PETERBOROUGH CITY COUNCIL

# HEALTH AND WELLBEING BOARD

## MONDAY 24 JUNE 2019
## 1.00 PM

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

## AGENDA



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**9. Overall Monitoring of the Health and Wellbeing Strategy**

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| **(a) Peterborough Health and Wellbeing Strategy 2016-19 Final Annual Review** | **113 - 156** |
| **(b) Peterborough Health and Wellbeing Strategy Update** | **157 - 166** |
| **10. Placed Based Working - Think Communities, Integrated Neighbourhoods and Primary Care Networks** | **167 - 172** |
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**INFORMATION AND OTHER ITEMS**

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

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Board Members:

Cllr J Holdich (Chairman), V Moore, H Daniels, Cllr W Fitzgerald, Dr G Howsam (Vice Chairman), W Ogle-Welbourn, Dr L Robin, Cllr Qayyum, Cllr I Walsh and J Bawden

Co-opted Members: Russell Wate and Claire Higgins

Substitute: Dr Adnan Tariq, Jo Proctor

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

**A MEETING OF THE CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND WELLBEING BOARDS: MINUTES**

**Date:** 28th March 2019

**Time:** 10.00am-12:30pm

**Venue:** Council Chamber, Shire Hall, Castle Street, Cambridge, CB3 0AP

**Present:**

Cambridgeshire County Council (CCC)
Councillor Roger Hickford (Chairman)
Councillor Mark Howell
Councillor Linda Jones
Councillor Susan van de Ven
Councillor Samantha Hoy
Dr Liz Robin - Director of Public Health
Wendi Ogle-Welbourn- Executive Director: People and Communities
Daniel Snowdon – Democratic Services Officer
James Veitch- Democratic Services Officer Trainee

Peterborough City Council (PCC)
Councillor John Holdich (Chairman)
Dr. Gary Howsam (Vice-Chair)
Councillor Mohammed Jamil

City and District Councils
Councillor Geoff Harvey – South Cambridgeshire District Council
Councillor Nicky Massey – Cambridge City Council

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Jessica Bawden- CCG, Director of Corporate Affairs

Healthwatch
Val Moore

NHS Providers
Keith Reynolds- North West Anglian Foundation Trust (NWAFT) (Substituting for Caroline Walker)
Matthew Winn - Cambridgeshire Community Services NHS Trust (CCS) (from 10.25am)

Hunts Forum
Julie Farrow- Chief Executive of the Hunts Forum of Voluntary Organisations

Also Present:
Councillor Lynda Harford- Cambridgeshire County Council

Cambridgeshire's Apologies:
Caroline Walker – North West Anglia Foundation Trust (NWAFT)
Chris Malyon – Section 151 Officer, Cambridgeshire County Council
Stephen Posey – Papworth Hospital NHS Foundation Trust
Councillor Joshua Schumann – East Cambridgeshire District Council
Vivienne Stimpson- NHS England Midlands and East Director of Nursing
Councillor Jill Tavener- Huntingdonshire District Council
Jan Thomas- CCG, Accountable Officer (Vice-Chair)
Ian Walker- Cambridge University Hospitals NHS Foundation Trust

Peterborough's Apologies:

Councillor Wayne Fitzgerald
Councillor Diane Lamb
Adrian Chapman- Service Director: Children's Services and Safeguarding,
Hilary Daniels- Chairman, Hichingbrooke Hospital Trust

## 20. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST FROM MEMBERS OF THE PETERBOROUGH HEALTH AND WELLBEING BOARD

Apologies for absence were noted as recorded above and there were no declarations of interest

## 21. MINUTES OF THE PETERBOROUGH HEALTH AND WELLBEING BOARD ON 10 DECEMBER 2018

The minutes of the meeting on 10 December 2018 were agreed as an accurate record and signed by the Chairman.

## 22. CAMBRIDEGSHIRE & PETERBOROUGH IMPROVED BETTER CARE FUND EVALUATION 2018-19

The Board received a report providing an update on the evaluation of the Improved Better Care Fund (iBCF) for Cambridgeshire and Peterborough in the period 2018-19. The Director of Commissioning provided a summary of how the BCF money was used in line with the three national conditions: to support Adult Social Care Provision, to Reduce Pressures on the NHS and to stabilise the Care Market. He stated that the Health and Wellbeing Boards (HWBs) delegated governance of the Better Care Fund to the Integrated Commissioning Board (ICB). The ICB formulated some potential areas of investment, following system wide planning and discussion, which were listed in the report. An evaluation process had taken place that assessed the effectiveness of the investments. The results of the evaluation process would inform recommendations for investment in 2019/20 once funding guidelines from NHS England had been received and these would be presented to the Board when available.

In the course of discussion:

- An elected Member enquired whether the 3.5% Delayed Transfer of Care (DTOC) target was feasible and whether they were any penalties for not reaching it. The Director of Commissioning confirmed that there were no BCF penalties for not meeting the DTOC target. He reminded the Board that the iCBF was just one of a number of schemes and investments to try to improve DTOC performance. The Director of Commissioning informed the Board that the DTOC programme Board was actively trying to reduce DTOCs to 3.5%.

- An elected Member raised concerns that not enough preventative work was being undertaken to negate hospital admissions. The Director of Commissioning noted that the Discharge Programme Demand and Capacity work stream had undertaken a deep dive of post discharge care demand. The outcomes of this were that they had enough capacity at a global level as a system. The issue was how demand presents itself and having the right capacity in the right place at the right time, 'capacity mismatch'. There had been significant investments across the system to ensure capacity could meet demand. Members were informed that since April 2017, Cambridgeshire's re-ablement capacity had increased by 42% and domiciliary care capacity had increased by 12% over the same period. An effective placed based health system using community resources and assets was an effective way to address this.

- An elected Member expressed concern that funding for placed based services was being reduced. She suggested that placed based services required investment in order to

provide people the support they needed in their homes in order to prevent hospital admission. The Director of Commissioning informed the Member that they were identifying solutions to increase placed based capacity but the process was complex.

- The elected Member from South Cambridgeshire District Council (SCDC) commented that discharge teams needed members with medical knowledge who could challenge consultants but also knew how the local social support networks operated. The Director of Commissioning commented that the benefit of a placed based approach was that health and social care providers would have a greater understanding of the specific needs and resources in that community.

The Head of Commissioning Partnerships and Programmes for CCC and PCC requested that the Board's delegate authority to approve the BCF 2019/20 Plan, prior to submission to NHS England.

It was resolved that the Peterborough Health and Wellbeing Board:

a) Consider the content of the report and raise any questions

b) Delegate authority to approve the BCF 2019/20 Plan, prior to submission to NHS England, to the Chair, Vice-Chair and wider Health and Wellbeing Board membership.

**23. CAMBRIDGESHIRE AND PETERBOROUGH JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) CORE DATA SET 2019**

The Board received a presentation by the Director of Public Health (attached at appendix 1 to these minutes) regarding the Cambridgeshire & Peterborough Joint Strategic Needs Assessment (JSNA) Core Dataset 2019.

In discussion:

- An elected Member expressed concern regarding the data related to the Fenland area, stating that schemes in the area had been working however; there was more that could be achieved. The Director of Public Health agreed and commented that health organisations needed to work together to improve results.

- The Vice-Chairman for the Peterborough Health and Wellbeing Board commented that the system needed to change in order to provide greater preventative work within communities.

- An elected Member followed on from this by agreeing with the Vice-Chair and commented that the definition of the system must be re-defined. It needed to include a greater range of socio-economic circumstances in which people lived, such as public transport and housing which were also determinants of health. The Director of Public Health commented that related work had been progressing through the CIVIC program.

- An elected Member requested additional information regarding the difference in emergency hospital admission rates between Cambridge and Peterborough. The Director of Public Health informed the Board that higher levels of deprivation in Peterborough resulted in higher rates of emergency hospital admissions.

- The Chairman of the Peterborough Health and Wellbeing Board clarified whether the higher proportions of older people in Peterborough City also related to the emergency admission rates. The Director of Public Health confirmed that this was the case.

- The CCG representative stated that they believed by 2021 the total population would be 30,000 higher than the figure predicted by the NHS. Therefore, the NHS's funding formula allocation might not accurately reflect the county's demands.

- The Director of Public Health stated that the JSNA report supported and informed the discussions held within the health-care system.

It was resolved that the Peterborough Health and Wellbeing Board:

a) Approve the Cambridgeshire and Peterborough Joint Strategic Neds Assessment (JSNA) Core Dataset 2019.

b) Consider the key health and wellbeing needs identified in the JSNA information presented and how these should influence the development of a future Joint Health and Wellbeing Strategy for Cambridgeshire and Peterborough

c) Note the substantial differences in health status and outcome observed between different areas of CAMBRIDGESHIRE and Peterborough and consider how this information should inform future commissioning/intervention decision-making to improve overall population health and wellbeing.

## 24. SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) UPDATE ON STRATEGIC DIRECTION 2018/19

The Board received a report that provided an update on the work of the Sustainability and Transformation Partnership (STP) and the North and South alliances. The Head of Communication & Engagement at the STP informed the Board that the STP had shifted to a distributed leadership model. In presenting the report, particular attention was drawn to the short, medium and long-term priorities of the system detailed in the report.

It was resolved that the Peterborough Health and Wellbeing Board:

a) Note the update report of the Sustainability and Transformation Partnership (STP), as well as the work of the North and South Alliances

## 25. CLINICAL COMMISSIONING GROUP (CCG) PLANNING FOR 2019/20 AND THE NHS 10 YEAR PLAN

The Board received a report that provided a top-level summary of the CCG planning for 2019/20 and the NHS Ten Year Plan. Members noted that the CCG were currently working through the detail of the planning guidance and deciding priorities for 2019/20. The Director of Corporate Affairs for the CCG drew attention to the background and key points of the report. The Board were advised of the short, medium and long-term operational plans and the updated prevention strategy. Extensive consultation with the population of Cambridgeshire and Peterborough would be a priority for 2019/20.

Discussing the report:

- The representative from the Voluntary Sector informed the two Boards that a financial agreement with the CCG was not in place for the coming financial year. She expressed concern that many small groups in the sector would be unable to continue their work. The Officer stated they would return to the Board with this information and investigate.

- An elected Member highlighted the importance of allocating resources to communities in order to enable them to build sustainable healthy organisations.

- An elected Member expressed their appreciation at the work being undertaken regarding workplace health. She raised her concerns that they should be promoting workplace health across the system and not just in the NHS. Members were informed that the Combined Authority had raised the issue that employers needed to support their employees through workplace health schemes.

- The representative from Cambridgeshire Community Services NHS Trust (CCS) enquired to why there was a separate NHS Prevention Strategy and suggested it would be more beneficial if they could produce one system wide strategy. The officer stated that the document aligned with the NHS Long Term Plan and acknowledged the role the NHS played in prevention strategies.

- The Director of Public Health welcomed the Prevention Strategy; she agreed with the representative from the CCS and stated that they needed to feed this strategy into the Joint Health and Wellbeing Strategy (JHWS) and joint commissioning which could lead to financial savings for the NHS.

- The representative from the CCS commented that the NHS Long Term Plan should be translated into a local plan. Further discussion was suggested of how the role of the HWB could progress this further.

- An elected Member raised concerns at the number of priorities in the NHS Long Term Plan. She commented that the system was already under pressure and it was vital they formulated a joint Action Plan. Different parts of the system would be able to contribute to the Action Plan to create a more connected working arrangement. The officer stated that their Prevention Strategy would start to feed into the work the Director of Public Health was undertaking.

- The Director of Corporate Affairs at the CCG informed the Boards that Healthwatch were performing a piece of work to assess the public's response to the NHS Long Term plan. The representative from Healthwatch stated that the survey had yielded beneficial results. She commented that the public had wanted more information regarding the co-operation between organisations in the health and social care system.

- The Executive Director, People and Communities stated that the HWB Development Session should involve discussing the JHWBS and the Action Plan that proceeds from this.

- The Director of Public Health stated that the JHWBS should not be labelled as a business plan but rather a joint up system wide plan. She commented that the CCG's Prevention Strategy would act as a firm foundation to build on.

- The Vice-Chair of the Peterborough Health and Wellbeing Board expressed his concern regarding the level of engagement the Board had regarding the STP item and requested further discussion took place at the HWB Development Session. He noted that the creation of an Action Log could be an enormous document and taking a vote on the creation of one could be too early at this stage.

It was resolved that the Peterborough Health and Wellbeing Board:

a) Note the CCG planning for 2019/20 and the updated Prevention Strategy for the NHS.

## 26. THINK COMMUNITIES UPDATE

The Board considered a report detailing an overview of the Think Communities approach. Attention was drawn to the background and main issues contained within the report. The Boards were informed of the eight work streams, which would enable the Think Communities approach to be delivered. Board members noted that extensive consultation with partners across the public sector on the Think Communities approach would continue.

In the course of discussion:

- The Chairman of the Cambridgeshire HWB expressed his appreciation that the report clearly presented the development of a number of the eight-work streams over a twelve-month period. However, he raised concerns that some of the other work streams in the report did not share this clarity and questioned where the streams would be in two to three years' time.

- An elected Member expressed her concerns regarding the Think Communities approach to assimilating themselves into the wider Health and Social Care system. She noted that they did have a contribution to make but they could not define themselves as the system. Officers stated that they were engaging with all parts of the system to establish networks.

- The representative from the voluntary sector was concerned that officers were only communicating with limited sections of the sector. She commented that communication with the voluntary sector needed to be a key priority. She noted that the sector already had a comprehensive knowledge of the communities they were working in. Officers recognised that an effective communications plan was required in order to engage with both internal staff and the wider health and social care system.

- The Vice-Chair of the Peterborough Health and Wellbeing Board commented that it was vital that communities were engaged. He commented further that it would be beneficial if organisations supported communities in the creation of a case study, where residents reflected on the work within their community. The Chairman of the Cambridgeshire Health and Wellbeing Board stated that local authorities were approaching communities in order to engage with them.

- An elected Member raised her concerns regarding the example of Wigan Council used in the report, she commented that it had a very different working dynamic to that of Cambridgeshire and it would not be a simple task to draw comparisons between them. Officers clarified that they were analysing the environment Wigan Council were in to learn from it and not simply copy it.

- The voluntary sector representative followed on from this by stating that it was very difficult to draw comparisons between Cambridgeshire and Peterborough, and Wigan due to their footprint size and their geographical diversity. Officers also recognised that Cambridgeshire and Peterborough were much more complex compared to Wigan but did note that there were learning opportunities to be had.

- The Executive Director, People and Communities stated that Wigan had an effective induction program provided to all members of staff; this element of could be adapted to meet the requirements of Cambridgeshire and Peterborough.

- An elected member commented that in her community they had seen children's health and social care services diminish. She recognised that the system was under severe financial pressures but would like to see greater investment into voluntary and community services.

  An elected Member raised concerns that smaller but effective organisations in the community did not have the capacity to make financial bids and therefore there was a risk they would cease operation. She commented that it was in the Boards best interest to support such organisations.

- The representative from the Voluntary Sector agreed with the elected Member and stated that the changes in the commissioning process had led to the exclusion of small organisations. She commented that commissioning groups were now using the Social Value Act to engage with these smaller organisations. She stated that more effective joint working would allow all organisations in the system to work more efficiently**.** The Executive Director, People and Communities agreed that the system needed to work more cohesively with the voluntary sector and communities.

- The Vice-Chair of the Peterborough Health and Wellbeing Board commented that it would be useful if the Boards could receive an insight into the present and future funding pressures, the system was subject too. **(Action Required- CCG- Director of Corporate Affairs)**

- The Executive Director, People and Communities stated that more work had to be undertaken to achieve greater joint up working within the system. She noted that the Think Communities ambition very much aligned with the work being performed by the North and South Alliances. She also recognised the need for a more effective communication plan.

- The Director of Public Health informed the Board that GP networks, Think Communities and Integrated Neighbourhoods were working with communities of under 30,000 residents. She noted that it was vital to have clear communication, as it would enable effective joint working in the system.

- The representative from the North West Anglian Foundation Trust was encouraged to see the work being undertaken by Think Communities in particular, the eight work streams contained in the report. He saw it beneficial to align the work and timescales of the North/South Alliances with the Integrated Neighbourhoods scheme and Think Communities.

- The Environmental Service Manager at East Cambridgeshire reassured the Boards that they were engaging and creating links with local stakeholders through the distribution of the Think Communities pilot.

- The representative from Healthwatch commented that it would be beneficial for the Think Communities project to work with CIVIC.

It was resolved that the Peterborough Health and Wellbeing Board:

a) Note, comment on and endorse the Think Communities approach to improving outcomes and preventing and delaying demand for statutory services across the public sector.

b) Comment on aspects of the approach, which are particularly important to the Board, in order to ensure they are given appropriate priority.

## 27. PUBLIC SERVICE REFORM: COMBINED AUTHORITY UPDATE

The Board received a report providing an update on the Cambridgeshire and Peterborough Combined Authority's (CPCA) public service reform programme. The Director of Strategy and Assurance began by setting the context of the CPCA within the wider health and social care system referring to their role as the statutory transport authority and its role in contributing to positive health outcomes.

Members noted the establishment of an Independent Commission on Public Service Innovation and Reform, initially focused on Health and Social Care integration. Following the submission of a draft report in January 2019, it was subsequently forwarded to the Independent Commissioning Board who would prepare their recommendation in summer 2019. The Director highlighted that the Commission was keen to engage with the two Health and Wellbeing boards, the voluntary sector and organisations such as Healthwatch.

In discussion:

- The Chairman of the Cambridgeshire Health and Wellbeing Board enquired to when the report from the Independent Commission would be available to view. The Director of

Strategy and Assurance explained, as the Commission was an independent body, it would not be appropriate for him to state a possible completion date. However, the Commission was aware that if they wanted to feed their work into the upcoming spending review in June 2019.

- The representative from the CCG commented that members of the Board should read the Independent Economic Report. The work undertaken by the Independent Commission needed to link their work into this report to make sure public services can continue to keep up with the current rates of economic growth.

- An elected Member requested if the Terms of Reference (TOR) for the Independent Commission. . The Director of Strategy and Assurance stated he would circulate the Independent Commission's TORs and membership list to the Boards.
  **(Action Required: Director of Strategy and Assurance)**

- The Director of Public Health commented that the Independent review would take place and would be very well researched. She noted that the deadline dates for the independent commission report, joint health and wellbeing strategy and the NHS response to the long-term plan would fall at around the same time. She questioned whether there was opportunity to create synergy between the reports, which would allow for greater joint up working. The Director of Strategy and Assurance reiterated that he could not represent the Independent Commission, but did confirm that the CPCA had discussions regarding greater joint up working and would feed this in the Independent Commission.

It was resolved that the Peterborough Health and Wellbeing Board:

a) Note the update in this paper

b) Request a further update in the summer when the Independent Commission on Public Service Reform has reported to the Mayor

## 28. PUBLIC HEALTH SYSTEM LOCAL GOVERNMENT ASSOCIATION (LGA) PEER REVIEW

The Board received a report that presented the findings of the Cambridgeshire and Peterborough Public Health System Local Government Association (LGA) Peer Review carried out in February 2019, and requesting the approval of the joint action plan prepared to address the key recommendations of the Review. The Director of Public Health stated that the LGA Peer Review had yielded beneficial results. The Review asked how well they were working to improve the health of the public in Cambridgeshire and Peterborough and how the health and social care system worked holistically. In reference to paragraph 3.3 of the report, she then outlined to the Board the key findings from the LGA peer review report. In reference to paragraph 3.4, she explained the final recommendations of the LGA Peer Review. She noted that the voluntary sector had made some good contributions to the Peer Review. The Health and Wellbeing Board potential had a key role in taking these recommendations forward by approving the joint action plan.

In the course of discussion:

- An elected Member raised their concerns with the number of areas of consideration in the report and noted that they must prioritise them effectively.

- An elected Member stated there was a profound misunderstanding of the roles public health played in Local Government. A culture change was needed to improve the understanding of the broader context of Public Health to Members and officers across the organisation.

- An elected Member commented that the public were not aware of the role of Public Health within Councils. He noted that work could be undertaken to try to change this. The

Chairman of the Cambridgeshire Health and Wellbeing Board stated that there was a common misconception of the term Public Health. The Director of Public Health agreed and stated that many of her staff were labelled as employees from NHS England in public meetings. She had instated that Public Health be publically associated with the County Council in press releases.

It was resolved that the Peterborough Health and Wellbeing Board:

a) Note and comment on the LGA Public Health System Peer Review finding and recommendations attached as Annex A

b) Approve the Public Health Peer Review draft action plan attached as Annex B

## 29. DEVELOPING A NEW JOINT HEALTH AND WELLBEING BOARD STRATEGY

The Board received a report outlining the next steps in developing a Joint Health and Wellbeing Strategy (JHWS) for Cambridgeshire and Peterborough and asking for the Boards endorsement of the proposed approach. The Director of Public Health drew attention and outlined the following main issues found in the report: Establishing the timescale for the JHWS, establishing priorities for the JHWS, Links to local implementation of the NHS Long Term Plan, Public Consultation on the JHWS and Approval of the JHWS. She noted that she hoped to start discussing the establishment of JHWS priorities at the Joint HWB Development Session in the afternoon and conversations had started, led by the STP regarding the response to the NHS Long Term Plan.

In the course of discussion,

- The representative from the CCG stated that the engagement on the NHS Long Term Plan had started and sought clarification of the time scale of the JHWS report. The Director of Public Health commented that the time scales were challenging, but the reports did not have to be published at the same time. She noted that it was very important that the strategies were cohesive and allowed the opportunity for greater joint up working arrangements.

- The representative from the Cambridgeshire Community Services NHS Trust (CCS) reinforced the point that the joint working strategies need to be simplified to allow more cohesive joint up working arrangements.

- The Vice-Chairman of the Peterborough Health and Wellbeing Board agreed that the JHWS should be aligned with community needs

- An elected Member agreed that the JHWS should be formulated earlier as a formative document, she noted that the public can find consultations onerous

- The Chairman of the Cambridgeshire Health and Wellbeing Board questioned whether there was a statutory duty to hold a public consultation on the strategy. The Director of Public Health explained that there was a statutory duty to publically consult on significant proposed service changes. However, officers would explore this further outside of the meeting.

It was resolved that the Peterborough Health and Wellbeing Board:

a) Endorse the proposed approach to developing a new joint health and wellbeing being strategy for Cambridgeshire and Peterborough.

## 30. HEALTH AND SOCIAL CARE SYSTEM PEER REVIEW ACTION PLAN UPDATE

The Board received a report providing an update on progress against the recommendations from the Health and Social Care System Peer Review (September 2018), in preparation for a Care Quality Commission Area Review. The Executive Director, People and Communities stated that the action plan in the report was a result of a Health and Social Care LGA review they had last year. They had developed the action plan with in conjunction with key officers from the Health Executive. She drew the Boards' attention to the actions and recommendations found in the action plan and commented that they reflected the results of the Health and Wellbeing Peer Review. She expressed her enthusiasm that the Joint Health and Wellbeing Development Session will cover the key actions found in the report.

In the course of discussion, members:

- Were reassured that this report would be a point of key discussion in the Joint HWB Development Session in the afternoon.

- The Chairman with agreement from both the Peterborough and Cambridgeshire Health and Wellbeing Board stated that the report should be brought to the back to the Board in around six months' time.

It was resolved that the Peterborough Health and Wellbeing Board:

a) Consider the content of the report and raise any questions

b) Decide when the action plan should next be presented to the Board

## 31. PETERBOROUGH HEALTH AND WELLBEING BOARD FORWARD AGENDA PLAN

The Chairman requested Hydrotherapy Pools be added to the Forward Agenda Plan. The Executive Director, People and Communities requested that a discussion took place outside of the meeting prior to it being added as an agenda item. .

Chairman

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 5 |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

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|---|---|---|
| Report of: | Wendi Ogle-Welbourn, Executive Director People and Communities | |
| Cabinet Member(s) responsible: | Cllr Lynne Ayres, Cabinet Member Children's Services, Education, Skills and the University | |
| Contact Officer(s): | Sheelagh Sullivan, Head of SEN and Inclusion | Tel. 863707 |

# SEND PEER REVIEW FINDINGS

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Executive Director, People & Communities | **Deadline date:** N/A |
| It is recommended that the Health and Wellbeing Board note the report, consider the content and raise any questions | |

## 1. ORIGIN OF REPORT

1.1 This report is presented to the Health & Wellbeing Board at the request of the Executive Director, People and Communities.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this paper is to update HWB members on the delivery of the Local Government Association (LGA) Peterborough Special Educational Needs and Disabilities (SEND) Peer Review, held in October 2018..

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.8.3.1 and 2.8.3.2

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

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

## 3. TIMESCALES

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

## 4. BACKGROUND AND KEY ISSUES

4.1 Peterborough City Council invited the Local Government Association (LGA) into the area to look

at where we are in terms of our progress with SEND since the 2014 reforms and to assist the area in preparing for an imminent Ofsted/Care Quality Commission inspection.

We anticipate that we will receive notice of an inspection this academic year. The first round of these inspections is now into year four of a five year cycle and the Government have recently announced that there will be a second cycle of inspections in the following five years.

The peer team were onsite at Sand Martin House for four days in October 2018. They observed practice, meet with staff/partners, engaged with focus groups and visited different schools.

It is important to understand that this was not a review of the local authority but of the way in which the local area: health, social care, education (including schools and settings) and other partners like voluntary groups, are working together to support children and young people with SEND achieve independent, happy and fulfilled lives from the earliest years.

The Peer Review Team consisted of four members:

- Tom Murphy (lead peer), Assistant Director of Early Intervention Prevention & SEND, LB Hillingdon
- Jayne Franklin, Head Teacher, The Children's Hospital School, Great Ormond St Hospital
- Chris Jones, SEND Strategic Development Lead, Nottinghamshire County Council
- Sam Barron, Split post: Head of SEND Strategy (NCC) and Designated Clinical Officer for Northumberland CCG

The key themes explored were:

- Leadership and governance of SEND across the local area
- Capacity and resources (including Finance)
- The identification of children and young people who have special educational needs and/or disabilities
- Assessing and meeting the needs of children and young people who have special educational needs and/or disabilities
- Improving outcomes for children & young people who have special educational needs and/or disabilities

The Key Lines of Enquiry (KLOE) were:

- How effective is the leadership and governance of SEND across the area?
- How effective is the capacity and resources (including finance) across the local area?
- How effectively does the local area identify children and young people who have special educational needs and/or disabilities?
- How effectively does the local area assess and meet the needs of SEND children and young people?
- How effectively does the local area improve outcomes for SEND children and young people?
- Have the council got it right in terms of challenges and strengths for SEND?
- Are the priorities right, in this period of development?
- The review will assess how it all works in practice and improves outcomes.

The peer review team were asked to consider a number of key documents to inform the review, These were:

- Our self evaluation and action plan plus best practice supporting evidence demonstrating impact and outcomes
- Draft Joint SEND strategy (Cambridgeshire and Peterborough)

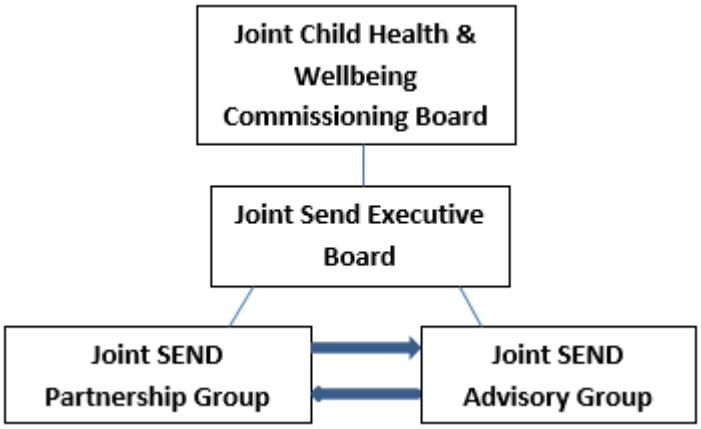
As part of the peer review process, the peer team assessed the quality of a number of Education, Health and Care Plans (EHCPs). The team looked at the input from health, education and social care and the involvement of children/young people and their parents/carers.

The final report is attached as Appendix 1. The key findings are summarised below:

- Continue to refine and strengthen our strategy - backed up by a robust data dashboard.

- Ensure the partnership provides focused leadership to map out forward demand. Understand in detail the changing local demographics, patterns of demand and throughput within our local offer. Make the best use of what we already know.
- Rank, action plan and deliver on our 'essential to success' priorities' – determine those priorities that are of critical importance to attend to over and above others, that reflect where we are now and enable us to go on to deliver on our SEND ambition, 'if we don't deliver this, we won't deliver the right services to the right people at the right time.'
- Ensure our monitoring and evaluation processes are focused on measuring progress against these priorities.
- Develop a workforce strategy to provide the capacity to respond to future patterns of need.
- Strengthen ways to evidence impact and outcomes for children and young people. In particular, increase your awareness of destinations/outcomes in the post 16 and post 18 age range.
- Continue to listen to, learn from and fully engage all stakeholders: open, honest conversations need to be part of continuous improvement. Consider ways to maximise engagement with all parent/carers.

The key action points will be incorporated into the Joint SEND Strategy Action Plan for monitoring. A new governance structure has been put in place by the Executive Director, as detailed below:




The ultimate objective of this structure is to enable delivery of key priorities to improve the lives of children and young people.

Membership across the structure includes: local authority and health leads, schools, lead members, key providers, voluntary sector, commissioning and parent/carer organisation representatives.

## 5. CONSULTATION

5.1 The final peer review report was shared with the lead member for Education, Cllr Lynne Ayres and published on the Local Offer.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The peer review has assisted in helping the local area prepare for an imminent Ofsted / CQC inspection.

## 7. REASON FOR THE RECOMMENDATION

7.1 Although the peer review was not an inspection, it provided a critical friend approach to challenge the local authority and our partners in assessing strengths and identifying our own areas for improvement.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 None.

## 9. IMPLICATIONS

### Financial Implications

9.1 The cost of the peer review was funded from the SEND strategic grant (Department for Education) given to all local authorities to support their development in responding to the continuing requirements of changes to legislation. The cost was £7,000.

### Legal Implications

9.2 There are no legal implications.

### Equalities Implications

9.3 There are no equality implications.

## 10. BACKGROUND DOCUMENTS

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

10.1 None

## 11. APPENDICES

11.1 Appendix 1: Final LGA SEND peer review report

# Peterborough City Council SEND peer review

1st to 4th October 2018

## Feedback Report

## Executive Summary

You asked the peer review team to focus on a small number of key areas for you as you review and revise your strategic approach to children and young people with special educational needs and/or disabilities (SEND). These were:

- Acknowledgement that you know your strengths and areas for development

  We felt that areas of strength and areas for development were known by individuals, teams and agencies but there did not appear to be a full, collective understanding of these across all levels of the partnership.

- Feedback on how new arrangements and strategies are embedded

  The recent past has seen Peterborough City Council 'travel at pace' to implement the SEND reforms. You have clearly had honest conversations to address improvements and there are areas that are being well embedded. However, there is still more work to be done. For example, you have established one of the key components of an effective SEND pathway via the Statutory Assessment and Monitoring Service (SAMs), which has begun to improve the process for Education Health and Care Plans (EHCPs), but not all parties are as yet fully engaged nor is there buy in at all levels.

- Identification of areas where you need to focus more attention

  We highlight a number of areas for further attention which include strategic long-term planning, workforce development and fine tuning improvements that have been put in place recently to ensure that they are fully embedded.

- Examples of innovative practice in the light of financial constraints

  A number of examples were seen, including your approach to early help/early support, the development of joint commissioning and the establishment of the HUBs.

We saw strong leadership around the SEND agenda, which is clearly a priority for the senior leadership team. It is equally apparent that there is also a commitment from council officers, councillors and school governors to progress the SEND reform agenda. The push from senior leaders has enabled partners to 'come around the table'.

Partners are engaged and committed to making SEND everyone's business. We saw examples of good collaboration and a collective problem solving approach has been employed to resolve challenges and establish specific initiatives.

There has also been an increase in pace over the last two years. There is a rigour and energy to drive progress and a collaborative approach is producing improvements.

We saw passionate and dedicated staff with a strong team ethos, across the whole partnership. Staff work positively together to maximise the local offer. Those we spoke to were of the opinion that once a diagnosis or assessment had been received then a good service was forthcoming. You prioritise the voice of parents, carers, children and young people and we saw how this is being weaved into strategic planning.

You are progressing increasing collaboration and joint working with Cambridgeshire County Council. This is producing synergies and learning for both authorities. As yet the desired end point of this journey is yet to be defined.

Demographic and other data suggests changing patterns of need and increasing demand at a time when financial pressures on all partners are increasing. It will be a challenge to meet these competing trajectories.

There remain areas where you wish to progress further and there is more work to do, not least on fully embedding the progress you have made to date. We found different perceptions of a number of key shared business processes you have put in place. At the most extreme this resulted in some seeing these as filters and others as barriers to entry or restricting/delaying access to services. These differing perceptions should be investigated and resolved as necessary. Not all partners and settings felt equally engaged.

There are a number of key areas to progress further

- Consider the whole system when addressing specific problems
- Moving from a focus on the here and now to a strategic long-term perspective
- Developing your approach to the use of data; you have good sources of data which could be used more effectively by including consideration of 'softer' intelligence.
- Co-production is an evident priority and was consistently referenced by a range of stakeholders but there are inconsistencies in understanding and application of the term.

The draft SEND strategy that is now going out for consultation will help to engage partners in shifting focus and begin to address these issues.

## Recommendations

There are a range of suggestions and observations within the main section of the report that will inform some 'quick wins' and practical actions, in addition to the conversations onsite, many of which provided ideas and examples of practice from other organisations. The following are the peer team's key recommendations to the council:

1. Continue to refine and strengthen your strategy - backed up by a robust data dashboard.

2. Ensure the partnership provides focused leadership to map out forward demand. Understand in detail the changing local demographics, patterns of demand and throughput within your local offer. Make the best use of what you already know.

3. Rank, action plan and deliver on your 'essential to success' priorities' – determine those priorities that are of critical importance to attend to over and above others, that reflect where you are now and enable you to go on to deliver on your SEND ambition, 'if we don't deliver this, we won't deliver the right services to the right people at the right time.' Ensure your monitoring and evaluation processes are focused on measuring progress against these priorities.

4. Develop a workforce strategy to provide the capacity to respond to future patterns of need.

5. Strengthen ways to evidence impact and outcomes for children and young people. In particular, increase your awareness of destinations/outcomes in the post 16 and post 18 age range.

6. Continue to listen to, learn from and fully engage all stakeholders: open, honest conversations need to be part of continuous improvement. Consider ways to maximise engagement with all parent/carers.

## Peterborough City Council SEND peer review - scope and focus

The fundamental aim of a SEND peer review is to help councils and their partners reflect on the provision in the local area for children and young people with special educational needs and/or disabilities as contained in The Children's and Families Act 2014 and in the SEND Code of Practice 0-25 years, 2015.

A peer review provides an assessment of the local area self-evaluation and overall progress in implementation of the SEND reforms.

The LGA SEND peer review lines of enquiry reflect the principles of the Code of Practice and the key themes of Ofsted inspections.

The lines of enquiry considered by all SEND peer reviews are:

- How effectively does the local area identify children and young people who have special educational needs and/or disabilities?
- How effectively does the local area assess and meet the needs of SEND children and young people?
- How effectively does the local area improve outcomes for SEND children and young people?
- Leadership and governance of the SEND Reforms
- Capacity and resources.

It is important to remember that a review is not an inspection; it provides a critical friend approach to challenge the council and its partners in assessing their strengths and identifying their own areas for improvement.

Peterborough City Council requested an LGA peer review to assess their progress in implementing the SEND reforms and the development of a new SEND Strategy, to ensure sufficient attention on this agenda and to assist in preparations for any future Ofsted inspection.

A team of LGA specialist peers reviewed documentation and data, a small sample (seven) of Education, Health and Care Plans (EHCPs), and interviewed children and young people, parents and carers and staff, across early year's settings, schools, colleges, the council, health commissioners and provider organisations. A number of visits to primary and secondary schools as well as a FE college were carried out alongside a range of focus group sessions.

Although the team employed the overall LGA framework, as set out above, the SEND peer review in Peterborough was developed in a bespoke manner to address a key current need of the council and its partners in relation to SEND.

The Council specifically asked the review team to look at the very recent development of your SEND strategy and to comment upon it in relation to the following five areas:

- Acknowledgement that you know your strengths and areas for development
- Feedback on how well you are embedding new arrangements and strategies
- Identification of areas where you need to focus more attention
- Innovative practice in the light of financial constraints
- An assessment of the quality of Education, Health & Care Plans.

The findings of the review are delivered as an assessment against these primary areas of focus from both a strategic and operational perspective. This assessment is framed as set of strengths and areas for consideration.

Peterborough City Council is encouraged to reflect with its partners on what the review findings mean in relation to the local area as a whole.

## The peer team

The make-up of the peer team reflected your requirements and the focus of the review. Peers were selected on the basis of their relevant experience and expertise and their participation was agreed with you.

The peers who delivered the SEND peer review in Peterborough were:

- Lead peer – Tom Murphy, Assistant Director, Early Intervention, Prevention and SEND, Hillingdon Borough Council
- Operational Peer SEND **–** Chris Jones, SEND Strategic Development Lead, Nottinghamshire County Council
- Operational Peer Education – Jayne Franklin Head Teacher, The Children's Hospital School at Great Ormond Street and UCH
- Health Peer – Gill Tyler, Designated Clinical Officer NHS Vale Royal CCG
- Review Manager – John Rylance, LGA

# Detailed findings

## Strategic level - strengths

We saw strong leadership and direction around the SEND agenda and the Council has consistently prioritised the maintenance of the educational resource allocation to support the delivery of the SEND reforms. A key strength lies in the individual relationships and collaborative working that we saw in action. There is considerable goodwill and a willingness to work together. This collaboration has already borne fruit and there are examples of how this has helped you join up and improve services, e.g. in the Speech and Language Therapy (SALT) specification, the new 0-19 Healthy Child approach and in agreeing and implementing a revised single point of assessment business process.

The principle that SEND is everyone's business is universally accepted and you have reached agreement across the partnership on high level principles. Differing roles and responsibilities are acknowledged and joint working occurs at all levels.

You clearly know where you are and have a good awareness of your strengths and areas for development. You acknowledge that you have needed to address some challenges and recognised the need to move at pace in response to the reform agenda, given your starting point. The last two years have seen senior leaders in Children's Services pushing the agenda forward and you have applied a rigorous approach to increasing pace, improving services and establishing fit for purpose joint working arrangements. Senior leaders from different agencies have come together and used a strength-based problem solving methodology to resolve challenges. There have been a number of honest and open discussions that have resulted in improved working arrangements.

Working together processes have been refined and you have put in place a governance structure, which includes a SEND Partnership Board and a Joint Commissioning Unit SEND Group, to provide effective oversight. SEND priorities and outcomes feature in local authority service plans.

There is an improving relationship across the various Peterborough City Council teams that contribute to the delivery of SEND services and an increasing contribution from health. Both of these have been brought about through a more effective, high level steer from senior leaders. Consolidating support within the 0-25 Children with Disability team is an example of how you are working to ensure services flow together more easily and minimise the impact of transitions. The relationship between the Council and Health has improved significantly over the last two years in terms of joint planning, joint funding and ensuring integrated pathways for assessment and diagnosis.

Your draft SEND strategy, once finalised and disseminated, will help to consolidate the progress that has been made.

## Strategic level - areas for consideration

You acknowledge that you have had to increase pace on implementing the SEND reform agenda. The vigour and energy that has been applied in the past two years has enabled you to make progress. There is a good understanding of the work there is still to do to fully implement the SEND reforms.

You have faced the need to improve provision and address challenges but acknowledge that this could have been perceived as reactive problem solving. The next stage of development requires problem solving across the whole system rather than against specific challenges. We would recommend moving to a whole system risk appraisal process linked to the roll out of your new strategy, taking account of the system pressures that you already know about e.g. recruitment and workforce issues, pressure on the delivery of Universal Plus interventions

The new SEND Strategy needs to provide a consensus on where you want to be across a three to five-year time frame. You need to put in place clear, consistent and SMART action planning which articulates to the overarching new strategy and plan going forward. It is important that the new strategy being consulted on, has one, consolidated, clearly defined and partnership owned implementation plan as the vehicle for ensuring agreed outcomes are realised. We note that, from April 2019, you do intend there to be only one action plan for the local area strategy including action relating to the implementation of the SEND reforms.

At the time of the review we saw a number of action plans which attended to the implementation of the SEND reforms and associated SEND development activity for the 3 years prior to the production of the current draft strategy. The fact that your current 18-19 action plan and the new draft Strategy do not align effectively was a cause of confusion to those we spoke with. The various action plans that we were presented with did not appear to us to have been fully evaluated nor always used to inform the next action plan.

Clear efforts are being made to involve partners and stakeholders in the development of the new strategy. It is important to make sure that everyone is equally engaged in the process of agreeing and then owning the new strategy. These efforts need to be maintained to ensure that the strategy is shaped and owned by all stakeholders.

Although everyone is signed up to a set of high level principles, there are a number of areas where there are differing opinions, co-production being one of the more contentious. There are differing opinions on the definition, and even more so on the reality, of co-production in Peterborough, particularly how it has been employed in relation to the new draft Strategy. Not all partners felt equally engaged in the development of the strategy and questioned whether the process was in fact consultation rather than co-production. We ask you to consider with your partners whether you are all clear about when you are co-producing and when you are consulting.

There is good engagement with schools around delivery of SEND but a sense that they had not been as fully engaged as they would have liked in the Sufficiency Audit

and development of the new strategy. There is no doubting schools' commitment to the SEND reform agenda and to delivering a high quality SEND offer but it is worth considering how to build a shared acknowledgement of schools as equal partners. This would entail further discussion to clarify expectations and responsibilities around involvement and engagement - areas where there is, at the moment, some confusion.

You provide funding to maximise parent and carer input into the development of SEND services and we saw the positive effects of this and attempts to widen recruitment in imaginative ways. Your emphasis on gaining the parent carer voice needs to be maintained and the local area should continue to employ a number of ways to ensure that it hears from the widest spread of parent/carer opinion. We heard of many interesting initiatives to extend parent carer voice such as the coach trips organised by Family Voice. We heard that employing a number of different ways to engage parents was felt to be very helpful and was increasing engagement. However, not all parents are fully engaged and a variety of methods will continue to be needed to be ensure your approach is as fully inclusive as possible.

We have concerns at the capacity within SENDIASS, given the demands placed upon it and the emerging new national standards. You may want to consider whether there are sufficient resources in SENDIASS and the ability of this service to deliver the national minimum standards that have recently been consulted on.

Peterborough has dedicated resource to the development of its Local Offer and website. This has led to a well-constructed and continually evolving website. Those leading its development have clear ambitions to continue developing the site, including the creation of a young people specific website. Work in relation to ensuring all stakeholders consistently contribute to its development is ongoing. We found that the full engagement of all relevant agencies in the development of the Local Offer and its website is a challenge in some instances. We advise that Peterborough considers how best to match Local Offer development, ambition and available resources. We also suggest that due attention is paid to ensuring contributions from all relevant parties to Local Offer content and website development.

We thought that better use should be made of the data that you hold to inform planning, performance management and evaluation. We were told that the data dashboard is still being developed and has taken a long time to get established. This is not to say that you need more data - there are already 165 indicators – and there does appear to be a range of good quality data available. Rather, we believe that you should focus on developing a limited series of key indicators that will tell the partnership that it is delivering the right service to the right people - alongside mechanisms to share, and make better use of, the data that you already possess in order to better predict and respond to demand. One example of this would be using your data to facilitate post 16 providers to match resources to likely levels of student demand for courses. This is obviously a specific instance but we were of the opinion that it may reflect a wider systemic need to develop your approach to data gathering and analysis so that the resulting intelligence, including 'softer' more qualitative

intelligence, is used to best effect. There was a general acknowledgement of a lack of data and intelligence on SEND outcomes.

Predictive data indicates increasing complexity and increasing demand. Your data shows particular areas where there is very likely to be higher levels of need in the future. This is against a context of tightening financial constraints. This was very effectively described to us as the debate about 'resourcing the ambition' and being able to provide 'bronze or platinum core statutory services.' There is self-evidently a need for medium to long term financial efficiency planning. Although education resources have been protected to date there is no allowance for growth in demand nor an increasing population. Consultation on the new SEND strategy provides an opportunity to set out the expected future financial and demand contexts and promote the honest and challenging discussions that will need to be had around a sustainable level of service provision in the medium to long term. You have begun this process and have already engaged in a sufficiency exercise to plan for the next 5 to 10 years, however this was described to us as 'still in the early days' and there were mixed messages fed back to us on how far some felt engaged in the process.

You have established two key fora to drive forward the SEND reform agenda, The SEND Partnership Board and the Joint Commissioning Unit SEND Group. The basis for effective governance across SEND is in place. The SEND Panel is seen as having strong representation from all partners and is viewed as 'transparent'.

We were told that the problem focused approach to SEND governance that has been applied to fast track challenges has produced a system that is very reliant upon strong individuals pressing for change. There is a risk that the change and transformation agenda could be viewed as over reliant on 'driven' individuals and we would advocate the continued fostering of collaborative leadership. The emerging challenge is to ensure that robust systems can drive forward as effectively as strong individuals have done to date. It is also about ensuring that the new strategy is brought forward as a collective effort.

A specific issue in relation to governance is the breadth and scope of responsibility of the Designated Clinical Officer (DCO), which at present only extends from 0-18 - although we acknowledge you are currently piloting inclusion in the 18-25 age range. Additionally, the DCO has two other roles which compete with their time. You have resourced and appointed an additional post to act as a central administration point for health requests but again this post only covers the age range 0-18.

There was a general message that not all stakeholders felt fully informed. There were examples of numerous processes in place to communicate across the system (e.g. the Governor's newsletter). However, improving communication, both internally and with partners, was frequently mentioned as an area for development. Some of the examples that were raised included timing or absence of partner notification of requirements to attend panels, hindering their ability to be present, and schools stating that developments in relation to the early draft of the new strategy were not effectively communicated to them. Many of those we interviewed said that they felt excluded from the development of the Sufficiency Audit. There is a need to hear the messages fed to us on the relationship with schools and to ensure that all schools

feel fully engaged with, and have ownership of, strategic development and operational policy and practice.

It is important to investigate the perception that internal and external communication hasn’t met the needs of all parties and resolve any outstanding issues.

We recognise the challenges and complexities of having effective channels of communication across the whole system and you may wish to consider 'communication' as a specific work stream within your SEND strategy, in order to address some of the perceptions shared with the review team.

## Operational level - strengths

SEND is clearly a priority at an operational level. We found skilled, passionate and knowledgeable staff across the partnership, good co-working and delivery of good quality services following assessment and/or diagnosis. There is increased clarity in your processes for referral and planning e.g. the Early Help Referral process and EHCPs. The renewal of your Early Support Pathway is having an impact on assessing and meeting need. The focus is clearly on the child and the 'All about me' folder, once accepted by the Early Support Panel, will further enhance the child's voice. The Neuro Developmental Pathway is highly valued and has improved waiting times

We saw increasing effectiveness of systems and information sharing e.g. 10% of health reports are returned within 6 weeks and from September 2018 direct referral to specialist services has been possible.

Schools are committed to support the SEND needs of pupils and families and Governing Bodies and Trust Boards are beginning to identify the need for improvement with relation to SEND policy and the information that they include on their websites. There is a strong operational level relationship with your schools and between schools and the PRU, which is promoting inclusion. This has resulted in limited evidence of off-rolling and a low level of exclusions. We were told of increasing use of preparation for adulthood (PFA) targets from Year 9 onwards and strong relationships with sixth forms (including vocational as well as academic offers, life skills and life beyond school options).

You have negotiated and jointly agreed with schools and FE independent providers a banded funding model for a three-year fixed period that plays out operationally and the High Needs Budget for 2018/19 is balanced.

There are increasingly effective processes in place within post 16 provision. Both FE colleges clearly prioritise SEND and we saw the work of the access champions at the City College. The Youth Service report that 99% of 16 to18 year old young people with SEND are known to the service and there is a specialised National Citizenship Service and a Gold Duke of Edinburgh for young people with SEND. There was good commitment to providing the best possible post 16 and post 18 provision but as with other sectors still some work to do to ensure seamless transition and effective outcomes. There was a lack of data on post 16 and post 18 outcomes. It's important that outcomes at post 16 and post 18 are tracked and measured to ensure that your provision delivers against your own aspirations for this cohort.

The SENDCo Network and the recent move to the HUBs (now in its second year) are valued and have generally been well received by staff, providing a good opportunity to share information and good practice. This is promoting joint understanding of work needs and issues and said to be generating efficiencies, increased accountability and improved links with specialist services and with area SENDCo.

You are beginning the process of reviewing services to provide sufficiency, improve outcomes and/or reduce costs (e.g. review of Short Breaks, Joint Funding Panel review of out of city placements, funding for a central point for requests within health to free up professional time and capacity). The problem-solving approach you have adopted has helped to mobilise and bring people together to effect change and strengthen the local offer e.g. developing links with leisure facilities, drop in SALT clinics.

You clearly prioritise the voice of families and children and young people. Family Voice are using creative means to increase engagement with seldom heard families and carers. The local SENDIASS is effective and highly regarded by parents and there are a number of other avenues being used by parents and carers who are not engaged with these two fora.

## Operational level - areas for consideration

You have moved quickly to address challenges and embed the SEND reform agenda and there is evidence throughout this report on how this is having an impact on a wide range of services and across agencies. You acknowledge that you have had to travel at pace to do this and inevitably this will mean that business processes recently introduced are not yet fully embedded.

Many settings were reported to be severely stretched and we heard many concerned about their ability to continue to manage need within resource constraints. Some schools were worried about their capacity to respond to requests and to act in a lead professional role. We were told of instances of good practice which could not be rolled out further because of capacity issues. For example, the nurture unit at Ken Stimpson School provides support up to Year 8 but would be even more valued if it was extended beyond this age group. Another example was the Clinical Commissioning Group funding that was secured to provide specialist input on Moderate and Severe Learning Difficulties but it was reported that this was only provided via telephone which whilst valued was not felt to be sufficient.

Because you have had to employ a somewhat reactive problem-solving approach (which has clearly proved effective in addressing blockages) we found that operational development, services and processes are not yet fully joined up. For example, there was widespread praise for the Neurodevelopmental Pathway, but in the new Speech and Language Therapy specification input into this pathway was not included. You have Alternative Provision, which is well regarded amongst schools, however, is it sufficient and able to meet demand?

The Early Support Pathway and Education and Health Care Plans (EHCPs) are still being embedded and the Early Support Pathway generated mixed comments during our site visit. It has without doubt enabled support for some but there is at least a perception, which needs to be investigated, that it has also created a wait for other services.

There has clearly been a lot of work on mapping and signposting this process. In the early stages of the on-site period the peer team had to work hard to identify the business process for referral, diagnosis and assessment and were left a little

confused when your new systems were described by those we interviewed. It took sometime before the peer team felt they had established for themselves a good grasp of this process.

We found that those we interviewed held differing perceptions and understanding of your referral and business processes and of transition points (e.g. confusion around whether the Early Support Pathway led to a referral or to a recommendation) and two significant differences of opinion. It is important to fully investigate both of these and clarify the guidance for professionals and families.

The first difference in understanding concerned whether - and why - referrals for community paediatric services had to be processed in the first instance via the Early Support Pathway. There was confusion and disagreement about the need for such referrals to go via the Early Support Pathway route. This should be addressed with the relevant professionals to ensure an effective referral system.

The second issue concerned the need to undertake a parenting group intervention as part of the assessment process. A key issue for some was whether it was necessary, in every case, to refer to a parent group. There was a clear body of opinion that this filter should be employed in a more differentiated manner and a fast track be included for those families where the diagnosis did not warrant a parent group intervention. Analysing your data will provide you with hard evidence on the value of parenting courses as a filter and on whether this is having a positive or a negative impact on the identification of need and on waiting times.

A number of other transition points or processes are still being embedded.

With the development in 2014 of a 0-25 Children with Disability Service, Peterborough has put in place a single route of access to all services across children's and adults including 0-25 specialist service. The referral process for the 0-25 Children with Disability Service is aligned with that for under 18 Children's Services.

We saw clear value in your 2014 establishment of a 0-25 Children with Disability Service. We heard of a number of positive developments from those we interviewed e.g. facilitating continuity of allocated worker, minimising transition points, enabling more coordinated provision of support to families and young people. This service continues to be developed whilst embedding positive practice.

There is a single route of access described for all social care services across children's and adults including the 0-25 service. Nevertheless, the Peer Review Team heard of confusion over the referral criteria for the 0-25 Children with Disability Service e.g. there were mixed views on whether the 0-25 Service was purely for children with an EHCP. There was also a strongly held perception, reported to us, that parallel referral processes into Children's Social Care teams still sit beside the 0-25 Service. We were told that managers were aware of this confusion and were working to resolve any outstanding issues. It would be worth testing out if there is any substance behind the perceptions that were shared with the review team, via an audit of recently referred SEND cases, alongside restating clearly what the expected referral pathway is so that all staff are clear about roles and processes.

The 0-25 team has undoubtedly helped to ease transition from children's services to adult services in many arenas, however, there remains a need to build a more effective transition from CAMHs to Adult Mental Health Services.

We were told that communication with, and within, health is sometimes impeded because not all health settings can access Google, with the result that they cannot fully participate in the new computer based business processes. Improvements to communication with and within Health may help eliminate this.

The Statutory Assessment and Monitoring Service (SAMs) were working exceptionally well to progress EHCPs and have been able to make real progress. This level of effective performance appeared to be have been achieved with relatively limited capacity within this service. There was a recognition that current capacity levels had impacted on e.g. completing annual review work, because other aspects of the EHCP process have had to be prioritised instead. There may be a need to consider resource levels within the SAMs service in order to sustain performance and to address areas for development.

We were told of issues with representation of some colleagues at EHC meetings, although we did not have the time to verify this across multiple sources. Another key issue is the involvement and recording of input of Children's Social Care into Plans and there was a suggestion this might be better facilitated by coordination across the Children in Care review and EHCP pathways.

We saw EHCPs as a marker for whole system coherence, providing a window on the wider collaborative process and revealing issues that need to be thought about and resolved.

We were told that it would be helpful if there were to be increased clarity on two education specific issues.

The first concerns the level of need that can be managed within a mainstream setting and when it is more appropriate to manage those needs within a special school setting.

The second was a perceived need for increased collaboration between head teachers and the SEND team on the challenges of placements.

There is a perception - amongst some - that the professional voice is not being heard. There is a clear desire on the part of Education Service managers and from schools to problem solve these issues.

There is still work to be done to ensure that all schools are equally engaged, including Academy chains. There was also widespread belief that closer integration and input of SENDCo within school strategic leadership teams would be beneficial in maximising the value of their offer.

Recruitment and retention in a number of professions is proving problematic, e.g. Educational Psychology, Health Visitors, School Nurses, Physiotherapy and

Occupational Therapy. Currently some individual schools are minimising the impact by employing freelance or agency professionals to supplement the statutory local offer. You are reviewing Physiotherapy and Occupational Therapy capacity and have developed a joint approach on the recruitment of Speech and Language Therapists; these provide a model for addressing other gaps in expertise/staffing.

There could be an improvement in planning for post 16 provision. There is also a need for better tracking of outcomes at post 16 and post 18 transition points.

Improved sharing of data would enable post 16 providers to predict trends and future demand and allocate resources appropriately. Increasing the links and exchange of information across special and mainstream schools and post 16 settings would help ensure that relevant concerns and information are shared and the transition to post 16 provision is as smooth as possible. We were told by many sources that currently this may not always be the case.

Your current processes ensure that the needs of your SEND population at the transition to post 16 provision are set out in EHCPs. There is less available information to track outcomes at post 18 and beyond. It is important that you know the destinations of young people with SEND as they move into adult services, not least so you can measure the impact of preparation for adulthood programmes and the effectiveness of the local offer for this age range.

There is a general need to increase the use of data on need, outcomes and how services are performing. It would also be useful to collect impact data for the SENDCo network and the HUBs. There was a reported lack of sharing of Early Support Pathway data with the SAMs team and the Education Health and Care needs assessment would be strengthened by routinely including the rich information held within the Early Help database to inform final EHCPs. Learning Disability annual health check for the 14-18 age range compliance is low at 27%.

## Next Steps

The Local Government Association would be happy to discuss how we could help you further. This can be done through the LGA's Principal Adviser for the East of England region, Rachel Litherland (07795 076834 rachel.litherland@local.gov.uk ) and/or the Children's Improvement Adviser for the East of England, Andrew Bunyan (07941 571047 andrew@abdcs.co.uk).

Thank you to everyone involved for their participation and for engaging in an open and honest way. Please pass on our thanks to the many colleagues who helped and supported the peer team in both preparing for the review and during the on-site phase.

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 6 |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Dr Liz Robin, Director of Public Health | |
| Cabinet Member(s) responsible: | Councillor John Holdich, Leader of the Council and Deputy Mayor of the Cambridgeshire and Peterborough Combined Authority | |
| Contact Officer(s): | Iain Green | Tel. 07946846561 |

**SCHEME OF AUTHORISATIONS FOR NHS ENGLAND PHARMACY APPLICATIONS**

| RECOMMENDATIONS | |
|---|---|
| **FROM:** *Dr Liz Robin, Director of Public Health* | **Deadline date:** *N/A* |

It is recommended that the Health and Wellbeing Board:

1. Note the statutory duty of the Health and Wellbeing Board to respond to "Excepted Applications" termed a "Consolidated Application", and
2. Delegate authority to the Director of Public Health in consultation with the Chairman/Vice Chair to respond to notifications from NHS England of "Excepted Applications" termed a "Consolidated Application" on behalf of the Board.

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a recommendation from the Director of Law and Governance & Monitoring Officer.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this paper is to request the board delegate responsibility to the Director of Public Health, in consultation with the Chairman/Vice Chair, for responding to notifications of pharmacy consolidations on behalf of the Health and Wellbeing Board, in order for the Board to fulfil its statutory duties.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.8.3.3

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

## 3. TIMESCALES

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

## 4. BACKGROUND AND KEY ISSUES

4.1 Since 1 April 2013, every Health and Wellbeing Board (HWB) in England has had a statutory responsibility to publish and keep up-to-date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment (PNA). It describes the pharmaceutical needs for the population of Peterborough, a separate

PNA is produced by the Cambridgeshire Health and Wellbeing Board and a paper requesting a similar delegation has been taken to the Cambridgeshire Board.

4.2 The Health and Wellbeing Board has a statutory duty to respond to applications for "consolidations", for all other applications the board has a power to respond but not a duty. Consolidations are where two or more pharmacies apply to merge, which could result in a pharmacy closing and therefore could create a gap in pharmacy provision.

4.3 Applications for consolidations are not common, in the lifetime of the current PNA there has only been one consolidation notification, however with the frequency of board meetings it is unlikely to be able to bring a paper outlining a suggested response on behalf of the Board for approval within the prescribed response time of 45 days.

## 5. CONSULTATION

5.1 No formal consultations have taken place as this is a request to change an internal process to enable the Board to meet its legal obligations, however the need for the Board to delegate it's duty in this regard has been discussed with the Director of Law and Governance & Monitoring Officer at Peterborough City Council & Cambridgeshire County Council and the Democratic and Constitutional Services Manager.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Delegating authority to the Director of Public Health in consultation with the Chair and Vice-Chair to respond to notifications from NHS England of "Excepted Applications" termed a "Consolidated Application" on behalf of the Board will enable the Board to fulfill its legal obligations without undue delay, thus safeguarding the Board and the Authority from legal challenge due to failure to respond in time to notifications of Excepted Applications.

## 7. REASON FOR THE RECOMMENDATION

7.1 Amendments were made to the pharmacy National Health Service (Pharmaceutical Services, Charges and Prescribing) Regulations in December 2016i. One key change was a new regulation which describes the potential consolidation of two or more pharmacies onto one existing site. A new pharmacy would be prevented from stepping in straight away if a chain closes a branch or two pharmacy businesses merge and one closes which would protect two pharmacies that choose to consolidate on a single existing site – where this does not create a gap in provision. The Health and Wellbeing Board has a statutory duty to respond to applications for "Excepted Application" termed a "Consolidated Application". The Health and Wellbeing Board has 45 days to respond from the date of the notification.

7.2 "Applications to consolidate will be dealt with as "excepted applications" under the 2013 Regulations, which means in general terms they will not be assessed against … the pharmaceutical needs assessment ("PNA") produced by the HWB. Instead, they will follow a simpler procedure, the key to which is whether or not a gap in pharmaceutical service provision would be created by the consolidation….. If the NHSCB is satisfied that the consolidation would create a gap in pharmaceutical services provision, it must refuse the application. The opinion of the HWB on this issue must be given when the application is notified locally and representations are sought (regulations 12 and 13). If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the HWB does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement published alongside its pharmaceutical needs assessment recording its view (regulation 3)."

7.3 Following endorsement by the HWB, any supplementary statements or revised assessments will be published on the Peterborough City Council website www.peterborough.gov.uk alongside the original 2018 PNA report. The steering group will write to all key stakeholders, who were involved in the development of the PNA, to inform them of the publication of any supplementary statements. Publication will be communicated to the public via the Peterborough

City Council website and social media accounts. Other members of the steering group will publicise the information via their websites and/or social media as they deem appropriate.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 No alternatives are available, the Board has a legal duty to respond to Excepted Applications within 45 days of receipt of such notifications.

## 9. IMPLICATIONS

### Financial Implications

9.1 There are no direct financial implications, however if the Board fails to meet its statutory duties it is open to legal challenge and therefore any associated costs due to the legal process.

### Legal Implications

9.2 The Health and Wellbeing Board has a statutory duty to respond to applications for "Excepted Application" termed a "Consolidated Application". The Health and Wellbeing Board has 45 days to respond from the date of the notification. Failure to do so leaves the Board open to legal challenge.

### Equalities Implications

9.3 None

## 10. BACKGROUND DOCUMENTS

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

10.1 Peterborough Pharmaceutical Needs Assessment 2018 (https://www.peterborough.gov.uk/healthcare/public-health/pharmaceutical-needs-assessment/)

## 11. APPENDICES

11.1 None

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| **HEALTH AND WELLBEING BOARD** | AGENDA ITEM No. 7a |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| Report of: | Dr Liz Robin, Director of Public Health | |
|---|---|---|
| Cabinet Member(s) responsible: | Councillor Holdich, Leader of the Council and Deputy Mayor of the Cambridgeshire and Peterborough Combined Authority | |
| Contact Officer(s): | Dr Liz Robin | Tel. 01733 207176 |

**FEEDBACK FROM THE JOINT DEVELOPMENT SESSION WITH PETERBOROUGH AND CAMBRIDGESHIRE HEALTH AND WELLBEING BOARDS**

| 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:** *N/A* |
| It is recommended that the Health and Wellbeing Board Note and comment on the content of the HWB Joint Development session update report | |

## 1. ORIGIN OF REPORT

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

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Health and Wellbeing Board with an update from the joint development session with Peterborough and Cambridgeshire Health and Wellbeing Boards, held on 28 March 2019.

2.2 This report is for the Health and Wellbeing Board ] to consider under its Terms of Reference No 2.8.3.9.

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

2.3 The priorities discussed at the development session included ‘A good start in life’.

## 3. TIMESCALES

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

## 4. BACKGROUND AND KEY ISSUES

### BACKGROUND

4.1 The purpose of this paper is to provide the Peterborough Health and Wellbeing Board (HWB) with an update on the joint development session held between both Peterborough and Cambridgeshire Health and Wellbeing Boards on the 28th March 2019

4.2 Health and wellbeing boards (HWBs) are forums where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. A significant number of HWBs are now beginning to play a genuine leadership role across local health and care systems.

4.3 The session was facilitated by Cllr Sue Woolley and Dr.Julia Simon, representatives from the Local Government Association (LGA) with an identified purpose around:-

- Understanding the statutory role of the HWB Board.
- Understanding what the JSNA tells us about the health and wellbeing of Peterborough and Cambridgeshire residents.
- Developing a joint vision for health and wellbeing
- Understanding how the organisational relationships operating in a complex system

### MAIN ISSUES

4.4 The theme of the development session was to examine how as a statutory partnership board, overseeing health and wellbeing in this area, partners can develop a new system vision given the organisational challenges around finances, workforce and performance. Board members were provided with an overview of the Cambridgeshire and Peterborough Joint Strategic Needs Assessment Core Dataset (2019).

4.5 A number of challenges across the system were acknowledged:-

- Funding and financial constraints
- Recruiting and retaining the local workforce
- Recognising the growing population of Peterborough and Cambridgeshire
- Recognising the ageing population of Peterborough and Cambridgeshire with increased demand for integrated health and social care services.
- Geographical inequalities (other inequalities also noted) e.g. inequalities in children's early years and life chances
- Impact of common lifestyle behaviours on health

4.6 Local priorities across organisations were summarised as:

- **Places where people want to live:** good education and work, housing, culture and leisure, green spaces and transport
- **A good start in life:** support for parents and children, good early years settings and schools
- **People are healthy throughout their lives:** physical and mental health
- **Quality health and social care** close to home

4.7 The outcomes are drawn from a range of partnership boards where there are common priorities Discussions at the development session did recognise that not everyone is engaged and the importance of the voluntary sector, service users and local community was identified as key to developing a whole system strategy. There was a general consensus that the priorities identified above were good outcomes to focus on.

4.8 Discussions also focused on ensuring wider engagement and consultation over the HWBs joint vision and the developing Joint Health and Wellbeing Strategy.

4.9 The importance of the social determinants of health in addressing health inequalities was recognised and led to discussions around understanding what "Health in all policies" means. There is room to further develop this as part of the work of the Health and Wellbeing Boards.

4.10 The development session identified that wider engagement and consultation (specifically with community and voluntary sector) around a Joint Peterborough and Cambridgeshire Health and Wellbeing Strategy was essential.

4.11 It was proposed that this engagement could be delivered working with Cambridgeshire & Peterborough Healthwatch, as they are already involved in the response to the NHS Long Term Plan. Whilst the timescales did not facilitate initial joint consultation there are opportunities that will enable joint engagement.

4.12 Healthwatch England was commissioned by NHS England to carry out an independent consultation on the NHS Long Term Plan. Cambridgeshire and Peterborough Healthwatch are responsible for co-ordinating the local response to the consultation which closed on 30th April 2019.

4.13 Our local Healthwatch will be providing a report to Healthwatch England (using the survey results, focus groups and local intelligence). A stakeholder engagement workshop is planned for June 2019 which will bring together key organisations to review the findings around the public response to the NHS Long term plan. The CCG is also working with Healthwatch to assist in pulling engagement plans together around their response to the NHS Plan. It is proposed that the findings of the stakeholder engagement workshop are also utilised to test out the vision for the HWB Strategy and alignment against the local response to the NHS Plan.

**JOINT WORKING TO SUPPORT WHOLE SYSTEM HEALTH AND WELLBEING**

4.14 The session further explored how we can develop these priorities practically across Peterborough and Cambridgeshire. Both Peterborough HWB Board and Cambridgeshire HWB Board have agreed we need joint structures, which are most easily delivered as a joint sub-committee of the two HWB Boards. Two distinct roles of the Health and Wellbeing Board impact on the Boards infrastructure. For broader system leadership on health and wellbeing, we need a range of viewpoints and decision makers in the room with the ability to provide constructive challenge to each other. Other decisions on financial and performance issues where there is a lot of detail, and organisational accountabilities are very specific to CCG and upper tier local authorities, would be more efficiently reached in a smaller group with the minimum statutory membership of HWB boards.

4.15 A separate report will be provided to the Peterborough HWB Board that will discuss the options presented at the development session. This report will also discuss the process required to create joint sub-committees and agreement on their Terms of Reference.

4.16 After the meeting calendar for both the Peterborough and Cambridgeshire Parent HWB Boards and the joint sub-committee's have been set, a programme for further joint development sessions will be developed if required.

## 5. CONSULTATION

5.1 Consultation and engagement working with local HealthWatch is covered in paragraphs 4.8-4.13

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The outcomes of the joint Peterborough Health and Wellbeing Board and Cambridgeshire Health and Wellbeing Board development session will help to inform the future development of joint working across the two Boards – including the proposals for Joint Sub-Committees. It will also help to inform the priorities for the Joint Health and Wellbeing Strategy and the approach to

engagement on the Strategy.

## 7. REASON FOR THE RECOMMENDATION

7.1 Many members of the Health and Wellbeing Board attended the joint development session. It is important that the workshop discussions and outcomes are summarised for Board members who were not present and for interested members of the public.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The outcome of the workshop could have been left unreported – however this would mean that not all Health and Wellbeing Board members or the public were aware of discussions at the development session, which will help to inform future developments as described.

## 9. IMPLICATIONS

### Financial Implications

9.1 Facilitation of the joint Health and Wellbeing Boards development session was delivered at no charge by the Local Government Association.

### Legal Implications

9.2 There are no direct legal implications from the joint Health and Wellbeing Boards development session.

### Equalities Implications

9.3 There are no direct equalities implications from the joint Health and Wellbeing Boards development session.

## 10. BACKGROUND DOCUMENTS

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

10.1 Cambridgeshire & Peterborough Joint Strategic Needs Assessment 2019
C&P JSNA - Core Dataset 2019

## 11. APPENDICES

11.1 N/A

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 7b |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Dr Liz Robin, Director of Public Health | |
| Cabinet Member(s) responsible: | Councillor Holdich, Leader of the Council and Deputy Mayor of the Cambridgeshire and Peterborough Combined Authority | |
| Contact Officer(s): | Dr Liz Robin | Tel. 01733 207176 |

**PROPOSAL TO UPDATE THE TERMS OF REFERENCE FOR THE PETERBOROUGH HEALTH AND WELLBEING BOARD AND TO CREATE TWO JOINT SUB-COMMITTEE WITH THE CAMBRIDGESHIRE BOARD**

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Director of Public Health | **Deadline date:** Recommendation is for onward referral to Full Council on 25 July 2019 |

It is recommended that the Health and Wellbeing Board:

1. Endorse the updated terms of reference for the Peterborough Health and Wellbeing Board and for its two new Joint Sub-Committees with the Cambridgeshire Health and Wellbeing Board, and refer these to full Council for agreement.
2. Review the functioning and effectiveness of the Joint Sub-Committees after one year

## 1. ORIGIN OF REPORT

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

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this paper is to propose arrangements to create two joint sub-committees of the Peterborough Health and Wellbeing Board and the Cambridgeshire Health and Wellbeing Board, –a 'Whole System' Joint Sub-Committee and a 'Core' Joint Sub-Committee. It is also proposed to amend the terms of reference of both the Peterborough and the Cambridgeshire Health and Wellbeing Boards so that they are aligned, which will then allow clear delegation of functions to the two Sub-Committees. The Health and Wellbeing Board is asked to endorse these proposals and the updated terms of reference then need to be referred to full Council for approval.

2.2 This report is for the Health and Wellbeing Board ] to consider under its Terms of Reference No. 2.8.3.11

To establish a joint Cambridgeshire and Peterborough sub-committee in relation to issues that cross local authority boundaries.

2.3 There is no direct link to the Children in Care pledge. However the Health and Wellbeing Board

and its joint sub-committees may sometimes consider issues relevant to children's health and wellbeing, including children in care.

## 3. TIMESCALES

| | | | |
|---|---|---|---|
| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | |
| Date for relevant Council meeting<br><br>25 July 2019 | | Date for submission to Government Dept. *(Please specify which Government Dept.)* | |

## 4. BACKGROUND

4.1 In March 2018, the Peterborough Health and Wellbeing Board recommended to Full Council that the Health and Wellbeing Board Terms of Reference should be amended, in order to delegate powers from the Council to the Health and Wellbeing Board to establish a joint Cambridgeshire and Peterborough sub-committee in relation to issues that cross local authority boundaries. Full Council agreed this recommendation in July 2018.

4.2 A joint development workshop for Peterborough and Cambridgeshire Health and Wellbeing Boards on March 28th 2019 explored options for how to take further forward joint working and priorities across the two Health and Wellbeing Boards (see Appendix A). Two distinct roles of the Health and Wellbeing Boards were identified for joint work. The first is a system leadership role for health and wellbeing, for which representation from a range of organisations which impact on the wider determinants of health is required. The second is oversight of detailed financial, joint commissioning and integration issues for health and social care, specific to NHS commissioners and upper tier local authorities, which can be done more efficiently by a smaller group, reflecting the core statutory membership of the Health and Wellbeing Boards.

**MAIN ISSUES**

4.3 In order to create a joint infrastructure which will effectively deliver both roles of the Health and Wellbeing Boards outlined under 4.2, it is proposed to create the following two Joint Sub-Committees:

**Whole System Joint Sub-committee**

Membership: Full membership of both Peterborough HWB Board and Cambridgeshire HWB Board

Role: To drive forward wider system health and wellbeing priorities, which require involvement from a range of organisations.

Delegations: Approve Cambridgeshire and Peterborough Joint Strategic Needs Assessments
Approve Cambridgeshire and Peterborough Joint Health and Wellbeing Strategy

**Core Joint Sub-committee**

Membership: Core statutory HWB Board membership – equal across Peterborough and Cambridgeshire HWB Boards
Total of nine members

- Four Local Authority members (including the Chairs of both HWB Boards or a nominated substitute, Director of Public Health, Director of Adult Social Care & Children)

- Four Clinical Commissioning Group members
- One representative of Cambridgeshire and Peterborough Healthwatch

Role: To drive forward and oversee joint commissioning and integration of specific NHS / upper tier local authority services.

Delegations: Better Care Fund approval
Joint commissioning of NHS and LA social care / public health services

4.4 It is proposed that the two parent Health and Wellbeing Boards would continue to meet to cover Peterborough only and Cambridgeshire only issues. Overall during one year the proposed calendar of meetings would include:

- Two meetings of the Peterborough (parent) Health and Wellbeing Board
- Two meetings of the Whole System Joint Sub-Committee
- Four meetings of the Core Joint Sub-Committee

4.5 In order to enable clear delegation of functions to the two sub-committees, the Monitoring Officer has advised that the terms of reference of the Peterborough Health and Wellbeing Board and the Cambridgeshire Health and Wellbeing Board should be aligned, so that the same wording is used to describe their functions. This will enable clarity in the delegation of functions to sub-committees. Since both Health and Wellbeing Boards have the same statutory duties, but describe the functions of the Board in different levels of detail, this alignment is relatively straightforward. The proposed updated terms of reference for the Peterborough Health and Wellbeing Board and the new terms of reference for the two proposed Joint Sub-Committees are attached as Appendix B. For the updated terms of reference, additional text is in bold and deleted text in 'strikethrough'.

4.6 The updated terms of reference of the Peterborough Health and Wellbeing Board must be agreed by full Council following consultation with the Health and Wellbeing Board. Therefore the Health and Wellbeing Board is asked to endorse the attached Terms of Reference for referral to full Council.

## 5. CONSULTATION

5.1 The proposal to create two Joint Sub-Committees of the Health and Wellbeing Boards was discussed at the HWB Boards development session on March 28th, which included the members of both Boards, together with wider stakeholders from the Office of the Police and Crime Commissioner, the Cambridgeshire Public Health Board and the Sustainable Transformation Partnership (STP) Delivery Unit.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Creation of a 'Whole System' Joint Sub-Committee of the Health and Wellbeing Boards, will maximise effective joint working on the developing Joint Health and Wellbeing Strategy for Cambridgeshire and Peterborough and on future Joint Strategic Needs Assessments.

6.2 Creation of a 'Core' Joint Sub-Committee of the Health and Wellbeing Boards, will enable joint commissioning and Better Care Fund planning across Peterborough City Council, Cambridgeshire County Council and the Cambridgeshire and Peterborough Clinical Commissioning Group to be driven forward more effectively and efficiently, by providing a high level forum to provide strategic direction and un-block issues which are preventing progress.

## 7. REASON FOR THE RECOMMENDATION

7.1 The reasons for the recommendation are

a) To achieve the outcomes outlined in paras 6.1 and 6.2
b) To ensure that what are new ways of working for the Health and Wellbeing Boards are reviewed after an appropriate period.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Alternative options considered for joint work and joint sub-committees between the Peterborough Health and Wellbeing Board and the Cambridgeshire Health and Wellbeing Board are outlined in Annex A.

## 9. IMPLICATIONS

### Financial Implications

9.1 It is not envisaged that there will be any additional costs to Peterborough City Council from the formation of the Health and Wellbeing Board Joint Sub-Committees. The proposal allows more efficient use of officer time, as officers who work jointly across Peterborough and Cambridgeshire will not be required to take the same or very similar papers to both Health and Wellbeing Boards on separate occasions.

### Legal Implications

9.2 Section 198 of the Health and Social Care Act 2012 provides that
Two or more Health and Wellbeing Boards may make arrangements for: -
(a) any of their functions to be exercisable jointly
(b) any of their functions to be exercisable by a joint sub-committee of the Boards
(c) a joint sub-committee of the Boards to advise them on any matter related to the exercise of their functions.

### Equalities Implications

9.3 There are no specific equalities implications related to these proposals.

## 10. BACKGROUND DOCUMENTS

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

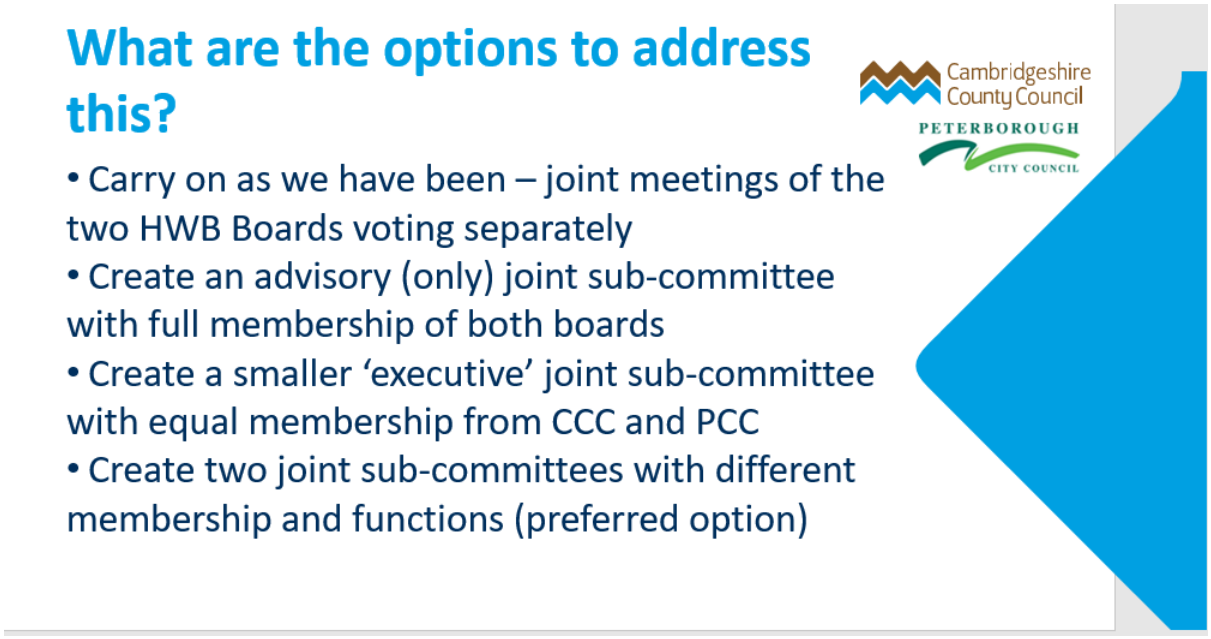
10.1 Paper to Peterborough Health and Wellbeing Board March 2018 'Feedback from the joint development session with Peterborough and Cambridgeshire Health and Wellbeing Boards'
HWB Board paper March 2018

## 11. APPENDICES

11.1 **Appendix A:** Options for joint working considered at joint Health and Wellbeing Boards Development Session

**Appendix B:** Draft terms of reference for Peterborough Health and Wellbeing Board and Joint Sub-Committees.

**APPENDIX A: OPTIONS PROPOSED AT JOINT HEALTH AND WELLBEING BOARD DEVELOPMENT SESSION**



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## 2.8 Peterborough Health and Wellbeing Board

**Purpose and Terms of Reference**

### 2.8.1. Background and context:

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

### 2.8.2. The aims are:

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

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

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

### 2.8.3. Its functions are:

2.8.3.1 **Authority to prepare the Joint Health and Wellbeing Strategy for the city based on the needs identified in the Joint Strategic Needs Assessment and overseeing the implementation of the Strategy,** ~~To develop a Health and Wellbeing Strategy for the city~~ which informs and influences the commissioning plans of partner agencies.

2.8.3.2 **Authority to prepare the Joint Strategic Needs Assessment (JSNA):** To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health & Wellbeing Strategy.

**2.8.3.3 Authority to respond to consultations about commissioning plans issued by clinical commissioning groups in connection with Section26 of the Health and Social Care Act 2012**

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

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

**2.8.3.6 Authority to encourage persons who arrange for the provision of any health or social care services in the Council's area to work in an integrated manner**

**2.8.3.7 Authority to provide any advice, assistance and support it thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 of the National Health Service Act 2006**

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

2.8.3.9 To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.

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

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

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

**2.8.3.13 Authority to prepare and provide Health and Wellbeing Board sign off for the Better Care Fund Plan.**

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

2.8.3.15 To establish a joint Cambridgeshire and Peterborough sub-committee in relation to issues that cross local authority boundaries.

**2.8.3.16 Authority to discharge any other functions specifically reserved to be undertaken by the Health and Wellbeing Boards as set out in legislation, guidance, circulars and directives received from national government.**

**2.8.4 Membership**

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

Peterborough City Council:

The Leader of the Council ~~/ Deputy Leader~~ – Chairman of the Board
**Deputy Leader and Cabinet Member for Adult Social Care, Health & Public Health**

~~Cabinet Member Adults & Health Integration~~
Cabinet Member ~~Public Health~~ **Communities**
An Opposition Councillor
Executive Director People and Communities Cambridgeshire and Peterborough Councils
Service Director Communities and Safety
The Director of Public Health

Cambridgeshire and Peterborough Clinical Commissioning Group

Clinical Chair (GP) of Cambridgeshire and Peterborough Clinical Commissioning Group (Deputy Chair)
1 further GP representative from the Peterborough area to cover when Clinical Chair is unavailable
**Nominated Director from Cambridgeshire and Peterborough Clinical Commissioning Group** ~~Director of Transformation and Delivery: Community Services and Integration~~

Lincolnshire
1 GP representing South Lincolnshire CCG

NHS England
1 representative from NHS England

Cambridgeshire and Peterborough Healthwatch
1 member

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

2.8.4.2 The membership will be kept under review periodically.

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

**2.8.5 Meetings**

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

2.8.5.2 The Board will meet in public.

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

2.8.5.4 The Board shall meet periodically and at least ~~quarterly~~ **twice yearly**. Additional meetings shall be called at the discretion of the Chairman where business needs require.

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

**2.8.6 Governance and Approach**

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

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

**2.8.7 Wider Engagement**

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

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

**2.8.8 Review**

2.8.8.1 These Terms of Reference will be reviewed periodically.

## CAMBRIDGESHIRE AND PETERBOROUGH HEALTH & WELLBEING BOARD WHOLE SYSTEM JOINT SUB-COMMITTEE): TERMS OF REFERENCE

**Membership**

Membership will comprise the full membership of both the Cambridgeshire and Peterborough Health and Wellbeing Boards. The Chairman/woman of the Sub-Committee shall alternate annually between the Chairman/woman of the Cambridgeshire and Peterborough Health and Wellbeing Boards. The Vice-Chairman/woman of the Sub-Committee shall be selected and appointed by the membership of the Sub-Committee.

**Aim: To drive forward wider system health and wellbeing priorities, which require involvement from a range of organisations.**

| **Delegated Authority** | **Delegated Condition** |
|---|---|
| Authority to prepare the Joint Strategic Needs<br>Assessment (JSNA) for Cambridgeshire and Peterborough : To develop a shared understanding of the needs of the community through developing and keeping under review the JSNA and to<br>use this intelligence to refresh the Health & Wellbeing Strategy. | Section 116, Local<br>Government<br>and Public Involvement in<br>Health Act 2007<br>Section 196, Health and<br>Social Care Act 2012 |
| Authority to prepare the Joint Health and Wellbeing<br>Strategy for Cambridgeshire and Peterborough based on the need identified in the Joint Strategic Needs Assessment and overseeing the implementation of the Strategy, which informs and influences the commissioning plans of partner agencies. | Section 116A, Local<br>Government and Public<br>Involvement in Health Act<br>2007. Section 196, Health<br>and Social<br>Care Act 2012 |
| Authority to approve non-statutory joint strategies on health and wellbeing issues (e.g. Cambridgeshire and Peterborough suicide prevention strategy), subject to agreement by the Chairs and Vice-Chairs of the two parent Health and Wellbeing Boards. | |

**Cambridgeshire and Peterborough Health and Wellbeing Board Whole System Joint Sub-Committee (Standing Orders)**

**1. Notice of Meetings**

Meetings of the Whole System Sub-Committee will be convened by Cambridgeshire County Council and Peterborough City Council on an alternating basis. The convening Council will also arrange the clerking and recording of meetings (a member of the Councils' Democratic Services Teams will act as Clerk).

**2. Chairmanship**

The Chairmanship will alternate annually between the Chair of the Cambridgeshire Health and Wellbeing Board and the Chair of the Peterborough Health and Wellbeing Board (*except for the first appointment where the appointed Chair will chair until the end of the 2020/21 municipal year)*. The Joint Sub-Committee will elect annually a Vice-Chairman/woman who will not represent either Council.

**3. Quorum**

The quorum for all meetings of the Joint Sub-Committee will be four members including members from both Councils and the CCG.

**4. Appointment of Substitute Members**

Nominating groups may appoint a substitute member for each position. These members will receive electronic versions of agendas and minutes for all meetings. Notification of a named substitute member must be made in writing or by email to the Clerk. Substitute members may attend meetings after notifying the Clerk of the intended substitution before the start of the meeting either verbally or in writing. Substitute members will have full voting rights when taking the place of the ordinary member for whom they are designated substitute.

**5. Decision Making**

It is expected that decisions will be reached by consensus, however, if a vote is required it will be determined by a simple majority of those members present and voting. If there are equal numbers of votes for and against, the Chairman/woman will have a second or casting vote. There will be no restriction on how the Chairman/woman chooses to exercise a casting vote.

**6. Meeting Frequency**

The Sub-Committee will meet at least twice a year. In addition, extraordinary meetings may be called from time to time as and when appropriate. A Board meeting may be called by the Chairman/woman, by any three members of the Board or by the Director of Public Health if he/she considers it necessary or appropriate.

**7. Supply of information**

The Sub-Committee may, for the purpose of enabling or assisting it to perform its

functions, request any of the following persons to supply it with such information as may be specified in the request—

(a) the local authority that established the Health and Wellbeing Board;

(b) any person who is represented on the Health and Wellbeing Board by

virtue of section 194(2)(e) to (g) or (8) of the Health and Social Care

Act 2012 ("the 2012 Act");

(c) any person who is a member of a Health and Wellbeing Board by virtue of section 194(2)(g) or (8) but is not acting as a representative.

A person who is requested to supply information under (a), (b) and (c) must comply with the request. Information supplied to a Health and Wellbeing Board or its Sub-Committees under this section may be used only for the purpose of enabling or assisting it to perform its functions.

**8. Status of Reports**

Meetings of the Whole System Joint Sub-Committee shall be open to the press and public and the agenda, reports and minutes will be available for inspection at both Cambridgeshire County Council and Peterborough City Council's offices and on the Council's websites at least five working days in advance of each meeting. [This excludes items of business containing confidential information or information that is exempt from publication in accordance with Part 5A and Schedule 12A to the Local Government Act 1972 as amended.] Other participating organisations may make links from their website to the Sub-Committee's papers.

**9. Press Strategy**

An electronic link to agendas for all meetings will be sent to the local media by the Councils' press offices. Press releases issued on behalf of the Board will be agreed with the Chairman/woman or Vice-Chairman/woman and circulated to all Board members.

**10. Members' Conduct**

The codes of conduct and protocols of the relevant Council will apply to all elected and 'co-opted' members of the Board.

**11. Governance and Accountability**

The Sub-Committee will be accountable for its actions to the Health and Wellbeing Boards and their individual member organisations. There will be sovereignty around decision making processes. Representatives will be accountable through their own organisations for the decisions they take. It is expected that Members of the Sub-Committee will have delegated authority from their organisations to take decisions within the terms of reference. Decisions within the terms of reference will be taken at meetings and will not normally be subject to ratification or a formal decision process by partner organisations. However, where decisions are not within the delegated authority of the Board members, these will be subject to ratification by constituent bodies. It is expected that decisions will be reached by consensus.

## 12.2 CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND WELLBEING BOARD CORE JOINT SUB-COMMITTEE: TERMS OF REFERENCE

**Membership**

- Chairman/woman of Cambridgeshire and Peterborough Health and Wellbeing Boards
- Four representatives of the Clinical Commissioning Group (CCG) (nominated by the CCG Governing Body)
- One representative of the local HealthWatch
- Director of Public Health
- Executive Director: People and Communities

**Aim: To drive forward and oversee joint commissioning and integration of specific NHS / upper tier local authority services.**

**Delegated functions**

| **Delegated authority** | **Delegated condition** |
|---|---|
| Authority to respond to consultations about commissioning plans issued by clinical commissioning groups in connection with Section 26 of the Health and Social Care Act 2012, where the response is for both Cambridgeshire and Peterborough. | Section 26, Health and Social Care Act 2012 |
| Authority to encourage persons who arrange for the provision of any health or social care services in the Council's area to work in an integrated manner, where this involves both Cambridgeshire and Peterborough. | Section 195, Health and Social Care Act 2012 |
| Authority to provide any advice, assistance and support it thinks appropriate for the purpose of encouraging the making of arrangements under Section 75 of the National Health Service Act 2006, where this involves both Cambridgeshire and Peterborough | Section 195, Health and Social Care Act 2012<br>Section 75, NHS Act 2006 |

| | |
|---|---|
| To consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Cambridgeshire and Peterborough to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults. | |
| To identify areas where joined up or integrated commissioning across Cambridgeshire and Peterborough, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities. | |
| By establishing sub groups as appropriate give consideration to areas of joint health and social care commissioning across Cambridgeshire and Peterborough, including but not restricted to services for people with learning disabilities. | |
| To keep under consideration, the financial and organisational implications of joint and integrated working across health and social care services across Cambridgeshire and Peterborough, and to make recommendations for ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system. | |
| Authority to prepare and provide Health and Wellbeing Board sign off for the Better Care Fund Plan. | |

| | |
|---|---|
| Authority to discharge any other relevant functions specifically<br><br>reserved to be undertaken by the Health and Wellbeing Boards as set out in legislation, guidance, circulars and directives received from national<br><br>government, subject to agreement by the Chairs and Vice-Chairs of the Parent Boards. | |

**Cambridgeshire and Peterborough Health and Wellbeing Board Core Joint Sub-Committee (Standing Orders)**

**1. Notice of Meetings**

Meetings of the Core System Sub-Committee will be convened by Cambridgeshire County Council. The convening Council will also arrange the clerking and recording of meetings (a member of the Council's Democratic Services Teams will act as Clerk).

**2. Chairmanship**

The Chairmanship will alternate annually between the Chair of the Cambridgeshire Health and Wellbeing Board and the Chair of the Peterborough Health and Wellbeing Board (*except for the first appointment where the appointed Chair will chair until the end of the 2020/21 municipal year).* The Joint Sub-Committee will elect annually a Vice-Chairman/woman who will not represent either Council.

**3. Quorum**

The quorum for all meetings of the Joint Sub-Committee will be four members including members from both Councils, the CCG and HealthWatch.

**4. Appointment of Substitute Members**

Nominating groups may appoint a substitute member for each position. These members will receive electronic versions of agendas and minutes for all meetings. Notification of a named substitute member must be made in writing or by email to the Clerk. Substitute members may attend meetings after notifying the Clerk of the intended substitution before the start of the meeting either verbally or in writing. Substitute members will have full voting rights when taking the place of the ordinary member for whom they are designated substitute.

**5. Decision Making**

It is expected that decisions will be reached by consensus, however, if a vote is required it will be determined by a simple majority of those members present and voting.

**6. Meeting Frequency**

The Sub-Committee will meet at least four times a year. In addition, extraordinary meetings may be called from time to time as and when appropriate. A Board meeting may be called by the Chairman/woman, by any three members of the Board or by the Director of Public Health if he/she considers it necessary or appropriate.

**7. Supply of information**

The Sub-Committee may, for the purpose of enabling or assisting it to perform its

functions, request any of the following persons to supply it with such information as may be specified in the request—

(a) the local authority that established the Health and Wellbeing Board;

(b) any person who is represented on the Health and Wellbeing Board by virtue of section 194(2)(e) to (g) or (8) of the Health and Social Care Act 2012 ("the 2012 Act");

(c) any person who is a member of a Health and Wellbeing Board by virtue of section 194(2)(g) or (8) but is not acting as a representative.

A person who is requested to supply information under (a), (b) and (c) must comply with the request. Information supplied to a Health and Wellbeing Board or its Sub-Committees under this section may be used only for the purpose of enabling or assisting it to perform its functions.

**8. Status of Reports**

Meetings of the Core System Joint Sub-Committee shall be open to the press and public and the agenda, reports and minutes will be available for inspection at both Cambridgeshire County Council and Peterborough City Council's offices and on the Council's websites at least five working days in advance of each meeting. [This excludes items of business containing confidential information or information that is exempt from publication in accordance with Part 5A and Schedule 12A to the Local Government Act 1972 as amended.] Other participating organisations may make links from their website to the Sub-Committee's papers.

**9. Press Strategy**

An electronic link to agendas for all meetings will be sent to the local media by both Council's press offices. Press releases issued on behalf of the Board will be agreed with the Chairman/woman or Vice-Chairman/woman and circulated to all Board members.

**10. Members' Conduct**

The codes of conduct and protocols of the relevant Council will apply to all elected and 'co-opted' members of the Board.

**11. Governance and Accountability**

The Sub-Committee will be accountable for its actions to the Health and Wellbeing Boards and their individual member organisations. There will be sovereignty around decision making processes. Representatives will be accountable through their own organisations for the decisions they take. It is expected that Members of the Sub-Committee will have delegated authority from their organisations to take decisions within the terms of reference. Decisions within the terms of reference will be taken at meetings and will not normally be subject to ratification or a formal decision process by partner organisations. However, where decisions are not within the delegated authority of the Board members, these will be subject to ratification by constituent bodies. It is expected that decisions will be reached by consensus.

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| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 8 |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Liz Robin, Director of Public Health | |
| Cabinet Member(s) responsible: | Councillor Wayne Fitzgerald, Deputy Leader and Cabinet Member for Integrated Adult Social Care and Health. | |
| Contact Officer(s): | Tiya Balaji<br>Senior Public Health Resilience Manager | Tel.<br>01223 703 241 |

# ANNUAL HEALTH PROTECTION REPORT, CAMBRIDGESHIRE AND PETERBOROUGH 2018

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Director of Public Health | **Deadline date:** *N/A* |
| It is recommended that the Health and Wellbeing Board note the contents of the Annual Health Protection Report and comment on future priorities for health protection in Peterborough. | |

## 1. ORIGIN OF REPORT

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

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an update on all key areas of health protection for Peterborough. It is important that there is publicly available information that demonstrates that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise. The services that fall within health protection include:

- Communicable diseases – their prevention and management;
- Infection control;
- Routine antenatal, newborn, young person and adult screening programmes;
- Routine immunisation programmes;
- Sexual health;
- Environmental hazards; and
- Planning for public health emergencies.

2.2 This report is for the Health and Wellbeing Board ] to consider under its Terms of Reference No. 2.8.3.3

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 *How does this report link to the Children in care Pledge?*
The needs of Children in Care are considered when carrying out health protection functions. The Public Health Directorate have good links with relevant colleagues in the Council's Children

Services, the CCG and the looked after children health team in CPFT.

## 3. TIMESCALES

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

## 4. BACKGROUND AND KEY ISSUES

4.1 The Annual Health Protection Report (2018) attached as Appendix A is submitted to the Board from the Peterborough City Council Public Health Directorate, and is produced using data and information provided by partner organisations including Public Health England, NHS England and the Cambridgeshire and Peterborough Clinical Commissioning Group. These organisations meet together on a quarterly basis at the Cambridgeshire and Peterborough Health Protection Steering Group, chaired by the DPH.

4.2 This year, a joint report for Cambridgeshire and Peterborough has been produced, although data is presented separately for Cambridgeshire and Peterborough where available. The data presented in the report was current and accurate at the time of producing the report (January 2019).

4.3 In summary, the report provides information on:

- **Communicable disease** surveillance and reporting of infectious disease outbreaks;
- The national **TB strategy** and local implementation of some key areas of the strategy, notably Latent TB Infection (LTBI) screening. The latest data shows an increase in the incidence of TB in Peterborough; TB continues to be a priority for the Health Protection Steering Group.
- **Immunisations** which shows that uptake is lower than needed in some programmes, including the pre-school vaccinations, HPV and seasonal flu vaccination. Improving immunisations uptake in Peterborough is a key priority for the Health Protection Steering Group.
- **Screening** in which cervical screening continues to have lower than 'acceptable' uptake in Peterborough, corresponding with the national pattern.
- **Healthcare associated infections** and the work to reduce **anti-microbial resistance**.
- The **Environmental Health** role of Peterborough City Council in protecting health including pollution control and air quality monitoring and advice.
- **Sexual health** which shows higher than average rates of late HIV diagnosis and improving teenage pregnancy rates.
- **Health emergency planning**, the work completed in the past 12 months and the priorities for the coming year.

## 5. CONSULTATION

5.1 This report has not been subject to consultation; it is for information only.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 This report demonstrates the Council's assurance role of the health protection system and enables the Health Protection Steering Group to set priorities.

## 7. REASON FOR THE RECOMMENDATION

7.1 The Board is asked to note the contents of the report, and comment on future priorities for health protection in Peterborough in order to inform priority setting of the Health Protection Steering

Group.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Not applicable

## 9. IMPLICATIONS

### Financial Implications

9.1 There are no direct financial implications resulting from this report, although findings within should be utilised within the development of a future Health & Wellbeing Strategy and associated commissioning/service delivery decisions. The cost of preparing the report in terms of officer time has been minimised by (a) a well-established annual process for the participating organisations (Public Health England, NHS England, Clinical Commissioning Group, Cambridgeshire County Council (CCC), Peterborough City Council (PCC) to send finalised data and text for each section to PCC/CCC. For the first time this year, a joint report has been prepared across PCC and CCC (rather than two separate reports) by jointly funded public health officers for which PCC contributes 23% of the cost. The total estimated cost to Peterborough City Council public health grant of the public health officer time required is £336.

### Legal Implications

9.2 This report supports the statutory health protection and public health emergency planning duties of Peterborough City Council, and enables the Peterborough Health and Wellbeing Board to have oversight of the main issues. There are no direct legal implications resulting from this report.

### Equalities Implications

9.3 There are no direct equalities implications resulting from this report, although it does contain analysis of data relating to equalities and equities of healthcare outcomes, wider determinants of health and wellbeing and service access/use that should be utilised within the development of a future Health & Wellbeing Strategy.

## 10. BACKGROUND DOCUMENTS

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

10.1 The report has been produced using information and data specifically provided to the Health Protection Steering group for the purpose of writing the report. External contributors include Public Health England, NHS England and Cambridgeshire and Peterborough Clinical Commissioning Group. The report is attached as Appendix A. References and data sources are specified in the report.

## 11. APPENDICES

11.1 Appendix A: Cambridgeshire and Peterborough Annual Health Protection Report 2018

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**Appendix A**

# Cambridgeshire and Peterborough Annual Health Protection Report 2018

Produced by partner organisations of the Cambridgeshire and Peterborough Health Protection Steering Group on behalf of the Director of Public Health (February 2019)

## Contents

# 1. Introduction

This report provides an annual summary of activities in Cambridgeshire and Peterborough to ensure health protection for the local population.

The services that fall within Health Protection include:

- The prevention and management of communicable (infectious) diseases;
- infection control;
- routine antenatal, new born, young person and adult screening;
- routine immunisation and vaccination;
- sexual health; and
- environmental hazards.

It is important that there is publicly available information that demonstrates that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise.

The Director of Public Health (DPH) produces an annual health protection report to the Health and Wellbeing Boards or Health Committee as appropriate, which provides a summary of relevant activity. This report covers multi-agency health protection plans that are in place to establish how the various responsibilities are discharged. Any other reports will be provided on an ad hoc or exceptional basis where a significant incident, outbreak or concern has arisen. Details of the legislative background to the role of DPH and the role of the County Council in relation to health protection have been included in previous annual health protection reports and will not be reproduced here.

# 2. Cambridgeshire and Peterborough Health Protection Steering Group

To enable the DPH to fulfil the statutory responsibilities in relation to health protection, the Cambridgeshire and Peterborough Health Protection Steering Groups were established in October 2013. These committees were replaced in October 2016 by a joint committee for Cambridgeshire and Peterborough that recognised the wider geography covered by many of the member organisations and the closer working on Public Health between the two local authorities. The Cambridgeshire and Peterborough Health Protection Steering Group (CP HPSG) enables all agencies involved to demonstrate that statutory responsibilities for health protection are being fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise. In addition, a memorandum of understanding (MOU) has been agreed with partner organisations. To ensure that the shared membership fully protected confidentiality of any sensitive items discussed, a Confidentiality / Non-disclosure Agreement was included with the Terms of Reference.

# 3. Surveillance of Infectious Diseases

## 3.1 Notifications of Infectious Diseases

Registered medical practitioners in England and Wales have a statutory duty to notify their local authority or local Public Health England Health Protection Team of suspected cases of certain infectious diseases. These notifications along with laboratory confirmed data enable surveillance of the diseases and for the Health Protection Team to take any required public health action to minimize risk to others.

| **TABLE 1:** Numbers of cases of notifiable diseases, Cambridgeshire and Peterborough, 2015 – 2018 (Source: Public Health England, East of England Health Protection Team HP Zone) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Cambridgeshire** | | | | **Peterborough** | | | |
| **Notifiable Disease†** | **2015** | **2016** | **2017** | **2018*** | **2015** | **2016** | **2017** | **2018** |
| **Acute infectious hepatitis** | 25 | 20 | 39 | 36 | 17 | 14 | 13 | 9 |
| **Acute meningitis** | 8 | 12 | 10 | 8 | <5 | <5 | <5 | <5 |
| **Food poisoning** (including the organisms below) | 205 | 226 | 195 | 183 | 63 | 86 | 59 | 67 |
| E coli O157 VTEC | 5 | <5 | <5 | <5 | <5 | <5 | <5 | <5 |
| Cryptosporidium | 90 | 85 | 90 | 68 | 18 | 19 | 15 | 11 |
| Giardia | 16 | 22 | 23 | 22 | 12 | 20 | 6 | 16 |
| Salmonella | 80 | 101 | 77 | 88 | 23 | 38 | 35 | 37 |
| **Infectious bloody diarrhoea** | 5 | 11 | 12 | 12 | <5 | 6 | <5 | <5 |
| **Invasive group A streptococcal disease** | 18 | 20 | 34 | 25 | <5 | 7 | 14 | 11 |
| **Legionnaires' disease** | <5 | 6 | <5 | 9 | <5 | <5 | <5 | <5 |
| **Malaria** | 9 | 13 | 7 | 7 | <5 | <5 | 0 | <5 |
| **Measles**** | 13 (<5) | 17 (6) | 18 (0) | 7 (0) | <5 (0) | <5 (0) | <5 (0) | <5 (0) |
| **Meningococcal septicaemia** | 9 | 11 | 8 | 8 | <5 | <5 | <5 | <5 |
| **Mumps**** | 24 (<5) | 39 (<5) | 55 (10) | 51 (10) | 8 (<5) | 11 (<5) | 10 (<5) | 11 (0) |
| **Rubella**** | 5 (0) | 5 (0) | 5 (0) | <5 (0) | <5 | 0 | <5 | 0 |
| **Scarlet fever** | 159 | 239 | 161 | 252 | 98 | 56 | 92 | 105 |
| **Whooping cough** | 80 | 203 | 157 | 88 | 15 | 49 | 33 | 10 |

*NB. Figures for 2018 are provisional.*

*** These are notifications of infectious disease and are not necessarily laboratory confirmed. Numbers in brackets indicate confirmed cases.*

† *Because of the confidentiality risk associated with reporting very small numbers, where there are fewer than 5 cases they are reported as <5.*

## 3.2 Outbreaks and Incidents

| **TABLE 2:** Number of outbreaks and incidents in Cambridgeshire and Peterborough, 2018 (Source: Public Health England, East of England Health Protection Team, HP Zone) | | |
|---|---|---|
| **Type of incident** | **Cambridgeshire** | **Peterborough** |
| Gastroenteritis in residential settings | 29 | 7 |
| Influenza / influenza-like illness in residential settings | 24 | 2 |
| Likely foodborne | 4 | 1 |
| Other | 1 | 1 |

There were a number of outbreaks notified to the Public Health England Health Protection Team which were investigated. In **Cambridgeshire** this included:

- 29 gastrointestinal (GI) outbreaks in residential settings, which included care homes, a custodial institution and a youth hostel.
- 24 influenza or influenza-like illness outbreaks which were all in care homes. Seven of these were confirmed outbreaks of influenza A, three influenza B and one each of metapneumovirus, parainfluenza, and rhinovirus.
- There were four outbreaks of gastrointestinal infection that were likely to be foodborne illness. This included a cluster of salmonella cases linked by whole genome sequencing. There were two separate outbreaks of gastrointestinal illness possibly associated with restaurants and an outbreak of GI illness following a self-catered party. The causal organism was not identified for either of these outbreaks.
- There was also notification of an outbreak of scarlet fever at a nursery.

In **Peterborough**, this included:

- There were seven outbreaks of gastrointestinal (GI) infection in care homes, and one outbreak of GI infection linked to a catered wedding event.
- Peterborough also saw two outbreaks of Influenza-like illness in care homes, along with an outbreak of scabies in a care home.
- Two separate tuberculosis (TB) screening events were held in in Peterborough following identification of significant TB exposure with employees screened at a factory and a distribution centre. All active TB cases were treated for TB and are no longer infectious and people who screen positive for TB are clinically assessed by the local NHS respiratory clinicians and offered appropriate treatment.

## 3.3 Tuberculosis

TB is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. It mainly affects the lungs, but it can affect any part of the body, including the abdomen glands, bones and nervous system. TB is a serious condition but it can be cured if it's treated with the right antibiotics. The Collaborative Tuberculosis Strategy for England (2015 to 2020) brings together best practice in clinical care, social support and public health to strengthen TB control, with the aim of achieving a year-on-year decrease in incidence, a reduction in health inequalities and, ultimately, the elimination of TB as a public health problem in England. The strategy aims to make improvements in a number of key areas including strengthening surveillance and monitoring, and systematically implementing new entrant latent TB screening.

### 3.3.1 Tuberculosis Surveillance

The minimal dataset collected through the Notification of Infectious Diseases (NOIDs) system affords no possibility to monitor trends within subgroups in the population. The increasing incidence of TB in England and Wales, particularly affecting subgroups within the population, led to the introduction, on 1 January 1999, of continuous Enhanced Tuberculosis Surveillance (ETS). This aims to provide detailed and comparable information on the epidemiology of TB by collecting a minimum dataset on all cases of TB reported by clinicians.

Official TB statistics are based on data extracted from ETS in April each year. The time to process and analyse this data takes a further six months, therefore the latest official statistics are for data to the end of 2017.

In 2017, 84 cases of TB were notified among residents of Cambridgeshire and Peterborough local authorities (figure 1). The TB rate in Cambridgeshire (6.2 per 100,000) remains below the East of England average (6.4 per 100,000). The rate in Peterborough (22.1 per 100,000) remains substantially higher than average, and increased between 2015 and 2017 following a decline from the peak in 2012 (31.6 per 100,000). The number of TB cases increased in both areas in 2017 compared to 2016.

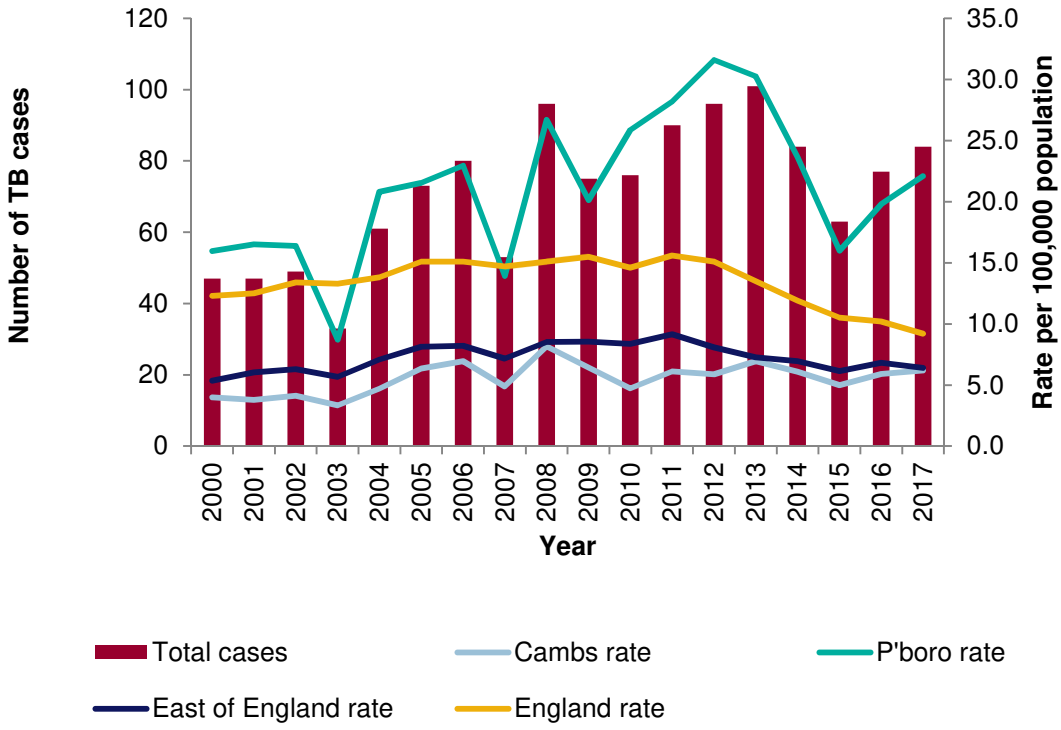


**Figure 1:** Annual TB notifications by area, 2000-2017 (Source: Public Health England ETS)

- Across Cambridgeshire and Peterborough, the majority of cases were aged 15-44 years, with a mean age of 39.8 years (figure 2).
- 77.1% of cases were non-UK born, with India, Lithuania, Pakistan and Timor-Leste being the most common non-UK countries of birth. In 2017, a similar number of cases were UK born as in 2016.
- In Cambridgeshire, a smaller proportion (8.8%) of patients had a social risk factor compared to the East of England region as a whole (11.3%), whereas a larger proportion of patients in Peterborough had social risk factors (22.9%).
- 4.5% of TB patients in Cambridgeshire, and 3.7% in Peterborough had multi-drug resistant TB. Across the East of England region as a whole, the percentage was 3.4%.
- In Cambridgeshire, 18.4% of TB patients received Directly Observed Treatment (DOT), compared to 4.9% in Peterborough. Across the East of England region as a whole 7.1% of TB patients received DOT.

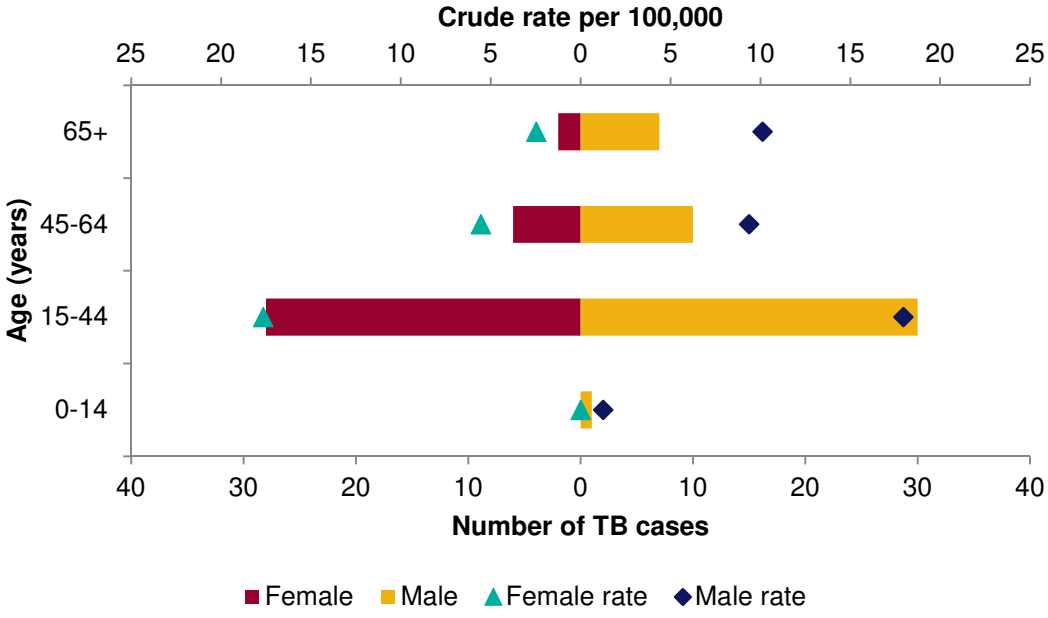


**Figure 2:** TB notifications by age and sex, Cambridgeshire and Peterborough, 2017 (Source: Public Health England ETS)

Further information on TB in Cambridgeshire and Peterborough can be found in the following resources:

- 2017 data on TB monitoring indicators for local authorities can be found on Fingertips: https://fingertips.phe.org.uk/profile/tb-monitoring.
- Tuberculosis East of England Annual Review 2018 (including data to the end of 2017): https://www.gov.uk/government/publications/tuberculosis-tb-regional-reports

### 3.3.2 Latent Tuberculosis Infection Screening Programme

#### *3.3.2.1 Background*

Latent TB infection (LTBI) is where a person has been infected with the TB bacteria but doesn't have any symptoms of active infection. In cases of LTBI, there is a risk that the infection may become active. The aim of the LTBI screening programme is to support the early diagnosis of latent TB and offer treatment of active disease.

Following the publication of the National Collaborative Tuberculosis Strategy, NHS England has committed £10 million for the establishment of testing for, and treatment of, LTBI in new entrants from countries of high TB incidence. Public Health England has committed £1.5 million for the establishment of the national TB office and support teams to the nine TB control boards. It is likely that the majority of TB cases in the UK are the result of 'reactivation' of LTBI, an asymptomatic phase of TB which can last for years. There is a 5% risk of a patient with LTBI becoming TB. LTBI can be diagnosed by a single, validated blood test and treated effectively with antibiotics, preventing TB disease in the future.

Following the publication of the national strategy, a review of TB services was undertaken in Cambridgeshire and Peterborough. The key epidemiology findings are summarised below which provide an overview of the impact of TB on the resident population of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

- There were 999 cases of TB reported in Cambridgeshire and Peterborough residents between 2004 and 2014. Cambridgeshire had an average of 44 cases/year, and Peterborough had an average of 47 cases/year despite its smaller population.
- Almost three quarters (73%) of TB cases between 2004 and 2014 were in non-UK born individuals.
- The most common countries of origin of TB cases in Cambridgeshire & Peterborough in the last three years were UK, India, Pakistan, Lithuania, East Timor and Kenya. Public Health England recommend screening patients born or spent >6 months in high TB incidence country (150 cases per 100,000 or more/Sub- Saharan Africa).

#### *3.3.2.2 Method*

The eligibility criteria for the LTBI Screening Programme is any new patient registering with a practice or retrospectively identified by the practice as being:

- Born or spent > 6 month in high TB incidence
- Entered the UK within the last 5 years
- Aged 16-35 years
- No history of TB either treated or untreated
- Never screened for TB in the UK

A number of stakeholders from across the local system are involved in the programme. These include the CCG, a number of local GP practices, North West Anglia Foundation Trust (NWAFT), Cambridgeshire and Peterborough Foundation Trust (CPFT), Peterborough City Council, Public Health England, Oxford Immunotec and Novice.

GP practices with a high crude rate of TB cases were identified by Public Health England (PHE). Of these, practices with a crude annual rate of active TB ≥ 20 cases/100,000 have been prioritised for the LTBI screening programme. High active TB rates are used as a proxy for an anticipated high incidence of latent TB. Engagement of the designated practices is on-going and all have agreed to deliver the project. The CCG offers a Local Enhanced Service (LES) to all participating practices.

The project initially commenced in March 2016 and from 1 April 2018, 18 practices have signed up to deliver (17 Greater Peterborough Practices and Cornford House based in Cambridgeshire).
We are now conducting outreach and face to face work with community organisations, leaders and members of the public to inform them of TB and the Latent TB programme.

#### *3.3.2.3 Communication and Engagement*

There is a comprehensive action plan to cover the communication and engagement elements of this project. This aims to:

- Raise awareness of Latent TB and the need for screening;
- Get people to visit their GP practice for screening;
- To register with a practice if not already; and
- To dispel myths and beliefs about TB.

The CCG has appointed a Project Support Officer to deliver the action plan and to carry out the face to face work with the public and community organisations. This will support the Latent TB programme and the identification of eligible people for screening. The main focus of the action plan is to target eligible people through community groups, educational settings, work place setting and the prison service.

#### *3.3.2.4 Activity*

**TABLE 3:** LTBI Screening Programme Activity to Date (until end of November 2018), Source: Cambridgeshire and Peterborough Clinical Commissioning Group

| **Activity** | **Data** |
|---|---|
| Negative | 475 |
| Positives | 90 |
| Borderline negative | 12 |
| Borderline positive | 11 |
| Indeterminate | 5 |
| Non reportable insufficient cells | 4 |
| Technical error | 3 |
| Assay not run | 5 |
| **Total screened** | **605** |

Oxford Immunotec continue to report the activity on a monthly basis and we also have confirmation of numbers via LES reporting and NWAFT. The CCG has acknowledged that there has been a reduction of activity due to exhaustion of eligible patient lists. However, numbers are continued to being picked up by the GP practices through new registrations and prospective searches. The CCG also anticipates that the uptake of screening will increase as a result of the targeted outreach and face to face work, alongside promotion of the screening programme.

#### *3.3.2.5 Next Steps*

There has been a positive response by the participating practices to the screening programme and the CCG is receiving positive feedback regarding the activity that is being seen and treated. The CCG has recruited a new Project Support Officer to conduct the outreach work. We will work closely with Public Health England to ensure that there is a coordinated approach to the outreach, which will ensure eligible people are targeted for the uptake of screening. The Project Support Officer will continue to work closely with representatives from community connectors, local Youth Support Team, colleges, employers, drug & alcohol service and rough sleepers in order to maintain the promotion and raising awareness of the screening programme.

# 4. Immunisation Programmes

The tables and figures in this section detail uptake of the various vaccination programmes over time and compared to the regional level of uptake. NHS England commissions various providers to deliver the vaccination programmes including GPs, pharmacies and school nursing teams. The full UK vaccination schedule can be found here: https://www.nhs.uk/Conditions/vaccinations/.

The Cambridgeshire and Peterborough Health Protection Steering Group receives regular reports on vaccination uptake and work that is happening to increase uptake for certain vaccines with lower uptake rates, which has recently included the pre-school booster, MMR and the flu vaccination. The aim for all childhood programmes is to achieve at least 95% uptake, the level which ensures herd immunity, although for many vaccinations, the target rate set by the Public Health Outcomes Framework is 90%.

Herd immunity occurs when the vaccination of a significant portion of a population provides a measure of protection for individuals who have not developed immunity. It arises when a high percentage of the population is protected through vaccination, making it difficult for a disease to spread because there are so few susceptible people left to infect. This can effectively stop the spread of disease in the community. It is particularly crucial for protecting people who cannot be vaccinated. These include children who are too young to be vaccinated, people with immune system problems, and those who are too ill to receive vaccines (such as some cancer patients). Details of the UK vaccination programme and what each vaccine protects against can be found on the NHS choices website.

The Cambridgeshire and Peterborough Immunisation Forum meets 3 – 4 times per year to discuss all issues relating to immunisations and to take forward the recommendations of a previous Immunisation 'Task and Finish' group that reported two years ago. The Task and Finish group had been set up to identify the reasons for lower immunisation uptake for childhood immunisation. Ongoing work includes:

- Close working with GP practices in some areas with particularly low uptake and high waiting lists to reduce the number of children waiting for their routine immunisations, including the pre-school booster; waiting lists have reduced by 65.7% [period Feb 2018 to Nov 2018].
- Immunisations targeted in a local campaign in March / April 2018 with specific focus on the pre-school booster, MMR2 and HPV vaccines.
- NHS England has commissioned Cambridgeshire Community Services to offer MMR vaccination to those school age adolescents who are partially or unimmunised, commencing in 2018-2019.
- Due to lower uptake rates of the shingles vaccination in Peterborough, a Shingles project was launched in October 2018, and will run until March 2019. GP practices voluntarily sign up to the project that involves reimbursement for sending 70 year old birthday cards with shingles vaccination reminders, additional training for their staff, and a resource pack for practices.

## 4.1 Childhood Primary Vaccinations

### 4.1.1 6-in-1 Vaccine (12 months)

**TABLE 4:** Uptake rates for 6-in-1 vaccine at 12 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B, hepatitis B – target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| **12 months DTaP/IPV/Hib/Hep B [target 95%]** | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 93.8 | 94.1 | 94.2 | 94.2 |
| Peterborough | 93.5 | 93.8 | 93.9 | 94.3 |
| East Anglia | 95.0 | 95.2 | 95.2 | 95.0 |

| | Q1 2017/18 % | Q2 2017/18 % | Q3 2017/18 % | Q4 2017/18 % |
|---|---|---|---|---|
| Cambridgeshire | 93.1 | 93.8 | 94.7 | 93.6 |
| Peterborough | 93.6 | 94.3 | 90.9 | 91.3 |
| East Anglia | 94.6 | 95.3 | 94.6 | 94.5 |

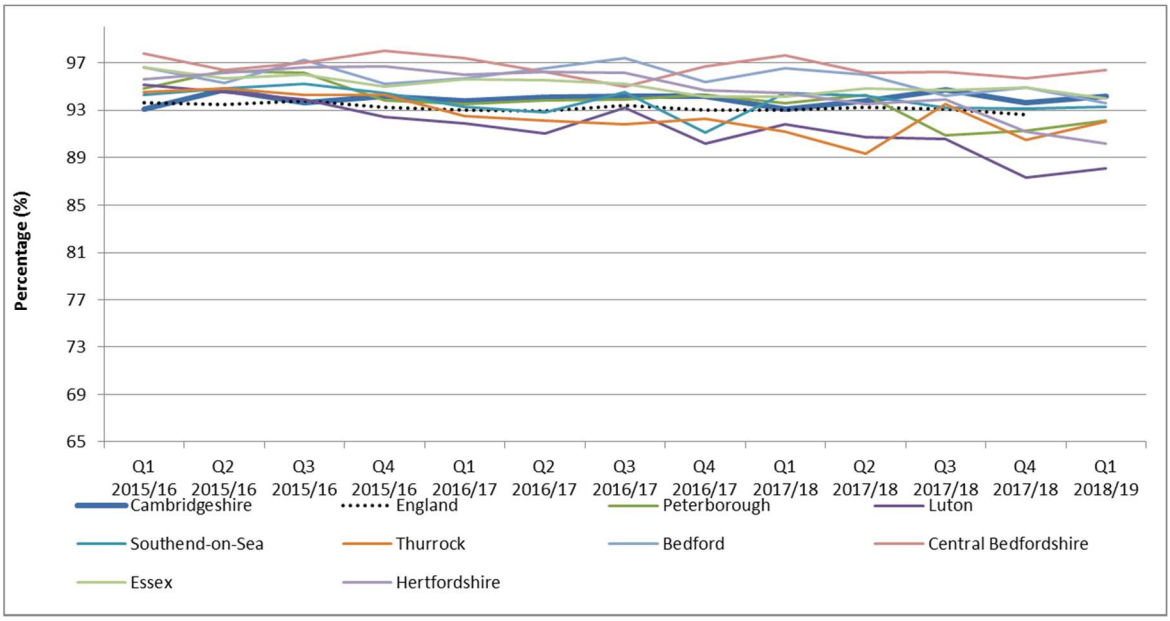


**Figure 3:** Uptake rates for 6-in-1 vaccine at 12 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B, hepatitis B – target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.2 Pneumococcal Vaccine (12 months)

**TABLE 5:** Uptake rates for pneumococcal (PCV) vaccine at 12 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | Q1 2016/17 % | Q2 2016/17 % | Q3 2016/17 % | Q4 2016/17 % |
|---|---|---|---|---|
| Cambridgeshire | 94.3 | 94.3 | 94.3 | 95.2 |
| Peterborough | 93.6 | 93.6 | 93.5 | 94.2 |
| East Anglia | 95.4 | 95.3 | 95.3 | 95.1 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 93.8 | 94.4 | 95.0 | 94.3 |
| Peterborough | 93.6 | 94.5 | 91.1 | 91.8 |
| East Anglia | 94.9 | 95.5 | 94.9 | 95.0 |

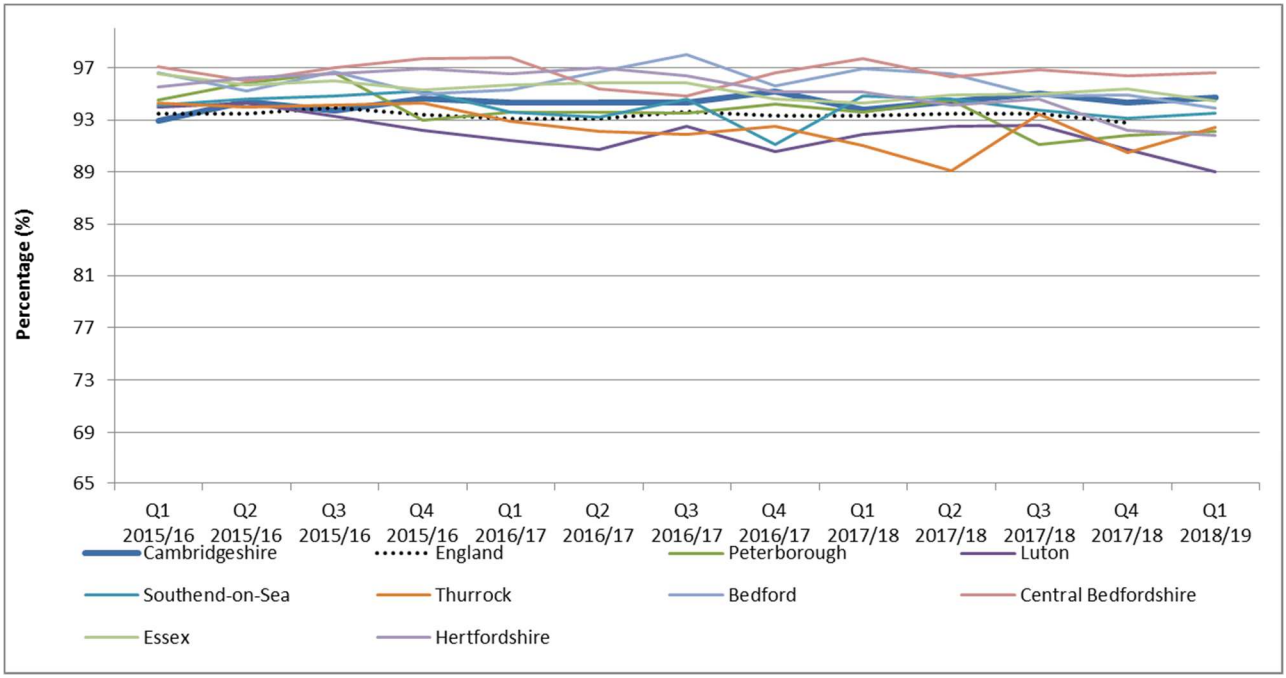


**Figure 4:** Uptake rates for pneumococcal vaccine at 12 months (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.3 5-in-1 Vaccine (24 months)

**TABLE 6:** Uptake rates for 5-in-1 vaccine at 24 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B – target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 93.7 | 95.4 | 94.8 | 95.6 |
| Peterborough | 95.6 | 96.9 | 96.4 | 96.4 |
| East Anglia | 96.1 | 96.2 | 96.4 | 96.3 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 95.3 | 95.6 | 96.2 | 96.1 |
| Peterborough | 96.1 | 95.1 | 93.8 | 95.7 |
| East Anglia | 96.3 | 96.3 | 95.9 | 96.3 |

### 4.1.4 Pneumococcal Vaccine (24 months)

**TABLE 7:** Uptake rates for pneumococcal vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 89.9 | 92.0 | 92.9 | 93.0 |
| Peterborough | 92.8 | 92.8 | 93.7 | 92.6 |
| East Anglia | 92.9 | 94.3 | 94.1 | 94.0 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 94.1 | 93.4 | 93.2 | 92.8 |
| Peterborough | 91.3 | 90.8 | 89.9 | 89.1 |
| East Anglia | 94.0 | 94.0 | 92.8 | 92.9 |

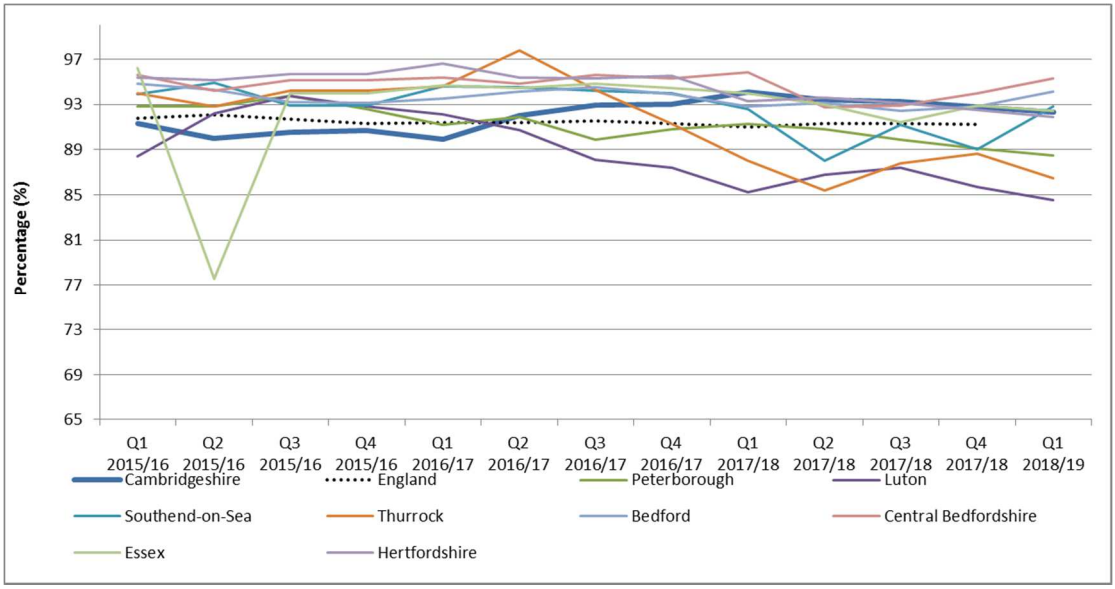


**Figure 5:** Uptake rates for pneumococcal vaccine at 24 months (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.5 Haemophilus influenza B and meningococcus C (24 months)

**TABLE 8:** Uptake rates for haemophilus influenza B and meningococcus C vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 89.6 | 92.0 | 92.7 | 93.0 |
| Peterborough | 90.8 | 92.6 | 89.5 | 90.7 |
| East Anglia | 92.8 | 94.3 | 94.1 | 94.0 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 94.2 | 93.3 | 92.6 | 93.1 |
| Peterborough | 91.0 | 91.4 | 90.1 | 88.9 |
| East Anglia | 94.0 | 93.9 | 92.5 | 92.8 |

### 4.1.6 Measles, mumps & rubella (MMR) Vaccine (24 months)

**TABLE 9:** Uptake rates for measles, mumps and rubella (MMR) vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 89.4 | 91.6 | 92.9 | 92.8 |
| Peterborough | 91.8 | 92.2 | 89.2 | 91.6 |
| East Anglia | 92.7 | 93.8 | 93.9 | 94.0 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 93.8 | 93.1 | 92.8 | 92.6 |
| Peterborough | 90.7 | 90.9 | 90.3 | 88.7 |
| East Anglia | 93.7 | 93.7 | 92.6 | 92.5 |

### 4.1.7 5-in-1 Vaccine (5 years)

**TABLE 10:** Uptake rates for 5-in-1 vaccine at 24 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B – target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 93.1 | 93.7 | 93.9 | 95.0 |
| Peterborough | 95.7 | 96.4 | 97.5 | 97.1 |

| | | | | |
|---|---|---|---|---|
| East Anglia | 96.0 | 96.9 | 96.2 | 96.2 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 94.6 | 94.0 | 96.1 | 96.4 |
| Peterborough | 97.0 | 96.6 | 95.1 | 96.3 |
| East Anglia | 96.1 | 96.1 | 96.6 | 96.8 |

### 4.1.7 Measles, mumps & rubella (MMR) Vaccine (5 years)

| **TABLE 11:** Uptake rates for measles, mumps and rubella (MMR) vaccine – first dose at 5 years (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England* | | | | |
|---|---|---|---|---|
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Cambridgeshire | 92.4 | 93.7 | 93.5 | 95.2 |
| Peterborough | 95.3 | 95.7 | 96.6 | 96.7 |
| East Anglia | 95.4 | 96.0 | 95.5 | 95.6 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 94.7 | 94.1 | 95.6 | 96.1 |
| Peterborough | 96.4 | 96.5 | 94.5 | 96.2 |
| East Anglia | 95.6 | 95.6 | 95.8 | 96.4 |

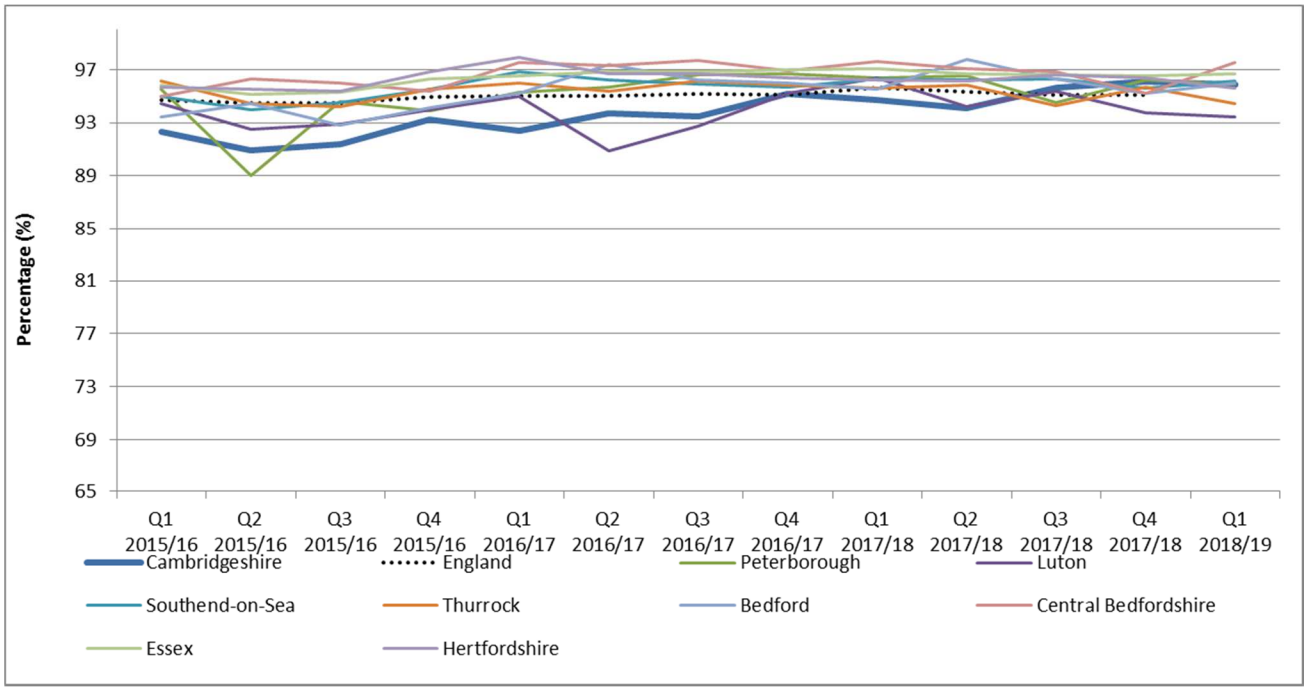


**Figure 6:** Uptake rates for MMR vaccine – **first dose** at 5 years (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| **TABLE 12:** Uptake rates for measles, mumps and rubella (MMR) vaccine – second dose at 5 years (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England* | | | | |
|---|---|---|---|---|
| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
| Cambridgeshire | 82.7 | 83.8 | 85.1 | 88.8 |
| Peterborough | 89.8 | 91.6 | 92.6 | 88.6 |
| East Anglia | 88.2 | 89.8 | 90.1 | 90.1 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 85.6 | 86.8 | 89.6 | 91.0 |
| Peterborough | 89.3 | 90.6 | 88.5 | 89.3 |
| East Anglia | 89.3 | 90.0 | 89.9 | 90.7 |

Source: Cover, Public Health England

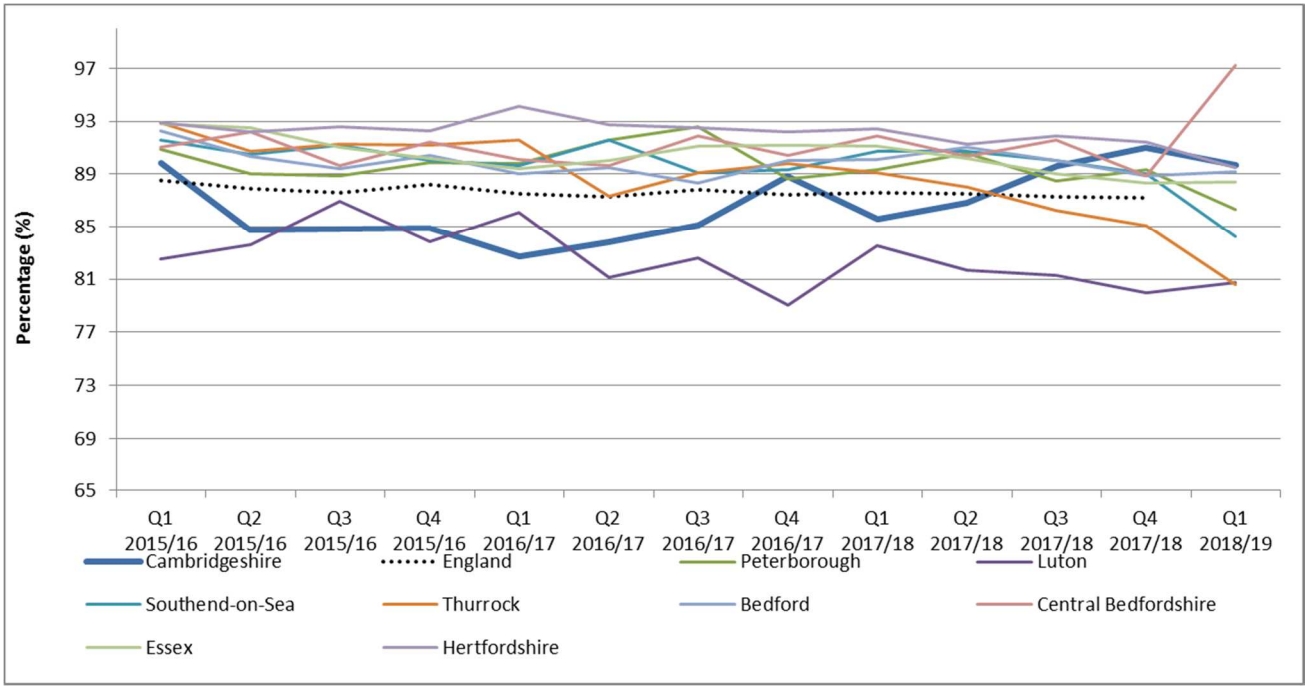


**Figure 7:** Uptake rates for MMR vaccine – **second dose** at 5 years (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.8 4-in-1 Pre-School Booster Vaccine (5 years)

**TABLE 13:** Uptake rates for 4-in-1 preschool booster at 5 years (diphtheria, tetanus, pertussis, polio - target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17** | **Q2 2016/17** | **Q3 2016/17** | **Q4 2016/17** |
|---|---|---|---|---|
| Cambridgeshire | 82.6 | 82.1 | 84.1 | 86.4 |
| Peterborough | 86.4 | 88.2 | 90.3 | 86.5 |
| East Anglia | 87.6 | 88.7 | 88.8 | 89.1 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 83.9 | 85.1 | 88.3 | 88.8 |
| Peterborough | 87.3 | 86.8 | 85.5 | 86.0 |
| East Anglia | 88.3 | 88.7 | 88.7 | 89.2 |

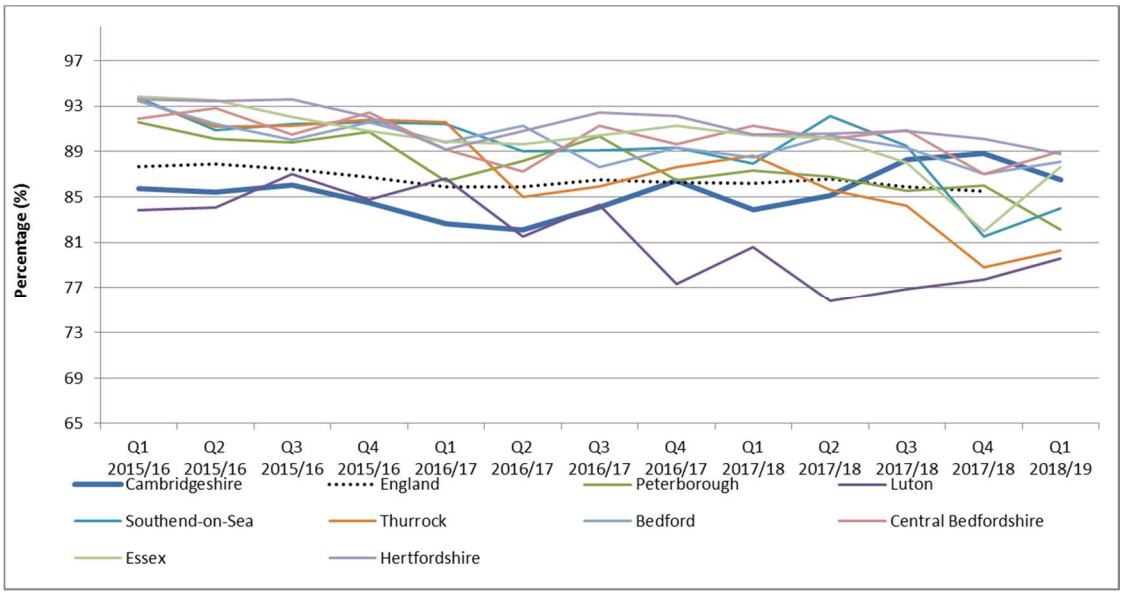

**Figure 8:** Uptake rates for 4-in-1 pre-school booster at 5 years (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

### 4.1.9 Haemophilus influenza B and meningococcus C Vaccine (5 years)

**TABLE 14:** Uptake rates for haemophilus influenza B and meningococcus C vaccine at 5 years (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | 87.6 | 88.6 | 90.2 | 92.1 |
| Peterborough | 88.9 | 88.5 | 91.3 | 92.9 |
| East Anglia | 91.2 | 93.4 | 93.0 | 93.2 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 90.4 | 90.4 | 91.1 | 92.5 |
| Peterborough | 91.7 | 92.9 | 89.0 | 92.1 |
| East Anglia | 92.5 | 92.8 | 92.7 | 93.3 |

### 4.1.10 Meningococcus B (12 and 24 months)

**TABLE 15:** Uptake rates for meningococcus B vaccine at 12 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

| | **Q1 2016/17 %** | **Q2 2016/17 %** | **Q3 2016/17 %** | **Q4 2016/17 %** |
|---|---|---|---|---|
| Cambridgeshire | **Data not collected** | **93.4** | **93.0** | **94.6** |
| Peterborough | **Data not collected** | **91.6** | **92.9** | **93.7** |
| East Anglia | **Data not collected** | 93.7 | 94.4 | 94.6 |
| | **Q1 2017/18 %** | **Q2 2017/18 %** | **Q3 2017/18 %** | **Q4 2017/18 %** |
| Cambridgeshire | 93.0 | 93.7 | 94.2 | 93.9 |
| Peterborough | 92.9 | 93.7 | 90.8 | 91.0 |
| East Anglia | 94.3 | 95.1 | 94.4 | 94.6 |

**TABLE 16:** Uptake rates for meningococcus B booster at 24 months (target 95%), by local authority, 2017/18, *Source: NHS Digital*

| | **Cambridgeshire** | **Peterborough** | **East of England** |
|---|---|---|---|
| Men B at 24 months (%) | 77.3 | 72.6 | 75.1 |

### 4.1.11 Rotavirus Vaccination

**TABLE 17**: Rotavirus vaccination – 2 doses at 12 months (target 95%), Cambridgeshire & Peterborough, monthly uptake January 2016 to December 2018, *Source: Immform*

| | **Jan 2016** | **Feb 2016** | **March 2016** | **April 2016** | **May 2016** | **June 2016** | **July 2016** | **Aug 2016** | **Sept 2016** | **Oct 2016** | **Nov 2016** | **Dec 2016** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cambridgeshire | 92.8 | 91.1 | 89.4 | 90.4 | 91.7 | 92.1 | 94.4 | 92.1 | 91.7 | 92.4 | 90.9 | 91.9 |
| Peterborough | 86.8 | 88.1 | 87.4 | 92.1 | 90.9 | 90.0 | 90.3 | 92.2 | 86.8 | 89.8 | 90.7 | 89.1 |
| East Anglia | 91.7 | 91.5 | 91.2 | 91.6 | 92.1 | 93.2 | 92.5 | 93.3 | 92.3 | 93.5 | 932.3 | 92.9 |
| | **Jan 2017** | **Feb 2017** | **March 2017** | **April 2017** | **May 2017** | **June 2017** | **July 2017** | **Aug 2017** | **Sept 2017** | **Oct 2017** | **Nov 2017** | **Dec 2017** |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cambridgeshire | 93.2 | 91.5 | 93.6 | 93.5 | 90.6 | 93.0 | 92.1 | 92.5 | 91.0 | 90.1 | 91.6 | 89.5 |
| Peterborough | 90.2 | 88.0 | 88.4 | 87.9 | 89.9 | 89.3 | 86.6 | 87.9 | 87.3 | 90.1 | 89.3 | 86.6 |
| East Anglia | 92.5 | 92.1 | 92.3 | 93.0 | 92.3 | 92.7 | 92.8 | 92.3 | 91.4 | 91.9 | 91.5 | 90.4 |
| | **Jan 2018** | **Feb 2018** | **March 2018** | **April 2018** | **May 2018** | **June 2018** | **July 2018** | **Aug 2018** | **Sept 2018** | **Oct 2018** | **Nov 2018** | **Dec 2018** |
| Cambridgeshire | 88.7 | 89.2 | 91.8 | 93.7 | 91.9 | 91.0 | 91.4 | 93.3 | 91.3 | 90.8 | 91.7 | NA |
| Peterborough | 84.7 | 92.2 | 85.7 | 86.5 | 90.2 | 89.2 | 89.4 | 86.6 | 83.9 | 89.3 | 89.5 | NA |
| East Anglia | 90.4 | 89.8 | 90.5 | 91.3 | 92.0 | 91.0 | 91.8 | 92.7 | 90.4 | 91.3 | 91.5 | NA |

### 4.1.13 Meningococcus ACWY (14 years)

**TABLE 18:** Uptake rates for meningococcus ACWY vaccine, Cambridgeshire and Peterborough, *Source: Immform*

| **Org Name** | **Vaccine uptake %** |
|---|---|
| Cambridgeshire and Peterborough CCG | 39.7 |
| East Anglia Total | 42.0 |

### 4.1.14 HPV Vaccine (Year 8 & Year 9)

**TABLE 19:** Uptake rates for HPV vaccine, by local authority and cohort, September 2017/18, *Source: Public Health England*

| **Local Authority** | | **Cambridgeshire** | **Peterborough** | **England** |
|---|---|---|---|---|
| Cohort 15: 12-13 Year Olds (Year 8) Birth Cohort: 1 September 2004 - 31 August 2005 | Number of females in Cohort 15 (Year 8) | 3,264 | 1,289 | 306,940 |
| | No. vaccinated with HPV Vaccine at least one dose by **31/08/2018** | 2,981 | 1,115 | 266,785 |
| | **% Coverage** | 91.3% | 86.5% | 86.9% |
| Cohort 14: 13-14 Year Olds (Year 9 Birth Cohort: 1 1 September 2003 - 31 August 2004 | Number of females in Cohort 14 (Year 9) | 3,205 | 1,310 | 300,464 |
| | No. vaccinated with HPV Vaccine at least one dose by **31/08/2018** | 2,954 | 1,188 | 267,689 |
| | % Coverage | 92.2% | 90.7% | 89.1% |
| | No. vaccinated with two doses by **31/08/2018** | 2,728 | 1,118 | 251,919 |
| | **% Coverage** | 85.1% | 85.3% | 83.8% |

### 4.1.15 School Immunisation Service

**TABLE 20**: School immunization service vaccinations, Cambridgeshire & Peterborough, end of school year 2017/18, *Source: CCS Immform*

| | Cambridgeshire % | Peterborough % |
|---|---|---|

| | | |
|---|---|---|
| Girls HPV vaccination by end of school year nine dose 2 | 85.1 | 85.3 |
| Cohort 5 (13-14) Sept 2003 -August 2004 Td/IPV by end of school year 9 | 88.4 | 92.0 |
| Cohort 4 (14-15) Sept 2002 –August 2003 Td/IPV by end of school year 10 | 88.2 | 85.4 |
| Cohort 5 (13-14) Sept 2003 -August 2004 Men ACWY by end of school year 9. | 88.4 | 91.5 |
| Cohort 4 (14-15) Sept 2002 –August 2003 Men ACWY by end of school year 9. | 88.4 | 85.9 |
| Childhood Flu vaccination school years 1 and 2 and 3 | 67.0 | 48.0 |
| Schools participating in the programme | 259/260 | 70/70 |

## 4.2 Seasonal Flu Vaccination

**TABLE 21:** Flu vaccination uptake by key groups - adults, Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Immform*

| **Area** | **Summary of flu vaccine uptake %** | | | | | |
|---|---|---|---|---|---|---|
| | **65 and over** | | **Under 65 (at risk)** | | **Pregnant women** | |
| | **2016/17** | **2017/18** | **2016/17** | **2017/18** | **2016/17** | **2017/18** |
| **Cambridgeshire LA** | 72.6 | 74.4 | 47.4 | 49.8 | 48.5 | 49.1 |
| **Peterborough LA** | 69.2 | 71.3 | 46.3 | 47.3 | 39.9 | 38.4 |
| **Cambridgeshire & Peterborough CCG** | 72.1 | 73.9 | 47.2 | 49.3 | 46.7 | 46.7 |
| **East Anglia** | 71.0 | 72.6 | 47.1 | 48.9 | 47.9 | 47.2 |

**TABLE 22:** Flu vaccination uptake – pre-school children, Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Immform*

| **Area** | **Summary of flu vaccine uptake %** | | | |
|---|---|---|---|---|
| | **All aged 2** | | **All aged 3** | |
| | **2016/17** | **2017/18** | **2016/17** | **2017/18** |
| **Cambridgeshire LA** | 42.6 | 45.5 | 44.7 | 47.1 |
| **Peterborough LA** | 30.3 | 25.5 | 32.9 | 30.0 |
| **Cambridgeshire & Peterborough CCG** | 39.7 | 40.5 | 42.0 | 42.7 |
| East Anglia | 42.1 | 42.8 | 43.9 | 44.2 |

| **TABLE 23:** Flu vaccination uptake – healthcare workers, by NHS trust, 2016/17 to 2017/18, *Source: Immform* | | | | |
|---|---|---|---|---|
| Org Name | No of HCW's with Direct Patient Care | Seasonal Flu doses since 1 September **2017-Jan 2018** | | % Seasonal Flu doses given since 1 September **2016-Jan 2017** |
| | | No | % | % |
| Papworth Hospital NHS Foundation Trust | 1,510 | 1,143 | 75.7 | 75.4 |
| Cambridge University Hospitals NHS Foundation Trust | 7,755 | 6,696 | 86.3 | 72.6 |
| North West Anglia Foundation Trust | 4,612 | 3,156 | 68.4 | NA |
| Cambridgeshire and Peterborough NHS Foundation Trust | 3,036 | 1,983 | 65.3 | 52.4 |
| Cambridgeshire Community Services NHS Trust | 1,455 | 851 | 58.5 | 60.3 |
| **East of England Total** | NA | NA | 65.7 | 66.2 |

## 4.3 Prenatal Pertussis Vaccination

| **TABLE 24**: Prenatal pertussis vaccination, Cambridgeshire & Peterborough, monthly uptake April 2015 to March 2018, *Source: Immform* | | | | |
|---|---|---|---|---|
| | Apr 2015 % | May 2015 % | Jun 2015 % | Jul 2015 % |
| Cambridgeshire & Peterborough CCG | 49.8 | 45.9 | 52.7 | 50.5 |
| **East Anglia** | **56.8** | **53.8** | **58.9** | **56.3** |
| | Aug 2015 % | Sept 2015 % | Oct 2015 % | Nov 2015 % |
| Cambridgeshire & Peterborough CCG | 51.2 | 50.5 | 54.1 | 52.5 |
| **East Anglia** | **58.5** | **67.2** | **60.3** | **61.4** |
| | Dec 2015 % | Jan 2016 % | Feb 2016 % | Mar 2016 % |
| Cambridgeshire & Peterborough CCG | 50.7 | 50.3 | NA | NA |
| **East Anglia** | **60.3** | **59.3** | **NA** | **NA** |
| | Apr 2016 % | May 2016 % | Jun 2016 % | Jul 2016 % |
| Cambridgeshire & Peterborough CCG | 52.7 | 73.8 | 73.3 | 71.9 |
| **East Anglia** | **60.2** | **73.6** | **74.4** | **74.7** |
| | Aug 2016% | Sept 2016 % | Oct 2016 % | Nov 2016% |
| Cambridgeshire & Peterborough CCG | 70.6 | 72.8 | 71.4 | 72.3 |
| **East Anglia Total** | **74.1** | **76.4** | **78.7** | **78.0** |
| | Dec 2016 % | Jan 2017 % | Feb 2017% | Mar 2017 % |
| Cambridgeshire & Peterborough CCG | 76.2 | 78.9 | 76.2 | 75.5 |
| **East Anglia Total** | **79.8** | **82.3** | **79.8** | **77.0** |
| | Apr 2017 % | May 2017 % | Jun 2017 % | Jul 2017 % |
| Cambridgeshire & Peterborough CCG | **77.0** | **70.2** | **72.1** | **73.8** |
| **East Anglia Total** | **78.8** | **75.4** | **77.3** | **75.8** |
| | Aug 2017 % | Sept 2017 % | Oct 2017 % | Nov 2017 % |
| Cambridgeshire & Peterborough CCG | **69.9** | **69.4** | **72.1** | **69.5** |
| **East Anglia Total** | **75.1** | **75.8** | **78.1** | **76.5** |
| | Dec 2017 % | Jan 2018 % | Feb 2018 % | Mar 2018 % |
| Cambridgeshire & Peterborough CCG | **75.3** | **73.1** | **70.3** | **68.6** |
| **East Anglia Total** | **79.8** | **76.9** | **75.6** | **73.2** |

| **TABLE 25**: Prenatal pertussis vaccination, Cambridgeshire & Peterborough, monthly uptake April 2015 to March 2018, *Source: Immform* | |
|---|---|
| **Annual Data 1.4.2017 to 31.3.2018 %** | |
| Cambridgeshire & Peterborough CCG | 68.1 |
| **East Anglia** | 73.7 |

## 4.4 Shingles Vaccination

| **TABLE 26**: Shingles vaccination – aged 70 & 78, Cambridgeshire & Peterborough, uptake July 2018, *Source: Immform* | | | | | | |
|---|---|---|---|---|---|---|
| **Area** | **Vaccine coverage for the Routine Cohort since 2013** | | | **Vaccine coverage for the Catch- up Cohort since 2013** | | |
| | **Registered Patients aged 70** | **Received Shingles vaccine** | | **Registered Patients aged 78** | **Received Shingles vaccine** | |
| | | **No of patients** | **% of patients** | | **No of patients** | **% of patients** |
| Cambridgeshire & Peterborough CCG | 10158 | 4707 | 46.3 | 5246 | 2568 | 49.0 |
| **East Anglia Total** | 37108 | 17037 | 45.9 | 18615 | 9107 | 48.9 |

# 5. Screening Programmes

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. The NHS offers a range of screening tests to different sections of the population. The aim is to offer screening to the people who are most likely to benefit from it. For example, some screening tests are only offered to newborn babies, while others such as breast screening and abdominal aortic aneurysm screening are only offered to older people.

NHS England commission a number of screening programmes which are delivered by a range of NHS providers within Cambridgeshire and Peterborough. Current screening programmes include:

- Antenatal and newborn screening;
- Breast cancer screening;
- Bowel cancer screening;
- Cervical cancer screening;
- Abdominal Aortic Aneurysm screening; and
- Diabetic eye screening.

Key performance information for each screening programme is provided in the sections below.

## 5.1 Antenatal and Newborn Screening

### 5.1.2 Antenatal and Newborn Screening Key Performance Indicators

| **TABLE 27:** Antenatal infectious disease screening KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services* | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | **2016-2017** | | | | **2017-2018** | | | |
| **Indicator** | **Accpt.** | **Ach.** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ID1 Antenatal HIV test coverage | >95% | 99% | CUH | 97.3 | 99.5 | 99.4 | 98.9 | 97.4 % | 99.0 % | 98.2% | 99.0 % |
| | >95% | 99% | HHT | 99.8 | 98.9 | 99.6 | 99.7 | 99.7 | 99.6 | 99.1 | 99.0 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | >95% | 99% | PCH | 99.5 | 99.4 | 99.4 | 99.3 | 99.4 | 98.9 | 99. | 99.6 |
| ID2 Hep B timely referral for women found to be Hepatitis B | >70% | 99% | CUH | No cases | 100 | 100 | No cases | No Cases | 100% | 100% | 100 |
| | >70% | 99% | HHT | 0 | 100 | 100 | 100 | No Cases | 100 | 100 | No Cases |
| | >70% | 99% | PCH | 50 | No cases | 100 | 80.0 | No Data | 100 | 0.0 | 80.0 |

**TABLE 28:** Fetal anomaly screening KPIs, by provider, 2017/18, *Source: maternity services*

| | | | | 2017-2018 | | | |
|---|---|---|---|---|---|---|---|
| FA1: Completion of laboratory request forms | **Accpt.** | **Ach.** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** |
| | >97% | >100% | CUH | 99.4 | 99.5 | 98.2 | 99.4 |
| | >97% | >100% | HHT | 95.7 | 97.3 | 97.7 | 99.0 |
| | >97% | >100% | PCT | 98.2 | 98.5 | 99.1 | 99.4 |
| FA2: Fetal anomaly screening fetal anomaly ultrasound) – coverage * | **Accpt.** | **Ach.** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** |
| | >90% | >95% | CUH | 99.5 | 98.5 | 99.9 | 99.9 |
| | >90% | >95% | HHT | 99.3 | 100.0 | 99.1 | 99.6 |
| | >90% | >95% | PCT | 99.6 | 99.3 | No Data | 99.6 |

**TABLE 29:** Antenatal sickle cell and thalassaemia KPIs, by provider, 2016/17 - 2017/18, *Source: maternity services*

| | | | | 2016/-2017 | | | | 2017-2018 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Standard** | **Achievable** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ST1 Antenatal sickle cell and thalassaemia screening – coverage | >95% | 99% | CUH | 91.4 | 98.5 | 98.8 | 96.1 | 96.4 | 97.6 | 96.3 | 98.2 |
| | >95% | 99% | HHT | 98.9 | 99.0 | 97.7 | 97.1 | 100.0 | 98.8 | 98.4 | 98.7 |
| | >95% | 99% | PCT | 96.6 | 97.8 | 97.8 | 97.5 | 97.1 | 97.4 | 99.6 | 98.9 |
| ST2 Antenatal sickle cell and thalassaemia screening Timeliness of Test | >50% | 75% | CUH | 31.7 | 43.3 | 43.5 | 30.1 | 57.9 | 55.7 | 54.9 | 54.6 |
| | >50% | 75% | HHT | 49.4 | 52.0 | 55.2 | 29.9 | 48.5 | 50.8 | 53.1 | 54.0 |
| | >50% | 75% | PCT | 69.1 | 65.5 | 68.0 | 61.4 | 63.8% | 59.5 % | 58.2 % | 56.9 % |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ST3 Antenatal sickle cell and thalassaemia completion of FOQ | 99% | 99% | CUH | 76.6 | 90.9 | 97.8 | 98.2 | 99.2 | 98.3 | 97.4 | 98.0 |
| | >95% | 99% | HHT | 98.6 | 97.5 | 97.7 | 100 | 98.3 | 96.4 | 96.1 | 97.5 |
| | >95% | 99% | PCT | 98.3 | 98.7 | 98.1 | 98.6 | 99.4 | 98.1 | 98.0 | 97.7 |

**TABLE 30:** Newborn blood spot screening KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

| | | | | 2016-17 | | | | 201718 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Standard** | **Achievable** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| NB1 Newborn blood spot screening coverage | >95% | 99.9% | CCS | 98.1 | 98.2 | 98.9 | 91.39 | 95.5 | 98.5 | 99.3 | 94.5 |
| | >95% | 99.9% | CPFT | 99.6 | 97.5 | 98.8 | 98.8 | 98.8 | 99.5 | 99.7 | 93.9 |
| NB2 Newborn blood spot screening avoidable repeats | <2% | 0.5% | CUH | 2.4 | *3.1 | 3.1 | 2.4 | 2.5 | 1.1 | 2.3 | 1.7 |
| | <2% | 0.5% | HHT | 3.4 | **2.1 | 3.4 | 2.8 | 3.1 | 3.0 | 1.4 | 2.5 |
| | <2% | 0.5% | PCT | 1.8 | 1.4 | 1.4 | 1.6 | 1.9 | 1.8 | 0.9 | 1.8 |
| NB4 Newborn blood spot screening coverage-movers in | >95% | 99.9% | CCS | 88.2 | *80.1 | 84.1 | 85.0 | 90.2 | 91.2 | 76.1 | 76.3 |
| | >95% | 99.9% | CPFT | 82.4 | 84.5 | 78.0 | 79.7 | 85.4 | 92.6 | 91.5 | 89.3 |

**TABLE 31:** Newborn hearing screening KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

| | | | | 2016-17 | | | | 2017-18 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Indicator** | **Accpt.** | **Ach.** | **Provider** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| NH1 Newborn hearing screening coverage | >97% | 99.5% | CUH | 99.2 | 98.6 | 98.3 | 99.0 | 98.7 | 99.8 | 99.2 % | 99.2 |
| | >97% | 99.5% | HHT | 99.7 | 99.2 | 99.9 | 99.8 | 99.6 | 99.7 | 99.6 % | 99.7 |
| | >97% | 99.5% | PCT | 99.8 | 99.9 | 99.5 | 100 | 99.9 | 99.8 | 99.9 % | 99.9 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| NH2 Newborn hearing screening timely referral for assessment | >90% | 95% | CUH | 77.8 | *93.8 | 88.0 | 94.4 | 90.0 | 93.8 | 100% | 89.5 |
| | >90% | 95% | HHT | 100 | No cases | 83.3 | 100 | 100 | 50.0 | 44.4 | 100 |
| | >90% | 95% | PCT | 100 | 100 | 100 | 92.9 | 100. | 76.9 | 85.7 | 100 |

**TABLE 32:** Newborn and infant physical examination KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

| | | | | 2016-17 | | | | 2017-18 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Indicator | Accpt. | Ach. | Provider | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| NP1 Newborn and Infant Physical Examination- coverage newborn | >95% | 99.5% | CUH | 97.3 | 94.5 | 94.5 | 95.2 | 95.3 | 94. | 95.5% | 93.9 |
| | >95% | 99.5% | HHT | 99.7 | 96.5 | 95.8 | 95.2 | 97.2 | 94.8 | 94.5 | 94.1% |
| | >95% | 99.5% | PCT | 96.9 | 97.4 | 97.3 | 97.6 | 96.8 | 97.2 | 96.1 | 97.1 |
| | | | | | | | | | | | |
| NP2 Newborn and Infant Physical Examination timely assessment | >95% | 100% | CUH | 100 | *66.7 | 28.6 | 66.7 | 75.0 % | 100 | 0.0% | 77.8 % |
| | >95% | 100% | HHT | 25 | No cases | No cases | 100 | 100 | 100 | 75 | 0.0 |
| | >95% | 100% | PCT | 33.3 | **50. 0 | No cases | No cases | 100. | 100 | 80. | No cases |

### 5.1.3 Antenatal and Newborn Screening Programme Updates

The Cambridge and Peterborough Programme board meet quarterly to review key performance indicators (KPIs) and performance. With the merger of Hinchingbrooke and Peterborough hospitals to form North West Anglia Foundation Trust, a programme board will be introduced for Cambridge and another programme board will be formed for North West Anglia foundation Trust.

- **Fetal anomaly:** KPIs and standards met. Introduction of coverage KPI for Patau's, Edwards and Downs (FA3) introduced from quarter 1 2018. There is no intention to publish this KPI by individual maternity service. Thresholds are not set for this KPI, performance between providers should not be compared. FASP supports informed choice for women.
- **Infectious diseases:** KPIs and standards met. Introduction of coverage KPIs for hepatitis B and syphilis introduced from quarter 1 2018.
- **Newborn hearing:** Smart for hearing IT system introduced successfully. Coverage KPIs met, with some slippage in the referral KPI, but appointments were offered in timely fashion.
- **Non-invasive prenatal testing:** the roll out of non-invasive prenatal testing has been delayed nationally due to unforeseen circumstances.
- **Newborn bloodspot:** there have been continued efforts to reduce the avoidable repeat rate on this programme.
- **Newborn and infant physical examination**: all trusts are compliant and using the Smart IT system. There have been some on-going issues with meeting the referral pathway KPI and this is currently under review nationally.

## 5.2 Cancer Screening programmes

### 5.2.1 Breast Screening

The two breast screening centres have regularly achieved the acceptable target for their KPIs in the last year. Both screening centres have plans in place to ensure more women get screened within the required 36 months including more advanced ways of booking appointments for women.

**TABLE 33:** Breast screening - % of women who attend for screening (aged 50 – 70), by screening centre, 2016/17 – 2017/18, *Source: Oracle Business Intelligence Enterprise Edition (OBIEE)*

| **Cambs. & Hunts. Screening Centre** | | **2016-2017** | | | | **2017-2018** | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Acceptable** | **Achievable** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 70.0% | ≤ 80.0% | 73.3 | 75.1 | 72.8 | 74.0 | 70.6 | 70.4 % | 68.5 | 69.8 % |
| **Peterborough Screening Centre** | | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 70.0% | ≤ 80.0% | 75.8 | 71.31 | 69.87 | 74.1 | 74.5 % | 72.5 % | 71.0 | 71.0 |

**TABLE 34:** Breast screening round length - % of women first offered an appointment within 36 months, by screening centre, 2016/17 – 2017/18, *Source: OBIEE*
**BS2 - Percentage of women first offered an appointment within 36 months**

| **Cambs. & Hunts. Screening Centre** | | **2016-2017** | | | | **2017-2018** | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Acceptable** | **Achievable** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 90.0% | ≤ 100.0% | 99.5 | 98.9 | 98.6 | 95.6 | 70.5 % | 70.4 % | 68.5 | 69.6 % |
| **Peterborough Screening Centre** | | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 90.0% | ≤ 100.0% | 98.1 | 98.3 | 98.9 | 98.2 | 92.3 % | 81.0 | 74.7 % | 56.2 % |

**TABLE 35:** Breast screening waiting time for assessment - % of women who attend for assessment within 3 weeks of attending for screening mammogram, by screening centre, 2016/17 – 2017/18, *Source: OBIEE*

| **Cambs. & Hunts. Screening Centre** | | **2016-2017** | | | | **2017-2018** | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Acceptable** | **Achievable** | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 90.0% | ≤ 100.0% | 93.6 | 93.0 | 97.2 | 94.0 | 99.6 | 91.6 | 100.00 | 99.3 |
| **Peterborough Screening Centre** | | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| ≥ 90.0% | ≤ 100.0% | 97.6 | 99.4 | 99.6 | 95.3 | 90.2 | 96.4 | 65.7 | 92.8 |

### 5.2.2 Cervical Cancer Screening

There has been a decline in the in the coverage in cervical screening which corresponds with the pattern which is seen nationally. The NHS England Screening and Immunisation team is working with a number of stakeholders on a project to improve access to screening for women and improve the quality of different aspects of the screening pathway. It is hoped that this project, along with national initiatives will help promote cervical screening for women in Cambridgeshire and Peterborough.

**TABLE 36:** Cervical cancer screening coverage of eligible population, by local authority and age group, 2017/18, *Source: Screening Quality Assurance Service (SQAS) and Open Exeter*

| Acceptable | Achievable | Provider | Q1 2017-18 | Q2 2017-18 | Q3 2017-18 | Q4 2017-18 |
|---|---|---|---|---|---|---|
| **CS2 - Coverage of eligible population (all women) every 5 years** | | | | | | |
| ≥ 80% | ≥ 95.0% | Cambridgeshire Upper Tier LA | 68.2 | 66.6 | 68.2 | 70.9 |
| ≥ 80% | ≥ 95.0% | Peterborough Upper Tier LA | 66.3 | 65.3 | 66.3 | 72.0 |
| **CS2a - Coverage of eligible population, all women aged 25-49 every 3 years** | | | | | | |
| ≥ 80% | ≥ 95.0% | Cambridgeshire Upper Tier LA | 64.5 | 62.9 | 64.5 | 68.0 |
| ≥ 80% | ≥ 95.0% | Peterborough Upper Tier LA | 63.4 | 62.4 | 63.4 | 70.0 |
| **CS2b - Coverage of eligible population, all women aged 50-64 every 5 years** | | | | | | |
| ≥ 80% | ≥ 95.0% | Cambridgeshire Upper Tier LA | 76.1 | 74.7 | 76.1 | 77.0 |
| ≥ 80% | ≥ 95.0% | Peterborough Upper Tier LA | 74.1 | 72.9 | 74.1 | 76.0 |

### 5.2.3 Bowel Cancer Screening

Although the uptake for bowel screening has remained consistently good in Cambridgeshire and Peterborough, the screening units have not been achieving the diagnostic waiting times KPIs. The NWAFT Screening Centre is working to address Specialist Screening Practitioner (SSP) and diagnostic waiting times. CUHFT has put in plans to address the diagnostic waiting times and both trusts are showing improvements in the waiting times for patients.

**TABLE 37:** Bowel cancer screening KPIs, by screening centre, 2016/17 – 2017/18, *Source: OBIEE*

| CUHFT Screening Centre | | | 2016-2017 | | | | 2017-2018 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Acc. | Ach. | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **BCS4 – Uptake** | ≥52% | ≥70% | 61.7 | 59.9 | 59.1 | 60.0 | No Data | 60.4 | 57.4 | 57.9 |
| **BCS7– SSP Waiting Times** | 100% within 14 days ≤1.0% | | 100 | 100 | 100 | 100 | 100 | 99.7 | 100 | 100 |
| **BCS8 - Diagnostic test waiting times** | 100% within 14 days | | 100 | 94.8 | 87.8 | 70.1 | 75.5 | 45.3 | 26.3 | 49.4 |

| NWAFT Screening Centre | | | 2016-2017 | | | | 2017-2018 | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Acc. | Ach. | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **BCS4 – Uptake** | ≥52% | ≥70% | 59.9 | 58.4 | 55.4 | 58.1 | 59.7 | 57.3 | 56.8 | 59.1 |
| **BCS7– SSP Waiting Times** | 100% within 14 days ≤1.0% | | 100 | 100 | 100 | 100 | 88.4 | 60.9 | 52.1 | 50.7 |
| **BCS8 - Diagnostic test waiting times** | 100% within 14 days | | 89.9 | 89.6 | 65.9 | 20.0 | 5.2 | 30.1 | 10.2 | 20.6 |

## 5.3 Adult and Young People Screening

### 5.3.1 Diabetic Eye Screening Programme

The KPI data for the diabetic eye screening programme carried out through Health Intelligence shows that for DE1 (uptake) and DE2 (results issued within 3 weeks) the achievable targets are regularly met for the population of Cambridgeshire and Peterborough, with good uptake of the screening programme. There are ongoing issues which are being addressed at hospital eye clinics affecting DE3 (timely assessment for R3A screen positive). This is for patients who are referred with a screen positive result to hospital eye services, who should be seen within the eye clinic within 13 weeks of referral. CUHFT has ongoing issues with capacity within eye clinics which has seen them regularly not meet this target for the whole of 2017-18. The Trust is trying to address this. NWAFT has met the target for 3 of the 4 quarters.

| **TABLE 38:** Diabetic eye screening KPIs for Cambridgeshire & Peterborough CCG through East Anglia DESP, by 2016/17 – 2017/18, *Source: Health Intelligence* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Indicator & Target** | **2016-2017** | | | | **2017-2018** | | | |
| | **Q1** | **Q2** | **Q3** | **Q4** | **Q1** | **Q2** | **Q3** | **Q4** |
| **Acceptable 70% Achievable 80%** | | | | | | | | |
| DE1-Uptake of routine digital screening event | 85.7 | 87.6 | 85.6 | 83.8 | 84.3 | 84.8 | 85.4 | 90.8 |
| **Acceptable 70% Achievable 80%** | | | | | | | | |
| DE2-Results issued within 3 weeks of screening | 99.8 | 99.7 | 99.8 | 99.8 | 98.5 | 99.8 | 100 | 100 |
| **Acceptable 80% Achievable 95%** | | | | | | | | |
| DE3 - Timely assessment for R3A screen positive | 80.0 | 75.0 | 58.3 | 70.0 | 70.8 | 75.0 | 75.0 | 80.0 |

### 5.3.2 Abdominal Aortic Aneurysm (AAA) Screening

The Cambridgeshire, Peterborough and West Suffolk AAA screening service has an eligible population of approximately 5,583. The service offers screening to all eligible men in the year they turn 65 years of age in line with national guidance. This is delivered by screening technicians in community settings such as GP practices and community hospitals. The service performs well against AA2 (coverage of initial screen) and AA3 (coverage of annual surveillance screen). AA4 (coverage of quarterly surveillance screen) is slightly under the acceptable level and this is monitored at the programme board with breaches discussed on an individual basis. Patients breach if they move their appointment forward as well as backwards, which affects this KPI, so patients breaching AA4 may be being seen earlier rather than later. The service also screened 176 self-referrals during 2017 to 2018. Self-referrals can be received via telephone or completion of a self-referral form.

| **TABLE 39:** AAA screening completeness of offer, Cambridgeshire population, 2015/16 – 2017/18 | | | | | |
|---|---|---|---|---|---|
| **Indicator** | **Acceptable** | **Achievable** | **2015-16** | **2016-17** | **2017-18** |
| AA1 Completeness of Offer | ≥ 52% | ≥ 70% | 99.9 | 99.9 | retired |

| **TABLE 40:** AAA screening KPIs, Cambridgeshire screening cohort, 2017/18 | | | | |
|---|---|---|---|---|
| **AAA Data - Cambridgeshire Screening Cohort** | | | | **2017-2018** |
| **Indicator** | | **Accpt.** | **Ach.** | |
| Coverage of Initial Screen | **AA2** | ≥ 75% | ≥85% | 80.6% |
| Coverage of Annual Surveillance screen | **AA3** | ≥ 85% | ≥95% | 89.7% |
| Coverage of Quarterly Surveillance screen | **AA4** | ≥ 85% | ≥95% | 83.6% |

# 6. Healthcare Associated Infections

Healthcare associated infections (HCAI) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections, including methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile).

HCAIs pose a serious risk to patients, staff and visitors, can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS.

## 6.1 MRSA bacteraemia

MRSA is a type of bacteria that is resistant to several widely used antibiotics and mainly affects people who are staying in hospital. The term MRSA bacteraemia refers to an MRSA blood stream infection.

The government considers it unacceptable for a patient to acquire an MRSA blood stream infection while receiving care in a healthcare setting and therefore has a zero tolerance approach (NHS Improvement March 2018). From April 2018, the requirements for reporting and monitoring through a post infection review (PIR) changed. Mandatory reporting remains in place, however only those organisations with the highest rates of infection are required to hold formal reviews, with the remainder of trusts adopting a local process, though still required to be a robust clinical review. The threshold for formal reviews was the top 15% of CCGs and non-specialist trusts with a rate of 1.6 or more community onset MRSA bacteraemia per 100,000 population and trusts with a rate of 1.7 per 100,000 bed-days or more. The rate in 2016/17 was 1.5. NHS England will maintain oversight of CCG performance and NHS Improvement the acute providers' performance. These are to be reviewed on a rolling 12-month basis. Cases have previously been assigned according to the outcome of the PIR, however since April, an onset of infection >2 days after admission is considered hospital onset and all other cases community onset.

**Neither Cambridgeshire and Peterborough CCG or its local acute hospital providers were in the top 15% requiring formal reviews, but have continued to conduct the PIR process as before, to ensure any timely learning is actioned or problem areas quickly identified.**

Locally, numerous interventions aimed at reducing the incidence of MRSA bacteraemia have been introduced and targeted to the acute care setting. However, with shorter hospital stays which should reduce the risk of acquiring a hospital onset infection, patients may have acquired infections within the hospital but not manifested the symptoms at the point of discharge. An admission to hospital would then be less than 2 days and according to the definition, community onset. Early detection of MRSA bacteraemia is improving with advanced diagnostics and increased clinical awareness of sepsis; this could possibly result in an increase of isolates found to be community onset.

**TABLE 41:** Numbers of MRSA bacteraemia cases, by area, 2017-18

| | **2017/18** | **2018/19 up to December 2018** |
|---|---|---|
| **National** | 846 | n/a |
| **Cambridgeshire and Peterborough CCG** | 11 | 16 |

Of the 16 cases reported to date this year, 5 were classed as hospital onset (one of which was a contaminant) and 11 community onset for the CCG (2 cases were for the same patient).

## 6.2 Clostridium difficile

C. difficile is a bacterial infection that affects the bowel and most commonly occurs in people who have recently been treated with antibiotics, especially broad-spectrum antibiotics.

During 2017/18, 13,286 cases of C. difficile were reported nationally which demonstrates a slight increase of 3.4%. The division of cases between community and hospital onset does not capture a recent admission/discharge of a patient or take into account complex healthcare pathways. The result of this is leading to a further change in the reporting process from April 2019 when the algorithm will be broken down into four categories. The objectives for each organisation were reduced by one case with plans for 2019/20 remaining unknown at this time.

Locally, scrutiny panel meetings continue to be held in each provider organisation for each individual case reported. At this meeting there is an agreement with the CCG Infection Control Lead as to whether there were any lapses in care to be addressed. Where lapses have been identified, this then becomes a sanctioned case. Lapses may include delay in sending a specimen, lack of isolation facility and no escalation, and poor documentation.

In Cambridgeshire and Peterborough:

- There were 135 cases of C. difficile reported between April to December 2018. This compares to 142 at the same point in 2017.
- The number of sanctioned cases for all hospital trusts cases is 26.
- The number of sanctioned cases for Cambridgeshire and Peterborough CCG registered patients is 17.
- Where trusts have seen more than 10 cases in a given month, support has been requested from NHS Improvement in conjunction with the CCG.

### 6.3 Escherichia coli bacteraemia

The term E. coli bacteraemia refers to a blood stream infection by E. coli bacteria. April 2017 saw the introduction of a Quality Premium for CCGs to reduce the number of E. coli cases by 10% during the period of 2017/18 which equated to 53 cases for Cambridgeshire and Peterborough CCG. Our total number for this period was 557 cases which was an increase of 6%. Overall a 5% increase between July to Sept 2017 and July to Sept 2018 has been reported.

Data published for the full year of 2017/18 identified that the rates are still high, in particular with the over 85-year old age group and greater in men than women. The source of these infections has changed little over time with urinary tract infection (UTI) the most frequent with 45-49% reported as the source.

Unlike MRSA bacteraemia and C. difficile, this infection is more challenging to reduce the incidence in number. The majority of these cases develop in the community in patients who may or may not have been receiving healthcare and therefore difficult to identify until the infection develops.

NHS Improvement developed a UTI collaborative and have been working with a number of hospital trusts over the past 9 months to make an impact where the reported number of cases is considered high. This has included CUHFT. To support the work and learning, we have brought together a wide multi-professional group from our health economy that includes infection control nurses, community continence service leads, acute hospital continence leads, consultant urologists, care home team and other senior practitioners along with the CCG contract leads for Urgent and Emergency Care to examine the service pathways for urinary catheters. This work remains in progress, with the main focus ensuring that urinary catheters are only used when absolutely required and removed as soon as possible. A positive impact from this work is anticipated during the year of 2019/20. A gap in team resources is being addressed by trusts to enhance the patient experience and reduce unwanted variation in practice across the health economy.

Between April and December 2018, 426 cases of E. coli bacteraemia have been reported, which is a rise of 5 cases for the same period last year.

### 6.4 HCAI further information and references

- Annual epidemiological commentary: Gram-negative bacteraemia, MSSA bacteraemia and *C difficile* infections, up to and including financial year April 2017 to March 2018. Public Health England. 12 July 2018
- Quarterly epidemiological commentary. Mandatory MRSA, MSSA, Gram-negative bacteraemia and *C. difficile* infections data (up to July to September 2018). Public Health England. December 2018
- Technical guidance for NHS planning 2017/18 and 2018/19 – Annex B, Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups

## 7. Antimicrobial Resistance

Antimicrobial resistance has been described as one the greatest threats to human kind. The overuse and incorrect use of antibiotics are major drivers of the development of antimicrobial resistance. The continued

threat from the development of antimicrobial resistance and a drastic reduction in the number of new antibiotics being developed, make the need to preserve the antimicrobials we currently have a local, national and global priority. Local targets, set nationally, for reducing the amount and certain types of antimicrobial drugs prescribed across all health care sectors are in place and achieving these requires co-operation from prescribers, patients and the public.

Research has shown that antibiotic stewardship programmes could halve the number of infections due to antibiotic-resistant bacteria compared with unguided prescribing. Locally, there has been a reduction in the number of antibiotics prescribed by GPs which will contribute to conserving the antibiotics we currently use. This has been achieved through the introduction of antibiotic stewardship programmes across all health sectors, use of educational materials for GPs and patients, provision of comparative antibiotic prescribing data to GP practices, peer group review, and public education programmes. Trimethoprim, an antibiotic used to treat infections such as urinary tract infections, is an effective treatment where infections have been shown to be susceptible and in situations where alternatives would be less suitable. However, the inappropriate use of trimethoprim, has been associated with the development of serious, life-threatening gram-negative bloodstream infections, particularly in vulnerable patients where their urine infection has been resistance to trimethoprim. 25.8% of urine community E. coli (or coliform) samples tested in quarter 3 2018 in the Cambridgeshire and Peterborough CCG area were found to be non-susceptible to trimethoprim. This figure has reduced compared to the same quarter in 2017-2018. Local and national targets have been introduced aimed at reducing the inappropriate use of this trimethoprim compared to alternatives and specifically for use in in patients over 70 years old who are the most vulnerable. Local targets for reducing the use of trimethoprim have been met through effective antibiotic stewardship initiatives and the addition of new antibiotic formulary choices which offer prescribers more alternatives to trimethoprim. Focusing on reducing inappropriate use of trimethoprim in urinary tract infections continues into 2019-20.

Broad spectrum antibiotics include the groups of antibiotics the quinolones, cephalosporins, and co-amoxiclav. They should normally only be used when narrow-spectrum antibiotics have not worked or are resistant to the infection being treated. Inappropriate use increases the risk of producing a resistant type of bacteria known as MRSA, other resistant urinary tract infections and may cause an unpleasant life-threatening infection, Clostridium difficile, to develop. Local and national targets have been set aimed at reducing the amount of broad spectrum antibiotics prescribed compared to all types of antibiotics. Locally, use of broad spectrum antibiotics continues to be higher than the National target. A system wide approach using antibiotic stewardship programmes with provision of prescribing data, audit, provision of education, peer group review and support to GPs in reducing their use of unwarranted broad spectrum antibiotics has been implemented to address this. Very limited success has been seen in the reduction of broad spectrum prescribing in 2018-2019 and further improvement is needed during 2019-2020 and will require the co-operation of prescribers, patients and the public.

## 7.1 AMR references and further information


1. The UK AMR Strategy High Level Steering Group. UK 5 Year Antimicrobial Resistance (AMR) Strategy 2013-2018. Third Annual progress report, 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662189/UK_AMR_3rd_annual_report.pdf and accessed 17.1.2019.
2. National Institute for Healthcare and Clinical Excellence (NICE). Key therapeutic topic [KTT9] Antimicrobial stewardship: prescribing antibiotics. Published date: January 2015. Last updated: January 2017. Available at: https://www.nice.org.uk/advice/ktt9/chapter/evidence-context and accessed 17.1.19.
3. Public Health England. East Region. AMR Local Indicators. Available at: http://fingertips.phe.org.uk/ and accessed 17.1.19.

4. Public Health England. English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) 2018 and accessed 17.1.19.

# 8. Environmental Health

Environmental Health teams and Regulatory Services play an important role in protecting the health of the Cambridgeshire and Peterborough population. Principal Environmental Health Officers sit on the Cambridgeshire and Peterborough Health Protection Steering Group reporting key environmental health issues by exception.

Environmental health is the responsibility of district and unitary councils and is delivered by the following councils within Cambridgeshire and Peterborough: Cambridge City Council, East Cambridgeshire District Council, Fenland District Council, Huntingdonshire District Council, Peterborough City Council and South Cambridgeshire District Council.

Although the role of environmental health staff vary between each council, the following regulatory services are usually delivered by environmental health teams or equivalent:

- Food safety
- Health and safety
- Pollution control – including noise pollution and contaminated land
- Private sector housing and houses of multiple occupation (HMOs)
- Licensing
- Trading standards

The work of regulatory services and environmental health teams helps to keep people healthy and safe, reduce health inequalities and contributes to the local economy.

## 8.1 Food safety

This includes carrying out hygiene inspections of food establishments, investigating complaints, regulating private water supplies, and working closely with Public Health England to manage infectious diseases. Food safety teams aim to protect consumers through the assessment or investigation of business compliance with relevant food legislation and centrally issued guidance, and/or to offer advice and guidance to businesses. These activities help to protect the community from ill health associated with poor food hygiene and safety practices.

Food Safety teams within Environmental health operate the national Food Hygiene Rating Scheme which helps consumers choose where to eat or shop for food by providing information about hygiene standards. In 2017/18, the proportion of food establishments across the country achieving broad compliance was 90.2% (broadly compliant is equivalent to a hygiene rating of 3, generally satisfactory, or above). Table 42 below shows the proportion of broadly compliant establishments locally:

**Table 42:** Proportion of food establishments achieving broad compliance, by local authority, 2017/18, *Source: Food Standards Agency LAEMS*

| | **Total number of establishments** | **Proportion of food establishments achieving broad compliance (equivalent to a hygiene rating of 3 or above), including those not yet rated** |
|---|---|---|
| Cambridge City | 1523 | 90.5% |
| East Cambridgeshire | 786 | 92.9% |
| Fenland | 842 | 95.3% |

| | | |
|---|---|---|
| Huntingdonshire | 1386 | 90.2% |
| Peterborough City | 1932 | 87.5% |
| South Cambridgeshire | 1306 | 90.8% |

Recent examples of work carried out by local food safety teams include:

- **Improving hygiene ratings at East Cambridgeshire District Council:** in order to improve hygiene ratings of food premises and public confidence within the district, the environmental health team set up a new scheme. Poorly performing businesses were identified and signed up to the scheme via a 'contract'. These businesses were offered a package of support including: an advisory visit, a good safety management system – Safer Food Better Business pack and diary sheets, an allergen pack and verbal advice on training, cleaning, labelling, structural advice and how to comply with and maintain management systems. Premises were then given three months to rectify identified issues during which time they were able to access the further support from the environmental health team. Businesses then received a further advisory visit before being inspected unannounced. The environmental health team then provide support to the businesses to help them maintain their improved ratings.

- **Investigating food fraud at Fenland District Council (FDC):** the environmental health team have been working closely with the Food Standards Agency (FSA) to investigate a significant amount (> 100 tonnes) of frozen meat detained by FDC environmental health officers. This meat did not meet hygiene standards due to suspected labelling issues. FDC officers have been working with the FSA to identify the origins of the meat product, its date of processing and whether it was fit to release back into the market place. The complex investigation has revealed common practices within the meat product industry which has helped both the council and FSA understand the risks associated with the onward sale products which may change hands many times over a period of months. The investigation confirmed breaches of hygiene standards and the company has agreed to dispose of the meat.

- **Pest infestations at Cambridge City Council and Peterborough City Council:** the food safety teams in these teams have been dealing with cockroach and rodent infestations at various premises including food businesses and a school. The teams have been taking necessary action to deal with the infestation including inspection and in some instances closure, to ensure there is no risk to public health.

- **Managing cases and outbreaks of infectious diseases:** environmental health officers throughout Cambridgeshire and Peterborough continue to work closely with Public Health England to provide an essential role in the management of complex cases of infectious diseases. Cambridge City Council have worked closely with Public Health England to assist with a case of TB which required the issuing of a warrant and a Part 2A order to prevent the patient from seconding into the community. Peterborough City Council (PCC) worked with Public Health England to investigate a gastroenteritis outbreak, providing support to the business in terms of infection prevention and control advice, providing advice to the public and working to identify the source of infection. South Cambridgeshire District Council worked closely with Public Health England to investigate a cluster of salmonella cases which had potential links to a local nursery. E coli gastrointestinal infections can be very serious and require a number of public health actions to minimise the risk to the public. PCC have dealt with a small number of cases of E. coli this year which has involved working with involved businesses, supporting the cases and their families, and liaising with Public Health England.

## 8.2 Health and safety

Health and safety teams within the district councils and Peterborough City Council are responsible for enforcing health and safety regulations in businesses which including catering and hospitality, hairdressing and beauty, motor vehicles, working in an office, retail and warehousing to make sure they are safe for employees and visitors. The health and safety teams carry out investigations into complaints, reportable accidents and ill health in relation to the workplace.

This year, the PCC health and safety team conducted a routine visit to a Shisha Bar in the City Centre, where officers observed that the smoking shelter was no longer compliant in that it had been altered to become an enclosed space.

Since 2006 smoking is not permitted inside workplaces. Smoking can take place in a smoking shelter as long as the shelter is more than 50% open. Shisha smoking is dealt with in the same manner as tobacco smoking and must also take place in a compliant shelter. At the time of the visit a number of customers were observed to be smoking in the now enclosed space. Officers worked with the business and the business returned the shelter to a compliant shelter by being more than 50% open. The business received a written warning to prevent making the shelter enclosed again.

## 8.3 Pollution control

Pollution control includes investigation of a wide range of statutory nuisances, air quality assessment, hoarding and infestations of vermin in domestic and commercial premises, and the issuing of permits for industrial processes. It also includes the inspection of potentially contaminated land where current or previous industrial activity may have had an impact on the condition of the land and left it contaminated with chemicals or other substances. All of these environmental hazards can have significant harmful effects on health; the pollution control teams therefore play a vital role in protecting the public's health from such hazards.

Recent examples of work carried out by pollution control teams include Cambridge City Council environmental health officers who have been working closely with Marshalls Airport to provide advice on noise, air quality, odour and contaminated land issues in relation to the new engine testing. The council have also been working on a challenging contaminated land case in the city, supporting planning colleagues to ensure the development is fit for purpose and does not pose a risk to human health.

**Case Study – Pollution Control at Peterborough City Council**

The PCC Pollution Team has a significant input into the development control process, acting as a statutory consultee for planning applications and for the discharge of conditions. The Pollution Team are consulted on approximately 500 development sites each year, recommending conditions and agreeing mitigation measures where noise, contaminated land, air quality and other such environmental issues may be of concern. Typical applications that are considered and advised upon in the development process are:

- New transport routes and industrial/commercial activities proposed in/near residential locations;
- Applications for residential development adjacent to noise sources such as industry or road/rail traffic;
- Proposed developments on brownfield sites when previous uses may have contaminated soils or produce ground gases with potential health impacts; and
- Major developments that may have air quality impacts upon the locality, for example by emissions from associated transport or particulates.

Examples of developments considered in the previous 12 months include:

- Developments in Hampton considering road and rail traffic impacts for proposed and existing development, the impact of new traffic routes or increased traffic flows on existing development in terms of noise and air quality; mitigation measures that may be required to protect residential and other developments from any soil contamination or ground gases that may be present; considering any potential impacts upon new schools proposed on brownfield sites adjacent to major traffic routes.
- Site for 104 affordable houses Former Perkins Engines Site Newark Road Fengate. Advice on measures to mitigate potential impact from noise sources from industrial premises, and to mitigate ground contamination and gas emissions associated with previous landfilling of the site.
- Upgrade of Werrington Gas Compressor assessed for air quality and noise impacts. Notices served to control noise levels and hours of work for the construction phase of the project which are programmed for completion in 2020.
- Werrington Grade Separation "Dive-Under" proposals. The railway at Werrington Junction is to undergo major redevelopment which is scheduled to be completed by mid-2021. The noise resulting from this significant construction scheme will impact on local residents. Officers worked with Network Rail for the agreement of work procedures and service of notices primarily to ensure the impacts of construction noise of the civil engineering project will be controlled so far as reasonably practicable.
- Energy from Waste and Biomass Generating Station, Storeys Bar Road, Fengate - Advice and recommendations have been provided in relation to emissions of pollutants to air from the plant, odour potential, operational noise, construction noise and dust, impacts of transport upon air quality and noise, and controls to mitigate lighting impacts.
- Consideration of potential noise and air quality impacts associated with proposed duelling of A47 Wansford-Sutton
- Assessment of impacts from Alwalton Hill commercial developments and their potential cumulative impacts upon future residential developments in Hampton and for Haddon.
- Consideration of proposals for industrial and commercial use on 166440 square metres of land at Red Brick Farm Fengate, advising upon controls for day and night time noise that may impact upon residents, additional traffic noise, air quality impacts, development on potentially contaminated land and lighting control
- Discharge of planning condition in relation to remediation requirements for ground contamination and required levels of ground gas protection for Sand Martin House, Fletton Quays
- Review of development proposals for housing that may be affected by the nearby Stanground Landfill and Fletton Parkway. The site has been assessed for potential impacts of landfill gas migration, contaminated land, air quality and noise.
- Stanground South: Tranches for housing development adjacent to the Stanground bypass have come forward and been assessed for noise impacts associated with traffic. Recommendations for the protection of indoor and outdoor amenities have been made as part of the planning consultation process.

**Contaminated Land at Burton Street:** the PCC Pollution Team identified significant levels of carcinogenic chlorinated solvents in the ground, potentially affecting some residential properties in the area. The presence of the contaminant was most likely associated with the historic industrial land use of a casting works in the locality. It was therefore necessary to establish if the chlorinated solvent levels in the soil amounted to unacceptable risk to human health. Following initial investigations by officers, environmental consultants were appointed who carried out investigations at locations agreed with affected residents. This identified that the measured concentrations were all below the vapour screening values that had been previously determined by risk modelling. Therefore the risk to occupants in the identified area, from vapour intrusion associated with subsurface contamination, is acceptable and does not constitute significant possibility of significant harm and land is not deemed to be 'contaminated'.

## 8.4 Private Sector Housing

Private sector housing teams within environmental health departments of district and unitary authorities undertake statutory housing and public health functions. They work with owner occupiers, private landlords and social housing providers to protect the health, wellbeing and safety of residents and visitors. This may involve taking action to deal with issues such as disrepair, fire safety, overcrowding inadequate facilities and issues relating to damp, mould or condensation. Many private sector housing teams also work to improve the health and safety of houses in multiple occupation (HMOs) including issuing HMO licenses. Some housing officers also provide advice to homeowners and landlords about energy efficiency issues such as insulation and availability of grants.

This year, for example, the Cambridge City Private Sector Housing Team worked with a number of different agencies to deal with a complex case of hoarding. The team identified a number of category 1 hazards under the Housing Health and Safety Rating System (HHSRS) which affected the safety and suitability of the housing and worked in partnership to resolve these issues.

## 8.5 Licensing Service

Licensing staff regulate the carrying on of all licensable activities by the appropriate control of licensed premises, temporary events and personal licence holders. Areas of licensing including alcohol, gambling, pet shops, petroleum sites, tattooists and skin piercing, dangerous animals and adult entertainments.

This year, a number of local councils have reviewed their Statement of Licensing Policy in relation to the Licensing Act 2003. A Cumulative Impact Policy is a local policy which introduce a presumption against new licences to sell alcohol from bars, shops, pubs or clubs in a designated area. They can be adopted where there is evidence that the number or concentration of premises give rise to a harmful impact on the promotion of the licensing objectives and where a licensing authority has consulted local people and businesses. Cumulative impact policies are in place in Cambridge City, Fenland and Peterborough City. In 2018, both Cambridge City Council and PCC reviewed the use of cumulative impact policies in their districts and it was agreed to continue with them.

A further example of local work in this area is the revocation of an alcohol licence of a convenience store in Peterborough following the seizure by trading standards of illicit cigarettes and tobacco. Cambridge City Council have also heightened enforcement in this area to ensure the licence holders, including taxi licensing, are adhering to the requirements of their licenses.

## 8.6 Trading standards:

On 1st April 2017 Cambridgeshire County Council's Trading Standards Service merged with Peterborough City Council's Trading Standards Service, becoming 'Cambridgeshire and Peterborough Trading Standards'. The service plays a vital role in enhancing and safeguarding the local economy, as well as protecting its residents. Through the effective delivery of its statutory duties it helps to ensure businesses based and operating in Cambridgeshire and Peterborough are aware of and comply with their legal obligations.

Trading Standards has a critical role in ensuring consumer safety, through its enforcement and advisory activities in the areas of product safety, food safety, upholding the integrity of the food chain, protecting the most vulnerable from rogue trading activity, and effective explosives and petroleum licensing. The service plays a crucial role in protecting the rural economy from animal disease outbreaks and continues to be a primary responder in the case of such an outbreak, as well as upholding animal health and welfare standards.

A key area of work is tackling illicit tobacco which can cause significant harm to the public's health due to unregulated sales of cheap cigarettes to children and high levels of contaminants in fake tobacco products. Trading Standards plays a role locally by detecting and seizing illegal tobacco products.

Cambridgeshire and Peterborough Trading Standards Service have been working on the following important issues which can pose a risk to the public's health:

- **Rabies:** the trading standards service have been working hard to disrupt the illegal importation of animals for onward sale which can present a risk of rabies when these animals come from countries with a high risk of rabies. A number of successful prosecutions have been undertaken against illegal importers (with one defendant receiving a 34 month prison sentence). This has provided a media platform allowing the service to raise awareness, educate the public and disrupt the importers resulting in a substantial drop in complaints in 2018.

- **Allergens:** the trading standards service has responsibility for food labelling including the correct labelling of allergens in food. Previous work has included sampling and analysis from takeaways but more recently the service has been focusing on caterers and hotels. Following a serious incident where a customer received food which contained nuts and had a severe allergic response, a series of inspections have taken place where controls were checked and advice given to ensure adequate controls were in place. Officers from across the councils have also provided training to caterers on allergens.

- **Illicit tobacco:** the service continues to work with partners across Cambridgeshire and Peterborough to disrupt the sale of illicit cigarettes, tobacco and alcohol. This is resource intensive work as often these products are concealed in shops or nearby vehicles so sniffer dogs are needed to find hiding places. These products are sold cheaply (£3 for packet of 20 cigarettes) thereby counteracting the Government initiatives of discouraging smoking through taxation and harming legitimate business. From four visits in Peterborough 32,000 cigarettes and 3.2kg hand rolling tobacco were seized. Licence reviews are underway against all these premises, with one premise having their licence revoked. Investigations are currently being carried out for possible court action. The trading standards service has also recently invested in new equipment to improve testing of seized cigarettes for 'reduced ignition propensity' requirements – an important safety feature on regulated cigarettes.

- **Vaping safety project:** As part of a Department of Health funded project, trading standards officers have been assessing compliance with the Tobacco and Related Products Regulations 2016. A range of premises were inspected and at each one approximately ten products (e-liquids and vaping merchandise) were inspected for compliance. Numerous non-compliances were seen around labelling and officers advised businesses on what they needed to do to comply with legal requirements. Issues found were referred to the Trading Standards departments where the suppliers were based. In addition to the funded work, 16 samples of e-liquids were taken and analysed in the laboratory of a Primary Authority Partner business for the presence of undesirable substances and nicotine strength. Of the 16 samples taken, one had high levels of acetyl propionyl and acetoin, which are both flavour ingredients that the Medicines and Healthcare Regulatory Agency (MHRA) have advised against. All nicotine strengths were within tolerance of that declared. This project has identified a range of issues facing consumers and businesses on how to comply with the law, and has fed into a larger national project.

- **Underage sales:** the trading standards service are responsible for age restricted products such as tobacco, alcohol, fireworks, knives and petrol. We, like many other authorities, do not receive many complaints about this, but recognise that it is a problem. In order to generate intelligence to target our action we have conducted a set of Challenge 25 test purchases, where a 20 year old was sent into shops claiming to operate a 21 or 25 age check policy and asked to buy cigarettes. From 46 premises visited 21 (45%) sold without asking for ID and of these 17 (80%) were illicit tobacco. This provides evidence for the perception that underage sales are still a problem, made worse by the fact many of the cigarettes were also illicit, and further work is planned.

- **Counterfeit alcohol:** Following a complaint from a consumer, trading standards officers examined a bottle of vodka purchased from a local off license. The labelling and smell of the vodka raised concerns that it may not be genuine. As a result inspections were conducted at 2 linked premises and further bottles seized. These were sent for analysis to determine whether the products are genuine or unsafe. In the past, counterfeit vodka has been found to contain industrial alcohol, such as isopropanol and ethanol, both of which can be very harmful.

## 9. Air Quality

## 9.1 Responsibility for improving air quality

The air quality agenda in Cambridgeshire and Peterborough is not owned by a single organisation or department. Cambridge City, Peterborough City Council and the four district councils have statutory requirements to assess and monitor air quality, and where required develop action plans; they also have plan making powers which can effect air quality. The Cambridgeshire County Council, Peterborough City Council and the combined authority and Greater Cambridgeshire Partnership are responsible for actions and intervention's (mainly relating to transport) which can mitigate or reduce air pollution.

The role of the public health directorate is to provide the evidenced based health implications of air quality at a population level. The public health directorate facilitate this by bringing together key stakeholders who may not normally meet for air quality issues or may only be considering the environmental aspects, for example Public Health have contributed to the Transport needs review of the Cambridge Biomedical Campus (one of the Greater Cambridge Partnership Projects) following concerns raised by members of the Cambridgeshire County Council Health Committee and officers at the Cambridge City Council, the Combined Authority's Strategic Bus Review, the Local Transport Plan and district/city level Local Plans.

There are number of challenges which need to be considered when developing a joined up county wide approach to air quality. As stated above the ownership of the air quality agenda rests with many organisations with responsibility for monitoring and mitigation held by different organisations, this makes a system wide response more challenging.

Last year the public health directorate identified a gap in the knowledge of air quality and its impact among transport and planning officers as transport planners and local planners are not experts in air quality, and in two tier areas do not have access to air quality expertise in their organisations, therefore Public Health commissioned a training programme for these officers to raise awareness of air quality and to foster closer working relationships.

There is a lack of specialist air quality capacity in many of the district and city councils, which means the majority of their focus is on their statutory duties, with little capacity for broader advocacy work or influencing planning and transport decisions.

There are co-benefits from wider interventions, as air quality should not be seen in isolation as health modelling shows that interventions to increase active travel can result in significantly greater benefits from increased physical activity, compared to direct interventions targeting air quality overall – so greater health benefits will be achieved by people switching to walking and cycling than by switching to electric cars.

The approach therefore is to focus on those areas of the county most effected by poor air quality whilst at the same time directly influencing broader strategic plans and programmes, such as transport plans and local plans, which have considerable impact on air quality across the whole of the county.

## 9.2 Monitoring air quality

Cambridge City Council, Peterborough City Council and the four district councils are required to assess the air quality in their area as part of the Air Quality Standards Regulations 2010 legislation. Levels of air pollutants such as benzene, carbon monoxide, nitrogen dioxide, industrial emissions and sulphur dioxide are assessed.

The assessment process is undertaken in a series of stages by using an updating and screening assessment of air quality which are produced every three years. The updating and screening assessment of air quality identifies the pollution levels within the local authority area. In between these publications, annual status reports (ASR) are produced which highlight any changes which might have occurred over the previous year. The guidance from DEFRA requires these ASRs to be signed off by the Director of Public Health.

Should any pollutants be suspected or shown to be above the objective level, the responsible local authority is required undertake a detailed assessment. If the detailed assessment shows that there is an area which exceeds the relevant air quality objective, the Council shall declare an air quality management area.

The burden of poorer air quality varies across Cambridgeshire and Peterborough. Currently, the main pollutants of concern in Cambridgeshire and Peterborough, as in most areas of the UK, are associated with road traffic, in particular $NO_2$ and particulate matter (PM) at locations close to busy, congested roads where people may live, work or shop. Air Quality Management Areas (AQMAs) have been declared in Cambridge City, Fenland, Huntingdonshire, Peterborough City and South Cambridgeshire; East Cambridgeshire currently do not have an AQMA. By nature this means that air quality does not have the same level of focus for all local authorities.

In areas with declared Air Quality Management Areas (AQMAs) the focus continues to be to support the authorities to bring forward measures to improve air quality and ensure that the most vulnerable are protected e.g. children and those with health conditions.

In addition to responsibility for monitoring air quality, the district and city councils also have plan making powers which can affect air quality. Recent examples of work by district and city councils to improve air quality include the introduction of a zero/ultra-low taxi vehicle policy and the introduction of electric vehicle charge points for taxis in Cambridge City Council.

## 9.3 Cambridgeshire and Peterborough Combined Authority

At a strategic level the Combined Authority is developing a new Cambridgeshire and Peterborough Local Transport Plan (LTP). As transport is one of the main contributors to air quality this will be considered in the LTP. Public Health will play a role in bringing together stakeholders on air quality to provide a more comprehensive joined up response. The development of the LTP would also provide an opportunity to champion and influence opportunities for more active travel within the plan.

The combined authority has also produced a Non Statutory Spatial Plan which focuses on providing a county perspective on infrastructure, linking up local plans and the LTP. Air quality has been considered as part of this process. The Combined Authority are reviewing and refreshing the Quality Charter for Growth which will take air quality into account. These plans will enable Public Health to indirectly influence air quality in those localities where air quality is not deemed to be a priority.

## 9.4 Cambridgeshire and Peterborough Air Quality Action Plan

The public health directorate are coordinating a Cambridgeshire and Peterborough Air Quality Action plan to address key concerns on air quality raised locally. The draft headline actions are:

- Review what resources have already been developed locally and nationally – develop / localise specific resources for planners and councillors on planning committee, councillors more broadly, children and young people, and make resources available on local authority air quality pages and Cambridgeshire Insight to address communication/key messages on air quality. There is a lack of local resources and key messages on air quality which can leave a vacuum and creates potential for inappropriate narrative.
- Examine current content on Cambridgeshire insight on Air Quality as there is a lack of links between districts air quality pages and Cambridgeshire insight and vice versa
- Identify resources from elsewhere and localise/develop resources for citizen scientists locally
- Apply for NHS sustainability fellow to work locally to better understand impact of the NHS (health service) on air quality and identify opportunities to change ways of working.
- Feed into the Combined Authority's Local Transport Plan and Quality Charter for Growth.

## 9.5 Air Quality – Further Information

Local authorities are required to publish regular air quality reports which can be found on their local websites and the Cambridgeshire Insight website.

# 10 Sexual Health

The following key indicators for sexual health in Cambridgeshire and Peterborough raise concerns about trends in population level sexual health.

## 10.1 New Sexually Transmitted Infections Diagnoses (STIs) (excluding <25 chlamydia)

The rate of new diagnoses of sexually transmitted infections (excluding <25 chlamydia) is below the England average for Cambridgeshire, with a downward trend. The rate of new diagnoses of sexually transmitted infections (excluding <25 chlamydia) for Peterborough has fluctuated in recent years. The Peterborough rate in 2017 declined from 2016 to a level statistically similar to the national average (876 to 761 per 100,000).

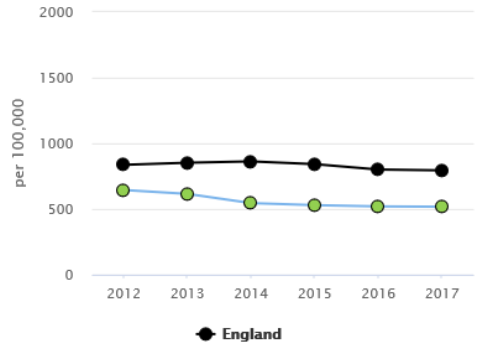


**Figure 9:** New STI diagnoses (excluding <25 chlaymdia), Cambridgeshire, 2012-2017, *Source: Sexual Health Profiles Public Health England (2018)*

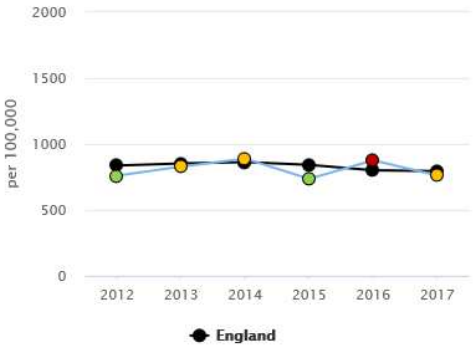


**Figure 10:** New STI diagnoses (excluding <25 chlaymdia), Peterborough, 2012-2017, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.2 New HIV Diagnosis Rate

There has been an overall downward trend in the rate of new HIV diagnosis in England and Cambridgeshire. However, the rate for Cambridgeshire in 2017 increased from 2016 (6.8 to 7.3 per 100,000) to a level statistically similar to the England average.

Peterborough has remained statistically significantly similar to England since 2011, although the Peterborough rate for this indicator declined between 2016 and 2017 (from 14.9 to 13.5 per 100,000) line with the England trend.

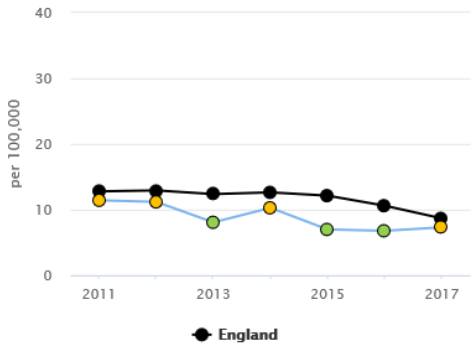


**Figure 11:** New HIV Diagnosis Rate, Cambridgeshire, 2011-2017, *Source: Sexual Health Profiles Public Health England 2018)*

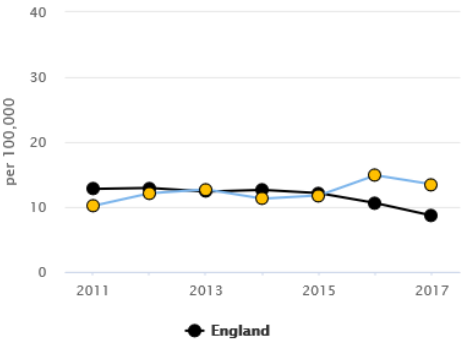


**Figure 12:** New HIV Diagnosis Rate, Peterborough, 2011-2017, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.3 Late HIV Diagnosis

England has a downward trend of HIV late diagnosis. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

The rate of HIV late diagnosis for Cambridgeshire was worse than the benchmarking goal (defined as ≥ 50%) at 51.1% in the period 2015-17 (shown below) and statistically significantly similar to England. Since 2009 it has been statistically significantly similar or above both the benchmarking goal and England.

The rate of late HIV diagnosis for Peterborough has been worse than the benchmarking goal (defined as ≥ 50%) at 51.2% during 2015-17 (shown below). Since 2013 the Peterborough rate for late diagnosis has been statistically worse than the England figure.

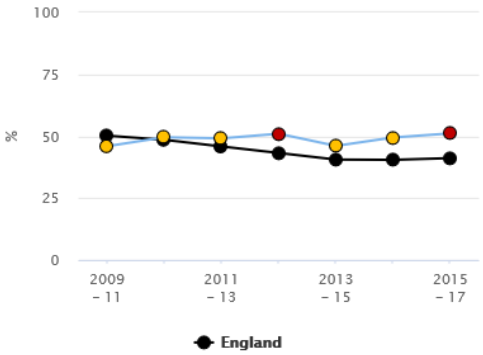


**Figure 13:** HIV Late Diagnosis (%)[1], Cambridgeshire, 2009/11-2015/17, *Source: Sexual Health Profiles Public Health England (2018)*

[1] *These graphs show the Cambridgeshire/Peterborough rate RAG-rated compared to the **benchmark** for this indicator, not England.

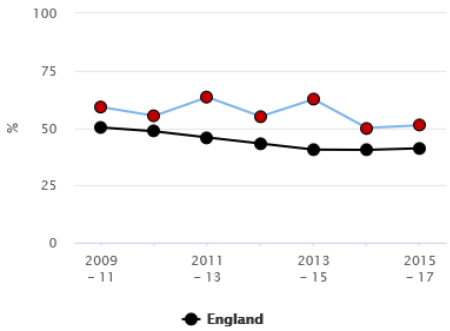


**Figure 14:** HIV Late Diagnosis (%)[2], Peterborough, 2009/11-2015/17, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.4 HIV diagnosed prevalence

The HIV diagnosed prevalence rate for Cambridgeshire has remained statistically significantly better than England since 2011. The HIV diagnosed prevalence rate for Peterborough was statistically significantly better than England from 2011 to 2015. For the periods 2016 and 2017 the HIV diagnosed prevalence rate for Peterborough has increased to a level statistically similar to England. The HIV diagnosed prevalence rate has exceeded 2 per 1,000, therefore defining the authority as a high HIV prevalence local authority according to 2017 NICE and PHE guidelines. For Peterborough, the increased rate is expected to be in part due to improved testing, diagnosis, and treatment.

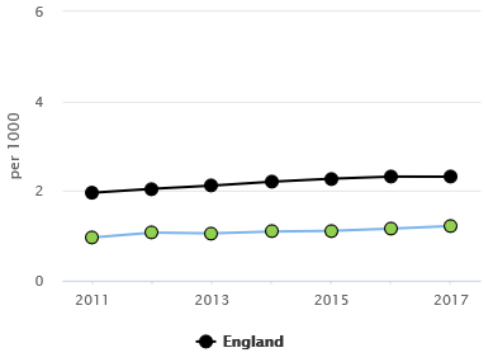


**Figure 15:** HIV diagnosed prevalence rate per 1000 (people aged 15 – 19 yrs), Cambridgeshire, 2011 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

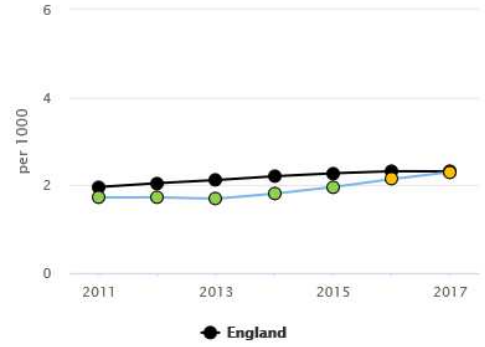


**Figure 15:** HIV diagnosed prevalence rate per 1000 (people aged 15 – 19 yrs), Peterborough, 2011 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.5 Chlamydia Diagnosis

Nationally, there has been a continued decline in Chlamydia detection amongst 15-24 year olds since 2012. For Cambridgeshire, the rate of chlamydia detection has remained significantly worse than the national average, and worse than the PHE recommended benchmarking goal of 2,300 per 100,000, since 2012. However it is difficult to interpret this as generally the rate of STIs in the Cambridgeshire population is below the national average.

[2] *These graphs show the Cambridgeshire/Peterborough rate RAG-rated compared to the **benchmark** for this indicator, not England.

The rate of chlamydia detection in Peterborough has remained significantly better than the national average, and better than the PHE recommended benchmarking goal of 2,300 per 100,000, since 2012. Continuing to exceed the national benchmarking goal is considered positive in terms of identifying and treating the infection in the population, however, it indicates clearly that there is high level of infection in the population despite the high detection and treatment rate.

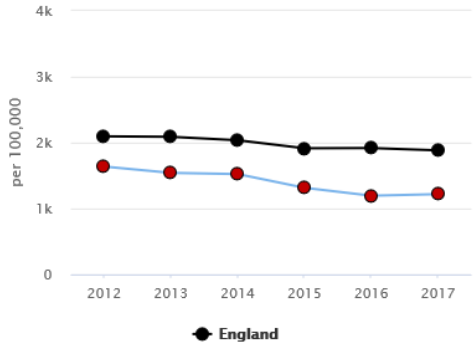


**Figure 17:** Chlamydia detection rate 15-24 yrs, Cambridgeshire, 2012 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

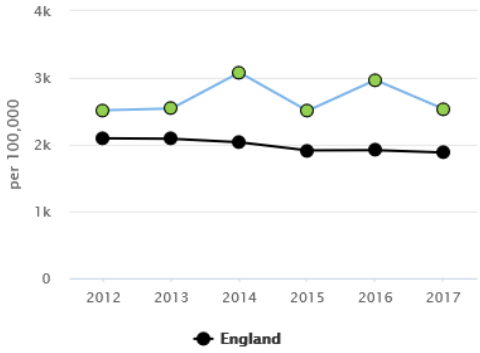


**Figure 18:** Chlamydia detection rate 15-24 yrs, Peterborough, 2012 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.6 Teenage Pregnancy (conceptions)

The under 18 conception rate per 100,000 has improved dramatically between 1998 and 2016 in Cambridgeshire and in Peterborough. The under 18 conception rate in Cambridgeshire continues to have a downward trend and it remains below the national average. The Fenland district, within Cambridgeshire, has a downward trend but remains statistically similar to England. Peterborough also has a downward trend in the under 18 conception rate, however it remains statistically significantly worse than the national average for the sixth consecutive year.

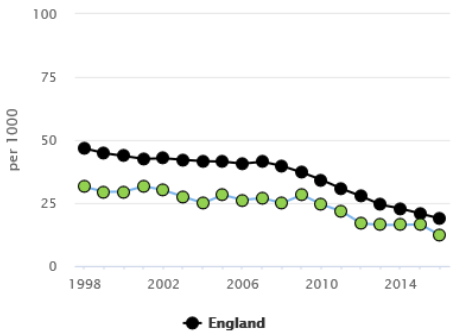


**Figure 17:** Under 18s Conception Rate, Cambridgeshire, 1998 - 2016, *Source: Sexual Health Profiles Public Health England (2018)*

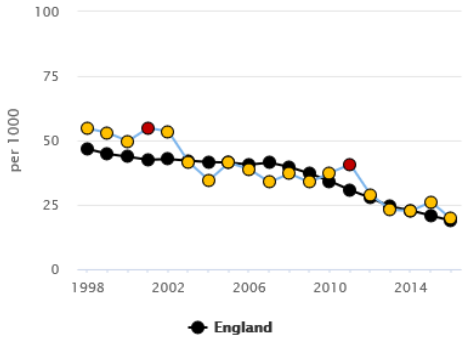


**Figure 18:** Under 18s Conception Rate, Fenland, 1998 - 2016, *Source: Sexual Health Profiles Public Health England (2018)*

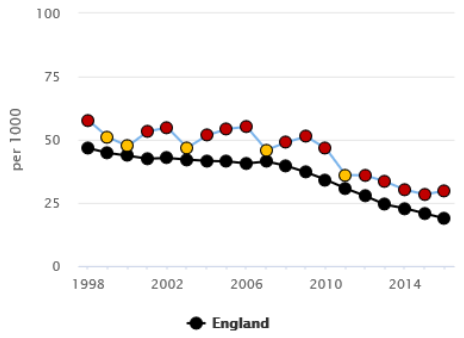


**Figure 19:** Under 18s Conception Rate, Peterborough, 1998 - 2016, *Source: Sexual Health Profiles Public Health England (2018)*

## 10.7 Sexual Health Services

The Integrated Sexual Health Service (ICaSH) in both Cambridgeshire and Peterborough is provided by Cambridgeshire Community Services. Both areas have since 2014 has seen a continuous increase in demand for its services. In Cambridgeshire during the last year this increase has been around 5% above the activity level commissioned in 2014. In Peterborough this increase has been substantially greater at around 25% above the 2014 commissioned levels. These increases in activity are found in both contraception and sexual health services.

In Cambridgeshire the Service is generally meeting its key targets. The historical Department of Health access target for GUM services was for securing access to sexual health treatment within 48 hours or two working days to reduce the risk of onward transmission of infection has consistently been met.

However the activity increase in Peterborough has contributed to a decrease in the percentage of patients being offered and accessing the sexual health services within 48 hours to around 70% on average for both measures. Measures have been taken to address the increase in activity. From October 2018 there were six clinic closures but also additional ongoing funding was secured from Peterborough City Council to address the increase in demand that had created substantial funding issues for the provider. In addition the contractual key performance indicators for the access targets were changed from being a contractual mandatory requirement to a reporting requirement. This will be reviewed regularly.

In Cambridgeshire chlamydia screening is commissioned from GPs for 15-25 year olds. And although numbers are low they have a high positivity rate which is associated with targeted opportunistic screening. Peterborough does not have comparable GP contract and the majority of screening is undertaken by the iCaSH clinic.

Community pharmacies provide Emergency Hormonal Contraception (EHC) and demand for this remains unchanged. Pharmacies who provide EHC are also required to offer access or provide advice on chlamydia screening Pharmacies are located in areas where access to other services is limited and where there are high risk groups are targeted for providing the service. In Cambridgeshire the service performs well and meeting its targets.

The Peterborough EHC Service was re-commissioned in 2017/2018 and a significant amount of work was undertaken to ensure pharmacies received the relevant training. There has been a doubling in six months in the number of pharmacies, with sixteen now providing the service in the high need areas.

### 10.8 Prevention

In both Cambridgeshire and Peterborough the voluntary organisations continue to provide a range of prevention services that range from outreach work with hard to reach/high risk groups, chlamydia screening to working in schools. The iCaSH service in Peterborough also provides an outreach service. Throughout the year a number of campaigns are also undertaken in line with the national programmes.

### 10.9 Cambridgeshire and Peterborough Sexual Health Delivery Board

The Cambridgeshire and Peterborough Sexual Health Delivery Board was established in 2017. This followed the formation of the Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU). The JCU is responsible for commissioning Public Health services across the two local authorities. The Sexual Health Delivery Board brings together commissioners and providers from across the two areas to set the strategic direction for sexual health and to implement collaborative partnership interventions to address issues. A Delivery Action Plan has been developed and the following priorities have been adopted by the Board to address initially.

- Under 18 conceptions in Peterborough and Fenland (has a trend similar to Peterborough).
- Late HIV diagnosis
- Improving pathways across different services (both clinical and non-clinical). This includes pathway design and closer alignment of commissioning across the three different commissioners of sexual health services i.e. the Local Authorities, the Cambridgeshire and Peterborough Clinical Commissioning Group and NHS England.

The Public Health England (PHE) lead for Teenage pregnancy led a multi-agency Workshop in 2018 that lead to the identification of priorities for organisations to take forward to address teenage pregnancy in Peterborough and Fenland.

There is a group working to address late HIV diagnosis which includes exploring the demographic characteristics associated with late diagnosis to ensure that interventions are appropriately targeted.

PHE invited sexual and reproductive health commissioners from the Cambridgeshire and Peterborough local authorities, Clinical Commissioning Group and NHS England to be one of two national pilot sites for a sexual health commissioning feasibility study. The aim is for local sexual heath commissioning organisations explore opportunities for future alignment and collaborative commissioning opportunities for sexual health services in the area, which would future proof, quality assure and optimise sexual health service pathways, better address needs and potentially realising system efficiencies where appropriate. This has been taken forward during 2018 with work including a multi-agency workshop that identified five priorities for development that are being taken forward. The progress has been reported to PHE Advisory Board.

There have been concerns in Peterborough about the prevention and support for people living with HIV from vulnerable groups. Sex workers and those misusing drugs have raised particular concerns. This has brought together a wide range of agencies to successfully address the particular acute health and social needs of an individual and this group is now working to look at the issues more widely to develop a more strategic approach across organisations.

## 9. Health Emergency Planning

Cambridgeshire County Council and Peterborough City Council are Category 1 responders under the terms of the Civil Contingencies Act 2004. As a result there is an emergency planning / resilience team that works in partnership with other organisations to lead emergency planning and response for the councils, along with some additional

responsibilities for health emergency preparedness passed with the move of Public Health into local authorities. In the role within local authorities the DPH is expected to:

- Provide leadership to the public health system for health Emergency Preparedness, Resilience and Response (EPRR).
- Ensure that plans are in place to protect the health of their population and escalate concerns to the Local Health Resilience Partnership (LHRP) as appropriate.
- Co-chair the Cambridgeshire and Peterborough LHRP with NHS England Locality and represent at Cambridgeshire and Peterborough Local Resilience Forum Strategic Board.
- Provide initial leadership with PHE for the response to public health incidents and emergencies. The DPH will maintain oversight of population health and ensure effective communication with local communities.

LHRPs provide strategic leadership for health organisations in the Local Resilience Forum (LRF) area and are expected to assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging needs. Member agencies share responsibility for oversight of health emergency planning in this forum. It is for the LRF and/or the LHRP to decide whether LHRP plans should be tested through a multi-agency exercise as a main or contributory factor. The DPH reports health protection emergency resilience issues to the LHRP on a regular basis. The DPH provides a brief update report on the activities of the LHRP to the HPSG to ensure sharing of cross cutting health sector resilience issues.

- The DPH has been supported in this work by a consultant in public health who co-chairs the Health and Social Care Emergency Planning Group (HSCEPG) with the Head of EPRR from the NHS England Midlands and East (East) and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.
- The HSCEPG has membership from local acute hospitals, East of England ambulance service, community services, mental health services, social care services, other NHS funded providers, Public Health England and NHS England.

The LHRP leads on the annual EPRR assurance process. The aim is to assess the preparedness of the NHS commissioners and providers, against common NHS EPRR Core Standards. All NHS funded organisations have completed their self-assessment against the EPRR Core Standards for 2018-2019. All organisations were either full or partially compliant.

The Cambridgeshire and Peterborough health system is, at this point in time, well prepared to deliver the EPRR core standards including planning for and responding to a wide range of emergencies and business continuity incidents that could affect health or patient safety.

There is strong engagement across health partners and a common aim to contribute and share best practice across the LHRP, LRF and East EPRR leads forum within the East Locality. There are also links into the Cambridgeshire & Peterborough Health & Wellbeing and A & E Delivery Boards through the Co-Chairs of the LHRP.

The LRF and LHRP priorities for the past year were validation of:

- PHE Health Protection audit;
- Cyber security;
- CPLRF Pandemic influenza Plan; and
- CPLRF CBRN Plan.

The LRF Pandemic Influenza Plan has been exercised and validated by the CPLRF Executive Board. The CBRN plan has been exercised and is going through the process of validation.

The period from 1 January 2018 to the date of this report has seen a very wide and varied training and exercise programme delivered by the CPLRF. Of significance were three exercises:-

1. Exercise Gallus: The discussion based table top exercise took place on the 24 July 2018 to test the arrangements within Cambridgeshire and Peterborough for Pandemic Influenza. Thirty six attendees from sixteen organisations took part in the exercise.
2. Exercise North Sea: This was a 'walk and talk' followed by 'question and answer' exercise that took place on 26 June 2018. The aim of the exercise was to assess, test and validate the procedures stated in the East Coast Flood plan for the tidal River Nene.
3. Exercise Green Cloud: This was a table top exercise that took place on the 18 and 19 September 2018. The overarching aim of the exercise was to rehearse working in a Tactical Coordinating Group (TCG) and Strategic Coordinating Group (SCG) environment and conduct a review of the recovery phase. The exercise was designed and facilitated by the Cabinet Office Emergency Planning College

The priorities for the year ahead have been agreed as:

- Actions from Health Protection audit;
- Winter Resilience; and
- Cambridgeshire and Peterborough Hospital Evacuation Plan.

# 10. Glossary

| | |
|---|---|
| AAA | Abdominal Aortic Aneurysm |
| AMR | Antimicrobial Resistance |
| AQMAs | Air Quality Management Areas |
| ASR | annual status reports |
| CBRN | Chemical, biological, radiological & nuclear |
| C. difficile | Clostridium difficile |
| CCG | Clinical Commissioning Group |
| CCS | Cambridgeshire Community Services NHS Trust |
| CP HPSG | Cambridgeshire and Peterborough Health Protection Steering Group |
| CPFT | Cambridgeshire and Peterborough NHS Foundation Trust |
| CUHFT | Cambridge University Hospitals NHS Foundation Trust |
| DEFRA | Department for Environment, Food & Rural Affairs |
| DOT | Directly Observed Treatment |
| DPH | Director of Public Health |
| DTaP | Diptheria, tetanus and pertussis (vaccine) |
| EHC | Emergency Hormonal Contraception |
| EPRR | Emergency Preparedness, Resilience and Response |
| ESPAUR | English Surveillance Programme for Antimicrobial Utilisation and Resistance |
| ETS | Enhanced Tuberculosis Surveillance |
| FDC | Fenland District Council |
| FSA | Food Standards Agency |
| GI | gastrointestinal |
| GNBSIs | Gram Negative Bloodstream Infections |
| GP | General Practice |
| HCAI | Healthcare Associated Infections |
| Hep B | Hepatitis B virus |
| HEPRO | Health Emergency Planning and Resilience Officer |
| HHSRS | Housing Health and Safety Rating System |
| Hib | Haemophilus influenzae type B |
| HIV | human immunodeficiency virus |
| HMOs | Houses of Multiple Occupation |
| HPV | Human papillomavirus |
| HSCEPG | Health and Social Care Emergency Planning Group |
| ICaSH | The Integrated Sexual Health Service |
| IPV | Polio (vaccine) |
| JCU | Cambridgeshire and Peterborough Public Health Joint Commissioning Unit |
| KPIs | key performance indicators |
| KTT9 | Key therapeutic topic |
| LA | Local authority |
| LES | Local Enhanced Service |
| LHRP | Local Health Resilience Partnership |
| LRF | Local Resilience Forum |
| LTBI | Latent TB infection |
| LTP | Local Transport Plan |
| MHRA | Medicines and Healthcare Regulatory Agency |
| MMR | Measles, Mumps & Rubella vaccine |
| MOU | Memorandum of Understanding |
| MRSA | methicillin-resistant Staphylococcus aureus |
| NICE | National Institute for Healthcare and Clinical Excellence |
| NOIDs | Notification of Infectious Diseases |
| NWAFT | North West Anglia NHS Foundation Trust |
| PCC | Peterborough City Council |

| | |
|---|---|
| PCV | Pneumococcal vaccine |
| PHE | Public Health England |
| PIR | post infection review |
| PM | particulate matter |
| SCG | Strategic Coordinating Group |
| SSP | Specialist Screening Practitioner |
| STIs | Sexually Transmitted Infections Diagnoses |
| TB | Tuberculosis |
| TCG | Tactical Coordinating Group |
| UTI | urinary tract infection |
| VTEC | Vero cytotoxin-producing |

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| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 9a |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| Report of: | Dr Liz Robin, Director of Public Health | |
|---|---|---|
| Cabinet Member(s) responsible: | Cllr Holdich – Leader of the Council and Deputy Mayor of the Cambridgeshire and Peterborough Combined Authority | |
| Contact Officer(s): | Ryan O'Neill, Advanced Public Health Analyst | Tel: 01733 207179 |

# PETERBOROUGH HEALTH & WELLBEING STRATEGY 2016-19 FINAL ANNUAL REVIEW, JUNE 2019

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

It is recommended that the Health and Wellbeing Board:

1. Note the findings within this final 2016-19 Health & Wellbeing Strategy annual review, including data showing improvements in health and wellbeing outcomes for Peterborough residents over the course of this strategy as well as areas that may require further continued intervention.
2. Use the information contained within this document to inform preparations for the next Peterborough Health & Wellbeing Strategy with a view towards improving general health and wellbeing in Peterborough and reducing observed inequalities/inequities. This may apply to both healthcare outcomes and associated wider determinants of health and wellbeing.

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health & Wellbeing Board as the third and final annual review of Peterborough Health & Wellbeing Strategy progress for the 2016-19 strategy, in accordance with the statutory requirement of Health & Wellbeing Boards to produce, maintain and monitor a Health & Wellbeing Strategy.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an annual summary to the Health & Wellbeing Board of progress against statistical targets and goals agreed by the Board on commencement of its 2016-19 Health & Wellbeing Strategy. The Board mandated that indicators and associated performance narratives be compiled at regular intervals for 11 key areas as noted below and this report summarises how health & wellbeing outcomes have developed in Peterborough over the course of the 2016-19 period.

Peterborough Health & Wellbeing Strategy 2016-19 themes:

a) children & young people's health
b) health behaviours & lifestyles
c) long term conditions & premature mortality
d) mental health for adults of working age
e) health & wellbeing of people with disability and/or sensory impairment
f) ageing well

g) protecting health
h) growth, health & the local plan
i) health & transport planning
j) tackling health inequalities
k) health & wellbeing of diverse communities

2.2 This report is for the Health and Wellbeing Board ] to consider under its Terms of Reference No 2.8.3.1.

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

2.3 This report does not link directly to the Children In Care pledge, although data relating to the health and wellbeing of children and young people are contained within the report.

## 3. TIMESCALES

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

## 4. BACKGROUND AND KEY ISSUES

4.1 Production of a Health and Wellbeing Strategy to meet the needs identified in the Joint Strategic Needs Assessment (JSNA) is a statutory function of the Peterborough Health and Wellbeing Board under the Health and Social Care Act (2012). Both NHS Commissioners and Local Authorities are required to have regard to the Joint Strategy in their service plans.

The Peterborough Health & Wellbeing Board have requested and received an annual report summarising progress with regards to its 2016-19 Health & Wellbeing Strategy in 2017 and 2018; this final 2019 report concludes analysis of Health & Wellbeing Board outcomes across the 2016-19 time period.

## 5. CONSULTATION

5.1 No consultations have taken place with regards to this document, as it is a data report relating to the Health & Wellbeing Strategy rather than the strategy document itself.

5.2 It is not suggested that any consultations take place with regards to this document, although the Health & Wellbeing Board may wish to publicise findings from this report.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Findings from this Health & Wellbeing Strategy review should inform development of a future Health & Wellbeing Strategy by the Peterborough Health & Wellbeing Board. Priorities with regards to Health & Wellbeing in Peterborough will necessarily change as a result of factors including national and local government policy and demographic changes and the data within this report can help illustrate possible new areas for focus and/or intervention in the design of the next Health & Wellbeing Strategy.

## 7. REASON FOR THE RECOMMENDATIONS

7.1 Producing a Health and Wellbeing Strategy to meet the needs identified in the Joint Strategic Needs Assessment (JSNA) is a statutory function of the Peterborough Health and Wellbeing Board under the Health and Social Care Act (2012). Both NHS Commissioners and Local Authorities are required to have regard to the Joint Strategy in their service plans.

Annual strategy reports summarise findings from available data from across the local healthcare system with regards to progress towards achieving goals as contained within the 2016-19

Peterborough Health & Wellbeing Strategy. This information should inform decisions by the Board with regards to future health & wellbeing goals contained within the next Health & Wellbeing Strategy.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 As it is a statutory duty for the Peterborough Health & Wellbeing Board to develop and maintain a Health & Wellbeing Strategy, alternative options are not available.

## 9. IMPLICATIONS

### Financial Implications

9.1 There are no direct financial implications resulting from this report, although findings within it should be utilised within the development of a future Health & Wellbeing Strategy and associated commissioning/service delivery decisions.

### Legal Implications

9.2 There are no direct legal implications resulting from this report.

### Equalities Implications

9.3 There are no direct equalities implications resulting from this report, although it does contain analysis of data relating to equalities and equities of healthcare outcomes, wider determinants of health and wellbeing and service access/use that should be utilised within the development of a future Health & Wellbeing Strategy.

## 10. BACKGROUND DOCUMENTS

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

10.1 This report was prepared with reference to the 2016-19 Peterborough Health & Wellbeing Strategy as well as data sourced from/generated by Public Health England, Peterborough/Cambridgeshire Public Health Intelligence, Peterborough City Council Adult Social Care, Peterborough City Council Business Intelligence, Cambridgeshire & Peterborough Clinical Commissioning Group and Cambridgeshire & Peterborough NHS Foundation Trust.

## 11. APPENDICES

11.1 Appendix A – Peterborough Health & Wellbeing Strategy 2016-19, 2019 Annual Review

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# Peterborough City Council Health & Wellbeing Strategy 2016-19, Annual Review

## June 2019

## Contents



# 1 Introduction

Producing a joint Health & Wellbeing Strategy to meet the health needs of local residents is one of the main duties of Health & Wellbeing Boards as identified in the Health & Social Care Act 2012[1] The Health & Wellbeing Board of Peterborough City Council approved the 2016-19 Health & Wellbeing Strategy for Peterborough in July 2016, after a period of collaboration between key stakeholders across the healthcare sector and members of the public to establish key priorities and goals related to the health of residents in Peterborough. The 2016-19 Health & Wellbeing Strategy is available at URL: https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/PCCHealthWellbeingStrategy-2016-19.pdf?inline=true and is comprised of 12 main sections that focus on key factors that influence healthcare outcomes in Peterborough:

1. Children & Young People's Health
2. Health Behaviours & Lifestyles
3. Long Term Conditions & Premature Mortality
4. Mental Health for Adults of Working Age
5. Health & Wellbeing of People with Disability and/or Sensory Impairment
6. Ageing Well
7. Protecting Health
8. Growth, Health & the Local Plan
9. Health & Transport Planning
10. Housing & Health
11. Geographical Health Inequalities
12. Health & Wellbeing of Diverse Communities

[1] https://www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets

Each Health & Wellbeing Strategy section performance report includes a quarterly update from the section lead on current and on-going activities, future plans and milestones, risks and key considerations. In addition to this, a number of key performance indicators have been chosen for each section in order that progress can be objectively monitored against national performance in relation to both observed numbers (e.g. mortality from all cardiovascular diseases) and statistical significance in comparison to England (e.g. directly age-standardised mortality rates, which take in to account differences in demographics between populations, such as disproportionately high percentages of older or younger people compared to England).

For each performance indicator, an appropriate partnership Board has been asked to agree both the appropriateness of the indicator and a three year improvement trajectory, encompassing the period from the start of Health & Wellbeing Strategy in 2016 through to March 2019.

This report summarises final outcome data for performance indicators for this iteration of the Peterborough Health & Wellbeing Strategy and may therefore be viewed as both an illustration of changes observed in Peterborough over the duration of this iteration of Peterborough's Health & Wellbeing Strategy and a reference document to inform the generation of the next Health & Wellbeing Strategy for the Peterborough area.

# 2 Health & Wellbeing Strategy 2016-19 – Annual Review 2018 Key Findings Overview

**Data that show recent improvements and/or positive trends within Peterborough in relation to Health & Wellbeing include:**

- The under 75 mortality rate from all cardiovascular diseases in females in Peterborough is now similar to England for the 2015-17 period having been statistically significantly higher (worse) for five consecutive pooled periods between 2009-11 and 2013-15.

- The suicide rate for all persons in Peterborough is similar to the national average, having been statistically significantly higher (worse) as recently as 2010-12.

- The crude rate of under 18 conceptions in Peterborough is statistically similar to the national average in 2017, ending a period of five consecutive years where the Peterborough value was statistically significantly higher (worse) than England.

- Rates of hospital admission episodes for alcohol-related conditions have improved from statistically significantly worse than England to similar to England for all persons and males only and remained similar to England for females over the course of the 2016-19 Health & Wellbeing Strategy.

- The rate of emergency hospital admissions due to falls in people aged 65+ in Peterborough has improved to be statistically similar to that of England after being statistically significantly higher (worse) in 2014/15 and 2015/16.

- Between April 16 – March 17 and April 18 – March 19, the number of readmissions within 28 days to Cambridgeshire & Peterborough NHS Foundation Trust reduced from 54 to 39 and the proportion readmitted reduced from 11.8% to 9.8% of all discharges for Peterborough residents.

- The proportion of the eligible population receiving an NHS health check in Peterborough has been higher (better) than the national average for each of the five years between 2013/14 and 2017/18.

- The crude rate of people killed and seriously injured on Peterborough roads has been statistically similar to England for five consecutive years, having been statistically significantly worse in 2009-11 and 2010-12.

- The number of adults with social care needs receiving short term services to increase independence rose from 739 in 2017/18 to 881 in 2018/19, an increase of 19.2%.

- The rate of clients receiving reablement services in Peterborough increased from 77.9/100,000 in 2017/18 to 97.3/100,000 in 2018/19.

- A multi-agency neglect strategy has been launched in Peterborough, with Local Safeguarding Children Boards (LSCBs) having monitored implementation through quality assurance activity including audits and surveys. Scrutiny is on-going and will continue to be measured by the LSCBs.

- The proportion of adults in contact with secondary mental health services who live in stable and appropriate accommodation and the gap in the employment rate for those in contact with secondary mental health services and the overall employment rate are both better in Peterborough than the respective indicator national averages.

- The proportion of 15-24 year olds screened for chlamydia and the chlamydia detection rate within this age group are both statistically significantly higher (better) than national averages.

- 69 business in Peterborough have travel plans designed to facilitate environmentally sustainable travel, exceeding the target at the initiation of this strategy of 60 businesses.

**Data that show recent negative trends and/or areas that may require further intervention to address over the course of a future Peterborough Health & Wellbeing Strategy:**

- The disparity in life expectancy between the 80% of people living in the least deprived areas and the 20% living in the most deprived areas of Peterborough (Bretton, Central, Dogsthorpe, North and Orton Longueville) has increased from 1.6 years in 2011-15 to 2.1 years in 2013-17. Residents in the most deprived 20% of Peterborough electoral wards have a life expectancy of 78.9 years, compared to 81.0 years in the least deprived 80% of Peterborough electoral wards.

- The under 75 mortality rates from all cardiovascular diseases for all persons and males only in Peterborough are statistically significantly higher (worse) than in England and both rates worsened between 2014-16 and 2015-17.

- The national benchmark value for HIV late diagnosis (defined as diagnosis of HIV when patient has a CD4 count of less than 350 cells per mm3) is 25.0% or less of total cases. The Peterborough value for 2015-17 is 51.2%, worse than national benchmark goal for the seventh consecutive period.

- The crude rate of hospital admissions caused by unintentional and deliberate injuries (including self-harm) for 15-24 year olds in Peterborough has remained statistically significantly higher (worse) than England between 2011/12 and 2017/18. Peterborough is one of only four local authorities in its group of 16 nearest socio-economic comparators to be statistically significantly worse than England for this indicator.

- 2017/18 data show that Peterborough is below minimum national benchmark for three key screening and immunisation indicators: Hib/MenC booster at 2 years old (goal 95.0%, Peterborough 89.9%), PCV booster (goal 95.0%, Peterborough 90.0%) and MMR for two doses at 5 years old (goal 95.0%, Peterborough 88.6%).

- The percentage of adults classified as overweight or obese in Peterborough is 68.3% for 2017/18, statistically significantly higher (worse) than the national average of 62.0%.

  Within this report, the below colour scheme is used within charts to indicate comparison to a benchmark value (usually England):

| |
|---|
| Statistically significantly better than benchmark |
| Statistically similar to benchmark |
| Statistically significantly worse than benchmark |

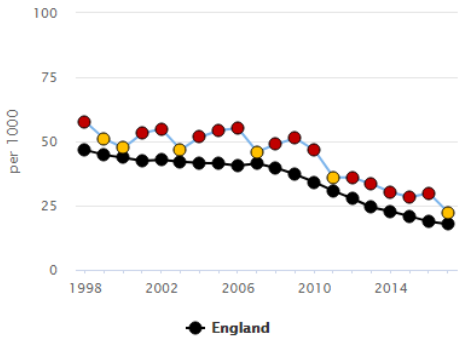
  For some indicators (e.g. HIV late diagnosis and screening/immunisation goals) comparison to a benchmark goal is used instead of a calculation of statistical significance, such as the below example for HIV diagnosis:

| |
|---|
| <25.0% of total cases 'late diagnosis' |
| 25.0% to 50.0% of total cases 'late diagnosis' |
| <50.0% of total cases 'late diagnosis' |

# 3 Health & Wellbeing Strategy 2016-19 – Annual Review 2019 Key Findings by Section

## 3.1 Children & Young People's Health

**Figure 1: Crude rate of under 18 conceptions per 1,000, 1998 – 2017**




Recent trend: ⬇

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 1998 | ● | 185 | 57.7 | 49.7 | 66.6 | 37.9 | 46.6 |
| 1999 | ● | 158 | 51.0 | 43.4 | 59.6 | 36.4 | 44.8 |
| 2000 | ● | 147 | 47.4 | 40.1 | 55.7 | 35.1 | 43.6 |
| 2001 | ● | 167 | 53.3 | 45.5 | 62.0 | 34.2 | 42.5 |
| 2002 | ● | 179 | 54.8 | 47.1 | 63.5 | 34.6 | 42.8 |
| 2003 | ● | 155 | 46.8 | 39.7 | 54.7 | 33.1 | 42.1 |
| 2004 | ● | 175 | 51.7 | 44.3 | 59.9 | 32.4 | 41.6 |
| 2005 | ● | 184 | 54.2 | 46.7 | 62.7 | 32.4 | 41.4 |
| 2006 | ● | 190 | 55.1 | 47.6 | 63.6 | 33.1 | 40.6 |
| 2007 | ● | 155 | 45.9 | 39.0 | 53.8 | 33.0 | 41.4 |
| 2008 | ● | 168 | 48.9 | 41.8 | 56.9 | 31.1 | 39.7 |
| 2009 | ● | 171 | 51.3 | 43.9 | 59.5 | 30.7 | 37.1 |
| 2010 | ● | 161 | 46.6 | 39.7 | 54.3 | 29.1 | 34.2 |
| 2011 | ● | 127 | 36.0 | 30.0 | 42.8 | 26.6 | 30.7 |
| 2012 | ● | 128 | 35.9 | 29.9 | 42.6 | 23.2 | 27.7 |
| 2013 | ● | 118 | 33.4 | 27.6 | 40.0 | 21.0 | 24.3 |
| 2014 | ● | 102 | 30.2 | 24.6 | 36.7 | 20.2 | 22.8 |
| 2015 | ● | 95 | 28.3 | 22.9 | 34.6 | 18.8 | 20.8 |
| 2016 | ● | 99 | 29.8 | 24.2 | 36.3 | 17.1 | 18.8 |
| 2017 | ● | 74 | 22.4 | 17.6 | 28.1 | 16.0 | 17.8 |

*Source: Office for National Statistics (ONS)*

**Source: Public Health Outcomes Framework**

The crude rate of under 18 conceptions per 1,000 is statistically similar to the national average in 2017, ending a period of five consecutive years where the Peterborough value was statistically significantly higher (worse) than England. The total of 74 conceptions is an unprecedented low in Peterborough and results in a crude rate of 22.4/1,000. Most teenage pregnancies are unplanned and around half end in abortion; evidence suggests that many young women find raising a child difficult and births to mothers under 18 often result in poor outcomes for both the parent and the child[2]. It is therefore a key success within the 2016-19 Peterborough Health and Wellbeing Strategy to have reduced the crude rate of under 18 conceptions to a level similar to that observed across England and to observe a general downward trend in both observed conceptions and rates in Peterborough over recent years.

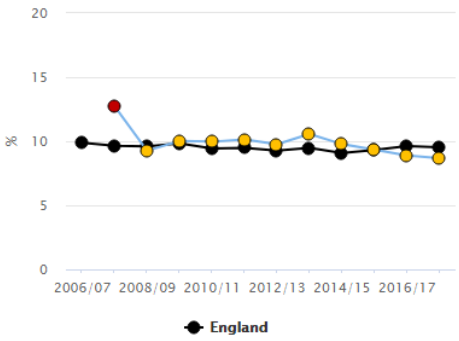
**Successful implementation of Peterborough Neglect Strategy:**

Indicator 1.5 of the 2016-19 Peterborough Health & Wellbeing Strategy relates to 'successful implementation of a multi-agency neglect strategy resulting in increased early intervention to prevent such patterns becoming entrenched'. This strategy was launched in 2016 and recent feedback states that the strategy is now live, with Local Safeguarding Children Boards (LSCBs) having

2 https://fingertips.phe.org.uk/search/pregnancy#page/6/gid/1/pat/6/par/E12000006/ati/102/are/E06000031/iid/20401/age/173/sex/2

monitored implementation of the strategy through quality assurance activity including audits and surveys. Scrutiny is on-going and will continue to be measured by the LSCBs.

**Figure 2: Reception year obesity prevalence, 2006/07 – 2017/18**




Recent trend: ⬇

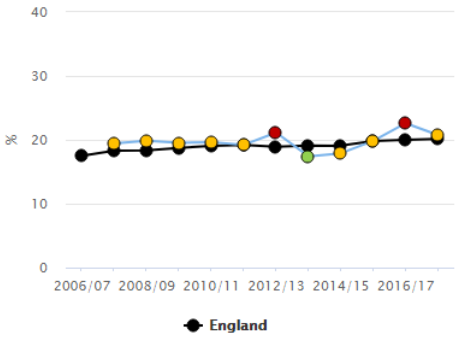
| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2006/07 | | - | * | - | - | * | 9.9% |
| 2007/08 | 🔴 | 248 | 12.7% | 11.3% | 14.3% | 9.4%* | 9.6% |
| 2008/09 | 🟡 | 198 | 9.3% | 8.1% | 10.6% | 8.7% | 9.6% |
| 2009/10 | 🟡 | 220 | 10.0% | 8.8% | 11.4% | 9.2% | 9.8% |
| 2010/11 | 🟡 | 226 | 10.0% | 8.8% | 11.3% | 8.9% | 9.4% |
| 2011/12 | 🟡 | 247 | 10.1% | 9.0% | 11.4% | 8.7% | 9.5% |
| 2012/13 | 🟡 | 260 | 9.8% | 8.7% | 10.9% | 8.1% | 9.3% |
| 2013/14 | 🟡 | 306 | 10.6% | 9.5% | 11.7% | 8.5% | 9.5% |
| 2014/15 | 🟡 | 266 | 9.8% | 8.7% | 11.0% | 8.2% | 9.1% |
| 2015/16 | 🟡 | 259 | 9.3% | 8.3% | 10.5% | 8.3% | 9.3% |
| 2016/17 | 🟡 | 231 | 8.9% | 7.9% | 10.1% | 8.6% | 9.6% |
| 2017/18 | 🟡 | 253 | 8.7% | 7.7% | 9.8% | 8.4% | 9.5% |

*Source: NHS Digital, National Child Measurement Programme*

**Source: Public Health Outcomes Framework**

Data show that the proportion of children in reception year who are obese (BMI greater than or equal to the 95$^{th}$ centile of the UK90 growth reference index) in Peterborough is similar to that of England and reducing over time. The 2017/18 obesity prevalence value of 8.7% in Peterborough is numerically the lowest observed since the commencement of the National Child Measurement Programme and is statistically significantly lower (better) than the first performance data gathered in Peterborough (12.7% in 2007/08, 95% confidence intervals 11.3% - 14.3%).

**Figure 3: Year 6 obesity prevalence, 2006/07 – 2017/18**




Recent trend: ⬆

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2006/07 | | - | * | - | - | * | 17.5% |
| 2007/08 | 🟡 | 277 | 19.4% | 17.4% | 21.5% | 16.7%* | 18.3% |
| 2008/09 | 🟡 | 378 | 19.9% | 18.1% | 21.7% | 16.6% | 18.3% |
| 2009/10 | 🟡 | 386 | 19.5% | 17.8% | 21.3% | 16.8% | 18.7% |
| 2010/11 | 🟡 | 388 | 19.6% | 18.0% | 21.5% | 17.7% | 19.0% |
| 2011/12 | 🟡 | 389 | 19.2% | 17.6% | 21.0% | 17.2% | 19.2% |
| 2012/13 | 🔴 | 438 | 21.1% | 19.4% | 22.9% | 17.1% | 18.9% |
| 2013/14 | 🟢 | 386 | 17.4% | 15.9% | 19.1% | 17.2% | 19.1% |
| 2014/15 | 🟡 | 345 | 17.9% | 16.2% | 19.7% | 16.9% | 19.1% |
| 2015/16 | 🟡 | 460 | 19.8% | 18.3% | 21.5% | 17.6% | 19.8% |
| 2016/17 | 🔴 | 524 | 22.6% | 20.9% | 24.4% | 17.9% | 20.0% |
| 2017/18 | 🟡 | 544 | 20.7% | 19.2% | 22.3% | 17.9% | 20.1% |

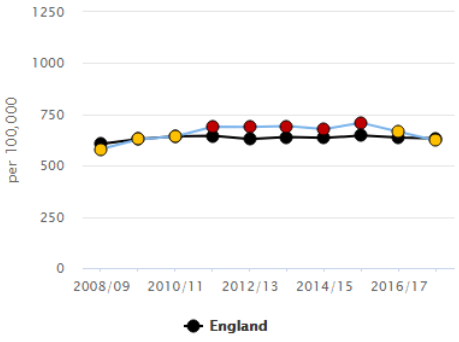
*Source: NHS Digital, National Child Measurement Programme*

**Source: Public Health Outcomes Framework**

In contrast to reception year obesity prevalence, year 6 data shows a worsening obesity trend in Peterborough. Although 2017/18 data show Peterborough's obesity prevalence of 20.7% has returned to be statistically similar to England, having been statistically significantly higher (worse) in 2016/17, prevalence has increased since the 2013/14 period, within which Peterborough was statistically significantly lower (better) than the national average with prevalence of 17.4%.

## 3.2 Health Behaviours & Lifestyles

**Figure 4: Admission episodes for alcohol-related conditions (narrow), persons, directly age-standardised rate per 100,000, 2008/09 – 2017/18**




**Recent trend:** –

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2008/09 | ● | 934 | 580 | 543 | 620 | 490 | 606 |
| 2009/10 | ● | 1,042 | 628 | 590 | 669 | 531 | 629 |
| 2010/11 | ● | 1,069 | 643 | 604 | 683 | 542 | 643 |
| 2011/12 | ● | 1,167 | 690 | 650 | 731 | 559 | 645 |
| 2012/13 | ● | 1,171 | 688 | 649 | 730 | 552 | 630 |
| 2013/14 | ● | 1,194 | 693 | 653 | 734 | 582 | 640 |
| 2014/15 | ● | 1,169 | 679 | 640 | 719 | 580 | 635 |
| 2015/16 | ● | 1,245 | 708 | 669 | 749 | 588 | 647 |
| 2016/17 | ● | 1,180 | 664 | 626 | 704 | 579 | 636 |
| 2017/18 | ● | 1,106 | 622 | 586 | 661 | 594 | 632 |

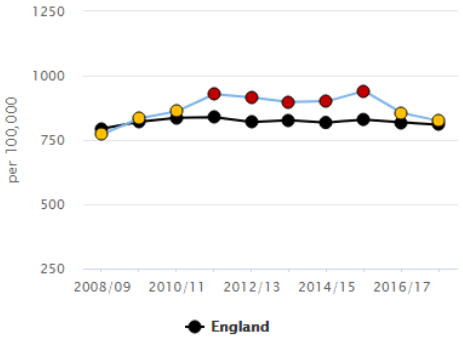
*Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.*

**Source: Local Alcohol Profiles for England**

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of health conditions. Alcohol misuse is estimated to cost the NHS approximately £3.5 billion per year and society as a whole approximately £21 billion[3].

The directly age-standardised rate of admission episodes for alcohol-related conditions (narrow, persons) in Peterborough is 622/100,000 in 2017/18 and has been statistically similar to England for two consecutive years. Between 2011/12 and 2015/16, Peterborough was statistically significantly worse than England for five consecutive years.

**Figure 5: Admission episodes for alcohol-related conditions (narrow), males, directly age-standardised rate per 100,000, 2008/09 – 2017/18**




**Recent trend:** –

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2008/09 | ● | 594 | 772 | 707 | 841 | 630 | 793 |
| 2009/10 | ● | 660 | 834 | 768 | 903 | 671 | 821 |
| 2010/11 | ● | 685 | 861 | 795 | 931 | 682 | 836 |
| 2011/12 | ● | 754 | 928 | 860 | 1,000 | 705 | 839 |
| 2012/13 | ● | 749 | 915 | 848 | 985 | 700 | 820 |
| 2013/14 | ● | 744 | 898 | 832 | 967 | 725 | 827 |
| 2014/15 | ● | 744 | 900 | 835 | 970 | 728 | 818 |
| 2015/16 | ● | 800 | 940 | 875 | 1,010 | 730 | 830 |
| 2016/17 | ● | 733 | 856 | 793 | 922 | 726 | 818 |
| 2017/18 | ● | 708 | 824 | 763 | 888 | 738 | 809 |

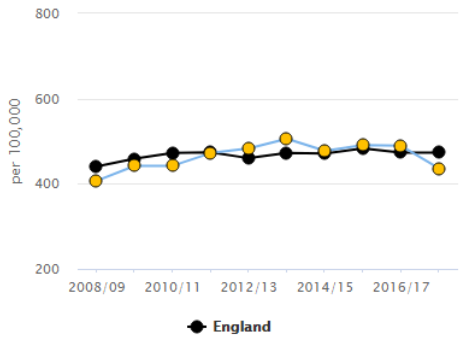
*Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.*

**Source: Local Alcohol Profiles for England**

As with the indicator for all persons, the directly age-standardised rate of admission episodes for alcohol-related conditions for males only has improved from being statistically significantly worse than England at the commencement of this Health & Wellbeing Strategy to now being statistically similar for two consecutive periods.

[3] https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/6/gid/1938132984/pat/6/par/E12000006/ati/102/are/E06000031/iid/91414/age/1/sex/4

**Figure 6: Admission episodes for alcohol-related conditions (narrow), females, directly age-standardised rate per 100,000, 2008/09 – 2017/18**




Recent trend: –

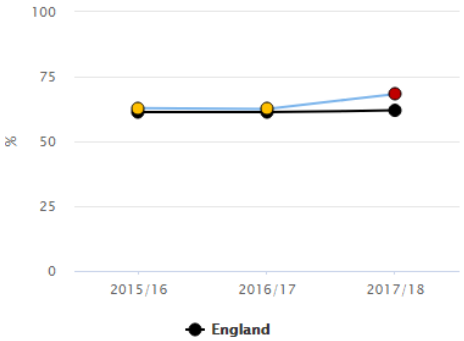
| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2008/09 | | 339 | 407 | 364 | 454 | 368 | 440 |
| 2009/10 | | 381 | 442 | 398 | 490 | 408 | 459 |
| 2010/11 | | 384 | 442 | 398 | 490 | 419 | 472 |
| 2011/12 | | 413 | 472 | 427 | 521 | 432 | 474 |
| 2012/13 | | 422 | 483 | 437 | 532 | 421 | 460 |
| 2013/14 | | 450 | 506 | 459 | 556 | 456 | 472 |
| 2014/15 | | 425 | 477 | 432 | 526 | 450 | 471 |
| 2015/16 | | 445 | 491 | 446 | 539 | 461 | 483 |
| 2016/17 | | 447 | 489 | 445 | 537 | 447 | 473 |
| 2017/18 | | 398 | 436 | 394 | 481 | 465 | 473 |

*Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.*

**Source: Local Alcohol Profiles for England**

The directly age-standardised rate of admission episodes for alcohol-related conditions for females has been statistically similar to the national average for each of the 10 years within the above figure.

**Figure 7: Percentage of adults (18+) classified as overweight or obese, 2015/16 – 2017/18**




Recent trend: –

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2015/16 | | - | 62.9% | 59.8% | 66.3% | 61.7% | 61.3% |
| 2016/17 | | - | 62.5% | 59.2% | 66.0% | 61.9% | 61.3% |
| 2017/18 | | - | 68.3% | 63.7% | 72.7% | 62.1% | 62.0% |

*Source: Public Health England (based on Active Lives survey, Sport England)*

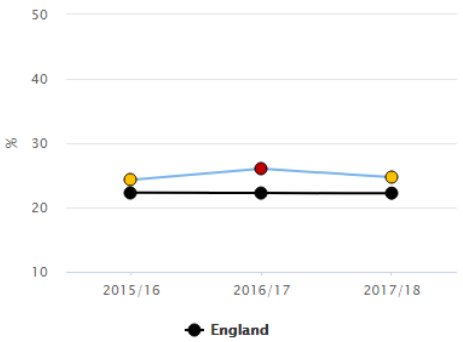
**Source: Public Health Outcomes Framework**

Adults are classified as overweight or obese if their body mass index (BMI) is greater than or equal to 25kg/m2. Being overweight or obese is recognised as a major determinant of premature mortality and avoidable ill health and it is therefore an aspiration of government at both local and national level to reduce observed levels of obesity[4].

Nationally, 62.0% of adults are classified as overweight or obese in 2017/18. In Peterborough, this proportion is statistically significantly higher (68.3%) and has increased by 5.8% between 2016/17 and 2017/18.

[4] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000006/ati/102/are/E06000031/iid/93088/age/168/sex/4

**Figure 8: Percentage of physically inactive adults (19+), 2015/16 – 2017/18**




Recent trend: –

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2015/16 | | - | 24.3% | 21.8% | 27.0% | 21.6% | 22.3% |
| 2016/17 | | - | 26.0% | 23.4% | 28.9% | 21.7% | 22.2% |
| 2017/18 | | - | 24.7% | 21.1% | 28.8% | 22.2% | 22.2% |

*Source: Public Health England (based on Active Lives, Sport England)*

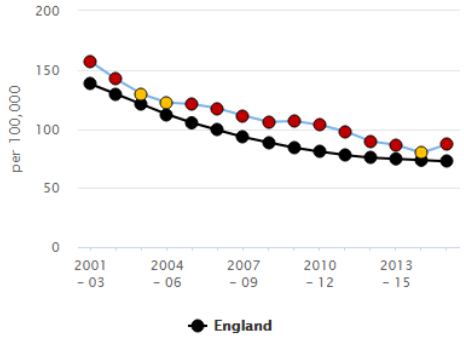
**Source: Public Health Outcomes Framework**

Adults (classified as those aged 19+ within this analysis) are considered physically inactive if they undertake fewer than 30 moderate intensity equivalent (MIE) minutes of physical activity per week. Physical inactivity is known to increase the risk of a number of conditions including cardiovascular disease, coronary heart disease, stroke, osteoporosis and colon/breast cancer, as well as increasing the likelihood of experiencing adverse mental health[5].

In Peterborough, the percentage of adults who are physically inactive has improved (reduced) from 26.0% in 2016/17 (statistically significantly worse than England) to 24.7% in 2017/18 which is now statistically similar to England.

## 3.3 Long Term Conditions & Premature Mortality

**Figure 9: Under 75 mortality rate from all cardiovascular diseases, persons, directly age-standardised rate per 100,000, 2001/03 – 2015/17**




Recent trend: –

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2001 - 03 | | 519 | 156.9 | 143.6 | 171.0 | 118.1 | 138.0 |
| 2002 - 04 | | 475 | 142.2 | 129.6 | 155.7 | 111.1 | 129.5 |
| 2003 - 05 | | 439 | 129.5 | 117.6 | 142.3 | 104.2 | 120.9 |
| 2004 - 06 | | 420 | 122.3 | 110.8 | 134.7 | 97.6 | 112.3 |
| 2005 - 07 | | 421 | 121.0 | 109.6 | 133.3 | 90.7 | 105.1 |
| 2006 - 08 | | 411 | 117.3 | 106.2 | 129.4 | 85.3 | 99.0 |
| 2007 - 09 | | 397 | 111.3 | 100.5 | 122.9 | 80.2 | 93.1 |
| 2008 - 10 | | 386 | 106.0 | 95.5 | 117.2 | 77.8 | 88.6 |
| 2009 - 11 | | 397 | 106.6 | 96.2 | 117.8 | 74.6 | 84.0 |
| 2010 - 12 | | 389 | 103.3 | 93.2 | 114.3 | 72.3 | 80.8 |
| 2011 - 13 | | 375 | 97.9 | 88.1 | 108.5 | 69.6 | 77.8 |
| 2012 - 14 | | 352 | 89.6 | 80.3 | 99.6 | 67.4 | 75.7 |
| 2013 - 15 | | 349 | 86.3 | 77.4 | 96.0 | 66.4 | 74.6 |
| 2014 - 16 | | 331 | 79.7 | 71.3 | 88.9 | 64.7 | 73.5 |
| 2015 - 17 | | 373 | 87.0 | 78.3 | 96.4 | 64.1 | 72.5 |

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

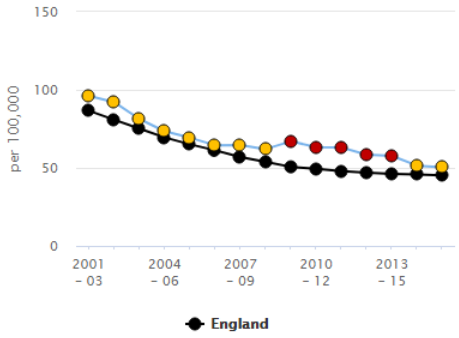
**Source: Public Health Outcomes Framework**

For all persons, the directly age-standardised under 75 mortality rate from all cardiovascular diseases in Peterborough increased to 87.0/100,000 in 2015-17 and has therefore returned to being

5 https://fingertips.phe.org.uk/search/physical%20activity#page/6/gid/1/pat/6/par/E12000006/ati/102/are/E06000031/iid/93015/age/298/sex/4

statistically significantly worse than England, as has been the case for 10 of the 11 pooled periods that cover the time period 2005-07 – 2015-17.

**Figure 10: Under 75 mortality rate from all cardiovascular diseases, females, directly age-standardised rate per 100,000, 2001/03 – 2015/17**




Recent trend: –

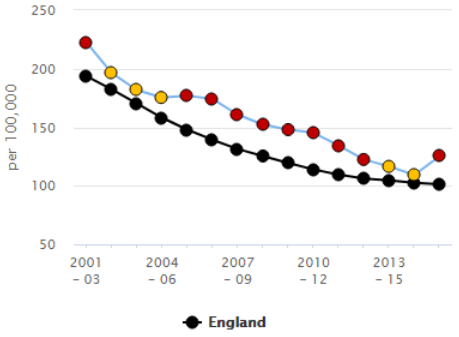
| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2001 - 03 | ● | 167 | 96.2 | 82.1 | 112.0 | 73.3 | 86.7 |
| 2002 - 04 | ● | 160 | 92.2 | 78.4 | 107.7 | 69.0 | 80.8 |
| 2003 - 05 | ● | 142 | 81.3 | 68.4 | 95.9 | 64.0 | 75.1 |
| 2004 - 06 | ● | 131 | 73.5 | 61.3 | 87.3 | 59.5 | 69.5 |
| 2005 - 07 | ● | 124 | 69.4 | 57.6 | 82.8 | 54.9 | 65.1 |
| 2006 - 08 | ● | 116 | 64.5 | 53.2 | 77.5 | 51.7 | 61.2 |
| 2007 - 09 | ● | 116 | 64.7 | 53.3 | 77.7 | 47.7 | 57.0 |
| 2008 - 10 | ● | 113 | 62.0 | 51.0 | 74.6 | 46.3 | 53.8 |
| 2009 - 11 | ● | 125 | 67.0 | 55.7 | 80.0 | 44.3 | 50.7 |
| 2010 - 12 | ● | 122 | 63.3 | 52.4 | 75.8 | 44.3 | 49.4 |
| 2011 - 13 | ● | 124 | 63.1 | 52.3 | 75.4 | 43.0 | 47.9 |
| 2012 - 14 | ● | 118 | 58.4 | 48.2 | 70.1 | 42.1 | 46.9 |
| 2013 - 15 | ● | 119 | 57.7 | 47.7 | 69.1 | 40.9 | 46.2 |
| 2014 - 16 | ● | 107 | 51.4 | 42.1 | 62.3 | 40.0 | 45.8 |
| 2015 - 17 | ● | 108 | 50.4 | 41.3 | 60.9 | 39.1 | 45.2 |

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

**Source: Public Health Outcomes Framework**

Over the course of this 2016-19 Health & Wellbeing Strategy, the directly age-standardised rate of mortality in females under 75 as a result of cardiovascular diseases has improved in Peterborough from statistically significantly worse than the national average to statistically similar in both 2014-16 and 2015-17.

**Figure 11: Under 75 mortality rate from all cardiovascular diseases, males, directly age-standardised rate per 100,000, 2001/03 – 2015/17**




Recent trend: –

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2001 - 03 | ● | 352 | 222.8 | 199.9 | 247.5 | 166.1 | 193.8 |
| 2002 - 04 | ● | 315 | 196.6 | 175.3 | 219.7 | 156.1 | 182.3 |
| 2003 - 05 | ● | 297 | 181.8 | 161.5 | 204.0 | 147.0 | 170.3 |
| 2004 - 06 | ● | 289 | 175.4 | 155.6 | 197.1 | 138.1 | 158.2 |
| 2005 - 07 | ● | 296 | 176.9 | 157.1 | 198.5 | 128.7 | 147.9 |
| 2006 - 08 | ● | 295 | 174.2 | 154.7 | 195.5 | 120.9 | 139.3 |
| 2007 - 09 | ● | 281 | 160.8 | 142.3 | 181.0 | 114.6 | 131.4 |
| 2008 - 10 | ● | 273 | 152.3 | 134.5 | 171.7 | 111.1 | 125.5 |
| 2009 - 11 | ● | 272 | 148.0 | 130.6 | 167.0 | 106.6 | 119.4 |
| 2010 - 12 | ● | 267 | 145.3 | 128.2 | 164.1 | 101.9 | 114.0 |
| 2011 - 13 | ● | 251 | 134.4 | 118.0 | 152.4 | 97.6 | 109.5 |
| 2012 - 14 | ● | 234 | 122.5 | 107.0 | 139.5 | 94.1 | 106.2 |
| 2013 - 15 | ● | 230 | 116.6 | 101.7 | 132.9 | 93.3 | 104.7 |
| 2014 - 16 | ● | 224 | 109.2 | 95.1 | 124.7 | 90.8 | 102.7 |
| 2015 - 17 | ● | 265 | 125.4 | 110.6 | 141.6 | 90.5 | 101.3 |

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

**Source: Public Health Outcomes Framework**

Among males, the directly age-standardised under 75 mortality rate from all cardiovascular diseases has worsened to 125.4/100,000 in 2015-17 and is now statistically significantly worse than the national average, having been statistically similar in 2013-15 and 2014-16.

**Figure 12: Key long term conditions & premature mortality indicators, Peterborough Health & Wellbeing Strategy 2016-19**

| Indicator Ref | Indicator | Peterborough Trend | Current Status |
|---|---|---|---|
| 3.4 | Inequalities between electoral wards in emergency CVD hospital admissions (disparity in directly standardised rate per 100,000) | ▶ | Disparity between most deprived 20% and least deprived 80% has increased between 2016/17 and 2017/18 but the difference is not statistically significant. Rate in most deprived 20% is 1,133.1/100,000, rate in least deprived 80% is 995.5/100,000 |
| 3.5 | Recorded Diabetes (proportion, %) | ▶ | Peterborough (8.7%) is statistically similar to England (8.5%). |
| 3.6a | The rate of hospital admissions for stroke (directly standardised rate per 100,000) | ▶ | 2017/18 rate has increased (now 191.5/100,000) but is statistically similar to 2016/17 rate (188.7/100,000). |
| 3.6b | The rate of hospital admissions for heart failure (directly standardised rate per 100,000) | ▶ | 2017/18 rate has increased (now 190.0/100,000) but is statistically similar to 2016/17 rate (149.4/100,000). |

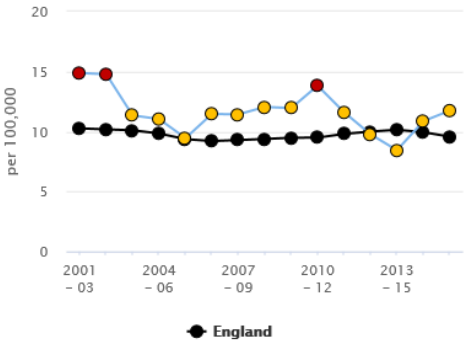
**Source: Hospital Episode Statistics & Public Health England**

Data for the four indicators within the table above show stable recent trends within Peterborough. For 2016/17, the directly age-standardised rate of emergency cardiovascular disease hospital admissions in the most deprived 20% of electoral wards in Peterborough is 1,133.1/100,000 compared to 995.5/1,000 in the least deprived 80% of electoral wards in Peterborough. This difference is not statistically significant. Directly age-standardised rates per 100,000 of emergency hospital admissions as a result of stroke and heart failure in Peterborough have stabilised in recent years, with no statistically significant trends observable with regards to rates for either indicator between the period 2015/16 and 2017/18.

8.7% of Peterborough residents registered with a GP practice aged 17+ have diabetes as per Quality Outcomes Framework data, similar to the national average of 8.5%. Prevalence in Peterborough has increased in line with a national rise over recent years.

## 3.4 Mental Health for Adults of Working Age

**Figure 13: Directly age-standardised rate of suicide per 100,000 population, 3 year pooled average, persons, 2001/03 – 2015/17**




Recent trend: –

| Period | | Count | Value | Lower CI | Upper CI | East of England | England |
|---|---|---|---|---|---|---|---|
| 2001 - 03 | ● | 60 | 14.9 | 11.3 | 19.2 | 9.6 | 10.3 |
| 2002 - 04 | ● | 58 | 14.8 | 11.1 | 19.2 | 9.6 | 10.2 |
| 2003 - 05 | ● | 46 | 11.3 | 8.2 | 15.2 | 9.3 | 10.1 |
| 2004 - 06 | ● | 46 | 11.0 | 8.0 | 14.8 | 9.1 | 9.8 |
| 2005 - 07 | ● | 43 | 9.4 | 6.8 | 12.8 | 8.8 | 9.4 |
| 2006 - 08 | ● | 53 | 11.5 | 8.5 | 15.1 | 9.0 | 9.2 |
| 2007 - 09 | ● | 53 | 11.4 | 8.5 | 15.0 | 8.9 | 9.3 |
| 2008 - 10 | ● | 55 | 12.0 | 9.0 | 15.8 | 8.9 | 9.4 |
| 2009 - 11 | ● | 55 | 12.0 | 8.9 | 15.6 | 8.8 | 9.5 |
| 2010 - 12 | ● | 65 | 13.8 | 10.6 | 17.7 | 8.9 | 9.5 |
| 2011 - 13 | ● | 56 | 11.6 | 8.7 | 15.1 | 8.9 | 9.8 |
| 2012 - 14 | ● | 48 | 9.8 | 7.2 | 13.0 | 9.0 | 10.0 |
| 2013 - 15 | ● | 42 | 8.4 | 6.0 | 11.5 | 9.3 | 10.1 |
| 2014 - 16 | ● | 54 | 10.9 | 8.1 | 14.2 | 9.7 | 9.9 |
| 2015 - 17 | ● | 59 | 11.7 | 8.9 | 15.2 | 9.3 | 9.6 |

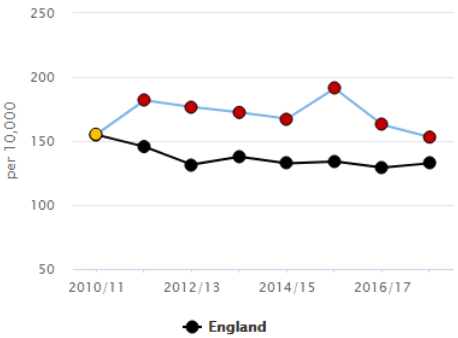
*Source: Public Health England (based on ONS source data)*

**Source: Public health England Suicide Prevention Profile**

Suicide is a leading cause of years of life lost, particularly for relatively young men. Suicide is often the end point of a complex history of risk factors and distressing events, but there are many ways in which services, communities, individuals and society as a whole can help to prevent suicides[6].

The 2015-17 directly age-standardised rate of suicide (all persons) in Peterborough is 11.7/100,000, statistically similar to the national average of 9.6/100,000. Peterborough was statistically significantly higher than England for this indicator as recently as 2010-12. However, although the Peterborough rate has been similar to England for each of the last four pooled periods for which data are available, the observed number of suicides has risen for each of the last two periods.

**Figure 14: Crude rate of hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years) per 10,000, 2010/11 – 2017/18**




Recent trend: →

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2010/11 | ● | 371 | 155.3 | 139.9 | 171.9 | 120.8 | 154.9 |
| 2011/12 | ● | 437 | 181.8 | 165.1 | 199.6 | 117.6 | 145.6 |
| 2012/13 | ● | 415 | 176.5 | 160.0 | 194.4 | 113.0 | 131.5 |
| 2013/14 | ● | 396 | 172.4 | 155.8 | 190.2 | 122.0 | 137.7 |
| 2014/15 | ● | 380 | 167.4 | 151.0 | 185.1 | 121.4 | 132.6 |
| 2015/16 | ● | 431 | 191.1 | 173.5 | 210.0 | 124.2 | 134.1 |
| 2016/17 | ● | 357 | 162.8 | 146.3 | 180.6 | 115.3 | 129.2 |
| 2017/18 | ● | 332 | 153.0 | 137.0 | 170.4 | 125.1 | 132.7 |

*Source: Hospital Episode Statistics (HES)*

**Source: Public health Outcomes Framework**

[6] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/6/gid/1938132828/pat/6/par/E12000006/ati/102/are/E06000031/iid/41001/age/285/sex/4

Injuries are a leading cause of hospitalisation and represent a major cause of premature mortality for children and young people. They are also a source of long term health issues, including mental health related to experiences[7].

The crude rate of hospital admissions caused by unintentional and deliberate injuries in 15-24 year olds in Peterborough has been statistically significantly higher (worse) than England for seven consecutive years and remains so for 2017/18.

**Figure 15: Crude rate of hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years) per 10,000, Peterborough & Nearest Socio-Economic Neighbours Comparison 2017-18**

| Area | Recent Trend | Neighbour Rank | Count | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|---|---|---|
| **England** | ↓ | - | 88,181 | 132.7 | 131.8 | 133.5 |
| Neighbours average | – | - | 6,050 | 140.0* | - | - |
| Coventry | ↓ | 15 | 715 | 111.9 | 103.9 | 120.4 |
| Derby | ↓ | 5 | 401 | 115.6 | 104.6 | 127.5 |
| Telford and Wrekin | ↓ | 6 | 260 | 120.0 | 105.9 | 135.5 |
| Thurrock | ↑ | 1 | 238 | 125.4 | 109.9 | 142.3 |
| Rochdale | ↓ | 7 | 336 | 129.2 | 115.8 | 143.8 |
| Blackburn with Darwen | ↓ | 11 | 245 | 129.7 | 113.9 | 147.0 |
| Bolton | → | 4 | 446 | 132.7 | 120.7 | 145.6 |
| Tameside | ↓ | 9 | 335 | 135.1 | 121.0 | 150.4 |
| Milton Keynes | ↓ | 2 | 382 | 138.0 | 124.5 | 152.5 |
| Oldham | ↓ | 8 | 399 | 138.3 | 125.0 | 152.5 |
| Bury | → | 14 | 300 | 146.3 | 130.2 | 163.9 |
| Calderdale | ↓ | 12 | 332 | 148.1 | 132.6 | 165.0 |
| Peterborough | → | - | 332 | 153.0 | 137.0 | 170.4 |
| Stockton-on-Tees | ↓ | 10 | 360 | 158.3 | 142.3 | 175.5 |
| Swindon | ↑ | 3 | 461 | 198.6 | 180.9 | 217.6 |
| Warrington | → | 13 | 508 | 225.4 | 206.2 | 245.9 |

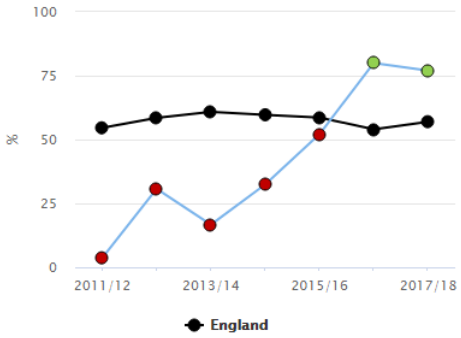
*Source: Hospital Episode Statistics (HES)*

**Source: Public health Outcomes Framework**

Peterborough is one of four local authorities within its Charted Institute of Public Finance and Accountancy (CIPFA) group of nearest-socioeconomic comparators to have a statistically significantly high crude rate of hospital admissions caused by unintentional and deliberate injuries in children and young people. Two areas have statistically significantly low crude rates and ten areas are statistically similar to England.

[7] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000006/ati/102/are/E06000031/iid/90285/age/156/sex/4

**Figure 16: Proportion of adults in contact with secondary mental health services who live in stable and appropriate accommodation, 2011/12 – 2017/18**




Recent trend: –

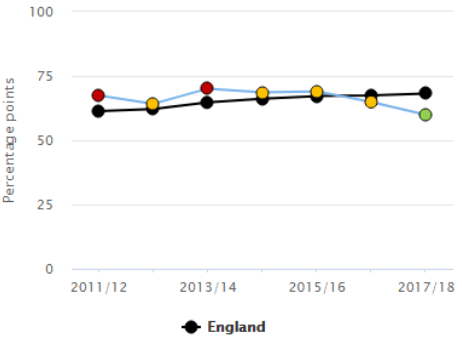
| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2011/12 | ● | - | 3.7% | 3.2% | 4.5% | 45.7% | 54.6% |
| 2012/13 | ● | - | 30.7% | 28.1% | 33.0% | 65.5% | 58.5% |
| 2013/14 | ● | - | 16.7% | 12.6% | 21.8% | 66.0% | 60.8% |
| 2014/15 | ● | - | 32.4% | 18.5% | 50.3% | 56.0% | 59.7% |
| 2015/16 | ● | - | 52.1% | 47.4% | 56.8% | 44.1% | 58.6% |
| 2016/17 | ● | - | 80.0%* | 75.3% | 84.0% | 43.0%* | 54.0%* |
| 2017/18 | ● | - | 77.0% | 72.1% | 81.3% | 56.0% | 57.0% |

*Source: NHS Digital. Measures from the Adult and Social Care Outcomes Framework, table 1H. (Resources)*

**Source: Public health Outcomes Framework**

The proportion of adults in contact with secondary mental health services who live in stable and appropriate accommodation is statistically significantly higher (better) than the national average in 2016/17 and 2017/18, having previously been statistically significantly lower (worse).

**Figure 17: Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate, 2011/12 – 2017/18**




Recent trend: –

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2011/12 | ● | - | 67.4 | 64.4 | 70.4 | 65.7 | 61.3 |
| 2012/13 | ● | - | 64.2 | 60.9 | 67.5 | 62.0 | 62.2 |
| 2013/14 | ● | - | 70.1 | 66.3 | 73.9 | 65.7 | 64.7 |
| 2014/15 | ● | - | 68.6 | 63.9 | 73.3 | 69.2 | 66.1 |
| 2015/16 | ● | - | 69.0 | 65.4 | 72.6 | 71.9 | 67.2 |
| 2016/17 | ● | - | 64.9* | 60.5 | 69.3 | 70.2* | 67.4* |
| 2017/18 | ● | - | 59.9 | 55.2 | 64.6 | 69.6 | 68.2 |

*Source: ONS Annual Population Survey and NHS Digital*

**Source: Public health Outcomes Framework**

In Peterborough, the gap in the employment rate for those in contact with secondary mental health services and the overall employment rate is 59.9 percentage points and therefore statistically significantly lower (better) than the national average of 68.2 percentage points.

**Figure 18: Annual Readmission within 28 days rate, Cambridgeshire & Peterborough NHS Foundation Trust, Peterborough residents, April 2016 – March 2019**

| Time Period | Readmissions | Discharges | % Readmissions | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|
| Apr 16 - Mar 17 | 54 | 457 | 11.8% | 9.2% | 15.1% |
| Apr 17 - Mar 18 | 53 | 375 | 14.1% | 11.0% | 18.0% |
| Apr 18 - Mar 19 | 39 | 397 | 9.8% | 7.3% | 13.1% |

**Source: Cambridgeshire & Peterborough NHS Foundation Trust**

Between April 2016 – March 2017 and April 2018 – March 2019, readmissions within 28 days to Cambridgeshire & Peterborough NHS Foundation Trust (CPFT) decreased numerically from 54 to 39, representing a reduction from 11.8% to 9.8% of all discharges for Peterborough residents.

## 3.5 Health & Wellbeing of People with Disability and/or Sensory Impairment

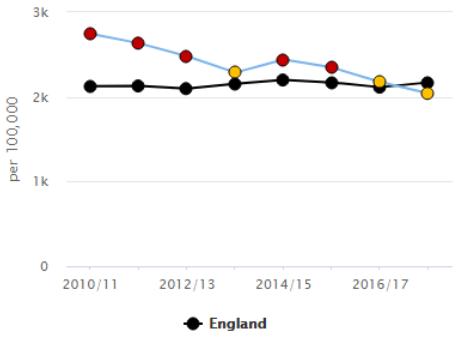
The majority of indicators within this section of the Health & Wellbeing Strategy come from the monthly data report prepared by Peterborough City Council's Adult Social Care/Business Intelligence teams, with some additional data sourced from the Adult Social Care Outcomes Framework (ASCOF).

**Key findings from these data sources to conclude the 2016-19 Peterborough Health & Wellbeing Strategy for indicators relating to health and wellbeing of people with disability and/or sensory improvement include:**

- An increase in the proportion of people who use adult social care services describing good levels of overall satisfaction with their care and support, from 65.8% in 2017/18 to 66.4% in 2018/19.
- The number of adults with social care needs receiving short term services to increase independence increased from 739 in 2017/18 to 881 in 2018/19 (+19.2%).
- The rate of clients receiving reablement services in Peterborough increased from 77.9/100,000 in 2017/18 to 97.3/100,000 in 2018/19.
- 81.2% of adults with learning disabilities live in their own home or with their family in Peterborough as per 2017/18 data, above the national average of 77.2%.
- The rate of long-term support needs of older adults (65+) met by admission to residential and nursing care homes in Peterborough is 441.8/100,000 for 2017/18, below the national average of 585.6/100,000.

## 3.6 Ageing Well

**Figure 19: Emergency hospital admissions due to falls in people aged 65 and over, directly age-standardised rate per 100,000, 2010/11 – 2017/18**




Recent trend: –

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2010/11 | ● | 678 | 2,746 | 2,540 | 2,964 | 1,886 | 2,126 |
| 2011/12 | ● | 680 | 2,634 | 2,438 | 2,842 | 1,917 | 2,128 |
| 2012/13 | ● | 648 | 2,480 | 2,291 | 2,681 | 1,973 | 2,097 |
| 2013/14 | ● | 619 | 2,287 | 2,109 | 2,476 | 2,025 | 2,154 |
| 2014/15 | ● | 665 | 2,440 | 2,256 | 2,634 | 2,026 | 2,199 |
| 2015/16 | ● | 663 | 2,348 | 2,171 | 2,535 | 1,989 | 2,169 |
| 2016/17 | ● | 628 | 2,176 | 2,008 | 2,355 | 1,974 | 2,114 |
| 2017/18 | ● | 602 | 2,041 | 1,880 | 2,212 | 2,026 | 2,170 |

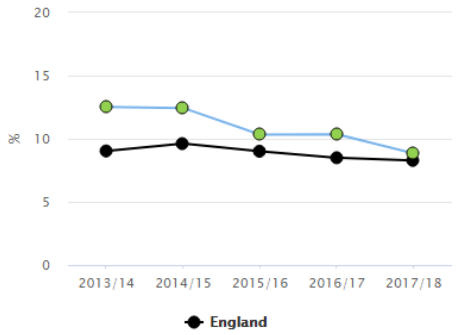
*Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2019, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England*

**Source: Public Health Outcomes Framework**

Falls are the largest cause of emergency hospital admissions for older people and significantly impact on long term outcomes (e.g. being a major precipitant of older people moving from their own home to long-term nursing or residential care).

The directly age-standardised rate of emergency hospital admissions due to falls in people aged 65 and over in Peterborough has improved to be statistically similar to that of England in both 2016/17 and 2017/18, having been statistically significantly higher (worse) in 2014/15 and 2015/16.

**Figure 20: Proportion of eligible population receiving an NHS Health Check per year, 2013/14 – 2017/18**




Recent trend: ↓

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2013/14 | ● | 6,042 | 12.5% | 12.2% | 12.8% | 10.4% | 9.0% |
| 2014/15 | ● | 6,104 | 12.4% | 12.2% | 12.7% | 10.8% | 9.6% |
| 2015/16 | ● | 5,153 | 10.3% | 10.1% | 10.6% | 9.9% | 9.0% |
| 2016/17 | ● | 5,232 | 10.4% | 10.1% | 10.6% | 9.7%* | 8.5% |
| 2017/18 | ● | 4,534 | 8.8% | 8.6% | 9.1% | 9.3%* | 8.3% |

*Source:*
*Public Health England*

**Source: Public Health England Health Check Dashboard**

The NHS health check programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40-74 who has not already been diagnosed with one of these conditions will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. A high take up of NHS health checks is important to identify early signs of poor health leading to opportunities for early interventions[8].

It is of note that the proportion of people receiving an NHS health check has been statistically significantly higher than the national average in each of the five years spanning the period 2013/14 – 2017/18, although there is an observed downward trend in Peterborough, with the 2017/18 proportion falling to 8.8%.

## 3.7 Protecting Health

**Figure 21: Screening & Immunisation Indicators, Peterborough Health & Wellbeing Strategy, 2016/17 & 2017/18 Comparison**

| PHOF Indicator Ref | Indicator | Benchmark Goal | Peterborough Value 2016/17 (%) | Peterborough Value 2017/18 (%) |
|---|---|---|---|---|
| 3.03iii | Dtap/IPC/Hib (1 year old) | >95.0% | 93.7 | 91.9 |
| 3.03iii | Dtap/IPC/Hib (2 years old) | >95.0% | 96.0 | 94.7 |
| 3.03v | PCV | >95.0% | 93.4 | 91.6 |
| 3.03vi | Hib/MenC Booster (2 years old) | >95.0% | 90.7 | 89.9 |
| 3.03vi | Hib/MenC Booster (5 years old) | >95.0% | 89.6 | 90.4 |
| 3.03vii | PCV Booster | >95.0% | 90.7 | 90.0* |
| 3.03viii | MMR for One Dose (2 years old) | >95.0% | 91.1 | 90.0** |
| 3.03ix | MMR for One Dose (5 years old) | >95.0% | 95.6 | 95.0 |
| 3.03x | MMR for Two Doses (5 years old) | >95.0% | 89.6 | 88.6 |
| 3.03xiii | PPV | >75.0% | 72.3 | 71.5 |

**Source: Public Health Outcomes Framework (PHOF)**

[8] https://fingertips.phe.org.uk/profile/nhs-health-check-detailed/data#page/6/gid/1938132726/pat/6/par/E12000006/ati/102/are/E06000031/iid/91040/age/219/sex/4

| Key: |
|---|
| Above upper national benchmark goal |
| Meeting minimum national benchmark but not above upper national benchmark goal |
| Below minimum national benchmark |

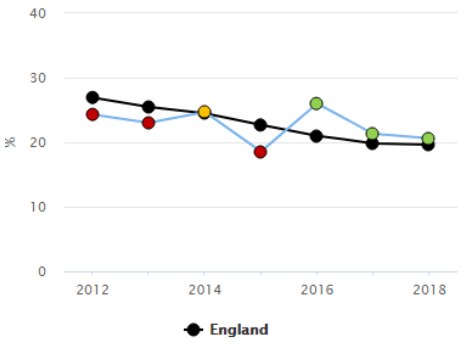
*Value is red as rounded from 89.9.

**Value is amber as rounded from 90.03.

For all indicators within the table above with the exception of PPV, the benchmark goal is 95.0% (represented by green shading in the above table). Values between 90.0% and 95.0% are shaded yellow and values below 90.0% are considered significantly below benchmark and shaded red. These thresholds are based on World Health Organisation guidance which states a requirement of 95.0% to ensure control of vaccine preventable diseases within the UK, with at least 90.0% coverage in each geo-political unit. The exception is the PPV vaccine, for which only adults aged 65+ are eligible and therefore a 75.0% benchmark value is considered appropriate[9].

2017/18 data show that Peterborough is now below benchmark goal for three indicators – Hib/MenC Booster (2 years old), PCV Booster and MMR for two doses (5 years old) and the Peterborough value for Dtap/IPC/Hib (2 years old) has fallen from above benchmark goal (96.0%) to 94.7%.

**Figure 22: Proportion of 15-24 year olds screened for chlamydia, (%), 2012 - 2018**




Recent trend: ↓

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2012 | ● | 5,705 | 24.3% | 23.7% | 24.9% | 22.8% | 26.9% |
| 2013 | ● | 5,304 | 23.0% | 22.4% | 23.6% | 22.0% | 25.5% |
| 2014 | ● | 5,620 | 24.7% | 24.0% | 25.3% | 21.0% | 24.5% |
| 2015 | ● | 4,222 | 18.6% | 18.0% | 19.1% | 19.0% | 22.7% |
| 2016 | ● | 5,713 | 26.0% | 25.4% | 26.7% | 16.9% | 21.0% |
| 2017 | ● | 4,625 | 21.3% | 20.7% | 21.9% | 17.1% | 19.8% |
| 2018 | ● | 4,470 | 20.6% | 20.0% | 21.2% | 17.9% | 19.6% |

*Source: Public Health England*

**Source: Public Health England Sexual & Reproductive Health Profiles**

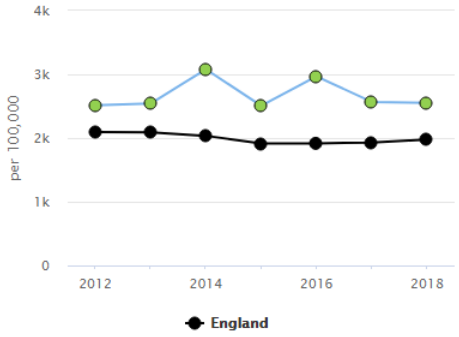
Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill-health, including symptomatic acute infections and complications such as pelvic inflammatory disease, ectopic pregnancy and tubal-factor infertility. The National Chlamydia Screening Programme recommends screening for all sexually active young people under 25 annually or on change of partner (whichever is more frequent).[10]

20.6% of 15-24 year olds in Peterborough were screened for chlamydia in 2018, statistically significantly higher than the England value of 19.6%. Peterborough has now been statistically significantly above (better than) England for three consecutive years for this indicator.

[9] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000043/pat/6/par/E12000006/ati/102/are/E06000031/iid/30301/age/30/sex/4

[10] https://fingertips.phe.org.uk/profile/sexualhealth/data#page/6/gid/8000057/pat/6/par/E12000006/ati/102/are/E06000031/iid/90776/age/156/sex/4

**Figure 23: Chlamydia detection rate (15-24 year olds), crude rate per 100,000, 2012 - 2018**




Recent trend: ➡

*Benchmarking against goal:* <1900 | 1900 to <2300 | ≥2300

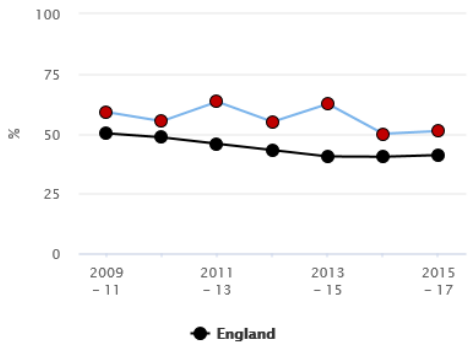
| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2012 | ● | 590 | 2,514 | 2,315 | 2,726 | 1,653 | 2,095 |
| 2013 | ● | 586 | 2,541 | 2,340 | 2,756 | 1,691 | 2,088 |
| 2014 | ● | 701 | 3,080 | 2,856 | 3,316 | 1,591 | 2,035 |
| 2015 | ● | 570 | 2,506 | 2,305 | 2,721 | 1,495 | 1,914 |
| 2016 | ● | 651 | 2,968 | 2,744 | 3,205 | 1,408 | 1,917 |
| 2017 | ● | 557 | 2,568 | 2,359 | 2,790 | 1,526 | 1,929 |
| 2018 | ● | 554 | 2,554 | 2,345 | 2,775 | 1,589 | 1,975 |

*Source: Public Health England*

**Source: Public Health England Sexual & Reproductive Health Profiles**

The chlamydia detection rate among 15-24 year olds in Peterborough remains above national benchmark goal of 2,300/100,000 in 2017 and has been above benchmark goal for seven consecutive years.

**Figure 24: HIV late diagnosis, proportion (%), 2009/11 – 2015/17**




Recent trend: –

*Benchmarking against goal:* <25% | 25% to 50% | ≥50%

| Period | | Count | Value | Lower CI | Upper CI | East of England | England |
|---|---|---|---|---|---|---|---|
| 2009 - 11 | ● | 26 | 59.1 | 43.2 | 73.7 | 53.3 | 50.2 |
| 2010 - 12 | ● | 21 | 55.3 | 38.3 | 71.4 | 51.2 | 48.5 |
| 2011 - 13 | ● | 26 | 63.4 | 46.9 | 77.9 | 51.8 | 45.8 |
| 2012 - 14 | ● | 22 | 55.0 | 38.5 | 70.7 | 52.5 | 43.2 |
| 2013 - 15 | ● | 25 | 62.5 | 45.8 | 77.3 | 51.1 | 40.5 |
| 2014 - 16 | ● | 22 | 50.0 | 34.6 | 65.4 | 47.6 | 40.4 |
| 2015 - 17 | ● | 22 | 51.2 | 35.5 | 66.7 | 47.1 | 41.1 |

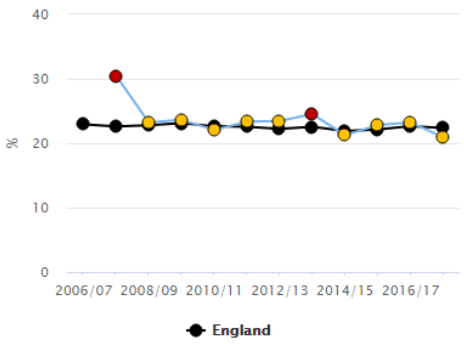
*Source: Public Health England*

**Source: Public Health England Sexual & Reproductive Health Profiles**

The national benchmark value for HIV late diagnosis (defined as diagnosis of HIV when patient has a CD4 count of less than 350 cells per mm3) is <25.0%. The Peterborough value for 2015-17 is 51.2%, worse than benchmark goal for the seventh consecutive period.

## 3.8 Growth, Health & the Local Plan

**Figure 25: National Child Measurement Programme – excess weight in 4-5 year olds, 2005/07 – 2017/18**




Recent trend: ⬇

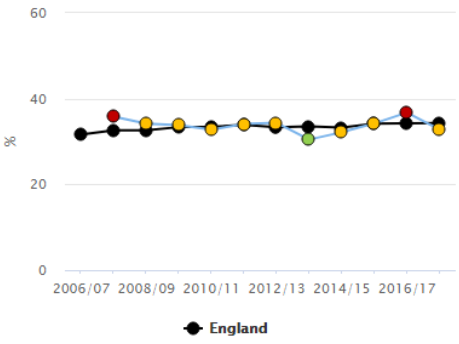
| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2006/07 | | - | * | - | - | * | 22.9% |
| 2007/08 | ● | 594 | 30.5% | 28.5% | 32.5% | 22.5%* | 22.6% |
| 2008/09 | ● | 496 | 23.2% | 21.4% | 25.0% | 21.8% | 22.8% |
| 2009/10 | ● | 518 | 23.6% | 21.9% | 25.4% | 22.6% | 23.1% |
| 2010/11 | ● | 500 | 22.0% | 20.4% | 23.8% | 22.1% | 22.6% |
| 2011/12 | ● | 569 | 23.4% | 21.7% | 25.1% | 21.9% | 22.6% |
| 2012/13 | ● | 625 | 23.5% | 21.9% | 25.1% | 21.1% | 22.2% |
| 2013/14 | ● | 710 | 24.5% | 23.0% | 26.1% | 21.5% | 22.5% |
| 2014/15 | ● | 578 | 21.3% | 19.8% | 22.8% | 20.7% | 21.9% |
| 2015/16 | ● | 632 | 22.8% | 21.3% | 24.4% | 20.9% | 22.1% |
| 2016/17 | ● | 603 | 23.2% | 21.6% | 24.9% | 21.1% | 22.6% |
| 2017/18 | ● | 610 | 20.9% | 19.5% | 22.4% | 20.6% | 22.4% |

*Source: NHS Digital, National Child Measurement Programme*

**Source: NCMP Local Authority Profile**

In 2017/18, 20.9% of 4-5 year olds in Peterborough had excess weight (defined as having a BMI on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex), similar to the national average of 22.4%. The long term trend for this indicator shows a general decrease in proportion of 4-5 year olds with excess weight in Peterborough.

**Figure 26: National Child Measurement Programme – excess weight in 10-11 year olds, 2006/07 – 2017/18**




Recent trend: ➡

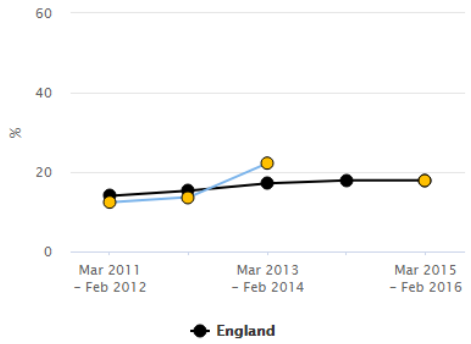
| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2006/07 | | - | * | - | - | * | 31.7% |
| 2007/08 | ● | 511 | 35.8% | 33.4% | 38.3% | 30.9%* | 32.6% |
| 2008/09 | ● | 651 | 34.2% | 32.1% | 36.4% | 30.7% | 32.6% |
| 2009/10 | ● | 669 | 33.8% | 31.8% | 36.0% | 31.4% | 33.4% |
| 2010/11 | ● | 647 | 32.8% | 30.7% | 34.9% | 31.7% | 33.4% |
| 2011/12 | ● | 690 | 34.1% | 32.0% | 36.2% | 31.7% | 33.9% |
| 2012/13 | ● | 712 | 34.4% | 32.3% | 36.4% | 31.0% | 33.3% |
| 2013/14 | ● | 675 | 30.5% | 28.6% | 32.4% | 31.1% | 33.5% |
| 2014/15 | ● | 620 | 32.2% | 30.1% | 34.3% | 30.7% | 33.2% |
| 2015/16 | ● | 794 | 34.2% | 32.3% | 36.2% | 31.7% | 34.2% |
| 2016/17 | ● | 852 | 36.8% | 34.8% | 38.7% | 31.5% | 34.2% |
| 2017/18 | ● | 860 | 32.8% | 31.0% | 34.6% | 31.7% | 34.3% |

*Source: NHS Digital, National Child Measurement Programme*

**Source: NCMP Local Authority Profile**

The proportion of 10/11 year olds in Peterborough with excess weight has varied substantially in comparison to England in recent years. For 2017/18, the Peterborough proportion fell from 36.8% to 32.8% is therefore statistically similar to the national average of 34.3%.

**Figure 27: Utilisation of outdoor space for exercise/health reasons, proportion (%), Mar 11/Feb 12 – Mar 15/Feb 16**




Recent trend: –

| Period | | Count | Value | Lower CI | Upper CI | East of England | England |
|---|---|---|---|---|---|---|---|
| Mar 2011 - Feb 2012 | ● | - | 12.4 | 6.5 | 18.3 | 16.3 | 14.0 |
| Mar 2012 - Feb 2013 | ● | - | 13.7 | 7.2 | 20.1 | 15.5 | 15.3 |
| Mar 2013 - Feb 2014 | ● | - | 22.2 | 12.8 | 31.7 | 18.7 | 17.1 |
| Mar 2014 - Feb 2015 | | - | * | - | - | 17.8 | 17.9 |
| Mar 2015 - Feb 2016 | ● | - | 17.8 | 11.2 | 24.4 | 18.7 | 17.9 |

*Source: Natural England: Monitor of Engagement with the Natural Environment (MENE) survey*

**Source: Public Health Outcomes Framework**

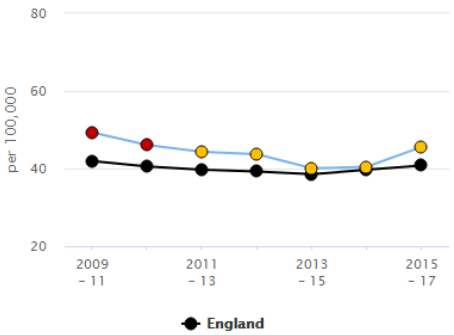
For the period March 2015 – February 2016, Peterborough has a statistically similar percentage of residents aged 16+ utilising outdoor space for exercise/health reasons to England. Data are unavailable for March 2014 – February 2015, but Peterborough has been similar to England for each of the four data periods for which data are available.

## 3.9 Health & Transport Planning

**Peterborough businesses with travel plans:**

The original target for the number of businesses in Peterborough with travel plans was set at 60 at the commencement of the 2016-19 Peterborough Health & Wellbeing Strategy. 69 businesses in the area have travel plans as of March 2019, 15.0% above target.

**Figure 28: Killed and seriously injured (KSI) casualties, crude rate per 100,000, 2009/11 – 2015/17**




Recent trend: –

| Period | | Peterborough | | | | East of England region | England |
|---|---|---|---|---|---|---|---|
| | | Count | Value | Lower CI | Upper CI | | |
| 2009 - 11 | ● | 269 | 49.3 | 43.6 | 55.6 | 44.1 | 41.9 |
| 2010 - 12 | ● | 255 | 46.1 | 40.6 | 52.1 | 42.2 | 40.5 |
| 2011 - 13 | ● | 248 | 44.3 | 39.0 | 50.2 | 40.9 | 39.7 |
| 2012 - 14 | ● | 247 | 43.7 | 38.4 | 49.5 | 40.5 | 39.3 |
| 2013 - 15 | ● | 229 | 40.1 | 35.0 | 45.6 | 39.6 | 38.5 |
| 2014 - 16 | ● | 235 | 40.4 | 35.4 | 46.0 | 42.4 | 39.7 |
| 2015 - 17 | ● | 269 | 45.6 | 40.3 | 51.4 | 44.3 | 40.8 |

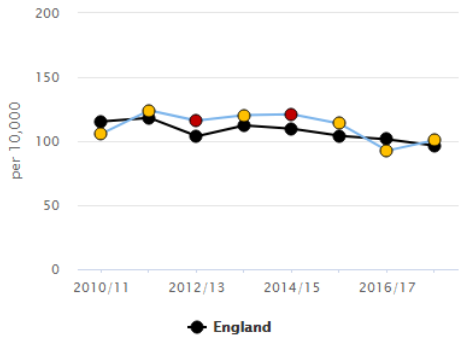
*Source: Department for Transport*

**Source: Public Health Outcomes Framework**

The crude rate of killed and seriously injured (KSI) casualties in Peterborough is 45.6/100,000 for 2015-17, statistically similar to the national average of 40.8/100,000. Of note, however, is an observed increase of 34 incidents between 2014-16 and 2015-17.

## 3.10 Housing & Health

**Figure 29: Hospital admissions caused by injuries in children aged 0-14 years, crude rate per 10,000, 2010/11 – 2017/18**




Recent trend: ⬇

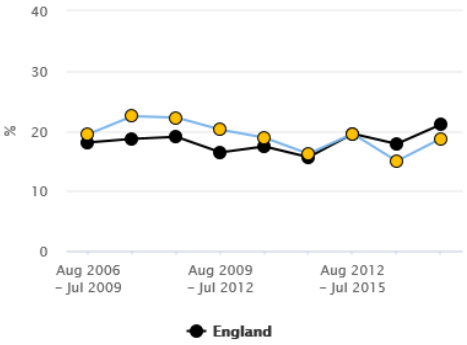
| Period | | Peterborough Count | Value | Lower CI | Upper CI | East of England region | England |
|---|---|---|---|---|---|---|---|
| 2010/11 | ● | 384 | 105.8 | 95.4 | 116.9 | 96.7 | 115.2 |
| 2011/12 | ● | 457 | 124.0 | 112.9 | 135.9 | 108.7 | 118.3 |
| 2012/13 | ● | 439 | 115.9 | 105.3 | 127.3 | 91.4 | 103.9 |
| 2013/14 | ● | 465 | 120.2 | 109.5 | 131.6 | 100.2 | 112.2 |
| 2014/15 | ● | 480 | 120.9 | 110.3 | 132.2 | 99.0 | 109.6 |
| 2015/16 | ● | 464 | 113.7 | 103.6 | 124.5 | 91.6 | 104.2 |
| 2016/17 | ● | 390 | 92.6 | 83.6 | 102.2 | 87.0 | 101.5 |
| 2017/18 | ● | 435 | 100.7 | 91.4 | 110.6 | 85.9 | 96.4 |

*Source: Hospital Episode Statistics (HES)*

**Source: Public Health Outcomes Framework**

Recent trend data shows a statistically significant reduction in hospital admissions caused by injuries in children aged 0-14 years in Peterborough. The rate within Peterborough for this indicator has been similar to that of England for three consecutive years, having been statistically significantly worse in 2012/13 and 2014/15.

**Figure 30: Excess winter deaths index, 3 years, all ages, ratio, Aug 06/Jul 09 – Aug 14/Jul 17**




Recent trend: –

| Period | | Count | Value | Lower CI | Upper CI | East of England | England |
|---|---|---|---|---|---|---|---|
| Aug 2006 - Jul 2009 | ● | 258 | 19.5 | 12.3 | 27.2 | 18.6 | 18.1 |
| Aug 2007 - Jul 2010 | ● | 294 | 22.5 | 15.1 | 30.3 | 19.2 | 18.7 |
| Aug 2008 - Jul 2011 | ● | 293 | 22.3 | 14.9 | 30.1 | 18.9 | 19.0 |
| Aug 2009 - Jul 2012 | ● | 272 | 20.2 | 13.0 | 27.9 | 17.0 | 16.4 |
| Aug 2010 - Jul 2013 | ● | 257 | 18.9 | 11.8 | 26.4 | 17.7 | 17.4 |
| Aug 2011 - Jul 2014 | ● | 221 | 16.2 | 9.2 | 23.6 | 15.8 | 15.6 |
| Aug 2012 - Jul 2015 | ● | 268 | 19.6 | 12.5 | 27.1 | 19.5 | 19.6 |
| Aug 2013 - Jul 2016 | ● | 212 | 15.0 | 8.2 | 22.2 | 17.3 | 17.9 |
| Aug 2014 - Jul 2017 | ● | 277 | 18.7 | 11.9 | 26.0 | 21.9 | 21.1 |

*Source: Office for National Statistics: Public Health England Annual Births and Mortality Extracts*

**Source: Public Health Outcomes Framework**

Excess winter deaths are defined as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths.[11] The Peterborough excess winter deaths index is statistically similar to the national average.

[11] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000044/pat/6/par/E12000006/ati/102/are/E06000031/iid/90641/age/1/sex/4

## 3.11 Geographical Health Inequalities

**Figure 31: Directly age-standardised rate of emergency hospital admissions, all causes, most deprived 20% of electoral wards in Peterborough, 2014-15 – 2016-17**

| Time Period | Number of episodes | Directly Age-Standardised Rate per 1,000 | Lower Confidence Interval | Upper Confidence Interval |
|---|---|---|---|---|
| 2014-15 | 5,800 | 117.3 | 114.1 | 120.5 |
| 2015-16 | 6,256 | 126.3 | 123.0 | 129.7 |
| 2016-17 | 5,670 | 113.9 | 110.8 | 117.0 |
| 2017-18 | 5,745 | 118.6 | 115.4 | 121.9 |

**Source: Hospital Episode Statistics**

It is a stated goal of the 2016-19 Health & Wellbeing Strategy to reduce emergency hospital admissions in the most deprived electoral wards in Peterborough (Bretton, Central, Dogsthorpe, North & Orton Longueville). The directly age-standardised rate of emergency hospital admissions per 1,000 within these electoral wards is 118.6/1,000 in 2017-18, which is a statistically similar to the rate observed in 2014-15 (117.3/1,000). Rates have stayed relatively stable over the course of this strategy period.

**Figure 32: Life expectancy trend, persons, 20% most deprived and 80% least deprived electoral wards in Peterborough, 2007-11 - 2013-17**

| Peterborough Electoral Ward Cluster | 2007-11 | 2008-12 | 2009-13 | 2010-14 | 2011-15 | 2012-16 | 2013-17 |
|---|---|---|---|---|---|---|---|
| 20% most deprived | 78.6 | 79.1 | 79.1 | 79.1 | 79.2 | 79.1 | 78.9 |
| 80% least deprived | 80.1 | 80.4 | 80.6 | 80.7 | 80.8 | 80.9 | 81.0 |
| Disparity between 20% most deprived and 80% least deprived | 1.5 | 1.3 | 1.5 | 1.6 | 1.6 | 1.8 | 2.1 |

**Source: Peterborough City Council & Cambridgeshire County Council Public Health Intelligence**

Life expectancy within the least deprived 80% of electoral wards within Peterborough has increased at a relatively steady level since 2007-11 and stands at 81.0 years for 2013-17. However, life expectancy in the most deprived 20% of Peterborough electoral wards has not increased at the same rate over this period and has fallen between 2012-16 and 2013-17 from 79.1 to 78.9 years. The Health & Wellbeing Strategy 2016-19 includes a goal to reduce the disparity in life expectancy between the most deprived 20% and least deprived 80% in Peterborough, whereas between 2007-11 and 2013-17 this disparity has increased from 1.5 to 2.1 years.

**Figure 33: GCSE attainment, Deprivation Quintile Comparison, 2017-18**

| Deprivation Quintile | Pupils Achieving English & Maths 9-5 | Total Pupils | % English & Maths 9-5 |
|---|---|---|---|
| 5 (Least Deprived) | 89 | 166 | 53.6 |
| 4 | 203 | 370 | 54.9 |
| 3 | 153 | 371 | 41.2 |
| 2 | 195 | 715 | 27.3 |
| 1 (Most Deprived) | 178 | 677 | 26.3 |
| Least Deprived 80% | 640 | 1,622 | 39.5 |
| All Pupils | 818 | 2,305 | 35.5 |

**Source: Department for Education**

Previously, the 2016-19 Health & Wellbeing strategy measured percentages of pupils attaining 5+ GCSEs at grades A*-C, whereas under the new GCSE system this indicator measures percentages achieving grade 5+ in both English and Mathematics. 26.3% of pupils within the most deprived quintile of Peterborough achieved grade 5+ in both English and Mathematics, which is statistically significantly lower than the overall Peterborough percentage of 35.5%. The cumulative percentage of attainment for this indicator within the most deprived two quintiles is 26.8% which is also statistically significantly lower than the Peterborough average and illustrates the high levels of disparity in outcome between the most and least affluent areas of Peterborough with regards to this indicator.

## 3.12 Health & Wellbeing of Diverse Communities

Work is in progress to take forward the recommendations from the Diverse Ethnic Communities Joint Strategic Needs Assessment which was completed in October 2016. This includes projects to produce and promote health and wellbeing information for diverse ethnic communities. A Video Communication project is underway with two pilot videos recently produced. These pilot videos have been created using animations and provide information about registering with a GP, out of hours services and accessing dental care as well as maternity services. The videos are being produced in English, Lithuanian, Latvian and Romanian in the first instance and will provide links to local resources in both Peterborough and Fenland. Further videos are being scoped to cover a range of topics.

A supplementary section to the diverse ethnic Communities JSNA which covers the needs of the South Asian community in Peterborough has been completed, including analysis of a health and wellbeing survey of the South Asian community to inform this supplementary section.

Additionally, a drive to improve data collection on ethnicity, particularly the recording of Eastern European ethnicities is being discussed. This is a challenging area as there are inconsistencies across the healthcare system on data recording by ethnicity.

**Report prepared by:**

**Ryan O'Neill**

**Advanced Public Health Analyst**

**Peterborough City Council**

APPENDIX A

# Appendix 1: Full Peterborough City Council 2016 – 19 Health & Wellbeing Board Dashboards – June 2019

## 1. Children & Young People's Health

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Current Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 1.1a | CAMH - Number of Children & Young People commencing treatment in NHS-funded community services | - | Indicator only currently available at national/regional level | - | - | - | - | - | - |
| 1.1b | CAMH - Proportion of Children & Young People with an eating disorder receiving treatment within 4 weeks (routine) and 1 week (urgent) | - | Indicator only currently available at national/regional level | - | - | - | - | - | - |
| 1.1c | CAMH - Proportion of Children & Young People showing reliable improvement in outcomes following treatment | - | Indicator only currently available at national/regional level | - | - | - | - | - | - |
| 1.1d | CAMH - Total bed days in CAMHS tier 4 per CYP population/total CYP in adult in-patient wards/paediatric wards | - | Indicator only currently available at national/regional level | - | - | - | - | - | - |
| 1.2 | Prevalence of obesity - reception year (proportion, %) | ▶ | Statistically similar to England | 2017-18 | 253 | 8.7% | 9.5% | 231 | 8.9% |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Current Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 1.3 | Prevalence of obesity - year 6 (proportion, %) | ▼ | Statistically similar to England | 2017-18 | 544 | 20.7% | 20.1% | 524 | 22.6% |
| 1.4 | Number of young people Not in Education, Employment or Training (NEET) (Proportion, %) | ▼ | Peterborough value has reduced for most recent data period (to April 2019) but is higher than national average | Apr-19 | 281 | 6.1% | 5.2% | 310 | 6.6% |
| 1.5 | Successful implementation of a multi-agency neglect strategy resulting in increased early intervention to prevent such patterns becoming entrenched | - | Local Safeguarding Children Boards (LSCBs) have monitored implementation of the neglect strategy through quality assurance activity including audits and surveys. Scrutiny is on-going and will continue to be measured by the LSCBs | - | - | - | - | - | - |
| 1.6 | Under 18 conceptions (crude rate per 1,000) | ▼ | Statistically similar to England | 2017 | 74 | 22.4% | 17.8% | 99 | 29.8% |
| 1.7 | Under 16 conceptions (crude rate per 1,000) | ▼ | Statistically similar to England | 2017 | 7 | 2.1% | 2.7% | 19 | 5.9% |

## 2. Health Behaviours & Lifestyles

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 2.1 | Smoking Prevalence - All (proportion, %) | ▶ | Statistically similar to England | 2017 | 26,226 | 17.6% | 14.9% | 26,043 | 17.6% |
| 2.2 | Smoking Prevalence - Routine & Manual Occupations (proportion, %) | ▶ | Statistically similar to England | 2017 | - | 28.5% | 25.7% | - | 27.9% |
| 2.3 | Excess weight in adults (proportion, %) | ▲ | Statistically significantly worse than England | 2017-18 | - | 68.3% | 62.0% | - | 62.5% |
| 2.4a | Physically active adults (proportion, %) | ▶ | Statistically significantly worse than England | 2017-18 | - | 61.7% | 66.3% | - | 61.1% |
| 2.4b | Physically inactive adults (proportion, %) | ▼ | Statistically similar to England | 2017-18 | - | 24.7% | 22.2% | - | 26.0% |
| 2.5 | The numbers of attendances to sport and physical activities provided by Vivacity (observed numbers) | ▼ | Reduction of 5.4% between 2017-18 and 2018-19 - although this decline is also observed nationally | 2018-19 | 1,356,681 | - | - | 1,434,135 | - |
| 2.6 | Admission episodes for alcohol-related conditions - Persons (directly standardised rate per 100,000) | ▶ | Statistically similar to England | 2017-18 | 1,106 | 622 | 632 | 1,180 | 664 |
| 2.7 | Admission episodes for alcohol-related conditions - Males (directly standardised rate per 100,000) | ▶ | Statistically similar to England | 2017-18 | 708 | 824 | 809 | 733 | 856 |
| 2.8 | Admission episodes for alcohol-related conditions - Females (directly standardised rate per 100,000) | ▶ | Statistically similar to England | 2017-18 | 398 | 436 | 447 | 489 | 473 |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 2.9 | The annual incidence of newly diagnosed type 2 diabetes (observed numbers) | - | Awaiting provision from CCG | - | - | - | - | - | - |

## 3. Long Term Conditions & Premature Mortality

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 3.1 | Under 75 mortality rate from all cardiovascular diseases - Persons (directly standardised rate per 100,000) | ▲ | Statistically significantly worse than England | 2015-17 | 373 | 87.0 | 72.5 | 331 | 79.7 |
| 3.2 | Under 75 mortality rate from all cardiovascular diseases - Males (directly standardised rate per 100,000) | ▲ | Statistically significantly worse than England | 2015-17 | 265 | 125.4 | 101.3 | 224 | 109.2 |
| 3.3 | Under 75 mortality rate from all cardiovascular diseases - Females (directly standardised rate per 100,000) | ▶ | Statistically similar to England | 2015-17 | 108 | 50.4 | 45.2 | 107 | 51.4 |
| 3.4 | Inequalities between electoral wards in emergency CVD hospital admissions (disparity in directly standardised rate per 100,000) | ▶ | Disparity between most deprived 20% and least deprived 80% has increased between 2016/17 and 2017/18 but the difference is not statistically significant. Rate in most deprived 20% is | 2017-18 | - | 137.6/100,000 | - | - | 106.2/100,000 |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| | | | 1,133.1/100,000, rate in least deprived 80% is 995.5/100,000 | | | | | | |
| 3.5 | Diabetes prevalence (Quality Outcomes Framework) | ▶ | Statistically similar to England | 2017-18 | 11,356 | 6.9% | 6.8% | 10,684 | 6.7% |
| 3.6a | The rate of hospital admissions for stroke (directly standardised rate per 100,000) | ▶ | 2017/18 rate has increased but is statistically similar to 2016/17 rate | 2017-18 | 300 | 191.5 | N/A | 291 | 188.7 |
| 3.6b | The rate of hospital admissions for heart failure (directly standardised rate per 100,000) | ▶ | 2017/18 rate has increased but is statistically similar to 2016/17 rate | 2017-18 | 293 | 190.0 | N/A | 223 | 149.4 |
| 3.7 | Outcomes for a wider range of long term conditions will be defined following completion of the long term conditions needs assessment | - | To be decided upon completion of relevant Joint Strategic Needs Assessment | N/A | N/A | N/A | N/A | N/A | N/A |

## 4. Mental Health for Adults of Working Age

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 4.1 | Hospital admissions caused by unintentional and deliberate injuries in young people (15-24 years, crude rate per 10,000) | ▶ | Statistically significantly worse than England | 2017-18 | 332 | 153.0 | 132.7 | 357 | 162.8 |
| 4.2 | Rates of use of section 136 under the mental health act | ▲ | Instances of use of S136 under the mental health act increased between 17/18 and 18/19 from 366 to 472 occurrences. | 2018-19 | - | 472 | - | - | 366 |
| 4.3 | Suicide Rate - Persons (directly standardised rate per 100,000) | ▶ | Statistically similar to England | 2015-17 | 59 | 11.7 | 9.6 | 54 | 10.9 |
| 4.4 | Suicide Rate - Males (directly standardised rate per 100,000) | ▶ | Statistically similar to England | 2015-17 | 43 | 17.1 | 14.7 | 36 | 14.3 |
| 4.5 | Suicide Rate - Females (directly standardised rate per 100,000) | ▶ | Statistically similar to England | 2015-17 | 16 | 6.6 | 4.7 | 18 | 7.7 |
| 4.6 | Hospital readmission rates for mental health problems (inpatient readmissions within 28 days) | ▶ | Readmissions have reduced from 54 (11.8% of total) in Apr 16 - Mar 17 to 39 (9.8% of the total) in Apr 18 - Mar 19. This year on year change is not statistically significant. | Mar-19 | 39 | 9.8% | - | 53 | 14.1% |
| 4.7a | Adults in contact with mental health services in settled accommodation (persons) | ▲ | Statistically significantly better than England | 2017-18 | - | 77.0% | 57.0% | - | 80.0% |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 4.7b | Gap in the employment rate for people in contact with secondary mental health services compared to the overall employment rate (persons) | ▼ | Statistically significantly better than England | 2017-18 | - | 59.9% | 68.2% | - | 64.9% |
| 4.8 | Carers for people with mental health problems receiving services advice or information | ▶ | Remains below England (statistical significance not calculated | 2013-14 | 5 | 2.9% | 19.5% | 5 | 2.6% |



## 5. Health & Wellbeing of People with Disability and/or Sensory Impairment

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 5.1 | ASCOF 1E: Supported working age adults with learning disability in paid employment (proportion, %) | ▼ | Statistical significance not calculated - Peterborough above national value for 17/18, although local data show reduction to 5.8% for 18/19. | 2017-18 | - | 6.3% | 6.0% | - | 9.6% |
| 5.2 | ASCOF 1G: Adults with learning disabilities who live in their own home or with their family (proportion, %) | ▼ | Statistical significance not calculated - Peterborough above national value. Local data show reduction to 805% for 18/19. | 2017-18 | - | 81.2% | 77.2% | - | 83.8% |
| 5.3 | ASCOF 2A2: Long-term support needs of older adults (65+) met by admission to residential and | ▲ | Statistical significance not calculated - Peterborough below national value | 2017-18 | - | 441.8 | 585.6 | - | 439.6 |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| | nursing care homes, rate per 100,000 | | | | | | | | |
| 5.4 | Numbers of adults in receipt of assistive technology | ▼ | Local metric - counts all those in receipt at month end March 18 = 328 - compared to end March = 19 285 - decrease although known recording issues | 2018-19 | - | 285 | - | - | 328 |
| 5.5a | ASCOF 3A: Overall satisfaction of people who use services with their care and support (Adult Social Care) | ▲ | Score has increased from 65.5 to 65.8 between 2016-17 and 2017-18 and local data show further improvement to 66.4 for 18/19. | 2017-18 | - | 65.8 | 65.0 | - | 65.5 |
| 5.5b | ASCOF 3B: Overall satisfaction of carers with social services (Adult Social Care) | ▼ | Score has decreased from 41.9 to 38.1 between 2014-15 and 2016-17. Local data show 18/19 value of 39.8 for Peterborough which would represent an improvement. | 2016-17 | - | 38.1 | 37.3 | - | 41.9 |
| 5.6 | Number of adults with social care needs receiving short term services to increase independence | ▲ | 2018-19 value is 881 compared to 739 in 2017-18 | 2018-19 | - | 881 | - | - | 739 |
| 5.7 | Number of clients receiving reablement per 100,000 resident population (18+, excludes Red Cross) | ▲ | March 2019 value is 97.3/100,000 compared to 77.9/100,000 in March 2018. | Mar-19 | - | 97.3 | - | - | 77.9 |

## 6. Ageing Well

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 6.1a | Injuries due to falls in people aged 65 and over (Persons, Directly Standardised rate per 100,000) | ▶ | Statistically similar to England | 2017-18 | 602 | 2,041 | 2,170 | 628 | 2,176 |
| 6.1b | Numbers of over 40s taking up NHS health check offers per year | ▶ | Statistically significantly better than England | 2017-18 | 4,534 | 8.8% | 8.3% | 5,232 | 10.4% |
| 6.1c | Report on take up of any preventative service commissioned directly as part of STP in the future | - | TBC | - | - | - | - | - | - |
| 6.2 | Reducing avoidable emergency admissions (BCF), (crude rate per 100,000) | ▶ | Statistically similar to England | Mar-13 (no subsequent updates) | 328 | 176.0 | 178.9 | 332 | 178.1 |
| 6.3a | The proportion of people who use services who feel safe (proportion, %) | ▼ | Statistically significantly worse than England | 2015-16 | - | 65.0% | 69.2% | - | 64.5% |
| 6.3b | The proportion of people who use services who say that those services have made them feel safe and secure (proportion, %) | ▶ | Statistically similar to England | 2017-18 | - | 85.6% | 86.3% | - | 88.3% |
| 6.4 | Using an Outcomes Framework - covering several key priority areas for older people in relation to their NHS | - | Will be expanded as part of on-going work with Clinical Commissioning Group on Sustainability & Transformation (STP) Plans | - | - | - | - | - | - |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| | care and the Social Care Outcomes Framework | | | | | | | | |
| 6.5 | Social Isolation: % of adults carers who have as much social contact as they would like (proportion, %) | ▲ | Statistically similar to England | 2016-17 | 120 | 33.2% | 35.5% | Value unavailable | 29.7% |
| 6.6 | Carer-reported quality of life score for people caring for someone with dementia | ▲ | Statistically similar to England | 2016-17 | 110 | 7.7% | 7.5% | Value unavailable | 6.7% |

## 7. Protecting Health



| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 7.1 | Percentage of eligible people screened for latent TB infection | - | Data not provided by CCG | - | - | - | - | - | - |
| 7.2 | Percentage of eligible newborn babies given BCG vaccination (aim 90%+) | - | Data unavailable from CCG due to IG developments - BCG data can only be shared confidentially with local Screening & Immunistation teams | - | - | - | - | - | - |
| 7.3 | Proportion of drug sensitive TB cases who had completed a full course of treatment by 12 months (proportion, %) | ▶ | Statistically similar to England | 2016 | 31 | 83.8% | 84.4% | 22 | 75.9% |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 7.4 | Evidence of increasing uptake of screening and immunisation | ▼ | Peterborough currently amber or green for 7/10 chosen indicators, previously 8/10 | 2017-18 | 7/10 | - | - | 8/10 | - |
| 7.5 | HIV late diagnosis (proportion, %) | ▶ | Remains above benchmark goal of 50.0% | 2015-17 | 22 | 51.2% | 41.1% | 22 | 50.0% |
| 7.6a | Chlamydia-proportion aged 15-24 screened (proportion, %) | ▶ | Statistically significantly better than England | 2018 | 4,470 | 20.6% | 19.6% | 4,625 | 21.3% |
| 7.6b | Increase in chlamydia detection rate (proportion, %) | ▶ | Remains above benchmark goal of 2,300/100,000 | 2018 | 554 | 2,554 | 1,975 | 557 | 2,568 |



## 8. Growth, Health & the Local Plan

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 8.1 | Excess weight in 4-5 year olds (% of all pupils) | ▶ | Statistically similar to England | 2017-18 | 610 | 20.9% | 22.4% | 603 | 23.2% |
| 8.2 | Excess weight in 10-11 year olds (% of all pupils) | ▶ | Statistically similar to England | 2017-18 | 860 | 32.8% | 34.3% | 852 | 36.8% |
| 8.3 | The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or | ▶ | Statistical significance not calculated - Peterborough percentage is now below England | 2016 | 6,110 | 3.1% | 5.5% | 5,020 | 2.7% |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| | more during the day time (proportion, %) | | | | | | | | |
| 8.4 | The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more during the night time (proportion, %) | ▶ | Statistical significance not calculated - Peterborough percentage is now below England | 2016 | 10,010 | 5.2% | 8.5% | 8,190 | 4.5% |
| 8.5 | Utilisation of outdoor space for exercise/health reasons (proportion, %) | ▶ | Statistically similar to England | 2015-16 | - | 17.8% | 17.9% | - | 22.2% |

## 9. Health & Transport Planning



| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 9.1 | The number of businesses with travel plans | ▼ | 69 businesses in Peterborough have travel plans; initial target was 60 by end of this Health & Wellbeing Strategy period | 2019 | 69 | - | - | 71 | - |
| 9.2 | To further develop a robust monitoring network to enable in depth transport model data to be measured | - | In progress | - | - | - | - | - | - |
| 9.3 | Measures of air quality | - | Peterborough currently has 1 Air Quality Assessment Area | 2019 | 1 | - | - | 1 | - |
| 9.4 | The numbers of adults and children killed or seriously injured in road | ▶ | Statistically similar to England | 2015-17 | 269 | 45.60 | 40.80 | 235 | 40.4% |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| | traffic accidents (crude rate per 100,000) | | | | | | | | |

## 10. Housing & Health

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 10.1 | Excess winter deaths index (3 years, all ages, Persons, Ratio) | ▶ | Statistically similar to England | Aug 2014 - Jul 2017 | 277 | 18.7 | 21.1 | 212 | 15.0 |
| 10.2 | Excess winter deaths index (3 years, all ages Males, Ratio) | ▶ | Statistically similar to England | Aug 2014 - Jul 2017 | 85 | 11.2 | 18.1 | 66 | 9.3 |
| 10.3 | Excess winter deaths index (3 years, all ages Females, Ratio) | ▶ | Statistically similar to England | Aug 2014 - Jul 2017 | 192 | 26.8 | 24.0 | 146 | 20.7 |
| 10.4 | Reduction in unintentional injuries in the home in under 15 year olds | ▶ | Statistically similar to England | 2017-18 | 435 | 100.7 | 96.4 | 390 | 92.6 |
| 10.5 | ASCOF 2C2: Delayed transfers of care from hospital that are attributable to adult social care, per 100,000 population | - | Value below national average | 2017-18 | - | 0.2 | 4.3 | - | - |

## 11. Geographical Health Inequalities

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 11.1a | Increase in levels of education and economic attainment in electoral wards with highest levels of deprivation (GCSE attainment) | ▶ | 26.8% of pupils in the most deprived 40% of Peterborough areas achieved grade 9-5 in English & Mathematics in 2017-18, compared to 35.5% across all of Peterborough. This difference is statistically significant. | 2017-18 | - | 26.8% of pupils in most deprived 40% of Peterborough areas achieved grade 9-5 in English & Mathematics. | - | - | - |
| 11.1b | Increase in levels of education and economic attainment in electoral wards with highest levels of deprivation (Benefits Claimants) | ▼ | The benefit claimant rate in the most deprived 20% of Peterborough electoral wards is 19.6/1,000 in June 2017, statistically significantly lower than the June 2016 rate of 21.2/1,000 in June 2016. For June 2017, rate in least deprived 80% of electoral wards is 12.7/1,000. This remains the most recent data as ONS mid-year populations are currently available to mid-year 2017 | Jun-17 | 605 | 19.6 | N/A | 655 | 21.2 |
| 11.2 | Increase in life expectancy in wards with highest levels of deprivation | ▼ | Life expectancy for most deprived 20% of Peterborough wards is 78.93 years for 2013-17, a decrease from 79.12 years in 2012-16. In the least deprived 80% of electoral wards, life expectancy increased over this period from 80.91 to 80.99 years | 2013-17 | - | 78.93 | N/A | - | 79.12 |
| 11.3 | Reduction in emergency hospital admissions from wards with the highest levels of deprivation (Bretton, Central, Dogsthorpe, North, | ▶ | Rate has has increased between 2016-17 and 2017-18 from 113.9/1,000 to 118.6/1,000, although the increase is not statistically significant. | 2017-18 | 5,745 | 118.6 | N/A | 5,670 | 113.9 |

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| | Orton Longueville) (directly standardised rates per 100,000) | | | | | | | | |
| 11.4 | Smoking cessation rates in wards with highest levels of deprivation (proportion, %) | ▶ | 4 week quit percentage fell between 2015-16 and 2016-17 from 35.5% to 29.2%. | 2016-17 | 240 | 29.2% | N/A | 260 | 35.5% |
| 11.5 | Smoking cessation rates in wards with highest levels of deprivation (proportion, %) | Disproportionately high level of health checks delivered to most deprived 20% | In 2016/17, 28.0% of health checks were delivered to residents registered with practices within the most deprived 20% of practices. The merger of multiple practices to form the Octagon group (Nene Valley, Hodgson, Thorney & Eye, Jenner, Minster, Park Road, Huntly Grove and Westgate) leads to difficulty in obtaining full accuracy for this indicator in subsequent years due to provision of one collective set of values for Octagon. | 2016-17 | 1,344 | 28.0% | N/A | 1,965 | 35.5% |
| 11.6 | Slope index of inequality in life expectancy at birth | ▶ | Has increased from 8.4 to 9.3 years for males and has remained at 5.8 years for females in most recent refresh - both statistically similar to England | 2015-17 | - | Male 9.3, Female 5.8 | - | - | Male 8.4, Female 5.8 |

## 12. Health & Wellbeing of Diverse Communities

| Indicator Ref | Indicator | Peterborough Trend | Current Status | Current Time Period | Peterborough Current (#) | Peterborough Current (Indicator Value) | England Value | Peterborough Previous (#) | Peterborough Previous (Indicator Value) |
|---|---|---|---|---|---|---|---|---|---|
| 12.1 | We will work with local health services to improve data collection on ethnicity, both generally and to assess the success of targeted interventions | - | To follow via Peterborough City Council policy team in collaboration with Public Health Intelligence | - | - | - | - | - | - |
| 12.2 | Outcome measures for health and wellbeing of migrants will be developed following completion of the JSNA | - | To follow via Peterborough City Council policy team in collaboration with Public Health Intelligence | - | - | - | - | - | - |

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 9b |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Wendi Ogle-Welbourn, Executive Director People and Communities<br>Dr Liz Robin, Director of Public Health | |
| Cabinet Member(s) responsible: | Cllr Wayne Fitzgerald, Cabinet Member for Adult Social Care, Health and Public Health | |
| Contact Officer(s): | Helen Gregg, Partnership Manager | Tel. 863618 |

# HWB STRATEGY PERFORMANCE REPORT

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Executive Director People and Communities and Director of Public Health | **Deadline date:** N/A |

It is recommended that the Health and Wellbeing Board:

1. Note the report, consider the content and raise any questions
2. Members to challenge performance and agree future actions to address

## 1. ORIGIN OF REPORT

1.1 This report is presented to the Health & Wellbeing Board at the request of Wendi Ogle-Welbourn, Executive Director and Dr Liz Robin, Director of Public Health.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide Board members with a summary of progress against the Future Plans identified for each of the focus areas outlined in the Health & Wellbeing Strategy 2016-2019. .

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference Numbers:

*2.8.3.1 To develop a Health and Wellbeing Strategy for the city which informs and influences the commissioning plans of partner agencies*
*2.8.3.2 To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health and Wellbeing Strategy*

## 3. TIMESCALES

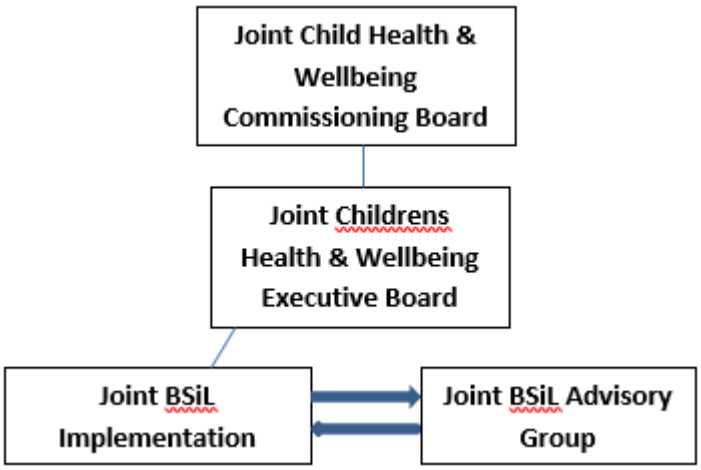
| | | | |
|---|---|---|---|
| Is this a Major Policy Item/Statutory Plan? | **NO** | If yes, date for Cabinet meeting | |

## 4. BACKGROUND AND KEY ISSUES

4.1 The 2016-19 Health & Wellbeing Strategy identified a number of key focus areas. Below is a summary of key highlights / activities during January to March 2019.

**Children and Young People**

- Following the Peterborough CC and Cambridgeshire CC Early Years Social Mobility Peer Review (July 2018), a Joint Best Start in Life (BSiL) strategy has been developed and will be presented to the Health & Wellbeing Board in September for consultation. The strategy focuses on three key outcomes which represent our ambition for children in Cambridgeshire and Peterborough.
    - Children live healthy lives
    - Children are safe from harm
    - Children are confident and resilient with an aptitude and enthusiasm for learning
- A new governance structure has been established, as shown in the image below:




- New mothers in Peterborough received a New Birth Visit Improved – 98% of all new mothers received this contact in Q4. This is greater than the average for England
- Families had a 12 month development check by 15 month Improved – 96% of families had this check by the time they turn 15 months old (Q4). This is greater than the average for England
- 46% of infants were being fully or partially breastfed at 6-8 weeks, which is better than the national average for England and has improved significantly over the past two years
- The provider is struggling to meet some targets due to workforce issues but is working hard to improve the current position. The two providers of the Healthy Child Programme across Cambridgeshire and Peterborough, are undergoing service redesign to implement a new integrated service specification based on a holistic 0-19 model, which includes reviewing current delivery and shift towards a skill mix model to best meet the needs of families.
- Parentline will be implemented from September 2019, offering parents a text based advice service for a range of information and support.
- Emotional Health and Wellbeing concerns continue to be the most prominent issue school nurses are dealing with. 507 pupils were seen for mental health/wellbeing issues during the quarter which is an increase against 389 in Q3.

- School Nurses co-delivered 98 HYPA clinics with ICash. These are drop-ins held on a weekly basis at most secondary schools. Young people can access these drops in for a range of support and advice.

**Growth, Health and the Local Plan**

- The Local Plan, which contains specific health and wellbeing policies, has been found to be 'sound' through the examination process (subject to certain modifications) and the council will look to adopt at full council in the summer.
- Building on the Local Plan, Public health are working with the Peterborough planning team to scope the potential for a Supplementary Planning Document to control Hot Food Takeaways in Peterborough as part of a wider healthy weight strategy.

**Health and Transport Planning**

- On 1 April, Road Safety moved to Highways Services department, which will allow for stronger links to be developed between Sustainable Travel and Road Safety. As well as strengthening links with Cambridgeshire County Council
- The Cambridgeshire and Peterborough Road Safety Partnership has recently been relaunched and a new strategy is to be developed.
- During 2018, 72 people were killed or seriously injured on Peterborough Roads, this is down from 89 in the previous year. The number of people slightly injured on Peterborough roads during 2018 was 373 compared to 445 the previous year.
- Over 1,300 post-16 students and 13 out of 14 schools have signed up to take part in Drive IQ, which is aimed at pre and new drivers.
- 24 schools participated in a National Big Pedal competition. Over 94% of pupils took part and St Thomas More finished 9th nationally, out of nearly 800 large primary schools. Seven of our schools finished in the top 100 and Peterborough accounted for 81,730 total journeys. Peterborough schools made up 0.78% of all schools registered however they accounted for 2.11% of all the Big Pedal journeys made nationally.
- In 2017, the Government published its first Cycling and Walking Investment Strategy that sets out ambitions to make walking and cycling the natural choices for shorter journeys or as part of a longer journey. Peterborough successfully applied for technical support from DFT to develop a Local Walking and Cycling Infrastructure Plan (LCWIP). Cycling and walking network analysis and the auditing process to inform a prioritisation of schemes is progressing well. It's anticipated that the LCWIP will be completed in August in readiness for any funding opportunities that may become available.
- Public Health have been working with the Combined Authority to develop the draft Local Transport Plan. Input to date has led to an increased focus on the health and wellbeing impacts of transport including on air quality, physical inactivity (through active travel), social isolation and road safety.

**Health and Wellbeing of Diverse Communities**

- The Cohesion Team has been working with Dr Val Thomas and Public Health colleagues to establish closer collaboration on the child obesity project in the Central and North ward. This includes linkages through faith groups and other community groups. A good network has been further developed by the Public Health team.
- Dr.Liz Robin attended the last Joint Mosques Group meeting held in March 2019 and shared current work programmes in place to engage with the diverse community. Details are intended to be discussed at the next meeting in July 2019, which will be themed under the Public Health agenda.
- The Diverse Ethnic Communities JSNA – South Asian Communities Supplement has been approved by Peterborough Living Well Partnership and is included with the circulated HWB Board papers as an item for information.

**Health Behaviours and Lifestyles**

- Drug and Alcohol Services (provided by CGL Aspire Service)
    - Peterborough's successful completions for all client groups (except alcohol and non-opiates) are on an upward trajectory with opiate rates now sitting in the top national quartile range
    - Higher rates of criminal justice clients successfully engaging in community

treatment following release from prison, than national rates (local 53.6% versus national 32.9%)
    - Unmet need rates across all substances are sitting below national rates indicating that local services are meeting higher levels of need
    - There has been an overall drop in numbers in treatment in the past year since reaching a peak in 17/18, which is in line with the national picture
    - Positive improvements in both Hepatitis B vaccination rates and Hepatitis C testing which both sit above national rates
- **Drug and Alcohol Service Development**
    - Public Health England invited bids for £10M of capital funding to improve access to alcohol misuse treatment. Local bids were developed with CGL (our specialist treatment provider) and submitted for both Cambridgeshire and Peterborough. The Peterborough bid was successful, securing £72k of capital funding to improve current service provision. The funding will be specifically used to extend the outreach and engagement capacity of the service, targeting problematic drinking in the community through the purchasing of a multi-purpose vehicle. The funding has already been used to undertake refurbishments to the CGL City Centre building to make it more welcoming, engaging and family friendly for those individuals and family members struggling with alcohol related issues.
    - CGL is working closely with Peterborough City Council to help address and provide outreach support to the increasing numbers of individuals who are rough sleeping, many of whom have substance misuse issues. Additional resourcing (secured from Central Government) have been committed by Peterborough City Council to enable outreach to be delivered by CGL Aspire staff directly to rough sleepers. The outreach will be undertaken jointly with the City Council Street Outreach Team and the vehicle (secured by the PHE alcohol capital monies) will enhance this work.
    - Positive strategic partnership work with HMP Peterborough has resulted in the distribution of take home naloxone (THN) to prisoners on release to help prevent drug related deaths. There are high rates of heroin/opioid overdoses amongst released prisoners nationally, particularly in the first few days and weeks back in the community when drug users revert to high levels of usage following months or years in prison, when heroin is generally less available and often of a much reduced purity. Naloxone is a useful medication for illicit drug users as it has no clear potential for abuse and is seen as part of a package of interventions. It has the advantage that it can be administered by individuals, family and friends after brief training.
- **Lifestyle Services provided by Solutions 4 Health (S4H) and Everyone Health**
    - The Integrated Lifestyle Service (S4H) continues to perform well against its Key Performance Indicators (KPIs). In 2018/19 it over achieved against all of its KPIs in terms of people assessed, receiving an intervention and having a positive outcome. It has a strong presence in the community with many of its services providing outreach through a mobile facility.
    - The Healthy Workplace Support Service was recommissioned and the new contract commenced in June 2018. The provider, Everyone Health, has started to gain traction with local employers and their workplaces.
    - The Healthy Schools Support Service which also receives funding from the Office of the Police and Crime Commissioner, has been tasked with developing a service that provides schools with information through a website and more intensive support in schools with high needs. Its overarching function however is to facilitate the joint working with the many organisations working in schools that will enable the better use of resources and avoid duplication. It has proved challenging but relationships with schools have now been formed and work is proceeding, overseen by a multi-agency Steering Group.

**Housing and Health**

- The First Time Central Heating project funded through the Warm Homes Fund is well underway. This funding provides a free gas connection, boiler and full central heating system to properties with expensive to run electric storage or panel heaters.

Representatives from the Department for Business, Environment and Industrial Strategy (BEIS) recently visited Peterborough to look at the work being done in the city which utilises a combination of several funding streams to take households out of fuel poverty. Feedback from the visit has been extremely positive.

- Selective licencing - the council has to date received over 7,886 applications for licences, of which 6,504 have been granted. Housing standards are showing clear signs of improvement.
- The licensing of HMO's (houses of multiple occupation) has been extended to include all dwellings that house 5 or more people. This has led to an additional 29 properties becoming licensed and having the appropriate fire and safety measures in place.
- The Council secured £80,000 Rogue Landlord Funding for a project to identify and inspect 105 residential units of accommodation above and behind the shops in Lincoln Road. 51 unlicensed flats have been identified, 9 flats with EPC ratings of E referred into the First Time Central Heating project through the Warm Homes Fund, 29 flats are going through enforcement action for having no EPC, and 22 flats have been identified as being F&G rated and are being dealt with under the Minimum Energy Efficiency Standards (MEES).
- The Council are working with PECT and Cambridge City Council on a BEIS sponsored Compliance & Enforcement Study on the MEES in the private rented sector. These standards prevent a landlord letting out a property which has an energy efficiency rating of F or G. Failure to comply results in a civil penalty notice. Peterborough & Cambridge CC's are one of 7 pilots for this study
- The Local Energy Advice Partnership (LEAP) continues to assist households in fuel poverty and those households living on a low income and vulnerable to the effects of living in a cold home. 1,014 referrals were made into the scheme resulting in 731 home energy assessments. Energy advice in those visits (if taken up) would identify £125,000 of lifetime energy bill savings. 5,965 easy measures were installed (e.g. LED light-bulbs, radiator reflectors, standby plugs) equating to a further £470,878 of lifetime energy bill savings. 158 households were identified as being on the best energy tariff or were switched to a better one and 179 households had extra benefit entitlements identified amounting to £537,000 in total. Overall a total of £1,166,560 of bill savings and extra income was achieved last year. The scheme also referred 103 households back to the Council with high risk hazards in the home and 52 households to the Community Fire Safety Team for a Safe & Well visit.
- Discretionary funding is being used to carry out work in homes to facilitate discharge from hospital when it has been deemed they cannot return home due to property condition. Several decluttering and deep cleans have been carried out with ongoing support being put in place. Work to prevent hospital admissions is also being carried out including heating systems and the mitigation of slip, trips and fall hazards.
- As part of this work, an increasing number of homes occupied by vulnerable adults with extreme hoarding behaviours have been identified. A Multi-agency Hoarding Group has been formed with representation from Housing, Mental Health, Psychology, Social Care, Fire Service and Safeguarding which adopts a panel approach to co-ordinate professionals to deal with these cases. This group is dealing with some of the most complex cases at risk of serious injury, fire and eviction.
- Housing Needs have been successful in securing additional funding from the MHCLG to support its ongoing work to tackle homelessness, the funding streams are as follows:
    - £280,968 – Rough Sleeping Initiative Funding – to continue supporting the ongoing work with partners in identifying rough sleepers early, providing them with emergency accommodation, health care, drug and alcohol misuse support, support to move towards permanent rehousing and help to maintain it once obtained.
    - £113,130 – Rapid Rehousing Pathway – funding to provide supported lettings in partnership with Cross Keys Homes and navigator roles to support rough sleepers once in accommodation
    - £326,000 – Flexible Homelessness Support Grant & Homelessness Prevention funding to increase capacity in the Housing Needs team to further support homelessness prevention and relieving pressures in Temporary Accommodation, including ending the use of B&B over 6 weeks.

- The Housing Needs team were successful in bringing all homeless households, who were placed into temporary accommodation out of Peterborough, back into the city before Christmas 2018. This was maintained through the first quarter of 2019.

**Mental Health for Adults of Working Age**

- Excellent progress with implementation of the Crisis Concordat Action Plan by the MH Delivery Board continues, with the Board following a process of continuous improvement. Current developments include:
    - Piloting a national approach to improving crisis response and support for people with a personality disorder
    - Contributing to research on the role of the voluntary sector in crisis response
    - A strategy to support to victims of crime and terrorism
    - Improvement to MH Act assessment by improving access to Section 12 doctors
    - Information sharing between agencies remains the biggest single barrier to effective joint working. This continues to be a barrier and is being raised with the STP.
- The work to develop an effective pathway to employment for people with mental health problems initiated in 2017 has continued:
    - The CPFT has secured NHS England investment in Individual Placement Support
    - Engagement with communities to identify and address barriers to employment is continuing
    - Priority is being given by commissioners to supporting employers to offer employment to people with mental health problems. This includes seeking employment opportunities within PCC and CCC
- The joint community mental health delivery plan has delivered the following improvements:
    - Peri-natal mental health - a successful bid was made by the CCG to NHS England for investment in a commissioner to lead the work and a range of improvements to services and the peri-natal mental health pathway
    - Increased numbers of physical health care checks being undertaken in Primary Care
    - Improvements to and achievement of targets related to psychological services and wellbeing
    - Completion of the re-procurement of the joint Recovery and Community Inclusion service which will now be mobilised in September. This will enable the next phase of development of the Primary Enhanced MH Service (previously known as PRISM) to commence
    - Improved support for carers of people with mental health problems following inclusion of a specialist lot within the carers service specification.
- The MH Housing and Accommodation review has been completed and is moving to procurement for mobilisation on 1 April 2020. This will make housing and support more accessible, including ensuring that accommodation that meets need is available. Variation in the pathway between PCC and CCC will be reduced.
- The aligned model of commissioning health and social care for Mental Health has continued, with the development of a joint plan for both acute and community mental health services. It means that that 'the Right Support, the First Time, at the Right Place, by the Right People' is more likely and that, where support in the community rather than in acute settings is appropriate, support to remain at home is more likely to be provided.
- Partnership and co-production approaches particularly inform improvement in the following areas: suicide prevention, mental health employment, the Recovery and Community Inclusion service and Information about mental health services

**Protecting Health**

- **National Screening programmes:**
    - Bowel cancer screening: uptake for the North West Anglia Foundation Trust (NWAFT) programme has improved. NHS England and NHS improvement is working with the screening centre to address diagnostic waiting times, and with GP practices with low uptake to pilot text reminders.

- Breast cancer screening: acceptable uptake levels are being achieved. Service workforce issues is improving.
- Cervical cancer screening: the decline in coverage observed recently appears to have levelled off with small improvements being observed, but coverage remains below acceptable level. NHS England and NHS improvement are leading a project to increase uptake. The Council and partners have been supporting a national campaign to promote uptake of cervical screening.
- Diabetic eye screening and abdominal aortic aneurysm screening programmes are generally performing well. NWAFT is implementing an action plan to address capacity issues in the eye services.
- Antenatal and newborn screening programmes are generally working well. NWAFT are implementing an action plan following the quality assurance visit in September 2018.

- **Immunisations:**
  - Childhood vaccinations: a number of childhood vaccination programmes have below optimal uptake rates. NHS England and NHS improvement and the council are working in partnership to address this including working with GP practices with low uptake, a local #VaccinesWork campaign in April 2019 and planned focus groups with parents who have declined a vaccination.
  - Rotavirus vaccination: uptake rates have improved. NHS England and NHS improvement are completing their investigation into reasons for poor uptake.
  - Shingles vaccination: NHS England and NHS improvement have extended their project working with participating GP practices to improve uptake.
  - Flu vaccination: provisional data for the 2018/19 flu vaccination programme shows that:
    - There was low uptake in primary school children which is thought to be due to issues with a new e-consent system and Muslim parents declining due to porcine content. The provider will work to address these issues for the 2019/20 season.
    - Adult uptake has decreased from last year. This is thought to be due to the phased delivery of a new vaccine which affected how GPs planned their clinics. The delivery of vaccines will return to normal for 2019/20.
    - Uptake rates in pre-school children increased which is thought to be due to invites being sent to parents.
    - The Council will continue to support the promotion of flu vaccination in 2019/20.
- **Sexual health**
  - **The Cambridgeshire and Peterborough Sexual Health Delivery Board** has been formed with representation from commissioners and providers of sexual health, contraception and reproductive services along with children's social care services. It is also supported by Public Health England. The Group is tasked with informing the development and commissioning of services and fostering collaborative working across organisations to improve outcomes. A Delivery Plan has been produced and priority areas identified.
  - **Teenage pregnancy** is a priority of the Sexual Health Delivery Board. The latest under 18 years of age conception rate for Peterborough is at its lowest level since 1998 when monitoring commenced. Although there has been a substantial decrease since 1998, it is now statistically similar to England. This decrease from 185 conceptions in 1998 to 74 in 2017 represents the ongoing collaborative efforts of organisations across Peterborough, that have worked together to put in place preventative interventions to ensure that young people have access to service and appropriate support.(Public Health Outcome Framework 2017)
  - **Late HIV Diagnosis –** Rates of late HIV diagnosis have been persistently statistically significantly higher than national average. People diagnosed and starting treatment early can expect a normal life expectancy. There is ongoing work to address this which includes a campaign to increase awareness in the population of HIV which will be targeted to certain high risk groups which includes sexworkers.
  - **Public Health England Collaborative Commissioning Pilot -** The

Cambridgeshire and Peterborough system has been asked by Public Health England to be one of two sites nationally to undertake a feasibility study for developing a model that will better align commissioning of sexual health services across the local authorities, the Clinical Commissioning Group and NHS England. Five priorities were identified through a multi-agency workshop which are being explored with the Clinical Commissioning Group and NHS England. The three that are being focused upon are "Women's" Hubs where women are able to access sexual health, contraception, gynaecological and termination of pregnancy services in one location; access to contraception post-partum as part of the maternity pathway and late HIV diagnosis

**Health and Wellbeing of People with Disability and/or Sensory Impairment**

- The charity, Little People UK, have recently joined the Physical Disability Partnership Board. The charity was set up by actor, Warwick Davis and his wife and is based in Peterborough.
- The Peterborough Downs Syndrome Group has also expressed an interest in joining the board.
- The Peterborough Physical Disability Partnership Board will combine with the Cambridgeshire Partnership Board by April 2020, as a result of a recent review by Healthwatch Paterborough and Cambridgeshire
- The Peterborough Information Network (PIN), which launched in February 2018, is a comprehensive information, advice and guidance platform. In April 2019, a brand new suite of Easy Read pages was launched. These have been co-produced with young people and adults with learning disabilities and autism. Pages include Easy Read leaflets, Your Health, Your Work and Training, Your Money and Benefits, Being Safe, Your Home, Getting Out and About and Your Rights and Choices.
- New pages have been created on the main site including Personal Budgets and Direct Payments, End of Life Care and Autism
- A new leaflet aimed at self funders leaving hospital has been created and copies have been delivered to all hospitals across Cambridgeshire and Peterborough. It has also been uploaded to the PIN
- As part of the Adults Positive Challenge Programme with Cambridgeshire County Council, a review is taking place of early intervention and prevention services including sensory services, which will aim to improve provision across Peterborough and Cambridgeshire

**Long Term Conditions and Premature Mortality**

- Cambridgeshire and Peterborough are rated as 'Requires Improvement' for diabetes in the CCG Improvement and Assessment Framework
- Dr Jessica Randall-Carrick has been appointed as the STP / CCG Clinical Lead for Diabetes. Dr Randall-Carrick is a GP based at Thistlemoor Practice, Peterborough and will work 1 ½ days per week to support improvements in diabetes care across Cambridgeshire and Peterborough.
- Virtual Clinic Reviews are now taking place across Peterborough.
- The demand for the Diabetes Prevention Programme is still high. To help manage demand, the CCG are working with practices to ensure appropriate patients are referred
- A system wide Diabetes and Obesity Clinical Community has formed to oversee and drive forward transformational change in diabetes and obesity management.
- Work is underway on the production of a Cambridgeshire and Peterborough Diabetes and Obesity Strategy.
- Final evaluation of the joint STP, LA, PH AF stroke prevention programme showed that the percentage of patients being treated with anticoagulants (blood thinners) increased from 74.7% to 82% over the two years of the programme leading to an additional 696 patients being anticoagulated. This could lead to an additional 28 strokes being prevented.

**Sustainable Transformation 5 Year Plan (including BCF)**

- Falls prevention: Further communications of the 'Stronger for Longer' strength and balance exercise campaign have been planned in partnership with districts and charity colleagues for launch in May 2019. Work to strengthen community falls prevention pathway with the acute hospital, Primary Care and Adult Social Care is underway.
- Investment in Housing for Vulnerable People: A cohort of service users with learning disabilities has been identified. They have very complex needs and require bespoke and specific accommodation and support. An initial property has been purchased and technology enabled care requirements for the property are being reviewed. Robust transition plans are in development for each service user.
- Development and implementation of local DTOC plans: a system wide evaluation of Improved Better Care Fund (IBCF) funded DTOC initiatives was undertaken and this has informed ongoing recommendations. A steering group has been established to oversee the ongoing monitoring of initiatives.
- Better Care Fund (BCF): NHS England national planning guidance for 2019/20 has been delayed and this is currently expected in June. There will be a once year planning cycle for 2019/20 and minimum change to the conditions of the BCF are anticipated. Local discussions are underway to inform agreement to the 2019/20 plans.
- Admissions Avoidance: The system is committed to the development of place based delivery and the Council has been working closely with NHS Partners around the development of local Integrated Neighbourhoods. This work sits alongside the development of Primary Care Networks with populations of 30,000 – 50,000 and is being aligned to the Council led Think Communities programme and Adults Positive Challenge. The model of delivery is driven by a neighbourhood, 'place based' approach, and success will mean that people have greater independence and better outcomes via a greater focus on prevention, empowerment and building self-sufficient and resilient communities.

**Next Steps**

The Peterborough and Cambridgeshire Public Health team are now beginning work to develop a joint health & wellbeing strategy. As part of the development phase, there will be a large programme of engagement and consultation with a number of staff / services, partners, councillors, local businesses/organisations, voluntary sector / community / charity organisations and the general public in order to gather information, data etc across the county.

## 5. CONSULTATION

5.1 Consultation has not been required.

## 6. ANTICIPATED OUTCOMES OR IMPACT

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

## 7. REASON FOR THE RECOMMENDATION

7.1 To ensure members are kept regularly informed of progress and any barriers/challenges that may be preventing progress so that members may assist in unblocking these.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The Board must be kept informed of progress against the identified focus areas within the current Health & Wellbeing Strategy.

## 9. IMPLICATIONS

**Financial Implications**

9.1 There are no financial implications associated with this report.

**Legal Implications**

9.2 There are no legal implications associated with this report.

**Equalities Implications**

9.3 There are no equality implications associated with this report.

## 10. BACKGROUND DOCUMENTS

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

10.1 PCC Health & Wellbeing Strategy 2016-19

## 11. APPENDICES

11.1 N/A

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 10 |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| Report of: | Adrian Chapman - Service Director Communities and Safety | |
|---|---|---|
| Cabinet Member(s) responsible: | Councillor Irene Walsh - Cabinet Member for Communities | |
| Contact Officer(s): | Ian Phillips | Tel. 863849 |

# PLACED BASED WORKING - THINK COMMUNITIES, INTEGRATED NEIGHBOURHOODS AND PRIMARY CARE NETWORKS

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Adrian Chapman Service Director - Communities and Safety | **Deadline date:** *n/a* |

It is recommended that the Health and Wellbeing Board:

1. Note, comment and endorse the joint approach being taken by the North Alliance and Peterborough City Council for placed based working through the Think Communities, Integrated Neighbourhoods and Primary Care Networks.

## 1. ORIGIN OF REPORT

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

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide the Board with an update on how placed based working between the council and the North Alliance will be delivered through the Think Communities, Integrated Neighbourhoods and Primary Care Network approaches.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No. 2.8.3.6

*To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.*

2.3 There is no link in this report to the Children in Care Pledge.

## 3. TIMESCALES

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

## 4. BACKGROUND AND KEY ISSUES

4.1 At its meeting of 28th March 2019, the Board considered the Think Communities approach to reforming the way the public sector delivers services throughout Cambridgeshire and Peterborough.

4.2 The report set out the collaborative approach being adopted by partners across all local authorities, police, fire service and health that will see services delivered through a placed based model. This approach is based upon a number of principles:

- the shared approach will need to adopt strengths-based principles
- it will need to address the ways in which demand for statutory and sometimes costly services will be prevented or delayed
- it will need to be cognisant of and reflect the role and input of all of our key partners
- it will need to allow a single cross-partnership conversation with communities to convey a shared vision to achieve mutual benefit
- it will need to set out the principles of the participatory approach that will be taken to delivery
- it will need to demonstrate how we will build and sustain trust, transparency and accountability with and between communities and our partners
- it will need to show how we will monitor the impacts of our work, how it will be evaluated, and how we will communicate outcomes to communities, partners and other Committees
- it will need to show how we will use evidence to inform our planning and decision making

4.3 Alongside the approach being taken by the council, partners within the North and South Alliances are also developing models to roll out placed based working for health services across Peterborough and Cambridgeshire through the Primary Care Networks and Integrated Neighbourhoods programmes.

4.4 **Primary Care Networks** are a group of GP practices working together and covering a population size of 30-50k. They will focus on improving primary care services, making General Practice sustainable and primary care collaboration with wider health, care and voluntary services. Primary Care Networks are based upon a national initiative led by the NHS.

4.5 **Integrated Neighbourhoods** have primary care networks as their cornerstone and will work together to cover the same community of 30-50k. It brings together community, social, secondary care, mental health, voluntary and wider services to provide proactive and integrated care to local communities which keeps people well and out of hospital.

4.6 Collectively, the council and health partners have agreed to that these three approaches should be merged into a single placed based model based upon three core objectives:

1. A collaborative approach to improving the health, wellbeing and quality of life for residents
2. Achieved by working together to create a focused and local approach to service design, delivery and improvement based on the needs of the local population. A single view of place will be created through shared data, intelligence and understanding of local issues
3. The placed based approach will have a common geographical boundary of 30-50k population size, based on GP practices through the Primary Care Network

**Placed based model**

4.7 NHS England announced a new Primary Care Network (PCN) Direct Enhanced Service (DES) in January 2019. This will be rolled out nationally and requires all GP practices to join a Primary Care Network covering a population of 30-50k. Over recent months, GP practices have therefore been developing proposals to establish Primary Care Networks and submitted their requests to the CCG on 31st May 2019. At the time of writing, these PCNs have yet to be formally agreed, but it is proposed that there will be five PCNs covering Peterborough, two of which are also likely to extend across neighbouring local authority boundaries (one with Fenland and the other with Huntingdonshire and Fenland).

4.8 The NHS recognises that a place-based approach will deliver better outcomes at the best price, and this very much aligns to the Think Communities philosophy. By aligning our own communities with those identified as Primary Care Networks we will have communities receiving services from the most appropriate part of the system, with access to a far broader range of alternatives to statutory interventions where appropriate. This approach also aligns to the emerging social prescribing approach for primary care, where often a community based offer can be far more effective than a medical prescription.

4.9 Once agreed, these PCNs will form an essential part of the core placed based working model and will be adopted by all local authorities (and other partners) as a single system wide approach. As PCNs are based upon GP practices, we will develop broader service delivery areas made up of populations of approximately 30-50,000. These broader areas will have a co-terminus boundary and provide an agreed focus for the public sector to understand local issues and deliver targeted services.

4.10 One of the fundamental principles of this model is that it will provide shared data and intelligence of each of the service delivery areas, allowing all partners to develop a single view of the issues, needs and demands specific to that place. This information will be mapped against existing service delivery and will therefore show where the council and partners are delivering services compared to the underlying demand. This will allow for services to be redesigned to more effectively be targeted at areas of greatest need and help to predict emerging trends where a preventative approach can be adopted.

**Role of the Community and Voluntary Sector**

4.11 For the service delivery areas to operate effectively, they will need to build a close relationship with the existing community and voluntary sector organisations within each area. These organisations typically understand the on the ground issues far better than the public sector and are able to develop innovative solutions to local issues. The Think Communities approach will see the public sector joining up with local community organisations to jointly understand what each area's needs are and co-design solutions.

4.12 The Orton area of Peterborough is a prototype area for the Think Communities approach and is focusing on 3 themed delivery areas:

**Isolation**, with specific focus around building a sense of community, place and belonging, including:

- Volunteer workers to support those with health needs
- Programme of Summer events - social activities to bring people together
- Development of a community hub, from which health sessions will be offered by professionals

**Youth,** offering development opportunities for young people:

- Programme of positive events such graffiti art workshops, cycling activities etc.
- Offering a volunteer mentoring / buddy scheme to support vulnerable young people
- Offering educational support - life skills classes, career guidance, interview training etc.

**Environmental**, building a sense of pride in the community:

- Organising community litter picks and clean up events
- Reviewing public land to reallocate ownership to residents so that they can take responsibility for neglected areas.
- Review of public car-parking provision

Additionally, a 'Community Deal' is being developed for the area. This is intended as an informal commitment between the public and services to work together to create a better community.

4.13 Residents are leading on designing and delivering the Orton Longueville Prototype, supported by agencies.

**Placed Based Delivery Boards**

4.14 To oversee the work of the service delivery areas, new placed based delivery boards will be established. These will be chaired by the Chief Executive/Corporate Director of the relevant district or unitary council. The purpose of these Boards will be to unblock any delivery issues at the local level and provide strategic direction and decision making to complex service delivery challenges. These Boards will also fulfill the responsibilities of the Safer Peterborough Partnership and the Living Well Partnership which will both cease.

4.15 The delivery boards will:

- Provide leadership and strategic direction to drive and support the delivery of placed based working across the service delivery areas
- Share data and intelligence across all partners to develop an agreed understanding, priority setting and vision across all public and community sector partners
- Align strategic evidence led priorities with local communities needs to deliver joint action
- Co-design local service provision with the local community and around the local needs of the population to meet complex challenges
- See residents, communities, businesses and organisations as equal partners
- Work together in true partnership to focus on the needs of place, rather than focussing on single organisational priorities
- Ensure the local people and services have the right tools and appropriate support to help improve their health and quality of life.

The Boards are expected to meet from September 2019.

## 5. CONSULTATION

5.1 Extensive consultation with partners across the public sector has been held on the placed based approach since its inception, and this will continue through individual arrangements, as well as via the Senior Officers Communities Network (a forum of senior leaders from across the public and voluntary sectors), whose sole focus will be on driving forward the approach across our system.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The placed based approach will deliver more effective services within local areas that are more responsive to local community needs. It will also build upon the community strengths and assets within each place, helping individuals to become resilient and able to access the right services at the right time.

## 7. REASON FOR THE RECOMMENDATION

7.1 The placed based approach is a significant enabling approach, designed to improve outcomes for citizens and prevent and delay demand for services, therefore driving down cost across the system. It is being designed for implementation as a new way of delivering public services within existing resource envelopes

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 To continue to operate services in a non placed based approach. This will however, not deliver the desired outcomes as outlined in the report.

## 9. IMPLICATIONS

**Financial Implications**

9.1 n/a

### Legal Implications

9.2 n/a

### Equalities Implications

9.3 n/a

## 10. BACKGROUND DOCUMENTS

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

10.1 *n/a*

## 11. APPENDICES

11.1 *n/a*

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| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 11 |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Will Patten, Director of Commissioning | |
| Cabinet Member(s) responsible: | Wayne Fitzgerald, Deputy Leader and Cabinet Member for Adult Social Care and Public Health | |
| Contact Officer(s): | Caroline Townsend, Head of Commissioning Partnerships and Programmes | Tel: 07976 832188 |

# UPDATE ON HEALTH AND SOCIAL CARE INTEGRATION

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

It is recommended that the Health and Wellbeing Board:

1. Note the contents of the report, which provides an update on the priorities and progress of health and social care integration.

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health & Wellbeing Board as an update on the progress of local health and social care integration.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an update to the Health and Wellbeing Board on progress and the current priorities for health and social care integration locally.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No 2.8.3.3

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

## 3. TIMESCALES

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

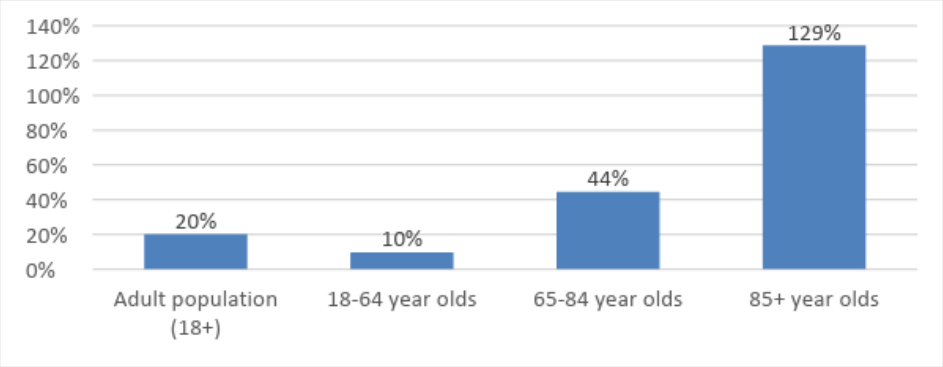
## 4. BACKGROUND AND KEY ISSUES

## 4.1 System Challenges

### 4.1.1 Population Growth

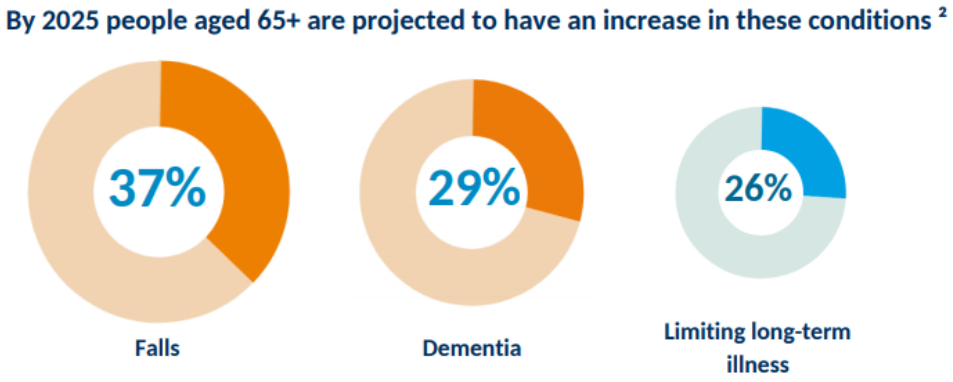
Peterborough's population is growing significantly, with an increasing older population. Cambridgeshire and Peterborough's population of people aged 18+ is estimated at 690,000. Forecasts suggest significant and disproportionate growth is expected, with those aged 65-84 expected to increase by around 44% and those aged 85+ expected to grow by nearly 130% by 2036, as can be seen in the chart below.

*Cambridgeshire and Peterborough projected population growth 2018-2036*




(Source: Cambridgeshire Business Intelligence Team)

By 2025, it is forecast that there will be a significant increase in the following conditions.




### 4.1.2 Financial Pressures

Being an underfunded system means we have to address increasing demand with decreasing budgets. Peterborough and Cambridgeshire is one of the most financially challenged health economies nationally. Peterborough City Council is facing a budget gap of £18m in 2020/21 and £20m in 2021/22.

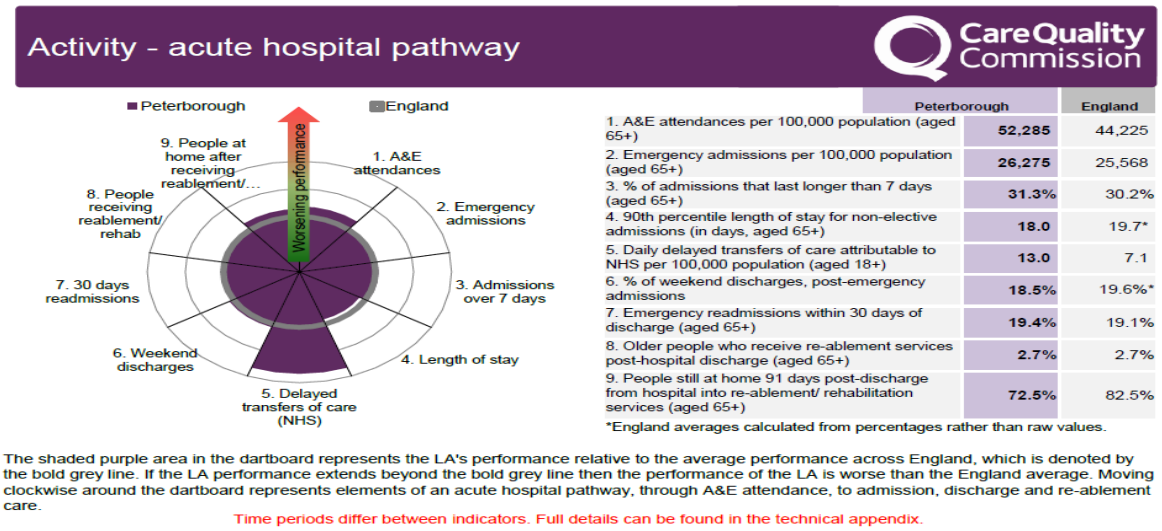
In addition, we are seeing financial pressures as a result of increasing costs of care as a result of providers facing a range of financial pressures, such as national living wage increases, recruitment and retention of staff and automatic enrolment.

To ensure we have financial sustainability for the future, we are working jointly with health to deliver community capacity and capability to meet the demands of local communities in the most cost effective way, supporting people to maintain their independence and wellbeing. In turn, preventing the unnecessary escalation of needs and the provision of more expensive services (e.g. domiciliary care, residential and nursing care, acute hospital intervention).

### 4.1.3 System Performance

The below diagram shows how Peterborough is performing comparatively across a key range

of health and social indicators.




| | Peterborough | England |
|---|---|---|
| 1. A&E attendances per 100,000 population (aged 65+) | 52,285 | 44,225 |
| 2. Emergency admissions per 100,000 population (aged 65+) | 26,275 | 25,568 |
| 3. % of admissions that last longer than 7 days (aged 65+) | 31.3% | 30.2% |
| 4. 90th percentile length of stay for non-elective admissions (in days, aged 65+) | 18.0 | 19.7* |
| 5. Daily delayed transfers of care attributable to NHS per 100,000 population (aged 18+) | 13.0 | 7.1 |
| 6. % of weekend discharges, post-emergency admissions | 18.5% | 19.6%* |
| 7. Emergency readmissions within 30 days of discharge (aged 65+) | 19.4% | 19.1% |
| 8. Older people who receive re-ablement services post-hospital discharge (aged 65+) | 2.7% | 2.7% |
| 9. People still at home 91 days post-discharge from hospital into re-ablement/ rehabilitation services (aged 65+) | 72.5% | 82.5% |

*England averages calculated from percentages rather than raw values.

The shaded purple area in the dartboard represents the LA's performance relative to the average performance across England, which is denoted by the bold grey line. If the LA performance extends beyond the bold grey line then the performance of the LA is worse than the England average. Moving clockwise around the dartboard represents elements of an acute hospital pathway, through A&E attendance, to admission, discharge and re-ablement care.

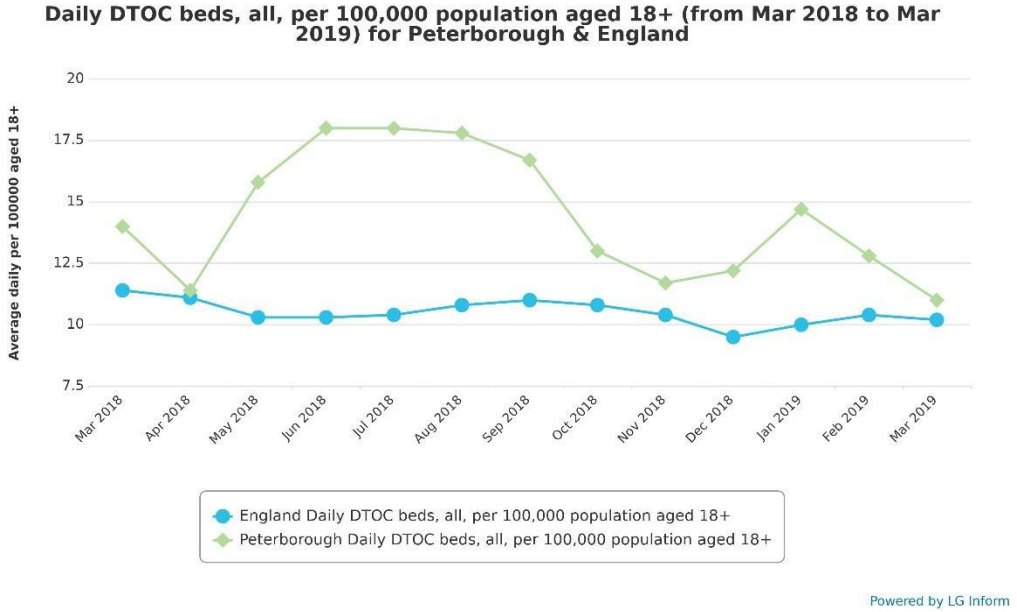
Time periods differ between indicators. Full details can be found in the technical appendix.

Key features highlighted from this data profile are:

- Peterborough Delayed Transfer of Care (DTOC) performance continues to be worst tha the England average, but there has been an overall improvement in performance over the last 12 months
- The number of people receiving reablement in Peterborough are now at England average levels.
- In Peterborough, A&E attendances of over 65s remain higher than the national average
- Emergency re-admissions within 30 days have reduced slightly in Peterborough since 2017
- Emergency admission for those aged 65+ have risen and remain higher than average in Peterborough
- Length of stay for emergency admissions has reduced in Peterborough and are lower than the national average
- Peterborough performance for care home acute pathways is better than the national averages

4.1.4 <u>Delayed Transfers of Care (DTOCs)</u>

DTOC performance has continued to be a challenge for the local system, but the below graph shows that there has been significant improvement in performance over the last 12 months.



For March 2019 Peterborough, compared to all single tier and county councils in England, is ranked 102 on the overall rate of delayed days per 100,000 population aged 18+, with a rank of 151 given to the area with the highest rate. It is ranked 136 on the rate of delayed days attributable to the NHS, and 13 on the rate of delayed days attributable to social care.

4.2 **Drivers and Strategic Priorities for Change**

The Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) key priorities, also illustrated below, mirror our system's principles around prevention, healthy lifestyles, early intervention, promoting independence, system sustainability and integration.

| Priorities for change | 10-point plan |
|---|---|
| **At home is best** | 1. People powered health and wellbeing<br>2. Neighbourhood care hubs |
| **Safe and effective hospital care, when needed** | 3. Responsive urgent and expert emergency care<br>4. Systematic and standardised care<br>5. Continued world-famous research and services |
| **We're only sustainable together** | 6. Partnership working |
| **Supported delivery** | 7. A culture of learning as a system<br>8. Workforce: growing our own<br>9. Using our land and buildings better<br>10. Using technology to modernise health |

*Peterborough and Cambridgeshire STP priorities for change*

Improved integration and joint working between health and social care has been a long-term strategic priority in Peterborough. Our shared system vision for integration was articulated in the 2017-2019 Better Care Fund (BCF), as outlined below:

Our vision across Cambridgeshire & Peterborough

*"Over the next five years in Cambridgeshire and Peterborough, we want to move to a system in which health and social care help people to help themselves, and the majority of people's needs are met through family and community support where appropriate. This support will focus on returning people to independence as far as possible with more intensive and longer-term support available to those that need it.*

This vision is underpinned by seven core principles to make sure we make a long-term difference to health and wellbeing throughout the county and that we help those who need it most. We aim to:

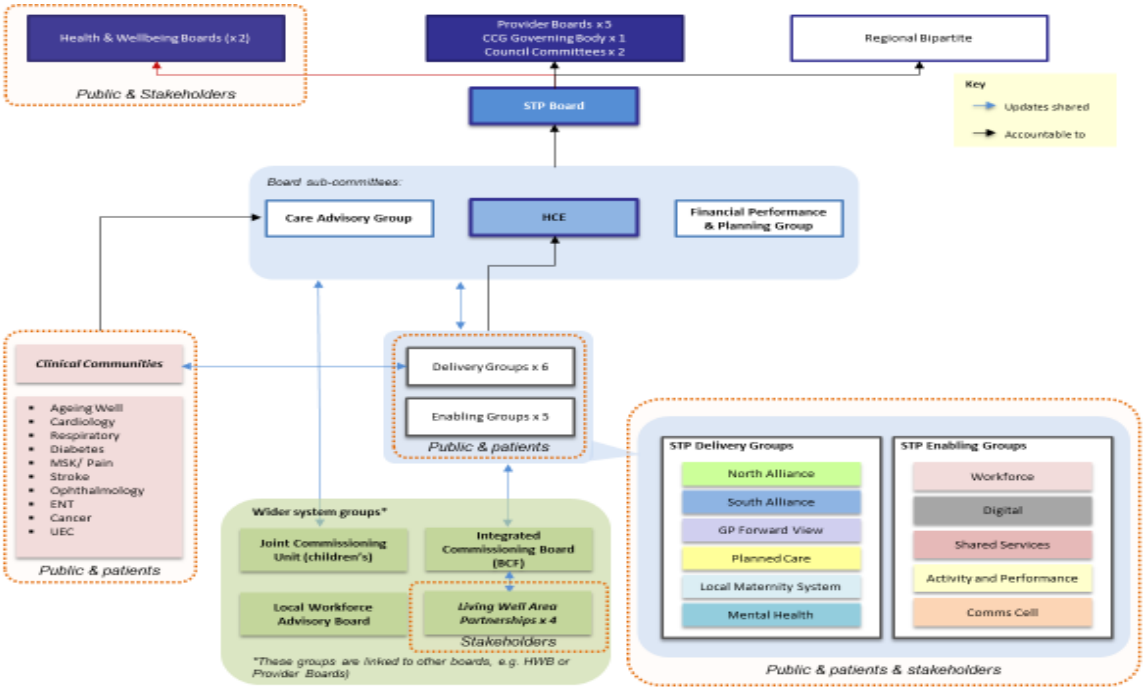
- Reduce inequalities by improving the health of the worst off fastest;
- Focus on preventing ill health by promoting healthy lifestyles while respecting people's choices and for those who have an illness, preventing their condition from worsening;
- Make decisions which are based on the best possible evidence;
- Develop solutions which are cost-effective and efficient;
- Recognise that different groups and communities have different needs;
- Encourage communities to take responsibility for making healthy choices; and
- Make sure services are sustainable.

4.3 **Governance**

Our shared strategic ambitions are delivered through longstanding and mature partnership arrangements. The Sustainability and Transformation Partnership (STP) has established a multi-agency multi-level governance structure to deliver our system priorities. The STP (please see governance diagram below) Board contains NHS partner Chairs and CEOs as well as elected members and directors of Cambridgeshire County Council and Peterborough City Council. STP governance also has the necessary structures and groups to ensure that senior

executive leaders, operational directors, finance leaders, local clinicians and other stakeholders are driving forward the delivery of priorities.

*STP governance arrangements*




**Health and Well-being Boards (HWB):** Provide the formal strategic leadership for health and social care services through two Boards – one for Cambridgeshire and for Peterborough. HWBs routinely meet jointly and include County Council/Unitary Authority (elected and Lead Officers), District Council representation, NHS provider representation, the CCG, the Police and Crime Commissioner, Healthwatch, with the voluntary sector co-opted.

The **Health Scrutiny Committees** review key areas of priority, for example, Delayed Transfers of Care. In addition, Scrutiny can effectively drill down via its 'topic' process into key issues where Members require greater levels of assurance. Most recently, Scrutiny examined issues such as workforce, patient transport and pressures on primary care services. Cambridgeshire and Peterborough Councils have an Adults Committee and a Communities and Adults Committee respectively that provide oversight of adult social care and a lead Portfolio holder for adults.

**Living Well Area Partnerships (transitioning to Place Based Delivery Boards):** the Living Well Partnerships are currently being reconfigured to become Place Based Delivery Boards. These boards will support the system priority of developing neighbourhood place based care and will lead on developing delivery at a local district level. Membership represents a wider community of stakeholders including patient representatives, Healthwatch, Local GP representatives, Primary Care Management Leads, NHS Trusts, District Councils, Public Health, the community & voluntary sector.

**Cambridgeshire and Peterborough Safeguarding Adults Board**: The Safeguarding Adults Board is made up of strategic leaders from a wide range of partner agencies whose activity is key in safeguarding adults. They have the responsibility for developing and authorising the strategic framework for safeguarding, including the policies and strategies needed to meet the core functions of the Board and the priorities in the Business Plan. The Board report to a Safeguarding Executive Group, made up of the three statutory partners (Local Authority, Police and CCG representing Health) at the highest Executive level. It holds the responsibility for ensuring there is an effective arrangement in place to safeguard children, young people and the adults who come under Section 42 of the Care Act. In doing so they are joined by senior leaders from Healthwatch and Public Health. They approve the Business Plan and ultimate

accountability lies with them.

**North and South Alliances:** Two, recently developed, Alliance Delivery Groups ensure providers of services for health and social care work together in partnership to better plan and deliver a wider range of services across a geographical area that are more proactive, person-centred and holistic, sometimes pooling resources and budgets. By working together at a neighbourhood level, and around our acute hospital footprints, these Alliances aim to improve population health outcomes, manage demand for services, reduce the unacceptable delays and barriers to people's care and, in particular, reduce the number of days people spend in a hospital bed as an emergency.

**A&E Delivery Boards:** These two Boards compliment the above Alliances and address operational performance issues and ensure urgent care needs are dealt with in the most appropriate setting by the most appropriate services (which in many cases should not be in A&E departments or acute hospital beds). They deliver nationally mandated improvement initiatives and core responsibilities to lead to A&E recovery, as well as oversee improvement projects that require locality tailoring for successful implementation. Our A&E Delivery Boards also provide a vehicle for strong and visible front-line clinical leadership and resident/patient involvement, as well as promote a culture of continuous quality improvement.

**Integrated Commissioning Board:** The Board's primary focus is to provide oversight and governance for joint strategic commissioning opportunities across health and social care, including delegated authority for the Better Care Fund.

4.4 **Current Priorities for Joint Working with Health**

There are a number of current key priorities for joint working with health, including:

- System working to address DTOCs
    - Improved Better Care Fund (iBCF) investment to support DTOCs
    - Joint Discharge Programme
    - Market management of capacity for home care, residential and nursing care
- Admission Avoidance initiatives
    - Neighbourhood Place Based Care
    - Supporting care homes to reduce avoidable hospital admissions
    - Joint Commissioning to support prevention and early intervention

4.4.1 ***System Working to Address DTOCs***

NHS partners and both councils have worked in close partnership, at a strategic level through the Sustainability and Transformation Partnership (STP) and through our Joint Better Care Fund Plans, resulting in significant investment to reduce current challenges. A range of operational forums have been established to co-ordinate our system wide activities to enable timely hospital discharge. That said it needs to be recognised that there are a number of major challenges, including a growing older population, greater acuity of need, workforce recruitment and retention and significant funding issues across the health and care system.

<u>iBCF Investment to Support DTOC Pressures</u>

Significant Improved Better Care Fund (IBCF) investment has been made to support DTOC pressures, including additional reablement capacity, social worker capacity to support discharge and prevent hospital admissions, investment in community equipment and occupational therapist support, the implementation of the trusted assessor model to support care homes to reduce assessment related discharge delays and investment in continuing healthcare resources to support implementation of a new CHC hospital discharge process.

<u>Joint Discharge Programme</u>

The Discharge Programme continues to be the highest priority for the System. It is a joint priority programme of work, which has been agreed with health and social care partners to support delivery of the 3.5% target. A Discharge Programme Operational Group has been

established to implement key operational changes to support delivery of the DTOC programme, with the key focus areas being:

- Following best practice learning from other areas, a review of validation processes ie being undertaken. This will support a consistent approach to reporting and reduce instances of over-reporting as a system.
- Referral and assessment pathways for discharge to assess pathway 1 (intermediate care and reablement at home provision) are being reviewed to support less handoffs and reduce unnecessary delays in discharges. This will ensure the use of light touch assessments and development trusted assessor models.
- Integrated Discharge Team (IDT) managers have been recruited to at Addenbrookes and Peterborough City Hospital, starting within May and June 2018. Hinchingbrooke is currently being recruited to you. These roles will take the operational day to day lead on the multi-disciplinary IDT to ensure a co-ordinated response to complex discharges, holding individual organisations to account.
- Revisions to patient choice communications and policies has been undertaken and is in the process of being implemented across the hospital sites. This work is happening alongside continued culture change and confidence building amongst staff, supporting difficult conversations with patients to happen earlier.

Demand and capacity modelling was undertaken as part of the discharge programme of work. It was led by a multi-disciplinary task and finish group, with the objective of understanding the capacity and demand gap for post hospital care provision; and developing recommendations for addressing capacity shortages. Following a detailed analysis into the key areas of demand for post hospital discharge support, the outcomes showed that we have adequate capacity at a global level across domiciliary care, residential, nursing and intermediate care beds. The issue is the way in which 'demand' presents itself. This means that we don't have the right capacity in the right place at the right time (**capacity mismatch**). There are a number of reasons for this, including - Flow in and out of services isn't 'average' or 'steady', we discharge in bunches, Geographical variations, Patient choice (e.g. male carers, time of calls), Not all patients are eligible (e.g. ward design, entry criteria, mixed sex wards etc.) and Flow out services impacts on blockages in short term provision. 'Capacity' is hiding 'Process Delays' in some instances. As a system we have already invested in additional capacity, increasing reablement, domiciliary care and care home provision and we continue to work with the market to maximise capacity. Therefore, the work of the discharge programme has now been configured to support how we can do things differently, including making the best use of process and flow, changing the conversation with patients, commissioning differently (e.g. personal health budgets, place based commissioning) and focusing on admissions avoidance to reduce flow into hospital.

<u>Market Management of Capacity</u>
The Council is working intensively with the independent care home market to increase supply to care provision. The local authority has actively commissioned additional domiciliary care capacity (10% increase since April 2017) and residential care home capacity (11.2% increase since April 2017). Additional investment from Hancock winter monies has also been made in ensure the provision of nursing care, which has been a particular pressure within Peterborough. We continue to work with the market to increase and maximise capacity which has included the development of our Joint Market Position Statement.

An integrated brokerage function is being developed across health and social care, providing a single point of managed access to the market across Cambridgeshire and Peterborough for Adults, including older people and physical disabilities. This will enable a managed response to demand, removing competitive agency behaviours, ensuring better control of market fees and maximising opportunities for optimising provider capacity through a dedicated route to market. The local authority and CCG continuing health care (CHC) brokerage teams are now co-located and further integration discussions continue to enable a refinement of aligned processes and practice.

4.4.2 ***Admissions Avoidance Initiatives***

A number of admission avoidance interventions have been implemented, including joint iBCF/STP investment in falls prevention and stroke prevention projects. The Council has established Adult Early Help services and continues to work with primary care and CPFT's neighbourhood Teams to identify people whose needs may be escalating or may be vulnerable to hospital admission.

*Neighbourhood Place Based Care*

The system is committed to the development of place based delivery and the Council has been working closely with NHS Partners around the development of local Integrated Neighbourhoods. This work sits alongside the development of Primary Care Networks with populations of 30,000 – 50,000 and is being aligned to the Council led Think Communities programme and Adults Positive Challenge. The model of delivery is driven by a neighbourhood, 'place based' approach, and success will mean that people have greater independence and better outcomes via a greater focus on prevention, empowerment and building self-sufficient and resilient communities.

*Supporting Care Homes to Reduce Avoidable Admissions*

The need to improve the quality of life, healthcare and planning for people living in care homes is essential as we move from reactive models of care delivery towards proactive care that is centred on the needs of residents, their families and staff working in care homes. It is recognised that many people living in care homes do not have their needs appropriately assessed and acted on in a holistic manner. This frequently leads to people experiencing unnecessary, unplanned and avoidable admissions to hospital, and inappropriate prescribing of medication which can lead to adverse health outcomes.

Key system priorities are focused on co-producing solutions to support implementation of the Enhanced Health in Care Home model and maximise opportunities for aligning health and social care resources to improve the support offer to care homes. This includes how we support discharge planning through coordinated multi-disciplinary support to care homes, closer alignment of quality assurance, contract management and care home support resources to maximise impact and upskilling the care home workforce to support effective management of residents, preventing unnecessary hospital admissions.

*Joint Commissioning to Support Prevention and Early Intervention*

Integrated commissioning approaches support us to increase consistency in service provision and enable better engagement and market management. The following are a number of existing integrated commissioning arrangements that we already have in place:

- BCF pooled budget: commissions a range of integrated initiatives, including: community multidisciplinary neighbourhood teams, prevention and early intervention initiatives such as falls prevention, interventions to support the management of DTOCs;
- Support for people with mental health issues;
- Learning Disability Partnership;
- Community Occupational Therapy Services; and
- Community Equipment Services and Technology Enabled Care Services.

As a system, we continue to work across Adult Social Care and health to develop joint up commissioning strategies, for example the development of our local Dementia Strategy.

## 5. CONSULTATION

5.1 Consultation has not been required.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Not applicable. The contents of this report provide an update for the board to note.

## 7. REASON FOR THE RECOMMENDATIONS

7.1 The report is for the information to the board.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Not applicable.

## 9. IMPLICATIONS

### Financial Implications

9.1 There are no direct financial implications resulting from this report.

### Legal Implications

9.2 There are no direct legal implications resulting from this report.

### Equalities Implications

9.3 There are no direct equalities implications resulting from this report.

## 10. BACKGROUND DOCUMENTS

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

10.1 Better Care Fund Plan 2017-19
Cambridgeshire and Peterborough Sustainability and Transformation Plan

## 11. APPENDICES

11.1 None

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| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 12 |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Will Patten, Director of Commissioning | |
| Cabinet Member(s) responsible: | Cllr Holdich – Leader of the Council and Deputy Mayor of the Cambridgeshire and Peterborough Combined Authority | |
| Contact Officer(s): | Caroline Townsend, Head of Commissioning Partnerships and Programmes | Tel: 07976 832188 |

# BETTER CARE FUND UPDATE

| RECOMENDATIONS | |
|---|---|
| **FROM: Director of Public Health** | **Deadline date: N/A** |

It is recommended that the Health and Wellbeing Board:

1. Note the contents of the report, which provides an update on the progress of the Better Care Fund (BCF).

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health & Wellbeing Board as an update, in accordance with the statutory requirement of Health & Wellbeing Boards to oversee local Better Care Fund plans.

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an update to the Health and Wellbeing Board on progress and performance of the local Better Care Fund plans.

2.2 This report is for the Health and Wellbeing Board to consider under its Terms of Reference No 2.8.3.6

*To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities.*

## 3. TIMESCALES

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

## 4. BACKGROUND AND KEY ISSUES

4.1 As previously reported, Peterborough's BCF has created a single pooled budget to support health and social care services (for all adults with social care needs) to work more closely together in the city. The BCF was announced in June 2013 and introduced in April 2015. The 2018/19 £18.5m budget is largely a reorganisation of funding currently used predominantly by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and Peterborough City Council (PCC) to provide health and social care services in the city. It includes funding for the Disabled Facilities Grant, which supports housing adaptations and Improved Better Care Fund (iBCF) monies.

4.2 **BCF Performance**

2018/19 performance was reported to NHS England on 25th April 2019. The below provides a summary of performance against the four BCF national metrics.

| Metric | Peterborough Performance | | Mitigating Actions |
|---|---|---|---|
| | Summary Performance to date | RAG Rating | |
| **Non-elective admissions to hospital** | At year end performance was at 18,780 against a target of 18,316 | | The refinement of the scope and criteria of the JET service and the co-location of JET triage within the 111 hub.<br>Improved usage and extended opening of Ambulatory Care services to avoid ED admissions. |
| **Delayed Transfers of Care (DTOCs) from hospital** | Full year performance was 7,824 against a target of 3,258 | | Significant Improved Better Care Fund (iBCF) investment has continued.<br>Integrated Discharge Service is in operation and continues to embed and be refined.<br>There has been streamlining of discharge processes to enable faster referral and prevent unnecessary delays as a result of process. |
| **Admissions to long-term residential and nursing homes in over 65 year olds** | There were 131 actual admissions against a target of 184 | | Target achieved |
| **Effectiveness of reablement services** | Final year performance was 82% against a target of 82.9% | | The service has suffered in respect of capacity at some points due to the reablement service supporting a number of bridging packages. |

However, it is important to note that success in these indicators is reliant on a significantly wider range of factors than activity contained within the BCF Plan. Whilst BCF-funded activity will have successfully had an impact on preventing non-elective admissions and reducing DTOCs, this has not been sufficient to mitigate all underlying demand and increased pressures across the system.

4.3 **Better Care Fund Planning 2019-20**

Peterborough will be required to submit new BCF plans for 2019-20 to NHS England. The plans will be for a 1 year period and Hancock winter monies will be required to be included in the pooled BCF budget for 2019-20. The Better Care Fund (BCF) Policy Framework for 2019-20 was published by the Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) on the 10th April 2019. There will be minimum change to the BCF in 2019-20. The detailed BCF Planning Guidance for 2019-20, which will contain more detailed information on the submission of local plans, is still awaiting publication. Discussions are currently underway with the CCG and local partners to inform the planning cycle.

4.4 **Progress of Delivery**

The BCF monies were not new monies into the system and nearly all of the funding included within the BCF budget was already being used in Peterborough to support local health and social care services. Therefore, BCF monies have been invested across business as usual activities and a number of transformation projects. The IBCF was introduced in April 2017, it was new monies to the system and the national conditions required the IBCF to be spent on Adult Social Care, with the aim of meeting adult social care needs, reducing pressures on the NHS (including DTOCs); and stabilising the care market. The below offers a brief summary of key progress to date:

***Prevention & Early Intervention:*** Falls prevention 'Stronger for Longer' campaign was launched in October 2018. Multi-factorial falls risk assessments and strength and balance exercise programmes are embedded. The Atrial Fibrillation project has seen an increase in the number of AF patients receiving anticoagulation across Greater Peterborough and Wisbech from 74.7% to 79.2%. Technology enabled care (TEC) steering group continues to oversee the development of an integrated offer across Peterborough and Cambridgeshire. TEC First training is being delivered to professionals across the health and social care sector.

***Community Services / MDT Working, Case Management:*** All neighbourhood teams (NTs) have in place a system of case management through multi-disciplinary team working (MDT).

***High Impact Changes (HIC):*** Delivery of the 8 HIC to manage discharges, supporting the system to deliver the 3.5% DTOC target. The HIC areas are: early discharge planning; systems to monitor patient flow; MDT/multi-agency discharge teams; home first / discharge to assess; 7 day services; trusted assessor; focus on choice; and enhancing care in care homes. Significant IBCF investment continues to support delivery of the local DTOC plan, with embedded increased reablement capacity, falls lifting service, additional social work capacity to support discharge and admissions avoidance, falls lifting service and voluntary sector hospital discharge support. An evaluation of 2018/19 progress has been undertaken to inform future approaches.

***Information, Communication and Advice:*** PCC have developed a single directory of services, the 'Peterborough Information Network' which brings together all core council directories into one directory source, improving quality, consistency and service user experience. NHS Online and 111 Online have been implemented. There are ongoing discussions to review the most appropriate opportunities for linkages across the wider system.

***Investment into housing options for vulnerable people:*** Due to unprecedented financial pressures resulting from increasing costs of care and increasing demands on resources from winter pressures. The 2018/19 money was invested in line with the national conditions to meet adult social care needs and stabilising the care market. The project deliverables are continuing, with a commitment to seek corporate capital investment as required. A cohort of service users with learning disabilities has been identified. An initial property has been purchased. Assistive Technology requirements for the property are being reviewed and a robust transition plan for each service-user is being developed.

4.5 **Governance**

A joint two year (2017-19) Cambridgeshire and Peterborough BCF and iBCF plan was submitted following Cambridgeshire Health and Wellbeing approval on 9th September 2017 and Peterborough Health and Wellbeing Board approval on the 11th September 2017. The plan received full NHS England approval in December 2017 and a two year section 75 agreement was established between Cambridgeshire County Council and Cambridgeshire and Peterborough Clinical Commissioning Group.

Quarterly updates on BCF progress are reported to NHS England. In addition, quarterly reporting to the Ministry of Housing, Communities and Local Government on the progress of the iBCF is also undertaken. Local monitoring of performance and financial spend is overseen by the Integrated Commissioning Board, which has delegated responsibility for the BCF and iBCF from the Health and Wellbeing Board. The Integrated Commissioning Board meets monthly.

Initiatives which are jointly funded with the STP are also monitored through the STP North and South Alliance Boards, which have health and social care system wide representation in attendance.

In addition, a system-wide steering group has been set up, meeting 6-weekly, to monitor and assess iBCF interventions and to perform "deep dives" on specific areas that demand greater scrutiny in order to inform plans for 2019/20.

## 5. CONSULTATION

5.1 As previously reported, in the developing and drafting of the BCF Plan there were detailed discussions and workshops with partners, including discussion at the A&E Delivery Board and appropriate STP governance boards. The Joint Cambridgeshire and Peterborough Integrated Commissioning Board, which has system wide health and care representation, has overseen the development of the plan In line with national requirements, local system partners have approved and are signatories to the 2017-19 BCF Plan. Joint working across Cambridgeshire and Peterborough continues and regular monitoring activities have been solidified to ensure clear and standardised reporting mechanisms. A multi-disciplinary steering group, accountable to the Integrated Commissioning Board has been established to ensure there is effective ongoing monitoring and review of Improved Better Care Fund funded initiatives.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 Not applicable. The contents of this report provide an update for the board to note.

## 7. REASON FOR THE RECOMMENDATIONS

7.1 The report is for the information to the board.

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 Not applicable.

## 9. IMPLICATIONS

### Financial Implications

9.1 Delivery assurance through the Board will enable the Council and the CCG to continue to meet NHS England's conditions for receiving BCF monies. The BCF financial allocation for 2018/19 for Peterborough was £18.6m. 2019/20 allocations are still in negotiation.

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

### Legal Implications

9.2 There are no direct legal implications resulting from this report.

### Equalities Implications

9.3 There are no direct equalities implications resulting from this report.

## 10. BACKGROUND DOCUMENTS

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

10.1 Peterborough Better Care Fund Plan 2017-19
Peterborough Better Care Fund 2018/19 Quarter 4 return to NHS England

## 11. APPENDICES

11.1 None

| HEALTH AND WELLBEING BOARD | AGENDA ITEM No. 13 |
|---|---|
| **24 JUNE 2019** | PUBLIC REPORT |

| | | |
|---|---|---|
| Report of: | Dr Liz Robin Director of Public Health | |
| Cabinet Member(s) responsible: | Cllr Wayne Fitzgerald, Deputy Leader and Cabinet Member for Adult Social Care, Health and Public Health | |
| Contact Officer(s): | Ben Brown, Public Health Specialist Registrar | Tel. 01733 207176 |

# DIVERSE ETHNIC COMMUNITIES JOINT STRATEGIC NEEDS ASSESSMENT - SOUTH ASIAN COMMUNITIES SUPPLEMENT

| RECOMMENDATIONS | |
|---|---|
| **FROM:** Dr Liz Robin | **Deadline Date**: N/A |

It is recommended that the Health and Wellbeing Board:

1. Note for information the Diverse Ethnic Communities Joint Strategic Needs Assessment South Asian Communities Supplement, which has already received delegated approval from the Peterborough Living Well Partnership.

## 1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a referral from the Director of Public Health

## 2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to ensure that the Health and Wellbeing Board are aware of the findings of the Peterborough Diverse Ethnic Communities Joint Strategic Needs Assessment (JSNA) South Asian Communities Supplement.

2.2 This report is for the Health and Wellbeing Board ] to consider under its Terms of Reference No 2.8.3.5.

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

2.3 The report does not link directly to the Children in Care Pledge, but does include some information on the health of children.

## 3. TIMESCALES

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

## 4. BACKGROUND AND KEY ISSUES/

4.1 Approval of the Diverse Ethnic Communities JSNA South Asian Communities Supplement was delegated to the Peterborough Living Well Partnership at the HWB Board's meeting in December 2018. The purpose of the delegation was to ensure that implementation of the JSNA supplement findings and recommendations was not delayed by waiting for the next meeting of the HWB Board.

4.2 The JSNA supplement findings were discussed and approval given by the Peterborough Living Well Partnership in February 2019.

4.3 The full JSNA supplement is attached as Annex A to ensure that the information within it is available to the HWB Board members.

## 5. CONSULTATION

5.1 The work to prepare the JSNA supplement included a community survey and focus groups.

## 6. ANTICIPATED OUTCOMES OR IMPACT

6.1 The JSNA supplement will help to inform work with local South Asian communities to support and improve health and wellbeing

## 7. REASON FOR THE RECOMMENDATION

7.1 Preparing a Joint Strategic Needs Assessment is a statutory duty of the Health and Wellbeing Board. Therefore, although approval of the JSNA supplement has already been delegated and agreed, it is important for the HWB Board to be aware of the JSNA findings

## 8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The alternative option would be not to bring a paper to the HWB Board, as approval for this JSNA supplement has already been delivered through delegation. However this option would mean that Board members were not made aware of the information and findings in the JSNA supplement.

## 9. IMPLICATIONS

### Financial Implications

9.1 N/a as report is for information only

### Legal Implications

9.2 N/a as report is for information only

### Equalities Implications

9.3 N/a as report is for information only - however the JSNA findings should be helpful in ensuring that equalities duties in respect to ethnicity are delivered.

## 10. BACKGROUND DOCUMENTS

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

10.1 Peterborough Health and Wellbeing Board December 10th 2018 agenda item 9: Delegated Authority - Long term conditions Joint Strategic Needs Assessment and Diverse Ethnic Communities Joint Strategic Needs Assessment - South Asian Communities Supplement

## 11. APPENDICES

11.1 Annex A: Peterborough Diverse Ethnic Communities Joint Strategic Needs Assessment - South Asian Communities Supplement

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# Diverse Ethnic Communities Joint Strategic Needs Assessment for Peterborough – South Asian Communities Supplement

# Contents

## Contributors and Acknowledgements

| Name | Role |
|---|---|
| Dr Kathy Hartley | Consultant in Public Health Medicine, Cambridgeshire County Council & Peterborough City Council |
| Ben Brown | Specialty Registrar Public Health, Cambridgeshire County Council & Peterborough City Council |
| David Lea | Assistant Director of Public Health Intelligence, Cambridgeshire County Council & Peterborough City Council |
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| Gen Fitzjohn | Public Health Information Analyst, Cambridgeshire County Council & Peterborough City Council |
| Elizabeth Wakefield | Public Health Information Analyst, Cambridgeshire County Council & Peterborough City Council |
| Shakeela Abid | Live Healthy Practitioner Specialist, Solutions4Health |

We are grateful to all those involved in the publication of the Diverse Ethnic Communities Joint Strategic Needs Assessment for Peterborough (2016) and subsequent survey of the South Asian communities in Peterborough.

# Executive Summary

## General Health

With the exception of West ward, that there is an association between higher rates of overall mortality, mortality from circulatory disease and coronary heart disease in wards with greater proportions of people in BME groups, including South Asian communities. Emergency hospital admissions are higher than the Peterborough average for these wards but elective (planned) admission rates are lower.

Nationally, mortality is higher for Pakistani infants compared to other ethnic groups. Low birth weight is also more prevalent amongst the South Asian communities compared to the national average.

People with a South Asian ethnicity have a 50% higher lifetime risk of developing type 2 diabetes than white Europeans.

Much of the risk associated with developing diabetes is related to lifestyle, such as diet and physical inactivity. Other factors may be important such as genetics or the way fat is stored and metabolised. Help seeking behaviour and language barriers may also help explain the higher incidence.

Overall, the South Asian population have a lower incidence of cancer than the white population. There are exceptions however. Liver cancer is more prevalent in the South Asian community, as is mouth cancer for females and cervical cancer for females over 65yrs.

*Local survey results found that the top 5 conditions that participants worried about were diabetes (11%) and having excess weight (11%). Heart disease (9%) High cholesterol (9%), high blood pressure (8%)*

## Screening

Nationally, uptake of screening for breast cancer, cervical, bowel and colorectal cancer is lower in the South Asian community than the population as a whole.

*Local survey results show that 33% of respondents who said that they had been offered a smear test either hadn't attended or didn't intend to. 35% of women thought that they hadn't been offered a breast examination or weren't sure. For bowel cancer 42% of those eligible thought that they hadn't been offered an appointment or weren't sure*

## Organ Donation

Although members of the South Asian Community are at higher risk of needing organ transplants, the proportion donating organs is lower than the general population.

## Communicable Disease

The highest rates of tuberculosis are found among people of Indian, Pakistani and Bangladeshi ethnicity who were born outside the UK. The numbers affected in the East of England have reduced significantly since 2011.

## Mental Health

Nationally, the proportion of Asian/Asian British women reporting a common mental disorder (CMD) is higher than the female population as a whole (29% and 21% respectively). Asian men are more likely than white men to report a psychotic episode in the past year.

*The local survey found that depression and anxiety is also something that people experience and worry about (10% and 8% of respondents respectively). A small but significant proportion of respondents do not have access to help (13%) or the ability to meet with friends/ family socially (5%).*

## Obesity, physical activity and diet

By Year 6 levels of obesity are significantly higher for children of Indian, Pakistani and Bangladeshi ethnicity than for England as a whole (37%, 41%, 44% and 34% respectively).

*The local survey found that a significant mismatch between those adults considering themselves to have excess weight (12%) and those who are overweight (65%).*

Nationally, the prevalence of risk factors for obesity, diabetes and heart disease are higher in the South Asian community compared to the population as a whole. For example, a lower proportion of Asian adults are physically active than the general population and eat 5 portions of fruit or vegetables per day.

*Approximately 16% of survey respondents report never achieving 30 mins exercise during a typical week. Approximately 26% do more than 120mins exercise/ week and 11% achieve 30 mins/day.*

*8% of those surveyed meet the recommendation '5-a-day' for consumption of fruit and vegetables. Females are more likely to be consuming more than two portions a day. The national Active Lives Survey estimated 57% of the population in Peterborough were meeting the '5-a-day' recommendation.*

## Smoking

Nationally, levels of smoking in the Asian community are lower than the general population (9% vs 15%). Smoking prevalence declines with age.

*Local survey data found very few female smokers. 15% of those under 65 reported smoking. Half of the 8 people over 65yrs reported smoking.*

## Perceptions of Health and Seeking Help

*Overall, 72% of respondents felt their health was 'good', 'very good' or 'excellent'. 9% rated their health as poor. This was similar between men and women.*

*Very few (2%) reported that they had wanted to seek medical attention in the past year but were unable to.*

*Physicians/doctors were the most common source of information, followed by family and friends. 60% of 18-24yr olds and 50% of 25-44yr olds use the internet, compared to 43% of 45-65yr olds.*

## Safety and Access to Community Services

*The vast majority of survey respondents feel safe at home or in the community most or all of the time (94% and 84% respectively).*

*Use of community facilities (swimming pool, libraries, parks) are comparable with usage amongst the general population.*

## Employment and Income

Members of South Asian communities are less likely to be economically active than white British residents. This disparity is particularly notable for Pakistani women, of which nearly 80% are economically inactive.

Nationally, 35% of people living in households headed by someone of Pakistani or Bangladeshi ethnic origin are living on a low income compared to 14% of the White population.

Nationally 20% of children live in a low income family. For children from Pakistani and Bangladeshi communities this proportion is more than double.

## Introduction

It is important that Local Authorities understand the composition and needs of their local population, in order to be able to plan and deliver services effectively, as well as being able to respond to any issues relating to community cohesion or address health inequalities. In 2016 Peterborough City Council published a Joint Strategic Needs Assessment (JSNA) which provided a framework for identifying and understanding the needs of diverse ethnic communities in Peterborough[1]. A key recommendation from this JSNA was to provide a supplement to the report focussing on the needs of the South Asian community.

This supplement provides information on the demography, education and health of the South Asian population in Peterborough, using local and national quantitative (numerical) data, together with national research, to provide information on the likely health and wellbeing needs of this community.

The data available comes from a number of sources, including national surveys and contact with health services. Data relating to ethnicity falls into two main categories. The first category is data related to people's self-reported ethnic group – for example from the national 2011 Census. The second category is data related to people's country of birth - for example National Insurance or GP registrations. Peterborough is often compared to other areas across Cambridgeshire or within the Eastern region or to England. Comparisons in this manner aim to highlight differences and therefore help to identify need that will help commissioners and planners allocate resources.

It's also important to understand the views and experiences of diverse communities, and of wider stakeholders which provide services and so a local community survey and focus group was undertaken to inform the JSNA. This is described in more detail below and the results are presented throughout the report.

## Ethnicity and Health

Ethnicity has been described as "a form of collective identity that draws on notions of shared ancestry, cultural commonality, geographical origins and shared biological features"[2]. For the purposes of this report the phrase 'of South Asian Community' is used to mean people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.

Ethnic identity can have an influence on health outcomes through a number of routes. For example, experiences of discrimination and exclusion, as well as the fear of such negative incidents, have been shown to have a significant impact on mental and physical health. Health-related practices, including healthcare-seeking behaviours, also vary importantly between ethnic groups[3].

[1] Diverse Ethnic Communities Joint Strategic Needs Assessment for Peterborough, 2016. Available at https://www.peterborough.gov.uk/healthcare/public-health/JSNA/

[2] Salway S, Carter L, Powell K, et al. Race equality and health inequalities: towards more integrated policy and practice. Race Equality Foundation Better Health Briefing Paper 32. Race Equality Foundation 2014:4

[3] Local action on health inequalities Understanding and reducing ethnic inequalities in health. PHE 2018.

Unfortunately, the quality of data relating to ethnicity is very variable. For example, although research suggests that uptake of screening programmes is low in some communities, no local data is available to examine this in detail. The small numbers in some local populations can make it hard to analyse data effectively, particularly if one then wants to examine differences by age or gender.

## South Asian Community Survey and Focus Group

The development and administration of the survey was led by the Public Health Team in association with colleagues from the Councils' Community Resilience and Integration team and healthy lifestyles provider, Solutions4Health. The survey took the form of a structured interview and was completed by volunteers using a number of routes, including attendance at Mosques and other community events.

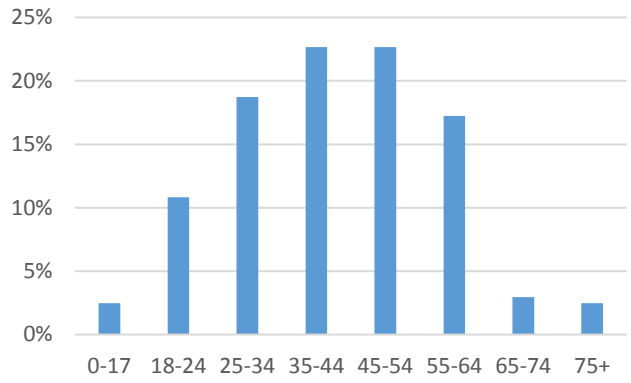
See Appendix 1 for full details of the questionnaire.

### Survey Respondents

The survey was completed by 249 people.

- Where gender was recorded (90% of respondents), 53% were male and 47% female
- The age profile of respondents is shown is Fig 1.

Fig1. Age Profile of Survey Respondents




- Where faith was recorded (87% of respondents), 82% were Islam/Muslim, 13% Hindu, Christian (3%), Sikh 1%, Christian and Muslim 1%
- Where primary language was recorded (78%), 38% spoke English, 27% Punjabi, 8% Urdu, 6% Gujarati, 3% Urdu/Punjabi, 3% Bengali, 3% Dari Pashto, 2% Telugu, 2% Tamil. A number of other languages were spoken by 2 or fewer people.[4]
- Where marital status was recorded (90%), 73% reported being married
- Of those reporting how long they had lived in the UK (88%), 48% had lived here all their lives. 48% had lived here more than 5 years but were born elsewhere.

[4] Tagalog/English, Hindi/English, Tagalog, Hindi, Kiswahil, Malayalam, Kannada

- Where employment status was recorded (88%), 66% reported being employed, 9% unemployed but not seeking work (e.g. caring for children), 5% unemployed and seeking work, 8% students, 8% retired, 3% carers, 1% unable to work due to illness.

It is important to view the results of the survey with these demographic characteristic in mind. The majority of respondents were of Islamic faith, married and long term residents of the UK. There are few responses from the unemployed, new arrivals to the country and those under 18 or over 65 years old. As a consequence it may be useful to complete further work targeted to these groups within the community.

**Recommendation:** Consider further work to explore the health needs of young people and the older population.

### Focus Group

A focus group was also undertaken with a sample of women in community worker roles within the South Asian Community. Six women participated, five of whom were Pakistani and one White British ethnicity. The session was facilitated jointly by members of the Public Health Team and Solutions4health. Discussion points are interspersed within the main report.

## Demography

The census data records information about people by how they describe their ethnicity, based on a choice of various ethnic groupings. This information does not necessarily reflect whether a person is born in the UK or not and therefore whether they are a migrant or not, it simply describes or assigns an ethnic origin to the person.

Details of ethnicity within a population are useful to determine the proportion and number of ethnic minority groups. Comparisons between populations on the ethnic mix provides useful information to commissioners and planners on where best to direct resources in order to address any need identified for particular ethnic communities.

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

Table 1 below gives a breakdown of the population of Peterborough in terms of overall numbers of people and percentage of the total population, by ethnic origin, as described in the 2011 census.

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

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

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

## Population trends of ethnic communities in Peterborough

Peterborough experienced big changes in its ethnic profile between the two census in 2001 and 2011. See Table 2. In terms of overall numbers, the population of Peterborough increased by 17.7% between 2001 and 2011. Whilst the Asian population experienced large percentage increases, the biggest change was within the 'white other' group and the Black British or Black African category.

As a proportion of the total population in Peterborough, the black or black British population (African or Caribbean) still accounted for less than 1.5% in 2011. Between 2001 and 2011, as a proportion of the total population,

- White British decreased from 86% to 71%
- White 'other' increased from 3% to 11%
- Asian or Asian British –Indian increased from 2% to 3%
- Asian or Asian British - Pakistani increased from 4% to 7%

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

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

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

Black and minority ethnic (BME) populations usually describe all non-white categories of people in a given population. The table below shows how the total BME population varies between Peterborough wards from 58.2% of the population of Central ward to 2.3% of the population of Northborough ward.

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

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

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

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

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

**Table 4 – Proportion of the population of each electoral ward as defined by ethnicity groups in the 2011 census**

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

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

# Health Profile

## Mortality

### Health impacts relating to country of origin

Describing the health of a population by country of birth is important as it represents a dimension of inequality in its own right and highlights significant health inequalities. It is not the same as considering ethnicity, as people born in the same country will identify with a number of ethnic groups and a substantial proportion of those from minority ethnic groups are born in the UK.

Data in Table 5 below shows mortality rates for common diseases according to countries of birth. It is likely that the influence of country of birth on health will depend on a number of factors including length of residence, age and socio-economic status.

It should be noted also that mortality rates within a country will be influenced both by the likelihood that people develop an illness, and by the local availability and quality of healthcare for that illness.

**Table 5: Causes of Death – Directly Age-Standardised Rate per 100,000 population, All Ages, 2012**

| Country | Diabetes | Cardio-vascular disease | Liver cirrhosis (male mortality only) | Cancer | Respiratory disease | Suicide |
|---|---|---|---|---|---|---|
| Bangladesh | 29.8 | 166.2 | 29.1 | 87.8 | 106.7 | 7.8 |
| India | 26.3 | 306.3 | 39.5 | 71.9 | 154.8 | 21.1 |
| Pakistan | 42.5 | 274.2 | 37.4 | 88.3 | 91.4 | 9.3 |
| UK | 4.2 | 111.8 | 16 | 130.4 | 30.5 | 6.2 |

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

Some main points from the table above:

- Diabetes in Pakistan causes age-standardised mortality rates ten times higher than the UK.
- Mortality from cardiovascular disease is higher in India and Pakistan than in the UK
- Cancer mortality rates are lower in the south Asian countries, compared to the UK
- Mortality from respiratory disease is high in the Asian countries listed
- Mortality rates from suicide are higher in India compared to the UK

Analysis conducted by Public Health England using ONS death registration data and the 2011 census data found a significantly worse cardiovascular disease mortality rate for both men and women born in India, Pakistan and Bangladesh compared to residents of England as a whole. The only exception were males born in India. The same analysis found that mortality rates from suicide and cancer were significantly lower for those born in India, Pakistan and Bangladesh compared to English residents. [5]

## Inequalities within Peterborough – mortality rates by electoral ward

Table 6 below shows the six Peterborough wards with the highest proportion in the population of BME ethnicities and compares overall mortality rates, mortality from circulatory disease and coronary heart disease. It also lists emergency and elective hospital admission rates for these wards.

It is clear, with the exception of West ward, that there is an association between higher rates of overall mortality, mortality from circulatory disease and coronary heart disease in wards with greater proportions of people in BME groups. It is also interesting that emergency hospital admissions are higher than the Peterborough average for these wards but elective (planned) admission rates are lower. This data does not directly link mortality risk and risk of emergency admission to ethnicity, but simply highlights the association in these wards. There is also a strong correlation between income deprivation and mortality rates and emergency hospital admission rates

[5] Public Health Outcomes Framework: Health Equity. Focus on ethnicity. Public Health England 2017.

and these wards have high levels of deprivation (apart from West ward). Deprivation is associated with risk factors for cardiovascular disease, including smoking prevalence, obesity and physical inactivity.

**Table 6 – Peterborough wards with the highest proportion of BME communities showing all-cause mortality rates, mortality from circulatory disease, coronary heart disease and rates of emergency and elective hospital admissions**

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

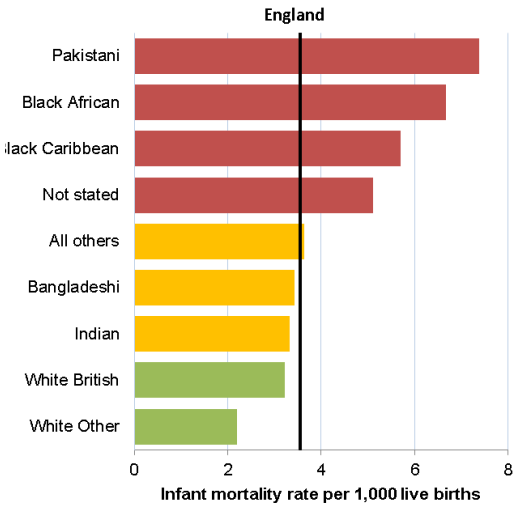
Red indicates rates higher than Peterborough average and green indicates rates lower than Peterborough average.

## Infant Mortality

Infant mortality is defined as the rate of deaths in infants aged under one year per 1,000 live births. It is a recognised 'barometer' for the health of the entire population and reflects many of the 'upstream' determinants of population health such as economic, social and environmental conditions.

For England as a whole, infant mortality rates have fallen over time, from 5.4 deaths per 1,000 live births in 2001-03 to 4 deaths per 1,000 live births in 2012-14. However, wide inequalities remain and rates vary considerably by ethnic group. In 2014, the Pakistani, Black African, and Black Caribbean ethnic groups, and those whose ethnic group was not stated, had significantly higher rates of infant mortality than England as a whole[6]. See Fig 2.

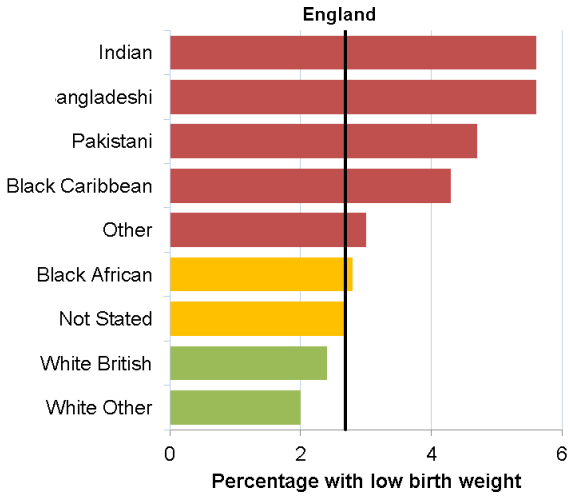
**Fig 2. Infant Mortality in selected ethnic groups, England, 2014.**




[6] Public Health Outcomes Framework: Health Equity. Focus on ethnicity. Public Health England 2017.

Low birth weight[7] increases the risk of childhood mortality and of developmental problems for the child, and is associated with poorer health in later life. A high proportion of low birth weight births could reflect issues with maternity services and/or behavioural factors of mothers. The proportion of low birth weight babies varies by ethnic group. In 2015, Indian, Pakistani, Bangladeshi, Black Caribbean, and Other ethnic groups had significantly higher proportions of term babies born with low birth weight than England as a whole[8]. See Fig 3.

**Fig 3. Low birth rate in selected ethnic groups, England, 2015**




## Cardiovascular disease (CVD) and ethnicity

Peterborough CVD JSNA 2015[9] contains a section describing risk of cardio-vascular disease associated with ethnicity.

It refers to data from the British Heart Foundation that shows a disparity between ethnicities in prevalence of CVD and in associated risk factors. Black Caribbean, Indian, Pakistani and Bangladeshi men have a higher prevalence of diabetes than the general population and black ethnic groups have a higher incidence of stroke for both sexes than the white ethnic groups (British Heart Foundation, 20106), while South Asian groups have a higher incidence of coronary heart disease.

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

Hospital admissions data for cardiovascular disease is available for Peterborough and broken down by ethnicity (Peterborough CVD JSNA 2015). This shows no increase in the incidence of admissions for CVD in the BME ethnicities compared with the white British community. However, there is a high

[7] Live births with a recorded birth weight under 2,500g and a gestational age of at least 37 complete weeks (full term) as a percentage of all live births with a recorded birth weight and a gestational age of at least 37 complete weeks.
[8] Public Health Outcomes Framework: Health Equity. Focus on ethnicity. Public Health England 2017.
[9] https://www.peterborough.gov.uk/upload/www.peterborough.gov.uk/healthcare/public-health/CardiovascularDiseaseJSNA-November2015.pdf?inline=true

proportion of ethnicity described as 'not known' in the data which is likely to make the results unreliable.

## Diabetes and ethnicity

As stated in the CVD JSNA, 2015, ethnicity is a risk factor for diabetes. People with a South Asian ethnicity have a 50% higher lifetime risk of developing type 2 diabetes than white Europeans. Diabetes in these groups can often occur at a younger age and in people with a lower Body Mass Index (BMI). Obesity and diabetes guidelines take account of this, by recommending services for weight management to those with South Asian ethnicity and lower BMI, in order to help prevent the development of diabetes or to help reverse new onset diabetes.[10]

As with cardiovascular disease, much of the risk associated with developing diabetes is related to lifestyle, such as diet and physical inactivity. Research also suggests that other factors may be important such as genetics or the way fat is stored and metabolised. Help seeking behaviour and language barriers may also help explain higher incidence of diabetes in the South Asian community[11].

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

### *Community Survey Result*

Diabetes was a top concern for those surveyed (12% or respondents) and one of the most prevalent conditions included within the survey (11% of respondents).

### *Focus Group Result*

Diabetes is a concern, however diseases such as these may be perceived by some as 'God's will' rather than preventable through lifestyle choices. People are less likely to be frightened by the prospect of diabetes in comparison to cancer.

## Variation in cancer incidence by ethnicity – evidence from the literature

BME groups have lower risk of cancer in general than people of white ethnicity.[12] Evidence shows that people of Asian, Chinese and mixed ethnic groups have significantly lower risk of cancer than those of white ethnicities if 'all malignancies combined' are analysed. Black females have a 10% - 40% lower risk of cancer than white females but the risk of cancer in Black males is similar to White males.

However, for specific cancers, the risk varied for different ethnic groups. The risk of liver cancer is 1.5 to 3 times greater for Asian ethnicities compared with White ethnicities. Cancer of the mouth was significantly increased for Asian females. The risk of cervical cancer is significantly higher in

[10] Obesity: identification, assessment and management. Clinical guideline [CG189] November 2014 and Weight management: lifestyle services for overweight or obese adults Public health guideline [PH53] May 2014
[11] Diabetes UK and South Asian Health Foundation recommendations on diabetes research priorities for British South Asians. Diabetes UK (2009)
[12] Cancer Incidence and Survival By Major Ethnic Group, England, 2002-2006 & National Cancer Intelligence Network, 2015

Asian females, for those aged 65 and over, but lower in Asian females below the age of 65, when compared with white females.

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

## Variation in cancer survival by ethnic group

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

## Cancer screening

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

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

It has been recommended that local language broadcasts on ethnic media and face-to-face approaches within community and faith settings should be developed to increase awareness of colorectal cancer and screening, and address challenges posed by written materials (Szczepura et al, 2008(2)).

This could be useful for enhancing bowel screening programmes locally that focus on hard to reach ethnic groups.

### *Community Survey Result*

Fig 4 below shows how the respondents, falling within the relevant age criteria answered when asked about cancer screening. Results for each screen are described below.

**Note:** *it should be noted when interpreting the data below that the numbers of eligible respondents who answered each question was low (smear test = 70, breast examination = 28, bowel screen =12). Therefore the results may not truly represent to the local community as a whole. However they are useful in identifying future lines of enquiry.*

Smear Test

Fig 5 shows that 54% of women have attended or intend to attend an offer of a smear test. According to NHS data, cervical cancer screening coverage in Peterborough during 2017 was 70%, however direct comparisons between these estimates is not possible due to the way the data was collected and the small number of respondents to the local survey. Perhaps of more concern are the 33% of respondents who said that they had been offered an appointment but either hadn't attended or didn't intend to. A further 13% said that they hadn't been offered or weren't sure whether this was the case.

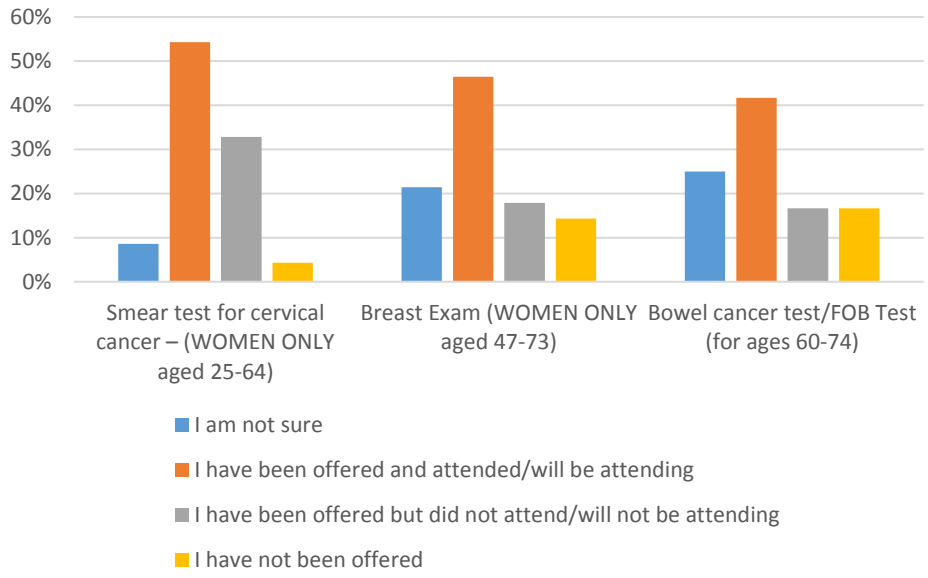
Breast Examination

46% of respondents have attended or intend to attend an offer of a breast examination. According to NHS data, breast cancer screening coverage in Peterborough during 2017 was 74%. Again direct comparisons between these estimates is not possible due to the way the data was collected and the small numbers of respondents to the local survey. It is notable however that 35% of women thought that they hadn't been offered a screen or weren't sure.

Bowel Cancer Screening

Only 42% of respondents said that they had attended or will be attending screening, having been offered it. Coverage of this screening nationally and locally is also low (59% and 54% respectively in 2017. Whilst a relatively low proportion (17%) said that they hadn't/wouldn't be attending an appointment which had been offered, 42% either weren't sure or hadn't been offered a screen.

**Fig 4.In the past five years, have you been offered and/or attended any of the following? (Select all that apply)**




## *Focus Group Result*

The participants highlighted that some women may not attend cervical screening appointments if they are not married. This is due to a belief that they will 'lose their virginity' through the process.

They may also think that they shouldn't be exposing themselves. There is also a need to dispel myths in relation to bowel screening.

## Cancer awareness in ethnic groups

There is evidence that awareness of cancer warning signs is low across all BME ethnic groups with lowest awareness in the African group. Women identified more emotional barriers and men more practical barriers to help seeking, with considerable ethnic variation (Waller, 200917). The study suggests the need for culturally sensitive, community-based interventions to raise awareness and encourage early presentation.

## Organ/Blood Donation

According to the NHS Blood and Transplant Service more donors from black, asian and minority ethnic groups are urgently needed to address an increase in patients from the same communities dying whilst waiting for an organ transplant. One in five people who died on the Transplant Waiting List last year were from a black, Asian or ethnic minority background[13].

Recent research found that almost a third of black and Asian people in England are unsure about donating their organs for lifesaving transplants after their death. A higher proportion - 37% - said they did not want to be an organ donor. Just 11% of those surveyed said they would definitely donate, while the remainder would consider it. The main barrier is the belief that organ donation is against their culture or religion. However, all the major religions in the UK support organ donation and transplantation.

Just 1 in 5 of those surveyed were aware that organs matched by ethnicity had the best chance of success. Only 1 in 10 knew that people from black, Asian and ethnic minority backgrounds are more likely to need an organ transplant than white people.[14]

## Communicable Diseases

Tackling tuberculosis (TB) is currently one of the key priorities of Public Health England. The highest rates of disease are found among people of Indian, Pakistani and Bangladeshi ethnicity who were born outside the UK. While reactivation of latent infections acquired outside the UK accounts for much of the disease burden, there is evidence that transmission within established communities in the UK may be an increasing issue, particularly among South Asian communities[15].

The rates of TB among people born outside the UK should be interpreted in the context of changes to the pre-UK entry screening policies. In 2005 the UK piloted the pre-entry screening of long term migrants to the UK for active pulmonary TB in 15 high TB incidence countries. In 2012 this pre-entry screening was extended to all countries with a high incidence of TB (>40 cases per 100,000 population).

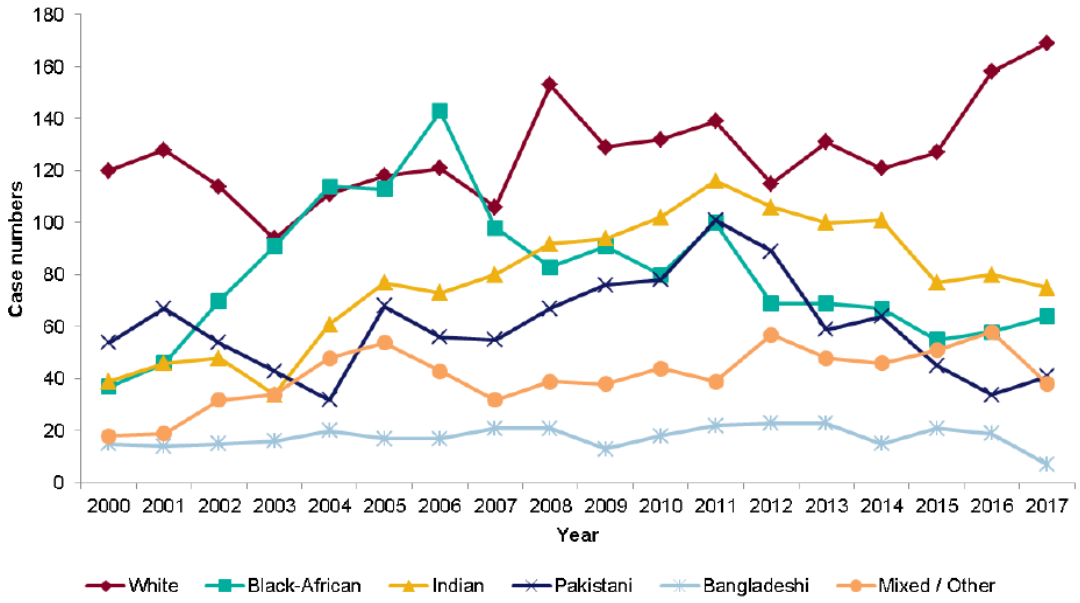
[13] https://organdonation.nhs.uk/about-donation/organ-donation-and-ethnicity/
[14] https://www.nhsbt.nhs.uk/news/survey-reveals-only-a-minority-of-black-and-asian-people-in-england-are-prepared-to-give-the-lifesaving-gift-of-organ-donation/#*
[15] Local action on health inequalities Understanding and reducing ethnic inequalities in health. PHE 2018.

In 2017 98.3% of people with TB had recorded a country of birth (402/409), and of these, 69.2% (278/402) were born outside the UK. The rate of TB was 16 times higher among these people (36.6 per 100,000) compared to UK born people with TB (2.3 per 100,000)[16][17]

Amongst TB patients born outside the UK and notified in 2017, the highest number were born in India and Pakistan. This accounted for 22% and 12% of non-UK born cases in the East of England. The median length of residence in the UK was 9 years and 13.5 years respectively.

Numbers of TB cases from Pakistan, India and Bangladesh have fallen significantly since 2011. However whilst there was a slight decline in the proportion of patients originating from India and Bangladesh between 2016-17, there was increase in those from Pakistan. See Fig 5.

**Fig 5. TB case number by ethnic group, East of England, 2000 to 2017**



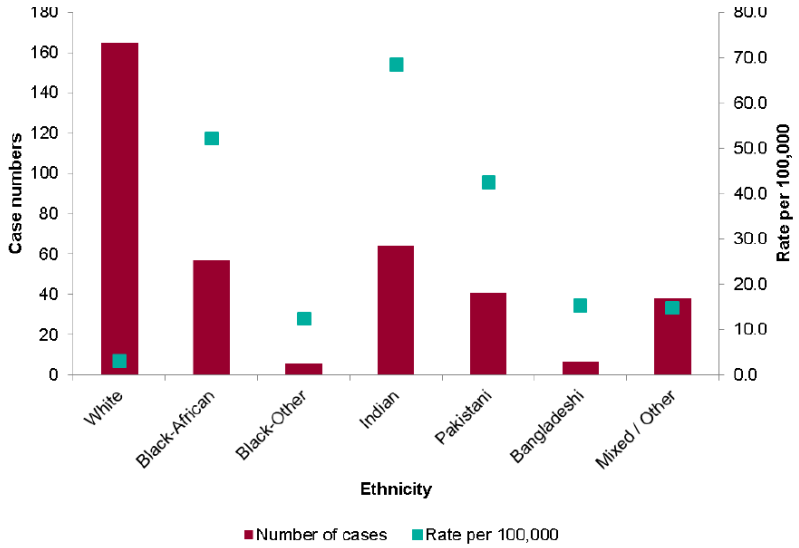

**Source:** Tuberculosis in East of England: Annual review (2017 data). Data from 2000 to 2017. Public Health England

In terms of age, there is a low rate of TB for those under 15 years old. For UK born cases, they are evenly distributed across the remaining age groups (49 cases aged 15-44 years, 38 aged 45-64 years, 33 aged 65 years or more). However, among those born outside the UK, the majority of cases are aged 15-44 years (67.3%, 187/278).

The reporting of TB cases by ethnic group is very good (98.5%). The highest numbers of TB cases in 2017 were white (43.7%). However, the highest rates were seen for Indian (68.5 per 100,000), black-African (52.2 per 100,000) and Pakistani (42.6 per 100,000) ethnic groups. See Fig 6.

[16] Tuberculosis in East of England: Annual review (2017 data). Data from 2000 to 2017. Public Health England
[17] These rates should be interpreted with caution, as population estimates, used as the denominators for UK born and non-UK born groups were calculated using the Labour Force Survey, which is liable to sampling error for small population groups

**Fig 6. TB case number and rate by ethnic group, East of England, 2017**




**Source:** Tuberculosis in East of England: Annual review (2017 data). Data from 2000 to 2017. Public Health England

## Mental Health

Tables 7 and 8 below provide a breakdown of rates of common mental disorders (CMD), psychotic disorders and other selected psychiatric symptoms, according to the national Adult Psychiatric Morbidity Survey 2014. It shows that South Asian women have higher rates of CMD, (which includes depression and anxiety), than other ethnic groups. Rates of psychotic disorder within the male Asian population are higher than white males and the population as a whole.

Anecdotal evidence from the healthy lifestyles provider in Peterborough, Solutions4Health suggests that dementia is growing concern for the South Asian community. This is partly due to a change in the choices being made by the younger generation to leave traditional extended family living arrangements. There is also a degree of stigma relating to the condition which may hinder diagnosis and provision of appropriate support. It is estimated that 65% of people with dementia living in Peterborough and Cambridgeshire have received a diagnosis[18]. Unfortunately this data is not available by ethnic group.

18 https://app.powerbi.com/view?r=eyJrIjoiM2Y0ZTUzMDUtMmYzOC00MDUxLWE1YTUtMjRhYzVkZjVlODRjIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

**Table 7. Age standardised rates of different mental disorder according to ethnicity, adults, 2014.**

| | | | Ethnic group | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | All adults | | White British | | White Other | | Black/ Black British | | Asian/ Asian British | | Mixed, multiple and other | |
| | male | female | male | female | male | female | male | female | male | female | male | female |
| **CMD*** | 13.2% | 20.7% | 13.5% | 20.9% | 13.1% | 15.6% | 13.5% | 29.3% | 12.9% | 23.6% | 10.5% | 28.7% |
| **Suicide** thoughts** | 18.7% | 22.4% | 19.6% | 23.5% | 23.3% | 18.6% | 21.4% | 20.3% | 12.0% | 14.3% | 9.5% | 26.6% |
| **Suicide* *attempts** | 5.4% | 8% | 5.3% | 8.5% | 6.0% | 6.2% | 8.9% | 3.9% | 5.1% | 5.6% | 1.5% | 10.0% |
| **Self-harm*** | 5.7% | 8.9% | 5.8% | 10.3% | 8.3% | 4.3% | 5.5% | 4.2% | 6.1% | 4.7% | 1.9% | 6.6% |
| *CMD past week, **lifetime , age standardised | | | | | | | | | | | | |

**Table 8 . Psychotic disorder in the past year (2007 and 2014 combined), by ethnic group and sex**

| | | Ethnic group | | | |
|---|---|---|---|---|---|
| | All | White | Black | Asian | Mixed/other |
| Men | 0.5 | 0.3 | 3.2 | 1.3 | - |
| Women | 0.6 | 0.7 | - | 0.4 | - |
| All adults | 0.5 | 0.5 | 1.4 | 0.9 | - |

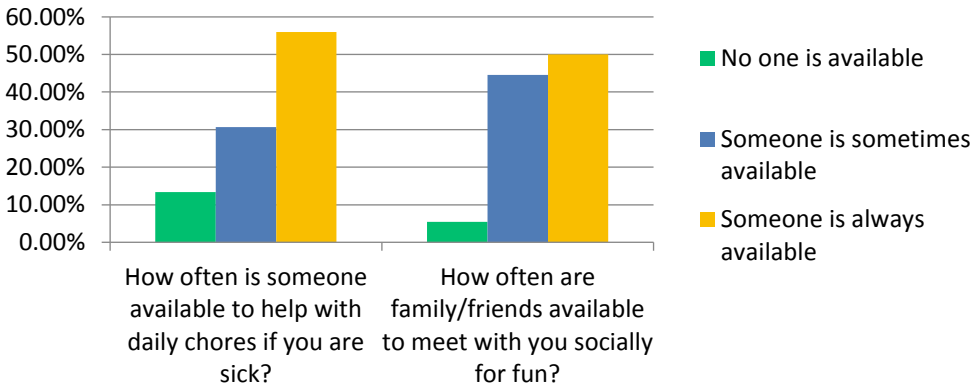
## *Community Survey Result*

There is evidence to show that loneliness is linked to a range of negative health outcomes and risk factors, such as inactivity, smoking, depression and low self-esteem. Feeling lonely can make a person more likely to perceive, expect and remember others' behaviour to be unfriendly. This can increase social anxiety and cause them to withdraw further, creating a vicious cycle. Feeling lonely frequently has a direct impact on individuals and can also have wider effects for society. For example, lonely people are more likely to be readmitted to hospital or have a longer stay. [19]

The survey asked people about the availability of help when sick and for social contact. See Fig 7. It shows that a small but significant proportion of respondents do not have access to help (13%) or the ability to meet with friends/ family socially (5%). However,

[19] A connected society. A strategy for tackling loneliness – laying the foundations for change. HM Government 2018

**Fig 7. Availabilty of help and social contact**




### *Focus Group Result*

There is a lack of understanding about dementia with the community and a reluctance (particularly amongst men) to discuss it, due to perceptions of shame. People may find real life examples helpful which they can relate to. There is power in sharing stories. Mental health problems are often a hidden issue for women, where a cultural attitude may persist that low mood is normal and people "just have to get on with things". This may be compounded by feelings of isolation resulting from a lack of contact with people outside the extended family

## Obesity, physical activity and diet

### Introduction

As well as increasing the risk of developing a whole host of diseases (including diabetes, high blood pressure and heart disease) obesity can harm people's prospects in life, their self-esteem and their underlying mental health. Research has shown that people who are obese or overweight are less likely to exercise in public as they feel discriminated against because of their weight.

Obesity also has wider and serious consequences for society. The overall cost of obesity to wider society is estimated at £27 billion. The UK-wide NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year.

Obesity, risk of obesity and obesity-related disease differs by ethnic group with some black and Asian populations showing increased risk for obesity and related disease compared with white British groups. (NOO Ethnicity and Obesity, 2011)

Research has shown that south Asian and black ethnicity is a predictor of obesity related behaviours among children in the UK and this cannot be explained by deprivation (Falconer et al, 2014)
There is consequently a need to develop culturally specific lifestyle interventions including assessments of dietary factors to reduce obesity-related health inequalities. This should be taken

into account when designing lifestyle services to help tackle obesity in children and adults within Asian and black communities in Peterborough.
The increased risk of obesity-related disease in some ethnic groups is acknowledged in NICE guidance which recommend reducing the threshold for obesity services for people with a black, black Caribbean or south Asian ethnicity from BMI of 30 to BMI of 27.5[20].

This would have an impact on weight management services in areas of Peterborough with higher proportions of people from these ethnic backgrounds. It will be important to ensure access to the relevant services for people from Asian and black ethnicities in general practices with higher proportions of people from these backgrounds.

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

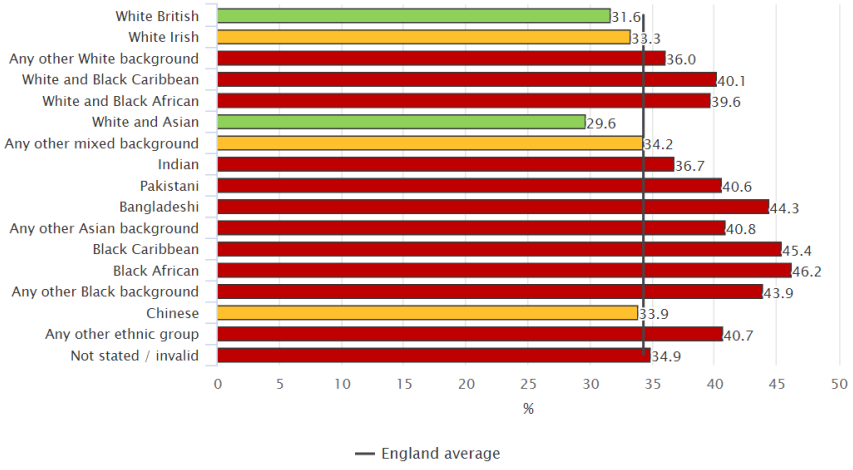
## Overweight and Obesity

In 2016/17, 23% of reception age children in Peterborough were estimated to be overweight (including obese)[21]. This was statistically significantly higher than the average for the East of England (21%). In year 6 (age 10-11), this is far higher (37%) which is again significantly higher than the region (32%).

Data is not available at local authority level by ethnic group, however national data shows that the proportion of reception age children from Indian, Pakistani, Bangladeshi or other Asian backgrounds who are overweight or obese (14.9%, 20.2%, 21.4% and 19.3% respectively) is significantly lower than England as a whole (22.6%).

However by year 6 (10-11 yr olds) the situation has reversed, with the proportion of children from Indian, Pakistani, Bangladeshi or other Asian backgrounds who are overweight (including obese) far higher than England as a whole (34.2%). See Fig 8.

**Fig 8. Year 6: Prevalence of overweight (including obese) England, 2016/17**




[20] Obesity: identification, assessment and management. Clinical guideline [CG189] November 2014 and Weight management: lifestyle services for overweight or obese adults Public health guideline [PH53] May 2014

[21] BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

By comparison, according to Sport England's Active Lives (AL) Survey, a lower proportion of adults of Asian ethnicity are overweight[22] than England as a whole (56% and 61% respectively). It should be noted that this data is derived from self-reported height and weight and so may produce different results to the children's data which is derived from independent direct measurement. However, it has been adjusted using a formula that compensates for some people misrepresenting their weight when reporting it themselves.

### *Community Survey Result*

12% of respondents indicated that they considered themselves to have excess weight. 11% reported being worried about having excess weight. Based on the self-reported height and weight of survey respondents, it was possible to calculate their BMI. The results were as follows,

| BMI | Percentage: |
|---|---|
| Underweight | 4% |
| Healthy Weight | 31% |
| Overweight | 38% |
| Obese | 21% |
| Morbidly Obese | 6% |

This suggests a significant mismatch between those considering themselves to have excess weight (12%) and those who do (65%). This disparity is not uncommon in the general population however. According to a recent study using 2013 data from a large nationally representative survey of UK respondents, 55% of adult men and 31% of women failed to identify their overweight weight status[23].

## Physical activity

According to the Active Lives Survey from Sport England (2016/17), 61.1% of adults in Peterborough were physically active[24] at that time. This is statistically significantly lower than the average for East of England and England (66.8% and 66% respectively). Data regarding particular ethnic groups is not available at local authority level, however national data suggests that a lower proportion of adults of Asian ethnicity are active compared to England as a whole (55% and 66% respectively). This and some older data sources suggest that on average Asian women are less active than men[25].

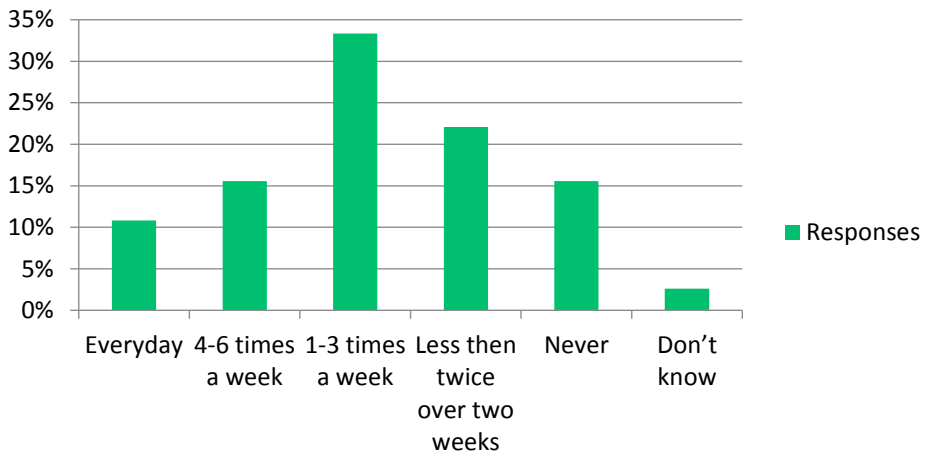
[22] Adults with a BMI of 25 or more are classed as overweight, while adults with a BMI of 30 or more are classed as obese.
[23] Robinson E, Oldham M. Weight status misperceptions among UK adults: the use of self-reported vs. measured BMI. BMC Obesity. 2016; 3(1): 21.
[24] Adults 19 yrs and over doing at least 150 moderate intensity equivalent (MIE) minutes physical activity per week in bouts of 10 minutes or more in the previous 28 days
[25] Health Survey for England (PHE 2004) and Fischbacher C, Hunt S, and Alexander L. How physically active are South Asians in the United Kingdom? A literature review. Journal of Public Health 2004;26(3):250-258

The WAY survey of 15 year olds in Peterborough (2014/15)[26] found that 12.7% were physically active[27] for at least one hour per day, seven days a week. This is similar to the average for East of England and England (13.3% and 13.9% respectively). Data is not available regarding the South Asian community in Peterborough, however nationally those of Asian/ Asian British (incl Chinese) ethnic group had statistically lower levels of physical activity than England as a whole (9.5% and 13.9% respectively).

### *Community Survey Result*

Approximately 16% of survey respondents report never achieving 30 mins exercise during a typical week. This compares to 22% of the population in England as a whole[28]. However, the survey suggests that very few members of the South Asian community are achieving the recommended 150mins of moderate physical activity a day. See Fig 9. Approximately 26% do more than 120mins exercise/ week and 11% achieve 30 mins/day. These more active individuals were split evenly between male and female.

**Fig 9. How often do you exercise for at least 30 minutes?**




* exercise is counted as any movement equivalent to or above that of a brisk walk

### *Focus Group Result*

Lack of exercise for females is a problem. Many women will only exercise in enclosed spaces where no one can see in or out. Sustainability of fitness and weight loss is difficult even if they do attend programmes. They may need support and 1:1 sessions to maintain motivation. Often a husband will need to give permission and the timings are important so that they don't interfere with family

[26] What About YOUth (WAY) survey, 2014/15. https://digital.nhs.uk/data-and-information/publications/statistical/health-and-wellbeing-of-15-year-olds-in-england/main-findings---2014
[27] engaged in moderate/vigorous physical activity
[28] https://fingertips.phe.org.uk/profile/physical-activity/data#page/3/gid/1938132899/pat/6/par/E12000006/ati/102/are/E06000031/iid/93015/age/298/sex/4

commitments, such as the wife needing to be at home at lunch time when the husband returns home.

## Diet

Poor diet and obesity are leading causes of premature death and mortality (Global Burden of Disease, 2017), and are associated with a wide range of diseases including cardiovascular disease and some cancers, which can have a significant impact on an individual's physical and mental health and wellbeing.

Unfortunately, there are gaps in knowledge regarding the dietary habits of South Asian communities living in the UK and there consequences for health[29]. For example, culinary practice varies widely and it is hard to know the extent to which members of the communities adopt non-traditional diets and whether these are more or less healthy.

There is some evidence of an association between those following traditional diets and higher consumption of fruit and vegetables. In addition, those form South Asian communities (whether UK or non-UK born) are more likely to report eating traditional diets than those from other ethnic groups[30].

However, whilst some components of traditional South Asian diets are healthy (such as lentils, vegetables and oily fish), the methods of preparation can be very unhealthy, such as deep frying. Large consumption of ghee, which is high in saturated fat and large measures of salt are also linked to poor health[31].

In 2016/17, 57.2% of adults in Peterborough were meeting the Governments recommended '5-a-day' recommendation. This is similar to the averages for East of England and England (58.2% and 57.4% respectively). Although data relating to ethnicity is not available locally, national data suggests significantly fewer Asian adults meet the recommendation (48.9%).

The WAY survey from 2014/15[32] reported that 50.1% of 15 year olds in Peterborough were meeting the Governments recommended '5-a-day' recommendation. This is similar to the average for the East of England and England (52.1% and 52.4% respectively). Data is not available regarding the South Asian community in Peterborough, however nationally a greater proportion of Asian/ Asian British (incl. Chinese) were meeting the recommendation compared to the population as a whole (60.3% and 52.4% respectively.

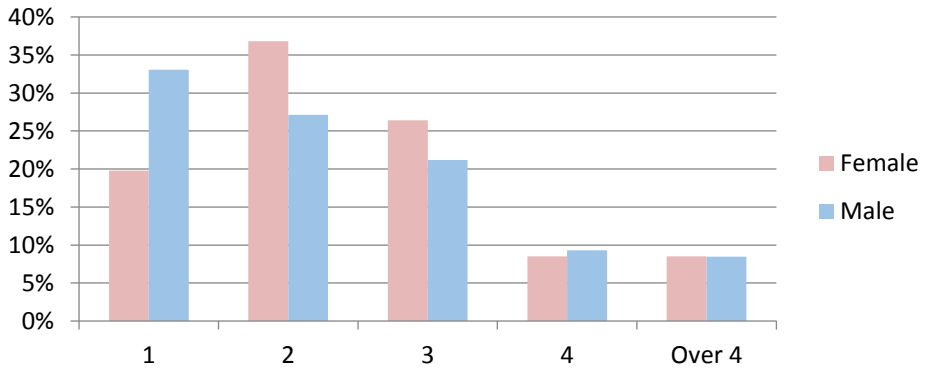
### *Community Survey Result*

The survey suggests that as few as 8% of those surveyed meet the recommended '5-a-day' recommendation for consumption of fruit and vegetables. Females are more likely to be consuming

[29] Khunti et al (2009) Diabetes UK and South Asian Health Foundation recommendations on diabetes research priorities for British South Asians. Diabetes UK.
[30] Local action on health inequalities Understanding and reducing ethnic inequalities in health. PHE 2018
[31] https://www.bhf.org.uk/informationsupport/heart-matters-magazine/medical/south-asian-background
[32] What About YOUth (WAY) survey, 2014/15 https://digital.nhs.uk/data-and-information/publications/statistical/health-and-wellbeing-of-15-year-olds-in-england/main-findings---2014

more than two portions a day. See Fig 10. The survey also sought views on salt and sugar intake. 56% reported being mindful of their salt intake, whilst 59% reported being mindful of their sugar intake.

**Fig 10. In a typical day, how many portions of fruit and vegetables do you eat?**




### *Focus Group Result*

A number of problems exist in relation to maintaining a healthy diet. There is a lack of knowledge regarding the potential health risks associated with traditional cooking and how to adapt recipes to make them healthier. The 'Eat Well' guide may be more accessible than information regarding calories, as its uses commonly understood portion and measures e.g. teaspoons of sugar. Misconceptions may exist in relation to the affordability of healthy diets.

Ramadan is associated with a change in eating patterns which may result in overeating at night and an overall worsening of diet during this period. Cultural festivals are usually food and eating focused which reinforces a culture around food. However it may also present an opportunity for education.

## Smoking

According to the Annual Population Survey (2017), 17.6% of adults in Peterborough are current smokers. This is statistically similar to England as a whole (14.9%) but higher than the average for the East of England (14.2%). However in line with national and regional trends levels of smoking have been on a steady decline.

National data suggests levels of smoking in the Asian community (9.3%) are lower than the national average (14.9%). This data also shows that prevalence of smoking declines with age, being highest amongst 25-39yr olds (20.8%). For those over 65-69 years it is 11%, reducing to 1.5% of those aged 90 or over.

Smoking rates amongst South Asian men (16.5%) are 5 times that of women (3.3%). Amongst men, prevalence of smoking for those of Muslim faith is 21.3%, which is higher than men from all other faiths used in the survey[33]. The survey found 7.3% of Sikh faith and 12.3% of Hindu faith smoked.

The 2004 Health Survey for England reported that chewing tobacco was most common among people identifying as Bangladeshi (9% of men and 16% among women aged 18 and over), with much lower rates among men and women in the Indian and Pakistani groups.

### *Community Survey Result*

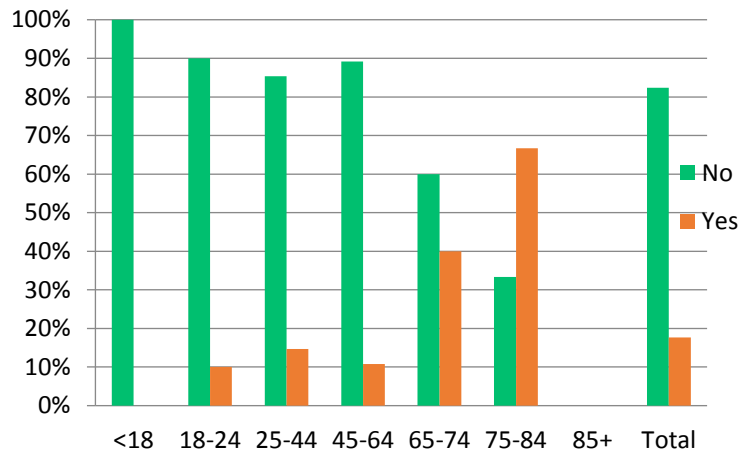
The local survey data found 11% of those under 65 reported smoking. The excludes 11% of respondents in that age group who didn't provide an answer. Data relating to those over 65yrs cannot be reported due to small number of responses

Overall 26% of men reported smoking. Very few women reported being a current smoker which suggests that the survey may not a reliable method for ascertaining smoking prevalence amongst women.

The proportion of those who smoke by age group is shown in Fig 11. This question was answered by 89% of respondents.

Anecdotal evidence from the healthy lifestyles provider in Peterborough, Solutions4Health suggests that smoking is more prevalent with young people (<25yrs) than the survey would suggest. They also report widespread popularity of shisha in this age group.

**Fig 11. Do you smoke?**




[33] Christian, Buddhist, Hindu, Jewish, Sikh, Other, None

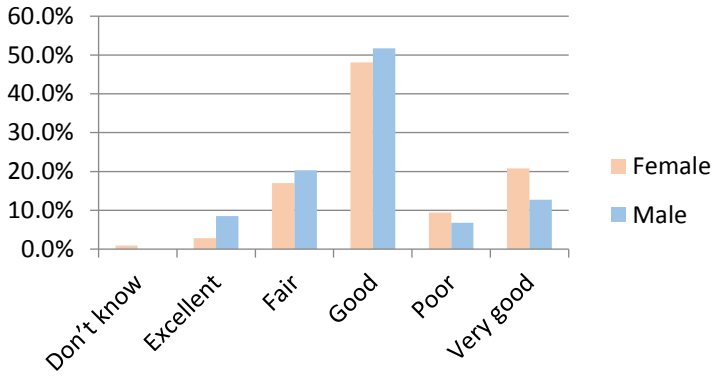
## Perceptions of Health and Seeking Help

***Community Survey Result***

Participants were asked how they would rate their health, the conditions they have and what they worry about.

Overall, 72% of respondents felt their health was 'good', 'very good' or 'excellent'. 9% rated their health as poor. This was similar between men and women. A greater proportion of men rated their health as excellent compared to women (8.5% vs 2.8%). See Fig 12.

**Fig 12. Thinking about your own health: would you say that in general your health is;**

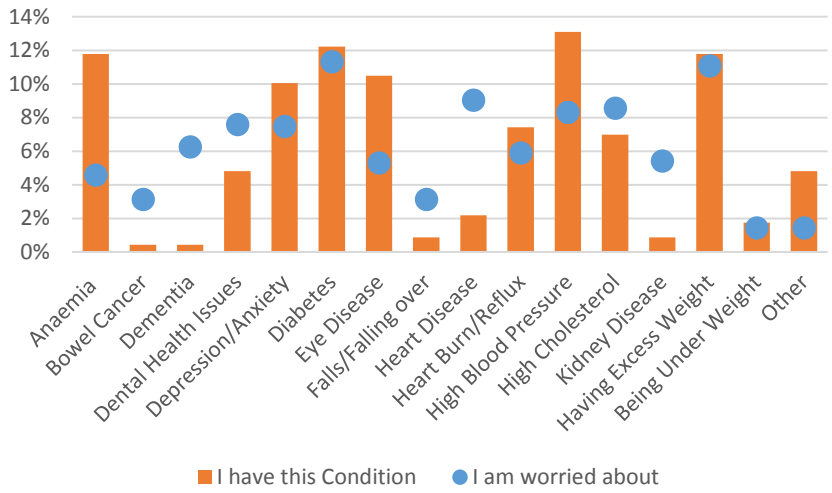



The top 5 most prevalent conditions amongst those surveyed were high blood pressure (13%), diabetes (12%), anaemia (12%), having excess weight (12%) and eye disease (10%).

The top 5 conditions that participants worried about were diabetes (11%) and having excess weight (11%). Heart disease (9%) High cholesterol (9%), high blood pressure (8%)

Depression and anxiety was also something that people experienced (10%) and worried about (8%).

**Fig 13. Please indicate what you are worried about:**

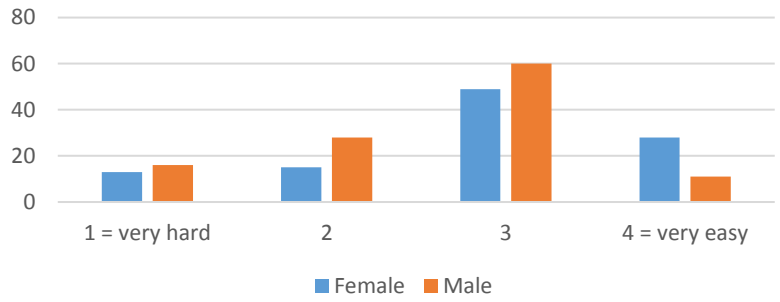


Survey participants were asked whether they had needed medical attention in the past 12 months. Less than half (49%) answered this question, of which two thirds had needed medical attention. The local GP was the place where the vast majority had sought help (97%). Nearly half (48%) had attended hospital (e.g. accident and emergency). A quarter had attended the Minor Illness and Injury Unit. Very few (2%) reported that they had wanted to seek medical attention but were unable to.

Unfortunately there was insufficient data to determine whether the need for medical attention varied by self-reported condition (e.g. depression/anxiety, high blood pressure).

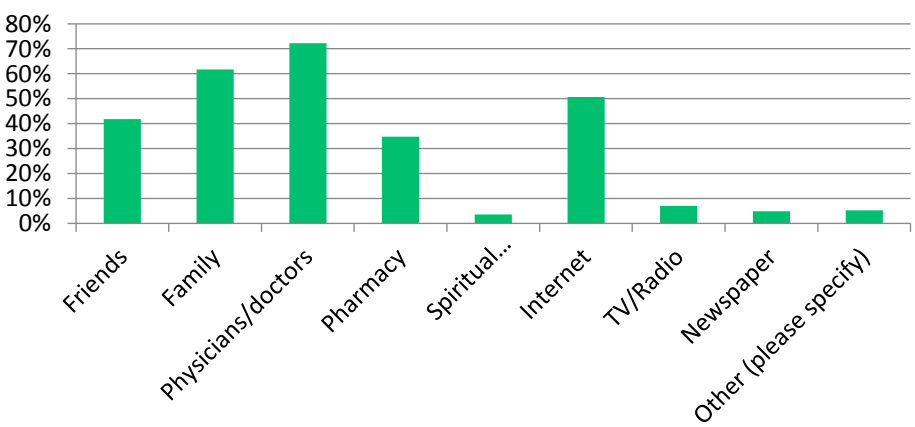
Fig 14 shows how people regard ease of access to health services. Men are more likely than women to report finding this hard.

**Fig 14. On a scale of 1-4, how easy is it to for you to access health services?**




Survey participants were asked where they get their health information from. See Fig 15. Physicians/doctors were the most common source of information, followed by family and friends. Approximately 50% of participants used the internet. A higher proportion if those aged under 44 use the internet as a source of information compared to older people. Sixty per cent of 18-24yr olds and 50% of 25-44yr olds use the internet, compared to 43% of 45-65yr olds.

**Fig 15. Where do you get health information from? (Select all that apply)**



### *Focus Group Result*

Some women may not access appointments or seek services in a timely fashion despite knowing that they have a problem/issue. This can be due to other pressures such as; family commitments and extended family pressures. They may have to seek permission to access services. Confidentiality may be comprised due to the involvement of spouses and the involvement of children who act as interpreters. The woman's mother-in-law may be required to come to the appointment with her sister in law. This all creates low motivation and barriers to attending services. These kind of issues and pressures can also lead to deteriorating mental health.

Language barriers are also an issue in understanding health related information and accessing services.

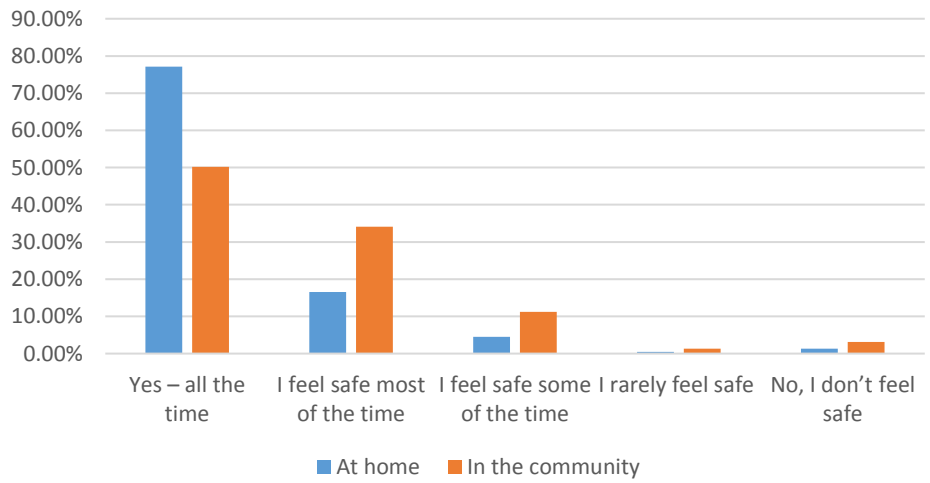
## Safety and Access to Community Services

### *Community Survey Results*

Access to community facilities can help support and improve health and wellbeing of those living in the area. For example, there is clear evidence that access to, and engagement with, the natural environment is associated with numerous positive health outcomes, including improved physical and mental health, and reduced risk of mortality and other conditions.[34] Community centres and libraries are often at the heart of local areas, and provide a place to meet, hold social, cultural and educational activities for all ages and a place for people to get involved in the community's life.

Perceptions of crime and feelings of safety are important factors contributing to mental health and well-being and influence our healthy behaviours such as physical activity and access to green spaces. Fig 16 shows that the vast majority of survey respondents feel safe at home or in the community most or all of the time. Of the 10 people over 65yrs who answered these questions, all but one indicated that they felt safe at home and in the community, all or most of the time. For those under 25 years old (n=13), none responded 'I rarely feeling safe' or 'no, I don't feel safe'.

**Fig 16. Do you feel at home and in the community?**



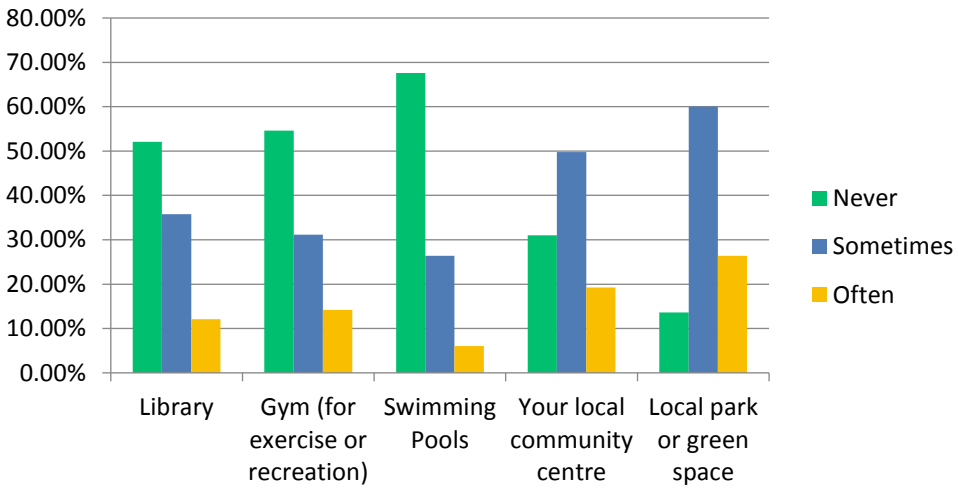

[34] Spatial Planning for Health. An evidence resource for planning and designing healthier places. PHE 2017.

There is some survey evidence[35] that as much as 75% of the population in England visit a library 1-2 times/year or less, with 67% not visiting at all. Approximately 15% visit a library more than once a month. By comparison our survey shows that just over half never visit a library, 12% visit often and 36% sometimes visit.

The same survey reported that 12.4% of those surveyed had participated in swimming or diving. Our survey found that 26% sometimes visited the swimming pool and 6% did so often.

It is estimated that approximately 18% of Peterborough residents take a visit to the natural environment for health or exercise purposes in an average week[36]. This includes anywhere which is "out of doors" but doesn't include routine shopping trips or time spent in own garden. Our survey found that 26% of respondents used a park/green space often, although reasons are not specified.

**Fig 17. How often do you use the following?**




# Children and Education

## Introduction

Education is an important social determinant of health. A good education confers a number of benefits, including the building of supportive social connections, accessing good work, life-long learning and problem solving and feelings of empowerment and value[37]. School readiness is an important measure of how prepared a child is to succeed in school cognitively, socially and emotionally. Children without a good level of development at age 5 will struggle with social skills,

[35]Taking Part Survey (2015/16) https://public.tableau.com/profile/taking.part.survey#!/vizhome/WhoParticipates-HeritageMuseumsandGalleriesLibrariesArchives/Responsesbreakdowns

[36] https://fingertips.phe.org.uk/profile/comm-assets/data#page/6/gid/1000031/pat/6/par/E12000006/ati/102/are/E06000031/iid/11601/age/164/sex/4

[37] https://www.health.org.uk/infographics/how-do-our-education-and-skills-influence-our-health

reading, maths and physical skills. This will have an impact on their childhood and later life, such as educational achievements, involvement with crime, health and life expectancy[3839]. People with the lowest healthy life expectancy are 3 times more likely to have no qualifications compared to those with the highest life expectancy[40].

## Ethnicity of school pupils across Peterborough

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

Table 9 below presents a more detailed picture of the ethnic mix of children in state funded schools in Peterborough, compared with Cambridgeshire, East of England and England. In Peterborough, Asian pupils are the largest minority ethnic group accounting for 17% of primary and 18% of secondary school pupils. Within this group Pakistani children are the largest group, making up 11% of primary and 13% of secondary school pupils.

**Table 9. Ethnicity of primary and secondary school pupils, School Census January 2018.**

| | White | White British | Mixed | White And Asian | Indian | Pakistani | Banglade shi | Any Other Asian Backgrou | Black | Chinese | Any Other Ethnic Group | All pupils |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Primary Schools** | | | | | | | | | | | | |
| **ENGLAND** | **3,485,200** | **3,115,863** | **291,019** | **69,250** | **145,021** | **208,826** | **80,666** | **87,486** | **261,674** | **22,552** | **92,380** | **4,716,244** |
| **EAST OF ENGLAND** | **422,866** | **375,008** | **31,982** | **7,762** | **9,608** | **12,868** | **6,345** | **6,788** | **17,460** | **2,150** | **5,063** | **520,187** |
| Cambridgeshire | 44,620 | 38,323 | 2,945 | 900 | 688 | 336 | 367 | 765 | 630 | 421 | 515 | 51,803 |
| Peterborough | 14,468 | 10,040 | 1,282 | 341 | 564 | 2,374 | 43 | 572 | 751 | 79 | 266 | 20,796 |
| **Secondary Schools** | | | | | | | | | | | | |
| **ENGLAND** | **2,416,841** | **2,222,444** | **170,140** | **40,322** | **98,749** | **142,011** | **59,244** | **60,018** | **189,653** | **12,930** | **58,650** | **3,258,451** |
| **EAST OF ENGLAND** | **305,698** | **280,727** | **19,000** | **4,677** | **6,505** | **8,573** | **4,367** | **5,081** | **13,311** | **1,562** | **2,857** | **373,639** |
| Cambridgeshire | 28,097 | 25,274 | 1,471 | 454 | 281 | 170 | 250 | 342 | 358 | 176 | 202 | 32,054 |
| Peterborough | 10,762 | 8,211 | 942 | 264 | 374 | 2,046 | 36 | 303 | 524 | 53 | 135 | 15,458 |

[38] Social Mobility Commission (2017) State of the Nation 2017: Social Mobility in Great Britain.
[39] Institute of Health Equity (2010) Fair society, healthy lives: The Marmot Review.
[40] An overview of lifestyles and wider characteristics linked to Healthy Life Expectancy in England: June 2017. Office for National Statistics.
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/articles/healthrelatedlifestylesandwidercharacteristicsofpeoplelivinginareaswiththehighestorlowesthealthylife/june2017

## Children who speak a language other than English at home

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

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

**Table 10 – Number and proportion of children who speak English and languages other than English at home – languages with over 2% prevalence are shown**

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

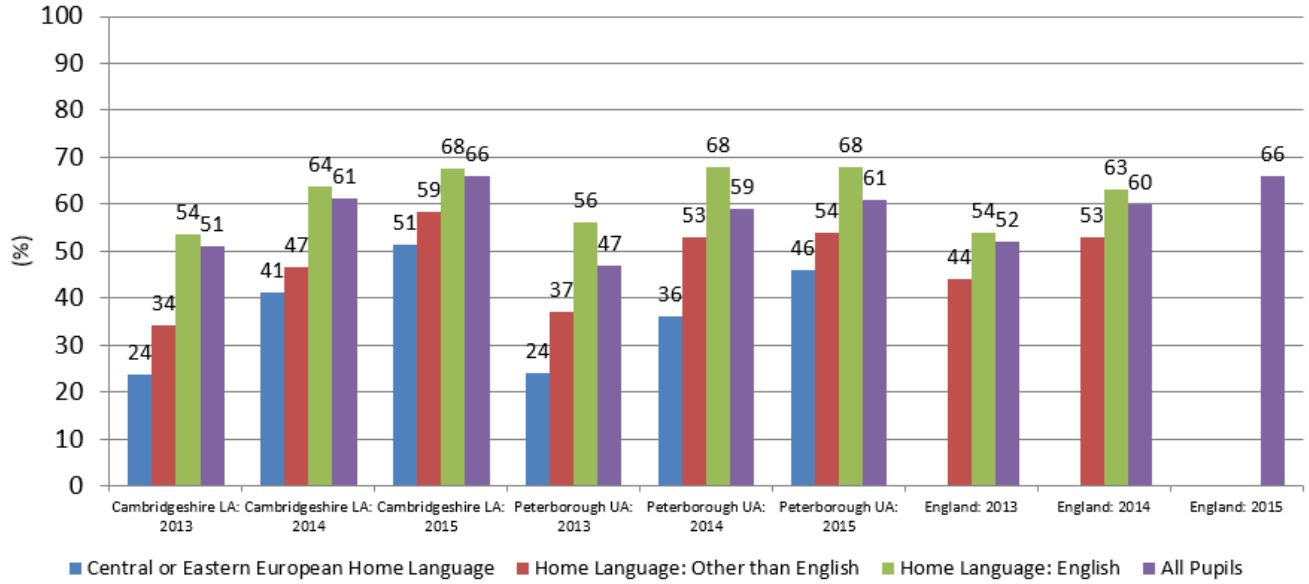
**Source: School census data 2015**

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

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

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

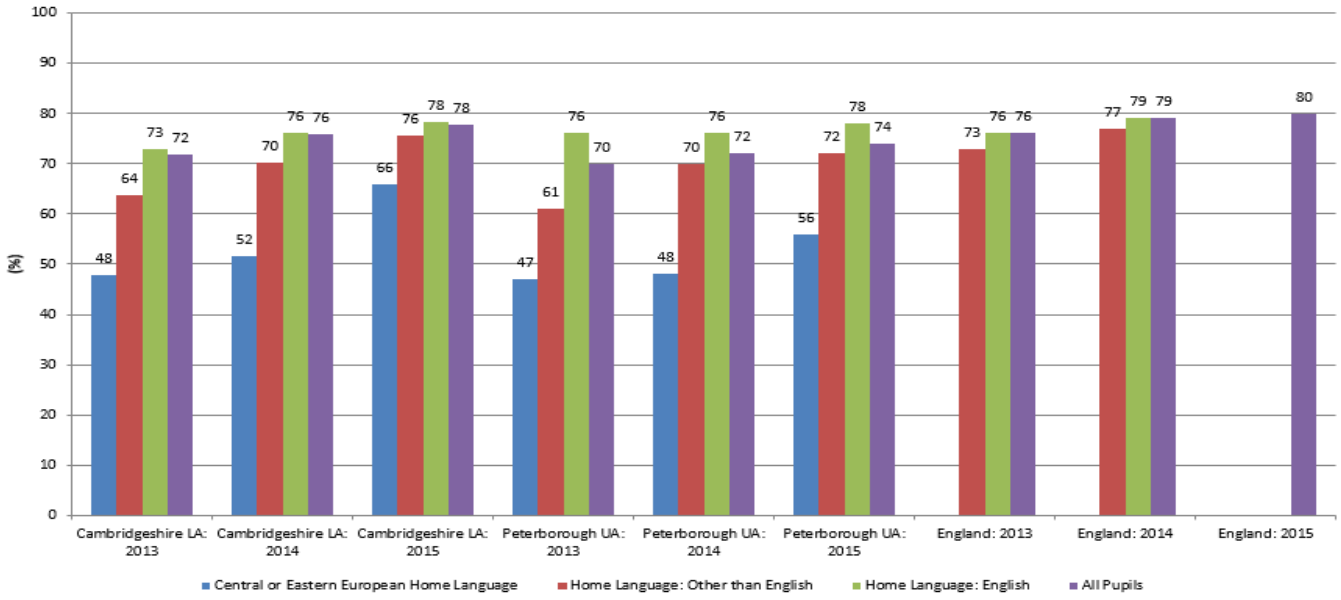
**Fig 18. Proportion of Pupils Achieving a Good Level of Development in the Early Years Foundation Stage Profile by Primary Language Spoken at Home , 2013-15**




Source: Department for Education, Statistical First Releases

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

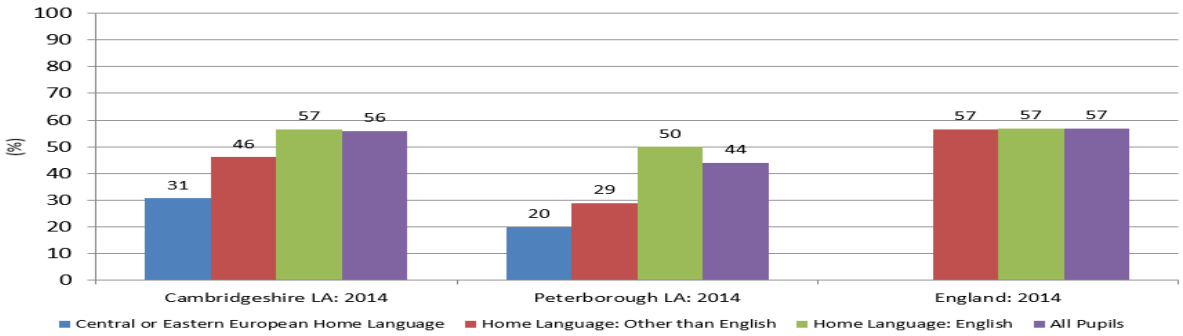
**Figure 19. Proportion of Pupils Achieving L4+ in Key Stage 2 Reading, Writing TA & Mathematics, 2013-15**




Source: Department for Education, Statistical First Releases

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

**Figure 20: Proportion of Pupils Achieving 5+ GCSE Grades A*-C, including English & Mathematics**




Source: Department for Education, Statistical First Releases

### Children in Need

A 'child in need' is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or the child is disabled.[41]

**Table 11. : Peterborough Children in Need Referrals Jan 2012 – Aug 2015, 10 Most Common Languages Spoken at Home**

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

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

Source: Peterborough City Council Children in Need Referral Data

Table 11 above shows the 10 primary languages spoken at home for which the highest number of children in need referrals in Peterborough were made between January 2012 and August 2015 and numbers of pupils attending Peterborough schools by language. Data show that, in Peterborough, 77.9% of children in need referrals were for primarily English-speaking pupils, whereas only 65.1% of pupils in the area speak English as a first language. This may be due to 'under-reporting' with regards to children who speak languages other than English; for example, pupils who primarily speak Panjabi represent 6.3% of the pupils in Peterborough but only 1% of referrals.

## Income, Employment and Poverty

There is a strong evidence to suggest that work is generally good for physical and mental health and wellbeing, taking into account the nature and quality of work and its social context, and that worklessness is associated with poorer physical and mental health.

Likewise, low incomes and poverty are important determinants of health, the impacts of which are numerous and far reaching. For example, poor access to good quality housing (which is safe, secure, free from damp, not overcrowded).

### Employment

In Peterborough during 2017/2018, 23% if the population aged 16-64yrs were economically inactive. This means they are either not in employment or unemployed. There are many reasons for this including studying, looking after family or long-term sickness. However, national surveys suggest that approximately 38% of men and 24% of women would like a job[42]

**Table 12. Proportion of economically inactive residents of Peterborough aged 16-64, 2017/18**

| Ethnic Group | % | CI |
|---|---|---|
| White | 21% | 5% |
| Indians | 32% | * |
| Pakistanis/Bangladeshi | 50% | 25% |
| Black or Black British | ! | ! |
| All ethnic minorities | 33% | 13% |
| Males | | |
| White | 18% | 7% |
| Indian | ! | ! |
| Pakistani/Bangladeshi | 18% | * |
| Black or Black British | ! | ! |
| All ethnic minorities | 18% | * |
| Females | | |

[42] Annual Population Survey. Www.nomisweb.co.uk

| | | |
|---|---|---|
| White | 24% | 7% |
| Indian | 44% | * |
| Pakistani/Bangladeshi | 78% | 28% |
| Black or Black British | ! | ! |
| All ethnic minorities | 44% | 18% |
| ! Estimate and confidence interval not available since the group sample size is zero or disclosive (0-2)<br>* Estimate and confidence interval unreliable since the group sample size is small (3-9). | | |

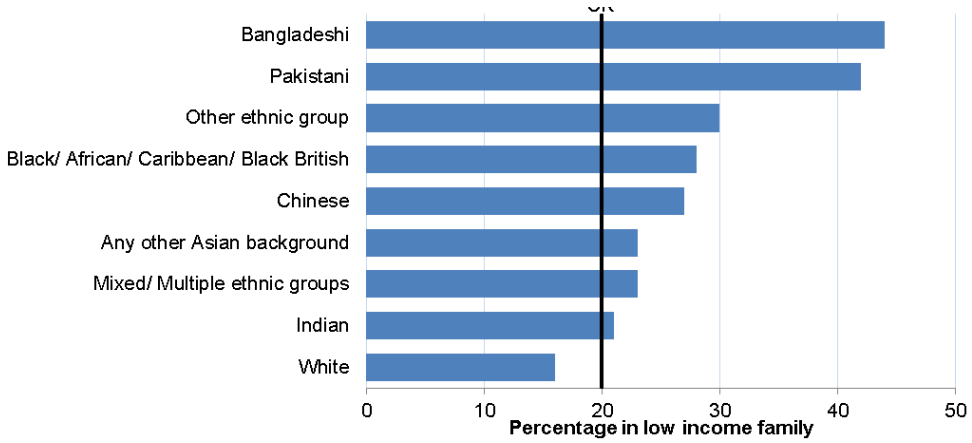
Table 12 shows that a there is a significant disparity between the Pakistani/Bangladeshi community and other ethnic groups in terms of those who economically inactive. This is even more marked for the community of Pakistani women, of which nearly 80% are inactive. This is double the proportion of all women from all ethnic minority groups.

## Income

Data from the Department of Work and Pensions shows that 16% of the UK population lives on a low income (defined as below 60% of the median national income). However, this varies by ethnic group. Thirty five per cent of people living in households headed by someone of Pakistani or Bangladeshi ethnic origin are living on a low income compared to 14% of the White population. The proportion on a low income is even higher after housing costs are taken into account, rising to about half of the Pakistani, Bangladeshi and Chinese populations affected[43].

Child poverty is an important issue for public health. The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Nationally, wide inequalities exist by ethnic group, with the highest proportion of children living in low income families in the Bangladeshi and Pakistani ethnic groups. See Fig 21.

**Fig 21. Proportion of children living within low income families. United Kingdom, 2015/16**




[43] Department for Work and Pensions. Households below average income statistics: 1994/95 to 2016/17. DWP March 2018. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691917/households-below-average-income-1994-1995-2016-2017.pdf

## Summary

The South Asian Communities in Peterborough face some significant public health challenges. The levels of obesity and its consequences for health (such as diabetes and cardiovascular disease) are known to be higher amongst the South Asian communities. Our local survey data supports national data suggesting physical activity levels are lower and diets are poorer in South Asian communities. By the age 11 years, a far higher proportion of children from South Asian communities are overweight compared to their peers. The survey found that the top 5 things people worry about were all related to excess weight, including, diabetes, high blood pressure, high cholesterol and heart disease.

Nearly three quarters of respondents to the local survey reported their health as 'good', 'very good' or 'excellent'. Whilst this is encouraging, there is a potential for complacency. The mismatch between respondents who are overweight (65%) and think they are (12%) may indicate that there is a need for targeted work to educate the community about healthy weight and the negative consequences of overweight.

The health needs assessment also highlighted a number of additional issues in relation to the health of women's in South Asian communities which would benefit from further exploration and co-ordinated action. For example; nationally, levels of breast and cervical screening are lower compared to the national average; the prevalence of common mental disorders are higher than for white British women; South Asian women are far less likely to be economically active than white British women; South Asian women face significant cultural barriers in accessing help and advice for health concerns.

The community also faces some wider challenges in relation to child poverty and employment, both of which have an impact on health. In particular, far fewer women are economically active than the white or BME population as a whole. Pakistani or Bangladeshi children are more likely to be living in low income households than other ethnic groups.

The needs assessment also identified some positive findings. The prevalence of tuberculosis has been on a steady decline. Generally, smoking levels are lower than the general population and overall, the South Asian population have a lower incidence of cancer than the white population. The vast majority of the survey respondents reported feeling safe at home and in their communities and very few report problems in seeking medical help or advice.

It should be noted however that many of the health challenges highlighted above are also present for other ethnic groups and for the population as a whole. It is clear however that when considering the recommendations presented by this report, consideration of the cultural context and working closely with the communities concerned will be key.

## Recommendations

1. Consider undertaking an equity impact assessment or similar to explore the uptake of screening amongst the South Asian communities.

2. Convene an expert group to explore need and options for targeted messaging around screening and organ donation to increase uptake.

3. Undertake a series of focus groups and workshops to consider how to improve access or support for mental health, working with colleagues from the provider mental health trust, Sustainability and Transformation Partnership and other stakeholders.

4. Work with the Joint Mosque Council and other community leaders to develop a public health awareness campaign focussed on diet, physical activity and their benefits for health.

5. Consider the development of a South Asian Women's Health Forum to explore and address the issues raised in the report.

6. Ensure that the current development of an early years (0-5) strategy takes into consideration the needs of the South Asian communities.

## Appendix 1 – Survey Questionnaire

Gender

Age band (0-17, 18-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75+)

Primary language

Highest level of education

Country of birth

Length of living in UK

Income

Employment status

Faith group

Household members (number)

Bedrooms

Thinking about your own health: would you say that in general your health is.. (poor….excellent)

Please indicate whether you are worried about or affected by any of the below the condition(s)

How often do you exercise for at least 30 minutes? (Note: exercise is counted as any movement equivalent to or above that of a brisk walk)

Do you smoke?

How often do have takeaway food/meals? (fast foods)

In a typical day, how many portions of fruit and vegetables do you eat?

Are you mindful of your sugar intake?

In the past 12 months, have you needed medical attention?

Where did you seek medical care? (Select All that apply) (e.g. GP, walk-in centre, A&E)

On a scale of 1-4, how easy is it to for you to access health services?

Where do you get health information from? (Select all that apply) (e.g. internet, family, GP, TV)

How often is someone available to help with daily chores if you are sick?

How often are family/friends available to meet with you socially for fun?

How often do you use the following? (library, parks, gym, swimming pool)

Do you feel safe at home?

Do you feel safe in the community?

Updated on: 28 May 2019

**HEALTH AND WELLBEING BOARD**
**AGENDA PLAN 2019/2020**

| MEETING DATE | ITEM | CONTACT OFFICER |
|---|---|---|
| **Monday 24 June 2019** | ● SEND Peer Review<br>● Peterborough Pharmaceutical Needs Assessment Delegated Authority.<br>● Creation of Joint Health and Wellbeing Board Sub Committee with Cambridgeshire County Council<br>o Feedback from the Joint Development Session<br>o Proposal to update the Terms of Reference for the Peterborough Health and Wellbeing Board and to create a further joint sub-committee with the Cambridgeshire Board<br>● Peterborough Health Protection Annual Report<br>● Peterborough Health and Wellbeing Strategy 2016-2019<br>o Performance monitoring report<br>o Annual Outcome metrics report<br>• North Alliance update on neighbourhood working, including links with Think Communities<br>● Update on health and social care integration<br><br>**For information**:<br>Diverse Ethnic Communities JSNA – South Asian Communities Supplement | Sheelagh Sullivan / Siobhan Weaver<br>Iain Green/Liz Robin<br><br>Liz Robin<br><br>Tiya Balaji<br><br>Helen Gregg<br>Ryan O'Neill<br>Amy Venner (STP Delivery Unit / Ian Phillips<br><br>Caroline Townsend / Will Patten<br><br>Liz Robin |
| **Monday 16 September 2019** | • BSIL<br><br>**For information**:<br>Better Care Fund Update<br>Health & Wellbeing Strategy Performance Update | |
| **Monday 16 December 2019** | | |

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|---|---|---|
| | **For information**:<br>Better Care Fund Update<br>Health & Wellbeing Strategy  Performance Update | |
| **Monday 9 March 2020** | **For information**:<br>Better Care Fund Update<br>Health & Wellbeing Strategy  Performance Update | |