NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Cambridgeshire
County Council

Agenda Item 6d)

Cambridgeshire Joint Strategic Needs Assessment (JSNA)

Summary Report 2013/14

Contents

1. Introduction

This report presents the executive summaries for the latest Joint Strategic Needs Assessment (JSNA) reports for Cambridgeshire completed during 2013/14, along with a summary of the latest key population and health statistics for the county. Updates are provided to accompany the executive summaries of the 2012/13 JSNA reports to describe key new data, policies, guidance and local initiatives since their production. Brief updates are also provided for previous JSNA topics.

This JSNA Summary Report for 2013/14 provides a brief overview and update on the entire breadth of the 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. Based on this breadth of work, the report concludes with a chapter describing the key health and wellbeing needs in the county in relation to 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; its aimis to contain enough information to help identify strategic priorities for health and wellbeing in the county. The detailed reports are available at: www.cambridgeshireinsight.org.uk/jsna.

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

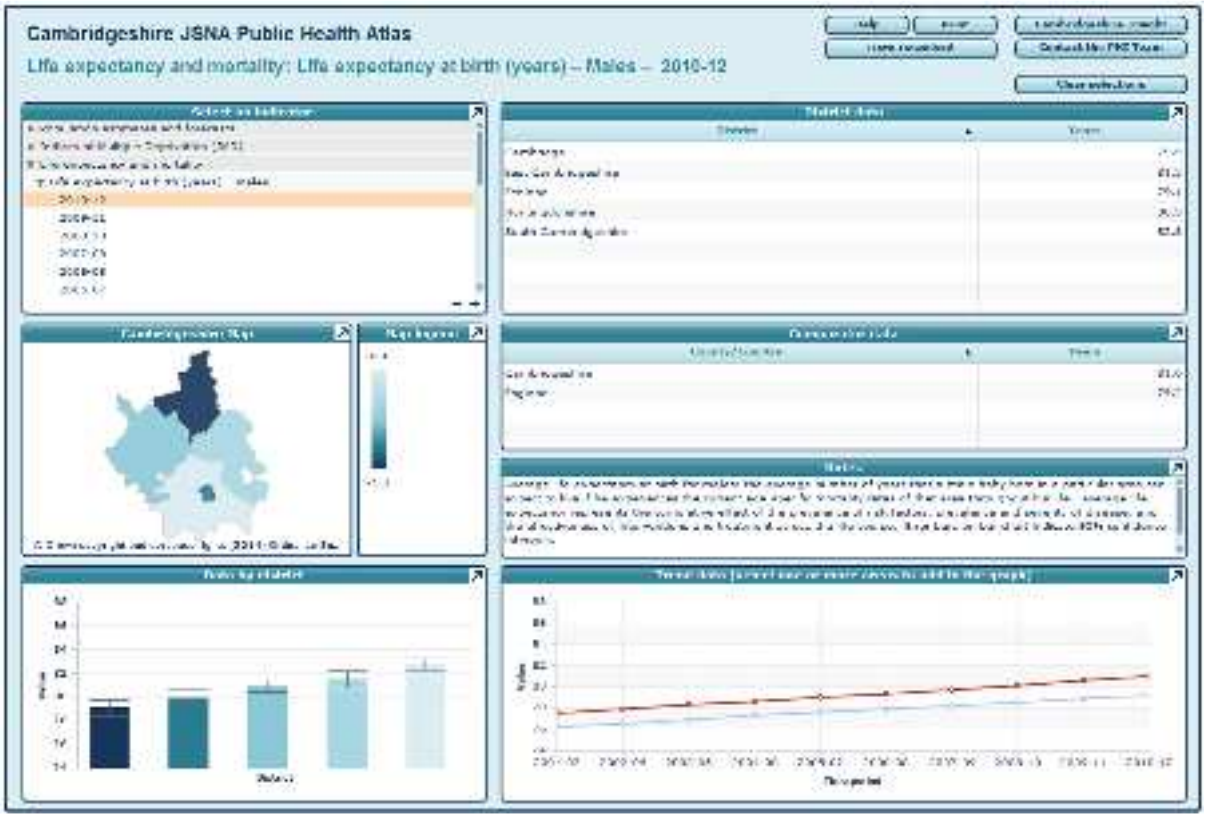
As part of the 2013/14JSNA programme of work, the following JSNA reports have been developed:

- Carers
- Older People's Mental Health
- Primary Prevention of Ill Health in Older People
- Adult Mental Health: Autism, Personality Disorder and Dual Diagnosis

Since April 2013, every Health and Wellbeing Board has held a statutory responsibility to publish a statement of needs for pharmaceutical services for the population in its area; although not formally part of the JSNA programme, the executive summary for this 'Pharmaceutical Needs Assessment' is also included here for completeness.

2. Population and Health Statistics for Cambridgeshire

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. A summary of the latest data at the time of this report is presented below. 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.



2.1 Population estimates and forecasts

- The estimated population of Cambridgeshire in 2012 was 628,339.[1]
- The district with the biggest population in the county is Huntingdonshire with a population of just over 171,000.[1]
- 16.9% of the population (106,234 people) in Cambridgeshire are aged 65 or over, which is the same as the England average; 18.2% are under 16 (114,329).[1]
- The age structures of the district populations vary: 21% of Fenland's population are aged 65+ compared with 12% in Cambridge; a bigger percentage of Cambridge's population are of working age compared with the other districts (around 73% are aged 16-64 years compared with 62-64% elsewhere).[1]
- The population is more ethnically diverse in Cambridge, with just 66% white: British compared with 87-90% elsewhere.[2]
- The population of Cambridgeshire is forecast to grow by 22.6% between 2012 and 2013, an additional 141,700 people; the areas forecast to see the biggest growth are South Cambridgeshire (31.9%) and East Cambridgeshire (24.8%).[3]

- The population aged 65+ in Cambridgeshire is expected to increase by 64.4% between 2012 and 2031, an additional 67,400 people; the area forecast to see the biggest increase in people aged 65+ is Huntingdonshire (73.6%).[3]
- The population aged under 15 is expected to increase by 23.4% between 2012 and 2031, an additional 24,900 children; the areas forecast to see the biggest increase in children under 15 are Cambridge and South Cambridgeshire (35.5% and 33% respectively).[3]

Sources:
1. Office for National Statistics mid-2012 population estimates
2. Office for National Statistics 2011 Census
3. Cambridgeshire County Council Research Group 2012-based population forecasts

2.2 Deprivation

- Levels of deprivation are low for the county as a whole but this varies by district; the most deprived district in the county is Fenland, the 112th most deprived local authority district out of 326 in England. The least deprived district is South Cambridgeshire (ranked 322).[4]
- District-level deprivation data can, however, mask little pockets of deprivation within them – some of the county's most deprived wards can be found in Cambridge and Huntingdon, for example.[4]

Sources:
4. Department for Communities and Local Government – Indices of Multiple Deprivation 2010

2.3 Life expectancy and mortality

- Average life expectancies for men and women in Cambridgeshire are higher than the national averages at 81.0 years and 84.6 years respectively.[5]
- Average life expectancy varies by district: for both men and women, the lowest life expectancies are found in Fenland (79.1 and 82.8 years respectively) and the highest in South Cambridgeshire (82.8 and 85.9 years respectively).[5]
- Age-standardised all-age all-cause mortality rates are lower in Cambridgeshire compared with the England average.[6]
- By district, age-standardised all-age all-cause mortality rates were highest in Cambridge for men and in Fenland for women; premature mortality (deaths before the age of 75) follow the same pattern.[6]

Sources:
5. Health and Social Care Information Centre using data from the Office for National Statistics, 2010-12
6. Health and Social Care Information Centre using data from the Office for National Statistics, 2012

2.4 Lifestyles

Smoking

- 17.9% of people in Cambridgeshire are estimated to smoke, similar to the national average of 19.5%.[7]
- The district with the highest prevalence of smokers is Fenland (29.5%) and the lowest Cambridge (11.5%).[7]
- Among routine and manual workers, the percentage smoking is higher in Cambridgeshire compared with the national average at 35.5% compared with 29.7%.[7]
- The estimated percentage of routine manual workers smoking is particularly high in Fenland at 49.0%.[7]

Sources:
7. Public Health England Public Health Outcomes Framework using data from the Integrated Household Survey, 2012

Childhood obesity

- The percentage of reception age children (4-5 years) who are obese in Cambridgeshire is 7.5%, better than the national average of 9.3%.[8]
- The percentage of Year 6 children (10-11 years) who are obese in Cambridgeshire is 15.8%, better than the national average of 18.9%.[8]
- The percentages of children who are obese are highest in Fenland but are statistically similar to the national average.[8]

Sources:
8. Public Health England – National Child Measurement Programme Local Authority profiles, 2012/13

Adult excess weight and physical activity

- The percentage of adults classified as overweight or obese in Cambridgeshire is 65%, similar to the national average of 63.8%.[9]
- The highest percentages of adult classified as overweight or obese in Cambridgeshire are in Fenland (72.4%) and Huntingdonshire (69.1%).[9]
- The percentage of adults achieving the recommended level of physical activity each week is better in Cambridgeshire compared with the England average at 60.3% compared with 56%.[9]
- At district level, however, the percentage is statistically worse than the national average in Fenland at 50.5%.[9]

Sources:
9. Public Health England - Public Health Outcomes Framework: Active People Survey, 2012

Alcohol-specific hospital admissions

- Alcohol-specific hospital admissions are significantly higher in men in Cambridge compared with the England average; in women rates are similar
- In all other districts, rates of alcohol-specific hospital admissions are better than the national average in both sexes.

Sources:
10. Public Health England – Local Alcohol Profiles for England using data from Hospital Episode Statistics, 2012

2.5 Sexual Health

- Rates of chlamydia diagnoses in Cambridgeshire are lower than the national average.[10] Public Health England currently regard lower rates as worse as they can indicate that screening coverage is low – higher diagnosis rates are desirable to pick up asymptomatic infections and reduce transmission. It is considered, however, that screening coverage in Cambridgeshire is good.
- The rate of HIV diagnoses is lower than the national average in Cambridgeshire and across all the districts compared with the national average, at 1.1compare with 2.1 per 1,000 people aged 15-59 years.[11]

Sources:
10. Public Health England Public Health Outcomes Framework using data from the National Chlamydia Screening Programme (chlamydia testing activity dataset)
11. Public Health England HIV data (Survey of Prevalent HIV Infections Diagnosed (SOPHID)

2.6 Teenage conceptions

- The rate of under 18 conceptions in Cambridgeshire is lower the than England average at 21 per 1,000 females aged 15-17 compared to 30.9 nationally.[12]
- At district level, the rate of under 18 conceptions is highest in Fenland at 35.7 per 1,000 females aged 15-17, statistically similar to the national average.[12]

Sources:
12. Office for National Statistics

2.7 Other key resources describing the health of Cambridgeshire's population

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
- 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 Cambridgeshire Atlas Ward Profiles 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.

3. Executive summaries from the latest JSNA reports

In this section, we have included the full executive summaries for the latest JSNA reports published for 2013/14. Further work is being carried out on aspects of the Adult Mental Health: Autism, Personality Disorder and Dual Diagnosis JSNA, so these aspects are excluded from the executive summary

- Carers
- Older People's Mental Health
- Primary Prevention of Ill Health in Older People
- Adult Mental Health: Autism, Personality Disorder and Dual Diagnosis

The executive summary for the Pharmaceutical Needs Assessment carried out in 2013/14 is also included.

Compared to the versions in the full reports, some minor changes to formatting and headings have been made for consistency within this summary report. Web links to the full reports on Cambridgeshire Insight are provided with each summary.

3.1 Carers

Full report available at: www.cambridgeshireinsight.org.uk/jsna/carers

Executive summary

JSNA scope and context

Definitions and scope
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. Carers are a valuable asset within our communities, providing not just voluntary, unpaid care to assist the person they care for to remain independent, but also love, friendship, reassurance and connection. Carers have good knowledge of the person they care for and their health issues, often coordinating and managing their care. Nationally the 1.25 million carers who provide care for more than 50 hours per week are a full-time workforce greater than the entire NHS!

Young carers are children and young people who assume inappropriate responsibilities to look after someone who has an illness, a disability, or is affected by mental ill-health or substance misuse. Young carers often take on practical and/or emotional caring responsibilities that would normally be expected of an adult.
The main question for the JSNA was 'What can we do to support carers to stay healthy and well?' In addition, to support the work around the Better Care Fund, the JSNA has also looked at the evidence for whether supporting carers reduces health and social care service use. The scope of the JSNA is carers across the whole life course.

Policy background
The Care Act 2014[1] recognises carers in law in the same way as those they care for. Carers who are over 18 will be entitled to an assessment of their support needs. There will be a shift to self-directed support and flexibility in fitting services around the family. The act has a key underpinning principle of the prevention of the escalation of need and there is an increased emphasis on integration.

The Children and Families Act 2014[2] states that local authorities in England must assess whether a young carer within their area has needs for support and, if so, what those needs are.

Key facts and figures
In the 2011 census 60,176 people in Cambridgeshire self-identified themselves as carers in response to the question 'do you look after, or give any help or support to family members, friends, neighbours or others because of long term physical or mental ill-health/disability or problems related to old age'. Overall 70% provide 1-19 hours per week of unpaid care, 10% provide 20-49 hours and 20% said that they provide 50 hours or more per week. There are more female carers than male. Around 60% of carers are aged over 50. Carers over 65 are more likely to provide informal care for more than 50 hours per week than younger carers and are also more likely than other age groups to report their own health as 'bad' or 'very bad'. The percentage of the population providing unpaid care is highest in Fenland (11.1%); this is the only district in Cambridgeshire with a higher percentage than the national average.

[1] http://services.parliament.uk/bills/2013-14/care.html
[2] www.legislation.gov.uk/ukpga/2014/6/contents/enacted

According to the 2011 census, 4,208 young people under 25 years in Cambridgeshire provide unpaid care. 385 young people aged 0-24 provide 50 or more hours care per week (including 92 under 16's). 1.3% of young carers reported 'bad' or 'very bad' health over the year prior to the census. The figures from the census for young carers or young adult carers are likely to under-represent the true number since census forms are completed on behalf of the household by an adult.

The number of people who reported caring responsibilities increased by 9,500 between the 2001 and 2011 censuses.This 19% increase was greater than the overall population increase, which was 12%. The highest proportional increase was in Fenland.

Issues affecting the health and wellbeing of adult and older carers

Health
The percentage of carers reporting bad or very bad health status in the 2011 census was 5.3% in Cambridgeshire, higher than the percentage for non-carers (3.8%), reflecting the pattern for England. Carers UK found that 84%of carers surveyed said that caring has a negative impact on health.Carers tend to neglect their own health.

The GP patient survey for Cambridgeshire and Peterborough Clinical Commissioning Group showed that the proportion of carers who reported a long standing health condition increased by number of hours care provided.

It is recommended that carers receive annual influenza vaccination.

Finance and employment
Families taking on caring responsibilities often face lasting financial pressure as a result of loss of earnings and rising household costs relating to the extra costs of ill-health or disability. A national survey found that one in five carers are forced to give up work as a result of their caring responsibilities.

In the 2011 census the percentage of people providing unpaid care varied with economic activity status. 10.6% of economically active Cambridgeshire residents (in work or actively seeking work) provide unpaid care compared with 13.5% of economically inactive residents (eg retired, looking after home/family, permanently sick or disabled).

4,430 people across Cambridgeshire received Carers Allowance in May 2013.

Housing, relationships and social isolation
The cared for person may require adaptions and aids or may need to move into new accommodation. Relocation may be stressful for both cared-for person and carer.It is important that appropriate aids and adaptions are available to prevent injury to carers whilst moving and handling.
Carers report that caring restricts their social activity resulting in social isolation and smaller social networks. Caring may also result in a deterioration of relationships with other family members

Issues affecting the health and wellbeing of young carers and young adult carers
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. The Longitudinal Survey of Young People in England found that young carers are 1.5 times more likely to have a disability, long-term illness or special educational needs, 1.5 times more likely to be from a black, Asian, or minority ethnic community and twice as likely

to not speak English as their first language. Young carers of someone with a mental health issue may suffer significant stigma.

Young carers in Cambridgeshire have identified:

- They want time to have fun and socialise, getting breaks from caring
- They want more help for the person they care for.
- They need to be less isolated and have people they can turn to.
- They need more money in their families.
- They need help at school with attendance, homework, course work and bullying.
- They need to be helped to get the best from learning and work towards an independent future.
- They need to be meaningfully involved in the planning for their cared for person, and given information and knowledge about the practicalities of caring.
- They need emotional support with worry, anxiety and low self-esteem
- They need help planning for and dealing with family crises.

Young adult carers are carers over the age of 18 who may be looking at moving out of home, going into higher education or juggling working lives with continuing to be a carer. Their needs may sometimes be different to those of other carers. For young adult carers caring roles often increase and result in strained family relationships and caring responsibilities resulting in little time for themselves. Young adult carers are more likely to be not in employment, education or training (NEET).

Issues affecting the health and wellbeing of specific groups of carers

Needs of carers of people with mental ill-health
The fluctuating nature of poor mental health may make the need for support by their carers unpredictable. Carers may be less willing to seek support because of the stigma surrounding mental ill health.

Needs of carers of people with Dementia:
Carers of people with Dementia need and value information and support at a number of critical points along their caring journey. These are:

- When dementia is diagnosed.
- When the carer takes on an active caring role.
- When the capacity of the person with dementia declines.
- When the carer needs emotional support and/or a break from caring.
- When the person with dementia loses their mobility.
- When the person with dementia has other health problems.
- When the carer has to cope with behaviour problems.
- When the carer's own circumstances change.
- When the person with dementia becomes incontinent.
- When decisions about residential care and end of life have to be made.

What is key at these points is 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 re:

dementia and that they engage with both the carer and the person with dementia and they understand the carer's needs and issues not just those of the person with dementia.

Needs of carers of people at the end of life:
Carers for a person approaching the end of his or her life share many of the positive and negative aspects of any other form of caring. However there are additional challenges faced, 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. The most valuable ways for palliative care services to support carers may be to:

- Offer opportunities and permission for the carer to express his or her needs
- Provide practical help with nursing and symptom control
- Equip them with information on the likely course of the illness and the dying phase
- Allocate time for the carer to have respite from their role

Needs of parent carers
Parent carers look after one or more children with a learning difficulty, a disability and/or an additional need. The role of parent carers blurs between being a parent and being a carer, as parents naturally 'care' for their children. However, parent carers are those that have children that need additional support 'to live ordinary lives' as a matter of course. Similar to other carers, parent carers are not always identified as they are parents first. This is especially true for parents of children that have additional needs who are not eligible for social care, short breaks or a statement of educational need. These are the carers that get the least support and often feel very alone. We don't know how many there are as they are usually unknown to services. However these parents can get support from the voluntary sector, especially parent support groups. Parent carers need:

- A break from their caring responsibilities.
- Access to continuous emotional support including out of hours, weekends and during school holidays. Support is needed from when a concern is first identified to diagnosis (and if there is no diagnosis) through to adulthood.
- Support from professionals and other parents.
- Support for their wellbeing and a safe place to show their feelings.

The needs of carers of people with a learning disability
The 2013 Cambridgeshire Physical and Learning Disability through the Life Course JSNA[3] identified that:

"Growing numbers of people (with a learning disability) experience a mid-life transition when their parents or family carer's who they have lived with since childhood become too ill to care for them or they die.

It is important that carers of adults with a learning disability are supported both emotionally and practically to plan early for this transition."

In addition to this it is important the person with the learning disability's rights to care for their loved one is recognised. Services for the older person and the person with the learning disability providing the care need to be joined up to ensure the needs of both are met.

[3] Available at www.cambridgeshireinsight.org.uk/jsna

Cambridgeshire carers' views surveys
An internet/ phone survey of Cambridgeshire carers was carried out as part of the JSNA. 85 carers responded and were predominantly parent carers. Findings were similar to national survey findings, including that around a third had given up work to care and carers reporting prioritising the health of the person they care for above their own. Only a small proportion had received advice on finance or knew where to get one. Most reported access to support out of hours is difficult and a third had not made plans should they be unable to care. Caution is needed, given small numbers, in generalising the results to all Cambridgeshire carers and in making comparisons to national survey results.

Focus groups involving children and young people aged 8-18 were held across Cambridgeshire. Questions asked related to how being a young carer affects friendships, hobbies and school. Findings for 8-11 year olds included difficulties in seeing friends out of school and worries about being made fun of at school. Issues for the older groups included limited time to themselves, difficulty at school because of worrying about the person they care for and worry about meeting deadlines and managing revision. 11-15 year olds spoke about their peers not understanding their caring role. Young carers valued going to young carer groups and making friendships there.

For information on feedback relating to specific Cambridgeshire services, see section 8 of the main report.

Literature review relating to key JSNA questions
A review of the literature was carried out to try to answer the question: 'what is effective in helping carers to stay healthy and well?' Reviews of multiple smaller studies were used to provide the highest level of evidence. The key findings are summarised below

- No consistent evidence was found that interventions for carers improve carers' wellbeing or quality of life. The reason for this is likely to be that many of the individual studies on which the reviews were based are small and variable in quality. The outcomes being measured in studies were often not standard across studies eg ways of measuring emotional wellbeing. There were very few (particularly UK based) studies which measured cost effectiveness of interventions. This is <u>not</u> the same as saying that there is evidence that interventions for carers do not have benefits or are not cost effective.
- There was contradictory evidence for the impact of any type of intervention on carers' burden. However, many interventions resulted in carer satisfaction. The best evidence was that education, training and information for carers (particularly when targeted at a particular parent group) improved knowledge and caring 'abilities'
- The relationship between breaks from care and carers' emotional wellbeing is not straight forward. Many of the studies in reviews are small and of variable quality. There was some evidence of respite having a negative effect in some groups (because of feelings of guilt). There was suggestion that it is important that interventions are tailored to the individual family situation.
- Cognitive reframing (aims to reduce carers' stress by changing certain of their beliefs, such as beliefs about their responsibilities to the person with dementia, their responsibilities to the person with dementia, their own need for support, and why their relatives behave as they do) may be useful when used alongside other interventions for carers of people with dementia (reduced carer depression, anxiety and stress, but did not impact on coping or burden)

A second brief literature review as part of the JSNA (again focussing on reviews of multiple studies) aimed to answer the question 'does supporting carers result in reduced service use

by the cared for person?' The review found that there are gaps in the limited UK-based evidence that supporting carers reduces service use in those they are caring for. This is not the same as saying there is evidence that these services are not effective. Modelling work such as in the Social Return on Investment modelling work on behalf of carers trust[4] indicate that support given or received has the potential to reduce service use. A report on the UK National demonstrator sites[5] identified that looking at cost effectiveness in the context of service delivery can be challenging. The evaluation identified the potential for cost-savings and the need to build tools for measuring cost-effectiveness into programme design. Locally the GP prescription service for carers has identified potential financial savings as a result of identification and support for carers.

Good practice guidance:

- The Triangle of Care - Carers Included: A Best Practice Guide in Acute Mental Health Care. Available at http://static.carers.org/files/caretriangle-web-5250.pdf
- Commissioning for carers. Royal College of General Practice 2013. Available at www.rcgp.org.uk/clinical/clinical-resources/~/media/Files/CIRC/Carers/RCGP-Commissioning-for-Carers-2013.ashx

Services for carers in Cambridgeshire

The carers JSNA has taken an assets mapping approach to services in Cambridgeshire. Services identified how many carers were in contact with them or received a service in the financial year 2012/13. The results are shown in the diagram below. The diagram is intended to be indicative of Cambridgeshire assets for carers and has several limitations:

- Many assets for carers can't be counted, for example the support provided by friends, family, local community networks and religious groups. Other assets are more challenging to count, for example the services provided by many voluntary and community services in Cambridgeshire.
- Where we have numbers, these may underestimate the number of contacts because of the way data are recorded; for example for social care, information may be recorded against the record of the carer or the cared-for person.
- The categories are not mutually exclusive, so carers are likely to be in contact with several of the assets shown.
- Some services are commissioned by one organisation and provided by another.

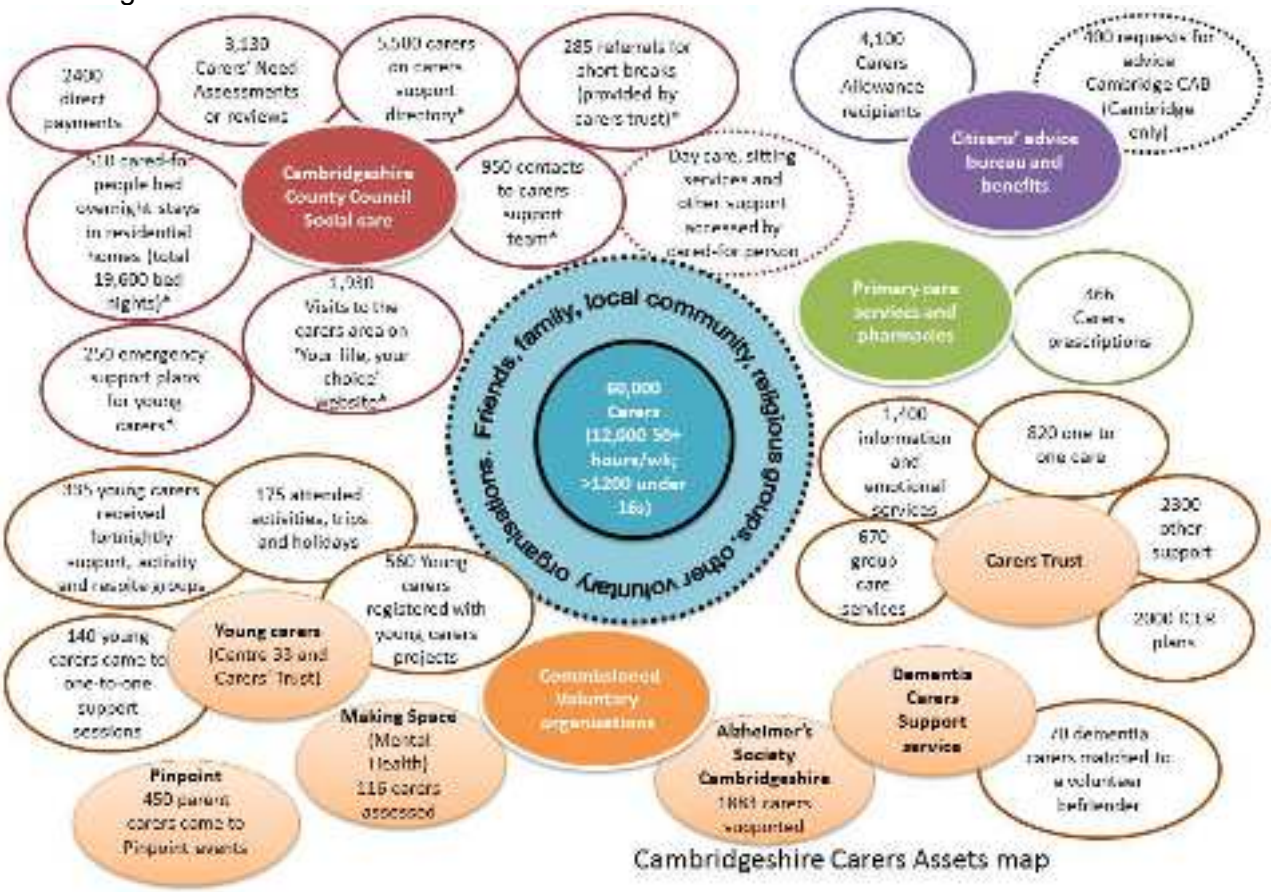
Key to the diagram:

- The diagram shows assets provided in one financial year (2012/13; unless marked with an asterisk, in which case the data are from 2013/14). Of the 60,000 informal carers in Cambridgeshire, not all will need to access services in a given year. The challenge is knowing how far we are meeting need with existing assets – this requires a range of information sources, most importantly feedback from carers themselves.
- The diagram is colour coded. Services provided by Cambridgeshire County Council Social care are coloured red, benefits and citizen's advice services in yellow, commissioned voluntary organisations in orange and primary care in green. Other community assets are shown as a blue ring around the central bubble, which shows some information about the number of carers in Cambridgeshire.
- Where the numbers presented are unknown, uncertain or likely to underestimate assets, a dotted line has been used in the diagram.

[4] The Princess Royal Trust for Carers (2011) Social Impact Evaluation of five Carers' Centres using Social Return on Investment.

[5] Circle (2011) New approaches to Supporting Carers' Health and Well-being: evidence from the National Carers' Strategy Demonstrator Sites programme.

See section 8 in the main report for more detail on individual services and a larger version of this diagram.



Cambridgeshire Carers Assets map

What is this telling us about carers in Cambridgeshire?

What are the key inequalities?
National survey data tells us that carers report that caring has an impact on their physical, emotional and economic wellbeing. Carers may also not prioritise their own health for 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 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.

In addition, young carers are more likely to grow up in poverty, have poorer school attendance and attainment, to be not in education, employment or training (NEET) and to be bullied and see physical aggression at home. All of these issues may impact on future life chances into adulthood.

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 particularly 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.

What are the key trends?
The number of carers in Cambridgeshire increased between 2001 and 2011, the proportionate increase was greater than for the general population. There will be further population growth in Cambridgeshire, including new developments, which means the number of carers are expected to increase. The population is Cambridgeshire is ageing, which will result in a larger number of adults with care needs.

What are the gaps in knowledge/services?

<u>All carers</u>
The Care Act 2014 requires services to prevent and reduce future needs through the early identification and support of carers. Considering the large number of carers identified in the census work is needed to understand how best to support carers who do a small amount of caring, especially those who are likely to go on to care more intensively for someone whose needs are increasing over time, with staying healthy and well. Given the low level of evidence available on what works best to keep carers healthy and well, building in evaluation of interventions will be crucial.

The survey carried out as part of the JSNA process yielded some useful information, but further work is needed to systematically capture the views of carers. This could include use of reference groups or known distributions groups (for example receiving carers magazine) or better use of information collected at contact points with carers (eg carers' assessment, carers' prescription). The best response was achieved with parent carers, suggesting that there are good networks within this particular group of carers. This further suggests that there may be learning from models like Pinpoint for other carer groups.

NICE guidance and good practice documents recommend that carers involved in patient care are identified as soon as possible and supported appropriately. This includes having information sharing and confidentiality protocols in place. In addition, national carer policy points to the need to take a holistic approach to assessing the needs of the carer and cared-for person together. .It is important that carers are recognised and supported within acute hospitals and that their needs are identified at hospital discharge. Work in Addenbrooke's hospital has shown the capacity to recognise and support carers and link to community based support, emergency planning and referral to GP carer registers where they exist. It is currently not possible to measure whether carer status is being recorded in the multidisciplinary team record at discharge across Cambridgeshire.

Asset mapping of services in Cambridgeshire suggests that fewer carers have a plan in place to deal with an emergency then the numbers identified in the 2011 census as providing high intensity care. However this information does not include carers who have nominated a friend or family member in this role. It is also important to ensure services and the wider community are able to support carers with lower level, 'urgent' issues, including supporting carers out of hours. Planning is also important for transitions in care e.g. child to adult, death of carer.

Accurate data are not available on the number of carers registered in primary care in Cambridgeshire. The GP surgery is often the first point of call for carers and most want to use surgeries as a source of support or referral. The Cambridgeshire carers prescription service has resulted in the identification and referral for support of carers not in receipt of any other support and linked many to emergency support and ICER plans. National surveys suggest that GPs could do more to support carers. A survey carried out as part of this JSNA suggests that many carers in Cambridgeshire are not registered as carers with their GP and

where they are, do not receive practice services tailored to their needs eg flexible appointments. The prescription service shows that some surgeries are providing very good support for carers but this is variable. Further work is needed to understand the provision of services to carers in Primary care in Cambridgeshire and include in a Cambridgeshire carers assets map.

Data are not available on the number of carers registered in primary care in Cambridgeshire. The GP surgery is often the first point of call for carers. The Cambridgeshire carers prescription service has resulted in the identification and referral for support of carers.The prescription service shows that some surgeries are providing very good support for carers but this is variable. National surveys suggest that GPs could do more to support carers. Further work is needed to understand the provision of services to carers in Primary care in Cambridgeshire and include in a Cambridgeshire carers assets map.

Most carers who are recently bereaved do not require specific 'bereavement counselling'. However, education is needed for GPs and other primary care professionals in identifying when a referral is needed. Whilst support services for the bereaved have been mapped by Cambridgeshire and Peterborough Clinical Commissioning Group, the availability and quality of services for bereaved carers in Cambridgeshire is not known. Support for carers both during a terminal illness and following death is variable and there are inequalities in provision on the basis of the diagnosis, place of death and socio-economic status.

In addition to the key findings above, a carers JSNA stakeholder event identified a general need for joint working and joint training across organisations.

Young carers

Joint working between services specifically working with young carers and mainstream preventive services for children and young people is needed to ensure that young carers are seen as a vulnerable group, their needs identified early and seen in the context of the whole family (for example through ensuring good parenting support).

National data tells us that young carers have poorer educational outcomes than their peers. Information from local focus groups tells us that children are worried about meeting deadlines and managing homework at school. However, at a population level it is not possible to identify numbers of young carers in Cambridgeshire schools or to look at local educational outcomes for this potentially vulnerable group. Support at transition to adulthood (from age 14) is needed to ensure young carers continue in education or training and to ensure good health outcomes. A multidisciplinary approach is needed to ensure each child or young person is able to access education and fulfil their educational potential.

Data on the referrals of young carers to organisations like Centre 33 and Carers Trust Cambridgeshire suggest that adult services need to do more to identify young carers and take action to support their needs, particularly mental health, drug and alcohol services. There is poor take up of young carers services by black and ethnic minority committees.

There are few dedicated services for young adult carers in Cambridgeshire although Carers Trust Cambridgeshire has funding for a new project this year in Huntingdon and Fenland. This suggests that this group of carers may be missing out on advocacy, information and advice on issues such as finance and employment as well as emotional support and opportunities to socialise. However, currently the way data on service use by young adults is recorded makes it difficult to identify what support this group is receiving from adult services. With a lack of engagement, young adult carers have no voice. They need mechanisms to be heard and involved in the planning, review and evaluation of Carers Services.

Cambridgeshire young adult carers have identified the following gaps:

- Poor access to Information and Advice for young adult carers.
- Poor access to Carers Assessmentsfor young adult carers.
- Poor access to support to access social and leisure activitiesfor young adult carers s
- Poor access to participation opportunities and chances to be heardfor young adult carers.

3.2 Older People's Mental Health

Full report available at: www.cambridgeshireinsight.org.uk/older-peoples-mental-health-2014

Executive summary

This joint strategic needs assessment reviews the mental health needs of older people in Cambridgeshire, with a particular focus on dementia and depression. It is important to be clear about the differences between mental wellbeing (or general mental health), and mental illness. In this document we refer to both using the definitions below:
Mental wellbeing (or mental health): There are many different definitions of mental wellbeing but they generally include factors known to promote mental health such as: life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support. Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against the development of many such problems.
Mental illness or disorder: Mental illness or disorder refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities eg dementia, depression, anxiety, and schizophrenia.

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. Other less common conditions include delirium (acute confusion), schizophrenia, bipolar disorder, personality disorder and autism, alcohol and drug (including prescription drug) misuse; this needs assessment focuses primarily on depression and dementia.

Dementia is a group of related symptoms associated with an ongoing decline of the brain and its abilities. This includes problems with memory loss, thinking speed, mental agility, language, understanding and judgement. People with dementia can become apathetic or uninterested in their usual activities, and have problems controlling their emotions. They may also find social situations challenging, lose interest in socialising, and aspects of their personality may change. A person with dementia may lose empathy (understanding and compassion), they may see or hear things that other people do not (hallucinations), or they may make false claims or statements. As dementia affects a person's mental abilities, they may find planning and organising difficult. Maintaining their independence may also become a problem. A person with dementia will therefore usually need help from friends or relatives, including help with decision making.

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. It affects how one feels, thinks and behaves. It may make it difficult to carry out normal day-to-day activities and make one feel that life is not worth living. Depression and dementia can co-exist and can be difficult to distinguish.

Both conditions, especially when moderate or severe, can reduce markedly the quality of life of those living with the condition. They also affect the family and friends who care for their loved ones. Depression is highly treatable, but the progressive nature of dementia can cause extensive physical, psychological, emotional and financial stresses to those with the condition, their family, carers and the wider community.

This report starts by describing the population of Cambridgeshire, with particular emphasis on the older population and the factors which contribute to mental health problems in that population. It goes on to estimate how many people in Cambridgeshire have depression and dementia, both now and in the future. The report then describes the present pattern of services available in Cambridgeshire for older people with mental health problems, and summarises relevant NICE guidance and reports findings from research about the

interventions which, if used early in the course of illness, may reduce its severity. The report then summarises the results of engagement with service users, carers and providers, before setting out some conclusions and key findings.

The difficulties with securing data on NHS activity meant that the report has adopted a qualitative approach. There are also other sources of information which were not available or accessible during this project, and these mean there are limits to the conclusions we are able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of service interventions. It has not been possible therefore to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.

Key Facts

1. The population of Cambridgeshire will age substantially by 2026: the number of people aged over 90 years will more than double, and the number of people in their 80s rise by more than 50%. This will lead to steep rises in the number of older people with dementia and, to a lesser extent, depression.
2. Cambridgeshire's population is more affluent and less ethnically diverse than that of England, but social isolation is no less common. Most risk factors for poor mental health show similar patterns of prevalence across Cambridgeshire, though in some cases the Cambridgeshire population shows a lower risk profile. There are also areas within the county where risk factors are concentrated, such as Fenland.
3. Assuming prevalence rates remain the same as current rates, between 2012 and 2026, the number of older people with depression in Cambridgeshire is expected to rise by 12%, from approx. 11,900 to 13,360. The number of people over 65 years with dementia is expected to rise from 7,400 to 12,100, an increase of 64%. There is forecast to be a 43% increase in the number of older people with learning disability. Increases of this size over a short period will put severe strain on existing services.
4. In Cambridgeshire, many people with depression and most of those with dementia have not been diagnosed and recorded by their primary care teams, which reflects a national trend. This means they cannot receive the treatment and support they need. This suggests that there is unmet mental health need within the population.
5. Cambridgeshire apparently devotes less health service spending per head to mental health than average for England. The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)is relatively under-funded and faces a challenging financial future.

Key findings

1. *Increasing older population*
    - Due to an increasing population there is forecast to be an increase in the number of older people with dementia and, to a lesser extent, depression, within a few years.
    - However, the resources available from statutory agencies, for health services given the current financial restraints, will at best remain the same, requiring the development of new service models to meet need. A holistic approach is vital.
2. *Risk factors for depression and dementia*
    - Older people's mental health needs are complex. They cause substantial impact on wellbeing and the ability to lead a normal life. They have wider impacts on the family and other carers.

- Mental health needs interact in complex ways with long-term physical health problems. Adults with severe mental illness have a substantially reduced life expectancy due to both mental and physical ill health. There is often inequality of access to health services for physical illness for people who use mental health services. Physical health and mental health are inseparable and demand a holistic approach to the care of all patients with mental health problems.
- Evidence-based guidelines from 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 levels.
- NICE are also currently developing two relevant pieces of public health guidance: the first, due to be published in February 2015, focuses on mid-life approaches to prevent or delay the onset of disability, dementia and frailty in later; the second, due for publication in November 2015, considers independence and mental wellbeing (including social and emotional wellbeing) for older people.

3. *Diagnosis and assessment*

- There is apparent widespread under-diagnosis of depression in primary care. Rates of diagnosis also vary between practices for unexplained reasons. 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.

4. *Current spending*

- The NHS in Cambridgeshire apparently spends 18% less per head on mental health services than the average for England. It is, however, less well funded than average. This information is based on programme budgets, and differences in budgetary definitions and coding behaviour may underlie these findings. More analysis of the reasons for the differences would be of value.

5. *Current service provision*

- The JSNA full report describes acute and community mental health services available for older people and details three local clinical pathways for ‘Functional mental illness’ (includes depression, anxiety, bipolar affective disorder, psychosis, personality disorder); ‘Memory assessment’; and ‘Complex dementia’. 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. These are jointly commissioned by the CCG and Cambridgeshire County Council (CCC) and are also described in more detail in the full report.
- 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, but it would merit further investigation.

- No information on activity levels and expenditure patterns, by the main NHS mental health service provider in Cambridgeshire, was available within the timescale of this report. This impedes service planning and evaluation by commissioners and limits the extent to which patterns of service delivery can be reported and analysed. The routinely collected anonymised national minimum dataset should be available in a timely and accessible format to providers and commissioners of mental health services.
- There are other sources of information which were not available or accessible during this project, and these limited the conclusions we are able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of service interventions. It has not been possible, therefore, to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.
- The current re-procurement of older people's services is expected to lead to improvements in mental health services for older people. The re-procurement process will involve clarifying what mental health services for older people are available, where and to whom.

6. *National guidance and evidence on provision of services and standards*
   - National guidance in the form of Clinical Guidelines and Quality Standards published by NICE describe, in detail, what patients should receive from the NHS and social services.
   - A review of the evidence did not find any reliably evaluated early interventions for mental health disorders in older peoplethat were not included in existing NICE guidance.
   - Existing service specifications from commissioners describe what should be available from NHS mental health services. The extent, to which national guidance and local service specifications are followed, in practice, was not reviewed as part of this JSNA. This could form part of a future work programme.
7. *Stakeholder feedback*
   - The main concerns of service users and carers reported to us were:
     - Service delivery
     - Organisational challenges
     - Coordination of services
     - Safeguarding of vulnerable people
     - Access to services
     - Transition between services
     - Continuity of relationships
     - Culture and equity
     - Physical health and mental health
     - Carers' 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.

8. *Further information*

Building on the findings of this JSNA, further work may be useful to:

- Establish the activity and cost levels at the main NHS mental health provider;
- Review the validity of the apparent low levels of NHS spending on mental health in Cambridgeshire;
- Audit the extent to which NICE guidance is followed and understand gaps in mental health service provision for older people;
- Investigate the apparent variation in referral rates to the older people's mental health service.

This report was commissioned from Solutions for Public Health (SPH) by the Public Health Team, Cambridgeshire County Council. The contents are based upon the work undertaken by SPH, with support and contributions from the Cambridgeshire Adult and Older Peoples Mental Health JSNA Steering Group and editorial amendments and additions made by the Public Health Team at Cambridgeshire County Council.

3.3 Primary Prevention of Ill Health in Older People

Full report available at: www.cambridgeshireinsight.org.uk/primary-prevention-ill-health-older-people2014

Executive summary

Introduction – context and scope
Cambridgeshire has an ageing population, and there are opportunities to maximise the potential for residents to enjoy good health and wellbeing throughout their lives, and ensure that local communities benefit from the vast assets of the older people population. This JSNA focusses on modifiable lifestyle behaviours, for which there are clear associations with poor health outcomes and opportunities to take a preventative approach: active ageing and physical activity, maintaining a healthy diet (including preventing malnutrition), and stopping smoking.

Primary Prevention for Older People
The underlying principle to primary prevention is that modification of risk factors in later life is still beneficial for health: chronic degenerative disease and ill health are not inevitable concomitants of ageing. A life course approach recognises the impact of earlier exposures to risk factors for health, on-going behavioural choices, and the opportunities for change and support through life-stages. 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.

Evidence suggests that interventions which focus on encouraging healthy behaviours in 55-75 year olds may be more effective as they may be more ready, interested and intend to change than individuals in older age groups. Older adults with negative health behaviours are less worried about the effect of the things they do on their health, and have less intention to change than those with positive health behaviours; this may reflect some of the complexities linked to health inequalities. Much of the societal emphasis on retirement is about winding down, and carers may, with good intention, also express care and concern in ways that discourage independence. Supporting primary prevention in older people may therefore require much broader discussions around ageing and society, as well as recognising the significant crossover between physical health, mental health and emotional wellbeing, as important influencers of health behaviours.

Wider Determinants of Health
The underlying social, economic and environmental conditions that influence the health and wellbeing of individuals and populations are recognised to be 'wider determinants of health'. These determine the context of daily life for older adults. One in five pensioners lives in a household receiving Housing Benefit or Council Tax Benefit. The distribution of the benefit population follows similar patterns to the distribution of poor educational attainment and poor health status. In measurements for the Income Deprivation Affecting Older People Index, deprivation is more widely spread across Cambridgeshire. There are some pensioners who are not receiving benefits, but who may be experiencing income poverty, particularly in areas with a high proportion of owner-occupied households.

The adequacy of housing for older people in Cambridgeshire is crucial; changes in both the population of older people resident in the county, their needs, and their preferences about the sort of housing they wish to occupy, require ongoing consideration. The sufficiency of housing for older people in Cambridgeshire has been recently assessed in chapter 9 of the Prevention of Ill Health in Older People JSNA, and in the Housing and Health JSNA, both published in 2013.

Cambridgeshire is by and large a rural county and the availability and access to means of transport is an important factor which influences healthy behaviours. An approach to facilitate active ageing requires consideration of how 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 is also important in maintaining a healthy diet. A Transport and Health JSNA is being prepared for 2015 which will consider the local situation, evidence base, and implications for health and wellbeing in detail, and inform local policy and decision making.

Social and emotional wellbeing is impacted by participation and engagement with family, friends, civic organisations, and services in the neighbourhood and further afield. Societal change including geographic dispersion and fragmentation of extended family networks may mean other local social networks are increasingly important. Primary prevention work offers an opportunity to support the role of communities in meeting the needs of older people and set health behaviours in the context of the social norms of the communities which older people relate to. Loneliness has detrimental impacts on physical and mental health, and increases the likelihood of multiple unhealthy behaviours. Effective interventions to tackle isolation and loneliness may be those with a theoretical basis, where older people are active participants, and which address the vicious cycle of. Isolation may also be addressed through provision of services in rural areas, and through embedding social elements within other public health interventions.

Physical Activity

Physical inactivity is the fourth leading risk factor for death worldwide; the positive impacts of physical activity and the negative impacts of physical inactivity on the health of older adults are well known.

'How active?' guidelines for older adults have been produced by Chief Medical Officer (CMO) which describe ideal levels of activity that are beneficial to health and wellbeing. In terms of how many older adults meet these guidelines, there is data for England available and an indication of participation for Cambridgeshire. Older adults are not a homogenous group; an interpretation of the CMO guidelines for three groups of older adults ('actives', in 'transition' and 'frail') is available.

There is some evidence of what works; volume of activity is more important that engaging in specific types of activity. There is evidence of the cost effectiveness of interventions and indication of the cost of physical inactivity.

Cambridgeshire is not a blank page; assets in the community exist. These may not be available to all, and sustained funding is not assured. The local assets include older adults who are trained volunteers.

Diet

Dietary factors contribute significantly to the global burden of disease. Dietary improvements made in older age significantly reduce the risk of chronic diseases.

There is very limited information about the healthiness of the food consumed in Cambridgeshire; new Public Health Outcomes Framework indicators on fruit and vegetable consumption will provide a snapshot in future. Nationally, older adults consume low levels of fruit and vegetables, fibre, oily fish, and high levels of salt relative to recommendations.

The evidence on primary prevention of cancer, cardiovascular disease, and diabetes draws from the all adult population; research for older adults focusses on bone health and

preventing cognitive decline. Population approaches to improving nutritional status include taking opportunities at all ages to prevent the development of chronic disease, and supporting behaviour change for healthier diet and healthy ageing. Weight management interventions (12 weeks with $\geq$1kg lost and maintained for life) can be more cost effective for older adults because older people gain health benefits sooner.

Daily vitamin D supplementation is recommended by the Department of Health for all adults aged 65 years and over. It is not known how far this is practiced locally; NICE guidance on the implementation of vitamin D recommendations is due November 2014.

Local assets include 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

Malnutrition is measured as a Body Mass Index (BMI) lower than 18.5kg/m^2 or unintentional 10% weight loss. NICE identified malnutrition as the sixth largest source for potential NHS savings. The annual health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient spells, more primary care consultations and the greater long-term care needs of malnourished individuals.

About two thirds of cases of malnutrition are not recognised; the impacts are increased burden of disease and treatment costs. It is estimated 10,000 to 14,000 older residents in Cambridgeshire are malnourished, many more are at risk. Social networks have a preventive role, as interest groups and shopping clubs support motivation and the means for good nutrition.

Regular screening for malnutrition is recommended by NICE; early intervention screening and appropriate treatment is cost-effective. Those at risk should have a 'food first' approach, including dietary advice to optimise their intake, and support with practicalities. NICE estimates that the overall resource impact of increased screening, early intervention and appropriate treatment could lead to a saving of £71,800 per 100,000 people.

Awareness of malnutrition needs to be improved by both healthcare workers and the wider public. Efforts to prevent malnutrition should be integrated with other care to prevent ill-health, and between healthcare workers, carers, social workers, and the voluntary sector. There is much good practice in place at Addenbrooke's Hospital, and developing plans for Hinchingbrooke Hospital. A clear pathway for post-discharge support for those at risk, particularly for older adults who live independently could help to prevent or reduce malnutrition. Community dietitians provide training for care home staff to screen residents for malnutrition; care homes should use a validated screening tool and should audit to ensure CQC compliance.

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. 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. Lack of awareness of the problem and services or support available can hinder engagement and access to support. This might be improved by raising awareness amongst older adults, their families and GPs about the services available in the community.

Smoking
Smoking is the primary cause of preventable and premature death in the UK, responsible for approximately 100,000 deaths/year. Nearly a fifth of the population of England smokes (19.5%); prevalence is lowest among the 60 and over age group (12%) and is probably the result of many factors including death before age 60 from both smoking and other causes of death, and higher cessation rates amongst older people. A recent systematic review of the evidence on smoking cessation in the 60+ age category concludes that smoking cessation significantly improves health and reduces mortality for all ages.

In Cambridgeshire, there are estimated to be 112,210 smokers and 17,461 of these are over the age of 60 years (16%). Prevalence is significantly higher in Fenland when compared to the national average.

There are no specific recommendations for reaching or delivering services specifically to older populations; smoking cessation interventions known to be effective in the general population have been found to be effective with older smokers across a variety of treatment methods.

9% of CAMQUIT (the local stop smoking service) clients are aged 65 and older. In Cambridgeshire the quit rate for all service users is 47%, and is 5% higher among those aged 65 and older (52%). Also, fewer older smokers are lost to follow-up than other age groups. Older adults are more likely to access the CAMQUIT service via their GP, and less likely to access support via core or pharmacy services. They appear to be less sensitive to some national smoking cessation campaigns; local tailored advertising is used. Increasing access to stop smoking services should be encouraged for older smokers. Local feedback suggests it might be important to emphasise the continued health benefits of quitting at older ages and that it is 'never too late to quit'. There are significant opportunities to encourage referral or signpost older adults to stop smoking services from a broad range of settings including primary care, social care, community and acute health care, housing, and community interest groups.

Conclusions
There are health and wellbeing benefits to be experienced by older adults in Cambridgeshire through modifying their health behaviours and lifestyle risk. This can be supported by interventions and enabling societal and environmental structures. There is a key message to disseminate that it is never too late to make changes, and this could be personalised to individuals to emphasise the specific benefits for their own quality of life. There are opportunities for local health and social care professionals to make every contact count towards this. A positive view of healthy ageing and an increased awareness of the available local assets will enable tailored support for older adults to access appropriate services, with potential advantages in overcoming social isolation and in strengthening local communities.

3.4 Adult Mental Health: Autism, Personality Disorder and Dual Diagnosis

The full report will be published in due course at www.cambridgeshireinsight.org.uk/jsna.

Executive summary

This joint strategic needs assessment reviews the mental health needs of people of working age with autism spectrum disorders, personality disorder and dual diagnosis, living in Cambridgeshire.

It is important to be clear that about the differences between mental wellbeing (or general mental health), and mental illness.

In this document we refer to both using the definitions below:
Mental wellbeing (or mental health): There are many different definitions of mental wellbeing but they generally include factors known to promote mental health such as: life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support. Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against the development of many such problems.
Mental illness or disorder: Mental illness or disorder refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities eg depression, anxiety, and schizophrenia.

The three conditions which are the focus of this report are all diagnosable mental illnesses. However, this document also highlights some of the factors which overall may increase our risk of poorer mental health. These include social factors such as deprivation, social support, long term conditions, employment, and homelessness.

The most common mental disorders are depression and anxiety. The three conditions this report looks at are all less common mental health disorders. The mental health needs of adults with Autistic Spectrum Disorder (ASD), personality disorder and dual diagnosis are complex. People with these conditions often experience comorbidities (both mental and physical), behaviour difficulties, social exclusion and unemployment. Some may have contact with the criminal justice system, as either victims of crime or offenders. Their mental health needs often bring significant implications for family and carers.

Autism Spectrum Disorders (ASD) affects social interaction, communication, interests and behaviour. The spectrum includes Asperger syndrome and childhood autism. The main problems facing people with the condition are:

- Problems with social interaction and communication; including problems understanding and being aware of other people's emotions and feelings. The condition can also include delayed language development and an inability to start conversations or take part in them properly.
- Restricted and repetitive patterns of thought, interests and physical behaviours, including making repetitive physical movements, such as hand-tapping or twisting, and becoming upset if these set routines are disrupted.

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. Changes in how a person feels and distorted beliefs about other people can lead to highly unusual behaviour, which can be distressing and may upset others.
People with **dual diagnosis** have a mental health problem and also misuse drugs or alcohol. The substance misuse may be related to the mental health problem: some people

use drugs or drink excessively in order to manage symptoms of mental illness such as anxiety or depression. Alternatively, mental illness may have been triggered or exacerbated by drug and alcohol use.

This report starts by describing the population of Cambridgeshire, with particular emphasis on the adult population and the factors which increase the risk or poor mental health. It goes on to estimate how many people in Cambridgeshire have the disorders covered by this report, both now and in the future. The report then describes the present pattern of services available in Cambridgeshire for people with these disorders, and it reports findings from research about the interventions which, if used early in the course of illness, may reduce their severity. The report then summarises the results of engagement with service users, carers and providers, before setting out its key findings.

The difficulties with securing data on NHS activity meant that the report has adopted a qualitative approach. There are also other sources of information which were not available or accessible during this project, and these mean there are limits to the conclusions we are able to draw. These include information on which areas of the county have the highest numbers of people with mental health problems, the exact nature of all clinical and social care services provided locally and the outcomes of service interventions. It has not been possible therefore to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards. The final report will be published once some of this further information is available and has been analysed.

Key Facts

1. The population of Cambridgeshire is expected to grow by 19% between 2012 and 2026, including growth in nearly all age-groups and all local authority areas.
2. Cambridgeshire's population is more affluent and less ethnically diverse than that of England, but social isolation is no less common.
3. Most risk factors for poor mental health show similar patterns of prevalence across Cambridgeshire, though in some cases the Cambridgeshire population shows a lower risk profile. There are also areas within the county where risk factors are concentrated, such as Fenland.
4. An increase in prevalence of common mental health disorders as well as those conditions specific to this report, is predicted across all Cambridgeshire districts, with growth in numbers concentrated in Cambridge City especially.
5. The number of people affected by mental illness in Cambridgeshire is expected to increase in line with the population.In Cambridgeshire, many people with depression have not been diagnosed and recorded by their primary care teams, which reflects a national trend. This means they cannot receive the treatment and support they need.This suggests that there is unmet mental health need within the population. In addition, depression occurs in people with ASD, personality disorder and dual diagnosis, so this under-diagnosis of depression is relevant to their needs.
6. The main concerns of service users and carers reported to us were:
    - Service delivery.
    - Organisational challenges.
    - Coordination of services.
    - Safeguarding of vulnerable people.
    - Access to services.
    - Transition between services.

- Continuity of relationships.
- Culture and equity.
- Physical health and mental health.
- Carers 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. Some of the case studies in the full JSNA illustrate innovative ways to improve services and respond to some of these suggestions.

Key findings

1. Due to an increasing population there will be an increase in the number of people with these mental health disorders within a few years. However,the resources available from statutory agencies for health servicesgiven the current financial restraints will at best remain the same, requiring the development of new service models to meet need. A holistic approach is vital.
2. National guidance in the form of Clinical Guidelines and Quality Standards published by NICE describe in detail what patients should receive from NHS and social services. Existing service specifications from commissioners describe what should be available from NHS mental health services, though not in the case of Autistic Spectrum Disorder. However, the extent to which national guidance and local service specifications are followed in practicewas not reviewed as part of this JSNA. This should form part of a future work programme.
3. We found no reliably evaluated early interventions for people with ASD, personality disorder and dual diagnosis published since the most recent NICE guidance. Therefore the most recent NICE guidance should be used as the basis for early intervention work.
4. 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 report 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. People with mental illness need equal access in order to improve their physical health problems and reduce their risk factors.
5. For adults with autism, a high-quality diagnostic service is available from CPFT. However, services to support adults with autism and their carers in the community are sometimes fragmented and difficult to access. The recently published quality standard[6] for autism (January 2014) is a good basis on which to review the commissioned service specification and to review the services provided for adults with autism.
6. 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 apparently willing to take on patients with more severe dual diagnoses, with no system for adjudication in such cases. As a result, some clients are left with no service.

[6] Autism.QS51, 2014.http://guidance.nice.org.uk/QS51

a. Commissioners should consider a review of services for dual diagnosis. An option, recommended by stakeholders, is to establish a jointly funded single service for those who had more severe dual diagnoses, which would take responsibility for those neither service would itself treat. This service would either treat the client, or assign them to one or other service.

b. NICE recommends that "Specialist substance misuse services should work closely with secondary care mental health services to develop local protocols derived from this guideline for adults and young people with psychosis and coexisting substance misuse. The agreed local protocols should set out responsibilities and processes for assessment, referral, treatment and shared care across the whole care pathway[7]." Although such a protocol exists in Cambridgeshire, its implementation appears to be incomplete.

7. 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[8] is aimed at making sure that people experiencing a mental health crisis receive an appropriate emergency mental health service. It reflects a new requirement for the NHS that "every community has plans to ensure no one in mental health crisis will be turned away from health services"[9]. There should be local implementation of the Crisis Care Concordat to ensure that adults in mental health crisis are able to recover, and that admissions to hospital or to prison might be avoided.

8. No information on activity levels and expenditure patterns by the main NHS mental health service provider in Cambridgeshire was available within the timescale of this report. This impedes service planning and evaluation by commissioners. It also limited the extent to which we can comment on patterns of service delivery. The routinely collected anonymised national minimum dataset should be available in a timely and accessible format to providers and commissioners of mental health services.

This report was commissioned from Solutions for Public Health (SPH) by the Public Health Team, Cambridgeshire County Council. The contents are based upon the work undertaken by SPH, with support and contributions from the Cambridgeshire Adult and Older Peoples Mental Health JSNA Steering Group and editorial amendments and additions made by the Public Health Team at Cambridgeshire County Council.

7 Psychosis with coexisting substance misuse: Assessment and management in adults and young people. CG120, 2011.www.nice.org.uk/CG120

8 Department of Health and Home Office Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis February 2014

9 Department of Health The Mandate: A mandate from the government to NHS England: April 2014 to march 2015. www.gov.uk/government/publications/nhs-mandate-2014-to-2015

3.5 Pharmaceutical Needs Assessment

Full report available at: www.cambridgeshireinsight.org.uk/other-assessments/pharmacy-needs-assessment

Executive summary

Introduction
From 1 April 2013, every Health and Wellbeing Board (HWB) in England has a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services for the population in its area, referred to as a 'pharmaceutical needs assessment' (PNA). The PNA will help in the commissioning of pharmaceutical services in the context of local priorities.

Decisions on whether to open new pharmacies are not made by the HWB. Pharmacies must submit a formal application to NHS England. The relevant NHS England Area Team will then review the application and decide if there is a need for a new pharmacy in the proposed location. When making the decision NHS England is required to refer to the local PNA. As these decisions may be appealed and challenged via the courts, it is important that PNAs comply with regulations and that mechanisms are established to keep the PNA up-to-date. In accordance with these regulations, the Cambridgeshire PNA will be updated every 3 years. The availability of new information for the PNA will be assessed by the PNA Steering Group every six months and if indicated 'Supplementary Statements of Fact' will be produced, which include information on new facts, for example: openings and closings of pharmacies, houses completed, changes to the population size.

This PNA describes the needs for the population of Cambridgeshire, including Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire. A separate PNA will be produced for Peterborough by the Peterborough Health and Wellbeing Board.

The PNA includes information on:

- Pharmacies in Cambridgeshire and the services they currently provide, including dispensing, providing advice on health, medicines reviews and local public health services, such as smoking cessation, sexual health and support for drug users.
- Other local pharmaceutical services, such as dispensing GP surgeries.
- Relevant maps relating to Cambridgeshire and providers of pharmaceutical services in the area.
- Services in neighbouring Health and Wellbeing Board areas that might affect the need for services in Cambridgeshire.
- Potential gaps in provision that could be met by providing more pharmacy services, or through opening more pharmacies, and likely future needs.

Process
This PNA was undertaken in accordance with the requirements set out in regulations 3-9 Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

In the process of undertaking the PNA the Cambridgeshire HWB sought the views of a wide range of key stakeholders to identify issues that affect the commissioning of pharmaceutical services and to meet local health needs and priorities.

A public consultation was undertaken from 16 December 2013 to 21 February 2014 to seek the views of members of the public and other stakeholders, on whether they agreed with the contents of this PNA and whether it addressed issues that they considered relevant to the provision of pharmaceutical services. A good response was received to the public consultation, with 238 responses to the survey from individuals or groups.

203 of 224 respondents (91%) felt that the purpose of the PNA was explained sufficiently and 205 of 220 respondents (93%) felt that the draft PNA adequately described current pharmaceutical services in Cambridgeshire. 198 of 220 respondents (90%) agreed with the key findings about pharmaceutical services in Cambridgeshire as outlined in the PNA. The feedback gathered in the consultation is described in the Consultation report produced by the CCC Research Team (see Appendix 7) and a summary of how the draft PNA was amended to produce this final report in response to the feedback received is included as Appendix 8.

Local context
This PNA for Cambridgeshire is undertaken in the context of the needs of the local population. Health and wellbeing needs for the local population are described in the Cambridgeshire Joint Strategic Needs Assessment. This PNA does not duplicate these detailed descriptions of health needs in the relevant JSNAs and should be read alongside the JSNA.

Cambridgeshire is a predominantly rural county with few urban settlements, which can create challenges for local transport and access to services. The health of the Cambridge population is generally similar to or better than the England average, but important local variations exist within the county.

Key findings

1. Provision of local pharmaceutical services
Cambridgeshire is well provided for by pharmaceutical service providers. There are 109 pharmacies across Cambridgeshire, an increase from 101 reported in the previous PNA in 2011. There are 43 dispensing GP practices, unchanged from 2011. There is also adequate access for the dispensing of appliances.

There are 24 pharmaceutical service providers per 100,000 registered population in Cambridgeshire. This is slightly more than in 2011 and also slightly higher than the national average of 23 per 100,000. This PNA has not identified a current need for new NHS pharmaceutical service providers in Cambridgeshire.

The majority of respondents to the public consultation (88%) felt that the needs for pharmacy services for the population of Cambridgeshire have been adequately identified in this PNA. 82% (179 out of 218) agreed that currently we do not need more pharmacies in Cambridgeshire and only 5% (13 individuals) suggested that additional pharmacies were required. 89.0% of pharmacies and 88.4% of dispensing GP surgeries responded to the PNA questionnaire about service provision. Of those responding 100% considered provision to be either ‘excellent’ ‘good’ or ‘adequate’. No responder considered provision to be ‘poor’.

Review of the locations, opening hours and access for people with disabilities, suggest there is adequate access to NHS pharmaceutical services in Cambridgeshire. There appears to be good coverage in terms of opening hours across the county. 89% (201 out of 225) respondents to the public consultation agreed that pharmacy services are currently available at convenient locations and opening times, although 14 (6%) suggested that some pharmacies could offer more convenient opening hours at lunchtimes, evenings or weekends. Overall, out of 109 community pharmacies, 50 (46%) are open after 6pm and 30 (28%) are open after 7pm on weekdays; 87 (80%) open on Saturdays; and 24 (25%) open

on Sundays. These findings are similar to those in the 2011 PNA. The extended opening hours of some community pharmacies are valued and these extended hours should be maintained.

Home delivery services can help to provide medications to those who do not have access to a car or who are unable to use public transport. Many pharmacies and dispensing surgeries have wheelchair access.

2. The role of pharmacy in improving the health and wellbeing of the localpopulation
Providers of pharmaceutical services have an important role to play in improving the health of local people. They are easily 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 motivational interviewing, providing information and brief advice, providing on-going support for behaviour change and signposting to other services.

Local commissioning organisations should consider pharmacies among potential providers when they are looking at the unmet pharmaceutical needs and health needs of the local population, including when considering options for delivering integrated care. Cambridgeshire Health and Wellbeing Board consider community pharmacies to be a key public health resource and recognises that they offer potential opportunities to commission health improvement initiatives and work closely with partners to promote health and wellbeing. Commissioners are recommended to commission service initiatives in pharmacies around the best possible evidence and to evaluate any locally implemented services, ideally using an evaluation framework that is planned before implementation.

<u>Services and support to encourage healthy lifestyle behaviours</u>
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 (for example, in response to 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. Smoking cessation activities in community pharmacies in Cambridgeshire have increased, but there are still many community pharmacies that do not provide a smoking cessation service. There is potential for further development in this area. Historically this has been challenging as it has been difficult to engage some pharmacies.

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 enable patients to provide a urine 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.

All pharmacies in Cambridgeshire have been offered the opportunity to deliver the Community Pharmacy Chlamydia Screening and Treatment service. Only 26 pharmacies have signed up to the chlamydia screening programme. Although there is some opportunity to expand, this is limited by the number of pharmacies that do not have the appropriate facilities to offer screening. It is advised to offer chlamydia screening when Emergency Hormonal Contraception is provided, since those requiring such contraception may also be at risk of infection. The extent to which local services signpost to services or carry out testing when EHC is provided could be examined in an audit, to stimulate best practice in this area.

People who use illicit drugs are often not 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 and syringes, and sharps containers for return of used equipment. Where agreed locally, associated materials will be provided (for example condoms, citric acid and swabs) to promote safe injecting practice and reduce transmission of infections by substance misusers.

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.

Medicines advice and support

In the community, pharmacists should work with GPs and nurse prescribers to ensure safe and rational prescribing of medication. Through the provision of Medicine Use Reviews (MURs), Dispensing Review of Use of Medicines (DRUMs), clinical screening of prescriptions and identification of adverse drug events dispensing staff work with patients to help them understand their medicines. This also ensures that medicines are not omitted unnecessarily and that medication allergies and dose changes are clearly documented and communicated.

94 community pharmacies in Cambridgeshire (86.2%) are signed up to the 'Not Dispensed Scheme', which highlights items that are not required by the patient and informs their GP's. This may have been caused by a misunderstanding on the part of any or all of the parties involved in the ordering and production of the repeat prescription, and helps to prevent waste. Previously GPs did not get any feedback on medicines which had not been dispensed or were returned to the pharmacy unused.

Pharmacy providers are involved in part of the public advice and campaign network to increase public awareness of antibiotic resistance and the rational approach to infection control matters regarding, for example, MRSA and *C.difficile*. Within primary care, dispensing staff are able to reinforce the message that antibiotics are not always necessary and explain the relationship between excessive use of antibiotics and Health Care Acquired Infections (HCAIs). In addition they are able to inform other primary care practitioners when an item prescribed is not normally available in the community.

Supporting co-ordinated care and self-care

The Royal Pharmaceutical Society (RPS) recommends that pharmacists collaborate with each other and with other healthcare professions, to develop models of care which enable commissioners to deliver integrated patient pathways, and ensure patients have consistent access to support with medicines use as they move between care settings.

This could be particularly relevant for frail older people and those with multiple conditions. Community pharmacies can support self -care where appropriate, as well as referring back to the GP service or signposting clients to other appropriate services. Many patients receive a range of different medications and up to 50% of patients do not take their prescribed medicines as intended. Pharmacists can help with this, particularly for those who have complex medication regimens or have problems with taking their medication regularly. If services are provided where vulnerable people are visited in their own homes, this also offers an opportunity to identify individuals who are at risk or require additional support, for example interventions to prevent falls.

Pharmacy staff can play a role in promoting awareness of good mental health, for example signposting to information about local support networks, mental health help lines etc. Community pharmacists can also help by promoting simple mechanisms to help people understand and take their medicines as intended.

The minor ailments service in Cambridgeshire aims to provide greater choice for patients and carers, and improved access to health care professionals by utilising the expertise of the pharmacists, so they become the first port of call for minor ailments. This can complement other medical services provisions and educate patients in self-care, thereby reducing the impact on GP consultations.

There is also potential to draw on experiences from areas where community pharmacies have worked innovatively to address key local public health challenges and benefit local communities. Section 5 of the PNA report describes a number of case studies from around the country.

3. Future pharmaceutical needs with population growth and housing developments
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. Several large-scale housing developments are in progress and considerations when assessing needs for local pharmaceutical service providers should be based on a range of local factors specific to each development site. These are further described in section 6.5.2 of the PNA report.

To facilitate commissioning of pharmaceutical services responsive to population needs the Health and Wellbeing Board partners will, in accordance with regulations, monitor the development of major housing sites and produce supplementary statements to the PNA if deemed necessary, to ensure that appropriate information is available to determine whether additional pharmacies might be required.

4. Summaries of previous JSNA reports

This chapter presents summaries of previously completed JSNA reports. Executive summaries from all of the reports from 2012/13 are included in full, with introductory paragraphs highlighting relevant data and progress updates since the time of their production. Older JSNA reports are summarised more briefly - key data for these summaries have been updated to aid current interpretation.

4.1 Armed Forces (2013)

The Armed Forces JSNA was completed in 2013. The following text presents the executive summary of the report – all data and content reflects the time of production. Updates to key data and other information precede the original executive summary.

The full report can be found at:www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/armed-forces-2013

2014 Updates

Since the report was published, data on Armed Forces from the 2011 Census have been released.These data present numbers employed by the armed forces by local authority, age group, sex and ethnicity and are available at www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-361202. The data relate to Census day (27 March 2011) and so are older than the figures presented in the JSNA.

A number of assessments referred to in the matrix, which relatesArmed Forces needs to current action plans and assessments, have now been updated or published. The 'Adults with a Physical or Sensory Impairment and or Long-Term Condition' JSNA is now complemented by the 'Physical Disabilities and Learning Disabilities through the Life Course (2013)' JSNA(see section 4.5), and the 'Housing and Health (2013)' JSNA(see section 4.2) has now been published, though neither specifically refer to Armed Forces. The Alcohol Needs Assessment has now been published and makes specific reference to Armed Forces – see: www.cambsdaat.org/?q=content/publications.

Armed Forces - Executive summary (2013)

Demographics
The Armed Forces JSNA focuses on military personnel, veterans, reservists and their dependents. For the purpose of the JSNA 'veterans' were classed as ex-service personnel who served at any time and irrespective of length of service.

There are four Armed Forces bases in Cambridgeshire - Bassingbourn (RAF/Army), Waterbeach (Army), Brampton/Wyton (RAF) and 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.

In general, there are poor data to quantify the number and demographics of veterans in Cambridgeshire, a picture also seen nationally. There is a variety of reasons for this, such as no central data collection, a perceived stigma by veterans leading to poor access of services and ex-service personnel not considering themselves to be a veteran, especially in younger personnel. However, national prevalence estimates suggest that there are between 54,000 and 58,000 veterans living in Cambridgeshire, including 9,000 reservists. 60% of

veterans are aged over 65, due to compulsory national service for men which continued until 1960. There will be a Census 2011 Armed Forces release in the spring of 2013, which will provide a wealth of data on existing service personnel, but not veterans.

Data and inequalities
Generally, service in the Armed Forces is 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.

The key inequalities that ex-service personnel face are:

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.

Priority Needs
Whilst the Armed Forces have specific needs many of these are also seen within the general population. For example, mental health disorders are relatively high within the veteran population but are also an issue for the general population, with the required services and treatments likely to be similar for both groups. However, specific needs for veterans need to be taken into consideration, such as their vulnerability to access services.

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.

In Cambridgeshire there are other Joint Strategic Needs Assessments that cover many of the key inequalities experienced by veterans, such as risk of homelessness and mental health. Table 7 Matrix of Military personnel, reservists, veterans and dependents (AF) against Covenant Board Action Plan and Current JSNAs shows the relationship between the key inequalities, the current JSNA's and the Covenant Board's action plan. This triangulation provides an action plan for the priority needs of military personnel, reservists, veterans and dependents in Cambridgeshire.

Matrix of Military personnel, reservists, veterans and dependents (AF) against Covenant Board Action Plan and Current JSNAs

Needs		Current relevant area		Comment	Suggested Action
		Covenant Board (CB)	JSNA's		
Health	Mental Health including PTSD, self harm and depression	×	✓ • Mental Health in adults of working age JSNA • Child and Adolescent Mental Health JSNA currently underway	The JSNA does not include Armed Forces (AF)	✓ • Make contact with relevant JSNA leads • Suggest the CB Health and Wellbeing Objective be widened to include a specific measure around AF mental health, e.g. access to care
	Physical Health (including long term conditions for veterans)	✓ Objective 2 - Health and wellbeing of veterans	✓ Adults with a Physical or Sensory Impairment and or Long Term condition	The JSNA does not include AF	✓ • Make contact with relevant JSNA leads • Suggest the CB Health and Wellbeing Objective be widened to include a specific measure for veteran physical health including long term conditions • Suggest Objective 2 be widened to include all AF, not just Veterans
	Barriers to care (including stigma, rurarlity, dependents access)	✓ Objective 6 - To enhance relationship between civilian and military communities	×		✓ This is covered under the CB Objective - but may need to add targets to minimise barriers to access/care - such as increasing GP registrations, reducing stigma
	Dependents access to NHS services	×	×		✓ • Suggest the CB Health and Wellbeing Objective be widened to include all AF and specific measures for immunisations, access to NHS dentistry and screening
Lifestyles	Alcohol Misuse	×	× Not specific but reference in Prevention of Ill Health in Adults of Working Age	There is currently an Alcohol Needs Assessment underway	✓ • Link has already been made with the relevant leads to ensure AF needs are considered in Alcohol Needs Assessment • Suggest the CB Health and Wellbeing Objective be widened to include alcohol misuse
Wider determinants of health	Homelessness	✓ Objective 1 - Housing for service personnel	✓ People who are homeless or at risk of homelessness JSNA	The JSNA does not include AF	✓ • Make contact with relevant JSNA leads
	Education and training - for dependents	✓ Objective 3 - Education for children of service personnel	×		× This is covered under the CB Objective
	Housing	✓ Objective 1 - Housing for service personnel	✓ Housing JSNA currently underway		✓ • Make contact with relevant JSNA leads
	Crime (including sexual offences, prisons and violence on discharge)	×	×		✓ • This is an area that needs further investigation with Cambridgeshire County Council Crime analysts • Suggest the CB have an objective relating to this and to also include the Police on the CB membership
	Employment - for veterans and dependents	✓ Objective 5 - Preparation for civilian life	×		× This is covered under the CB Objective
	Social Care and Welfare needs not covered elsewhere e.g. finances	✓ Objective 2 - Supporting veterans	×		✓ • Suggest further this objective is widened to ensure veterans have access to financial advise etc
Other	Transition to civilian life, with a focus on Early Service Leavers	✓ Objective 5 - Preparation for civilian life	×	The Objective does not specifify Early Service Leavers	✓ • Suggest the CB Preparation for civilian life Objective be widened to include a focus on Early Service Leavers

4.2 Housing and Health (2013)

The Housing and Health JSNA was completed in 2013. The following text presents the executive summary of the report – all data and content reflects the time of production. Updates to key data and other information precede the original executive summary.

The full report can be found at: http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/housing-and-health-2013

2014 Updates

Indicators relating to fuel poverty and homelessness are included in the Public Health Outcomes Framework – see www.phoutcomes.info (Indicators 1.17 and 1.15 respectively). Fuel poverty data for 2011 indicate that although Cambridgeshire as a county favours well compared to the England average for the percentage of households considered to be in fuel poverty, Cambridge rates significantly worse at 15.8%. There were 590 statutory homeless households in 2012/13, 2.3% of households in Cambridgeshire, a figure similar to the national average for England. 270 were living in temporary accommodation.

For the latest local information and data relating to housing, please see the Housing pages on Cambridgeshire Insight at www.cambridgeshireinsight.org.uk/housing. The latest Strategic Housing Market Assessment for 2013 can be found at: www.cambridgeshireinsight.org.uk/housing/shma/shma-current-version.

Housing and Health – Executive summary (2013)

Summary

This Joint Strategic Needs Assessment (JSNA) provides a succinct introduction to a wealth of information and data on housing and housing issues in Cambridgeshire; to the local and national organisations which deliver housing services and funding (much of which is relevant to health and wellbeing); and to strategic housing plans for Cambridgeshire and the mechanisms through which these plans can be influenced. Health professionals and managers who wish to learn about the potential links between health and housing services are strongly recommended to read the full JSNA report.

The seven broad housing priorities for Cambridgeshire agreed by the Cambridge sub-regional housing board are to:

- Deliver new homes to support economic success.
- Enable better health and wellbeing through housing, affordable housing and housing-relatedsupport.
- Create mixed, balanced, sustainable and cohesive communities.
- Improve standards in existing homes and encourage best use of all housing stock.
- Extend housing choice and meet housing need.
- Prevent and tackle homelessness.
- Promote the benefits good partnership working can bring to housing-related issues.

The aim of the JSNA is to identify how each of these areas of housing activity is relevant to the health and wellbeing of Cambridgeshire residents and the priorities of the Health and

Wellbeing Board. It also relates activities where applicable to the three commissioning priorities of the Clinical Commissioning Group.

Key findings identified in this assessment focus heavily on partnership working, building networks, learning from each other, and sharing information, while addressing new challenges due to organisational change.

This JSNA is a starting point to try to help build these connections and strengthen existing partnerships and highlights areas the sub-regional housing board would like to explore further with partners in 2013-14.

It provides an introduction to some of the issues, plans, partnerships and practices across Cambridgeshire which aim to help residents navigate their way through often complex systems, to meet their housing, community and support needs.

Introduction and Overview
These sections outline the statutory housing functions of district councils; the role of housing associations in delivering both social housing and community services; the way that 'affordable housing' is currently defined; the role of the national Homes and Communities Agency in funding affordable housing and housing targeted to the needs of vulnerable groups; and a range of useful sources of information on Cambridgeshire housing and on examples of best practice. Information on the impact of housing on health and wellbeing is included, such as adverse health effects of cold and damp homes, pollutants associated with respiratory problems, features that increase the risk of physical injury, and the impact of overcrowding.

Deliver new homes to support economic success

- Housing needs in the Cambridge sub-region are regularly assessed and updated through the Strategic Housing Market Assessment (SHMA). Across the county more than 70,000 new homes are planned to be built between 2011 and 2031. This reflects the significant need for new homes to support local population growth and to meet the requirements of people moving into the county for employment.
- The scale of developments across our county on a variety of small and larger sites, provide opportunities to meet needs and to create thriving communities and economies. Between 2001 and 2012, a total of around 33,000 homes were built; around half on sites of less than 100 homes, and half on sites of more than 100 homes.
- There are a range of mechanisms through which partner agencies can influence district level Local Plans for housing development. The JSNA report outlines funding mechanisms such as the Community Infrastructure Levy (CIL) and the Cambridgeshire local investment plan for affordable housing.
- Information from residents' surveys for new housing developments across Cambridgeshire is presented which is relevant to health needs, together with a range of good practice examples including 'lifetime homes', the Cambridgeshire Quality Charter for new housing, health impact assessment built into the planning process, and other local case studies. Carefully designed new developments can impact positively on health through new facilities, green spaces, specialist housing schemes, shared services, targeted community development resource, or increased walking and cycling access.
- A key gap is that agencies do not explicitly link the way that housing needs are quantified and predicted in the strategic housing market assessment, with the work on health and social care needs through the JSNA.

- Working together in 2013-14, housing, health and social care data could be shared and improved, to help inform plans for new developments of all scales across the county. If this proves useful and successful, partners could consider a joint plan for investment to meet our communities needs in future.

Enable better health and wellbeing through housing, affordable housing and housing-related support

- Affordability of housing is a key issue for Cambridgeshire, and has been for some time. The average house price was nine times the average income in Cambridge, and the lower quartile house price was 14 times the lower quartile income. Affordability ratios vary across the county, but even in Fenland which is a relatively affordable area, the average house price was 4.7 times average income, and lower quartile house price were 8.3 times lower quartile income (Hometrack, September 2012).
- Since 2003 a total of almost 6,000 new affordable tenure homes have been built across Cambridgeshire – that is, around 27% of the total number of homes built.
- Affordable housing is under pressure as people find it hard to access the private housing market, particularly those on lower incomes. This includes households who are key to the health, social care and service industries, and who provide childcare and other services which enable others to go to work. Changes to benefits are an issue for some, as is availability of homes, in the right location and of the right type.
- 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. Client groups include single homeless, homeless families and rough sleepers, ex-offenders and those at risk of offending, people with physical or sensory disability, people suffering domestic violence, people with alcohol or drug problems, teenage parents, vulnerable older people, young people at risk/leaving care, people with HIV or AIDs, people with learning difficulties, Gypsies and Travellers, migrant workers, refugees and asylum seekers, and people with mental health problems. Housing related support is vital to many, helping them recover from a life trauma, maintain their existing housing, or continue to live at home instead of needing care.

Create mixed, balanced, sustainable and cohesive communities

- As outlined above, affordability of housing and the limited availability of affordable tenure homes are significant issues across Cambridgeshire. This section looks at the importance of balanced and mixed communities, and the role partners play in creating them.
- Part of a community's 'mix' relates to a cross-section of age and income groups. In Cambridgeshire, given the pressurised housing markets, the affordability issue is key. As housing and welfare reforms take effect a concern is that housing benefits and local housing allowances will not keep up with housing costs. People may not be able to continue to afford their current home, and be obliged to either secure more income, or move to a cheaper housing area with associated impacts of increased travel to work times, effect on children's schooling, effect on ties with local communities, friends and families.

- A local Welfare Reform Strategy Group has been formed to monitor such trends by collating a small set of key data. The aim is to identify trends or impacts early on before they become a problem, and prepare to help and support those most affected and most vulnerable.
- The design of homes and estates also plays a role in supporting mixed and cohesive communities, where people of all ages and backgrounds feel safe and included. 'Secured by design' principles have been shown to reduce crime by combining minimum standards of physical security and well tested principles of natural surveillance and defensible space.

Improve standards in existing homes and encourage best use of all housing stock

- Local authorities work with local private landlords and home owners on a range of housing issues, some of them statutory, including:

– Works and advice to improve the condition of homes, to put right serious disrepair.

– Enforcement action if a property fails to reach a minimum standard.

– Ensuring houses in multiple occupation (HMOs) pass standard and are licensed if necessary.

– Give advice to help bring empty homes back into use.

– License mobile home parks.

– Make sure resources are directed to improve housing standards for the most vulnerable households.

- The 'Decent Homes' standard in a nutshell is that a 'decent' home must:

– Be free from category 1 hazards (serious risk to health and safety).

– Be in a reasonable state of repair.

– Have reasonable modern facilities and services.

– Provide a reasonable degree of thermal comfort.

- Across the county there is variation in the numbers of privately owned dwellings which have at least one category 1 hazard and therefore fail the decent homes standard – most commonly due to excess cold or risk of falls on stairs. Based on the most recent stock surveys carried out by each individual district and presented in the main JSNA report, up to 27,000 homes (around 10% of the total number of private homes) in Cambridgeshire are estimated to be in this group. Homes built before 1919 commonly present more serious levels of risk than more recently built homes.
- In 2009/10 a total of 483 homes were made good by the direct action of the local authority.
- Access to decent housing is a reflection of affordability. Low income households and vulnerable groups are the most likely to occupy poor standard homes, often related to issues of overcrowding, fuel poverty, disrepair and damp and mould.
- 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. 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.

- There are local Home Improvement Agencies, Handyperson schemes, and Winter Warmth initiatives which help support older and more vulnerable people to maintain safety and independence in their homes.

Extend housing choice and meet housing need

- Housing needs are high, and the supply of affordable tenures homes does not meet the expressed need. In Cambridgeshire, how people access affordable housing and find solutions to their housing issues is dealt with through three main routes:

– Making a homelessness application to the district council.

– Applying for social housing through the 'Home-Link system'.

– Applying for intermediate tenures through the Orbit system.

- In March 2013, nearly 20,000 people were registered with Home- Link as 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. The JSNA report presents detailed statistics by district of Home- Link registrations and housing needs categories. Because the number of people registered is greater than the number of homes let each year, the register of need continues to grow. [A review of applicants on the register is being carried out which will end in April 2013 and may result in changes to these numbers if people's circumstances have changed].
- Housing lettings systems are complex. While the Home-Link system aims to be as fair, accessible and transparent as possible, feedback from customers points to the fact it is not easy to navigate and that people may need more help and support. There is potential to investigate possible improvements eg with the Speak Out council and other partners and to test any solutions which would help.

Prevent and tackle homelessness

- The 2010 Homelessness JSNA identified three overlapping groups of homeless people:

– Single homeless and rough sleepers.

– The statutorily homeless.

– Hidden homeless.

- Homelessness is still a major issue across the County. More than 800 households approached the local authority as homeless in 2011/12, of which nearly 600 were accepted as 'statutory homeless' (definition provided in the main JSNA report). Some 250 of these households were living in temporary accommodation at the end of March 2012.
- Although some homelessness is being prevented, it continues to be a major concern as the number of people applying as homeless, and the severity of the impact of homelessness on health and wellbeing, warrant a continued focus on tackling homelessness across the county.
- Placing individuals and families in temporary accommodation can cause disruption and impact on health and wellbeing, for example meaning people may have to travel to reach school and family networks, and may have limited facilities for cooking fresh meals.
- Since the homelessness JSNA was launched in 2010, the action plan has been progressed by the various partners involved. There is a network of active agencies across Cambridgeshire, particularly but not exclusively focused on Cambridge, who work to prevent, tackle and reduce the effects of homelessness. Examples include the

Cambridge Access Surgery, Winter Comfort, Foyers, Jimmy's night shelter, Octavia View in Wisbech, Cambridge Cyrenians, Emmaus, Single Homelessness Service Project, targeted housing related support, and district homelessness and housing advice services.

- While there has been much progress on the plan, partners are predicting an increase in homelessness in parts of the county. The action plan might benefit from a review and update in collaboration with the agencies which originally contributed. New actions may be needed to tackle new issues and challenges, should partners support this idea.

Promote the benefits good partnership working can bring to housing-related issues

- Partnership working, sharing resources and opportunities, and working to resolve issues, helps us achieve the sixth health and wellbeing strategic priority to work together effectively, across all agencies.
- Partnership working is increasingly important to ensure all agencies work together to the benefit of residents. Current changes in organisations and partnerships can challenge ability to maintain contact, continuity, understanding, or referral systems. New ways to communicate and identify shared agendas can help in this area.
- As this JSNA presents a review of secondary data from a wide variety of sources and partners, a key outcome would be to explore further the data and the issues raised during the drafting process. An event in 2013-14 and further sharing of data, plus identifying shared outcomes, would help build on this 'introductory' JSNA.

4.3 Prevention of Ill Health in Older People (2013)

The Prevention of Ill Health in Older People JSNA was completed in 2013. The following text presents the executive summary of the report – all data and content reflects the time of production. Updates to key data and other information precede the original executive summary.

The full report can be found at: www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013

2014 Updates

The latest demographic picture for the county, including the latest forecast increase in population aged 65+, can be found in section 2 of this report (Population and Health Statistics for Cambridgeshire).

Indicators relating to falls and hip fracture, and referred to in this JSNA, are included in the Public Health Outcomes Framework (PHOF) –see www.phoutcomes.info (Indicators 2.24 and 4.14 respectively). The latest data now available relate to 2012/13 and indicate the patterns described in the JSNA have continued. The rate of emergency hospital admissions due to falls in people aged 65 and over is significantly worse than the national average in Cambridge in men, women and for all persons combined. The rate of hip fractures in people aged 65 and over is also statistically higher than the England average in Cambridge.

Fuel poverty and excess winter deaths are also included in the PHOF (Indicators 1.17 and 4.15 respectively). The latest data for 2011 indicate that although Cambridgeshire as a county favours well compared to the England average for the percentage of households considered to be in fuel poverty, Cambridge rates significantly worse at 15.8%. The latest number of excess winter deaths occurring in Cambridgeshire (2011/12) is 218, 123 of which were in people aged 85+.

The latest locally available data on emergency bed day rates per person aged 65+ years indicate a small decrease between 2012/13 and 2013/14.

The future JSNA report covering primary prevention approaches, referred to in this JSNA, has now been published (Primary Prevention of Ill Health in Older People – see section 3.4). Specific JSNA reports have also now been published which cover some of the issues referred to in this report in more detail, such as dementia and carers – see the Older People's Mental Health JSNA (section 3.3) and the Carers JSNA (section 3.2). A dedicated report on Census data relating to Older People has also now been published – see http://www.cambridgeshireinsight.org.uk/census-2011/census-2011-reports. The Joint Commissioning Strategy for the Mental Health and Well-being of Older People (2013 – 2016) has now been published and is referred in the Older People's Mental Health JSNA (section 3.3).

The National Institute for Health and Care Excellence has now published a review of its guidance on 'Falls: assessment and prevention of falls in older people' which includes changes relating to preventing falls in older people during a hospital stay – see http://www.nice.org.uk/nicemedia/live/14181/64088/64088.pdf.

Many of the recommendations in the JSNA have influenced the CCG's procurement process for older people's services and accompanying outcomes framework – see http://www.cambridgeshireandpeterboroughccg.nhs.uk/pages/older-peoples-programme.htm.

Prevention of Ill Health in Older People – Executive summary (2013)

Purpose and process
The purpose of this JSNA is to bring together information to inform how cross-sector partners and local communities can best work together to prevent ill health and achieve priority two of the Cambridgeshire Health and Wellbeing Strategy, 2012-2017: 'support our older people to be independent, safe and well'.

In Cambridgeshire in 2011, there were 101,400 people aged 65 or over. People in Cambridgeshire are living longer and the number of people over 65 is set to grow by approximately 19% in the next four years and 33% in the next nine years. Preventative approaches are important to ensure older people remain healthy and independent in the community for longer, and to reduce the unsustainable cost of health and social care services for this growing population. This report aims to inform local discussions to help shape the planning and commissioning of preventative services.

The Prevention of Ill Health in Older People JSNA has been developed to complement and build on the JSNAs for Older People produced in 2008 and 2010 and the Older People Financial Services Review (2012), as well as specific JSNAs on prevention, housing, physical impairments and long term conditions. The Older People JSNA steering group agreed this JSNA would initially focus on secondary and tertiary prevention approaches for older people with a view to updating information on primary prevention approaches in future JSNA phases.

This report therefore reviews early interventions which can enable older people to remain well and live independently at home, or in a community setting where appropriate, and prevent or reduce unnecessary hospital admissions. The group identified five priority areas to review which are important for the prevention of ill health in older people of Cambridgeshire:

- Integrated care and joined-up working to provide person-centred care and sharing of information.
- Identification of frail older people and those at risk of avoidable hospitalisation, and targeted multi-disciplinary interventions to provide support and prevent crisis eg active case management, rehabilitation and falls prevention.
- Early interventions to prevent or treat mental health problems in older people and initiatives to support and enhance mental wellbeing, including tackling social isolation and loneliness.
- Housing and social care support services tailored to the individual needs of older people.
- Community support and information, including the supportive roles of voluntary organisations and informal carers.

This JSNA has been produced in collaboration with key stakeholders, local voluntary organisations and the Older People's Partnership Board. The report presents views from our local communities collected from the Ageing Well Consultation (2011) and the draft Cambridgeshire Health and Wellbeing Strategy consultation (2012). It also informs the future planning of a number of key community engagement events including focus groups, to seek the views of local older people and community groups to ensure our assessments, services and interventions are responsive to local needs.

Early interventions to support older people to be independent, safe and well

a) Preventing hospital admissions and developing integrated care models
Preventing avoidable hospital admissions for those over the age of 65 through early interventions to prevent ill health and deterioration is desirable for both older people and their families or carers, and to reduce the use of expensive acute hospital care.

A national study by the King's Fund reported significant variation in the number and rate of emergency bed days used by people over 65 years of age (per weighted population) between Primary Care Trusts (PCTs) in England in 2010/2011. Where the top ranking (1st) has the lowest emergency bed days and admissions, Cambridgeshire ranked 98th out of 151 PCTs nationally. Factoring in population growth, there has been a 10.6% reduction in the rate of emergency bed day usage by people aged over 65 in Cambridgeshire between 2009/10 and 2011/2012. However, even continuing this progress will not be sufficient to achieve the same performance of the top quartile of PCTs in England. In Cambridgeshire in 2011/12, nearly 70% of all emergency occupied bed days were for people aged 65 or over.

The top 10 PCTs with lowest emergency bed day rates use different models of integrated primary and community 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.

- Local commissioners are currently working together through the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Older People Programme Board to develop models of joint working to promote early intervention for better health and wellbeing, to deliver high quality care for older people and their carers, and reduce avoidable emergency admissions.
- There is limited evidence available to support specific interventions or models of care which can be demonstrated to reduce emergency admissions. Key to the success of a variety of reported case studies is developing integrated, co-ordinated systems which are responsive to local needs and have support from local stakeholders.

There are significant benefits to be realised by greater joint working within health and social care both at an operational and strategic level. However, at present integrated working remains a challenge, which is under review at the local level.

The following sections review a number of cross-sector interventions across health, social care, the voluntary sector and in local communities that can help to prevent ill health or dependency in older people in Cambridgeshire.

b) Case management by multi-disciplinary teams for 'frail' elderly people
Some older people are often referred to as 'frail', a non-specific term which is used to describe someone with a number of physical or mental disabilities or a cumulative loss of function, which makes an older person more vulnerable to an acute health or social crisis. Applying national estimates of frailty to the local population suggests that nearly 17,000 people over 65 (16.8%) are likely to be 'frail' in Cambridgeshire.

A fundamental element of intervening early requires identification of those who are most at risk. The Department of Health supported the development of a national risk stratification tool which uses data from primary and secondary health care to predict the patient's risk of future emergency admission.

- A modified version of this national tool is being piloted in Cambridgeshire to identify older people from GP surgery lists at higher risk of hospitalisation, for active case management and early intervention by multi-disciplinary teams.

- Evaluations are being conducted for a number of active case management approaches by multi-disciplinary teams throughout Cambridgeshire and Peterborough which will generate learning to share across the counties.
- Stakeholders have also emphasised that the development of information sharing across health, social care and the voluntary sector would facilitate more co-ordinated, cross-sector early interventions.

There are inter-collegiate guidelines for preventing avoidable hospital admissions during an acute episode and improving early recognition and interpretation of non-specific syndromes in older people which can be markers of poor outcomes.

- These recommendations are being used locally as a guide to audit, evaluate and improve the local response for an older person with an acute health crisis in the urgent care system.

Primary preventative approaches are important in reducing the risk of respiratory and circulatory diseases which are the main causes of mortality and morbidity and the top two causes of hospital admissions in Cambridgeshire for people over 65. There is also a strong evidence base for secondary and tertiary prevention to reduce the impact of a stroke or heart attack, with national standards for cardiac and stroke rehabilitation.

- Coping with multiple morbidities and illnesses are significant challenges for older people and 'upstream' interventions should include optimising management of long term conditions and ensuring appropriate rehabilitation after stroke or cardiac events.

c) Falls prevention

Falls are a major cause of disability and the leading cause of mortality due to injury in older people over 75 in the UK. In each of the three 2012 falls related indicators in the Older People's Health and Well-Being Atlas (in those over 65: hospital admissions for falls, hospital admission injuries due to a fall, hip fractures) Cambridge City is significantly worse than the England average. In Cambridgeshire, there were 2,650 emergency admissions (and 17,890 bed days) in 2011/12 for injury due to falls in the over 65s, which accounts for 7.7% of emergency admissions in the over 65s.

- There are a range of falls prevention and falls services available across Cambridgeshire, but little data available on the outcomes or quality of these services. An audit of falls prevention strategies and interventions throughout Cambridgeshire could offer insight into local models, highlight gaps in service provision, identify areas of inequality and examples of good practice.
- A strong evidence base exists with national recommendations for commissioners to underpin the development of an integrated falls service across Cambridgeshire, building on assets and good practice already in place.
- There are also local opportunities to collaborate with research colleagues to strengthen and expand the evidence base into effective interventions for reducing falls in specific population groups, such as people with dementia.

d) Mental health

Over a third of older people in the UK are likely to experience mental health problems. The mental health needs of older people are often complex due to co-morbidities with mental health and/or physical health conditions or frailty being present at the same time.

In Cambridgeshire in 2013 there were estimated to be 7,240 people with dementia, and this number is likely to grow. This increase will lead to increasing demands on social services, primary care and families, as well as increasing pressure on acute hospitals and specialist mental health services. 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.

Mental health problems are under-identified by professionals and older people themselves, and older people are often reluctant to seek help, both of which can result in a delay before individuals and their carers are offered support.

- Increasing awareness of possible mental health problems affecting older people (including cognitive impairment) and access to advice and support could help to improve early diagnosis and access to effective help. This is important both for those caring for older people in all care settings including own home/community, care homes and hospitals.

A joint commissioning strategy for the mental health and well-being of older people (2013 – 2016) has been drafted by Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire County Council and Peterborough City Council and is due to be finalised in April 2013. This focuses on:

- early diagnosis and improving access to effective help, in particular, increasing awareness of mental health problems amongst those caring for older people;
- developing integrated services for mental health which facilitate early intervention and support older people and their carers in the community.
- advice and support for carers of older people with mental health problems including cognitive impairment;
- improved commissioning processes to promote joint working across health, social care and voluntary organisations.

- There is a need to further investigate local needs and service provision to support and evaluate the commissioning of mental health services and early interventions for older people. Specifically, further information would be helpful on the needs of older people in vulnerable groups, and alcohol and drug misuse.
- There is a need to ensure equity of access and services and sufficient capacity to meet the increasing mental health needs of older people. Improved joint-commissioning and better integration of services with joined-up working could enhance patient and carer experience, deliver better health outcomes and facilitate timely intervention.
- National case studies have shown that liaison psychiatry services in the acute hospital can generate improved mental health outcomes for older people as well as potential savings through an integrated approach to physical and mental health, reducing length of stay and readmissions.

e) Reducing social isolation and loneliness

Isolation and loneliness amongst older people is a key issue which impacts on their health and wellbeing. Nationally it is estimated that between 6% and 13% of people over 60 often or always feel lonely. In Cambridgeshire, approximately 29,000 people over 65 live alone.

Reducing loneliness can contribute to achieving a number of health and wellbeing board priorities and addressing it should result in stronger communities in which older people play a greater role. Reducing loneliness and isolation can also help to address health inequalities.

- The issue of loneliness and social isolation is multi-faceted and the design of services needs to be informed by the complexity and inter-relationship of the causes of

loneliness. Several local initiatives are described which help to promote social interaction and engage older people in meaningful activity.

- The evolving evidence base and sharing of effective local interventions to tackle social isolation and loneliness is a key priority for further analysis and consideration.
- There is a need to strengthen social capital through initiatives such as time banking and peer-group support models to drive wider health and wellbeing initiatives in local communities. It is recognised that local authorities may particularly need to stimulate community activity in areas where social networks are poorly developed because of deprivation or rural geography.

f) Social care and support in the community

There are a number of local interventions and examples of good practice which help to support older people and their carers, as well as prevent or delay the need for health and social care, including hospital admissions.

- Encouraging systematic evaluations of the impact of these interventions could help to promote, enhance and share best practice.

Re-ablement services are now widely available and proven to be effective in helping older people regain their independence through assisting with re-learning everyday tasks.

- The development of this approach needs to continue, to benefit more people.

The Ageing Well asset-based approach sees older people as community assets and demonstrates the benefits of engaging with them.

- This underlines the need to continue working in partnership and involving older people in service design, delivery and review.

Progress has been made in responding to older people's views about needing better information, through 'Community Navigators' and 'Information@GPs' and embedding 'Your Life, Your Choice' and 'Ask SARA' in other services. There is considerable potential to improve the way in which information and advice is offered across the whole health and social care sector. GPs are a key point of contact with 'at risk' older people and provide an opportunity to signpost to preventative and community support services.

- Raising awareness of local databases and sources of information about local support groups in the community could help to prevent ill health or crises and enhance the health and wellbeing of older people and their families or carers.

g) Housing

Supporting older people to remain in their own homes meets their aspirations and generates significant financial savings. This JSNA highlights key interventions delivered by local Home Improvement Agencies (HIA) or the Housing Related Support Team including grant and loan funding for adaptations and essential property repairs, low level housing-related support relating to security, personal safety, personal budgeting and minor repairs. More information is available in the Housing and HealthJSNA and Cambridgeshire Strategic Housing Market Assessment (2011).

- The challenges for housing support services are to ensure the continuation and co-ordination of interventions to support an increasing older population to remain in their own homes.
- The Health and Wellbeing Board and Local Health Partnerships offer new opportunities for joint working to ensure services, support and information to make informed choices are accessible for older people in need, particularly those in rural areas.

Fuel poverty is a growing problem, with the percentage of households in fuel poverty increasing from 11.5% to 14.5% in Cambridgeshire between 2008 and 2010. There were 211 excess deaths in winter in Cambridgeshire in 2009/10. The Winter Warmth programme supports older people by providing a fast, responsive system to provide advice on benefits and access to other services such as for insulation.

- The evaluation of this project highlights key learning which could be embedded into existing services to address the needs of vulnerable groups during the winter months.

h) Supporting carers

Carers provide a crucial role in supporting older people to be independent and live in the community, preventing unnecessary hospital admissions and reducing the need for health and social support. Better recognition of a caring role would help older people identify themselves as a carer at an earlier stage, and potentially be more likely to access appropriate support services before the point of crisis. 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 (aged 60 to 94) have long-term health problems or a disability themselves and 69% say that being a carer has an adverse effect on their mental health.

- This group have been identified as a specific client group for whom a JSNA would be useful to further investigate their needs.

There are 60,000 informal carers in Cambridgeshire, but fewer than 5% are 'known' to GPs. In the 2012 Carers Survey, local carers identified a need for local and accessible information to enable informed decisions and choice, isolation and carer breaks and easily accessible advice on financial benefits.

- There is a need to widen the range of information and advice to ensure that all carers can access support appropriate to their need through a range of communication channels and across all sectors, particularly those in rural or deprived areas and hard to reach groups.
- Reaching carers who do not meet the Social Care eligibility criteria for services is also a priority, as they could benefit from accessing information and free low level/ preventative services that would support them to continue in their caring role.

Next Steps

The findings of this JSNA will be fed into commissioning plans for health and adult social care and support plans to develop local models of integrated teams working to support and deliver person-centred care tailored to the needs of individuals and their families or carers. There is a need to continue robust evaluation of local pilot interventions and to share good practice between all agencies and across the county where appropriate.

There is also a need to update the evidence base and local information about a primary prevention approach including active ageing, a healthy diet and nutrition, smoking and alcohol use, and oral and dental health.

4.4 The Mental Health of Children and Young People in Cambridgeshire (2013)

The Mental Health of Children and Young People in Cambridgeshire JSNAwas completed in 2013. The following text presents the executive summary of the report – all data and content reflects the time of production. Updates to key data and other information precede the original executive summary.

The full report can be found at: www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/mental-health-children-and-young-people

2014 Updates

The latest demographic picture for the county, including the latest forecast increase in population aged under 15, can be found in section 2 of this report (Population and Health Statistics for Cambridgeshire).

Public Health England's 2014 Child Health Profile for Cambridgeshire, which includes the latest self-harm data, is summarised and linked to at www.cambridgeshireinsight.org.uk/health/profilesdata/childhealthprofiles. Data for 2012/13 show that hospital admissions as a result of self-harm among 10-24 year olds are significantly higher than the national average in Cambridgeshire. Hospital admissions for mental health conditions in 2012/13 were similar to the national average in Cambridgeshire.

The Public Health Outcomes Framework includes an indicator on the emotional well-being of looked-after children (Indicator 2.8). The average difficulties score for children in Cambridgeshire for 2012/13 was similar to the England average. See www.phoutcomes.info.

Public Health England have recently launched the Mental Health Dementia and Neurology Intelligence Network, presenting four data tools to support commissioning, planning and providing mental health services locally – see http://fingertips.phe.org.uk/profile-group/mental-health.

The JSNA formed the basis for the 'Emotional Wellbeing and Mental Health Strategy for children and young people 2014-16'. This strategy has been agreed and work has begun on the implementation of the strategy. Self-harm has been identified as a particular area of concern and training and awareness work is being focused on this. As a result of the JSNA the recording of whether mental health patients accessing specialist services are parents is now a contract requirement.

The Mental Health of Children and Young People in Cambridgeshire – Executive summary (2013)

Introduction

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, poor peer and family relationships, witnessing domestic violence and having a parent that 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 have been shown to have consistently higher levels of mental health problems, including post-traumatic stress, anxiety and depression (Child and Adolescent Mental Health, A guide for healthcare professionals, June 2006, British Medical Association.http://bma.org.uk/about-the-bma/how-we-work/professional-activities-and-special-interest/board-of-science/board-of-science-

publications). The way that children are parented, their diet and exercise, their school and education, and experimentation with drink, drugs and other substances, along with many other factors will all affect a child's mental wellbeing or mental ill health.

The following report examines local and national data sources and information relating to the mental health of children and young people in Cambridgeshire. This builds on the previous report 'A profile of Child and Adolescent Mental Health in Cambridgeshire 2008' produced by the Cambridgeshire PCT Public Health Information Team. Children and Young People in this report are generally those under the age of 18, unless a specific age group is referred to.

It is important to note that two of the Cambridgeshire Joint Strategic Needs Assessments (JSNA) cover mental health: the Children and Young People JSNA and Mental Health in Adults of Working Age JSNA. There are some overlaps between the two reports for people in the older age bands. In addition there is overlap between this report and the Physical Disabilities and Learning Disabilities through the Life CourseJSNA.

This report starts by setting the scene with the population estimates and forecasts of children and young people and maps of deprivation within the County. It then examines the prevalence of mental disorders in Cambridgeshire, and the factors that influence the mental health of children, and specific groups of vulnerable children. The report goes on to look at service and benchmarking information and finally the evidence base. It is important to note that this JSNA relates to children and young people living in Cambridgeshire only and does not relate to service catchment areas. It also only looks at services commissioned directly by NHS Cambridgeshire and/or Cambridgeshire County Council.

Key Findings: What is this telling us?
The World Health Organisation (WHO)October 2011(www.who.int/features/factfiles/mental_health/en/) defines mental health as:
"A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

If children and young people are not able to develop the resilience, self-awareness, social skills and empathy required to form relationships, enjoy one's own company and deal constructively with normal setbacks in life, then they are at risk of developing poor mental health at a later stage. It is in everyone's best interests to help them develop these capacities whilst being ready to intervene early if problems develop, or to refer to specialist services if problems become more serious.

National estimates show that one in ten (10%) children and young people aged five to sixteen years (the statutory school age) have a clinically significant mental health problem, and approximately 2% have more than one diagnosable mental health disorder concurrently(ONS, 2005 'the Mental Health of Children and Young People in Great Britain 2004'). In general boys have a higher prevalence of mental disorder than girls.

The mental health disorders most relevant to children and young people are:

- conduct disorders, for example defiance, physical and verbal aggression, vandalism
- emotional disorders, for example phobias, anxiety, depression or obsessive compulsive disorder
- neurodevelopmental disorders, for example attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorder (ASD)

- attachment disorders, for example children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major caregivers
- substance misuse problems
- eating disorders, for example pre-school eating problems, anorexia nervosa and bulimia nervosa.

The most common disorders are conduct and emotional disorders.
(A more detailed guide to these is in Appendix 2 of the main report).

Mental health disorders in childhood can have high levels of persistence (Child and Maternal Health Observatory (ChiMat) 2011). Around 50% of lifetime mental illness starts before the age of 14, and continues to have a detrimental effect on an individual and their family for many years. Potentially, half of these problems are preventable.

According to a national study (BOND – Better Outcomes New Deliverywww.youngminds.org.uk/assets/0000/4412/BOND_learning_from_practice_report_edited_030912_.pdf) the following was noted:

- 25% of children with a diagnosable emotional disorder and 43% with a diagnosable conduct disorder still had the problem three years later.
- Persistence rates in diagnosable emotional disorder and diagnosable conduct disorder were higher for children whose mothers had poor mental health (37% and 60% respectively).
- Young people experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood.

Some children are more vulnerable to mental health problems than others. There are a number of risk factors, in particular, which increase the vulnerability of those children (ChiMat 2011). This includes being from low-income households; families where parents are unemployed or families where parents have low educational attainment. Other risk factors include being looked after by the local authority, having a disability (including learning disability), being from gypsy and traveller communities, being in the criminal justice system, misusing substances and having a parent with a mental health problem.

Many children experience more than one of these risk factors. Four or five adverse childhood experiences (child abuse, parental depression, domestic abuse, substance abuse or offending) increase the risk of developing mental health problems throughout life (New Horizons Confident Communities, Brighter Futures: A framework for developing wellbeing. HM Government March 2010).

Key Findings

Demography and Prevalence
It is estimated that there are around 136,000 children and young people under the age of 19 living in Cambridgeshire. The area with the highest number of children is Huntingdonshire but the area predicted to have the greatest increase in the number of children by 2016 is Cambridge City (15.8%) while Huntingdonshire will see a 1.6% reduction by 2016. Overall the population of children in Cambridgeshire is due to rise 3.9% by 2016 and 10.3% by 2021.

Applying national prevalence data of Cambridgeshire to the local population shows the following:

- There are approximately 5,000 children under the age of five with mental health problems.
- There are approximately 8,000 children between the ages of 5-16 and 1,275 children between 16 and 17 years of age.
- It is estimated that children aged 5-16 years in Cambridgeshire 3,100 have an emotional disorder,
- It is estimated that 4,800 have a conduct disorder, 1,200 have a hyperkinetic disorder and 1,100 have a less common disorder, including 740 with autism.

Conduct disorder is still the most common diagnosis, the majority of which is found in boys and emotional disorder (anxiety) is the next most common, the majority of which is found in girls.

There is a clustering of indicators, in parts of Fenland and Cambridge City, which make mental disorders likely to be more prevalent. These indicators tend to mirror broad patterns of child poverty and household deprivation. North Fenland, Huntingdon North and North-east Cambridge have the greatest levels of relative deprivation. Waterlees in Fenland and Abbey in Cambridge City have the highest levels of child poverty within the county, with over half of children living in means tested benefit-reliant families. Average prevalence levels are therefore an underestimation of need in these areas, as risk levels are likely to be two to three times higher amongst some disorders (eg conduct disorder).

The wellbeing measures available, which are based on 2009 work, suggest that Cambridgeshire children and young people generally have a better wellbeing than the England average. However, when this is broken down by district Fenland ranked 251 out of 354 local authorities with number one as the best performing.

There has been an increase in the number of children and young people admitted to hospital for self-harm since 2010/11. However the national rates have substantially decreased over the same period leaving Cambridgeshire well above the national average.

Vulnerable groups
There are higher levels of mental health disorders among the following groups of children and young people in Cambridgeshire. Those with learning disabilities, looked after children, children in need, young carers, young offenders, refugees, teenage parents, those who are substance misusers or who have experienced abuse.

Local and national data highlights the need to ensure that services cater for these vulnerable groups of children and young people. This will help to prevent long term health inequalities.

Parental mental health and substance misuse
Parental mental health has a critical impact on a child's mental health. There are an estimated 22,700 children and young people living with a parent with mental illness in Cambridgeshire. Between one and two thirds of these children and young people are likely to develop mental health problems themselves.

Maternal mental health, particularly in the first 18 months of life, has an impact on a child's long term mental health. Based on 2011 births, there are an estimated 754 women with major post natal depression in Cambridgeshire. Services supporting vulnerable families with children aged five and under, and families with children with Special Educational Needs (SEN) find high levels of mental health problems in both parents and children.

It is estimated that 5,400 children and young people are living with a problem drinker with concurrent mental health problems. 3,300 children and young people are living with a drug user with concurrent mental health problems and 1,300 are living with a parent with all three. Currently, 27-40% of young carers in contact with support services care for someone in their family with a mental health problem.

Current services
In terms of overall NHS and Local Authority commissioned Tier 2 and above service capacity, the service would have to double or treble in size to meet estimated levels of prevalence. As a result, there is considerable unmet need, however, it is not clear if this need is comparatively more or less than elsewhere in the country. This estimate does not take into account services provided by the voluntary sector and at Tier 1 such as GP, health visitor, school nursing and other universal provision. It is based on an artificial split between estimates of need at the different Tiers, which takes no account of how effectively the whole system works to support children and young people.

Current NHS and Local Authority commissioned Tier 2 and above capacity is largely focused on those over 15 years of age. This means that opportunities to intervene early in the progression of some disorders may be missed. In addition, there is increasing evidence that the ideal age to impact upon a child's development and improve social and emotional capability is at 0-3 years.

Up to date and clear benchmarking information is limited. NHS Benchmarking have just begun a programme on Child and Adolescent Mental Health (CAMH) benchmarking. This programme will provide useful data in the future, alongside the national data collection required of services from April 2013 onwards.

Hospital Admissions
Child and adolescent psychiatry admissions have risen for 2011/12. However, given the numbers involved it is difficult to tell if this is a significant increase. The numbers of admissions under the age of 18 where the primary diagnosis was mental health appears to have risen since 2009/10. Eating disorders and mental health behaviours, because of the use of alcohol and depressive episodes, make up 47% of the admissions. The majority of admissions for children under nine are for disorders of psychological development. Again these trends are hard to interpret given the small numbers.

Cambridge and Peterborough Foundation Trust (CPFT)
There has been a decrease in referrals and a 20% decrease in contacts (number of appointments) between 2011/12 and 2012/13. At the same time waiting times have increased considerably across Cambridgeshire and are below the 2008/09 national benchmark. CPFT are currently running with approximately 24% vacancies in their Cambridgeshire CAMH services. This explains the pattern of reduced contacts (activity). This drop in activity correlates with feedback from patients, parents and other services for children and young people. The drop in referrals may be due to the annual variation seen in referral numbers.

Other findings include:

- Referrals and contacts increase with age, however, contacts (activity) are more skewed to the older age band than referrals.
- Did Not Attend (DNA) rates have decreased in Cambridge Association to Commission Health (CATCH) for Cambridge City and Cambridgeshire South but increased in Huntingdonshire and Wisbech. Overall, DNA rates have remained static at 8%. 80% of DNA appointments are in eight local services.

- GPs in Hunts Health and Wisbech Locality Commissioning Groups (LCG) had longer waiting times in 2011/12 than other LCG areas.
- CATCH make less referrals to CPFT than other Locality Commissioning Groups of GPs. It is not clear why this is the case.
- The quality data available CAMHS Outcomes Research Consortium (CORC) and a recent peer review shows good quality CAMH services, including good outcomes where that information is available to be benchmarked nationally.
- Transition to adult services at age 17 is still seen as arbitrary by service users. The most common post-transition problem is a perceived lack of support from the new service (GP or adult mental health). Young people feeling prepared for transition is critical to reduce its impact.

Other commissioned counselling services
There is more capacity in Cambridge and the surrounding areas through Centre 33 than in Huntingdon and Wisbech through YMCA (http://www.ymca.org.uk/). Outcomes and capacity in the YMCA service for Fenland appear to be particularly poor, and action has been taken to address this. These are only the NHS and Local Authority commissioned counselling services. There are other counselling services provided within schools, GP surgeries and other settings which are not covered in this report.

Benchmarking
The benchmarking data available suggests that specialist CAMH services in Cambridgeshire may be understaffed when there are no vacancies. However, this does not take skill mix into account.

Children and Parent Views
The findings of local consultation work with children, young people and parents are described later in the report. In the consultation, children and young people describe what makes them well, what helps them recover if they are unwell and what mental health workers and services should be like and do. The following is a summary of what children and young people said makes them well.

What makes young people well?

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

It was also found that young people may be reluctant to seek help from GPs. They generally did not know who to see and how to get help, and found waiting times for services particularly challenging. They valued services, but confidentiality and a good balance of shared power and responsibility between the clinician and themselves was key.

Parents wanted improved access and local venues to meet, including GPs and schools as well as continuity and consistency of staff and service. They wanted clear signposting and sensitive and listening services as well as a reduction in the gaps between child and adult services.

Priority needs

- Service planning should take account of future demographics.
- Services need to cater for and monitor the number of children and young people in vulnerable groups who access mental health services.
- Service planning should take into account higher levels of prevalence in the most deprived wards.
- Prevention should focus on building resilience in children and young people.
- Improving the mental health of parents is key to improving the mental health of children and young people. In particular this should be focused on children under three for maximum impact.
- There should be more focus on services for children and young people under 16.
- CPFT activity should be increased urgently.
- Preparation of young people for transition to adult services should be the focus of future work for CAMH services. More mental health services should be available in local venues.

Next Steps

The findings of this JSNA will be fed into a Joint Commissioning Strategy for the Mental Health of Children and Young People, which is currently being put together by NHS Cambridgeshire and Cambridgeshire County Council.

The JSNA focuses on Tier 2 to Tier 4 services commissioned by Cambridgeshire County Council and NHS Cambridgeshire. There is a need to map other services provided by the voluntary sector, and other universal NHS and social care services to obtain a complete picture of how current service provision meets current needs.

4.5 Physical Disabilities and Learning Disabilities through the Life Course (2013)

The Physical Disabilities and Learning Disabilities through the Life Course JSNAwas completed in 2013. The following text presents the executive summary of the report – all data and content reflects the time of production. Updates to key data and other information precede the original executive summary.

The full report can be found at: http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/physical-disabilities-and-learning

2014 Updates

The future JSNA referred to on carers has now been published – see section 3.2. Data on long-term health problems and disability from the 2011 Census have also now been published – results and analysis for Cambridgeshire are presented in a report at www.cambridgeshireinsight.org.uk/health/2011census. These data show that 90,420 people (15.1% of household residents) reported a long-term activity-limiting illness. After adjusting for age, the percentage was found to be significantly higher than the England average in Fenland but significantly lower elsewhere and for the county as a whole.

Many of the estimates of numbers with learning and physical disabilities presented in the JSNA are based on national estimates of prevalence applied to local population numbers and so changes in numbers will be in line with small demographic changes which will have occurred over the last year. The latest demographic data are presented in section 2. The Projecting Older People Population Information (POPPI) and Projecting Adult Needs and Service Information (PANSI) systems were used to obtain many of the estimates – for the latest data see www.poppi.org.uk and www.pansi.org.uk.

The Public Health Outcomes Framework (PHOF) includes data relating to employment in people with learning disabilities (Indicator 1.8ii). The gap in the employment rate between those with a learning disability and the overall employment rate in Cambridgeshire in 2011/12 was 68.1 percentage points, higher than the average for England of 63.2. PHOFindicator 1.6i shows that the percentage of people with learning disabilities living in settled accommodation in Cambridgeshire in 2012/13 was 75.1, statistically similar to the national average. See www.phoutcomes.info.

In terms of sensory impairment, indicators in the PHOF relating to preventable sight loss (Indicators 4.12i-iv) show that Cambridgeshire favoured better than or similar to the national average in 2011/12.

Public Health England's latest Learning Disabilities Profile for Cambridgeshire can be found at: www.improvinghealthandlives.org.uk/profiles/index.php?view=E10000003.

Physical Disabilities and Learning Disabilities through the Life Course – Executive summary 2013

Introduction

The aim of this Joint Strategic Needs Assessment (JSNA) is to provide information on people with a disability across the life course. Many people with learning disability will also have physical and sensory disabilities. There is less emphasis on older people and people with long-term conditions, as these are areas covered in previous and (potentially) future JSNAs. The effects of social and environmental factors are considered; of which housing is

the subject of another JSNA. While the needs of carers have not been considered in this JSNA, this important group will be the subject of a future JSNA.

Key findings

Numbers of people with a disability
Most of us will experience some form of disability in our lives, either personally or through caring for others. There is no one source of information on numbers of people with a disability and various sources of data have been looked at for this JSNA. Various definitions of disability are used across datasets. As more detailed age-band information becomes available through the 2011 census, later this year, further information will also be available concerning long-term health problems and disability.

Children
In Cambridgeshire (information for 2012 unless stated otherwise):

- 10,060 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. The number of children with a Statement (SEN) or are on School Action Plus, are only an estimate of the number of children with disability. The true numbers are likely to be higher.
- In February 2013, 868 children were receiving direct social care support; these are children and young people whose needs are beyond those of a non-disabled child of the same age, meaning they are likely to require lifelong support from statutory services, in the future.

Adults
In Cambridgeshire (information for 2012 unless otherwise stated):

- 11,424 adults aged 18+ were predicted to have a learning disability and 2,376 to have moderate or severe learning disability (and therefore likely to be in contact with services). The number of adults on Cambridgeshire GP practice-based learning disability registers was 1,922 and 1,630 adults with learning disability received social care services.
- 3452 men and 374 women, aged 18-64, are predicted to have autistic spectrum disorders.
- 38,319 people aged 18-64 are predicted to have a moderate or severe physical disability, of whom 8,766 are severe. The Countywide Physical Disability Team supports 808 adults with a physical disability (January 2013), plus a further 24 with HIV.
- 246 people aged 18-64, were predicted to have a severe visual impairment while 9,341 aged 65+ were predicted to have a moderate or severe visual impairment. From April 2012 to February 2013, 251 adults were added to the Cambridgeshire County Council register for severe sight loss (blindness) or sight loss (partially sighted); with 57 of these individuals identified as having dual sensory loss.
- 59,770 people aged 18+ were predicted to have a moderate or severe hearing impairment.

Trends

- 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 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. The number of children with statements of special educational needs has increased in Cambridgeshire.

Key inequalities and issues for Cambridgeshire

Disability and disadvantage

- People with disability are more likely to live in poverty and be unemployed. There are differences experienced by people who have had a disability since birth and those who have become disabled later in life.
- Children with special educational needs are three times more likely to be recipients of free-school meals.
- 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.

Prevention and staying healthy

- Physical disability is related to a number of chronic health conditions. People receiving support from the physical disabilities social care team at Cambridgeshire County Council are most likely to have a disability resulting from Multiple Sclerosis, spinal or skeletal injury or acquired brain injury.
- People with disabilities have similar oral diseases but significantly poorer oral health and access to oral health care services, with worse health outcomes than the general population.
- 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 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.
- Health checks for adults with learning disability are important to reduce inequalities in accessing healthcare. 75% of eligible adults received a health check, in Cambridgeshire, in 2012.
- People with Learning disabilities are less likely to take up screening and other health promotion activities. In Cambridgeshire, work is underway to ensure screening is signposted at health checks and to look at how information on screening uptake can be obtained from primary care.

- Identifying adults with a learning disability on information recorded during a hospital admission is important to ensure reasonable adjustments are made. This is happening less often in Cambridgeshire, than the England average for psychiatric admissions. Learning disabilities specialist nurses, based at two Cambridgeshire NHS trusts, identify when people with Learning disabilities are admitted to those trusts and advise on necessary reasonable adjustments.
- People with learning disability in England are more likely to go into hospital for conditions that could have been treated in the community. Admission rates in Cambridgeshire are not significantly different from the England average, suggesting that this may be a problem in Cambridgeshire as well. Better sharing of information on people with a learning disability across agencies would allow us to look into this further.
- 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 learning disabilities in Cambridgeshire reported certain shortcomings in the provision of health care services, in 2007. This included a lack of easy read information; poor attitudes from some health staff towards people with learning disabilities and their carers; insufficient care available whilst person with learning disability is in hospital; inadequate hospital facilities, including access and delays in referrals. Local surveys identified that people with autism have unmet needs, such as difficulties with identification and diagnosis, and lack of training amongst staff concerning people with autism with whom they came into contact.

Education and Employment

- Children in Cambridgeshire with Special educational needs have poorer outcomes at all stages of schooling and are more likely to be NEET (not in employment, education or training).
- Being in employment is associated with better health and a better quality of life. People with a disability are less likely to be in employment than their non-disabled peers. People with learning disabilities have particularly low rates of employment.
- In 2011-12, only about 6% of adults in Cambridgeshire with Learning disability, known to Cambridgeshire County Council, were in paid employment and approximately 5% were in unpaid voluntary work. This is part of a downward trend over the past few years, possibly as a result of the economic recession.

Transition

- The term, ‘Transition,' is used to describe the process of moving from childhood into adulthood. Transition can be defined as: ‘A purposeful, planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions, as they move from child-centred to adult-oriented health care systems.’
- The transition between children’s and adult social care and health services is regularly cited as one of the most difficult experiences for young people and their families. Poor transition processes are associated with poor health and social care outcomes. Carers in Cambridgeshire have described it as feeling like a ‘no man’s land’ (2010/11), although 92% of carers felt supported in person-centred planning.

Housing and accommodation

- Most adults of a working age with a physical disability, or adults/older people with a sensory impairment, live in mainstream accommodation within the community. Some with profound needs or multiple disabilities are supported in specialist accommodation.
- 72% of people with learning disabilities, known to Cambridgeshire's social care services, live in settled accommodation; which is higher than national and regional averages.
- The recent Winterbourne Concordat placed a duty on Clinical Commissioning Groups to review out-of-county hospital placements with a view to bringing people back into the county in more local, community-based services. In Cambridgeshire the local authority as lead commissioner is required under the concordat to review the care of all people with learning disability or autism inpatient beds and agree a personal care plan for each individual, based on their and their families' needs and agreed outcomes, as soon as possible, enabling community-based care arrangements to be put in place, as appropriate.

Safety and relationship

- Children and adults with disabilities are vulnerable to abuse.
- In 2011-12, most cases of alleged abuse were for adults with learning disability, with most abuse occurring in the adults' own homes. There was an increase in safeguarding referrals for adults with learning disability, compared with the previous year, which is thought to reflect good practice in the community.
- People with learning disabilities in Cambridgeshire would like to make friends and have a partner. A recent community survey revealed that only half of all adults with learning disability knew where to access sexual health services, and less than half of those have received training on appropriate relationships.
- People with autism in Cambridgeshire have reported needing support with getting a job or with social skills.

Key needs for Cambridgeshire

Children with a disability
Children and young people with disabilities are a diverse group who access a range of different services, provided by both health and social care. It is therefore important that services are well joined up. The National Service Framework for Children, Young People and Maternity Services, expects local authorities, Primary Care Trusts (now Clinical Commissioning Groups) and NHS Trusts, to ensure that there are 'arrangements to encourage multi-agency strategic planning of services for disabled children… which allow for development and implementation of a locally-based, multi-agency database, containing core data on disabled children, based on shared and agreed definitions'. There is no agreed definition for children with a disability across services. It is therefore difficult to plan and improve services for children with disabilities. Although this issue is not unique to Cambridgeshire, sharing information across services is needed in order to enable understanding of whether children with complex needs are receiving optimum care, for example, whether they have a key worker.

Transition to adult services
There is a lack of flexibility in the transition age from children's to adult services and a need for joint planning across agencies in line with the Children and Families Bill 2012-13. Although work on this is underway in Cambridgeshire, there is no current strategic county

overview and policy between children and adult services that describes the multi-agency approach required to support young people in transitions.

Adults with a disability
Within adult social care (physical and sensory):

- Delayed discharges from hospital have been identified as a result of delays in care packages being set up at home (this affects both adults and older people). However, it is not currently possible (using current data systems) to identify whether these individuals required re-ablement or support from the physical disabilities service, it is necessary to be able to identify this in order to understand the reason for the delay.
- Supporting those with the most complex needs requires joint working across sensory, learning disabilities, older peoples and complex care teams.

Accommodation for a Transitions/Move on Unit is needed to help those with an acquired brain injury or other disability where they need more support in their tenancy and community that enables them to move towards more independence.

A recent mapping exercise identified key gaps in the provision of services to people with hearing loss.

There will be a need to ensure good and timely community provision for adults with learning disabilities in out-of-county, in-patient settings, reviewed as per the Winterbourne view concordat.

Key to improving the health and wellbeing of people with learning disabilities is the ability for services to share information. This facilitates, for example, the delivery of the evidence-based GP Health Check. In their report on unnecessary hospital admissions, the Improving Health and Lives: Learning Disabilities Observatory recommended the following:

"GPs and community learning disabilities teams should collaborate in developing a local register of people with learning disabilities, identifying their NHS numbers, age and gender. This should be done on the basis of requesting explicit consent from subjects and carers, and 'best interests' agreements, where the individuals concerned are not able to understand. At a local level, this would permit proper epidemiological monitoring of condition-specific admission patterns.

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

The Prevention of Ill Health in Adults of Working Age JSNA was completed in 2011. The following text presents a summary of the JSNA report with key data updated to the latest available to aid current interpretation. The full report from 2011 can be found at: www.cambridgeshireinsight.org.uk/currentreports/jsna-prevention-ill-health-adults-working-age-2

The latest data for a number of indicators summarised here are included in the Cambridgeshire JSNA Public Health Atlasand the Public Health Outcomes Framework.

Prevention of Ill Health in Adults of Working Age (2011) – Report summary (updated 2014)

The Cambridgeshire JSNA has identified prevention as a key need that cuts across various population groups and ages.

Prevention may work at different levels:

- Through improving the 'wider determinants of health' - the wider socio-economic and environmental factors which influence our behaviour. Wider determinants such as educational outcomes, employment and income and housing are closely linked to health inequalities between different groups in the population.
- Through influencing individual lifestyle behaviours such as smoking, diet physical activity and alcohol use amongst people who are currently in good health, but have behaviours which increase the risk of future illness (eg smoking related lung disease, obesity related diabetes).
- Through preventive interventions for people who already have health problems ('secondary prevention'), where lifestyle changes will slow or halt the rate at which these problems worsen.

Preventing ill health necessitates integrated approaches that bring together the wider determinants of health with how people live their lives when healthy or when suffering from ill health.

Demography
The estimated number of working age adults (16-64 years) in Cambridgeshire in 2012 was 407,776 (Office for National Statistics mid-2012 population estimates). The number of people aged 15-64 (the nearest data to working age available) in Cambridgeshire is forecast to rise by 11.9% (49,400 people) by 2031 (Cambridgeshire County Council Research Group 2012-based population forecasts).

Data and inequalities
Data included in the Public Health Outcomes Framework (Indicator 2.14) from the Integrated Household Survey (2012) indicate that in Cambridgeshire about 18% of adults are smokers - Fenland has the highest rates where 29.5% of the population is estimated to smoke and Cambridge has the lowest rate at 11.5%; the percentage of routine and manual workers who smoke in Cambridgeshire is significantly higher than the national average.

The age-standardised rates of alcohol-specific hospital admissions are significantly higher than the national average in men in Cambridge and similar in women; rates are better than average in the county's other districts for both sexes (Public Health England Local Alcohol profiles for England 2014).

The percentage of adults classed as 'physically active' is better than the national average in for the county as a whole at 60% compared with 56%, but is lower for adults in Fenland (50.5%) (Public Health Outcomes Framework Indicator 2.13i).

GP practices maintain registers of the number of their patients diagnosed with particular long term health problems. The commonest problems seen on these registers across all practices in NHS Cambridgeshire and Peterborough CCG (2012/13) were:

- High blood pressure (112,990 patients)
- Asthma (56,630 patients)
- Depression (38,710 patients)
- Diabetes (38,535 patients)
- Hypothyroidism (29,089 patients)
- Coronary heart disease (25,888 patients)
- Chronic kidney disease (24,792 patients)

Source: Quality and Outcomes Framework 2012/13

With the exception of asthma, rates of these health problems increase with age. High blood pressure, diabetes and heart disease in particular have strong links with lifestyle behaviours such as physical activity, diet and smoking.

Evidence and best practice
A wide range of evidence for best practice in prevention of ill health is available through NICE public health guidance www.nice.org.uk/guidance/phg/index.jsp

Some preventive interventions have been shown to be effective in creating savings for the NHS by reducing use of health services in the short to medium term, as well as effective in improving wellbeing and healthy life expectancy. These include a range of interventions and services to help people stop smoking, brief interventions in general practice giving advice on alcohol consumption, and some contraceptive services. A much wider range of preventive interventions, such as advice on increasing physical activity and mass media campaigns have been shown to be very good value (cost effective) in improving health and wellbeing, compared to the majority of NHS treatment interventions.

Local views
For the first time a bespoke community consultation process was developed and implemented for the 'Prevention' JSNA. This involved the use of social media, an online survey and focus groups.

A persistent theme from both the data trends and the community consultation is that despite the generally positive wellbeing and health statistics for Cambridgeshire as a whole, the current economic climate has created some new areas of concern. Unemployment rates, benefits claims, and debt have increased in Cambridgeshire in recent years, all of which may impact on people's mental health and longer term physical health. There is a particular concern with the availability and affordability of housing, increasing levels of fuel poverty, and changes to the benefits system.

Priority needs for preventing ill health amongst adults of working age
The Steering Group and a wider Stakeholder event identified the following priorities for prevention of ill health amongst adults of working age in Cambridgeshire:

- Addressing socio-economic factors with a focus on housing issues.

- Supporting people to address lifestyle issues and behaviour change.
- Initiatives for Workplace Health.
- Building preventive interventions into patient pathways for people with Long Term Conditions.
- Addressing Domestic Violence.

4.7 Children and Young People (2010)

The Children and Young People JSNA was completed in 2010. The following text presents a summary of the JSNA report with key data updated to the latest available to aid current interpretation. The full report from 2010 can be found at:www.cambridgeshireinsight.org.uk/currentreports/children-and-young-people

Children and Young People (2010) – Report summary (updated 2014)

Demography
The number of children aged 0 to 15 years in Cambridgeshire in 2012 was 114,329 (Office for National Statistics mid-2012 population estimates). The number of children aged under 15 is estimated to increase by 23.4% by 2031, an additional 24,900 children (Cambridgeshire County Council Research Group 2012-based population forecasts).

Data and inequalities
There are key inequalities in outcomes for children and young people, and these are demonstrated in a number of key indicators, including differences in life expectancy, rates of young people not in employment, education or training, attainment rates across all key stages of education, rates of unhealthy weight, teenage pregnancies and childhood deaths.

Underpinning these outcomes is the significance of deprivation and childhood poverty - the impact of deprivation can reduce the life chances of individuals whether for those living in an area where there is much deprivation or those from disadvantaged groups found throughout the county such as those with disabilities. Looked after children and young offenders are particularly likely to have poor outcomes.

Four or more adverse childhood experiences (child abuse, parental depression, domestic abuse, substance abuse or offending) increase the risk of developing mental health problems throughout life. It is estimated that half of all mental illness (excluding dementia) starts by age 14 (New Horizons: Confident Communities, Brighter Futures. DH March 2010).

Evidence and best practice
National reports with evidence of best practice include: the Healthy Child Programme [1][2] , the Marmot Review [3] and New Horizons, Confident Communities, Brighter Futures: a framework for developing wellbeing, the Graham Allen review, Early intervention: the next steps [4] and NICE guidance on social and emotional wellbeing in the early years [5]. All stress the importance of the early years and providing a good start in life together with prevention, early intervention and targeted support to those with greatest needs.

[1] Healthy Child Programme Pregnancy and the first five years of life. Department of Health, October 2009. www.gov.uk/government/publications/healthy-child-programme-pregnancy-and-the-first-5-years-of-life
[2] Health Child Programme from 5 to 19 years old. Department of Health. October 2009 . http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_107566
[3] Fair Society, Health Lives: Strategic Review of Health Inequalities in England post-2010. The Marmot Review, February 2010. www.marmotreview.org/
[4] Early Intervention: The Next Steps. An independent report to her Majesty's Government. Graham Allen MP 2011. www.dwp.gov.uk/docs/early-intervention-next-steps.pdf
[5] Social and emotional wellbeing – early years. NICE 2012. http://guidance.nice.org.uk/PH40

Local Views
Detailed information on views and behaviours of children in year 8 and 10 of secondary school is collected in the 2012 health related behaviour survey. For example in 2012; 27% of pupils said that they have smoked in the past or smoke now, 51% of pupils responded that they exercised and had to breathe harder on at least three days last week and 47% of pupils responded that they worry about relationships with friends ‘quite a lot’ or ‘a lot’.

Priority needs for children in Cambridgeshire

- 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.

4.8 Mental Health in Adults of Working Age (2010)

The Mental Health in Adults of Working Age JSNA was completed in 2010. The following text presents a summary of the JSNA report with key data updated to the latest available to aid current interpretation. The full report from 2010 can be found at: www.cambridgeshireinsight.org.uk/currentreports/mental-health-adults-working-age

Public Health England have recently launched the Mental Health Dementia and Neurology Intelligence Network, presenting four data tools to support commissioning, planning and providing mental health services locally – see http://fingertips.phe.org.uk/profile-group/mental-health.

Mental Health in Adults of Working Age (2010) – Report summary (updated 2014)

Demography
Mental health problems are common - with one in six people estimated to have a diagnosable mental health problemat any one time.

In 2014 it is estimated that 63,512 Cambridgeshire residents aged 18-64 have a common mental disorder (including disorders of depression, anxiety, and obsessive compulsive disorder), 28,468 have more than one mental health condition, 1,773 have a borderline personality disorder, 1,397 have an anti-social personality disorder and 1,577 have a psychotic disorder (Source: PANSI).

Data and inequalities
The JSNA for adults with mental health problems found that while mental ill health is an issue throughout Cambridgeshire, rates are highest in Cambridge City and Fenland. Known risk factors include deprivation, employment, housing needs, incapacity benefit, limiting long-term illness, violence, safety, substance misuse, physical health and marginalised groups.

Gypsies and Travellers, migrant workers, people from ethnic minorities, offenders, homeless people, people with substance misuse problems, people with learning disabilities, carers and people living in new communities are at increased risk of mental ill-health and are less likely to access the services that could help them.

The Community Mental Health Profile (2013) for Cambridgeshire is encouraging in showing that the majority of mental health indicators reported on are significantly better than or not significantly different to England overall. The percentage of adults (18+) with depression was significantly worse than England in 2011/12 – although this may reflect levels of diagnosis and data recording in GP surgeries rather than true prevalence. The rate of emergency hospital admissions for self-harm for 2011/12 was also worse than the national average in Cambridgeshire. Also, the number of people (aged 18-75) in drug treatment, number of people using adult and elderly NHS secondary mental health services and the number of total contacts with mental health services are significantly lower than England.

Evidence and best practice
The evidence base for promoting community mental health and wellbeing at all ages has been summarised in the 2010 Department of Health Report 'Brighter futures: a framework for developing wellbeing':www.apho.org.uk/resource/item.aspx?RID=90364

Good practice for treatment and care of people with a range of mental health problems is available on the NICE website:
http://guidance.nice.org.uk/Topic/MentalHealthBehavioural#/search/?reload

No Health Without Mental Health (2011) is a cross-government mental health outcomes strategy for people of all ages. It sets out six shared objectives to improve population mental health and wellbeing:

- More people will have good mental health.
- More people with mental health problems will recover.
- More people with mental health problems will have good physical health.
- More people will have a positive experience of care and support.
- Fewer people will suffer avoidable harm.
- Fewer people will experience stigma and discrimination.

Our NHS Care: A Draft Mandate to the NHS Commissioning Board (2012) has an explicit mandate to develop a collaborative programme of action to achieve the ambition that mental health should be on a par with physical health.

Local Views

The Cambridgeshire and Peterborough Shadow Clinical Commissioning Group Joint Commissioning Strategy (2013-16) summarised key messages from local service users and carers. These included:

- Accessing the appropriate services easily or promptly, either for the first time or in the event of a recurrence.
- Avoidance of multiple assessments.
- Responsiveness, especially during a "crisis" situation.
- Not always having a seamless transfer between services.
- Acknowledging the role of carers in supporting people with severe and enduring mental illness in particular.

Priority needs for mental health in Cambridgeshire

There are common themes to maintaining good mental health across the life-course which is supported by the evidence base:

- 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.

4.9 New Communities (2010)

The New Communities JSNA was completed in 2010. The following text presents a summary of the JSNA report with key data updated to the latest available to aid current interpretation. The full JSNA report, which can be found at www.cambridgeshireinsight.org.uk/cambridgeshire-jsna/new-communities, contains more detailed and specific priorities and recommendations and should be viewed alongside the Housing and Health JSNAfrom 2013 (see section 4.2) which provides updated information on health and housing issues and the planning system with examples of good practice.

For the latest local information and data relating to Housing, please see the Housing pages on Cambridgeshire Insight at www.cambridgeshireinsight.org.uk/housing

New Communities (2010) – Report summary (updated 2014)

Land Use Planning Policy changes
There have been significant changes in land use planning policy with the abolition of the Regional Spatial Strategy, introduction of the National Planning Policy Framework (NPPF) in March 2012 and consequent new duties on relevant local authorities (District Councils in Cambridgeshire). The NPPF acknowledges the importance of health stating 'the planning system can play an important role in facilitating social interaction and creating healthy, inclusive communities'

Demography
This JSNA was unusual in that it looked at the future health and wellbeing needs of communities in new housing developments which do not yet exist. Demographic information from previous new developments such as Cambourne, Bar Hill and Hardwick was drawn on to develop understanding of the population structure.

Data and inequalities
The initial populations in new growth areas tend to have a young age structure, with many young couples and young children, and very few older people. However, the demographic profile changes over time and so do health needs. Planning for new growth should ensure that adequate services, including healthcare services, are available to early residents and can respond to changing and diverse needs as more people move into the new developments and grow older.

Evidence and best practice
The Cambridgeshire Quality Charter for growth was developed locally and identifies best practice in developing new communities which support residents' wellbeing: www.cambridge.gov.uk/sites/www.cambridge.gov.uk/files/documents/cambridgeshire_quality_charter_2010.pdf

Building Communities that are Healthy and Well in Cambridgeshire. The detailed JSNA (Social Environment Chapter) describes a methodology – 'People Proofing Principles' that offers a community development approach for planning for the diverse needs of communities. The model provides a monitoring system so that adjustments for community support infrastructure can be made as the community grows and becomes established.

Local Views
A local survey carried out by South Cambridgeshire District Council compared the views of people in new communities with those of established residents. It found that residents of new developments generally reported that they were in good health, which probably reflects the younger age structure of these communities. They were less likely to feel that they

belonged to their neighbourhood, and more likely to perceive anti-social behaviour as being a problem locally. Satisfaction with the neighbourhood was lower than for long term residents but was still over 80%.

Further new development surveys have since been conducted in other districts and the findings are described in the Housing JSNA. Additional analysis of these surveys will be conducted in 2013 to gain further insight/ lessons learnt that can be applied to future developments.

Priority needs for new communities in Cambridgeshire
Key needs identified in the JSNA include

- 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.

Health and Wellbeing Strategy
New Communities are 'settings' in which people will live and work and getting these right will support all the priorities of the health and wellbeing strategy. However, in particular, this JSNA relates to Priority 5 - 'Create a sustainable environment in which communities can flourish'. Action plans are currently being developed and a key issue that has been identified is to ensure that 'health is plugged into the planning system'. Opportunities being identified to strengthen this include:

- Including health and social care as a theme in the Cambridgeshire Strategic Spatial Framework (currently under development).
- Holding an event to bring together partners agencies to understand the planning system and how their roles can contribute to this. In particular, partners with new roles and responsibilities in the health system such as the Clinical Commissioning Group, Local Clinical Commissioning Groups, National Commissioning Board and NHS Property Services.

4.10 Travellers (2010)

The Travellers JSNA was completed in 2010. The following text presents a summary of the JSNA report with key data updated to the latest available to aid current interpretation. The full report from 2010 can be found at:www.cambridgeshireinsight.org.uk/currentreports/travellers. This report should also be viewed alongside the Housing and Health JSNAfrom 2013 (see section 4.2) which also refers to Gypsy and Traveller communities.

Travellers (2010) – Report summary (updated 2014)

Demography
In the 2005 Travellers Needs Assessment, Gypsies and Travellers were found to make up almost 1% of the population of Cambridgeshire, about 5,700 people. Of these, it was estimated that 58% lived in caravans and 42% in settled housing. Gypsy or Traveller was included as an ethnic group in the Censes for the first time in 2011 – data from the Census, however, show just 1,508 gypsies/travellers in Cambridgeshire, 0.2% of the population; it is likely that this is an underestimate of the true number.

In the January 2014, the total caravan count in Cambridgeshire was 1,174. Of these, 89% (1040) were on authorised sites (with planning permission) and 11% (134) were on unauthorised sites (without planning permission) (Department for Communities and Local Government). Of those on unauthorised sites, 87% (117) were on 'tolerated' sites, where the landowner or local authority have not sought removal of the encampment and which accrue legal rights after existing for a specified number of years.

Data and inequalities

- There are clear inequalities in outcomes for the Gypsy and Traveller population, often as a result of lack of secure accommodation. Gypsies and Travellers have significantly poorer health status than the rest of the population. This includes a lower life expectancy, higher infant mortality rate, poorer health outcomes and poorer access to preventative care, with evidence that mental health problems are more widespread.
- Gypsy and Traveller children remain highly disadvantaged in terms of educational achievement.
- Locally, there is experience that the Gypsy and Traveller community lack confidence and knowledge about how to access services such as health and social care and there is a tendency not to ask for external agency support.

Evidence and best practice
The evaluation of the National Pacesetters Programme [1], which involves delivering equality and diversity improvements and innovations, has identified some short term gains which included making links and engaging with community members, improving cultural awareness among healthcare staff, increasing awareness of health needs and health services among Gypsies, Roma and Travellers and raising the profile of their health needs. It is noted that many of these gains have been made in the process of involvement.
[1] Pacesetters Programme Gypsy, Roma and Traveller core strand Evaluation Report for the Department of Health. Van Cleemput P, Bissell P, Harris J, April 2010. www.shef.ac.uk/polopoly_fs/1.43553!/file/Final-full-Pacesetters-report-edited-with-photos-May-2010.pdf

Fenland District Council's work with Travellers has been identified nationally as an example of good practice.

Local views
Interviews with Traveller children showed concerns about their environment such as location, lack of safe play spaces/facilities and distance/isolation from local communities. Misunderstanding by others about the nature of their identity and reluctance to reveal ethnicity for fear of bullying are particular concerns. Children expressed a constant expectation of racism and many had been exposed to racially motivated threats or attacks.

Priority needs for Gypsies and Travellers in Cambridgeshire

- 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.

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

The JSNA report for people who are homeless or at risk of homelessness was completed in 2010. The following text presents a summary of the JSNA report with key data updated to the latest available to aid current interpretation. The full report from 2010 can be found at: www.cambridgeshireinsight.org.uk/currentreports/people-who-are-homeless-or-risk-homelessnessand should be viewed alongside the Housing and Health JSNAfrom 2013 (see section 4.2) which includes a chapter on preventing and tackling homelessness.

People who are homeless or at risk of homelessness (2010) – Report summary (updated 2014)

Demography
Homelessness describes a wide range of circumstances where people have nosecure accommodation. This JSNA categorises homeless people into threeoverlapping groups:

- Single homeless and rough sleepers (SHRS) – a group of homeless people for whom there may be no statutory duty or simple solution.
- Statutory homeless - those defined in law as being in priority need and entitled to housing support from local authorities.
- Hidden homeless and those at risk of homelessness – those not recognised by local authorities or services (thought to be much larger than the two other groups together).

Data included in the Public Health Outcomes Framework (Indicator 1.15) indicate that there were 590 statutory homeless households in 2012/13, 2.3% of households in Cambridgeshire, a figure similar to the national average for England. As of April 2014, around 400 people were registered with Cambridge Access Surgery, a dedicated GP practice largely for single homeless and rough sleepers (NHS Cambridgeshire and Peterborough CCG Practice Populations).

Data and inequalities
The JSNA focussed on the SHRS group as these have demonstrably very poor outcomes. Physical health, drugs, alcohol, mental health and wellbeing have been recognised as priority health issues among the homeless. Amongst the patients registered at the Cambridge Access Surgery, of the 40 who are known to have died over the last five years (prior to 2010), the average age at death was 44.

Evidence and best practice
The SHRS in Cambridge include a small number of chronically excluded adults, with chaotic lifestyles, behavioural, substance misuse and control issues, and poor mental and physical health. They are often difficult to engage with services but represent significant costs to the tax payer as prolific offenders, having frequent hospital admissions and A & E visits, and intensive users of community and housing support services.

Following the findings of the JSNA a partnership funded project has been put in place to work with this group and co-ordinate preventive services. This project is now part of the national coalition Making Every Adult Matter (MEAM) pilot programme. The evaluation of the programme has shown significant wellbeing improvements for clients and a reduction in the overall cost of service use. From February 2011 to January 2012 the pilot led to a 31% (£100,000) reduction in client's costs to the criminal justice system. While the costs of providing housing, medical treatment and help with substance misuse have increased, these have been offset by the criminal justice savings.

Local views
A patient and stakeholder survey undertaken by the Cambridge Access Surgery in 2007 reported high levels of satisfaction with the service and that if the service as not available just under half of respondents would attend A&E or not access healthcare at all.

Priority needs for homeless people in Cambridgeshire

- 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.

4.12 Migrant Workers (2009)

The Migrant Workers JSNA was completed in 2009. The following text presents a summary of the JSNA report with key data updated to the latest available to aid current interpretation. The full report from 2009 can be found at:
www.cambridgeshireinsight.org.uk/currentreports/migrant-workers

Further information on migrant workers can be found in the 2012 Migrant Worker Monitoring Report – see www.cambridgeshireinsight.org.uk/population-and-demographics/migration-0

Migrant Workers (2009) – Report summary (updated 2014)

Demography
International migrants in Cambridgeshire come from all over the world and with different socio-economic backgrounds. Between 2003 and 2012, more than 78,000 foreign nationals registered for a National Insurance Number (NINo) in Cambridgeshire. The 2011 Population Census indicates that the total number of Cambridgeshire residents who were born outside the UK was 85,700 in 2011. Following EU expansion in 2004, a rapid increase in migration took place which has brought high inflows of people from the eight Eastern European accession countries (A8) to the county. The number of NINo registrations for the county has fluctuated around 8,000-9,000 registrations each year since 2005. The most common countries of origin for migrant workers registering in Cambridgeshire in 2012 were Lithuania, Poland, Spain and Italy; the numbers from Spain and Italy rose in 2012 in line with national trends.

Data and inequalities

- Pupil Level School Census data published in January 2012 indicates that 2.3% of pupils were from an A8 country (based on home language). The largest group are from Eastern Europe, principally Poland and Lithuania, but including other Baltic and Balkan states and Slovakia. Most of these, 1,229, were in Nursery and Primary schools with 601 in Secondary schools. (Note that first language data for under 5s is not collected consistently for all pupils so numbers for nursery and reception pupils may be understated). Educational attainment was generally lower in children with an Eastern European home language than the county average, but there was variation around the county.
- Housingis one of a number of key factors that has an important influence on people's health. Research indicates that the majority of newer migrants are living in privately rented or tied accommodation. The numbers of migrants living in houses in multiple occupation has also increased locally, especially in Fenland. This type of accommodation is often of low quality and overcrowded.

Local views
In 2012, a series of discussions took place with local stakeholders on the needs of European families. Key issues for families included language and communication, understanding and accessing systems and services (including age at starting school), poverty and access to benefits and issues relating to housing including over-crowding and unscrupulous landlords.

Priority needs for migrant workers in Cambridgeshire
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. Funding has been identified for

projects relating to European families. This will be used to address an area of need identified in the discussions with local stakeholders.

5. Summary of Key Health and Wellbeing Needs in Cambridgeshire

JSNA work in 2012/13 and 2013/14 has added to the summary of health and wellbeing needs in Cambridgeshire, which was used to support development of the Cambridgeshire Health and Wellbeing Strategy:

1. To focus on ensuring a positive start to life for children, given the growing evidence of the impact this will have throughout their lives. Work in a targeted way with more vulnerable families to:
   - promote parental mental and physical health
   - support good parenting skills
   - develop social and emotional skills
   - prevent violence and abuse
2. To plan now for the significant forecast growth in the number of older people in Cambridgeshire over the next 20 years by prioritising
   - Prevention of ill health and promotion of good health amongst older people.
   - Reconfiguration of services to support older people to live in a community setting as long as possible, avoid admission to hospital/care homes, and return to a community setting after discharge from hospital.

   The evidence base as to what works in preventive services and admission avoidance to hospital or care homes for older people is still developing, so it is essential to evaluate initiatives and measure how well they are working.
3. To recognise the major impact of common lifestyle behaviours which often start in childhood and continue throughout life – eg smoking, physical activity levels, healthy eating and alcohol use – on the development of long term health problems; and to encourage communities to support lifestyle change.
4. To promote individual and community resilience and mental health, including promotion of social networks/self-management support and community engagement. To be aware of current social and health inequalities and trends in Cambridgeshire, and monitor the potential impacts of unemployment, poor educational attainment, housing benefit/ universal credit changes, fuel poverty, debt and other social issues on local people's health and wellbeing.
5. To consider the needs and outcomes for particularly vulnerable or marginalised populations in Cambridgeshire – including Gypsies and Travellers, homeless people, migrant workers, people with learning disabilities, people with mental health needs, people with physical/sensory impairments, when developing or changing services.

The JSNA work completed in 2012/13 and 2013/14 has provided additional information to plan for meeting these priority needs, rather than flagging major changes in priorities:

- The 'Housing and Health JSNA' (2013) and the 'Carers JSNA' (2014) provide additional information about key support systems for more vulnerable adults and children.
- The 'Prevention of Ill Health in Older People JSNA' (2013) and the 'Primary Prevention of Ill Health in Older People JSNA' (2014) provide evidence and data relevant to maintaining older people's health, quality of life and independence.
- The 'Mental Health of Children and Young PeopleJSNA' (2013) adds to local information and evidence about this important priority area.

- The ‘Armed Forces JSNA’ (2013) identifies another group within our population with particularly health needs and potential inequalities.
- The ‘Physical Disabilities and Learning Disabilities through the Life Course JSNA’ (2013) the ‘Older People,’s Mental Health JSNA’ (2014) and the ‘Adult Mental Health: Autism, Personality Disorder and Dual Diagnosis JSNA’ (2014 - still in progress) update or expand information and evidence in previous JSNAs.

Given the challenges to the local Health and Care systems which we are all aware of, it is essential that the local information and evidence available through the JSNA process is fully factored into local health and social care commissioning strategies, supported by the statutory remit of the Health and Wellbeing Board.