NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Updated Prevention Strategy for the NHS in Cambridgeshire and Peterborough

2018

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Contents

List of Abbreviations

1. NHS – National Health Insurance
2. CAMBRIDGESHIRE AND PETERBOROUGH CCG – Cambridgeshire and Peterborough Clinical Commissioning Group
3. PA – Physical Activity
4. CYP – Children and Young People
5. YO – Years Old
6. PHE – Public Health England
7. COPD – Chronic Obstructive Pulmonary Disease
8. WHO – World Health Organizations
9. NCDs – Non-Communicable Diseases
10. UK – United Kingdom
11. LA – Local Authority
12. NICE – National Institute for Health and Care Excellence
13. GPs – General Practitioners
14. ROI – Return of Investment
15. BMI – Body Mass Index
16. PAFs – Population Attributed Factors
17. SCOPE – Specialist Certification of Obesity Professional Education
18. JSNA – Joint Strategic Needs Assessment
19. LARCs – Long Acting Reversible Contraceptives
20. HIV – Human Immunodeficiency Virus
21. NCSP – National Chlamydia Screening Programme
22. IUD – Intrauterine Device
23. iCASH – Integrated Contraception and Sexual Health Service
24. QALYs – Quality-Adjusted Life-Year
25. NICU – Neonatal Intensive Care Unit
26. CVD – Cardiovascular Diseases
27. OCD – Obsessive Compulsive Disorder
28. PTSD – Post-traumatic Stress Disorder
29. ADHD – Attention Deficit Hyperactivity Disorder
30. CR – Cardiac Rehabilitation
31. AF – Atrial Fibrillation
32. FEV1 – Forced Expiratory Volume in 1 Second
33. ONS – Office of National Statistics
34. NDA – National Diabetes Audit

1. Introduction and Summary

Purpose

In 2015 the CCG commissioned a Prevention Strategy for the NHS in Cambridgeshire and Peterborough. This strategy considered areas where the NHS could work to prevent ill health and there were also likely to be benefits to the NHS.

The 2012 Health and Social Care Act gave Local Authorities the duty to improve health and promote wellbeing for the people in their areas. Responsibility for major population prevention programmes such as screening and immunization passed to NHS England. Much of the work to prevent ill health is taken by Local Authorities, national government and wider areas of society such as educational institutions and the voluntary sector.

The 2015 Strategy was narrower in scope than a cross-sector population wide prevention strategy for Cambridgeshire and Peterborough as it focused on actions taken by and impacting on the NHS. The purpose of this refreshed 2018 Prevention Strategy for the NHS in Cambridgeshire and Peterborough is to review progress against the 2015 Strategy and to suggest improvements. This Updated Prevention Strategy identifies inequalities, considers challenges to implementation and, where possible, identifies opportunities for investment and savings.

Priority Areas for NHS action

All of the areas mentioned in this strategy are important to improving health.

To enable focused delivery of this Updated Prevention Strategy page 10 presents a prioritization framework. This has considered whether the area is one of increasing concern, the potential impact on health inequalities, financial savings and number of people affected and the feasibility for the NHS of delivering the recommendations.

As a result of this three priority action areas for the NHS prevention have been identified:

- Hypertension
- Work place health in the NHS
- Smoking

Areas of progress between 2015 and 2018

Obesity

The prevalence of obesity and overweight adults and children in reception and year 6 have improved in both Cambridgeshire and Peterborough. This is a significant finding. Significantly inequalities persist, both between areas and within Cambridgeshire.

Smoking

Overall prevalence rates for smoking have decreased in both Peterborough and Cambridgeshire. Again there is a **significant inequality**: smoking prevalence in routine and manual workers in Peterborough has increased from 26.7% in 2015 to 28.5% in 2017, despite levels in England falling from 29% to 25%.

Falls

A programme of work has started to reduce falls. Rates of admissions due to falls have decreased in Peterborough but not yet in Cambridgeshire.

Areas where more work is needed

Hypertension

There has been a 1% increase in those with hypertension who are diagnosed and of those diagnosed 1.9% more are well controlled, however the CCG is performing worse than comparator CCGs in both detection and management.

Breast feeding

There have been no significant changes in breast feeding rates.

Smoking at delivery

Smoking at delivery is significantly higher than the rest of Cambridgeshire, and the national ambition of 6% in hospitals covering Peterborough and north Fenland.

LARCs

There is more that could be done to increase the use of long acting reversible contraception.

Malnutrition

Relatively little work has been undertaken in malnutrition over the last 3 years and this remains a significant cause of ill health associated with increased health services usage.

Mental Health

Much work has been undertaken in mental health however recorded depression rates continue to rise and rates of self-harm remain above the national average although with an apparent recent decline.

Alcohol

Significant inequalities remain between Cambridgeshire and Peteborough. Admissions episodes for alcohol-related cardiovascular conditions have risen in England and Cambridgeshire and Peterborough since 2015, though the rise has been slower in Peterborough and Cambridgeshire than the England average. The number of people in treatment for alcohol disorders remains the same. There appears to have been a recent decline in alcohol related admissions in Peterborough.

Physical activity

There have been improvements in physical activity levels in Cambridgeshire with a worsening picture in Peterborough.

Layout of this Updated Strategy

Each chapter of this Updated Prevention Strategy follows the following format:

- Background to the area
- The situation in 2015
- The situation in 2018
- Interventions since 2015
- Recommendations
- Figures and data

Note on the use of the term "prevention" and how areas relate

Prevention can be classified as "primary", "secondary" or "tertiary".

Primary Prevention: takes place before the health effects occurs

Secondary Prevention: identifies diseases in the earliest stages and intervenes to stop progression.

Tertiary Prevention: managing disease after diagnosis to slow or stop disease progression (1).

An intervention can act as primary prevention for one outcome and at the same time secondary prevention for another.

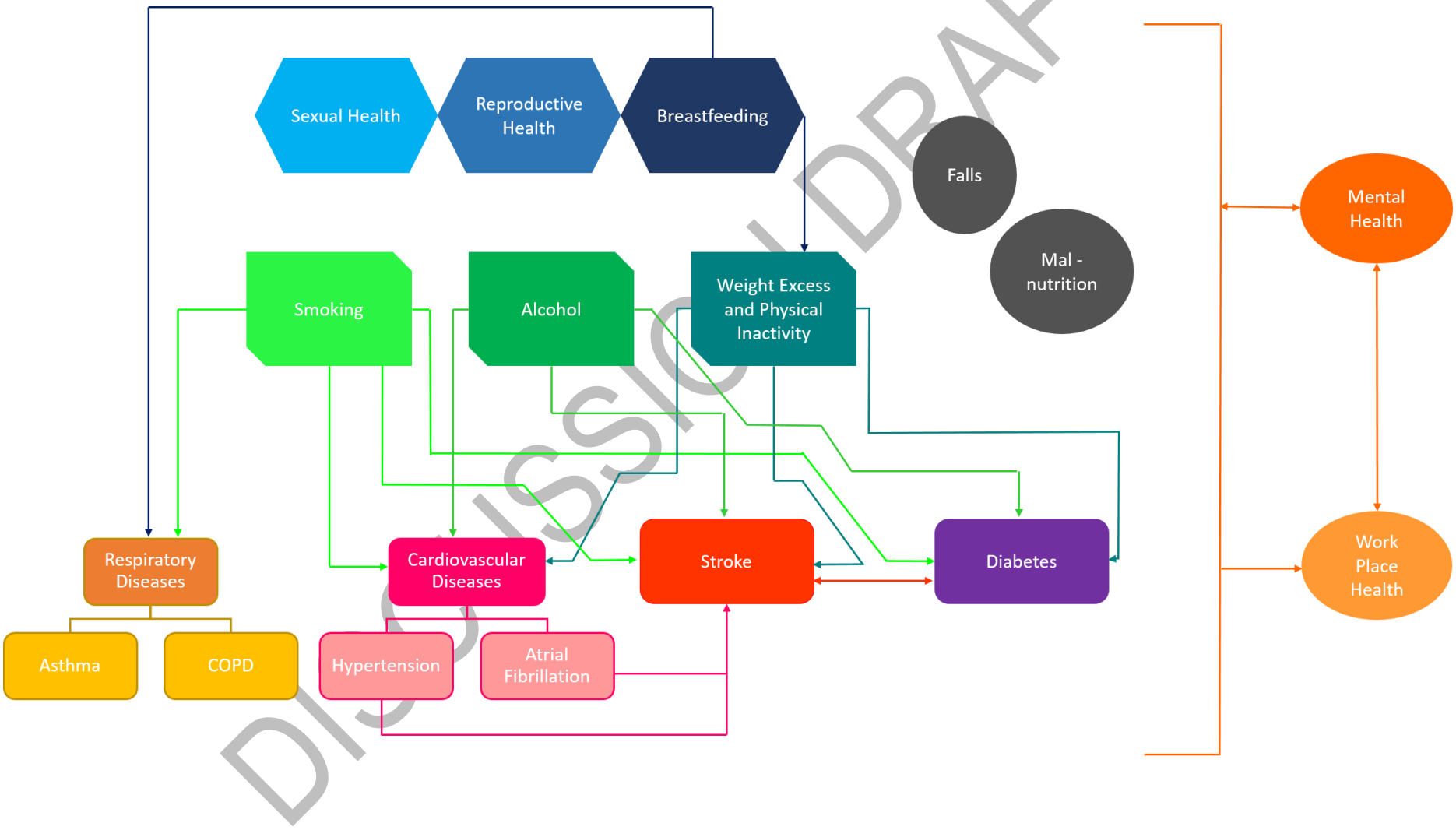
For example, treating early hypertension is secondary prevention for hypertension and primary prevention for stroke.

Many preventative interventions are synergistic. Figure 1 below shows some of the connections.

References

1. CDC web page on prevention https://www.cdc.gov/pictureofamerica/pdfs/picture_of_america_prevention.pdf Accessed on 5th November 2018

Figure 1: interrelationship of factors that are amenable to prevention and disease states



Summary Grid

Trend?	Increasing concern = 2 No change = 1 Positive indications = 0
If the recommendations were implemented what would be the potential impact on: - Health inequalities - Financial savings to the health system - Numbers of people with improved health outcomes	Negative impact = -1 Medium impact = 1 Very large impact = 2
How feasible are the proposed recommendations?	Difficult to implement = -1 Barriers exist but possible = 1 Feasible = 2

Hypertension	The increase in detection and management is less than has been seen nationally, CCG is bottom of its similar demographic group, no previous sustained plan on hypertension.
Smoking	Smoking prevalence in Peterborough has plateaued in the general population and increased in routine and manual workers despite falling levels nationally. High levels at time of delivery in Peterborough hospital.
Malnutrition	Lack of ownership or leadership on the issue.
Reproductive health	Increasing rates of abortion, lower than recommended increase in LARCs.
Physical activity	Physical inactivity has increased in Peterborough with a decrease in physical activity.

		Hypertension	Workplace health	Smoking	Obesity	Malnutrition	Mental health	Alcohol	Falls	Reproductive health	Physical activity	Breastfeeding
Trend?		2	1	2	0	2	0	0	0	2	2	1
Impact	Health inequalities	2	2	2	2	1	2	2	1	1	2	2
	Financial savings	2	2	2	2	2	2	2	2	2	1	2
	Nos. of people with improved health outcomes	2	2	2	2	1	2	2	2	1	2	1
Feasibility?		2	2	1	1	1	1	1	2	1	-1	-1
Score		10	9	9	7	7	7	7	7	7	6	5

2. Hypertension

Background

High blood pressure is the third biggest risk factor for disease and disability in England after smoking and poor diet (1). High blood pressure can increase the risk of developing a number of conditions including heart failure, coronary artery disease, chronic kidney disease peripheral arterial disease and vascular dementia. The cost to NHS in England from conditions attributable to high blood pressure has been estimated to be £2 billion (2). In Cambridgeshire and Peterborough, it is estimated that optimising anti-hypertensive treatment of diagnosed hypertensives would prevent 150 heart attacks and 230 strokes over 3 years, this would have an estimated combined health and care saving of around £4.5 million over this time period (3).

As high blood pressure often has no symptoms, people may not be aware of the condition, it has been estimated that more than 40% of people with high blood pressure are undiagnosed in England (4). In 2014 Public Health England and partners from across local and national government, the NHS, voluntary sector and academia came together to form a national Blood Pressure System Leadership Board which published actions to improve the prevention of high blood pressure in England (5). This was updated in 2018 (6).

What was the situation in 2015?

- In 2013/14 approximately 55% of people with hypertension were diagnosed in Cambridgeshire and Peterborough, compared to 56% nationally. It was estimated that there were 92,241 people with undiagnosed hypertension in NHS Cambridgeshire and Peterborough CCG. There was considerable variation in GP practice diagnosis of hypertension.
- In total, including exceptions, there were 22,023 people whose blood pressure is not less than 150/90 in Cambridgeshire and Peterborough at their latest blood pressure reading. The CCG average was 76.3% of people on the hypertension register being well controlled. Therefore between 10.2% and 44.9% of GP patients on the hypertension register are not well controlled. If all practices were to perform as well as the average of the best achieving practices, in terms of treating hypertension, then an additional 6,641 people would have their hypertension controlled.
- Modelling showed that lifestyle interventions both those aimed at the general population, and those focused on those with diagnosed hypertension were potentially cost saving at 10 years and over a lifetime.

Recommendations in 2015

- Maximise opportunities provided in the NHS Health Check to diagnose and treat hypertension, including through lifestyle interventions as well as drugs.
- There should be a variety of lifestyle interventions for those diagnosed with hypertension meaning an expansion to existing lifestyle services, such as health trainer/coaches.

- Work to increase diagnosis and management of those with hypertension should focus initially on Peterborough and Fenland.

What is the situation in 2018?

- The proportion of hypertensives diagnosed has increased by 1% but Cambridgeshire and Peterborough CCG (CP CCG) still has the lowest percentage of hypertensives detected amongst its group of 10 demographically similar CCGs. Approximately 56% of people with hypertension have been diagnosed, compared to 59% nationally and 60% in the best performing similar CCG. This is an estimated 88,000 people with undiagnosed hypertension. Variation between practices ranges from 26% to 79% in terms of the percentage of observed versus expected numbers of hypertensives (7) (Figure 2.1)). The prevalence of detected hypertension is increasing nationally but decreasing in both Cambridgeshire and Peterborough (Figure 2.4).
- In total, including exceptions, in 2017 there were over 25,000 people with hypertension whose blood pressure was not controlled to less than 150/90 in Cambridgeshire and Peterborough at their latest blood pressure reading. The CCG average was 78.2% of people on the hypertension register being well controlled. Between 9.6% and 42.4% of patents on the hypertension register were not well controlled. Cambridgeshire and Peterborough CCG were second lowest in their group of similar CCGs in terms of the percentage of hypertensives whose blood pressure is controlled (Figure 2.2).
- The percentage of patients over the age of 45 who have a record of blood pressure taken in the last 5 years has declined slightly from 90.2% in 2014/15 to 89.8% in 2026/17 (Figure 2.3)

What has happened since 2015?

- The Health and Wellbeing Board commissioned a detailed cardiovascular disease joint strategic needs assessment for Peterborough (8)
- Until 2016 the Cambridgeshire and Peterborough CCG 'Tackling Health Inequalities in Coronary Heart Disease Programme Board' worked closely with Local Authority Public Health team to improve uptake of CVD 'health checks' for 40-74-year-olds and to promote smoking cessation services for people at risk of heart and respiratory disease.
- CP CCG have developed a 2018 Hypertension Plan to improve detection and management across the practices.

Recommendations

- Support implementation of the CCG Hypertension Plan.
- Work with partners to support an annual *Know your numbers* public health campaign to encourage people to know their blood pressure.
- Continue partnership working between the CCG and Healthy Lifestyle services to:
    - Increase the use of the lifestyle service for hypertension management.
    - Include blood pressure in baseline health lifestyle services measurements.
    - Increase referrals from GP practices.

Figures

Figure 2.1 Hypertension observed prevalence (7)

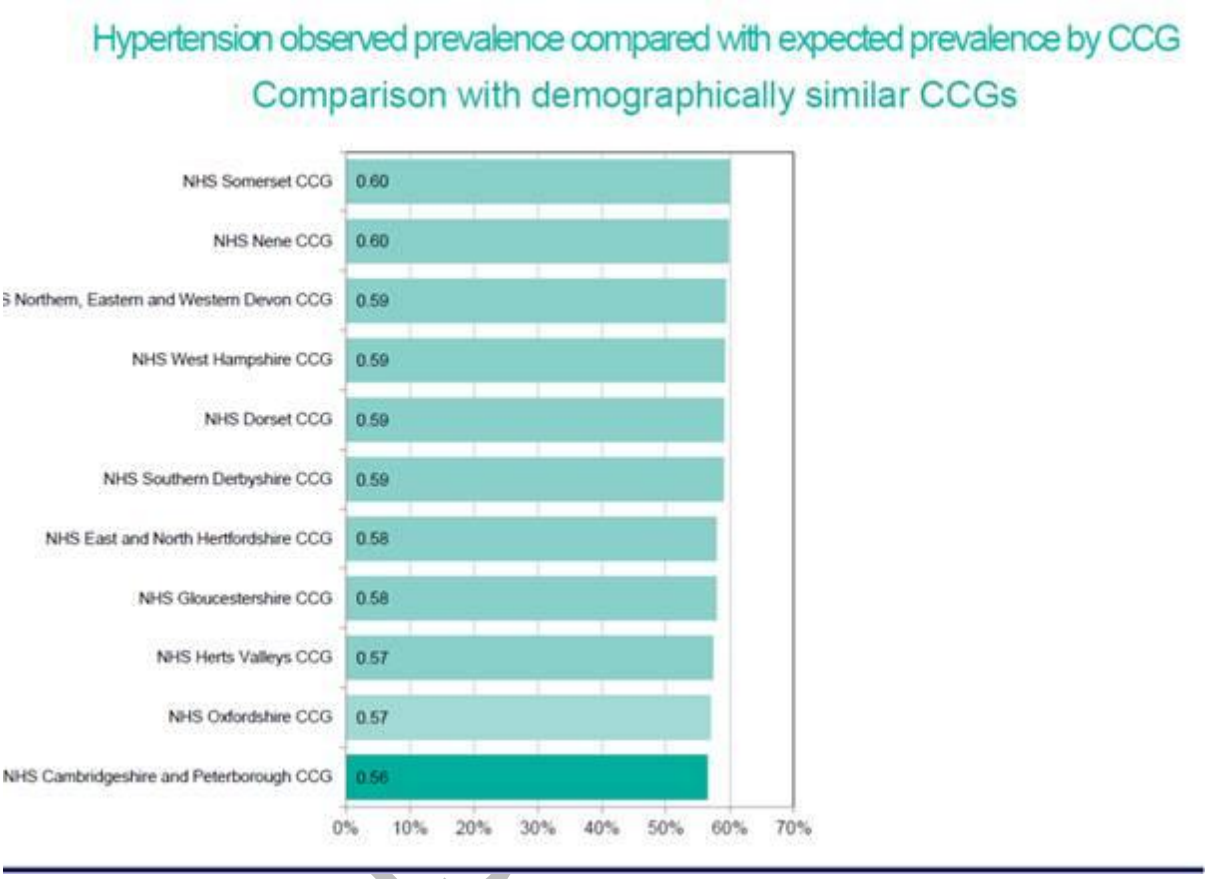


Figure 2.2 hypertension management (7)

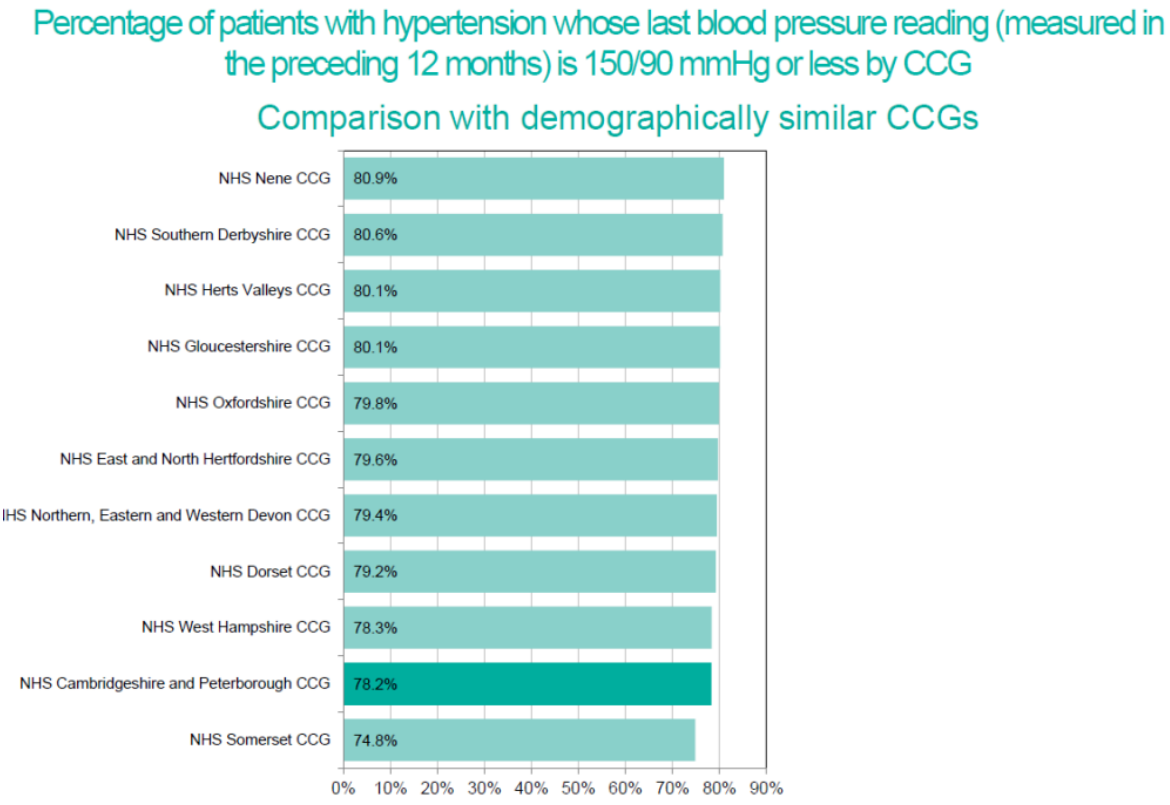


Figure 2.3 Record of blood pressure over time (9)

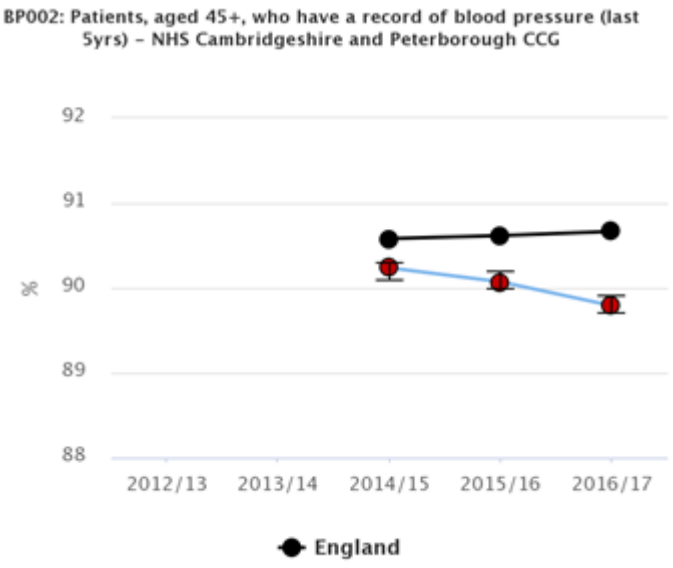


Figure 2.4 Hypertension prevalence in Peterborough between 2012 and 2017 (9)

Recent trend:

Period		Count	Value	Lower CI	Upper CI	East of England	England
2012/13		22,894	12.2	12.1	12.4	13.4*	13.7
2013/14		23,171	12.1	12.0	12.2	14.1	13.7
2014/15		23,410	11.9	11.8	12.1	14.2	13.8
2015/16		23,855	11.8	11.6	11.9	14.1	13.8
2016/17		24,420	11.7	11.6	11.9	14.1	13.8

Source: QOF

Figure 2.5 Hypertension prevalence in Cambridgeshire between 2012 and 2017 (9)

Recent trend:

Period		Count	Value	Lower CI	Upper CI	East of England	England
2012/13		83,903	13.0	12.9	13.1	13.4*	13.7
2013/14		84,779	12.9	12.8	13.0	14.1	13.7
2014/15		86,076	12.8	12.7	12.9	14.2	13.8
2015/16		87,589	12.7	12.7	12.8	14.1	13.8
2016/17		89,074	12.7	12.7	12.8	14.1	13.8

Source: QOF

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10. Public Health England, Fingertips, Cardiovascular disease profile https://fingertips.phe.org.uk/cardiovascular#page/0/gid/1938133106/pat/46/par/E39000031/ati/152/are/E38000026 accessed on the 5th October 2018

3. Workplace Health

Background

Supporting staff wellbeing in the workplace can have important beneficial effects both for individual employees and for the organisation in reducing absenteeism, presentism and improving productivity (1). Poor staff health and wellbeing significantly impacts on the performance of NHS organisations. Public Health England estimates that the cost to the NHS of staff absence due to poor health is £2.4 billion a year, that is £1 in every £40 of the total budget (1).

Working adults spend a third of their waking hours in work, workplaces are key spaces for improving wellbeing and can be a crucial area to address inequalities in health that can be seen across the paygrades. The NHS is a major employer in Cambridgeshire and Peterborough, employees people across the whole geographical area and across all socio-economic groups, and can shape the environments for the significant number of people in the workforce.

PHE (2) has highlighted how workplaces can:

- Promote physical activity amongst staff,
- Encourage sedentary employees to move more
- Help employees eat well
- Promote mental well being
- Provide staff with information to help them improve their health and wellbeing
- Include everyone who contributes to the workforce be they part-time, full-time, working from home or even contractors.

NICE published guidance on management practices to improve workplace health in 2015 (3) and quality standards for workplace health in 2017(4). NHS England has worked in partnership to create a new Health and Wellbeing Framework and accompanying diagnostic tool to help NHS organisations plan and implement their own approach for improving staff health and wellbeing (1). This framework has been developed by NHS Employers, NHS England and NHS Improvement with support from partners across the NHS, voluntary sector and government to bring best practice, research and insights together in one accessible place for the first time for NHS organisations. The three health areas (mental health, musculoskeletal and healthy lifestyles) have emerged. Interventions fall under two categories either prevention and self-management or targeted support.

What was the situation in 2015?

In Cambridgeshire in 2015, the annual public health spend on general workplace health in the population was £45,000. Peterborough carried over a small reserve, £90,000 of which was committed in principle for a workplace health programme over the next two years. Table 3.1 below shows there were over 22,000 people employed in each of the main NHS employers in Cambridgeshire and Peterborough, as of June 2015.

Recommendations in 2015

NHS employers should see considerable productivity savings from investing in workplace health. In particular, this needs to focus on improved management and awareness of mental

health and illness. The previous Health System Prevention Strategy modelled a package that could be carried out in the NHS employers in Cambridgeshire and Peterborough. This package included mental health first aid lite champions, health champions, ACAS training for managers, physical activity brief intervention and weight management tier 1 and 2 services. The model was estimated to save approximately £3.9m over 3 years for an initial investment of £335k.

What is the situation in 2018?

The same large NHS employers in Cambridgeshire and Peterborough exist. As of August 2017, there were over 18,000 employed by these organizations, there may be up to 4,000 more depending on the number employed by Peterborough and Stamford Hospitals Trust (Table 3.1) (5). Table 3.2 shows that the investment in workplace health from 2015 onwards in total has fallen year on year.

What has happened since 2015?

A workplace health and wellbeing programme has been commissioned by Cambridgeshire Local Authority and Peterborough Local Authority since 2015. The programme promotes health interventions to workplaces of all types across Cambridgeshire and Peterborough with a specific focus upon those with predominantly routine and manual workers in order to focus on health inequalities. The current workplace programme offers employers the following support and interventions;

- On site delivery of the NHS Health Check programme,
- Mental Health First Aid training,
- Training for volunteer Health Champions within the workforce,
- Support to carry out a needs assessment of staff health and wellbeing,
- Networks for Health and Wellbeing leads and Health Champions,
- Interactive workshops for staff on health topics,
- Onsite stop smoking clinics/training for Occupational Health staff,
- Onsite weight management services (dependant on demand).

The Workplace Health Programme can be accessed by all types of employers across Cambridgeshire and Peterborough.

Programme data shows that out of the large NHS employers, only Cambridgeshire and Peterborough CCG have taken up this Workplace Health Programme. Addenbrookes has its own occupational health programme which covers the same elements as the Workplace Health Programme.

Recommendations

- There needs to be senior leadership and high level organisational commitment to improving staff health and wellbeing and addressing health inequalities that exist within NHS organisations. This needs board level engagement, a strategy and evaluation to ensure continuous improvement.
- It is important to capitalise on the existing resources available e.g. the online resources and the Cambridgeshire and Peterborough Workplace Health Programme offer. Ensure a supportive environment exists for healthy behaviours.

- In line with commitments of the NHS Five Year Forward View, encourage staff to acknowledge their position as role models and health advocates

Tables

Table 3.1 – Headcount of NHS employees by NHS Provider organisation, as of June 2015

NHS employer	Headcount as of June 2015	Headcount as of June 2017
Cambridge University Hospitals NHS Foundation Trust	9,509	9,437
Peterborough and Stamford Hospitals Trust	4,021	No data
Cambridgeshire and Peterborough NHS Foundation Trust	3,665	3,742
Cambridgeshire Community Services NHS Trust	1,955	2,019
Papworth Hospital	1,899	1,754
Hinchingbrooke Health Care NHS Trust	1,689	1,700
TOTAL	22,738	18,652 + PSHT

Source: Health and Social Care Information Centre

Table 3.2 – Investment in workplace health programmes across Cambridgeshire and Peterborough

Year	Provider	Investment Cambridgeshire Local Authority	Investment Peterborough Local Authority	Total
2015/16	Business in the Community and PCC in-house	£45,000	£42,000	£87,000
2016/17	Business in the Community	£45,000	£45,000	£90,000
2017/18	Business in the Community	£48,000	£52,000	£100,000
2018/19	Everyone Health	£56,800	£23,200	£80,000
2019/20	Everyone Health	£53,250	£21,750	£75,000
2020/21	Everyone Health	£46,150	£18,850	£65,000

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1. NHS England (2018) Workforce health and wellbeing framework. NHS England, London
2. Public Health England (2018) 5 ways business can help employees eat well and move more. https://publichealthmatters.blog.gov.uk/2018/03/07/5-ways-businesses-can-help-employees-eat-well-and-move-more/ accessed 8th October 2018
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4. Smoking

Background

Smoking is the single largest cause of preventable ill health and premature death in England (1). Reducing smoking rates has the single biggest potential to improve the nation's health as it will reduce cardiovascular disease, respiratory conditions and cancer. The annual cost of smoking to society in England is estimated to be £14.7 billion and out of this, the direct costs to the NHS are estimated at £2.5 billion (2). Smoking rates remain highest amongst the most disadvantaged, with smoking rates nationally almost 3 times higher amongst the lowest earners compared to the highest earners (3) More than 40% of adults with a serious mental illness smoke (4). NHS England has made commitments to a smoke free NHS in the latest Tobacco Control Plan and Five Year Forward View (2).

What was the situation in 2015?

- In Cambridgeshire, around 16% of adults were estimated to smoke. Although this was below the national average of 18%, it represented around 79,000 smokers across the county. Rates varied through the county with Fenland showing consistently higher rates.
- In Peterborough, around 18% of adults were estimated to smoke. Peterborough smoking rates were consistently higher than the national average but showing a decline similar to that seen nationally. The smoking levels equated to around 27,000 smokers.
- Smoking is more common among people working in routine or manual professions. 27% of these workers were estimated to smoke in the county in 2015 in Cambridgeshire and Peterborough, similar to the national average of 28%. Data suggests smoking rates have been higher in this group in Peterborough, Fenland and East Cambridgeshire.
- There were high smoking in pregnancy rates in Peterborough. In 2014, data showed that 18% of mothers were smokers at the time of delivery in Peterborough compared to 13% in Cambridgeshire and in England as a whole.
- The pace of the reduction in smoking was levelling off, with a fall in the number of people setting a four week quit date, and the number of four week quitters, particularly in Peterborough.
- In Cambridgeshire, annual public health spend on smoking and tobacco control was £1,167,000. In Peterborough, spend per head on smoking and tobacco control was £1.84 per head, compared with a national average of £3.36 and an average for Peterborough's deprivation decile of £3.38.
- Survey data of over 8,500 year 8 and 10 pupils in Cambridgeshire found that in 2014 1% of year 8 and and 7% of Year 10 pupils reported that they smoked regularly, with around half wishing to give up. Prevalence was higher in girls than boys, in children in care and in children in single parent families.

Recommendations from 2015

- Continue to invest in regional programme work, such as tobacco control.

- There are additional savings to the NHS to be made from stopping people smoking before operations, and this along with sub-groups in the population with high prevalence levels should be a focus for the additional numbers setting a quit date.
- An additional investment of £346k, only £175k of which is new investment, is needed to generate a net saving over £356k over the next two years.

What is the situation in 2018?

- Smoking prevalence in Cambridgeshire continues to decline in line with national figures. It is currently 14.5% which is not significantly different from the England prevalence of 14.9%. This now equates to 74,295 smokers. Within Cambridgeshire, Fenland has seen a decrease in smoking prevalence from 2011 when it was significantly higher than England levels to a prevalence that is currently not significantly different (Figures 4.1 and 4.2), smoking prevalence in Fenland has fallen to 16.3%. Cambridge city now has the highest prevalence of smokers in Cambridgeshire (17%). In 2017 there were just over 100,000 smokers in the combined authorities (5).
- In Peterborough, in contrast to the national decline, smoking prevalence appears to have plateaued with only a marginal decrease since 2014, with 17.6 % of the population smoking (Figure 4.3). This equates to over 26,000 smokers.
- Smoking prevalence in routine and manual workers in Peterborough has increased from 26.7% in 2015 to 28.5% in 2017, despite levels in England in this group falling from 29.6% to 25.7% (Figure 4.4). In Cambridgeshire there does appear to have been a sustained fall in routine and manual workers from 27.2% in 2014 to 22.8% in 2017 (Figures 4.4 and 8.5). Stop Smoking service data (Figure 4.6 and 4.7) shows that there has been a sustained increase in the numbers of routine and manual workers accessing services from 2015 (337 to 402) and that the quit rate at 4 weeks is high 65% compared to national figure of 50%.
- Whilst there has been a continuous decline in the prevalence nationally for smoking at the time of delivery to 10% in England with a national ambition to achieve a level of 6% of less by 2022. In both Cambridgeshire and Peterborough PHE has flagged up issues with the data quality of smoking status at the time of delivery. Local hospital data for 2017/18 show 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 (6).
- In both Cambridgeshire and Peterborough the rate per 100,000 smokers successfully quitting at 4 weeks has been sustained, whereas this is declining nationally (Figure 4.6).
- The NICE tobacco return on investment tool can be used to estimate that the total annual cost of smoking to Cambridgeshire and Peterborough is £36M (£26M in Cambridgeshire and £10M in Peterborough) of which £21M is costs to the health services alone. This includes an estimated 110,000 additional GP consultations and 4480 additional hospital admissions.

- 2016 school survey data indicates that 1% of Year 8 and 6% of Year 10 pupils reported that they smoked regularly, with around half wishing to give up, this is a decline of 1% in year 10 pupils from the 2014 survey. Prevalence remains higher in girls than boys, in children in care and in children in single parent families. The proportion of Year 10 children in Cambridgeshire who reported never having smoked, has increased from 54% in 2008, 65% in 2014 to 76% in 2016.

What has happened since 2015?

- The central Stop Smoking services in Cambridgeshire and Peterborough have been transferred into the Integrated Lifestyle Services provided by Everyone Health (Cambridgeshire) and Solutions 4 Health (Peterborough). This has enabled a larger workforce to deliver smoking cessation brief interventions and intensive support to people accessing the Lifestyle services, increasing their reach into routine and manual client group and the migrant population. Multilingual health trainers and Stop Smoking advisors, along with increased partnership work, have improved the delivery of services scope and reach. The services have adopted a mobile approach (i.e. taking clinics out to workplaces, community centres for the migrant population, job centres).
- Access to stop smoking clinics in high prevalence areas within both Peterborough and Fenland has increased. This has included clinics being provided in community settings such as community centres, places of worship, community pharmacies, market place clinics, workplaces, mobile van-based health clinics in high footfall areas, supermarket car parks, car boot sales.
- Comprehensive Stop Smoking campaigns have continued to support national campaigns e.g. January Health Harms, No Smoking day and Stoptober.
- There is an ongoing training programme for Stop Smoking advisers to complete with health professionals, midwifes, health visitors and young people, as part of the young people smoking prevention programme. Over 100 health professionals in Cambridgeshire and Peterborough have received the Public Health Brief Advice- Ask, Advise, Assist information sheets for smoking, alcohol, physical activity, healthy eating and falls prevention.
- Ongoing support and monitoring of Stop Smoking services is provided to GP and community pharmacy services.
- Cambridgeshire & Peterborough Local Authority Public Health team is working with the Better Births team to recruit to a Smoking in Pregnancy Specialist, funded by the Better Care fund.
- Work continues to understand the impact of vaping and exploring developments for the future. Meanwhile local GP templates and data collection forms have been amended to include ‘the use of electronic cigarettes’, all Stop Smoking training includes information about vaping to improve knowledge and confidence about the use of electronic cigarettes.
- Cambridgeshire & Peterborough Local Authority Public Health have commissioned a Healthy Workplace Support Service to target workplaces in both Cambridgeshire and

Peterborough with a particular focus on routine and manual workforces launched in September 2018.

- Cambridgeshire & Peterborough Local Authority Public Health and the local Stop Smoking services worked with partners and local authorities in the Eastern Region during 2017-18 to deliver a project on illicit tobacco. The project aimed to reduce demand and gather intelligence about sellers of illicit tobacco.
- A policy has been developed on stopping smoking before elective surgery, which has now been in place since the last Health System Prevention Strategy and is one of the longest established in the region. The requirement is that the patient should have had contact with a Stop Smoking service prior to surgery, rather than that they should have stopped smoking. The effect of the policy is hard to evaluate. The Stop Smoking service collects referral information and to date has not had referrals recorded due to the policy. The majority of smoking cessation support is provided within GP surgeries which do not report on whether referrals to in-house clinics were prompted by the policy. Anecdotally there are reports of patients who have quit before their operation and the policy is accepted as being generally supportive of the move to encourage patients to quit.
- Cambridgeshire & Peterborough Local Authority Public Health have commissioned a Healthy Schools Support Service for Schools, launching in October 2018.

Recommendations

- Ensure there is whole system support around work of the Smoking in Pregnancy Specialist and impetus to implement the NICE guidelines on stopping smoking in pregnancy and after childbirth.
- There is a high quit rate in routine and manual workers who access the Stop Smoking service in Peterborough, however there is still a rising rate of smoking in this group. A focus is needed on how to increase the numbers of routine and manual workers accessing the Stop Smoking services.
- There may be geographic variation in the application of the stopping smoking before pre-elective surgery policy which is not being picked up. It would be worth looking into how data on the success of the policy could be collected and compared.

Figures and Tables

Figure 4.1 Estimated smoking prevalence in Cambridgeshire (5)

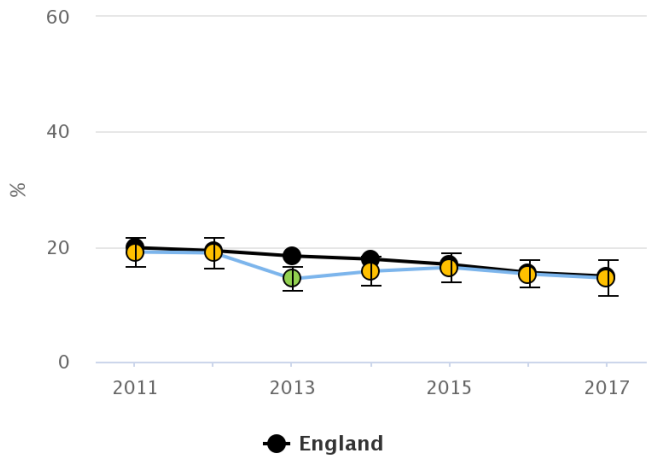


Figure 4.2 Estimated smoking prevalence in Fenland (5)

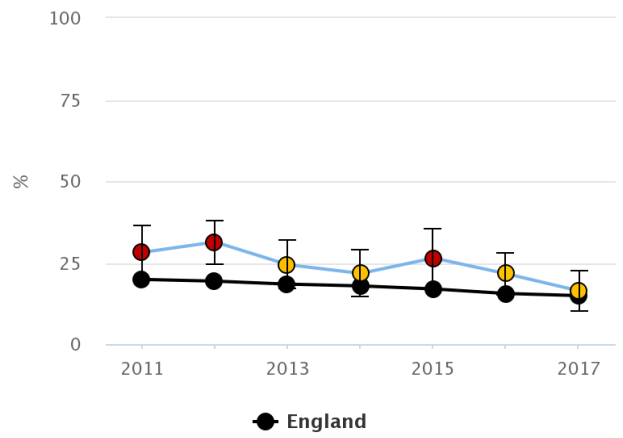


Figure 4.3 Estimated smoking prevalence in Peterborough (5)

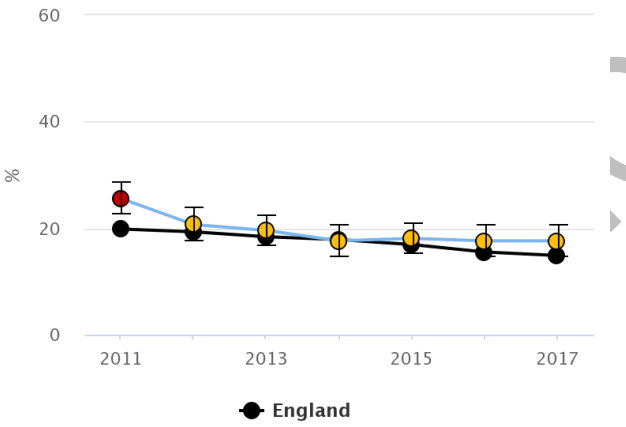
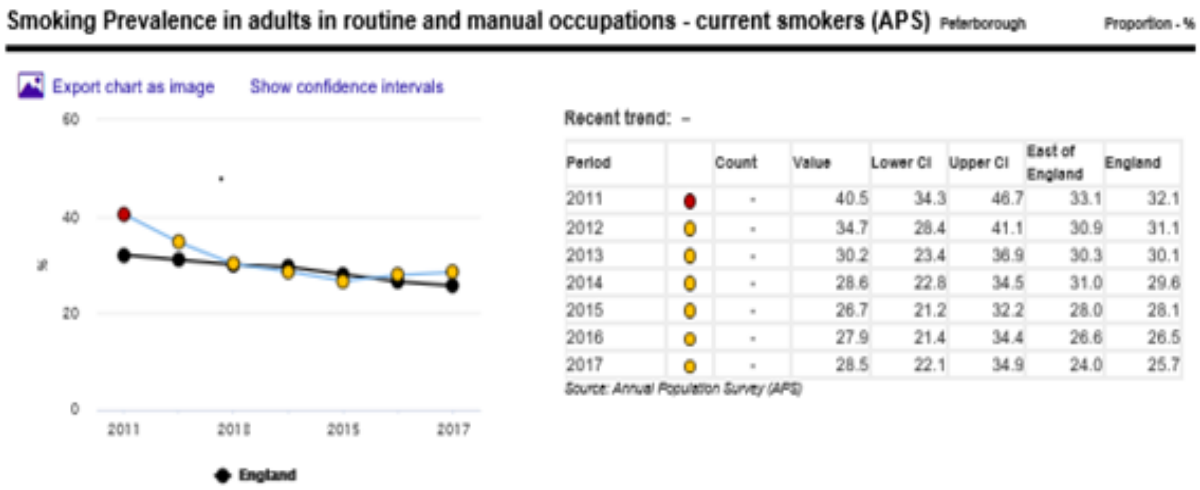


Figure 4.4 Smoking Prevalence in adult in routine and manual occupations in Peterborough – current smokers (5)



Smoking Prevalence in adults in routine and manual occupations - current smokers (APS) Peterborough Proportion - %

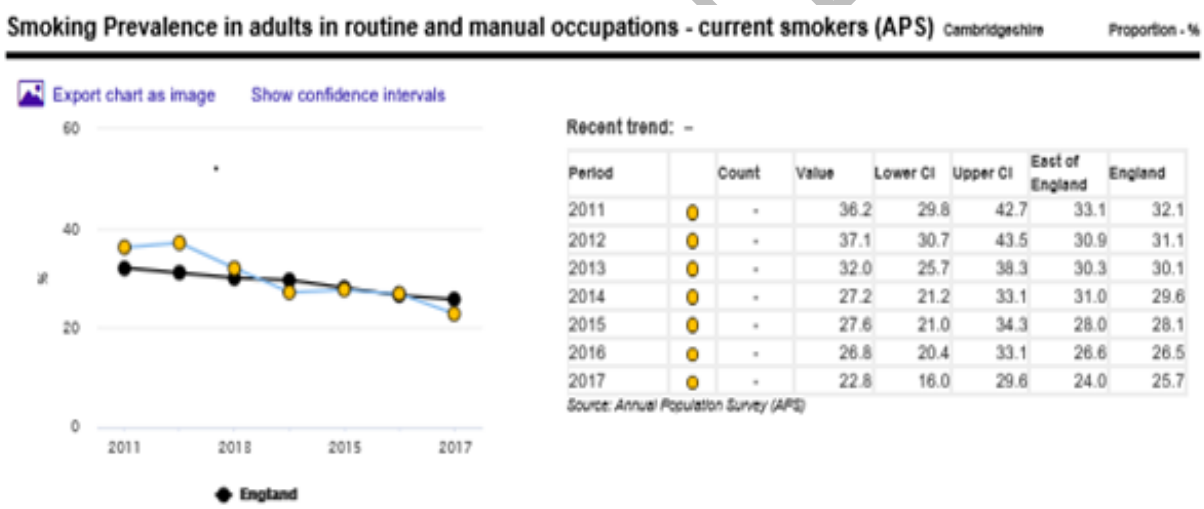
Export chart as image Show confidence intervals

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011		-	40.5	34.3	46.7	33.1	32.1
2012		-	34.7	28.4	41.1	30.9	31.1
2013		-	30.2	23.4	36.9	30.3	30.1
2014		-	28.6	22.8	34.5	31.0	29.6
2015		-	26.7	21.2	32.2	28.0	28.1
2016		-	27.9	21.4	34.4	26.6	26.5
2017		-	28.5	22.1	34.9	24.0	25.7

Source: Annual Population Survey (APS)

Figure 4.5 Smoking Prevalence in adult in routine and manual occupations in Cambridgeshire – current smokers (5)



Smoking Prevalence in adults in routine and manual occupations - current smokers (APS) Cambridgeshire Proportion - %

Export chart as image Show confidence intervals

Recent trend: –

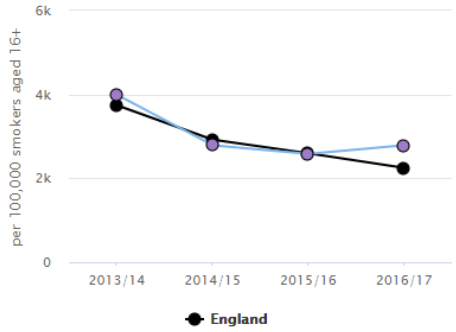
Period		Count	Value	Lower CI	Upper CI	East of England	England
2011		-	36.2	29.8	42.7	33.1	32.1
2012		-	37.1	30.7	43.5	30.9	31.1
2013		-	32.0	25.7	38.3	30.3	30.1
2014		-	27.2	21.2	33.1	31.0	29.6
2015		-	27.6	21.0	34.3	28.0	28.1
2016		-	26.8	20.4	33.1	26.6	26.5
2017		-	22.8	16.0	29.6	24.0	25.7

Source: Annual Population Survey (APS)

Figure 4.6 Crude Rate of Successful quitters at 4 weeks in Cambridgeshire and Peterborough per 100,000 smokers age 16+ (5)

Successful quitters at 4 weeks Cambridgeshire — Crude rate - per 100,000 smokers aged 16+

Export chart as image Show confidence intervals



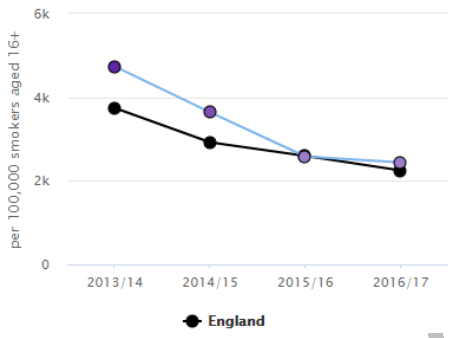
Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2013/14		2,978	3,993	-	-	4,113	3,743
2014/15		2,297	2,791	-	-	2,963	2,924
2015/16		2,243	2,585	-	-	2,787	2,598
2016/17		2,253	2,787	-	-	2,652	2,248*

Source: Risk Factors Intelligence Team, Public Health England

Successful quitters at 4 weeks Peterborough — Crude rate - per 100,000 smokers aged 16+

Export chart as image Show confidence intervals



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2013/14		1,367	4,738	-	-	4,113	3,743
2014/15		953	3,640	-	-	2,963	2,924
2015/16		706	2,583	-	-	2,787	2,598
2016/17		656	2,441	-	-	2,652	2,248*

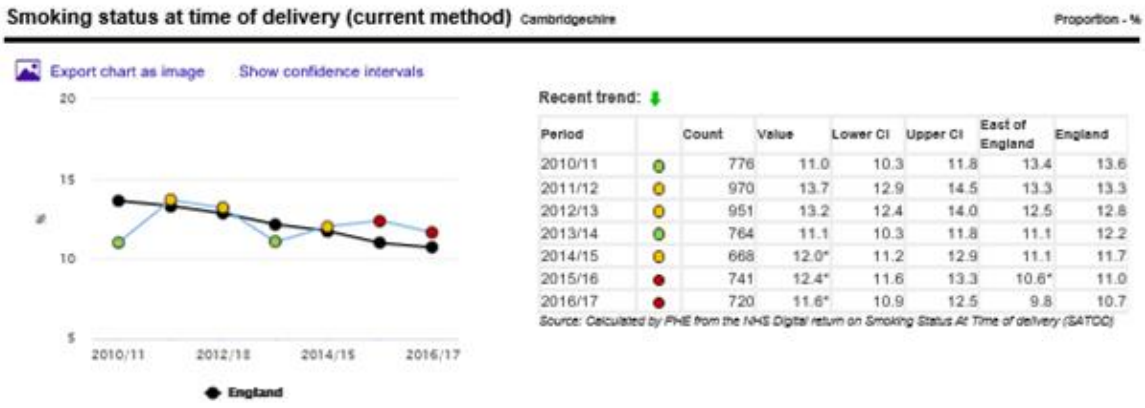
Source: Risk Factors Intelligence Team, Public Health England

Figure 4.7 Stop Smoking Services Summary

Cambridgeshire	Set a quit date	Quit at 4 weeks (%)	R & M set a quit date	R & M quit at 4 weeks (%)
2017-18	3819	2090 (55%)	1058	577 (56%)
2016-17	4243	2253 (53%)	1177	638 (54%)
2015-16	4450	2243 (50%)	1242	651 (52%)

Peterborough	Set a quit date	Quit at 4 weeks (%)	R & M set a quit date	R & M quit at 4 weeks (%)
2017-18	1415	876 (62%)	402	263 (65%)
2016-17	1043	656 (63%)	370	233 (63%)
2015-16	912	706 (77%)	337	270 (80%)

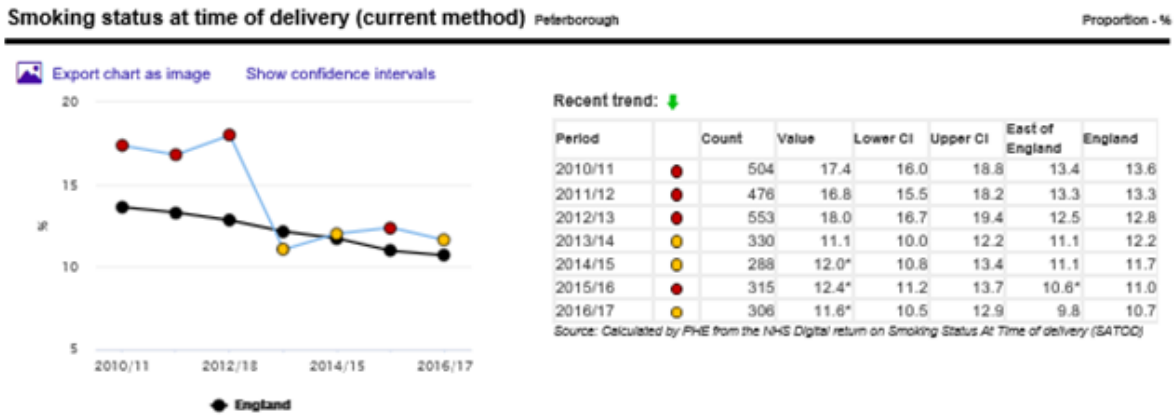
Figure 4.8 Smoking status at time of delivery Cambridgeshire (5)



Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		776	11.0	10.3	11.8	13.4	13.6
2011/12		970	13.7	12.9	14.5	13.3	13.3
2012/13		951	13.2	12.4	14.0	12.5	12.8
2013/14		764	11.1	10.3	11.8	11.1	12.2
2014/15		668	12.0*	11.2	12.9	11.1	11.7
2015/16		741	12.4*	11.6	13.3	10.6*	11.0
2016/17		720	11.6*	10.9	12.5	9.8	10.7

Source: Calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery (SATOD)

Figure 4.9 Smoking status at time of delivery Peterborough (5)



Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		504	17.4	16.0	18.8	13.4	13.6
2011/12		476	16.8	15.5	18.2	13.3	13.3
2012/13		553	18.0	16.7	19.4	12.5	12.8
2013/14		330	11.1	10.0	12.2	11.1	12.2
2014/15		288	12.0*	10.8	13.4	11.1	11.7
2015/16		315	12.4*	11.2	13.7	10.6*	11.0
2016/17		306	11.6*	10.5	12.9	9.8	10.7

Source: Calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery (SATOD)

References

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5. Obesity

Background

Obesity is a major cause of premature mortality and avoidable ill health, increasing risk of diabetes, heart disease, cancer, musculoskeletal problems, depression and dementia. The NHS Five Year Forward View notes that the NHS spends more on bariatric surgery than on intensive lifestyle intervention programmes that have been shown to be effective (1). As outlined in the Foresight Report (2), the causes of obesity are multifactorial with seven cross cutting clusters of themes: physiology, individual activity, physical activity, environment, food consumption, food production, individual psychology and social psychology.

The healthcare costs of overweight and obesity have been estimated to be £5.1 billion per year (3), with the costs to wider society of up to £27billion (4). Public Health England launched its Childhood Obesity Strategy: A Plan for Action in 2016 with chapter 2 following in 2018 (5). There is an increasing evidence base on the role of exposure to fast food outlets in determining obesity, independent of income level (6).

What was the situation in 2015?

- Unmet need with weight management services seeing only 1-2% of the population who are obese.
- Marked inequalities within the county and compared to national figures. Fenland, East Cambridgeshire and Huntingdonshire each had worse levels than Cambridgeshire's county average. The prevalence of obesity in Cambridgeshire was significantly lower than the national average, although Fenland and Peterborough had higher rates of obesity than the rest of the country (7)

Recommendations in 2015

- Immediately expand weight management services in Peterborough to reach NICE recommended levels.
- Maximise opportunities for lifestyle interventions identified through health checks across Cambridgeshire and Peterborough.
- Make 'lifestyle interventions' available on a much larger scale, including intensive health trainer options, for those identified as at risk of diabetes, or with hypertension through a health check or opportunistically. This should be underpinned by initiatives which help create an environment which encourages a healthy weight and should include the promotion of active travel.

What is the situation in 2018?

- In Cambridgeshire, the prevalence of adults classified as overweight or obesity has fallen from 60.8% (2015/16) to 59.8% (2016/17) overall, while in Peterborough it remains above national average having only reduced from 62.9% to 62.5% (2016/17) (7).

However, even within Cambridgeshire, inequalities remain, with the prevalence of adults overweight or obese in Fenland reaching 70.7% in 2016/17.

- The prevalence of overweight and obese children in year 6 in Cambridgeshire and Peterborough shows clear inequalities in health. In Cambridgeshire the prevalence has remained below the national level (34.2%) and showed a sustained decrease from 2011 onwards to 27.1% in 2016/17. In Peterborough the most recent data from the National Childhood Measurement Programme for 2017/18 show that there is a prevalence of 32.8% of overweight and obese children in year 6. In terms of a trend, this is a decrease from 2015/16 and lower than the national prevalence of 34.3 %. The 2016/17 data that showed a spike of 36.8% appear to have been due to problems with the data return accuracy for that year (Figure 5.1).

What has happened since 2015?

- Addenbrooke's Life is an initiative to promote health and wellbeing for staff at Cambridge University via Hospitals Healthy lifestyle challenging poor health and promoting healthy activities, inner wellbeing and creating a community culture through social events. However, a PR Communication in 2010 Addenbrooke's Life is run on a minimal budget by sharing responsibility for organising initiatives across a number of teams (8).
- Cambridgeshire Local Authority finalised a Healthy Weight Strategy in 2016. The strategy emphasized a whole system approach across the lifecourse, working particularly with districts of Cambridgeshire and targeting approaches addressing environment, settings and information & skills to support healthy lifestyles (9). Cambridgeshire Local Authority are feeding into PHE's pilot programme to tackle obesity using a sustained whole systems approach. Guidance will be published in Spring 2019 (10).
- Weight management services commissioning is now allocated based on need with an increased number of services available in Peterborough than in 2015.
- All district councils have signed up to a Healthier Options Scheme. However, uptake of the Healthier Options Scheme by retailers has been low (2 in 2018) (11).
- Cambridgeshire Local Authority have been working with colleagues at the Centre for Diet and Activity Research (CEDAR) using their Food Environment Assessment Tool to inform the planning agenda (12). There has been engagement between the Local Authority planning and public health departments to influence decisions on planning for new communities in Cambridgeshire and Peterborough.
- A Healthy Schools Programme is due to be launched in October 2018.
- Cambridgeshire Local Authority spends £1.6m annually on health eating, weight management and physical activity. In Cambridgeshire, there are 1.4k people being supported by weight management services every year, which costs £571k annually; In Peterborough 278 people were supported by health eating services (71% completed the course) which cost £132k in 2016/2017. There were 131 children and young people were enrolled in a weight management program (63% completed), costing £66k in 2016/2017. A recent evaluation of weight management services was completed as an MPH thesis (in publication) (13)

Recommendations

- Make hospitals exemplar sites for healthy lifestyles in line with Healthy Hospitals and Healthier Options schemes using WHO's Health Promoting Hospital's Standards (14) and in line with Healthier Hospitals Initiative (15) in the USA. Consider making this a commissioning standard for local providers
- Assess the need for more accredited Making Every Contact Count training for all NHS frontline staff (16) to support healthcare professionals to feel confident in discussing weight, nutrition and physical activity through motivational interviewing
- Weight management services are only serving a minority, consider radical widespread approaches that make weight management a routine part of all aspects of healthcare.
- Prioritise and ensure action on wider opportunities for obesity prevention and weight management including using Nudge Theory and creating an environment to support healthy behaviours. Make full use of local academic expertise from the Behaviour Research and Health Unit (17), Centre for Diet and Activity Research (CEDAR) (18) and Institute of Public Health (19) who have had limited experience working with local commissioners and providers to date.

Figures and Tables

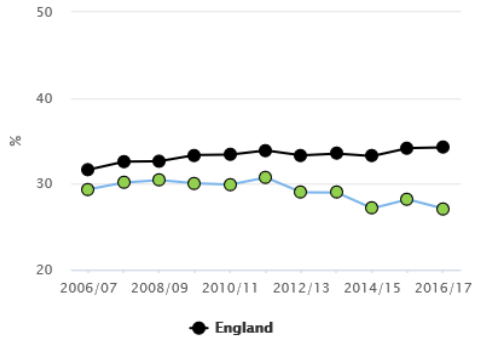
Table 5.1 Prevalence of overweight and obesity in people aged 18 and over

Year	NHS Cambridgeshire and Peterborough CCG (%)	England (%)
2015/16	60.8	61.3
2016/17	59.8	61.3

Figure 5.1 Prevalence of overweight children in year 6 in Cambridgeshire and Peterborough

Year 6: Prevalence of overweight (including obese) Cambridgeshire — Proportion - %

Export chart as image Show confidence intervals



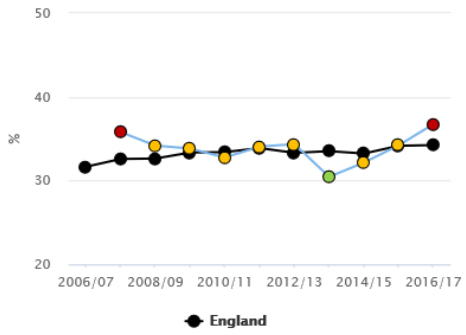
Recent trend: ⬇

Period		Count	Value	Lower CI	Upper CI	East of England	England
2006/07		1,205	29.4	28.0	30.8	*	31.7
2007/08		1,565	30.2	28.9	31.4	30.9*	32.6
2008/09		1,724	30.4	29.3	31.6	30.7	32.6
2009/10		1,655	30.1	28.9	31.3	31.4	33.4
2010/11		1,569	29.9	28.7	31.2	31.7	33.4
2011/12		1,655	30.7	29.5	32.0	31.7	33.9
2012/13		1,568	29.0	27.8	30.2	31.0	33.3
2013/14		1,636	29.0	27.8	30.2	31.1	33.5
2014/15		1,524	27.2	26.0	28.3	30.7	33.2
2015/16		1,592	28.2	27.0	29.4	31.7	34.2
2016/17		1,556	27.1	26.0	28.3	31.5	34.2

Source: NHS Digital, National Child Measurement Programme

Year 6: Prevalence of overweight (including obese) Peterborough — Proportion - %

Export chart as image Show confidence intervals



Recent trend: ➡

Period		Count	Value	Lower CI	Upper CI	East of England	England
2006/07		-	*	-	-	*	31.7
2007/08		511	35.8	33.4	38.3	30.9*	32.6
2008/09		651	34.2	32.1	36.4	30.7	32.6
2009/10		669	33.8	31.8	36.0	31.4	33.4
2010/11		647	32.8	30.7	34.9	31.7	33.4
2011/12		690	34.1	32.0	36.2	31.7	33.9
2012/13		712	34.4	32.3	36.4	31.0	33.3
2013/14		675	30.5	28.6	32.4	31.1	33.5
2014/15		620	32.2	30.1	34.3	30.7	33.2
2015/16		794	34.2	32.3	36.2	31.7	34.2
2016/17		852	36.8	34.8	38.7	31.5	34.2

Source: NHS Digital, National Child Measurement Programme

Figure 5.2 Healthy weight strategy

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18. Centre for Diet and Activity Research http://www.cedar.iph.cam.ac.uk/resources/evidence/
19. Institute of Public Health https://www.iph.cam.ac.uk/
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6. Malnutrition

Background

Malnutrition is measured as a Body Mass Index (BMI) lower than 18.5kg/m2 or unintentional 10% weight loss. It is estimated that one in ten people over the age of 65 are malnourished or at risk of malnutrition. NICE have identified malnutrition as the sixth largest source for potential NHS savings (1). The annual health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient stays, more primary care consultations and the greater long-term care need. Malnourished people visit their GP twice as often, are admitted to hospital three times more often and have longer lengths of stay, have longer recovery times and increased mortality (2,3,4)

About two thirds of cases of malnutrition are not recognised. Nutrition Screening Surveys estimate that 32% of people admitted to hospital are already malnourished or at risk of malnutrition and 35% on admission to a care home (2).

Every provider organisation is required by the Health and Social Act 2008 (Regulated Activities) Regulations 2014 (Regulation 14) to make sure the individuals must have their nutritional needs assessed and food must be provided to meet those needs" (5) Regular screening for malnutrition is recommended by NICE; early intervention screening and appropriate treatment is cost-effective (1,3,4,6). Those at risk should have a 'food first' approach, including dietary advice to optimise their intake, and support with practicalities.

The total health and social care public expenditure associated with malnutrition in adults and children in England in 2011-12 identified using the 'Malnutrition Universal Screening Tool' (MUST) was estimated to be £19.6 billion (about 15% of total expenditure). Older adults accounted for 52% of the total, younger adults for 42%, and children for 6%. Institutionalisation of malnourished people (hospital inpatients and care home residents) accounted for up to £9.3 billion (4)

Since the last Heath System Prevention Strategy several initiatives and guidelines have been published. In 2015 the British Association for Parenteral and Enteral Nutrition (BAPEN) launched a Malnutrition Self Screening Tool for use by individuals and their carers who were concerned about malnutrition. In 2016 the BAPEN Managing Adult Malnutrition in the Community Pathway was made available to assist professionals to identify and manage malnutrition. NHS England and NICE have both published guidelines, and campaigns have been launched such as 'protected mealtimes' and 'Nutrition Now' (Royal College of Nursing). These have helped to raise the profile of nutrition but understanding of malnutrition and nutritional support appears to remain poor. In 2016, Malnutrition Taskforce published research showing that only half of health professionals thought malnutrition was a priority in their organisations or knew what support and services were available.

What was the situation in 2015?

An estimated 13,000 to 18,300 older people malnourished in the Cambridgeshire & Peterborough population, and more at risk.

Recommendations in 2015

Potential cost savings may be achieved by increasing the proportion screened for malnutrition among inpatients, outpatients and new GP registrations to 90% and appropriate treatment; investment of £524k and savings in the order of £543k primarily from reducing length of stay in acute care. At worst this intervention should not cost the NHS additional funding, and will improve quality of life for older people.

What is the situation in 2018?

No updates are available since the 2015 Strategy. PHE's Local Knowledge and Intelligence Service knew of no local data on malnutrition. An additional enquiry was made to the National Risk Factors Intelligence team which leads on nutrition who said they were also unaware of any data. They looked into using the National Diet and Nutrition Survey but the sample size was thought to be too small and individuals with malnutrition would be poorly represented.
British Association for Parenteral and Enteral Nutrition (BAPEN) ran four Nutrition Screening Week surveys undertaken by in 2007, 2008, 2010 and 2011. Further Nutrition Screening week planned for October 2018 but at the time of publishing this information is not yet available.

BAPEN launched the Nutritional Care Tool in 2015 and 70 organisations are currently registered and have submitted data. From providers in Cambridgeshire and Peterborough Papworth Hospital NHS Foundation Trust were one of 12 trusts to submit data for each quarter in at least one of the last two years (9).

What has happened?

- Malnutrition was one of four main targets within the Healthy Ageing agenda at Cambridgeshire Local Authority in 2016. However, it was removed as a priority at the Ageing Well Strategy Board in May 2017 due to a lack of capacity to progress relevant actions..
- Malnutrition was included in Cambridgeshire Local Authority's Healthy Weight Strategy but did not feature in the implementation plan.

Recommendations

- Build strategic ownership and leadership on malnutrition across the health and care system. Raise understanding of the importance and costs of malnutrition and launch a working group to implement national guidance including from NHS England, NICE, CQC and BAPEN.
- Focus on implementing the Patient Pathway as per NICE guidelines including screening of all hospital inpatients on admission and all outpatients at their first clinic appointment. Screening should be repeated weekly for inpatients and when there is clinical concern

for outpatients. People in care homes should be screened on admission and when there is clinical concern. Screening should take place on initial registration at general practice surgeries and when there is clinical concern. Screening should also be considered at other opportunities (for example, health checks, flu injections).

- Attention should be paid to cultural, ethical and legal issues, providing patients with information and ensuring clear treatment goals at all stages, appropriate nutritional support, monitoring and review. Link with third sector and community contacts to better utilise existing services.
- Ask all local trusts to use the BAPEN Nutritional Care Tool and submit data. Work with GP practices, communities and care homes to monitor screening and management of malnutrition locally.
- Improve awareness and scale up use of BAPEN Tools and training resources by healthcare workers, carers, social workers, and the voluntary sector.

Figures

Figure 6.1 The distribution of total public health and social care expenditure in England (£127.5 billion) and in the subgroup of individuals with malnutrition (£19.6 billion) according to type of care (upper graph) and age category (lower graph) (base case analysis) (1ry = primary care; 2ry = secondary care) (4)

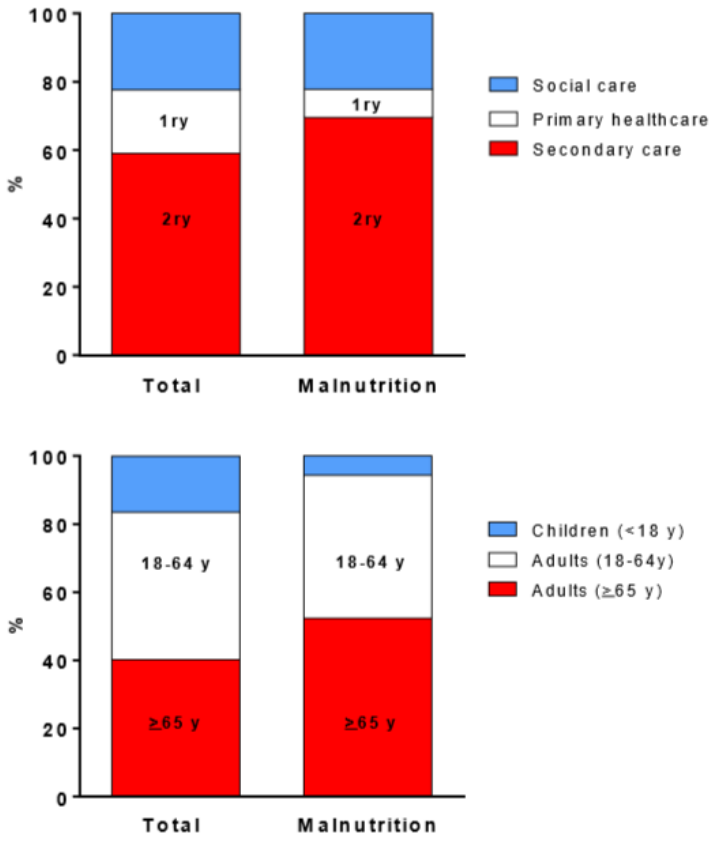

Table 6.1 Total health and social care expenditure and the estimated cost of malnutrition in England 2011/12 (4)

Type of care	Expenditure (£billion)	% due to malnutrition	Cost of malnutrition (£billion)
Health care			
Operating expenditure			
Secondary care			
Hospital inpatients			
Older adults	9.580	39.6	3.798
Younger adults	8.370	30.3	2.536
Children	1.745	18.7	0.326
Adults + children	***19.694***	***33.8***	***6.659***
Hospital outpatients		0.0	
Older adults	2.137	15.0	0.321
Younger adults	3.222	15.0	0.483
Children	0.765	7.5	0.057
Adults + children	***6.124***	**14.1**	***0.861***
Other			
Older adults	19.323	15.0	2.898
Younger adults	19.323	15.0	2.898
Children	4.294	7.5	0.322
Adults + children	***42.940***	***14.3***	***6.119***
Total secondary care purchased	**68.759**	**19.8**	**13.639**
Primary care			
Older adults	6.924	10.0	0.692
Younger adults	11.683	7.0	0.818
Children	3.029	4.0	0.121
Adults + children	***21.636***	7.4	***1.631***
Total primary care purchased	**21.636**		**1.631**
Capital and revenue grants	**0.212**		
Non-operating expenditure	11.000		
TOTAL HEALTH CARE	**101.607**	**15.0**	**15.271**
Social care			
Adult older people (≥65 years)			
Residential provision: nursing and residential care	4.690	36.0	1.688
Assessment and management	1.020	29.0	0.296
Day and domiciliary provision	3.210	18.0	0.578
Total for adults ≥65 years	**8.920**		**2.562**
Adults 18–64years*			
Residential provision: nursing and residential care	2.820	24.0	0.677
Assessment and management	0.860	19.0	0.163
Day and domiciliary provision	4.230	16.0	0.677
Total for adults 18–64 years	**7.910**		**1.517**
Total adults >18 years	**16.830**		**4.079**
Children (2010–11)	**9.300**	**3.0**	**0.279**
Other*	**0.370**		
TOTAL SOCIAL CARE	**26.500**		**4.358**
TOTAL HEALTH AND SOCIAL CARE	**128.107**	**15.29**	**19.629**

Figure 6.2 The costs, cost savings and budget impact (net effect) of providing nutritional support to ~85% of subjects with high risk of malnutrition (model 5). PN = parenteral nutrition, ETF = enteral tube feeding, ONS = oral nutritional supplements. (4)

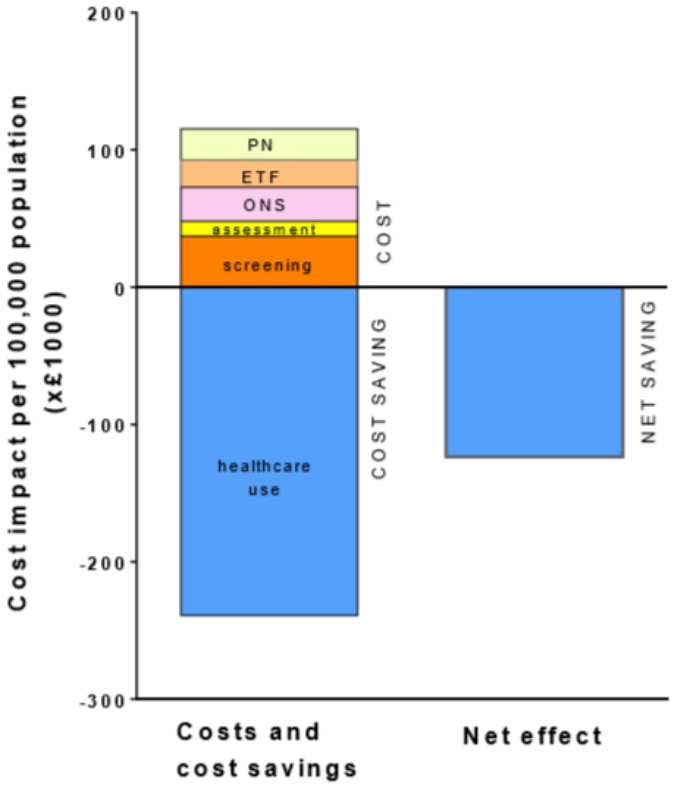

Figure 6.4 The Financial Case for Prevention and Early Treatment of Malnutrition (11)

Costs

- Malnourished patients visiting their GP incur an additional health care cost of £1449 per patient in the year following diagnosis (Guest et al, 2011; Malnutrition Task Force, 2013).
- The estimated costs of malnutrition in the UK range from :
  - £5bn for direct health care costs (Guest et al, 2011: Malnutrition Task Force, 2013)
  - To £13bn for associated health and social care expenditure in 2007 (Elia & Russell for BAPEN, 2009).
- Dehydration is a significant problem among older people, but there are no reported studies which demonstrate the total cost.

Saving opportunities

- Investing in screening and early intervention could result in a net saving of £71,800 per 100,000 of the population for the average Primary Care Trust (National Institute for Health & Care Excellence, 2012).
- Regular screening and monitoring all people in care homes has been shown to cost half that of treating those who are malnourished (Meijers et al, 2011).
- Investing in community meal services has shown every £1 invested in community meals leads to a Social Return on Investment of between £3.00-£5.30 (Leicestershire Meals Service, 2012; Hertfordshire Community Meals, 2012).
- Appropriate use of Oral Nutritional Supplements (ONS) in hospitals has been found to save £849 per patient based on length of stay and reduce GP attendances (Elia & Stratton, 2009).
- Proper hydration alone has been identified as potentially leading to significant savings to the NHS (Campbell, 2011), but further research is needed to determine costs.

Note: The costs of treating malnutrition and the interventions do not explicitly differentiate between age groups.

Figure 6.5 Cost-effectiveness (cost per QALY gained) of screening inpatients, by malnutrition risk and baseline mortality (1)

Patients at moderate or high malnutrition risk	All-cause mortality in 60 days from admission						
	1.0%	1.5%	2.0%	2.5%	3.0%	3.5%	4.0%
1%	65,300	44,400	33,900	27,600	23,400	20,400	18,200
2%	37,800	26,000	20,000	16,500	14,100	12,500	11,200
3%	28,600	19,800	15,400	12,800	11,100	9,800	8,900
4%	24,000	16,800	13,100	11,000	9,500	8,500	7,700
5%	21,200	14,900	11,700	9,800	8,600	7,700	7,000
6%	19,400	13,700	10,800	9,100	8,000	7,100	6,500
7%	18,100	12,800	10,200	8,600	7,500	6,800	6,200
8%	17,100	12,200	9,700	8,200	7,200	6,500	6,000

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7. Mental Health

Background

It is estimated that the NHS spent over £9 billion in 2015/16 on mental health (2). These costs under-estimate the full impact of poor mental health which increases the risk of poor physical health and poor management of pre-existing health problems. Early intervention is key in mental health, 50% all lifetime mental health problems begin before the age of 14 and 75% by the age of 18 (1). Adults with learning disabilities have been shown to have higher rates of depression, anxiety and schizophrenia, but are more likely to be under diagnosed (8).

PHE published a review of the cost-effectiveness of services for the promotion of mental health and the prevention of mental ill-health in 2017 (2), this built on earlier economic modelling (4). The combined studies found the following return on investment for every £1 spent on interventions in the NHS, these were over varying time frames:

Intervention	Return on investment to the NHS	Total return on investment to all sectors
Health visitor interventions to reduce postnatal depression	0.4	0.8
Suicide and self-harm prevention	2.17	39.11
Early intervention for depression in diabetes	0.19	0.33
Early intervention for medically unexplained symptoms	1.01	1.75
Early detection of psychosis	2.62	10.27
Screening for alcohol misuse	2.24	11.75
Promoting the mental health of people with physical health problems	0.26	1.52

The Five Year Forward View for Mental Health (5) published in 2016 emphasizes that prevention and early intervention should be prioritised. In 2017 Public Health England published the Prevention Concordat for better mental health, a set of resources designed to help local areas put in place effective prevention planning arrangements (3).

Recommendations in 2015

Mental health was taken to be outside the scope of the previous Health System Prevention Strategy because of a weaker evidence base for financial impact and savings to the NHS in 2015. There were however some specific recommendations made on mental health service provision for people with long term conditions (LTC):

- Routine management of LTCs should include the identification of those requiring further assessment for depression and anxiety early in the pathway. Physical and mental health pathways should be integrated to facilitate this.
- There should be maximum utilisation of the IAPT LTC team, and there should continue to be a focus on rapidly increasing referrals. There should be a focus on those with multiple long-term conditions.
- There should be an economic evaluation of the impact on healthcare costs of identification and treatment for common mental health disorders in those with multiple long-term conditions.

What is the situation in 2018?

- The recorded prevalence of depression has been rising in England over the last 5 years, and both Cambridgeshire and Peterborough have mirrored this rise with increases from 6.2% of practice registers to 8.3% and 8.0% respectively (7) (Figure 7.1 and 7.2).
- The estimated prevalence of mental health disorders (all mental health disorders) was 8.4% in children and young people (aged 5-16) in Cambridgeshire in 2015 and 9.8% in Peterborough in the same year (7). It is estimated that there are around 22,000 young people under 25 in Cambridgeshire and 6600 in Peterborough with a diagnosable mental health problem (6) (Figure 7.3).
- The emergency admissions rates for intentional self-harm (all ages) are higher in both Cambridgshire (directly standardised rate of 217.3 per 100,000 people) and Peterborough (247.4 per 100,000) than nationally (185 people per 100,000). In both areas there appear to be a recent fall from 2015/16 to 2017/18. The rates in Cambridgeshire and Peterborough are not significantly different from each other. When this decline is explored further in relation to age, it can be seen in young people aged 20 – 24, 15 – 19 and ages 10 – 14 in both Cambridgeshire and Peterborough (Figures 7.4, 7.5, 7.6 and 7.7).
- Projections based on rates of perinatal psychiatric disorders indicate that by 2012 there will be between 4000 and 6500 women with perinatal mental health problems in Cambridgeshire and Peterborough, with roughly 1/5 of these in the catchment for Hinchginbrooke Hospital and 2/5 each for CUHFT and PCH.

What has happened since 2015?

- The following strategies on mental health have been published:
    - Public mental health strategy, 2015 – 18.
    - Summary of needs for children and young people, 2017.

    - Suicide prevention strategy supporting the national suicide prevention strategy, 2014-17.
    - Local Transformation plan for children and young people's emotional/mental health and well-being, 2017/18.
- The Psychological Wellbeing service was extended to target people with long term conditions with support for their mental health. The conditions currently covered are diabetes, coronary heart disease and COPD. A formal evaluation is underway to look at the extent that this has decreased health care utilisation.
- Funding has recently been awarded for the development of a specialist community service that will work with mothers with severe and complex mental health problems.
- A service for early intervention in psychosis allowing for the treatment of the first episode of psychosis with 2 weeks of referral has been set up.
- The First Response Crisis Mental Health Service has been developed. This is a 24/7 community mental-health based crisis service that can be accessed through an option on the 111 phone line. It is currently managing around 400 referrals a week with indications that it may be having significant effects in reducing A&E attendances, emergency admissions, ambulance and out of hours GP use.
- Cambridgeshire and Peterborough is a national I-THRIVE accelerator site. In December 2016, professionals from across Cambridgeshire and Peterborough that support children and young people with their emotional wellbeing and mental health needs undertook a full review of how the local system was working. Key priorities were identified as a result of this exercise including increasing the use of outcome measures in commissioning and providing further mental health guidance and training for schools. Several new services have subsequently been set up to support and prevent young people with achieving emotional and mental health and wellbeing:
    - The website www.keep-your-head.com serves as a first port of call in terms of signposting to services, apps and self-help.
    - Parenting programmes for children with challenging behaviour, are funded in partnership with the local authority.
    - Kooth website provides open access, online counselling, forums advice and information, this has been commissioned as an alternative to face to face counselling.
    - Emotional well-being service provides advice, guidance and support to professionals on mental health issues, has been rolled out in the areas of greatest need using indicators of increased risk of mental ill health.
    - CHUMS provides a range of support services as well as resilience workshops to assist children and young people and their families with mental health issues.

Recommendations

- Review the progress made towards the recommendations in the suicide prevention and public mental health strategies and consider creation of a system-wide mental ill health prevention strategy that promotes emotional and mental health well-being. This should

build on the learning from the potential successes of the new services: wellbeing service for chronic conditions, FRS, PRISM and the I-THRIVE programme.

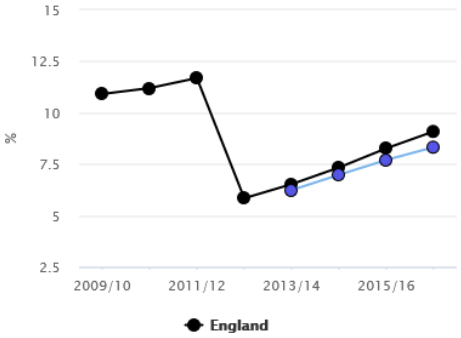
- Continue to focus investment on services in early years, including adolescence, for the prevention of mental health problems occurring later in life.

Figures

Figure 7.1 Depression prevalence from GP records in Cambridgeshire (7)

Depression recorded prevalence (QOF): % of practice register aged 18+ Cambridgeshire — Proportion - %

Export chart as image Show confidence intervals



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2009/10		-	-	-	-	-	10.9
2010/11		-	-	-	-	-	11.2
2011/12		-	-	-	-	-	11.7
2012/13		-	-	-	-	-	5.8
2013/14	●	32,950	6.2	6.2	6.3	6.5*	6.5
2014/15	●	37,741	7.0	6.9	7.0	7.2	7.3
2015/16	●	42,658	7.7	7.6	7.8	8.0	8.3
2016/17	●	46,910	8.3	8.2	8.4	8.6	9.1

Source: Quality and Outcomes Framework (QOF). http://content.digital.nhs.uk/qof

Figure 7.2 Depression prevalence from GP records in Peterborough (7)

Depression recorded prevalence (QOF): % of practice register aged 18+ Peterborough — Proportion - %

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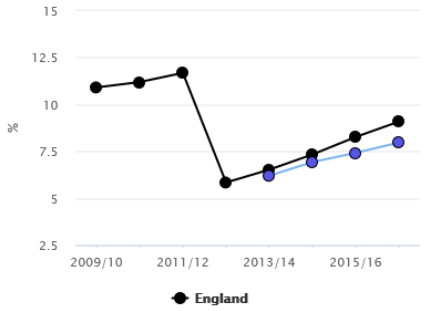


Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2009/10		-	-	-	-	-	10.9
2010/11		-	-	-	-	-	11.2
2011/12		-	-	-	-	-	11.7
2012/13		-	-	-	-	-	5.8
2013/14	●	8,992	6.2	6.1	6.3	6.5*	6.5
2014/15	●	10,283	6.9	6.8	7.1	7.2	7.3
2015/16	●	11,385	7.4	7.3	7.6	8.0	8.3
2016/17	●	12,554	8.0	7.8	8.1	8.6	9.1

Source: Quality and Outcomes Framework (QOF). http://content.digital.nhs.uk/qof

Figure 7.3 Estimated number of children and young people with a diagnosable mental health problem in 2017 (6)

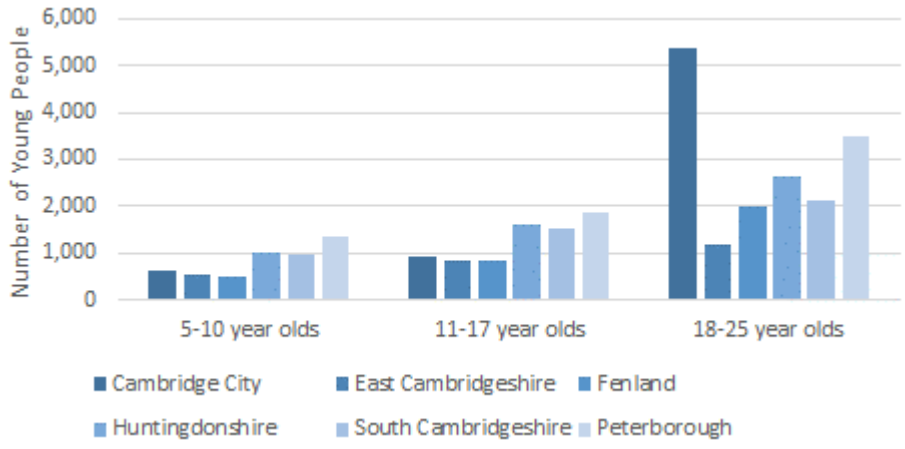
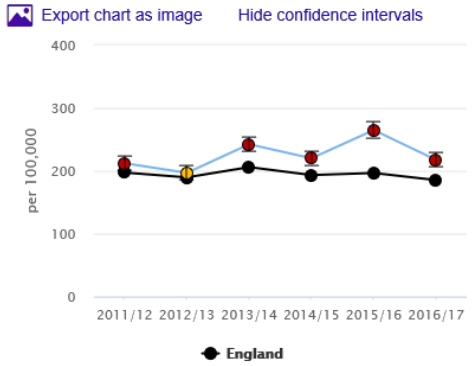


Figure 7.4 Emergency hospital admissions for intentional self-harm in Cambridgeshire (7)

2.10ii - Emergency Hospital Admissions for Intentional Self-Harm Cambridgeshire — Directly standardised rate - per 100,000



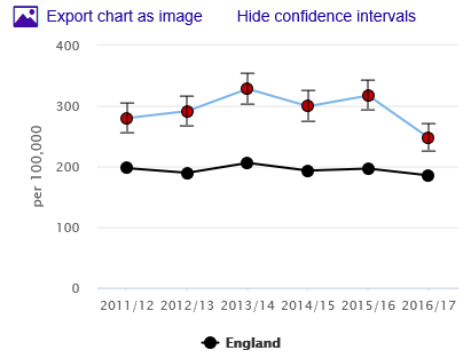
Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12	●	1,386	212.1	201.0	223.6	154.1	197.2
2012/13	●	1,296	196.8	186.2	207.8	153.5	189.6
2013/14	●	1,598	242.3	230.5	254.5	183.5	205.9
2014/15	●	1,454	220.0	208.8	231.6	173.0	193.2
2015/16	●	1,777	264.9	252.6	277.5	179.5	196.5
2016/17	●	1,453	217.3	206.3	228.8	160.3	185.3

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to Public Health England Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

Figure 7.5 Emergency hospital admissions for intentional self-harm in Peterborough (7)

2.10ii - Emergency Hospital Admissions for Intentional Self-Harm Peterborough — Directly standardised rate - per 100,000



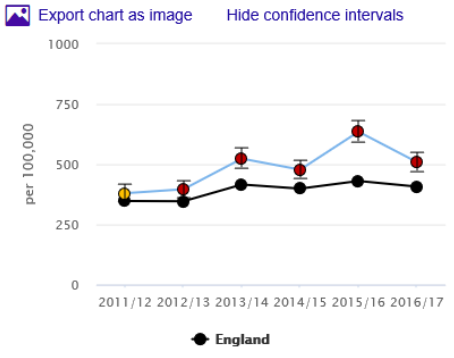
Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12	●	551	279.8	256.6	304.5	154.1	197.2
2012/13	●	567	291.4	267.6	316.7	153.5	189.6
2013/14	●	650	328.1	303.1	354.6	183.5	205.9
2014/15	●	583	299.3	275.2	324.8	173.0	193.2
2015/16	●	634	317.0	292.6	342.9	179.5	196.5
2016/17	●	490	247.4	225.7	270.5	160.3	185.3

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to Public Health England Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

Figure 7.6 Emergency hospital admissions for intentional self-harm in 10 – 24 year olds in Cambridgeshire (7)

Hospital admissions as a result of self-harm (10-24 years) Cambridgeshire — Directly standardised rate - per 100,000



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12	●	459	379.7	345.7	416.1	262.7	347.4
2012/13	●	474	396.2	361.3	433.6	291.2	346.3
2013/14	●	622	523.4	483.0	566.2	378.3	415.8
2014/15	●	567	477.6	439.0	518.6	354.7	398.8
2015/16	●	763	635.2	590.9	682.0	411.2	430.5
2016/17	●	606	509.1	469.3	551.3	353.0	407.1

Source: Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

Figure 7.7 Emergency hospital admissions for intentional self-harm in 10 – 24 year olds in Peterborough (7)

Hospital admissions as a result of self-harm (10-24 years) Peterborough — Directly standardised rate - per 100,000

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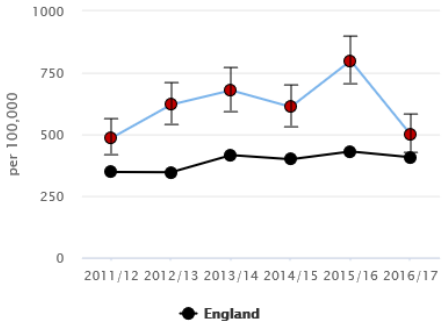

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12		172	485.2	415.4	563.4	262.7	347.4
2012/13		215	620.5	540.3	709.2	291.2	346.3
2013/14		232	678.6	594.1	771.8	378.3	415.8
2014/15		208	611.2	530.9	700.2	354.7	398.8
2015/16		273	798.7	706.7	899.3	411.2	430.5
2016/17		167	499.8	426.8	581.7	353.0	407.1

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8. Alcohol

Background

Among those aged 15 to 49 in England, alcohol is now the leading risk factor for ill-health, early mortality and disability and the fifth leading risk factor for ill-health across all age groups (1). In recent years, many indicators of alcohol-related harm have increased nationally. There are now over 1 million hospital admissions relating to alcohol each year, half of which occur in the lowest three socioeconomic deciles (2).

Alcohol misuse contributes to 200 health conditions (3) leading to hospital admission, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cancers, cardiovascular conditions, depression and liver disease.

In 2015 to 2016, there were 1.1 million admissions related to alcohol consumption, of which alcohol was the main reason for admission for about 339,000 cases. The economic burden of alcohol is estimated between 1.3% and 2.7% of annual GDP. Around three quarters of the cost to the NHS is incurred by people who are not alcohol dependent, but whose alcohol misuse causes ill health (1).

What was the situation in 2015?

In 2012/13, alcohol-related hospital admissions for men were lower than the national average across Cambridgeshire but highest in Cambridge and Fenland. In 2012/13, alcohol-related hospital admissions for women were higher than the England average in Cambridge and Huntingdonshire. There were 1,171 alcohol-related hospital admissions in Peterborough in 2012-13, which was the highest in the East of England.

Recommendations from 2015

The 2016 Health System Prevention Strategy recommended:

- Maximising opportunities to provide brief advice on alcohol to more GP practice patients at new registrations and or next appointment.
- Monitoring the GP provision of brief advice and provide training as necessary
- Agreeing a training model and associated costs for information and brief advice in primary care and A&E and expand the provision of this service in A&E

What is the situation in 2018?

- There are persistent inequalities in the rate of alcohol-related admissions between Cambridgeshire and Peterborough, with Cambridgeshire consistently lower than the national rate and Peterborough higher, though there are signs that the rate may be improving in Peterborough. It is too soon to be clear on whether it is a trend, but there has been a recent decline in alcohol related admissions in Peterborough in both sexes, though to a greater degree in males. Peterborough is no longer the worst in the region in terms of alcohol-related hospital admissions and is now not significantly different from the England average (Figure 8.4).

- There continues to be a disparity between the directly standardized rate of alcohol – related admissions in women and men in Cambridgeshire. Alcohol-related hospital admissions for men are rising, but still lower than the national average, and alcohol-related admissions for women are higher, though not significantly so, than the England average (Figures 8.2 and 8.3).
- Admissions episodes for alcohol-related cardiovascular conditions have risen in England and Cambridgeshire and Peterborough since 2015, though the rise has been slower in Peterborough and Cambridgeshire than the England average (Figures 8.7 and 8.8).
- In terms of alcohol-related mortality, there has been a slow decline nationally between 2008 and 2016 in alcohol mortality (from 48.5 to 46 deaths per 100,000 population), Cambridgeshire was significantly less than England and has seen a similar slow decline (from 39 to 36 deaths per 100,000 population). Peterborough figures are so low that the confidence levels are large and overlap with national figures throughout the period, but there does seem to be an upward trend with the last 4 years of data (2013 – 2016) appearing to show an increase in alcohol-related mortality per 100,000. There may have been a recent decline in 2016, in line with the figures for alcohol related admissions (Figures 8.13 and 8.14).
- The numbers of people in treatment and the percentage of clients completing treatment in Cambridgeshire appear to have declined over the last 2 years. According to the National Drug Treatment Monitoring System (4) there were 772 people registered in treatment for alcohol only in Cambridgeshire (Jan 16 – Dec 16) compared to 876 people being treated in March 2015. There does not appear to have been any change in the number of people in treatment in the Peterborough service, though the percentage of clients completing treatment and not re-presenting has similarly declined over the past 2 years (Figures 8.9 and 8.10).
- The Spend and Outcome Tool (SPOT) from PHE (5) for 2017 indicates that the Cambridgeshire spend for alcohol misuse was £1.61 per head for adults and £0.33 for young people for alcohol and drug misuse. In Peterborough the spending was £2.03 per adult and £0.84 for drug and alcohol misuse of young people. The average of national level of spending is £4.13 for adults' alcohol misuse and £1.02 for young people drug and alcohol misuse. The spend has increased in Peterborough since 2015 for both adults and young people and decreased in Cambridgeshire for both groups (Figures 8.11 and 8.12)

What has happened since 2015?

- In 2016 a Substance Misuse Joint Strategic Needs Analysis was undertaken for Cambridgeshire.
- In Peterborough from the 1st of April 2016 a new fully integrated treatment service contract was awarded to Aspire part of the national substance misuse provider Change Grow Live (CGL). This includes a service to address alcohol misuse as part of this broader substance misuse contract which supports all ages from 12+clients in the community and also provides the Hospital Liaison Service (HALP). Aspire picks up the work previously undertaken Drinksense in Peterborough.

- In Cambridgeshire the service has also been recommissioned and a new integrated substance misuse treatment service comes into operation on the 1st of October 2018. This has been also awarded also to Change Grow Live (CGL) who will take over from the current provider Inclusion when their contract ends on the 30th of September 2018.
- The Audit-C tool was introduced into the NHS Health Checks programme across Cambridgeshire and Peterborough at the time of the last Health System Prevention Strategy. Primary care as part of the NHS Health Checks programme have completed approx. 14,000 Audit-C brief interventions per year.
- There is currently an alcohol liaison worker in Addenbrookes and Peterborough and there are plans to put one in place in Hinchingbrooke through CGL. These workers have found it is not a good use of their time to be based in A&E when people are presenting when intoxicated and instead they visit patients in the hospital to work with them in the departments they are based in. In Addenbrookes there was an historical system of identification and brief intervention in A&E using the FAST screening test that was linked to a clinic of 20-minute slots for patients to come back to be seen by the community alcohol provider and members of the community mental health team. This was abandoned due to poor penetration of screening, poor attendance, severe winter pressures, the introduction of e-records and the expectations of a more comprehensives service from patients that did attend. There is regular training for Addenbrookes A&E staff as part of their mental health study day.

Recommendations

- The opportunity remains to provide brief advice on alcohol within GP practices beyond Health Checks, full incorporation of Making Every Contact Count and use of health promotional tools (such as the “One You” drinks tracker) into new registration and opportunistically at appointments provided by a range of clinicians.
- The Cambridgeshire JSNA recommends that brief interventions are particularly needed for those who are misusing alcohol, but not yet dependent, with a number of risk factors e.g. unemployed, ongoing mental health problems, poor housing.
- There have been multiple attempts to provide screening and brief advice in A&E, it would be worth reviewing the evidence and looking at implementing a very simple, potentially single question, screening and intervention in a systematic way, across all providers
- Following the recommendations from the Cambridgeshire JSNA:
    - Investigate the potential for community detoxification in partnership with primary care.
    - Develop a pathway for addressing the gap identified in the JSNA for those with moderate to severe substance misuse problems and mild to moderate mental health problems.
- Make efforts to understand and reinforce the apparent recent decline in alcohol related admissions in Peterborough.

Figures

Figure 8.1 Directly standardized rate of admission episodes (person) for alcohol-related conditions in Cambridgeshire (2)

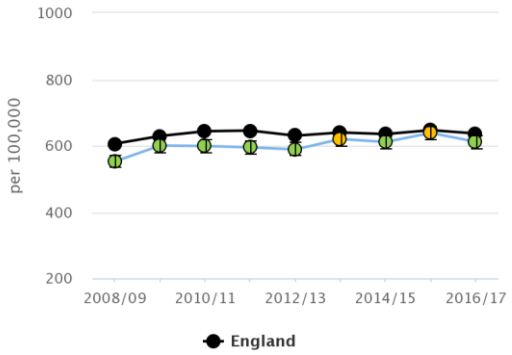


Figure 8.2 Directly standardised rate of admissions episodes (male) for alcohol-related conditions in Cambridgeshire (2)

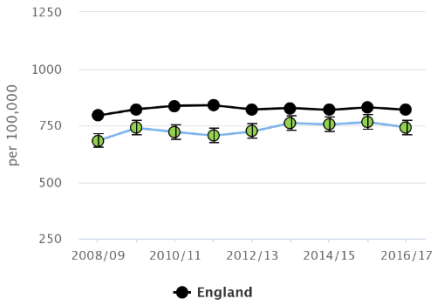


Figure 8.3 Directly standardised rate of admissions episodes (female) for alcohol-related conditions in Cambridgeshire (2)

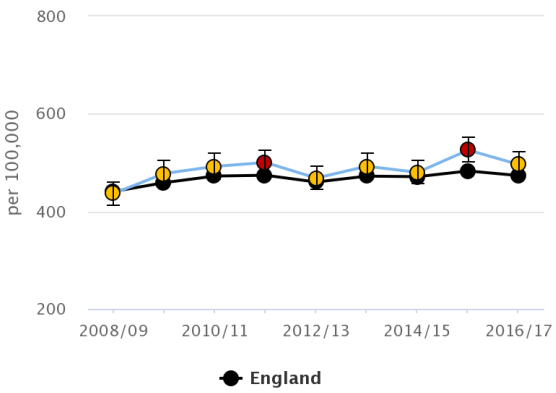


Figure 8.4 Directly standardised rate per 100,000 of admissions episodes (person) for alcohol-related conditions in Peterborough (2)

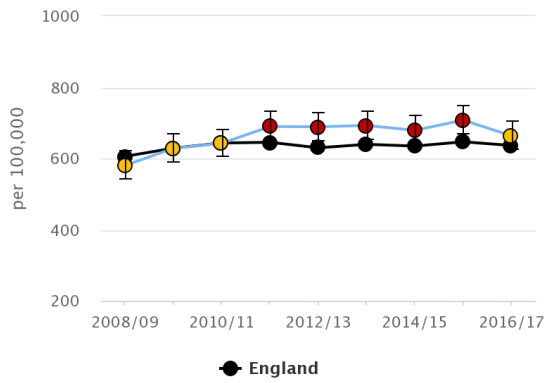


Figure 8.5 Directly standardised rate of admissions episodes (male) for alcohol-related conditions in Peterborough (2)

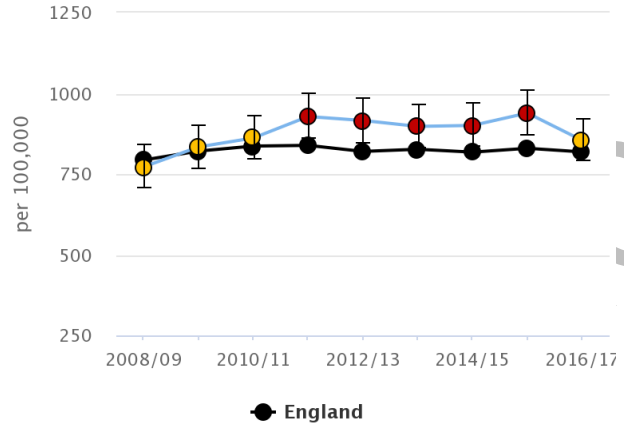


Figure 8.6 Directly standardised rate of admissions episodes (female) for alcohol-related conditions in Peterborough (2)

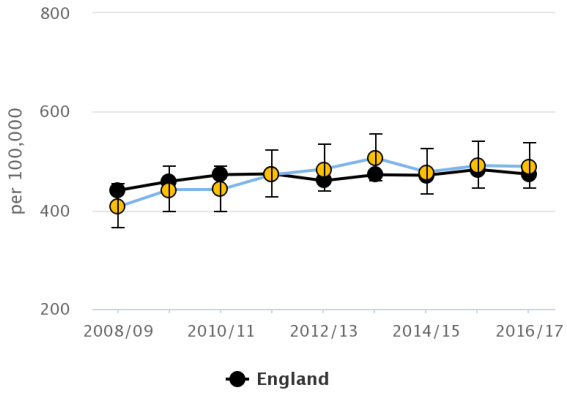


Figure 8.7 Directly standardised rate per 100,000 of admissions episodes for alcohol-related cardiovascular disease conditions in Cambridgeshire (2)

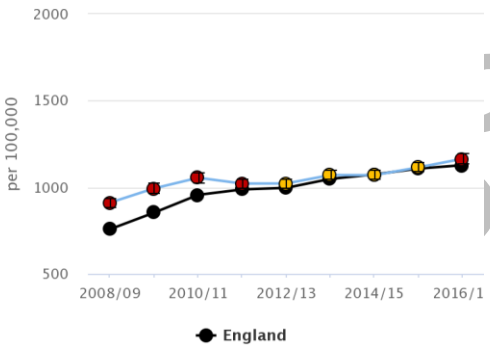


Figure 8. 8 Directly standardised rate per 100,000 of admissions episodes for alcohol-related cardiovascular disease conditions in Peterborough (2)

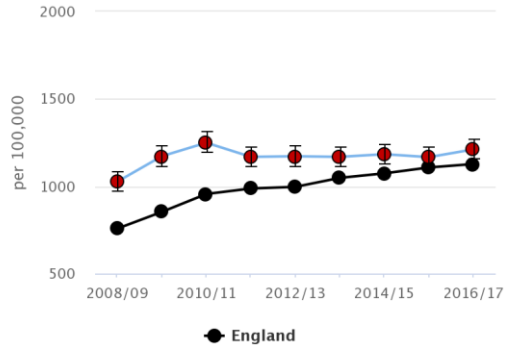


Figure 8.9 Clients in Treatment in Cambridgeshire (5)

Completion Period	Feb15 - Jan16	Mar15 - Feb16	Apr15 - Mar16	May15 - Apr16	Jun15 - May16	Jul15 - Jun16	Aug15 - Jul16	Sep15 - Aug16	Oct15 - Sep16	Nov15 - Oct16	Dec15 - Nov16	Jan16 - Dec16
Reporting Period	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
All clients in treatment		876	850	853	838	807	815	813	805	789	785	772
Number of completions without re-presentation		364	346	343	351	329	321	325	307	296	291	285
% of all clients completing and not re-presenting		41.55%	40.71%	40.21%	41.89%	40.77%	39.39%	39.98%	38.14%	37.52%	37.07%	36.92%

Figure 8.10 Clients in Treatment in Peterborough (5)

Completion Period	Feb15 - Jan16	Mar15 - Feb16	Apr15 - Mar16	May15 - Apr16	Jun15 - May16	Jul15 - Jun16	Aug15 - Jul16	Sep15 - Aug16	Oct15 - Sep16	Nov15 - Oct16	Dec15 - Nov16	Jan16 - Dec16
Reporting Period	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
All clients in treatment		338	320	314	320	322	323	323	329	339	344	349
Number of completions without re-presentation		161	165	152	141	129	126	121	108	105	117	122
% of all clients completing and not re-presenting		47.63%	51.56%	48.41%	44.06%	40.06%	39.01%	37.46%	32.83%	30.97%	34.01%	34.96%

Figure 8.11 Spend and Outcomes tool for alcohol Cambrigeshire

Selected measures for Cambridgeshire	Local value	Z score (-3 -2 -1 0 1 2 3)	National	PHE centre	ONS cluster	Deprivation decile
Drugs and Alcohol						
Substance misuse - Alcohol misuse - adults (RO)	£1.61		£4.13	£3.27	£2.72	£3.39
Substance misuse - Drug misuse - adults (RO)	£7.67		£8.56	£6.84	£5.19	£6.99
Substance misuse - (drugs and alcohol) - youth services (RO)	£0.33		£1.02	£0.77	£0.80	£0.69
Months of life lost due to alcohol (Men, <75yr)	49		81	70	60	64
Months of life lost due to alcohol (Women, <75yr)	19		31	27	24	25
Alcohol-related mortality (Persons)	36		48	44	39	41
Mortality from chronic liver disease (Persons)	8		13	10	9	10
Alcohol-specific hospital admission (Persons)	524		623	435	414	470
Hospital admissions due substance misuse (15-24 yr)	83		97	85	78	88
Successful completion drug treatment - opiate users	7%		7%	7%	9%	9%
Successful completion drug treatment - non-opiate users	33%		37%	31%	40%	40%
Claimants of benefits due to alcoholism	65		144	84	68	88

Figure 8.12 Spend and Outcomes tool for alcohol Peterborough

Selected measures for Peterborough UA	Local value	Z score (-3 -2 -1 0 1 2 3)	National	PHE centre	ONS cluster	Deprivation decile
Drugs and Alcohol						
Substance misuse - Alcohol misuse - adults (RO)	£2.03		£4.13	£3.27	£3.89	£4.43
Substance misuse - Drug misuse - adults (RO)	£5.70		£8.56	£6.84	£5.83	£11.12
Substance misuse - (drugs and alcohol) - youth services (RO)	£0.84		£1.02	£0.77	£0.97	£1.41
Months of life lost due to alcohol (Men, <75yr)	84		81	70	77	89
Months of life lost due to alcohol (Women, <75yr)	26		31	27	30	32
Alcohol-related mortality (Persons)	51		48	44	47	51
Mortality from chronic liver disease (Persons)	14		13	10	13	14
Alcohol-specific hospital admission (Persons)	536		623	435	524	717
Hospital admissions due substance misuse (15-24 yr)	147		97	85	96	104
Successful completion drug treatment - opiate users	5%		7%	7%	7%	6%
Successful completion drug treatment - non-opiate users	25%		37%	31%	39%	34%
Claimants of benefits due to alcoholism	100		144	84	113	178

Figure 8.13 Directly standardised rate per 100,00 for alcohol-related mortality in Peterborough (2)

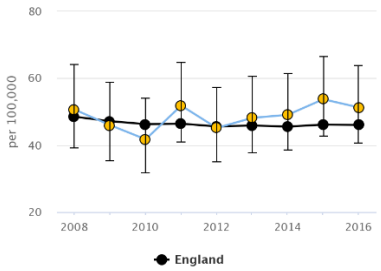
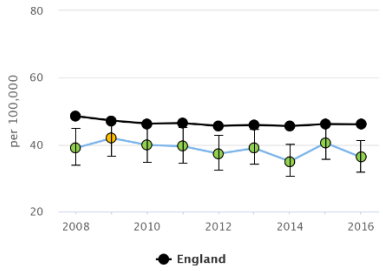


Figure 8.14 Directly standardised rate per 100,00 for alcohol-related mortality in Cambridgeshire (2)



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9. Falls

Background

Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged 75 and over in Cambridgeshire and Peterborough. The cost of falls and fractures to the health and social care system in Cambridgeshire and Peterborough was estimated to be £85.5M in 2017, with direct costs of £32.1M to the NHS and £46.6M costs incurred post discharge by community health care and social care. These financial costs do not include the additional costs of distress, pain, injury, loss of confidence, independence and anxiety caused by falls. The evidence-base to support falls prevention activities is strong, and a large body of research literature and NICE guidance indicates that effective approaches to reduce the rate of falls and the risk of injurious falls include screening to identify falls risk, multi-factorial falls risk assessment and multi-factorial interventions (2). New guidance from NICE on Falls in Older People and Osteoporosis was released in 2017 (3,4).

Since 2015 the Royal College of Physicians has produced a national audit of inpatient falls which contains key recommendations (5). PHE and the National Falls Prevention Coordination Group member organisations have a falls and fractures consensus statement detailing key interventions, approaches to commissioning and the commitment to national support (5). It is accompanied by a pack which contains resources relating to the key interventions and an additional section on frailty. The consensus statement advocates a whole system approach to prevention which takes in: risk factor reduction across the life-course; case finding and risk assessment; strength and balance exercise programmes; healthy homes; high-risk care environments; fracture liaison services and collaborative care for severe injury.

What was the situation in 2015?

- In 2014/15 the directly standardised rate of emergency hospital admissions due to falls in people aged 65 or over was 2,129 in Cambridgeshire which was not significantly different to the England average of 2,199 per 100,000 people. In Peterborough the rate was 2440 per 100,000 people which was significantly higher than the England and East of England average (3). Figure 9.1 shows that trends of Cambridgeshire rates were going upwards towards the national rate from a position below and Peterborough started well above the national rate in 2010/11 but has shown a continued trend downwards to the national rate.
- In 2014/15 the directly standardised rate of hip fractures in people aged 65 and over was 554 per 100,000 in Cambridgeshire and 705 per 100,000 in Peterborough. The national rate was 599 per 100,000. Peterborough was significantly higher and was continuing along a trend of a higher than national rate.

Recommendations in 2015

- Recognising that potential savings may require delivery of preventative approaches at much wider scale than current provision – a health-system wide emphasis on falls prevention is advocated.
- Collaboration across sectors to agree which combination of clinical and population health interventions are needed locally to achieve population reductions in the incidence and consequences of falls – which would serve to consolidate the mix of interventions required.
- Ensuring delivery of evidence-based interventions, for example, strength and balance exercise targeted at people with heightened risk of falling, are delivered at appropriate scale and quality.
- Having a system-wide approach to ensure that local assets are as effective as possible, notably, that health professionals are undertaking appropriate assessments and referring on through a consistent, comprehensive & integrated falls prevention pathway.
- Integrated and hig- quality reporting of falls and outcomes linked to falls is fundamental to understanding where improvements can be made to reduce harm and cost.
- Building on powerful strategic opportunities locally to ensure leadership, integration and sustainability.

The Prevention Strategy noted that falls prevention efforts are unlikely to be successful unless they are sustained at a systems level. The opportunities identified to deliver cost-effective interventions and outcomes among our older populations at risk of falling are not simply stand-alone strategies. Rather, they comprise component parts that ideally, interact synergistically to create an effective falls prevention system that will make a real difference in an area that causes pain and distress to many people every day.

What is the situation in 2018?

The 2016/17 data indicated that whilst there has been a slow but steady decline in emergency admissions due to injurious falls nationally, there has been no change in Cambridgeshire till 2016/17 with a directly standardised rate of 2,170 per 100,000 people. Peterborough in contrast has seen a decline from the 2014/15 levels to 2,117 falls per 100,000 people which is now not significantly different from Cambridgeshire or the national rate (3) (Figures 9.1 and 9.2). In 2016/17 there has been a marked decline in Peterborough between 2014/15 and 2015/16 such that the directly standardised rate of hip fractures in people aged 65 and over are now no longer significantly different from the national average at 628 per 100,000. Cambridgeshire has not changed significantly since 2014/15 and has a directly standardised rate of 572 per 100,000 people (3) (Figure 9.4 and 9.5).

What has happened?

- A Better Care Fund funded falls prevention pilot was implemented in St Ives, between July 2016 and June 2017 to test interventions to reduce falls and fall-related injuries in the community through improving the identification, multi-factorial assessment, uptake

and compliance of evidence-based interventions in people aged 65+ who have reported a fall or are at risk of falling. The success of the pilot led to the development of the STP falls prevention programme.

- The STP falls prevention programme started in October 2017 with investment of £261K from the STP in year 1 and £232K investment from the Public Health Directorate and Better Care Fund. The work includes:
    - Proactive identification of those at risk of falls;
    - Comprehensive multifactorial assessment offered to those at risk of falling with appropriate intervention plan to address risks identified;
    - Increased provision and improved quality of evidence-based targeted interventions;
    - Strengthened system-wide integration and co-ordination.
- A falls clinical lead, a senior partnership manager, 4 falls locality leads, 2 falls prevention health trainers and 3 therapy assistants were recruited in 2017/18.
- Comprehensive CPFT IT falls documentation has been adapted and embedded to support the screening and identification of patients on CPFT therapy case-loads who are at risk of falls
- Staff in all four Cambridgeshire and Peterborough CPFT localities have been trained, are receiving ongoing clinical supervision and are delivering high quality assessments
- Recruitment, induction and delivery of increased capacity of Everyone Health Falls Prevention Health Trainer service in Cambridgeshire from September 2018
- Agreement of service contract, recruitment, service mobilisation and delivery of Solutions4Health Falls Prevention Health Trainer service in Peterborough from May 2018
- A falls metrics dashboard has been developed and is monitored monthly.
- Cambridgeshire and Peterborough wide 'Stay Stronger for Longer' strength and balance campaign launched (1st October 2018) complete with marketing materials, communications toolkit(s) and Be Well webpages developed based on academic research and local engagement with older people
- There has been a review of the fracture liaison service (FLS) provision across Cambridgeshire and Peterborough.
- Inception of the Cambridgeshire and Peterborough Falls Prevention Strategy Group and a multi-agency falls implementation group.

Recommendations

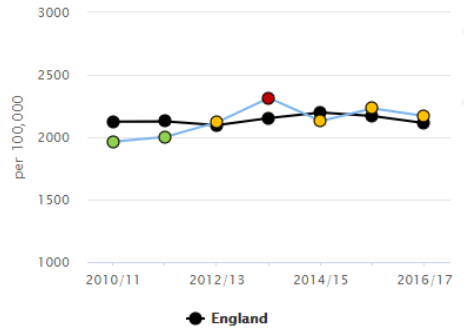
- Continue to fund the system-wide implementation of the Falls Prevention Programme to build on learning, existing practice and consolidate cross-agency join-up and action
- Calculate the potential financial savings of the STP Falls Prevention Programme to other parts of the system e.g. Cambridgeshire County Council adult social care
- Explore the implementation of evidence-based interventions shown to be effective at reducing injurious falls e.g. Home hazard assessments and modifications.
- Implement the high impact changes identified in the PHE Falls and Fragility Fracture Consensus Statement and the RightCare pathway through the Cambridgeshire and Peterborough Falls Strategy Group.
- Support NWAFT with the implementation of a Fracture Liaison Service

Figures

Figure 9.1 The directly standardised rate of emergency hospital admissions due to falls in people aged 65 and over in Cambridgeshire

2.24i - Emergency hospital admissions due to falls in people aged 65 and over Cambridgeshire Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



Recent trend: –

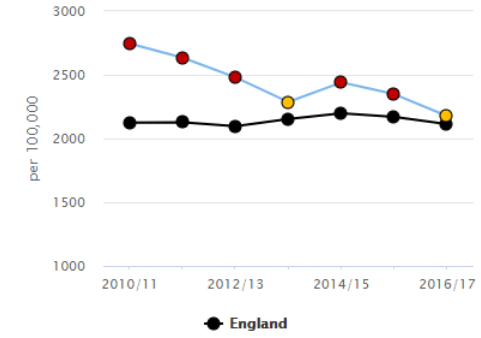
Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		1,973	1,965	1,879	2,054	1,886	2,126
2011/12		2,080	2,002	1,916	2,090	1,917	2,128
2012/13		2,291	2,119	2,032	2,208	1,973	2,097
2013/14		2,577	2,316	2,227	2,407	2,025	2,154
2014/15		2,448	2,129	2,046	2,216	2,026	2,199
2015/16		2,613	2,232	2,147	2,319	1,989	2,169
2016/17		2,600	2,170	2,087	2,255	1,975	2,114

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Figure 9.2 The directly standardised rate of emergency hospital admissions due to falls in people aged 65 and over in Peterborough

2.24i - Emergency hospital admissions due to falls in people aged 65 and over Peterborough Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



Recent trend: –

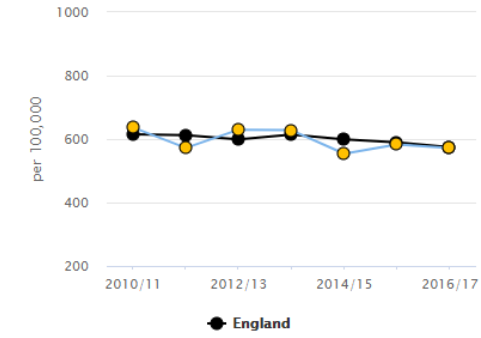
Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		678	2,746	2,540	2,964	1,886	2,126
2011/12		680	2,634	2,438	2,842	1,917	2,128
2012/13		648	2,480	2,291	2,681	1,973	2,097
2013/14		619	2,287	2,109	2,476	2,025	2,154
2014/15		665	2,440	2,257	2,634	2,026	2,199
2015/16		663	2,348	2,171	2,535	1,989	2,169
2016/17		628	2,177	2,008	2,355	1,975	2,114

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Figure 9.3 Hip fractures in people aged 65 and over in Cambridgeshire

4.14i - Hip fractures in people aged 65 and over Cambridgeshire Directly standardised rate - per 100,000

Export chart as image Show confidence intervals



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		639	636	588	688	-	615
2011/12		600	572	527	620	-	612
2012/13		683	630	583	679	-	599
2013/14		698	628	582	677	-	614
2014/15		635	554	511	599	-	599
2015/16		681	583	540	629	-	589
2016/17		684	572	530	617	-	575

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

Figure 9.4 Hip fracture in people aged 65 and over in Peterborough

4.14i - Hip fractures in people aged 65 and over Peterborough — Directly standardised rate - per 100,000

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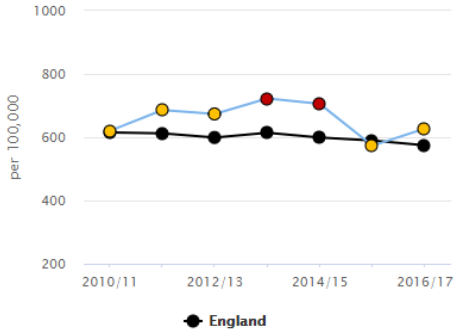

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		157	620	526	727	-	615
2011/12		180	686	588	794	-	612
2012/13		177	674	577	782	-	599
2013/14		196	722	624	832	-	614
2014/15		192	705	608	813	-	599
2015/16		164	573	488	669	-	589
2016/17		181	628	539	727	-	575

Source: Hospital Episode Statistics (HES), NHS Digital for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England

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10. Reproductive Health: LARCs

Background

A contraceptive method is classified as a “Long-acting reversible contraception” (LARC) if it requires administering less than once per cycle or month. LARCs include copper intrauterine devices (non-hormonal) and three progestogen-only methods of contraception (intrauterine system, injectable contraception and the implants).

It is clear that investment in contraception services not only helps to avoid the personal and social costs of unintended pregnancies, but is also economically effective. According to the Government, the prevention of unintended pregnancy by NHS contraception services probably saves the NHS over £2.5bn a year, and research has shown that every £1 spent on contraception services saves the NHS £117. Work commissioned by the charity sector (FPA and Brook) also shows the benefit to the wider NHS of effective contraception (1).

There is widespread agreement that increasing use of LARC in women at all stages of their reproductive lives is a vital component of the strategy to reduce unwanted fertility. Improving both access to and provision of LARC methods was recommended by the 2005 NICE guideline on LARC,1 which was updated in 2014. NICE made a decision in 2017 not to update this strategy and in October 2017 the Faculty of Sexual and Reproductive Health of the Royal College of Obstetricians and Gynaecologists published some updates and clarifications (2).

LARC contraceptive methods were both more effective and cost efficient when compared with the most popular user-dependent methods. Long acting reversible contraception is both more clinically effective also cheaper per year than other forms of contraception (3).

What was the situation in 2015?

In 2015/16 a considerable drop in LARC activity in Cambridgeshire was seen. This was largely due to trained GPs retiring and not being replaced at the same rate. This had brought the rate of LARCs down in Cambridgeshire to 68 per 1000 population, or 8,168 LARCs, compared to 82 per 1,000 population, or 3,101 LARCs in Peterborough (4).

Recommendations in 2015

Recommendations in 2015 were aimed at increasing LARC use in Cambridgeshire and Peterborough

- For every £1 invested in contraception services, there is a £11.09 saving to the NHS, rising to £13.42 for long-acting reversible contraceptives (LARCs).
- It is proposed to increase the number of women with LARCs by approximately 859 a year in Cambridgeshire & Peterborough. This should generate savings of £935k in 2016/17, £1.15m in 2017/18 and £1.26m in 2018/19.

- This would require an additional investment of £115k. However, the additional investment needed for Cambridgeshire, is already within the Council budget proposals for 2016/17 (4)

What is the situation in 2018?

- Comparable data is available from PHE fingertips which shows that LARCs increased by 330 in Peterborough and by 102 in Cambridgeshire by 2016 compared to 2015. This total of 432 is half of the recommended increase of 859 per annum,
- There has been a slight increase in the rate of LARC insertion in Peterborough but Cambridgeshire rates have remained flat (Figure 10.1), national data are not yet published for 2017/18.
- Cambridgeshire County Council and Peterborough City Council Public Health Joint Commissioning Unit have published activity data for 2017/18 (5). Trajectories for the numbers LARCs used for both GP providers and ICASH (the Sexual health clinic provider across Cambridgeshire and Peterborough) were set to be the same as they were in 2016/17.
- Even before the national PHE data is published it is possible to say that it is unlikely that the overall rate of LARC use has increased.
- Peterborough rates of abortion are significantly above national abortion rates and Cambridgeshire are significantly below. The abortion rates in both Cambridgeshire and Peterborough have been steadily increasing since 2012 with the steepest increase seen in Cambridgeshire (Figure 10.2).

What has happened?

- Commissioning of contraception moved to the Local Authorities under the 2012 Health and Social Care Act. LARCs are provided mainly in primary care and specialised sexual health clinics (iCASH). Locally there has been no recent change in this configuration.
- Cambridgeshire County Council are currently considering an integrated sexual health services that could bring together the sexual health services commissioned by the Local Authority, CCG and NHS England.

Recommendations

- Keep investing in sexual and reproductive health to improve prescription and use of LARCs, which will reduce costs and avoid unintended pregnancy among all ages.
- Use the scoping of joint sexual health commissioning to examine the case for investing in more provision of LARCs and the benefits to the health service and wider public sector bodies.

Figure 10.1 LARC uptake in Cambridge shire and Peterborough 2014-2016 (5)

Total prescribed LARC excluding injections rate / 1,000 Peterborough — Crude rate - per 1000

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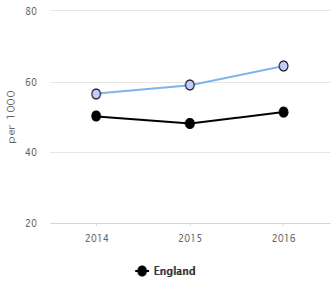

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2014		2,197	56.6	54.3	59.0	47.9	50.2
2015		2,306					
2016		2,527					

Source: NHS Digital, NHS Business Services

Total prescribed LARC excluding injections rate / 1,000 Cambridgeshire — Crude rate - per 1000

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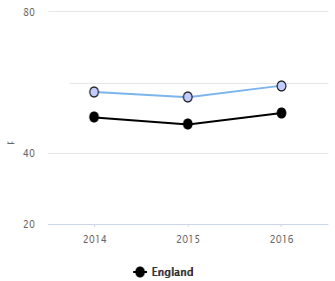

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2014		7,106	57.4	56.1	58.7	47.9	50.2
2015		6,922	55.9	54.6	57.2	47.0	48.2
2016		7,278	59.2	57.8	60.5	48.1	51.4

Source: NHS Digital, NHS Business Services Authority and Office for National Statistics

GP prescribed LARC excluding injections rate / 1,000 Peterborough — Crude rate - per 1000

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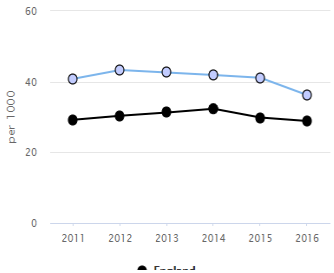

Recent trend: ↓

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011		1,608	40.8	38.9	42.9	33.0	29.2
2012		1,698	43.3	41.3	45.4	34.0	30.4
2013		1,666	42.6	40.6	44.7	34.4	31.3
2014		1,626	41.9	39.9	44.0	35.7	32.3
2015		1,607	41.1	39.1	43.2	33.4	29.8
2016		1,421	36.2	34.4	38.2	32.6	28.8

Source: NHS Business Services Authority and Office for National Statistics

GP prescribed LARC excluding injections rate / 1,000 Cambridgeshire — Crude rate - per 1000

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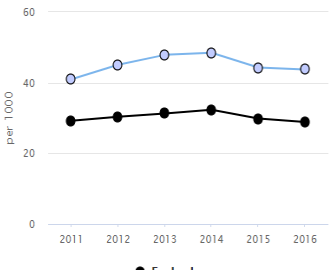


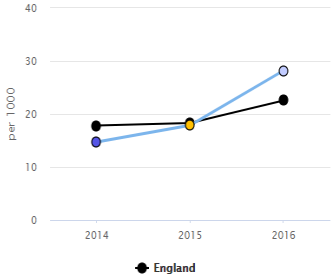
Recent trend: ↓

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011		5,131	41.0	39.9	42.1	33.0	29.2
2012		5,608	45.0	43.9	46.2	34.0	30.4
2013		5,937	47.9	46.7	49.1	34.4	31.3
2014		6,001	48.5	47.2	49.7	35.7	32.3
2015		5,485	44.3	43.1	45.5	33.4	29.8
2016		5,380	43.7	42.6	44.9	32.6	28.8

Source: NHS Business Services Authority and Office for National Statistics

SRH Services prescribed LARC excluding injections rate / 1,000 Peterborough — Crude rate - per 1000

Export chart as image | Show confidence intervals



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2014		571	14.7	13.5	16.0	12.1	17.8
2015		699	17.9	16.6	19.3	13.7	18.3
2016		1,106	28.2	26.6	29.9	15.5	22.6

Source: NHS Digital and Office for National Statistics

SRH Services prescribed LARC excluding injections rate / 1,000 Cambridgeshire — Crude rate - per 1000

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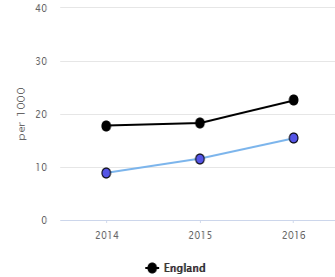

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2014		1,105	8.9	8.4	9.5	12.1	17.8
2015		1,437	11.6	11.0	12.2	13.7	18.3
2016		1,898	15.4	14.7	16.1	15.5	22.6

Source: NHS Digital and Office for National Statistics

Figure 10.2 Abortion rates per 1000 in Cambridgeshire and Peterborough (5)

Total abortion rate / 1000 Cambridgeshire — Crude rate - per 1000

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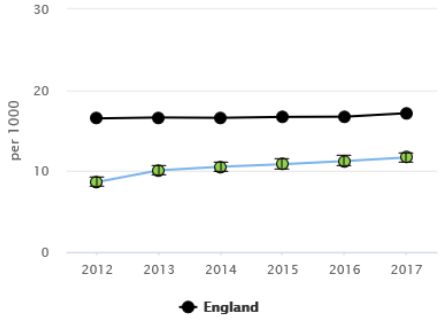


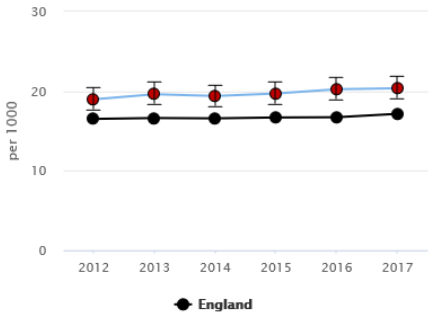
Recent trend:

Period		Count	Value	Lower CI	Upper CI	East of England	England
2012		1,070	8.7	8.2	9.2	14.3	16.5
2013		1,241	10.1	9.6	10.7	14.5	16.6
2014		1,287	10.5	10.0	11.1	14.6	16.6
2015		1,321	10.9	10.3	11.5	14.7	16.7
2016		1,350	11.2	10.7	11.9	15.1	16.7
2017		1,395	11.7	11.1	12.3	15.6	17.2

Source: Department of Health based on data from abortion clinics

Total abortion rate / 1000 Peterborough — Crude rate - per 1000

Export chart as image Hide confidence intervals



Recent trend:

Period		Count	Value	Lower CI	Upper CI	East of England	England
2012		746	19.0	17.6	20.4	14.3	16.5
2013		768	19.6	18.3	21.1	14.5	16.6
2014		754	19.4	18.0	20.8	14.6	16.6
2015		770	19.7	18.3	21.1	14.7	16.7
2016		793	20.2	18.9	21.7	15.1	16.7
2017		796	20.4	19.0	21.8	15.6	17.2

Source: Department of Health based on data from abortion clinics

Over 25s abortion rate / 1000 Cambridgeshire — Crude rate - per 1000

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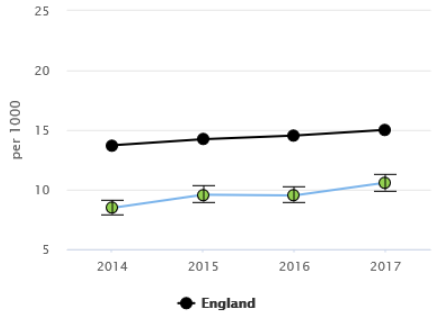

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2014		716	8.5	7.9	9.1	11.8	13.7
2015		806	9.6	8.9	10.3	12.4	14.2
2016		801	9.5	8.9	10.2	12.7	14.5
2017		854	10.6	9.9	11.3	13.4	15.0

Source: Department of Health based on data from abortion clinics

Over 25s abortion rate / 1000 Peterborough — Crude rate - per 1000

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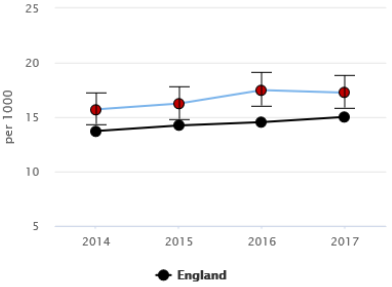

Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2014		437	15.7	14.3	17.2	11.8	13.7
2015		452	16.2	14.8	17.8	12.4	14.2
2016		491	17.5	16.0	19.1	12.7	14.5
2017		494	17.2	15.8	18.8	13.4	15.0

Source: Department of Health based on data from abortion clinics

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11. Physical Activity

Background

There are multiple benefits to adequate physical activity including optimising physical and mental health, reducing risk of multi-morbidity, chronic disease and frailty(1). Physical activity guidelines for adults (19-64 years) are to aim to be active daily, totaling 150 minutes (2.5hours) of moderate intensity activity in bouts of 10 minutes or more. One way to do this is by completing 30minutes at least 5 days a week. Comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week. Adults should also undertake activity to improve muscle strength at least two days a week and minimize the amount of time spent being sedentary for extended periods (2).

Low physical activity is one of the top 10 causes of disease and disability in England (3). The Chief Medical Officers' Start Active, Stay Active report highlighted that physical inactivity is a risk factor for many cancers (4). It is estimated that physical inactivity cost NHS England around 0.9 billion pounds annually (5) and is accountable for 1 in 6 UK deaths (equal to smoking) in the UK annually. A number of common health inequalities exist that can prevent adults from meeting the recommended levels of physical activity, people living in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas.

The Centre for Diet and Activity Research have published their Department of Transport funded Propensity to Cycle Tool to guide policies and investments (6, 7). They also now have comprehensive evidence reviews including evaluations of three interventions in this area: cycling initiatives, new routes for walking and cycling, and a new transport system that supports walking, cycling and public transport (8). Sport England published their strategy Towards an Active Nation which aims to focus resources on tackling inactivity as the area for the biggest gain (9).

What was the situation in 2015?

In 2015 there were clear health inequalities apparent, with a greater proportion active in Cambridgeshire; 19.7% inactive, 68.6% active, 60.8 overweight or obese than Peterborough; 24.3% inactive, 61.6% active, 62.9% overweight or obese (10)

Recommendations in 2015

- Develop initiatives to create a wider environment that supports a healthy weight including active travel initiatives.
- In Cambridgeshire, scale up the current health trainer service, to provide more 'health coaches'.
- In Peterborough, introduce a health trainer/coach programme
- Ensuring full GP practice engagement with Making Every Contact Count (11) and Let's Get Moving initiatives.
- Exploring point of care testing for Peterborough GP practices providing health checks, as this makes onward referral to other services quicker and easier.

What is the situation in 2018?

- There have been improvements in Cambridgeshire with a worsening picture in Peterborough.

- Between 2015/16 and 2016/17, in Cambridgeshire physical inactivity has decreased, physical activity increased and obesity and overweight decreased.
- In Peterborough physical inactivity has increased, physical activity has decreased and there has been less of a fall in overweight and obesity.
- In 2016/17, 71 % of Cambridgeshire adults and 61.1% of Peterborough adults were physically active. Inactive adults were 17.9% of the adult population in Cambridgeshire and 26% in Peterborough

What has happened?

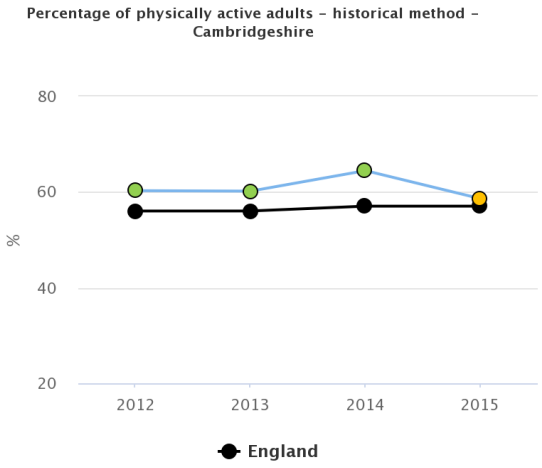
- In 2017, Living Sport and the Local Authority completed a mapping audit to identify the offer of physical activity and sport across Cambridgeshire and Peterborough and areas of need
- The provision of lifestyle services across Cambridgeshire and Peterborough are now weighted according to local inequalities.
- Several exercise referral schemes are in place in Cambridgeshire (Start-Up or Health wise facilities,), South Cambridgeshire (active and health for life scheme) Huntingdonshire, and Peterborough (More-Life Programme for children and the Fit for Life and Let's get Moving programmes for adults).
- In Fenland, there has been the development of the Active Fenland Initiative, which is a Sport England initiative aimed at getting people more active across Fenland
- Increasing physical activity is part of the workplace health programme
- Let's Get Moving functions across five districts with an evaluation due in 2019.
- A Sport England bid was awarded May 2018 for £325,000 of National Lottery funding to help low income families get active with their children. Active Families will first focus on Fenland, Peterborough and Cambridge City, to deliver free and fun physical activities for children and families most in need.

Recommendations

- Continue to focus on Peterborough and other areas of inequality for the provision of initiatives to increase physical activity, remembering the wider determinants behavior and health
- Scale up health service provision of health exercise interventions for staff (such as the Workplace Challenge) and patients (such as Exercise for Life), making this part of routine practice. Reinforce wherever possible the use of brief interventions, including physician advice or individual counselling (9, 11)
- Investigate the potential of social prescribing and asset-based community development to increase physical activity.
- Make use of local academic expertise in developing and evaluating physical activity interventions, including the role of natural experiments.

Figures & Tables

Figure 11.1 Percentage of physically active adults in Cambridgeshire and Peterborough



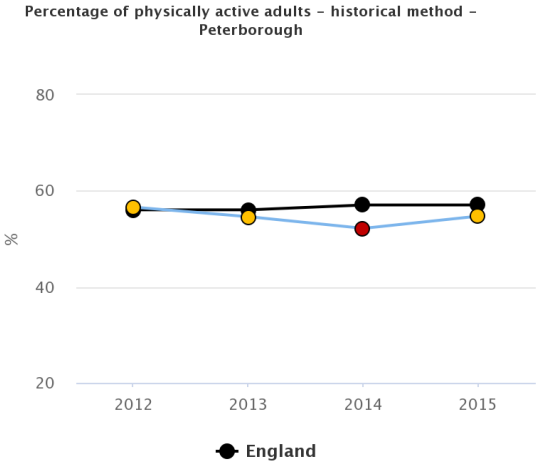
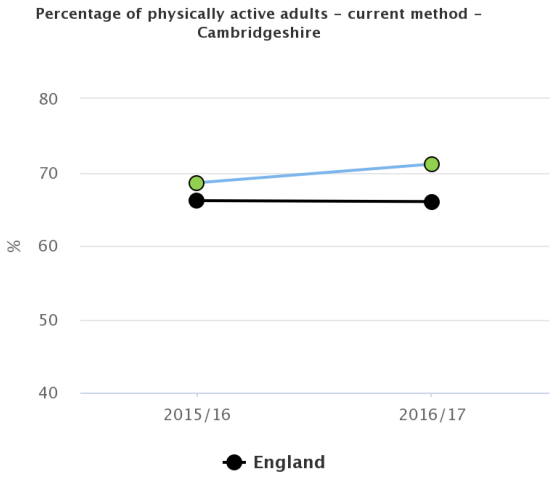


Figure 11.2 Prevalence of Overweight versus Physical Active Adults using historic measurement method



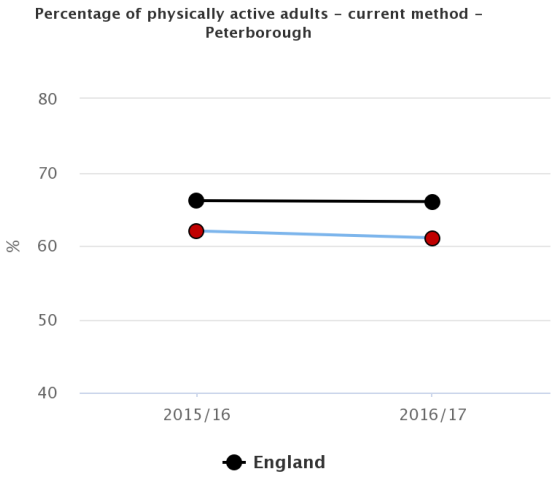
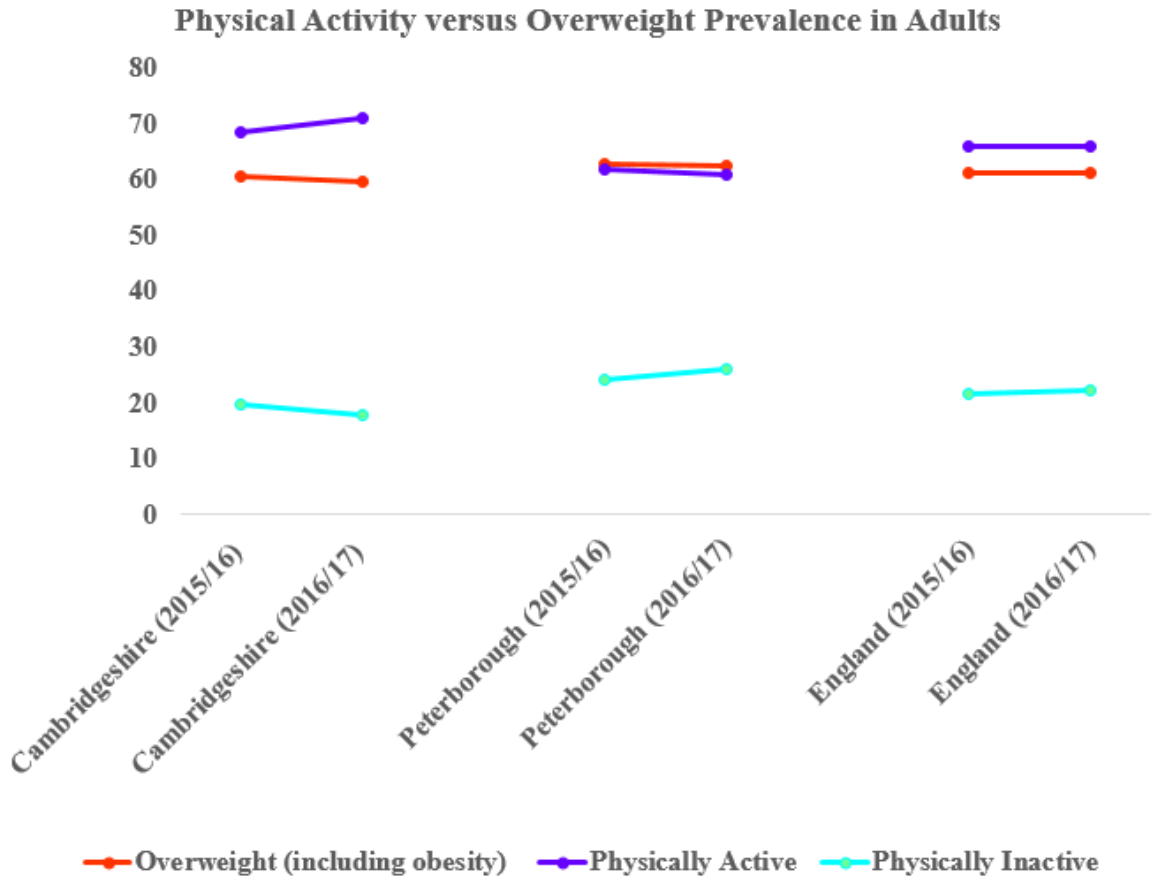


Figure 11.3. Prevalence of Overweight versus Physical Active Adults using current measurement method

	Cambridgeshire (2015/16)	Cambridgeshire (2016/17)	Peterborough (2015/16)	Peterborough (2016/17)	England (2015/16)	England (2016/17)
Overweight (including obesity)	60.8	59.8	62.9	62.5	61.3	61.3
Physically Active	68.6	71.1	62	61.1	66.1	66
Physically Inactive	19.7	17.9	24.3	26	21.7	22.2



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12. Breastfeeding

Background

The benefits of human milk for both preterm and term infants are well established (1,2), with evidence demonstrating that human milk can aid development and reduce risks of certain infections. There are multiple causal pathways for this. The WHO recommends human milk as the exclusive source of nutrients for infants under 6 months of age. A UNICEF report on the potential contribution of increasing breastfeeding rates in the UK modelled that if 45% of women exclusively breastfed for 4 months over £17 million could be gained annually by avoiding the cost of treating 4 acute diseases in infants with an incremental benefit of more than £31 million over the lifetime of each cohort of first-time mothers (3).

The prevalence of breastfeeding is particularly low among very young mothers and disadvantaged socio-economic groups, potentially widening existing health inequalities and contributing further to the cycle of deprivation. Data from the 2010 Infant Feeding Survey showed that 46% of mothers in the most deprived areas were breastfeeding, compared with 65% in least deprived areas (7).

What was the situation in 2015?

Breastfeeding initiation was falling from a previous high in 2013/14.

- Breast feeding initiation was higher than the national average in Cambridgeshire and lower than the national average in Peterborough.
- Breastfeeding at 6 – 8 weeks was similar to the national average in 2015 in Peterborough and above the national average in Cambridgeshire.

Recommendations in 2015

Joint commissioning with local authorities to improve breastfeeding support, and implementing or piloting interventions in both acute and community settings. The interventions should include strengthening breastfeeding support and advice in acute settings, and easily accessible breastfeeding peer support programmes focused on the most deprived areas of the CCG.

What is the situation in 2018?

- Breastfeeding initiation has plateaued at a new lower level than in 2013/14 (Figure 12.1) but does not appear to be continuing to fall. Nationally, initiation rates have remained at around 74% for the last few quarters. Initiation rates are higher than the national average in Cambridgeshire (77% in 2015/16) and lower in Peterborough (68.8% in 2016/17) (Figures 12.2 and 12.3).
- There have been ongoing issues with data quality in Cambridgeshire due to a change in software supplier, this has had a significant impact on data capture. The most recent data available shows CUHFT were missing 11% of their values and NWAHFT were missing 2% of values (4).
- The picture is the same as it was in 2015 (Figure 12.4) with very little change in either Cambridgeshire or Peterborough in terms of rates of breastfeeding at 6 – 8

weeks. Cambridgeshire remains above the national average and Peterborough remains with a prevalence similar to the national average. There has been a recording issue within the provider unit in Cambridgeshire with staff not recording breastfeeding status. This has been addressed and as of Quarter 1 2018 the breastfeeding status was recorded for 92% of 6-8 week olds.

- The national strategy “Better Births” is being rolled out by the Local Maternity System. Current plans include:
- Cambridgeshire and Peterborough NHS Foundation Trust Health Visiting Services, Cambridgeshire Community Services Health Visiting, Anglia Ruskin University Midwifery and Peterborough Maternity Unit have full UNICEF “Baby Friendly” Accreditation. The Rosie Hospital, Cambridgeshire Community Services NHS Trust, Hinchingbrooke Hospital have stages 1 and/or 2 accreditation.

What has happened since 2015?

- The national strategy “Better Births” is being rolled out by the Local Maternity System. Current plans include:
    - improving the recording methodology for breast feeding,
    - developing a prevalence map of breast feeding locally,
    - implementing a reward scheme to support breast feeding,
    - investigating ways to develop feeding in public,
    - increasing compliance with the Baby Friendly Initiative.
- Cambridgeshire and Peterborough NHS Foundation Trust Health Visiting Services, Cambridgeshire Community Services Health Visiting, Anglia Ruskin University Midwifery and Peterborough Maternity Unit have full UNICEF “Baby Friendly” Accreditation. The Rosie Hospital, Cambridgeshire Community Services NHS Trust, Hinchingbrooke Hospital have stages 1 and/or 2 accreditation.

Recommendations

- Work through the Local Maternity System to increase initiation of breastfeeding, feeding at 6 – 8 weeks and reduce the gap between Cambridgeshire and Peterborough.
- Ensure a focus on breastfeeding support programmes in the most deprived areas.
- Continue to progress attaining full UNICEF accreditation for those organisations that are at stage 1 or 2.
- Analyze, where possible, the reasons for decrease in initiation in breastfeeding from the 2013/14 level.
- Ensure data is being adequately captured on breast feeding across all providers.

Figures and tables

Figure 12.1 Breast feeding initiation in Cambridgeshire and Peterborough CCG, compared to England and the East of England (5)

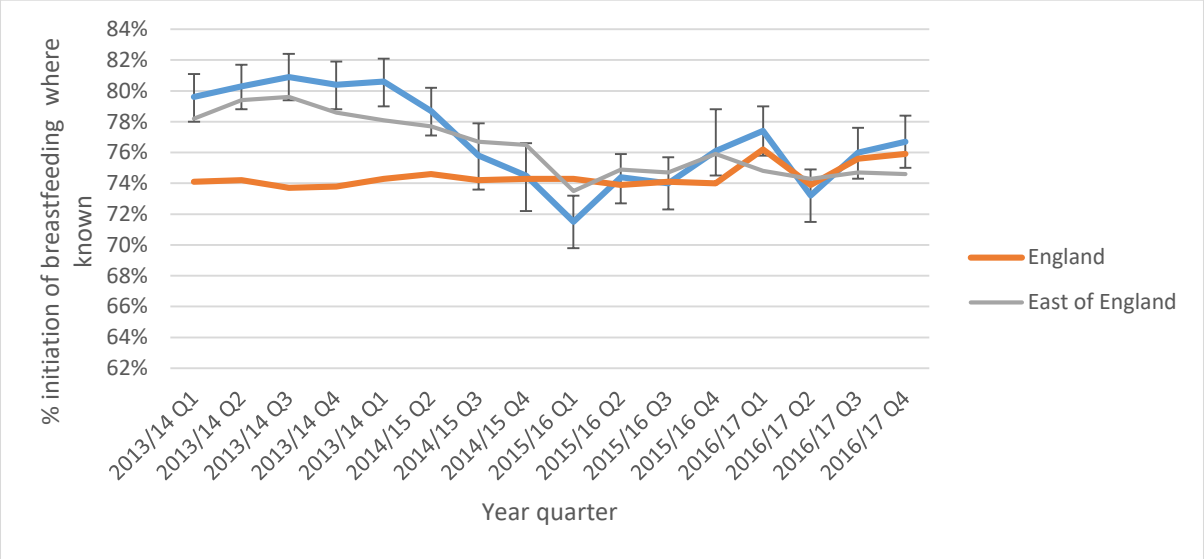


Figure 12.2 Breast feeding initiation in Cambridgeshire compared to England (6)

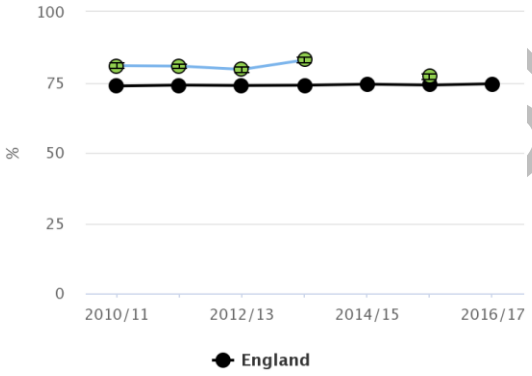


Figure 12.3 Breast feeding initiation in Peterborough compared to England (6)

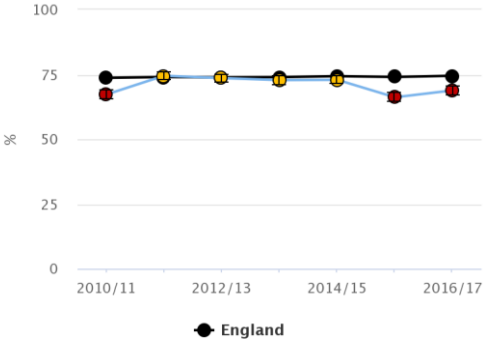
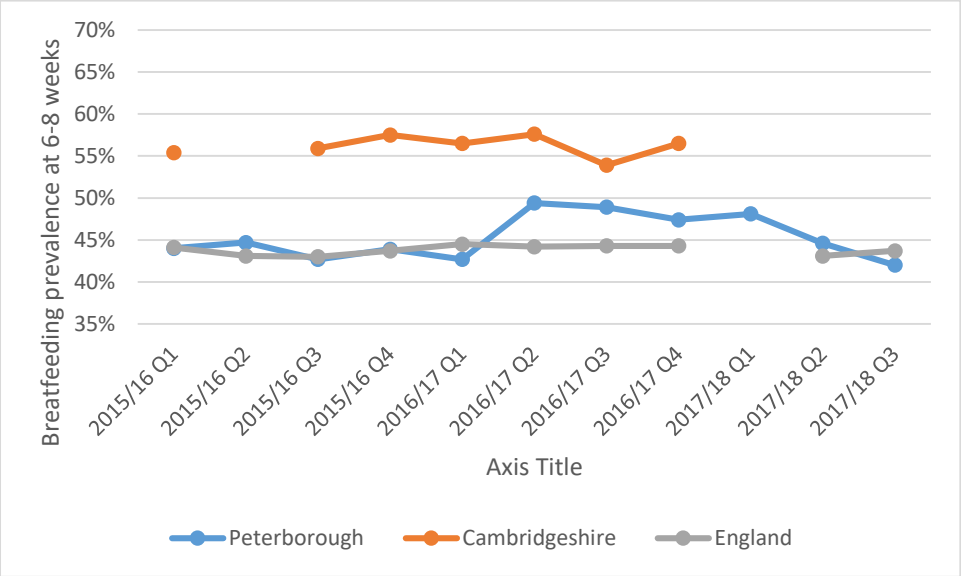


Figure 12.4 Breast feeding prevalence at 6 – 8 weeks after birth (5)



There are several data measurements missed for breast feeding at 6-8 weeks.

Table 12.1 Prevalence of Breastfeeding at 6 – 8 weeks in Peterborough, Cambridgeshire and England (5)

Quarter	Peterborough	Cambridgeshire	England
2015/16 Q1	44%	55.40%	44.10%
2015/16 Q2	44.70%	-	43.10%
2015/16 Q3	42.70%	55.90%	43.0 %
2015/16 Q4	43.90%	57.50%	43.70%
2016/17 Q1	42.70%	56.50%	44.50%
2016/17 Q2	49.40%	57.60%	44.20%
2016/17 Q3	48.90%	53.90%	44.30%
2016/17 Q4	47.40%	56.50%	44.30%
2017/18 Q1	48.10%	-	-
2017/18 Q2	44.60%	-	43.10%
2017/18 Q3	42%	-	43.70%

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