Appendix 2

Health and Wellbeing Strategy Performance Report

Performance Management Framework Structure

The performance management framework is based upon three national outcome frameworks that cover different areas of the health and care system:

- The Public Health Outcomes Framework (PHOF)
- NHS Outcomes Framework (NHSOF)
- Adult Social Care Outcomes Framework (ASCOF).

These frameworks help highlight common challenges at the local level across the health and care system, thereby informing local priorities and joint action. They are therefore an important tool in understanding progress made against the HWBS.

The outcome frameworks have common themes. The PHOF and NHSOF share goals on preventing premature death, whereas the NHSOF and ASCOF share goals on ensuring positive experience of care. The themes are supported by more detailed indicators that may be shared or complementary where there are shared goals.

The indicators from PHOF, NHSOF and ASCOF have been aligned to each of the HWBSs six Objectives and populated with the latest data available from across the health and social care system. The pages that follow provide information about the indicators currently showing red for each Objective as well as a more detailed understanding of how each of these indicators is performing.

Performance to Date

Objective 1

The indicators showing red for Objective 1 are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'.
Indicators under this header to which Objective 1 contributes are:

- PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
- NHSOF: Indicator 2.3ii - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (2012 -2013) and is mapped to objectives 1, and 6
- ASCOF: 2(B) – Part 1: The proportion of people (aged 65 and over) who were still at home 91 days after hospital discharge into reablement/rehabilitation services. 2013/14 is mapped to objective 1, 5 and 6
- ASCOF: 2(C) – Part 2 - Delayed transfers of care attributable to social care 2013/14 and
  mapped to objective 1 and 6.

Objective 2

PHOF: Indicator 2.02 Breast feeding Initiation and prevalence at 6 – 8 weeks after birth (period 2012/13)

A key priority for providing the best start in life for a child is breastfeeding. Babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection than babies who are not, and breastfeeding is associated with lower levels of childhood obesity. There are also benefits to the mother including a faster return to pre-pregnancy weight and lower risk of breast and ovarian cancer. Increases in breastfeeding are expected to reduce illness in young children. This in turn will reduce hospital admissions for the 0-1 age group.

When compared with England (47.2%), and regional averages (31.2%), Sunderland (27.8%) performs worse in terms of the percentage of babies who continue to be breast fed at 6-8 weeks after birth. However this is an improvement from 24.7% in 2011/12 and almost one third of all babies who are breast fed at birth (60.3%) are no longer breastfeeding 6 to 8 weeks later (27.8%). Our ambition should be that all babies are breastfed so it is important that all should start to be breastfed at birth and continue to be breastfed during the first 6 months of life. Increasing breastfeeding rates must continue to be a priority.

PHOF: Indicator 2.03 Smoking at Time of Delivery (2012/13)

In the year 2012-13, 523 mothers were smoking at time of delivery in Sunderland. This represents 18.5% of all mothers in Sunderland, compared with 19.7% in the North East, and 12.7% in England. In Sunderland rates have fallen over recent years from 21.6 in 2010/11 to 18.5 in 2012/13. Smoking at time of delivery varies by age with younger mothers in their teens and twenties much more likely to smoke than mothers in their thirties and forties. Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

PHOF: Indicator 2.04 Under 18 Conception Rate (2012)

There were 207 conceptions in Sunderland during 2012 for females aged under 18, with around half leading to a birth. The latest annual conception rate is 43.1 per 1,000 females compared with 35.5 for the North East, and 27.7 for England. There is a very clear link between area deprivation and teenage conception, with rates in the most deprived areas around four times higher than the least deprived areas both locally and nationally. However Sunderland has seen a substantial and sustained reduction in the rate of conceptions in girls under the age of 18 years from 63.78 per 1000 girls in 2003 to 43.1 per 1000 in 2012. Nevertheless, although the gap is narrowing, Sunderland's rate is still significantly higher than the national average (27.7 per 1000).

PHOF: Indicator 2.07 Hospital Admissions for injuries, aged 0 to 14 (2012/13)

719 persons aged 0 to 14 were admitted to hospital due to accidental and deliberate injuries in 2012-13. The Sunderland rate was 160.2%, which is higher than the North East rate of 146.8% and England rate of 103.8. It has improved significantly from 211.4% in 2011/12 to 160.2% in 2012/13. Higher admission levels were also seen in very young children 0 to 4 years 211.2% compared 134.7 nationally.

PHOF: Indicator 4.02 Tooth decay in children aged 5 (2011-12)

Whilst children's oral health has improved over the past 20 years, five-year olds experiencing tooth decay in Sunderland was 1.32 slightly worse than England average of .9 and North East value of 1.02.

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. Poor oral health can impact upon a child's ability to sleep, eat, speak, play and socialise with other children. Other consequences include pain, infections, poor diet, and impaired nutrition and growth. Oral health is thus a fundamental part of overall health and wellbeing. When children are not healthy, this affects their ability to learn, thrive and develop. In this way, good oral health can contribute to school readiness.

NHSOF: Indicator 3.2 - Preventing lower respiratory tract infections (LRT) in children from becoming serious: Emergency admissions for children with LRTI (2013/14)

Sunderland's performance at 468.9 is higher than National (368.6) and North East (452.7) average. No target set for 2014/2015; however direction of travel shows improvement compared to 2012/13 outturn of 591.4.

- There are other indicators showing red for Objective 2 that are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 2 contributes are:
  - PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.17 Fuel Poverty (period 2012) is mapped to objective 2, 3 and 5.

Objective 3

PHOF: Indicator: 2.20 Cancer screening coverage breast cancer (2013)

At March 2012 the breast screening coverage rate in Sunderland was 77.3%. This is lower than the North East average of 77.9% but better the national average of 76.3. Participation in the breast cancer screening programme can reduce deaths from breast cancer by about 35% among women who are regularly screened. Breast

cancer screening coverage in Sunderland has decreased from 78.9 in 2012 to 77.3 in 2013.

Breast screening supports early detection of cancer and is estimated to save 1,400 lives in England each year. Inclusion of this indicator will provide an opportunity to incentivise screening promotion and other local initiatives to increase coverage of cancer screening. Improvements in coverage would mean more breast cancers are detected at earlier, more treatable stages.

PHOF: Indicator 2.24 Injuries Due to Falls in people aged 65 and over (2012-13)

There were 1,163 admissions due to falls in 2012-13 in Sunderland for people aged 65 and over. The age standardised rate per 100,000 was 2378 in Sunderland, which is above the North East (2172), and England (2011.0) rates. The rate has increased from 2247 in 2011-12 to 2378 in 2012 -13

Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care. Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people.

- There are other indicators showing red for Objective 3 that are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 3 contributes are:
  - PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.17 Fuel Poverty (period 2012) is mapped to objective 2, 3 and 5
  - PHOF: Indicator 2.13 Proportion of Physically Active Adults (2013) is mapped to objective 3 & 4
  - PHOF: Indicator: 2.18 Alcohol-Related Admissions (2012/13) is mapped to objective 3 & 4
  - PHOF: Indicator 2.22 Percentage Receiving an NHS Health Check (2013/14) is mapped to objective 3 and 4
  - PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
  - PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
  - PHOF: Indicator 4.11 Emergency readmissions within 30 days of discharge from hospital (2011-12) and is mapped to objectives 3, 5 and 6
  - NHSOF: Indicator 1a - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (2012) and is mapped to objectives 3, 5 and 6

- NHSOF: Indicator 1b - Life expectancy at 75: Males (2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Females (2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 3.a - Emergency admissions for acute conditions that should not usually require hospital admission (2011/12) and is mapped to objectives 3, 5 and 6.

Objective 4

PHOF: Indicator 1.01 Children in Poverty (under 16s) (period 2011)

12,655 children (25.7%) in Sunderland live in households dependent on benefits or tax credits, compared with 24.5% in the North East and 20.6% nationally. Child poverty rates in Sunderland fell between 2009 and 2011 from 26.7% (13340) to 25.7% (12,655). The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

- There are other indicators showing red for Objective 4 that are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 4 contributes are:
  - PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
  - PHOF: Indicator 2.13 Proportion of Physically Active Adults (2013) is mapped to objective 3 & 4
  - PHOF: Indicator: 2.18 Alcohol-Related Admissions (2012/13) is mapped to objective 3 & 4
  - PHOF: Indicator 2.22 Percentage Receiving an NHS Health Check (2013/14) is mapped to objective 3 and 4
  - PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
  - PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6.

Objective 5

The indicators showing red for Objective 5 are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 1 contributes are:

- PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators

- PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
- PHOF: Indicator 1.17 Fuel Poverty (period 2012) is mapped to objective 2, 3 and 5
- PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
- PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
- PHOF: Indicator 4.11 Emergency readmissions within 30 days of discharge from hospital (2011-12 and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1a - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Males **(**2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Females (2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 3.a - Emergency admissions for acute conditions that should not usually require hospital admission (2011/12) and is mapped to objectives 3, 5 and 6
- ASCOF: 2(B) – Part 1: The proportion of people (aged 65 and over) who were still at home 91 days after hospital discharge into reablement/rehabilitation services. 2013/14 is mapped to objectives 1, 5 and 6.

Objective 6

The indicators showing red for Objective 6 are shared with other Objectives and be found towards the end of this report under the header of 'Cross-cutting Indicators'. Indicators under this header to which Objective 6 contributes are:

- PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like – mapped to all indicators
- PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like – mapped to all indicators
- PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
- PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6
- PHOF: Indicator 4.11 Emergency readmissions within 30 days of discharge from hospital (2011-12 and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1a - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Males **(**2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 1b - Life expectancy at 75: Females (2010 -2012) and is mapped to objectives 3, 5 and 6
- NHSOF: Indicator 2.3ii - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (2012 -2013) and is mapped to objectives 1, and 6

- NHSOF: Indicator 3.a - Emergency admissions for acute conditions that should not usually require hospital admission (2011/12) and is mapped to objectives 3, 5 and 6
- ASCOF: 2(B) – Part 1: The proportion of people (aged 65 and over) who were still at home 91 days after hospital discharge into reablement/rehabilitation services. 2013/14 is mapped to objective 1, 5 and 6
- ASCOF: 2(C) – Part 2 - Delayed transfers of care attributable to social care 2013/14 and
  mapped to objective 1 and 6.

Cross Cutting Indicators

PHOF: Indicator 1.16 Utilisation of green space for exercise/health reasons - all indicators

This has improved from 5.8% in 2011-2012 to 14.1% in 2012 – 2013. Inclusion of this indicator is recognition of the significance of accessible outdoor space as a wider determinant of public health. There is strong evidence to suggest that outdoor spaces have a beneficial impact on physical and mental well-being and cognitive function through both physical access and usage

PHOF: Indicator 1.18i The percentage of adult social care users who have as much social contact as they would like - all indicators

This has remained stable over the last 3 years at 45.3% but is better than the north east average of 44.6%

PHOF: Indicator 1.18i The percentage of adult carers who have as much social contact as they would like - all indicators

At 40.6% this is much lower than the north east average of 49.6%.

There is a clear link between loneliness and poor mental and physical health. Social isolation has major health implications. It is linked in particular with factors such as growing older, loss of mobility, deprivation and sensory impairment. Strong social networks are often overlooked but are in fact critical to our health and wellbeing. A lack of social interaction can be as bad for health as smoking, obesity, lack of physical activity or misuse of alcohol

PHOF: Indicator 1.17 Fuel Poverty (period 2012) is mapped to objective 2, 3 and 5

Just over 1 in 11 households in Sunderland are in fuel poverty (11.7%), which is above the North East (11.6%) and above the England (10.41%) rates. Levels of fuel poverty fell between 2011 and 2012 in Sunderland from 11.9% (14,482) to 11.7% (13,805). Fuel poverty in more prevalent in groups with low household incomes, including pensioners, persons on benefits, and working families with below average incomes and the low wage economy, particularly in North East and higher living costs contribute to levels of fuel poverty locally. Marmot Review Team report showed that low temperatures are strongly linked to a range of negative health outcomes.

PHOF: Indicator 2.13 Proportion of Physically Active Adults (2013) is mapped to objective 3 & 4

46.2% of adults in Sunderland were physically active for at least 150 minutes per week in 2013. This is significantly lower than the North East region (52.8) and national (55.6%) rates. Levels of physical activity decreased from 47.8% in 2012 to 46.2% in 2013

PHOF: Indicator: 2.18 Alcohol-Related Admissions (2012/13) is mapped to objective 3 & 4

There were around 2,884 alcohol-related admissions to hospital for Devon residents in 2012-13. The Direct Age Standardised Rate of Admissions (1071 per 100,000) is much higher than the North East (856) and national (637) rates. The rate has decreased from 1088 in 2011/12 to 1071 in 2012/13.
Alcohol-Related Admission rates vary by age, with the highest rates in older age groups, reflecting the long-term effects of alcohol-use through life. Acute admissions (accidents and poisonings) are most common in young adults, mental health admissions in persons in their 40s and 50s, and admissions for chronic conditions in older age groups. Admission rates are higher for males than females.

PHOF: Indicator 2.22 Percentage Receiving an NHS Health Check (2013/14) is mapped to objective 3 and 4

6,444 people in Sunderland received a health check in 2013- 14. This represents 7.6% of the eligible population, which is below the North East (10.4%), and England (9%) rates.
The NHS Health Checks programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. A high take up of NHS Health Checks is important to identify early signs of poor health leading to opportunities for early interventions.

PHOF: Indicator 4.04 Under 75 Mortality Rate Cardiovascular Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6

In Sunderland there were 706 cardiovascular deaths in under 75s, with an direct age standardised rate of 99.9 per 100,000 for 2010-12. The Sunderland rate in 2010-12 was above the North East (92.4) and England (81.1) rates. Significant reduction has been made from 173 in 2001 to 101.9 in 2009 – 11 to 99.9 in 2010 -12. Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment. Mortality from circulatory disease increases rapidly with age, with the highest mortality rates in under 75s in the 65 to 74 age group, and very few deaths in persons aged under 40.

PHOF: Indicator 4.07 Under 75 Mortality Rate – Respiratory Diseases (2010-2012) is mapped to objective 3, 4, 5 and 6

The early death rate from respiratory disease in Sunderland in under 75s during 2010-2012 was 47.6 compared to North East rate of 42.2 and England rate of 35.5. There were 333 early deaths rates from respiratory disease in Sunderland between: 2010-2012. Smoking is considered the leading risk factor and a significant contributor to these deaths. Respiratory disease is one of the top causes of death in England in under 75s and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases. This indicator will focus public health attention on the prevention of smoking and other environmental factors that contribute to people getting respiratory disease.

PHOF: Indicator 4.11 Emergency readmissions within 30 days of discharge from hospital (2011-12) and is mapped to objectives 3, 5 and 6

Sunderland's rate of emergency readmissions within 30 days (13.3%) is higher than the North East value of 12.7% and England's value of 11.8%. It has increased from 12.9% in 2009–11 to 13.3% in 2011-12 or from 4787 readmissions to 5021 in 2011-12
This indicator will follow individuals discharged from hospital to monitor success in avoiding emergency admissions. Health interventions and social care will play significant roles in putting in place the right reablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short term.

NHSOF: Indicator 1a - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (2012) and is mapped to objectives 3, 5 and 6

Current performance at 3458.3 is higher than the North East (3254.6) and National (2801.4) figure. SCCG target for 2014/15 is 2,278 and Quality Premium national indicator for 2014/15 - however includes both adult and child.

NHSOF: Indicator 1b - Life expectancy at 75: Males **(**2010 -2012) and is mapped to objectives 3, 5 and 6

Sunderland figure of 10.5 is lower than National (11.5) and North East (10.8) average, and slight deterioration based on 2009-2011 at 10.4

NHSOF: Indicator 1b - Life expectancy at 75: Females (2010 -2012) and is mapped to objectives 3, 5 and 6

Sunderland figure of 11.9 is lower than National (13.3) and North East (12.5) average, but improvement based on 2009-2011 at 12.0

NHSOF: Indicator 2.3ii - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (2012 -2013) and is mapped to objectives 1, and 6

Sunderland's performance at 518 is higher than National (340) and North East (340) average. CCG have an aspiration over next 5 years to reduce non electives by 15%, although focus is on frail elders rather than under19s.

NHSOF: Indicator 3.a - Emergency admissions for acute conditions that should not usually require hospital admission (2011/12) and is mapped to objectives 3, 5 and 6

Sunderland's performance at 13.30 is higher than National (11.8) and North East (12.7) average. It has increased from 12.9% in 2010/11 to 13.3 in 2011/12 or from 4787 in 2010/11 to 5021 in 2011/12

ASCOF: 2(B) – Part 1: The proportion of people (aged 65 and over) who were still at home 91 days after hospital discharge into reablement/rehabilitation services.
2013/14 is mapped to objective 1, 5 and 6

Sunderland's target for this was 86.4 % and achievement was 85.53% and National average was 81.4%. This measure reflects the effectiveness of reablement services**.**

ASCOF: 2(C) – Part 2 - Delayed transfers of care attributable to social care 2013/14 and mapped to objective 1 and 6

A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. Sunderland year end result was 4.8% for 2013-2014 and National figure was 3.1. It has improved from 9.65 in 2012/13 to 4.8 in 2013/14.
This measures the impact of hospital services and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population, and is an indicator of the effectiveness of the interface within the NHS, and between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of both health and social care.