Annual Public Health Report for Cambridgeshire (DRAFT) 2010

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Contents

Introduction

Section 1: Health Statistics and Inequalities in Cambridgeshire

1.1 The Population -
1.2 Mortality
1.3 Common Long-term Health Conditions
1.4 Healthy lifestyles update
1.5 How Does Cambridgeshire's Health Compare with Other Areas?

Section 2: Joint Strategic Needs Assessment 2010

2.1 Children and Young People
2.2 Older People Including Dementia
2.3 Mental Health in Adults of Working Age
2.4 Travellers
2.5 New Communities
2.6 Next Steps

Section 3: Variations in Healthcare

3.1 Mapping variation in healthcare
3.2 The Sustainable Health Partnership

Section 4: Health Protection

4.1 Immunisations
4.2 Swine Flu H1N1
4.3 Healthcare Acquired Infections
4.4 Notifiable Diseases

Section 5: Progress against Recommendations of the APHR 2009

Section 6: Recommendations of the APHR 2010

Introduction

For Directors of Public Health and our teams, the 'patient' we look after is the whole population of the area which we serve – that is, all the people who live in Cambridgeshire. We have a professional duty to protect and improve the health of local people, to monitor local trends in the different causes of health and illness and the inequalities in health between different communities, and to advise public sector bodies on effective use of resources to improve population health.

Since my first Annual Public Health Report for Cambridgeshire (2006) the estimated population of the county has increased from about 570,000 people to over 600,000. Close to a third of this estimated increase was amongst people aged 65 or over. Life expectancy has improved overall in Cambridgeshire as have premature death rates for circulatory disease and cancer, but inequalities in life expectancy between different communities have persisted. Surveys of adult health and lifestyles in Cambridgeshire carried out in both 2008 and 2009 showed no significant change in the main lifestyle behaviours which impact on health (smoking, alcohol, diet and physical activity) over this relatively short period. Children also adopt lifestyles which will influence their later health – in Cambridgeshire the well known trend of rising childhood obesity appears to have levelled over the past two years but not reversed.

Since 2007, Local Authorities and Primary Care Trusts have had a statutory duty to co-operate and to prepare a Joint Strategic Needs Assessment (JSNA), looking at the health and wellbeing needs of local communities, including needs for preventive, health and social care. A wealth of new information about local people's health and wellbeing, and the factors which affect health, is now available on www.cambridgeshirejsna.org.uk and this information is used by several local organisations to plan services to meet local needs. One use for JSNA is to assess which population groups are most vulnerable and have the greatest need for public services, enabling resources to be targeted most effectively. The current financial constraints on both local authorities and the NHS make this particularly relevant at this point in time.

At the time of writing there are changes proposed to both NHS and Public Health structures, as laid out in the draft Health and Social Care Bill. This includes a welcome focus on the role and involvement of local communities, and an increased role for local authorities. Although the new statutory roles for health improvement will sit with Cambridgeshire County Council, it will be essential to have close involvement from District and City councils in order to achieve the intended outcomes. As at any time of change, it will be important to strike a balance between maintaining aspects of existing work that are demonstrably improving outcomes, and being open to new opportunities for joint working and to innovative approaches.

As always I'd like to thank the Cambridgeshire Public Health Team for their input to this report – especially Caroline Tomes as overall co-ordinator, David Lea and the Public Health Intelligence Team who supplied data and analyses, and Dr Lincoln Sargeant for writing the health protection section.

Dr Liz Robin

Section 1: Health Statistics for Cambridgeshire

1.1 The Population

The latest estimates available for the number of people living in Cambridgeshire are for mid-2009. These indicate that there were about 600,800 people living in Cambridgeshire at this point, around a quarter were under 20 years and around one in seven aged 65 years and over.

Table 1: Total population - population estimates, mid 2009 (CCCRG)

Local Authority	Population
Cambridge City	119,100
East Cambridgeshire	80,300
Fenland	93,300
Huntingdonshire	164,600
South Cambridgeshire	143,600
Cambridgeshire	**600,800**

Source: Cambridgeshire County Council Research Group.
Definition: Mid 2009 population estimates (Note: Figures are rounded to the nearest 100).

Cambridge City has a noticeably higher proportion of people aged 15-34 years and a smaller proportion of children and older people. This is due to the high student population in the district.

Table 2: Total population - population estimates, mid 2009 (CCCRG)

Area	Age band										Total
	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	
Cambridge City (num)	6,400	10,500	27,700	22,900	14,400	12,200	10,800	7,200	4,800	2,100	119,100
Cambridge City (%)	5.4%	8.8%	23.3%	19.2%	12.1%	10.2%	9.1%	6.0%	4.0%	1.8%	100%
East Cambridgeshire (num)	5,200	9,500	8,800	8,600	12,600	11,500	10,500	7,200	4,900	1,700	80,300
East Cambridgeshire (%)	6.5%	11.8%	11.0%	10.7%	15.7%	14.3%	13.1%	9.0%	6.1%	2.1%	100%
Fenland (num)	5,100	11,200	10,500	10,400	12,700	12,700	12,500	9,400	6,800	2,100	93,300
Fenland (%)	5.5%	12.0%	11.3%	11.1%	13.6%	13.6%	13.4%	10.1%	7.3%	2.3%	100%
Huntingdonshire (num)	9,500	20,200	19,300	18,300	26,200	24,500	21,400	14,400	7,800	2,800	164,600
Huntingdonshire (%)	5.8%	12.3%	11.7%	11.1%	15.9%	14.9%	13.0%	8.7%	4.7%	1.7%	100%
South Cambridgeshire (num)	8,800	17,900	15,100	15,300	22,400	20,700	19,200	13,300	8,100	2,900	143,600
South Cambridgeshire (%)	6.1%	12.5%	10.5%	10.7%	15.6%	14.4%	13.4%	9.3%	5.6%	2.0%	100%
Cambridgeshire (num)	35,000	69,100	81,500	75,400	88,300	81,600	74,400	51,500	32,400	11,500	600,800
Cambridgeshire (%)	5.8%	11.5%	13.6%	12.5%	14.7%	13.6%	12.4%	8.6%	5.4%	1.9%	100%
England (num)	3,196,100	5,879,700	6,866,100	6,774,700	7,610,900	6,955,200	6,092,700	4,380,000	2,891,600	1,162,900	51,809,700
England (%)	6.2%	11.3%	13.3%	13.1%	14.7%	13.4%	11.8%	8.5%	5.6%	2.2%	100%

Source: Cambridgeshire County Council Research Group (CCCRG) and ONS.
Definition: Mid 2009 based single year population estimates (Note: Figures are rounded to the nearest 10). Please note that the source of the local estimates is Cambridgeshire County Council Research Group's estimates, which are derived from ONS estimates and modelled locally. The source of the England estimates is the ONS data directly.

Population forecasts predict that between 2008 and 2021, there will be a further 78,000 people living in Cambridgeshire. The biggest actual increases and also proportional increases are expected in Cambridge City and South Cambridgeshire.

Table 3: Total population - population forecasts, mid 2008 based (CCCRG)

Local Authority	Year				% Change 2008 to 2021
	2008	2011	2016	2021	
Cambridge City	117,700	125,000	141,400	153,600	30.5%
East Cambridgeshire	79,400	79,300	80,200	81,100	2.1%
Fenland	92,900	93,100	96,300	100,300	8.0%
Huntingdonshire	163,100	165,500	165,800	166,800	2.3%
South Cambridgeshire	142,500	142,200	158,600	171,900	20.6%
Cambridgeshire	595,500	605,000	642,300	673,700	13.1%

Source: Cambridgeshire County Council Research Group Mid-2008 district level population forecasts.
Note: Table above: these forecasts have been produced using specific assumptions and may not be appropriate for all uses. These forecasts remain subject to revision. These figures have been rounded to the nearest 100. Totals may not add due to rounding. These forecasts are indicative and do not represent the policy of the County Council or any District Council.

In general, most local authorities in Cambridgeshire have small proportions of minority ethnic residents. However, Cambridge City has higher proportions of minority ethnic groups than England, with a higher proportion of people from 'Chinese or Other Ethnic Groups'. The minority ethnic groups in Cambridge include a high proportion of students and professionals. Cambridgeshire also has considerable populations of Travellers and migrant workers.

Deprivation levels vary widely across Cambridgeshire, with Fenland having the greater relative deprivation and South Cambridgeshire the lesser. South Cambridgeshire is the fifth least deprived local authority in England. Although Cambridgeshire as a county is prosperous with a low overall deprivation score, there are pockets of socio-economic deprivation in all of the districts.

Table 4: Indices of deprivation 2007, local authority rank

Local Authority	IMD 2007 Score (Average of LSOA Scores)	LA Rank (England)*
Fenland	20.50	139
Cambridge	13.87	236
East Cambridgeshire	10.84	285
Huntingdonshire	9.31	311
South Cambridgeshire	6.55	350
Cambridgeshire	11.49	135

NB: *LA rank (England): the rank for 5 district authorities represents the relative rank within the 354, tier 2 local authorities in England where rank 1 is the most deprived authority and rank 354 the least deprived. The rank for Cambridgeshire represents the relative rank within the 149, tier 1 local authorities where rank 1 is the most deprived authority and rank 149 the least deprived.
Source: The English Indices of Deprivation 2007, Department for Communities and Local Government (DCLG).
Definition: The English Indices of Deprivation 2007 include domains at lower super output area (LSOA) for income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services housing, living environment deprivation and crime. An average score has been calculated for each local authority district based on LSOA scores weighted according to their population. This measure takes into account the full range of scores across a district and averages the LSOA scores in each district after they have been population weighted.

1.2 Mortality

Life expectancy is an artificial measure created by looking at the mortality (death) rates for each age

group in an area, and calculating the average expected length of life if these rates applied to someone born now. There is a close correlation in Cambridgeshire between socio-economic deprivation and life expectancy both at district level, and for smaller pockets of social deprivation.

Table 5: Life expectancy at birth (years), 2007-2009

Area	Males	Females
England	78.3	82.3
East of England	79.3	83.0
Cambridgeshire	79.8	83.5
Cambridge	78.3	83.0
East Cambridgeshire	81.0	83.8
Fenland	77.2	82.0
Huntingdonshire	79.7	83.7
South Cambridgeshire	81.6	84.5

Source: ONS, Life expectancy at birth (2007-2009), November 2010.

In the years 2007-9, there was a difference of more than four years in average life expectancy between men born in Fenland (most deprived) and those born in South Cambridgeshire (least deprived), the difference for women was closer to three years. Fenland has statistically significantly lower LE at birth than Cambridgeshire as a whole and East of England region for both males and females. Fenland has statistically significantly lower male LE at birth than England. Female LE at birth in Fenland is lower than England but not significantly so.

All Cambridgeshire districts show an improving trend in both male and female life expectancy, as does England as a whole. However the long term improvement is slower than the national trend in Fenland and most markedly in Cambridge City.

Figure 2: Trend in male life expectancy

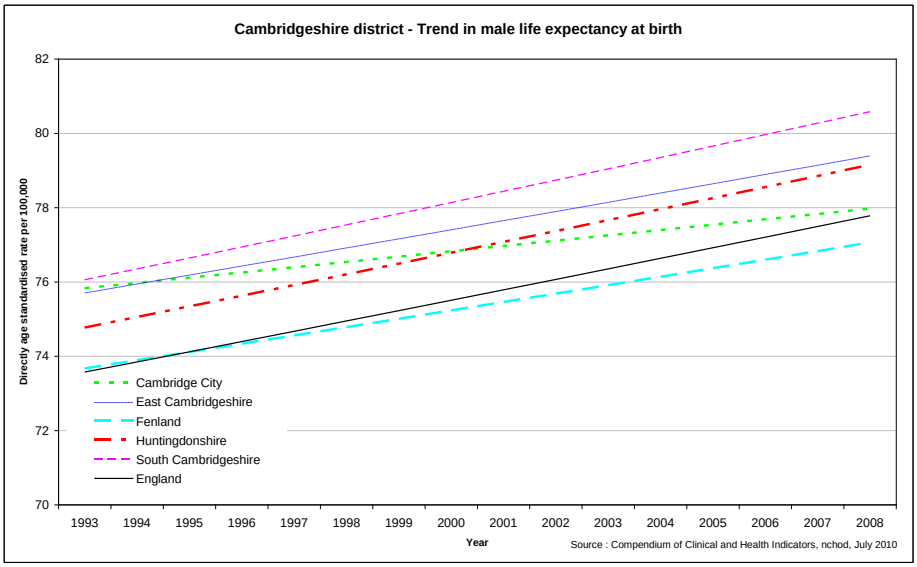


Figure 3: Trend in female life expectancy

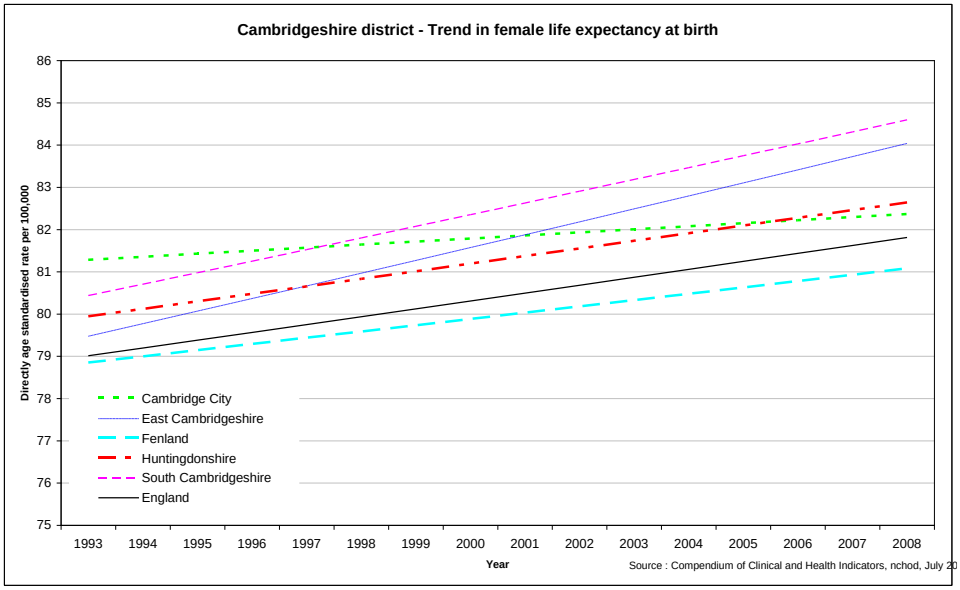
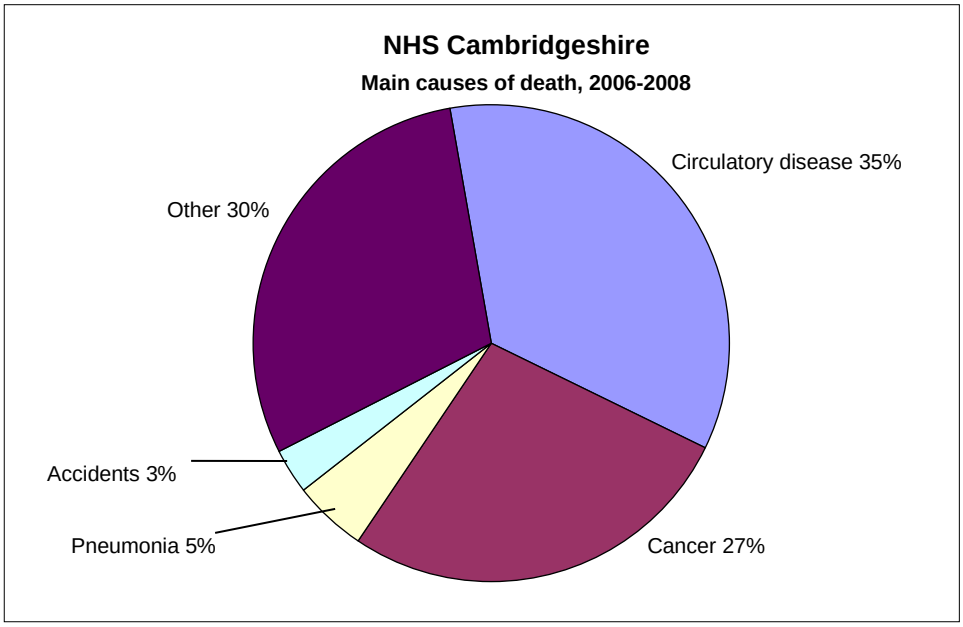


Figure 1: Mortality: main causes of death, total population, 2006-2008



Source: Compendium of Clinical and Health Indicators, NCHOD, July 2010

Circulatory disease and cancer are the main causes of death in the overall population. Conditions originating at the time of birth and transport accidents are the main causes of death for children.

1.3 Long term conditions

Much of the work of the NHS is supporting patients with long term health conditions to prevent exacerbations or deterioration in the condition. The following table shows updated information from Cambridgeshire GP practice registers on the number of people diagnosed with a range of long-term conditions, together with some estimates from the national public health observatories of the total number of people with these conditions. Diagnosis and recording rates for diabetes and coronary heart disease appear reasonably good, whereas there are likely to be many people with undiagnosed high blood pressure, as is the case nationally. We would expect to see some further improvements in diagnosis rates, following introduction of the national 'health checks' programme for 40-74 year olds.

Table 6: Information from Cambridgeshire GP practice registers on the number of people diagnosed with a range of long-term conditions, (2009/10 QOF) and model based estimates of disease (APHO and PANSI)

Condition	Number of Patients Recorded on Cambridgeshire GP Registers	Estimated Total Number of Patients in Cambridgeshire, Modelled by Public Health Observatory
Hypertension (high blood pressure)	79,095	138,910(2009 figure)
Depression	60,427	62,231 (2010 figure)
Asthma	40,999	-
Diabetes	24,039	31,167 (2009 figure)
Coronary heart disease	19,082	23,385 (2009 figure)
Hypothyroidism	19,324	-
Chronic kidney disease	17,987	40,048
Stroke or transient ischaemic attack	9,389	11,154
Cancer	9,752	7,016 (2004 based)
Atrial fibrillation	8,831	-
Chronic Obstructive Pulmonary Disease	8,763	12,483
Heart failure	4,210	-
Severe mental health problem	4,422	-
Epilepsy	3,468	-
Dementia	2,682	6,821 (2010 figure)
Learning disabilities	1,791	-
Palliative care	851	-

Data source: Quality and Outcomes Framework (QOF), 2009/10, Information Centre for Health and Social Care, APHO disease prevalence models at http://www.apho.org.uk/resource/view.aspx?RID=48308 (17/12/2010) and PANSI at http://www.pansi.org.uk (19/08/2010). Please note that modelled based estimates are not available for all diseases.

1.4 Health and lifestyles

There is accumulating evidence that adopting 'healthy' behaviours can reduce the risk of many long-term health conditions and increase life expectancy, in turn reducing the requirements on local services.

Cambridgeshire participated in a telephone survey of health and lifestyle behaviours carried out across the East of England in 2008 and 2009, from which we can calculate the approximate number of people with these key behaviours in the county. Table 8 presents the estimated number and percentage of people in Cambridgeshire engaging in each of these key behaviours for the 2008 and the 2009 survey. Comparing the results of the two years, there are some differences – but none of these are statistically significant – in other words they could have occurred by chance, due to a different 'sample' of people being asked the questions in the two years.

Table 8: Estimated number and percentage of people in Cambridgeshire with each 'healthy' behaviour

Lifestyle Behaviour	2008		2009	
	Estimated Number of People Aged 16+ in Cambridgeshire With the Behaviour[1]	Percentage (95%confidence intervals)	Estimated Number of People Aged 16+ in Cambridgeshire With the Behaviour[2]	Percentage (95%confidence intervals)
Non-smoker	417,000	84.4% (82.1-86.5%)	409,300	82.6% (80.3%-84.8%)
Male - drinking within recommended limits	172,600	70.3% (72.9-80.5%)	176,816	71.9% (67.8%-75.7%)
Female - drinking within recommended limits	211,000	84.9% (84.6-90.1%)	205,171	82.2% (78.9%-85.1%)
Eats five portions of fruit and veg 5-7 days a week	233,200	47.2% (44.2-50.3%)	225,957	45.6% (42.6%-48.5%)
Male high level of physical activity	115,400	47% (42.5-51.5%)	123,944	50.4% (46.0%-54.8%)
Female high level of physical activity	115,600	46.5% (42.4-50.7%)	106,829	42.8% (38.8%-46.8%)
All four healthy behaviours	76,600	15.5% (13.4-17.9%)	69,373	14.0% (12.0%-16.2%)

There has been a recent focus on childhood obesity as a lifestyle factor likely to have an important effect on children's current and future health.

Cambridgeshire has recorded 15.6% of childhood obesity in Year 6 demonstrating a decrease compared to previous data. The slight decrease in Year 6 pupils recorded as obese is opposite to the national trend where there has been a recent increase. There has been a slight increase in Reception pupils recorded as obese this year (8.7%), but these are no higher than the figures for two years ago. Overall, the rising trend of childhood obesity appears to have halted. Cambridgeshire is in line with the national average of children who participate in at least three hours of quality physical education and out of hours sport in a typical week.

Trends in alcohol related hospital admissions have also shown an increase, particularly in Cambridge City. This trend can be difficult to interpret as 'alcohol related hospital admissions' is a complex indicator, including a large number of admissions for general conditions such as high blood pressure and other chronic illnesses, of which a proportion are assumed to be due to use of alcohol. Further work is needed to establish the exact causes of the rising trend in different areas of the county.

1.5 How does Cambridgeshire's Health Compare with Other Areas?

Since 2008, in addition to comparing health in Cambridgeshire to national averages, local analysts have also compared Cambridgeshire to other socio-demographically similar areas, as classified by the Office of National Statistics (ONS).

Generally, the people of Cambridgeshire are healthier than the England average, but compared to its cluster average, consisting of Primary Care Trusts (PCTs) with similar demographic and socio-economic characteristics, it fares less well and several of the health indicators are significantly worse than the cluster average. Analyses for Cambridgeshire and all its local authority districts are also presented in the Phase 4 Joint Strategic Needs Assessment (JSNA).

Table 7: NHS Cambridgeshire benchmarking spine chart compared to ONS cluster group

NHS Cambridgeshire Benchmarking Spine Chart

Key Spine chart England comparison

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

ONS Cluster group – Prospering Southern England

Cluster av. National av.

Worst — 25th Percentile 75th — Best

Key Cluster comparison

- Significantly better than cluster average
- Not significantly different
- Significantly worse than cluster average

	Indicator	Local avg number per year	Local value	Eng avg	Eng worst	England range	Eng best	Cluster avg	Sig diff from cluster avg
1	GCSE achievement (%)	3,284	56.2	50.7	33.5		68.2	60.5	■
2	Statutory homelessness (per 1,000 hh)	580	2.3	2.8	8.9		0.2	1.2	■
3	Unemployment rate (per 1,000 working age population)	16,000	5.1	6.4	14.8		2.8	4.0	♦
4	Infant mortality rate (per 1,000 live births)	29	4.1	4.8	9.0		2.2	3.4	♦
5	Abortions under 10 weeks (%)	847	66.6	73.3	46.6		85.3	77.5	■
6	Perinatal mortality rate (per 1,000)	39	5.5	7.8	12.7		4.5	6.0	♦
7	Low birth weight babies (%)	435	5.9	7.5	11.2		4.9	6.4	♦
8	Breast feeding initiation (%)	1,403	80.4	73.7	35.7		94.7	-	
9	Breast feeding 6-8 weeks (%)	1,026	58.2	46.2	-		-	-	
10	Smoking during pregnancy (%)	192	11.0	13.3	-		-	-	
11	Obesity in Reception year children (%)	513	8.7	9.8	14.8		6.2	8.3	♦
12	Obesity in Year 6 year children (%)	865	15.6	18.7	28.6		12.1	15.3	♦
13	Teenage pregnancy rate (u18) (per 1000)	276	26.0	40.9	74.8		15.2	23.7	■
14	Breast screening in 53-64s (%)	34,527	80.2	77.0	50.9		84.8	79.1	●
15	Cervical screening in 25-64s (%)	122,419	81.1	78.9	65.8		85.8	80.4	●
16	Chlamydia screening in 15-24s (%)	3,831	4.4	4.1	2.0		9.0	-	
17	MMR vaccination u2 (%)	6,323	88.2	88.2	73.0		96.7	88.0	♦
18	Year 8 girls receiving HPV all 3 doses (%)	3,038	93.7	70.4	0.3		97.9	76.3	●
19	Flu vaccination in 65+ (%)	69,882	74.9	74.1	68.7		79.8	74.4	●
20	Physical activity (16+) (%)	556	22.3	21.4	13.1		28.4	24.3	♦
21	Hospital admissions for alcohol related harm (per 100,000)	11,352	1596.2	1582.7	2856.4		777.5	-	
22	Modelled CHD prevalence (%)	23,385	4.6	5.6	8.5		3.0	4.5	
23	Modelled COPD prevalence (%)	12,483	2.5	3.7	6.0		2.1	2.8	
24	Modelled diabetes prevalence (%)	22,274	3.8	4.5	6.2		3.5	3.9	
25	Modelled hypertension prevalence (%)	138,910	27.5	30.4	37.3		21.8	28.3	
26	Modelled stroke prevalence (%)	11,154	2.2	2.5	3.7		1.4	2.1	
27	Female life expectancy	-	83.1	82.0	78.8		88.9	-	
28	Male life expectancy	-	79.3	77.9	73.6		84.3	-	
29	Female mortality from all causes (per 100,000)	2,510	442.9	490.6	653.8		295.2	432.0	♦
30	Male mortality from all causes (per 100,000)	2,352	621.3	692.3	942.7		440.9	590.2	■
31	Mortality from all cancers (u75) per 100,000)	624	99.6	114.0	159.7		70.5	99.4	♦
32	Mortality from all circulatory diseases (u75) (per 100,000)	387	61.0	74.8	125.0		49.2	55.6	■
33	Mortality from accidents (15-24) (per 100,000)	12	14.7	13.7	40.6		2.5	15.1	♦
34	Mortality from accidents (65+) (per 100,000)	79	66.4	58.9	106.6		21.0	56.4	♦
35	Mortality from land transport accidents (per 100,000)	46	7.1	4.8	11.7		1.3	4.9	■

Indicator, Year, Data Source

1 academic yr 2008/09, DCSF; **2** 2007/08, DCLG; **3** 2008/09, ONS; **4** 2006-08, NCHOD; **5** 2008, NCHOD; **6** 2006-08, NCHOD; **7** 2008, NCHOD; **8** Q2 2010/11, DH; **9** Q2 2010/11, DH; **10** Q2 2010/1, DH; **11,12** academic yr 2009/10 NCMP; **13** 2006-08, ONS; **14,15** 31 March 2009; **16** Q1 2009/10 NCSP; **17,18** 2009/10 IC; **19** Oct 08-Jan 09, HPA; **20** 2008/09, Sport England; **21** 2008/09, NWPHO; **22,23** 2009 projection, APHO; **24** 2005, YHPHO; **25,26** 2009 projection, APHO; **27-35** 2006-08, NCHOD.

Section 2: Joint Strategic Needs Assessment

The Cambridgeshire Joint Strategic Needs Assessment (JSNA) is an annual publication which identifies current and future health and wellbeing needs of local populations and informs the strategic direction of service delivery to meet those needs. In Cambridgeshire, we carry out separate JSNAs for different population groups, for which the full documents are available on website www.Cambridgeshirejsna.org.uk

In 2010 we completed the fourth phase of the JSNA in Cambridgeshire which focuses on children and young people, older people including dementia, mental health in adults of working age, Travellers and new communities. We develop each JSNA in collaboration with a range of organisations which commission or provide relevant services and advocacy. Each JSNA contains a small number of recommendations which have been developed using available information and evidence, and discussed through the multi-agency steering group. Feedback indicates that the process of working together to gain a joint understanding of needs and priorities is as important as the document produced at the end of the process. A dominant theme in 2010's JSNA summary has been the role of communities in supporting people's health and wellbeing. This reflects the government's recognition of the importance of community involvement and empowering people to take control of their own health.

2.1 Children and Young People

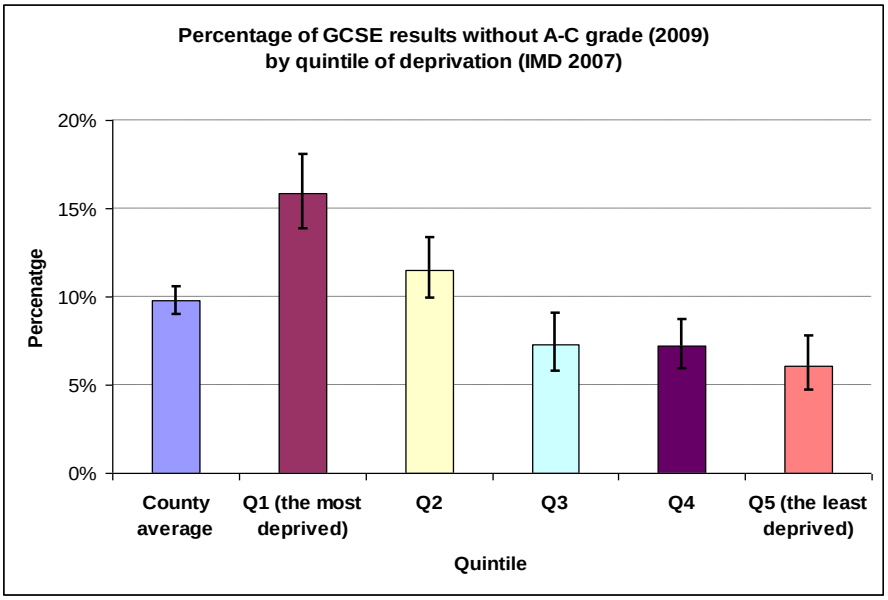
The Children and Young People's JSNA is an overview of key issues affecting outcomes for children in Cambridgeshire, and updates the first JSNA for children and young people developed in 2007/08. Much of the information is broken down to district and area level in order to inform commissioning decisions at a local level.

The JSNA identified inequalities in outcomes for children and young people, including: differences in life expectancy, numbers of young people becoming NEET (not in employment, education or training), attainment rates across all key stages of education, rates of unhealthy weight and childhood deaths. Underpinning these variations in outcomes are levels of deprivation and childhood poverty.

As well as continuing to implement the recommendations from the 2007/08 children and young people JSNA, the following recommendations were made for the Children's Trust and partners:

- ensure all children get a good start in life as an increasing body of evidence shows that the first few years will impact lifelong;
- support good mental health and emotional wellbeing which are fundamental to achieving good health and outcomes across all five Every Child Matters domains (be healthy, stay safe, enjoy and achieve, make a positive contribution, economic wellbeing)

Figure 4: Education: proportion of pupils with no GCSE grades A*-C, 2009 by quintile of deprivation (IMD 2007)



Source: Children and Young People's Services, Cambridgeshire County Council (2010) and Index of Multiple Deprivation 2007, Department of Community and Local Government.

Definition: Average proportion of pupils with no GCSE grades A*-C, 2009 by quintiles based on the Index of Multiple Deprivation 2007. Each quintile has 20% of wards in Cambridgeshire. Q1 shows the rate for the fifth of the most deprived wards in the county and Q5 the rate for the fifth of least deprived wards.

- prevent/reduce the negative impact of alcohol and substance misuse, obesity and overweight, childhood accidents, child poverty, domestic violence and disabilities and the consequent inequalities in outcomes;
- consider a more radical multi agency approach to workforce and service redesign;
- ensure that schools, colleges, GP clusters, and partners within the Children's Trust understand the needs and issues for children in their areas and know what they should be doing to improve the outcomes for their children and young people;
- consider how best to support localised delivery through localised commissioning while preventing geographic variation leading to inequality in outcomes.

And specifically, the Children's Trust and its partners should:

1. Work in partnership to tackle child poverty and deprivation to reduce inequalities in outcomes for children and young people across all districts and between particular areas and the rest of Cambridgeshire, e.g. Fenland, particularly Wisbech, north Cambridge and parts of Huntingdon and for vulnerable groups of children and young people wherever they live. This recommendation is made recognising that many children experiencing poverty in Cambridgeshire live outside the areas listed and the causes of inequalities in outcomes are of course broader than just deprivation and poverty.

2. Ensure the Healthy Child Programme is delivered effectively to all children and young people though the NHS, Children's Centres and supported by schools and colleges

3. Ensure a positive start in life and promote good emotional health and wellbeing

4. Give the Children's Trusts Area Partnerships, GPs clusters (primary and community care) and schools clear messages about their roles and responsibilities, devolving decisions and planning to the area level wherever feasible.

5. Adopt a community assets approach to tackle inequalities with local communities and the voluntary sector.

2.2 Older People including Dementia

In Cambridgeshire in 2009, there were around 95,000 people aged 65 and over (almost 16% of residents). In all localities apart from Cambridge City, the number of older people is forecast to rise steadily until at least 2021. Although life expectancy in Cambridgeshire is higher than the national average, people are living longer in poor health. Nationally, males aged 65 can expect to spend 4.4 years in poor health whereas females can expect to spend 5.4 years in poor health.

In 2008, around 4,300 older people in Cambridgeshire were found to have housing support needs, and between 6,000 and 15,000 older people households are thought to be living in fuel poverty. The JSNA endorsed the proposed project by the Strategic Housing Market Assessment team to examine the housing needs of older people in Cambridgeshire. Small investments in services such as housing and leisure can reduce or delay care costs and improve wellbeing.

It is important to promote that healthy lifestyle choices can still have health benefits even at older ages. Cigarette smoking is the largest cause of preventable death yet in Cambridgeshire there are estimated to be 40,000 smokers over the age of 50. Less than half of all older people in Cambridgeshire are thought to consume a healthy diet, and 20% of older people are thought to be obese. Significant numbers are heavy drinkers. Around 30% of older people consider themselves to be physically active.

The number of older people with dementia in Cambridgeshire is expected to double from 7,000 to 14,000 over the next 20 years. Interventions to reduce the incidence of dementia should include exercise and anti-hypertensive treatment where appropriate. Cambridgeshire has prioritised the promotion of good mental health and management of poor mental health including dementia.

A range of surveys have given the following findings:

- Fewer than 30% of people felt that residents are given the support they need to live at home as long as they want. Within Cambridgeshire, this ranges from 25% in Cambridge City to just fewer than 30% in South Cambridgeshire.
- Most care and support is unpaid and informal.

- ❖ Men are less likely than women to participate in organised groups.
- ❖ People aged 85 and over continue to be involved in community groups.
- ❖ Income, ability to travel, the availability of physical activities and access to information are important concerns.
- ❖ Older people in Cambridgeshire are most concerned about:
    - Income.
    - Transport and social inclusion.
    - Access to information on services and activities.
    - Housing, including help in the home.

Despite concerted efforts and success in some areas, inequalities among older people continue to exist. The reduction of inequalities remains a high priority across Cambridgeshire and the JSNA made the following recommendations:

1. Promote the message that stopping smoking, sensible alcohol consumption, healthy eating and physical activity have health benefits even at older ages.
2. Hold a multiagency conference to agree and take forward the future approach to the development of key services to meet the range of needs of people with dementia in Cambridgeshire.
3. Re-examine the access to and availability of health and social care services (including the third sector), in the light of changes to health and social care.
4. Develop active partnerships with older people in pathway redesign and decision-making for long term conditions using outcome-based measures that reflect patient experience.
5. Comply with the requirements of the national Carers' Strategy as identified by the Joint Carers' strategy for Cambridgeshire.
6. In future needs assessments, explicitly consider the needs of older people as a specific group (e.g. among prisoners and Travellers).

2.3 Mental Health in Adults of Working Age

The prevalence of mental ill health among the working age population varies across Cambridgeshire. Figures for suicide mortality and injury in 2006-2008 indicate that compared to the national rate Cambridge City and Fenland rates are statistically significantly higher, and the rates for Huntingdonshire and South Cambridgeshire are statistically significantly lower. Vulnerable groups such as the homeless, travellers and prison populations have disproportionately high levels of mental ill health.

In addition to services directly provided by the NHS and Local Authorities, the Mental Health JSNA highlights the importance of the voluntary sector in supporting people with mental health problems:

- ❖ A range of voluntary and community (third sector) organisations provide services locally. Examples of provision in 2009/10 include:

- ❖ Throughout Cambridgeshire, at least 2,000 people have accessed the services of **Lifecraft** where main interventions offered are a telephone helpline and counselling.
- ❖ 596 people have accessed the services of **Hunts MIND**. They offer counselling services, mental health promotion through the Well Life Project, a Day Service and Home and Community Support.
- ❖ 470 people have accessed the services of **Rethink** which offers as its main services a newsletter, telephone helpline and monthly meeting for carers in Cambridge.
- ❖ 301 people have accessed the services of the **Richmond Fellowship** where employment advice is given, and interventions are used to enable people with wide ranging severe and enduring mental health problems to retain and regain work.
- ❖ 197 people have accessed the services of **Making Space**. The main interventions continue to be one to one support and information for carers.
- ❖ 42 people have accessed the services of **Choices Counselling** which offer specialist counselling for up to two years for individuals who have been victims of sexual abuse both in childhood and adulthood.
- ❖ 31 people accessed the services of **Arts on Prescription** from the **Arts and Minds Project** where arts and crafts activities are offered mainly to those with mild to moderate levels of depression, stress and anxiety.

Childhood and early adulthood are key periods in the development of personal resilience and educational and social skills that will provide the foundations for good mental health across the whole life course. Interventions that particularly help to maintain mental health in later years include reducing poverty, keeping active, keeping warm, lifelong learning, social connections and community engagement, such as volunteering.

The JSNA outlined the following recommendations:

1. The comprehensive evidence base of what works to promote mental health and wellbeing in communities should be used by the range of partnerships that operate within the Local Strategic Partnerships and Cambridgeshire Together structures when developing and commissioning strategies and plans. The Mental Wellbeing Impact Assessment Tool can be used to ensure that a programme maximises its positive impact.

2. Strengthen and extend partnership working to promote mental health and wellbeing, and provide responsive services by:
    - Obtaining views of local stakeholders on all changes to mental health services to ensure they are patient-centred and socially inclusive.

- Working with GP Commissioning Clusters to ensure equitable provision and targeting of mental health services based on needs assessments that identify the areas and populations at greatest need.

3. NHS organisations and the Local Authority should take a lead partnership role to ensure a healthy workplace for their own and partner organisations.

4. Ensure equitable access to services and mental health promotion for vulnerable groups by:
   - Reviewing and implementing where appropriate the recommendations of the Bradley Report to reduce inequalities experienced by prisoners.
   - Evaluating the effectiveness of alcohol pilots within A&E, homeless shelters and police stations in improving equitable access for vulnerable groups.
   - Explore best methods to engage with the Travelling communities.

5. Review the availability of counselling services for groups where evidence shows greatest benefit to include:
   - Applying learning and experience from the 14-19s IAPT pilot to implement a 'transition' service for primary care mental health
   - Ensure seamless service for those who do not meet criteria for the IAPT or secondary care services but can benefit from provision of "talking therapies".

2.4 Travellers

Gypsies and Travellers account for almost 1% of the Cambridgeshire population and represent the largest ethnic minority in the county. The Traveller JSNA identified a number of inequalities faced by the Gypsy and Traveller population, including: a lack of secure accommodation and risk of homelessness; significantly poorer health status and more self-reported symptoms of ill-health than the rest of the population; Gypsy and Traveller children remain highly disadvantaged in terms of access to education and achievement; racism and discrimination; poor levels of literacy and a lack of information in appropriate formats; and importantly communications and access to services.

- ❖ The JSNA outlined some services in place to address these inequalities. A number of areas of good practice have been highlighted across Cambridgeshire, in particular the work of the Traveller's Health Team, which supports Travellers in accessing NHS care appropriately, and accessing a wider range of opportunities, the County Council CREDS team which supports Traveller children in education, and Ormiston Children and Families Trust, which supports Travellers through advocacy and on housing and financial issues. Fenland District Council (FDC) has been cited as an example of good practice both nationally and locally. FDC works with the Travelling community to enable them to lead safe, healthy and supported lives. A Traveller welcome pack is provided to all new arrivals and every child receives a support plan. Traveller forum meetings have been established and work has been carried out around reporting of hate crime. FDC have

achieved high levels of satisfaction from the Gypsy and Traveller community.

Despite the good work that is already been undertaken to improve outcome for Gypsies and Travellers in Cambridgeshire, there is still more that can be done and the JSNA made the following recommendations:

1. Develop a County wide Gypsy and Traveller strategy to improve outcomes and life chances for Gypsy and Travelers communities and promote and enable community cohesion in Cambridgeshire.

2. Data collection and ethnic monitoring:
    - There is a need for better data collection and ethnic monitoring. Local authorities, the NHS and other public bodies should review their ethnic monitoring systems to include Romany Gypsy and Irish Traveller as separate categories.
    - The resulting data should be used for better planning and commissioning.
    - Work should be undertaken to encourage Gypsies and Travellers to complete the 2011 census.

3. A number of health issues have been identified and there should be a focus on:
    - Early intervention/prevention and promotion of immunisations and screening
    - Mental health specialist support services
    - Male health specialist support services
    - More support around complex health needs
    - Investigation into infant and maternal mortality and prevalence of disabilities in the Gypsy and Traveller population; further work is needed to help understand this.
    - Awareness raising of Gypsy and Traveller culture with professionals
    - Training health champions from the Gypsy and Traveller community

4. Service information and communications need to be provided in an accessible format to the Gypsy and Traveller population and the content appropriate.

5. Accommodation:
    - The implications of the revocation of the Regional Spatial Strategy should be considered and the need for additional Gypsy and Traveller accommodation addressed.
    - Promote consistent site management practices across the County.

6. Continue emphasis on promoting good practice for the education of Gypsy, Roma and Traveller children, young people and their families in schools and other educational settings.

7. Encourage sharing of good practice across different organisations.

8. Promote continuing community engagement with the Gypsy and Traveller population.

9. Develop strategies to promote integration between the settled and Traveller communities to reduce mistrust, fear and discrimination.

2.5 New Communities

The JSNA for new communities identified that people who move into new residential developments tend to have a young age structure and contain few older people. The demography will change markedly as the developments mature and the residents age becoming gradually more similar to the surrounding population. However, this process may take as long as 30 years. Building specific types of properties, such as retirement or sheltered housing, can help create a more balanced community in the initial phases.

Housing affordability is a major issue for Cambridgeshire, affecting Cambridge City and South Cambridgeshire to a greater degree than the three other districts. The need for socially rented housing across the sub-region has increased without a proportional increase in social housing stock.

Planning for green spaces may help to reduce the inequalities of life expectancy experienced between socio-economic groups. People are more likely to walk, cycle and play in natural attractive spaces. The overall 'quality' of the green space is an important factor in the frequency and consistency of its use.

When planning for new communities, it is important to understand and make provision for the factors that contribute to developing the social environment alongside planning for the more visible aspects of the physical environment. Aspects that contribute to the social environment include social capital, social cohesion and social infrastructure. Although the social environment is recognised as important for the development of healthy new communities, the focus of planners and developers is often primarily on the provision of physical infrastructure. There is a substantial gap in understanding how to ensure these softer elements do not fall off the agenda or lose priority.

A recent survey by South Cambridgeshire District Council has shown differences in perceptions between residents of new communities within the district when compared with existing communities, with a mix of positive and negative:

Table 8: Results of a survey carried out with all residents in the new communities to allow South Cambridgeshire District Council to compare and contrast the results with the overall district results.

Indicators where residents in new communities have higher scores than the district	Indicators where residents in new communities have lower scores than the district
People 'very well' or 'fairly well' informed about what to do in the event of a large-scale emergency (26.7% compared to District score of 14.6%)	People who 'very' or 'fairly' strongly feel that they belong to their neighbourhood (46.2% compared to District 63.9%)
People who rate their health in general as very good or good (89.0% compared to District 81.6%)	People who perceive drunk or rowdy behaviour to be a problem in local area (17.9% compared to District 8.6%)
People who are treated with respect and consideration by local public services 'all' or 'most' of the time (83.1% compared to District 77.5%)	People who perceive drug use or drug dealing to be a problem in local area (22.0% compared to District 13.1%)
People who agree the police and local public services seek people's views about anti-social behaviour and crime issues (29.1% compared to District 27.5%)	People who have participated in regular volunteering in last 12 months (24.1% compared to District 33.0%)
	People satisfied overall with local area (81.7% compared to District 90.4%)
	Anti-social behaviour (15.9% compared to District 7.5%)
	People who think older people receive the support they need to live independently (23.8% compared to District 29.8%)
	People who have taken part in a civic activity (15.1% compared to District 20.1%)
	People who agree they can influence decisions in their locality (30.3% compared to District 33.6%)

The New Communities JSNA has agreed the following recommendations:

1. Plan housing and the places we live so that they reflect the changes that occur over the lifetime, and so that people are not excluded by design as they grow older and frailer or as their circumstances change. 'Lifetime homes' is a mechanism for achieving this.
2. Provision for affordable housing needs to include a range of options to address the need for social rented housing.
3. Options need to be developed to fund more flexible service provision to allow greater integration of new communities with existing settlements than offered by current Section 106 arrangements.

4. Ensure resourcing of community development roles which may be fulfilled by different workers employed by different agencies and in different phases but within an agreed and coordinated approach. This is in keeping with the findings of the 'Building Communities that are Healthy and Well in Cambridgeshire report and its recommendations.

5. There should be a mixture of formal and informal green spaces, which should include considerations for community gardens and allotments that are close to residential areas, accessible, well-maintained and well connected to existing networks of strategic spaces and walking routes such as green chains.

7. There should be consultation with residents of new communities, at the earliest opportunity, about the provision of community resources including green space provision, a clear allocation of responsibilities in managing these resources and a mechanism to ensure that locally agreed monitoring is implemented and the results acted upon.

Section 3: Variation in Healthcare

The need for healthcare varies from one population to the next and the principle reason for variation in need is that some populations have higher levels of the same types of common chronic disease than other populations. Age and level of deprivation are the principle determinants of rates of disease in any population, affecting both incidence of the disease – the number of new cases that develop in a defined period – and prevalence – the number of people who have a chronic disease at any point in time.

To overcome the effects of age and deprivation, data is often 'standardised' and presented as if each population has the same age and social class distribution as the national average, allowing them to be comparable. This still leaves significant variations in provision of healthcare, which may be the result of different levels of service provision and different clinical practices. Use of this type of information helps to identify questions about how healthcare in Cambridgeshire compares with that in other areas, and to support debate on the best use of available resources to improve health outcomes.

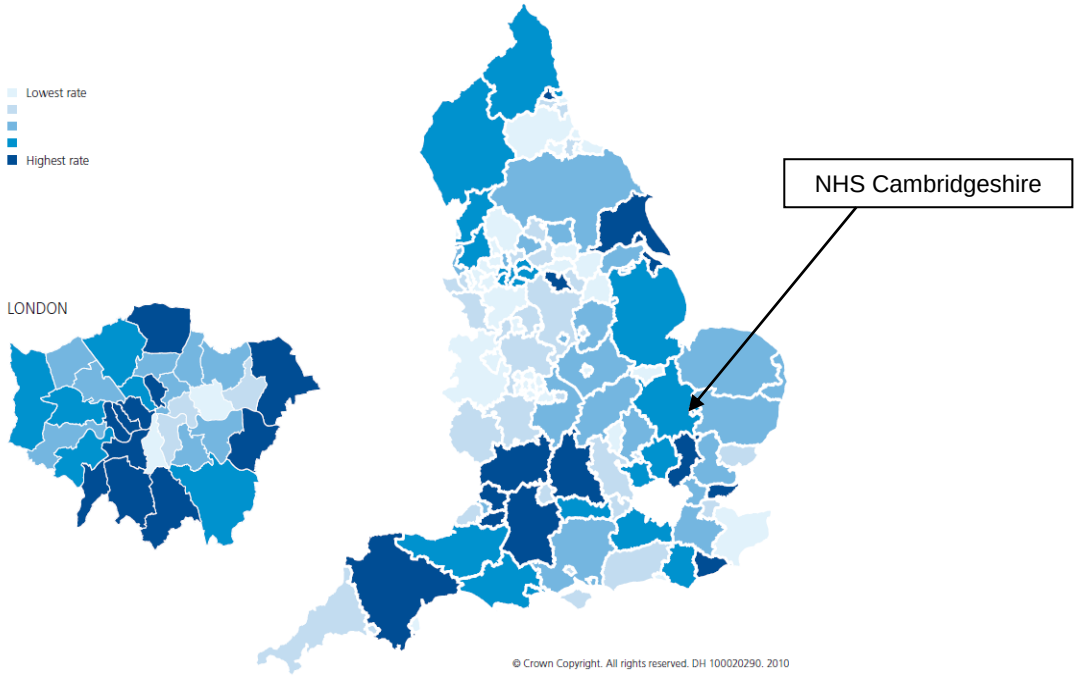
3.1 Mapping variations in healthcare

A national Atlas of Variations in Healthcare has recently been published and includes a range of useful information about how healthcare in Cambridgeshire compares with other areas of the country. These variations always have to be investigated further using local knowledge and data, rather than taken at face value, as they may be the results of data artefacts or other specific local factors.

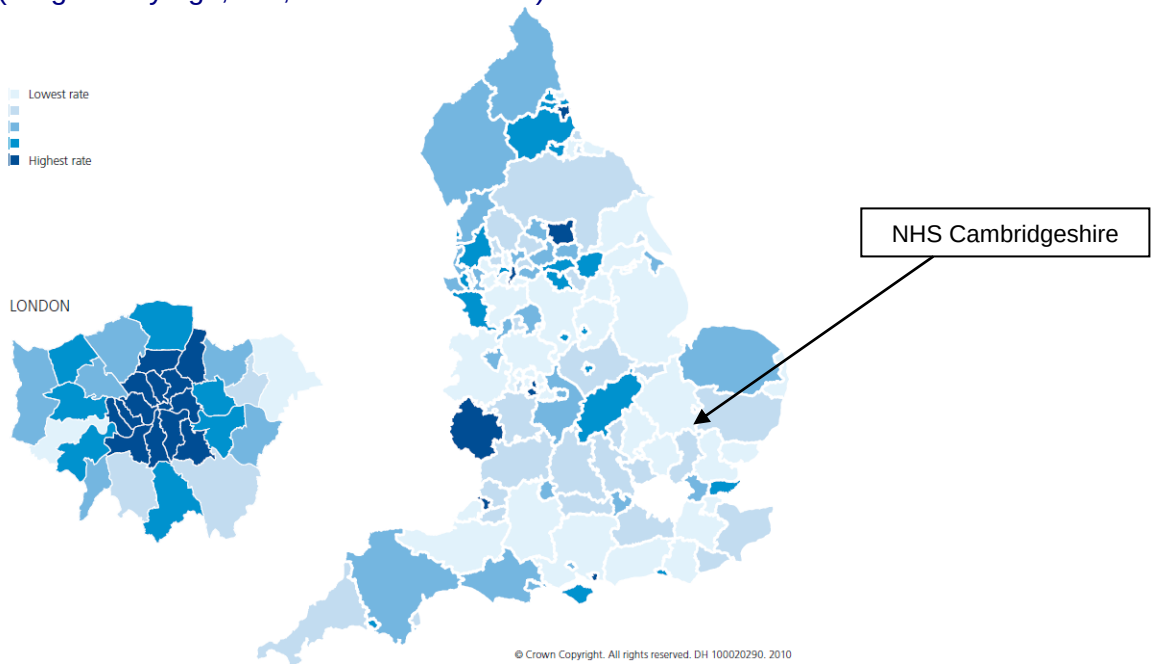
The following maps show examples of variations in healthcare and indicate that in Cambridgeshire, the number of days spent as a hospital in-patient by people with cancer is higher than average. In contrast the overall expenditure on mental health

services and treatments for a population the size of Cambridgeshire appears to be less than average

Number of cancer bed-days per 1000 population by PCT
(weighted by age, sex and need; Q4 2008/9 - Q3 2009/10)



Map 3: Mental health expenditure per 1000 population by PCT
(weighted by age, sex, and need 2008/09)



The full Atlas of Variation in Healthcare – which covers a range of healthcare activity information and outcomes as well as data on expenditure is available on weblink: http://www.rightcare.nhs.uk/atlas/

3.2 The Sustainable Health Partnership in Cambridgeshire

During 2010 NHS Cambridgeshire undertook a research and analysis project looking at variations in healthcare between Cambridgeshire and comparable PCTs around the country, using similar information to that demonstrated in the national Atlas of Variation in Healthcare. Using this analysis, the leaders of health organisations across Cambridgeshire selected areas for further joint working and agreed to establish the Sustainable Healthcare Partnership (SHP). Further information regarding the SHP can be found at www.sustainablehealthcambs.nhs.uk

The Partnership is a coordinated commitment by all the health organisations across Cambridgeshire to deliver improving outcomes across nine work streams; cancer, cardiology, COPD, dermatology, diabetes, end of life, gastroenterology, patient flow and urology and continence. Each work stream has a dedicated work programme that is clinically-led. The overall objective of SHP is to improve quality of care whilst saving resources for re-investment: patients seen by the right people, with the right care, at the right time and in the right place.

Section 4: Health Protection

The ability of Public Health working in partnership with other agencies and the public to protect against infectious disease and environmental hazards remains an important function in the 21st century.

4.1 Immunisation

Immunisation as an entity is one of the greatest achievements of public health. It is important not to become complacent to its contribution to modern health standards and to recognise the need to keep immunisation levels high.

The coverage for childhood immunisations in NHS Cambridgeshire was better than or equal to the England average for 2009/10 and better than the East of England average for all but the pneumococcal (PCV) booster at 2 years. While this represents an improvement over the previous year, World Health Organisation recommended coverage targets still need to be achieved and maintained.

A local survey of a sample of GP practices in the county found that practices with higher uptake of childhood immunisations have a structured approach for accessing the most recent information on immunisations, a clear policy on dealing with non attendees (with involvement of health visitors) and reminded parents opportunistically about vaccinating their children if overdue.

The continued success of childhood immunisations programmes delivered in primary care depends on practice staff receiving immunisation training (basic and regular updates) in a consistent manner.

The schools based Human Papilloma Virus (HPV) immunisation programme is in its third year. A national HPV immunisation programme was introduced for all girls aged

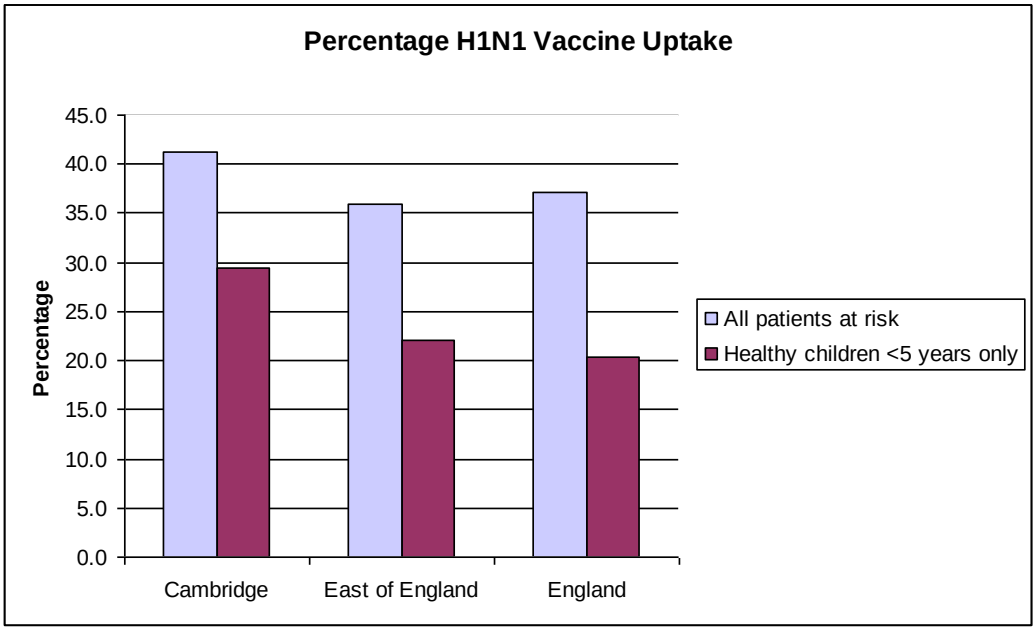
12-13 years (school year 8) in Autumn 2008 to offer protection against developing cervical cancer. In 2009/10, 90.1% of year 8 girls completed the full course.

4.2 Swine Flu (H1N1)

The response to swine flu H1N1 of public education, vaccination of at risk groups and prophylaxis and treatment with Tamiflu (oseltamivir) ensured mitigation of the potential of the pandemic to cause illness and fatalities.

The vaccination rates in 2009/10 for the patient group most at risk from H1N1 influenza was better than the national average with the coverage in Cambridgeshire at 41.2% compared with 37.1% nationally as can be seen from figure 5.

Figure 5: Percentage uptake of H1N1 in patients at risk in 2009/10.



Source: Department of Health Website

The seasonal influenza vaccine for the winter of 2010/11 contains H1N1 and over this winter, people at higher risk from influenza, including pregnant women, have been encouraged to come forward to receive the receive the vaccination. Final vaccination uptake statistics for the winter of 2010/11 will be available later this year.

4.3 Healthcare Acquired Infections

The number of cases of healthcare acquired infection due to Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile for NHS Cambridgeshire continues to fall. The estimated rate of C. difficile infection per 100,000 population aged 2 years or above was below the East of England PCT average for April to October 2010 and NHS Cambridgeshire ranked 7th of the 13 PCTs in the East of England. NHS Cambridgeshire ranked 5th for MRSA rates over the same period, having slightly exceeded the East of England average.

Table 10: Number of MRSA bacteraemia cases 2006-2010

	Number of MRSA Bacteraemia cases 2006-2010				
Trust	2006/7	2007/8	2008/9	2009/10	April-Oct 2010
CUHFT	81	41	30	20	5
Hinchingbrooke	15	11	6	11	2

Source: Health Protection Agency MRSA mandatory surveillance

Table 11: Number of Trust acquired Clostridium Difficile cases 2007-2010

	Number of Trust acquired Clostridium Difficile cases 2007-2010			
Trust	2007/8	2008/9	2009/10	April-Oct 2010
CUHFT	373	274	126	62
Hinchingbrooke	70	80	73	14

Source: Health Protection Agency Clostridium Difficule mandatory surveillance

4.4 Notifiable Diseases

A notifiable disease is one that doctors are legally obliged to report to the local authority proper officer. As of 6th April 2010 the Health Protection (Notification) Regulations 2010 replaced previous Regulations. There have been some alterations to the list of notifiable diseases including making Legionnaire's Disease and invasive Group A Streptococcus notifiable for the first time. Further changes on 1st October 2010 when a list of causative agents also become notifiable need to be considered when examining trends over time.

Table 12: Notifiable Diseases: 1st January 2004 – December 2010

Disease	2004	2005	2006	2007	2008	2009	2010
Dysentery	17	23	21	18	18	19	21
Food poisoning	937	890	962	955	964	838	868
Measles	9	11	49	61	51	27	46
Meningococcal Disease (meningitis/septicaemia)	22	11	19	21	19	16	12
Mumps	217	324	71	68	60	242	123
Rubella	8	14	9	15	17	15	8
Scarlet Fever	23	17	40	31	14	33	18
Tuberculosis	30	47	42	29	57	42	27
Viral Hepatitis (Hepatitis A, B, C, E)	88	101	95	130	125	105	107
Hepatitis B (acute and chronic)	45	66	46	69	70	46	34
Hepatitis C	36	29	44	54	47	54	63
Whooping Cough	8	<5	<5	<5	15	<5	7

Section 5: Progress against Recommendations of the APHR 2009

This section describes progress against the recommendations of last year's Annual Public Health Report. Each recommendation is listed, followed by feedback on progress obtained from a variety of sources.

Recommendation 1: (2008): Full implementation of the Child Health Promotion Programme (CHPP) across Cambridgeshire should continue to be a priority for local NHS community health services. This includes a holistic antenatal and postnatal family health needs assessment, which will enable early intervention and prevention of poor outcomes, and the targeting of services to those with the greatest needs.

Progress with the Healthy Child Programme is monitored by the multi-agency Healthy Child Programme Board, which feeds into the Children's Trust and is able to challenge area partnerships to act where there are concerns.

The Healthy Child Programme is still in process of implementation, and a key aspect is the Cambridgeshire Community Services health visitor transformation work, which when complete, should lead to ante-natal assessments of pregnant women by health visitors, to decide whether they will receive a universal or progressive treatment pathway.

The work on the Healthy Child Programme has provided a valuable opportunity to clarify and confirm the contribution community health staff make to local authority Children's Centres delivery of improved outcomes in the early years.

Recommendation 2: (2008): Work currently being undertaken to develop a strategic approach to mental health promotion in Cambridgeshire should be considered carefully by public sector and other agencies, to ensure that protective factors for good mental health are supported and encouraged in local communities.

The latest adult mental health JSNA 2010 (Phase 4) has used the most recent evidence base to recommend a strategic approach for improving wellbeing and promoting mental health. The approach is based on the public mental health framework described in *Confident Communities, Brighter Futures* published by HM Government in March 2010. This takes a life course approach setting out risk and protective factors for wellbeing and acknowledges the role of different sectors in this. Interventions in childhood can have the most effect because of their impact on a range of outcomes throughout life. This has been taken into account in the Children's JSNA 2010 which recommends that the Children's Trust and its partners should ensure a positive start in life and promote good emotional health and wellbeing.

Programmes to address health and wellbeing in the workplace (adults of working age) are being implemented by all NHS Trusts across Cambridgeshire and a

collaborative programme of Mental Health First Aid training for staff across the Trusts has also been developed.

Cambridgeshire Celebrates Age, a multi agency programme that promotes social inclusion and a range of physical and social activities for older people is an example of a county wide community initiative that incorporates 'protective' factors for wellbeing.

Protective factors for wellbeing such as community involvement, building social networks and enjoying green spaces are also described in the JSNA New Communities and are closely associated with the localism agenda.

The newly published report *The role of local government in promoting wellbeing*[1] further stimulates thinking and provides practical examples of good practice, opportunities for change and a guide for action for local authorities. A new national mental health strategy is forthcoming that will provide further guidance.

Recommendation 3: Practical ways should be found of involving GP practices in work with Local Authorities and other non-NHS organisations, to jointly plan services which are relevant to the health of their patients.

As part of the development of GP commissioning in Cambridgeshire, some leading local GPs have received an initial training session on the roles and responsibilities of Local Authorities and existing joint working. A more detailed development session on Local Authority work will be offered to a wider range of local GP commissioners during 2011.

The Cambridgeshire Community Wellbeing Partnership, with representation from a range of local public sector organisations, has agreed that the county should become an early implementer of a Health and Wellbeing Board. Statutory Health and Wellbeing Boards have been proposed in the draft Health and Social Care Bill, in order to lead the strategic coordination of joined up commissioning of services across the NHS, social care, and related childrens and public health services. To achieve effective integration and joint action, core members of the board must include at least one local elected representative, GP commissioners, the director of adult social services, the director of children's services, the director of public health and a representative from local HealthWatch.

In Cambridgeshire a number of services are already commissioned jointly across the NHS and social care. These include services for Older People, adult Mental Health Services, joint Equipment Services and Learning Disability Services. It will be essential to review these arrangements during the move to GP led commissioning.

Recommendation 4: There is now such strong evidence for the beneficial effects on long term health of the four healthy behaviours – not smoking, being physically active, eating five fruit or vegetable portions a day, and staying within recommended alcohol limits – that all local public sector organisations and employers should play an active part in promoting them. This means

[1] Aked J, Michaealson J, Steuer N., The role of local government in promoting wellbeing. Nov 2010. Authors from New Economics Foundation (NEF) and commissioned by Local Government Improvement and Development (LG) and the National Mental Health Development Unit. http://www.idea.gov.uk/idk/core/page.do?pageId=23692693

creating environments and workplaces which make it easy to choose these behaviours, as well as more direct promotion.

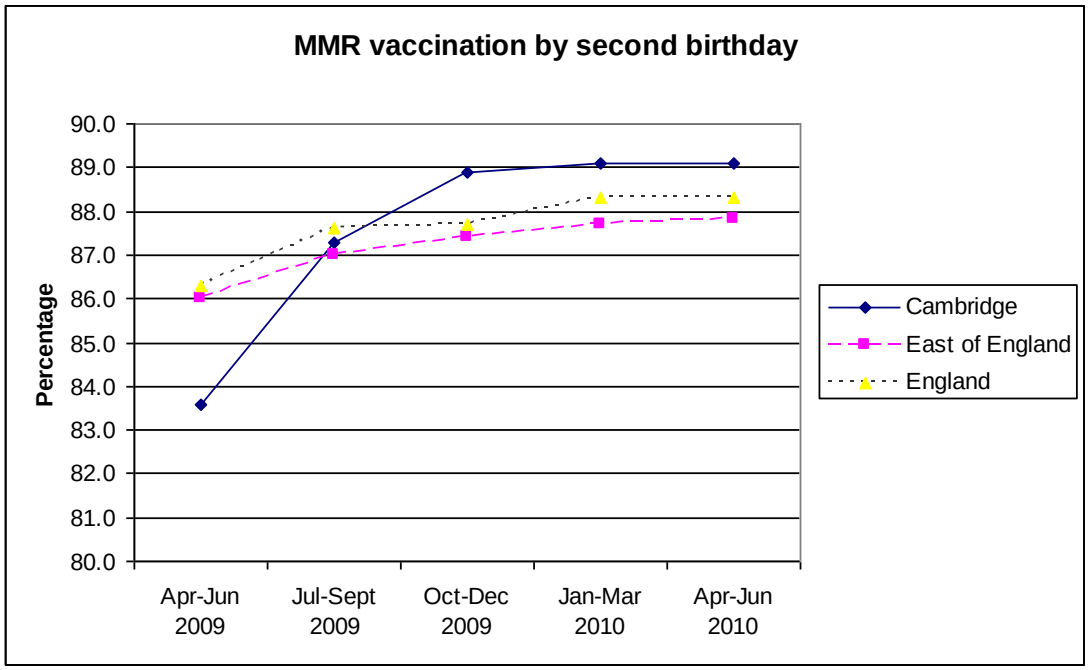
There are a wide range of programmes which local public sector organisations are taking forward to promote healthy behaviours in a range of environments. These include:

- Joint work between County Council Children's Centre managers and NHS Cambridgeshire Public Health to ensure healthy eating behaviours are developed at the significant early stages in life.
- Environmental Health Services from Huntingdonshire Fenland and South Cambridgeshire District Council's in conjunction with Cambridgeshire Trading Standards Division completed a successful 'Tips on Chips' pilot in 2009/10. Working with a number of fish and chip shops across the local authorities the pilot tested and promoted improved frying procedures aimed to reduce saturated fat levels in chips and deep fried products. Information from the pilot was submitted to the FSA and the scheme will now be launched nationally in 2010/11.
- District/City Councils are promoting physical activity. For example Huntingdonshire District Council's Sport & Active Lifestyle's team continue to provide a range of activities and services and in particular an environment for people to engage in physical activity. From 4 years of age to 90 years of age individuals have taken part in activities ranging from play sessions to structured sports sessions to led walks and in particular an increase in demand in people attending classes for people with mobility issues or long term conditions. 2009/10 saw a total growth of 25% to over 38,500 attendances
- Addenbrookes hospital has worked closely with NHS Cambridgeshire to develop a brief intervention programme, encouraging patients attending the hospital to engage with NHS Stop Smoking Services
- Local Mental Health Services in Cambridge/South Cambridgeshire have been recognised through national awards for their local implementation of National Stop Smoking Day in 2010.
- NHS Cambridgeshire put its own advice into practice and ran a series of activities for staff during national Staying Healthy at Work week in October, including walks, body conditioning classes, health checks and social events

Recommendation 5: MMR is a safe vaccination which protects children against potentially serious infectious disease. Further work should be done to boost rates of MMR vaccination for two year olds within Cambridgeshire, which are currently below both regional and national averages and to increase rates for five year olds towards the World Health Organisation recommendation of 95%.

The APHR 2009 recognised the need to increase measles, mumps and rubella (MMR) vaccination coverage in the county. Between 2008/09 and 20098/10 vaccination coverage has increased markedly. MMR vaccine uptake at 2 years increased from 85% to 88.2% while at 5 years the percentage of children having both doses of MMR improved from 74% to 84.6%.

Graph 1. MMR vaccination by second birthday



Source: COVER data HPA

The success in increasing immunisation uptake in the county was achieved in collaboration with all the partners involved in delivering immunisation services. Some of the actions that have contributed to the improvement and which will need to be maintained to achieve the WHO recommendation of 95% coverage include:

- Identification of a named lead for immunisation in every GP practice
- Improving the accuracy of data on immunisation uptake by child health system managers and GP practices cross-checking the coverage statistics to detect data errors
- Recruiting a health care assistant to follow up children who are late for immunisations and arrange appointments with the practices.
- Ensuring that all practices have access to immunisation information leaflets in all relevant languages
- Encouraging practices to check immunisation status on every occasion a child is seen and make arrangements for any missed vaccines to be given
- Linking with existing work through Health Inequalities Strategy targeting 20% most deprived wards and working with health trainers serving most deprived practices.
- Linking with existing work targeting marginalised groups such as the Migrant Workers JSNA Action Plan and the Traveller Health Team.

Recommendation 6: Given current financial constraints, public sector organisations across the county should use the information contained in the Joint Strategic Needs Assessment (JSNA) or equivalent analyses to support careful decision making about allocation of resources to meet the needs of the population, with particular consideration of geographical areas and population groups at risk of inequalities.

The primary purpose of the JSNA is to feed into the planning processes of services related to health and wellbeing, within the resources available. For example, the

children and young people's JSNA is informing the strategic commissioning intentions of the Children's Trust.

This year, there has been recognition of the need to communicate the findings of the JSNA more widely and to make it accessible to everybody. A new JSNA website will be launched in 2011 which will enable users to navigate to specific topics they are interested in.

At the time of writing, local authorities are finalising their budget setting processes. Information from the JSNA on the health and wellbeing needs of vulnerable populations is available to feed into these processes.

As one specific example, the JSNA for the Homeless and those at risk of Homelessness, completed in 2009, demonstrated the very poor outcomes for the most excluded group of homeless adults. Partnership funding was provided by NHS Cambridgeshire, Cambridgeshire County Council, Cambridgeshire Constabulary and Cambridge City Council to employ a Chronically Excluded Adults Development Worker to take forward the recommendations of the JSNA.

This included a successful bid to become one of 3 national sites which will pilot co-ordination style intervention packages with a small number of chronically excluded adults. The pilot is being run by MEAM (Making Every Adult Matter: a group of homelessness charities) and will part fund the development worker and packages of care for the homeless which would not otherwise be available. It will be rigorously evaluated and will use the 'Working Together for Change' approach[2]. This innovative project is a direct result of the JSNA process, and aims both to improve outcomes for the most chronically excluded, and to save the public sector money by reducing usage of emergency health care, crisis services and the criminal justice system.

Section 6: Recommendations of the APHR 2010

The recommendations of this Annual Public Health Report are made at a time of unprecedented financial challenge for the public sector, associated with considerable organisational change. It is important to remember that whilst these issues may be of major concern to the staff involved, local public service delivery is only one of many factors which impact on people's health and wellbeing, and it is important to maintain a broad perspective of population needs.

Over the past three years the Joint Strategic Needs Assessment (JSNA) has become a sophisticated vehicle for making recommendations to improve health and wellbeing. The individual JSNA strands look in depth at issues affecting the health and wellbeing of particular population groups, and the JSNA recommendations are

2 http://www.dhcarenetworks.org.uk/Personalisation/Topics/Browse/General/?parent=2734&child=5802

negotiated and agreed between a variety of stakeholders with the relevant knowledge and experience. This role of JSNA will continue into the future, since the draft Health and Social Care Bill 2011 places a statutory requirement on both local authorities and GP commissioning consortia to have regard to the findings of the JSNA, when carrying out their functions.

The full recommendations from the five JSNA strands carried out in 2010 are given in section 2 of this report. Recommendations which I would particularly like to highlight are:

- The ongoing need to ensure the Healthy Child Programme is delivered effectively to all children and young people though the NHS, Children's Centres and supported by schools and colleges (Children and Young People's JSNA)
- The importance of local planning and housing services being fully engaged with a range of health and wellbeing issues – including the housing needs of an ageing population, and wider community issues for people moving into new housing developments (Older People's JSNA, New Communities JSNA).
- Opportunities to pilot and use a new Mental Health Impact Assessment toolkit when considering a range of decisions made within the local public sector (Mental Health JSNA)
- The recognition of Gypsies and Travellers as a significant community within Cambridgeshire which is at risk of discrimination and poor health and educational outcomes (Travellers JSNA).

A recommendation which is outside the scope of this year's JSNA, and specifically geared to NHS commissioners, is to make careful use of information on variations in clinical care, either at a national level (see section 3) or at a much more local level such as variations between different GP practices, to support clinically led decision making on the best use of local NHS resources.

In relation to the changes outlined in the draft Health and Social Care Bill 2011 and the Public Health White Paper I would make the following recommendations:

- That the opportunities to improve health and care outcomes for local people, both through an increased public health role for local authorities, and through the strategic potential of Health and Wellbeing Boards, should be welcomed and developed to their full potential by local partner agencies.
- That attention is paid over the next two years to ensuring a robust and safe transition of the emergency planning and health protection functions currently held by NHS Cambridgeshire.