

Annual Report by the Director of Public health 2008-09



Foreword

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Before I started my formal public health career I spent four years running a primary healthcare project in rural Tunisia. You could be forgiven for thinking that the issues I faced over 1,000 miles away on the edge of the Sahara were very different to those in Norfolk, and of course some were, but in many respects the challenges for Norfolk are exactly the same.

Unlike Tunisia, the overall indicators of health show that health in Norfolk is very good. Not only is health in Norfolk good but it continues to improve with falling rates of cardiovascular disease and cancer (the major causes of death in Norfolk). Why then should the major challenges be the same in such different places? The answer is simple; it lies in the inequality that exists in each place.

Both Tunisia and Norfolk are places of contrast. In both places, within the space of a short walk or bike ride one can go from places of great wealth and privilege to places of real poverty. This inequality, which is manifest in terms of inequalities in housing, educational attainment, employment status and many other factors, also gives rise to inequality in health.

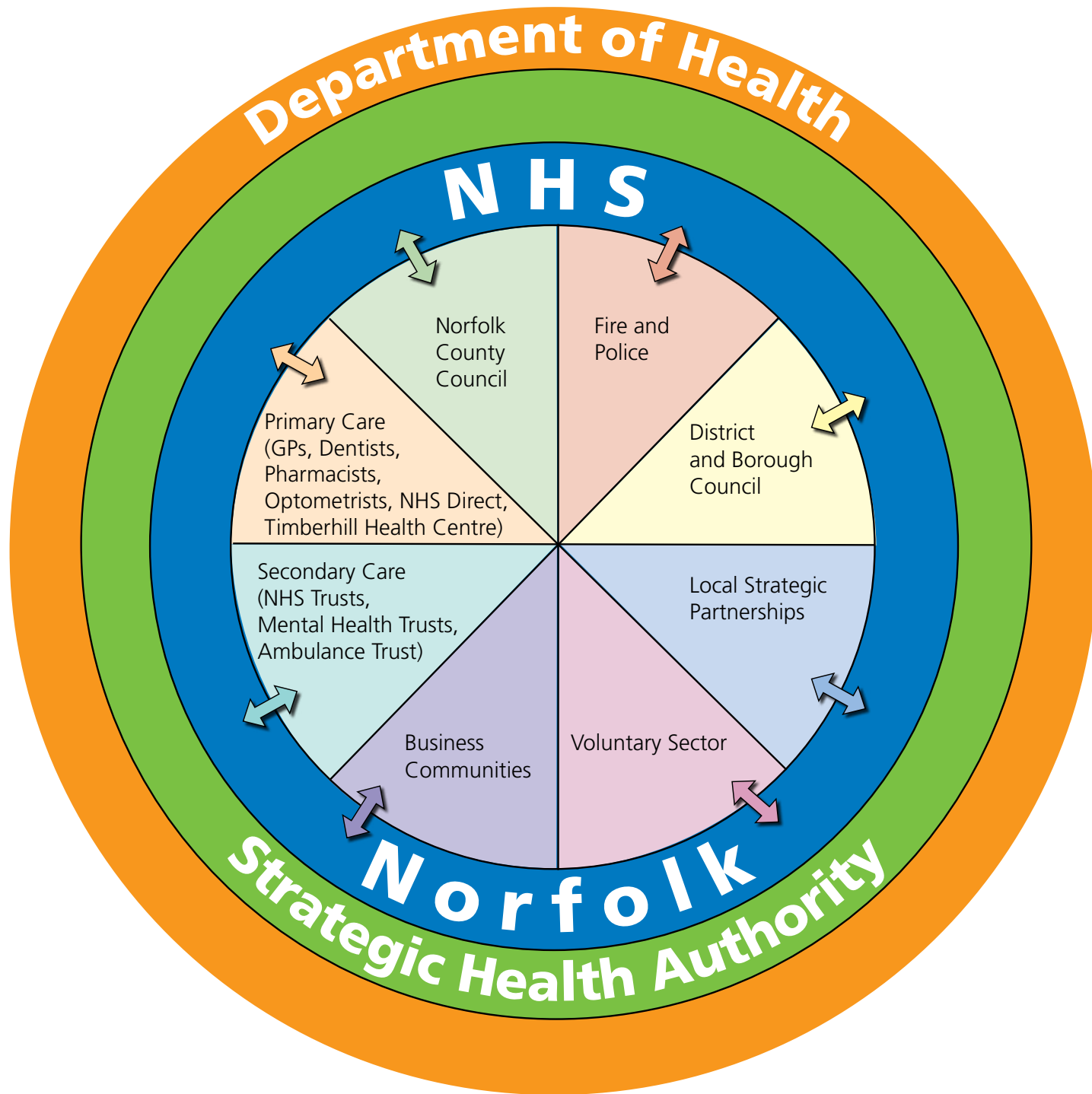
Inequalities in health can be measured in all sorts of ways but are especially striking in some of the overall measures such as life expectancy. Life expectancy (2007) in Norfolk was about 5 years greater than in Tunisia, perhaps not a surprise, however, in NHS Norfolk the gap between the area with the highest life expectancy and the area with the lowest was 8.1 years. Whilst for men in Norfolk there is more than 3 years difference in life expectancy between those in the least deprived 20% of the population and those in the most deprived 20%.

If the inequality gap isn't bad enough there is clear evidence that for some disease areas notably cardiovascular disease, which is the biggest cause of death in Norfolk, the inequality gap is growing. Thus, whilst for some life expectancy continues to improve, for others in Norfolk, the rate of improvement is much slower.

Although this report touches on all aspects of public health within NHS Norfolk, inequalities in health are the thread that runs through it. The inequality gap may be news, but the good is that it can and is being addressed in a number of ways. Bold and Ambitious is NHS Norfolk's Strategic Plan and this outlines NHS Norfolk's approaches to tackling inequalities and some of those approaches are detailed in this report.

Whilst health services can and do contribute to both increasing and reducing inequalities, the nature of the problem means that ultimately progress can only be made by working across a wide range of organisations. There is a wealth of evidence that proves the many links between such factors as poor educational attainment and poor health outcomes, unemployment, poor housing and so on. Tackling inequalities therefore has to be everyone's business. This is recognised and is the reason that we are encouraged and expected to work 'in partnership' with others.

NHS Norfolk is only part of a system as Norfolk County is covered by two Primary Care Trusts (NHS Norfolk covers the six district areas of North, South, West Norfolk, Breckland, Broadland and Norwich, and NHS Great Yarmouth and Waveney covers the Great Yarmouth area). Everything comes together at a County level under the Norfolk Local Area Agreement (LAA) and the County Strategic Partnership. Both NHS Norfolk and NHS Great Yarmouth and Waveney are partners in agreeing the content of the Local Area Agreement and in sitting on the County Strategic Partnership. This relationship has been developed over the last year with the establishment of the Norfolk Health and Wellbeing Partnership. This new partnership sits within the County Strategic Partnership alongside a range of groups including the Children and Young People's Partnership. The Health and Wellbeing Partnership is still in its infancy but it provides a clear foundation for the development of partnership working which is focussed on reducing inequalities across Norfolk.



INDEX

	Page No
Introduction	1
The Joint Strategic Needs Assessment (JSNA)	2
What does the JSNA tell us?	4
Demography of Norfolk	
Population	4
Population Projections	5
Births and deaths	5
Ethnicity	5
Migration	6
General Health Features of Norfolk’s Population	7
Lifestyles of people in Norfolk	7
The Local Index of Child Well-Being	8
New Homes	9
Levels of Deprivation in Norfolk	9
NHS Norfolk CVD Health Equity Audit	11
Key Findings	11
Equity Audit Conclusions	13
Health Inequalities	13
Tackling Health Inequalities	13
Direct Action on Tackling Health Inequalities	15
Health Checks	15
Lifestyle Support	15
Smoking	15
Healthy Diet	18
Joy of Food	18
Physical Activity	19
Alcohol misuse	19
Teenage Pregnancy	19
Mental Health	20
Health Protection	21
Pandemic influenza	21
Vaccination	22
Education	22
Public Health Awareness Online Training Programme	23
Research and Development	24
Conclusions	24

Introduction

Welcome to the Annual Report of the Director of Public Health for NHS Norfolk. This report focuses on the local evidence and the work that is going on across public health to address inequalities.

Unlike traditional public health reports it is not the definitive source of data on health in Norfolk. That exists in the guise of Norfolk's Joint Strategic Needs Assessment (JSNA) which can be found on line at www.norfolkinsight.org.uk / click on the JSNA button (top left corner of front page).

This report is therefore designed to compliment the JSNA and to highlight its potential as a key strategic tool for the NHS, Local Strategic Partnerships and thematic partnerships as they work together to tackle health inequality.

At the beginning of the report we provide an introduction to the JSNA which, although a relatively new concept, has already shown its potential to harness the power of data, information and intelligence to influence health and well-being.

The report continues by outlining some of the initiatives which have been used to construct the JSNA, for instance a Health Equity Audit on Cardio Vascular Disease and concludes by highlighting the path that the JSNA will take in the coming years to ensure a strategic approach in reducing health inequalities.

The Joint Strategic Needs Assessment (JSNA)

The Joint Strategic Needs Assessment (JSNA) is a comprehensive review of the health and well being of the people of Norfolk. It works by pulling together information from a wide variety of sources to help understand the health issues of the population,

The key word is 'Joint'

- A shared information resource and data warehouse for lead agencies in health and social care organisations
- A way of bringing together expert teams to pool their knowledge and skills
- A means of sharing strategic priorities by providing a common evidence base
- A shared way of understanding the impact of initiatives and evaluating the outcomes of change programmes on the population

The JSNA helps us understand;

- What the needs of the population are
- Where those needs are greatest
- Where there are gaps in services.
- Those groups and communities in Norfolk who do not experience equivalent positive health and wellbeing, or who do not have the same access to services as others where inequalities, or 'unfair differences' are occurring.

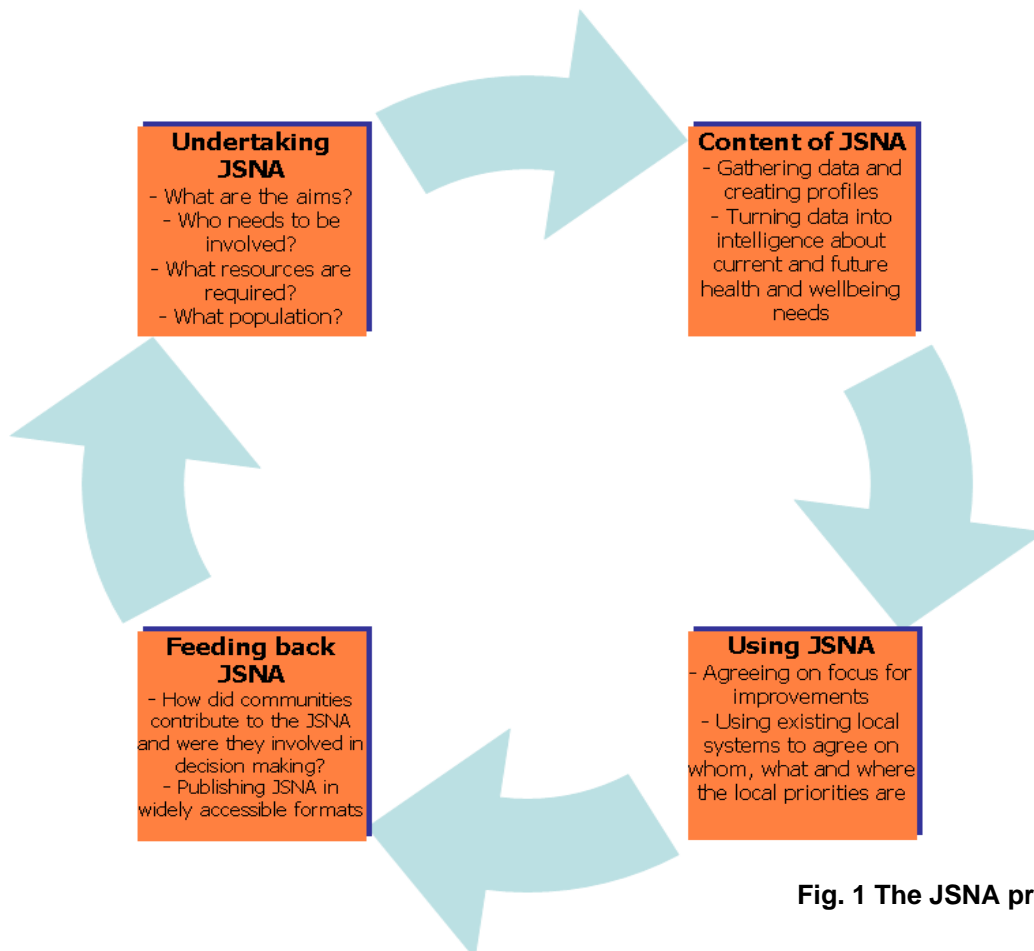


Fig. 1 The JSNA process

The JSNA 'core data set' includes

- the population of the county
- information on deprivation
- The prevalence of key diseases and profiles of ill health
- lifestyle behaviours
- life expectancy
- Detail on services available

The JSNA also includes education, housing, crime and antisocial behaviour and employment which play an important part in our overall health and well-being



Whitehead and Dahlgren's Model of Health (1991)

In the future the JSNA will become the key 'evidence base' for issues relating to Health and Wellbeing for Norfolk, and the 'first stop' for anyone looking for health data and intelligence.

What does the JSNA tell us?

Demography of Norfolk

Population

Norfolk is a largely rural county. It has sparsely populated rural areas with small, Villages and market towns. Around 50% of the population lives in rural areas. NHS Norfolk serves the majority of the county, with only Great Yarmouth being served by NHS Great Yarmouth and Waveney. NHS Norfolk's population was an estimated 746,700 in mid-2007, an increase of 39,000 since mid-2001 (5.5 per cent), a little above the East of England average of 4.8 per cent. Population density in 2007 was 1.44 people per hectare, relatively low when compared with the Region's 2.96 and the England figure of 3.92

In the twelve months to mid-2007 the population rose by around 7,700 and:

- in terms of broad age groups, numbers of children increased marginally, working age adults increased by over 5% and older people (aged 65+) increased by over 2%;
- In terms of five-year age groups the most significant change was the rising number of 60-64 year olds in conjunction with the fall in 55-59 year olds, largely due to effects of the post-war baby boom.

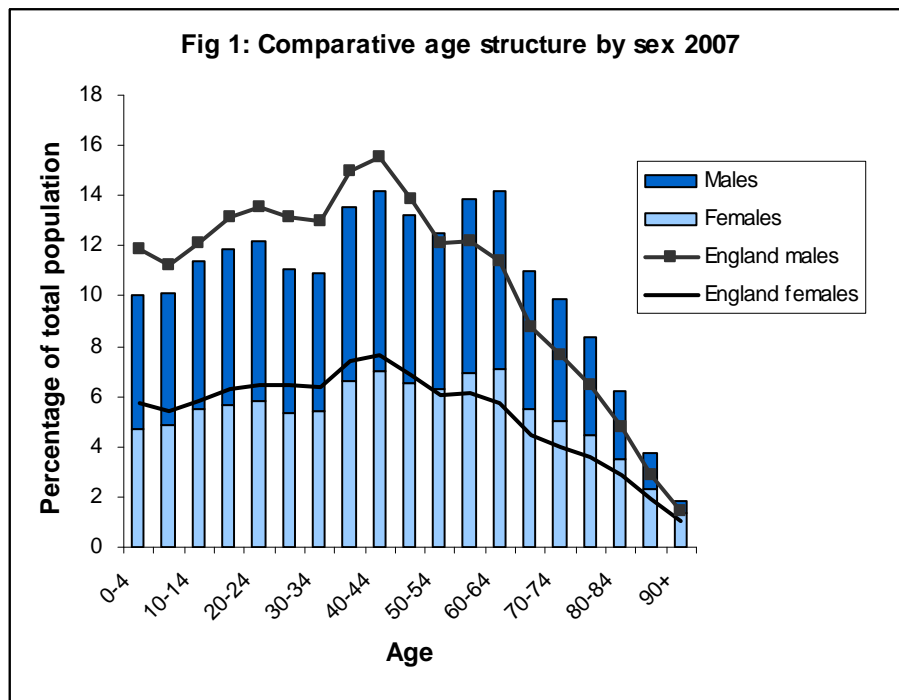
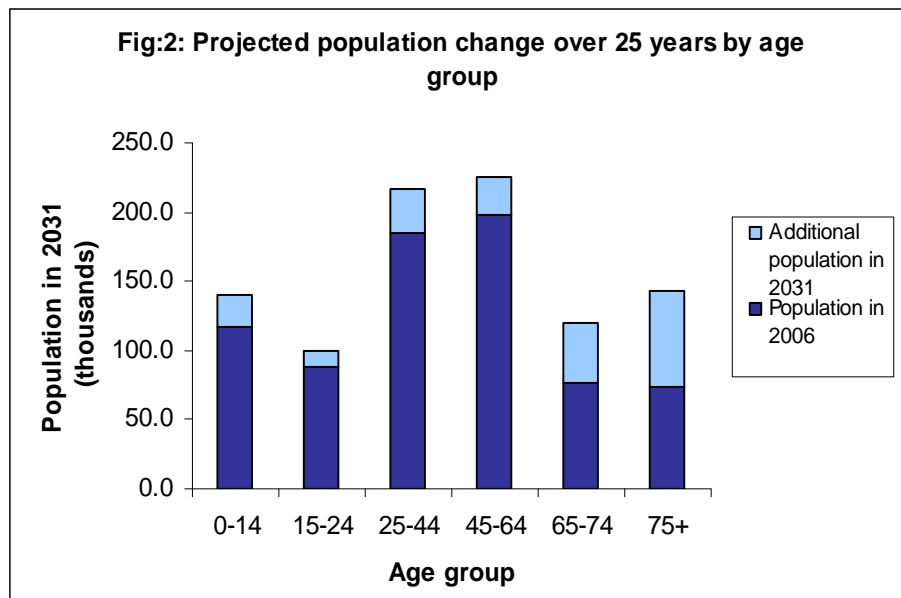


Figure 2. shows that compared with England, NHS Norfolk has maintained a relatively older age profile, with higher proportions of both men and women aged 50-54 and over and lower proportions in younger age groups. Around 21 per cent of NHS Norfolk's population in 2007 was aged 65 and over, as against 16 per cent in England, and ten per cent aged 75 and over compared with 7.8 per cent nationally. There are currently significantly high numbers of 60-64 and 55-59 year olds living in NHS Norfolk

Population projections

The ONS 2006-based population projections, which are trend-based, suggest that NHS Norfolk's population could increase from an estimated 738,800 in mid-2006 to 864,600 in 2021 and 944,800 in 2031.

Figure 3. Illustrates the relative scale of change over the twenty-five years to 2031: some increase could be expected across all broad age groups, though with very little change in the young adults - people aged 15-24. The most significant numerical and proportional increase would be in those aged 75 and over, but there would also be significant increases in ages 65-74. The largest group numerically would remain those aged 45-64.



These changes will have a significant impact on local demand for health and social services as the prevalence of conditions such as dementia and disabling life events such as heart attack and stroke increase with age. For example, about one in four people aged over 85 develop dementia and this age group is projected to increase by around 20,600 over the next 20 years (2006 to 2026). The total number of older people with dementia in Norfolk is projected to increase from around 14,000 now to over 20,000 in the same period.

Births and deaths

In 2007 there were around 7,600 live births to mothers resident in NHS Norfolk and just fewer than 7,900 deaths of NHS Norfolk residents. The gap has widened considerably up to 2002 and since then, births have been on a strong upward trend so that the difference is now very small.

Ethnicity

The 2001 Census recorded a minority ethnic population of 27,400 (3.9 per cent of the total). By mid-2007 this is estimated to have more than doubled to 57,700 (7.7 per cent). Similarly, numbers in ethnic groups other than White, rose from 1.5 per cent of the population in 2001 to around 4 per cent in 2007.

Table 1.

In thousands	All people	White*	White British	Other than White**	Minority Ethnic***
2001 Census					
Mid-2007 estimate	746.7	716.6	689.1	30.2	57.7
Percentage of population 2007	100.0	96.0	92.3	4.0	7.7

*White British, White Irish, White Other White

**All persons other than White

***All persons other than White British

Migration

In the year to mid-2008, based on GP patient re-registrations the county of Norfolk gained around 25,100 migrants from elsewhere in the UK and lost around 20,700, giving a net gain of around 4,400; with net losses in the 20-24 and 25-29 year olds and net gains in all other age groups. People in the older age groups were a relatively small proportion of migrants but accounted for a disproportionately large share of the net migration gains. To illustrate this, migrants aged 50 and over accounted for around only 23 per cent of in-migrants and 18 per cent of out-migrants, but 50 per cent of the area's net migration increase. There was generally a net loss of young people aged 16-24 but net gains in other age groups.

In terms of international migration, however, over the same period NHS Norfolk gained around 7,750 people and lost around 2,930, giving a net gain of around 4,800. This was higher than the previous twelve months, when the net gain was 2,600. Though the main impact of the numbers was in Norwich (a net gain of 2,800), over the last three years all local authority Districts in the area have recorded net gains from international in-migration.

The area has received significant international migration from the EU, originally from Portugal and latterly from Poland, Lithuania and Latvia. There is in addition a largely unquantifiable element of international migration attributable to short-term migrants, here primarily to seek work and highly mobile, but unlikely to be counted as part of the resident population.

General Health Features of Norfolk's Population

A general assessment of the health of people in Norfolk is produced annually by the Department of Health and this year's analysis gave a number of highlights

- The health of people in Norfolk is generally better than the England average. Many indicators, including life expectancy, deaths due to smoking and early deaths caused by cancer, heart disease and stroke, are all better than the England average.
- There are inequalities in Norfolk by location, gender, deprivation and ethnicity. For example, men in South Norfolk can expect to live 3 years longer than men in Great Yarmouth, the most deprived local authority area in Norfolk.
- Over the past ten years rates of deaths from all causes, early deaths from cancer and early deaths from heart disease and stroke have improved and remain better than the national average
- One in 11 children in Reception in Norfolk is obese, a rate similar to the England average. Rates of smoking in pregnancy, breast feeding initiation and physical activity in schools are all better than average.
- The rate of road injuries and deaths is higher than the national average, resulting in 510 casualties per year in Norfolk (county)
- The key priority for Norfolk is the reduction of inequalities gaps across the county, particularly the inequality in early deaths from heart disease and stroke.

Lifestyles of people in Norfolk

The lifestyles of people living within NHS Norfolk tend to be similar or better than the East of England average.

The Eastern Region Public Health Observatory (ERPHO) carried out a lifestyle survey¹ within Norfolk at the end of 2008 and results showed that although we consider the county to be a healthy place to live, there are still significant inequalities in several lifestyle behaviours. Sometimes these inequalities are not always found in the most deprived neighbourhoods: overweight males and hazardous drinking by men are both seen significantly more in the least deprived areas.

The survey demonstrated that around 1 in 4 people living in the most deprived areas are likely to smoke, compared to 1 in 6 in non-deprived areas. 63% of smokers would like to give up smoking but often haven't made any attempt to do so in the last 12 months. There is no difference in the proportion of smokers who have attempted to stop smoking between deprived and non-deprived areas.

More men than women are obese in the deprived areas. Harmful drinking (36+ units per week) is seen more in women living in deprived areas but 18% of men participate in hazardous drinking (22-50 units per week) if they come from a non-deprived area.

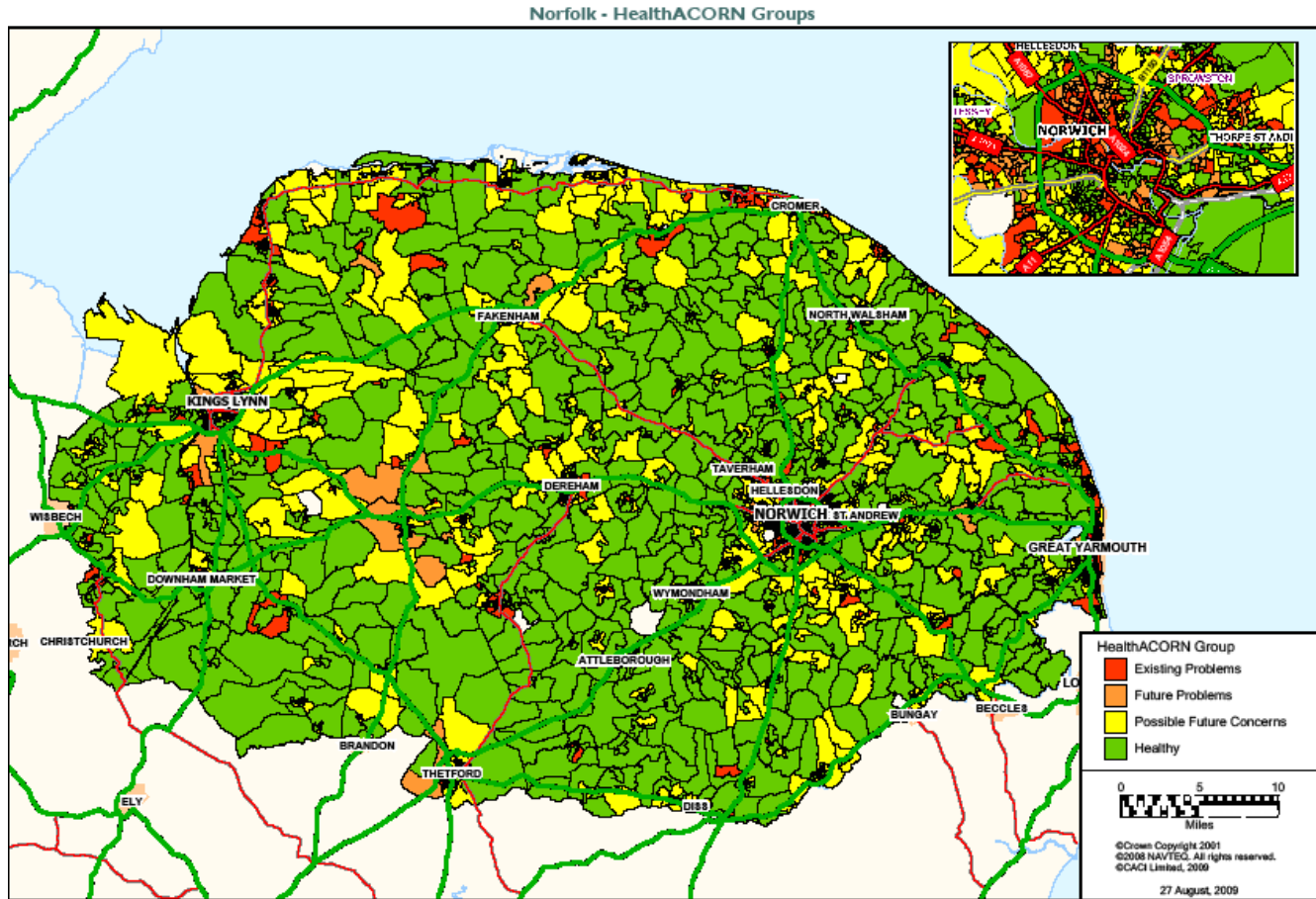
13% of our adult population take part in at least four healthy behaviours (non-smoker, moderate drinker, recommended exercise and 5-a-day portions of fruit and vegetables) each

¹ ERPHO's lifestyle survey questioned over 26,000 people in the Eastern region, only 1259 came under NHS Norfolk (502 from 20% most deprived MSOAs and 757 from the 80% least deprived MSOAs)

week, which is better than the average but work is being done to increase this proportion as the number is still low.

Map 1.

The map below demonstrates how the majority of NHS Norfolk is generally a healthy place to live. However, it does highlight the areas of most concern to us, those that have 'existing problems' and those with 'future problems.' These areas tend to correspond to our urban neighbourhoods but our rural pockets also demonstrate the same problems.



The Local Index of Child Well-Being

Child well-being is generally represented by how children are doing in a number of different elements of their life, including material well-being, health, education, crime, housing, environment and safety. The new Index of Child Well-being shows that both Norwich and Kings Lynn and West Norfolk emerge as areas where children in Norfolk face most difficulties in their well-being and development, which obviously has an impact on their future health and well-being, but the figures show that there are challenges across the County.

Table 2.

Index of Child Well-Being 2009 by district for NHS Norfolk

Area	CWI average score	CWI rank of average scores	
Breckland	124.05	170	Out of 354 districts in England
Broadland	76.68	47	Out of 354 districts in England
<i>Great Yarmouth</i>	<i>191.74</i>	<i>289</i>	
King's Lynn and West Norfolk	161.58	238	Out of 354 districts in England
North Norfolk	127.87	179	Out of 354 districts in England
Norwich	236.45	329	Out of 354 districts in England
South Norfolk	83.22	67	Out of 354 districts in England
Norfolk	141.54	58	Out of 149 counties 9 in England

Educational attainment continues to improve across the county, but has been traditionally below national and regional averages. The basic literacy and numeracy skills in Norfolk are below the UK and East of England region. 38% of Norfolk people of working age have NVQ Level 3 and above compared with 42%, regionally. 15% of the economically active people in Norfolk have no qualifications.

New Homes

An additional challenge for public services in Norfolk, is the new growth agenda – 78,000 new homes and 55,000 new jobs are expected to come to Norfolk by 2021, under the Regional Spatial Strategy, with much of this growth being concentrated in the Greater Norwich area. There is currently a shortage of affordable accommodation in the County, with the cost of a Norfolk house compared with the average salary up by 50% between 2003 and 2006, and the 'growth agenda' will further impact on availability of good quality affordable housing.

Levels of Deprivation in Norfolk

Deprivation can take many forms, but people can be said to be deprived if they lack a quality of life (or elements of) which is customary or the normal for the society to which they belong. Although there are areas of affluence, Norfolk has high levels of deprivation in both urban and rural areas that are characterised by:

- Low level skills attainment and aspirations
- High levels of Job Seekers Allowance and Invalidity Benefit claimants

- Lone parent households
- Income deprivation affecting children
- Low level of business start-ups
- Lack of employment opportunities through economic stagnation and challenging accessibility

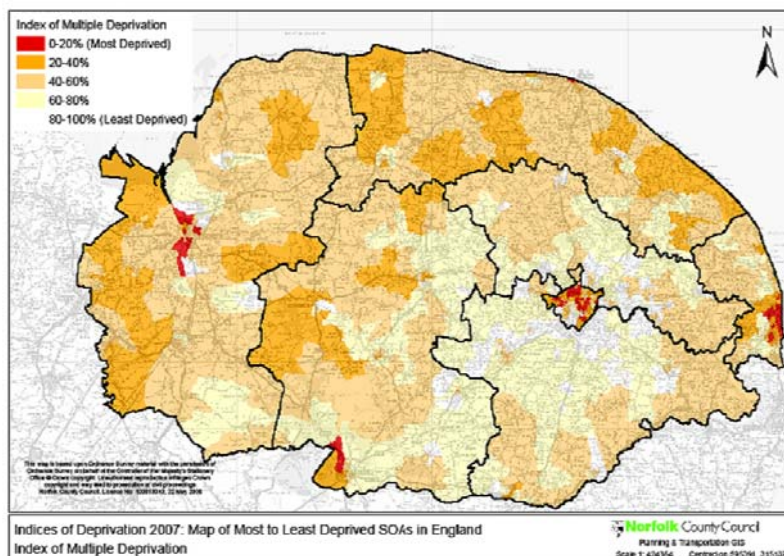
The Index of Multiple Deprivation (IMD) is the normal way of measuring deprivation and is produced by the Department of Communities and Local Government.

The scores and ranks of Norfolk (district level) can be observed in table 3.

Table 3 : IMD score and rank at district level

District	Average IMD score	Rank of average score
Breckland	15.30	213
Broadland	10.09	301
King's Lynn and West Norfolk	20.58	137
North Norfolk	18.06	160
Norwich	27.84	62
South Norfolk	10.84	286
Norfolk	18.55	97 (out of 149)

Overall levels of deprivation in Norfolk



NHS Norfolk CVD Health Equity Audit

Cardiovascular disease causes heart attacks and strokes and is the leading killer in many countries; it is a major public health issue. The World Health Organization identifies Cardiovascular Disease (CVD) to be the cause of nearly a third of deaths worldwide.

It is estimated in Norfolk that for those aged under 75 years, around 22% for males and 13% for females will die prematurely from Coronary Heart Disease (CHD) or Stroke. These rates, although disturbing, are on average less than those for the rest of the UK, however for both men and women in the most deprived areas, CHD rates of death before aged 75 are double those from the least deprived areas.

This 'Inequity' prompted NHS Norfolk to prioritise carrying out a 'Health Equity Audit' (HEA) of Cardio Vascular Disease (CVD) as part of its annual audit cycle. The audit was completed in July 2009 and provides a unique 'snapshot' of health inequalities

A Health Equity Audit (HEA) is a method by which local partner organisations can systematically review inequalities to show:

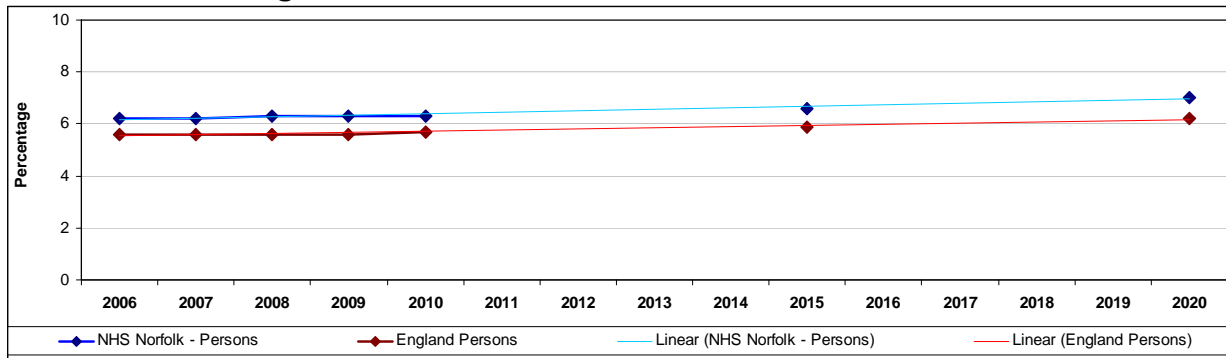
1. How fairly services or other resources are distributed in relation to the health needs of different groups and areas.
2. Priority actions required to provide services relative to need.
3. The overall aim is not to distribute resources equally but, rather, relative to health need

The audit examines the use of healthcare services by all NHS Norfolk inhabitants between April 2006 and March 2008 (two financial years), and the mortality rates for two years 2006 and 2007.

Key Findings

The key findings of the HEA show that, as a whole, NHS Norfolk has a higher prevalence of both Stroke and Coronary Heart Disease when compared to the region (East of England) and England as a whole. It also shows that the rate of all premature deaths for men and women in NHS Norfolk increases with the measure of deprivation they experience in their lives

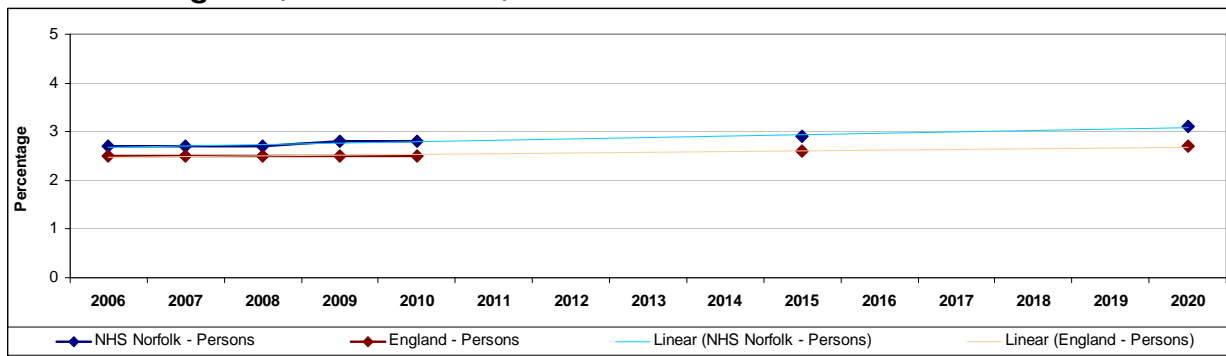
Figure 1: Estimated prevalence of CHD, comparison of persons aged over 16 years from NHS and England, 2006 – 2020 (APHO Model)



We also find evidence that people who have or are at risk of CVD are not always accessing the services available to them. The estimated number of people that potentially had CHD in 2008 was 39,278, whilst the actual number of people who were registered as having the condition with their GP was 29,381. This shows a deficit of approximately 26% of patients (9,897 individuals) in NHS Norfolk with a CHD related condition not being actively diagnosed or treated.

A similar comparison between registered and estimated cases of stroke and Transient Ischaemic Attacks (TIA) is 16% (2,694 individuals).

Figure 2: Estimated prevalence of Stroke and TIA persons aged over 16 years from NHS and England, 2006 – 2020, APHO



The prevalence of CHD over time for NHS Norfolk is predicted to increase between 2006 and 2020 for males (from 7.7% in 2009 to 8.7% in 2020), and for females (from 4.9% in 2009 to 5.4% in 2020) for those aged 16 years and above.

Men and women in NHS Norfolk are therefore projected to have a higher prevalence of CHD than counterparts in England between 2006 and 2020

Stroke and TIA prevalence for men and women in NHS Norfolk is higher than that for counterparts in England and is predicted to increase between 2006 – 2020 for men (from 2.8% in 2009 to 3.2% in 2020) and for women (from 2.7% in 2009 to 2.9% in 2020)

Equity Audit Conclusions

The CVD Equity Audit has given us the opportunity to investigate the links between incidence and mortality from Cardio Vascular Disease and deprivation. The results have confirmed the link, and raised further questions about the depth and patterns of these inequalities. We have been able to show some of the differences by gender and age, but have not yet fully investigated them by other determinants of inequality, such as ethnicity.

We need to further investigate the patterns of diagnosis and referral, by looking in more detail at other data sources, and comparing these with some key lifestyle characteristics to improve our understanding. Additional intelligence will assist us in targeting the necessary actions to address these findings. The findings do, however, reinforce the agreed focus of NHS Norfolk in the next five years, to reduce Health Inequalities and their outcomes to improve the health of the people of Norfolk.

Health Inequalities

The Department of Health has appointed Professor Sir Michael Marmot to chair an independent review to establish the most effective strategies for reducing health inequalities in the UK from 2010 onwards. The Review, due to be completed by the end of the year, follows on from the publication of a Report from global Commission on Social Determinants of Health (CSDH) – called 'Closing the Gap in a Generation'.

The review will advise on health inequality targets and explore the best way that national and local government partners can work to reduce the health inequalities of their population. The initial findings support the view that we need to tackle the social determinants of health, in particular employment and poverty, educational attainment and skills, neighbourhoods and housing issues, before much progress on reducing health inequalities can be made.

Tackling Health Inequalities

The NHS Norfolk Strategic Plan 'Bold & Ambitious' provides a clear framework for tackling and reducing health inequalities within the three focus areas:

- Lifestyle and Prevention
- Personalisation, Independence and choice
- Right Care, Right Time, Right Place

Using this framework and the information provided through the JSNA, we now understand that the PCT needs to commission specifically to reduce inequalities in health outcomes, ensuring that the services provided by the NHS are focussed upon reducing the gap.

We must also make sure that the PCT looks beyond geography to communities of need, where we know that individuals have poorer health outcomes. These groups would include, for example, looked after children, migrant workers, people with learning difficulties and those in the criminal justice system.

This section of the report looks in more detail at the strategy for reducing the inequality gap. It is clear that improving the health of the most deprived individuals and communities is a complex task and that a range of partners need to be engaged in order to tackle all of the

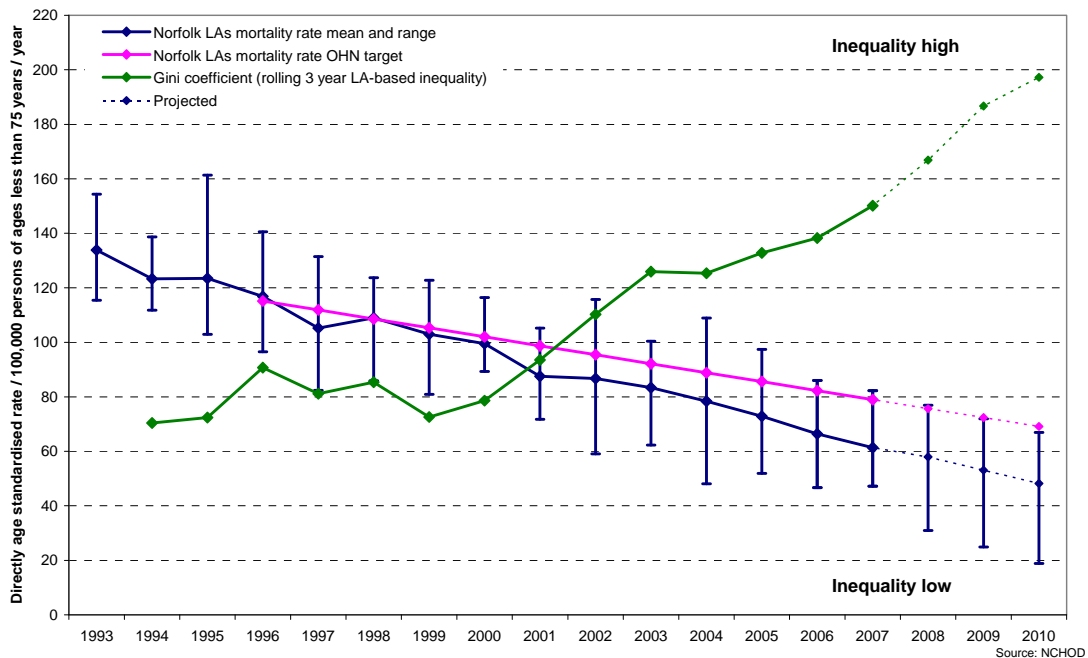
wider determinants which contribute to Norfolk's inequality gap. To assist in this, NHS Norfolk has put Public Health support into working with local authorities and with GP groups to provide information from the JSNA about local health needs and issues and to make links between partners.

Realistically there will always be inequalities in health and life experience affected by factors beyond the control or influence of the NHS. However, in our commissioning of services we are working to ensure that existing inequalities are minimised and that inequalities are not increased by new services. NHS Norfolk has therefore agreed some key factors which influence inequalities should be considered in commissioning services.

- Equity - In order to narrow the inequalities gap services need to be targeted to the people with the most need and in a way which takes account of special needs and encourages uptake. The aim should be to achieve equality in outcomes, which requires an acceptance that this does not necessarily result from an equality of input.
- Access - In order for people to benefit from services they must obviously be able to access them. This means thinking broadly about access in a range of contexts. For example in terms of transport and cost, in terms of people's ability to read and understand information given and in terms of the other things which are happening in their lives.
- Empowerment - The thrust of the NHS over recent years has been to support and encourage individuals to take responsibility for their own health and it is generally accepted that the feeling of not being in control is a major cause of stress which is likely to be detrimental to both community and individual health and wellbeing. There is a general need to find more imaginative and productive ways of working with, empowering and involving hard to reach groups.
- The Healthy Default - People may be prevented from exercising the power of choice for a number of reasons including finance, understanding, culture, being in possession of information or having the capacity and confidence to act. In order to ensure that inequalities do not grow between those who can choose easily and those who cannot, the default option should be wherever possible the one least likely to widen the inequalities gap.

The biggest contributor to the inequality gap is cardiovascular disease – heart disease and stroke. This is no great surprise as the development of cardiovascular disease very much depends on a range of lifestyle factors (smoking, physical activity diet and obesity).

The graph below shows how statistical methods can be used to calculate the increase in inequality around premature death from heart disease and stroke. The graph shows that although the rate of early death is better than the national target, the inequality measure, the difference between the experience of the most and the least deprived is increasing rapidly.



Direct Action on Tackling Health Inequalities

Health Checks

Like other PCTs throughout the country, NHS Norfolk is introducing the NHS Health Check in 2009-10. The Health Check is a national screening programme to detect individuals in the 40-74 year old age range who are at risk of developing cardiovascular disease (CVD). In the NHS Norfolk area there are approximately 319,000 people in the 40-74 age band. The PCT Strategy contains a commitment to reach 80% of the eligible population. We are therefore in the process of developing a screening programme and supporting lifestyle services that will serve in the region of 40,000 people per year.

People participating in the checks will be given an assessment of the level of their own risk of developing CVD within the next 10 years and will be offered appropriate advice and interventions. For those with the least risk, this may be a simple discussion around healthy lifestyles, for moderate risk, recommendations may include brief interventions around smoking or physical activity and referral to lifestyle support services. Those most at risk may require a more clinical approach such as statin prescription or referral to a specialist service.

Lifestyle Support

Alongside the health checks programme it is obviously vital to be able to offer support to those who need or wish to make changes to improve their health.

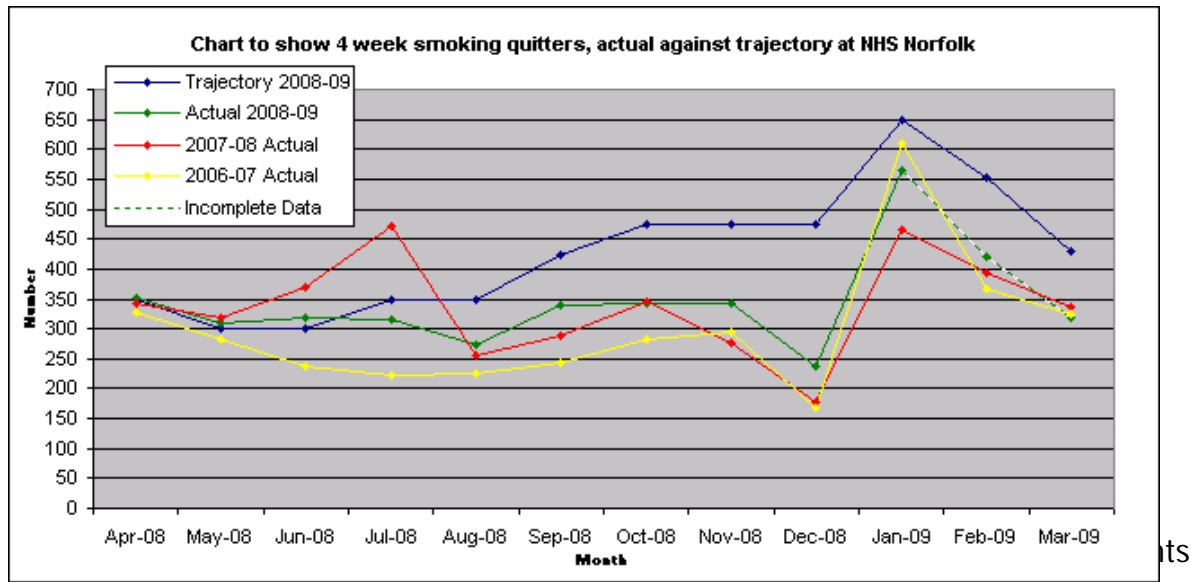
Smoking

Smoking is one of the most significant contributing factors to life expectancy, health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease. NHS Norfolk provides a smoking cessation service which aims to support every person who is motivated to make a quit attempt.

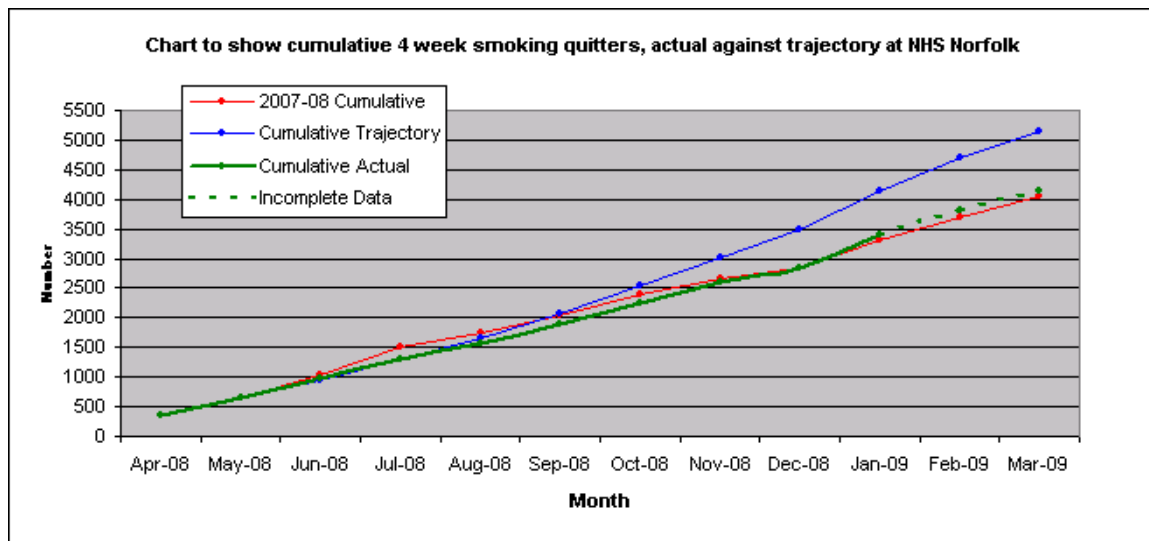
NHS Norfolk commissions a service from a specialist team of smoking cessation advisers working in partnership with trained advisers in GP practices, pharmacies and other community sites to provide an integrated service. Interventions can include intensive support through group therapy or one-to-one support. A client is counted as a successful quitter if, when assessed 4 weeks after setting a quit date, they declare that they have not smoked in the past two weeks and/or this is confirmed by carbon monoxide monitoring.

Over the last year a number of initiatives have been introduced and additional funding provided to increase the number of people giving up smoking. These measures were aimed at increasing GP practice, pharmacy and acute trust activity, increased access to nicotine replacement therapy, increased flexibility of service delivery, and an intensive publicity and marketing programme.

The charts below indicate the 4-week quit performance month by month and cumulatively.



> increased service staffing including recruiting a Service Facilitator



- A total of 4263 quits was achieved in 2008-09. This was a 6% increase over the previous year.
- A total of 8087 clients set a quit date and received support from the service.
- 53% of clients were successfully quit at 4-weeks compared to 50% nationally.

In the coming year we will be making Stop Smoking services more available in the high street through pharmacists and other providers. We will also be targeting groups where we know there is a high prevalence of smoking, such as migrant worker populations and people with

mental health problems and those with particular risks, including pregnant women and those booked into hospital for surgery.

Healthy Diet

Inappropriate nutrition is also a significant factor in the early onset of a range of chronic diseases, particularly CVD, certain cancers and diabetes. One of the basics of a balanced diet is to eat at least 5 portions a day of a variety of fruit and vegetables. Estimates suggest that less than a quarter of people living in Norfolk are eating five portions of fruit and vegetables per day (JSNA)

A recent survey suggests that 58% of general population in the east of England is eating 5 A DAY, but in the 15% most deprived wards this figure is only 9%. (Low income diet and nutrition survey FSA 2008) Those working with the more deprived groups feel that the true figure may be even lower

The Nutritional Health of the Population report produced by the Scientific Advisory Committee on Nutrition makes reference to the inequalities that exist around diet, and notes that those living on low incomes are less likely to eat a balanced diet, wholegrain cereals and fruit and vegetables. They are more likely to consume foods with high levels of saturated fat, salt and sugar, in snack foods, pastries, comminuted meat products and confectionary and fizzy drinks.

Reasons for not eating 5 A DAY and balanced diets are wide-ranging, and relate to age, gender, access and availability, skills deficits, knowledge and budget constraints, particularly in low income groups. Increasingly in young people a lack of food knowledge and experience, coupled with a lack of skills significantly reduces the likelihood of achieving the 5 A DAY target. This has tremendous implications for the following generations.

Food offers social cohesion opportunities in recently mixed communities, but this is generally not a spontaneous process and requires promotion and facilitation. Skills and resources to support this are extremely limited.

Joy of Food

NHS Norfolk continues to host the lottery funded Joy of Food project, which has developed a programme that helps to address the inequalities in healthy eating for disadvantaged groups.

The aims are

- to teach basic food preparation and cooking skills
- To promote the social aspects of food and eating
- To communicate with a 'generation' that haven't always had the opportunity to learn about cooking skills
- To provide a real alternative to 'fast' convenient foods
- To support and encourage meal planning, shopping and budgeting skills

The project has recruited and trained a bank of volunteer trainers to work initially with young people aged 14-30 to teach the skills needed to buy, prepare and cook food on a low income, with a focus on increasing consumption of 5 A DAY. It is hoped that The Joy of Food can be extended and adapted to other vulnerable groups.

Physical Activity

Physical activity has a beneficial effect not only on physical, but also on mental health and is another major preventative factor in relation to chronic disease. Fewer than 1 in 2 men and only around 1 in 3 women in the East of England are highly physically active, that is broadly equivalent to the recommended 30 minutes of physical activity 5 times a week. In Norfolk, men are slightly more active than the regional average and women about the same.

NHS Norfolk is working in partnership with Active Norfolk to improve levels of physical activity in the PCT area and as part of this has joint funded

Alcohol misuse

Alcohol misuse is a growing problem in Norfolk, with an increasing recognition that alcohol consumption, whilst being an important contributor to social welfare and the economy on the one hand, is increasingly understood to have a range of harmful consequences. In Norfolk, although the prevalence of hazardous, harmful, binge or underage drinking is below the England average, there are variations across the County, with Norwich and Great Yarmouth having much higher rates and growing rates of alcohol consumption across the County for women. The proportion of women drinking over sensible limits (more than 21 units per week), is increasing from 12 to 17%, as is the proportion of women drinking very heavily. Male drinking has remained stable - the frequency of exceeding sensible limits in men has remained stable at 26% with an average consumption of 16 units per week.

Although death rates as a result of alcohol misuse are increasing in Norfolk, they are doing at a slower rate than nationally. Hospital admission rates have also been rising, and there is some evidence that rates are increasing in younger age groups. It appears that alcohol misuse also adds to levels of violent crime, domestic violence and road traffic injury, and recent research shows that the patterns of incidence are highly correlated to area deprivation scores.

In terms of treatment, estimates of need based on recent figures suggest that there is a shortfall in access to specialist treatment across Norfolk.

Teenage Pregnancy

Teenage conception rates in Norfolk have risen by 9.1% between 1998 and 2007, against a drop in the England average of 10.7%. The Norfolk rate per 1000 girls aged 15-17 is slightly lower than the national average (40.4% compared to 41.7% nationally) but we have wards in every area of the county where up to 1 in every 9 young women are pregnant before 18.

Teenage pregnancy is known to be strongly associated with the most deprived communities and socially excluded young people. Difficulties in young people's lives such as poor family relationships, low self-esteem and unhappiness at school also put them at greater risk. From the perspective of young people in such circumstances, early parenthood can appear a rational choice, providing a means for marking their transition to adulthood or having somebody to love in their lives. There are also some communities in which early parenthood is seen as normal and not a cause for concern. But evidence clearly shows that having children at a

young age can damage young women's and young men's health and well-being and severely limit their education and career prospects. Also, while young people can be competent parents, longitudinal studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves.

A range of initiatives have been developed over recent years to tackle this issue, these include;

- 21 'Hotspot' schools have been chosen to deliver a school based advice and liaison service
- Extra training in sexual health for youth workers and Connections
- Projects working with voluntary organisations to help increase spread of Teenage Pregnancy Prevention
- A strong partnership agenda between all agencies supported by the Local Safeguarding Children Board and the Corporate Parenting Strategic Board

Despite this work, progress has been slow and a concerted effort is required across all agencies to see an improvement in the statistics for our most deprived communities.

Mental Health

National and regional strategies recognise that there is no health without mental health and mental health problems are common and often go unacknowledged. Raising awareness of mental health issues and tackling stigma are major challenges for the county. The following examples are priority areas for service development over the coming years.

- Dementia is expected to be much more common in the future complicated by the ageing population.
- Mild to moderate depression is recognised as common among all sectors of the population; increasing access to psychological therapies is a key area for attention, targeting areas of deprivation, being innovative and developing NHS services in tandem with the vibrant voluntary sector and other providers.
- The transition to adulthood is recognised as a time when many people become extremely vulnerable and services must strengthen their partnership working to protect the people who need them most. Parents, carers, children and families are all recognised as crucial in the development of a mentally healthy society.

Mental health is an area where partnership working is essential – ensuring integrated and complimentary services are available in the community, and making services flexible to the specific needs of clients. In this work, the voluntary sector have a crucial role to play as we seek to understand the specific needs of our communities particularly the most marginalised and hard to reach groups

NHS Norfolk will be carrying out a Mental Health Equity Audit in the coming year.

Health Protection

An important part of public health is the protection of the population against infectious disease and other environmental dangers to health. To do so we work very closely with the Health Protection Agency to monitor the emergence and spread of potential harmful disease. This year has understandably seen an emphasis upon the spread of the H1N1 influenza virus (Swine Flu)

Pandemic influenza

For several years the Chief Medical Officer has been advising the government to make preparations for pandemic influenza. Over the last six months Sir Liam's predictions have been largely realised. Pandemic flu has arrived but, contrary to expectations, it has arisen from H1N1 swine flu virus from Mexico rather than H5N1 avian flu from South East Asia.

Pandemics occur on an approximate 40 year cycle. They arise from the mixing of different strains of flu virus to produce a new strain to which there is no significant immunity in the global population. Consequently spread can be rapid and the number of people affected (the attack rate) high. Modelling based on the experience of previous pandemics has suggested that we can expect two or more pandemic waves each lasting around 13 – 14 weeks with a peak in cases during the middle part of each wave.

This time round the initial experience has shown that we have had the majority of cases within a 13 week period but the numbers have been considerably lower than predicted. There are a number of reasons for this; it isn't unusual for the first pandemic wave to involve lower numbers than the second wave, the first wave struck over the summer period in the UK and there was extensive use of antiviral drugs in the UK which may well have altered the epidemiological picture. Nevertheless, experience suggests that we need to be fully prepared for a second wave which may involve larger numbers of people.

So far the influenza A (H1N1) or 'swine flu' virus has caused a mild type of flu in the vast majority of people. As predicted in modelling, the young have been particularly affected with the virus circulating rapidly in school settings. A small number of individuals have become more seriously ill and there have been a number of deaths that have been related to swine flu. It is important to remember that each year seasonal flu causes a significant number of deaths in the UK and so far the impact of swine flu has been much less. Fortunately, there is no evidence at present that the virus is either becoming more virulent or that it is becoming resistant to antiviral drugs. It is, however, likely that resistance will become a problem at some stage, a change in virulence is also a real risk but remains much more difficult to predict.

NHS Norfolk has implemented its pandemic flu plans and, in the first four months, distributed approximately 10,000 courses antiviral drugs via a network of pharmacy and NHS Norfolk run antiviral collection points. Inevitably, there have been changes in national policy and planning guidance as more has been learned about the virus but overall the NHS Norfolk plans have stood up well. As I write this we are experiencing a lull in the number of cases, however, the workload has not reduced because there is ongoing planning to prepare for the next wave and also for the forthcoming vaccination programme. It is important also to recognise the very hard work of a number of people across NHS Norfolk without which we would not have been so well prepared.

Throughout the first four months of the pandemic NHS Norfolk has worked closely with other category 1 responders through the Norfolk Resilience Forum. The Forum, which is chaired by Norfolk Police, has representation from all relevant organisations. Early on in the pandemic the Forum established a Strategic Coordination Group and this has met regularly since then to oversee the strategic response across the county.

Vaccination

On the 13th august the Secretary of State for Health announced the priority groups who are to receive swine flu vaccinations once the vaccine has been licensed. The decision was taken following consultation with two independent expert committees – the Joint Committee for Vaccination and Immunisation (JCVI) and the Scientific Advisory Group for Emergencies (SAGE). The groups considered those who could be identified as having the highest risk of developing severe illness should they come in to contact with the swine flu virus.

The priority groups include:

1. individuals aged 6 months and up to 65 years in the current seasonal flu vaccine clinical at risk groups
2. Pregnant women, subject to licensing conditions on trimesters
3. Household contacts of individuals whose natural immunity is compromised, for instance through illness or treatment programmes
4. People aged 65 and over in the current seasonal flu vaccine clinical at-risk groups

At NHS Norfolk we have now prepared our plans for initiating the programme of immunisation likely to begin in early October.

Education

Throughout health and social care commissioners and providers are increasingly being required to demonstrate a clear evidence-base for the decisions they make. This relates to the fundamental issues of diagnosis and treatment of disease but also to the wider aspects of health care planning and provision. The JSNA is key to this as we pull together the information that helps us understand the problems, potential solutions and the impact of interventions and actions taken to improve health.

Health care information comes from a wide array of sources, in particular from the results of research studies. This makes it imperative for health professionals to understand the research methodology used in order to make judgements on the validity and applicability of the research findings. Education and links with expert research is therefore central to developing and maintaining the capability of the public health function within the organisation.

The department also plays an active part in the regional public health specialty training programme by providing placements to specialty public health trainees (medical/non-medical graduates) and Foundation doctors in Norfolk.

Links with the UEA School of Medicine, Health Policy and Practice, Norwich

The School of Medicine Health Policy and Practice, University of East Anglia, Norwich produced its first graduates in 2007. Several members of the Public Health directorate, at NHS Norfolk continue to be involved in the admissions process, curriculum development and teaching activities at the medical school. Through this, staff members of the Directorate have been able to develop their teaching and communication skills and share real-life public health experiences with the students. There are also opportunities for collaborations between academic and service colleagues to develop and implement local research studies.

Public Health Awareness Online Training Programme

Public health is everybody's business, and we all have a part to play in health improvement. It is not just the role of the public health team or of the NHS. An online learning programme providing an introduction to Public Health (commissioned by the Department of Health) has recently been developed by the Open University and the NHS Core Learning Unit. This programme covers the following topics:

- Promoting Public Health
- Protecting People's Health
- Food and Health
- Physical Activity
- Mental Health and Wellbeing
- Tackling Unhealthy Behaviours: Alcohol and Smoking

It is aimed at all employees across the Health Care economy, and learners are encouraged to recognise that they are working in a health promoting organisation and as such have a responsibility to contribute at an individual and organisational level. The programme will help the learner understand how they can contribute to improving:

- their own health and the health of their families
- the health of colleagues and others in their organisation
- the health of patients and carers
- the health of people in their communities

This course covers the national priorities in Public Health (Obesity, Smoking, Alcohol, Mental Well Being and Sexual Health) and also ensures that factors which influence behavior in these areas, such as poverty, unemployment and lifestyle, are acknowledged throughout the material.

The programme will be launched in the East of England on 22 Sept 2009. NHS staff can register free and online for the programme at www.corelearningunit.nhs.uk. Social Care staff can access it though www.socialcare.corelearningunit.com

For further information please contact the Core Learning Unit at clpu@skillsforhealth.org.uk.

Research & Development

NHS Norfolk continues to host an excellent and successful R&D team who work across Norfolk and Suffolk ensuring that research continues to take a central role in the development of health intelligence and evidence based decision making.

The R&D Office manages a high quality and streamlined process of RM&G in primary care across Norfolk & Suffolk. An audit of activities for 08/09 showed that total activity remained high with 102 studies approved across 3 PCTs, this increase of 40% reflects the incorporation of activity in Suffolk, with 74 projects across Norfolk & Waveney remaining similar to 07/08 (73). Over the last year the no. of portfolio studies in Norfolk & Waveney has doubled; the inclusion of Suffolk has increased this 2.5 fold. The amount of non-portfolio work is down by over 80% (excluding commercial and student projects).

The team have worked to integrate the new system for obtaining NHS Permissions (NIHR-CSP) across PCTs, contributing nationally to the development of CSP. They have achieved sign-off for their first CSP study in a faster than average time (8th national sign off). They have implemented and are actively running the HR Good Practice Guidelines across all 3 PCTs, and are working to get this integrated into policy in each PCT.

Over 08/09 100% of primary care practices have hosted research across Norfolk and Waveney including 37 portfolio studies (an increase of 60% on 07/08) with 6444 patients entering portfolio studies .

A full R&D annual report is available through the NHS Norfolk website

Conclusions

This report has highlighted the challenge which lies ahead for NHS Norfolk, the local authorities and its other partners as we work towards reducing health inequalities for our population. Most of all it has emphasized the role of the JSNA as an important innovation in the development of joint strategy and public policy and has indicated its potential for the future.

The JSNA is a key element in the work of NHS Norfolk as we strive to achieve the competencies of 'World Class Commissioning', requiring the PCT to demonstrate vigorous leadership and engagement with our partners, the public and local communities.

In following this development pathway the JSNA becomes a powerful performance management tool as we examine the health outcomes for our population in the context of those identified needs and services provided.

In conclusion therefore, it is important to stress that the JSNA is a process and not to be misinterpreted as merely a technical or academic report. It is first and foremost about people and places. It is about the environments within which we live, the choices we make and how best our communities can be supported to ensure those choices promote health and well-being in the long run.

If you would like this document in large print, audio, Braille, alternative format or in a different language, please contact the Public Health Department on 01603 257105 and they will do their best to help.



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