NHS

Lincolnshire COUNTY COUNCIL
Working for a better future

Lincolnshire JSNA: Overview Report 2014

Introduction

Since the publication of the 2013 JSNA Overview Report a total of ten JSNA topic commentaries have been updated. This document brings together the executive summaries of those commentaries, with each one looking at 'What do we know?' and 'What is this telling us?' The intention of this document is to provide a concise overview of updates to the JSNA. It is hoped that it will be read in conjunction with the range of information published on the Lincolnshire JSNA web-site, which can be accessed here http://www.research-lincs.org.uk/Joint-Strategic-Needs-Assessment.aspx.

Cancer: June 2014 (version 3.0)

What do we know?

Around one in three of us will develop cancer at some time in our lives according to our lifetime risk estimation (Sasieni PD, et al 2011). The 'lifetime risk of cancer' is an estimation of the risk that a new-born child has of being diagnosed with cancer at some point during its life. It is based on current incidence, life expectancy and mortality rates, and therefore is calculated on the assumption that the current rates (at all ages) will remain constant during the life of the new-born child.

An individual's risk of being diagnosed with cancer depends on many factors, including age, lifestyle and genetic factors. It is estimated that more than four in 10 cancer cases could be prevented by lifestyle changes, such as not smoking, cutting back on alcohol, maintaining a healthy body weight, and avoiding excessive sun exposure (Parkin et al 2010). Hence, cancer is largely preventable.

According to data from the Lincolnshire Research Observatory (LRO); the incidence rates (new cases) of cancer are higher in Lincolnshire than the national average whilst death rates linked to cancer in Lincolnshire are comparable to the national average.

Cancer is a disease of ageing. In Lincolnshire, there is an ageing population, so it is to be expected that the number of new cases of cancer each year will increase substantially in the future.

What is this telling us?

Primary prevention of cancer through promoting a healthier lifestyle (particularly in relation to tobacco use, maintaining a healthy weight, undertaking physical activity, and drinking alcohol at sensible levels) remains an important part of cancer prevention.

Earlier detection of cancer may be achieved through:

- Encouraging attendance for cancer screening;

- Promoting awareness of cancer signs and symptoms; and
- Encouraging people to attend their GPs earlier in the disease process, in order to improve their outcomes and survival rates.
- Providing rapid care pathways to diagnosis and care

Cancer services, although planned in a co-ordinated manner, will be revisited as part of the Lincolnshire Health and Care review.

Chlamydia screening: September 2013 (version 2)

What do we know?

Chlamydia is the most common sexually transmitted infection in the UK, with sexually active young people at highest risk. As chlamydia often has no symptoms and can have serious health consequences (e.g. pelvic inflammatory disease, ectopic pregnancy and infertility), screening remains an essential element of good quality sexual health services for young adults.

The aim of the National Chlamydia Screening Programme (NCSP) is to control chlamydia though early detection and treatment, so reducing the spread and health consequences of untreated infection. Lincolnshire's local programme Lincolnshire Face Facts has been part of the NCSP since 2008 and supports screening in over 400 healthcare (e.g. general practice, pharmacies, LCHS services) and non-healthcare settings (e.g. education, employers, youth services, pubs and clubs) across the county.

The test itself is easy and can be done by the young person themselves by providing a urine specimen (males and females) or a self-swab (females only). If the person has the infection they are treated with antibiotics. Partners are also offered antibiotics and a test to confirm whether or not they have the infection.

In order to reduce the amount of chlamydia infection in the community it is important to find and treat as many people as possible. The public health outcome indicator is to achieve 2,300 diagnoses, per 100,000 15-24 year olds[1]. The aim for 2013 is to screen 30% (25,650) of young people in this age group. In order to achieve the outcome, 1,975 (8%) of those screened will need to be diagnosed with the infection.

What is this telling us?

To summarise there continues to be a significant amount of chlamydia infection in 15 to 24 year olds within Lincolnshire. There were 1646 diagnoses of the infection during 2012. As only a quarter of the population of this age group were tested, there is an assumption that there are still people out there who have the infection and don't know, particularly as they often have no symptoms. This leads to further spread of the infection and continued health consequences, as mentioned above.

[1] This target has since been revised locally and with effect from April 2014/15 the target is 2182 diagnoses per 100,000 15-24 year olds.

Chronic Obstructive Pulmonary Disease: May 2014 (version 2.0)

What do we know?

Chronic Obstructive Pulmonary Disease (COPD) is a long-term condition, which is affecting increasing numbers of people.

There is a wide range of interventions to address COPD, from prevention to the ongoing management of the condition. COPD is a health issue that is managed across the whole health sector, and therefore a 'joined-up' approach to the prevention and management of this condition is particularly vital.

The Joint Strategic Needs Assessment for Lincolnshire has a number of topics that are relevant to COPD, including smoking, for example. The Lincolnshire Health and Wellbeing Strategy has a number of themes which give priority to the prevention and management of COPD.

What is this telling us?

COPD is a key health issue in many national and local strategies. Various interventions are commissioned and provided to address the prevention, management and care of COPD for the Lincolnshire population. Some of these will be included as part of Lincolnshire Health and Care (formerly the Lincolnshire Sustainable Services Review) work.

Diabetes: May 2014 (Version 2.0)

What do we know?

Diabetes is a long-term condition, which is affecting increasing numbers of people. There are two main types of diabetes: Type 1 and Type 2, with Type 2 being particularly influenced by the ageing population and overweight/obesity.

There is a wide range of interventions to address diabetes, from prevention to the ongoing management of the condition. Diabetes is a health issue that is managed across the whole health sector, and therefore a 'joined-up' approach to the prevention and management of this condition is particularly vital.

The Joint Strategic Needs Assessment for Lincolnshire has a number of topics that are relevant to diabetes, including food and nutrition, obesity and physical activity.

The Lincolnshire Health and Wellbeing Strategy has a number of themes which give priority to the prevention and management of diabetes.

What is this telling us?

As outlined in the 'Targets' section, there is a range of indicators which are relevant to diabetes.

The national Outcomes Frameworks have a range of indicators which are relevant to diabetes, and these form part of the performance reporting of CCGs and local authorities.

The QOF provides information about the quality of care that is provided in general practice for people on a diabetes register.

Various data sources provide information on how Lincolnshire compares to other geographical areas, for example, in relation to prevalence, primary and secondary care indicators and mortality (see 'some sources of additional information section').

Looked after Children: June 2014 (version 3)

What do we know?

We know that Looked after Children are a particularly vulnerable group and are at high risk of social exclusion, health inequalities, and poor educational attainment. Although many looked after children do well across all of these areas, there is significant evidence that they do less well than their peers.

The NICE guidance on Looked after Children issued in April 2013 confirms the need for this group of children to have:

- Stable placements which promote the young person's sense of identity and self esteem;
- Dedicated services to promote mental health and well-being;
- Effective health assessments and treatment, twice yearly for children under five and annually for all others.

In addition, the Local Authority has specific duties:

- To promote and safeguard the welfare of Looked After Children;
- To listen to the wishes and feelings of children before making a decision that is important in their lives;
- To promote the educational attainment;
- To regularly review the needs and circumstances of all children Looked After;
- To continue to support young people after they have left care.

What is this telling us?

Data shows that following high profile cases, such as Baby P, that there is a greater awareness of signs of abuse and neglect and that LAC numbers have risen as a result.

This appears to be reflected within the LAC population in Lincolnshire.

Despite the increase in numbers of LAC, 87% of these children are placed in foster care within the county with only 21 placed with Independent Fostering Agencies. Recruitment of carers has remained steady, but has been challenged by a reduction in retention rates.

Lincolnshire is currently subject to a Department For Education review of foster carers' recruitment in order to assist us with our recruitment and retention strategy. This will be particularly important in ensuring a sufficient supply and choice of placements. The response to this has been to:

Plan initial placements through the weekly support panels and reduce the need for emergency placements.

To ensure that services (Placement Support Workers, Family Support, CAMHS (Children and Adolescent Mental Health Service), Education, Health) work together more effectively targeted and co-ordinated to support carers.

To review each case defined as permanent to ensure that support to carers is agreed and regular

To improve communication with Looked After Children based on the Pledge and "What I want from my social worker" agreement.

Looked After Children leave home far earlier than their peers. In partnership with Barnardo's, District Councils and the Fostering Service, a youth housing strategy is being developed. This has been in recognition of the need to provide safe and suitable housing for all young people including Care Leavers. Lincolnshire, as a result, has been able to provide a more comprehensive choice of accommodation and currently, there are 30 young people within Staying Put foster placements (post 18) and 40 in supportive lodgings. This is offering better choice but is something that needs to develop further in order to meet the needs of more care leavers. The current percentage of young people in suitable accommodation is 88% which is marginally below the target of 90%.

Obesity: May 2014 (version 3.1)

What do we know?

The causes of overweight and obesity are complex. Over the past 50 years, physical activity has declined significantly in the UK contributing to a more sedentary lifestyle, for example there are fewer jobs requiring physical work, introduction of labour saving technology in the home and the increased reliance on the car as a mode of transport in preference to walking or cycling. There has been greater access to high fat, high sugar foods and eating outside of the home has becoming increasingly popular. Food is abundantly available and presented to encourage us to have the larger-sized chocolate bar at the garage forecourt or to 'buy one, get one free' at the supermarket.

Obesity is associated with several health problems, including type 2 diabetes, cardiovascular disease and cancer. The resulting costs to the NHS that are attributable to being overweight and obese are projected to reach £9.7 billion by 2050, with wider costs to

society estimated to reach £49.9 billion per year (Foresight 2007). These factors combine to make the prevention and treatment of obesity a major public health challenge.

The obesity epidemic cannot be prevented by individual action alone and it demands a fiscal, economic and community approach. Tackling obesity requires far greater change then anything tried so far and at many levels: personal, family, community and national.

Partnership working will be essential if we are to tackle this serious public health issue.

What is this telling us?

Obesity is a key issue nationally and across Lincolnshire. We will need to continue to commission preventative services to reduce the risk of people becoming overweight and obese and to provide support for those trying to lose weight.

Obesity is a complex, multifaceted condition that has no easy or obvious solution. Having services in place to treat obesity, such as structured weight loss programmes, and medical interventions, such as surgery, is only a couple of the areas we need to focus on. We also need to be looking at the ways in which we can tackle the rise in obesity more generally, for example the built environment, such as access to cycle paths and green areas and assisting people in making healthier choices to prevent obesity.

The population of Lincolnshire is typically ageing, sedentary, with higher rates of diabetes, CHD and hypertension. All factors associated directly with obesity and future health problems.

Road Traffic Collisions: May 2014 (version 3)

What do we know?

In Lincolnshire:

- Killed or seriously injured casualties have reduced year on year since 2011.
- There has been one child (0 – 15 yrs) fatal casualty in the three years 2011- 2013.
- With the exception of 2007, fatal casualties have been in continual decline since 2003.

During 2013:

- The number of people killed or seriously injured (KSI) was 415.*
- There was one child fatality.
- The number of children seriously injured was 21.
- The number of fatalities was 36 which are the lowest on record.
- The number of KSI casualties per 100,000 population is 57.7 for Lincolnshire.
- West Lindsey District had the highest ratio of 74.4 KSI casualties per 100,000 population.
- Lincoln had the lowest ratio of 37.0 KSI casualties per 100,000 population.
- Road safety services in Lincolnshire continue to be provided by the multi-agency Lincolnshire Road Safety Partnership (LRSP). Their priorities for 2014 are young

drivers (17 to 24 years of age), car drivers, pedestrians, riders of two wheel vehicles and pedal cyclists.

What is this telling us?

Road safety services in Lincolnshire are provided by the multi-agency, data led LRSP.

Road safety targets for 2013 were achieved.

The number of fatal casualties in 2013 was the lowest ever recorded.

Not doing anything may mean we will see an increase in casualties resulting from road traffic collisions with resulting economic and human costs per casualty saved[2].

- Fatal £ 1,703,822
- Serious £ 191,462
- Slight £ 14,760

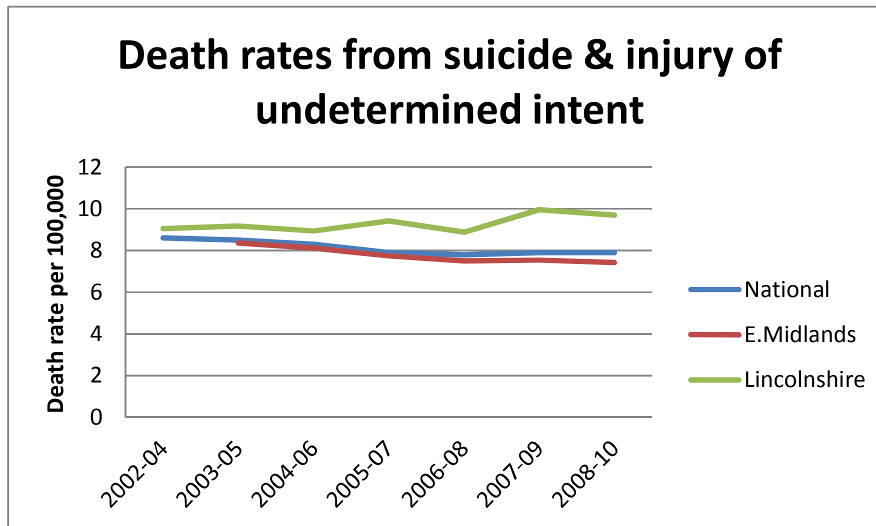
Suicide: April 2014 (version 2.1)

What do we know?

This JSNA section focuses on 3-year average data from 2008-2010 and specific data from the calendar year 2010, using the latest available information.

Nationally there has been a decrease in the overall rate of suicide over the last decade. In Lincolnshire, although the annual rate has dropped from 9.13 per 100,000 people in the year 2000 to 8.13 in 2010, the years in between give a fluctuating picture, with the death rate at its lowest in 2004 with 7.49 and at its highest in 2009 with 12.44. With regard to the actual number of deaths, this ranges from 53 to 90. The graph below represents the recent trend using a 3-year average death rate.

[2] *Calculated using casualty costs from Table RAS60001 of DfT's Reported Road Casualties GB – 2012.*



The majority of suicides continue to occur in middle aged men. With reference to gender and mortality rates across the districts, those which stand out are Lincoln City with a male death rate of 25.82 per 100,000; the worst ranking of 326 local authorities and East Lindsey with a female death rate of 12.41. (Compendium of Population Health Indicators - indicator.ic.nhs.uk)

Nationally and locally, the most common method of suicide for men and women is hanging, strangulation and suffocation with self-poisoning as the second most common method. With regards to the location of death, the local position is approximately 2:1 Home: Elsewhere.

Within Lincolnshire, the City of Lincoln and East Lindsey have the first and second highest rates of suicide of their resident population per 100,000. There was a greater number and higher rate of suicide in the most deprived areas of the county. The majority of people who died were resident within urban areas.

The likelihood of a person dying from suicide appears to depend on several underlying factors. These include physically disabling or painful illness and mental illness; alcohol and drug misuse; and level of support. Stressful life events such as loss of job, imprisonment, a death or divorce can also play a part. For many people, it is the combination of factors which is important, rather than any single factor.

'Preventing Suicide in England' a cross-government strategy to save lives was published by the Department of Health in September 2012. This strategy sets out key areas for action, states what government departments will do to contribute, and brings together knowledge about groups at higher risk, effective interventions and resources to support local action.

A new strategy and action plan for Lincolnshire are currently being developed and due for completion in 2013. There are a number of local interventions in place to reduce suicide and self-harm.

With effect from 1 April 2013, suicide and self-harm prevention became part of the Public Health mental health responsibilities of Lincolnshire County Council (LCC).

What is this telling us?

Lincolnshire has a higher than national and regional average death rate. This rate fluctuates and peaked in 2009. Lincoln City has the highest rate for male suicide of all local authorities in England. A new Lincolnshire suicide and self-harm prevention strategy is currently being developed, based on the National Suicide Prevention Strategy published in September 2012.

It is clear from local audit and engagement with stakeholders that further targeted work on understanding suicide and developing prevention tactics is required, for example, the factors influencing suicide in certain areas of work and the extraordinary rate in the City of Lincoln.

There are some clear risk factors that increase the likelihood of suicide and these include on-going mental illness and substance misuse, serious and long term debilitating illness and adverse life events like the ending of a relationship and bereavement. Whilst individual factors are important a more useful predictor of risk for individuals is the coincidence of more than one factor.

A key factor to note from the nature of some of the risks is that many people who die by suicide are known to and in contact with services in the run up to their decision and action. However many are not and methods of getting essential information or an immediate response when someone is seriously contemplating suicide needs to be considered carefully.

There are some anecdotal indications from Coroners and Coroners Officers that are worthy of consideration. One is around the impact of media reporting on suicides, especially where details of the 'successful' method is published, with Coroners suggesting 'copy-cat' deaths rise in the wake of such reporting. The second important factor is around the number of cases where Coroners judge that the individual did not mean to kill themselves. It seems clear that a number of deaths occur each year because the person either did not know how fast and effective their chosen method was (for example, hanging and strangulation) or underestimated how long it would be before they were discovered following overdose, and how quickly the substances used would irreversibly harm them.

Unpaid Carers: May 2014 (version 2)

What do we know?

The number of unpaid family carers both nationally and locally is set to increase over the next twenty five years, and it is anticipated that the number of carers in England will increase to 9 million by 2037. The caring role ranges from helping with small tasks to providing continuous care. Local and national evidence indicates that carer’s finances, employment possibilities and both physical and mental wellbeing are affected by their caring role.

Carers report a frustration at not being able to access information on where to seek help and support. In Lincolnshire over 40% of known carers do not access the internet. A difficulty with Broadband coverage in Lincolnshire exacerbates this situation.

Universally many carers do not recognise themselves as a carer or do not want to be labelled as a carer. There are many reasons for this including stigma, and fear of the unknown. A 2012/13 survey of Lincolnshire carers over age 18 gave the following results:

A combination of lack of recognition, a desire not to be labelled, and no easy way to access information results in many carers continuing to care without the support they need. This results in a higher risk of carer breakdown, which leads to potential hospital or care home admission resulting in increased and avoidable costs of care. A greater priority for services for carers would result in less expenditure on expensive hospital and social care[3].

What is this telling us?

There are many unsupported carers in Lincolnshire who do not access appropriate and timely advice and information and who therefore fail to benefit from preventative services such as a carer's assessment or Carers Emergency Response Service (CERS).

Carers tell us that social isolation, slow diagnosis, lack of service support all have a serious effect on the physical and mental wellbeing of the carer, with anxiety, low self - esteem and lack of confidence being well identified characteristics of the caring role.

The national Personal Social Services Survey of Adult Carers in England survey 2012/13 reported that 57,810 people out of a sample of 125,950 carers of social care users responded to the survey, which is a response rate of 46%. The main findings of the survey stated:

36% of respondents reported that they were either extremely or very satisfied with the support and services they and the person they care for received from Social Services in the last 12 months, with 29% saying they were quite satisfied. However, 5% reported they were quite dissatisfied, and 4% stated they were either very or extremely dissatisfied. 11% said that they were neither satisfied nor dissatisfied and 16% said that they hadn't received any support or services from Social Services in the last 12 months;

29% reported they have as much control as they want over their daily lives. 60% reported they have some control with the remainder (12%) stating they had no control over their daily lives.

85% of carers reported that they had no worries about their personal safety. A further 14% stated they had some worries about their safety. 2% of carers reported that they were extremely worried about their personal safety.

[3] Castleton, B (1998), Developing a whole system approach to the analysis and improvement of health and social care for older people and their carers: A pilot study in West Byfleet, Surrey. Unpublished. Referenced by Banks, P (1998) 'Carers: making the connections'. Managing Community Care, vol 6, issue 6.; and Newbrunner, L (2010), 'The Princess Royal Trust for Carers Out of Hospital Project – Learning from the Pilot Projects'. London:Acton Shapiro Ltd. Available at : http://professionals.carers.org/health/hospitals,806,PP.html.)

The average score for carer related quality of life was 8 out of a maximum possible score of 12. This is a composite measure calculated using a number of questions which cover 6 different outcome domains relating to quality of life.

Other key findings in the same report include:

43% of respondents stated they felt they were encouraged and supported in their caring role. Conversely, 16% said they had no encouragement or support. The remainder (40%) reported they had some encouragement but not enough.

71% of respondents reported that the person they cared for lived them, with the remainder (29%) saying that they lived somewhere else.

42% of respondents said they had as much social contact as they wanted with people they liked, while 45% had adequate contact. However, the remainder (14%) said they have little social contact and felt socially isolated.

50% of those who responded stated it was either very or fairly easy to find information and advice about support in their caring role. 15% said it was fairly difficult to find with 7% stating they found it very difficult. 28% of respondents said that they had not tried to find information or advice in the last 12 months.

Information and advice received was reported to be either very or quite helpful by 65 per cent of respondents. 5% said they found it quite unhelpful and 2% said they found it very unhelpful. 27% said they had not received any information or advice in the last 12 months.

60% of respondents said they felt that, in terms of getting enough sleep or eating well, they were able to look after themselves in their current situation. 26% said they felt they couldn't look after themselves well enough with 14% saying they felt they were neglecting themselves.

32% of respondents said they always felt involved or consulted as much as they wanted to be in discussions about the services provided to the person they care for. 24% stated they were usually involved. However, 5% said they never felt involved or consulted and 16% stated that they sometimes felt involved. The remainder (24%) said that there had been no discussions that they were aware of, in the last 12 months[4].

Young People within the Criminal Justice System: October 2013 (version 3)

What do we know?

The number of young people entering the criminal justice system continues to fall in line with national trends, although there has been an increase in community resolutions that put the needs of the victim first. They are asked what outcome they would like to see

[4] Personal Social Services Survey of Adult Carers in England 2012-13: Provisional Report. Health and Social Care Information Centre.

thereby, becoming part of the solution. This could include a simple apology, an offer of compensation or a promise to clear up any graffiti or criminal damage.

The Youth Offending Service (YOS) client group remains predominantly white, male 16+yrs old. Typically the YOS will work with people up to the age of 18, but going beyond the 18th birthday in cases where interventions are on-going or where issues such as mental health or learning difficulties mean that a probation referral would be inappropriate for a young adult.

Lincolnshire continues to remain below the national average in relation to First Time Entrants (FTE's), reoffending and custody.

What is this telling us?

The YOS continues to come under financial pressure to reduce costs. However, it has also to continue to provide a high achieving, consistent service, whilst responding to local and national changes. We continue to work with partner agencies whilst giving additional focus to early intervention, health needs, remand management, private care homes and the use of legal highs (Newly Emerging Drugs- NEDs).

Summary of Updated Data-Sets

What has changed this year?

The JSNA is 'live' process which means that data sets are constantly being refreshed and updated on the web-site. The table below shows how many data-sets, under each topic area have been updated during the last year. To access any of these topic pages directly, just click on the hyperlinks within the table.

JSNA Topic	Number of Data Sets Updated in last 12 months
Breastfeeding	1
Cancer	6
CHD	5
Childhood Immunisation	6
Chlamydia Screening	4
COPD	2
Diabetes	1
Educational Attainment	6
Educational Attainment (Foundation)	3
Falls	3
Housing	7
Learning Disabilities	2
Life Expectancy	5
Mental Health	3
Obesity (Adults)	2
Physical Activity	1
Physical Disabilities	2
Pregnancy and maternal health	3
Road Traffic Collisions	10

Smoking (Adults)	5
Special Educational Needs	36
Stroke	2
Teenage Pregnancy	1
Young People within Criminal Justice System	1
Grand Total	117