HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 06 December 2018

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

13:30hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Kreis Viersen Room
Shire Hall, Castle Hill, Cambridge, CB3 0AP

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code*	
2	**Minutes - 8th November 2018**	**5 - 12**
3	**Health Committee Action Log**	**13 - 16**
4	**Petitions and Public Questions**	

KEY DECISIONS

5	**The Adoption of a Dynamic Purchasing System (DPS) for Public Health Primary Care Commissioning**	**17 - 26**

DECISIONS

The Health Committee comprises the following members:

Councillor Peter Hudson (Chairman) Councillor Chris Boden (Vice-Chairman)

Councillor David Connor Councillor Lynda Harford Councillor David Jenkins Councillor Linda Jones Councillor Kevin Reynolds Councillor Simone Taylor Councillor Peter Topping and Councillor Susan van de Ven

For more information about this meeting, including access arrangements and facilities for people with disabilities, please contact

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HEALTH COMMITTEE: MINUTES

Date: Thursday 8 November 2018

Time: 1.30pm to 4.55pm

Present: Councillors C Boden (Vice Chairman), D Connor, L Harford, M Howell (substituting for Cllr Reynolds), P Hudson (Chairman), D Jenkins, L Jones, P Topping and S van de Ven.

District Councillors M Cornwell, G Harvey, N Massey and J Tavener

Apologies: County Councillor K Reynolds

156. DECLARATIONS OF INTEREST

There were no declarations of interest.

157. MINUTES AND ACTION LOG: 11th OCTOBER 2018

The minutes of the meeting held on 11th October 2018 were agreed as a correct record and signed by the Chairman subject to the amendment of the second paragraph of minute 147 to read, "it was confirmed that the responses would be discussed at the quarterly liaison meeting for review and the addition of "Voluntary Sector Role in Supporting Public Health Outcomes" to the training programme.

The Action Log was noted including the following updates:

Minute 142 - The Director of Public Health relayed the following update regarding the Community First (Learning Disability Beds Consultation) - the Clinical Commissioning Group (CCG) conducted a public consultation on proposed changes to the provision of inpatient beds for people with a learning disability in Cambridgeshire and Peterborough. The consultation concluded on 12 October 2018. The CCG's Clinical Executive Committee (CEC) received the draft consultation response, and a paper on next steps in delivering the preferred model at its last meeting. At this stage, CEC determined that further work was required to provide clarity on the over-arching strategy for Learning Disability Services, our commissioning intentions and the future work plan. CEC has asked the Senior Responsible Owner for this work to review the proposals and bring back a further paper to a future meeting of the CEC.

158. PETITIONS

There were no petitions.

159. THE ADOPTION OF A DYNAMIC PURCHASING SYSTEM (DPS) FOR PUBLIC HEALTH PRIMARY CARE COMMISSIONING

The Committee received a report that described the issues relating to the multiple primary care contracts that Cambridgeshire County Council and Peterborough City

Council Public Health hold with Primary Care providers. The report sought the Committee's approval to adopt the Dynamic Purchasing System (DPS) contractual arrangements for Cambridgeshire County Council Public Health contracts with Primary Care providers for the duration of five years, effective from April 2019.

Members were informed that there were approximately 140 Primary Care contracts that placed significant strain on resources for what were relatively low value contracts when they were due for renewal. Following discussions with LGSS Law and the procurement team the adoption of the DPS was proposed as a potential solution which provided greater flexibility and allowed for providers to be added to the system.

During the course of discussion Members:

- Highlighted the potential risks associated with the proposed system and questioned the level of scrutiny of potential providers. Officers explained that although the contractual process was classed as light touch, the contract would be managed and monitored with the same rigour as all contracts

- Commented that there were no alternatives to the DPS presented and requested further information on the definition of 'light touch' in terms of procurement.

Members having sought further clarity regarding the 'light touch' approach and the DPS, requested that the item be deferred in order for further information to be provided and for a member of the LGSS Procurement Team to attend Committee and answer Member questions.

It was resolved unanimously to:

Defer the decision to the December meeting of the Committee.

160. FINANCE AND PERFORMANCE REPORT – SEPTEMBER 2018

The Committee received the September 2018 iteration of the Finance and Performance Report which showed an increase in the underspend of £110k from August's reported position. Officers explained how underspends would be managed as set out in paragraph 2.2 of the officer report. Members noted that the performance data for quarter for the Health Visiting and School Nursing Service had not yet been received and therefore not updated within the report.

During discussion Members:

- Emphasised the importance of Public Health spending and its impact upon all areas of the Council.

- Noted the update provided by the Chairman regarding the use of the underspend on a direct marketing campaign for smoking cessation.

- Commented that the county was not increasingly healthy and highlighted the importance of being bold when allocating Public Health spending.

- Questioned whether it was possible for areas to be over-budgeted for with an inbuilt provision for an underspend.

- Drew attention to the importance of early interventions together with invest to save proposals.

- Questioned how Health visiting for 12 month to 2.5 years was currently being delivered in the Huntingdonshire area. It was noted that Fenland had moved to a home visiting service however, this was part of a targeted approach. Officers agreed to provide a briefing note which would provide further information. **ACTION**

- Drew attention to JTA scheme contained at page 44 of the report and the relatively small amounts that were spent on road safety and active travel, while emphasising the benefits of the scheme.

- Expressed concern regarding the accuracy of the wording related to Children's Centres on page 39 of the report. Members noted that an update report on Children's Centres was to be presented at the next meeting of the Children's and Young Peoples Committee. Officers confirmed that they would address the text within the Memorandum of Understanding section of the report to ensure accuracy. **ACTION**

- Requested that the Chairman contact the Chairman of the Children's and Young Peoples Committee to express Members concern. **ACTION FOR CHAIRMAN**

- Noted the general consensus of Members regarding the vital importance of Public Health spending for younger people and questioned the appropriateness of certain indicators. Although it was appreciated that many indicators were dictated by the nature of the contracts it was requested that where possible they be amended for the coming new financial year. **ACTION**

It was resolved to:

> Review and comment on the report and to note the finance and performance position as at the end of September 2018.

161. PROGRESS REPORT – PROGRAMMES FUNDED FROM PUBLIC HEALTH RESERVES

Members were presented a paper that provided progress reports on three pilot programmes funded by the Health Committee from Public Health reserves.

Officers introduced the Falls Prevention Programme that had made significant progress in reducing the number of serious falls that required medical attention. An evaluation was being produced for the Sustainability and Transformation Partnership and the results were encouraging with a reduction in the number of falls.

In discussing the report members:

- Echoed support of Falls Prevention Scheme that demonstrated the positive impact on individuals lives. However, Members were concerned that there was limited data available and questioned when there would be a separation of Peterborough and Cambridgeshire as it would provide essential comparative data. Officers confirmed that the Sustainability and Transformation Partnership (STP) were working on this and it was anticipated that the data would be available in the near future.

- Commented that in the longer term falls prevention should form part of standard practice rather than a stand-alone project and question what work was being undertaken to ensure the sustainability of the programme and embed within the health system. Members were informed that falls prevention had been embedded within neighbourhood teams, also 350 nurses had been trained and awareness had been increased across the system.

- Welcomed the positive response from the health care system regarding the falls prevention programme and congratulated officers for effectively co-ordinating many different areas of the system to work collaboratively.

- Commented that the Ambulance Service was affected significantly by falls as attending them was labour intensive.

- Emphasised the positive impact on people's lives and the savings that falls prevention provided to the system as a whole. Members questioned how the different elements of the healthcare system could be encouraged to contribute to the programme and whether there were any other metrics used for measuring the success of the programme other than presentations to Accident and Emergency departments. Officers explained that the start of the programme was delayed because it was too large for Public Health to undertake alone. The funding for the programme was also provided through the NHS, STP and Better Care Fund (BCF). Metrics assessing the success of the programme were being developed including how to assess the impact on individuals.

- Emphasised the importance of falls prevention and noted that there was 24/7 service run through the Reablement Service that responded to falls and were alerted through a person's Lifeline and were able to attend within the hour. The Ambulance Service would also triage emergency calls in order that the most appropriate response was dispatched.

- Noted the Fenland District Council Health and Wellbeing Strategy which was designed to demonstrate how everyone in the Council could impact upon health outcomes for its residents.

- Following concern raised by Members regarding maintenance and the standard of pavements and footpaths in their Divisions and the importance physical activity for particularly older people who were at risk of falls, requested that the matter be brought to the attention of the Highway's and Community Infrastructure Committee. The Chairman undertook to report back to the Committee his discussion with the Chairman of the Highways and Community Infrastructure Committee regarding maintenance of footpaths and pavements. **ACTION FOR CHAIRMAN**

It was resolved to:

> Note that the Public Health allocated funding to support the system-wide Falls Prevention Programme will end in January 2020 and its future funding will require review by the Health Committee.

Following conclusion of the discussion relating to the Falls Prevention Programme, the Committee considered the Let's Get Moving Programme which equated to £513k over 2 years. District Councils were requesting that the funding be continued. Funding would cease end of March 2019.

During discussion the course of discussion Members:

- Requested that the report be presented at a later date and for it to include end of year data. Members noted that within table 2 contained at page 71 of the report the majority of people engaged were undertaking limited physical activity and emphasised the need to reach more inactive people.

- Reported concern regarding the robustness of the data collected to date, commenting that the scheme was probably one that should be supported, however the evidence was not presented within the report. Members suggested that the funding of the scheme be extended to the end of the financial year in order for further evaluation data to be presented.

- Expressed concern that the scheme had been advertised without acknowledging the funding was provided by Cambridgeshire County Council.

- Drew attention to different types of exercise and the mental health and wellbeing benefits of exercise.

- Highlighted the connection between the Lets Get Moving and Falls Prevention programmes. While expressing disappointment in the figures for South Cambridgeshire, commented that residents were probably healthier due to the affluence of the area however the population was aging and emphasised the benefit of the Falls Prevention programme.

- Noted the events that had been and were due to take place in the Huntingdon area

- Commented that due to the nature of the programme it was difficult to get started and there were risks with over-reliance on statistical data and evidence.

In conclusion to the discussion it was proposed with the unanimous agreement of the Committee to defer the decision regarding recommendation (b) to the December meeting of the Committee at which further evidence of plans to build evaluation data into the programme to increase the evidence base of the project would be presented.

It was proposed by the Chairman with the agreement of the Committee to defer discussion of the Healthy Fenland Fund to the January meeting of the Committee.

It was resolved to:

a) Acknowledge the positive progress achieved by the three programmes

b) Defer a decision to continue to fund the Let's Get Moving Programme for a minimum of one year from April 2019 until the December meeting of the Committee.

c) Defer discussion of the Healthy Fenland Fund until the January meeting of the Health Committee

d) Note that the Public Health allocated funding to support the system-wide Falls Prevention Programme will end in January 2020 and its future funding will require review by the Health Committee.

162. SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) WORKFORCE UPDATE REPORT

The Chairman invited David Wherrett, Director of Workforce at Cambridgeshire University Hospitals Foundation Trust (CUH), Stephen Legood, Director of People and Business Development at Cambridgeshire and Peterborough Foundation Trust (CPFT) and Claire London, Programme Manager Workforce Lead to provide an update regarding workforce issues.

In discussing the report Members:

- Noted the target for the international recruitment of GPs was 30 and there was currently 3 recruited. Officers accepted that the recruitment campaign had not been particularly successful. There had been an increase in the number of people beginning GP training, however it would take a long time for those trainees to come through and there was an immediate need for trained GPs.

- Commented that the development of Care Navigator roles implied structural complexity issues in the health care system. Members sought further information regarding Super Healthcare Assistants. Officers explained that they were not Registered Nurses but Support Workers with extended roles and drew attention to the Thistlemoor Road Surgery in Peterborough where staff were developing a range of skills that included translation services and therefore better support patients when they first arrive at the surgery.

- Requested that caution be exercised when evaluating new roles to ensure there were clear career pathways.

- Noted that 10% of the workforce at CUH were of European Union (EU) origin and if destabilised could pose a significant risk to the organisation. Cambridge remained an attractive place to live and work and therefore there had not been a significant reduction in recruitment from EU countries

- Sought assurance that an ethical approach was taken to overseas recruitment. Officers explained that checks were undertaken on applicants and there was reliance on specific countries such as the Philippines where CUH worked closely with the Ambassador.

- Noted the reliance on overseas recruitment and the difficulties that were experienced in delivering Intensive Care services.

- Noted that CPFT did not currently undertake international recruitment and was the lead organisation for delivering Nursing Associates.

- Questioned why the GP international recruitment campaign had performed so poorly and if it continued what changes would be made. Officers explained that it was a nationally commissioned programme that contained significant investment. Analysis was being undertaken however as yet there were no clear reasons. International recruitment formed part of the GP Five Year Forward View programme

and officers requested that they present the programme to a future meeting of the Committee. **ACTION**

- Noted that there was currently a significant lack of clarity regarding the future status of EU workers. In response, CUH was providing assistance to EU workers, including the provision of immigration lawyers to provide advice.

- Noted the status the recruitment of international doctors for the acute sector that was well established. For GPs, international recruitment was relatively new and officers shared the concerns of the Committee regarding the success of the recruitment programme.

- Questioned how apprenticeships were being advertised and the level to which apprentices could reach. It was explained that the apprenticeship scheme was a 4 year programme. The recruitment profile of apprentices was predominantly female and older cohort drawn from the existing pool of healthcare assistants External advertising of the apprenticeship scheme was undertaken and recruits were required to work for the organisation for 6 months before being eligible for enrolment onto the degree programme. It was noted that CPFT administered a number of in-house apprenticeships and the 4th cohort was currently being recruited.

It was resolved to:

a) Note the content of the report and request a further update in 6 months having been encouraged but the programmes outlined by officers and sharing concerns regarding the short-term future.

b) Send a letter to encourage MPs to support the local NHS in international recruitment and current international employees working in the NHS.

163. UPDATE ON CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP'S (CCG) FINANCIAL POSITION AND IMPROVEMENT DELIVERY PLAN

Members received a report from Jan Thomas, Chief Accountable Officer, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). In introducing the report the Chief Accountable Officer (CAO) informed the Committee that since being appointed to the role 5 months previously a robust plan had been implemented, a new strategic team with greater transformational experience had been appointed. Consultation had been undertaken, the result of which requested a greater public and patient focus.

Members noted the context of the £35m deficit that was set against an overall budget of £1.2bn and the key areas of focus that would begin to address the financial issues including, delayed discharges from hospital and Section 117 (S117) funding of mental health patients. The CAO informed Members that the Continuing Health Care Team had improved greatly with the backlog of cases reduced to under 300 from a starting position of over 900.

During the course of discussion Members:

- Welcomed the performance of the delivery plan and noted the professional realism of it and that risks were being managed in a transparent manner. Members questioned the overall funding formula and whether it delivered the funding required given the demographic pressures in Cambridgeshire. The CAO informed Members that it had been agreed that if the deficit remained at £35.1m at the end of the financial year it would not have to be added to the cumulative debt position of the CCG. It was explained that it was possible that because of the geographical size of the CCG, acute demographic changes had been blended and diluted.

- Noted the overall downward trajectory regarding winter pressure figures which had reduced from a variance of 6,731 to 599. Data was scrutinised by regulators and NHS England who have confidence in the data reported.

- Noted concern regarding S117 cases. The CCG had embarked on a piece of work to review S117 after care through the establishment of a task force that had a breadth of skills as a multi-disciplinary team.

- Drew attention to Section 106 funding which represented capital funding for buildings and infrastructure but was not able to provide the staff necessary to operate the facilities, which was leading to S106 funding having to be returned to developers because it had not be utilised within the required timescale. Members sought further information regarding how the CCG was tackling the issue. The CAO advised that long term planning was required to ensure that primary care infrastructure was being built in its entirety. Meetings had taken place with Planning Officers and MPs to address the issue and a team was to be established within the CCG to review, ensuring that S106 funding was not lost.

It was resolved to:

a) Note with concern the CCG's financial position and express optimism regarding the progress made and the improvement plan.

b) Request an update in 3 months.

164. TRAINING PROGRAMME

It was resolved to:

Note the Committee training programme

165. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO OUTSIDE BODIES

The Committee examined its agenda plan

It was resolved unanimously to:

Note the Forward Agenda Plan, the changes that arose during the course of discussion and the additional items requested.

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee up to the meeting on **12 July 2018** and updates Members on progress in delivering the necessary actions.

Meeting of 12 July 2018

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
130	**Finance and Performance Report – May 2018**	**L Robin**	Emphasised the benefits of interventions for cycle and pedestrian safety as an investment in the future. It was requested that officers explore ways to find funds in order to avoid any reduction in the "Bikeability" scheme.	Work is continuing to bring together different streams of cycle safety and promoting active travel.	**Ongoing**
131	**Annual Public Health Performance Report 2017/18**	**Democratic Services**	Questioned whether regarding significant procurement exercises there was scope for greater Member involvement at an earlier stage of the procurement process. Officers agreed to investigate further the possibility of earlier Member involvement.	This query has been raised with the LGSS Procurement Team correspondence is continuing and an update will be provided.	**Ongoing**

Meeting of 13 September 2018

142	**Community First (Learning Disability Beds Consultation)**		Officers agreed to provide a spreadsheet detailing the funding of the project.	Update provided at November meeting. Awaiting further information from the CCG	**Ongoing**

Meeting of 8th November 2018

160	**Finance & Performance Report – September 2018**		Officers to provide a briefing note to Members regarding the provision of Health Visiting for 12 month to 2.5 years and its delivery in Huntingdonshire	Will be covered within the HCP item on the agenda.	**Completed**
160	**Finance & Performance Report – September 2018**		Officers to review the wording relating to Children's Centres within the MOU section of the report.	Review reported back to relevant officers and updated MOU Q2 performance will be presented to the January Committee with revised wording.	**Completed**
160	**Finance & Performance Report – September 2018**	**Chairman**	Chairman to contact the Chairman of Children's and Young Peoples Committee to express Members' concerns regarding Children's Centres.	Chairman has discussed the matter with the Chairman of CYP Committee. A report was presented to 13 November meeting of the Committee and encourage members to review the minutes.	**Completed**
160	**Finance & Performance Report – September 2018**	**Liz Robin / Clare Andrews**	Requested that indicators within the report be reviewed in readiness for the new financial year.	An update will be provided on this piece of work in the new year.	**Ongoing (March 2019)**
161	**Progress Report – Programmes Funded from Public Health Reserves**	**Chairman**	Chairman to contact the Chairman of the Highways and Community Infrastructure Committee regarding the state of repair of footpaths and pavements and report back to Committee.	Chairman has discussed the matter with the Chairman of H&CI Committee who emphasised the importance of reporting highway defects. A rolling programme of improvements and repairs to	**Completed**

				pavements is ongoing and the Chair of H&CI undertook to ensure the programme was moving as swiftly as possible.	
162.	**Sustainability and Transformation Partnership (STP) Workforce Update**	**Democratic Services**	Item to be placed on forward agenda plan regarding GP	Item scheduled for March 2019	**Completed**

Agenda Item No: 5

THE ADOPTION OF A DYNAMIC PURCHASING SYSTEM (DPS) FOR PUBLIC HEALTH PRIMARY CARE COMMISSIONING

To: **Health Committee**

Meeting Date: **December 6th 2018**

From: **Director of Public Health**

Electoral division(s): **All**

Forward Plan ref: **2018/069**

Key decision: **Yes**

Purpose: The purpose of this paper is to provide the Health Committee with the additional information it requested in relation to the proposal presented at the meeting in November 2018 to adopt the "Dynamic Purchasing System" (DPS) for contractual arrangements that Cambridgeshire County Council Public Health has with primary care providers

Recommendation: **The Health Committee is asked to review the additional information and approve the proposal to adopt the Dynamic Purchasing System (DPS) contractual arrangements that Cambridgeshire County Council Public Health has with its primary care providers.**

Officer Contact:		***Chair Contact:***	
Name:	Val Thomas	Name:	Councillor Peter Hudson
Post:	Consultant in Public Health	Post:	Chairman
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1. BACKGROUND

1.1 There are 77 GP practices and 109 community pharmacies located within the boundaries of CCC. All are offered, providing they meet the clinical requirements for providing them, the option of providing all or some of the services. In 2017/18 in CCC and PCC 91 practices provided at least one of the services. The majority provided all of them. Of the community pharmacies 46 provided Emergency Hormonal Contraception. There is a range of annual contract values between £15k to £30k per annum as the contract may include some or all of the services.

1.2 GP practices are in a unique position in terms of the provision of their services. Firstly in terms of access to the target populations for the services that are being commissioned means that they can improve their uptake. There is strong evidence that endorsement of a service by a GP or any clinician increases acceptability and compliance with a service. Access to GP records is necessary to identify and invite those eligible for an NHS Health Check.

1.3 Consequently when these primary care contracts transferred to Local Authorities in 2013, as part of the transfer of the Public Health function from the NHS to Local Authorities under the Health and Social Care Act they were not competitively tendered. Through the exemption process the contracts are renewed on annual basis.

1.4 The constant exemption processes and contract renewal is time consuming and challenges commissioning/contracting capacity and is not cost-effective given the large number of relatively low value contracts.

1.5 In addition primary care contractors are experiencing new expectations for their services and high levels of demand. The constant renewal of contracts is viewed as time consuming and is a disincentive to providing the services.

1.6 There are concerns about repeat exemptions and in general these are not encouraged by the Authority.

1.7 There are also a number of process advantages that could be afforded by the adoption of the DPS.

1.8 The CCC total aggregated annual value of all the primary care services commissioned includes payments to providers and drug costs. The drug costs are CCG and community

pharmacy re-charges, (contraception, nicotine replacement therapy, stop smoking and drug detoxification medications). Individual contract values with each practice range from £20, 000 to £30,000 per annum.

Provider payments: £1,146,000

Drug recharges to the CCG and community pharmacies: £1,080,000

Total: £2,226,000

2. MAIN ISSUES

2.1 The Public Health Joint Commissioning Unit is responsible for commissioning these contracts across both local authorities. It is proposed to adopt the DPS procedure for Primary Care contracts held by CCC and PCC, based on the rationale of creating efficiencies and improving the commissioning relationship with primary care providers.

2.2 There are two contractual arrangements that could be termed an “umbrella agreement” which could potentially be used to avoid the annual contracting process for GP contracts. These contractual arrangements are possible under what is known as the Light Touch Regime (LTR). This new legislation is a specific set of rules for certain service contracts that tend to be of lower interest to cross-border competition. These service contracts include social, health and education services, defined by Common Procurement Vocabulary (CPV) codes.

LTR allows Authorities the flexibility to use any process or procedure they choose to run the procurement, as long as it respects the obligations of transparency and equality. There is no requirement to use the standard EU procurement procedures (open, restricted and so on) that are available for other (non-LTR) contracts. Authorities can use those procedures if helpful, or tailor those procedures according to their own needs, or design their own procedures altogether.

The LTR rules are flexible on the types of award criteria that may be used, but make clear that certain considerations can be taken into account:

- the need to ensure quality, continuity, accessibility, affordability availability and comprehensiveness of the services
- the specific needs of different categories of users1, including disadvantaged and vulnerable groups
- the involvement and empowerment of users
- innovation

The LTR also has a relatively high threshold (when compared with the threshold for Part A Services)–750,000 euros (the current sterling equivalent is £615,278), contracts below the

LTR threshold, do not need to be advertised in the OJEU, unless there are concrete indications of cross-border interest.

The LTR also allow Councils the opportunity to modify the system (where necessary) to suit the requirements of social/health care. This type of Dynamic Purchasing System (DPS) is already being used successfully in social care and is now referred to as a ‘pseudo-DPS'. It can be used to make procurement more efficient for both providers and buyers, as providers are not required to demonstrate suitability and capability every time they wish to tender under the DPS, they are also only required to demonstrate the minimum requirements, so for services that are regulated this procedure is very simplistic. They can run for more than four years which supports the development of relationships with key providers.

2.3 Table 1 describes the advantages and disadvantages of the different procurement and contractual options.

Table 1: Options Appraisal of the different contractual arrangements

Option 1	**Option 2**	**Option 3**
Status Quo: • Annually the Authority is extending, reissuing and signing new contracts with multiple suppliers • The process is time consuming as described above and not meeting the requirements of the EU regulations • Therefore this no longer a viable option.	**Framework:** • In the context of procurement, a framework agreement is an agreement between one or more organisations, "the purpose of which is to establish the terms governing contracts to be awarded during a given period, in particular with regard to price and, where appropriate, the quantity envisaged. Consequently framework agreements are commonly set up to cover things like office supplies, IT equipment, consultancy services, and repair and maintenance services. • The framework is not flexible and does not allow new suppliers to join during the life of the framework. • This option is not deemed viable as it is too restrictive.	**Pseudo DPS** • They save time and money by being a quick and easy way to access services through an OJEU compliant route. • It is fully electronic system with no complicated evaluations and moderations. • The DPS is flexible and will alleviate the annual administrative burden of contract re-issuing. • The DPS also allows new suppliers to join /leave at any time during the life of the contract. It gives providers another opportunity if at first they are unsuccessful. Many contractors are not poor providers, they are poor tenderers. The use of frameworks unnecessarily locks these providers out of the market for up to four years. DPS offers a solution where if they don't succeed at first they can try again. • Due to the flexible nature of the DPS it will assist in effective management of the market, while ensuring the Authority is EU compliant. • A DPS is likely to have more providers awarded into the system than a framework agreement. This would serve to spread the risk for the authority. • A DPS is therefore deemed the most viable option.

2.4 The DPS system will also facilitate various improvements in terms of quality assurance and efficiencies in performance management.

- Currently there are differences in the approaches to primary care contracts across CCC and PCC. There is a good working relationship with the Primary Care commissioners in the Clinical Commissioning Group (CCG) and the Local Medical Committee (LMC) and are keen to harmonise the contracts across the local authorities. The introduction of a DPS system affords the opportunity to align contract timeframes, ensure specifications include the same quality assurance processes and payment systems across all contracts. The pricing system however is based on historical differences and some differences will remain.
- It will be a more time effective system though reducing the administration time for both CCC and PCC Public Health JCU along with the Authorities' respective procurement and legal teams.

2.5 The primary care landscape is changing and going forward there is the risk that different contractual arrangements will be required, the DPS would be sufficiently flexible to accommodate these changes.

2.6 Establishing DPS system will require each primary care provider to effectively "bid" to provide a service. This would be a new approach for most GP practices and community pharmacists. However the JCU will work with practices to support them with these processes.

2.7 LGSS Procurement has advised on the adoption of the DPS and the proposal has been approved by the Cambridgeshire and Peterborough Joint Commissioning Board.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The following bullet points set out details of implications identified by officers:

- The introduction of DPS will improve the efficiency of the contracting process and encourage primary care providers to deliver the services to avoid more complex annual contractual arrangements.

3.2 Helping people live healthy and independent lives

- The DPS system will encourage more primary care providers to deliver services that aim to improve the health of the population.

3.3 Supporting and protecting vulnerable people

- The DPS system will encourage more primary care providers to deliver services that aim to improve the health of the population. These services are designed to target areas of higher need.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in ***1.8***

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The report above sets out details of significant implications in **2.2, *2.3***

4.3 Statutory, Legal and Risk Implications

The report above sets out details of significant implications in **2.2, *2.3, 2.5 and 2.6***

4.4 Equality and Diversity Implications

There are no significant implications within this category

4.5 Engagement and Communications Implications

The report above sets out details of significant implications in 2.6

4.6 Localism and Local Member Involvement

The report above sets out details of significant implications in 2.6

4.7 Public Health Implications

The following bullet points set out details of implications identified by officers:

The introduction of DBS will encourage and support practices to deliver public health services that will improve the health of the population.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Paul White
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Allis Karim
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Liz Robin

Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Jo Dickson
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Liz Robin

Source Documents	**Location**
Mills and Reeve User Guide to the Public Contracts Regulations 2015	://www.procurementportal.com/files/Uploads/Documents/public_contracts_regs_2015_guide.pdf

Agenda Item No: 6

HEALTHY CHILD PROGRAMME UPDATE

To:	**Health Committee**
Meeting Date:	**6th December 2018**
From:	**Dr Liz Robin, Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**N/A**
Key decision:	***No***
Purpose:	**The purpose of this report is to update the Health Committee on the workforce and financial issues in relation to the 0-19 Healthy Child Programme (0-19 HCP) and work undertaken to integrate the service across Cambridgeshire and Peterborough. To present an options appraisal regarding the service model with a reduced budget (annual savings of £398K in Cambridgeshire and £200K in Peterborough).**
Recommendation:	**a) To note the workforce update on the Health Visiting and School Nursing service** **b) To note the proposed service model for the 0-19 HCP, including the options for the delivery of support to teenage mothers, and to endorse the model for implementation from April 2019**

Officer Contact:		*Chair Contact:*	
Name:	Ruth Derrett, Dr Raj Lakshman	Name:	Councillor Peter Hudson
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1. BACKGROUND

1.1 Overview of 0-19 Healthy Child Programme

The foundations for virtually every aspect of human development – physical, intellectual and emotional – are established in childhood. Good health, wellbeing and resilience are vital for all our children now and for the future of society. With 80% of brain development taking place by the age of 3, the experiences of children and their immediate care givers, during pregnancy and the first few years of life, are significant determinants of long-term health and wellbeing in adulthood. Mitigating risk factors in physical health, social and psychological development, including poor perinatal mental health, malnutrition and obesity, parental drug and alcohol misuse, and speech and language deficits, is therefore essential.

In 2009, the Department of Health set out an evidence-based programme of best practice, the Healthy Child Programme (HCP), with the ambition of making everywhere as good as the best by developing improvements in health and wellbeing for children and young people. The universal reach of the Healthy Child Programme provides an invaluable opportunity from early in a child's life to identify families that need additional support and children who are at risk of poor outcomes.

Health Visitors and School Nurses, as Specialist Community Public Health Nurses, use a strength-based approach to build non-dependant relationships enabling them to work effectively with their population (children, young people and their families) to support behaviour change, promote health protection and to keep children safe.

The HCP identifies six high impact areas for the **0-5** years:

- **transition to parenthood** and the early weeks
- maternal (perinatal) **mental health**
- **breastfeeding** (initiation and duration)
- **healthy weight** (including healthy nutrition and physical activity)
- managing minor illness and **reducing hospital attendance** and admission
- health, wellbeing and development of children aged 2 and **school readiness**

The high impact areas for the **5-19 HCP** are

- **building resilience** and supporting **emotional wellbeing** as highlighted in 'Future in Mind', working closely with schools, parents and local services
- **keeping safe**, managing risk and reducing harm including child sexual abuse and exploitation; sexual and domestic abuse; neglect; PREVENT; alcohol and substance misuse; mental health issues
- improving **healthy lifestyles** and health literacy including reducing childhood obesity and increasing physical activity; smoking prevention and cessation; healthy relationships and positive sexual health
- maximising **learning** and achievement -helping children to realise their potential and reducing inequalities, and supporting additional health and wellbeing needs
- promotion of **immunisation and screening**
- seamless **transition**- specifically entry into Reception Year (ages 4/5years); changing school, leaving school; supporting the transfer into further and higher education. Preparing for adulthood aligning with the NHS Five Year Forward View (self-care and prevention

agenda)

1.2 HCP Commissioning Responsibility and Plans for wider service integration

Public Health is responsible for commissioning the 0-19 Healthy Child Programme (HCP) which consists of Health Visiting (0-5yrs), Family Nurse Partnership (for vulnerable teenage parents), and School Nursing (5-19yrs) services. Commissioning arrangements for Health Visiting and FNP transferred to the Local Authority in October 2015. The Local Authority has commissioned school Nursing since April 2013 when Public Health responsibilities transferred from the NHS.

A Section 75 agreement is in place for Cambridgeshire Community Services NHS Trust (CCS) to deliver these services in Cambridgeshire. Peterborough City Council have a Section 75 agreement with Cambridgeshire and Peterborough Foundation Trust (CPFT). These are both due to expire at the end of March 2019. Continuation of S75 approach is subject to Key Decision in January 2019.

This paper outlines the first stage of the wider integration process for Children's Health and Wellbeing services in Cambridgeshire and Peterborough, which has been discussed with the Health Committee at the following meetings:

Date	Health Committee	Title of paper	Comments
14/6/17	Committee paper in public	0-19 Joint Commissioning of Children's Health and Wellbeing Services	Focus on the work of the children's health joint commissioning unit and integration of children's health services
14/12/17	Committee paper in public	Integrated commissioning of children's HWB services	Focus on the children's centre restructure and the links to health provision in children's centres (midwives, health visiting etc)
17/5/18	Committee paper in public	Children's Health Joint Commissioning Unit Integration Update	Focus on achievements of the children's health joint commissioning unit and progress towards integration of services

At its meeting on December 14th 2017, the Health Committee discussed savings proposals related to integration of Children's Health and Wellbeing Services as part of the agenda item 'Public Health Service Committee Review of Draft Revenue Business Planning Proposals for 2018/19 to 2022/23'. The Committee decided to 'Comment on the draft revenue savings proposals that are within the remit of the Health Committee for 2018/19 to 2022/23, and agree that the Committee's preferred option was to defer the 2018/19 savings relating to the 0-19 service and fund the £238k shortfall through the Public Health reserves, in order to develop a more transformational approach to integrated children's services across Cambridgeshire and Peterborough.

The proposed model for integration of HCP 0-19 outlined in this paper, is therefore the first stage of a wider ambition to further integrate children's health and wellbeing services across Cambridgeshire and Peterborough, developing a joint venture between the two health trusts currently delivering in the area. An overarching 'Best Start in Life' workstream is bringing together stakeholders from across the local system, to develop an overarching strategy for Early Years and design the new system offer.

1.3 Strategic Outcomes

The HCP directly contributes to the achievement of the Cambridgeshire & Peterborough Children and Young people's Outcomes Framework. The Framework consists of key national and local outcomes from the NHS Outcomes Framework, Public Health Outcomes Framework and Think Family Outcomes Framework.

The Cambridgeshire and Peterborough Children and Young Peoples (CYP) Outcomes Framework will be used by commissioners and providers in conjunction with local intelligence to inform strategic service planning and prioritisation in response to local health needs. It will provide a basis of annual service objective setting and service development planning overseen by commissioners. This will ensure that the HCP is working towards the same shared outcomes as other child health services in the local health and care system. These outcomes cannot be achieved by the HCP in isolation and are system-wide outcomes that can be achieved by greater integration of all Children and Young Peoples services.

The detailed Cambridgeshire and Peterborough District level CYP Outcomes framework is available as Appendix 1 and is available at the link https://cambridgeshireinsight.org.uk/health/popgroups/cyp/ . The health and wellbeing of children and young people in Cambridgeshire is relatively positive in comparison to the experience of children in England with child poverty, breastfeeding prevalence at 6-8 weeks, teenage conceptions, excess weight, children in care, dental health, 16-17 year olds not in education, employment and training (NEET), pupil absence, A&E attendances and hospital admissions for asthma, mental health conditions and unintentional and deliberate injuries all statistically significantly better than the England averages. However, there are some outcomes where Cambridgeshire fares worse than England average such as:

Cambridgeshire- School readiness for children receiving free-school meals and hospital admissions for self-harm
Cambridge City- Admissions for self-harm and alcohol-related conditions
East Cambridgeshire- Admissions for self-harm
Fenland- Children living in poverty
Huntingdonshire- Admissions for alcohol-related conditions
South Cambridgeshire- Health of CYP is relatively good

1.4 Finance

Cambridgeshire
When the commissioning responsibility for Health Visiting and FNP (0-5 HCP) transferred over to the Local Authority in October 2015, the 2015/16 budget was £7,593,199. With the cut in the Public Health ring-fenced grant, £340K (4.5% reduction) savings were made over 2 years (£190K in 16/17 and £150K in 17/18), and the contract value in 2018/19 is **£7,253,199** (£238,000 savings proposals were deferred for the integration work to go ahead).

The School Nursing budget has been protected and in 2015/16 and 2016/17, the budget for school nursing was £1,446,540. In 2017/18 and an additional £60,000 investment was put into school nursing for the extension of coverage to special schools, taking the annual contract value to **£1,506,540** (4.1% increase).

Vision screening was added to the 0-19 HCP in April 2018 with a budget of **£167,000**

Total Cambridgeshire 0-19 HCP budget for **2018/19 is £8,926,739**. A saving proposal of £398K would take the budget for **19/20 to £8,528,739**.

Peterborough
The contract value that was novated from NHS England was **£3,066,226** for Health Visiting and FNP. Similar to Cambridgeshire, a saving of £130K was made in 16/17 and the contract value in 2018/19 is **£2,936,226** (£200,000 savings proposals were deferred for the integration work to go ahead).

The SN budget has been protected and the 2018/19 value is the same as the transfer from NHSE i.e. **2018/19 budget £759,000** for school nursing (including NCMP, vision and hearing screening).

Total Peterborough 0-19 HCP budget for **2018/19 is £3,695,226**. A deferred saving of £200K approved in 2018/19 Peterborough Business Plan would take the budget for **19/20 to £3,495,226**.

The **19/20 Total Cambridgeshire and Peterborough** budget for the 0-19 HCP would be **£12,023,965,** a 5.3% reduction from the current budget of £12,621,965.

2 HEALTHY CHILD PROGRAMME SERVICE MODEL

2.1 The Healthy Child Programme is provided by CCS in Cambridgeshire and CPFT in Peterborough. CCS and CPFT have been working collaboratively to develop an integrated 0-19 years Healthy Child Programme (HCP) across Cambridgeshire and Peterborough within a reduced financial envelope – a reduction of £398k in Cambridgeshire and £200k in Peterborough.

The service offer is summarised below, and Appendix 2 sets out the proposed changes in more detail. If the proposed service model is supported, a detailed implementation plan will be developed (within four weeks of service decision), incorporating an engagement and communications plan. Both providers have confirmed an implementation timeline of 3-6 months to deliver the proposed model.

In order to ensure that the service model can achieve the best outcomes for children, young people and their families in Cambridgeshire and Peterborough, CCS and CPFT considered the following:

- public health data across Cambridgeshire and Peterborough
- current service offers provided by each provider
- evidence based practice
- extensive experience and learning from CCS as a provider of the 0-19 years Healthy Child Programme in other counties (Bedfordshire, Luton and Norfolk)
- other service models that are being implemented nationally
- current and future management arrangements required

2.2 The principles that underpin the HCP service model are that it will be:

Outcomes focused

- Service model will support the delivery of the Cambridgeshire and Peterborough Children and Young Peoples (CYP) Outcomes

Needs-led

- Interventions will be needs led and targeted to meet needs of different communities and vulnerabilities

Accessible and flexible

- The service will introduce a single point of access (SPA) to improve responsiveness and accessibility of advice and support
- In addition to access to clinicians via the SPA, support can be accessed from improved self-management resources on the internet and through the implementation of Parentline and Chathealth
- School community profiling and liaison with schools will enable themed support work to be developed, tailored to the needs of children in schools
- For school aged children and young people, venues and times that fit their needs will be identified

Integrated

- Integrated 0-19 years HCP service across Cambridgeshire and Peterborough, using a 3-locality based model (Peterborough, North Cambs and South Cambs)
- Integrated 0-19 years HCP service that is not age-focused and takes a "whole family" approach for children of mixed ages
- Integration with Early Years settings, Child & Family/Children's Centres, Emotional Health and Wellbeing Service, Early Help teams, CAMHS etc
- Integrated antenatal and postnatal pathways that include maternity and primary care alongside community health service provision of the Healthy Child Programme

2.3 The service model for **0-5 years** will include the following interventions:

Universal

- Antenatal contact
- New Birth visit (14 days)
- Post-natal contact (6-8 weeks)
- Healthy Child Clinics
- Feeding Clinics
- Introducing Solids workshop
- 9-12 months review
- Integrated approach to 2-2.5 year reviews and integrated reviews for children in more deprived areas of the County
- Health reviews for children transferring into the County
- Screening of A&E attendance notifications
- Access to 1:1 advice from a clinician in a Single Point of Access, either by phone or via Parentline (a text messaging service)

Universal Plus

- Behavioural and development support
- Nutritional support (complex feeding)
- Support for maternal/perinatal mental health concerns
- Neonatal blood spot screening
- Care of Next Infant following a death of a baby/infant
- A&E attendance follow ups following screening process
- An enhanced teenage parent pathway that includes Family Nurse Partnership for teenage parents from the most deprived areas/complex needs and a Teenage Parent Pathway for other teenage parents. (The options that were considered to best support teenage parents are outlined at Paragraph 2.6)

Universal Partnership Plus

- Safeguarding (Child Protection and Child in Need) – in addition to any intervention
- Undertaking Early Help Assessments
- Supporting families where there is domestic abuse

2.4 The HCP service model for school aged children (**5-19yrs**) will include the following:

Universal

- School community profiling and liaison with schools to agree themed workshops and support
- Health screening
  - Review and triage of digital health questionnaires at key transition points i.e. Reception, Year 6 and Year 9
  - Vision screening in Cambridgeshire
  - NCMP and vision screening in Peterborough
- Review of health records for young people transferring into the County
- Screening of A&E attendance notifications
- Access to same day, 1:1 advice from a clinician in a Single Point of Access, either by phone or via Chathealth (a text messaging service for young people)

Universal Plus

- Young People Appointment Clinics for secondary school aged children
- Appointment clinics for primary school aged children and their parents
- Medicines management support for more complex cases
- Themed sessions/workshops based on community profiling data
- Enuresis clinics
- A&E attendance follow ups following screening process
- Communicable disease outbreak control

Universal Partnership Plus

- Safeguarding (Child Protection and Child in Need) – in addition to any intervention
- Undertaking Early Help Assessments
- Support the development of Educational Health Care Plans

2.5 Healthy Child Programme 0-19 Workforce Modelling and Service Capacity Utilisation

The Benson-Wintere model is nationally recognised and utilised by over 40 Community NHS Trusts. The Benson model is a standardised demand forecasting model used to assist providers and commissioners with understanding and planning clinical workload, workforce and future service development. Benson draws on publically available data to profile local demographics, and uses local health intelligence to analyse historic service delivery and to validate the baseline model. Service and workforce profiles are derived from the trusts with assistance from Benson. These help to predict time needed to deliver the service safely and effectively, ensuring caseloads in each area are sensitised to reflect local needs. The outputs produced include predicted workloads, optimum workforce and costing.

The model also allows the breakdown of the workload to be categorised into the different levels of the Health Visiting and School Nursing offer as described in the Healthy Child Programme. The tables below demonstrate the workforce hours required to deliver the 0-5 and 5-19 elements of the HCP model that have been described in sections 2.3 and 2.4.

Workforce hours to deliver 0-5 years service offer

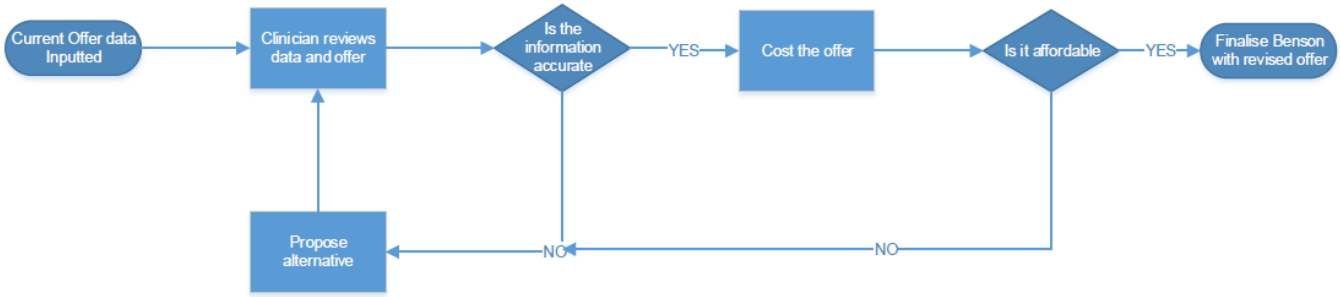
Service Potential	ALL	UNI	UNI+	UPP
Work force hrs required	175,344	115,334 (66%)	28,017 (16%)	31,992 (18%)

Workforce hours to deliver 5-19 years service offer

Service Potential	ALL	UNI	UNI+	UPP
Work force hrs required	43,454	13,590 (31%)	16,604 (38%)	13,259 (31%)

The above data also demonstrates the proportion of time that is required to deliver the different levels of the HCP model – Universal, Universal Plus and Universal Partnership Plus. It is worth noting that a significant proportion of the 0-19 team capacity is being utilised to support safeguarding work (Universal Partnership Plus) – 21% across the whole 0-19 team, 31% for School Nurses and 18% for Health Visitors. This demonstrates that staff resources are being prioritised to meet the needs of those children identified at being of greatest risk of poorest outcomes.

The Benson modelling process is summarised in the following figure



2.6 Family Nurse Partnership: Options Considered

Service Model	Advantages	Disadvantages
Option 1: Service Model set out in section 6.2 below	• Sustainable, flexible, Integrated • Greater use of technology (Parentline, ChatHealth, single point of access) • Improved support for all teenage parents while maintaining FNP for the most vulnerable • Health questionnaires at transitions (new for Cambridgeshire) • Safeguarding procedures streamlined	• Some areas where outcomes are good may see a reduction in the face-to-face clinics
Option 2: Decommission FNP to realise savings	• Savings easy to identify without service redesign	• Lose all the benefits of having an FNP service which has a strong evidence base, measures of outcomes and support from the National Unit • Some of the most vulnerable teenagers who would have met the FNP criteria will not get this level of support and therefore the Universal 0-19 services would be managing more complex cases • The above could have an impact on:

		○ Delivery of core mandated checks ○ Staff resilience – higher turnover of staff • Loss of FNP skills and knowledge • Increased costs to the system esp social care • Increased safeguarding concerns • No interventions to break the cycle of teenagers having children
Option 3: Maintain current service model	• Users will not see any change	• Savings not realised and will have to be made from other Public Health services • Not future-proof • The current offer is to a small cohort, and not available to every teenage mother.

3 RECRUITMENT AND RETENTION STRATEGY

There are workforce challenges in the delivery of the Healthy Child Programme. Nationally, since the completion of Call to Action in 2015, the Health Visiting workforce has decreased by 10% per year, this figure is in part attributed to the age profile of the workforce with over 30% eligible for early retirement. Locally we have seen a similar picture summarised in Appendix 3. Staff resources are prioritised to certain aspects of service delivery such as new birth visits and 6-8 week checks and a focus on the needs of those children identified as being at greatest risk of poor outcomes. However, this prioritisation has impacted on the performance in other aspects of service delivery, in particular antenatal, 1 year and 2-2.5 year checks as set out in Appendices 4a and 4b.

Similarly to health visiting, between 2014 and 2018 nationally, the school nursing workforce has decreased. This national picture has been reflected locally and the Trusts are taking steps to address this. Central to this is the greater use of skill-mix in both the 0-5 and 5-19 workforce; best practice models identify the importance of the pathway being led by a workforce with a specialist public health nurse qualification (SCPHN) supported by an experienced, relevant skill mix resource.

Other measures that are being implemented to improve recruitment and retention within the

HCP service are:

- Increasing the number of students in training e.g. there are 9 Health Visitor and 5 School Nurse students who are due to qualify as Specialist Community Public Health Nurses SCPHN) in August 2019
- Establishing a rolling programme of "Growing our own" from the Trusts current Band 4 workforce, so that there will always be people on the Nursing programme who once they have completed this, will then have the opportunity to do the SCPHN qualification. There are currently 3 Band 4 staff who have started the nursing programme, and this will be extended to other staff as part of the rolling programme.
- Within the service model the Trusts have included a Band 5 development role that will then lead to undertaking the SCHPN qualification
- The service model has also included new Band 5 roles within the 5-19 offer that do not require nursing qualification and therefore will attract other expertise such as graduate psychologists, youth workers etc.
- The Trusts have agreed a Recruitment and Retention Premium (RRP) across both organisations for roles within Cambridgeshire city, Peterborough and Fenland where there are recruitment hotspots.

4 SAFEGUARDING

Safeguarding is a critical and core part of the Healthy Child Programme. A significant proportion of the 0-19 team capacity is being utilised to support safeguarding work. Work is required to ensure that safeguarding responsibilities are met in a way that is efficient, effective, and less resource intensive.

In response to the pressure on resources from safeguarding and the significant proportion of time required to deliver the different levels of the HCP model both Trusts are working together to review the HCP involvement within the safeguarding arena. This is intended to review current processes and working practices to ensure they meet safeguarding requirements but remain resource efficient at the same time.

Current areas under review are:

- Attendance at initial case conferences (ICPC) and review case conferences for children aged 0-19 to ensure there is an agreed pathway across both areas
- Streamlining case conference reporting to ensure quality and consistency and greater use of electronic case recording system.

These changes will be supported by a multi-agency training package to support clinicians to increase their skills and knowledge around report writing and their role in an ICPC. The aim is to deliver this training in the new year to ensure the new process can be instigated from April 2019.

5 STAKEHOLDER ENGAGEMENT

The service model has been developed with clinical and operational leads from both Trusts. Public Health and Local Authority Commissioners have also been part of these discussions. Once the service model is agreed, there will be a range of staff engagement sessions to help the teams understand the service model – what remains the same and what will change. In addition to ongoing user engagement and feedback which has informed development of the

model, the service providers will develop a communications and engagement strategy which meets the consultation requirements of both the NHS and the Local Authorities.

6 HCP TRANSFORMATION: DEVELOPING THE MODEL AND DELIVERING THE CHANGE

6.1 Cambridgeshire Community Services NHS Trust (CCS) and Cambridgeshire and Peterborough Foundation Trust (CPFT): provider alignment to share best practice and innovation

Both CCS and CPFT have successful experience of providing in-patient and community services to children and young people across the East of England. CCS is the provider of three other Healthy Child Programmes, including Norfolk, Bedfordshire and Luton. This provides opportunities for sharing learning; developing best practice; and creating a professional and learning environment to retain and recruit staff.

The Trusts are developing a joint partnership approach with the aim of promoting integrated working to ensure that children and families in Cambridgeshire and Peterborough are kept safe and healthy; have excellent health services; enjoy school, play and family life; are helped to help themselves; and have strong and inclusive networks of support. Specifically, the objectives of this joint working arrangement are:

- to improve outcomes for children, young people and families in Cambridgeshire and Peterborough, within a sustainable financial envelope;
- to provide responsive, integrated and consistent services that are delivered flexibly around the needs of children and families;
- to support families to be more in control of their own health by reducing avoidable conditions such as obesity and infections, and for families and communities to be more resilient in terms of emotional health and wellbeing;
- to consider the timing of support and interventions to maximise their impact;
- to offer a consistent core service which can be tailored based on local demographic needs, so that differentiated services can be delivered as appropriate; and
- provide services that are best value for money

To-date, CCS and CPFT have successfully:

- Developed a joint leadership and management structure for the Healthy Child Programme across Cambridgeshire and Peterborough; This has also been supported with the delivery of joint leadership development programme which is supporting joint working
- Used a workforce modelling tool, to develop a service model to deliver the Healthy Child Programme
- Engaged with current system work on a Best Start in Life strategy, which includes current providers of Child & Family/Children's Centres and Early Years to develop greater integrated models of delivery.
- Shared clinical leadership and joint working in Speech and Language Therapy, Occupational Therapy and Physiotherapy
- Developed a jointly run Emotional Health and Wellbeing Service.

6.2 Service integration to generate efficiencies

CCS and CPFT believe the new proposed offer provides a comprehensive integrated and targeted service across Cambridgeshire and Peterborough within the reduced cost envelope. This has been achieved through redesign and reallocation. A significant proportion of the service model will continue and the key changes which include enhancements to the service model are set out below:

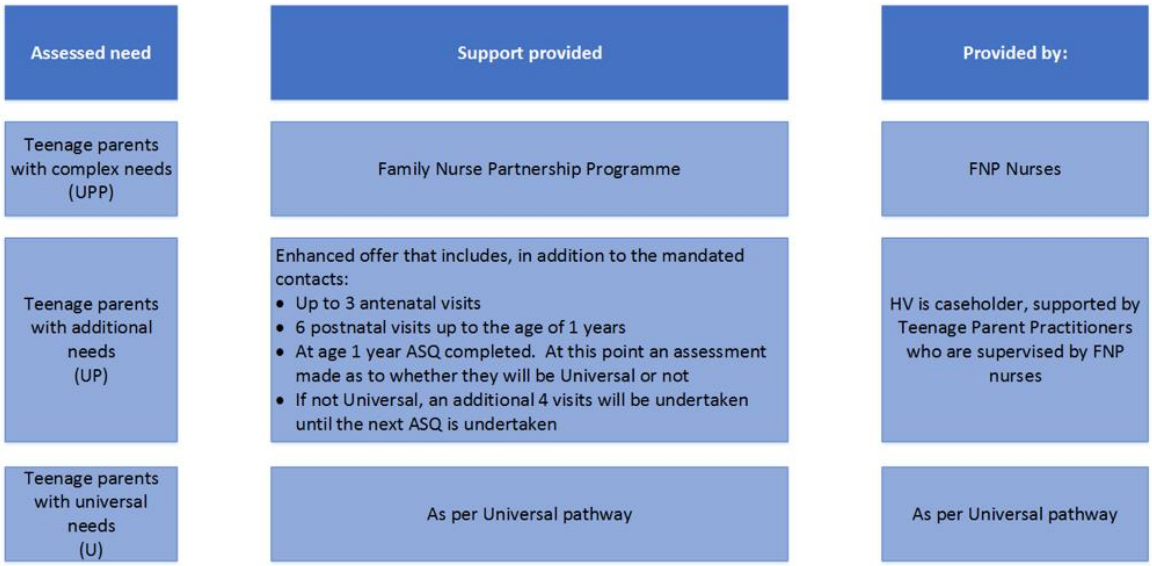
Streamlining the Management Structure

By working effectively together across the Cambridgeshire and Peterborough geography the two Trusts have been able to integrate and rationalise the management structure as there are posts that span across the whole geography giving flexibility in supporting the identified health needs of our population, alongside a focussed locality delivery team with unique local knowledge, giving the service a robust management and leadership model moving forward.

Improving support for teenage parents- FNP and enhanced teenage parent pathway

Whilst a very important resource, with a sound evidence base and outcomes focussed approach, the Family Nurse Partnership only delivers to a small proportion of our teenage parent population. The Trusts are proposing a revised service offer for teenage parents (see diagram below):

- Continue to deliver FNP to 100 of our most at risk teenage parents (reduced from the current 200 which are often not taken up) and,
- Utilise some of the savings from this to create and deliver an enhanced pathway of care for all teenage parents who require additional support, which would be in addition to the universal mandated offer



CCS is looking at collaborating with the national Family Nurse Partnership Unit to evaluate a similar model that is being delivered in Norfolk, so that an assessment of impact on outcomes for this cohort of young people, can be made.

Change in workforce skill mix to deliver the service model

The mandated reviews in the Healthy Child Programme offer a unique insight into the developmental needs of all children and their families living in Cambridgeshire and Peterborough. An analysis of the skills required to carry out these reviews using nationally benchmarked data, has been undertaken. This has enabled the Trusts to propose the introduction of a skill mixed team that includes:

- Additional nursery nurse capacity – an under-utilised resource who have the skills to support the 1-8 year old age group. The skill mix team will ensure that there is always support from a Health Visitor available for Nursery Nurses within the Single Point of Access, to have case discussions and to escalate any immediate concerns or challenges.
- As set out in Appendix 2, Health Visitors will carry out the antenatal, new birth and 6-8 week checks and support nursery nurses to carry out the 1 and 2-2.5 year checks for children on the universal pathway.
- Different roles within the 0-19 teams to support school aged children.

The skill mixed workforce will be supported by robust delegation and supervision processes which will include case management discussions which will enable safe, facilitated discussions on those cases that need a wider consideration from the 0-19years team expertise.

Redesigning access to advice

The service model has streamlined the provision of healthy child clinics by increasing access to immediate advice and support through an improved digital/intranet offer, Parentline (text messaging service for parents), Chathealth (text messaging service for young people) and support from clinicians in the Single Point of Access (SPA) – a resource for all families and in particular for those families who are not digitally literate or who do not have access to these platforms. These tools are intended to offer immediate and easy access to information and advice, as well as promoting self-help and self-care.

As the digital platform goes live and is publicised, the Trusts will assess the impact that this has on clinics and therefore, those less well attended would be closed. The Trusts intend to work in partnership with Children Centre's/Child and Family Centres and potentially Libraries to support access to a "self-weigh" model. This will rely on wider redesign of the services being undertaken as part of the Best Start in Life/Early Years strategy.

Weekend development review clinics

To improve access for families, the service model includes delivering development review clinics on a Saturday. This builds on the experience from piloting this in Cambridgeshire, where the feedback has been very positive with families and staff. It is envisaged that there will be one a month in each of the 3 localities. The service will look at extending this model based on uptake and feedback from service users.

7 NEXT STEPS

A paper will be brought to Health Committee in January/February following further consultation if required depending on whether the preferred option is significantly different to the current service. Legal and Procurement advice will be sought on this.

8 ALIGNMENT WITH CORPORATE PRIORITIES

8.1 Developing the local economy for the benefit of all

Children contribute to the future economy. Good physical and mental health of children is importa make the NHS and the economy sustainable.

8.2 Helping people live healthy and independent lives

See section 1.3. The 0-19 HCP aims to improve outcomes for all children and young people.

8.3 Supporting and protecting vulnerable people

The 0-19 HCP aims to narrow the gap in outcomes between the most vulnerable children and their peers.

9 SIGNIFICANT IMPLICATIONS

9.1 Resource Implications

As detailed in Section 1.4, the 19/20 Total Cambridgeshire and Peterborough budget for the 0-19 HCP would be £12,023,965, a 5.3% reduction from the current budget of £12,621,965 over a two year period. This is in line with the reduction in the Public Health grant.

9.2 Procurement/Contractual/Council Contract Procedure Rules Implications

Advice has been sought from the strategic Procurement manager for Cambridgeshire (LGSS).

Under Section 75 of the NHS Act 2006 (as amended), the Secretary of State can make provision for local authorities and National Health Service (NHS) bodies to enter into partnership arrangements in relation to certain functions, where these arrangements are likely to lead to an improvement in the way in which those functions are exercised. The specific provision for these arrangements is set out in the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. The regulations set out how partners can enter into arrangements whereby an NHS body may exercise the prescribed health-related functions of local authorities.

There are also a number of contracts that are excluded from the scope of the Public Contracts Directive. Articles 12 of the Directive outline situations whereby Public contracts between entities within the public sector are excluded. The establishment of a section 75 whereby delegation of duties is assigned to the Health Authority are not required to be procured.

The risks of pursuing this option may be mitigated by issuing a Voluntary Ex-Ante Transparency Notice (VEAT) outlining the proposed arrangement. A VEAT notice is a means of advertising the intention to let a contract without opening it up to formal competition evidencing that under the “Duty of Best Value” the arrangements being proposed secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

9.3 **Statutory, Legal and Risk Implications**

Since the value of the Cambridgeshire budget is higher, it is proposed that Cambridgeshire County Council will act as the lead commissioner on behalf of Cambridgeshire County Council (CCC) and Peterborough City Council (PCC). A Memorandum of delegation is required between CCC and PCC.

9.4 **Equality and Diversity Implications**

See section 3. This scope of this project includes all children in Cambridgeshire and Peterborough between the ages of 0-19. It considers Universal, Universal Plus and Universal Partnership Plus services within the 0-19 Healthy Child Programme (HCP) including Health Visiting, FNP (0-5 HCP) and School Nursing (0-19 HCP). The Healthy Child Programme starts before birth so also includes pregnant women.

9.5 **Engagement and Communications Implications**

See section 5. This paper is prepared in conjunction with the current providers CCS and CPFT. The integration work is overseen by the Joint Children's Transformation Board.

9.6 **Localism and Local Member Involvement**

Some areas where outcomes are good may see a reduction in service in order to target areas of highest need.

9.7 **Public Health Implications**

The foundations for virtually every aspect of human development including physical, intellectual and emotional; are established in early childhood. Professor Sir Michael Marmot and the Chief Medical Officer have highlighted the importance of giving every child the best start in life and reducing health inequalities throughout life through universal provision and targeted support. The success of an integrated (across Cambridgeshire and Peterborough) 0-19 service in achieving improved outcomes for children while also delivering on the savings will be essential to improving population health now and in the future.

The Health and wellbeing strategy seeks to ensure a positive start to life for children, young people and their families. The provision of a high quality, 0-19 HCP will be fundamental to this.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrew
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Paul White
Has the impact on statutory, legal and risk	Yes

implications been cleared by LGSS Law?	Name of Legal Officer: Allis Karim
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Dr Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Dr Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Dr Liz Robin

Source Documents	Location
Commissioning guides and evidenc reviews	https://www.gov.uk/government/publications/healthy-child-programme-0- health-visitor-and-school-nurse-commissioning https://www.gov.uk/government/publications/commissioning-of-public-he services-for-children http://www.eif.org.uk/publication/what-works-to-enhance-the-effectivenes the-healthy-child-programme-an-evidence-update/. https://www.gov.uk/government/publications/health-matters-giving-every- the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life Healthy Child Programme: Pregnancy and the first five years of life Healthy Child Programme: From 5-19 years old http://www.nhs.uk/conditions/pregnancy-and-baby/pages/baby-reviews.a
Child health profiles	https://cambridgeshireinsight.org.uk/health/popgroups/cyp/ https://www.gov.uk/government/publications/health-profile-for-england- 2018/chapter-4-health-of-children-in-the-early-years

Cambridgeshire & Peterborough Children and Young People's Health and Wellbeing

District Outcomes Profile

2018

Contents

1. Introduction

The annual national Child Health Profiles [1] are published at upper tier Council level only. These profiles present data on factors related to the health and wellbeing of pregnant women, children and young people, with the indicators designed to help local authorities and health services improve the health and wellbeing of children and tackle health inequalities.

This report presents data at district level, where available, to help identify the local needs of children and young people at, and between, lower geographical levels. Data for Cambridgeshire and Peterborough are presented where district level data are not available, to enable benchmarking against the national position. The indicators used are those from the Child Health Profiles (Appendix 1) and those from the locally defined and agreed Children's Outcome Framework (Appendix 2).

Local authority summaries are included and highlight the areas where the districts are statistically significantly worse than England, where there could be possible future areas of concern and where improvements have already been seen. It should be noted that some measures may still be important even if they are not shown to be locally or nationally adverse, for example, if significant numbers of children and young people are involved, they are good overall measures of population health status or trends are adverse. Similarly, some issues may be masked at a higher level of geography and smaller area analysis may highlight particular pockets of deprivation where there are relatively worse health determinants and outcomes.

For the purpose of this report the districts, Cambridgeshire and Peterborough have been benchmarked against England, using the following key:

Tables

- Statistically significantly better than the England average
- Statistically similar to the England average
- Statistically significantly worse than the England average

Charts

- Statistically significantly better than the England average
- Statistically similar to the England average
- Statistically significantly worse than the England average

[1] Child Health Profiles, Public Health England (https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview/area-search-results/E12000006?search_type=list-child-areas&place_name=East%20of%20England)

2. Summary

2.1 Cambridgeshire

There are almost **151,000** children and young people aged under 20 years living in Cambridgeshire, **23%** of the total population. The population is forecast to increase by almost 25,000 children and young people (16.4%) over the next 10 years, with the largest actual and proportional increases expected in 10 to 14 year olds and 15 to 19 year olds. [2]

The health and wellbeing of children and young people in Cambridgeshire is relatively positive in comparison to the experience of children in England with child poverty, breastfeeding prevalence at 6-8 weeks, teenage conceptions, excess weight, children in care, dental health, 16-17 year olds not in education, employment and training (NEET), pupil absence, A&E attendances and hospital admissions for asthma, mental health conditions and unintentional and deliberate injuries all statistically significantly better than the England averages.[3] However, there are several measures where Cambridgeshire fares worse than England.

Potential priority areas *

- **Hospital admissions as a result of self-harm (10-24 years):** In 2016/17 there was a reduction in the rate of hospital admissions for self-harm, but the County rate remained notably, and statistically significantly, higher than the England rate.

- **Chlamydia screening and detection (15-24 years)**: In 2016/17, as in previous years, Cambridgeshire had a statistically significantly low proportion of 15 to 24 year olds screened for chlamydia, with a detection rate that was below the nationally set benchmark.

- **School readiness – Reception:** In 2016/17 the percentage of Reception aged children achieving a good level of development at the end of the school year was statistically similar to England, but for those with free school meal status the level of development was statistically significantly worse than experienced nationally. The gap between the Cambridgeshire and England rate increased in 2016/17. The proportion of pupils that achieved a good level of development at the end of Reception increased in Cambridgeshire (from 69.7% in 2015/16 to 70.7% in 2016/17) but the proportion of those with such good development in pupils with free school meal status decreased (from 49.3% in 2015/16 to 47.9% in 2016/17).

- **School readiness – Year 1:** In 2016/17 the proportion of Year 1 pupils achieving the expected level in the phonics screening check was statistically significantly worse than England in all pupils and those with free school meal status, but there were increases in achievement between 2015/16 and 2016/17 (from 78.2% to 79.8% in all pupils and from 58.2% to 60.9% in those with free school meal status). There have been improvements in rates since 2014/15, with the most marked increase in achievement in those with free school meal status.

- **Vaccinations in 5 year olds:** the one booster dose of Hib/Men C vaccine by 5th birthday was below the target of 95% in 2016/17 at 89.4%. Two doses of MMR vaccinations was below the target of 95% in 2016/17 at 85.1%.

[2] Mid 2015 based population forecasts, 2016 to 2026, Research Group, Cambridgeshire County Council
[3] Public Health Outcomes Framework, Public Health England (https://fingertips.phe.org.uk) – as at June 2018

Areas that could be of future possible concern **

- **Low birth weight of term babies**: in 2016 an increase in the proportion of term babies born with a low birth weight (under 2,500g) moved Cambridgeshire from being statistically significantly better than England to being statistically similar.
- **Vaccinations**: the following vaccinations were below the target of 95% but above 90% in 2016/17: Dtap/IPV/Hib (1 year olds); PCV (1 year olds); Hib/MenC booster (2 year olds); PCV booster (2 years old), MMR for one dose (2 year olds) and MMR for one dose (5 year olds) HPV coverage has declined over the last four years with coverage in 2016/17 statistically similar to England at 86%.
- **Conceptions, under 16 year olds:** a slight increase in the rate in 2016, against a nationally continued decrease in rates, has led to Cambridgeshire becoming statistically similar to England, from being statistically better in 2015.
- **Teenage mothers:** the proportion of teenage mothers has stabilised in Cambridgeshire (2013/14 to 2016/17), but there has been a downward trend nationally, which has led to Cambridgeshire becoming statistically similar to the England rate since 2015/16.
- **Persons under 18 admitted to hospital for alcohol-specific conditions**: there has been an upward trend in rates since 2011/12-2016/17, against a notable downward trend seen nationally. This has led to Cambridgeshire having a rate that is higher, but statistically similar, to England.
- **First time entrants to the youth justice system:** an increase in the rate in 2016 led to Cambridgeshire moving from being statistically significantly better than England (between 2013 and 2015) to being statistically similar.

Areas of improvement ***

- **Dtap/IPV/Hib vaccinations for 2 year olds:** a notable increase in the coverage in 2016/17 has led to Cambridgeshire becoming statistically significantly better than the average for England.
- **Pupil absence:** there was a reduction in the rate in 2015/16 which led to Cambridgeshire becoming statistically significantly better than England, where it had previously been statistically similar.
- **Hospital admissions caused by injuries in young people (15-24 years):** a decrease in the rate in 2016/17 led to Cambridgeshire becoming statistically similar to England, where previously it had been statistically significantly worse. There have also been improvements in the rates for 0-4 year olds and under 15 year olds, which have been, and remain, statistically significantly better than England.
- **Long acting contraceptive use (excluding injections in Sexual Reproductive Health Services), under 25 year olds:** an increase in 2016 has led to Cambridgeshire having statistically significantly high LARC uptake compared to the England average.

Notes

* Statistically significantly worse than England.
** Statistically similar and below the England average; moved from being statistically significantly better than England to being statistically similar; a negative trend regardless of statistical significance.
*** Statistically significantly better than England where had previously been statistically similar; statistically similar to England where had been statistically significantly worse.

2.2 Peterborough

Peterborough has a younger population than the national average. There are over **54,000** children and young people aged under 20 years living in Peterborough, **27%** of the total population. The population is forecast to increase by almost 9,500 children and young people (17.3%) over the next 10 years, with the largest actual and proportional increases expected in 10 to 14 year olds and 15 to 19 year olds. [2]

The health and wellbeing of children and young people in Peterborough is overall poorer in comparison to the experience of children in England as a whole, with around 1 in 5 children aged under 16 years living in poverty. Measures relating to pregnancy and birth are similar to the national average with low birth weight babies, stillbirths and infant mortality around the England rates. However, teenage conceptions, breastfeeding initiation and smoking at the time of delivery are significantly worse than England. As children move into early years there are more areas that are statistically significantly worse than England such as excess weight, dental health problems and attendances at A&E. Educational attainment generally fares worse in Peterborough when compared to England with poorer levels of development at the end of reception, phonics achievement in Year 1 and attainment at GCSE's. Hospital admissions for self-harm, unintentional and deliberate injuries in older teenagers and asthma are high. However, there are several indicators where notable improvements are being made including the prevalence of breastfeeding at 6-8 weeks, the proportion of teenage mothers, first time entrants to the youth justice system and hospital admissions due to unintentional and deliberate injuries in younger children. [3]

Potential priority areas *

- **Children in low income families (under 16 years):** In 2015 18.7% of children were living in poverty, which was statistically significantly worse than the national average of 16.8%. The gap between Peterborough and England narrowed in 2015.
- **Breastfeeding initiation:** the rates dropped to being statistically significantly worse than England in 2015/16 and 2016/17, having been statistically similar to England in the previous 4 years.
- **Smoking status at the time of delivery:** The data reported in the Public Health Outcomes Framework relate to a CCG figure, which is not representative of the variation across Cambridgeshire and Peterborough. Local hospital data for 2017/18 shows that smoking at the time of delivery was 6.7% at Cambridge University Hospital Foundation Trust, 10.3% at Hinchingbrooke, 14.4% at Peterborough and Stamford Hospitals and 21.9% at the Queen Elizabeth Hospitals, with the prevalence in the latter two hospital being statistically significantly higher than the average for Cambridgeshire and Peterborough. These hospitals predominantly cover the populations of Peterborough and north Fenland.
- **A&E attendances, 0-4 years:** there was a reduction in attendance rates in 2016/17 but they remained notably, and statistically significantly, higher than the England rate.
- **Vaccinations in 5 year olds:** the one booster dose of Hib/Men C vaccine by 5th birthday was below the target of 95% in 2016/17 at 89.6%. Two doses of MMR vaccinations was below the target of 95% in 2016/17 at 89.6%. One dose of MMR at 5 year olds was above target at 95.6%. The national target for all vaccinations is 95%.
- **Children with one or more decayed, missing or filled teeth, 5 year olds:** in 2016/17 Peterborough had a statistically significantly high number of children with one or more decayed, missing or filled teeth compared to England.
- **Children achieving a good level of development at the end of reception:** There was a slight increase in achievement in 2016/17, but due to a greater increase experienced nationally, the gap in achievement between Peterborough and England has widened. However, the achievement of those pupils with free school meal status is slightly better and statistically similar to England.

- **Children achieving expected level in the phonics screening check, Year 1:** there was a decrease in expected achievement in 2016/17 whilst there was an increase in the national average, leading to a widening of the gap in achievement between Peterborough and England. There was also a reduction in the achievement in pupils with free school meals, which led to Peterborough becoming statistically significantly worse than England in 2016/17, where it had been statistically similar to England in 2015/16.
- **Excess weight, 10-11 years:** there have been annual increases in the percentage of pupils aged 10-11 years with excess weight, which that has led to Peterborough becoming statistically significantly worse than England in 2016/17. The proportion of obese children in Peterborough was also statistically significantly worse than England in 2016/17.
- **GCSEs achieved (5A*-C including English and Maths):** there was a slight decrease in attainment in 2015/16, against an increasing national trend in attainment, which widened the gap between Peterborough and England.
- **Conceptions, under 16 years:** there was a notable increase in rates in 2016 that led to Peterborough becoming statistically significantly worse than the England average, whereas it had previously been statistically similar. The numbers are small and fluctuate annually.
- **Conceptions, under 18 years:** the rates have been statistically significantly worse than England since 2012 and, due to an increase in the rate in 2016 against a decreasing national trend, the gap between Peterborough and England is widening.
- **Hospital admissions as a result of self-harm, 10-24 years:** there was a notable decrease in rates in 2016/17, following an annual increasing trend. However, the rate remains statistically significantly higher than the England rate.
- **Hospital admissions due to substance misuse, 15-24 years:** there is an upward trend in admission rates in Peterborough and, whilst rates until recently were also increasing nationally they have decreased in the latest time period (2014/15-2016/17), leading to the rates being substantially higher in Peterborough than the national average.
- **Hospital admissions caused by injuries in young people, 15-24 years:** there is an overall downward trend in admission rates in Peterborough, but in 2016/17 they remained notably, and statistically significantly, higher than the England rate.
- **Hospital admissions for asthma, under 19 years:** rates have been increasing since 2013/14, with the rate in 2016/17 being notably, and statistically significantly, higher than the England rate.
- **Family homelessness:** there is a notable increasing trend in the rate of family homelessness in Peterborough, against a static national trend. In 2016/17 the rate was over three times higher in Peterborough than England.
- **Children in care:** Peterborough has historically had statistically significantly high rates of children in care compared to the England average but, due to a reduction in the Peterborough rate in 2016/17 and a slight increase in England's rate, the gap between Peterborough and England appears to be narrowing.

Areas that could be of future possible concern **

- **Low birth weight of term babies:** there was an increase in the proportion of full term babies born with a low birth weight (under 2,500g) in 2016 and, whilst this remains statistically similar to England, there has been a general increase in the proportion since 2010.

- **Excess weight, 4-5 year olds**: whilst Peterborough is statistically similar to England there have been annual increases in the proportion of 4-5 year olds with excess weight since 2014/15, as also experienced nationally. However, the proportion of children that were identified as obese has declined annually from 2013/14.

- **Vaccinations**: the following vaccinations were below the target of 95% but above 90% in 2016/17: Dtap/IPV/Hib (1 year olds); PCV (1 year olds); Hib/MenC booster (2 year olds); PCV booster (2 year olds) and MMR for one dose (2 year olds). HPV coverage has declined over the last three years with coverage in 2016/17 being statistically similar to England, at 86%.
- **Child mortality rate, 1-17 years:** there was a notable increase in rates in 2014-16 which were higher, but statistically similar, to the England rate.
- **Long acting contraceptive use (excluding injections in Sexual Reproductive Health Services), under 25 year olds:** a decrease in LARC uptake in 2016 has led to Peterborough becoming statistically similar to England, from previously being statistically significantly better.

Areas of improvement ***

- **First time entrants to the youth justice system**: there was a notable decrease in rates between 2015 and 2016 that led to Peterborough becoming statistically similar to England, whereas it had previously been statistically significantly worse.
- **Breastfeeding prevalence at 6-8 weeks after birth:** an increase in prevalence in 2016/17 has led to a statistically significantly better rate in Peterborough than experienced nationally.
- **Hospital admissions caused by unintentional and deliberate injuries:** there were notable decreases in the rates for children aged under 5 years and under 15 years in 2016/17 and, whilst Peterborough remains statistically similar to England, the rates are now lower than the national average.
- **Teenage mothers:** a reduction in the proportion of teenage mothers in 2016/17 has led to Peterborough becoming statistically similar to England, whereas previously it had been statistically significantly worse. The rate in Peterborough was the same as England in 2016/17.

Notes

* Statistically significantly worse than England.
** Statistically similar and below the England average; moved from being statistically significantly better than England to being statistically similar; a negative trend regardless of statistical significance.
*** Statistically significantly better than England where had previously been statistically similar; statistically similar to England where had been statistically significantly worse.

2.3 Districts

2.3.1 Cambridge

There are approximately **30,000** children and young people aged under 20 years living in Cambridge, **22%** of the total population, with a notably high proportion of 15 to 19 year olds due to the university student population. The population is forecast to increase by almost 5,500 children and young people (18.0%) over the next 10 years, with the largest actual and proportional increase expected in 10 to 14 year olds.[2]

The health and wellbeing of children and young people in Cambridge is relatively positive in comparison to the experience of children in England with children living in poverty, breastfeeding initiation, teenage conceptions, excess weight, dental health and hospital admissions caused by unintentional and deliberate injuries all statistically significantly better than the average for England. However, as explored below, there are several measures where the Cambridge fares worse than the England averages. [3] Also, whilst child poverty is statistically significantly better than the England average it is statistically significantly worse than the Cambridgeshire average.

Potential priority areas *

- **Pupil absence**: the proportion of absent pupils increased in 2015/16 and became statistically significantly worse than the England average.
- **Hospital admissions for self-harm, 10-24 years**: this currently isn't produced nationally for districts, but local analysis shows that admission rates in 2016/17 were statistically significantly high in Cambridge compared to the England rate.
- **Chlamydia detection rates, 15-24 years:** the detection rate in 2017 was lower than the nationally set benchmark, with rates declining since 2012.
- **Hospital admissions for alcohol-specific conditions, under 18 year olds**: rates have been increasing since 2013/14-2015/16 and were statistically significantly worse than England for the first time in 2014/15-2016/17. Nationally there is a downward trend in these admissions.

Areas that could be of future possible concern **

- **Infant mortality**: rates are statistically similar to England but have been increasing since 2011-13 and are now higher, but not significantly higher, than England.
- **Low birth weight of term babies**: the proportion is statistically similar to the England average but has remained relatively stable over the last 10 years, as it has nationally.
- **Childhood excess weight, 10-11 year olds**: there was a notable increase in the proportion of Year 6 pupils with excess weight in 2016/17 and, although the rates remain statistically significantly better than England average, the gap has narrowed between Cambridge and England.

Areas of improvement ***

- **Conceptions, under 18 years**: In 2016 the rates, for the first time since 2012, were statistically significantly better than the England average.
- **Chlamydia screening, 15-24 year olds**: an increase in the proportion of people screened in 2017 has led to Cambridge becoming statistically similar to the average for England, where it had been statistically significantly worse in the previous two years.

Notes

* Statistically significantly worse than England.
** Statistically similar and below the England average; moved from being statistically significantly better than England to being statistically similar; a negative trend regardless of statistical significance.
*** Statistically significantly better than England where had previously been statistically similar; statistically similar to England where had been statistically significantly worse.

2.3.2 East Cambridgeshire

There are approximately **21,000** children and young people aged under 20 years living in East Cambridgeshire, **24%** of the total population. The population is forecast to increase by over 4,000 children and young people (19.5%) over the next 10 years, with the largest actual and proportional increases expected in under 5 year olds and 10 to 19 year olds, with a relatively small increase in 5 to 9 year olds. [2]

The health and wellbeing of children and young people in East Cambridgeshire is relatively positive in comparison to the experience of children in England with child poverty, infant mortality, teenage conceptions, excess weight, pupils absence, hospital admissions caused by unintentional and deliberate injuries and dental health all being significantly better than England. [3]

Potential priority areas *

- **Hospital admissions for self-harm, 10-24 years**: this currently isn't produced nationally but local analysis shows that admissions rates in 2016/17 were statistically significantly high in East Cambridgeshire compared to the England rate.

- **Chlamydia detection rates, 15-24 year olds**: there is a downward trend in detection rates, with less people also being screened.

Areas that could be of future possible concern **

- None found

Areas of improvement ***

- **Child poverty, under 16 year olds**: there was a notable decrease in the percentage of children living in poverty between 2014 and 2015, with an overall downward trend since 2006. East Cambridgeshire has always had a statistically significantly low proportion of children living in poverty compared to the national averages.

- **Child excess weight, 4-5 year olds**: a decrease in rates in 2016/17 has led to East Cambridgeshire becoming statistically significantly better than England, from being statistically similar in 2015/16.

- **Pupil absence:** an improvement in rates in 2015/16 resulted in East Cambridgeshire becoming statistically significantly better than England.

Notes

* Statistically significantly worse than England.
** Statistically similar and below the England average; moved from being statistically significantly better than England to being statistically similar; a negative trend regardless of statistical significance.
*** Statistically significantly better than England where had previously been statistically similar; statistically similar to England where had been statistically significantly worse.

2.3.3 Fenland

There are approximately **22,000** children and young people aged under 20 years living in Fenland, **22%** of the total population. The population is forecast to increase by almost 3,000 children and young people (13.0%) over the next 10 years, with the largest actual and proportional increases expected in 10 to 14 year olds.[2]

The health and wellbeing of children and young people in Fenland is generally similar to the experience of children in England, but fares poorer in comparison to those in Cambridgeshire as a whole. There are a few areas where the district fares worse than the national averages (as detailed below) but there are further areas where the rates in Fenland are statistically significantly worse than those for Cambridgeshire as a whole. These include child poverty, teenage conceptions, excess weight in 10-11 year olds, hospital admissions caused by unintentional and deliberate injuries and dental health. [3]

Potential priority areas *

- **Child living in poverty, aged under 16 years:** historically Fenland has had statistically significantly higher proportions of children living in poverty than England. There was a decrease in the proportion in 2015 (latest time period available), which reflected a reduction in the national rates.
- **Breastfeeding initiation:** there appears to be a decreasing trend in Fenland, against a fairly static national trend.
- **Chlamydia detection rates**: this is lower than the nationally set benchmark, and has been decreasing annually since 2013.

Areas that could be of future possible concern **

- **Infant mortality:** there has been an overall upward trend in infant mortality rates since 2009-11 with the rate, although remaining statistically similar to England, notably higher than the national rate in 2014-16.
- **Low birth weight of term babies**: this was statistically similar to England in 2016, as it has been since 2006, but there was notable increase in the proportion in 2016.

Areas of improvement ***

- **Child excess weight, 4-5 year olds**: there has been an overall decreasing trend in the proportion of children aged 4-5 years old with excess weight, with rates now statistically similar to England, where they had previously been statistically significantly high in comparison.
- **Pupil absence:** there is a notable downward trend in pupil absence in Fenland, with the rate in 2015/16 statistically similar to England.

Notes

* Statistically significantly worse than England.
** Statistically similar and below the England average; moved from being statistically significantly better than England to being statistically similar; a negative trend regardless of statistical significance.
*** Statistically significantly better than England where had previously been statistically similar; statistically similar to England where had been statistically significantly worse.

2.3.4 Huntingdonshire

There are approximately **41,000** children and young people aged under 20 years living in Huntingdonshire, **23%** of the total population. The population is forecast to increase by over 5,600 children and young people (13.8%) over the next 10 years, with the largest actual and proportional increases expected in 10 to 14 year olds. [2]

The health and wellbeing of children and young people in Huntingdonshire is generally more positive in comparison to the experience of children in England as a whole with children living in poverty, breastfeeding initiation, excess weight, infant mortality and dental health all statistically significantly better than the national averages. However, in comparison to Cambridgeshire the area has statistically significantly high teenage conception rates and hospital admissions for unintentional and deliberate injuries. [3]

Potential priority areas *

- **Chlamydia detection rates, 15-24 year olds**: the detection rate in 2017 was lower than the nationally set benchmark, with rates declining since 2014. The proportion of 15 to 24 year olds screened is also decreasing annually.

- **Persons under 18 admitted to hospital for alcohol-specific conditions**: there has been an increasing trend since 2010/11-2012/13, with the rate in 2014/15-2016/17 being statistically significantly higher than the national rate.

Areas that could be of future possible concern **

- **Low birth weight of term babies**: in 2016 there was an increase in the proportion of low birth weight term babies that has led to the proportion becoming statistically similar to England, where it had previously (in 2015) been statistically significantly better.

- **Conceptions, under 18 year olds:** since 1998 rates have been statistically significantly better than England. However, an increase in the rate in 2016 has led to the area becoming statistically similar to the national average, with the rate just below the England rate.

Areas of improvement ***

- **Infant mortality:** a reduction in rates in 2014-16 has led to the area becoming statistically significantly better than England.

- **Hospital admissions caused by unintentional and deliberate injuries in children, 0-14 year olds:** a decrease in rates in 2016/17 has led to the area becoming statistically significantly better than England, but it remains statistically significantly worse than the Cambridgeshire average. There has also been a decrease in the rates of admissions in 0-4 year olds.

Notes

* Statistically significantly worse than England.
** Statistically similar and below the England average; moved from being statistically significantly better than England to being statistically similar; a negative trend regardless of statistical significance.
*** Statistically significantly better than England where had previously been statistically similar; statistically similar to England where had been statistically significantly worse.

2.3.5 South Cambridgeshire

There are approximately **38,000** children and young people aged under 20 years living in South Cambridgeshire, **24%** of the total population. The population is forecast to increase by almost 7,000 children and young people (18.4%) over the next 10 years, with the largest actual and proportional increases expected in 15 to 19 year olds. [2]

The health and wellbeing of children and young people in South Cambridgeshire is relatively positive in comparison to the experience of children in England with child poverty, teenage conceptions, excess weight, pupil absence, hospital admissions caused by unintentional and deliberate injuries and dental health all being significantly better than England. [3]

Potential priority areas *

- **Chlamydia detection rates**: the detection rate in 2017 was lower than the nationally set benchmark, with relatively stable rates over the last 5 years. There was a slight increase in the proportion screened in 2017, but the screening rate remained statistically significantly worse than the England average.

Areas that could be of future possible concern **

- **Infant mortality**: rates are statistically similar to the England average, but have been increasing since 2011-13 and are now (2014-16) around the national average.

- **Low birth weight of term babies**: an increase in this proportion in 2016 has led to the area becoming statistically similar to the England average, whereas previously it had been statistically significantly better.

Areas of improvement ***

- **Pupil absence**: a decrease in the rates in 2015/16 has resulted in South Cambridgeshire becoming statistically significantly better than the England average, whereas it had previously been statistically similar.

Notes

* Statistically significantly worse than England.
** Statistically similar and below the England average; moved from being statistically significantly better than England to being statistically similar; a negative trend regardless of statistical significance.
*** Statistically significantly better than England where had previously been statistically similar; statistically similar to England where had been statistically significantly worse.

3. Wider determinants of health

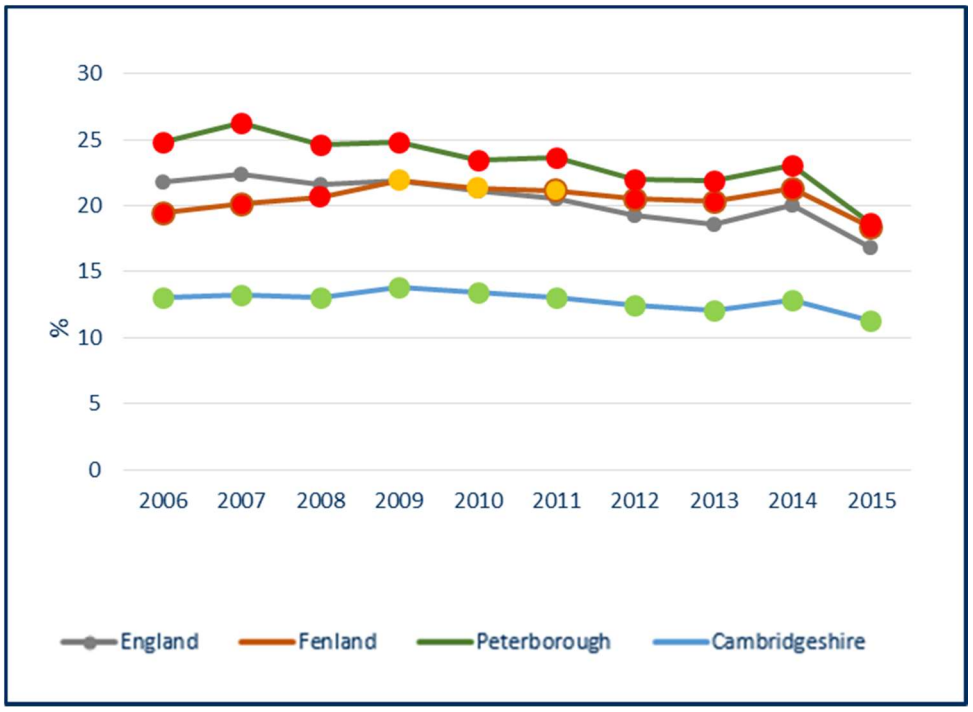
3.1 Child poverty

Table 1: Children in low income families, under 16 year olds (%), 2015

Area	Number	%	95% Confidence Intervals
Cambridge	2,340	13.7	(13.2 - 14.2)
East Cambridgeshire	1,340	8.6	(8.2 - 9.0)
Fenland	3,275	18.4	(17.8 - 19.0)
Huntingdonshire	3,255	10.5	(10.2 - 10.9)
South Cambridgeshire	2,140	7.6	(7.3 - 7.9)
Cambridgeshire	12,350	11.3	(11.1 - 11.5)
Peterborough	8,525	18.7	(18.4 - 19.1)
Cambridgeshire and Peterborough	20,880	13.5	(13.3 - 13.6)
England	1,678,030	16.8	(16.8 - 16.9)

Source: HM Revenue and Customs, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Figure 1: Children in low income families, under 16 year olds (%), Fenland, Cambridgeshire and Peterborough, 2006 to 2015



Source: HM Revenue and Customs, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points – child poverty

- Fenland and Peterborough have statistically significantly worse child poverty rates than the average for England. All other districts are statistically significantly better than England.
- There is a decreasing trend in child poverty in Cambridgeshire and Peterborough. Overall there has been a slight increasing trend in Fenland, but there was a notable decrease in the latest in 2015 (21.3% in 2014 to 18.4% in 2015).

3.2 Family homelessness

Table 2: Family homelessness, crude rate per 1,000 households, 2016/17

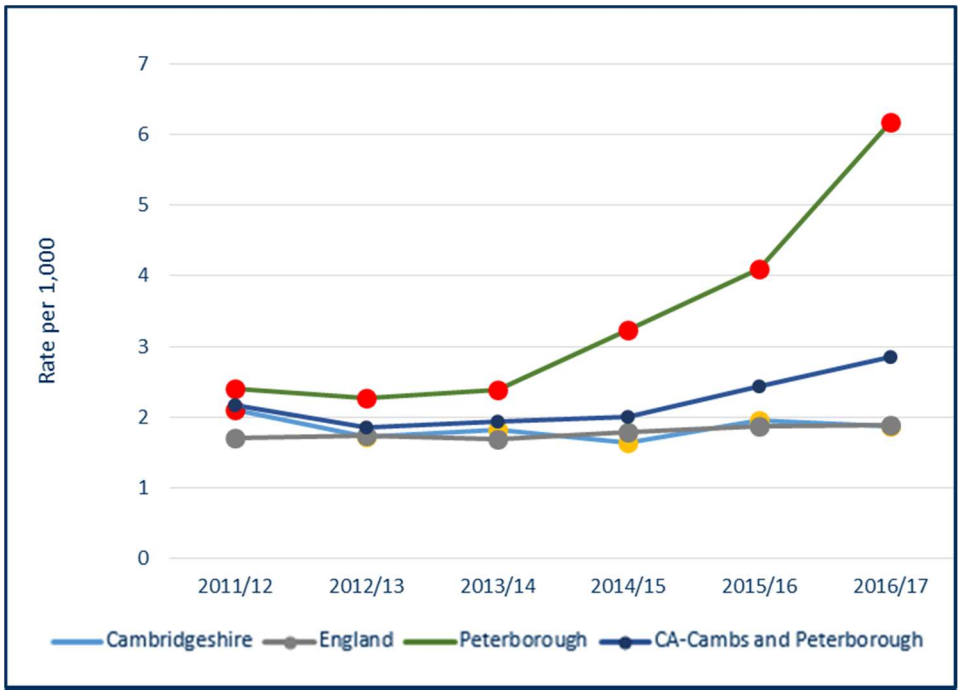
Area	Number	Crude rate per 1,000 households	95% Confidence Intervals
Cambridgeshire	502	1.9	(1.7 - 2.0)
Peterborough	489	6.2	(5.6 - 6.8)
Cambridgeshire and Peterborough*	991	2.9	-
England	43,919	1.9	(1.9- 1.9)

Data not available at District level

*Aggregated from all known lower geography values

Source: P1E quarterly returns, Department for Communities and Local Government from PHE Child Health Profiles (https://fingertips.phe.org.uk/)

Figure 2: Family homelessness, crude rate per 1,000 households for Cambridgeshire and Peterborough, 2011/12 to 2016/17



Source: P1E quarterly returns, Department for Communities and Local Government from PHE Child Health Profiles (https://fingertips.phe.org.uk/)

Key points – family homelessness

- Peterborough has a statistically significantly high rate of family homelessness compared to the England average, with a marked increasing trend.

3.3 Education

3.3.1 Good level of development in Reception

Table 3: Children achieving a good level of development at the end of reception (%), 2016/17

Area	%	95% Confidence Intervals
Cambridgeshire	70.7	(69.6 - 71.7)
Peterborough	63.2	(61.5 - 64.8)
Cambridgeshire and Peterborough	68.5	(67.6 - 69.3)
England	70.7	(70.6 - 70.8)

Data not available at District level

Source: Department for Education, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Table 4: Children with free school meal status achieving a good of level of development at the end of reception (%), 2016/17

Area	%	95% Confidence Intervals
Cambridgeshire	47.9	(44.7 - 51.2)
Peterborough	57.3	(52.5 - 61.9)
Cambridgeshire and Peterborough	50.9	(48.3 - 53.6)
England	56.0	(55.7 - 56.3)

Data not available at District level

Source: Department for Education, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points - good level of development at reception

- The percentage of children achieving a good level of development at the end of reception is statistically significantly lower in Peterborough than England.
- The percentage of children with free school meal status achieving a good level of development at the end of reception is statistically significantly lower in Cambridgeshire than England.
- Both Cambridgeshire and Peterborough have experienced increases in the development of all reception aged children and those with free school meal status over the last 5 years.

3.3.2 Phonics screening check in Year 1

Table 5: School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check, 2016/17

Area	%	95% Confidence Intervals
Cambridgeshire	79.8	(78.9 - 80.7)
Peterborough	75.5	(73.9 - 76.9)
Cambridgeshire and Peterborough	78.6	(77.8 - 79.3)
England	81.1	(81.0- 81.2)

Data not available at District level

Source: Department for Education, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Table 6: School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check, 2016/17

Area	%	95% Confidence Intervals
Cambridgeshire	60.9	(57.2 - 64.5)
Peterborough	62.4	(58.0 - 66.7)
Cambridgeshire and Peterborough	61.5	(58.7 - 64.3)
England	68.4	(68.1 - 68.7)

Data not available at District level

Source: Department for Education, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points – achievement of expected level in the phonics screening check in Year 1

- The percentage of pupils achieving the expected level in the phonics screening check is statistically significantly lower in both Cambridgeshire and Peterborough than England, for all Year 1 pupils and those that have free school meal status.
- Cambridgeshire is experiencing an upward trend in the percentage of pupils meeting the expected level in phonics screening, with the gap between those with free meal status and the national average narrowing.
- Peterborough experienced a decrease in the attainment of those with free school meal status in 2016/17 but overall there has been an increase in the last 5 years.

3.3.3 GCSE's

Table 7: GCSEs achieved - % of pupils achieving 5A*-C including English & Maths, 2015/16

Area	%	95% Confidence Intervals
Cambridge	63.3	(59.9 - 66.7)
East Cambridgeshire	58.7	(55.2 - 62.1)
Fenland	52.2	(49.1 - 55.2)
Huntingdonshire	59.2	(56.9 - 61.5)
South Cambridgeshire	70.2	(67.8 - 72.5)
Cambridgeshire	61.2	(59.9 - 62.4)
Peterborough	47.8	(45.7 - 49.9)
Cambridgeshire and Peterborough*	57.5	-
England	57.8	(57.6 - 57.9)

*Aggregated from all known lower geography values

Source: Department for Education, from PHE Health Profiles (https://fingertips.phe.org.uk/)

Table 8: GCSE achieved 5A*-C including English & Maths with free school meal status, 2014/15

Area	%	95% Confidence Intervals
Cambridgeshire	23.4	(20.0 - 27.2)
Peterborough	24.7	(20.2 - 29.8)
Cambridgeshire and Peterborough*	23.9	-
England	33.3	(33.0 - 33.6)

Data not available at District level

*Aggregated from all known lower geography values

Source: Department for Education, from PHE Wider Determinant of Health (https://fingertips.phe.org.uk/)

Key points – GCSE attainment

- Cambridge, South Cambridgeshire and Cambridgeshire have GCSE attainment rates that are significantly better than the England average.
- Fenland and Peterborough have a GCSE attainment rates that are statistically significantly worse than the England average.
- Both Cambridgeshire and Peterborough have statistically significantly worse GCSE attainment for pupils with free school meal status when compared to the England average.

3.3.4 Pupil absence

Table 9: Pupil absence - % of half days missed by pupils due to overall absence (including authorised and unauthorised absence), 2015/16

Area	%	95% Confidence Intervals
Cambridge	5.0	(4.6 - 5.4)
East Cambridgeshire	4.1	(3.7 - 4.4)
Fenland	4.7	(4.3 - 5.1)
Huntingdonshire	4.4	(4.1 - 4.7)
South Cambridgeshire	4.0	(3.7 - 4.3)
Cambridgeshire	4.4	(4.2 - 4.5)
Peterborough	4.6	(4.4 - 4.9)
Cambridgeshire and Peterborough	4.5	(4.4 - 4.9)
England	4.6	(4.6 - 4.6)

Source: Department for Education, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points – pupil absence

- Cambridge has a statistically significantly high percentage of pupil absence compared to the England average.
- East Cambridgeshire, South Cambridgeshire and Cambridgeshire have statistically significantly low percentages compared to the England average.
- All areas have seen decreasing (positive) trends in the percentage of absent pupils.

3.3.5 Not in education, employment or training (NEET)

Table 10: 16-17 year olds not in education, employment or training (NEET) or whose activity is not known (%) - current method, 2016

Area	Number	%	95% Confidence Intervals
Cambridgeshire	470	3.7	(3.4 - 4.1)
Peterborough	310	6.6	(6.0 - 7.4)
Cambridgeshire and Peterborough	780	4.5	(4.2 - 4.8)
England	69,540	6.0	(6.0 - 6.1)

Data not available at District level

Source: Department for Education, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points – not in education, employment or training (NEET)

- Cambridgeshire has a percentage that is statistically significantly better than the England average.
- Peterborough's percentage is statistically similar to England's, and is statistically significantly higher than the average for Cambridgeshire.

3.4 Children in care

Table 11: Children in care, rate per 10,000 population aged under 18 years, 2017

Area	Number	Crude rate per 10,000 population	95% Confidence Intervals
Cambridgeshire	690	51.0	(47.6 - 55.3)
Peterborough	355	73.0	(65.1 - 80.4)
Cambridgeshire and Peterborough*	1,045	57.0	-
England	72,670	62.0	(61.2- 62.1)

Data not available at District level

*Aggregated from all known lower geography values

Source: Department for Education, from PHE Child Health Profiles (https://fingertips.phe.org.uk/)

Key points – children in care

- Peterborough has a statistically significantly higher rate of children in care than England, with an overall decreasing trend.
- Cambridgeshire has a statistically significantly lower rate of children in care than England, with an overall increasing trend.

3.5 First time entrants to the youth justice system

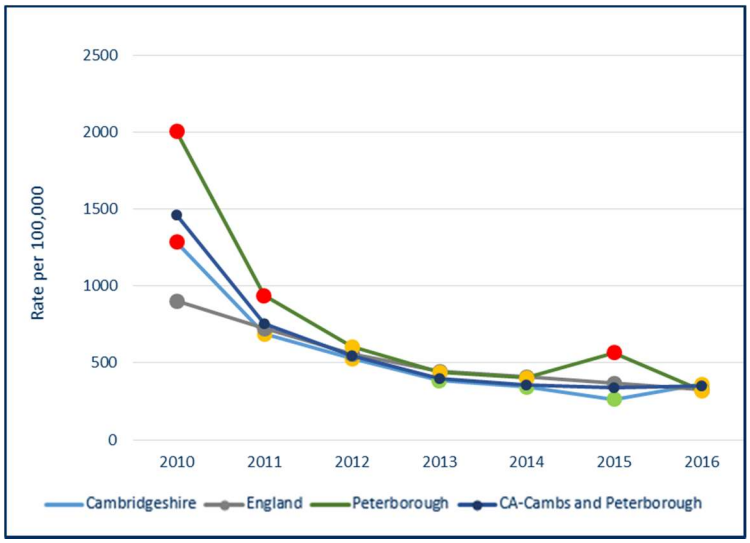
Table 12: First time entrants to the youth justice system - rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population, 2016

Area	Number	Crude rate per 100,000	95% Confidence Intervals
Cambridgeshire	205	364.9	(316.6 - 418.4)
Peterborough	58	320.2	(243.2 - 414.0)
Cambridgeshire and Peterborough	263	354.0	(312.5 - 399.5)
England	15,980	327.1	(322.0 - 332.2)

Data not available at District level

Source: Police National Computer, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Figure 3: First time entrants to the youth justice system - rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population for Cambridgeshire and Peterborough, 2010 to 2016



Source: Police National Computer, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points – first time entrants to the youth justice system

- Rates are around the national average in both Cambridgeshire and Peterborough.
- All areas have seen a notable decrease in rates over the last 6 years, but there was a peak in Peterborough in 2015.

3.6 Children killed and seriously injured

Table 13: Children killed and seriously injured (KSI) on England's roads, crude rate of children aged 0-15 years per 100,000 population, 2014/2016

Area	Number	Crude rate per 100,000 population	95% Confidence Intervals
Cambridgeshire	51	14.4	(10.7 - 18.9)
Peterborough	20	15.4	(9.4 - 23.8)
Cambridgeshire and Peterborough	71	15.4	-
England	5,353	17.1	(16.7- 17.6)

Data not available at District level

*Aggregated from all known lower geography values

Source: Department for Transport (DfT), from PHE Child Health Profiles (https://fingertips.phe.org.uk/)

Key points – children killed and seriously injured

- Both Cambridgeshire and Peterborough have statistically similar rates of children killed and seriously injured (KSI) to the England average.

4. Health improvement

4.1 Low birth weight

Table 14: Low birth weight of term babies, % of all live births at term with low birth weight (under 2,500g), 2016

Area	Number	%	95% Confidence Intervals
Cambridge	31	2.4	(1.7 - 3.4)
East Cambridgeshire	17	1.9	(1.2 - 3.0)
Fenland	33	3.1	(2.2 - 4.4)
Huntingdonshire	42	2.3	(1.7 - 3.1)
South Cambridgeshire	40	2.6	(1.9 - 3.5)
Cambridgeshire	163	2.5	(2.1 - 2.9)
Peterborough	93	3.3	(2.7 - 4.1)
Cambridgeshire and Peterborough	256	2.7	(2.4 - 3.1)
England	16,788	2.8	(2.7 - 2.8)

Source: Office for National Statistics, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points – low birth weight of term babies

- All districts in Cambridgeshire have statistically similar percentages to the England average, as do Cambridgeshire and Peterborough.
- The percentages fluctuate annually but there has generally been a static trend in all areas across Cambridgeshire and Peterborough over the last 10 years.

4.2 Breastfeeding

Table 15: Breastfeeding initiation - % of all mothers who breastfed their babies in the first 48 hours after delivery, 2016/17

Area	%	95% Confidence Intervals
Cambridge	84.8	(83.0 - 86.5)
East Cambridgeshire	*	-
Fenland	65.3	(62.6 - 67.9)
Huntingdonshire	78.3	(76.4 - 80.1)
South Cambridgeshire	*	-
Cambridgeshire	*	-
Peterborough	68.8	(67.1 - 70.5)
Cambridgeshire and Peterborough*	75.5	-
England	74.5	(74.4 - 74.6)

*Aggregated from all known lower geography values

- Value not published for data quality reasons

Source: NHS England, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Table 16: Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - current method - % of all infants due a 6-8 week check that are totally or partially breastfed, 2016/17

Area	%	95% Confidence Intervals
Cambridgeshire	56.1	(55.0 - 57.3)
Peterborough	47.1	(45.3 - 48.9)
Cambridgeshire and Peterborough	53.4	-
England	44.4*	(44.3- 44.6)

Data not available at District level

*Aggregated from all known lower geography values

[1]Annual figure includes constituent area(s) with annual figure scaled up data from three quarters' data
Source: Public Health England National Child and Maternal Health Intelligence Network, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points - breastfeeding

- Breastfeeding initiation in Cambridge and Huntingdonshire is statistically significantly higher than the average for England.
- Breastfeeding initiation in Fenland and Peterborough is statistically significantly lower than the England average, with both areas experiencing decreasing trends in recent years.
- Cambridgeshire and Peterborough have statistically significantly high breastfeeding prevalence rates at 6-8 weeks compared to the England average, with both areas, most notably Peterborough, experiencing increases in rates between 2015/16 and 2016/17.

4.3 Lifestyles

4.3.1 Smoking

Nationally reported data on smoking status at the time of delivery are based on CCG returns and relate to CCG boundaries, so all local authority data provided through the Public Health Outcomes Framework state the same figure for 2016/17 i.e. 11.6% compared to 10.7% for England. Local data are available from the CCG at Trust level for 2017/18, as reported below.

Table 17: smoking status at time of delivery - % of women who smoke at time of delivery, 2017/18

Trust	Smoking	% Smoking
Cambridge University Hospitals	254	6.7%
Hinchingbrooke	215	10.3%
Peterborough and Stamford	508	14.4%
Queen Elizabeth	103	21.9%
Total	1,080	10.9%

Statistically significantly better than the Cambridgeshire and Peterborough CCG average
Statistically similar to the Cambridgeshire and Peterborough CCG average
Statistically significantly worse than the Cambridgeshire and Peterborough CCG average

Source: Cambridgeshire and Peterborough CCG Smoking at the time of delivery returns

Table 18: Smoking prevalence at 15 years old - current smokers, regular smokers and occasional smokers, Cambridgeshire and Peterborough, 2014/15

Area	% Current smokers[1]	% Regular smokers[2]	% Occasional smokers[3]	% E-cigarettes[4]	% Other[5]
Cambridgeshire	8.2	5.2	3.1	15.0	16.2
Peterborough	9.1	6.6	2.5	22.0	17.5
England	8.2	5.5	2.7	18.4	15.2

1. Regular smokers (>1 cigarette per week) and occasional smokers (smoke cigarettes sometimes)
2. Regular smokers (>1 cigarette per week)
3. Occasional smokers (<1 cigarette per week)
4. Have ever used/tried electronic cigarettes with the combination of currently, used to and tried e-cigarettes
5."Have you ever used/tried other tobacco products (i.e. shisha pipe, hookah, hubble-bubble, waterpipe etc.?") with the combination of currently, used to use and tried other tobacco products.

Source: What About YOUth (WAY) Survey, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points - Smoking

- Smoking status at the time of delivery is notably higher in Peterborough and Stamford and the Queen Elizabeth Hospitals compared to the others local hospitals.
- Based on data from the What About YOUth Survey, the percentages of 15 year olds that are current smokers and regular smokers are statistically similar to the England average in both Cambridgeshire and Peterborough.
- Peterborough has a statistically significantly high proportion of 15 year olds that have used or tried e-cigarettes.

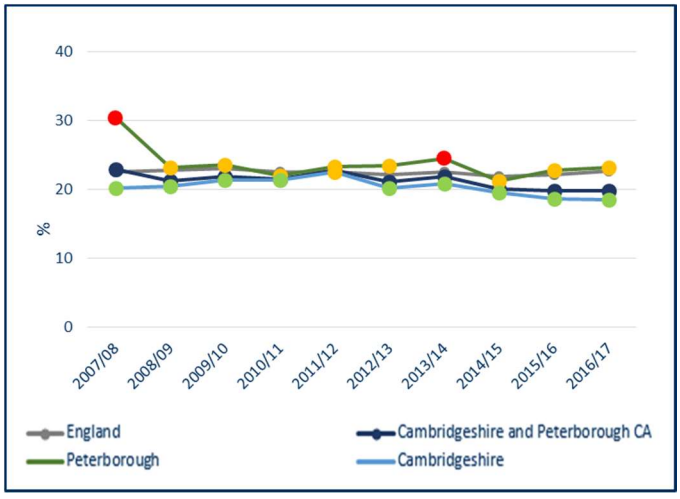
4.3.2 Excess weight in children

Table 19: Overweight (including obese) children, 4-5 years (%), 2016/17

Area	Number	%	95% Confidence Intervals
Cambridge	181	16.9	(14.7 - 19.2)
East Cambridgeshire	168	16.9	(14.7 - 19.4)
Fenland	223	20.2	(17.9 - 22.6)
Huntingdonshire	383	19.7	(18.0 - 21.5)
South Cambridgeshire	317	18.2	(16.5 - 20.1)
Cambridgeshire	1,272	18.5	(17.6 - 19.5)
Peterborough	603	23.2	(21.6 - 24.9)
Cambridgeshire and Peterborough	1,875	19.8	(19.0 - 20.6)
England	142,419	22.6	(22.5 - 22.7)

Source: National Child Measurement Programme, NHS Digital from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Figure 4: Overweight (including obese), 4-5 years (%) for Cambridgeshire and Peterborough, 2007/08 to 2016/17



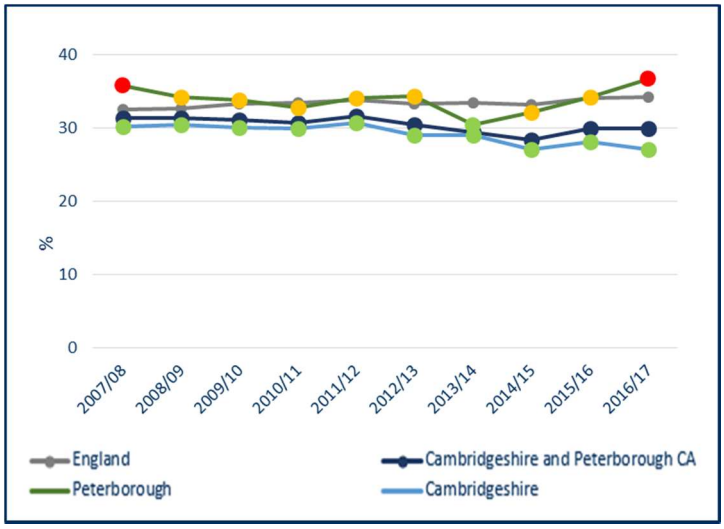
Source: National Child Measurement Programme, NHS Digital from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Table 20: Overweight (including obese) children, 10-11 years (%), 2016/17

Area	Number	%	95% Confidence Intervals
Cambridge	232	28.7	(25.7 - 31.9)
East Cambridgeshire	198	23.7	(21.0 - 26.7)
Fenland	331	34.5	(31.5 - 37.5)
Huntingdonshire	443	28.2	(26.0 - 30.5)
South Cambridgeshire	352	22.5	(20.5 - 24.6)
Cambridgeshire	1,556	27.1	(26.0 - 28.3)
Peterborough	852	36.8	(34.8 - 38.7)
Cambridgeshire and Peterborough	2,408	29.9	(28.9 - 30.9)
England	190,574	34.2	(34.1 - 34.4)

Source: National Child Measurement Programme, NHS Digital from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Figure 5: Overweight (including obese) children, 10-11 years (%) for Cambridgeshire and Peterborough, 2007/08 to 2016/17



Source: National Child Measurement Programme, NHS Digital from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

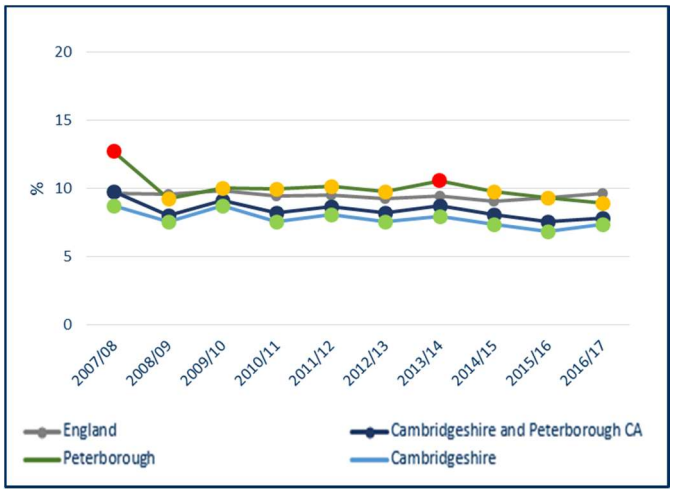
4.3.3 Childhood obesity

Table 21: Obese children, 4-5 years (%), 2016/17

Area	Number	%	95% Confidence Intervals
Cambridge	68	6.3	(5.0 - 7.9)
East Cambridgeshire	65	6.5	(5.2 - 8.2)
Fenland	100	9.0	(7.5 - 10.9)
Huntingdonshire	150	7.7	(6.6 - 9.0)
South Cambridgeshire	124	7.1	(6.0 - 8.4)
Cambridgeshire	507	7.4	(6.8 - 8.0)
Peterborough	231	8.9	(7.9 - 10.1)
Cambridgeshire and Peterborough	738	7.8	(7.3 - 8.4)
England	60,502	9.6	(9.5 - 9.7)

Source: National Child Measurement Programme, NHS Digital from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Figure 6: Obese children (4-5 years) % for Cambridgeshire and Peterborough, 2007/08 to 2016/17



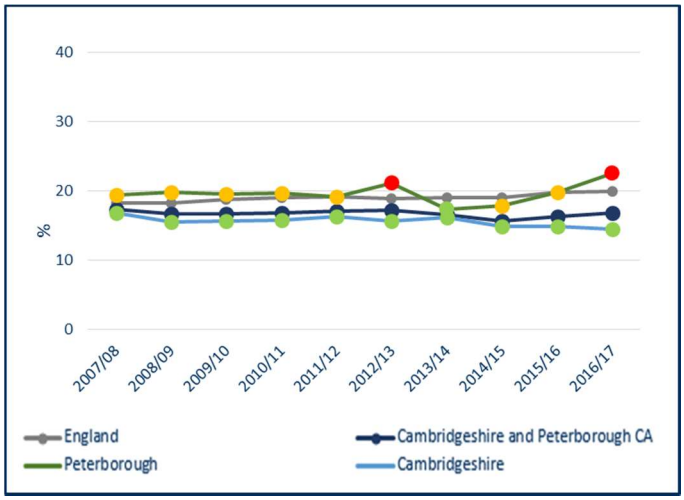
Source: National Child Measurement Programme, NHS Digital from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Table 22: Obese children, 10-11 years (%), 2016/17

Area	Number	%	95% Confidence Intervals
Cambridge	127	15.7	(13.4 - 18.4)
East Cambridgeshire	94	11.3	(9.3 - 13.6)
Fenland	196	20.4	(18.0 - 23.1)
Huntingdonshire	247	15.7	(14.0 - 17.6)
South Cambridgeshire	171	10.9	(9.5 - 12.6)
Cambridgeshire	835	14.6	(13.7 - 15.5)
Peterborough	524	22.6	(20.9 - 24.4)
Cambridgeshire and Peterborough	1,359	16.9	(16.1 - 17.7)
England	111,169	20.0	(19.9 - 20.1)

Source: National Child Measurement Programme, NHS Digital from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Figure 7: Obese children (10-11 years) % for Cambridgeshire and Peterborough, 2007/08 to 2016/17



Source: National Child Measurement Programme, NHS Digital from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk/)

Key points – childhood excess weight

4-5 year olds - Excess weight

- All districts in Cambridgeshire, except Fenland, have statistically significantly lower percentages compared to England.
- Fenland and Peterborough have statistically similar percentages compared to England.
- Cambridgeshire has a statistically significantly lower percentages compared to England.
- There is a decreasing trend in Cambridgeshire, Cambridge and Fenland.
- There have been slight annual increases in Peterborough over the last three years.

4-5 year olds - Obesity

- All districts in Cambridgeshire, except Fenland, have statistically significantly lower percentages than England.
- Fenland and Peterborough have statistically similar percentages compared to England.
- There is a decreasing trend in the proportions in Cambridgeshire.
- There is no significant change in recent trend in Peterborough.
- Cambridge and Fenland have been experiencing downward trends, with all other Cambridgeshire districts showing a relatively static trend over the last 10 years.

10-11 year olds – Excess weight

- All districts in Cambridgeshire, except Fenland, have statistically significantly lower percentages compared to England. Fenland has a statistically similar percentage.
- Cambridgeshire has a statistically significantly lower percentages compared to England.
- Peterborough has a statistically significantly high percentage compared to England.
- The trend in Cambridgeshire is decreasing, as it is in Cambridge, East Cambridgeshire and South Cambridgeshire.
- The trend in Peterborough has been notably increasing since 2013/14.

10-11 year olds – Obesity

- All districts in Cambridgeshire, except Fenland, have statistically significantly lower percentages compared to England. Fenland has a statistically similar percentage.
- Peterborough has a statistically significantly high proportion compared to England.
- Cambridgeshire has a decreasing trend.
- Peterborough has been experiencing an upward trend in recent years (2013/14 to 2016/17).
- All Cambridgeshire districts have static trends, with the exception of South Cambridgeshire which has been assessed as experiencing a downward trend.

4.3.4 Alcohol

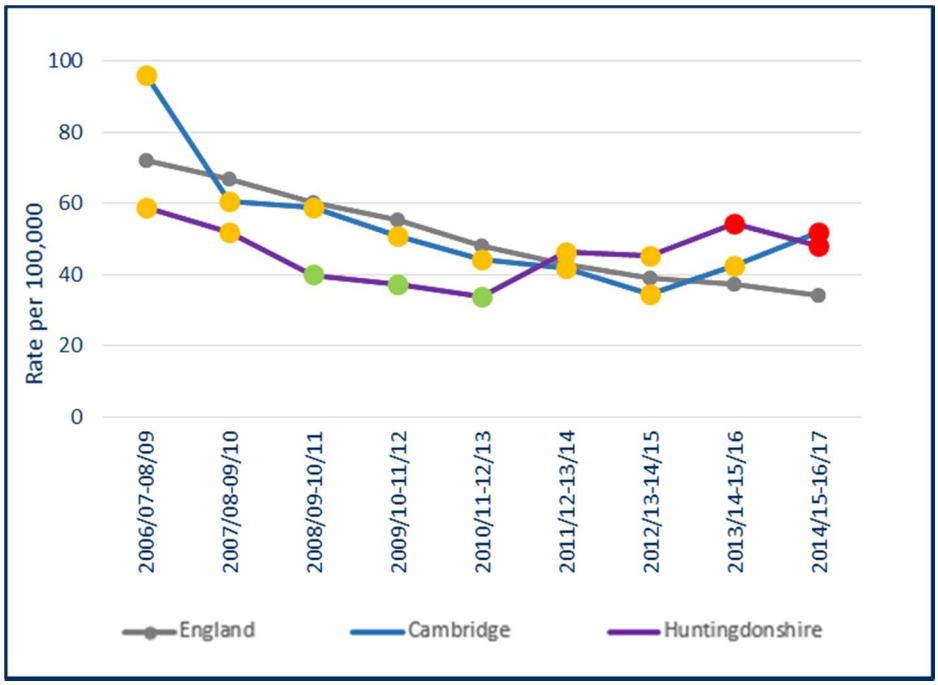
Table 23: Admission episodes for alcohol-specific conditions - Under 18s crude rate per 100,000, 2014/15 - 2016/17

Area	Number	Crude rate per 100,000	95% Confidence Intervals
Cambridge	35	51.8	(36.1 - 72.0)
East Cambridgeshire	12	20.7	(10.7 - 36.1)
Fenland	19	32.1	(19.3 - 50.2)
Huntingdonshire	53	47.9	(35.9 - 62.7)
South Cambridgeshire	33	31.9	(22.0 - 44.8)
Cambridgeshire	152	38.1	(32.3 - 44.7)
Peterborough	53	37.0	(27.7 - 48.4)
Cambridgeshire and Peterborough*	205	37.8	-
England	11,987	34.2	(33.6 - 34.8)

*Aggregated from all known lower geography values

Source: Calculated by Public Health England: Risk Factors Intelligence (RFI), from PHE Health Profiles (https://fingertips.phe.org.uk/)

Figure 8: Admission episodes for alcohol-specific conditions - Under 18s crude rate per 100,000 for, Huntingdonshire and Cambridge 2006/07 - 2008/09 to 2014/15 - 2016/17



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.

Key points – alcohol admissions

- Cambridge and Huntingdonshire have statistically significantly higher rates compared to England, with both areas experiencing increasing trends in recent years.
- There has been an increasing trend in South Cambridgeshire, with the latest rate now being statistically similar to England, whereas historically it had been statistically significantly better than England.
- The rate in Peterborough has remained fairly stable in recent years.

4.3.5 Substance misuse

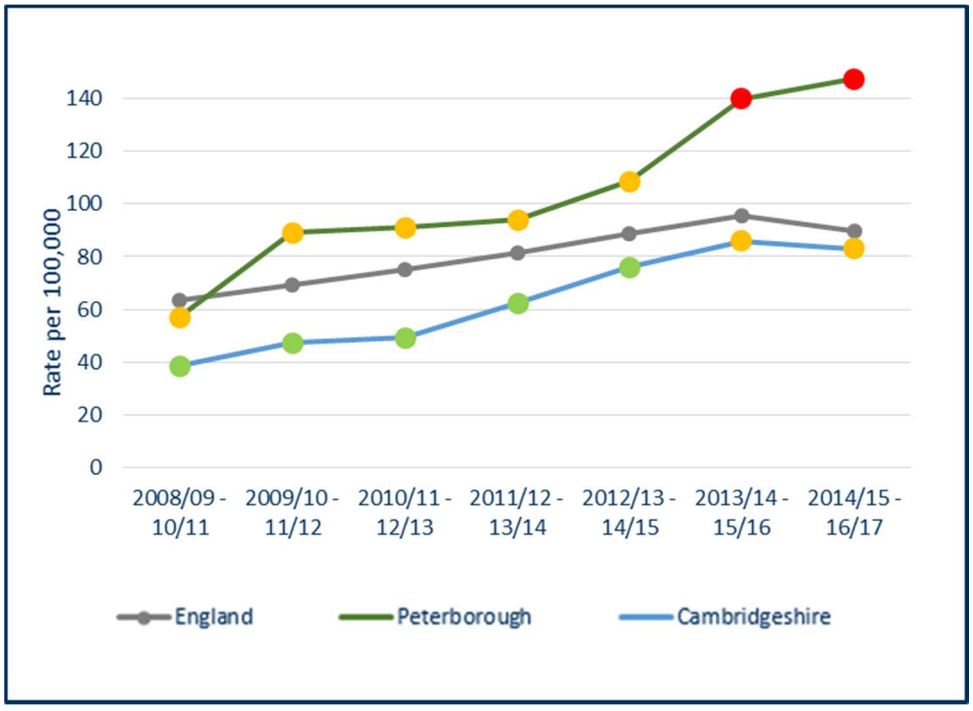
Table 24: Hospital admissions due to substance misuse, directly standardised rate per 100,000 population aged 15-24 years, 2014/15 - 2016/17

Area	Number	DASR per 100,000	95% Confidence Intervals
Cambridgeshire	205	83.1	(72.1 - 95.3)
Peterborough	100	147.4	(119.9 - 179.3)
Cambridgeshire and Peterborough	-	-	-
England	18,324	89.8	(88.5 - 91.1)

Data not available at District or Combined Authority level

Source: Hospital Episode Statistics (HES), from PHE Child Health Profiles (https://fingertips.phe.org.uk/)

Figure 9: Hospital admissions due to substance misuse, 15-24 years, directly standardised rate per 100,000 population aged 15-24 years for Cambridgeshire and Peterborough, 2008/09 - 2010/11 to 2014/15 - 2016/17



Source: Hospital Episode Statistics (HES), from PHE Child Health Profiles (https://fingertips.phe.org.uk/)

Key points – substance misuse

- Peterborough has a statistically significantly higher rate compared to England, with a notable increasing trend.
- There is an increasing trend in Cambridgeshire with the latest rates being statistically similar to England, compared to historically being statistically significantly better.

4.3.6 Sexual health

Table 25: Chlamydia proportion aged 15-24 years screened (%), 2017

Area	%	95% Confidence Intervals
Cambridge	19.1	(18.6 - 19.6)
East Cambridgeshire	15.3	(14.5 - 16.2)
Fenland	17.8	(17.0 - 18.6)
Huntingdonshire	18.1	(17.5 - 18.7)
South Cambridgeshire	17.4	(16.7 - 18.0)
Cambridgeshire	18.0	(17.7 - 18.3)
Peterborough	21.0	(20.4 - 21.6)
Cambridgeshire and Peterborough	18.6	(18.4 - 18.9)
England	19.3	(19.3 - 19.4)

Source: CTAD Chlamydia Surveillance System, from PHE Sexual and Reproductive Health Profiles (https://fingertips.phe.org.uk/)

Table 26: Chlamydia detection rate, crude rate per 100,000 aged 15-24 years, 2017

Area	Number	Crude rate per 100,000	95% Confidence Intervals
Cambridge	323	1,133.4	(1,013.2 - 1,264.0)
East Cambridgeshire	87	1,048.8	(840.1 - 1,293.7)
Fenland	148	1,373.0	(1,160.7 - 1,612.9)
Huntingdonshire	246	1,381.1	(1,213.9 - 1,564.9)
South Cambridgeshire	175	1,163.5	(997.5 - 1,349.2)
Cambridgeshire	979	1,217.3	(1,142.2 - 1,296.0)
Peterborough	556	2,534.9	(2,328.5 - 2,754.6)
Cambridgeshire and Peterborough	1,535	1,499.6	(1,425.5 - 1,576.6)
England	126,828	1,881.9	(1,871.6 - 1,892.3)

Benchmarked against goal: <1,900 | 1,900 to 2,300 | ≥2,300

Source: CTAD Chlamydia Surveillance System, from PHE Sexual and Reproductive Health Profiles (https://fingertips.phe.org.uk/)

Key points – chlamydia screening and detection

- All Cambridgeshire districts, except Cambridge, have statistically significantly low proportions of 15-24 year olds screened for chlamydia compared to England. Cambridge has a statistically similar proportion.
- Peterborough has a statistically significantly high proportion of chlamydia screening than England.
- Cambridgeshire has a statistically significantly low screening proportion compared to England.
- Cambridgeshire and all the districts have low chlamydia detection rates compared to the nationally set benchmark.
- Peterborough has a high chlamydia detection rate compared to the nationally set benchmark.
- Cambridgeshire, Cambridge, East Cambridgeshire, Fenland and Huntingdonshire have experienced downward trends in detection rates for the last 5 years.

Table 27: Percentage of women aged under 25 choosing long acting reversible contraceptives (LARC) excluding injections as their main method of contraception at Sexual and Reproductive Health Services for Cambridgeshire and Peterborough, 2016

Area	%	95% Confidence Intervals
Cambridge	22.6	(20.3 - 25.0)
East Cambridgeshire	28.8	(21.6 - 37.3)
Fenland	24.1	(20.4 - 28.4)
Huntingdonshire	19.0	(16.5 - 21.7)
South Cambridgeshire	24.2	(20.5 - 28.5)
Cambridgeshire	22.3	(20.8 - 23.8)
Peterborough	21.4	(19.7 - 23.3)
Cambridgeshire and Peterborough	21.9	(20.8 - 23.1)
England	20.6	(20.4- 20.7)

Statistically significantly lower than the England average
Statistically similar to the England average
Statistically significantly higher than the England average

Source: NHS Digital, from PHE Sexual and Reproductive Health Profiles and Office for National Statistics

Key points – LARC

- East Cambridgeshire has a statistically significantly high percentage of women aged under 25 choosing long acting reversible contraceptives (excluding injections) as their main method of contraception compared to England.
- Cambridgeshire has a statistically significantly high percentage of women aged under 25 choosing long acting reversible contraceptives (excluding injections) as their main method of contraception compared to England.

Table 28: Repeat abortions, under 25 year olds (%), 2016

Area	Number	%	95% Confidence Intervals
Cambridgeshire	115	20.9	(17.8 - 24.5)
Peterborough	80	26.5	(21.8 - 31.7)
Cambridgeshire and Peterborough	195	22.9	(20.2 - 25.9)
England	18,949	26.7	(26.3 - 27.0)

Data not available at District level

Source: Department of Health, from Sexual and Reproductive Health Profiles (https://fingertips.phe.org.uk)

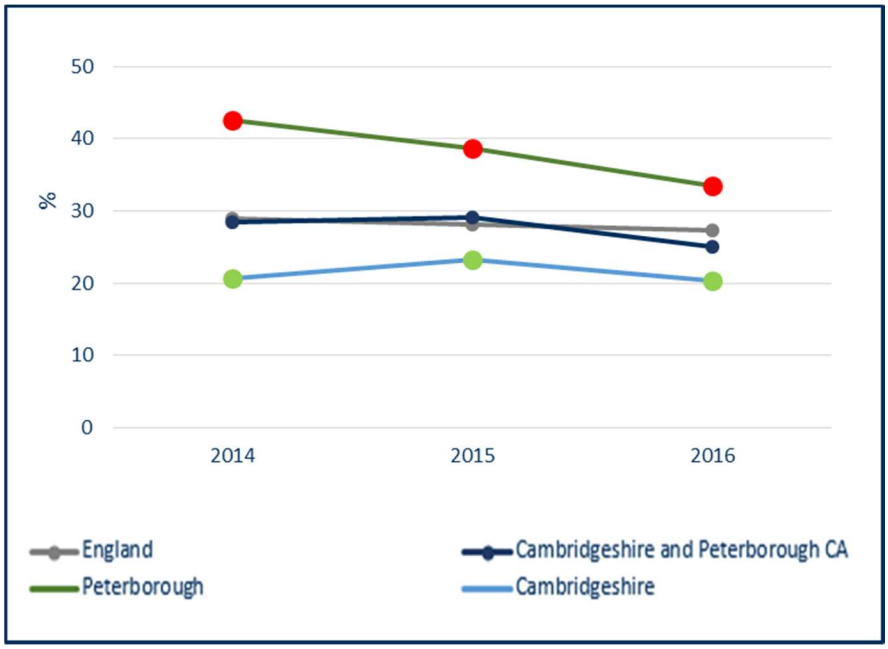
Table 29: Abortion after a birth, under 25 year olds, 2016

Area	Number	%	95% Confidence Intervals
Cambridgeshire	112	20.4	(17.2 - 24.0)
Peterborough	101	33.4	(28.4 - 38.9)
Cambridgeshire and Peterborough	213	25.0	(22.2 - 28.0)
England	19,477	27.4	(27.1 - 27.7)

Data not available at District level

Source: Department of Health, from Sexual and Reproductive Health Profiles (https://fingertips.phe.org.uk)

Figure 10: Abortion after a birth, under 25 year olds, 2014 to 2016



Source: Department of Health, from Sexual and Reproductive Health Profiles (https://fingertips.phe.org.uk)

Key points – Abortions in under 25 year olds

- Cambridgeshire has a statistically significantly low percentage of repeat abortions in under 25 year olds compared to England.
- Cambridgeshire has a statistically significantly low percentage of abortions after a birth in under 25 year olds when compared to England.
- Peterborough has a statistically significantly high percentage of abortions after a birth in under 25 year olds when compared to England.
- The Peterborough percentage has been statistically significantly higher than England for the last 3 years, but is decreasing.

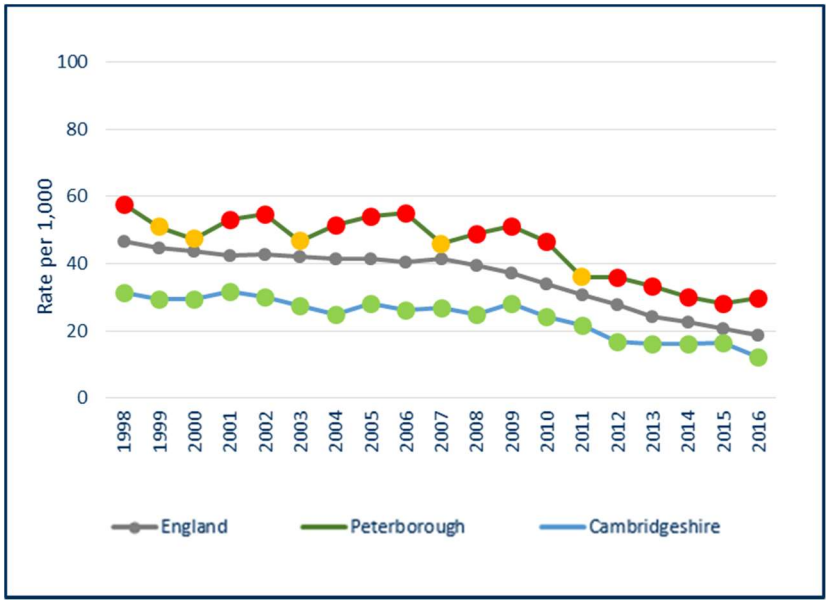
4.4 Teenage conceptions

Table 30: Under 18 conceptions crude rate per 1,000 females aged 15-17 years, 2016

Area	Number	Crude rate per 1,000	95% Confidence Intervals
Cambridge	19	11.3	(6.8 - 17.6)
East Cambridgeshire	16	11.6	(6.6 - 18.8)
Fenland	32	19.6	(13.4 - 27.6)
Huntingdonshire	50	17.1	(12.7 - 22.5)
South Cambridgeshire	9	3.3	(1.5 - 6.3)
Cambridgeshire	126	12.2	(10.2 - 14.5)
Peterborough	99	29.8	(24.2 - 36.3)
Cambridgeshire and Peterborough	225	16.5	(14.4 - 18.8)
England	17,014	18.8	(18.5 - 19.1)

Source: Office for National Statistics (ONS), from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Figure 11: Under 18 conceptions crude rate per 1,000 females aged 15-17 years for Cambridgeshire and Peterborough, 1998 to 2016



Source: Office for National Statistics (ONS), from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Table 31: Under 18s conceptions leading to abortion %, 2016

Area	Number	%	95% Confidence Intervals
Cambridge	-	31.6	(15.4 - 54.0)
East Cambridgeshire	10	62.5	(38.6 - 81.5)
Fenland	16	50.0	(33.6 - 66.4)
Huntingdonshire	34	68.0	(54.2 - 79.2)
South Cambridgeshire	-	44.4	(18.9 - 73.3)
Cambridgeshire	70	55.6	(46.8 - 63.9)
Peterborough	44	44.4	(35.0 - 54.3)
Cambridgeshire and Peterborough	114	50.7	(44.2- 57.1)
England	8,813	51.8	(51.0 - 52.5)

Statistically significantly lower than the England average
Statistically similar to the England average
Statistically significantly higher than the England average

'-' denotes fewer than 6 conceptions

Source: Office for National Statistics (ONS), from PHE Sexual and Reproductive Health Profiles (https://fingertips.phe.org.uk)

Table 32: Under 16 conceptions crude rate per 1,000 females aged 13-15 years, 2016

Area	Number	Crude rate per 1,000	95% Confidence Intervals
Cambridgeshire	24	2.4	(1.5 - 3.6)
Peterborough	19	5.9*	(3.6 - 9.3)
Cambridgeshire and Peterborough	19	5.9	(3.6 - 9.3)
England	2,646	3.0	(2.9 - 3.2)

Data not available at District level

*There is a data quality issue with this value.

Source: Office for National Statistics (ONS), from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Table 33: Teenage mothers, % of delivery episodes where the mother is aged under 18 years, 2016/17

Area	Number	%	95% Confidence Intervals
Cambridgeshire	44	0.7	(0.5 - 0.9)
Peterborough	24	0.8	(0.6- 1.2)
Cambridgeshire and Peterborough*	68	0.7	-
England	4,707	0.8	(0.7- 0.8)

Data not available at District level

*Aggregated from all known lower geography values

Source: Hospital Episode Statistics (HES) Copyright © 2016 from PHE Sexual and Reproductive Health Profiles (https://fingertips.phe.org.uk)

Key points – teenage conceptions, abortions and births

Teenage conceptions

- Cambridgeshire, Cambridge and South Cambridgeshire have statistically significantly low teenage conception rates compared to England
- Peterborough has a statistically significantly high teenage conception rate compared to England.
- Cambridgeshire, Peterborough and all the districts have experienced downward trends in rates over the last 10 years. However, rates in Huntingdonshire have increased annually since 2012, with the latest rate (2016) statistically similar to England, whereas historically is had been statistically significantly better.
- Peterborough appears to have a statistically significantly high proportion of conceptions in under 16 year olds compared to the England average, but there is a data quality issues with the figure.

Teenage conceptions leading to abortion

- Cambridgeshire, Peterborough and all the districts have statistically similar rates compared to England, with the exception of Huntingdonshire which has a statistically significantly high percentage.
- There was a noticeable increase from 23.3% in 2015 to 50.0% in 2016 in Fenland.
- The Huntingdonshire percentage has been increasing year on year, and is now statistically significantly higher than England.

Teenage mothers

- Cambridgeshire and Peterborough both have statistically similar percentages of teenage mothers to England.
- There was a notable decrease in teenage mothers in Peterborough between 2015/16 and 2016/17 (1.3% in 2015/16 to 0.8% in 2016/17).

4.5 Decayed, missing or filled teeth

Table 34: DMFT (decayed, missing or filled teeth), 5 year olds, average number, 2016/17

Area	Average number	95% Confidence Intervals
Cambridge	0.4	(0.2 - 0.6)
East Cambridgeshire	0.3	(0.1 - 0.4)
Fenland	0.7	(0.5 - 0.9)
Huntingdonshire	0.4	(0.2 - 0.5)
South Cambridgeshire	0.2	(0.1 - 0.3)
Cambridgeshire	0.4	(0.3 - 0.4)
Peterborough	1.1	(0.8 - 1.4)
Cambridgeshire and Peterborough	-	-
England	0.8	(0.8- 0.8)

Source: Dental Public Health Epidemiology Programme for England, from PHE Oral Health Profile (https://fingertips.phe.org.uk)

Table 35: Children (5 year olds) with one or more decayed, missing or filled teeth, %, 2016/17

Area	%	95% Confidence Intervals
Cambridgeshire	12.9	(11.2 - 15.0)
Peterborough	32.4	(26.6 - 38.8)
Cambridgeshire and Peterborough	-	-
England	23.3	(23.0- 23.6)

Data not available at Combined Authority or District Level

Source: Dental Public Health Epidemiology Programme for England, from PHE Oral Health Profile (https://fingertips.phe.org.uk)

Table 36: Proportion (%) of 5 year olds free from dental decay, 2014/15

Area	%	95% Confidence Intervals
Cambridge	81.7	(76.9 - 86.5)
East Cambridgeshire	89.9	(86.4 - 93.4)
Fenland	76.6	(71.6 - 81.7)
Huntingdonshire	81.5	(76.9 - 86.0)
South Cambridgeshire	84.0	(79.9 - 88.0)
Cambridgeshire	83.1	(81.2 - 85.1)
Peterborough	70.0	(64.6 - 75.4)
Cambridgeshire and Peterborough*	80	-
England	75.2	(75.0- 75.5)

*Aggregated from all known lower geography values

Source: National Dental Epidemiology Programme for England: oral health survey of five-year-old children 2015, from PHE Oral Health Profile (https://fingertips.phe.org.uk)

Key points – decayed, missing or filled teeth and 5 year olds free from dental decay

- All districts in Cambridgeshire, except Fenland, have a statistically significantly low average number of decayed, missing or filled teeth in 5 year olds compared to England. Fenland is statistically similar.
- Cambridgeshire has a statistically significantly low average number of decayed, missing or filled teeth in 5 year olds compared to England.
- Peterborough has a statistically significantly similar average number of decayed, missing or filled teeth in 5 year olds compared to England. Fenland is statistically similar.
- All districts except Fenland have statistically significantly high proportions of 5 year olds free from decay compared to England. Fenland is statistically similar.
- Cambridgeshire has a statistically significantly high proportion of 5 year olds free from decay compared to England.

5. Health protection

5.1 Vaccinations and immunisations

5.1.1 Summary table of all childhood vaccinations

Vaccination coverage and benchmark	<90% / 90% to 95% / ≥95%	Period	England %	C&P^	C&P recent trend	Cambs %	Cambs recent trend	Pboro %	Pboro recent trend
Dtap / IPV / Hib (1 year old) [1,2]	<90% / 90% to 95% / ≥95%	2016/17	93.4	94.1	→ 7	94.3	→ 7	93.7	→ 7
Dtap / IPV / Hib (2 years old) [1,2]	<90% / 90% to 95% / ≥95%	2016/17	95.1	95.3	↓ 6	95.0	↓ 6	96.0	→ 7
Meningitis C [2]	<90% / 90% to 95% / ≥95%	2015/16	DQ [3]	95.2	-	95.2~	-	DQ [3]	-
Hib / MenC booster (2 years old) [2,4]	<90% / 90% to 95% / ≥95%	2016/17	91.5	91.9	↓ 6	92.4	↓ 6	90.7	→ 7
Hib / MenC booster (5 years old) [2,4]	<90% / 90% to 95% / ≥95%	2016/17	92.6	89.5	↓ 5	89.4	↓ 5	89.6	↑ 5
MMR for 1 dose (2 years old) [2,5]	<90% / 90% to 95% / ≥95%	2016/17	91.6	92.0	↑ 6	92.3	↑ 5	91.1	↑ 7
MMR for 1 dose (5 years old) [2,5]	<90% / 90% to 95% / ≥95%	2016/17	95.0	94.2	↑ 5	93.6	↑ 5	95.6	↑ 5
MMR for 2 doses (5 years old) [2,5]	<90% / 90% to 95% / ≥95%	2016/17	87.6	86.4	→ 7	85.1	↓ 5	89.6	↑ 5
Flu (2-4 years old) [2]	<40% / 40% to 65% / ≥65%	2016/17	38.1	37.6	-	41.1	-	28.9	-
PCV (1 year old) [2,6]	<90% / 90% to 95% / ≥95%	2016/17	93.5	94.2	→ 7	94.6	→ 7	93.4	→ 7
PCV (2 years old) [2,6]	<90% / 90% to 95% / ≥95%	2016/17	91.5	92.0	↑ 7	92.5	→ 7	90.7	↑ 7
HPV vaccination for 2 doses (females 13-14 years old) [2,7]	<80% / 80% to 90% / ≥90%	2016/17	83.1	85.4	-	85.6	-	85.2	-

Note:1 - Vaccination - Dtap / IPV / Hib (1 year old) = diphtheria, hepatitis B, Hib (Haemophilus influenzae type b), polio, tetanus, whooping cough (pertussis).
Note:2 - benchmarked against threshold based goals - see http://www.phoutcomes.info/
Note:3 - DQ = value not published for data quality reasons
Note:4 - Hib = Haemophilus influenzae type b; MenC = meningitis C
Note:5 - MMR = measles, mumps and rubella
Note 6 - PCV= pneumococcal infections that can cause pneumonia, septicaemia or meningitis
Note:7 - HPV = Human papilloma virus
^ Aggregated from all known lower geography values
- Data not available
~ Value estimated from former primary care organisations covered by the local authority
The number next to the trend arrow indicates the number of year that the trend relates to.

Source: Public Health Outcomes Framework, PHE (https://fingertips.phe.org.uk/)

Key points – vaccinations

- Vaccinations in 5 year olds are in the lowest nationally prescribed threshold in both Cambridgeshire and Peterborough, at under 90% coverage. This includes Hib/MenC boosters and two doses of MMR. The majority of other vaccinations are between 90-95% coverage. The national target is 95%.
- Flu uptake in 2-4 year olds is below the minimum threshold in Peterborough.

5.1.2 MMR

Table 37: MMR vaccination - % of eligible children who have received one dose of MMR, 2 years old, 2016/17

Area	%	95% Confidence Intervals
Cambridgeshire	92.3	(91.7 - 92.9)
Peterborough	91.1	(90.0 - 92.1)
Cambridgeshire and Peterborough*	92.0	-
England	91.6	(91.5 - 91.7)

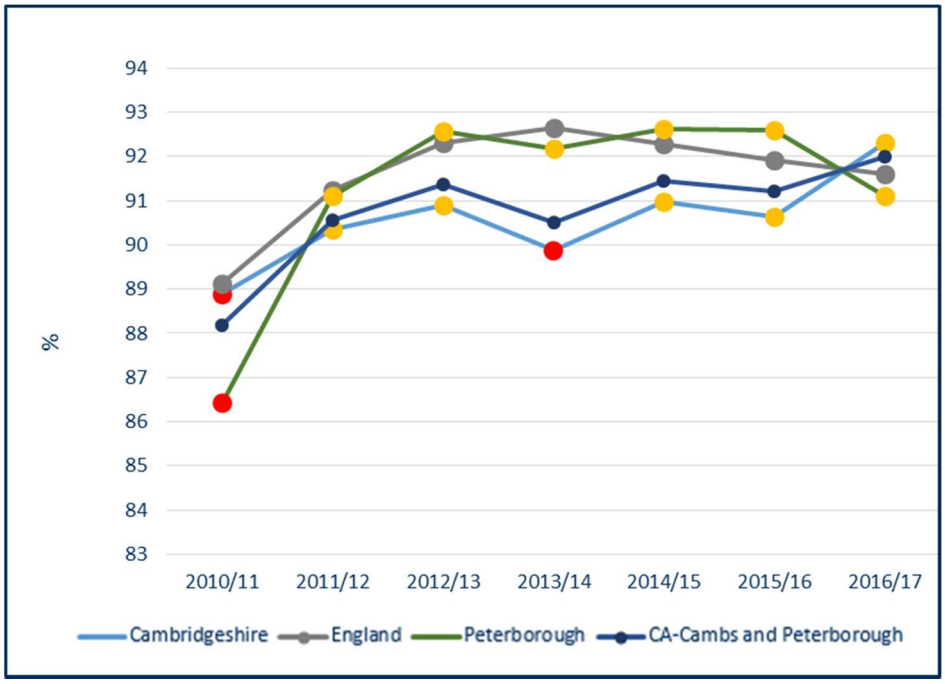
Data not available at District level

*Aggregated from all known lower geography values

Benchmarking against goal: <90% | 90% to 95% | ≥95%

Source: Cover of Vaccination Evaluated Rapidly (COVER) data, from Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Figure 12: MMR vaccination - % of eligible children who have received one dose of MMR, 2 years old, for Cambridgeshire and Peterborough, trend 2010/11 to 2016/17



Benchmarking against goal: <90% 90% to 95% ≥95%

Source: Cover of Vaccination Evaluated Rapidly (COVER) data, from Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Table 38: MMR vaccination - % of eligible children who have received two doses of MMR, 5 years old, 2016/17

Area	%	95% Confidence Intervals
Cambridgeshire	85.1	(84.3 - 85.9)
Peterborough	89.6	(88.5 - 90.6)
Cambridgeshire and Peterborough*	86.4	-
England	87.6	(87.5 - 87.6)

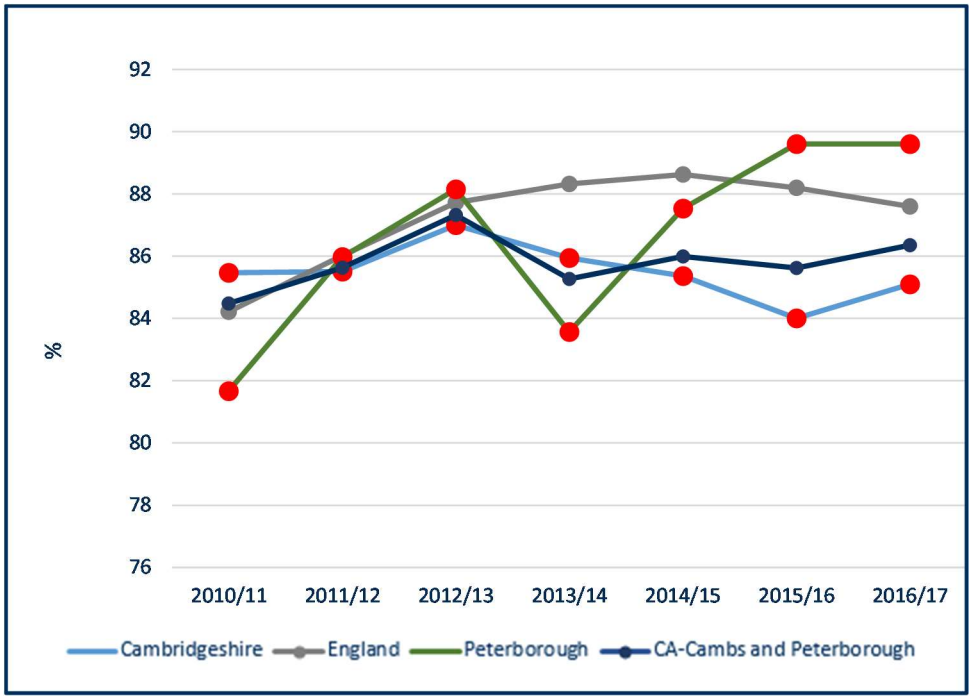
Data not available at District level

*Aggregated from all known lower geography values

Benchmarking against goal: <90% 90% to 95% ≥95%

Source: Cover of Vaccination Evaluated Rapidly (COVER) data, from Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Figure 13: MMR vaccination - % of eligible children who have received two doses of MMR, 5 years old, for Cambridgeshire and Peterborough, trend 2010/11 to 2016/17



Benchmarking against goal: <90% 90% to 95% ≥95%

Source: Cover of Vaccination Evaluated Rapidly (COVER) data, from Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Key points - MMR

- The percentage of eligible children who have received one dose of MMR at 2 years old in Cambridgeshire and Peterborough are within the benchmark of 90% to 95%. Above 95% is the main target.
- There is an increasing trend in both Cambridgeshire and Peterborough for MMR coverage in 2 year olds, although there was a reduction in Peterborough in 2016/17.
- The percentages of eligible children who have received two doses of MMR at 5 years in Cambridgeshire and Peterborough are below 90%. The target is 95%.
- There is an increasing trend in Peterborough and a decreasing trend in Cambridgeshire for MMR coverage at 5 years old.

5.1.3 HPV

Table 39: Population vaccination coverage - HPV vaccination coverage for two doses, females aged 13-14 years old, 2016/17

Area	Number	%	95% Confidence Intervals
Cambridgeshire	2,671	85.6	(84.3 - 86.7)
Peterborough	1,005	85.2	(83.0 - 87.1)
Cambridgeshire and Peterborough*	3,676	85.4	-
England	240,590	83.1	(83.0 - 83.2)

Data not available at District level

*Aggregated from all known lower geography values

Benchmarked against goal: <80% 80% to 90% ≥90%

Source: Public Health England (PHE). https://www.gov.uk/government/statistics/annual-hpv-vaccine-coverage-2015-to-2016-by-local-authority-and-area-team

Key points - HPV

- Two dose HPV vaccination coverage in females aged 13-14 years old in Cambridgeshire and Peterborough are within the benchmark goal of 80% to 90%. The national target is over 90%.
- There has been a notable decrease in coverage in Peterborough.

5.1.4 Children in care immunisations

Table 40: Children in care under 18 years - % of children in care for at least 12 months whose immunisations were up to date, 2017

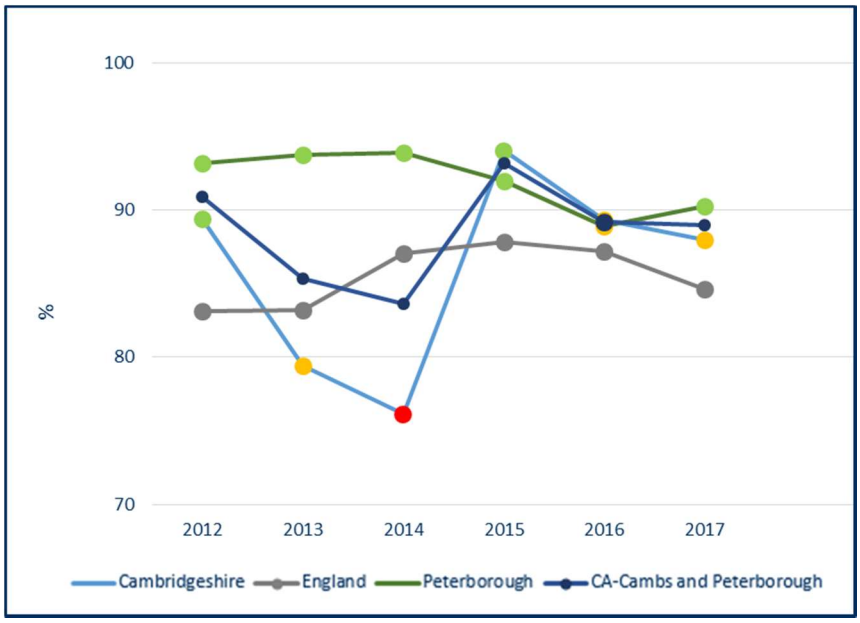
Area	%	95% Confidence Intervals
Cambridgeshire	88.0	(84.6 - 90.8)
Peterborough	90.3	(86.0 - 93.3)
Cambridgeshire and Peterborough*	89.0	-
England	84.6	(84.3 - 84.9)

Data not available at District level

*Aggregated from all known lower geography values.

Source: Department for Education (DfE) https://www.gov.uk/government/collections/statistics-looked-after-children

Figure 14: Children in care under 18 years - % of children in care for at least 12 months whose immunisations were up to date, trend 2012 to 2017



Source: Department for Education (DfE) https://www.gov.uk/government/collections/statistics-looked-after-children

Key Points

Key points – children in care immunisations

- The percentage of children in care (for at least 12 months) whose immunisations are up to date in Peterborough is statistically significantly higher than England, with a relatively static trend over the last 6 years.
- The percentage of children in care (for at least 12 months) whose immunisations are up to date in Cambridgeshire is statistically similar to England, with a decreasing trend since 2015.

6. Prevention of ill health

6.1 A&E attendances

Table 41: A&E attendances, 0-4 years - A&E attendance rate per 1,000 population aged 0-4 years, 2016/17

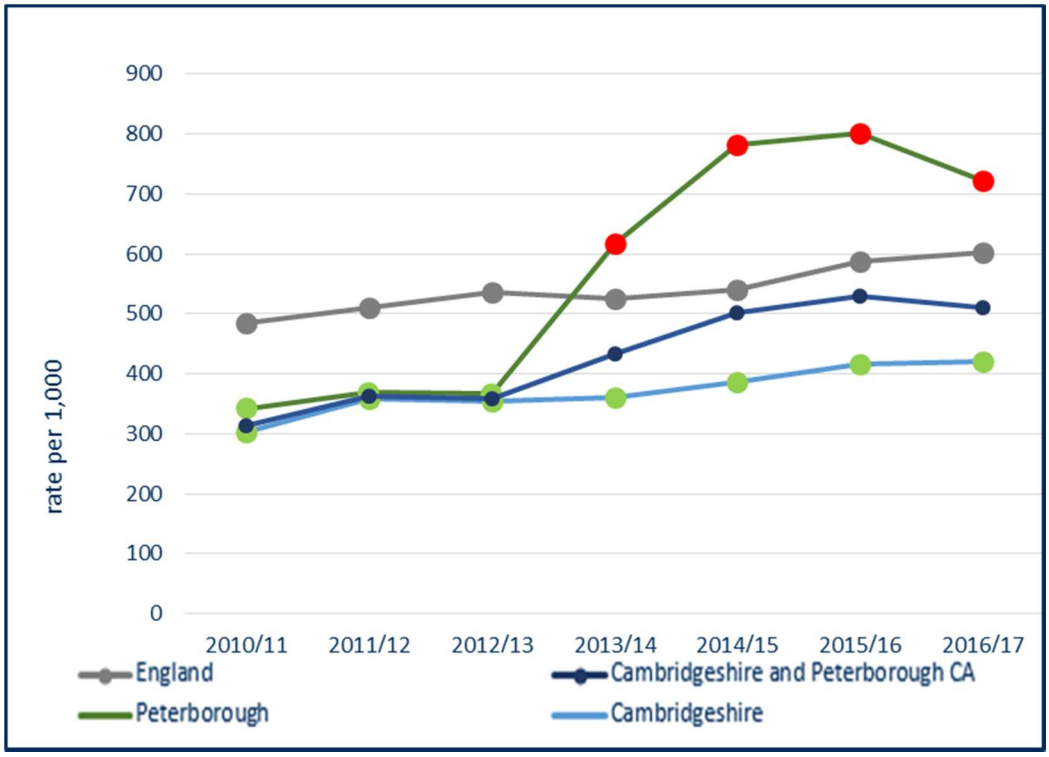
Area	Number	Crude rate per 1,000	95% Confidence Intervals
Cambridgeshire	16,255	420.5	(414.1 - 427.0)
Peterborough	11,754	722.7	(709.7 - 735.9)
Cambridgeshire and Peterborough*	28,009	510.0	-
England	2,063,580	601.8	(601.0- 602.6)

Data not available at District level

*Aggregated from all known lower geography values.

Source: Hospital Episode Statistics (HES) Copyright © 2018, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Figure 15: A&E attendances, 0-4 years - A&E attendance rate per 1,000 population aged 0-4 years for Cambridgeshire and Peterborough, 2011 to 2017



Source: Hospital Episode Statistics (HES) Copyright © 2018, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Key points – A&E attendances

- The A&E attendance rate in children aged 0-4 years is statistically significantly higher in Peterborough than the national average.
- The A&E attendance rate in children aged 0-4 years is statistically significantly lower in Cambridgeshire than the national average.
- Similar to the national trend, there appears to be an increasing trend in Cambridgeshire and, most notably, in Peterborough.

6.2 Hospital admissions – unintentional and deliberate injuries

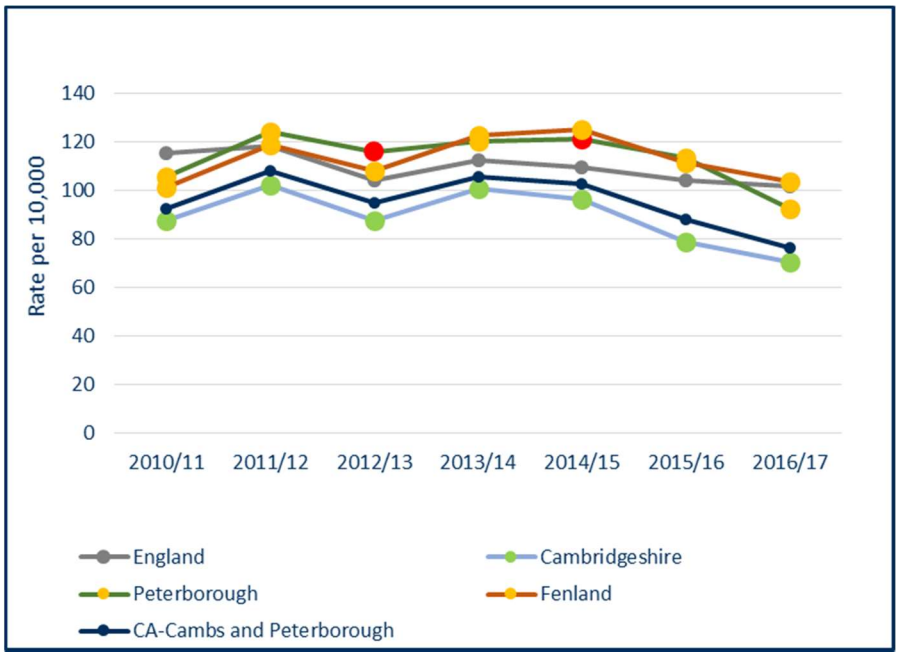
Table 42: Hospital admissions caused by unintentional and deliberate injuries in children, 0-14 years - crude rate per 10,000 resident population aged 0-14 years, 2016/17

Area	Number	Crude rate per 10,000	95% Confidence Intervals
Cambridge	112	56.9	(46.8 - 68.4)
East Cambridgeshire	94	56.4	(45.6 - 69.0)
Fenland	172	103.8	(88.9 - 120.6)
Huntingdonshire	261	84.8	(74.8 - 95.8)
South Cambridgeshire	159	54.1	(46.0 - 63.1)
Cambridgeshire	798	70.6	(65.7 - 75.6)
Peterborough	390	92.5	(83.5 - 102.1)
Cambridgeshire and Peterborough*	1,188	76.5	-
England	100,728	101.5	(100.8 - 102.1)

*Aggregated from all known lower geography values.

Source: Hospital Episode Statistics (HES) Copyright © 2018, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Figure 16: Hospital admissions caused by unintentional and deliberate injuries in children, 0-14 years - crude rate per 10,000 resident population aged 0-14 years for Cambridgeshire, Peterborough and Fenland, 2010/11 to 2016/17



Source: Hospital Episode Statistics (HES) Copyright © 2018, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Key points – hospital admission caused by unintentional and deliberate injuries, 0-14 year olds

- The rate of hospital admissions caused by injuries in children (0-14 years) is statistically significantly lower in all districts compared to the national average, with the exception of Fenland which is statistically similar.
- In Cambridgeshire the rate is statistically significantly lower than the national average.
- In Peterborough the rate is statistically similar to the national average.
- The trend in both Cambridgeshire and Peterborough is improving.
- There has been no significant change in the trend in Fenland.

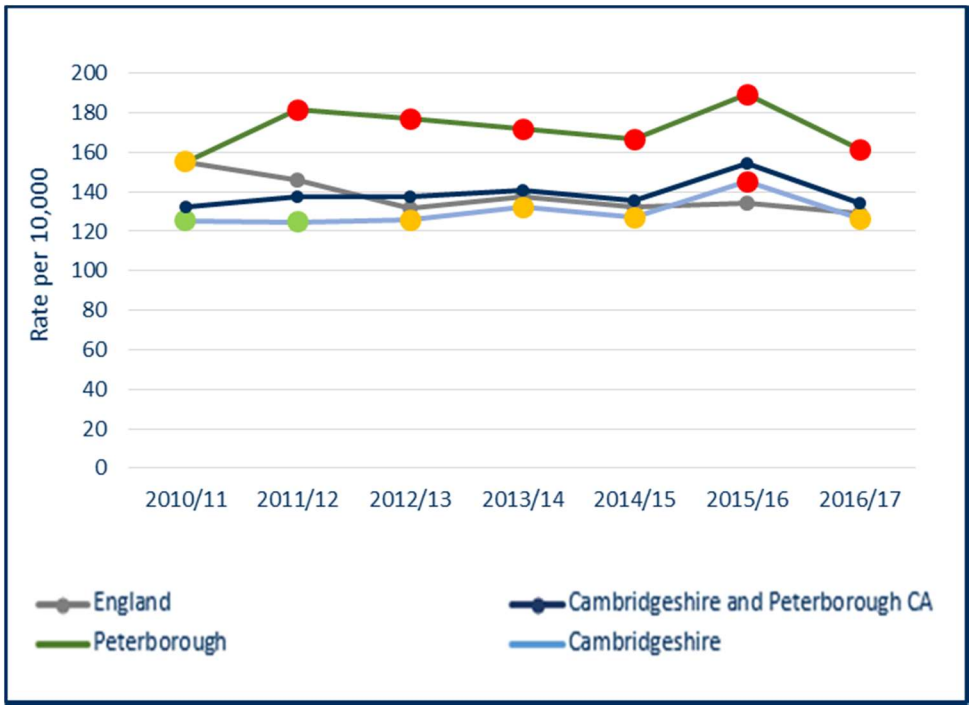
Table 43: Hospital admissions caused by unintentional and deliberate injuries in young people, 15-24 years - crude rate per 10,000 population aged 15-24 years, 2016/17

Area	Number	Crude rate per 10,000	95% Confidence Intervals
Cambridge	366	122.9	(110.6 - 136.1)
East Cambridgeshire	110	133.5	(109.7 - 160.9)
Fenland	150	137.5	(116.4 - 161.4)
Huntingdonshire	203	114.4	(99.2 - 131.2)
South Cambridgeshire	206	136.8	(118.7 - 156.8)
Cambridgeshire	1,035	126.6	(119.0 - 134.6)
Peterborough	357	161.7	(145.4 - 179.4)
Cambridgeshire and Peterborough*	1,392	134.1	-
England	87,049	129.2	(128.3 - 130.0)

*Aggregated from all known lower geography values.

Source: Hospital Episode Statistics (HES) Copyright © 2018, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Figure 17: Hospital admissions caused by unintentional and deliberate injuries in young people, 15-24 years - crude rate per 10,000 population aged 15-24 years for Cambridgeshire and Peterborough, 2010/11 to 2016/17



Source: Hospital Episode Statistics (HES) Copyright © 2018, from PHE Public Health Outcomes Framework (https://fingertips.phe.org.uk)

Key points – hospital admission caused by unintentional and deliberate injuries, 15-24 year olds

- Peterborough has a statistically significantly higher rate than the national average.
- Cambridgeshire and Peterborough have both seen no significant change in the trend over the last 7 years. However, in 2016/17 Cambridgeshire moved from being statistically significantly worse than the national average to being statistically similar.

6.3 Hospital admissions – asthma, diabetes and epilepsy

Table 44: Hospital admissions for asthma, under 19 years - crude rate per 100,000 population aged 0-18 years, 2016/17

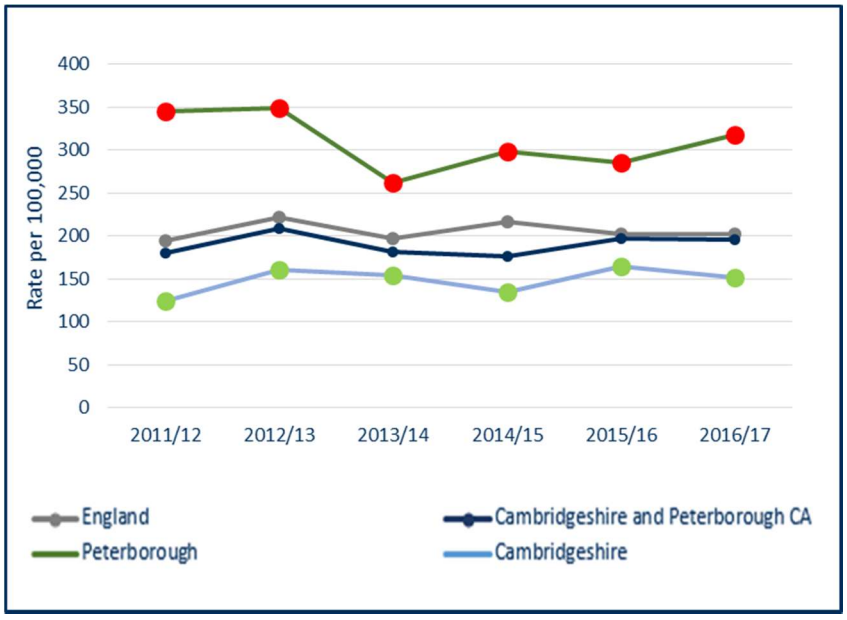
Area	Number	Crude rate per 100,000	95% Confidence Intervals
Cambridgeshire	216	152.0	(132.4 - 173.7)
Peterborough	163	318.1	(271.1 - 370.8)
Cambridgeshire and Peterborough*	379	196.0	-
England	25,216	202.8	(200.3 - 205.3)

Data not available at district level

*Aggregated from all known lower geography values.

Source: Hospital Episode Statistics (HES) Copyright © 2016, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Figure 18: Hospital admissions for asthma, under 19 years - crude rate per 100,000 population aged 0-18 years for Cambridgeshire and Peterborough, 2011/12 to 2016/17



Source: Hospital Episode Statistics (HES) Copyright © 2016, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

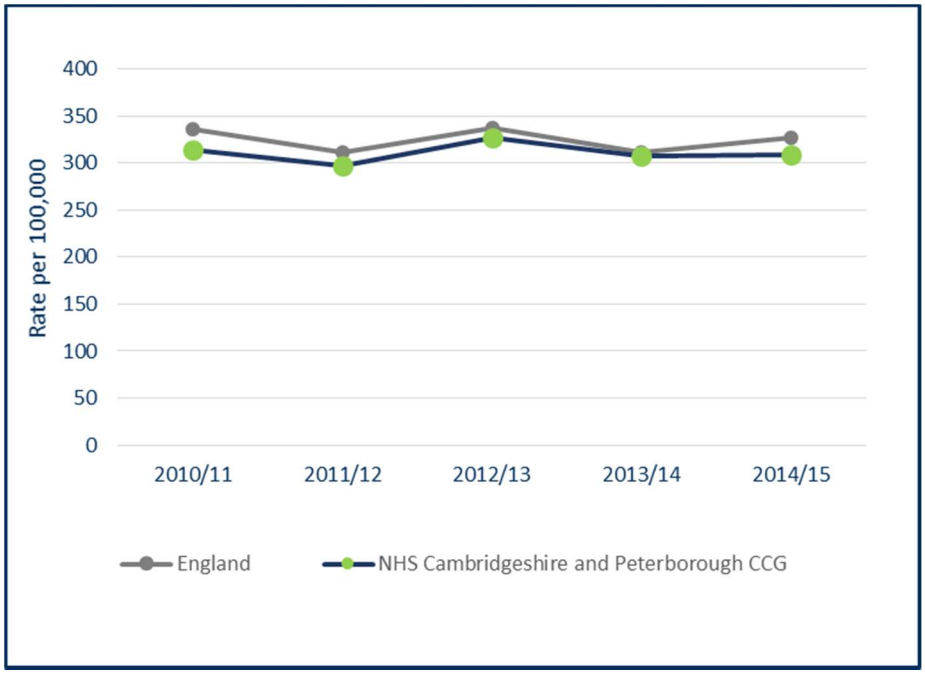
Table 45: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (directly standardised rate) population aged 0-18 years, 2014/15

Area	Number	DASR per 100,000	95% Confidence Intervals
NHS Cambridgeshire and Peterborough CCG	611	309.2	(285.2 - 334.8)
England	40,491	327.0	(323.8 - 330.2)

Data only available at CCG level

Source: Hospital Episode Statistics (HES) Copyright © 2016, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Figure 19: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (directly standardised rate) population aged 0-18 years, 2010/11 to 2014/15



Source: Hospital Episode Statistics (HES) Copyright © 2016, from PHE Child Health Profiles

Key points – hospital admissions for asthma, diabetes and epilepsy

Asthma

- Cambridgeshire has a statistically significantly low rate compared to the national average.
- Peterborough has a statistically significantly high rate compared to the national average.
- Peterborough has been experiencing an upward trend in rates since 2013/14.

Asthma, diabetes and epilepsy

- The CCG admission rate for these three conditions combined is similar to the national average, with rates remaining relatively stable over the last 5 years.

6.4 Hospital admissions – mental health conditions

Table 46: Hospital admissions for mental health conditions, under 18 year olds - crude rate per 100,000 population aged 0-17 years, 2016/17

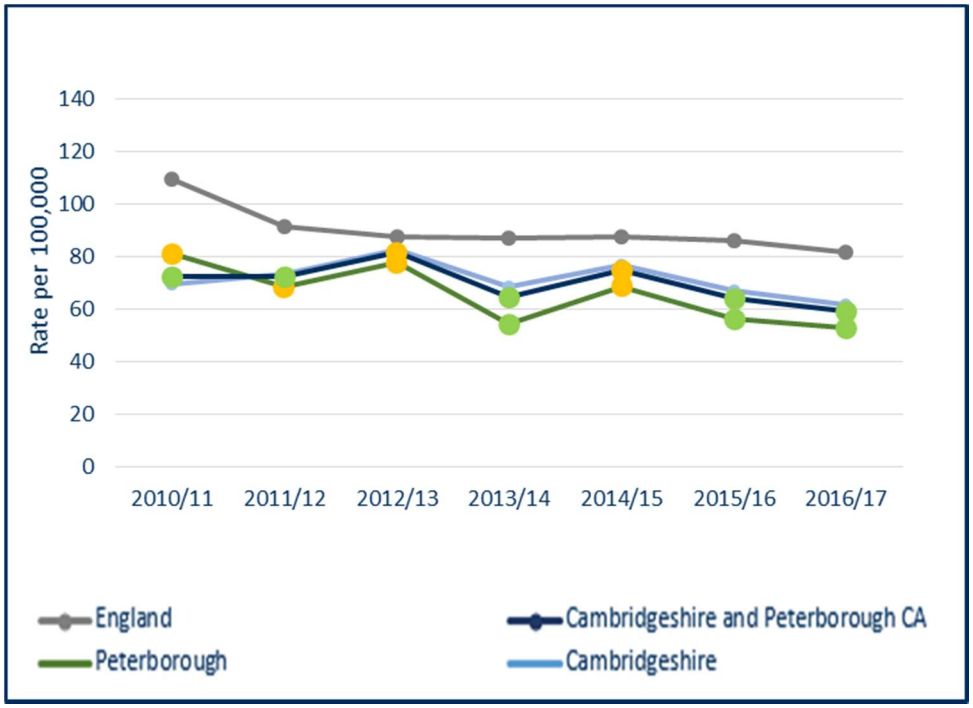
Area	Number	Crude rate per 100,000	95% Confidence Intervals
Cambridgeshire	83	61.8	(49.2 - 76.6)
Peterborough	26	53.1	(34.7 - 77.8)
Cambridgeshire and Peterborough*	109	59.5	-
England	9,605	81.5	(79.9 - 83.1)

Data not available at district level

*Aggregated from all known lower geography values.

Source: Hospital Episode Statistics (HES) Copyright © 2016, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Figure 20: Hospital admissions for mental health conditions, under 18 year olds - crude rate per 100,000 population aged 0-17 years for Cambridgeshire and Peterborough, 2010/11 to 2016/17



Source: Hospital Episode Statistics (HES) Copyright © 2016, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Key points – hospital admissions for mental health conditions

- Both Cambridgeshire and Peterborough have statistically significantly lower rates of hospital admissions for mental health conditions than the national average.
- The trend in Cambridgeshire has been relatively stable over the last 7 years.
- There has been an overall downward trend in Peterborough over the last 7 years.

6.5 Hospital admissions – self-harm

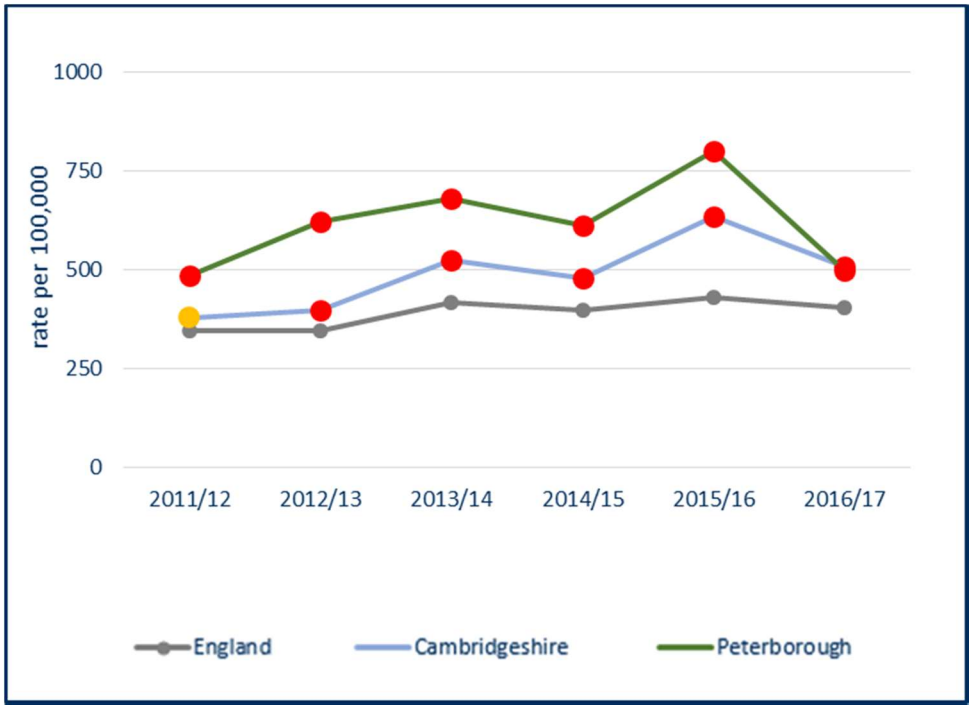
Table 47: Hospital admissions as a result of self-harm, 10-24 years - directly standardised rate per 100,000 resident population aged 10-24 years, 2016/17

Area	Number	DASR per 100,000	95% Confidence Intervals
Cambridgeshire	606	509.1	(469.3 - 551.3)
Peterborough	167	499.8	(426.8 - 581.7)
Cambridgeshire and Peterborough	-	-	-
England	39,897	404.6	(400.7 - 408.6)

Data not available at district level

Source: Hospital Episode Statistics (HES) Copyright © 2016, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Figure 21: Hospital admissions as a result of self-harm, 10-24 years - directly standardised rate per 100,000 resident population aged 10-24 years for Cambridgeshire and Peterborough, 2011/12 to 2016/17



Source: Hospital Episode Statistics (HES) Copyright © 2016, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Key points – hospital admissions for self-harm

- Both Cambridgeshire and Peterborough have statistically significantly higher rates of hospital admissions as a result of self-harm (10-24 years) compared to the national average.
- The Cambridgeshire rate has been statistically significantly higher than England since 2012/13.
- The Peterborough rate has been statistically significantly higher than England since 2011/12.
- Local analysis on self-harm hospital admission rates has shown that Cambridge City and East Cambridgeshire had the highest rates in Cambridgeshire in 2016/17, with rates that are statistically significantly higher than the England rate. Admission rates are highest in young people, especially 15 to 19 year olds and are higher in females than males. Intentional self-poisoning is the most common reason for self-harm hospital admissions. A small number of patients account for notable frequent admissions.

7. Premature mortality

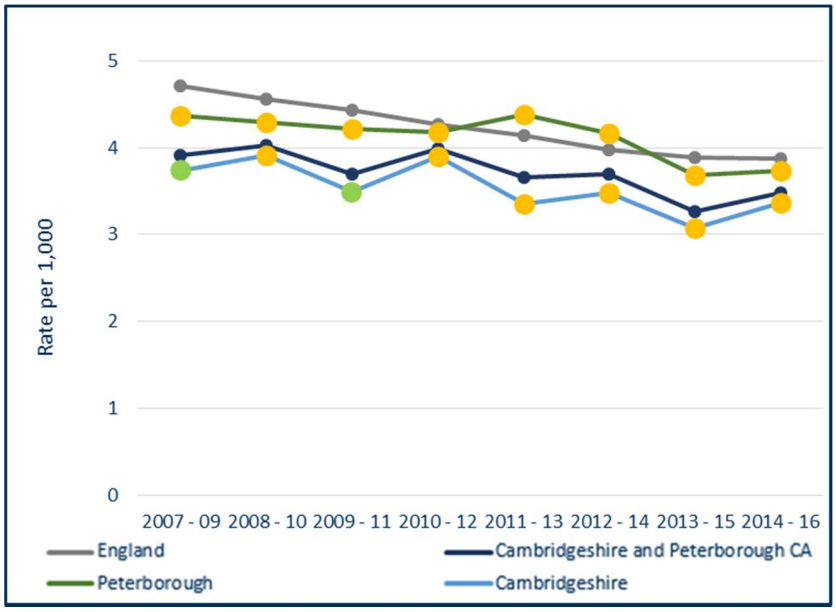
7.1 Infant Mortality

Table 48: Infant mortality - rate of deaths in infants aged under 1 year per 1,000 live births, 2014-16

Area	Number	Rate per 1,000 births	95% Confidence Intervals
Cambridge	18	4.2	(2.5 - 6.6)
East Cambridgeshire	4	1.3	(0.4 - 3.4)
Fenland	19	5.6	(3.3 - 8.7)
Huntingdonshire	12	2.0	(1.0 - 3.5)
South Cambridgeshire	21	4.0	(2.5 - 6.1)
Cambridgeshire	74	3.4	(2.6 - 4.2)
Peterborough	35	3.7	(2.6 - 5.2)
Cambridgeshire and Peterborough	109	3.5	(2.9 - 4.2)
England	7,710	3.9	(3.8 - 4.0)

Source: Office of National Statistics, from PHE Pubic Health Outcomes Framework (https://fingertips.phe.org.uk)

Figure 22: Infant mortality - rate of deaths in infants aged under 1 year per 1,000 live births for Cambridgeshire and Peterborough trend 2007-2009 to 2014-2016



Source: Office of National Statistics, from PHE Pubic Health Outcomes Framework (https://fingertips.phe.org.uk)

Key points – infant mortality

- East Cambridgeshire and Huntingdonshire have statistically significantly lower rates compared to England. A decrease in rates in Huntingdonshire in 2014-16 led to the area becoming statistically significantly better than the national average, having been statistically similar since 2001-03.
- The rates of infant mortality in Cambridgeshire and Peterborough remain statistically similar to the England average.
- Numbers are relatively small and rates fluctuate but there has generally been an increasing trend in Cambridge City since 2011-13, in Fenland since 2009-11 and in South Cambridgeshire since 2011-13.

7.2 Child Mortality

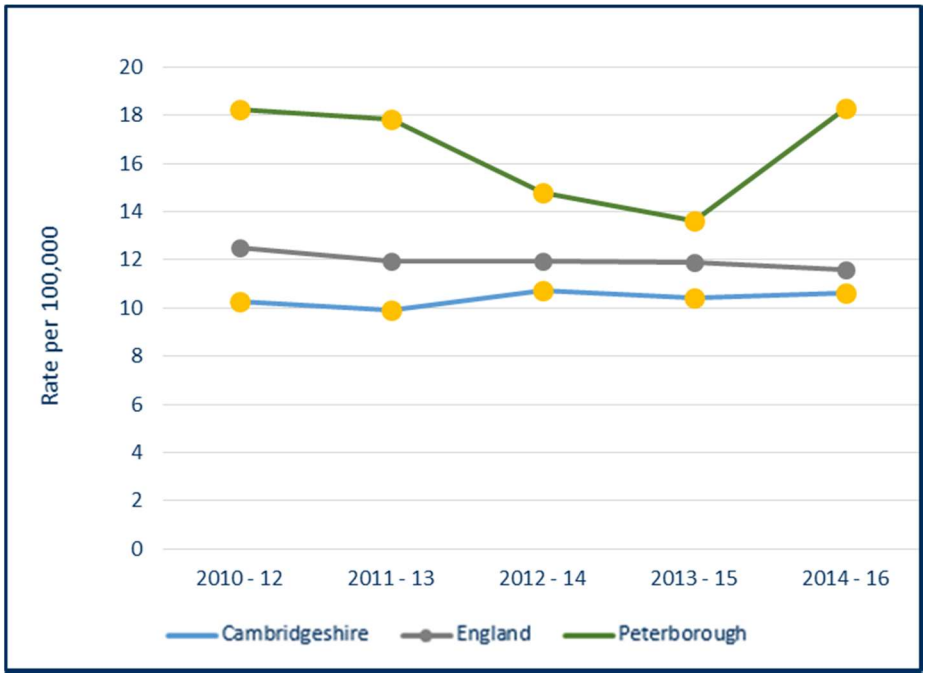
Table 49: Child mortality in persons aged 1-17 years - directly age-standardised rates (DASR) per 100,000 population, 2014-16

Area	Number	DASR per 100,000	95% Confidence Intervals
Cambridgeshire	40	10.6	(7.6 - 14.5)
Peterborough	23	18.3	(11.5 - 27.5)
Cambridgeshire and Peterborough	-	-	-
England	3,882	11.6	(11.3 - 12.0)

Data not available at District level

Source: Office of National Statistics, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Figure 23: Child mortality in persons aged 1-17 years, Cambridgeshire and Peterborough, trend 2010-12 to 2014-16



Source: Office of National Statistics, from PHE Child Health Profiles (https://fingertips.phe.org.uk)

Key points – child mortality

- The rates of child mortality in both Cambridgeshire and Peterborough are statistically similar to the England rate and have been since 2010-12.
- There was a notable increase in rates in Peterborough between 2013-15 and 2014-16.

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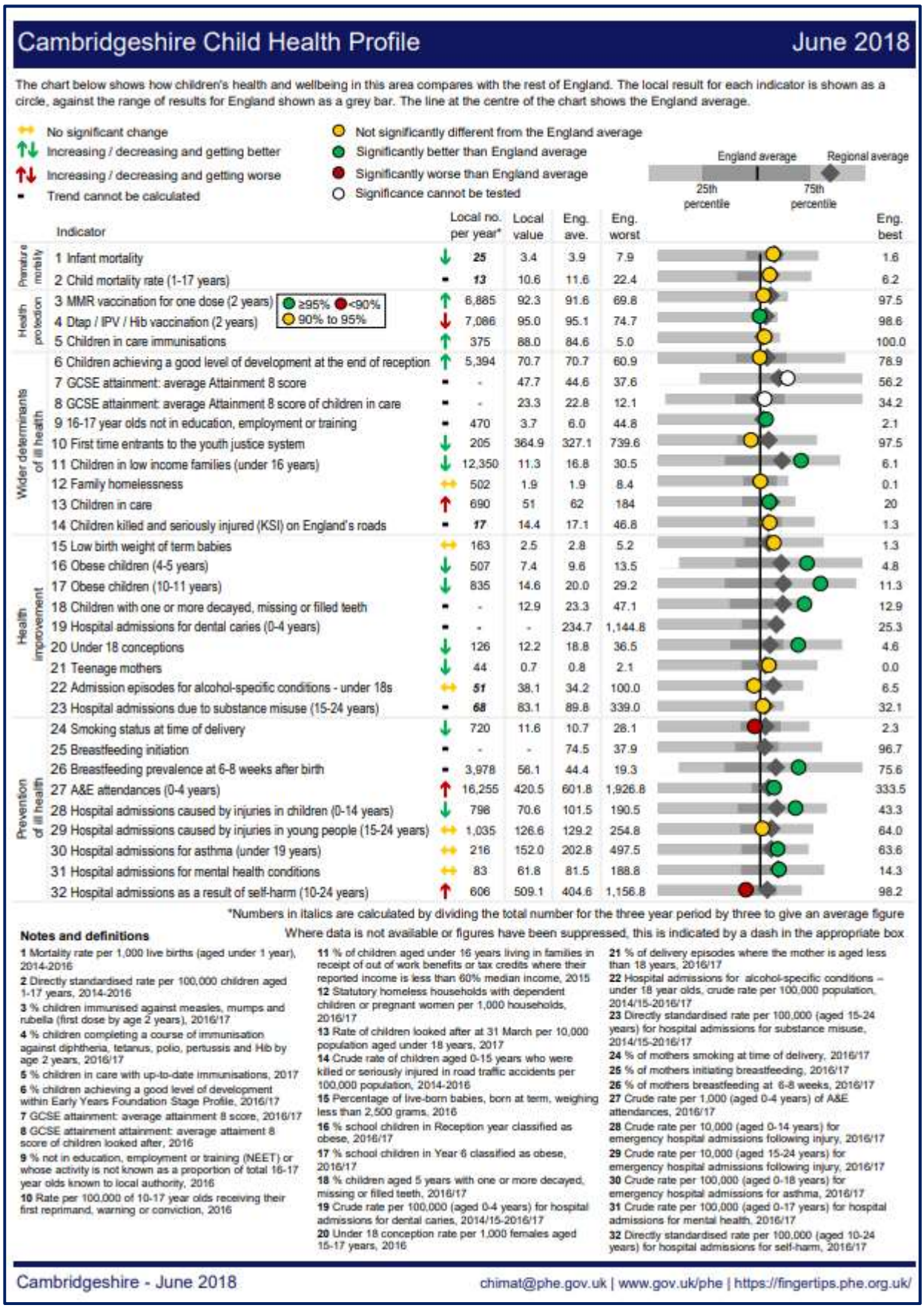
8. Appendices

8.1 Child Health Profile – Cambridgeshire



Cambridgeshire Child Health Profile — June 2018

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

- No significant change
- Increasing / decreasing and getting better
- Increasing / decreasing and getting worse
- Trend cannot be calculated
- Not significantly different from the England average
- Significantly better than England average
- Significantly worse than England average
- Significance cannot be tested

England average | Regional average | 25th percentile | 75th percentile

	Indicator		Local no. per year*	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	↓	*25*	3.4	3.9	7.9	1.6
	2 Child mortality rate (1-17 years)	-	*13*	10.6	11.6	22.4	6.2
Health protection	3 MMR vaccination for one dose (2 years)	↑	6,885	92.3	91.6	69.8	97.5
	4 Dtap / IPV / Hib vaccination (2 years)	↓	7,086	95.0	95.1	74.7	98.6
	5 Children in care immunisations	↑	375	88.0	84.6	5.0	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	↑	5,394	70.7	70.7	60.9	78.9
	7 GCSE attainment: average Attainment 8 score	-	-	47.7	44.6	37.6	56.2
	8 GCSE attainment: average Attainment 8 score of children in care	-	-	23.3	22.8	12.1	34.2
	9 16-17 year olds not in education, employment or training	-	470	3.7	6.0	44.8	2.1
	10 First time entrants to the youth justice system	↓	205	364.9	327.1	739.6	97.5
	11 Children in low income families (under 16 years)	↓	12,350	11.3	16.8	30.5	6.1
	12 Family homelessness	↔	502	1.9	1.9	8.4	0.1
	13 Children in care	↑	690	51	62	184	20
	14 Children killed and seriously injured (KSI) on England's roads	-	*17*	14.4	17.1	46.8	1.3
Health improvement	15 Low birth weight of term babies	↔	163	2.5	2.8	5.2	1.3
	16 Obese children (4-5 years)	↓	507	7.4	9.6	13.5	4.8
	17 Obese children (10-11 years)	↓	835	14.6	20.0	29.2	11.3
	18 Children with one or more decayed, missing or filled teeth	-	-	12.9	23.3	47.1	12.9
	19 Hospital admissions for dental caries (0-4 years)	-	-	-	234.7	1,144.8	25.3
	20 Under 18 conceptions	↓	126	12.2	18.8	36.5	4.6
	21 Teenage mothers	↓	44	0.7	0.8	2.1	0.0
	22 Admission episodes for alcohol-specific conditions - under 18s	↔	*51*	38.1	34.2	100.0	6.5
	23 Hospital admissions due to substance misuse (15-24 years)	-	*68*	83.1	89.8	339.0	32.1
Prevention of ill health	24 Smoking status at time of delivery	↓	720	11.6	10.7	28.1	2.3
	25 Breastfeeding initiation	-	-	-	74.5	37.9	96.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	-	3,978	56.1	44.4	19.3	75.6
	27 A&E attendances (0-4 years)	↑	16,255	420.5	601.8	1,926.8	333.5
	28 Hospital admissions caused by injuries in children (0-14 years)	↓	798	70.6	101.5	190.5	43.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	↔	1,035	126.6	129.2	254.8	64.0
	30 Hospital admissions for asthma (under 19 years)	↔	216	152.0	202.8	497.5	63.6
	31 Hospital admissions for mental health conditions	↔	83	61.8	81.5	188.8	14.3
	32 Hospital admissions as a result of self-harm (10-24 years)	↑	606	509.1	404.6	1,156.8	98.2

≥95% <90% 90% to 95%

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

Notes and definitions

1 Mortality rate per 1,000 live births (aged under 1 year), 2014-2016
2 Directly standardised rate per 100,000 children aged 1-17 years, 2014-2016
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2016/17
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2016/17
5 % children in care with up-to-date immunisations, 2017
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2016/17
7 GCSE attainment: average attainment 8 score, 2016/17
8 GCSE attainment attainment: average attainment 8 score of children looked after, 2016
9 % not in education, employment or training (NEET) or whose activity is not known as a proportion of total 16-17 year olds known to local authority, 2016
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2016
11 % of children aged under 16 years living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2015
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2016/17
13 Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2017
14 Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2014-2016
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2016
16 % school children in Reception year classified as obese, 2016/17
17 % school children in Year 6 classified as obese, 2016/17
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2016/17
19 Crude rate per 100,000 (aged 0-4 years) for hospital admissions for dental caries, 2014/15-2016/17
20 Under 18 conception rate per 1,000 females aged 15-17 years, 2016
21 % of delivery episodes where the mother is aged less than 18 years, 2016/17
22 Hospital admissions for alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2014/15-2016/17
23 Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2014/15-2016/17
24 % of mothers smoking at time of delivery, 2016/17
25 % of mothers initiating breastfeeding, 2016/17
26 % of mothers breastfeeding at 6-8 weeks, 2016/17
27 Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2016/17
28 Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2016/17
29 Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2016/17
30 Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2016/17
31 Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2016/17
32 Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2016/17

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8.2 Child Health Profile – Peterborough

Peterborough Child Health Profile — June 2018

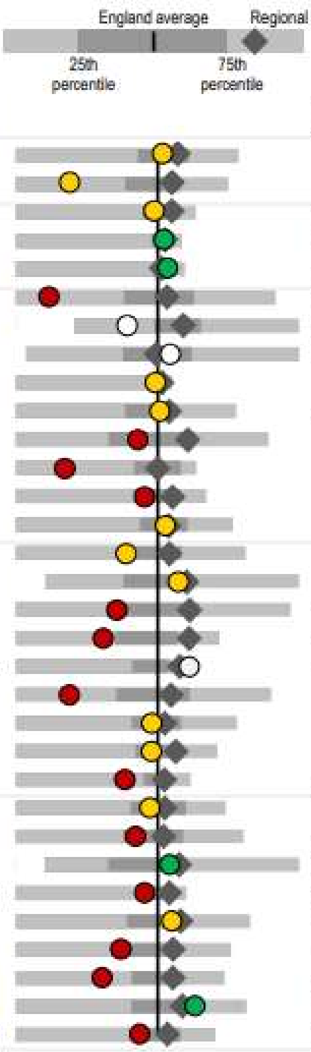
The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

- ↔ No significant change
- ↑↓ Increasing / decreasing and getting better
- ↑↓ Increasing / decreasing and getting worse
- ▪ Trend cannot be calculated

- ○ Not significantly different from the England average
- ● Significantly better than England average
- ● Significantly worse than England average
- ○ Significance cannot be tested

	Indicator	Trend	Local no. per year*	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	↓	*12*	3.7	3.9	7.9	1.6
	2 Child mortality rate (1-17 years)	▪	*8*	18.3	11.6	22.4	6.2
Health protection	3 MMR vaccination for one dose (2 years)	↑	2,676	91.1	91.6	69.8	97.5
	4 Dtap / IPV / Hib vaccination (2 years)	↔	2,821	96.0	95.1	74.7	98.6
	5 Children in care immunisations	↔	230	90.3	84.6	5.0	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	↑	1,999	63.2	70.7	60.9	78.9
	7 GCSE attainment: average Attainment 8 score	▪	-	42.1	44.6	37.6	56.2
	8 GCSE attainment: average Attainment 8 score of children in care	▪	-	23.8	22.8	12.1	34.2
	9 16-17 year olds not in education, employment or training	▪	310	6.6	6.0	44.8	2.1
	10 First time entrants to the youth justice system	↓	58	320.2	327.1	739.6	97.5
	11 Children in low income families (under 16 years)	↓	8,525	18.7	16.8	30.5	6.1
	12 Family homelessness	↑	489	6.2	1.9	8.4	0.1
	13 Children in care	↓	355	73	62	184	20
	14 Children killed and seriously injured (KSI) on England's roads	▪	*7*	15.4	17.1	46.8	1.3
Health improvement	15 Low birth weight of term babies	↔	93	3.3	2.8	5.2	1.3
	16 Obese children (4-5 years)	↔	231	8.9	9.6	13.5	4.8
	17 Obese children (10-11 years)	↔	524	22.6	20.0	29.2	11.3
	18 Children with one or more decayed, missing or filled teeth	▪	-	32.4	23.3	47.1	12.9
	19 Hospital admissions for dental caries (0-4 years)	▪	*5*	31.4	234.7	1,144.8	25.3
	20 Under 18 conceptions	↓	99	29.8	18.8	36.5	4.6
	21 Teenage mothers	↓	24	0.8	0.8	2.1	0.0
	22 Admission episodes for alcohol-specific conditions - under 18s	↓	*18*	37.0	34.2	100.0	6.5
	23 Hospital admissions due to substance misuse (15-24 years)	▪	*33*	147.4	89.8	339.0	32.1
Prevention of ill health	24 Smoking status at time of delivery	↓	306	11.6	10.7	28.1	2.3
	25 Breastfeeding initiation	↓	1,927	68.8	74.5	37.9	96.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	▪	1,452	47.1	44.4	19.3	75.6
	27 A&E attendances (0-4 years)	↑	11,754	722.7	601.8	1,926.8	333.5
	28 Hospital admissions caused by injuries in children (0-14 years)	↓	390	92.5	101.5	190.5	43.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	↔	357	161.7	129.2	254.8	64.0
	30 Hospital admissions for asthma (under 19 years)	↔	163	318.1	202.8	497.5	63.6
	31 Hospital admissions for mental health conditions	↔	26	53.1	81.5	188.8	14.3
	32 Hospital admissions as a result of self-harm (10-24 years)	↑	167	499.8	404.6	1,156.8	98.2

Indicators 3 and 4: ● ≥95% ● <90% ○ 90% to 95%



*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

Notes and definitions

1 Mortality rate per 1,000 live births (aged under 1 year), 2014-2016
2 Directly standardised rate per 100,000 children aged 1-17 years, 2014-2016
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2016/17
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2016/17
5 % children in care with up-to-date immunisations, 2017
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2016/17
7 GCSE attainment: average attainment 8 score, 2016/17
8 GCSE attainment attainment: average attaiment 8 score of children looked after, 2016
9 % not in education, employment or training (NEET) or whose activity is not known as a proportion of total 16-17 year olds known to local authority, 2016
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2016
11 % of children aged under 16 years living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2015
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2016/17
13 Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2017
14 Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2014-2016
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2016
16 % school children in Reception year classified as obese, 2016/17
17 % school children in Year 6 classified as obese, 2016/17
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2016/17
19 Crude rate per 100,000 (aged 0-4 years) for hospital admissions for dental caries, 2014/15-2016/17
20 Under 18 conception rate per 1,000 females aged 15-17 years, 2016
21 % of delivery episodes where the mother is aged less than 18 years, 2016/17
22 Hospital admissions for alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2014/15-2016/17
23 Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2014/15-2016/17
24 % of mothers smoking at time of delivery, 2016/17
25 % of mothers initiating breastfeeding, 2016/17
26 % of mothers breastfeeding at 6-8 weeks, 2016/17
27 Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2016/17
28 Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2016/17
29 Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2016/17
30 Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2016/17
31 Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2016/17
32 Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2016/17

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8.3 Cambridgeshire and Peterborough Children's Outcomes Framework - baseline

Cambridgeshire and Peterborough - Children and Young People's Outcome Framework													
No	Outcome Description	Outcome Measure	Age	Currency (% or rate per)	Time Period	Source	Cambridgeshire			Peterborough			National average
							Number	Denom	Rate	Number	Denom	Rate	
Families enjoy good physical and mental health and have a healthy lifestyle													
1.1	More babies are **born healthy** and have the best chance of survival'	Infant mortality	<1 years	1,000	2013-15	PHOF 4.01	68	22,103	3.1	35	9,489	3.7	3.9
		Child morality	1-17 yrs	100,000	2013-15	CHP	39	372,443	10.4	18	130,609	13.6	11.9
		Low birth weight of term babies	-	%	2015	PHOF 2.01	111	6,245	1.8%	78	3,946	2.6%	2.8%
1.2	Less children attend hospital as an emergency	A&E attendances	0-4 yrs	1,000	2015/16	CHP	16,080	38,587	416.7	12,763	15,940	800.7	587.9
		Unplanned admissions for asthma, diabetes and epilepsy : CCG indicator	< 19 yrs	100,000	2014/15	CCG OIS - Indicator 2.7	611	199,466	309.2	611	199,466	309.2	327.0
		Hospital admissions for asthma	<19 yrs	100,000	2015/16	CHP	232	140,708	164.9	143	50,050	285.7	202.4
1.3	More Children and Young People have better oral health to prevent tooth decay and promote **dental** health.	Children with one or more decayed, missing or filled teeth	5 yrs	%	2014/15	CHP			16.9%			30.0%	24.8%
		Five year old children free from dental decay	5 yrs	%	2014/15	PHOF 4.02	1,076	1,308	83.1%	201	280	70.0%	75.2%
1.4	Children and Young People are safe and protected, resulting in a reduction of hospital admissions caused by **unintentional injuries** in Children and Young People.	Hospital admissions caused by unintentional and deliberate injuries in children	0-4 yrs	10,000	2015/16	PHOF 2.07i	406	38,587	105.2	212	15,940	133.0	129.6
			<15 yrs	10,000	2015/16	PHOF 2.07i	876	111,495	78.6	464	40,868	113.5	104.2
1.5	Children and Young People are safe and protected, resulting in a reduction of the number of Children and Young People killed or seriously injured **(KSI)** on Cambridgeshire and Peterborough roads.	Children killed or seriously injured in road traffic accidents	<16 yrs	100,000	2013-15	CHP	49	350,650	14.0	18	126,080	14.3	17.0
1.6	More Children and Young People are a healthy **weight.**	Excess weight (overweight and obese)	4-5 yrs	%	2015/16	PHOF 2.06i	1,270	6,805	18.7%	632	2,771	22.8%	22.1%
			10-11 yrs	%	2015/16	PHOF 2.06ii	1,592	5,646	28.2%	794	2,320	34.2%	34.2%
		Obese children	4-5 yrs	%	2015/16	CHP	468	6,805	6.9%	259	2,771	9.3%	9.3%
			10-11 yrs	%	2015/16	CHP	840	5,646	14.9%	460	2,320	19.8%	19.8%
1.7	More babies are **fed breastmilk**, through an increase in breastfeeding initiation and prevalence.	Breastfeeding initiation	At birth	%	2013/14 (n/a 14/15)	PHOF 2.02i	5,860	7,063	83.0%	2,137	2,931	72.9%	74.3%
		Breastfeeding prevalence at 6-8 weeks after birth	6-8 weeks	%	2015/16	PHOF 2.02ii	4,017	7,276	55.2%	1,392	3,179	43.8%	43.2%
1.8	More Pregnant Women, Parent /Carers, Children and Young People are **smoke free**, reducing the prevalence of smoking in Cambridgeshire and Peterborough	Smoking status at time of delivery Note : Hospital based and where smoking status is known	All ages	%	2015/16	CCG data submissions	-	-	10.2%			15.3%	10.8%
		Smoking Prevalence	18 and over	%	2015	PHOF 2.14	-	-	16.4%			18.1%	16.9%
1.9	Children and Young People, Parents and Carers are supported to reduce **substance misuse.**	Hospital admissions due to substance misuse	15-24 yrs	100,000	2013/14 - 2015/16	CHP	213	247,447	85.9	96	68,574	139.9	95.4
		Hospital admissions due to alcohol specific conditions	<18 yrs	100,000	2012/13-2014/15	CHP	125	390,602	32.0	59	137,418	42.9	36.6
		Children in treatment for substance misuse	Age?		?	Local							
1.1O	Children and Young People, Parents and Carers are supported to reduce **teenage conception**s and improve **sexual health**.	Under 18 conceptions	<18 yrs	1,000	2014	PHOF 2.04	171	10,553	16.2	102	3,374	30.2	22.8
		Under 18 conceptions: conceptions in those aged under 16	<16 yrs	1,000	2014	PHOF 2.04	38	10,207	3.7	22	3,271	6.7	4.4
		Teenage mothers	<18 yrs	%	2015/16	CHP	47	7,149	0.7%	39	3,071	1.3%	0.9%
		Chlamydia proportion aged 15-24 screened	15-24 yrs	%	2015	SRHP	17,080	82,458	20.7%	4,203	22,763	18.5%	22.5%
		Chlamydia detection	15-24 yrs	100,000	2015	PHOF 3.02	1,050	82,458	1,273	569	22,763	2,499	1,887
		Long acting contraceptive use (excluding injections at SRH services)	<24 yrs	%	2014	SRHP	610	2,924	20.9%	318	1,423	22.3%	20.1%
		Abortions (%)	<18 yrs	%	2014	SRHP	95	171	55.6%	35	102	34.3%	51.1%
		Under 25s repeat abortions (%)	15-24 yrs	%	2015	SRHP	107	515	20.8%	75	318	23.6%	26.5%

Cambridgeshire and Peterborough - Children and Young People's Outcome Framework													
No	Outcome Description	Outcome Measure	Age	Currency (% or rate per)	Time Period	Source	Cambridgeshire			Peterborough			National average
							Number	Denom	Rate	Number	Denom	Rate	
Families enjoy good physical and mental health and have a healthy lifestyle													
1.11	Improved **mental health** in children and young people	Add indicators from the CAMH minimum data set			In development								Not available
		Emotional well-being of lac - average total of strengths and difficulties score for all looked after children in care for at least 12 months	5-16 yrs	Value	2015/16	PHOF 2.08	-	-	14.7		16.3	-	14.0
1.12	Improved access to **mental health support** for Children and Young People & their families	Hospital admissions for self harm	10-24 yr olds	100,000	2015/16	CHP	763	117,238	635.2	273	34,008	798.7	430.5
		Under 18 year olds attending A&E primarily for mental health issues	<18 years		In development								Not available
		Add indicators from the CAMH minimum data set	<18 years										
		Maternal mental heatlh			In development								
1.13	Increased population **immunisation** coverage and **screening** for Children and Young People to reduce prevalence of preventable ill health.	Population vaccination coverage - Hepatitis B	1 yr	%	2014/15	PHOF 3.03i	-	-	-	14	15	93.3%	-
			2 yrs	%	2014/15	PHOF 3.03i	-	-	-	15	17	88.2%	-
		Immunisation targets met - 1 year olds (3 immunisations)	1 yr	%	2015/16	PHOF 3.03	-	-		-	-		
		Immunisation targets met - 2 year olds (4 immunisations)	2 yrs	%	2015/16	PHOF 3.03	-	-		-	-		
		Immunisation targets met - 5 year olds (3 immunisations)	5 yrs	%	2015/16	PHOF 3.03	-	-		-	-		
		Population vaccination coverage - HPV	12-13 yrs	%	2014/15	PHOF 3.03xii	2,760	3,118	88.5%	1,056	1,147	92.1%	89.4%
		Children in care with up to date immunisations	<18 yrs	%	2016	CHP	335	375	89.3%	200	225	88.9%	87.2%
		Newborn bloodspot screening	Newborn	%	2015/16	PHOF 2.21xi	6,308	6,400	98.6% *	1,891	1,918	98.6% *	95.6%
		Newborn hearing screening	Newborn	%	2015/16	PHOF 2.21xii	7,319	7,364	99.4%	3,206	3,208	99.9%	98.7%
Children are ready for and attend school, and make expected progress													
2.1	More Children and Young People achieve positive physical and emotional milestones (contributing to improved rates of **school readiness**).	School Readiness: The percentage of children achieving a good level of development at the end of reception	5 yrs	%	2015/16	PHOF 1.02i	5,280	7,573	69.7%	1,937	3,079	62.9%	69.3%
		School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	5 yrs	%	2015/16	PHOF 1.02i	364	739	49.3%	284	526	54.0%	54.4%
		School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	6 yrs	%	2015/16	PHOF 1.02ii	5,717	7,309	78.2%	2,388	3,117	76.6%	80.5%
		School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	6 yrs	%	2015/16	PHOF 1.02ii	395	679	58.2%	334	485	68.9%	68.6%
		Percentage of children who score above the cut off in the 5 domains of child development (communication, gross motor skills, fine motor skills, problem solving and personal-social skills) as measured by ASQ 3	2-2.5 yrs	National indicator in development									
2.2	More Children and Young People improve **academic** results, particularly the most disadvantaged children, to close the **attainment** gap between the most and least deprived	GCSE achieved 5A*-C inc. Eng & Maths	16 yrs	%	2015/16	CHP	3,552	5,807	61.2%	1,053	2,204	47.8%	57.8%
		GCSE achieved 5A*-C inc. Eng & Maths with free school meal eligibility	16 yrs	%	2014/15	DFE	122	521	23.4%	76	308	24.7%	33.3%
		Children in Care who GCSE achieved 5A*-C inc. Eng & Maths	16 yrs	%	2015	CHP	7	30	23.3%	No data - small numbers			13.8%
2.3	More Children and Young People develop and achieve their potential, through improved rates of school **attendance**.	Pupil absence (Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence) - Secondary and Primary Schools	5-15 yrs	%	2014/15	PHOF 1.03	1,168,104	25,666,040	4.55%	487,743	10,401,499	4.69%	4.62%
Adults and young people have the skills, qualifications and opportunities to succeed in the employment market and make a positive contribution													
3.1	More 16-18 year olds are able to achieve their potential, through increasing percentage of 16-18 yr. olds in Employment Education and Training and reducing numbers Not in Employment Education and Training (**NEET**).	Not in education employment or training	16-18 yrs	%	2015	PHOF 1.05	670	19,740	3.4%	360	6,760	5.3%	4.2%

Cambridgeshire and Peterborough - Children and Young People's Outcome Framework														
No	Outcome Description	Outcome Measure	Age	Currency (% or rate per)	Time Period	Source	Cambridgeshire			Peterborough			National average
							Number	Denom	Rate	Number	Denom	Rate	
Families are protected from harm and neglect and are provided with support with their problems before they become too difficult to manage, increasing their resilience													
4.1	Children and Young People are safe and protected.	Children in care (Continuously LAC for 12 months)	<18 yrs	10,000	2015	DFE	335	131,490	25.5	250	46,607	53.6	41.1
Families contribute to the community and are not engaging in anti-social or offending behaviour													
5.1	Parents, Carers, Children and Young People are supported to reduce youth **offending**.	First time entrants to the youth justice system	10-17 yrs	100,000	2015	PHOF 1.04	148	55,906	264.7	102	18,012	566.3	368.6

Key

- Statistically significantly higher/worse than England
- Statistically similar to England
- Statistically lower/better than England

Immunisation target

- The 90% coverage target was met for < 50% of the immunisations in this age group
- The 90% coverage target was met for 50-90% of the immunisations in this age group
- The 90% coverage target was met for over 90% of the immunisations in this age group

'-' denotes data not available due to suppression/disclosure rules
'*' denotes value estimated from former provider

PHOF	Public Health Outcomes Framework	http://www.phoutcomes.info/
CHP	Child Health Profiles	http://fingertips.phe.org.uk/profile/child-health-profiles
SHRP	Sexual and Reproductive Health Profiles	http://fingertips.phe.org.uk/profile/sexualhealth
CYPB	Children and young people benchmarking tool	http://fingertips.phe.org.uk/profile/cyphof
DFE	Department for Education	GCSE - free school meals
		Children in care + mid 2014 population estimates ONS

Chlamydia screening - detection rates

- Detection rate under 1,900 per 100,000
- Detection rate between 1,900 and 2,300 per 100,000
- Detection rate over 2,300 per 100,000

Under 18s conceptions leading to abortion (%)

- Statistically lower than England
- Statistically similar to England
- Statistically significantly higher than England

Note : Smoking in pregnancy data is based on CUHFT + Hinchingbrooke for Cambridgeshire and PSHFT for Peterborough and where smoking status is known - which differs from the indicator used in PHOF

https://www.gov.uk/government/statistics/revised-gcse-and-equivalent-results-in-england-2014-to-2015
https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015

Appendix 2 service changes

0-5 Universal	Current	Future	Impact
Antenatal Contact From 28 weeks gestation	- Targeted offer - 50% of total births	- Targeted offer - 95% of First time parents and vulnerable parents	- Improved offer targeted at first time and vulnerable parents
New Birth Visit 10-14 days	- Universal Offer - 98% Target	- No Change to Offer	- Meet 98% Target
6-8 week review	- Universal offer - 95% Target	- No change to offer	- Meet 95% Target
9-12 month review	- 50/50 HV/NN - Home visit - By 12mth 90% - By 15mth 95%	- 10% HV, 90%NN with HV oversight - Continue home visits - Same targets	- Right skills – utilising registered workforce effectively based on clinical needs of child and parents - Achieve targets
2-2.5 year review	- 40/60 split HV/NN - Target 90% - ASQ3 (100%)	- 10% HV, 90% NN with HV oversight - Target 90% - ASQ3 (100%) and target ASQ SE	- Right skills – utilising registered workforce effectively based on clinical needs of child and parents - Achieve targets - Impact of SE – early identification of social/emotional deficits
2-2.5 integrated review	- Cambs – integrated approach (information sharing with separate reviews in health and early years) P'boro – share information & targeted joint review	- Information sharing to continue, with targeted integrated review depending on need.	- Early years, Health and Parents have shared information and a joint plan to support early intervention. Most at risk children have a combined approach to assessing learning and development – supporting improving Early Years Foundation Skills at reception entry
Healthy child clinics	- Delivered by HV and Nursery Nurse. - Currently 172 per month across C&P	- Delivered by NN overseen by HV - No change in No. of clinics Year 1 (may change once digital service launched) - Explore having weighing stations in public places eg Child & Family/Children's Centre's/Libraries	- Right skills, right time, right place - Improved & flexible & timeliness access to support & advice
Feeding Clinics	- Cambs feeding clinics appointment based (all types of feeding)	- Open access for all feeding support across C&P	- Equality of access and support for all feeding issues

	- P'boro-baby café – open access only for breastfeeding mothers (licensed)		
Introducing solids workshops	- Cambs only	- P'boro & Cambs	- Equality of access and support - Evidence impact of early weaning leads to increased obesity
Transfers-in reviews	- Review of clinical records and targeted visit for any children moving into area	- No change	- Identification of health need
A & E notification and Follow Up	- Cause for concern sheets received from A&E depts. - Review of clinical record and follow up telephone call	- No change	- Identifying regular attenders to A&E with a thematic review of risk to identify any increased risk or health need.
Parentline Text back service for parents of children aged 0-19 yrs	- No Offer	- Implement parentline	- For those who don't have digital resources – can access via Single Point Access
Enhanced digital resources	- Minimum offer	- Coproduced enhanced digital offer	- Improved access to service
Single Point Access (SPA) clinicians	- Access via duty desks	- Access through SPA clinical staff	- Telephone access to SPA clinician
0-5 Universal Plus			
Behavioral and Development support	- 40/60 HV/NN. - oversight by HV - Use of Solihull Pack - 1-4 visits on specific problems	- 10% HV 90% HV - future systems focus formulation could lead to reduction in duplication of support from other providers	- Early identification & support - Reduction of referrals to specialists services
Nutritional support (complex feeding)	- Home visits - 50/50 HV/NN	- Home visit - 25/75 HV/NN	- Right skills, right place, right time
Maternal mental health	- HV - 2-6 listening visits at home	- HV - Practitioners supported by specialist perinatal mental health practitioners	- Early support & intervention - Specialist Practitioners Will have enhanced skill set to support more complex parents
Neonatal Blood spot	Any baby older than 28 days who requires a repeat screening sample must be offered and, where accepted, have a repeat sample taken by a trained Bloodspot Screener from the Provider and sent to the laboratory for processing.	- No change	- No Change

	If there are any positive results the family will have results shared with them by a trained HV		
CONI (+)	- support to parents who are expecting a new baby where either parent has previously experienced the death of a child (less than 2 years of age) through sudden unexpected death. - HV	- No change	- Continue to support families through a difficult and traumatic time.
Teenage parents support	- 200 FNP places commissioned across P'boro & Cambs	- 100 FNP places for the most vulnerable teenagers. Enhanced teenage parent pathway for all other teenage parents	- All teenage parent receive the appropriate level of support
0-5 Universal Partnership Plus			
Safeguarding	- Support Child Protection and Child in Need assessments and any interventions	- Streamlining case conference reporting to ensure quality and consistency and greater use of electronic case recording system - supported by training	safeguarding responsibilities will be met in a way that is efficient and less resource intensive freeing up capacity for other work
Early Help Assessments	- Appropriate referral to Early Help Hub	- No change	- No Change
Education Care Plans	- Support development	- No change	- No Change

5-19 Universal	Current	Future	Impact
School profiling/liaison	- Adhoc - SN	- Annual review & discussion with schools - SN	- Targeted HCP support - Right skills
Health Screening: Digital questionnaire at key transition points . (YR,Y5,Y9)	- P'boro Paper based questionnaire to specified year groups - Cambs Information leaflet on how to access service	- Digital (plus support for those not digitally literate) - Targeted intervention	- Identification of health requirements & needs - Improve efficiency/capacity moving from paper to digital - Right skills
Vision Screening (Cambs only)	- Cambs only	- Continue to deliver, subject to future commissioning intentions	- Right skills, right time, right place
NCMP, Hearing and Vision screening	- Peterborough only	- Continue to deliver subject to future commissioning intentions	- Right skills, right time, right place
Transfers-In	- Clinical review of records SN	- No change	- Identification of health need
A&E notification and follow up	- Admin tasks – admin - Triage + Follow up by most appropriate skilled practitioner	- No change	- Identifying regular attenders to A&E with a thematic review of risk to identify any increased risk or health need.
Drop in clinics	- P,boro only. SN	- No drop in	- Chat health + SPA provide virtual drop in links to appt clinics in f2f near
HYPA led by ICASH just sexual health	- P'boro only, in some secondary schools - SN	- HYPAS continue without SN support as they were not being utilised effectively	- Releases SN capacity - Right skills – for issues young people were attending clinics for.
SPA Chathealth Telephone advice	- Chathealth in Cambs only - Telephone through duty	- Across C&P - Through SPA clinicians	- For those who don't have digital resources – can access via Single Point of Access
5-19 Universal Plus			
Enuresis	- NN/SN - Weekly, term-time only	- NN with SN oversight	- Evidenced based Intervention - Excellent engagement by families - Reduces attendance at Acute/specialist settings
Medicine Management face to Face	- P'Boro	- Across C&P	- Improved health knowledge in school settings, where there are children with complex needs attending
Young People Appointment clinics for Primary	- Peterborough once a term only, targeted to	- Across C & P - Targetted to 50% of Primary Schools	- Improved access - Parents as partners

School Age Children (child & parent)	schools in deprived wards. - SN only	- 6hrs per term - Split between SN/NN	- Early Identification of health issues
Themed sessions	- PSHE-P'boro	- Targetted according to school pop comm profile	- PSHE-school delivery - Themed session – based on robust needs assessment which may change to reflect changing population.
Young Peoples Appointment Clinics for Secondary Age Children. (Young People only)	- Both C & P - SN only	- SN assessment - Intervention by right person, right skill - Targetted to 40% of most deprived secondary schools	- Release SN Capacity - Right Skill, Right time - Increase workforce expertise and knowledge
5-19 Universal Partnership Plus			
Safeguarding	- Support Child Protection and Child in Need assessments and any interventions	- Streamlining case conference reporting to ensure quality and consistency and greater use of electronic case recording system - supported by training	safeguarding responsibilities will be met in a way that is efficient and less resource intensive freeing up capacity for other work
Early Help Assessments	- Appropriate referral to Early Help Hub	- No change	- No Change
Education Care Plans	- Support development	- No change	- No Change

Key
HV: Health Visitor
NN: Nursery Nurse
SN: School Nurse

Service User Experience

Jade, a mum to a 3month old baby girl who has not been feeding well over the last couple of days. Her mum has told her to start the baby on some solid food but Jade know's that isn't right. She is feeling very tired and just wants the baby to settle down. Her next baby clinic is 5 days away and although there are other clinics in the city she is anxious about going somewhere new. Jade continues to try and breastfeed her baby, places a call to the Health Visitor and leaves a message on the answerphone.

Current possible outcome:

Health visitor calls Jade back but receives no answer, leaves a message asking Jade to call back or come to the baby clinic. Jade misses the call and is too tired to call back, the baby becomes more unsettled. The baby doesn't seem to be very alert and Jade is worried ,so takes the baby to the GP surgery, baby has sunken fontanelle and appears dehydrated and is sent into A&E. Baby is found to be severely dehydrated and is started on a drip and has an nasogastric tube inserted to give her some formula feed. Jade continues to try and breastfeed but baby does not want to feed. Baby is discharged within 48 hour and is now fully formula fed. Jade feels like a failure as a mum because she is unable to continue to breastfeed, her anxiety is increased and she becomes more isolated leading to her becoming depressed and interacting less with her baby.

Future possible outcome.

Jade has texted Parentline and receives a response from a Health Visitor in the Single point of access team. This is followed up by a phone call to Jade with Jade walking the Health Visitor through the feeding problems. A home visit is arranged with a nursery nurse the following morning to observe a feed and to talk through the baby's neuro-biological development. Explaining that the baby's vision is becoming more defined and therefore they often have periods of fussy feeding due to this, and that this isn't a sign that the baby needs solid food. However the baby may need to have different experiences to stimulate its visual connections, such as going outside and seeing the sky, to experiencing new visual sights. The nursery Nurse also talks to Jade about trying out a mother and baby group at the local Child&Family/ Children's centre where she could meet other mums, and discusses access to the local feeding clinic if she has any further concerns.

The future outcomes have a greater impact for not only the outcomes for Jade and her baby but as a health system in preventing a GP appointment, A&E attendance and admission.

The ability for parents to receive quick easy access to Health support early means that our Specialist Community Public Health Nurses and their team are able to meet the prevention agenda effectively and efficiently, by utilising the right skills at the right time for the right outcome.

Staff experience

15-year old presents with Emotional health concerns.

Currently there might be a School Nurse supporting the young person, but would have to wait for an appointment in the school appointment clinic/drop-in. The young person may

have spoken to someone in school to facilitate ‘a referral’. However, due to recruitment pressures the young person might have to wait longer for an appointment.

New Service

In the new model there is the opportunity for a Band 4 Assistant Practitioner to support this family and the support would be offered in a more timely way.

The young person has made contact with the service via ChatHealth. They were made aware of this service as her school has a dedicated ChatHealth School Ambassador, who had spoken in a Year 11 assembly. She had also seen a YouTube animation about it. A ‘conversation’ had started via ChatHealth and over the next few days the School Nurse on duty assessed that the young person would benefit from a face-to-face intervention to address the health need. The intervention would be delegated to the Assistant Practitioner in the team, who is linked to this particular school.

The Assistant Practitioner would be educated to degree level and would be a post-graduate from either a psychology, social work or children and families education route. There would be the opportunity to undertake additional learning. Two examples are: the foundation Solihull training and the CAMHS foundation module. This would provide them expertise when offering interventions and strategies to support young people around emotional health, anxiety and self-esteem. They will use a goals based outcome approach. They would be supervised by the School Nurse and could access the Emotional Health and Wellbeing Team for additional support/resources.

Appendix 3

HCP WORKFORCE UPDATE

1. Background

1.1 The 0-19 Healthy Child Programme is delivered through three key service elements:

- Health Visiting
- School Nursing
- Family Nurse Partnership

1.2 Health Visitors and School Nurses are qualified and registered nurses or midwives, who may have undertaken further training to become a Specialist Community Public Health Nurse (SCPHN) and work in teams with a range of skill mix.

1.3 In April 2013, local authorities took on the statutory responsibility of delivering and commissioning public health services, including the school nursing services. Subsequently Health Visiting was transferred to the Local Authority in October 2015. Cambridgeshire currently commissions the service from Cambridgeshire Community Services NHS Trust (CCS), a local health provider.

2. Main Issues

2.1 Health Visiting.
Nationally, since the completion of Call to Action in 2015, the Health Visiting workforce has decreased by 10% per year. This figure is in part attributed to the age profile of the workforce, with over 30% eligible for early retirement. Locally, the picture is similar.

2.2 School Nursing
Similar to Health Visiting, between 2014 and 2018 nationally, the school nursing workforce has decreased, and this is mirrored locally. In March 2017, CCS reported staffing issues within the school nursing service due to staff leaving, combined with long term sickness. The Royal College of Nursing recognised in 2017 that this was a national issue, and identified a reduction in the number of full time school nurses of 16% between 2010 and 2017. At the same time, the number of school aged children in the population is rising, and forecast to rise further over the next 5 years. Between 2016 and 2021, it is forecast that the number of children aged between 11 and 16 will rise by 14.7%, and this trend continues to 2026.

2.3 The purpose of this summary is to:

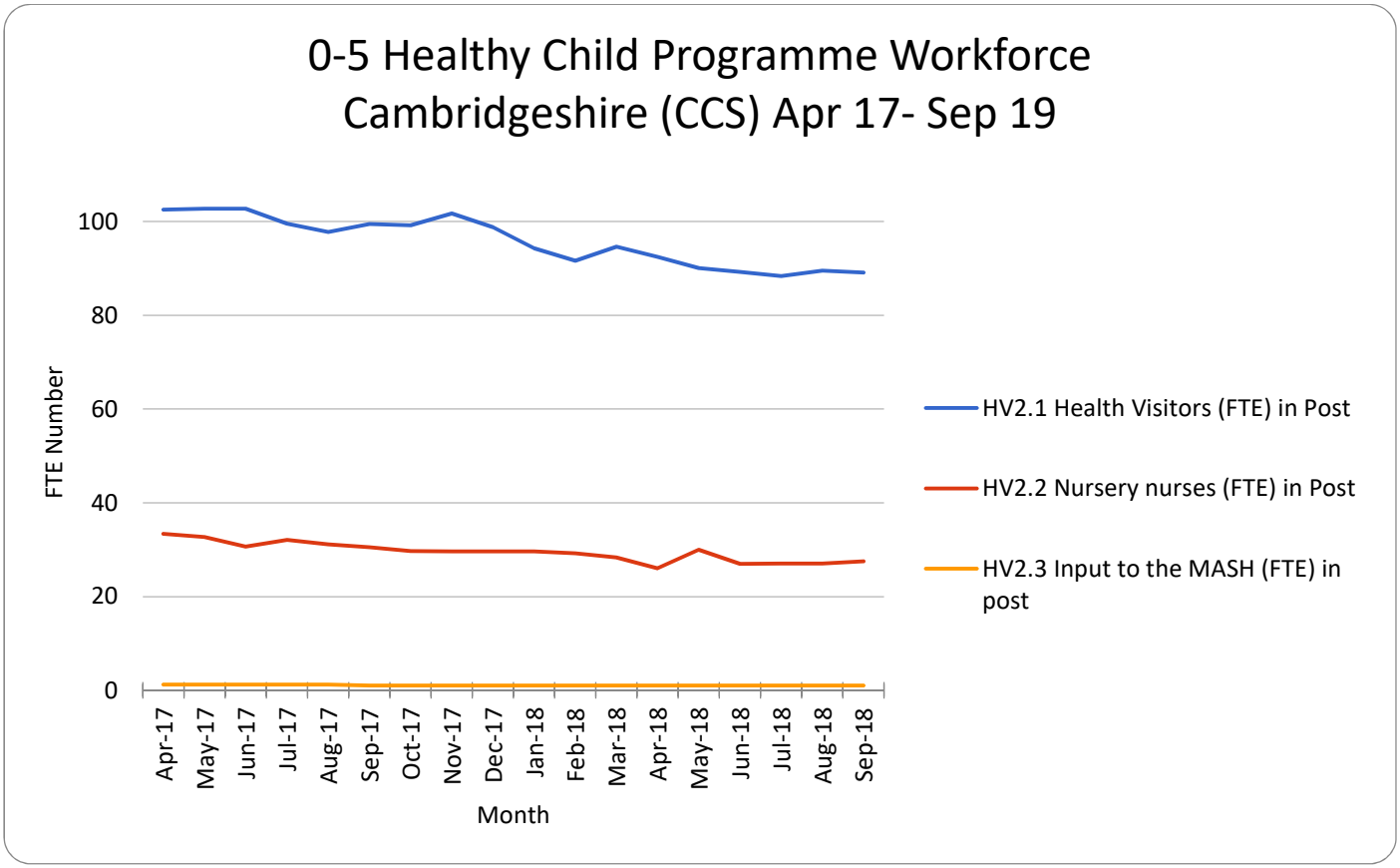
- Provide workforce figures to show:
  - Changes in workforce numbers from April 2017 to September 2018
  - An overview of the age profile of staff in the Health Visiting and School Nursing services
- Summarise the actions that CCS is taking to address both the recruitment and retention of staff.

3. Summary of workforce statistics 1 April 2017 – 30 September 2018

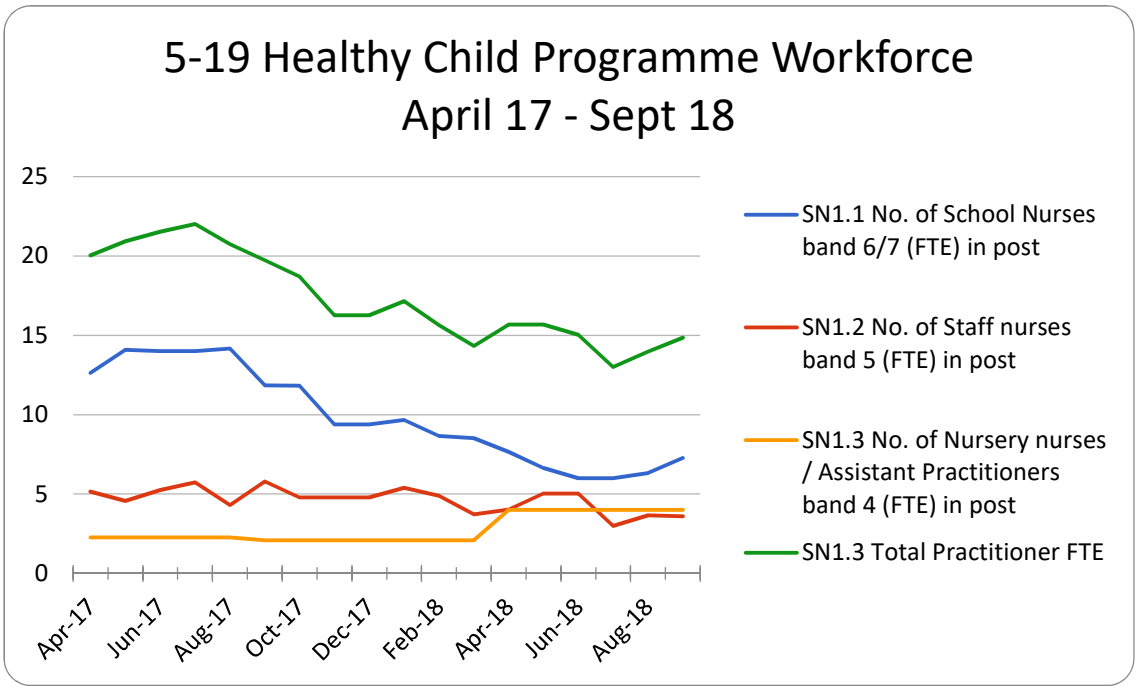
The following charts show the changes in staffing numbers from April 2017 to date. The charts show that Health Visitor and Nursery Nurse numbers are currently stable, following a steady decline since April 2017. School Nursing numbers have recently started to improve following a similar period of decline.

The figure at 3.3 highlights the challenge faced by an ageing workforce. 29% of Health Visitors are currently over the age of 55. The School Nursing workforce is younger, however most staff are over 40, with very few younger staff.

3.1 Health Visitor staff in post 1 April 2017 – 30 September 2018



3.2 School Nursing staff in post 1 April 2017 – 30 September 2018



3.3 Age profile of qualified Health Visiting and School Nursing Staff in Cambridgeshire

	Headcount								
	Age Profile								
Role Descriptions	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**
Health Visitor Community Services	1%	2%	10%	21%	13%	17%	10%	23%	5%
Qualified School Nurse - School Nursing	0%	7%	7%	0%	29%	29%	29%	0%	0%

4. Actions to address workforce pressures

4.1 Skill mix

In order to develop a sustainable and effective service model, the Trust has undertaken a workforce modelling and service capacity exercise and proposed a service model which makes use of changes to skill mix to deliver effective services which meet the requirements of the Healthy Child Programme, within a realistic staffing level.

4.2 Safeguarding

A significant proportion of the time of qualified staff is spent on safeguarding. Current processes have been reviewed and streamlined to ensure that working practices meet safeguarding requirements, but the paperwork required has been streamlined so that less time is spent on report-writing, but time spent attending case conferences is protected.

4.3 Recruiting and retaining staff

Other measures that are being implemented to improve recruitment and retention within the HCP service are:

- Increasing the number of students in training e.g. there are 9 Health Visitor and 5 School Nurse students who are due to qualify as Specialist Community Public Health Nurses SCPHN) in August 2019
- Establishing a rolling programme of "Growing our own" from the Trusts current Band 4 workforce, so that there will always be people on the Nursing programme who once they have completed this, will then have the opportunity to do the SCPHN qualification. There are currently 3 Band 4 staff who have started the nursing programme, and this will be extended to other staff as part of the rolling programme.
- Within the service model the Trusts have included a Band 5 development role that will then lead to undertaking the SCHPN qualification
- The service model has also included new Band 5 roles within the 5-19 offer that do not require nursing qualification and therefore will attract other expertise such as graduate psychologists, youth workers etc.
- The Trusts have agreed a Recruitment and Retention Premium (RRP) across both organisations for roles within Cambridgeshire city, Peterborough and Fenland where there are recruitment hotspots.

5. Summary

Following a steady decline in the numbers of staff in post in both the Health Visiting and School Nursing services, numbers appear to have stabilised in recent months. It is too early to know whether this position will be maintained in the medium term.

The Trust continues to take actions to improve staffing levels through improved role design, increasing the numbers in training, and financial incentives in areas where recruitment is particularly difficult.

Strategically, the proposed service offer is based on a sustainable service model which will use skill mix to ensure that service standards are met within the resource envelope.

Health visitor service delivery metrics: 2017 onwards in Cambridgeshire and Peterborough

Quarterly and annual datasets and commentary for local authority health visits to pregnant women, children and their families during pregnancy and early childhood.

2017/18

	2017/18 Quarter 1 (July 2018 release)							2017/18 Quarter 2 (July 2018 release)						
	C2: New birth visits within 14 days	C3: New birth visits after 14 days	C8i: 6 - 8 week reviews	C4: 12 mth reviews by 12 mths of age	C5: 12 mth reviews by 15 mths of age	C6i: 2.5 yr reviews by 2.5 yrs of age	C6ii: 2.5 yr reviews using ASQ 3	C2: New birth visits within 14 days	C3: New birth visits after 14 days	C8i: 6 - 8 week reviews	C4: 12 mth reviews by 12 mths of age	C5: 12 mth reviews by 15 mths of age	C6i: 2.5 yr reviews by 2.5 yrs of age	C6ii: 2.5 yr reviews using ASQ 3
England	86.2%	11.2%	81.6%	74.4%	82.6%	75.7%	90.7%	88.0%	9.9%	84.3%	75.4%	82.5%	75.8%	92.1%
Cambridgeshire	94.6%	2.8%	93.4%	87.2%	87.2%	80.8%	45.9%	95.2%	2.9%	86.2%	80.5%	87.3%	78.8%	87.9%
Peterborough	90.0%	6.0%	87.9%	80.3%	95.4%	71.9%	93.1%	91.4%	6.0%	87.3%	82.6%	94.3%	80.0%	94.9%

	2017/18 Quarter 3 (July 2018 release)							2017/18 Quarter 4 (July 2018 release)						
	C2: New birth visits within 14 days	C3: New birth visits after 14 days	C8i: 6 - 8 week reviews	C4: 12 mth reviews by 12 mths of age	C5: 12 mth reviews by 15 mths of age	C6i: 2.5 yr reviews by 2.5 yrs of age	C6ii: 2.5 yr reviews using ASQ 3	C2: New birth visits within 14 days	C3: New birth visits after 14 days	C8i: 6 - 8 week reviews	C4: 12 mth reviews by 12 mths of age	C5: 12 mth reviews by 15 mths of age	C6i: 2.5 yr reviews by 2.5 yrs of age	C6ii: 2.5 yr reviews using ASQ 3
England	88.6%	9.5%	85.7%	76.5%	83.3%	76.1%	91.5%	88.5%	9.7%	84.9%	77.6%	82.1%	76.4%	88.7%
Cambridgeshire	95.3%	2.8%	89.9%	83.3%	81.2%	80.7%	91.7%	95.8%	2.2%	84.3%	78.5%	85.2%	76.9%	93.7%
Peterborough	90.4%	6.3%	88.8%	84.8%	93.9%	87.6%	96.4%	89.5%	7.2%	89.1%	82.9%	91.6%	79.3%	-

2018/19 – Quarter 2 provisional, data supplied from Performance monitoring workbooks

	2018/19 Quarter 1 (October 2018 release)						
	C2: New birth visits within 14 days	C3: New birth visits after 14 days	C8i: 6 - 8 week reviews	C4: 12 mth reviews by 12 mths of age	C5: 12 mth reviews by 15 mths of age	C6i: 2.5 yr reviews by 2.5 yrs of age	C6ii: 2.5 yr reviews using ASQ 3
England	88.3%	9.2%	85.5%	77.0%	81.9%	76.5%	89.2%
Cambridgeshire	95.3%	2.4%	85.0%	71.2%	85.1%	64.8%	94.1%
Peterborough	90.1%	7.4%	88.3%	85.3%	93.0%	90.3%	92.6%

	2017/18 Quarter 2 (local quarterly performance reports)						
	C2: New birth visits within 14 days	C3: New birth visits after 14 days	C8i: 6 - 8 week reviews	C4: 12 mth reviews by 12 mths of age	C5: 12 mth reviews by 15 mths of age	C6i: 2.5 yr reviews by 2.5 yrs of age	C6ii: 2.5 yr reviews using ASQ 3
England	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Cambridgeshire	92.2%	2.4%	91.7%	81.2%	77.4%	72.3%	97.8%
Peterborough	87.5%	n/a	88.6%	85.3%	90.7%	84.6%	86.4%

'-' Failed stage 2 validation Source: Public Health England https://www.gov.uk/government/publications/health-visitor-service-delivery-metrics-2017-to-2018

Quarter 2 2018/19: Data from trust performance reports, national data not available

Indicators are benchmarked against the England average and are colour coded to indicate their rating:

- Statistically significantly better than the England average
- Statistically similar to the England average
- Statistically significantly worse than the England average

Health visitor service delivery metrics: Q4 2016/2017 and Q4 2017/2018 comparison for Cambridgeshire and Peterborough

Quarterly and annual datasets and commentary for local authority health visits to pregnant women, children and their families during pregnancy and early childhood.

	2016/17 Quarter 4 (November 2017 release)							2017/18 Quarter 4 (July 2018 release)						
	C2: New birth visits within 14 days	C3: New birth visits after 14 days	C8i: 6 - 8 week reviews	C4: 12 mth reviews by 12 mths of age	C5: 12 mth reviews by 15 mths of age	C6i: 2.5 yr reviews by 2.5 yrs of age	C6ii: 2.5 yr reviews using ASQ 3	C2: New birth visits within 14 days	C3: New birth visits after 14 days	C8i: 6 - 8 week reviews	C4: 12 mth reviews by 12 mths of age	C5: 12 mth reviews by 15 mths of age	C6i: 2.5 yr reviews by 2.5 yrs of age	C6ii: 2.5 yr reviews using ASQ 3
England	88.3%	9.9%	83.5%	76.0%	82.5%	77.4%	91.2%	88.5%	9.7%	84.9%	77.6%	82.1%	76.4%	88.7%
Cambridgeshire	95.3%	4.7%	95.0%	84.5%	81.7%	81.7%	100.0%	95.8%	2.2%	84.3%	78.5%	85.2%	76.9%	93.7%
Peterborough	90.5%	9.5%	97.1%	80.6%	85.2%	82.7%		89.5%	7.2%	89.1%	82.9%	91.6%	79.3%	-

'-' Failed stage 2 validation Blank cells (with no colour highlight) show where data does not meet validation criteria, therefore values can not be published

Source: Public Health England https://www.gov.uk/government/publications/health-visitor-service-delivery-metrics-2017-to-2018
Published 31 January 2018
Last updated 26 July 2018

Note: The health visiting information has been obtained via the interim reporting system. It was submitted to PHE by local authorities on a voluntary basis. It covers Quarter 4 of 2017/18, which is the twelfth reporting period. The full data can be found at https://www.gov.uk/government/publications/health-visitor-service-deliverymetrics-2017-to-2018.

Where totals are presented for England these are aggregate totals of the areas that submitted information and passed initial validation.
Indicators are benchmarked against the England average and are colour coded to indicate their rating:

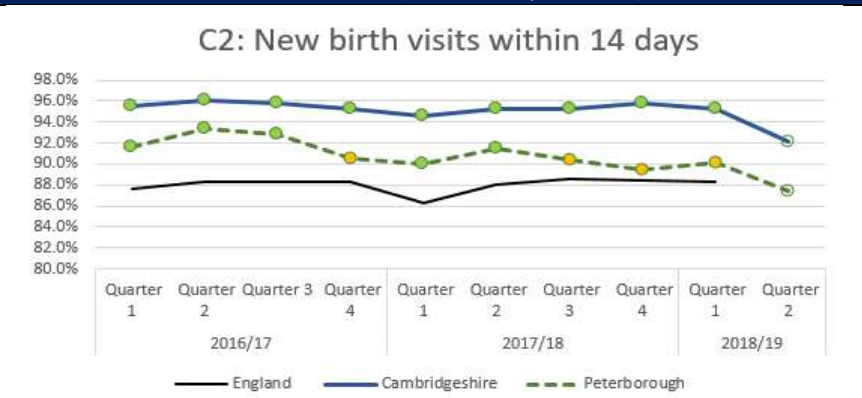
Tables

- Statistically significantly better than the England average
- Statistically similar to the England average
- Statistically significantly worse than the England average

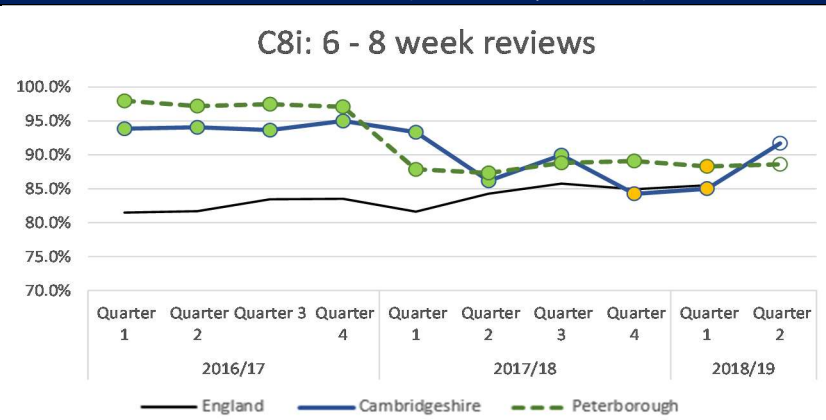
Charts

- Statistically significantly better than the England average
- Statistically similar to the England average
- Statistically significantly worse than the England average
- England rate not available to test significance

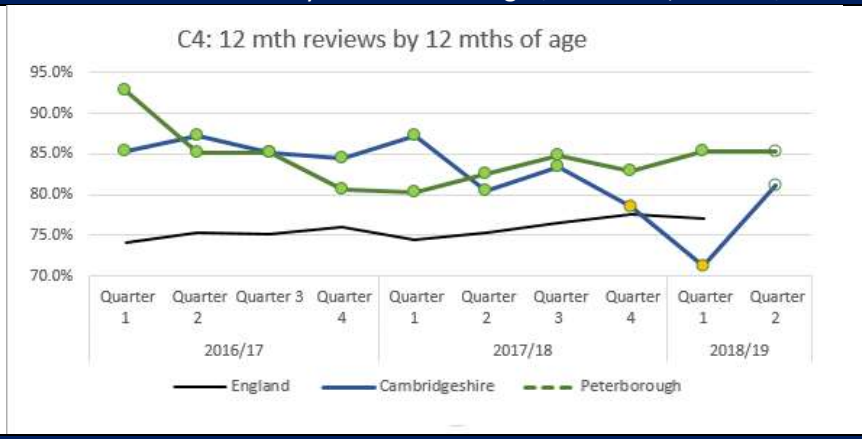
New Birth Visits (Q2 2018/19 provisional)



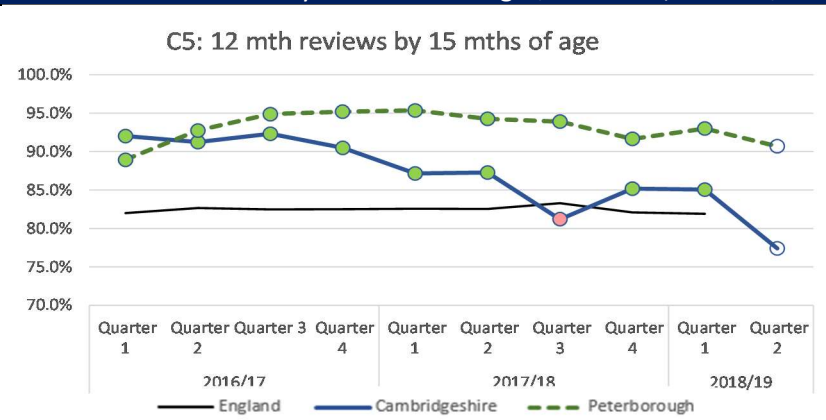
6-8 week reviews (Q2 2018/19 provisional)



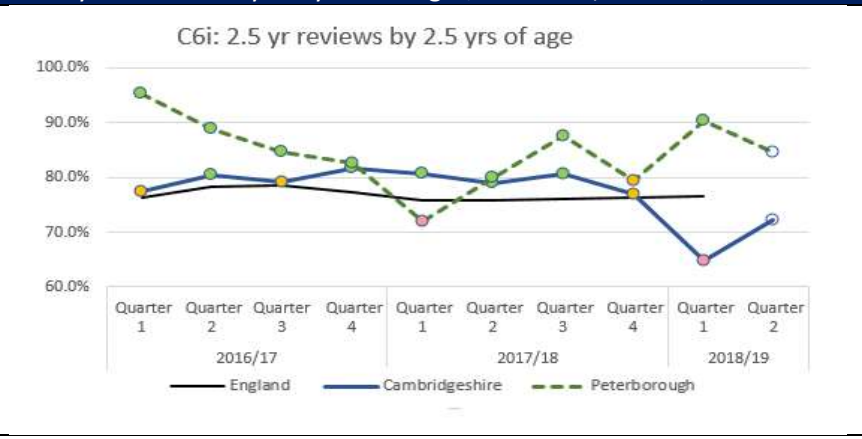
12 month reviews by 12 months of age (Q2 2018/19 provisional)



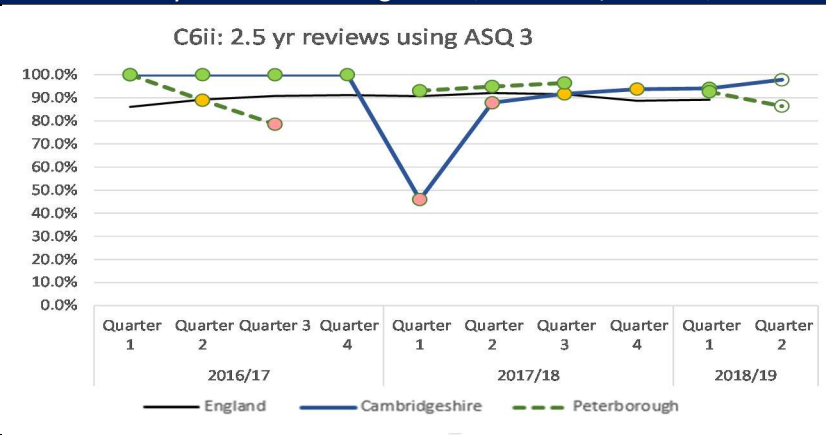
12 month reviews by 15 months of age (Q2 2018/19 provisional)



2.5 year reviews by 2.5 years of age (Q2 2018/19 provisional)



2.5 year reviews using ASQ3 (Q2 2018/19 provisional)



Summary of data

Indicators C2 and C3: Percentage of births that received a face-to-face new birth visit (C2: within 14 days and C3: after 14 days): The percentage of new birth visits within 14 days (indicator C2) for England in Quarter 4 was 88.5%, which is similar to Quarter 4, 2016/17 (88.3%). In Cambridgeshire, the percentage of new birth visits within 14 days for Quarter 4 was statistically significantly higher than England at 95.8%, and was similar to Quarter 4, 2016/17 (95.3%). Peterborough, at 89.5%, was similar to the Q4 England percentage of 90.5%. Within the year the percentages increased slightly in Cambridgeshire, whilst there were quarterly decreases from Q2 onwards in Peterborough.

Provisional Q2 2018/19: There was a decrease in new birth visits in Cambridgeshire in Q2, but the proportion remained higher than Peterborough, where there was also a decrease in the latest quarter reported.

C8i: Percentage of children who received a 6 to 8 week review by 8 weeks: The percentage of infants receiving a 6–8 week review for England in Quarter 4 was 84.9%, which was higher than Quarter 4, 2016/17 (83.5%). In Peterborough, the percentage of infants receiving a 6–8 week review was statistically significantly higher than England at 89.1%, but was lower than Quarter 4, 2016/17 (97.1%). Cambridgeshire, at 84.3%, was similar to the England percentage, and was notably lower than Quarter 4, 2016/17, where the percentage was statistically significantly higher at 95.0%.

Provisional Q2 2018/19: There was an increase in the proportion of 6-8 reviews in Cambridgeshire, whilst they slightly decreased in Peterborough. In Q1 2018/19 both areas had proportions that were statistically similar to England, whereas Cambridgeshire had previously been statistically significantly higher.

C4: Percentage of children who received a 12-month review by 12 months: The percentage of children receiving a 12-month review by 12 months of age for England in Quarter 4 was 77.6%, which was higher than Quarter 4, 2016/17 (76.0%). In Peterborough, the percentage of children receiving a 12-month review by 12 months of age in Quarter 4 was statistically significantly higher than England at 82.9%, and is slightly higher than Quarter 4, 2016/17 (80.6%). Cambridgeshire at 78.5% was statistically similar to the England percentage, and lower than Quarter 4, 2016/17, where the percentage was statistically significantly higher than England at 84.5%.

Provisional Q2 2018/19: There was a notable increase in 12 month reviews by 12 months in Cambridgeshire. Statistical testing against the national rate is currently unavailable for quarter 2 but in the previous quarter Cambridgeshire had a proportion that was statistically similar to England. Peterborough has consistently had proportions that were statistically significantly higher than England.

C5: Percentage of children who received a 12-month review by 15 months: The percentage of children receiving a 12-month review by 15 months of age for England in Quarter 4 was 82.1%, which was similar to Quarter 4, 2016/17 (82.5%). In both Cambridgeshire and Peterborough the percentages of children receiving a 12-month review by 15 months of age for Quarter 4 were statistically significantly higher than England at 85.2% and 91.6%, with notable improvements from Quarter 4, 2016/17 (81.7% and 85.2% respectively).

Provisional Q2 2018/19: There was a notable decrease in the proportion of 12 month visits by 15 months in Cambridgeshire and a slight increase in Peterborough. Peterborough had consistently had statistically significantly higher proportions than England.

C6i: Percentage of children who received a 2 to 2½ year review by 2½ years: The percentage of children receiving a 2 to 2½ year review by the age of 2½ for England in Quarter 4 was 76.4%, which was slightly lower than Quarter 4, 2016/17 (77.4%). The Cambridgeshire and Peterborough percentages of children receiving a 2 to 2½ year review by the age of 2½ in Quarter 4 were similar to England at 76.9% and 79.3% respectively. This is lower than Quarter 4, 2016/17 figures, where both Cambridgeshire (81.7%) and Peterborough (82.7%) were statistically significantly higher than England.

Provisional Q2 2018/19: There was an increase in the proportion of 2 to 2 ½ year reviews by 2 ½ years in Cambridgeshire, where the proportion in Quarter 1 had been statistically significantly lower than the England average. There was a decrease in the proportion in Peterborough from Q1, where the proportion had been previously statistically significantly higher than England.

C6ii: Percentage of children who received a 2 to 2½ year review using Ages and Stages Questionnaire (ASQ-3): The percentage of children receiving a 2 to 2½ year review which used ASQ3 for England in Quarter 4 was 88.7%, which was lower than Quarter 4, 2016/17 at 91.2%. The percentage of children receiving a 2 to 2½ year review which used ASQ3 in Quarter 4 in Cambridgeshire was similar to England at 93.7%, with notable quarterly improvements throughout the year. Peterborough failed stage 2 validation for this indicator in Quarter 4 therefore there is no value. However, in Quarter 3, 2017/18, the Peterborough value (96.4%) was statistically significantly higher than the England value (91.5%).

Provisional Q2 2018/19: There was an increase in the proportion of 2 to 2 ½ year old reviews in Cambridgeshire between Q1 and Q2 2018/19, whilst there was a decrease in Peterborough.

Appendix 4b

HCP 0-5 service provision in Cambridgeshire at District level

1. Background

Appendix 4a shows the 0-5 metrics trend for Cambridgeshire and Peterborough and compares to performance across England.

This Appendix 4b highlights the service performance across the 0-5 Health Visiting service at district level, including a summary of achievement against Key Performance Indicators, and a brief commentary outlining the challenges and how these have been addressed to date.

2. HCP Age 0-5 key performance metrics by District

	2017	2018		
Antenatal visits (target 50%)	**Qtr3**	**Qtr4**	**Qtr12**	**Qtr2**
Cambridge	6%	9%	14%	8%
East Cambridgeshire	28%	23%	23%	25%
Fenland	22%	21%	24%	23%
Huntingdonshire	36%	35%	35%	46%
South Cambridgeshire	7%	7%	11%	8%
New birth visits (target 98% overall, 90% within 14 days)	**Qtr3**	**Qtr4**	**Qtr1**	**Qtr2**
Cambridge within 14 Days	94%	96%	96%	95%
Cambridge after 14 Days	4%	4%	4%	3%
East Cambridgeshire within 14 Days	94%	98%	97%	94%
East Cambridgeshire after 14 Days	3%	2%	1%	2%
Fenland within 14 Days	92%	96%	94%	98%
Fenland after 14 Days	3%	2%	2%	0%
Huntingdonshire within 14 Days	97%	97%	96%	94%
Huntingdonshire after 14 Days	2%	3%	2%	3%
South Cambridgeshire within 14 Days	97%	97%	98%	97%
South Cambridgeshire after 14 Days	2%	2%	2%	2%
6-8 week checks completed/breast feeding coverage (target 90%)	**Qtr3**	**Qtr4**	**Qtr12**	**Qtr2**
Cambridge	85%	88%	89%	92%
East Cambridgeshire	95%	88%	88%	96%
Fenland	79%	62%	50%	86%
Huntingdonshire	94%	94%	96%	95%
South Cambridgeshire	93%	90%	97%	94%
6-8 Week Breast Feeding Prevalence (target 56%)	**Qtr3**	**Qtr4**	**Qtr1**	**Qtr2**
Cambridge	65%	66%	69%	72%
East Cambridgeshire	57%	53%	53%	55%
Fenland	28%	21%	16%	34%
Huntingdonshire	49%	52%	53%	53%
South Cambridgeshire	65%	59%	67%	65%

1 year review at 12 months (target 90%)	Qtr3	Qtr4	Qtr1	Qtr2
Cambridge	84%	83%	82%	84%
East Cambridgeshire	88%	78%	50%	82%
Fenland	82%	91%	76%	91%
Huntingdon	82%	85%	83%	81%
South Cambridgeshire	90%	90%	88%	88%
2.5 year review (target 90%)	**Qtr3**	**Qtr4**	**Qtr1**	**Qtr2**
Cambridge 2.5 Yr Check with ASQ	96%	90%	93%	90%
East Cambridgeshire 2.5 Yr Check with ASQ	99%	98%	95%	98%
Fenland 2.5 Yr Check with ASQ	97%	92%	96%	94%
Huntingdon 2.5 Yr Check with ASQ	96%	95%	96%	96%
South Cambridgeshire 2.5 Yr Check With ASQ	96%	94%	92%	95%

3. Health visiting services Cambridgeshire: key issues at District level

3.1 Fenland

Within the Fenland district there are ongoing pressures around the recruitment of registered nursing staff. This has an impact on performance and is compounded by the demographics of the population, with the area being of highest deprivation and an increase in the population of English as a second language. The service offers a retention premium targeted to some staff groups and this is currently being reviewed across Peterborough & Cambridgeshire to ensure there is a consistent approach. The service has also utilised bank and agency staff who are now working regular shift patterns within the caseloads to ensure continuity of care.

The service has responded innovatively to deliver universal support to families by offering some mandated checks in a clinic setting which has been well-received by the service users. In addition to this the service has addressed the missed appointments by offering the 1 & 2 years developments checks within the home environment which has improved accessibility and uptake.

3.2 Huntingdon

Generally, Huntingdon has fewer challenges around recruitment and retention and generally performance is consistent across the 5 mandated visits. Staff where possible, are asked to support other districts on a temporary basis.

3.3 Cambridge City

This district has pressures with the recruitment and retention of staff and have been utilising bank staff to address some of the gap in service. Unfortunately, there have been no agency staff available to work in the City to-date. The cost of living is higher in the City impacting on staff availability, which is compounded further by congestion of movement within the City. The Trust has introduced bicycles for staff who are interested in utilising this mode of transport These pressures impact on the performance data more broadly. The service has offered regular Saturday morning

sessions within the Peacock centre for mandated reviews and these have been well attended and positively evaluated by service users and staff.

3.4 East Cambridgeshire

Generally East Cambridgeshire has fewer challenges with recruitment and retention and is able to deliver the service favourably in comparison to some of the other districts. With this in mind this area is currently offering wider support to Cambridge City in order to be able to deliver the service to enable an equitable service.

3.5 South Cambridgeshire

Again, South Cambridgeshire has fewer workforce challenges and is therefore able to support the health needs of families. The three smaller teams covering Cambourne, Melbourn and Sawston have come together to form a wider team meaning that capacity and resources have been shared creating a greater expertise and staff availability.

Overall the service has 7.2 wte staff across Cambridgeshire unavailable to work due to maternity leave, secondments, career breaks and long-term absence impacting on service delivery. A staffing prediction tool is reviewed and updated monthly by the senior leadership team to support planning and predict the staffing availability at any one time.

Agenda Item No: 7

FINANCE AND PERFORMANCE REPORT – OCTOBER 2018

To:	**Health Committee**
Meeting Date:	**6th December 2018**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the October 2018 Finance and Performance report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of October 2018.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the finance and performance position as at the end of October 2018.**

	Officer contact:		***Member contacts:***
Name:	Martin Wade	Names:	Councillor Peter Hudson
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1.0 BACKGROUND

1.1 A Finance & Performance Report for the Public Health Directorate (PH) is produced monthly and the most recent available report is presented to the Committee when it meets.

1.2 The report is presented to provide the Committee with the opportunity to comment on the financial and performance position of the services for which the Committee has responsibility.

2.0 MAIN ISSUES IN THE OCTOBER 2018 FINANCE & PERFORMANCE REPORT

2.1 The October 2018 Finance and Performance report is attached at Annex A.

2.2 The forecast outturn for the Public Health Directorate is currently an underspend of £459k. This is an increase of £68k from last month's reported position due to an underspend of £50k being identified against the Public Health Directorate staffing budgets following a review of commitments against budget, with a further £20k underspend expected against Emergency Planning. A previously reported underspend on general preventions activities has reduced by £2k to £8k.

Any underspend within the Public Health directorate up to the level of corporate funding allocated on top of the public health grant funding (£391k) will be attributed to corporate reserves at year end.

A balanced budget was set for the Public Health Directorate for 2018/19, incorporating savings as a result of the reduction in Public Health grant. Savings are tracked on a monthly basis, with any significant issues reported to the Health Committee, alongside any other projected under or overspends.

Further detail on the outturn position can be found in Annex A.

2.3 The Public Health Service Performance Management Framework for September 2018 is contained within the report. Of the thirty one Health Committee performance indicators, six are red, two are amber, twenty are green and three have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

4.1.1 This report sets out details of the overall financial position of the Public Health Service.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

4.2.1 There are no significant implications for this priority

4.3 Statutory, Legal and Risk Implications

4.3.1 There are no significant implications within this category.

4.4 Equality and Diversity Implications

4.4.1 There are no significant implications within this category.

4.5 Engagement and Communications Implications

4.5.1 There are no significant implications within this category.

4.6 Localism and Local Member Involvement

4.6.1 There are no significant implications within this category.

4.7 Public Health Implications

4.7.1 There are no significant implications within this category.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	N/A
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	N/A
Have the equality and diversity implications been cleared by your Service Contact?	N/A
Have any engagement and communication implications been cleared by Communications?	N/A
Have any localism and Local Member involvement issues been cleared by your Service Contact?	N/A
Have any Public Health implications been cleared by Public Health?	N/A

Source Documents	Location
As well as presentation of the F&PR to the Committee when it meets, the report is made available online each month.	https://www.cambridgeshire.gov.uk/council/finance-and-budget/finance-&-performance-reports/

From: Martin Wade

Tel.: 01223 699733

Date: 10 October 2018

Public Health Directorate

Finance and Performance Report – October 2018

1 SUMMARY

1.1 Finance

Previous Status	Category	Target	Current Status	Section Ref.
Green	Income and Expenditure	Balanced year end position	**Green**	2.1

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
Sept (No. of indicators)	6	2	20	3	31

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Outturn Variance (Sep) £000	Service	Budget for 2018/19 £000	Actual to end of Oct 18 £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
0	Children Health	9,266	4,409	0	0%
0	Drug & Alcohol Misuse	5,625	3,991	0	0%
-331	Sexual Health & Contraception	5,157	1,963	-331	6%
-50	Behaviour Change / Preventing Long Term Conditions	3,812	1,338	-50	-1%
0	Falls Prevention	80	53	0	0%
-10	General Prevention Activities	56	35	-8	-14%
0	Adult Mental Health & Community Safety	256	60	0	0%
0	Public Health Directorate	2,019	926	-70	-3%
-391	**Total Expenditure**	**26,271**	**12,774**	**-459**	**-2%**
0	Public Health Grant	-25,419	-19,271	0	0%
0	s75 Agreement NHSE-HIV	-144	144	0	0%
0	Other Income	-40	-12	0	0%
0	Drawdown From Reserves	-39	0	0	0%
0	**Total Income**	**-25,642**	**-19,139**	**0**	**0%**
0	**Contribution to/(Drawdown from) Public Health Reserve**	**0**	**0**	**68**	
-391	**Net Total**	**629**	**-6,365**	**-391**	**-73%**

The service level budgetary control report for 2018/19 can be found in appendix 1.

Further analysis can be found in appendix 2.

2.2 Significant Issues

A balanced budget has been set for the financial year 2018/19. Savings totalling £465k have been budgeted for and the achievement of savings will be monitored through the monthly savings tracker, with exceptions being reported to Heath Committee and any resulting overspends reported through this monthly Finance and Performance Report.

The total forecast underspend for the Public Health Directorate is £459k, an increase of £68k from last months reported position. An underspend of £50k has been identified against the Public Health Directorate staffing budgets following a review of commitments against budget, with a further £20k underspend expected against Emergency Planning. A previously reported underspend on general preventions activities has reduced by £2k to £8k. Any underspend within the Public Health directorate up to the level of corporate funding allocated on top of the public health grant funding (£391k) will be attributed to corporate reserves at year end.

2.3 Additional Income and Grant Budgeted this Period (De minimus reporting limit = £160,000)

The total Public Health ring-fenced grant allocation for 2018/19 is £26.253m, of which £25.541m is allocated directly to the Public Health Directorate.

The allocation of the full Public Health grant is set out in appendix 3.

2.4 Virements and Transfers to / from Reserves (including Operational Savings Reserve) (De minimus reporting limit = £160,000)

Details of virements made this year can be found in appendix 4.

3. BALANCE SHEET

3.1 Reserves

A schedule of the Directorate's reserves can be found in appendix 5.

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

The performance data reported on relates to activity in September 2018.

Sexual Health (KP1 & 2)

- Performance of sexual health and contraception services is good.

Smoking Cessation (KPI 5)

This service is being delivered by Everyone Health as part of the wider Lifestyle Service.

- There has been an improvement in this month's performance with the trajectory moving up but indicators for people setting and achieving a four week quit remain still remain at red.
- Appendix 6 provides further commentary on the ongoing programme to improve performance.

National Child Measurement Programme (KPI 14 & 15)

- The coverage target for the programme was met. Year end data for the 2017/18 programme will be available at the end of 2018.
- Measurements for the 2018/19 programme are taken during the academic year and the programme will re-commence in November 2018.

NHS Health Checks (KPI 3 & 4)

- Indicator 3 for the number of health checks completed by GPs is reported on quarterly. Q2 is presented whilst this indicator is reporting as red it is an improvement on performance from this time last year.
- Indicator 4 for the number of outreach health checks remains red but the trajectory is moving upward. Further details of the refocus for the service are available in the commentary in Appendix 6.

Lifestyle Services (KPI 5,16-30)

- There are 16 Lifestyle Service indicators reported on, the overall performance is good and the same as last month showing 13 green, 1 amber and 2 red indicators.
- Appendix 6 provides further explanation on the red indicators for the personal health trainer service, proportion of Tier 2 clients completing weight loss interventions (which is seeing an improvement in the trajectory) and smoking cessation.

Health Visiting and School Nurse Services (KPI 6-13)

The performance data provided reports on the Q2 (July –Sept 2018) for the Health Visiting and School Nurse service.

Health Visiting (KPI 6-11)

- The breastfeeding target for 2018/19 will remain at 56%- this is recognised across the county as a challenging target however performance for Q2 has seen a 3% increase and is now reaching this target. The performance indicator for the second quarter is at green.
- Breastfeeding rates are very varied across Cambridgeshire and Appendix 6 provides more detail on this.
- Improved performance against Health Visitor mandated checks for the percentage of births that receive a New Birth Visit (NBV) and children who receive a 6-8 week review is noted and the indicators are green.

- Whilst the percentage of first face to face antenatal contacts with a health visitor from 28 weeks is red the direction of travel from the previous quarter is up.
- Appendix 6 commentary provides further detailed explanation on the current performance.
- Performance against the 12 month Health Visitor check by 15th months has reduced in Q2. The service has focused on completing reviews by the12th month hence we expect to see an improvement in this KPI during Q3. Including exception reporting takes performance to 94%.
- The indicator for performance against the children who receive a 2 – 2 1/2year check is red. Performance has improved from Q1 to Q2. Appendix 6 provides detailed commentary.

School Nursing (KPI 12,13a and 13b)

- Quarter 2 reports 108 young people received brief interventions face-to-face. The commentary in Appendix 6 provides a further analysis of the types of interventions.
- Performance indicator 13 has been further broken down into number of calls made to the duty desk (13a) and number of young people who access advice and support though Chat Health (13b).
- Numbers are lower in Q2 due the summer school holidays the commentary reports emotional health is the most frequent reason to access the service.

4.2 Public Health Services provided through a Memorandum of Understanding (MOU) with other Directorates (Appendix 7)

- Quarter 2 report to be provided in a future report.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Previous Outturn (Sep) £'000	Service	Budget 2018/19 £'000	Actual to end of Oct £'000	Outturn Forecast £'000	%
	Children Health				
0	Children 0-5 PH Programme	7,253	1,837	0	0%
0	Children 5-19 PH Programme - Non Prescribed	1,706	2,246	0	0%
0	Children Mental Health	307	327	0	0%
0	**Children Health Total**	**9,266**	**4,409**	**0**	**0%**
	Drugs & Alcohol				
0	Drug & Alcohol Misuse	5,625	3,991	0	0%
0	**Drugs & Alcohol Total**	**5,625**	**3,991**	**0**	**0%**
	Sexual Health & Contraception				
-281	SH STI testing & treatment – Prescribed	3,829	1,641	-281	-7%
-50	SH Contraception - Prescribed	1,176	289	-50	-4%
0	SH Services Advice Prevn Promtn - Non-Presribed	152	34	0	0%
-331	**Sexual Health & Contraception Total**	**5,157**	**1,963**	**-331**	**-6%**
	Behaviour Change / Preventing Long Term Conditions				
0	Integrated Lifestyle Services	1,980	1,140	-0	0%
0	Other Health Improvement	413	43	0	0%
-50	Smoking Cessation GP & Pharmacy	703	-175	-50	-7%
0	NHS Health Checks Prog – Prescribed	716	330	0	0%
-50	**Behaviour Change / Preventing Long Term Conditions Total**	**3,812**	**1,338**	**-50**	**-1%**
	Falls Prevention				
0	Falls Prevention	80	53	0	0%
0	**Falls Prevention Total**	**80**	**53**	**0**	**0%**
	General Prevention Activities				
-10	General Prevention, Traveller Health	56	35	-8	-14%
-10	**General Prevention Activities Total**	**56**	**35**	**-8**	**-14%**
	Adult Mental Health & Community Safety				
0	Adult Mental Health & Community Safety	256	60	0	0%
0	**Adult Mental Health & Community Safety Total**	**256**	**60**	**0**	**0%**

Previous Outturn (Sep) £'000	Service	Budget 2018/19 £'000	Actual to end of Oct £'000	Outturn Forecast £'000	%
	Public Health Directorate				
0	Children Health	189	98	0	0%
0	Drugs & Alcohol	287	120	0	0%
0	Sexual Health & Contraception	164	75	0	0%
0	Behaviour Change	753	348	-50	-7%
0	General Prevention	199	109	0	0%
0	Adult Mental Health	36	13	0	0%
0	Health Protection	53	29	-20	-38%
0	Analysts	338	134	0	0%
0		**2,019**	**926**	**-70**	**-3%**
-391	**Total Expenditure before Carry forward**	**26,271**	**12,774**	**-459**	**-2%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**68**	**0.00%**
	Funded By				
0	Public Health Grant	-25,419	-19,271	0	0%
0	S75 Agreement NHSE HIV	-144	144	0	0%
0	Other Income	-40	-12	0	0%
	Drawdown From Reserves	-39	0	0	0%
0	**Income Total**	**-25,642**	**-19,139**	**0**	**0%**
-391	**Net Total**	**629**	**-6,365**	**-391**	**-73%**

APPENDIX 2 – Commentary on Expenditure Position

Number of budgets measured at service level that have an adverse/positive variance greater than 2% of annual budget or £100,000 whichever is greater.

Service	Budget 2018/19 £'000	Forecast Outturn Variance	
		£'000	%
Sexual Health Testing and Treatment	**3,829**	**-281**	**-7%**
An underspend of £281k has been identified against the Sexual Health budget. This is as a result of an over-accrual which had been carried forward from a previous financial year in error. The over-accrual will be moved into Public Health ring-fenced grant reserve and will be used to fund £281k of Public Health eligible funding during 2018/19 in place of £281k of general CCC funding, producing an underspend against the CCC corporate funding.			

APPENDIX 3 – Grant Income Analysis
The tables below outline the allocation of the full Public Health grant.

Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Notes
Public Health Grant as per Business Plan	**26,253**	**26,253**	Ring-fenced grant
Grant allocated as follows;			
Public Health Directorate	25,419	25,419	
P&C Directorate	283	293	£10k movement of Strengthening Communities Funding moved from P&E to P&C
P&E Directorate	130	120	£10k movement of Strengthening Communities Funding moved from P&E to P&C
CS&T Directorate	201	201	
LGSS Cambridge Office	220	220	
Total	**26,253**	**26,253**	

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan		
Virements		
Non-material virements (+/- £160k)		
Budget Reconciliation		
Current Budget 2018/19		

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2018	2018/19		Forecast Closing Balance	Notes
		Movements in 2018/19	Balance at end Oct 2018		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,040**	0	1,040	**1,040**	
subtotal	**1,040**	**0**	**1,040**	**1,040**	
Other Earmarked Funds					
Healthy Fenland Fund	300	0	300	200	Anticipated spend £100k per year over 5 years.
Falls Prevention Fund	378	0	378	259	Planned for use on joint work with the NHS in 2017/18 and 2018/19.
NHS Healthchecks programme	270	0	270	270	This funding will be used to install new software into GP practices which will identify patients for inclusion in Health Checks. The installation work will commence in June 2017. Funding will also be used for a comprehensive campaign to boost participation in NHS Health Checks.
Implementation of Cambridgeshire Public Health Integration Strategy	579	0	579	300	£517k Committed to the countywide 'Let's Get Moving' physical activity programme which runs for two years from July 2017-June 2019.
subtotal	**1,527**	**0**	**1,527**	**1,029**	
TOTAL	**2,567**	**0**	**2,567**	**2,069**	

(+) positive figures should represent surplus funds.
(-) negative figures should represent deficit funds.

Fund Description	Balance at 31 March 2018	2018/19		Forecast Closing Balance	Notes
		Movements in 2018/19	Balance at end Oct 2018		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	136	0	136	136	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**145**		**145**	**145**	

APPENDIX 6 PERFORMANCE

	More than 10% away from YTD target
	Within 10% of YTD target
	YTD Target met

↓	Below previous month actual
↔	No movement
↑	Above previous month actual

The Public Health Service Performance Management Framework (PMF) for September 2018 can be seen within the tables below:

	Measures											
KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
1	GUM Access - offered appointments within 2 working days	Sep-18	98%	98%	100%	102%	G	98%	98%	100%	↔	
2	GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	Sep-18	80%	80%	91%	113%	G	91%	80%	91%	↔	
3	Number of Health Checks completed (GPs)	Q2 (Jul-Sept 18)	18,000	9000	7251	81%	R	77%	4500	3447	↔	This is an improvement on performance at this time last year.
4	Number of outreach health checks carried out	Sep-18	1,800	900	610	68%	R	63%	108	102%	↑	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. This includes securing access to workplaces in Fenland where there are high risk workforces. Wisbech Job Centre Plus is receiving sessions for staff and those claiming benefits. In addition sessions in community centres in areas that have high risk populations are ongoing A mobile service has been piloted and will be introduced. Performance in Fenland continues to overachieve. However although performance in the rest of county has improved it remains below target and consequently this KPI remains on red.
5	Smoking Cessation - four week quitters	Aug-18	2154	960	617	64%	R	76%	170	78%	↑	• There has been an ongoing improvement in performance in the past two months. There is an ongoing programme to improve performance that includes targeting routine and manual workers (rates are known to be higher in these groups) and the Fenland area. A new promotional campaign is planned and other new approaches are being developed. •The most recent Public Health Outcomes Framework figures released in July 2018 with data for 2017) suggest the prevalence of smoking in Cambridgeshire is statistically similar to the England figure , 14.5% v 14.9%. All districts are now statistically similar to the England figure. Most notable has been the improvement in Fenland where it has dropped from 21.6% to 16.3%, making it lower than the Cambridge City rate of 17.0%

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
6	Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	Q2 Jul-Sept	56%	56%	55%	98%	G	53%	56%	56%	↑	Despite being a challenging target, county breastfeeding statistics have seen a further 3% increase in Q2 on top of the 3% improvement in Q1. Cambs is now reaching target of 56% based on quarterly averages. Overall, breastfeeding rates in Cambridgeshire remains higher than the national average of 44%. Breastfeeding rates vary across the county however there has been a notable improvement in East Cambs & Fenland in Q2, raising from 33% to 43%, coming close to national average.
7	Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV from 28 weeks	Q2 Jul-Sept	50%	50%	23%	46%	R	20%	50%	23%	↑	In Cambridgeshire a local target has been set for 50%, with the longer term goal of achieving a target of 90% by 2020. The overall performance this quarter has improved by 3%. Locally, Huntingdon has increased it's antenatal visits from 38% in Q1 to 47% in Q2. However East Cambs & Fenland has dropped from 37% in Q1 to 24% in Q2 and South Cambs from 13% in Q1 to 5% in Q2. Steps to improve this include introduction of mobile working which is being rolled out across the patch and will be completed by the end of the calendar year. Incentives are also being offered to encourage staff to work across a wider geographic area. Progress has been made in securing agreement from all 4 hospitals to provide antenatal notifications.
8	Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	Q2 Jul-Sept	90%	90%	92%	102%	G	90%	90%	92%	↑	The 10 - 14 new birth visit remains consistent each month and numbers are well within the 90% target.
9	Health visiting mandated check - Percentage of children who received a 6 - 8 week review	Q2 Jul-Sept	90%	90%	92%	102%	G	85%	90%	92%	↑	Performance for the 6 - 8 week review has continued to improve since Q4 17/18 and is now above target threshold of 90%. This has been achieved in each of the 3 local areas and notably with Huntingdon reaching 94%.
10	Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	Q2 Jul-Sept	95%	95%	81%	85%	A	85%	95%	77%	↓	Performance has reduced in Q2 from 85% to 77%, however there has been an improvement in the number of children receiving their 1 year check by their 1st birthday. Due to this we anticipate that there will be an improvement in this KPI for Q3. Including exception reporting takes performance to 94%. Exception reporting includes those that 'did not want' or 'did not attend' their appointment. However it also includes those who were not recorded (n=213 children in Q2). Work is being undertaken to clarify the definition of 'not recorded' and to improve data completeness in this regard. An additional challenge has been the delayed transfers in notifications from the Child Health Information System (CHIS) presenting a capacity issue to the service. This has now been resolved.
11	Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	Q2 Jul-Sept	90%	90%	69%	76%	R	67%	90%	72%	↑	Performance has improved from Q1 to Q2. Performance ranges from 67% in South Cambs, 73% in Huntingdon to 79% in East Cambs and Fenland. East Cambs & Fenland improved from 45% to 79%. Initiatives to continue to improve uptake of this mandated visit include 1.) Home visiting offer reinstated in deprived areas 2.) Additional Saturday morning clinics put on in Cambs City which have proven popular 3.) reviewed processes for sending out appointments to ensure they are sent out earlier to be able to offer second appointment within timeframe if needed.
12	School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management, emotional health and well being, substance misuse or domestic violence	Q2 Jul-Sept	N/A	N/A	208	N/A	N/A	100	N/A	108	N/A	The School Nursing service is actively delivering brief interventions for Healthy Weight, Mental Health, Sexual Health and Domestic Violence. The numbers of brief interventions for domestic violence are particularly high and are to be applauded. There have been no brief interventions for substance misuse or smoking cessation. This is worrying given the number of onwards referrals to substance misuse and smoking cessation services is very low too. Urgent review of school nursing service offer and pathways with young people's substance misuse and smoking cessation services being undertaken during November.
13a	School nursing - number of calls made to the duty desk	Q2 Jul-Sept	N/A	N/A	1490	N/A	N/A	Not applicable	N/A	689	N/A	Numbers overall are lower in Q2 due to the summer school holidays. Emotional health is by far the most popular topic. Events promoting Chat Health have been well received across the area.
13b	School nursing - Number of children and young people who access health advices and support through Chat Health	Q2 Jul-Sept	N/A	N/A	1123	N/A	N/A	Not applicable	N/A	381	N/A	

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
14	Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	Sep-18	>90%	>90%	>90%	91%	G	91.3%	91.0%	90.0%	N/A	The National Child Measurement Programme (NCMP) has been completed for the 2016/17 academic year. The coverage target was met and the measurement data has been submitted to the PHE in line with the required timeline. The 2018/19 measurement programme commences in November
15	Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	Sep-18	>90%	>90%	>90%	95%	G	95.1%	95.0%	90.0%	N/A	
16	Overall referrals to the service	Sep-18	5300	2173	2650	122%	G	148%	318	108%	↓	Although downwards the number of referrals is still above target.
17	Personal Health Trainer Service - number of Personal Health Plans produced (PHPs) **(Pre-existing GP based service)**	Sep-18	1670	685	694	101%	G	92%	100	116%	↑	
18	Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	Sep-18	1252	513	612	119%	G	222%	75	128%	↓	
19	Number of physical activity groups held **(Pre-existing GP based service)**	Sep-18	730	299	507	169%	G	262%	44	223%	↓	
20	Number of healthy eating groups held **(Pre-existing GP based service)**	Sep-18	495	203	236	116%	G	50%	30	53%	↑	
21	Personal Health Trainer Service - number of PHPs produced (Extended Service)	Sep-18	800	328	452	138%	G	190%	48	121%	↓	
22	Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	Sep-18	650	267	276	104%	G	113%	39	105%	↓	
23	Number of physical activity groups held (Extended Service)	Sep-18	830	340	354	104%	G	102%	50	114%	↑	

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
24	Number of healthy eating groups held (Extended Service)	Sep-18	570	234	265	113%	G	39%	34	47%	↑	
25	Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	Sep-18	30%	30%	24.0%	80%	R	22%	30%	30%	↑	There is an improvement this month but there has been an ongoing issue with staff changes. To address this Everyone Health has contracted with Weight Watchers (WW reimaged) and Slimming World to provide the services. The services tthat these organisations provide have been very well evaluated and they have robust evidence for the effectiveness of their services. These will commence in October.
26	Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	Sep-18	60%	60%	58.0%	96%	A	67.0%	60%	56.0%	↓	Generally this service performs well but it does have some very challenging complex patients that find meeting the 10% weight loss target difficult.
27	% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	Sep-18	80%	80%	80%	100.0%	G	0%	80%	0%	↔	A new programme has commenced.
28	Number of referrals received for multi factorial risk assessment for Falls Prevention	Sep-18	520	213	341	100.0%	G	295%	31	309%	↑	
29	Number of Multi Factorial Risk Assessments Completed - Falls Prevention	Sep-18	442	181	367	100.0%	G	511%	27	244%	↓	
30	Number clients completing their PHP - Falls Prevention	Sep-18	331	136	212	100.0%	G	158%	20	385%	↑	

* All figures received in October 2018 relate to September 2018 actuals with exception of Smoking Services, which are a month behind and Health Checks, some elements of the Lifestyle Service, School Nursing and Health Visitors which are reported quarterly.

** Direction of travel against previous month actuals

*** The assessment of RAG status for services where targets and activity are based on small numbers may be prone to month on month variation. Therefore RAG status should be interpreted with caution.

APPENDIX 7

PUBLIC HEALTH MOU 2018-19 UPDATE FOR Q2

To be provided in a future report.

Agenda Item No: 8

HEALTH COMMITTEE REVIEW OF DRAFT REVENUE AND CAPITAL BUSINESS PLANNING PROPOSALS FOR 2019/20 TO 2023/24

To: Health Committee

Meeting Date: 6 December 2018

From: Director of Public Health

Electoral division(s): **All**

Forward Plan ref: **Not applicable** ***Key decision:*** **No**

Purpose: **This report provides the Committee with an overview of the draft Business Plan revenue and capital proposals for services that are within the remit of the Health Committee.**

Recommendation:

a) It is requested that the Committee note the overview and context provided for the 2019/20 to 2023/24 Business Plan revenue proposals for the Service, updated since the last report to the Committee in October.

b) It is requested that the Committee comment on the draft revenue savings proposals that are within the remit of the Health Committee for 2019/20 to 2023/24, and endorse them to the General Purposes Committee (GPC) as part of consideration for the Council's overall Business Plan.

c) It is requested that the Committee comments on the changes to the capital programme that are within the remit of the Health Committee and endorse them to the General Purposes Committee (GPC) as part of consideration for the Council's overall Business Plan.

	Officer contact:	***Member contact:***
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1. PURPOSE AND BACKGROUND

1.1 The Council's Business Plan sets out how we will spend the resources we have at our disposal to achieve our vision and priorities for Cambridgeshire, and the outcomes we want for people. This paper presents an overview of the proposals being put forward as part of the Council's draft revenue and capital budgets, with a focus on those which are relevant to this Committee. The report forms part of the process set out in the Medium Term Financial Strategy whereby the Council updates, alters and refines its revenue and capital proposals in line with new savings targets.

1.2 In developing our plan we are responding to a combination of cost increases and reduced Government funding which mean we have to make our resources work harder than ever before. To balance the budget whilst still delivering for communities we need to identify savings or additional income of £26.3m for 2019-20, and totalling £68.2m across the full five years of the Business Plan.

2. FINANCIAL OVERVIEW UPDATE

2.1 In October, Committees received information about emerging draft proposals to respond to this challenge – at that point we had identified 44% of the savings required and the remaining budget gap for 2019/20 was £21.5m. Additional gaps also existed for the later years of the business plan.

2.2 Since October, work on the business plan has continued with a focus on;

- Further exploring the existing schemes, refining the business cases and seeking to push schemes further wherever possible
- Identifying mitigation measures for the identified pressures – aiming to minimise their impact on the savings requirement for the organisation

2.3 We are continuing as an authority to explore every avenue to identify further efficiency or to bring in more funding to the local economy and public sector. In particular;

- We continue to drive forward our Fairer Funding Campaign – arguing for Cambridgeshire to receive a higher and fairer allocation of national funding for education, social care and a range of other services
- We have applied to be a pilot area for the Government's Business Rates Retention Scheme – which would allow us to reinvest the output of local business growth in local public services and infrastructure
- We are working in partnership with Peterborough City Council on shared services where it will lead to better outcomes for service users
- We are driving forward the Adults Positive Challenge Programme which is supporting us to develop a new approach in our adult social care model in the face of growing demand

2.4 However the number and scale of the pressures on the organisation which are not directly controllable continues to increase. In addition to the ongoing

reductions in grant from Government, we continue to see demand for services and in particular the most vulnerable increasing significantly.

Throughout the year Adults Services has seen increased demand for services from both older people and people with learning disabilities, above the level expected when budgets were set. We have been successful through early help in constraining this demand and reducing the proportion of over 85s in service but the level of services required by people is rising, putting pressure on the health and social care system (locally and nationally). This rising demand is pushing up unit costs of care which has put pressure on budgets in the second half of the year. Within the Learning Disability Partnership, demand for services is rising as more people are discharged from inpatient units into the community as part of the Transforming Care agenda, and efforts to constrain costs are taking longer than anticipated. The considerable impact on care budgets of this demand for services continues to be mitigated through funding provided by central government, but demand has continued to rise in the second part of the year.

2.5 Within Children's services, numbers of children in care remain at around 100 higher than expected based on the performance of Cambridgeshire's statistical neighbours. These higher than anticipated numbers in care have resulted in continuing overspends in directly related budgets – those associated with placement costs, supervised contact and transport costs. Additionally, the foster placement capacity both in house and externally is very stretched by demand both locally and nationally. The shortfall in appropriate fostering provision is increasing the numbers of children requiring residential placements which cost around four times more than equivalent fostering placements.

2.6 There has also been a significant increase in numbers of unaccompanied asylum seeking children (UASC) over the last two months. The council receives fixed government grants to fund accommodation costs and support care leavers however this income has not increased in proportion with the UASC population. Additionally, the majority of recent arrivals have been placed in high cost placements due to the unavailability of lower cost accommodation. Within Children's Services we have seen a 13% increase in pupils with Education, Health and Care Plans (EHCPs) between September 2017 and September 2018 and a 20% increase in pupils attending special schools over the same period. These increases, which are in line with national trends, have caused pressures on all elements of the Special Educational Needs Development (SEND) budget.

The increasing number of pupils with EHCPs has also resulted in an increased pressure on the Home to School Transport – Special budget. We are seeing more pupils with SEND being transported and, due to local provision reaching capacity, pupils are being transported significant distances to access education which results in higher transport costs. An increase in complexity of needs has also contributed to this pressure with more pupils needing specialist equipment or passenger assistants to assist their travel. This is against a backdrop of a challenging transport market with quoted costs for routes being significantly higher than in previous years resulting in pressure on Mainstream and LAC transport as well as Special. These two areas are also seeing growing demand due to continuing increases in LAC

numbers and a high volume of in-year admissions to schools outside of catchment area resulting in further budgetary pressures.

2.7 The table below provides a summary of the various material (£100k or greater) changes since October in the overall business planning position for 2019/20. It reflects both the positive impact of the new proposals and transformation agenda and the growing pressures we face as a sector. As shown below, the level of unidentified savings has reduced by £2.2m to £19.3m. Work to identify and work up further ideas to fill the gap is ongoing and the pressures emerging are still under review as we monitor trends and develop mitigating strategies.

Description	2019-20 £'000	2020-21 £'000	2021-22 £'000	2022-23 £'000	2023-24 £'000
Remaining Unidentified Savings at October Committees	**21,505**	**8,838**	**3,807**	**8,078**	**3,151**
Anticipated further savings within People and Communities	121				
Changes to People and Communities fees, charges and schools income compared to 2018-19	1,048				
Passenger Transport - Remove Discretionary Concessions	260				
Anticipated further savings within Place and Economy	250	250			
Partnership, Projects and Funding team	101				
Subtotal Business Planning Savings removed since October	**1,780**	**250**	**-**	**-**	**-**
Dedicated Schools Grant Contribution to Combined Budgets - decision by schools forum	-1,579	1,579	1,500		
Better Care Fund - Investing to support social care and ease pressures in the health and care system	-1,000	1,000			
Income from energy investment schemes			-5,668	89	201
Subtotal reduction in pressures	**-2,579**	**2,579**	**-4,168**	**89**	**201**
Increase in inflationary pressures	341		-155	-155	-155
Underachievement of planned 2018/19 waste contract savings	900				
Citizen First, Digital First - underachievement of planned savings from previous years	182				
Reduced LGSS Law dividend expectation	96		-96		
Microsoft Licensing Costs	240				
Increase in Traded Services to Schools pressure	100				
Increase in Home to School Transport for Special Schools - pressure	725				

Home to School Transport for Looked After Children - increased pressure	275				
Subtotal revised pressures	**2,859**	**-**	**-251**	**-155**	**-155**
Smoothing fund applied one-off to Children's Services in 18/19, permanent benefit unwound in 2020-21	-3,413	3,413			
Investment into Social Work (in relation to the Adults Positive Challenge programme)			1,000		
Operating costs associated with energy investment projects		39	787	22	26
Revised debt charges forecast [costs of borrowing]	-1,197	664	3,176	2	1,922
Improvement in in-year position and combination of minor adjustments	372	272			
Household waste recycling centre changes	-60				
Changes in external income assumptions [future year assumptions about iBCF and RSG*		-5,000			
Additional changes to funding forecasts		135	-2	-1	-1
Total of Other Changes to Business Plan Assumptions / Finance Adjustments	**-4,298**	**-477**	**4,961**	**23**	**1,947**
Revised Gap at December Committees	**19,267**	**11,190**	**4,349**	**8,035**	**5,144**

**Taking account of government announcements and treatment in similar authorities, we have assumed in 2020-21 that £8m of improved BCF previously assumed as ending will now continue, this is partially offset by assuming a £3m worsening in general funding position (such as RSG).*

2.8 The following table shows the total level of savings necessary for each of the next five years, the amount of savings attributed from identified savings and the residual gap for which saving or income has still to be found:

	2019-20 £'000	2020-21 £'000	2021-22 £'000	2022-23 £'000	2023-24 £'000
Total Saving Requirement*	26,322	17,591	11,578	7,690	4,972
Identified Savings	-14,506	-6,903	-1,438	246	-23
Identified additional Income Generation*	7,451	502	-5,791	99	195
Residual Savings to be identified	**19,267**	**11,190**	**4,349**	**8,035**	**5,144**

**The Total Saving Requirement and Identified additional Income Generation in 2019-20 have both been reduced by £9m as a result of the closure of Cambridgeshire Catering and Cleaning Services with a net nil impact on the budget gap.*

2.9 The following funding options are available to the council to contribute towards closing the gap for 2019/20 and beyond:

Item	2019-20	2020-21	Recurring/ non-recurring	Confirmed/ unconfirmed
Further 1% Council tax increase	**-£2.75m**		Recurring	Local Decision
Revenue investment of recurring MRP savings	**-£6.1m**	**£0.55m**	Recurring but diminishing	Local Decision
Revenue investment of recurring smoothing fund	**-£9.1m**		Recurring	Local Decision
Subtotal - locally controlled/recurrent	**-£17.95m**	**£0.55m**		
Assume negative RSG deferred	**-£7.1m**		Unclear	Preferred national option
Subtotal – national funding changes	**-£7.1m**			
Transformation fund closure after current commitments	**-£14.0m**		Non-recurring	Local decision with conditions
Income from Business Rates Pilot	**-£7.67m**	**£7.67m**	Non-recurring	National decision
Subtotal non-recurring funding	**-£21.67m**	**£7.67m**		

3 ASSUMPTIONS AND RISKS

3.1 In the business planning tables the level of savings required is based on a 3.99% increase in Council Tax in 2019-20, through levying the Adult Social Care precept of 2% and a 1.99% general Council Tax increase. It is unclear whether the Adult Social Care precept will continue after 2019-20, therefore only a general Council Tax increase of 1.99% is included from 2020-21 onwards. For each 1% more or less that Council Tax is changed, the level of savings required will change by approximately +/-£2.75m.

3.2 There is currently a limit on the increase of Council Tax to 2.99%, above which approval must be sought from residents through a positive vote in a local referendum. The estimated cost of a referendum in May 2019 would be £742k with further costs incurred if the public reject the proposal as new bills would need to be issued.

3.3 There are also a number of risks which are not included in the numbers above, or accompanying tables. These will be incorporated (as required) as the Business Plan is developed and the figures can be confirmed:

- Movement in current year pressures – Work is ongoing to manage our in-year pressures downwards however any change to the outturn position of the Council will impact the savings requirement in 2019-20. This is particularly relevant to demand led budgets such as children in care or adult social care provision.

- Due to the level of reduction in Government grants in later years the Council did not take the multi-year settlement offered as part of the 2015 Spending Review. The settlement included a negative allocation of Revenue Support Grant for the Council in 2019/20. There has been a recent consultation regarding Negative Revenue Support Grant however the outcome will not be known until the provisional Local Government Finance Settlement on 6 December. Our business plan currently makes a prudent assumption of a £7m negative RSG allocation in 2019/20 as proposed in the 2015 Spending

Review. The Government's preferred treatment is to eliminate negative RSG using the central share of business rate receipts.

- From 2020/21, local authorities will retain 75% of business rates, the tier split of business rates between Counties and Districts is subject to change, and the funding baselines for local authorities will be reassessed. There is therefore a significant level of uncertainty around the accuracy of our funding assumptions from 2020/21 onwards. The Council's future funding position will remain unclear until Government provides an indicative allocation of business rates in Spring 2019.

4. CAPITAL PROGRAMME UPDATE

4.1 The draft capital programme was reviewed individually by service committees in October and was subsequently reviewed in its entirety, along with the prioritisation of schemes, by GPC in November. As a result further work was required on a handful of schemes, as well as further work ongoing to revise and update the programme in light of continuing review by the Capital Programme Board, changes to overall funding or to specific circumstances surrounding individual schemes.

4.2 The Council is still awaiting funding announcements regarding various capital grants which are expected to be made during December/January, plus the ongoing nature of the capital programme inevitably means that circumstances are continually changing. Therefore Services will continue to make any necessary updates in the lead up to the January GPC meeting at which the Business Plan is considered.

5. OVERVIEW OF HEALTH'S DRAFT REVENUE PROGRAMME

5.1 This section provides an overview of the savings and income proposals within the remit of the Committee which have been added to the draft plan since the proposals were presented in October or where the business case has altered materially.

5.2 As a result of reductions to the public health grant, all areas of service have made 'cash savings' over previous years (in addition to internal cost improvement programmes to cover inflationary or demographic pressures) as outlined in the table below:

Service Category	Original Funding April 2015	Saving 2016/17	Saving 2017/18	Saving 2018/19	% Saving since 2015
Drug and alcohol services	£6269k	£289k	£100k	£154k	8.7%
Sexual Health & Contraception	£5692k	£280k	£100k	£140k	9.1%
Smoking Cessation & Tobacco Control	£1253k	£220k	£110k	£112k	35.3%
General Prevention: Obesity, Health Checks, Falls Prevention	£2465k	£125k	£101k	-	9.3%
Public Mental Health	£224k	£60k	£60k reinvested	£7k	3.1%
Children's 0-19 Public Health Services	£9527k (indicative)	£190k	£188k	£238k	6.5%
Public Health Directorate staffing & Income generation	£2567k	£524k	£75k	£49k	25.2%

5.3 All of the proposals within the remit of the Committee, including those which are unaltered since October, are described in the business planning tables (Appendix 1) and business cases (Appendix 2). The October papers are available to view here.

5.4 The main changes to proposals are as follows:

- The business case for proposals E/R.6.036 & ER.6.037 'Integrating Healthy Child Programme across Cambridgeshire and Peterborough' has been updated following further work on the integrated service model, which is described in detail in a separate paper to Health Committee.

- The business case for proposal E/R.6.035 'Children 5-19 Mental health training for children's workforce' has been updated.

- The proposal E/R.6.034 'Re-commissioning of Sexual Health Services' now shows a saving in 2020/21 but no saving for 2019/20. This is because further work is required to determine the timing of the re-procurement of this contract, in order to maximise the potential benefits from our current national pilot of alignment and integration with NHS commissioned sexual and reproductive health services.

- A saving E/R.6.041 'Expected operational savings across Public Health staffing and contracts' has been introduced. This recognises that there are always some underspends in year due to staff turnover, maternity leave and vacancies; and to variation in delivery of some demand-led or workforce dependent contracts - for example those with GP practices and pharmacies. A saving of 109k has therefore been included to cover in-year underspends.

5.5 The Committee is asked to comment on these revised proposals, and endorse them to GPC for consideration as part of the Council's development of the Business Plan for the next five years. Although now well developed, the proposals are still draft at this stage and it is only at Full Council in February 2019 that proposals are finalised and become the Council's Business Plan. The following proposals are available in Appendix 2.

5.6 **E/R.6.031 NHS Health Checks IT Contract (-41k in 2019-20)**

5.7 **E/R.6.032 NHS Health Checks Funding (-50k in 2019-20)**

5.8 **E/R.6.033 Re-commissioning of Drug and Alcohol Treatment Service (-162k in 2019/20)**

5.9 **E/R.6.035 Mental Health Training - focusing on children and young people's workforce (-36k in 2019-20)**

5.10 **E/R.6.036 & ER.6.037 Integrating Healthy Child Programme across Cambridgeshire and Peterborough (-398k in 2019-20)**

5.11 **E/R.6.038 Public Health Directorate Staffing Rationalisation (-80k in 2019-20)**

5.12 **E/R.6.039 Reduce long acting reversible contraception (LARCs) funding in line with audit results and completion of clinician training (-60k in 2019-20)**

5.13 **E/R.6.040 Mainstream work to promote immunisations (-13k in 2019-20)#**

5.14 **E/R.6.041 Expected operational savings across Public Health staffing and contracts (NEW) (-109k in 2019/20)**

6. NEXT STEPS

6.1 Following December service committees, GPC will review the overall programme in December, before recommending the programme in January as part of the overarching Business Plan for Full Council to consider in February.

December	GPC will consider the whole draft Business Plan for the first time Local Government Financial Settlement Published
January	GPC will review the whole draft Business Plan for recommendation to Full Council
February	Full Council will consider the draft Business Plan

7. ALIGNMENT WITH CORPORATE PRIORITIES

7.1 **Developing the local economy for the benefit of all**
Public health services provide support to the local economy through their role in maintaining a healthy and productive workforce.

7.2 **Helping people live healthy and independent lives**
The purpose of public health services is to help people live healthy and independent lives at all ages.

7.3 **Supporting and protecting vulnerable people**
The majority of public health services include a focus on identifying and supporting children or adults who are more vulnerable to ill health and poor outcomes, as well as providing more universal preventive services.

8. SIGNIFICANT IMPLICATIONS

8.1 **Resource Implications**
Resource Implications – All implications are detailed in the Business Cases and CIAs in Appendix 2

8.2 **Procurement/Contractual/Council Contract Procedure Rules Implications**
Procurement/Contractual/ Council Contract Procedure Rules – All implications are detailed in the Business Cases and CIAs in Appendix 2

8.3 **Statutory, Legal and Risk implications**
All implications are details in the Business Cases and CIAs in Appendix 2

8.4 **Equality and Diversity Implications**
The Community Impact Assessments describe the impact of each proposal, in particular any disproportionate impact on vulnerable, minority and protected groups. (See Appendix 2)

8.5 **Engagement and Consultation Implications**
Draft Community Impact Assessments (CIAs) for the savings proposals are attached to this paper for consideration by the Committee, and where applicable these will be developed based on consultation with service users and stakeholders. (See Appendix 2)

8.6 **Localism and Local Member Involvement**
The proposals made are all for county-wide public health programmes and services.

8.7 **Public Health Implications**
The savings proposals aim to achieve best value through public health services while minimising the risk of impact on public health outcomes.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Stephen Howarth
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Paul White
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes Fiona McMillan
Are there any Equality and Diversity implications?	Covered in Impact Assessments Julia Turner
Have any engagement and communication implications been cleared by Communications?	Yes Christine Birchall
Are there any Localism and Local Member involvement issues?	No Julia Turner
Have any Public Health implications been cleared by Public Health	Yes Liz Robin

Source Documents	Location
October 2018 Committee Business Planning Papers	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/879/Committee/6/Default.aspx

Appendix 1a **Public Health Revenue Finance Table 1**
Appendix 1b **Public Health Revenue Finance Table 2**
Appendix 1c **Public Health Revenue overview Finance Table 3**

Appendix 2 **Public Health Draft Business Cases**

Section 3 - E: Public Health

Table 1: Revenue - Summary of Net Budget by Operational Division

Budget Period: 2019-20 to 2023-24

Net Revised Opening Budget 2018-19 £000	Policy Line	Gross Budget 2019-20 £000	Fees, Charges & Ring-fenced Grants 2019-20 £000	Net Budget 2019-20 £000	Net Budget 2020-21 £000	Net Budget 2021-22 £000	Net Budget 2022-23 £000	Net Budget 2023-24 £000
	Children Health							
7,253	Children 0-5 PH Programme	6,855	-	6,855	6,855	6,855	6,855	6,855
1,706	Children 5-19 PH Programme - Non Prescribed	1,706	-	1,706	1,706	1,706	1,706	1,706
307	Children Mental Health	271	-	271	271	271	271	271
9,266	**Subtotal Children Health**	**8,832**	**-**	**8,832**	**8,832**	**8,832**	**8,832**	**8,832**
	Drugs & Alcohol							
5,625	Drug & Alcohol Misuse	5,655	-192	5,463	5,336	5,273	5,273	5,273
5,625	**Subtotal Drugs & Alcohol**	**5,655**	**-192**	**5,463**	**5,336**	**5,273**	**5,273**	**5,273**
	Sexual Health & Contraception							
3,829	SH STI testing & treatment - Prescribed	3,829	-	3,829	3,829	3,829	3,829	3,829
1,176	SH Contraception - Prescribed	1,116	-	1,116	1,101	1,101	1,101	1,101
152	SH Services Advice Prevn Promtn - Non-Prescribed	152	-	152	152	152	152	152
5,157	**Subtotal Sexual Health & Contraception**	**5,097**	**-**	**5,097**	**5,082**	**5,082**	**5,082**	**5,082**
	Behaviour Change / Preventing Long Term Conditions							
2,062	Integrated Lifestyle Services	2,062	-	2,062	2,062	2,062	2,062	2,062
299	Other Health Improvement	299	-	299	299	299	299	299
735	Smoking Cessation GP & Pharmacy	735	-	735	735	735	735	735
716	NHS Health Checks Prog - Prescribed	625	-	625	625	625	625	625
3,812	**Subtotal Behaviour Change / Preventing Long Term Conditions**	**3,721**	**-**	**3,721**	**3,721**	**3,721**	**3,721**	**3,721**
	Falls Prevention							
80	Falls Prevention	80	-	80	80	80	80	80
80	**Subtotal Falls Prevention**	**80**	**-**	**80**	**80**	**80**	**80**	**80**
	General Prevention Activities							
56	General Prevention, Traveller Health	56	-	56	56	56	56	56
56	**Subtotal General Prevention Activities**	**56**	**-**	**56**	**56**	**56**	**56**	**56**

Section 3 - E: Public Health

Table 1: Revenue - Summary of Net Budget by Operational Division

Budget Period: 2019-20 to 2023-24

Net Revised Opening Budget 2018-19 £000	Policy Line	Gross Budget 2019-20 £000	Fees, Charges & Ring-fenced Grants 2019-20 £000	Net Budget 2019-20 £000	Net Budget 2020-21 £000	Net Budget 2021-22 £000	Net Budget 2022-23 £000	Net Budget 2023-24 £000
	Adult Mental Health & Community Safety							
256	Adult Mental Health & Community Safety	256	-	256	256	256	256	256
256	**Subtotal Adult Mental Health & Community Safety**	**256**	**-**	**256**	**256**	**256**	**256**	**256**
	Public Health Directorate							
1,796	Public Health - Admin & Salaries	1,794	-184	1,610	1,610	1,610	1,610	1,610
-25,419	Public Health Grant	-	-24,726	-24,726	-	-	-	-
-23,623	**Subtotal Public Health Directorate**	**1,794**	**-24,910**	**-23,116**	**1,610**	**1,610**	**1,610**	**1,610**
	Future Years							
-	Inflation	-	-	-	18	36	55	74
-	Savings	-	-	-	-	-	-	-
629	**PUBLIC HEALTH TOTAL**	**25,491**	**-25,102**	**389**	**24,991**	**24,946**	**24,965**	**24,984**

Note: *Public Health - Admin & Salaries* includes direct delivery of health improvement programmes, health protection, and specialist healthcare public health advice services by public health directorate staff.

The above Public Health Directorate does not constitute the full extent of Public Health expenditure. The reconciliation below sets out where the Public Health grant is being managed in other areas of the County Council.

Public Health Grant breakdown	**2019-20**
People and Communities	
Public Health expenditure delivered by P&C	293
Subtotal People and Communities	**293**
Place and Economy	
Public Health expenditure delivered by P&E	120
Subtotal Place and Eceonomy	**120**
Corporate Services	
Public Health expenditure delivered by CS	201
Subtotal Corporate Services	**201**
LGSS - Cambridge Office	
Overheads associated with Public Health function	220
Subtotal LGSS - Cambridge Office	**220**
PUBLIC HEALTH MANAGED IN OTHER SERVICE AREAS TOTAL	**834**
PH Grant Managed in PH Directorate	24,726
EXPENDITURE FUNDED BY PUBLIC HEALTH GRANT TOTAL	**25,560**

Section 3 - E: Public Health

Table 2: Revenue - Net Budget Changes by Operational Division

Budget Period: 2019-20

Policy Line	Net Revised Opening Budget £000	Net Inflation £000	Demography & Demand £000	Pressures £000	Investments £000	Savings & Income Adjustments £000	Net Budget £000
Children Health							
Children 0-5 PH Programme	7,253	-	-	-	-	-398	6,855
Children 5-19 PH Programme - Non Prescribed	1,706	-	-	-	-	-	1,706
Children Mental Health	307	-	-	-	-	-36	271
Subtotal Children Health	**9,266**	**-**	**-**	**-**	**-**	**-434**	**8,832**
Drugs & Alcohol							
Drug & Alcohol Misuse	5,625	-	-	-	-	-162	5,463
Subtotal Drugs & Alcohol	**5,625**	**-**	**-**	**-**	**-**	**-162**	**5,463**
Sexual Health & Contraception							
SH STI testing & treatment - Prescribed	3,829	-	-	-	-	-	3,829
SH Contraception - Prescribed	1,176	-	-	-	-	-60	1,116
SH Services Advice Prevn Promtn - Non-Prescribed	152	-	-	-	-	-	152
Subtotal Sexual Health & Contraception	**5,157**	**-**	**-**	**-**	**-**	**-60**	**5,097**
Behaviour Change / Preventing Long Term Conditions							
Integrated Lifestyle Services	2,062	-	-	-	-	-	2,062
Other Health Improvement	299	-	-	-	-	-	299
Smoking Cessation GP & Pharmacy	735	-	-	-	-	-	735
NHS Health Checks Prog - Prescribed	716	-	-	-	-	-91	625
Subtotal Behaviour Change / Preventing Long Term Conditions	**3,812**	**-**	**-**	**-**	**-**	**-91**	**3,721**

Section 3 - E: Public Health

Table 2: Revenue - Net Budget Changes by Operational Division

Budget Period: 2019-20

Policy Line	Net Revised Opening Budget £000	Net Inflation £000	Demography & Demand £000	Pressures £000	Investments £000	Savings & Income Adjustments £000	Net Budget £000
Falls Prevention							
Falls Prevention	80	-	-	-	-	-	80
Subtotal Falls Prevention	**80**	**-**	**-**	**-**	**-**	**-**	**80**
General Prevention Activities							
General Prevention, Traveller Health	56	-	-	-	-	-	56
Subtotal General Prevention Activities	**56**	**-**	**-**	**-**	**-**	**-**	**56**
Adult Mental Health & Community Safety							
Adult Mental Health & Community Safety	256	-	-	-	-	-	256
Subtotal Adult Mental Health & Community Safety	**256**	**-**	**-**	**-**	**-**	**-**	**256**
Public Health Directorate							
Public Health - Admin & Salaries	1,796	16	-	-	-	-202	1,610
Public Health Grant	-25,419	-	-	-	-	693	-24,726
Subtotal Public Health Directorate	**-23,623**	**16**	**-**	**-**	**-**	**491**	**-23,116**
PUBLIC HEALTH TOTAL	**629**	**16**	**-**	**-**	**-**	**-256**	**389**

Section 3 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2019-20 to 2023-24

		Detailed Plans	Outline Plans					
Ref	**Title**	**2019-20 £000**	**2020-21 £000**	**2021-22 £000**	**2022-23 £000**	**2023-24 £000**	**Description**	**Committee**
1	**OPENING GROSS EXPENDITURE**	**26,478**	**25,491**	**25,367**	**25,322**	**25,341**		
E/R.1.001	Base Adjustments	-54	-	-	-	-	Adjustment for permanent changes to base budget from decisions made in 2018-19.	**Health**
1.999	**REVISED OPENING GROSS EXPENDITURE**	**26,424**	**25,491**	**25,367**	**25,322**	**25,341**		
2	**INFLATION**							
E/R.2.001	Inflation	16	18	18	19	19	Forecast pressure from inflation in the Public Health Directorate, excluding inflation on any costs linked to the standard rate of inflation where the inflation rate is assumed to be 0%. Inflation appears low due to the majority of public health spend being committed to external contracts. Providers are expected to meet inflationary and demographic pressures within the agreed contract envelope.	**Health**
2.999	**Subtotal Inflation**	**16**	**18**	**18**	**19**	**19**		
3	**DEMOGRAPHY AND DEMAND**							
3.999	**Subtotal Demography and Demand**	**-**	**-**	**-**	**-**	**-**		
4	**PRESSURES**							
4.999	**Subtotal Pressures**	**-**	**-**	**-**	**-**	**-**		
5	**INVESTMENTS**							
5.999	**Subtotal Investments**	**-**	**-**	**-**	**-**	**-**		
6	**SAVINGS**							
	Health							
E/R.6.031	NHS Health Checks - IT software contract decommissioned	-41	-	-	-	-	NHS Health Checks is a cardiovascular risk assessment offered to people aged to 40 to 74 year olds every five years who do not have a diagnosed health condition. GP practices are commissioned to identify and invite eligible individuals to have an NHS Health Check. A robust data collection process is required to manage patient data and to ensure that anonymized data is sent to the Local Authority as part of the performance monitoring and payment system to the GPs. In 2017 after securing agreement from the Clinical Commissioning Group (CCG) which has responsibility for practice systems new software was commissioned to sit on GP practice systems. The introduction of GPPR compromised the security of the software as it could not meet fully the GDPR requirements and therefore the contract was decommissioned. The IT company fully agreed with this approach and assumed any additional cost for removing systems already in practices. GP practice systems have developed rapidly and they are now able to manage NHS Health Check data electronically and share anonymized data with the Local Authority at no cost to the Local Authority.	**Health**

Section 3 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2019-20 to 2023-24

	Detailed Plans	Outline Plans				
Ref	**Title**	**2019-20 £000**	**2020-21 £000**	**2021-22 £000**	**2022-23 £000**	**2023-24 £000**	**Description**	**Committee**
E/R.6.032	NHS Health Checks Funding	-50	-	-	-	-	There has been a recurrent underspend on the NHS Health Checks Programme since the transfer of the funding from the NHS to the Local Authority which has reflected fairly stable activity levels.	Health
E/R.6.033	Drug & Alcohol service - funding reduction built in to new service contract	-162	-127	-63	-	-	Savings will be secured through the re-commissioning of the Cambridgeshire Adult Drug and Alcohol Treatment Services, which will enable transformational changes to be undertaken. The Drugs and Alcohol Joint Strategic Needs Assessment, (2016) indicated changes in needs that are addressed in the new service model. An aging long-term drug using population that enter and re-enter the Service has complex health and social problems that do not require intensive acute drug treatment services but more cost effective support services to ensure their good mental and physical health and social support needs are met. Strengthened recovery services using cost-effective peer support models to avoid readmission, different staffing models and a mobile outreach service.	Health
E/R.6.034	Recommissioning of the Integrated Contraception and Sexual Health (iCASH) Service contract	-	-15	-	-	-	The iCaSH Service will be recommissioned with a new contract scheduled to start in October 2019. It will be a joint contract between Cambridgeshire County Council and Peterborough City Council. The current services have already undertaken transformational changes reflecting new technologies and rationalising clinics to ensure that they are not located where there is very little activity. This transformational work is ongoing but there will be “backroom” savings from having one contract across the two areas.	Health
E/R.6.035	Children 5-19 - Mental Health Training for Children’s workforce	-36	-	-	-	-	This proposal ceases funding for intensive training for a relatively small number of the young people’s workforce each year, delivered face to face by Cambridgeshire and Peterborough NHS Foundation Trust. Instead it is proposed that Public Health staff work together with the Heads of Early Help to establish a clear specification of the training requirements and success criteria for an e-learning training package with less intensive face to face training in 2019/20, focussed on the mental health training needs of Young People’s workers in the Early Help Teams.	Health

Section 3 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2019-20 to 2023-24

Detailed Plans	Outline Plans

Ref	Title	2019-20 £000	2020-21 £000	2021-22 £000	2022-23 £000	2023-24 £000	Description	Committee
E/R.6.036	Children's 0-19 Services - Healthy Child Programme - Proposal previously agreed in 2017/18 business planning process	-238	-	-	-	-	This £238k savings proposal was previously discussed by Health Committee in the autumn 2017 business planning round. It was agreed to fund the £238k saving from public health reserves in 2018/19, to allow further time to develop the 0-19 Healthy Child integration programme (and associated savings) for implementation in 2019/20. The Healthy Child programme is a universal-progressive, needs-based service delivered at 4 levels: Community, Universal, Universal Plus (single agency involvement) and Universal Partnership Plus (multi-agency involvement). All children, young people and families are offered a core programme of evidence based, early intervention and preventative health care with additional care and support for those who need it. The 0-19 Healthy Child Programme (HCP) consists of Health Visiting (0-5yrs), Family Nurse Partnership (for vulnerable teenage parents), and School Nursing (5-19yrs). It is delivered by CCS in Cambridgeshire and CPFT in Peterborough. The 2018/19 budget allocations are £8,926,739 in Cambridgeshire and £3,695,226 in Peterborough. Total approximately £12.6 million. Savings will be achieved by integrating the two services with a common management structure, and redesigning the service model to achieve savings through improved skill mix. A Transformation Board including commissioners, public health and senior management from the two provider organisations has been set up to oversee the project from design to implementation. The positive impact of this integration is that it will reduce duplication freeing up workforce capacity to improve areas of poor performance across the HCP particularly in mandated 0-5 checks. There will be an increased focus on areas of need so workforce and services will be resourced to ensure there is an improvement in outcomes and reduced inequalities. The Benson modelling tool has been used to model the workforce requirements and various options possible by changing the skill-mix and activities delivered. Implementation is expected to take 3-6 months from decision, and will include a communications and engagement plan, to include service users and local GP practices.	Health
E/R.6.037	Children's 0-19 Services - Healthy Child Programme - Additional savings proposal for 2018/19	-160	-	-	-	-	See description for proposal E/R.6.036. This proposal is for additional savings associated with integration of the 0-19 Healthy Child integration programme, not previously discussed in autumn 2017.	Health
E/R.6.038	Public Health Directorate - In house staff rationalisation	-80	-	-	-	-	It has been possible to build on the efficiencies created by creating a joint public health directorate across Cambridgeshire County Council and Peterborough City Council, by merging two team leader posts in the joint public health commissioning unit. In addition it is proposed to delete three vacant posts in the public health directorate. The saving will be shared across Cambridgeshire County Council and Peterborough City Council, and some of the saving is offset by a technical change to the recharge across the two Councils.	Health
E/R.6.039	Reduce Long Acting Reversible Contraception (LARCs) funding in line with audit results and completion of clinician training	-60	-	-	-	-	LARCs are commissioned from GP practices. The Clinical Commissioning Group (CCG) recharges the LA for the cost of the contraception devices. Audits have been undertaken of the services which revealed that the recharges included the cost of items for which the LA is not liable i.e. injectable contraception and the use of devices for gynaecological purposes. In addition the training programme for clinicians to ensure that there is capacity in the system to accommodate retiring GPs has now been completed.	Health

Section 3 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2019-20 to 2023-24

		Detailed Plans	Outline Plans					
Ref	**Title**	**2019-20 £000**	**2020-21 £000**	**2021-22 £000**	**2022-23 £000**	**2023-24 £000**	**Description**	**Committee**
E/R.6.040	Reduce immunisations promotion budget	-13	-	-	-	-	In 2016/17 funding of £20k per annum was allocated by Cambridgeshire County Council for promotion of immunisations. Since then childhood immunisation rates have improved, although still with some further work to do, and the PHE/NHS England screening and immunisations team have been actively taking forward further improvement measures. It is proposed to mainstream promotion of immunisations within the wider health protection and communications functions. £7k will be allocated to the health protection budget and the remaining £13k taken as a saving.	Health
E/R.6.041	Expected operational savings across Public Health staffing and contracts	-109	-	-	-	-	In-year vacancy savings and efficiencies within demand-led contracts.	Health
6.999	**Subtotal Savings**	**-949**	**-142**	**-63**	**-**	**-**		
	TOTAL GROSS EXPENDITURE	**25,491**	**25,367**	**25,322**	**25,341**	**25,360**		
7	**FEES, CHARGES & RING-FENCED GRANTS**							
E/R.7.001	Previous year's fees, charges & ring-fenced grants	-25,849	-25,102	-376	-376	-376	Fees and charges expected to be received for services provided and Public Health ring-fenced grant from Government.	Health
E/R.7.002	Changes to fees, charges & ring-fenced grants in 2018-19	54	-	-	-	-	Permanent changes to income from fees, charges & ring-fenced grants as a result of decisons made in 2018-19.	Health
	Changes to fees & charges							
E/R.7.201	Change in Public Health Grant	693	24,726	-	-	-	Grant reductions announced in the comprehensive spending review, and removal of the ring-fence in 2019-20	Health
7.999	**Subtotal Fees, Charges & Ring-fenced Grants**	**-25,102**	**-376**	**-376**	**-376**	**-376**		
	TOTAL NET EXPENDITURE	**389**	**24,991**	**24,946**	**24,965**	**24,984**		

Business Case

E/R.6.031 NHS Health Checks IT Contract

Project Overview			
Project Title	E/R.6.031 NHS Health Checks IT Contract		
Project Code	TR001402	**Business Planning Reference**	E/R.6.039
Business Planning Brief Description	NHS Health Checks are commissioned from GP practices. The contract for an IT software system to manage the data in practices and for performance management has been terminated as it could not fully meet GDPR requirements. New arrangements with the Clinical Commissioning Group are now available at no additional cost.		
Senior Responsible Officer	Val Thomas		

Project Approach

Background

Why do we need to undertake this project?

Cash reductions in the Public Health Grant and financial pressures upon the Local Authority require efficiencies and cost-effective innovative approaches to delivering commissioned services.

What would happen if we did not complete this project?

The savings would not be secured.

Approach

Aims / Objectives

This proposal aims to secure savings from severing the contract for the provision of an IT system that facilitates and improves the data collection and collation processes for the NHS Health Check Programme.

Project Overview - What are we doing

Background

NHS Health Checks is a cardiovascular risk assessment (offered to people aged from 40 to 74 years old) every five years who do not have a diagnosed health condition. Eligible individuals are identified by GP practices and sent an invitation to have an NHS Health Check at their practice. GP practices are paid for each NHS Health Check that they undertake.

We introduced outreach NHS Health Checks that are provided by the lifestyle service 'Everyone Health' that target high risk and often hard to reach populations through offering NHS Health Checks at workplaces and other community locations. The results are sent to the GP practices for them to follow up if necessary. Everyone Health is funded through a block contract that does not have a threshold for its activity.

A robust data collection process is required to: ensure that the correct patients are identified, any intervention is recorded whether in the GP practice or in the Outreach Service, that anonymized data is sent to the Local Authority as part of the performance monitoring of activity which also enables GPs to be paid, that data is sent from safely from the Outreach Service to the participants' GPs.

New technologies have been emerging that allow software to sit on GP practice systems, and after securing agreement with the Clinical Commissioning Group (CCG) which has responsibility for practice systems we commissioned new software that started to be installed in GP practices in 2017.

Current position

The introduction of GDPR compromised the security of the software as it could not fully meet the GDPR requirements and therefore it was not considered safe to continue with the contract. Although prior to GDPR it had been rigorously assessed by the CCG Information Governance and CCC Information Governance to ensure it was fully compliant with the pre-GDPR information governance requirements. The IT company fully agreed with this approach and assumed any additional cost for removing systems already in practices.

What assumptions have you made?

N/A

What constraints does the project face?

N/A

Delivery Options

Has an options and feasibility study been undertaken?

Scope / Interdependencies

Scope

What is within scope?

NHS Health Checks IT software contract

What is outside of scope?

The other parts of the NHS Health Checks Programme which includes payments to GPs and lifestyle service Outreach Health Checks programme and point of care blood testing.

Project Dependencies

Title

The CCG IT Improvement Programme

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

The CCG IT improvements also affect the reporting of other Public Health services commissioned from GP practices.

Title

Risks

Title

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

NHS Health Check recipients both in GP practices and the Outreach Programme. These will be in the eligible age range of 40-74 years and do not have a diagnosed ongoing condition. However this will be in terms of their information and any changes will not be experienced as part of the NHS Health Check.

Staff providing the service and responsible for data collecting will also be affected.

What positive impacts are anticipated from this proposal?

It will support the development of the local GP practice system and is a good local example of shared data protocols.

What negative impacts are anticipated from this proposal?

N/A

Are there other impacts which are more neutral?

N/A

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

Business Case

E/R.6.032 NHS Health Checks Funding

Project Overview			
Project Title	E/R.6.032 NHS Health Checks Funding		
Project Code	TR001403	**Business Planning Reference**	E/R.6.039
Business Planning Brief Description	This proposal secures savings through a reduction in the allocation of funding for NHS Health Checks based on an historical budget that was transferred from the NHS. There has been a recurrent underspend and stable levels of activity.		
Senior Responsible Officer	Val Thomas		

Project Approach

Background

Why do we need to undertake this project?

Cash reductions in the Public Health Grant and financial pressures upon the Local Authority require efficiencies and cost-effective innovative approaches to delivering commissioned services.

What would happen if we did not complete this project?

The savings would not be achieved.

Approach

Aims / Objectives

To reduce the allocated funding to the NHS Health Checks Programme without reducing its activity levels.

Project Overview - What are we doing

Background

NHS Health Checks is a cardiovascular risk assessment offered to those aged between 40 and 74 year old, every five years, who do not have a diagnosed health condition. Eligible individuals are identified by GP practices and sent an invitation to have an NHS Health Check at their practice. GP practices are paid for each NHS Health Check that they undertake. GP's are paid for each Health Check, it is a unit cost and relevant to the whole business case.

We introduced outreach NHS Health Checks that are provided by the lifestyle service 'Everyone Health' that target high risk and often hard to reach populations through offering NHS Health Checks at workplaces and other community locations. The results are sent to the GP practices for them to follow up if necessary. Everyone Health is funded through a block contract that does not have a threshold for its activity i.e. it is a block contract therefore no matter how many outreach checks are undertaken the contract price remains the same.

Current position

The funding allocation that was transferred from the NHS has not been met by the activity. Although improvements have been made and numbers have increased there has been a persistent underspend on the funding allocation.

The outreach programme has contributed to this as it has slowly been increasing the number of completed

NHS Health Checks but this has not created a cost pressure as the Provider is not paid for each NHS Health Check.

What assumptions have you made?

That the demand for GP delivered NHS Health Checks does not increase above the level that can be contained in the proposed new funding allocation.

What constraints does the project face?

An unprecedented increase in GP practice activity of NHS Health Check activity.

Delivery Options

Has an options and feasibility study been undertaken?

Scope / Interdependencies

Scope

What is within scope?

NHS Health Checks funding allocation

What is outside of scope?

The NHS Funding allocation covers all aspects of the programme including GP payments, outreach NHS Health Checks and point of care blood tests.

Project Dependencies

Title

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

None

Title

Risks

Title

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

The 40 to 70 year olds who are eligible for an NHS Health Check who do not have diagnosed condition.

What positive impacts are anticipated from this proposal?

The GP Practice NHS Health Check Programme will not be affected and efforts are ongoing to increase the uptake in the Outreach Programme as this targets the most at risk populations and the costs are contained

within the block contract price.

What negative impacts are anticipated from this proposal?

N/A

Are there other impacts which are more neutral?

N/A

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

This proposal will not have disproportionate impacts upon protected characteristics but it will increase the focus upon more deprived areas that have populations with higher risks of cardiovascular disease through the outreach service where costs are contained within the contract cost

Business Case

E/R.6.033 Re-commissioning of Drug and Alcohol Treatment Service (Public Health)

Project Overview			
Project Title	E/R.6.033 Re-commissioning of Drug and Alcohol Treatment Service (Public Health)		
Project Code	TR001380	**Business Planning Reference**	E/R.6.033
Business Planning Brief Description	The Adult Drug and Alcohol Treatment Services was re-commissioned in 2017 and the new Service will commence in October 2018. The value of the contract is being reduced over the course of the contract reflecting transformational changes in response to changing needs and service efficiencies.		
Senior Responsible Officer	Val Thomas		

Project Approach

Background

Why do we need to undertake this project?

Cash reductions in the Public Health Grant and financial pressures upon the Local Authority require efficiencies and cost-effective innovative approaches to delivering commissioned services. The re-commissioning of this service has enabled transformational service redesign and efficiencies that will be delivered over the course of the five year lifetime of the contract.

What would happen if we did not complete this project?

The required savings would not be realised.

Approach

Aims / Objectives

The aim of this proposal is that the new Adult Drugs and Alcohol Treatment Service makes transformational changes that produce efficiencies and contribute towards improved outcomes.
The key objectives will impact at different stages of the contract and are as follows:
Increase community treatment alternatives and the introduction of new cost-effective technologies as they come on stream.
Manage service demand through strengthening early intervention and prevention services, strengthening work with other organizations to develop holistic care packages that support recovery and targeting high risk groups with harm reduction and community support interventions.
Expand and strengthen recovery services to reduce clients re-presenting to the services.

Project Overview - What are we doing

Background

The Drug and Alcohol Joint Strategic Needs Assessment in 2016 found that there is a changing landscape for drug and alcohol misuse with changing patterns of demand and different client groups.
The current Adult Drug and Alcohol Treatment Service provided by the South Staffordshire NHS Foundation Trust through its Inclusion Service has evolved over the past five years in response to the changing needs of

the client population. However in the current contract there are still services that are being delivered in a hospital setting when there is evidence that these could be undertaken safely in a more cost effective community setting. For example detoxification is currently undertaken in the community but also through a separate contract with the Cambridgeshire and Peterborough Foundation Trust that provides inpatient care at its Fulbourn site.
The current service design means that there has been limited investment in early intervention or prevention work. Providing intervention and brief advice to at risk populations is a cost-effective evidence based approach that has been undertaken randomly and not funded on an ongoing basis.
There are pathways between services that provide support for adult drug and alcohol users that usually have wide ranging needs. It is essential that these services work together to provide a holistic package of care that will produce positive outcomes for the client. These pathways especially with mental health and primary care services need to be strengthened to secure better outcomes and decrease ongoing demand for services.
Good recovery services that offer wide ranging support and link effectively with other services is recognized as being essential for ensuring good treatment outcomes and reducing representation to services.

Current position

To be able to meet these needs, in the context of reduced funding, the request for agencies bidding for the contract was to present proposals that would enable transformational change to deliver services in a different way and impact on demand going forward.

The following transformational changes have been built into the new service specifications and the contract has been awarded at a reduced value:

- More treatment will be undertaken in the community including an increased number of detoxification treatments.

- Funding has been allocated to the Lifestyle service for it to provide a Drugs and Alcohol Health Trainer who will focus on providing Identification and Brief Intervention (IBA) Training to a range of organisations to enable their staff to increase the numbers of high risk substance misusers who are identified and receive an appropriate service to prevent their misuse becoming a dependency. There will also be increased focus on promoting prevention generally in the community.

- The Recovery element of the service has been strengthened to provide more support and the provider will work with a range of organisations to ensure that the wide range of needs of clients in recovery are met to ensure that there is a decreased number of re-presentations to the Drug and Alcohol Service.

- Services have been redesigned to meet the new needs that have emerged, the increased number of older people accessing the service, the misuse of prescription drugs and the aging cohort of long term primarily opiate users whose dependency has effectively become a long term condition. These require different more cost effective approaches that are based on working with different organisations to ensure that they receive the right type of support that will enable them to remain in the community with less support from the treatment services.

Other savings are through providing a mobile service, thereby avoiding accommodation costs.

What assumptions have you made?

- All clients diagnosed with requiring detoxification will be assessed for their suitability for community detoxification. Based on experience in other services the majority of clients can be effectively treated in the community. However, this assessment has not yet been undertaken on Cambridgeshire clients and there is an assumption that there will be a high number of patients suitable for a community detoxification.
- That organisations will engage with the IBA training and their staff will make an appropriate

intervention and refer when necessary.
- For the Recovery Services to secure the desired positive outcomes will mean the engagement and collaboration of partner organisations.

What constraints does the project face?

- The contract for the new Service has been awarded and it will be performance monitored. .However some of the transformational changes are dependent on collaborative working with other agencies and subject to the assumptions described above.
- There could also be a delay before the positive impact of increasing the level of IBA in the community is experienced by the Service.

Delivery Options

Has an options and feasibility study been undertaken?

Scope / Interdependencies

Scope

What is within scope?

Adult Drug and Alcohol Services including all four tiers of the treatment Service

What is outside of scope?

Children and Young People Drug and Alcohol Treatment Services.

Project Dependencies

Title

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

The transformational changes are aiming to improve outcomes for those misusing drugs and alcohol in terms of successful recovery and fewer representations to the Service.
Earlier identification of those at risk of developing from at risk users to dependent users.
Improved and more appropriate treatment of long term misusers of opiates, misuse of prescription drugs and older people.

Title

Risks

Title

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

Adults who misuse Drugs and Alcohol ranging from those who are putting themselves at risk to those who are dependent on drugs and alcohol.

What positive impacts are anticipated from this proposal?

More individuals who misuse substances are identified early and commence treatment before they become dependent.
That more people will recover and do not re-present into services.
That more people are treated in the community and are not admitted to hospital for treatment.
Increased collaboration with other services will ensure that people will be treated early and the diverse needs that clients present with are better addressed increasing the chances of positive outcomes.

What negative impacts are anticipated from this proposal?

None

Are there other impacts which are more neutral?

N/A

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

This proposal will aim to target groups that have a high risk of misusing substance which includes those who deprived, homeless, in the criminal justice system and older people. The Service design includes a mobile service to increase accessibility and outreach work to ensure that these groups are targeted. In addition the IBA training programme will target organisations that work with high risk groups.

Business Case

E/R.6.035 Mental Health training - focusing on children and young people's workforce

Project Overview			
Project Title	E/R.6.035 Mental Health training - focusing on children and young people's workforce		
Project Code	TR001397	**Business Planning Reference**	E/R.6.035
Business Planning Brief Description	Reduction in funding for mental health training, with a focus on a smaller workforce group.		
Senior Responsible Officer	Raj Lakshman		

Project Approach

Background

Why do we need to undertake this project?

Financial constraints on Local Authority budgets require a review of current spending to ensure the best use of resource. A funding reduction can be achieved through a change in the type of training delivered and a re-focusing of the targeted workforce.

What would happen if we did not complete this project?

Required savings would not be met.

Approach

Aims / Objectives

The training seeks to:

- improve knowledge and understanding of mental health within the children and young people's workforce.
- improve confidence in identifying and responding to mental health issues in children and young people.
- improve understanding of the mental health services and support available for children and young people.

This proposal aims to achieve these objectives with a reduced budget.

Project Overview - What are we doing

The service now delivers the following training for the broader children and young people's workforce (which will still include some schools that wish to access further training):

- Mental Health Awareness Courses (1 day course)
- Child and Adolescent Mental Health Foundation Module (12 days)
- Introduction to CBT (6 days)
- CPD day courses (for those who have attended the Foundation Module course)
- E-learning package (piloting)

Previous analysis has shown that the Foundation Module course in particular is quite an expensive course (approximately £1,500 per person) with the nature of the Public Health grant meaning places can't be

subsidised, but must be paid in full. The course is popular and does receive good outcomes in terms of people's increased understanding and confidence, but with the current investment it is limited in terms of how many people can be reached. In addition, although the course is always full, the length of the course (12 days) is a limitation for some individuals in terms of securing the days for attendance.

There is a variety of mental health training available, some of which is free (e.g. CHUMS training), and some training that schools/settings pay for. The Government also funds some Youth Mental Health First Aid training for secondary schools (every secondary school is entitled to 1 free place on the 1 day course). In addition the 2018 'Transforming children and young people's mental health provision' Green Paper indicates that there will be additional training made available for Designated Senior Leads for Mental Health in the future.

Where there is less training available is the broader children and young people's workforce, with bespoke training being commissioned in the past for certain workforce groups. With financial constraints it is logical to focus on upskilling a targeted part of the workforce.

Within the Local Authority, Early Help teams frequently work directly with young people and families, yet there is currently limited free training available (mainly LGSS training and the CPFT training). In particular, the Heads of Early Help have identified Young People's Workers as a group that would benefit from greater mental health training investment. Young People's Workers form part of district teams and provide 1-to-1 support to young people, supporting them to overcome barriers.

A more flexible and cost effective mechanism for delivery of training is through a greater use of e-learning. A variety of providers offer e-learning packages locally, including the current Provider CPFT who is trialling a new mental health (risk and resilience) e-learning package as part of this year's investment. E-learning wouldn't be appropriate for all training requirements, therefore a mixed approach which includes face-to-face training is proposed.

It is proposed that Public Health work together with the Heads of Early Help to establish a clear specification of the training requirements and success criteria. Following appropriate procurement procedures a Provider would be identified that could deliver the training package in 2019/20.

Current work with Early Help Teams identifies training requirements in the following areas as part of this work:

- Suicide and self-harm training
- Pre-bereavement training
- Developing further skills, this would depend on course availability within funding constraints but could include CBT or basic counselling skills.

Current training cost = £46k

Proposed savings = £36k

What assumptions have you made?

What constraints does the project face?

It is believed that a suitable training package could be procured within the reduced budget of £10,000 for 2019/20.

Delivery Options

Has an options and feasibility study been undertaken?

Scope / Interdependencies

Scope

What is within scope?

Mental Health Training investment (£46k) – provides mental health training to the children and young people's workforce.

What is outside of scope?

Project Dependencies

Title

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

A more flexible training offer for Early Help Teams, hopefully enabling greater access to mental health training.

Title

Risks

Title

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

The current training provider – CPFT. This would have implications in terms of their workforce. Constant communications are being held to identify how to best manage this impact.

Other groups that would be affected are the broader children and young people's workforce who currently have access to training, including the social care workforce, the health sector and school and college staff.

What positive impacts are anticipated from this proposal?

More flexible and tailored training for the Early Help Teams (especially Young People's Workers). It is anticipated the take up of training would be considerable because of the greater flexibility of the training package.

What negative impacts are anticipated from this proposal?

Some staffing groups would not be able to attend the training, in particular the Foundation course is well received by those that attend, but places are limited and the cost per individual is quite high.

Are there other impacts which are more neutral?

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

With reduced funding for training inevitably there is likely to be fewer people within the workforce receiving training to ensure quality of training is maintained. The use of a variety of delivery methods, including e-learning will hope to reduce this impact but there will be fewer people trained. This could in turn have an impact on the identification of vulnerable young people with mental health problems. However, there is a range of training available to the schools workforce in particular, that has not previously been on offer, that would hope to counter this impact.

In terms of specific groups with protected characteristics, the following impact would be expected from the changes:

Impact	**Positive**	**Neutral**	**Negative**
Age		X	
Disability		X	
Gender reassignment		X	
Marriage and civil partnership		X	
Pregnancy and maternity		X	
Race		X	
Religion or belief		X	
Sex		X	
Sexual orientation		X	
The following additional characteristics can be significant in areas of Cambridgeshire:			
Rural isolation		X	
Deprivation		X	

Business Case

E/R.6.036 Integrating Healthy Child Programme across Cambridgeshire and Peterborough

Project Overview			
Project Title	E/R.6.036 Integrating Healthy Child Programme across Cambridgeshire and Peterborough		
Project Code	TR001398	**Business Planning Reference**	E/R.6.036 E/R.6.037
Business Planning Brief Description	Integrating the Healthy Child Programme (Health Visiting, Family Nurse Partnership, School Nursing) across Cambridgeshire and Peterborough.		
Senior Responsible Officer	Dr Liz Robin, Dr Raj Lakshman		

Project Approach

Background

Why do we need to undertake this project?

- The public health grant which is used to commission the Healthy Child Programme has been reduced, and this programme will redesign services to accommodate the reduced budget. This is aligned to the national integration agenda and will see provision streamlined from two separate providers, systems and processes to one integrated provision.

- It will reduce system complexities and duplication of services for children, young people and families in accessing the Healthy Child Programme (HCP 0-19).

- A saving proposal of £238k was agreed in the previous business planning round, but deferred until April 2019 in order for further work on the integration model to take place, with the gap being funded by PH reserve (proposal E/R.6.036). An additional proposal for £160k saving is being included in this year's business planning (proposal E/R.6.037). The total saving from the two proposals is £398k.

What would happen if we did not complete this project?

With the public health grant being reduced, we would overspend in this area if we are unable to make these savings.

Approach

Aims / Objectives

- To improve delivery of the current outcomes framework for children and young people.
- To improve performance where applicable to the Healthy Child Programme (HCP)
- To ensure the statutory responsibilities of the Director of Public Health for delivery of the Healthy Child Programme (HCP) are met
- To ensure provision is in line with the nationally reduced public health grant

Project Overview - What are we doing

Integrating the Healthy Child Programme (Health Visiting, Family Nurse Partnership, School Nursing) across Cambridgeshire and Peterborough. The Benson modelling tool has been used to model the workforce

requirements and various options possible by changing the skill-mix and activities delivered. Combined with management cost savings, savings of £398k for Cambridgeshire and £200k for Peterborough have now been identified. The Benson modelling tool is a workforce modelling tool that has been used by Cambridgeshire Community Services for some time, and is nationally used by some 40 NHS Trusts. It has been populated with information about the tasks that Health Visitors, School Nurses and allied staff do to deliver the service offer. Across Cambridgeshire and Peterborough a model has been produced which has been used to develop a service offer for the HCP. In summary this has included:

- Reviewing the workforce aligned to the Healthy Child Programme and teenage pregnancy pathway across Cambridgeshire Community Services (CCS) and Cambridgeshire and Peterborough Foundation Trust (CPFT) to determine the activities that are currently undertaken, the skill mix involved to create a baseline. This baseline was then used to model different scenarios in order to achieve Public Health Grant savings of £398k in Cambridgeshire and £200k in Peterborough.

- Reviewing the current separate section 75 agreements (in readiness for start at 1 April 2019) in conjunction with the above and wider service delivery to determine service provision, updating in line with outcomes for the above activity, and determining other activity within the current specification which requires amendment.

Current budget: £12.6 million (combined); £8,926,739 (Cambridgeshire)
Target savings: £598k (combined); £398k (Cambridgeshire)

What assumptions have you made?

That the costs of workforce change will be borne by the provider
That recruitment to nursery nurse grades will be achievable
That there will be no delay to the project implementation required by wider public consultation

What constraints does the project face?

The need for stakeholder consultation if there are significant changes to the service model would result in delays in implementing the section 75 agreement.

Delivery Options

Has an options and feasibility study been undertaken?

A range of options for delivery of the Family Nurse Partnership pathway for vulnerable teenage parents has been considered.

The Benson modelling has been iterative, therefore a preferred option has been identified which meets service and financial criteria

Scope / Interdependencies

Scope

What is within scope?

The Healthy Child programme across Cambridgeshire and Peterborough delivered by CCS and CPFT

The 0-19 Healthy Child Programme (HCP) consists of Health Visiting (0-5yrs), Family Nurse Partnership (for vulnerable teenage parents), and School Nursing (5-19yrs).

What is outside of scope?

The wider children and young people's services commissioned by the CCG (community paediatrics, community nursing, specialist therapies) and Local Authorities (Child and Family Centres, Early Help).

Project Dependencies

Title

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

To be confirmed based on preferred option chosen by Health committee and based on streamlined service experience, reduction of duplication, use of appropriate skill-mix, use of technology.

Title

Risks

Title

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

The scope of this project includes all children in Cambridgeshire and Peterborough between the ages of 0-19. It considers Universal, Universal Plus and Universal Partnership Plus services within the Healthy Child Programme (HCP) including Health Visiting, FNP and School Nursing. The Healthy Child Programme starts before birth so also includes pregnant women.

What positive impacts are anticipated from this proposal?

The new proposed offer provides a comprehensive integrated and targeted service across Cambridgeshire and Peterborough within the reduced cost envelope. This has been achieved through redesign and reallocation. A significant proportion of the service model will continue and the key changes which include enhancements to the service model are set out below:

1 Streamlining the Management Structure

By working effectively together across the Cambridgeshire and Peterborough geography the two Trusts have been able to integrate and rationalise the management structure as there are posts that span across the whole geography giving flexibility in supporting the identified health needs of our population, alongside a focussed locality delivery team with unique local knowledge, giving the service a robust management and leadership model moving forward.

2 Support for teenage parents- FNP and enhanced teenage parent pathway

Whilst a very important resource, with a sound evidence base and outcomes focussed approach, the Family Nurse Partnership only delivers to a small proportion of our teenage parent population. The Trusts are proposing a revised service offer for teenage parents.

- Continue to deliver FNP to 100 of our most at risk teenage parents (reduced from the current 200 which are often not taken up) and,
- Utilise some of the savings from this to create and deliver an enhanced pathway of care for all teenage parents who require additional support, which would be in addition to the universal mandated offer
- CCS is looking at collaborating with the national Family Nurse Partnership Unit to evaluate a similar

model that is being delivered in Norfolk, so that an assessment of impact on outcomes for this cohort of young people, can be made. A summary of the options considered is at 3.5

3 Change in workforce skill mix to deliver the service model

The mandated reviews in the Healthy Child Programme offer a unique insight into the developmental needs of all children and their families living in Cambridgeshire and Peterborough. An analysis of the skills required to carry out these reviews using nationally benchmarked data, has been undertaken. This has enabled the Trusts to propose the introduction of a skill mixed team that includes:

- Additional nursery nurse capacity – an under-utilised resource who have the skills to support the 1-8 year old age group. The skill mix team will ensure that there is always support from a Health Visitor available for Nursery Nurses within the Single Point of Access (SPA), to have case discussions and to escalate any immediate concerns or challenges.

- Different roles within the 0-19 teams to support school aged children.

The skill mixed workforce will be supported by robust delegation and supervision processes which will include case management discussions which will enable safe, facilitated discussions on those cases that need a wider consideration from the 0-19years team expertise.

4 Redesigning access to advice

The service model has streamlined the provision of healthy child clinics by increasing access to immediate advice and support through an improved digital/intranet offer, Parentline, Chathealth and support from clinicians in the Single Point of Access – a resource for all families and in particular for those families who are not digitally literate or who do not have access to these platforms.

As the digital platform goes live and is publicised, the Trusts will assess the impact that this has on clinics and therefore, those less well attended would be closed. The Trusts intend to work in partnership with Children Centre's/Child and Family Centres and potential Libraries to support access to a "self-weigh" model. This will rely on wider redesign of the services being undertaken as part of the Best Start in Life/Early Years strategy.

5 Saturday development review clinics

To improve access for families, the service model includes delivering development review clinics on a Saturday. This builds on the experience from piloting this in Cambridgeshire, where the feedback has been very positive with families and staff. It is envisaged that there will be one a month in each of the three localities.

What negative impacts are anticipated from this proposal?

Majority of the savings will be made by reduced management costs (£330k for Cambridgeshire and £100k for Peterborough). The remainder will be achieved by changing the skill mix within the workforce model and greater use of technology. The Transformation Board will review all proposed changes and consult with staff and service users to ensure negative impacts are mitigated.

Are there other impacts which are more neutral?

The majority of the service model remains the same. Details of changes are in the accompanying paper to health committee.

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

With reduced funding the service will be targeted to areas of highest need.
In terms of specific groups with protected characteristics, the following impact would be expected from the changes:

Impact	Positive	Neutral	Negative
Age		X	
Disability		X	
Gender reassignment		X	
Marriage and civil partnership		X	
Pregnancy and maternity		X	
Race		X	
Religion or belief		X	
Sex		X	
Sexual orientation		X	
Rural isolation		X	
Deprivation		X	

Business Case

E/R.6.038 Public Health Directorate staffing rationalisation

Project Overview			
Project Title	E/R.6.038 Public Health Directorate staffing rationalisation		
Project Code	TR001394	**Business Planning Reference**	E/R.6.038
Business Planning Brief Description	Deletion of vacant posts within structure and removal of one PHJCU team leader post.		
Senior Responsible Officer	Liz Robin		

Project Approach

Background

Why do we need to undertake this project?

There is a need to reduce the overall public health budget in line with reductions in the national public health grant (approximately £700,000 for 2019/20). There are some staff posts which became vacant in 2017/18 and 2018/19 and for which the vacancies have been held. This has been associated with some decreases in service provision, but it is feasible to delete the vacancies and maintain current levels of delivery. There is also a restructure within the Public Health Joint Commissioning Unit with Peterborough City Council. The proposed merger of two team leader posts will also lead to a saving. Reduction of the staff budget will enable the organisation to meet its 2019-20 business planning savings.

What would happen if we did not complete this project?

The budget amount for these posts would remain unused and the organisation would miss out on the opportunity to make savings towards the budget.

Approach

Aims / Objectives

- Creating savings
- Removing vacant posts

Project Overview - What are we doing

This project involves removing vacant posts from the Public Health Budget.

What assumptions have you made?

Assumptions made are that:
- The posts are no longer required
- The staff within the service will continue to have sufficient capacity to cover the workload that these posts previously shared

What constraints does the project face?

N/A

Delivery Options

Has an options and feasibility study been undertaken?

Scope / Interdependencies

Scope

What is within scope?

1. Deletion of three vacant posts within the structure:

- Mental Health Promotion Officer
- Drug and Alcohol Health Improvement Specialist
- Senior Public Health Analyst

2. Restructure within the Public Health Joint Commissioning Unit to remove one team leader post (already in progress)

3. Partly offset by increase in Peterborough City Council recharge

What is outside of scope?

Deletion of any additional posts

Project Dependencies

Title

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

N/A

Title

Risks

Title

Overstretching staff within the service

Increase in sickness absence

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

Staff within the Public Health Directorate

What positive impacts are anticipated from this proposal?

Savings of £80k to contribute to meeting the 2018-19 budget pressure

What negative impacts are anticipated from this proposal?

- Staff workload will continue to be shared between lower numbers of staff
- Some reduction in public health analytical capacity, including ability to deliver JSNA and other products.
- Reduced capacity for in-house mental health first aid training. Mitigation: this training can be brought in when required.

- Reduced capacity for mental health promotion initiatives. Mitigation: initiatives developed through this post are now embedded e.g. 'Keep your Head' child and adult websites content is now being maintained through voluntary sector organisations; MIND have a contract to run 'Stop Suicide' and other mental health anti-stigma campaigns.
- Reduced capacity for prevention and partnership work on drug and alcohol misuse issues: This post was created in the restructure which formed the PHJCU, but it was not possible to recruit. Prevention and partnership work on drug and alcohol misuse issues is being prioritised according to capacity through the PHJCU drug and alcohol commissioning team, and picked up through the wider Public Health team.
- Removal of one team leader post in the PHJCU through the merger of the healthy lifestyles and primary care team leader posts leads to increased workload for the new post holder. Mitigation: A proposal is being brought to Health Committee to simplify contracting arrangements with primary care which will reduce workload and maximise joint working across the PHJCU team.

Are there other impacts which are more neutral?

Removal of one team leader post in the PHJCU through a merger of the healthy lifestyles and primary care team leader posts: There are some benefits through only one team leader having oversight of both areas; some primary care contracts deliver integrated lifestyles work (e.g. smoking cessation, health checks).

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

No disproportionate impacts on protected characteristics

Business Case

E/R.6.039 Long Acting Reversible Contraception (LARC)

Project Overview			
Project Title	BP 19/20 E/R.6.039 Long Acting Reversible Contraception (LARC)		
Project Code	TR001439	**Business Planning Reference**	E/R6.039
Business Planning Brief Description	Long Acting Reversible Contraception (LARCs) are commissioned from GP practices. The Clinical Commissioning Group (CCG) recharges the cost of the contraception devices. Audits revealed that the recharges included the cost of items for which the LA is not liable i.e. injectable contraception and the use of devices for gynaecological purposes. In addition the training programme for clinicians to ensure that there is capacity in the system is now completed.		
Senior Responsible Officer	Liz Robin		

Project Approach

Background

Why do we need to undertake this project?

Nationally cash reductions have been applied to the Public Health Grant. Consequently savings are being made through efficiencies and transformational changes in the services that are commissioned.

What would happen if we did not complete this project?

Approach

Aims / Objectives

Project Overview - What are we doing

What assumptions have you made?

What constraints does the project face?

Delivery Options

Has an options and feasibility study been undertaken?

Scope / Interdependencies

Scope

What is within scope?

The funding allocated to commission Long Acting Reversible Contraception from GP practices

What is outside of scope?

This does not include funding allocated to other public health services commissioned from GP practices. It will also not affect the cost of the services. GP practices are paid for each unit provided not as part of a block contract. No provision threshold will be applied.

Project Dependencies

Title

Increase in demand for LARCs

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

Not applicable

Title

Risks

Title

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

Women seeking LARCs. Current demand levels for LARCs are being met within budget

What positive impacts are anticipated from this proposal?

N/A

What negative impacts are anticipated from this proposal?

N/A

Are there other impacts which are more neutral?

N/A

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

N/A

Business Case

E/R.6.040 Immunisation Promotion – Mainstreaming Budget

Project Overview			
Project Title	E/R.6.040 Immunisation Promotion – Mainstreaming Budget		
Project Code	TR001460	**Business Planning Reference**	E/R.6.040
Business Planning Brief Description	Mainstreaming the separate immunisation promotion budget into the generic health protection and public health communications work and funding streams.		
Senior Responsible Officer	Katie Johnson		

Project Approach

Background

Why do we need to undertake this project?

There is a need to reduce the overall public health budget in line with reductions in the national public health grant (approximately £700,000 for 2019/20). This project will contribute £13K towards this savings target.

What would happen if we did not complete this project?

These savings will not be made.

Mainstream work to promote immunisations –Childhood immunisation rates have improved since this budget was created, and Council staff work closely with NHS England and Public Health England to support continued improvement.

Approach

Aims / Objectives

This savings proposal is to mainstream work to promote immunisations, which currently has a separate budget of £20K, into generic health protection and public health communications work and funding streams.

NHS England are responsible for commissioning vaccination programmes in Cambridgeshire; these include infant vaccinations, school-based vaccination programmes and vaccinations for adults, including the flu and shingles vaccinations. The public health directorate work closely with NHS England and other partners to increase vaccination uptake rates. It is important to maintain high vaccination rates in order to protect individuals and the community from a number of infectious diseases which can cause serious harm.

Project Overview - What are we doing

The £20K immunisation budget will be reduced to £7K which will be incorporated into the generic health protection budget, resulting in a saving of £13K. This value has been calculated based on current levels of spend and should enable effective promotion of immunisations. The public health directorate continue to work closely with NHS England, Public Health England and other partners to promote immunisations, often using cost-free mechanisms such as direct communication from trusted professionals, printed resources from the NHS, radio interviews and social media. In addition, immunisation promotion will continue to be incorporated into mainstream public health communications work, such as through the Stay Well workstream and pharmacy public health campaigns. The Director of Public Health carries out an assurance role for health protection across Cambridgeshire and receives regular reports from NHS England on immunisations rates via the Health Protection Steering Group. These reports show that childhood immunisations rates have generally increased since the creation of the immunisations budget, although there is still further room for improvement.

What assumptions have you made?

It is assumed that the public health directorate will continue to be able to work in partnership with key stakeholders from across the system to share expertise, networks and promotion mechanisms to increase uptake of immunisation.

What constraints does the project face?

None identified

Delivery Options

Has an options and feasibility study been undertaken?

Scope / Interdependencies

Scope

What is within scope?

Reduction of the immunisation budget by £13K.

What is outside of scope?

Project Dependencies

Title

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

Title

Risks

Title

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

Not applicable. It is anticipated that the current level of immunisation promotional work will continue but that the funding will be from the wider health protection budget.

What positive impacts are anticipated from this proposal?

No significant impacts/changes to current service delivery are anticipated. Immunisations will continue to be promoted by the public health department in partnership with key stakeholders including the commissioners in NHS England and Public Health England.

What negative impacts are anticipated from this proposal?

No significant impacts/changes to current service delivery are anticipated.

Are there other impacts which are more neutral?

No significant impacts/changes to current service delivery are anticipated.

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

No significant impacts/changes to current service delivery are anticipated.

Business Case

E/R.6.041 Expected operational savings across Public Health staffing and contracts

Project Overview

Project Title	BP 19/20 E/R.6.041 Expected operational savings across Public Health staffing and contracts		
Project Code		**Business Planning Reference**	E/R6.041
Business Planning Brief Description	In year vacancy savings and efficiencies across demand led contracts		
Senior Responsible Officer	Liz Robin		

Project Approach

Background

Why do we need to undertake this project?

Nationally, cash reductions have been applied to the Public Health Grant for the past four years. This means that significant efficiencies and transformational savings have been made and further reductions in public health budgets are required.

What would happen if we did not complete this project?

Alternative savings from public health funded services would need to be found.

Approach

Aims / Objectives

The aim of this project is to integrate predictable levels of underspend against the public health budget as a whole into financial planning for 2019/20 and beyond.

Project Overview - What are we doing

It is clear from close financial monitoring that there is a predictable in-year underspend in the overall public health directorate budgets, due firstly to in-year staff changes such as vacancies and maternity leave, and secondly to changes in costs of demand led contracts. For example, the underspends on contracts may result from changes in demand, audits identifying interventions which do not come under local authority funding remit, or reductions in the cost of pharmaceutical products in a competitive market. This savings proposal introduces this predictable overall underspend into business planning for 2019/20 and beyond, meaning that further recurrent savings do not need to be made on front line public health services.

What assumptions have you made?

That, based on experience in previous years, an overall underspend of at least 109k can be predicted against the total public health directorate budget.

What constraints does the project face?

Delivery Options

Has an options and feasibility study been undertaken?

Scope / Interdependencies

Scope

What is within scope?

The overall public health directorate budget.

What is outside of scope?

Project Dependencies

Title

Cost and Savings

See accompanying financial report

Non Financial Benefits

Non Financial Benefits Summary

Not applicable

Title

Risks

That an underspend of at least £109k does not materialize in 2019/20 (or a future year). This would be mitigated by funding the shortfall from public health reserves.

Project Impact

Community Impact Assessment

Who will be affected by this proposal?

This proposal will not impact on communities or front line services

What positive impacts are anticipated from this proposal?

N/A

What negative impacts are anticipated from this proposal?

N/A

Are there other impacts which are more neutral?

N/A

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

N/A

Agenda Item No: 9

Let's Get Moving Physical Activity Programme

To:	**Health Committee**
Meeting Date:	**December 6th 2018**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **Yes**
Purpose:	**The purpose of this paper is to provide additional information requested by the Health Committee regarding the Let's Get Moving Physical Activity Programme that was presented to the November 2018 meeting of the Health Committee.**
Recommendation:	**The Committee is asked to review the additional information and approve the following recommendations.**

a) **Extend the Lets Get Moving Programme Public Health Reserve funding for an additional year in line with timeline indicated in this paper.**
b) **The introduction of the proposed interventions to strengthen the longer term monitoring of sustained behaviour change.**

	Officer contact:		***Member contacts:***
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1. BACKGROUND

1.1 In November 2018 the Health Committee received information regarding the countywide Let's Get Moving (LGM) Physical Activity Programme that was funded £513,000 over two years from Public Health Reserves in 2016.

1.2 The Lets Get Moving Programme proposal was developed as a collaborative initiative between the district councils, their partners and County Schools Partnership, Living Sport, to provide a countywide physical activity that would increase levels of physical activity especially in areas and groups with high needs. It has a key role in the delivery of the Cambridgeshire Healthy Weight Strategy with its central themes of collaboration across the system to support healthy behavioural change and communities taking responsibility for their health and wellbeing. These themes and objectives are reflected in the Lets Get Moving Programme which focuses upon increasing levels of physical activity through engaging local communities in the use of the district council facilities to a level that will enable them to become self-sustaining.

2. MAIN ISSUES

2.1 Table 1 details the original funding for LGM. The Health Committee is being asked to approve funding of £256,500 to extend LGM for an additional year.

Table 1: Original LGM Annual Budget

	Cost	**Living Sport Contribution**		**Actual Funding required**
		Cash	In-kind	
Programme Co-ordinator	£39,000*	£10,000		£29,000
Locality Co-ordinators x 5 @ £32.5K	£162,500**			£162,500
Training, Development and Mentoring	£5,000			£5,000
Operational Budget	£50,000			£50,000
Promotion and Marketing	£10,000		£2,500	£7,500
Evaluation	£10,000		£7,500	£2,500
Total	**£276,500**	**£10,000**	**£10,000**	**£256,500**

Funding became available in April 2017, however contract commencement dates vary due to different processing times within the local authorities. In view of the different contract commencement dates the Health Committee is asked to approve the funding for a third year commencing July 1 2019 until June 30th 2020. This is captured in Table 2.

Table 2: LGM Spend Schedule April 1 2017 to August 31 2019.

Living Sport and LA funding schedule	Public Health Reserves Spend	Living Sport Cash Funding	Living Sport In Kind Funding
Living Sport April 2017 – March 2019	£58,000	£20,000	
Cambridge City Council South Cambridgeshire District Council Huntingdonshire District Council July 2017 – June 2019	£195,000		
East Cambridgeshire District Council Fenland District Council September 2017-August 2019	£130,000		
Training, development and mentoring	£10,000		
Operational budget	£100,000		
Promotional and Marketing	£15,000		£5,000
Evaluation	£5,000		£15,000
Total	£513,000	£20,000	£20,000

The proposal to extend funding until June 30th 2020 will mean that the two district authorities that have contracts that commenced in September 2017 will have been funded for thirty four months as opposed to 36 months. This provides a saving of £10,833. The Living Sport contract would end on the March 31st 2020 and it is proposed that this additional funding along with evaluation and operational funding will enable Living Sport to continue to support the Programme and complete the evaluation.

2.2 The key objective of the LGM Programme is to demonstrate that it has stimulated the development of new physical activity programmes that support sustained behaviour change. The rationale for extending the LGM finding for another year reflects the earlier paper that was recently presented to the Health Committee. This indicated that LGM had started to provide evidence of impact but a longer timeframe is required to consolidate the programmes and secure more robust evidence of their impact and effectiveness.

2.3 LGM has been collecting data that is based on the Public Health England Standard Evaluation Framework (SEF) for Physical Activity. This was originally developed by the National Obesity Forum and provides a checklist and a set of guidance notes for evaluating a physical activity programme. It is recognised nationally and it aims to standardise the evaluation of physical activity programmes across the country and increase comparability across programmes. The data set that the Living Sport and the district authorities have been asked to collect is taken from the SEF. Table 3 captures the most recent key data that measures activity and impact of LGM and is based on the SEF dataset.
There has been improvement over the first five quarters but the weakest areas are the number of completers from the structured programmes and media activities. There are issues related to the number of completers as this is a weaker area of data capture. (See below)

Table3: Key Evaluation Indicators for the Lets Get Moving Programme (countywide)

	Countywide figures	Q1		Q2		Q3		Q4		Q5			
		0 - 3 months		3 - 6 months		6 - 9 months		9 - 12 months		12 - 15 months		Totals	
KPI no.	Key Performance Indicators	Jul - Sep '17		Oct - Dec '17		Jan - Mar '18		Apr - Jun '18		Jul - Sep '18			
1	**Programme projects**	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1.1	Number of new programmes developed through LGMC	2	6	6	13	11	32	17	54	27	75	63	180
	Number of new activities continuing 6 months after initiation (sustained)	0	0	0	0	2	3	2	3	15	29	19	35
	Number of existing "LA" programmes supported through LGMC (added value)	2	7	5	9	8	15	15	30	20	45	50	106
1.2	Number of participants	482	494	925	696	1547	2007	2017	2763	2547	3647	7518	9607
	Number of mass participation attendees	100	201	150	225	150	225	150	856	1350	3510	1900	5017
1.3	% of participants that undergo an assessment (where appropriate)	60%	22%	56%	75%	56%	52%	56%	73%	61%	69%	60%	67%
1.4	% of programme completers (where appropriate)	60%	0%	60%	37%	60%	25%	60%	48%	60%	48%	60%	46%
	additional information provided regarding relevant 'fixed term' programmes												
1.5	% of participants who report that they have achieved their physical activity objectives/goals	52%	0%	52%	100%	52%	0%	52%	48%	52%	85%	52%	61%
1.6	% of initiatives in areas with lowest levels of physical activity	50%	93%	50%	79%	50%	49%	50%	64%	50%	55%	50%	63%
3	**Community resilience**	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
3.1	Number of community led physical activity programmes 'initiated' through the brand	2	3	5	6	9	13	13	23	19	31	48	76
	qualitative data included each quarter: Type of programmes												
3.2	Number of community led programmes 'supported' through the brand	2	7	8	27	14	56	18	60	24	77	66	227
3.3	% of physical activity community led programmes continuing and led by community members after 6 months	55%	0%	55%	0%	55%	100%	55%	67%	55%	83%	55%	72%
4	**District media and promotional activity**	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
4.1	Number of promotional events in the district	5	7	10	16	14	20	23	37	25	59	77	139
4.2	% that received media / social media coverage	96%	100%	96%	100%	96%	81%	96%	70%	96%	95%	96%	85%
5	**Countywide media and promotional activity**	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
5.1	Number of countywide promotional events supported by the district programme	0	0	5	2	10	12	15	17	20	27	50	58

2.4 Demonstrating the impact of behaviour change programmes presents challenges. The data for the first year of the Programme is promising but it is challenging to capture the impact of behaviour change programmes in terms of participant reporting and overlap of the structured physical activity programmes across years. The activities that LGM has developed have been a mixture of high profile events and campaigns that focus on population level messages. The other element has been supporting the development of the structured targeted programmes which afford the opportunity of capturing longer term behavioural changes. Specifically the funding for an additional year would enable further development of programmes but the focus would be on improving the capture of any sustained behaviour change. Consequently it is proposed that a proportion of the operational and evaluation funding be used to increase compliance with the longer term monitoring of behaviour change outcomes. The operational and evaluation funding would be used as follows.

- Provide additional training for the coaches who run the structured programmes that will reinforce their responsibility for capturing evidence of behaviour change data.
- Test the impact of small incentives on compliance with completion of the behaviour change surveys. For example engagement in follow up behaviour change monitoring could be rewarded with free swim or gym session. Alternatively a healthy shopping voucher. This approach could be used with selected interventions to capture any differences.
- The Public Health England Standard Evaluation Framework (SEF) for Physical Activity strongly recommends that participants in structured programmes should be followed up for a minimum of one year. An additional year would enable additional longer term behavioural change data to be collected.
- The promotional work requires further development. In addition its impact also requires more assiduous assessment through assessing the penetration of its messages at the wider events and more social marketing activity.

2.5 Addressing heath inequalities is a key objective for LGM and the first paper indicated that all districts had targeted its initiatives in their more deprived areas where rates of physical activity are lower. In addition it showed how LGM had integrated many of its new initiatives into the work of other organisations, often targeting specific groups, which had brought benefits for groups of people who often have limited access to physical activity opportunities and experience health inequalities. This illustrated especially through the case studies which described the impact that LGM has had on the health and wellbeing of individuals. There was also evidence of how collaboration across the county had increased learning and comparability of interventions amongst the districts. These aspects of the Programme will continue to be monitored if the Programme is extended.

2.6 The Health Committee also requested assurance that the partners funded to deliver the LGM programme clearly indicate on all LGM promotional activities and branding that it is funded by Cambridgeshire County Council. This has been discussed with LGM partners and it has been agreed that any branded information or promotional activities will acknowledge the role of Cambridgeshire County Council.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The following bullet points set out details of implications identified by officers:

The programme will contribute to reducing the costs to the local economy through reducing ill health

3.2 Helping people live healthy and independent lives

The Programme aims to improve the health and wellbeing of the population and enable people to live independently.

3.3 Supporting and protecting vulnerable people

The Programmes has focus upon supporting and protecting those most in need and any associated health inequalities.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in ***2.1***

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The following bullet points set out details of significant implications in 2.1

4.3 Statutory, Legal and Risk Implications

The following bullet points set out details of significant implications identified by officers:

- Any legal or risk implications occurring from additional funding will be considered with the appropriate officers from these Departments and presented to the Health Committee before proceeding.

4.4 Equality and Diversity Implications

The following bullet points set out details of significant implications identified by officers:

- The Programme is monitored to ensure that any equality and diversity implications are identified and any ensure that appropriate action is undertaken.

4.5 Engagement and Communications Implications

The following bullet points set out details of significant implications identified by officers:

- The Programme secure regular feedback from their patients and clients
- The Programme involve ongoing engagement with individuals and communities

4.6 Localism and Local Member Involvement

The following bullet points set out details of significant implications identified by officers:

- The Programme reflects the differing needs found across Cambridgeshire and are tailored to address these through consultation with residents, stakeholders and partner organisations.

4.7 Public Health Implications

The following bullet points set out details of significant implications identified by officers:

- The Programme presents growing evidence that they are preventing ill health and improving health of the population through the range of interventions that have been developed.

- The Programme also targets those most vulnerable and in need to address inequalities and improve the outcomes for these population groups.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Unchanged since previous paper
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Unchanged since previous paper
Have the equality and diversity implications been cleared by your Service Contact?	Unchanged since previous paper
Have any engagement and communication implications been cleared by Communications?	Unchanged since previous paper
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Unchanged since previous paper
Have any Public Health implications been cleared by Public Health	Unchanged since previous paper

Source Documents	Location
Paper to Health Committee November 8th 2018: Agenda item 7: Progress report – programmes funded from public health reserves: Cover paper and Appendix B	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/880/Committee/6/Default.aspx
National Evaluation Framework for Physical Activity National Obesity Observatory/Public Health England	http://www.getirelandactive.ie/Professionals/Built%20Environment/Resources/Evaluating-Physical-Activity-.pdf
Cambridgeshire Healthy Weight Strategy	..\..\Health Improvement\Obesity\PHRG Obesity Strategy from 2016\DRAFT Healthy Weight Strategy 28 July 2016.docx
UK Active Report Let's Get Moving	http://www.ukactive.com/partnerships/working-with-ukactive/let-s-get-moving
Department of Health Let's Get Moving:	http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/PhysicalActivity/DH_099438

Agenda Item No: 10

NHS DENTAL SERVICES ENTER AND VIEW VISITS BY HEALTHWATCH CAMBRIDGESHIRE AND PETERBOROUGH

To:	**Health Committee**
Meeting Date:	**6th December 2018**
From:	**Chief Executive Officer, Healthwatch Cambridgeshire and Peterborough**
Electoral division(s):	**All**
Forward Plan ref:	**N/A**
Key decision:	**No**
Purpose:	**The Committee is asked to consider the findings of the Healthwatch Enter and View visits to Wisbech Dental Access Centre**
Recommendation:	**The Committee is asked to note the report**

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1. BACKGROUND

1.1 Healthwatch Cambridgeshire and Peterborough are the independent champion for people who use health and social care services. Healthwatch were set up under the Health and Social Care Act 2012 to listen to people's experiences of using health and care services and formulate views about what could be improved.

1.2 In April 2017 Healthwatch Cambridgeshire merged with Healthwatch Peterborough to form a new organisation called Healthwatch Cambridgeshire and Peterborough delivering the Healthwatch function for both areas.

1.3 Shortly after the merger Healthwatch Cambridgeshire and Peterborough became aware of the difficulties people in Peterborough were experiencing finding an NHS dentist and so undertook work to find out more about dentistry services. It was established that this is a problem for people living in Cambridgeshire also, particularly the north of the county.

2. MAIN ISSUES

2.1 Healthwatch have recently undertaken Enter and View visits to the Dental Access Centres (DACs) in Peterborough and Wisbech to speak to people about their experiences trying to access an NHS dental service.

2.2 It is clear that people in other areas of Cambridgeshire also experience the same problem. However, Healthwatch has focussed on these two centres as this is where most feedback has been received from.

2.3 There is a general misconception that people register with an NHS dentist but this is not the case since a new contract was introduced in 2006. NHS dentists take people on for a specific course of treatment only.

2.4 There are a number of significant concerns that are impacting upon the health and wellbeing of many people in Cambridgeshire. Lack of preventative care and the disproportionate effect on people o lower incomes and other vulnerable groups is especially worrying. More detail is set out below.

2.5 Children have no priority in the present system. All adults and children are treated equally. Healthwatch understands that the numbers of children having multiple tooth extractions in Cambridgeshire are increasing. The impact of multiple tooth extractions on young people's future dental health is concerning.

2.6 Preventative dental care and information is minimal across the County.

2.7 The report about the Healthwatch findings is currently being drafted. The sections below set out a summary of what Healthwatch has found so far. Further detail will be given verbally at the meeting. The report is expected to be published before the end of the year.

3. WHAT LOCAL PEOPLE TOLD HEATHWATCH

3.1 People are experiencing problems finding an NHS dentist and do not have access to routine dental care.

3.2 When people have a dental emergency it is extremely hard to find an NHS dentist who will treat them so they attend a DAC.

3.3 Many NHS dentists have set up in private practice.

3.4 The DAC service is highly valued by local people.

4. WHAT THE DENTAL ACCESS CENTRES TOLD HEATHWATCH

4.1 The DAC service cannot meet the needs of all of the people who come to the service. Often they can only provide pain relief. People have to find a dentist for the treatment, in many instances this is not possible.

4.2 People are often referred to the DACs for root canal treatment and extractions. The DACs are not altogether sure why this happens.

4.3 The numbers of people being turned away from the DACs is substantial and increasing. Healthwatch has been informed that in 2016/17, 5,474 people were turned away from Dental Access Centres in in Cambridge, Huntingdon and Wisbech. In 2017/18 this rose to 7,425

5. FURTHER CONTEXT

5.1 NHS England are aware of the problems that people have accessing NHS dentists in many areas of Cambridgeshire and have informed Healthwatch that commissioning arrangements are being reviewed.

5.2 There is a shortage of dentists and dental nurses. Dentists recruited from abroad have to wait several months to be cleared to work in the UK. This process is through a private company. The delays are frustrating for practices as they need dentists urgently.

5.3 There are concerns that the UK leaving the EU will impact on the number of European dentists willing and able to work in this country. There is evidence to show that some European dentists and dental nurses have already returned home.

5.4 GPs have told Healthwatch that they often have people presenting to them with dental problems because people cannot find an NHS dentist and cannot afford a private one. GPs are then in a very difficult situation as they do not give dental care but are aware of the impact of poor oral health on people general wellbeing. Th exact extent of this and what the GPs responses are is unknown.

Agenda Item No: 11

NHS England Report for General Dental Services

Cambridgeshire County Council Health and Scrutiny Committee

December 2018

Overview of NHS dental provision in Cambridgeshire

There has been no change in NHS dental provision in the Cambridge and Peterborough CCG area.

As reported previously there are 68 contracts providing dental care in the Cambridge area. The contractual mechanism is via 53 General Dental Service (GDS) contracts and 15 Personal Dental Service (PDS) agreements.

58 of the contracts/agreements are for general dental services, including routine care, urgent care and domiciliary care. 10 agreements are for orthodontics (teeth straightening).

The total spends for primary care dental service provision in the Cambridgeshire area in 2018/19 (national uplift to contract values has not yet been applied for the current year) is £30,369,755.34. £26,646,029.60 is spent on general dentistry including access and minor oral surgery and £3,723,725.74 on orthodontics.

Dental providers in Cambridgeshire have been reasonably consistent in delivering their contracted activity over the last three years. The majority of providers have delivered at least 96% of their contracted activity for general dental and orthodontic services. There remain a small number of providers who have not delivered their contracted activity. NHS England is currently working with all dental providers across East who have consistently not been able to deliver their activity and will review the delivery of contracted activity from the current providers, and the provider's ability to deliver activity or additional activity going forward. The review will also determine if additional services will be needed and propose the most effective and efficient way to accomplish this.

Adult patients seen in the previous 24 months and child patients seen in the previous 12 months as a percentage of the population, by patient type and LA

	30 June 2018		
	Adult	Child	Total
England	50.73	58.56	52.40
NHS England Midlands and East (East)	51.69	56.46	52.68
NHS Cambridgeshire and Peterborough CCG	45.40	58.48	48.22
Peterborough City Council	44.21	62.60	48.78
Cambridgeshire County Council	46.20	57.24	48.49

Source: NHS Dental Services, NHS Business Services Authority (BSA) – eng – 17-18 annex 2

Current service provision in East

A review is being undertaken by NHS England's Dental Strategy Group around access to routine and urgent dental care, initial focus will be on several areas including parts of Cambridgeshire and Peterborough CCG area.

List of dental practices in Cambridgeshire area are in appendix 1.

Dental access centres

There are a number of Dental Access Centres in East Anglia with services in the Cambridgeshire and Peterborough CCG area provided in Peterborough, Cambridge, Huntingdon and Wisbech. The purpose of the Dental Access Centres is to provide urgent dental care (treatment to relieve pain) for patients who do not have access to a regular dentist.

NHS England has been working with the provider of these services, Cambridgeshire Community Services, over a period of time, due to patients having difficulty accessing urgent dental care. As a result, NHS England commissioned £248,912 of additional non recurrent activity from the provider of services at the Dental Access Centre in Peterborough from October 2017 to 31 March 2019 to allow a minimum of an additional 4,158 patients to receive urgent dental care.

A scoping exercise to review dental access centres in East Anglia has been undertaken in last few months. NHS England's Dental Strategy Group is considering the findings of the scoping exercise.

In the first instance, consideration has been given to difficulties patients are having in accessing ongoing dental care and this was discussed at the Dental Strategy Group meeting on 21 November 2018. A paper will be taken to NHS England's Direct Commissioning Oversight Group for the meeting on 30 November for them to consider a pilot of Personal Dental Services Agreements which will, if supported improve access to urgent dental care in areas of high need and allow patients to have further dental treatment to stabilise their oral health.

Secondly, further work will be undertaken regarding the long term future of Dental Access Centres across East Anglia.

Population growth in Cambridge and new developments

Across East there are a number of areas where there is a growth of population, some of this is predicted and taken into account in the oral health needs assessment (appendix 2). There is also population growth due to building programmes including the Northstowe development.

NHS England has set up a Dental Strategy Group whose membership consists of Commissioners, Consultants in Dental Public Health and Chairs of the Managed

Clinic Networks. The Dental Strategy Group will take into account the local populations (including growth) and oral health needs when making commissioning recommendations to NHS England.

NHS England continues to review and assess NHS dental provision across East and will review commissioning intentions where it is identified that additional NHS dental services are required.

Review and procurement of the out of hours dental services in Peterborough, Cambridge, Norfolk, Great Yarmouth and Waveney

In Cambridge, the dental out of hours service is currently delivered by Cambridge Community Services and are delivered from the Cambridge Dental Access Centre. The out of hours service is available are Saturday, Sunday and bank holidays. The current Agreements for dental out of hours services are due to expire 31 March 2019.

A review of out of hours dental services was undertaken in late 2017/early 2018 with a procurement exercise commencing in September 2018. The procurement is due to complete at the end of December 2018 with new services to commence 1 April 2019.

Patients will continue to be able to access urgent dental treatment, where considered clinically necessary, outside of core hours for dental practices, including weekends and bank holidays.

Community dental services for people with special care needs

Cambridgeshire Community Services provide dental services for people with special care needs. This service is only available upon referral from a health professional in Cambridge, Ely, Huntingdon, Wisbech and Peterborough. The service is performing well with 100% of patients starting treatment within a maximum of 18 weeks from referral.

As all the current contracts come to an end in September 2019, NHS England is re-procuring these services in line with the NHS England Guidance for commissioning dental specialties - *Special Care Dentistry*, which supports general dental services for vulnerable adults and children, and also supports hard to reach groups to ensure that patients have access to general dental services. The Commissioners have been working with both Cambridgeshire County Council and Peterborough City Council's Public Health Department to review the Dental Public Health Functions; Oral Health Promotion and Epidemiology which will be delivered as part of this service.

Domiciliary services

There are two providers of domiciliary dental services. The main provider is Cambridgeshire Community Services who provides domiciliary dental care for housebound patients in the Cambridge and Peterborough CCG area. There is an

additional provider, Mr Mullins based in Porson Road, Cambridge for housebound patients local to the Cambridge City area.

Workforce

NHS England does not hold details about the number of dentists who provide private dental care. Below is information regarding the number of dentists providing NHS dental services at CCG level.

Number of dentists with NHS activity, for years ending 31 March 2018, England

	Total number of dentists	Population per dentist	Dentists per 100,000 population
England	24,308	2,274	44
Midlands and East of England	7,395	2,269	44
Midlands and East (East)	1,987	2,177	46
NHS Cambridgeshire and Peterborough CCG	457	1,936	52

Source: NHS Digital Dental Statistics – eng – 17-18 annex 2

Appendix 1 – list of dental providers in Cambridgeshire

Cambridge practices.pdf

Appendix 2 – oral health needs assessment

oral health needs assessment East Angli

Contractor(s)	Surgery Name	Treatment Address Line 1	Treatment Address Line 2	Treatment Address Line 3	Treatment Address Line 4	Treatment Address Postcode	Type	Contract Purpose	TCV 17-18 £	Total Contracted UDA 17/18	Total Contracted UOA 17/18
Dr Veehar Malde	Church Street Dental	6A Church Street	Somersham	Huntingdon	Cambridgeshire	PE28 3EG	GDS Contract	General	100,728.54	4029	
OASIS DENTAL CARE LTD	Oasis Dental Care Cambridge	Cambridge Dencare	45 Glisson Road	Cambridge	Cambridgeshire	CB1 2HA	GDS Contract	General	195,106.52	7953	
Petrie Tucker and Partners Ltd	Chesterton Dental Practice	Chesterton Road Dental Surgery	36 Chesterton Road	Cambridge	Cambridgeshire	CB4 1EN	GDS Contract	General	3,742,506.98	144576	
IDH Limited	Victoria Bridge Dental Practice	Victoria Bridge Dental Practice	13 - 13A Victoria Avenue	Cambridge	Cambridgeshire	CB4 1EG	GDS Contract	General	616,013.29	21213	
CAMBRIDGE UNIVERSITY	University Dental Practice	Dental Surgery	University Of Cambridge	3 Trumpington Street	Cambridge	CB2 1QA	PDS Contract	General	108,269.21	3878	
Histon Dental Surgery	Station Road Dental Surgery	Townsend House Dental Surgery	66-68 Station Road	Histon	Cambridgeshire	CB24 9LF	GDS Contract	General	711,143.14	22500	
Histon Dental Surgery	Station Road Dental Surgery	Townsend House Dental Surgery	66-68 Station Road	Histon	Cambridgeshire	CB24 9LF	GDS Contract	General	98,889.39	3625	
Parish Vaid & Snehal Radia & Sanjay Shah	Dental Surgery	Dental Surgery	170 Chesterton Road	Cambridge	Cambridgeshire	CB4 1DA	GDS Contract	General	444,767.08	16174	
Littleport Dental Practice	Littleport Dental Practice	11 Granby Street	Littleport	Ely	Cambridgeshire	CB6 1NE	GDS Contract	General	361,823.38	14288	
Cambourne Dental Practice	Cambourne Dental Practice	Cambourne Dental Practice	Monkfield House	Monkfield Lane	Great Cambourne	CB23 6AJ	GDS Contract	General	530,532.45	17913	
Mr Wadhwani & Mr Hirani	Antwerp House Dental Practice	Antwerp House Dental Practice	36 Brookfields	Cambridge	Cambridgeshire	CB1 3NW	PDS Contract	Orthodontic	301,429.89	0	4800
Mr Wadhwani & Mr Hirani	March Dental Practice	21 Darthill Road	March	Cambridgeshire		PE15 8HP	PDS Contract	Orthodontic	75,357.47	0	1200
The High Street Dental Practice	The High Street Dental Practice	High Street Dental Practice	47 High Street	Sawston	Cambridge	CB22 3BG	GDS Contract	General	95,441.07	4321	
Wensleydale Dental Practice	Wensleydale Dental Practice	Wensleydale Dental Practice	11 George Street	Huntingdon	Cambridgeshire	PE29 3BD	GDS Contract	General	820,700.10	32267	
Wensleydale Dental Practice	Wensleydale Dental Practice	Wensleydale Dental Practice	11 George Street	Huntingdon	Cambridgeshire	PE29 3BD	PDS Contract	Orthodontic	85,706.60	0	1365
Apple Tree Dental Practice	Apple Tree Dental Practice	The Appletree Dental Practice	1-3 West Street	Comberton	Cb23 7Ds	CB23 7DS	GDS Contract	General	326,098.41	9642	
Caring Dentistry Ltd	Oasis Dental Care Wisbech	Alexandra Road Dental Practice	11 - 12 Alexandra Road	Wisbech	Cambridgeshire	PE13 1HQ	GDS Contract	General	371,851.42	13335	
Market Square Dental Practice	Market Square Dental Practice	Market Square Dental Practice	8 Market Square	St Neots	Cambridgeshire	PE19 2AW	GDS Contract	General	59,535.37	2639	
Great Shelford Dental Practice Ltd	Great Shelford Dental Surgery	Dental Surgery	19 Woollards Lane	Great Shelford	Cambridge	CB2 5LZ	GDS Contract	General	348,369.31	14267	
Burleigh Street Dental Practice	Burleigh Street Dental Practice	Holland Dentists	16A Burleigh Street	Cambridge	Cambridgeshire	CB1 1DG	GDS Contract	General	12,914.14	547	
Anglia Orthodontics	Anglia Orthodontics	Anglia Orthodontics	Huntingdon Dental Access C	Hinchingbrooke Hospit	Hinchingbrooke Park	PE29 6NT	PDS Contract	Orthodontic	1,288,110.41	0	20512
Anglia Orthodontics	Prince Of Wales Hospital	Princess Of Wales Hospital	Lynn Road	Ely	Cambridgeshire	CB6 1DN	PDS Contract	Orthodontic	322,027.60	0	5128
Mr Gawain King and Mrs Antoinette King	The Village Dental Practice	D C Jones Dental Surgery	37B High Street	Longstanton	Cambridge	CB24 3BP	GDS Contract	General	201,570.28	7500	
The Old Grammer School Dental Surgery	The Old Grammar School Dental Sur	Dental Surgery	Old Grammar School	Ramsey Road	St Ives	PE27 5BZ	GDS Contract	General	254,908.44	10000	
The Hollies Dental Practice	The Hollies Dental Practice	The Hollies Dental Practice	14 Park Street	Chatteris	Cambridgeshire	PE16 6AF	GDS Contract	General	49,046.00	1067	
1A Dental Practice Limited	Mydentist Ely	Dental Surgery	26 St Marys Street	Ely	Cambridgeshire	CB7 4ES	GDS Contract	General	513,727.39	20907	
P.V. Humber & C. Hancock	Hopvine House Dental Surgery	Dental Surgery	Hopvine House	21 Clay Street	Soham	CB7 5HJ	GDS Contract	General	120,572.92	4694	
St Marks Orthodontics	St Mark Orthodontics	6 Chapel Street	Cambridge	Cambridgeshire		CB4 1DY	PDS Contract	Orthodontic	88,910.12	0	1454
1A Group Dental Practice Partnership	Station Road Dental Practice	Dental Surgery	10 Station Road	St Ives	Cambridgeshire	PE27 5BH	GDS Contract	General	890,235.24	30813	
Chequer Hall Dental Practice	Chequer Hall Dental Practice	Chequer Hall Dental Practice	6 Chequer Lane	Ely	Cambridgeshire	CB7 4LN	GDS Contract	General	1,448,280.85	48026	
Unnati Limited	Dental Surgery	Dental Surgery	2 - 4 Exchange Square	Wisbech	Cambridgeshire	PE13 1RA	GDS Contract	General	786,419.66	22500	
Cambridge Street Dental Practice	Cambridge Street Dental Practice	Dental Surgery	28 Cambridge Street	St Neots	Cambridgeshire	PE19 1JL	GDS Contract	General	402,473.32	16000	
Chokshi Ltd	March Dental Practice	Dental Surgery	21 Darthill Road	March	Cambridgeshire	PE15 8HP	GDS Contract	General	580,722.47	21607	
Priory Park Dental Practice	Priory Park Dental Practice	Priory Park Dental Practice	29 - 31 New Street	St Neots	Cambridgeshire	PE19 1AJ	GDS Contract	General	964,959.59	28201	
ORTHOWORLD 2000 LTD		Orthoworld 2000 Ltd	2B Milton Road	Cambridge	Cambridgeshire	CB4 1JY	PDS Contract	Orthodontic	717,197.23	0	10779
Dr Jai Prathap Reddy	Cromwell Place Dental Practice	Cromwell Place Dental Practice	Slepe House	Cromwell Place	St Ives	PE27 5JB	GDS Contract	General	414,367.41	14985	
CCS Dental Service	Brookfields Dental Access Centre	Brookfields Health Centre	Seymour Street	Cambridge	Cambridgeshire	CB1 3DQ	PDS Contract	General and	2,623,276.44	23865	420
CCS Dental Service	Brookfields Dental Access Centre	Brookfields Health Centre	Seymour Street	Cambridge	Cambridgeshire	CB1 3DQ	PDS Contract	General	922,350.08	8690	
CCS Dental Service	Church Mews Dental Access Centre	Dental Surgery	1 - 4 Church Mews	Wisbech	Cambridgeshire	PE13 1HL	PDS Contract	General	15,729.63	500.00	
Shiamiela Hussain	Heartsease Dental Surgery	9 Broad Street	Ely	Cambridgeshire		CB7 4AJ	GDS Contract	General and	174,092.31	4640	420
MR PG SANDERS	Melbourn Dental Practice	Dental Surgery	24A Orchard Road	Melbourn	Royston	SG8 6HH	GDS Contract	General	189,901.33	6951	
MR S KORDANY	Stukely Road Dental Surgery	69 Stukeley Road	Huntingdon	Cambridgeshire		PE29 6HH	GDS Contract	General	195,249.02	8000	
Dr Baker & Dr. Al-Ali	Huntingdon Dental Care	Dental Surgery	3 Brampton Road	Huntingdon	Cambridgeshire	PE29 3BQ	GDS Contract	General	519,628.13	22763	
MISS O OMOREGIE	Bassingbourn Dental Practice	Dental Surgery	2 High Street	Bassingbourn	Royston	SG8 5NF	GDS Contract	General	179,800.61	6666	
MR DN ABDAH	Dentastique	Dental Surgery	4 Bishops Road	Cambridge	Cambridgeshire	CB2 9NH	GDS Contract	General	251,584.86	8749	
Dental Surgery	Ramsey Dental	Dental Surgery	2 High Street	Ramsey	Huntingdon	PE26 1AE	PDS Contract	General	631,805.51	22405	
MR NA BURNETT	Burnett, Nikolas & Assoc.S	20 Newmarket Road	Cambridge	0		CB5 8DT	GDS Contract	General	589,161.12	22584	
MR SG NICOLL	Hurst Park Dental Practice	Hurst Park Dental Practice	2A Hurst Park Avenue	Cambridge	Cambridgeshire	CB4 2AE	GDS Contract	General	50,080.79	1800	
MR RM WADHWANI	Newmarket Road Dentistry	Dental Surgery	165 167 Newmarket Road	Cambridge	Cambridgeshire	CB5 8HA	GDS Contract	General	910,521.52	31500	
MR RM WADHWANI	Falkner House Dental Practice	Dental Surgery	108 High Street	Linton	Cambridge	CB1 6JT	GDS Contract	General	249,517.10	10000	
Mobeen Ahmed	St Mark Orthodontics	6 Chapel Street	Cambridge	Cambridgeshire		CB4 1DY	GDS Contract	General	256,307.47	10082	
Mr T Mullan	Burnside Dental Surgery	Dental Surgery	97 99 Burnside	Cambridge	Cambridgeshire	CB1 3PA	GDS Contract	General	25,236.49	950	
MR PG MULLINS	Norfolk Street Dental Practice	Norfolk Street Dental Surgery	24 Norfolk Street	Cambridge	Cambridgeshire	CB1 2LF	GDS Contract	General	169,639.81	5240	

MR PG MULLINS	Domiciliary Services	28 Porson Road	Cambridge	Cambridgeshire		CB2 2EU	PDS Contract	General	32,392.89	441	
MISS M DE VOS	Gable Dental Practice	The Gables Dental Practice	332 Cherry Hinton Road	Cambridge	Cambridgeshire	CB1 8AZ	GDS Contract	General	505,478.02	18640	
MR RA PARKER	Cambridge Centre For Orthodontics	Dental Surgery	72 Canterbury Street	Cambridge	Cambridgeshire	CB4 3QF	PDS Contract	Orthodontic	252,473.96	0	3762
MISS H NGUYEN	Bar Hill Dental Practice	Bar Hill Dental Practice	Hanover Close	Bar Hill	Cambridge	CB23 8EH	GDS Contract	General	82,152.52	2042	
MISS Z WIESE	Cottenham Dental Practice	Wiese And Associates	Old Telephone Exchange	Margett Street	Cottenham	CB4 8QY	GDS Contract	General	83,238.76	2160	
MISS Z WIESE	Upwell Road Dental Centre	Dental Surgery	84 Upwell Road	March	Cambridgeshire	PE15 0DA	GDS Contract	General	198,831.87	7400	
MISS Z WIESE	Upwell Road Dental Centre	Dental Surgery	84 Upwell Road	March	Cambridgeshire	PE15 0DA	GDS Contract	General	385,321.05	13400	
MR A MOBLI	Charnock House Dental Surgery	Dental Surgery	233 Chesterton Road	Cambridge	Cambridgeshire	CB4 1AS	GDS Contract	General	1,357.63	60	
MR WA BOTHA	Cambridge Orthodontic Practice	Cambridge Orthodontic Practice	43 Long Road	Cambridge	Cambridgeshire	CB2 8PP	PDS Contract	Orthodontic	539,760.46	0	8595
MR BS SANGHERA	Green Tree Dental	Dental Surgery	50 Metcalfe Road	Cambridge	Cambridgeshire	CB4 2DD	GDS Contract	General	149,098.33	4123	
MISS GM O'CALLAGHAN	St Neots Dental Practice	Dental Surgery	18 Huntingdon Street	St Neots	Cambridgeshire	PE19 1BG	GDS Contract	General	230,290.37	9313	
MR GV SHAW	Gv Shaw Dental Practice	111 Brewery Road	Pampisford	Cambridge	Cambridgeshire	CB2 4EW	GDS Contract	General	41,409.84	1586	
MRS CH JACKMAN	Bottisham Dental Surgery	Dental Surgery	Tunbridge Lane	Bottisham	Cambridge	CB5 9DU	GDS Contract	General	542,141.45	20400	
MR OB QURESHI	Cambridge Smile Studio	Cambridge Smile Studio	27 Milton Road	Cambridge	Cambridgeshire	CB4 1UZ	GDS Contract	General	668,423.43	22001	
MR B GHALEKHANY	Regent Dental Practice	Dental Surgery	102 Regent Street	Cambridge	Cambridgeshire	CB2 1DP	GDS Contract	General	252,789.85	10295	
									30,369,755.34	866,713.00	58,435.00

Updated Draft Oral Health Needs Assessment for East Anglia Area Team

Updated 13th October 2014

Amanda Crosse, Consultant in Dental Public Health

Draft Oral Health Needs Assessment for East Anglia Area Team

EXECUTIVE SUMMARY

Oral health in adults and children in East Anglia is generally good. It is better than England averages and in many cases is among some of the best in the country. Recent oral health surveys have shown that the dental health of both adults and children has improved significantly in recent years. Across most of East Anglia, except in Peterborough, more than seventy per cent of five years olds are free from dental decay.

However, population averages mask oral health inequalities. A well- recognised association exists between socioeconomic status and oral health and information suggests that oral diseases are increasingly concentrated in the lower income and more excluded groups. In some parts of the area, for example Cambridge, Norwich, Great Yarmouth and Huntingdon, five year old children have four or more decayed primary teeth and most of this decay remains untreated. Nearly 1400 children in the area a year attend hospital to have dental extractions under general anaesthesia and this is still the most common reason for children's admissions to hospital. This is likely to be an under estimate as it does not include some children treated under salaried dental services. Severe, untreated dental decay may not only cause pain, discomfort and disruption to sleeping and eating habits, but may also adversely affect child growth and school performance.

East Anglia has an ageing population. People are living longer and keeping more of their teeth for longer. This will have implications for the provision of dental services in the future as more people will be maintaining teeth that have already been heavily restored. The Independent review of dentistry in England carried out by Professor Jimmy Steele in 2009 refers to this group as the "heavy metal generation". In future there may be greater need and demand for more specialist services such as complex restorative care, domiciliary services, minor oral surgery services and anxiety management pathways.

Oral diseases are important public health issues as they are among the most commonly found chronic diseases and are almost entirely preventable. The causal relationships between sugar and dental decay and gum disease and poor oral hygiene, for example are well understood. Although we have seen considerable reductions in dental disease since the 1970s there are still improvements to be made. The most effective and efficient method of promoting oral health is to integrate oral health with generic health promotion using the common risk factor approach. Common risk factors include poor diet, tobacco use, poor hygiene, injuries and high alcohol consumption, factors associated with obesity, cancer, heart disease, diabetes and strokes.

In addition to this common risk factor approach targeted oral health improvement interventions such as community fluoride varnish schemes and tooth brushing programmes must also be considered for children in areas of high need. Local dental practices also have an important role to play in improving oral health for their patients by implementing the Department of Health document "Delivering Better Oral Health- a guide to practice based prevention"

In April 2013 responsibility for commissioning dental services transferred to the newly created NHS England Area Teams and dental public health functions including

oral health improvement programmes, epidemiological surveys and water fluoridation schemes became the responsibility of Local Authorities. These changes also saw the inception of Local Professional Networks who, as part of NHSE Area Teams, have responsibility for providing strong clinical leadership in improving oral health locally. Clinical engagement via the LPN, Local Dental Committees and any managed clinical networks is important for the success of any commissioning arrangements and service provision if oral health is to improve.

The priorities for East Anglia Area Team and its stakeholders are:

- Improving oral health of the population throughout the life course ensuring that every child gets the best start in life
- Reducing oral health inequalities
- Improving access to NHS dentistry
- Maintaining good patient experience and patient safety
- Driving quality, innovation, productivity and prevention forward

Across East Anglia access to dental services is generally good although uptake is not always high. Most patients in East Anglia report that they are able to find an NHS dentist when they want one and the vast majority are satisfied with the service they receive. Historically most dental services have been provided in more affluent areas and there are limited opportunities to re-commission services within the same budget in underserved areas because of the nature of the non- time limited GDS contracts. However when these opportunities do present new services should be commissioned in areas of deprivation and high need.

The rural nature of much of East Anglia may affect people's ability to access dental services. In addition not everyone wishes to visit a dentist on a regular basis and some may only require care when they have a problem. Different models of service provision such as Dental Access Centres, out of hours services, urgent care services and mobile dental units should be maintained to allow flexibility and patient choice and the public voice should help inform these arrangements.

A reformed dental contract, with a focus on prevention and patient registration is expected to be delivered in 2016. The introduction of the last new dental contract in 2006 saw marked changes in NHS general dental service delivery. This in turn led to increasing demand for the provision of more specialised services such as minor oral surgery and restorative dentistry. Future commissioning of local dental services must be flexible enough to accommodate any changes in GDS delivery that these reforms may bring.

Until recently dental services were commissioned by PCTs and arrangements for the provision of these services showed local variation. With one organisation there is now the opportunity to achieve a consistency of services across the area using a single operating model. This single operating model has the potential to achieve an equitable provision of services which are delivered to a high standard and which demonstrate excellent quality.

Although there is a wealth of information available, the way it has been collated and reported in the past varied. There is now the opportunity for consistent data capture as well as monitoring and evaluation of all services against an agreed set of

outcomes which will provide valuable information for future commissioning of dental services in East Anglia.

1. Introduction

Good oral health is integral to general health as it 'contributes to general well being' and allows people to 'eat, speak, and socialise without active disease, discomfort or embarrassment'.

Oral diseases are important public health issues as they are among the most commonly found chronic diseases. Although we have seen considerable reductions in dental disease since the 1970s, there are still substantial reductions to be made. Dental decay, for example, is commonly found despite being almost entirely preventable.

While dental decay has reduced overall, population averages mask oral health inequalities. Oral disease varies according to gender, age, ethnicity, geographic location and socio-economic group. Trends suggest that dental disease is increasingly concentrated in areas of social deprivation.

From April 2013 Local Authorities (LA) were given the responsibility for improving the oral health of their populations. Part of the planning for this involves an assessment of the local oral health needs of the population, followed by the development of an oral health strategy. The local oral health strategy must incorporate the national priorities detailed in *Choosing Better Oral Health – an Oral Health Plan for England* as well as other key policy drivers.

At the same time NHS England (NHSE) was given the responsibility for commissioning primary care dental services through the local Area Teams. Specialist dental public health advice is provided by Public Health England to NHSE and LAs.

This Oral Health Needs Assessment is designed to inform NHSE East Anglia Area team commissioning or primary care dental services as well as facilitate the development of long-term strategies aimed at improving oral health and reducing health inequalities.

2. Broader Context

2.1 Call to action

In launching the 'Call to Action' in February 2014 (http://www.england.nhs.uk/wp-content/uploads/2014/04/imprv-oral-health-info.pdf) NHS England's Chief Dental Officer made the case for change by quoting from *An Independent Review of NHS Dental Services in England*, 2009:

Oral health should be for life. The two common dental disease – dental decay and gum disease – are chronic and the damage they cause is cumulative and costly. The NHS is still dealing with, and paying for, the consequences of disease that developed more than 50 years ago. The trends in disease prevalence and the way it has been managed are visible in the oral health of different generations. We still need to deal with this burden of the past and manage the demands of the present, but keep a very clear focus on the future so that we can minimise the risk, discomfort and costs for future generations"

He identified the key challenges as:

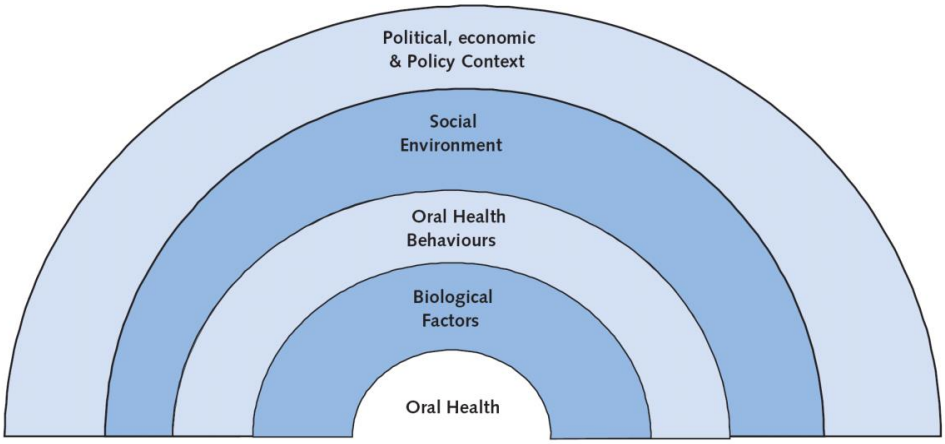
- Improving oral health: quality and prevention
- Improving oral health: reducing health inequalities
- Access
- Information for patients
- The pathway approach and integrated care
- Patient and public engagement
- Workforce

The structure of this document is briefly to review the determinants of oral health and impact of oral disease, and to outline local strategic options to meet the key challenges identified in *A Call to Action*. A detailed report *Oral Health Needs and Determinants in East Anglia* has been produced to support local organisations understanding of appropropriate evidence-informed actions to maintain and improve oral health.

2.2 The determinants of Oral Health and Impact of Oral Disease

Oral diseases are important public health issues as they are among the most commonly found chronic diseases and are almost entirely preventable.
A person's oral health is shaped by complex set of determinants, some closely related to that individuals' choices and behaviour, others more distanly determined:

Figure 1: Determininants of oral health



Source: Modified from Watt, 2005 in *Choosing Better Oral Health. An Oral Health Plan for England. 2005*
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251

When applying this model, strategies for oral health improvement need to be balanced to operate at each level:

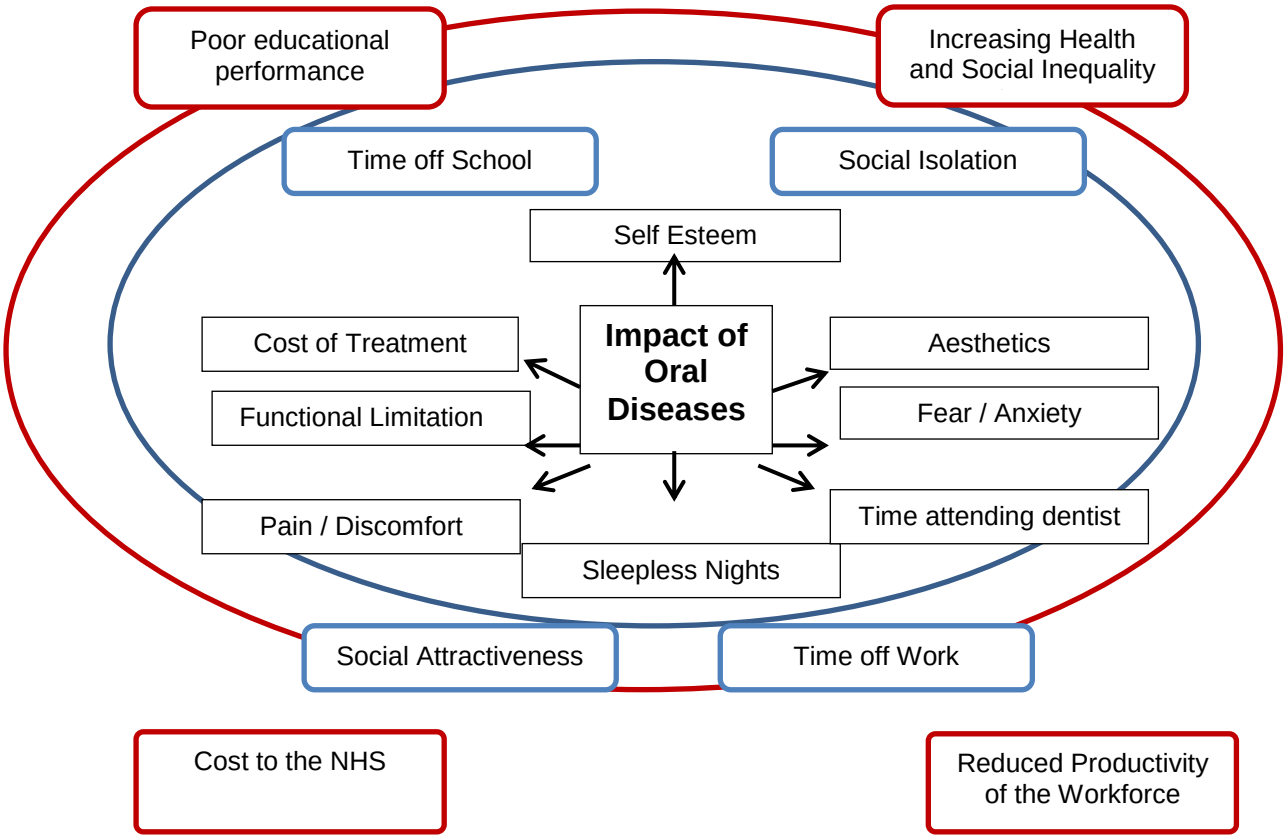
Table 1: Strategies for Health improvement

Levels		***Example of how they can be applied – Reducing the use of tobacco***
Biological – immunisation, vaccinations, treatments		Nicotine replacement therapy and cognitive tools for cravings
Individual Behavioural – helping individuals to stop smoking		Individual and group behavioural change and support
Environmental – encouraging green transport, reducing pollution, changing the public realm		Environmental cues, display legislation Smokefree playgrounds
Social – changing social norms about health, e.g. acceptability of binge drinking, acceptability of taking smoking breaks		Behavioural economics, social marketing Young people
Structural – policy changes such as workplace health, school health policies		Workplace policies Tobacco control partnerships
Legislative – the smoking ban, legislation on alcohol sales		The ban on smoking Legislation on displays

Source: The Six Levels of Public Health Strategy (from the Hertfordshire Public Health Strategy.)
Adapted from Dettels et al, 2009)

Similarly, the national burden of oral disease extends beyond the cost of NHS treament services, through a wide range of broader impacts both on the individual and society as a whole (reference nnnnnn):

Figure 2: Impact of oral disease



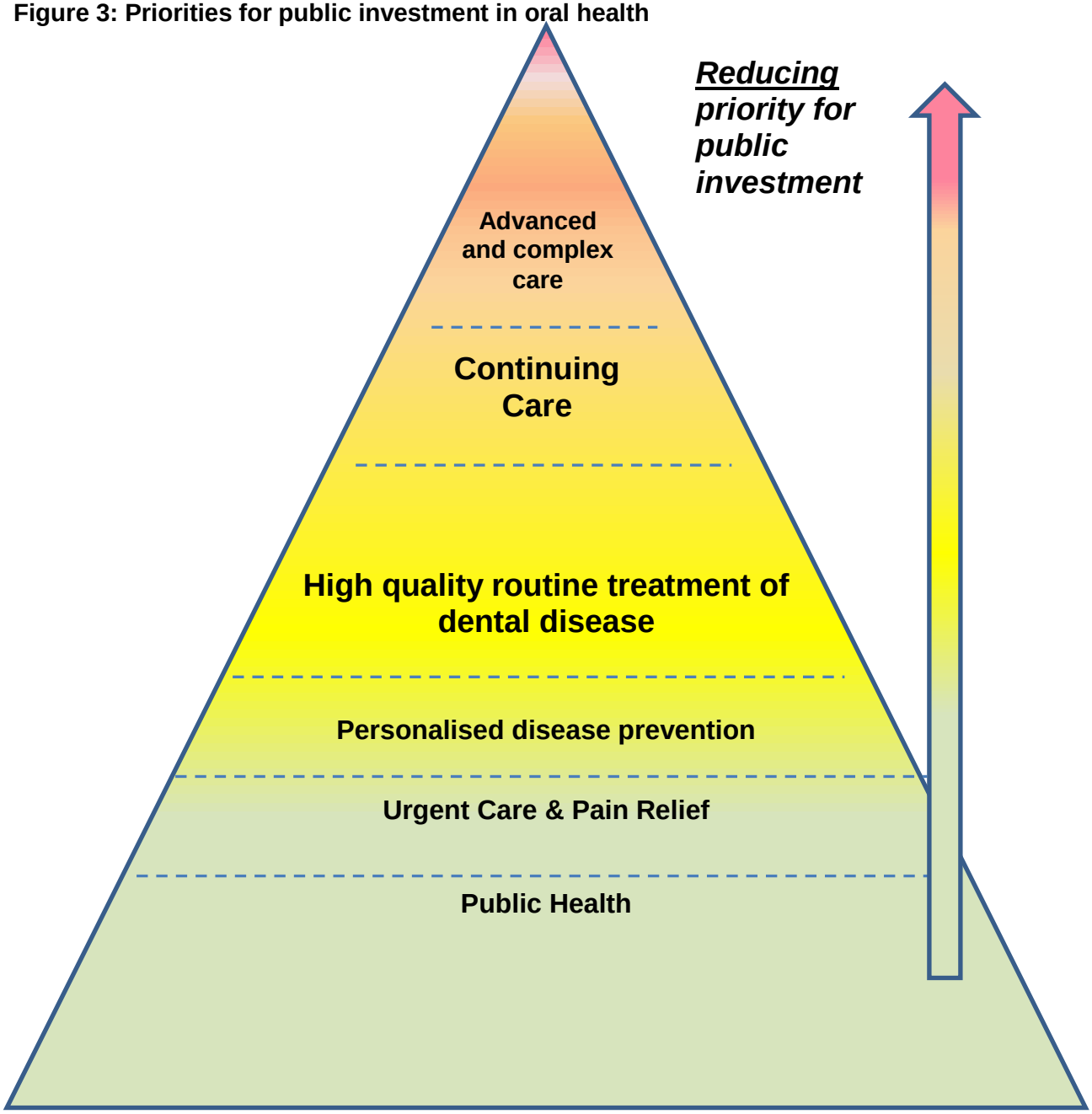
2.3 The Steele Review

NHS Dental Services in England- An independent review led by Professor Jimmy Steele June 2009 said that the overall ambition of the NHS dentistry service should be to be a lifetime-focused, evidence-based oral health service, which aims:

- to prevent oral disease and the damage it causes
- to minimise the impact of oral disease on your health, when it occurs
- to maintain and restore quality of life when this is affected by the condition of your mouth

It is this set of priorities, in this order, that should aim to be achieved through the system of professional obligations, contracts, charges and regulation we create.

Figure 3: Priorities for public investment in oral health



Source: NHS Dental Services in England. An independent review led by Professor Jimmy Steele, June 2009

The priorities are as follows, in order:

There needs to be a strong, co-ordinated public health system, recognising the common risks to oral health and health overall and providing support to the profession and information to patients about how to minimise these risks.

Any dental service should then be able to provide quick and definitive pain relief to anyone who needs it. This should not be a large or expensive part of a service, but it must be there.

Preventing the damage caused by disease at an individual level is a high priority for investment. Every cavity or periodontal pocket represents irreversible damage, with lifetime consequences and costs.

Treating disease is still inevitable where prevention fails, but treatment can be damaging, so minimising damage through quality restoration is an essential step.

Oral health is a lifetime concept, so continuing care arrangements should be facilitated to allow long-term relationships to be established between dentists and patients.

2.4 The NHS Outcomes Framework (2013-2014) and the Public Health Outcomes Framework (2013-2016)- oral health indicators

Both the NHS Outcomes Framework and the Public Health Outcomes Framework (PHOF) have indicators relating to oral health improvement and dental services.

The NHS Outcomes Framework (2013-14) describes overarching indicators to ensure that people have a positive experience of care from NHS Dental Services (4aiii), and improved access to NHS dental services (4.4ii)[1].

Within the Public Health Outcomes Framework (2013-16) tooth decay in five-year old children is the oral health outcome indicator. The data to monitor this indicator is sourced from the National Dental Epidemiology Programme and provides a measure for local authorities to monitor and evaluate children's oral health improvement programmes[2].

2.5 Securing excellence in commissioning primary care -Single Operating Model

NHS England is responsible for the direct commissioning of services beyond the remit of clinical commissioning groups, namely primary care including primary dental care, offender health, military health and specialised commissioning. A suite of documents detailing policies and procedures to support the commissioning of primary care are in production and are intended to achieve a "do once approach" intended to ensure consistency and eliminate duplication. The development process for the suite of documents reflects the principles set out in Securing excellence in commissioning primary care.
http://www.commissioningboard.nhs.uk/2012/06/22/ssom-comm-pc/

3. Broad Context: Local Responsibilites for East Anglia

3.1 Local Authorities

From April 2013 Local Authorities (LAs) became responsible for improving oral health in their population. Section 29 of the 2012 act amended the NHS Act 2006 to transfer primary care trust existing functions around Oral Public health to Local

Authorities including responsibility for water fluoridation.[3] There are four LAs in East Anglia, Cambridgeshire, Suffolk, Norfolk and Peterborough and their priorities for improving the health and wellbeing of their populations are detailed in the respective Health and Wellbeing Strategies

Suffolk Health and Wellbeing Strategy: A ten year strategy 2012-2022
http://www.waveney.gov.uk/egov_downloads/item_5_21_.pdf

Norfolk Joint Health and Wellbeing Strategy 2014-2017
http://www.norfolk.gov.uk/view/NCC122775

Cambridgeshire Health and Wellbeing Strategy 2012-17 www.cambridgeshire.gov.uk

Peterborough Health and Wellbeing Strategy 2012-15
http://www.peterborough.gov.uk/health_and_social_care/health_and_wellbeing_strategy.aspx

3.2 NHS England East Anglia Area Team

Since April 2013 NHS England East Anglia Area team has had responsibility for commissioning primary care dental services and some secondary care dental services. http://www.england.nhs.uk/about/our-vision-and-purpose/
These changes also saw the inception of Local Professional Networks who, as part of NHSE Area Teams, have responsibility for providing strong clinical leadership in improving oral health locally. Clinical engagement via the LPN, Local Dental Committees and any managed clinical networks is important for the success of any commissioning arrangements and service provision if oral health is to improve.

3.3 Public Health England

Public Health England is the expert public health agency and it has a statutory duty to protect health and reduce inequalities and to promote the health and well- being of the population https://www.gov.uk/government/organisations/public-health-england

3.4 Clinical Commissioning Groups

Clinical Commissioning Groups (CCG) replaced Primary Care Trusts and commission most services funded by the NHS in England. They now control around two thirds of the NHS budget and have a legal duty to support quality improvement in general practice. There are eight CCGs across East Anglia and their priorities are set out in the NHS Outcomes Framework and CCG Outcomes Indicator Set 2013/2014
http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-at-a-glance.pdf
https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014

3.5 Summary, Local Priorities

In terms of oral health improvement and reducing oral health inequalities there are common themes running between the priorities for all the local organisations that have a stake in improving the health and wellbeing of the local population.

Tackling the common risk factors such as smoking, alcohol and drug use, poor diet, stress poor hygiene and injury that contribute to ill health will also help to tackle poor oral health.

Common themes are:

- Reduce the prevalence of smoking.
- Prevent and address childhood and adult obesity.
- Explore the potential for preventative work to reduce high rates of alcohol related hospital admissions
- Joint planning to meet the needs of the growing older population.
- Implementation of the Child Health Programme (CHPP) to enable early intervention and prevention of poor outcomes.
- Improve outcomes for children and young people living in areas of higher socioeconomic deprivation and for specific population groups such as children in care, traveller children and children with disabilities

3.6 Priorities for Investment in oral health

Table 2 summarises the priorities for oral health, NHS Dental Services in England- An independent review led by Professor Jimmy Steele June 2009.

Table 2: Priorities for Investment in oral health

Priorities for public investment	Steele rationale	Comments
Public Health	Strong, co coordinated system, recognising common risks and providing support to profession and info to patients on how to minimise risks	Strong evidence of association between prevalence of oral cancers (expensive to treat in secondary care) and smoking and alcohol use. Traumatic facial injury can result from violence/accidents related to alcohol misuse. Smoking exacerbates periodontal disease hence risk of tooth loss. Links between sugars in diet and tooth decay.
Urgent care	Quick, definitive pain relief to anyone who needs it; relatively inexpensive	Delaying seeking help for dental pain can result in severe dental infections that may need admission. This happens quite rarely, but is reported to be on the increase. Population groups who do not use current services regularly, with poorer dental health are more likely to need services for urgent care and ultimately secondary care for complex oral surgery that might arise.
Personalised disease prevention	High priority for investment at individual level as failure results in cavity or periodontal pockets that are irreversible damage, with lifetime consequences and costs	A large population group will benefit; rectifying where prevention fails, and where restorations don't last is currently the majority of work in primary care. The current impact on secondary care is where need arises for difficult oral surgery or more complex restorative work although the latter is not routinely provided at specialist level or in secondary care.
Routine treatment and continuing care	Quality primary care and continuing card as oral health is a lifetime concept	A large population group already benefits and there would be high demand for specialist care if it was available. Currently there is an advice only service re complex restorative care provided in secondary care setting in Norfolk, mainly to support dentists' treatment planning.
Advanced, complex and expensive treatments	Offered for quality of life rather than disease management; not an automatic right for everyone but targeted to where risks are managed and where need and benefits greatest.	For secondary care this includes dental implants for e.g. severe facial deformity or facial reconstruction after a major accident or following cancer surgery. Implant surgery is becoming more available in primary care, but it is not funded by the NHS.

4. Population and Demography of East Anglia

4.1 East Anglia Area Team population

East Anglia Area team overlaps four upper tier local authorities, Norfolk, Suffolk, Peterborough and Cambridgeshire. There are eight CCGs with a registered population of 2,457,100 and an indicative running cost of £60 million. 330 out of East Anglia Area Team's 1445 Local super output areas (LSOA) are in the 20% most deprived LSOAs in the country.

East Anglia AT has a lower proportion of 0-39 year olds in its population than the England average, and a higher proportion of residents aged 60+.

Graph 1

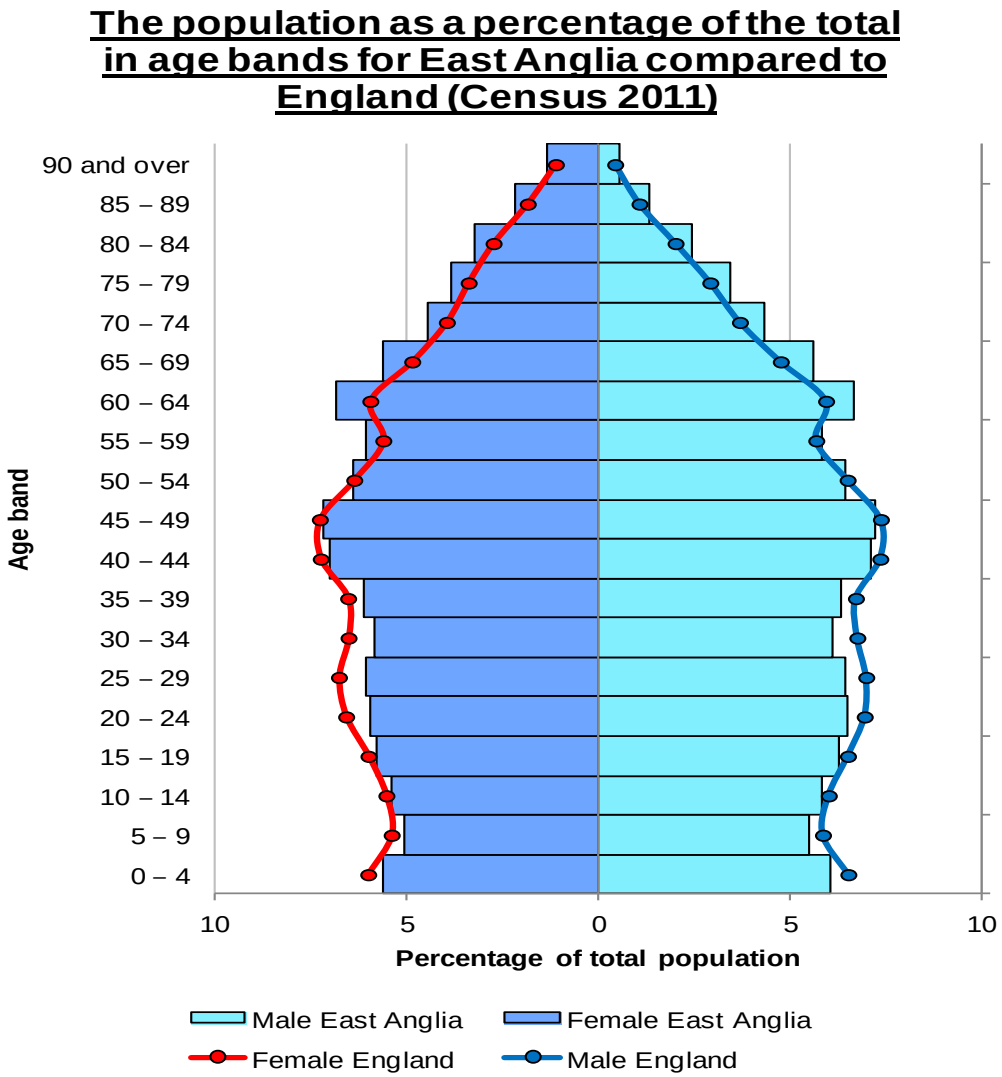
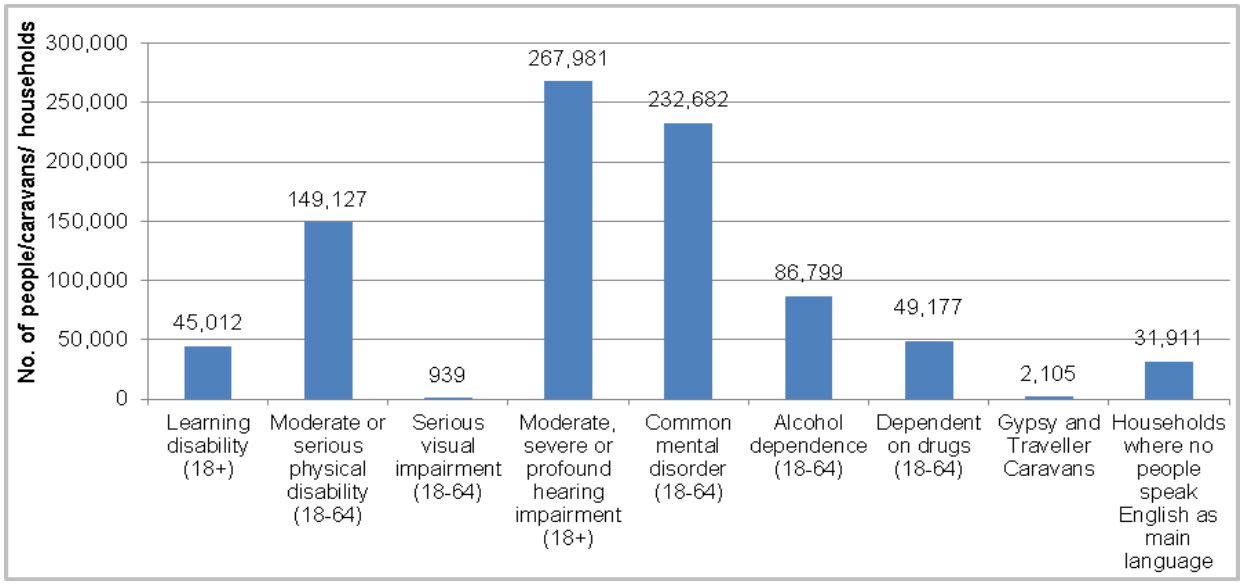


Table 3: Population for East Anglia

East Anglia	Census 2011
Total Registered	2,457,100
Total Resident	2,396,328
Male Resident	1,184,032
Female Resident	1,212,296
0-4 Resident	139,941
65+ Resident	459,694
85+ Resident	64,406

.

Graph 2: The number of people in a variety of 'hard to reach groups' is shown in the graph



The numbers are sourced from the **P**rojected **A**dult **N**eeds & **S**ervice Information system which applies prevalence rates from national research to resident populations, the Office of National Statistics and the Department for Communities & Local Government

Across the LAs that make East Anglia AT life expectancy at birth for men is better than the England average of 78.58 years in all authorities other than Peterborough where it is significantly worse.

For women born in East Anglia life expectancy at birth is better than the England average of 82.57 years, except in Peterborough where it is significantly worse.

Table 4: Life expectancy at birth in East Anglia

AREA: LA	Life expectancy at birth		Gap in life expectancy between most & least deprived	
	Male	Female	Male	Female
Cambridgeshire	80.1	83.9	7.2	5.3
Norfolk	79.5	83.3	5.8	1.9
Peterborough	77.5	81.9	9.4	5.6
Suffolk	79.9	83.6	5.7	4.4

Worse than England Average

Similar to England Average

Better than England Average

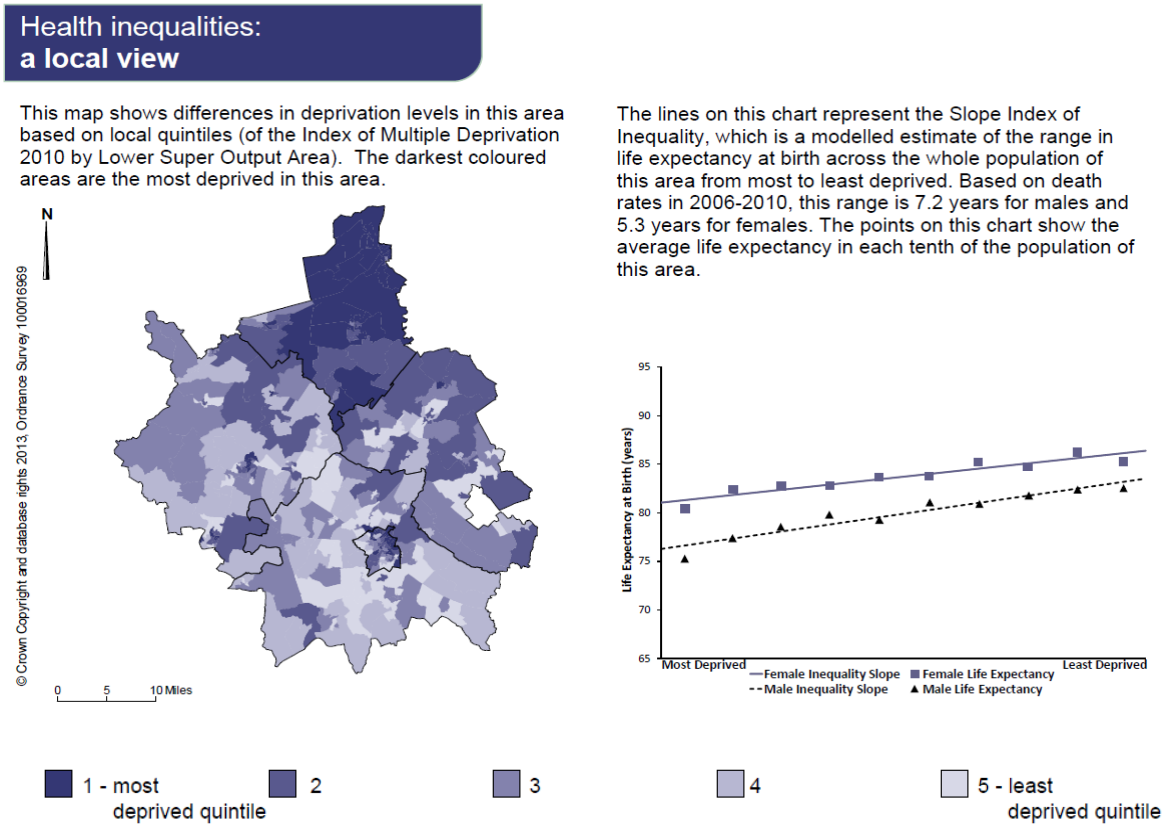
The slope index of inequality measures the gap in life expectancy between the most and least deprived communities in an upper tier authority:

- For women across all four LAs the gap in life expectancy varies between 1.9 to 5.6 years. The gap is statistically better than the England average of 5.9 years in Suffolk and Norfolk but statistically similar in the other two areas.
- For men across all four LA's the gap in life expectancy varies between 5.7 to 9.4 years. Two LA's are statistically similar to the average across England of 8.9 years and two LA's are statistically better.
- Across the LAs that make East Anglia AT there is some variation in the rate of premature deaths per 100,000 population.
- Peterborough has a significantly worse death rate compared to the England average, ranked 87th out of the 150 LA's.
- The remaining three LAs by contrast are amongst the best performing LAs in England.
- Common causes of high levels of premature death in England include smoking, poor diet, alcohol & blood pressure.

4.2 Health Profiles in East Anglia

4.2. 1 Cambridgeshire

- The health of people in Cambridgeshire is generally better than the England average. Deprivation is lower than average, however about 14,400 children live in poverty. Life expectancy for both men and women is higher than the England average.
- Life expectancy is 7.2 years lower for men and 5.3 years lower for women in the most deprived areas of Cambridgeshire than in the least deprived areas. Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.
- In Year 6, 16.3% of children are classified as obese, better than the average for England. The level of GCSE of teenage pregnancy, alcohol-specific hospital stays attainment is worse than the England average. Levels among those under 18 and breast feeding are better than the England average.
- Estimated levels of adult 'healthy eating', physical activity and obesity are better than the England average. The rate of road injuries and deaths is worse than the England average. Rates of sexually transmitted infections and smoking related deaths are better than the England average. The rates of incidence of malignant melanoma and hospital stays for self-harm are worse than average.
- Priorities include focussing on health inequalities, the ageing population and long term prevention of ill health across all ages. www.cambridgeshirejsna.org.uk

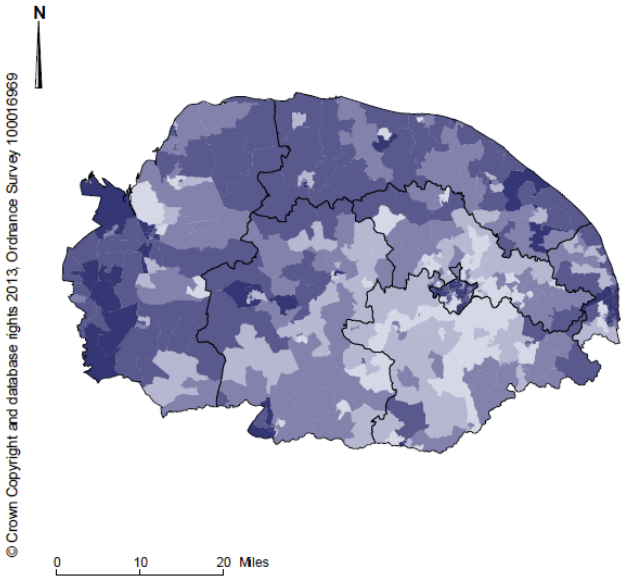


4.2.2 Norfolk

- The health of people in Norfolk is generally better than the England average. Deprivation is lower than average, however about 26,200 children live in poverty. Life expectancy for both men and women is higher than the England average.
- Life expectancy is 5.8 years lower for men in the most deprived areas of Norfolk than in the least deprived areas.
- Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.
- In Year 6, 19.2% of children are classified as obese. Levels of GCSE attainment and smoking in pregnancy specific hospital stays among those under 18 and are worse than the England average. Levels of alcohol breast feeding are better than the England average.
- An estimated 20.3% of adults smoke and 24.8% are obese. Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are better than the England average. The rate of hospital stays for self-harm is worse than average.
- Priorities in Norfolk include stopping smoking, particularly in pregnancy, monitoring and preventing early deaths from cancer (targeting risk factors) and reducing diabetes by promoting healthy lifestyles. For more information see www.norfolkinsight.org.uk and www.norfolk.gov.uk/

Health inequalities: a local view

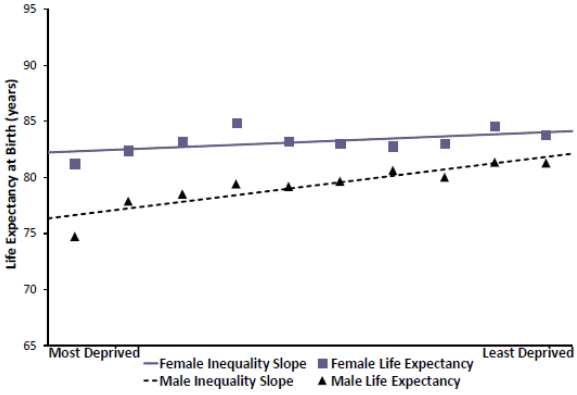
This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



Legend as above

1 - most deprived quintile | 2 | 3 | 4 | 5 - least deprived quintile

The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 5.8 years for males and 1.9 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.

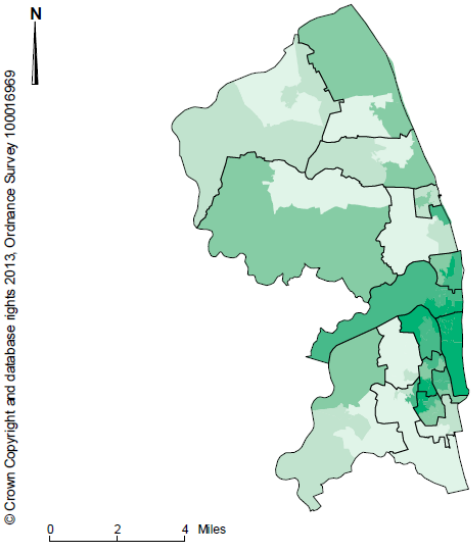


4.2.3 Great Yarmouth

- The health of people in Great Yarmouth is generally worse than the England average. Deprivation is higher than average and about 4,400 children live in poverty.
- Life expectancy for both men and women is lower than the England average. Life expectancy is 9.5 years lower for men and 5.3 years lower for women in the most deprived areas of Great Yarmouth than in the least deprived areas.
- Over the last 10 years, all cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen and is similar to the England average. In Year 6, 22.1% of children are classified as obese, worse than the average for England. Levels of teenage pregnancy, GCSE attainment, breast feeding and average. smoking in pregnancy are worse than the England
- Estimated levels of adult physical activity and obesity are worse than the England average. Rates of smoking related deaths and hospital stays for alcohol related harm are worse than the England average. Rates of sexually transmitted infections and road injuries and deaths are better than the England average.
- Priorities in Great Yarmouth include the reduction of smoking levels, especially in pregnancy, and reducing obesity, diabetes and alcohol related harm. For more information see www.norfolkinsight.org.uk

Health inequalities: a local view

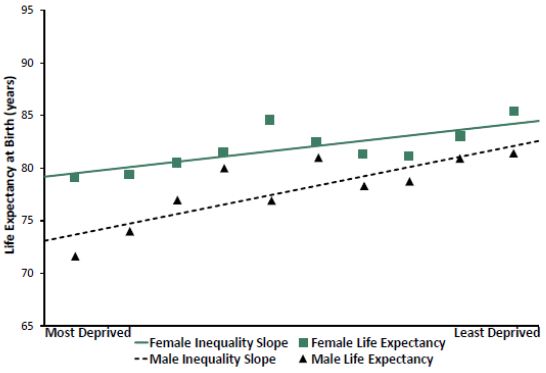
This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



Legend as above

1 - most deprived quintile | 2 | 3 | 4 | 5 - least deprived quintile

The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 9.5 years for males and 5.3 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.

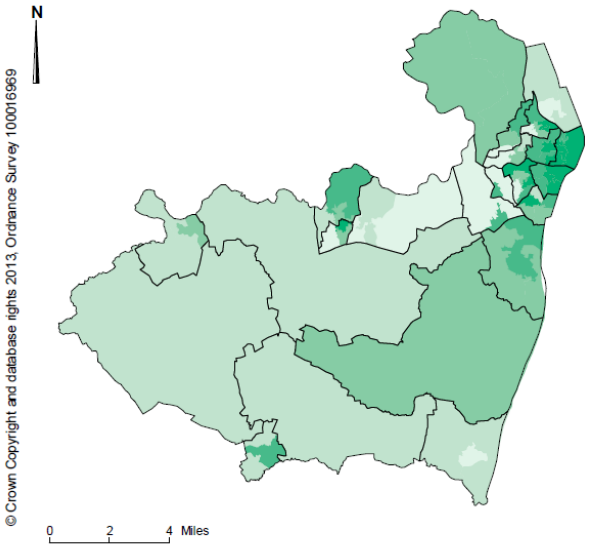


4.2.4 Waveney

- The health of people in Waveney is varied compared with the England average. Deprivation is lower than average, however about 4,400 children live in poverty. Life expectancy for women is higher than the England average.
- Life expectancy is 5.9 years lower for men and 5.3 years lower for women in the most deprived areas of Waveney than in the least deprived areas.
- Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen.
- In Year 6, 18.3% of children are classified as obese. Levels of teenage pregnancy, GCSE attainment, breast feeding and smoking in pregnancy are worse than the England average.
- The estimated level of adult obesity is worse than the England average. England average. The rate of road injuries and deaths is worse than the England average. Rates of sexually transmitted infections and smoking related deaths are better than the England average. The rates of violent crime and long term unemployment are worse than average. The rates of statutory homelessness and drug misuse are better than average.
- Priorities in Waveney are to ensure that every child has the best start in life; residents have access to a healthy environment and take responsibility for their own health and wellbeing; older people have a good quality of life; people have the opportunity to improve their mental health and wellbeing. See www.suffolk.gov.uk

Health inequalities: a local view

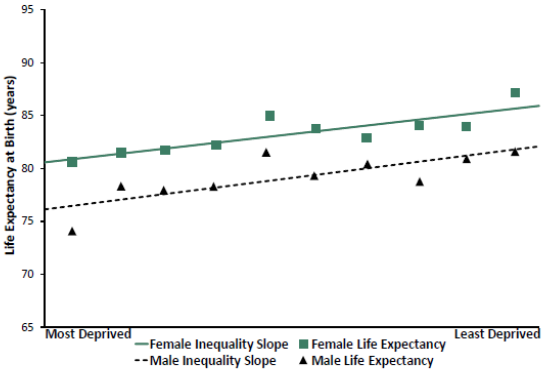
This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



Legend as above

1 - most deprived quintile | 2 | 3 | 4 | 5 - least deprived quintile

The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 5.9 years for males and 5.3 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.

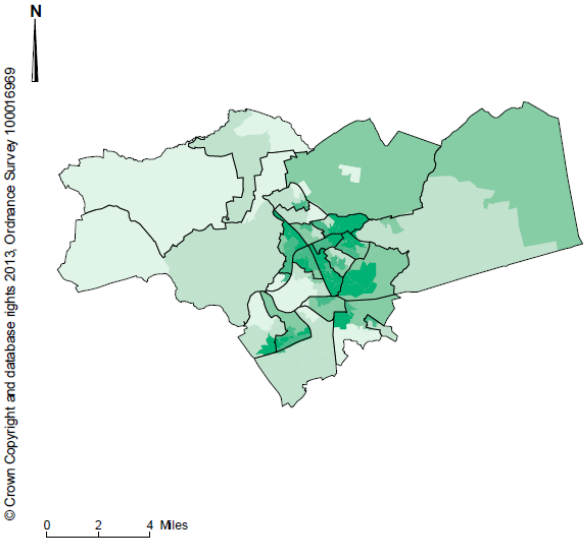


4.2.5 Peterborough

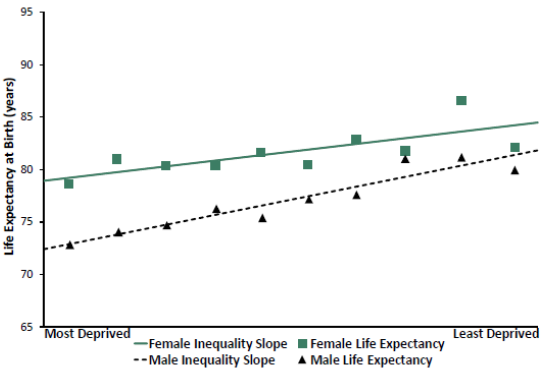
- The health of people in Peterborough is generally worse than the England average. Deprivation is higher than average and about 9,500 children live in poverty. Life expectancy for men is lower than the England average.
- Life expectancy is 9.4 years lower for men and 5.6 years lower for women in the most deprived areas of Peterborough than in the least deprived areas.
- Over the last 10 years, all-cause mortality rates have fallen. The early death rate from heart disease and stroke has fallen but is worse than the England average.
- In Year 6, 19.2% of children are classified as obese. Levels of teenage pregnancy, GCSE attainment and average. The level of alcohol-specific hospital stays smoking in pregnancy are worse than the England among those under 18 is better than the England average.
- The estimated level of adult smoking is worse than the England average. Rates of road injuries and deaths and hospital stays for alcohol related harm are worse than the England average.
- Priorities in Peterborough include reducing premature mortality, reducing inequalities in coronary heart disease and promoting healthy lifestyles. For more information see www.peterborough.gov.uk and www.cambridgeshireandpeterboroughccg.nhs.uk

Health inequalities: a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 9.4 years for males and 5.6 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.



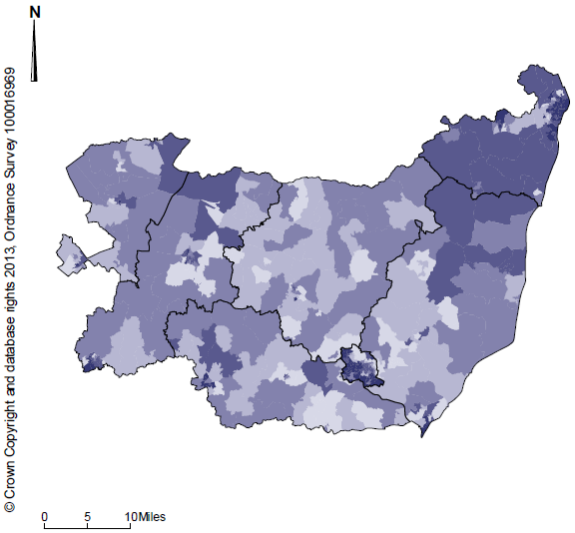
1 - most deprived quintile | 2 | 3 | 4 | 5 - least deprived quintile

4.2.6 Suffolk

- The health of people in Suffolk is varied compared with the England average. Deprivation is lower than average, however about 20,000 children live in poverty. Life expectancy for both men and women is higher than the England average.
- Life expectancy is 5.7 years lower for men and 4.4 years lower for women in the most deprived areas of Suffolk than in the least deprived areas.
- Over the last 10 years, all cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.
- In Year 6, 15.9% of children are classified as obese, better than the average for England. Levels of GCSE the England average. Levels of teenage pregnancy, attainment and smoking in pregnancy are worse than alcohol-specific hospital stays among those under 18 and breast feeding are better than the England average.
- An estimated 20.4% of adults smoke and 24.3% are obese. The rate of road injuries and deaths is worse than the England average. Rates of sexually transmitted infections, smoking related deaths and hospital stays for alcohol related harm are better than the England average. The rate of incidence of malignant melanoma is worse than average.
- Local priorities include lowering alcohol admissions and smoking rates (particularly in pregnancy) and improving breast feeding rates. See www.suffolk.gov.uk

Health inequalities:
a local view

This map shows differences in deprivation levels in this area based on local quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are the most deprived in this area.



Legend as above

The lines on this chart represent the Slope Index of Inequality, which is a modelled estimate of the range in life expectancy at birth across the whole population of this area from most to least deprived. Based on death rates in 2006-2010, this range is 5.7 years for males and 4.4 years for females. The points on this chart show the average life expectancy in each tenth of the population of this area.

A link for all the above health profiles can be found below:
http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES

4.3 Population projections for East Anglia

Population projections for East Anglia show that the population is likely to grow between 2011 and 2016 with further growth expected between 2011 and 2021. By 2021 the population in Cambridgeshire is expected to grow by 11 per cent, in Norfolk by nine per cent, Peterborough 13 per cent and Suffolk by seven per cent. The table below shows the interim 2011-based subnational population projections by the Office for National Statistics (ONS) 2011 to 2021 by population age cohorts for all persons by upper tier and unitary authorities in East Anglia. The largest growth in population is predicted to be in the 55 years and over group and within this group there is likely to be a greater increase in the 85+ age group.

Table 5: Interim 2011-based subnational population projections, 2011 to 2021 by population age cohorts for all person

Local authority area	Age group (years)	Year						
		2011	2016			2021		
		Num	Num	Change 2011-2016		Num	Change 2011-2021	
				Num (+/-)	%		Num (+/-)	%
Cambridgeshire	0-18	135,522	145,169	9,647	7%	154,303	18,781	14%
	19-54	311,660	316,610	4,950	2%	314,414	2,754	1%
	55-74	127,581	140,521	12,940	10%	153,615	26,034	20%
	75-84	33,489	36,730	3,241	10%	44,658	11,169	33%
	85+	14,060	17,251	3,191	23%	20,721	6,661	47%
	Total	622,312	656,280	33,968	5%	687,712	65,400	11%
Norfolk	0-18	175,119	180,251	5,132	3%	189,594	14,475	8%
	19-54	381,585	390,248	8,663	2%	386,165	4,580	1%
	55-74	213,053	227,257	14,204	7%	241,055	28,002	13%
	75-84	63,636	68,785	5,149	8%	80,634	16,998	27%
	85+	26,033	30,813	4,780	18%	36,558	10,525	40%
	Total	859,426	897,353	37,927	4%	934,007	74,581	9%
Peterborough	0-18	46,445	49,899	3,454	7%	53,328	53,328	15%
	19-54	93,860	99,128	5,268	6%	101,706	101,706	8%
	55-74	31,864	34,912	3,048	10%	38,467	38,467	21%
	75-84	8,923	9,092	169	2%	9,998	9,998	12%
	85+	3,365	3,804	439	13%	4,405	4,405	31%
	Total	184,457	196,834	12,377	7%	207,904	23,447	13%
Suffolk	0-18	160,044	164,406	4,362	3%	171,369	11,325	7%
	19-54	327,979	327,076	-903	0%	319,586	-8,393	-3%
	55-74	171,850	186,656	14,806	9%	200,646	28,796	17%
	75-84	49,312	53,762	4,450	9%	64,041	14,729	30%
	85+	20,948	24,614	3,666	17%	29,213	8,265	39%
	Total	730,133	756,513	26,380	4%	784,855	54,722	7%

Source:http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Subnational+Population+Projections#tab-data-tables - downloaded 10/04/14

5. Common Oral Diseases and their Causes

5.1 Definitions of Common Dental Diseases

5.1.1 Dental Decay (Caries)

Dental decay is one of the most common chronic diseases. It occurs when tooth tissue is demineralised by the acids formed by dental plaque in response to dietary sugars.

A wealth of evidence has consistently shown that sugars are the most important factor in caries development.[4] 'Free sugars' include all monosaccharides and disaccharides as well as those naturally present in honey, fruit juices and syrups.[4] The annual consumption of free sugars has increased since the 1970s.[5] The sugars naturally present in whole fruits, vegetables and milk are not thought to be harmful to dental or general health.

5.1.2 Gum (Periodontal) Disease

Gum or periodontal disease is caused by inflammation of the gums and bone that support and anchor teeth. When severe, the bony support for teeth is extensively compromised causing otherwise healthy teeth to be lost.

There are a number of gum (or periodontal) diseases, however the disease with public health implications is chronic periodontitis. Chronic periodontitis can cause bleeding gums, loss of periodontal attachment, recession of gums, periodontal abscesses, drifting of teeth, tooth mobility and ultimately tooth loss. These symptoms can have a significant impact on the individual ranging from halitosis and discomfort to changes in appearance and loss of function.[6] Prevalence tends to increase with age.

Risk factors for chronic periodontitis include poor plaque control, smoking, certain systematic diseases (such as Diabetes), genetic factors, stress and social deprivation.[6]

5.1.3 Oral Cancer

Oral cancer is a generic term that is used to describe all malignancies of the oral cavity, oropharynx and hypo pharynx (such as squamous cell carcinoma of the lip and tongue).

Almost all oral cancers are thought to be preventable. An estimated 80% are caused by tobacco (smoking or chewing), alcohol or a combination of the two. Although tobacco and alcohol are independent risk factors, their combined effect is greater than the sum of the risks from exposure to either on its own.[7] An estimated 10–15% of oral cancers may be caused by unhealthy diets.[8]

Mouth Cancer is the largest group of head and neck cancers. [9]

It is more common in men than women and the vast majority of cases are in people over the age of 50, however more than one in ten cases is diagnosed in people below this age. Although most lesions are related to the risk factors listed above, some especially at the back of the mouth in the oropharynx are related to exposure to human papillomavirus (HPV). Although patients' quality of life during and after treatment has steadily improved, survival rates from the disease have barely increased. Cancer Research UK (CRUK)

5.1.4 Malocclusion and Orthodontics

Malocclusion is not a disease but the collective term given to natural variations from the 'ideal' in the relationships of the teeth and jaws. Its presence is not synonymous with a need for treatment.[10] There is a lack of evidence to suggest that malocclusions have a detrimental effect on oral health, although by affecting facial appearance malocclusions can have an impact on psychological well-being and quality of life.[11] Because malocclusion is not a disease and orthodontic treatment carries risks (eg root resorption, decalcification and non-improvement)[10] it is particularly important to evaluate the risk-benefit balance of any possible treatment.

In the UK, need for orthodontic treatment in the NHS is assessed using the 'Index of Orthodontic Need' (IOTN). The IOTN incorporates both an aesthetic and dental health component. Both of these aspects of a malocclusion are clinically assessed to determine whether a patient is likely to benefit from treatment. The clinician assigns a dental health component grade of treatment need between 1 and 5 (with 5 representing greatest need) and an aesthetic component grade of treatment need between 1 and 10. Under the current regulations, a patient is entitled to NHS orthodontics if their malocclusion has been graded as follows:[12].

- Grade 4 or 5 of the Dental Health Component of the Index of Orthodontic Treatment Need.
  Or
- Grade 3 of the Dental Health Component of that Index with an Aesthetic Component of 6 or above.

In England approximately a fifth of all twelve year olds fit into each dental health component grade and approximately half the twelve year old population are likely to have an IOTN score of 3 (Dental Health Component) and an aesthetic component of 6 or above.

When this need is combined with demand approximately a third of twelve year olds are likely to undertake orthodontic treatment.

5.1.5 Cleft Lip and Palate

Cleft lip and palate is a phrase used to describe a group of congenital facial malformations that occur when the upper lip and/or palatal shelves fail to fuse during embryonic development. There are a range of conditions within this definition from a simple notch of the upper lip to a full bilateral cleft of the lip and hard and soft palate.

Successful management of patients requires multidisciplinary, highly specialised treatment from birth to early adulthood including multiple surgeries, genetic and psychological counselling, speech and language therapy, orthodontics and long-term preventive and restorative dental care.[13]

Orofacial clefts occur in around 1 in 500 live Caucasian births.[10] Clefts occur more frequently in oriental people and less frequently in black people.

Patients with orofacial clefts have a high need for care from an experienced multidisciplinary team co-ordinated from a single regional centre.

Local data on the prevalence of cleft lip and palate are not routinely collected.

5.1 6 Facial Injury and dental trauma

Facial injury and dental trauma are associated with alcohol use, road traffic accidents sports injuries, domestic violence and accidental and non- accidental injury There is risk of increased facial injury associated with alcohol consumption. There are nearly 1 million violent incidents each year in the UK where the victim believed the offender to be under the influence of alcohol (The Home Office Statistical Bulletin, Crime in in England and Wales 2008/09. The British Crime Survey and police recorded crime http//www.homwoffice.gov.uk/rds/pdfs09/hosb1109vol1.pdf) The cost to the NHS for alcohol related harm, including assault injuries is an estimated £ 2.7bn a year. 9 DH (2008) The Cost of Alcohol Harm to the NHS in England)

Glass inflicted injuries to the eyes and face often require stitches or surgery and can result in heavy blood loss and even loss of sight. Assault and alcohol consumption are the two major factors responsible for serious facial injuries in young adults[14].

Four times more men than women sustained facial injuries in assaults, but in the home the reverse was true. Nearly half of all facial injuries sustained in assaults on women occurred in the home and one half of these incidents were associated with alcohol.

From 1977 to 1987 the proportion of patients with facial injuries sustained in road traffic accidents fell by 34 per cent. Road traffic accidents accounted for only five per cent of facial injuries and, 15 per cent of road accident victims had consumed alcohol within four hours of their injury. Public policies and national legislation such as the compulsory wearing of seat belts have also contributed to the reduction in the number of facial injuries sustained as a result of road traffic accidents. However facial trauma has been consistently shown to be the single most common injury to the occupants of vehicles involved in crashes.[15]

It has long been known that participation in sports carries a considerable risk of sustaining dental injury[16]. In a 10 year review of over 21,000 cranio-maxillofacial injuries seen at an Austrian OMFS clinic 31% were sports-related.[17]

Mouth guards offer considerable protection against sports-related dental injuries.

Recent national epidemiological surveys of children identified levels of accidental injury to children. Eleven per cent of twelve year olds and 13 per cent of fifteen year olds were found to have fractures into dentine of their permanent central incisors. NHS Epidemiology Programme for England. Dental Health 2013

One fifth of the injuries involving children were related to assault, underlining the need for anti-bullying policies in schools.

5.2 Biological Determinants (Risk Factors) of Oral Disease

The factors that are concerned with the development of poor oral health are generally well known to the public and the underlying science is well researched and understood.

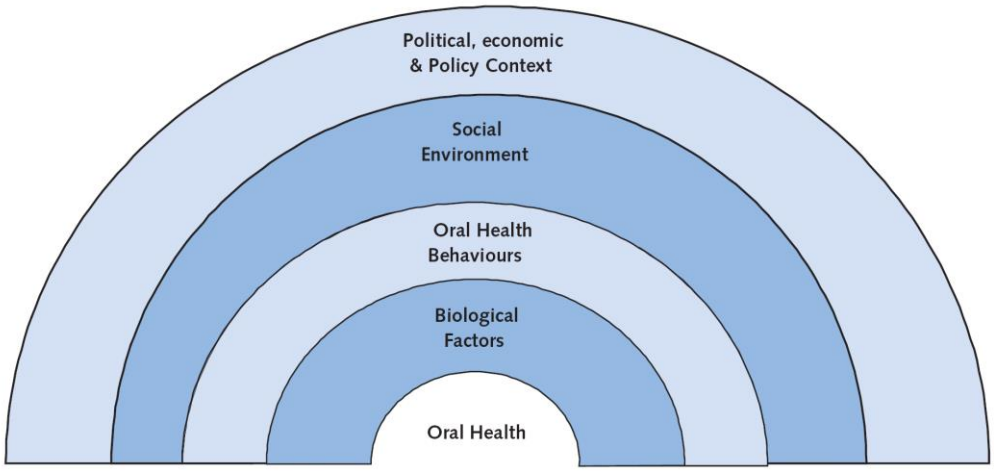
The main risk factors include:

1. Poor diet and nutrition:
   - High consumption of free sugars leads to dental caries.
   - Poor nutrition can increase risk of oral cancer.
2. Poor oral hygiene:
   - Poor plaque control will increase risk of dental caries and gum disease
3. Lack of exposure to Fluoride:
   - Regular exposure to fluoride has a protective, anti-caries effect
4. Tobacco and alcohol:
   - Smoking increases the severity of gum disease and is one of the main risk factors for mouth cancer. Smoking combined with excessive alcohol consumption leads to a much greater risk of cancer than either in isolation.
5. Injury:
   - Injury to teeth can occur through accidental injury or violence or contact sports.

5.3 Social Determinants of Oral Disease

For sustainable reductions in oral health inequalities, it is important to tackle the underlying causes of oral diseases. It is now well recognised that oral health is determined by a wide range of factors, from individual lifestyle choices (eg amount of sugar in diet), to national policy (eg smoke-free environments) (see Figure 2). A successful public health approach must focus on these wider determinants, as focusing on behaviour or lifestyle change has been shown to have a limited long-term effect.

Figure 4: The Underlying Causes of Oral Health



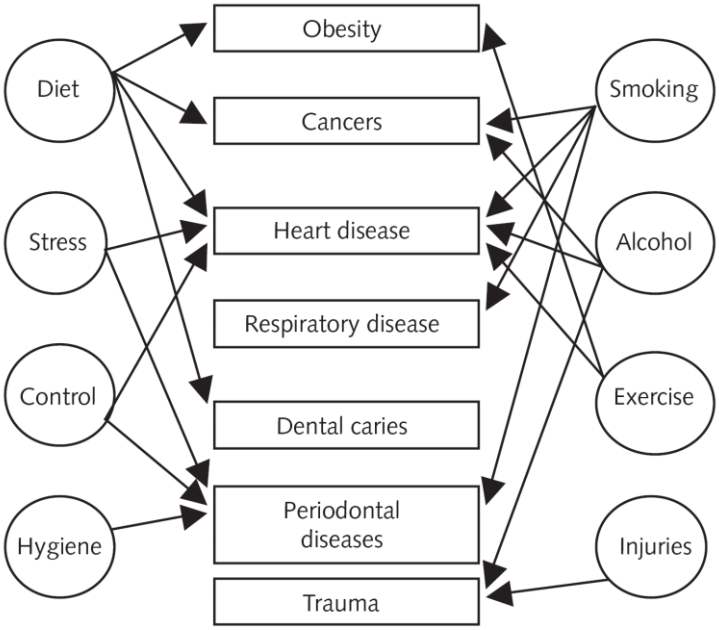
Source: Modified from Watt, 2005 in Department of Health Choosing Better Oral Health. An Oral Health Plan for England. 2005 Available at URL: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251

5.4 Common Risk Factor Approach

The provision of high quality dental services is only one aspect of the public health action needed to reduce oral health inequalities. Dental services are, by necessity, treatment focused and cannot eliminate oral health inequalities alone, no matter how accessible or effective they may be.

Evidence suggests that tackling the causes of oral diseases and promoting oral health will reduce the oral health inequalities. The most effective and efficient method of promoting oral health is to integrate oral health promotion with generic health promotion. The Common Risk Factor Approach emphasises the need to tackle the common risk factors and conditions that are shared by common chronic non-communicable diseases.[18] See Figure 3.

Figure 5: The Common Risk Factor Approach



Source: Sheiham and Watt, 2000 in Department of Health Choosing Better Oral Health. An Oral Health Plan for England. 2005 Available at URL: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251

These common risk factors include tobacco use, poor diet, stress, high alcohol consumption, poor hygiene, injuries and a sedentary lifestyle. Targeting these risk factors at a population level would simultaneously reduce the incidence of obesity, health disease, stroke, cancers, diabetes and mental illness, in addition to oral diseases. If the Common Risk Factor Approach is broadly adopted, it has the added advantage that all health professionals will communicate consistent health messages to the public. Strategic approaches to improving oral health will therefore be linked to other, more general, health promotion initiatives.

5.5 Common Risk Factors

5.5.1 Obesity

There appears to be an association between dental caries and obesity, although there is limited supporting evidence at this time.[19] Dental teams should apply the Common Risk Factor Approach to health promotion and play an active role in promoting healthy food choices. It is important that all health care workers give consistent nutritional messages.

Improving diets in this group and the promotion of consistent nutritional messages about making healthy choices has the potential to improve oral health by reducing the amount and frequency of sugar consumption as well as reduce obesity.

In the UK 24% of men and 25 % of women are obese, BMI> 30 a rise from 13 and 16 % respectively from 1998. By 2015 this is expected to rise to 36 and 28% respectively. Obesity is linked to a number of oral health problems. A meta analysis of 70 studies found a link between obesity and periodontal disease. Obese adults experience more dental trauma and generally dental problems are probably higher in the obese.

Accessing dental care can be more difficult in this group. The practice environment, narrow stairs and doorways, cramped toilets and the safe working limit of dental chairs, 140Kg (22 stone), limits access. Patient factors such as excess soft tissues and saliva, the preference for being treated sitting up, the anaesthetic and sedation risk as well as possible patient embarrassment of being too heavy for the chair may all make patients more reluctant and less able to access care. Obese patients may well not be attending for dental care with the consequent loss of opportunity to deliver preventative care and oral health messages.

Other diseases and public health concerns share risks and contributory factors, for example childhood obesity. The 2012-13 report of the national Child Measurement Programme (Department of Health: Health and Social Care Information Centre (2013). National Child Measurement Programme: England, 2012/13 school year. www.hscic.gov.uk/catalogue/PUB13115 identifies a similar relationship between childhood obesity and deprivation. This is understandable given the common factors that lead to dental decay and obesity, and consideration should be given to this when preventive strategies and local interventions are being developed.

The impact of sugar on health has recently been reviewed by the Scientific Advisory Committee on Nutrition (SACN) and their position statement is currently open for scientific consultation;
http://www.sacn.gov.uk/reports_position_statements/reports/scientific_consultation_draft_sacn_carbohydrates_and_health_report_-_june_2014.html

There are a variety of sugars found in the daily diet, some occurring naturally in foods, some added during food and drink manufacturing, or at the table. SACN reports that the outcome of a number of studies, conducted in childhood and adolescence and looking forward to assess later health problems, indicate that higher consumption (i.e. the amount) of sugars, sugars-containing foods and sugars containing beverages is associated with a greater risk of dental decay in the deciduous ('milk teeth') and permanent dentitions. A higher frequency of consumption of sugars-containing foods and beverages, but not total sugars, is also associated with greater risk of dental caries in the deciduous and permanent dentitions. Sugars contained within the whole foods were not as damaging as 'free' sugars, such as those used in food manufacture.

5.5.2 Smoking

Smoking or chewing tobacco can affect oral health in a number of significant ways. These include increased risk of oral cancers and pre-cancers, increased severity of gum disease, premature tooth loss and poor wound healing. In May 2007, the Department of Health published *Smokefree and Smiling*: *helping dental patients to quit tobacco'* as part of their ongoing campaign to involve dental teams in supporting people to stop using tobacco.[20] This guidance had been updated 12th March 2014.

5.5.3 Alcohol

There is a well-recognised relationship between alcohol misuse and oral disease. Research suggests that patients suffering from alcohol use disorders experience poor oral health (including significant levels of dental caries, gingival inflammation, soft tissue abnormalities, tooth erosion and an increased risk of developing periodontal disease).[21] Excessive alcohol use is also a significant risk factor for oral cancer. Of particular concern is the synergistic action of excessive alcohol consumption with tobacco (smoked and chewed), which when used together, will substantially increase the risk of developing oral cancer.[22] Joint Strategic Needs Assessments (JSNA) have been undertaken by PHE across Norfolk, Suffolk, Cambridgeshire, Peterborough and Great Yarmouth and Waveney detailing the local issues around alcohol use. Joint Strategic needs assessments around alcohol use have been undertaken for East Anglia by Public Health England.

As well as this is the risk of increased facial injury associated with alcohol consumption. There are nearly 1 million violent incidents each year in the UK where the victim believed the offender to be under the influence of alcohol.[23]

The British Crime Survey and police recorded crime

http//www.homwoffice.gov.uk/rds/pdfs09/hosb1109vol1.pdf) The cost to the NHS for alcohol related harm, including assault injuries is an estimated £ 2.7bn a year. 9 DH (2008) The Cost of Alcohol Harm to the NHS in England)

One half of the facial injuries in the 15 - 25 year age group are sustained in assaults, usually in bars or streets, and were associated with alcohol consumption by the victim or the assailant. There was also an increase in vulnerability of those who have been drinking heavily and this may be more important than the effect of alcohol on aggression.

The proportion of injuries sustained in assaults increased from 40 per cent in 1977 to 50 per cent in 1987 and since then has continued to rise. It is estimated that around 500,000 people suffer facial injuries annually, 125,000 of them in assaults. The psychological legacy of facial injury can persist long after the injury has occurred, as facial scars serve as a constant reminder of the assault.

Oral health promotion strategies should include joint working with other partners such as local authorities, the police and owners of licensed premises in known flashpoints. Since the 2003 Licensing Act consideration can now be given to the awarding of alcohol licences and this responsibility now rests with the local authority. Other preventive measures such as replacing glass bottles and glasses with safe non glass materials such as plastic or polycarbonate material should be encouraged and this can now be a condition of the licence.(Warburton A, Shepherd J. P. Effectiveness of toughened glass in terms of reducing injury in bars: a randomised controlled trial, Injury prevention Vol 6, pp36-40 2000) (Rickinson, B and Preston, S Materials for Drinking Glasses, A short test programme with one pint glasses, Executive Summary London IOM3 March 2009) Local data from hospitals and the police should continue to be collated to help identify problem areas.

As well as local policies brief interventions around alcohol use following NICE guidance have also been demonstrated to be effective in modifying future behaviour. These can be delivered by hospital staff, both with the victim and the assailant, at the time of treatment and from other health care professionals in different settings. http://pathways.nice.org.uk/pathways/alcohol-use-disorders/brief-interventions-for-alcohol-use-disorders)

5.5.4 Drug Abuse

Intravenous drug use is associated with poor oral health, in particular dental decay and periodontal disease. This is thought to be due to a complex relationship between a number of factors, which include poverty, self-neglect, consumption of high sugar foodstuffs, poor oral hygiene and the intake of methadone syrup.[24,25] Prolonged drug use is often associated with self-neglect and a cariogenic (decay promoting) diet.[26] There are indications that drug addicts experience severe dental and periodontal tissue destruction.[27]

In comparison with the general population, drug users tend to have poorer oral health and display lower utilisation of dental services[28]. Nationally there are 9.9 adult drug misusers per 1,000 population.[19] Joint Strategic Needs Assessments around drug use have been undertaken for East Anglia by Public Health England.

5.5.6 Vulnerable Groups

It is clear that despite substantial improvements in oral health, marked inequalities remain. Socially deprived and/or vulnerable groups in society tend to have poorer oral health and poorer access to oral health care services.

Groups of people particularly at risk from oral diseases include the following:

People living in areas of material and social deprivation

East Anglia has relatively low levels of deprivation. In Cambridgeshire, however, Fenland, northeast Cambridgeshire and areas of Huntingdonshire have the highest levels of relative deprivation. For example 1 child in 9 in Cambridgeshire lives in a household dependent on means-tested benefits. Areas of Norwich have 28 LSOAs in the most deprived twenty per cent and Kings Lynn and West Norfolk. Great Yarmouth has 17 LSOAs in the most deprived twenty per cent. Although large parts of Suffolk are fairly affluent some of the most deprived communities live in the towns around Ipswich, Lowestoft, Felixstowe and Haverhill. Peterborough also has LSOAS in the most deprived twenty per cent in the county, particularly Breton and Dogsthorpe. In Norfolk an estimated 26,200 children are living in poverty and the figures for Suffolk, Cambridgeshire and Peterborough are 20,000, 14,400 and 9,500 respectively.

People who have a learning disability

Individuals with disabilities experience more oral disease and have fewer teeth than the general population. They also have greater unmet dental needs[29] as they have more difficulty in accessing dental care.[30] Access to oral health care is affected by where people with learning disabilities live: evidence suggests that adults with learning disabilities living in the community have greater unmet oral health needs

than their residential counterparts and are less likely to have regular contact with dental services[31]

People with mental illness

It is estimated that one in four people in the population will suffer from a mental health problem at some time. While there is no direct link between mental health issues and poor oral health suffers may find it more difficult to access services for a variety of reasons to obtain the care that they need.

People in long term institutional care (including residential homes, psychiatric hospitals, prisons)

The standard of oral health in prison populations, is significantly worse that of the general population.[32]

There are three prisons in Norfolk, HMP Norwich, HMP Wayland and HMP Bure and four prisons in Suffolk, HMP High Point, HMP Warren Hill, HMP Hollesley Bay and HMP Blundeston. HMP High Point is the largest prison in the country.

Cambridgeshire has two prisons: HMP Whitemoor and HMP Littlehey as well as YOI Littlehey. Peterborough has one privately run prison Prisoners tend to have more decayed teeth, fewer filled teeth and less natural teeth than the general population, even when social class is taken into account (adults in social classes IV and V have been shown to have fewer decayed or unsound teeth than the prison population).[33] Evidence suggests that there is a substantial amount of unmet need in British prisons.[34] A survey of prison dental services is currently being undertaken nationally and the results were expected in January 2014. To date this has not been published.

Homeless people

Homeless people tend to have poorer health than the rest of the population. The level of statutorily homeless households nationally is 7.8 per cent. Data on the oral health status of homeless individuals is limited; however studies consistently report a high clinical and perceived need for oral health care within this population[35]. They have a higher dmft (decayed, missing and filled teeth) than the general population and there is a greater prevalence of dental pain and periodontal (gum) disease.[36] Homeless people tend to have fewer remaining teeth and heavy plaque accumulation.[37] Despite these high levels of need however, homeless people experience difficulty in accessing dental services[38]

Some ethnic minority groups (where they are socially disadvantaged)

There are oral health inequalities with certain Asian groups experiencing more dental disease. This may be linked more to deprivation than ethnic group but as data on the oral health of ethnic minorities are not routinely collected in the UK knowledge of the oral health status of different groups is limited. Other black and minority ethnic groups (BME) who habitually chew tobacco may have increased risk of developing oral cancer. The two main ethnic groups likely to have significant oral health needs in East Anglia are Asian groups and Travellers.

In Suffolk, for example, the proportion of those in the non-white British ethnic group is 10.2% (2009) and the largest ethnic group in Ipswich is Asians which accounts for a third of the BME population. In Norfolk the proportion of ethnic groups has changed

significantly since the Census in 2001 and has doubled to approximately 3.1% of the general population.

East Anglia is also seeing an increase in the numbers of settlers coming from Poland, Lithuania, Portugal and Latvia who may have complex needs both in terms of accessing dental services and communication.

Asian Community

Evidence suggests that the oral health of this group is poorer than that of their indigenous white peers and those subsequent, British born generations, tend to have even higher caries experience.[39] Caries levels are high in children, while older Asians of Pakistani origin tend to suffer from periodontal disease.[40]

There is further evidence to suggest that, despite high levels of dental need, minority ethnic groups experience barriers to accessing oral health care. These include language, a mistrust of dentists, cost, anxiety, cultural misunderstanding and concern about standards of hygiene, although perceived barriers differ across ethnic groups.[41] It is important to consider the cultural characteristics of each subgroup when designing oral health promotion activities for diverse ethnic groups.

Travelling community

There is very little published literature on the oral health of travellers. While there are no robust data on the prevalence of oral disease in this population, it seems reasonable to assume that disease levels will be relatively high, as this is a socially deprived group. A small study in the early 1990s found that 70% of traveller children had dental caries.[42] The limited data available supports this supposition. Access to health services appears to be minimal and evidence suggests that a dedicated dental service may be required to remedy this. This group make little use of preventive services with the majority of travellers neglecting to visit a dentist regularly. Those who do are more likely to be settled and literate. Travellers report going to the dentist mainly when they are in pain.[42] Primary care dental services are in place in the East Anglia to meet the needs of this community but access may vary across the whole area.

Elderly people and those living in residential care

Older people have specific oral health needs as oral health problems increase with age. In particular, age related changes can lead to xerostomia (often drug related), root caries, recurrent decay and decreased manual dexterity can lead to reduced plaque control. Systemic problems can also have an effect on oral health, for example, many older people suffer from progressive neurocognitive impairing illnesses (eg Parkinson's disease and Alzheimer's disease) and this may cause difficulties in controlling and retaining dentures.[43] In older people, the retention of natural teeth into old age makes a major positive contribution to the maintenance of good oral health related quality of life and there is a clear and consistent relationship between retention of natural teeth and a healthy diet and good nutrition.[44] People in East Anglia are living longer and the number of people over the age of 65 is set to grow by approximately 20 per cent in the next four years. This ageing population is also likely to retain their natural teeth for longer and may present an increased burden on NHS dental services.

The proportion of people retaining a useful number of natural teeth into retirement age has increased dramatically during the past forty years. This improvement has been tracked by the ten yearly Adult Dental Health Surveys carried out by the Office for National Statistics.[45] As the number of older people rises and their complexity of care increases there will be an associated rise in demands on the service and a change in the nature of care required.

There are a number of specific dental problems and complications that occur in later life. Older people for example, will generally have a reduced salivary flow and this effect may be worsened by the side effects of medication. Saliva both lubricates the mouth during eating and speaking but it also has an important protective role in combating the decay-producing plaque acid.

Gums recede as a result of the natural process of ageing or through the cumulative effect of chronic gum disease. This, together with the reduction of the protective benefits of saliva, can bring about the onset of new decay, including attack on the newly-exposed soft root surface. A healthy, sugar-controlled diet and the continuing use of fluoride toothpaste are needed to help contain this problem.

If manual dexterity becomes reduced with age, for example because of rheumatoid arthritis, then effective oral hygiene including tooth brushing with a fluoride toothpaste can be compromised.

Dietary habits may also change, for a variety of reasons, as people become older and this may impact on oral health. If access to shops becomes harder because of mobility problems then fresh fruit and vegetables may not be readily available and there may be increased dependency on processed foods with longer shelf lives. Many of these products have a high sugar content. Tooth loss can reduce the ability to chew effectively and diet choices may become more restricted as a result.

A lack of mobility in later life may also make accessing dental services more difficult and if incomes are reduced paying for dental care may not be seen as a priority. People may only visit the dentist when they have a problem which can result in treatment becoming more complex or in late diagnosis of, for example, oral cancer.

At the time of the first survey of adult dental health in 1968, a legacy of disease and extraction were clearly visible. Nearly half the adult population had no teeth at all and, even among the relatively young, there were many who wore complete dentures. However, by 1978, and the second national survey of adult oral health, the pattern was beginning to change. Generations who had lost all their teeth were gradually being replaced by generations who had their natural teeth filled rather than extracted. A group between 30 and 65 could be identified who had experienced high levels of disease which had been treated by fillings and other restorations (the “heavy metal generation”) and who will have high maintenance needs as they age further.

Many older patients suffer from long-term conditions such as diabetes, which increases the risk of developing periodontal disease.[46] Rheumatoid arthritis, which influences the ability of patients to adequately control oral hygiene, also increases the risk.[47]

Children at risk of neglect and abuse

Working Together to Safeguard Children HM Government, Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of 2013 children is everyone's responsibility.[48] Paediatricians now acknowledge dental neglect as being important in child protection[49] . Markers include visible dental decay, untreated trauma and multiple hospital admissions for dental care. Using the concept of M*aking Every Contact Count* staff across healthcare, social care and education should have the skills and responsibility to recognise signs of poor oral health and neglect and be able to take appropriate action. [50]

Looked after children

There is a requirement that looked after children have an annual health assessment and that this should include a dental check-up. Currently this requirement is not being met and figures for Norfolk and Suffolk are low, 65.2% and 58.1 % respectively completed. This group of children is likely to have poorer oral health and, if they are moved between different carers, more erratic and irregular access to dental care.

6. Epidemiology of Oral Disease

In the UK data on dental caries is regularly collected to allow trends in dental disease to be monitored. The key surveys that provide information on trends in oral disease at a national level are the decennial Adult Dental Health Survey and Children's Dental Health Survey. The most recent Adult Dental Health Survey was conducted in 2009 and for children this was 2003. The 2013 Child Dental Health Survey is currently been undertaken concurrently with a survey of children attending special schools.

At a local level, the British Association for the Study of Community Dentistry (BASCD) co-ordinates regular surveys of children's teeth. This regular programme is now known as the NHS Dental Epidemiology Programme. Surveys of five year olds have been undertaken most recently in 2007/08 and 2011/12

Dental caries is commonly measured using the dmft index, which is a record of the number of decayed, missing and filled deciduous teeth (dmft). By convention, upper case DMFT is used to denote permanent teeth while lower case dmft is used to denote primary teeth.

The dental health of adults and children has improved significantly in recent years however population averages mask oral health inequalities. A well-recognised association exists between socio-economic status and oral health, and trends suggest that disease is increasingly concentrated in the lower income groups.

7. Oral Health in Adults

7.1 Adult Dental Health Survey 2009- Summary of main findings

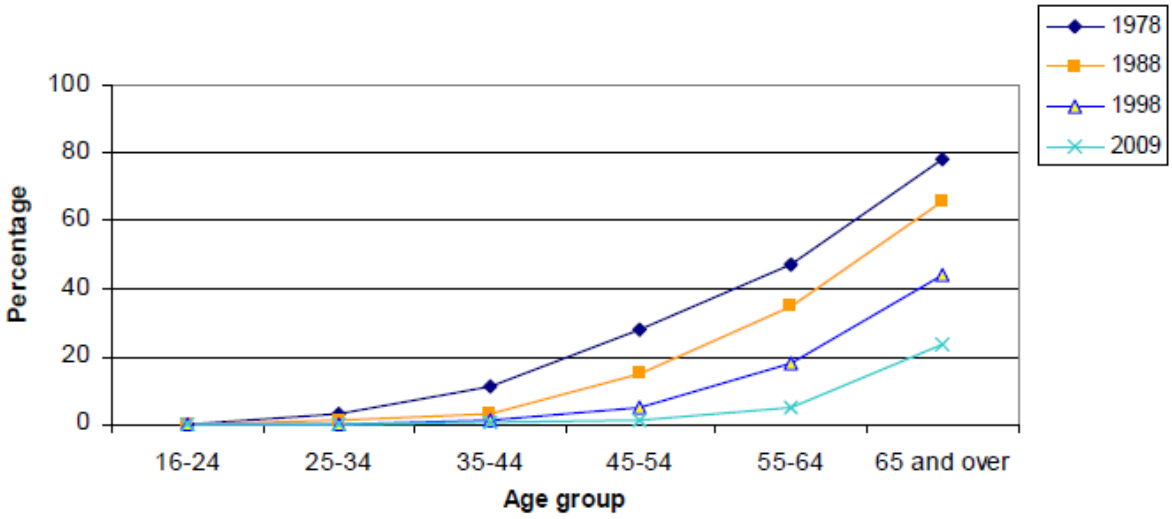
There is a lack of local information on adult oral health. Most information on adult dental health is provided by the Office of National Statistics decennial Adult Dental Health Survey which began in 1968. The main purpose of these surveys has been to gain a picture of the dental health of the adult population and how this has changed over time. The most recent survey was undertaken in 2009[51].
The Adult Dental Health Survey 2009 shows that adults' dental health continues to improve over time and that accessing NHS dental services only remains difficult for a small minority.

- The proportion of adults in England who are edentate (no teeth) has fallen by 31% from 37% in 1968 to 6% in 2009
- The prevalence of tooth decay in England has also fallen in all age groups from 46% in 1998 to 28% in 2009
- 86% of dentate adults nationally had 21 or more natural teeth
- Adults under the age of 45 years were less likely to have fillings or crowns
- 9% of all adults reported suffering from dental pain
- 7% of all adults were observed to have any PUFA symptoms (open pulp involvement, ulceration, fistula, abscess)
- 12% of all adults (who had ever been to the dentist) were classified as having extreme dental anxiety.
- A quarter of young adults (aged 16-24 years) had no fillings
- The prevalence of periodontal disease was 45% although for the majority of these the disease was moderate
- Over three-fifths (61%) of dentate adults said they attended the dentist for regular check-ups
- There is an increased need for complex dental treatment for those aged 45 years and over

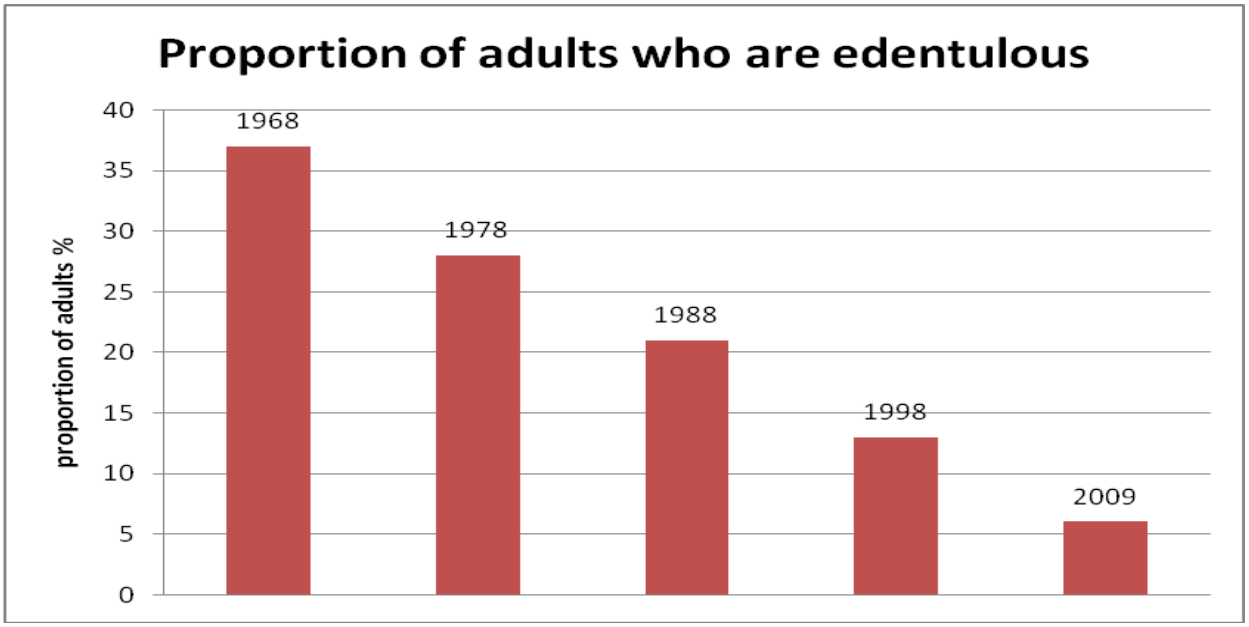
The dental health of most people in the UK has improved dramatically during the past 50 years due largely to the widespread use of fluoride toothpaste.[52]. During the post-war years, the nation's oral health was poor and dental disease was rife[53] and there was little expectation that teeth would last a lifetime. This expectation has now changed, with the proportion of adults with no teeth dropping from 37% in 1968 to 6% in 2009 (see Figure 4 and 1.5.1).

The percentage of adults over 65 years with no natural teeth has fallen since 1978.More people retaining their natural teeth into later life has implications for the provision of health services and may place a burden of more complex restorative care with an ageing population.

Figure 1.5.1 Trends in percentage edentate by age, England: 1978-2009



Graph 3: The Proportion of Adults with No Natural Teeth in England, 1968–2009

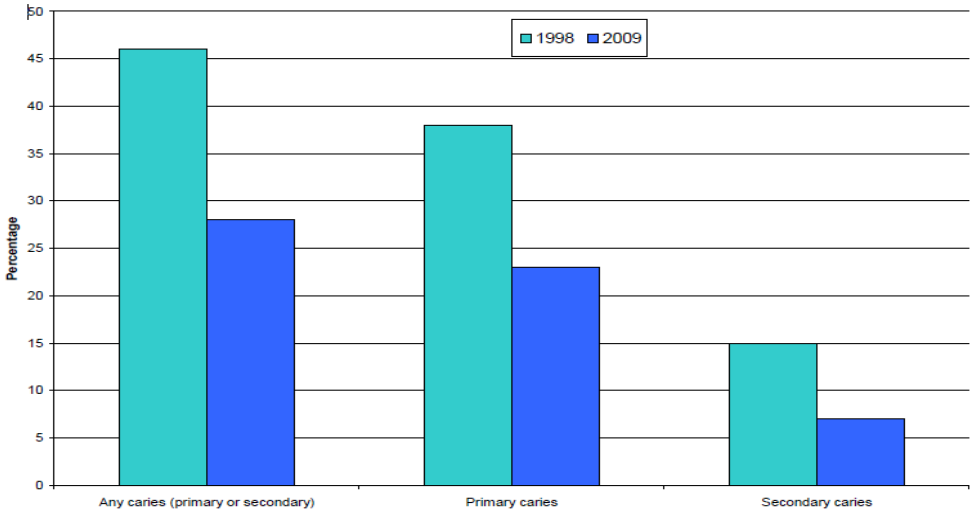


Source: National Adult Dental Health Surveys, 1968 to 2009. Kelly M, Steele J, Nuttall N, Bradnock G, Morris J, Nunn J, Pine C, Pitts N, Treasure E and White D (2000).

National surveys, conducted decennially, show that adult dental health is improving.

It is predicted that by 2028, around 96% of the population will have their natural teeth. The proportion of younger adults who have a sound dentition (ie without any restorations or caries) has also improved dramatically, rising from 9% in 1978 to 30% in 1998.[54]

Graph 4: Trends in percentage of dentate adults with dental caries: England 1998 to 2009



[1] NHS Information Centre (2011): Adult Dental Health Survey 2011 available at: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/adult-dental-health-survey-2009--summary-report-and-thematic-series

[1] PUFA: Open pulp involvement, Ulceration, Fistula, Abscess

The average number of decayed teeth has dropped substantially from 1.9 teeth in 1978 to 1.1 teeth in 1998[55] and the proportion of younger adults, with a sound dentition (i.e. without any dental restorations or decay) has risen dramatically from 9% in 1978 to 30% in 1998[56].

Trends by age in adults

At the time of the first survey of adult dental health in 1968, a legacy of disease and extraction were clearly visible. Nearly half the adult population had no teeth at all and, even among the relatively young, there were many who wore complete dentures. However, by 1978, and the second national survey of adult oral health, the pattern was beginning to change. Generation who had their natural teeth filled rather than extracted.

National surveys of children's oral health were also undertaken at 10-year internals and in 1983 the first signs of a sustained reduction in dental decay in children were observed. This was probably largely the result of the widespread introduction and marketing of fluoride tooth paste in the early 1970s. By 1988 (the next adult dental health survey) this reduction was visible in young adults.

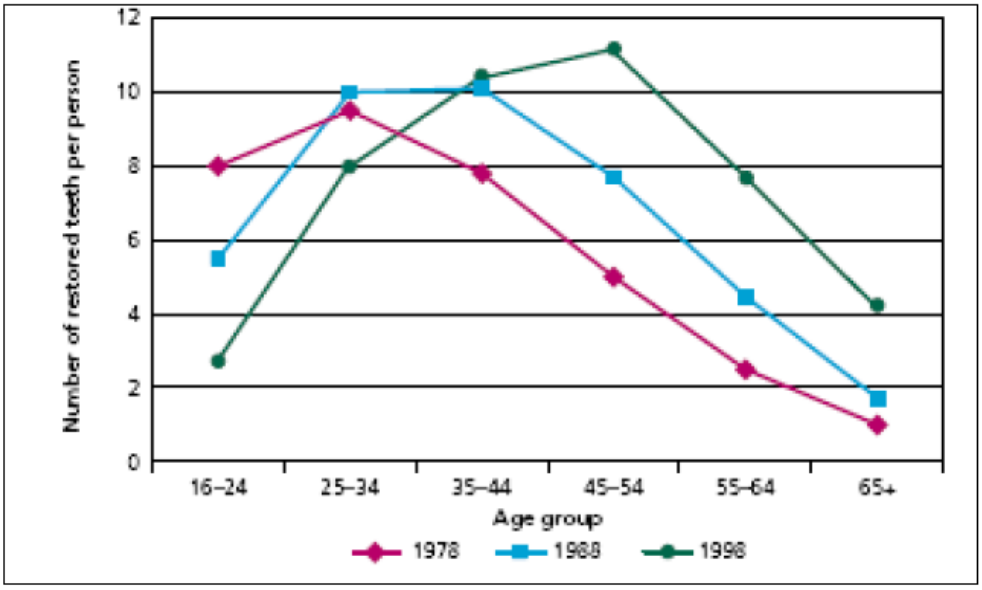
The younger generation of 1978 (16-34 year- olds) had high levels of decay and many fillings, mostly of dental amalgam. The wave of restoration can be traced as the cohort ages, so by 1998 three groups moving through the population could be clearly identified, each with very different needs:

- Older age groups (those past the age of retirement) were dominated by those with no natural teeth at all and a need for complete dentures.
- A young generation (under the age of about 30) had lower levels of decay than their parents. They had low restorative needs and will benefit from maintaining this state throughout adult life.

- Finally, and importantly, a group between 30 and 65 could be identified who had experienced high levels of disease which had been treated by fillings and other restorations (the “heavy metal generation”) and who will have high maintenance needs as they age further.

The independent review of NHS dental services in England (Steele 2009) uses trends from successive adult national dental surveys to illustrate this “heavy metal wave” (Figure 6) where the younger adult generation of 1978 had high levels of decay and many fillings, and by 1998, they were in middle age and still exhibited the highest treatment need and rates.

Graph 5: The heavy metal wave (Steele 2009)



Source: NHS dental services in England-An independent review led by Professor Jimmy Steele 2009

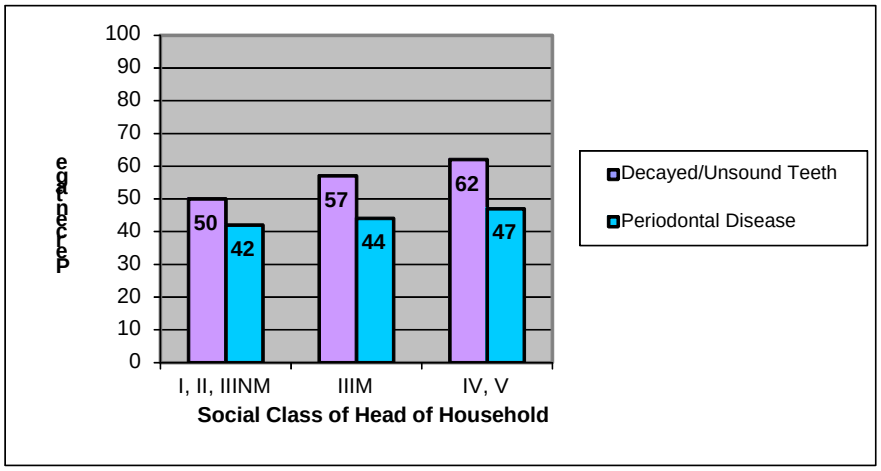
This improvement means more people are able to eat a healthy diet and talk and smile without embarrassment, however populations with high proportions of older people in the future will require significant resource to maintain past restorations. As people age their ability to maintain good oral health through regular brushing may diminish particularly if manual dexterity reduces. This will impact negatively on their oral health which in turn will impact on general health as diet may be influenced by ability to chew certain foods.

There will be an increased demand on dental services to maintain this high level of treatment as restorations inevitably fail. An ageing population will add an extra burden to dental services.

7.1.1 Inequalities in Dental Caries in Adults

While oral health has improved generally, it is not all good news. Population averages hide oral health inequalities, as seen in Figure 7. This highlights that the prevalence of oral disease is highest in areas of social deprivation

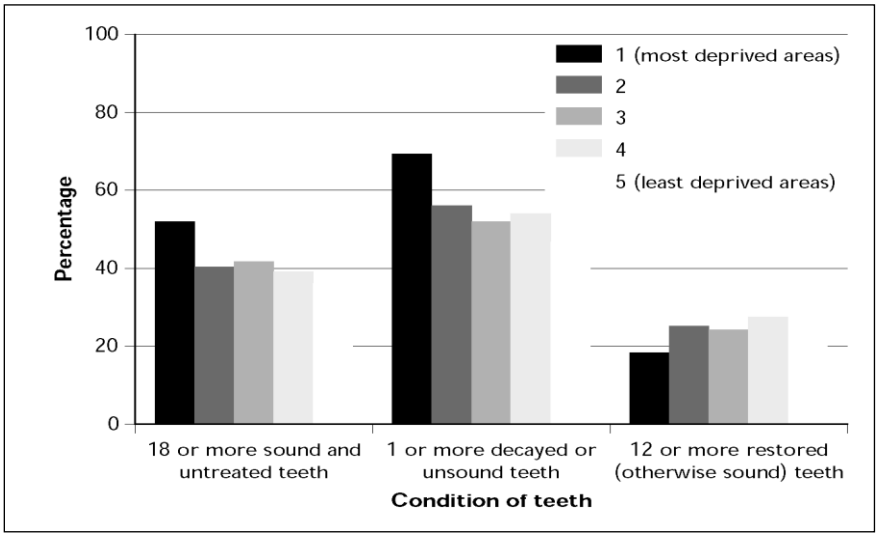
Graph 6: Proportion of Adults with Decayed/Unsound Teeth or Periodontal (Gum) Disease by Social Class



Source: Kelly M, Steele J, Nuttall N, Bradnock G, Morris J, Nunn J, Pine C, Pitts N, Treasure E, White D. Adult Dental Health Survey. Oral Health in the United Kingdom 1998.

Adults from the most deprived areas are more likely to have one or more decayed or unsound teeth than those from less deprived areas, as seen in Figure 8

Graph 7: The Condition of Teeth among Dentate Adults in England by Jarman Area



Source: Kelly M, Steele J, Nuttall N, Bradnock G, Morris J, Nunn J, Pine C, Pitts N, Treasure E, White D. Adult Dental Health Survey. Oral Health in the United Kingdom 1998. Available at URL: http://www.statistics.gov.uk/downloads/theme_health/AdltDentlHlth98_v3.pdf

Although oral health has improved, the 2009 ADHS still reported differences in dental status by socioeconomic status. Table 1 still describes a gradient between managerial and professional occupations, intermediate occupations and routine and manual occupations.

Table 6: Dental status by characteristics of adults- ADHS 2009

Socio-economic classification of	% Dentate	% Edentate

household		
Managerial and professional occupations	98	2
Intermediate occupations	96	4
Routine and manual occupations	90	10

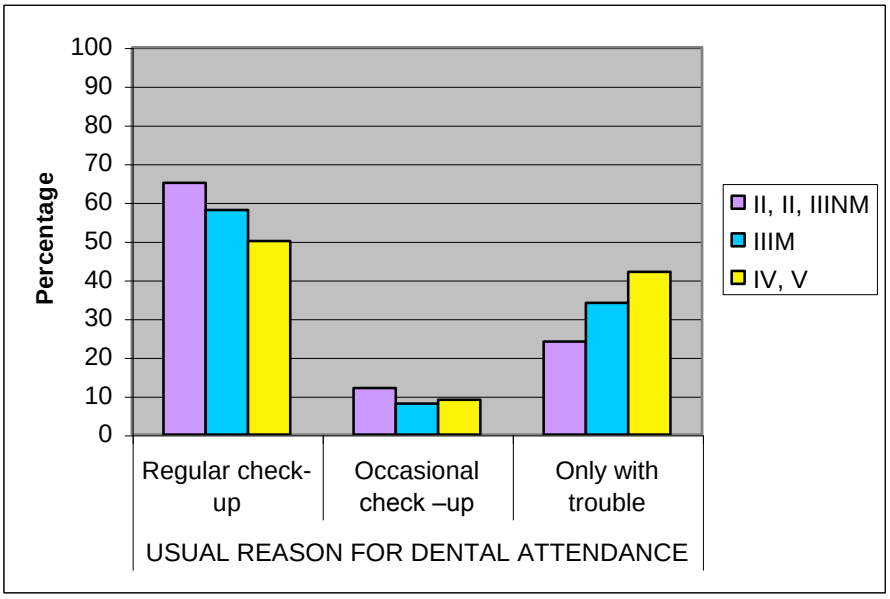
Source: The Information Centre 11: Adult Dental Health Survey 2009-Key Findings. Chenery, V. March 2011

Attendance for Treatment

Despite the higher level of need in adults from deprived areas, it is adults from the least deprived areas that are more likely to have restored teeth. This suggests that those from higher socio-economic groups are more likely to seek dental treatment. Similarly, individuals from socially deprived groups report that they are more likely to attend irregularly and only when they have a problem (see Figure 9).

Figure 9 shows that much decay goes untreated (even in the least deprived socio-economic groups the proportion of untreated decay is as high as 50%).

Graph 8: Reported Usual Reason for Dental Attendance of Dentate Adults by Social Class



Source: Kelly M, Steele J, Nuttall N, Bradnock G, Morris J, Nunn J, Pine C, Pitts N, Treasure E, White D. Adult Dental Health Survey. Oral Health in the United Kingdom 1998.

7.1.2 Dental Health of Adults in East Anglia

Local data on adult oral health are not routinely collected in the UK. In many areas there is a paucity of local information on adult oral health so measures of child dental health are the most commonly used indicators of dental disease. The decennial national surveys do however collect data to regional level.

Overall, in the most recent Adult Dental Health Survey 2009, twenty per cent of dentate adults in the East of England were found to have excellent oral health. That

is they had twenty one or more natural teeth, 18 or more sound and untreated teeth, no active decay at any site, no periodontal pocketing or loss of attachment above 4mm and no plaque or calculus. This is the highest percentage in England and compares with an England average of ten per cent.

Table 7: Proportion of adults with excellent oral health by English Strategic Health Authority- England 2009

Dentate Adults	Percentage with excellent oral health
All	10
North East	10
North West	7
Yorkshire and Humber	8
East Midlands	7
West Midlands	4
East of England	20
London	11
South East Coast	17
South Central	7
South West	6

Source: The Information Centre Adult Dental Health Survey 2009- England Key Findings. Chenery, V. published March 2011

The findings of the ADHS survey (2009) suggests that oral health inequalities continue to be geographically clustered however as tables 2 and 3 show, adults in the South of England tend to have better oral health than adults in the North. More adults are retaining more of their natural teeth and East of England compares favourably to the rest of England and has improved between 1998 and 2009. The percentage of adults who are edentulous has more than halved in the same time period from eleven to four per cent.

Table 8: Dental status by characteristics of adults- ADHS 2009

English Strategic Health Authority	Dental Status	
	% dentate	% edentate
North East	**92**	**8**
North West	**93**	**7**
Yorkshire and The Humber	**93**	**7**
East Midlands	**94**	**6**
West Midlands	**91**	**9**
East of England	**96**	**4**
London	**96**	**4**
South East Coast	**95**	**5**
South Central	**98**	**2**
South West	**94**	**6**

Source: The Information Centre Adult Dental Health Survey 2009- England Key Findings. V Chenery published March 2011

Dental Caries in Adults in East Anglia

- Adults in the East of England had on average 0.5 carious teeth compared with 1.1 carious teeth for dentate adults in the North East and South West.
- Adults in the East of England with at least one carious tooth had on average 2.2 carious teeth compared with 3.2 among adults in the North East and South West.
- Fifteen per cent of dentate adults had primary caries in the East of England compared with 28 per cent of dentate adults in the West Midlands.

7.2 Gum (Periodontal) Disease in Adults in East Anglia

It is difficult to collect robust data on periodontal disease, however national surveys suggest that the incidence of severe periodontal disease is declining.[56] Nevertheless, chronic periodontitis still affects a significant proportion of the population. The most recent Adult Dental Health Survey, in 2009, found that 54 % experience bleeding in the mouth, 45 per cent had pocketing of 6mm or more and 1 per cent had pocketing of 9mm or more . Prevalence increases with age as 14% of 16-24 year olds and 85% of people aged 85 years and over have signs of the disease. Approximately 5% of the population suffer from severe disease[57] and are, therefore, at significant risk of tooth loss.

Thirty two per cent of dentate adults in the East of England had bleeding in the mouth compared with 64% of dentate adults in South Central. Thirty two per cent of dentate adults in the East of England had pocketing of 4mm or more compared with 59% of adults in the South West.

Findings of national surveys suggest that the pattern of oral health inequalities in gum disease mirrors that of dental decay; adults who have the most severe disease tend to come from the more socio-economically deprived groups. Figure 7 and 8 shows that groups with the highest need, both in terms of dental decay and periodontal (gum) disease, come from the most deprived socio-economic classes.

7.3 Tooth Wear in Adults in East Anglia

In an ageing population, more of whom are retaining more of their natural teeth in later life, tooth wear is likely to become a more significant problem. It can present restorative challenges to general dental practitioners (GDPs) and may present more of a financial burden on dental commissioning services.

Seventy seven per cent of dentate adults in England had some wear in their anterior teeth; 15% had some moderate wear, and 2% had some severe wear on their anterior teeth. In the East of England 70% had any wear, 9% some moderate wear and 1% some severe wear on their anterior teeth.

7.4 Urgent dental conditions and dental pain in adults in East Anglia

Urgent conditions including dental pain, dental pulpitis and oral sepsis, and untreated teeth with extensive decay, are an important and sometimes dominant factor in dental behaviour and the prevalence and distribution of these conditions need to be considered alongside estimates of the current state of adult dental health. Ten per

cent of all dentate adults in the East of England reported current pain compared with an England average of 9%. Seventy three per cent reported that they had never had any dental pain in the last 12 months, 20% reported occasional pain and 7% reported dental pain fairly or very often. This compares with England averages of 70%, 22% and 8% respectively.

Seven per cent of all dentate adults in the East of England had PUFA symptoms (pain, ulceration, fistula, abscess) the same percentage as England, 7% had un-restorable caries, compared with 8% for England and 21% had one or more urgent dental conditions compared with 22% for England.

7.5 Preventive Behaviour and risks to oral health in adults in East Anglia

Good oral hygiene helps prevent dental problems such as the accumulation of plaque and calculus which contribute to the development of gum disease and tooth decay. Daily preventive care including brushing with a fluoride toothpaste is essential and will help stop dental problems before they develop.

7.6 Oral Hygiene

Seventy seven per cent of dentate adults in the East of England reported tooth cleaning twice a day or more often and 21% once a day. The vast majority of these reported using fluoride toothpaste. Eighty two per cent said they had been given advice on brushing.

Table 8: Reported preventive behaviour by dentate adults ADHA 2009

Reported behaviour	East of England % dentate adults	England % dentate adults
Frequency of tooth cleaning- twice a day or more often	77	75
Frequency of tooth cleaning- once a day	21	22
Frequency of tooth cleaning-less than once a day	2	2
Frequency of tooth cleaning- never	1	1
The use of a fluoride toothpaste 1350-1500ppm (excluding those who reported that the never cleaned their teeth)	78	76
The use of a fluoride toothpaste 1000-1350ppm (excluding those who reported that the never cleaned their teeth)	17	19
Had been given advice on brushing	82	78

Source: The Information Centre Adult Dental Health Survey 2009- England Key Findings. V Chenery published March 2011

7.7 Risks to dental health in adults in East Anglia

Smoking, poor oral hygiene and diets high in both sugar content and frequency of intake all present risks to oral health for dental decay, periodontal disease and oral cancer.

Twenty one per cent of dentate adults in the East of England reported smoking compared with 21% for England.

Fifty five per cent in the East of England reported having a high sugar intake, (cakes, biscuits, puddings or pastries, sweets or chocolate or fizzy drinks 6 or more times a week) compared with an England average of 50%.

Forty two per cent of dentate adults in the East of England had visible plaque compared with an England average of 66%.

7.8 Dental attendance patterns of adults in East Anglia

Regular attendance at the dentist allows the early detection and treatment of conditions that may become more serious with time. For example, the early detection of oral cancer improves five-year survival rates dramatically, to just below 90%.[58] Often the dentist, because of the painless nature of the condition, is the first person to identify the condition. A dental visit is also a good opportunity to reinforce preventive messages. Gingivitis, the first stages of periodontal disease is reversible with good oral hygiene practices and the dentist is well placed to give advice about oral cleaning and brushing techniques as well as dietary advice.

Sixty two per cent of all dentate adults in the East of England report that their usual reason for attending a dentist is that they like to go regularly. This compares with 61% in England. Eleven per cent attend only occasionally and 26% only when they have trouble. Fifty per cent report that they go every six months, 23% once a year, seven per cent once every two years, 10 per cent less than every two years and 10 per cent only when they have a problem.

Seventy nine per cent of dentate adults in the East of England reported that they had attended a dentist at least every last two years compared with 76 % for England. The 21% who reported that they did not visit a dentist at least every two years gave various reasons outlined in table 9.

Table 9: Reported reason for not attending the dentist in the last two years, England and East of England. ADHS 2009. (Dentate adults who have not been to the dentist in the last two years)

Reason for not attending the dentist in the last two years	East of England % who said	England % who said
No need to go to the dentist/nothing wrong with my teeth	46	40
I can't find an NHS dentist/dentist changed to private	16	25
I am afraid of going to the dentist	22	23
I can't afford the NHS charges	18	20
Keep forgetting/haven't got round to it	18	18
I've had a bad experience with a dentist	15	17
I don't see the point in going to the dentist	14	15
I haven't got time to go	10	9

It's difficult to get to/from the dentist	5	6
I'm embarrassed to go to the dentist	4	5

Source: The Information Centre Adult Dental Health Survey 2009- England Key Findings. Chenery, V. published March 2011

NICE guidance issues in October 2004 makes recommendations about intervals between routine dental examinations[59]. CG19 Dental recall: Recall interval between routine dental examinations. The guideline recommends that the largest interval between oral health reviews for patients aged 18 years and older should be 24 months.

Although 62 % of all dentate adults in the East of England report that their usual reason for attending a dentist is that they like to go regularly on average only 50% of the population attend within a 24 month period.

Dentists have an important role to play in improving oral health both in the early detection of disease and the opportunity of a dental visit offers to promote preventative behaviour.

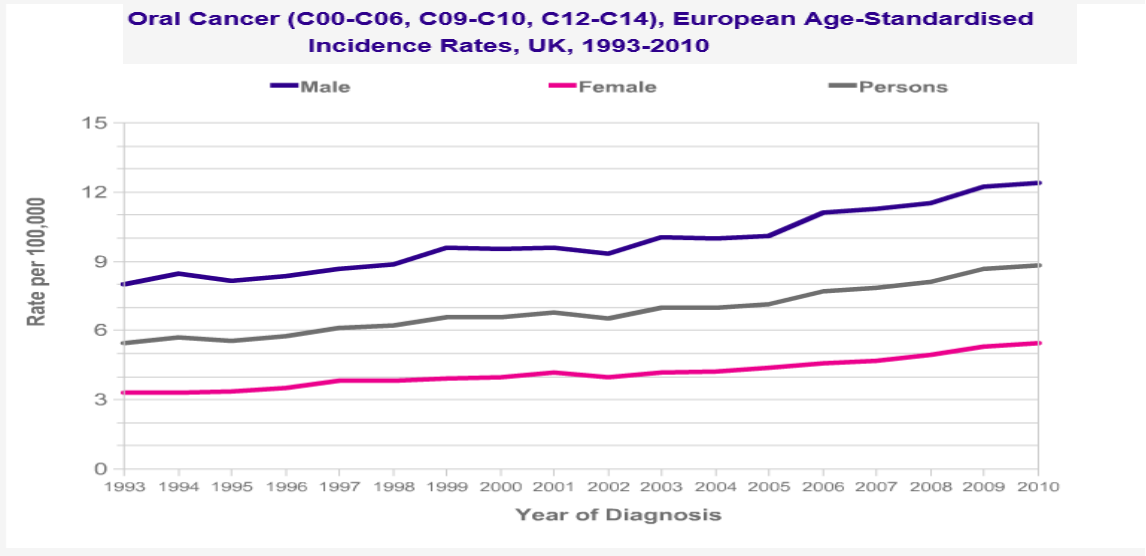
7.9 Oral Cancer in Adults

Cancers of the head and neck are a set of serious diseases. Improved outcomes result from early detection and treatment. The prevalence of oral cancer had been declining steadily over the past few decades, but it has recently begun to rise[60]. In 2001, national survey data estimated that there were 4400 new cases in the UK, making up 2% of all cancers. In 2003, approximately 1600 deaths were attributed to oral cancer. While mouth cancers account for only around 1% of all new UK cancers per year, the incidence is rising and now accounts for approximately 800 deaths annually.

The five-year survival rate in England is around 50% if the patient presents at an advanced stage. However, early detection improves five-year survival rates dramatically, to just below 90%.[61] Unfortunately, the low awareness of oral cancer among the public, and the painless nature of oral cancer in its early stages, mean that early presentation is rare. People tend to only seek treatment when the cancer is more advanced and difficult to treat. The risk factors include tobacco and alcohol use and in the case of lip cancer sun exposure. Smokeless tobacco such as areca nuts betel quid and oral snuff has been found to independently increase the risk of oesophageal cancer.[62]

Incidence of oral cancer increases with age from 30 years, although prevalence is beginning to increase in younger adults.[63] It is twice as common in men as in women however, the gender difference is becoming less pronounced over time. There are wide geographic variations in prevalence and those in lower socio-economic groups are more susceptible.[64]

Graph 9



Source: Office for National Statistics, Cancer statistics registrations series MB1 http://www.statistics.gov.uk/statbase/product.asp?vlnk=8843

Oropharyngeal cancer incidence has more than doubled in recent years, representing the biggest rise in any head and neck cancer. Recent research suggests a change in patterns of causation, with human papilloma virus (rather than smoking and alcohol) being the primary risk factor in a younger subpopulation. The incidence of palate cancer has also increased by 66% nationally. The reasons for this are unclear. [1] National Cancer Intelligence Network (2010): Oral Cavity Cancer – Survival Trends in England available at http://www.ncin.org.uk/publications/data_briefings/oralcancer.aspx

Ethnicity and oral cancer

A link has been demonstrated between ethnicity and oral cancer. Oropharangeal cancer was more common in Bangladeshi, Indian and Pakistani females than in white females even with lower smoking levels (Donaldson 2102). Moles in 2008 also demonstrated a higher incidence in South Asians versus non-South Asians that was associated with deprivation. The health Survey for England in 2004 found a higher incidence of oral cancer in South Asian women associated with betel quid use. [65] [66] [67]

7.10 Prevalence of Oral Cancer in East Anglia

Oral cancer is on the increase in Anglia with a 50% increase in age-standardised oral cancer incidence over the last 20 years. Table 10 shows the new registrations for oral cancer ICD-10 code C00-C14

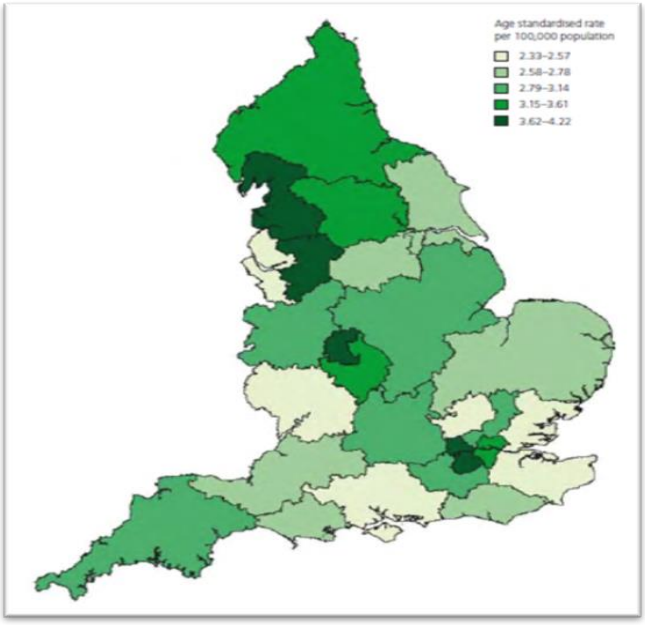
Table 10: Registrations of newly diagnosed cases of cancer (3rd digit) site, sex and region of residence. England 2011. Registered by February 2013

site		England	North East	North West	Y and H	East Midlands	West Midlands	East	London	South East	South West
Malignant neoplasm of lip oral cavity	M	4,071	244	636	444	370	435	383	464	629	466
	F	2,137	100	326	212	177	242	217	277	334	252

and pharynx ICD-10 code C00-C14											

The map below shows the incidence of oral cavity cancer by network 2002-2006

Map 1: To show incidence of oral cavity cancer by network 2002-2006



8. Oral Health in Children

8.1 Dental caries In Children

Introduction

For the past 20 years nationally coordinated surveys of child dental health have been undertaken across the UK which produced robust, comparable information which could be used at local level and compared regionally, nationally and internationally. These surveys have been jointly run by the NHS and the British Association for the Study of Community Dentistry (BASCD). This is now known as the National Epidemiology Programme for England.

The information produced from the nationally coordinated surveys of child dental health is used by Primary Care Trusts (PCTs) and now Local Authorities and NHS England when conducting oral health needs assessments at local level.

In recent years concern was expressed by all parties about compliance with the programme and the quality of the data. New arrangements were established in England during 2006/07 which embedded the programme within the governance of the NHS and maintained the important advisory role of BASCD in ensuring quality standards. The NHS Dental Epidemiology Programme for England was established (NHS DEP) and is delivered in accordance with Directions (DH, 2008) made under

the Functions of Primary Care Trusts (Dental Public Health) (England) Regulations 2006 (OPSI, 2006).

The North West Public Health Observatory (NWPHO) and The Dental Observatory (TDO) worked with the Department of Health (DH), BASCD and other stakeholders to develop the NHS DEP.

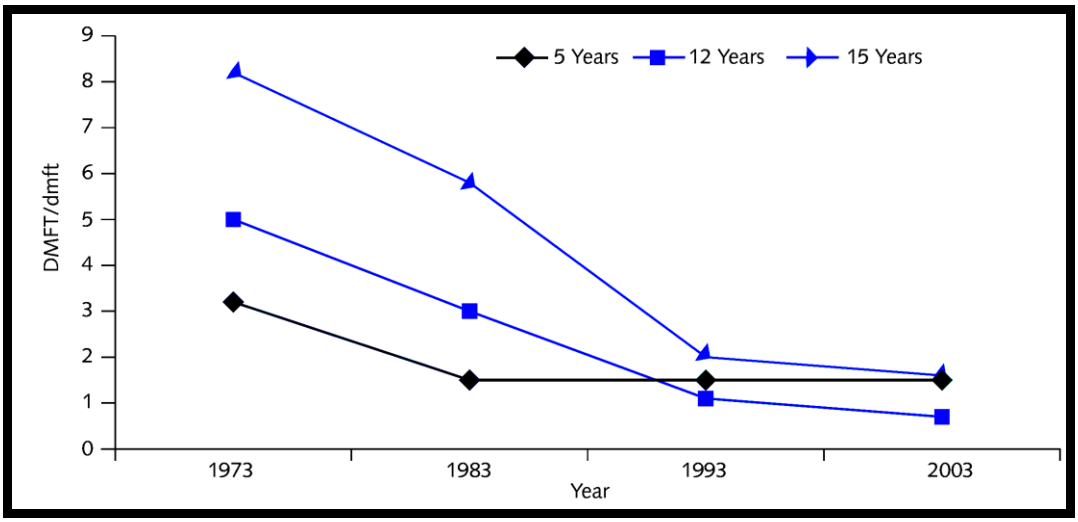
Following guidance from the Deputy Chief Dental Officer in 2005, the protocol also required that positive consent was obtained prior to the survey from the child's parent or from someone with the competence to give consent on behalf of the child. In previous surveys, parents were informed about the survey and unless the parents objected, children were examined.

The prevalence of dental caries in young children has decreased substantially over the past 40 years (see Figure 13). The greatest improvement in the decay experience of five-year-olds was seen between 1973 and 1983, during which time the mean number of decayed, missing and filled teeth (dmft) per child halved and the percentage of children without any caries (caries free) doubled. This is associated with the widespread use of fluoride toothpaste.
Other diseases and public health concerns share risks and contributory factors with dental decay, for example childhood obesity. The 2012-13 report of the national Child Measurement Programme (Department of Health: Health and Social Care Information Centre (2013). National Child Measurement Programme: England, 2012/13 school year.

www.hscic.gov.uk/catalogue/PUB13115 identifies a similar relationship between childhood obesity and deprivation. This is understandable given the common factors that lead to dental decay and obesity, and consideration should be given to this when preventive strategies and local interventions are being developed.

The impact of sugar on health has recently been reviewed by the Scientific Advisory Committee on Nutrition (SACN) and their position statement is currently open for scientific consultation;
http://www.sacn.gov.uk/reports_position_statements/reports/scientific_consultation_draft_sacn_carbohydrates_and_health_report_-_june_2014.html

Graph 10 : Changes in Mean dmft/dmft Over Time for Children in UK

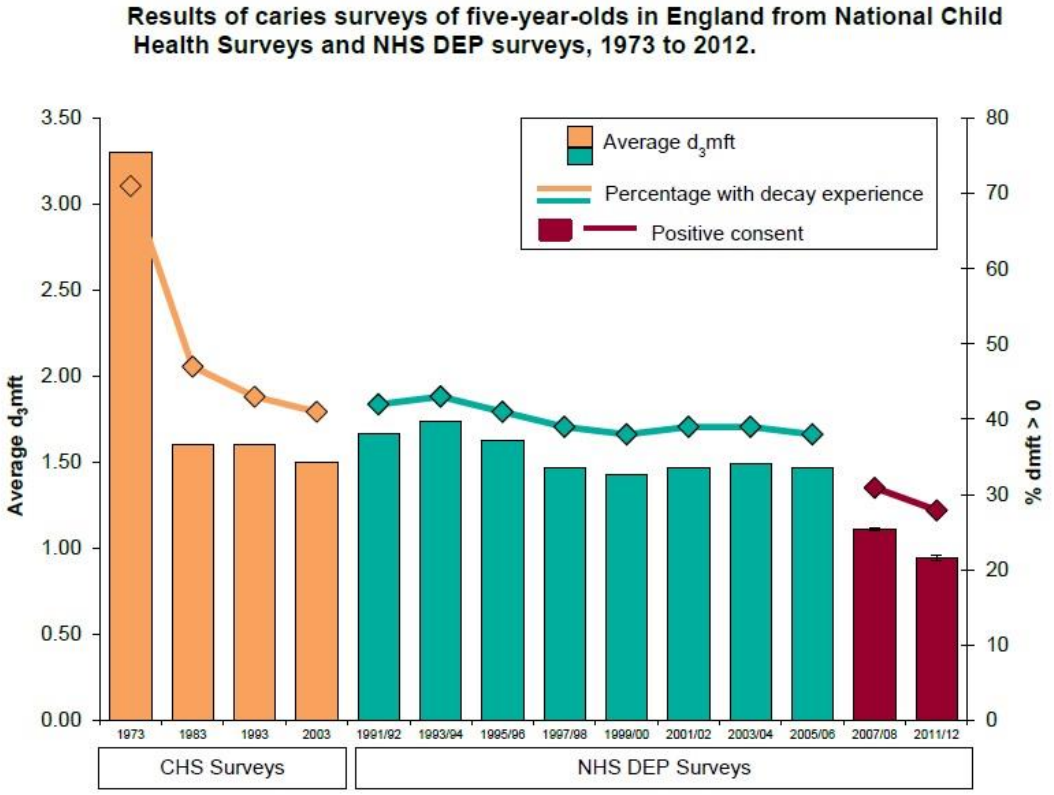


Source: National Children's Dental Health Surveys 1973 to 2003. Harker R and Morris J (2005). Office for National Statistics, London. In Choosing Better Oral Health, Department of Health (2005): http://www.dh.gov.uk/assetRoot/04/12/32/53/04123253.pdf

Trends suggest however, that disease levels are now static. Between 1983 and 1993, the decline was less marked. Since 1993, the overall trend in the oral health of five-year-olds seems to be one of modest worsening following a long plateau. Therefore, there continues to be a burden of disease in small children, which is difficult to address. The most recent Child Dental Health Survey 2013 is currently underway.

Graph 11 shows the results of caries surveys of five year olds in England from National Child Health Surveys and NHS DEP surveys 1973-2012. BASCD national epidemiological data reflects what was found in the national decennial surveys with a plateau both in percentage of children with decay and dmft levels.

Graph 11: Results of Caries surveys of five year-olds in England



Source: National Child Dental Health Surveys 1973-2003. The dental caries experience of 5-year-old children in Great Britain1991-2012). Surveys co-ordinated by the British Association for the Study of Community Dentistry.. NB. Pitts, J Boyles, Z.J. Nugent, N. Thomas, and C.M. Pine . Available at URL: http://www.bascd.org/viewdoc.php?doc_id=45&offset=0&keyword=

The methodology used for the 2012 oral health survey of children was the same as that used in the 2008 survey and therefore it is possible to make comparisons between the two. The issue of positive consent makes comparisons with earlier data less reliable.

Overall 27.9% of five year old children in England whose parents gave consent for participation in the survey had experienced dental decay. There was wide variation in prevalence and severity of dental decay with poorer oral health in the north and

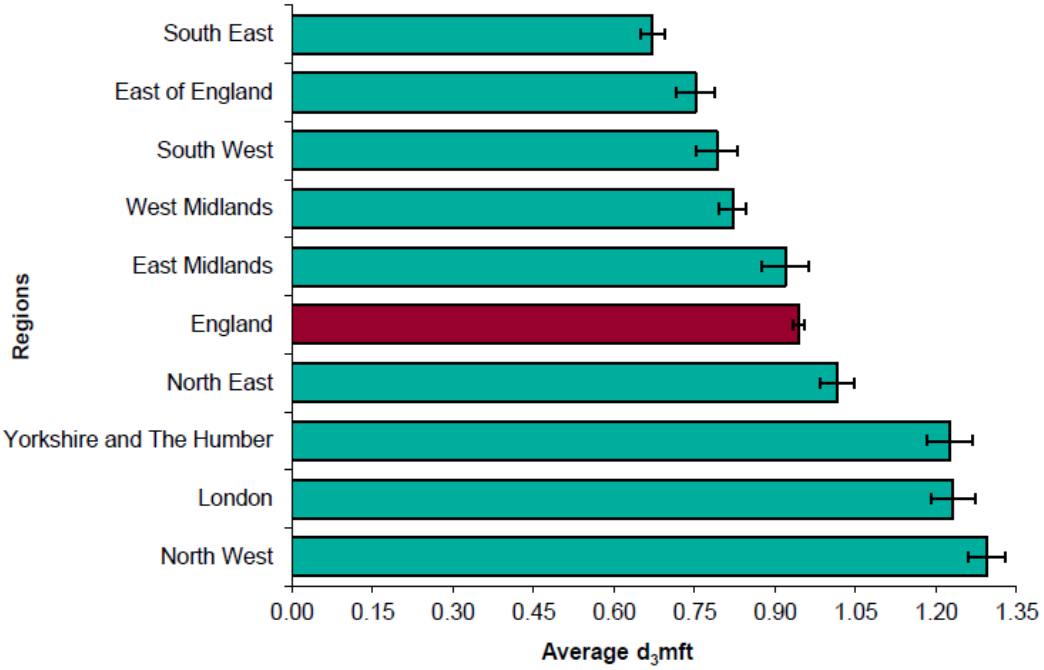
the more deprived local authorities. The results show a reduction in the proportion of children with dental decay from 30.9% in 2008 to 27.9% in 2012 equating to a percentage change of 9.7%. Reductions in severity were also evident, with the number of decayed missing or filled teeth falling from 1.11 in 2008 to 0.94 in 2012 a reduction of 15%.

8.1.1 Inequalities in Dental Caries in Children

These averages fail to present the full picture of dental disease by masking oral health inequalities. In reality, a small proportion of the population experiences a high proportion of the disease. Disease experience is polarised, therefore the distribution of caries prevalence is skewed. As Figures 15 and 16 shows, the mean dmft for 5-year-olds who have decay experience is substantially higher than the overall mean dmft. This means that children who have decayed teeth will have, on average, between 3 and 4 decayed teeth therefore most of the decay is found in a small number of children. The same pattern is found at both regional and national levels (see Figure 6 and 7).

Figure 6: Average number of dentinally decayed, missing (due to decay) and filled teeth (d3mft) among five year old children in England by region 2012

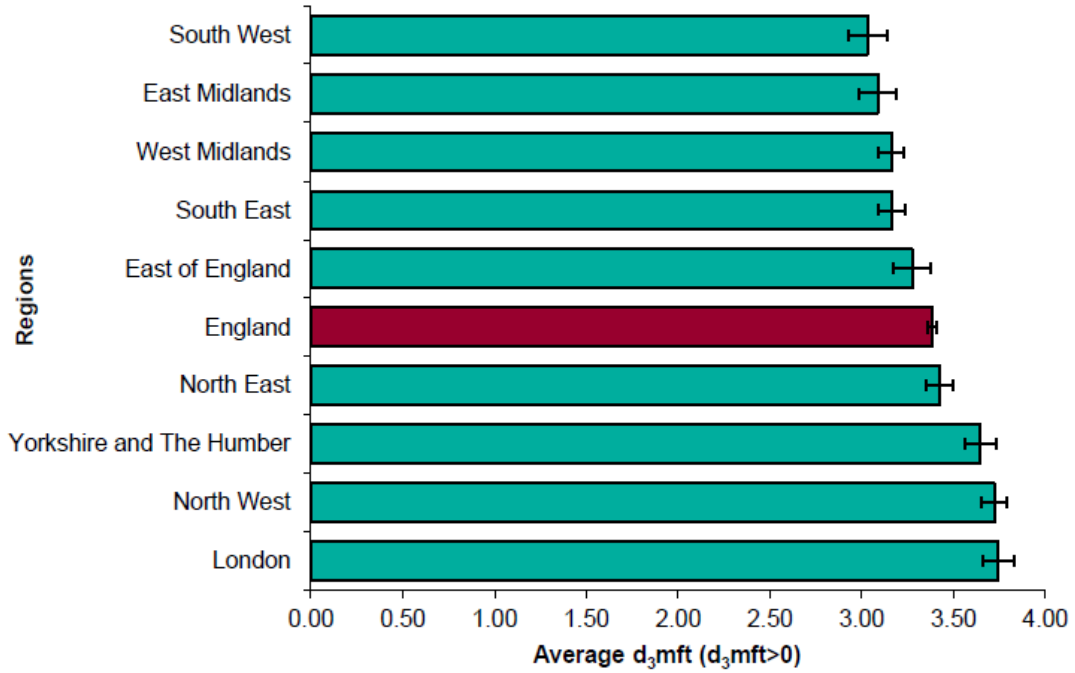
Error bars represent 95% confidence limits



Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public Health Team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team(North West)

The average dmft for five year old children living in the East of England, is lower than the England average of 1.0 and is among the best in the country, second lowest by region however when children who are free from decay are excluded the average dmft for the East of England rises to 3.3 only slightly better than the England average of 3.4.

Figure 7: Average number of dentinally decayed, missing (due to decay) and filled teeth (d3mft) among five year old children with decay experienece (d3mft>0) England by region 2012

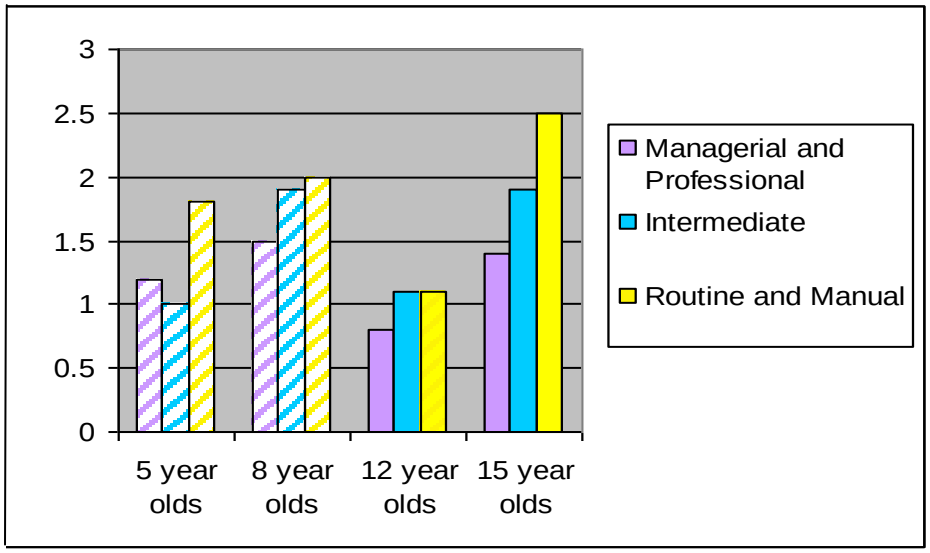


Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public health team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team (North West)

Looking at the average dmft for the whole sample population does not give a clear indication of the disease burden in those children that have decay. In 2012, 72.1% of the children included in this average have no decay and therefore all of the decay identified must be in the remaining 27.9% surveyed. Among the children with decay experience the average number of decayed, missing (due to decay) or filled was 3.38. A child at this age normally has 20 primary teeth. Figure 7 shows the England average and variation across the regions.

Dental caries, like many other diseases, is increasingly associated with social deprivation.[68] Children from socially disadvantaged groups experience disproportionately high levels of dental disease.[69] The 2003 National Children's Dental Health Survey found that children from manual classes are more likely to experience caries than those from non-manual classes (see Graph 12).[70]

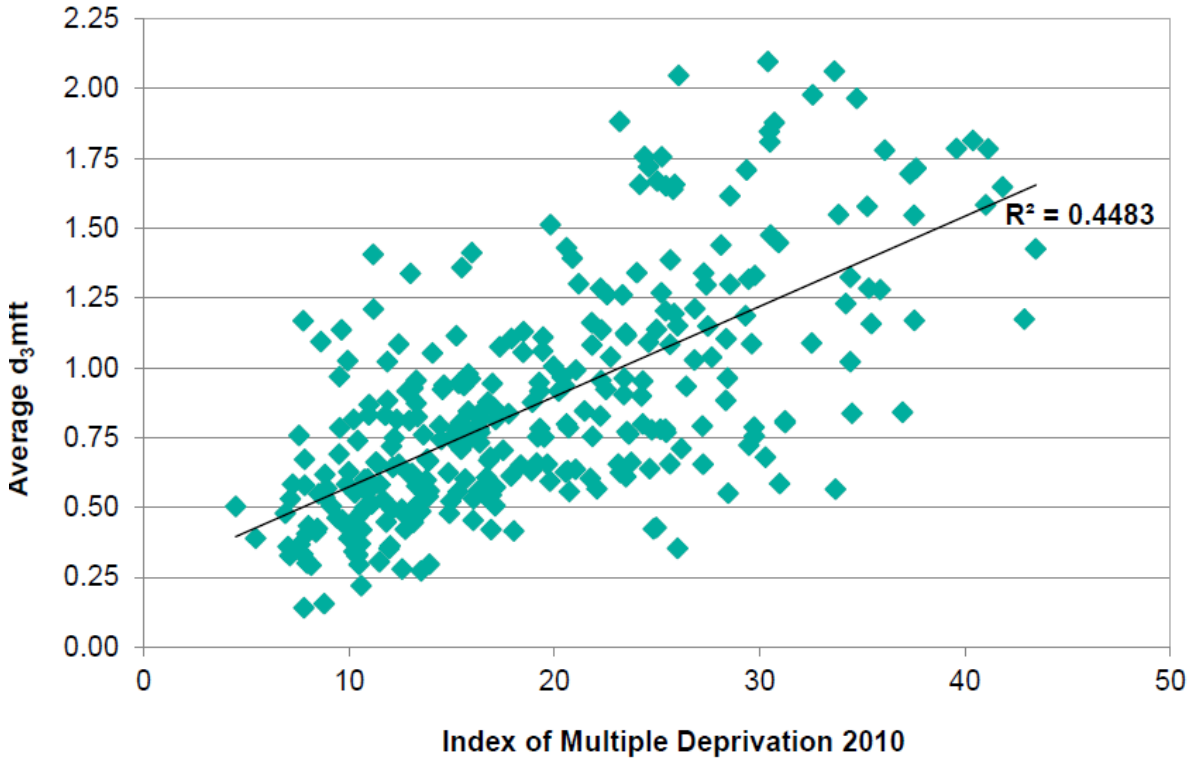
Graph 12: Mean Number of Teeth with Obvious Decay Experience by Socio-Economic Status of Household in the UK 2003*



Source: The dental caries experience of 5-year-old children in Great Britain (2005/2006). Surveys co-ordinated by the British Association for the Study of Community Dentistry.. NB. Pitts, J Boyles, Z.J. Nugent, N. Thomas, and C.M. Pine . Available at URL: http://www.bascd.org/viewdoc.php?doc_id=45&offset=0&keyword=
*Hashed columns indicate primary teeth, solid columns indicate permanent teeth

Similarly, there is a correlation between the percentage of children with decay experience (% of children caries free) and deprivation. This means that deprived groups are more likely to have decay experience. Graph 12 from the 2003 survey shows that this pattern is seen in both the primary and secondary teeth. This variation persists and is also evident in the 2012 survey at the lower tier local authority level and the severity of decay is well correlated with deprivation.

Graph 13: Correlation between number of dentinally decayed, missing (due to decay) and filled teeth (d3mft) among five-year-old children and Index of Multiple Deprivation (IMD 2010) score. Lower tier local authorities in England, 2012



Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public health team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team (North West)

The Care Index

The care index is the proportion of teeth with caries that have been filled. ft/d3mft expressed as a percentage. Opinions differ regarding the appropriateness and benefit of filling decayed deciduous teeth and there is a lack of definitve evidence based guidance on this. It is difficult thefore to make assumptions about the extent or the quality of clinical care available. How ever it appears that althought children visit the dentist their deciduous teeth, for whatever reason, are not be routinely filled or extracted.

The care index was 11.2% across England as a whole showing that just over a tenth of decayed teeth are treated by filling them. This compares with the care index for the East of England of 14.2%.

Oral disease can have a significant negative impact on the quality of life of pre school children.[71]

For example, severe untreated caries may not only cause pain, discomfort and disruption to sleeping and eating habits, but may also adversley affect child growth and school performance.[72] It is therfore of paramount importance for dental professional to provide appropriate prevention and high quality treatment for children.

Dental teams may need more training and support to develop their clinical mangement skills needed for the effectove care of preshool and young children. Establishing effective links between local dental practices, chilrens centres and primary schools may facilitate across to dental services and to provide oral health support and advice.

8.2 Oral Health in Children in East Anglia

8.2.1 Dental Caries

The dental health of children in East Anglia is relatively good. Local data on the oral health of children are regularly collected through the National Dental Public Health Epidemiology Programme (DEP) for England co-ordinated surveys.
On 30th September 2014 the DEP published an " Oral health survey of three year old children 2013". Of the 5,259 three year old children examined in Anglia and Essex and 92.9% had no visible tooth decay or evidence of past dental treatment. For the remaining 7.1% who had some obvious decay experience, the average number of decayed teeth and teeth treated for decay was 2.99 per child. The average number of decayed, missing and filled teeth, per child, across the whole sample was 0.2. Table 11 shows the results across Anglia and Essex

Table 11:Local Results to upper tier LA level; 3 year old population as sampled: average number of teeth with decay experience and proportion of total sample with any obvious decay experience

	Total number of children examined		**Average number of teeth with decay experience ($d_3$mft)**	$d_3$mft *Lower 95% confidence limit*	$d_3$mft *Upper 95% confidence limit*		**Proportion with any visible decay experience ($d_3$mft>0)**	$d_3$mft>0 *Lower 95% confidence limit*	$d_3$mft>0 *Upper 95% confidence limit*
England	53,640		**0.36**	*0.35*	*0.37*		**11.7**	11.5	12.0
Anglia and Essex	5,259		**0.21**	*0.18*	*0.24*		**7.1**	6.38	7.8
Cambridgeshire	1,103		**0.16**	*0.11*	*0.22*		**4.8**	3.5	6.0
Essex (data for Basildon, Braintree, Brentwood, Castle Point, Chelmsford, Colchester, Epping Forest, Harlow, Maldon, Rochford and Uttlesford only)	1,290		**0.17**	*0.12*	*0.21*		**6.3**	4.9	7.6
Norfolk	1,173		**0.27**	*0.20*	*0.35*		**9.9**	8.2	11.6
Peterborough	134		**0.46**	*0.11*	*0.8*		**10.7**	5.1	16.4
Southend-on-Sea	229		**0.22**	*0.07*	*0.38*		**5.6**	2.6	8.5
Suffolk	1,267		**0.20**	*0.14*	*0.26*		**6.8**	5.4	8.3
Thurrock	63		**0.15**	*0.01*	*0.29*		**7.3**	1.3	13.4

The report provides further information relating only to children who did have evidence of decay experience. Average number of teeth affected by decay (and 95% confidence limits) within this group is:

Table 12: dmft for three year olds in East Anglia where dmft > 0 2013

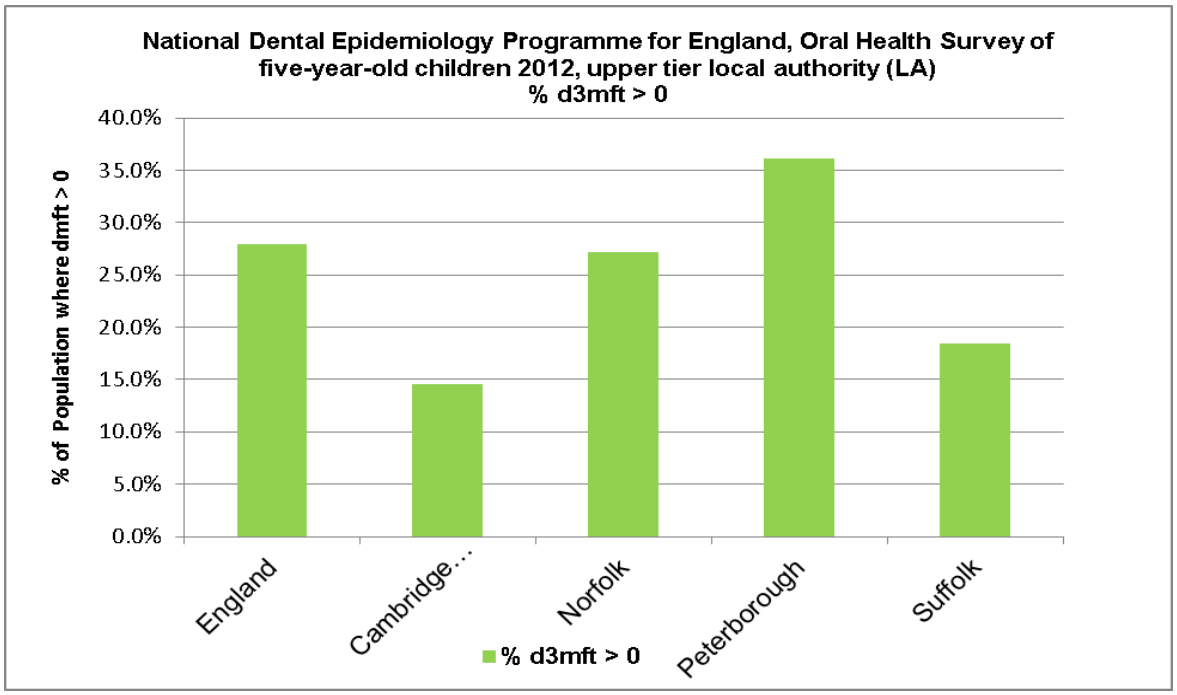
England	3.08 (*3.01 – 3.14*)	*Values for Peterborough, Southend-on-Sea and Thurrock are based on less than 30 children in this category examined in each of these LAs*
Anglia and Essex	2.99 (2.7-3.27)	
Cambridgeshire	3.38 (2.67-4.1)	
Essex (as above)	2.65 (2.24-3.05)	
Norfolk	2.77 (2.24-3.30)	
Peterborough	4.27 (1.92-6.63)	
Southend- on- Sea	4.01 (2.32-5.71)	
Suffolk	2.94 (2.31-3.56)	
Thurrock	2.09 (2.09-2.09)	

The number of children examined who fell into in this category, resident in Peterborough was 14, Southend- on- Sea, 13 and Thurrock, 5 and therefore the findings are likely to be unreliable.

The Report does provide data to lower tier LA level but these are likely to have limited practical value; sample numbers are small and confidence intervals wide.

In the sample of five year old children surveyed during 2011-2012 there was variation across the area however. In Cambridgeshire 86% of 5 year old children are decay free, in Suffolk 83%, Norfolk 73% and Peterborough 64%. See Graph 14 . This compares with an England average of 72.5%.

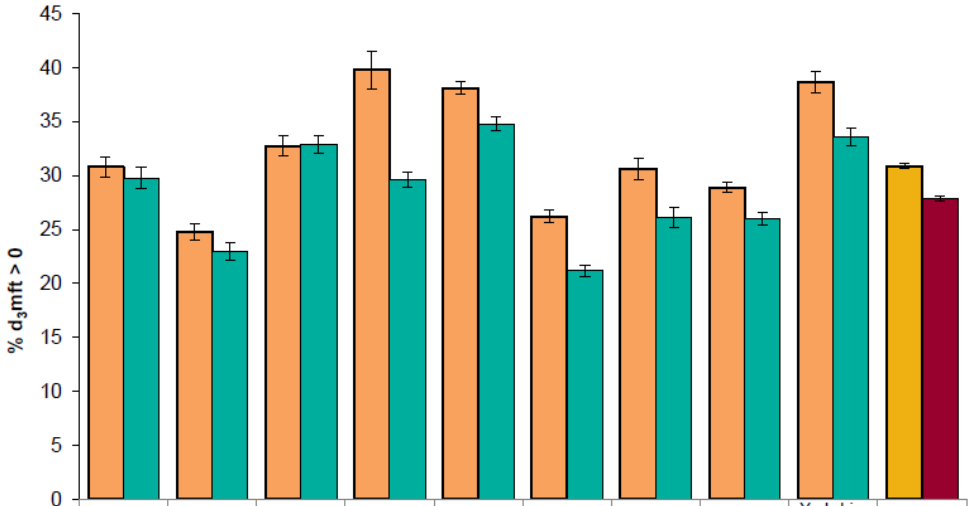
Graph 14: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012



Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public health team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team(North West)

Although these surveys have been undertaken over a number of years the methodology had changes so it is not possible to make comparisons with the 1992 to 2006 series. Data from the 1992 to 2006 series shows there was little change in the prevalence or severity of dental decay between 1992 and 2006. The first two points of the 2008 to 2012 series shows a reduction that would require further investigation to determine the possible causes. Surveys in Wales and Scotland have shown similar trends over similar period. In terms of the methodology, however, surveys undertaken from 2008 required that, for the first time, parents given positive consent for their child to be examined. This may have a bearing on the findings and there may be an element of self- selection in this method. Graph 15 show the comparison between the 2008 and 2012 epidemiological survey.

Graph 15: Percentage of five year olds children with decay experience (d3mft>0) in England by region 2008 and 2012



	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire and the Humber	England
2008	30.8	24.8	32.7	39.8	38.1	26.2	30.6	28.9	38.7	30.9
2012	29.8	23.0	32.9	29.7	34.8	21.2	26.1	26.0	33.6	27.9

Error bars represent 95% confidence limits

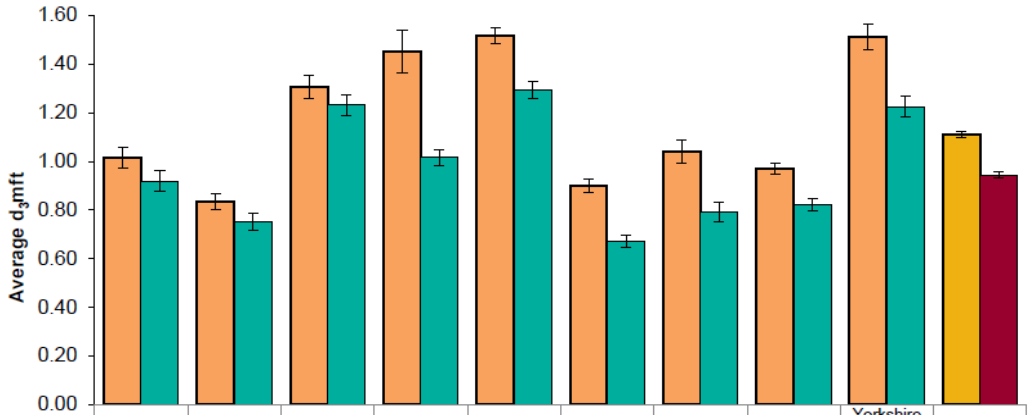
Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public health team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team(North West)

The East of England averages for 5 year old children in the East of England is 0.83 and 0.75 in 2008 and 20012 respectively and is higher only then figures for the South West of England. Again this reduction between 2008 -2012 may not be significant.

The chart below also shows a reduction in the mean d3mft from 1.11 in 2008 to 0.9 in 2012 which is an overall reduction of 15.3%. The reduction in England severity was recorded for all regions but not all local authorities.

Graph 16

Figure 11: Average number of dentinally decayed, missing (due to decay) and filled teeth ($d_3$mft) among five-year-old children in England by region, 2008 and 2012.

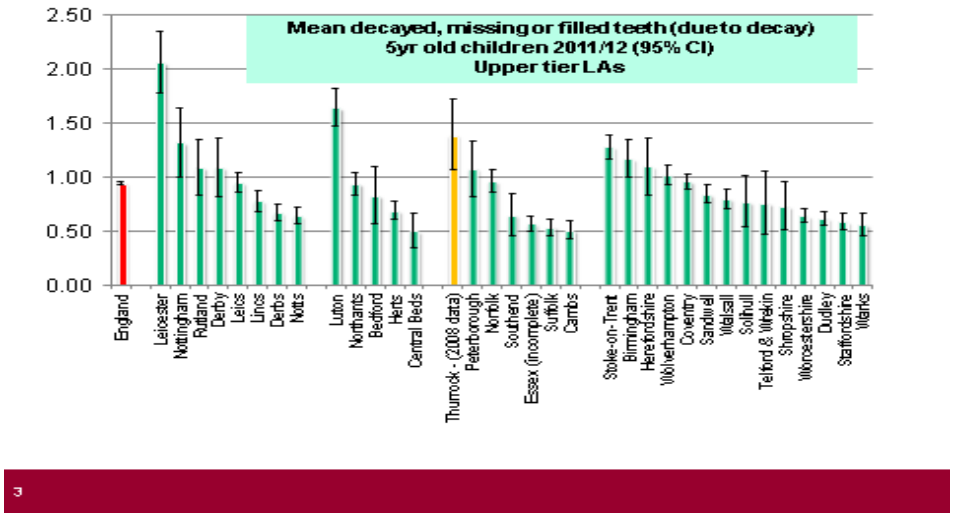


	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire and the Humber	England
2008	1.02	0.83	1.31	1.45	1.52	0.90	1.04	0.97	1.51	1.11
2012	0.92	0.75	1.23	1.02	1.29	0.67	0.79	0.82	1.23	0.94

Error bars represent 95% confidence limits

Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public health team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team(North West)

Graph 16 : below shows the mean decayed, missing of filled teeth (due to decay) in 5 year old children 2001.12 for Upper Tier Local Authorities



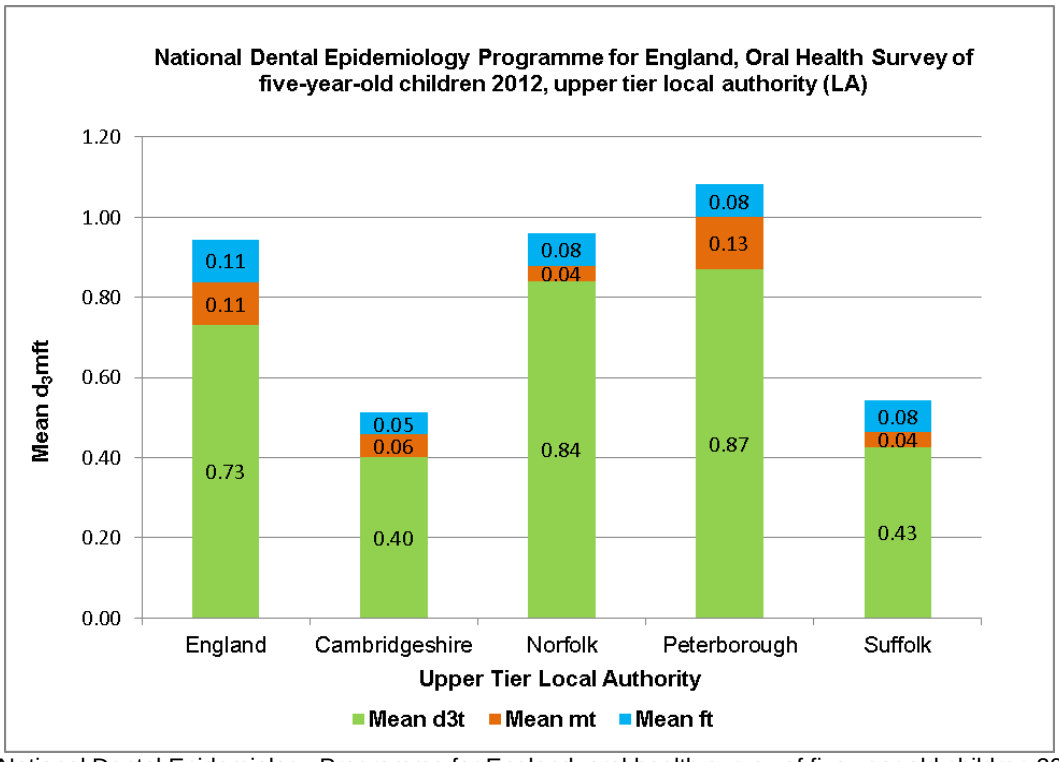
Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public health team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team(North West

Graph 16 above shows the mean decayed, missing of filled teeth (due to decay) in 5 year old children 2012 for Upper Tier Local Authorities

Across the Midlands and East Region Cambridgeshire and Suffolk Upper Tier Local Authorities have some of the lowest mean d3mft values of 0.5, lower also than the England average. Peterborough and Norfolk have mean d3mft values of 1.1 and 0.9 respectively, closer to the average value for England.

Graph 17 shows the components of the dmft index while the average dmft in all areas except Peterborough is lower than the England average the largest component is untreated decay: Only a very small number of five year old children with dental decay receive active treatment for this condition, i.e. filling or extractions. While many decayed teeth may remain symptomless the impact of a decayed tooth in terms of pain, infection and sleepless nights in a child should not be under estimated.

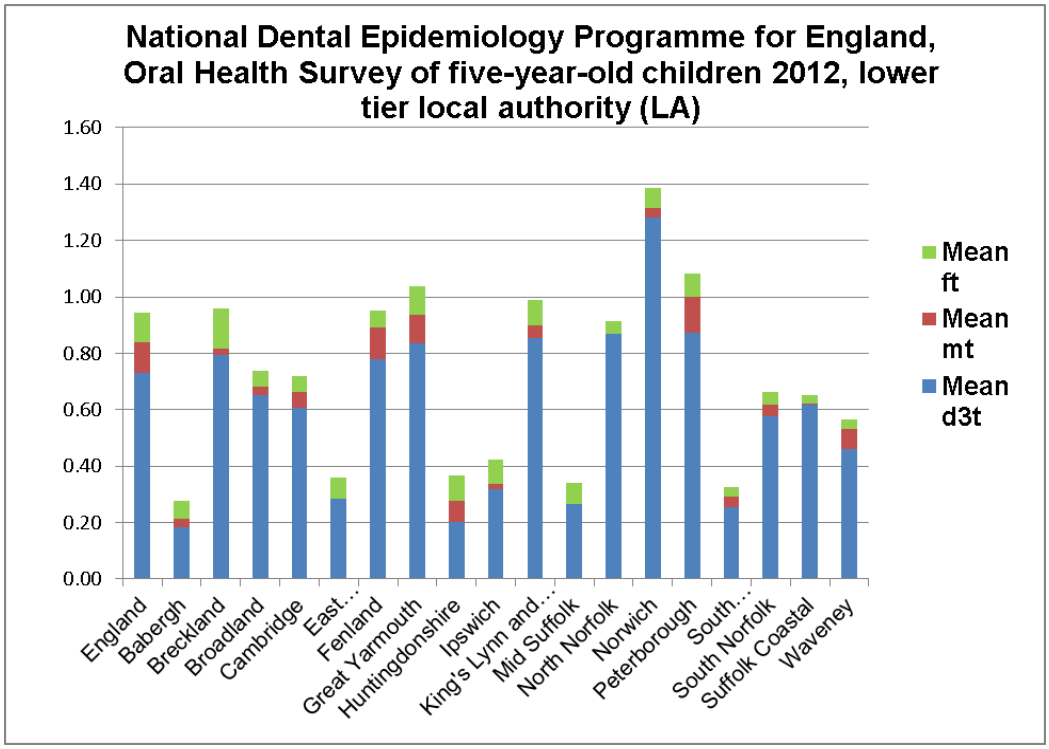
Graph 17: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012



Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public health team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team(North West

Graph 17 shows the breakdown of dmft scores by lower tier local authorities. Local differences appear more marked with Norwich, Great Yarmouth and Peterborough exhibiting higher average dmft scores than England and the rest of the area.

Graph 18 : shows the breakdown into decayed, missing and filled components for each of the Lower Tier Local Authorities



Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public health team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team(North West

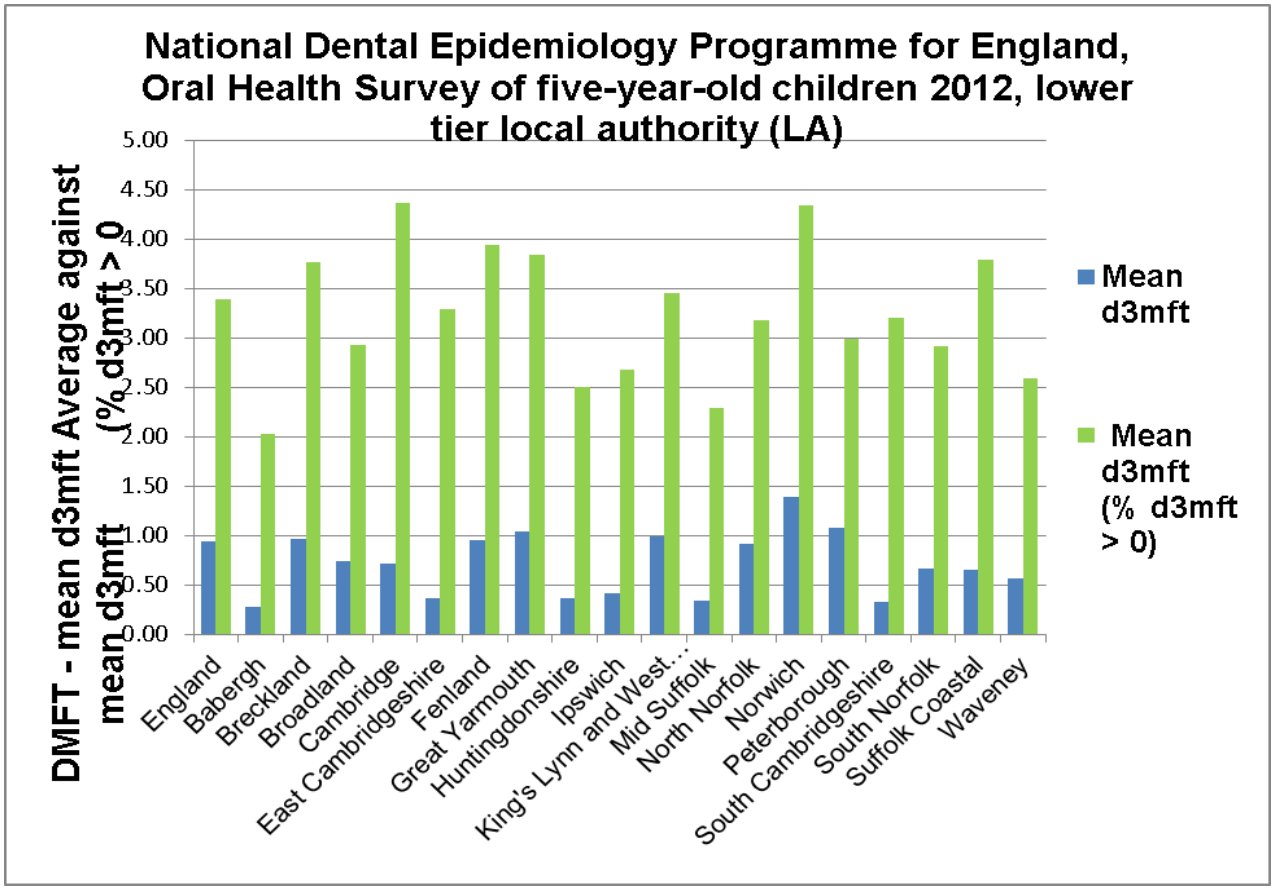
Average dmfts at higher tier local authority level can mask local variation. Targeted interventions such as community fluoride varnish schemes or brushing programmes in primary schools may help reduce levels of dental decay.

8.2.2 Inequalities in Oral Health of Children in East Anglia

The pattern of oral health inequalities seen at a national level is repeated locally. Again national averages hide oral health inequalities and the fact that a small proportion of the population experiences a high proportion of dental disease. The stark contrast between average $d_3$mft values across the whole population and $d_3$mft values in those with decay experience can be seen in figure 24.

For example in Cambridge a relatively affluent part of the region the difference between the average d3mft and the average d3mft of those with dental decay is from 0.7 to 4.4. Similar variation is seen most notably in areas such as Fenland, Norwich, Great Yarmouth and Suffolk Coastal.

Graph 19: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012



Source: National Dental Epidemiology Programme for England: oral health survey of five year old children 2012, A report on the prevalence and severity of dental decay. PHE G Davies, J Neville, E Rooney. Dental Public health team. M Robinson. A Jones, C Perkins, Knowledge and Intelligence Team(North West

These figures highlight the wide variation in the levels of decay experienced by five year old children living in different parts of the Midlands and East Region, in Cambridgeshire, Norfolk, Suffolk and Cambridgeshire and even between areas covered by lower tier authorities.

The figures also highlight the differences in the level of decay experienced by five year old children living in different life circumstances. The cause of dental decay is well understood and is related to the frequent exposure of teeth to fermentable carbohydrates, most commonly through eating and drinking sugary snacks and drinks.

These are also contributory factors to other issues of public health concern in children, for example childhood obesity. The variation in dental decay reported at the local authority (lower-tier level) is well correlated with the index of multiple deprivation, with the highest levels of disease tending to be seen in the most deprived areas. The 2011-12 report of the national Child Measurement Programme (Department of Health: Health and Social Care Information Centre (2012). National Child Measurement Programme: England, 2011/12 school year. Available at: https://catalogue.ic.nhs.uk/publications/public-health/obesity/nati-chil-meas-prog-eng-2011-2012/nati-chil-meas-prog-eng-2011-2012-rep.pdf) identifies a similar relationship between childhood obesity and deprivation. This is understandable given

the common factors that lead to dental decay and obesity, and consideration should be given to this when preventive strategies and local interventions are being developed.

The 2011/12 survey is the second one to be carried out following a number of methodological changes including the requirement to seek positive written consent in 2007. It is likely that the non-responders have different levels of dental decay beyond that explained by deprivation alone. No clinical data exists on this non-consented part of the sample and therefore it is not possible to model or measure the impact this has had. Direct comparisons between this survey and surveys conducted before 2008 should not be made, as response bias may have resulted in lower estimates of levels of decay. .[73] [74]
There is also consistency in the relationship found between dental decay and deprivation, the most deprived local authorities having the highest decay levels. This relationship is supported by other studies.[75] [76]

Between 2008 and 2012 there was a reduction in the proportion of children affected by dental decay and its severity. The last time a substantial change in the levels of dental decay was observed among this population was in the Child Dental Health Surveys of 1973 and 1983. The reduction was widely considered to have been a result of the wholesale introduction of fluoride toothpaste in the late 1970s.

The increasing focus on prevention in general dental practice may also have had an influence. Evidence from the Health and Social Care Information Centre (HSCIC) shows an almost three-fold increase in dentists' prescriptions for fluoride-based products between 2007 and 2012,19 and a continuing increase in the application of fluoride varnish for children (a 63% increase between 2010-11 and 2011-12)20.

Although further work is needed to determine the reasons for the changes, widespread inequalities related to deprivation are still present and, under the arrangements introduced by the Health and Social Care Act 2012, upper-tier local authorities now have a duty to address dental health within their public health responsibilities. Data from this survey will be used to produce the dental indicator (4.2 tooth decay in children aged five) in the PHOF.

8.3 Orthodontic Treatment Need in East Anglia

The most recent Children's Dental Health Survey in 2003 found that 35% of 12-year-olds in England would benefit from orthodontic treatment.[77] While this figure is often used to plan commissioning of orthodontic services, it would be wrong to assume that all of these children will seek, accept or be suitable for orthodontic treatment.

Unlike most oral conditions, malocclusion does not vary between genders or social classes (although racial characteristics mean that there is some ethnic variation). Despite this, there have historically been inequalities in the receipt of orthodontic treatment[10], e.g. girls receive more treatment than boys and adolescents in deprived areas are more likely to have untreated malocclusion.[78] Local data on the prevalence of malocclusion are not routinely collected.

A review of orthodontic services across East Anglia was undertaken in July 2014. This document, An orthodontic needs assessment and service review for East Anglia 2014, can be viewed separately.

In summary the main findings indicate that orthodontic provision across East Anglia is variable. In some areas such as Cambridge and Great Yarmouth and Waveney there appear to be areas of over commissioning orthodontic services while other areas such as Fenland, East Cambridgeshire, Kings Lynn and Thetford are more poorly served. At the same time the 12 year old population has fallen by approximately 1000 between 2008 and 2012. The majority of orthodontic services are provided under time limited personal dental services (PDS) contracts and this gives the Area Team opportunities to re-commission services to more appropriately meet the needs of the population.

9. Current Service Provision

9.1 Access to NHS primary care dental services in East Anglia

The vast majority of primary care NHS dental services are provided by 'high street' dentists working under General Dental Services (GDS) non time limited contracts. Salaried dental services also provide NHS dental services and they tend to be small and well established and are intended to be complementary to the 'high street' provision. They generally offer services to patients who, for various reasons may find it more difficult to access routine care. These groups of patients include adults and children with special needs, irregular attenders, older patients requiring domiciliary care, adults with anxiety and dental phobia, prisoners and people living in long term institutional care.

The Department of Health defines access as "the percentage of children in the population who have seen the dentist within the last 24 months". This is a very narrow definition of access.

The priorities for dental service provision are access to:

- Routine and preventive services
- Urgent care services
- Specialist services

9.2 Availability of NHS dental services

Since the inception of the new dental contract in March 2006 the number of dentists with NHS activity has increased everywhere in East Anglia apart from in Peterborough (see Table 13). It is interesting to note that Peterborough, with the highest level of childhood decay, has a much higher number of dentists per 100,000 population than England.

Table 13: The number of dentists with NHS activity Cambridgeshire, Norfolk, Peterborough, Suffolk and Great Yarmouth and Waveney March 2007 and March 2012

	March 2007			March 2012		
	Total number of dentists	Population per dentist	Dentists per 100,000 of population	Total number of dentists	Population per dentist	Dentists per 100,000 of population
England	20,160	2,518	40	22,920	2,279	44
Cambridgeshire	232	2,521	40	331	1,862	54
Norfolk	301	2,444	41	350	2,186	46
Peterborough	90	1,861	54	88	1,971	51

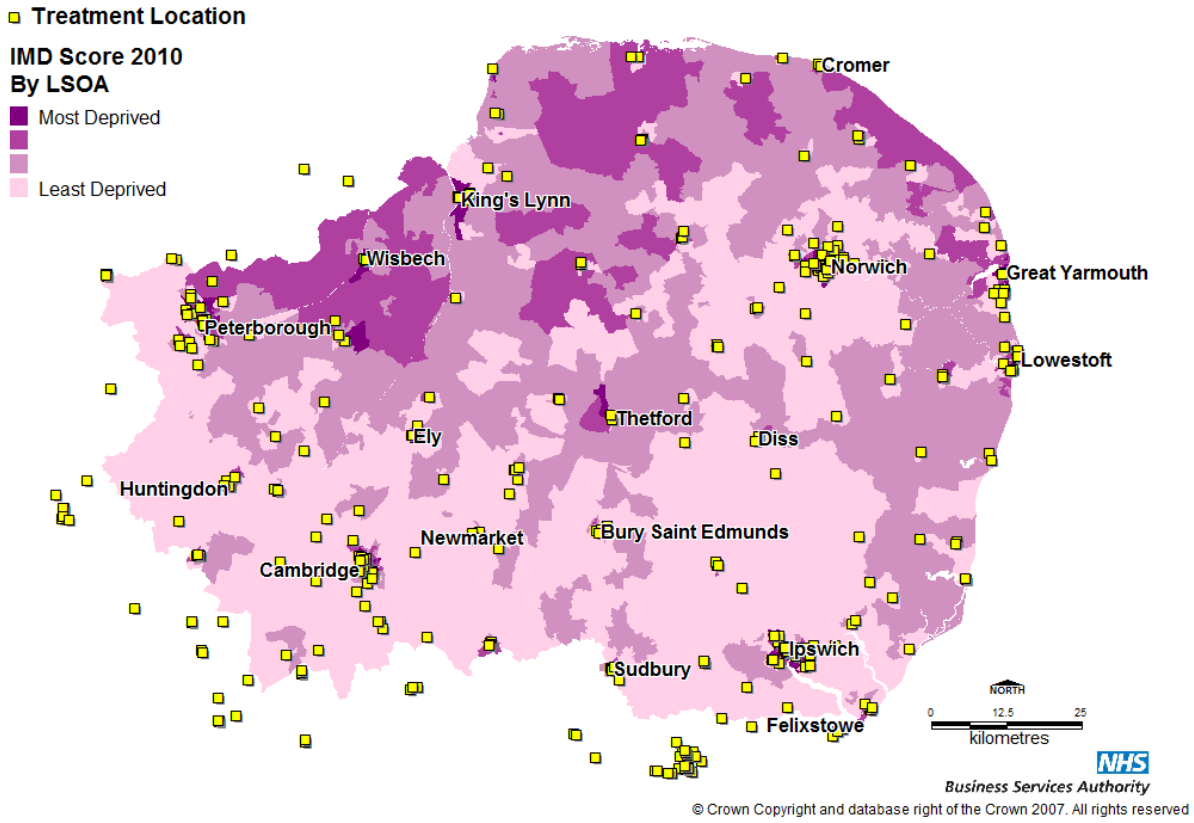
Suffolk	249	2,335	41	315	1,911	52
Great Yarmouth and Waveney	92	2,305	43	129	1,664	60

Source: NHS Dental Statistics for England: 20011-12. Annex 2: PCT & SHA Factsheet, Activity Statistics. Available at URL: http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry/nhs-dental-statistics-2011-12

9.3 Location of NHS dental practices

Most NHS dental practices are located in the towns and cities. There is good provision in some of the most deprived areas of East Anglia for example Peterborough, Great Yarmouth and Lowestoft but not in others for example Wisbech, Kings Lynn and Thetford. Map 2 shows the distribution of NHS dental practices mapped to deprivation across the Anglia area and demonstrates that dental practices are mainly based in urban areas and do not map to the areas of highest deprivation. It is unclear whether this mis-match in provision contributes to poor dental health but should be considered when planning new services.

Map 2: Treatment locations and IMD Score 2010 by LSOA 2013/ 2014



9.4 Barriers to Dental Care

Access to dental services is not just about the location of the practices. Most dental practices in East Anglia are situated in towns and cities where most of the population

reside yet still only just over half the population in East Anglia (54.2%) visit the dentist in a two year period. The way people use services depends on other factors as well including acceptability, affordability, availability, accessibility and the appropriateness of the service offered.

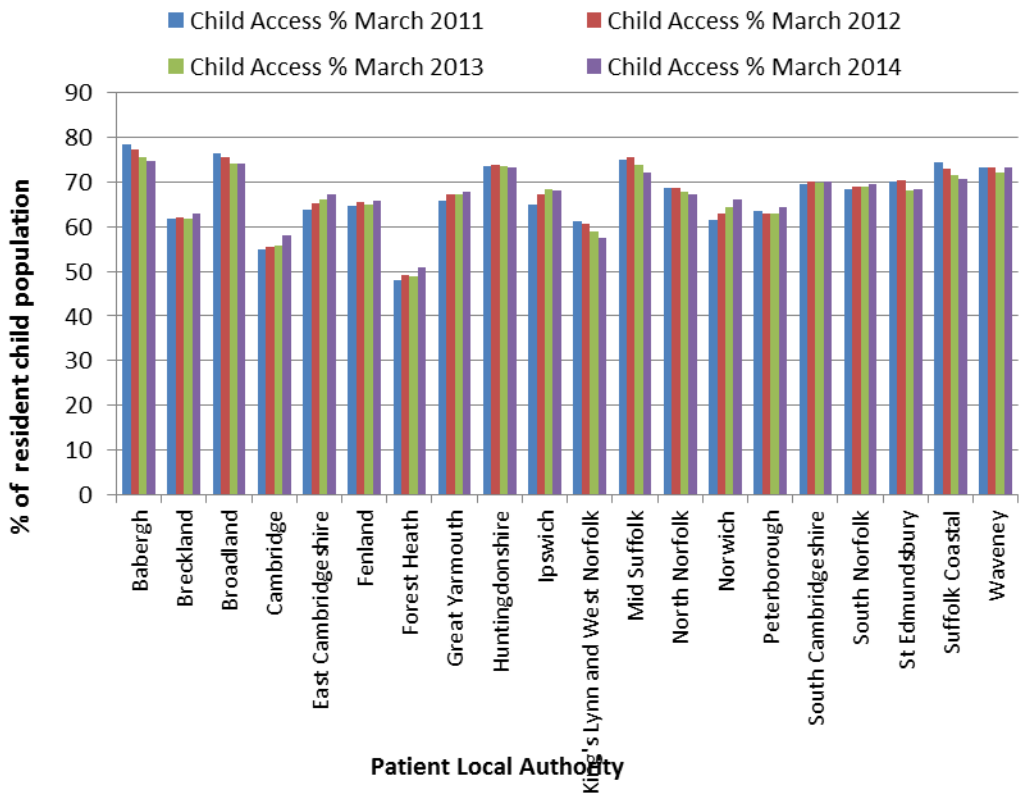
Obstacles to attending the dentist include dental anxiety, cost of treatment and the attributes of the dental practice.[79808182] Just over a quarter of adults (26%) surveyed in the ADHS 2009 said that the type of dental treatment they had opted for in the past had been affected by cost and almost a fifth (19%) said they had delayed dental treatment for the same reason.

The rural nature of the area and poor public transport will affect peoples' ability to access dental services as well as lack of availability of appointments at evenings and weekends.

9.5 Access to primary care dental services for children

Access to dental services is defined by the Department of Health as the percentage of the population who have visited the dentist within the last 24 months. The data is based on where the patient is resident irrespective of where the visit took place. In March 2014 67.4% of the child population had visited the dentist. This is unchanged since March 2011. Graph 20 shows the access rates for children across East Anglia at March 2014

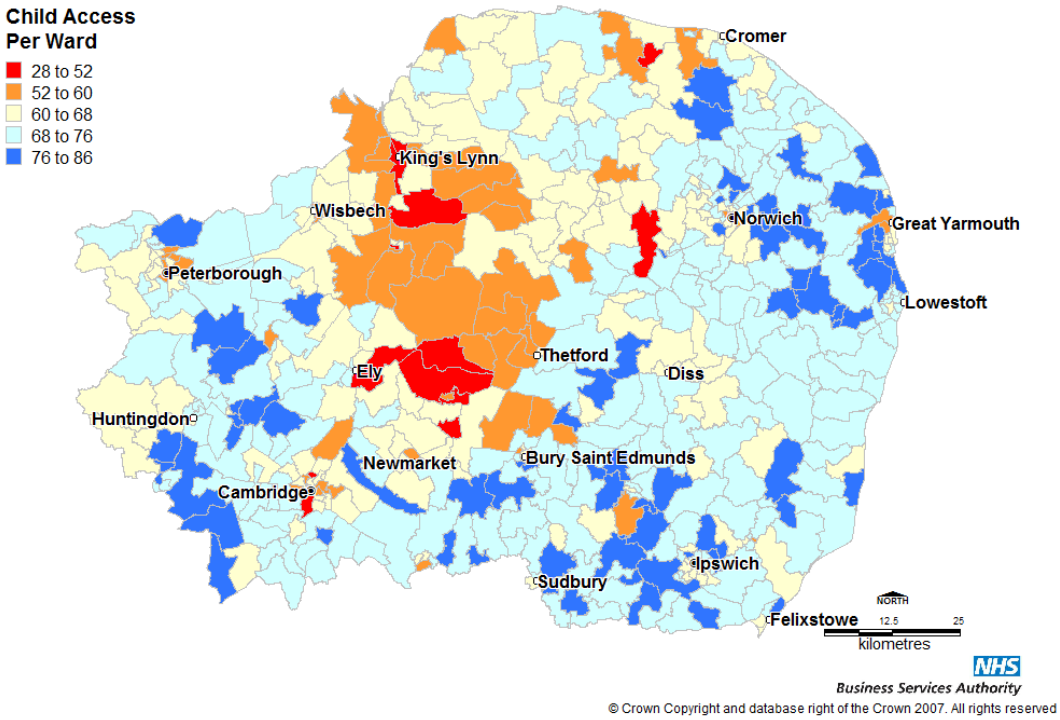
Graph 20 : Child access rates trend by lower tier local authority in East Anglia March 2014



Source: NHSBSA Information Services (dental) Dental Public Health Report: East Anglia June 2014

The map below shows child access rates by ward. Those shown in red (>60%) have the lowest access rates and this is mostly in Fenland, Forest Heath, Kings Lynn and West Norfolk, parts of Peterborough and the North Norfolk coast.

Map 3: Access rate resident child patients in East Anglia (24 months to March 2014)

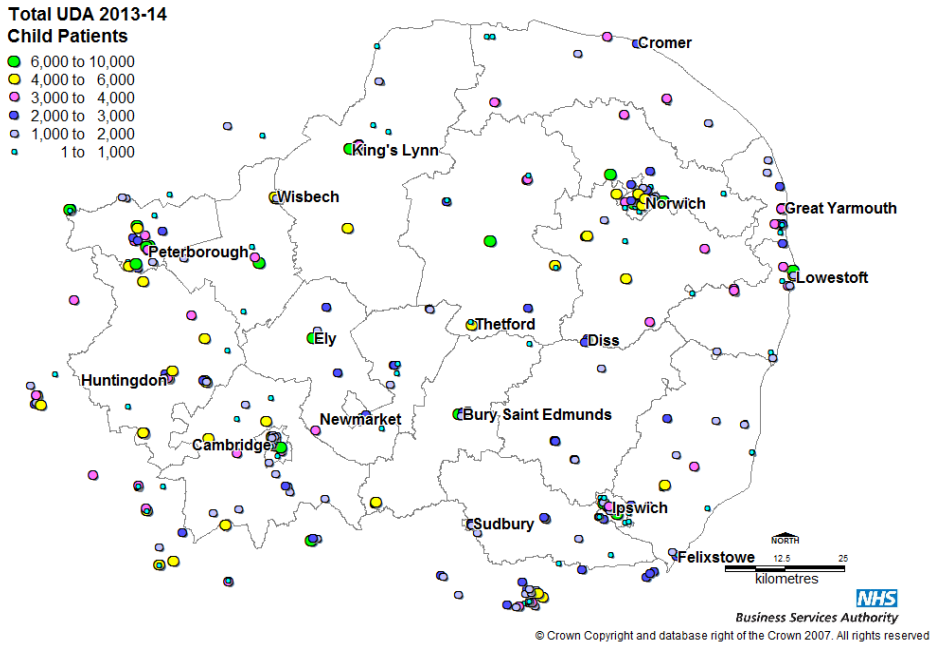


Source: NHSBSA Information Services (dental) Dental Public Health Report: East Anglia June 2014

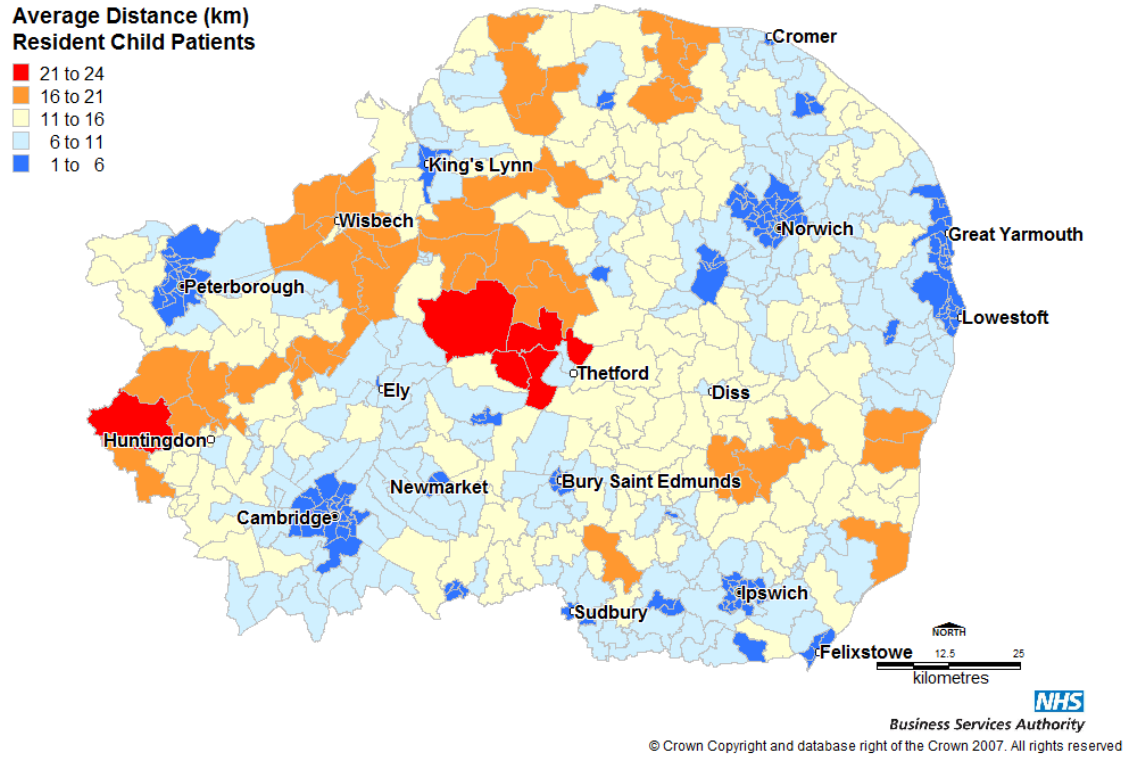
9.6 Treatment locations and distance travelled for child patients

Most dental services are located in the towns and cities in Peterborough, Norwich, Cambridge and Ipswich. The maps below show the treatment locations for child patients in East Anglia by the number of Units of Dental Activity (UOAs) 2013 -2014 and the distance travelled by those patients to access dental care.

Map 4 : Treatment locations for child patients in East Anglia by the number of Units of Dental Activity (UOAs) 2013 -2014.



Map 5 : Average distance travelled by resident child patients in East Anglia (24 months to March 2014)



Not surprisingly access is lowest when children have to travel furthest to visit a dentist. Again patients from areas such as Forest Heath, Kings Lynn and West Norfolk, Fenland, North Norfolk and Suffolk Coastal are affected.

9.7 Dental treatment provided for children living in East Anglia

Most children who visit an NHS dentist (72.1%) receive a Band I course of treatment only. This covers an examination and may include preventive advice, scaling and polishing and application of fluoride varnish. A further 22.7% receive this plus any further treatment such as fillings, root canal work or extractions. A very small number 0.6% may also receive crowns, dentures or bridges. 4.7% of courses of treatment are for urgent care. Just under half of those who visit a dentist (46.5%) will re attend within 6 to 12 months. 13.9% re attend within 3 months and 19.8% between 3 to 6 months. National Institute of Clinical Excellence (NICE) guidelines recommend an interval of between three months and two years, depending on the oral health of the patient. Intervals shorter than three months may indicate poor quality treatment or diagnosis. This may also indicate that patients are at greater risk of poor oral health, for example from deprived communities and more frequent interventions are required.

Access to urgent care is a priority for the relief of pain and for accidental damage. In 2013/2014 4.7% of all courses of treatment provided for children were for urgent care compared with an England average of 4.6%. This may not reflect need as children are dependent on others, such as parents to arrange urgent dental care. Delivering Better Oral Health: an evidence based toolkit for prevention, third edition, June 2014 recommends that all children over 3 years should receive a professional application of fluoride varnish to the teeth two times a year. Children aged from 7 years who give concern to the dentist, including those with current active decay and those with special needs should have their permanent molars fissure sealed. However, compared to national averages the percentage of children living in East Anglia who receive a preventive intervention as part of a course of treatment is low, about half the rate for England.

Table 14: Rate of fluoride varnish or fissure sealant application per 100 courses of treatment by age group for children resident in East Anglia 2013/2014

	Children aged 0-2 years		Children aged 3-5 years		Children aged 6-12 years	
	England	E. Anglia	England	E. Anglia	England	E. Anglia
Fissure sealants	0.0	0.0	0.1	0.0	1.4	0.7
Fluoride Varnish	5.4	2.6	24.6	13.6	30.7	22.1

Source: NHSBSA Information Services (dental) Dental Public Health Report: East Anglia June 2014

9.8 Access to dental services for looked after children

There is a requirement that looked after children have an annual health assessment and that this should include a dental check- up within the last year. Currently this requirement is not being met and figures for Norfolk and Suffolk are low, 65.2% and 58.1 % respectively. Table 15 Interestingly, Peterborough achieves the highest take up of annual health assessment compared to other areas, and much higher than then England average. It should be noted that attendance at a dental check- up does

not provide any information about the quality of care or if any necessary treatment was completed. This group of children is likely to have poorer oral health and, if they are moved between different carers, more erratic and irregular access to dental care.

Table 15 : Percentages of looked after children attending for a dental check- up 2011 and 2012

	England	East of England	Cambridgeshire	Norfolk	Peterborough	Suffolk
2011	82.4	74.7	92.6	27.2	84.4	68.8
2012	82.4	79.9	92.4	65.2	93.2	58.1

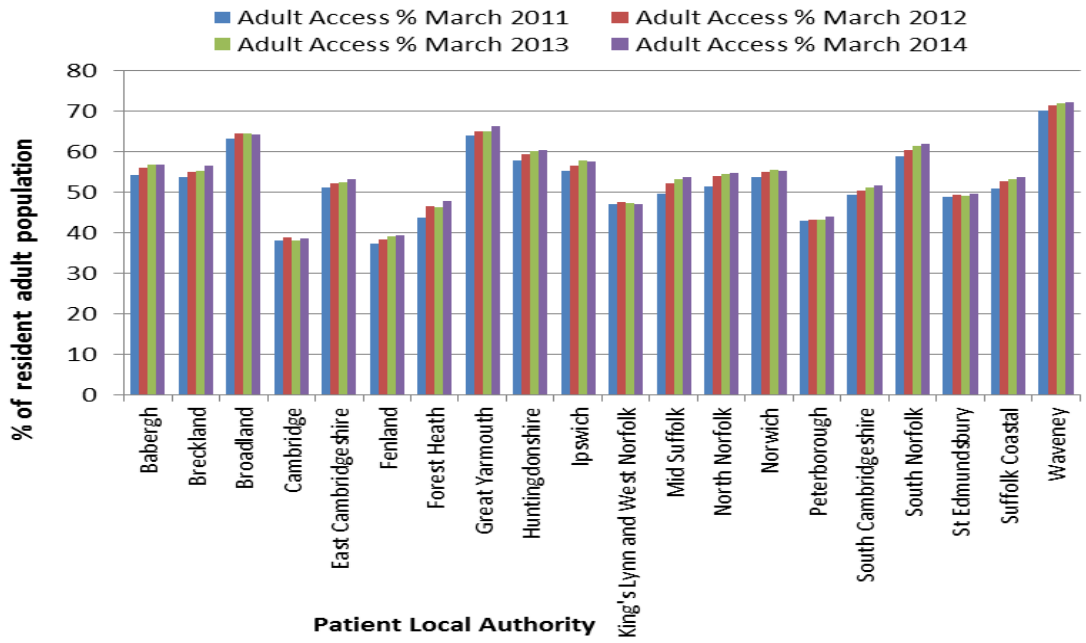
Source: Fingertips 2012

9.9 Access to primary care dental services for adults

The Department of Health defines access as the percentage of patients who have seen the dentist within the last 24 months. Access was highest in Waveney and Great Yarmouth and lowest in Cambridge, Fenland, Forest Heath, Kings Lynn and West Norfolk and Peterborough where less than fifty per cent, and in some case less than forty per cent of the population have visited the dentist within the last two years, Figure ?. Again this does not include access to private services for which there is no data.

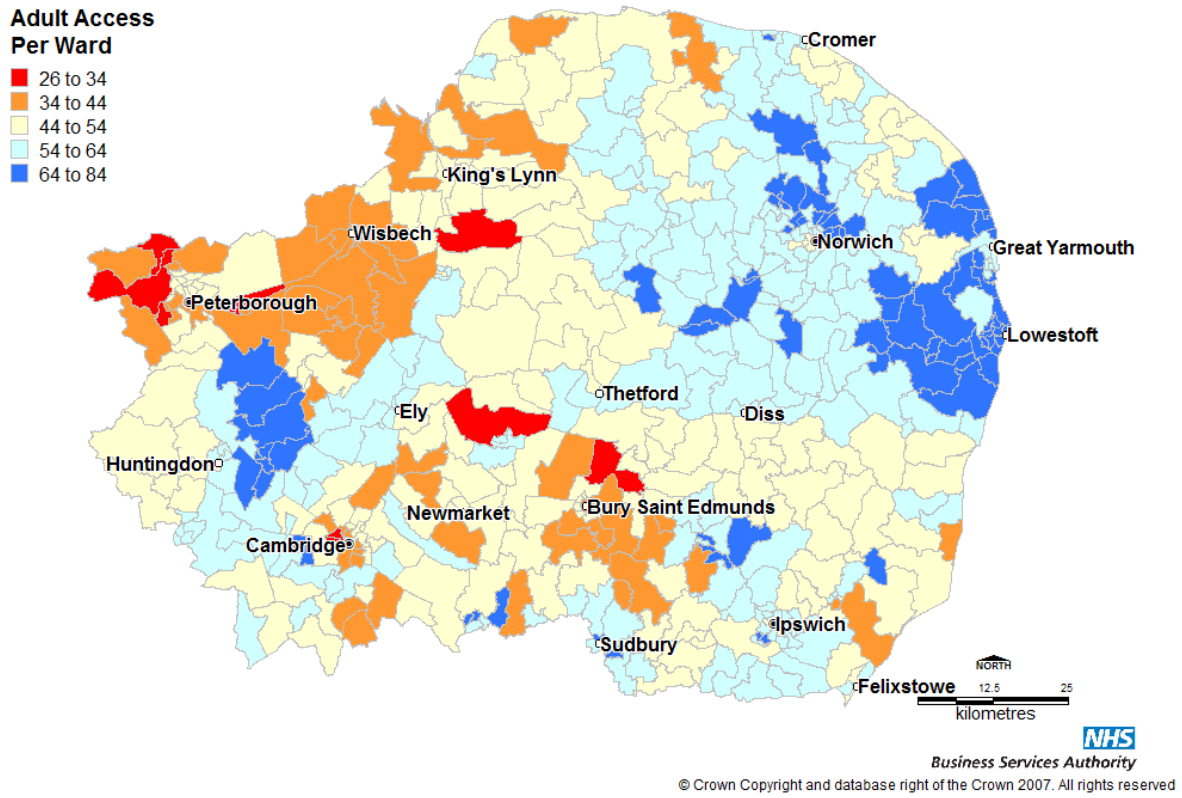
Overall the percentage of the adult population visiting an NHS dentist within the last 24 months has not changed and remains stable at 54.2%. A visit to the dentist also provides the opportunity to deliver evidence based preventive interventions such as oral hygiene and diet advice smoking cessation advice and scaling and polishing (DBOH).

Graph 21: Adult access rates by Local Authority in East Anglia March 2011-March 2014



The map below shows adult access rates by ward. Those shown in red (>60%) have the lowest access rates and this is mostly in Fenland, Forest Heath, Kings Lynn and West Norfolk, parts of Peterborough and the North Norfolk coast.

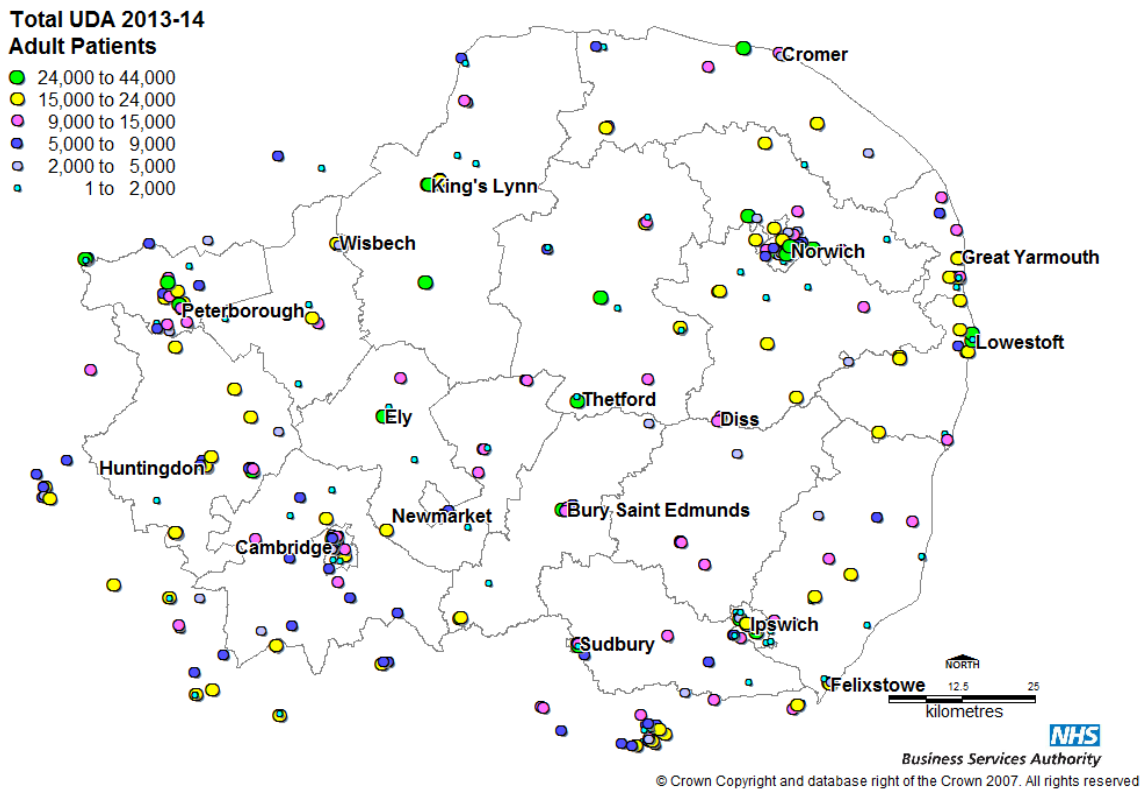
Map 6 : Access rate resident adult patients in east Anglia (24 months to March 2014)



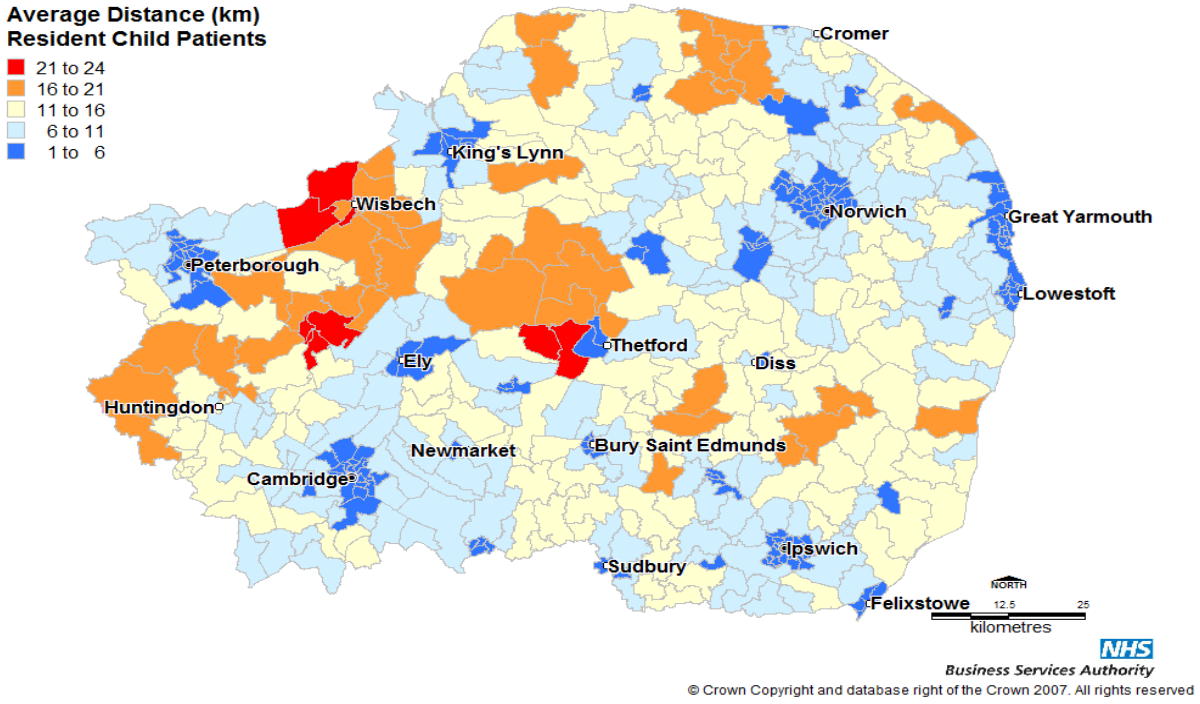
9.10 Treatment locations and distance travelled for adult patients

Most dental services are located in the towns and cities in Peterborough, Norwich, Cambridge and Ipswich. The Maps below show the treatment locations for adult patients in East Anglia by the number of Units of Dental Activity (UOAs) 2013 -2014 and the distance travelled by those patients to access dental care.

Map 7: Treatment locations for adult patients in East Anglia by the number of Units of Dental Activity (UOAs) 2013 -2014.



Map 8: Average distance travelled by resident Adult patients in East Anglia 2013/2014



Again, as in children access is lowest when adults have to travel furthest to visit a dentist. Again patients from areas such as Forest Heath, Kings Lynn and West Norfolk, Fenland, Thetford North Norfolk and Suffolk Coastal are affected

9.11 Dental treatment provided for adults living in East Anglia

52.3% of adults who visit a dentist receive a Band 1 course of treatment. This may include an examination, diagnosis (including X rays), advice on how to prevent future problems, a scale and polish and application of fluoride varnish or fissure sealant. 29.5% receive a Band 2 course of treatment which may include everything in a band 1 plus any further treatment such as fillings, root canal work or removal of teeth. A further 5.6% receive a band 3 course of treatment which may include all of the above plus crowns, denture and bridges.

Across all ages the examination rate was approximately 80%. This seems low as an examination should be an integral part of any course of treatment. Around 25% received fillings and about 6% extractions. Around half were provided with a scale and polish. Very few had crowns (2.0%), bridges (0.2%), root fillings (2.0%) and dentures (0.1%)

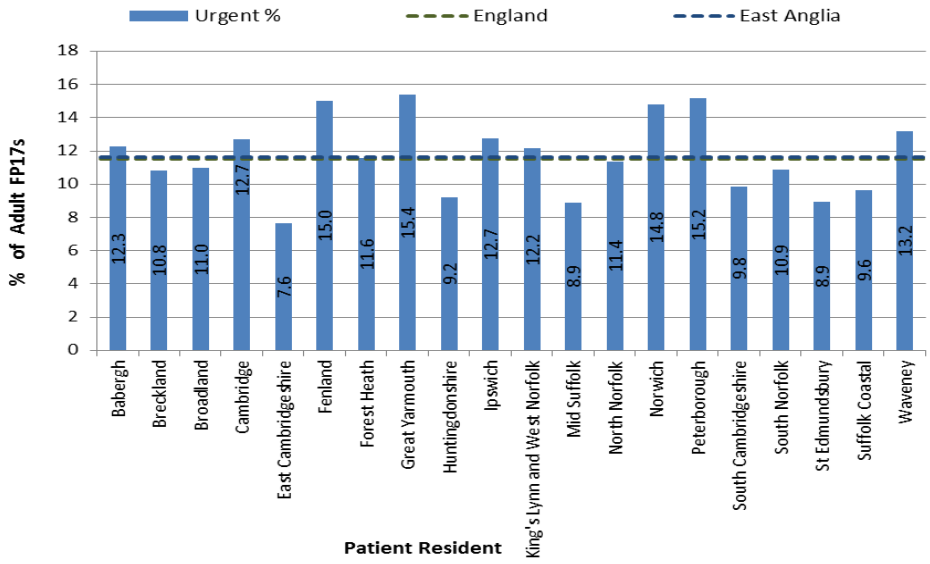
9.12 Access to urgent dental care

Access to urgent care is a priority for the relief of pain and for accidental damage. One in four, (26%), of the adult population in the East of England report that they only go to the dentist when they have problem. (ADHS 2009). Just under half the population in East Anglia (45.8%) has not visited the dentist in the last two years and may not have a regular dentist when they have a problem.

Patients' use of urgent care services is more complex than just a failure to access preventive or routine care and a range of services should be available to meet the needs of patients who choose to access dental services in different ways

Figure 4 shows the percentage of courses of treatment that were recorded as urgent treatment and compares this with national levels.

Figure 4: Percentage of claim forms (FP17s) that were for Band I urgent courses of treatment for adults March 2014.



Source: BSA Dental Public Health Report June 2014. R. Wise

Levels for urgent care are highest in Fenland (5,466 claims), Great Yarmouth (10,078 claims), Ipswich (8,730), Kings Lynn and West Norfolk (8,434), Norwich (11,148), Peterborough (10,026) and Waveney (10,933). All of these are higher than the national average. Higher levels of urgent care can indicate an issue with the quality of diagnosis and treatment planning, patients not able to access routine dentistry or patient choice. Dental Access Centres (DAC) in Wisbech, Cambridge, Kings Lynn and Norwich provide only access to urgent care and this may have skewed the data.

Research indicates that DACs are offering treatment to a different population of patients from that seen in neighbouring 'high street' practices. Patients attending DACs were younger and from a more disadvantaged background. They had worse oral health, experienced more frequent episodes of dental pain, were more likely to be dentally anxious and had different attitudes to dental health than their 'high street ' counterparts'[83]. It is important that access to urgent care is offered to patients when they need it and to enable different sectors of the population to access dental services in different ways.

9.13 Access to out of hours dental care

From April 2006 the provision of out of hours (OOH) dental care became the responsibility of the Primary Care Trusts. From April 2013 this responsibility was transferred to NHSE and the Area Teams.

Out of hours dental services across East Anglia are provided by a number of different providers including local general dental practitioners and salaried dental services. The opening hours vary and in some areas are only accessible at weekends and bank holidays. Acceptance and triage criteria vary across the patch and in some instances telephone only advice is available. There is no evidence that the provision of these services is related to need .Data collection on service use is not consistent across the area. Some patients may choose to attend Accident and Emergency services in local hospitals or use the primary medical care out of hours services and information about this is not routinely collected or reported. Information about out of hours dental services is poor and this will impact on future commissioning of these services

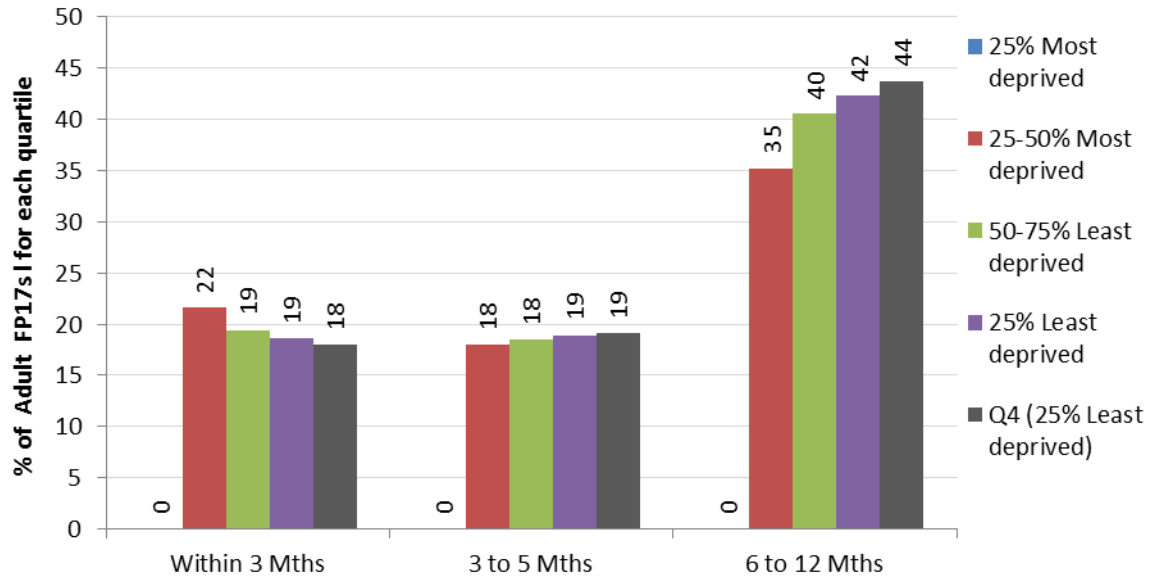
9.14 Re-attendance rates for adults and children

Re-attendance patterns are based on the length of time between re-attending at an NHS dentist for patients resident in the area. NICE guidelines recommend that the recall interval should be appropriate to the level of risk of dental disease for each patient. For adults and children the recommendations are that the shortest interval (exceptionally) should be 3 months. The longest should be 12 months for children and 24 months for adults, where there is no sign or risk of dental disease in the patient. If guidelines were being followed then a relatively small proportion of treatments would be expected to be within 3 months of a previous course of treatment.

The chart below shows the proportion of total courses of treatment by re-attendance intervals under a year for adult patients resident in the area by the relative deprivation of the patients' resident area, defined as before using by IMD National Quartiles.

A high proportion of re-attendance interval within 3 months could signify greater dental need whilst high levels in the 6-12 month interval may suggest that a significant number of patients and their dentists are continuing with the long established pattern of twice yearly dental attendance, it is feasible for some patients that such an attendance pattern is required, but for others a longer recall may be appropriate. The pattern for children is similar.

Graph 22: Adult re-attendance intervals as a percentage of total courses of treatment 201/2014



9.15 Patient flow in and out for child and adult patients

Patient flow in details where the patients treated in an area reside. Significant numbers of patients from outside an area can limit access to services for residents. In East Anglia 97.7% of adults and 97.5% of children who live in East Anglia are treated in East Anglia.

Patient flow out details where patients living in an area have received their dental treatment. Significant numbers of patients travelling outside may be an indication of poor quality or a lack of services in the area. Very few people, (2%) travel outside the area for treatment and this may be related to other factors for example where patients work.

9.16 Deprivation and access to dental services in children and adults

Socio-economic factors have often been cited as a crucial determinant in dental health. (Impacts of poor oral health, Department of Health Annual report 2007).

Table below shows the proportion of the child and adult population in East Anglia attending an NHS dentist by IMD quartile.

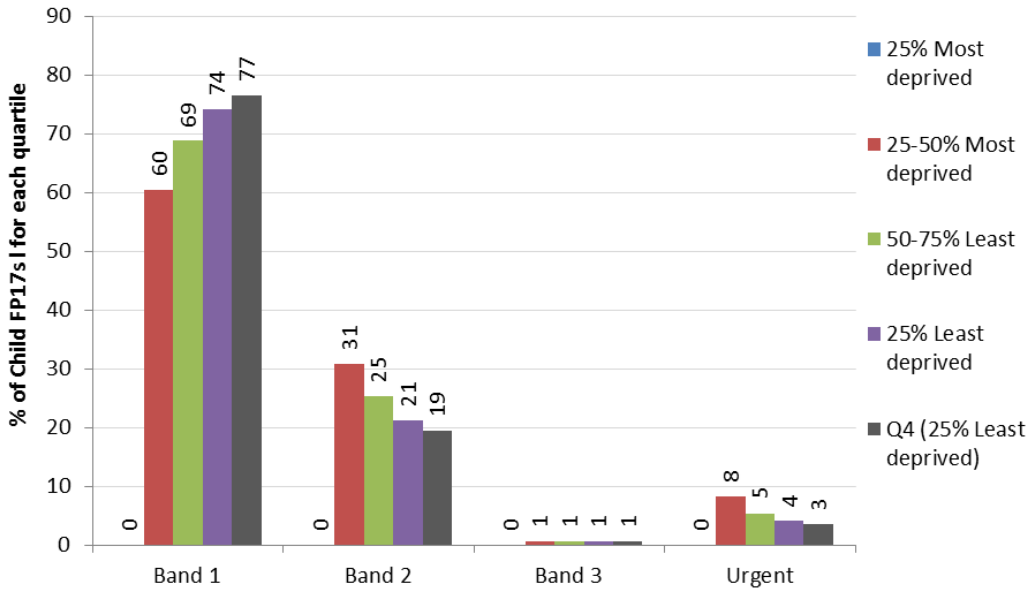
Table 16: Child and Adult Access rates by IMD quartiles

Quartile rank	Children		Adults	
	East Anglia	England	East Anglia	England
25% most deprived	64.4	67.5	52.6	53.3
25-50% most deprived	66.9	66.2	53.9	52.0
50-75% least deprived	69.0	71.1	54.4	51.0
25% least deprived	71.0	72.3	55.4	51.0

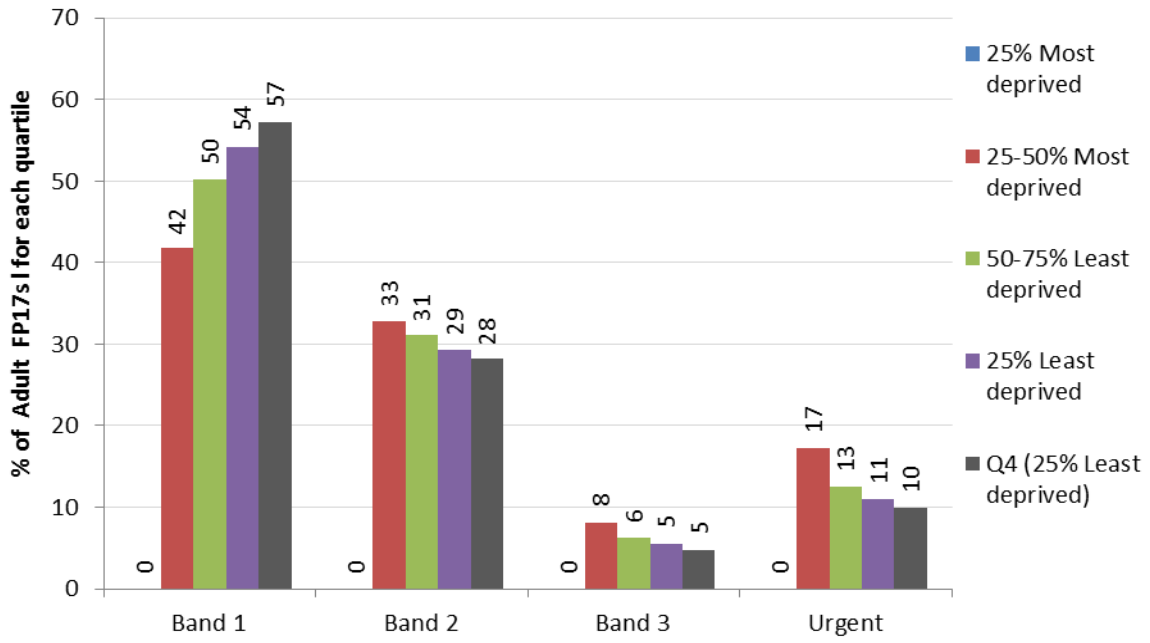
Source: NHSBSA Information Services (dental) Dental Public Health Report: East Anglia June 2014

Generally it is expected that Band 1 treatments are the most frequent courses of treatment provided. However the proportion that is made up of Band 1 treatments may differ depending on deprivation. In the most deprived areas, Band 1 treatments often account for a noticeably lower proportion than the overall proportion, with higher levels in each of the other treatment bands. An inference from this is that in more deprived areas there are higher levels of more serious treatment, reflecting increased dental need. In the least deprived areas, treatments involving check-ups and examinations reflect lesser needs. The graph below show the types of treatment provided by IMD quartile.

Graph 23: Treatment bands for child patients resident in East Anglia 2013/2014 as % of the total courses of treatment by IMD National Quartiles



Graph 24 : Treatment bands for adult patients resident in East Anglia 2013/2014 as % of the total courses of treatment by IMD National Quartiles



9.17 Access to specialist services in primary care

9.17.1 Access to salaried dental services

The salaried dental services traditionally provide a number of specialist services. These include;

Oral health promotion, the key strategic features include links to other health promotion programme delivery to maximise impact through common risk factor approaches and programmes are targetted to reduce inequalities.

Clinical Treatment the key strategic features include provision of services, complementary to those available in 'high street 'dental practices, offering routine care for people unlikely to be successful in obtaining necessary routine care in such practices, as a provider of services requiring specialised facilities or expertise and a provider of safety net services to the general population.

Dental inspection (screening) of school age children the key strategic features include Screening for disease without mechanisms to ensure provision of follow-up treatment when needed has no health benefit.

Epidemiological Fieldwork is still a formal requirements under formal regulations the key strategic features include calibrated/trained examiners are needed and links to national programme leads required for data analysis and reporting.

Teaching and Training the key strategic features include a need to ensure quality of service maintained by existing staff and ensuring continuing availability of appropriately trained dental workforce in the future.

More detail on these functions is attached at **Annex 1**

9.17.2 Access to domiciliary dental services

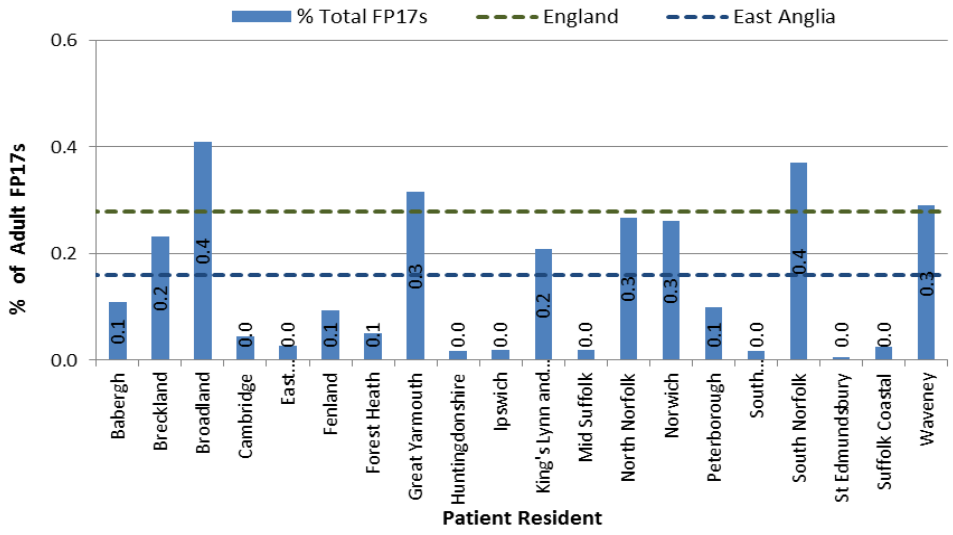
Domiciliary dental care can be the only care available to patients who are housebound. Poor access to timely domiciliary services has the potential to further increase oral health inequalities in the most vulnerable groups of patients particularly elderly people and those suffering from dementia. (Borreani E et al – ref 80) A lack of preventive interventions increases the risk of poor oral health and dental pain and infection, which when left untreated, is likely to affect the ability to eat and speak. There is a clear and consistent relationship between good oral health, the retention of natural teeth and a healthy diet and good nutrition especially in older people. (Gerodontology 2005)

Domiciliary visits undertaken in East Anglia included an examination,(64.4%). provision of a denture(12%), extractions (6%) and permanent fillings (11%). Most visits, (72%) are provided for people who are seventy five years and over.
The level of service across East Anglia varied and was not associated with age, level of deprivation or level of disability across the population graph 25.

Areas with the highest level of deprivation, for example East Cambridgeshire, Fenland and Ipswich had little or no service provision.

In 2011 Suffolk had the second highest number of people over the age of 75 years and yet Ipswich, South Suffolk and Suffolk Coastal had little or no service provision (Peterborough 12,288, Cambridgeshire 47,549, Suffolk 70,260, Norfolk 89,669). (ONS). Figure 5 and Table W

Graph 25: Percentage of adult FP17s by local authority with a domiciliary visit for patients resident in East Anglia 2013/2014



Source: BSA Dental Public Health Report June 2014. R. Wise

The percentages for domiciliary visits in Broadland, Great Yarmouth and South Norfolk were higher than the national average and much higher than the average for East Anglia.

There are marked discrepancies across East Anglia and eight districts had almost no services at all Table W. No information is available about the quality of the service and because referral criteria vary across East Anglia there is no information about whether patients who have the most need of this service are able to access it. This variation is of concern.

In future there may be greater demand for these services as population projections from the Office for National Statistics indicate that by 2021 the population of adults over 75 years living in East Anglia is likely to increase by about 30% (source: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Subnational+population=Projections#t) (KITS PHE)

Table 17: number of courses of treatment provided as domiciliary services 2013-2014

Lower tier LA	Total claims with domiciliary
Babergh	52
Breckland	176
Broadland	352
Cambridge	20
East Cambs	12
Fenland	34
Forest Heath	15
Great Yarmouth	206
Huntingdonshire	19
Ipswich	13
Kings Lynn and West Norfolk	144
Mid Suffolk	9
North Norfolk	171
Norwich	197
Peterborough	65
South Cambs	12
South Norfolk	298
St Edmundsbury	3
Suffolk Coastal	17
Waveney	240

Source: NHSBSA Information Services (dental) Dental Public Health Report June 2014. R. Wise

9.17.3 Access to anxiety management services

In East Anglia 232,796 (12%) of the adult population (19 years and above), (ONS 2011), is likely to suffer from dental phobia and avoid dental care as a result. (ADHS 2009)
The ADHS 2009 also found that the proportion of adults with extreme dental anxiety varies by socioeconomic occupation of the household and is higher in adults from

routine and manual occupation households (15%) than professional and managerial occupation households (10%)

The provision of adequate anxiety control is an integral part of the practice of dentistry. Child dental anxiety, for example, is widespread and many anxious children, and adults, can be satisfactorily treated using behaviour management techniques.

Dental anxiety is a potential barrier to those seeking dental care and its association with oral health is of central importance. [79] There is a continuum of dental anxiety ranging from those who feel relaxed during dental treatment to those who are dentally anxious but cope, through to those who are dentally phobic and avoid care [81] [82] In the 2009 ADHS dental anxiety was assessed by the Modified Dental Anxiety Scale (MDAS)[100] Using this scale 12% of the adult population had a score of 19 or more suggesting extreme anxiety.
http://medicine.st-andrews.ac.uk/supplemental/humphris/MDASscale.pdf

Adequate provision of anxiety management services, including behaviour management and sedation techniques is important in reducing barriers to accessing dental care as well as reducing the health inequalities associated with deprivation.

9.17.4 Sedation services as an adjunct to dental services.

Some patients will have reasons, other than anxiety, to have need of sedation to complete dental treatment for example to manage the pain and discomfort of surgical dentistry where local analgesia alone is not adequate or effective. Certain groups of patients for example those with learning or physical disabilities such as cerebral palsy benefit from the provision of sedation services.

When sedation services are offered the quality of the clinical dental care provided in these situations must be excellent to minimise the risk of repeat procedures.

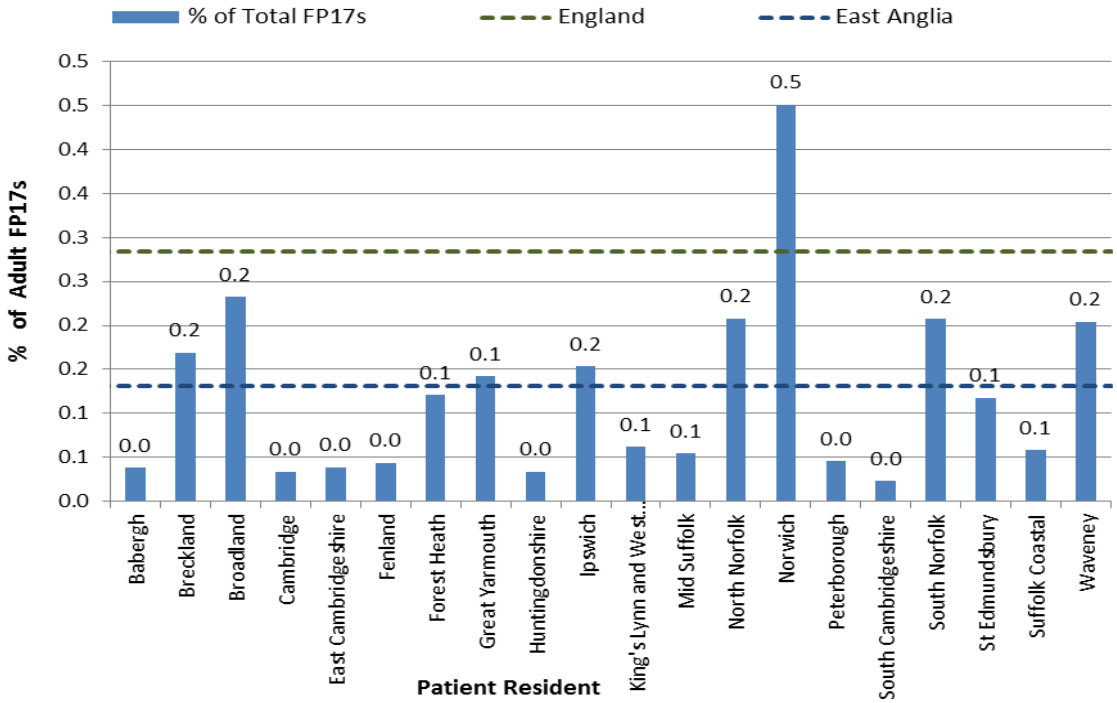
Seven per cent of courses of treatment including sedation are provided for children up to the age of five years Most (61%) are provided for children between the ages of six and twelve years and are mostly for fillings (42%) and extractions (67%).

9.17.5 Access to sedation services for adults in East Anglia

Only 0.1 % of adults who attend for NHS dental treatment in East Anglia receive sedation as part of that course of treatment. Most of the care provided under these arrangements is for extractions, (71%), or fillings (44.5%). Nearly half of the patients, (49%) are aged 25 to 44 years.

Provision across the area shows a great deal of variation and this may reflect ease of access to NHS services rather than patient need. It is not known how many patients may visit private providers to use these services.

Graph 26: Percentage of adult courses of treatment by Local Authority with sedation for patients resident in East Anglia 2013/2014



Source: NHSBSA Information Services (dental) Dental Public Health Report June 2014. R. Wise

Patients in seven districts have almost no access to sedation services and this is unlikely to be related to need. Areas with higher deprivation and consequently higher need and higher anxiety levels such as Fenland, East Cambridgeshire, Peterborough, have very limited access to sedation services and this is of concern

Table 18: Number of courses of treatment provided by Lower Tier Authority in East Anglia including sedation services 2013/2014

Lower tier LA	Total claims with sedation	
	Adults	Child
Babergh	18	-
Breckland	128	1
Broadland	200	5
Cambridge	15	-
East Cambs	17	-
Fenland	16	-
Forest Heath	36	-
Great Yarmouth	93	28
Huntingdonshire	38	-
Ipswich	105	-
Kings Lynn and West Norfolk	43	1
Mid Suffolk	27	-
North Norfolk	133	-
Norwich	340	-
Peterborough	30	-
South Cambs	17	1
South Norfolk	167	2
St Edmundsbury	60	1
Suffolk Coastal	39	3
Waveney	169	-

Source: NHSBSA Information Services (dental) Dental Public Health Report June 2014. R. Wise

9.17.6 Access to Primary Care Minor Oral Surgery Services in East Anglia

Despite the promising reports from the 2009 adult health survey of improving dental health, recent data has demonstrated a trend for an increasing demand for extractions, possibly related to less complex care being offered in primary care by GDPs due to the current General Dental Services contract, which will hopefully be rectified by the currently trialled dental contract[84] . The population is ageing and may provide a singular challenge with regard to increasing difficulty of surgery and increased pathology[85] . These patients are also likely to be more medically complex. Furthermore, research from 2012 highlighted the increasing age of patients undergoing third molar removal, probably due to the introduction of surgical guidelines instituted by the National Institute for Clinical Excellence (NICE) between 1997 and 2000.[86]

Cambridgeshire

Minor Oral Surgery services have been operating in Dental Access Centres in Cambridgeshire and Peterborough since April 2006 and more recently in Wisbech and Huntingdon. These are provided by dentists who are on the GDC specialist list for oral surgery or dentists who were recognised by the former PCTs to have a special interest (Dwsi). This service provides a range of Minor Oral Surgery procedures, including routine extractions, surgical extractions and apicectomies, and accepts referrals directly from local dentists. The primary care services also provide a clinical triage process with on- ward referral to secondary care services where appropriate. These services are currently provided by Cambridgeshire Community Services (CCS) and Oasis in Peterborough.

A service review was carried out in March 2013 to look at patient pathways. The document can be viewed in full but the main findings are detailed below.

Table 25 below shows the breakdown of the total number of patients accepted for treatment by CCS Primary Care MOS service between April 2012 - Jan 2013, after the initial paper triage assessment. This is essentially the number of “please contact” letters that are sent out to patients.

Between April 2012 - Jan 2013, 14.3% of patients failed to respond to the initial contact letter, and after 6 weeks were discharged back to the referring GDP. 6.3% of patients then fail to attend their scheduled appointment for assessment and likely treatment.

Table 19: Total number of patients accepted for treatment to PCMOSS April 2012 - Jan 2013

Centre	Number of patients
Brookfields	1900
Huntingdon	1148
Wisbech	390
Total	**3438**

Table 20 demonstrates the complexity of treatment undertaken. Non-surgical treatment includes extractions that require simple elevation. Surgical procedures include any extraction involving raising a flap, bone removal and/or suture placement; apicectomies; OAC closure; and frenectomies. From the table below it is evident that the vast majority of treatment undertaken is non-surgical in nature.

Table 20: Total number of patients treated by PCMOSS April 2012 - Jan 2013

	Non surgical	surgical	Total
Cambridge	970	533	1503
Huntingdon	860	236	1096
Wisbech	213	20	233
Total	**2043**	**789**	**2832**

Peterborough

In the same time period the MOS service provide by Oasis in Peterborough received 1885 referrals and accepted 989 for treatment. 108 referrals were referred on to secondary care. The failure rate for patients was approximately seven per cent.

Overall a service review completed in July 2013 found that patients were being treated in an appropriate setting either in primary or secondary care. Areas of good practice were identified and these should be taken forward in any new commissioning arrangements. These include strategies for reducing the failure rate, up-skilling referring GDPs and managing referrals that are inappropriately sent directly to secondary care. Challenges still remain however including reducing the number of inappropriate referrals, inconsistent data recording and improving the quality or referrals particularly the quality of radiographs.

Suffolk

A minor oral surgery service is also in operation in Suffolk using a central Referral Management Service (RMS) commissioned from CCS. Referrals that meet the acceptance criteria are referred on to a number of Any Qualified Providers or secondary care. A review of this service in being undertaken currently and results are expected in 2014.

Norfolk

Norfolk also operates a RMS and patients are referred to a number of specialist providers. Information from 2010-2013 oral health needs assessment suggested that the service receives approximately 1,300 referrals a year. A third of these were referred on to secondary care and the remainder to specialist providers. The annual spend is around £514,000.

No other information in minor oral surgery services in primary care in Norfolk and Suffolk has been supplied.

9.17.7 Future commissioning of oral surgery services

Patients should be treated in the most appropriate setting, it is important that there is collaboration between GDPs, primary care MOS units OMFS departments in hospitals and commissioning organisations to allow effective patient pathways to develop. It is also important that there are clear acceptance criteria for each stage of the pathway as well as an availability of suitably trained staff, appropriate treatment tariffs and longevity of commissioned contracts.

It is likely that in the future oral surgery procedures will be classified according to complexity into 3 levels. The expectation is that level 1 procedures will be carried out by GDPs under mandatory services and that treatment in levels 2 and 3 will be undertaken by practitioners with more specialised skills.

A single operating model framework for the commissioning or oral surgery services is expected from NHS England detailing a MOS patient pathway. Any future commissioning will need to follow these standard operating policies.

9.17.8 Access to Orthodontic Primary Care Services in East Anglia

A review of orthodontic services across East Anglia was undertaken in July 2014. This document, An orthodontic needs assessment and service review for East Anglia 2014, can be viewed separately.

In summary the main findings indicate that orthodontic provision across East Anglia is variable. In some areas such as Cambridge and Great Yarmouth and Waveney there appear to be areas of over commissioning orthodontic services while other areas such as Fenland, East Cambridgeshire, Kings Lynn and Thetford are more poorly served. At the same time the 12 year old population has fallen by approximately 1000 between 2008 and 2012. The majority of orthodontic services are provided under time limited personal dental services (PDS) contracts and this gives the Area Team opportunities to re-commission services to more appropriately meet the needs of the population.

9.17.9 Future commissioning or orthodontic services in primary care.

In November 2013 NHD England published Transitional commissioning of primary care orthodontic services- Single Operating Model. Gateway reference 00642. November 2013 and National guidance is expected in March 2015. Future commissioning of primary care orthodontic services will need to comply with these standard operating policies and procedures for primary care.

9.17.10 Dental treatment provided under general anaesthesia for children in East Anglia

Dental extractions, carried out under general anaesthesia (GA), in children with decayed teeth occur when all other interventions have failed.
Dental decay is almost entirely preventable and the causal relationship between sugar and dental decay is well understood.
The decision to use GA is complicated by the knowledge that there is a small but real risk of death associated with GA. The knowledge that the majority of operative care can be carried out using either local analgesia (LA) or LA with conscious

sedation sets dentistry aside from other paediatric surgical specialties where GA is the norm (Blain KM et al) (Shaw A et al). (Smallridge JA), (Holt R D et al)
Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012/13.[87]

Dental extractions carried out on children under the age of ten are most likely to be because of dental decay. Extractions for older children could also include teeth removed to relieve crowding as part of a course of orthodontic treatment. Approximately 0.1 to 0.6 per cent of the child population visit hospital to have dental extractions under general anaesthesia each year. These figures are likely to be an under estimate as any extractions carried out as part of a PDS salaried dental service contract may not be recorded.

Table 21 : Number of finished consultant episodes (FCEs) for children and adolescents aged 0-19 years in East Anglia admitted to hospital for extraction during 2012/ 2013

Lower tier LA	0-4	5-9	10-14	14-19	**Total 2012/13**	*Total 2011/12*
Babergh		28	16	19	**63**	*65*
Breckland			25	19	**44**	*41*
Broadland			15	12	**27**	*41*
Cambridge			14	10	**24**	*44*
East Cambs		6	21	9	**36**	*31*
Fenland	20	36	28	16	**100**	*107*
Forest Heath			10	10	**20**	*32*
Great Yarmouth	6		22	28	**46**	*66*
Huntingdonshire	23	62	57	32	**174**	*207*
Ipswich	29	115	46	24	**214**	*172*
Kings Lynn and West Norfolk		9	51	70	**130**	*125*
Mid Suffolk		9	19	14	**42**	*58*
North Norfolk			24	11	**35**	*39*
Norwich		9	26	14	**49**	*37*
Peterborough	11	19	39	30	**99**	*99*
South Cambs		12	42	17	**71**	*81*
South Norfolk			22	19	**41**	*53*
Suffolk Coastal		24	18	25	**75**	*97*
Waveney		8	29	27	**64**	*85*
Total	**89**	**337**	**524**	**406**	**1356**	***1480***

Source: http://www.nwph.net/dentalhealth/

The picture is complex. Increasing numbers of children undergoing dental extractions under general anaesthesia may not, in itself, reflect a growing burden of disease. Increasing provision and improved access to general dental services may increase the number of children referred on for the service who otherwise may not have received treatment.

The majority undergoing treatment under GA however are likely to be children living in deprived areas who suffer the poorest oral health and who are less likely to visit the dentist unless there is a problem.

Following the publication of A Conscious Decision: A review of the use of general anaesthesia and conscious sedation in primary dental care. Department of Health 1 July 2000. Gateway 21967 dental treatment can only be provided under GA in a hospital with a critical care facility For children living in rural areas without a family car and poor public transport accessing these services, especially in a timely manner, can be difficult. Any delay in the provision of care can result in pain, infection, sleepless nights and failure to thrive.

9.17.11 Access to specialist restorative services in primary care in East Anglia

At present there are no local restorative dental services provided in primary care in East Anglia. Until March 2013 Norfolk PCT commissioned a small amount of restorative services provided by local dentists who were prepared to accept referrals for patients requiring more complex care but who did not meet the acceptance criteria for the most complex level of care required by patients who would benefit from a multi- disciplinary approach offered by secondary care services. Treatment was generally carried out under the guidance of the consultant restorative dentistry at the NN&UH and followed a prescribed treatment plan. Triage to this service was carried out by the local dental practice adviser.

9.17.12 Access to prison dental services in East Anglia

Public Health England Anglia and Essex Centre has undertaken health needs assessments of all the prisons within the patch and this is likely to include an oral health needs assessment. This will be reported separately. A national survey, A survey of dental services in adult prisons in England and Wales July 2014 has been carried out by Public Health England Gateway 2013420 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/328177/A_survey_of_prison_dental_services_in_England_and_Wales_2014.pdfput in link.

9.18 Access to secondary care dental services

9.18.1 Secondary Care Dental Services in East Anglia

The principal hospital dental specialties are orthodontics and oro-maxillofacial surgery. Other specialties provided in hospital may include paedodontic and restorative dentistry. All referrals into secondary care are now subject to the 18-week rule. The Operating Framework for the NHS 2008-2009 has as one of its targets: Improving access through achievement of the 18-week referral to treatment pledge. These principles apply to pathways that involve or could potentially involve care led by a dental consultant. This includes oral surgery, orthodontics, paediatric dentistry, perodontics, prosthetics, endodontic oral medicine, and dental and maxillofacial radiology.

9.18.2 Oral and Maxillofacial Surgery Services (OMFS)

The OMFS department of Cambridge University Hospital NHS Foundation Trust Hospital, Peterborough City Hospital, NHS Foundation Trust Norfolk and Norwich University Hospital (N&NUH), James Paget, Queen Elizabeth Hospital Kings Lynn and Ipswich Hospital will see patients requiring more complex care mostly on referral, but also via the accident and emergency route. This includes reconstruction

of the mouth and jaws, oral cancer, treatment of patients with cleft lip and palate and facial trauma.

They also receive, mostly from local dentists, a significant number of referrals for more routine care including wisdom teeth removal and simple or surgical extractions of single or multiple teeth.

Although many treatments carried out are most appropriately provided in a hospital setting, a significant number could be offered in primary care either by local GDPs or in a specialist minor oral surgery service. In recent years services have been developed in primary care to meet this need.

9.18.3 Orthodontics Services

Most orthodontic treatment is provided in primary care. More complex cases, including cleft lip and palate, hypodontia and severe dental skeletal discrepancies are more appropriately treated in secondary care.

Hospital data collection is measured as outpatient visits and recorded only as first or subsequent appointments. This is unsatisfactory as it gives no indicators of the length or complexity of the treatment.

Training for orthodontic specialist is also carried out in secondary care.

9.18.4 Restorative Services

Consultants in restorative dentistry make up part of the multidisciplinary team in secondary care required to treat patients with the most complex problems. At present Addenbrookes NHS Foundation Trust Hospital and Peterborough City Hospital employ part time consultants for six and two sessions per week respectively. N&NUH is carrying a part time vacancy as there have been problems with recruitment.

There is a potential, where capacity exists, to use these specialist services to support local GDPs with advice and treatment planning. The ageing population and the increasing demands from this population for more complex restorative services to address the increasing problems of tooth wear may lead to an increased need for this type of support service.

Information about hospital procedures is limited and the only data available to the East Anglia Area Team are procedures carried out from April 2013

Table 22 shows a summary of all procedures carried out in all secondary care services from April 2013

Table 22: Procedures in all hospitals April 2013-September 2013

	April	May	June	July	August	September	**Total**
Dental medicine specialities	27	35	39	24	24	25	**174**
Maxillo-	534	12	16	352	340	473	**1727**

facial surgery							
Oral surgery	3012	2969	2771	3365	3212	3267	**18596**
orthodontics	1720	1189	1211	1745	1503	1714	**9082**
Paediatric dentistry	14	28	21	25	10	17	**115**
restorative	201	178	180	201	143	168	**1071**
Total	**5522**	**4423**	**4249**	**5726**	**5244**	**5674**	**30,838**

Under patient choice arrangements patients are able to choose where they wish to access secondary care services. The main providers of dental secondary care services are still the local hospitals in the three counties. Table 23 shows the number of out- patient procedures carried out from April to September 2013 by provider.

Table 23: All dental specialities outpatient procedures by secondary care provider April-September 2013

	April	May	June	July	August	September	**Total**
Cambridge University Hospital	1426			1033	85	1303	**4,618**
Ipswich	1188	1462	1467	1469	1443	1410	**8,439**
N&NUH	1264	1229	1158	1378	1286	1215	**7,330**
Peterborough & Stamford Hospital	732	753	737	815	779	815	**4,631**
Queen Elizabeth	564	617	515	636	579	629	**3,537**
UCL London	139	141	143	144	137	140	**844**
Other	209	221	229	251	935	165	**2010**
Total	**5,522**	**4,423**	**4,249**	**5,726**	**5,244**	**5,674**	**30,838**

The majority of out- patient procedures for the dental secondary care specialities are coded as oral surgery procedures. From April to September 2013 18,596 were coded as oral surgery procedures although the detail of what the intervention was for the vast majority appears to be blank. Table 24 summarises a selection of the most common procedures carried out in secondary care.

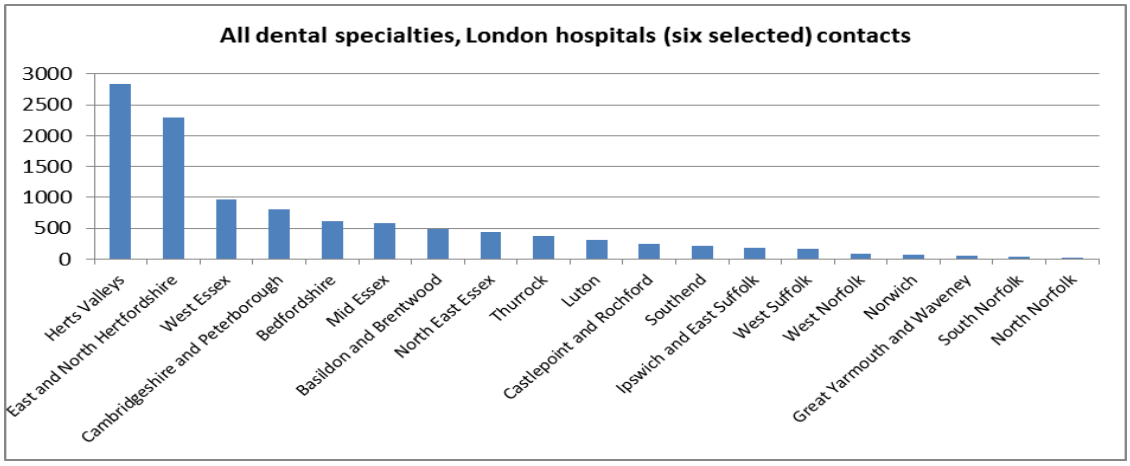
Table 24: Summary of the most commonly recorded reasons for an oral surgery procedure in secondary care April-September 2013

Procedure	**Number**
Surgical removal of impacted wisdom tooth	14
Extraction of multiple teeth	162
Surgical removal of retained root	19
Surgical removal of tooth	181
Surgical removal of non- impacted wisdom tooth	33
Blank	15,767
Total	**18,596**

9.19 Tertiary Care

Patient across East Anglia are also referred to the London dental hospitals either as a tertiary referral from the local secondary care providers for more specialist care or directly by local GDPs for patients who may benefit from specialist restorative care. This service is provided on referral to Guys and Thomas Hospital and the Eastman Dental Hospital where the AT now holds contracts. Data about referral and treatment patterns within these services is not readily available and patient pathways appear unclear and ill defined. The following figure, 29 -33 show the number of contacts seen by the six main London dental hospitals by CCG compared to the rest of the East of England and figure 29 shows the distribution across the specialities. Relatively few patients from the eight East Anglia CCGs receive care from the London dental hospitals.

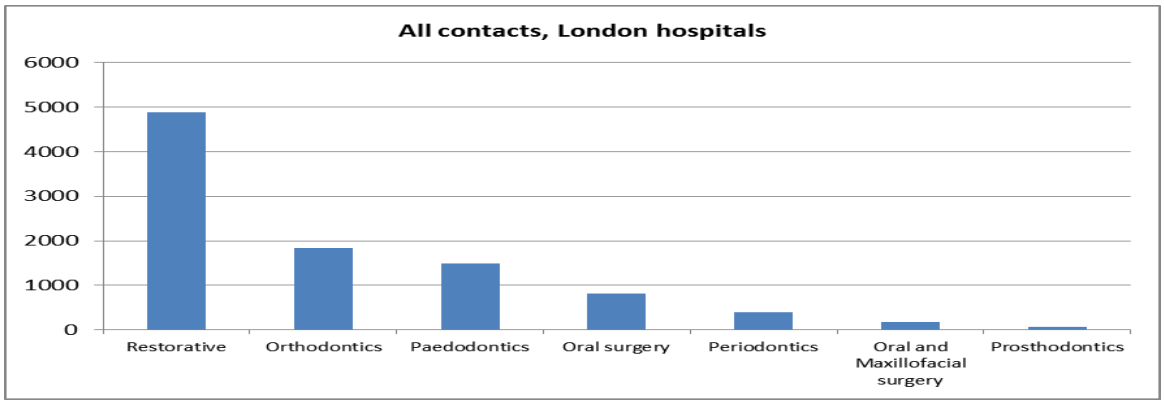
Graph 27: Number of contacts by East of England CCG for London dental hospitals April – September 2013



Source : The information is taken from a spread sheet listing all contacts by residents of CCGs in Anglia, Essex and Herts & South Midlands with secondary care dental specialties is created monthly by the North and East Commissioning Support Unit. Data from April to September 2013 has been used. Data before April 2013 is not available to the CSU.

The main specialities that patients are referred for are restorative dentistry, orthodontics, paedodontics, oral surgery, maxillofacial surgery, periodontics and prosthodonics. The vast majority of patients that are referred and accepted are for restorative dentistry but the numbers from the eight East Anglia CCGs are small.

Figure 30: All contacts at London dental hospitals by speciality April-September 2013



10 Preventive Interventions

10.1 Dental public health programmes

Dental public health programmes, which are the responsibility of local authorities, should be commissioned following strategic planning. Guidance for local authorities is available from *Local authorities improving oral health: commissioning better oral health for children and young people, An evidence-informed toolkit for Local Authorities.* June 2014, PHE gateway number 2014147 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321503/CBOHMaindocumentJUNE2014.pdf
Other guidance is currently in preparation through NICE and is expected in November 2014. There is good evidence that in addition to place-based generic health improvement activities, which will address some of the common risk factors for dental decay, strategies to increase the exposure to fluoride are effective.

10.2 Fluoride delivery

10.2.1 Water Fluoridation

Water fluoridation is defined as "the controlled adjustment of a fluoride compound to a public water supply in order to bring the fluoride ion concentration up to a level which effectively prevents caries".[56] The optimal concentration in temperate climates is 1 part per million (ppm). Approximately 10% of the UK population (6 million people) are currently receiving water with a fluoride content adjusted to the optimal level (including naturally and artificially fluoridated areas). The water supply to East Anglia is not artificially fluoridated and the naturally occurring level is around 0.3 to 0/7ppm.[88]

The best available evidence suggests that the fluoridation of drinking water reduces the prevalence of caries, both in terms of the proportion of children who are caries free and by the mean change in dmft. There is also evidence to suggest that water fluoridation reduces the severity of caries (as measured by dmft) across social groups and between geographical locations.[89] Research has shown that socially deprived areas benefit more from fluoridation.[90] Water fluoridation is consequently one of the few public health interventions that directly reduce health inequalities.

Following a local oral health needs assessment PCTs, before April 2013 and now the Local Authorities may elect to fluoridate their water supply in order to reduce oral health inequalities. Until recently, water companies have had the right to refuse to fluoridate, which has limited the number of people in the UK receiving fluoridated water. This changed with the Water Act 2003, which gave Strategic Health Authorities (SHAs) and now Local Authorities the authority to make this decision, following a public consultation. Public opinion has not been formally tested in East Anglia.

In the recently published best practice guidance on Fluoridation of Drinking Water Gateway 9361, the Department of Health states that water fluoridation schemes would ideally 'serve precisely only the high-need target population' where the prevalence of disease is high,[Error! Bookmark not defined.] although it is likely that any

scheme will also serve some areas with low decay levels. A further consideration is that any feasible scheme may cross AT, and LA and regional boundaries necessitating a joint consultation process.

PHE has a national lead for water fluoridation and any feasibility study proposed in East Anglia would be led by PHE.

PHE, on behalf of the secretary of state for health, is required to monitor the effects of water fluoridation schemes on the health of people living in the areas covered, and to produce reports at no greater than four yearly intervals. In March 2014 PHE published Water Fluoridation, health monitoring report for England 2014, gateway number 2013547. The main findings of the report were that, on average, there are 15 per cent fewer five year olds with tooth decay in fluoridated areas than non-fluoridated areas and 11 per cent fewer 12 year olds with tooth decay. When deprivation and ethnicity are taken into account (both important factors for dental health) 28 per cent of five year olds and 21 per cent of 12 year olds have tooth decay in fluoridated areas than non- fluoridated areas.

In fluoridated areas there are 45 per cent fewer hospital admissions of children aged one to four for dental caries (mostly extraction of decayed teeth under a general anaesthetic) than in non- fluoridated areas.

Dental fluorosis (mottles or flecks on teeth caused by fluoride) has been found to be higher in fluoridated areas than non -fluoridated areas but the difference, one per cent, is low.

Other non-dental health indicators were examined, such as hip fractures, bladder cancer, osteosarcoma and Down's syndrome and there was no evidence of increased harm associated with water fluoridation. The report provides further reassurance that water fluoridation is a safe and effective public health measure.

10.2.2 Targeted community based fluoride varnish programmes

These schemes involver the application of fluoride varnish to children's teeth carried out by dental personnel outside dental practices. There is strong evidence of effectiveness. These programmes can have a positive impact on inequalities if high risk populations are targeted. [91] [92] [93]

10.2.3 Targeted provision of toothbrushes and fluoride toothpaste and supervised tooth brushing programmes established in targeted childhood settings

The effectiveness and benefit of fluoride toothpaste is firmly established. These schemes rely on targeted and timely provision of free toothbrushes and toothpaste either through health visitors, schools or postal schemes. The success of brushing programmes will rely on co-operation with parents, schools and early years settings.[94]

10.2.4 Other targeted fluoride delivery programmes

Commissioning better oral health (CBOH) found that fluoride rinsing programmes, provision of fluoridated milk schemes in schools and community based fissure sealant programmes were of limited value.

10.3 Training of health care and other professionals

The document Commissioning Better Oral Health recommends oral health training for the wider health, social care and education workforce, based on capacity building (i.e. increasing the knowledge and skills of others) to support oral health improvement in their daily role. Oral health should also be integrated into targeted home visits by health and social workers. There is little evidence to support one off dental health education by the dental workforce to the general population. It is short term in nature and improvements are unlikely to be sustained in the longer term.

10.4 Practice based oral health improvement interventions

Delivering better oral health- an evidence based toolkit for prevention was first published in 2007. The third edition was published June 2014, PHE gateway number: 2014126.
https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention
This practice based toolkit puts a greater emphasis on prevention of ill-health and reduction of inequalities of health by the giving of advice, provision of support to change behaviour and application of evidence-informed actions. It is important that the whole dental team, as well as other healthcare workers, give consistent messages and that those messages are up to date and correct. Recent thinking suggests that all patients should be given the benefit of advice and support to change behaviour regarding their general and dental health, not just those thought to be 'at risk'. Delivering better oral health lists the advice and actions that should be provided for all patients to maintain good oral health. For those patients about whom there are greater concern (e.g., those with medical conditions, those with evidence of active disease and those for whom the provision of reparative care is problematic) there is guidance about increasing the intensity of generally applied actions.

10.5 Improving oral health through the common risk factor approach (CRFA)

Diet

Improving diets in the population and the promotion of consistent nutritional messages about making healthy choices has the potential to improve oral health by reducing the amount and frequency of sugar consumption as well as reduce obesity. Sugar Reduction-responding to the challenge June 2014 PHE Gateway number 2014155 details the problems with eating sugar and says that diet and obesity related diseases including cardiovascular disease and some cancers cost the NHS at least 11 billion pounds per year.
https://www.gov.uk/government/publications/sugar-reduction-responding-to-the-challenge

Smoking and Tobacco use- Preventive interventions

There is a close relationship between, periodontal disease and oral cancer and smoking. The Department of Health published *Smokefree and Smiling*: *helping dental patients to quit tobacco'* as part of their on-going campaign to involve dental teams in supporting people to stop using tobacco.[95] This guidance had been updated 12th March 2014.

Public health policies and legislation such as banning smoking in public places, warnings on tobacco products and the ban on advertising products have all been introduced in an attempt to reduce smoking. Smokeless tobacco such as areca nuts betel quid and oral snuff has been found to independently increase the risk of oesophageal cancer. Recommendations to decrease their use focus on the provision of brief advice and training for health practitioners.

Alcohol-Preventive interventions

Oral health promotion strategies should include joint working with other partners such as local authorities, the police and owners of licensed premises in known flashpoints. Since the 2003 Licensing Act consideration can now be given to the awarding of alcohol licences and this responsibility now rests with the local authority. Other preventive measures such as replacing glass bottles and glasses with safe non glass materials such as plastic or polycarbonate material should be encouraged and this can now be a condition of the licence.(Warburton A, Shepherd J. P. Effectiveness of toughened glass in terms of reducing injury in bars: a randomised controlled trial, Injury prevention Vol 6, pp36-40 2000) (Rickinson, B and Preston, S Materials for Drinking Glasses, A short test programme with one pint glasses, Executive Summary London IOM3 March 2009) Local data from hospitals and the police should continue to be collated to help identify problem areas.

As well as local policies brief interventions around alcohol use following NICE guidance have also been demonstrated to be effective in modifying future behaviour. These can be delivered by hospital staff, both with the victim and the assailant, at the time of treatment and from other health care professionals in different settings. http://pathways.nice.org.uk/pathways/alcohol-use-disorders/brief-interventions-for-alcohol-use-disorders)

HPV vaccinations

Oral cancers associated with the human papilloma virus (HPV) are increasing in cadence in anew population. Between 1990 and 2008 there was an increase of 160% in males and 110% in females. Since 2008 all girls aged 12-13 years in the UK are offered the HPV vaccine. It is effective for eight years or more. The US and Australia offers the vaccine to both sexes.

Prevention of injury

CBOH indicates that the use of mouth guards during contact sports can reduce the risk of injuries. There are clear individual benefits although it is limited as population measure. Commissioning arrangements would need to be in place in NHS England to support widespread use otherwise there is the potential to increase inequalities as mouth guards may be in greater use in more affluent population groups. There should be additional complementary action to create safe environments.

11 Public Voice

11.1 National Surveys

11.1.1 Dentistry Watch

In 2007, the Commission for Patient and public involvement in Health conducted a national survey to find out what patients really think about NHS dental services. The resulting *Dentistry Watch* report was published in October 2007[96].

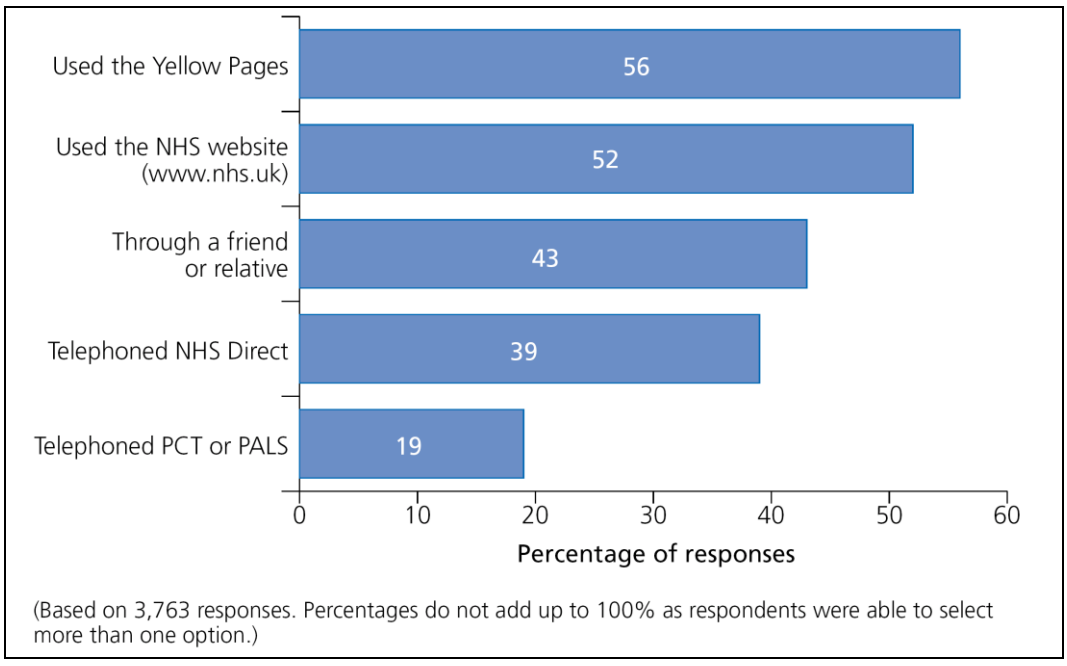
The main findings of this survey were as follows:[96]

- 93% of NHS patients are happy with the treatment they receive.
- Almost a fifth of patients have gone without treatment because of the cost.
- Almost half of all NHS patients do not understand NHS dental charges.
- 78% of patients using private dental services are doing so because either their dentist stopped treating NHS patients (49%), or because they could not find an NHS dentist (29%).
- 35% of those not currently using dental services stated it is because there is not an NHS dentist near where they live.

11.1.2 Citizen's Advice Bureau Survey

The Department of Health recommended that people searching for an NHS dentist should contact either their PCT or NHS Direct. A 2007 report from the Citizen's Advice Bureau, however, suggested most people found a dentist (63%) by asking family or friends.[97] In the East of England, for example, around 63% of patients heard about their current dentist from friends and family and around 42% do not know how to get emergency treatment outside office hours. This means that even where services are available, people may not be able to access them.

Graph 29: Citizen's Advice Bureau Data on How People Go About Finding an NHS Dentist



(Based on 3,763 responses. Percentages do not add up to 100% as respondents were able to select more than one option.)

Source: CAB Evidence Briefing Gaps to fill. CAB evidence on the first year of the NHS dentistry reforms. March 2007 Available at URL: http://www.citizensadvice.org.uk/pdf_gaps_to_fill.pdf

The CAB found that 65% of people who were unable to find an NHS dentist simply went without treatment, 9% went to A& E, 19% went to a private dentist and 2% went to their GP.

11.1.3 Omnibus Survey

The Omnibus survey gathered data about the impact of oral problems on the quality of life of adults. Population representative samples of 2,507 adults across the UK were briefly interviewed on oral health related quality of life. The results were analysed by the Dental Observatory.

The main findings of this survey were as follows:[98]

- 7% of adults in England and 5% of adults in the East of England, experience 'painful aching in the mouth fairly or very often'. The figures for men and women are equal
- Experience of painful aching in the mouth varied little between counties.
- As age of respondents increased, there was a general reduction of reported painful aching.
- The prevalence of painful aching 'fairly or very often' and experience of oral problems compare closely with the values arising from the Adult Dental Health Survey 1998. This finding suggests that this parameter varies little over time.

11.1.4 Patients Association Report

The Patients Association published their report, *The New Dental Contract - Full of Holes and Causing Pain*, on the new dental contract in March 2008.

The report was based on the Association's survey of PCTs (although they are unspecific about their methodology). Their main findings were as follows:[99]

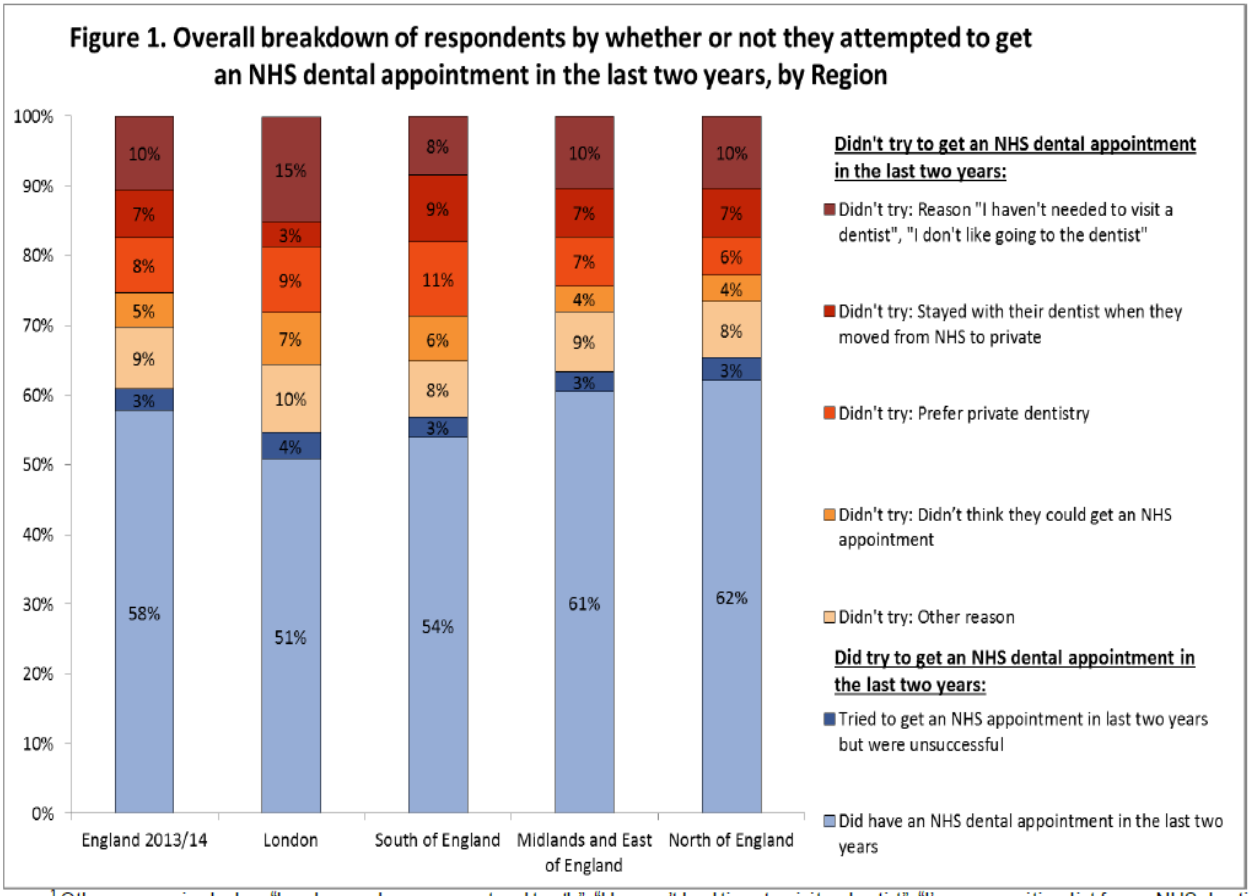
- The NHS dentistry service provided by PCTs varies from PCT to PCT creating a 'postcode lottery'.
- Patients are confused about how to access dental services in their locality.
- Patients are at risk of inadequate care because 'UDAs, rather than patient need, is being funded'.
- Prevention of oral disease is at risk under the new contracting system.

11.1.5 GP Patient Survey July – September 2013

Dental questions were originally added to the GP survey in January to March 2010 as the Department of Health wanted information on NHS dental access and demand for services based on peoples reported experience. THE GP patients survey was chose to capture this information as a portal to access the proportion of the population who do not use NHS dental services (or have not recently) to give a fuller picture of people's dental behaviour and experience.

The following graph shows the overall survey population breakdown of dental behaviour.

Graph 30



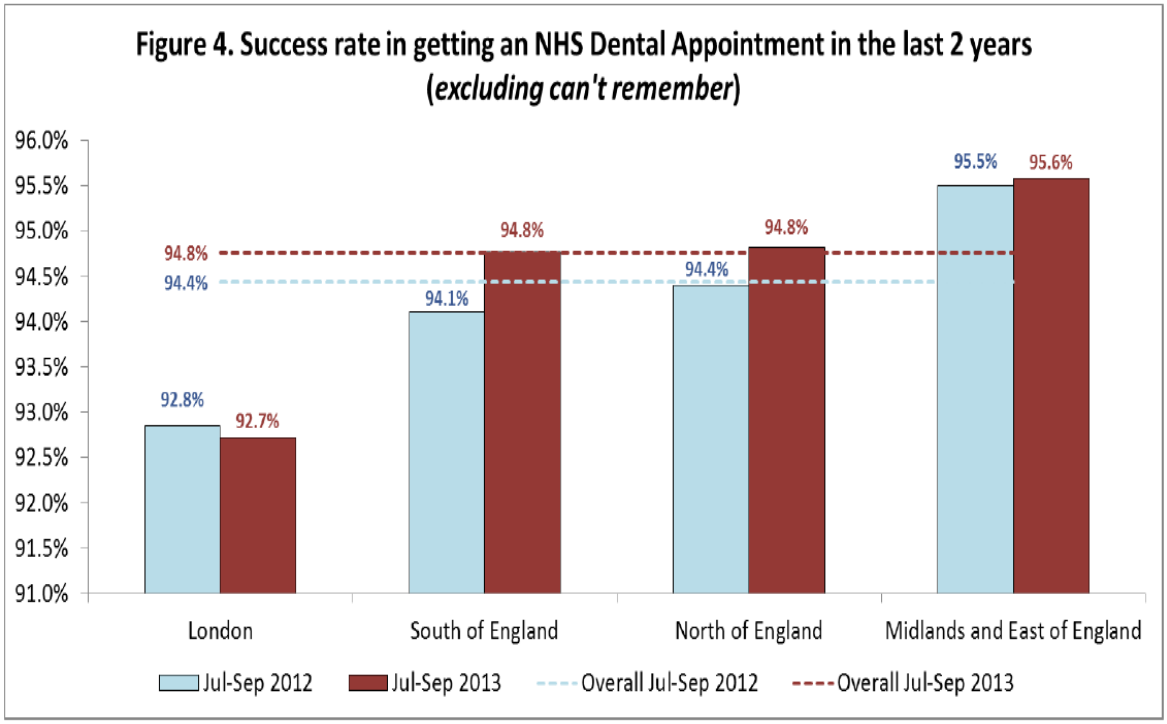
[1] Other reason includes: "I no longer have any natural teeth", "I haven't had time to visit a dentist", "I'm on a waiting list for an NHS dentist", "NHS dental care is too expensive", "Another reason".

Nationally just under three fifths (58%) of all respondents stated that they had visited an NHS dentist in the last two years. Of the remaining, 10% didn't try to see an NHS dentist because they stated they " didn't need to go " or " don't like going " and 8% didn't try because they prefer private dentistry.

Midlands and East show a much higher use of NHS Dental services that the south of England and London. (Just over 60% of all respondents compared to 54% of the south and 51% of London respondents)

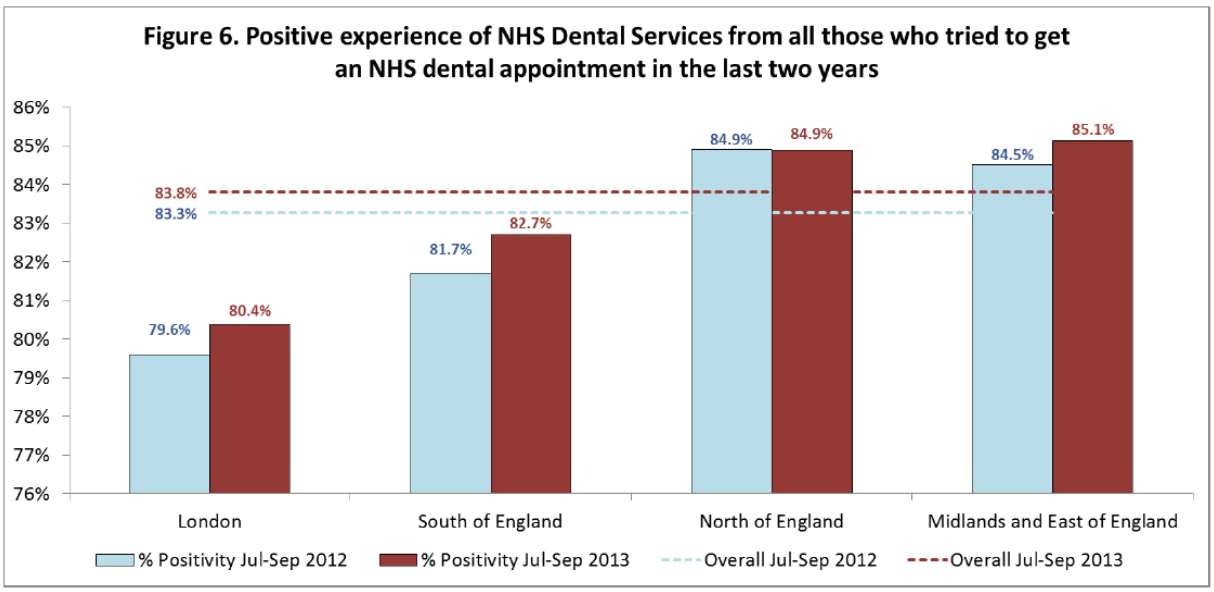
In the Midlands and East the vast majority of dental patients were successful at getting an NHS dental appointment in the last two years. This is the highest across England.

Graph 31



The graph below show that Midlands and East of England had the highest positive patient experience at 85 percent across England.

Graph 32



11.1.6 GP Patient Survey March 2014 – Responses to questions about dental services

In January to March 2014 the GP survey for NHSE East Anglia Area Team / CCGs in East Anglia was repeated.

This large survey samples adult patients registered with General Medical Practices in the local CCG area with questions mainly related to their primary medical care. 41,368 survey forms were distributed, and 18,123 returned (44% response rate). Several questions cover experience of dental practice. It is important though to recognise that responses may relate to dental practices outside of the specific CCG or NHSE Area boundary used for the data presentation, as analysis relates to the location of the respondents medical practice only, not the dental practice.
The weighting strategy applied is described in the Technical Annex: http://gp-survey-production.s3.amazonaws.com/archive/2014/July/1301375001_Technical%20Annex%202013-2014_FINAL%20v1.pdf

Table 25: When did you last try to get an NHS dental appointment for yourself? by number and proportion of respondents

All East Anglia

	Number of respondents	Percentage of respondents
In the last 3 months	4,846	24%
Between 3 and 6 months ago	3,458	17%
Between 6 months and a year ago	2,875	14%
Between 1 and 2 years ago	1,522	8%
Over 2 years ago	3,602	18%
Never tried to get an NHS appointment	*3,905*	*19%*

Table 26: When did you last try to get an NHS dental appointment for yourself?, by proportion of respondents

East Anglia CCGs

	In last 3 months	3- 6 months ago	6-12 months ago	12-24 months ago	Over 24 months ago	Not tried in last 24 months
All East Anglia	*24%*	*17%*	*14%*	*8%*	*18%*	*19%*
NHS Cambs & Peterborough CCG	23%	16%	12%	7%	19%	22%
NHS Ipswich & E Suffolk CCG	24%	18%	14%	7%	18%	19%
NHS Gt Yarmouth & Waveney CCG	30%	19%	18%	9%	13%	12%
NHS N. Norfolk CCG	26%	19%	16%	6%	15%	19%
NHS Norwich CCG	24%	19%	15%	10%	17%	16%
NHS S. Norfolk CCG	26%	17%	18%	6%	17%	16%
NHS W .Norfolk CCG	21%	16%	14%	9%	19%	21%
NHS W. Suffolk CCG	21%	15%	15%	7%	21%	22%

Table 27: Last time you tried to get an NHS dental appointment, was it with a dental practice you had been to before for NHS dental care?

	Yes	No	Can't Remember
All East Anglia	*88%*	*10%*	*3%*
NHS Cambs & Peterborough CCG	86%	10%	4%
NHS Ipswich & E Suffolk CCG	87%	11%	2%

NHS Gt Yarmouth & Waveney CCG	92%	7%	1%
NHS N. Norfolk CCG	90%	8%	2%
NHS Norwich CCG	87%	11%	2%
NHS S. Norfolk CCG	89%	7%	4%
NHS W .Norfolk CCG	91%	11%	3%
NHS W. Suffolk CCG	87%	9%	2%

Table 28: Respondents who last tried to get an NHS Dental Appointment in the last 2 years;

Proportion who said they were they successful in getting the appointment.
East Anglia CCGs

	Successful	Unsuccessful	Can't Remember
All East Anglia	94%	4%	2%
NHS Cambs & Peterborough CCG	93%	6%	2%
NHS Ipswich & E Suffolk CCG	96%	3%	1%
NHS Gt Yarmouth & Waveney CCG	95%	4%	2%
NHS N. Norfolk CCG	97%	2%	1%
NHS Norwich CCG	93%	4%	3%
NHS S. Norfolk CCG	94%	4%	2%
NHS W .Norfolk CCG	93%	5%	2%
NHS W. Suffolk CCG	96%	3%	1%

Table 29: Overall experience of NHS dental services [respondents visiting dentist in past 2 years]?

East Anglia CCGs

	Very good	Fairly good	Neither good nor poor	Fairly poor	Very poor
All East Anglia	*47%*	*38%*	*9%*	*4%*	*2%*
NHS Cambs & Peterborough CCG	43%	39%	10%	5%	3%
NHS Ipswich & E Suffolk CCG	48%	36%	9%	5%	2%
NHS Gt Yarmouth & Waveney CCG	56%	33%	7%	3%	1%
NHS N. Norfolk CCG	48%	38%	8%	4%	2%
NHS Norwich CCG	48%	37%	10%	4%	1%
NHS S. Norfolk CCG	46%	39%	8%	4%	2%
NHS W .Norfolk CCG	42%	37%	13%	4%	4%
NHS W. Suffolk CCG	47%	39%	8%	4%	2%

Table 30: Why haven't you tried to get an NHS dental appointment in the last two years [single main reason]?
All East Anglia

	Percentage of respondents
I haven't needed to visit a dentist	18%
I no longer have any natural teeth	8%
I haven't had time to visit a dentist	20%

I don't like going to the dentist	7%
I didn't think I could get an NHS dentist	11%
I'm on a waiting list for an NHS dentist	+
I stayed with my dentist when they changed from NHS to private	21%
I prefer to go to a private dentist	22%
NHS dental care is too expensive	4%
Another reason	9%

Please note, these figures should only be compared to January to March 2012 and January to March 2013 results, due to changes that were made to the GP Patient Survey methodology prior to these dates.

GP Patient Survey website **http://www.gp-patient.co.uk/**

Questions relating to NHS Dentistry

Q46 **When did you last try to get an NHS dental appointment for yourself?**

In the last 3 months
Between 3 and 6 months ago
Between 6 months and a year ago
Between 1 and 2 years ago More than 2 years ago **.....Go to Q50** I have never tried to get an NHS dental appointment**.....Go to Q50**

Q47 **Last time you tried to get an NHS dental appointment, was it with a dental practice you had been to before for NHS dental care?**

Yes
No
Can't remember

Q48 Were you successful in getting an NHS **dental appointment?**

Yes
No
Can't remember

Q49 Overall, how would you describe your **experience of NHS dental services?**

Very good
Fairly good
Neither good nor poor
Fairly poor
Very poor

Q50 **Why haven't you tried to get an NHS dental appointment in the last two years?**

If more than one of these applies to you, please tick the main ONE only

I haven't needed to visit a dentist
I no longer have any natural teeth
I haven't had time to visit a dentist
I don't like going to the dentist
I didn't think I could get an NHS dentist
I'm on a waiting list for an NHS dentist
I stayed with my dentist when they changed from NHS to private
I prefer to go to a private dentist
NHS dental care is too expensive
Another reason

11.1.7 Healthwatch

Healthwatch is the national consumer champion in health and social care. They have been given significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. Across East Anglia there are four services in Cambridgeshire, Peterborough, Suffolk and Norfolk. Healthwatch is an important stakeholder for East Anglia Area Team and representation on the Local Professional Network would strengthen that link. There are opportunities for Healthwatch to use the public voice to help influence the commissioning of local dental services.

12. General Principles

Oral diseases are important public health issues as they are among the most commonly found chronic diseases and are almost entirely preventable. The causal relationships between sugar and dental decay and gum disease and poor oral hygiene, for example, are well understood.

Primary prevention, employing the principles of universal proportionalism and integrating oral health with generic health, using the common risk factor approach (CRFA) is the most effective way of improving the oral health of the population of East Anglia. Working with other agencies such as local authorities is important to tackle these common risk factors such as poor diet, tobacco use, poor hygiene, alcohol consumption and injuries, factors which are also associated with obesity, cancer, heart disease, diabetes and strokes. This is consistent with Commissioning Better Oral Health June 2014

Secondary prevention, using targeted interventions such as fluoride varnish and brushing schemes, are important in areas where oral health is worse.
Access to high quality dental services, delivering consistent oral health promotion interventions such as preventive advice, tooth brushing instruction and fluoride varnish applications is key and is consistent with Delivering Better Oral Health, third edition June 2014

13. Summary

Oral health in East Anglia is generally good. This, however, masks oral health inequalities and a small number of people bear the burden of disease. They are children and adults living in material and social deprivation and people in at risk groups, such as older people and people living with disability or in long term institutional care. This health divide is of concern.

Access to dental services is variable across East Anglia and, for some marginalised groups, access is poor. Not much is known about the quality of these services or how accessible patients find them. Referral criteria and access for specialist dental services vary.

Access to a range of dental services is available but there is little evidence that this is meeting the differing needs of the population. At present these inequities in service provision have the potential to increase rather than decrease oral health inequalities.

The quality and availability of information both about the oral health status of the population and the services provided is poor and provides little information for future commissioning of these services.

14. Key messages

Prevention
Oral health problems are not being prevented in adults and children from marginalised and deprived groups in East Anglia.

Access
Dental service provision in East Anglia bears little relation to oral health need. There are discrepancies between the availability of services and need, and patients do not always get the right care when they access dental services.

At risk groups
People in marginalised or deprived groups in East Anglia are more likely to have poor oral health and less likely to access services. This includes people living in areas of material and social deprivation as well as those with physical and learning disabilities, dementia sufferers or people in long term institutional care.

Data
Information about services and the quality of those services is limited. There is some local data about the oral health of children but no local data available about the oral health of adults.

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ANNEX 1

BD CDS matrix final.rtf

Agenda Item No: 12

CAMBRIDGESHIRE AND PETERBOROUGH SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP DIGITAL STRATEGY

To:	**Cambridgeshire Health Committee**
Meeting Date:	**6 December 2018**
From:	**Chief Executive or Executive Director etc.**
Electoral division(s):	***All***
Forward Plan ref:	***N/A*** *Key decision:* ***No***
Purpose:	**UPDATE REQUESTED BY COMMITTEE**
Recommendation:	**To note and comment on the contents of the report**

1. BACKGROUND

1.1 Across Cambridgeshire & Peterborough we have a varied digital landscape which is currently in a state of intense change. Two of our Partners are recognised nationally for their digital maturity, while our other providers are in the process of replacing their electronic patient health records systems. Addenbrookes as a digitally mature organisation, reflected by its Global Digital Exemplar status, with the EPIC system it has already taken steps towards become paperless. Whilst, sharing information safely to support direct patient care – for example by installing EPIC viewer at the Granta GP practice in Sawston. We also have Royal Papworth who are a Lorenzo Digital Exemplar to help push forward the development of that particular Patient Administration System (PAS). Meanwhile North West Anglia Foundation Trust are currently implementing a new Medway PAS system along with the local authorities move to Mosaic. In the community and mental health setting CPFT are looking to replace two of their PAS systems by 2020. The upgrades to the PAS at NWAFT and CPFT are key steps as it gives us a foundation to build upon in terms of having modern IT infrastructure to make the sharing of information feasible.

1.2 This report provides an update on the work of the Digital Enabling Group which was set up as part of the Cambridgeshire & Peterborough Sustainability and Transformation Partnership. In particular, it focuses on the Digital Strategy and key next steps. It also addresses the queries raised by the committee around:

- Details of the new Digital Strategy & it's implementation over the next two years.
- Focus on how the System is moving towards sharing patient records effectively between health and health and health and social care.
- What are the barriers and how are these being overcome?
- Information sharing agreements and clinical governance.

2. MAIN ISSUES

2.1 *Details of the new Digital Strategy & it's implementation over the next two years*

The Cambridgeshire & Peterborough STP Digital Strategy was presented and endorsed at the Health and Care Executive on the 20 September, and further the STP Board on the 27 September. The strategy sets out a vision for how we can become the most digitally enabled system and how technology can support the greater integration of health and care, and in particular around individuals and communities. This vision aligns our local vision to that of the Five Year Forward View and identifies five areas of focus:

Digital Vision – Becoming the most digitally enabled system

Empower patients - using apps, wearables, smart homes so our community is confident in managing their own health and feel independent, in control and connected with their healthcare providers.

Support and empowering staff - Developing our staff digital skills, providing decision support and releasing more time for care for example through the use of virtual assistants and robotics.

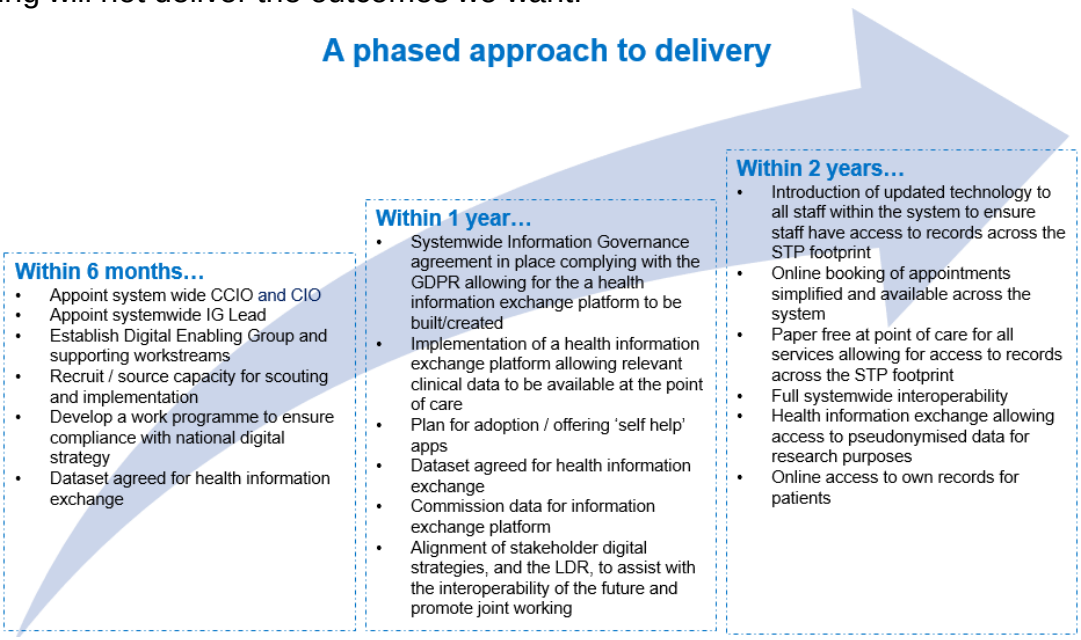
Integrate services - Create systematic, seamless and high quality care using standardised records, ready access to necessary information, and close to real time flows of information across clinical pathways.

Manage the system effectively - Aligned digital strategy to create system convergence and interoperability, create a common approach to information governance, data definitions and standards and procurement.

Create the future - In collaboration with patients and industry, support innovation, research and service development by creating rich, integrated information resources and analytics, by using machine learning and AI and by continually looking ahead to see what emerging technologies can be used in healthcare.

The Digital Enabling Group meets monthly to progress the strategy and includes representation from the two Local Authorities, the three Acute Providers, Primary Care, the two Community Providers (which also provide mental health) and the Academic Health Science Network[1].

We have set ourselves key actions and milestones over the next two years, these try to get the system moving at pace whilst also acknowledging that if we want to do this right then rushing will not deliver the outcomes we want:



2.2 *Focus on how the system is moving towards sharing patient records effectively between health and health and social care*

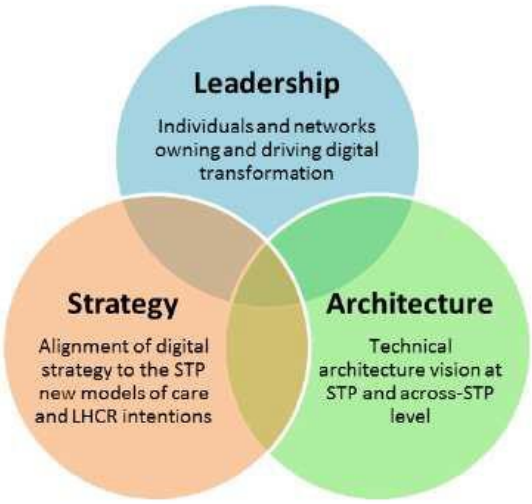
Work with stakeholders across the system has identified the need for an integrated care record. You will see from our Digital Strategy the ability for clinicians to access a complete patient record is key to delivering better services. The areas of focus above all relate to the

[1] Collectively, as a national network, AHSNs support improvements around common themes such as improving patient safety.

delivery of an integrated care record across the system and how it can help us empower our patients and staff.

In order to establish an integrated care record, we need investment. To access national funds for digital innovation, the Cambridgeshire & Peterborough system unsuccessfully bid for national Local Health Care Record (LHCR) funding in June 2018 as part of the Eastern Region bid which was pulled together by the Eastern Academic Health Science Network. We have also been told we will not be part of the 2nd wave of exemplars due to our lack of digital maturity across the region. However, establishing integrated care records is now a national directive, as set out in the recent digital strategy by the Secretary of State for health and care[2], so at some point we will be part of a national wave. System partners are even more committed to achieving this objective as early as possible and are part of the Eastern Region LHCR programme. As part of this we are working with neighbouring STP areas (Norfolk, Suffolk, Essex, Hertfordshire & Bedfordshire) to identify a workplan to ensure that as a system wherever possible we do activities once e.g. information standards and definitions as well as information governance frameworks. There is a workshop on the 29 November to progress this work and clarify the next steps.

NHS England have also commissioned a piece of work looking at "Building a Digital Region in the Midlands and East of England". The focus of this work is on understanding the digital plans and ambitions of the 17 STPs in the area to help accelerate the journey towards development of LHCRs allowing frictionless flow of patient information across the region. The work will focus on three key areas:



This work will help foster digital networking between STPs throughout the region
It will support coordination of STPs in developing LHCRs
Engagement will help build individual STP preparedness for the next wave of the Local Health and Care Record Exemplar Programme
The work will provide a basis for successful bids in future regional digital initiatives

2.3 *What are the barriers and how are these being overcome?*

There are many challenges to creating an integrated care record including; cost, patient consent, digital maturity and methodology.

[2] https://www.gov.uk/government/news/matt-hancock-launches-tech-vision-to-build-the-most-advanced-health-and-care-system-in-the-world

In terms of cost the Local Health Care Record Exemplars (LHCRE) will receive up to £7.5m of capital per system to deliver integrated health and care records. This was expected to be matched locally both with financial and expert resource. In terms of overcoming a lack of funding for digital investment we need to ensure we are clear on what we need as a system and to describe the most cost effective option for achieving this purpose. For example, we must answer whether we need instant access to the latest information on a patient or can some data be updated weekly or monthly? These types of decisions will help clarify the future costs of the system.

For patient consent there are various national programmes in place to record consent for information to be shared. However we could go a step further and put the patient in control of that information sharing using a service like Patients Know Best (PKB). PKB is a Social Enterprise that puts patients at the centre of sharing their information. They have created a cloud solution that allows patients to decide who their information is shared with and what it is used for. This type of approach is under consideration, along with others, that involve asking patients to give their consent for sharing their care records for specific purposes (in a manner compliant with GDPR).

Methodology will also help us understand consent and cost implications. There are two different ways of delivering an integrated care record. You can create a data repository – sometimes called a “warehouse” or a “lake” – that contains all the information you need; clinicians can then link to this dataset to obtain relevant information when the patient grants consent (Norfolk). The second methodology doesn’t create one place for the data to be stored but instead creates links between the different systems e.g. Hospital, Primary Care that present the information to the clinician via a portal after patient consent has been gained (for example the West Suffolk Cerner and Addenbrookes EPIC linkage).

For any barrier there is likely a solution. We are therefore looking at what others have achieved already. In Peterborough, North West Anglia Foundation Trust have been in discussion with the team behind Lincolnshire Care Portal. This is already up and running across Lincolnshire. We are meeting with both NHS colleagues from Lincolnshire and the system developers to look at how we can quickly learn lessons.

We must also acknowledge that some work has already happened. As a system we have shared records currently available in the form of the Summary Care Record which has been deployed across the system and allows medical professionals the ability to view primary care information (medication, allergen and [drug] reactions). There are currently 830,000 SCR records available to view with consent across all health settings for Cambridgeshire and Peterborough patients. The ability to view this information is via a portal separate to the main PAS system, this requires staff to log in to a second system to retrieve the information. It also only provides them with part of the patient record (Primary Care). The partial information and needing to login to a second system are seen as some of the barriers to use. Busy staff, especially in A&E departments, don’t have the time to carry out multiple logins to only find the information they need is not included. This makes access to the information via current systems one of the key requirements of future work.

2.4 *Information sharing agreements and clinical governance*.

In May this year the Cambridgeshire Information Sharing Framework was published. The

Framework is a high level agreement between a number of public organisations in Cambridgeshire. Its aim is to facilitate more effective data sharing across Cambridgeshire where this is needed to improve service delivery or to enable each organisation to respond quickly to customer needs.

Information can only be shared when it is appropriate and legal to do so and the Framework helps to ensure that all of the involved parties understand and comply with their obligations in this area. The Framework sets out common standards and also helps to ensure that information that is shared is managed consistently and securely.

The current partners are:

Cambridge City Council, Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridgeshire Community Services NHS Trust, Cambridgeshire Constabulary, Cambridgeshire County Council, Cambridgeshire Fire and Rescue Service, Cambridgeshire University Hospitals NHS Foundation Trust, East Cambridgeshire District Council, Fenland District Council, IMP/YOI Littlehey, Huntingdonshire District Council, North West Anglia NHS Foundation Trust, Peterborough City Council ,South Cambridgeshire District Council, Urgent Care Cambridgeshire.

In terms of Clinical Governance, the Digital Enabling Group has Chief Clinical Information Officer, Medical Director and GP oversight to ensure that the strategy helps create an environment where clinical excellence will flourish. As part of that strategy we have identified key posts to support delivery of digital change. We see the need for two part time roles in the form of a Chief Information Officer and a Chief Clinical information officer to give both technical and clinical input to delivery. We also see the need for a full time information governance post to ensure that the framework above is utilised to its full potential and that obtaining appropriate patient consent and assuring the public we are handling their data safely is not seen as a blocker. Our strategy is currently in the process of being publicised across the system with the clear point that technology is an enabler, if we don’t ensure our processes are right and our staff willing to use it, it will not add value.

NHS England

Fit for the Future
Working together to keep people well

NHS Improvement

Cambridgeshire & Peterborough

STP Digital Strategy – *working draft*

September 2018

NHS Cambridgeshire and Peterborough Clinical Commissioning Group
NHS Cambridgeshire and Peterborough NHS Foundation Trust
NHS Cambridgeshire Community Services NHS Trust
NHS Cambridge University Hospitals NHS Foundation Trust
NHS North West Anglia NHS Foundation Trust
NHS Royal Papworth Hospital NHS Foundation Trust
Cambridgeshire County Council
PETERBOROUGH CITY COUNCIL
NHS East of England Ambulance Service NHS Trust

Contents

Introduction

This working draft represents a first step a developing a digital strategy setting out how we seek to harness the opportunities technology presents to improve how we deliver health and care services across Cambridgeshire and Peterborough. It is, by nature, a working draft and therefore more work is needed to:

- Understand the resources required to deliver, as well as the investments and benefits from delivery.
- Engage with partners in detail to ensure alignment with organisational plans.
- Engage wider stakeholders to understand what we can learn, and what they can offer, as we take the next steps.
- Develop a plan for implementation to build and maintain momentum.
- Challenge ourselves by developing measures of success against which we can be held to account.
- Learn from others, nationally and internally, allowing us to take strides quickly.
- Ensure alignment to the short term (operational performance, financial plan), medium term (Integrated Neighbourhoods, North/South Alliances) and long term (potential Integrated Care System, Devolution) priorities of the STP.
- Ensure there are clear links to the six system digitisation priorities:
    - Deploying EPR solutions at scale across systems.
    - Extending system capacity management.
    - Improving system-wide staff rostering.
    - Extending real-time coded data collection in community and mental health settings.
    - Improving ambulance and first responder access to clinical information and support.
    - Sharing health and social care information to support health and care professionals working in people's homes.
- Engage with Delivery and Enabling Groups (including North/South Alliances) to understand what we can offer and what they need from the digital community.

And finally, and most importantly, we need to ensure that delivery of this strategy will continue to improve the services we offer patients and the wider population focusing on primary, acute, community, mental health and social care services in their broadest forms.

Context

- Within Cambridgeshire and Peterborough; the NHS partners, Primary Care and local government have come together to improve the health and care of our local population (just under a million) and, in time, to return the System back to financial sustainability.

- Cambridgeshire and Peterborough is one of the most, if not the most, challenged local health economies in England, making it essential that we work together to develop robust plans for long-term transformation. We have in place strong, visible, collective leadership and a well-resourced programme of work to address:
    - the health and care needs of our **rapidly growing and increasingly elderly population**;
    - significant **health inequalities**, including the health and wellbeing challenges of diverse ethnic communities;
    - **workforce shortages** including recruitment and retention in general practice;
    - **quality shortcomings** and inconsistent operational performance; and
    - **financial challenges** which exceed those of any other STP area in England on a per capita basis, such that by 2021 we expect our collective NHS deficit, if we do nothing, to exceed £500m

- To enable us to deliver the best possible care, we have agreed a unifying ambition for health and care in Cambridgeshire and Peterborough. This is to develop the beneficial behaviours of an 'Integrated Care System' (ICS) by acting as one System, jointly accountable for improving our population's health and wellbeing, outcomes, and experience, within a defined financial envelope.

- Digital initiatives will require upfront investment, and we've built up a back log of System digitisation efficiencies. There is potential cost savings of efficiency including:
    - Replacing for cheaper systems.
    - Robotics improving automated systems.
    - Improving quality and safety through the use of with improved data e.g. allergies and drug data.
    - Patient management apps linked to EPR for self management and prevention.
    - Commercial links with industry to reduce costs.

- We are currently not in a position to quantify any potential savings from these efficiencies however hope in the longer term (10-20 years) there would be a positive outcome in terms of savings, quality and efficiencies.

Fit for the Future
Working together to keep people well

STP digital strategy – a one page summary

STP Ambition – Working together to keep people well

- At home is best
- Safe and effective hospital care, when needed
- We're only sustainable together
- Supported delivery

Digital Vision – Becoming the most digitally enabled system

Empower patients - using apps, wearables, smart homes so our community is confident in managing their own health and feel independent, in control and connected with their healthcare providers.

Support and empowering staff - Developing our staff digital skills, providing decision support and releasing more time for care for example through the use of virtual assistants and robotics.

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Create the future - In collaboration with patients and industry, support innovation, research and service development by creating rich, integrated information resources and analytics, by using machine learning and AI and by continually looking ahead to see what emerging technologies can be used in healthcare.

Which we will achieve, by putting in place….

- New governance and processes
- New behaviours and mindsets
- New skills and training programmes
- New roles
- New resources and tools

Skilled capacity to support implementation at pace:

- Project management
- Subject matter experts (e.g., from industry , NHSD)
- IT & Informatics
- Clinicians
- Front line staff
- Patients

A series of product offerings on behalf of the system
e.g., integrated care record, interoperability & integration opportunities, apps & patient support tools

The local case for change and national FYFV priorities

Only by working as a system, by adopting the behaviors of an integrated care system, can we address our biggest system problems. We are individually unviable, as we:

- have substantial health inequalities (most unequal combined authority in the country),
- are out of financial balance (c£500m as a system by 2021),
- have an increasingly ageing population with complex health needs and co-morbidities (>65's will grow 35% by 2031)
- are planning for significant population growth (2.5% per annum)
- experience major workforce challenges in recruitment & retention (local medical vacancies 9.8% vs national 7.5%)
- are concerned about the clinical sustainability of one of our three A&Es,
- are not universally well advanced in models of integrated working especially around proactive management of long-term conditions & frailty at a neighbourhood level,
- are struggling with day to day clinical workload, across all our providers, and
- face growing demand for adult social care and high levels of children with very complex needs, which cannot be met sustainably without more radical transformation.

The five year forward view identified the need to simplify patient access to care, in the most appropriate location, while supporting people in managing their own health. It identified key solutions needed over the next two years to support these aims:

- Make it easier for patients to access urgent care on line.
- Enable 111 to resolve more problems for patients without telling them to go to A&E or their GP.
- Simplify and improve the online appointment booking process for hospitals.
- Make patients' medical information available to the right clinicians wherever they are.
- Increase the use of apps, both developed nationally and local expertise, to help people manage their own health.

The local landscape - complex and not integrated

3 Main Acute Providers:
CUH
NWAngliaFT
RPHFT

101 GP practices
Around 600 GPs

2 Community Providers:
CPFT
CCS

1 Mental Health provider
CPFT

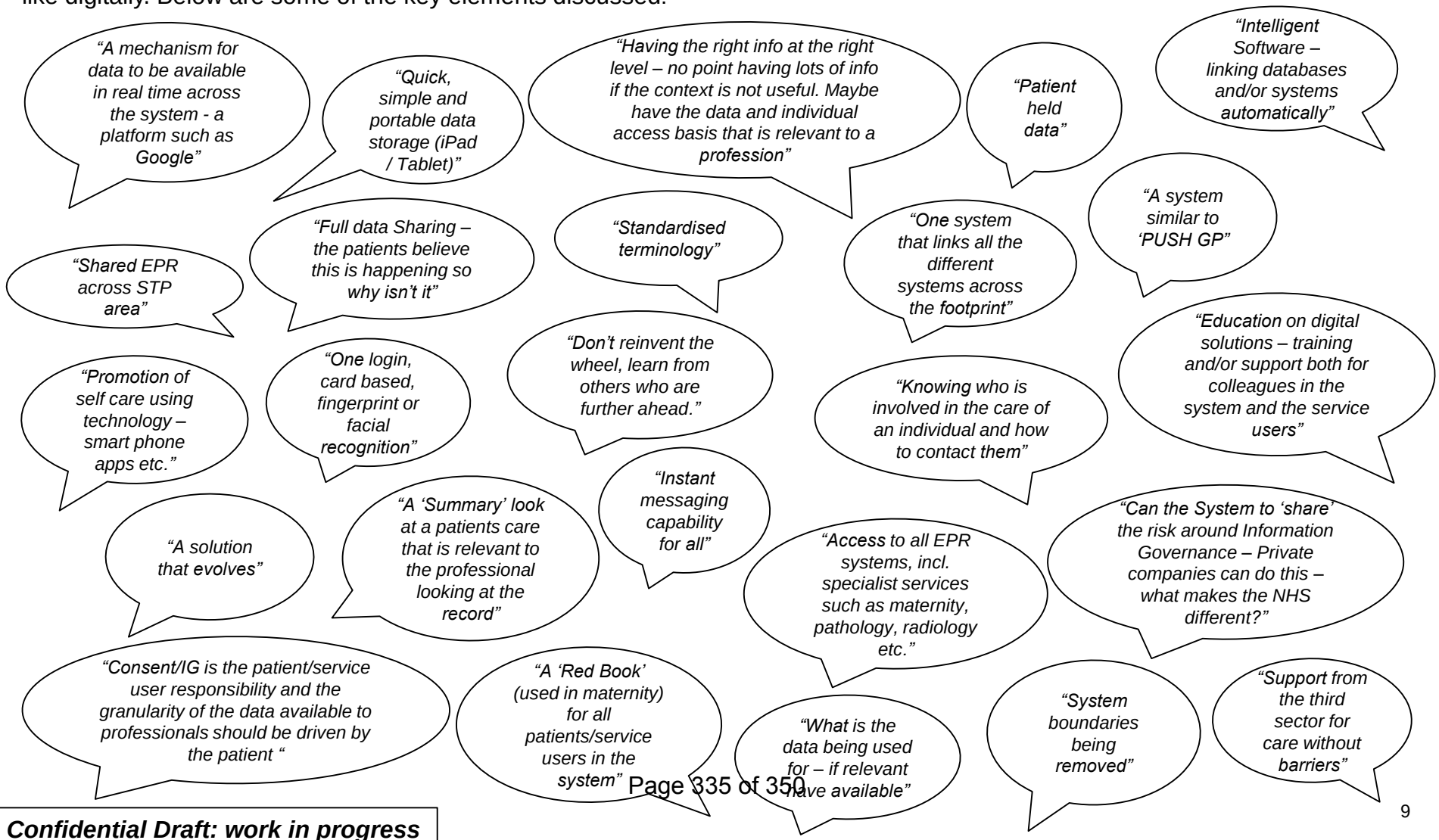
- The STP shares a boundary with the CCG so covers a population of 960,000.
- Cambridgeshire County Council and Peterborough City Council cover a population of 847,000.
- 265,000 patients go through our A&E departments and 87,000 go through our minor injury units each year.
- There are an estimated 3,000,000 GP visits by our patients (3.18 visits per registered population) each year.
- Our community providers carry out around 1,000,000 contacts each year.
- Our Mental Health provider carries out 177,000 contacts each year.
- But limited integration across providers using multiple EPR systems of varying functionality, interoperability and scope and no agreed data definitions and standards.
- Two of our acute hospitals, Peterborough & Stamford Hospitals and NHS Foundation Trust and Hinchingbrooke Healthcare NHS Trust merged in April 2017 to form North West Anglia NHS Foundation Trust (NWAngliaFT).

Building on what we have already achieved

- CUH is a **Global Digital Exemplar** and Royal Papworth are a **Lorenzo Digital Exemplar**.
- There are approximately 830,000 **Summary Care Records** available to view with consent across all health settings for Cambridgeshire and Peterborough patients.
- We currently have 8 EMIS practices and 61 SystmOne practices signed up to use the **End of Life Care dashboard**.
- Frailty patients that have an Summary Care Record with Additional Information 779 (for the period to end of March 2018) (case management data- live for 6 months Frail and Elderly patients**)
- There is ability for **CPFT staff to view EPIC record viewer** when appropriate and with consent.
- Link between the **EPIC systems used by CUH and Western Sussex Hospitals NHS Foundation Trust** to allow staff to view **EPIC/CERNER records** when appropriate and with consent.
- Link between the **EPIC systems used by CUHFT and Granta group practices** to allow staff to view EPIC records when appropriate and with consent.
- The CUH patient portal **MyChart** was deployed in 2016, with 660+ users; further rollout is planned this year to thousands of patients with chronic diseases
- 148,000 appointments booked via a **GP Online booking service** between April 2017 and February 2018.
- NWAngliaFT established **electronic patient records for the maternity department**.
- **MyCOPD app launched** to support patients suffering with COPD.

What do our staff say our system needs

Local front line staff, informatics, clinicians, patients and tech colleagues imagined a world where everything was as they would like digitally. Below are some of the key elements discussed:



The enablers to turn our identified needs into our digital vision

In order to achieve our vision, we need to develop the following products….

New governance and processes

- An established system digital leadership including CIO and CCIO and underpinning governance structure i.e. Digital Enabling Group.
- Centralised/standardised information governance processes and data sharing agreements
- Review baseline status of organisations looking at technology currently available to them, their plans for any future developments and assess interoperability and integration opportunities between partners.
- Integrated analytical function between partners supporting investment decisions and population health management.
- Using social media to advise patients of the digital opportunities that are out there already.

New behaviours and mindsets

- Shared decision making with patients through technology e.g. patient portal.
- Thinking as a system rather than an individual organisation.

New skills and training programmes

- New system wide training programmes for existing staff.
- Recruiting new staff with a recognition of the need for digital skills.

New roles

- System wide CIO.
- System wide IG lead.
- CCIO, clinical, Aligned Health Professionals input both from different healthcare sectors and professional groupings.

New resources and tools

- Shared view of the patient record (this may eventually be an integrated care record) and agreed minimum clinical data set.
- Use apps and other patient support tools to increase self –management for patients, decision support, robotics and AI.
- Directory of digital resources for staff.

Our digital vision – 5 priorities

Our digital vision is aligned to the five priority areas as described in the Five Year Forward View. In the following slides we align our enablers to delivering against the following five areas:

- Empower patients
- Support and empowering staff
- Integrate services
- Manage the system effectively
- Create the future

Empower patients

Outcomes

Population happy and confident to share decision making with health professionals through innovative connected services.

Products

- **Using apps, wearables, smart homes so our community is confident in managing their own health and feel independent, in control and connected with their healthcare providers.**
- **Using social media to advise patients of the digital opportunities that are out there already.**

Implementation

- **Use patients forums and links with Healthwatch to ensure patients are represented at Digital Enabling Group. Ensuring their views drive forward the use of technology, review products already available and have a role in prevention/health promotion.**
- **Work with Neighbourhoods (especially Northstowe) and others with new housing development.**

Support and empowering staff

Outcomes

Staff have ready access to intuitive and easy to use technology and the training to get the most out of it. This will make their working lives more efficient and free up time for patient care.

Products

- **Developing our staff digital skills through system wide training programmes.**
- **Provide decision support tools.**
- **Virtual assistants and robotics to release more time for care.**
- **Staff to regularly discuss and exchange digital best practice.**

Implementation

- **Dedicated training resource to develop and deliver the programme, linked to the Workforce Enabling Group for staff planning and skills.**
- **Project team to source, procure and implement decision support tools, virtual assistants and robotics.**
- **Create forum for staff and super users to discuss digital best practice.**

Fit for the Future

Working together to keep people well

Integrate services

Outcomes

Systematic, seamless and high quality care using standardised records, ready access to necessary information, and close to real time flows of information across clinical pathways.

Products

- **Clinically consistent pathways across all providers to improve outcomes and efficiency, with fewer, more specialist centers across our hospitals.**
- **Risk Stratification and predictive analytic tools based on Secondary, Primary, Community, Mental Health and Social Care activity.**
- **System Wide Decision Support tools available across all care settings.**
- **Shared view of the patient record (this may eventually be an integrated care record) and agreed minimum clinical data set**

Implementation

- **Digital links to North and South Alliance Delivery Groups, to support neighbourhood and GP federations development.**
- **Links to national work around new care models and how they are supported by digital infrastructure e.g. National Population Health Management forum.**

Manage the system effectively

Outcomes

Aligned digital strategy to create system convergence and interoperability, create a common approach to information governance, data definitions and standards and procurement.

Products

- An established system digital leadership including CIO and CCIO and underpinning governance structure
- System wide agreement around purchasing of new technologies, leverage our purchasing power.

Implementation

- Digital enabling group as a forum to discuss organisational priorities and how they fit into the system.
- Task & Finish groups to support each element of the Digital Vision.

Create the future

Outcomes

In collaboration with patients and industry, support innovation, research and service development by creating rich, integrated information resources and analytics, by using machine learning and AI and by continually looking ahead to see what emerging technologies can be used in healthcare.

Products

- **Centralised/standardised information governance processes.**
- **Integrated analytical function between partners supporting population health management.**

Implementation

- **Review baseline status of organisations looking at technology currently available to them, their plans for any future developments and assess interoperability and integration opportunities between partners**

A phased approach to delivery

Within 6 months…

- Systemwide Information Governance agreement in place complying with the GDPR allowing for the a health information exchange platform to be built/created
- Appoint system wide CCIO and CIO
- Appoint systemwide IG Lead
- Establish Digital Enabling Group and supporting workstreams
- Recruit / source capacity for scouting and implementation
- Develop a work programme to ensure compliance with national digital strategy
- Dataset agreed for health information exchange

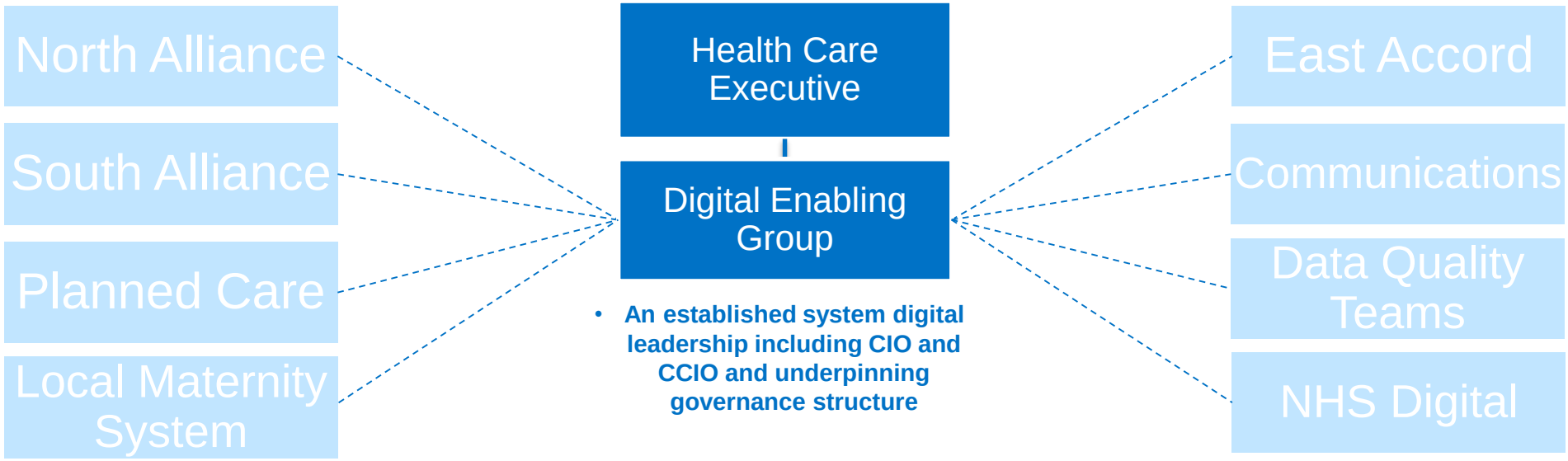
Within 1 year…

- Implementation of a health information exchange platform allowing relevant clinical data to be available at the point of care
- Plan for adoption / offering 'self help' apps
- Commission data for information exchange platform
- Alignment of stakeholder digital strategies, and the LDR, to assist with the interoperability of the future and promote joint working
- Health information exchange allowing access to pseudonymised data for research purposes

Within 2 years…

- Introduction of updated technology to all staff within the system to ensure staff have access to records across the STP footprint
- Online booking of appointments simplified and available across the system
- Paper free at point of care for all services allowing for access to records across the STP footprint
- Full systemwide interoperability
- Online access to own records for patients
- Taking stock of NWAngliaFT and RPHFT PAS implementations.

Proposed task & finish groups



- **An established system digital leadership including CIO and CCIO and underpinning governance structure**

Empower patients	Support and empowering staff	Integrate Services	Manage the system effectively	Create the Future

Review opportunities to use apps and other patient support tools to increase self –management for patients
• Harnessing the power of technology: apps, wearables and smart homes.
• Link with Smart Cambridge programme.
	Integrated analytical function between partners supporting population health management
	• Led by STP / CCG / PHI
	• Direct support to North and South Alliance delivery groups
	• Two way flow of information, answer questions as well as identifying developing issues.
		Shared view of the patient record (this may eventually be an integrated care record) and agreed minimum clinical data set
		• Led by CUHFT, NWAFT, CPFT, RPHFT and Primary Care
		• Find interoperability & integration opportunities e.g. build on CCG work around SCR.
			Centralised/standardised information governance processes
			• Led by System IG lead (resource required)
			• Common Consent Model
			• Local issue resolution for:
			  • Direct care
			  • Secondary Uses
			• Links to NHS Digital for longer term changes
				Review baseline status of organisations looking at technology currently available to them, their plans for any future developments and assess interoperability and integration opportunities between partners
				• Identifying new technologies and ways of working:
				  • Automation or substitution of human tasks with AI
				• Significant change that is coming from regulators.

HEALTH COMMITTEE TRAINING PLAN 2018/19	Updated November 2018	**Agenda Item No: 13**

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
7.	***Health in Fenland***	To provide a deep dive into reviewing and understand the key health inequalities in the Fenland District. To be held at FDC Boathouse, Wisbech	1	19th Sep 2018	Public Health	Development Session	All members of Health Committee	8	80%
1.	***Business Planning (Strategic)***	To provide the committee members with an overview of CCC strategic Business Planning timescales and deadlines	1	9th August	Public Health	Development session	All CCC Health Committee members	6	60%
2.	***Business Planning (Operational)***	To discuss the Public Health Business Planning priorities for 2019/20	1	13th Sept 2018	Public Health	Development Session	All CC Health Committee members + districts	8	53%
3.	***Delayed Transfers of Care – System wide perspective***	To be Confirmed Awaiting officer availalbity	1		Public Health		All CCC Health Committee members + districts		
4.	***Proposed: Transport & Access to Addenbrookes Site***	Agreed to receive a briefing from the Greater Cambridgeshire Partnership around transport and access issues for the biomedical site.	2	TBA	Public Health	Development Session	All CCC Health Committee + district + ETE committee		

		Briefing paper circulated to discuss.							
5.	***Health in Fenland***	To hold a follow up session from the Fenland Deep Dive that was held on 19th September	2	11th October	Public Health	Development Session	CCC Health Committee members	8	80%
6.	***Voluntary sector role in supporting public health outcomes***	To understand the local voluntary sectors role in delivering services that can have public health outcomes	2	Feb 7th (provisional)	Public Health	Development Session	All CCC Health Committee members + districts		

In order to develop the annual committee training plan it is suggested that:

- The relevant Executive/Corporate/Service Directors review training needs and develop an initial draft training plan;
- The draft training plan be submitted to a meeting of the relevant committee spokesmen/women for them (in consultation with their Groups as appropriate) to identify further gaps/needs that should be addressed within the training plan; The draft plan should be submitted to each meeting of the committee for their review and approval. Each committee could also be requested to reflect on its preferred medium for training (training seminars; more interactive workshops; e-learning etc and also to identify its preferred day/time slot for training events.)

Each attendee should be asked to complete a short evaluation sheet following each event in order to review the effectiveness of the training and to guide the development of future such events

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Updated 21st November 2018	Cambridgeshire County Council **Agenda Item No: 14**

Notes

Committee dates shown in bold are confirmed.
Committee dates shown in brackets and italics are reserve dates.

The definition of a key decision is set out in the Council's Constitution in Part 2, Article 12.
* indicates items expected to be recommended for determination by full Council.
+ indicates items expected to be confidential, which would exclude the press and public.

Draft reports are due with the Democratic Services Officer by 10.00 a.m. eight clear working days before the meeting.
The agenda dispatch date is six clear working days before the meeting

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
17/01/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Update on Public Health Reserves – Fenland Fund	Val Thomas	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Scrutiny Item: NWAFT CQC Inspection	Caroline Walker	Not applicable		
	Section 75 for Health Visiting and School Nursing Service	Liz Robin	2019/015		
	Scrutiny Item: Eating Disorders Service	Tracy Dowling	Not applicable		
	Scrutiny Item: Provision of 111 Out of Hours service for Wisbech	CCG/CPFT	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[07/02/19] Provisional meeting					
14/03/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Scrutiny Item: CCG Finances update position	Jan Thomas	Not applicable		
	Scrutiny Item: Motor Neurone Disease	CCG	Not applicable		
	Scrutiny Item: GP Five Year Forward View	Jan Thomas	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[11/04/19] Provisional meeting					
23/05/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Scrutiny Item: Minor Injury Unit Update				
	Scrutiny Item: STP Workforce Planning				
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		