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HEALTH AND WELLBEING BOARD

THURSDAY 18 JUNE 2015
1.00 PM

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

AGENDA

	Page No
1. Apologies for Absence	
2. Declarations of Interest	
3. Minutes of the Previous Meeting	5 - 12
4. Health and Wellbeing Board Membership	13 - 20
The Board is requested to consider membership of the HWBB and how new Members are agreed going forward.	
COMMISSIONING ISSUES	
5. Clinical / Local Commissioning Groups	
(a) Primary Care Programme Update	21 - 24
The Board is requested to note the report and to discuss the developments in the Primary Care Strategy.	
(b) System Transformation Programme	25 - 28
The Board is requested to discuss the progress of the System Transformation Programme and to make comments.	
(c) Borderline And Peterborough Primary Care Transformation Programme, Including Prime Minister's Challenge Fund Delivery	29 - 32
The Board is requested to note the report and comment on the development of the programme.	

There is an induction hearing loop system available in all meeting rooms. Some of the systems are infra-red operated, if you wish to use this system then please contact Philippa Turvey on 01733 452460 as soon as possible.

(d) **Operational Plan and Quality Premium 2015 - 2016** **33 - 36**

The Board is requested to note and consider the contents of the report.

6. Public Health

(a) **Annual Director of Public Health Report** **37 - 56**

The Board is requested to review and consider the contents of the report.

(b) **Report On The Findings Of The Task And Finish Groups On Bowel And Cervical Cancer Screening And Immunisation Uptake In Peterborough** **57 - 120**

The Board is requested to consider the implications of the findings of the Task and Finish groups and support the recommendations.

7. Adult Social Care

(a) **Adult Social Care Better Care Fund Update** **121 - 126**

The Board is requested to note and comment on the report.

8. Children's Services

(a) **Peterborough 2014 / 15 Children & Young People's Joint Strategic Needs Assessment** **127 - 184**

The Board is requested to note and consider the recommendations in the report.

(b) **Healthy Child Programme** **185 - 194**

The Board is requested to note the report.

9. Health Watch

(a) **Children / Young People Engagement** **195 - 196**

For the Board to receive a presentation.

INFORMATION AND OTHER ITEMS

10. Health and Wellbeing Strategy **197 - 254**

The Board is requested to agree to update the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy and to approve the process for this.

11. Section 256 Agreement for Hospital Alcohol Liaison Project **255 - 256**

The Board is requested to note the contents of the report.

12. Performance Report **257 - 270**

The Board is requested to note the contents of the report and review performance.

13. Schedule of Future Meetings and Draft Agenda Programme **271 - 274**

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

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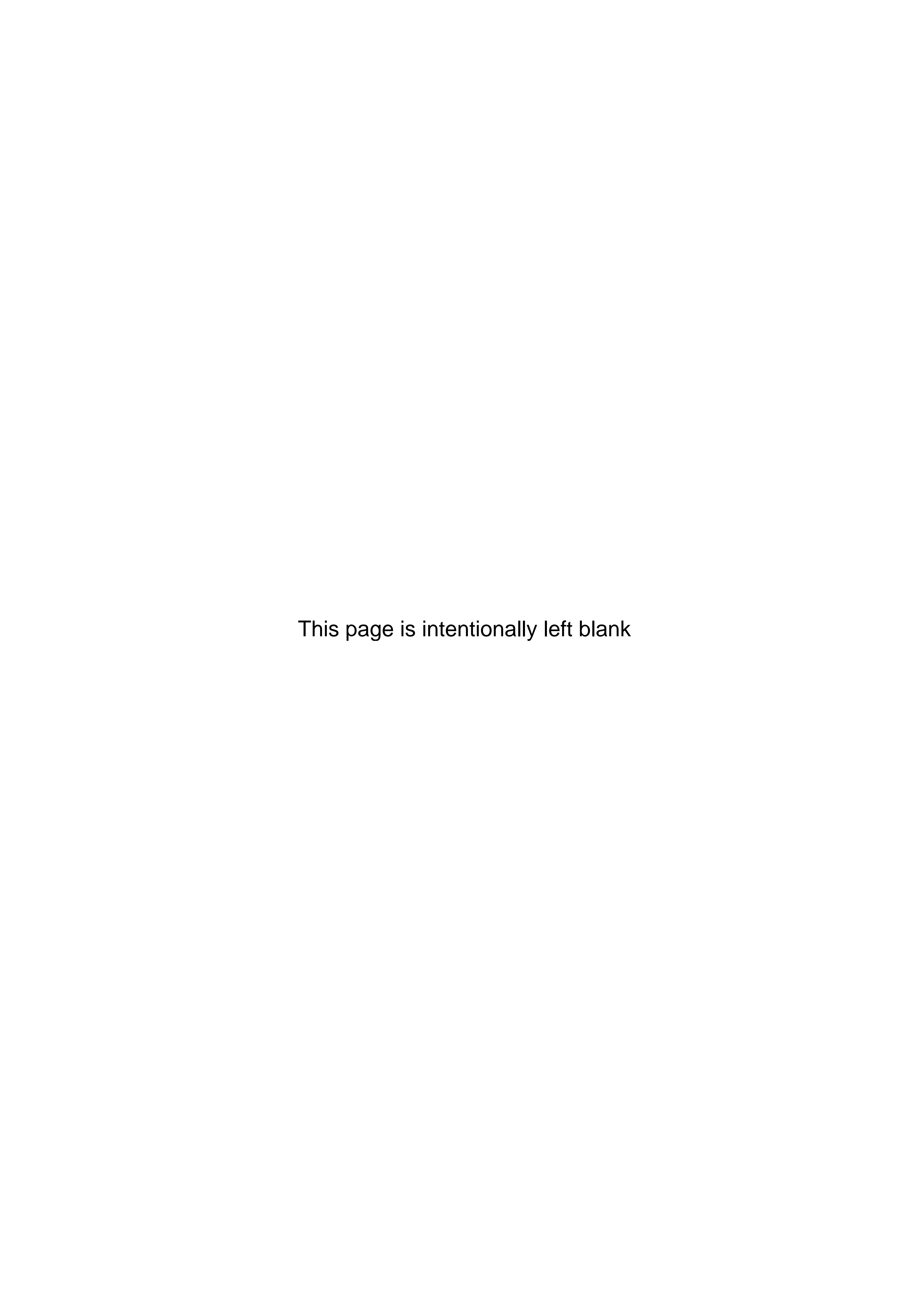
http://democracy.peterborough.gov.uk/documents/s21850/Protocol%20on%20the%20use%20of%20Recording.pdf

Board Members:
Cllr Holdich (Chairman), Cllr Fitzgerald, Cllr Lamb, Cllr Maqbool, Cllr Scott, Wendi Ogle-Welbourn, Adrian Chapman, Dr Liz Robin, Andy Vowles, Cathy Mitchell, Dr Michael Caskey, Dr Paul van den Bent, Dr Gary Howsam, Dr Kenneth Rigg, Andrew Reed and David Whiles

Co-opted Members: Russell Wate and Claire Higgins

Substitutes: Dr Harshad Mistry

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



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MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 26 MARCH 2015

Members Present:	Councillor Marco Cereste, Leader of the Council (Chairman) Councillor Diane Lamb, Cabinet Advisor for Health (Vice Chairman) Councillor Holdich, Deputy Leader and Cabinet Member for Education, Skills and University Gillian Beasley, Chief Executive Wendi Ogle-Welbourn, Corporate Director People and Communities Dr Liz Robin, Director for Public Health Cathy Mitchell, Local Chief Officer Dr Paul Van den Bent David Whiles, Healthwatch
Also Present:	Will Patten, Assistant Director for Adult Commissioning Ryan O'Neill, Public health Analyst – Advanced Paul Duell, Chair East Anglia Pharmacy Local Professional Network Anne McConville, Interim Consultant, Public Health Tina Hornsby, Assistant Director, Quality Information & Performance Paulina Ford, Senior Governance Officer

1. Apologies for Absence

Apologies for absence were received from Councillor Fitzgerald, Andy Vowles, Dr Michael Caskey, Dr Gary Howsam and Dr Kenneth Rigg. Apologies were also receive from Co-opted Member Claire Higgins.

2. Declarations of Interest

There were no declarations of interest.

3. Minutes of the Meeting Held on 7 January 2015

The minutes of the meeting held on 7 January 2015 were approved as a true and accurate record.

Chairman's Announcements

The Chairman welcomed and introduced the new Director of Public Health, Dr Liz Robin and also informed the Board that there had been a change in the Corporate Management Structure and Wendi Ogle-Welbourn had been appointed Corporate Director for People and Communities and she also holds the statutory DAS and DCS roles

4. NHS England/CCG

a) Primary Care Co-Commissioning

The Board received a report which updated members on the Primary Care Co-Commissioning and specifically the decision made by Cambridgeshire and Peterborough Clinical

Commissioning Group Governing Body on 13 January 2015 on the future of Primary Care Co-Commissioning.

Catherine Mitchel, Local Chief Officer, introduced the report and provided an overview update. Key points highlighted and raised during discussion included:

- NHS England had presented three proposals for a co-commissioning model to the CCG to see if they would wish to jointly commission primary care services with NHS England or whether the CCG would want to fully commission Primary Care Services.
- Cambridgeshire and Peterborough CCG Governing Body took the decision to enter into a joint commissioning arrangement with NHS England. This will commence from April 2015. The Governing Body would also review a third option of delegated commissioning of Primary Care prior to 2016.
- Entering into Option 2, Joint Commissioning will mean that a Joint Committee would be created to oversee the new arrangements. The national terms of reference required representation from Health and Wellbeing Boards and Healthwatch. The CCG would seek nominations for the Joint Committee. The first meeting would be in May 2015.
- The Joint Committee had a national Terms of Reference and would bring the CCG, regional representatives from NHS England and external partners together to discuss how the Joint Commissioning of Primary Care would be implemented going forward.
- Primary Care was key to delivering better outcomes across the city. Joint Commissioning would provide an opportunity to discuss the different commissioning models to provide better outcomes and getting the right service in the right place.
- Having a representative of the Health and Wellbeing Board on the Joint Committee would provide an opportunity to highlight some of the challenging health issues in Peterborough and addressing them.
- Concern was raised that social care had not been included in the commissioning process. The Local Chief Officer advised that the architecture and national terms of reference had been quite prescriptive but the inclusion of social care could be raised at the first meeting of the Joint Committee.

RESOLVED

1) The Board noted that the Cambridgeshire and Peterborough Clinical Commissioning Group will Jointly Commission Primary Care Services with NHS England East from 1 April 2015.

2) The Board requested that at the first meeting of the Joint Committee consideration be given to the inclusion of social care in the joint commissioning arrangements.

3) The Chair would write to the Secretary of State to request that social care be included in the new Joint Commission arrangements.

5. Clinical Commissioning Groups

a) CCG 2015-2016 Operational Plan

Catherine Mitchel, Local Chief Officer, introduced the item and gave a presentation to the Board which provided an overview of the CCG 2015-16 Operational plan. Areas covered included:

- An overview of the Plan on a Page
- Principles to underpin operational planning
- Planning assumptions and priorities
- The approach taken to creating the Operational Plan 2015-2016
- An overview of Clinical Service Commissioning priorities
- Areas of focus, particularly around quality and performance
- Outcomes and next steps

Key points highlighted and raised during discussion included:

- The Operational Plan was linked to the big transformation programme.
- The draft Operation Plan had been sent out to members of the Health and Wellbeing Board for comment via email.
- Local plans were being devised for Borderline and Peterborough Clinical Commissioning Group. For example non-elective work was being done through the resilience group to find their own solutions.
- There would be additional investment into adult and child Mental Health Services to a level equivalent to growth in allocation of 5.6%.
- Additional support had been put in to schools with regard to training to identify emotional issues earlier.

RESOLVED

The Board noted the presentation.

b) Better Care Fund s75 Agreement

Will Patten, Assistant Director for Adult Commissioning introduced the report. The report sought comments from the Board on the daft Section 75 Agreement and also sought approval from the Board on the Section 75 agreement between PCC and the CCG. Key points highlighted and raised during discussion included:

- Gillian Beasley, Chief Executive congratulated everyone involved in putting together the Better Care Fund s75 Agreement.
- The Chief Executives and Chief Operating Officers from across the health and social care system had recently met to start to talk about better working together and what governance structure were needed to drive the outcomes forward in a more efficient and effective way.
- Following on from approval the design phase will begin where the five key work streams are looked at to see how they would be implemented.

RESOLVED

1. The Board approved the Section 75 Agreement between PCC and the CCG and;
2. Confirmed that the Joint Commissioning Forum (JCF) will oversee the Better Care Fund Plan and Section 75 Agreement and pooled budget on behalf of the Peterborough Health and Wellbeing Board.
3. The Board approved the readiness report which had been previously circulated to the Board for comments and agreed that it could now be sent out.

6. Public Health

(a) Health Protection Annual Report

The Board received a report which presented the first Annual Health Protection Report for Peterborough City Council. The Annual Health Protection Report focused on the statutory responsibilities for health protection and complimented the Annual Report of the DPH.

Dr Anne McConville, Interim Consultant in Public Health introduced the report and provided further background information and context. Key points highlighted and raised during discussion included:

- The Annual Report looked at the Health Protection Functions and the health input into emergency planning and resilience for Peterborough.

- The purpose of the report was to provide assurance to the Health and Wellbeing Board and the population that the statutory duties with regard to health protection were being carried out efficiently and effectively.
- Specific challenges which had been identified were Tuberculosis (TB), poor uptake for cervical and bowel screening programmes, poor uptake of childhood immunisation programmes and some aspects of sexual health.
- Routine data for ethnic and minority groups was not readily collected and therefore more difficult to analyse. There was a need to engage with these groups in conversation to ensure that they understood what the screening programmes were and what the barriers were to them taking the screening tests.
- Community Connectors were being recruited to engage with community groups to understand the barriers they faced.
- Providing information on the symptoms of TB to enable people to recognise the symptoms sooner was important and ensuring people knew that treatment for TB was free as this might help take away the stigma of TB.
- Dr Robin thanked Dr Henrietta Ewart and Dr Anne McConville for developing the Health Protection Steering Group and congratulated them on the partnership working which had helped to develop the report.

<u>RESOLVED</u>

The Board:

1. Noted the Annual Health Protection Report for Peterborough City Council, 2014;
2. Noted that the Task and Finish Groups will report their recommendations to improve uptake of childhood immunisations and bowel and cervical cancer screening to the Health and Wellbeing Board in June, and produce costed plans for the Health and Wellbeing Programme Board;
3. Supported the recommendation that Public Health England (PHE) and PCC public health explore the roll out of the PHE pilot of testing for latent tuberculosis (TB) infection to eligible new migrants from high prevalence communities in line with the new collaborative TB strategy;
4. Asked the Children and Families Board to progress an action plan to address continuing high rates of teenage pregnancy;
5. Supported the recommendation that the public health team meet with the sexual health commissioner to explore opportunities in the sexual health contract to improve HIV and chlamydia screening in relevant population groups;
6. Supported the recommendation that qualitative and survey methods should be used to understand health beliefs and barriers to uptake of services to inform the Eastern European Joint Strategic Needs Assessment and subsequent community engagement and development.

(b) Peterborough 2015 Pharmaceutical Needs Assessment (PNA)

The Board received a report of the Peterborough 2015 Pharmaceutical Needs Assessment (PNA) for approval.

Ryan O'Neill, Advanced Public Health Analyst introduced the report. Paul Duell, Chair East Anglia Pharmacy Local Professional Network was also present. Key points highlighted and raised during discussion included:

- The purpose of the report was to inform the Health and Wellbeing Board about the completion of the PNA process, its key findings and recommendations.
- A public consultation of the PNA document had been undertaken between December 2014 and February 2015 and had received a good response.

- The document was an evidence based commissioning tool and was also used by NHS England to control the number of pharmacies in the area. It was a live document which needed to be kept up to date.
- Members of the Board felt that the report was a high quality piece of work and a really important document which highlighted the importance of the pharmacies within the city and if used properly could make a real difference in the city.
- In the pharmacy contract there was a requirement for six health promotion campaigns. Work could be done with pharmacies through the campaigns to target specific issues.

RESOLVED

The Board approved and authorised the publication of the Peterborough 2015 Pharmaceutical Needs Assessment (PNA) report.

(c) Cardiovascular Disease Programme update

The Board received a report which provided an update on work undertaken to develop the local cardiovascular disease strategy, to reduce prevalence and improve outcomes for the population of Peterborough.

Dr Anne McConville, Interim Consultant in Public Health introduced the report and provided further background information and context. Key points highlighted and raised during discussion included:

- The report set out the outcomes of a cardiovascular disease workshop that Public Health had held for partners on 30 January 2015. The three areas of focus at the workshop were: prevention and early intervention, treatment and reablement and continuing care.
- Next steps: to establish the three programme groups and the Health and Wellbeing Board to nominate senior managers to provide Chairs and leadership for those groups.

- The report asked the Board to consider the outcomes from the cardiovascular disease programme workshop, nominate both senior champions and lead officers to support the cardiovascular disease programme and approve the proposal for a new Public Health Board, reporting into the Health and Wellbeing Programme Board.
- The Chair proposed that the Corporate Director for People and Communities and the Director of Public Health consider the recommendations in further detail and check the governance arrangements regarding the Public Health Board.
- The Chair to take into consideration Public Health when discussing the regeneration of the city.

RESOLVED

The Board considered the recommendations but agreed that the Corporate Director for People and Communities and the Director of Public Health should discuss the recommendations in further detail and check the governance arrangements regarding the Public Health Board.

2.30pm, Councillor Lamb left the meeting.

7. Adult Services

(a) Care Act Plan and Implications

The Board received a report which provided an update on the Councils preparations for the introduction of the Care Act on 1 April 2015 and implications with particular reference to Adult Social Care.

Tina Hornsby, Assistant Director, Quality Information and Performance introduced the report to the Board. Key points highlighted and raised during discussion included:

- The Care Act put safeguarding on a statutory footing and focused on the person.
- There would be a new national eligibility criteria for services.
- Advocacy would be provided in a more prescribed way.
- There would be a new eligibility criteria for carers support.
- Introduction of new duties for assessment and support for those in prison.
- Expansion of existing deferred payment scheme.
- Specific regulations in place around discharge from hospital.
- The Care Act was not only a change to law but a change to culture.

RESOLVED

The Board noted the report.

INFORMATION ITEMS

The remainder of the items on the agenda were for information only and were noted without comment.

8. Exception Report: Health and Wellbeing Board Action Plan Progress Update

The Board received a report which updated members with regard to progress made against the Health and Wellbeing Board Action Plan. The report outlined any issues and challenges since the last update report provided at the HWB meeting held on 11 December 2014.

RESOLVED

The Board noted the report.

9. Healthy Child Programme

The Board received a report which provided an update on performance within the Healthy Child Programme (HCP) and informed the Board of the joint working initiatives, developments and priorities.

RESOLVED

The Board noted the report.

10. Winterbourne Review and Update

The Board received a report which provided an overview of developments and progress made to date in Peterborough in respect of the Winterbourne View Review and to satisfy itself that appropriate progress was being made.

RESOLVED

The Board noted the report.

11. Schedule of Future Meetings and Draft Agenda Programme

The Board noted that the schedule of future meetings had not been approved at Full Council yet and that the Corporate Director for People and Communities would bring to the first

meeting of the new municipal year a draft agenda programme for consideration along with proposals for governance arrangements of the new Public Health Board.

RESOLVED

The Board requested that the Corporate Director for People and Communities bring to the first meeting of the new municipal year the following:

1. A draft agenda programme for consideration
2. Proposals for governance arrangements for the new Public Health Board

1.00pm – 2.45pm
Chairman

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 4
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn Corporate Director People and Communities	Tel. 01733 863749

HEALTH AND WELLBEING BOARD MEMBERSHIP

R E C O M M E N D A T I O N S	
FROM : Wendi Ogle-Welbourn, Corporate Director of People and Communities	**Deadline date:** N/A

- Reduce number of Local Authority Councillors on the Board
- Appoint GP for Peterborough as the Vice Chair
- Agree Health and Wellbeing Programme Board becomes a Board that brings chairs of all the boards that report into the Health and Wellbeing board together to deliver on the Health and Wellbeing Strategy
- Where agencies or organisations request membership on the Health and Wellbeing Board they are to submit request in writing to the Chair and they will be asked to present their case at the Health and Wellbeing Board for consideration.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board following the Peer Review in March 2014, the review suggested the Board should consider reviewing membership of the Board and subsequent national guidance.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to seek the agreement of the Health and Wellbeing Board on the proposed revised membership and makeup of the Health and Wellbeing Board.

2.2 This report is for the Board to consider under its terms of reference 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 SUMMARY

3.1 The Health and Wellbeing Board Peer Review suggested that the Health and Wellbeing Board membership was heavily weighted towards the Local Authority and that we should consider a better balance. The Health and Social Care Bill mandates a minimum membership of:

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

3.2 Local boards are free to expand their membership to include a wide range of perspectives and expertise, such as representatives from the charity or voluntary sectors.

3.3 Membership is not the only way to engage with the work of the boards, all boards regardless of their political or geographic make-up will be expected to ensure that the needs of local people as a whole are taken into account. In Peterborough we have created the Health and Wellbeing Programme Board which has a diverse range of commissioners and providers from the statutory and voluntary sector, this board drives the delivery of the Health and Wellbeing Strategy outcomes.

4. Recommendations

4.1 It is recommended that the Local Authority reduce the number of Councillors on the Board to the Leader of the Council as Chair or as delegated and the Cabinet Member for Adult Services & Health Integration and Cabinet Member for Public Health. This would not preclude other Councillors attending where an issue that impacts on their portfolios is being discussed.

4.2 The Health and Wellbeing Board Peer Review suggested that it may be appropriate for the Vice Chair of the Health and Wellbeing Board to be someone from the CCG. It is recommended that a GP from Peterborough is appointed as vice chair.

3.3 It is recommended that the Health and Well-being Programme Board brings together the chairs/advisers of all the boards that report into the Health and Wellbeing Board; the board will pull together all the work of these boards to ensure they are efficiently and effectively delivering the priorities in the Health and Wellbeing Strategy. (See appendix 2)

3.5 It is recommended that where agencies or organisations want to become members of the Health and Wellbeing Board that these requests are put in writing to the Chair and these will be considered at the Board. However the board should not consist of more than 15 members.

5. CONSULTATION

5.1 The Peer Review team spoke to a number of agencies and organisations and their views have informed the recommendations in this report.

6. ANTICIPATED OUTCOMES

6.1 That the Health and Wellbeing Board agree changes to the Health and Wellbeing Board membership and this will lead to a strengthened and more effective Board.

7. REASONS FOR RECOMMENDATIONS

7.1 To respond to the Peer Review feedback and national guidance on how the Health and Wellbeing Board can be strengthened to become more effective.

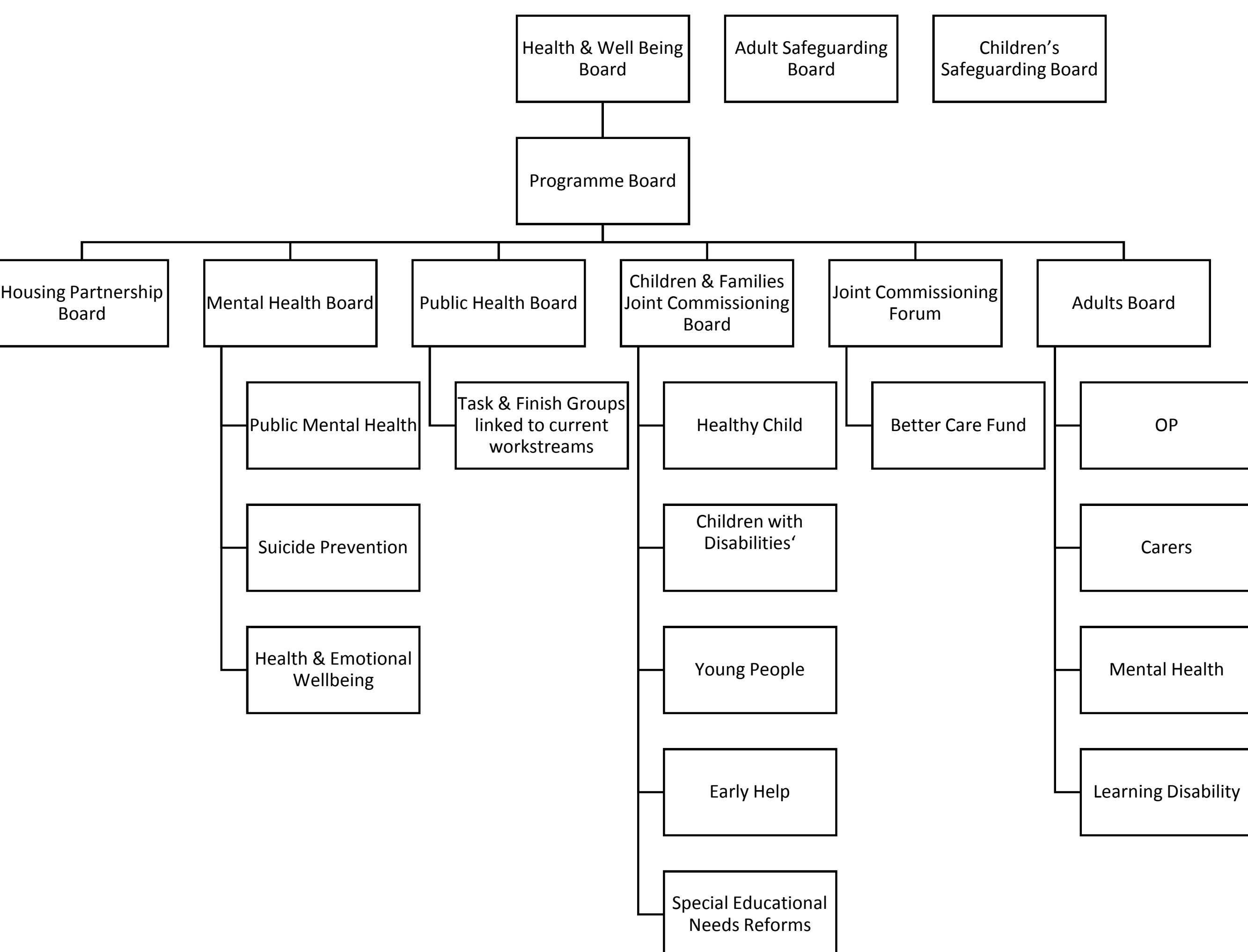
8. BACKGROUND DOCUMENTS

- Peer Review feedback

9. APPENDICES

- Partnership Structure
- Revised recommended membership
- Terms of Reference

Health and Wellbeing Board Structure



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Membership

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

Peterborough City Council:
The Leader of the Council / Deputy Leader – Chairman of the Board
Cabinet Member Adults & Health Integration
Cabinet Member Public Health
The Corporate Director People and Communities
Service Director Adults and Communities
The Director of Public Health

Cambridgeshire and Peterborough Clinical Commissioning Group
The Chief Operating Officer
Local Chief Officer for Peterborough City and Borderline LCG
2 GP members representing Peterborough City Local Commissioning Group (Vice Chair)
1 GP member representing Borderline Local Commissioning Group

Lincolnshire
1 GP representing South Lincolnshire CCG

National Commissioning Board
1 representative of the NCB Local Area Team

Peterborough Healthwatch
1 member

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

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HEALTH AND WELLBEING PARTNERSHIP DELIVERY BOARD

Terms of Reference

Purpose of Board

1. To inform and develop the Joint Strategic Needs Assessment and Health and Wellbeing Strategy

2. To delegate tasks to existing boards that sit below the Health and Wellbeing Board and set up task and finish groups as needed to deliver the Health and Wellbeing Strategy

3. To monitor the performance of the boards that sit below the Health and Wellbeing Board and task and finish groups set up to deliver the Health and Wellbeing Strategy

4. To support the boards that sit below the Health and Wellbeing Board and task and finish groups in facilitating performance against the Health and Wellbeing Strategy, challenging performance where necessary

5. To report performance against the Health and Wellbeing Strategy to the Health and Wellbeing Board, seeking assistance in addressing blockages to delivery where necessary

6. To report to the Health and Wellbeing Board on a regular basis, identifying issues, challenges and barriers and seeking their guidance and direction in addressing these issues

7. Delivery Board members are expected to work together outside of meetings to ensure that problem solving and sharing resources is embedded into the work to deliver against the Health and Wellbeing Strategy

8. O support the development of the Health and Wellbeing Board and the setting of the agenda

9. To review the Terms of Reference and membership on an annual basis

Organisation of meetings

1 The Board will meet on a bi - monthly basis

2 The Board will be serviced by the Corporate Director of People and Communities office Manager with agendas and papers circulated in advance of the meetings.

Membership

Chair
Corporate Director People and Communities

Vice Chair
Service Director Adults and Communities
Members
Children and Families Joint Commissioning Board – Claire Higgins and Lou Williams
Public Health Board – Dr Liz Robin
Joint Commissioning Forum Cathy Mitchel/ Alan Sadler
Housing Partnership – Simon Machen
Mental Health – Terry Prior/Janet Dullaghan
Education & Skills – Johnathan Lewis

Advisers
Senior Analyst Public Health
Performance Officer – Helen Gregg
Business Management and Commercial Operations – Oliver Hayward
Other advisors identified as necessary

Any meeting with less than 4 members present (regardless of the number of advisers) will be deemed to be inquorate.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5(a)
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Matthew Smith, Assistant Director of Improving Outcomes	Tel. 01223 725389

PRIMARY CARE PROGRAMME UPDATE

R E C O M M E N D A T I O N S	
FROM : Matthew Smith, Assistant Director, Improving Outcomes	**Deadline date :** N/A
Members are asked to note this report	

1. ORIGIN OF REPORT

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

2. PURPOSE AND REASON FOR REPORT

The purpose of this report is to provide additional or background information requested by the committee regarding Cambridgeshire and Peterborough CCG's Primary Care Programme.

3. BACKGROUND AND OVERVIEW

3.1 The vision for primary care in Cambridgeshire and Peterborough is for:

- People to be proactively cared for as close to home as possible where appropriate
- Increased primary care which is provided in an integrated, equitable way with services organised around the patient
- Services to be designed and implemented locally, building on best practice and sensitive to local health needs

3.2 The CCG established Primary Care Programme Board in December 2014. The high level objectives of the programme are:

- Clarity on role of primary care in Cambridgeshire and Peterborough
- Improvement in patient experience, access to primary care, equity of access and reduced inequalities
- Improvement of outcomes and alignment of outcomes with other programmes of work
- Development of sustainable primary care organisation through developing options, piloting and implementing primary care provision models
- Improvement in the quality of general practice services
- Development of high quality, integrated out-of-hospital services with services organised around the patient and closer to home
- Workforce development and investment in resources to deliver the programme objectives
- Increased role in primary care commissioning leading to increased empowerment to improve primary care services locally
- Involvement and contribution to the Cambridgeshire and Peterborough system five year transformation plan

- Ensuring that the commissioning arrangements are joined up and support the above objectives

3.3 The following sections cover progress with the main workstreams of the Primary Care Programme: workforce development; service development; co-commissioning; and primary care at scale.

3.4 Workforce Development

3.4.1 Purpose of the workstream: The primary care workforce is changing and also facing difficulties in terms of recruitment and retention of GPs and nurses in particular. Through this workstream we will facilitate and coordinate work with other organisations, such as Health Education East of England (HEE), to develop initiatives which will support Cambridgeshire and Peterborough CCG practices with these challenges.

3.4.2 The CCG is working closely with HEE on a Cambridgeshire and Peterborough plan to develop the primary care workforce and address recruitment and retention challenges insofar as this is possible at a local level.

3.4.3 As part of this work we have recruited three clinical (non medical) tutors whose role will be to support clinical placements in practices, coordinate and quality manage training, and support the existing workforce with training. In particular, they will work to increase the number of pre-registration nurse placements in practices.

3.4.4 We have also appointed a 'Widening Participation Officer', funded by HEE but managed by the CCG, whose role is to promote primary care as a career choice. She has focused initially on the opportunity for practices to take on Health Care Assistant apprentices.

3.4.5 A third strand relates to development of a GP fellowship scheme designed to attract doctors who have just completed their training, and more than 10 practices have expressed an interest in the scheme so far.

3.4.6 There are a number of challenges to be overcome in terms of increasing staff time out of practice for training, and making primary care a more attractive option for doctors, nurses and Health Care Assistants.

3.5 Service Development

3.5.1 Purpose of the workstream: This workstream is intended to drive service innovation, learning from elsewhere and evidence reviews, sharing best practice, coordinating development of new schemes or services. In addition, we will ensure that, where appropriate, there is coordination across the CCG in relation to commissioning primary care services, including consultation with the Local Medical Committee.

3.5.2 The CCG commissioned a number of new Local Enhanced Services for 2015/16 which are designed to secure phlebotomy, complex dressings and 'treatment room' services in primary care. This represents a significant investment by the CCG in local practices, recognising the pressures created by changes in national funding policy.

3.6 Co-commissioning

3.6.1 Purpose of the workstream: The main commissioners of primary care are NHS England, but the CCG also commissions some specific primary care services, and clearly has an interest in ensuring that broader pathway re-design / re-configuration includes primary care. The CCG and NHS England commenced joint commissioning arrangements in April 2015. This workstream will focus on the development and operation of co-commissioning processes.

3.6.2 Following NHS England approval of the CCG's application to take on Joint Commissioning, discussions have taken place with NHS England colleagues on the next steps. A

development session with new Joint Committee was held in May where the approach and 2015/16 work programme was discussed, including representation from both Cambridgeshire and Peterborough Health and Wellbeing Boards and Healthwatch. The first formal public meeting is likely to be in July.

3.6.3 We are also developing the process which will lead to a decision on whether or not the CCG takes on full delegated commissioning of primary medical services from April 2016. This has two main strands: preparing the specification for due diligence (budgets and resources), and agreeing the consultation process with member practices.

3.7 Primary Care at Scale

Purpose of the workstream: This workstream is intended, as a first phase, to develop thinking and options on the future configuration and organisation of primary care 'at scale', based on engagement with practices carried out in conjunction with the Local Medical Committee. This workstream is also mandated by the Whole System Re-design Programme Board.

3.8 Recap on Rationale

3.8.1 There are a number of issues which have led us to conclude that transforming primary care is a vital part of the wider whole system transformation programme, and securing high quality care for patients.

- there are significant difficulties in recruiting GPs and practice staff in some of our localities
- the current workforce is changing and ageing, staff (particularly GPs) are retiring, and an increasing proportion of GPs work part-time and as salaried employees rather than partners in the practice: this can make it difficult to sustain the current way of organising primary care
- demographic changes - the general population is ageing, so the numbers of people needing healthcare is increasing
- workload pressures – which are increasing, partly driven by demographic change with increasing population and more older people, but also by advances in medicine and technology, and by rising public expectations
- national changes in how primary care is funded, which means that some practices are experiencing significant reductions in their funding
- it is difficult for health and social care organisations to engage effectively with 107 GP practices, and for practices to represent a collective view

3.8.2 The current primary care model with 107 GP practices working as separate, independent businesses is unlikely to be sustainable in the future due to workload, workforce and financial factors. However, there are significant potential advantages for both patients and health care professionals in practices working in new ways – 'at scale' to deliver a wider range of services, improved access, and consistent standards.

3.8.3 It would also offer improved development, specialisation and training opportunities for GPs and staff, combined with greater flexibility in working hours and expansion of the range of specialist staff working in practices. In turn, these larger organisations are likely to attract the best staff, with an associated benefit for patients. There would also be potential 'back office' efficiencies achieved through sharing specialist staff skills between practices, and economies of scale which reduce overheads, thereby maximising funds for 'front-line' patient care.

3.8.4 It is important to emphasise that 'primary care at scale' is focused on how GP practices organise themselves as a network or federation or 'super partnership'. It is not looking at any change in the number of surgeries which operate throughout Cambridgeshire and Peterborough – any such proposal would need separate and specific consultation.

3.9 Prime Minister's Challenge Fund

3.9.1 Borderline and Peterborough practices were successful in their bid to secure £2.6m from the Prime Minister's Challenge Fund to enhanced services for patients through primary care offering extended hours, a service in A&E and innovative use of technology to improve access. The approach is based on practices coming together to form 'hubs'. It is anticipated that learning from this project will potentially be used to roll out similar initiatives or inform development of primary care across Cambridgeshire. The key features are:

- Primary Care to operate at scale to cover 250,000 population in Borderline and Peterborough practices.
- Practices will group into hubs serving 50,000 to 80,000 patients
- 8.00am to 8.00pm access on weekdays; direct booking to appointments via NHS 111
- At weekends 8am-8pm primary care delivered at Front Door Emergency Department.
- Promote 24 hour access to primary care through 'WebGP'
- Better able to serve the expectations of new staff; resilience and consistency of service.

3.9.2 The anticipated benefits will be:

- A simpler system and extended access for patients
- Reducing pressure on Emergency Departments
- Continuity of care for patients within larger primary care hubs
- Creating additional capacity for direct patient care
- Enhancing professional morale (sense of control and clarity on workload)
- Integrating care for older people
- Integrating pharmacy within the new approach
- Making better use of Information Technology (IT) and communications technology

3.8 Developing the Vision and Specification for Primary Care

As a commissioner working on behalf of patients in Cambridgeshire and Peterborough, it is important that the CCG develops a clear vision and specification which sets out what we are likely to buy from organisations offering primary care at scale. This is shown in the diagram below. It will need to be developed with NHS England with involvement from member practices, the LMC, patients and other stakeholders.

4. CONSULTATION

The work on primary care at scale is at a development and engagement stage.

5. ANTICIPATED OUTCOMES

The purpose of this report is to inform Members of the work of the CCG Primary Care Programme, which is a potential enabler to delivery of the Health Wellbeing strategy.

6. REASONS FOR RECOMMENDATIONS

This report is for information and noting.

7. ALTERNATIVE OPTIONS CONSIDERED

Not applicable.

8. IMPLICATIONS

The Primary Care Programme is designed to secure sustainable high quality primary care for the future and to support whole system transformation.

9. BACKGROUND DOCUMENTS

None.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5(b)
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Dr Fiona Head System Transformation Programme Director Cambridgeshire and Peterborough CCG	Email: fiona.head@nhs.net

SYSTEM TRANSFORMATION PROGRAMME

R E C O M M E N D A T I O N S	
FROM : Fiona Head, Programme Director, Cambridgeshire and Peterborough Health and Care System Transformation Programme	**Deadline date :** N/A
Health and Wellbeing Board members are asked to discuss the progress of the programme to date and to make comments.	

1. ORIGIN OF REPORT

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

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Peterborough Health and Wellbeing Board on the work of the Cambridgeshire and Peterborough System Transformation Programme.

3. BACKGROUND

3.1 Programme strategic aims and values

3.1.1 The Cambridgeshire and Peterborough System Transformation Programme has been set up to address the challenges facing the local health service across Cambridgeshire and Peterborough.

3.1.2 The strategic aims and values of the programme are:

- People at the centre of all that we do
- Empowering people to stay healthy
- Developing a sustainable health and care system
- Improving quality, improving outcomes

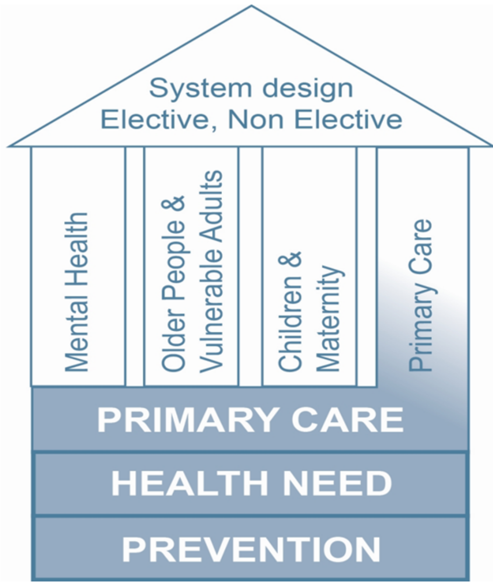
3.1.3 The work of the Programme is overseen by a Programme Board which is made up of the Chief Executives from organisations in the local health service, Directors of Adult Social Services and Healthwatch representatives. The programme is led by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and all health organisations have contributed to a joint fund to resource the work. Secondees from across the system have come together to form a team to work on the programme.

3.2 Programme structure

3.2.1 The Cambridgeshire and Peterborough System Transformation Programme has five main workstreams:

- System design – which covers planned (elective) and unplanned (non-elective) care
- Mental health
- Older people
- Children and maternity
- Primary Care

3.2.2 These workstreams are shown in the diagram below.



3.3 Analytical work from the Programme: some initial results

3.3.1 The analytical work of the programme is generating information for engagement and discussion. It is not the decision making process.

3.3.2 The method of working has been to build up a cross section of activity across the health economy. At present this consists of activity data from acute providers. This has been projected forwards by demographic growth.

3.3.3 An additional increase for “non-demographic growth” or “acuity” has also been applied.

3.3.4 This gives a forecast of activity over the next five years. This activity forecast can be converted into costs.

3.3.5 This work is ongoing but some initial key findings are:

- Demographic change alone predicts that the system will need an extra 160 non-elective beds by 2018/19.

- A top level analysis shows that non-demographic growth is almost completely accounted for by the impacts of obesity on our population. This equates to an extra 1.6% p.a. uplift in activity and 2.4% p.a. uplift in costs over and above demographic growth.

- UnitingCare data predicts a reduction in non-elective bed demand by 160 beds across the system by 2018/19.

3.4 The forward planning process

3.4.1 The programme is currently in Phase 2. These are the key elements of this phase:

- Detailed analysis of the issues facing the health system, working with key stakeholders about areas of challenge
- Engagement with the public around the key challenges facing the health system now and into the future
- Getting feedback from the public about current services and how they think things could change.

3.4.2 Between October and December there will be a second phase of engagement that focuses on discussing the potential solutions and options for change.

3.4.3 The next steps will depend on the outcome of the engagement process. The earliest that any formal public consultation would take place is January 2016.

3.5 The Five Year Forward View and "Vanguard" site applications

3.5.1 In October 2014 NHS England published the "Five Year Forward View" and launched the "New Models of Care" Programme. This Programme aims to co-design different types of new care models for the NHS. More details of these models can be found in the "Five Year Forward View", the link to which is in the 'Background Documents' table.

3.5.2 In February 2015 the Cambridgeshire and Peterborough Health System expressed an interest to be a "Vanguard site".

3.5.3 The Cambridgeshire and Peterborough application centred on working towards "one system one budget" by:

- Closer working between acute providers
- Increased focus on neighbourhood delivery of care
- Primary care at scale

3.5.4 We were selected to go through to the second round of the application process and were represented in London by four Chief Executives from the system but were not selected to be in the initial group adopting new models of care - the "Vanguard group".

3.5.5 NHS England has recently announced a second wave of "Vanguard" applications that centre on closer collaboration between acute hospitals – details can be found at the link in the 'Background Documents' table. The System Transformation Programme will consider whether to apply again through this process to be a "Vanguard" site.

4. BACKGROUND DOCUMENTS

Source Documents	Location
• Cambridgeshire and Peterborough health system Blueprint 2014/15 to 2018/19: Main text	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm
• Cambridgeshire and Peterborough health system Blueprint 2014/15 to 2018/19: Appendices	http://www.cambridgeshireandpeterboroughccg.nhs.uk/five-year-plan.htm
• Cambridgeshire and Peterborough System Transformation Programme Frequently asked Questions	http://www.cambridgeshireandpeterboroughccg.nhs.uk/STP_FAQS_Feb_2015docx.pdf
• NHS England " Five Year Forward View"	http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
• NHS England "Acute Care Collaboration" web site	http://www.england.nhs.uk/ourwork/futurenhs/5yfv-ch3/new-care-models/acute-care-collaboration/

Author
Dr Fiona Head
Programme Director
Cambridge and Peterborough System Transformation Programme
28 May 2015

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5(c)
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Cathy Mitchell, Local Chief Officer, Borderline and Peterborough System, NHS Cambridgeshire and Peterborough Clinical Commissioning Group	Tel. 01733 758505

BORDERLINE AND PETERBOROUGH PRIMARY CARE TRANSFORMATION PROGRAMME, INCLUDING PRIME MINISTER'S CHALLENGE FUND DELIVERY

R E C O M M E N D A T I O N S	
FROM : Gary Howsam, Chair, Borderline and Peterborough Clinical Commissioning Group	**Deadline date:** N/A
The Health and Wellbeing Board is asked to note the contents of this update.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following the successful outcome of Borderline and Peterborough Local Commissioning Groups' (LCG) primary care bid to the Prime Minister's Challenge Fund in March15.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Board on the successful bid by Primary Care providers in the locality to the Prime Minister's Challenge Fund, and the development of the Primary Care Transformation Programme being established to implement this work.

3. BACKGROUND

3.1 The original Prime Minister's Challenge Fund (PMCF) was launched by NHS England (NHSE) in October 2013 to help improve access to general practice and stimulate innovative ways of providing primary care services. In April 2014 20 Wave 1 sites were announced , and invitations to submit bids against Wave 2 of the PMCF were publicised by NHSE in October 2014. Clinical and management leads in Borderline and Peterborough LCGs worked hard to develop wide engagement from Primary Care providers and other stakeholders in the locality and from this to develop a bid to Wave 2 of the fund. The system was informed on 27 March that the bid for funding, developed and submitted in January, had been successful, and further work has been undertaken since that time to complete NHSE Due Diligence, and to put the foundations in place for delivery of the associated programme of work.

3.2 The PMCF bid is a locally designed vision for transforming Primary Care across the Borderline and Peterborough locality and the associated programme of work is the 'Primary Care Transformation Programme'. The PMCF bid represents £2.6m of investment to enhance the Primary Care offer locally, and is intended to "prove" itself over the initial period with a view to developing a Business Case for sustainable local funding for the new model. The bid remains subject to final due diligence by the NHSE Primary Care Programme Team leading on the PMCF, but a formal letter of intent has been received from the NHSE Area Team and it is presently expected that programme funds will be available to draw down through NHSE for programme delivery from July (although commencement of programme delivery will be stepped following this time).

3.3 The Borderline and Peterborough PMCF bid includes the following main areas of work:

- **Increased access on weekdays and weekends:** Primary Care across the locality will reconfigure to operate at scale, with practices grouping into hubs - very much in line with work that is likely to be supported more widely across the CCG, although in some instances these may cover smaller practice populations, at least in the first instance. The new system will offer extended and more innovative access, ultimately offering 8.00am to 8.00pm weekday access for the whole population, with direct booking to appointments in Primary Care through NHS 111. At weekends and on Bank Holidays 8.00am-8.00pm Primary Care will be delivered "in front of" the Emergency Department (ED) at Peterborough City Hospital, reducing demand on this service.

- **24 hour access to Primary Care:** 24 hour access to Primary Care will be developed through 'WebGP'. This system will be accessed through primary care websites, linked directly to hubs to generate seamless access to Primary Care services, including self care information, signposting to alternative health professionals (e.g. community pharmacists), telephone advice from primary care staff in NHS 111, and e-consultations with GPs. The programme will also support the delivery of self management tools, and email and Skype consultations will be developed through the integrated SystmOne appointment management tool.

- **Increased capacity in Primary Care:** Practices will operate as larger units offering resilience and consistency of service, and offering workforce innovations such as integrated Primary Care Pharmacists. This will free up primary care nurses' and doctors' time, and therefore maximise clinical capacity within the existing workforce. These changes will help to address current workload pressures and help the recruitment and retention of doctors and nurses. Primary Care will offer a more reasonable workload and a more attractive workplace, better able to serve the changing expectations of staff. The Primary Care Transformation Programme across Borderline and Peterborough LCGs is the delivery programme for the Prime Minister's Challenge Fund (PMCF) bid in 2015-16, but more widely for sustainable transformation of Primary Care provision in the locality following that period of funding. A Programme Board has been developed to oversee the work and will include clinical and management leads, patient representatives, and others involved in the work. The Primary Care Transformation Programme will report to NHSE in relation to the PMCF funding, but will also be both accountable to, and representative of, Primary Care providers in the locality. It will provide regular updates to both the Cambridgeshire and Peterborough CCG Primary Care Programme Board, and to the Borderline and Peterborough Executive Partnership Board.

4. Stakeholder Engagement

4.1 Due to the necessarily speculative nature of a bidding process, and indeed the very short time frame available in which to develop and submit the bid to NHSE, no formal public consultation was required as part of the bid's development. However, patient representatives were involved in meetings at which the bid was discussed, bearing in mind the short timeframe for completion. More generally, the outcomes associated with the bid in terms of increased and more flexible access, and increased care and support delivered in the community and via Primary Care are generally seen as positive in more general planning and service development.

4.2 Going forwards, local clinicians perceive a strong patient voice and wider input to the programme as being essential to its success. Patient Participation Groups at practices across the Borderline and Peterborough locality have been contacted and invited to become involved both as representatives on the Programme Board and on specific workstreams of the Programme. It is hoped that there will be wide interest in doing so. Patient satisfaction measures are one of the key metrics associated with the centrally delivered evaluation of the PMCF pilots. Feedback from patients and patient groups will

also provide an essential component of the Business Case for future funding to make sustainable the initial developments underwritten by the PMCF bid which will arise out of the present work.

5. ANTICIPATED OUTCOMES

5.1 The Primary Care Transformation Programme represents a major development in primary care delivery in Peterborough, not only in terms of short-term benefits for patients and carers, but also in medium and longer term changes in the structure and practice of primary care. It is anticipated that the Board may wish to monitor and review these changes over time, and in particular as part of medium term oversight and review of local service provision.

6. REASONS FOR RECOMMENDATIONS

6.1 Whilst there is no decision required of the Board relating to the delivery of the Primary Care Transformation Programme at this time, it is hoped that the Board will be interested to review this development as it progresses. The Programme Board will be pleased to receive any views on the programme offered by the Health and Wellbeing Board.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 In deciding whether or not to put in a bid to the PMCF the view was taken that much of the work which might be required in delivering it would most likely become necessary in the near future as part of the national direction of travel, and funding was available to support the transformation of Primary Care on the basis of rising demand on Primary Care, workforce pressures, and wider system pressures. It was considered, therefore, a beneficial option to bid for funds to support the commencement of this work, and to help drive it forwards at pace.

8. IMPLICATIONS

8.1 The pilot which is funded for 15/16 will enable Primary Care to test out different models and the outcomes will be shared across Cambridgeshire and Peterborough CCG which will inform the System Transformation Programme which has Primary Care as one of its workstreams.

9. BACKGROUND DOCUMENTS

None.

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5(d)
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Cathy Mitchell, Local Chief Officer, Borderline and Peterborough System, NHS Cambridgeshire and Peterborough Clinical Commissioning Group	Tel. 01733 758505

OPERATIONAL PLAN AND QUALITY PREMIUM 2015/16

R E C O M M E N D A T I O N S	
FROM : Sarah Shuttlewood, Director of Contracting, Performance and Delivery; NHS Cambridgeshire and Peterborough Clinical Commissioning Group	**Deadline date : 24 June 2015**
For the Board to: 1. Note the current status of the NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Operational Plan 2015/16. 2. Note and consider the content of the CCG Quality Premium 2015/16 and, in particular, to signal agreement to two of the proposed local indicators.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board following discussion held by the Board on 26 March 2015 on the draft CCG Operational Plan. Since that meeting, the draft Operational Plan has been refined further and the national and local Quality Premium indicators for 2015/16 which form part of the overall CCG plans have been developed.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

a) brief the Board on the current position relating to the draft CCG Operational Plan and the range of indicators identified for the Quality Premium for 2015/16

b) seek the Board’s views on the content of this report and, in particular, to signal agreement to two of the proposed local indicators which will form part of the Quality Premium for 2015/16

3. CURRENT POSITION

3.1 DRAFT OPERATIONAL PLAN 2015/16

3.1.1 CCGs are required by NHS England to refresh their operational plans and set out how, in the financial year 2015/16, they will deliver the Government’s key service priorities for the NHS within their financial allocation.

3.1.2 A final draft of the Cambridgeshire and Peterborough CCG Operational Plan was submitted to NHS England on 14th May 2015. Over the next month or so, the draft plan will undergo an external assurance process to ensure that it is fully compliant with national and local planning guidance.

3.1.3 Members of the Board are aware from discussion at their last meeting that the scope of the draft operational plan is wide-ranging, for example:

a) Confirming the CCG's commitment and the actions needed to meet the NHS Constitution performance standards
b) Setting out an improved framework for commissioning through the establishment of seven clinical transformation programmes
c) Developing more integrated care through the implementation of the Older People's and Adult Community Services Contract and, in partnership with Local Authorities, the Better Care Fund
d) Re-affirming the CCG's strong commitment to high quality, safe clinical services and improved patient experience through implementing a comprehensive and focussed programme of work

3.1.4 Local health systems are finalising their local plans which are aligned with the CCG Operational Plan and which set out their local priorities and initiatives.

3.2 QUALITY PREMIUM 2015/16

3.2.1 National planning guidance requires CCGs to submit two local Quality Premium Indicators which, when combined with the national set of Quality Premium Indicators, will form the basis of payment of the 2015/16 Quality Premium.

3.2.2 The purpose of the Quality Premium is to reward CCGs who improve the quality of services they commission and for any associated improvements in health outcomes and reductions in inequalities. As in previous years, there is a combination of nationally mandated priorities and the opportunity for CCGs to select some local priorities. For 2015/16, the guidance makes provision for two local indicators to be selected. The maximum quality premium payment for a CCG equates to £5 per head of population.

3.2.3 For ease of reference, the table below provides an overview of the national Quality Premium measures which will be used to measure the CCG's performance in 2015/16 and several proposed local indicators for discussion and agreement by the Board:

Indicator	% Weighting
Reducing Potential Years of Life lost through causes amenable to healthcare	**10%**
Urgent and Emergency Care – composite indicator comprising: a) Delayed transfers of care which are an NHS responsibility b) Increase in the number of patients admitted for non-elective reasons who are discharged at weekends or bank holidays	**30%**
Mental Health – composite indicator comprising: a) Reduction in the number of patients attending an A&E department for mental health-related needs who wait more than four hours to be treated and discharged or admitted together with a defined improvement in the coding of patients attending A&E b) Increase in the proportion of adults in contact with secondary mental health services who are in paid employment c) Improvement in the health related quality of life for people with a long term mental health condition	**30%**
Improving antibiotic prescribing in primary and secondary care – composite indicator comprising: a) Reduction in number of antibiotics prescribed in primary care (worth 50% of the total quality premium payment) b) Reduction in the proportion of broad spectrum antibiotics prescribed	**10%**

in primary care (worth 30% of the total quality premium payment) c) Secondary care providers validating their total antibiotic prescription data (worth 20% of the total quality premium payment) **Local Indicators**: To be agreed. Proposed local indicators comprise: a) Prevalence of breast feeding at 6-8 weeks from birth b) Stroke patients admitted to stroke unit within 4 hours c) Antenatal assessment <13 weeks	 **20%**
Total weighting	**100%**

3.2.4 In considering the range of possible local indicators, the CCG wished to ensure that the indicators:

a) Were in alignment with the Joint Health and Wellbeing Strategy
b) Would result in health gain for our population
c) Had the potential to consolidate and improve partnership working

3.2.5 Accordingly, the table below sets out for discussion several local indicators which appear to have good alignment with the Board's health and wellbeing strategic priorities whilst being feasible for implementation in 2015/16:

Potential Local Indicator	Aligns with HWBB Strategy?	Notes
Antenatal assessment <13 weeks	Yes. "Securing the Foundations of Good Health"	Both proposed indicators would encourage joint working across primary care, secondary care and the local authority. They would contribute to ensuring the a good start to early years.
Prevalence of breast feeding at 6-8 weeks from birth	Yes. "Securing the Foundations of Good Health"	
Stroke patients admitted to stroke unit within 4 hours	Yes. "Healthier Older People who maintain their Independence for longer".	The prime purpose of this proposed measure would be to improve the management of stroke and to ensure that patients receive the most clinically appropriate treatment at the right time. This work links into service development being undertaken in partnership with others, for example, the work led by Uniting Care on improving services for older people and adult community services and the development of better integrated services through implementation of the Better Care Fund.

3.2.6 The Board are requested to comment on the full range of indicators and, in particular, to discuss and agree two of the proposed local indicators which could be taken forward in 2015/16 in support of the Board's health and wellbeing strategy.

4. CONSULTATION

4.1 In drawing up the draft Operational Plan, discussions were held with Peterborough and Cambridgeshire Health and Wellbeing Boards and taken into account where possible during the drafting of the plan.

4.2 In addition, the CCG Governing Body has discussed the Operational Plan at their meetings in public.

4.3 As soon as approval of the plan has been received from NHS England, the CCG will update the status of the draft plan to final and it will be published on the CCG website and shared with key stakeholders.

5. ANTICIPATED OUTCOMES

5.1 The Board is requested to:

a) Note the current status of the NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Operational Plan 2015/16

b) Note and consider the content of the CCG Quality Premium 2015/16 and, in particular, to signal agreement to the two local indicators

6. REASONS FOR RECOMMENDATIONS

6.1 NHS planning guidance for 2015/16 has placed even greater emphasis on ensuring that plans are aligned and are not drawn up in isolation. In particular, there should be alignment between plans and the local health and wellbeing strategy. The views of the Board are sought, in order to ensure consistent development and implementation of operational plans for 2015/16.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 The production of a CCG Operational Plan and agreement of the Quality Premium indicators is required by NHS England through the national planning guidance. There is no alternative option available.

8. IMPLICATIONS

8.1 Implementation of the Operational Plan and the Quality Premium indicators will require strong partnership working and input from the Board as needed throughout the year.

9. BACKGROUND DOCUMENTS

Source Documents	Location
Quality Premium: 2015/16 Guidance for CCGs; Gateway Reference 03394; NHS England; published 27 April 2015	http://www.england.nhs.uk/wp-content/uploads/2015/04/qual-prem-guid-1516.pdf
Peterborough Health and Wellbeing Strategy	http://www.peterborough.gov.uk/healthcare/public-health/health-and-wellbeing-strategy

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6(a)
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel. 01733 207175

ANNUAL DIRECTOR OF PUBLIC HEALTH REPORT 2015

R E C O M M E N D A T I O N S	
FROM : Dr Liz Robin, Director of Public Health	**Deadline date: June 18th 2015**

Main recommendation

- The Board is asked to review the key health issues raised within the Annual Report and consider how the information and evidence presented can inform future planning.

1. ORIGIN OF REPORT

1.1 The origin of this report is the statutory duty of the Director of Public Health to prepare an annual report on the health of the population and of the local authority to publish this report (Health and Social Care Act 2012)

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is for the Health and Wellbeing Board to receive and discuss the Public Health Annual Report 2015.

3. BACKGROUND AND SUMMARY

3.1 The Director of Public Health's Annual Report 2015 – *Peterborough: A Healthy City?* is the first Peterborough annual report to be published since the transfer of Public Health from the NHS to local government in April 2013. This transfer resulted from the Health and Social Care Act 2012, legislation that also conferred on local authorities a statutory duty to improve the health of their populations.

3.2 *Peterborough: A Healthy City?* is the independent report of the former Director of Public Health, Dr. Henrietta Ewart. It is intended to provide an overview of the health of Peterborough and to identify those areas that have the greatest need for improvement.

3.3 The report has been reviewed by the Health and Wellbeing Programme Board while specific information about the local health challenges and inequalities taken from the report were considered at a public health workshop for councillors in February.

3.4 The Annual Report highlights local issues across the life course with specific consideration of children and young people and older people. Local mortality and morbidity rates are evidenced, with emphasis on inequalities in health outcomes and poor health in later life stressed.

3.5 Developing a clear strategic direction, drawing on the evidence within the Annual Report and Joint Strategic Needs Assessments, to achieve a sustained improvement in the health of our population and address health inequalities is therefore needed.

3.6 The Annual Report emphasises that this should be based on collaboration across organisations whose activities impact on health and through engagement with communities. The Health and Wellbeing Board has an overview of this strategic direction.
.

4. RECOMMENDATIONS

4.1 The Board is asked to review the key health issues raised within the Annual Report and consider how the information and evidence presented can inform future planning.

5. CONSULTATION

5.1 The Annual Report is designed to make key information on health in Peterborough accessible to a wide range of audiences.

6. ANTICIPATED OUTCOMES

6.1 The Annual Report will act as a means to communicate information about health in Peterborough to a range of organisations and communities to consider in their services and plans.

7. REASONS FOR RECOMMENDATIONS

7.1 The Health and Wellbeing Board has the strategic leadership role for health and wellbeing in Peterborough.

8. BACKGROUND DOCUMENTS

8.1 Appendix 1: The Director of Public Health's Annual Report 2015 – *Peterborough: A Healthy City*

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1

Introduction

"Where people live affects their health and chances of leading flourishing lives." World Health Organisation

This is our first annual report to be published since the transfer of Public Health from the NHS to local government in April 2013. This transfer resulted from the Health and Social Care Act 2012, legislation that also conferred on local authorities a statutory duty to improve the health of their populations. We would like to use the report as an opportunity to provide an overview of the health of Peterborough and to identify those areas that have the greatest need for improvement.

We now have available more data about the health of our population and factors relating to health than we have ever had before. Bringing Public Health into the council gives a wonderful opportunity to enhance our understanding of our population's current health and health needs through combining the data held by different departments within the council with that held by other organisations: the NHS, voluntary sector and so on. Many of these data are publicly available in different formats (for example, the Public Health Outcomes Framework and locality profiles produced by Public Health England and the Joint Strategic Needs Assessments produced locally for the Health and Wellbeing Board). However, these reports and databases are not always easily accessible to a wider audience. The aim of this report is to provide an overview of the health of Peterborough in a format that will be easily accessible to a general audience.

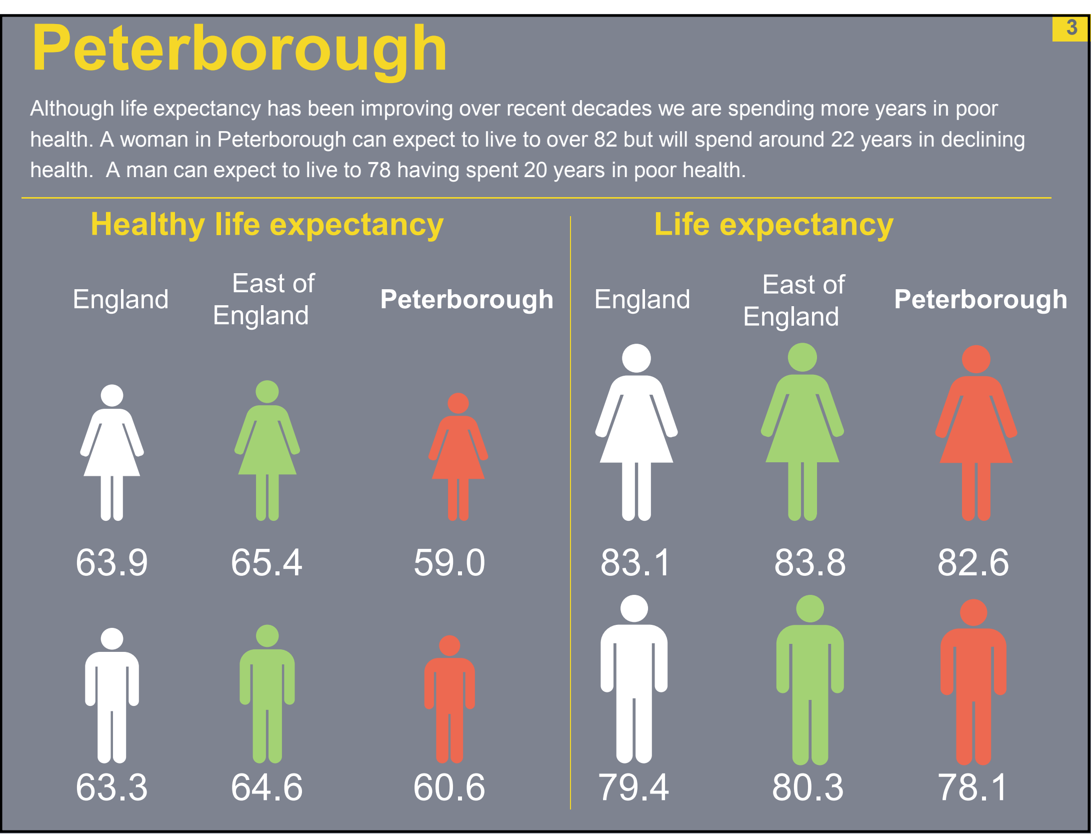
Peterborough, along with the rest of the United Kingdom, has seen significant improvements in life expectancy over recent decades. However, the gains in life expectancy have not been uniform across the country and there can be variations between areas that are geographically close – even within Peterborough. While life expectancy has increased, the years of life lived in full health have not increased to the same extent with the result that we can now expect to spend the last twenty years of life in declining health. This results in reduced quality of life for individuals and their families and also places an unsustainable burden on health and social care services. We know that by reducing lifestyle risk factors across our population (smoking, obesity, poor diet, physical inactivity, drinking too much alcohol) we could significantly reduce the burden of ill health. This report illustrates how these risk factors currently impact on the health of people in Peterborough and outlines some of the interventions that could reduce this.

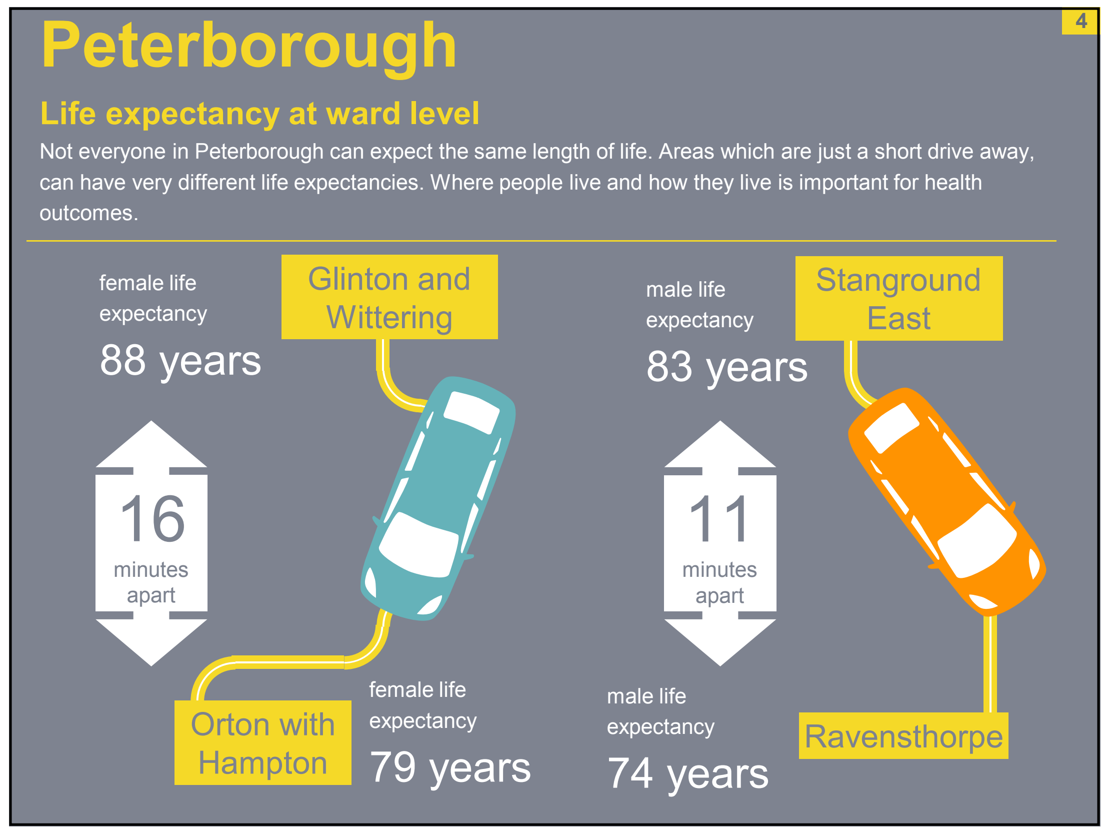
Dr Henrietta Ewart
Interim Director of Public Health

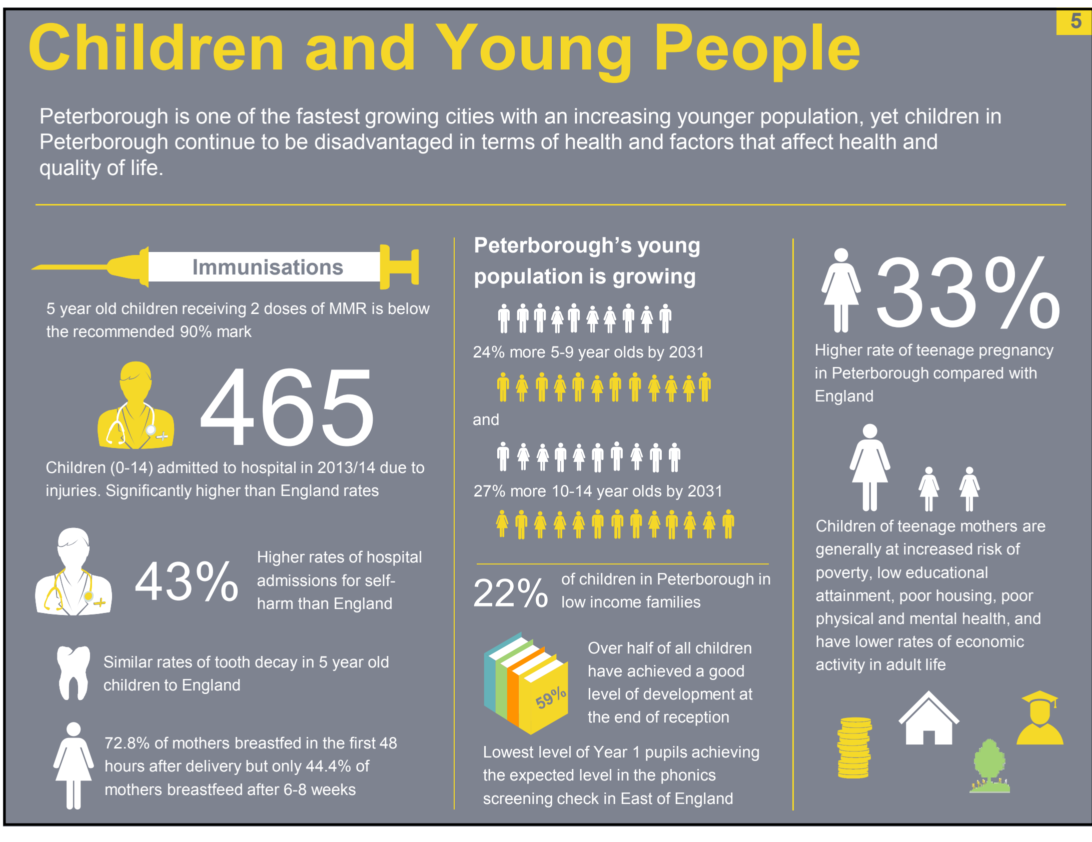
February 2015

2

Our Population


Peterborough
3
Although life expectancy has been improving over recent decades we are spending more years in poor health. A woman in Peterborough can expect to live to over 82 but will spend around 22 years in declining health. A man can expect to live to 78 having spent 20 years in poor health.
Healthy life expectancy
Life expectancy
England
East of England
Peterborough
England
East of England
Peterborough
63.9
65.4
59.0
83.1
83.8
82.6
63.3
64.6
60.6
79.4
80.3
78.1


Peterborough
4
Life expectancy at ward level
Not everyone in Peterborough can expect the same length of life. Areas which are just a short drive away, can have very different life expectancies. Where people live and how they live is important for health outcomes.
female life expectancy
88 years
Glinton and Wittering
16 minutes apart
Orton with Hampton
female life expectancy
79 years
male life expectancy
83 years
Stanground East
11 minutes apart
male life expectancy
74 years
Ravensthorpe


5
Children and Young People
Peterborough is one of the fastest growing cities with an increasing younger population, yet children in Peterborough continue to be disadvantaged in terms of health and factors that affect health and quality of life.
Immunisations
5 year old children receiving 2 doses of MMR is below the recommended 90% mark
465
Children (0-14) admitted to hospital in 2013/14 due to injuries. Significantly higher than England rates
43%
Higher rates of hospital admissions for self-harm than England
Similar rates of tooth decay in 5 year old children to England
72.8% of mothers breastfed in the first 48 hours after delivery but only 44.4% of mothers breastfeed after 6-8 weeks
Peterborough's young population is growing
24% more 5-9 year olds by 2031
and
27% more 10-14 year olds by 2031
22%
of children in Peterborough in low income families
59%
Over half of all children have achieved a good level of development at the end of reception
Lowest level of Year 1 pupils achieving the expected level in the phonics screening check in East of England
33%
Higher rate of teenage pregnancy in Peterborough compared with England
Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing, poor physical and mental health, and have lower rates of economic activity in adult life

6
Children and young people
Children have some poor outcomes in Peterborough in terms of health, education and wellbeing. It is therefore important that resources are targeted appropriately for children and families to support lifestyle choices that encourage healthy development.
A best start in life
Early experiences of life are crucial to lifelong health and development. Children who grow up in a nurturing environment with good nutrition, education, housing and opportunities will be more successful adults with better health and wellbeing. Children in Peterborough deserve the best start in life: the healthiest environment for children from conception through their early years.
Pregnancy
Research shows us that good health starts during pregnancy and children born with low birth weight have higher risks of obesity and diabetes later in life.
Encourage breastfeeding
Breastfeeding not only benefits a growing infant but also leads to better health outcomes later in life. Less than half our babies continue to be breastfed by 6-8 weeks of age. We need to increase the number of babies who are breastfed over the first few months of life by providing support to expectant and new mothers.
Prevent illness
Protecting our children against infectious disease is achievable through good uptake in immunisations. Education and support to parents is important to ensure high immunisation rates.
Effective parenting
A stable, loving relationship with parents or caregivers promotes emotional, social and cognitive development, emotional resilience and healthy lifestyles in children. It is known that infants do better if they are cared for in a safe, warm and responsive way.

7

Children and young people

Our vision is for healthy, happy families living in thriving communities. However, Peterborough has higher numbers of children living in poverty. The relationship between poverty and health is well established.

Opportunities for healthy children

Children born into poorer households will be at greater risk of premature mortality and reduced life expectancy. They are more likely to be lower achievers, smoke, become teenage mothers and suffer mental health problems. Moreover, the gap in outcomes between the most and least deprived widens with age and the effect of these inequalities accumulates throughout life.

In Peterborough, we must ensure that the most deprived and hard to reach families and communities, including new migrants, have access to the services and opportunities they need to achieve the best possible health outcomes. To do this we must work together to tackle the wider determinants of health from education, housing, communities and the environment and provide the best start in life for our children.

Health visitors - Local authorities will have responsibility for commissioning health visiting, and other children's public health services from September 2015. Health visitors will be able to support families where it is most needed.

Growth and housing - are key factors for health with worse outcomes linked to poorer areas. Improving housing conditions of young families will enable better living conditions, reduce illness and promote better achievement in young people.

Education and schools - There is a clear link between good health and wellbeing and high levels of academic achievement. The healthy child programme and pupil premium will help improve health and educational outcomes for the most disadvantaged. Schools can also be supported to address bullying as a first step towards improving mental wellbeing in young people and reducing the risk of self-harm.

Environment and health – Opportunities for play and access to green space both encourage physical activity and improve mental health. Access to these facilities are particularly important in areas where children are living in poverty.

8

Older People

Older age often presents health challenges. The number of people aged over 65 in Peterborough is increasing and will continue to increase over the next 20 years. This will put pressure on health and social services. However, some simple measures can be taken to help prevent illness and disability and enable older people to live healthier longer lives and to live independently.

Our local challenges

74%

Increase in the number of people over the age of 65 by 2031 (compared with 2010)

2010	2021	2031
26,600	37,200	46,400

2X more people aged over 80 in 2031 than 2010

In Peterborough, 69 more people aged over 85 died during winter months than at other times of year between 2010 and 2013

72% of older people take up the offer of the flu immunisation

1 in 17 people aged over 65 are living with dementia, which is over

1500 people in Peterborough

415 emergency hospital admissions for injuries from falls in persons aged 80 and over in Peterborough in 2012/13.

£2.3 Million health and social care bill for hip fractures in Peterborough per year.

177 hip fractures in people aged over 65 in Peterborough in 2012/13

1 in 3 people who fracture their hip die within 12 months after the fracture

Older people

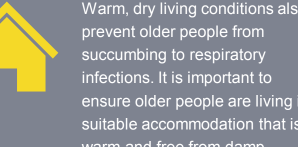
We would like older people to live longer, healthier lives in their own homes. To do this, we need to focus on promoting activities and interventions that help to prevent illness and injury in older people.

Our approach

Preventing respiratory illness

A major cause of mortality in older people is through respiratory infections. The flu virus can be devastating for older people and it is therefore important that all eligible older people take up the offer of the annual flu immunisation to prevent this infection.

Around 1 in 4 older people do not take up the offer of the flu immunisation and these people will be at higher risk during the winter months.



Warm, dry living conditions also prevent older people from succumbing to respiratory infections. It is important to ensure older people are living in suitable accommodation that is warm and free from damp.

Preventing falls

Injuries resulting from falls are a major problem for older people. In Peterborough, there are higher rates of injuries due to falls than anywhere else in the East of England. Falls that result in hip fractures are a major cause of mortality in older people and are costly to both health and social care services - £2 billion per year in the UK.

Fear of falling can prevent older people from living fulfilling and healthy lives and increase the risk of falling.

Some simple measures help to reduce the risk of older people falling:

Keep warm in winter - a warm house will encourage mobility around the home and keep older people more active and healthy and reduce the risk of cardiovascular disease.

Stay active - maintaining physical activity in older age can prevent falls and reduce the fear of falling and help people to stay at home.

Eat healthy balanced diet and prevent dehydration

Create a healthy living environment - Assess living space obstacles that may cause falls. Consider installing hand rails to help in bathrooms and other rooms if required.

Older people

Both physical health and mental health are important to achieve a healthy older age and one often affects the other. Depression is common in older people and can considerably reduce quality of life, and increase healthcare usage and the risk of mortality. Just as stopping smoking, maintaining a healthy weight, doing exercise and drinking alcohol in moderation will help to maintain good physical health, some simple measures can be taken to reduce the risk of older people developing depression.

Reducing loneliness and social isolation

Transitions such as retirement or bereavement may act as a trigger for loneliness and developing depression. Peterborough has started a befriending service that may help to reduce loneliness. Increasing social networks and opportunities for community engagement are important for older people to reduce the effects of social isolation.

Promoting physical activity

Physical activity in older people is not only essential for good physical health but can also prevent depression. Structured group physical activity programmes are recommended by NICE for people with mild to moderate mental health problems.

Preventing dementia

Dementia is a disease of the brain, characterised by impaired cognitive function including memory, which is usually chronic or progressive. Older age is a risk factor for dementia. As the population in Peterborough is predicted to age, the numbers of people living with dementia over the age of 65 will double by 2030. This will put a strain on existing services, particularly social care.

A healthy, engaged life is the best way to prevent dementia. Risk factors for dementia include those linked to vascular disease - smoking, excessive alcohol use, hypertension, raised cholesterol levels and diabetes. Reducing or treating these risk factors will help reduce dementia and depression.

Peterborough Dementia Action Alliance aims to make Peterborough a dementia friendly city. A dementia resource centre provides information and support to people with dementia and their carers. It also supports a network of dementia friends to provide community support

Our Lifestyle Choices

Reducing Deaths from Cardiovascular Disease

Cardiovascular disease includes stroke, heart disease and aortic and peripheral vascular disease; all involve damage to blood vessels and have common risk factors. Diabetes and chronic kidney disease are also included in the cardiovascular disease family as they have similar risk factors and increase the risk of cardiovascular disease.These risk factors include smoking, obesity, lack of physical activity, high blood lipids and high blood pressure.

Peterborough City Council and the Local Clinical Commissioning Groups have identified cardiovascular disease as a priority for action.

The challenge in Peterborough

1 in 3

430 deaths in Peterborough between 2008-10 were caused by Cardiovascular Disease. 230 of these people died from heart disease and 63 from strokes under the age of 75.

2 out of 3

Cardiovascular Disease deaths under the age 75 are preventable with current knowledge - but are the right people getting the care they need?

125 out of 150

Peterborough ranks 125/150 local authorities for premature deaths from heart disease and stroke in 2011-13 with 377 premature deaths.

14 out of 15

Peterborough ranks 14/15 among local authorities with similar social and economic factors and similar deprivation levels for premature deaths from heart disease and stroke in 2011-13.

13

Developing a strategy to reduce

cardiovascular disease

Through the Health and Wellbeing Board, Peterborough City Council and health partners are developing a five year strategy to reduce cardiovascular disease and deaths, to support people living with cardiovascular disease and tackle the risk factors in the population.

Around half of all deaths from cardiovascular disease are due to coronary heart disease - when the blood vessels in the heart become blocked. Over 5,000 people are recorded as having coronary heart disease but this is less than half the expected number - so people may not be getting the help and support they need.

Almost 1 in 5 cardiovascular disease deaths are from a stroke - when blood vessels in the brain are blocked or burst and bleed into the brain tissue. Over 4,000 people are expected to have had a stroke, but again, only half this number have this recorded.

About 1 in 8 (22,600 people) have been diagnosed with high blood pressure but the estimated number is 54,000. Untreated blood pressure is a risk factor for stroke, heart failure, and diseases of the kidneys and aorta (the main blood vessel in the body).

Cardiovascular disease is a major cause of disability, reducing the quality of life and independence of many living with the condition.

Cardiovascular disease prevalence and mortality are higher in areas of greater deprivation - in part due to the higher prevalence of risk factors such as smoking, and poorer access to, and uptake of, treatment e.g Health Checks, statins and blood pressure drugs.

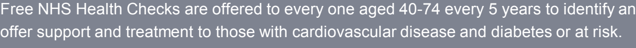
14

Our approach to reducing

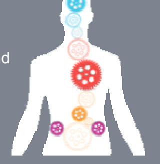
cardiovascular disease

The strategy will include: prevention for individuals and the population, treatment and reablement and support for people living with cardiovascular disease.

We will create an environment which supports people making healthy lifestyle choices, using the opportunities available to the Council e.g planning and licensing to support active living and limit fast food outlets. We shall also commission evidence based services to support healthy lifestyles.



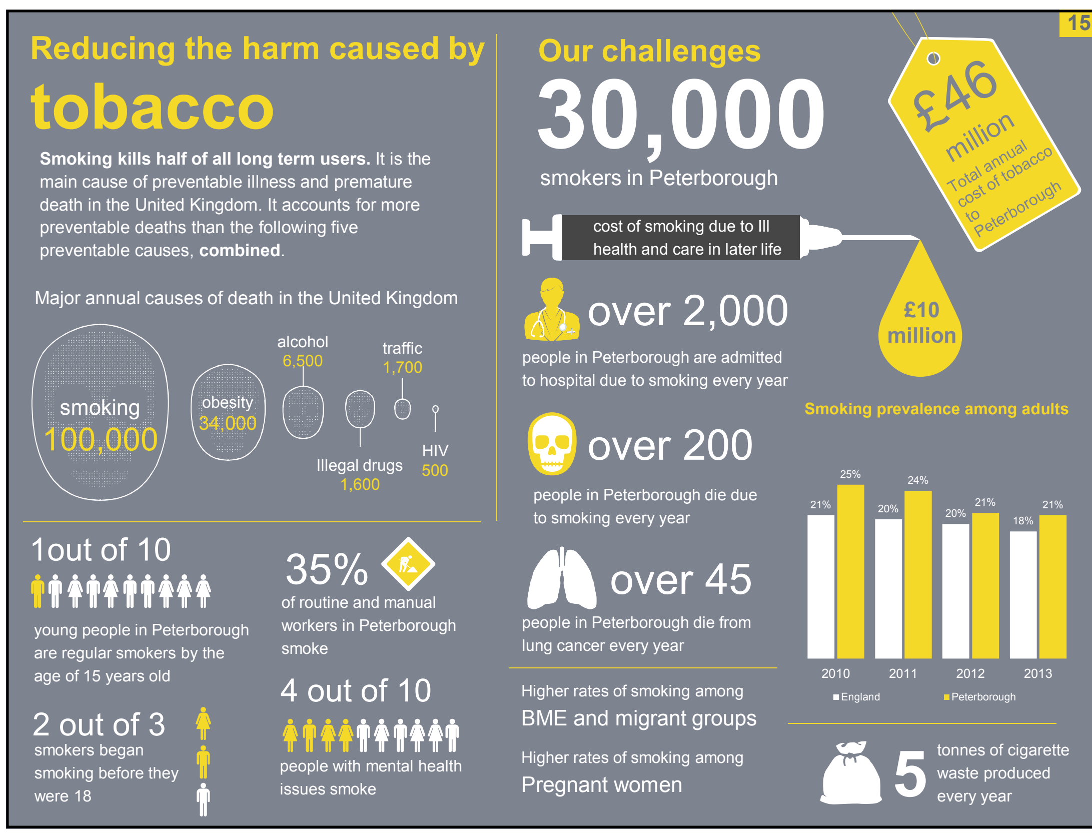
Free NHS Health Checks are offered to every one aged 40-74 every 5 years to identify and offer support and treatment to those with cardiovascular disease and diabetes or at risk.



We will work with the Clinical Commissioning Group to improve identification and treatment of people with high blood pressure, high blood fats or an irregular heart beat (atrial fibrillation) to ensure they get the treatment they need; we will work with them to commission evidence based hospital services and access to specialist rehabilitation e.g after a stroke or heart attack.

We will map services for those living with cardiovascular disease long term to ensure that they have access to lifestyle services and the support they need, including care at the end of life e.g for those with heart failure.

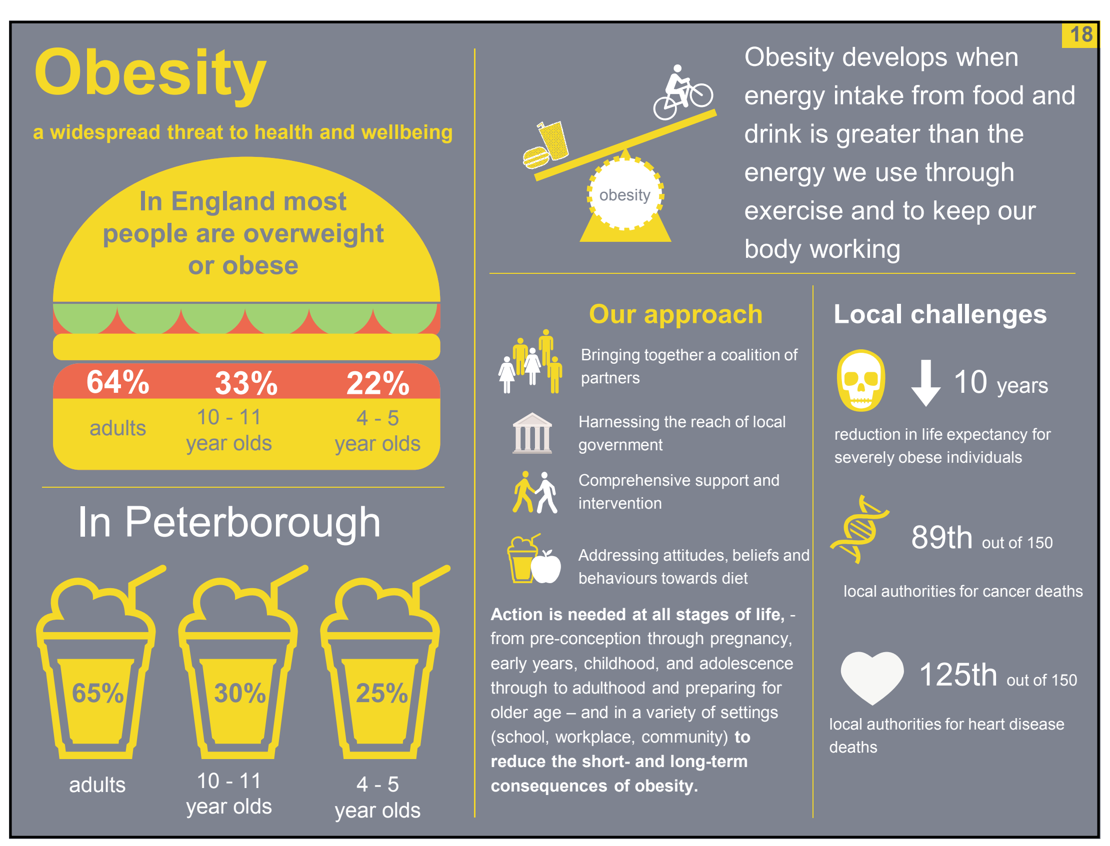
For more information on cardiovascular disease and its risk factors see http://www.nhs.uk/conditions/cardiovascular-disease/Pages/Introduction.aspx



15
Reducing the harm caused by
tobacco
Smoking kills half of all long term users. It is the main cause of preventable illness and premature death in the United Kingdom. It accounts for more preventable deaths than the following five preventable causes, combined.
Major annual causes of death in the United Kingdom
smoking 100,000
obesity 34,000
alcohol 6,500
traffic 1,700
Illegal drugs 1,600
HIV 500
1out of 10
young people in Peterborough are regular smokers by the age of 15 years old
35%
of routine and manual workers in Peterborough smoke
2 out of 3
smokers began smoking before they were 18
4 out of 10
people with mental health issues smoke
Our challenges
30,000
smokers in Peterborough
£46 million
Total annual cost of tobacco to Peterborough
cost of smoking due to Ill health and care in later life
£10 million
over 2,000
people in Peterborough are admitted to hospital due to smoking every year
over 200
people in Peterborough die due to smoking every year
over 45
people in Peterborough die from lung cancer every year
Higher rates of smoking among
BME and migrant groups
Higher rates of smoking among
Pregnant women
Smoking prevalence among adults
21%
25%
20%
24%
20%
21%
18%
21%
2010
2011
2012
2013
England
Peterborough
5
tonnes of cigarette waste produced every year

16
Reducing the harm caused by tobacco
Reducing smoking prevalence remains a key public health priority and a national focus. Healthy Lives, Healthy people: A Tobacco Control Plan for England sets out three national ambitions to focus tobacco control work. These national ambitions represent an assessment of what could be delivered through national action, supported and associated with locally driven comprehensive tobacco control practice. These ambitions should be adopted locally to enable our efforts to be amplified and benefit from nationally driven activity.
2010
2020
Reduce smoking during pregnancy
18%
10%
Giving up smoking remains one of the key actions that women can take to reduce the risks to themselves and their baby during pregnancy. Action during pregnancy will reduce the number of new born children that are exposed to secondhand smoke, reducing the number of infants that may suffer serious respiratory infections, such as bronchitis and pneumonia.
Reduce smoking among young people
15%
10%
When smoking is seen by young people as an acceptable part of everyday life, they are much more likely to become smokers themselves. Therefore we need to demonstrate why smoking should not be seen as a normal. An addiction to smoking cannot only last their lifetime but may also cost their life.
Reduce smoking among adults
21%
16%
Smoking prevalence in Peterborough is reducing but there are still more adult smokers than the national average requiring comprehensive action to reduce local smoking attributable deaths from for example, heart disease; stroke; lung cancer and chronic obstructive pulmonary disease.
Priority groups
Smoking prevalence remains higher among certain groups so action should be taken to support routine and manual workers; people with mental health problems, ethnic and migrant people and pregnant women.

17
Reducing the harm caused by tobacco
Tobacco use is an economic and health burden for Peterborough that needs to be addressed through comprehensive tobacco control, requiring a combination of educational, clinical, regulatory, economic and social action, as outlined below.
Reducing exposure to secondhand smoke - Tobacco use not only harms those that smoke but the people around them, through secondhand smoke. Exposure to smoking is a particular health risk to children. Locally parents who smoke need to be aware that their children may become ill as a result of breathing in secondhand smoke.
Locally enforcing tobacco legislation - The legal age for the purchase of tobacco in England is 18 making it more difficult for young people to buy tobacco. Underage sales are still taking place in Peterborough and illegal tobacco, that often contains more harmful additives and chemicals than legitimate tobacco products remain available.
Communicate the harm caused by tobacco - Effective communication about the harms of tobacco encourages people to quit smoking and discourages others from beginning to smoke. Local action to support national campaigns is needed to ensure the harms of tobacco are clearly understood.
Normalise smokefree lifestyles - Young people often underestimate the dangers of smoking while overestimating the number of their peers who smoke and can view smoking as normal. As such it is during childhood and adolescence that the majority of people experiment with smoking and can become regular smokers after only a few cigarettes.
Support people to stop smoking - People are four times as likely to quit with support from local stop smoking services which follow National Institute of Health Care and Excellence guidance emphasising the need for local services.
A note about E-cigarettes - These products aren't currently regulated like products that contain tobacco and while considered safer than smoking, by the public health charity ASH, we don't know enough about whether they are completely safe from toxic chemicals, effective in helping people cut down or quit smoking tobacco or made to consistent quality standards.


18
Obesity
a widespread threat to health and wellbeing
In England most people are overweight or obese
64%
adults
33%
10 - 11 year olds
22%
4 - 5 year olds
In Peterborough
65%
adults
30%
10 - 11 year olds
25%
4 - 5 year olds
obesity
Obesity develops when energy intake from food and drink is greater than the energy we use through exercise and to keep our body working
Our approach
Bringing together a coalition of partners
Harnessing the reach of local government
Comprehensive support and intervention
Addressing attitudes, beliefs and behaviours towards diet
Action is needed at all stages of life, - from pre-conception through pregnancy, early years, childhood, and adolescence through to adulthood and preparing for older age – and in a variety of settings (school, workplace, community) to reduce the short- and long-term consequences of obesity.
Local challenges
10 years
reduction in life expectancy for severely obese individuals
89th out of 150
local authorities for cancer deaths
125th out of 150
local authorities for heart disease deaths

19

Obesity

Obesity is a major concern; two out of three adults are overweight or obese and one in three children age 10-11. Being obese significantly increases the risk of developing diabetes, heart and liver disease and some cancers. It can make it harder for people to find and stay in work and can affect self-esteem and mental health. It is estimated that being moderately obese reduces life expectancy by about three years and being severely obese by 10 years or more. Obesity is estimated to cost the NHS £5 billion a year and type 2 diabetes (often caused by obesity) a further £9 billion. NICE has produced evidence-based guidance to support local authorities with prevention and treatment.

Tackling the causes

Work with businesses to improve menus and calorie labelling; promote healthy alternatives to fast food; cut portion size and sugary drinks.

Improve access to healthy, fresh, food especially in deprived areas.

Make it easier for all to walk and cycle as part of everyday life - to school and work; plan and build safe footpaths and cycle ways.

Work with schools and workplaces to make sure healthy food and active travel are part of everyday life.

Reducing the burden

The World Health Organisation estimates that 7-40% of some cancers are due to obesity and overweight.

Public Health England estimate that dietary risk factors contribute to 12% of disability adjusted life years and that severely obese people are three times more likely to need formal social care than those of normal weight.

Develop a strategy to prevent and treat cardiovascular diseases; encourage adults age 45-74 to take up NHS health checks.

Review and develop services to manage and treat diabetes and prevent the onset of complications such as eye, vascular and kidney disease as part of the cardiovascular disease strategy.

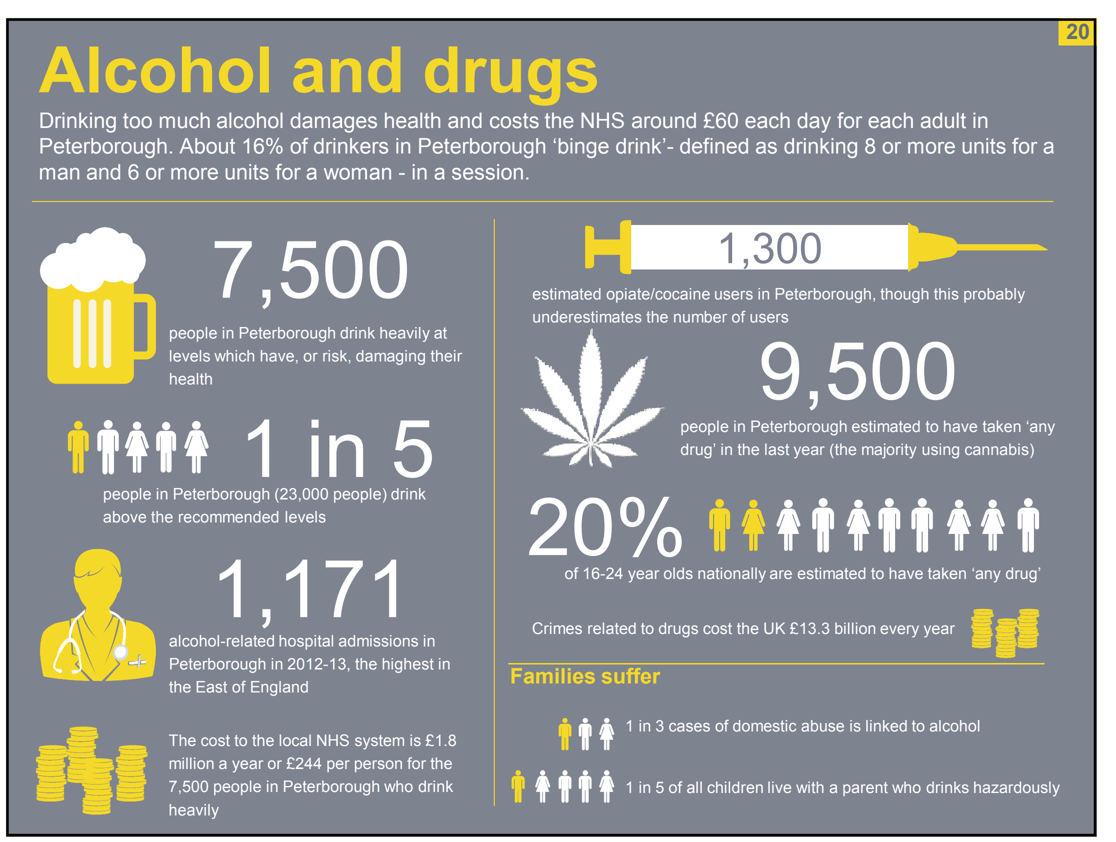
Commission evidence -based services to help children and adults lose weight and live more healthily.

Join NHS 'Change for Life'

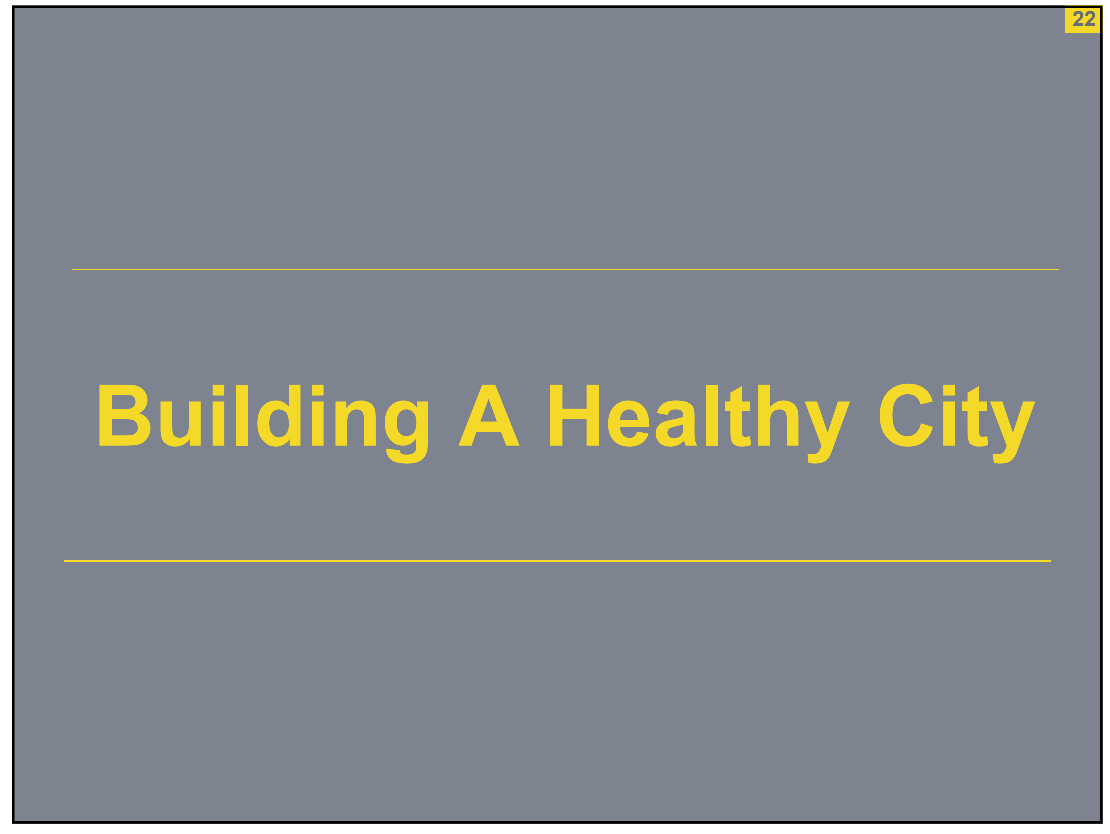
http://www.nhs.uk/change4life/Pages/change-for-life.aspx
helping people eat and drink more healthily and be more active

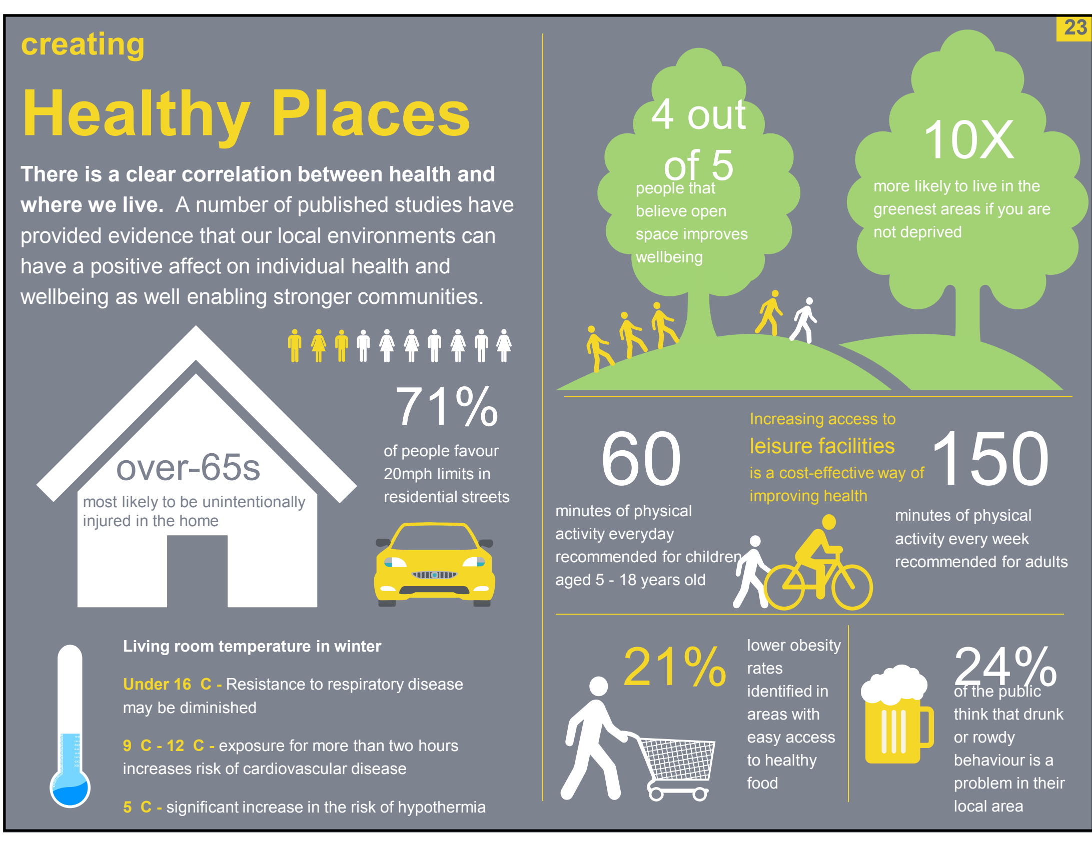
2020 Ambitions: by 2020, we want to see:

a downward trend in the level of excess weight in adults
a sustained downward trend in the level of excess weight in children



21
Alcohol and drugs
Our 2020 ambition
Reduce the number of 11-15 year olds drinking and the amount they drink
Reduce binge drinking and alcohol fuelled crime
Reduce alcohol related deaths and admissions
Reduce the number of adults drinking above the NHS guidelines
The Chief Medical Officer advises an alcohol-free childhood. However, around 1 in 4 11-15 year olds think its OK to have a drink a week, while less than 1 in 4 parents have a plan to talk to their children about alcohol.
Drinkaware provides information for adults and supports parents talking to their children about the harms of alcohol.
http://www.drinkaware.co.uk
Our approach
Share information on where people involved in crime, or attending A&E, have been drinking to inform Licensing decisions
Public Health Specialist recommends minimum unit price for alcohol
Consider alcohol control zones e.g. where there is street drinking
Train nurses and doctors to use AUDIT-C, a 3-item alcohol screen that can help identify people who are hazardous drinkers or are misusing alcohol (including alcohol abuse or dependence) as part of NHS Health Check
Provide information on the harms of alcohol and drugs as part of the Healthy School programme
Promote aspiration and achievement and reduce the number of young people not in work, education or training
Commission evidence-based services to support outcomes e.g. completion of drug treatments


22
Building A Healthy City



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Creating healthy places

Improving the places we live through high quality housing, removing fuel poverty, safe accessible places for children to play, open green space and access to healthy food is beneficial. RIBA, the Royal Institute of British Architects, recently found that the healthiest cities have the most green space and lowest density housing.

Housing - Poor housing can cause or contribute to many preventable diseases including respiratory and cardiovascular diseases. Fuel poverty and cold housing directly contribute to the prevalence of these diseases and to associated excess winter deaths, often among those with lower incomes. Poor housing can also be associated with injuries due to falls, which are more prevalent in Peterborough than the rest of the East of England and requires action to reduce injury and deaths.

Leisure Facilities – Access to leisure and sports facilities improves health and wellbeing; access is not universal with limited facilities and access not uncommon within deprived areas. In Birmingham a city-wide scheme called the 'Be Active' programme provided free access to physical activity sessions and demonstrated different ways to increase access and reduce health inequality. Evidence from this particular programme suggests that up to £23 has been saved for every £1 spent, in terms of better quality of life, reduced NHS use, productivity gains, and other gains to the local authority.

Wellbeing - The environments in which we live can promote or inhibit wellbeing.There are numerous studies that demonstrate well planned built environments that provide access to open and green spaces can alleviate stress and depression among residents. Evidence suggests that there is a positive correlation between greater access to green spaces and reduced health inequalities.

Road Safety - Unintentional injury is still a leading cause of death among children and young people, with almost half being traffic related. Younger children are most commonly injured on streets close to their home. People can be traumatised by near misses and can avoid activities such as walking, cycling and street play because of danger (real or perceived) on the streets where they live. The introduction of 20 mph speed limits on residential streets has been used to reduce unintentional injury and can be effective in some areas – the evidence needs to be carefully considered.

Creating healthy places

Access to Healthy Food - Areas with high concentration of fast food outlets have been found to have higher levels of obesity among residents including children. Action should be taken to control the number of fast food outlets near schools, colleges and places where children gather while work should be undertaken with local businesses and partners to increase access to healthy food choices. Communities should be helped to develop initiatives such as community grow and eat schemes, supported through land use agreements and aligned to Peterborough's Food for Life school programme to increase access to healthy food choices and increase physical activity.

Green Space - Access to open and green spaces can have significant benefits on people's physical and mental health, and support stronger communities. This is particularly evident within areas of deprivation that have access to green space. Within such areas all-cause mortality rates of residents have been found to be significantly lower compared to those of other residents in deprived areas with less access to green space. Working with local communities to plan for green space within broader neighbourhood plans should be adopted by the Council, with priority given to deprived areas which currently have limited access to green space.

Active Travel - Choosing to walk and cycle as part of everyday life can have a universal impact on public health, while targeted interventions may reduce inequalities in health. Recent evidence has suggested that eliminating inactivity has a greater impact on mortality rates than eliminating obesity. Development of a cross-sector, coordinated programme that incorporates public health driven outcomes should therefore be progressed as part of the adoption locally of a Healthy Place programme.

Alcohol Control - The over consumption of alcohol is made easier by lower prices and increased availability meaning that people can drink more for less. Implementation of the Licensing Act locally, including the cumulative impact policy to restrict new premises in certain areas, is helping in part to address the issue of overconsumption. However, alcohol remains a risk factor for chronic diseases including cardiovascular disease, many cancers and liver disease and an issue for Peterborough, evident in the fact that alcohol related admissions to hospital in Peterborough are higher than anywhere else in the East of England.

Celebrating Healthy Schools

Schools play a vital role in nurturing the health and wellbeing of children and young people. Providing support and recognition of their role in enhancing emotional and physical health to improve long term health, increase social inclusion and raise achievement for all through a **Healthy Schools, Peterborough** programme should therefore be a local priority.

74%

of schools achieved Healthy School status as part the national programme that operated until 2011

Role of Healthy Schools programme identified through the national evaluation

Instigator	justification	Tool	Awareness
enabling changes to practice in schools	providing reasons to change for management teams	acting as a tool to re-evaluate existing practice	raising the profile of health and well being among staff

74%

of schools stated that the national programme had a positive impact on the emotional health and wellbeing of pupils

87%

of schools stated that the national programme had a positive impact on their schools' provision of PSHE (personal, social and health education)

impacts of healthy eating

improvement to pupil behaviour in school
increased take-up of school lunches
awareness of healthy food choices
increased healthy eating outside of school

72%

of schools stated that the national programme had a positive impact on their schools' physical activity provision

27
Encouraging
Healthy Workplaces
Reducing sickness absence, lowering staff turnover and increasing productivity are all outcomes of investing in a healthy workforce. The workplace provides an ideal place to promote healthy lifestyles to a large proportion of the local population. Improving the physical and mental wellbeing among our workforce will benefit individuals, organisations and Peterborough as a whole - after all 'health means wealth'.
80%
chance of being off work for 5 years among those who have been off sick for 6 months or longer
Public Services
£889
average sickness absence cost per employee per year
Production and Manufacturing
£754
average sickness absence cost per employee per year
Call Centre
£940
average sickness absence cost per employee per year
Professional Services
£904
average sickness absence cost per employee per year
£835,355
estimated annual cost of mental ill health to an organisation with 1,000 employees. Prevention and early identification of problems in the workplace should enable employers to save at least 30% of this cost
4
extra sick days, on average, taken by obese people each year
27%
less sick days taken by physically active workers
33
more hours off sick per year taken by a person who smokes than a non-smoker each year

28
Encouraging healthy workplaces
Around one third of our adult life is spent at work, so creating healthy workplaces can have a major impact on health and wellbeing. The Workplace Wellbeing Charter for England provides employers with an easy and clear guide on how to make workplaces into supportive and productive environments in which employees can flourish.
Mental Health - It has been estimated that a reduction of productivity due to mental health conditions accounts for 1.5 times as much working time lost as sickness absence. Mental health problems, alongside musculoskeletal disorders, are the major workplace health and wellbeing issues. Reducing the stigma of mental health, providing advice and guidance including those related to legal entitlements, and establishing mental health management training are all advocated through the Charter.
Smoking - Motivating and changing employees' smoking behaviours benefits the individual while improving productivity rates and reducing sickness absences. Brief interventions, individual and group behaviour therapy with the workplace are all recommended by NICE. Such support should be underpinned by a smoke-free policy that complies with smokefree legislation and is clearly understood and adhered to by employees.
Physical Activity - NICE has stated that efforts made in the workplace, alongside wider strategies to increase physical activity levels, could help improve people's health significantly. Organisational polices that encourage physical activity including active travel to work, and enable staff to be physically active during work, are beneficial.
Healthy Eating - The workplace has a key role in encouraging staff to make healthier choices by improving access to healthier food and drinks at work. Active promotion of healthy choices, guidance on nutrition and support for weight management all have demonstrable benefits for organisations as well as employees.
Alcohol - Misuse of alcohol among employees results in lost productivity through increased absenteeism and risks injuries as well as unemployment and premature death. Organisations, for example, with policies regarding the use of alcohol in the workplace, those that provide information about the effects and dangers of alcohol, and those that undertake alcohol awareness training including understanding the links to mental health, achieve improved health and wellbeing outcomes.

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Conclusions

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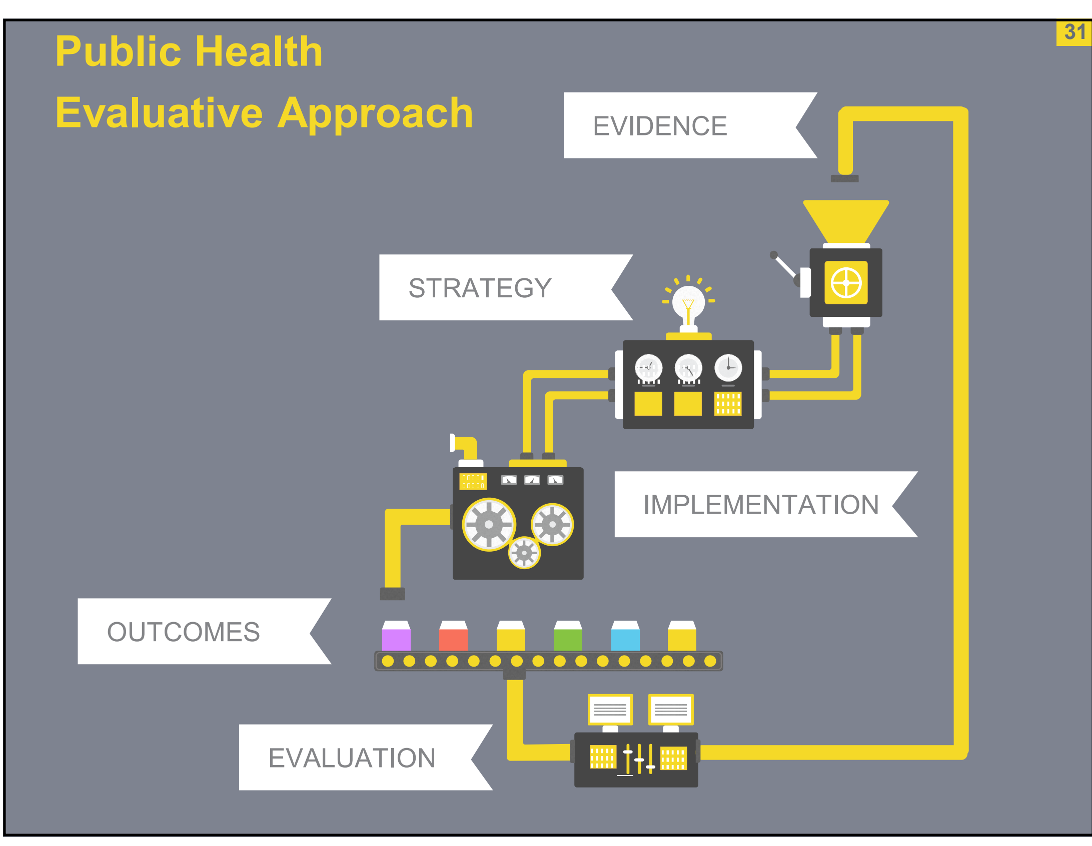
Conclusions

This report has demonstrated that Peterborough faces considerable challenges if we are to achieve a sustained improvement in the health of our population and reduce the inequalities in health that some of our communities currently experience. It is important that we address these challenges because increasing levels of health and reducing inequalities across our community will benefit everyone, right through from the individual to the socio-economic level. In addition, the council now has a statutory duty to improve the health of the population and to consider inequalities in determining how to allocate public health grant funding. The Clinical Commissioning Group has a legal duty to reduce inequalities between patients in both access to and outcomes from the health services that it commissions.

Although the challenges are great, we are better placed than ever before to take action. We have better data through which to understand the health issues facing our community and we have a growing body of evidence about interventions that have been proven to work in promoting health and wellbeing. In the past, we have not always been as good at using these sources of evidence to inform what we do locally as we could be. We now have the means for ensuring better collaboration between all organisations whose activities impact on health through the Health and Wellbeing Board.

In parallel with work at organizational level, we also need to engage and involve our local communities and community groups. Communities are the building blocks for health – within them they hold vital qualitative information about health needs and they also have within them assets that can be harnessed to improve health – skills, knowledge and local networks, for example. To fully understand our communities and how best to engage them in working with us to improve health, we need to go beyond rigorous analysis of quantitative data around health and its wider determinants. We need to work with our communities to ensure that qualitative data drawn from their own experiences are included within health needs assessments.

To achieve lasting change we need to ensure that we take a consistent and fully systematic approach to each of the topics presented in this report – involving all relevant stakeholders in scoping and ensuring that the actions and interventions we plan all fit together and complement each other. We also need to get much better at clearly identifying what we expect interventions to achieve and agreeing ways to measure this. We must not be afraid to try innovative approaches and to tailor interventions to meet specific needs of specific groups but we must evaluate these and not be afraid to stop or change what we are doing if it does not work or has achieved its aim. We have not been good at this in the past, with the result that we have some programmes which may show high levels of activity but for which we have little idea about the outcomes. The evaluative approach is shown diagrammatically on the next page.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Statistical Appendix
Further detail regarding the themes explored within this report are available within the JSNA core dataset and other information relating to public health in Peterborough are available on our website at http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen.aspx
Relevant data at local, regional and national level is also available via the below sources:
Public Health Outcomes Framework - http://www.phoutcomes.info/
Public Health Profiles - http://fingertips.phe.org.uk/
Health & Social Care Information Centre – http://www.hscic.gov.uk/home
Office for National Statistics – http://www.ons.gov.uk/ons/index.html
Acknowledgements:
Julian Base, Head of Health Strategy
Dr. Anne McConville, Interim Consultant in Public Health
Dr. Kathy Hartley, Consultant in Public Health
Ryan O'Neil, Advanced Public Health Analyst

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6(b)
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Dr Anne McConville	Tel.

REPORT ON THE FINDINGS OF THE TASK AND FINISH GROUPS ON BOWEL AND CERVICAL CANCER SCREENING AND IMMUNISATION UPTAKE IN PETERBOROUGH

R E C O M M E N D A T I O N S

FROM : Dr Liz Robin	**Deadline date : N/A**

The Health and Wellbeing Board is invited to consider the implications of the findings of the Task and Finish groups and support the recommendations:

1. Develop and deliver targeted community engagement, health education and information programmes to raise awareness, promote uptake and to better understand health beliefs and barriers to uptake of cancer screening and immunisations, based on the findings in the reports and the best evidence of effectiveness. Consider use of community leaders, social media and 'community connectors' to achieve greater reach with the target populations.

2. Explore undertaking a Did Not Attend Analysis (DNA) pilot of those who have not taken up cancer screening to
    - Validate data quality and continuing residence
    - Explore reasons for DNA
    - And scope resource implications to inform the development of an action plan.

3. Develop a targeted and more responsive immunisation offer through better explanation of immunisation schedules; targeted reminders to parents; regularly updating contact details and capturing documented immunisations in the home country at new patient registration.

4. Review progress and uptakes in a year.

1. ORIGIN OF REPORT

1.1 The Health and Wellbeing Board, in July 2014, received a report which identified poor uptake of bowel and cancer screening programmes and of childhood immunisations.

1.2 To investigate the local factors underlying these uptake rates, Public Health England, NHS England and the Peterborough Public Health Directorate established a steering group and 'task and finish' groups, drawing on expertise and input from analysts, local GPs, nurses, the CCG and other providers (Peterborough and Stamford Hospital Foundation Trust and Cambridge and Peterborough Foundation Trust).

2. PURPOSE AND REASON FOR REPORT

2.1 This report is submitted to Board to present the findings of the task and finish groups established to investigate the poor uptake rates for the bowel and cervical cancer screening programmes; and of childhood immunisations and prenatal pertussis in Peterborough.

The Health and Wellbeing Board is invited to consider the implications of the findings of the Task and Finish groups and support the recommendations.

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

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

2.3 This report supports the Health and Wellbeing Board strategic priority of 'Preventing and treating avoidable illness' and particularly the linked outcomes of addressing disease and poor health indicators; and the HWB aims 1 and 2:

- *To actively promote partnership working across health and social care in order to further improved health and well being of residents.*

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

2.4 The discharge of the Health Protection responsibilities of the PCC links with the following priorities of the Health & Wellbeing Strategy 2012-15:

- Ensure that children and young people have the best opportunities in life to enable them to become healthy adults and make the best of their life chances.
- Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes.
- Enable older people to stay independent and safe and to enjoy the best possible quality of life.

3. SUMMARY OF THE KEY FINDINGS OF THE TASK AND FINISH GROUPS

3.1 Bowel and cervical cancer screening programmes.

Bowel cancer screening uptake:

- Uptake varies by practice and is lower in Peterborough than neighbouring areas, with more deprived populations having lower uptake rates.

Cervical cancer screening uptake:

- There has been a steady decrease in uptake across the area, CCG and Peterborough, with Peterborough statistically significantly lower than the England average, similar local authorities and the national 80% target;
- There is considerable variation between practices and age groups in Peterborough, with lower uptake in the younger (25-49) population and in the more deprived practice.

A survey of the 25 Peterborough practices was undertaken to understand the factors they considered influenced the variation in screening uptake rates for these cancers. This showed that

- ethnicity and cultural factors (low awareness of the screening programmes; health beliefs; language; and cultural acceptability of the screening process) together with the mobility of migrant populations may be key factors locally.

A national review of evidence supports these local findings; in addition, male gender and fear of confirmed cancer diagnosis were identified as barriers to uptake.

The task and finish group reviewed national evidence on effective interventions to reduce inequalities in screening uptake rates. The evidence, whilst limited, suggests that:

- direct engagement of the target group (1:1 or by telephone), practical help with making appointments; audit and user feedback could improve uptake;
- a combination of interventions was usually more successful.

3.2 Childhood primary immunisations and pre-natal pertussis

- Generally the uptake of childhood immunisations in Peterborough is lower than that in the East of England as a whole, and lower than the national target of 95% required for 'herd immunity' i.e. to prevent disease transmission and provide protection for those who can't or won't be immunised;
- Childhood immunisation uptake varies by practice and shows a weak correlation with deprivation i.e. lower in practices in more deprived areas, but this is not a sufficient explanation;
- A survey of practice nurses (who give the immunisations) raised a number of issues- forgotten or inconvenient appointments; an ill child; lack of understanding of the immunisation schedule and the need for multiple immunisations to complete the primary course; lack of documentation of immunisation in the home country; language and literacy; mobility of traveller and migrant families; and, in a small number, lack of confidence in the effectiveness of the vaccine or fear of side effects;
- Issues with the invitation and scheduling system were identified (suspensions and waiting lists).These have been addressed by the Cambridge and Peterborough Vaccination and Immunisation committee with the commissioners;
- Pertussis (whooping cough) vaccine is offered to all pregnant women after 28 weeks, but many are not aware of this despite midwives saying that they discuss it with women. Immunisation is via the GP; midwives in PSHFT are not commissioned to give the vaccine;
- Data quality e.g. the mobility of some migrant populations can mean that children or pregnant women are registered on the GP system and contribute to the denominator when they have returned home. Frequent local changes of address can mean that contact details are out of date.

4. CONSULTATION

4.1 Whilst there has been no formal consultation, the partnership approach and survey work of the Task and Finish groups and the steering group have ensured professional engagement and awareness together with joint ownership of the findings and recommendations.

4.2 The Health and Wellbeing Programme Board received a summary of findings and recommendations from the Task and Finish groups for comment electronically as the scheduled meeting was cancelled. One response was received and informs this summary report.

5. ANTICIPATED OUTCOMES

- Better engagement with, and understanding of, the knowledge, health beliefs and barriers to access to services for targeted communities;
- Improved knowledge and self-efficacy in the targeted populations; better uptake of screening and immunisation –improving outcome measures *and* better health and wellbeing, so reducing health inequalities;
- More responsive services.

6. REASONS FOR RECOMMENDATIONS

6.1 The local findings and national evidence make the case for targeted community engagement to both raise awareness and to better understand the health beliefs and barriers to uptake; and to promote the salience of the screening and immunisations programmes.

6.2 The audit of those who don't attend for bowel and cervical cancer screening will inform the development of appropriate interventions and information, targeted to need and help scope the impact on practices in terms additional workload.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Alternative options include:
- Doing nothing;
- Hoping that national awareness campaigns 'trickle down' to the local target population.

8. IMPLICATIONS

8.1 The Task and Finish groups on screening and immunisation uptake identified variation in uptake rates across practices in Peterborough that showed some correlation with deprivation. The survey work with health professionals delivering these services in practices in Peterborough and the national evidence supports barriers to uptake in migrant, BME and traveller populations. Poor uptake rates for these evidence-based public health prevention programmes are likely to be associated with poorer outcomes through late diagnosis of cancer and exposure to preventable infectious diseases. Poorer health can limit educational, employment and economic opportunities for individuals and populations.

Legal duties to reduce inequalities

8.2 NHS bodies –the CCG, NHS England, Monitor-have a legal duty under the Health and Social Care Act, 2012, to give due regard in the exercise of their functions to reducing inequalities between patients in access to and outcomes from health services.

8.3 Whilst no specific legal duty to reduce health inequalities applies to local authorities, a local authority must, in using the grant, have regard to the need to reduce inequalities between people in an area with respect to the benefits that they can obtain from that part of the health service provided by the local authority.

9. BACKGROUND DOCUMENTS

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

Task and Finish Group reports, PHE & NHS England area team, May 2015
- Immunisation Uptake in Peterborough
- Cervical and Bowel Cancer uptake in Peterborough.

Dr Anne McConville
Interim Consultant in Public Health
07/06/15

CERVICAL AND BOWEL CANCER SCREENING UPTAKE IN PETERBOROUGH

Authors: Olabisi Williams, Screening and Immunisation Co-ordinator and Colin Uju, Screening and immunisation manager

Analytical Support: Paul Bingham, NHS England Analyst, Analytical Services (Midlands & East) and Jane Robinson, Public Health England, Interim Public Health Analyst

Report: of Peterborough Cancer Screening Task and Finish Subgroup

Date: May 2015

1. Introduction

Following recent concerns about low uptakes for cervical and bowel cancer screening and some vaccines programmes in Peterborough, Peterborough Local Authority, Public Health England and NHS England set up a Screening and Immunisation Task and Finish Steering Group; out of which, the Screening Task and Finish subgroup was subsequently constituted. This report presents the findings of the Screening subgroup from the data analysed, the survey undertaken and the evidence gathered locally and nationally; all of which have informed the recommendations outlined in this report.

2. Background

The NHS Bowel Cancer Screening and the Cervical Screening Programmes are two of the 15 national screening programmes in the UK. The Bowel screening programme is aimed at detecting bowel cancer at an early stage (in men and women aged 60-69years with no symptoms), when treatment is more likely to be effective. This age range is currently being extended to 74. Bowel screening, which has been shown to reduce the risk of dying from bowel cancer by 16%, is offered every two years to all eligible men and women. The NHS Cervical Screening Programme, on the other hand, targets women aged 25 to 64; inviting them for regular cervical screening as part of the screening programme. The screening is

intended to detect abnormalities within the cervix that could, if undetected and untreated, develop into cervical cancer. Women aged 25-49 are invited for routine screening every 3 years, whereas those aged 50-64 are invited for routine screening every 5 years.

Following a review of uptake rates for bowel and cervical screening, which have seen a year-on-year decline across Peterborough, a dedicated Task and Finish Cancer Subgroup was constituted. The Subgroup was set up to;

- investigate the reasons underpinning the falling uptake in bowel and cervical screening;
- gain some useful insight into any barriers to uptake;
- as well as explore possible solutions to addressing these issues.

The Group membership consisted, and drew on the expertise, of key partner organisations including; Public Health England, Primary Care, Local Authority, Cambridgeshire and Peterborough Foundation Trust (CPFT), Cambridgeshire and Peterborough CCG, Peterborough and Stamford Hospital Foundation Trust as well as Voluntary Sector Organisations including Jo's Trust, Bowel Cancer UK) .

3. Methodology

The Group utilised a number of data collection methods including;

- Commissioning a quantitative data analysis of the uptake[1] and coverage[2] data across Peterborough.
- Undertaking a qualitative literature review of national evidence and published research on interventions on improving uptake.
- Undertaking a qualitative data collection in the form of a survey of primary care practices
- Drawing on expert views from members of the Task and Finish group

[1] Uptake is an indicator used to measure the proportion of those invited for bowel screening who are adequately screened

[2] Coverage represents the percentage of eligible women within the appropriated age cohorts (25-49 years and 50-64years respectively) adequately screened within the previous 3 ½ or 5 years depending on age.

4. Keys Findings and Outcomes

4.1. Cervical Screening uptake

The analysis of the trend data[3] presented in Figure 1 below shows a steady decline in the, local, regional, national as well as the CCG-wide cervical screening coverage across the eligible age range; with the CCG-wide performance being comparatively lower.

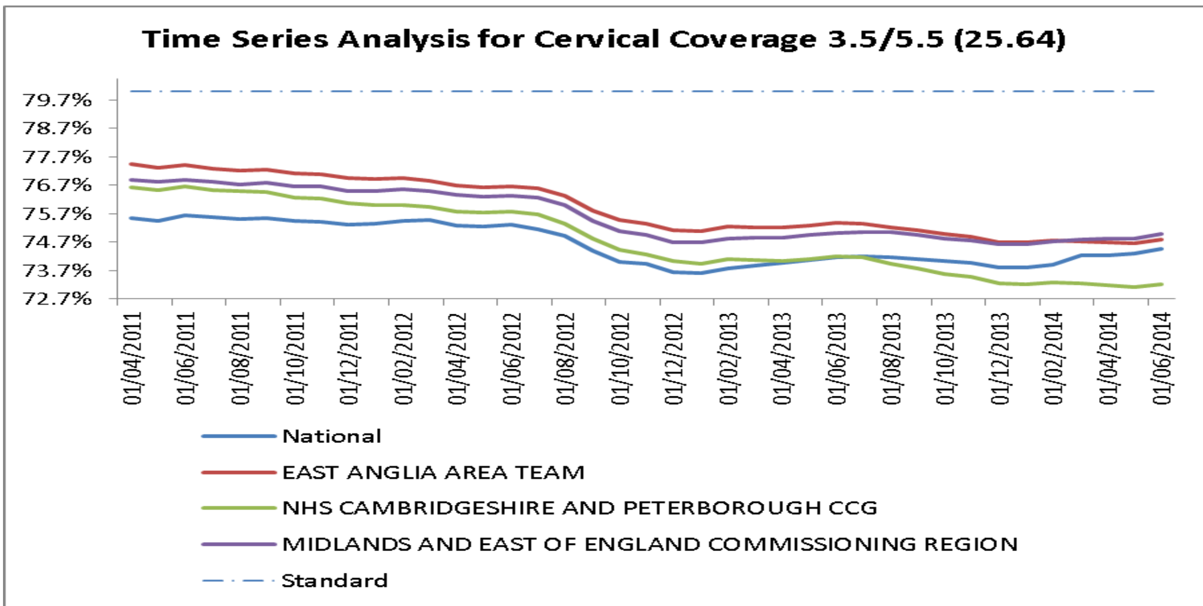

Figure 1: Cambridgeshire and Peterborough CCG Cervical Screening Coverage Trend 25 – 64 years

When compared with other local authorities that are most similar in demographic profiling (using CIPFA Nearest Neighbour comparators) (Fig. 2 overleaf), Peterborough has the lowest coverage and is statistically significantly lower than those local authorities in its comparator group. Peterborough is also statistically significantly lower than the England average as well as the national target of 80%.

[3] Data were only available to quarter 1 2014/15 at the time of the analysis, with trend data being from April 2011

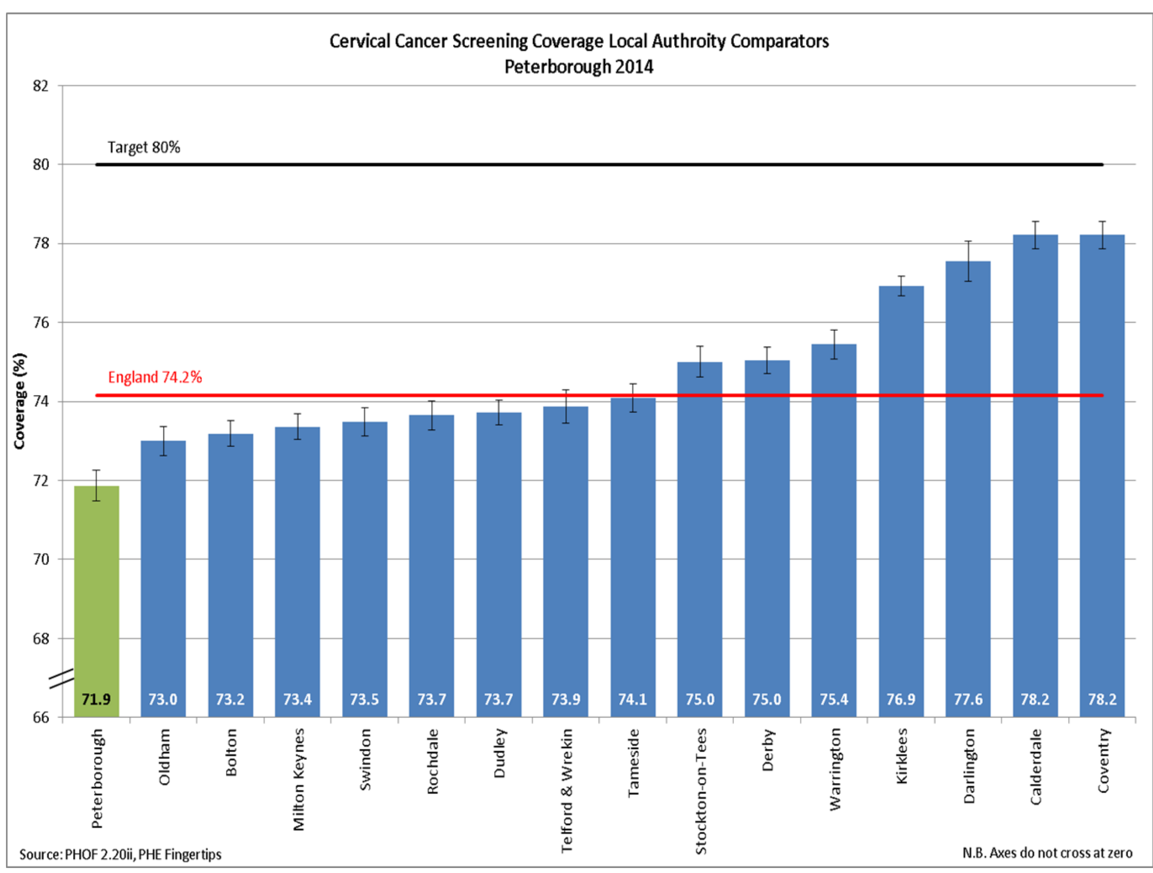

Figure 2: Peterborough Cervical Coverage Compared with Similar Local Authorities

Clearly, the decline in uptake for cervical screening is a national and far-reaching issue which is not unique to just the Peterborough population. That said, it is worth noting that the trends depicted in Fig. 1 masks the considerable variation in performance across the Cambridgeshire and Peterborough CCG practices and at the Local Authority levels as well as between the different eligible age cohorts. Coverage in the younger age cohort (25 – 49) is generally lower than in the 50 – 64 age group, with Peterborough trend being considerably lower compared with other trended data. (Fig. 3)

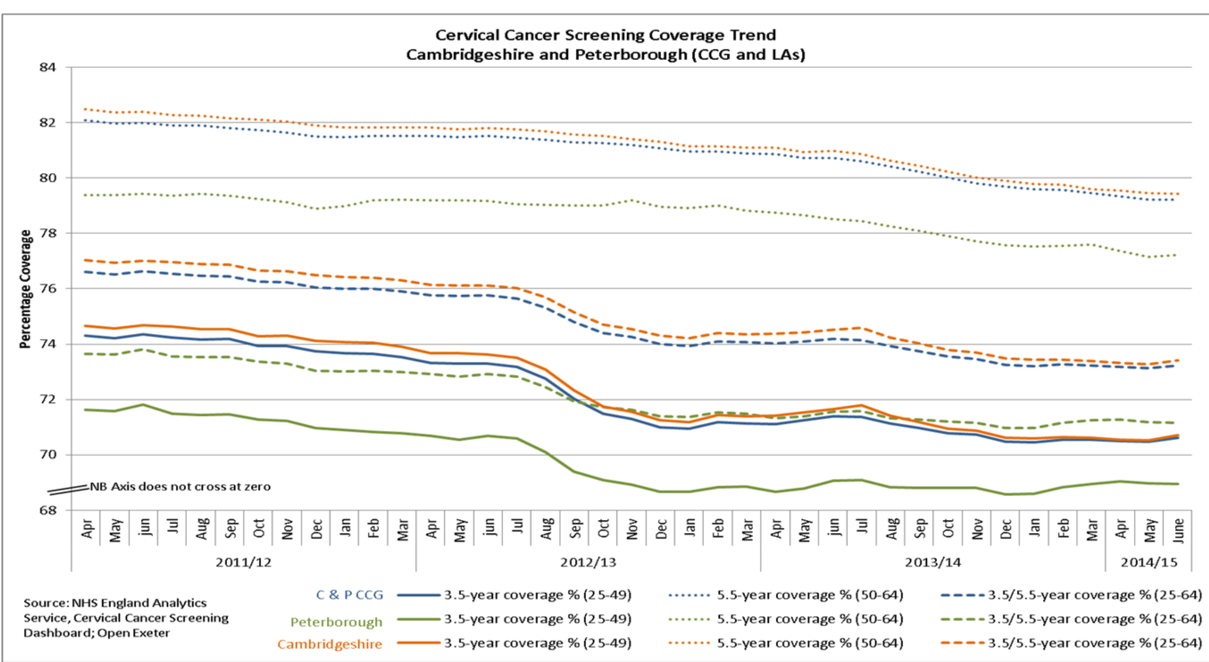

Figure 3: Cervical Screening Coverage Trend

The cervical screening coverage data was correlated against deprivation data (Index of Multiple Deprivation 2010). This analysis shows a fairly strong correlation to deprivation for Peterborough (R2 0.48)[4] and lends considerable support the theory that the practices with the more deprived populations have the lowest uptake. (Fig.4).

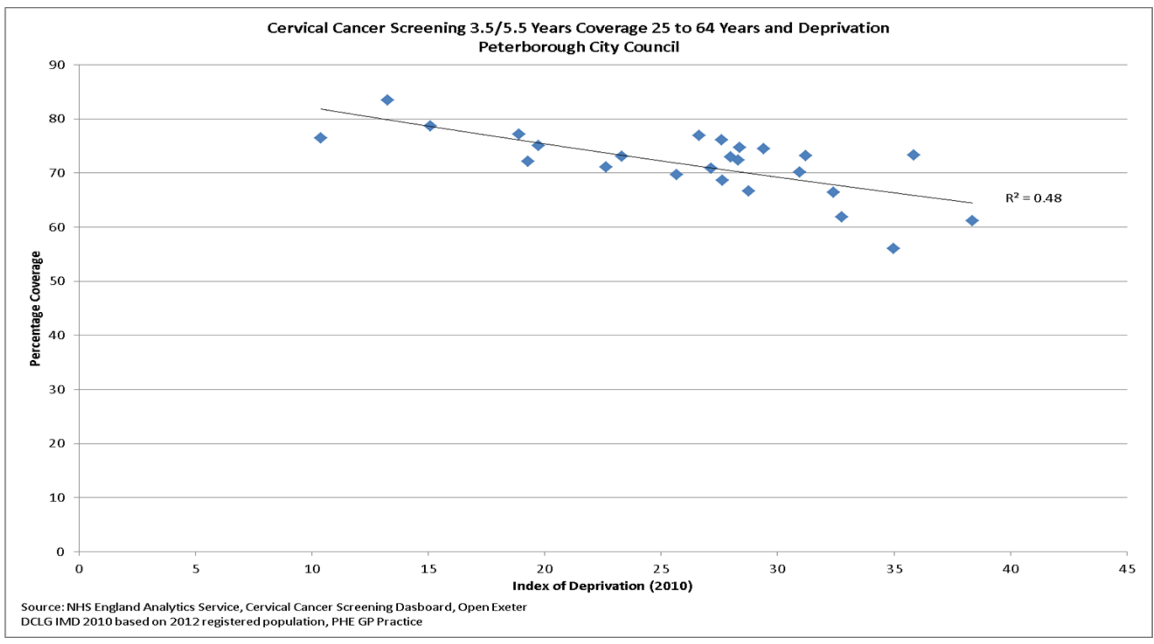

Figure 4: Cervical Screening Coverage data correlated to Index of Multiple Deprivation 2010 (Peterborough) 25 to 64 years

[4] R^2 value of 1.00 shows 100% correlation

A mapping of the coverage data indicates that the area from the North West of Peterborough City covering areas around the A15 and Lincoln road has the poorest uptakes and this is the same area with the highest deprivation scores in Peterborough.

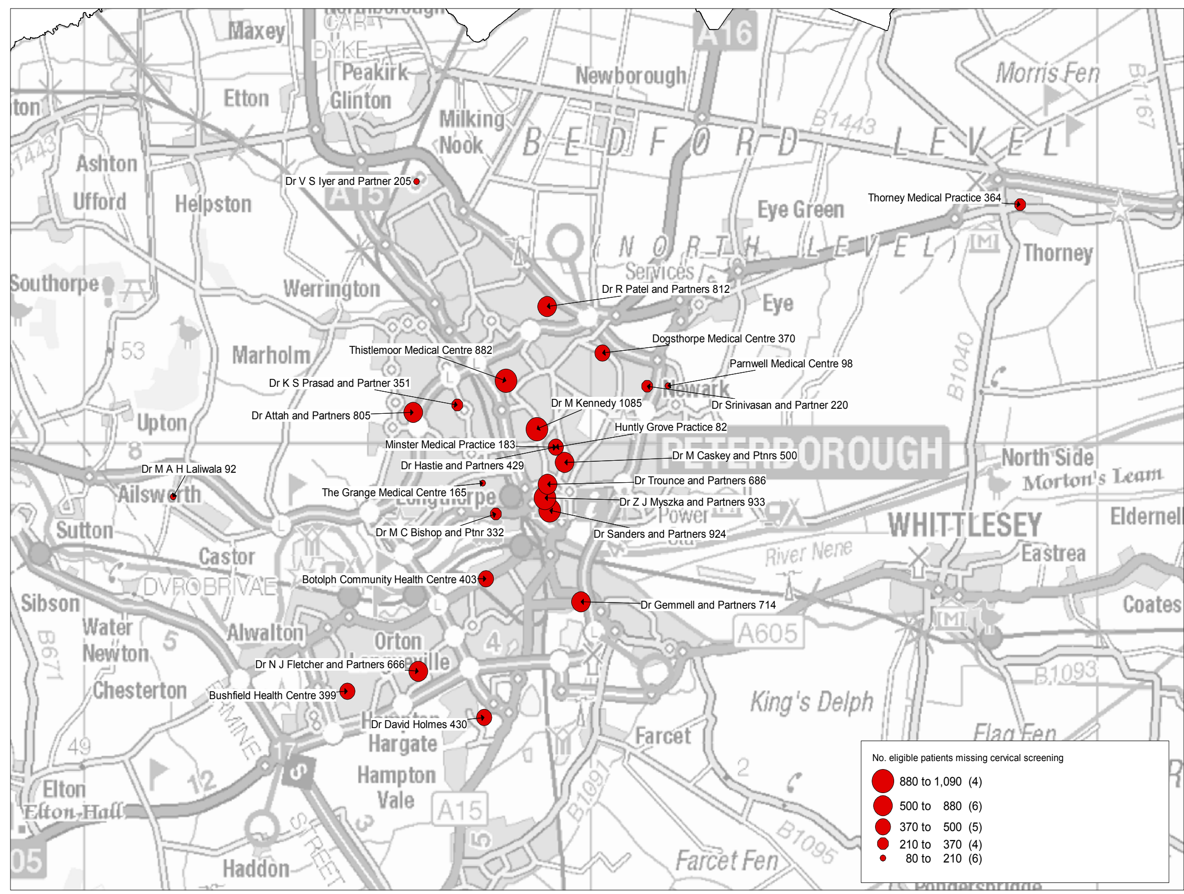

Figure 5: Cervical Screening Coverage mapped on the Peterborough City map

A practice level review of coverage data for all the practices in the Peterborough LA area shows that;

- 24 of the 25 practices in the Peterborough LA area achieved coverage rates less than the 80% national target in the period reviewed to Q1 (2014/15)[5].
- 15 practices are below the CCG average
- 10 practices are below the LA average

To contextualise this issue, as well as quantify the variation in performance and understand how many more screening needs to be done to bring performance up to the nationally set target of 80%, an analysis was undertaken and revealed;

[5] Data were only available to quarter 1 2014/15 at the time of the analysis, with trend data being from April 2011

- Peterborough needs just over 4,300 more cervical screens to reach the national target
- For practices within Peterborough City Council that fall below the CCG average (73.2%) they need to do a further 1,000 screens

Bowel Cancer Screening

The average uptake for the Peterborough and Hinchingbrooke Bowel Screening Centre for the period January to December 2014 was 57.1% against the target uptake of 52%[6]. Whilst this cumulative performance indicates that the centre, on whole, is meeting the target. Again, overall performance appears to mask the considerable variation in performance across the 25 practices in Peterborough; with 56% (n=14) of practices performing markedly below the 52% standard and uptake rates ranging from between 30% to 66%. Additionally, uptake has also been shown to display some seasonal variation; with performance dipping in some summer months. It also has to be noted that uptake in Peterborough is comparatively lower than neighbouring areas.

Correlation between bowel cancer screening uptake and deprivation shows a fairly strong correlation (R2 =0.49); suggesting that the practices with the more deprived populations also have the lowest bowel uptake for Peterborough.

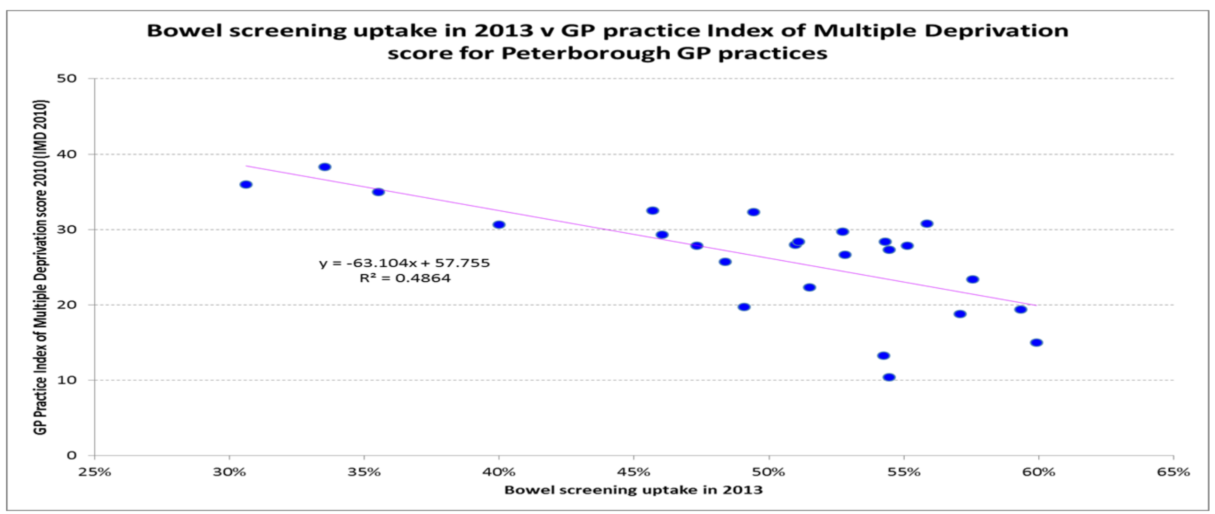

Figure 6: Bowel Cancer Screening Coverage data correlated to Index of Multiple Deprivation 2010 (Peterborough)

[6] Uptake target was recently reduced from 60% to 52%

A mapping of the uptake data indicates that the area from the North West of Peterborough City covering areas around the A15 and Lincoln road has the poorest uptakes and this is the same area with the highest deprivation scores in Peterborough. This unfortunately is a replicates the cervical screening coverage distribution in the unitary authority.

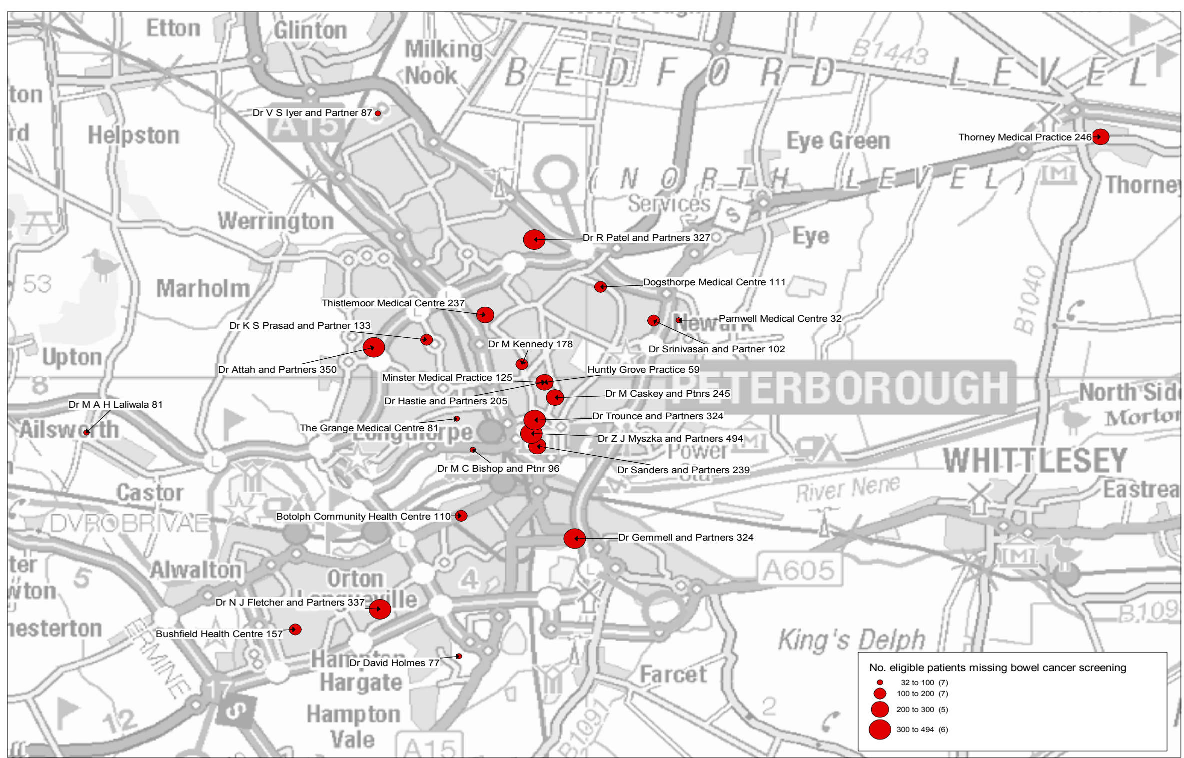

Figure 7: Bowel Cancer Screening Coverage mapped on the Peterborough City map

Survey Outcome

A survey of the practices was undertaken to investigate the issues and get a primary care perspective on the reasons for the low uptake in cervical and bowel screening. The survey had two primary aims which were to;

a) Explore and better understand issues relating to access, demography, deprivation, ethnicity, cultural beliefs and any other barriers to taking up screening and,

b) Understand current capacity and engagement levels within primary care to support any proposed initiatives to improve uptake.

All 25 practices were surveyed including those who achieving the national target to try and understand why they are better performing. Of these, there was a 32% response rate (n=8).

The summary of findings from the survey on reasons for low uptake includes;

- Culturally influenced health beliefs- for example Asian women are reportedly more reluctant to have a smear done before their first pregnancy.
- High migrant population so language is considered to be a barrier
- Lack of cultural acceptance of testing procedure for the bowel test.
- Lack of awareness of screening programmes and the benefits
- Transient nature of some Eastern European groups means that patient held information is not always up to date.
- The undignified procedure of cervical smear sample taking

National Evidence Review

An evidence review into reasons for variation in uptake was conducted by the UK National Screening Committee and identified a number of factors as well as groups of people more likely to have low bowel screening uptake. They include;

- Men;
- The younger cohort;
- Those living in a deprived area;
- Black and minority ethnic (BME) groups;
- Those living in an urban area;
- People with a lower socioeconomic status.

The barriers to uptake identified through literature research include;

- Practical issues such as ease of completing the test kit[7] which were found to be an important determinant of uptake among the Asian community;

[7] There are plans to replace the current FOB test kit with a more user friendly test kit and it is hoped that this

- Other potential reasons for lower uptake in Asian communities relate to lower levels of knowledge and awareness of bowel cancer and screening;
- Fear of confirmed cancer diagnosis has also been blamed;
- Language difficulties;
- Failure to meet religious sensitivities;

National evidence on possible interventions:

A couple of reviews at a national level [8] examined the evidence of the effectiveness of interventions aimed at reducing inequalities in screening uptake rates. The evidence, although found to be somewhat limited and often contradictory reveals:

- Interventions which actively engage the target audience (e.g. in-person education, telephone calls to patient) were more likely to succeed than reminder letters.
- Practical help with booking and attending screening appointments (e.g. through patient navigators) were generally helpful and were successful in improving uptake rates amongst BME groups.
- Written information and media messages have limited impact on screening rates.
- Service provider audit and feedback helped increase uptake rates.
- The effectiveness of one-to-one education and structural interventions in bowel screening specifically is unclear, but such interventions have been shown to be effective in other programmes.
- A combination of interventions was usually more successful than single interventions.

Summary

This report has reviewed uptake levels for bowel and cervical screening and shows generally poorer uptake when compared to its statistical neighbours. The data analysed

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would minimise the reservation that some service users have expressed about the current sample collection procedure.

[8] Porter (2008) and the recent UK National Screening Committee literature review (Wallace, 2013)

also shows variation in performance across practices, with a fairly strong correlation between uptake and deprivation for both cervical and bowel screening.

The evidence gathered from literature, local intelligence and survey, overall, suggests cultural acceptance and health beliefs, language barrier, lack of awareness of screening or its benefits and the transient nature of the population are primarily to blame for the low uptake. To address this, a targeted community engagement, health education and awareness approach is needed as well as undertaking a patient data validation exercise to ensure patient lists are accurate.

The key recommendations and indicative costs are set out tables 1 and 2 below;

Table 1: The key recommendations to be considered and implemented.

Themes	Recommendations
Community Engagement and screening awareness campaigns	1. Running focus groups targeted at ethnic minority groups to better understand the reasons for particularly low uptake amongst this group and seek their views on how best to engage them. 2. Outcome of the focus groups to inform the programme of work to be developed which will incorporate an educational training package, awareness raising campaigns on the importance of screening with particular focus on cervical and bowel screening, as well as face to face health promotion events. 3. Offer education and raise awareness of screening at places of worship especially for the Asian women and appointing a Health Champion or Community connectors to facilitate engagement. 4. Offer educational sessions to better raise awareness of screening services among primary care staff. 5. Promote engagement through the use of existing Housing Officers, Cohesion Managers and Communication Connectors to bridge access to services for the vulnerable and hard to reach groups. 6. As part of the wider health campaign, develop and deliver a

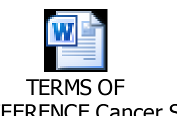
Themes	Recommendations
	programme of public facing health promotion events through the use of public stalls/stands so that there a culture and understanding of screening at a young age. 7. Develop language-specific posters to put up in specific shops and Saturday Language Schools local to migrant groups and advertise screening in their local newsletters.
Primary care-focused initiative	1. Integrate screening uptake promotional work into other programmes, such as the health check programmes. 2. Opportunistic reminders by GPs when in consultation with patients who have missed their screening appointment. 3. A Did Not Attend (DNA) analysis exercise to be undertaken for a pilot practice, 1:1 contacts to be made with the patients who have not attended screening to understand , as well as validate their continued residence in the area. The outcome of this exercise will inform plans to roll out to other practices and help understand resource implications - both human and financial - for undertaking a wider roll out. 4. Primary care to ensure resource is committed to the regular and systematic validation and submission of the Prior Notification Lists for cervical screening, which will ensure the invites go out to the eligible women.
Integrated and collaborative initiatives	1. An integrated and opportunistic approach to delivering screening which will see eligible individuals offered screening not just in primary or community care settings but equally in secondary care 2. Formalise the commissioning opportunistic cervical smear screening in sexual health clinics.

Table 2: Indicative costs and responsible partners identified for the different proposed projects.

Work Areas	Indicative costs	Responsible Partners
Health Promotion campaign and engagement work for raising awareness of childhood vaccinations, prenatal pertussis for pregnant women and cancer screening programmes	£10,000	Peterborough Public Health Team
DNA Analysis/Database validation exercise	TBC	General practices and Call/Recall Services
Training and education on screening for primary and community care staff	TBC	Bowel Cancer UK.
Dedicated Project for immunisations exploring in more depth barriers for some Eastern European / traveller families	TBC	Peterborough local authority PH team
Total	TBC	

Embedded documents:

1. **Terms of reference**



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IMMUNISATION UPTAKE IN PETERBOROUGH

Authors: Dr. Karen Lake, Screening and Immunisation Clinical Co ordinator

Jane Robinson, Interim Public Health Analyst

Report: of Peterborough Immunisation Task and Finish Group

Date: 4th May, 2015

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1. Introduction

1.1. Following recent concern about low uptakes for some vaccination programmes in Peterborough, Peterborough Local Authority, Public Health England and NHS England set up a Steering Task and Finish Group. The Immunisation Task and Finish subgroup was subsequently set up. This paper presents the findings of the Immunisation subgroup. Data is presented on Immunisation uptakes in Peterborough, specifically for childhood primary vaccinations and parental pertussis programme for pregnant women. This paper describes the background, methodology, data findings, key themes identified as barriers to uptakes, and discussion. The paper summaries its findings and makes recommendations.

2. Background

2.1. The Immunisation 'Task and Finish Group' was set up in February 2015. Membership from key partners[1] including; Public Health England, Primary Care, Local Authority, Cambridgeshire and Peterborough Foundation Trust (CPFT), Cambridgeshire and Peterborough CCG, Peterborough and Stamford Hospital Foundation Trust. Terms of Reference[2] for the Task and Finish group agreed and meeting dates.

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[1] Full list of membership Appendix 4
[2] TOR see appendix 4

3. Methodology

3.1. The methodology combined both quantitative and qualitative data.

- Quantitative data collected from COVER and Immform.
- Qualitative data collected from interviews and surveys from health professionals, including practice managers, midwives, health visitors, practice nurses, GP, children centre staff, parents and clients.
- Data from existing research including a local audit undertaken in 2012 on 'MMR and non-attendees[3]' and a literature review of published studies on improving immunisation uptakes.
- Expert views from members of the Task and Finish group.

4. Data Findings

Childhood Primary Immunisation uptakes

4.1. Childhood uptakes are outlined in Appendix 1. Data for childhood immunisations are made available through COVER and via NHS England Midlands and East Analytical Service.

4.2. Generally the uptake of childhood immunisations in Peterborough is lower than East Anglia in all quarters for 2013/14 and 2014/15 year to date for all age cohorts and most immunisations. The target for childhood immunisation uptake is 95%.

4.3. 12 month PCV immunisations in Peterborough are lower than in East Anglia as a whole in each quarter and for 12 month DTaP, IPV and Hib all quarters but 1 (Q1 2014/15) were lower. For immunisations in the 12 month cohort there are data submissions issues with Men C.

4.4. 24 month PCV immunisations in Peterborough are lower than East Anglia in all quarters. Quarter 1 2014/15 sees Peterborough with a higher percentage of

[3] Local audit in 2012 on MMR and not attendees n=64 responses from nurses, n=15 no reply, n=49 parents replied

children immunised for MMR and Hib and Men C than East Anglia. For all other quarters for these vaccines Peterborough has lower uptake than East Anglia. Peterborough has a higher uptake than East Anglia for DTaP, IPV and Hib in all quarters but Q1 2013/14. This shows a different pattern than for DTaP from the 12 month and 5 year cohorts.

4.5. For the 5 year cohort for DTaP and polio all quarters show a lower uptake in Peterborough than East Anglia. DTaP/ IPV booster in the Peterborough 5 year cohort show that all quarters have an uptake lower than East Anglia. There are only data for the 5 year cohort Pertussis (whooping cough) for 2014/15 and again Peterborough has a lower uptake than East Anglia. All quarters for MMR in the 5 year cohort show Peterborough with a lower uptake than East Anglia as a whole. For Hib and Men C Peterborough has a lower uptake rate than East Anglia for all quarters in 2013/14 and the first two quarters in 2014/15.

4.6. The uptake data for Peterborough (and East of England) are shown in Appendix 1 charts 1-12. Note for data: caution that the charts' axes do not always cross at zero.

Immunisation uptake by Practice

4.7. Childhood immunisation uptake varies significantly between Peterborough practices. The uptakes for each immunisation programme has been plotted on a funnel plot to show that some practices are outliers based on their percentage uptake and the eligible population for that immunisation (Appendix 1 chart 13-23). 2 standard deviations from the mean are the same as 95.5 to 99.7% confidence intervals so we are at least 95.5% confident that the practice's variation is significantly lower than other practices in Peterborough. 3 standard deviations from the mean are the same as 99.7% confidence intervals so we are 99.7% or more certain that the variation from Peterborough is lower for these practices.

4.8. The data for aged 12 month Men C is not complete and so there is no funnel plot for this immunisation.

4.9. Appendix 1 Table 1 shows the percentage uptake range for each immunisation and the number and percentage of practices that have reached the 95% target. All vaccinations have an upper range of 100% uptake except Men C in the 12 month cohort.

4.10. Practice level data range from 67 – 100% for the different immunisations and cohorts. 1 practice has achieved 100% uptake in all immunisations.

Data caveats for childhood primary immunisations:

- Data submission issues for Men C in the 12 month cohort.
- 2013/14 data are from COVER statistics at https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2013-to-2014-quarterly-figures. 2014/15 figures are from NHS England Analytical Service.
- Practice level chart and table data are only available for 2014/15 year to date.

Childhood Primary Immunisations compared with local authorities

4.11. A comparison of uptake rates for the childhood immunisations has been analysed for all local authorities (LAs) that are Nearest Neighbour comparators for Peterborough (Appendix 2). Nearest Neighbours are calculated by Chartered Institute of Public Finance and Accountancy (CIPFA).

4.12. The comparators for Peterborough are shown in Table 1 Appendix 2 and the charts by immunisation type and age group are shown in charts 1 to 11 Appendix 2. Milton Keynes data are not available for these data due to issues of coterminosity between health and local government.

4.13. Peterborough is the worst performing LA for 6 of the immunisations, is the second worst performing LA for 4 immunisations and third worst for one immunisation. The target for childhood immunisations is 95% uptake (Appendix 2 shown on each chart by the red line). There are only 2 immunisations where the 95% target has been met by Peterborough for 24 month DTaP, IPV and Hib and 5 year DTaP and Polio.

Childhood Immunisations and Deprivation (IMD 2010)

4.14. Correlation between all the childhood immunisations and deprivation show that there is greater uptake of immunisations in less deprived areas. However, the R2 value is low in each case (less than or equal to 0.3) showing that the correlation is weak. (N.B. the R2 value calculation includes the CCG value.) As the correlation is weak plotting these data on funnel plots may help identify outliers although this will not take in to account deprivation. In all cases there is lower uptake in the more deprived areas although correlation is **weak**.

Surveys and Audits

The following section outlines some of the main issues highlighted in the surveys and interviews.

4.15. Practice nurse [1] "*We have quite a large population of travellers who often do not believe in vaccinations or want to have their children immunised. Families within the area move around frequently. Their base may be Peterborough but they are often staying with family in other regions. There is also quite a large eastern European population whose children have often started their vaccinations in another country and cannot always understand why they have to have more vaccinations when the move the England. Some parents are illiterate*"

4.16. Practice nurse [1] reasons given by parents for non-attendance: forgot appointment, fear of side effects, vaccine not protective, and parent did not understand letter.

4.17. Practice nurse [2] survey, parent declined Prevenar vaccine because parent said she was "unsure how long protection would last". A few parents asking for single MMR because of fear of MMR and autism or parent has knowledge of another child affected after MMR.

4.18. Practice nurse [3] reported all 10 non attendees at recent immunisation clinic were Eastern European families, all reported their child had vaccine in own country of origin, but no documents.

4.19. Practice nurse [2] reported pregnant ladies saying they were unaware of the prenatal pertussis vaccine programme.

4.20. Practice manager [1] reported many non-attendees are families from Eastern Europe. Surgery has dedicated staff to follow up non attendees, but families are difficult to contact as they move and change addresses, and return to country of origin for long periods. Same issues with the prenatal pertussis for pregnant women.

4.21. Survey of children centre (Paston/Orton), n=34 parents, n=30 had child immunised, n=4 not immunised. Out of the 4 not immunised, n=3 '*fear of side effect*', n=2 '*did not feel the vaccine is protective'*, n=1 replied "*not sure if they can be trusted in long run side effects, too many new ones that we won't know about the effects for years or even if they will be effective*". Children centre parent survey, one parent had child immunised except for the MMR, because parent "*know of families who have been affected by vaccine side effects*."

4.22. Children centre staff survey reasons given out of 7 responses, 57% n=4 forgot appointment, 42% n=3 MMR risk outweigh benefit of vaccine, 42% n=3 wrong address/details, 42% n=3 did not understand appointment [language], 28.5% n=2 did not know about appointment, not convenient, and fear of side effects, n=1 did not think vaccine effective. Children centre staff also commented reasons for parents not attending immunisation clinics as: "*chaotic family, can't manage to keep appointments*", "*too many other issues going on e. g. financial, housing, domestic violence, mental health, drug use, vaccine not a priority*".

4.23. Children centre staff asked what they could do to encourage parents, staff replied: "*posters promoting benefits of vaccinations*", "*staff knowledge how to make appointment", "staff sharing information how they got their own child vaccinated*",

"*information in different languages*", "*family support workers encourage parents to take child to appointment.*"

4.24. Health visitor [1] "*I think the problems are centred around the issue of language and lack of understanding of the UK system and transient populations, in Central ward we are constantly chasing families from one address to another, often within weeks of them first transferring to area. They don't understand the letters sent to them as they are in English, don't specify which vaccines and are confusing…often they question why we are repeating vaccines when actually we are completing courses or adding missing vaccines*." "*Another issue is the part time opening on my patch…. clients find it difficult to contact the surgery*."

4.25. Health visitor [2] "*As health visitors we don't see the pre-school age children as much so maybe some sort of training or posters in preschool…I don't know whether uptake used to be better when health visitors did imms with practice nurses..*?"

4.26. Health Visitor [3] "*my belief is many families are coming in from outside the UK, our immunisation schedule may be very different they do not always seem to see the importance of pre-school boosters…I did find that many Eastern European families appeared sceptical about the Men C vaccine*." *I used to do home immunisations for those who couldn't attend in [other area] and found it useful digging out safeguarding ..getting children into nursery point of view.." "Would be good idea if child health informs health visitor when they suspend a child".*

4.27. Health Visitor [4] *one surgery ran out of vaccines and had to cancel booked clinic, the surgery has lot of children from abroad, health visitor told the child is away back in a month but when HV visits same thing happens and they never see the child*.

4.28. Local Peterborough MMR audit 2012, follow up non attendees by practice nurses n=64 response n=15 not able to contact parent, n=49 parents contacted:

Reasons given by parent for non-attendance of MMR	% [out of n=49]

appointment 2012	
Parent forgot appointment	24%
Child ill	12%
Did not know about appointment	8.1%
Date/time not convenient	8.1%
Fear of side effects	6.1%
Wrong address/details	6.1%
Out of country	4%
MMR risk outweighs benefit of vaccine	4%
Travelling family	2%
Wants single MMR	2%
Venue not convenient	2%
Vaccine not effective	2%

Prenatal Pertussis

4.29. Practice level data is only available for the current financial year by GP practice for Prenatal Pertussis. 2013/14 data are for the Cambridgeshire and Peterborough CCG as a whole and don't show the split for Peterborough practices only. Data are reported monthly via ImmForm. In 2013/14 the process of submitting data was manual and some practices were unable to submit data but the process changed for 2014/15 and has become automated. The data are shown in tables 1 to 3 (Appendix 4). There is no target *per se* but clinically all pregnant women ought to be immunised.

4.30. Tables 1 and 2 (Appendix 3) show the uptake and coverage percentages for 2013/14 by quarter. Uptake is the proportion of women who were vaccinated of all the women in the eligible cohort and coverage is the proportion of women vaccinated of the GP practices that entered data (i.e. the denominator population will reduce so coverage rates are usually slightly higher).

4.31. There is a range of uptake percentages from 0% to 87.5% in Peterborough practices but the Peterborough uptake as a whole is 40.3% compared with the CCG at 51.4%. 15 of the 27 Peterborough practices have uptake lower than the CCG. Only 6 practices have an uptake rate more than that of East Anglia as a whole.

4.32. If the uptake in Peterborough was the same as the CCG as a whole, there would need to be approximately an additional **240** women immunised each year. In some practices this is as many as 15 per quarter but 9 practices would not need to do additional immunisations. It is important to note that where a practice has no eligible women in the quarter their data will show as zero which can be misleading in uptake figures.

Prenatal Pertussis vaccination and Deprivation (IMD 2010)

4.33. Whilst the correlation between uptake and deprivation (IMD2010 based on 2012 practice populations) is not strong (R2 = 0.1) the analysis does show that there is greater uptake where there are less deprived populations.

Prenatal Pertussis Data caveats:

- One practice noted issues submitting data to ImmForm and therefore the data show zeroes. It is also important to note that at a practice level numbers of pregnant women is relatively low and when looking at these data especially by quarter there will be fluctuation in the percentage uptake.
- Whilst there were 6 practices that either did not immunise any patients or did not upload the data (2013/14 was a manual upload process but for 2014/15 it is automatic) the uptake was higher for Peterborough as a whole, for the CCG and for East Anglia. There has been a drop of 15.5 percentage points for Peterborough between 2013/14 and 2014/15 year to date. Cambridgeshire and Peterborough CCG has dropped by 11.8 percentage points and East Anglia by 8.2 percentage points (percentage points are the difference between the percentages and are not the percentages in their own right). 15 individual practices had a drop in their uptake rate but 11 have improved, 1 practice has stayed the same but reporting zeroes. The change in uptake is shown in table 3 Appendix 3.

- When comparing the 2013/14 and 2014/15 year to date data it is important to remember that there are slight differences to the data. From April 2014 the denominator was changed to be based on birth date rather than expected delivery date. The numerator should still be the same as based on the immunisation being

recorded as given or declined within the clinical system. The numerator and denominator populations are slightly different cohorts at the time of reporting uptake (doses given in time period reported of the number of women with an appropriate delivery date/ estimated delivery date).

- By directly comparing the full year data for 2013/14 with the year to date data for 2014/15 we assume that the number of women expecting is consistent throughout the year.

Surveys and Audits

The following section outlines some of the main issues highlighted in the surveys and interviews

4.34. Practice nurse [2] reported pregnant ladies saying they were unaware of the prenatal pertussis vaccine programme.

4.35. Practice manager [1] reported many non-attendees are families from Eastern Europe. Surgery has dedicated staff to follow up non attendees, but families are difficult to contact as they move and change addresses, and return to country of origin for long periods. Same issues with the prenatal pertussis for pregnant women.

4.36. Midwife team leader [1] *the midwife discusses the vaccines [with ladies] and believes the majority of ladies accept. Paston surgery sends out a letter monthly inviting ladies to attend.*

4.37. Senior midwife [2] *Thistlemoor surgery contacts their patients by telephone or text and it is recorded on SystemOne if declined or accepted. All community midwives discuss with women at their 16 week and 25 week appointment.*

5. Potential Barriers to uptakes

5.1. Using grounded theory approach[4] qualitative data were collected from health professionals and clients using surveys and interviews[5]. Three of the outlier practices were contacted and interviews undertaken with staff including practice managers, practice nurses and GP. The emerging data were highlighting similar themes. Once there are no new themes emerging from the data it means it is saturated.

6. Barriers to uptakes: Key Themes

6.1. The data collection findings were discussed with the members of the Task and Finish group. The data were collated and the main issues highlighted can be categorised into several themes:

- Access
- Demographics
- Changing to UK schedule
- Parent Health Beliefs
- Data Quality

7. Further detailed analysis

7.1. Following the initial collection of data, further detailed data collection and analysis were undertaken. One of the emerging themes included lower uptake in Eastern European families.

[4] Grounded theory is the generation of theory from data of social research, it starts with an area of inquiry and allows whatever is theoretically relevant to emerge, rather than to begin with a theory and to test it: Glaser B. G and Straus AL (1967).

[5] See appendix 5 for example of template used, used as prompt for interviews

7.2. Further analysis was undertaken on one outlier practice which showed registered population as 43% 'White other' group, Asian 24.3% and White British 17.3%. It is difficult to test the hypothesis that Eastern European families have a lower immunisation uptake, because individuals from Eastern Europe are included in the 'White Other' category, which means it is not possible to distinguish those White but not from Eastern Europe.

7.3. An alternative way to test this hypothesis is to use main language spoken as a close proxy, specifically to look at 'Main language spoken by immunisation uptake'. This data was collected from one practice. This showed that there are some groups whose main language is not English uptake is lower and range from 0.1% to 8% uptake of any immunisation compared to 20.7% English language and any immunisation. This is worthy of further research.

8. **Barriers to uptakes and potential solutions: Discussion**

Access

8.1. One of the issues identified was that a significant number of children had not been invited for their immunisations[6]. The current policy is that any child who does not attend two appointments is temporarily suspended from being scheduled. This temporary suspension is then lifted every 2-3 months. However, it emerged that the suspension list had not been lifted for a period of approximately 6 months; this affected an estimated 1,500 children. This system failure would have had an impact on the uptake figures. This incident was escalated to commissioners. Child Health Record Department immediately lifted these suspensions.

[6] The CHRD identified estimated 1,500 children not lifted from suspensions, this was escalated as an incident, as outside terms of reference for task and finish group, the suspensions were lifted immediately. This means some children would not have received an invitation to attend immunisation.
6

8.2. Waiting list for childhood immunisations impact on uptakes. Waiting list fluctuates, however, in Peterborough in Jan 2014 estimated 298 children on waiting list. Practices should have zero children waiting. Where a waiting list exists, priority is given to primaries, Hep B and MMR, followed by other vaccinations, and pre-school booster is the last priority. Pre-school booster has the lowest uptakes out of all the childhood immunisation programmes. Hence, it is important to ensure waiting lists are reduced.

8.3. Qualitative evidence highlighted difficulty understanding the appointment letter/invitation particularly for some parents whose first language is not English or who are illiterate. One practice reported having a significant traveller population, some of whom are illiterate.

8.4. Anecdotal evidence from health visitors in Central area highlighted difficulty for some parents to access immunisation appointments because some local surgeries only open part time. Other issues highlighted by health visitors and practice nurses are that parents are reluctant to take their child out of school, if the appointment clashes with school/term times. As the data shows that the pre-school booster has a significantly lower uptake, it is likely to affect those parents whose child is at school. One possible solution is the ensure immunisation clinics are offered out of school hours.

8.5. Currently NHS England commissions primary care to deliver the prenatal pertussis vaccination to pregnant women. However, the main health professional involved in the pregnant women's care is the midwife. Midwives are employed by the local acute trust [Peterborough and Stamford Hospital Foundation Trust]. PSHFT are not commissioned to administer prenatal pertussis vaccination to pregnant women.

8.6. Currently, midwives discuss the prenatal pertussis programme with pregnant women at their 16 week and 25 week appointment, midwives then signpost women to their local GP. Practice varies, some GP practices telephone or text the pregnant women inviting them for vaccination, some send letters, whereas others do not target specifically but expect women to contact the surgery.

8.7. Perceptions differ about the information given to pregnant women between midwives and pregnant women. Whereas midwives report they discuss pertussis with women, some pregnant women have reported they did not know about the prenatal pertussis programme. Even if the reality is that pregnant women are given the information, they may not recall this. Potential solutions should include reiterating the prenatal pertussis programme through health promotion campaign.

Demographics

8.8. A key recurring theme from the qualitative evidence is that many Eastern European families' frequently move address or spend long periods returning to their country of origin. As such practices report that it is difficult or almost impossible to contact these families to arrange or follow up their non-attendance at immunisation appointments. For example, one practice reported they have a dedicated member of staff to follow up non attendees, but with little success.

8.9. Health visitors have visited family addresses, to be informed that the child has moved abroad to the family country of origin for a 'few weeks', but unknown when they will be back.

8.10. Potential solutions include offering opportunistic appointments and flexible clinics. It is important to inform CHRD of any unscheduled appointment to avoid CHRD sending a duplicate appointment [thus wasting a slot]. The other important issue is that immunisations can only be given within certain time frames, i.e for childhood vaccinations there is a schedule and a requirement for a certain gap between vaccinations, similarly prenatal pertussis can only be given from 28 weeks gestation, so these time frames may limit opportunistic appointments.

Changing to UK schedule

8.11. Qualitative evidence from a number of health professionals reported that there are a significant number of families whose child has already had vaccinations

in their country of origin, but the family are not able to give a reliable history[7] or documentation. The problem is that these vaccinations cannot be 'counted' in the numerator as being given. However, because these children remain in the denominator it has a negative impact on percentage uptakes. Under current guidance this situation is 'stale mate', because parents firmly believe that their child has had the vaccines, and do not wish to give any further doses, but without documentation [date/name of vaccine] it cannot be counted. Potential solutions are to encourage parents to find the documented evidence from their country of origin.

8.12. The surveys and audit only found a few parents sighting having or wishing to have the single MMR as reason why they did not attend MMR appointment. However, it is noteworthy that if parents have their child vaccinated with single MMR, it is not counted as given[8], and therefore, the child will remain in the denominator.

Parent Health Beliefs

8.13. Qualitative evidence from parents interviewed in children's centres, identified some parents are fearful of vaccine side effects, some parents are unsure if vaccines are effective. There are still a few parents believing that MMR is linked to autism despite this being disputed and no evidence linking MMR with autism. Potential solutions should include reiterating the key health messages about vaccine safety.

8.14. Surveys and the local 2012 MMR audit[9] showed the main reasons for non-attendance of the childhood vaccinations and MMR appointment included 'forgot appointment', 'did not know' or 'understand appointment'. Currently invitation letters from CHRD are written in English. Potential solutions for increasing immunisation uptake should include strategies for inviting parents/pregnant women whose first language is not English and/or who may be illiterate.

[7] Reliable history is required to document vaccine given according to the Green Book www.dh.gov
[8] The DH guidance is that single MMR is not recognised in the UK, not licenced and unknown of efficacy, therefore cannot be counted towards full protection for Measles/Mumps/Rubella
[9] Local Peterborough audit 2012, non-attendees for MMR vaccine, parents contacted by practice nurse

Data Quality

8.15. One of the issues highlighted is children or pregnant women who are still registered with a practice but who are either out of the country for long periods or have left the country i.e 'Ghost patients' on GP systems. Unless 'Ghost patients' are deducted they will still be included in the denominator for immunisations because they are registered population, but if these individuals are not in UK or abroad for long periods they will not be able to access immunisation services. This in turn will have a negative impact the uptakes.

8.16. There is a potential conflict of interest in relation to 'Ghost patients', because payment to practices is based on the number of their registered population. In addition, there are potential ethical dilemmas, if a practice deducts the 'Ghost patient', but then the child/pregnant woman returns to the UK/local area, they may miss receiving important health information or immunisation appointments.

8.17. Accurate data collection relies upon accurate coding of denominators in practices. One of the issues has been the recording of denominator for prenatal pertussis. Previously the denominator used was the Estimated Date of Delivery EDD, this has now changed and is the Date of Delivery DD. One of the difficulties for practices is to ensure the status of the pregnant woman is up to date. Evidence collected suggested that some practices have been unable to report uptakes of prenatal pertussis due to lack of denominator. Since the introduction of DD as the denominator, this is now collected via Immform automatically from practices (sentinel).

9. **Summary**

9.1. This paper has presented data on childhood immunisations and prenatal pertussis; it shows that Peterborough has a lower uptake than the average in East Anglia, and lower uptakes than statistical neighbouring local authorities. The pre-school booster age 5years is the lowest uptakes out of all the childhood immunisations. There is significant variation in uptakes amongst Peterborough practices, some practices are

significant outliers. The correlation between childhood immunisation and prenatal pertussis with deprivation is weak.

9.2. Data were gathered from a variety of sources, to identify barriers to uptakes and potential solutions, this has shown some key themes emerging: Access, demographics [Eastern European and traveller families], changing to UK schedule, parent health beliefs and data quality.

9.3. Possible solutions have been discussed. Key recommendations are detailed below.

10. **Key Recommendations**

Themes	Recommendations
Improving Access to immunisations	
1.Access	1. Ensure CHIS have a robust process/procedure in place to lift suspensions on child immunisation non attendees regularly 2. Ensure all non-attendees are followed up by practice, by creating 'red flag' system on GP systems, when child fails to attend [DNA]. 3. CHIS to send 'task' to named health visitor or school nurse if child DNA's 4. Reduce waiting list, CHRD contact practices with waiting list to arrange increase in clinic capacity 5. Ensure invitations/letters have contact details for those whose first language is not English 6. Invitations by telephone for those parents who are illiterate

	7. Practices to consider opportunistic appointments for frequent non attendees, if used, practice to inform CHIS within 24 hours, to avoid duplication of appointment being sent. 8. Practices to consider holding clinics out of hours 9. LA Public Health to Provide information to Nurseries to give to parents 10. Practices to consider sending targeted letters to eligible pregnant women 11. Commissioners to consider commissioning midwifery services to deliver prenatal pertussis vaccination programme 12. Midwifery services and practices to work together to consider holding antenatal clinics within surgeries
Addressing inequalities in health	
2.Demographics	13. Further research project with LA PH team and community leaders for Eastern European families and traveller families, looking at access to immunisation services
3.Changing to UK schedule	14. Practices to request immunisation documentation at 'new patient registration', as part of requirement 15. Practices to reiterate importance of family informing practice of any change in contact details, practice to check details as each contact
Increasing parents awareness and knowledge of the benefits of vaccinations	
4.Parent health beliefs	16. Health Promotion campaign to reiterate safety of vaccines, use of various medium/face book/local radio/children centres to promote vaccinations 17. Practices to send reminder to parents before appointment 18. CHIS to reiterate importance of keeping appointment in the invitation
Improving data quality	
5.Data Quality	19. Practices to ensure accurate GP practice list, deduct Ghost patients [as per policy] 21. Practices to ensure accurate data base of eligible pregnant women
Evaluation	

6. Evaluation and Review post implementation	22. Review immunisation uptakes in 12 months following implementation of key recommendations

20. **Conclusion**

20.1. This report has presented immunisation data on childhood vaccination programmes and the Prenatal Pertussis programme in Peterborough for 2013-2015 to date. The data shows the uptakes are lower than average compared to East Anglia and worse than other local authorities. There is significant variation between practices in Peterborough. Those practices which are outliers have highlighted several recurring themes as potential barriers to immunisation uptakes. These include: access, specific demographic characteristics, parental health beliefs, and data quality issues. This report proposes some key recommendations to address the low uptake of immunisations in Peterborough. It is recommended that a review is undertaken of immunisation uptakes in 12 months post implementation.

APPENDICES

Report: Immunisation uptake in Peterborough

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Appendix 1

Chart 1: 12 month DTaP, IPV and Hib 2013/14 and 2014/15 year to date

Chart 2: 12 month PCV 2013/14 and 2014/15 year to date

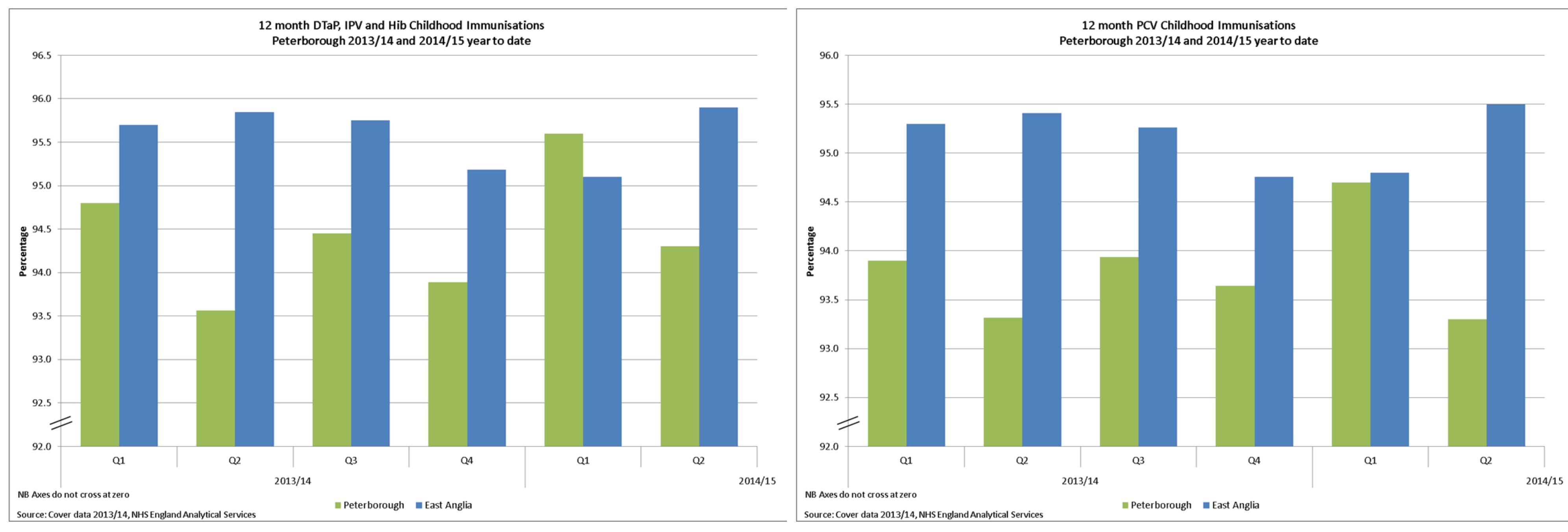


Chart 3: 12 month Men C 2013/14 and 2014/15 year to date

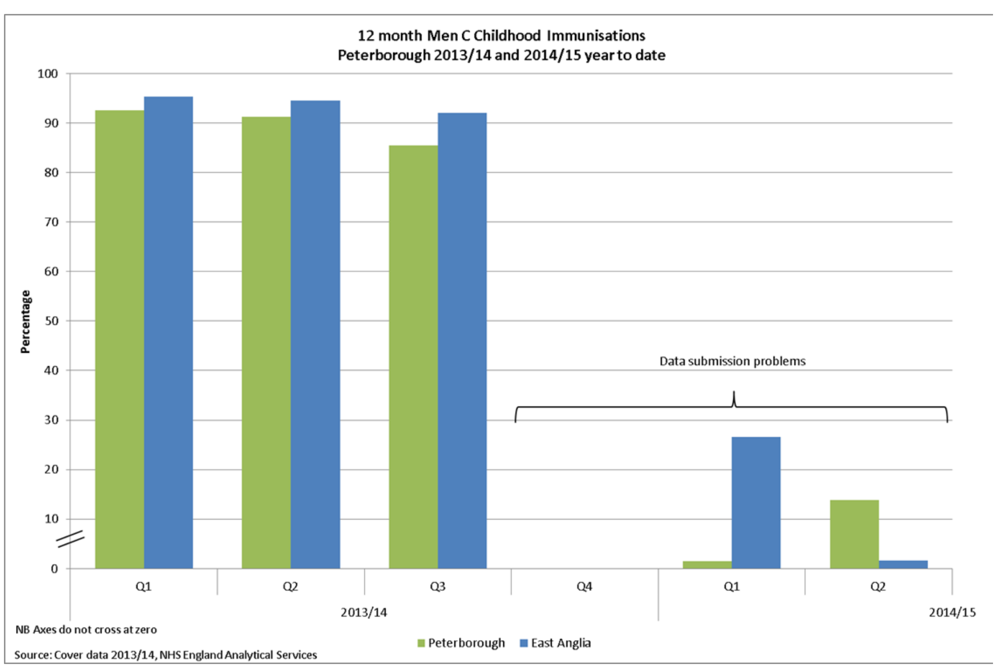


Chart 4: 24 month DTaP, IPV and Hib 2013/14 and 2014/15 year to date

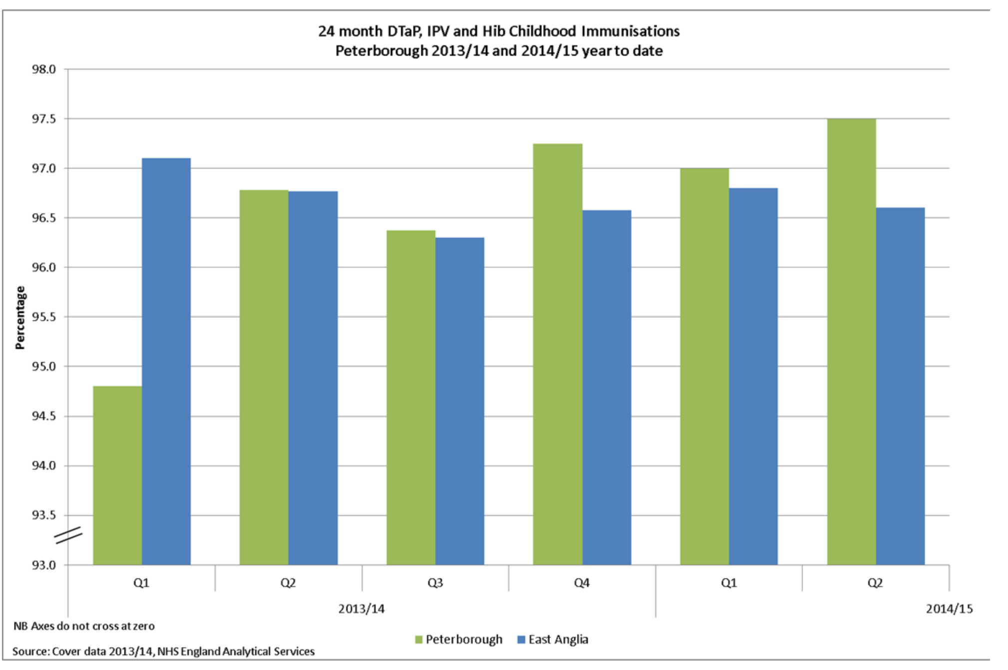


Chart 5: 24 month PCV 2013/14 and 2014/15 year to date

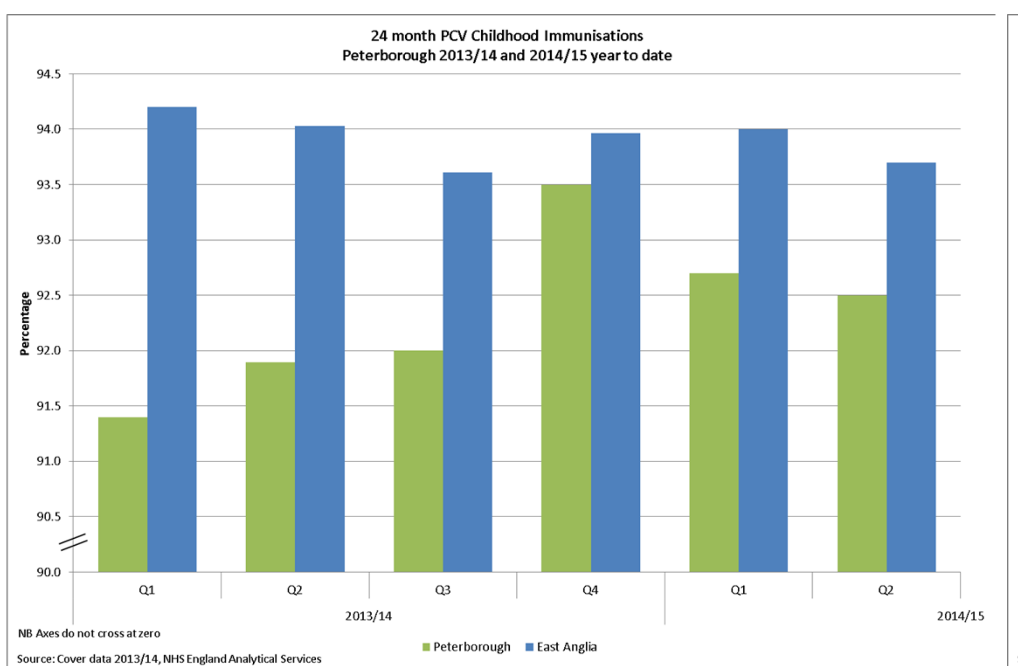


Chart 6: 24 month Hib and Men C 2013/14 and 2014/15 year to date

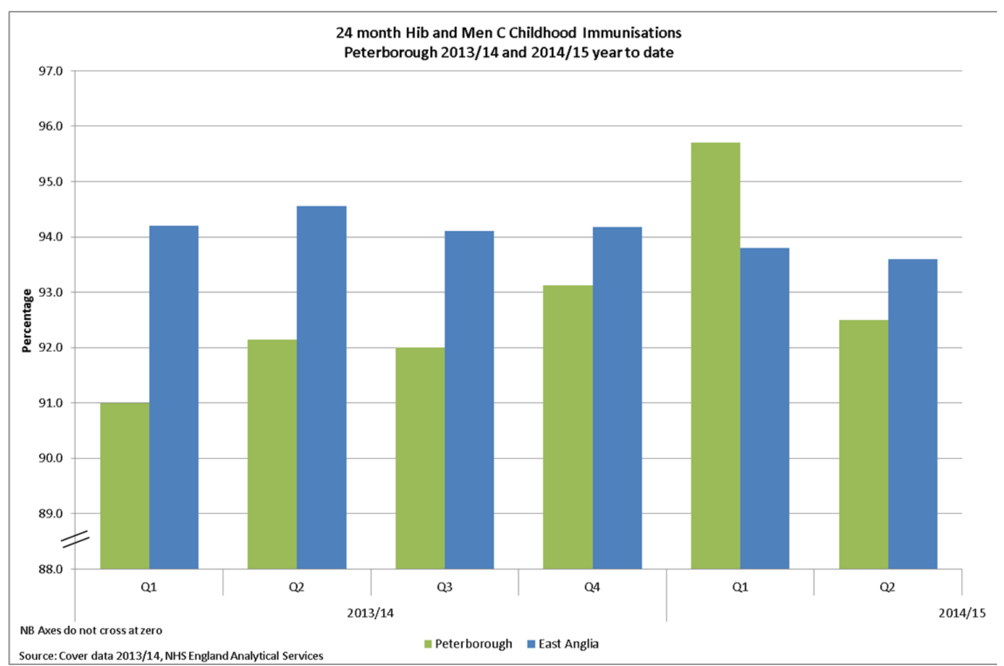


Chart 7: 24 month MMR 2013/14 and 2014/15 year to date

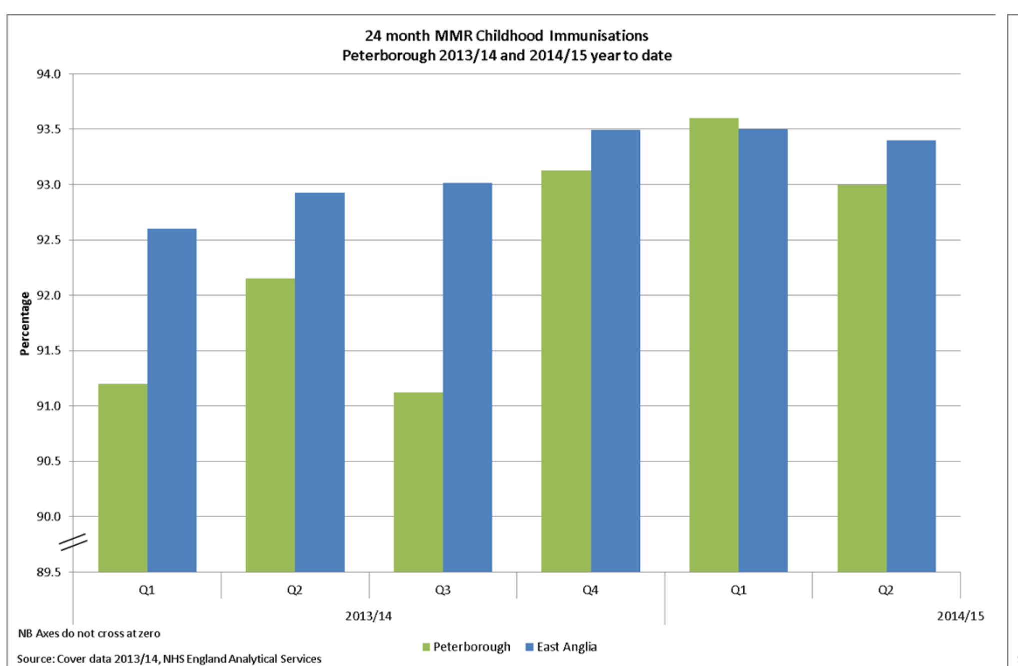


Chart 8: 5 year DTaP and Polio 2013/14 and 2014/15 year to date

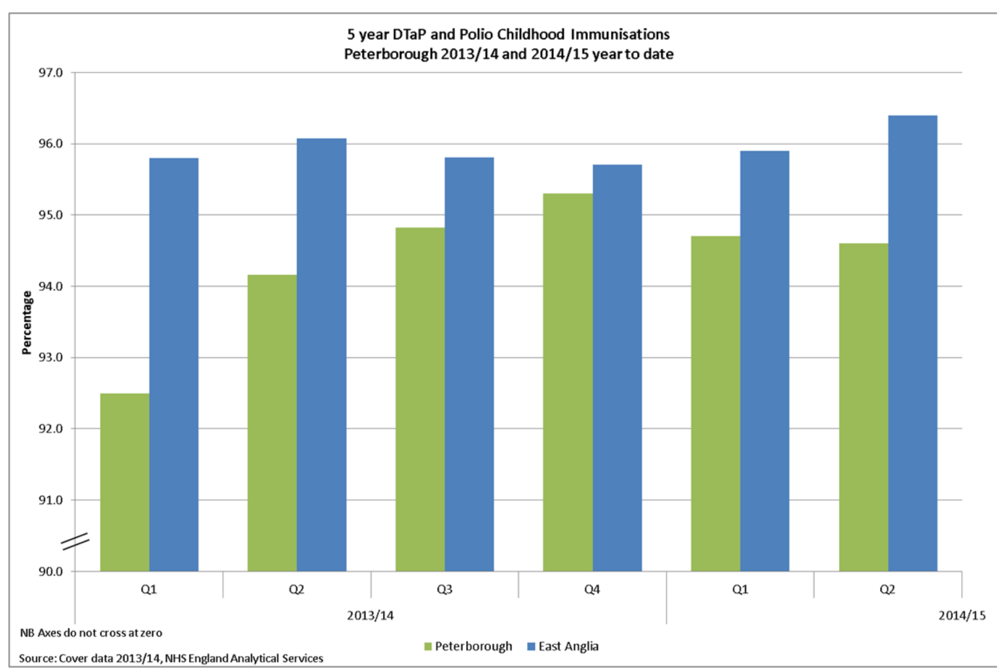


Chart 9: 5 year Pertussis 2013/14 and 2014/15 year to date

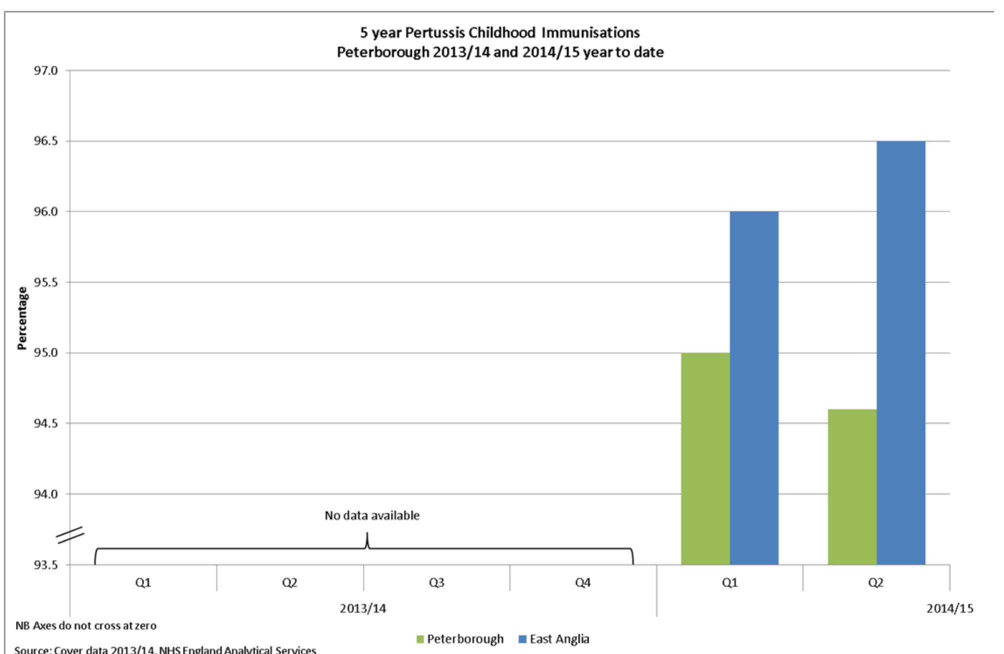


Chart 10: 5 year MMR 2013/14 and 2014/15 year to date

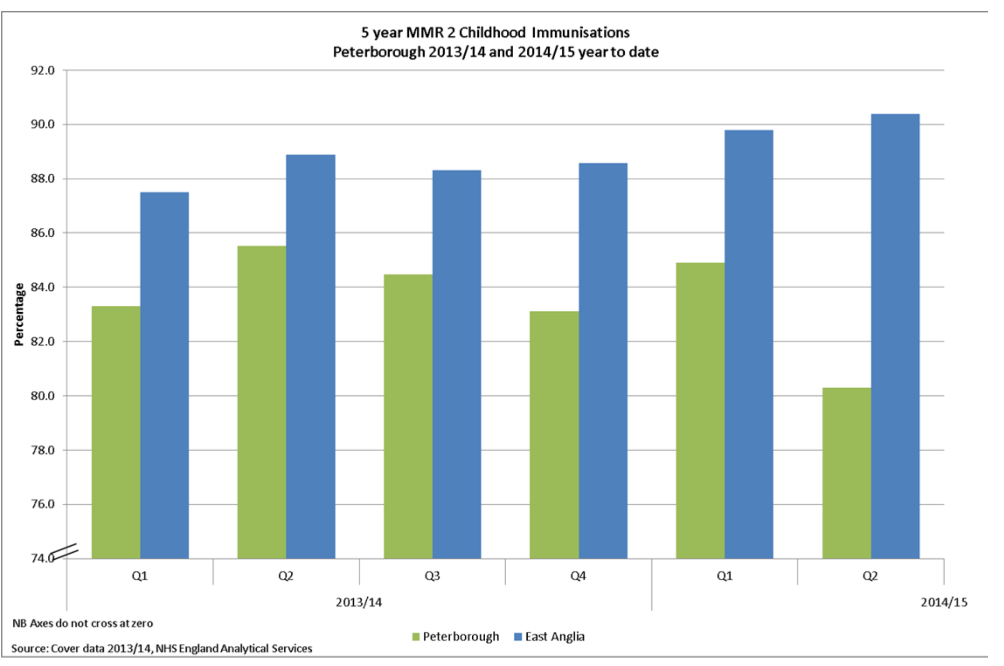


Chart 11: 5 year DTaP and IPV 2013/14 and 2014/15 year to date

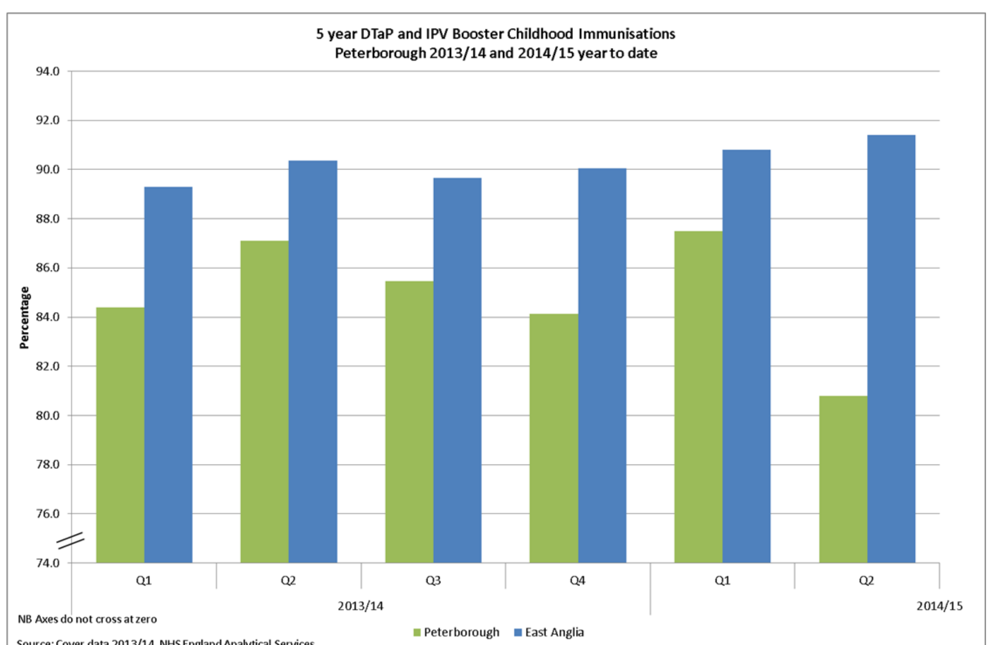
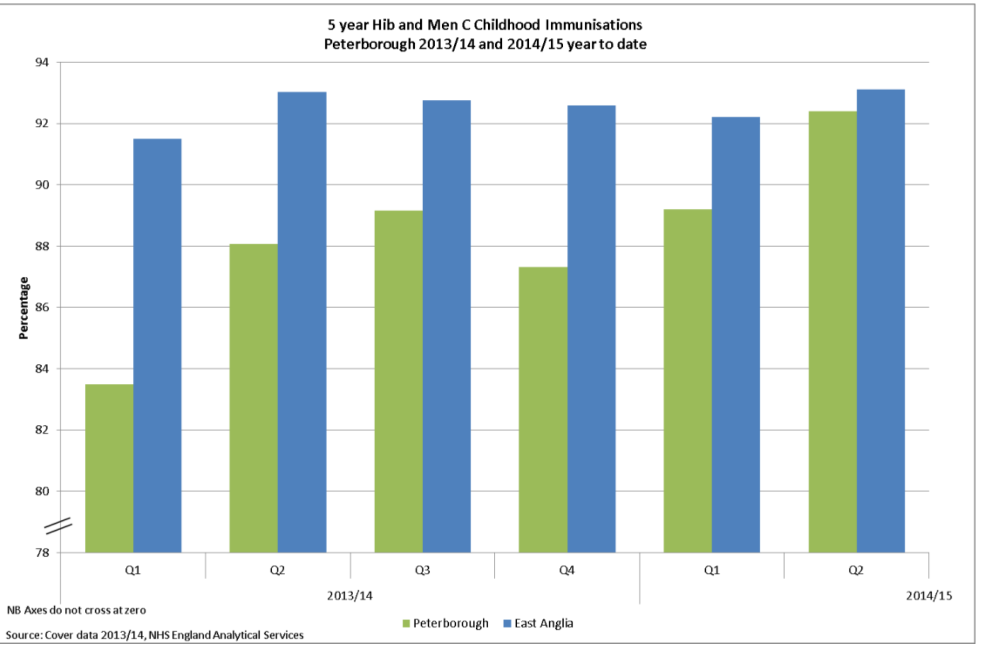


Chart 12: 5 year Hib and Men C 2013/14 and 2014/15 year to date



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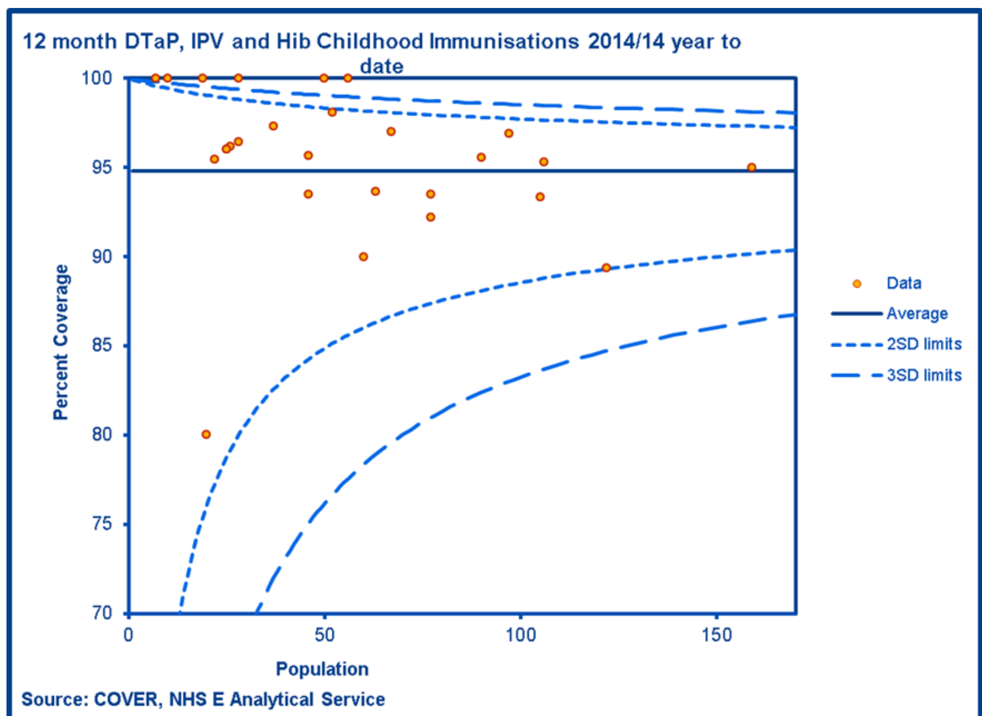

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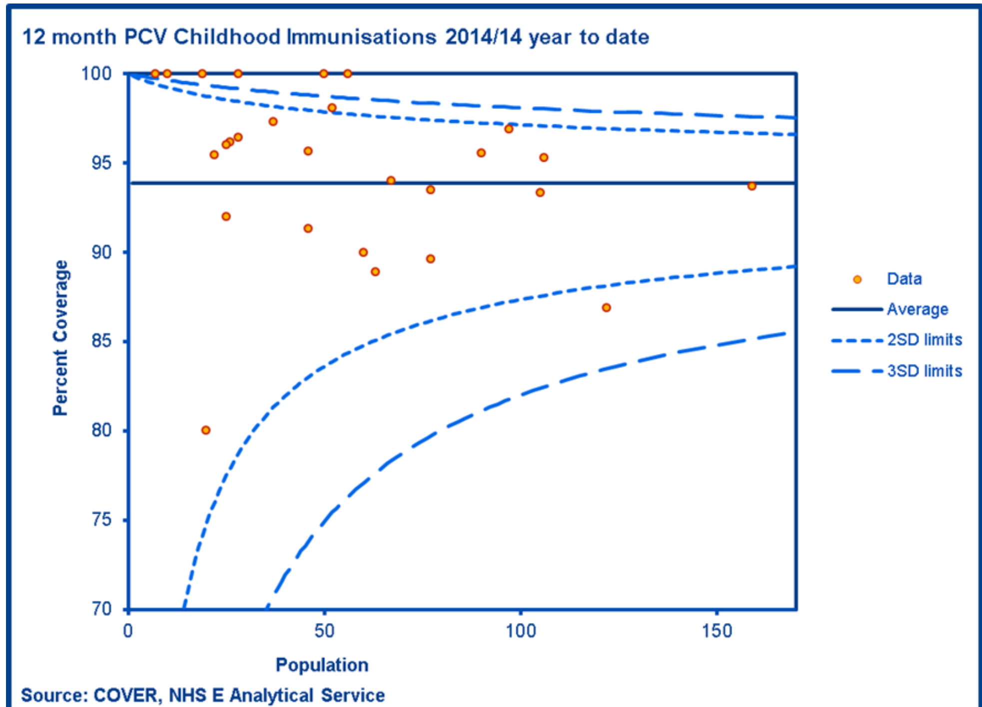

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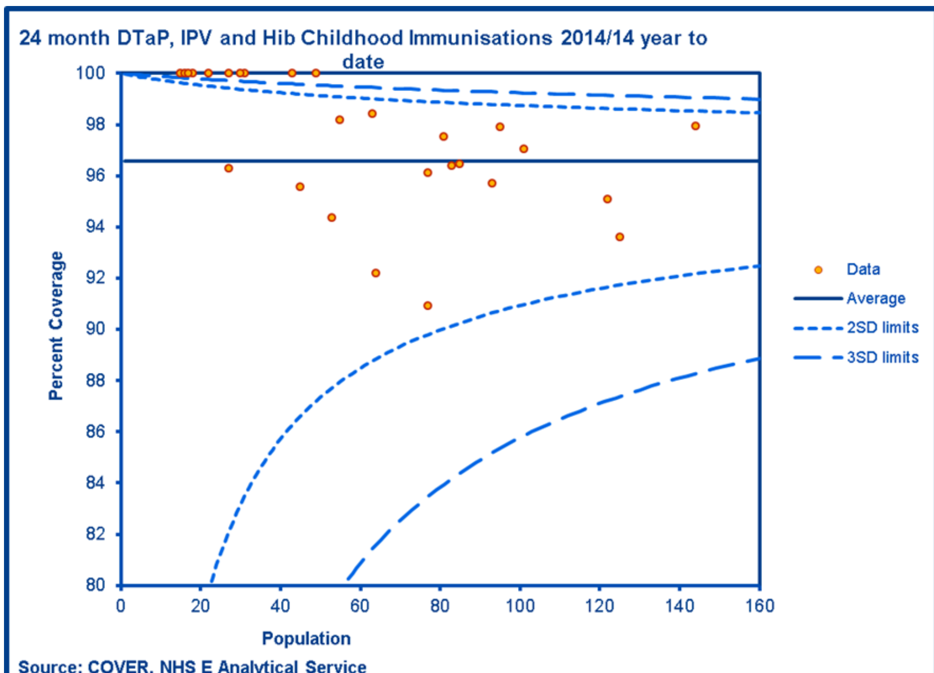

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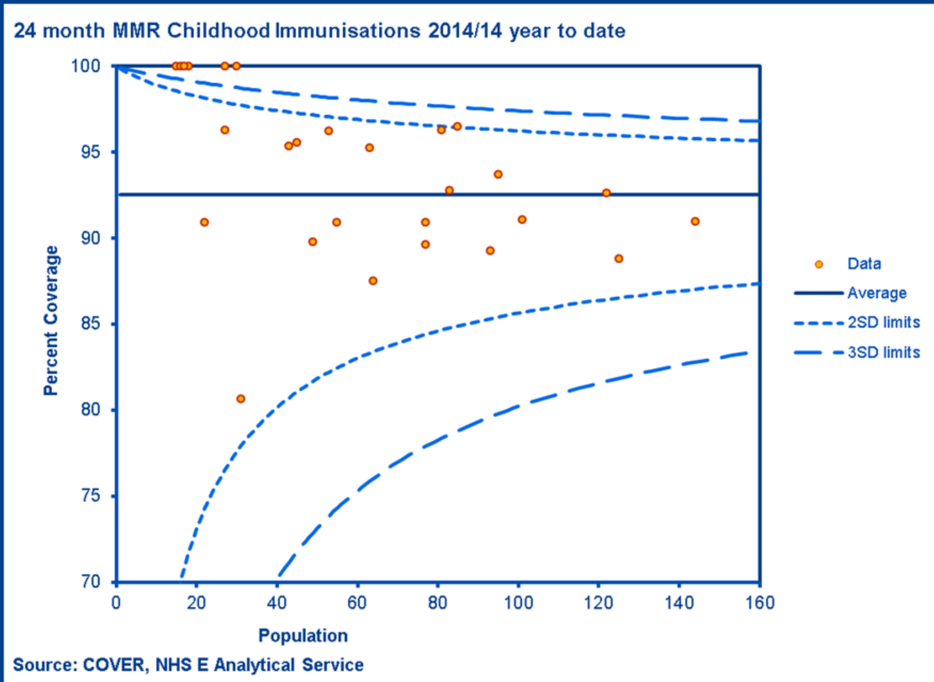

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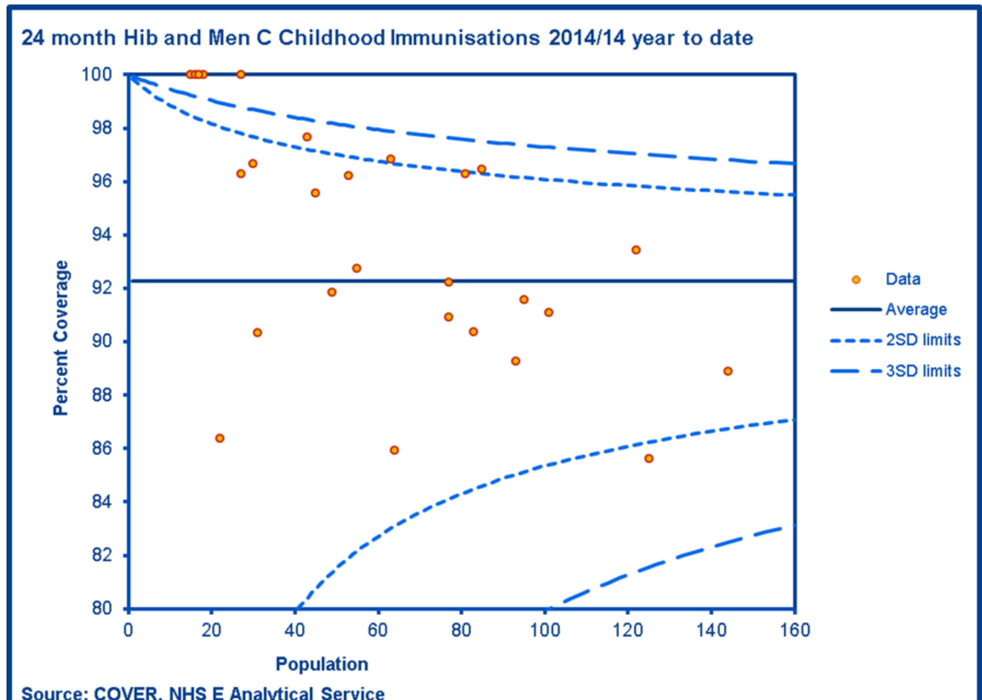

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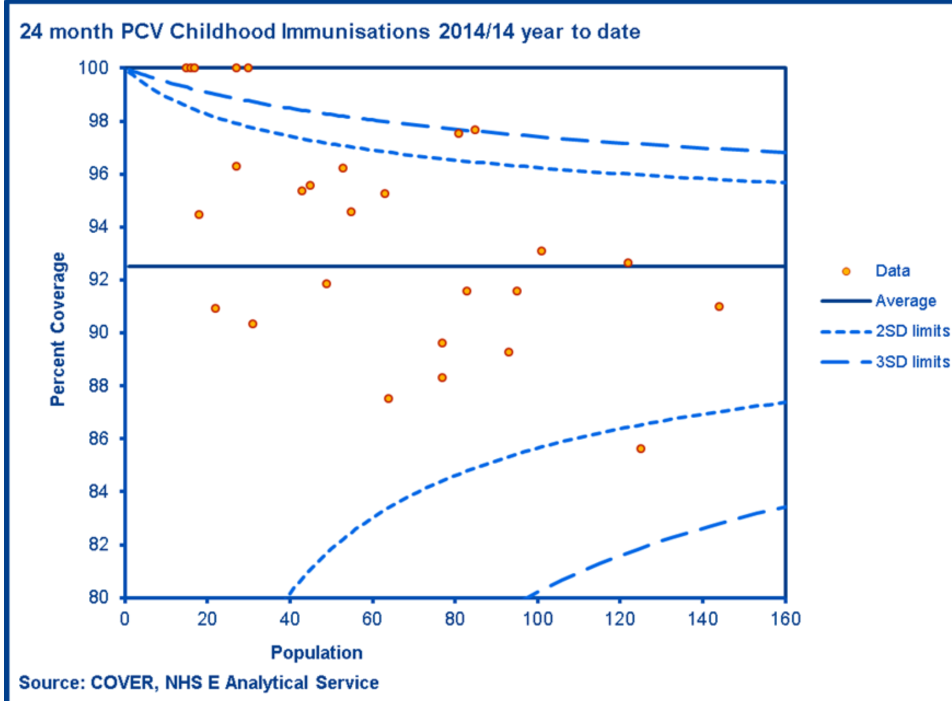

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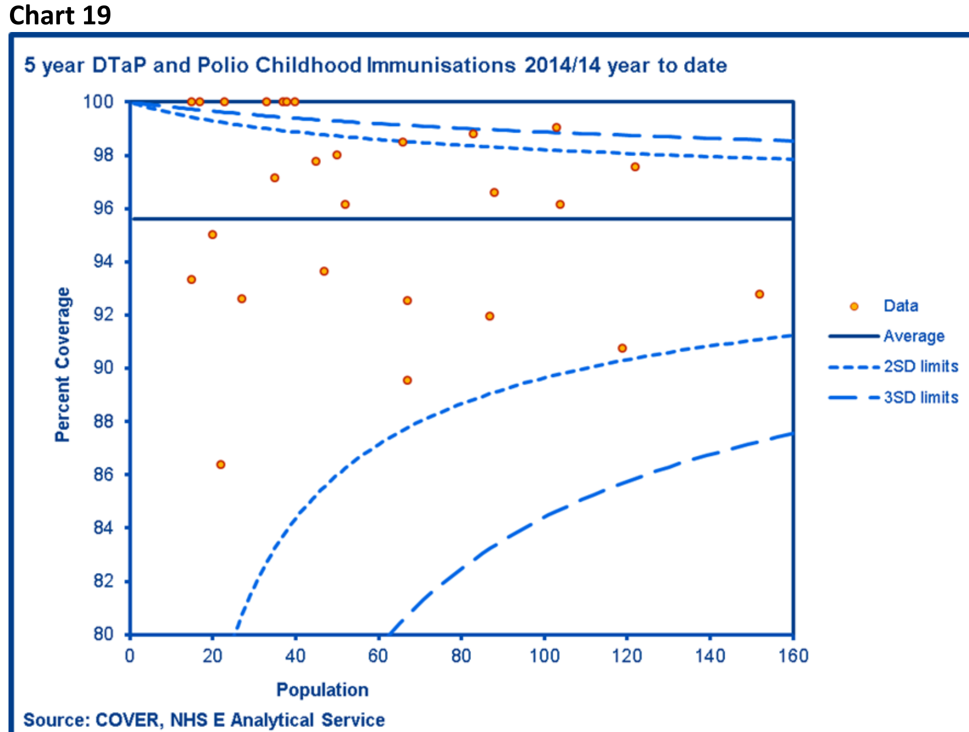

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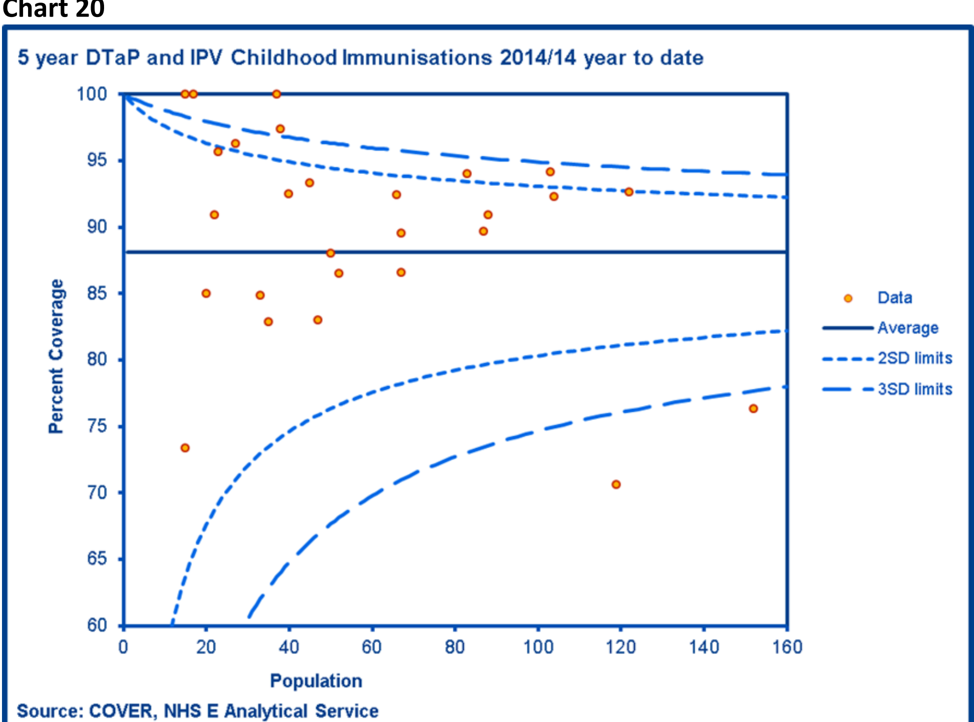

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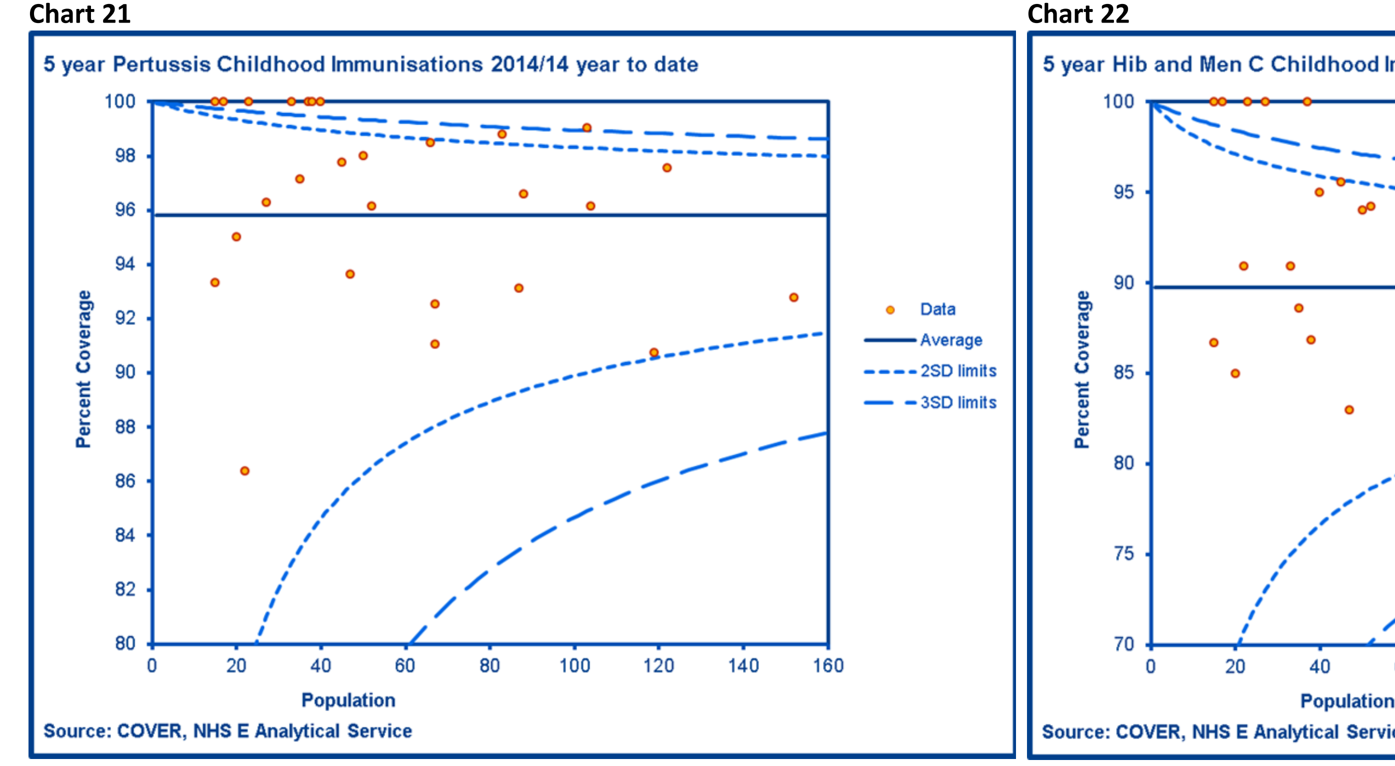

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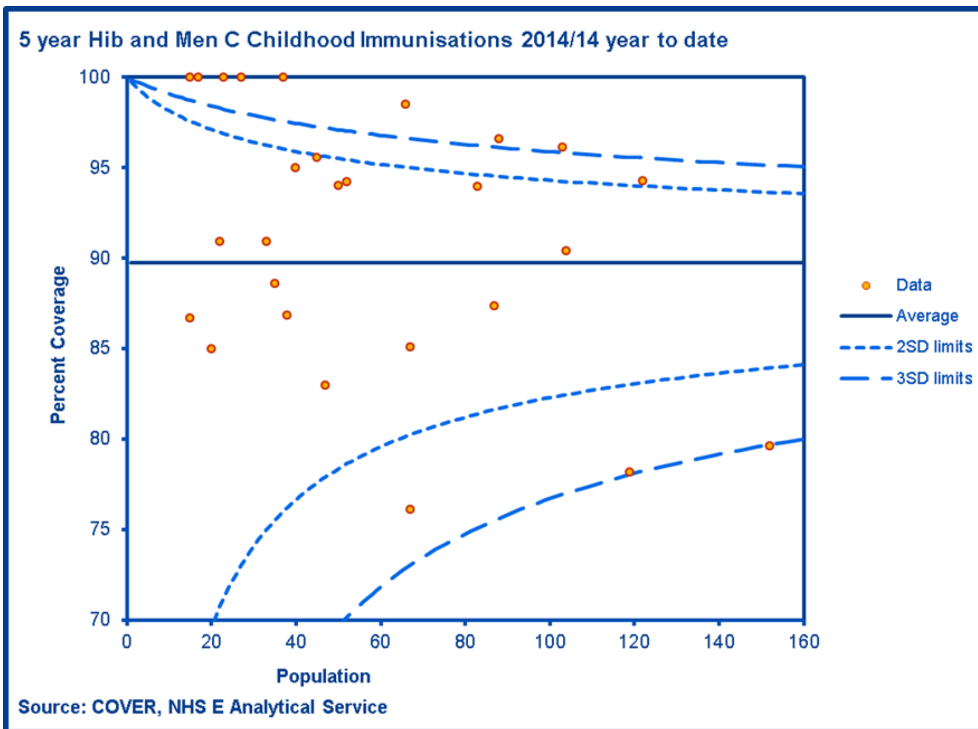

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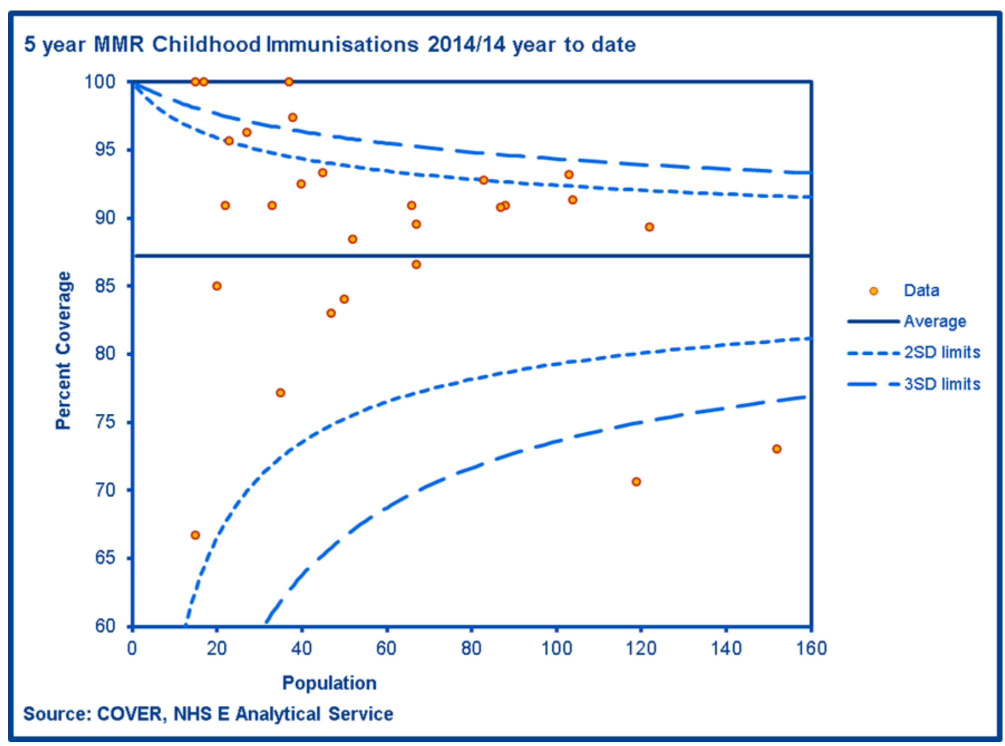


Table 1: Uptake range of immunisations for GP Practices and the proportion that have achieved the 95% target Quarter 2 2014/5

		Uptake range (percentage)	Number of Practices under 95% (of 28)	Percentage of practices with an uptake under 95%
12month	12m_DTaP/IPV/Hib%	83 - 100	15	53.6%
	12m MenC*	63 - 100	28	100.0%
	12m_PCV%	83 - 100	16	57.1%
24month	24m_DTaP/IPV/Hib%	89 - 100	6	21.4%
	24m_PCVB%	75 - 100	3	10.7%
	24m_HibMenC%	85 - 100	14	50.0%
	24m_MMR1%	83 - 100	14	50.0%
5years	5y_DTaP/Pol%	83 - 100	3	10.7%
	5y_Pertussis	83 - 100	2	7.1%
	5y_MMR2%	60 - 100	14	50.0%
	5y_DTaP/IPVBooster%	60 - 100	16	57.1%
	5y_HibMenCB	83 - 100	8	28.6%

2014/15 calculated from CCG data for Peterborough only practices

2014/15 data from NHS England Analytical Service

*Data submission problems

Appendix 2 Childhood Immunisations comparison LA: Charts and Tables

Table 1: CIPFA: Nearest Neighbour Comparators for Peterborough

Peterborough	Milton Keynes
Swindon	Kirklees
Derby	Warrington
Calderdale	Oldham
Coventry	Stockton-On-Tees
Bolton	Darlington
Rochdale	Dudley
Telford & Wrekin	Tameside

Chart 1: 12 month DTaP, IPV and Hib

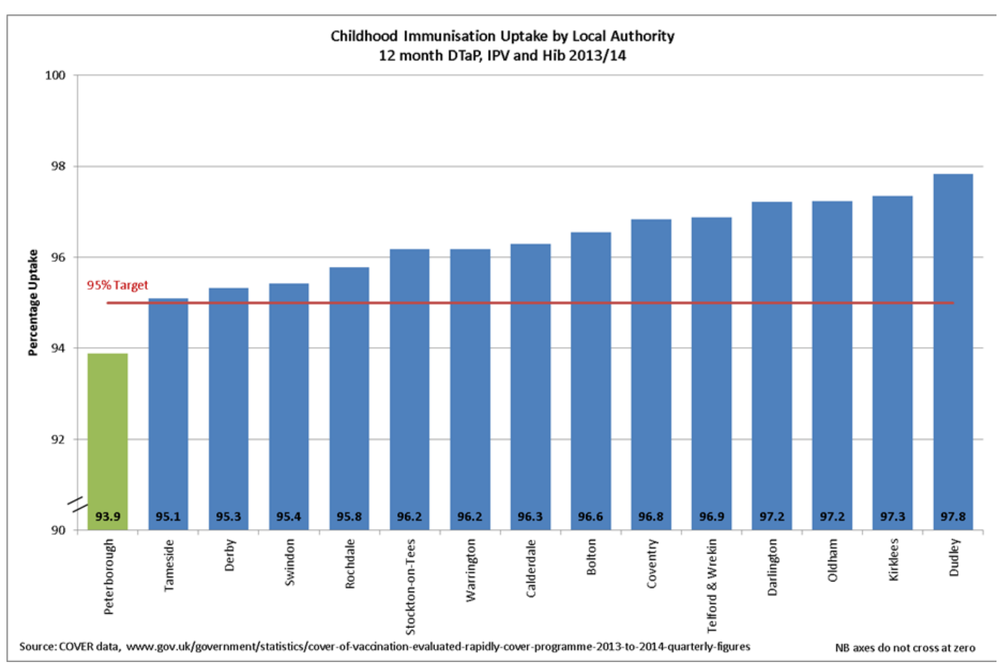


Chart 2: 12 month PCV

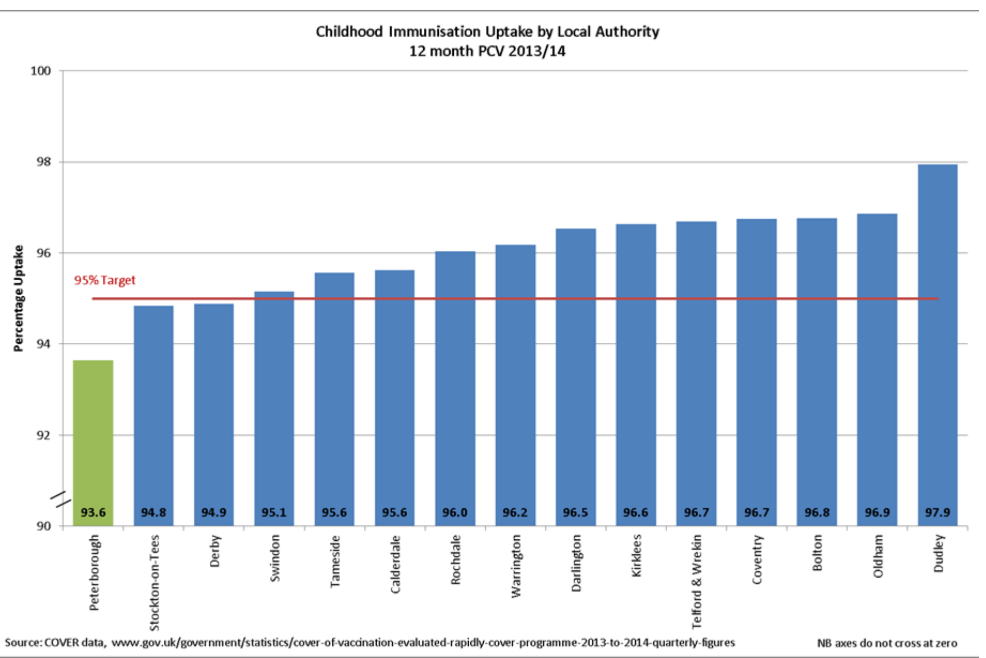


Chart 3: 24 Month DTaP, IPV and Hib

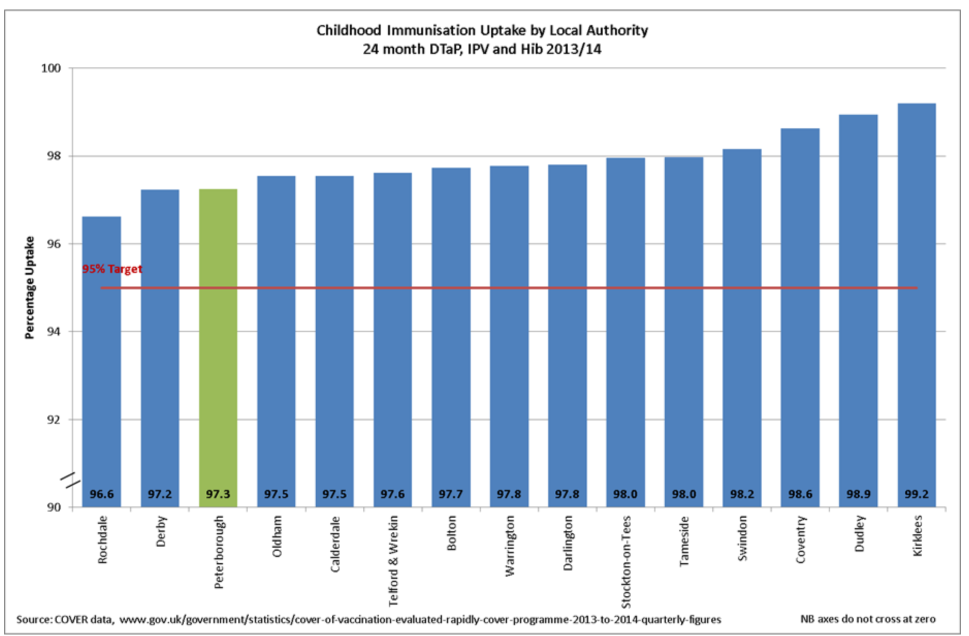


Chart 4: 24 Month PCV B

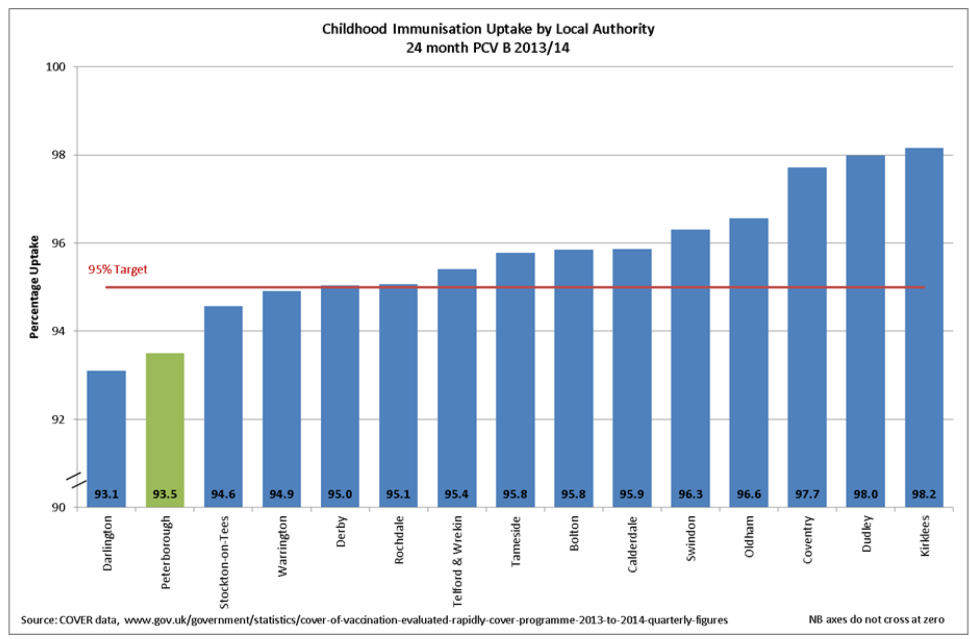


Chart 5: 24 Month Hib and Men C

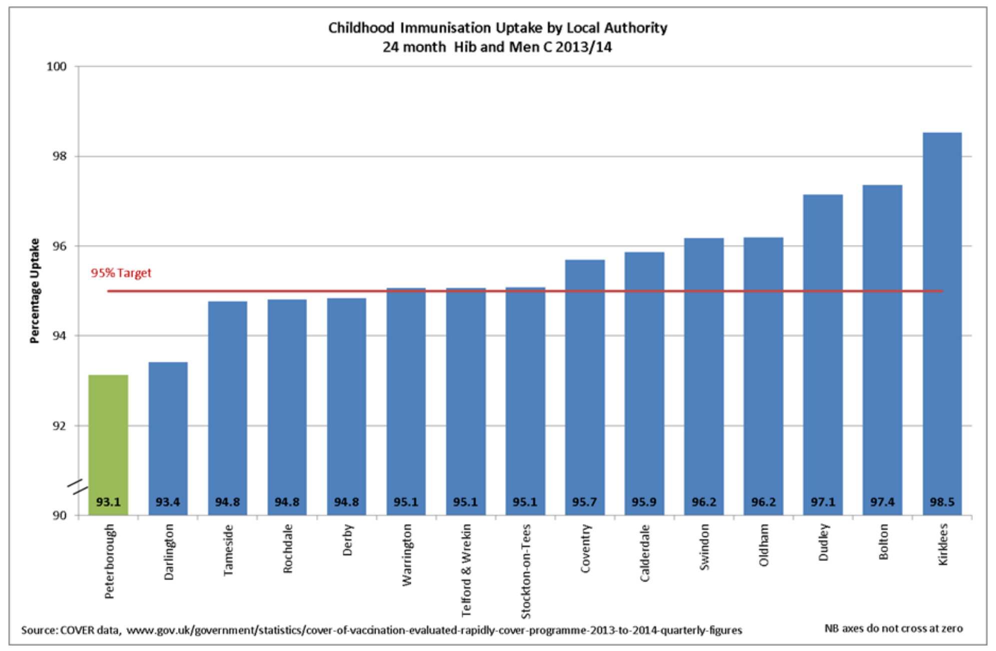


Chart 6: 24 Month MMR 1

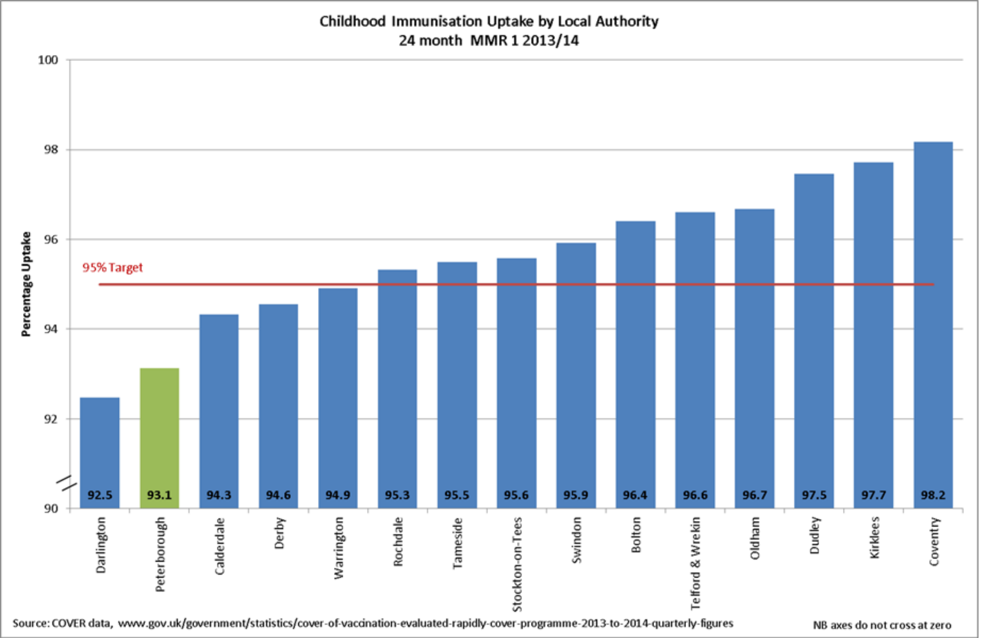


Chart 7: 5 Year DTaP and IPV

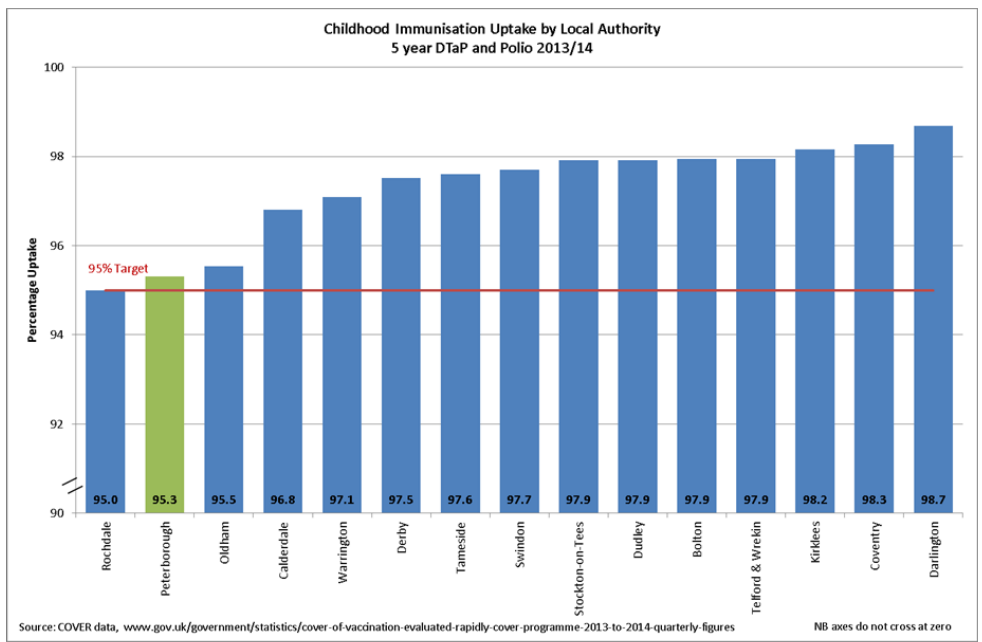


Chart 8: 5 Year DTaP and IPV

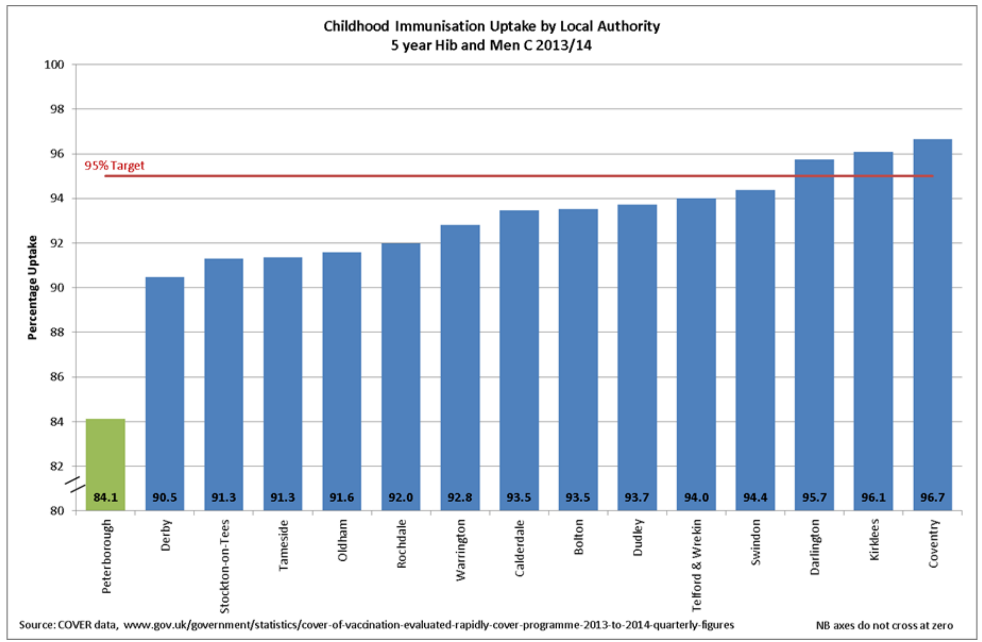


Chart 9: 5 Year MMR 1

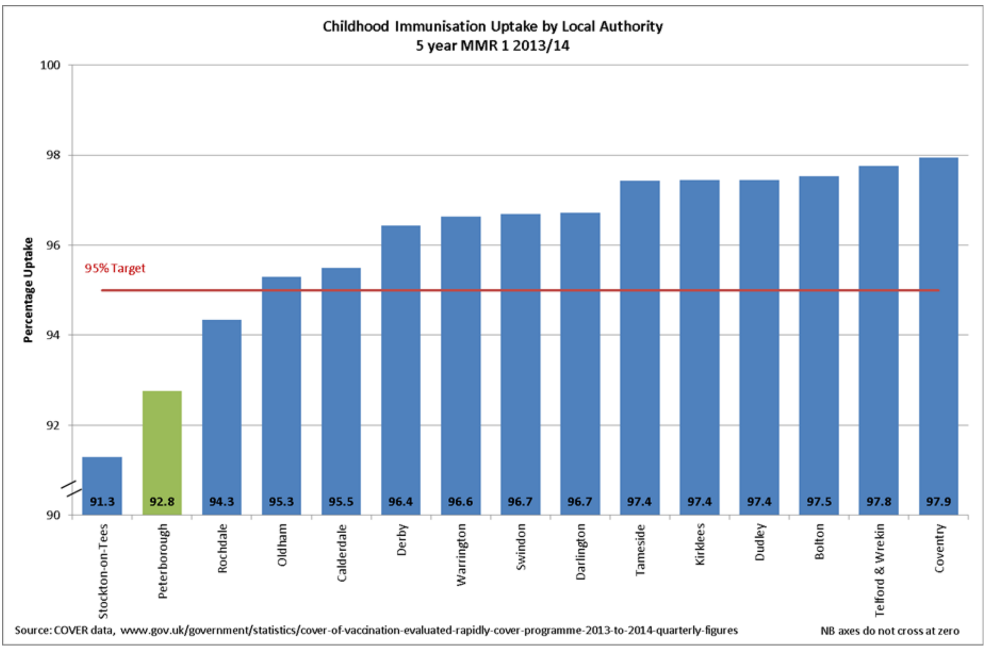


Chart 10: 5 Year MMR 2

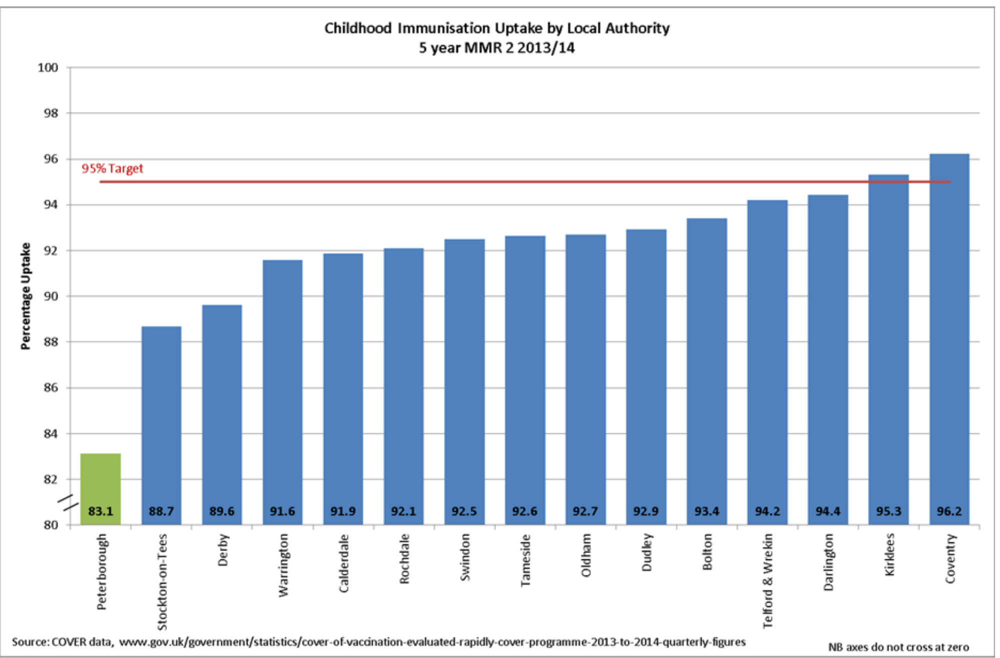
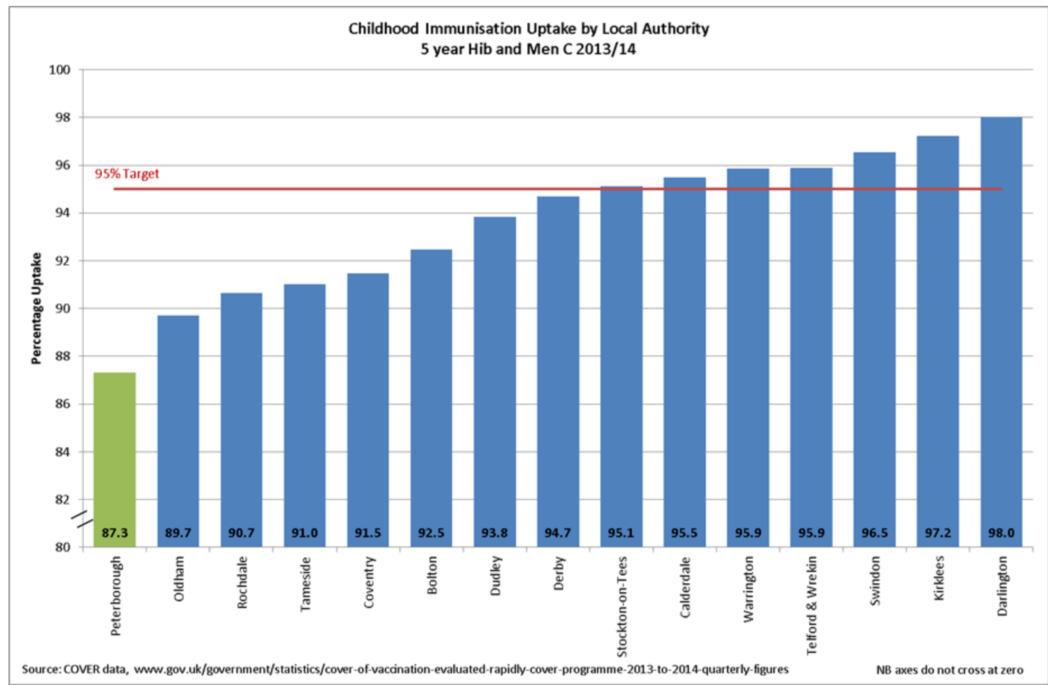


Chart 11: 5 Year Hib and Men C



Appendix 3: Prenatal Pertussis: Charts and Tables

Table 1: Prenatal Pertussis Uptake and Coverage Rates 2013/14

	Prenatal Pertussis 2013/14											
	Q1 2103 %			Q2 2013 %			Q3 2013 %			Q4 2013/14 %		
	April 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	March 2014
CCG % uptake	63.8	60.4	60.0	60.8	65.0	61.3	58.7	62.6	64.5	69.1	66.0	69.1
CCG % coverage	63.0	64.8	55.6	70.4	72.2	73.8	79.4	79.4	79.4	79.4	79.4	79.4
East Anglia uptake %	65.9	66.6	62.0	64.7	66.5	63.9	64.4	68.1	70.3	70.7	68.7	69.4
East Anglia Coverage %	65.6	64.6	63.3	62.2	62.2	73.6	76.4	74.6	69.8	67.0	67.0	67.7
Coverage is % of practices submitting data												

Source Immform

Table 2: Prenatal Pertussis Uptake and Coverage Rates 2014/15 year to date

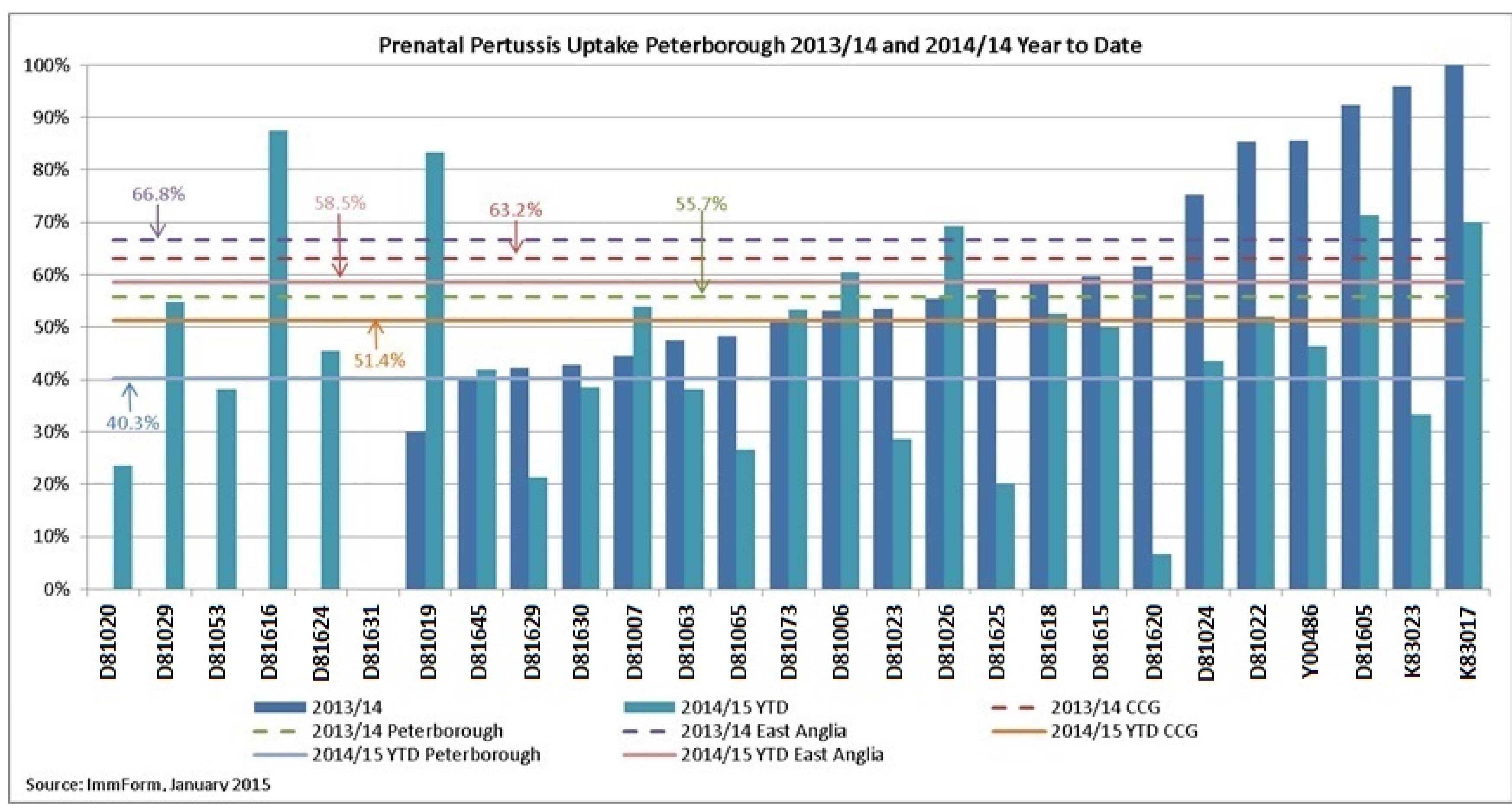
	Pertussis in Pregnant women 2014/15											
	Q1 2014 %			Q2 2014 %			Q3 2014 %			Q4 2014/15 %		
	April 2014	May 2014	June 2014	July 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015
CCG % uptake	58.6	53.0	51.6	48.5	48.1	51.3	52.0	50.8	n/a	n/a	n/a	n/a
CCG % coverage	72.9	74.8	75.7	75.7	86.9	88.8	91.6	91.6	n/a	n/a	n/a	n/a
East Anglia uptake %	63.8	63.3	60.5	57.2	55.5	58.3	60.3	60.8	n/a	n/a	n/a	n/a
East Anglia Coverage %	65.2	68.3	70.9	70.9	91.7	92.0	93.4	93.8	n/a	n/a	n/a	n/a
Coverage is % of practices submitting data												

Source Immform accessed 13/1/15, n/a = not available

Table 3: Change in Uptake by GP Practice for Prenatal Pertussis

Practice	2013/14	2014/15 YTD	Difference	Practice	2013/14	2014/15 YTD	Difference
D81020	0.0%	23.5%	23.5	D81023	53.6%	28.7%	-24.9
D81029	0.0%	54.9%	54.9	D81026	55.4%	69.2%	13.8
D81053	0.0%	38.2%	38.2	D81625	57.3%	20.1%	-37.1
D81616	0.0%	87.5%	87.5	D81618	58.6%	52.6%	-6.0
D81624	0.0%	45.5%	45.5	D81615	59.7%	50.0%	-9.7
D81631	0.0%	0.0%	0.0	D81620	61.5%	6.7%	-54.9
D81019	30.0%	83.3%	53.3	D81024	75.3%	43.5%	-31.8
D81645	40.0%	41.9%	1.9	D81022	85.5%	52.1%	-33.4
D81629	42.3%	21.2%	-21.1	Y00486	85.7%	46.5%	-39.2
D81630	42.9%	38.6%	-4.3	D81605	92.3%	71.4%	-20.9
D81007	44.5%	53.8%	9.3	K83023	96.0%	33.3%	-62.7
D81063	47.6%	38.1%	-9.5	K83017	100.0%	70.0%	-30.0
D81065	48.2%	26.5%	-21.7	Peterborough	55.7%	40.3%	-15.5
D81073	51.6%	53.3%	1.8	Cambridgeshire and Peterborough CCG	63.2%	51.4%	-11.8
D81006	53.2%	60.5%	7.2	East Anglia	66.8%	58.5%	-8.2

Chart 1: Prenatal Pertussis Uptake by Practice 2013/14 and 2014/15 Year to Date



Appendix 4

TERMS OF REFERENCE

Integrated Peterborough City Council, NHS England, Public Health England and Peterborough LCG Health Improvement/ Immunisation Task and Finish Subgroup

KEY DETAILS:

Document Type:	Peterborough Immunisation Task and Finish Subgroup
Date document valid from:	Feb 2015
Document review due date:	March 2015

AUDIT TRAIL:

Date reviewed	**Version number**	**Date achieved**
3.2.15	**1**	
Date agreed	**Version number**	
Details of most recent review: (Outline main changes made to document)		
Signature of the Task and Finish Subgroup Chair: **Print Name: Dr Karen Lake** **Post Held: SIC** **Date: 3.2.15**		

Purpose and Scope

To develop a shared understanding of the uptake and delivery in Peterborough of the national childhood immunisation programmes, specifically Prenatal Pertussis, MMR and preschool booster.

Aim

The aim of the Task and Finish subgroup is to identify local issues relating to the low uptake of childhood immunisations and Prenatal Pertussis; in addition, to identify potential solutions and to make recommendations to resolve barriers to uptake of immunisations.

Objectives

To produce a report describing the coverage and uptake of immunisations in Peterborough, any potential barriers to uptake, an action plan with key recommendations and associated costs.

The Task and Finish subgroup will report to the Task and Finish Steering Group. The final report and action plan will be agreed by the Health and Wellbeing Board.

Authority

The Task and Finish subgroup is authorised by NHS England East Anglia Area Team and Peterborough Local Authority via the Health and Wellbeing Programme Board.

Meeting Frequency and Time Scales

The Task and Finish subgroup will establish a plan of meetings to synchronise with the key delivery milestones of the project.

The process is expected to be completed by ***31st March 2015, initial presentation on 26th March****.*

The frequency of meetings will be total of 3 meetings, for approx. one hour, in Feb/March 2015.

This may be reviewed at any time and additional meetings will be called to meet the demands of the project.

In addition, group members will need to be able to deal in a timely manner with the reading of draft documents as well as advising with the production of any consultation documents.

Membership of Subgroup

Dr Karen Lake [chair]	Public Health Screening and Immunisation Coordinator [PHE/NHS England]
Janet Dullaghan	Head of Commissioning Children health and well-being [PCC]
Sarah Kennedy	Practice Manager [Millfield]
Jane Robinson	Interim Public Health Analyst [PHE]
Dr H Mistry	LCG clinical governance lead [CCG]
Dr Malcolm Bishop	GP [CCG]
Teresa Casey	Practice Nurse [Bretton]
Angela Jeffers	Outpatient Lead Midwife [PSHFT]
Angela Rees	Service Manager Universal [CPFT]
Kelly Horn	Manager CHIS [CPFT]
Charlie Young	Clinical Information Facilitator [CCG]
Sharon Egdell	Senior Health Protection Nurse [PHE]
Correspondence	
Dr Shyla Thomas	Screening and immunisation Lead [PHE/NHSE]
Dr Colin Uju	Screening and immunisation Manager [PHE/NHSE]
Dr Anne McConville	Interim Consultant Public Health [PCC]

For the Task and Finish subgroup meeting quorum to be achieved, a minimum of 50% of members should be present or participate in the meeting by telephone.

Reporting Arrangements -The action points of the Task and Finish subgroup shall be formally recorded.

1. In your experience, what are the main reasons that families give for non-attendance for their child MMR immunisations?

Circle any responses given

1. Did not know about appointment
2. Forgot appointment
3. Not convenient
4. Venue not convenient/easy access
5. Fear of side effects
6. Parent does not think vaccine is protective
7. Parent thinks risk of infection risk outweigh benefits of vaccine
8. Wrong address/parent details on system
9. Did not understand appointment information [language or other]
10. Parent had single MMR vaccines

Any other reasons?

Appendix 5: Example of Survey template

2. In your experience what are the main reasons that parents do not have their child vaccinated with MMR?
3. In your experience what can practices do to encourage parents to bring their child to be vaccinated?
4. Does your practice contact parents that do not attend their vaccine appointment?

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<table>
<tr><td colspan="2">HEALTH AND WELLBEING BOARD</td><td colspan="2">AGENDA ITEM No. 7(a)</td></tr>
<tr><td colspan="2">18 JUNE 2015</td><td colspan="2">PUBLIC REPORT</td></tr>
<tr><td>Contact Officer(s):</td><td colspan="2">Will Patten, Interim Assistant Director Adult Strategic Commissioning, Peterborough City Council</td><td>Tel. 07919 365883</td></tr>
</table>

ADULT SOCIAL CARE, BETTER CARE FUND UPDATE

<table>
<tr><td colspan="2">R E C O M M E N D A T I O N S</td></tr>
<tr><td>FROM : Directors</td><td>Deadline date : N/A</td></tr>
<tr><td colspan="2">The Board is requested to:

1. Note the update on the Better Care Fund monitoring and non-elective admissions targets; and
2. Comment on the development of the projects.</td></tr>
</table>

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing at the request of the Corporate Director for People and Communities.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information for the Board; it sets out an update on delivery and monitoring following Peterborough's successful re-submission to the Better Care Fund (BCF) and the start of BCF funding on 01st April 2015.

2.2 This report is for Board to consider under its Terms of Reference No. 3.6, 'To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.'

3. BCF BACKGROUND, GOVERNANCE, MONITORING AND WORKSTREAM UPDATES

3.1 Background

3.1.1 As previously reported, Peterborough's Better Care Fund (BCF) has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the city. The BCF was announced in June 2013 and established in April 2015. The £11.9 million budget is not new money; it is a reorganisation of funding currently used predominantly by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and the City Council to provide health and social care services in the city.

3.1.2 In order to receive approval for the BCF, Peterborough had to show how it would meet a number of statutory conditions, including the protection of social care services; a reduction in non-elective admissions to hospital; greater seven day working across health and social care services to support discharge; and support for information sharing between social care and health to improve coordination of people's care. Peterborough worked collaboratively with Cambridgeshire County Council (CCC), Peterborough & Stamford Hospitals NHS Foundation Trust (PSHFT), CCG, UnitingCare (UC) and the voluntary sector to develop its BCF submission.

3.2 Governance

3.2.1 At the previous meeting, the Health and Wellbeing Board confirmed that the Joint Commissioning Forum, now the Borderline & Peterborough Executive Partnership Board, Commissioning (BPEPB), will oversee the delivery of the BCF Plan and management of the pooled budget on behalf of the Peterborough H&WB Board.

3.2.2 Following approval by this Board in March 2015 of the draft Section 75 Agreement between Peterborough City Council and the CCG, the Agreement was in place by 01st April 2015 when BCF funding began.

3.2.3 Therefore, all necessary formal governance arrangements for the BCF were in place by April 2015.

3.3 Monitoring

3.3.1 The Health and Wellbeing Board agreed to delegate responsibility for reporting to the BPEPB. The process and templates for reporting of local areas' BCF progress were issued following the meeting by NHS England and the Local Government Association.

3.3.2 The first quarterly monitoring return for NHS England was submitted on the 29 May 2015. This was approved by the BPEPB. Given the significant joint working across Cambridgeshire and Peterborough, the returns between the two health and wellbeing board areas were closely aligned with one another. This first return covered the fourth quarter of 2014/15 and so largely related to the setting up of arrangements for the BCF.

3.3.3 Separately to the return to NHS England, the CCG – in line with other CCGs - has also had an opportunity to revise the BCF targets for a 1% reduction in non-elective admissions, in line with actual performance – or outturn - for 14/15. The Q4 2014/15 plan was to achieve a 1% reduction when compared to 2013/14 Q4. The system actually saw a marginal reduction of 0.3% (reduction in 14 admissions). Therefore the planned levels were not reached prior to the BCF coming into effect.

3.4 Workstream Updates

3.4.1 As previously reported, five projects have been established reporting to the BPEPB, to be taken forward as part of the work funded by BCF; these project areas were aligned across Cambridgeshire and Peterborough.

3.4.2 Initiation workshops took place on each of the five schemes detailed in our BCF submission. These workshops were jointly hosted with CCC, the CCG and attendees included representation from other relevant (existing and potential) delivery partners. Following the initial workshops, each scheme is moving forward as follows:

3.4.3 Data Sharing

Background

This workstream will deliver an effective and secure joint approach to data sharing across the whole system, enabling improved co-ordination and integration of services for adults and older people. It is a critical element of the overall transformation programme in Peterborough because the delivery of all other schemes will rely, at least in part, on effective and secure data sharing mechanisms being in place, particularly the Person-Centred Care workstream (see below) and the UnitingCare delivery model and solution.

The workstream will focus on four areas of delivery:

- Ensuring practitioners and professionals have access to holistic information when making decisions related to adults and older people's care needs;
- Enabling information to be shared at the earliest possible stage to prevent people developing care needs where possible;
- Ensuring data and information is shared in order to inform strategic planning; and
- Data sharing as an enabler for delivery of the broader Borderline & Peterborough Executive Partnership Board's objectives.

Next steps

The Project Scope outlines the priority areas for delivery over the next 3 years; this is based on current requirements and will be revised in order to reflect changing priorities. It has been agreed that in the first 12 months, a specific workstream of the project should focus on improving data sharing for the 5% cohort of patients identified by UnitingCare to be supported by the multi disciplinary teams (MDTs). A tiered approach to identifying subsequent patient cohorts for data sharing improvements will also be developed during this time. This approach was developed in recognition of the fact that specific changes to data sharing mechanisms will take some time to develop. By focusing on a smaller cohort of people, professionals can share data about those people through whatever means are possible in the shorter term, before processes are streamlined. This will help to ensure that the project can have an impact on patient outcomes even in its early stages.

A second strand of the project will focus on delivery of the BCF requirements within the next 12 months, and work will commence on the standardisation of relevant data sharing systems and processes across Cambridgeshire, Peterborough and the CCG – and potentially beyond where possible.

A project scope has been developed, a project board has been established and progress will continue to be reported to BPEPB.

3.4.4 7 Day Working:

Background

7 Day Working is an enabler of better outcomes for patients; the model enables discharge planning to be undertaken in response to patient need as opposed to organisational availability and will improve outcomes for patients because they will be able to leave acute hospital as soon as they are clinically fit and it is safe to do so. The 7 Day Working workstream will deliver an integrated approach to discharge planning and non-elective admission avoidance by ensuring that appropriate services are operating 24 hours a day, 7 days a week. This will not mean that all services will operate in this way; it is about ensuring that appropriate services are available across the system when needed and will include expansion of health and social care services, and residential and nursing home services. In addition this project will focus on out of hours admission avoidance in order to ensure that the increased pace and capacity created by improved 7 day discharge planning is not filled by an increase in admissions.

Next steps

Following the initial joint workshop jointly hosted with CCC, a workshop for system partners in Peterborough took place in May 2015. Principles and activities of work were identified and a delivery approach and plan is being prepared. Attendees at the workshop included representatives from: Peterborough City Council's ASC Commissioning and Operations Teams; Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), Peterborough & Stamford Hospitals NHS Foundation Trust (PSHFT); GP community; Cambridgeshire and Peterborough Clinical Commissioning Group (CCG); UnitingCare (UC); The Ambulance Service; patient and carer groups; and the voluntary sector. A project team is being established for this work, and a draft scope has been developed based on the outcomes of workshops held both in Cambridgeshire and Peterborough. Within the first 12 months, at a high-level, the workstream will focus on three areas:

1. Understanding the current state: mapping current service hours

A mapping of current service hours should be conducted across the system in order to understand what services are available at what times in different settings. This will inform an understanding of where there are gaps and identify opportunities to commission to fill these;

2. Joint working with SRGs

Working closely with the System Resilience Groups (SRGs), and linking with existing work on the Eight High Impact Changes and actions resulting from 'Breaking the Cycle'. Further

work will be undertaken to understand the specific areas where increased seven day working would impact on admissions and discharges in order to identify priority areas for action .An aligned plan will be presented the July BPEPB;

3. **Developing and implementing quick wins**
Develop a series of quick changes that will be implemented within the current financial year, based on the outputs of the above work.

3.4.5 Information and Communication:

Background
The Information and Communication workstream will develop and deliver high quality sources of information and advice based on individuals' needs as opposed to organisational boundaries. Part of this work will include the establishment of the principle of an integrated system wide 'front door' for people that require information and advice about any part of the system irrespective of their presenting need(s). There is recognition that support and information will invariably be accessed via a broad range of routes. Therefore part of this work may involve embedding a principle of 'no wrong front door' and focusing efforts on supporting people to navigate the system in a way that best suits them, including self-service opportunities. This work will require all of our organisations, and residents to think differently about how they pass on or receive information.

Next Steps
Scoping work to understand the synergies and differences across Cambridgeshire and Peterborough is underway. The next step is for a core group to scope the work in detail; this will be informed by conversations regarding the broader programme that have taken place to date. The scope will be presented to the BPEPB for consideration in July.

3.4.6 Ageing Healthily & Prevention:

Background
This project was envisaged as having a focus on the development of community based preventive services to support and enable older people in particular to enjoy long and healthy lives and feel safe within their communities. Three project proposals emerged from the first discussion. These were:

1. **Triggers and Pathways:** to jointly develop a recognised set of triggers of vulnerability which generate a planned response across the system;
2. **Planning for growth**: which would support the growing numbers of older people in future through a coordinated approach to primary prevention; and
3. **Strong and supportive communities**: linking to a number of existing initiatives across the system to ensure that people were linked in to appropriate support in their community wherever possible

Next Steps
Further work is required to define the scope of this project and the deliverables. It has been agreed that Public Health will lead this project across Cambridgeshire and Peterborough and a Project Sponsor from within Public Health has been nominated. Given the broad potential scope of the work, it has been agreed that an effective approach would be an overarching prevention framework with targeted projects and areas of delivery that sit underneath, focused around frailty and reducing avoidable admissions. This work will develop alongside existing initiatives that are already underway. Public Health have been tasked with developing a more detaied scope for presenation to the July BPEPB

3.4.7 Person Centred Care:

Background
This workstream will build upon the existing multi-disciplinary team (MDT) approach to the delivery of services to the cohort of service users who are vulnerable or at risk of becoming frail or requiring high cost services and to put in place community based solutions to provide support at a local neighbourhood level. The MDT approach enables effective

integrated decision making and for the team around the person to have a common understanding of need and agree plans to address those needs. This project will deliver the tools required to facilitate and strengthen the MDT approach including an agreed risk stratification tool which will be used with all professionals and providers to describe the level of need, stratify risk and use as a basis for decision making, and an integrated joint assessment which will provide a common understanding of a persons need and agree an appropriate plan, facilitated by an accountable lead professional.

Next steps
Following a workshop held on 05th May 2015 with a range of partners (including UC, CCG and the voluntary sector), further work is being undertaken in the following areas:

- **Integrated Neighbourhood Teams (MDTs):** Scoping activity is underway on a review of social care involvement in current MDTs and how this might feed into a new model;
- **Risk assessment tool:** Planning how UC's use of the Rockwood Frailty Score can be supplemented/ adapted for wider use (given the currently exclusive medical context) and how this would be implemented/delivered;
- **A 'Pre statutory assessment':** A process to promote health and wellbeing in older people.

4. CONSULTATION

4.1 As previously reported, in the developing and drafting of the BCF Plan there were detailed discussions and workshops with system partners. The purpose of these discussions and workshops was to create the vision, goal, objectives and scope of the Strategic level Plan for BCF and the specific delivery projects/schemes. The Board is asked to note the necessary balance between consultation and development of robust project scopes and the need for delivery in recognition that the BCF is currently time limited.

5. ANTICIPATED OUTCOMES

5.1 The Board:

- Notes the update on the Better Care Fund monitoring and non-elective admissions targets; and
- Comments on the development of the projects.

6. REASONS FOR RECOMMENDATIONS

6.1 To inform the delivery of the BCF Plan.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Do nothing – this option is discounted as the Council would not be able to access the BCF.

8. IMPLICATIONS

Financial

8.1 Delivery assurance through the Board will enable the Council and the CCG to continue to meet NHS England's conditions for receiving £11.9m BCF.

8.2 The BCF funding is in-line with the Council's MTFS (Medium Term Financial Strategy).

9. BACKGROUND DOCUMENTS

i) Peterborough City Council's BCF Submission, January 2015
ii) Borderline & Peterborough Executive Partnership Board's Terms of Reference
iii) Section 75 Agreement, final version

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8(a)
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel.01733 207175

PETERBOROUGH 2014/15 CHILDREN & YOUNG PEOPLE'S JOINT STRATEGIC NEEDS ASSESSMENT

R E C O M M E N D A T I O N S	
FROM : Public Health Department	**Deadline date :** 18 June 2015, Health & Wellbeing Board

1. The Board notes the information and analysis incorporated within the Joint Strategic Needs Assessment and approves the report for publication on our public website.
2. The Board confirms the Children & Families Joint Commissioning Board as an appropriate forum to review effectiveness of existing strategies, interventions and provision in meeting the needs in the Children and Young People's JSNA and improving outcomes for the children and young people in the city.
3. The Board are asked to consider an engagement strategy to share initial JSNA findings and ensure partnership representation as appropriate on the further phases and deep dive work.
4. The Board confirm the Children & Families Joint Commissioning Board as an appropriate forum to commission selected further analysis based on these JSNA findings.
5. The Board agrees the recommendation that this JSNA be linked to the Safer Peterborough Plan and used to underpin the delivery of priorities within the delivery plan.

1. ORIGIN OF REPORT

1.1 In 2014, Peterborough City Council began undertaking a collaborative Joint Strategic Needs Assessment (JSNA) in conjunction with Green Ventures Ltd on the theme of Children & Young People within Peterborough Unitary Authority. This report summarises the outcome of this work and proposes recommendations for further work to address the needs identified by the JSNA.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to summarise findings from the Public Health Department's Children & Young People's JSNA and for the committee to consider the stated conclusions and recommendations for future actions and to approve publishing the final report.

3. MAIN BODY OF REPORT

3.1 The Peterborough Children and Young People's JSNA analyses data relating to children and young people in Peterborough and describes a very fast growing city with a young and ethnically diverse population, significant levels of deprivation and concomitant poor health and educational outcomes. There are wards in the centre of Peterborough with long-standing problems: poverty, over-crowding, poor educational attainment, poor health, unemployment and poor housing stock. Other issues for young people in Peterborough include alcohol, drugs, sexually transmitted infections, teen pregnancies and smoking and

high levels of hospital attendances and admissions for some conditions. The life-course approach to analysis of the data shows the potential impact on outcomes throughout life, with events in early life affecting children as they grow to adulthood.

3.2 Strategic priorities and the principles for commissioning effective services were identified in the Peterborough Health and Well-Being Strategy 2012-2015; in light of the needs identified through this JSNA, a review is now needed of their implementation and impact on the outcomes for children and young people.

3.3 Most of the needs identified are not new but the rapid population growth and diversity within Peterborough, together with shrinking public sector funding have intensified the challenges.

3.4 However, there are also significant opportunities to make real improvements to outcomes for the children and young people of Peterborough and their families with the introduction of the Children and Families Act 2014 and the Health and Social Care Act 2012, as well as the commissioning of Health Visiting and Family Nurse Partnership Services moving to the Council in October 2015.

3.5 The Children & Young People JSNA is comprised of the attached appendices:

Appendix 1 – CYP JSNA Full Report
Appendix 2 – Public Health England Benchmarking – Children & Young People
Appendix 3 – Public Health Profile – Children & Young People
Appendix 4 – CYP Public Health Profile
Appendix 5 – Policy context and recommendations

4. CONSULTATION

4.1 The Board is being asked to consider the appropriate consultation and engagement routes for this phase of the JSNA and further phases and work streams. This JSNA has previously received approval at both the Peterborough City Council Health & Wellbeing Programme Board and Children & Families Commissioning Board.

5. ANTICIPATED OUTCOMES

Recommendation 1: The Board notes the information and analysis incorporated into the JSNA and approves the report for publication on our public website.

Recommendation 2: The Board requests the Children & Families Joint Commissioning Board review effectiveness of existing strategies, interventions and provision in meeting the needs in the Children and Young People's JSNA and improving outcomes for the children and young people in the city.

Recommendation 3: The Board are asked to consider an engagement strategy to share initial JSNA findings and ensure partnership representation as appropriate on the further phases and deep dive work.

Recommendation 4: Selective and focused further analysis could help to inform the use of our resources to achieve the best possible outcomes. The following work streams are proposed:

1. Deep dive analysis of the impact of drugs and alcohol on children and young people in the city, with a view to formulating a multi-agency young person's drugs and alcohol strategy – suggested lead organisation Safer Peterborough Partnership.

2. A recent survey received from the Office of the Children's Commissioner suggests consideration of a wider range of issues for potential inclusion in further phases of the JSNA. These should be reviewed.

3. Further analysis of the child poverty data should be undertaken to ascertain the numbers and proportions of all children living in poverty in each ward of the city; this will help to determine proportions impacted by geographical targeting of a limited number of wards.

Recommendation 5: It is recommended that the JSNA links to the Safer Peterborough Plan as an understanding of the needs of Children and Young People in Peterborough is key to underpinning the delivery of priorities contained within the delivery plan.

6. REASONS FOR RECOMMENDATIONS

6.1 The above recommendations are to be considered with a view towards improving the health and wellbeing of the local population and improving collaborative working between appropriate stakeholders within the healthcare community to facilitate better service delivery and outcomes.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 The convening of a specific task and finish group to address the recommendations within the JSNA was considered; it is, however, felt that this would primarily be comprised of members of the Children & Families Joint Commissioning Board and represent duplication.

8. IMPLICATIONS

8.1 To achieve better life outcomes for children and young people in Peterborough and longer term cost savings for the city, services must focus on early intervention and prevention, meeting the needs of individual children and families and building on their strengths and on community assets.

Key financial drivers have been identified within the JSNA and further work could aid commissioners to deliver savings in high cost areas including:

- Hospital Admissions
- Accident and Emergency Attendances
- Young people Not in Employment, Education or Training

9. BACKGROUND DOCUMENTS

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

None.

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Children & Young People's Joint Strategic Needs Assessment

June 2015

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Children and Young Persons Joint Strategic Needs Analysis (JSNA)

Executive summary

The Peterborough Children and Young People's JSNA analyses data relating to children and young people in Peterborough and describes a very fast growing city with a young and ethnically diverse population, significant levels of deprivation and concomitant poor health and educational outcomes. There are wards in the centre of the City with long-standing problems: poverty, over-crowding, poor attainment, poor health, unemployment and poor housing stock. Alcohol, drugs, sexually transmitted infections, teen pregnancies, smoking, low birth weight and infant mortality are also issues for these areas of Peterborough as are high levels of injuries, asthma, dental problems and hospital attendances and admissions. The life-course approach to analysis of the data shows that outcomes are poor throughout life, with events in early life affecting children as they grow to adulthood.

Most of the needs identified are not new but the speed of population growth and the changing ethnic mix of the population together with shrinking public sector funding have intensified the challenges for Peterborough.

However there are also significant opportunities to make real improvements to outcomes for the children and young people of Peterborough and their families from the introduction of the Children and Families Act 2014 and the Health and Social Care Act 2014 and the commissioning of Health Visiting and Family Nurse Partnership Services moving to the Council in October 2015.

1 Introduction

The Peterborough Children's and Young People's Joint Strategic Needs Assessment (CYP JSNA) commenced with some multi-agency stakeholder workshops during the autumn period of 2013. The key themes that emerged from the workshop were pressures resulting from the socio-economic profile of Peterborough's population and from the city's high levels of growth, both in absolute numbers and the corresponding demand for services. Early findings from detailed analysis were subsequently presented at the Health and Wellbeing Board in January 2014.

Following on from this, the themes were subjected to robust evaluation, from which the messages are summarised as a report to support Commissioners and other relevant stakeholders in the identification of priorities.

What is the Children and Young People's JSNA?

A JSNA is a process whereby public sector economies bring together their knowledge of the needs of the population and the impacts on health and wellbeing in order to formulate commissioning plans, and best target resources. The CYP JSNA has been informed by the following analytical products and tools:

- Data collated by Public Health England detailing Peterborough performance vs regional neighbours and national benchmarks
- The Child Health Profiles produced by ChiMat

- The CYP JSNA data visualisation tool of ward and lower level distributions of health and socio-economic factors produced in partnership with Green Ventures Ltd
- Analysis of hospital related activity for children and young people of Peterborough, undertaken by the Health and Wellbeing Board Information Working Group.
- National General Practice Profiles focusing on child health.

2 Recommendations from the Peterborough CYP JSNA

Recommendation 1: The Board notes the changes and additional information and analysis incorporated into the JSNA.

Recommendation 2: The Board requests the Children & Families Joint Commissioning Board review effectiveness of existing strategies, interventions and provision in meeting the needs in the Children and Young People's JSNA and improving outcomes for the children and young people in the city.

Recommendation 3: The Board are asked to consider an engagement strategy to share initial JSNA findings and ensure partnership representation as appropriate on the further phases and deep dive work.

Recommendation 4: Selective and focused further analysis could help to inform the use of our resources to achieve the best possible outcomes. The following work streams are proposed:

1 Deep dive analysis of the impact of drugs and alcohol on children and young people in the city, with a view to formulating a multi-agency young person's drugs and alcohol strategy – suggested lead organisation Safer Peterborough Partnership.

2 A recent survey received from the Office of the Children's Commissioner suggests consideration of a wider range of issues for potential inclusion in further phases of the JSNA. These should be reviewed.

3 Further analysis of the child poverty data should be undertaken to ascertain the numbers and proportions of all children living in poverty in each ward of the city; this will help to determine proportions impacted by geographical targeting of a limited number of wards.

Recommendation 5: It is recommended that the JSNA links to the Safer Peterborough Plan as an understanding of the needs of Children and Young People in Peterborough is key to underpinning the delivery of priorities contained within the delivery plan.

3 Key Messages from the Peterborough CYP JSNA

- Children and young people in Peterborough continue to be statistically disadvantaged compared to the average for England and the East of England, with regards to both key public health and quality of life/aspiration metrics. Data show Peterborough to be below the national average in areas ranging from children living in poverty to mothers smoking while pregnant and poor levels of educational attainment.
- The city of Peterborough is the fastest growing of all cities within the UK and research commissioned by Peterborough City Council suggests that growth is outpacing predictions from the Office for National Statistics, particularly with regard to the growth rate of the population aged under 18. This will result in a substantial increase in demand for services, while public sector funding continues to reduce.
- Poor public health outcomes are noted to be of particular significance in four of Peterborough's most central wards – Ravensthorpe, North, Park and Orton Longueville. Peterborough remains a city with wide disparities in socio-economic status, needs and outcomes.

There is clear evidence[1] of the link between adverse events in early life and poor outcomes in throughout childhood and into adulthood. Understanding what is happening in early life to the children in our communities and intervening early not only improves lifelong outcomes but also saves money[2].

4 Messages from the ChiMat and Public Health England Child Health Profile and National Benchmarking Profile March 2014

The latest Child Health Profile was published in March 2014 and is included as Appendix 2. The profile covers the city as a whole and shows how we compared to England and the East of England on a range of key factors.

Children and young people under the age of 20 made up 26.5% of the population of Peterborough in 2012, a figure 2.6% higher than the national population percentage. This population of children and young people is increasingly diverse. In 2013 40.8% of school children were from a minority ethnic background, significantly higher than the national rate of 26.7%.

[1] http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61012/earlyintervention-smartinvestment.pdf

The level of child poverty was worse than average, with 23.6% of our children aged under 16 living in poverty compared to 20.6% overall in England in the March 2014 Child Health profile.

Within our proportionately larger and more diverse child population outcomes were worse than nationally. The health and wellbeing of children in Peterborough was generally worse than would be expected of an 'average' child in England. We have similar rates of obesity in children to that of England, but our rates of alcohol related admissions to hospital for children under 18 were high and increasing compared a decreasing trend nationally. We also had higher rates of children admitted to hospital as a result of self-harm than the England average and lower rates of women breastfeeding than the England average. The rate of family homelessness was worse than the England average, and we also had higher rates of children in care (as referred to as 'Looked After Children'). The educational attainment in 2012/13 for children at the end of Reception and for children achieving 5 or more GCSEs at A*-C were both below the national average and more young people aged 16-18 were 'Not in Education, employment or Training'.

5 Taking a local view of the issues

As noted from the core data set and Child Health Profiles, Peterborough as a city has a number of very significant issues to tackle in respect of improving the health and wellbeing of and ultimately outcomes for children and young people. In order to understand the actions we need to prioritise we must first understand the causal factors and characteristics of the communities where the greatest need is seen.

Peterborough was listed by the 2014 Centres for Cities report 'Cities Outlook 2014[3]' as the fastest growing city in the UK and this presents unique opportunities and challenges, particularly considering the number of children and young people within the city is expected to grow substantially over the next few years. The below table shows Office for National Statistics predictions of population growth over the years 2013-2031[4] and highlights a predicted population growth of 17.8% by 2031, with growth rates of 16.8% and 31.8% for the age groups 5-9 and 10-14 respectively.

[3] http://www.centreforcities.org/assets/files/2014/Cities_Outlook_2014.pdf
[4] http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html

Figure 1 – Peterborough predicted growth rate 2013-2031 (Office for National Statistics)

Age Group	2013	2015	2019	2023	2027	2031	% Change 2013-2031
0-4	14,900	15,300	15,400	15,200	15,000	14,900	0.0
5-9	12,500	13,400	14,800	14,900	14,800	14,600	16.8
10-14	11,000	11,100	12,700	14,100	14,400	14,500	31.8
15-19	11,400	11,300	10,800	12,000	13,400	13,900	21.9
20-24	12,000	11,800	11,500	11,000	11,400	12,700	5.8
25-29	15,200	15,300	15,400	15,000	14,400	14,400	-5.3
30-34	14,900	15,300	15,800	16,000	15,600	15,100	1.3
35-39	12,900	13,600	14,900	15,400	15,800	15,400	19.4
40-44	13,300	12,900	13,000	14,300	14,900	15,300	15.0
45-49	13,000	13,100	12,800	12,400	13,600	14,300	10.0
50-54	11,700	12,400	12,900	12,800	12,100	13,000	11.1
55-59	9,900	10,400	11,700	12,500	12,400	11,800	19.2
60-64	9,100	9,100	9,600	10,800	11,800	11,800	29.7
65-69	8,300	8,800	8,500	8,900	9,900	11,000	32.5
70-74	5,800	6,200	7,900	7,900	8,200	9,000	55.2
75-79	5,000	5,100	5,400	6,900	7,200	7,300	46.0
80-84	4,000	4,000	4,200	4,400	5,600	6,400	60.0
85-89	2,400	2,500	2,800	3,000	3,200	3,900	62.5
90+	1,200	1,300	1,500	1,900	2,300	2,700	125.0
All ages	**188,500**	**193,000**	**201,700**	**209,400**	**216,100**	**222,000**	**17.8**

Source: ONS 2012-based sub-national population projections
Note: Total may not sum due to rounding

However, ONS population predictions are based on trends of previous population growth. Research commissioned in 2010 by the LGSS Research, Performance and Business Intelligence team on behalf of Peterborough City Council also takes in to account the ambitious plans for growth within the city and revised growth predictions upwards based on the Council's current policy and planning decisions. The revised predictions are presented in the table below and show an overall predicted population growth between 2013 and 2031 of 28% rather than the 17.8% predicted by the ONS. Population growth rates for children and young people are also substantially increased; of particular note is a predicted growth of 55% in the 11-15 age group and 49% in the 16-19 age group by 2031.

Although this research predicts that the number of older residents within the city will also increase substantially, with a resultant growth in the healthcare demands that accompany a demographic change of this nature, the impact of a substantial population growth amongst children and young people and the subsequent rise in demand for local primary and acute services should be incorporated in future decisions regarding the development of the healthcare economy within Peterborough.

Figure 2 – Peterborough predicted growth rate 2011 - 2031

Age Group	2011	2013 [5]	2016	% change 2013-16	2021	% change 2013-21	2026	% change 2013-26	2031	% change 2013-31
0-4	14,300	14940	15,900	6%	17,500	17%	17,300	16%	17,100	14%
5-10	13,800	15320	17,600	15%	19,800	29%	21,000	37%	20,800	36%
11-15	10,800	11000	11,300	3%	14,500	32%	16,000	45%	17,000	55%
16-19	8,200	8320	8,500	2%	9,000	8%	11,400	37%	12,400	49%
20-24	11,400	11720	12,200	4%	12,000	2%	12,000	2%	15,000	28%
25-34	22,300	24020	26,600	11%	29,600	23%	27,700	15%	25,900	8%
35-44	25,900	25860	25,800	0%	27,100	5%	29,600	14%	30,300	17%
45-54	23,400	24400	25,900	6%	27,200	11%	26,400	8%	26,500	9%
55-64	20,300	20660	21,200	3%	23,700	15%	25,500	23%	26,200	27%
65-74	14,100	15500	17,600	14%	19,400	25%	20,100	30%	22,000	42%
75-84	9,400	9760	10,300	6%	11,900	22%	14,800	52%	16,200	66%
85+	3,800	4200	4,800	14%	5,900	40%	6,900	64%	8,300	98%
Total	177,700	**185700**	197,700	**6%**	217,600	**17%**	228,700	**23%**	237,700	**28%**

The Council has worked with Green Ventures to develop a mapped model of need within the City which enables us to link factors together.

In doing this we looked to linked thematic data together that shows the impact of:

Who we are – our demographic make up
Where we live – our communities, their facilities and characteristics
How we live – our behaviours, the things we do that impact on our health and wellbeing

These factors often link together to impact on individual and population outcomes. The following sections seek to set out our findings within three thematic summary areas:

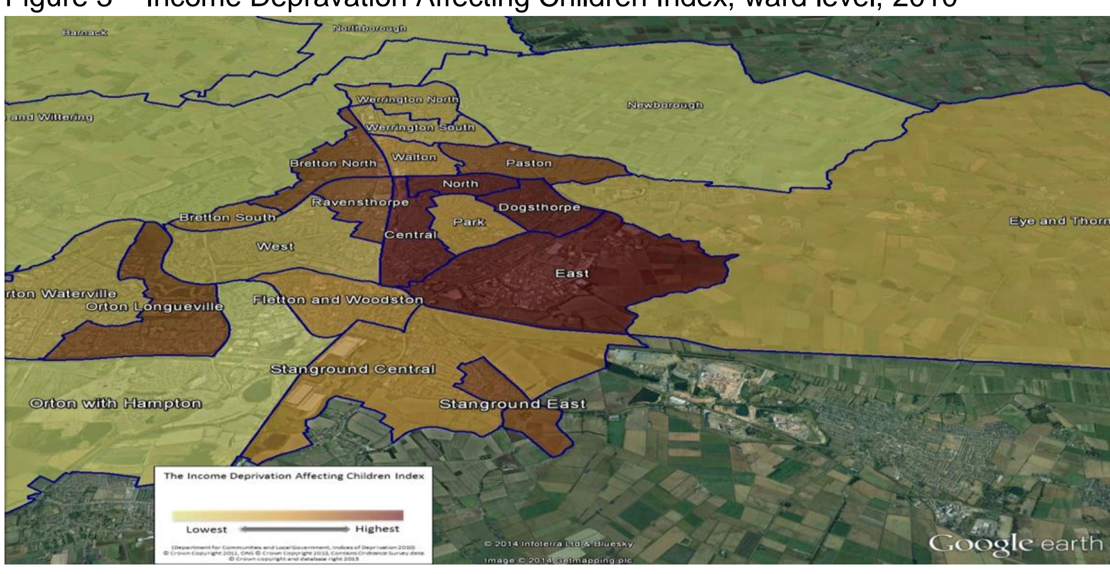
1. Deprivation significantly affects children in early years
2. Aspirations and Attainment are closely linked to where we live and our communities
3. Growth and Housing are key factors in our most deprived areas.

6 Deprivation affects our children in early years

The Income Deprivation Affecting Children Index (IDACI) shows income deprivation is clearly most prevalent in the 'doughnut shaped' group of wards in the centre of Peterborough - Central, East, North and Dogsthorpe wards. Rates are also high in Orton Longueville, Bretton North, Ravensthorpe, Stanground East and Paston, as shown in figure 3 below.

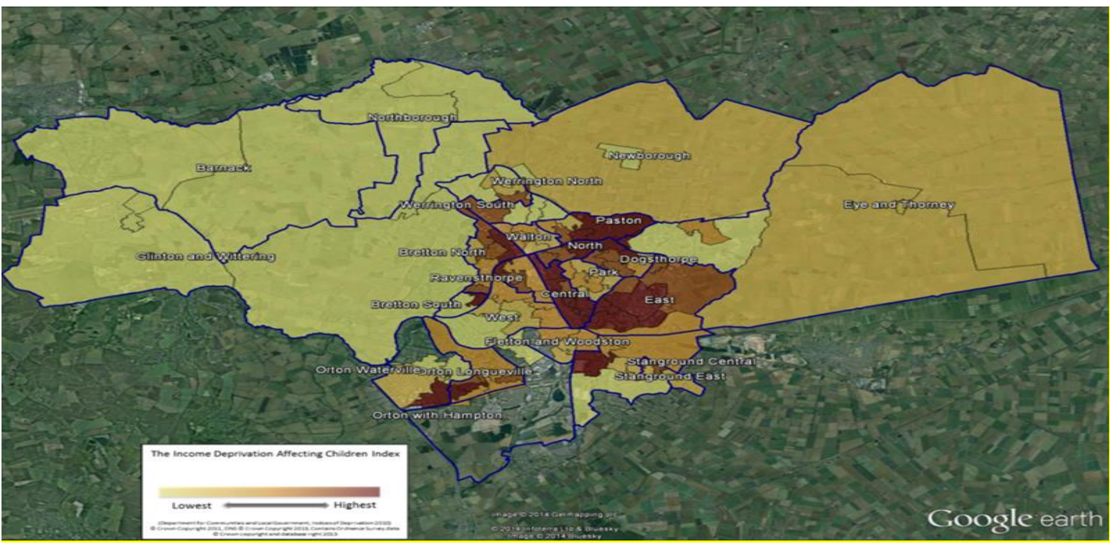
[5] 2013 figures are estimated by assuming growth between 2011 and 2016 for each age band follows a linear progression between these years.

Figure 3 – Income Depravation Affecting Children Index, ward level, 2010



There are also pockets of significant deprivation in Stanground Central and Orton Waterville. The IDACI for Hampton and Orton is not yet available, although it likely that we may see a pocket of income deprivation here also when data is released.

Figure 4 – Income Deprivation Affecting Children Index by Lower Super Output Area – 2010.

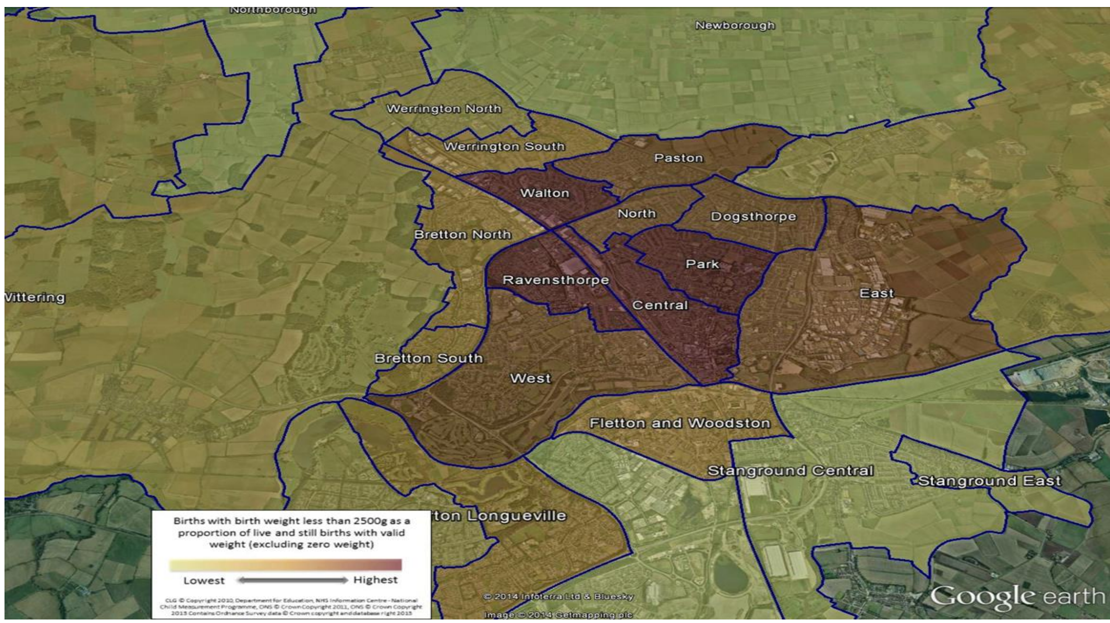


It is worth noting that even in the wards where there are significant levels of income deprivation affecting children there are also pockets where this deprivation is more severe.

When reviewing where babies are born we can see that the highest numbers of births are occurring in the areas where there are also the high levels of deprivation affecting children, with the Central, Ravensthorpe and East wards having the highest rates

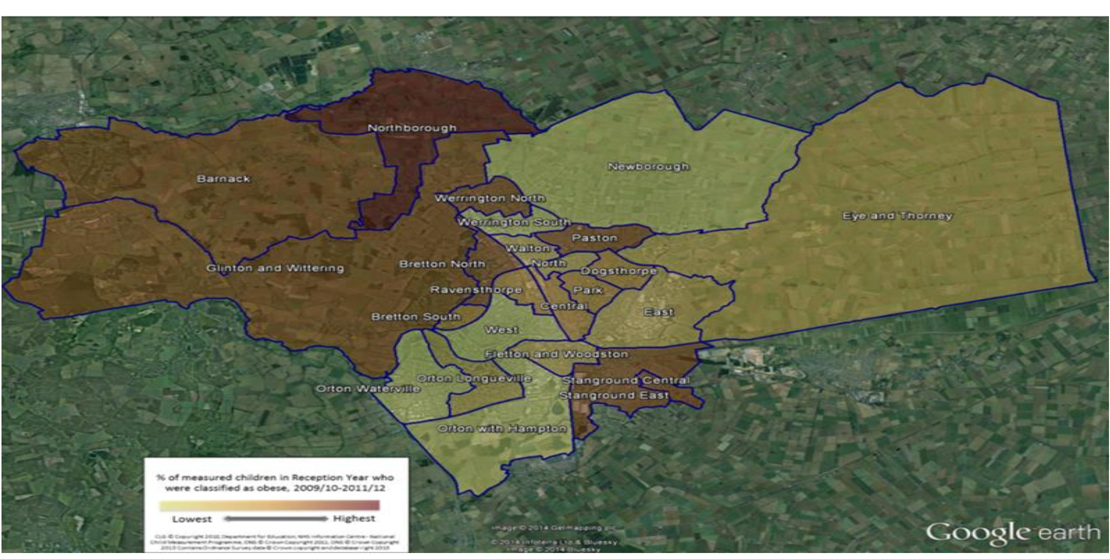
alongside Park ward. These wards also have the highest proportion of low birth weight babies.

Figure 5 – Births with birth weight less than 2500g as a proportion of live and still births by ward, 2008-2012



Low birth weights are often associated with smoking in pregnancy and / or prematurity and with poor health and development in early years. The data from the reception years weight and measurement programme suggests that children from deprived areas are less likely to be overweight when starting school. This could be down to low birth weight, and continuing poor diet. There is evidence of a strong link between low birth weight and coronary heart disease in later life[6].

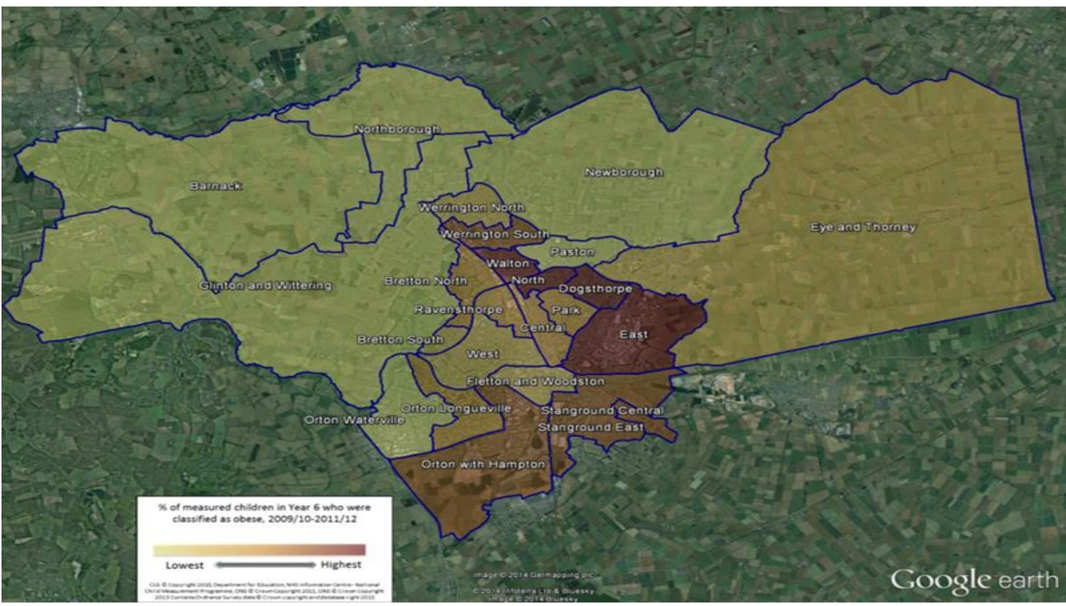
Figure 6: Percentage of measured children in reception year who were classified as obese 2009/10-2011/12.



[6] http://www.thebarkertheory.org/heart.php

However, by the time that children reach the final year of primary education, year 6, the trend is reversed and children in these areas are showing higher rates of obesity. There are particularly significant differences seen in Walton, North and East wards.

Figure 7: Percentage of measured children in year 6 who were classified as obese 2009/10-2011/12.

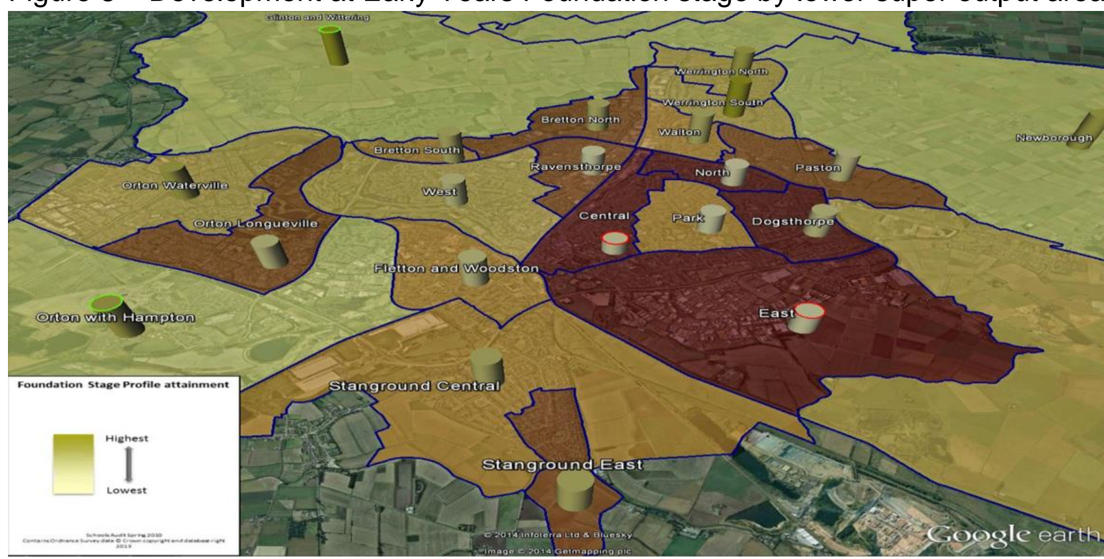


7 Aspirations and Attainment are closely linked to where we live and our communities

A key marker of development in early years is the level of development at foundation stage (age 5). Figure 8 below shows the foundation stage attainment in column form, against the IDACI map. Columns with green highlights on top denote high levels of attainment and those with red highlights show low levels of attainment in the Early Years Foundation Stage profile results.

The two wards with the lowest levels of development at foundation stage are East and Central, although, the attainment levels in Paston, Dogsthorpe, North, Park, Ravensthorpe and Orton Longueville are also fairly low as denoted by the lighter shading of the column. When viewed at lower super output level the pattern of lowest attainment is clearly aligned to a strip down the centre of Peterborough, around the Lincoln Road.

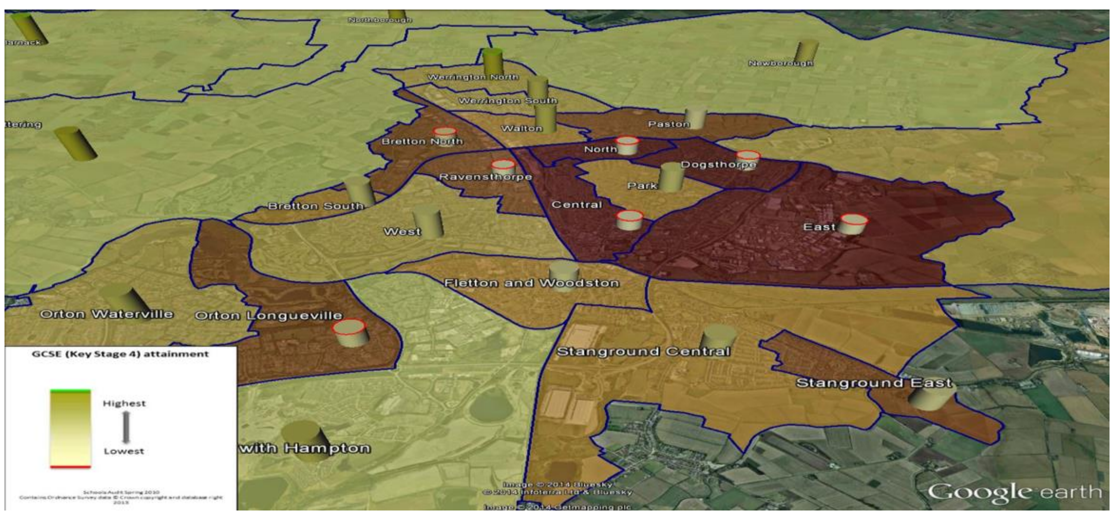
Figure 8 – Development at Early Years Foundation stage by lower super output area



The 2014 Public Health England paper ‘The link between pupil health and wellbeing and attainment’[7] outlines a clear link between good health and wellbeing and high levels of academic achievement.

The early years development of children does correlate with levels of aspiration and attainment as they become older. The early years development at foundation stage and GCSE attainment shows a clear alignment between poor attainment and areas impacted by childhood poverty. Significantly poorer levels of GCSE attainment are seen in Paston, Dogsthorpe, Central, East, North, Orton Longueville, Ravensthorpe and Bretton North Wards as shown in figure 9 below.

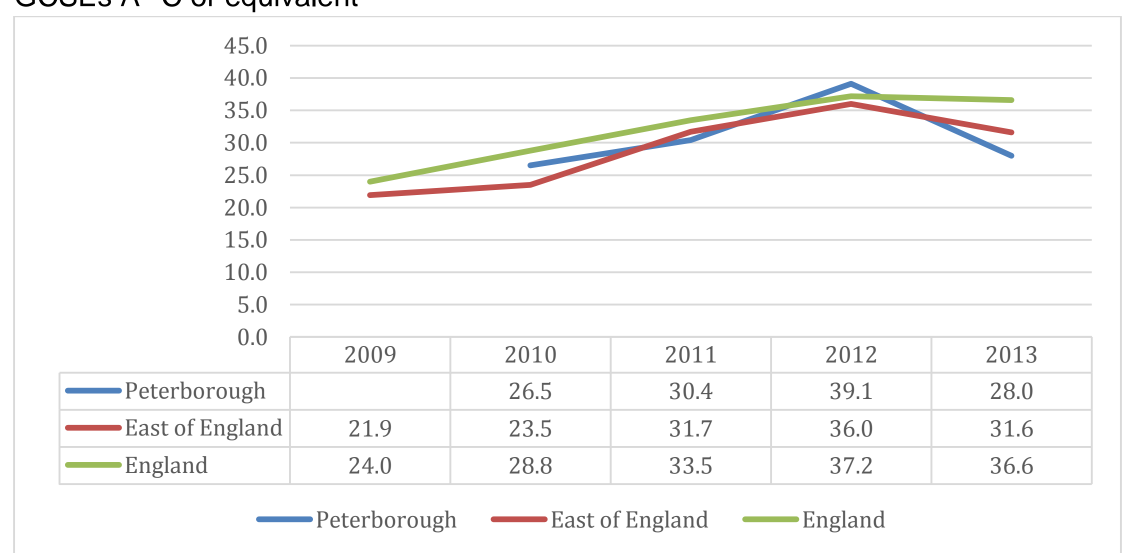
Figure 9 - Percentage of pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent in schools maintained by the Local Education Authority at the end of the academic year, 2012/2013 by ward.



[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/370686/HT_briefing_layoutvFINALvii.pdf?utm_medium=email&utm_source=The+King%27s+Fund+newsletters&utm_campaign=4925400_HWBB+2014-11-10&dm_i=21A8,2XKGO,H6UJ06,AL62U,1

Data from the Department for Education[8], displayed below in figure 10, provides numbers of children in care achieving at least 5 GCSEs at A*-C or equivalent. Data specific to Peterborough for 2009 is not available, however the trend for 2010-2012 shows a continuous improvement in the percentage of children in care reaching this level of educational attainment. However, the 2013 data (currently considered provisional) shows a drop to 28.0%, below the figure for both the East of England and England collectively. A direct comparison to attainment of children who are not in care is not possible as the standard educational measure of GCSE attainment is based on achieving 5 GCSEs at A*-C including English and Mathematics whereas data for children in care is only available pertaining to achieving 5 GCSEs at A*-C in any subject. However, it can be inferred from data showing that in 2011/12, 48.3% of children within Peterborough obtained 5 A*-C GCSEs including English and Mathematics that education attainment for looked after children is below the average standard achieved by all children undertaking GCSE examinations.

Figure 10: % of children looked after continuously for at least 12 months achieving 5+ GCSEs A*-C or equivalent

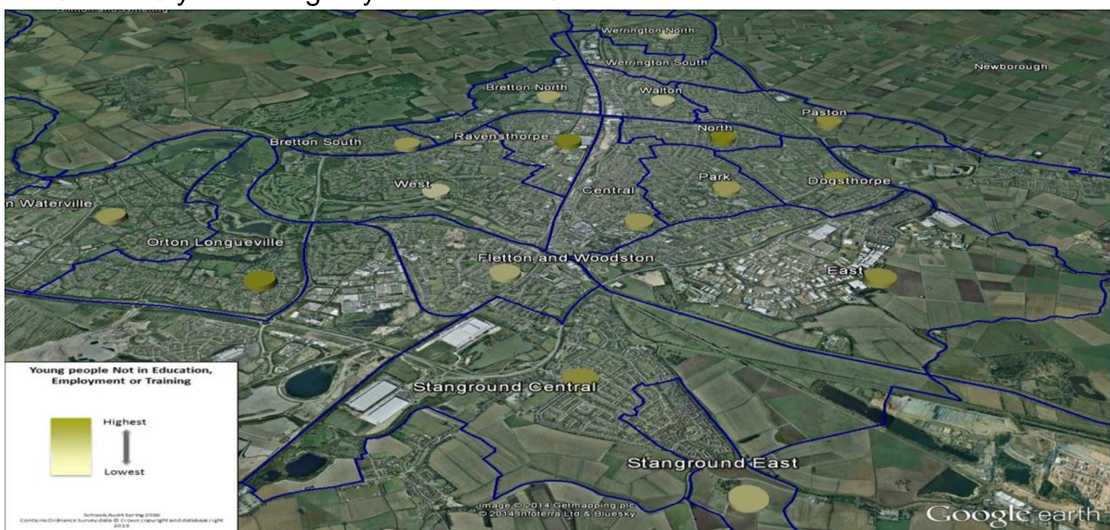


	2009	2010	2011	2012	2013
Peterborough		26.5	30.4	39.1	28.0
East of England	21.9	23.5	31.7	36.0	31.6
England	24.0	28.8	33.5	37.2	36.6

There is clear evidence that a higher number of those failing to achieve 5 A*-C GCSEs will end up not in education, employment or training upon leaving school. Figure 11 below shows the percentages of young people Not in Education, Employment or Training (NEET) at 16 and 18 years of age by ward as at 2012. It is too early to gauge the effect of the change in compulsory education whereby young people have to continue in education or training until 18. High rates of NEET are denoted by darker cylinders and can be seen highest in Ravensthorpe, North, and Orton Longueville wards, all three of which also have significantly low GCSE attainment. It is of note that rates of young person NEET are not high in Central ward, despite the lower levels of GCSE attainment.

[8] https://www.gov.uk/government/statistics/outcomes-for-children-looked-after-by-las-in-england

Figure 11: -Percentage of young people not in education training or employment NEET at 16 and 18 years of age by ward as at 2012.



Young teenage mothers are not counted within NEET figures. Deprived areas also have higher rates of teenage pregnancies. Figure 12 below shows the rates of teenage conceptions by ward. Rates of conceptions amongst 15-17 year olds are highest within the East, Dogsthorpe and Orton Longueville wards. As with NEET, rates are lower in Central ward.

Figure 12: - Rates of 2008-2010 conceptions for girls aged 15-17 by ward.

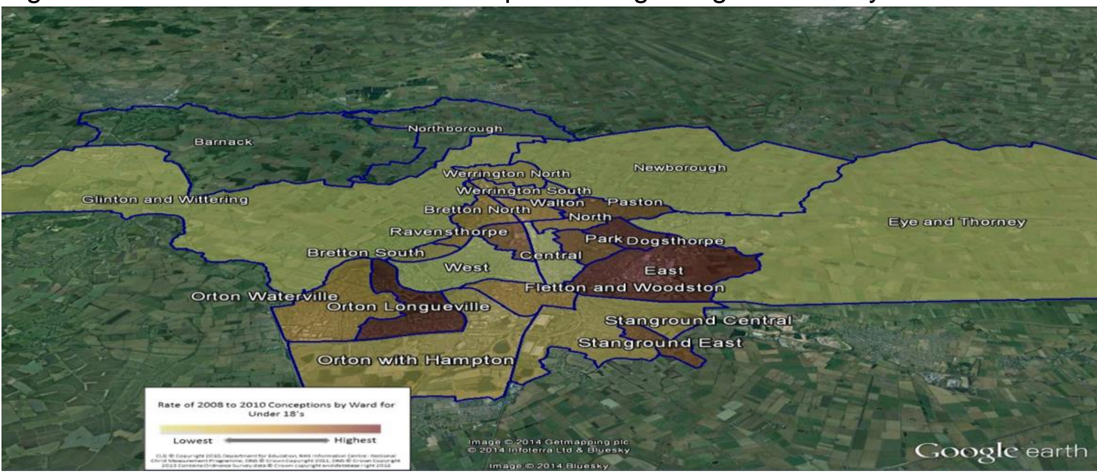
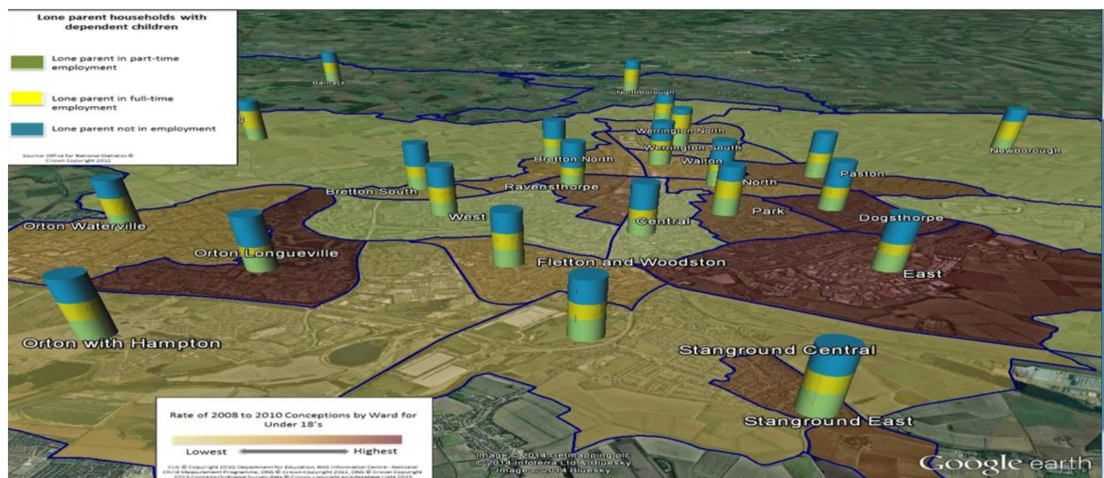


Figure 13 below shows the employment status of lone parents by ward mapped against the rate of teenage pregnancies. Each cylinder represents 100% of lone parents, with the shading within the cylinder represents the percentage of lone parents in full time employment (yellow), part time employment (green) and not in employment (blue). The wards shaded darker are those with high rates of teenage pregnancy. In areas where there are high rates of teenage pregnancy the blue proportion of the cylinder is larger denoting that lone parents are less likely to be in employment. Central ward, although having low rates of teenage pregnancies also has a higher percentage of lone parents not in employment.

Figure 13: - Lone Parent Households with Dependent Children, Census 2011 (KS107EW) mapped against Rates of 2008-2010 conceptions for girls aged 15-17 by ward



8 National GP Practice Profiles

Data collated by Public Health England allows for the analysis of healthcare statistics relating to children & young people by GP practice (i.e. the population registered with each practice). As shown within the below table, a composite indicator analysis of all of the 18 indicators within the dataset, incorporating statistics relating to demographics, deprivation and hospital admissions for young people, ranks Ailsworth Medical Centre as having the registered population with the lowest healthcare burden for children and young people and Dogsthorpe Medical Centre as having the highest burden. The used metrics are listed below:

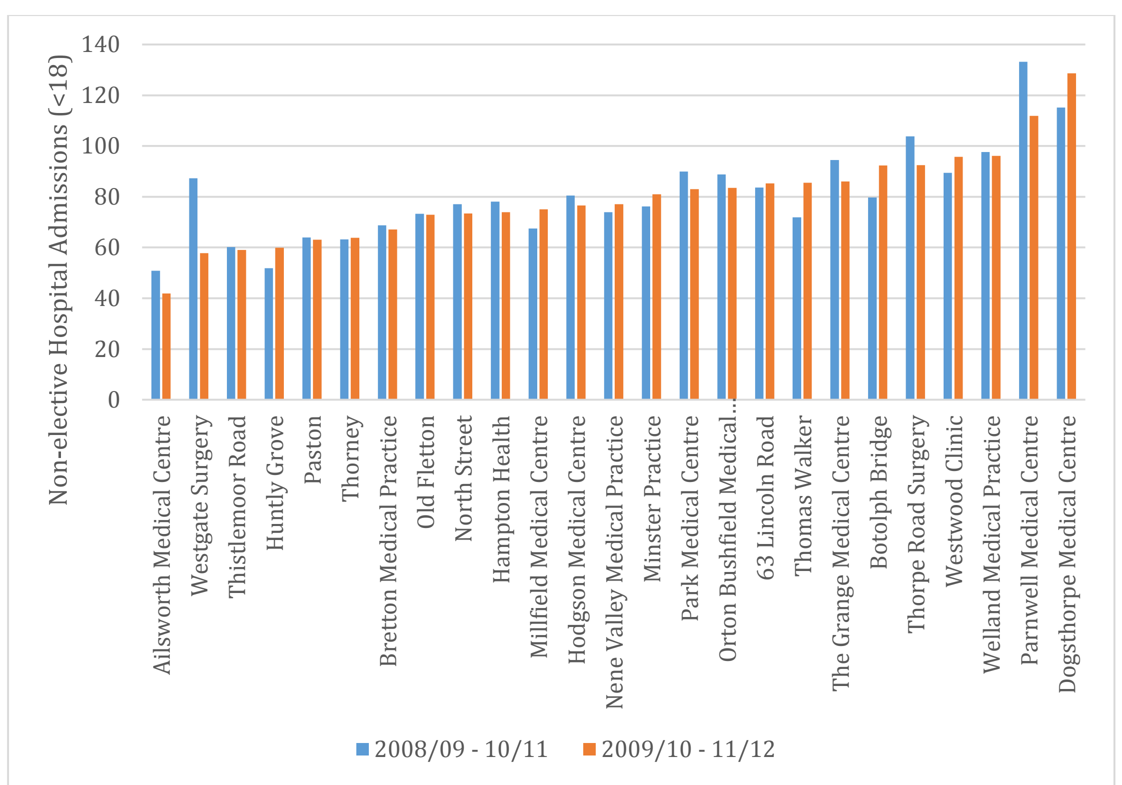
- % of residents aged 0-4 years
- % of residents aged 5 to 14 years
- % aged under 18 years
- IDACI (Income deprivation affecting children)
- Fertility rate
- Low birth weight births
- A&E attendances (0-4 years)
- A&E attendances (5-17 years)
- A&E attendances (<18 years)
- Elective hospital admissions for all causes (<18)
- Emergency hospital admissions for all causes (<18)
- Emergency respiratory admissions (<18)
- Emergency gastroenteritis admissions (0-4)
- Emergency admissions for asthma, diabetes or epilepsy (<18)
- Admissions due to injury (<18)
- Outpatient first attendances (<18)
- Ratio of first to follow-up outpatient attendances (<18)
- DNA rate for outpatient appointments (<18)

Figure 14 – Children & Young People Composite Indicator Ranking (1 = lowest healthcare burden)

Practice	Rank	Ward - Geographically Located Within	Ward - Majority Population Registered Within
Ailsworth Medical Centre	1	Glinton & Wittering	Glinton & Wittering
Westgate Surgery	2	Central	Central
Thorney	3	Eye & Thorney	Eye & Thorney
Thistlemoor Road	4	North	North
Millfield Medical Centre	5	Park	Central
Huntly Grove	6	Park	Park
Botolph Bridge	7	Fletton	Fletton
Hampton Health	8	Orton & Hampton	Orton & Hampton
Park Med Centre	9	Park	Park
63 Lincoln Road	10	Central	Werrington South
Paston	11	Paston	Paston
Hodgson Medical Centre	12	Werrington North	Werrington North
Thomas Walker	13	Park	Park
The Grange Medical Centre	14	West	West
Thorpe Road Surgery	15	West	West
Old Fletton	16	Fletton	Fletton
North St	17	Central	East
Nene Valley Medical Practice	18	Orton Longueville	Orton Longueville
Bretton Medical Practice	19	Bretton North	Bretton North
Orton Bushfield Medical Practice	20	Orton Waterville	Orton Waterville
Welland Medical Practice	21	Dogsthorpe	Dogsthorpe
Westwood Clinic	22	Ravensthorpe	Ravensthorpe
Parnwell Medical Centre	23	East	East
Minster Practice	24	Park	East
Dogsthorpe Medical Centre	25	Welland	Welland

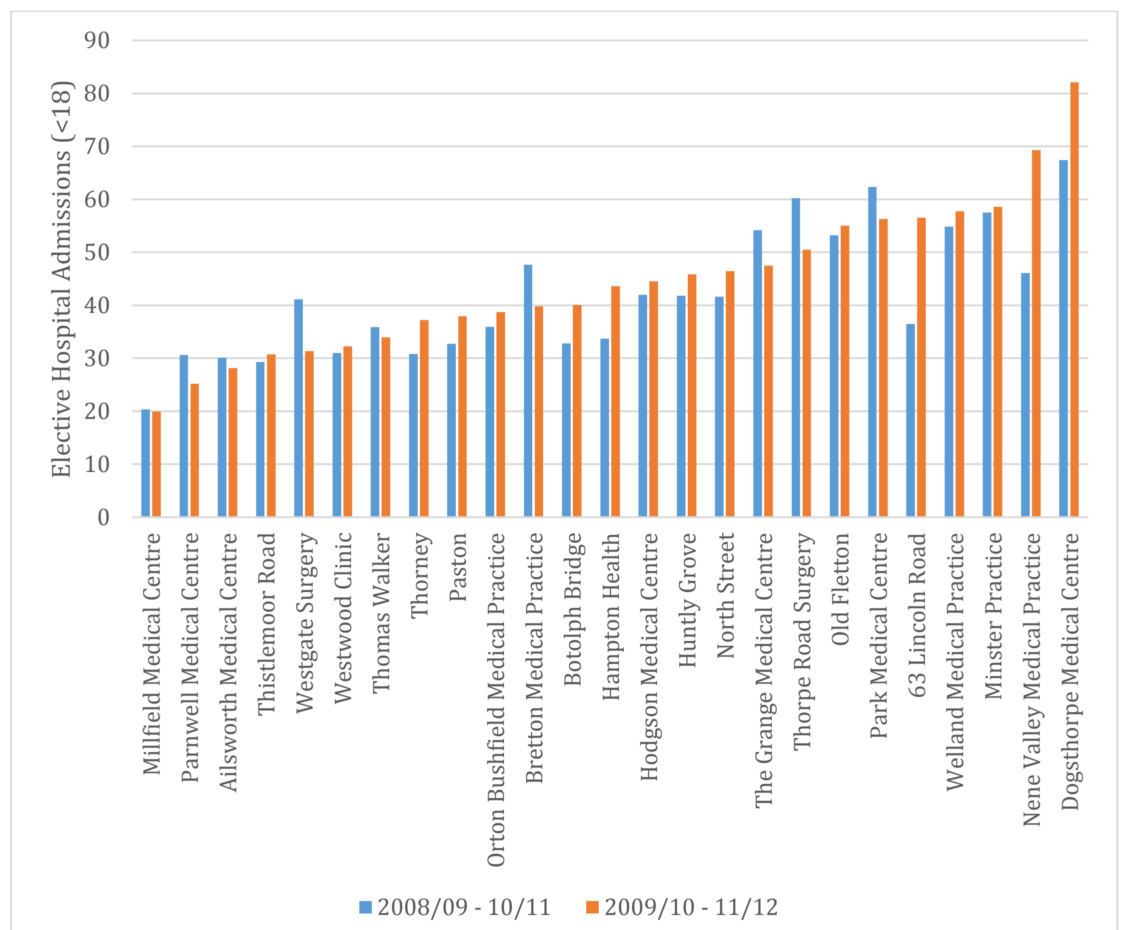
The 3 GP practices with the highest numbers of non-elective hospital admissions for 2009/10-2011/12 were Dogsthorpe Medical Centre, Parnwell Medical Centre and Welland Medical Centre as noted below.

Figure 15 – Non-elective hospital admissions 2009/10-2011/12, crude rate per 1,000 0-18



The 3 GP practices with the highest numbers of elective hospital admissions for 2009/10-2011/12 were Dogsthorpe Medical Centre, Nene Valley Medical Practice and Welland Medical Centre. Dogsthorpe Medical Centre and Welland Medical Centre are both within the 'worst' performing 3 practices for both observed non-elective and elective admissions, which is likely to be due to the practices also being in the top 3 practices for population under 18. However, consideration may therefore be given to whether adequate resources are being allocated to the health of children and young people within these areas with a proportionately higher percentage of young people overall and resultant higher observed numbers of admissions to hospital for both elective and non-elective purposes.

Figure 16 – Elective hospital admissions 2009/10-2011/12, crude rate per 1,000 0-18



9 Hospital activity

Figure 17 is a summary breakdown of the most common five reasons for attendances at A&E by children and young people in the 2013/14 financial year. Data show that 5,967 attendances were for treatment in relation to 'Guidance/advice/prescription/observation/wound care/sling/intravenous cannula' that could perhaps have been provided outside of an acute hospital setting and further work may be considered to publicise the availability of services outside of the acute sector to reduce demand on local Accident & Emergency.

Figure 17 – Peterborough children and young People Hospital Attendances, associated costs and common diagnostic conditions – Top 5 A&E Attendance Causes - 2013/14[9]

	Attendance Type	Attendances	Cost
1	Sprain/ligament/dislocation/fracture/joint injury/amputation/abdominal and pelvic pain/inguinal hernia	9,527	£1,064,189.79
2	Guidance/advice/prescription/observation/wound care/sling/intravenous cannula	5,967	£483,941.50
3	Dermatological conditions/burns/scalds/abrasions/laceration	4,974	£463,889.55
4	Neurological conditions/Head injury/electrocardiogram/pulse oximetry	3,467	£311,298.03
5	Ophthalmological conditions/facio-maxillary conditions/foreign body/ENT conditions/Urological conditions	2,982	£274,927.08
	Total	**26,917**	**£2,598,245.95**

[9] Source – Cambridgeshire and Peterborough CCG Information Dept (SUS data)

With regards to all children's A&E admissions and attendances, across Peterborough attendances were between standardised rates of 185 and 367 per 1,000 aged under 24, with the average for the area at approximately 301/1.000. Areas with significantly higher than Peterborough rates were Bretton North (364/1,000) and Ravensthorpe (367/1,000), and with significantly lower rates were Northborough (185/1,000) and Glinton and Wittering (215/1,000).

Also, for planned admissions, estimated to be around 7,000 a year, the standardised average rates (electives and non-electives) [10] at 134/1,000 masked the variations in different areas of Peterborough. With rates ranging between 15-170 per 1,000; these wards - Paston, Central, West, Stanground Central, Ravensthorpe and North had significantly higher rates.

10 Children and Young People's Mental Health and Wellbeing Profile

Public Health England produce a Children & Young People's Mental Health & Wellbeing Profile that benchmarks Peterborough's performance against geographical neighbours and that of England nationally with regards to metrics focusing on risk factors affecting mental health, the estimated prevalence of mental health issues, hospital admissions related to mental health, social care and education. The full profile is available via the Public Health website[11] and included as appendix 4.

Each of the composite sections within the profile are broken down in the below analysis that details the overall mental health and wellbeing profile of Peterborough within a national and local context. Within the profile, light blue shading represents above national average performance, dark blue represents below national average performance and yellow represents performance in line with national benchmarks.

Risk factors affecting mental health:

As previously noted within this JSNA, the relatively high levels of deprivation within the city translate in to statistically high numbers of children under 20 and under 16 living in poverty compared to national benchmarks. Peterborough also has a statistically high number of young people aged 16-24 providing unpaid care (5.2% vs 4.8% nationally) and young people aged 16-24 providing 20 or more hours of unpaid care per week (1.7% vs 1.3% nationally). The data also show that Peterborough has a higher than average rate of a number of indicators deemed risk factors for mental health issues, including family homelessness, lone parent households with dependent children, families with dependent children where no adults are in employment and families with dependent children where at least one person has a long term health problem or disability.

Of 20 metrics for which benchmarking assessment is available, Peterborough's performance is considered to be worse than benchmark for 15 (75%) and within expected confidence intervals for two metrics (10%). Data is within expected limits for the under 16 pregnancy and parents in drug treatment rates and better than average for obesity in Year 6 and children under 15 giving care to others.

[10] Elective and non-elective admissions in 2013/14 up to month 10 – 6975.

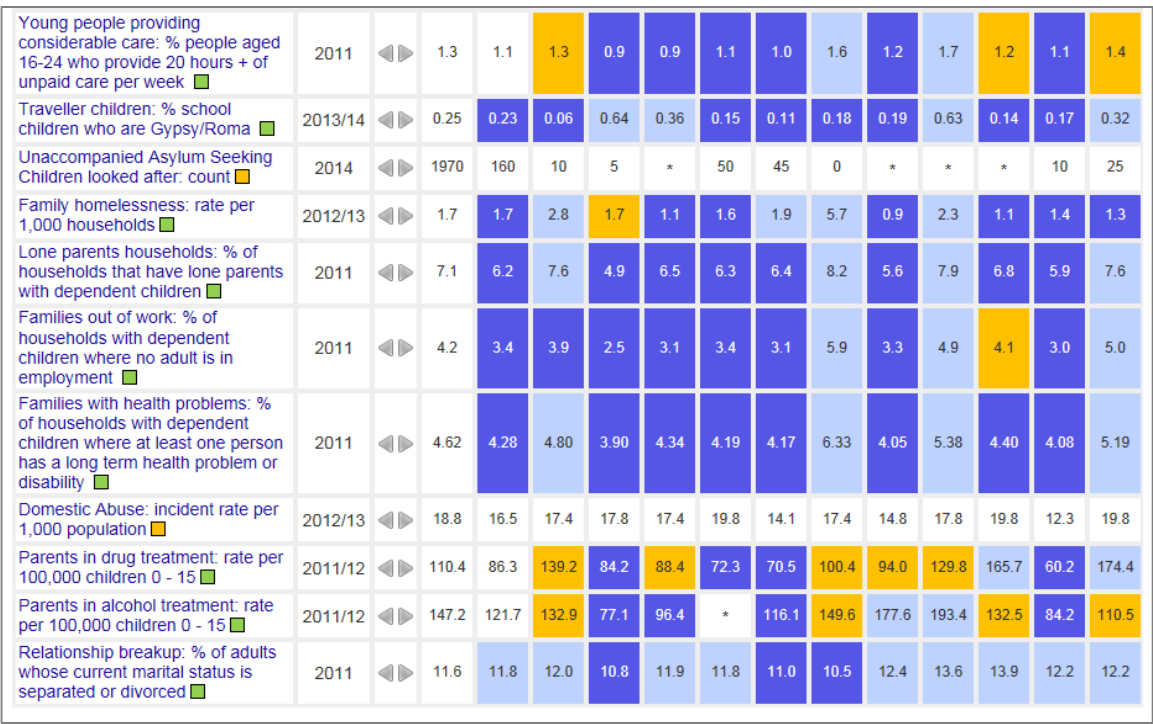
[11] http://fingertips.phe.org.uk/profile/cyphof/data

The overall message from this section of the profile is that the socio-economic pressures affecting Peterborough present a significantly high risk of increased mental health problems in the future and that the impact on mental health should be incorporated in to decision making regarding commissioning and service provision within the city. The mental health prevalence estimates within Figure 18 are not based on robust data so no inferences can be drawn. There are some concerns about the quality of the data in Figure 20 but it suggests that the rate of hospital admissions for children and young people for self-harm per 100,000 is higher than that for England (506.9 vs 352.3) and also for accidents and injuries for children 0-14 and young people 15-24.

Figure 18 - PHE Mental Health Profile for Children & Young People – Risk Factors, 2015

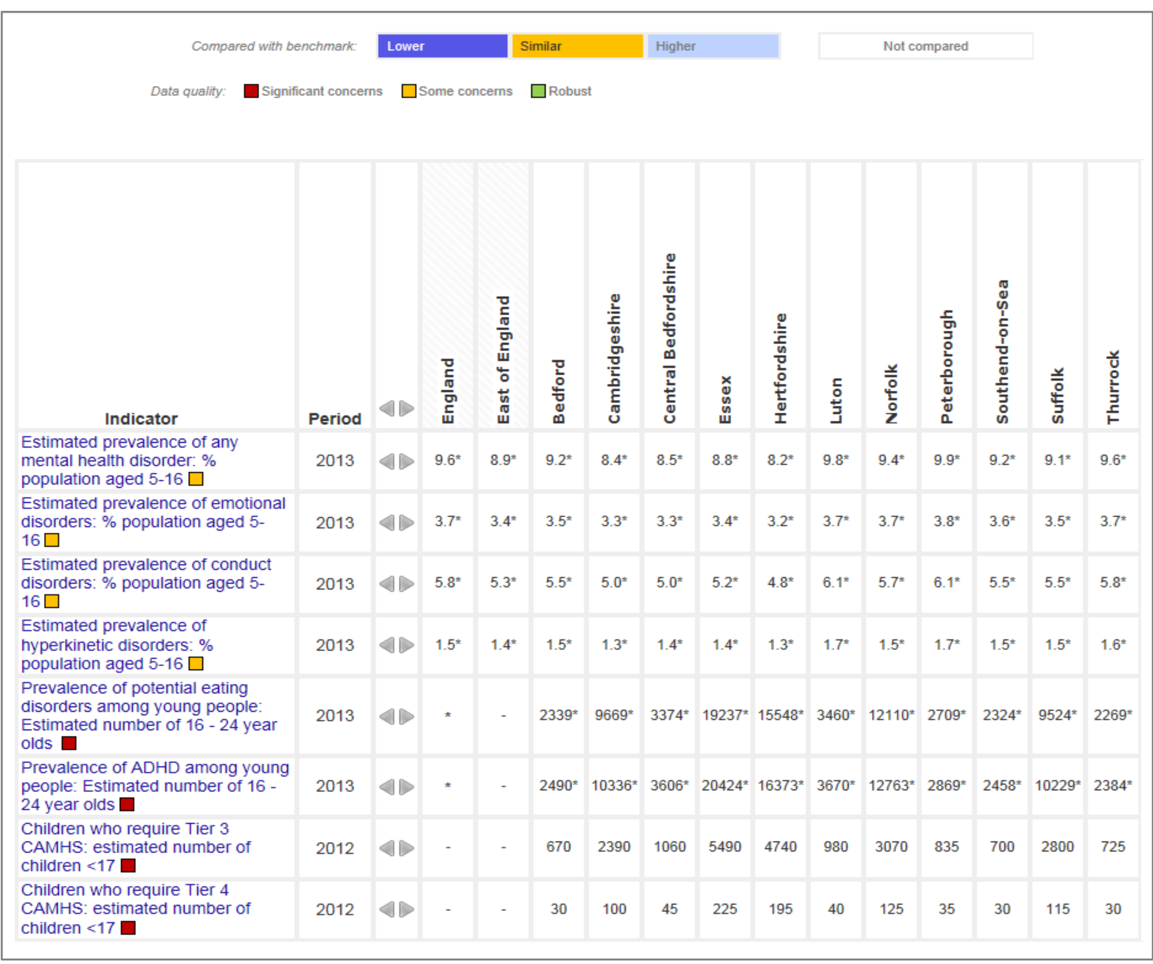
Compared with benchmark: Lower | Similar | Higher | Not compared

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Children under 20 in poverty: % of all dependent children under 20	2012	18.6	15.1	17.0	11.9	12.4	15.4	12.3	22.1	16.3	21.3	20.8	14.3	20.0
Children under 16 in poverty: % of dependent children under 16	2012	19.2	15.9	17.6	12.5	13.1	16.2	12.9	22.4	17.1	22.0	21.7	15.1	20.8
Child Well-being Index: average score	2009	-	-	95.1	99.6	95.1	113.0	84.2	194.5	141.5	185.2	191.0	112.6	165.8
Underweight children (Reception year): % of children	2013/14	0.95	0.78	0.91	0.55	0.63	0.78	0.95	1.82	0.50	1.31	0.63	0.49	0.55
Underweight children (Year 6): % of children	2013/14	1.36	1.38	1.51	1.13	0.65	1.29	1.54	1.88	1.22	3.44	1.10	1.14	1.42
Obese children (Reception year): % of children	2013/14	9.5	8.5	8.9	8.1	8.1	8.1	8.0	10.5	8.6	10.6	9.3	8.8	8.8
Obese children (Year 6): % of children	2013/14	19.1	17.2	18.5	16.2	15.9	16.7	15.1	23.7	18.0	17.4	17.7	17.4	22.1
Under 18 pregnancy: rate of conceptions per 1,000 females aged 15 - 17	2012	27.7	23.2	28.9	16.8	26.7	23.9	17.4	29.3	23.9	36.0	30.4	24.8	30.5
Under 16 pregnancy: rate of conceptions per 1,000 females aged 13 - 15	2012	5.6	4.4	5.1	3.4	4.2	4.9	3.3	5.0	4.4	4.7	6.5	5.0	6.3
Children providing care: % children aged <15 who provide unpaid care	2011	1.11	1.08	1.08	1.09	1.04	1.05	1.00	1.06	1.21	1.01	1.19	1.13	1.02
Young people providing care: % people aged 16-24 who unpaid care	2011	4.8	4.4	4.9	3.9	4.3	4.4	4.3	5.6	4.3	5.2	4.6	4.3	4.4
Children providing considerable care: % children aged <15 who provide 20+ hours of unpaid care per week	2011	0.21	0.19	0.20	0.19	0.18	0.19	0.16	0.21	0.23	0.14	0.25	0.20	0.21



Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Young people providing considerable care: % people aged 16-24 who provide 20 hours + of unpaid care per week	2011	1.3	1.1	1.3	0.9	0.9	1.1	1.0	1.6	1.2	1.7	1.2	1.1	1.4
Traveller children: % school children who are Gypsy/Roma	2013/14	0.25	0.23	0.06	0.64	0.36	0.15	0.11	0.18	0.19	0.63	0.14	0.17	0.32
Unaccompanied Asylum Seeking Children looked after: count	2014	1970	160	10	5	*	50	45	0	*	*	*	10	25
Family homelessness: rate per 1,000 households	2012/13	1.7	1.7	2.8	1.7	1.1	1.6	1.9	5.7	0.9	2.3	1.1	1.4	1.3
Lone parents households: % of households that have lone parents with dependent children	2011	7.1	6.2	7.6	4.9	6.5	6.3	6.4	8.2	5.6	7.9	6.8	5.9	7.6
Families out of work: % of households with dependent children where no adult is in employment	2011	4.2	3.4	3.9	2.5	3.1	3.4	3.1	5.9	3.3	4.9	4.1	3.0	5.0
Families with health problems: % of households with dependent children where at least one person has a long term health problem or disability	2011	4.62	4.28	4.80	3.90	4.34	4.19	4.17	6.33	4.05	5.38	4.40	4.08	5.19
Domestic Abuse: incident rate per 1,000 population	2012/13	18.8	16.5	17.4	17.8	17.4	19.8	14.1	17.4	14.8	17.8	19.8	12.3	19.8
Parents in drug treatment: rate per 100,000 children 0 - 15	2011/12	110.4	86.3	139.2	84.2	88.4	72.3	70.5	100.4	94.0	129.8	165.7	60.2	174.4
Parents in alcohol treatment: rate per 100,000 children 0 - 15	2011/12	147.2	121.7	132.9	77.1	96.4	*	116.1	149.6	177.6	193.4	132.5	84.2	110.5
Relationship breakup: % of adults whose current marital status is separated or divorced	2011	11.6	11.8	12.0	10.8	11.9	11.8	11.0	10.5	12.4	13.6	13.9	12.2	12.2

Figure 19 – PHE Mental Health Profile for Children & Young People - Estimated prevalence of mental health issues, 2015

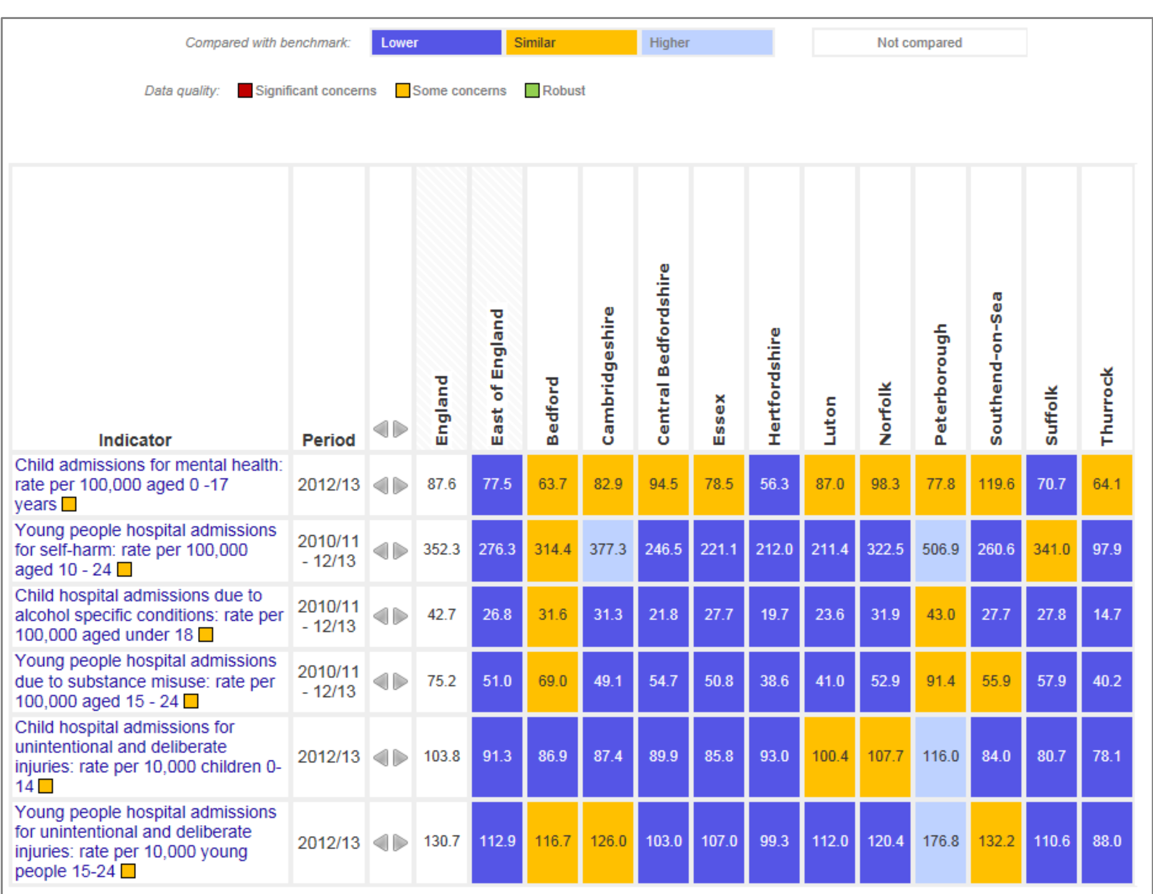


Compared with benchmark: Lower | Similar | Higher | Not compared

Data quality: Significant concerns | Some concerns | Robust

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Estimated prevalence of any mental health disorder: % population aged 5-16	2013	9.6*	8.9*	9.2*	8.4*	8.5*	8.8*	8.2*	9.8*	9.4*	9.9*	9.2*	9.1*	9.6*
Estimated prevalence of emotional disorders: % population aged 5-16	2013	3.7*	3.4*	3.5*	3.3*	3.3*	3.4*	3.2*	3.7*	3.7*	3.8*	3.6*	3.5*	3.7*
Estimated prevalence of conduct disorders: % population aged 5-16	2013	5.8*	5.3*	5.5*	5.0*	5.0*	5.2*	4.8*	6.1*	5.7*	6.1*	5.5*	5.5*	5.8*
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2013	1.5*	1.4*	1.5*	1.3*	1.4*	1.4*	1.3*	1.7*	1.5*	1.7*	1.5*	1.5*	1.6*
Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds	2013	*	-	2339*	9669*	3374*	19237*	15548*	3460*	12110*	2709*	2324*	9524*	2269*
Prevalence of ADHD among young people: Estimated number of 16 - 24 year olds	2013	*	-	2490*	10336*	3606*	20424*	16373*	3670*	12763*	2869*	2458*	10229*	2384*
Children who require Tier 3 CAMHS: estimated number of children <17	2012	-	-	670	2390	1060	5490	4740	980	3070	835	700	2800	725
Children who require Tier 4 CAMHS: estimated number of children <17	2012	-	-	30	100	45	225	195	40	125	35	30	115	30

Figure 20 - PHE Mental Health Profile for Children & Young People – Hospital Admissions, 2015



Compared with benchmark: Lower | Similar | Higher | Not compared

Data quality: Significant concerns | Some concerns | Robust

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Child admissions for mental health: rate per 100,000 aged 0 -17 years	2012/13	87.6	77.5	63.7	82.9	94.5	78.5	56.3	87.0	98.3	77.8	119.6	70.7	64.1
Young people hospital admissions for self-harm: rate per 100,000 aged 10 - 24	2010/11 - 12/13	352.3	276.3	314.4	377.3	246.5	221.1	212.0	211.4	322.5	506.9	260.6	341.0	97.9
Child hospital admissions due to alcohol specific conditions: rate per 100,000 aged under 18	2010/11 - 12/13	42.7	26.8	31.6	31.3	21.8	27.7	19.7	23.6	31.9	43.0	27.7	27.8	14.7
Young people hospital admissions due to substance misuse: rate per 100,000 aged 15 - 24	2010/11 - 12/13	75.2	51.0	69.0	49.1	54.7	50.8	38.6	41.0	52.9	91.4	55.9	57.9	40.2
Child hospital admissions for unintentional and deliberate injuries: rate per 10,000 children 0-14	2012/13	103.8	91.3	86.9	87.4	89.9	85.8	93.0	100.4	107.7	116.0	84.0	80.7	78.1
Young people hospital admissions for unintentional and deliberate injuries: rate per 10,000 young people 15-24	2012/13	130.7	112.9	116.7	126.0	103.0	107.0	99.3	112.0	120.4	176.8	132.2	110.6	88.0

Social care and associated factors relating to the mental health of Children & Young People

Data show that Peterborough has a significantly high rate of children considered 'in need' and of newly identified applicable cases. However the rate of children considered to be in need for more than 2 years as a percentage of all children in need is statistically significantly low. The general trend shown by data within this section is that wider socio-economic circumstances may be contributing towards a higher than expected number of children and young people requiring intervention from social care, but that where interventions are required, Peterborough often outperforms national benchmarks in terms of providing assessments and support. For example, the percentage of looked after children who had an annual assessment stands at 93.9%, higher than the England average of 86.5% and development assessments for children under the age of 5 whose development assessments were up to date stands at 100%, substantially higher than the East of England average of 88.9%.

Figure 21 - PHE Mental Health Profile for Children & Young People – Social Care, 2015

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Children in need: Rate of children in need during the year, per 10,000 aged <18	2013/14	679	542	655	407	508	446	486	866	599*	802	546	610	767
New cases of children in need: Rate of new cases identified during the year, per 10,000 aged <18	2013/14	371.7	320.9	327.6	216.2	239.4	222.6	276.5	393.4	549.5	453.5	267.8	376.3	435.4
Children in need due to abuse, neglect or family dysfunction: % of children in need	2014	65.8	70.0	71.6	79.5	55.9	66.6	62.7	56.7	80.7*	84.4	73.8	68.0	69.7
Children in need for more than 2 years: % of children in need	2014	31.6	28.0	39.6	28.5	34.4	40.4	37.4	26.8	4.6*	29.6	38.0	24.3	37.4
Children in need referrals: Rate of children in need referrals during the year, per 10,000 aged <18	2013/14	572	444	335	380	404	427	309	507	584*	575	533	558	491
Assessment of children in need referrals: % of referrals with a completed initial assessment	2013/14	46.9	71.8	*	78.6	41.5	61.6	55.0	71.9	91.7	95.6	7.0	89.7	83.6
Looked after children: Rate per 10,000 <18 population	2013/14	59.8	49.8	73.5	38.5	46.5	38.1	39.1	73.6	69.1	79.7	64.7	48.0	72.3
Looked after children in foster placements: % of looked after children	2014	74.6	75.0	72.2	72.0	75.9	75.3	73.8	78.5	72.6	83.6	79.6	72.4	78.9
Looked after children in secure units, children's homes and hostels: % of looked after children	2014	9.2	9.9	9.3	16.0	9.3	8.4	9.9	2.5	15.7	5.5	10.2	6.2	10.5
Health assessments for looked after children: % who had an annual assessment	2014	88.4	86.5	86.1	91.0	94.1	90.2	78.8	78.6	84.4	93.9	90.9	85.0	86.8
Development assessments for young looked after children: % aged <5 whose development assessments were up-to-date	2014	86.8	88.9	100	100	100	83.3	100	50.0	86.4	100	75.0	92.9	50.0
Emotional well-being of looked after children: average score	2013/14	13.9	14.2	16.1	13.6	14.1	13.9	12.6	14.2	14.5	13.5	13.6	15.9	14.8
Emotional and behavioural health assessment of looked after children: % eligible children assessed	2013	71.0	75.0	82.0	73.0	100	65.0	84.0	69.0	91.0	86.0	61.0	54.0	99.0
Emotional and behavioural health outcome for looked after children: % eligible children considered 'of concern'	2012/13	38.0	39.0	53.0	39.0	44.0	40.0	32.0	34.0	39.0	35.0	43.0	45.0	41.0

Figure 21 (continued) - PHE Mental Health Profile for Children & Young People – Social Care, 2015

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Child protection cases: Rate of children who were the subject of a child protection plan at the end of the year (31 March)	2013/14	42.0	34.6	44.6	30.4	33.1	14.1	44.1	50.5	32.3	52.2	43.0	39.8	72.6
New child protection cases: Rate of children who became the subject of a child protection plan during the year, per 10,000 aged <18	2013/14	52.0	44.2	55.5	40.6	45.7	18.3	54.7	72.7	49.5	55.4	56.8	48.1	70.3
Repeat child protection cases: % of children who became subject of a child protection plan for a second or subsequent time	2014	15.8	17.3	25.5	13.6	15.5	18.5	16.8	24.6	19.0	12.2	14.0	18.6	8.3
Review of child protection cases: % of children under child protection who were reviewed within the required timescales	2014	94.6	96.2	100	100	100	98.6	97.0	98.7	80.5	95.8	100	99.5	96.5
Children leaving care: Rate per 10,000 <18 population	2013/14	26.4	21.3	21.8	16.1	17.2	16.8	20.1	30.7	27.9	32.7	27.7	21.2	26.6
First time entrants to the youth justice system: rate per 100,000 aged 10 - 17	2013	441	462	381	376	263	547	311	410	672	433	602	446	517
All entered to the youth justice system: rate per 1,000 aged 10 - 18	2012/13	8.9	8.2	5.9	8.0	5.9	8.7	6.2	10.0	10.5	11.0	10.3	7.7	8.4
Spend (£000s) on Local Authority children and young people's services (excluding education): rate per 10,000 0-17	2012/13	7778	6711	8072	6854	6343	6425	6049	7694	7150	9414	7605	5813	8353
Spend (£000s) on Sure Start Children's Centres and early years: rate per 10,000 0-17	2012/13	1045	743	761	568	716	653	621	1255	954	0	656	515	3074
Spend (£000s) on Children looked after: rate per 10,000 0-17	2012/13	3060	2788	3310	2347	3026	2478	2325	2713	4177	5178	2891	2085	2865
Spend (£000s) on Safeguarding children and young people's services: rate per 10,000 0-17	2012/13	1721	1368	2115	2242	1225	1488	1216	1767	456	1789	2316	1210	639
Spend (£000s) on Youth justice: rate per 10,000 0-17	2012/13	281	135	379	162	114	69	52	325	76	285	417	209	173

Social Care Spend

Data within figure 22 below shows that Peterborough spends more per 10,000 people aged 0-17 on children and young people’s services than the average of both England collectively and the East of England. Spend is also fractionally higher, although broadly in line with, national rates for looked after children, safeguarding and spend on youth justice. Peterborough is noted in the below table as having a nil spend on Sure Start Centres and early years; this nil spend is actually in relation to Sure Start centres only. A sum of approximately £743,000 is allocated from our Dedicated Schools Grant to support work relating to early years development and the childcare sector, including advice, support and training across all relevant areas including Special Educational Needs (SEN) schools.

Figure 22 - PHE Mental Health Profile for Children & Young People – Social Care Spend, 2015

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Spend (£000s) on Local Authority children and young people's services (excluding education): rate per 10,000 0-17	2012/13	7778	6711	8072	6854	6343	6425	6049	7694	7150	9414	7605	5813	8353
Spend (£000s) on Sure Start Children's Centres and early years: rate per 10,000 0-17	2012/13	1045	743	761	568	716	653	621	1255	954	0	656	515	3074
Spend (£000s) on Children looked after: rate per 10,000 0-17	2012/13	3060	2788	3310	2347	3026	2478	2325	2713	4177	5178	2891	2085	2865
Spend (£000s) on Safeguarding children and young people's services: rate per 10,000 0-17	2012/13	1721	1368	2115	2242	1225	1488	1216	1767	456	1789	2316	1210	639
Spend (£000s) on Youth justice: rate per 10,000 0-17	2012/13	281	135	379	162	114	69	52	325	76	285	417	209	173

11 Addressing issues in the deprived areas

The JSNA work completed so far identifies a cluster of areas of high deprivation – Ravensthorpe, Central, Dogsthorpe, East and North wards as shown in the summary table 5 below. Collating data in this fashion allows any wards that consistently perform poorly but not necessarily in a statistically significant way to be highlighted as an area that shows a consistent need for intervention, as is the case for the Ravensthorpe ward which flags as consistently below average for a number of metrics. In total, the below composite indicator analysis encompasses 13 metrics ranging from demographic data such as the percentage of young people within the population of a ward through to health-specific information such as A&E attendances and also data tangentially linked to public health and associated risk factors such as the percentage of the population living in overcrowded residences and numbers of 'NEET' individuals, i.e. those not in education, employment or training.

Figure 23 - Summary of ward level Children's and Young People's Health Statistics by Ward

Rank of each indicator by ward	% Breastfeeding	% smoking at delivery	low birthweights - % of births under 2.5kg	% child poverty	fertility rates per 1000 females aged 15-44	% of population living in overcrowded residences	% population under 16	% population under 20	% primary school children on FSMs	NEET - % of aged 19s not In employment or education	A&E attendances - DSR per 10,000 up to age 24 years old	Elective admissions - DSR per 10,000 up to age 24 years old	FSP - % children achieving a good level of development within Early Years Foundation Stage Profile 2012
Barnack	83.3	1.6	6.2	5.1	72.8	2.2	19.9	12.2	5.1	0.0	216	10	94.7
Bretton North	74.3	26.2	7.8	36.2	83	9.1	23.2	12.3	27.4	7.7	364	32	58.4
Bretton South	76.9	20.3	7.5	24.4	68.4	5.4	18.9	10.8	28.1	9.4	321	34	65.4
Central	72.9	14.5	9.4	35.9	105.2	18.5	22.9	14.7	22.5	8.7	317	51	26.7
Dogsthorpe	73.3	25.2	8	39.6	89	10.4	22.9	11.9	28.7	10.3	338	45	52.3
East	66.7	19.0	7.9	38.8	96.3	13.8	22.2	11.9	23.9	11.0	320	48	40.0
Eye and Thorney	65.9	12.5	7.1	16.4	68.4	2.9	19.5	9.8	12.1	5.6	272	34	76.3
Fletton and Woodston	68.6	14.9	7.8	24.8	84.1	8.3	19.7	11.3	15.5	7.7	290	37	57.9
Glinton and Wittering	77.6	10.8	6.2	6.2	62.2	2.2	18.4	10.9	3.1	2.3	215	30	82.9
Newborough	72.7	17.9	4.7	11.1	55.8	2.2	16.8	9.5	4.5	1.1	235	28	76.2
North	73.3	16.6	8.3	36.6	93.1	11.5	22.6	12.4	29.0	11.5	297	66	43.0
Northborough	83.3	0.0	5.7	5.4	38.9	2.3	17.5	9.5	7.1	4.8	185	0	80.0
Orton Longueville	75.4	21.5	7.4	37.6	81	9.1	24.9	12.1	31.8	11.1	336	55	52.7
Orton Waterville	73.0	15.8	7	18.3	62.7	3.5	17.4	9.9	18.1	8.9	265	35	66.7
Orton with Hampton	65.1	10.6	5.9	16	77.8	7.3	26.1	11.1	13.8	5.7	275	50	69.3
Park	64.4	11.7	10	29.1	96.2	15.8	24.4	14.8	16.0	9.3	278	35	42.9
Paston	70.8	25.1	7.9	37.9	85	9.3	23.2	12.2	24.7	9.8	335	44	57.7
Ravensthorpe	71.2	24.0	8.7	37.6	96.2	11.8	24.6	13.4	25.2	11.3	367	46	48.0
Stanground Central	76.1	17.7	5.9	21.7	66.9	5.8	17.8	10.8	16.2	10.7	305	51	62.6
Stanground East	78.3	16.7	5.5	20	61.7	4.3	17.9	10.5	13.3	7.6	317	35	64.0
Walton	62.9	23.2	9.2	25.2	71.9	6.9	17.5	10.8	15.4	4.8	317	40	66.2
Werrington North	64.1	14.5	6.2	15	54.2	6.6	20	11.6	10.9	4.4	273	36	69.3
Werrington South	71.4	9.8	7.2	16.2	58.6	3.8	16.3	9.8	4.0	1.0	284	44	81.3
West	72.5	9.1	8.4	17.2	70.7	4.5	17.6	10.4	12.6	5.2	300	54	53.6
Peterborough	70.4	17.1	7.7	27.2	79.7	8.3	21.3	11.7	23.4	8.0	301	42	55.8

Rank 1 - 5

Rank 20 - 24

12 Substance Misuse – Alcohol & Other Drugs

Use of 'any drug' -

There are limited local data on the prevalence of general illicit drug use. According to the ONS[12], around 8.8% of the national population aged 16-59 are thought to have taken 'any drug' in the last year which equates to around 1 in 11. When applied to Peterborough we suspect this to be an underestimate. According to the Crime Survey England & Wales methodology[13], of the estimated 9692 people that have taken 'any drug in the last year' around 7260 will have taken Cannabis.

As mentioned, ONS predict that around 8.8% of adults aged 16 to 59 had taken an illicit drug in the last year. When looking specifically at the age range of 16-24 though, we discovered that around 18.9% of citizens within that age bracket had taken an illicit drug, with the most common drug being Cannabis at around 15.1%.

Within this same age bracket, around 4.2% of people are thought to have taken Powdered Cocaine within the last year.

Young adults are generally more likely to use drugs frequently than older people. Over the last year, around 6.6% of 16 to 24 year olds would be classed as frequent drug users which is over double the percentage for all adults between 16 and 59.

The average age of illicit drug users over the past year is 29.3 years old.

New Psychoactive Substances/ Club Drugs –

There is little captured information/data regarding club drugs in Peterborough, however, nationally, this is a growing problem. It has been suggested that the main drug of choice among under 20s are ecstasy and LSD and they are being bought on the internet and sold/distributed at these parties.

Young people –

There are no specific prevalence estimates on young people's substance use in Peterborough. Peterborough's data from the school-based Health Related Behaviour Survey (2012)[14] indicates that 20% Year 10 pupils (roughly 400 individuals) reported having an alcoholic drink in the last seven days. 7% (c140) had drunk on more than one day, with Saturday, Friday and Sunday being the most common drinking days. 4% of respondents had drunk spirits; 3% beer or lager15.

The same survey shows that 16% of Year 10 boys and 10% of girls said they had used an illegal drug. 7% and 5% respectively admitted to using the drug in the last month. Cannabis (6%) was almost invariably the drug most used, with ecstasy and solvents also named (both 1%).

In terms of referrals to children's social care for the 12 month period to June 2014, 42 children/young people were recorded as having a factor of "concerns about drug misuse by the child", and 30 children/young people were recorded as having a factor

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[12] https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2013-to-2014-csew/drug-misuse-findings-from-the-201314-crime-survey-for-england-and-wales
[13] http://www.ons.gov.uk/ons/guide-method/method-quality/specific/crime-statistics-methodology/index.html
[14] http://sheu.org.uk/content/page/secondary-schools-health-related-behaviour-questionnaire
[15] Young People in Peterborough Schools, the health related behaviour survey, 2012

of “concerns about alcohol misuse by the child” (16 therefore having concerns about use of both alcohol and drugs). This equates to just over 2% of all initial assessments completed by the Local Authority.

Children and young people affected by parental substance misuse –

Unfortunately, there is limited data to quantify the number of children and young people affected by parental substance misuse. There is limited scope within both social care and CAF recording systems to identify where parental substance misuse is a factor. However, we do know that out of a total of 244 referrals to the Peterborough’s multi-agency support groups (MASG’S) in the year September 2013-August 2014, 19.7% of children referred were subject to a alcohol misuse issue within the family which equated to 48 referrals and 14 (5.7%) of young persons had an alcohol misuse presenting issue. 11.5% (28 referrals) had adult drug misuse within the family as a presenting issue and 8.2% (20) young persons with drug misuse. Given the nature of hidden harm, the number of children affected by parental substance misuse is likely to be much higher.

43% of referrals for young people come from Youth Justice (n=65), including the secure estate, which is higher than the National rate of 31% , with slightly , but not significantly lower rates across Self referrals, Children’s services and other services.

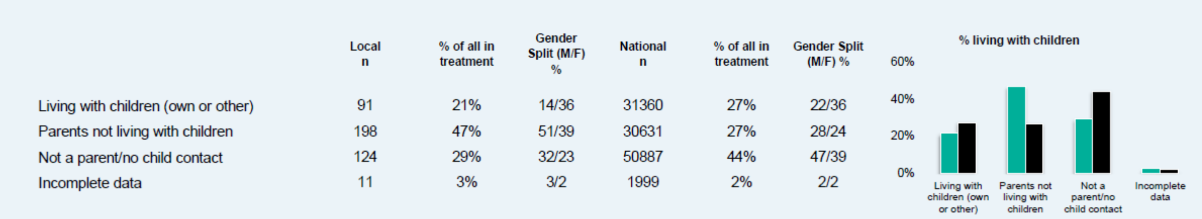
Parents (Drugs/Alcohol JSNA Support pack)

Peterborough has lower rates of clients in drug treatment who live with children, but higher rates who are parents not living with children. Similar observations with alcohol clients as drug clients in that there are lower numbers living with children (21%) than average (27%), but higher proportions who are parents, but not living with their children (47%).

Figure 24: Proportion of the adult drug treatment population living with children

	Local	Proportion of treatment population	Gender split (M/F)	National	Proportion of treatment population	Gender split (M/F)
Living with children (own or other)	177	18%	13% / 32%	60,949	32%	27% / 45%
Parents not living with children	356	35%	36% / 32%	46,230	24%	25% / 21%
Not a parent/no child contact	472	47%	50% / 35%	82,365	43%	46% / 32%
Incomplete data	5	0%	0% / 1%	3,716	2%	2% / 2%

Figure 25: Proportion of the adult alcohol treatment population living with children



	Local n	% of all in treatment	Gender Split (M/F) %	National n	% of all in treatment	Gender Split (M/F) %
Living with children (own or other)	91	21%	14/36	31360	27%	22/36
Parents not living with children	198	47%	51/39	30631	27%	28/24
Not a parent/no child contact	124	29%	32/23	50887	44%	47/39
Incomplete data	11	3%	3/2	1999	2%	2/2

Children and Young People Treatment Profile

The local profile of young people in specialist services in Peterborough shows that when compared to National rates there:

- Higher rates with alcohol use (PB – 9%/ Nat -5%) – 4 local clients
- Higher rates using two or more substances (PB -70% / Nat -61%) – 32 local Clients
- Higher rates who are Looked after Children (PB- 26% / Nat – 10%) – 12 local Clients
- Significantly higher rates of Children in Need (PB - 59% / Nat – 5%) – 27 local Clients
- Higher rates recorded as affected by Domestic Abuse (PB – 35% / Nat 17%) – 16 local clients
- Higher rates of NEETs (PB – 24% / Nat - 17%) – 11 local clients
- Higher rates involved in Offending (PB 33% / Nat 24%) – 15 local clients
- Higher rates subject to a child protection plan (PB 17% / Nat 5%) – 8 local clients
- Higher rates affected by others' substance misuse (PB 20% / Nat 16%) – 9 local clients
-

There is a lower reported rate who have an identified Mental health problem (PB-7% / Nat 15%) – 3 local Clients.

Substances –

Cannabis and Alcohol are the predominant substances, both of which have higher rates than National comparators

Unlike Peterborough's adult treatment population, the split by sex shows that there is a greater proportion of CYP females accessing treatment (53% n=76), the National rate for CYP females is 34%. This cohort also reports that they are affected by domestic abuse at greater rates than national comparators.

Both males (66%) and females (83%) cite alcohol as a problematic substance at higher rates than national comparators. (49% and 71% respectively). Lower rates cite Amphetamine and Ecstasy use compared to the national picture and there were no clients citing NPS or nicotine as a substance.

13 Domestic Abuse, Domestic Violence & Neglect

Statement of provision –

Peterborough City Council provide an integrated support service for medium to high risk victims of domestic abuse and/or sexual violence and specialist therapeutic interventions for children and young people who have experienced domestic abuse and/or sexual violence.

The issue of domestic abuse and sexual violence was highlighted nationally by the Government's Call To End Violence Against Women and Girls. In March 2013, the

definition of domestic abuse was changed to allow 16 and 17 year olds to be considered as victims.

At a local level domestic abuse is a priority of the Safer Peterborough Partnership and the local needs assessment highlighted the prevalence of sexual violence, particularly experienced by young people. Domestic abuse and sexual violence support services have traditionally been commissioned and delivered separately. However, domestic abuse and sexual violence are not mutually exclusive. By integrating the services we are able to offer a more comprehensive and joined up service which places the victim at the centre.

The overarching aim of the service is to provide accessible and appropriate interventions to improve safety and reduce risk and harm to both male and female victims of domestic abuse and/or sexual violence and their dependents. The service caters for all ages, sexuality and relationship status.

During April 2014 and March 2015, the specialist adults abuse service received a total of 1,723 referrals. Since July 2014 the children and young people's service received 152 referrals and since December 2014, the children and young people's sexual violence worker worked with 32 children and young people (28 female and 4 male).

The specialist abuse service aims to:

- Increase the safety of victims
- Reduce future risk to victims
- Improve the health and wellbeing of victims
- Provide high quality support for victims and those directly affected
- Reduce the physical and psychological impact of abuse/violence on victims
- Offer a family based approach where appropriate to ensure impact on children and young people is identified and addressed
- Increase confidence to access services and support

Eligible service users are:

- Proven resident of Peterborough
- Be experiencing or have previously experienced domestic abuse and/or sexual violence

The service provides:

- An open, accessible service for all ages, sexuality and relationship status
- Crisis interventions in response to incidents of domestic abuse and support access to emergency accommodation where needed
- Risk assessment and safety management via a comprehensive support plan
- Provision of information and guidance about Police and legal processes, sanctions and remedies available through civil or criminal court and victims entitlements to other support or benefits
- Identification of wider victim needs and support to access services (i9cluding housing, health, mental health, debt advice and substance misuse services)
- Undertake, where appropriate, family focused support to aid non-offending parents/carers or family members to support victims
- Support and advocacy through Police, legal and court processes
- Longer term emotional and practical support following incidents or domestic abuse and/or sexual violence

- Delivery of evidence-based group work programmes for victims of domestic abuse and/or sexual violence
- Adapt advice and interventions to be age appropriate and accessible to victims with learning disabilities
- Work with partner agencies to co-ordinate victim-centred service planning on behalf of victims
- Provide support to the Specialist Domestic Violence Court and to victims whose cases are being heard at court
- Provide holistic advice and support (including housing related support, advocate and signposting with and on behalf of victims) with the aim of increasing the ability of the client to live successfully and independently
- Provide additional support to access other relevant support services for example parenting support, welfare provision, education training and employment
- Support clients wishing to remain in their own home, including safety and security measures

Refuge Service

Peterborough has one refuge ran by Peterborough Women's Aid. Over the last year, the refuge has managed residents with complex needs including mental health and substance misuse, co-ordinating and liaising with other services across the city. A total of 29 residents were placed at the refuge during 2014/15 and 35 residents in 2013/14.

Domestic abuse

Domestic abuse has been identified as a key issue in the city and has been one of the Safer Peterborough Partnership's priorities. The local alcohol treatment provider recently analysed its client base and identified that a high proportion of clients were involved in domestic abuse as either victims or perpetrators or sometimes both.

Taken from the SaferPeterborough Domestic Abuse Needs Audit 2013, the figures below show the estimated prevalence of domestic and sexual abuse in an area the size of Peterborough, based on regional data by the British Crime Survey.

Figure 26: Prevalence of domestic and sexual abuse estimates

Indicator	2011 - 2012	2012 - 2013
Women and girls aged 16-59 have been a victim of domestic abuse	4,366[16]	4,731[17]
Women and girls aged 16-59 have been a victim of sexual assault	1,370[18]	1,484[19]

[16] Margin of error +/- 1,054
[17] Margin of error +/- 1,142
[18] Margin of error +/- 851
[19] Margin of error +/- 923

Women and girls aged 16-59 have been a victim of stalking	6,010[20]	6,513[21]

National data suggests a slight increase in the number of victims of domestic abuse, sexual assault and stalking, but there are wide margins of error.

Nationally, this is believed to be due to; the increase in population numbers, the increase of foreign nationals and due to the rise of awareness within the community the numbers of reported incidents has increased.

It is difficult to ascertain what the difference is between this estimated prevalence and the actual numbers of recorded incidents because it is not currently possible to identify the number of unique individuals reporting violence in Peterborough.

- There were 978 recorded domestic abuse crimes in Peterborough compared to 909 between the period May 2011 to April 2012,[22]
- Of these 978, there were 663 individual victims.

From December 2012 to December 2013 the Sexual Assault Referral Centre had received 184 referrals for clients living within Peterborough:

- 80 of which were domestic abuse
- 25 of the 80 were acute (within 7 days)
- 57 of the 80 were historic (older than 7 days)
- 2 victims reported acute and historic abuse
- 39 of the 80 received Independent Sexual Violence Advisor support and engaged
- 35 of the 80 received counselling
- 6 declined support

Of those adult alcohol clients who have family and relationships, it is estimated that around 40%[23] (both male and female) are possibly involved in domestic abuse. The Children and Families service encounters cases of alcohol fuelled abuse some of which have been witnessed in some way by the children. The link between domestic abuse and alcohol abuse is supported by a number of pieces of national research:

- Over ⅓ of domestic abuse is linked to alcohol[24]
- 22% of all children live with a parent who drinks hazardously and 6% of all children live with a dependent drinker[25]
- 60-80% of women receiving support for alcohol problems have suffered domestic abuse in the previous 6-12 months[26]

[20] Margin of error +/- 1,163
[21] Margin of error +/- 1,260
[22] Data from CADET
[23] Figure estimated by Drinksense staff
[24] Over the Limit, The truth about families and alcohol, 4children, 2012
[25] Over the Limit, The truth about families and alcohol, 4children, 2012
[26] Safeguarding children: working with parental alcohol problems and domestic abuse, Alcohol Concern, 2006

Domestic abuse is higher in families where there are also alcohol problems. This results in children being exposed to parental alcohol misuse and domestic abuse which significantly increases their risk of harm.

Child Protection –

The number of children looked after, on child protection plans or considered 'in need' is noted below, as taken from the Peterborough Children Services monthly performance report December 2014;

Number of Looked After Children: 372
Number of Children on Child Protection Plans: 228
Number of Children in Need: 1193

The below tables provide data on issues raised as a result of assessments undertaken by the team within Children's Social Care.

Figure 27: Issues raised on single assessments

Type	Sub-Type	Total DV,Drug or Physical/Mental Health of Parent issues raised
Alcohol	Alcohol misuse by parent/carer	227
	Alcohol misuse by another person living in the household.	27
	Alcohol misuse by the child	46
Drug	Drug misuse by the parent/carer	223
	Drug misuse by another person in the household.	62
	Drug misuse by the child	74
DV	Child's parent/carer is subject of DV	533
	Another person living in the household is the subject of DV.	78
	Child is subject of DV	184
Physical/Mental Health of Parent/carer	Concerns about a physical disability or illness of the parent/carer	74
	Concerns about the mental health of the parent/carer	337

Figure 28: Percentage of single assessments where issues have been raised

Type	Sub-Type	Total DV,Drug or Physical/Mental Health of Parent issues raised
Alcohol	Alcohol misuse by parent/carer	8%
	Alcohol misuse by another person living in the household.	1%
	Alcohol misuse by the child	2%
Drug	Drug misuse by the parent/carer	8%
	Drug misuse by another person in the household.	2%
	Drug misuse by the child	3%
DV	Child's parent/carer is subject of DV	19%
	Another person living in the household is the subject of DV.	3%
	Child is subject of DV	7%
Physical/Mental Health of Parent/carer	Concerns about a physical disability or illness of the parent/carer	3%
	Concerns about the mental health of the parent/carer	12%
	None of the above	68%

Figure 29 - Single assessments where either domestic violence, drug of physical/mental health of parent issues have been raised

Type	Total DV,Drug or Physical/Mental Health of Parent
Total DV,Drug or Physical/Mental Health of Parent	893
Total Single assessments	2803
% of single assessments which include one of the above	**32%**

14 Summary of Multiagency strategies and programmes for CYP

Many multi-agency strategies and programmes are already in place to meet the needs identified in this JSNA and they should be reviewed and updated in the light of the findings of the JSNA and evidence of effectiveness.

- Peterborough Health and Well-Being Strategy 2012-2015
- Child Poverty Strategy
- Healthy Child Programme
- Family Nurse Partnership Programme
- CCG Operating Plan
- Education/SEND strategy(s)
- Child Sexual Exploitation strategy

15 Conclusion

Peterborough is the UK's fastest growing city and population growth is predicted to be particularly high amongst children and young people and people over 65. Future commissioning decisions should acknowledge the increased pressure on services likely to arise from this substantial population increase.

Peterborough is a Unitary Authority with substantial disparities between wards; however, data show that in general terms children and young people are statistically disadvantaged compared to the East of England and England national averages across a range of socio-economic indicators, ranging from economic deprivation to education attainment.

Poor public health outcomes are noted to be of particular significance in the Ravensthorpe, East, North, Dogsthorpe and Central with high birth rates observed within the wards. Data show that there is clear correlation between deprivation, poor educational attainment and poor health throughout life. There is also correlation between poor educational attainment and subsequent high levels of long term unemployment in some wards and there is a need to raise levels of aspiration to break the 'cycle' of poor performance in school leading to poor economic outcomes in later life and the health-related issues that tend to be prevalent in this socio-economic group. Targeted responses would need to include.

- Housing
- Health provision, particularly primary care
- Education
- Community engagement and community asset building
- Early intervention and prevention

Peterborough's mental health profile for children & young people shows some variance from national averages, with trend data suggesting that alcohol related hospital admissions and numbers of children admitted to hospital as a result of self-harm are worse than the England average.

APPENDIX 2

Child Health Profile

March 2014

Peterborough

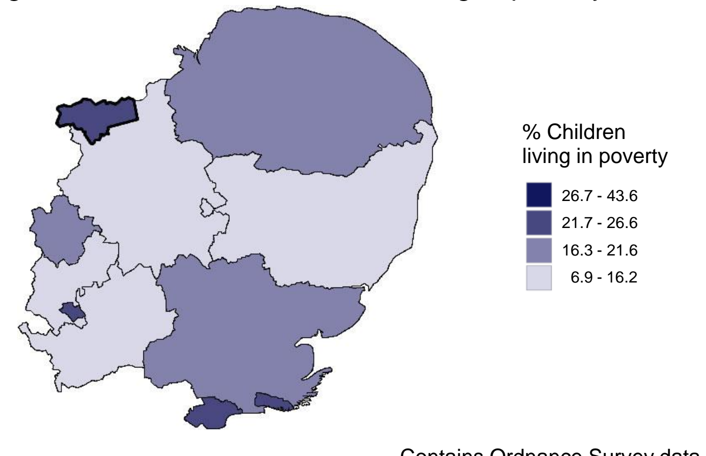
This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

	Local	East of England	England
Live births in 2012			
	3,270	74,571	694,241
Children (age 0 to 4 years), 2012			
	14,700 (7.9%)	370,700 (6.3%)	3,393,400 (6.3%)
Children (age 0 to 19 years), 2012			
	49,300 (26.5%)	1,406,000 (23.8%)	12,771,100 (23.9%)
Children (age 0 to 19 years) in 2020 (projected)			
	54,500 (26.5%)	1,519,300 (23.7%)	13,575,900 (23.7%)
School children from minority ethnic groups, 2013			
	11,454 (40.8%)	145,655 (19.7%)	1,740,820 (26.7%)
Children living in poverty (age under 16 years), 2011			
	23.6%	16.7%	20.6%
Life expectancy at birth, 2010-2012			
Boys	77.9	80.1	79.2
Girls	82.5	83.7	83.0

Children living in poverty

Map of the East of England, with Peterborough outlined, showing the relative levels of children living in poverty.



Contains Ordnance Survey data

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Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2011-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 26.5% of the population of Peterborough. 40.8% of school children are from a minority ethnic group.

The health and wellbeing of children in Peterborough is generally worse than the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 23.6% of children aged under 16 years living in poverty. The rate of family homelessness is worse than the England average.

9.8% of children aged 4-5 years and 21.1% of children aged 10-11 years are classified as obese.

There were 350 children in care at 31 March 2013, which is a higher rate than the England average. A higher percentage of children in care are up-to-date with their immunisations compared to the England average for this group of children.

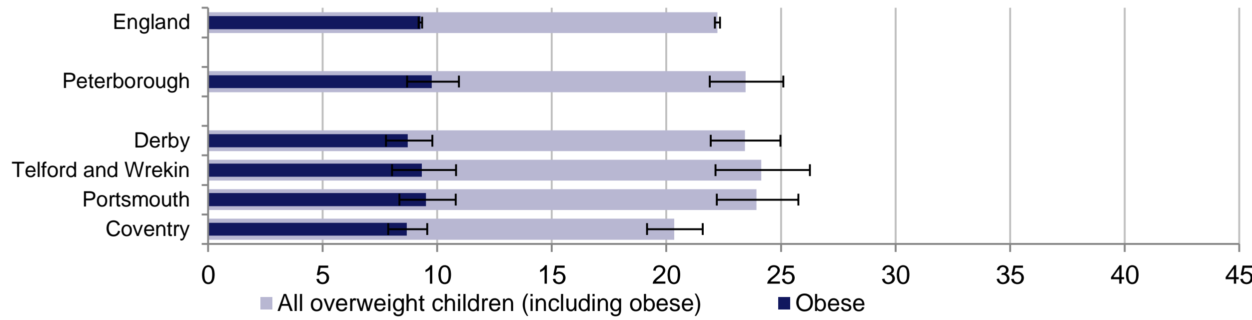
In 2011/12, there were 5,183 A&E attendances by children aged 4 years and under. This gives a rate which is lower than the England average. The hospital admission rate for injury in children is higher than the England average, and the admission rate for injury in young people is higher than the England average.

Any enquiries regarding this publication should be sent to info@chimat.org.uk.

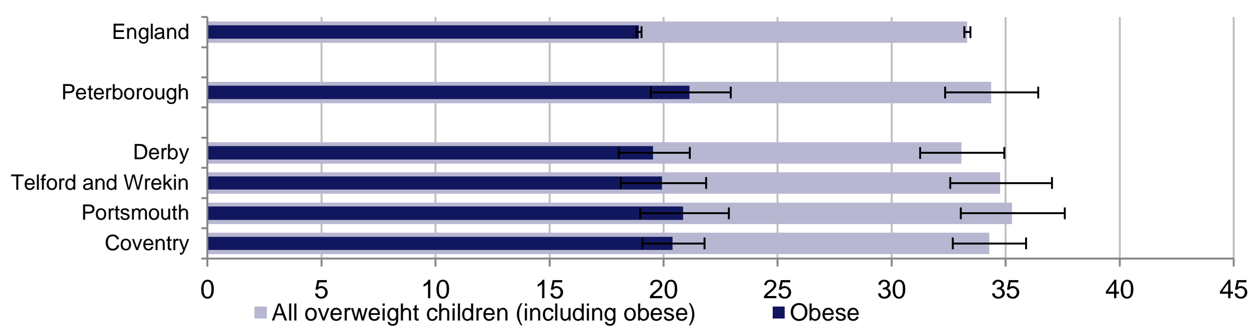
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared with their statistical neighbours. Compared with the England average, this area has a similar percentage in Reception and a similar percentage in Year 6 classified as obese or overweight.

Children aged 4-5 years classified as obese or overweight, 2012/13 (percentage)



Children aged 10-11 years classified as obese or overweight, 2012/13 (percentage)

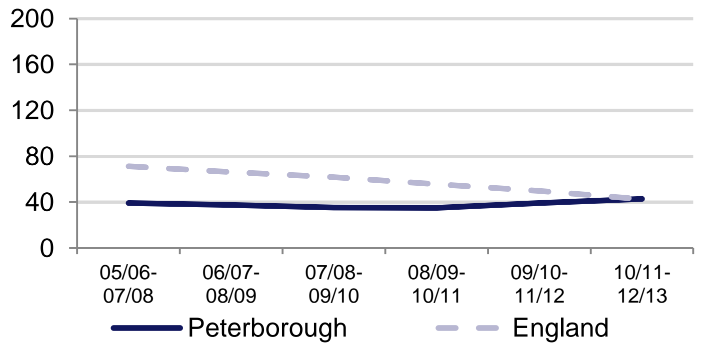


Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.
I indicates 95% confidence interval. Data source: National Child Measurement Programme (NCMP), Health and Social Care Information Centre

Young people and alcohol

In comparison with the 2005/06-2007/08 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is similar in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is similar to the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

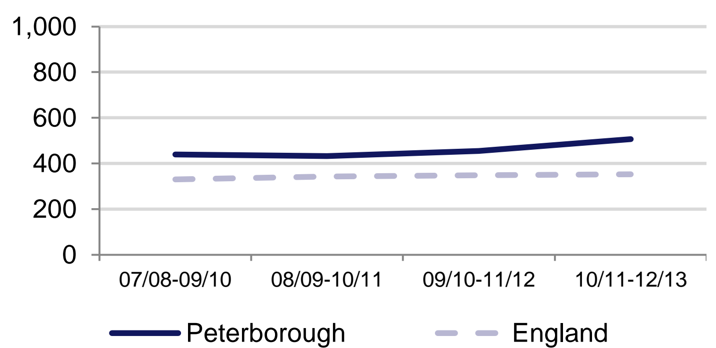


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)

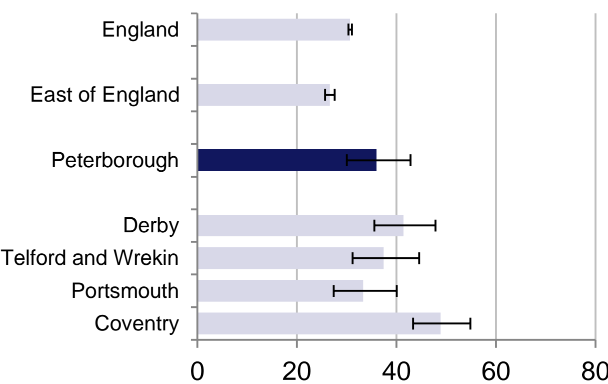


*Information about admissions in the single year 2012/13 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

These charts compare Peterborough with its statistical neighbours, the England and regional average and, where available, the European average.

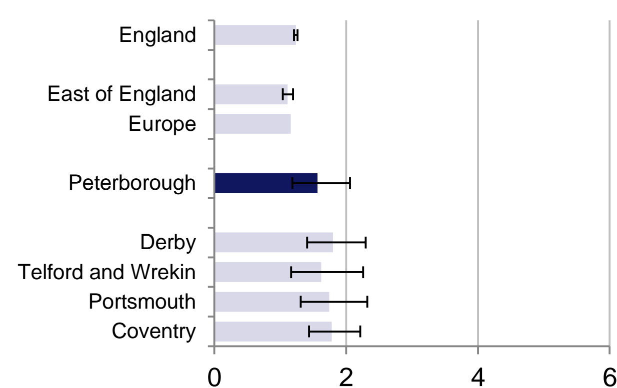
Teenage conceptions in girls aged under 18 years, 2011 (rate per 1,000 female population aged 15-17 years)



In 2011, approximately 36 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is higher than the regional average. The area has a similar teenage conception rate compared with the England average.

Data source: ONS

Teenage mothers aged under 18 years, 2012/13 (percentage of all deliveries)

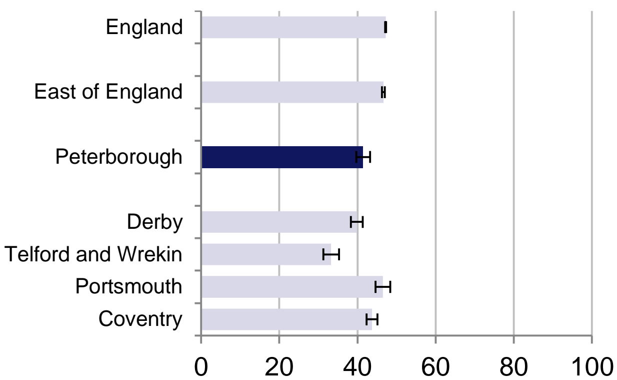


In 2012/13, 1.6% of women giving birth in this area were aged under 18 years. This is higher than the regional average. This area has a similar percentage of births to teenage girls compared with the England average and a higher percentage compared with the European average of 1.2%*.

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

* European Union 27 average, 2009. Source: Eurostat

Breastfeeding at 6 to 8 weeks, 2012/13 (percentage of infants due 6 to 8 week checks)

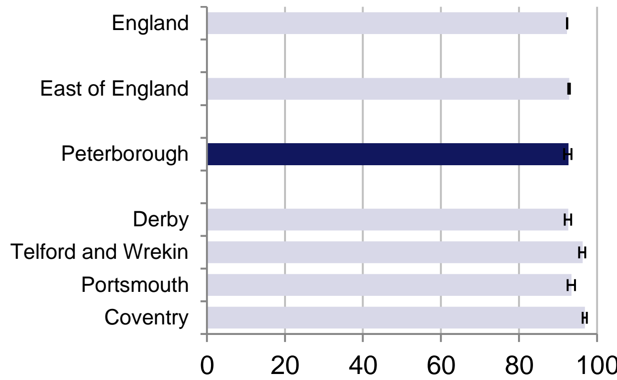


In this area, 41.4% of mothers are still breastfeeding at 6 to 8 weeks. This is lower than the England average. 73.6% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*.

* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Data source: PHE

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2012/13 (percentage of children age 2 years)



Compared with the England average, a similar percentage of children (92.6%) have received their first dose of immunisation by the age of two in this area. By the age of five, 88.2% of children have received their second dose of MMR immunisation. This is similar to the England average. In the East of England, there were 34 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Data sources: Health and Social Care Information Centre, PHE

Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

Peterborough Child Health Profile March 2014

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

25th percentile | England average | 75th percentile

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	**1** Infant mortality	13	4.2	4.3	7.7	1.3
	2 Child mortality rate (1-17 years)	8	18.2	12.5	21.7	4.0
Health protection	**3** MMR vaccination for one dose (2 years)	2,809	92.6	92.3	77.4	98.4
	4 Dtap / IPV / Hib vaccination (2 years)	2,933	96.7	96.3	81.9	99.4
	5 Children in care immunisations	225	93.8	83.2	0.0	100.0
	6 Acute sexually transmitted infections (including chlamydia)	848	36.1	34.4	89.1	14.1
Wider determinants of ill health	**7** Children achieving a good level of development at the end of reception	1,348	46.7	51.7	27.7	69.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	1,262	56.2	60.8	43.7	80.2
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	15.3	0.0	41.7
	10 16-18 year olds not in education, employment or training	510	7.4	5.8	10.5	2.0
	11 First time entrants to the youth justice system	106	571.2	537.0	1,426.6	150.7
	12 Children in poverty (under 16 years)	9,715	23.6	20.6	43.6	6.9
	13 Family homelessness	173	2.3	1.7	9.5	0.1
	14 Children in care	350	78	60	166	20
	15 Children killed or seriously injured in road traffic accidents	10	24.6	20.7	45.6	6.3
Health improvement	**16** Low birthweight of all babies	228	7.0	7.3	10.2	4.2
	17 Obese children (4-5 years)	260	9.8	9.3	14.8	5.7
	18 Obese children (10-11 years)	438	21.1	18.9	27.5	12.3
	19 Children with one or more decayed, missing or filled teeth	-	36.1	27.9	53.2	12.5
	20 Under 18 conceptions	127	36.0	30.7	58.1	9.4
	21 Teenage mothers	49	1.6	1.2	3.1	0.2
	22 Hospital admissions due to alcohol specific conditions	19	43.0	42.7	113.5	14.6
	23 Hospital admissions due to substance misuse (15-24 years)	22	91.4	75.2	218.4	25.4
Prevention of ill health	**24** Smoking status at time of delivery	553	18.0	12.7	30.8	2.3
	25 Breastfeeding initiation	2,261	73.6	73.9	40.8	94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	1,229	41.4	47.2	17.5	83.3
	27 A&E attendances (0-4 years)	5,183	369.1	510.8	1,861.3	214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	439	116.0	103.8	191.3	61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	415	176.8	130.7	277.3	63.8
	30 Hospital admissions for asthma (under 19 years)	165	348.7	221.4	591.9	63.4
	31 Hospital admissions for mental health conditions	35	77.8	87.6	434.8	28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	215	620.5	346.3	1,152.4	82.4

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2010-2012
2 Directly standardised rate per 100,000 children age 1-17 years, 2010-2012
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2012/13
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2012/13
5 % children in care with up-to-date immunisations, 2013
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2012
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2012/13
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2013 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2012
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2012
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2012/13
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2013
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2010-2012
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2012
17 % school children in Reception year classified as obese, 2012/13
18 % school children in Year 6 classified as obese, 2012/13
19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
20 Under 18 conception rate per 1,000 females age 15-17 years, 2011
21 % of delivery episodes where the mother is aged less than 18 years, 2012/13
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2010/11-2012/13
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2010/11-2012/13
24 % of mothers smoking at time of delivery, 2012/13
25 % of mothers initiating breastfeeding, 2012/13
26 % of mothers breastfeeding at 6-8 weeks, 2012/13
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2012/13
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2012/13
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2012/13
32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2012/13

Appendix 3 Public Health England Benchmarking – Children & Young People

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Healthy life expectancy at birth (Male)	2010 - 12	63.4	64.9	67.9	65.0	66.5	64.9	65.5	59.9	64.0	59.9	64.1	66.1	64.3
Healthy life expectancy at birth (Female)	2010 - 12	64.1	66.1	67.1	66.8	65.6	66.3	67.5	60.4	64.5	59.8	64.9	68.2	63.1
Life Expectancy at birth (Male)	2010 - 12	79.2	80.1	79.3	81.0	80.5	79.9	80.4	78.0	80.0	77.9	79.7	80.6	79.2
Life Expectancy at birth (Female)	2010 - 12	83.0	83.7	83.1	84.6	84.0	83.4	83.8	82.1	83.8	82.5	82.6	84.1	82.4
Children in poverty (all dependent children under 20)	2011	20.1	16.2	18.6	12.6	12.6	16.1	13.2	25.1	17.3	23.3	22.8	15.1	21.4
Children in poverty (under 16s)	2011	20.6	16.7	19.0	13.1	13.3	16.8	13.7	24.9	18.1	23.6	23.5	15.8	22.0
School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/13	51.7	51.8	47.8	50.8	49.1	52.5	61.2	47.1	45.6	46.7	44.9	49.0	53.0
School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	36.2	34.6	32.2	30.9	28.7	34.7	40.6	39.7	31.3	34.4	26.0	32.9	41.7
School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	69.1	67.3	70.1	70.2	68.4	67.2	71.0	64.1	61.3	59.9	63.6	67.9	71.0
School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/13	55.8	50.9	51.6	49.3	52.0	51.5	50.7	57.9	46.4	48.8	48.1	53.9	52.3
Pupil absence	2012/13	5.26	5.34	5.29	5.39	5.34	5.34	5.01	4.98	5.72	5.39	5.36	5.57	5.23
First time entrants to the youth justice system	2013	441	462	381	376	263	547	311	410	672	433	602	446	517
16-18 year olds not in education employment or training	2013	5.3	5.1	6.2	4.2	4.3	4.9	4.1	5.6	5.8	6.7	6.2	6.2	5.4
Low birth weight of term babies	2011	2.8	2.5	2.5	2.3	2.2	2.5	2.5	5.3	2.0	2.8	2.1	2.4	2.3
Breastfeeding - Breastfeeding initiation	2012/13	73.9	76.0	78.8	79.6	78.8	73.5	78.0	72.3	76.7	73.6	73.0	77.1	69.5
Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2012/13	47.2	46.6	46.4	53.6	46.4	43.4	51.4	56.0	*	41.4	36.7	45.6	36.1
Smoking status at time of delivery	2012/13	12.7	12.4	13.0	13.0	13.0	11.5	9.0	13.5	14.3	18.0	11.5	14.8	11.4
Under 18 conceptions	2012	27.7	23.2	28.9	16.8	26.7	23.9	17.4	29.3	23.9	36.0	30.4	24.8	30.5
Under 18 conceptions: conceptions in those aged under 16	2012	5.6	4.4	5.1	3.4	4.2	4.9	3.3	5.0	4.4	4.7	6.5	5.0	6.3

Appendix 3 Public Health England Benchmarking – Children & Young People

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2012/13	22.2	21.1	23.7	20.2	19.7	20.4	19.8	22.3	23.0	23.4	22.9	20.9	22.1
Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2012/13	33.3	31.0	34.5	29.0	28.5	30.8	28.8	37.3	32.1	34.0	32.0	30.5	35.6
Hospital admissions for accidental and deliberate injuries in children (aged 0-4)	2012/13	134.7	115.3	106.0	114.8	116.6	104.0	114.7	144.3	143.8	139.2	101.1	98.0	96.4
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	103.8	91.3	86.9	87.4	89.9	85.8	93.0	100.4	107.7	116.0	84.0	80.7	78.1
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	130.7	112.9	116.7	126.0	103.0	107.0	99.3	112.0	120.4	176.8	132.2	110.6	88.0
Emotional well-being of looked after children	2012/13	14.0	14.2	15.8	14.5	14.8	14.1	12.9	13.4	14.5	13.7	14.6	15.4	14.8
Chlamydia diagnoses (15-24 year olds) - Old NCSP data <2,000 2,000 to 2,400 ≥2,400	2011	2092	1741	2722	1803	1492	1563	1484	1815	1937	2009	2074	1937	1481
Chlamydia diagnoses (15-24 year olds) - CTAD (Male) <1,900 1,900 to 2,300 ≥2,300	2013	1387	-	2168	924	742	1305	1244	1298	940	1640	1502	965	1063
Chlamydia diagnoses (15-24 year olds) - CTAD (Female) <1,900 1,900 to 2,300 ≥2,300	2013	2634	-	3823	2169	1683	2173	2299	2320	1838	3370	3088	2135	1995
Chlamydia diagnoses (15-24 year olds) - CTAD (Persons) <1,900 1,900 to 2,300 ≥2,300	2013	2016	-	2993	1520	1190	1740	1901	1799	1387	2489	2299	1529	1529
Infant mortality	2010 - 12	4.1	3.8	5.7	3.8	3.4	3.8	2.9	5.2	4.3	4.2	3.8	3.9	2.5
Tooth decay in children aged 5	2011/12	0.94	0.75	0.83	0.51	0.50	0.57	0.69	1.64	0.96	1.08	0.65	0.54	*

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Risks Factors affecting Mental Health

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Children under 20 in poverty: % of all dependent children under 20	2011	20.1	16.2	18.6	12.6	12.6	16.1	13.2	25.1	17.3	23.3	22.8	15.1	21.4
Children under 16 in poverty: % of dependent children under 16	2011	20.6	16.7	19.0	13.1	13.3	16.8	13.7	24.9	18.1	23.6	23.5	15.8	22.0
Child Well-being Index: average score	2009	-	-	95.1	99.6	95.1	113.0	84.2	194.5	141.5	185.2	191.0	112.6	165.8
Underweight children (Reception year): % of children	2012/13	0.88	0.75	1.08	0.72	0.45	0.67	0.83	1.80	0.52	0.94	0.54	0.74	0.46
Underweight children (Year 6): % of children	2012/13	1.33	1.24	1.01	1.17	1.42	1.14	1.23	2.37	0.95	1.87	1.78	1.01	1.48
Obese children (Reception year): % of children	2012/13	9.3	8.1	10.2	7.5	6.6	7.9	7.2	10.9	8.8	9.8	8.1	7.8	9.6
Obese children (Year 6): % of children	2012/13	18.9	17.0	19.3	15.8	14.7	16.7	14.7	23.1	18.6	20.7	16.0	16.9	19.8
Under 18 pregnancy: rate of conceptions per 1,000 females aged 15 - 17	2012	27.7	23.2	28.9	16.8	26.7	23.9	17.4	29.3	23.9	36.0	30.4	24.8	30.5
Under 16 pregnancy: rate of conceptions per 1,000 females aged 13 - 15	2012	5.6	4.4	5.1	3.4	4.2	4.9	3.3	5.0	4.4	4.7	6.5	5.0	6.3
Children providing care: % children aged <15 who provide unpaid care	2011	1.11	1.08	1.08	1.09	1.04	1.05	1.00	1.06	1.21	1.01	1.19	1.13	1.02
Young people providing care: % people aged 16-24 who unpaid care	2011	4.8	4.4	4.9	3.9	4.3	4.4	4.3	5.6	4.3	5.2	4.6	4.3	4.4
Children providing considerable care: % children aged <15 who provide 20+ hours of unpaid care per week	2011	0.21	0.19	0.20	0.19	0.18	0.19	0.16	0.21	0.23	0.14	0.25	0.20	0.21
Young people providing considerable care: % people aged 16-24 who provide 20 hours + of unpaid care per week	2011	1.3	1.1	1.3	0.9	0.9	1.1	1.0	1.6	1.2	1.7	1.2	1.1	1.4
Traveller children: % school children who are Gypsy/Roma	2013/14	0.25	0.23	0.06	0.64	0.36	0.15	0.11	0.18	0.19	0.63	0.14	0.17	0.32
Unaccompanied Asylum Seeking Children looked after: count	2012/13	1860	130	*	10	10	40	35	*	*	*	*	*	20
Family homelessness: rate per 1,000 households	2012/13	1.7	1.7	2.8	1.7	1.1	1.6	1.9	5.7	0.9	2.3	1.1	1.4	1.3
Lone parents households: % of households that have lone parents with dependent children	2011	7.1	6.2	7.6	4.9	6.5	6.3	6.4	8.2	5.6	7.9	6.8	5.9	7.6
Families out of work: % of households with dependent children where no adult is in employment	2011	4.2	3.4	3.9	2.5	3.1	3.4	3.1	5.9	3.3	4.9	4.1	3.0	5.0
Families with health problems: % of households with dependent children where at least one person has a long term health problem or disability	2011	4.62	4.28	4.80	3.90	4.34	4.19	4.17	6.33	4.05	5.38	4.40	4.08	5.19
Domestic Abuse: incident rate per 1,000 population	2012/13	18.8	16.5	17.4	17.8	17.4	19.8	14.1	17.4	14.8	17.8	19.8	12.3	19.8
Parents in drug treatment: rate per 100,000 children 0 - 15	2011/12	110.4	86.3	139.2	84.2	88.4	72.3	70.5	100.4	94.0	129.8	165.7	60.2	174.4
Parents in alcohol treatment: rate per 100,000 children 0 - 15	2011/12	147.2	121.7	132.9	77.1	96.4	*	116.1	149.6	177.6	193.4	132.5	84.2	110.5

Estimated prevalence of mental health issues

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Estimated prevalence of any mental health disorder: % population aged 5-16	2013	9.6*	8.9*	9.2*	8.4*	8.5*	8.8*	8.2*	9.8*	9.4*	9.9*	9.2*	9.1*	9.6*
Estimated prevalence of emotional disorders: % population aged 5-16	2013	3.7*	3.4*	3.5*	3.3*	3.3*	3.4*	3.2*	3.7*	3.7*	3.8*	3.6*	3.5*	3.7*
Estimated prevalence of conduct disorders: % population aged 5-16	2013	5.8*	5.3*	5.5*	5.0*	5.0*	5.2*	4.8*	6.1*	5.7*	6.1*	5.5*	5.5*	5.8*
Estimated prevalence of hyperkinetic disorders: % population aged 5-16	2013	1.5*	1.4*	1.5*	1.3*	1.4*	1.4*	1.3*	1.7*	1.5*	1.7*	1.5*	1.5*	1.6*
Prevalence of potential eating disorders among young people: Estimated number of 16 - 24 year olds	2013	*	-	2339*	9669*	3374*	19237*	15548*	3460*	12110*	2709*	2324*	9524*	2269*
Prevalence of ADHD among young people: Estimated number of 16 - 24 year olds	2013	*	-	2490*	10336*	3606*	20424*	16373*	3670*	12763*	2869*	2458*	10229*	2384*
Children who require Tier 3 CAMHS: estimated number of children <17	2012	-	-	670	2390	1060	5490	4740	980	3070	835	700	2800	725
Children who require Tier 4 CAMHS: estimated number of children <17	2012	-	-	30	100	45	225	195	40	125	35	30	115	30

Hospital admissions related to mental health issues

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Child admissions for mental health: rate per 100,000 aged 0 -17 years	2012/13	87.6	77.5	63.7	82.9	94.5	78.5	56.3	87.0	98.3	77.8	119.6	70.7	64.1
Young people hospital admissions for self-harm: rate per 100,000 aged 10 - 24	2010/11 - 12/13	352.3	276.3	314.4	377.3	246.5	221.1	212.0	211.4	322.5	506.9	260.6	341.0	97.9
Child hospital admissions due to alcohol specific conditions: rate per 100,000 aged under 18	2010/11 - 12/13	42.7	26.8	31.6	31.3	21.8	27.7	19.7	23.6	31.9	43.0	27.7	27.8	14.7
Young people hospital admissions due to substance misuse: rate per 100,000 aged 15 - 24	2010/11 - 12/13	75.2	51.0	69.0	49.1	54.7	50.8	38.6	41.0	52.9	91.4	55.9	57.9	40.2
Child hospital admissions for unintentional and deliberate injuries: rate per 10,000 children 0-14	2012/13	103.8	91.3	86.9	87.4	89.9	85.8	93.0	100.4	107.7	116.0	84.0	80.7	78.1
Young people hospital admissions for unintentional and deliberate injuries: rate per 10,000 young people 15-24	2012/13	130.7	112.9	116.7	126.0	103.0	107.0	99.3	112.0	120.4	176.8	132.2	110.6	88.0

Social Care

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Children in need: Rate of children in need during the year, per 10,000 aged <18	2012/13	646	537	754	350	576	453	452	741	*	825	640	576	780
New cases of children in need: Rate of new cases identified during the year, per 10,000 aged <18	2012/13	346.6	287.7	402.4	190.9	337.2	205.5	255.4	359.4	*	493.7	241.9	364.5	431.6
Children in need due to abuse, neglect or family dysfunction: % of children in need	2012/13	65.3	67.0	69.3	78.1	69.2	66.6	59.7	62.5	*	83.7	74.3	64.9	68.8
Children in need for more than 2 years: % of children in need	2012/13	34.2	36.5	43.3	31.1	33.8	42.7	41.6	32.7	*	31.9	44.8	26.4	36.4
Children in need referrals: Rate of children in need referrals during the year, per 10,000 aged <18	2012/13	521	411	413	365	399	350	300	502	-	705	457	500	450
Assessment of children in need referrals: % of referrals with a completed initial assessment	2012/13	74.4	83.9	80.5	88.7	82.3	82.6	89.7	76.7	*	84.4	92.3	86.1	96.9
Looked after children: Rate per 10,000 <18 population	2012/13	60.0	50.0	69.0	36.0	43.0	42.0	41.0	73.0	65.0	78.0	62.0	48.0	68.0
Looked after children in foster placements: % of looked after children	2013	74.7	75.4	78.1	76.0	74.4	73.5	78.1	80.4	71.2	79.7	81.3	70.7	80.7
Looked after children in secure units, children's homes and hostels: % of looked after children	2013	8.8	9.4	10.9	12.7	12.6	7.6	8.6	2.8	15.9	5.1	10.2	8.2	*
Health assessments for looked after children: % who had an annual assessment	2012/13	86.3	78.6	82.6	87.9	87.0	85.6	86.0	55.2	56.0	93.2	86.5	77.8	88.9
Development assessments for young looked after children: % aged <5 whose development assessments were up-to-date	2012/13	80.2	65.3	100	100	100	*	100	75.0	81.8	90.0	0.0	91.7	0.0
Emotional well-being of looked after children: average score	2012/13	14.0	14.2	15.8	14.5	14.8	14.1	12.9	13.4	14.5	13.7	14.6	15.4	14.8
Emotional and behavioural health assessment of looked after children: % eligible children assessed	2013	71.0	75.0	82.0	73.0	100	65.0	84.0	69.0	91.0	86.0	61.0	54.0	99.0
Emotional and behavioural health outcome for looked after children: % eligible children considered 'of concern'	2012/13	38.0	39.0	53.0	39.0	44.0	40.0	32.0	34.0	39.0	35.0	43.0	45.0	41.0
Child protection cases: Rate of children who were the subject of a child protection plan at the end of the year (31 March)	2012/13	37.9	28.3	29.8	15.6	47.0	18.4	22.6	36.0	*	60.3	19.4	33.8	52.2
New child protection cases: Rate of children who became the subject of a child protection plan during the year, per 10,000 aged <18	2012/13	46.2	34.6	50.2	22.9	46.3	22.6	30.1	40.9	*	71.5	30.3	37.0	57.6
Repeat child protection cases: % of children who became subject of a child protection plan for a second or subsequent time	2012/13	14.9	16.1	15.0	17.2	20.2	15.4	16.0	20.3	*	14.7	13.2	13.9	21.4
Review of child protection cases: % of children under child protection who were reviewed within the required timescales	2012/13	96.2	98.3	100	100	100	98.5	99.5	100	*	98.3	100	100	91.3
Children leaving care: Rate per 10,000 <18 population	2012/13	24.9	20.8	30.5	12.8	16.6	20.2	18.9	28.4	24.7	30.0	23.9	18.2	28.2
First time entrants to the youth justice system: rate per 100,000 aged 10 - 17	2013	441	462	381	376	263	547	311	410	672	433	602	446	517
All entered to the youth justice system: rate per 1,000 aged 10 - 18	2011/12	11.0	11.1	8.3	11.3	8.3	11.2	10.5	12.7	13.2	14.6	8.2	10.3	9.8

Social Care Spend

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Spend (£000s) on Local Authority children and young people's services (excluding education): rate per 10,000 0-17	2012/13	7778	6711	8072	6854	6343	6425	6049	7694	7150	9414	7605	5813	8353
Spend (£000s) on Sure Start Children's Centres and early years: rate per 10,000 0-17	2012/13	1045	743	761	568	716	653	621	1255	954	0	656	515	3074
Spend (£000s) on Children looked after: rate per 10,000 0-17	2012/13	3060	2788	3310	2347	3026	2478	2325	2713	4177	5178	2891	2085	2865
Spend (£000s) on Safeguarding children and young people's services: rate per 10,000 0-17	2012/13	1721	1368	2115	2242	1225	1488	1216	1767	456	1789	2316	1210	639
Spend (£000s) on Youth justice: rate per 10,000 0-17	2012/13	281	135	379	162	114	69	52	325	76	285	417	209	173

Education

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
School Readiness: % of children achieving a good level of development at the end of reception	2012/13	51.7	51.8	47.8	50.8	49.1	52.5	61.2	47.1	45.6	46.7	44.9	49.0	53.0
Pupils with special educational needs (SEN): % of all school age pupils with special educational needs	2014	17.9	16.8	16.3	17.8	15.7	15.9	16.0	17.7	18.1	19.8	14.2	17.6	18.0
Pupils with a SEN statement: % of all school age pupils with a statement	2014	2.79	2.90	2.73	3.27	2.61	3.34	1.89	2.35	3.71	3.77	3.25	2.66	3.59
Pupils with SEN on School Action: % of all school age pupils on School Action	2014	8.7	8.0	9.5	8.8	8.8	6.9	7.9	9.2	8.0	10.2	6.3	8.1	8.3
Pupils with SEN on School Action Plus: % of all school age pupils on School Action Plus	2014	5.6	5.1	3.1	4.5	4.2	5.1	4.9	6.1	5.6	5.9	4.4	6.0	6.1
Pupils with Learning Disability: % of school pupils with Learning Disability	2014	2.87	2.99	1.85	2.66	2.21	3.94	2.02	3.31	3.10	4.07	3.88	2.87	3.99
Pupils with behavioural, emotional and social support needs: % of school pupils with behavioural, emotional and social support needs	2014	1.66	1.59	0.92	1.79	1.46	1.53	1.47	1.66	1.85	1.68	1.40	1.68	1.76
Pupils with speech, language or communication needs: % of school pupils with speech, language or communication needs	2014	1.67	1.36	0.87	1.13	0.96	1.22	1.41	1.26	1.95	1.08	0.90	1.62	1.59

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Pupils with speech, language or communication needs: % of school pupils with speech, language or communication needs	2014	1.67	1.36	0.87	1.13	0.96	1.22	1.41	1.26	1.95	1.08	0.90	1.62	1.59
Pupils with autism spectrum disorder: % of school pupils with autism spectrum disorder	2014	0.91	0.84	0.69	1.02	1.14	0.81	0.71	0.80	0.85	1.11	0.80	0.82	0.92
Free school meals: % uptake among all pupils	2014	16.3	12.4	12.8	10.5	9.7	11.8	9.2	19.5	14.6	18.7	14.6	13.2	15.6
Primary school pupil absence: % of half days missed	2012/13	4.68	4.75	4.82	4.87	4.75	4.68	4.52	4.56	4.96	4.83	4.78	5.01	4.79
Secondary school pupil absence: % of half days missed	2012/13	5.89	5.94	5.51	5.99	5.71	6.07	5.50	5.46	6.63	6.03	5.77	6.13	5.76
Primary school fixed period exclusions: % of pupils	2012/13	0.88	0.91	0.24	0.96	0.99	0.81	1.14	0.54	0.86	0.27	0.61	1.23	1.02
Secondary school fixed period exclusions: % of school pupils	2012/13	6.8	5.8	3.7	4.6	5.3	6.4	5.7	6.4	6.7	6.4	6.8	5.0	4.8
Fixed period exclusion due to persistent disruptive behaviour: % of school pupils	2012/13	0.85	0.77	0.38	0.48	0.94	0.90	0.68	0.38	1.03	0.77	0.74	0.73	0.89
Fixed period exclusion due to drugs/alcohol use: % of school pupils	2012/13	0.093	0.091	0.074	0.086	0.177	0.106	0.094	0.067	0.065	0.107	0.151	0.049	0.060
16-18 year olds not in education employment or training	2013	5.3	5.1	6.2	4.2	4.3	4.9	4.1	5.6	5.8	6.7	6.2	6.2	5.4
Planned spend (£000s) on special schools: spend per 100,000 pupils	2013/14	12415	-	2313	11484	8965	7518	11211	11781	9591	15380	10165	5359	11151
Planned spend (£000s) on pupil referral units: spend per 100,000 pupils	2013/14	2555	-	0	1893	985	2435	1071	1186	2320	4689	2075	1828	3458

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Appendix 5 Peterborough Children and Young Person's JSNA 2015

Policy context and recommendations

Dr Fay Haffenden, Consultant in Public Health 24 May 2015

1. Context

The Peterborough Children and Young People's JSNA analyses data relating to children and young people in Peterborough and describes a very fast growing city with a young and ethnically diverse population, significant levels of deprivation and concomitant poor health and educational outcomes. There are wards in the centre of the City with long-standing problems: poverty, over-crowding, poor attainment, poor health, unemployment and poor housing stock. Alcohol, drugs, sexually transmitted infections, teen pregnancies, smoking, low birth weight and infant mortality are also issues for Peterborough as are high levels of injuries, asthma, dental problems and hospital attendances and admissions. The life-course approach to analysis of the data shows that outcomes are poor throughout life, with events in early life affecting children as they grow to adulthood.

While this gives a clear picture of the needs of children, young people and families in Peterborough, there is limited analysis of effective interventions, locally and more widely, to meet the needs identified. Strategic priorities and the principles for commissioning effective services were identified in the Peterborough Health and Well-Being Strategy 2012-2015 but a review is now needed of their implementation and impact on the outcomes for children and young people.

Most of the needs identified are not new but the speed of population growth and the changing ethnic mix of the population together with shrinking public sector funding have intensified the challenges for Peterborough.

However there are also significant opportunities to make real improvements to outcomes for the children and young people of Peterborough and their families from the introduction of the Children and Families Act 2014 and the Health and Social Care Act 2014 and the commissioning of Health Visiting and Family Nurse Partnership Services moving to the Council in October 2015.

2. Effective interventions

2.1 Early intervention and prevention

There is very strong evidence[1,2] that reducing inequalities and focusing on early intervention and prevention both improves outcomes and saves money and these are priorities in the Peterborough HWB Strategy. The Graham Allen Reports provide analysis of the rational and

[1] Wanless reports 2002 and 2004 http://webarchive.nationalarchives.gov.uk/+/http:/www.hm-treasury.gov.uk/media/D/3/Wanless04_summary.pdf

[2] Fair Society, Healthy Lives: Marmot Review 2010 http://www.apho.org.uk/resource/item.aspx?RID=87440

cost-effectiveness of prevention and Early Intervention as well as evidence for specific programmes[3,4].

Graham Allen's *Early Interventions the Next Steps* shows examples of effective targeted and universal interventions:

Effective Intervention Examples by Age Fig 6.1: (Early Interventions the Next steps. Graham Allen Jan 2011 P69)

2.2 The Healthy Child Programme

In October 2015, the council will take over the commissioning of the Health Visiting Services and Family Nurse Partnership Programme. Health Visitors are the lead professionals for the Healthy Child Programme 0-5. The Healthy Child Programme (HCP) can provide a focus for early intervention and prevention activities helping to give all children the best possible start in life. With the recent increase in Health Visitor numbers, there is a real opportunity to strengthen the HCP and improve outcomes. Pregnancy to 2 is the most important period for brain development and this period is a key determinant of lifelong social, emotional, behavioural health and wellbeing, cognition, and communication. Strong positive attachment in first 2 years of life is crucial to long-term outcomes. The cover of Graham Allen's first report

[3] http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61012/earlyintervention-smartinvestment.pdf

shows graphically the extreme difference in brain development between a normal and an extremely neglected 3 year old.

The increase in numbers of health visitors can allow HVs have the time to assess the needs and strengths of all families and identify vulnerable families that may need additional support.

For the majority of families, universal services will meet their needs for most of the time, but identifying and meeting additional needs in a timely way can dramatically improve outcomes and reduce escalation of problems with resultant higher service usage and costs. Needs and strengths should be reassessed briefly at all universal mandated contacts enabling identification of families who need to be escalated to the 'Universal Plus' pathway with additional health service input or 'Universal Partnership Plus' with multi-agency interventions. The evidence base for the HCP has been regularly updated (2008, 2009 and in 2015 Rapid Review to Update Evidence for the Healthy Child Programme 0–5 Summary[5]).

For effective Early Intervention and Prevention programmes, the needs and strengths of the family should also be reassessed whenever a child's progress starts to falter, with the professionals working closely with the child and family in the context of their community and educational setting, enabling them to access early interventions and support promptly before problems escalate.

Working with the family the health visitor can insure the family have access to early interventions, preventative and health promoting activities as well as integrated services for the child and family problems such as poor mental health, domestic violence, debt management or drug and alcohol problems.

2.3 SEND Reforms

The approach of early intervention and prevention and working together with the family is at the heart of the Children and Families Act 2014 has resulted in far-reaching reforms for children and young people with Special Educational Needs and Disabilities (SEND).

The new Education Health Care Plans which replace Statements of Educational Need represent a major change. The EHC plan requires integration of education, health and social care provision and the plan is produced jointly between the professionals and the child, young person and family to meet the outcomes that matter to them, which might be making friends or being able to go on a school outing, rather than narrow academic achievements.

The Local Offer should provide comprehensive information to families of children with Special Educational Needs and Disabilities (SEND) about the services available in the local area and beyond and their access criteria; this should help enable families to be equal partners in the EHC planning process and enables them to feed back about service issues or gaps in services.

This outcomes focused, person centred, collaborative approach has the potential to save money by focusing on early interventions, and by reducing tribunals and out of county placements, enabling some of the saved money to be invested in providing better services

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[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409773/150305RapidReviewHealthyChildProg_FINAL_SUMMARY_5_MARCH_2015.pdf

locally. This same approach needs to be applied to the Assess, Plan, Do, Review process for those with SEND who do not meet the criteria for EHC plans but whose progress is faltering or who are not achieving.

The Health and Social Care Act 2012 also promotes a high degree of personalisation, well integrated services, and 'co-production': working together with parents and young people as equal partners and ensuring parents have the knowledge and skills they need to be equal partners

2.4 Vulnerable Families and Parenting programmes

There are some evidence-based parenting programmes for positive and resilient parenting available for vulnerable families but the issue is often ensuring that the parents that need them are identified and can access them. The Family Nurse Partnership (FNP) programme is a good example of an effective parenting programme for teen parents but evidence shows that programme fidelity is crucial for success. The commissioning of the FNP moves to the council in October 2015 along with Health Visiting.

The Troubled Families Programme is another programmes which focuses on outcomes for the whole family covering parental issues such Mental Health, Drugs and Alcohol, Domestic Violence with integrated service provision rather than service-specific interventions focusing on a single need.

2.5 Interventions to prevent obesity Birth - 6 years

There is good evidence also for obesity prevention, focusing on:

- Breastfeeding and appropriate advice for mothers who start formula-feeding
- Weaning- when (around 6 months), what (fruit and vegetables), how much (appropriate portion size)
- Role for Peer support, family workers and Health Visitors
- ↓ Sugar- sweetened beverages
- ↓ Unhealthy diets (nutrient-poor & energy-dense/junk food)
- ↑ Fruit & vegetable consumption
- ↑ Physical activity , ↓ screen time/TV viewing
- Role for – Parental modelling, Preschool settings

3.Extracts from the Peterborough Health and Well-Being Strategy 2012-2015

The Peterborough Health and Well-Being Strategy 2012-2015 provides the strategic priorities to meet the needs identified in the JSNA and the principles for commissioning effective services.

3.1 Strategic Priorities

i) Securing the foundations of good health

Ensure that children and young people, including those with complex needs and disabilities have the best opportunities in life to enable them to become healthy adults and make the best of their life chances

ii) Preventing and treating avoidable illness

Narrow the gap between those neighbourhoods and communities with the best and the worst health outcomes, whilst improving the health of all

iii)Healthier older people who maintain their independence for longer

iv) Supporting good mental health

Enable good child and adult mental health through effective, accessible mental health promotion and early intervention and rapid response services to impact upon early signs of mental ill health or deterioration

v) Better health and wellbeing outcomes for people with life-long disabilities and complex needs

Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs. This is through robust, integrated care pathways, care planning and commissioning arrangements from early years into adulthood and old age

The Health and Wellbeing Strategy 2012-15 will come to an end this year, and a new HWB Strategy, starting in 2016 needs to be agreed. The findings of this JSNA should be feed into the review of the current strategy and priorities for the future.

3.2 Commissioning principles

The JSNA findings are instructive in terms of where we need to make an impact on outcomes for the children and adults of Peterborough.

It suggests that we need to be commissioning services that are underpinned by the following principles. They will:

- Build on the many assets and resources that are available
- Enable early intervention and prevention through robust arrangements for identifying those with needs
- Address health inequalities and equity of access to and delivery of services in different neighbourhoods and communities
- Secure consistency in quality of care
- Tackle the underlying causes of ill health
- Demonstrate integrated health and social care service solutions
- Deliver discernible improvements to the agreed outcomes that will underpin the given priority area
- Make good use of existing strategic partnerships to address complex health and social care issues and use the authority of the Health and Wellbeing Board to enable and encourage partners to work together

4. Recommendations

Recommendation 1: The Board notes the changes and additional information and analysis incorporated into the JSNA.

Recommendation 2: The Board requests the Children & Families Joint Commissioning Board review effectiveness of existing strategies, interventions and provision in meeting the needs in the Children and Young People's JSNA and improving outcomes for the children and young people in the city.

Recommendation 3: The Board are asked to consider an engagement strategy to share initial JSNA findings and ensure partnership representation as appropriate on the further phases and deep dive work.

Recommendation 4: Selective and focused deep dive analysis could help to inform the use of our resources for the best achievable outcomes. The following deep dive work streams are proposed:

2a Deep dive analysis of the impact of drugs and alcohol on children and young people in the city, with a view to formulating a multi-agency young person's drugs and alcohol strategy – suggested lead organisation Safer Peterborough Partnership.

2b A recent survey received from the Office of the Children's Commissioner suggests consideration of a wider range of issues for potential inclusion in further phases of the JSNA. These should be reviewed.

2c Further analysis of the child poverty data should be undertaken to ascertain the numbers and proportions of all children living in poverty in each ward of the city; this will help to determine proportions affected by geographical targeting of a limited number of wards.

Recommendation 5: It is recommended that the JSNA links to the Safer Peterborough Plan as an understanding of the needs of Children and Young People in Peterborough is key to underpinning the delivery of priorities contained within the Children & Families Commissioning Board delivery plan.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8(b)
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Janet Dullaghan, Head of Commissioning Child Health and Wellbeing Wendi Ogle-Welbourn Director People and Communities	Tel: 01733 863730

HEALTHY CHILD PROGRAMME

R E C O M M E N D A T I O N S	
FROM : Wendi Ogle-Welbourn, Corporate Director People and Communities	**Deadline date :** N/A
The board is asked to: • Note current activity and performance in child health commissioning and delivery	

1. PURPOSE OF REPORT

1.1 The purpose of this report is to:

(a) Update on Healthy Child Programme (HCP).

(b) Update on Emotional Wellbeing and Mental Health (EWMH).

(c) Update on Joint Child Health Commissioning Unit

2. HEALTHY CHILD PROGRAMME

2.1 The HCP is the early intervention and prevention public health programme that lies at the heart of our universal service for children and families at the crucial stages of life. It not only supports all children within universal services but also supports children, young people and families who have special needs or disabilities, and is designed to ensure everyone can access information and services that are the most relevant, meaningful and helpful.

2.2 The HCP includes input from all partners working within universal services and includes midwives, health visitors, children's centres and early support services, GPs, schools and school nurses. The HCP offers every family a programme of screening tests, immunisations, developmental reviews and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

2.3 There is a multi-agency Healthy Children's Strategic Board that oversees and monitors progress of this programme and identifies key priorities and issues. This is chaired by the Head of Joint Commissioning Child Health.

3. KEY TARGETS WITHIN THE HCP BEING ACHIEVED

3.1 <u>**New Birth Checks**</u>
New birth checks have consistently been above the national target of 95% since April 2014. The latest figures are 97.2%.

3.2 **Proportion of mothers who are continuing to breastfeed at 6-8 weeks**

- The number of mothers still breastfeeding at six weeks is 45.1% against a national target of 45%. This target has been above 45% for the past four months.
- The Health Visiting Service has just passed the UNICEF assessment and will be retaining their level 3 baby friendly status. Representatives from UNICEF formally interviewed 20 health visitors and 34 mothers. They also visited three children's centres and two child health clinics where they spoke to mothers attending with their babies. The service scored 100% in several categories. The health visitors who were interviewed were described as knowledgeable, friendly and supportive of each other and the lead health visitor was described as exceptional in this area.

3.3 **2 ½ year checks completed**

- The 2 ½ year check is an important check for children to assess their development and identify issues. Height, weight, play and social interaction are part of this along with a comprehensive developmental assessment. The checks are currently at 93.4% against a target of 75%.
- A joint workshop was recently held to explore the possibility of delivering integrated 2 ½ year checks with health visitors and children's centres. This was very positive with a real desire to take this forward and develop a variety of approaches that will work across the city. Some health visitors are already looking where possible to go into settings to undertake the checks in partnership with the settings and parents.

3.4 **Child Care Settings - To ensure that children are accessing high quality child care settings and are supported to arrive in school ready to learn and socialise. The following areas are assessed:**

3.5 **% of pre-school setting rated good or above by Ofsted**

The last statistical data released detailing inspection outcomes of early years shows that 84% of pre-schools and nursery settings are rated good or above in Peterborough.
This now places Peterborough fourth out of 11 statistical neighbours and 1% above the national average of 84%.

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3.6 **Child-minders**

Over the past two years our performance compared to our statistical neighbours has improved. The latest statistical data released in November shows 79% of child-minders were rated good or above. This now places Peterborough fifth out of 11 statistical neighbours and 1% above the national average of 78%.

3.7 **Ensure that any early indications of additional needs among children are identified in a timely way**

On starting school, all children are offered the school entry health check which includes height and weight, hearing and vision testing and a handover from health visitors of any children they are still working with. Developmental assessments at age 4-5 years are completed by the school nursing service. 91.4% of children were seen against a target of 90%.

3.8 **National Childhood Measurement Programme**

- Every year, as part of the NCMP, children in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) have their height and weight measured during the school year to inform local planning and delivery of services for children; and gather population-level surveillance data to allow analysis of trends in growth patterns and obesity.
- The NCMP also helps to increase public and professional understanding of weight issues in children and is a useful vehicle for engaging with children and families about healthy lifestyles and weight issues.
- For 2012/13 excess weight in 4-5 year olds is 23.5% against a national average of 22.2%.
- Excess weight in 10-11 year olds is 34% against a national average of 33.3%.

- For 2013/14 excess weight in 4-5 year olds is 24.6% against a national average of 22.2% and excess weight in 10-11 year olds is 30.4% against a national average of 33.3%. The data for 2013/14 show a trend towards more underweight children in both reception and year 6, more overweight children in reception but a positive trend for year 6 children.

3.9 **Action**

While the local position is similar to the national position, there is a clear increase in excess weight between these two age groups that requires local action and therefore the initial next steps will be undertaken:

- Refresh the local NCMP Evaluation report.
- Refresh the Change 4 Life Strategy (potentially separating weight management and physical activity to replicate regional programmes).
- Establish Change 4 Life professional group (potentially separating weight management and physical activity to replicate regional programmes).
- Evaluate PH and partnership financial allocations, commissioned and delivered interventions.
- Establish Healthy Schools programme to incorporate healthy eating theme.

3.10 **Immunisations**

Generally the uptake for childhood immunisations in Peterborough is lower than East Anglia in all quarters 2013/14 and 2014/15 to date for all age cohorts and most immunisations. The target for childhood immunisation uptake is 95%.

Some of the reasons for this are:

- Some families choose not to have their child immunised.
- Some families may have difficulty accessing services for immunisation.
- Some children have been immunised but not according to the schedule in England, resulting in their immunisation not being recorded on the national system. This is a particular problem in Peterborough where there is a high, relatively transient population of related migrant workers and new immigrants whose children may have been fully immunised in their home country, but not recorded by the UK system.
- Some children have been immunised according to the schedule but the data has not been recorded or properly reported. A new electronic template is in development by CCG staff for Cambridgeshire and Peterborough GP practices to use to improve recording.

3.11 **Action**

A multi-agency Task and Finish group has been working on an action plan to find solutions to these issues and addresses the inequalities in uptake of childhood immunisations in inner city practices and deprived populations particularly with Prenatal Pertussis, Men C. and Preschool booster. It is planned to report initial findings and recommendations to the Health Public Committee in May 2015 and to the Health and Wellbeing Board. In Addition NHSE has given each LA £9k to support uptake awareness.

3.12 **HPV**

- The school based Human Papilloma Virus (HPV) has been very successful.
- This relatively recent programme of vaccination of girls aged 12–13 against HPV which is a causative factor in cervical cancer has been very successful with a 91.5% uptake against a national average for England of 86.1%.

3.13 **Developments**

- PCC is working closely with NHS England on the transfer of HVs and the Family Nurse Partnership programme (FNP) to ensure a smooth transfer of the commissioning of these services to PCC in September 2015. Service specification and KPIs have been agree that reflect the needs of Peterborough children and families.
- The Perinatal Mental Health pathway has been strengthened with an increase in CPN support and IAPT. Information on this pathway will be going out to all partners and GPs over the next month. This will also provide a named link for GPs.

3.14 **Children's Centres**

A review of the children's centre provision led this year to the development of four children's centre hubs, three outreach services and the dedesignation of eight of the children's centre facilities.

The changes were made in the context of changing government policy including:

- The increase in two year old funded places, supporting the most disadvantaged two year olds in Peterborough.
- The increase in the number of health visitors supporting families in Peterborough.
- Need to make 1 million savings.

The impact of the dedesignation of eight centres was mitigated through the following actions:

- The hubs were developed on the basis of need, being located within the most disadvantaged areas of Peterborough. The hubs were located in or near to areas where there were significant numbers of children living in the highest levels of deprivation. The location of the hubs were also planned to ensure that there was provision in all of the three localities across Peterborough.
- The hubs do service the full locality, although are targeted at families most in need of support. Were families are identified in need of particular support, outreach provision is provided outside of the immediate "reach" area, ensuring high need families can access support. Such families would be identified through the Locality Multi Agency Support Panels.
- The eight dedesignated centres, whilst not operating under the children's centre banner, continue to operate some early childhood services. These includes the expansion of childcare provision in some areas including Westwood and Ravensthorpe, Hampton and Stanground.
- Childcare provision, where already on site, continues to be delivered from the dedesignated facilities – East Rural, Caverstede, Westwood and Ravensthorpe, Hampton, Stanground and Werrington.
- Provision was made to continue to provide the local early year's health provision from the dedesignated centres, so health clinics, ante natal appointments, baby cafes and parentcraft continue to be delivered in the centres, ensuring universal local access.
- Parents in the communities were encouraged and supported to use the centres through parent led activities.

3.16 **Oral Health**

The oral health in five year old children in Peterborough is worse than the England average (27.9%), with 36.1% of this age group still experiencing tooth decay in 2012. Regional data demonstrate that the prevalence of dental decay in twelve year olds was 35.5% in Peterborough, higher than the national average of 33.4% in 2009. A well-recognised association exists between socioeconomic status and oral health, and research suggests that oral diseases are increasingly concentrated in the lower income and more excluded groups. Local and regional data certainly demonstrate that the higher the deprivation, the more decay the children are experiencing, and this is particularly evident in Peterborough. A task and finish group under NHS England has completed its work and advice and guidance will be provided to schools and children's centres and child care settings to support their work with parents.

4 EMOTIONAL WELLBEING AND MENTAL HEALTH

4.1 The Emotional Wellbeing and Mental Health Strategy Group has agreed the priorities for promoting and improving the emotional wellbeing and mental health for children and young people (C&YP). The multiagency group has adopted a broad definition of children's and adolescent mental health, recognising that having good mental health is everybody's business.

4.2 **The key priorities identified to be addressed over the next year are:**

4.3 **Involving children and young people in the development of services**

- Healthwatch have developed a short video with young people in Peterborough on emotional health and wellbeing to raise awareness and provide advice and guidance. This is available to all partners - contact Jennifer Hodges at jennifer@healthwatchpeterborough.co.uk who is happy to provide a copy of this for Peterborough.
- Healthwatch work with children and young people on key issues and are currently working on a video scribe on self-harm. They have also developed with CYP a mental health and wellbeing pack.
- CAMH work with children and young people on the development of information and involve them in training i.e. young people who have self-harmed in the past are involved with training A/E staff.

4.4 **Develop the workforce by having consistent training in universal settings**

- Training around recognising and supporting C&YP with emotional health issues within universal services, such as schools, has been developed over the past few months. Uptake from this is good with excellent feedback (Appendix 1).
- All school nurses have received training in self-harm.

4.5 **Clear multiagency pathways to tier 2 and tier 3 services**

- Work has been ongoing with all partners through the Emotional Wellbeing and Mental Health Strategy Group on a core pathway for help and support around EWMH and CAMH services. This work is currently out to consultation (Appendix 2).

4.6 **Waiting times for assessment and treatment will be reduced by introducing early identification and support to children with complex needs through the early support model**

4.7 **Early Support Delivery Model**

- Early Support is a way of working that aims to improve the delivery of services for disabled children, young people and their families. It enables services/professionals to coordinate their activity better, providing families with a single point of contact and continuity through key working.
- All those who work with young children should be alert to emerging difficulties and respond early. Early Support ensures that service delivery is child-, young person- and family-centered. It focuses on enabling services and practitioners to work in partnership with children, young people and their families, supporting the delivery and coordination of services for disabled children and their families.
- The Early Support Co-ordinator is the single access point for referrals where a child 0-5 is identified as having complex needs which will require additional support. They ensure a coordinated approach to all support services / interventions, providing signposting and information, acting as a central point for coordination and contact.
- This resource will be provided to children whose needs cannot be met by mainstream or universal services alone. A child who has complex needs may require considerable ongoing specialist support from across Education, Health and Social Care (Appendix 3).

4.8 **Early intervention and prevention by the development of a single point of access in Peterborough with clear pathways and good training and guidance on referral pathways**

- A single point of access for CAMH services in Peterborough has started with clear pathways and feedback on if referrals have been accepted is within three days the pathway and referral information will be sent to GP's and all partners by the end of February.

4.9 **Good perinatal Mental Health support pathway support**

- This work has been ongoing with good investment from the CCG. The pathway has now been agreed linking this to maternity and health visiting services.

4.10 **Children with Disabilities SEND reforms**

The SEND reforms support children, young people and families who are affected by special needs or disabilities, and are designed to ensure everyone can access information and services that are the most relevant, meaningful and helpful.

Over the past year all partners have been working with the Local Authority to identify their core offer for services and a joined up assessment process in developing health, education and social care plans for children who have additional needs. This not only encourages an integrated approach, but allows more choice around personalisation where children can be given a personal budget for some aspects of their care which can be used flexibly to meet their needs. There is also a duty on partners to jointly commission services together.

Outcomes to date

- Strategic group set up to oversee work streams.
- Local offer for SEND now on website.
- Work ongoing to develop individualised budgets and direct payments.
- Early support co-ordinators now employed to deliver the Education and healthcare pathway. (EHC plans).

4.11 **OT**

Had a waiting list of over 100 children a year ago with up to eight months wait for assessment. With service redesign and investment this is now down to eight children on the waiting list with an eight week wait and five days for emergencies.

4.12 **Enhance tier 2 services**

- Tier 2 support which is the 3 T's service to help and support young people 11+ with emotional health needs has been increased by 50k.

4.13 **Ensure there is a whole system integrated partnership approach that links to adult mental health services and suicide prevention pathways. Good transition pathway to adult services**

- A group looking at the transition pathway to adult services has being established. The first workshop identified an action plan that will be addressed and monitored through the 0-25 service redesign work stream.
- The Chair of the EWMH strategy group is a core member of the adult stakeholders group, suicide prevention group and part of the crisis concordat.

5. CAMH

5.1 One of the main challenges CAMH services are facing is the growing waiting list for referral to CAMH services. A deep dive exercise was completed.

5.2 **CAMHS Deep Dive exercise**

- A deep dive exercise carried out looked at the increase in referrals and the findings set out current CAMHS service efficiency improvements and made future proposals.
- It includes reference to the work that CAMHS are already doing to enhance capacity at tier 2, by training the children's workforce, providing supervision, supporting professionals in schools, delivering the CAMHS champions model and supporting the development of a Single Point of Contact function for referrals into EWB & MH services.
- CCG has agreed to invest £900k into CAMH services recurrently. This is in response to the increased demand and to address the current waiting lists.
- In addition, three CPNs are currently being recruited to help and support the EWMH of children in schools.

6. JOINT COMMISSIONING

6.1 Over the past year, Cambridge and Peterborough Clinical Commissioning Group (CCG) Peterborough City Council and Cambridgeshire County Coucil have worked towards developing a joint commissioning unit (JCU) under a Memorandum of Understanding. The vision is that through a shared commissioning function the Clinical Commissioning Group and the two Local Authorities can offer an integration of efforts by agencies working for children, young people and families. By developing integrated services and strengthening our commissioning we will achieve a better and more comprehensive analysis of need, a whole system approach to planning and investment, alignment of commissioning cycles and intentions and effective use of resources. The current work programme of priorities is being agreed.

6.2 **Implications**

- This will mean that we can better design pathways with early intervention solutions, increase efficiencies and prevent duplication.
- This approach to commissioning acknowledges the interdependencies between communities, service users, organisations and services and the focus will be on commissioning FOR outcomes rather than simple commissioning OF services.

7. LAC

7.1 The Children in Care Health Service in Peterborough is a nurse lead service provided by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). An external review of the service was commissioned by the CCG and found that the service provided by the Children in Care Health team within CPFT was of a very high standard and improved the health outcomes for children and young people coming into care in Peterborough. They felt that the process of the health assessments for children in care being carried out by the specialist team was the preferred option compared to other areas that use GPs and that this care pathway made a difference to the holistic assessment and ultimate outcome for the health needs of children and young people coming into care.

7.2 **Initial Health Assessments**

- All requests for Initial Health Assessments (IHAs) are triaged by the Team Leader for Children in Care. Part of this triage is to collect and collate any current health knowledge regarding the child or young person concerned. This information is requested from the GP, CAMHS and any other health team that is or has been involved with the young person.
- The designated doctor sees all children under 12 years old. Most young people aged 12 and over are seen by the Team Leader for their IHA, except where they have more complex health needs. Young people with more complex health needs are either assessed by the designated doctor or assessed jointly by the designated doctor and Team Leader.
- The Team Leader is experienced in assessing and delivering health promotion over a range of areas including smoking, internet safety, substance misuse, alcohol and sexual health and activity. The designated doctor is always available should more complex health issues arise during an IHA that is being completed by the Team Leader.
- All health assessments are holistic in nature and address physical, mental and emotional health.

7.3 **Formulation of Health Action Plans**

- Following the health assessment, a health action plan is formulated in conjunction with the child or young person and carer, if appropriate. This health action plan clearly identifies the child or young person's health needs and plan as to how these needs will be addressed. It also states who is responsible for following up the identified health need and gives a timeframe for the action to be completed.

7.4 **Review health assessments**

- This year all children and young people were offered an appointment for their review health assessment within the statutory timescales. All children under five years are

seen every six months for a review health assessment and children over five years are seen on an annual basis.

- Children and young people may be seen by the team for an interim review health assessment based on need. Social workers, carers and the young person themselves are able to request an interim assessment if they feel this is needed.
- Over the past two years there has been a steady increase in referrals to health for initial assessments.

	Jan	Feb	March	April	May	June	July	Aug	SEPT	Oct	Nov	Dec	Total
2012/2013	1	2	3	2	13	5	8	3	2	2	8	8	57
2013/2014	9	9	8	3	10	5	9	13	17	13	21	16	133

- This increase in demand led to the development of a waiting list, particularly in relation to assessments by the designated doctor. This caused the LA and CCG to jointly request CPFT to undertake a remedial action plan, which in turn resulted in the CCG funding an additional doctor's session until the end of the year.
- Weekly reporting has evidenced that this has had the desired impact with the waiting list cleared by December 2015. Monthly monitoring is in place.
- Work has started through the JCU to audit each of the LAC services in Peterborough and Cambridge against the new LAC guidance which will be completed by 1st May.

7.5 **Child Protection medicals**

7.5.1 The Child Protection Clinic that provides medicals is currently run by a Consultant Community Paediatrician and Specialist Safeguarding/CIC Nurse who are available for these medical examinations Monday, Wednesday and Friday in the afternoons. There are three clinic slots offered at 2.00pm, 3.00pm and 4.00pm. Since December 2014 the sexual abuse examinations were also decommissioned as the staff in CPFT did not fulfil the required competencies as outlined by the RCPCH/FFLM guidance and all cases of sexual abuse whether acute or chronic are now referred and seen at the SARC in PETERBOROUGH by Paediatric FMEs. Therefore the CP clinic provided by CPFT will just see neglect, emotional abuse and physical abuse (excluding pre mobile babies which are all seen at Peterborough City Hospital in accordance to LSCB protocol).

7.5.2 When a child protection medical examination might be needed outside these clinic hours, the Social Worker can discuss with the Paediatric Consultant on call at the Peterborough City Hospital and the child will be seen on the Jungle Assessment Unit for a child protection medical.

7.5.3 The JCU are working towards a single point of referral as well as access to a daily service in Peterborough. This work is part of the whole review of commissioning children's services.

7.6 **Speech and Language Therapy (SLT) – Demand and Capacity Issue**

Recent monthly Contract Performance meetings with the CCG and Local Authorities have consistently highlighted the increased pressure within the CPFT SLT service. As a result, a Contract Activity Notice was raised and representatives from CPFT have met with CCG representatives. A paper which outlines the reasons for the increase in demand and considers possible solutions to ensure a clinically safe and high quality service is currently being considered and work ongoing to look at a joint commissioning model for SLT.

8. BACKGROUND DOCUMENTS

- CAMH Health Needs Assessment

- JSNA Performance and Delivery plan
- Cambridge and Peterborough's Emotional Wellbeing and Mental Health Strategy 2014

Janet Dullaghan 15/04/2015

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 9(a)
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Angela Burrows, Chief Operating Officer, Healthwatch Peterborough	Tel. 01733 887926

CHILDREN / YOUNG PEOPLE ENGAGEMENT

R E C O M M E N D A T I O N S	
FROM : Healthwatch Peterborough	**Deadline date :** N/A
1. For the committee to be aware of strategy and activity on the subject on engagement with children/young people in Peterborough area.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing at the request of the Corporate Director for People and Communities.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

- Provide information to the committee on the ongoing and development of engagement with children/young people in Peterborough by Healthwatch Peterborough.
- To provide the committee an opportunity to comment/recommendations and/or request further information on this or subsequent activity of their local commissioned Healthwatch.
- For the committee to have an understanding of the focussed engagement work carried out by their local Healthwatch.
- For the committee to have an understanding of the partnership working carried out by their local Healthwatch.

2.2 This report is for Board to consider under its Terms of Reference No. 3.8.

3. PRESENTATION

3.1 The Board will be provided with a presentation, '**Engagement with children and young people, creating ... *an informed generation!***'

3.2 A hand-out of this presentation will be available on the day of the meeting.

4. CONSULTATION

4.1 N/A

5. ANTICIPATED OUTCOMES

5.1 For the committee to be aware of the engagement and strategy of their local Healthwatch.

5.2 For the committee to provide input/feedback to enrich the work of Healthwatch Peterborough.

5.3 For the committee to take into account the activities of Healthwatch Peterborough in future processes/projects.

5.4 For the committee to approve and uphold the vision and strategy of their local Healthwatch.

6. REASONS FOR RECOMMENDATIONS

6.1 N/A

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 N/A

8. IMPLICATIONS

8.1 N/A

9. BACKGROUND DOCUMENTS

9.1 None.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 10
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Dr Liz Robin, Director of Public Health	Tel. 01733 207175

HEALTH AND WELLBEING STRATEGY

RECOMMENDATIONS	
FROM : Dr Liz Robin, Director of Public Health	**Deadline date:** N/A

Main recommendation

- Update the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) to ensure they reflect current needs and strategic priorities in Peterborough:

Detailed recommendations

- Agree new JSNA core dataset (Appendix 1) and comment on further core content required (to be updated annually)
- Agree 2015/16 JSNA forward programme (Appendix 2)
- Carry out a comprehensive review of the JHWS 2012-15 (Appendix 3) including consultation with stakeholders and the public, and deliver a new JHWS 2016-20 by the end of this year.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board due to the need to update the Joint Health and Wellbeing Strategy (JHWS) 2012-15 which expires at the end of this year.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to seek the agreement of the Health and Wellbeing Board to update the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) and to approve the process for doing this.

2.2 This report is for the Board to consider under its terms of reference 2.3 'To influence commissioning strategies based on the evidence of the Joint Strategic Needs Assessment'.

3. BACKGROUND AND SUMMARY

3.1 Health and wellbeing boards have a series of statutory responsibilities, which are set out in the Health and Social Care Act 2012. The King's Fund (2012) summarised these core roles or functions as:

- To assess the needs of the local population by preparing a Joint Strategic Needs Assessment (JSNA), which is an analysis of the changing health and care needs and assets of the area

- To produce a local joint health and wellbeing strategy (JHWS) as the overarching framework within which commissioning plans are developed for health services, social care, public health and other services which the board agrees are relevant
- To promote and provide advice, assistance and support for greater integration and partnership between health and social care services; including joint commissioning, integrated provision, and pooled budgets, where appropriate (as outlined Section 75 of National Health Service Act 2006)
- Health and wellbeing boards should respond to draft CCG commissioning plans and can refer these plans back to CCGs or NHS England if they feel they do not sufficiently take account of the local JHWS.

3.2 Under the Health and Social Care Act (2012) the JHWS is required to meet the needs outlined in the JSNA. Peterborough shadow Health and Wellbeing Board published its JSNA in 2011, and the needs in the JSNA were used as the basis for the JHWS 2012-15.

3.4 The information in the Peterborough JSNA (2011) requires updating. In January 2014, the Health and Wellbeing Board agreed to update the JSNA on a thematic basis – taking one theme at a time. The first of these in depth thematic updates, a JSNA on the needs of children and young people, is being brought to the HWB Board today for approval, as a separate item.

3.5 It will take a long time to produce in depth updates for all themes in the JSNA, so it is proposed that a new 'high level' core JSNA dataset is adopted (Appendix 1), which will be updated on an annual basis. This means that Peterborough will have a core of up to date and relevant JSNA information available at all times for stakeholders and the public. A timetable for further JSNA thematic updates, which have already been identified as priorities by the HWB Board, is included at Appendix 2.

3.6 It is proposed that the process to update the JHWS, which expires at the end of 2015 is started now and that a draft JHWS 2016-2020 is brought to the HWB Board in September 2015. This would allow for full stakeholder and public consultation on the draft JHWS, before its adoption in December 2015.

4.0 RECOMMENDATIONS

4.1 It is recommended that the Health and Wellbeing Board agrees to:

- Update the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) to ensure they reflect current needs and strategic priorities in Peterborough

- Approve the new JSNA core dataset (Appendix 1) and comment on any further core content required, which will be updated annually.

- Approve the 2015/16 JSNA forward programme (Appendix 2)

- Carry out a comprehensive review of the JHWS 2012-15 (Appendix 3) including consultation with stakeholders and the public, and deliver a new JHWS 2016-20 by the end of this year.

5. CONSULTATION

5.1 It is proposed that the draft JHWS 2016-20 is brought to the September meeting of the Health and Wellbeing Board, and is fully consulted on with stakeholders and the public before adoption in December 2015. .

6. ANTICIPATED OUTCOMES

6.1 That an updated JSNA and JHWS will support organisations in Peterborough to work effectively in partnership and influence the wider health system.

7. REASONS FOR RECOMMENDATIONS

7.1 To deliver a robust process to review and update the Peterborough JHWS, based on up to date JSNA information on the health and wellbeing needs of local residents.

8. BACKGROUND DOCUMENTS

Local Government Association (2014). 'A councillor's guide to the health system in England'. LGA website. Available at:
http://www.local.gov.uk/documents/10180/5854661/A+councillor's+guide+to+the+health+system+in+England/430cde9f-567f-4e29-a48b-1c449961e31f

9. APPENDICES

- Draft core JSNA Dataset (2015)
- JSNA work programme (2014/16)
- Peterborough Health and Wellbeing Strategy 2012-15

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Joint Strategic Needs Assessment Core Dataset Overview 2015

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Executive summary

Demography

Peterborough has a young population with a higher than average number of children and young people. It is also one of the fastest growing cities in the UK, with predicted population growth of 34.9% between the 21 years spanning 2010-2031. The city is ethnically diverse, with 29.1% of residents not self-identifying as White English/Welsh/Scottish/Northern Irish/British. The next most common ethnicities declared in the 2011 census were Asian/Asian British: Pakistani or British Pakistani (6.6%), White Polish (3.1%) and Asian/Asian British: Indian or British Indian (2.5%).

In 2014, economic migration was most common from Poland (1,100 migrant national insurance registrations), Republic of Lithuania (974), Portugal (504), Romania (427) and Latvia (397). There are socio-economic inequalities within the local authority area, with areas of significant deprivation close to central Peterborough.

Children's health

Peterborough has a higher number of children than the national average living in poverty (27.2%) and a high level of diversity among the child population. The level of school readiness is at the national average and is better than average for children entitled to free school meals. However levels of educational attainment at GCSE vary significantly between electoral wards and poor attainment is closely associated with socio-economic deprivation. Childhood obesity is higher than the national average at 'reception' age, but lower than average amongst 10-11 year olds, although the proportion of underweight children is high at this age. The proportion of teenagers not in employment, education or training is higher than average, as are the numbers of teenage pregnancies. Hospital admissions for self-harm amongst children and young people, and admissions for injury amongst 15-24 year olds are also higher than average.

Adult health

A feature of adult health in Peterborough is a relatively high rate of premature death and disability, with life expectancy and healthy life expectancy being below national averages. Premature deaths from cardiovascular disease including in particular coronary heart disease, and from respiratory disease are higher than average – and these high rates of cardiovascular disease are focussed in electoral wards with the highest levels of socio-economic deprivation. Rates of premature death from cancer and liver disease are similar to the national average. Standardised hospital admission rates follow the pattern of premature mortality, with high admission rates for cardiovascular disease (and for all causes) from the more deprived wards.

There are lifestyle and health behaviour issues with longer term implications for public health – adult smoking rates are above the national average at 21%, hospital admissions specific to alcohol use are higher than average, and about two thirds of adults are overweight or obese (similar to the national average). It is known that smoking, excess alcohol and obesity all cause

long term medical conditions which require treatment and that high prevalence of these behaviours will result in additional demand on health and social care services.

Suicide rates in Peterborough are currently similar to the national average, but admissions to hospital for mental health causes are higher than average. The predicted increase in the number of older people in the population means that the numbers of people with dementia in Peterborough, as well as older people suffering from depression is forecast to increase significantly over the next ten years, which will increase demand on health and social care services. .

1. Introduction -

This report provides an overview of data that comprises the Peterborough 'Joint Strategic Needs Assessment (JSNA) Dataset'; key data maintained and updated by Public Health Intelligence relating to the demography of our population and incorporating general health and lifestyle factors that allow us to build a holistic picture of the health needs of our population. This dataset is used by strategic partners and commissioners as part of the evidence on which to base future strategic commissioning decisions and allocation of resource with a view to improving health outcomes in Peterborough Unitary Authority (UA) and reducing health inequalities.

Our Health & Wellbeing Strategy 2012-15 includes the below five priorities to improve the health and wellbeing of everyone in Peterborough:

- Ensure that children and young people have the best opportunities in life to enable them to become healthy adults and make the best of their life chances.
- Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes.
- Enable older people to stay independent and safe and to enjoy the best possible quality of life.
- Enable good child and adult mental health through effective, accessible health promotion and early intervention services.
- Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs.

The work undertaken by Public Health Intelligence for this dataset focuses on residents of all ages and on both physical and mental health. We know Peterborough to be one of the fastest growing cities in the UK and that, in general terms, our local health profile is worse than that of England overall; the effective use of data helps us to identify areas where we can improve both service experience and outcome for our residents and ensure our provision is adequate to meet the needs of our growing and changing population.

Data within this document provide an overview of our current and predicted demographics, specific areas of health within which we know Peterborough's population currently experiences worse outcomes than nationally (such as overall life expectancy and mortality from cardiovascular disease), a focus on mental health and an analysis of key related determinants of public health ranging from alcohol/tobacco consumption to education attainment and employment rates. This analysis forms part of our on-going strategy to use data to support evidence-based, pragmatic improvement in healthcare and related commissioning to make tangible improvements to the health and wellbeing of the residents of Peterborough.

Much of the data within this summary is updated regularly by Public Health England. The latest nationally available information is available via the below sources:

- Public Health Outcomes Framework: http://www.phoutcomes.info/
- Public Health England – Local Health Profiles: http://www.localhealth.org/
- Public Health England – National Public Health Profiles: http://fingertips.phe.org.uk/

2. Demographics –

2.1 Age structure

Peterborough is a young city with a higher proportion of children and young people and a slightly lower proportion of older people when compared with the national average

Figure 1: ONS Population Estimates 2012[1]

Area Name	ONS Population Estimate - All (2012)	ONS Population Estimate - % Under 16 (2012)	ONS Population Estimate - % 16-24 (2012)	ONS Population Estimate - % 25-64 (2012)	ONS Population Estimate - % 65+ (2012)	ONS Population Estimate - % 85+ (2012)
Barnack	2,936	19.0	7.6	7.6	23.4	2.6
Eye and Thorney	6,222	19.1	9.7	9.7	18.3	1.8
Glinton and Wittering	7,332	20.6	11.7	11.7	13.2	1.4
Newborough	2,873	18.0	10.0	10.0	16.7	1.8
Northborough	2,697	16.2	8.6	8.6	24.7	2.3
Bretton North	9,418	22.9	11.1	11.1	12.6	1.1
Bretton South	3,052	20.7	11.4	11.4	14.4	1.3
Central	12,318	25.3	15.7	15.7	7.9	1.3
Dogsthorpe	9,751	22.8	12.9	12.9	14.2	2.2
East	11,436	23.5	11.3	11.3	12.0	2.1
Fletton and Woodston	11,660	20.8	10.7	10.7	9.2	1.1
North	6,238	22.8	10.6	10.6	15.6	2.3
Orton Longueville	10,092	23.3	11.0	11.0	12.4	1.3
Orton Waterville	8,242	17.1	9.9	9.9	18.7	2.5
Orton with Hampton	14,225	27.2	11.2	11.2	6.7	1.1
Park	10,688	23.9	13.1	13.1	11.5	2.7
Paston	8,599	23.4	11.1	11.1	11.1	1.2
Ravensthorpe	8,138	24.4	13.3	13.3	9.9	1.1
Stanground Central	9,150	16.9	10.8	10.8	18.6	2.3
Stanground East	3,050	20.3	10.4	10.4	17.5	1.7
Walton	5,624	18.9	10.7	10.7	16.2	2.0
Werrington North	7,670	19.3	11.8	11.8	11.7	1.5
Werrington South	6,369	13.2	7.9	7.9	30.5	3.5
West	8,592	18.3	10.0	10.0	22.3	3.5
Peterborough UA	**186,372**	**21.6**	**11.3**	**53.2**	**13.9**	**1.8**
England	**53,493,729**	**18.9**	**11.7**	**52.4**	**16.9**	**2.3**

[1] http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/mid-2012/mid-2012-population-estimates-for-england-and-wales.html

2.2 Population Growth

Peterborough was listed by the 2015 Centres for Cities report 'Cities Outlook 2015[2]' as the second-fastest growing city in the UK (behind only Milton Keynes) and this presents unique opportunities and challenges for us as a Unitary Authority, particularly considering the number of children, young people and people over the age of 65 within the city is expected to grow substantially over the next few years.

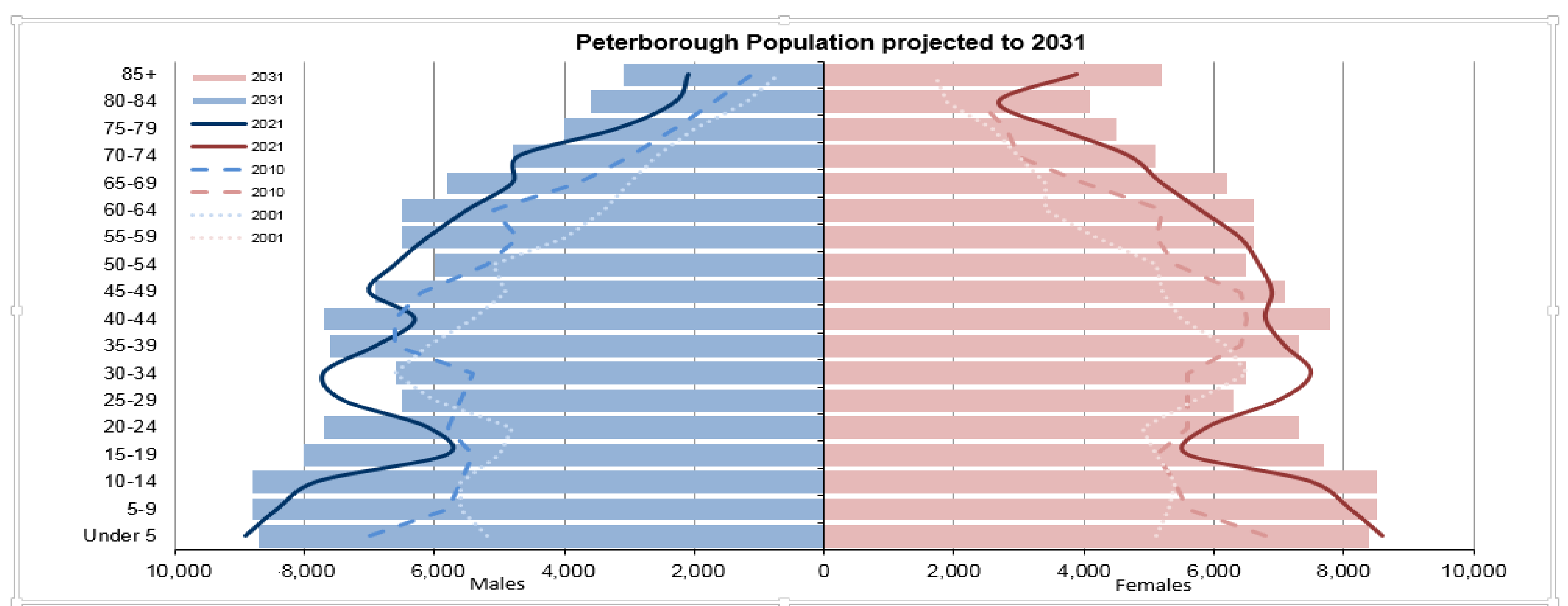
Research undertaken by the Cambridgeshire County Council Research Group takes in to account the city's ambitious plans for growth over coming decades and subsequently revised growth predictions upwards compared to Office for National Statistics projections based on the Council's current policy and planning decisions. The revised predictions are presented in the table below and show an overall predicted population growth between 2010 and 2031 of 34.9% rather than the 20.5% predicted by the ONS. Population growth is predicted to be particularly high with regards to under 19s and people over the age of 65.

Figure 2 - Peterborough predicted growth rate 2001 - 2031[3]

Age Range	2001	2010	2021	2031
Under 5	10,300	13,800	17,500	17,100
5-9	10,900	11,400	16,500	17,300
10-14	11,000	11,000	15,300	17,300
15-19	10,100	10,500	11,400	15,700
20-24	9,700	11,400	12,000	15,000
25-29	11,700	11,200	14,400	12,800
30-34	13,100	11,000	15,200	13,100
35-39	12,300	13,000	14,000	14,900
40-44	10,900	13,100	13,100	15,500
45-49	10,100	12,600	13,900	14,000
50-54	10,200	10,600	13,300	12,500
55-59	8,200	9,800	12,500	13,100
60-64	6,800	10,300	11,300	13,100
65-69	6,400	7,800	10,000	12,000
70-74	5,600	6,000	9,400	9,900
75-79	4,600	5,100	6,800	8,500
80-84	3,100	4,100	5,000	7,700
85+	2,400	3,600	6,000	8,300
Total	**157,400**	**176,300**	**217,600**	**237,800**
% Increase	**-**	**12.0%**	**23.4%**	**9.3%**

[2] http://www.centreforcities.org/reader/cities-outlook-2015/
[3] Data sourced by Peterborough City Council from Cambridgeshire County Council Research Group http://www.cambridgeshire.gov.uk/info/20132/research_and_statistics/511/our_services

Figure 3 - Peterborough population prediction 2001-2031



Data from the Cambridgeshire County Council Research Group showed Peterborough to have a population of 176,300 in 2010; this figure is predicted to rise to 23.4% to 217,600 by 2021 and then a further 9.3% to 237,800 by 2031. Population growth to 2021 is expected to be particularly high for males in the 85+, 70-74 and 5-9 age groups, with increases of 90.9%, 56.7% and 44.8% respectively. For females, the highest growth predictions are for the 70-74, 85+ and 5-9 age groups, with predicted rises of 56.7%, 56.0% and 44.6% respectively.

2.3 Ethnicity

Peterborough has a diverse population, bringing together many different cultures in the City. Data from the 2011 Census show Peterborough 70.9% of residents self-identified as White English/Welsh/Scottish/Northern Irish/British, with the next most common ethnicities being Asian/Asian British: Pakistani or British Pakistani (6.6%), White Polish (3.1%) and Asian/Asian British: Indian or British Indian (2.5%).

Figure 4: 2011 Census – Peterborough Ethnicities (Ethnicities Comprising Below 0.5% of Population Removed)[4]

Electoral Ward	All categories: Ethnic group)	White: English/Welsh/Scottish/Northern Irish/British	Asian/Asian British: Pakistani or British Pakistani	White: Polish	Asian/Asian British: Indian or British Indian	White: Baltic States	White: European Mixed	Black/African/Caribbean/Black British: African	White: Any other ethnic group	Mixed/multiple ethnic group: White and Black Caribbean	White: Other Western European	Mixed/multiple ethnic group: White and Asian	White: Other Eastern European	White: Italian	White: Irish	Black/African/Caribbean/Black British: Caribbean	Asian/Asian British: Chinese	Mixed/multiple ethnic group: White and Black African
Barnack	2,876	2,727	5	2	19	3	8	0	4	20	18	11	4	0	13	7	0	2
Bretton North	9,374	7,168	162	278	257	150	243	154	113	114	72	60	43	13	73	77	33	58
Bretton South	3,071	2,356	39	71	133	25	61	80	12	28	18	20	8	15	23	30	11	14
Central	12,013	2,073	4,629	635	348	844	442	211	207	53	211	203	315	94	53	55	61	86
Dogsthorpe	9,620	6,556	471	338	278	284	207	131	97	75	125	116	58	24	59	76	36	87
East	11,021	5,747	938	811	500	402	360	178	185	95	105	94	128	69	83	111	83	81
Eye and Thorney	6,138	5,656	12	24	66	13	32	20	27	47	11	31	5	8	27	24	10	7
Fletton and Woodston	11,416	8,439	150	508	257	103	225	232	153	106	91	64	94	275	117	75	65	46
Glinton and Wittering	7,233	6,823	8	13	31	6	18	29	26	23	27	23	9	17	40	14	11	12
Newborough	2,845	2,621	0	16	26	2	11	18	6	21	8	13	8	9	10	11	2	1
North	6,101	3,496	677	257	132	245	232	84	111	49	50	40	145	30	59	42	10	45
Northborough	2,684	2,575	9	0	15	0	11	2	2	8	9	9	1	4	9	2	2	4
Orton Longueville	10,159	8,092	52	363	121	89	165	268	108	129	81	57	55	34	83	55	25	79

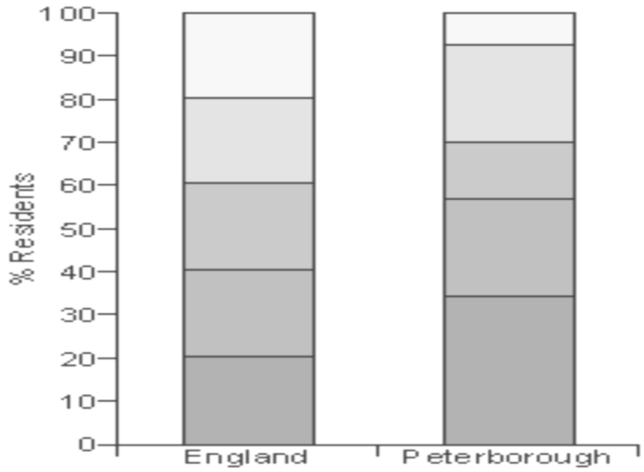
[4] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-286262

Electoral Ward	All categories: Ethnic group)	White: English/ Welsh/Scottish/ Northern Irish/British	Asian/Asian British: Pakistani or British Pakistani	White: Polish	Asian/Asian British: Indian or British Indian	White: Baltic States	White: European Mixed	Black/African/Caribbean/Black British: African	White: Any other ethnic group	Mixed/ multiple ethnic group: White and Black Caribbean	White: Other Western European	Mixed/ multiple ethnic group: White and Asian	White: Other Eastern European	White: Italian	White: Irish	Black/African/Caribbean/Black British: Caribbean	Asian/Asian British: Chinese	Mixed/multiple ethnic group: White and Black African
Orton Waterville	8,305	7,182	35	134	136	31	59	75	49	45	47	46	28	29	87	48	49	29
Orton with Hampton	13,660	10,468	232	385	371	117	156	266	138	186	110	141	61	72	81	103	134	78
Park	10,418	4,323	2,406	617	307	553	355	96	250	60	94	110	215	87	67	58	58	34
Paston	8,550	6,965	42	255	94	75	110	116	68	128	39	52	40	17	65	87	52	27
Ravensthorpe	7,990	4,381	807	287	431	283	194	192	94	72	83	90	48	46	49	100	31	60
Stanground Central	8,808	7,245	47	307	150	48	98	86	64	61	49	31	24	270	60	38	32	25
Stanground East	3,076	2,605	17	79	33	15	13	33	22	29	13	13	4	34	18	15	14	12
Walton	5,649	4,780	57	90	115	67	67	37	26	52	37	32	9	32	48	38	28	3
Werrington North	7,719	6,755	50	104	123	23	44	60	45	82	23	46	35	17	39	46	42	17
Werrington South	6,443	5,922	38	34	90	3	19	17	15	33	19	30	13	32	37	20	11	8
West	8,462	5,277	1,195	170	603	91	93	95	56	26	53	52	33	75	57	42	72	12
Total (#)	**183,631**	**130,232**	**12,078**	**5,778**	**4,636**	**3,472**	**3,223**	**2,480**	**1,878**	**1,542**	**1,393**	**1,384**	**1,383**	**1,303**	**1,257**	**1,174**	**872**	**827**
Total (%)	**100.0**	**70.9**	**6.6**	**3.1**	**2.5**	**1.9**	**1.8**	**1.4**	**1.0**	**0.8**	**0.8**	**0.8**	**0.8**	**0.7**	**0.7**	**0.6**	**0.5**	**0.5**

3. Deprivation –

The overall level of economic deprivation is higher for Peterborough Unitary Authority (UA) than for that of England overall, with a higher percentage of residents than of England overall within the most deprived economic quintile and a lower percentage in the most affluent quintile.

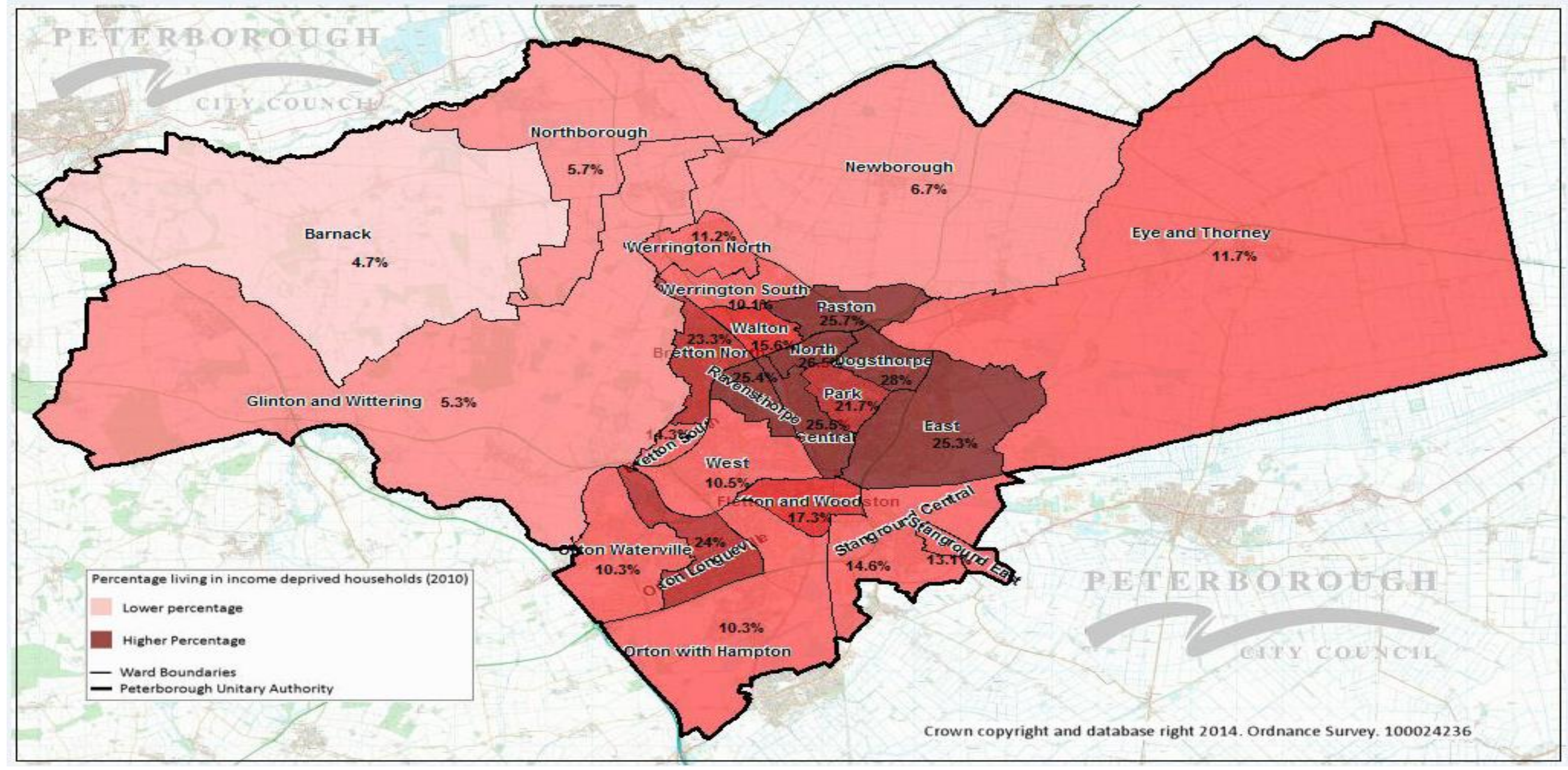
Figure 5 - Peterborough vs England deprivation quintiles[5]



Deprivation does, however, vary significantly throughout the UA – the below map illustrates that income deprivation prevalence is most apparent in wards near the centre of the UA, with the darkest shaded areas representing some of the most deprived wards in England. The percentage of residents living in income deprived households is highest in Dogsthorpe (28.0%), North (26.5%) and Central (25.5%).

[5] www.apho.org.uk/resource/view.aspx?RID=142246

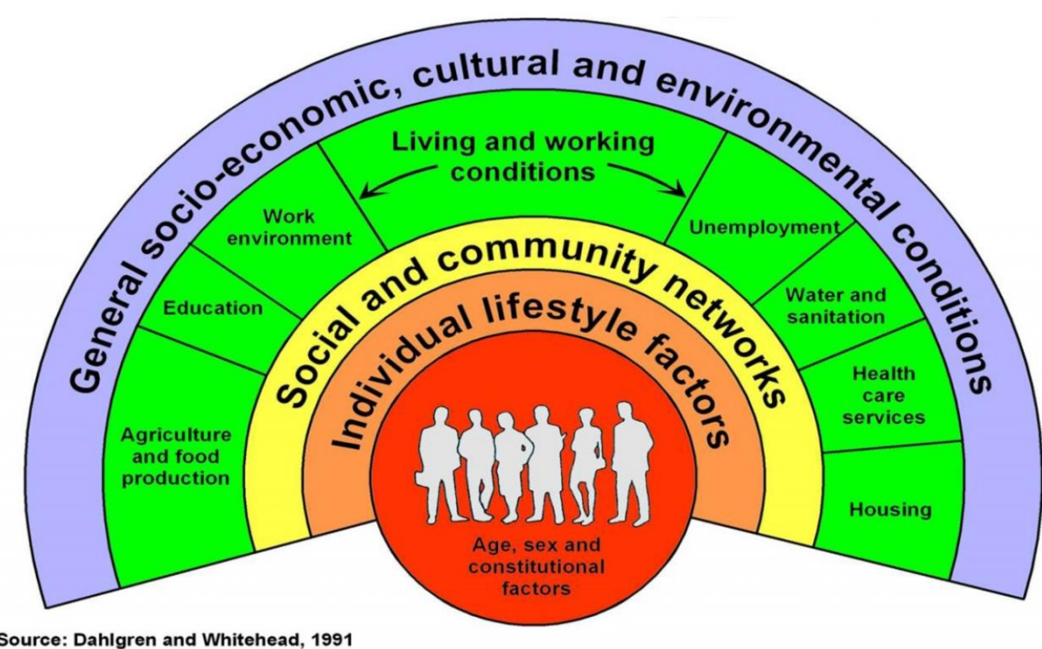
Figure 6 - Peterborough income deprivation rates by electoral ward[6]



[6] http://www.localhealth.org/#v=map4;l=en

Wider determinants of health

To understand why deprivation is important to health, Dahlgren & Whitehead's 1991 'rainbow model', illustrated below, describes how health is not only affected by unmodifiable factors such as genetics but is determined by a complex interaction between individual characteristics, lifestyle choices and the physical, social and economic environment within which the individual lives. Most experts agree that these 'broader determinants of health' are even more important than healthcare in ensuring a healthy population (although both are needed). Improving public health in Peterborough is therefore not only about advising our population on appropriate lifestyle choices such as diet, alcohol/tobacco intake and amounts of exercise to undertake; it also involves ensuring our young people receive the educational opportunities to fulfil their potential, providing employment for residents of working age and ensuring our unitary authority is populated with adequate housing, green spaces and opportunities for meaningful social interaction.



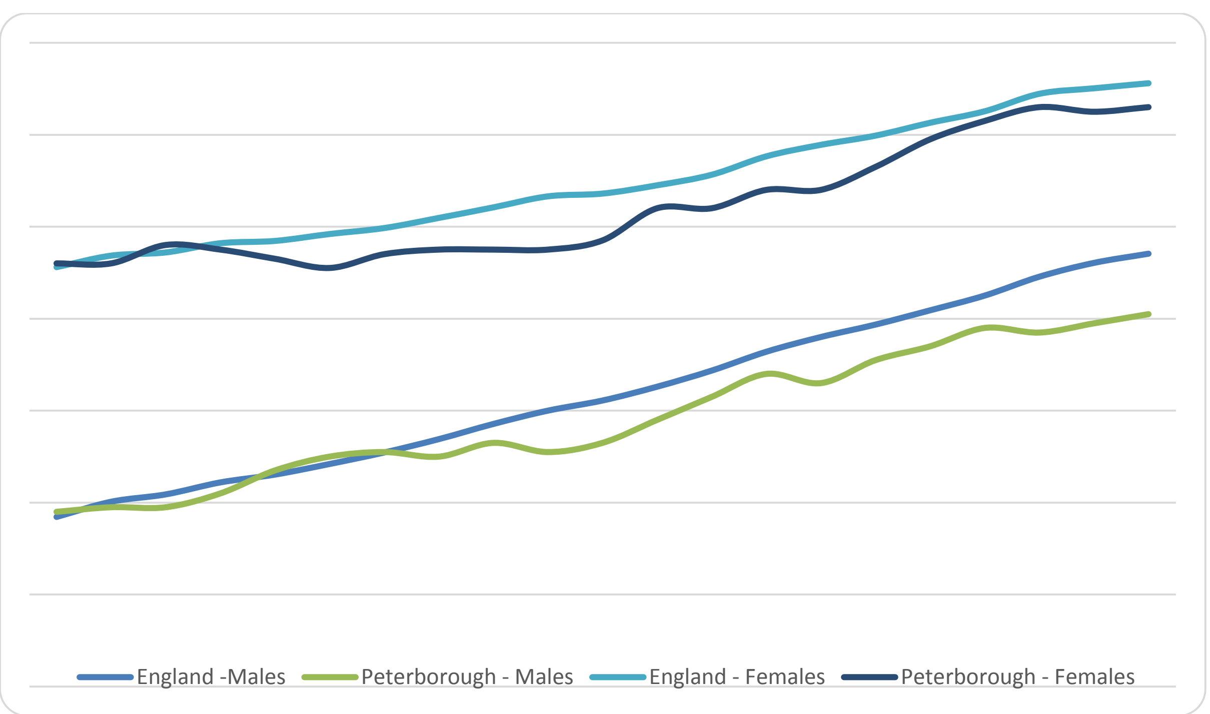
Source: Dahlgren and Whitehead, 1991

4. Life expectancy

Life expectancy at birth for females has risen in England from 79.1 years in 1991/93 to 83.1 years in 2011/13, an increase of 4.0 years or 5.1%. In Peterborough, the increase in life expectancy in this period has been slower than that observed nationally, from 79.2 to 82.6 years, an increase of 3.4 years or 4.3%. Evidently, the life expectancy in Peterborough has fallen from slightly above the England average to slightly below over this 20 year period.

For males, life expectancy at birth has risen more substantially but also at a slower rate than observed in England. Male life expectancy nationally has increased from 73.7 years in the 1991/93 time period to 79.4 years in 2011/13; an increase of 5.7 years, or 7.7%. However, life expectancy in Peterborough has increase more slowly, from 73.8 years in 1991/93 to 78.1 years in 2011/13. This represents an increase of 4.3 years or 5.8%.

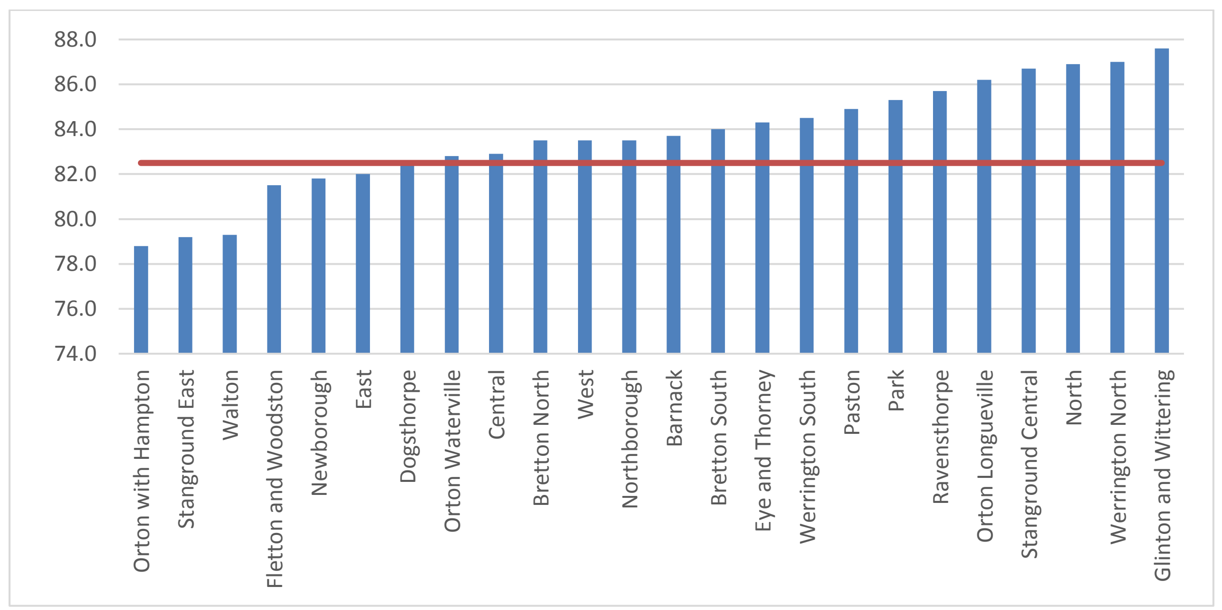
Figure 7 - Life Expectancy at birth, 1991/93 – 2011/2013[7]



Life expectancy by electoral ward

The chart below shows that six wards – Orton with Hampton, Stanground East, Walton, Fletton and Woodston, Newborough and East- have a female life expectancy below the Peterborough Unitary Authority average, represented by the red line. Life expectancy varies from a low of 78.8 years in Orton with Hampton to 87.6 years in Glinton & Wittering, a difference of 8.8 years. There is not a strong correlation for women between overall 'deprivation' level in an electoral ward and life expectancy – however at electoral ward level, life expectancy can also be influenced by other factors such as high numbers of nursing homes.

Figure 8 Female life expectancy at birth, Peterborough Wards 2008-2012[8]

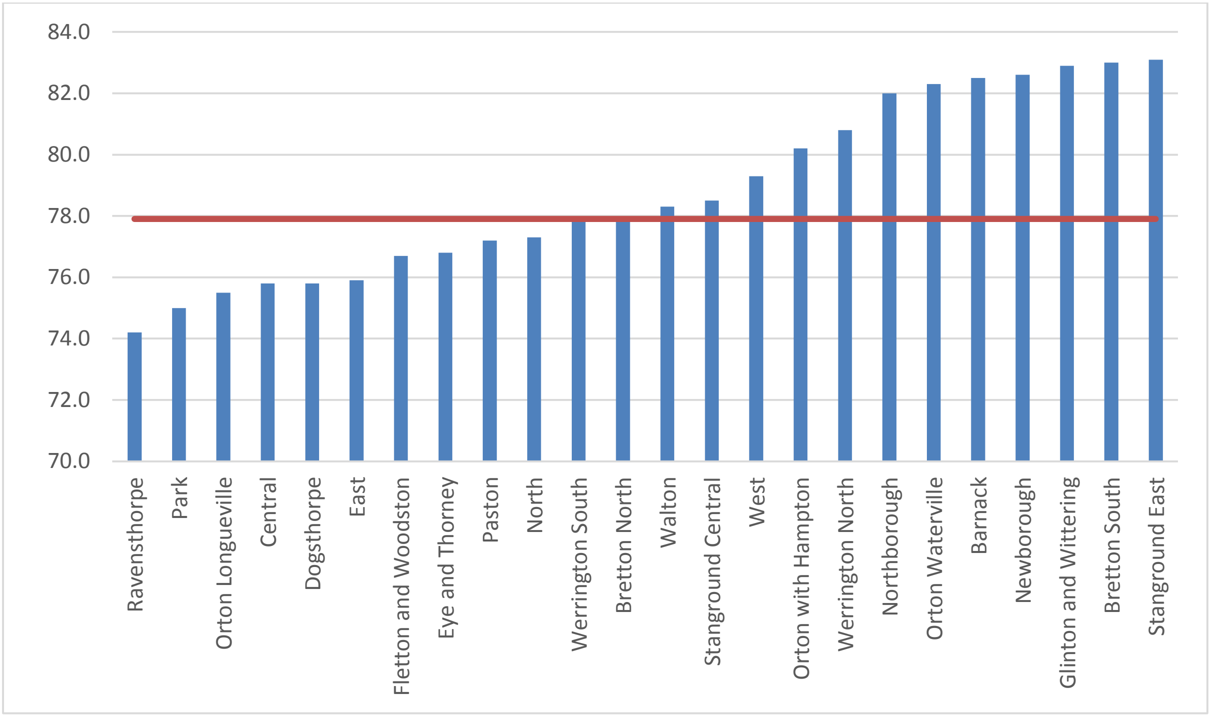


Eleven electoral wards within Peterborough have a male life expectancy at birth below the Peterborough Unitary Authority average, represented in the below chart by the orange line. Life expectancy for males is lowest in

[7] https://indicators.ic.nhs.uk/webview/
[8] http://www.localhealth.org/#l=en;v=map4

Ravensthorpe (74.2 years) and highest in Stanground East (83.1 years). Male life expectancy appears to be much more closely related to the deprivation level of electoral wards than female life expectancy.

Figure 9 Male life expectancy at birth, Peterborough Wards 2008-2012[9]



The Office for National Statistics last produced a comparison of life expectancy and disability-free life expectancy for Peterborough the 2009-2011 period. These data are listed in the table below and show that Peterborough's disability free life expectancy is substantially below that of the East of England and England. Resultantly, data show that Peterborough residents can, on average, expect to live for 17.4 years (22.4% of their overall lifespan) with a disability, which compares unfavourably with the 15.0 years (19.0% of lifespan) for England.

Figure 10 Life expectancy/disability-free life expectancy 2009-2011[10]

Area	Life expectancy	Disability- free life expectancy	Expected years with a disability	Proportion of life disability-free	Proportion of life with a disability
Peterborough	77.7	60.3	17.4	77.6	22.4
East of England	79.9	65.2	14.7	81.6	18.4
England	78.9	63.9	15.0	81.0	19.0

[9] http://www.localhealth.org/#l=en;v=map4
[10] http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/sub-national-health-expectancies/disability-free-life-expectancy-by-upper-tier-local-authority--england-2009-11/stb-disability-free-life-expectancy.html

5. Health of Children & Young People

5.1 Children & Young People - Demography and determinants of health

Children and young people under the age of 20 make up 26.5% of the population of Peterborough a figure 2.6% higher than the national population percentage for this age group. This population of children and young people is increasingly diverse. In 2013 40.8% of school children were from a minority ethnic background, significantly higher than the 26.7% nationally.

Office for National Statistics predictions of population growth over the years 2010-2031[11] highlight a predicted population growth of 20.5% by 2013, with growth rates particularly high amongst children and young people – predications are for growth of 23.6% and 27.3% for the age groups 5-9 and 10-14 respectively.

The level of child poverty is worse than average with 23.6% of our children aged under 16 living in poverty compared to 20.6% overall in England. The rate of family homelessness is worse than the England average, and we also have higher rates of children in care.

There is substantial evidence of a link between educational attainment and health. People who are socioeconomically deprived tend to have poorer health and lower levels of education. It is encouraging that school readiness in Peterborough is similar to the national average in Peterborough, and better than average for children eligible for free school meals. However pupils in year 1 achieving the expected level in the phonics screening check is low.

Figure 11: School Readiness, Public Health Outcomes Framework, February 2015[12]

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
1.01i - Children in poverty (all dependent children under 20)	2012	18.6	15.1	17.0	11.9	12.4	15.4	12.3	22.1	16.3	21.3	20.8	14.3	20.0
1.01ii - Children in poverty (under 16s)	2012	19.2	15.9	17.6	12.5	13.1	16.2	12.9	22.4	17.1	22.0	21.7	15.1	20.8
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	2013/14	60.4	60.9	57.0	61.2	57.2	61.4	65.9	51.6	58.1	59.2	61.6	58.9	66.1
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2013/14	44.8	44.1	41.3	41.2	35.9	43.4	45.8	45.4	43.2	52.0	42.5	42.4	54.3
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2013/14	74.2	73.0	72.5	73.9	71.5	73.8	76.6	67.7	68.8	66.2	73.9	73.5	75.5
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2013/14	61.3	56.8	55.0	57.9	54.5	56.5	57.7	56.5	55.8	53.3	58.0	57.6	62.6

[11] http://www.peterborough.gov.uk/pdf/CommunityInformation-About-PopulationEstimates-PopulationForecast.pdf
[12] http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/0/par/E12000006/are/E06000031

Determinants of health at electoral ward level

Local data shows that electoral wards with high levels of childhood poverty and low levels of education attainment also contain relatively high numbers of young people not in employment, education or training and of adults of working age claiming out of work benefit. This demonstrates the importance of reducing levels of deprivation and increasing education attainment in order to best equip people with the skills required to become economically self-sufficient when they reach working age. The table below shows the high level of correlation between deprivation and unemployment in an electoral ward, and children's educational attainment at GCSE.

Figure 12 – Peterborough educational/economic attainment correlation[13] (red = below Peterborough average, green = above Peterborough average)

Area Name	% of children living in poverty	% of pupils achieving 5 or more GCSEs A*-C including English & Maths)	% of 16-18 NEET (not in employment, education or training)	% of working age population claiming out of work benefit	Working age population claiming out of work benefit for longer than 12 months (rate per 1,000 of population)
Barnack	5.1	66.7	1.1	1.5	2.1
Bretton North	36.3	31.7	8.9	8.2	23.6
Bretton South	25.4	47.7	6.1	5.1	13.5
Central	35.5	35.2	7.7	7.9	18.1
Dogsthorpe	39.6	31.5	9.8	7.2	19.3
East	38.8	29.0	5.9	6.7	16.3
Eye and Thorney	16.4	54.7	4.3	3.2	7.6
Fletton and Woodston	24.7	46.1	9.1	5.0	11.1
Glinton and Wittering	6.2	72.3	1.0	1.7	2.7
Newborough	11.1	62.5	1.9	2.1	4.8
North	36.6	31.4	6.1	6.8	16.6
Northborough	5.4	76.8	1.2	2.0	3.2
Orton Longueville	39.0	35.3	10.0	7.6	21.7
Orton Waterville	18.4	63.2	5.7	3.3	7.7
Orton with Hampton	16.0	62.4	5.0	3.0	6.1
Park	29.1	42.0	8.2	6.4	13.2
Paston	37.3	42.1	6.8	7.2	21.1
Ravensthorpe	37.4	32.8	5.2	8.1	21.4
Stanground Central	21.9	46.0	8.5	4.2	8.3
Stanground East	20.0	46.5	12.5	3.6	6.4
Walton	24.3	62.3	5.2	4.5	10.9
Werrington North	15.2	72.2	5.1	3.2	7.1
Werrington South	16.1	65.4	1.0	3.0	7
West	17.2	64.4	2.2	3.3	6.6
Peterborough	**27.2**	**48.3**	**6.5**	**5.3**	**12.7**

[13] http://www.localhealth.org/#

5.2 Child Health outcomes

Within our proportionately larger and more diverse child population we are seeing some worse health outcomes than nationally – the chart below shows the East of England to be statistically significantly better than England for each of the 14 indicators, whereas Peterborough is statistically significantly worse than England for five indicators and similar to England for the other nine. Peterborough is 'worse than benchmark' for under 18 conceptions, hospital admissions caused by unintentional and deliberate injuries in 15-24 year olds, hospital admissions for asthma and hospital admissions as a result of self-harm (two indicators):

Figure 13: Public Health England Children's Public Health Benchmarking

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
4.01 - Infant mortality	2011 - 13	4.0	3.7	5.4	3.2	3.2	3.6	2.9	5.1	4.5	4.3	3.7	3.7	2.8
2.01 - Low birth weight of term babies	2012	2.8	2.7	2.6	2.7	2.0	2.5	2.7	5.0	2.5	2.7	2.7	2.2	2.8
2.02i - Breastfeeding - Breastfeeding initiation	2013/14	73.9	76.7	79.7	83.0	77.5	*	76.7	75.6	77.8	72.8	*	78.4	*
Under 18 conceptions	2013	24.3	21.0	22.0	16.1	19.9	22.3	16.4	24.4	22.2	33.4	26.6	19.6	36.1
Hospital admissions for accidental and deliberate injuries in children (aged 0-4)	2013/14	140.8	120.5	86.9	127.1	116.5	110.3	118.6	125.1	153.8	146.5	107.1	110.2	96.3
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2013/14	112.2	100.1	79.6	100.5	95.3	92.3	103.9	100.5	122.1	120.1	88.8	92.1	82.4
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2013/14	136.7	122.0	119.4	132.7	131.7	114.6	112.7	124.9	124.8	171.7	153.0	121.0	86.3
Tooth decay in children aged 5	2011/12	0.94	0.75	0.83	0.51	0.50	0.57	0.69	1.64	0.96	1.08	0.65	0.54	*
Hospital admissions due to alcohol specific conditions	2010/11 - 12/13	42.7	26.8	31.6	31.3	21.8	27.7	19.7	23.6	31.9	43.0	27.7	27.8	14.7
Hospital admissions due to substance misuse	2010/11 - 12/13	75.2	51.0	69.0	49.1	54.7	50.8	38.6	41.0	52.9	91.4	55.9	57.9	40.2
Hospital admissions for asthma	2012/13	221.4	173.7	237.7	160.5	129.3	139.0	119.5	267.5	195.7	348.7	166.0	248.0	141.4
Hospital admissions for mental health conditions	2012/13	87.6	77.5	63.7	82.9	94.5	78.5	56.3	87.0	98.3	77.8	119.6	70.7	64.1
Hospital admissions as a result of self-harm	2012/13	346.3	291.2	300.5	396.2	280.1	222.4	227.6	235.5	368.1	620.5	268.9	321.6	82.4
Hospital admissions as a result of self-harm (pooled)	2010/11 - 12/13	352.3	276.3	314.4	377.3	246.5	221.1	212.0	211.4	322.5	506.9	260.6	341.0	97.9

5.3 Childhood obesity

Figure 14 shows that Peterborough's prevalence of healthy weight and overweight among reception year children and underweight among year six children was worse than the national and regional averages for the period 2013/14. The prevalence of obesity amongst year 6 children is better than the national average.

Figure 14: Child Weight, Public Health England, NCMP Local Authority Profile, 2013/14[14]

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Reception: Prevalence of underweight	2013/14	0.95	0.78	0.91	0.55	0.63	0.78	0.95	1.82	0.50	1.31	0.63	0.49	0.55
Reception: Prevalence of healthy weight	2013/14	76.5	77.7	77.6	78.6	79.3	78.0	78.3	75.0	77.2	74.1	77.6	77.4	77.4
Reception: Prevalence of overweight (including obese)	2013/14	22.5	21.6	21.5	20.9	20.0	21.2	20.8	23.2	22.3	24.6	21.8	22.1	22.0
Reception: Prevalence of obesity	2013/14	9.5	8.5	8.9	8.1	8.1	8.1	8.0	10.5	8.6	10.6	9.3	8.8	8.8
Year 6: Prevalence of underweight	2013/14	1.36	1.38	1.51	1.13	0.65	1.29	1.54	1.88	1.22	3.44	1.10	1.14	1.42
Year 6: Prevalence of healthy weight	2013/14	65.1	67.6	65.7	69.8	70.0	68.0	69.9	60.5	66.6	66.3	66.4	67.2	60.1
Year 6: Prevalence of overweight (including obese)	2013/14	33.5	31.1	32.8	29.0	29.3	30.7	28.6	37.6	32.2	30.2	32.5	31.7	38.5
Year 6: Prevalence of obesity	2013/14	19.1	17.2	18.5	16.2	15.9	16.7	15.1	23.7	18.0	17.4	17.7	17.4	22.1

The below table outlines, by electoral ward, the percentage of children deemed obese or with excess weight as measured by the National Child Measurement Programme in reception year and in year 6. In reception year rates of obesity and overweight by electoral ward do not appear to be linked to deprivation, whereas by year 6 there appears to be a stronger linkage between the level of deprivation in an electoral ward and the rate of childhood obesity.

Figure 15 – Peterborough National Child Measurement Programme Data 2010/11-2012/13[15] (red = below Peterborough average, green = above Peterborough average)

Area Name	% obese children in reception year (2010/11-2012/13)	% children with excess weight in reception year (2010/11-2012/13)	% obese children in year 6 (2010/11-2012/13)	% children with excess weight in year 6 (2010/11-2012/13)
Barnack	9.2	23.1	9.3	25.3
Eye and Thorney	5.9	17.7	19.3	33.7
Glinton and Wittering	10.6	29.2	12.1	28.0
Newborough	12.2	19.4	8.5	24.5
Northborough	11.3	22.6	15.3	30.6
Bretton North	11.0	23.1	24.4	40.8
Bretton South	7.1	22.8	17.3	36.7
Central	10.8	20.7	22.7	35.1
Dogsthorpe	9.7	20.7	20.3	34.8
East	11.3	25.0	22.9	38.9
Fletton and Woodston	8.9	26.0	19.1	35.1

[14] http://fingertips.phe.org.uk/profile/national-child-measurement-programme
[15] http://www.localhealth.org/#l=en;v=map4

Area Name	% obese children in reception year (2010/11-2012/13)	% children with excess weight in reception year (2010/11-2012/13)	% obese children in year 6 (2010/11-2012/13)	% children with excess weight in year 6 (2010/11-2012/13)
North	10.2	24.0	24.6	40.8
Orton Longueville	11.6	27.9	19.4	31.9
Orton Waterville	7.3	22.4	12.5	21.6
Orton with Hampton	8.9	21.7	22.4	36.0
Park	9.3	21.2	20.3	31.8
Paston	8.7	21.3	20.2	34.0
Ravensthorpe	10.5	23.7	23.2	37.6
Stanground Central	11.0	25.2	24.2	35.7
Stanground East	6.0	19.7	19.3	29.4
Walton	11.2	23.9	24.4	37.2
Werrington North	12.6	24.8	17.7	29.2
Werrington South	11.3	24.2	12.8	24.8
West	9.7	18.4	17.2	31.1
Peterborough UA	**10.0**	**23.0**	**20.0**	**33.7**

5.4 Child Healthcare Usage

Data collated by Public Health England allows for the analysis of healthcare statistics relating to children & young people by GP practice (i.e. the population registered with each practice). As shown within the below table, a composite indicator analysis of all of the 18 indicators within the dataset, incorporating statistics relating to demographics, deprivation and hospital admissions for young people, ranks Ailsworth Medical Centre as having the registered population with the lowest healthcare burden for children and young people and Dogsthorpe Medical Centre as having the highest burden.

Figure 16 – Peterborough GP Practice Children & Young People Health Burden (1 = Lowest Burden, 25 = Highest Burden)

Practice	Rank	Ward - Geographically Located Within	Ward - Majority Population Registered Within
Ailsworth Medical Centre	1	Glinton & Wittering	Glinton & Wittering
Westgate Surgery	2	Central	Central
Thorney	3	Eye & Thorney	Eye & Thorney
Thistlemoor Road	4	North	North
Millfield Medical Centre	5	Park	Central
Huntly Grove	6	Park	Park
Botolph Bridge	7	Fletton	Fletton
Hampton Health	8	Orton & Hampton	Orton & Hampton
Park Med Centre	9	Park	Park
63 Lincoln Road	10	Central	Werrington South
Paston	11	Paston	Paston
Hodgson Medical Centre	12	Werrington North	Werrington North
Thomas Walker	13	Park	Park
The Grange Medical Centre	14	West	West
Thorpe Road Surgery	15	West	West

Practice	Rank	Ward - Geographically Located Within	Ward - Majority Population Registered Within
Old Fletton	16	Fletton	Fletton
North St	17	Central	East
Nene Valley Medical Practice	18	Orton Longueville	Orton Longueville
Bretton Medical Practice	19	Bretton North	Bretton North
Orton Bushfield Medical Practice	20	Orton Waterville	Orton Waterville
Welland Medical Practice	21	Dogsthorpe	Dogsthorpe
Westwood Clinic	22	Ravensthorpe	Ravensthorpe
Parnwell Medical Centre	23	East	East
Minster Practice	24	Park	East
Dogsthorpe Medical Centre	25	Welland	Welland

Figure 17 – Electoral Ward Child Health Statistics (Green = statistically significantly better than Peterborough average, orange = statistically worse than Peterborough average)

Rank of each indicator by ward	% Breastfeeding	% smoking at delivery	low birthweights - % of births under 2.5kg	% child poverty	fertility rates per 1000 females aged 15-44	% of population living in overcrowded residences	% population under 16	% population under 20	% primary school children on FSMs	NEET - % of aged 19s not In employment or education	A&E attendances - DSR per 10,000 up to age 24 years old	Elective admissions - DSR per 10,000 up to age 24 years old	FSP - % children achieving a good level of development within Early Years Foundation Stage Profile, 2012
Barnack	83.3	1.6	6.2	5.1	72.8	2.2	19.9	12.2	5.1	0.0	216	10	94.7
Bretton North	74.3	26.2	7.8	36.2	83	9.1	23.2	12.3	27.4	7.7	364	32	58.4
Bretton South	76.9	20.3	7.5	24.4	68.4	5.4	18.9	10.8	28.1	9.4	321	34	65.4
Central	72.9	14.5	9.4	35.9	105.2	18.5	22.9	14.7	22.5	8.7	317	51	26.7
Dogsthorpe	73.3	25.2	8	39.6	89	10.4	22.9	11.9	28.7	10.3	338	45	52.3
East	66.7	19.0	7.9	38.8	96.3	13.8	22.2	11.9	23.9	11.0	320	48	40.0
Eye and Thorney	65.9	12.5	7.1	16.4	68.4	2.9	19.5	9.8	12.1	5.6	272	34	76.3
Fletton and Woodston	68.6	14.9	7.8	24.8	84.1	8.3	19.7	11.3	15.5	7.7	290	37	57.9
Glinton and Wittering	77.6	10.8	6.2	6.2	62.2	2.2	18.4	10.9	3.1	2.3	215	30	82.9
Newborough	72.7	17.9	4.7	11.1	55.8	2.2	16.8	9.5	4.5	1.1	235	28	76.2
North	73.3	16.6	8.3	36.6	93.1	11.5	22.6	12.4	29.0	11.5	297	66	43.0
Northborough	83.3	0.0	5.7	5.4	38.9	2.3	17.5	9.5	7.1	4.8	185	0	80.0
Orton Longueville	75.4	21.5	7.4	37.6	81	9.1	24.9	12.1	31.8	11.1	336	55	52.7
Orton Waterville	73.0	15.8	7	18.3	62.7	3.5	17.4	9.9	18.1	8.9	265	35	66.7
Orton with Hampton	65.1	10.6	5.9	16	77.8	7.3	26.1	11.1	13.8	5.7	275	50	69.3
Park	64.4	11.7	10	29.1	96.2	15.8	24.4	14.8	16.0	9.3	278	35	42.9
Paston	70.8	25.1	7.9	37.9	85	9.3	23.2	12.2	24.7	9.8	335	44	57.7
Ravensthorpe	71.2	24.0	8.7	37.6	96.2	11.8	24.6	13.4	25.2	11.3	367	46	48.0
Stanground Central	76.1	17.7	5.9	21.7	66.9	5.8	17.8	10.8	16.2	10.7	305	51	62.6
Stanground East	78.3	16.7	5.5	20	61.7	4.3	17.9	10.5	13.3	7.6	317	35	64.0
Walton	62.9	23.2	9.2	25.2	71.9	6.9	17.5	10.8	15.4	4.8	317	40	66.2
Werrington North	64.1	14.5	6.2	15	54.2	6.6	20	11.6	10.9	4.4	273	36	69.3
Werrington South	71.4	9.8	7.2	16.2	58.6	3.8	16.3	9.8	4.0	1.0	284	44	81.3
West	72.5	9.1	8.4	17.2	70.7	4.5	17.6	10.4	12.6	5.2	300	54	53.6
Peterborough	70.4	17.1	7.7	27.2	79.7	8.3	21.3	11.7	23.4	8.0	301	42	55.8

6. Adult Health & Determinants

6.1 Smoking

It is estimated that of Peterborough's adult (18+) population of approximately 140,000 people, around 29,000 (20.8%) are current smokers.

The dashboard below shows that Peterborough has a statistically worse smoking prevalence rate than the national average among the general population and routine and manual workers. The rate of smoking attributable hospital admissions is also worse than the national average. Rates of overall smoking attributable mortality and smoking attributable deaths from lung cancer, chronic obstructive pulmonary disease, heart disease are broadly similar to national averages, which does however compare unfavourably with the East of England overall which has below average prevalence for these indicators.

Figure 18 - Tobacco Control Indicators Dashboard, Public Health England, February 2015

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Smoking Prevalence (IHS)	2013	18.4	17.5	13.7	13.5	15.0	18.9	15.5	20.0	18.0	20.8	21.8	18.5	22.8
Smoking prevalence - routine & manual	2013	28.6	28.4	22.3	27.3	22.4	29.3	25.7	29.1	29.5	34.7	29.7	30.9	25.6
Successful quitters at 4 weeks	2013/14	3524	3839	4143	3228	3528	4176	4221	3594	3070	4404	4158	3827	4396
Successful quitters (CO validated) at 4 weeks	2013/14	2472	2724	2966	2081	2658	2887	2780	2077	2481	3673	2765	2918	3218
Completeness of NS-SEC recording by Stop Smoking Services	2013/14	86.2	94.8	100	83.9	100	93.7	100	93.3	95.4	100	100	90.9	100
Smoking status at time of delivery	2013/14	12.0*	10.8*	12.6	10.6	12.6	*	7.3	12.1	12.9	10.6	10.9	12.5	*
Low birth weight of term babies	2012	2.8	2.7	2.6	2.7	2.0	2.5	2.7	5.0	2.5	2.7	2.7	2.2	2.8
Smoking prevalence age 15 years - regular smokers	2013	8	-	-	-	-	-	-	-	-	-	-	-	-
Smoking prevalence age 15 years - occasional smokers	2013	10	-	-	-	-	-	-	-	-	-	-	-	-
Lung cancer registrations	2009 - 11	75.5	64.4	54.7	59.7	60.3	66.8	61.3	76.9	66.0	71.2	72.7	60.2	87.6
Oral cancer registrations	2009 - 11	12.8	10.7	10.3	11.2	8.6	10.9	9.4	12.1	10.6	12.9	17.2	10.8	10.8
Deaths from lung cancer	2011 - 13	60.2	52.5	43.0	46.7	54.0	55.9	50.5	70.1	49.4	62.0	63.4	48.2	73.8
Deaths from chronic obstructive pulmonary disease	2011 - 13	51.5	43.7	46.6	40.8	41.9	47.6	45.9	42.9	39.4	56.6	49.4	36.2	63.3
Smoking attributable mortality	2011 - 13	288.7	258.2	238.4	229.8	255.6	266.8	256.6	286.2	252.4	304.5	301.2	239.7	352.7
Smoking attributable deaths from heart disease	2011 - 13	32.7	29.5	29.1	24.4	30.0	28.4	27.4	42.4	31.1	37.4	35.0	28.8	39.4
Smoking attributable deaths from stroke	2011 - 13	11.0	9.7	8.8	8.4	8.7	9.3	9.7	11.2	10.7	10.9	9.2	9.3	12.8
Smoking attributable hospital admissions	2012/13	1688	1571	1230	1694	1489	1416	1364	1904	1844	1885	1838	1549	1829

How does tobacco impact on local NHS Healthcare?

The effect on the local health sector in Peterborough as a result of smoking is an additional:

31,030 GP consultations;
8,139 practice nurse consultations;
5,374 outpatient visits;
1,018 hospital admissions; and
17,215 Prescriptions

Alcohol and drug misuse

6.2 Alcohol

People who consume alcohol in excessive amounts place themselves at a substantial risk of damaging their health, which in turn places a higher financial burden on the local healthcare economy. The NHS recommends that men should not exceed 3-4 units of alcohol a day and women not more than 2-3units a day.[16] There are approximately 2 units of alcohol in a regular strength (ABV 3.6%) beer, 3 units in a large glass of wine (ABV 12%) and 1 unit in a standard 25ml shot of spirits (ABV 40%). Nationally[17] it is estimated that in 2012 almost a quarter of men (24%) drank more than the recommended 21 units a week, including 5% who drank more than 50 units (a level considered to be higher risk). Among women, 18% usually drank more than the recommended 14 units a week, including 4% who drank more than 35 units (the higher risk level for women).

There were an estimated 1171 alcohol related admissions to hospital (narrow definition) for Peterborough residents in 2012/13, and of these 749 were for men and 422 for women. The rates of hospital admission for men but not for women were significantly higher than the national average.

Figure 19: Peterborough Alcohol related admissions to hospital 2012/13[18]

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
2.18 - Alcohol related admissions to hospital - narrow definition (Persons)	2012/13	637	552	482	589	518	498	472	684	671	689	643	568	461
2.18 - Alcohol related admissions to hospital - narrow definition (Male)	2012/13	829	700	659	723	653	633	608	885	849	916	812	693	660
2.18 - Alcohol related admissions to hospital - narrow definition (Female)	2012/13	465	421	323	468	398	382	356	496	512	484	496	457	284

[16] http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx
[17] Health Survey for England 2012
[18] http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/0/par/E12000006/are/E06000031

6.3 Drug misuse

Peterborough has approximately 850 Opiate/Crack users currently in structured treatment, though prevalence estimates suggest that the number of Opiate users in the city is considerably higher than this with a rate of 10.5/1000[i] population which compares to rates of 5.8/1000 and 8.4/1000 for regional and national comparators respectively. The drug using population is aging and becoming more complex in Peterborough meaning that more time and resource have to be inputted into each client to achieve abstinence and to allow the client to exit treatment successfully, though there remains high levels of representations back into treatment

Non Opiate use in the city brings with it its own challenges. Although there are significantly lower numbers of clients accessing structured treatment for their addiction, the prevalence of non-opiate users is considered to be high. According to the ONS, around 8.8% of our national population whom are between the age of 16-59 are thought to have taken 'any drug'[1] in the last year which equates to around 1 in 11. With these proportions translated in to a population the size of Peterborough, we can 'estimate' that there were over 9,500 people that had taken 'any' drug in the last year – with the predominance being cannabis – this rate increases to almost 20% of all 16-24 year olds.

The percentage of clients successfully completing drug treatment is better than the national average in Peterborough for both opiate and non-opiate users, as is the proportion of people with substance misuse problems entering prison who are not already known to local services.

Figure 20: Drug Treatment Indicators, PHOF 2012/13[19]

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
2.15i - Successful completion of drug treatment - opiate users	2013	7.8	7.4	8.6	8.0	5.4	5.1	8.5	8.6	6.2	11.3	4.2	8.6	12.0
2.15ii - Successful completion of drug treatment - non-opiate users	2013	37.7	34.8	26.9	39.2	34.3	40.1	31.0	26.4	31.3	49.2	31.3	26.9	47.2
2.16 - People entering prison with substance dependence issues who are previously not known to community treatment	2012/13	46.9	46.5	49.3*	49.3	49.3*	56.9	46.6	47.1	36.8	37.1	43.2	41.7	46.9

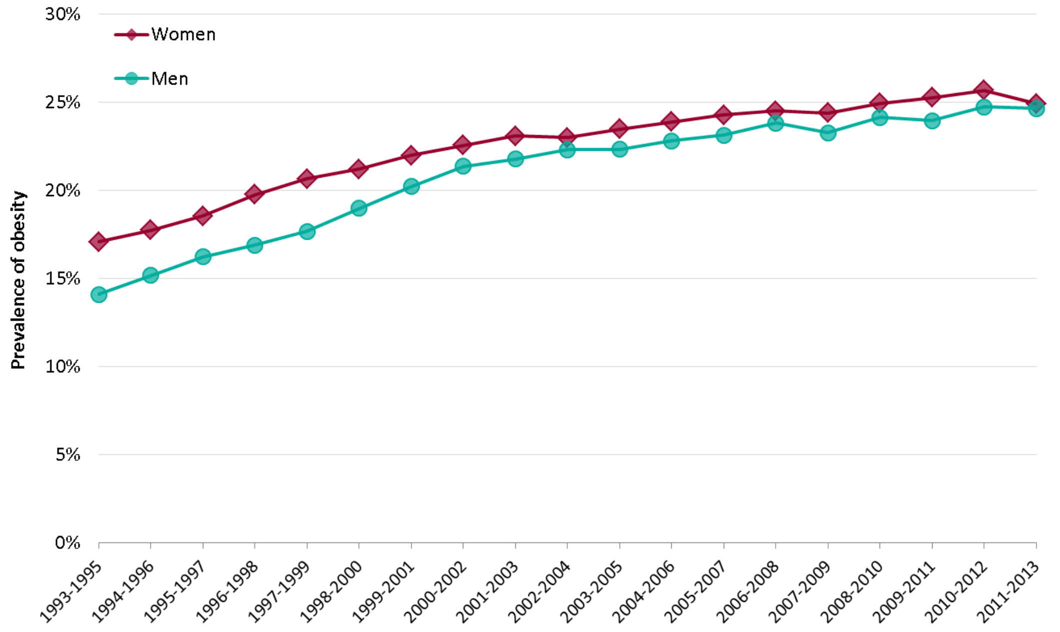
[1] 'Any drug' comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, ketamine, heroin, methadone, amphetamines, methamphetamine, cannabis, tranquillisers, anabolic steroids, amyl nitrite, any other pills/powders/drugs smoked. Mephedrone is not included in the 'Any drug' category but is presented in the tables to show use by different characteristics and factors.

[19] http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/0/par/E12000006/are/E06000031

7. Obesity, Healthy Eating and Physical Activity

Physical activity and healthy eating are often considered in the context of obesity – although physical activity has significant health benefits regardless of a person's weight, as does a healthy diet. Obesity is a significant public health concern - due to the increase that has been seen in the UK over the last 20 years, and the growing impact this is having on use of the health service. Obesity increases people's risk of diabetes, circulatory disease, some cancers, and musculoskeletal problems.

Figure 21 Increase in obesity rates in England 1993-2013



Source: Health Survey for England, Public Health England Obesity Observatory

The chart below shows that about two thirds of people in Peterborough are overweight or obese. While this is similar to the national average – it indicates that overweight and obesity are becoming the 'social norm' which may have long term implications for public health. Rates of healthy eating (consuming five or more portions of fruit or vegetables per day) are significantly lower than average in Peterborough – this is often linked with people's socio-economic circumstances, and rates of physical activity are similar to the national average, with only just over half of adults (55%) meeting the Chief Medical Officer for England's recommendation of at least 150 minutes of moderate physical activity per week to maintain health.

Figure 22- Public Health Outcomes Framework – Healthy Eating/Physical Activity Indicators 2012-14[20]

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
2.11i - Fruit and Veg '5-a-day'	2014	56.3	56.9	55.7	59.3	55.6	55.4	56.9	43.8	59.1	50.3	52.0	60.4	48.0
2.11ii - Average portions of fruit eaten	2014	2.64	2.65	2.63	2.73	2.61	2.60	2.64	2.30	2.70	2.52	2.51	2.73	2.43
2.11iii - Average portions of vegetables eaten	2014	2.36	2.39	2.35	2.39	2.47	2.34	2.37	1.98	2.44	2.31	2.27	2.53	2.18
2.12 - Excess Weight in Adults	2012	63.8	65.1	60.9	65.0	69.1	67.3	61.8	59.0	65.7	65.5	64.4	65.3	70.8
2.13i - Percentage of physically active and inactive adults - active adults	2013	56.0	57.8	61.8	60.2	53.8	57.6	59.2	52.3	57.2	54.6	55.6	59.1	52.4
2.13ii - Percentage of active and inactive adults - inactive adults	2013	28.3	26.9	23.4	24.6	29.6	27.2	25.0	30.3	28.1	31.2	28.3	26.6	28.9

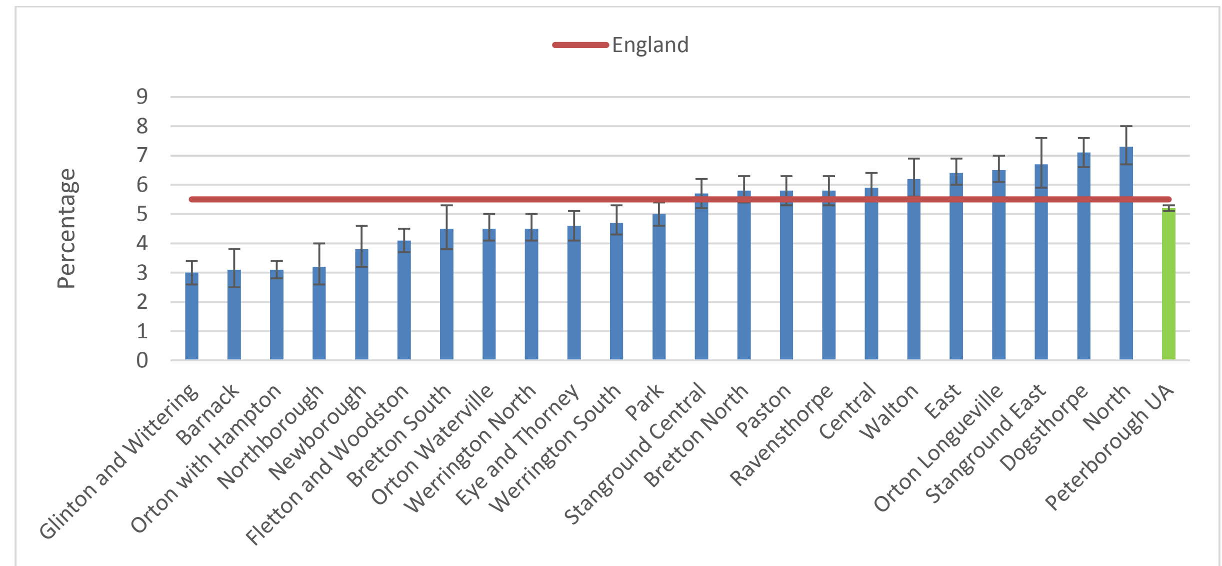
7.1 Associated Health outcomes

In the 2011 Census, respondents were asked about their health and about whether they had any long term limiting illness or disability. The results show that there is quite significant variation across electoral wards in Peterborough in the responses. It is important to remember that long term limiting illness and disability become more common with age, so wards with more older people are likely to report higher rates even if the overall health of people in that area is good.

Figure 23- Public Health Outcomes Framework – Healthy Eating & Physical Activity, 2012 - 2014

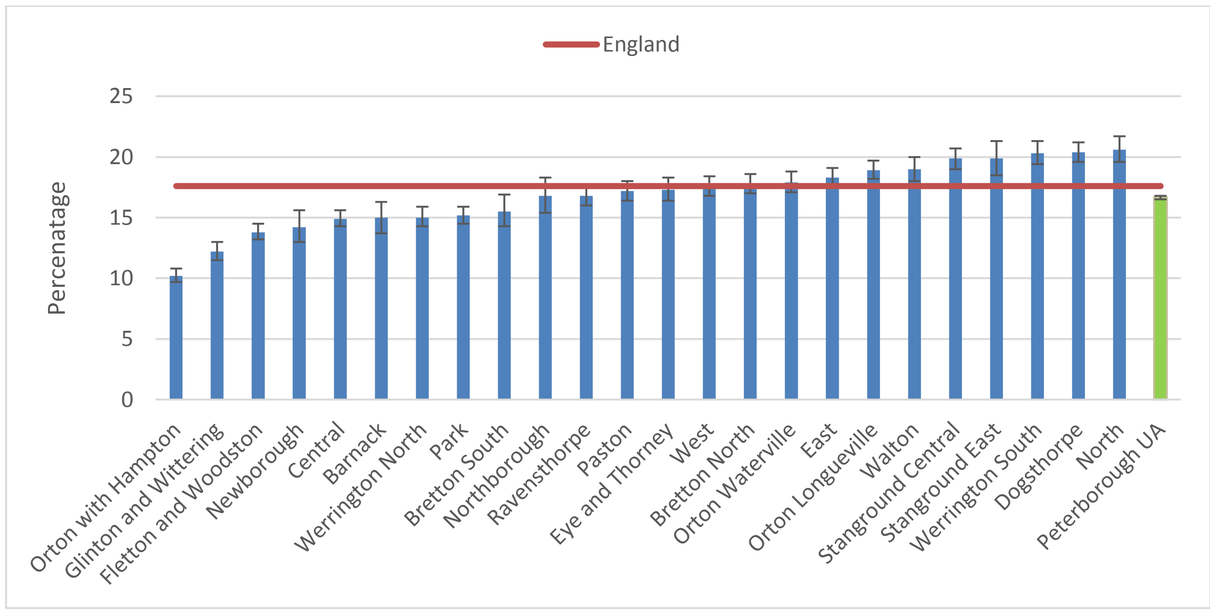
Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
2.11i - Fruit and Veg '5-a-day'	2014	56.3	56.9	55.7	59.3	55.6	55.4	56.9	43.8	59.1	50.3	52.0	60.4	48.0
2.11ii - Average portions of fruit eaten	2014	2.64	2.65	2.63	2.73	2.61	2.60	2.64	2.30	2.70	2.52	2.51	2.73	2.43
2.11iii - Average portions of vegetables eaten	2014	2.36	2.39	2.35	2.39	2.47	2.34	2.37	1.98	2.44	2.31	2.27	2.53	2.18
2.12 - Excess Weight in Adults	2012	63.8	65.1	60.9	65.0	69.1	67.3	61.8	59.0	65.7	65.5	64.4	65.3	70.8
2.13i - Percentage of physically active and inactive adults - active adults	2013	56.0	57.8	61.8	60.2	53.8	57.6	59.2	52.3	57.2	54.6	55.6	59.1	52.4
2.13ii - Percentage of active and inactive adults - inactive adults	2013	28.3	26.9	23.4	24.6	29.6	27.2	25.0	30.3	28.1	31.2	28.3	26.6	28.9

Figure 24 – Reporting of health as 'poor' – Peterborough wards[21]



Peterborough also has 7 wards with a statistically significantly higher percentage of people with Limiting Long term illness or disability.

Figure 25 – Limiting Long Term Illness/Disability – Peterborough wards[22]



[21] http://www.localhealth.org/#l=en;v=map4
[22] http://www.localhealth.org/#l=en;v=map4(2)

7.2 Mortality

The main causes of deaths for all ages in Peterborough and England 2010 – 2012 are shown in the pie charts below.

Figure 26 - Major Causes of Death – Peterborough 2010-2012[23]

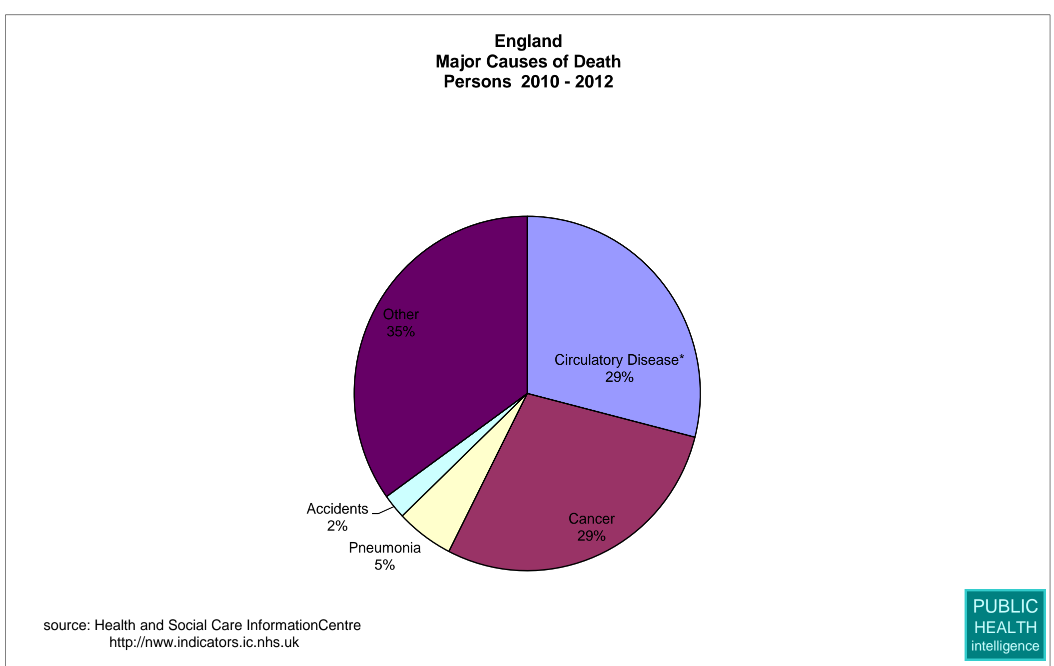
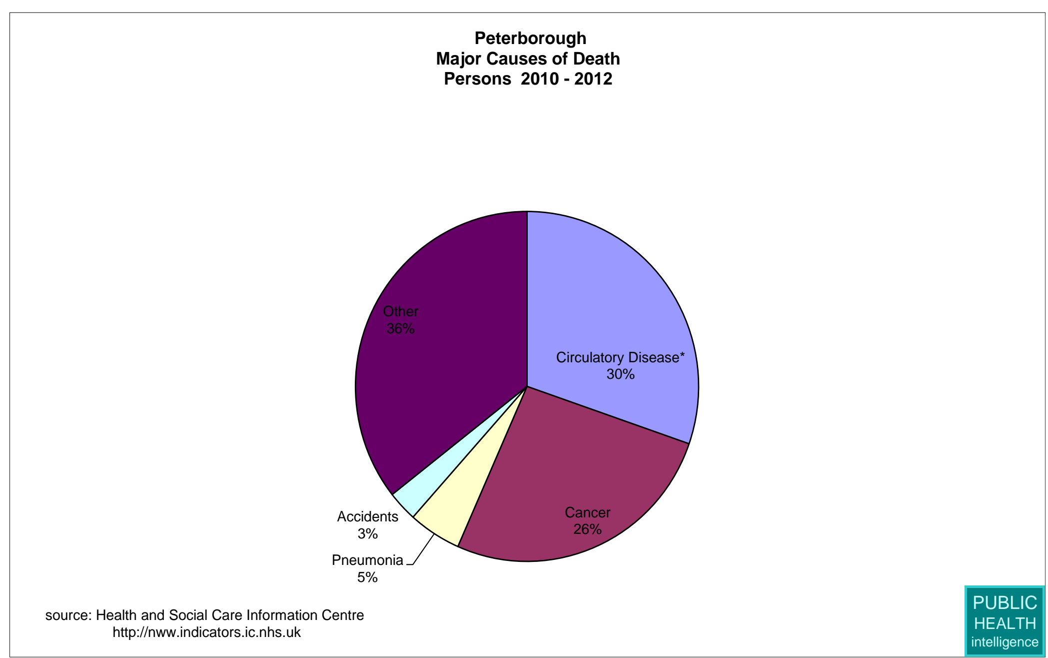


Figure 27 - Major Causes of Death – England 2010-2012[24]



[23] http://www.hscic.gov.uk/
[24] http://www.hscic.gov.uk/(2)

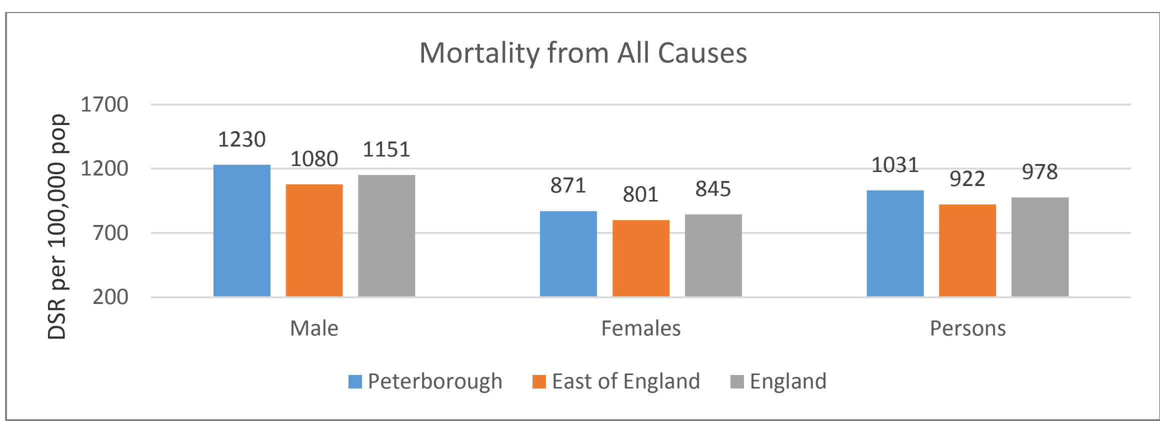
Deaths from circulatory disease (30%) and cancer (26%) contribute to 56% of all deaths in Peterborough compared to 58% in England, where 29% of deaths are from circulatory disease and 29% from Cancer.

7.3 Standardised mortality rates

Directly age standardised mortality rates (DSR) show the number of deaths, usually expressed per 100,000, that would occur in an area if it had the same age structure as a standard population, in this case the 2013 European Standard Population. Expressing mortality data in this fashion avoids the implication that areas with an older population, within which more people would be expected to die, are 'worse' than areas with a younger population if their mortality rate is higher due to the increased prevalence of older people.

For the period 2011-13, Peterborough had a mortality rate of 1,230 deaths per 100,000, a higher rate than that of East of England and England. The Peterborough mortality rates for males and females were also higher than the regional and national rates (Chart 6).

Figure 28 Deaths per 100,000 population, 2011-2013[25]



As the chart below shows, Peterborough had a significantly higher mortality rate (210.9/100,000 population) from causes considered preventable by public health interventions than the regional (165.7/100,000) and national (187.8/100,000) averages for the period 2010-12.

Peterborough also had a higher premature mortality rate – i.e. deaths under the age of 75 - from cardiovascular diseases considered preventable, at 75.1 per 100,000 compared to a regional average of 48.1/100,000 and a national average of 53.5/100,000, together with higher premature mortality rates from respiratory disease and higher all age death rates from communicable (infectious) disease. Premature mortality rates from cancer and liver disease and all age mortality rates for suicide were within the national average range. .

[25] https://indicators.ic.nhs.uk/webview/

Figure 29 - Age standardised mortality rates per 100,000 population[26]

Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
4.03 - Mortality rate from causes considered preventable (Persons)	2010 - 12	187.8	165.7	189.4	149.4	161.8	167.0	158.2	222.4	168.0	210.9	182.5	156.5	187.4
4.03 - Mortality rate from causes considered preventable (Male)	2010 - 12	238.4	207.7	235.0	186.3	206.2	210.3	196.7	279.3	212.1	282.1	206.2	195.6	236.0
4.03 - Mortality rate from causes considered preventable (Female)	2010 - 12	140.6	126.5	146.7	114.3	119.7	127.4	123.4	166.9	125.9	144.9	160.4	119.1	141.3
4.04i - Under 75 mortality rate from all cardiovascular diseases (Persons)	2010 - 12	81.1	72.6	81.3	62.7	64.8	70.4	71.0	111.5	73.5	103.8	83.3	67.9	90.4
4.04i - Under 75 mortality rate from all cardiovascular diseases (Male)	2010 - 12	114.0	101.9	107.4	86.6	87.3	100.2	100.4	155.7	101.2	145.4	121.1	96.5	128.9
4.04i - Under 75 mortality rate from all cardiovascular diseases (Female)	2010 - 12	50.1	45.0	55.9	39.5	42.9	42.8	43.6	68.7	47.2	64.3	47.7	40.6	54.0
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2010 - 12	53.5	48.1	58.6	39.3	45.7	45.8	45.3	83.1	49.6	71.5	56.6	45.5	59.7
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2010 - 12	80.8	72.4	78.4	59.0	65.3	71.2	67.8	121.6	73.1	110.8	81.3	69.2	96.2
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2010 - 12	27.6	25.2	39.4	20.1	26.6	22.3	24.4	46.0	27.3	34.1	33.2	22.8	25.2
4.05i - Under 75 mortality rate from cancer (Persons)	2011 - 13	144.4	136.0	131.9	128.4	135.0	141.7	130.6	149.8	132.9	151.2	140.6	134.8	153.3
4.06i - Under 75 mortality rate from liver disease (Persons)	2011 - 13	17.9	13.6	21.3	11.9	12.3	13.3	14.1	18.0	13.2	17.4	15.9	12.3	12.1
4.07i - Under 75 mortality rate from respiratory disease (Persons)	2011 - 13	33.2	26.2	35.4	23.6	24.6	25.6	27.3	36.0	24.8	41.9	32.5	21.8	33.1
4.08 - Mortality from communicable diseases (Persons)	2011 - 13	62.2	56.9	65.3	47.6	63.4	54.3	64.6	69.9	53.8	74.7	67.4	49.6	69.4
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2012/13	347.2	-	391.9	318.6	295.7	291.6	351.0	320.4	385.9	341.2	265.2	379.6	248.1

7.4 Premature mortality rates by electoral ward

As outlined in figure 30 below, Peterborough had significantly more premature deaths (under 75) than expected from all causes and specifically for circulatory disease and CHD, and respiratory disease. The table below shows standardised mortality ratios (SMRs) for premature deaths of residents aged under 75, for each electoral ward in Peterborough.

The standardised mortality ratio (SMR) highlights the differences between the number of admissions/deaths that occurred within a population and the number that would have been statistically expected within the population, adjusted for variance in the age and sex of the population. The SMR for England overall is always expressed as 100.0, reflecting the exact number of deaths that would have been expected within the total population of the country. An SMR higher than 100.0 illustrates that the mortality rate was higher than statistically expected based on the

[26] http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000044/pat/6/ati/102/page/0/par/E12000006/are/E06000031

national rate; conversely, an SMR lower than 100.0 shows that the mortality rate was lower than the national rate.

A clear picture emerges in which premature death rates and in particular premature deaths from cardiovascular disease and coronary heart disease are highest in wards with higher deprivation scores. The wards with statistically significantly high rates of premature death from all causes, cardiovascular disease and CHD are Central, Dogsthorpe, East, Orton Longueville, Park and Ravensthorpe. This includes five of the seven wards with the highest level of income deprivation. The other two electoral wards in the highest category of income deprivation – North and Paston – also have high all-cause premature death rates, but their premature death rates from cardiovascular disease and CHD are not statistically significantly high.

Figure 30 - Under 75 Standardised mortality ratios (SMR), 2008-2012[27]

Area Name	Numerator	Deaths under 75 all causes	Numerator	Deaths under 75 all Cancers	Numerator	Deaths Under 75 Circulatory Disease	Numerator	Deaths under 75, CHD
Barnack	49	87.9	28	119.1	13	100.2	6	78.3
Bretton North	149	115.4	50	96.3	36	123.9	19	114.5
Bretton South	47	110.5	15	86.8	10	101.4	9	164.1
Central	146	150.6	34	98.5	34	172.1	25	229.9
Dogsthorpe	153	131.5	49	106.8	42	161.0	29	197.1
East	177	142.9	55	114.4	50	181.2	29	188.9
Eye and Thorney	96	99.4	45	112.8	23	100.5	11	85.8
Fletton and Woodston	134	116.3	40	92.3	37	149.6	23	167.2
Glinton and Wittering	74	79.7	39	105.7	15	69.6	4	34.0
Newborough	34	74.1	17	89.7	6	54.4	3	48.7
North	100	129.5	37	121.6	24	137.4	16	161.5
Northborough	37	69.0	20	87.7	8	60.5	6	81.2
Orton Longueville	179	139.8	67	131.8	48	166.6	29	178.6
Orton Waterville	110	84.7	36	67.2	29	96.0	11	63.5
Orton with Hampton	82	77.8	36	96.3	15	68.2	6	51.0
Park	148	142.3	41	102.8	46	200.8	27	212.6
Paston	122	126.6	43	115.5	28	134.0	16	134.4
Ravensthorpe	139	159.2	35	104.2	43	224.5	28	262.0
Stanground Central	144	108.5	53	97.8	31	100.5	21	119.7
Stanground East	33	76.6	16	92.7	8	79.3	3	53.6
Walton	79	104.8	37	122.3	19	108.3	12	123.5
Werrington North	67	72.3	24	65.5	17	84.3	10	85.5
Werrington South	103	75.7	31	53.5	31	93.4	17	89.7
West	125	87.7	52	87.6	29	86.5	12	62.3
Peterborough UA	**2,527**	**109.0**	**900**	**97.7**	**641**	**122.3**	**370**	**125.8**
England	**762,945**	**100.0**	**310,211**	**100.0**	**176,217**	**100.0**	**99,575**	**100.0**

[27] http://www.localhealth.org/#l=en

7.5 Hospital admissions

The hospital standardised admission rate (SAR) highlights the differences between the number of hospital admissions that occurred within a population and the number that would have been statistically expected within the population, adjusted for variance in age and sex of the population. The SAR for England overall is always expressed as 100.0, reflecting the exact number of admissions that would have been expected within the total population of the country. An SAR higher than 100.0 illustrates that the admission rate within Peterborough was higher than statistically expected based on the national rate; conversely, an SAR/SMR lower than 100.0 shows that the admission rate within Peterborough was lower than the national rate.

Overall, between 2008 and 2013, the SAR for Peterborough was statistically significantly higher than the SAR for England, standing at 104.2. The ward level data shows clearly that, as for premature deaths, high standardised admission ratios for all causes and for CHD in particular are associated closely with the electoral wards which also have high levels of income deprivation.

Figure 31- Standardised admissions ratios for all causes, CHD, Stroke and COPD 2008-2013[28]

Area Name	Standardised Admission Ratio: Emergency hospital admissions for all causes (2008/09-2012/13)	Standardised Admission Ratio: Emergency hospital admissions for coronary heart disease (2008/09-2012/13)	Standardised Admission Ratio: Emergency hospital admissions for stroke (2008/09-2012/13)	Standardised Admission Ratio: Emergency hospital admissions for myocardial infarction (2008/09-2012/13)
Barnack	88.8	87.8	89.9	78.9
Bretton North	111.9	115.5	88.3	99.2
Bretton South	95.0	90.2	98.6	70.9
Central	127.5	160.9	145.2	115.4
Dogsthorpe	113.0	126.6	98.3	75.9
East	114.4	139.0	113.0	105.0
Eye and Thorney	94.3	91.5	99.9	73.3
Fletton and Woodston	109.8	117.3	119.8	93.3
Glinton and Wittering	85.8	95.1	89.4	88.5
Newborough	76.7	87.0	47.6	87.9
North	117.4	135.8	107.3	63.4
Northborough	86.8	116.9	95.0	115.1
Orton Longueville	118.3	137.7	98.3	92.9
Orton Waterville	86.2	91.9	84.6	78.5
Orton with Hampton	96.8	96.6	102.1	81.2
Park	119.3	150.4	122.4	113.0
Paston	107.2	111.1	84.1	101.3
Ravensthorpe	123.1	146.9	116.8	115.5
Stanground Central	99.6	104.9	114.1	86.5
Stanground East	93.9	105.7	105.0	92.2
Walton	99.1	104.3	95.1	81.4
Werrington North	85.4	109.0	79.2	94.4

[28] http://www.localhealth.org/#l=en

Area Name	Standardised Admission Ratio: Emergency hospital admissions for all causes (2008/09-2012/13)	Standardised Admission Ratio: Emergency hospital admissions for coronary heart disease (2008/09-2012/13)	Standardised Admission Ratio: Emergency hospital admissions for stroke (2008/09-2012/13)	Standardised Admission Ratio: Emergency hospital admissions for myocardial infarction (2008/09-2012/13)
Werrington South	85.7	92.9	71.8	83.4
West	92.8	92.6	107.4	71.3
Peterborough Unitary Authority	**104.2**	**114.3**	**101.4**	**89.9**
Cambridgeshire & Peterborough Clinical Commissioning Group	**86.8**	**97.7**	**89.3**	**85.6**
England	**100**	**100**	**100**	**100**

8. Use of adult social care

One of the priorities for all Health and Wellbeing Boards is the integration of health and social care. Benchmarking data on adult social care is available from URL: http://fingertips.phe.org.uk/adultsocialcare#gid/1000102/pat/6/ati/102/page/0/par/EMREG/are/E06000015

Figure 32 – Adult Social Care Indicators – Public Health England

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Permanent admissions to residential and nursing care homes per 100,000 aged 18-64	2013/14	14.4	16.7	5.1	14.0	3.1	9.5	15.8	15.5	44.7	17.3	4.8	12.9	10.0
Permanent admissions to residential and nursing care homes per 100,000 aged 65+	2013/14	651	649	665	724	510	604	630	440	776	582	640	630	619
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital	2013/14	82.5	82.2	50.0	83.3	75.0	82.0	85.0	82.6	87.2	76.9	78.6	73.8	90.0
Adults receiving day care services during the year per 100,000	2013/14	301.1	305.7	437.3	234.0	414.0	*	395.6	320.8	375.2	305.1	290.0	329.2	242.9
Adults who received direct payments during the year per 100,000	2013/14	367	355	241	284	276	*	303	590	505	316	515	331	329
Adults who received equipment and adaptations during the year per 100,000	2013/14	844	752	481	1212	278	*	585	590	265	1613	1718	3	0
Adults who received home care during the year per 100,000	2013/14	1110	1132	1023	986	859	*	1058	839	1351	1543	1504	1580	688
Adults who received meals during the year per 100,000	2013/14	75.4	79.1	84.3	2.0	67.8	*	6.8	81.0	0.0	168.4	228.4	130.0	0.0
Adults who received other services during the year per 100,000	2013/14	177	100	871	124	617	*	42	0	0	25	87	141	272
Adults who received professional support during the year per 100,000	2013/14	460	298	514	232	85	*	345	272	59	337	272	333	21
Adults who received short term residential care (not respite) during the year per 100,000	2013/14	155.1	69.1	4.0	57.8	232.4	*	86.1	116.6	45.5	270.1	0.0	81.2	119.4
Adults who received any community based support during the year per 100,000	2013/14	2482	2347	2303	2316	1741	2790	2264	2041	1978	2869	3197	2323	1149

Indicator	Period													
Overall satisfaction of people who use services with their care and support	2013/14	64.8	65.6	67.0	65.4	63.6	59.2	60.3	54.7	70.1	64.9	61.0	67.5	62.5
Overall satisfaction of carers with social services	2012/13	42.7	40.0	42.3	39.2	36.7	36.7	41.3	36.4	44.6	42.1	44.4	36.5	45.8
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2013/14	2064	1948	1881	2221	1793	2021	2033	1966	1756	2172	2162	1786	1627
Admissions for falls per 100,000 aged 65+	2010/11	2475	2208	2137	2126	2116	2253	2097	2533	2062	3015	3092	2239	1588

9. Adult Mental health –

Figure 33- Public Health England Mental Health Data – Prevalence, Risks & Treatment

Indicator	Period	England	East of England region	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	Peterborough	Southend-on-Sea	Suffolk	Thurrock
Estimated prevalence of opiate and/or crack cocaine use	2011/12	8.4	5.8	9.3	4.3	4.4	4.8	4.6	11.8	7.3	10.5	9.4	5.2	4.8
Admission to hospital for mental and behavioural disorders due to alcohol	2012/13	84.1	51.8	43.1	58.6	42.1	43.1	41.3	92.7	74.6	66.1	58.7	51.9	19.7
Smoking Prevalence (IHS)	2013	18.4	17.5	13.7	13.5	15.0	18.9	15.5	20.0	18.0	20.8	21.8	18.5	22.8
Number in treatment at specialist drug misuse services	2013/14	193252	15342	593	1510	480	3090	2518	950	2437	1010	842	1487	425
Number in treatment at specialist alcohol misuse services	2013/14	89265	6800	139	565	195	1460	1271	437	1217	381	267	675	193
Numbers in stop smoking services	2013/14	586337	63738	1805	6403	2343	15372	11720	2227	8066	1716	2818	8896	2372
Concurrent contact with mental health services and substance misuse services for drug misuse	2013/14	17.5	17.2	17.0	15.4	24.0	22.4	15.5	17.7	17.2	13.6	12.2	17.8	5.2
Concurrent contact with mental health services and substance misuse services for alcohol misuse	2013/14	21.2	19.4	18.9	13.4	30.6	28.1	18.8	20.4	14.9	8.3	9.1	22.5	5.6
Proportion waiting more than 3 weeks for drug treatment	2013/14	2.0	2.2	1.1	6.8	0.0	1.0	0.2	6.5	0.6	0.5	1.4	7.3	4.5
Proportion waiting more than 3 weeks for alcohol treatment	2013/14	7.3	3.9	1.3	5.6	0.5	3.6	1.5	5.3	1.2	2.4	3.1	4.9	25.4
Successful completion of drug treatment - opiate users	2013	7.8	7.4	8.6	8.0	5.4	5.1	8.5	8.6	6.2	11.3	4.2	8.6	12.0
Successful completion of drug treatment - non-opiate users	2013	37.7	34.8	26.9	39.2	34.3	40.1	31.0	26.4	31.3	49.2	31.3	26.9	47.2
Successful completion of alcohol treatment	2013	42.5	38.0	45.3	41.4	32.3	37.5	39.3	29.1	39.8	67.2	17.2	26.5	43.0
Quit rate from stop smoking services	2013/14	51.3	54.4	51.5	46.5	58.7	57.4	57.9	54.7	52.7	79.7	46.3	50.7	48.3
Successful quitters confirmed by biochemical validation	2013/14	70.1	71.0	71.6	64.5	75.3	69.1	65.9	57.8	80.8	83.4	66.5	76.2	73.2

9.1 Working age adults: Prevalence of Mental Illness

NHS England is committed to valuing mental health equally with physical health. Mental illnesses are very common; among people under 65, nearly half of all ill health is mental illness and mental health problems impose a total economic and social cost of over £105 billion per year.[29]

Prevalence of common mental disorders (CMDs)

CMDs include different types of depression and anxiety. They cause appreciable emotional distress and interfere with daily function, but do not usually affect insight or cognition. The table below shows the prevalence of mental health conditions taken from the Adult Psychiatric Morbidity Survey 2007.

Figure 34- Peterborough CMD prevalence estimates[30]

Prevalence	Males	Females
Common mental disorder	12.5%	19.7%
Borderline personality disorder	0.3%	0.6%
Antisocial personality disorder	0.6%	0.1%
Psychotic disorder	0.3%	0.5%
Two or more psychiatric disorders	6.9%	7.5%

Estimated number of people by mental health disorder, aged 18-64, April 2015, Peterborough Unitary Authority

The table below shows the estimated number of people in Peterborough with the above mental health conditions by mental disorder. These are based on the Adult Psychiatric Morbidity Survey prevalence estimates applied to the April 2015 GP Registered population aged 18-64 in Peterborough.

Figure 35- Peterborough CMD estimated numbers[31]

Mental disorder	Peterborough estimated number as at Apr 2015
Common mental disorder	20,000
Borderline personality disorder	600
Antisocial personality disorder	400
Psychotic disorder	500
Two or more psychiatric disorders	8,900

[29] http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/

[30] Adult Psychiatric Morbidity Survey 2007

[31] Adult Psychiatric Morbidity Survey 2007 applied to Quarterly Age Sex Breakdown, aged 18-64, April 2015, Peterborough GP Practices

A further breakdown of common mental disorder prevalence is shown in the table below taken from the Adult Psychiatric Morbidity Survey 2007.

Figure 36- Peterborough CMD estimated numbers[32]

Prevalence of CMD in past week, by age and sex 2007

All adults

		Age band (years)							All
Mental disorder	**Sex**	***16-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**	
Mixed anxiety and depressive disorder	Male	8.2%	7.4%	7.4%	8.1%	6.8%	3.9%	3.8%	6.9%
	Female	12.3%	14.1%	9.7%	14.3%	9.0%	8.6%	7.2%	11.0%
Generalised anxiety disorder	Male	1.9%	4.1%	4.7%	4.1%	2.7%	2.9%	2.2%	3.4%
	Female	5.3%	4.3%	5.9%	8.0%	5.5%	3.6%	2.9%	5.3%
Depressive episode	Male	1.5%	2.7%	2.6%	2.6%	1.5%	0.4%	0.5%	1.9%
	Female	2.9%	1.7%	3.2%	4.9%	2.2%	1.6%	2.1%	2.8%
All phobias	Male	0.3%	1.5%	1.5%	0.7%	0.6%	0.3%	-	0.8%
	Female	2.7%	2.4%	2.7%	2.2%	2.2%	0.4%	0.2%	2.0%
Obsessive compulsive disorder	Male	1.6%	1.5%	1.2%	0.7%	0.4%	0.2%	0.3%	0.9%
	Female	3.0%	1.5%	1.0%	1.6%	0.7%	0.4%	0.5%	1.3%
Panic disorder	Male	1.4%	0.9%	1.3%	0.8%	0.6%	1.0%	0.3%	1.0%
	Female	0.8%	2.3%	1.4%	1.1%	1.4%	0.1%	0.6%	1.2%
Any CMD	Male	13.0%	14.6%	15.0%	14.5%	10.6%	7.5%	6.3%	12.5%
	Female	22.2%	23.0%	19.5%	25.2%	17.6%	13.4%	12.2%	19.7%

Estimated number of people by mental health disorder, aged 18-64, April 2015, Peterborough City Council

The table below shows the estimated number of people in Peterborough with these mental health conditions by mental disorder.

Figure 37- Peterborough CMD estimated numbers[33]

		Age band (years)					All
Mental disorder	**Sex**	***18-24**	**25-34**	**35-44**	**45-54**	**55-64**	
Mixed anxiety and depressive disorder	Male	720	1240	1130	1050	630	4,780
	Female	1100	2360	1310	1770	870	7,400
	Total	1,830	3,600	2,440	2,820	1,500	12,190
Generalised anxiety disorder	Male	170	690	720	530	250	2,360
	Female	470	720	800	990	530	3,510
	Total	640	1,400	1,510	1,520	780	5,870
Depressive episode	Male	130	450	400	340	140	1,460
	Female	260	280	430	610	210	1,790
	Total	390	740	830	950	350	3,250
All phobias	Male	30	250	230	90	60	650
	Female	240	400	360	270	210	1,490
	Total	270	650	590	360	270	2,150
Obsessive compulsive disorder	Male	140	250	180	90	40	700
	Female	270	250	140	200	70	920
	Total	410	500	320	290	110	1,620
Panic disorder	Male	120	150	200	100	60	630
	Female	70	390	190	140	140	910
	Total	200	540	390	240	190	1,550
Any common mental disorder	Male	1,160	2,440	2,290	1,880	1,000	8,760
	Female	1980	3850	2630	3130	1690	13,280
	Total	3,140	6,290	4,920	5,000	2,690	22,040

[32] Adult Psychiatric Morbidity Survey 2007

[33] Adult Psychiatric Morbidity Survey 2007 applied to Quarterly Age Sex Breakdown, aged 18-64, April 2015, Peterborough GP Practices (*prevalence assumed the same for 18-24 as 16-24)Note: numbers may not add up due to rounding

9.2 Older people: prevalence of mental illness

We do not know exactly how many people in Peterborough have conditions such as dementia, because many people living with the condition are un-diagnosed. This means that we have to use ways to estimate the number of people with dementia in Peterborough.

Below data detail the number of people that we estimate have dementia in Peterborough both in 2015, and projected further into the future (2020 and 2025). Prevalence estimates were obtained from the Dementia UK Report (Alzheimer's Society, 2007) and applied to the official ONS population estimates. The prevalence, the number of people with dementia (including early onset) living in Peterborough, is predicted to increase from 2,011 in 2015 to 2,274 in 2020 and 2,655 in 2025 – an increase of 32% over the next ten years.

Figure 38 - Number of People with Dementia – By Age Band (2015 to 2025)[34]

Age Band	2015	2020	2025
under 65	43	48	52
65-69	110	105	116
70-74	167	225	218
75-79	304	323	432
80-84	493	513	573
85+	894	1,060	1,264
all ages	2,011	2,274	2,655

Figure 39 - Number of People with Dementia – By Gender (2015 to 2025)[35]

Gender	2015	2020	2025
Males	739	857	1018
Females	1,272	1,417	1,636
Total	2,011	2,274	2,655

The table below provides details of **Quality and Outcomes Framework (QOF)** GP practice data showing that in 2012/13 only 889 people in Peterborough had a confirmed diagnosis of dementia – based on GP practice registers. This is nearly half (45%) of the 1,978 people estimated to be living with dementia in Peterborough in 2014, indicating a high level of under ascertainment.

[34] http://www.poppi.org.uk/index.php?pageNo=334&areaID=8318&loc=8318
http://www.pansi.org.uk/index.php?pageNo=408&areaID=8640&loc=8640
[35] http://www.poppi.org.uk/index.php?pageNo=334&areaID=8318&loc=8318
http://www.pansi.org.uk/index.php?pageNo=408&areaID=8640&loc=8640

Figure 40 - Number of People Estimated to have Dementia compared with QOF dementia register 2012/13[36]

Area	Number of people predicted to have dementia			
	By 2014 prevalence estimates	According to 12/13 QOF register	Difference	Percentage on register
Peterborough PCT	1,978	889	1,089	44.94%
East	81,670	34,535	47,135	42.29%
England	675,789	318,669	357,120	47.16%

Depression

The tables below shows that the numbers of older people with depression and severe depression are expected to increase over the next ten years, due to the overall rise in the older population.

Figure 41 - Change in projected number of people with depression compared with 2012 in people aged 65 and older, in Peterborough, 2012 to 2026[37]

	2012	2016	2021	2026
Peterborough				
Number of cases	2,225	2,413	2,686	3,020
Variance from 2012		+188	+461	+795

Severe Depression

The table below shows the number of older people expected to have severe depression, based on national prevalence estimates using POPPI. Between 2012 and 2026 the number of older people expected to have severe depression is predicted to rise from 712 to 974.

Figure 42 - Change in projected number of people with severe depression compared with 2012 in people aged 65 and older, in Peterborough, 2012 to 2026[38]

	2012	2016	2021	2026
Peterborough				
Number of cases	712	767	848	974
Variance from 2012		+55	+136	+263

[36] *http://www.poppi.org.uk/index.php?pageNo=334&areaID=8318&loc=8318*
http://www.pansi.org.uk/index.php?pageNo=408&areaID=8640&loc=8640 dementia prevalence and 2012/13 QOF dementia diagnosis[36]
[37] POPPI prevalence estimates applied to CCC Research and Performance Team population forecasts (2012 based)
[38] POPPI prevalence estimates applied to CCC Research and Performance Team population forecasts (2012 based)

9.3 Health service usage - Mental Health Comparators

Peterborough is shown in the figure 43[39] below to have a significantly higher than average rate for hospital admissions for mental health (directly standardised to account for variance in age of population) and a low percentage of referrals entering treatment from Improving Access to Psychological Therapies – although this information is now quite out of date, being from 2011/12.

Figure 43 – Key Health Service Usage Indicators

	Indicator	Period	England	East of England	Bedford	Cambridgeshire	Central Bedfordshire	Essex	Hertfordshire	Luton	Norfolk	**Peterborough**	Southend-on-Sea	Suffolk	Thurrock
15	Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	2009/10 to 2011/12	243	201	200	172	139	197	150	241	368	**321**	323	234	175
16	Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12	2009/10 to 2011/12	32.1	27.2	19.9	26.8	13.0	25.1	19.5	17.0	34.9	**32.4**	21.8	46.2	17.5
17	Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	2009/10 to 2011/12	80	75	100	67	74	96	62	50	67	**39**	59	62	179
18	Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12	2009/10 to 2011/12	57	43	69	35	29	28	32	92	56	**55**	40	69	22
19	Allocated average spend for mental health per head, 2011/12	2011/12	183	166	155	157	155	168	162	178	172	**181**	176	164	171
20	Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11	2010/11	2.5	2.5	2.0	2.4	2.0	2.8	2.2	2.7	2.3	**2.8**	3.7	2.2	3.8
21	Percentage of referrals entering treatment from Improving Access to Psychological Therapies, 2011/12	2011/12	60.1	59.8	52.7	59.9	52.7	60.5	48.5	43.0	58.9	**50.5**	74.3	71.2	75.9
22	Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11	2010/11	6.4	5.3	4.8	14.9	4.8	3.9	4.6	5.0	2.7	**15.0**	5.1	2.3	5.4
23	In-year bed days for mental health, rate per 1,000 population, 2010/11	2010/11	193	187	168	156	168	221	207	159	149	**184**	284	141	270
24	Number of contacts with Community Psychiatric Nurse, rate per 1,000 population, 2010/11	2010/11	169	175	89	168	89	105	293	125	166	**295**	136	211	110
25	Number of total contacts with mental health services, rate per 1,000 population, 2010/11	2010/11	313	314	195	289	195	256	431	226	250	**496**	383	368	377

10. Conclusion

This report summarises a multitude of data sources from both within and outside of Peterborough City Council that provide a 'snapshot' of the health of the population of Peterborough and the opportunities and risks that our rapidly growing city present from a public health perspective. Taken in conjunction with the 2015 Director of Public Health Annual Report, this report highlights the need for Peterborough City Council and associated stakeholders throughout the local healthcare economy to continue to strategically and proactively collaborate to meet the priorities of our Health and Wellbeing Strategy. This strategy has acknowledged the existence of substantial disparities in Peterborough, ranging from economic affluence to life expectancy to educational attainment, and a stated commitment to reducing these inequalities.

The current priorities of our Health & Wellbeing Board remain focused on narrowing inequalities and providing the best levels of opportunities in life and care when needed to residents ranging from children and young people to our older residents. It is anticipated that the data within this 'core dataset' will inform and underpin the development of a new Health & Wellbeing Strategy.

[39] http://fingertips.phe.org.uk/profile-group/mental-health

Peterborough's population is expected to increase 34.9% by 2031, with growth particularly high with regards to under 19s and people over the age of 65; this makes Peterborough one of the fastest growing cities in the country. Such high growth presents both the obvious risks associated with increasing service demand but also the opportunity to ensure the health of our residents improves through the design and commissioning of appropriate services, particularly preventative services, to enable people to stay healthier for longer.

This approach focuses on how shaping 'the wider determinants of public health' such as educational attainment, employment opportunities and empowering people to take responsibility for their own healthcare, can improve the health of individuals and reduce their demand for services whilst simultaneously providing effects desirable for any fast-growing city, such as improved overall happiness/wellbeing and substantial economic growth.

Data demonstrate a high level of health inequalities within Peterborough, particularly in electoral wards nearer the centre of the City which have above average rates of premature mortality, particularly from cardiovascular disease including coronary heart disease. However, some other electoral wards show life expectancy and mortality figures that are substantially better than that of England.

Appendix 2: Peterborough City Council Joint Strategic Needs Assessments Roadmap

Assessment topics & demographic groups

The public health team have elected to approach JSNAs using a methodology based on demographic segmentation in order to be able to greater concentrate resources on issues specific to the target group within each project; it is anticipated that this will result in more focused and easily accessible final products. For example, the topic of mental health/mental illness will be focused in this JSNA period on 'adults' i.e. the 18-65 age group only; future JSNAs will focus on this topic in relation to children and young people and people over the age of 65 in order that adequate focus to the specific needs of the demographic group be assessed within each project.

JSNA topics are chosen by Peterborough City Council's Health & Wellbeing Board; chosen topics for the 2014/15 and 2015/16 financial years (to date) are listed below. In addition to five JSNA topics, the public health team have been obligated by statutory requirement to produce a Pharmaceutical Needs Assessment fit for publication by 31/03/2015.

Topic	Demographic Group		
	Children & Young People (0-18)	**Adults of Working Age (>18 - <65)**	**Older People (65+)**
Pharmaceutical Needs Assessment	X	X	X
Children & Young People's Joint Strategic Needs Assessment	X		
Cardiovascular Disease Joint Strategic Needs Assessment	X	X	X
Mental Health/Mental Illness in Adults Joint Strategic Needs Assessment		X	
Eastern European Migrants Joint Strategic Needs Assessment	X	X	X
Older People's Primary Prevention			X

Joint Strategic Needs Assessment			

Prospective Timeline for JSNA Presentation April 2015 – June 2016

The below table outlines proposed presentation dates for completed JSNA projects as chosen by the Health & Wellbeing Board in 2014/15. All completed JSNAs will initially be presented at the Health & Wellbeing Programme Board preceding the intended Health & Wellbeing Board presentation date for approval prior to submission to Health & Wellbeing Board.

Topic description	April 2015	May 2015	June 2015	July 2015	August 2015	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016	April 2016	May 2016	June 2016
Pharmaceutical Needs Assessment (presented March 2015, published April 2015)															
Children & Young Persons Joint Strategic Needs Assessment															
Cardiovascular Disease Joint Strategic Needs Assessment															
Mental Health/Mental Illness in Adults Joint Strategic Needs Assessment															
Eastern European Migrants Joint Strategic Needs Assessment															
Older People's Primary Prevention Joint Strategic Needs Assessment															

Project rationales:

Pharmaceutical Needs Assessment: Every Health & Wellbeing Board (HWB) in England has a statutory duty to publish and keep up to date a statement of need for pharmaceutical services in its area, otherwise referred to as a Pharmaceutical Needs Assessment (PNA). PNAs are key reference documents as regards the development and improvement of local pharmaceutical services. According to the NHS Pharmaceutical Service Regulations 2013, NHS England Area Teams must consider local PNAs whilst dealing with applications from new pharmaceutical service providers i.e. in deciding whether a new pharmacy should be allowed in a particular locality or not, otherwise referred to as market entry.

PNAs involve analysis of contemporaneous health data/statistics to ascertain the health needs of the local population and any gaps in service provision that may be addressed by services that could be commissioned by pharmacies. Responsibility for compilation of the PNA has rested with the Public Health Intelligence team in conjunction with an advisory stakeholder group consisting of key pharmaceutical contacts in the area including representatives from NHS England and Cambridgeshire & Peterborough Clinical Commissioning Group.

Children & Young Person's Joint Strategic Needs Assessment: Peterborough's Health and Wellbeing Strategy 2012-15 prominently features a commitment to improving opportunities for children and young people, with the first priority within the strategy stating 'Ensure that children and young people have the best opportunities in life to enable them to become healthy adults and make the best of their life chances'. Resultantly, a Children and Young Person's Joint Strategic Needs Assessment was commissioned, commencing with some multi-agency stakeholder workshops during the autumn period of 2013. Early findings were presented at the Health and Wellbeing Board in January 2014 and further work was subsequently undertaken at the behest of the H&WBB and Children & Families Commissioning Board throughout 2014.

The final JSNA product analyses the health profile of children & young persons in people with regard to a range of indicators including healthcare-specific information such as obesity levels and mental illness prevalence and broader socio-economic data such as deprivation levels and educational attainment. The final product was presented to the Children & Families Commissioning Board in December as the end of 'phase one' of this needs assessment, with a request that the Board set up stakeholder working groups to work in conjunction with Public Health to take forward initiatives designed to meet the Health and Wellbeing Strategy's aims with regards to children and young people in 2015.

Cardiovascular Disease, Mental Health/Mental Illness in Adults, Eastern European Migrants & Older People's Primary Prevention Joint Strategic Needs Assessments:

In quarter 3 of 2014/15, Peterborough City Council's Health & Wellbeing Programme Board approved work to begin on four themed Joint Strategic Needs Assessments; firstly cardiovascular disease (CVD) and mental health/mental illness in adults followed by JSNAs on Eastern European migrants and older people's primary prevention. CVD is considered the top priority by the Health & Wellbeing Board, therefore a full JSNA will be undertaken in conjunction with targeted related work streams with a view towards improving the performance of Peterborough's healthcare economy with regards to CVD.

The three other chosen themes reflect current priorities for health in Peterborough; it is a stated goal of the NHS to give genuine parity to mental health/mental illness alongside physical health and as the UK's fastest growing city, it is considered appropriate to also undertake JSNAs pertaining to the substantial Eastern European migrant population within the city and older people's primary prevention, as growth in our older population is predicted to be disproportionately higher over the coming years.

Peterborough Health and Wellbeing Board

Health and Wellbeing Strategy 2012-15

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

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Introduction to the Health and Wellbeing Strategy

The Health and Wellbeing Board is pleased to present this first Health and Wellbeing strategy for Peterborough.

It marks an important milestone in the implementation of the 2012 Health and Social Care Act.

Perhaps more importantly it represents a further step in developing the shared vision for improving the health and wellbeing of the Peterborough population.

Through this strategy the board:

- **Identifies health and wellbeing priorities that can be owned and acted upon by the key strategic partnerships**
- **Sets clear markers for NHS and Local Authority commissioners as they act to put in place the right mix of services and initiatives to meet the needs of the population**
- **Holds commissioners to account for their decisions**
- **Helps to develop partnerships with statutory and voluntary sector colleagues that provide solutions to commissioning challenges including the wider determinants of health and wellbeing e.g housing**

The Health and Wellbeing Board is a new partnership. It comprises of representatives from the new Shadow Cambridgeshire and Peterborough Clinical Commissioning Group, alongside elected members and senior managers from Peterborough City Council's Children's and Adult Social Care Services and the Director of Public Health and Link/Local Healthwatch representatives. It will take time to develop strong and effective working relationships during this period of transition. Achieving a consensus on priorities and starting a process of wider engagement with the public and interest groups is the best place to start. It is recognised that this work will be taking place in
a context of significant financial challenge across public services and within the local economy and population as a whole.

The Health and Wellbeing Board's strategic priorities have grown out of detailed assessments of need that culminated in the Joint Strategic Needs Assessment (JSNA) 2012. In the paragraphs that follow, the strategic priorities that are presented are underpinned by the findings of the JSNA. (http://www.peterborough.gov.uk/health_and_social_care/joint_strategic_needs_assesmen.aspx)

These priorities represent those areas of activity that need a high level of collaboration between services and where the interdependence of health and social care is most marked. By working together, there is a greater chance that real, sustainable improvements to health and wellbeing can be made. In this regard every effort has and will be made to align the commissioning processes of the Local Authority and Clinical Commissioning Group, and ensure the engagement of the full range of health and council services that can contribute to that improvement.

Statutory and voluntary sector partners represented on the Health and Wellbeing Board are committed to ensuring that this strategy respects, protects and gives due regard to the health and wellbeing needs of disadvantaged groups specified within the Equalities Act (2010). Through the priorities indentified within this strategy, key themes regarding the needs of specific groups with protected characteristics as identified within the Act are addressed. It is expected that commissioning intentions will reflect these needs through the embedding of the principles of equality, diversity and inclusiveness.

This strategy is not intended to be a compendium of all relevant, national and local strategies and plans, but it does draw from them and also the national outcomes frameworks. These frameworks, NHS, Adult Social Care, Public Health, provide the Health and Wellbeing Board with tools for identifying Peterborough's current baseline and for measuring year on year progress.

The strategy is intended to closely align with, but not duplicate, the strategies of other key partnership boards such as the Greater Peterborough Partnership, Safer Peterborough Partnership, Adult's and Children's Safeguarding Boards.

1. How healthy are we?

The city is thriving, with high birth and fertility rates when compared with similar authorities. It has a young population, with a rich mix of ethnic minority populations and an overall white British majority. The initial findings of the 2011 Census indicate the population of Peterborough has grown significantly over the past decade and is expected to grow by a further 20,000 people in the next ten years, with particularly significant increases in the number of new births and older people.

Peterborough is also a city with relatively high levels of deprivation. Within the city there are areas that are amongst the ten per cent most deprived areas in the country. It is estimated that nearly one in four children, 10,500, live in poverty. In those most deprived areas, the health of residents, as reflected in life expectancy, is markedly worse. Compared with those who live in the least deprived areas, on average men die more than nine years earlier, and women more than five years earlier.

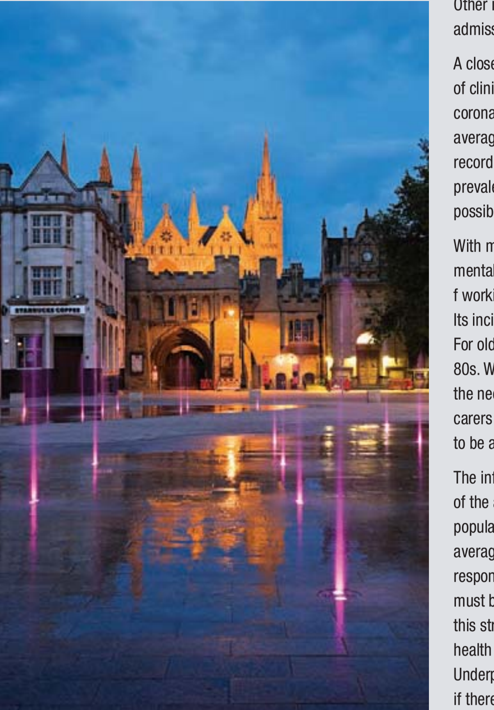
A good start in life is important, yet child mortality and numbers of low birth weight babies are significantly higher than average in some areas; fewer babies benefit from breastfeeding and more than average numbers of children at age 11 are obese. Teenage pregnancy rates are higher than average. The proportion of young people who are not in education, employment or training (NEET) is higher than average, placing Peterborough third highest for NEETs amongst the ten authorities described as our statistical neighbours.

Over 1,400 children and young people aged 0-17 are in receipt of Disability Living Allowance, again placing Peterborough third highest in the number of children in receipt of this benefit amongst comparator authorities. Peterborough consistently has a higher than average number of pupils who are determined as having Special Educational Needs (SEN), as reflected in the numbers of SEN statutory statements.

Another significant feature of the local demography is the presence of the local prison. HMP Peterborough houses male and female prisoners and includes a mother and baby unit. The prison has capacity for 1,020 individuals. In health and social care terms, this is a high needs population, some of whom receive specialist care from local services.

Peterborough has experienced significant inward migration from the European Community. Some communities within the city experience a relatively high turnover of population which is reflected in the experience of some GP surgeries. This feature of the local demography is relevant because of the added complexity of meeting the health needs of this more transient, younger population. This complexity can relate to language and cultural barriers and where, due to a high turnover, it is more difficult to establish continuity of care

A key strategic issue for Peterborough, in common with many other authorities, is the growth of the population aged over 85. This frailer age group need well organised and responsive health and social care services to meet higher levels of complex clinical and social care needs and to help them and their carers to remain independent.
The JSNA indicates that Peterborough now has a significantly higher than the national average rate of hip fractures, a key cause of emergency admissions to hospital. It also indicates that there will be a 52 per cent growth in the 85 plus population over the next ten years.



"By working together, there is a greater chance that real, sustainable improvements to health and wellbeing can be made."

In addition to the anticipated growth in the older people's population, Peterborough City Council currently commits substantially more of its gross budget on services for adults with a learning disability than its comparator authorities. It commits 37 per cent as opposed to 25 per cent and by contrast it commits comparatively less on services for older people, 41 per cent as opposed to the 56 per cent committed by its comparator group. Both represent significant challenges for commissioners.

Peterborough's adult population when assessed against some of the key determinants of health, such as smoking, weight, activity, reflects a community where a higher than average number smoke, are above average in terms of obesity and low in terms of physical activity.
Other indicators such as alcohol related and smoking specific hospital admissions portray, in both cases, high levels of need.

A closer look into the data on hospital admissions for two key areas of clinical concern, chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD) is instructive. Peterborough is about average for emergency hospital admissions for COPD, but the numbers recorded on GP disease registers is significantly below the assumed prevalence of the disorder. For CHD, there are high mortality rates but possibly a lower level of detection and earlier intervention.

With mental health, applying national prevalence rates for common mental health problems suggests that approximately 22,000 adults f working age in Peterborough will suffer from those problems.
Its incidence correlates strongly with other indicators of deprivation.
For older people, dementia is estimated to affect 20 per cent of the over 80s. When population growth figures for that age group are considered, the needs of substantially growing numbers of older people and their carers affected by this most serious and demanding illness will have to be addressed.

The information set out in this section is intended to give a picture of the authority by identifying some key features of the health of its population . At all age levels, there are marked areas of high or above average needs and demographic factors that suggest that those responsible for commissioning services for Peterborough's population must balance a complex range of competing priorities. It is the task of this strategic document to provide guidance and direction on the key health and wellbeing priorities. These are described in section 5 below. Underpinning those priorities is the notion that they can only be tackled if there is shared ownership of the issue in question and a commitment to concerted collaborative action. Put simply, we are stronger together.

2. What do we spend our commissioning resources on?

In very broad terms the statutory services have the following budgets available, based on:

NHS
Cambridgeshire and Peterborough Clinical Commissioning Group

NHS Peterborough's total budget in 2010/11 was £355 million spent on:

- Doctors, dentists, opticians and pharmacists (24 per cent)
- Hospitals and other patient services (49 per cent)
- Community and adult social care services (19 per cent)
- Other services (8 per cent)
- A ring-fenced Public Health budget of approximately £8 million will transfer to Peterborough City Council from April 2013.

PETERBOROUGH CITY COUNCIL

Peterborough City Council's children and adult's budget for 2012/13 is £75 million, spent on:

- Children and young peoples services including education and social care - £29 million
- Adult social care - £46.8 million.

With reducing budgets and rising demand there is a need for sound financial management. Budgetary pressures will impact on the ability of services to respond to needs and will focus the attention of commissioners and providers on the most effective way to deploy resources. These resources are committed to a range of health, local authority and third sector services to meet priority needs. Whilst there is limited room to manoeuvre financially, there is real potential to achieve more through joined-up approaches to the commissioning and delivery of core services. This strategy is intended to support such efforts. In doing so it endorses the following description of commissioning:

The process that health commissioners and local authorities use to secure the best care at the best value for individuals and the local population. It involves translating their aspirations and needs into services that:

- **deliver the best possible health and well-being outcomes, including promoting equality**
- **provide the best possible health and social care provisions and**
- **achieve this with the best use of available resources.**

In the following sections the Health and Wellbeing Board will set out its priorities along with the outcomes frameworks that should be used to assess impact of services.

3. Identifying strategic priorities to make an impact on health and wellbeing

Factors which influence health outcomes and health inequalities

The health and wellbeing of Peterborough's residents is affected by where they live, their environment, economic circumstances, social and family support, interaction with the local community, lifestyle choices that are made, community safety and access to appropriate services.

Making a difference to the health and wellbeing of the population is the responsibility and business of all. Action is required at the individual, family, community and service level to improve health outcomes and life chances. This will include a recognition of and action to support informal carers who play such a crucial role for children and adults in need

The Health and Wellbeing Board has agreed a broad criteria to underpin the inclusion of its strategic priorities. These priorities:

a) are agreed to be the most important

b) require a multi-agency response

c) address the wider determinants of health

d) deliver the most benefit to the health and wellbeing of the population

e) impact upon health inequalities

f) will have a positive preventative effect through promoting timely intervention.

4. A summary of strategic priorities

The following priorities are set out in the form of a key strategic theme; the underlying objectives; reasons for taking action and outcomes that will be addressed by taking action. The priorities are not set out in any rank order.

i) Securing the foundations of good health	
Objective	Ensure that children and young people, including those with complex needs and disabilities have the best opportunities in life to enable them to become healthy adults and make the best of their life chances.
Why is this an issue for Peterborough?	JSNA evidence of: • significant incidence of low birth weight babies, smoking in pregnancy, child mortality • lower than average educational achievement • above average teenage pregnancy rates • average childhood obesity rates • above average Not in Education, Employment or Training (NEET) figures • domestic abuse represents a significant proportion of all recorded crime and is recognised as a key priority by the Safer Peterborough Partnership
How will it be addressed	Commissioning those services that deliver: • high quality ante and post-natal care, early years and healthy childhood services, high quality education and social care and transitional care arrangements
Which outcomes will underpin the priority	• key maternity and children's Public Health outcomes • NEET data • educational attainment

ii) Preventing and treating avoidable illness	
Objective	Narrow the gap between those neighbourhoods and communities with the best and the worst health outcomes, whilst improving the health of all
Why is this an issue for Peterborough?	JSNA evidence of: • significant difference in average life expectancy between council wards • population increase • high mortality rates for coronary heart disease (CHD) and lower than expected prevalence on GP registers • variability in prevalence and admission rates by GP practice for patients with chronic obstructive pulmonary disorder (COPD) • significantly lower levels of physical activity in adults • high levels of smoking and smoking attributable deaths • around a quarter of adults are estimated to be obese • significantly higher levels of alcohol related hospital admissions • significantly higher levels of smoking attributable hospital admissions • high proportion of deaths attributable to diabetes
How will it be addressed	Through action to: • identify and respond proactively to those who are known to be most vulnerable and to address variability in screening, diagnosis and treatment rates. • encourage the adoption and maintenance of healthy lifestyles across all age groups by building on achievements in smoking cessation, obesity reduction and increasing physical activity. • develop a comprehensive care pathway for alcohol, including improved screening and access to specialist treatment services delivered collaboratively across acute, community and primary care services
Linked outcomes	Public health outcome framework indicators, health and lifestyle indicators from the Peterborough Health Profile, in particular: • disease and poor health indicators • life expectancy and causes of death indicators • take-up of health checks programme by those eligible • take-up of non-cancer and cancer screening programmes • immunisations and vaccinations • smoking prevalence in adults aged 18 and over • alcohol related hospital admissions

iii) Healthier older people who maintain their independence for longer	
Objective	Enable older people to stay independent and safe and enjoying the best possible quality of life
Why is this an issue for Peterborough?	JSNA evidence of: • increase in population (especially those in the 65+ age group) • higher than average rates of hip fracture (the most commonly reported diagnosis for emergency admission of adults over 85) • increase in incidence of reported vulnerable adults investigation for those aged over 85 • flu vaccination for over 65s is below average • incidence of dementia is rising • some evidence of lower rates of access to specialist mental health services for over 65s
How will it be addressed	Through concerted and timely action to: • promote and support people to maintain their independence • reduce unnecessary hospital admissions and continue to focus on falls and accident prevention • deliver a personalised approach to care that addresses physical, mental and psychological health • empower people to engage with their communities and have fulfilled lives, including healthy active ageing
Linked outcomes	Selected outcomes/indicators from the Adult Social Care Outcomes Framework and Public Health Outcomes Framework

iv) Supporting good mental health	
Objective	Enable good child and adult mental health through effective, accessible mental health promotion and early intervention and rapid response services to impact upon early signs of mental ill health or deterioration
Why is this an issue for Peterborough?	JSNA evidence of: • mortality from suicide and injury undetermined is higher than average • unemployment levels in Peterborough are above average, (unemployment correlates with mental ill-health) • above average numbers in drug treatment • high level of school exclusions and out of city placements for children and young people with statements with the primary category being behavioural emotional and social difficulties (BESD) • rate of access to adult specialist mental health services are low • increasing numbers of older people with dementias • high numbers of young people self reporting poor mental health
How will it be addressed	Through commissioning of: • universal, targeted and specialist early intervention mental health services for children and young people • early intervention services at primary care level for adults and older people • appropriate levels of support to people with dementia and their carers
Linked outcomes	NHS outcomes framework, PUBLIC HEALTH OUTCOMES FRAMEWORK

v) Better health and wellbeing outcomes for people with life-long disabilities and complex needs	
Objective	Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs. This is through robust, integrated care pathways, care planning and commissioning arrangements from early years into adulthood and old age
Why is this an issue for Peterborough?	JSNA evidence of: • Peterborough has the highest number of 'statemented' children in its comparator group • Peterborough commissions a higher than average number of out of area placements for children and young people with disabilities and complex needs • Adult Social Care commits a much higher than average proportion of its total budget on adults with learning disabilities • the "Valuing People" white paper anticipated substantial increases in the numbers with moderate, severe, profound and multiple learning disabilities • increase in birth numbers in Peterborough will include an increased number of children born with special needs • people with learning disabilities have greater physical and mental health needs than the general population
How will it be addressed	Through taking action on a number of fronts including a strengthened commitment to personalisation; close attention to the delivery of high quality health, education and social care to children and adults with disabilities; focus on whole-life costs rather than a more fragmented approach to children's and adult's commissioning, excellence in transitional care arrangements
Linked outcomes	• trends in out of area placements and costs of care for children and adults • trends in numbers of statements of special educational need • consistent delivery of Early Support Plans for children with complex needs and disabilities • evidence of annual GP health checks for adults with learning disabilities • evidence of quality assured, costed, personalised transition plans

5. Messages to commissioners

The JSNA findings are instructive in terms of where we need to make an impact on outcomes for the children and adults of Peterborough.

It suggests that we need to be commissioning services that are underpinned by the following principles. They will:

- Build on the many assets and resources that are available
- Enable early intervention and prevention through robust arrangements for identifying those with needs
- Address health inequalities and equity of access to and delivery of services in different neighbourhoods and communities
- Secure consistency in quality of care
- Tackle the underlying causes of ill health
- Demonstrate integrated health and social care service solutions
- Deliver discernible improvements to the agreed outcomes that will underpin the given priority area
- Make good use of existing strategic partnerships to address complex health and social care issues and use the authority of the Health and Wellbeing Board to enable and encourage partners to work together

In appendix one, a broad model of commissioning is described and commended to those responsible for responding to the priorities outlined in this document and developing matching commissioning intentions and plans.

"A key strategic issue for Peterborough, in common with many other authorities, is the growth of the population aged over 85. There will be a 52% growth in the 85 plus population over the next 10 years."

6. Conclusion and next steps

Drawing on the JSNA evidence base, this first Health and Wellbeing Strategy highlights the issues and needs of the population. It recognises marked health inequalities, differences in outcomes for those living in different neighbourhoods and by implication, the importance of having robust care pathways.

This is to enable those with needs to have those needs met in a timely manner, with the best quality services and interventions. The nature of the health and wellbeing issues referred to in this strategy can only be addressed through well coordinated, collaborative action. Action is required at the level of the individual taking responsibility for his or her health and wellbeing to the best of their ability through to jointly commissioned services providing a "whole system" response to complex health and social care needs.

Alongside its focus on health inequalities this strategy is also highlighting the importance of ensuring that informal carers needs are taken into account when commissioning services. Their contribution to the health and wellbeing of young and older people alike is crucial and it is appropriate that this is recognised and reflected in commissioner intentions.

Whilst these priorities do not mainly describe detailed and specific actions for service commisioners or providers, they are intended to influence commissioners as they formulate commissioning intentions and detailed plans. The Health and Wellbeing Board will hold commissioners to account on the extent to which these broad priorities are reflected in detailed and specific actions and in addition, which outcome measures will be identified as the key indicators of performance and improvement.

"With reducing budgets and rising demand there is a need for sound financial management. Budgetary pressures will impact on the ability of services to respond to needs and focuses the attention of commissioners and providers on the most effective way to deploy resources."

Appendix 1

The Health and Wellbeing Board endorses a commissioning model that systematically draws on the intelligence available from a number of sources and it anticipates commissioning plans that have addressed the following key questions on the road to finalising those plans:

- How healthy is the community relative to reliable benchmarks?
- What information has been considered and assessed in respect of the efficiency of health and social care services and their effectiveness in delivering the right care that avoids duplication and promotes integration of health and social care services?
- What does it cost and are we maximising value for money with the best selection of acute and community interventions?
- How do we compare with other areas in terms of outcomes, productivity and value for money?
- Are provider services providing the services that were commissioned and are they performing to plan?
- What improvements could be made through service and pathway redesign?
- What do service users tell us about the impact, effectiveness and value of our services?
- What are our future plans and are health, social care and educational service objectives in alignment?

For further details contact

Wendi Ogle-Welbourn, Assistant Director Childrens Services
Sue Mitchell, Interim Director of Public Health
Jana Burton, Director Adult Social Services

If you would like the information in another language or alternate format contact,
Peterborough city council communications team on: (01733) 747474

Polish Jeżeli chcieliby Państwo uzyskać informacje w innym języku lub w innym formacie, prosimy dać nam znać.
Portuguese Se deseja obter informação noutro idioma ou formato, diga-nos.
Urdu اگر آپ کو معلومات کسی دیگر زبان یا دیگر شکل میں درکار ہوں تو برائے مہربانی ہم سے پوچھئے۔

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 11
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Oliver Hayward, Head of Business Management & Commercial Operations	Tel. 863910

SECTION 256 AGREEMENT FOR HOSPITAL ALCOHOL LIAISON PROJECT

R E C O M M E N D A T I O N S	
FROM : Corporate Director: People & Communities	**Deadline date :** N/A
1.The board is asked to note the contents of the report	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request by the Corporate Director: People & Communities.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Board with additional information regarding the joint commissioning of the HALP and it will be commissioned from the next financial year 16/17

2.2 This report is for Board to consider under its Terms of Reference No. 3.5.

3. MAIN BODY OF REPORT

3.1 The council is currently conducting a retender process for all contracts associated with drug and alcohol treatment. The end result will be an Integrated Substance Misuse Treatment System. The new service will commence on 1st April 2016 which coincides with the end of the current contracts.

3.2 HALP is presently commissioned by Cambridgeshire and Peterborough Clinical Commissioning Group and delivered by Drink Sense, who are also the current provider of the Adult Alcohol Treatment Service. However, to include the HALP within the Integrated Substance Misuse Treatment System specification, a section 256 agreement is required between the Council and Cambridgeshire and Peterborough Clinical Commissioning Group.

3.3 Pursuant to section 256 of the National Health Service Act 2006, payments will be made to the Council under a section 256 agreement for the inclusion of the HALP within the Integrated Substance Misuse Treatment System specification. This legislation allows the NHS to make funding transfers to a local authority in order to secure more health gain than an equivalent expenditure within the NHS. Subsequently the HALP will be embedded within the Integrated Substance Misuse Treatment System contract.

3.4 The total amount to be transferred for each year of the Integrated Substance Misuse Treatment System contract is £105,000. This figure will be reviewed annually.

4. CONSULTATION

4.1 Consultation has been undertaken with key officers within the CCG.

5. ANTICIPATED OUTCOMES

The section 256 transfer will allow the specification for the Integrated Substance Misuse Treatment System tender to include the HALP. This will result in the HALP being fully funded and embedded within the Integrated Substance Misuse System contract.

6. REASONS FOR RECOMMENDATIONS

6.1 The section 256 transfer allows Peterborough City Council to include HALP within the Integrated Substance Misuse Treatment System specification. HALP enables the detection of people who have been admitted to hospital for alcohol related causes. When a patient has been admitted to hospital there is an ideal opportunity to deliver brief interventions and advice with the aim of preventing further hospital admissions. When necessary patients may be referred to and engage with the alcohol treatment service. According to DrinkSense who currently deliver HALP, 901 referrals were made, 1300 brief interventions and 553 brief advice sessions were delivered between April 2014 and March 2015.

6.2 It is anticipated that embedding HALP will maximise opportunities to engage with problematic alcohol users, who are unwilling to self-refer. A seamless and robust pathway in to treatment will be created while increasing alcohol harm awareness and reducing repeat admissions into hospital.

6.3 The project also fits Peterborough's partnership approach, being in line with the multi-agency Safer Peterborough Partnership's objectives of tackling alcohol-related harm. It is further in line with HM Government's Alcohol Strategy (March 2012) which advocates alcohol liaison work in all hospitals

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Not to include HALP in the retender. Without HALP the Integrated Substance Misuse Treatment System would be without a tried and tested referral route and would have to rely more on outreach programmes and self-referrals. There is also a risk that Cambridgeshire and Peterborough Clinical Commissioning Group would commission a different provider to deliver HALP on their behalf. This could undermine the integration of the new treatment service as there would be a separate organisation potentially making referrals which could lead to fractured pathways and missed referrals.

8. IMPLICATIONS

9.1 Financial implications:

The section 256 transfer stipulates that HALP will be funded by Cambridgeshire and Peterborough Clinical Commissioning Group.

9.2 Legal implications:

Section 256 of the National Health Service Act 2006 provides authority for a Clinical Commissioning Group to make payments to a Local Authority if the Clinical Commissioning Group is satisfied that the payment is likely to secure a more effective use of public funds than the deployment of an equivalent amount on the provision of services.

9. BACKGROUND DOCUMENTS

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

None.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 12
18 JUNE 2015		PUBLIC REPORT
Contact Officer(s):	Helen Gregg, HWPB Co-ordinator	Tel. 863618

PERFORMANCE REPORT

R E C O M M E N D A T I O N S	
FROM : Wendi Ogle-Welbourn, Corporate Director of People & Communities	**Deadline date :** 18 June 2015
1. To review the performance report, note the next steps and key considerations under each section and comment accordingly	

1. ORIGIN OF REPORT

1.1 This exception report is submitted to the HWB following a request from the HWB chair to report progress against the action plan created following the LGA peer review in February 2014.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update Board members with regard to performance progress, outlining any issues and challenges, since the last report presentation on 26 March 2015.

2.2 This report is for the Board to consider numerous points under its Terms of Reference Section 3.

3. BACKGROUND AND UPDATE

3.1 The performance report takes into account key recommendations from the LGA peer review and key priorities from the Joint Childrens and Families Commissioning Board. Elements of the now defunct Health & Wellbeing Delivery Plan have also been covered within the report.

Theme	Lead	Key Considerations
Children and Young People	Lou Williams Service Director, Childrens Services and Safeguarding	Successful implementation of the transfer of the commissioning of health visiting services. Development of the revised plan and priorities relating to Healthy Schools.
Better Care Fund	Will Patten Assistant Director, Adults Commissioning	The first quarterly monitoring return for NHS England was submitted on the 29 May 2015. This was shared with BPEPB for comments and approved. Given the significant joint working across Cambridgeshire and Peterborough, the returns between the two health and wellbeing board areas were closely aligned with one another. This first return covered the fourth quarter of 2014/15 and so largely related to the setting up of arrangements for the BCF. Separately to this return, the CCG – in line

		with other CCGs - has also had an opportunity to revise the BCF targets for a 1% reduction in non-elective admissions, in line with actual performance – or outturn - for 2014/15. The Q4 2014/15 plan was to achieve a 1% reduction when compared to 2013/14 Q4. The system actually saw a marginal reduction of 0.3% (14 admissions). Therefore the planned levels were not reached prior to the BCF coming into effect. There was a £67k performance payment attached to this quarter.
Health Protection	Dr Liz Robin Director of Public Health	Capacity and resources for the targeted outreach and the related recommendations of the Task and Finish groups. Salience and relationship (e.g. scope, timing) of this work to the development of the JSNA for migrant / Eastern European communities.
Joint Strategic Needs Assessment (JSNA)	Dr Liz Robin Director of Public Health	Is further core JSNA content needed to underpin the Health and Wellbeing Strategy? Referral of the key needs and recommendations from the Children and Young People's JSNA to the CYP Partnership Board. Identification of any partnership issues and issues that the Board considers will impact on delivery of the JSNAs.
Health & Wellbeing Board Development and Scrutiny	Wendi Ogle-Welbourn Corporate Director, People and Communities	Revised HWB membership

4. CONSULTATION

4.1 The performance report was last consulted with HWB members in March 2015. The report was approved by all members in attendance.

5. ANTICIPATED OUTCOMES

5.1 HWB members are asked to comment on performance since March 2015 and assist where possible in moving forward any issues and challenges.

6. REASONS FOR RECOMMENDATIONS

6.1 The aim of the performance report is ensure the recommendations from the LGA peer review are actioned and the HWB Strategy's priorities are continually reviewed and considered.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 N/A

8. IMPLICATIONS

8.1 N/A

9. BACKGROUND DOCUMENTS

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

9.1 HWB performance report June 2015

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Peterborough Health & Wellbeing Board Performance Report 2015

Introduction

This combined action and delivery plan report sets out the key priority areas for delivery:

- Children and Young People
- Better Care Fund
- Health protection
- JSNA
- Health & Wellbeing Board Development and Scrutiny

The Health & Wellbeing Programme Board will scrutinise the reports submitted by each of the thematic leads.

For each key priority area, a RAG rating has been included to indicate if the indicators and actions are on track.

Overarching Strategic Priorities

The Health & Wellbeing Programme Board is committed to delivering the overarching priorities as outlined in the Health & Wellbeing Strategy 2012-2015:

Securing the foundations of good health
Objective: ensure that children and young people, including those with complex needs and disabilities, have the best opportunities in life to enable them to become healthy adults and make the best of their life chances.

Preventing and treating avoidable illness
Objective: narrow the gap between those neighbourhoods and communities with the best and the worse health outcomes, whilst improving the health of all.

Healthier older people who maintain their independence for longer
Objective: Enable older people to stay independent and safe and enjoying the best possible quality of life.

Supporting good mental health
Objective: Enable good child and adult mental health through effective, accessible mental health promotion and early intervention and rapid response services to impact upon early signs of mental ill health or deterioration.

Better health and wellbeing outcomes for people with life-long disabilities and complex needs
Objective: Maximise the health and wellbeing opportunities for independent living for people with life-long disabilities and complex needs. This is through robust, integrated care pathways, care planning and commissioning arrangements from early years into adulthood and old age.

Report Layout

The report is set out under each of the key priority areas shown above.

Within each section the main thematic areas of focus are then shown with their associated performance indicators.

Theme 1: Children and Young People	
Responsibility:	Lou Williams
OVERALL RAG RATING	
Outcomes: • Improve the health and wellbeing of children and young people in the city	
Performance Indicators: 1. Delivering the Healthy Child Programme 2. Securing emotional health and wellbeing for children and young people 3. Develop the Healthy Schools Programme	

Performance Narrative

The Healthy Child Programme:

- The perinatal pathway has been strengthened through an increase of CPN support through Increasing Access to Psychological Therapies [IAPT]. This will result in a named contact for GPs and an increase in training for midwifery and support for midwives and health visitors
- Quality of pre-school and child-minding settings continues to improve with 82% of child-minders and 83% of nursery and pre-school settings rated good or better
- Breastfeeding continuation rates remain on target at 45% and remained at or above target for the whole of 2014/15 - a significant gain on performance in the 2013-14 financial year

Securing emotional health and wellbeing for children and young people:

- Waiting lists for tier 3 specialist services remain too long
- Increased investment into CAMH services has now been secured, to include an additional £600K recurring funding
- Partners are working on measures elsewhere in the system that may help to reduce pressure on specialist services

Develop the Healthy Schools Programme:

- The incoming DPH, Dr. Liz Robin asked that plans are reviewed internally before undertaking follow up work with schools, mainly to ensure we have sufficient capacity to deliver the programme
- A workshop with schools is being held on 5th June to map current activities and any areas of duplication or gaps in delivery in order to inform the programme in the future
- An update will be provided verbally to the Board at the next meeting

Next Steps

The Healthy Child Programme:

- Will remain a theme reported on a quarterly basis to the Children and Families Joint Commissioning Board but will be more closely aligned to Early Help, which will no longer be a stand-alone theme
- The main priority is to secure the successful transfer of responsibility for commissioning of health visiting to the local authority in October 2015

Securing emotional health and wellbeing for children and young people

- This area remains a proposed priority for the Children and Families Joint Commissioning Board and at next meeting, specifications for a CPN-led primary school facing team to assist in identifying emerging difficulties at an early stage and to support schools to meet needs, reducing the level of onward referrals in the process

- Following on from this, investment in developing this service alongside a continuing review of pathways and resourcing levels in the wider system

Develop the Healthy Schools Programme:

- Completion of review of plans and priorities, informed by workshops with schools taking place on 5th June 2015 – further information will be available at the Board

Key Considerations

- Successful implementation of the transfer of the commissioning of health visiting services
- Development of the revised plan and priorities relating to Healthy Schools

Theme 2: **Better Care Fund**	
Responsibility:	Will Patten
OVERALL RAG RATING	
Outcomes: The BCF will contribute to Peterborough's vision for integration by focussing on initiatives that will help to prepare the system for a bigger change in the medium term by: • Protecting existing social care services • Supporting the development of 7 day working and data sharing • Supporting the development of closer working, including development of joint assessments with an accountable lead professional	
Performance Indicators: 1. Establish the UnitingCare partnership model 2. Establishment of joint assessments and an accountable lead professional to support other elements of the system to align with the UCP integrated neighbourhood team model and fulfil Care Act requirements 3. Establishment of a multi-agency team to lead our approach to integration and transformation in Peterborough, and the creation of an ideas bank to assist in piloting small scale integration projects	

Performance Narrative

As previously reported, Peterborough's Better Care Fund (BCF) has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the city. The BCF was announced in June 2013 and established in April 2015. The £11.9 million budget is not new money; it is a reorganisation of funding currently used predominantly by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and the City Council to provide health and social care services in the city.

In order to receive approval for the BCF, Peterborough had to show how it would meet a number of statutory conditions, including the protection of social care services; a reduction in non-elective admissions to hospital; greater seven day working across health and social care services to support discharge; and support for information sharing between social care and health to improve coordination of people's care. Peterborough worked collaboratively with Cambridgeshire County Council (CCC), Peterborough & Stamford Hospitals NHS Foundation Trust (PSHFT), CCG, UnitingCare (UC) and the voluntary sector to develop its BCF submission.

The Section 75 Agreement between Peterborough City Council and the CCG, was developed, approved and in place by 1 April 2015 when BCF funding began. Formal governance arrangements for the BCF were also in place by April 2015.

Establishing the UnitingCare Model (Older People and Adult Community Services Contract):
There has been a significant amount of work preparing the contract and with Monitor in order to ensure everything was in place for the new service provider (UnitingCare) to commence the Older People and Adult Community Services (OPACS) contract. Service delivery under OPACS commenced on 1 April 2015. This contract forms a major part of our BCF plan. This is an outcomes based contract and two of its aims are to reduce non-elective hospital admissions and length of stay for people aged 65 years and over and for adults with long term conditions. The focus will increasingly be on care provision closer to home rather than the traditional reliance on secondary care. To achieve this there will be significant joint working across the health system, local authorities and the voluntary sector.

There is continued good joint working between Peterborough and Cambridgeshire to ensure alignment across the CCG area in the development and delivery of our BCF plans. Initiation workshops have taken place on each of the five schemes detailed in our BCF submission. These workshops were jointly hosted with CCC, the CCG and attendees included representation from other relevant (existing and potential) delivery partners.

Next Steps

Following the initial workshops, each scheme will move forward as follows:

- Data Sharing – a joint working group was established to develop a draft delivery plan. Areas of focus for the delivery were agreed and a scope and plan has been developed, which is currently out for review. The Project Scope outlines the priority areas for delivery over the next 3 years; this is based on current requirements and will be revised in order to reflect changing priorities. It has been agreed that in the first 12 months, a specific workstream of the project should focus on improving data sharing for the 5% cohort of patients identified by UnitingCare to be supported by the Integrated Neighbourhood Teams. Progress with be reported monthly to the Borderline & Peterborough Executive Partnership Board (BPEPB)

- Information, Advice and Guidance – further work is being undertaken to develop the approach and high-level planning. This work is identifying the synergies and differences across Cambridgeshire and Peterborough and the next step is for a core group to finalise and agree the detailed scope in detail; this will be informed by conversations regarding the broader programme that have taken place to date. The scope will be presented to both Cambridgeshire's and Peterborough's Executive Partnership Boards for consideration

- Ageing Healthily and Prevention – Public Health in Cambridgeshire have taken on the ownership to develop and drive this scheme. As the overall project sponsor, they have been tasked with developing greater detail for July 2015

- Seven Day Working – a follow up workshop for system partners in Peterborough took place; principles and activities were identified and a delivery approach and plan is being prepared. Attendees at the workshop included representatives from: Peterborough City Council's ASC Commissioning and Operations Teams; Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), (PSHFT); GP community; CCG; UC; The Ambulance Service; patient and carer groups; and the voluntary sector

- Person Centred Care – following a workshop held on 05th May with a range of partners (including UC, CCG and the voluntary sector), further work is being undertaken in the following areas:
  - **Integrated Neighbourhood Teams (MDTs)** – Scoping activity is underway on a review of social care involvement in current MDTs and how this might feed into a new model
  - **Risk assessment tool** – agreement that further work is required on how UC's use of the Rockwood Frailty Score can be supplemented/ adapted for wider use (given the currently exclusive medical context) and how this would be implemented/delivered

Work is being undertaken to ensure there are strong links between the BCF projects and the work of the System Resilience Groups (SRGs) and the outcomes of the 'Breaking the Cycle' weeks held in each acute provider area, in order to ensure triangulation of joint working across the system. Therefore as initial plans and project documentation is developed, BCF projects will be communicated with system partners to ensure synergies and opportunities are maximised.

Key Considerations

- The first quarterly monitoring return for NHS England was submitted on the 29 May 2015. This was shared with BPEPB for comments and approved. Given the significant joint working across Cambridgeshire and Peterborough, the returns between the two health and wellbeing board areas were closely aligned with one another. This first return covered the fourth quarter of 2014/15 and so largely related to the setting up of arrangements for the BCF.
- Separately to this return, the CCG – in line with other CCGs - has also had an opportunity to revise the BCF targets for a 1% reduction in non-elective admissions, in line with actual performance – or outturn - for 2014/15. The Q4 2014/15 plan was to achieve a 1% reduction when compared to 2013/14 Q4. The system actually saw a marginal reduction of 0.3% (14 admissions). Therefore the planned levels were not reached prior to the BCF coming into affect. There was a £67k performance payment attached to this quarter.

Theme 3: **Health Protection**	
Responsibility:	Liz Robin
OVERALL RAG RATING	
Outcomes: • The population's health is protected from communicable disease, environmental hazards and major incidents and other threats, while reducing health inequalities	
Performance Indicators: 1. Build and improve relationships with the local PHE and NHS England representatives 2. Review poor uptake of childhood immunisations 3. Review the poor uptake of the bowel and cervical cancer screening programmes 4. Provide an annual report on health protection to the HWB.	

Performance Narrative

1. The membership, terms of reference and governance of the Peterborough Health Protection Committee have been reviewed;
2. A task and finish group on childhood immunisations was established and findings are reported to the HWB in June ;
3. A task and finish group on bowel and cervical cancer screening uptake was established and reports to the HWB in June;
4. The first annual report on health protection was received by the HWB in April 2015.

Next Steps

1. The task and finish groups on childhood immunisation and bowel and cervical cancer screening identified inequalities and barriers to uptake, particularly for migrant and deprived populations. The HWB is invited to support recommendations to address these issues and to review the progress and outcomes in a year.
2. The Peterborough Health Protection Committee has agreed to explore closer working with the Cambridgeshire.

Key Considerations

1. Capacity and resources for the targeted outreach and the related recommendations of the Task and Finish groups.
2. Salience and relationship (eg scope, timing) of this work to the development of the JSNA for migrant / Eastern European communities.

Theme 4: JSNA	
Responsibility:	Liz Robin
OVERALL RAG RATING	
Outcomes: • The JSNA will describe the future health, care and wellbeing needed of Peterborough and will inform the joint health and wellbeing strategy, which lays out how we aim to address the needs identified.	
Performance Indicators: • Define achievement improvements in health and wellbeing outcomes for the local community and support the delivery of these outcomes. • Support the delivery of better health and wellbeing outcomes for the local community • Work with partners to commission and provide interventions and services to meet these needs. • Enable and improve decision making on health and care needs for commissioners in the local NHS and the local authority. • Underpin the development and implementation of the joint health and wellbeing strategy	

Performance Narrative

The Children and Young People's JSNA will be presented to the Health and Wellbeing Board on 18/06/2015, along with the underpinning JSNA Core Dataset. The JSNA Core Dataset will lay out the key health and care indicators for Peterborough and will provide an overview of our current performance against key population health measures. The Dataset will underpin the development of the second Peterborough Health and Wellbeing Strategy issues.

There are currently 2 JSNAs in production:

- Cardiovascular disease JSNA. Due to be presented to the Health and Wellbeing Board in September 2015.
- Mental health in adults of working age JSNA. Due at Health and Wellbeing Board in December 2015.

For both of these JSNAs Steering Groups have been held or convened, initial scoping and analytical work has been conducted and both are on track in terms of timescales for delivery to the Health and Wellbeing Board.

The migrant worker and older people's primary prevention JSNAs are due to be delivered later (March 2016 Board) and scoping is not yet underway.

Next Steps

- Present the Children and Young People's JSNA and the JSNA Core Dataset to the Health and Wellbeing Board on 18/06/15 and follow up on any comments made.
- Update the Core Dataset on a quarterly basis to reflect the changes made to the Public Health Outcomes Framework by Public Health England.
- Ensure that the cardiovascular disease JSNA and the mental health in adults of working age JSNA remain on track.
- Ensure that the scoping of the migrant worker and older people's primary prevention JSNAs.

Key Considerations

- Is further core JSNA content needed to underpin the Health and Wellbeing Strategy?
- Referral of the key needs and recommendations from the Children and Young People's JSNA to the CYP Partnership Board. Identification of any partnership issues and issues that the Board considers will impact on delivery of the JSNAs.

Theme 5: Health & Wellbeing Board Development and Scrutiny

Theme 5: Health & Wellbeing Board Development and Scrutiny	
Responsibility:	Wendi Ogle-Welbourn
OVERALL RAG RATING	
Outcomes: • Improved partnership delivery of the health and wellbeing strategy	
Performance Indicators: 1. Review current Board membership 2. Improve political engagement 3. Maintain quality, cost and resource effectiveness 4. Strengthen effectiveness of the health scrutiny commission 5. Launch a communications campaign	

Performance Narrative
A paper is being presented to the Health and Wellbeing Board on 18th June recommending revised membership of the Health and Wellbeing Board and the reformation of the Programme board into a delivery board. Dr Liz Robyn is taking over lead responsibility for the Health Scrutiny and alongside the Director of People and Communities, has developed a presentation for the first Health Scrutiny of this municipal year that clearly identifies the role of the scrutiny committee and makes suggestions on the areas it should scrutinise to fulfil its responsibilities.
Next Steps
If the Health and Wellbeing Board agree to the recommendations about revised membership and reformation of the programme board, implementation will proceed and a refreshed communications strategy will be prepared and circulated to members for comment/approval.
Key Considerations

UPDATED: 16 MARCH 2015

HEALTH AND WELLBEING BOARD
PROPOSED AGENDA PLAN 2015

MEETING DATE	ITEM	CONTACT OFFICER
18th June 2015	**CCG**	
	Primary Care Commissioning	**Andy Vowles**
	System Transformation Programme	**Andy Vowles**
	Prime Minister Challenge Fund	**Gary Howsam**
	CCG Operational Plan and local quality premium	**Cathy Mitchell**
	Public Health	
	Annual DPH report on health of the local population	**Liz Robin**
	Task group report – screening and immunisations	**Anne McConville**
	Adult Social Care	
	Better Care Fund update on implementation plan	**Will Patten**
	Children	
	Children's JSNA	**Ryan O'Neil**
	Joint Child Health Commissioning Unit update	**Wendi Ogle - Welbourn**
	Other	
	Health and Wellbeing Board Membership and Terms of Reference	**Wendi Ogle Welbourn**
	Health and Wellbeing Strategy	**Liz Robin**
	For Information:	**Oliver Hayward**
	S75 HALP	**Helen Gregg**
	Performance Report	
10 September	**CCG**	
	System Transformation Programme	
	Commissioning Intentions 2016/17	
	Do we want to say anything about City Council commissioning intentions/service plans 2016/17 at this point?	
	Public Health	
	Cardiovascular disease JSNA	
	Mental health JSNA	
	Adult Social Care	
	Better Care Fund update	
	Children	
	? Item on transfer of healthy child 0-5 commissioning?	

MEETING DATE	ITEM	CONTACT OFFICER
	Other Draft Health and Wellbeing Strategy 2016-20 for consultation **For Information:** ***Do we want to provide information on joint winter/system resilience planning at this point?*** ***? Section 75s/256s***	
10th December	**CCG** System Transformation Programme Operational planning 2016/17 **Public Health** Older people – prevention of ill health JSNA **Adult Social Care** Better Care Fund update ***?Report from Adult Safeguarding Board (not sure if you do this at Pboro HWB Board – could be duplication?)*** **Children** ***? Joint commissioning update*** ***? Report from LSCB (not sure if you do this at Pboro HWB Board – could be duplication?)*** **Other** Draft Health and Wellbeing Strategy 2016-20 for approval **For Information:** ***Do we want to provide information on winter/system resilience planning?***	
24th March	**CCG** System Transformation Programme Operational planning 2016/17 **Public Health** Migrant workers JSNA Health protection Annual Report	

UPDATED: 16 MARCH 2015

MEETING DATE	ITEM	CONTACT OFFICER
	Adult Social Care Better Care Fund update **Children** **Other** **For Information:**	

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