Joint Strategic Needs Assessment

Summary of Themed JSNA Reports 2017

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The purpose of **Cambridgeshire's Joint Strategic Needs Assessment** is to identify local needs and views to support local strategy development and service planning. In order to understand whether we are achieving good health and care outcomes locally, it is useful to benchmark outcomes in Cambridgeshire against those in other areas and look at trends over time.

This **Joint Strategic Needs Assessment (JSNA) Summary of Themed Reports 2017** provides a brief overview and update on the entire breadth of themed JSNA work in Cambridgeshire to date. It is designed to identify and flag key pieces of information about the health and wellbeing needs of people who live in Cambridgeshire and local inequalities in health for specific population groups, through the 'deep dive' themed needs assessments, which are summarised here.

This report should be read in conjunction with the **Joint Strategic Needs Assessment Core Dataset 2017**, which provides a general overview of health data and statistics for Cambridgeshire's residents. Both documents inform the county-wide Health and Wellbeing Strategy.

This JSNA Summary of Themed Reports does not have the depth of information needed to support planning of services, however, the detailed reports are available at:

http://cambridgeshireinsight.org.uk/jsna

As part of the **2016/17 JSNA programme of work**, the following JSNA reports have been developed:

- **Drugs and Alcohol (published in 2016)**
  http://cambridgeshireinsight.org.uk/JSNA/Drugs-and-Alcohol-2015

- **Migrant and Refugee (published in 2016)**
  http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/migrant-and-refugee-2016

Summary of Health and Wellbeing Needs

The needs identified in the JSNA are addressed by the Health and Wellbeing Board through the priorities in their **Joint Health and Wellbeing Strategy**. The table below highlight the key priorities for Cambridgeshire for **2012-2017**.

Cambridgeshire

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

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

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

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

5. **Create a sustainable environment in which communities can flourish**

6. **Work together effectively**

Further details of these priorities are available in the executive summary of the Cambridgeshire HWB Strategy and the full HWB Strategy 2012-17, available at:

www.cambridgeshire.gov.uk/info/20004/health_and_keeping_well/548/cambridgeshire _health_and_wellbeing_board

The following strategies have been adopted as annexes to the Health and Wellbeing Strategy:

- **Learning Disability Partnership Commissioning Strategy**

www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=9416

- **Children and Young People's Emotional Wellbeing and Mental Health Strategy**

www.cambridgeshire.gov.uk/downloads/file/2664/emotional_well_being_and_mental_health_strategy _children_and_young_people

- **Older People's Strategy**

www.cambridgeshire.gov.uk/download/downloads/id/3669/cambridgeshire_older_people_strategy

- **Joint Adult Carers Interim Strategy**

www.cambridgeshire.gov.uk/info/20166/working_together/577/strategies_and_plans

- **Crisis Care Concordat Declaration and Action Plan**

www.crisiscareconcordat.org.uk/wp-content/uploads/2014/11/Cambridgeshire-and-Peterborough-Local-Mental-Health-Crisis-Care-Declaration-November-2014-signed.pdf

JSNA core dataset 2017

The **Cambridgeshire JSNA core dataset 2017** contains local benchmarked information for a range of health and wellbeing determinants and outcomes, as well as local demographic data. The report is structured around these key topic areas:

- Geography and demography.
- Relative deprivation and the wider determinants of health.
- Lifestyles, risk factors and health and wellbeing.
- Screening, vaccination and immunisation.
- Levels of illness and health and social care services.
- Life expectancy and mortality.

The high-level executive summary for the report shows:
- Overall, **Cambridgeshire is a healthy place** to live and one that **compares generally well** with national health and wellbeing determinants and outcomes.
- However, there are **areas within Cambridgeshire** with **more widespread health and wellbeing issues** where health determinants and outcomes are often more adverse than in Cambridgeshire and often **similar to, or worse than, national averages**. In **Fenland** it is a priority to broadly improve health determinants and outcomes and to reduce health inequalities.
- There are also some **very small areas**, often with relatively high levels of disadvantage and deprivation, which have correspondingly **adverse** health and wellbeing determinants and outcomes. In some areas of **Cambridge City** in particular further attention may be needed to **reduce health inequalities** and to **reverse emerging adverse trends** in some health determinants and outcomes.
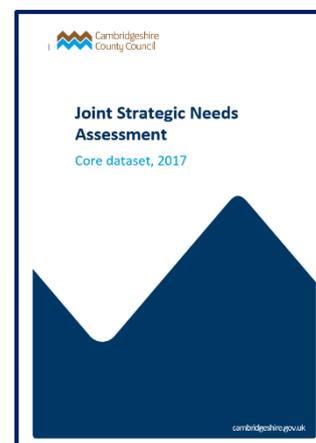
Please **note** that any summary is by necessity high-level, relatively crude, and cannot include the detailed differences and nuances of health and wellbeing across a large area like Cambridgeshire. For more information see the full JSNA core dataset 2017 at http://cambridgeshireinsight.org.uk/jsna.

Cambridgeshire Insight and other sources of health and wellbeing data

As well as the Cambridgeshire JSNA Core Dataset 2017, the Health and Wellbeing pages of **Cambridgeshire Insight** host a number of other health related resources:

- http://cambridgeshireinsight.org.uk/health

The most wide-ranging of these is the **Public Health Outcomes Framework (PHOF)** at http://cambridgeshireinsight.org.uk/health/phof.

Other areas of **Cambridgeshire Insight** provide further information on the wider determinants of health and background population based information covering:

- Community safety
- Deprivation
- Economy
- Education
- Housing and planning.
- Population and demographics
- Voluntary and community sector (VCS)

Public Health England also provide a range of information profiles for various health and wellbeing topics and these can all be accessed from:

https://fingertips.phe.org.uk/

To date the following JSNA's have been completed in Cambridgeshire.
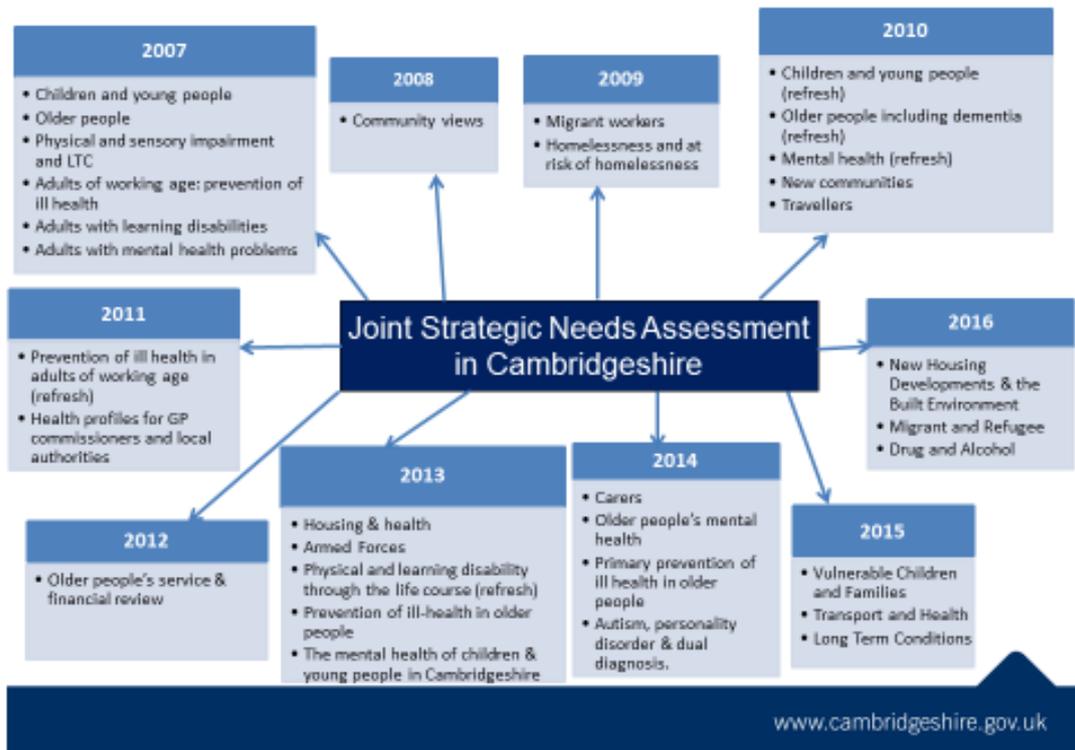
The following sections provide a brief summary of the key information presented in each JSNA topic, along with stakeholder views and a link to the full JSNA. It is strongly advised that the full report is read to gain an understanding of the breadth and depth of each JSNA.

Please note that the sources and references for data and evidence have not been included within these summary sections, as they can be found in the original document. It is also important to note that any figures presented are as at the time the JSNA was completed and therefore more up to date data may be available. The data sources are available in the full JSNA document and up to date wider determinants and health data are available on Cambridgeshire Insight (www.cambridgeshireinsight.org.uk).

Stakeholder and Community views

An important part of producing a JSNA is to seek the views of stakeholders and the local community to help inform the JSNA. In Cambridgeshire, the JSNA teams have held a range of workshops with stakeholders from defining the scope of the JSNAs to agreeing the key findings and the next steps. These events, together with closer partnership working, have helped to ensure the gathering of differing and varying perspectives. With community views, the priority has been to ensure that they are fairly represented and include capturing information with different groups and in different ways right through the process.

Migrant and Refugee (2016)

For the purposes of this JSNA, the term 'migrant' is used to describe a person who has moved to the UK who at the time of entry to the UK is not a British national. Migrants are not a homogeneous group, coming from all over the world and with different socio-economic backgrounds.

In terms of data, Migrants can be defined by: place of birth (i.e. foreign-born), nationality (i.e. foreign citizens), and length of stay in the UK. The JSNA also uses information based on language spoken at home to define migrants locally.

The local population of Cambridgeshire, like that of all areas of England, has experienced migration of people coming from non-UK countries to live, study, work or seek asylum for many years. Some migrants are now long-established in Cambridgeshire communities while others are recent arrivals, often seeking work, or in the case of Cambridge City, seeking education.

This JSNA focuses on migrants from the A8 countries. The **A8 countries are: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.**

Key findings

Demography

- Non-UK born residents in the East of England are primarily adults of working age, 43% aged 20-39 and 71% aged 20-59 years of age.
- Existing migrant populations are highest in Cambridge City. Fenland has a relatively low rate of non-UK born population overall. The East of England continues to experience relatively high levels of migration in comparison to other areas of the UK. The percentage increase in migration has been high in Fenland and Peterborough.
- Cambridge City has a higher rate of long-term migration (defined as migrants settling for a period of 12 months or longer) than England and the East of England as well as Peterborough and other districts of Cambridge.

Children and Education

- Although academic attainment at key stage 2 and at GCSE level has improved between 2013 and 2015 in Cambridgeshire for pupils who primarily speak a Central or Eastern European language at home, attainment remains below that of pupils who primarily speak English.
- The percentage of pupils within Cambridgeshire that primarily speak an EU A8 language is 3.8% and among districts, it is highest in Fenland at 8.6%.
- Communication with parents can be problematic due to poor English skills and poor overall literacy skills. Translators are required in schools to communicate effectively with parents.

Employment

- The highest rate of employment in non-UK born residents is in Fenland (73.5%), followed by East Cambridgeshire (72.0%). This is much higher than the England rate (56.7%) and higher than the East of England rate (61.2%), indicating that migrants in Fenland and East Cambridgeshire are settling in these locations for employment purposes
- A8 migrants in Fenland often work in low-skilled, seasonal jobs that are low-paid and may be subject to zero-hours contract and often are working below their skill level.

Housing

- 82% of migrants who answered the survey question in Cambridgeshire and Peterborough live in rented accommodation, with **39% living in shared rented housing**. This compares with 32% of the general population in Cambridgeshire living in rented housing and only 2% living in shared rented accommodation.
- There is a prominence of Houses in Multiple Occupation (HMO) making up the private rented sector in Wisbech. Analysis of HMOs and migrant housing needs through 'Operation Endeavour' and 'Operation Pheasant' in Wisbech have uncovered a broad range of issues: overcrowding, unhygienic and unsafe living conditions and illegal evictions.

Health

- Over the 10 years 2003/04 - 2013/14, new migrant GP registrations have risen by 37.6% in England. In Cambridgeshire, the increase over this time period has been 55.6% and the rise has been most substantial in percentage terms in Fenland (a 113.5% increase in migrant registrations.
- Evidence suggests rates of smoking and excessive alcohol consumption is higher among Eastern European communities. Dental care in A8 migrants is thought to be poor.
- Fenland and Cambridge City are among the areas with the highest unadjusted rate of tuberculosis (TB) within the Anglia & Essex area. TB in the UK is higher among migrants from countries with high incidence of TB and these include Lithuania and Latvia.
- Sexual health is an area of concern in the migrant population.
- Suicide rates are higher in all of the EU A8 countries compared to England and there is evidence that the suicide rate of Eastern European migrants living in Cambridgeshire is also higher than would be expected.
- The percentage of births to non-UK born mothers was 53% of all births in the Cambridge City area in 2014.

Migrants and Criminal activity

- 'Operation Pheasant' in Fenland uncovered a broad range of issues: Exploitation of individuals was uncovered in terms of no tenancy rights, illegal evictions, child protection issues, control, trafficking, and threats of violence.
- The wider community is concerned about some of the consequences of migrant exploitation and behaviours particularly when work 'dries up', including street drinking, homelessness and anti-social behaviour.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/migrant-and-refugee-2016

Drugs and Alcohol (2015/16)

The impact of substance misuse is addressed throughout the lifecourse allowing consideration of key transition periods for prevention and treatment.

There are many factors associated with an increased risk of the misuse of drugs and alcohol among young people and adults. These factors often lead to risk taking behaviours and poor health outcomes such as mental health problems and offending. The aim of preventative interventions is to tackle risk factors and build resilience to developing drug and alcohol problems.

The cost of alcohol and drug misuse

There are far ranging effects upon the physical and mental health of those who misuse drugs and alcohol which impact upon their families and communities and across wider aspects of their lives.

There are socio-economic costs to society and services which includes health services, social care, the criminal justice system, employers and housing services.

Parental drug use is a risk factor in 29% of all serious case reviews; heroin and crack addiction causes crime and disrupts community safety; a typical heroin user spends around £1400 per month on drugs. The public value drug treatment because it makes communities safer and reduces crime.

Alcohol misuse harms families and communities

- Almost **half** of violent assaults
- Domestic violence and marital breakdown
- **27%** of serious case reviews mention alcohol misuse
- Physical, psychological, and behavioural **problems for children** of parents with alcohol problems
- 13% of **road casualties**

The JSNA provides information about the evidence of effectiveness and also the cost benefits of interventions. The headline figures are as follows and sourced from Public Health England (Alcohol and drugs prevention, treatment and recovery: Why invest? 2014)

- Every £1 spent on interventions on young people's drug and alcohol services brings benefits of £5-£8.
- For every 100 alcohol dependent people treated at a cost of £40,000, £60,000 is saved on 18 Accident & Emergency visits and 22 hospital admissions.
- Every 5,000 patients screened in primary care may prevent 67 Accident and Emergency visits and 61 hospital admissions - costs of £25,000 saves £90,000.
- One alcohol liaison nurse can prevent 97 Accident & Emergency visits and 57 hospital admissions so costs of £60,000 saves £90,000.
- For every £1 spent on drug treatment £2.50 is saved through averting costs to society.
- Drug treatment prevents an estimated 4.9 million crimes every year.
- Treatment saves an estimated £960 million of costs to the public, businesses, criminal justice and the NHS.

www.cambridgeshireinsight.org.uk/JSNA/Drugs-and-Alcohol-2015

Children and Young People

The Cambridgeshire Health Related Behaviour Survey found that alcohol use amongst young people has fallen since 2008. In 2014 the percentage of Year 10 pupils reporting drinking alcohol in the seven days prior to the survey fell from 50% in 2008 to 36% in 2014. The same survey found that nearly 17% of Year 10 pupils reported taking drugs. The percentage reporting ever taking drugs was statistically significantly higher than the county average in Cambridge at 22% and statistically significantly lower than the county average in Huntingdonshire at 14.4%.

Amongst young people, admissions to hospital for alcohol and drug misuse are statistically significantly lower than the national figures. However, in line with national figures, the number and rate of admissions have doubled over the last five years. The number of young people in treatment fell in 2014/15 to 200 from 245 in 2013/14 and over 90% of the planned exits from treatment did not re-present within six months. The majority of children and young people have one or more vulnerabilities, the most common being mental health and self-harming.

A **key concern** is the needs of children and young people in **vulnerable groups** who are at a **higher risk** of misusing substances for example **looked after children** and children who live with **parents or carers who misuse**. This includes those who have not started and those who are using but are not yet dependent on substances.

> Overall, alcohol and drug misuse among young people in Cambridgeshire is not dissimilar to national figures but there is still a proportion of children and young people who are starting and continuing to misuse drugs

Adults

Overall, in line with national figures, hospital admissions for conditions totally attributable to alcohol (specific) and related conditions have increased and they fall within the top 25% of local authorities. In 2013/14 1,890 people in Cambridgeshire were admitted to hospital for conditions totally attributable (specific) to alcohol. In the same year there were around 6,650 people who were admitted to hospital for alcohol related conditions. Hospital admission rates are generally higher in Fenland and Cambridge.

In terms of illicit drugs there were 143 hospital admissions with a primary diagnosis of illicit drug poisoning, with rates lower in men and similar in women to national figures. 732 admissions were with a primary or secondary diagnosis of drug-related mental health and behavioral disorders. In Cambridgeshire the annual rate of drug related deaths has been stable for over the past 10 years but they are statistically significantly higher in the more deprived wards.

> There were 211 deaths in Cambridgeshire due to alcohol related causes in 2014. Alcohol specific mortality rates are generally higher in the more disadvantaged areas and average life expectancy is reduced from alcohol related conditions in Fenland. The rate of alcohol related liver disease has increased amongst women in 2012/14 to a level similar to the national figure.

Older People

There is increasing awareness that substance misuse, especially alcohol, is more prevalent in the older population (over 65 years) than previously thought. Many who misuse alcohol may have started earlier in life but some commence in response to traumatic life events such as loss of a partner. Professionals often find it difficult to ask 'embarrassing' questions of older people but there are **warning signs**.

> Key risk factors for substance misuse in older people are **loneliness** and **life changes** including **bereavement;** more time and opportunity to drink; **loss of friends** and social status**; being a carer** and **chronic pain**

New Housing Developments and the Built Environment (2016)

- Cambridgeshire was the fastest growing county authority between 2001 and 2011 and is expected to continue to grow. It is estimated that there are 627,000 people living in Cambridgeshire.

- Forecasts suggest that the population of Cambridgeshire is set to increase by 25% over the next 20 years, with the majority of the increase seen in Cambridge City and South Cambridgeshire. This is associated with a forecast increase in the number of new dwellings up to 2036 of 73,000.

- The age profile breakdown for GP Practice populations serving new developments show the that majority have an age structure similar to the CCG area, except for Cambourne which shows a spike in the 0-14, and 25-44 age groups.

- The average household size in new developments ranges from 2.6 to 2.8.

There is strong evidence that the following aspects of the environment affect health and wellbeing:

- Generic evidence supporting the impact of the built environment on health.
- Green space.
- Developing sustainable communities.
- Community design (to prevent injuries, crime, and to accommodate people with disabilities).
- Connectivity and land use mix.

- Communities that support healthy ageing.
- House design and space.
- Access to unhealthy/"Fast Food".
- Health inequality and the built environment.

The Built Environment – this term includes open space, networks and connectivity between areas as well as the physical structures and includes the places where people work, live, play and socialise. The built environment includes several material determinants of health, including housing, neighbourhood conditions and transport routes, all of which shape the social, economic and environmental conditions on which good health and wellbeing is dependent.

The planning system involves making decisions about the future of cities, towns and the countryside. This is vital to balance the desire to develop the areas where we live and work with ensuring the surrounding environment isn't negatively affected.

Key findings

- There is a lack of consistency across the Local Authority Local Plans with regard to the inclusion of policies to improve health. The main policies to include in future local plans need to focus on green infrastructure, active travel, suicide prevention and Health Impact Assessment requirements.
- There is a lack of consistency and understanding on the funding of Primary Care facilities and securing Community Infrastructure Levy/Section 106 funding.
- Importance of accessible green space and parks, which need to be designed to maximise potential use. There is a need for an open space specific design code to complement the policies on open space within Local Plans, design code should cover provision of paths, cycleways and unstructured routes through and to the green space, provision of toilets and other facilities.
- The importance of providing infrastructure to enable people to make more active travel choices.
- Securing what can be perceived as "nice to have" infrastructure as part of the overall design of new development to support healthy ageing, eg street furniture, public toilets.
- The need to consider suicide prevention and public mental health as part of the design of high rise private and public buildings to limit their access and opportunities for suicide.
- The NHS Local Estates Plan should be reflected in the District/City Councils local plans and Infrastructure Delivery Plans.

Social Cohesion/Community Development - There is a marked difference between those occupying private rented market homes and other tenures in the amount of time those occupiers intend to stay in those properties, with the majority intending to stay less than three years. Occupiers in new developments show a difference in occupations compared to the working population as a whole. More residents are employed in the managers and senior officials, associate professional and technical occupation sectors. Less residents are employed in the skilled trade, sales and customer service, process, plant and machine, and elementary occupation sectors.

Key findings
- The need for community development in the early stages of new developments is strong, however, more research is needed locally into the measures of and approaches taken to improve social cohesion and community resilience in new developments, and the funding opportunities available to secure this.
- Community development work needs to continue to focus on building resilient empowered communities rather than dependent communities. This should be carried out with other key agencies. Responsibility lies with all stakeholders and that all statutory agencies can benefit from active participation in building resilient empowered communities.

Assets and Services - Of the larger new communities in Cambridgeshire, feedback from some frontline practitioners, including housing, children's social care and family workers, report that they are seeing higher needs in the initial years in new communities. Data has been used from some of the new communities in Cambridgeshire and has been analysed to see whether these reports of higher needs in new communities are translating into increased utilisation of health and social care services.

Key findings
- A joint strategy is needed to develop a way to engage and attract the leisure market into new communities early in the development.
- Further research to understand the length of time that referral to Social Services cases are open, and what was the primary reason for referral.
- During the pre-application stage of the planning process, services and the community should be engaged and a working group of people centred support established so that there is a clear co-ordinated effort and communication channels between services and the planning of the new community.
- Additional support to be provided to schools to enable them to deal with the additional challenges that new community schools can expect to face.
- Provide incentives to attract full day care/early years providers to developments.
- Further research into categories of crime committed and to look into other new communities and compare them to the rest of the county.

NHS Commissioning - the landscape is complex with commissioners at different levels (from local to regional to national) commissioning different services which make up the NHS.

Main findings:
- The current engagement between Planning Authorities, CCG and NHS England need to be strengthened, with NHS England and the CCG needing robust cases when seeking Section 106/CIL contributions with a defined need and costed solution.
- Health partners should come together at the earliest opportunity to discuss needs at strategic sites.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/new-housing-developments-and-built-environment

Long Term Conditions across the Lifecourse (2015)

Long Term Conditions (LTCs) include any ongoing, long term or recurring condition requiring constant care that can have a significant impact on people's lives, limiting quality of life.

The JSNA focussed on adults and older people with LTCs who may be considered 'at-risk' of poor health outcomes (such as admission to hospital or increased need for care).

Long Term Conditions Across the Lifecourse - LTCs develop over a long period of time and similarly, many important adult risk factors for LTCs (poverty, smoking, diet, physical activity) also have their own natural histories. Thus by adopting a lifecourse approach to LTCs a range of potential interventions, which includes the wider determinants of health, that could reduce the risk of development of a condition or improve health outcomes is a useful and holistic population health approach.

This JSNA complements the work and findings of the Primary Prevention JSNA

Nearly a third of people in Cambridgeshire (31.7%) reported having at least one LTC in the GP survey, and the 2011 census found that 90,420 people (15.1% of household residents) reported a long term activity-limiting illness.

LTCs in the Population: characteristics of those at high risk.

This JSNA is scoped to focus on care management for high risk people with adult-onset LTCs representing 10-15% of the population with LTCs. In discussion with local stakeholders, the key characteristics that described people with LTCs were determined as: multiple long term physical and mental health conditions; important level of limitations, such as in activities of daily living (ADL); living with a significant level of pain and experiencing depression and/or anxiety.

The Department of Health estimates that those with multiple LTCs are due to rise from 1.9 million in 2008 to 2.9 million in 2018.

LTCs in Cambridgeshire

A longstanding illness is defined as any physical or mental health condition of illness lasting or expected to last 12 months or more. If a longstanding illness reduces participants' ability to carry out day-to-day activities, either a little or a lot, it is considered a limiting longstanding illness.

For the adult population aged 18-64 years, individual level data was analysed from the Health Survey for England (HSE 2012) and those results were applied to the local Cambridgeshire population. In terms of health conditions the survey is all inclusive – participants report any longstanding illnesses and specify up to six conditions.

Results

- For the adult population - 9.8% of people reported two or more longstanding illnesses which equates to over 39,000 people in Cambridgeshire.

- People aged 18 to 64 years estimated to have two or more LTCs and who report limitation is around 14,700 people. When mental ill health is considered as well around 11,000 people report two or more LTCs, with limitation and with mental ill health.

For the older population aged 65 and above, local data from the MRC Cognitive Function and Ageing Study (CFAS II) was used.

For the purpose of this JSNA, the following conditions were selected as LTCs: angina, intermittent claudication, hypertension cancer, diabetes, Parkinson's Disease, stroke, myocardial infarction and chronic obstructive pulmonary disease (COPD), asthma, arthritis and thyroid problems.

- 45% of people aged 65 and over with two or more LTCs experience limitation. Applied to the Cambridgeshire population, this suggests around 29,800 people aged 65 and over with two or more LTCs and limitation, an additional 2,800 people with mental ill health and an additional 5,400 with multiple LTC, limitation and mental ill health (dementia, anxiety and depression). In total, it is estimated that **66,200** people aged 65 and over in Cambridgeshire have two or more LTCs.

- Over 51% of those with multiple (three or more) LTCs experience limitation. Applied to the Cambridgeshire population, this suggests around 17,700 people aged 65 and over with multiple LTC with limitation, an additional 1,300 people with mental ill health and an additional 3,700 with multiple LTC, limitation and mental ill health (primarily dementia, anxiety and depression). In total, it is estimated that **34,700** people aged 65 and over in Cambridgeshire have three or more LTCs.

Living with LTCs: Local Views
The views of Cambridgeshire people living with LTCs and their carers.

They detailed challenges and difficulties that they faced, the impact of the physical, emotional and mental health symptoms, including pain and fatigue. Many are providing care for family and friends with even more complex needs, and experience the complexity of balancing caring responsibilities with their own health issues. Some of the stakeholders' concerns included managing household tasks, getting out and about, financial and practical issues, and a lack of knowledge of what is available in the community for support or social opportunities.

The theme that emerged for the health and care system is that there is a level of fragmentation, a lack of communication between different services and providers of care and a very broad web of care that people with LTCs interact with; this can mean that coordination is difficult and care is not optimal.

Care Management: The House of Care
NHS England recognises that care needs to be designed and implemented around the individual, the King's Fund 'House of Care' model has been adopted as a framework to describe the components of personalised care. This is a co-ordinated service delivery model which is designed to deliver proactive, holistic, preventive and patient-centred care for people with long term conditions.

Improving Care Management: Targeting and Intervening
This chapter gives an overview of the current evidence exploring interventions to prevent hospital admissions and admissions to care settings. The current health care system attempts to discharge elderly patients quicker from acute care facilities. There is strong evidence that an individualised discharge plan for hospital inpatients is more effective than routine discharge care that is not tailored to the individual.

National Expert Panels have recommended the following key approaches to reducing and preventing unplanned hospital admissions: direct delivery of rapid access care in the community; Access to rapid response nursing and social care at home; Intermediate care and acute nursing home beds; Mental health crisis teams; Rapid access specialist clinics; Increased nursing home capacity for acute illness.

Improving Care Management: Supporting Self-Management
It is estimated that during each year for a person with LTCs, only a few hours are spent in the presence of health care professionals. The vast majority is 'self-care' or 'self-management' of conditions.

www.cambridgeshireinsight.org.uk/JSNA/LTCs-across-the-lifecourse-2015

Transport and Health (2015)

The Transport and Health JSNA covered air pollution, active travel and access to transport.

Air pollution

There are several hotspots of traffic air-related pollution in Cambridgeshire, especially in busy urban areas and around arterial and trunk roads, such as the A14. Some new developments in the county are sited near to poor air quality areas.

> In 2010 it was estimated that there were **257** deaths attributable to air pollution in Cambridgeshire and that over **5%** of population mortality is attributed to air pollution

Air pollution impacts on respiratory and cardiovascular hospital admissions and incidence of respiratory disease. There are higher levels of nitrogen dioxide in the winter months and peaks of larger particulate matter in the spring, which may lead to seasonal health impact. Stakeholders identified **priorities** as **lower emission passenger transport fleet, modal shift from cars to walking and cycling** and **exploring the potential for reducing person specific exposure**. Increasing physical activity reduces all-cause mortality and reduces ischemic heart disease, stroke and dementia. **Those that are most inactive benefit the most, with even small increases in walking and cycling helping health.**

Active travel

Half of **work trips** are **walked or cycled** in **Cambridge City** compared with only **one in seven** in the **rest of the county**. The proportion of people who use active transport for work decreases with distance and most notably in those that walk, although cycling rates do not

> There are over **18,000 car trips** to work that are **less than 2km** (1.2 miles) in Cambridgeshire, with over a third of these in Huntingdonshire

decline until the trip is longer than 5km. Nearly 60% of primary school children walk to school, but only 35.3% of secondary school children do. Cycling is much less popular with only 6.7% of primary school and 15.5% of secondary school children cycling to school. **Priorities** identified were: **improving safety** and **perception of safety, infrastructure, culture** and **further assessment of data and intelligence**. It was also emphasised that an initial focus modal shift on densely populated towns and cities may be a preferred starting point.

Access to transport

People vulnerable to transport barriers include:

- Those who may be **socially excluded** (or in lower socioeconomic groups)
- Those living in **rural areas**
- Those **without cars** or stopping driving
- Those **lacking** the **knowledge** or **skills** and **confidence** to use available modes of transport

Transport barriers are not experienced equally through the population. There is evidence to suggest that transport barriers are a contributory cause of missed and cancelled health appointments, delays in care, and non-compliance with prescribed medication. These forms of disrupted and impaired care are associated with adverse health outcomes. In Cambridgeshire, there are geographical wards where there are high numbers of vulnerable people with limiting conditions, many in households without access to a car, living a long distance from health services and these may impact access to services. Stakeholders identified **priorities** of **system led perspective on health and transport planning, additional provision such as bus provision or novel alternatives**, **alternative models of health support**, such as telemedicine and **further analysis of travel to GP practices** and **other health services.**

www.cambridgeshireinsight.org.uk/JSNA/Transport-and-Health-2014/15

Vulnerable Children and Families (2015)

Children can experience many adverse 'risk factors' relating to health, family or environment. These risk factors rarely occur in isolation and can combine to lead to relatively poor outcomes later in life. Establishing which children face different combinations of these risk factors would allow for a whole range of services to be better targeted and coordinated to improve positive outcomes later in life.

The JSNA looked at both geographical patterns of vulnerability factors and explored joining datasets together to identify which groups of children and young people were most vulnerable in Cambridgeshire, and to examine which services they were in touch with.

Vulnerability factors **Maternal qualifications**, **language spoken** at **home**, **mother's** self-rated **health**, **depression** and **socio-economic** situation are **common risk factors** across **educational**, **behavioural** and **health outcomes** for **children**. The **home learning** environment, where mothers provide more stimulation and teaching, was found to be a **protective factor**. Data were analysed at low geographical areas for proxies of these indicators and concluded that there are **areas outside of those most deprived** that would benefit from **additional prevention** work. The table below presents the data at district level. **Fenland** appears challenged for all indicators reported.

Indicator		Cambridge City	East Cambridge shire	Fenland	Huntingdon shire	South Cambridge shire
Poor performance (all pupils)	EYFS	High	Low	High	Low	Low
	KS2	High		High	Low	Low
	KS3	High		High		Low
Breastfeeding 6-8 weeks		High	Unknown	Low	Low	Unknown
Teenage conceptions			Low	High		
Mothers aged under 22 years		Low		High		
Hospital admissions due to unintentional and deliberate injuries	0-4 years			High	High	Low
	0-14 years				High	Low
A&E attendances (0-14 years)		High (under 5's only)	High	High	Low	Low
Female population with low qualifications		Low	High	High	High	Low
Household overcrowding		High	Low	High	Low	Low

▮ Statistically significantly higher/worse than Cambridgeshire   ▯ Statistically significantly lower/better than Cambridgeshire

Please note : admissions for Huntingdonshire may be over-represented due to local data recording issues

Person specific analysis The main aim of the JSNA was to identify groups of children and young people who had risk factors which made them potentially vulnerable to poor educational outcomes and to examine which services they were in contact with. The original scope of the study was wider than this, with the intention of bringing together data from stakeholders at an individual level to better understand how risk factors combine over several services, but this proved not possible at the time and was limited to County Council services and data only.

Key findings

- **Poor attainment** is more **concentrated** in the **most deprived** parts of the county. Almost one in three (29%) children with poor attainment levels live in the 20% most deprived parts of the county (and approximately two in three (71%) outside these areas).
- A **large proportion** of children with **poor levels of attainment** accessing **free school meals are in touch with council services**, particularly at Key Stage 2.
- Children with **special educational needs** account for a **large proportion** of children with **poor attainment** who access **free school meals**, particularly in Key Stage 2, where the Council is also in contact with a high percentage of these children.
- There are **parts of the county** where there are **lower levels of good attainment**, and these are not necessarily in the most deprived parts of the county.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/vulnerable-children-and-families-2015

Carers (2014)

A carer is a person of any age - adult or child - who provides unpaid support to a partner, child, relative or friend who could not manage to live independently or whose health or wellbeing would deteriorate without this help. Those receiving this care may need help due to frailty, disability or a serious health condition, mental ill-health or substance misuse.

Young carers are significantly more likely to grow up in **poverty**. They have significantly **lower attendance** and **attainment** at school and may be **victims of bullying**. Young carers may be at **higher risk** of **poorer health** and **risk-taking behaviour** as they move into **adulthood**.

In Cambridgeshire young carers reported that they want time to have **fun** and **socialise**, to get **breaks** from caring, to get **more help** for the person they care for, to be **less isolated**, to have **more money** in their families, to have **help at school**, to get help to get the best from **learning** and **work towards** an **independent future**. As well as, to be meaningfully **involved** in the planning for their cared for person, to be given **information** and **knowledge** about the practicalities of caring, to have **emotional support** with worry, anxiety and low self-esteem and to get help **planning** for and dealing with **family crises**.

In the 2011 census **60,176** people in **Cambridgeshire** self-identified themselves as **carers**, with a **fifth** providing **50 or more hours** of unpaid care per week

Around **60%** of carers are **aged over 50 years**. The highest proportion of unpaid carers are in **Fenland (11.1%).** There were **4,208** young people aged **under 25 years** providing care, with almost **one** in **ten** providing **over 50 hours**

Dementia carers need and value **information** and **support** at a number of **critical points** along their caring journey. It is key that the carer knows where to go to for **advice**, knows what **support** is **available**, that the **professionals** they are in contact with are **knowledgeable** regarding dementia, that they **engage** with both the carer and the person with dementia and they understand the **carers needs** and issues, not just those of the person with dementia.

End of life carers share many of the positive and negative aspects of any other form of caring, but there are **additional challenges**, including **rapidly changing** care **needs**, the need to understand **complex** and often uncertain **medical information** around prognosis and symptom control, and the prospect and reality of **death** and **bereavement**. The impact on health and wellbeing of caring for someone who is dying includes the physical and psychological impacts of any caring role but with the additional strain of bereavement.

Parent carers need **breaks** from their caring responsibilities, access to **continuous emotional support** including out of hours, weekends and during school holidays and support from diagnosis through to **adulthood**. This includes support from professionals and other parents and support for their wellbeing and a safe place to show their feelings.

Carers may **not prioritise** their **own health** and may miss routine health appointments like influenza vaccinations or check-ups with doctors or dentist. Carers may **give up work** as a result of their caring responsibilities. This is significant given the importance of 'meaningful activity' (such as employment) to maintaining an individual's positive **mental health**. Such activity also reduces **social isolation**. **Cambridgeshire carers asset mapping** has identified the importance of **local community networks** and services in supporting the health and wellbeing of carers. Carers in **new communities** may therefore be at risk of having fewer opportunities for support. Carers from **BME groups** are likely to be under-identified in Cambridgeshire. Services for carers are not necessarily culturally sensitive in relation to the **Gypsy and Traveller** community. This community is at particular risk of missing out on Carers Allowance because of the impact of travelling and may be forced to move away from established community networks to be able to access equipment and adaptions.

www.cambridgeshireinsight.org.uk/jsna/carers

Primary Prevention of Ill Health in Older People (2014)

Modification of risk factors in later life is still beneficial for health: chronic degenerative disease and ill health are not inevitable outcomes of ageing

It is never too late to make changes

There is significant variety in the way individuals experience and respond to their senior years, and a range of cultural differences, preferences and perspectives on what healthy ageing means for each person which could inform effective preventative work locally.

Encouraging healthy behaviours in 55-75 year olds may be most effective as they may be more ready, interested and intend to change than individuals in older age groups.

Active ageing needs to ensure the **mobility** of older people so that they are able to participate in society and the community around them, maintain social networks, access services, and benefit from leisure, social and volunteering opportunities. **Access** to **local shops** and **food sources** are important in maintaining a **healthy diet**. **Loneliness** has detrimental impacts on **physical** and **mental health**, and **increases** the likelihood of multiple **unhealthy behaviours**. Access to **transport** influences healthy behaviours.

Physical Activity is the fourth leading risk factor for death worldwide. Volume of activity is more important that engaging in specific types of activity. Community assets in Cambridgeshire exist but may not be available to all and sustained funding is not assured.

Dietary improvements made in older age significantly **reduces** the risk of chronic diseases. Nationally, older adults consume **low levels** of **fruit and vegetables**, **fibre**, **oily fish**, and **high levels of salt** relative to recommendations. Daily **vitamin D** supplementation is recommended by the Department of Health for all adults aged 65 years and over. Locally there are **lifestyle support services** accessed by older adults, and **practical advice** and **support** through social care and voluntary sector organisations. There may be **opportunities** to look at **enhancing messaging** about a healthy balanced diet for older adults through local services, stakeholders, health and social care professionals, and to consider the **healthiness** of the food offered in **residential** and **social settings**.

Malnutrition in about **two thirds** of cases are **not recognised**; the impacts are increased burden of disease and treatment costs. **Social networks** have a **preventive role**, as interest groups and shopping clubs support motivation and the means for good nutrition. **Regular screening** for malnutrition in care settings is recommended by NICE. Awareness of malnutrition needs to be improved by both healthcare workers and the wider public. The majority of individuals at **risk** of malnutrition **live** in the **community**. **Preventative resources** include home help schemes, community navigators, lunch clubs, day care centres, shopping services and the support offered by voluntary organisations. **Service coverage** is **not even** across the **county** e.g. there are fewer lunch clubs in rural areas, where social isolation may be a greater problem.

> An estimated **10,000** to **14,000** older residents in Cambridgeshire are **malnourished**, with many more are at risk

Smoking cessation in people aged 60+ years **significantly improves health** and **reduces mortality**. **Increasing access** to **stop smoking services** should be **encouraged** for older smokers.

> An estimated **17,700** people aged over 60 years **smoke** in Cambridgeshire, with prevalence being higher in Fenland

There are opportunities for local health and social care professionals to make every contact count in modifying these risk factors in older people. A **positive view** of **healthy ageing** and an **increased awareness** of the **available services** will enable **tailored support for older adults,** with potential advantages in overcoming social isolation and in strengthening local communities.

www.cambridgeshireinsight.org.uk/primary-prevention-ill-health-older-people2014

Older People's Mental Health (2014)

Over a **third** of **older people** in the UK are likely to experience **mental health problems**. **Depression** and **anxiety** are the most common conditions, followed by **dementia**. The JSNA focussed primarily on depression and dementia.

> **Dementia** is a group of related symptoms associated with an **ongoing decline of the brain** and its abilities, including problems with memory loss, thinking speed, mental agility, language, understanding and judgement

> **Depression** is a **mood disorder** that causes a persistent feeling of sadness and loss of interest

There appears to be widespread under-diagnosis of depression in primary care in Cambridgeshire, as reflected nationally. Rates of diagnosis also vary between practices. Depression is a distressing, but highly treatable condition, so improvement in rates of diagnosis is important.

Dementia is also under-diagnosed in primary care, with unexplained variation in rates of diagnosis and prescribing. **Early diagnosis** means that patients and carers can receive appropriate information and support, so ensuring the condition is recognised promptly is beneficial. **Improving diagnosis** in primary care is a priority, as part of an integrated approach and partnership working, to improve awareness of mental health needs in the community. Training programmes to raise awareness of dementia are in place across primary care, community and acute settings. Local support services are also provided by the Alzheimer's Society and Mind.

> By **2026** the number of people aged **over 90 years** is forecast to more than **double**, with the number of people in their **80s** rising by **more than 50% ***
>
> Over this time it is expected that the number of older people with **depression** will **increase by 12%*** (1,500 people) and the number with **dementia** will **increase by 64%* (**4,700 people)
>
> **Increases** of this size over a short period will put **severe strain** on **existing services**
>
> * between 2012 and 2026

> NICE recommend **reviewing** and **treating vascular** and other **risk factors** for **dementia** in **middle-aged** and **older** people. These include **smoking**, **excessive alcohol use**, **obesity**, **diabetes**, **hypertension** and raised **cholesterol**.

There is substantial **variation** in the **rate of referrals** to the older people's mental health service, with **lower** rates seen in **South Cambridgeshire**, and **higher** rates in **Cambridge City, Fenland** and **East Cambridgeshire**. The reasons for this variation are unclear, and may relate to data quality problems so would merit further investigation.

The main concerns of local service users and carers were:	
• Service delivery	• Transition between services
• Organisational challenges	• Continuity of relationships
• Co-ordination of services	• Culture and equity
• Safeguarding of vulnerable people	• Physical health and mental health
• Access to services	• Carer's needs

Service improvement ideas from service users and carers included more **help** with **practical things**, such as **maintaining relationships**, **applying for benefits**, and a **focus** on the **positives** rather than the diagnosis. **Community support** and **signposting** for where to go for **help**, **ideas or friendship** were also considered important. **Information** and **training** for **families** and **carers** as well as those with mental health disorders, and seeing the **same health professional consistently** were also suggested.

> www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/older-peoples-mental-health-2014

Adult Mental Health : Autism, Personality Disorder and Dual Diagnosis (2014)

Autism Spectrum Conditions are a group of complex brain development disorders that affect the way people communicate, relate to others and make sense of the world around them.

Personality disorders are conditions in which an individual differs significantly from an average person, in terms of how they think, perceive, feel or relate to others.

People with **dual diagnosis** have a mental health problem and also misuse drugs or alcohol.

An **increase** in prevalence of **common mental health disorders**, as well as those conditions specific to this JSNA, is predicted **across all Cambridgeshire districts**, with growth in numbers concentrated **especially in Cambridge City,** due to **population growth**.

In Cambridgeshire, many people with depression have not been diagnosed and recorded by their primary care teams, which reflects a national trend. This suggests that there is unmet mental health need within the population. In addition, depression occurs in people with Autism Spectrum Conditions, personality disorder and dual diagnosis, so this under-diagnosis of depression is relevant to their needs.

Adults with **severe mental illness** have a substantially **reduced life expectancy** due to both mental and physical ill health, with a significant proportion of excess deaths being associated with physical conditions. A proportion of those within the specific conditions considered in this JSNA are likely to have severe mental illness. In addition, there is often **inequality of access** to **health services** for **physical illness** for people who use mental health services.

By **2026 *** it is predicted that there will be:

- **2,000** people with **borderline personality disorder**
- **1,600** with **anti-social personality disorder**
- **5,100** with **autism spectrum conditions**

    * from 2012

For adults with autism, a high-quality diagnostic service is available from Cambridgeshire and Peterborough Foundation Trust. However, services to support adults with **autism** and their **carer's** in the **community** are sometimes **fragmented** and **difficult** to **access**. There are strong indications of problems in services for people with **dual diagnosis**. There are examples from both service providers and service users which suggest that sometimes neither the substance misuse service nor mental health services are willing to take on patients with more severe dual diagnoses.

Adults with mental disorders, including personality disorder, dual diagnosis and autism, sometimes experience mental health crisis and need help quickly to stop them harming themselves or others. The Crisis Care Concordat is aimed at making sure that people experiencing a mental health crisis receive an appropriate emergency mental health service.

The main concerns of local service users and carers were:

- Service delivery
- Organisational challenges
- Co-ordination of services
- Safeguarding of vulnerable people
- Access to services
- Transition between services
- Continuity of relationships
- Culture and equity
- Physical health and mental health
- Carer's needs

Service improvement ideas from service users and carers included more **help** with **practical things**, such as **maintaining relationships**, **applying for benefits**, and a **focus** on the **positives** rather than the diagnosis. **Community support** and **signposting** for where to go for **help**, **ideas or friendship** were also considered important. **Information** and **training** for **families** and **carers** as well as those with mental health disorders, and seeing the **same health professional consistently** were also suggested.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/autism-personality-disorders-and-dual

Armed Forces (2013)

The Armed Forces JSNA focuses on **military personnel, veterans, reservists** and their **dependents.**

> **Service in the Armed Forces is generally associated with good physical and mental health, due to good diet, exercise and access to medical services. However, there is a variety of health and lifestyle issues that ex-service personnel face on leaving the Armed Forces, with Early Service Leavers being the most vulnerable.**

There are **four** Armed Forces bases in Cambridgeshire

- **Bassingbourn** RAF/Army
- **Waterbeach** Army
- **Brampton/Wyton** RAF **Alconbury** USAF

As at **1 January 2013** there were **1,240 Armed Forces personnel** located in **Cambridgeshire** (70% Army, 28% Royal Air Service and 2% Naval Service)

Two thirds of personnel live in **South Cambridgeshire**, with a further **31%** living in **Huntingdonshire** and **2%** in **Cambridge City**

Health The majority of **veterans** are older people who face the **same health issues** as the general population. However, veterans may have a **higher prevalence** of **musculoskeletal** conditions, **cardiovascular disease**, **respiratory** problems, **sight** problems and **mental health** problems. **Stigma** and **reluctance** to access services are the **main barriers** to **care**.

Mental health The **prevalence** of **mental disorders** in **younger veterans** is **three times higher** than the **UK population** of the same age. **Exposure** to **violent** or **traumatic experiences**, **instability** in **domestic life**, **difficulties** in making the **transition** from **service** to **civilian** life and the consequences of the **excessive drinking culture increase mental health risks** for **veterans**.

Oral health **Dental emergencies** are up to **five times higher** in a **dentally ill-prepared Force**, compared to a well-prepared force. Dental morbidity is one of the most significant causes of Disease and Non Battle Injury (DNBI) and subsequent lost time from operation is considerable.

Lifestyles **Alcohol misuse** in the serving population is **substantially higher** than the **general population**, at **over double the rate**.

Wider determinants of health The Armed Forces, especially the Army, **recruit** from more **deprived communities**. **Unemployment** rates in people of working age are similar to the national average, but double the national average for people aged 18-49 years. There is an increased risk of **violence** by veterans due to experiences of combat and trauma, mental health problems and alcohol misuse. It is estimated that 3.5% of the **prison** population are veterans, with a higher prevalence of sexual offences compared to the general prison population. Access to **housing** is an issue for personnel leaving the service. All districts in Cambridgeshire include Armed Forces personnel in their eligibility criteria for social housing. It is estimated that between 6% and 12% of **rough sleepers** are ex-armed forces personnel.

Dependents and families Service children who face regular moves from home and school can suffer high levels of **anxiety** and **stress**. **Access to services**, such as NHS dentistry, immunisations and planned hospital care, is a particular issue for families that frequently move, as is their opportunities for **employment**, **education** and **training**.

Cambridgeshire has an **Armed Forces Covenant Board** that aims to improve the outcomes and life choices of military personnel, reservists, their families and veterans living in Cambridgeshire and Peterborough. The Covenant Board also aims to enhance the relationship between the civilian and military communities.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/armed-forces-2013

Housing and Health (2013)

Housing needs in the Cambridgeshire are regularly assessed and updated through the Strategic Housing Market Assessment (SHMA). The JSNA examined the link between the health and wellbeing of Cambridgeshire residents and the housing priorities from the SHMA.

Affordability of housing is a key issue for Cambridgeshire. Affordability ratios vary across the county, but even in Fenland, which is a relatively affordable area, the average house price was 4.7 times above the average income. **Affordable housing** and the **limited availability of affordable tenure homes** are significant issues across the county, and is under pressure as people find it hard to access the private housing market, particularly those on lower incomes.

Another significant issue for Cambridgeshire is the provision of **appropriate housing** for the **growing older population**, for example through 'floating support services', sheltered housing or extra-care housing, which are likely to reduce the need for residential care.

Housing-related support (previously known as the 'Supporting People Programme') **supports** some of the most **vulnerable** and **socially excluded** members of society. The primary purpose is to develop and sustain an individual's capacity to live independently in their accommodation. Housing related support is vital to many, helping them recover from a life trauma, maintain their existing housing, or continue to live at home.

Across the county more than **70,000 new homes** are planned to be built between **2011** and **2031**

Since 2003, a total of almost **6,000 new affordable tenure homes** have been built across Cambridgeshire (27% of the total number of homes built)

Low income households and **vulnerable groups** are the most **likely** to occupy **poor standard homes**, often related to issues of **overcrowding**, **fuel poverty**, **disrepair**, **damp** and **mould**. **Homelessness** remains a major issue across the county.

As fuel prices rise more rapidly than income and benefit levels, **heating** will become increasingly difficult to afford for some groups. The risk to vulnerable and older residents is likely to increase, and measures to improve energy efficiency will be needed even more than at present to maintain health and independence at home.

In **March 2013**, nearly **20,000 people** were **registered with Home- Link** i.e. in housing need and applying for social housing, across Cambridgeshire. Of these, more than 1,000 had an 'urgent' or 'high' health and safety or medical need

More than **800 households** approached the local authority as **homeless** in **2011/12**, of which nearly **600 were accepted** as 'statutory homeless'- **250** of these were living in **temporary accommodation** at the end of March 2012

Estimates made in 2010 showed more than **46,000** of Cambridgeshire **households**, or 14.5%, were in fuel **poverty** (ie more than 10% of household income is spent on heating) compared with 11.5% in 2008. Levels of **fuel poverty** were **highest** in **Fenland** and **lowest** in **Huntingdonshire**

A local new development survey found that:

- **Younger population** than the general population; 78% aged under 45 years; 9% aged 60+ years
- The main reasons for moving were: **larger/smaller home, employment** and to be near **family and friends**
- Negative issues experienced were **lack of shops, parking, public transport, anti-social behaviour** and **too much traffic**

www.cambridgeshireinsight.org.uk/housing-jsna-2013

Prevention of Ill Health in Older people (2013)

Early interventions can enable older people to remain well and live independently at home, or in a community setting, and prevent or reduce unnecessary hospital admissions

Preventing hospital admissions and developing integrated care model

Early interventions to prevent ill health and deterioration are desirable for both older people and their families or carers, and to reduce the use of expensive acute hospital care. Nationally, integrating care for older people is proposed as an approach to meet the funding challenges of financial austerity, rising acute healthcare costs and an ageing population with an increasing demand on acute services.

Case management by multi-disciplinary teams for 'frail' elderly people

A frail person is someone with a number of physical or mental disabilities or a cumulative loss of function, which makes a person more vulnerable to an acute health or social crisis. Intervening early requires identification of those who are most at risk. Risk stratification tools use data from primary and secondary health care to predict a patient's risk of future emergency admission. Primary prevention is also important in reducing the risk of respiratory and circulatory diseases, the top two causes of hospital admissions in Cambridgeshire for older people. There is also strong evidence base for secondary and tertiary prevention to reduce the impact of a stroke or heart attack.

Nearly **17,000** people aged **over 65 years** (16.8%) are likely to be '**frail**'

Falls prevention

Falls are a major cause of disability and the leading cause of mortality due to injury in older people over 75 years old. Cambridge City has significantly high admission rates for falls and hip fractures. There are a range of falls prevention and falls services available across Cambridgeshire.

There were **2,650** emergency admissions in **2011/12** for **injury due to falls** in the **over 65s**, accounting for **7.7%** of **all emergency admissions**

Mental Health

Over a third of older people in the UK are likely to experience mental health problems. The prevalence of depression in older people is almost three times more common than dementia (and increases with age), particularly in those living alone with poor material circumstances. Although 20% to 40% of older people in the community show symptoms of depression, only 4% to 8% will consult their GP about this problem.

Reducing social isolation and loneliness

Loneliness and isolation amongst older people is a key issue which impacts on their health and wellbeing

Approximately **29,000** people over 65 years old **live alone** in Cambridgeshire

Social care and support in the community

There are a number of local interventions and examples of good practice which help prevent or delay the need for health and social care. Re-ablement services are widely available and proven to be effective in helping older people regain their independence. GPs are a key point of contact with 'at risk' older people and provide an opportunity to signpost to preventative and community support services.

Housing

Supporting older people to remain in their own homes meets their aspirations and generates significant financial savings. Fuel poverty is a growing problem, with the percentage of households in fuel poverty increasing from 11.5% to 14.5% between 2008 and 2010.

Supporting carers

Carers provide a crucial role in supporting older people to be independent and live in the community. Better recognition of a caring role would help older people identify themselves as a carer at an earlier stage. Many carers are older people themselves and have specific health and wellbeing needs, as well as needs relating to their caring role.

Nationally **65%** of **older carers** have **long-term health problems** or a **disability** and **69%** report being a carer has an **adverse effect** on their **mental health**

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013

The Mental Health of Children and Young People (2013)

There are a large number of **risk factors** that increase the vulnerability of children and adolescents experiencing mental health problems. These include **deprivation**, **poor educational** and **employment opportunities**, **enduring poor physical health**, **peer** and **family relationships**, **witnessing domestic violence**, and having a **parent who misuses substances** or **suffers from mental ill-health**. Children who have been **physically and sexually abused** are at particular risk. **Asylum seeker** and **refugee** children can have higher levels of mental health problems, including post-traumatic stress, anxiety and depression. The way that children are **parented**, their **diet** and **exercise**, their **school** and **education**, **experimentation** with **drink**, **drugs** and other **substances**, along with many other factors, will all affect a child's mental wellbeing or mental ill-health.

Many children experience more than one risk factor, and four or five adverse childhood experiences (child abuse, parental depression, domestic abuse, substance abuse or offending) which increases the risk of developing mental health problems throughout life. Around half of lifetime mental illness starts before the age of 14 years. Potentially, half of these problems are preventable.

If children and young people are at risk of developing poor mental health, they need to **develop resilience**; **self-awareness**; **social skills**; **empathy to form relationships**; **enjoyment of one's own company; deal with life's normal setbacks constructively.**

it is estimated that **one** in **ten** children and young people aged **five to sixteen** years have a **clinically significant mental health** problem, with a **higher** prevalence of mental disorder in **boys** than girls. It is estimated that mental health disorders more prevalent in parts of Fenland and Cambridge City.

> **Since 2010/11, the number of children and young people admitted to hospital for self-harm has increased.**

A local consultation asked children and young people to describe what makes them feel well, what helps them recover if they are unwell and how mental health workers and services should behave.

It is estimated that there are following number of children and young people have mental health problems:

- **5,000** children **under** the age of **five**
- **8,000** between the ages of **5-16**
- **1,275 16-17** year-olds

Of the children aged **5-16 years**:

- **3,100** have an **emotional disorder**
- **4,800** have a **conduct disorder**
- **1,200** have a **hyperkinetic disorder**
- **1,100** have a **less common disorder** including **740** with **Autism**

Conduct disorder is the **most common** diagnosis, with the **majority** found in **boys**. **Emotional disorder** (depression and anxiety) is the next most common condition, the **majority** of which is found in **girls**

Parental mental health has a critical impact on children's mental health. It is estimated that there are the following number of children and young people in Cambridgeshire:

- **22,700** living with at **least one parent** with **mental illness**
- **5,400 living with a problem drinker** with **concurrent mental health problems**
- **3,300 living with a drug user** with **concurrent mental health problem**

What makes young people well?
(from local consultation)

- **Accessible support** in general is important, rather than waiting to be 'ill'
- **Support** from **family** and **friends** is important, as is their **awareness** of mental health
- **Support needs** to be from **friendly**, **approachable** and **empathic people**.
- Being **protected** from harm/bullying, parents
- Learning **to deal with stress**

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/mental-health-children-and-young-people

Physical disabilities and Learning Disabilities through the life course (2013)

People with **disability** are more likely to **live in poverty** and be **unemployed**. People with **learning disabilities** are more likely than their non-disabled peers to be exposed to **poverty, poor housing conditions, unemployment**, **social exclusion, violence, abuse** and **discrimination**. Those who are already disadvantaged are at a greater risk of becoming disabled later in life. Children and adults with disabilities are **vulnerable to abuse**.

As the Cambridgeshire population grows and ages, the number of people with disabilities is also expected to rise. The proportion of people with a learning disability aged over 55 years is expected to increase and parents caring for them are likely to have died or become frail. **Social care** requirements for people with learning disability in England are expected to **increase** by **14%**, up to **2030.**

The number of **children** with **disabilities** is predicted to **increase**. Children with **special educational needs** are **three times more likely** to be recipients of **free-school meals**. Parents of children with disabilities in Cambridgeshire report a need for better emotional and relationship support for parents right from the start, and for access to skilled, knowledgeable and sensitive health workers.

People with disabilities are subject to the **same risk of chronic diseases** as the population as a whole, but may be less able to **access healthy choices**. People with disabilities may be less able to **access leisure services**, and people with learning disability and their carers may have poor knowledge of **healthy eating**. People with learning disabilities are less likely to take up **screening** and other **health promotion** activities.

People with learning disabilities are more likely to experience **ill health** and to die younger. In part, this is related to a number of environmental factors, including, poverty, discrimination and unemployment. Preventable causes of death are relatively common, such as pneumonia, which can result from swallowing difficulties and seizures.

Supporting those with the most complex needs requires joint working across sensory, learning disabilities, older peoples and complex care teams. The key to improving the health and wellbeing of people with learning disabilities is the ability for services to share information.

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/physical-and-learning-disability-through-life

Summary of older JSNAs completed

The following section outlines the priority needs in the older JSNA's completed.

Prevention of Ill Health in Adults of Working Age (2011)

There is substantial evidence that prevention works, it can provide cost benefits and importantly can make significant improvements to the health of the population, decrease health inequalities and effectively address health and social problems.

Up to date local data on lifestyle indicators are available through the
Public Health Outcomes Framework : www.cambridgeshireinsight.org.uk/health/phof

- Surveys indicate that participation in physical activity decreases with age.
- Nationally, the prevalence of obesity among adults has increased sharply in recent decades. Key factors for prevention of obesity are a healthy diet and physical activity.
- Tobacco use remains the leading cause of preventable morbidity and mortality worldwide. Smoking prevalence is higher in more deprived populations and amongst routine and manual group of workers.
- Excessive alcohol use, either in the form of heavy drinking or binge drinking, can lead to increased risk of health problems such as liver disease or unintentional injuries.
- Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by the prevalence of hepatitis B and hepatitis C infections, which are both amenable to public health interventions. Persons who inject drugs are at higher risk of contracting hepatitis B and C infections.
- The vulnerable and socio-economically disadvantaged groups are more likely to be at risk of poor dental and oral health. Adults who smoke, take drugs, binge drink or who are obese are more likely to suffer from gum disease and mouth cancer.

Screening programmes that are mostly accessed through general practices are well established and generally meet the targets to ensure that the population as whole is protected. However there is some inequity of service provision across the county and there is insufficient information about screening in vulnerable and hard to reach groups.

Prevention priorities identified :

- Lifestyle issues
- Workplace health
- Domestic violence
- Socio-economic factors especially housing
- Long term conditions

www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013

Children and Young People (2010)

The priority needs that were identified for Cambridgeshire were:

- Ensuring that all children get a good start in life as an increasing body of evidence shows that the first few years will impact lifelong.
- Supporting good mental health and emotional wellbeing which are fundamental to achieving good health.
- Preventing/reducing the negative impact of alcohol and substance misuse, obesity and overweight, childhood accidents, child poverty, domestic violence and disabilities and the consequent inequalities in outcomes for children, young people and their families.

www.cambridgeshireinsight.org.uk/currentreports/children-and-young-people

Mental Health in Adults of Working Age (2010)

The priority needs that were identified for Cambridgeshire were:

- Ensuring a positive start to life: childhood and early adulthood are key periods in the development of personal resilience and educational and social skills that will provide the foundations for good mental health across the whole life course. Key interventions to promote a positive start in early life are:

    - Promoting parental mental and physical health.
    - Supporting good parenting skills.
    - Developing social and emotional skills.
    - Preventing violence and abuse.
    - Intervening early with mental disorders.
    - Enhancing play.

- Interventions that particularly help to maintain mental health for older people include reducing poverty, keeping active, keeping warm, lifelong learning, social connections and community engagement, such as volunteering.
- Interventions to increase individual, family and community resilience against mental health problems include those which reduce inequalities, prevent violence, reduce homelessness, improve housing conditions and debt management, and promote employment.

www.cambridgeshireinsight.org.uk/currentreports/mental-health-adults-working-age

New Communities (2010)

The priority needs that were identified for Cambridgeshire were:

- Provision of 'lifetime homes which can be adapted to the needs of residents as they become older.
- Incorporating a range for formal and informal green space into new developments.
- Identification of community development roles, (which could be funded from a variety of sources) during building of large new housing developments – to provide early social infrastructure and support the integration of new residents including young families into the community.

www.cambridgeshireinsight.org.uk/cambridgeshire-jsna/new-communities

Travellers (2010)

The priority needs for Gypsies and Travellers in Cambridgeshire were:

- Continue to implement and evaluate the existing county wide Gypsy and Traveller strategy to improve outcomes and life chances for Gypsy and Traveller communities and promote and enable community cohesion in Cambridgeshire.
- Improving data collection and ethnic monitoring to support better planning and commissioning of services.
- Ensuring good access to health services and support especially for early intervention/prevention, health promotion, mental health and wellbeing and for those with complex health needs. Providing public health and other service information and communications in an accessible format to the Gypsy and Traveller population with appropriate content.
- Improving site management and provision, promoting good practice in education, sharing good practice across different organisations and promoting continuing community engagement between the settled and Traveller communities to reduce mistrust, fear and discrimination.

www.cambridgeshireinsight.org.uk/currentreports/travellers

People who are homeless or at risk of homelessness (2010)

The priority needs for homeless people in Cambridgeshire were:

- Addressing the needs of chronically excluded adults, single homeless and rough sleepers in Cambridgeshire focusing on the complex interrelationships between health, housing and social care to improve outcomes. The MEAM project is showing good initial outcomes.
- Developing methods to encourage service user and frontline staff engagement in planning, service redesign and commissioning processes. Service users' experience and perceived needs should be embedded in the planning of their own care and of wider services.
- Developing integrated information systems, data collection tools and ways of unifying individual client records so they can be used and accessed across services to allow more holistic and person-centred care.
- Developing services enabling prevention of homelessness and early intervention for the newly homeless to improve individual lives and to reduce overall homelessness. Support is particularly required at transition points such as leaving care, prison release and hospital discharge.

www.cambridgeshireinsight.org.uk/currentreports/homelessness-and-at-risk-of-homelessness

Migrant workers (2009)

The wellbeing and integration of migrant workers is affected by their financial situation, access to adequate and affordable accommodation and access to English language courses. The numbers of international migrants are increasingly spread throughout the county, with notable migration from Western Europe and Asia. Access to good quality and affordable accommodation is critical in providing stable circumstances for migrants to be economically active and to promoting community cohesion.

A number of projects have been undertaken to meet needs in recent years. Continuing work of partners in Fenland includes promoting community cohesion, provision of support for English as a second language, multiagency action to address issues relating to Houses in Multiple Occupation and provision of community services.

www.cambridgeshireinsight.org.uk/currentreports/migrant-workers

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