NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Cambridgeshire
County Council

Cambridgeshire JSNA

Summary report

2014/15

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Introduction

This JSNA Summary Report for 2014/15 provides a brief overview and update on the entire breadth of the JSNA work in Cambridgeshire to date, along with a description of the latest key population and health statistics for the county. 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. Based on this breadth of work, the report includes a summary of the key health and wellbeing needs in the county and informs the county-wide Health and Wellbeing Strategy.

The purpose of the JSNA 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. This summary report does not have the depth of information needed to support planning of services, however, the detailed reports are available at: **www.cambridgeshireinsight.org.uk/jsna.**

The JSNA is becoming increasingly important as a shared resource, through which different organisations can understand the health and wellbeing needs of communities in Cambridgeshire. It provides an information base for the Cambridgeshire Health and Wellbeing Board and Network.

As part of the 2014/15 JSNA programme of work, the following JSNA reports have been developed:

- Transport and Health
- Vulnerable Children and Families

As part of the 2015/16 JSNA programme of work, the following JSNA reports are currently in development:

- Long Term Conditions (due to be published July 2015)
- Drugs and Alcohol (due to be published in early 2016)
- New Communities (due to be published in early 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 on:

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

Population and health statistics

Cambridgeshire - Summary of Health Profile 2015

Cambridgeshire is a relatively affluent county, but significant pockets of deprivation exist across the area, most notably in Fenland, north Huntingdon and north of Cambridge City.

Life expectancyfor both males and females is significantly **higher**in Cambridgeshire when compared to England. However, life expectancy is 6.8 years lower for men and 5.0 years **lower**for women in the **most deprived areas**of Cambridgeshire thanin the least deprived areas.

Child Health

In Year 6, 16.2% of children were classified as **obese**,**better** than the average for England. The rate of **alcohol specific**hospital stays among those under 18 was**better**than the average for England. This represents 42 stays peryear. Levels of **teenage pregnancy, breastfeeding and smoking at time of delivery** are **better** than the Englandaverage.

Adult Health

In 2012 21.6% of adults were classified as obese.The rate of **self-harm hospital** stays are**worse** thanthe average for England, with 1,597 stays per year.The rate of **smoking** related deaths are **better**than theaverage for England. This represents 767 deaths per year.

Estimated levels of **adult smoking** and **physical activity** are**better** than the England average. The rate of people **killed and seriously injured on roads** is **worse** than average. Rates of**sexually transmitted infections** and **TB** are **better** than average.The rate of new cases of **malignant melanoma** is **worse** thanaverage. Rates of **violent crime**, **long termunemployment**,**drug misuse**, **excesswinter deaths**,**early deaths** from**cardiovascular** diseases and early deaths from **cancer** are**better** than average.

Cambridgeshire Priorities

To address the impacts of population growth and ageing, mental health issues and health inequalities, by embedding public health improvement throughout local government and the NHS.

Link to Health Profiles

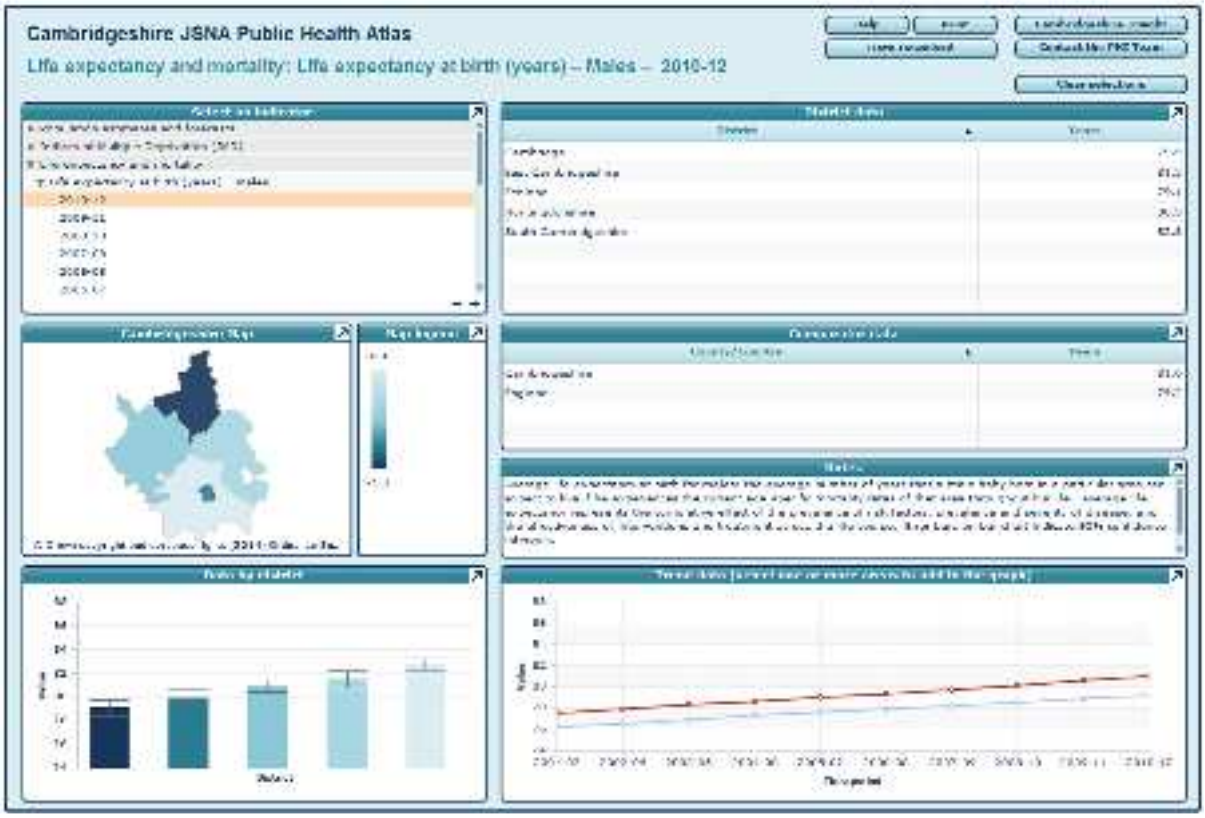
www.cambridgeshireinsight.org.uk/health/profilesdata/lahealthprofiles

Source : Health Profiles, 2015, Public Health England

Cambridgeshire JSNA Public Health Atlas

Cambridgeshire Insight
Data | Insight | Local

The Cambridgeshire JSNA Public Health Atlas has been developed in support of the JSNA programme. This interactive atlas provides the latest available data by local authority district for a number of key indicators relating to the health of the local population and is continually being expanded and updated.



For the latest data, including tables, maps, graphs and trend data, and more detailed information on sources and metadata, please visit:

www.cambridgeshireinsight.org.uk/health/profilesdata

As well as the Cambridgeshire JSNA Public Health Atlas, the Health and Wellbeing pages of Cambridgeshire Insight host a number of other resources which are useful for needs assessments and service planning. For example, information is provided on:

- **Public Health Outcomes Framework**www.cambridgeshireinsight.org.uk/health/phof
- **Annual Director of Public Health report** www.cambridgeshireinsight.org.uk/health/aphr
- **NHS Cambridgeshire and Peterborough CCG Health Profile**
- **Local Alcohol Profiles for England**
- **Child Health Profiles**

Other topic areas on Cambridgeshire Insight provide further information on the wider determinants of health, covering the **2011 census**, **community safety**, **economy**, **education**, **housing**, **planning** and **population**, for example. The **CambridgeshireAtlasWardProfiles** provide data covering the breadth of these topics at ward level which can be helpful to highlight within-district variation and potential areas of focus.

The table below presents a snapshot of some of the key population and health statistics for Cambridgeshire and the districts from Cambridgeshire Insight. The indicators are

highlighted if they are significantly better than England (green) or significantly worse than England (red).

KEY POPULATION AND HEALTH STATISTICS

			Source	Cambridge City		East Cambridgeshire		Fenland		Huntingdonshire		South Cambridgeshire		Cambridgeshire	
				Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Population	Population estimates	Children (under 16 years)	1	18,600	14.5%	16,800	19.6%	16,700	17.5%	33,000	18.8%	29,800	19.8%	114,900	18.1%
		Working age (16-64 years)	1	94,300	620.4%	53,000	337.6%	58,200	281.2%	112,300	369.4%	93,300	344.3%	411,100	377.2%
		Older people (age 65+ years)	1	15,200	11.9%	15,700	18.4%	20,700	21.7%	30,400	17.3%	27,100	18.0%	109,000	17.2%
		Total		128,000	100.0%	85,500	100.0%	95,600	100.0%	175,700	100.0%	150,200	100.0%	635,000	100.0%
	Population forecasts % change 2013 to 2021	Children (under 16 years)	2	23,300	25.3%	19,800	17.9%	18,200	9.0%	37,000	12.1%	34,100	14.4%	132,400	15.2%
		Working age (16-64 years)	2	106,600	13.0%	58,900	11.1%	60,900	4.6%	117,100	4.3%	101,800	9.1%	445,300	8.3%
		Older people (age 65+ years)	2	18,500	21.7%	19,700	25.5%	24,800	19.8%	39,400	29.6%	33,800	24.7%	136,100	24.9%
		Total		148,300	15.9%	98,300	15.0%	104,000	8.8%	193,400	10.1%	169,800	13.0%	713,800	12.4%
LE	Life Expectancy	Male (years)	3	80.0		81.8		79.5		81.0		83.0		81.2	
		Female (years)	3	84.4		85.6		82.8		84.3		85.9		84.6	
Lifestyles	Smoking	All	4	9.5		18.1		21.9		11.6		11.4		13.5	
		Routine and manual	4	25.5		34.5		34.7		17.2		28.7		27.3	
	Excess weight (overweight and obese)	Children aged 4-5 years	5	19.7		22.1		22.4		22.2		18.3		20.9	
		Children aged 10-11 years	5	29.3		30.3		33.2		28.4		26.3		29.0	
		Adults	6	54.3		65.0		72.4		69.1		64.7		65.0	
	Physical Activity	Recommended level	7	66.9		57.6		51.1		60.1		61.7		60.2	
	Alcohol	Hosptial admissions - male	8	832		669		814		738		641		723	
		Hosptial admissions - female	8	549		374		484		519		410		468	
	Teenage conceptions	Under 18 years	9	21.9		8.6		23.1		15.4		13.4		16.1	
Mortality	All age all cause mortality	Male	10	1,096.7		976.4		1,155.0		1,011.5		898.4		1,014.9	
		Female	10	773.9		696.4		859.1		764.0		665.6		749.1	
	Premature mortality (under 75 years)	Male	10	388.3		285.3		415.1		356.3		263.1		335.9	
		Female	10	217.1		196.4		285.29		237.5		193.4		225.5	

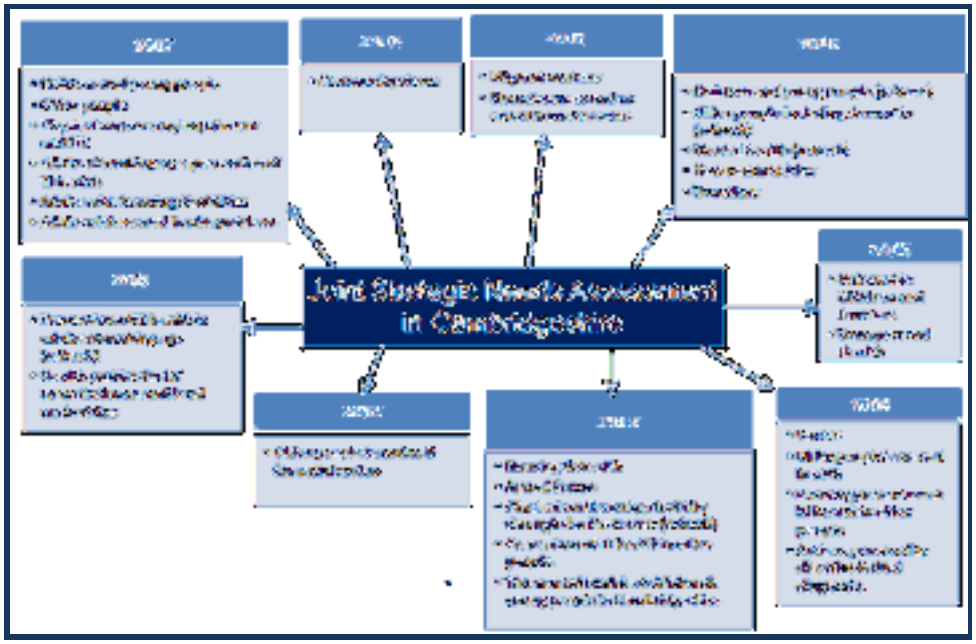
Source

1 Mid 2013 population estimates, Research and Performance Team, Cambridgeshire County Council
2 Mid 2013 based population forecasts, Research and Performance Team, Cambridgeshire County Council
3 Life expectancy, 2011-2013, Public Health Outcomes Framework, Fingertips, PHE
4 Smoking, 2013, Public Health Outcomes Framework, Fingertips, PHE
5 Childhood excess weight, 2013/14, Public Health Outcomes Framework, Fingertips, PHE
6 Adult excess weight, 2012, Public Health Outcomes Framework, Fingertips, PHE
7 Adult Physical actvity, 2013, Public Health Outcomes Framework, Fingertips, PHE
8 Alcohol admissions, 2012/13, Public Health Outcomes Framework, Fingertips, PHE
9 Teenage conceptions, 2013, Public Health Outcomes Framework, Fingertips, PHE
10 Mortality, 2011-2013, Indicator Portal, HSCIC

Statistically signficantly worse than England
No statistical difference to England
Statistically signficantly better than England
\- Significance not tested

Cambridgeshire Joint Strategic Needs Assessments

To date there have been 27 JSNA's completed in Cambridgeshire, as shown in the map below, with a further three currently being undertaken; 'Long Term Conditions'is due for completion in July 2015 and the 'Drugs and Alcohol' and 'New Communities' JSNA'sare due to be published in early 2016.



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.

Recent community views work has involved close working with partners from the Healthwatch Cambridgeshire, East of England NHS Citizen Senate, Coalition for Collaborative Care and Cambridgeshire Alliance for Independent Living, who have raised the profile of the JSNA work and encouraged direct feedback, as well as conducting further consultation discussions with other groups.

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 **prioritiesas loweremission 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.**

Activetravel

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

Half of **worktrips** are **walkedor 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 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: **improvingsafety**and **perceptionofsafety, infrastructure, culture**and **furtherassessment 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.

Accessto 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 **prioritiesof system led perspective on health and transport planning,additionalprovision such as bus provision or novel alternatives**, **alternative models of support health**, 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**, **languagespoken** 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 youngpeople 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 servicesand 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 schoolmeals 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 **freeschool 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 **higherrisk** 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 **morehelp** for the person they care for, to be **lessisolated**, to have **moremoney**in their families, to have **helpat school**, to gethelp to get the best from **learning** and **worktowards** an **independentfuture**. 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 **emotionalsupport** with worry, anxiety and low self-esteem and to get help **planning** for and dealing with **familycrises**.

In the 2011 census **60,176** people in **Cambridgeshire** self-identified themselves as **carers,** with a **fifth** providing **50 or morehours** 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 **over50 hours**

Dementia carers need and value **information** and **support** at a number of **criticalpoints** 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 **rapidlychanging** 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 **continuousemotionalsupport** 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.

Carersmay **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 andmay be forced to move away from established community networks to be able to access equipment and adaptions.

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 ageingneeds 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 **localshops** and **foodsources** are important in maintaining a **healthydiet**.**Loneliness** has detrimental impacts on **physical** and **mentalhealth**, and **increases** the likelihood of multiple **unhealthybehaviours**.Access to **transport**influenceshealthybehaviours.

Physical Activityis 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.

Dietaryimprovements 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 **socialsettings**.

Malnutritionin about**two thirds**of cases are**notrecognised**; 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 cessationin people aged 60+ years **significantly improves health**and **reduces mortality**.**Increasingaccess** 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 contactcount**in modifyingthese 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

Depressionis a **mooddisorder** 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.

Dementiais 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 ofpeople 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 **severestrain** on **existing services**

NICE recommend **reviewing** and **treatingvascular** 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
- 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 professionalconsistently** 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 disordersthat affect the way people communicate, relate to others and make sense of the world around them.

Personality disordersare 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 **reducedlife 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 Concordatis 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 professionalconsistently** were also suggested.

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

Pharmaceutical Needs Assessment (2014)

Pharmaceutical Needs Assessments (PNA) are a statutory responsibility of Health and Wellbeing Boards. The aimis to publish and keep up-to-date a statement of the needs for pharmaceutical services of Cambridgeshire's population.

Cambridgeshire is well provided for by pharmaceutical service providers. The review of the locations, openinghours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services across the county.

There are **109pharmacies**across **Cambridgeshire**, with **43 dispensing GP practices**

There are **24 pharmaceutical service providers per 100,000 registered population**in Cambridgeshire, slightly**higherthan** the

Pharmaciesare **accessible** and are often the **first point of contact**, including for those who might otherwise not access health services. **Community pharmacies**can contribute to the health and wellbeing of the local population in a number of ways, including **direct service** provision, for example, Emergency Hormonal Contraception, along with providing **ongoing support** for **lifestyle behaviour change** through **motivationalinterviewing**, providing **information** and brief **advice**, and **signposting** to other services.

The **range** of **services** provided by community pharmacies **varies** due to several factors, including: **availability** of **accredited pharmacists**, **capacity** issues in the pharmacy, changes to **service level agreements** and the **need for a service** e.g. pandemic flu.

The **Community Pharmacy Smoking Cessation Service**in Cambridgeshire illustrates how community pharmacies can improve population health through smoking cessation services, as evaluated by NICE. Some pharmacies in Cambridgeshire provide Stop Smoking Services, but there are still many community pharmacies that do not provide a service. There is **potential** for further development in this area.

Community pharmacies are **easily accessible for young people**and are crucial for offering treatment of **chlamydia**infections. In some cases it can be challenging to offer testing in the pharmacy setting as not all pharmacies have the facilities required to provide a sample for diagnostic testing on site. There is a **potential** for offering advice on **barrier contraception methods** for both males and females and for **raising awareness of HIV, chlamydia and other STIs.**

People who use **illicit drugs**may not be in contact with health care services and their only contact with the NHS may be through a **needle exchange service** within a community pharmacy. Some community pharmacies in Cambridgeshire provide access to sterile needles, syringes and sharps containers for return of used equipment.

Several opportunities exist to **encourage**a **healthy weight** such as providing **advice**, **signposting** services and providing **on-going support** towards achieving behavioural change for example through monitoring of weight and other related measures.

Opportunistic **alcohol screening** and provision of brief advice is another area where pharmacies could potentially contribute to improving the health of the local population. This could, for example, potentially be integrated into agreements around medication checks.

Community pharmacies can support **self-care** where appropriate, as well as referring back to the GP service or signposting clients to other appropriate services.

Over the coming years the population in Cambridgeshire is expected to both age and grow substantially in numbers. An **increase in population size**is likely to generate an **increased need for pharmaceutical services**, but on a local level changes in population size may not necessarily be directly proportionate to changes in the number of pharmaceutical service providers required, due to the range of other factors influencing local pharmaceutical needs.

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 **samehealth 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 **UKpopulation** 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 cultureincrease mental health risks** for **veterans**.

Oral health **Dental emergencies** are up to **five times higher** in a **dentally ill-preparedForce**, 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 housingis 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 **growingolder population**, for example through 'floating support services', sheltered housing or extra-care housing, which are likely to reduce the need for residential care.

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

Since2003, a total of almost **6,000 new affordable tenure homes** have been built across Cambridgeshire (27% of the total number of homes built)

Housing-related support(previously known as the 'Supporting People Programme') **supports** some of the most **vulnerable** and **sociallyexcluded** 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.

Low income householdsand **vulnerable groups**are the most **likely** to occupy **poorstandard 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 **temporaryaccommodation** 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**

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

Prevention of Ill Health in Older people (2013)

Earlyinterventions 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 **over65 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

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

well as needs relating to their caring role.	**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**, **pooreducational** and **employmentopportunities**, **enduring poor physical health**, **peer** and **family relationships**, **witnessing domesticviolence**, 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. **Asylumseeker** 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 startsbefore 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** yearshave 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

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 **lesscommon 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**

behave.

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.

Children

- **11,100** children are estimated to meet the Equality Act (2010) definition of disability.
- **7,124** children had a Statement of Special Educational Needs (**SEN**) or were registered at School Action Plus, of which **76** had a **visual impairment**; **138** had a **hearing impairment**; **1,767** had **learning difficulties** typical of a learning disability; and **215** had a **physical disability.**
- In February 2013, **868 children** were receiving **direct social care support**

Adults

It is estimated that:

- **11,400** adults (18+) have a **learningdisability**
- **2,400** adults have **moderate** or **severe learning disability**
- **38,300** people aged 18-64 years have a **moderate or severe physical disability**, of whom **8,800** are **severe**
- **240** people aged 18-64 years have a **severe visual impairment**
- **9,300** people aged 65+ have a **moderate or severe visual impairment.**
- **59,800** people aged 18+ have a **moderate or severe hearing impairment.**

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 outline the priority needs to 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

Forfurther information please contact:

Wendy Quarry
JSNA Programme Manager

Public Health Directorate
Cambridgeshire County Council
Castle Court
Castle Hill
Cambridge
CB3 0AP

Telephone 01223 729158
EmailWendy.Quarry@cambridgeshire.gov.uk