. However in other age groups there are examples of serious reductions in uptake in all population age groups but disturbingly also by deprivation and ethnicity. There are recommendations about how to mitigate these outcomes as we move forward.

Screening programmes have also been impacted by COVID as some programmes ceased during the lockdown period. As with V&I there were pre-existing inequalities but the impact of the drop in screening is likely to emerge with delayed diagnoses in cancers such as bowel, breast and cervical cancer. Some new intelligence is flagged which highlights some cultural/ethnic disparities that need to be addressed to improve uptake by BAME communities. This report will be shared with the local and regional NHS partners.

2.3 Health Behaviours

The health behaviours that we examined include physical activity, diet and obesity, smoking and drugs/alcohol. As with other determinants there are pre-existing inequalities across C&P which need to be addressed.

The pandemic has had an adverse impact on many of these risk factors with early trends in increasing physical activity in lockdown reducing over time and potentially linked to the reduction in organised sport and recreational activity. There is some evidence too that is linked to more sedentary behaviours at home and snacking/drinking more alcohol than before. Surveys report an increase in obesity that will be linked to this change in lifestyle. Some unexpected benefits might be seen by a possible reduction in smoking rates and some drug taking behaviours.

The LRF Recovery group has flagged the need to try and hold onto positive changes while trying to mitigate the risks inherent in restrictions applied in pandemic control measures such as variants of lockdown. This report points at ways we can approach this in regard to health behaviours and by working with partners such as supporting the BMI Can do it healthy weight campaign.

2.4 Mental Health

The pandemic has had a serious impact on mental health with the call to stay at home and social distance affecting mental wellbeing such as increased loneliness and anxiety/depression. This has also been challenging to families and care workers who have had to revert to internet meetings rather than face to face meetings.

Despite the limitations innovative programmes have developed to support people's mental wellbeing such as Every Mind Matters and the support offered by many voluntary groups. This includes maintaining neighbourly contact for particularly at risk people seen during the period of shielding with support of food parcels and prescription collections.

Environmental considerations have also emerged as the risk in dense urban areas without easy access to green spaces, playgrounds has made home life stressful for parents with young children who spent time out of school. This is particularly difficult for families living in crowded and low quality housing with poor internet accessibility, no garden and difficult access to play space/green spaces.

As the pandemic continues the impact on mental wellbeing will continue to grow with adverse impacts already seen such as domestic violence, child abuse and deterioration in children's educational and life-skill milestones. Employers also need to review their employees' welfare as there are potential negative impacts from both working from home as well as travelling to a changed workplace environment.

2.5 Housing and Health

As with other sub groups the Housing group noted the pre-existing pressures on housing across C&P with the quality of existing stock and the affordability for young local people. In addition the pandemic has demonstrated the value of having sufficient space in-doors for families to live comfortably during lockdown. The guidance on self-isolating at home has been very challenging for many shielded and symptomatic people living in family groups. Multigenerational households and houses of multiple occupation has been a public health challenge.

Homelessness is the extreme point in housing deprivation and there has been positive national government and local initiatives to provide accommodation for rough sleepers and homeless people. The feared impact of COVID on these high risk group has not materialised and in many respects they have benefited from improved contact with health and social services. The voluntary sector has played a key role here as well as those primary care groups who provide enhanced services. The uptake for Hepatitis C vaccine is an example of opportunistic access to this group.

Looking forward there is some comfort in MCHLG funding continuing over the winter for the homeless but entitlement remains a challenge, the cold is a risk for this group as well as those living in poorly insulated and heated accommodation.

3.0 Conclusion

This interim report represents work in progress and has been produced in uncertain times with the National Public Health Emergency Response Phase still very active with many parts of the UK in Lockdown or variants of that. People and the economy are living and working under the constraints of infection prevention and control. However this Recovery Planning process adds value by assessing the impacts that the first wave has had on the health and wellbeing of the population and points towards taking paths to Recovery which harness the positive changes that we have identified during the pandemic and deliberately tackling the adverse impacts that have occurred many of which have been built on pre-existing patterns of deprivation.

We look forward to obtaining feedback from LRF partners on this interim report which has summarised a complex web of determinants of health and wellbeing, using what data is available on impacts and proposing positive actions that can be taken by us all.

Dr Tony Jewell

Consultant in Public Health

Chair of the Sub Group.

Oct 2020

Membership – Public Health and Prevention LRF Recovery Sub Group

Antoinette Jackson	Cambridge City Council
Barbara Paterson	PHE
Adrian Chapman	CCC & PCC
Liz Knox	East Cambs District Council
Phil Hughes	Fenland District Council
Fiona Head	CCG
Sandie Smith	Health Watch
Tony Jewell	CCC
John Ford	Public Health Registrar
Julie Farrow	Hunts Forum
Vasiliki Kyriakidou	CCC
Shylaja Thomas	NHSE Screening and Imms
Neil Modha	North Alliance
Liz Robin	CCC & PCC
Jude Simpson	South Alliance
Emmeline Watkins	PCC
Clare Gibbons	Senior Health Lead South Cambs District Council
Suzanne Hemingway	Cambridge City Council
Val Thomas	CCC
Adam Gallop	Cambridgeshire Police

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Public Health and Prevention Sub Group

Health Inequalities Work Stream

1.0 Introduction

In July 2020, the Health Inequalities Task and Finish Group was formed to take forward work for the Public Health and Prevention LRF Recovery Sub-Group. This Sub-Group is part of the system wide Recovery work. The Recovery sub group is identifying the impacts of COVID 19 in several prevention and public health areas. Health inequalities is one of these areas and the Task and Finish Group has been formed to report back on COVID-19 related impacts and opportunities.

Inequalities covers a broad range of themes and it should be noted that the following areas are covered within other sub groups:

- Climate emergency – Environment LRF sub group
- Walking and Cycling – Health Behaviours and Environment sub groups
- Housing related issues – Housing sub group
- Loneliness and isolation – Mental Health and Vulnerable People sub groups
- Looked after Children – Vulnerable People sub group

2.0 Health Inequalities Task and Finish Group members

Adrian Chapman (PCC/CCC)

Matt Oliver (PCC/CCC)

Tony Jewell (Public Health)

Val Thomas (Public Health)

John Ford - Norfolk and Norwich University Hospital NHS Foundation Trust

Clare Gibbons South Cambs DC

Phil Hughes – Fenland DC

3.0 Initial Discussions and Findings from Task and Finish Group

Health inequalities are systematic, avoidable and unfair differences in health (and wider quality of life) outcomes between populations, between social groups within the same population or as a gradient across a population ranked by social position. Inequalities in health outcomes arise from inequalities in social determinants of health, risk factors and health care access and provision.

Health inequalities is a core component of the draft Cambridgeshire and Peterborough Health and Wellbeing Strategy 2019-24. The strategy, which has been informed by a Joint Strategic Needs Assessment (JSNA), sets out clear priorities and outcomes to address the wider determinants of health and healthy lifestyles inequalities. These are:

Priority 1: **Places that support health and wellbeing**

- New housing developments and transport infrastructure which support residents' health and address climate change
- Preventing homelessness and improving pathways into housing for vulnerable people.
- Reducing inequalities in skills and economic outcomes across our area.

Priority 2: **Helping children achieve the best start in life**

- Delivering the Best Start in Life from pre-birth to age five
- Developing an integrated approach for older children and adolescents

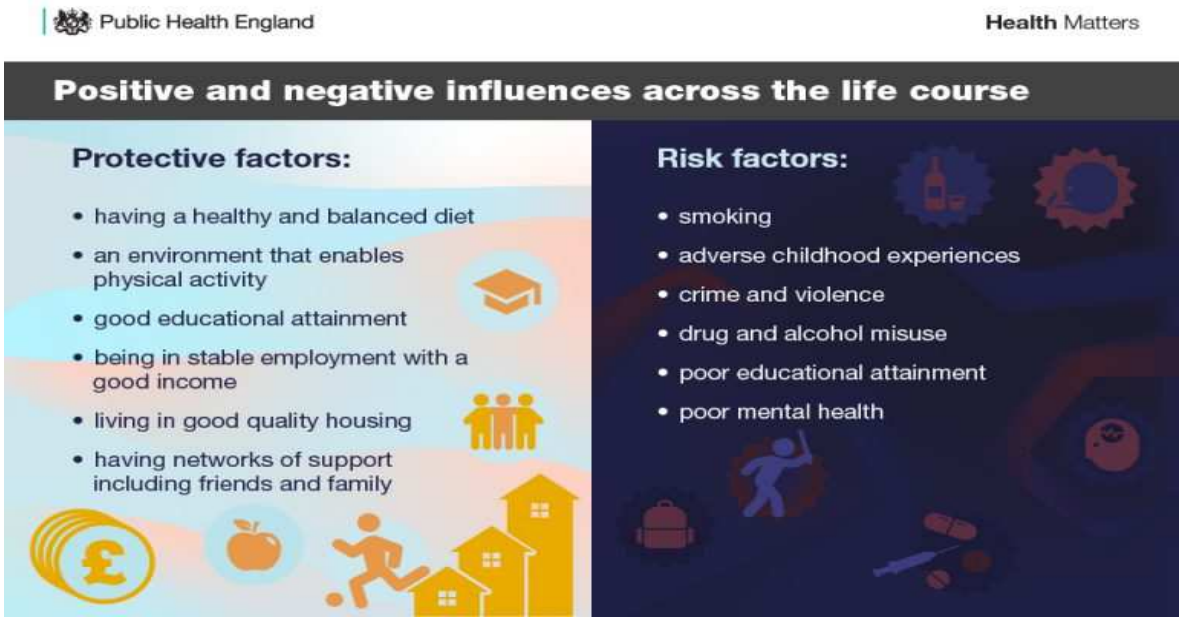
Priority 3: **Staying healthy throughout life**

- A joined up approach to healthy weight, obesity and diabetes
- Reducing inequalities in heart disease and smoking
- Improving mental health and access to services
- Ageing Well – meeting the needs of a growing older population

Priority 4: **Good Quality health and social care**

- Embedding the 'Think Communities' approach to place based working
- A joint approach to population growth
- Addressing financial challenges together
- Acting as a system to reduce health inequalities

A person's physical and mental health are significantly influenced by a range social, economic and environmental factors. These can be categorised as follows:



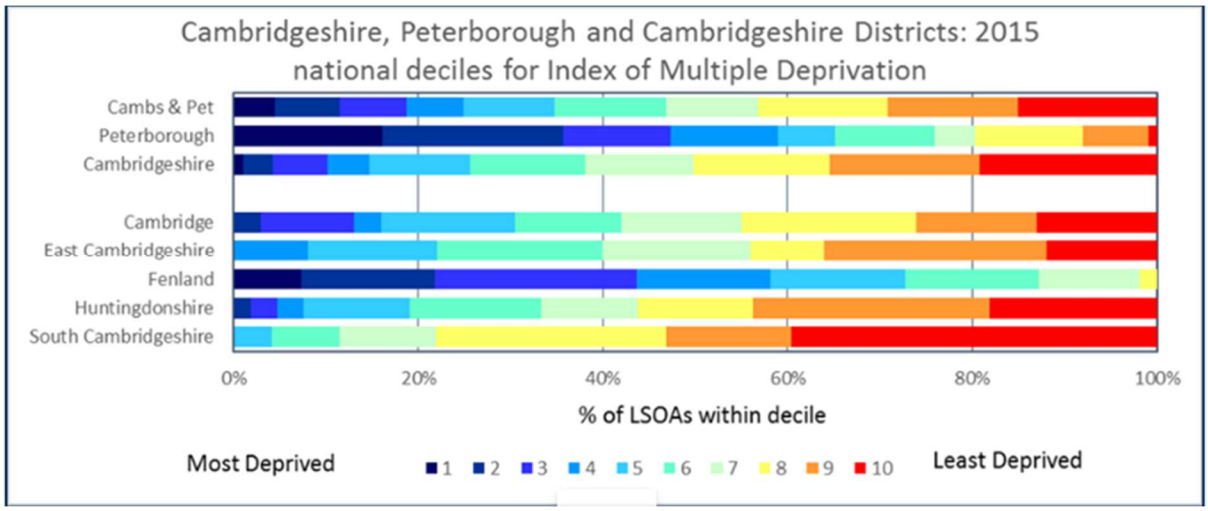
Addressing the wider determinants of health will help improve overall health by optimising the conditions into which people are born, live and work.

The broad social and economic circumstances that together influence health throughout the life course are known as the 'social determinants of health'. There is a social gradient across many of these determinants that contribute to health with poorer individuals experiencing worse health outcomes than people who are better off.

PHE, https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health, 2017

On average, men who live in areas with the worst social and economic deprivation have significant health problems by their early fifties – while in the least deprived areas they stay healthy until over age seventy. The picture for women shows a similar gradient.

In Cambridgeshire and Peterborough we see these same inequalities. Many communities are prosperous and healthy with good outcomes compared to the national picture. But some communities experience poverty, low education and skills, and poor health outcomes. There are more communities with these issues (shown as blue-black on the chart below) in Peterborough and Fenland, and a smaller number in Cambridge and Huntingdon.



The CCG's Cambridgeshire and Peterborough Health Inequalities Strategy sets out the stark inequalities that exist in the social determinants of health, risk factors, health care provision and clinical outcomes across socio-economic, disadvantaged and inclusion health groups. A 10 year life expectancy gap exists between men living in the poorest areas of Peterborough compared to the richest areas of Cambridge. The gap in life expectancy is driven by early deaths in cardiovascular disease, cancer and respiratory conditions – many of these are caused by the socioeconomic factors within our communities. Low income, poor quality housing, and poor education are all key factors which contribute to health inequalities. The strategy sets out the following objectives:

- Preventing homelessness and improving pathways into housing for vulnerable people.
- Reducing inequalities in skills and economic outcomes across our area.
- Reducing inequalities in heart disease and smoking
- Acting as a system to reduce health inequalities

The cost to the NHS alone of health inequalities was estimated in 2011/12 to be at least £12.5 billion/year. This was calculated by estimating the difference in NHS spend between the most and least disadvantaged fifth of the population. In Cambridgeshire and Peterborough CCG this would be equivalent to approximately £106 million/year, at 2011/12 costs.

COVID-19 has significantly changed the health inequalities context. However, this is just the tip of the iceberg with health inequalities likely to worsen even more due to the impact on health care services, mental wellbeing and economic impact on employment, debt, housing, benefit payments and education. These social influences are key determinants of what makes people healthy or unwell and have been significant factors in peoples' exposure to and outcomes from COVID-19.

COVID-19 has disproportionally affected poor areas with a 1,000 extra people dying in the most deprived decile in England due to COVID-19 during March to May 2020, compared with the least deprived areas and 2,500 extra people from any cause of death during this period. There is a clear socio-economic trend in COVID deaths.

COVID has particularly highlighted just how significant the health impact is on marginalised and vulnerable groups. Public Health England's report (*Disparities in the risk and outcomes of Covid 19*, June 2020) set out the key risk factors include age, sex, occupation, living in a deprived area and coming from a Black, Asian and Minority Ethnic (BAME) group.

Some of the risk factors are:

Age

There is a sharp gradient in COVID risk with ageing so that more older people get a severe illness, often requiring hospitalisation and sadly die as a result of Covid 19.

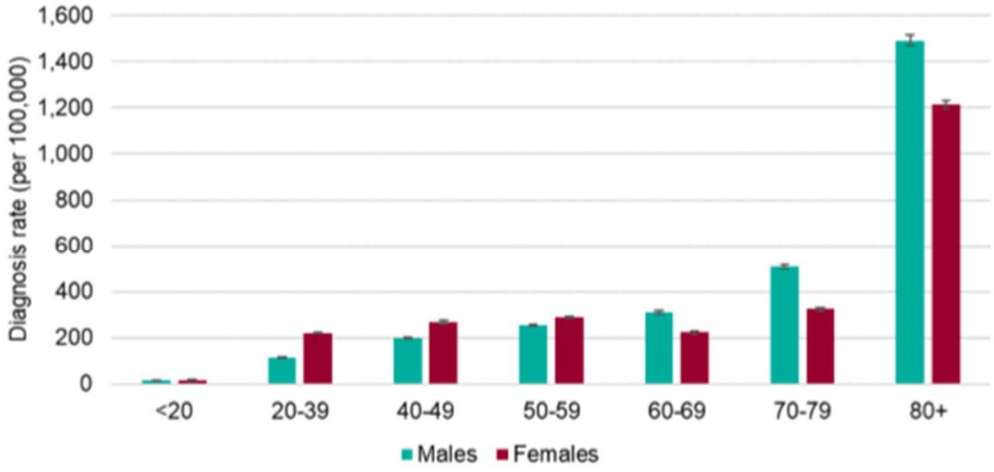


Figure 1.2. Diagnosis rates by sex and age as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

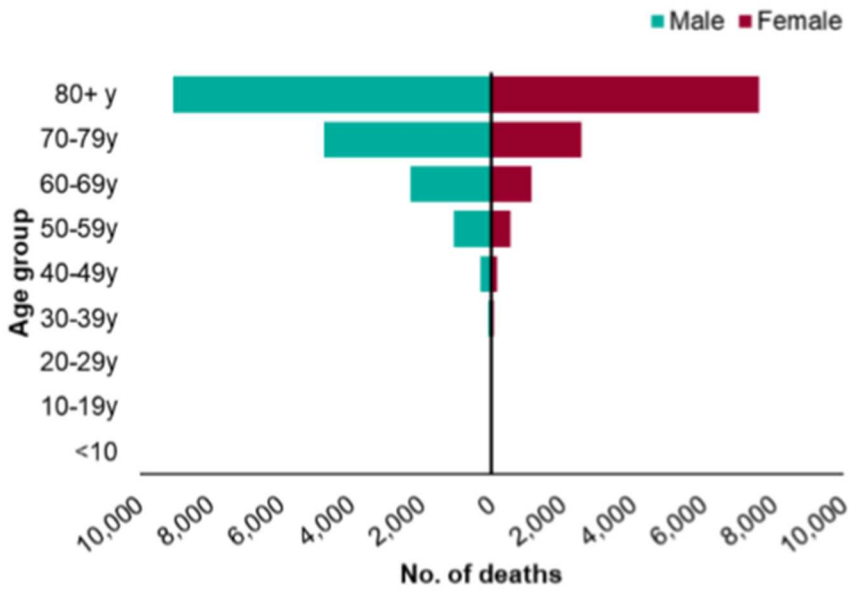


Figure 1.4. Age sex pyramid of laboratory confirmed COVID-19 deaths as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

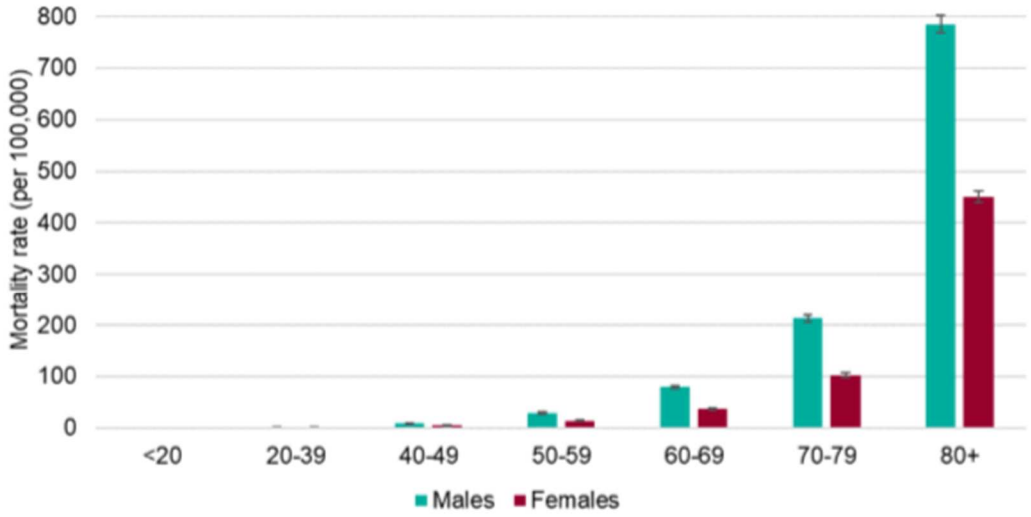
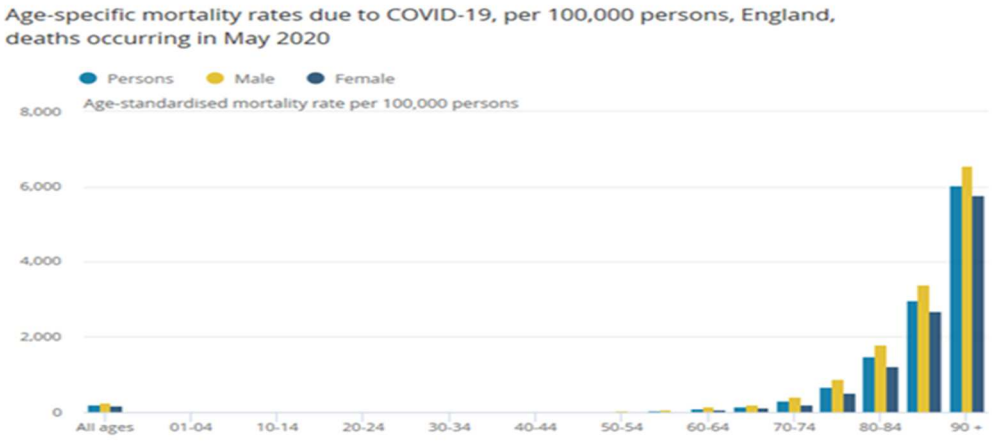


Figure 1.5. Crude mortality rates of laboratory confirmed COVID-19 deaths per 100,000 population by age group and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

Sex

Taking into account the age structure of the population, more men than women die of COVID-19. The age-standardised mortality rate (ASMR) in England in May for all ages combined was significantly higher in males (250.2 deaths per 100,000 males) than females (178.5 deaths per 100,000 females).

Looking at the mortality rates by age and sex, the difference between males and females increased with age. In all age groups below 50 years, the age-specific mortality rates were similar in males and females However, analysing April's data, the PHE *Disparities* report finds that among working age men as a group (which includes men from 50-64 as well), those diagnosed with a positive test are twice as likely to die as females. In the oldest age groups (starting from 80 to 84 years), males had a significantly higher COVID-19 mortality rate than females (see figure below).



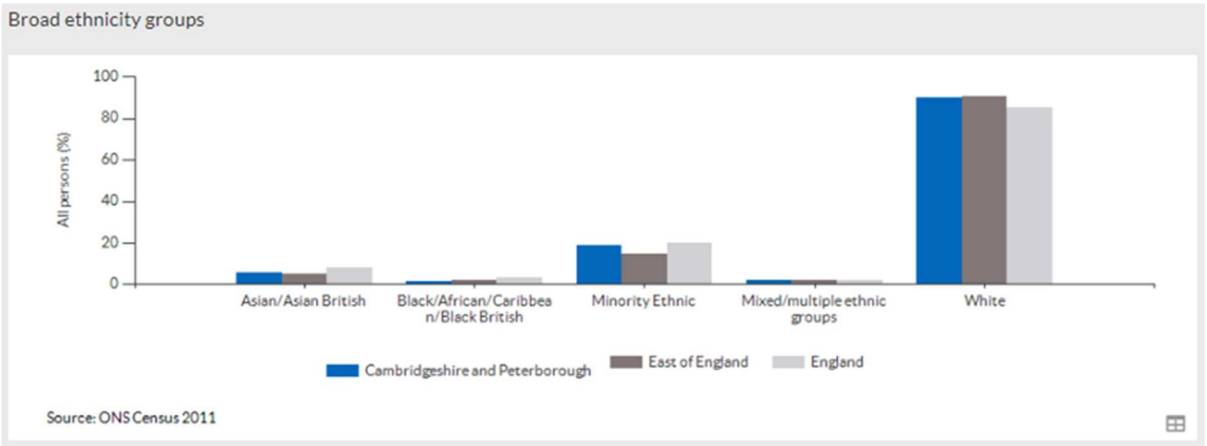
Source: Office for National Statistics – Deaths involving COVID-19

Ethnicity and BAME risk

One of the next biggest risk factors in getting severe illness and dying from Coronavirus is ethnicity. Black people make up only 3% of the population, but they account for six out of every 100 coronavirus deaths. The PHE *Disparities* study stated that once age standardised the highest diagnosis rates of COVID-19 per 100,000 were in people of Black Ethnic Groups and the lowest in White ethnic groups.

However, it is not just Black ethnic groups that are at further risk when compared to White ethnic groups. After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Indian, Pakistani, other Asian, Caribbean, and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British. These analyses did not account for the effect of occupation, comorbidities or obesity. These are important factors because they are associated with the risk of acquiring COVID-19, the risk of dying, or both. Other evidence has shown that when comorbidities are included, the difference in risk of death among hospitalised patients is greatly reduced.

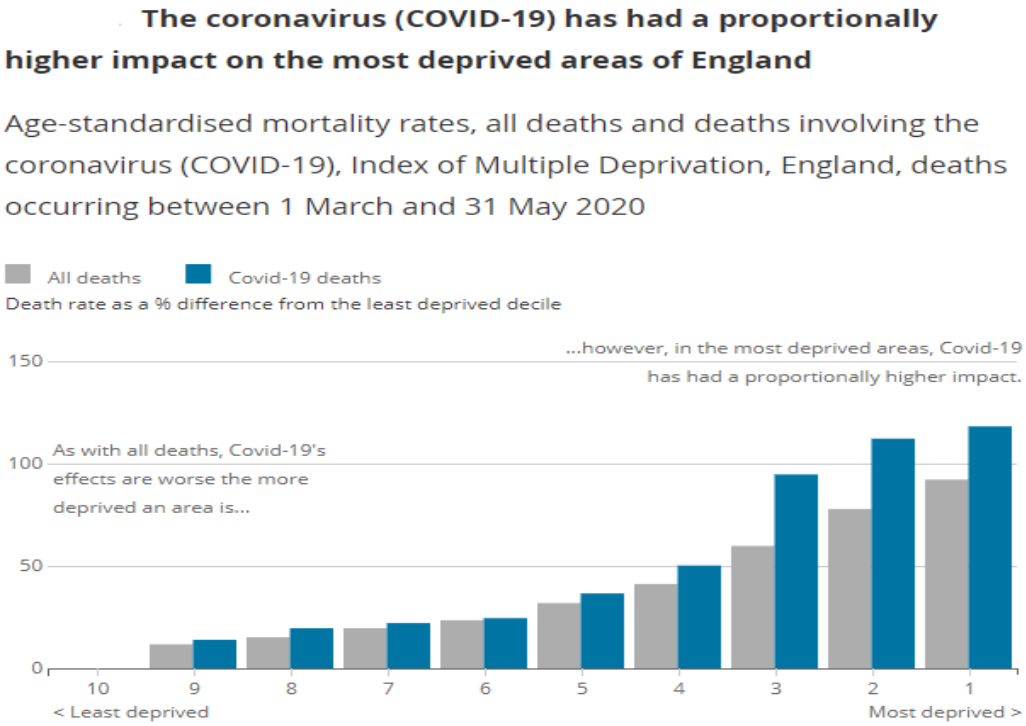
In Cambridgeshire and Peterborough the overall percentage of BAME groups are low in comparison with England, however the rates differ significantly across the different district and city local authority areas. For example, the White population account for 96.2% of the population in East Cambridgeshire, whereas in Peterborough the White population accounts for 82.5% of the population.



	Cambridgeshire and Peterborough		East of England		England	
	Count	%	Count	%	Count	%
Asian/Asian British	47,130	5.9	278,372	4.8	4,143,403	7.8
Black/African/Caribbean/Black British	10,174	1.3	117,442	2	1,846,614	3.5
Minority Ethnic - Total	149,992	18.6	860,795	14.7	10,733,220	20.2
Mixed/multiple ethnic groups	16,029	2	112,116	1.9	1,192,879	2.3
Other ethnic group	4,977	0.6	28,841	0.5	548,418	1
White	726,531	90.3	5,310,194	90.8	45,281,142	85.4

Deprivation

The government has observed that people living in the poorest areas of England and Wales have been twice as likely to die from COVID-19 as those in less deprived areas. The analysis done by the ONS highlights the disparity in deaths per 100,000 people from those areas with high levels of socio-economic deprivation compared with areas with low levels. The graph below shows this.



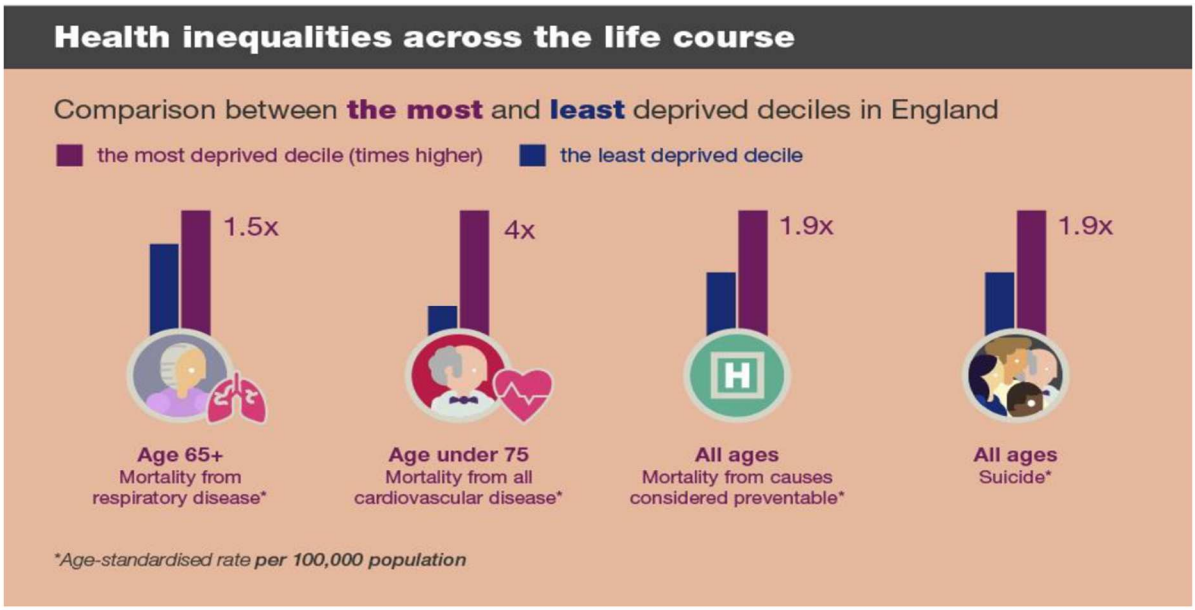
Source: Office for National Statistics – Deaths involving COVID-19

Looking at deaths involving the coronavirus (COVID-19), in England, the rate for the least deprived area (Decile 10) was 58.8 deaths per 100,000 population and the rate in the most deprived area (Decile 1) was 128.3 deaths per 100,000 population; this is 118% higher than the least deprived area. In the least deprived area, the age-standardised mortality rate for all deaths was 242.6 deaths per 100,000 population. In the most deprived area, the age-standardised mortality rate for all deaths was 92.2% higher than that of the least deprived, at 466.2 deaths per 100,000 population."

High diagnosis rates may be due to geographic proximity to infections or a high proportion of workers in occupations that are more likely to be exposed. Poor outcomes from COVID-19 infection in deprived areas remain after adjusting for age, sex, region and ethnicity, but the role of comorbidities requires further investigation.

In Cambridgeshire and Peterborough there are approximately 97,000 people living in areas that are deemed to be within the 20% most deprived areas in England (or decile 1 and 2 of 10).These areas are most concentrated in Peterborough, Cambridge and Fenland.

Deprivation is a significant factor in health inequality across the life course with social and economic factors remain relevant in adulthood, with big differences in health between the most and least deprived communities, locally and nationally.



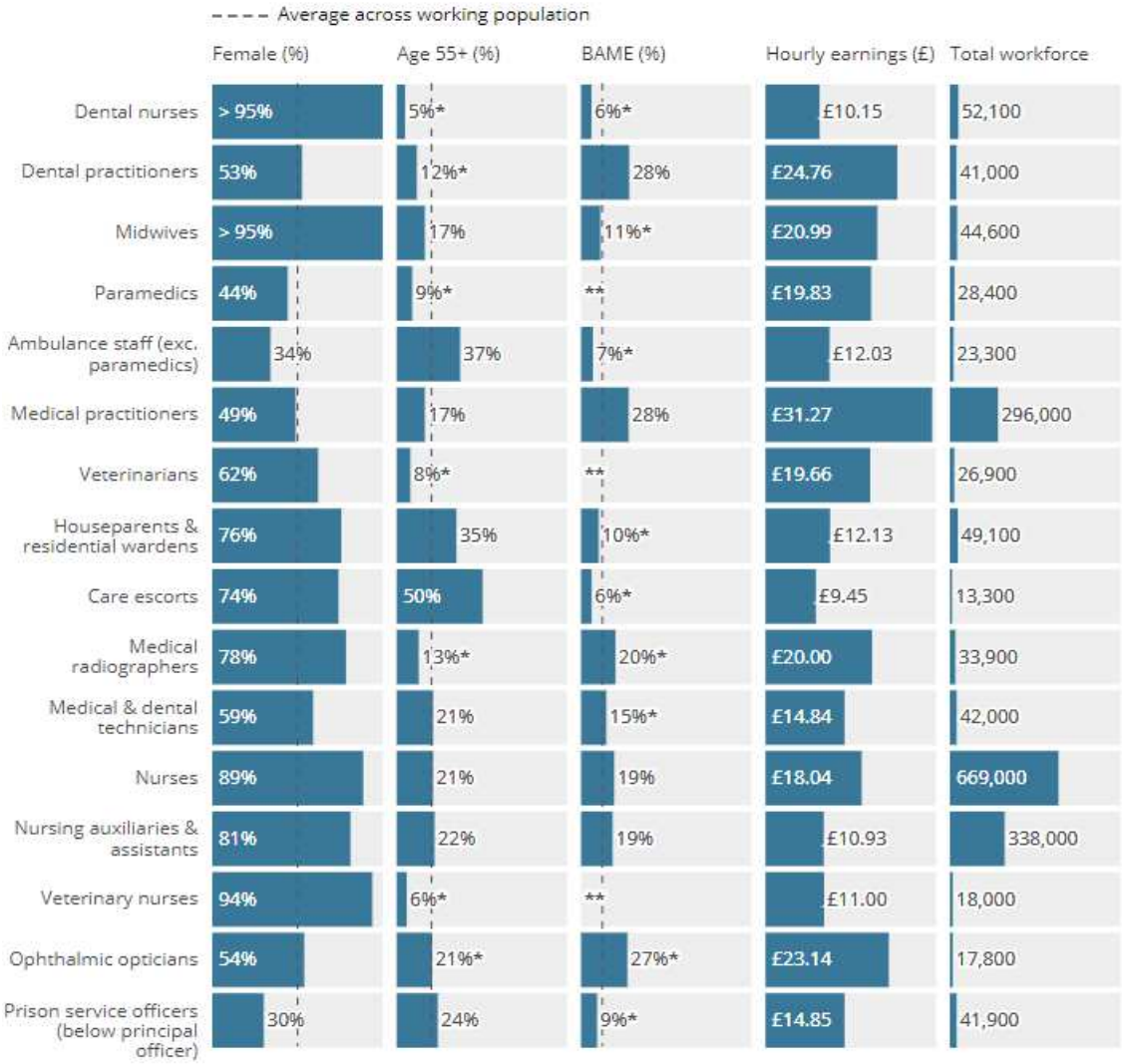
High risk occupations

There are numerous occupations that have greater exposure to individuals with COVID-19 and therefore increase the risk of contracting it themselves. For example, healthcare professionals are more exposed to individuals that have contracted the virus. Other occupations include bus drivers, store assistants, teachers, security guards and any other occupation that requires the individual to be present in an environment where there is physical proximity to other individuals. This may make them more likely to come into contact with someone that has COVID-19. However much of this risk could be mitigated with adequate PPE.

Certain demographics are disproportionately represented in the most at-risk occupations relative to the general population. For example, midwives are almost exclusively female as shown in the table below. BAME groups are disproportionately represented among medical practitioners, dental practitioners and ophthalmic opticians relative to the population of BAME groups. People with lower earnings are more likely to live in deprived areas and are less likely to have the option to work from home due to the nature of the work. This further increases their risk to contracting COVID-19.

An analysis of occupations therefore will cross-reference the key risk factors discussed in the preceding parts of Category A above as in the case of BAME workers. To understand the occupational risk, it is necessary to assess each occupation by the demographics of its workforce, as suggested by the following diagram which looks at characteristics of occupations nationally:

Characteristics of workers in highest exposure occupations

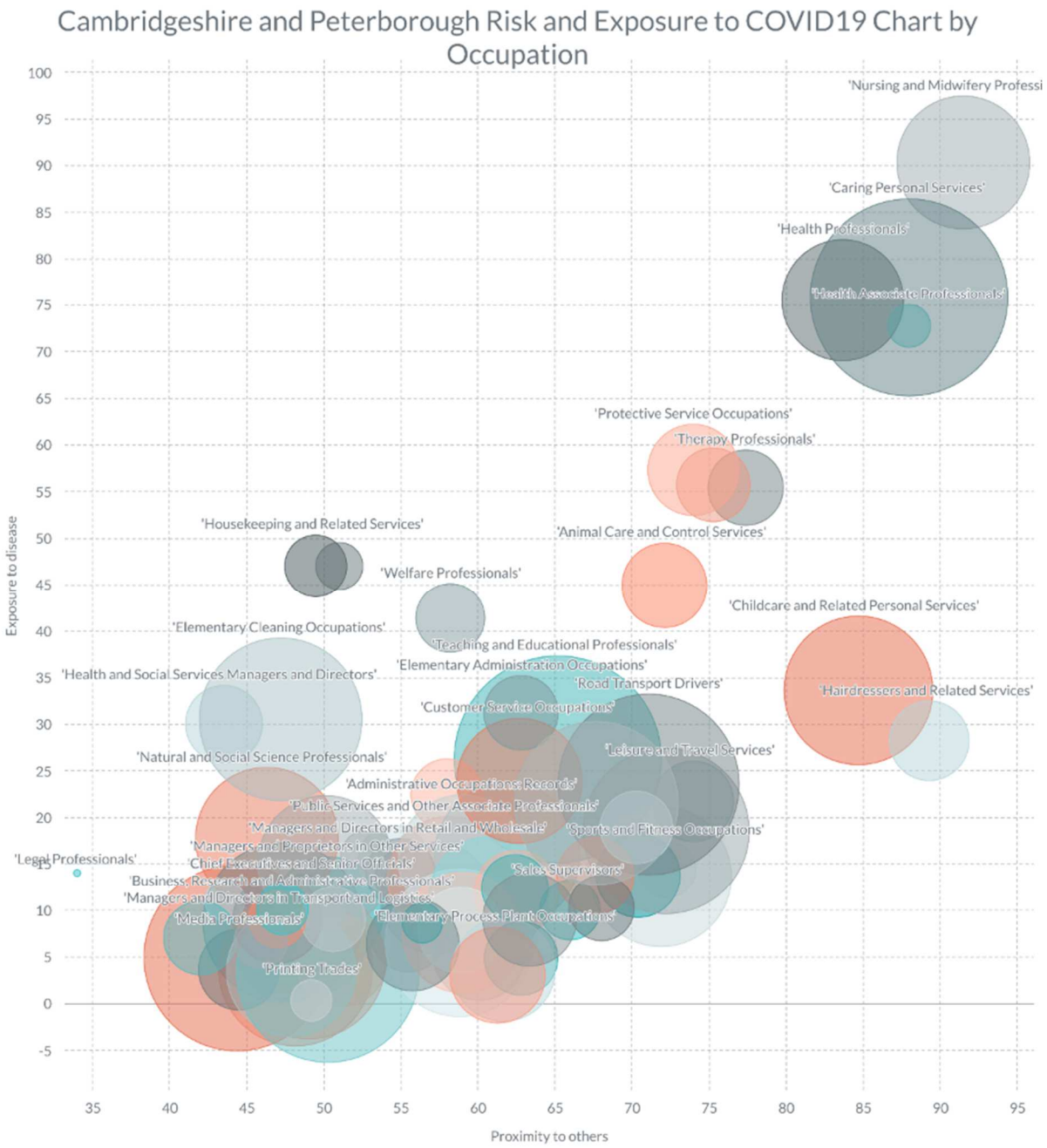


* Data is based on low sample sizes and should be used with caution

** The sample size is too small to produce a reliable estimate

Source: Annual Population Survey and Annual Survey of Hours and Earnings - Office for National Statistics

The graph below provides an indicative view of what proportion of people are working in high risk occupations across Cambridgeshire and Peterborough. The chart shows that there are significant numbers of people with jobs working in high risk occupations, primarily in a healthcare setting. The full data table used to populate this chart can be found in the references section

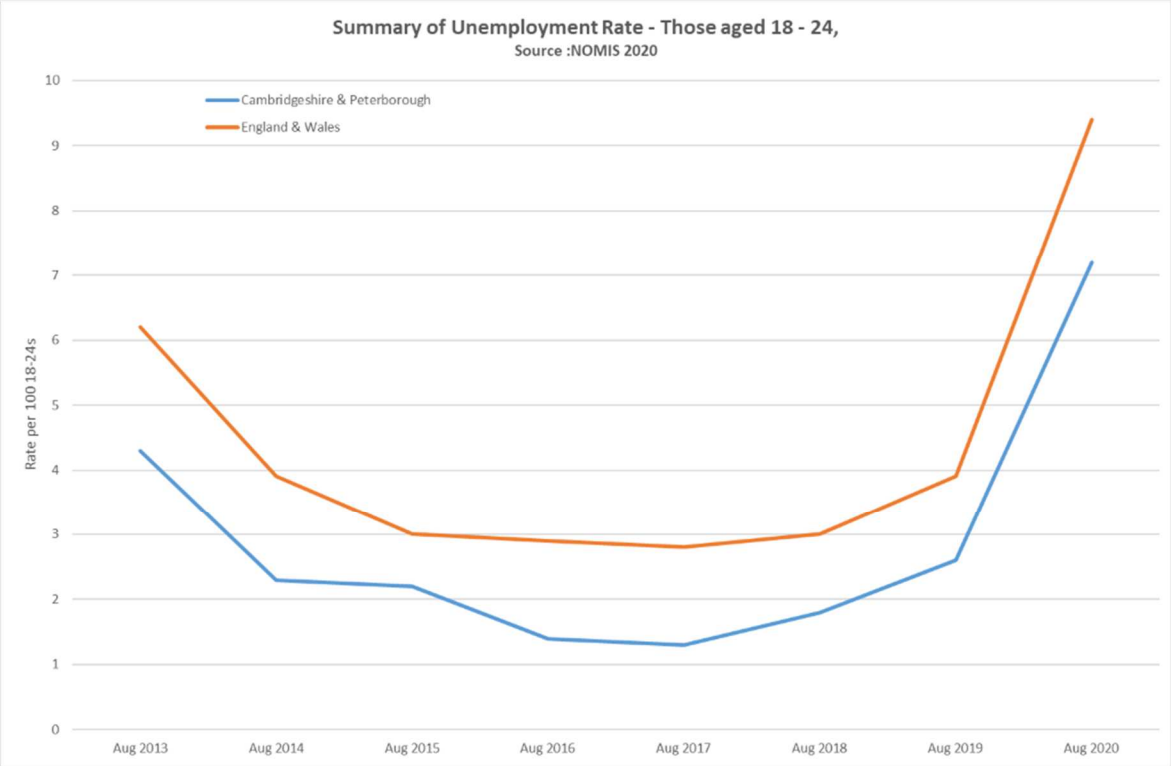


The Economy sub group are leading on these issues and are developing plans for inclusive growth across the economy

Young People

The long term impacts of the pandemic are likely to be felt by young people both now and for decades to come. Prior to lockdown, youth unemployment had already been rising with over 700,000 people aged 16-24 not in education, employment or training nationally, compared to the same three month period last year. A report by a panel of experts and led by the Learning and Working Institute estimates that a further 500,000 young people will enter long term claimant unemployment (without a job for 6 months) over the next 18 months.

Locally, we have seen an increase of 3,100 young people aged 18-24 claiming Universal Credit comparing August 2020 to March 2020 pre-pandemic. The unemployment rate amongst this group has increased from 2.6% of 18-24 year olds to 7.2% over the year to August 2020.



COVID 19 has caused impacts on many different groups of people, some clear and obvious, some known to public services, and others more hidden and affecting people who would not normally be involved with public services.

We know that some people are at higher risk of severe and lasting harm or death from COVID-19. These people were the focus of the 'shielding' elements of the pandemic management regime. Other high risk areas include:

- People at risk of poor mental health due to anxiety about COVID-19 or the increased social isolation caused by the lockdown measures. This would also include people experiencing bereavement due to COVID-19 infection
- People at risk from economic impacts caused by lock down and the supressed economic operating conditions that outbreak management has caused. The economic impacts arise from the restrictions on movement imposed by the Government to manage the pandemic, and affect economic sectors differently. However, despite the significant investment Government has provided on job retention schemes, unemployment is rising rapidly and will likely continue to rise over the coming months. People at risk from harm in this category may not have been known to public services before. There will also be people who are already in deprived circumstances who face further issues as a result of the economic impacts they experience.

Think Communities and placed based working

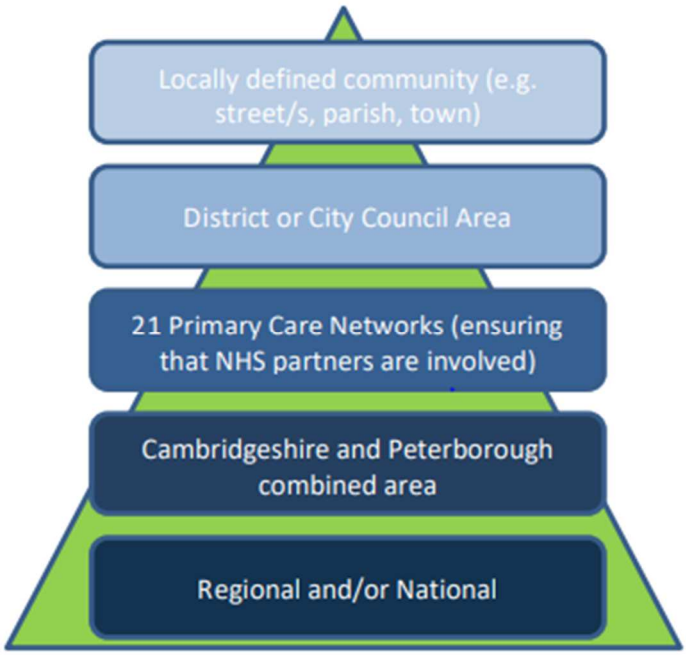
Since the beginning of the pandemic, the coordinated Hub response developed across Cambridgeshire has proven the concept of the Think Communities approach in real time supporting tens of thousands of residents to protect themselves from COVID-19, and as such not overload the NHS or other statutory services. This way of working together across all local councils, services and communities has resulted in positive outcomes for our residents, communities, the council and our partners. It hasn't relied on public sector reform, but instead a common-sense approach to working smarter together. This unified approach is something we want to build on, taking Thinking Communities as a concept into delivery across Peterborough and the county.

It is important that we now capitalise on the relationships, working arrangements and processes that have been shown to work well, as well as review where necessary, as we evolve our services into a new normal of outbreak management and coping with the social, health and economic challenges which our citizens will face in the future. We have a unique opportunity to work differently to support residents and communities in need, to provide opportunities for everyone, and to ensure our communities truly are at the centre of our organisation.

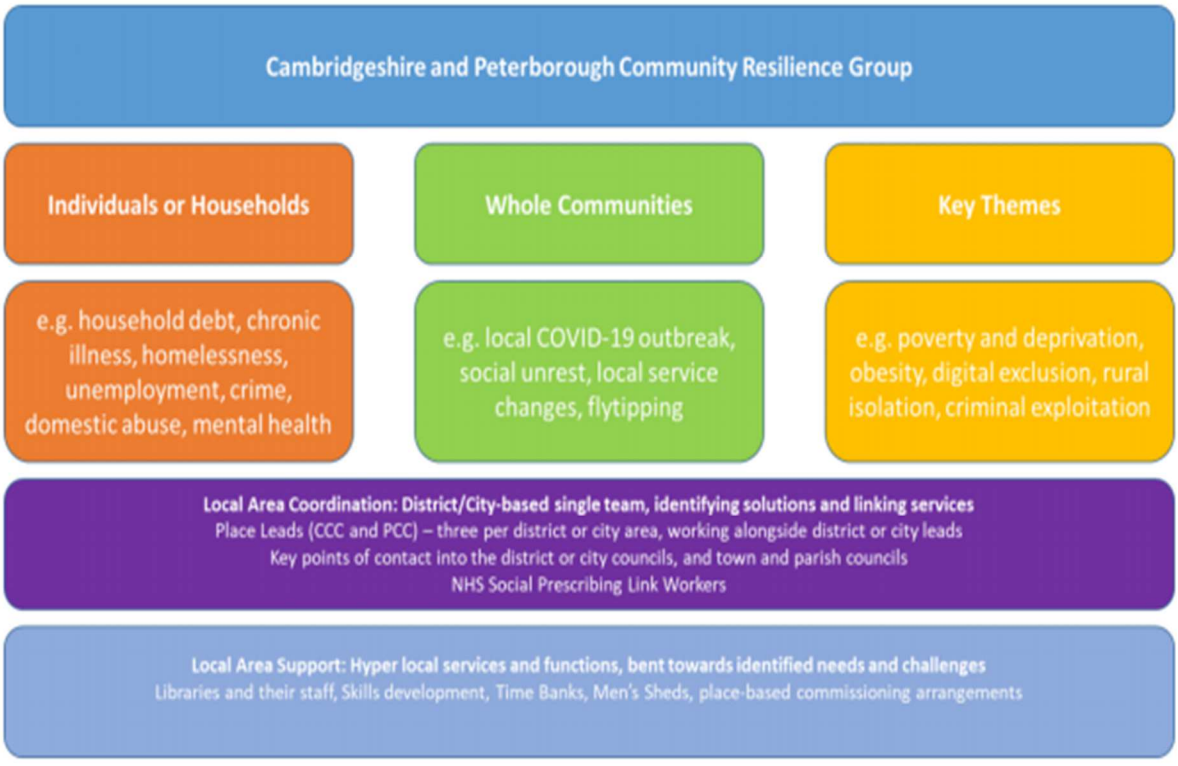
This step-change is perhaps best described as seeking to create a unified approach across our public sector system, using the now well-developed principles of Think Communities. Our aim is to ensure that communities are given the opportunities and access to information and support where necessary at the most local level, in ways that make most sense to them. Our residents shouldn't be concerned about who delivers which service or provides what opportunity; instead, they should experience a unified public sector response that feels and is accessible, proportionate, timely and effective.

To ensure focussed leadership, the Communities and Partnerships Service Directorate in PCC/CCC will align its whole focus to the Think Communities Unified Approach – for example, libraries will lead or directly contribute to much of the place-based work (including place-based commissioning, community responses, befriending), our skills service will support the social mobility agenda, and our regulatory services functions will support economic and community recovery.

The Service Directorate will work with our partners to fully establish place-based approaches to collaborative public service delivery, in support of the council's strategic priorities. Our work during the pandemic has shown that, in fact, the unified approach we are seeking to take needs to work at a number of different geographical levels, as required and defined by our communities – see the diagram below.



The experience of delivering a Think Communities approach in real time over the past few months has enabled a sharper focus to be determined for the things we should focus on, as illustrated in the diagram below:



Other key points

- Income, environment and education are all significant factors which impact health and whilst the links between deprivation and poor health outcomes are not new, they have been further highlighted during the pandemic. The

councils and its partners recognise the need to jointly tackle inequalities which has formed the basis of the Health and Wellbeing strategy. The strategy is underpinned by the Joint Strategic Needs Assessment which provides a 2019 baseline of health needs.

- The environment where people live can play a critical role in shaping long term health. CCC are working with partners to develop innovative ways of building new housing and communities that can adopt new planning principles to improve health and quality of life. Northstowe in South Cambridgeshire, is one of ten Healthy New Towns nationally and has received funding to create a healthy environment. Learning from these towns has led to agreement of ten national 'Healthy New Town' planning principles ("Putting Health into Place"), which have been adopted by several large housing developers. Locally we're developing a toolkit to implement the 'Healthy New Town' principles.

  District Council planning officers from Cambridgeshire and Peterborough have met with representatives of the local NHS 'Estates' group, to work out how to plan better together for health and care services in new housing developments.

- In 2014, the Equality Trust published its findings on inequality. They noted that the overall cost of inequality in the UK was £39 billion per year and resulted not only in a financial impact, but reduced physical and mental health, lower life expectancy and higher crime and imprisonment. The report argues that even small improvements to equality would result in lower levels of crime and imprisonment, better mental health, higher healthy life expectancy, and would lead to a socially and financially richer society.

- When we consider Health Inequalities across the system, it is helpful to view them through the lens of the four grand challenges. The evidence demonstrated in this report highlights that the impact of the pandemic, will widen the gaps that already exist. It could be suggested that this shared vision helps frame our focus, in conjunction with other Subgroups.

  The Four Grand Challenges

  - **Give people a good start in life**
  - **Ensure people have good work**
  - **Create a place where people want to live**
  - **Ensuring people are healthy throughout their lives.**

4.0 Links to existing strategies and the system wide landscape

Draft Cambridgeshire and Peterborough Health and Wellbeing Strategy

PCC Draft Healthy Weight Strategy

Tobacco Control Alliance

Priorities for local Integrated Neighbourhoods

CCG Diabetes and Obesity Clinical Community (including the BMI Can Do It campaign)

New Government Obesity strategy

PHE Better Health Campaign

Other STP clinical communities

PCC Active Lifestyles and Sport Strategy

National Sport England Strategy ‘Towards an Active Nation’

PHE COVID-19 review of disparities in risks and outcomes

NHS Long Term Plan

Cambridgeshire and Peterborough Health Inequalities Strategy

Think Communities

Joint Strategic Needs Assessments

Better Start in Life

Adults Positive Challenge

Better Care Funding

Impacts of Covid 19 in Cambridgeshire and Peterborough Needs Assessment

5.0 Key Partners

District Councils (including their partners and stakeholders)

Cambridgeshire and Peterborough Clinical Commissioning Group (including Primary and Secondary Care)

All LRF partners should act as champions and consider workplace interventions to ensure a healthy happy workforce (Police, Fire, Ambulance service etc.)

Voluntary and community sector who deliver at community level

Disability/inclusive agencies

Everyone Health (including their partners and stakeholders)

Living Sport (including their partners and stakeholders)

Sport England

Early years and education sector

Workplaces

Social Prescribers

Primary Care Networks

PCVS

Hunts Forum

Adrian Chapman

Chair of Inequalities work-stream.

October 2020

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 8
7 DECEMBER 2020	PUBLIC REPORT

Report of:	Cambridgeshire and Peterborough Clinical Commissioning Group	
Contact Officer(s):	Rob Murphy, North Alliance Programme Director Laura Halstead, Head of Communications and Marketing	Tel. 01733 724000

BMI CAN DO IT: PROGRAMME TO SUPPORT OBESITY AND DIABETES INEQUALITIES – DECEMBER UPDATE

RECOMMENDATIONS
It is recommended that the Health and Wellbeing Board: 1. Acknowledge updates for the BMI Can Do It programme, including the rollover of some budget allocations due to current COVID-19 pressures within Primary Care.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request from the Board.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update on the work of the NHS-driven BMI Can Do It Programme, in accordance with proposals made to the CCG's Governing Body in July 2020.

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

2.8.2.1 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.

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

3. BACKGROUND AND KEY ISSUES

3.1 In July the CCG's Governing Body approved the launch of a major initiative across the system to address obesity, people who are overweight and diabetic patients specifically, that would benefit from losing weight. This initiative has become known by its brand name of BMI Can Do It and has so far been predominantly driven by a widespread healthy living movement, encouraging people to 'eat well, sleep well, and move more' through extensive communications and marketing.

3.2 Since the Governing Body approved the proposals to launch an Obesity and Diabetes programme, a small Project Management team was put in place and work to progress the individual elements of the programme commenced. The table in Appendix 1 summarises progress on the individual elements, or 'milestones' (M1-17), of the programme to date, all of which are RAG rated, and we will highlight key exceptions and successes below.

4. COMMUNICATIONS AND ENGAGEMENT: BMI CAN DO IT MOVEMENT

4.1 The CCG communications team has worked in close collaboration with system partners and external stakeholders to make the public-facing BMI Can Do It movement a significant and growing success.

4.2 Key highlights of the programme to date include securing partnership with a range of fitness experts who have agreed to share exclusive content for free via BMI Can Do It, over a dozen healthy recipes approved by our dietician, and a number of guest blogs to help inspire a positive drive for change amongst our population.

From the outset of the movement we have worked with groups of people who have traditionally faced barriers in accessing health care. We have spoken with culture and faith groups, and charities as well as people from BAME backgrounds who work in the healthy living sphere. To date this has resulted in us being able to feature recipes co-created with individuals who are part of BAME communities, share free fitness content from instructors from a range of backgrounds, and receive positive feedback from culture and faith groups in response to our key messages. We have also had significant positive engagement with the movement from key system partners as well as from local organisations like the SUN Network, the University of Cambridge and Living Sport. We will continue to build on this work as the movement grows.

4.3 Our next steps on the public facing campaign are to generate even more original content that is free to access, launch a new standard “onboarding” challenge that will support new joiners of the movement irrespective of the month they join, and work towards exciting new partnership initiatives including development of a healthy living week with our LAs.

5. BMI CAN DO IT PROGRAMME UPDATES

5.1 Programme work to date: The focus of activity has been on the Very Low Calorie Diet trial (M15); bringing Tier 4 bariatric services within area (M17); and supporting the current work of Family and Early Years services across the system (M10).

5.2 Key successes to date include:

- Milestone 8 is complete, following the successful joint promotion of the 15 Health checks via Local Pharmacies working with Diabetes UK.
- BMI Can Do It supported a local National Childbirth Trust bid for Starting Well Health and Wellbeing Funding. If funding is awarded, the local NCT would expand their Birth and Beyond Community Support project, further reaching out to young families in local BAME communities.
- The new Diabetes Local Enhanced Service (LES) agreement has been rolled out with an alternative agreement in place for the remainder of the financial year to take into consider the impact COVID-19 has had on Primary Care. This will focus on the 8 Care Processes, including calculating the BMI of patients and offering Very Brief Interventions to improve their outcomes.
- In light of COVID-19 pressure on primary care, the additional £500k for targeting the 3 treatment targets as outcomes is being deferred into 2021/22. One of the recommendations to the December private meeting of the CCG’s Governing Body is for this funding to be available in 2021/22.

- Promotion of the National Diabetes Prevention Programme (NDPP) is prepared and text messages to patients are ready to be sent as part of the Diabetes LES following the change of NDPP provider. The October NDPP Activity overview is at Appendix 2.
- Agreement of the local specification/protocol for the Very Low-Calorie Diet with an aim to start patient recruitment in January.
- System consensus on starting Tier 4 bariatric services from April 21 subject to contract agreements.
- Rollout of Patient Activation Measures (PAMs) to the Early Adopter Primary Care Networks (PCNs) is restarting following a pause, due to COVID-19. Social Prescribing Link Workers have been trained and are using PAM to assess patient progress. Workshops for other Health Professionals are scheduled for December 2020 and February 2021.
- Engagement with Trusts to work on the inclusion of healthy lifestyle messaging to be included in patient letters in advance of surgery as part of the pre-hab programme.

5.3 Summary updates on all the programme workstreams, set out as per the July proposals to the CCG's Governing Body for ease of reference, are available in Appendix 1; BMI Can Do It update table – December 20.

6. ANTICIPATED FINANCIAL IMPACT

6.1 No additions to the current budget are proposed.

6.2 The CCG's Governing Body has been asked to approve the rollover of the £500k allocation for diabetes 3 treatment target outcomes incentive for Primary Care to 2021/22 due to current COVID-19 pressures.

6.3 Without funding available for Eating Disorders (ED) pathway support there is a possibility that M12 work may have to be postponed until Spring 2021, when Obesity-related ED and Nutrition training for Primary Care health professionals could be included as part of the 2021 Diabetes Local Enhanced Service. This would, however, then coincide with the proposed launch of the integrated ED service.

7. PROJECT DELIVERY

7.1 A small project team oversees the delivery of this programme, with specialist support from other CCG Teams and system partners as required. Update reports will be taken to all future Governing Body meetings. The team is supported and advised on appropriate and realistic prioritisation of work within the set timeframe by the CCG Programme Director, who has oversight of the BMI Can Do It programme. A Task and Finish Group, chaired by the CCG Accountable Officer also takes place monthly, bringing together external partners to ensure a continued system wide approach.

8. REASON FOR THE RECOMMENDATION

8.1 The Impact of health inequalities on obesity and diabetes has been highlighted through the COVID-19 epidemic. The death rate in the areas of highest deprivation is significantly higher for COVID-19 due in part to obesity and diabetes. There is an existing health inequality for non COVID-19 patients within our area which also results in worse outcomes for some of our patients. This could result in c. £3m of savings to the system if the weight loss across the population is achieved, some mitigation of second – or subsequent – wave COVID-19 risk for our population, and will address some of the pre-COVID-19 health inequalities in the STP.

9. CONCLUSION

9.1 The BMI Can Do It programme has made significant gains in its Communications and Engagement workstreams to date. The focus is also now on finalising the clinical workstreams in Q4 with project support, and regular reporting to the Governing Body until the projected end of the programme.

Rob Murphy, North Alliance Programme Director
Laura Halstead, Head of Communications and Marketing
Cambridgeshire and Peterborough Clinical Commissioning Group
24 November 2020

10. APPENDICES

10.1 Appendix 1: BMI Can Do It update table – December 20
Appendix 2: NDPP Activity October 20

Area	Interventions – Milestones on GB paper aligned with Project Plan (M1-17)	Cost agreed by GB	Est. time scales	RAG	Updates/next steps	Outcomes/impact
Communi-cations and Engagement	**M1** Large scale **Social Media & community 'movement'** across all stakeholders to promote healthier lifestyle options (Sleep / Eat / Move / Live well) from 1st July to 1st January & advertise those resources already available (e.g. NHS weight loss plan). Work with people with larger body size and involve academic expertise as well as comms expertise when designing this campaign / movement. To aim to lose **1 million kg** in those C&P residents who are overweight and promote more physical activity	£20k	July onwards		Website live and regularly updated Daily social media updates Worked with people with lived experience to ensure communications are sensitive Proactive collaborations with personal trainers and yoga instructors, creating a combined total of 9+ hours of free fitness content Proactive collaboration with food bloggers as well as CCG staff, creating over a dozen healthy recipes	12,900 website visits to date 211,200 social impressions (Instagram, Facebook, twitter) Over 850 registered members Over 1,100 downloads of monthly challenges in October and November Over 550 visits to our healthy recipe page
	M2 To reach out to **older residents** and promote increased daily activity, promoting better cardiovascular and brain health and reduce risk of falls.	Inc. Above	July onwards		Seated exercise challenge and video created for less mobile people Shared healthy living information with parish council magazines to reach target audience Contacted local voluntary organisations and charities with an older target demographic	BMI Can Do It featured in a number of parish council magazines, reaching thousands of households
	M3 To develop a **Health & Wellbeing week for Year 10,11 and 12 students**, to promote self-care in minor injuries and illness, contraception, healthier lifestyle choices, maintaining a healthy weight, with height & weight measurements taken, immunisations offered and NHS career fair	Inc. Above	Delivery planned for Feb 2021		Age focus changed to Y7 and Y8 following provider feedback. Communications team working with LAs to progress a plan for a virtual wellbeing week.	Intended outcome: Delivery of the week in February.

Area	Interventions – Milestones on GB paper aligned with Project Plan (M1-17)	Cost agreed by GB	Est. time scales	RAG	Updates/next steps	Outcomes/impact
	M4 To ensure all residents are reached with specific messaging to those **BAME communities** at increased risk of ill health. **Maternity -** overweight mothers are a group also requiring specific focus.	Inc. Above	July onwards		Reached out to 40 local faith/culture groups to signpost to BMI Can Do It Worked with BAME food bloggers on authentic recipes with a healthy twist Linked in with system partners to ensure all communications are sensitive to different cultures and backgrounds Partnered with local yoga school to create videos, featuring skilful teachers from a range of backgrounds and ages Worked with NCT on Starting Well DHSC funding bid that is geared towards expanding services for BAME mothers, with a specific focus on reducing health inequalities Linking with PH and the LMNS to support the Reducing Obesity in Maternity Project as part of M10.	Positive response from some community groups to indicate they would share with their members Several recipes representing culturally diverse diets Reputational risk avoided through sensitive comms Several hours of fitness content featuring teachers from BAME communities Bid for NCT BBCS HW Funding submitted and feedback expected December.
Provider weight loss interventions	M5 **Primary Care –** Make weight and height measurement a routine part of primary care and promote **proactive opportunistic weight conversations**, including Very Brief Intervention, with those seeking healthcare advice, across the system	In Diabetes LES.	Included in Nov update of October 2020 LES.		Routine measurements/VBI are included in the Oct 2020 LES and the November update. Toolkits promoting BMI Can Do It/Healthy lifestyles have been shared with Primary Care. SMSs promoting BMI Can Do It to pre-diabetic patients and patients with high BMI also included in LES. See also: related updates in M13	Patients to be measured for population data capture Promotion of BMI Can Do It to Primary Care patients and workforce via SMS, practice websites and extranets. See also: related outcomes in M13

Area	Interventions – Milestones on GB paper aligned with Project Plan (M1-17)	Cost agreed by GB	Est. time scales	RAG	Updates/next steps	Outcomes/impact
Provider weight loss interventions	**M6 Acute and community contract** - To promote **proactive opportunistic weight conversations**, including Very Brief Intervention (VBIs), with those seeking healthcare advice, across the system. Pre-hab initiative.	None	Sept onwards		Working with acutes on additional text for prehab letters Working with acutes to include VBIs within 2021/22 contracts.	Intended outcomes: Elective patient 'Pre-hab' letters to feature BMI Can Do It as a helpful resource VBIs ideally to be included in next round of acute provider contract (s).
	M7 To promote uptake of self-referrals of those residents with Pre-Diabetes to the remote **National Diabetes Prevention Programme**	SMS costs £25k	Sept onward. SMS included in October 2020 LES and its Nov update		SMSs promoting NDPP and BMI Can Do It are part of Diabetes LES. Preparing promotional materials to increase uptake of self-referrals. CCG sharing NDPP data to allow us to pinpoint any uptake in self-referrals as well as follow progress	Primary Care notified of switch to new NDPP provider. Intended outcome: monitor NDPP data to evaluate effectiveness of NDPP promotion via SMS
	M8 To work with Diabetes UK to promote the **15 Health checks through Local Pharmacy**	No additional cost	Complete		Complete. Diabetes UK survey runs until 15 Nov. Evaluative outcomes to be shared with the CCG.	Leaflets included in patient prescriptions, survey details for evaluation also disseminated Achieved coverage via a joined press release for this strong piece of work
	M9 Support overweight or obese NHS staff in the CCG and our NHS providers to lose weight through provision of on-site lifestyle support services (which should also be able to support change in other lifestyle factors)	Providers	Sept onwards		On-site lifestyle support services are available through LAs and offered to all NHS employers in our area, but current uptake is low. Communications team to work with LAs in New Year to ensure BMI Can Do It is signposted to.	Intended outcome: Promote BMI Can Do It to NHS staff when lifestyle services are refreshed in 2021.

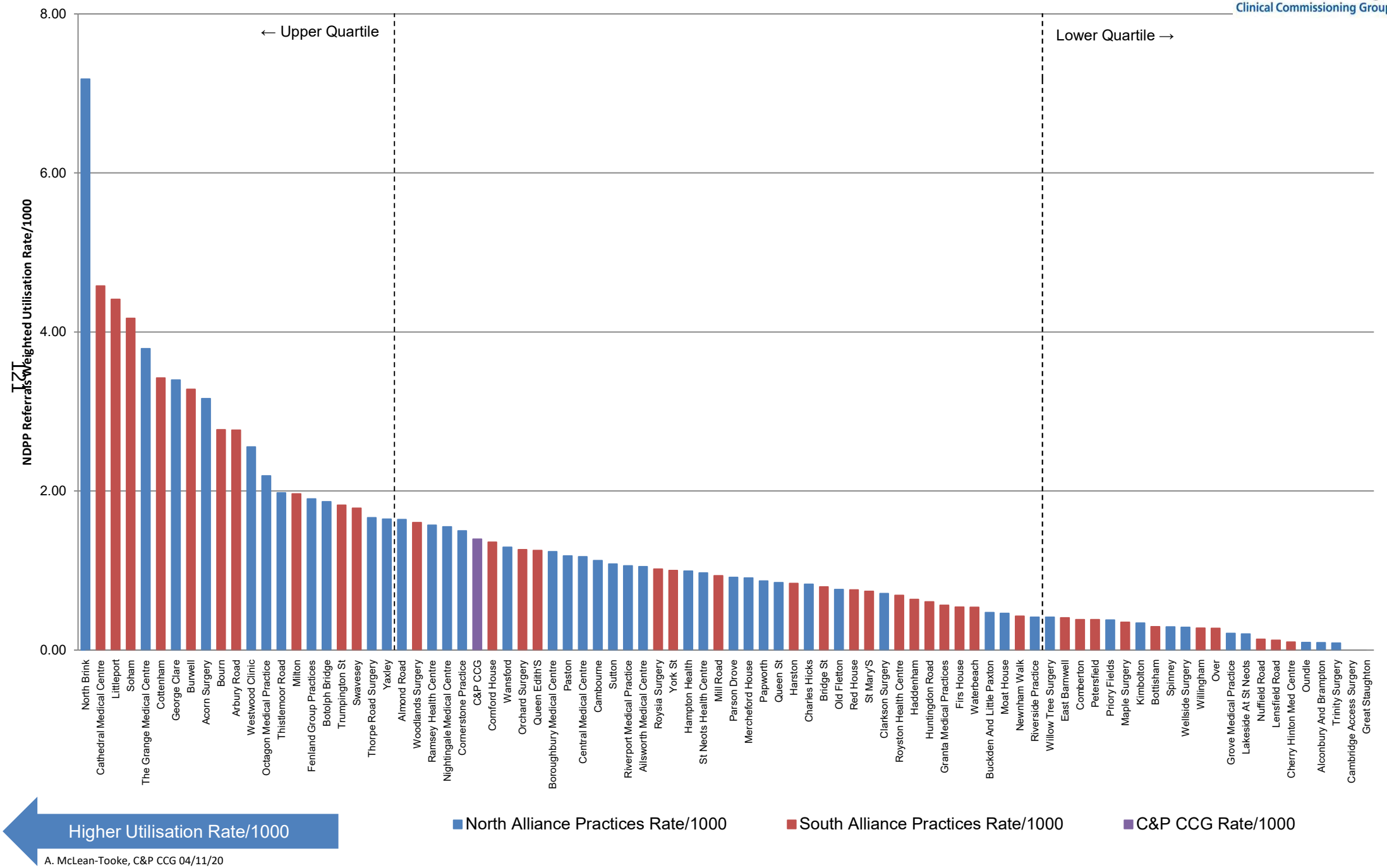
Area	Interventions – Milestones on GB paper aligned with Project Plan (M1-17)	Cost agreed by GB	Est. time scales	RAG	Updates/next steps	Outcomes/impact
Prevention in the community	**M10** To engage proactively with all families identified to have Primary school age children who are overweight or obese - the intention is to work with Healthy Schools Services, Tier 1 weight loss services and Family Support Workers to encourage healthier shopping/cooking/eating habits in 500 families.	£50k	Sept onwards		Working with commissioners and providers on BMI Can Do It signposting within Family/Early Years services. Working with Public Health to include BMI Can Do It messaging within the National Child Measurement Programme letters to families of Reception/Y6 age children. Despite available funding, capacity for additional funded pilots is currently limited due to COVID-19. **Meeting to review clinical support opportunities 11 Dec.**	Intended outcome is to direct families who might need additional support to BMI Can Do It Intended outcome is for NCMP letters to feature BMI Can Do It as a helpful resource in 2021 Intended outcome is to identify clinical opportunities to support existing work
	M11 To utilise the 50,000 Patient Activation Measure licenses and support improved activation amongst our residents	Licences available	July onwards		21 Patient Activation Measure licenses have been activated, 1 for each Primary Care Network (PCN). Social Prescribing Link Workers (SPLWs) have undertaken PAM training and are supporting patient progress with PAMs PAM training scheduled in for other Health Professionals Roll out to Early Adopter PCNs, focusing on people with Diabetes now restarted, post pause due to COVID-19.	SPLWs already supporting PAM use. Intended outcomes: More health professionals trained to support people in using PAM tool People with Diabetes empowered to self-manage their LTC, with support, leading to better health outcomes Qualitative data expected Spring 2021
Management and Treatment	**M12** To improve access to **Eating Disorders (ED) pathway** for those with emotional eating and binge eating disorders. Identify sources of advice and support for patients who do not meet criteria for ED pathway.	None	July onwards		3rd sector ED service PEDS is best clinical pathway to support. Working with Mental Health Team and partners to identify next steps. One option is nutrition and obesity-related ED training for Primary Care Health professionals via the 2021 LES.	Intended outcome: raise awareness within Primary Care of common but lesser known eating disorders related to obesity, e.g. binge eating disorder, to support patient pathways.

Area	Interventions – Milestones on GB paper aligned with Project Plan (M1-17)	Cost agreed by GB	Est. time scales	RAG	Updates/next steps	Outcomes/impact
Management and Treatment					Lived experiences meetings are part of BMI Can Do It's ongoing communications and engagement work, including the SUN Network and a member of the CCG's ED Steering Group.	Independent evaluation of public facing elements of the programme and coproduction through engagement
	M13 To ensure that local referral pathways for people with Diabetes are functional and meet national guidelines, including DISN and MDFT, and meeting the 8 Care Processes and 3 Treatment Targets and to be the regional pilot site for NHSE Eclipse Healthcheck 2020 - Between £100- £500k incentive for patient total completion bonus (£10 per wtd patient) for 20/21 only	Addition to Diabetes LES – propose to postpone until 21/22	October onwards		Alternative Diabetes LES discussions are ongoing due to delays linked to pandemic response and flu vaccination programme delivery. Practices have been asked to focus on the 8 Care Processes for the remainder of 2020/21 as an interim measure to include BMI assessment £500k to be deferred until 21/22	Current anticipated outcome for 2020/21 – to capture BMI of patients and offer appropriate interventions. Intended 2021/22 outcome: a revised, more outcomes based Diabetes LES. Intended outcome: follow Eclipse data to evaluate ongoing effectiveness of diabetes pathway
	M14 To promote the implementation and evaluation of remote digital support for People with Diabetes, including the trial of MyDESMOND and Low Carb DDM apps. Evaluate the overall weight loss programme.	From within system resource	March '21		Working with University of Cambridge to implement these two apps for patients next year, including formal research study.	Intended outcomes: Roll out digital support via apps and evaluation
	M15 To replicate the DiRECT trial success for 400 people with diabetes, holding an #AmbitionForRemission for 1000 people through offering a **Very Low Calorie Diet (VLCD) programme**. Maximum uptake and cost for 1000 people. 1000 VLCD programme - £1900 per patient – max £1.9m	Initial pilot of 100 patients - £190k	Sept onward. Estimate recruit to pilot Jan '21, estimate launch pilot		Work underway to launch pilot before end of 2020/21 financial year.	Intended outcomes: Patients take part in VLCD pilot Patients identified as in Diabetes remission post pilot.

Area	Interventions – Milestones on GB paper aligned with Project Plan (M1-17)	Cost agreed by GB	Est. time scales	RAG	Updates/next steps	Outcomes/impact
Management and Treatment			March '21 latest			
	M16 To promote utilisation and implementation of virtual group consultations to support our residents using the full MDT (both community-based e.g. Health Coaches & Practice Nurses; and secondary care)	Working with external providers and practices	Sept onwards		The CCG's North Alliance hosted a webinar to promote Virtual Group Consultations to Primary Care Networks Very well attended webinar with re-run later in November. VCR bookings increased significantly and looking to increase capacity to keep wait times to 6 weeks.	Increase in skills and training in practices. Reduced referral to CPFT/acute
	M17 To develop the local Tier 3 and 4 Bariatric services at Peterborough. Tier 3 requires more funding due to demand. Tier 4 cost neutral.	£100k recurrent cost to meet demand.	From Sept; launch of new services estimate April 2021		System meetings taking place to evaluate Tier 4 business case and mitigate risk of 'bottlenecking' Tier 3 services by anticipating further increased demand/ provision of Weight Management Services overall Tier likely start in Q1 21/22. Tier 3 backlog clearance and increased capacity starting in January.	Intended outcomes: Improved Tier 3 service provision within area Tier 4 service available within area RTT, patient experience and patient outcomes improved
Total		**£635k (Max £2.6m)**	July onwards			

Practice NDPP Referral Weighted Utilisation Rate/1000 - Oct-20

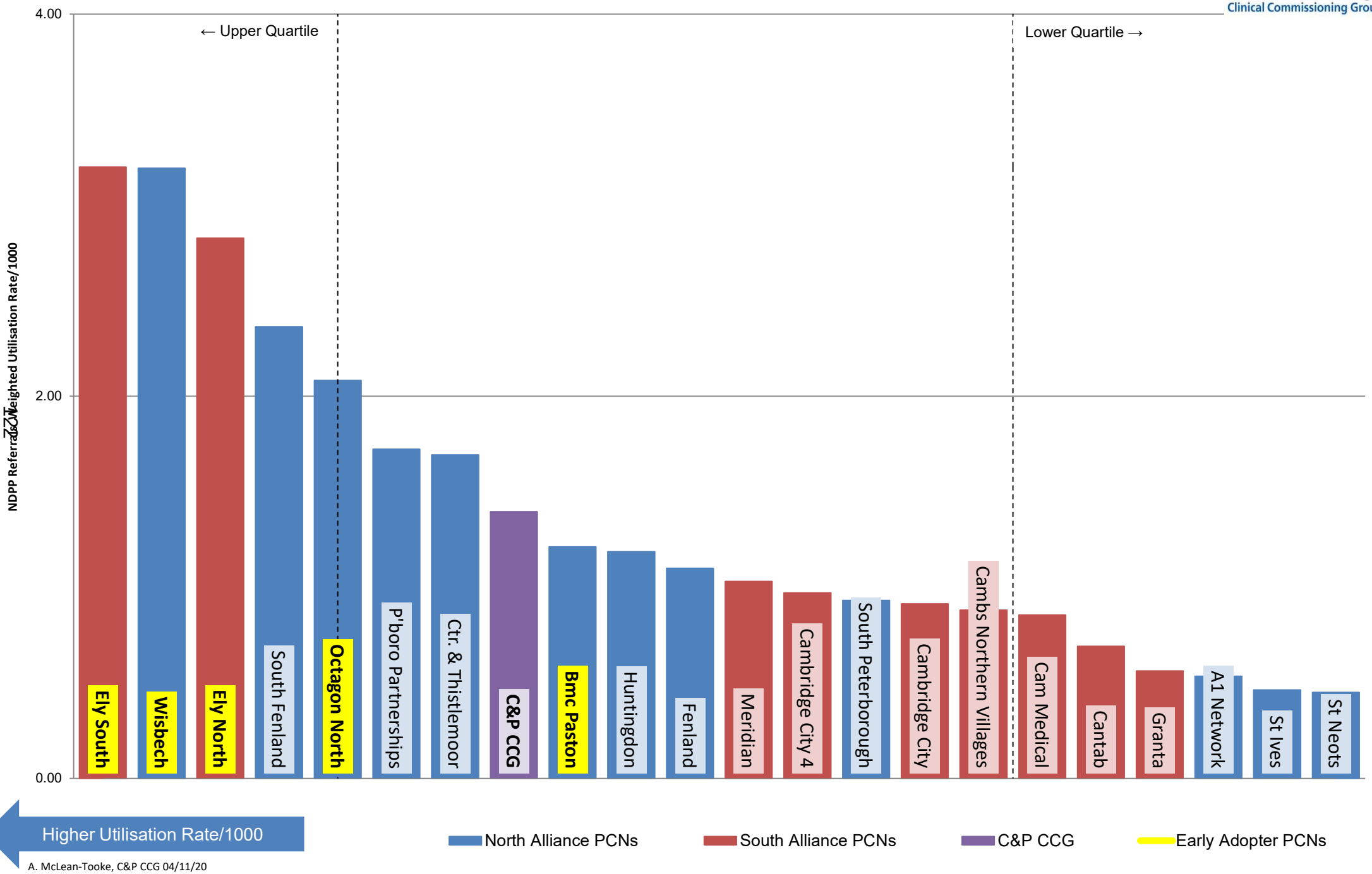
NHS Cambridgeshire and Peterborough Clinical Commissioning Group



A. McLean-Tooke, C&P CCG 04/11/20

PCN NDPP Referrals Weighted Utilisation Rate/1000 - Oct-20

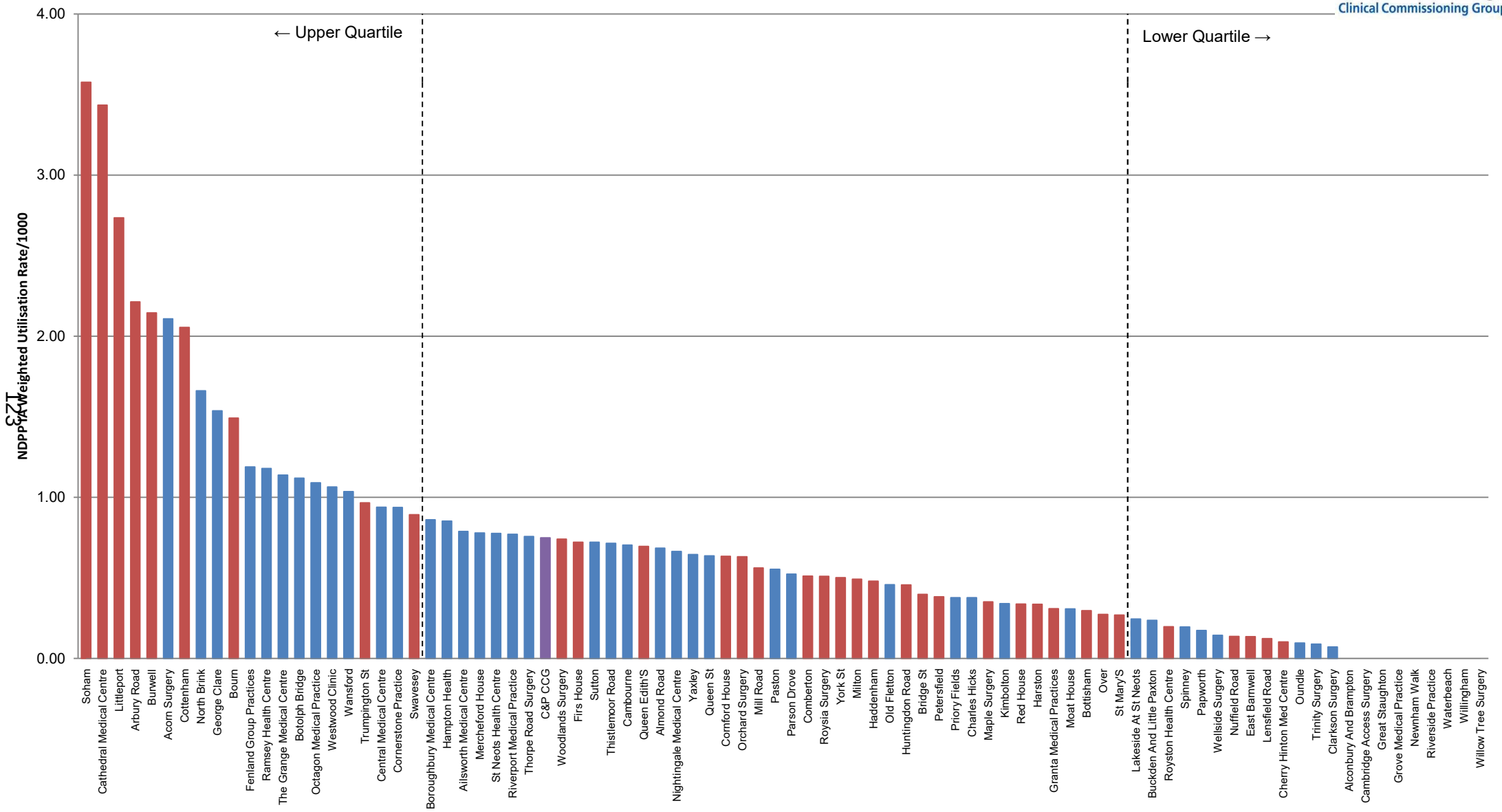
NHS Cambridgeshire and Peterborough Clinical Commissioning Group



A. McLean-Tooke, C&P CCG 04/11/20

Practice NDPP Intitial Assessment Weighted Utilisation Rate/1000 - Oct-20

NHS Cambridgeshire and Peterborough Clinical Commissioning Group



Higher Utilisation Rate/1000

North Alliance Practices Rate/1000

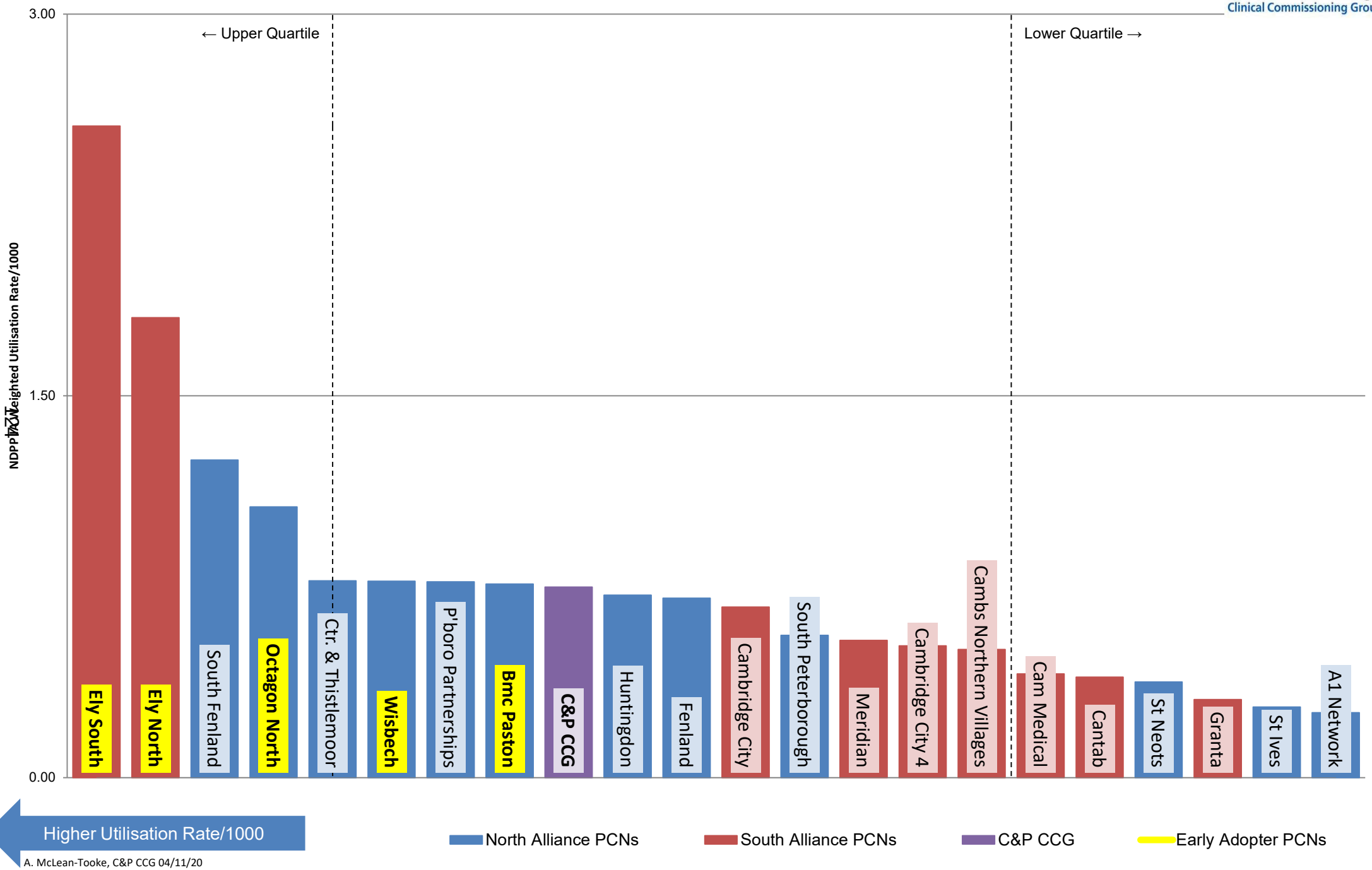
South Alliance Practices Rate/1000

C&P CCG Rate/1000

A. McLean-Tooke, C&P CCG 04/11/2020

PCN NDPP Intitial Assessment Weighted Utilisation Rate/1000 - Oct-20

NHS Cambridgeshire and Peterborough Clinical Commissioning Group



A. McLean-Tooke, C&P CCG 04/11/20