Cambridgeshire County Council

NHS Cambridgeshire

Joint Strategic Needs Assessment for Cambridgeshire: DRAFT Phase 3 Summary December 2009

Joint Strategic Needs Assessment for Cambridgeshire

Contents

Introduction

What is a Joint Strategic Needs Assessment (JSNA)?

Joint Strategic Needs Assessment (JSNA) was introduced in the Government's *Commissioning framework for health and well-being* published in March 2007. JSNAs form the basis of a new duty to co-operate for PCTs and local authorities, formalised in the Local Government and Public Involvement in Health Act 2007.

A JSNA is the means by which Primary Care Trusts (PCTs) and local authorities describe the future health, care and well-being needs of the local populations and the strategic direction of service delivery to meet those needs. The reason for doing a JSNA is to develop the whole health and social care response so that it more closely meets the wants and needs of local people.

The aim of a JSNA is to:

- Provide analyses of data to show the health and well-being status of local communities.
- Define where inequalities exist.
- Use local community views and evidence of effectiveness of interventions to shape the future investment and disinvestments of services.

Why do we do JSNAs?

There are many different factors which have an important influence on people's health. The factors which have been found to have the most significant influence are widely known as the determinants of health. While health services make a contribution to health, most of the key determinants of health lay outside the direct influence of health care, for example, education, employment, housing, and environment.

What is this document aiming to do?

In Cambridgeshire, we have so far carried out three phases of JSNA, working in partnership across the NHS and Local Authorities to gather the relevant information.

In phase 1 a public health and health inequalities dataset was produced, which included the data recommended in national JSNA guidance. We also produced six JSNAs, which focussed on different groups within the population. These were:

- Children and Young People.
- Adults of Working Age.
    - Adults with mental health problems.
    - Adults with learning disabilities.
    - Adults with sensory or physical impairment and long term conditions.
- Older People.

In phase 2, we undertook a review of existing surveys and consultation with service users, carers and the public, to provide qualitative information on local health needs. The full report, 'Joint strategic needs assessment for Cambridgeshire: Community Views' is available on the public health pages of the NHS Cambridgeshire website (www.cambridgeshirepct.nhs). The direct link is http://www.cambridgeshire.nhs.uk/default.asp?id=656

In phase 3, we produced two further JSNAs which looked at the needs of groups at particular risk of social exclusion within Cambridgeshire – people who are homeless or at risk of homelessness; and migrant workers. These are summarised in this document in Section 2 – 4.1/4.2. We also compared key health outcomes for Cambridgeshire against national averages and against other areas with similar socio-demographic characteristics to Cambridgeshire to and each of its Local Authority Districts. This work is included in Appendix A. Finally, wherever possible, we updated the statistics in the Phase 2 JSNA so that this document contains the most up to date information possible.

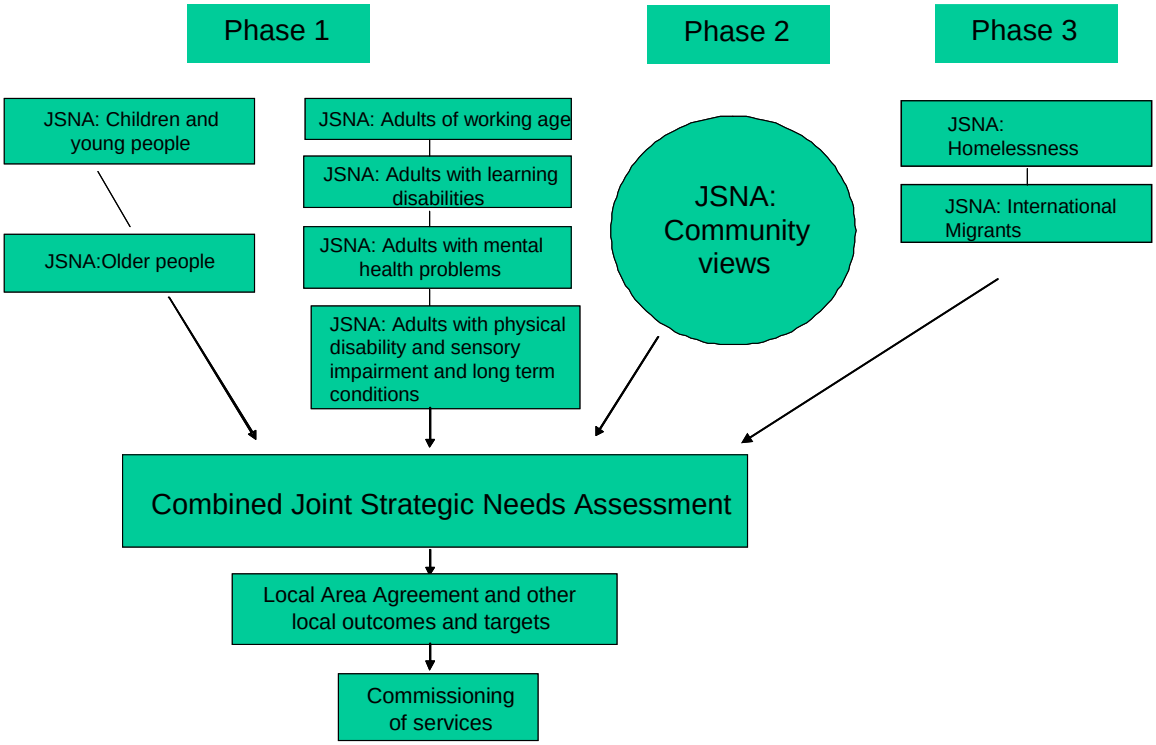
This summary document does **not** attempt to replicate all the detail or findings of each of the JSNAs, including the JSNA on community views, but brings together the key points from each of them.

This document aims to:

- Give an overview of the Cambridgeshire population.
- Describe the key findings from each of the JSNAs.
- Identify any overarching themes from all of the JSNAs.
- Describe the ongoing work attached to the JSNAs.
- Describe the work that the combined JSNA will feed into.

This document is part of a process which provides evidence to inform decisions on how to improve the health and wellbeing of the Cambridgeshire population now and in the future. These decisions include the setting of local targets as well as what services are commissioned. The diagram below illustrates this process.

Figure 1



How has the JSNA been used so far?

The different phases of the JSNA have been presented in a wide range of settings – including the Cambridgeshire Together Board, County Council Cabinet, NHS Cambridgeshire Board, NHS Cambridgeshire Professional Executive Committee, District Level Health Partnerships and local LINKS groups. This has enabled partners from different agencies and stakeholder groups to gain a shared understanding of health and wellbeing needs in Cambridgeshire.

In addition to its contribution to the Cambridgeshire Together Vision, and the selection of LAA targets, the Cambridgeshire JSNAs have been used in many strategies and planning documents, including the following:

The NHS Cambridgeshire Strategic Plan for which the JSNA provided an important information base on health needs.
Cambridgeshire County Council's Integrated Planning Process, which included use of JSNA information.
Cambridgeshire Older People's Joint Commissioning Strategy, which used health and care needs information from the Older People's JSNA.
The refresh of **Cambridgeshire's Children and Young People's Big Plan**, which incorporated the findings of the Children and Young People's JSNA.
Cambridgeshire's Adult Mental Health Joint Commissioning Strategy which used health and care needs from the Adult Mental Health JSNA, particularly the needs of marginalised groups.

The Cambridgeshire Learning Disability Commissioning Strategy which used information from the Learning Disabilities JSNA.
The Cambridge City and South Cambridgeshire Health Improvement Plan (2008-11) which used information from the combined JSNA which was of particular relevance to the southern part of Cambridgeshire.
The Fenland District Council 2009/10 Corporate Plan which used information from the JSNA of particular relevance to Fenland.
The draft Strategy to Tackle Health Inequalities in Cambridgeshire which draws heavily on information from the JSNA.

Updating the JSNAs

This JSNA summary is being continuously updated as new demographic and other information becomes available. Since the first version of this document (Phase 1) was published, population estimates and forecasts as well as the Index of Multiple Deprivation have been revised. This version of the JSNA includes the latest available information on these areas. It is not possible to update or rework all of the more complex calculations and forecasts in the light of new figures. However, it is made clear in the document which set of figures are being presented and which figures any particular calculation is based on.

Overall, changes in population estimates and forecasts are unlikely to be so substantial as to make a significant difference to the key messages from the document.

This Phase three summary JSNA contains a new section on population groups at risk of social exclusion. The two population groups at risk of exclusion for which JSNAs have been completed this year are:

- Homeless people and those at risk of homelessness.
- Migrant workers.

For both of these population groups, the JSNA was carried out collaboratively by a range of multi-agency stakeholders who provided both quantitative and qualitative information. Both JSNAs made clear recommendations for action, which are being taken forward by partnership groups with reporting lines to Cambridgeshire Together Board.

The Phase 3 summary JSNA also contains an appendix which benchmarks Cambridgeshire and of its Local Authority Districts against national and ONS Comparator averages for key health determinants and outcomes. This increases the opportunity for the reader to understand how Cambridgeshire compares with the rest of the country and with other socio-demographically similar areas, as well as highlighting key health inequalities within the County.

JSNA National Project

During 2009 the NHS Cambridgeshire participated in a national exemplar project for JSNA. NHS Cambridgeshire's bid to be part of the project was successful because of the strength of the PCT's population segmentation, or client group, approach to JSNA.. As well as learning about best practice elsewhere, the project enabled the PCT to progress work towards a potential web-based portal for JSNA data and information. Further information about the national project and NHS Cambridgeshire's contribution can be found on the Information Centre for Health and Social Care's website at http://www.ic.nhs.uk/jsna.

Section 1: Key Demographics

The statistics and conclusions in this section are based on the Public Health and Health Inequalities Dataset 2007 for NHS Cambridgeshire, although some statistics have been updated since publication of the Dataset. The full document can be found on the NHS Cambridgeshire website at **http://www.cambridgeshirepct.nhs.uk/** under 'About Us' and then 'Public Health'.

Summary

- It is estimated that there are 595,650 people living in Cambridgeshire, around a quarter are under 20 years and around one in seven is aged 65 years and over[1].
- Population forecasts suggest that the population of Cambridgeshire is set to increase by 13% by 2021, with the majority of the increase seen in Cambridge City and South Cambridgeshire[2]. This is associated with a forecast increase in the number of new dwellings between 2007 and 2021, of 56,000[3].
- Cambridgeshire has a predominantly white population. However, Cambridge City has a higher proportion of people from non-white ethnic groups[4] when compared to the national average, many of whom are students or professionals. There are also considerable numbers of Travellers[5] and migrant workers within Cambridgeshire.
- Deprivation varies greatly across the county, with Fenland, north-east Cambridge and parts of North Huntingdon having the highest levels of relative deprivation[6]. The same pattern exists for children living in poverty. Income deprivation for older people is more widely dispersed.
- Cambridgeshire is a predominately rural area[7]. Nearly a fifth of Cambridgeshire's population do not have access to a car or van[8]. This goes down to less than tenth for children living in households with no access to a car or van but up to four in ten pensioners. Cambridge City has the lowest levels of car ownership, which may be expected given that it is an urban area. However, Fenland has the second highest levels of non-car ownership in Cambridgeshire.
- The unemployment rate in Cambridgeshire increased from 1.2% in September 2007 to 2.6% in 2009. The highest level of unemployment is seen in Fenland (4.1%)[9].
- Overall, a half of lone parents do not work, with higher proportions in South Cambridgeshire and Huntingdonshire[10].
- Educational attainment varies greatly across the county, with low levels of Key Stage 2 Level 4+ in Fenland and Cambridge City and noticeably low GCSE attainment in Fenland. South Cambridgeshire has markedly high attainment in both of these qualification areas (2002-2008 data)[11].

1 Cambridgeshire County Council Research Group, Mid-2008 district level population estimates.
2 Cambridgeshire County Council Research Group, Mid-2008 district level population forecasts by age and gender.
3 Cambridgeshire County Council Research Group local authority dwelling forecasts, 2001 to 2021 based on 2007-based ward age-group forecasts.
4 2001 Census.
5 Cambridge sub-regional Traveller Needs Assessment 2006.
6 The English Indices of Deprivation 2007, Department for Communities and Local Government (DCLG).
7 DEFRA classification 2004.
8 2001 Census.
9 NOMIS, Claimant count, September 2009.
10 2001 Census.
11 Cambridgeshire County Council and NHS Cambridgeshire, Children & Young People Data Profile 2009.

- All districts in Cambridgeshire except for Fenland have higher life expectancy at birth than seen nationally in 2006-2008. This is most noticeable in South Cambridgeshire. Life expectancy in Fenland is at the national level[12].
- There are on average 4,855 deaths a year in Cambridgeshire[13]. Circulatory disease and cancer are the main causes of death in the overall population. Conditions originating in the perinatal period and transport accidents are the main causes of death for children. County level death rates for circulatory disease and cancer are significantly lower than the national average, but transport accident deaths are higher. Fenland has high all age mortality for all causes compared with that seen nationally[14].

Community Views in PLACE Survey 2008

In the Place Survey from autumn 2008 at least 86% of Cambridgeshire residents in Cambridge, East Cambridgeshire, Huntingdonshire and South Cambridgeshire are satisfied with their local area as a place to live. In Fenland 75% of residents are satisfied (79.7% in the national Place Survey).

Every four in five residents (79%) agree that people from different backgrounds get on well together in their local area. In Fenland every three in five residents agree (61%).

At least 70% of residents rate their health in general as very good or good.

Among residents who have used their local public services 84% were satisfied with their GP, 80% were satisfied with their local hospital and 69% with their local dentist.

Facilities and services that are the most important in making somewhere a good place to live for Cambridgeshire residents are: public transport, affordable decent housing, shopping facilities and low level of crime. In residents' opinion all the above areas require improvement[15, 16].

JSNA: Community Views – Health Services[17]

- Patients rated GP Services in Cambridgeshire in the top 20% nationally on a number of questions asked in the Healthcare Commission Survey undertaken in 2008. GP services were not rated in the worst 20% nationally on any question.
- Access to NHS dental services, included out of hours is highlighted by more than one report.
- Inpatient services at Papworth were rated by patients in the top 20% of trusts nationally on almost all questions. Both Addenbrookes and Hinchingbrooke were rated by patients in the top 20% of trusts on a number of different questions, but there were some areas where they scored in the bottom 20% of trusts.
- The inpatient and GP services surveys both found that patients in Cambridgeshire rated local doctors in the top 20% for understanding the answers given by doctors, being treated with respect and having trust and confidence in doctors.

12 ONS, November 2009.
13 ONS Death Registrations 2006-2008.
14 Compendium of Clinical and Health Indicators 2005-2007.
15 Cambridgeshire County Council, Cambridgeshire Place Survey 2008 (commissioned from Cello MRUK).
16 Audit Commission, Place Survey 2008 (commissioned from Cello MRUK).
17 This section reports the result of several patient surveys – for full references see JSNA: Community Views.

- Maternity services are rated above the national average by women in the areas identified nationally as strong. Broadly, the areas identified for improvement nationally are also those for Cambridgeshire.
- Responses to PCT consultations on service changes raise a number of different issues including service capacity, funding and access and transport.

Table 1: Total population : population estimates, mid 2008 (CCCRG)

Local Authority	Population
Cambridge City	117,700
East Cambridgeshire	79,400
Fenland	92,900
Huntingdonshire	163,100
South Cambridgeshire	142,500
Cambridgeshire	595,600

Source: Cambridgeshire County Council Research Group.
Definition: Mid 2008 population estimates (Note: Figures are rounded to the nearest 100) .

Cambridge City has a noticeably higher proportion of people aged 15-34 years. This is due to the high student population in the district.

Table 2: Total population : population estimates, mid 2008 (CCCRG)

Local Authority	Age band										Total
	0-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	
Cambridge City (num)	6,170	10,260	28,020	22,070	14,630	12,070	10,440	6,980	4,910	2,130	117,660
Cambridge City (%)	5%	9%	24%	19%	12%	10%	9%	6%	4%	2%	100%
East Cambridgeshire (num)	5,080	9,450	8,730	8,550	12,670	11,170	10,380	6,920	4,760	1,660	79,380
East Cambridgeshire (%)	6%	12%	11%	11%	16%	14%	13%	9%	6%	2%	100%
Fenland (num)	5,030	11,420	10,370	10,570	12,920	12,350	12,220	9,260	6,650	2,070	92,860
Fenland (%)	5%	12%	11%	11%	14%	13%	13%	10%	7%	2%	100%
Huntingdonshire (num)	9,340	20,520	19,280	18,120	26,590	23,950	21,280	13,720	7,650	2,760	163,210
Huntingdonshire (%)	6%	13%	12%	11%	16%	15%	13%	8%	5%	2%	100%
South Cambridgeshire (num)	8,660	17,800	15,280	15,510	22,750	20,250	19,050	12,420	7,940	2,890	142,550
South Cambridgeshire (%)	6%	12%	11%	11%	16%	14%	13%	9%	6%	2%	100%
Cambridgeshire (num)	34,280	69,450	81,680	74,820	89,560	79,790	73,370	49,300	31,900	11,500	595,650
Cambridgeshire (%)	6%	12%	14%	13%	15%	13%	12%	8%	5%	2%	100%

Source: Cambridgeshire County Council Research Group.
Definition: Mid 2008 based single year population estimates (Note: Figures are rounded to the nearest 10).

By 2021 it is estimated that there will be a further 78,000 people living in Cambridgeshire. The biggest actual increases and also proportional increases are expected in Cambridge City and South Cambridgeshire.

Table 3: Total population : population forecasts, mid 2008 based (CCCRG)

Local Authority	Year				% change 2008 to 2021
	2008	2011	2016	2021	
Cambridge City	117,700	125,000	141,400	153,600	30.5%
East Cambridgeshire	79,400	79,300	80,200	81,100	2.1%
Fenland	92,900	93,100	96,300	100,300	8.0%
Huntingdonshire	163,100	165,500	165,800	166,800	2.3%
South Cambridgeshire	142,500	142,200	158,600	171,900	20.6%
Cambridgeshire	595,500	605,000	642,300	673,700	13.1%

Source: Cambridgeshire County Council Research Group Mid-2008 district level population forecasts
Note: table above: These forecasts have been produced using specific assumptions and may not be appropriate for all uses. These forecasts remain subject to revision. These figures have been rounded to the nearest 100. Totals may not add due to rounding. These forecasts are indicative and do not represent the policy of the County Council or any District Council.

In general, most local authorities in Cambridgeshire have small proportions of minority ethnic residents. However, Cambridge City has higher proportions of minority ethnic groups than England, with a higher proportion of people from 'Chinese or Other Ethnic Groups'. The minority ethnic groups in Cambridge include a high proportion of students and professionals. Cambridgeshire also has considerable populations of Travellers and migrant workers.

Table 4: Ethnicity : total population, Local Authority, 2007

Ethnicity	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire	England
White	83.9%	94.9%	96.0%	94.0%	93.6%	92.3%	88.2%
Mixed	2.3%	1.4%	1.0%	1.5%	1.5%	1.5%	1.7%
Asian or Asian British	5.9%	1.2%	1.3%	2.0%	2.0%	2.6%	5.7%
Indian	3.1%	0.6%	0.7%	1.0%	1.0%	1.3%	2.6%
Pakistani	0.9%	0.2%	0.3%	0.6%	0.4%	0.5%	1.8%
Bangladeshi	1.0%	0.1%	0.1%	0.2%	0.2%	0.4%	0.7%
Other Asian	0.9%	0.2%	0.2%	0.2%	0.4%	0.4%	0.7%
Black or Black British	2.5%	1.0%	0.9%	1.4%	1.3%	1.5%	2.8%
Caribbean	0.8%	0.4%	0.3%	0.4%	0.5%	0.5%	1.2%
African	1.5%	0.4%	0.4%	0.6%	0.7%	0.8%	1.4%
Other Black	0.2%	0.2%	0.1%	0.4%	0.1%	0.2%	0.2%
Chinese or Other Ethnic Group	5.4%	1.5%	0.7%	1.1%	1.7%	2.1%	1.5%
All Groups	**120,000**	**81,000**	**91,400**	**167,700**	**137,300**	**597,400**	**51,092,000**

Source: ONS, Experimental Population Estimates by Ethnic Group Mid-2007
Definition: Percentage of all people by ethnic group.

Table 5: Indices of Deprivation 2007, Local Authority rank

Local Authority	IMD 2007 score (average of LSOA scores)	LA rank (England)*
Fenland	20.50	139
Cambridge	13.87	236
East Cambridgeshire	10.84	285
Huntingdonshire	9.31	311
South Cambridgeshire	6.55	350
Cambridgeshire	11.49	135

NB: *LA rank (England): the rank for 5 district authorities represents the relative rank within the 354 tier 2 local authorities in England where rank 1 is the most deprived authority and rank 354 the least deprived. The rank for Cambridgeshire represents the relative rank within the 149 tier 1 local authorities where rank 1 is the most deprived authority and rank 149 the least deprived.

Source: The English Indices of Deprivation 2007, Department for Communities and Local Government (DCLG).

Definition: The English Indices of Deprivation 2007 include domains at lower super output area (LSOA) for income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services housing, living environment deprivation and crime. An average score has been calculated for each local authority district based on LSOA scores weighted according to their population. This measure takes into account the full range of scores across a district and averages the LSOA scores in each district after they have been population weighted.

Wards in Table 6 are the 20% of wards in Cambridgeshire which are the most socio-economically deprived. Deprivation levels vary widely across Cambridgeshire, with Fenland having the greater relative deprivation and South Cambridgeshire the lesser. South Cambridgeshire is the fifth least deprived local authority in England. There are pockets of deprivation in all of the districts.

Table 6: Index of Multiple Deprivation, 2007 : fifth most deprived wards in Cambridgeshire

Local Authority	Ward name	IMD Score
Fenland	Waterlees	41.52
Fenland	Clarkson	32.83
Fenland	Medworth	32.01
Fenland	Staithe	31.21
Huntingdonshire	Huntingdon North	27.00
Fenland	Elm and Christchurch	25.73
Fenland	Parson Drove and Wisbech St Mary	25.39
Cambridge	King's Hedges	25.10
Fenland	Hill	24.41
Fenland	Kirkgate	24.36
Fenland	Kingsmoor	23.01
Cambridge	Abbey	21.93
Fenland	Roman Bank	21.24
Fenland	Peckover	20.42
Fenland	March East	20.08
Cambridge	East Chesterton	20.03
East Cambridgeshire	Littleport West	19.47
Cambridge	Arbury	18.97
Fenland	March North	17.83
Fenland	Lattersey	17.24
Fenland	Birch	16.78
Fenland	March West	16.49
East Cambridgeshire	Littleport East	16.48
Fenland	Wenneye	16.06
Fenland	Wimblington	15.55

Source: The English Indices of Deprivation 2007, Department for Communities and Local Government (DCLG).

Definition: The fifth most deprived wards in Cambridgeshire.

Life Expectancy

Life expectancy in Cambridgeshire is overall better than the national average in 2006-08. Life expectancy in different areas of the county closely mirrors socio-economic circumstances, as indicated by IMD scores. It is lowest for both males and females in Fenland and highest in South Cambridgeshire. South Cambridgeshire and East Cambridgeshire have statistically significantly higher life expectancy at birth for males than Cambridgeshire. In Cambridge and Fenland it is significantly lower. Life expectancy for females is significantly higher than the county's average in South Cambridgeshire, whereas in Fenland it is significantly lower.

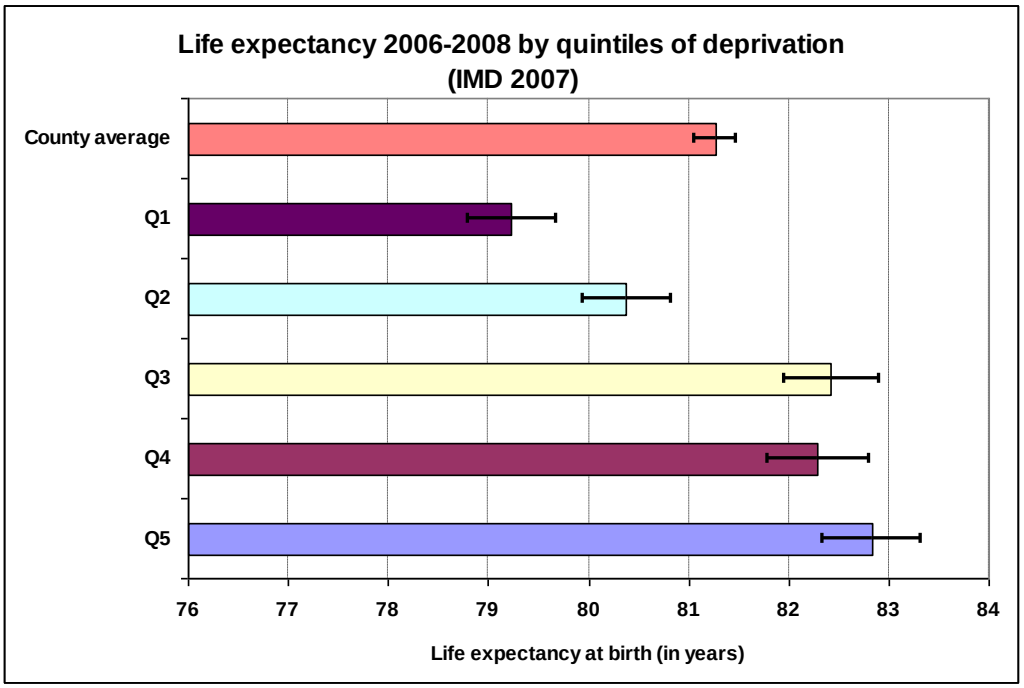
Table 7: Life expectancy at birth (years), 2006-2008

Area	Males	Females
England	77.9	82.0
East of England	78.9	82.8
Cambridgeshire	79.3	83.1
Cambridge	78.1	82.8
East Cambridgeshire	80.5	83.8
Fenland	77.3	81.3
Huntingdonshire	79.1	83.0
South Cambridgeshire	81.1	84.5

Source: ONS, Life expectancy at birth (2006-2008), November 2009.

Life expectancy in the fifth of Middle Level Super Output Areas (MSOAs) in Cambridgeshire with the higher levels of deprivation is statistically significantly lower than all other groups of MSOAs (based on quintiles of deprivation) and the county and national average. Most of these MSOAs are in Fenland, but some are in north east Cambridge, Huntingdon and East Cambridgeshire. Those in the 60% of MSOAs with the least levels of deprivation (i.e. Q3, Q4 and Q5) have statistically significantly higher life expectancy than the county average (2006-2008).

Figure 2: Life expectancy 2006-2008 by quintile of deprivation (IMD 2007)



Source: Population data: ONS population estimates. Annual extract of deaths, Vital Statistics, Office for National Statistics 2006-2008. Index of Multiple Deprivation 2007, Department of Communities and Local Government. Life expectancy calculator: ERPHO 2009.

Definition: Average life expectancy at birth by Middle Level Super Output Area (MSOA) quintiles based on the Index of Multiple Deprivation 2007. Q1 shows the rate for the fifth of the most deprived MSOAs in Cambridgeshire and Q5 the rate for the fifth of least deprived MSOAs.

Cambridgeshire is predominantly a rural area. The DEFRA classification (2004) reflects the local area relatively well, separating out the large market town population from the village and dispersed populations. The most rural districts are Huntingdonshire and East Cambridgeshire (including the large market towns). Fenland has 52% of its population in large market towns. East Cambridgeshire has 26% in villages and 9% is dispersed amongst the more rural areas.

Table 8: Rural or urban location, 2004

Local Authority	Other Urban*	Large Market Town	Rural Town	Total Rural (incl large mkt town)	Village	Dispersed	Total Rural (incl large mkt town)	Total population
Cambridge	108,900 100%	- -	- -	- -	- -	- -	- -	108,900 100%
East Cambridgeshire	- 0%	15,890 22%	32,000 44%	47,890 65%	19,060 26%	6,360 9%	73,310 100%	73,313 100%
Fenland	12,510 15%	43,650 52%	10,670 13%	54,320 65%	12,850 15%	4,030 5%	71,200 85%	83,706 100%
Huntingdonshire	330 -	66,850 43%	56,490 36%	123,340 79%	28,860 18%	4,340 3%	156,540 100%	156,863 100%
South Cambridgeshire	22,660 17%	0 0%	59,150 46%	59,150 46%	42,270 33%	5,850 5%	107,260 83%	129,926 100%
Cambridgeshire	144,390 26%	126,390 23%	158,310 29%	284,690 52%	103,040 19%	20,590 4%	408,310 74%	552,710 100%

Source: DEFRA. *Cambridge City is classified as 'Other Urban' (ie not Large or Major Urban).

Definition: 2001 Census Output Areas (OAs) assigned to the rural definitions in the table. 'Larger market towns' are identified as those urban areas having a set of functional attributes that serve a wider rural hinterland.

Cambridge City has the highest proportion of households without access to a car or van. This may be less of an issue within such an urban area due to public transport provision and the proximity to services. One in five households in Fenland do not have access to a car or a van.

Table 9: No access to a car or van : total population, 2001

Local Authority	All Households		
	No cars or vans available	All households	% with no access to car or van
Cambridge City	13,567	42,649	32%
East Cambridgeshire	4,399	29,780	15%
Fenland	6,861	35,194	19%
Huntingdonshire	8,971	63,060	14%
South Cambridgeshire	6,179	52,185	12%
Cambridgeshire	39,977	222,868	18%

Source : Census 2001 © Crown Copyright 2003.
Definition: Number and proportion of all households living in households with no access to a car or van.

Cambridgeshire experienced an increase in the level of unemployment from 1.2% (as of September 2007) to 2.6% in 2009. Fenland has the highest unemployment rate for both sexes and the overall population (4.1%) followed by Huntingdonshire (2.7%). The observed increase in the level of unemployment is a consequence of the UK economy entering recession in the second quarter 2008. Long term unemployment is likely to have an adverse impact on health of those people who are unemployed[18].

Table 10: Unemployment : total population, September 2009

Local Authority	**Male**		**Female**		**Total**	
	Number	**Rate**	**Number**	**Rate**	**Number**	**Rate**
Cambridge	1,428	3.0	548	1.4	1,976	2.3
East Cambridgeshire	848	3.3	333	1.4	1,181	2.4
Fenland	1,509	5.4	703	2.8	2,212	4.1
Huntingdonshire	2,047	3.7	837	1.7	2,884	2.7
South Cambridgeshire	1,144	2.6	448	1.1	1,592	1.9
Total	**6,976**	**3.5**	**2,869**	**1.6**	**9,845**	**2.6**

Source: NOMIS, Claimant count September 2009
Definition: The employment rates based on claimant counts. Proportion of resident working age population estimates.

[18] ERPHO, Inpho 38: The Impact of the Recession on Health, 2009

Fenland has a noticeably low percentage of pupils attaining five or more GCSE grades A*-C, with less than 55% of such pupils. This compares to over 75% of South Cambridgeshire pupils achieving these grades.

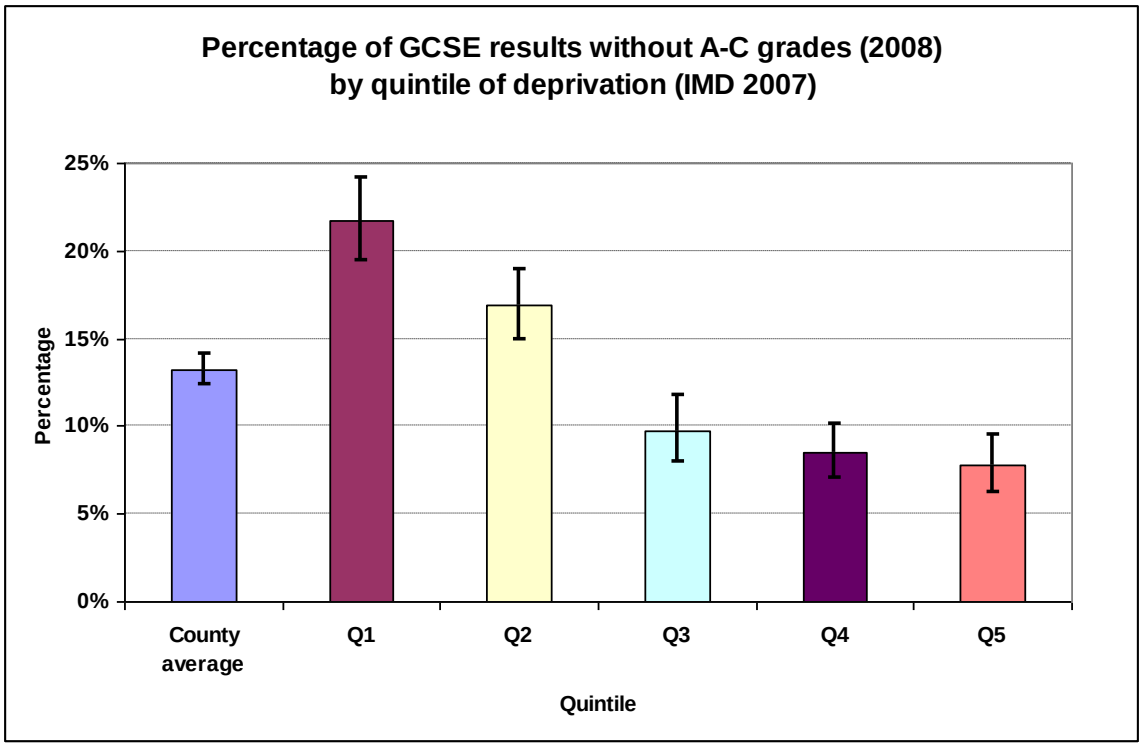
Table 11: Education: GCSE attainment, 5 or more A*-C, 2008 by district of school attended

Area	No. of pupils achieving 5+ GCSE grades A*-C	% pupils achieving 5+ GCSE grades A*-C
Cambridge City	472	60.7
East Cambridgeshire	463	61.9
Fenland	509	52.4
Huntingdonshire	1,240	64.7
South Cambridgeshire	1,140	77.2
Cambridgeshire	**3,922**	**64.9**
England		**64.6**

Source: Cambridgeshire County Council, NHS Cambridgeshire, Children & Young People Data Profile 2009.
Definition: All pupils by residence (includes Special School & Pupil Referral Unit)

Figure 3 shows the gradient between the groups of wards based on deprivation levels for GCSE attainment. As can be seen, the wards with greater levels of deprivation (Q1 and Q2) have lower levels of GCSE attainment (that is below A-C grades). Deprivation, however, is not the only factor that determines educational attainment.

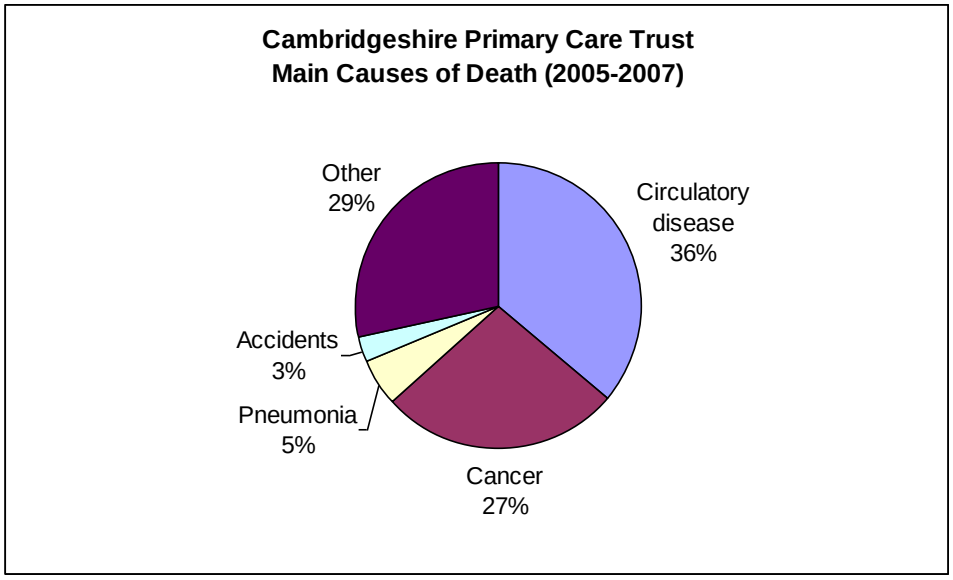
Figure 3: Education : proportion of pupils with no GCSE grades A*-C, 2008 by quintile of deprivation (IMD 2007)



Source: Children and Young People's Services, Cambridgeshire County Council (2008) and Index of Multiple Deprivation 2007, Department of Community and Local Government.
Definition: Average proportion of pupils with no GCSE grades A*-C, 2008 by quintiles based on the Index of Multiple Deprivation 2007. Each quintile has 20% of wards in Cambridgeshire. Q1 shows the rate for the fifth of the most deprived wards in the county and Q5 the rate for the fifth of least deprived wards.

Deaths from circulatory disease and cancer make up 63% of all deaths in NHS Cambridgeshire.

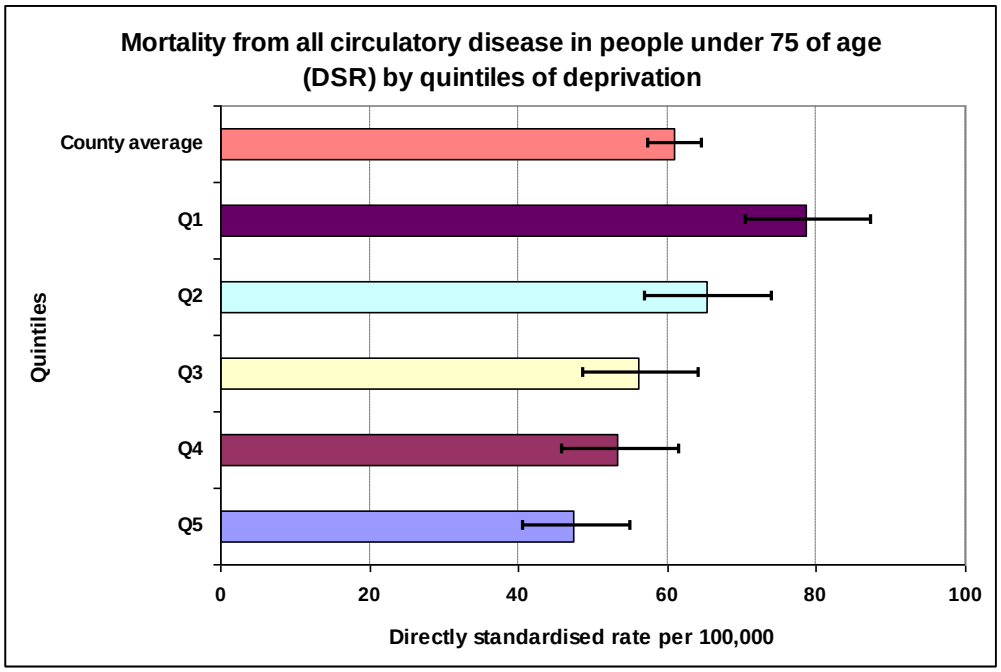
Figure 4: Mortality : main causes of death, total population, 2005-2007



Source: Clinical and Health Outcomes Knowledge Base.

The circulatory disease mortality rate in people aged under 75 years in the fifth of the most deprived LSOAs (Q1) in Cambridgeshire is statistically significantly high compared to the three least deprived LSOAs (Q3, Q4 and Q5) and the county average.

Figure 5: Mortality : circulatory disease, under 75 years (2006-2008) by quintile of deprivation (IMD 2007)



Source: ERPHO (2009).
Definition: Average mortality rate for circulatory disease in people aged under 75 years by quintiles based on the Index of Multiple Deprivation 2007. Each quintile has 20% of Cambridgeshire Lower Level Super output Areas (LSOAs). Q1 shows the rate for the fifth of the most deprived LSOAs in the county and Q5 the rate for the fifth of least deprived LSOAs.

Section 2: Key Findings of Each of the JSNAs

1. Children and Young People

1.1 Key Findings Summary

- Currently around 141,000 children and young people aged 0-19 live in the county, with Huntingdonshire currently having the largest such population[19]. On average there are around 7,000 in each single-year age group.
- Forecast growth in the population aged 0-19 in Cambridgeshire between 2008 and 2021 is 6% (8,250 children in total). The 0-19 population is forecast to fall by 14% in Huntingdonshire (5,620 children) and to rise by 42% in Cambridge City (10,590 children) and 15% in South Cambridgeshire (5,140 children)[20].
- On average, outcomes for children in Cambridgeshire are good. The children and young people identified in this JSNA as most at risk of not achieving their potential are:

    - Children and young people with lifestyle issues, eg obesity, smoking, sexual health.
    - Children and young people from areas of deprivation.
    - Children and young people in families where the adults have problems.
    - Vulnerable children and young people, eg those at risk of abuse, those with disabilities, those with mental health problems.

- In Cambridgeshire as a whole:
    - Around 8% of children in reception and 16% of children in Year 6 are obese[21].
    - Around one in six boys and one in five girls aged 14-15 smokes occasionally or regularly [22].
    - Nearly a quarter of Year 8 children had had an alcoholic drink in the last week and nearly a half of Year 10 children [23].
    - Around one in thirty seven girls aged 15-17 become pregnant each year, with the highest teenage pregnancy rates in Fenland, Cambridge City and Huntingdonshire [24].
    - Around 5% of young people aged 15-24 in Cambridgeshire screen positive for Chlamydia (a sexually transmitted infection) [25].

19 Cambridgeshire County Council Research Group, Mid-2008 population estimates by a single year age group.
20 Cambridgeshire County Council Research Group, Mid-2008 population forecasts.
21 National Childhood Measurement Programme 2008/9.
22 Health Related Behaviour Survey, Cambridgeshire 2008.
23 Health Related Behaviour Survey, Cambridgeshire 2008.
24 Office for National Statistics and Teenage Pregnancy Unit, Conceptions in females aged under 18 years 2005-2007 (provisional data).
25 NHS National Chlamydia Screening Programme, Vital Signs table 2008/09 based on data from 01 April – 30 June 2008.

- There are noticeably poor educational outcomes in Fenland, compared with other districts in Cambridgeshire. In general, the poorest educational outcomes and highest rates of unhealthy lifestyle behaviours are in areas of higher deprivation: Wisbech/ north Fenland, north Huntingdon, and parts of the north and east of Cambridge City[26]. There are also particularly poor outcomes for gypsy and Traveller children[27] and children in care.
- Around one child in 30 in Cambridgeshire is defined as a 'child in need' – for example through a physical and/or learning disability, neglect, risk of physical or sexual abuse, or through living with parents with specific problems. Just under 3,600 children (slightly below 3%) were referred to Social Care between April 2008 and March 2009. Rates were highest in the north of Huntingdon, Cambridge North (school locality), Wisbech and surrounding villages. Most referrals are for physical or sexual abuse; for carers with a relationship which places the child at risk; for child neglect and for issues around the child's behaviour[28].
- At the time of the 2001 Census 2001 over 1,250 children provided care. This is the equivalent to nearly 1 child per 90 dependent children, but the proportions were slightly higher in Fenland and Cambridge City[29].
- Currently 3.3% of pupils in Cambridgeshire schools have a statement of special educational need, rising to 9.4% with significant identified need (pupils in School Action Plus programme). Rates are highest in Wisbech, although numbers are high in Cambridge North and South (school localities) [30].
- On 31st March 2008 there were around 360 children subject to a Child Protection Plan in Cambridgeshire, equivalent to 0.29% of the county's child population. Rates were highest in Huntingdon, Cambridge North (school locality) and Wisbech. The highest CP rate was for children aged 0-4[31].
- In the same period there were 415 children in care of Cambridgeshire County Council (Looked After Children - LAC) with the highest rates in Huntingdon, Cambridge North, Wisbech, March and Chatteris. The highest LAC rate was for young people aged 15-17[32].

JSNA: Community Views - Children and Young People[33]

- Children and young people in Cambridgeshire describe themselves as living quite sedentary lives. They may not undertake enough physical activity, may have a poor diet and are often bored. Young people believe that this is because their leisure options are restricted.
- Young people in Cambridgeshire are aware that STIs exist and that the incorrect use of contraceptives could also lead to unwanted pregnancies. However, they believe that a more effective and timelier sexual health education could help decrease the incidence of diseases and unwanted pregnancies.

26 Cambridgeshire County Council, Children and Young People's Services.
27 Cambridge Sub-Regional Traveller Needs Assessment 2006.
28 Cambridgeshire County Council, NHS Cambridgeshire, Children & Young People Data Profile, November 2009.
29 2001 Census, theme table T01.
30 Cambridgeshire County Council, NHS Cambridgeshire, Children & Young People Data Profile, November 2009.
31 Ibid.
32 Ibid.
33 For full range of references see JSNA: Community Views.

- Mental health problems, mainly anxiety and stress, are often a result of bullying, disagreement and poor communication with parents or family and because of boredom.
- A poor physical environment at home can also increase children and young people's anxiety and stress.
- Smoking, drinking and consumption of substances are mainly caused by imitation and peer pressure. Anti-social behaviour is often linked to these activities.
- Minority groups such as Gypsy and Traveller children and young people describe themselves as being at risk of mental health problems and a decrease of their general well-being because of bullying and racism.

Introduction

All children have access to health services and education in order that they can attain the five Every Child Matters outcomes of being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well-being. Most children's needs are met by their family and by universally available education and health services. Some children, young people and families will, at times, have greater needs or have difficulty in accessing the services they need. This JSNA sought to identify those groups who are most likely to need additional services and support in order to achieve their potential.

Table 12: Children and young people most at risk of not achieving their potential

Group	Types of services needed
Children and young people with lifestyle issues, e.g. obesity, smoking, sexual health.	Services to meet individual needs* and provide supportive environments for prevention as well as treatment in the family, peer group and school settings.
Children and young people from areas of deprivation.	Services to meet individual and family needs* plus community development and regeneration.
Children and young people in families where the adults have problems.	Services to meet individual needs* plus adult/family services; GPs and Primary Care staff are key in identifying needs of children and other family members.
Vulnerable children and young people, e.g. those at risk of abuse, those with disabilities, those with mental health problems.	Services to meet individual needs*

*Each individual child and family's needs must be viewed and assessed holistically using the three domains of the Common Assessment Framework:

- the child;
- their parents and carers; and
- the family and the environment.

1.2 Key Facts: The Population

Currently some 141,000 children and young people aged 0-19 live in the county, with Huntingdonshire currently having the largest such population. On average there are around 7,000 in each single-year age group, although age groups of younger children are smaller following the drop in the birth rate during the 1990s. Numbers of young people aged 18 and above are inflated in Cambridge by students attending higher education institutions.

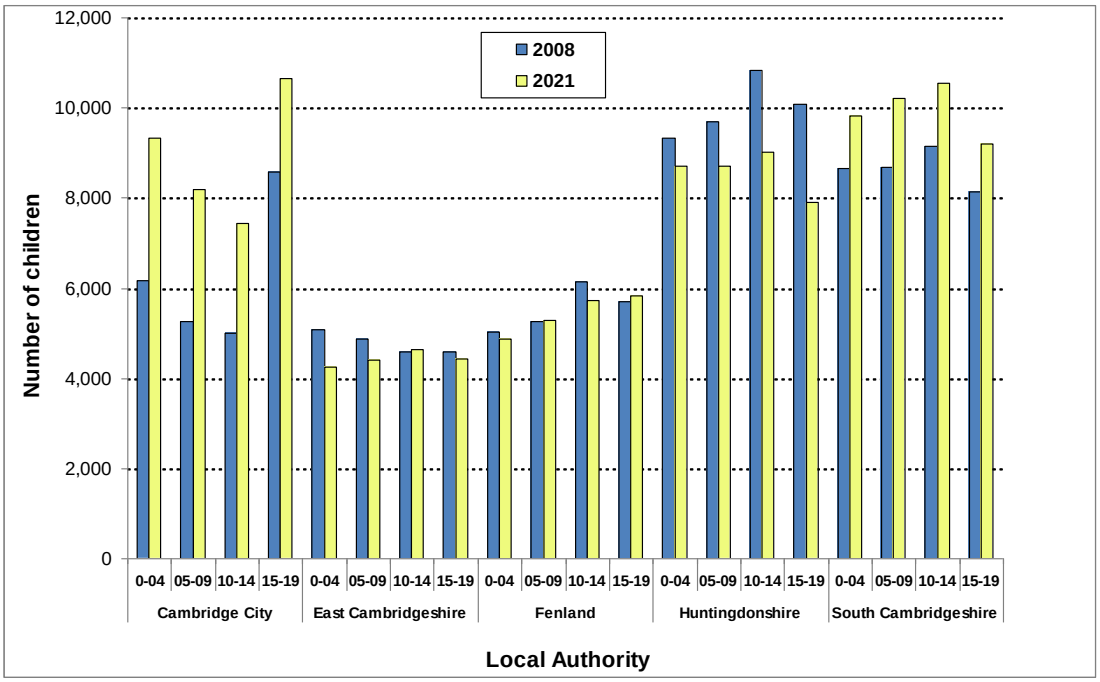
Table 13: Mid-2008 based population estimates by local authority and age-band, ages 0-19 years (CCC RG)

Local Authority	Age band				Total 0-19 population	Total population
	0-4	5-9	10-14	15-19		
Cambridge City (num)	6,170	5,260	5,010	8,580	25,020	117,660
Cambridge City (%)	5%	4%	4%	7%	21%	-
East Cambridgeshire (num)	5,080	4,880	4,590	4,590	19,140	79,380
East Cambridgeshire (%)	6%	6%	6%	6%	24%	-
Fenland (num)	5,030	5,270	6,150	5,690	22,140	92,860
Fenland (%)	5%	6%	7%	6%	24%	100%
Huntingdonshire (num)	9,340	9,690	10,830	10,070	39,930	163,210
Huntingdonshire (%)	6%	6%	7%	6%	24%	-
South Cambridgeshire (num)	8,660	8,670	9,150	8,140	34,620	142,550
South Cambridgeshire (%)	6%	6%	6%	6%	24%	-
Cambridgeshire (num)	34,280	33,770	35,730	37,070	140,851	595,650
Cambridgeshire (%)	6%	6%	6%	6%	24%	-

Source: Cambridgeshire County Council Research Group, Mid 2008 based single year population estimates

There is expected to be a 6% growth in the population aged 0-19 in Cambridgeshire between 2008 and 2021, but this growth is not spread evenly across the county. Some Districts are predicted to have a decrease: Huntingdonshire, which currently has the largest child population, is facing the greatest decrease with a fall of 14% predicted in the population aged 0-19, while Cambridge City should see the largest increase with a forecast rise of 42% and South Cambridgeshire a 15% rise. There are also decreases between 2008 and 2021, but to a smaller extent, in East Cambridgeshire and Fenland districts.

Figure 6: Population forecasts, number of children by age band, 2008 to 2021



Source: Cambridgeshire County Council Research Group, Mid-2008 population forecasts for 0-19s in Cambridgeshire

1.3 Existing Needs and Inequalities

Lifestyle Issues

Lifestyle issues such as smoking can impact on the health and achievement of children, young people and later as adults.

In Cambridgeshire, 8% of Reception pupils and 16% of Year 6 pupils are obese**:** this increases their risk of serious health problems in childhood and as adults, can cause psychological distress, impacts on confidence and self-esteem, and can lead to isolation and depression, affecting their educational attainment. Breast feeding reduces not only the risk of a child becoming obese, but also the risk of infections, hospital admissions and other health problems.

Balancing a healthy diet with increased physical activity is key to preventing and combating obesity. 60% of Year 8 and 54% of Year 10 pupils in Cambridgeshire reported that they exercise hard at least 3 times a week in 2008.

Around one in six boys and one in five girls aged 14-15 smoke occasionally or regularly. Smoking in the household and during pregnancy can harm children increasing the risk of low birth weight, Sudden Infant Death, hospital admissions and asthma.

Alcohol misuse in young people, with binge drinking in particular, is a major contributor to antisocial and criminal behaviour, accidents and unplanned pregnancy, with evidence that early drinking increases risk of alcohol dependence. Britain has amongst the highest percentage of children consuming alcohol in the world.

Cambridgeshire has a relatively low proportion of young people in treatment for substance misuse compared with the East of England. The highest primary problematic substance is cannabis. Substance misuse appears to be higher among children with a mental disorder. There is increasing evidence of risk of serious mental illness associated with cannabis use in susceptible individuals.

Around 290 under 18-year olds become pregnant every year (around one in 37 girls in the 15-17 age group). The teenage conception rate is highest in Fenland, Cambridge City and Huntingdonshire. The children of teenage parents have higher rates of infant mortality, are more likely to be born prematurely and have a higher rate of admission to Accident and Emergency Departments. In the longer term, more children of teenage mothers experience lower educational attainment, are at higher risk of unemployment as adults, and are more likely to be teenage parents themselves.

Research nationally has shown that more than a quarter of young people are sexually active before they reach 16. Chlamydia is the most common sexually transmitted infection (STI), and can lead to pelvic infections and infertility. Between 1995 and 2004 the rate of Chlamydia in young people (aged 16-24 years) has more than trebled nationally. Uptake of our screening programme is low, as in the rest of England and in 2007 around 6% of those tested were positive.

Areas of Deprivation

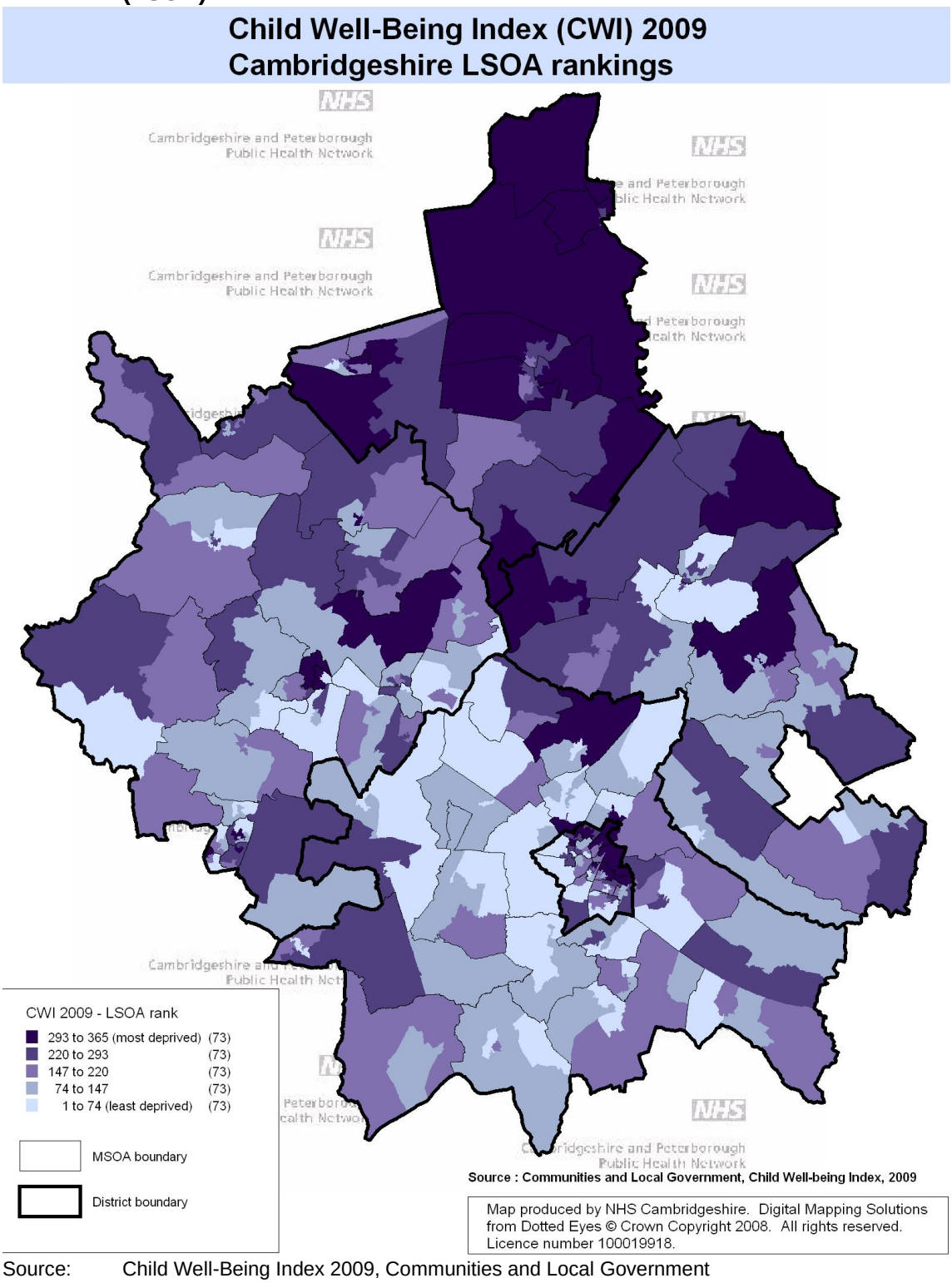
Children and young people living in the most deprived of wards in Cambridgeshire on average are:

- more likely to have a low birth-weight, which can be associated with other health problems;
- more likely to have poor educational achievement, which is associated with poorer lifetime health and economic achievement;
- more likely to be admitted to hospital as an emergency, particularly for respiratory or gastrointestinal illness.

Clear links with socio-economic deprivation are seen for the majority of indicators of child health. Poverty has an adverse effect on the health, development and lifestyles of children. Children from lower socio-economic groups, born in the year 2000, have shown signs of falling behind their more advantaged peers by the age of three.

The greatest areas of deprivation are in north Fenland, north Huntingdon and the north east of Cambridge City. These have both the highest scores within Cambridgeshire on the Child Well Being Index 2009 (CWI 2009) as shown on Map 1, and the highest rates of eligibility for free school meals. However, there are other areas of Cambridgeshire with significant pockets of deprivation.

Map 1: Child Well Being Index 2009 (CWI 2009) by Lower Super Output Area (LSOA)



Source: Child Well-Being Index 2009, Communities and Local Government

Educational attainment has long been linked to health outcomes: people with lower levels of educational attainment have poorer adult health. Education can directly affect an individual's employment prospects as well as influencing their ability to make informed healthy choices about how they lead their lives. These all have an impact on the health and well-being of not only the individual but also their family.

In Fenland, 52% of pupils attain five or more GCSE grades A* - C, compared to a county average of 65% and over 77% in South Cambridgeshire (see Section 1, Table 11 for more detail).

Levels of young people 'Not in Employment, Education or Training' (NEET) are highest in Fenland and Cambridge City. Teenagers who are NEET are most at risk of being unemployed, in ill health, unqualified, a parent, at the age of 21.

Parents With Problems

It is estimated that mental health problems affects one in four people at some point in their lives and, therefore, many children will grow up with a parent who, at some point, will have a mental health problem. A few children live with a parent who has a severe mental illness such as schizophrenia or manic-depressive illness. Many more children live with a parent who has a long-term problem, such as alcohol or drug dependency, personality disorder or long-standing depression. Adult mental health problems are associated with poor outcomes for their children if not addressed.

Children suffer the effects of domestic violence in a number of different ways. These include impact on their behaviour and emotional well-being and effects on their cognitive abilities and attitudes. Generally, children witnessing domestic violence have significantly more frequent behavioural and emotional problems than children who are not in these abusive environments. There is a strong link between domestic violence and the incidence of child abuse.

Parental alcohol and drug misuse can have multiple impacts on the foetus and child. The adverse consequences for children are typically multiple and cumulative and include failure to thrive; blood-borne virus infections; a wide range of emotional, cognitive, behavioural and other psychological problems; early substance misuse and offending behaviour and poor educational attainment.

Many parents with physical health problems or disabilities are able to support their children provided they have access to additional services when needed. For those who cannot access the support they need, roles may be reversed and the child or young person may take on the caring role. In 2001, over 1,250 dependent children aged 0-18 in Cambridgeshire provided some care for a person with physical or mental health problems who could be a family member, neighbour or friend. This equates to nearly one child per 90 dependent children, with more children providing higher hours of care in Fenland and Huntingdonshire.

Vulnerable Children and Young People

All children are vulnerable to some extent as they are dependent on the adults who care for them as they undergo rapid physical, mental and social development. However there are circumstances that can make a child more vulnerable and can affect their development and the chances they have for a happy, fulfilled life.

'Children in need' are defined as those in need of additional services in order to attain a reasonable standard of health and development. Just under 3,600 children (slightly below 3%) were referred to Social Care between April 2008 and March 2009. Rates were highest in Huntingdon, Cambridge North (school locality), Wisbech and surrounding villages. Most referrals were for physical or sexual abuse; for carers with a relationship which places the child at risk; for child neglect and for issues around the child's behaviour.

On 31st March 2008 there were around 360 children subject to a Child Protection Plan in Cambridgeshire, equivalent to 0.29% of the county's child population. The highest rates were in Huntingdon, Cambridge North and Wisbech. The highest CP rate was for children aged 0-4. In the same period there were 415 children in care of Cambridgeshire County Council (Looked After Children - LAC) – the highest rates in Huntingdon, Cambridge North (school locality), Wisbech, March and Chatteris. The highest LAC rate was for young people aged 15-17. These children are most at risk of having poor educational outcomes, at risk of becoming young offenders and teenage parents, and vulnerable to mental health problems.

Across the county, currently 3.3% of pupils have a statement of special educational need, rising to 9.4% including children with significant educational needs (pupils in School Action Plus programme). Rates are highest in Wisbech, although numbers are high in Cambridge North and South (school localities). The majority of these have moderate or specific learning difficulties, behaviour, emotional and social difficulties or speech, language and communication needs.

From national prevalence information, around 3,500 children in Cambridgeshire could have some form of disability. The lack of a disability register and robust information on children with disabilities makes accurate numbers of children with more severe and complex needs difficult to source. The new computer system being installed at the County Council will help. There are currently 104 children receiving respite care, but details of their care packages and type of disability cannot currently be extracted easily for analysis.

Again, vulnerable children often experience multiple issues, e.g. the frequency of mental ill health in children increases with severity of intellectual impairment and it is estimated that up to 50% of children with a learning disability are likely to need special services for emotional/mental health problems at some time during their childhood. Between 5 and 15% of people with learning disabilities also have challenging behavior and many experience being bullied.

There are other groups of vulnerable children identified in the Children's National Services Framework as 'Children in Special Circumstances'. These include: children who suffer from sexual exploitation; excluded from school or truanting; young people in prison; homeless children. Currently, we do not have robust data for these groups in Cambridgeshire, but we know that they are at risk.

1.4 Relevant LAA Indicators

NI 51: Effectiveness of child and adolescent mental health services.
NI 54: Services for disabled children.
NI 56: Obesity among primary school children in Year 6.
NI 70: Hospital admissions caused by unintentional and deliberate injuries to children and young people.
N 110: Young people's participation in positive activities.
NI 111: First time entrants to the criminal justice system.
NI 112: Under 18 conception rate.
NI 148: Care leavers in employment, education, or training.
NI 198: Children travelling to school (mode of travel used).
NI 69: Children who have experienced bullying (local indicator).
NI 115: Substance misuse by younger people (local indicator).

The sixteen statutory LAA targets for educational attainment:

2. Adults of Working Age

2a Key Findings Summary

- It is estimated that there are almost 392,350 people of working age living in Cambridgeshire, approximately two-thirds of the total population[34]. Between 2008 and 2021 the working age population in Cambridgeshire is forecast to increase by slightly above 7% (28,000 people in total)[35]. The largest increase of around one quarter is expected in Cambridge City. East Cambridgeshire and Huntingdonshire are expected to see a decline in working age population over the same time period.
- Median household income for Cambridgeshire is £31,900 which is above the national median of £29,100. But in Fenland median income is lower at £26,900[36]. Fenland also has a noticeably higher proportion of the population without qualifications, as do other areas with higher deprivation scores within the county[37].
- In Cambridgeshire at any one time, there are an estimated 10,000 people with work related ill health[38]. It is estimated that musculoskeletal disorders, stress and respiratory conditions account for over 80% of prevalent cases nationally. Fenland has the highest reported rate in the county for injuries in the workplace[39].
- Cambridgeshire, as whole, has a well below national average proportion of incapacity benefit claimants, but the proportion in Fenland is above average[40]. Figures from the 2001 Census showed that a higher proportion of working age Fenland residents described themselves as having 'limiting long term illness' or 'not good health' than the county average[41].
- Poor housing is known to be linked to ill health. At the 2001 Census Cambridge City had the highest number of properties that fail to meet the decent homes standard although this could be associated with student accommodation[42]. Lack of affordable housing and geographical barriers to accessing services are also significant issues for the county[43].
- Road traffic deaths rates are significantly above the national average for residents of Cambridgeshire, notably in the rural districts[44]. 68% of those killed or seriously injured are males, with the peak age being 17 [45].

- Information on the prevalence of health and lifestyle behaviours in Cambridgeshire is limited. Synthetic estimates from the Office for National Statistics (2005)[46], East of England Health and Lifestyle Survey (2008)[47], and other sources indicate that:

34 Cambridgeshire County Council Research Group, Mid-2008 population estimates (buy a single year age group)
35 Cambridgeshire County Council Research Group, Mid-2008 population forecasts
36 CACI, Paycheck 2008
37 2001 Census
38 Health and Safety Local Authority profiles based on Labour Force Survey, October 2007
39 HSE, Provisional data for 2007/8 : Injuries and rates of injuries to employees by country, government office region, county and local authority as reported to all enforcing authorities (2009)
40 NOMIS, Benefit data (February 2009)
41 2001 Census
42 2001 Census
43 DCLG, The English Indices of Deprivation 2007, Barriers to Housing and Services
44 Compendium of Clinical and Health Indicators, 2005/7 data
45 Cambridgeshire County Council Joint Road Casualty Data Report 2008
46 Office for National Statistics, Synthetic estimates of healthy lifestyle behaviours 2005
47 2008 East of England Lifestyle Survey conducted by Ipsos MORI between 29/10/2008 and 21/12/2008 on a sample of 26,290 people (a telephone survey).

- Smoking prevalence in the county is slightly below the national average, but there are high rates in some areas associated with socio-economic deprivation. A significant inequality exists between the 20% most deprived and the 80% least deprived areas in the county in smoking prevalence in the East of England Health and Lifestyle Survey.
- Estimated obesity rates are 29% in Fenland compared with a national average of 22%. A significant inequality exists in the county between the 20% most deprived and the 80% least deprived areas for both males and females in terms of obesity. Participation in physical activity in Fenland is noticeably lower than the national average[48].
- Estimated prevalence of consumption of five or more fruit or vegetables per day ranges from 40% in Newnham ward, Cambridge to 12% in Waterlees ward, Wisbech. A significant inequality exists in the county between the 20% most deprived and the 80% least deprived areas in estimated prevalence of consumption of five fruits or vegetables 5-7 times a week.
- Cambridge City has the highest estimated rates of binge drinking in the county, and has rates of alcohol specific and alcohol related hospital admissions[49] which are significantly above the national average. Prescriptions for drug misuse are also higher in Cambridge[50].
- There has been an increase in the number of people living with HIV in Cambridgeshire over the past few years. There has also been an increase in diagnoses of Chlamydia[51].

- There are on average 727 deaths a year of people aged between 16 and 64 years in Cambridgeshire, 80% of whom are aged 45-64 years. Deaths from injury (particularly road traffic deaths) followed by self-harm are the most common causes of death in 16-44 year olds, whilst cancers and circulatory disease are the most common causes amongst 45-64 year olds. Death rates amongst 16-64 year olds in Fenland are significantly higher than the Cambridgeshire average[52].
- External causes such as injury are the most common specific cause of emergency hospital admission for adults aged 16-44. Ischaemic heart disease is the most common specific cause of emergency admission for 45-64 year olds[53].

  The views of Adults of working age are reflected in the broad quality of life surveys reported in section 1. However JSNA phase 1 identified Gypsies and Travellers as a group on which further work should be undertaken. The views of Gypsies and Travellers form part of JSNA 2 and are therefore summarised here.

JSNA: Community Views - Gypsies and Travellers[54]

- The main reported health problems among Gypsies and Travellers are anxiety and depression, respiratory problems, chest pain, arthritis and possibly back problems.
- Smoking rates are high among Gypsy and Traveller communities and poor nutrition is common, including lack of knowledge of nutrition.

48 Active People Survey; Sport England 2005/6 data, published 2007.
49 North West Public Health Observatory, Local Alcohol Profiles for England 2009.
50 Epact, Anglia Support Partnership (April – September 2009).
51 KC60 statistics, Health Protection Agency.
52 Annual Extract of Deaths, Vital Statistics, National Statistics. 2006/8 data.
53 Admitted Patient Care Commissioning Data Set, Anglia Support Partnership 2007/8.
54 For full references see JSNA: Community Views.

- Lack of secure accommodation with basic amenities is the most commonly identified factor relating to the main health problems. General site safety and disabled access are further concerns.
- Gypsy and Traveller children may experience racism and bullying from other pupils and low expectation from teachers.
- There are a number of cultural and practical factors leading to low-take up of primary health care by Gypsies and Travellers. Their favoured option is culturally sensitive outreach services such as health visitors.

Introduction

There is now substantial evidence that preventive interventions can make significant improvements to the health of the adult population, decrease health inequalities and effectively address health and social problems.

Inequalities in health outcomes are widely documented and persistent between the socially disadvantaged and affluent sections of the population, males and females and people from different ethnic groups. There are wide variations in health status reflecting the multiple problems of material disadvantage facing some communities. These begin at conception and continue through working and into old age.

Preventing ill health and improving health should occur throughout the life course. We know that the health of people of working age can be influenced by the workplace environment.

The "Commissioning Framework for Health and Well being" published in 2007 states that "persuading local decision makers to shift investment patterns to earlier targeted interventions that promote health, independence and well-being" is a priority. This is an acknowledgement that core NHS and social care investment has traditionally concentrated on commissioning treatments for people with ill health and the highest level of need, with intervention being at the point of crisis.

2b Key Facts: The Population

It is estimated that there are almost 392,350 people of working age living in Cambridgeshire, approximately two-thirds of the total population.

Table 14: Working age population, 16-64 years, mid 2008 (CCCRG)

Local Authority	Age bands (years)				% of total population
	16-24	25-34	40-64	Total 16-64	
Cambridge City	27,080	29,660	29,580	86,320	73.4%
East Cambridgeshire	7,850	14,650	28,160	50,660	63.8%
Fenland	8,980	16,580	31,490	57,050	61.4%
Huntingdonshire	17,170	30,760	59,220	107,150	65.7%
South Cambridgeshire	13,600	26,440	51,130	91,170	64.0%
Cambridgeshire	74,680	118,090	199,580	392,350	65.9%

Source: Mid-2008 population estimates by age groups and districts in Cambridgeshire

The Cambridgeshire County Council Research Group predict that between 2008 and 2021 the working age population in Cambridgeshire will increase by slightly above 7% (around 28,000 people in total). The largest actual and proportional increase is expected in Cambridge City, with a 25% increase in the working age population by 2021.

Table 15: Working age population forecasts, 16-64 years (CCCRG mid 2008)

Local Authority	Year				% change 2008 to 2021
	2008	2011	2016	2021	
Cambridge City	86,320	92,170	102,570	108,230	25.4%
East Cambridgeshire	50,660	50,520	49,170	48,650	-4.0%
Fenland	57,050	58,280	58,600	59,640	4.5%
Huntingdonshire	107,150	109,630	106,030	103,480	-3.4%
South Cambridgeshire	91,170	89,520	95,740	100,360	10.1%
Cambridgeshire	392,210	400,000	412,010	420,250	7.1%

Source: Mid-2008 population forecasts by working age population (2001-2021) Cambridgeshire County Council Research Group (2009)

Cambridge City has a higher proportion of people from a non-white ethnic group than the England average, with the main difference being in 'Chinese and other ethnic group'. Cambridge City also has a noticeably lower proportion of White British and higher proportion of Other White population when compared to England and the average for Cambridgeshire. The minority ethnic groups in Cambridge include a high proportion of students and professionals. The other Cambridgeshire districts have relatively low proportions of residents from a non-white ethnic group.

Table 16: Ethnicity of working age population (16-64 years males, 16-59 years females), mid-2007

Ethnicity	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire	England
White	82.0%	93.9%	95.3%	93.6%	92.9%	91.1%	87.1%
British	69.3%	85.8%	92.0%	87.1%	87.0%	83.5%	81.8%
Irish	1.3%	0.8%	0.6%	0.8%	1.0%	0.9%	1.0%
Other White	11.4%	7.3%	2.8%	5.8%	4.9%	6.7%	4.3%
Mixed	2.2%	1.2%	0.9%	1.2%	1.1%	1.3%	1.4%
Asian	6.6%	1.6%	1.7%	2.2%	2.4%	3.1%	6.3%
Indian	3.7%	0.8%	0.7%	1.1%	1.2%	1.6%	3.0%
Pakistani	1.0%	0.4%	0.4%	0.6%	0.5%	0.6%	1.8%
Bangladeshi	0.9%	0.2%	0.2%	0.2%	0.2%	0.4%	0.7%
Other Asian	1.0%	0.2%	0.4%	0.3%	0.5%	0.5%	0.8%
Black	2.9%	1.2%	0.9%	1.6%	1.5%	1.8%	3.1%
Caribbean	0.9%	0.4%	0.4%	0.5%	0.6%	0.6%	1.3%
African	1.7%	0.6%	0.6%	0.7%	0.8%	0.9%	1.6%
Other Black	0.2%	0.2%	0.0%	0.5%	0.1%	0.3%	0.2%
Chinese or Other Ethnic Group	6.4%	2.0%	0.9%	1.3%	2.1%	2.7%	2.0%
Total population	**87,400**	**49,200**	**53,500**	**105,300**	**84,100**	**379,500**	**31,791,700**

Source: ONS experimental population estimates by ethnic group mid-2007 (published 2009)

The Traveller population is a significant group within Cambridgeshire representing approximately 1% of the population. The county has the largest number of Travellers in the UK. Within the county, Fenland has around 51%, South Cambridgeshire 24% East Cambridgeshire 19%; and the other two districts 3% each of the Traveller population.

An assessment of Traveller's health needs was undertaken in 2006 in East Cambridgeshire and Fenland. This study drew on the Cambridge sub-region Traveller Needs Assessment and included a literature review and interviews with local stakeholders.

The literature review demonstrated that Travellers experience a wide variety of health problems compared to the general population, including lower life expectancy. Building on the health needs assessment in East Cambridgeshire and Fenland; a Health Strategy for Travellers in Cambridgeshire has been developed by a health sub group of the County Travellers Co-ordination Group. The strategy is based on recognising the wider determinants of health such as accommodation and education, empowering communities and breaking down barriers to discrimination.

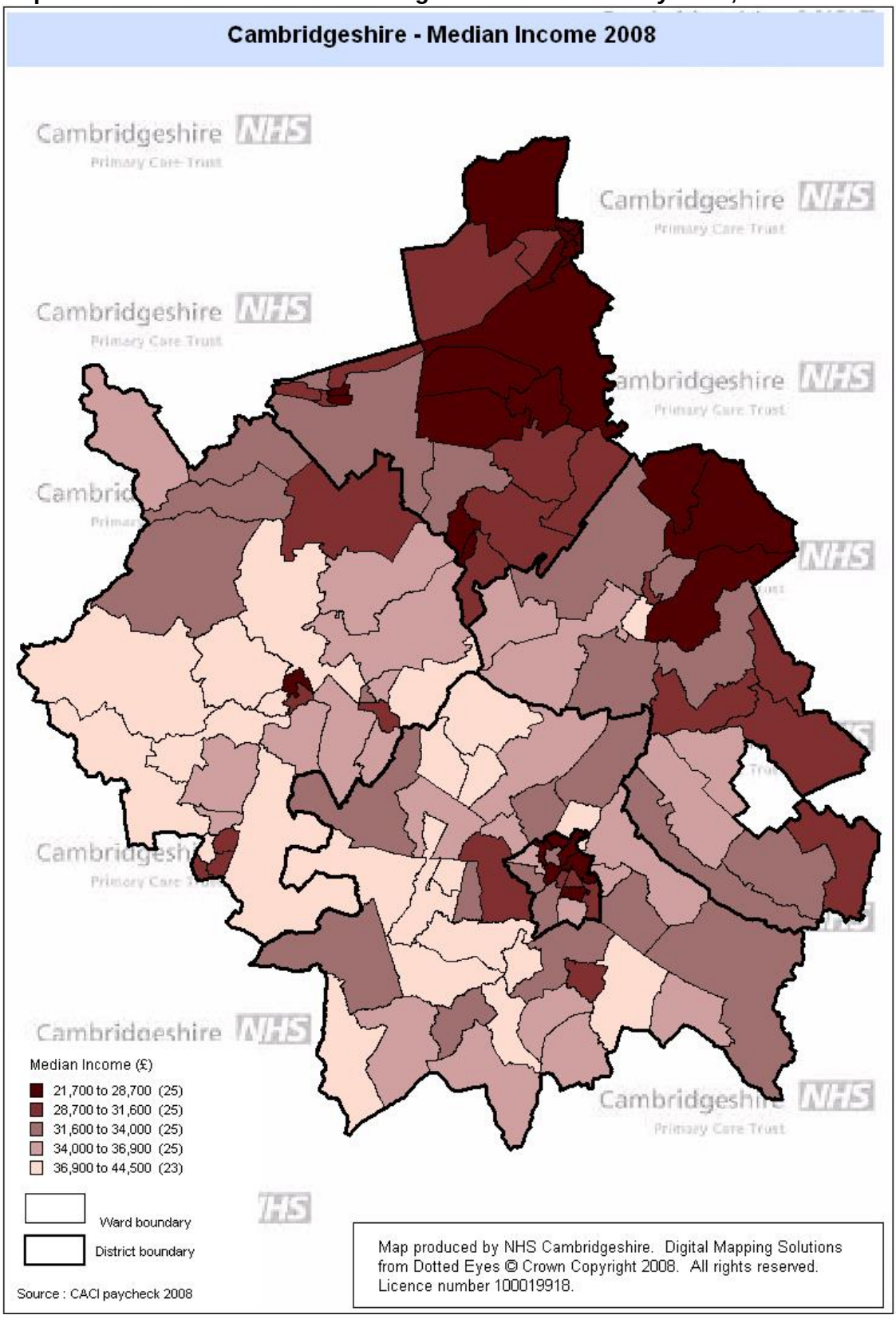
The migrant worker population is made up of several groups of people who do not speak English as their first language and who may have moved into Cambridgeshire, particularly into the Fenland area, over the last few years. These are mainly seasonal workers (not classed as migrants), asylum seekers and refugees, undocumented migrants and economic migrants. A report on the impact of demographic change, including an assessment of the scale of the migrant worker population is being carried out and will be reported when available.

Household Income

South Cambridgeshire has the highest median income in Cambridgeshire at £35,400 and Fenland the lowest at £26,900. The median for England was £29,100.

The map below shows median income by household in Cambridgeshire wards. As can be seen, households on the lowest median income are concentrated in the north of Fenland, East Cambridgeshire, parts of Huntingdonshire and the north-east of Cambridge City.

Map 2: Median income of Cambridgeshire households by ward, 2008



Workplace Health

Indicators of the effect on the health and well-being of the working population are important in identifying potential areas for preventative interventions. It is estimated that musculoskeletal disorders, stress and respiratory conditions account for over 80% of prevalent cases nationally. It is estimated that at any one point in time there are almost 10,000 people who have self-reported work-related ill health in Cambridgeshire. The prevalence of self-reported work-related ill health is lower in the East of England (3.44%) than the national average (3.93%), as is the incidence (1.51% compared to 1.64% respectively).

Table 17: Self-reported work-related ill health, 2005/06

Estimated numbers in 2006	Prevalence - limited to people who worked in the last 12 months	Incidence (new cases in the last 12 months)
Cambridge	1,900	800
East Cambridgeshire	1,300	600
Fenland	1,300	600
Huntingdonshire	2,900	1,300
South Cambridgeshire	2,400	1,100
Cambridgeshire	9,800	4,400

Source: Health and Safety Local Authority profiles, October 2007 – based on Labour Force Survey

Benefits

As Section 1 has already illustrated, deprivation varies greatly across the county, with Fenland, north-east Cambridge and areas within Huntington having the highest levels of relative deprivation. A small selection of other measures linked to health and deprivation outlined below confirm this pattern.

In February 2009, there were nearly 37,000 benefit claimants in working age people (16-64 for males, 16-59 for females) in Cambridgeshire. Fenland has by far the highest key benefit claimant count in Cambridgeshire and is slightly higher than the England average.

In February 2009, there were nearly 15,000 Incapacity Benefit (IB) or Severe Disablement Allowance (SDA) working age claimants in Cambridgeshire. Fenland has the highest rate of such claimants, as can be seen in the Table below, and the rate is higher than the England average.

Table 18: People of working age claiming Incapacity benefit (IB) or Severe Disablement Allowance (SDA), Local Authority, February 2009

Area	Recipients of IB / SDA	Working age population	Rate per 1,000
Cambridge	3,260	89,900	36.3
East Cambridgeshire	1,660	49,600	33.5
Fenland	3,790	53,300	71.1
Huntingdonshire	3,640	105,600	34.5
South Cambridgeshire	2,480	84,800	29.2
Cambridgeshire	14,830	383,200	38.7
England	**1,969,360**	**31,937,600**	**61.7**

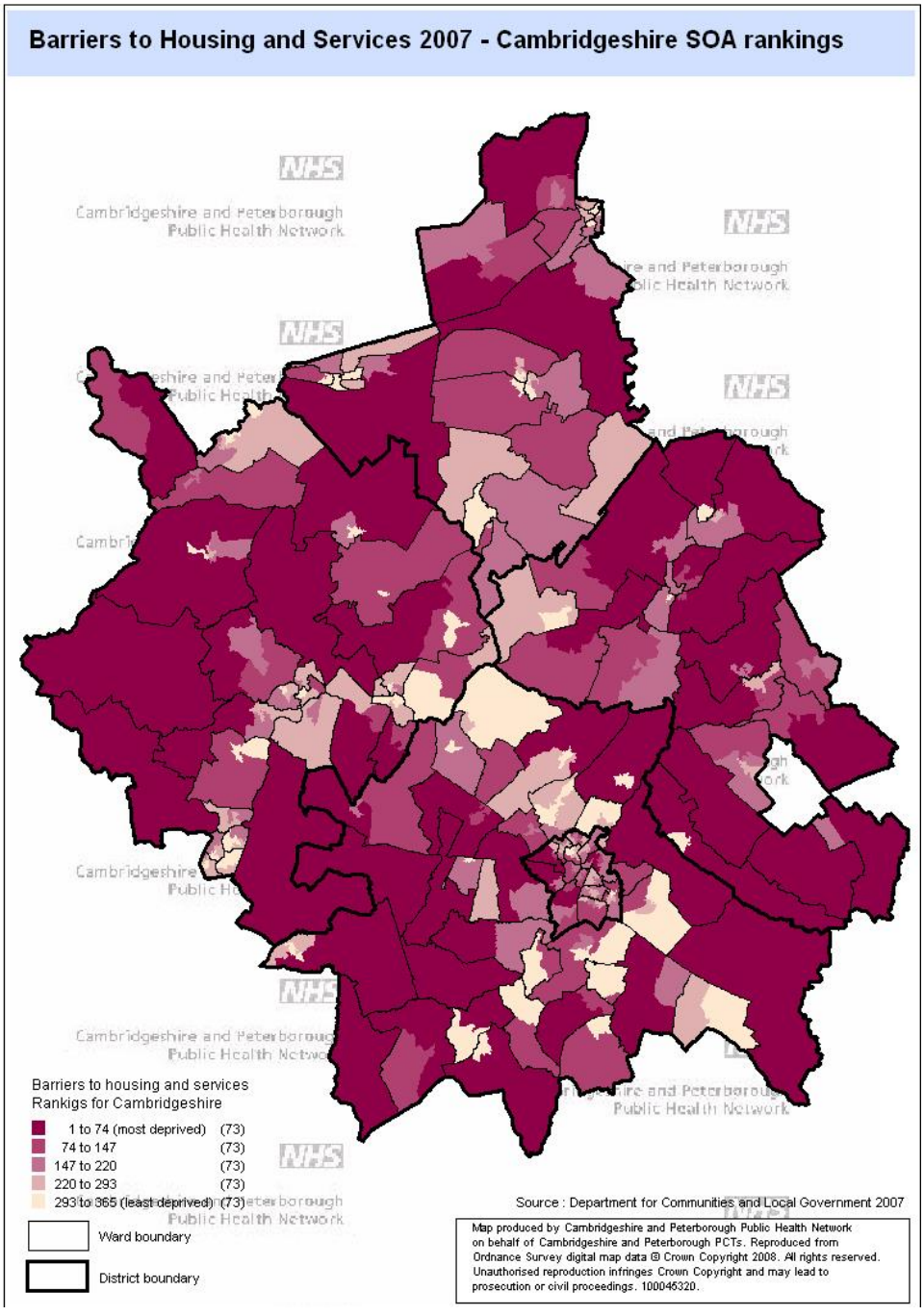
Source: NOMIS, Claimant count February 2009, ONS Mid-2008 population estimates

Housing and Services

The Barriers to housing and services domain is included in the Index of Multiple Deprivation 2007. This domain looks at geographical barriers such as road distance to GP surgery, general store or supermarket, primary school and post office and wider barriers such as household overcrowding, homeless provision applications and difficulty to access to owner-occupation.

As can be seen, the majority of Cambridgeshire is relatively deprived for this indicator. This would be expected given the rural nature of most of Cambridgeshire.

Map 3: Barriers to housing and services deprivation, 2007



Air Quality

In Cambridgeshire, the working age population are likely to be most susceptible to the effects of poor air quality, as they will be most mobile population in the county. The areas that have been designated as Air Quality Management Areas, i.e. where statutory UK air quality standards are not being met, or are expected to be breached, are mainly concentrated along the A14 or in urban areas. However, there are also other areas within the county. In Cambridgeshire, the majority of the Air Quality Management areas are for nitrogen dioxide (NO_2), but there are two in Fenland for sulphur dioxide (SO_2) and one for particulate matter (PM_{10}).

2c Existing Needs and Inequalities

Mortality

There are on average 727 deaths a year in people aged between 16 and 64 years in Cambridgeshire, 80% of whom are aged 45-64 years (3% aged 16-24 years and 17% 25-44 years).

Fenland has a working age mortality rate, which is statistically significantly higher than the Cambridgeshire average. Cambridge City has a statistically significantly lower rate than the county. Numbers are too small at ward level to complete meaningful analysis. National 2006-2008 mortality rates are yet to published in December this year, which will allow the local rates to be compared against the national ones.

Table 19: Mortality rates, 16-64 years, 2006-2008

Local Authority	Average annual deaths	Rate / 100,000	95% CI
Cambridge City	119	135.3	(122.0 - 150.1)
East Cambridgeshire	97	198.4	(176.9 - 222.4)
Fenland	153	287.9	(262.8 - 315.4)
Huntingdonshire	209	198.1	(183.2 - 214.2)
South Cambridgeshire	149	176.6	(161.0 - 193.8)
Cambridgeshire	727	191.5	(183.6 - 199.7)

Source: Annual Extract of Deaths, Vital Statistics, National Statistics.

Transport accidents were the main reason for mortality in people aged 16-24 years between 2003 and 2005, with 35% of total deaths in this age range. The next highest was for intentional self-harm with 10% of deaths.

In people aged 25-49 years, the highest cause of death was transport accidents, with almost 10% of all deaths in this age range between 2003 and 2005 – 9% of deaths were for ischaemic heart disease, 9% for intentional self-harm, 7% for breast cancer, 6% for cancer of the digestive organs and 5% for other external causes of accidental injury.

The main causes of death in people aged 50-64 were cancers and ischaemic heart disease. Ischaemic heart disease accounted for 17% of all deaths in this age range between 2003 and 2005 – 11% of deaths were for cancer of the digestive organs, 10% for respiratory and intrathoric organ cancer, 6% for breast cancer, 4% for cancers of the lymphoid, haematopoietic and related tissue and 4% for cerebrovascular disease.

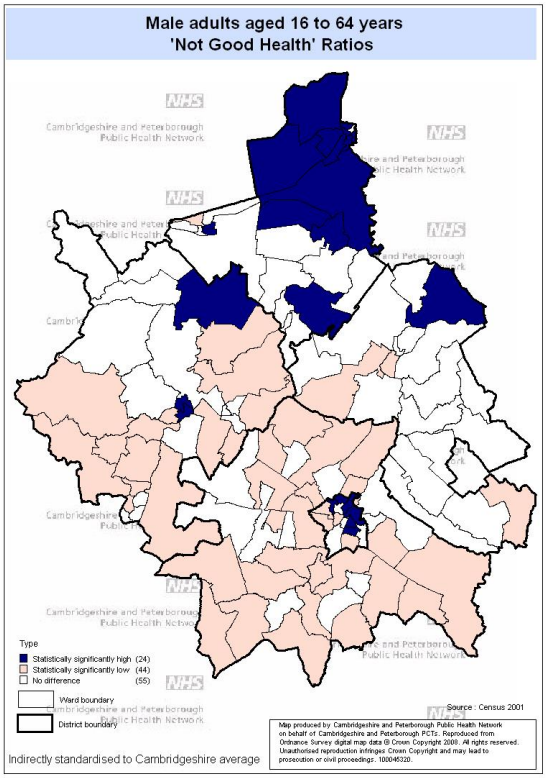
Morbidity

The north of Fenland and east of Cambridge City have higher rates of people reporting in the 2001 Census that they had a limiting long term illness. At district level, Fenland and Cambridge City had statistically significantly high ratios compared to the Cambridgeshire average, for both males and females. There appears to be a high correlation to deprivation.

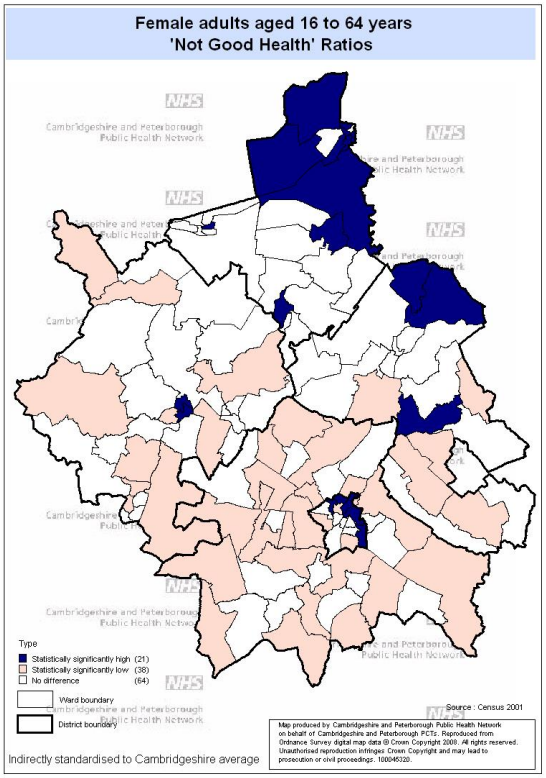
The standardised 'not good health' ratios for males and females show a similar pattern. These data are taken from the 2001 Census and compare the actual number of people reporting that they felt they were not in good health to that that would be expected given the size and structure of their population, compared to the Cambridgeshire average

Map 4: Standardised 'Not Good Health' ratios, 2001

Males, 16-64 years



Females, 16-64 years



Hospital Usage

Emergency Admissions

In 2007/08, there were 19,300 emergency hospital admissions for working age people living in Cambridgeshire, with higher rates in the older age band. The most common cause of admission for 16-44 year olds was 'injury, poisoning and certain other consequences of external causes', whilst amongst 45-64 year olds, the commonest cause was circulatory disease.

Elective Admissions

In 2007/08, there were over 50,500 elective hospital admissions for the working age population, with noticeably higher rates in the older age band. Diseases of the digestive system and the genitourinary system were the most common reason for elective admission for people aged 16-45 years. For people aged 45-64 years, diseases of the genitourinary system and neoplasms were the highest reason for elective admission.

Lifestyle

Physical Activity

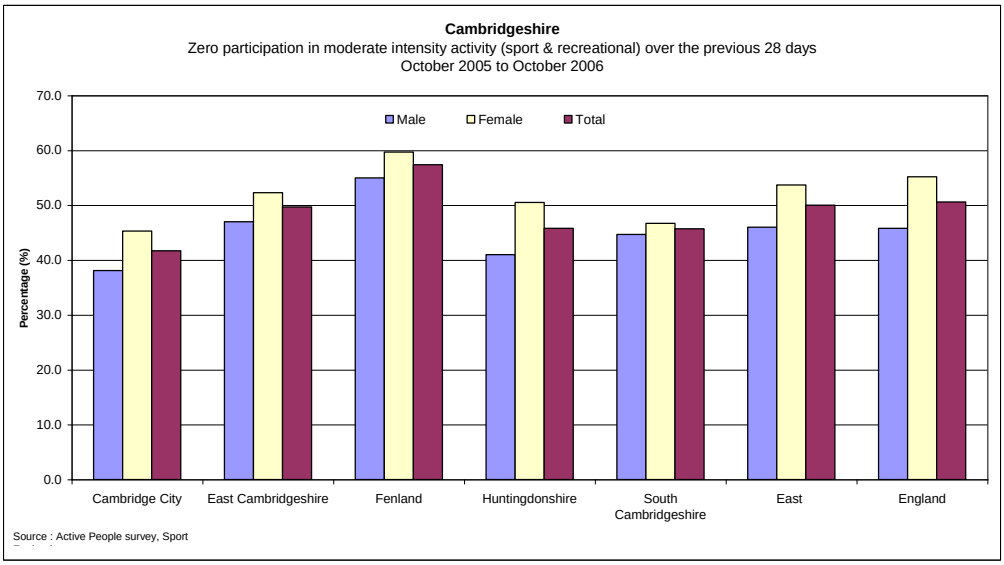
In July 2007, Sport England published the results of a national survey of adult participation in physical activity.

Levels of such participation on at least three occasions of 30 minutes per week over the previous 28 days are higher amongst males than females, with Cambridge City and Huntingdonshire having the highest levels. Fenland has noticeably lower levels compared to the other districts in the east and England.

Fenland has the highest levels of zero participation in moderate intensity activity across the county and compared to the East and England averages. Levels of non-participation are higher in females than males.

In all areas at least 40% of people had zero participation in moderate activity in the previous 28 days, with Fenland having the highest proportion.

Figure 7: Zero participation in moderate intensity activity over the previous 28 days



Levels of participation are highest in people from higher socio-economic groups. The levels of non-participation are similar between people from the higher and lower socio-economic groups in Fenland, but in all other districts non-participation is highest in the lower socio-economic groups.

Adult Consumption of Five or More Fruit and Vegetables

In general, areas with higher levels of deprivation tend to have lower levels of the recommended daily fruit and vegetable consumption.

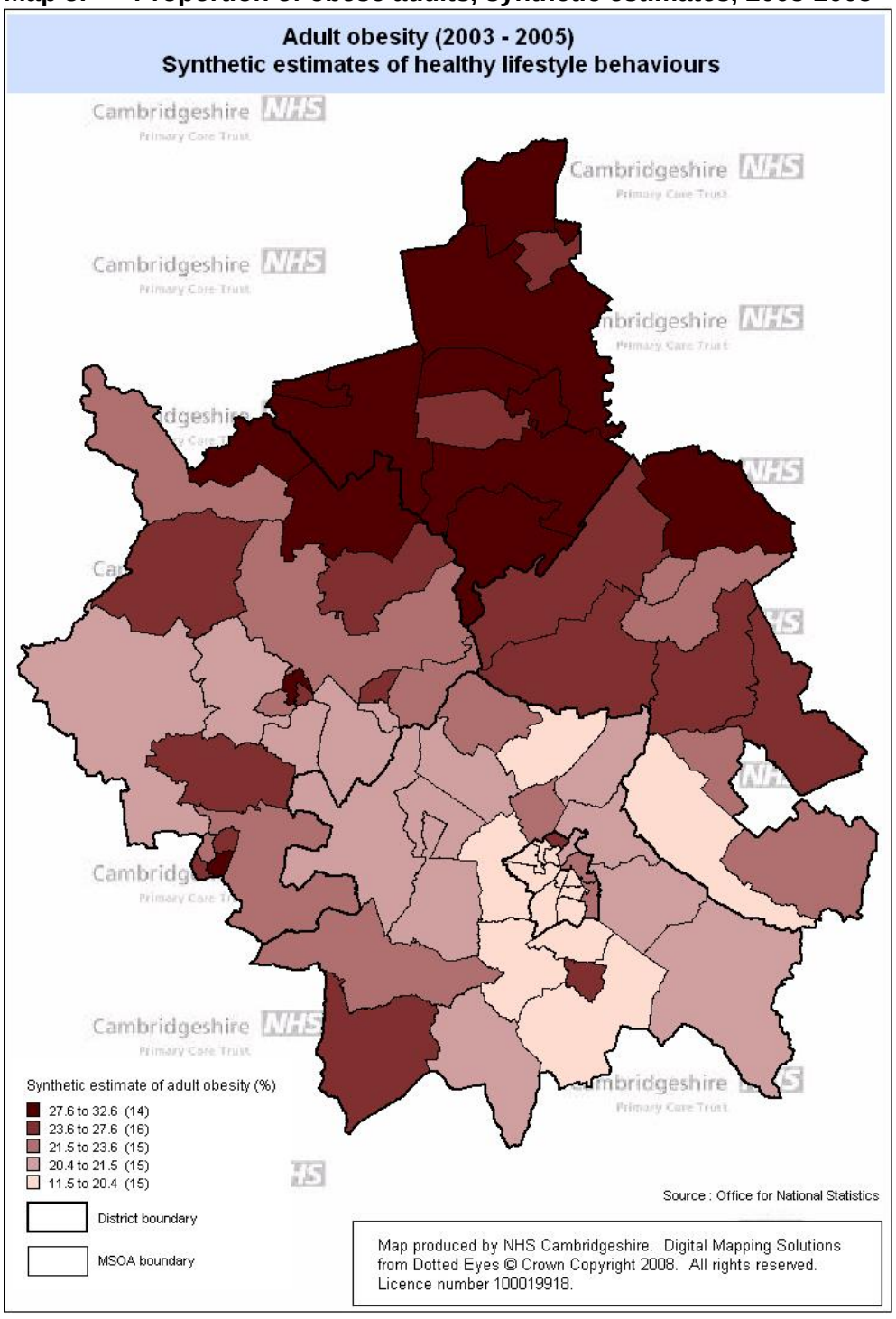
On average, just under a quarter (23.7%) of adults in England consume five or more portions of fruit and vegetables a day. In Cambridgeshire, it is estimated that Newnham in Cambridge City had the highest consumption at 39.5% and Waterlees in Fenland the lowest at 11.9%. A significant inequality exists between the 20% most deprived and the 80% least deprived in the county in the East of England Health and Lifestyle Survey.

Obesity

It is estimated that Fenland has the highest proportion of obese adults at 29%, which is significantly higher than the national average of 22%. Of the 123 wards in Cambridgeshire, Fenland had the top 18 wards with highest estimated prevalence of obese adults.

East Cambridgeshire had the second highest proportion at 21% and the remaining Cambridgeshire district rates were significantly lower than the national average. In the East of England Health and Lifestyle Survey a significant inequality exists between the 20% most deprived and the 80% least deprived areas in the county.

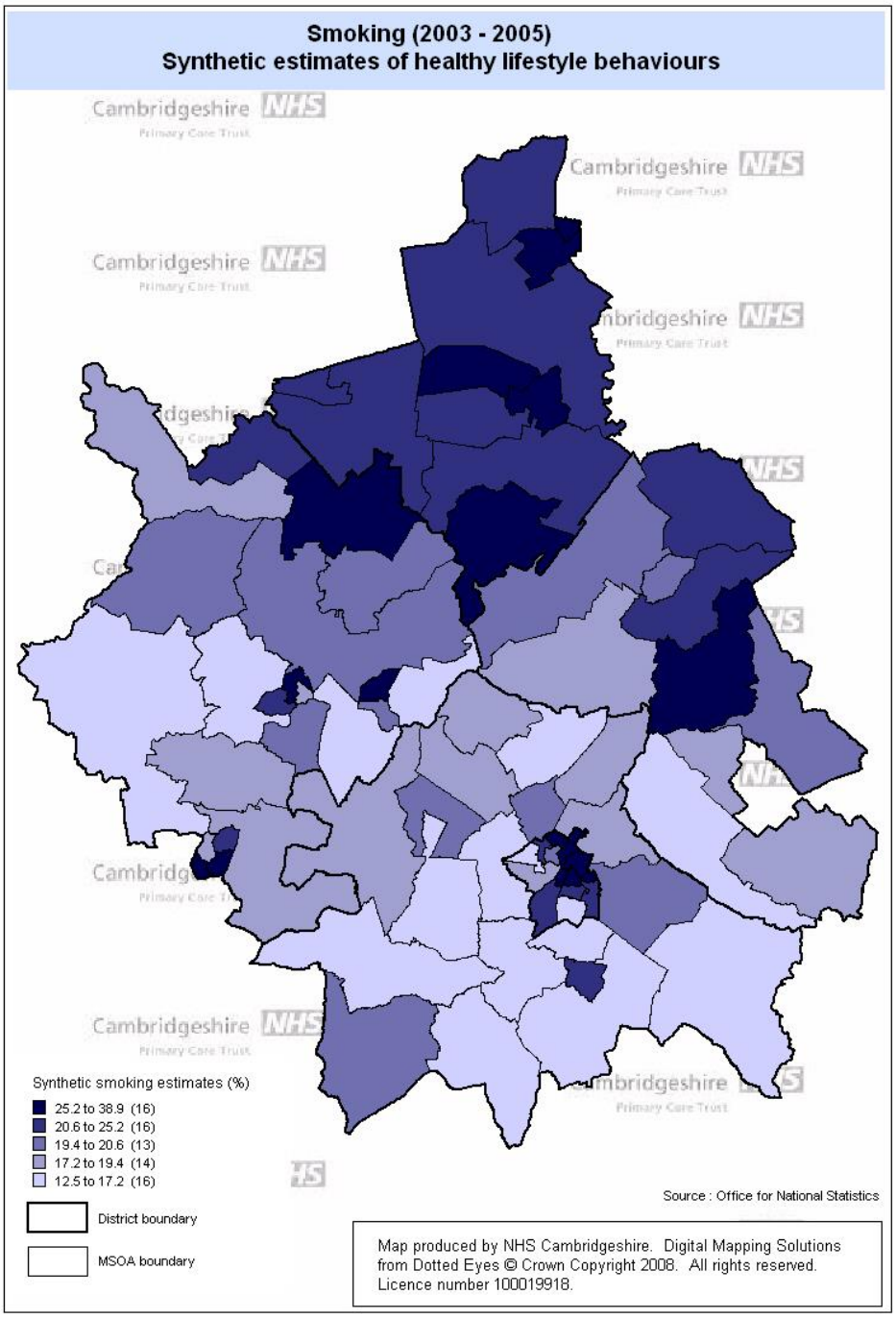
Map 5: Proportion of obese adults, synthetic estimates, 2003-2005



Smoking

Fenland, the North East of Cambridge, parts of Huntingdonshire and East Cambridgeshire have the highest estimated prevalence of smoking. The top five wards for estimated smoking prevalence are Waterlees (FE) at 40%, Huntingdon North (HU) at 38%, Kingsmoor (FE) at 36%, King's Hedges (CC) at 36% and Abbey (CC) at 35%. In England the average is 25.8%. In the East of England Health and Lifestyle Survey a significant inequality exists between the 20% most deprived and the 80% least deprived areas in the county.

Map 6: Estimated smoking prevalence, 2003-2005



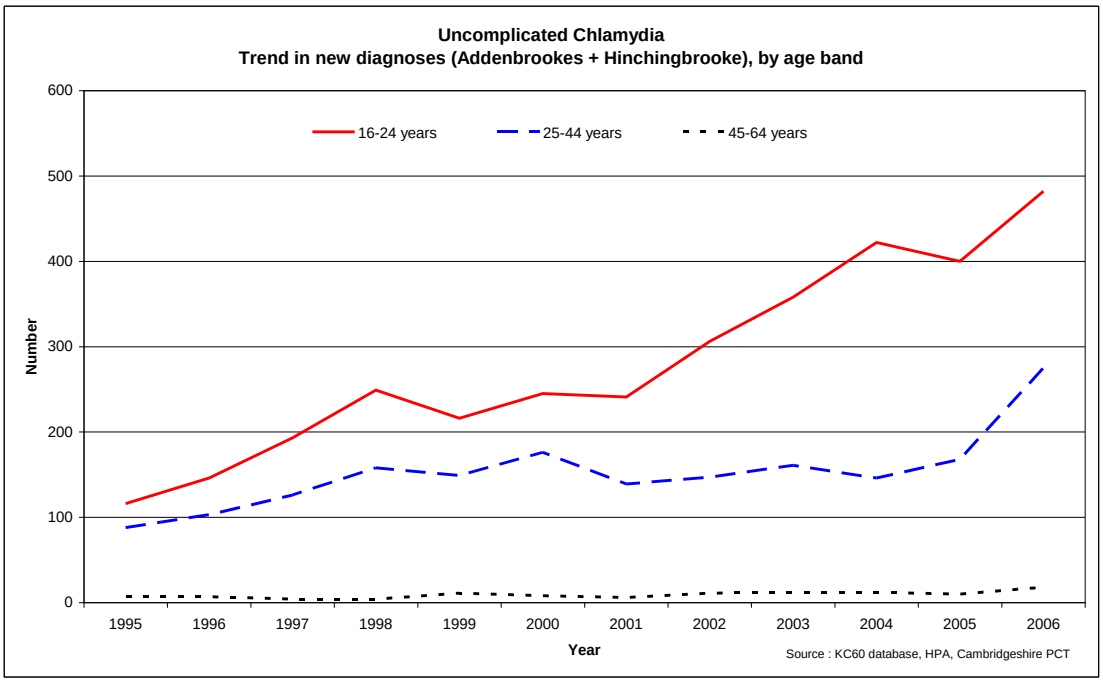
Sexual Health

By far the most commonly diagnosed sexually transmitted infection in the working age population is Chlamydia. In 2006 there were over 780 new cases of uncomplicated Chlamydia diagnosed in Cambridgeshire GUM Clinics (CUHFT and Hinchingbrooke), of which over 60% were in people aged between 16 and 24 years.

There has been a significant increase in new diagnoses of uncomplicated Chlamydia in people aged between 16 and 24 years since 1995.

Between 2002 and 2006 there has been an 87% increase in the number of people living with diagnosed HIV infections in NHS Cambridgeshire, from 145 people in 2002 to around 270 people in 2006. Between 2002 and 2005 there was a 4% decrease in the number of new presentations of HIV and AIDS diagnosed in the Cambridge University Hospitals NHS Foundation Trust and Hinchingbrooke Health Care NHS Trust GUM clinics.

Figure 8: Trend in new diagnoses of uncomplicated Chlamydia, CUHFT and Hinchingbrooke

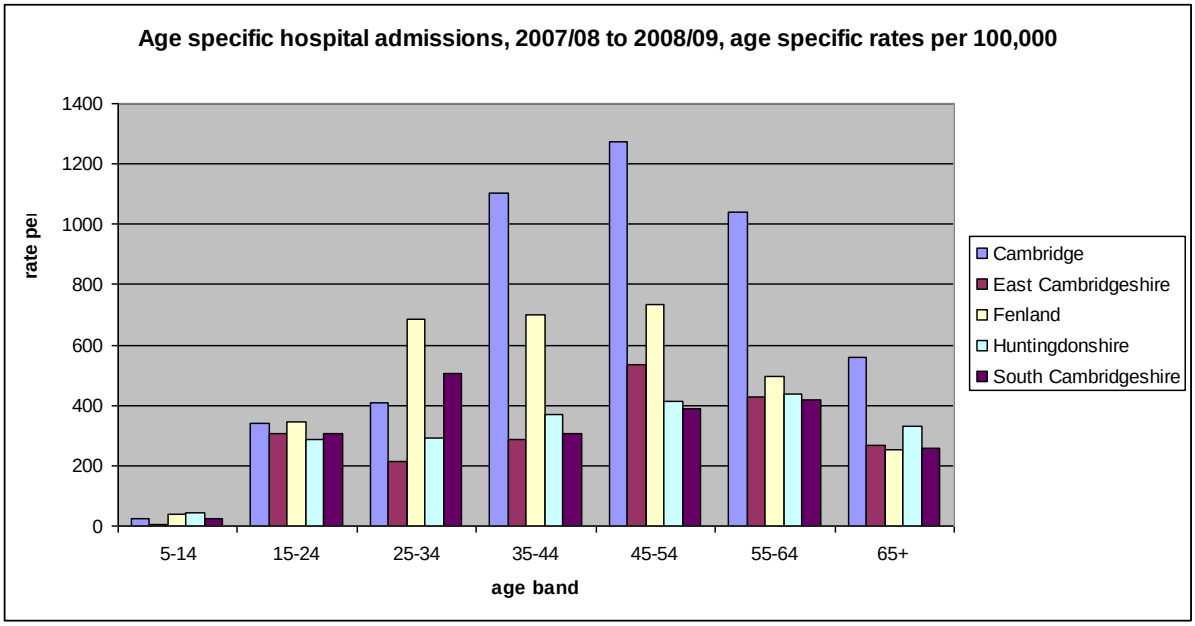


Alcohol

The amount of health issues due to alcohol varies throughout Cambridgeshire. Cambridge City appears to be the district with the most issues, followed by Fenland then Huntingdonshire[55]. Cambridge City is the only district in Cambridgeshire to have a statistically significantly high rate of alcohol specific hospital admissions for men and women and alcohol attributable hospital admissions for females compared to England. Fenland has significantly worse alcohol attributable hospital admissions for both men and women compared to England.

55 NWPHO Local Alcohol Profiles 2009 for England http://www.nwph.net/alcohol/lape/#

Figure 9: Alcohol-specific hospital admissions, age specific rates, 2007/08 – 2008/09



Source: Numerator: Admitted Patient Care Commissioning Data Set, Anglia Support Partnership
Denominator: ONS mid year population estimates 2007 and 2008.

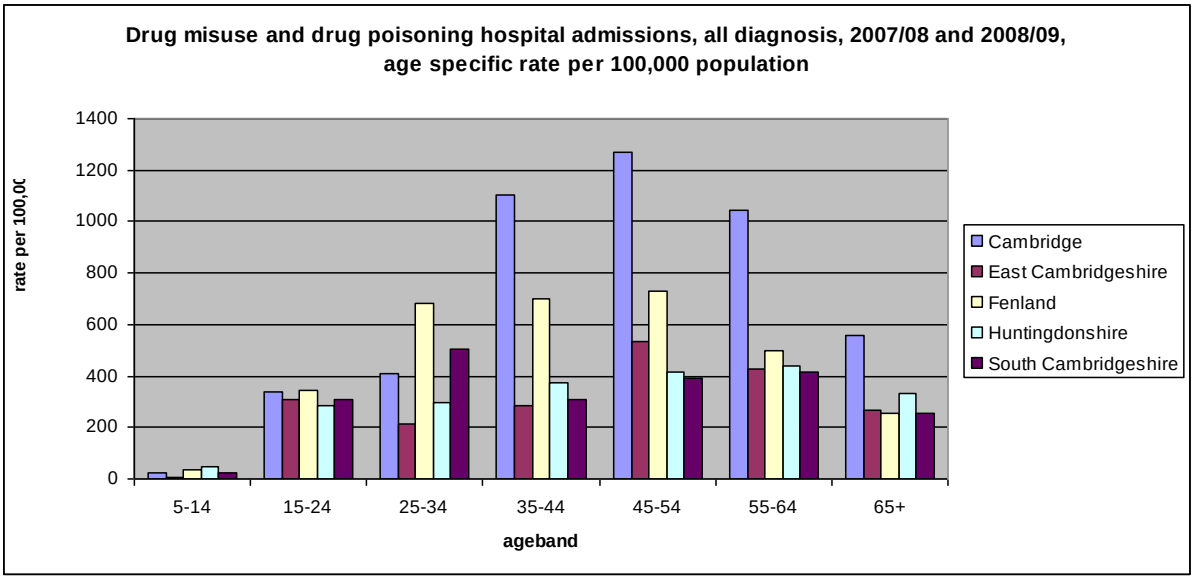
Drug Misuse

In mid 2006, it was estimated that almost 55,000 people aged between 16 and 59 years had used one or more illicit drug in the previous year and almost 18,000 of had used a Class A drug.

Cambridge City has statistically significantly high drug misuse and drug poisoning crude hospital admission rates compared to the Cambridgeshire rate[56].

[56] Admitted Patient Care Commissioning Data Set, Anglia Support Partnership

Figure 10: Drug misuse and drug poisoning hospital admissions, age specific rates, 2007/08 – 2008/09



Source: Numerator - Admitted Patient Care Commissioning Data Set, Anglia Support Partnership
Denominator – ONS mid year population estimates for 2007 and 2008

Road Traffic Accidents

Mortality rates for road traffic accidents are significantly higher than the national average for residents of Cambridgeshire, as a result of high rates in rural districts.

The following bullet points, and Figure 11 illustrate the main conclusions from the Joint Road Casualty Data Report 2008, relating to the adult working age population:

In Cambridgeshire the total number of accidents and casualties were 1,977 and 2,667 in 2008 respectively. Results refer to the area of Cambridgeshire and Peterborough.

- 68% of those killed or seriously injured are males. The peak age is 17.
- 54% of car driver casualties are male. The peak age is 18 – 19.
- 60% of car passenger casualties are female. For those aged over 50 this figure rises to 78%. The peak age is 17-18.
- 8% of all casualties and 19% of those killed and seriously injured are two-wheel motor vehicle riders or passengers. 29% of two-wheel motor vehicle user casualties are either killed or seriously injured, compared with 13% of other road users.
- 87% of two-wheel motor vehicle rider casualties are male. The peak age is 16-17.
- 12% of all casualties in Cambridgeshire and Peterborough are pedal cyclists. 46% of these are injured in Cambridge City, where pedal cycles were involved in 50% of all accidents last year.
- 45% of casualties in Cambridge are female, compared with 30% elsewhere.
- 60% of pedestrian casualties are male, and children between the ages of three and 16 account for 29% of the total.

Figure 11: People killed and seriously injured in Cambridgeshire and Peterborough by mode of travel (2006-2008 average)

2d Relevant LAA Indicators

NI 8: Adult participation in sport.
NI 17: Perceptions of anti-social behaviour.
NI 32: Repeat incidents of domestic violence.
NI 47: People killed or injured in road accidents.
NI 120: All age all cause mortality in the 20% most deprived areas in Cambridgeshire.
NI 123: 16+ current smoking prevalence.
NI 155: Number of affordable homes delivered (gross).
NI 152: Working age people on out of work benefits.
NI 163: Working age people qualified to at least level two or higher.

2.1 Adults with Mental Health Problems

2.1.1 Key Findings Summary

- If rates of mental health problems found in national surveys are applied to the Cambridgeshire population, it is estimated that in Cambridgeshire there are 9,000 - 35,000 people with anxiety states, 12,000-29,000 with depressive disorders, 600-3,000 people with schizophrenia, and 1,200 - 3,000 with affective psychosis[57]. The overall estimate for the number of people in Cambridgeshire with mental health problems if national average rates apply is around 64,000[58].
- This may be a slight overestimate, as Cambridgeshire is below the national average for mental health need as predicted by statistical indices[59] and for the proportion of the population on incapacity benefit for mental health problems[60]. The Cambridgeshire rate of suicides/undetermined deaths is lower than the national average, but the difference is not statistically significant[61].
- A population survey using the GHQ 12 questionnaire indicated that the Cambridgeshire prevalence of mental health problems was higher than national average but the difference was not statistically significant[62]. The proportion of people on GP registers recorded as having severe mental health problems managed in primary care in Cambridgeshire is at a national level (0.7%); the proportion in Cambridge City is higher than in the county (1,1%)[63].
- Most sources of information indicate that within the county, Fenland and Cambridge City have higher rates of mental health problems than the other districts.
- NHS Cambridgeshire' total spend on mental health services (indicated by spend per 100,000 unified weighted population) in 2007/08 was below the national and national average, and was at a similar level for its cluster of similar PCTs[64].
- The provision of mental health care for people from black and minority ethnic communities raises important and complex issues. Nationally, variations between ethnic groups in rates of various types of treatment and in particular of the use of compulsion of the Mental Health Act are the subject of debate.
- The population in prisons have complex mental health needs with up to 90% of all prisoners having a diagnosable mental health or substance misuse problem or both. Studies in our prisons show a high prevalence of personality and neurotic disorders, 64% and 40% respectively[65]. There are approximately 1,150 prison inmates in Cambridgeshire, all male.

57 Health of the Nation Mental Illness Key Area Handbook – 2nd Edition, 1994 and Mid 2006 population estimates, Cambridgeshire County Council Research Group.
58 Mental Health National Service Framework and Mid 2006 population estimates, Cambridgeshire County Council Research Group.
59 Regional Atlas for East of England, Mental Health Workbook 2007, The Mental Health Observatory at NEPHO.
60 NOMIS IB-SDA.
61 Compendium of Clinical and Health Indicators 2009 based on ONS mortality data (2005-07).
62 Compendium of Health and Clinical Indicators using General Household Survey data (2004-06).
63 Quality Outcomes Framework 2008/09.
64 National Programme Budgeting Atlas 2007/8. National Centre for Health Outcomes Development.
65 Health Needs Assessment in HMP Whitemoor and HMP Littlehey. Cambridgeshire PCT. (Personal Communication, 2008.)

- There is a developing evidence base for methods of promoting mental health amongst adults, which will be used locally in developing a mental health promotion strategy in 2008-09. There are close links between mental health and lifestyle, and people with mental health problems are much more likely to smoke[66] and to have raised alcohol consumption[67].
- Strong social networks are known to promote good mental health[68]. As new communities develop in Cambridgeshire, both through housing expansion in the south and west of the county, and through new workers migrating into all areas, it is important to understand how social networks are forming. This will be the subject of further joint strategic needs assessment work in 2008.

JSNA: Community Views - Adults with Mental Health Problems[69]

- In a patient survey carried out by the Healthcare Commission in 2008, local community mental health services scored in the top 20% nationally for patients finding talking therapy helpful, but in the lowest 20% nationally for some other indicators.
- There was positive feedback about the approach of community mental health services, including the non-judgemental and team approach taken and the provision of talking therapies.
- The care review process/pathway could be improved along with a clarity in roles.
- There are issues with understanding how to contact out of hours and other emergency support.
- Carers described unmet needs for care reviews, respite services and information on services for carers.
- There is general concern about the future provision of services.

Introduction

Mental health is fundamental to good health, well-being and quality of life. It impacts on how we think, feel, communicate and understand. It enables us to manage our lives successfully and live to our full potential.

The JSNA report for Mental Health in Cambridgeshire presents a wide range of data on the factors that can give rise to poor mental health, the mental health status of populations, provision of interventions of care for mental illness, service user experience and traditional outcomes such as suicide. The report also covers mental health promotion and data on the expenditure by the PCT on mental health disorders. The choice of indicators has been guided by key issues, recommendations and targets identified in a range of policies including the *National Service Framework* and *Choosing Health*.

66 Health Development Agency. Smoking and Patients with Mental Health Problems. HDA. 2004.
67 Association of Public Health Observatories. Indications of Public Health in the English Regions No. 7: Mental Health. APHO. 2007.
68 Social Epidemiology eds Berkman & Kawachi, pub. the Oxford University Press 2000.
69 For full references see the JSNA: Community views.

2.1.2 Key Facts: The Population

The mental health 'need' indices use population characteristics to predict the likelihood of people in that area to suffer from mental illness. For planning and evaluation of mental health care it is helpful to have quantitative estimates of the extent to which rates are likely to vary between parts of the county.

It is interesting to note that these indices show a relatively similar need for Cambridge and South Cambridgeshire (which are relatively less deprived) and East Cambridgeshire and Fenland (which are relatively more deprived). The need is predictably lower in Huntingdonshire.

The provision of mental health care for people from black and minority ethnic communities raises important and complex issues including linguistic and cultural competence. Variations between ethnic groups in rates of various types of treatment and in particular of the use of compulsion of the Mental Health Act have been the subject of considerable debate over the last two decades.

The population in prisons have complex mental health needs. In the local prisons there are about 700 inmates in HMP Littlehey and about 450 in HMP Whitemoor; all male. The prison population typically experiences poorer health than the general population; this is shown in the reporting of ill-health, such as a disproportionately higher incidence of mental health need and substance misuse compared to the general population. Up to 90% of all prisoners have a diagnosable mental health or substance misuse problem and commonly have both (a dual diagnosis). Studies in our prisons show a high prevalence of personality and neurotic disorders, 64% and 40% respectively. This translates to a heavy burden of illness, about 723 inmates with personality disorders and 452 with neurotic disorders in the two prisons.

2.1.3 Existing Needs and Inequalities

Psychiatric Disorder

The GHQ 12 is an epidemiological measure of population mental health, covering a wide range of behavioural and psychological functioning. A GHQ score of four or more indicates a possible psychiatric disorder.

The figures show that Cambridgeshire has about 13% of adults with a GHQ 12 score of four or more (2004-06). This is not statistically significantly higher than other counties in the East of England and is similar to that in England (15%).

Psychiatric Morbidity

Many people with mental health problems do not seek help for them. In order to identify the true extent of mental health problems in the community it is necessary to use the national prevalence figures and estimate the likely burden of illness in the local population. The mental health minimum data set has been recently released and will be able to provide information on the number of people accessing services for their illnesses.

Assuming national average rates of mental health problems, it is estimated that there are between 9,000 - 35,000 people with anxiety states in Cambridgeshire, 12,000-29,000 with depressive disorders, 600-3,000 people with schizophrenia, and 1,200 - 3,000 with affective psychosis.

For neurotic disorders, an estimated 37,640 people have mixed anxiety and depressive disorder in Cambridgeshire, 18,820 people have a generalised anxiety disorder, 11,120 have a depressive disorder, 7,700 have a phobia, 4,710 have an obsessive-compulsive disorder and 2,990 have a panic disorder.

Dementia

It is estimated that there are around 160 people with early onset dementia in Cambridgeshire in 2009[70]. Dementia is a term used to describe various brain disorders that have in common a loss of brain function that is usually progressive and eventually severe. This is an important indicator for planning and providing services.

Severe Mental Illness on GP Register

General Practices register patients who have severe mental health problems in the QOF register. According to the definition used by the national QOF dataset this indicator records only people who are registered with a GP, and who have agreed to treatment/follow up in primary care settings.

From the QOF registers, Cambridge City has an unadjusted prevalence rate of 1,1%, which is statistically significantly higher than that seen in other districts of Cambridgeshire. The unadjusted prevalence for Cambridgeshire as a whole is 0.7%.

Suicides and Injury Undetermined

National targets for reduction in suicides have been in place since *The Health of the Nation* in the early 1990s. While reducing the death rate from suicide is worthwhile, and there is good evidence of preventability in many cases, it has more controversially been used as an indicator of the quality of mental health services. Though useful as an easily quantified measure, the relationship between mental health and suicide is complex with many other societal factors playing an important role. There are effective interventions in mental health services such as reducing in-service user risks and improving the follow-up of recently discharged service users, but only about a quarter of people who commit suicide have been in contact with services in the preceding year.

Overall, Cambridgeshire has a lower directly age-standardised rate than England and Wales for suicide and injury undetermined for 2005-07, but the difference from the E&W rate is not statistically significant. The rate for Cambridgeshire is 7.59 per 100,000, and that for England & Wales is 7.97 per 100,000. It is 7.89 per 100,000 for England. However, there is considerable variation across the county, with Cambridge City having the highest rate at 11.59 per 100,000 and South Cambridgeshire the lowest at 4.45 per 100,000.

[70] Projecting Adult Needs and Service Information System, 2009.

Social Infrastructure and Mental Health

There will be major new housing developments and new communities being formed in Cambridgeshire over the period to 2021 and beyond. The population forecasts show that the biggest growth is predicted in South Cambridgeshire and Cambridge City.

Planning for communities' health and well-being goes beyond designing buildings, facilities and services but also has to take into account the social infrastructure which contributes to the quality of life and well-being of the population. Studies have identified the need to put in place mechanisms for building social capital and for community support in order to create a sense of belonging for people. It will be necessary to ensure people (new and existing communities) are informed and involved and supported in decision making in order to create cohesive, healthy communities. This is a core foundation block in building a healthy environment and must be given equal weight with the physical environment.

Local discussions have highlighted the need to ensure that for both new and existing communities, measures of social cohesion are agreed and built into routine monitoring indicators. It also recommends that these should be regularly reviewed with the local community as partners as part of a continuous improvement programme.

Promotion of Mental Health and Well-being

Mental Health Promotion is a positive approach and involves any action to promote mental health and well-being. This involves strengthening individuals and communities, and reducing barriers to mental health. At each of these levels it involves strengthening *protective* factors for mental health (e.g. social support, good physical health) and reducing *risk factors* (e.g. unemployment, violence).

Mental health promotion has a wide range of health and social benefits including improving physical health (a holistic approach to health care), increasing emotional resilience, increasing emotional literacy, promoting social inclusion/participation and challenging stigma and discrimination. It also has a key role to play in service delivery.

NICE has published evidence on the effectiveness of public health interventions related to MHP for adults. This includes areas around the workplace, primary care, physical activity, older people, carers, parenting and the mass media. Additional areas identified from the evidence base include: children and young people and work in schools supporting people with mental health problems, tackling violence and arts and health.

The Department of Health has published New Horizons; a Shared Vision for Mental Health (December 2009) which will build on the previous 10 year National Service Framework for Mental Health. New Horizons has twin aims:

- improve the mental health and well-being of the population;
- improve the quality and accessibility of services for people with poor mental health.

A public mental health approach (i.e. the prevention of mental ill health and promotion of mental health and well-being) links the twin aims. To take forward this approach, a summary framework "Flourishing people, Connected Communities" will be published in early 2010 as a guide for local Strategic Partnerships and other local partners. A full report of the Framework and review of the supporting evidence will be published in Spring 2010.

New Horizons Framework to be reviewed on publication in Spring 2010 to consider how this will inform a strategic approach to promoting mental health and wellbeing in Cambridgeshire[71].

Risk and Protective Factors and Determinants

Many of the risk factors for mental illness are linked to deprivation. Given the evidence that adults and children from disadvantaged backgrounds are more likely to suffer mental health disorders, measures of deprivation can help to identify areas where the need for mental health services is likely to be greatest, thus ensuring that mental health service provision is targeted appropriately.

There is considerable evidence to support the beneficial effects of employment on an individual's mental health. Employment can protect a person's mental health by boosting confidence and self-esteem; unemployment can be both a consequence and cause of mental health problems. Employment is thought to play an important role in rehabilitation. People suffering from mental health problems who are not in employment are thought to be less likely to recover from their illness.

Incapacity benefit is a social security benefit, which can be claimed by working age adults unable to work because of illness, and this report looks at those with a diagnosis in the mental and behavioural disorders category. Numbers claiming Incapacity Benefits are significantly lower in Cambridgeshire (around 150 per 10,000 population) as compared to England (around 250 per 10,000 population). However, within Cambridgeshire these are substantially higher in Cambridge City and Fenland (between 187 - 250 per 10,000 population).

Poor quality of life through physical illness is closely related to mental health problems. People with mental health problems are up to twice as likely to report experiencing a long-term illness or disability; over two-thirds of people with a persistent mental health problem also have a long-term physical complaint.

There is a fairly consistent pattern across the county, with residents being more likely to have a limiting long-term illness or to perceive their health to be poor in wards to the north of the county particularly in and around Wisbech, North Huntingdon, and in parts of Cambridge City. The pattern of poor health, as measured by the Census, is broadly similar to the pattern of deprivation as measured by the Index of Multiple Deprivation.

[71] NHS Cambridgeshire, Public Health Directorate

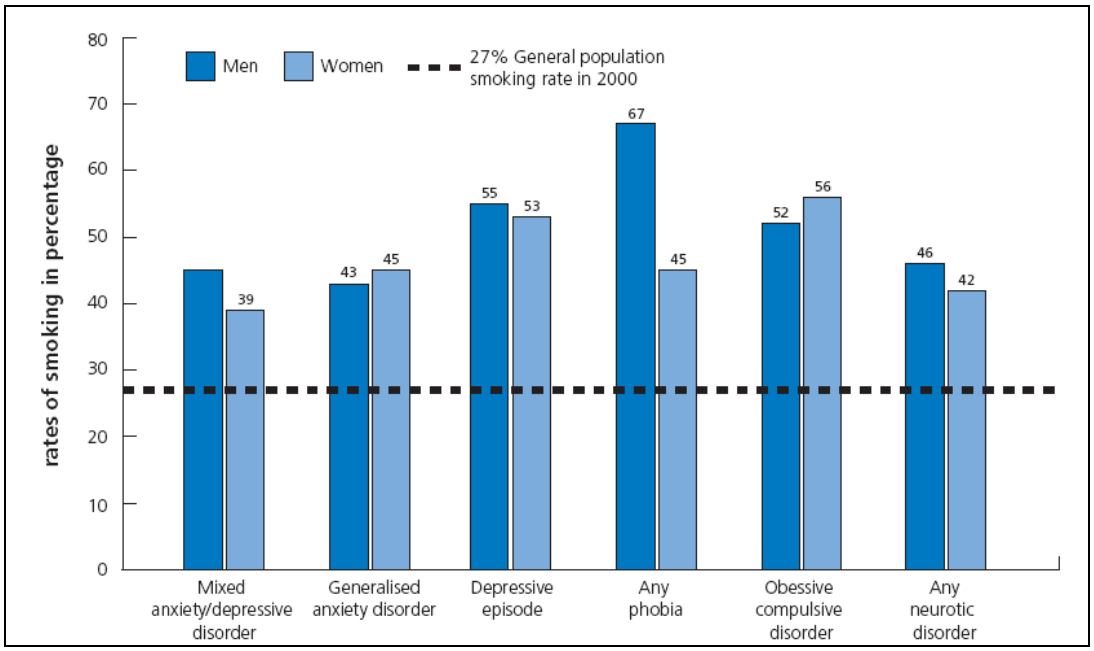
Education has significant bearing upon employment and social inclusion, both of which impact upon mental health. There is an extensive literature on the mental health benefits of learning**,** which may include both personal growth and development and the value of participation in learning opportunities. Improved health outcomes may relate to increases in human capital, (knowledge and skills), social capital (trust and dependency) and identity capital (positive self-image, assertiveness and confidence). Participation in adult learning, therefore, does not narrow the gap between those who did and did not flourish at school, but if appropriate provision is available at the right time, it may play an important role in promoting healthy lifestyles, well-being and mental health.

Healthy Living

There is robust evidence for the impact of physical activity on mental health: as a treatment or therapy for existing mental health problems; to improve the quality of life of people with mental health problems; to prevent the onset of mental health problems; and to improve the mental well-being of the general population. While it is too early to state definitively the links between diet and mental health or ill-health, there is sufficient evidence to suggest that nutrition may have an important part to play, and that the essential fatty acids (especially omega-3) may be particularly significant. Anti-oxidants and minerals in fruit and vegetables may also be relevant.

Smoking rates are much higher among people with mental health problems than among the general population. The Figure below shows that rates of smoking are much higher than the general population and in some cases twice that of the general population. Smoking rates are higher in people with phobias and depressive illnesses, and relatively lower in neurotic illnesses.

Figure 12: Smoking rates by mental health problem



Source: Health Development Agency (2004) Smoking and Patients with Mental Health Problems.

In addition, we know that over 70% of mental health inpatients with psychotic illness smoke.

Smoking exacerbates stress, anxiety and sleep disorders – all of which will be detrimental to most mental health conditions. Smoking has a serious impact on the physical and financial well-being of smokers with mental health problems and smoking-related diseases are more prominent among mental health patients than in the general population. This along with the physical health inequality that exists for people with mental health problems shows the necessity to tackle smoking in this at-risk population. Many smokers with mental health problems want to stop smoking, but do not receive the advice and support they need to do so. Good evidence exists that smokers with mental health problems can be helped to stop smoking.

Evidence suggests an association between increased alcohol consumption and mental ill health. Alcohol consumption can be a cause of mental ill health, or a resulting factor. Less than 1% of the general population were classified as being moderately or severely dependent on alcohol, this increased to 2% in people with neurotic disorders, 5% among those with phobias and 6% among those with two or more neurotic disorders. Alcohol dependence is often treated within mental health services.

Alcohol is responsible for much psychiatric co-morbidity – with chronic heavy drinkers likely to suffer from depression, anxiety, and/or more serious cognitive impairment and psychosis.

Programme Budgeting Analysis

Programme budgeting is a technique that enables personnel in a health service, and those who use the health service, to identify how much money has been invested in major health programmes, with a view to influencing future investment.

The analysis can be used within programmes of care or across services and programmes within a health organisation. The technique provides users with the capacity to identify:

- Where resources are currently being invested.
- The level of effectiveness of those investments.
- The most effective way of investing in health services in future in relation to the needs of the population for which services are being commissioned.

Programme budgeting expenditure data for the financial year 2007-08 published by the Department of Health was analysed for the specific programme budget category (number 5) on Mental Health Disorders. This specific programme analysis shows how the pattern of the PCT's expenditure compares with the average for that of England and the average for that of PCTs in the same cluster.

The findings from this programme budgeting analysis raise a variety of questions for further analysis.

NHS Cambridgeshire spending for Mental Health Disorders in 2007/08 was £13,580,337 per 100,000 population (adjusted for need) and the PCT was ranked 146 out of 152 PCTs in England. The adjusted spend was slightly below national and regional averages, and was at a similar level for its cluster of similar PCTs .

NHS Cambridgeshire spending for Mental Health Disorders programme and its sub-programmes in 2007/08 per 100,000 population (adjusted for need) was as follows:

Table 20: NHS Cambridgeshire expenditure / 100,000 population on mental health disorders in 2007/08

Programme Budgeting Category		Spend (per 100,000 population - adjusted for need)	Rank (out of 152 PCTs)
5	Mental Health Disorders	13,580,337	146
5a	Substance Misuse	1,677,020	61
5b	Organic Mental Disorders	2,198,465	40
5c	Psychotic Disorders	5,349,314	40
5d	Child and Adolescent Mental Health Disorders	1,448,876	38
5x	Other Mental Health Disorders	2,906,663	146
21b	NSF (National Service Framework) Mental Health Prevention	2,377	74

Source: Department of Health (2009), Programme budgeting.
Note: The bigger spend is recorded in PCT, the higher it is ranked.

It is possible that higher ranked spends in specific areas of mental health care outlined above, and lower spend on 'other mental health disorders' reflects differences in disease coding and accounting practices between PCTs contributing data to Programme Budgeting, rather than genuine differences in spending.

2.1.4 Relevant LAA Indicators

NI 1: Percentage of people who believe that people from different backgrounds get on well together in their local area.
NI 4: Percentage of people who feel they can influence decisions in their locality.
NI 135: Carers receiving needs assessment or review and a specific carer's service or advice and information.
NI 136: People supported to live independently through Social Services.
NI 141: Number of vulnerable people achieving independent living.
NI 152: Working age people on out of work benefits.

2.2 Adults with Learning Disability

2.2.1 Key Findings Summary

- The Department of Health definition describes learning disability as "a state of arrested or incomplete development of mind that includes significant impairment of intelligence and social functioning".
- Across Cambridgeshire there are estimated to be around 10,000 people with learning disabilities aged 15 and above[72], the majority being people with mild learning disabilities who mainly do not require specialist health or social care support.
- People with learning disabilities may be amongst the most vulnerable and marginalised people within Cambridgeshire[73]. They are more likely to:
  - be socially excluded;
  - have poorer physical and mental health;
  - have difficulties in accessing health care;
  - be at risk from abuse;
  - be discriminated against;
  - need support to access housing, health, employment and independent living;
  - be at greater risk of ending up in prison.
- Learning Disability Partnership teams currently provide health or social care support to around 2,230 individuals with learning disability, of whom around 1,700 receive social care support[74]. There is a higher than expected number of service users in Fenland[75]. It is predicted that by 2021 the number of adults with learning disabilities needing support will increase by between 300 and 450[76]. In 2008/2009, Cambridgeshire County Council Adult Social Care provided services for 1,340 clients with learning disabilities (18 years and above)[77].
- Very few adults requiring support have jobs, live in their own homes or have control over their lives.[78]
- There are some differences in health and further education provision for people with learning disability across Cambridgeshire, and further assessment of inequalities in outcomes is required.
- There are a number of out of county placements for people with learning disabilities, including children[79], and increasing provision of services in county should be explored.

72 Emerson and Hatton (2004) and CCC Research Group mid-2005 population estimates.
73 Survey of Adults with Learning Disabilities in England 2003/4. ONS and NHS Information Centre.
74 Cambridgeshire Learning Disability Partnership June 2007.
75 Head .V MPhil "A new geography of learning disability" University of Cambridge 2007.
76 Emerson and Hatton (2004) and CCC Research Group mid-2005 population forecasts.
77 Cambridgeshire County Council Adult Care Social Services 2009.
78 Learning Disabilities and Health: *SE Regional PH Group* Information Series 1 August 2006.
79 Head .V MPhil "A new geography of learning disability" University of Cambridge 2007.

- Significant issues for people with learning disability which are explored in the joint strategic needs assessment are:
  - transitions from children and young people's services to adult services;
  - choice and control, with access to advocacy, information and person centred planning;
  - support for carers, including forward planning as the carer ages;
  - increased risk of physical health problems, health inequalities and barriers in access to mainstream health services;
  - increasing demand for quality housing and support;
  - access to training, education and leisure services;
  - support to access employment opportunities;
  - vulnerability to abuse or bullying.
  - There are estimated to be around 3,400 adults with Autistic Spectrum Disorder (ASD) in Cambridgeshire, of whom around 750 would meet the criteria for learning disability[80]. Individuals who do not meet the criteria may still need significant support.

JSNA: Community Views – Adults with a Learning Disability[81]

- Local consultation reflects the findings of national survey work, and of the JSNA Phase 1.
- Transport is key to access in number of areas including, improving social networks, leisure opportunities, work and housing choices.
- LDP want access to community based services and more flexible and varied day care services with more opportunities to go out into the community and to learn new skills.
- People with learning disabilities want the right to get part-time work, voluntary work or work experience as well as a full time paid job depending on their wishes. It is felt that a person centred approach and more support is need to enable this.
- People with learning disabilities want a choice about where they live and who they live with. There are concerns about the funding for housing, particularly for tenancies.
- There is national and local evidence that people with learning disabilities face difficulties once they enter the criminal justice system, and in dealing with the discrimination and crime they face in society.
- Consultation with people with learning disabilities and their carers highlights a number of areas where they face difficulties accessing and using health services.

[80] Paul Shattock & Paul Whiteley, "The changing prevalence of autism?", Autism Research Unit, University of Sunderland & Cambridgeshire County Council Research Group, mid-2006 population figures

[81] For full references see JSNA: Community Views.

Introduction

The Department of Health definition describes learning disability as "a state of arrested or incomplete development of mind that includes significant impairment of intelligence and social functioning". This definition includes people with mild, moderate and severe/profound learning disabilities and generally refers to those who have acquired learning difficulties at or before birth or at an early age. Disability is not categorical, but occurs on a continuum.

However, diagnosis of learning disability is not an exact science, whilst it is generally accepted that around 2% of the general population is likely to have some form of learning disability this figure includes people with mild disabilities who largely do not require specialist health or social care support.

LAC (92) 15 Social Care for Adults with Learning Disabilities, suggests that most people with severe or profound disabilities will require "considerable help in order to live, initially in their homes and later in appropriate residential accommodation". Those with a mild or moderate degree of learning disability are more likely than the general population "to require additional emotional, mental, health and social support". Some of these individuals may be people whose behaviour is perceived as challenging and/or brings them into contact with the criminal justice system.

People with learning disabilities are amongst the most vulnerable and marginalised people within Cambridgeshire. They are more likely to:

- be socially excluded;
- have poorer physical and mental health;
- have difficulties in accessing health care;
- be at risk from abuse;
- be discriminated against;
- need support to access housing, health, employment and independent living;
- be at greater risk of ending up in prison.

People with learning disabilities are often at the margins of our society. Very few have jobs, live in their own homes or have control over their lives. There is a significant risk that the compounding impact of disability, health inequalities and social deprivation will affect health, wellbeing, opportunity and outcomes for this group.

This JSNA is structured using the key headings from the Government's White Paper *Valuing People* (DH 1999).

2.2.2 Key Facts: The Population

Across the total population, 2% of adults are estimated to have some form of learning disability. In Cambridgeshire, this corresponds to around 10,000 people aged 15 and above. If local service provision patterns reflected national patterns, we would expect around 2,200 of these people to be receiving support or services through the County Council. Of these, eight out of ten are likely to be aged between 20 and 64, one in ten is likely to be aged between 15 and 19 and one in ten aged over 65. Travellers represent the largest single ethnic minority group in Cambridgeshire making up about one percent of the population. There is a much higher than national prevalence of learning disability in the Traveller community.

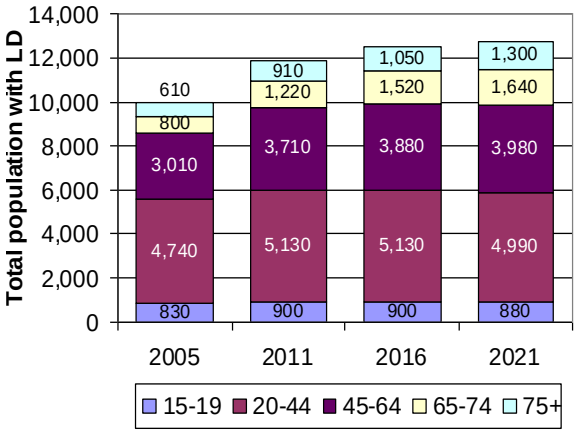
The actual figures for people with learning disabilities in Cambridgeshire receiving support correlate well with the national picture. Learning Disability Partnership teams currently provide health or social care support to around 2,230 individuals with learning disability, of whom around 1,700 receive social care support (LDP June 2007). In 2008/2009, Cambridgeshire County Council Adult Social Care provided services for 1,340 clients with learning disabilities (18 years and above).

Cambridgeshire's population is forecast to grow by around 16% between 2006 and 2021. As the total population grows, we would expect the number of people with learning disabilities also to increase. In addition, as people with learning disabilities are living longer and more babies with complex needs are surviving, we would expect increased numbers of people with learning disabilities in the population (we call this the prevalence) and increasing numbers with multiple severe disabilities.

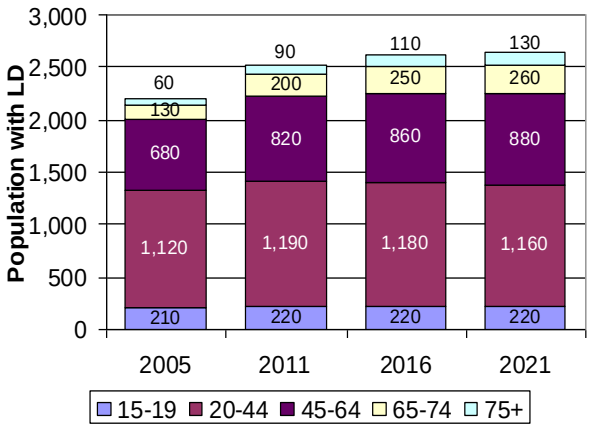
Figure 13 shows the likely age structures of the population with learning disabilities in the future. Although there will be an increase in people of all ages, the greatest increases will be among those aged over 45. The number of people with a learning disability aged over 65 is forecast to more than double by 2021

Figure 13: Estimated age structure of people with learning disabilities 2005-2021

a) Total population with learning disabilities



b) People with learning disabilities receiving support



Source: Emerson + Hatton (2004) and CCC Research Group mid-2005 population estimates.

The location of people with learning disability is affected by service location, housing costs and development opportunity. As a result of cheaper housing, more people with learning disability live in Fenland. This is illustrated in Table 21.

Table 21: LD service users by local authority district of residence - observed and expected

The standardised ratio of service users is the observed number of service users in a district divided by the expected number based on the district's population and Cambridgeshire's average age-specific prevalence of service users.

Local authority district	LD service users	Expected number of service users	Standardised ratio of service users	95% confidence limits
Cambridge City*	241	332	0.74	0.64-0.83
East Cambridgeshire	197	221	0.89	0.77-1.02
Fenland	347	257	1.35	1.21-1.49
Huntingdonshire	384	419	0.93	0.82-1.03
South Cambridgeshire*	383	495	0.84	0.75-0.92
Total	1,550	1,724	0.90	0.85-0.94

*Includes adults with LD living in Cambridge City but are within the care of Cambridge City

Source: Head V MPhil "A new geography of learning disability" University of Cambridge 2007.

2.2.3 Existing Needs and Inequalities

There are estimated to be around 3,400 people with Autistic Spectrum Disorder (ASD) in Cambridgeshire, of whom around 750 would be classed as having a learning disability (IQ<70).

People with ASD have a range of needs that may not be addressed by one agency. Within the current arrangements the needs of people with ASD are not easily met by the current service provision in either adult mental health or learning disability services. There is, therefore, a risk that people with low level needs or Autistic Spectrum are unable to, or have difficulty in accessing services.

People with learning disabilities placed out of county will receive local health services that may not be adequately resourced to meet their needs in addition to the local population. Likewise, people with learning disability from other counties placed in Cambridgeshire will access our primary care, secondary and sometimes specialist health services that may equally not be adequately resourced to meet their needs. Improved monitoring of people placed into Cambridgeshire is required, and there is a need for appropriate resources in county to minimise the need for out of county placements.

Children and Young People, and Transitions

As young people with learning disabilities move into adulthood, to ensure continuity of care and support for the young person and their family, and to provide equality of opportunity in order to enable as many disabled young people as possible to participate in education, training or employment. *(Valuing People DOH 1999)*

There have been inconsistencies of experience leading on occasions to poor transitions and planning. Following Cambridgeshire's Joint Area Review a member led Scrutiny review was undertaken leading to a substantial "Life after School" report. The main issues and shortfalls identified were in respect to: limited information; poor access to FE Education, limited training and employment opportunities; a poorly co-ordinated response to transitions planning and limited person centred services. Since the review significant progress has been made to improve both operational and strategic development.

Whilst younger children might be accommodated by the local authority in foster placements we are aware that there are small numbers of 16–18 year olds who for different reasons might need access to long term accommodation. There is a danger that if solutions are not available when these situations occur, particularly with family emergencies, the young person may move to out of county placements.

Choice and Control

To enable people with learning disabilities to have as much choice and control as possible over their lives through advocacy and a person-centered approach to planning the services they need. *(Valuing People DOH 1999)*

Cambridgeshire already promotes access to Direct Payments enabling individuals to purchase the type of service they need. Twice the number of people with learning disabilities are using Direct Payments in Cambridgeshire compared to the national average. There were 101 people with learning disabilities, or 6% of those who are known to services, receiving direct payments in Cambridgeshire in June 2007. In addition to the growth of people using Direct Payments, Cambridgeshire is also increasing the numbers of people using individualised budgets.

Person centred planning, advocacy, and provision of information in appropriate forms are also central to supporting choice and control.

Supporting Carers

To increase the help and support carers receive from all local agencies in order to fulfill their family and caring roles effectively. *(Valuing People DOH 1999)*

Accesses to short breaks are key to providing support to family carers and are provided across the county. There are a total of 19 residential respite beds covering the county. Occupancy rates are often 95–100% as breaks are planned carefully. Short breaks beds are sometimes used for emergency placements.

Plans to extend the Adult Placement service to offer both short breaks and independent skills training across the county are in hand. In 2008/09, there are an anticipated 46 carers who are unlikely to be able to maintain their caring role for a number of reasons. This is likely to result in additional services being needed costing in the region of £1million.

Good Health

There is good evidence that in England and Wales, people with learning disabilities are much more likely than other citizens to:

- Experience significant health risks and major health problems including obesity and respiratory disease, as well as epilepsy, cerebral palsy, visual disorders, hearing problems, impaired communication and social difficulties, mental illness or problem behaviour.
- Die younger than other people.
- Develop major illness at a younger age (5-10 years earlier).
- Experience poverty and the compounding effects of social exclusion, discrimination and isolation.

During 2007, the LDP Board and Speaking Up (Advocacy organisation) sought the views and experiences of people locally both in respect to their experience of primary and acute care. The comments, issues and outcome from this recent consultation exercises with people with learning disabilities and family carers reflects the national picture. A key issue was the need for training/awareness raising for core mainstream health professionals about the needs of people with learning disabilities.

People with learning disabilities and family carers presented their findings to local Councillors recently to raise awareness of some of the issues. Cambridgeshire LDP Board have noted local experience and are working with local Hospitals to attempt to address local issues though the development of the Disability Equality Schemes and action plans.

In Cambridgeshire, 6.7% of people with learning disabilities are in paid employment. On the indicator measuring the employment outcomes for people with learning disabilities Cambridgeshire is slightly above its comparator group (6.3%), however, it is below England's average (8.4%)[82].

Housing

Access to Housing and support is one of the priority areas in *Valuing People Now* (DH 2008). We know from both national evidence and local consultation that people want:

- a secure and homely place to live;
- to live alone or with people whom they choose and like to be with;
- sufficient levels of support to live full lives in their local community.

Whilst some individuals live in residential or nursing care current trends are to access mainstream housing opportunities. In general, people want choice about the type of accommodation, where they live and who they live with. Current demand for both housing and support outstrips available resources. In Cambridgeshire 72.7% of people with learning disabilities are in settled accommodation, which is above county's comparator group (64.1%) and also above England's average (69.9%)[83].

Fulfilling Lives

'To enable people with learning disabilities to lead full and purposeful lives within their community and to develop a range of friendships, activities and relationships'. *(Valuing People DOH 1999)*

82 NHS Information Centre, NASCIS001, 2008/09 (Note: Data are provisional.)
83 Ibid

People with learning disabilities want the same range of opportunities as their non disabled counterparts. Generally, people with learning disabilities would like:

- To increase the choice and opportunities they currently have.
- To have more opportunities to spend time in the community like:
  - college or adult community education classes;
  - leisure and sport activities;
  - and to have access to the resources to facilitate it.
  - To have opportunities to work or volunteer.
  - Develop friendships and relationships.
  - To be cared for and have help with personal care if needed.
  - To get help with problems and to have someone to talk things through with.
  - To learn new skills, cooking and independence skills.
  - To be involved in recruiting and training staff, and in how services are run.

Moving into Employment

A recent Cambridgeshire Parliament confirmed that people with learning disabilities want:

- The right to get part-time work, voluntary work or work experience as well as a full-time paid job dependent on their wishes.
- To get information about opportunities and schemes that provide support.
- To get advice about the impact on benefits.
- To get training and work experience that leads to real work.
- To get support with “getting ready for work”, like job clubs.
- To have support when looking for work and applying for a job. This would include support in interviews and when in work.

There is considerable anxiety for both people with learning disabilities and their families around paid work, particularly the impact on benefits. The numbers of people with learning disability known to be working by the local authority are still low with approximately 130 people currently in part or full time employment. Fifteen new people commenced work in 2007-08.

Quality

To ensure that all agencies commission and provide high quality, evidence based, and continuously improving services which promote both good outcomes and best value. *(Valuing People DOH 1999)*

The Learning Disability Partnership uses a range of methods to monitor, maintain and drive up the quality of its staff and commissioned services. The primary objective is to ensure that individuals have their needs met in the most effective way that maintains their independence and wellbeing. We know that using a person centred approach to the assessment, care management and review process is the best way to check and review the quality and appropriateness of services. The annual review provides a good opportunity to see what is working well and what needs to be changed.

People with learning disabilities are amongst the most vulnerable within our society. Whilst robust Protection of Vulnerable Adults policies and training are in place this does not prevent the occurrence of incidents. The safety of people with learning disabilities is of paramount importance.

During the period 2008/2009 there were 141 substantiated cases of abuse against people with learning disabilities. Every third case of abuse involved physical abuse (49 cases in total); also every third case abuse happened in a residential care home (48 cases in total)[84].

Multi-agency work continues on developing and implementing practice guidance and procedures across Cambridgeshire to further improve the arrangements for protecting vulnerable adults from abuse. A training strategy is being implemented.

Workforce and planning

To ensure that social and health care staff working with people with learning disabilities are appropriately skilled, trained and qualified; and to promote a better understanding of the needs of people with learning disabilities amongst the wider workforce. *(Valuing People DOH 1999)*

The wider workforce includes NHS staff, the police, children's services, the leisure industry and many others. Whilst many organisations undertake general diversity training some of these courses lack the depth of awareness of the needs of people with learning disability.

Cambridgeshire has a range of challenges with recruitment and retention of health and social care staff. These are reflected in the Learning Disability Partnership and its commissioned services.

Partnership

To promote holistic services for people with learning disabilities through effective partnership working between all relevant local agencies in the commissioning and delivery of services. *(Valuing People DOH 1999)*

There are a number of areas where there is current partnership working and where partnerships can be developed. A number of areas where a focus on partnership working may be beneficial have been identified.

84 Cambridgeshire Adult Safeguarding Board, Annual Report, April 2008 – March 2009

2.2.4 Relevant LAA Indicators

NI 4: Percentage of people who feel they can influence decisions in their locality.
NI 135: Carers receiving needs assessment or review and a specific carers service or advice and information.
NI 136: People supported to live independently through Social Services.
NI 141: Number of vulnerable people achieving independent living.
NI 152: Working age people on out of work benefits.

2.3 Adults with a Physical or Sensory Impairment and/or Long Term condition

2.3.1 Key Findings Summary

- Estimates of disability prevalence are highly dependent on the definition of disability used. The OPCS Survey of Disability[85] estimated that in 2006 8% of the Cambridgeshire population had a disability, and in the Census[86] 11% of the Cambridgeshire population reported having a long term illness, health problem or disability which limits daily activities or work. Estimates suggest that by 2021 these numbers will rise by 14% and 13% respectively[87].
- There is a fairly consistent pattern across the county, with residents being more likely to have a limiting long term illness or to perceive their health to be poor in wards to the north of the county particularly in and around Wisbech, Huntingdon North, and in parts of Cambridge City[88].
- The pattern of poor health, as measured by the Census, is broadly similar to the pattern of deprivation as measured by the Index of Multiple Deprivation[89]. Prevalence of disability is positively correlated with age[90].
- There were 3,020 disabled people receiving benefits in May 2009. Of these 2,990 were receiving Disability Living Allowance (only)[91]. "Disabled" claimants represent 0.8% of resident working age people in Cambridgeshire[92].
- Between April 2008 and March 2009, 3,074 new blue badges were issued to people who automatically qualify for a badge, i.e. those who: are registered blind; receive the higher rate of the mobility component of the Disability Living Allowance; receive a war pensioner's mobility supplement; have a vehicle supplied by a Government Health Department; hold a valid driving licence and have severe disability. In total during the period there were nearly 13,000 blue badges on issue[93].
- Many disease processes are wide ranging in their impact. In some, the result is disability: a state in which the individual may experience loss or limitation of physical function; reduced opportunities in social functioning; economic hardship or disadvantage, negative attitudes and prejudice. Aside from disease, disability can arise through other causes, such as foetal abnormalities and accidents.

85 OPCS surveys of disability in Great Britain, Crown Copyright 1988; Cambridgeshire County Council Research Group, Mid 2006 population estimates and forecasts.
86 Census 2001, Table S016, Crown Copyright 2003.
87 OPCS surveys of disability in Great Britain, Crown Copyright 1988; Census 2001, Table S016, Crown copyright 2003; Cambridgeshire County Council Research Group, mid 2006 population estimates and forecasts.
88 Limiting Long Term Illness by Ward, Indirectly Age-Standardised (All Ages). 2001 Census National Statistics. Crown Copyright 2003.
89 Limiting Long Term Illness by Ward, Indirectly Age-Standardised (All Ages). 2001 Census National Statistics. Crown Copyright 2003. Index of multiple deprivation, 2007, Department of Community and Local Government.
90 Age and sex breakdown of users of Cambridgeshire physical disability services 2008. Cambridgeshire County Council. Number of blind or partially sighted people (total and new) registered with councils by Age Group at 31 March 2006. National Statistics.
91 NOMIS ,Disability Living Allowance clients, Cambridgeshire, May 2009
92 Ibid
93 Cambridgeshire County Council Blue Badge Service, Summary 2009.

- Individuals with the most severe forms of physical and sensory impairment are eligible for social services support. In 2008/2009, Cambridgeshire County Council Adult Social Care provided services for 2,110 clients with physical disability, frailty and sensory impairment (in people aged 18 – 64)[94].
- There are 570 people aged between 18 and 64 who are Blind and Partially Sighted People Registered with Councils by Age Group at 31 March 2008[95]. There are 1,510 people of all ages registered with social services in Cambridgeshire who are deaf (435) or hard of hearing (1,075) at 31 March 2007[96].
- In Cambridgeshire, there were 1,266 hospital admissions for head injury in 2007/08. Of these 642 were between the ages of 15 to 64[97]. There are at least 70 people known to social services requiring Level 3 and Level 4 follow up care for severe physical disabilities following a head injury. Much can be done on prevention.
- The Health Survey for England in 2001 reported 18% of adults having a moderate or serious disability; 40% of these disabilities were attributed to musculoskeletal conditions[98]. 11.4% of GP consultations in 2004 in England and Wales are related to diseases of the musculoskeletal system and connective tissue.
- In 2008/2009, nearly 780 new people aged 16 to 64 years with physical disabilities had completed assessments[99]. 96% of people with physical disabilities are receiving community-based services in their own home[100].
- It appears that many disabled people still live in unsuitable accommodation, from national estimates[101]. The JSNA contains a summary of the identified gaps and priorities for action.
- The JSNA provides a variety of data on the prevalence and incidence of:
    - Chronic Obstructive Pulmonary Disease
    - Diabetes
    - Coronary heart disease
    - Stroke
    - Myalgic encephalomyelitis
    - Parkinson's disease
    - Spina Bifida
    - Epilepsy
    - Huntingdon's Disease
    - Alcohol

94 Cambridgeshire County Council. Adult Social Services Number of clients receiving services during period 01/04/2008-31/03/2009, 2009.
95 Cambridgeshire. National Statistics / NHS Information Centre, Total number of Blind and partially sighted people registered with councils by Age Group at 31 March 2008.
96 Cambridgeshire County Council: People Registered as Deaf or Hard of Hearing, Year Ending 31 March 2007. Health and Social Care Information Centre.
97 Number of Hospital Admissions for Head Injury by Age Group (ICD10 S00-S99) 2005/06-2007/08. Cambridgeshire PCT residents. ASP CDS.
98 Reported Causes of Disabilities Among Adults. Health Survey for England 2001.
99 Number of completed assessments for new clients by primary client type and age group 2009/09.
100 Cambridgeshire County Council. Adult Social Services Number of clients receiving services in 01/04/2008-31/03/2009, 2009.
101 National data presented by The Papworth Trust.

- HIV and AIDS
- Cerebral Palsy
- Muscular Dystrophy
- Blind and partially sighted
- Deafness

JSNA: Community Views - Adults with a physical and sensory impairment and long term conditions[102]

- Housing is a major factor determining physically disabled people's health and well-being. It appears from national reports that most disabled people live in unsuitable accommodation.
- Physical disability also affects family members, as they often give up their employment to become carers or, if parents, they need to face the costs of a disabled child.
- Low-income people are more likely to have disabilities than medium or high-level income people. Moreover, people with physical disabilities tend to have less disposable income than people without disabilities. Often, this leads into debt problems and housing deprivation.
- Hospital and care staff may have negative attitudes towards physically disabled people mainly due to lack of knowledge of their condition.

Introduction

Social Model of Disability

The social model of disability is about a clear focus on the economic, environmental and cultural barriers encountered by people who are viewed by others as having some form of impairment – whether physical, sensory or intellectual. The barriers disabled people encounter include education systems, working environments, access to services and benefits, housing issues and access to public buildings and amenities.

Many disease processes are wide ranging in their impact. In some, the result is disability: a state in which the individual may experience loss or limitation of physical function, reduced opportunities in social functioning, economic hardship or disadvantage, negative attitudes and prejudice. Many initiatives are in place to help overcome this.

More recently, "Long term conditions" has been introduced and is widely used in the terminology of the National Health Service. The PCT has produced a 'Long Term Conditions Strategy' which has patient pathways, clinical outcomes and information on guidance from the National Institute of Clinical Excellence (NICE). This is on the NHS Cambridgeshire website:
http://www.cambridgeshire.nhs.uk/default.asp?id=656

[102] For full references see JSNA: Community Views.

Policy Context

The Government aims to ensure that disabled people are able to play a full and active role in society. In 2005, the report 'Improving the Life Chances of Disabled People' was published. In that report there is a commitment to achieving equality for disabled people by 2025.

The recently published 'Independent Living Strategy' contains over 50 commitments aimed at ensuring that disabled people who need support to go about their daily lives have greater choice and control over how that support is provided. The strategy is an example of co-production. This means working in partnership with the people whose lives are affected by policies and by their implementation, to ensure that people have the opportunity from the outset to influence and shape policy and the design, planning and delivery of services.

The new employment and support allowance replaces incapacity benefit for new applicants from October 2008.

Local Context

Disability is an important issue for public health for a number of reasons. Firstly, the proportion of people who develop disability could be reduced with more effective health promotion measures aimed at eliminating the underlying causes. Secondly, the effective use of treatment and rehabilitation services directed at restoring function in people who are already ill or injured can reduce residual disability. For example, an active multi-professional approach to the clinical recognition, treatment and rehabilitation of people with stroke helps to prevent long term major disability in some of those affected. Thirdly, disabled people have special needs. It is a responsibility of those planning and providing services to ensure that the needs of disabled people are clearly identified and that an appropriate and personalised response is made to them. The needs of disabled people are very wide ranging and addressing them requires approaches in many areas. Perhaps the greatest challenge is to create an infrastructure of help, support and care which enables disabled people to be fully integrated within society as well as creating a climate in which they are recognised and respected as individuals, with commensurate rights and entitlements.

2.3.2 Key Facts: The Population

Definitions and Data Sources – Cambridgeshire Figures

Estimates of disability prevalence are highly dependent on the definition of disability used. There is no single or 'gold standard' measure or estimate of disability. The two most widely used sources are the 2001 Census and OPCS disability surveys (1988), both of which have their advantages and disadvantages.

The OPCS Surveys of Disability

The OPCS Surveys of Disability were carried out between 1985 and 1988. These estimated the prevalence and severity of disability by age, gender, region and the West Indian & Asian ethnic groups These surveys focus specifically on disability rather than on Limiting Long Term Conditions.

2001 Census

Asks whether any long term illness, health problem or disability limits daily activities or work. It is a self assessment which covers any long-term illness, health problem or disability, which limits daily activities or work. Because the definition is wider than just disability, then numbers are larger.

Table 22: Comparison of Estimated Number of People with a Disability from Two Data Sources - OPCS and Census. Cambridgeshire 2006 And 2021

Source of data	2006 estimate (15-64 years and % of population)	2021 estimate	Increase (no)	Increase (%)
OPCS Survey of disability	28,500 (8%)	30,885	+4,000	14%
Census LLTI	41,336 (11%)	44,791	+5,000	13%

Long Term Illness

There is a fairly consistent pattern across the county, with residents being more likely to have a limiting long term illness or to perceive their health to be poor in wards to the north of the county particularly in and around Wisbech, Huntingdon North, and in parts of Cambridge City. The pattern of poor health, as measured by the Census, is broadly similar to the pattern of deprivation as measured by the Index of Multiple Deprivation.

In the Place Survey from autumn 2008, 33% of respondents in Cambridgeshire reported having some long-standing illness, disability or infirmity. The rate was higher than the county's average in Fenland (40%) and East Cambridgeshire (34%); it was lower in Cambridge City (30%), Huntingdonshire (31%) and especially lower in South Cambridgeshire (28%). Note: results were not weighted for age. In the 65+ age group more than half of respondents reported having some long-standing illness, disability or infirmity.

Disability Living Allowance (DLA)

There were 3,020 people receiving any benefits in the grouping 'disability' in the benefits data. Of these, 2,990 were receiving Disability Living Allowance.

Table 23: Disabled people receiving benefits by District and Duration of Claim, May 2009

Disabled people receiving benefits	Total	< 6 months	6 months - 1 year	1 - 2 years	2 - 5 years	5 years <
Cambridgeshire	3,020	180	170	250	510	1,920
Cambridge	450	30	20	40	80	280
East Cambridgeshire	370	20	20	30	60	230
Fenland	610	30	40	40	110	400
Huntingdonshire	870	50	50	70	140	550
South Cambridgeshire	710	40	40	60	110	470

Source: ONS, NOMIS 2009

Blue Badges

Between April 2008 and March 2009, 3,074 new blue badges were issued to 18-64 year olds and in total during the period there were nearly 13,000 blue badges on issue. Average number of new badges issued per month was 250.

Reported Causes of Disabilities Among Adults

Table 24: The Health Survey for England 1995 illustrates the reported causes of disabilities among adults.

Health Complaint	%
Diseases of the musculoskeletal system and connective tissue:	34%
• Arthritis	21%
• others	13%
Disease of the ear and mastoid processes	24%
Disease of the circulatory system	16%
Diseases of the respiratory system	10%
Eye disorders	8%
Diseases of the nervous system (other than eye or ear)	5%
Injury and poisoning	4%
Endocrine, nutritional and metabolic diseases and immunity disorders	3%
Neoplasms	2%
Mental disorders	2%
Others	13%

Cambridgeshire Service Users – Breakdown by 'Cause'

Clients with the most severe forms of physical and sensory impairment are eligible for social services support.

Social services authorities are required to maintain registers of people in their areas who are blind or partially sighted. There are 570 people aged between 18 and 64 who are Blind and Partially Sighted People Registered with Councils by Age Group at 31 March 2008. Twenty per cent will also have an additional disability.

Social services are also required to maintain registers of people who are deaf or hard of hearing.

2.3.3 Existing Needs and Inequalities

Generic Patient Pathways

There are National Service Frameworks (NSFs) covering coronary heart disease, cancer, mental health, older people, diabetes, long term neurological conditions, renal services, children and paediatric intensive care, and chronic obstructive pulmonary disease (in development) available at: http://www.dh.gov.uk/en/Sitemap/DH_A-Z_AZSI?indexChar=N

The Long Term (Neurological) Conditions National Service Framework (NSF) was launched in March 2005. The NSF aims to transform the way health and social care services support people to live with long term neurological conditions. Key themes are independent living; care planned around the needs and choices of the individual; easier, timely access to services and joint working across all agencies and disciplines involved. The principles of the NSF are also relevant to service development for other long term conditions. This NSF is a key tool for delivering the government's strategy to support people with long term conditions outlined in the White Paper 'Our health, our care, our say' and the NHS Improvement Plan 'Putting People at the Heart of Public Services'. It applies to health and social services working with local agencies involved in supporting people to live independently, such as providers of transport, housing, employment, education, benefits and pensions.

The PCT has access to pathways from various sites including the Department of Health 18 week wait website: (www.18weeks.nhs.uk) and the pathways which are being produced in the East of England as part of the Darzi review.

There is a recognised need for personal care plans.

HIV and AIDS

Data is available from SOPHID (Survey of Prevalent HIV Infections Diagnosed) data, which is collected and summarised clinical and epidemiological information on all cases with diagnosed HIV seeking statutory care in the year of reporting. Clinician reporting began in 2000 but may show underreporting.

There were nearly 360 patients in treatment in 2008 by age and gender, 64% were men and 36% were women. Around two in five patients (37%) were in the 35-44 age group[103].

The county wide specialist social worker offers social care support to everyone that attends the specialist clinics, working closely with the two specialist nurses. They are backed up by support from the local voluntary agency and Local Authority Supporting People service.

Trauma and Head Injury

Head injury in England is common. It has been estimated that 6.6% of those attending A&E in any given year have a head injury and over 100,000 people are admitted as a consequence. In Cambridgeshire, there were 1,266 hospital admissions for head injury in 2007/08. Of these 642 were between the ages of 15 to 64.

[103] Health Protection Agency 2009

Much also needs to be done on prevention. Road traffic accidents, for example are high in some parts of Cambridgeshire.

There are at least 70 people known to social services requiring Level 3 and Level 4 follow up care for severe physical disabilities following a head injury.

Chronic Obstructive Pulmonary Disease (COPD)

The primary care disease registers show that there are 8,360 people with COPD. The unadjusted recorded prevalence is 1.4% (2008/09)[104]. It is estimated that the adult COPD prevalence in 2009 is 2.5% and that this will increase to 2.6% in 2015[105]. The PCT is a national pilot site for Co-creating Health which promotes physician and patient training and self care. Effective stop smoking campaigns should reduce the numbers of people with COPD in future generations. There is unmet need for more people to receive pulmonary rehabilitation services.

Diabetes

The total number of people on the primary care QOF register for diabetes in 2008/09 in Cambridgeshire GP practices is 22,720. The QOF unadjusted recorded diabetes prevalence in the 17+ population is 4.6% and YHPHO projects the prevalence to increase to 4.7% by 2015 (based on modelled estimates)[106].

A draft Local Enhanced Service has been crafted by Practice Based Commissioners along with initial analyses partly using the diabetes commissioning toolkit.

Arthritis

The Health Survey for England in 2001 reported 18% of adults having a moderate or serious disability; 40% of these disabilities were attributed to musculoskeletal conditions. 11.4% of GP consultations in 2004 in England and Wales are related to diseases of the musculoskeletal system and connective tissue.

Coronary Heart Disease

In 2009/08, coronary heart disease prevalence in Cambridgeshire was 3.1% (19,000 people in total)[107].
Some cases on CHD may go undetected. APHO estimates the prevalence of CHD to be 4.6% in 2009 and projects this to increase to 4.9% by 2015. Reduction of CHD is one of the key health targets and pledges in the East of England. In 2008/09, unadjusted recorded heart failure prevalence in Cambridgeshire was 0.7% (4,250 people in total).

Stroke

The unadjusted recorded QOF prevalence of stroke or transient ishaemic attacks is 1.5% out of the whole practice population (2008/09). It is estimated that the prevalence could be 2.2% in the adult population and is projected to increase to 2.4% by 2015.

[104] NHS Information Centre, Quality and Outcomes Framework (QOF), April 2008 - March 2009, England
[105] APHO Disease Prevalence Models http://www.apho.org.uk/resource/item.aspx?RID=48308
[106] YHPHO Phase 3 PBS Diabetes Prevalence Model: http://www.yhpho.org.uk/resource/item.aspx?RID=9905
[107] NHS Information Centre, Quality and Outcomes Framework (QOF), April 2008 - March 2009, England

One risk factor for stroke is atrial fibrillation of the heart. The unadjusted recorded prevalence of atrial fibrillation is 1.4% (2008/09). Reduction of stroke and the immediate diagnosis and management of stroke is a national priority.

Multiple Sclerosis

In the UK, the prevalence of multiple sclerosis is around 100-150/100,000. Careful attention to aids at home and work can provide real benefit to an individual with MS. Vehicles can be adapted to allow hands only driving, and visual aids or computer technology can allow continuation of employment.

Cerebral Palsy

Prevalence of cerebral palsy is best calculated around the school entry age of about six years and the prevalence is around 2.4 out of 1,000 children.

Muscular Dystrophy

This is a group of inherited disorders characterised by progressive degeneration of groups of muscles.

Myalgic Encephalomyelitis

Evidence suggests a diagnosed incidence of 0.04% and a population prevalence of 0.2% to 0.4% in the UK.

Parkinson's Disease

Parkinson's disease can occur at any age, but is mainly a condition of middle and later life; about 1% of the over 65s and 2% of the over 80s are affected.

Spina Bifida

The features are invariably present at birth.

Epilepsy

About 1 in 200 individuals have active epilepsy. Epilepsy is more common in people with learning difficulties. In 2009, 3,440 patients aged 18 and above were registered with epilepsy in Cambridgeshire.

Huntingdon's Disease

This is an inherited disorder with autosomal dominant transmission, affecting males and females, and usually starting in adult life.

Alcohol

About 1% of the general population are classified as being moderately or severely dependent on alcohol, this increases to 2% in people with neurotic disorders, 5% among those with phobias and 6% among those with two or more neurotic disorders.

Transition In and Out of Client Groups

At present it appears that around 30 people per year move into the age group at which Older People Services provide support.

Service Uptake Social Care

The following data are taken from Referrals and Assessment Packages (RAP) returns.

Assessments

During 2008/2009, 946 new people with physical disabilities aged 16 to 64 years had completed assessments. Over 80% of first assessments for new clients are for people with physical disability, frailty and/or temporary illness. As tables 1 and 2 below illustrate the majority of people are receiving community-based services in their own home.

Table 25: Number of New Clients for Whom Assessments by Primary Client Type with Known or Anticipated Sequel to Assessment, Age Group 18-64, 2008/2009

Client type	Some or all (New) services intended or already started	No (new) services offered or intended to be provided	(New) service(s) offered but declined	Other sequel to assessment
Physical disability, frailty and sensory impairment (of which)	778	67	19	-
Physical disability, frailty and /or temporary illness	664	51	17	-
Hearing / visual impairment or dual sensory loss	49	-	-	
Mental health	81	-	-	-
Dementia	8	-	-	-
Vulnerable people	10	-	-	-
Learning disability	74	13	-	-
Substance misuse	-	-	-	-
Total	**946**	**86**	**21**	**-**

Note: '-' denotes where there are less than five individuals.
Source: RAP return 2008/09.

Note that a client may receive services from different service types simultaneously.

Table 26: Number of Clients Receiving Services During Period, Provided or Commissioned by the CSSR, by Primary Client Type, Service Type, Age Group 18-64, 2008/2009.

Client type	Total of Clients	Community based services	Residential care	Nursing care
Physical disability, frailty and sensory impairment (of which)	2,110	2,033	54	38
Physical disability, frailty and /or temporary illness	1,823	1,752	50	36
Hearing / visual impairment or dual sensory loss	160	150	6	-
Mental health	1,060	929	63	18
Dementia	24	17	-	-
Vulnerable people	65	61	-	-
Learning disability	1,343	1,021	352	22
Substance misuse	15	10	-	-
Total	**4,593**	**4,046**	**473**	**79**

Note: '-' denotes where there are less than five individuals.
Source: RAP return 2008/09.

Housing

Housing is a major factor in determining physically disabled people's health and well-being. It appears that many disabled people still live in unsuitable accommodation, from national estimates. A draft Disability Housing Strategy was produced by the Disability Strategic Housing Network in February 2008[108]. The Summary of Gaps and Priorities for action are:

- Undertake further work to refine knowledge about the level of housing need and shortfalls in provision.
- Ensure information is available and accessible to all.
- Move from a model of residential provision and grouped living arrangements to that of single or shared, where requested, tenancies and home ownership.
- Maintain access to adaptations and assistive technology to maintain and develop independence.
- Maintain consultation and involvement of disabled people in the continuing development of housing and support.
- Develop flexible support services to include floating and where necessary specialist support services.
- Ensure best practice and standards inform developments across the county.
- Take account of 16+ needs to avoid the need for out of county placement. (develop work practices and a protocol between local housing authorities and social care including young people with an aim if possible to include 16+).

Education, Training and Employment Opportunities

The Papworth Trust led on a project during 2007 called CREATE Research Project (Cambridgeshire Research into Education, Training and Employment Opportunities for Disable people). Members of the Physical Disability & Sensory Board were involved in this project and the recommendations from the project focused on:

[108] Cambridgeshire Horizons, Disability Housing Strategy February 2008.

The key findings from this were:

- People with learning disabilities had a broad interpretation of work, many valued work experience and training activities in their own right.
- Using a person-centred approach to planning services, which is easily accessible to individuals and parents/carers, covering a wide range of support needs (day opportunities, training, respite care, housing and support, transport, etc.), supported by good information and personal guidance was key.
- There should be clarity around the role of social training enterprises and other work-based providers in supporting people to progress into work, and that we should look at social firms, co-operatives and other models and to increase access to job clubs and similar activities

- Other issues identified included:

    - Jobcentres, training providers and colleges to recognising and meeting the differing support needs of people.
    - Communicating clearly about benefit issues.
    - Minimising the impact of transport and/or location on access training and employment.
    - Promoting positive attitudes and flexible practices among employers, and sharing good practice.

Transport

A review by the County Council, of passenger transport was completed in January 2008. In summary, the outcome of the review led to a number of recommendations:

- Adoption of a new scoring model to assess subsidised bus services.
- Creation of a community transport brokerage scheme for Cambridgeshire.
- Pilot schemes for 'demand-responsive' rural transport services in Cambridgeshire.
- Creation of a 'one-stop shop' for travel information in Cambridgeshire.
- Review of bus stop roles and responsibilities.

2.3.4 Relevant LAA Indicators

NI 4: Percentage of people who feel they can influence decisions in their locality.
NI 135: Carers receiving needs assessment or review and a specific carers service or advice and information.
NI 136: People supported to live independently through Social Services.
NI 141: Number of vulnerable people achieving independent living.
NI 152: Working age people on out of work benefits.

3. Older People

3.1 Key Findings Summary

- There are an estimated 92,7680 people aged 65 or over (16% of the total population) and over 43,000 people aged 75 or over (7% of the total) in Cambridgeshire. Fenland has the highest proportion of older people with over 19% of residents aged 65+ [109].
- Older people make a major contribution to society. A recent study has estimated that the total economic value of the contributions of older people aged 50+, who are in work, to the economy is £200 billion per annum.[110]
- People aged 65+ make up 69% of all adult clients of social services[111]. Also, because there are significant numbers of older people with chronic diseases, hospital usage increases rapidly with age. In 2006/07 elective admissions to hospital for people over 75 years cost over £14m, and for emergency care £6m[112].
- By 2021, the population aged 65+ in Cambridgeshire is forecast to increase by 54% (around 50,000 people). The population aged 75+ is forecast to increase by 54% between 2008 and 2021. This increase is spread unevenly across districts, with a predicted 80% increase in South Cambridgeshire, 65% in Huntingdonshire, 47% in East Cambridgeshire, 33% in Fenland and 27% in Cambridge City in people aged 75 and over[113].
- Frailty in older people will place more demands for care at home. Currently, there are estimated to be 13,900 elderly people in Cambridgeshire who are physically or mentally frail or both. By 2011 the numbers of elderly frail people is predicted to increase in Cambridgeshire to 15,700 by 2016 to 18,600 and by 2021 to 21,500[114].
- As part of this increase, the number of people with dementia is set to rise from approximately 6,580 in 2006 to 10,240 in 2021[115].
- The dependency ratio is also predicted to change, with relatively fewer people of working age to provide support for an older population. The number of people aged 15-64 per person aged over 65 is forecast to drop by 30% by 2021 in Cambridgeshire[116].
- Partners need to plan together to ensure that the living circumstances of older people will be matched to their social care needs. As part of this, the Best Value Review of Sheltered and Extracare housing has set challenging targets for further development of Extracare housing[117].

109 Cambridgeshire County Council Research Group mid 2008 population estimates
110 Older People and the Economy. Age Concern Policy Unit 2004
111 Cambridgeshire RAP returns (Referral, Assessment and Packages of Care Project) 2008/2009
112 Anglia Support Partnership Commissioning Dataset 2006/7
113 Cambridgeshire County Council Research Group Mid-2008 district level population forecasts by age and gender
114 MRC Cognitive Frailty and Ageing Study (CFAS) 1999 estimates applied to Cambridgeshire County Council 2005-based ward age forecasts.
115 Dementia UK. A report to the Alzheimer's Society on the prevalence and economic cost of dementia in the UK produced by King's College London and London School of Economics. PSSRU 2007 applied to Cambridgeshire County Council Research Group 2005-based ward age forecasts
116 Cambridgeshire County Council Research Group, Mid-2008 population forecasts
117 Best Value Review of Sheltered Housing – Report to Supporting People Commissioning Body 2007

- Tackling health inequalities in later life, including improving the underlying socio-economic determinants for older people should be at the core of any healthy-ageing strategy and health promotion activity. The pattern of income deprivation for older people is more dispersed than that for children and working age adults, with eight of the most deprived small areas in Cambridge, five in Fenland and four in Huntingdonshire – and more small areas of income deprivation in rural villages[118].
- The proportion of older people claiming benefits in Cambridgeshire is well below the national average.[119]
- Health promotion interventions can extend longevity and improve quality of life. Cigarette smoking is implicated in eight of the top 14 causes of death for people aged 65 and over. Further implementation of NICE guidelines for falls prevention in Cambridgeshire could result in reduced of hospital admissions for falls.[120]

JSNA: Community Views – Older People[121]

- There is a need for more consultation with older people in Cambridgeshire about the delivery of health and social care in the County. In particular to test whether the priorities identified in national work are also local priorities for older people.
- A large number of older people report feeling secure in their own home, in control of their daily lives and have a good quality of life.
- Social networks are key to reducing isolation which is an issue for some older people.
- Some older people may not be claiming benefits they are entitled to.
- Some older people may lack knowledge about a healthy diet.
- Older carers have the same needs as most carers, and support for carers, including respite care, are important issues.

In the Place Survey carried out in autumn 2008, more than a half of Cambridgeshire respondents in the 65 and over age group reported having some long-standing illness, disability or infirmity.

Introduction

For many older people, later life is a time to enjoy the rewards of years contributing to the growth and well-being of their families, their communities and their workplaces.

Older people remain partners, parents, friends, daughters and sons, often caring for grandchildren or parents, and sometimes both. They are volunteers, employees, chief executives and board members. A recent study has estimated that the total economic value of the contributions of older people aged 50+ who are in work to the economy is £200 billion per annum.

118 DCLG, English Indices of Deprivation 2007, Income deprivation affecting older people index (IDAOPI)
119 Department of Work and Pensions. Population: CCC Mid 2006 estimates.
120 Benefits of implementing NICE Falls Prevention guidelines on utilization of healthcare. Dr Raj Nagaraj. East of England Strategic Health Authority
121 For full references see JSNA: Community Views.

Whilst, in general, older people are living longer in good health, it is still the case that many older people have increased needs and requirements of healthy services and formal and informal care services. The national policy context demands service providers to rethink the focus of their interventions away from treating ill health towards an agenda that is about promoting quality of life, independence and well being, addressing ageism and recognising older people as citizens in society. This approach highlights the importance of preventative services to enable people to remain independent. All of this needs to be planned for in the context of an ageing population.

3.2 Key Facts: The Population

The Current Population

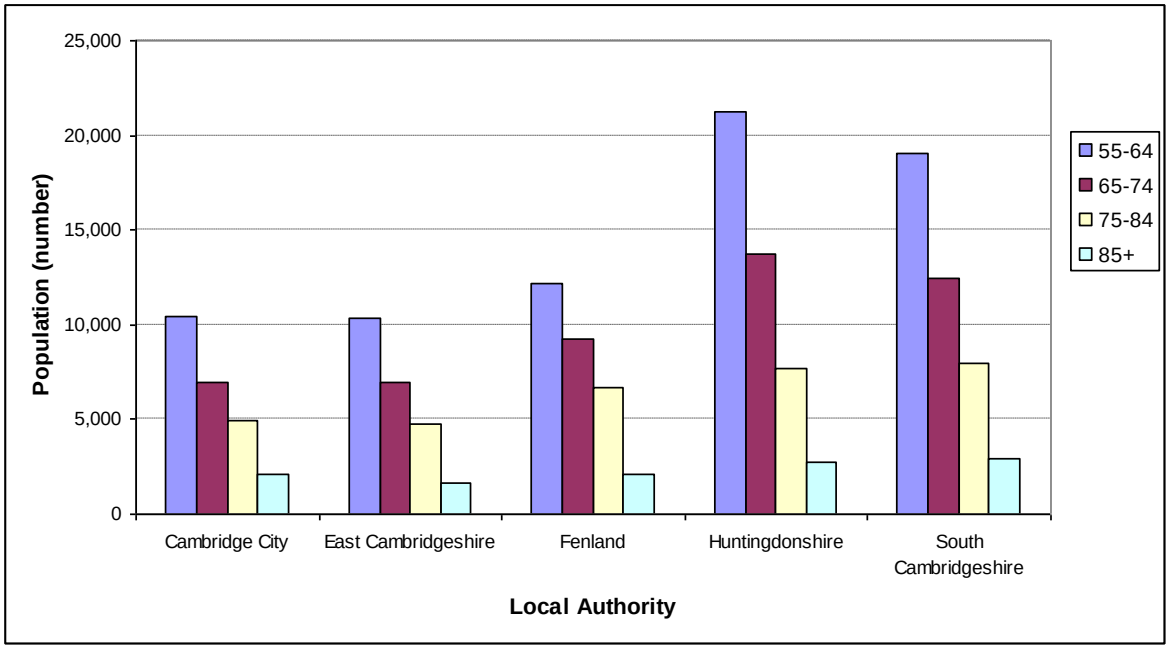
In 2008, there were an estimated 92,680 people aged 65 or over (16% of the total) and over 43,000 people aged 75 or over (7% of the total) in Cambridgeshire. Comparable figures for England were 16% and 8% so the county age structure is similar to the national average. However, there is local variation and Fenland district has 19% of its population aged over 65 and 9% over 75.

Table 27: Mid-2008 population estimates by Local Authority and age-band

Local Authority	Age group						All ages
	55-64	65-74	75-84	65+	75+	85+	
Cambridge City (num)	10,440	6,980	4,910	14,030	7,060	2,130	117,700
Cambridge City (%)	8.9%	5.9%	4.2%	11.9%	6.0%	1.8%	100%
East Cambridgeshire (num)	10,380	6,920	4,760	13,360	6,450	1,660	79,400
East Cambridgeshire (%)	13.1%	8.7%	6.0%	16.8%	8.1%	2.1%	100%
Fenland (num)	12,220	9,260	6,650	17,950	8,700	2,070	92,900
Fenland (%)	13.2%	10.0%	7.2%	19.3%	9.4%	2.2%	100%
Huntingdonshire (num)	21,280	13,720	7,650	24,140	10,410	2,760	163,100
Huntingdonshire (%)	13.0%	8.4%	4.7%	14.8%	6.4%	1.7%	100%
South Cambridgeshire (num)	19,050	12,420	7,940	23,260	10,850	2,890	142,500
South Cambridgeshire (%)	13.4%	8.7%	5.6%	16.3%	7.6%	2.0%	100%
Cambridgeshire (num)	**73,370**	**49,300**	**31,900**	**92,680**	**43,390**	**11,500**	**595,500**
Cambridgeshire (%)	**12.3%**	**8.3%**	**5.4%**	**15.6%**	**7.3%**	**1.9%**	**100%**
England (num, shown in 000s)	6,058	4,274	2,877	8,285	4,012	1,135	51,446
England (%)	11.8%	8.3%	5.6%	16.1%	7.8%	2.2%	100%

Source CCC Research Group - Cambridgeshire County Council mid 2008 population estimates. (Note: Figures rounded to the nearest 10.) ONS mid 2008 population estimates.

Figure 14: Mid 2008 population estimates by age-band and local authority (CCCRG)



Source: Research Group, OCS - Cambridgeshire County Council mid 2008 population estimates.

Population forecasts indicate an increase and an ageing of the Cambridgeshire population

By 2021, the total population in Cambridgeshire is forecast to increase by 13% (78,00 people in total). In the same period population aged 65+ in Cambridgeshire is forecast to increase by 54% (around 50,000 people). The population aged 75+ is forecast to increase by 54% between 2008 and 2021. The population forecasts indicate at ageing of the Cambridgeshire population.

This increase is spread unevenly across districts, with a predicted 80% increase in South Cambridgeshire, 65% in Huntingdonshire, 47% in East Cambridgeshire, 33% in Fenland and 27% in Cambridge City in people aged 75 and over. Population ageing is hence likely to have the greatest impact in the rural districts. The data are in Table 28 and Table 29.

Table 28: Local authority population forecasts by age, 2008-2021 (CCC RG)

Local Authority	Age band	Year				% change
		2008	2011	2016	2021	2008-2021
Cambridge City	55-64	10,440	12,580	12,300	13,490	29.2%
	65-74	6,980	7,840	9,880	11,440	63.9%
	75-84	4,910	4,880	5,210	6,400	30.3%
	85+	2,130	2,180	2,340	2,580	21.1%
	Total population	117,700	124,990	141,380	153,590	30.5%
	65+	14,030	14,900	17,430	20,420	45.5%
	% 65+ of total population	11.9%	11.9%	12.3%	13.3%	-
East Cambridgeshire	55-64	10,380	11,520	10,760	12,440	19.8%
	65-74	6,920	7,650	9,240	9,750	40.9%
	75-84	4,760	5,080	5,730	6,790	42.6%
	85+	1,660	1,750	2,110	2,670	60.8%
	Total population	79,400	79,330	80,230	81,110	2.2%
	65+	13,360	14,480	17,080	19,210	43.8%
	% 65+ of total population	16.8%	18.3%	21.3%	23.7%	-
Fenland	55-64	12,220	13,770	12,990	14,700	20.3%
	65-74	9,260	9,850	12,090	13,270	43.3%
	75-84	6,650	6,820	6,860	7,750	16.5%
	85+	2,070	2,390	3,190	3,830	85.0%
	Total population	92,900	93,060	96,280	100,280	7.9%
	65+	17,950	19,060	22,140	24,850	38.4%
	% 65+ of total population	19.3%	20.5%	23.0%	24.8%	-
Huntingdonshire	55-64	21,280	23,520	21,320	23,780	11.7%
	65-74	13,720	15,830	19,360	19,750	44.0%
	75-84	7,650	8,290	10,070	12,950	69.3%
	85+	2,760	2,860	3,340	4,250	54.0%
	Total population	163,100	165,490	165,780	166,780	2.3%
	65+	24,140	26,980	32,770	36,950	53.1%
	% 65+ of total population	14.8%	16.3%	19.8%	22.2%	-
South Cambridgeshire	55-64	19,050	20,770	19,450	21,800	14.4%
	65-74	12,420	14,980	19,860	21,420	72.5%
	75-84	7,940	8,620	10,730	14,350	80.7%
	85+	2,890	3,050	3,910	5,230	81.0%
	Total population	142,500	142,160	158,600	171,930	20.7%
	65+	23,260	26,650	34,500	41,000	76.3%
	% 65+ of total population	16.3%	18.7%	21.8%	23.8%	-
Cambridgeshire	55-64	73,370	82,150	76,820	86,160	17.4%
	65-74	49,300	56,090	70,420	75,650	53.4%
	75-84	31,900	33,670	38,590	48,210	51.1%
	85+	11,500	12,200	14,890	18,520	61.0%
	Total population	595,500	605,030	642,270	673,690	13.1%
	65+	92,680	10,1960	123,900	142,380	53.6%
	% 65+ of total population	15.6%	16.9%	19.3%	21.1%	-

Source: Cambridgeshire County Council Research Group Mid-2008 district level population forecasts by age and gender.

By 2021, Cambridgeshire population in the 75 and over years is forecast to increase by 54% (around 23,300 people in total).

Table 29: Population change for ages 75+ years, 2008-2021, Local Authority (CCCRG)

Local Authority	Forecast (year)				% change				Actual change 2008-2021
	2008	2011	2016	2021	2008-2011	2011-2016	2016-2021	2008-2021	
Cambridge	7,060	7,060	7,550	8,980	0.0%	6.9%	18.9%	27.2%	1,920
East Cambridgeshire	6,450	6,830	7,840	9,460	5.9%	14.8%	20.7%	46.7%	3,010
Fenland	8,700	9,210	10,050	11,580	5.9%	9.1%	15.2%	33.1%	2,880
Huntingdonshire	10,410	11,150	13,410	17,200	7.1%	20.3%	28.3%	65.2%	6,790
South Cambridgeshire	10,850	11,670	14,640	19,580	7.6%	25.4%	33.7%	80.5%	8,730
Cambridgeshire	**43,390**	**45,870**	**53,480**	**66,730**	**5.7%**	**16.6%**	**24.8%**	**53.8%**	**23,340**

Source: Cambridgeshire County Council Research Group Mid-2008 district level population forecasts by age and gender.

Note: These forecasts are based on a series of assumptions and are indicative only; they do not represent the policy of the County Council or any district council.

A changing dependency ratio with more older people to care for by fewer younger people

As population structures change, the balance of the population of working age compared to the 'dependent' population may shift. This changes the proportion of people likely to be economically active in relation to the proportion of people more likely to be supported by the state. In the majority of Local Authorities, the number of people aged 15-64 per person aged over 65 is forecast to drop by between 13.9% in Cambridge City to 36.9% in Huntingdonshire and 37.5% in South Cambridgeshire.

Table 30: Number of people aged 15-64 per person aged over 65

Local Authority	Year				% change
	2008	2011	2016	2021	2008-2021
Cambridge City	6.2	6.2	5.9	5.3	-13.9%
East Cambridgeshire	3.8	3.5	2.9	2.5	-33.2%
Fenland	3.2	3.1	2.6	2.4	-24.5%
Huntingdonshire	4.4	4.1	3.2	2.8	-36.9%
South Cambridgeshire	3.9	3.4	2.8	2.4	-37.5%
Cambridgeshire	4.2	3.9	3.3	3.0	-30.3%

Source: Cambridgeshire County Council Research Group Mid-2008 district level population forecasts by age and gender.

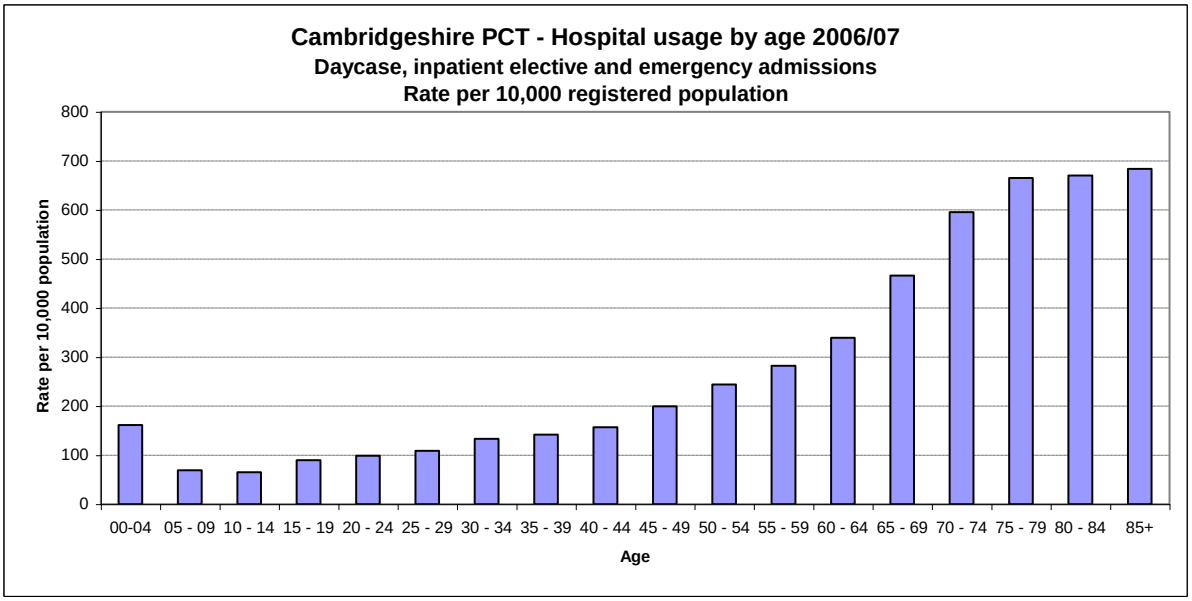
Use of Health and Social Services

Older people make up 69% of all adult clients of social services. When contacts are initially made to Councils with Social Services Responsibilities (CSSRs), they are screened to identify whether information, advice or a basic service is appropriate or whether further investigation and assessment are required.

In 2008/09, Cambridgeshire County Council Adult Social Care Services provided care to around 10,360 people aged 65+ and over (69% of all adult social care clients). In the same period around 3,350 clients in the 65+ age group had their assessment completed, which accounted for 78% of all clients.

Hospital usage increases rapidly with increasing age, to a rate of nearly 700 per 10,000 population over age 85. In 2006/07 there were 4,973 elective spells and 59,696 bed days occupied by people aged over 75 years totalling over £14m. For emergency care there were 6,533 spells and 7,342 total bed days totalling an additional £6m. The main expenditures for elective care in hospital were in trauma and orthopaedics, surgery and ophthalmology, and urology. The main expenditure in emergency care was general medicine, trauma and orthopaedics, geriatric medicine and general surgery. The largest category is emergency medicine, which totals nearly £7m.

Figure 15: Hospital admissions by type and age group – emergency, elective and day case



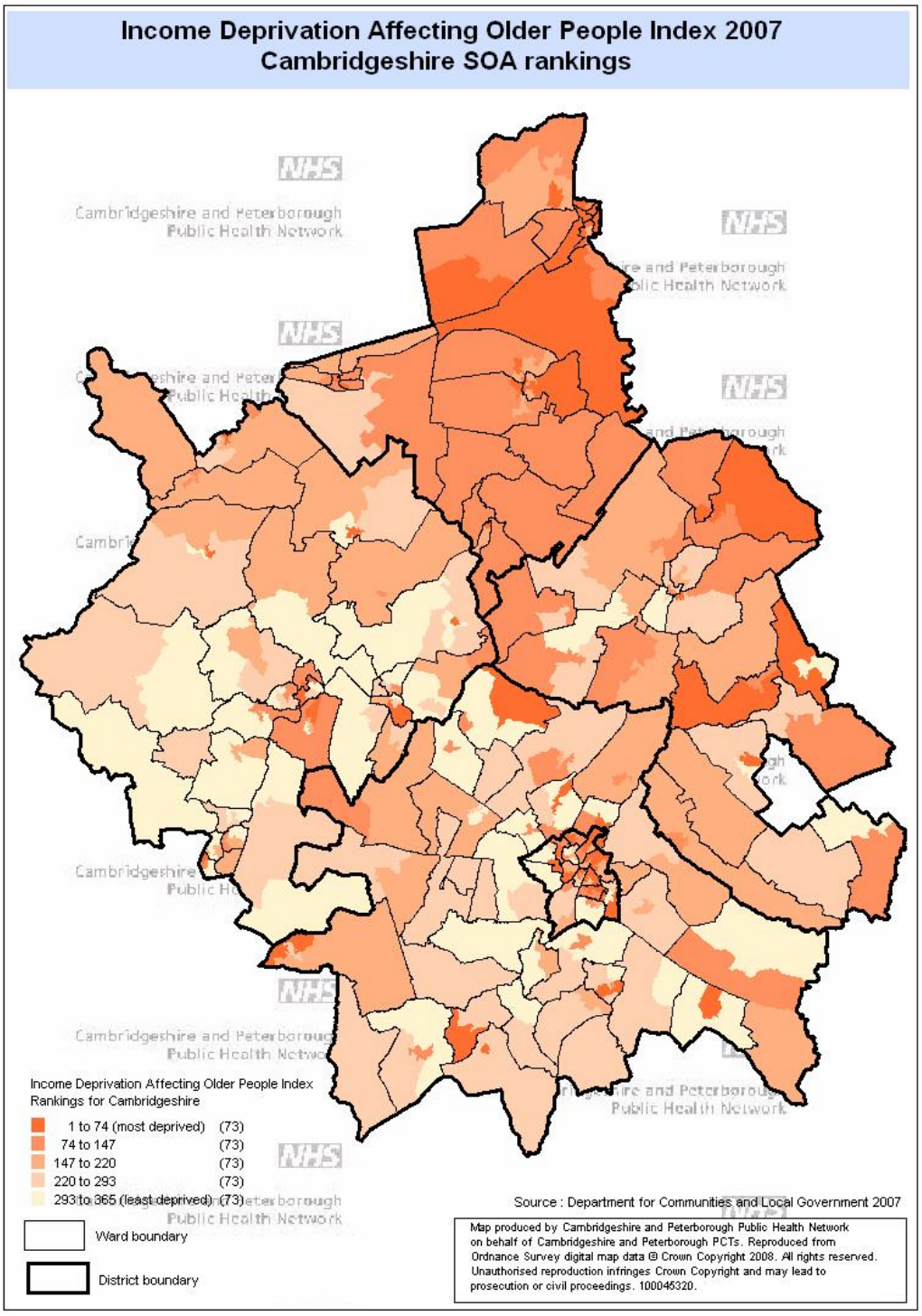
3.3 Existing Needs and Inequalities

The Social and Environmental Context

Within the Index of Multiple Deprivation 2007 the Income Deprivation Affecting Older People Index (IDAOPI) shows the percentage of pensioners living in Lower Super Output Areas (LSOA – small area statistical geography consisting of around 1,500 people) who claim benefits. Of the 32,482 LSOAs nationally, seven in Cambridgeshire are within the most deprived quintile (all in Cambridge City and Fenland). At the other end of the scale, 114 of Cambridgeshire's 365 LSOAs (i.e. 31%) lie within England's least deprived quintile.

Although Fenland consistently scores as more deprived, deprivation in this domain is slightly more evenly spread across the county, with local concentrations in Cambridge and Huntingdon as well as the centres of many of the rural villages as shown in Map 7 overleaf.

Map 7: Cambridgeshire income deprivation affecting older people index (IDAOPI score from IMD 2007) by quintiles of LSOA based on the IDAOPI score. The LSOAs shaded darkest represent the most deprived 20% of Cambridgeshire's LSOAs in terms of income deprivation affecting older people



Fewer older people claim benefits than would be expected at present

Over 14,000 people in Cambridgeshire aged 65 or over were entitled to receive Attendance Allowance in November 2006, 16% of the population aged over 65 (range from 15% to 18%). All areas appear to be considerably lower than the proportion in England as a whole. The age variation within the older population receiving Attendance Allowance has implications for potential vulnerability with a range from 52% to 61% of the population aged 85 and over receiving these benefits.

In total, approaching 19,000 people in Cambridgeshire were entitled to Disability Living Allowance in November 2006 of whom nearly 4,000 (21%) were over 65 years. However, for older people the figures are lower than the England average.

The carer's allowance is a non-contributory benefit for people who look after a severely disabled person for at least 35 hours a week who are not gainfully employed and who are not in full-time education. In Cambridgeshire, 38% of people receiving the carers allowance are aged over 65 compared to the England average of 34%.

Partners need to plan together to ensure that the living circumstances of older people will be matched to their social care needs

The living circumstances of older people affect both opportunities for social interaction and the need for additional support from formal and informal services. In Cambridgeshire, 62% of pensioner households are owned outright or with a mortgage or loan compared to the England average of 63%. Some 28% are rented from the council or other social rented, which is the same as the England average. 62% of pensioners who live alone do not have a van or car in the household, compared to the England average of 68%, while 19% of two pensioner households do not have a car compared to the England average of 27%. The latter is highest in Cambridge City at 32%.

Around 30% of households in Cambridgeshire include at least one person of pensionable age and around 10% of households consisted of two or more people, all of whom were pensioners. Both East Cambridgeshire and Fenland have a higher proportion of ‘all pensioner’ households (11% and 13%) than the national figure (9%).

The highest proportion of one-person pensioner households is in Fenland where over 15% of households consist of one pensioner living alone. In 2001, there were 8,200 households consisting of pensioners living alone in the PCT area (29%) of all pensioners. There were a further 6,700 households consisting of other pensioner families.

While there are over 50,000 people at the 2001 Census recorded as providing some level of unpaid care, this includes nearly 9,500 people of 65 and over.

Based on data from 2001/3 there were over 13,000 households in Cambridgeshire in fuel poverty[122]. Five areas in Cambridge City, two in Huntingdonshire and one in Fenland were in the worst 10% in England. The level of fuel poverty varied across Cambridgeshire. Most areas had a lower proportion of pensioners living alone without central heating than the national average. Cambridge City had large numbers of pensioners living alone without central heating, over 600 in Cambridge. In Cambridge City, nearly 200 people aged 85 and over (15% of those aged 85 and over who were living alone) had no central heating. The main underlying causes of excess winter deaths related to cold weather are ischaemic heart disease, influenza and pneumonia, cerebrovascular disease and chronic lower respiratory disease[123].

In addition, Cambridge City had a higher proportion of pensioners living on the first floor or above than the other districts or the national average (1,686 people). 2,126 pensioners lived in overcrowded households of which 774 were in Cambridge City and 475 in Huntingdonshire[124].

Based on 2006 data (modelled), there were over 22,200 households in Cambridgeshire in fuel poverty (9.4% of all households). Fenland had higher proportion of households in fuel poverty than the county average at nearly 13% (5,021 households in total). In Huntingdonshire the proportion was slightly lower at 7.2% (4,792 households in total)[125]. Nationally, the trend in fuel poverty was increasing in 2003-2007: from 5.9% in 2003 to 13.2% of households in poverty in 2007[126].

The county policy is to work in partnership to enable a shift from residential care homes to extra care housing. This includes enabling the increase in the provision of nursing care for elderly mentally ill people. Countywide there is a target to provide the shift to 1500 extra care units representing 18 units per 1,000 population aged over 65. These are major shifts. So for example Huntingdonshire has to increase from 86 places to 209 by 2011. Fenland from 74 to 200, South Cambridgeshire from 97 to 190, East Cambridgeshire from 94 to 124 and Cambridge City from 57 to 117. This would total a shift of 432 in the County, but a further shift of 1,068 is required by 2016. Therefore, planning has to be in place for major shifts in the setting of care in people's home environments.

Health status and lifestyle in mid-life and in older people

Healthy ageing is the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life. Evidence indicates that health promotion interventions can extend longevity and improve quality of life. Heath promotion and prevention are possible even in groups of very high ages. The national policy highlights the importance of preventative services to enable people to remain independent and is in line with the European Union Healthy Ageing policy http://www.healthyageing.nu.

[122] Data modelled by University of Bristol using 2001 Census and 20032 English Housing Condition Survey. Centre for Sustainable Energy (CSE) http://www.cse.org.uk/
[123] Ibid
[124] Ibid
[125] Department of Energy and Climate Change (2009), Fuel poverty regional statistics http://www.decc.gov.uk/en/content/cms/statistics/fuelpov_stats/fuelpov_stats.aspx
[126] Department of Energy and Climate Change (2009), Trends in fuel poverty: England. 2003, 2004, 2005, 2006 and 2007 http://www.decc.gov.uk/en/content/cms/statistics/fuelpov_stats/fuelpov_stats.aspx

Cigarette smoking is implicated in eight of the top 14 causes of death for people 65 years or older. There are benefits from stopping smoking at any age, but these are greater the earlier cessation takes place. The prevalence of smoking is 17% of men over 60 (10,000 men) and 14% of women over 60 (9,260 women). The likelihood of success of an attempt to quit smoking with NHS support increases with age.

For people of all ages, physical activity improves the quality of life in many ways. Physical benefits include improved and increased balance, strength, co-ordination, flexibility and endurance. Physical activity has also been shown to improve mental health, motor control and cognitive function.

Good nutrition for elderly people is vital both to promote good health by eating plenty of fruit and vegetables and to reduce the risk of heart disease, stroke and cancer and by having enough food energy from food and drink to maintain bone and muscle strength mobility and general health. The Dietetic Service has provided advice to care homes since 1997 in Cambridge City, South and East Cambridgeshire. The total number of homes served is now 63 with several more to be built. The population of these homes has become increasingly frail with a high incidence of poor eaters. The Dietetic service has implemented nutrition risk screening in homes in Cambridge City, South and East Cambridgeshire areas since 1998 and in Fenland homes since 2006.

Even modest alcohol use in old age may be potentially harmful as a contributor to falls, compromised memory, medicine mismanagement, inadequate diet and limitations on independent living. Prevalence of hazardous drinking decreased with age, though there were differences between sexes. The prevalence of hazardous drinking was higher among men (38%) than among women (15%). There were 6,890 admissions to hospital related to alcohol in 2006 in those aged 65 or over.

The Cochrane review on falls prevention concluded that ‘multidisciplinary, multifactorial, health/environmental risk factor screening/intervention programmes’ are likely to be beneficial with a falls risk reduction of 20%. Applying national figures 30% of people aged over 60 (36,180 people) will suffer a fall each year, 6,450 visit A&E and 2,040 are admitted into hospital for falls related injury each year. Therefore, the cost of treating falls in Cambridgeshire is likely to be up to £9,768,680. Further implementation of the NICE guidelines for falls prevention in Cambridgeshire could result in a reduction of 15% to 30%. This would mean up to 5,400-10,900 less falls, saving £1.5m in hospital admissions and saving 2,260 bed days.

Problems associated with the use of medication can be avoided by the systematic use of quality indicators for drug use and better co-ordination among care providers.

There is NICE guidance on most of these areas of health promotion.

Frailty in older people will place more demands for care at home

With increasing life expectancy, more people (particularly men) are living to an age where they are more likely to be physically frail or confused, which has significant implications for service planning. There are around 13,900 frail people aged over 65 in Cambridgeshire. Around 8,620 will be physically frail, around 2,570 will be mentally frail, and 2,700 will have combined mental and physical frailty.

Between 2006 and 2011, the numbers of elderly frail people is predicted to rise from 2,370 to 2,500 in Cambridge City, increase from 1,960 to 2,200 in East Cambridgeshire, from 2,650 to 2,930 in Fenland, from 3,470 to 4,020 in Huntingdonshire and from 3,450 to 4,000 in South Cambridgeshire.

By 2011, the estimated increase in Cambridgeshire is to 15,700, by 2016 to 18,600 and by 2021 to 21,500.

Those with combined mental and physical frailty are likely to be heavy users of services, and to be more difficult to place.

Table 31: Estimated number of frail older people, Cambridgeshire, 2006-2021 by age

	Age	2006	2011	2016	2021	% change
Physical	65-74	*2,030*	*2,510*	*3,130*	*3,350*	65%
	75-84	*3,580*	*3,850*	*4,380*	*5,300*	48%
	85+	*3,020*	*3,360*	*3,960*	*4,590*	52%
	Total	*8,620*	*9,720*	*11,470*	*13,240*	54%
Cognitive	65-74	*670*	*830*	*1,040*	1,100	64%
	75-84	*1,100*	*1,190*	*1,370*	1,700	55%
	85+	*930*	*1,050*	*1,250*	1,460	57%
	Total	*2,700*	*3,070*	*3,650*	4,260	58%
Combined	65-74	*290*	*360*	*450*	480	66%
	75-84	*880*	*950*	*1,080*	1,340	52%
	85+	*1,400*	*1,570*	*1,870*	2,170	55%
	Total	*2,570*	*2,880*	*3,390*	3,990	55%
All disabled	Total	*13,890*	*15,670*	*18,510*	*21,490*	55%

Source: MRC CFAS Study estimates applied to Cambridgeshire County Council 2005-based ward age forecasts.

The Best Value Review of Sheltered and Extracare housing sets challenging targets for housing repetition

The vast majority of provision of sheltered and Extracare housing in the county remains social rented accommodation provided through Councils and registered social landlords. There is a growing private market for sheltered housing for older people with some element of support, particularly in the Cambridge City area. A Best Value Review of Sheltered Housing was carried out during 2004 to 2007. The current target for growth in provision of Extracare is set at 1,500 units by 2016. The distance from target varies by District: Cambridge City (103), East Cambridgeshire (133), Fenland (189), Huntingdonshire (370), South Cambridgeshire (372). Likewise, the distance from target for sheltered housing varies by district: Huntingdonshire requires 187 more sheltered housing units, whereas South Cambridgeshire, Cambridge City and East Cambridgeshire seem to have an excess of sheltered housing.

Key to the strategic switch is that the funding element for housing support is not predicted to grow and that, therefore, any new model of provision must be based upon use of existing revenue resources. Growth in extra care is seen as imperative given the growth of the elderly population over 80 and the desire to provide alternatives to residential care.

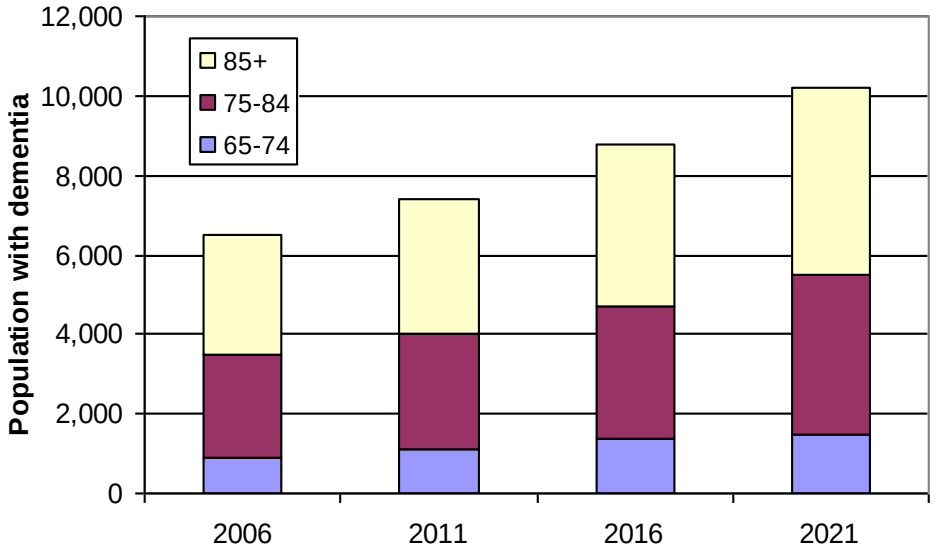
In October 2009 the total number of nursing and residential home beds in the county was 3,384. Homes can be dual registered as nursing and residential, as long as they meet individual need. In 2009, 50% of beds were residential (1,687 beds in total), 10% nursing beds (355 beds in total) and 40% dual registered (1,342 beds in total). A proportion of each of these (in each category) is specified for dementia. Overall, 80% of all beds are specified for dementia. Some of these beds are occupied by Cambridgeshire residents whose care is funded by the County Council, others are self funding. If there is no switch in provision towards Extracare housing then usage of funded residential care placements is predicted to increase to 1,650 by 2021. This modelling has not adjusted for increasing frailty or prevalence of dementia, which will increase the demands for supported care.

Overall, the future requires commissioners and providers to develop a greater potential range of options, delivering in a more flexible way and exploiting the use of new technology. Community alarms are a vital link in providing remote monitoring and assistance in this and the Best Value Review also sets targets for the provision of community alarms for older people living outside of sheltered accommodation. Fenland, Huntingdonshire and East Cambridgeshire are significantly below these targets.

The number of people with dementia is set to rise and depression is significant

Much is being done to raise the awareness of mental issues relevant to older people such as depression and dementia. Prevalence estimates suggest that, in 2006, there are around 6,580 older people with dementia in Cambridgeshire. By 2021, this is forecast to rise by 56% to 10,240. The prevalence estimates are 7,380 people by 2011, 8,690 by 2016 and 10,240 by 2021. The incidence estimates are 1,720 in 2006, 1,950 in 2011, 2,310 in 2016 and 2,690 by 2021. As the incidence of dementia rises sharply with age, local estimates will vary according to the age structure of the older population. For example, the incidence of dementia is 6.3 per 1,000 person years for women aged 65 to 69 and rises to 71.7 per 1,000 person years to women aged 85 and over.

Figure 16: Estimated and forecast number of people with dementia, by age, for Cambridgeshire



The burden of mental health problems is also considerable with 7.6% of men over 65 years with depression and 11.3% of women.

Chronic Diseases

General Practitioners have registers that provide a count of people they are treating with chronic diseases. There is under-ascertainment. However the recorded prevalence for people in NHS Cambridgeshire shows 19,000 with coronary heart disease, 9,200 with stroke and transient ischaemic attack, 22,720 with diabetes, 8,360 with chronic obstructive pulmonary disease and 2,434 with dementia in the community. These are all chronic diseases and steps are being made to modernise services through the Primary Care Trust Long term Conditions Board and to meet the standards of care set in the National Service Frameworks (NSFs). The occurrence of these conditions increase with age.

Further NICE guidelines are expected in many of these areas. These will have implications for service redesign on a large scale. For example, using national study estimates, the estimated annual number of first new strokes for the Cambridgeshire population is 1,136 of which 872 are in people aged 65 and over.

Health Inequalities in Later Life

Tackling health inequalities in later life and improving the underlying socio-economic determinants for older people should be at the core of any healthy-ageing strategy and health promotion activity. Equity in health for older people explicitly includes non-discrimination of older people.

A recent report identifies three dimensions that interact to produce health inequalities. These include social and economic factors (poverty, housing, gender, ethnicity and isolation). Issues of access which include transport, information, technology, mobility, safety, discrimination and ageing in service provision). Then there are issues of power such as public involvement, decision-making, discrimination and ageism.

3.4 Relevant LAA Indicators

NI 4: Percentage of people who feel they can influence decisions in their locality.
NI 7: Environment for a thriving third sector.
NI 17: Perceptions of anti-social behaviour.
NI 120: All age all cause mortality in the 20% most deprived areas in Cambridgeshire.
NI 125: Achieving independence for older people through rehabilitation/ intermediate care.
NI 131: Delayed transfers of care from hospitals.
NI 135: Carers receiving needs assessment or review and a specific carers service, or advice and information.
NI 136: People supported to live independently through Social Services.

4. Population Groups at Risk of Social Exclusion

4.1 People Who are Homeless or at Risk of Homelessness

4.1.1 Key Findings Summary

- Homelessness describes a wide range of circumstances where people have no secure accommodation. This JSNA categorises homeless people into three overlapping groups:
    - **single homeless and rough sleepers (SHRS)** - group of homeless people for whom there may be no statutory duty or simple solution (around 500 are registered with CAS);
    - **statutory homeless** - those defined in law[127] as being in priority need and entitled to housing support from local authorities (around 600 households across Cambridgeshire each year, largely families);
    - **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)
- There is a great deal of overlap between these groups with people frequently moving in, out and between them. This JSNA has particularly focused on the SHRS population as this group has the poorest outcomes in Cambridgeshire. However, the other two groups also have a constellation of needs and issues.
- Homelessness is complex and there is rarely a simple explanation for someone becoming homeless. A number of interlinked personal and social factors can contribute towards people becoming homeless.[128] These may include individual factors, family background and/or an institutional background.
- Housing is one of a number of factors that has an important influence on people's health. Homelessness is more than a housing issue and can occur as a result of poor health, unemployment, imprisonment or poverty. Health care, social services and criminal justice systems all impact on homelessness[129].
- Compared to the general population, homeless people experience poorer health outcomes. Physical health, drugs, alcohol, mental health and well-being have been recognised as priority health issues among the homeless. However, homeless people generally experience difficulties with accessing health services; this poor access also impacts on their health status. Health outcomes are generally worst for SHRS but may also be poor in the statutory and hidden homeless. People who are accepted as statutory homeless are at risk of moving into non-statutory homeless groups for a variety of reasons.

127 Her Majesty's Stationary Office, 2002. Homelessness Act 2002.
128 Department for Communities and Local Government, 2001. Homelessness Strategies; a good practice handbook.
129 British Columbia. Ministry of Social Development and Economic Security, 2001. Homelessness: causes and effects. Volume 1. The relationship between homelessness and the health, social services and criminal justice systems: a review of the literature.

- Homeless people are much more likely to die young than people who are not homeless. Amongst the patients registered at CAS (a dedicated GP practice largely for single homeless and rough sleepers), of the 40 who are known to have died over the last five years, the average age at death was 44. The registered patients at CAS are relatively young and range from young adulthood to middle age. Many are at the very lowest point in their lives. Of CAS patients, ½ have an alcohol problem; 2/3 have a drug problem, ½ have a mental health problem and many people have two or all three of these problems. Taken together, drugs, alcohol and poor mental health play a major part in nearly all deaths among the homeless. Note that this should not be confused with life expectancy. Life expectancy at birth for the general population of Cambridgeshire is 80 for men and 82 for women. This does not mean that life expectancy for the CAS population is half that of the rest of the population in Cambridgeshire but does highlight that, consistent with poor health outcomes and multiple morbidity, the the mortality figures for the CAS population of single homeless and rough sleepers are comparatively very poor.
- The housing pathway differs for statutory and non-statutory homeless with the statutory homelessness pathway being undertaken by local authorities and governed by homelessness legislation. For non-statutory homeless there are a range of entry points and the often chaotic lifestyle of this group means that their journey may not follow a clear pathway.
- The purpose of the JSNA for Homelessness and those at risk of homelessness is to identify the current and future health and well being needs of people who are identified as homeless or at risk of homelessness in Cambridgeshire, and inequalities and stigma faced by the homeless population. It recommends ways to achieve real improvements in health and well-being outcomes for this group.
- Partnership working has been an essential part of this JSNA and key to understanding the needs of the local homeless population. The JSNA has been developed through joint working between the NHS, the County Council, the City and District Councils in Cambridgeshire, and voluntary sector agencies.
- Early intervention and proactive prevention of both homelessness and the poor outcomes associated with homelessness are key to improving the health and wellbeing of the homeless and those at risk of homelessness.
- Having more integrated, person-centred services would enable more comprehensive joint care planning, information sharing and monitoring of outcomes with a common record of individual homeless pathways. This could avoid duplication, therefore saving money while improving outcomes.
- Engagement of the homeless population in planning their own care is essential, and using the insight, information and interaction from the care planning process should inform commissioning and provision of services.
- Joint commissioning provides an opportunity to ensure services are integrated, needs-led, evidence based and person-centred, focusing on prevention and early intervention and will make a real difference to outcomes for SHRS and for chronically excluded adults.

JSNA Community Views - The Homeless

Generally there appears to be limited involvement of the homeless population in developing and evaluating local services. Homeless people often present with multiple and complex needs. Further work is needed to identify the individual outcomes that the homeless population want and it should be recognised that these outcomes may not be homogenous, just as the population described within this JSNA is not.

An example of service user involvement was in the development of the Cambridge City Homeless Strategy where current and former users of homelessness services and frontline staff were invited to a series of consultation events. The comments made at these events were incorporated into the strategy where appropriate which allowed the homeless population direct input into shaping the future of homeless provision in Cambridge City.

Other examples of obtaining views of the homeless population include:

- Public consultation on the alcohol service specification for Cambridgeshire, engaging with Winter Comfort to consult with the homeless regarding this service as well as frontline homeless service staff.
- A patient and stakeholder survey undertaken by CAS in 2007 which reported high levels of satisfaction with the service and that if the service was not available just under half of respondents would attend A&E or not access health care at all.

There needs to be more work done in engaging the views of this population to ensure services are responsive to their needs. 'Working together for change'[130] is an approach for engaging with people using services to review their experiences and determine priorities for change and places service users at the heart of the commissioning process and it is hoped that this model can be used with the homeless population.

Introduction

Homelessness and being at risk of homelessness are complex issues which can have wider implications for an individual's health, employment prospects and education. Making the transition out of homelessness can be an intensely difficult process, involving much more than the provision of housing.

These complexities are also reflected in the commissioning of services for the homeless which involves different funding streams and a variety of commissioning and provider organisations.

[130] Department of Health, 2009. Working together for change: using person-centred information for commissioning

4.1.2 Key Facts: The Population

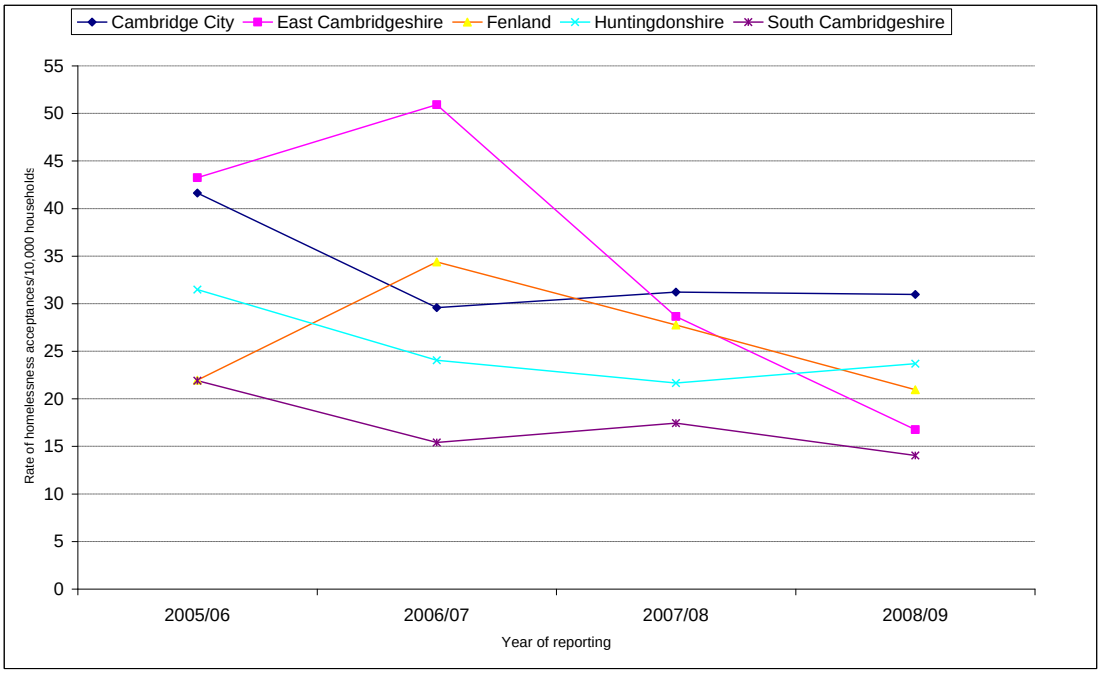
In Cambridgeshire, data on homelessness are collected by numerous service providers. However, most of these operate stand-alone information systems and there is no robust way of uniquely identifying service users and so there are likely to be instances of double-counting. There are a number of factors concerning the current information base on the homeless population of Cambridgeshire which has made it difficult to clearly describe the homeless population, such as:

- The transient nature of the homeless population with high geographic mobility and turnover. Each individual is likely to go through rapid chronological changes with respect to street homelessness/ different temporary accommodations and also health indicators.
- There are seemingly insurmountable problems in correlating information from different agencies due to categories used, double counting and the impossibility of identifying individuals across services.
- There is large geographical variation of services, particularly for SHRS, between town and rural areas with an overwhelming concentration in Cambridge City and, generally speaking, where there are no services there are no data. Therefore we have limited information for much of Cambridgeshire.

Supporting People and other agencies tend to view the homeless population as different client groups such as single homeless, rough sleepers, older people, ex-offenders, homeless families, young people (at risk, leaving care or teenage parents), people with disabilities, travellers, migrants, refugees and asylum seekers and also people with drug, alcohol, mental health and domestic violence problems. These categories are not mutually exclusive and one person may fit into or move between different client groups at any one time. Their rather arbitrary nature makes it very hard to get a clear picture of individuals and the complexity of their needs.

The overall trend in the number of households accepted as homeless both in Cambridgeshire (Figure 1) and nationally is downwards, largely due to local authority prevention strategies. However, there is some concern that the number of applications may increase due to the recession. In 2008/09, 40% of homelessness acceptances were as a result of parents/relatives/friends being no longer willing or able to provide housing and 74% of households accepted as homeless had a dependent child.

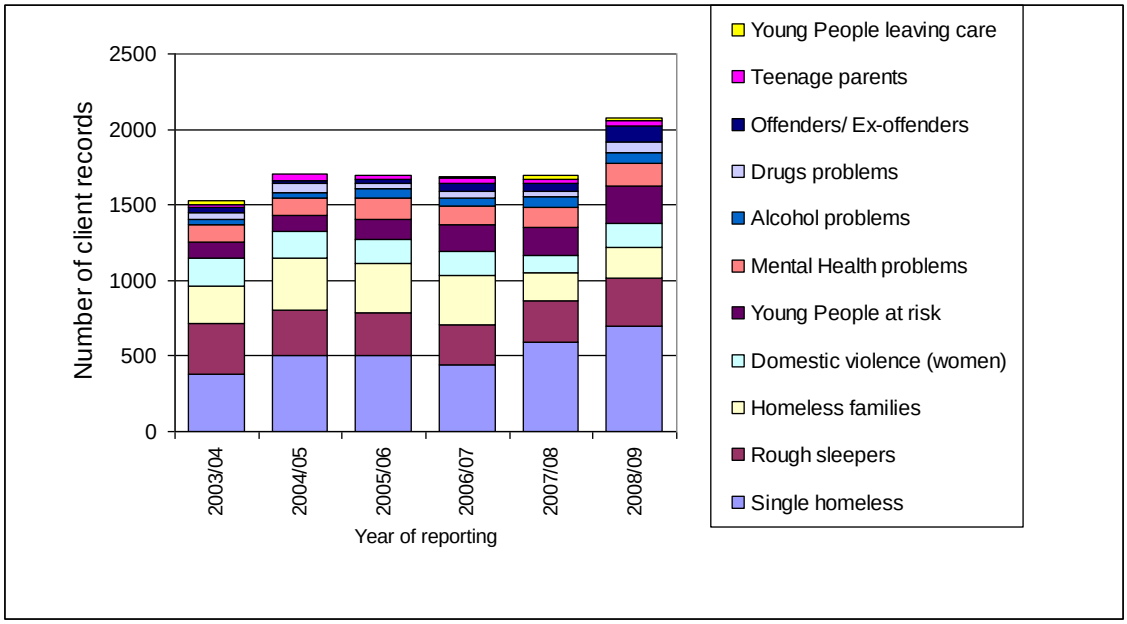
Figure 1: Rate of homelessness acceptances per 10,000 households by District, 2005/06 – 2008/09



Source: P1E. Household estimates: Research Group, Cambridgeshire County Council

The largest client group accessing Supporting People funded services is single homeless and rough sleepers with 49% of clients being recorded as such in 2008/09 (Figure 2). Data from Supporting People and Cambridge City Council show that the majority of people presenting to services for the homeless are white British males aged between 26 and 49.

Figure 2: Number of clients accessing SP funded services by year of reporting and primary client group (presentations to services)



Source: Supporting People

The registered population of Cambridge Access Surgery is around 500 people. The majority of people accessing the service are single homeless/rough sleepers with a higher proportion of males. A substantial proportion have mental health, substance misuse (drugs and/or alcohol) and 'dual diagnosis' with a mean age of death being 44 years.

The voluntary and statutory agencies in Cambridge have identified 27 clients they believe to be chronically excluded[131]. These are individuals with very complex needs, who have usually experienced rough sleeping, and may currently be sleeping rough.

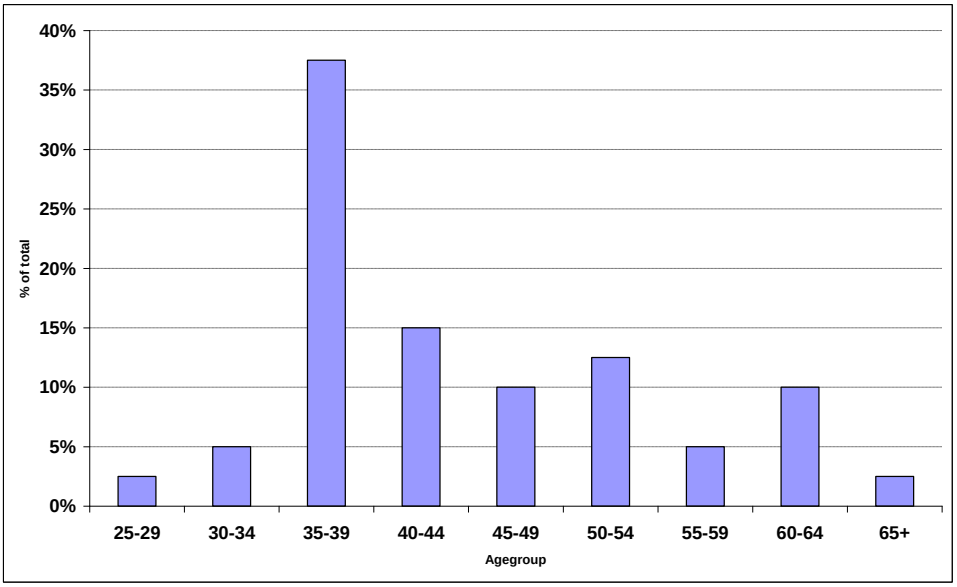
4.1.3 Existing Needs and Inequalities

Single Homeless and Rough Sleepers (SHRS)

The most common needs recorded for SHRS accessing Supporting People services are stated as support to maximise income, support to maintain accommodation and avoid eviction, support to access external groups and services and support to better manage substance misuse. The main reported reasons for these needs not being met are in relation to the client being unwilling or unable to engage or ceasing support before the outcome has been achieved.

The SHRS have very poor outcomes as illustrated by the age distribution of recorded deaths occurring amongst the population registered with CAS (Figure 3). This partially reflects 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. Although this group represents relatively small numbers, it is essential that services are developed to help reduce the poor outcomes for this population.

Figure 3: Age distribution of recorded deaths occurring among CAS registered population 2004-2006



Source: ONS Public Health Mortality File

[131] New Directions Team Assessment, August 2009

Single homeless and rough sleepers too often end up on a downward spiral of deteriorating mental and physical health with behavioural and control issues fuelled by alcohol and/or drugs on a background of socio-economic deprivation, dysfunctional relationships and inadequate access to support. Lack of past experience of a stable, emotionally secure existence reduces the chances of emerging from this downward spiral of homelessness. Homelessness further exacerbates the poor outcomes of the already disadvantaged because of the loss of daily living skills together with the pervasive culture of drug and alcohol use and associated crime and anti-social behaviour which are strong forces preventing successful re-housing. Many SHRS feel that they have been repeatedly failed by services and find engaging with services difficult. There are many dedicated staff trying to support the SRHS, who are constrained by a system that is not designed to meet the complex multi-factorial needs of their clients.

A substantial proportion of all homelessness services are based in Cambridge City however of newly homeless people in Cambridge City only 1 in 3 have a local connection with Cambridge City, while 2 in 5 have a local connection with other districts in Cambridgeshire. The size and character of Cambridge City make it an attractive place for homeless people and services have largely been developed there to meet their needs which in turn may attract individuals from both within and beyond Cambridgeshire.

At present, services for homelessness are commissioned independently and often covering different geographic and demographic domains with some services being commissioned by more than one agency within the same areas. There are concerns that the fragmented commissioning of services does not work well for the homeless and an integrated approach to providing services should be more robust.

This JSNA describes the wide range of current services for the homeless throughout the county. These include housing, health and drug and alcohol treatment, housing support and broader services directed towards rehabilitation such as training and employment. These services are delivered by statutory and non-statutory organisations, ranging from small local charities to national or county-wide organisations.

For many the main route out of SHRS is through being accepted as statutory homeless, but provision of accommodation alone is seldom adequate and many SHRS will require ongoing long term support to maintain tenancies and some will never find the personal resources to enable rehabilitation into society.

Statutory Homeless

Of clients referred to Supporting People, 22% were statutory homeless. This differs by client group with 72% of homeless families receiving SP services being statutorily homeless compared to only 2% of rough sleepers.

All Cambridgeshire local authority Homelessness Strategies have a focus on homelessness prevention and provision of appropriate accommodation, particularly reviewing the use of temporary accommodation. User involvement, partnership working and provision of support and services are also common themes. Some strategies also have a focus on specific client groups.

Hidden Homeless and Those at Risk of Homelessness

The characteristics of the hidden homeless population are largely unknown as those hidden homeless people who do not access services may never appear in the data collection systems and so the picture of the homeless population painted by existing data often misses this group as well as those at risk of homelessness. The hidden homeless are thought to be a transient population made up of some SHRS, 'sofa surfers', those living in hostels. There may be a large group who are in insecure accommodation, who may be at risk of either a crisis or relationship breakdown or loss of a temporary unskilled job

Effect of the Recession

Moving into the second decade of this century, there will be increasing pressure on public spending which will have an impact on health and social care budgets. Economic recession leads to increased unemployment, repossessions, homelessness and numbers of young people with difficulties in achieving a stable future. The effects of recession may include social problems and rising crime. The 'inverse care law' first described by Julian Tudor Hart in 1971[132] states that 'the availability of good medical care tends to vary inversely with the need for it in the population served.' The commissioning process needs to ensure that integrated solutions are provided for some of the most excluded and deprived sections of our society.

4.1.4 Relevant LAA Indicators

NI 1 % of people who believe people from different backgrounds get on well together.
NI 4 % of people who feel they can influence decisions in their locality.
NI 5 overall/general satisfaction with the local area.
NI 17 perceptions of antisocial behaviour.
NI 20 assault with less serious injury.
NI 21 dealing with local concerns about antisocial behaviour and crime.
NI 141 number of vulnerable people achieving independent living.

4.1.5 Recommendations

The following recommendations have emerged from this partnership working venture. The consistency in the needs identified by key stakeholders inspires confidence that these recommendations are founded in the experience of working with homelessness. It is recognised that there are significant constraints in the public sector at present. However a number of these recommendations are about using resources better across agencies, in a way which engages service users.

Development of a multi-agency steering group to strengthen joint commissioning to address the needs of chronically excluded adults, single homeless and rough sleepers in Cambridgeshire with a focus on improving outcomes and the complex interrelations between health, housing and social care. Where possible more integrated multi-agency services should be commissioned including funded posts for liaison and co-ordination between services. This group could also consider development of a MARAC (multi-agency risk assessment conference) approach for chronically excluded adults.

[132] Hart JT. The Inverse Care Law. *Lancet* 1971;i:405-12.

Develop methods to encourage service user engagement in the commissioning process. Service users' experience and perceived needs should be embedded in the care planning process. Information from individual care plans should be used to inform service development and commissioning to ensure direct input of homeless people and front-line service providers using the 'Working together for change' model.

Develop integrated information systems, data collection tools and ways of unifying individual client records so they can be used and accessed across services and care personalised across pathways to allow more holistic and person-centred identification of needs, commissioning of services and monitoring of outcomes. Develop a process for the sharing and disseminating of knowledge and experience on service provision for the homeless.

Develop 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. In addition services should be co-ordinated, accessible and responsive to the needs of the homeless population.

Develop a strategy to address the health needs of the homeless population in Cambridgeshire as part of a joint commissioning strategy with action plans to support implementation and supporting the existing district homelessness strategies and action plans.

Recognise that the issues identified in this JSNA are ongoing and that there needs to be ownership and multi-agency partnership for action planning to implement the recommendations.

4.2 Migrant Workers

4.2.1 Key Findings Summary

- Migrants are not a homogeneous group. International migrants in Cambridgeshire come from all over the world and with different socio-economic backgrounds. They provide much needed labour and skills for local business as well as vital public services and thus help to deliver higher living standards and a wider choice of better and more affordable products and services to local people[133].
- Many migrant workers are working below their skill level even though the skills they possess can be in areas where there are skills shortages. The wellbeing and integration of migrant workers is affected by their financial situation, access to adequate and affordable accommodation and access to English language courses designed to meet their needs[134].
- In terms of geographical spread, it is Cambridge City which has the highest proportion of migrants in its population. However, other districts also receive migrants. Over recent years, overall, the number of international migrants has increased and they are increasingly spread around the county. There is significant diversity and variation in the migrant populations and their needs in different districts within Cambridgeshire.
- Since 2001, National Insurance Registrations indicate that approximately 30,000 people have come to Cambridgeshire to work. Of these, it is estimated that around 13,100 have remained for over one year, bringing the total number of Cambridgeshire residents who were born abroad to 61,500. This indicates a slight rise in the proportion of the population born abroad from 9% in 2001 to 11% in 2006. Following EU expansion in 2004 when the EU was expanded by 10 countries, a rapid increase in migration took place which has brought high inflows of people from the eight accession countries (A8)[135] to the county, and in many districts there continues to be notable migration from Western Europe and Asia[136].
- Housing is one of a number of key factors that has an important influence on people's health[137]. The housing report from the Migration Impacts Forum (2008)[138] states that access to good quality and affordable accommodation is critical in providing stable circumstances for migrants to be economically active and to promoting community cohesion. The housing report indicates that the majority of 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.

133 Legrain, P. (2008) Why the East of England needs migrant workers and what it must do to make the most of them, East of England Development Agency

134 Cambridgeshire County Council wwww.camweb.ccc.cambridgeshire.gov.uk?NR?rdonlyres/8707CA50-DEC9-4A7F-87E4-C8C108452C5D/0/CambsVision20072021.pdf (Accessed on 05/05/2009)

135 The A8 refers to all the A10 countries that joined the EU in 2004 except Cyprus and Malta. The A8 includes: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia

136 The Research Group, Cambridgeshire County Council, March 2008

137 Chartered Institute of Environmental Health (2008) Good Housing Leads to Good Health www.cieh.org.uk/library/policy/publications_and_information_services/policy_publications/good_housing_leads_to_good_health_2008.pdf (accessed 15/07/09)

138 Sheffield City Council (2008) Housing report to the Migrants Impact Forum www.ukba.homeoffice.gov.uk/sitecontent/documents/managingourborders/mif/papersandagendas (Accessed 15/06/2009)

- The latest Pupil Level School Census data published in January 2009 indicates that black, minority ethnic (BME) children, those in the category 'white: other group' and the categories of Gypsy/Roma and travellers comprise 13.2% of Cambridgeshire's total school population. The data also identifies that across the county's school population 87 languages are spoken with new communities growing in areas with traditionally less linguistic diversity[139]. Educational attainment of BME and traveller groups in Cambridgeshire is similar to national trends, with Bangladeshi, Black African, Black Caribbean, Pakistani heritage and Gypsy/Roma and travellers of Irish heritage reaching lower levels of attainment than the population as a whole at all key stages[140].
- The availability of English language provision is key. Evidence suggests that English language learning has a significant and positive impact on individuals, communities and the productivity and safety of workplaces with lack of fluency in the language condemning many to poverty[141].
- Although the impact of migrant workers has many positives large social changes can occur which can alter community cohesion. There is little evidence of the increase in the number of migrants generally leading to problems with community safety or cohesion but the perception of the indigenous community in some areas can be negative.

Introduction

This document focuses on the current and future needs of international migrants in Cambridgeshire. In recent years the level of international migration into the UK, and into Cambridgeshire, has increased.

International migrants in Cambridgeshire come from all over the world and with different socio-economic backgrounds. In the majority of cases, international migrants are working age population who work in different sectors of the economy (migrant workers). 'Overall, migrant workers are not only self-financing they are generally net contributors to public finances. They are mostly young, healthy, without dependents and working . They pay income tax, national insurance and council tax but make very few claims on the public purse. The NHS and the care sector rely on foreign staff and though their broader contribution to economic growth, migrants help make the welfare state more affordable for everyone.'[142]

There are however, a number of categories of migrants and they are not a homogeneous group. These categories include temporary labour migrants, highly skilled migrants, irregular or undocumented/illegal migrants, family reunion or reunification migrants, return migrants and forced migrants which includes refugees and asylum seekers.

139 Department for Children Schools and Families, Pupil Level Annual School Census, January 2009.
140 The Research Group, Cambridgeshire County Council, March 2008.
141 Learning and Skills Council (LSC) Migrant Workers and the Labour Market Review of LSC research on labour market participation, skills and skills provision for migrant workers January 2007. www.readingroom.lsc.gov.uk/lsc/national/nationalmigrantworkersandthelabourmarket.pdf (Accessed 05/06/2009)
142 Legrain, P. (2008) Why the East of England needs migrant workers and what it must do to make the most of them, East of England Development Agency.

The focus of this document is on migrant workers, this reflects both the focus of interest on those coming to the UK from the A8 states (The European Union Accession countries, the 10 countries that joined the EU in 2004 except Malta and Cyprus) to take up work, as well as the greater availability of data relating to the working migrant population.

The information and data used in this document comes from a variety of sources. Where possible local data is used mainly from Cambridgeshire County Council. Where local data is not available, information from research carried out at a regional or national level is used as evidence. It is important that international migrants' diversity are taken into account when accessing their needs. Variations between different migrant groups are by: age, gender, country of origin, marital status, education, type of employment, place of residency in Cambridgeshire and others.

It is worth noting that research on international migrants encounters methodological difficulties in sampling and recruiting migrants. It can be difficult to give an accurate estimate of a given group of migrants, some migrants for example undocumented migrants and/or migrants who live in rural areas can be difficult groups to reach.

4.2.2 Key Facts: The Population[143]

The 2001 Census showed that **9**% of Cambridgeshire's population were born outside of the UK, of which 34% were born in Western Europe, 24% were born in Asia and 20% were born in America.

Analysis of data from National Insurance Number registrations and the Worker Registration Scheme (A8 citizens are required to register with the Worker Registration Scheme (WRS) in order to join the formal economy) suggests that Cambridgeshire has among the highest numbers of migrant workers in the East of England whilst the East of England ranks third in the country after London and the South East. Within Cambridgeshire, Cambridge City has the highest number of work-related migrants overall. This high proportion reflects Cambridge City's global prominence on education, research and high tech. industries.

The highest number of migrants in terms of individual countries are from Poland, Lithuania and India. There is however a great diversity of international migration across Cambridgeshire. While European Union (EU) expansion has brought inflows of people from the A8 countries, in many districts there continues to be notable migration from Western Europe and Asia. Whilst South Cambridgeshire, Cambridge City and Huntingdonshire exhibit this particularly mixed pattern of migration in East Cambridgeshire and Fenland migration is much more dominated by those from the A8 countries, most likely to be due to the prevalence of agricultural industry and seasonal employment.

Following the EU expansion in 2004 a rapid increase in migration from the A8 countries took place. Numbers of new migrants from these countries peaked in 2005 and fell in 2006. This suggests that, as might be predicted, the numbers of migrants may be stabilising or falling, perhaps in relation to available jobs in this country and economic expansion in the A8 countries. The majority of migrants from these countries are young adults and the numbers of dependent children are generally low.

143 The Research Group, Cambridgeshire County Council, March 2008

4.2.3 Existing Needs and Inequalities

Housing

Housing is one of a number of factors that has an important influence on people's health. The association between housing conditions and physical and mental ill health has long been recognised and there are a broad range of specific elements relating to housing that can affect health outcomes[144].

Only a small proportion of social housing is allocated to foreign nationals. Foreign nationals from outside the EU are not eligible for social housing unless they are:

- An asylum seeker granted refugee status, or an asylum seeker or other vulnerable person granted humanitarian protection or discretionary leave.
- A person granted Indefinite Leave to Remain.

Migrant workers from countries that were members of the EU prior to 2004 have the same rights to benefits and housing as UK nationals, providing they are working. However, EU nationals' rights to live in the UK are based on an expectation that they should be economically active or self-sufficient and not place a burden on UK social assistance. For A8 nationals there are different rules restricting eligibility to housing and benefits. A8 migrant workers have to prove they are working and are registered on the Worker Registration Scheme (WRS) in order to be eligible for public funds. Once registered they are eligible to apply for welfare assistance, including housing immediately. However, once an A8 national ceases to work and therefore ceases to be registered as a worker their eligibility is lost. Only if they have completed 12 consecutive months on the WRS are they allowed to apply for housing and benefits on the same terms as other EU nationals from the older EU states[145].

In order to qualify foreign nationals must not only be eligible but must also have sufficient priority under the local authority's allocation scheme. Their priority is considered on the same basis as all other applicants.

A consequence of this is that around 90% of people who arrived in the UK in the last two years and currently living in England are in the private rental sector[146]. Key issues include pre arranged and tied accommodation, suitability and quality of accommodation, increase of houses in multiple occupation (HMOs) and overcrowding.

The high cost of housing and a shortage of affordable housing is a key issue for migrants in Cambridgeshire. The average price of houses in the County is approximately 6.4 times greater than average earnings[147].

144 Chartered Institute of Environmental Health (2008) Good Housing Leads to Good Health www.cieh.org.uk/library/policy/publications_and_information_services/policy_publications/good_housing_leads_to_good_health_2008.pdf (accessed 15/07/09).

145 Shelter (2008) Policy Briefing: Eastern European migrant workers and housing www.shelter.org.uk/policybriefings (accessed 11/11/09).

146 Sheffield City Council (2008) Housing report to the Migrants Impact Forum www.ukba.homeoffice.gov.uk/sitecontent/documents/managingourborders/mif/papersandagendas (Accessed 15/06/2009).

147 Strategic Housing Market Assessment – Profile of Cambridge sub-region (2008) www.cambridgeshirehorizons.co.uk/our_challenge/housing/shma.aspx (Accessed 15/06/2009).

Employment

Migrant workers in Cambridgeshire vary in terms of their skills and occupations and this pattern is no different from the national picture. It is estimated that a larger proportion are employed in the public administration, education and health, and distribution, hotels and restaurants sectors of the economy. The presence of the University of Cambridge together with a major teaching hospital and a number of high tech. industries means that Cambridge is also a prime destination for highly skilled migrants. This group of migrants are probably the least likely group to experience material disadvantage or poor housing conditions that could affect their health[148]. For many highly skilled workers the driving factors for choosing the UK were familiarity with the country, the language and the culture. A national report found that comparatively few intended to leave the UK before their visa expired and most wanted to become naturalised[149].

Foreign-born workers have traditionally formed an important sector of the seasonal labour force in Cambridgeshire; recently, migrant communities are becoming more established and less 'seasonal' [150]. The distribution, hotels and restaurant industries are important employers for foreign born workers in Cambridge City. In other districts, the majority of migrant workers are employed in agriculture, manufacturing and construction industries.

Migrants that are employed as shift workers in these occupations, receiving relatively low earnings, are a group of migrants probably most likely to have limited access to healthy lifestyles or to experience socio-economic disadvantage and poor housing conditions. Poorly designed shift working arrangements and long working hours that do not balance the demands of work with time for rest and recovery can result in fatigue, accidents, injuries and ill health[151].

Language and Education

Evidence from the Learning and Skills Council (2006)[152] highlights that English language learning has a significant and positive impact on individuals, communities and the productivity and safety of workplaces in England. For individuals it enables better communication, improves their self esteem and makes realising their potential easier. It also improves job opportunities and prevents them from being exploited in the workplace. For communities effective communication is vital, it enables their social inclusion and social cohesion.

148 McKay et al (2006) Migration of highly skilled workers – opening new channels Working Lives Research Institute, London Metropolitan University.

149 IPPR (2009) Migrant Worker availability in the East of England An economic risk assessment www.ippr.org.uk/publicationsandreports (Accessed 26/06/09).

150 Cambridgeshire County Council Research Group(2008) District reports http://www.cambridgeshire.gov.uk/business/research/other/DistrictReports.htm (accessed 10/07/2009).

151 National Prevention Research Initiative (2007) Shift work, sleep patterns and health, Liverpool John Moores University. www.ljmu.ac.uk/NewsUpdate/86893.asp (accessed 30/06/09).

152 Learning and Skills Council (LSC) Migrant Workers and the Labour Market Review of LSC research on labour market participation, skills and skills provision for migrant workers January 2007 www.readingroom.lsc.gov.uk/lsc/national/nationalmigrantworkersandthelabourmarket.pdf (Accessed 05/06/2009).

Over 80 languages are spoken in Cambridgeshire and the main and relatively established community languages are Bengali (Sylheti dialect) Cantonese, Punjabi and Urdu. New communities speaking languages other than English are also growing in areas with less linguistic diversity. There are increasing numbers of Portuguese and Polish speakers in Fenland and East Cambridgeshire and Tagalog and Malayalam speakers in areas around the hospitals[153].

The Department for Children Schools and Families expects that all pupils, or their parents/carers on their behalf, will provide schools with information on their ethnicity. The latest school census results were released in January 2009 and identified that of the total school population 13.2% were from minority ethnic groups, 7.9% in black and minority ethnic groups 0.6% in travellers and gypsy/roma groups and 4.7% in the category 'White: other groups'[154].

The data published in January 2007 provides an ethnicity breakdown between primary and secondary pupils. 11.8% of pupils in Cambridgeshire primary schools were from a minority ethnic community, below the England rate of 22.4%. The largest groups were: White: other (4.2%) Travellers (0.8%); Indian (0.8%); Bangladeshi (0.7%) Chinese (0.5%) Black African (0.4%) and Pakistani (0.4%)[155]. 9.4% of pupils in Cambridgeshire secondary schools[156] were from a minority ethnic community.

Mental Health and Community Cohesion

Individuals who migrate could be subject to change in culture, food, climate as well as family and friends who may become relatively inaccessible compared with before they migrate[157]. They often experience a certain amount of loss through the change which is counterweighted with excitement by the thoughts of a better life. If the fluency in English is used as a proxy for the amount of acculturation a migrant has, it can be shown that the better the language skills are, the less likely one is to show depressive symptoms[158].

However, migrants are not a homogeneous group and their risk of poor mental health depends on the conditions under which they emigrate and the conditions within which they live in the UK. Nevertheless, there are mental health conditions which are more common in non-UK populations and certain migrant groups[159] [160]. Cultural difference makes diagnosing a mental health problem particularly difficult and this may be compounded by language barriers and a lack of knowledge about services.

153 Cambridgeshire County Council, English as an Additional Language www.cambridgeshire.gov.uk/education/parents/race/achievements/default.htm (Accessed 05/06/09).
154 Department for Children Schools and Families, Pupil Level Annual School Census, January 2009.
155 All about primary pupils in Cambridgeshire 2006 – 2007 www.cambridgeshire.gov.uk/education/about/statitics (Accessed 05/06/09).
156 All about secondary pupils in Cambridgeshire 2006 – 2007 www.cambridgeshire.gov.uk/education/about/statitics (Accessed 05/06/09).
157 Carta et al (2005) Migration and Mental Health in Europe Clinical Practice and epidemiology in mental health 1:13.
158 Bhugra (2003) Migration and depression Acta Psychiatrica Scandinavica, Supplementum 418 (67-72 0065 – 1591.
159 London (1986) Mental illness among immigrant minorities in the UK British Journal of Psychiatry, 149: 265-73.
160 LeTouze et al (2003) Good Practice in mental health and social care provision for refugees and asylum seekers, Report on the United Kingdom.

In terms of community cohesion the government set up the Commission on Integration and Cohesion in 2006. This advisory body has advised that there is a clear responsibility on local authorities, housing associations and other agencies to work together to make certain that migration does not lead to community tension. The Government's Migrant Impact Fund has also been set up to support this work and help local public services manage any short-term pressures resulting from migration. The lack of adequate supply of good housing has been found to increase tension with migrant and indigenous communities especially where anxiety was present over local services and infrastructure as it is in the East of England[161].

Health

Information on live births by the country or origin of the mother can be an additional indicator of migrant patterns. This indicator does not necessarily provide information on recent migration but it can reflect patterns of past migration. For 2007 the nationalities that recorded the highest numbers of live births in the county were the United States, Poland, Germany, South Africa and India.

In comparing National Insurance Number registrations and GP registrations the data suggests that many people who come to Cambridgeshire and work do not register with a GP. There is especially low GP registration among migrant workers from the A8 countries. This may indicate that there are unmet health needs among this population or it may be due to a lack of awareness about available services, but is also likely to reflect the young age profile of this group, and therefore their relative health, as well as their more transient nature.

In terms of road accidents, according to the Association of British Insurers[162] based on national and European evidence cross border drivers cause a disproportionate number of collisions in the UK and the European Union. A cross border driver is anyone who is driving in a Member State where they are not normally a resident, including those visiting on a temporary basis and non-residents living and working in a country for a longer period. Existing evidence[163] suggests that foreign vehicles cause a disproportionate number of collisions. As cross border driving increases, it is becoming evident that it is having an adverse impact on road safety. Road accidents are an important public health issue because they represent a major cause of preventable deaths and years of life lost, especially in younger age groups.

Community Engagement

The third sector, comprised of voluntary, community and faith groups has contributed a significant role in towards meeting the needs of migrants. The East of England Development Agency has played a key role in setting up and supporting such organisations and a number of organisation exist in Cambridgeshire running a variety of projects aimed at supporting migrants.

161 McKay et al (2005) Migrant Workers in the East of England, EEDA.

162 Association of British Insurers (2007) European Drivers: Crossing Borders Safely www.abi.org.uk/BookShop/ResearchReports/European_Drivers.pdf (Accessed 09/07/2009).

163 Department of Transport (2008) Goods vechicle accidents and casualties road accident and road freight statistics Factsheet no. 1 www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casultiesgbar/suppltablesfactsheets/flagchgvfsheet.pdf (Accessed 09/07/09.

One such project is the Rosmini Centre in Wisbech. The Rosmini Centre is the focus for a range of activities helping the families of migrant workers to access services, training and work. Building on the strength of much goodwill and a strong team of volunteers, further investment in the Centre is providing more structured support for migrant workers living and working in Wisbech and the rural hinterland and promoting cohesion with the established communities in addition to promoting local services.

The community centre provides employment and accommodation advice, and also help on practical issues such as who to go to for what. The focus for the initiative is community cohesion, with emphasis on ensuring the development is a community 'development resource' for both the local people and those new to the area.

4.2.4 Relevant LAA Indicators

Specifically NI 1: Percentage of people who believe that people from different backgrounds get on well together in their local area

4.2.5 Key Recommendations

The following are the key recommendations coming from this work, a full set of recommendations are available within the full JSNA document.

- Increase awareness of and access to primary care health services amongst migrant workers, including GP practices, dentists, optometrists and pharmacies with emphasis on health promotion and disease prevention.
- Engage with employers and other stakeholders to establish networks for sharing information and good practice with the aim of promoting healthy work conditions for migrants.
- Improve access to language provision both in terms of initial access to short term translation and interpretation facilities and also access to appropriate English language courses.
- Improve the access and condition of appropriate housing in order to reduce migrant worker dependence on poor quality tied accommodation and Houses in Multiple Occupation (HMOs).
- Foster stronger community cohesion and better engagement with voluntary and community organisations.
- Improve organisations' adaptive capacity; ensuring that service providers are flexible enough to respond to the changing needs of the migrant population, a population that can be highly mobile and transient in nature.
- Improve data collection to ensure more robust, timely and comprehensive data acknowledging the difficulties in accessing accurate information on undocumented migrants.
- Examine the needs of those who have no recourse to public funds or who are destitute in order to ascertain how these individuals and families may be best supported.

- There needs to be ownership and multiagency partnership to ensure that the recommendations featured within this report are translated into action within available resources. This will be driven by the Migrant Workers Network as a sub group of the Cambridgeshire Safer and Stronger Partnership. This network should be responsible for developing and monitoring an action plan outlining the delivery of measurable outcomes.

Appendix: NHS Cambridgeshire Cluster Dataset 2009

Introduction

NHS Cambridgeshire is a relatively affluent PCT and tends to fare well on many health indicators when compared to the national average. Due to this it can be difficult to prioritise health needs for the area from these national comparisons. It may therefore be more useful to compare Cambridgeshire with similar demographic and socio-economic areas, to see how Cambridgeshire compares in its health outcomes, and where improvements can feasibly be made. In addition, Cambridgeshire consists of five district councils: Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire, which all have different characteristics and health needs.

For this reason the Cluster Dataset benchmarks NHS Cambridgeshire and its constituent districts with the England average and also the appropriate Office of National Statistics (ONS) cluster. The ONS clusters are based on the 2001 Area Classification which groups together geographic areas according to key characteristics common to the population in that grouping. These groupings are called clusters, and are derived using census data. These groups should provide more useful benchmarks than the national or regional average as it enables comparison with areas of a similar demographic, household type, housing; socioeconomic, employment and industry sector composition. There are 3 levels of hierarchy within the ONS cluster benchmarks: supergroup, group and subgroup. This Cluster Dataset uses the 'group' cluster as the comparison, which is the level of hierarchy recommended to be used by ONS. There are 12 cluster groups under this hierarchy.

Benchmarking against these similar areas will provide NHS Cambridgeshire with the necessary insights and evidence to set more challenging targets to achieve health gain and to improve health outcomes in the area. It is useful to extend this benchmarking to locality population segments (using local authority districts) as there are important differences in health status, determinants and outcomes between Cambridgeshire overall and some districts and also between districts.

NHS Cambridgeshire is in the Prospering Southern England cluster for health areas; Cambridge City is in the Thriving London Periphery cluster; East Cambridgeshire, Fenland and Huntingdonshire are all in the Prospering Smaller Towns cluster and South Cambridgeshire is in the Prospering Southern England cluster. Table 1 shows the other PCT and local authority members of these four groups.

This dataset gives some background demographic information for NHS Cambridgeshire and its constituent districts and shows how the area is doing against the England average and cluster average for a number of health indicators (47 indicators for the PCT and 25 for the local authority districts) in the form of a presentation tool known as a spine chart.

Table 1: Cambridgeshire ONS Cluster Groups and their Members

Cluster group	Cluster group members			
Health Area Prospering Southern England	Berkshire West Buckinghamshire **Cambridgeshire**	Mid Essex Oxfordshire Surrey	West Hertfordshire West Kent	
LA area Thriving London Periphery	Bromley **Cambridge** Hillingdon	Kingston-upon-Thames Oxford Reading	Richmond upon Thames Sutton Watford	
LA area Prospering Smaller Towns	Adur Ashford Babergh Bath and North East Somerset Blaby Boston Braintree Breckland Bridgnorth Broadland Bromsgrove Broxtowe Bury Canterbury Castle Morpeth Castle Point Castlereagh Charnwood Cheltenham Cherwell Chester Chorley Colchester Congleton Cotswold County of Herefordshire Crewe and Nantwich Daventry Derbyshire Dales Durham	**East Cambridgeshire** East Dorset East Dunbartonshire East Northamptonshire East Renfrewshire East Riding of Yorks Eastleigh Fareham **Fenland** Forest of Dean Gedling Hambleton Harborough Harrogate High Peak Hinckley and Bosworth **Huntingdonshire** Kettering Kings Lynn and West Norfolk Lewes Lichfield Macclesfield Maidstone Maldon Malvern Hills Melton Mendip	Mid Bedfordshire Mid Devon New Forest Mid Suffolk Monmouth Newark and Sherwood North Dorset North Down North Kesteven North Shropshire North Somerset North Warwickshire North West Leicestershire Oadby and Wigston Oswestry Poole Ribble Valley Richmondshire Rugby Rushcliffe Rutland Salisbury Sedgemoor Selby Shrewsbury and Atcham Solihull South Bedfordshire South Derbyshire South Gloucestershire	South Holland South Kesteven South Norfolk South Northamptonshire South Ribble South Somerset South Staffordshire St. Edmundsbury Stafford Staffordshire Moorlands Stirling Stockport Stratford-on-Avon Stroud Suffolk Coastal Taunton Deane Tewkesbury Trafford Tynedale Vale of Glamorgan Vale Royal Warrington Warwick Wealden Welwyn Hatfield West Lancashire West Lindsey West Oxfordshire West Wiltshire Wychavon Wyre Forest York
LA area Prospering Southern England	Aylesbury Vale Basingstoke and Deane Bracknell Forest Brentwood Chelmsford Chiltern Dacorum East Hampshire East Hertfordshire Elmbridge Epping Forest Epsom and Ewell	Guildford Hart Hertsmere Horsham Kennet Mid Sussex Mole Valley North Hertfordshire North Wiltshire Reigate and Banstead Rochford	Runnymede Sevenoaks South Bucks **South Cambridgeshire** South Oxfordshire Spelthorne St.Albans Surrey Heath Tandridge Test Valley Three Rivers	Tonbridge and Malling Tunbridge Wells Uttlesford Vale of White Horse Waverley West Berkshire Winchester Windsor and Maidenhead Woking Wokingham Wycombe

Interpreting the spine chart

A spine chart is a method of summarising health information and summarising how an area is performing against a benchmark on a number of health indicators. In this case the benchmark is the England average which is illustrated by the red line. The blue diamond marks the cluster average benchmark value, and the circle the local Cambridgeshire or district area value.

The colour of the circle indicates whether the area is statistically significantly worse, better, or no different than the England average for a particular indicator. The local value may be different from the national value due to chance, therefore statistical tests have been used to determine if observed local value is different from the England average by more than chance alone i.e. if it is significantly better (green circle) or worse (red circle). The significance level is set at 95%. This means that there is only a 1 in 20 probability that the result observed is due purely to chance. If the local value is not significantly different from the England value the circle is white. If the significance cannot be calculated, in this case because the indicator is based on a modelled estimate and not an actual value, it is a grey circle.

The amount of variability around an indicator is displayed by the grey bars. The dark grey bar represents the interquartile range (the middle 50% of values) of all the PCTs or local authorities in England. The light grey bar represents the range (the difference between the minimum and maximum value). The longer the bar the more variability there is around that indicator.

The spine chart shows where the cluster average lies for that particular indicator, but it does not show whether the local value is statistically significantly different from the cluster group average. This is shown in the right hand column next to the spine chart. If the local area is statistically significantly better than the cluster average this is shown by a green circle; statistically significantly worse a red square; not statistically significantly different an amber diamond. If the row is blank this is because either the significance could not be calculated as in the case for modelled estimates, or the cluster average value was not available.

The methodology behind the spine chart and significance calculation, and the detailed metadata for all of the indicators in the spine chart are available in a separate document. Data sources are listed at the foot of each page underneath the spine chart.

The spine charts displayed are calculated using a modified version of the West Midlands Public Health Observatory Spine Chart Creator tool which is publically available to download.[164]

[164] WMPHO Spine Chart Creator tool http://www.wmpho.org.uk/tools/ (Accessed 29/09/09)

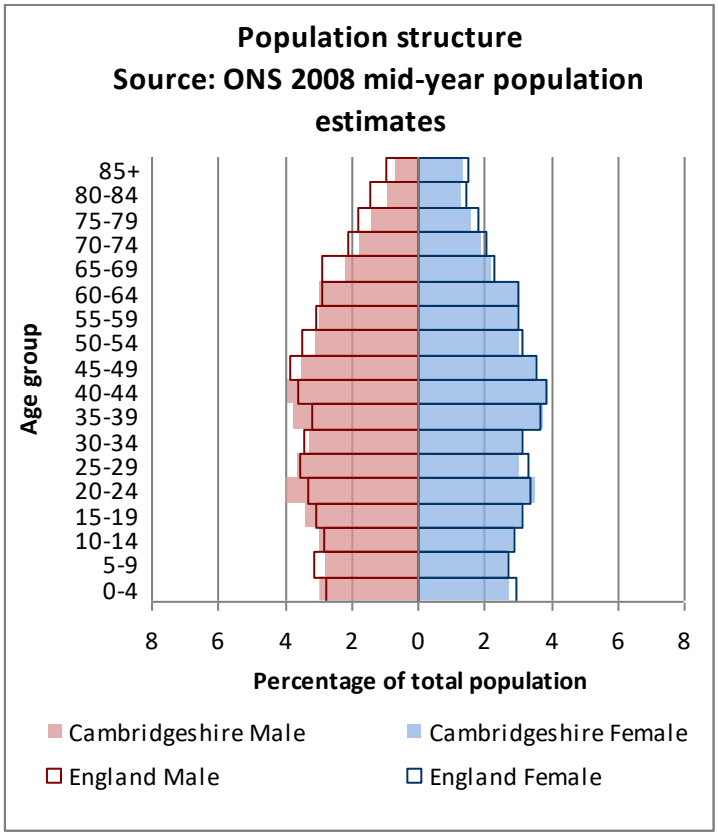
Table 2: Acronyms used in the spine chart

Acronym	Description
%	percentage
APHO	Association of Public Health Observatories
Avg	Average
CBR	Crude Birth Rate
CCCRG	Cambridgeshire County Council Research Group
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
DCSF	Department for Children, Schools and Families
DCLG	Department for Communities and Local Government
DfT	Department for Transport
DH	Department of Health
GP	General Practitioner
hhs	households
HPA	Health Protection Agency
IC	The Information Centre for Health and Social Care
IMD	Indices of Multiple Deprivation
LA	Local authority
MMR	Mumps, measles and rubella
NCHOD	National Centre for Health Outcomes Development
NCMP	National Child Measurement Programme
NHSC	NHS Cambridgeshire
ONS	Office for National Statistics
PCT	Primary Care Trust
QOF	Quality and outcomes framework
TFR	Total Fertility Rate
TIA	Transient Ischaemic Attack
u75	under 75 years old
YHPHO	Yorkshire and Humber Public Health Observatory

NHS Cambridgeshire

NHS Cambridgeshire is coterminous with Cambridgeshire County Council boundaries and made up of 5 district councils: Cambridge City, East Cambridgeshire, Fenland, Huntingdonshire and South Cambridgeshire.

- ONS Cluster group is Prospering Southern England.
- It is a relatively prosperous area with an IMD rank of 140/152 PCTs, whereby 1 is the most deprived.
- The 2008 ONS population estimate is 605,000 and is projected to grow by around 15%. This is higher than the CCCRG population estimate which is 595,600 for the same year.
- NHS Cambridgeshire has a lower fertility rate than England.
- It has a similar population structure to the England average, although there are proportionally more men in their early 20s and proportionally less older men.
- Cambridgeshire has a smaller proportion of non-white ethnic minority groups, but a higher proportion of Chinese and ethnic other and white Irish and other ethnic groups compared to the England average.



Indicator	Year	Cambridgeshire	England
IMD score (rank)	2007	11.5 (140)	n/a
Total population	2008	605,000	51,446,200
Projected population	2018	692,800	55,540,100
Crude birth rate per 1,000 females aged 15-44 (number of births)	2007	56.11 *CI 54.85-57.40* (7,015)	62.13 *CI 61.98-62.28* (655,357)
Total period fertility rate	2007	1.73 *CI 1.69-1.77*	1.91 *CI 1.91-1.92*
Population ≤15 (%)	2008	110,000 (18.2%)	9,669,500 (18.8%)
Population 65+ (%)	2008	93,300 (15.4%)	8,285,300 (16.1%)
White British (%)	2007	513,200 (85.9%)	42,736,000 (83.6%)
White Irish or other (%)	2007	38,300 (6.4%)	2,346,800 (4.6%)
Mixed (%)	2007	9,200 (1.5%)	870,000 (1.7%)
Asian or Asian British (%)	2007	15,500 (2.6%)	2,914,900 (5.7%)
Black or Black British (%)	2007	8,700 (1.5%)	1,447,900 (2.8%)
Chinese or ethnic other (%)	2007	12,400 (2.1%)	776,400 (1.5%)

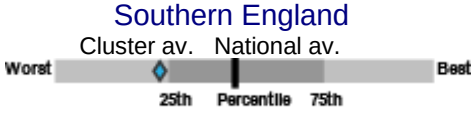
Source: IMD score - DCLG; population and projections - ONS; CBR and TFR - NCHOD

NHS Cambridgeshire Benchmarking Spine Chart

Key Spine chart England comparison

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

ONS Cluster group – Prospering Southern England



Key Cluster comparison

- Significantly better than cluster average
- Not significantly different
- Significantly worse than cluster average

	Indicator	Local avg number per year	Local value	Eng avg	Eng worst	England range	Eng best	Cluster avg	Sig different from cluster avg
1	GSCE achievement (%)	3,220	53.5	48.3	29.9		64.7	58.9	
2	Statutory homelessness (per 1,000 hh)	580	2.3	2.8	8.9		0.2	1.2	
3	Unemployment rate (per 1,000 working age population)	16,000	5.1	6.4	14.8		2.8	4.0	
4	Infant mortality rate (per 1,000 live births)	26	3.9	4.9	8.3		2.2	3.3	
5	Abortions under 10 weeks (%)	963	69.9	70.3	43.9		84.7	77.3	
6	Perinatal mortality rate (per 1,000)	37	5.4	7.9	12.3		4.7	6.0	
7	Low birth weight babies (%)	441	6.3	7.5	11.2		5.4	6.3	
8	Obesity in Reception year children (%)	475	8.8	9.6	16.2		5.4	7.5	
9	Teenage pregnancy rate (u18) (per 1000)	290	27.2	41.2	79.1		15.1	23.7	
10	Physical activity (16+) (%)	556	22.3	21.4	13.1		28.4	24.3	
11	Cervical screening in 25-64s (%)	122,419	81.1	78.9	65.8		85.8	80.4	
12	MMR vaccination u2 (%)	5,669	82.2	84.9	56.3		94.7	84.2	
13	Flu vaccination in 65+ (%)	69,882	74.9	74.1	68.7		79.8	74.4	
14	Hospital admissions for alcohol related harm (per 100,000)	10,543	1525.1	1472.5	2719.8		639.9	-	
15	Road injuries and deaths (per 100,000)	433	74.3	54.3	122.8		24.9	61.0	
16	Modelled CHD prevalence estimates (%)	23,385	4.6	5.6	8.5		3.0	4.5	
17	Modelled COPD prevalence estimates (%)	12,483	2.5	3.7	6.0		2.1	2.8	
18	Modelled diabetes prevalence estimates (%)	22,274	3.8	4.5	6.2		3.5	3.9	
19	Modelled hypertension prevalence estimates (%)	138,910	27.5	30.4	37.3		21.8	28.3	
20	Modelled stroke prevalence estimates (%)	11,154	2.2	2.5	3.7		1.4	2.1	
21	Female life expectancy*	-	83.1	82.0	-		-	-	
22	Male life expectancy*	-	79.3	77.9	-		-	-	
23	Female mortality from all causes (per 100,000)	2,521	451.8	500.2	671.5		312.6	443.0	
24	Male mortality from all causes (per 100,000)	2,335	638.0	710.1	967.6		461.4	608.8	
25	Mortality from all cancers (u75) per 100,000)	628	102.3	115.5	164.3		75.7	101.4	
26	Mortality from all circulatory diseases (u75) (per 100,000)	389	62.7	79.1	131.6		51.0	58.8	
27	Mortality from accidents (15-24) (per 100,000)	13	15.9	14.0	34.0		2.9	17.1	
28	Mortality from accidents (65+) (per 100,000)	75	64.9	59.3	107.2		27.4	56.1	
29	Mortality from land transport accidents (per 100,000)	48	7.7	5.0	9.7		1.8	5.5	

*National PCT value was not available for the spine chart

Indicator, Year, Data Source

1 academic yr 2007/08, DCSF; **2** 2007/08, DCLG; **3** 2008/09, ONS; **4** 2005-07, NCHOD; **5** 2007, NCHOD; **6** 2005-07, NCHOD; **7** 2007, NCHOD; **8** academic year 2007/08. NCMP; **9** 2005-07, DCSF; **10** 2008/09, Sport England; **11,12** 2008/09, IC; **13** Oct 08-Jan 09, HPA; **14** 2005-07, NWPHO; **15** 2005-07, DfT; **16,17** 2009 projection, APHO; **18** 2005, YHPHO; **19,20** 2009 projection, APHO; **21,22** 2006-08, NCHOD; **23-29** 2005-07, NCHOD

Key Messages

Generally the people of Cambridgeshire are healthier than the England average. However compared to its cluster average, consisting of PCTs with similar demographic and socio-economic characteristics, it fares less well and the majority of the indicators in the spine chart are significantly worse than the cluster average.

Life expectancy and all cause mortality for men and women are significantly better than the England average, but male all cause mortality is significantly worst than the cluster average. The premature death rate from circulatory diseases although significantly better than England is significantly worse than the cluster average, suggesting that there is room for improvement here.

Mortality from road traffic accidents and deaths and injuries from road traffic accidents are significantly higher than the England and cluster average, which suggests that this may be a health priority for Cambridgeshire.

Hospital admissions for alcohol related harm are significantly higher than the national average (the figure is not available for the cluster average).

GCSE achievement, levels of statutory homelessness, levels of obesity in Reception year children, teenage conception rate, male all cause mortality rate and early deaths from circulatory disease although all significantly better than the England average are significantly worse than the cluster average. This suggests that further improvements on these indicators are achievable.

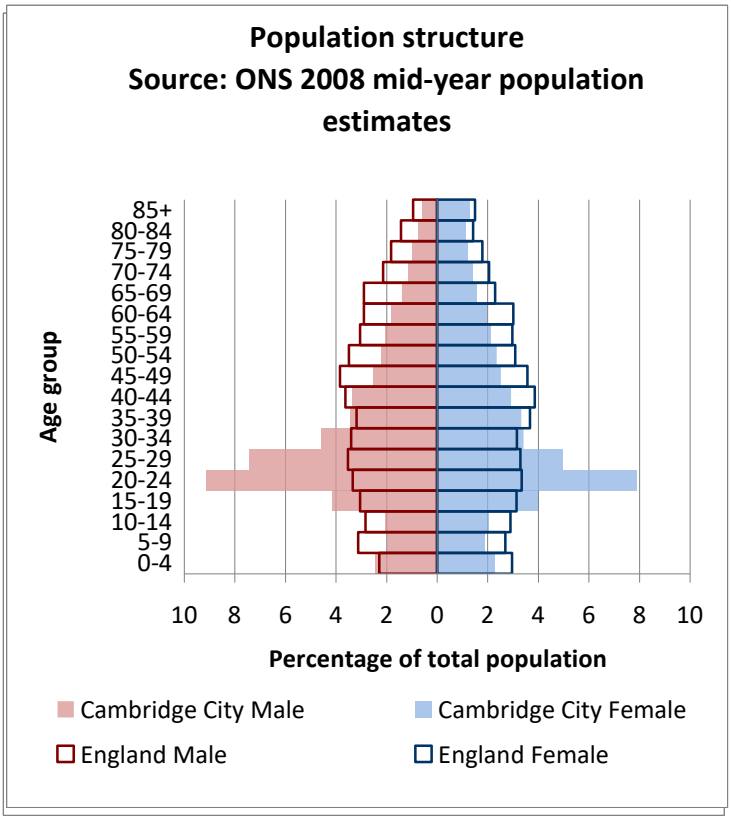
70 percent of abortions take place in under 10 weeks, which is similar to the national average, however the cluster average is 77 percent which suggests that this figure could certainly be improved.

The proportion of under twos receiving their first dose of MMR by their second birthday is significantly worse than the England average and cluster average.

With the exception, of diabetes (which is based on an earlier year), the modelled prevalences for Cambridgeshire are higher than the recorded prevalences displayed in the QOF spine chart at the back of this section, this is the same for the cluster and England figures, which may illustrate under diagnosis of chronic diseases in Cambridgeshire as well as the rest of the country. The difference between the recorded prevalence and the modelled prevalence is particularly large for hypertension and COPD. It should be noted that a modelled prevalence estimate is not the actual prevalence, it is an estimate based on variables known to be associated with the condition. It may or may not be similar to the actual figure, but it is the best estimate we have given the information available.

Cambridge City Council

- ONS cluster group is Thriving London Periphery.
- It is a relatively prosperous city and is ranked in the least deprived third of local authorities on its IMD score.
- The 2008 ONS population estimate is 122,888 which is higher than the CCCRG estimate of 117,700 for the same year.
- The ONS has projected the population to grow by 12% in the next ten years.
- The birth rate is much lower than the national average
- It has a large proportion of the population in the late teens, twenties and early thirties, which is largely due to a large student and young professional population in the city.
- The majority of the population are white, although over twice the national proportion are white Irish or white other which partly represents the large Eastern European population in the city.
- There is also over three times the national average of Chinese or ethnic other population.



Indicator	Year	Cambridge City	England
IMD score (rank)	2007	13.9 (236)	n/a
Total population	2008	122,800	51,446,200
Projected population	2018	137,800	55,540,100
Crude birth rate per 1,000 females aged 15-44		42.60	62.13
(number of births)	2007	*CI 40.46-44.84* (1,387)	*CI 61.98-62.28* (655,357)
Total period fertility rate	2007	1.42 *CI 1.34-1.50*	1.91 *CI 1.91-1.92*
Population ≤15 (%)	2008	16,500 (13.4%)	9,669,500 (18.8%)
Population 65+ (%)	2008	13,900 (11.3%)	8,285,300 (16.1%)
White British (%)	2007	87,000 (72.5%)	42,736,000 (83.6%)
White Irish or other (%)	2007	13,700 (11.4%)	2,346,800 (4.6%)
Mixed (%)	2007	2,800 (2.3%)	870,000 (1.7%)
Asian or Asian British (%)	2007	7,100 (5.9%)	2,914,900 (5.7%)
Black or Black British (%)	2007	3,000 (2.5%)	1,447,900 (2.8%)
Chinese or ethnic other (%)	2007	6,500 (5.4%)	776,400 (1.5%)

Source: IMD score - DCLG; population and projections - ONS; CBR and TFR - NCHOD

Cambridge City Benchmarking Spine Chart

Key Spine chart England comparison

- 0 Significantly better than England average
- 0 Not significantly different from England average
- 0 Significantly worse than England average
- 0 No significance can be calculated

ONS Cluster group – Thriving London Periphery

Cluster av. National av.

Key Cluster comparison

- Significantly better than cluster average
- Not significantly different
- Significantly worse than cluster average

	Indicator	Local avg number per year	Local value	Eng avg	Eng worst	England range	Eng best	Cluster avg	Sig different from cluster avg
1	GSCE achievement (%)	462	53.6	48.3	26.5		73.3	55.3	♦
2	Statutory homelessness (per 1,000 hh)	138	2.8	2.8	8.9		0.0	3.1	♦
3	Unemployment rate (per 1,000 working age population)	3000	4.8	6.4	14.8		1.7	4.9	
4	Infant mortality rate (per 1,000 live births)	7	5.7	4.9	9.6		1.3	4.0	♦
5	Perinatal mortality rate (per 1,000)	9	7.2	7.9	14.1		1.6	7.3	♦
6	Low birth weight babies (%)	87	6.3	7.5	10.7		3.7	7.3	♦
7	Obesity in Reception year children (%)	80	10.4	9.6	16.2		3.9	8.2	■
8	Teenage pregnancy rate (u18) (per 1000)	54	29.2	41.2	79.1		15.0	35.2	●
9	Physical activity (16+) (%)	117	23.3	21.4	13.1		29.7	21.9	♦
10	Hospital admissions for alcohol related harm (per 100,000)	2000	1788.3	1472.5	2615.1		639.9	-	
11	Road injuries and deaths (per 100,000)	48	41.5	54.3	188.3		18.4	42.8	♦
12	Modelled CHD prevalence estimate (%)	3622	3.4	5.6	9.4		3.0	4.2	
13	Modelled COPD prevalence estimate (%)	2374	2.2	3.6	6.0		1.9	3.3	
14	Modelled hypertension prevalence estimate (%)	23592	21.9	30.4	41.6		21.4	26.1	
15	Modelled stroke prevalence estimate (%)	1691	1.6	2.5	4.0		1.4	2.0	
16	Modelled diabetes prevalence estimate (%)	3849	3.3	4.5	6.5		3.3	4.0	
17	Female life expectancy	-	82.8	82.0	78.8		88.9	-	
18	Male life expectancy	-	78.1	77.9	73.6		84.3	-	
19	Female mortality from all causes (per 100,000)	460	465.9	500.2	671.5		312.6	457.4	♦
20	Male mortality from all causes (per 100,000)	409	692.3	710.1	967.6		461.4	656.7	♦
21	Mortality from all cancers (u75) per 100,000)	94	106.3	115.5	164.3		75.7	108.7	♦
22	Mortality from all circulatory diseases (u75) (per 100,000)	53	58.7	79.1	130.5		39.6	70.5	●
23	Mortality from accidents (65+) (per 100,000)	18	91.7	59.3	118.0		19.8	44.9	■
24	Mortality from accidents (15-24) (per 100,000)	0	0.8	14.0	83.1		0.0	7.6	●
25	Mortality from land transport accidents (per 100,000)	4	3.6	5.0	22.7		1.6	3.6	♦

Indicators, Year, Data Sources
1 academic yr 2007/08, DCSF; **2** 2007/08, DCLG; **3** 2008/09, ONS; **4,5**, 2005-07, NCHOD; **6** 2007, NCHOD; **7** academic year 2007/08, NCMP; **8** 2005-07, DCSF; **9** 2008/09, Sport England; **10** 2005-07, NWPHO; **11** 2005-07 DfT; **12-15** 2009 projection, APHO; **16** 2005, YHPHO; **17,18** 2006-08, NCHOD **19-25** 2005-07, NCHOD

Key Messages

The health of the Cambridge population is generally similar or better than England average and is similar to its cluster.

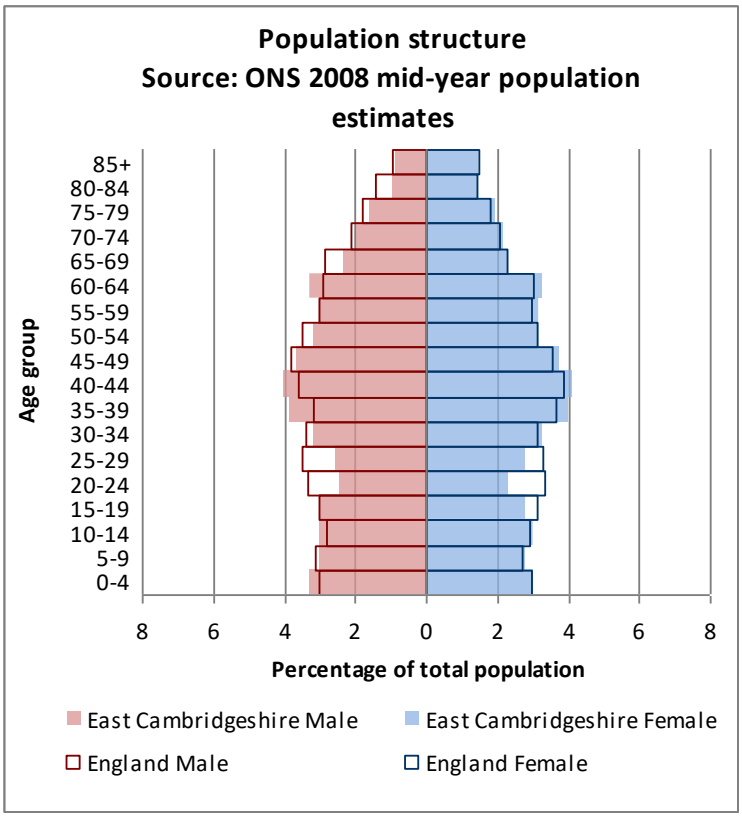
Mortality from accidents in the over 65 population is higher in Cambridge compared to the cluster group and England average and hospital admissions for alcohol related harm are also higher in Cambridge compared to England (data was not available for a cluster comparison).

Although the prevalence of obesity in Reception year children is lower in Cambridge compared to England it is significantly higher than its cluster group average.

Cambridge's teenage conception rate is significantly lower than the England and the cluster average.

East Cambridgeshire District Council

- ONS cluster group is Prospering Smaller Towns.
- East Cambridgeshire is an affluent area and is in the least deprived 20% of local authorities in England based on IMD score 2007.
- According to the most recent ONS estimate the population of East Cambridgeshire is 82,300 which is lower than the CCCRG estimate of 79,400.
- ONS projects the population to grow by 20% in the next decade.
- The total fertility rate and crude birth rate is similar to the national average.
- East Cambridgeshire has a similar population structure to the England average, although it has proportionally less people in their 20s and men of retirement age but more people in their late 30s and 40s.
- Compared to the national average, East Cambridgeshire is less ethnically diverse, but has a higher proportion of white Irish or white other persons.



Indicator	Year	East Cambridgeshire	England
IMD score (rank)	2007	10.8 (285)	n/a
Total population	2008	82,300	51,446,200
Projected population	2018	98,400	55,540,100
Crude birth rate per 1,000 females 15-44 (number of births)	2007	62.04 *CI 58.39-65.9* (984)	62.13 *CI 61.98-62.28* (655,357)
Total period fertility rate	2007	1.93 *CI 1.81-2.05*	1.91 *CI 1.91-1.92*
Population ≤15 (%)	2008	16,000 (19.4%)	9,669,500 (18.8%)
Population 65+ (%)	2008	14,000 (17.0%)	8,285,300 (16.1%)
White British (%)	2007	71,200 (87.9%)	42,736,000 (83.6%)
White Irish or other (%)	2007	5,700 (7.0%)	2,346,800 (4.6%)
Mixed (%)	2007	1,100 (1.4%)	870,000 (1.7%)
Asian or Asian British (%)	2007	1,000 (1.2%)	2,914,900 (5.7%)
Black or Black British (%)	2007	800 (1.0%)	1,447,900 (2.8%)
Chinese or ethnic other (%)	2007	1,300 (1.6%)	776,400 (1.5%)

Source: IMD score - DCLG; population and projections - ONS; CBR and TFR - NCHOD

East Cambridgeshire Benchmarking Spine Chart

Key Spine chart England comparison

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

ONS Cluster group – Prospering Smaller Towns

Cluster av. National av.

Key Cluster comparison

- Significantly better than cluster average
- Not significantly different
- Significantly worse than cluster average

	Indicator	Local avg number per year	Local value	Eng avg	Eng worst	England range	Eng best	Cluster avg	Sig different from cluster avg
1	GSCE achievement (%)	400	49.9	48.3	26.5		73.3	52.4	♦
2	Statutory homelessness (per 1,000 hh)	87	2.6	2.8	8.9		0.0	2.1	♦
3	Unemployment rate (per 1,000 working age population)	1600	3.7	6.4	14.8		1.7	5.1	
4	Infant mortality rate (per 1,000 live births)	2	2.4	4.9	9.6		1.3	4.2	♦
5	Perinatal mortality rate (per 1,000)	3	3.1	7.9	14.1		1.6	6.7	●
6	Low birth weight babies (%)	64	6.5	7.5	10.7		3.7	6.5	♦
7	Obesity in Reception year children (%)	72	9.2	9.6	16.2		3.9	8.5	♦
8	Teenage pregnancy rate (u18) (per 1000)	34	23.3	41.2	79.1		15.0	31.4	●
9	Physical activity (16+) (%)	99	19.8	21.4	13.1		29.7	22.9	♦
10	Hospital admissions for alcohol related harm (per 100,000)	1279	1279.7	1472.5	2615.1		639.9	-	
11	Road injuries and deaths (per 100,000)	65	83.5	54.3	188.3		18.4	62.5	■
12	Modelled CHD prevalence estimate (%)	3499	5.2	5.6	9.4		3.0	5.5	
13	Modelled COPD prevalence estimate (%)	1731	2.6	3.6	6.0		1.9	3.0	
14	Modelled hypertension prevalence estimate (%)	20194	29.8	30.4	41.6		21.4	31.6	
15	Modelled stroke prevalence estimate (%)	1658	2.4	2.5	4.0		1.4	2.5	
16	Modelled diabetes prevalence estimate (%)	3175	4.1	4.5	6.5		3.3	4.3	
17	Female life expectancy	-	83.8	82.0	78.8		88.9	-	
18	Male life expectancy	-	80.5	77.9	73.6		84.3	-	
19	Female mortality from all causes (per 100,000)	333	411.8	500.2	671.5		312.6	467.7	●
20	Male mortality from all causes (per 100,000)	320	588.3	710.1	967.6		461.4	652.3	●
21	Mortality from all cancers (u75) (per 100,000)	81	90.2	115.5	164.3		75.7	106.4	●
22	Mortality from all circulatory diseases (u75) (per 100,000)	54	58.2	79.1	130.5		39.6	67.2	♦
23	Mortality from accidents (65+) (per 100,000)	11	64.2	59.3	118.0		19.8	60.4	♦
24	Mortality from accidents (15-24) (per 100,000)	2	20.7	14.0	83.1		0.0	18.0	♦
25	Mortality from land transport accidents (per 100,000)	6	7.6	5.0	22.7		1.6	6.6	♦

Indicator, Year, Data Source
1 academic yr 2007/08, DCSF; **2** 2007/08, DCLG; **3** 2008/09, ONS; **4,5**, 2005-07, NCHOD; **6** 2007, NCHOD; **7** academic year 2007/08, NCMP; **8** 2005-07, DCSF; **9** 2008/09, Sport England; **10** 2005-07, NWPHO; **11** 2005-07 DfT; **12-15** 2009 projection, APHO; **16** 2005, YHPHO; **17,18** 2006-08, NCHOD **19-25** 2005-07, NCHOD

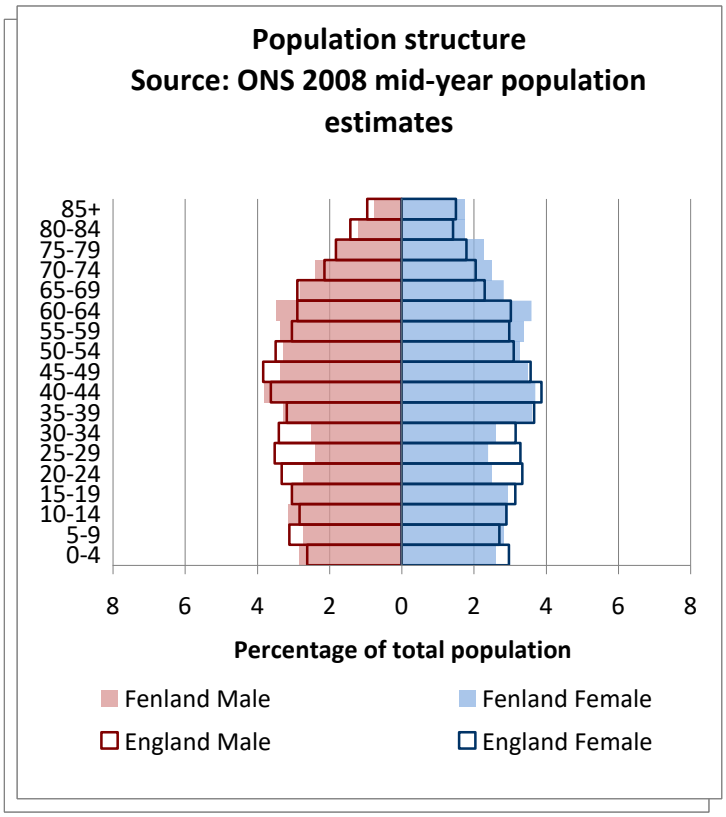
Key Messages

The health of the people of East Cambridgeshire is generally better than the England average and it is similar to or better than its ONS cluster average.

Out of all the indicators measured here the only one which is significantly worse than the England and cluster average is the rate of road injuries and deaths. This is a crude rate and measures the numbers killed or injured on East Cambridgeshire's roads whether or not they are residents of the area, divided by the total resident population. However, the directly standardised land transport mortality rate (indicator 25) which is based on the resident population is not significantly different from either comparator. This suggests that the high crude rate may be due to the ratio of roads to resident population and there may be a high volume of people travelling through the district.

Fenland District Council

- ONS cluster group is Prospering Smaller Towns.
- Fenland is a relatively deprived local authority. It is in the most deprived 40% of LAs according to the IMD score 2007.
- The 2008 ONS population estimate is 91,800, which is very close to the CCCRG estimate for the same year (92,900).
- The ONS projects the population to increase by 17% over the next decade.
- The fertility rate is higher than the national average.
- There are proportionally more older people in Fenland compared to the England average and less people in their 20s and early 30s.
- The population of Fenland is less ethnically diverse than the England average.



Indicator	Year	Fenland	England
IMD score (rank)	2007	20.5 (139)	n/a
Total population	2008	91,800	51,446,200
Projected population	2018	107,300	55,540,100
Crude birth rate per 1,000 females aged 15-44 (number of births)	2007	61.61 *CI 58.05-65.38* (1,018)	62.13 *CI 61.98-62.28* (655,357)
Total period fertility rate	2007	2.06 *CI 1.93-2.19*	1.91 *CI 1.91-1.92*
Population ≤15 (%)	2008	16,700 (18.2%)	9,669,500 (18.8%)
Population 65+ (%)	2008	18,500 (20.2%)	8,285,300 (16.1%)
White British (%)	2007	85,000 (93.0%)	42,736,000 (83.6%)
White Irish or other (%)	2007	2,700 (3.0%)	2,346,800 (4.6%)
Mixed (%)	2007	900 (1.0%)	870,000 (1.7%)
Asian or Asian British (%)	2007	1,300 (1.4%)	2,914,900 (5.7%)
Black or Black British (%)	2007	800 (0.9%)	1,447,900 (2.8%)
Chinese or ethnic other (%)	2007	600 (0.7%)	776,400 (1.5%)

Source: IMD score - DCLG; population and projections - ONS; CBR and TFR - NCHOD

Fenland District Benchmarking Spine Chart

Key Spine chart England comparison

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

ONS Cluster group – Prospering Smaller Towns

Cluster av. National av.

Key Cluster comparison

- Significantly better than cluster average
- Not significantly different
- Significantly worse than cluster average

	Indicator	Local avg number per year	Local value	Eng avg	Eng worst	England range	Eng best	Cluster avg	Sig different from cluster avg
1	GSCE achievement (%)	377	39.6	48.3	26.5		73.3	52.4	■
2	Statutory homelessness (per 1,000 hh)	108	2.6	2.8	8.9		0.0	2.1	■
3	Unemployment rate (per 1,000 working age population)	3300	7.3	6.4	14.8		1.7	5.1	
4	Infant mortality rate (per 1,000 live births)	4	4.1	4.9	9.6		1.3	4.2	◆
5	Perinatal mortality rate (per 1,000)	6	6.1	7.9	14.1		1.6	6.7	◆
6	Low birth weight babies (%)	70	6.9	7.5	10.7		3.7	6.5	◆
7	Obesity in Reception year children (%)	100	11.5	9.6	16.2		3.9	8.5	■
8	Teenage pregnancy rate (u18) (per 1000)	64	39.0	41.2	79.1		15.0	31.4	■
9	Physical activity (16+) (%)	86	17.4	21.4	13.1		29.7	22.9	■
10	Hospital admissions for alcohol related harm (per 100,000)	2042	1760.3	1472.5	2615.1		639.9	-	
11	Road injuries and deaths (per 100,000)	68	76.4	54.3	188.3		18.4	62.5	■
12	Modelled CHD prevalence estimate (%)	4858	6.3	5.6	9.4		3.0	5.5	
13	Modelled COPD prevalence estimate (%)	2675	3.4	3.6	6.0		1.9	3.0	
14	Modelled hypertension prevalence estimate (%)	26689	34.4	30.4	41.6		21.4	31.6	
15	Modelled stroke prevalence estimate (%)	2128	2.7	2.5	4.0		1.4	2.5	
16	Modelled diabetes prevalence estimate (%)	4393	4.9	4.5	6.5		3.3	4.3	
17	Female life expectancy	-	81.3	82.0	78.8		88.9	-	
18	Male life expectancy	-	77.3	77.9	73.6		84.3	-	
19	Female mortality from all causes (per 100,000)	542	537.0	500.2	671.5		312.6	467.7	■
20	Male mortality from all causes (per 100,000)	495	733.0	710.1	967.6		461.4	652.3	■
21	Mortality from all cancers (u75) (per 100,000)	125	111.5	115.5	164.3		75.7	106.4	◆
22	Mortality from all circulatory diseases (u75) (per 100,000)	98	83.4	79.1	130.5		39.6	67.2	■
23	Mortality from accidents (65+) (per 100,000)	13	62.5	59.3	118.0		19.8	60.4	◆
24	Mortality from accidents (15-24) (per 100,000)	1	13.1	14.0	83.1		0.0	18.0	◆
25	Mortality from land transport accidents (per 100,000)	11	11.8	5.0	22.7		1.6	6.6	■

Indicators, Year, Data Sources
1 academic yr 2007/08, DCSF; **2** 2007/08, DCLG; **3** 2008/09, ONS; **4,5**, 2005-07, NCHOD; **6** 2007, NCHOD; **7** academic year 2007/08, NCMP; **8** 2005-07, DCSF; **9** 2008/09, Sport England; **10** 2005-07, NWPHO; **11** 2005-07 DfT; **12-15** 2009 projection, APHO; **16** 2005, YHPHO; **17,18** 2006-08, NCHOD **19-25** 2005-07, NCHOD

Key Messages

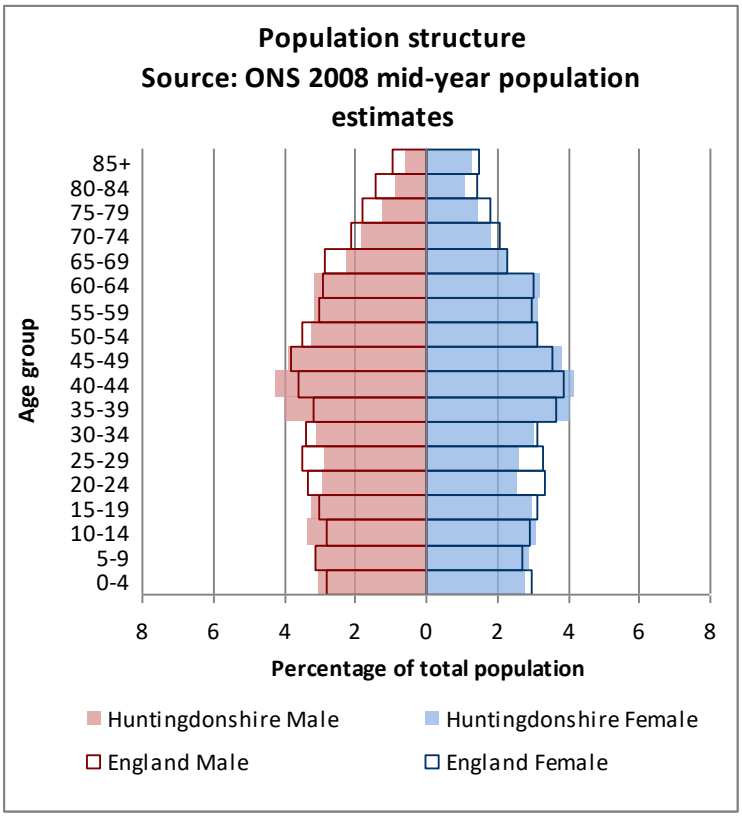
The health of the people of Fenland is generally worse than the England and cluster average. The percentage of students achieving 5 GCSEs grades A*-C including English and Mathematics is around 10% lower than the national and cluster group average. There are significantly more statutory homeless people in Fenland than in the cluster average. The levels of physical activity in adults are significantly lower than the cluster and national average. Hospital admissions for alcohol related harm are significantly higher than the national average (a cluster average is not available for this indicator). Both indicators on land traffic accidents are significantly worse for Fenland compared to the national and cluster average, which suggests that this is a issue for the district.

Female life expectancy and female all cause mortality are both significantly worse than the national average, although male life expectancy and male all cause mortality are not significantly different. The latter, however, is significantly worse than the cluster average.

Although the levels of obesity in Reception year children and the teenage pregnancy rate are not significantly different than the England average, they are both significantly higher than the cluster group average, which suggests that there is room for improvement here. Premature deaths from circulatory disease are similar to the national rate, but are significantly higher than the cluster group average, which again suggests potential for improvement.

Huntingdonshire District Council

- ONS cluster group is Prospering Smaller Towns.
- Huntingdonshire is a relatively affluent area and is in the least deprived 15% of local authorities based on the IMD score 2007.
- The ONS estimates the 2008 population to be 168,900, which is higher than the CCCRG estimate of 163,100.
- The ONS project the population to grow by 14% over the next decade.
- The fertility rate is lower than the national average.
- The population structure is similar to the England average, although there are proportionally less people in the in their 20s and early 30s and of retirement age.
- Huntingdonshire is less ethnically diverse than the England average.



Indicator	Year	Huntingdonshire	England
IMD score (rank)	2007	9.3 (311)	n/a
Total population	2008	168,900	51,446,200
Projected population	2018	192,600	55,540,100
Crude birth rate per 1,000 females aged 15-44 (number of births)	2007	55.85 *CI 53.45-58.36* (1,877)	62.13 *CI 61.98-62.28* (655,357)
Total period fertility rate	2007	1.79 *CI 1.71-1.88*	1.91 *CI 1.91-1.92*
Population ≤15 (%)	2008	33,000 (19.5%)	9,669,500 (18.8%)
Population 65+ (%)	2008	25,000 (14.8%)	8,285,300 (16.1%)
White British (%)	2007	148,200 (88.4%)	42,736,000 (83.6%)
White Irish or other (%)	2007	9,500 (5.7%)	2,346,800 (4.6%)
Mixed (%)	2007	2,500 (1.5%)	870,000 (1.7%)
Asian or Asian British (%)	2007	3,300 (2.0%)	2,914,900 (5.7%)
Black or Black British (%)	2007	2,300 (1.4%)	1,447,900 (2.8%)
Chinese or ethnic other (%)	2007	1,700 (1%)	776,400 (1.5%)

Source: IMD score - DCLG; population and projections - ONS; CBR and TFR - NCHOD

Huntingdonshire Benchmarking Spine Chart

Key Spine chart England comparison

- 0 Significantly better than England average
- 0 Not significantly different from England average
- 0 Significantly worse than England average
- 0 No significance can be calculated

ONS Cluster group – Prospering Smaller Towns

Cluster av. National av.

Key Cluster comparison

- Significantly better than cluster average
- Not significantly different
- Significantly worse than cluster average

	Indicator	Local avg number per year	Local value	Eng avg	Eng worst	England range	Eng best	Cluster avg	Sig different from cluster avg
1	GSCE achievement (%)	968	50.5	48.3	26.5		73.3	52.4	♦
2	Statutory homelessness (per 1,000 hh)	146	2.1	2.8	8.9		0.0	2.1	♦
3	Unemployment rate (per 1,000 working age population)	5500	6.1	6.4	14.8		1.7	5.1	♦
4	Infant mortality rate (per 1,000 live births)	9	4.9	4.9	9.6		1.3	4.2	♦
5	Perinatal mortality rate (per 1,000)	10	5.4	7.9	14.1		1.6	6.7	♦
6	Low birth weight babies (%)	133	7.1	7.5	10.7		3.7	6.5	♦
7	Obesity in Reception year children (%)	87	5.6	9.6	16.2		3.9	8.5	●
8	Teenage pregnancy rate (u18) (per 1000)	92	29.0	41.2	79.1		15.0	31.4	♦
9	Physical activity (16+) (%)	119	23.6	21.4	13.1		29.7	22.9	♦
10	Hospital admissions for alcohol related harm (per 100,000)	2946	1531.0	1472.5	2615.1		639.9	-	
11	Road injuries and deaths (per 100,000)	120	72.7	54.3	188.3		18.4	62.5	■
12	Modelled CHD prevalence estimate (%)	6551	4.7	5.6	9.4		3.0	5.5	●
13	Modelled COPD prevalence estimate (%)	3413	2.4	3.6	6.0		1.9	3.0	●
14	Modelled hypertension prevalence estimate (%)	39473	28.2	30.4	41.6		21.4	31.6	●
15	Modelled stroke prevalence estimate (%)	3076	2.2	2.5	4.0		1.4	2.5	●
16	Modelled diabetes prevalence estimate (%)	5933	3.6	4.5	6.5		3.3	4.3	●
17	Female life expectancy	-	83.0	82.0	78.8		88.9	-	
18	Male life expectancy	-	79.1	77.9	73.6		84.3	-	
19	Female mortality from all causes (per 100,000)	656	463.9	500.2	671.5		312.6	467.7	♦
20	Male mortality from all causes (per 100,000)	609	638.8	710.1	967.6		461.4	652.3	♦
21	Mortality from all cancers (u75) per 100,000)	188	108.0	115.5	164.3		75.7	106.4	♦
22	Mortality from all circulatory diseases (u75) (per 100,000)	106	61.0	79.1	130.5		39.6	67.2	♦
23	Mortality from accidents (65+) (per 100,000)	19	65.3	59.3	118.0		19.8	60.4	♦
24	Mortality from accidents (15-24) (per 100,000)	7	35.4	14.0	83.1		0.0	18.0	■
25	Mortality from land transport accidents (per 100,000)	15	9.7	5.0	22.7		1.6	6.6	■

Indicator, Year, Data Source
1 academic yr 2007/08, DCSF; **2** 2007/08, DCLG; **3** 2008/09, ONS; **4,5**, 2005-07, NCHOD; **6** 2007, NCHOD; **7** academic year 2007/08, NCMP; **8** 2005-07, DCSF; **9** 2008/09, Sport England; **10** 2005-07, NWPHO; **11** 2005-07 DfT; **12-15** 2009 projection, APHO; **16** 2005, YHPHO; **17,18** 2006-08, NCHOD **19-25** 2005-07, NCHOD

Key Messages

The health of the people in Huntingdonshire is generally better than the England average, although compared to its cluster group average it is generally not significantly different.

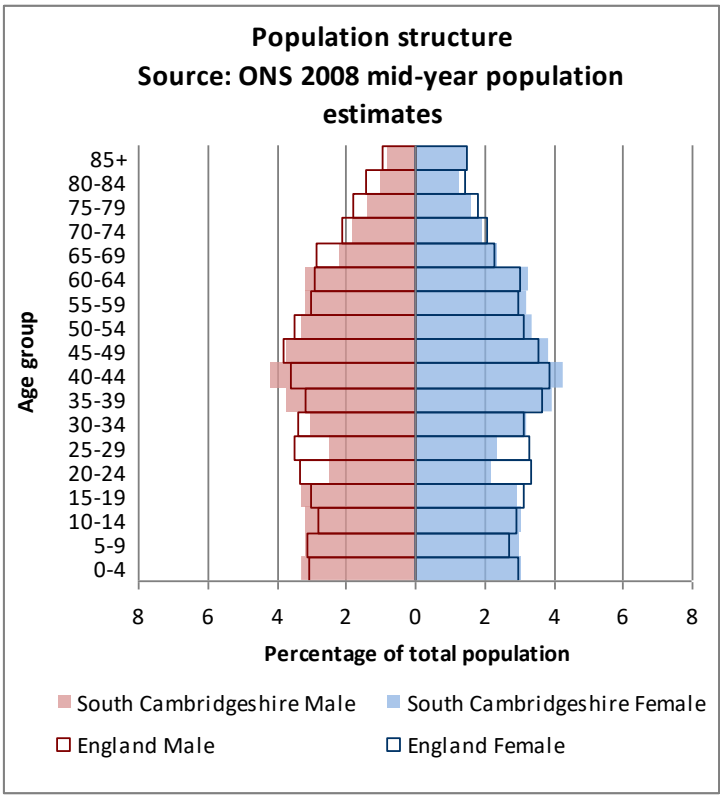
Both indicators on land traffic accidents are significantly worse for Huntingdonshire compared to the national and cluster average, which suggests that this is a issue in the district. In addition, mortality from accidents in the 15-24 year age group is significantly higher than the national and cluster average and all but one of these deaths are attributable to land based transport accidents.

Hospital admissions for alcohol related harm are also higher than the national and cluster average, which is a public health concern for the district.

Obesity levels of children in Reception year are significantly lower than the national and cluster average.

South Cambridgeshire District Council

- ONS cluster group is Prospering Southern England.
- South Cambridgeshire is a very affluent area. It is in the least deprived 5% of local authorities based on their IMD score 2007.
- The 2008 ONS population is 139,300 which is lower than the CCCRG population estimate for the same year which is 142,500.
- The ONS projects the population to increase by 12% over the next decade.
- It has a higher fertility rate than the national average.
- It has a higher proportion of children, teenagers and adults in their late 30s and early 40s, but notably proportionally less young adults than the national average.
- It is less ethnically diverse than the England average.



Indicator	Year	South Cambridgeshire	England
IMD score (rank)	2007	6.6 (350)	n/a
Total population	2008	139,300	51,446,200
Projected population	2018	156,700	55,540,100
Crude birth rate per 1,000 females aged 15-44 (number of births)	2007	66.07 *CI 63.14-69.13* (1,749)	62.13 *CI 61.98-62.28* (655,357)
Total period fertility rate	2007	2.06 *CI 1.96-2.16*	1.91 *CI 1.91-1.92*
Population ≤15 (%)	2008	27,800 (20.0%)	9,669,500 (18.8%)
Population 65+ (%)	2008	22,200 (15.9%)	8,285,300 (16.1%)
White British (%)	2007	121,800 (88.7%)	42,736,000 (83.6%)
White Irish or other (%)	2007	6,700 (4.9%)	2,346,800 (4.6%)
Mixed (%)	2007	1,900 (1.4%)	870,000 (1.7%)
Asian or Asian British (%)	2007	2,800 (2.0%)	2,914,900 (5.7%)
Black or Black British (%)	2007	1,800 (1.3%)	1,447,900 (2.8%)
Chinese or ethnic other (%)	2007	2,300 (1.7%)	776,400 (1.5%)

Source: IMD score - DCLG; population and projections - ONS; CBR and TFR - NCHOD

South Cambridgeshire Benchmarking Spine Chart

Key Spine chart England comparison

- 0 Significantly better than England average
- 0 Not significantly different from England average
- 0 Significantly worse than England average
- 0 No significance can be calculated

ONS Cluster group – Prospering Southern England

Cluster av. National av.

Key Cluster comparison

- Significantly better than cluster average
- Not significantly different
- Significantly worse than cluster average

	Indicator	Local avg number per year	Local value	Eng avg	Eng worst	England range	Eng best	Cluster avg	Sig different from cluster avg
1	GSCE achievement (%)	1013	68.2	48.3	26.5		73.3	58.9	●
2	Statutory homelessness (per 1,000 hh)	101	1.7	2.8	8.9		0.0	1.2	■
3	Unemployment rate (per 1,000 working age population)	2600	3.6	6.4	14.8		1.7	4.0	
4	Infant mortality rate (per 1,000 live births)	4	2.2	4.9	9.6		1.3	3.3	♦
5	Perinatal mortality rate (per 1,000)	8	5.1	7.9	14.1		1.6	6.0	♦
6	Low birth weight babies (%)	87	5.0	7.5	10.7		3.7	6.3	●
7	Obesity in Reception year children (%)	136	9.7	9.6	16.2		3.9	7.5	■
8	Teenage pregnancy rate (u18) (per 1000)	46	18.1	41.2	79.1		15.0	23.7	●
9	Physical activity (16+) (%)	121	24.5	21.4	13.1		29.7	24.3	♦
10	Hospital admissions for alcohol related harm (per 100,000)	2271	1393.2	1472.5	2615.1		639.9	-	
11	Road injuries and deaths (per 100,000)	132	97.7	54.3	188.3		18.4	61.0	■
12	Modelled CHD prevalence estimate (%)	4674	4.2	5.6	9.4		3.0	4.5	
13	Modelled COPD prevalence estimate (%)	2364	2.1	3.6	6.0		1.9	2.4	
14	Modelled hypertension prevalence estimate (%)	32924	29.4	30.4	41.6		21.4	29.1	
15	Modelled stroke prevalence estimate (%)	2150	1.9	2.5	4.0		1.4	2.1	
16	Modelled diabetes prevalence estimate (%)	4962	3.7	4.5	6.5		3.3	3.9	
17	Female life expectancy	-	84.5	82.0	78.8		88.9	-	
18	Male life expectancy	-	81.1	77.9	73.6		84.3	-	
19	Female mortality from all causes	530	395.1	500.2	671.5		312.6	443.0	●
20	Male mortality from all causes	502	570.0	710.1	967.6		461.4	608.8	●
21	Mortality from all cancers (u75)	139	94.8	115.5	164.3		75.7	101.4	♦
22	Mortality from all circulatory diseases (u75) (per 100,000)	78	53.1	79.1	130.5		39.6	58.8	♦
23	Mortality from accidents (15-24) (per 100,000)	3	21.6	14.0	83.1		0.0	17.1	♦
24	Mortality from accidents (65+) (per 100,000)	14	49.9	59.3	118.0		19.8	56.1	♦
25	Mortality from land transport accidents	11	8.4	5.0	22.7		1.6	5.5	■

Indicator, Year, Data Source
1 academic yr 2007/08, DCSF; **2** 2007/08, DCLG; **3** 2008/09, ONS; **4,5**, 2005-07, NCHOD; **6** 2007, NCHOD; **7** academic year 2007/08, NCMP; **8** 2005-07, DCSF; **9** 2008/09, Sport England; **10** 2005-07, NWPHO; **11** 2005-07 DfT; **12-15** 2009 projection, APHO; **16** 2005, YHPHO; **17,18** 2006-08, NCHOD **19-25** 2005-07, NCHOD

Key Messages

The health of the people of South Cambridgeshire is generally better than the England average and similar to the cluster group average.

The proportion of students gaining at least 5 GCSEs grades A*-C including English and Mathematics is 20% higher than the national average and 10% higher than the cluster average. The level of obesity in Reception year children is very similar to the national average, just under 1 in 10 Reception year children are obese, however this is significantly worse than the cluster average.

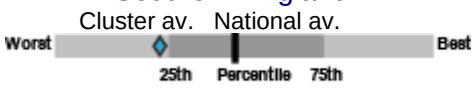
The only indicators that are significantly worse than the both the England and cluster average are the two land transport accidents indicators. The number of people killed or seriously injured on South Cambridgeshire's roads and the number of residents killed in road traffic accidents are high. In a district that fares well in many other health indicators this is potentially a public health priority.

NHS Cambridgeshire QOF Benchmarking Spine Chart

Key Spine chart England comparison

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

ONS Cluster group – Prospering Southern England



Key Cluster comparison

- Significantly better than cluster average
- Not significantly different
- Significantly worse than cluster average

	Indicator	Local avg number per year	Local value	Eng avg	Eng worst	England range	Eng best	Cluster avg	Sig different from cluster avg
1	Asthma GP recorded prevalence (%)	40,506	6.6	5.9	6.9		3.4	5.8	
2	Atrial Fibrillation GP recorded prevalence (%)	8,492	1.4	1.3	2.2		0.5	1.4	
3	Cancer GP recorded prevalence (%)	8,579	1.4	1.3	2.0		0.5	1.3	
4	CHD GP recorded prevalence (%)	19,007	3.1	3.5	5.2		1.4	2.9	
5	CKD GP recorded prevalence 18+ (%)	17,946	3.7	4.1	7.7		1.3	4.3	
6	COPD GP recorded prevalence (%)	8,357	1.4	1.5	3.2		0.7	1.1	
7	Dementia GP recorded prevalence (%)	2,434	0.4	0.4	0.7		0.2	0.4	
8	Depression GP recorded prevalence(%)	56,636	9.2	8.1	15.9		3.0	8.0	
9	Diabetes GP recorded prevalence 17+ (%)	22,724	4.6	5.1	7.8		3.0	4.3	
10	Epilepsy GP recorded prevalence 18+ (%)	3,436	0.7	0.8	1.1		0.4	0.7	
11	Heart failure due to LVD GP recorded prevalence (%)	2,281	0.4	0.4	0.8		0.2	0.3	
12	Heart failure GP recorded prevalence (%)	4,246	0.7	0.7	1.1		0.3	0.6	
13	Hypothyroidism GP recorded prevalence (%)	18,541	3.0	2.8	4.6		1.2	2.9	
14	Hypertension GP recorded prevalence (%)	77,134	12.6	13.1	16.5		8.0	12.3	
15	Learning Disabilities GP recorded prevalence 18+ (%)	1,608	0.3	0.4	0.6		0.1	0.3	
16	Mental health GP recorded prevalence (%)	4,224	0.7	0.7	1.4		0.5	0.6	
17	Palliative Care GP recorded prevalence (%)	572	0.1	0.1	0.3		0.0	0.1	
18	Stroke and TIA GP recorded prevalence (%)	9,201	1.5	1.7	2.4		0.8	1.5	

Indicator, Year, Data Source 2008/09 QOF, IC

The 18 health indicators above come from the Quality and Outcomes Framework (QOF), which is a voluntary incentive scheme rewarding GPs for systematic improvement of patient care. These figures should be interpreted with caution as they are a measure of recorded prevalence and not actual prevalence. This means that a high prevalence of a condition could be because it is very common in the population or well recorded or a combination of the two.

For most of these indicators Cambridgeshire has a significantly lower recorded prevalence than the national average but a significantly higher recorded prevalence than the cluster average. Cambridgeshire is generally a healthier area compared to the England average and so it is expected that the disease prevalence would be lower. The fact that it is significantly higher than the cluster average may indicate better recording, but from these data alone it is impossible to draw definitive conclusions.