Cambridgeshire County Council

Cambridgeshire

Annual Public Health Report 2017

Contents

INTRODUCTION

The purpose of this Annual Public Health Report 2017 is to provide a clear picture of the main health issues and trends in Cambridgeshire. Sitting behind the report is a wealth of web-based statistics and information, which can be accessed through the website for Public Health England's Outcomes Framework www.phoutcomes.info/ and Local Health www.localhealth.org.uk/

My Annual Public Health Report for 2016 focussed on health at a very local electoral ward level – providing information through pictograms and maps rather than traditional text and tables. It was designed to start a conversation with all three tiers of local government and the voluntary and community sector, understanding how we can work with communities to improve health and building on activities and assets which already exist at local level. The 2016 Report is available on http://cambridgeshireinsight.org.uk/health/aphr

This year's report has a different focus – concentrating on the wider social and environmental factors affecting our health and wellbeing, and how these influence the differences in health outcomes we see across the county. A brief report such as this can only skate across the surface of these complex issues, but can reflect some of the main findings and trends. The report also looks at key lifestyle behaviours which impact on longer term health and wellbeing, and at trends in life expectancy and preventable deaths in the county.

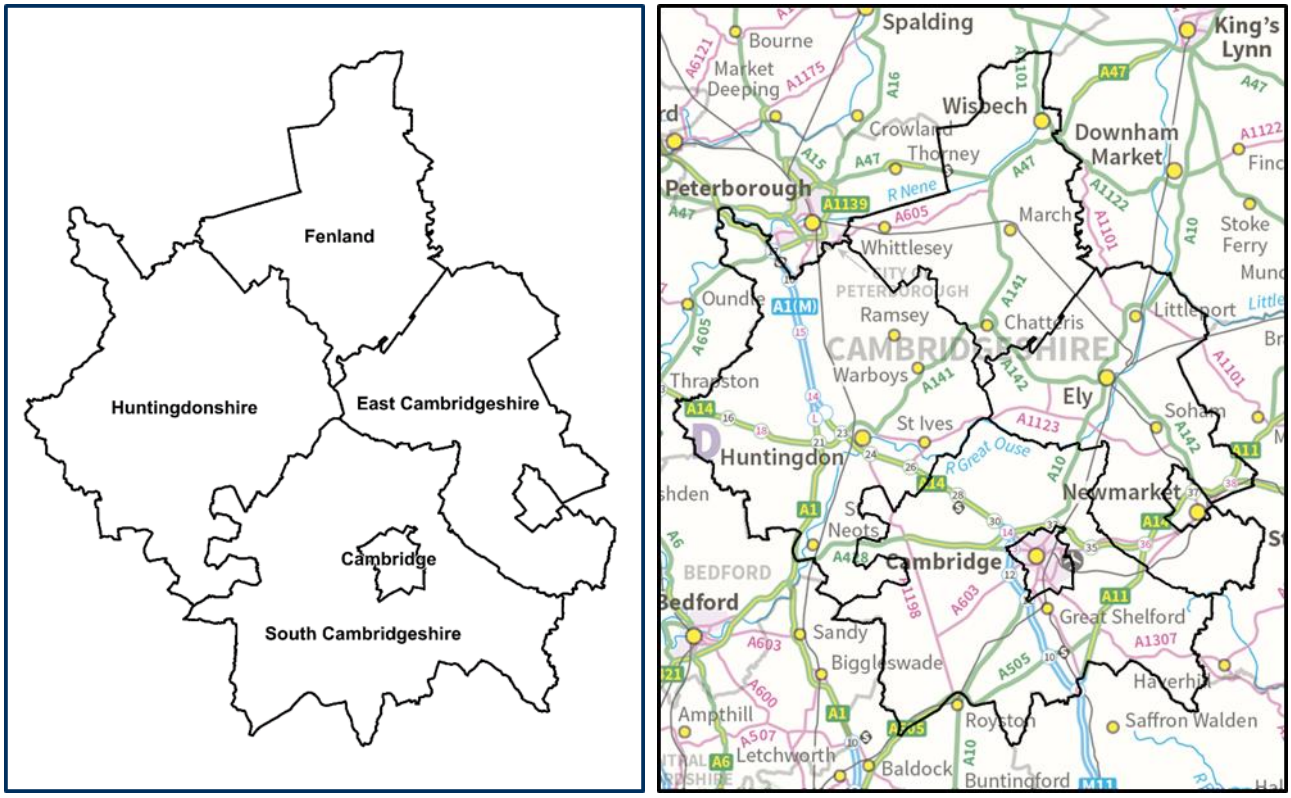
While issues of population growth and increasing demand on health and care services are critical issues for Cambridgeshire, these are covered in some depth in the Joint Strategic Needs Assessment Core Dataset available on http://cambridgeshireinsight.org.uk/jsna so are not duplicated in this report.

I'd like to thank the local Public Health Intelligence Team for their work in extracting and interpreting the key health information for Cambridgeshire and its districts, and for carrying out more detailed local analyses.

MAPPING HEALTH IN CAMBRIDGESHIRE

Because much of the information in this report is based on the five District/City Councils in Cambridgeshire, it's important to understand the geography of the county. The map below shows the boundaries of the District/City Councils within Cambridgeshire and the main towns and villages which sit within each district. .

Map 1: Local authority districts and major market towns, Cambridgeshire



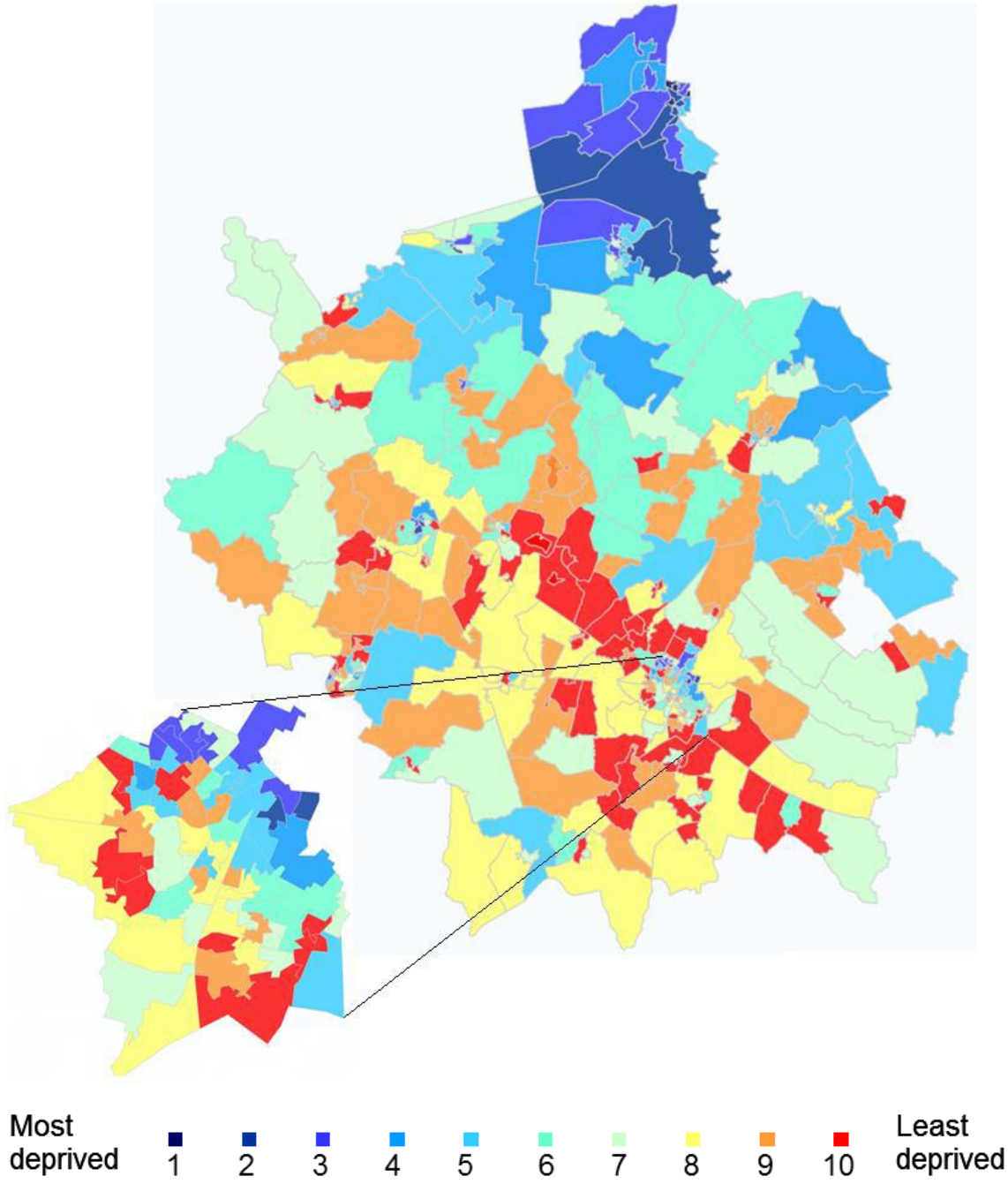
SECTION 1: THE DETERMINANTS OF HEALTH AND HEALTH OUTCOMES

1.1 The Index of Multiple Deprivation (2015)

An accepted way to look at the multiple factors which influence outcomes across communities and combine these into a single measure, is the 'Index of Multiple Deprivation' (IMD) which was last updated in 2015. The IMD (2015) calculates scores for neighbourhoods of about 1,500 people (called lower super output areas or 'LSOAs) for a range of factors, and then ranks all LSOAs in the country for their level of socio-economic deprivation.

The map of Cambridgeshire below shows neighbourhoods (LSOAs) in the county with their IMD (2015) ranks. Neighbourhoods among the most deprived 10% in the county are coloured dark blue, and those among the least deprived are coloured red. Cambridge City is expanded for clarity.

Map 2: Lower Super Output Areas in Cambridgeshire, ranked by IMD (2015) decile



It is clear that there is a north-south gradient in Cambridgeshire, with neighbourhoods with higher levels of deprivation concentrated in the north of Fenland district, while the most socio-economically advantaged neighbourhoods cluster in the southern part of the county. But there is also significant variation between neighbourhoods in each district.

IMD (2015) DNA charts

An alternative way of presenting information shown on the map above is called a ‘DNA chart’ because the bars on the chart look like pieces of DNA. Instead of putting each neighbourhood (LSOA) onto the geographical map of an area, the LSOAs from that area are lined up in rank order, and colour coded by the

national decile (10% banding) in which they fall. The national DNA chart would have ten colour coded bands of equal size (10% each). The DNA chart below for the districts of Cambridgeshire shows most districts have more neighbourhoods in the least socio-economically deprived deciles than the national average, although all have some neighbourhoods in more deprived deciles. The notable exception is Fenland district, which has no neighbourhoods in the most socio-economically advantaged 20%, and a higher proportion in the most deprived deciles.

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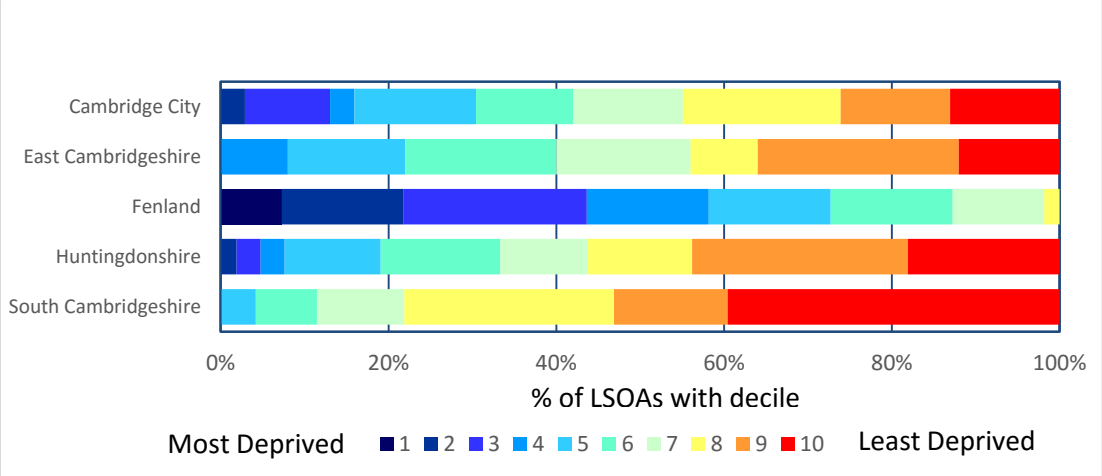
Figure 1: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.2 What is the impact of socio-economic deprivation on health?

This section of the report breaks down the key components of the IMD (2015) in order to look in more detail at the impact of socio-economic deprivation on health. The IMD (2015) score for each neighbourhood (LSOA) is created from a range of data summarised into seven 'domains as follows. The percentage next to each domain, shows its contribution to the overall IMD (2015) score.

IMD (2015) Domains

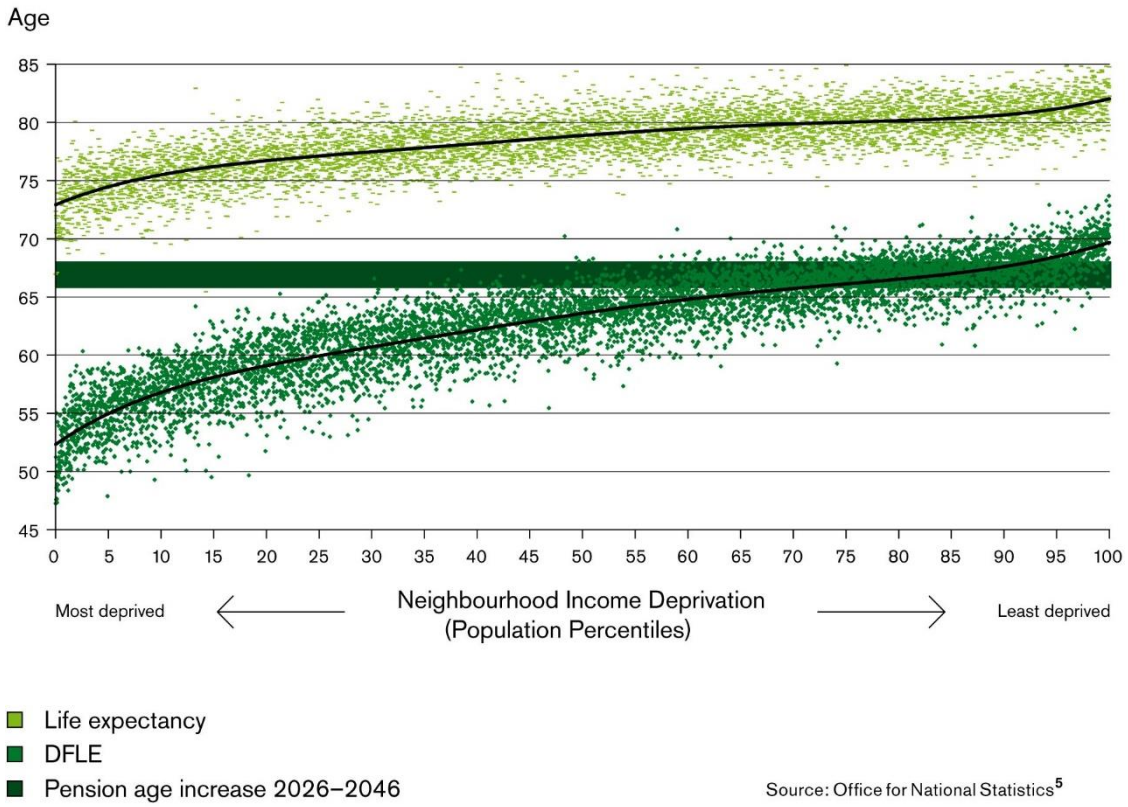
- Income (22.5%)
- Employment (22.5%)
- Education, Skills and Training (13.5%)
- Health deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment (9.3%)

More detail of the data included in each of these IMD (2015) domains is provided in Appendix A.

1.3 Income and health

We know that income levels are strongly linked with overall health and wellbeing. National research by the Institute of Health Equity showed that while there was a difference of around 10 years in overall life expectancy between neighbourhoods with the lowest and the highest incomes, the difference in 'disability free life expectancy' was closer to 20 years. This indicates that people who live in neighbourhoods with low average levels of income are likely to experience significant illness and disability at an earlier stage in their lives.

Figure 2: Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England 1999-2003

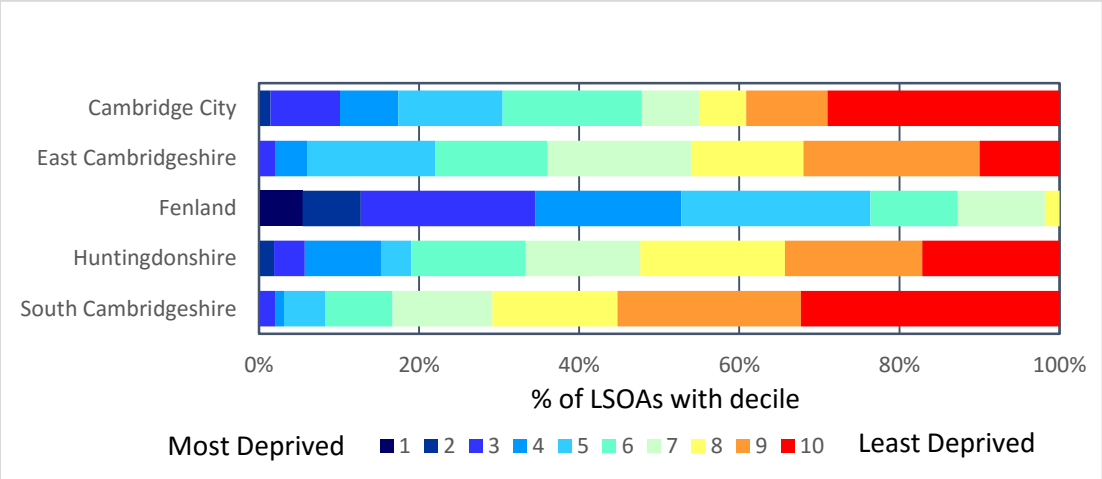


Source: Office for National Statistics[5]

1.4 Income levels in Cambridgeshire districts

The following DNA chart shows the 'Income' domain scores for IMD (2015) for each Cambridgeshire district. Most districts have more neighbourhoods with low income deprivation. It's clear that Fenland has a higher proportion of income deprived neighbourhoods than other districts. The research from the Institute of Health Equity would predict that Fenland would have shorter average life expectancy and 'disability free life expectancy' than the rest of the county.

Figure 3: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Income)



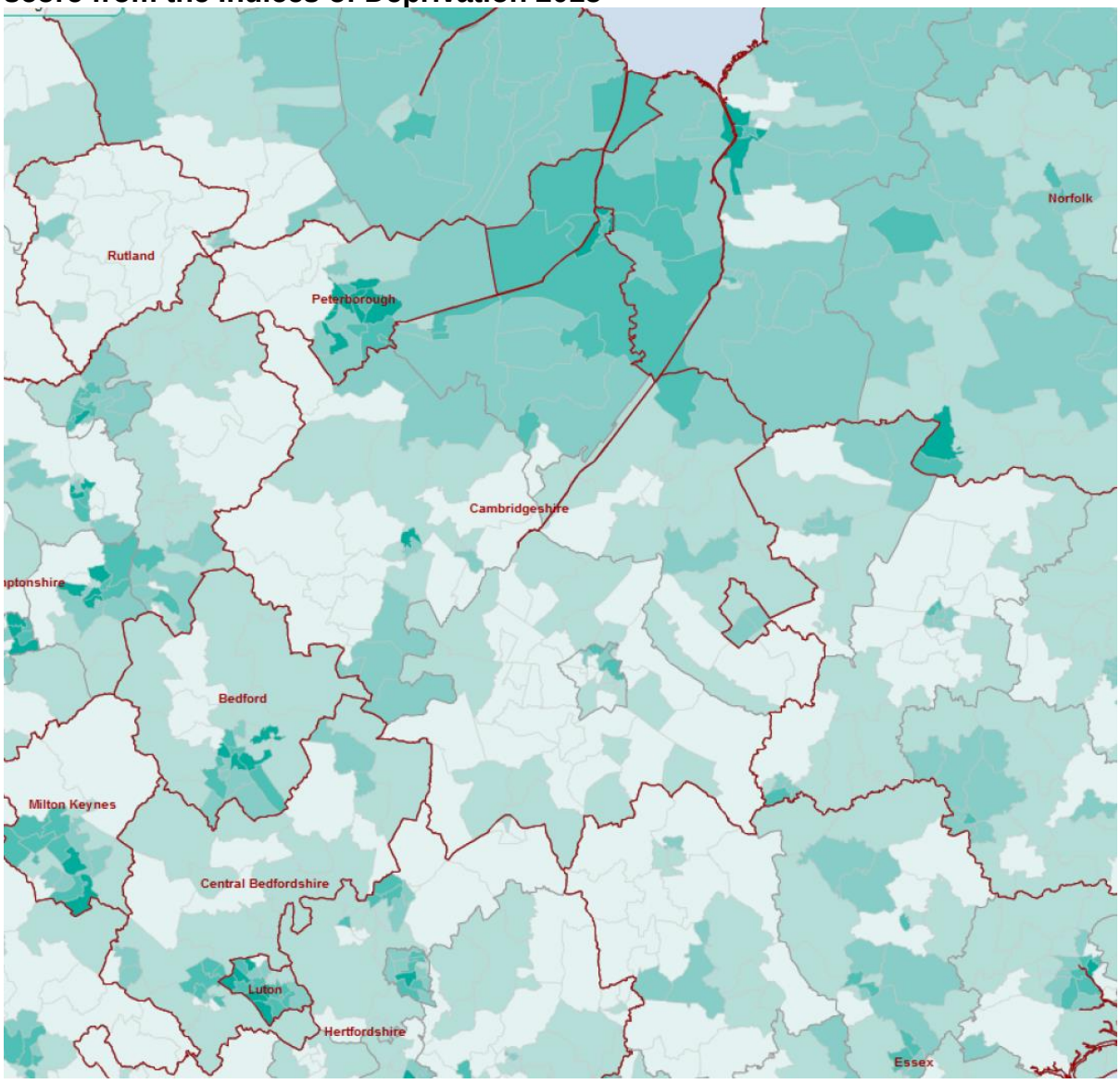
Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

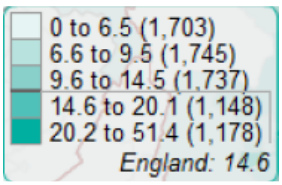
1.5 Factors affecting income deprivation

Income deprivation is related to the proportion of low paid work in the local economy, which in turn depends on the types of employment available. This varies across the county, with a higher dependence on farming and associated industries such as food processing and packing in the northern rural areas. The map below shows the IMD (2015) income deprivation domain for Cambridgeshire and surrounding areas. It's clear that the higher levels of income deprivation in North Fenland form part of a wider picture, extending into West Norfolk and Lincolnshire. Conversely the low levels of income deprivation in South Cambridgeshire district are part of a wider picture extending into Suffolk, Essex and Hertfordshire.

It is also important to note that for people on low incomes living in the south of the county including Cambridge City, high housing costs can significantly limit the income they have available to meet other needs. More sophisticated economic analyses would also include measures of income deprivation after allowing for housing costs.

Map 3: Cambridgeshire and surrounding areas - % living in income deprived households reliant on means tested benefit, income domain score from the Indices of Deprivation 2015

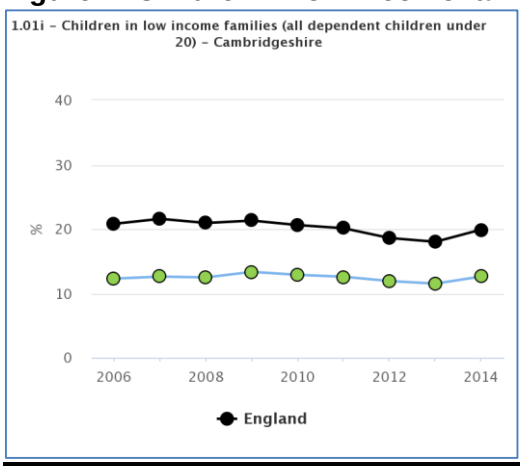


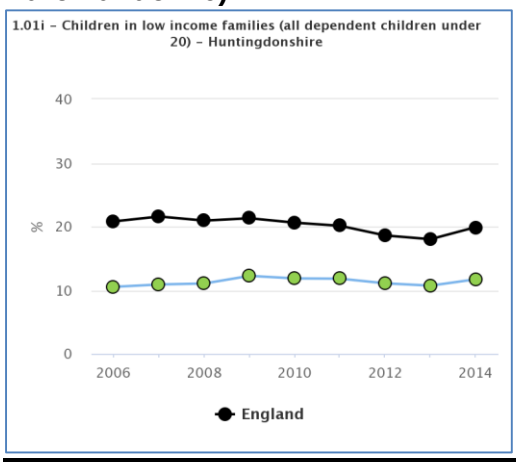


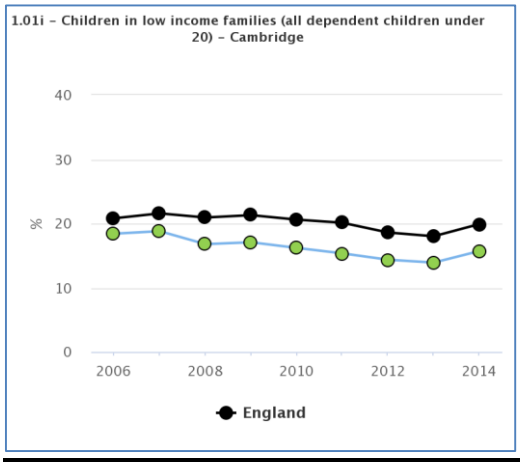
1.6 Children in low income families

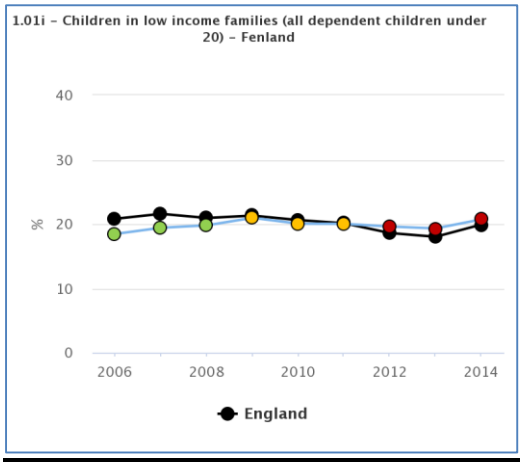
While the IMD (2015) is a useful overall measure of deprivation across the county it describes one point in time and it is also useful to look at long term trends. One measure that is routinely presented as part of the national Public Health Outcomes Framework is the proportion of children under 20 living in low income families. The following charts show the trend in this measure for Cambridgeshire as a whole and for each of its district/city councils, against the average for England.

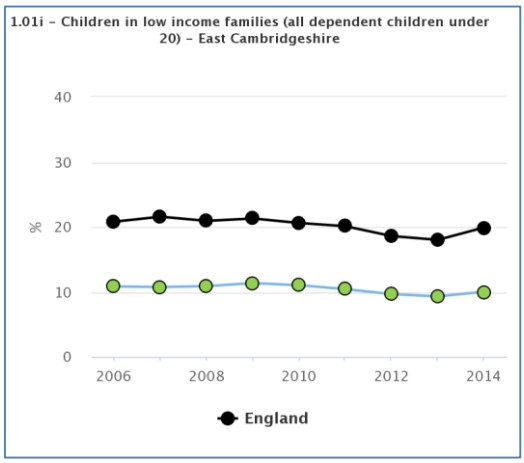
Figure 4: Children in low income families (children under 20)

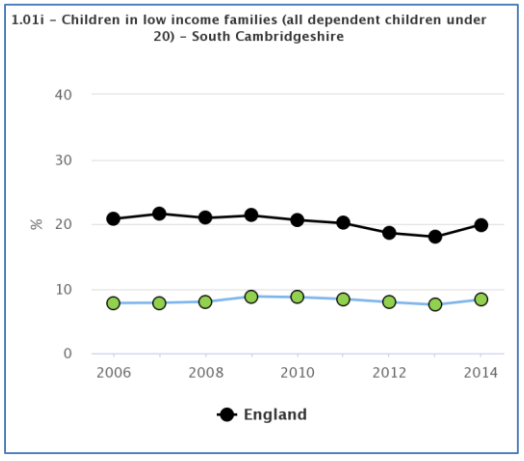












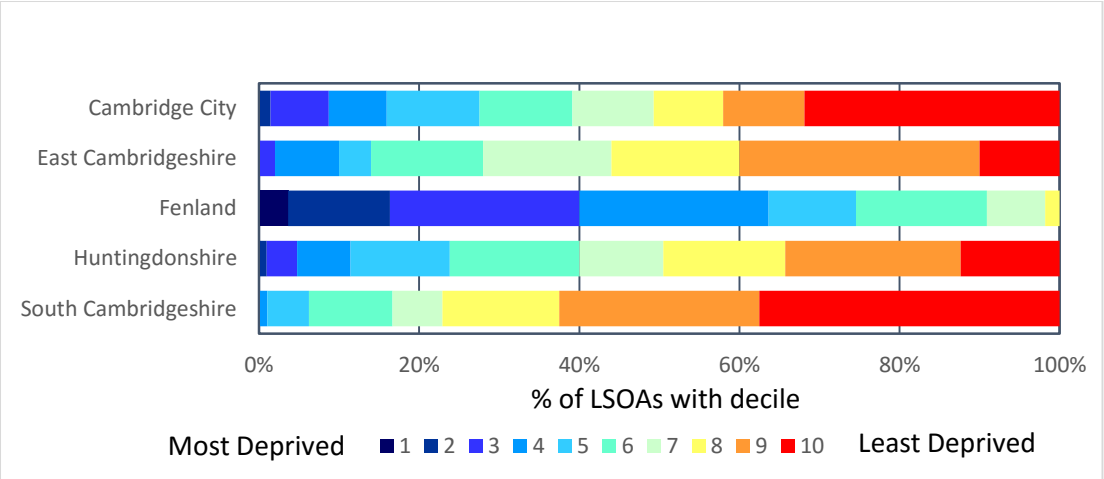
Source: Public Health Outcomes Framework

For Cambridgeshire and most of its districts, the percentage of children in low income families has remained well below the national average. While the proportion of children in low income families was similar in Cambridge City and in Fenland in 2006, the two areas have since diverged – with Cambridge City now having significantly fewer children in income deprived families than the national average, while in Fenland the percentage has increased and is now significantly above average. However the impact of high housing costs in Cambridge City on lower income families should also be considered.

1.7 Employment and health

The IMD (2015) DNA chart for employment for Cambridgeshire districts, which is based on the proportion of residents receiving out of work benefits, is very similar to that for income. As for other measures, there is a high proportion of neighbourhoods (LSOAs) in the least deprived 20% nationally in most Cambridgeshire districts, but Fenland has no neighbourhoods in the least deprived 20% and a higher proportion in the more deprived deciles.

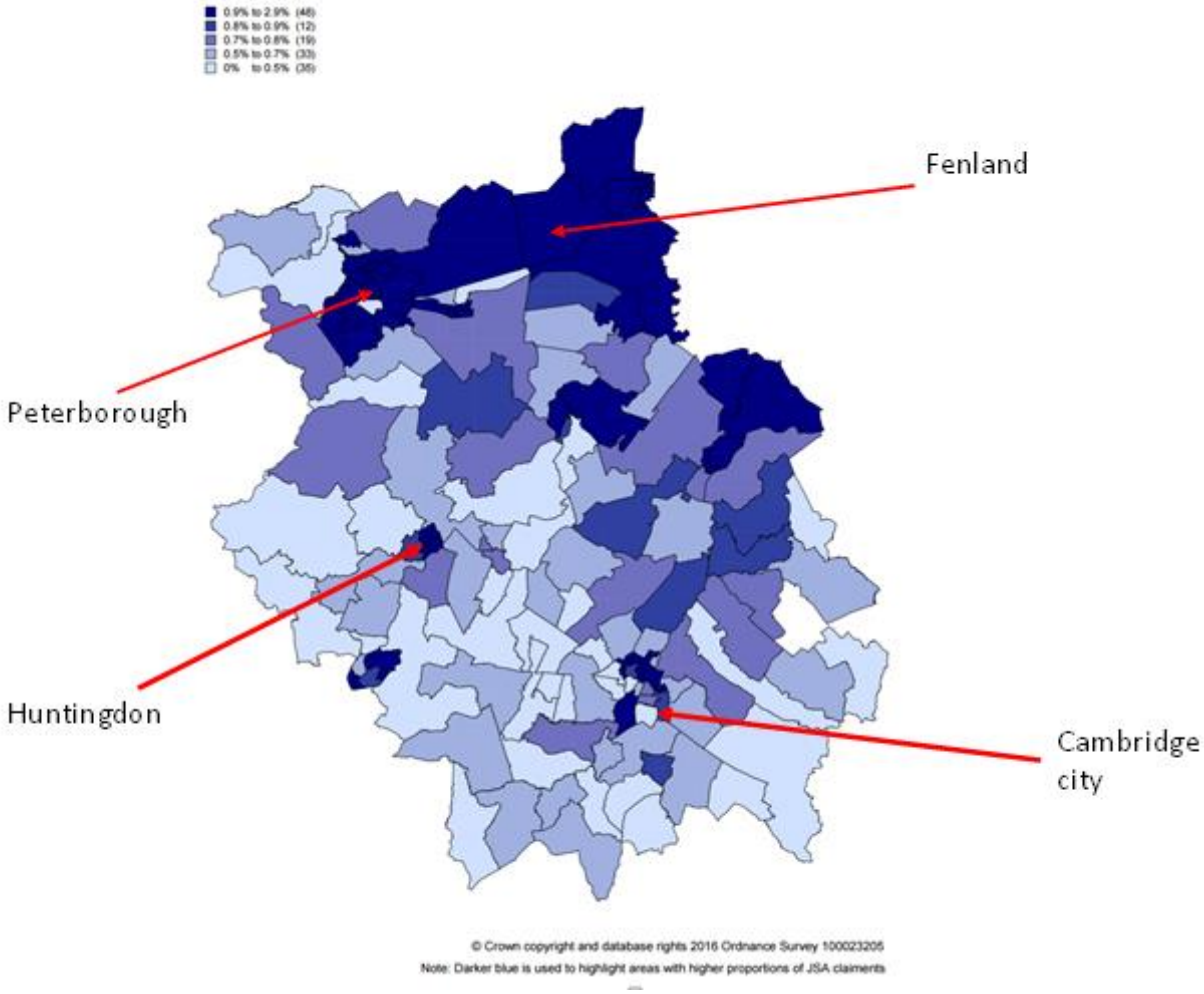
Figure 5: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Employment)



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

The most common out of work benefit claimed is Employment Support Allowance (ESA) which provides financial support to people with illness and disability who are unable to work or are receiving personalised support to help them return to work. There is a complex relationship between work and health – where unemployment and low income are known to be risk factors for poorer health outcomes, but poor health can in turn lead to reduced productivity, unemployment or reduced income. The map below shows the rates of ESA claimants for neighbourhoods in Cambridgeshire and Peterborough, with closely mirrors the picture for wider IMD (2015) deprivation levels.

Map 4: Rate of Employment Support Allowance (ESA) claimants in Cambridgeshire, May 2016

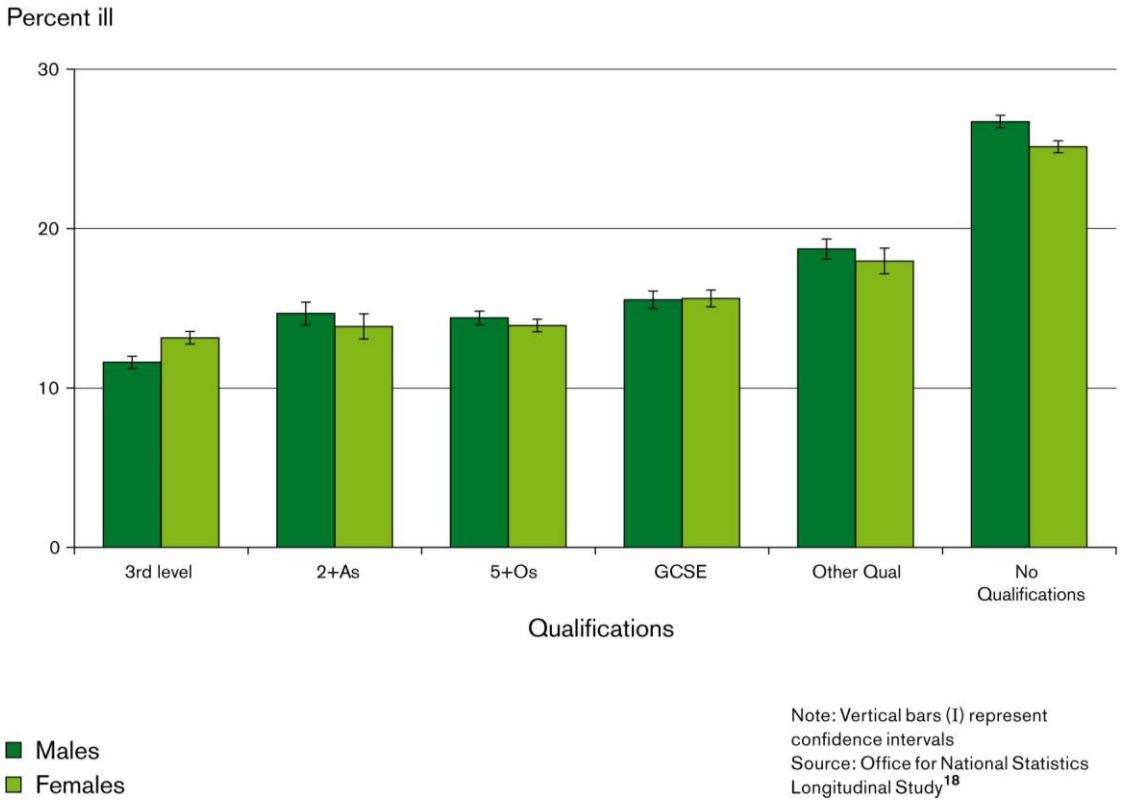


Source: DWP Data and Analytics

1.8 Education and health

We know that levels of education are closely related to health. Much of this relationship is likely to be the result of better employment prospects and incomes for people with higher qualifications. But there is also evidence that education is linked to better 'health literacy' and adoption of healthier lifestyles. The graph below shows that nationally, for adults up to the age of 75, people with no educational qualifications are more than twice as likely to have an illness which limits their daily life than people with degree level or similar qualifications.

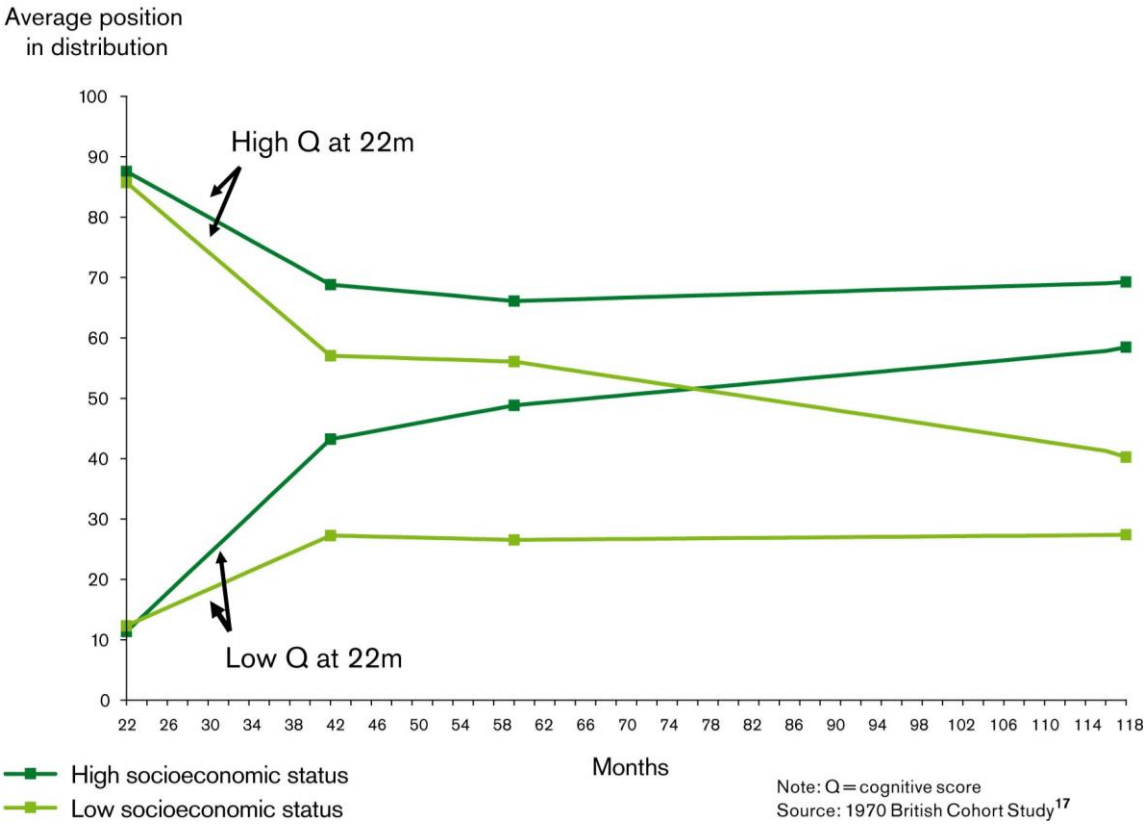
Figure 6: Standardised limiting illness rates in 2001 at ages 16-71, by education level recorded in 2001



Note: Vertical bars (I) represent confidence intervals
Source: Office for National Statistics Longitudinal Study[18]

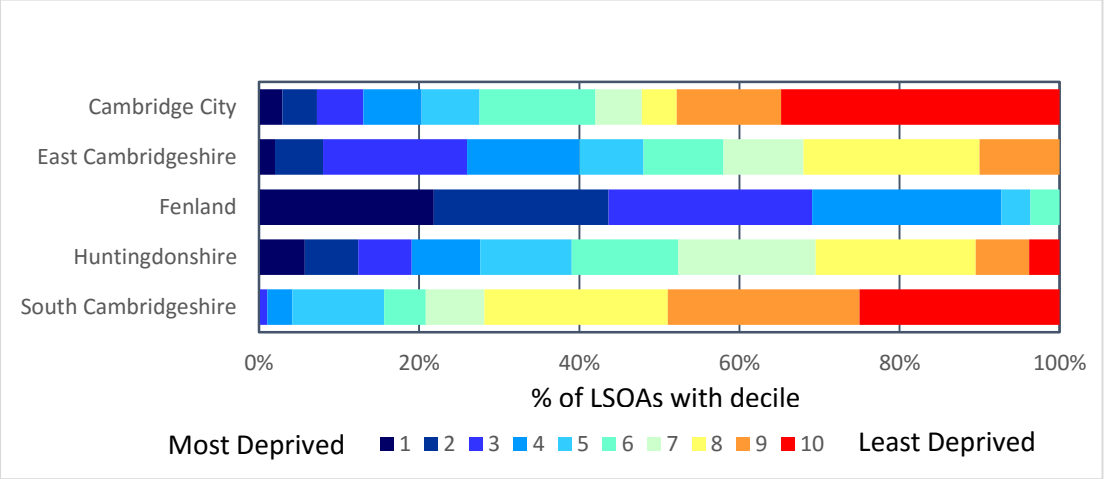
We also know that as children grow, their cognitive ability - which will enable them to do well at school, is strongly influenced by their social background. The following graph, based on a study of children born in 1970, shows that children from disadvantaged social backgrounds who had some of the highest (best) cognitive scores (Q) at age two, had moved to below average cognitive scores by age ten. Children from the most advantaged backgrounds with poor cognitive (Q) scores at age two, had moved to better than average scores by age 10.

Figure 7: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years



The Cambridgeshire DNA chart for the IMD (2015) Education Skills and Training, shows that some Cambridgeshire districts score less well for this domain than for income and employment. While Cambridge City and South Cambridgeshire have relatively high numbers of neighbourhoods in the least deprived 20% for this domain, the proportion in both Huntingdonshire and East Cambridgeshire in the top deciles is lower than the national average. Fenland has no neighbourhoods (LSOAs) in the top 40% nationally, and nearly half of its LSOAs are in the lowest 20%. There are also significant inequalities within districts. Huntingdonshire, Cambridge City and East Cambridgeshire all have neighbourhoods (LSOAs) in the lowest 10% nationally. Educational attainment, including its future impact on health and wellbeing is therefore a particular concern for Cambridgeshire.

Figure 8: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Education, Skills and Training)



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.9 School readiness

The first step to good educational attainment is for children to be ready to start school, so that they are prepared for learning and can enjoy lessons. The 'school readiness' of pupils is assessed in primary schools at the end of Reception year and involves a range of assessment areas: personal, social and emotional development; physical development; and communication and language; as well as the specific areas of mathematics and literacy. Figures for the 2015/16 school year showed that for Cambridgeshire as a whole, the percentage of children who were 'school ready' at age five was 69.7% - similar to the England average of 69.3%. However, a more detailed breakdown figures from the 2014/15 school year showed that only 49.3% of Cambridgeshire children from more disadvantaged backgrounds who were eligible for free school meals were 'school ready', lower than the England average of 54.4% for this group.

CASE STUDY – MAKING A DIFFERENCE

Waterlees (Wisbech) Community Literacy Project

This project ran from 2012 to 2014. The total funding was £77,000, provided by Cambridgeshire County Council. The project aimed to develop a community approach to literacy development. The focus was the youngest children and their families, and any people with low literacy within the community, supported by initiatives that drew on local skills and capacity.

In 2013 in Wisbech only 31% of Reception children achieved a good level of development at the end of Reception year, using the national 'school readiness' measure. Two years later in 2015 this had risen to 57%, showing an increase of 26%. This was almost double the national rate of improvement.

Because of the good results seen the County Council has agreed to fund a further community literacy project in Wisbech and a small number of other areas around the county, and planning is underway for this.

1.10 GCSE attainment

In 2015/16, 61.2% Cambridgeshire children achieved five or more GCSEs at grade A-C including English and Maths. This was better than the national average of 57.8% and Cambridgeshire ranked sixth out of a comparator group of 16 County Councils with similar social and economic characteristics.

However in in the more detailed national analysis of GCSE results from 2014/15, only 23.4% of Cambridgeshire children eligible for free school meals achieved five or more GCSEs grade A-C. The national average for children eligible for free school meals was considerably higher than this at 33.3%. Cambridgeshire children eligible for free school meals had the worst results in our comparator group of similar local authorities.

Figure 9: Children who attained five A*-C GCSE's and who are eligible for free school meals, Cambridgeshire compared to similar local authorities (2014/15)

Area	Value	Lower CI	Upper CI
England	33.3	33.0	33.6
Hertfordshire	35.3	32.3	38.4
Essex	32.3	29.8	34.8
Buckinghamshire	32.2	27.6	37.2
West Sussex	31.9	28.5	35.6
Warwickshire	31.3	27.3	35.7
Oxfordshire	31.2	27.2	35.5
Staffordshire	30.3	27.2	33.5
North Yorkshire	30.0	25.8	34.5
Gloucestershire	29.2	25.4	33.4
Leicestershire	29.0	25.4	32.9
Worcestershire	28.3	24.7	32.3
Suffolk	27.7	24.7	30.9
Somerset	27.4	23.6	31.6
Northamptonshire	27.2	24.4	30.3
Hampshire	26.3	23.7	28.9
Cambridgeshire	23.4	20.0	27.2

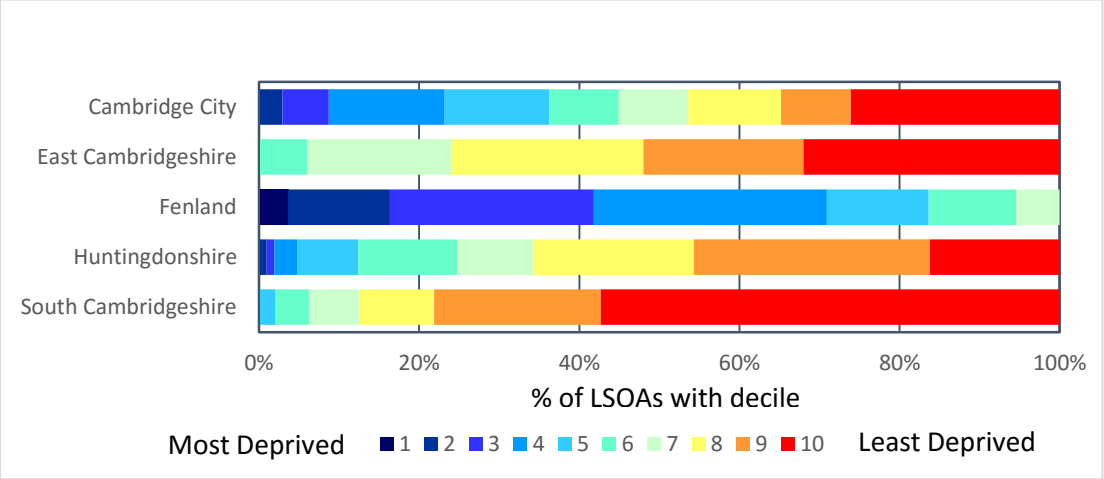
Source: Department for Education

This is a county-wide issue which isn't confined to one geographical area, and demonstrates the risk that economic disadvantage associated with reduced health and wellbeing can continue across generations.

1.11 Health deprivation and disability

The health domain of IMD (2015) combines information on life years lost through premature death, illness and disability ratios, acute illness leading to emergency hospital admission, and mental health. The majority of areas in Cambridgeshire show very good scores on this domain, with nearly 80% of South Cambridgeshire neighbourhoods in the least deprived 20% nationally, and all neighbourhoods in East Cambridgeshire in the least deprived 50%. This does make the difference between Fenland and the rest of the county more striking, as over 80% of Fenland neighbourhoods are in the most deprived 50% nationally. Cambridge City and Huntingdonshire also have internal inequalities, with a small number of neighbourhoods in the lowest 20% nationally. As expected, the DNA chart shows that health deprivation and disability is closely linked with and shows a similar picture to, other aspects of the IMD (2015) in Cambridgeshire.

Figure 10: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Health)



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.12 Other IMD Domains

The three remaining IMD (2015) domains which together account for 28% of the overall IMD score are 'crime', 'barriers to housing and services', and 'living environment'. Of these 'barriers to housing and services' is an area which generally scores poorly across Cambridgeshire.

Figure 11: Public Health England's framework for understanding the relationship between health and housing

Source: Public Health England

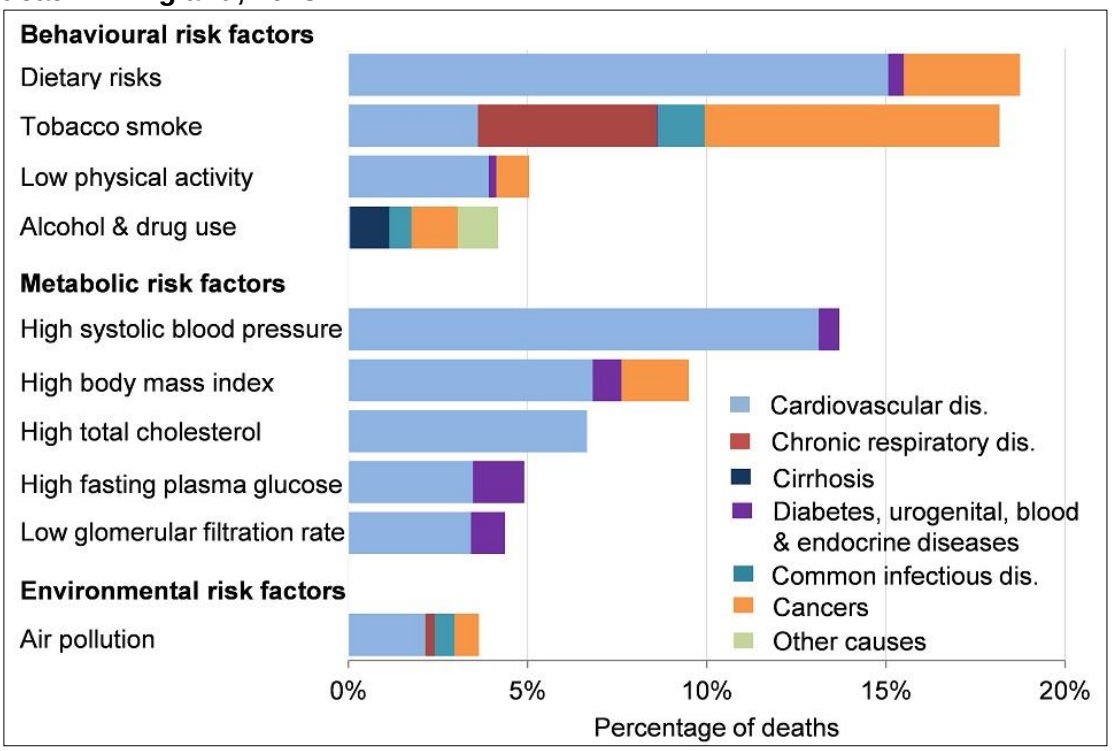
It is a composite of the distance of neighbourhoods from services such as primary schools and GP surgeries, which is often higher in rural areas; together with factors indicating reduced access to housing such as overcrowding, homelessness and housing affordability.

Housing affordability is a particular issue across much of Cambridgeshire, and can increase the risk of homelessness. There are a number of issues for areas with high private sector market rents such as Cambridge City, which can accentuate disadvantage for people on low incomes and significantly reduce the money they have available to spend on needs other than housing.

SECTION 2: KEY LIFESTYLE AND HEALTH BEHAVIOURS - HOW DOES CAMBRIDGESHIRE COMPARE WITH OTHER AREAS?

It is increasingly recognised that a set of key lifestyle and health behaviours influence people's risk of developing long term health conditions earlier in life and of dying prematurely. The chart below indicates that almost one in five deaths in England can be attributed to dietary factors and almost one in five to smoking. Lack of physical activity and alcohol/drug use are also important risk factors.

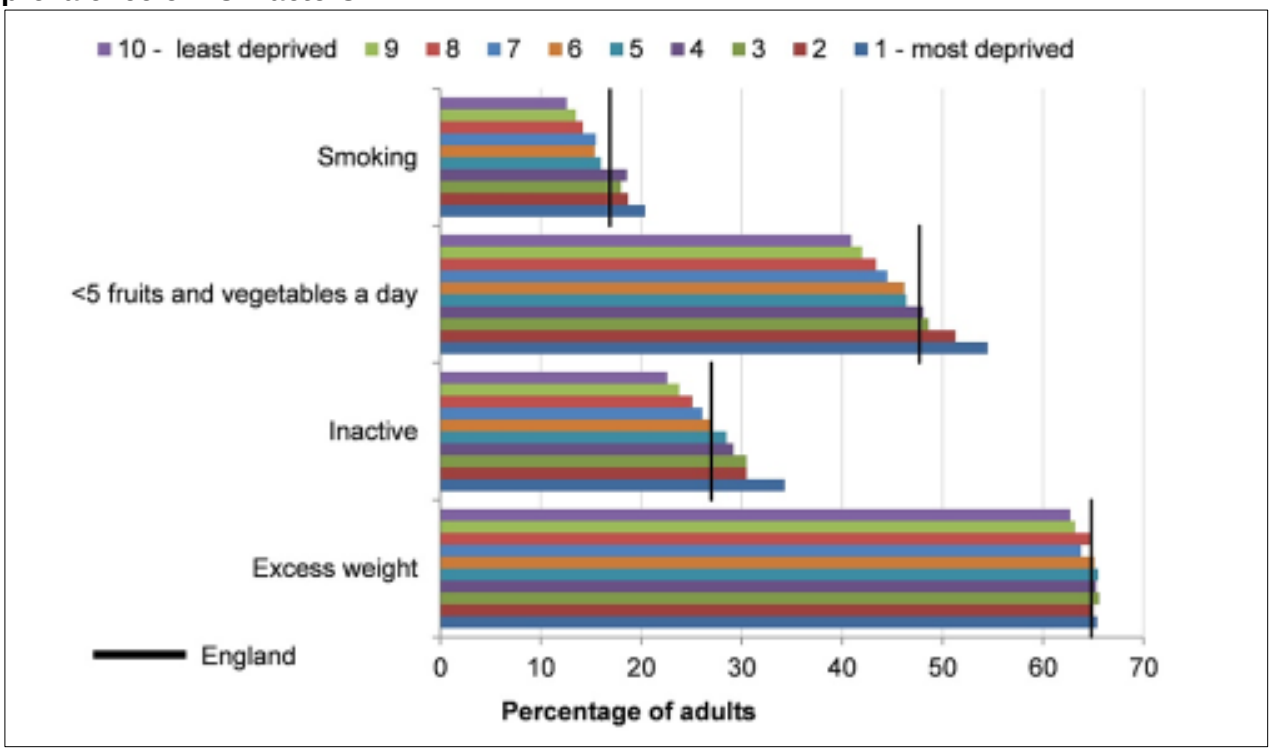
Figure 12: Attribution of deaths to risk factors and broken down by broad causes of death in England, 2013



Source: Public Health England 'Health Profile for England' 2017

It is also known that people's social and environmental circumstances are linked with their lifestyle behaviours and this has recently been mapped at local authority level by Public Health England.

Figure 13: The prevalence of risk factors varies across upper tier local authorities grouped into deprivation deciles, whereby the least deprived areas had the lowest prevalence of risk factors



Source: Public Health England 'Health Profile for England' 2017

2.1 Smoking and tobacco in Cambridgeshire

The table below shows that the percentage of adults who smoked in Cambridgeshire in 2016 was similar to the national average in most District/City Council areas and for Cambridgeshire as a whole. In Fenland the smoking prevalence was significantly worse than the national average, at 21.6% compared with 15.5% nationally.

Figure 14: Percentage of adults who smoked, Cambridgeshire & Districts 2012-2016

Area	Smoking Prevalence (%)				
	2012	2013	2014	2015	2016
Cambridge City	13.4	9.2	16.5	17.7	15.1
East Cambridgeshire	19.6	18.9	16.2	14.4	15.3
Fenland	31.3	24.3	21.7	26.4	21.6
Huntingdonshire	18.8	12.7	15.2	13.9	14.0
South Cambridgeshire	15.5	11.5	11.6	12.8	12.8
Cambridgeshire	18.9	14.4	15.7	16.4	15.2
England	19.3	18.4	17.8	16.9	15.5

Source: Public Health Outcomes Framework

Key

	Statistically significantly lower (better) than England
	Statistically similar to England
	Statistically significantly higher (worse) than England

By comparing Fenland with local authorities which are socially and economically similar, we can see whether the rate of smoking is at the expected level, given the local socio-economic circumstances, or whether it still seems high. Fenland has the second highest smoking prevalence in its 'nearest neighbour' group of local authorities, which indicates there is potentially more local work to be done to encourage a reduction in smoking.

Figure 15: Smoking prevalence in adults – current smokers (APS) 2016

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	15.5	15.3	15.7
Boston	–	10	-	24.9	16.9	32.9
Fenland	–	-	-	21.6	15.6	27.5
Mansfield	–	12	-	20.9	15.1	26.7
East Staffordshire	–	14	-	20.2	14.6	25.7
South Holland	–	1	-	19.0	13.4	24.7
West Lancashire	–	13	-	16.5	11.0	21.9
Newark and Sherwood	–	7	-	16.3	11.2	21.5
South Kesteven	–	15	-	16.0	11.5	20.4
Wyre Forest	–	4	-	15.6	10.3	21.0
King's Lynn and West Norf...	–	9	-	15.5	11.2	19.8
Bassetlaw	–	3	-	14.9	9.8	19.9
Carlisle	–	8	-	14.2	10.1	18.2
Kettering	–	11	-	13.2	7.9	18.4
Breckland	–	2	-	11.9	7.7	16.2
Amber Valley	–	5	-	10.7	6.3	15.1
Erewash	–	6	-	10.7	5.6	15.7

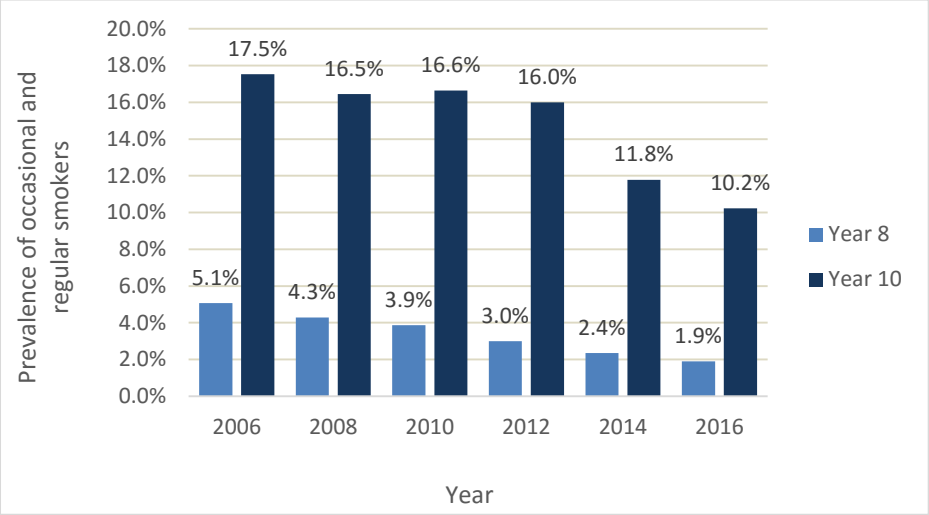
Source: Annual Population Survey (APS)

Source: Public Health Outcomes Framework (August 2017)

2.2 Smoking: children and young people

Two thirds of smokers start before they reach the age of 18, so when looking to the future it's important to understand current smoking behaviour among teenagers. In Cambridgeshire we are lucky to have data collected over several years from the Health Related Behaviour Survey carried out for school years 8 and 10 in nearly all Cambridgeshire secondary schools. These data show that since 2006, there has been a signifcant reduction in the percentage of children who say that they either occasionally or regularly smoke, both among children in year 8 (12-13 year olds) and year 10 (14-15 year olds).

Figure 16: Health Related Behaviour Survey – smoking – occasional and regular smokers (%), Cambridgeshire, 2006-2016



Source: Health Related Behaviour Survey

CASE STUDY – MAKING A DIFFERENCE

Kick Ash – A young person led smoke free programme in Cambridgeshire schools

Cambridgeshire's young person led smoke free programme, Kick Ash, has been running in selected schools since 2009/10, working with support from a range of staff including public health, Personal, Social, Health, Education (PSHE), trading standards and communications experts. Year 10 peer mentors lead and deliver the programme, focusing on smoking-related decision-making and promoting a smoke free lifestyle to Years 5, 6 and 8.

Initial analysis suggests that the percentage of Year 10 students currently smoking in Kick Ash schools has fallen significantly since the programme began, and the percentage never having smoked has increased. Whilst we know that young people's smoking has fallen across the county, our findings suggest that the rate of decline in Kick Ash schools has been faster than in other schools.

The results are particularly encouraging as schools included in the Kick Ash programme have been those in areas where a higher proportion of both young people and adults are smokers. The programme reports many additional benefits, including increased confidence and communication skills from the mentors and improved transitioning from primary to secondary school.

2.3 Unhealthy weight and obesity

There has been national concern for some time about the long term rising trend in both childhood and adult obesity, the implications that this has for individual health and wellbeing, and the potential for increased demands on the health service due to obesity related illness such as diabetes, joint problems and heart disease.

In Cambridgeshire a lower proportion of adults have an unhealthy weight than the national average. When this is reviewed at a district level it's clear that while Cambridge City, with its young population, has a very low proportion of people with unhealthy weight, East Cambridgeshire, Huntingdonshire and in particular Fenland all have proportions of people with unhealthy weight which are significantly above the national average. Fenland also has a high rate of people with recorded diabetes (associated with overweight and obesity) at 7.8% of adults, compared with 6.4% nationally.

Figure 17: Percentage of adults with excess weight, Cambridgeshire & Districts, 2012/14 – 2013/15

Area	Excess weight in adults, %	
	2012/14	2013/15
Cambridge City	48.3	46.7
East Cambridgeshire	68.0	68.1
Fenland	73.1	72.9
Huntingdonshire	67.3	67.6
South Cambridgeshire	63.6	63.6
Cambridgeshire	63.6	63.2
England	64.6	64.8

Source: Public Health Outcomes Framework

Key

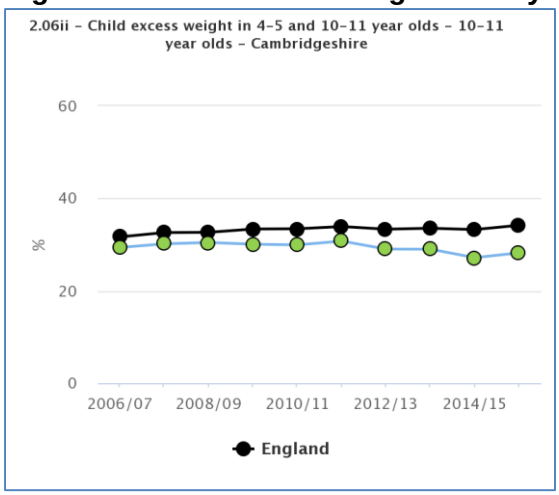
	Statistically significantly lower (better) than England
	Statistically similar to England
	Statistically significantly higher (worse) than England

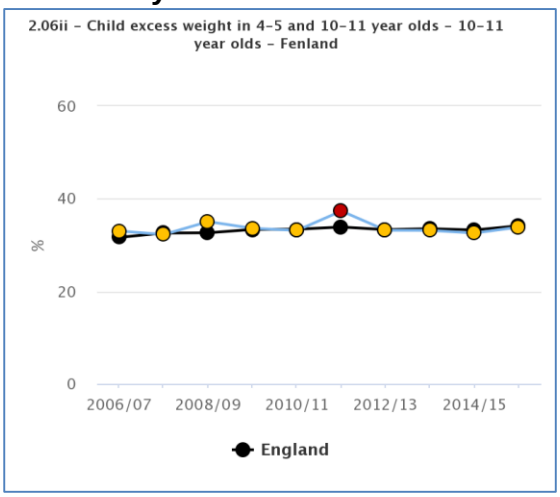
2.4 Unhealthy weight and obesity: children and young people

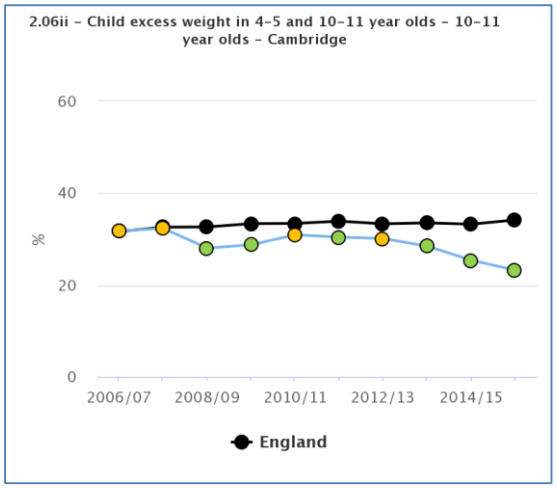
The weight of children in reception (age 4-5) and year 6 (age 10-11) is now measured at school as part of the National Childhood Measurement Programme (NCMP).

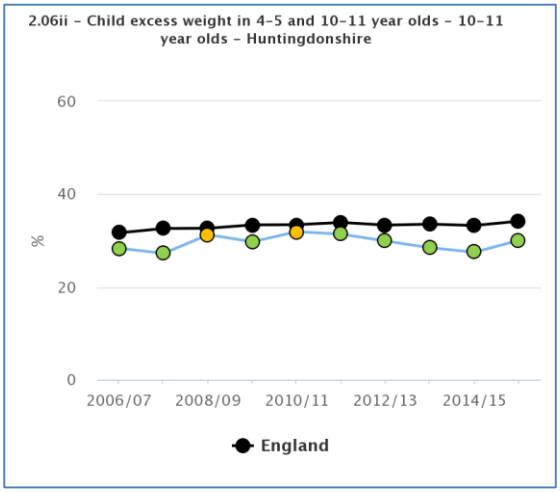
The following trend graphs from 2006/07 through to 2015/16 show that the percentage of children in year 6 in Cambridgeshire with an unhealthy weight has fallen slightly from 29.4% to 28.2% between 2006/07 and 2015/16, compared with a national increase from 31.7% to 34.2%. In Fenland rates have stayed similar to the national average.

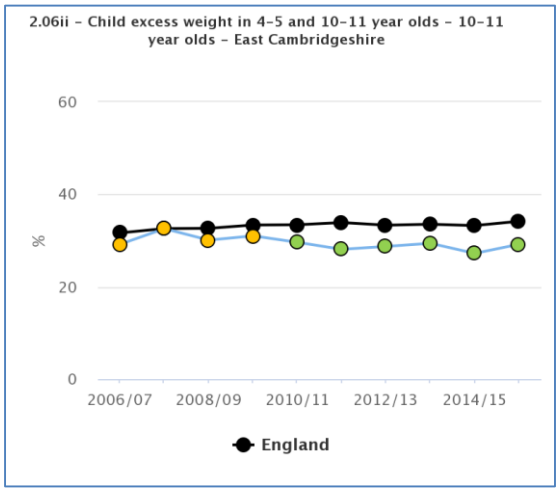
Figure 18: Child excess weight in 4-5 year olds and 10-11 year olds

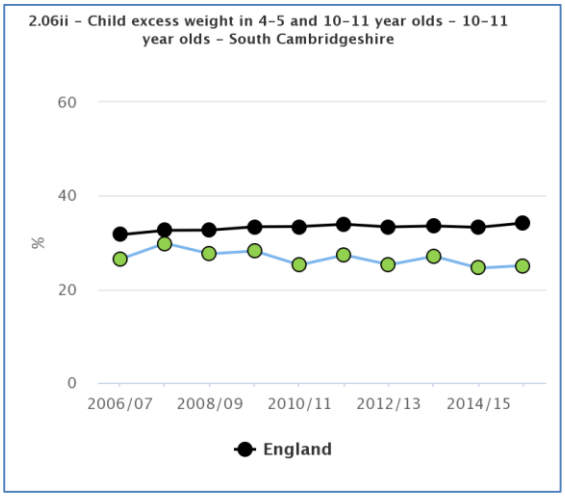












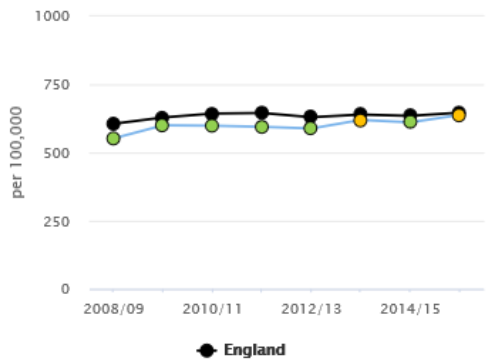
Source: Public Health Outcomes Framework August 2017

2.5 Alcohol and drug use

While alcohol and drug misuse have a smaller impact on overall population mortality than smoking and diet, they cause a higher proportion of deaths under the age of 50, and are associated with significant costs to wider society, including the criminal justice system.

Hospital admissions for alcohol related conditions have been increasing slightly in Cambridgeshire as a whole and are now similar to the national average. Both Cambridge City and Fenland have alcohol related hospital admission rates which are significantly above the national average and which have risen in recent years. Rates in the other districts of Cambridgeshire remain below the national average.

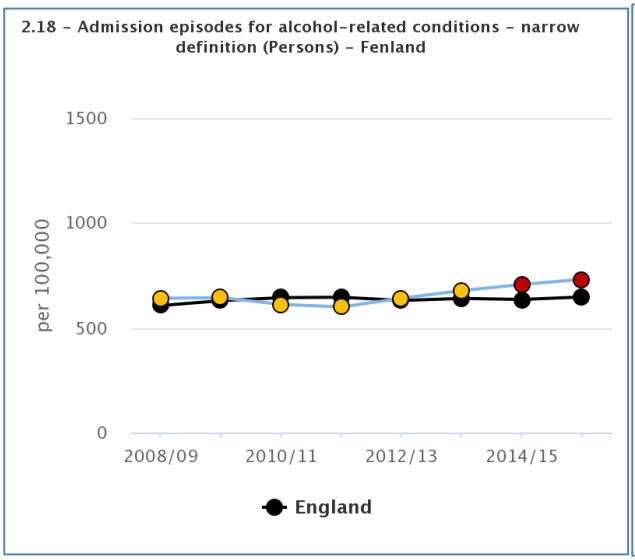
Figure 19: Cambridgeshire - admission episodes for alcohol-related conditions - narrow definition (persons), 2008/09 to 2015/16

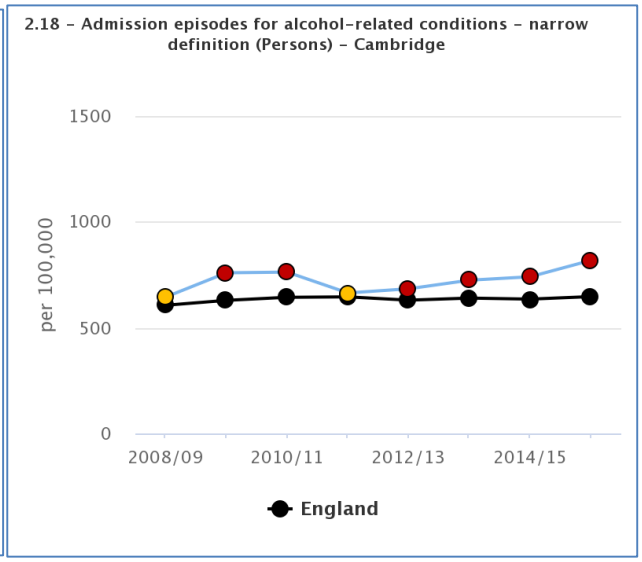


Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2008/09		3,168	552	533	572	490	606
2009/10		3,464	600	580	621	531	629
2010/11		3,503	599	579	619	542	643
2011/12		3,536	595	575	615	559	645
2012/13		3,526	589	569	608	552	630
2013/14		3,782	620	600	640	582	640
2014/15		3,772	611	591	631	580	635
2015/16		3,981	638	618	658	588	647

Source: Calculated by Public Health England: Risk Factors Intelligence team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.



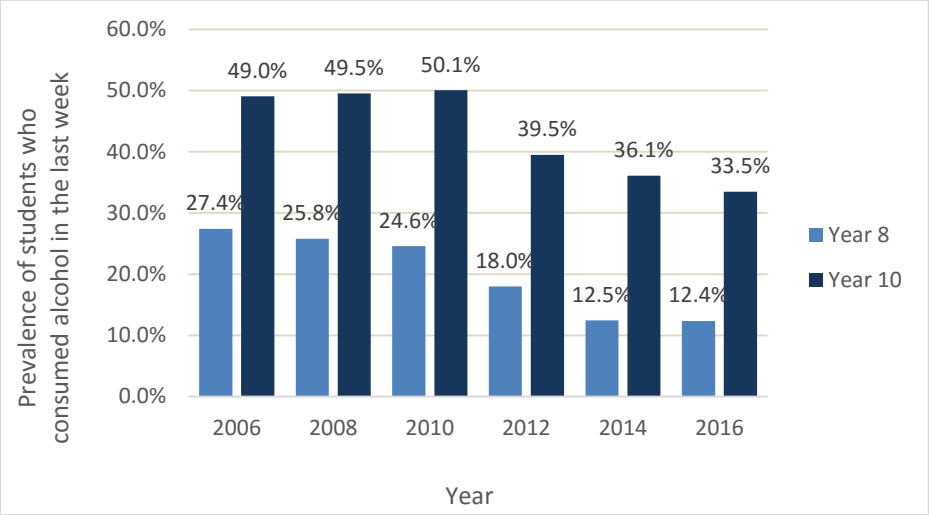


Source: Public Health Outcomes Framework August 2017

2.6 Alcohol use: children and young people

The Health Related Behaviour Survey carried out every two years in Cambridgeshire for school children in year 8 and year 10, shows that the proportion of children who have had an alcoholic drink in the week before the survey has fallen significantly since 2006.

Figure 20: Health Related Behaviour Survey – alcoholic drink consumed in the past seven days (%), Cambridgeshire



Source: Health Related Behaviour Survey

SECTION 3: MENTAL HEALTH TRENDS IN CAMBRIDGESHIRE

3.1 Suicide

Suicide is always a very sad and distressing event, and is the commonest cause of death nationally for men under 50 and women under 35. The suicide rate in Cambridgeshire is similar to the national average. While in the past, suicide rates in both Cambridge City and Fenland have sometimes been significantly above the national average, more recently suicide rates in Cambridgeshire and all its districts have been similar to the national picture.

Figure 21: Suicide rate, persons, directly age-standardised rate per 100,000, Cambridgeshire & Districts, 2001/03 – 2013/15

Area	Suicide rate, directly age-standardised rate per 100,000, persons												
	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15
Cambridge City	15.3	15.7	13.0	14.6	14.2	15.6	12.8	12.1	11.3	11.9	9.6	9.4	7.6
East Cambridgeshire	*	*	*	*	*	*	*	*	*	*	*	*	*
Fenland	11.1	*	*	*	11.4	14.4	15.7	14.6	10.2	9.9	*	12.0	12.7
Huntingdonshire	*	*	6.6	8.8	9.5	8.4	7.7	6.9	8.0	7.2	9.0	8.9	9.2
South Cambridgeshire	10.2	13.0	10.5	7.8	*	6.9	8.7	8.0	7.2	*	8.3	7.9	9.7
Cambridgeshire	9.6	9.8	8.7	8.8	9.4	10.1	10.2	9.1	8.3	7.8	8.7	9.0	9.1
England	10.3	10.2	10.1	9.8	9.4	9.2	9.3	9.4	9.5	9.5	9.8	10.0	10.1

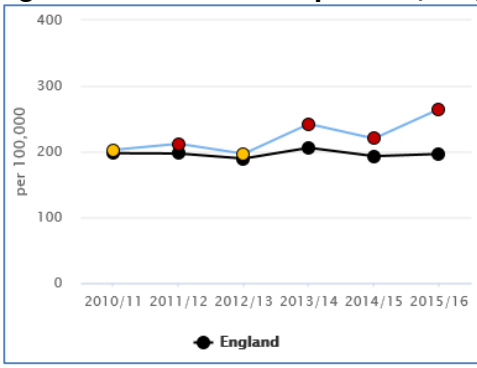
Source: Public Health Outcomes Framework

Key

	Statistically significantly lower (better) than England
	Statistically similar to England
	Statistically significantly higher (worse) than England

Unlike the suicide rate, emergency hospital admissions for self-harm have been increasing recently, and are now higher than the national average in all Cambridgeshire districts apart from South Cambridgeshire. Some caution is needed in interpreting rising admissions for self-harm as these may be partly dependent on better recording and coding by hospitals. But the rise is of concern and needs further careful investigation.

Figure 22: Emergency hospital admissions for intentional self-harm, persons, directly age-standardised rate per 100,000, Cambridgeshire, 2010/11 – 2015/16



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		1,311	202.8	191.9	214.1	150.7	197.6
2011/12		1,386	212.1	201.0	223.6	154.1	197.2
2012/13		1,296	196.8	186.2	207.8	153.5	189.6
2013/14		1,598	242.3	230.5	254.5	183.5	205.9
2014/15		1,454	220.0	208.8	231.6	173.0	193.2
2015/16		1,777	264.9	252.6	277.5	179.5	196.5

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to Public Health England Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

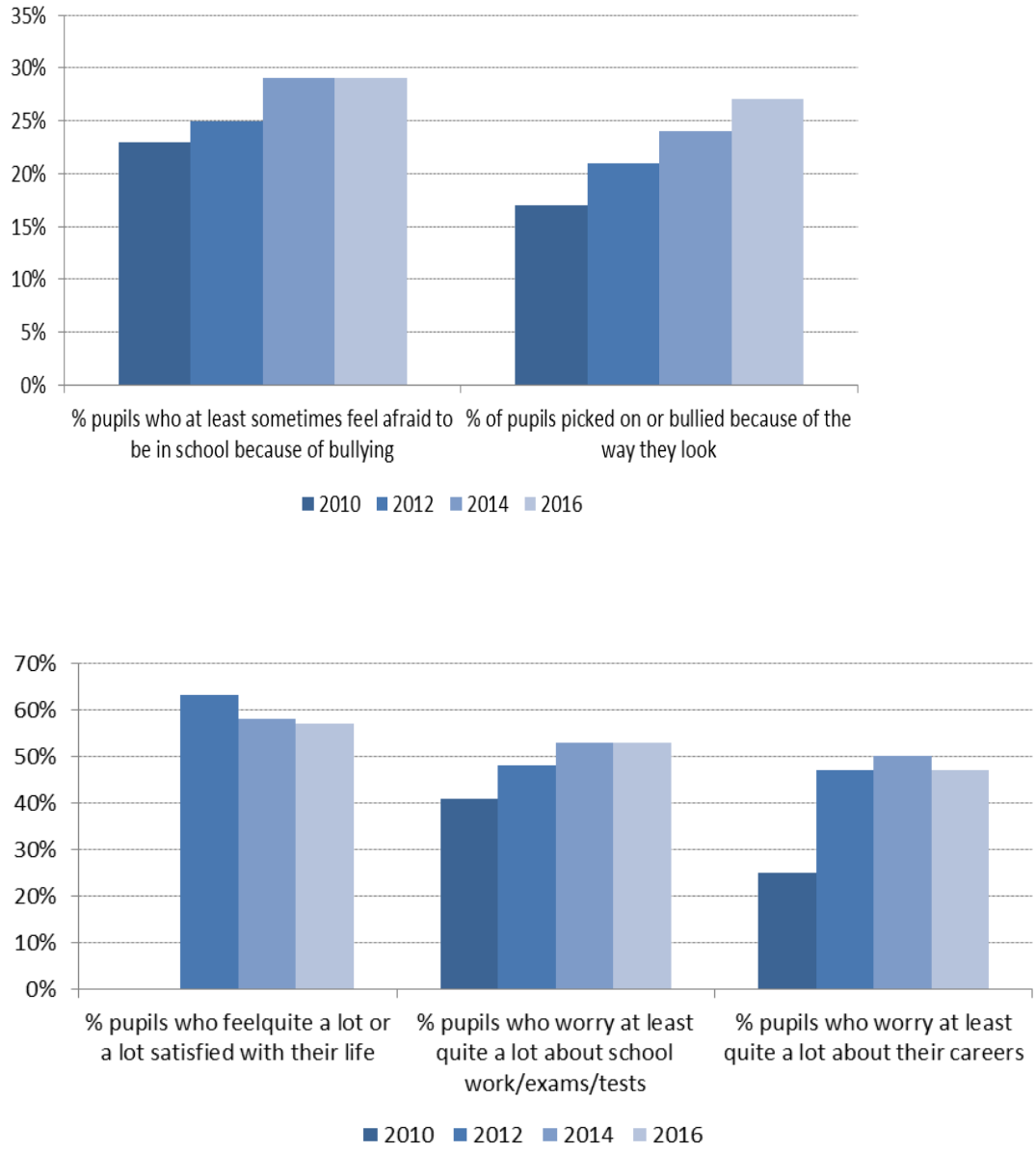
Source: Public Health England 'Fingertips' website

3.2 Children and young people's mental health

There has been concern nationally about children's and young people's mental health and access to appropriate mental health services, with a national commitment to invest more in these services.

In Cambridgeshire, the Health Related Behaviour Survey of children in years 8 and 10 of secondary schools indicates some adverse trends in emotional wellbeing since 2010, although these appear to have levelled out. Since 2010 the proportion of children who describe themselves as sometimes afraid to go to school because of bullying has increased, and the proportion of children worried about exams and their future careers is also higher.

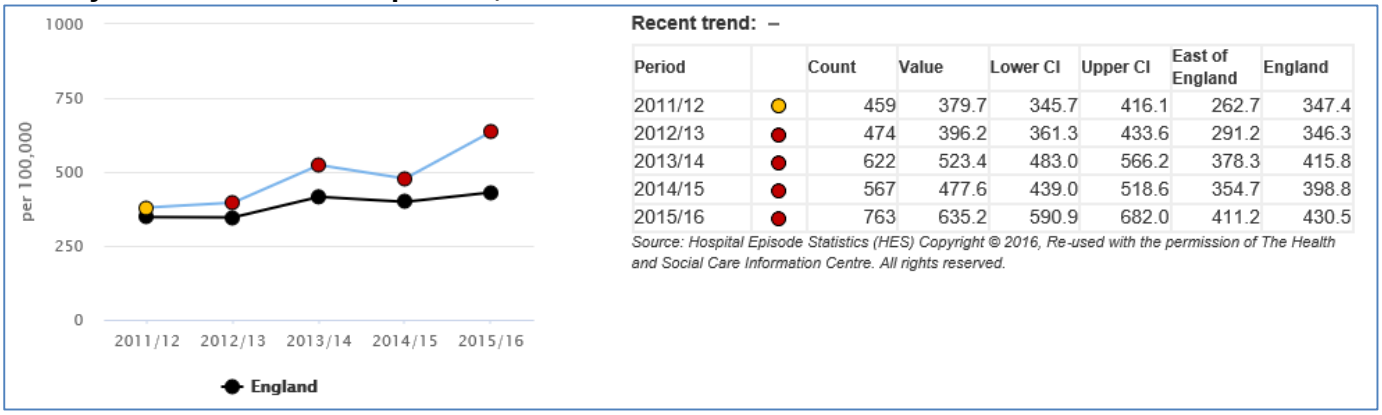
Figure 23: Cambridgeshire Schools Health Related Behaviour Survey findings 2010-2016



Source: Health Related Behaviour Survey

Rates of hospital admissions for self-harm amongst young people aged 10-24 have a rising trend in Cambridgeshire between 2011/12 and 2015/16, and are well above the national average. Some caution is required as trends may be the result of improved recording and coding by hospitals, but the issue is of significant concern and requires further investigation.

Figure 24: Hospital admissions as a result of self-harm (10-24 years) Cambridgeshire. directly standardised rate – per 100,000



Recent trend: –

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

Source: Public Health England Child and maternal health profiles

CASE STUDY – MAKING A DIFFERENCE

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Mental Health Crisis First Response Service (FRS) and Sanctuaries

What was the problem?

Before this service was launched in September 2016 there was no capacity to see people in need of mental healthcare out of hours except via A&E, and no self-referral route, meaning many sought help direct from A&E. Service users told us that it was very difficult and stressful trying to get help when in a mental health crisis and they found the emergency department a stressful environment.

What was the solution?

- A new community-based crisis mental health service – 'first response' – provides timely access to safe, effective, high quality care for people in mental health crisis.
- The first response service provides assertive and responsive support and triage for anyone experiencing mental health crisis, including face-to-face assessment if needed.
- Open 24/7 for people of all ages throughout Cambridgeshire and Peterborough.
- Welcomes self-referrals via dialing 111 and asking for option2 as well as urgent referrals from carers, GPs, ambulance crews, police (anyone!) and the emergency department.

What were the results?

- The service has demonstrated an immediate decline in the use of hospital emergency departments for mental health needs with a 21% reduction in attendance despite the local context of many years of rapidly increasing figures.
- A 26% reduction in the number of people with mental health needs being admitted to acute hospitals from the emergency department.

SECTION 4: LIFE EXPECTANCY AND PREVENTABLE DEATHS

Life expectancy is an important summary measure for the overall health outcomes in an area. It is generally quoted as an average over three years to make the statistic more reliable. Life expectancy in Cambridgeshire as a whole has been consistently above the national average since 2001-03 and has improved by over three years for both men and women between 2001-03 and 2013-15. However life expectancy in the county has 'plateaued' more recently, with no improvement for men since 2010-12 and only a small improvement for women.

There are inequalities in average life expectancy across the county, reflecting differences in the wider determinants of health and lifestyle 'risk' behaviours described in earlier sections. Average life expectancy for men in Fenland in 2013/15 was 78.6 years (significantly worse than the national average), while all other districts in Cambridgeshire have above average male life expectancy, the highest being South Cambridgeshire at 82.1 years. For women life expectancy in Fenland is similar to the national average at 82.6 years, and again above average in all other districts, the highest being South Cambridgeshire at 85.2 years.

Figure 25: Cambridgeshire and districts average life expectancy by gender, 2013 to 2015

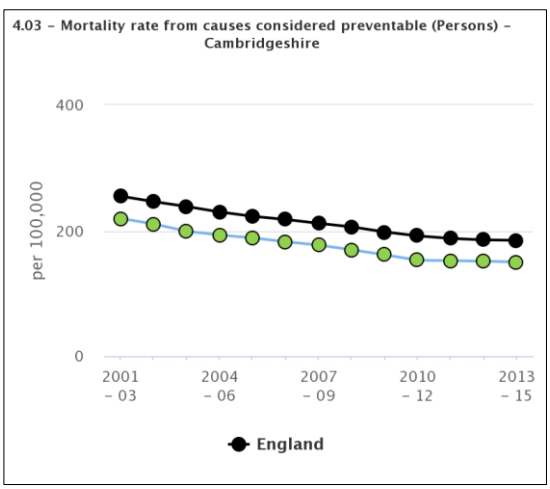
Indicator	Data period	Cambs Value	England value	Cambridgeshire Districts				
				Cambridge	E Cambs	Fenland	Hunts	S Cambs
Life expectancy at birth (Males), years	2013-15	80.9	79.5	80.3	81.6	78.6	81.0	82.1
Life expectancy at birth (Females), years	2013-15	84.4	83.1	84.1	84.8	82.6	84.7	85.2

Source: Public Health Outcomes Framework

	Statistically significantly higher (better) than England
	Statistically similar to England
	Statistically significantly lower (worse) than England

4.1 Trends in preventable deaths

Public Health England calculates a summary measure of deaths considered preventable through public health interventions in their broadest sense, and Cambridgeshire as a whole has shown a positive trend on this measure since 2001- 03. However there has been a worrying upward movement in the most recent data on preventable mortality in Fenland, associated with an upturn in preventable deaths under the age of 75 from cardiovascular disease (heart disease and stroke).



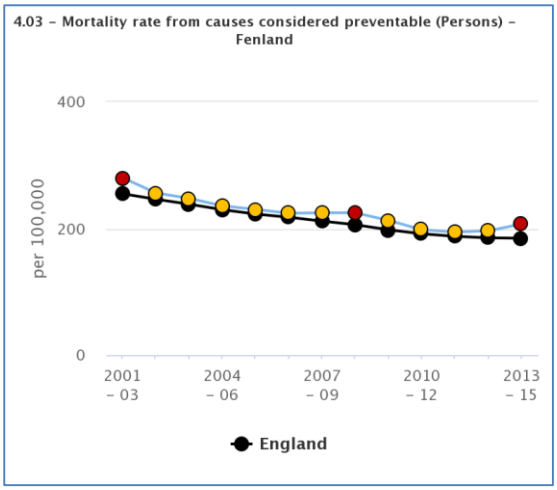
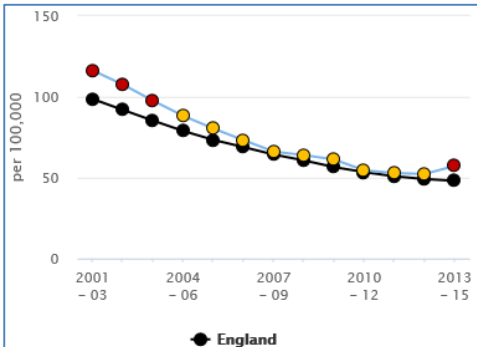


Figure 26: Under 75 mortality rate from cardiovascular diseases considered preventable (persons), directly age-standardised rate per 100,000, Fenland, 2001-03/2013-15



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2001 - 03	●	264	116.3	102.6	131.2	84.2	98.6
2002 - 04	●	250	107.6	94.7	121.9	78.5	91.9
2003 - 05	●	231	97.6	85.4	111.0	73.3	85.3
2004 - 06	●	214	88.3	76.8	100.9	68.5	78.9
2005 - 07	●	198	80.4	69.6	92.4	63.3	73.4
2006 - 08	●	183	73.2	63.0	84.7	59.3	68.9
2007 - 09	●	169	66.1	56.5	76.9	55.2	64.3
2008 - 10	●	166	64.0	54.6	74.5	53.5	60.7
2009 - 11	●	160	61.3	52.1	71.5	50.3	56.6
2010 - 12	●	144	54.5	46.0	64.2	48.1	53.5
2011 - 13	●	143	52.9	44.6	62.4	45.2	50.9
2012 - 14	●	144	52.3	44.0	61.6	43.5	49.2
2013 - 15	●	162	57.3	48.8	66.9	42.0	48.1

Source: Public Health England (based on ONS source data)

Source: Public Health Outcomes Framework

SUMMARY AND RECOMMENDATIONS

This Annual Public Health Report 2017 has attempted to give a brief overview of some of the factors and circumstances which affect the health and wellbeing of Cambridgeshire residents. It is clear that there are significant differences in health and the factors affecting health, both across the County as a whole and between neighbourhoods within individual districts. One recommendation for the future is that where possible and statistically valid, we should be mapping more health and wellbeing indicators at the local neighbourhood level to help 'fine tune' the provision, targeting and monitoring of campaigns and services.

It is often difficult to obtain data which is defined by circumstances other than geography, but this is possible for data on educational outcomes. The disparity in educational outcomes between children receiving free school meals and their peers of the same age is a county-wide issue, and is consistent from the measurement of school readiness in reception year right through to GCSE attainment at age 16. Addressing this should be a key public health priority due to the impact of educational attainment on future health and wellbeing.

Another county-wide issue is young people's emotional wellbeing – with some adverse trends seen since 2010 in the school based Health Related Behaviour Survey, and more recently a rising trend in hospital admissions for self-harm. Joint work is already taking place across the NHS and local authorities to improve early intervention and support for young people with mental health problems, so we would hope to see these trends improving, and the impact of this work needs careful monitoring.

Finally, there are a wealth of statistics throughout this report which demonstrate the health and wellbeing challenges for Fenland residents – in particular for the North Fenland and Wisbech area. The causes are complex, with no easy answers – but a consistent and sustainable focus on the area from a range of organisations will be needed to address the determinants of health such as educational attainment and economic development, as well as a focus from health and care providers on delivering accessible prevention, treatment and support services to meet current needs.

APPENDIX A

Domains and indicators for the updated Index of Multiple Deprivation IMD (2015) showing changes from the IMD (2010). ***DCLG 2014***