Cambridge City Council

# Cambridge Local Health Partnership

**Date:** Friday, 13 October 2017

**Time:** 12.00 pm

**Venue:** Committee Room 1 - The Guildhall, Market Square, Cambridge, CB2 3QJ

**Contact:** democratic.services@cambridge.gov.uk, tel:01223 457013

## Agenda

1 Apologies

2 Public Questions

3 Minutes and Matters Arising

4 Children's Centre Services in Cambridge: A view from Romsey Mill Trust (Pages 5 - 10)

James Bennett, Children's Centre Manager at Romsey Mill Trust and Neil Perry, Chief Executive at Romsey Mill Trust, will outline the early intervention work that is currently being delivered through the Children's Centres that the Trust run in Cambridge and the possible implications for the health and wellbeing of families and communities arising from proposals to re-designate the sites, set out in the recent public consultation, as outreach locations.

A decision will be taken about the proposals at a Full County Council meeting on 17 October 2017. This is an opportunity for members to consider some of the implications of any new arrangements.

5 Local Authorities and Health: Joint Working (Pages 11 - 14)

Suzanne Hemingway, Director of Community Services for the City Council, will update members on the development of a "Living Well Partnership Concordat" and progress with the formation of an "Area Delivery Partnership" that will involve the merging of Area Executive Partnerships and Local Health Partnerships. A paper from the Health and Wellbeing Board meeting on 6 July 2017 provides further background on page 15.

6 Refresh of Cambridgeshire's Health and Wellbeing Strategy (Pages 15 - 24)

Graham Saint, Strategy Officer for Cambridge City Council, will invite members to identify local health and wellbeing issues or priorities that can contribute to the current consultation for the "refresh" of Cambridgeshire's Health and Wellbeing Strategy.

7 Update on the work of the Health and Wellbeing Board

Kate Parker, Head of Public Health Business Programmes at Cambridgeshire County Council, will update members on the work of the Board.

The HWB last met on 21 September 2017. Details of this meeting can be found here:
https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/638/Committee/12/Default.aspx

The next meeting of the HWB will be on 23 November 2017.

8 Progress Report on the Advice on Prescription project, led by Cambridge Citizens Advice Bureau

Rachel Talbot, Chief Executive of Cambridge CAB will outline progress with the project and discuss any issues moving. The first quarter report for this year will be circulated to members separate to this agenda.

9 Presentation: Cambridgeshire Annual Public Health Report (Pages 25 - 52)

Dr. Liz Robin, Director of Public Health, Cambridgeshire County Council, will present the Annual Public Health Report 2017. This year's report looks at wider social and environmental factors affecting our health and wellbeing, and how these influence the differences in health outcomes we see across the county.

10 Next Meeting

The next meeting of the Cambridge Local Health Partnership is scheduled for 16 November 2017, starting at 12 noon in the Guildhall.

## Information for the public

The public may record (e.g. film, audio, tweet, blog) meetings which are open to the public. For details go to: www.cambridge.gov.uk/have-your-say-at-committee-meetings

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- Email: democratic.services@cambridge.gov.uk
- Phone: 01223 457013

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Cambridgeshire County Council

**Public Consultation Paper July – September 2017**

# Children's Centre Services

Cambridgeshire Children's Centres

The County Council is proposing redesigning Children's Centre services. We are asking people who use Children's Centres, other citizens and stakeholders what they think of the plans. This document explains what those proposals are and how you can have your say.

# The Consultation

## What are we consulting on and why?

Cambridgeshire's first Children's Centre opened in 2005 with the aim of helping families in more deprived areas to give their children the best start in life. There has been significant growth and change in the level of provision over the past 12 years.

At the present time there are 40 designated Children's Centres across the County delivered by a combination of the County Council, schools and voluntary organisations. The contracts for externally delivered Children's Centres conclude in April 2018 and the County Council is looking at how to ensure that the money spent has the greatest positive impact on young children's development before re-tendering contracts.

Services for the families and the under 5's delivered from these centres include:

- Access to midwives and health visitors
- Family support services – trained staff providing parenting support and advice
- Advice about early years education and childcare
- Employment, training and benefits advice
- Drop-in play sessions
- A meeting place for child carers

The Centres have played a vital role in delivering early childhood services to families with young children, bringing together key services such as childcare, health visiting, midwifery, employment and adult learning into one place. We also know from our work together over many years the importance of delivering support in the community rather than over focusing on the buildings, which is why we already deliver services in over 100 different locations.

Under the 2006 Childcare Act Cambridgeshire County Council must ensure the sufficient provision of children's centres in its area to meet the local need of parents, prospective parents and young children, especially for those in the greatest need of support.

Cambridgeshire County Council has a statutory duty to consult with those affected about any proposals that may result in significant changes to, and/or the closure of, its Children's Centres, which are part of the proposed redesigned Children's Centre service.



## National and Local Context

Over recent years Government policy on supporting families and young children has changed. There is no longer a Government pot of money to pay for Children's Centres or any funding for new ones.

At the same time the Government has introduced a number of other ways to support Families:

- Funding for 15 hours free childcare for two-year-olds in low income families
- Funding for 15 hours free childcare for all three and four-year-olds, and from September this year, up to 30 hours in low income families
- A Family Nurse Partnership which offers intensive and structured home visiting, delivered by specially trained family nurses, from early pregnancy until the child is two for first time mothers and fathers under the age of 19;
- A Healthy Child Programme for children, young people and families, which focuses on early intervention and prevention offering a programme of screening tests, immunisations, developmental reviews, information and guidance on parenting and healthy choices.
- £5.3 million funding for the Troubled Families Programme Together for Families in Cambridgeshire, supporting work with families with complex issues. This is the current total assumed level of income from Phase 2 of the national programme, 2015-2020.

Government policy on increasing free early education means that the Council needs to look at how to create more childcare places as part of its Early Years strategy. There is an opportunity to consider this agenda alongside delivery of Children's Centre services.

Alongside these changes the County Council has over the five years 2012-2017 seen a £86.8m per annum (46% per cent) reduction in the funding received from Central Government and we have been working with partners to ensure we look to do things differently to ensure the services we are responsible for delivering are the most efficient and have the biggest impact on improving the lives of Children, Families and Communities across t he County.

There has been a delay in the proposed national consultation on the future of Children's Centres over recent years. However the All Party Parliamentary Group on Children's Centres (APPG) undertook an inquiry into the future of Children's Centres in 2016. The findings of this inquiry focussed on the development of "Family Hubs" concluding that Children's Centres needed to be to be increasingly available across the whole family age range, and spectrum of need. Family Hubs should be the identified 'go to' place for a wider range of support particularly targeted to families with significant needs including mental health and relationship support. These findings have helped shape our proposals.

The proposals outlined will enable the council to deliver cost effective services while ensuring that vulnerable families have access to services they need for themselves and their children until they reach adulthood.

It is currently estimated that the proposals would save £1m per year in line with the savings target set by Council last year for 2018-19.

## Cambridgeshire current and proposed delivery model by districts

There are currently 40 designated Children's Centres across the county. Children's Centre services are already delivered from other community buildings to provide easier access for families. The enhanced partnerships with midwifery, health visiting, childcare providers and schools will allow us to deliver effective support to those families that most need it where they are able to access it.

The consultation document is structured into Districts (see pages 9-19) in order to highlight the proposals at a local level.

We know there is no 'one size fits all' solution for Cambridgeshire. We want to work with local communities to agree how services can be delivered across the 5 districts of Cambridgeshire.

## Where will I be able to get support?

Cambridgeshire is a large and diverse county. We know we need a flexible offer to make sure you can access our services, no matter where you live.

**We will offer services in the following 4 ways:**

# City

**In this section we are going to look at the area of Cambridgeshire where you live. This page will look at our current delivery in Cambridge City and what we need to think about when planning services here.**

We will then look at how we are proposing to change our delivery in your district and ask for you feedback on that.

## Things to know about City

- Cambridge is a rapidly growing city with large new housing developments, especially around the south and west of the City
- We know that we are likely to need to offer more support to families in new communities for the first few years as the community is established.
- Cambridge is a diverse city, with more families with additional support needs in the north city, Abbey and Cherry Hinton Wards. New community areas are also demonstrating higher support needs.
- It is difficult for a number of families to access childcare across the city, particularly in Cherry Hinton, Coleridge, Romsey, and Trumpington. As the 30 hours free childcare is introduced from September this need will increase.

## How things would change in the City

| Current Children's Centres | Proposed Child and Family Centres | Proposed Child and Family Zones | Proposed Children's Centres that will be re-designated |
|---|---|---|---|
| Romsey Mill | | Brookfields (potential shared building with health) | Romsey Mill |
| The Fields | Abbey Child and Family Centre (The Fields) | | |
| Fawcett | | Clay Farm (new shared use space) | Fawcett |
| Homerton | | | Homerton |
| Cherry Hinton | | | Cherry Hinton (we will look to deliver services as part of the redeveloped Library) |
| North Cambridge | North Cambridge Child and Family Centre (split site across North Cambridge and Chesterton) | | |
| Chesterton | North Cambridge Child and Family Centre (split site across North Cambridge and Chesterton) | | |
| | | Central Library | |
| 7 sites | 2 Centres across 3 sites | 3 sites | 4 sites |

More large housing developments are planned across Cambridge City and we will look to create Child and Family Zones in these locations as they develop.

Outreach Programme venues across this district would include libraries, health centres, community venues and schools.

### Current Children's Centres to be re-designated in City

We are proposing that some Children's Centres would no longer be needed as Children's Centres. We would look to re-designate these spaces to meet other needs of families in the area including Childcare provision, community use and wherever possible ongoing outreach provision as required. In Cambridge City these would be:

| | |
|---|---|
| **Cherry Hinton** | **Fawcett** |
| **Homerton** | **Romsey Mill** |

In **Cherry Hinton** we are proposing moving to a different building in the community to deliver outreach services as part of the redeveloped library.

**In addition we would no longer run full Children's Centre services from Fawcett School, Homerton Nursery, or Romsey Mill although they are likely to remain as outreach delivery locations.**



The full consultation document and data briefing can be found here:

https://www.cambridgeshire.gov.uk/residents/children-and-families/children-s-centres/children-s-centres-consultation/

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**Agenda Item No: 10**

**LOCAL AUTHORITIES AND HEALTH JOINT WORKING - UPDATE**

*To*: **Health & Wellbeing Board**

*Meeting Date*: **6th July 2017**

*From:* **Mike Hill, Director, Health & Environmental Services, South Cambridgeshire District Council**

*Recommendations:* The Health & Wellbeing Board is recommended to:

a) Support the development of a "Living Well" Partnership Concordat to demonstrate commitment to "whole system" partnership working by all partner organisations involved in the delivery of Health & Wellbeing for Cambridgeshire residents, and so provide an alternative to signing the Sustainability & Transformation Plan Memorandum of Understanding;

b) Note progress to form joint "Area Delivery Partnerships" by merging Local Health Partnership and Area Executive Partnerships, as discussed at the Health & Wellbeing Board Development session in March 2017.


| | ***Officer contact:*** |
|---|---|
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## 1.0 PURPOSE

**1.1** To seek Health & Wellbeing Board support for the development of a "Living Well" Partnership Concordat to demonstrate commitment to "whole system" partnership working by all partner organisations involved in the delivery of Health & Wellbeing for Cambridgeshire residents

**1.2** To note progress to form joint "Area Delivery Partnerships" by merging Local Health Partnership and Area Executive Partnership meetings, as discussed at the Health & Wellbeing Board Development session in March 2017.

## 2.0 BACKGROUND

**2.1** To move towards a "whole system approach" to delivery of health and wellbeing of Cambridgeshire residents, the Cambridgeshire Public Service Board (PSB) and Health & Care Executive (HCE) have agreed to hold quarterly joint meetings to provide joined-up leadership and oversight of a range of projects and opportunities, including those under the Sustainability & Transformation Plan.

**2.2** At its joint meeting on 25th May, and as part of the refresh of the Sustainability & Transformation Plan (STP) governance, the PSB & HCE agreed to develop a "Living Well" Partnership Concordat which all partner organisations could sign to demonstrate partnership commitment to a "whole system approach" to the delivery of health & wellbeing outcomes for Cambridgeshire residents.

**2.3** For those partners yet to sign it, the "Living Well" Partnership Concordat would provide an alternative to the proposal to sign the STP Memorandum of Understanding (STP MoU), a matter which has previously been before the Health & Wellbeing Board. For clarity, the STP MoU remains in place for key partners who have chosen to sign it as it fulfils important financial and risk management purposes for the delivery of the STP.

**2.4** A draft of a suggested "Living Well" Partnership Concordat will be developed by partners over the summer and presented to the Health & Wellbeing Board for comment in September 2017.

**2.5** At its Development Day in March 2017, Health & Wellbeing Board discussed ideas to improve partnership working and reduce duplication and the number of meetings needed to deliver "whole system" health work. At its meeting on the 25th May, the PSB & HCE Chief Executives supported practical proposals to create 4 Area Delivery Boards (covering Peterborough, Huntingdonshire, East Cambridgeshire & Fenland, and Cambridge City & South Cambridgeshire) to oversee delivery of joint working by merging

(and ending) separate Local Health Partnership and STP Area Executive Partnership meetings and seek to align these better with Community Safety Partnership meetings. This will reduce the number of meetings from around 60 to 16. Terms of Reference and a Communications Plan for the new Area Delivery Partnerships are now being worked-up and it is anticipated that the new Area Delivery Boards will start work in September 2017.

**2.6** There was general agreement amongst PSB & HCE Chief Executives that organisational structures and barriers need to be broken down to deliver what are clear, shared health and organisational outcomes and outputs. HCE & PSB agreed to focus a joint work programme on exploring ideas and opportunities for future Devolution deals, workforce & skills, procurement, estates and ICT. It was also agreed to map out all current partnership projects and shared outcomes to support improved joint programme management and delivery, to include more clinical / health improvement projects.

## 3.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

**3.1** The proposals outlined will contribute to improved partnership working and delivery of Priority 6 “Work together effectively”.

## 4.0 IMPLICATIONS

**4.1** The proposals outlined will reduce duplication and costs associated with Members and officers attending multiple meetings.

**4.2** “Responsible Authorities” under the Crime & Disorder Act 1998 (as amended) will need to review their current arrangements for delivery of statutory Community Safety duties and how these may be impacted by the proposals outlined.

## 5.0 SOURCES

| Source Documents | Location |
|---|---|
| Crime and Disorder Act 1998 | http://www.legislation.gov.uk/ukpga/1998/37 |
| Minutes of the Cambridgeshire Health and Wellbeing Board 19 January 2017 | https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/156/Committee/12/Default.aspx |

**Cambridge Local Health Partnership**
Friday 13 October 2015

## 1. Introduction

**1.1** The Cambridgeshire Health & Wellbeing Board is currently seeking the views of partners in setting the strategic priorities for a refreshed Health and Wellbeing Strategy for 2018 and beyond. The current strategic priorities are shown in Appendix A.

**1.2** During the life of the current (near to end) Health and Wellbeing Strategy 2012-2017 the health and wellbeing system has changed significantly with the creation of the Sustainability and Transformation Plan; greater collaboration between local authorities; and changes in local and national priorities. It is expected that a draft strategy will be pulled together in the near future. Some members may also have been involved in workshops convened on behalf of the Health & Wellbeing Board.

## 2. Putting forward views

**2.1** The refresh of the Health and Wellbeing Strategy is an opportunity for members of the Cambridge Local Health Partnership, as a body that involves representatives that have an understanding of local issues and the needs of Cambridge residents, to put forward views about what it thinks the priorities for Cambridge should be, taking into account available evidence.

## 3. Focus of Cambridge Local Health Partnership

**3.1** During the past 3 years the Cambridge Local Health Partnership has, as part of its agenda, looked at:

- Supported housing and homelessness – the increase in homelessness
- Sustainable Food City status and local projects – especially the relief of food poverty
- Fuel poverty and local schemes to improve energy efficiency in low income households
- Falls prevention and opportunities for partnership working

- Local mental health community support and prevention – the isolation of older people
- Local lifestyle services and local promoting physical activity programmes, including the exercise referral scheme
- New communities – work to prepare for and welcome new communities, including the early provision of facilities
- Assisting migrants and refugees in Cambridge
- Offering advice on prescription in local GP Health Centres

## 4. Background

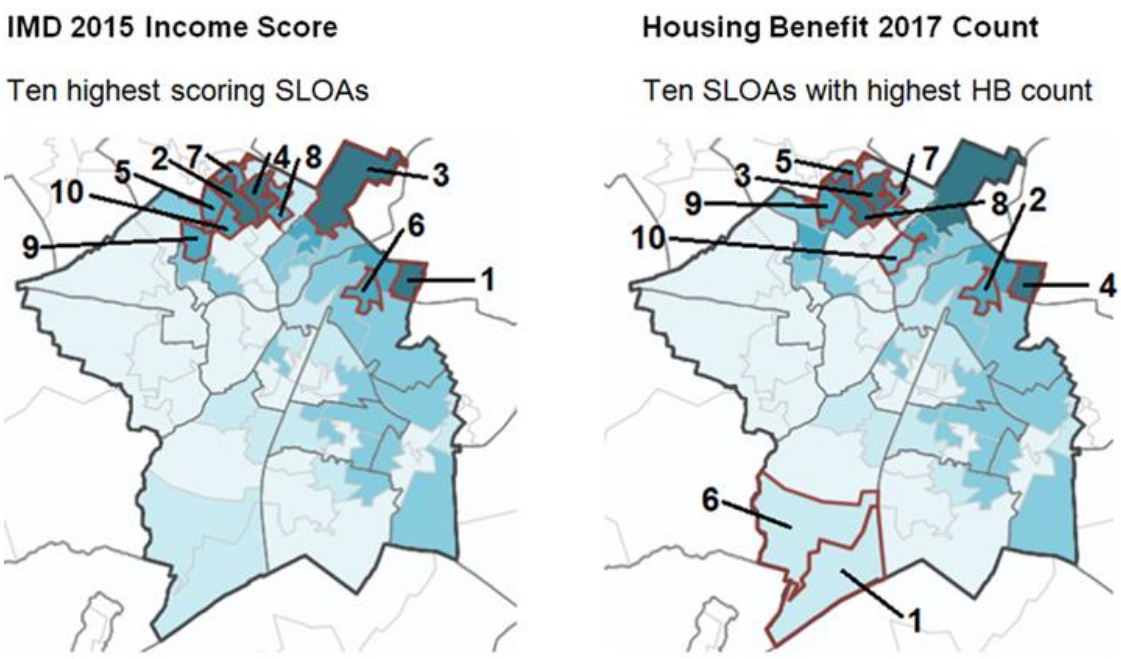
**4.1** Cambridge City, as a place, has population characteristics that are shared by only a limited number of other local authorities. These include Oxford and some inner London Boroughs. These are defined by: high migration rates and population churn; a young adult population; under representation of children and the elderly; a high cost of living; high levels of social renting, and; low levels of housing affordability. Cambridge City is also a place of housing growth, having seen its population increase (by just over 15% between Census), and is, overall, a relatively prosperous place with continuing high levels of economic investment. It is also a diverse place with just over one third of its residents born outside the UK.

**4.2** Within its compact urban area Cambridge City has communities living side-by-side that are amongst the least deprived (most well-off 10%) and most deprived (bottom 20%) in the country. This has led to substantial levels of inequality of income being present in the City. According to the Centre for Cities and its adaptation of the Gini Coefficient, it is the most unequal City in the country. The disparity between the most deprived areas and least derived areas is also highlighted in the difference in life expectancy for people living in the areas – a gap of 9.3 years for men and 7.4 years for women.

**4.3** The City Council's recent review of its administrative records for Housing Benefit has shown a marked increase in benefit claimants in some LSOAs covering new community areas, which indicates that higher support needs will become more apparent in these areas in the

future. Presently, just over one person in ten in the City lives in a household claiming benefit. The highest proportion for a ward is just over 20% and the lowest proportion for a ward is under 5%.

**Maps 1 & 2: Changes in the pattern of distribution for low income households**




**4.4** The City Council's refreshed Anti-Poverty Strategy gives further insight into the needs of low income groups of people. As part of the review of the Anti-Poverty Strategy a Mapping poverty 2017 report was prepared to capture and present data about low income households in the city. The above maps are taken from this report.

## 5. Cambridge Local Health Profile 2017

**5.1** The Cambridge Health Profile 2017, Appendix B, shows summary characteristics of the Cambridge population, including the aforementioned health inequalities, and provides a national view of deprivation using the Index of Multiple Deprivation 2015, which is largely based on 2013 data. The health summary section presents a small set

of some of the most important health indicators that show how each area compares to the national average in order to highlight potential problem areas.

Significantly worse than the England average are:

- Hospital stays for self-harm
- Hospital stays for alcohol harm
- Statutory homelessness

## 6. Summary by JSNA Core Dataset 2017

**6.1** Overall Cambridge has many health and wellbeing indicators that are better than national averages. However, there is an increasing trend of some indicators moving towards national, rather than overall local, averages and this is of some concern. Issues that the Executive Summary by JSNA Core Dataset 2017 report highlight for Cambridge are: alcohol abuse; smoking; mental health and self-harm; TB incidence; sexual health; falls and hip fractures in older people; dementia diagnosis rate; suicide; excess winter deaths. In addition there has been a marked increase in homelessness in recent years, with the Council's housing advice and homelessness service seeing a rise in the number of local people it has helped prevent becoming homeless in the last year, from 770 to 1,200.

## 7. Cambridge Residents' Survey 2016

**7.1** Residents in Cambridge say they like living in Cambridge. In our 2016 Residents' Survey 89% of our residents told us they are satisfied with their local area as a place to live compared to 87% in 2008. 63% of our residents strongly felt that they belong to their local area compared to 48% in 2008 but slightly fewer residents at 78% agreed that people from different backgrounds get on well together in their area compared to 86% in 2008. Residents said they liked living in Cambridge because of its open spaces, opportunities to cycle, there is a lot going on and the availability of good schools but disliked the congestion, the high cost of living and the limited access to good jobs for local people.

**7.2** Residents in Cambridge are said to have slightly lower levels of happiness (7.12) compared to the UK average (7.4) in the ONS Annual Population Survey but according to What Works Wellbeing is one of the most equal local authorities for overall wellbeing in the country, ranked at 28th (with 1 being the best).

## 8. Sources:

The City Council's draft refreshed Anti-Poverty Strategy can be viewed here:

https://democracy.cambridge.gov.uk/documents/s40075/170920%20Revised%20anti-poverty%20strategy%202017-2020%20-%20final%20v2.pdf

The 2017 Cambridge Mapping Poverty report can be viewed here:

https://www.cambridge.gov.uk/mapping-poverty

Executive Summary by JSNA Core Dataset 2017 can be viewed here:

https://cmis.cambridgeshire.gov.uk/CCC_live/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=RSlknzpU%2fFfHXWg0Z5k44nmZtEE1sgSxE5%2bxQs9%2fAeD%2b4mb1KqtkPg%3d%3d&rUzwRPf%2bZ3zd4E7Ikn8Lyw%3d%3d=pwRE6AGJFLDNlh225F5QMaQWCtPHwdhUfCZ%2fLUQzgA2uL5jNRG4jdQ%3d%3d&mCTIbCubSFfXsDGW9IXnlg%3d%3d=hFflUdN3100%3d&kCx1AnS9%2fpWZQ40DXFvdEw%3d%3d=hFflUdN3100%3d&uJovDxwdjMPoYv%2bAJvYtyA%3d%3d=ctNJFf55vVA%3d&FgPIIEJYlotS%2bYGoBi5olA%3d%3d=NHdURQburHA%3d&d9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJFf55vVA%3d&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctNJFf55vVA%3d&WGewmoAfeNQ16B2MHuCpMRKZMwaG1PaO=ctNJFf55vVA%3d

**Paper prepared by:**

Graham Saint

Corporate Strategy Officer

Cambridge City Council

Cambridgeshire County Council

# Cambridgeshire Health & Wellbeing Strategy **2012–17**

EXECUTIVE SUMMARY

All aspects of our everyday lives have an impact on our health and wellbeing; from health services through to our environment, transport, our homes and our involvement in local communities (as described in the diagram below). This means that working to improve health and wellbeing, while respecting people's personal lifestyle choices, is everybody's business and in everybody's interest.

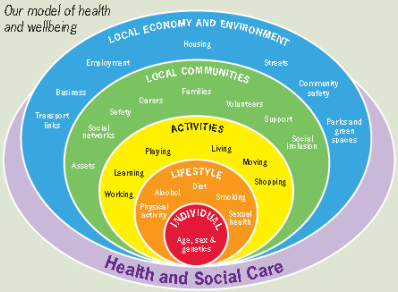
The Cambridgeshire Health and Wellbeing Board and Network brings together leaders from local organisations which have a strong influence on health and wellbeing, including the commissioning of health, social care and public health services. The Board focusses on planning the right services for Cambridgeshire and securing the best possible health and wellbeing outcomes for all residents.

Throughout Cambridgeshire each partner organisation has strategies and action plans to address specific health and wellbeing needs. The Health and Wellbeing Board believes that it can add value by working with these partners to address the issues together, for example;

- How we can address the most important local needs, now and in future;
- How we can build on the strengths in our communities;
- How we can best protect the most vulnerable people in our communities;
- How we can work together to use our resources most efficiently;
- How working together can bring the most benefit to Cambridgeshire residents.

The Cambridgeshire Health and Wellbeing Strategy 2012-17 sets out the priorities the Board and Network feel are most important for local people.

*Our model of health and wellbeing*




Source: Modified from Dahlgren & Whitehead's rainbow of determinants of health (G Dahlgren and M Whitehead, Policies and strategies to promote social equity in health, Institute of Futures Studies, Stockholm, 1991) and the LGA circle of social determinants (Available at: http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3511263/ARTICLE-TEMPLATE)

From June to September 2012 we consulted the public on our draft strategy asking if we had identified the right priorities for Cambridgeshire. The majority agreed with what we proposed to focus on. In response to feedback, we made "working together differently" an additional priority and included issues that local communities identified as important to them.

The Health and Wellbeing Board and Network will focus on the six priorities overleaf to improve the physical and mental health and wellbeing of Cambridgeshire residents. In particular we will work to improve the health of the worst off fastest, by targeting efforts in more disadvantaged communities and marginalised groups.

We also agreed a number of principles to make sure we make a long-term difference to health and wellbeing throughout the county and that we help those who need it most. We aim to:

- Reduce inequalities by improving the health of the worst off fastest.
- Focus on preventing ill health by promoting healthy lifestyles while respecting people's choices and for those who have an illness, preventing their condition from worsening.
- Make decisions which are based on the best possible evidence.
- Develop solutions which are cost-effective and efficient.
- Recognise that different groups and communities have different needs.
- Encourage communities to take responsibility for making healthy choices.
- Make sure services are sustainable.

This strategy is the first step in a bold vision to achieve change together. Our next steps are to identify what success will look like so we can monitor progress against these priorities.
To do this we will develop an action plan with specific responsibilities for each partner, for 2013-14.

www.cambridgeshire.gov.uk

**Cambridgeshire Health & Wellbeing Board and Network will focus on these six priorities to improve the physical and mental health and wellbeing of Cambridgeshire residents. In particular, within each of these priorities, we will work to improve the health of the poorest fastest.**

### Priority 1
**Ensure a positive start to life for children, young people and their families**

- Strengthen our multi-agency approach to identifying children who are in poverty, who have physical or learning disabilities or mental health needs, or whose parents are experiencing physical or mental health problems.
- Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services.
- Support positive and resilient parenting, particularly for families in challenging situations, to develop emotional and social skills for children.
- Create and strengthen positive opportunities for young people to contribute to the community and raise their self esteem, and enable them to shape the programmes and services with which they engage.
- Recognise the impact of education on health and wellbeing and work to narrow local gaps in educational attainment.

### Priority 2
**Support older people to be independent, safe and well**

- Promote preventative interventions which reduce unnecessary hospital admissions for people with long term conditions, enable them to live independently at home or in a community setting where appropriate and improve their health and wellbeing outcomes e.g. through falls prevention, stroke and cardiac rehabilitation, supporting voluntary organisations and informal carers.
- Integrate services for frail older people and ensure that we have strong community health, housing, voluntary support and social care services tailored to the individual needs of older people, which enable them to improve their quality of life and minimise the need for long stays in hospitals, care homes or other institutional care.
- Enhance services for the early prevention, intervention and treatment of mental health problems in older people, including timely diagnosis and joined up services for the care and support of older people with dementia and their carers.
- Ensure appropriate and person-centred end of life care for residents and their families and informal carers.

### Priority 3
**Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices**

- Encourage individuals and communities to get involved and take more responsibility for their health and wellbeing.
- Increase participation in sport and physical activity, and encourage a healthy diet, to reduce the rate of development of long-term conditions, increase the proportion of older people who are active and retain their independence, and increase the proportion of adults and children with a healthy weight.
- Reduce the numbers of people who smoke.
- Promote individual and community mental health and wellbeing, prevent mental illness and reduce stigma and discrimination against those with mental health problems.
- Work with local partners to prevent hazardous and harmful alcohol consumption and drug misuse.
- Promote sexual health, reduce teenage pregnancy rates and improve outcomes for teenage parents and their children.

### Priority 4
**Create a safe environment and help to build strong communities, wellbeing and mental health**

- Implement early interventions and accessible, appropriate services to support mental health, particularly for people in deprived areas and in vulnerable or marginalised groups.
- Work with partners to prevent domestic violence, raise public awareness especially amongst vulnerable groups, and provide appropriate support and services for victims of domestic abuse.
- Minimise the negative impacts of alcohol and illegal drugs and associated antisocial behaviour on individual and community health and wellbeing.
- Work with local partners to prevent and tackle homelessness and address the effects of changes in housing and welfare benefits on vulnerable groups.

### Priority 5
**Create a sustainable environment in which communities can flourish**

- Develop and maintain effective, accessible and affordable transport links and networks, within and between communities, which ensure access to services and amenities and reduce road traffic accidents.
- Ensure that housing, land use planning and development strategies for new and existing communities consider the health and wellbeing impacts for residents in the short and long term.
- Encourage the use of green, open spaces including public rights of way, and activities such as walking and cycling.
- Seek the views of local people and build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion, and promote social inclusion of marginalised groups and individuals.

### Priority 6
**Work together effectively**

- Commit to partnership working, joint commissioning and combining resources in new ways to maximise cost-effectiveness and health and wellbeing benefits for individuals and communities.
- Identify sustainable, long-term solutions to manage the increased demand on health and social care services.
- Encourage increased partnership working with research organisations to better inform the evidence base supporting the development and evaluation of future services.
- Encourage increased involvement of service user representatives and local groups in planning services and policies.
- Recognise the importance of the Voluntary and community sector and their valuable contribution to implementing the strategy.

**Cross cutting principles:** Equitable • Evidence-based • Cost-effective • Preventative • Empowering • Sustainable

Public Health England

Protecting and improving the nation's health

# Cambridge

District

This profile was published on 4th July 2017

# Health Profile 2017

**Health in summary**
The health of people in Cambridge is varied compared with the England average. About 16% (2,700) of children live in low income families. Life expectancy for both men and women is higher than the England average.

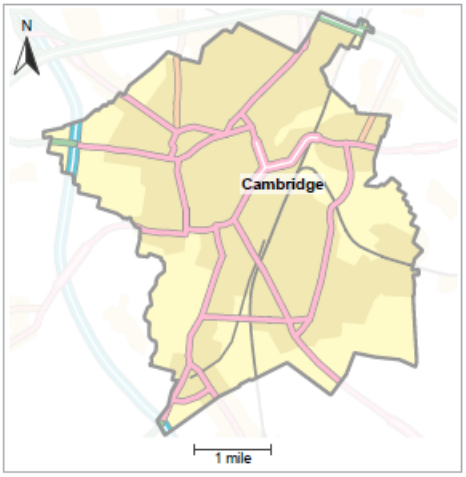
**Health inequalities**
Life expectancy is 9.3 years lower for men and 7.4 years lower for women in the most deprived areas of Cambridge than in the least deprived areas.

**Child health**
In Year 6, 11.3% (92) of children are classified as obese, better than the average for England. The rate of alcohol-specific hospital stays among those under 18 is 43*. This represents 9 stays per year. Levels of GCSE attainment are better than the England average.

**Adult health**
The rate of alcohol-related harm hospital stays is 818*, worse than the average for England. This represents 895 stays per year. The rate of self-harm hospital stays is 352*, worse than the average for England. This represents 598 stays per year. Estimated levels of adult excess weight and physical activity are better than the England average. The rate of statutory homelessness is worse than average. Rates of violent crime, long term unemployment and early deaths from cancer are better than average.

**Local priorities**
Priorities in Cambridge include improving mental health, addressing drug and alcohol misuse, and tackling health inequalities including homelessness. For more information see http://cambridgeshireinsight.org.uk

* rate per 100,000 population



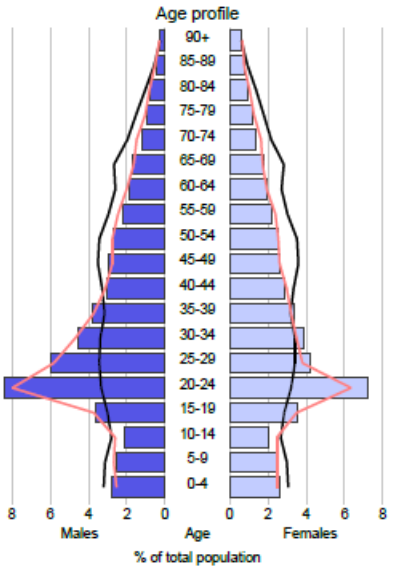



This profile gives a picture of people's health in Cambridge. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

Follow @PHE_uk on Twitter

# Population: summary characteristics




| | Males | Females | Persons |
|---|---|---|---|
| **Cambridge** (population in thousands) | | | |
| Population (2015): | 68 | 63 | 131 |
| Projected population (2020): | 71 | 63 | 134 |
| % people from an ethnic minority group: | 15.8% | 11.7% | 13.8% |
| Dependency ratio (dependants / working population) x 100 | | | 39.4% |
| **England** (population in thousands) | | | |
| Population (2015): | 27,029 | 27,757 | 54,786 |
| Projected population (2020): | 28,157 | 28,706 | 56,862 |
| % people from an ethnic minority group: | 13.1% | 13.4% | 13.2% |
| Dependency ratio (dependants / working population) x 100 | | | 60.7% |

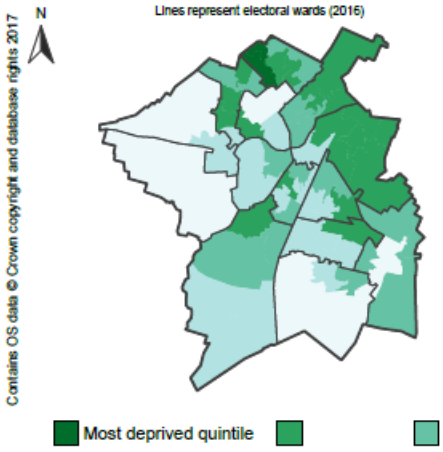
The age profile and table present demographic information for the residents of the area and England. They include a 2014-based population projection (to 2020), the percentage of people from an ethnic minority group (Annual Population Survey, October 2014 to September 2015) and the dependency ratio.

The dependency ratio estimates the number of dependants in an area by comparing the number of people considered less likely to be working (children aged under 16 and those of state pension age or above) with the working age population. A high ratio suggests the area might want to commission a greater level of services for older or younger people than those areas with a low ratio.

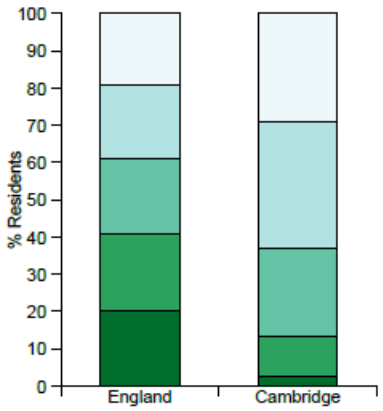
Cambridge 2015 (Male) — England 2015
Cambridge 2015 (Female) — Cambridge 2020 estimate

# Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using national quintiles (fifths) of the Index of Multiple Deprivation 2015 (IMD 2015), shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.




This chart shows the percentage of the population who live in areas at each level of deprivation.



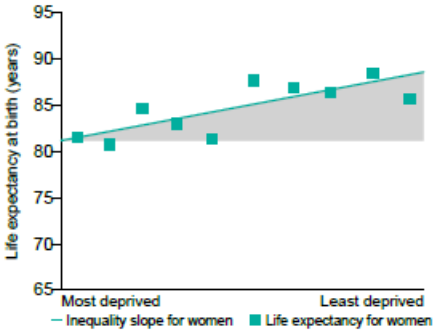

Most deprived quintile — Least deprived quintile

## Life expectancy: inequalities in this local authority

The charts show life expectancy for men and women in this local authority for 2013-15. The local authority is divided into local deciles (tenths) by deprivation (IMD 2015), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy the line would be horizontal.

Life expectancy gap for men: 9.3 years

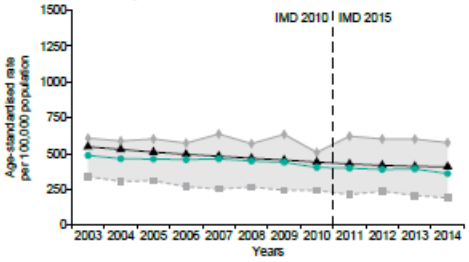

Life expectancy gap for women: 7.4 years



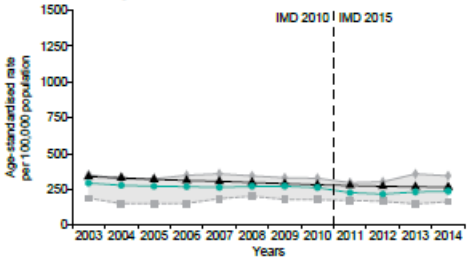

## Health inequalities: changes over time

These charts provide a comparison of the changes in death rates in people under 75 (early deaths) between this area and England. Early deaths from all causes also show the differences between the most and least deprived local quintile in this area. Data from 2010-12 onwards have been revised to use IMD 2015 to define local deprivation quintiles (fifths), all prior time points use IMD 2010. In doing this, areas are grouped into deprivation quintiles using the Index of Multiple Deprivation which most closely aligns with time period of the data. This provides a more accurate way of discriminating changes between similarly deprived areas over time.

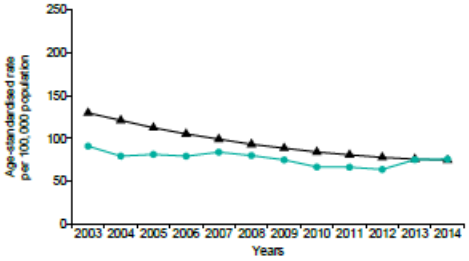
Early deaths from all causes: men



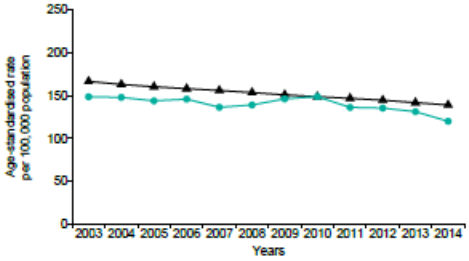

Early deaths from all causes: women




Early deaths from heart disease and stroke




Early deaths from cancer




Data points are the midpoints of three year averages of annual rates, for example 2005 represents the period 2004 to 2006. Where data are missing for local least or most deprived, the value could not be calculated as the number of cases is too small.

England average | Local average | Local least deprived | Local most deprived | Local inequality

# Health summary for Cambridge

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared

Regional average[€] | England average | England worst | 25th percentile | 75th percentile | England best

| Domain | | Indicator | Period | Local count | Local value | Eng value | Eng worst | England range | Eng best |
|---|---|---|---|---|---|---|---|---|---|
| Our communities | 1 | Deprivation score (IMD 2015) | 2015 | n/a | 13.8 | 21.8 | 42.0 | | 5.0 |
| | 2 | Children in low income families (under 16s) | 2014 | 2,715 | 15.9 | 20.1 | 39.2 | | 6.6 |
| | 3 | Statutory homelessness | 2015/16 | 108 | 2.3 | 0.9 | | | |
| | 4 | GCSEs achieved | 2015/16 | 487 | 63.3 | 57.8 | 44.8 | | 78.7 |
| | 5 | Violent crime (violence offences) | 2015/16 | 2,078 | 16.2 | 17.2 | 36.7 | | 4.5 |
| | 6 | Long term unemployment | 2016 | 153 | 1.6 ^20 | 3.7 ^20 | 13.8 | | 0.4 |
| Children's and young people's health | 7 | Smoking status at time of delivery | 2015/16 | x[1] | x[1] | 10.6 $[1] | 26.0 | | 1.8 |
| | 8 | Breastfeeding initiation | 2014/15 | 739 | x[1] | 74.3 | 47.2 | | 92.9 |
| | 9 | Obese children (Year 6) | 2015/16 | 92 | 11.3 | 19.8 | 28.5 | | 9.4 |
| | 10 | Admission episodes for alcohol-specific conditions (under 18s)† | 2013/14 - 15/16 | 28 | 42.5 | 37.4 | 121.3 | | 10.5 |
| | 11 | Under 18 conceptions | 2015 | 27 | 15.9 | 20.8 | 43.8 | | 5.4 |
| Adults' health and lifestyle | 12 | Smoking prevalence in adults | 2016 | n/a | 15.1 | 15.5 | 25.7 | | 4.9 |
| | 13 | Percentage of physically active adults | 2015 | n/a | 69.8 | 57.0 | 44.8 | | 69.8 |
| | 14 | Excess weight in adults | 2013 - 15 | n/a | 46.7 | 64.8 | 76.2 | | 46.5 |
| Disease and poor health | 15 | Cancer diagnosed at early stage | 2015 | 191 | 55.8 | 52.4 | 39.0 | | 63.1 |
| | 16 | Hospital stays for self-harm† | 2015/16 | 598 | 351.5 | 196.5 | 635.3 | | 55.7 |
| | 17 | Hospital stays for alcohol-related harm† | 2015/16 | 895 | 817.9 | 647 | 1,163 | | 374 |
| | 18 | Recorded diabetes | 2014/15 | 4,943 | 3.3 | 6.4 | 9.2 | | 3.3 |
| | 19 | Incidence of TB | 2013 - 15 | 38 | 9.8 | 12.0 | 85.6 | | 0.0 |
| | 20 | New sexually transmitted infections (STI) | 2016 | 731 | 761.4 | 795 | 3,288 | | 223 |
| | 21 | Hip fractures in people aged 65 and over† | 2015/16 | 122 | 660.5 | 589 | 820 | | 312 |
| Life expectancy and causes of death | 22 | Life expectancy at birth (Male) | 2013 - 15 | n/a | 80.3 | 79.5 | 74.3 | | 83.4 |
| | 23 | Life expectancy at birth (Female) | 2013 - 15 | n/a | 84.1 | 83.1 | 79.4 | | 86.7 |
| | 24 | Infant mortality | 2013 - 15 | 17 | 4.0 | 3.9 | 8.2 | | 0.8 |
| | 25 | Killed and seriously injured on roads | 2013 - 15 | 151 | 39.2 | 38.5 | 103.7 | | 10.4 |
| | 26 | Suicide rate | 2013 - 15 | 26 | 7.6 | 10.1 | 17.4 | | 5.6 |
| | 27 | Smoking related deaths | 2013 - 15 | n/a | n/a | 283.5 | | | |
| | 28 | Under 75 mortality rate: cardiovascular | 2013 - 15 | 164 | 75.8 | 74.6 | 137.6 | | 43.1 |
| | 29 | Under 75 mortality rate: cancer | 2013 - 15 | 261 | 119.9 | 138.8 | 194.8 | | 98.6 |
| | 30 | Excess winter deaths | Aug 2012 - Jul 2015 | 198 | 24.6 | 19.6 | 36.0 | | 6.9 |

**Indicator notes**

1 Index of Multiple Deprivation (IMD) 2015 2 % children (under 16) in low income families 3 Eligible homeless people not in priority need, crude rate per 1,000 households 4 5 A*-C including English & Maths, % pupils at end of key stage 4 resident in local authority 5 Recorded violence against the person crimes, crude rate per 1,000 population 6 Crude rate per 1,000 population aged 16-64 7 % of women who smoke at time of delivery 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery 9 % school children in Year 6 (age 10-11) 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population 11 Under-18 conception rate per 1,000 females aged 15 to 17 (crude rate) 12 Current smokers (aged 18 and over), Annual Population Survey 13 % adults (aged 16 and over) achieving at least 150 mins physical activity per week, Active People Survey 14 % adults (aged 16 and over) classified as overweight or obese, Active People Survey 15 Experimental statistics - % of cancers diagnosed at stage 1 or 2 16 Directly age sex standardised rate per 100,000 population 17 Admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause (narrow definition), directly age standardised rate per 100,000 population 18 % people (aged 17 and over) on GP registers with a recorded diagnosis of diabetes 19 Crude rate per 100,000 population 20 All new diagnoses (excluding chlamydia under age 25), crude rate per 100,000 population aged 15 to 64 21 Directly age-sex standardised rate of emergency admissions, per 100,000 population aged 65 and over 22, 23 The average number of years a person would expect to live based on contemporary mortality rates 24 Rate of deaths in infants aged under 1 year per 1,000 live births 25 Rate per 100,000 population 26 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (aged 10 and over) 27 Directly age standardised rate per 100,000 population aged 35 and over 28 Directly age standardised rate per 100,000 population aged under 75 29 Directly age standardised rate per 100,000 population aged under 75 30 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths (three years)

† Indicator has had methodological changes so is not directly comparable with previously released values. € "Regional" refers to the former government regions.
^20 Value based on an average of monthly counts x[1] Value not published for data quality reasons $[1] There is a data quality issue with this value

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk

# **Cambridgeshire** Annual Public Health Report **2017**





www.cambridgeshire.gov.uk

# 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 would 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)

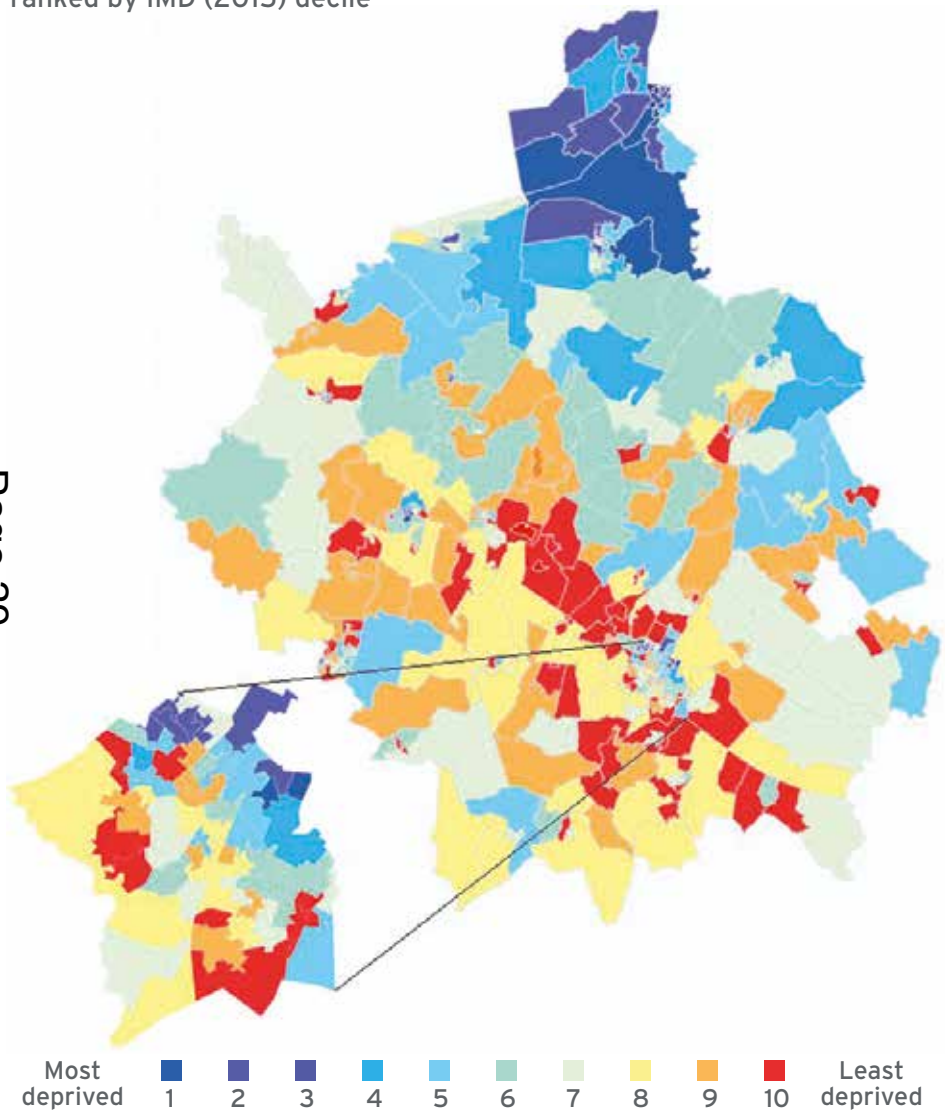
An accepted way to look at the multiple factors which influence outcomes across communities and combine these into a single measure, is the 'Index of Multiple Deprivation' (IMD) which was last updated in 2015.

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 opposite shows neighbourhoods (LSOAs) in the county with their IMD (2015) ranks. Neighbourhoods among the most deprived 10 per cent in the county are coloured dark blue, and those among the least deprived are coloured red. Cambridge City is expanded for clarity.

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.

Map 2: Lower super output areas in Cambridgeshire, ranked by IMD (2015) decile







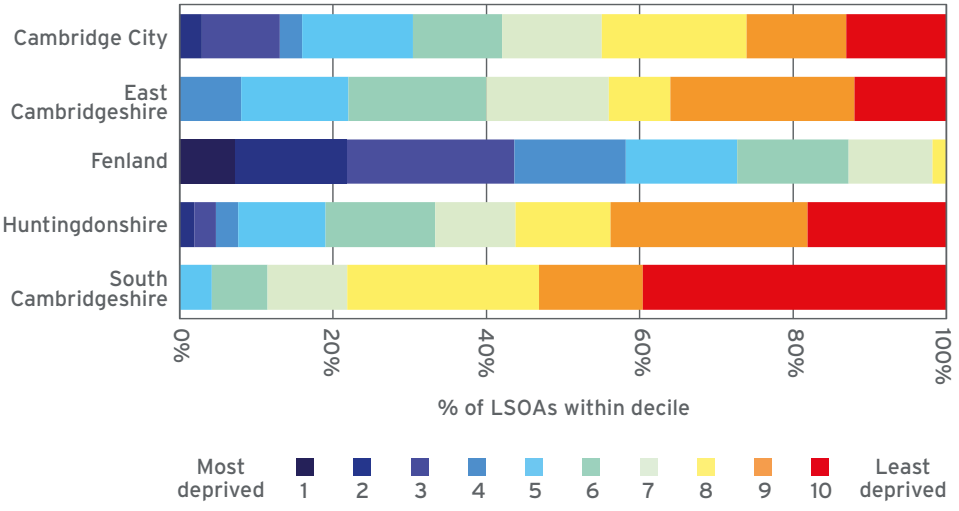

## IMD (2015) DNA charts

An alternative way of presenting information shown on map 2 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 per cent banding) in which they fall. The national DNA chart would have 10 colour coded bands of equal size (10 per cent each).

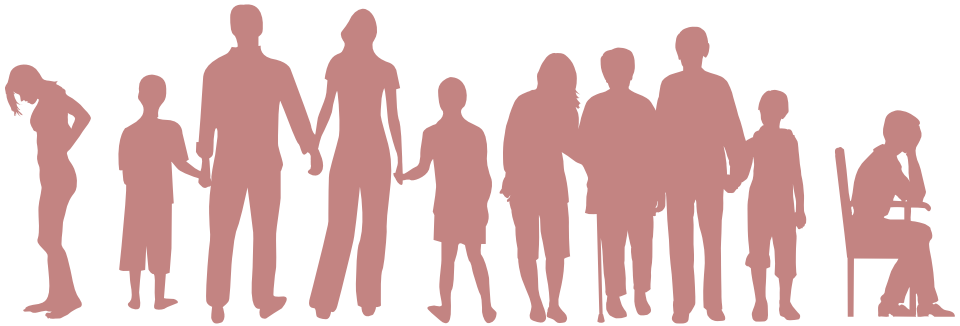
The DNA chart below for the districts of Cambridgeshire shows most districts have more neighbourhoods in the least socio-economically deprived deciles than the national average, although all have some neighbourhoods in more deprived deciles.

The notable exception is Fenland district, which has no neighbourhoods in the most socio-economically advantaged 20 per cent, and a higher proportion in the most deprived deciles.

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.

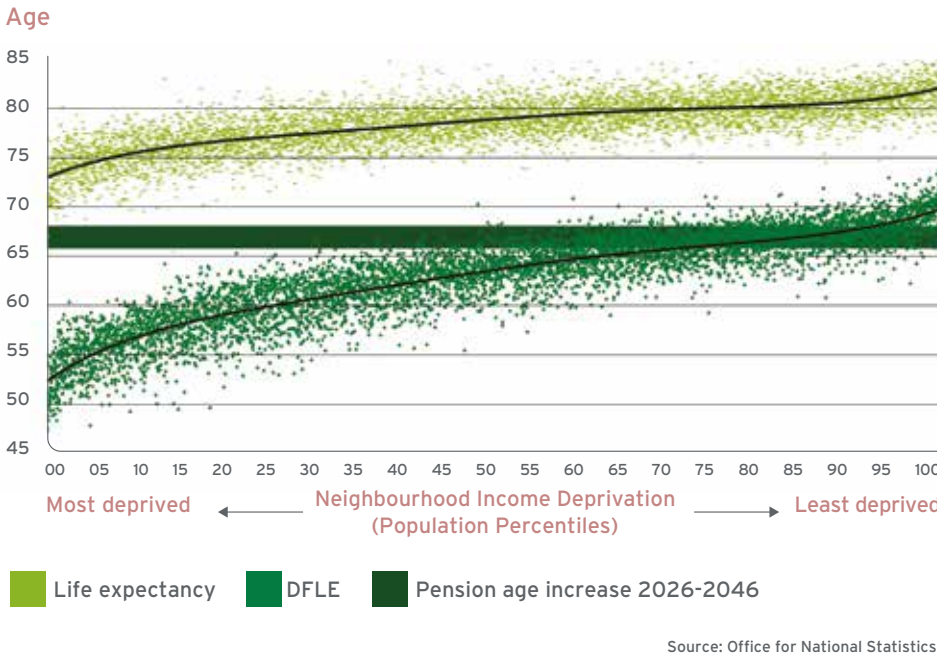


## 1.3 Income and health

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

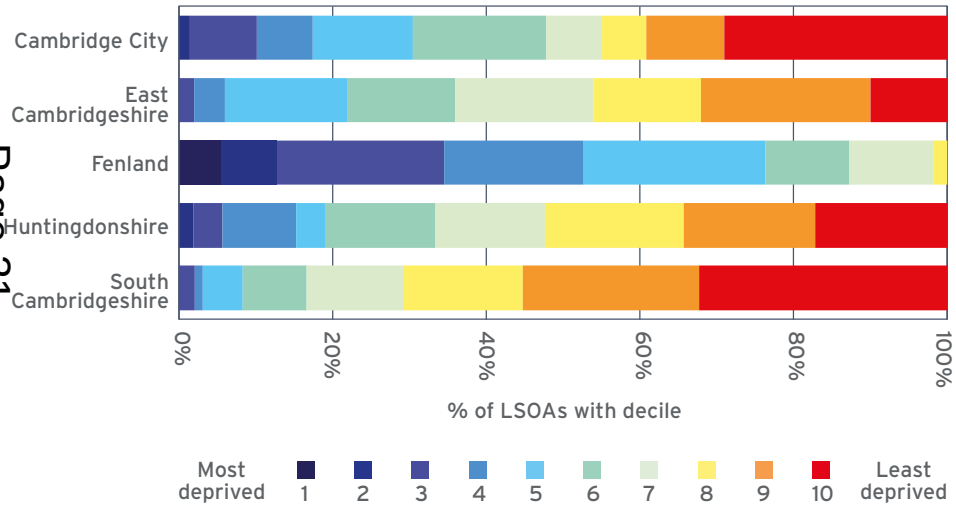



Source: Office for National Statistics

## 1.4 Income levels in Cambridgeshire districts

The following DNA chart shows the 'Income' domain scores for IMD (2015) for each Cambridgeshire district. 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

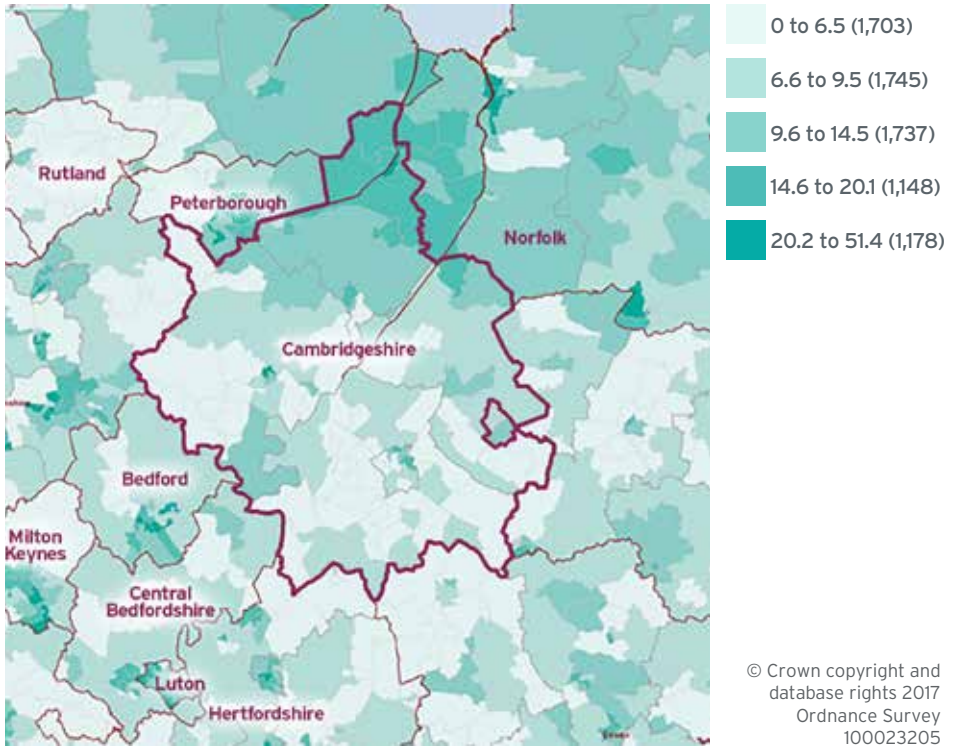
## 1.5 Factors affecting income deprivation

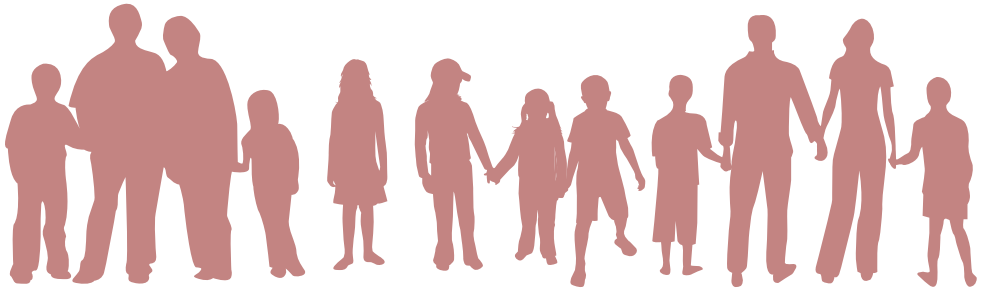
Income deprivation is related to the proportion of low paid work in the local economy, which in turn depends on the types of employment available. This varies across the county, with a higher dependence on farming and associated industries such as food processing and packing in the northern rural areas. map 3 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



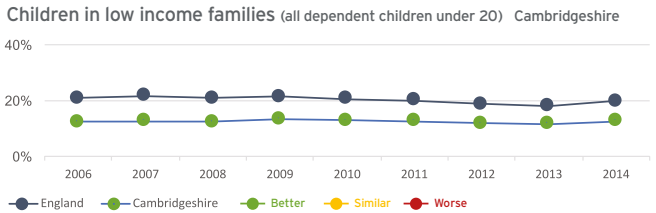


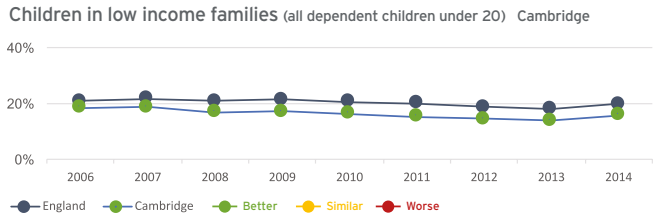
## 1.6 Children in low income families

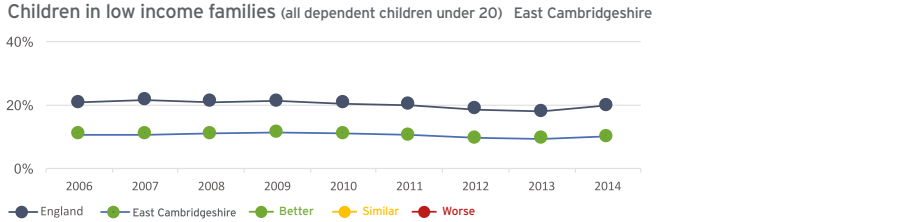
While the IMD (2015) is a useful overall measure of deprivation across the county it describes one point in time and it is also useful to look at long term trends. One measure that has been routinely presented as part of the national Public Health Outcomes Framework is the proportion of children under 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.

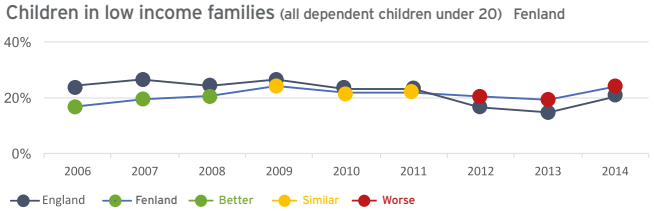


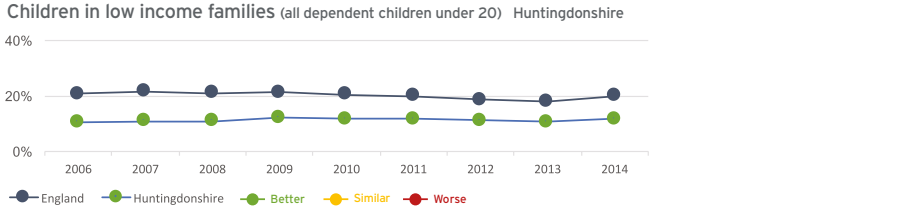
Figure 4: Percentage of Children in low income families (children under 20) *(continued opposite)*

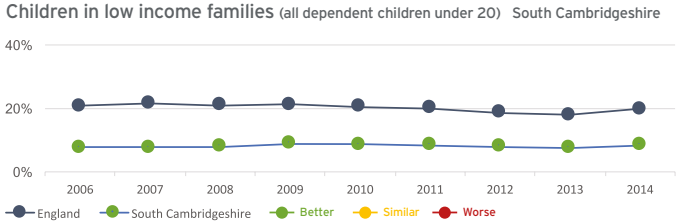


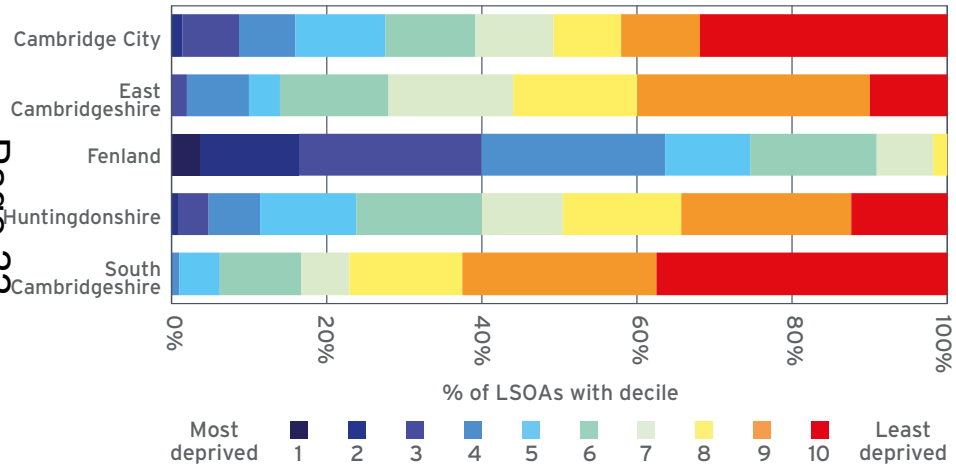

Source: Public Health Outcomes Framework

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 per cent nationally in most Cambridgeshire districts, but Fenland has no neighbourhoods in the least deprived 20 per cent and a higher proportion in the more deprived deciles.

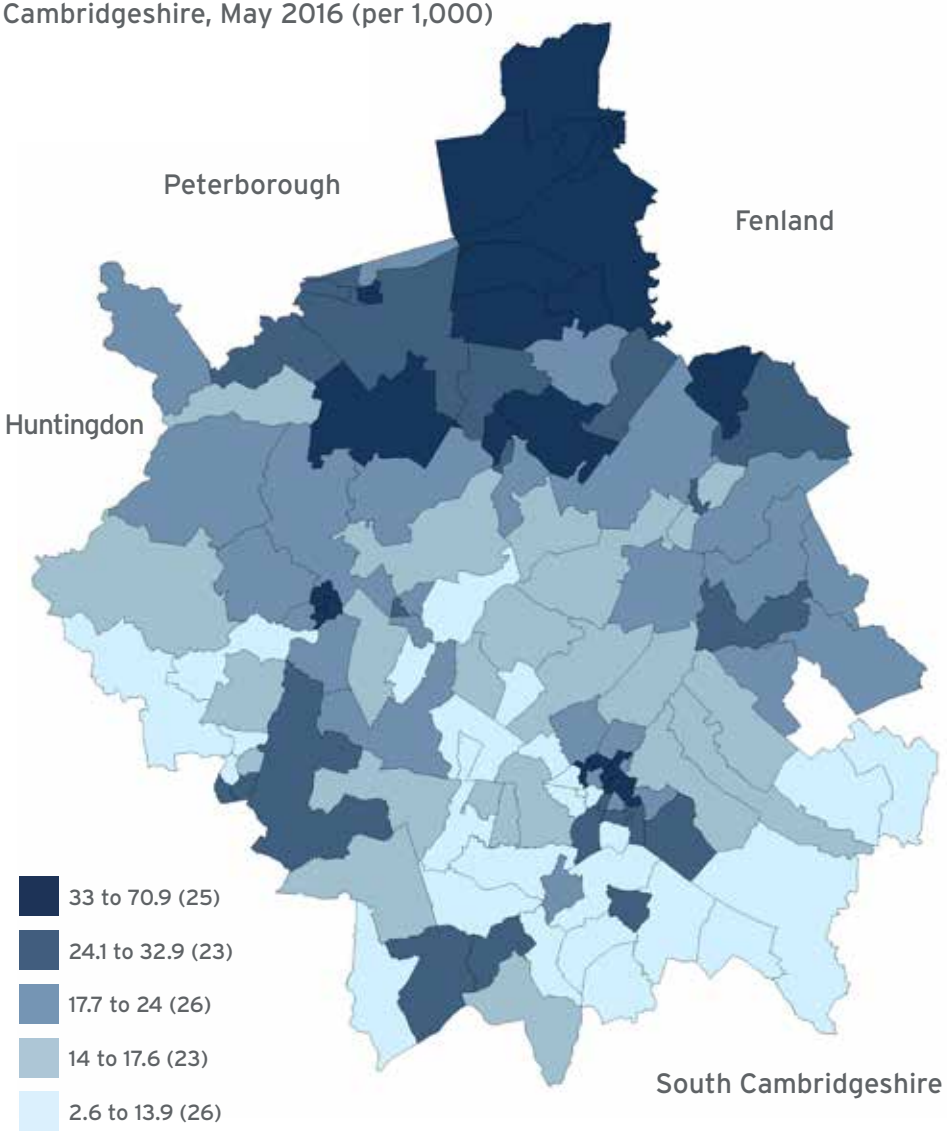
Figure 5: Cambridgeshire districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Employment)




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. Map 4 shows the rates of ESA claimants for neighbourhoods in Cambridgeshire, which closely mirrors the picture for wider IMD (2015) deprivation levels.

Map 4: Rate of Employment Support Allowance (ESA) claimants in Cambridgeshire, May 2016 (per 1,000)

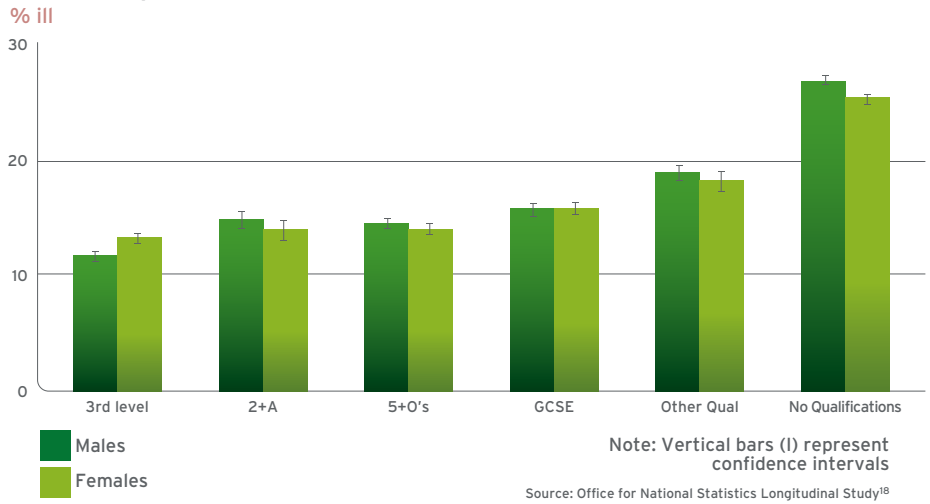


## 1.8 Education and health

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.

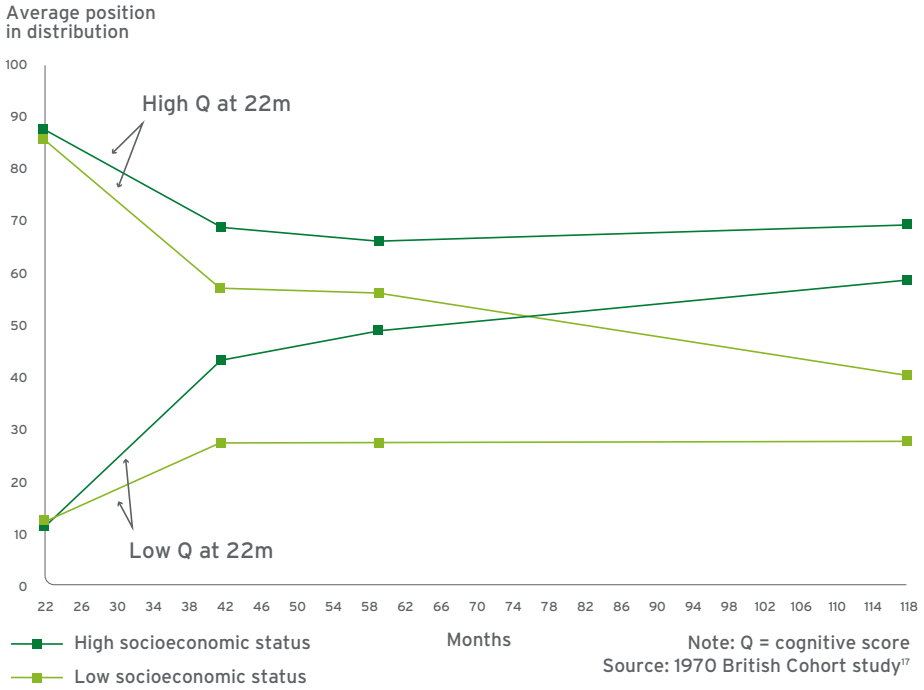


Figure 6: Standardised limiting illness rate in 2001 at ages 16-71, by education level recorded




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 10. Children from the most advantaged backgrounds with poor cognitive (Q) scores at age two, had moved to better than average scores by age 10.

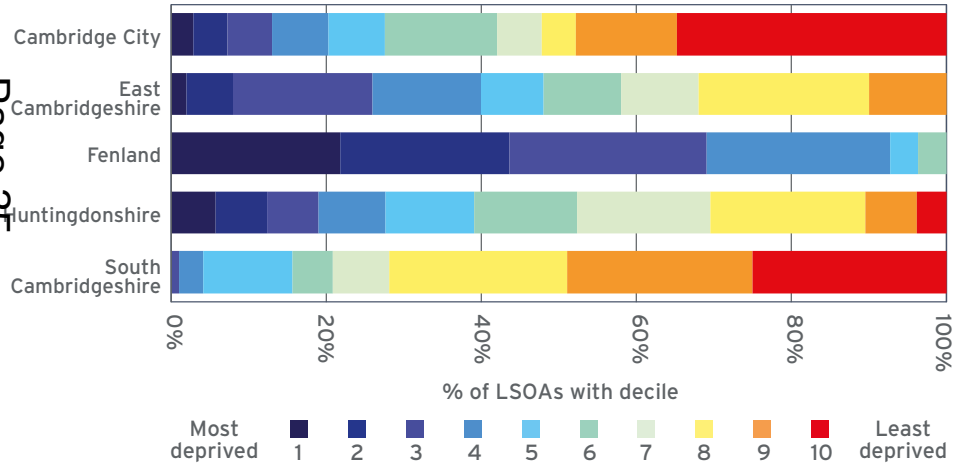
Figure 7: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years




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 per cent 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 per cent nationally, and nearly half of its LSOAs are in the lowest 20 per cent. There are also significant inequalities within districts. Huntingdonshire, Cambridge City and East Cambridgeshire all have neighbourhoods (LSOAs) in the lowest 10 per cent 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 per cent - similar to the England average of 69.3 per cent. However, a more detailed breakdown of figures from the 2014/15 school year showed that only 49.3 per cent 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 per cent for this group.

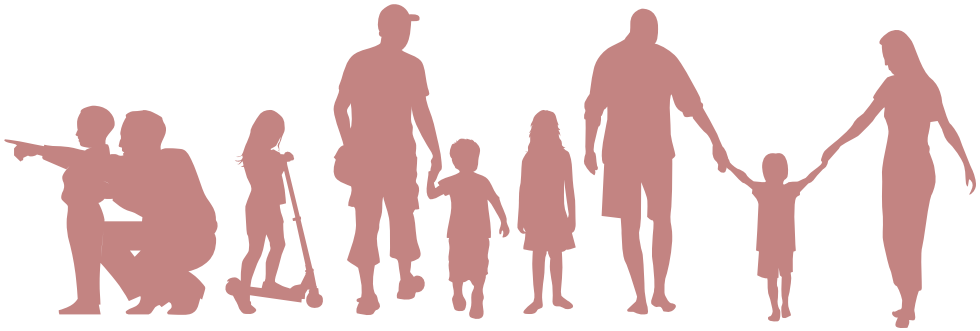
### Case Study – Making a difference

#### 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 per cent 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 per cent, showing an increase of 26 per cent. 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 per cent of Cambridgeshire children achieved five or more GCSEs at grade A*-C including English and Maths.

Figure 9: Percentage of 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 | 95% Lower CI | 95% 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 |

Compared with benchmark: Better | Similar | Worse

Source: Public Health Outcomes Framework

This was better than the national average of 57.8 per cent and Cambridgeshire ranked sixth out of a comparator group of 16 County Councils with similar social and economic characteristics.

However in the more detailed national analysis of GCSE results from 2014/15, only 23.4 per cent 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 per cent. Cambridgeshire children eligible for free school meals had the worst results in our comparator group of similar local authorities.

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

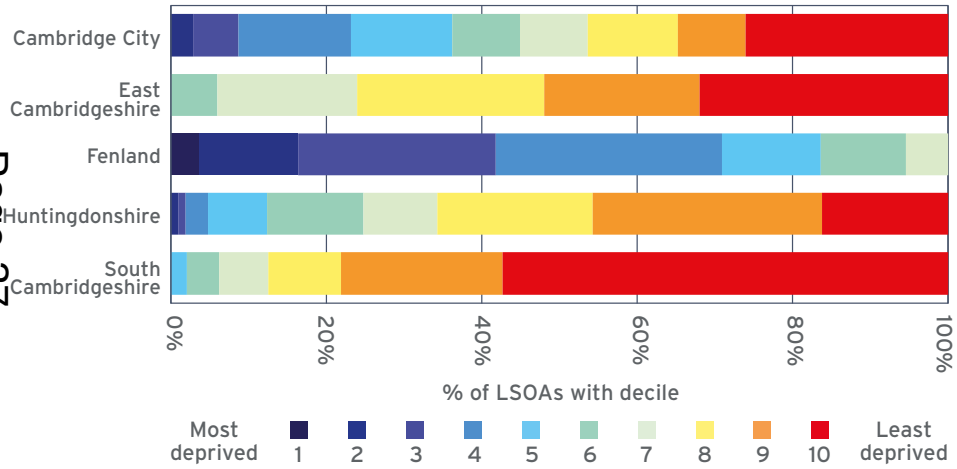
The health domain of IMD (2015) combines information on life years lost through premature death, illness and disability ratios, acute illness leading to emergency hospital admission, and mental health.

The majority of areas in Cambridgeshire show very good scores on this domain, with nearly 80 per cent of South Cambridgeshire neighbourhoods in the least deprived 20 per cent nationally, and all neighbourhoods in East Cambridgeshire in the least deprived 50 per cent.

This does make the difference between Fenland and the rest of the county more striking, as over 80 per cent of Fenland neighbourhoods are in the most deprived 50 per cent nationally. Cambridge City and Huntingdonshire also have internal inequalities, with a small number of neighbourhoods in the lowest 20 per cent 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 per cent 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

From Public Health England

**A framework for understanding**

- **A healthy home:** warm, safe, free from hazards
- **A suitable home:** suitable to household size, specific needs of household members eg, disabled people, and to changing needs eg, as they grow up, or age
- **A stable, secure home** to call your own: without risk of, or actual homelessness or other threat eg, domestic abuse
- **Healthy communities and neighbourhoods**

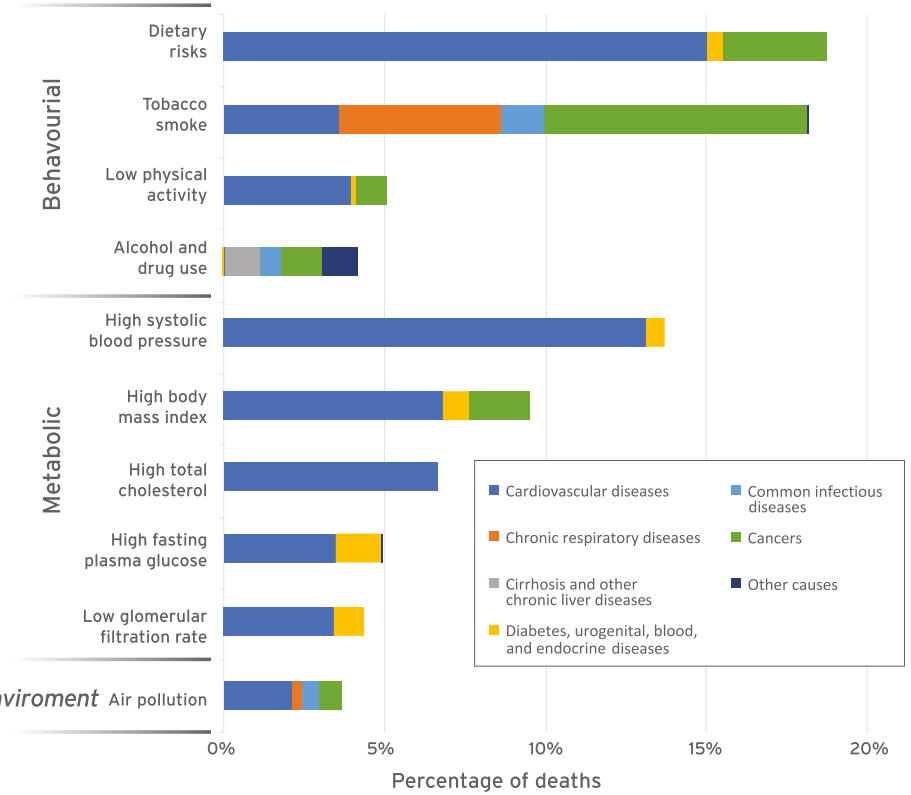
Barriers to housing and services is a composite of the distance of neighbourhoods from services such as primary schools and GP surgeries, which is often higher in rural areas; together with factors indicating reduced access to housing such as overcrowding, homelessness and housing affordability.

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.

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

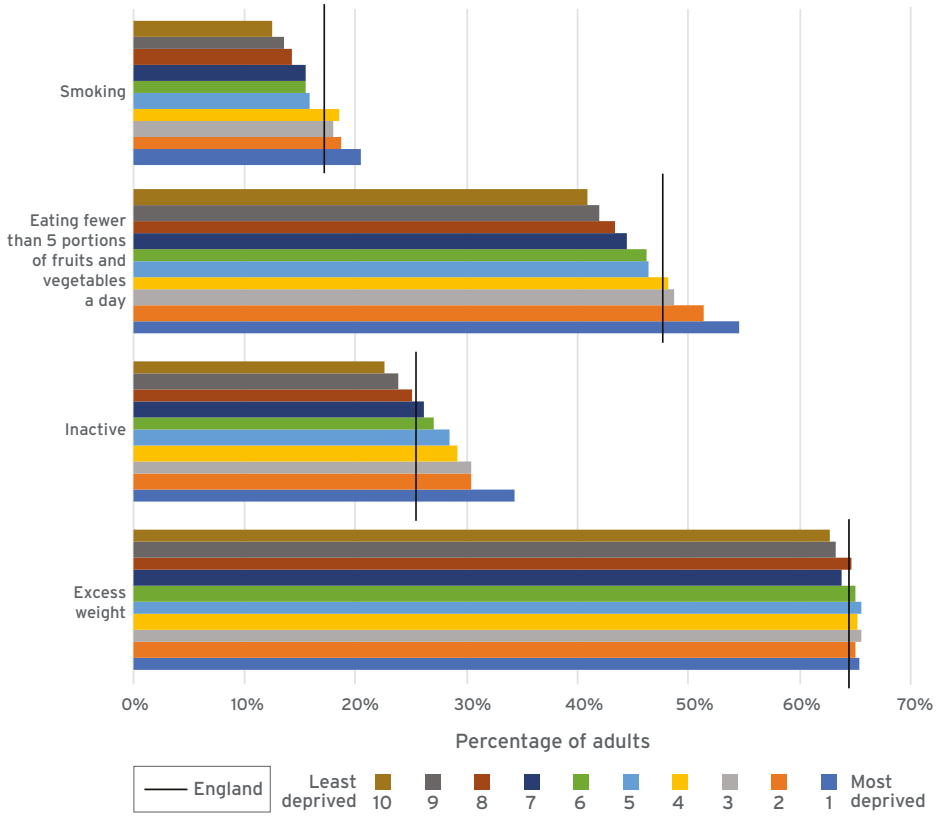



Source: Public Health England 'Health Profile for England' 2017

The chart opposite 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.

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 across upper tier local authorities grouped into deprivation deciles. The most deprived areas have the highest 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 per cent compared with 15.5 per cent nationally.



Figure 14: Percentage of adults who smoked, Cambridgeshire and 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 |
| 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 |

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

Source: Public Health Outcomes Framework

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 | Value | 95% Lower CI | 95% Upper CI |
|---|---|---|---|
| England | 15.5 | 15.3 | 15.7 |
| Boston | 24.9 | 16.9 | 32.9 |
| Fenland | 21.6 | 15.6 | 27.5 |
| Mansfield | 20.9 | 15.1 | 26.7 |
| East Staffordshire | 20.2 | 14.6 | 25.7 |
| South Holland | 19.0 | 13.4 | 24.7 |
| West Lancashire | 16.5 | 11.0 | 21.9 |
| Newark & Sherwood | 16.3 | 11.2 | 21.5 |
| South Kesteven | 16.0 | 11.5 | 20.4 |
| Wyre Forest | 15.6 | 10.3 | 21.0 |
| King's Lynn & West Norfolk | 15.5 | 11.2 | 19.8 |
| Bassetlaw | 14.9 | 9.8 | 19.9 |
| Carlisle | 14.2 | 10.1 | 18.2 |
| Kettering | 13.2 | 7.9 | 18.4 |
| Breckland | 11.9 | 7.7 | 16.2 |
| Amber Valley | 10.7 | 6.3 | 15.1 |
| Erewash | 10.7 | 5.6 | 15.7 |

Compared with England average: Better | Similar | Worse

Source: Public Health Outcomes Framework (August 2017)

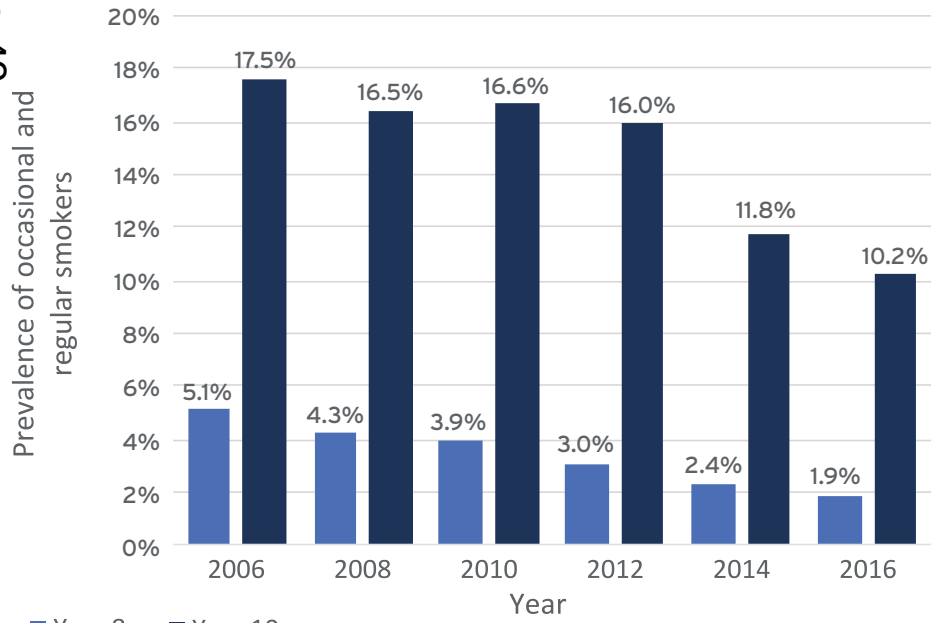
## 2.2 Smoking: children and young people

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

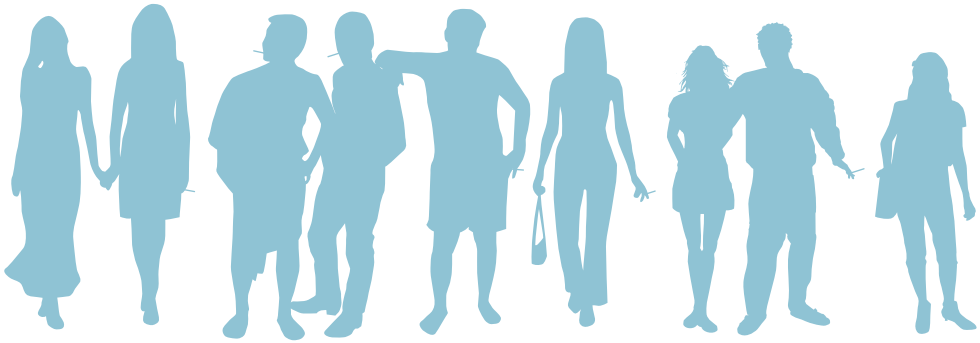
#### Kick Ash – A young person led smoke free programme in Cambridgeshire schools

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 and health eduction (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 per cent of adults, compared with 6.4 per cent 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 |

Statistically significantly lower (better) than England

Statistically similar to England

Statistically significantly higher (worse) than England

Source: Public Health Outcomes Framework

## 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 per cent to 28.2 per cent between 2006/07 and 2015/16, compared with a national increase from 31.7 per cent to 34.2 per cent. In Fenland rates have stayed similar to the national average.

Figure 18: Child excess weight in 10-11 year olds (%)

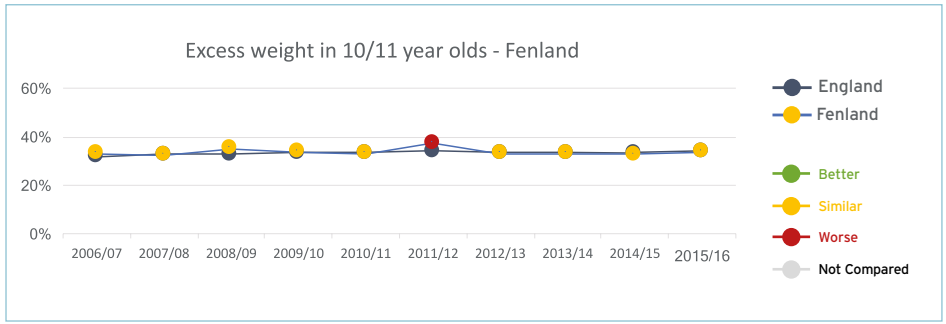

Source: Public Health Outcomes Framework August 2017

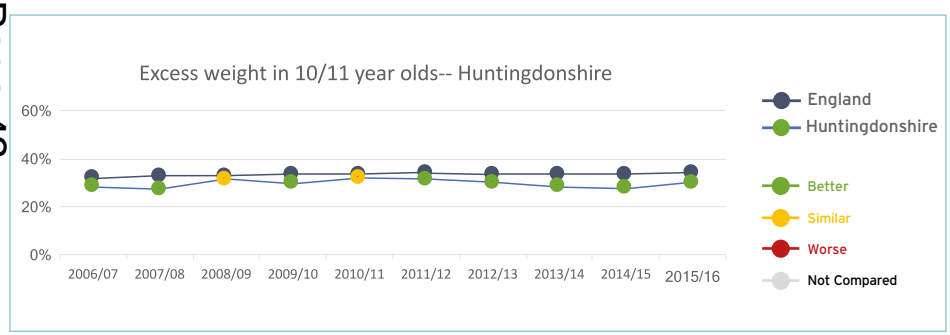
Figure 18 continued overleaf

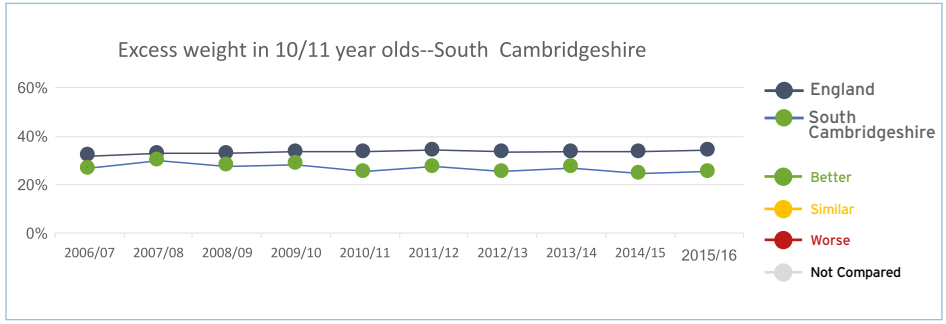
## 2.4 Unhealthy weight and obesity: children and young people

Continued from page 17

Figure 18 (continued): 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

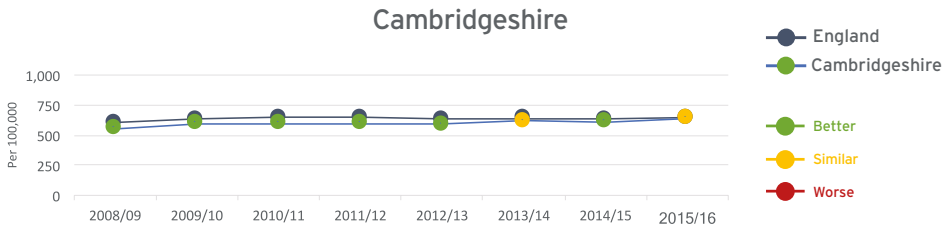


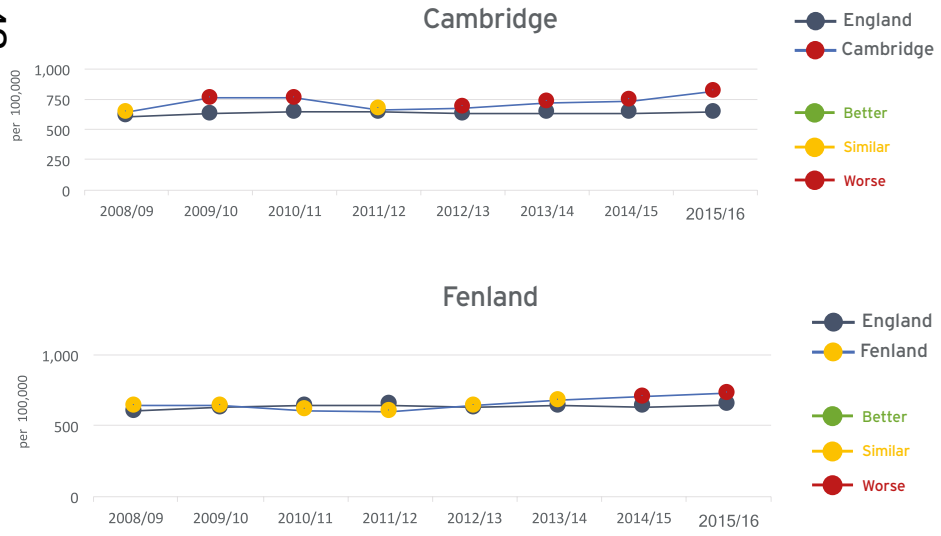

Figure 19 continued on page 19

Source: Public Health Outcomes Framework August 2017

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

### Recent trend

| Year | Cambridgeshire | England | 95% LowerCI | 95% Upper CI |
|---|---|---|---|---|
| 2008/09 | 552.2 | 605.8 | 533.0 | 572.0 |
| 2009/10 | 600.1 | 628.9 | 580.1 | 620.6 |
| 2010/11 | 598.7 | 643.3 | 578.8 | 619.0 |
| 2011/12 | 594.6 | 645.3 | 575.0 | 614.7 |
| 2012/13 | 588.5 | 629.8 | 569.1 | 608.4 |
| 2013/14 | 619.8 | 639.6 | 600.1 | 640.0 |
| 2014/15 | 610.9 | 634.7 | 591.5 | 630.8 |
| 2015/16 | 638.2 | 646.6 | 618.4 | 658.4 |

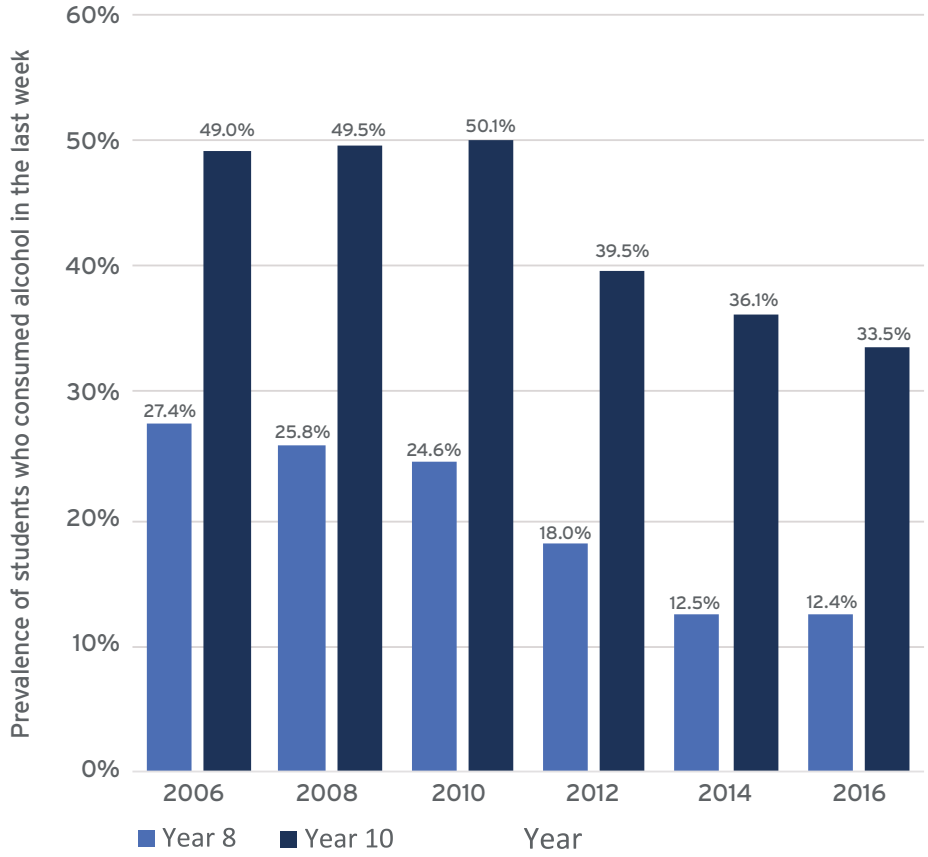



Source: Public Health Outcomes Framework August 2017

## 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.

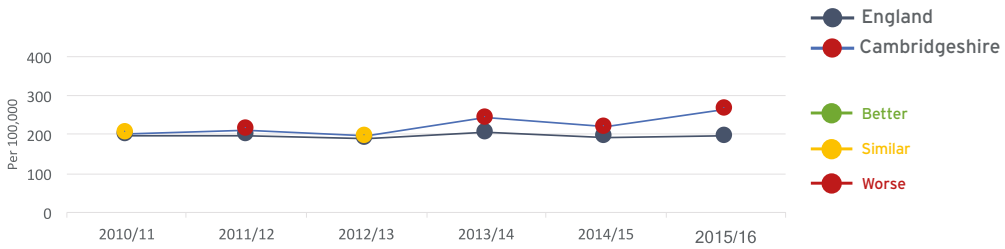
Unlike the suicide rate, emergency hospital admissions for self-harm have been increasing recently, and are now higher than the national average in all Cambridgeshire districts apart from South Cambridgeshire. Some caution is needed in interpreting rising admissions for self-harm as these may be partly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

Figure 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 | 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 | 12.7 |
| Huntingdonshire | * | * | 6.6 | 8.8 | 9.5 | 8.4 | 7.7 | 6.9 | 8 | 7.2 | 9 | 8.9 | 9.2 |
| South Cambridgeshire | 10.2 | 13 | 10.5 | 7.8 | * | 6.9 | 8.7 | 8 | 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 | 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 | 10.1 |

Statistically significantly lower (better) than England | Statistically similar to England | Statistically significantly higher (worse) than England | * Numbers too small to include in the table

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



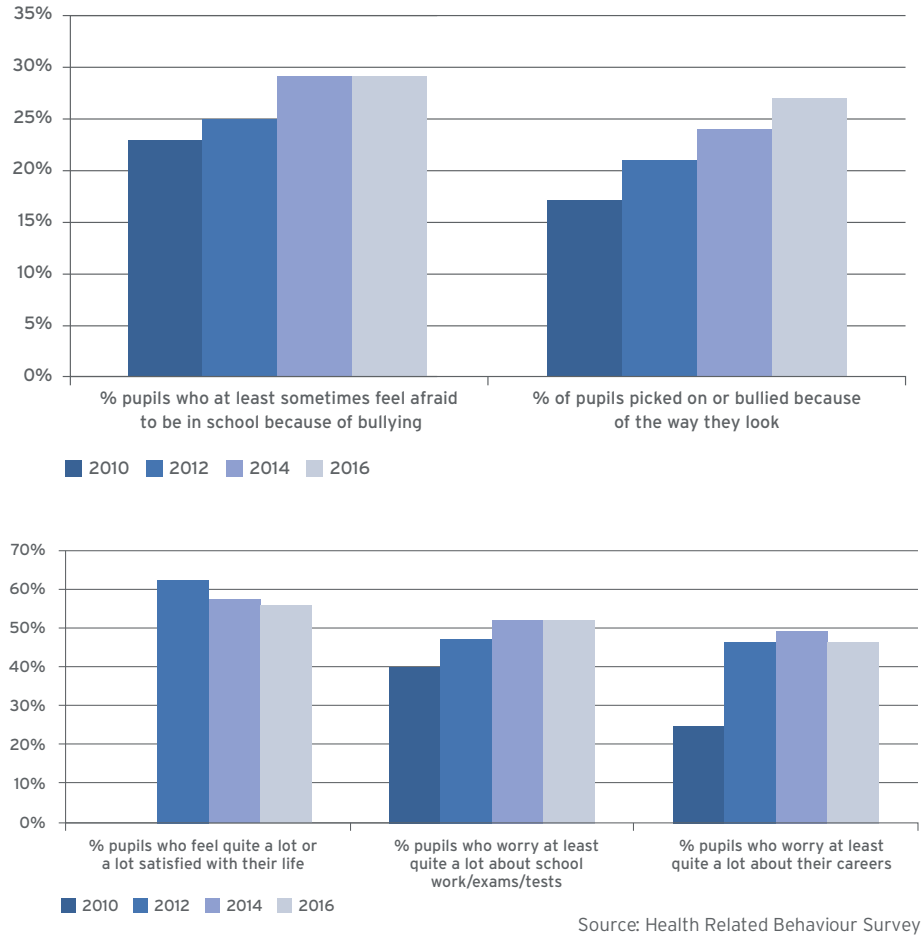

### Recent trend

| Year | Cambridgeshire | England | 95% LowerCI | 95% Upper CI |
|---|---|---|---|---|
| 2010/11 | 202.8 | 197.6 | 191.9 | 214.1 |
| 2011/12 | 212.1 | 197.2 | 201.0 | 223.6 |
| 2012/13 | 196.8 | 189.6 | 186.2 | 207.8 |
| 2013/14 | 242.3 | 205.9 | 230.5 | 254.5 |
| 2014/15 | 220.0 | 193.2 | 208.8 | 231.6 |
| 2015/16 | 264.9 | 196.5 | 252.6 | 277.5 |

## 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.

**Figure 23:** Cambridgeshire schools health related behaviour survey findings 2010-2016



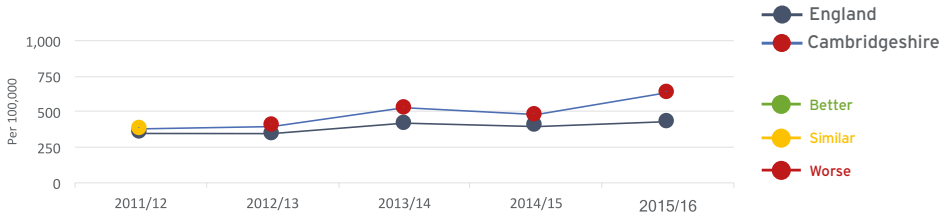

Source: Health Related Behaviour Survey

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 generally 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.

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

| Year | Cambridgeshire | England | 95% LowerCI | 95% Upper CI |
|---|---|---|---|---|
| 2011/12 | 379.7 | 347.4 | 345.7 | 416.1 |
| 2012/13 | 396.2 | 346.3 | 361.3 | 433.6 |
| 2013/14 | 523.4 | 415.8 | 483.0 | 566.2 |
| 2014/15 | 477.6 | 398.8 | 439.0 | 518.6 |
| 2015/16 | 635.2 | 430.5 | 590.9 | 682.0 |

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 per cent reduction in attendance despite the local context of many years of rapidly increasing figures
- A 26 per cent 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 | Camb's 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 |

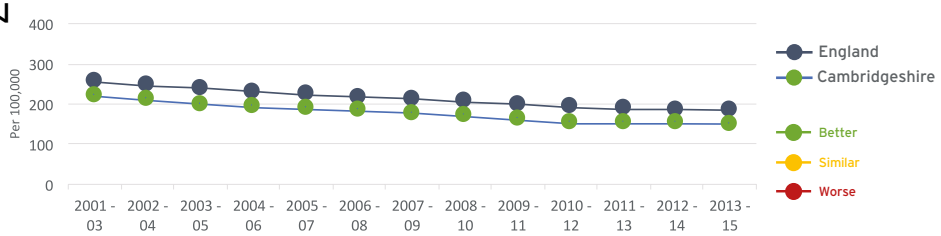
Statistically significantly higher (better) than England
Statistically similar to England
Statistically significantly lower (worse) than England

## 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).



Mortality rate from causes considered preventable (persons) - Cambridgeshire




Mortality rate from causes considered preventable (persons) - Fenland

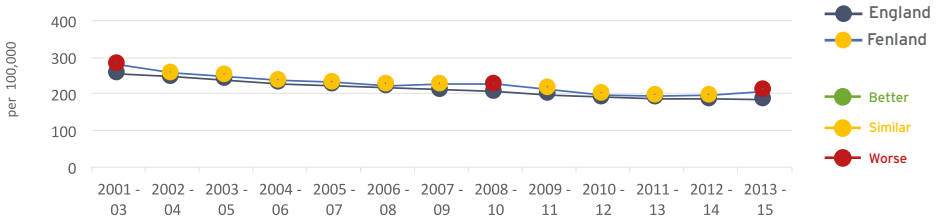
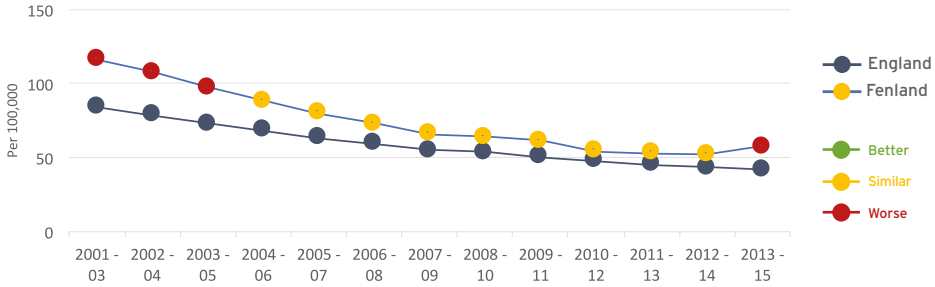



Figure 26: Under 75 mortality rate from cardiovascular diseases considered preventable (persons), directly age-standardised rate per 100,000, Fenland, 2001-03/2013-15




### Recent trend

| Year | Fenland | England | 95% LowerCI | 95% Upper CI |
|---|---|---|---|---|
| 2001 - 03 | 116.3 | 98.6 | 102.6 | 131.2 |
| 2002 - 04 | 107.6 | 91.9 | 94.7 | 121.9 |
| 2003 - 05 | 97.6 | 85.3 | 85.4 | 111.0 |
| 2004 - 06 | 88.3 | 78.9 | 76.8 | 100.9 |
| 2005 - 07 | 80.4 | 73.4 | 69.6 | 92.4 |
| 2006 - 08 | 73.2 | 68.9 | 63.0 | 84.7 |
| 2007 - 09 | 66.1 | 64.3 | 56.5 | 76.9 |
| 2008 - 10 | 64.0 | 60.7 | 54.6 | 74.5 |
| 2009 - 11 | 61.3 | 56.6 | 52.1 | 71.5 |
| 2010 - 12 | 54.5 | 53.5 | 46.0 | 64.2 |
| 2011 - 13 | 52.9 | 50.9 | 44.6 | 62.4 |
| 2012 - 14 | 52.3 | 49.2 | 44.0 | 61.6 |
| 2013 - 15 | 57.3 | 48.1 | 48.8 | 66.9 |

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.

Domains and indicators for the updated Index of Multiple Deprivation IMD (2015)

## Income Deprivation 22.5%

- Adults and children in Income Support families
- Adults and children in income-based Jobseeker's Allowance families
- Adults and children in income-based Employment and Support Allowance families
- Adults and children in Pension Credit (Guarantee) families
- Adults and children in Child Tax Credit and Working Tax credit families not already counted**
- Asylum seekers in England in receipt of subsistence support, accommodation support or both

## Employment Deprivation 22.5%

- Claimants of Jobseeker's Allowance (both contribution-based and income-based), aged 18-59/64
- Claimants of Employment and Support Allowance, aged 18-59/64
- Claimants of Incapacity Benefit, aged 18-59/64
- Claimants of Severe Disablement Allowance, aged 18-59/64
- Claimants of Carer's Allowance, aged 18-59/64++

## Education, Skills and Training Deprivation 13.5%

Children and young people

- Key Stage 2 attainment average points score
- Key Stage 4 attainment average points score
- Secondary school absence
- Staying on in education post 16
- Entry to higher education

Adult skills

- Adults with no or low qualifications aged 25-58/64**
- English language proficiency, aged 25-59/64++

++ New indicators ** Modified indicators

(% illustrates the weight of each domain in the Index of Multiple Deprivation)

# APPENDIX A

## Health Deprivation and Disability 13.5%

- Years of potential life lost
- Comparative illness and disability ratio
- Acute morbidity
- Mood and anxiety disorders

## Crime 9.3%

Recorded crime rates for:

- Burglary
- Violence
- Theft
- Criminal damage

## Barriers to Housing and Services 9.3%

- Road distance to: GP, supermarket or convenience store Primary school, Post Office — Geographical Barriers
- Household overcrowding
- Houses affordability**
- Homelessness

Wider Barriers

## Living Environment Deprivation 9.3%

- Housing in poor condition** — Indoors Living Environment
- Houses without central heating
- Air quality — Outdoors Living Environment
- Road traffic accidents

++ New indicators ** Modified indicators

(% illustrates the weight of each domain in the Index of Multiple Deprivation)