Cambridgeshire
Joint Strategic Needs Assessment

Physical and Sensory Impairment and Long-Term Conditions

PHD/partnerships/JSNA/physical disability/
PSI JSNA to PEC 27OCT08

Cambridgeshire Physical and Sensory Impairment Joint Strategic Needs Assessment

Content

1. EXECUTIVE SUMMARY

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 Primary Care Trust (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

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.

Demographic Trends, Cambridgeshire, People of Working Age

The working age group (18-64 years) in Cambridgeshire in 2006 constitutes 65% of the total population. The proportion is noticeably higher in Cambridge City (72%). This is mainly due to the large resident student population in the district.

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 any limiting long-term illness and includes information on the nature and severity of the disability.

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. The definition is therefore wider than disability and no information is given about the severity. Therefore the numbers will be much higher.

Table 1: 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

Maps show the variation in self-reported health status across Cambridgeshire, taking the age and sex structure of the population into consideration. 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.

Disability Living Allowance (DLA)

There were 2,850 people receiving any benefits in the grouping 'disability' in the benefits data. Of these, 2,820 were receiving Disability Living Allowance.

Table 2: Disability LIving Allowance by District and Duration of Claim

Disability Living Allowance clients only (all benefits)	Total	<6 mths	6 mths - 2 yrs	1-2 yrs	2-5 yrs	7 yrs+
East Cambridgeshire	350	30	30	20	70	190
Fenland	560	40	30	30	100	370
Huntingdonshire	820	50	40	70	160	500
South Cambridgeshire	660	30	30	50	130	430
Cambridge City	460	30	30	40	90	280
Total	2,850	180	160	210	550	1,770

Blue Badges

Over three years, 2,500 new badges were issued to 18 to 64 year olds and in total, over the same three year period there were over 10,500 badges on issue. Average number of new badges issued per month is 135.

Reported Causes of Disabilities Among Adults

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. For example, the current case load of 770 people receiving Level 3 and Level 4 of care, illustrates this for Cambridgeshire County Council.

Social services authorities are required to maintain registers of people in their areas who are blind or partially sighted. There are 560 people aged between 18 and 64 who are Blind and Partially Sighted People Registered in Cambridgeshire at 31 March 2006. 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. The following table provides figures for the numbers registered as deaf or hard of hearing.

Table 3: Cambridgeshire County Council: People Registered as Deaf or Hard of Hearing, Year Ending 31 March 2007

Condition	All Ages	0-17	18-64	65-74	75 or over
Deaf	435	25	195	45	175
Hard of hearing	1,075	10	205	160	700
Total	**1,510**	**35**	**400**	**205**	**875**

Source: Health and Social Care Information Centre
http://www.ic.nhs.uk/statistics-and-data-collections/social-care/disability/people-registered-as-deaf-or-hard-of-hearing-year-ending-31-march-2007-england-ns

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: www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/DH_4070951

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.

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 are 271 patients in treatment by age and gender, 62% were men and 38% were women. The majority of men (70) and women (40) were in the 35-44 year age group.

The countywide 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. The social workers currently have an active case load of 32 service users.

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.

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 significant 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 7,207 people with COPD. The unadjusted recorded prevalence is 1.2%. 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 have pulmonary rehabilitation.

Diabetes

The total number of people on the primary care Quality and Outcomes Framework (QoF) register for diabetes in 2006/07 in Cambridgeshire GP practices is 19,579.

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

The estimated numbers of new cases of each year of coronary heart disease in men across Cambridgeshire is 785 and for women is 312, between the ages of 25 and 74. The new cases of heart failure in people aged 25 to 64 is 79 men and 37 women. Reduction of coronary heart disease is one of the key health targets and pledges in the East of England.

Stroke

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.

One risk factor for stroke is atrial fibrillation of the heart. An estimate of the number of cases of atrial fibrillation in Cambridgeshire and local PCT areas is that there are 6,752 of which 81% (5,454) will be in people aged 65 and over and 51% (3,707) in people aged 75 and over. 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 about 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 about 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.

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 2006/2007, 780 new people aged 16 to 64 years with physical disabilities had completed assessments. Over 70% of first assessments for new clients are for people with physical disability, frailty and/or temporary illness. The majority of people, or 96%, of people with physical disabilities, are receiving community-based services in their own home.

Analysis of the breakdown of community based services by client type, aged years 18-64 shows that people with physical disabilities are most likely to receive day care services (10%), home care services (24%) and overnight respite outside their home (4%) and meals (2%). Note: each client may receive services from different service type simultaneously. 266 patients had direct payments, 193 required professional support and 1,180 required equipment and adaptations.

Housing

The draft Disability Housing Strategy was produced by the Disability Strategic Housing Network in February 2008. The JSNA contains a summary of the identified gaps and priorities for action. Housing is a major factor in determining physically disabled people's health and wellbeing. It appears that many disabled people still live in unsuitable accommodation, from national estimates.

Employment

The Government has set an aspiration of moving one million people off incapacity benefit, and largely into work by 2015. The Papworth Trust led on a project during 2007 called CREATE Research Project (Cambridgeshire Research into Education, Training and Employment Opportunities for Disable people). The JSNA contains summaries of the recommendations from the project. The "disabled" claimants represent 0.8% of all resident working age people in Cambridgeshire. There is a correlation between disability and lower social class.

Transport

A review by the County Council, of passenger transport was completed in January 2008. The outcome of the review led to a number of recommendations. This included creation of a community transport brokerage scheme for Cambridgeshire. Also creation of "one-stop shop" for travel information in Cambridgeshire, and a pilot scheme for "demand-responsive" rural transport services in Cambridgeshire.

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Acknowledgement to all others involved in the production of this JSNA

2. INTRODUCTION

2.1 Purpose

The Local Government and Public Involvement in Health Act (2007) places a duty on upper-tier local authorities and PCTs to undertake Joint Strategic Needs Assessment (JSNA). JSNA is a process that will identify the current and future health and well being needs of a local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

The expected outcomes from the Joint Strategic Needs Assessment is strategic and effective commissioning and service redesign. There should be evidence that services are shaped by local communities. The Joint Strategic Needs Assessment can help in identifying the needs and health inequalities across Cambridgeshire. Outcomes include improved health and wellbeing and that the outcomes and quality of services improve.

The Joint Strategic Needs Assessment is "a systematic method for reviewing the health and wellbeing needs of a population, leading to agreed commissioning priorities that will improve the health and wellbeing outcomes and reduce inequalities".

2.2 Definitions – The Meaning of Disability

Whilst many classifications and definitions of disability have been formulated, the most widely accepted is that adopted by the World Health Organisation in the early 1980s. In this a sequence is recognised – disease or disorder, impairment, disability, handicap.

Progress through the sequence is not necessary or inevitable but each of the terms has been given a particular meaning which is helpful in exploring the concepts both for individual need and for population needs assessment.

- **Impairment:** Disturbance of the normal structure or functioning of the body, which may be temporary or permanent.

  A state of impairment represents a deviation from normal bodily function or status, irrespective of whether it arose from injury, disease or congenital malformation. It is concerned with parts or systems of the body that do not work.

- **Disability:** Loss of, or restriction in, functional ability or activity as a result of impairment.

  A disability represents a limitation in tasks or activities, either physical, social or psychological, arising from the impairment. Disability is about things people cannot do.

- **Handicap:** A disadvantage for a given individual, resulting from an impairment or a disability that limits or prevents his or her fulfilment of a role that would be expected (depending on age, sex, social and cultural factors) for a group of which that individual is a member. Handicap is very dependent on the structure and attitudes of the society in which the individual exists; handicap therefore is a relative concept.

Social Model of Disability

> *"In the broadest sense, the social model of disability is about nothing more complicated than 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 inaccessible education systems, working environments, inadequate disability benefits, discriminatory health and social support services, inaccessible transport, houses and public buildings and amenities and the devaluing of disabled people through negative images in the media – films, television and newspapers."*
>
> Extract from Oliver (2004) '*The Social Model in Action: If I Had A Hammer.* Chapter 2 of Barnes & Mercer's book '*Implementing the Social Model of Disability: Theory & Research.'*

The following definition from the Union of the Physically Impaired Against Segregation is quoted in the same publication:

> *"In our view it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society"*
>
> (UPIAS 1976: p14)

Service providers also need to recognise that they may, through their actions and thoughts unwittingly further disable people. Giving choice requires an organisation to be hugely flexible in terms of labour and geography when it comes to meeting individual needs. The days of traditional Day Centre have ended and service providers must evolve or die. (personal communication from Andrew Gardiner in Headway.

More recently the term 'Long-Term Conditions' has been introduced and is widely used in the terminology of the National Health Service. Long-term conditions are those conditions that cannot, at present be cured, but can be controlled by medication and other therapies. The Government's priority is to improve care for people with long-term conditions by moving away from reactive care based in acute systems, towards a systematic, patient-centred approach. Much that has been written about long-term conditions is relevant to this Joint Strategic Needs Assessment. 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

2.3 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 report involved six government Departments: the Department of Health; the Department of Education; the Department of Skills, Work and Pensions; the Department of Communities and Local Government; the Department of Transport; and the Department of Trade and Industry.

The Disability Discrimination Act in 2005 introduced a statutory duty on public authorities to promote equality of opportunity for disabled people. The Office of Disability Issues (ODI) was created to drive forward a cross-Government strategy to 'Improve the Life Chances of Disabled People', and also to provide a source of knowledge and expertise on disability inside government. They have recently conducted a large research project on the experiences and expectations of disabled people which is due to be published soon. The first longitudinal survey of disabled people is also being planned to track the experiences of disabled people over time, to establish what happens when they become disabled and when people move from childhood to adulthood and also in or out of work. An information needs project is looking at how disabled people get information about public services and how it can be improved.

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 range of specialist disability services has been expanded. A review of specialist employment services has recently taken place to ensure higher and more consistent quality of services, and to ensure there is a focus on individual needs, rather than one size fits all. The new employment and support allowance replaces incapacity benefit for new applicants from October 2008. This is designed to help establish what a person can do rather than what they cannot do.

The Government has a proposal for a 'Single Equality Bill', with an accompanying package of measures that will provide a clearer, fairer legal framework for discrimination law in this country. The UK was one of the first countries to sign the United Nations Convention. The government also plans to ratify the UN convention on the rights of persons with disabilities by the end of the year.

A group known as Equality 2025 is an advisory group to government.

2.4 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.

2.5 Key Issues

- The “disabled” claimants represent 0.8% of resident working age people in Cambridgeshire.
- There were 2,860 people receiving any benefits in the grouping “disability” in the benefits data. Of these 2,820 were receiving Disability Living Allowance.
- Over three years, 2,500 new badges were issued to 18 to 64 year olds and in total, over the same three year period there were over 10,500 badges on issue.
- 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 and negative attitudes.
- Aside from disease, disability can arise through other causes, such as foetal abnormalities and accidents.
- There is a strong association between disability and lower social class.

3. NEEDS ASSESSMENT AND COMMUNITY ENGAGEMENT

3.1 Demographic Trends, Cambridgeshire, People of Working Age

Table 4: Population Estimates, Mid 2006, People of Working Age (18 To 64 Years), Local Authority

	Male	Female	Total 18 – 64 years	% of total population
Cambridge City	42,530	39,640	82,180	72%
East Cambridgeshire	23,500	23,880	47,380	62%
Fenland	26,920	27,250	54,170	60%
Huntingdonshire	51,620	51,250	102,880	64%
South Cambridgeshire	43,710	43,310	87,010	63%
Cambridgeshire	188,280	185,330	373,610	65%

Source: Cambridgeshire County Council Research Group

The working age group (18-64 years) in Cambridgeshire in 2006 constitutes 65% of the total population. The proportion is noticeably higher in Cambridge City (72%). This is mainly due to the large resident student population in the district.

Table 5: Population Forecasts 2006 – 2021, Working Age (20 – 64 Years), Local Authority

Year	2006	2011	2016	2021	% change 2006-2021	Absolute change 2006-2021
Cambridge	81,540	95,970	105,660	102,380	26%	+20,840
East Cambridgeshire	46,620	48,840	47,600	45,340	-3%	-1,280
Fenland	53,320	54,100	55,310	56,930	7%	+3,610
Huntingdonshire	101,460	105,570	100,760	98,660	-3%	-2,800
South Cambridgeshire	85,840	90,460	92,820	95,230	11%	+9,390
Cambridgeshire	368,780	394,940	402,150	398,540	8%	+29,760

Source: Cambridgeshire County Council Research Group 2005-based forecasts.

Population forecasts for an approximation of the total working age population – shown here for the age groups 20 to 64 years, show that the greatest increases in the population are likely to be in Cambridge City and South Cambridgeshire. A relatively small increase is forecast in Fenland with a decline in the working age population in Huntingdonshire and East Cambridgeshire.

3.2 Demographic Profile of People with Physical Disabilities

3.2.1 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

Advantages: focuses specifically on disability rather than LLTI and includes information on the nature and severity of disability

Disadvantages: potentially out-of-date, not available for Cambridgeshire specifically or for small geographical areas. Estimates are based on application of national age-specific prevalence rates to the Cambridgeshire population.

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.

Advantages: Available to small areas (output areas) and cross-tabulated with other variables such as age, sex, ethnicity, household composition, health status, tenure, caring, economic activity and socio-economic status. Prevalence rates are specific to Cambridgeshire districts.

Disadvantages: Definition is wider than just disability and no information about the nature of the problem or the severity.

Table 6: OPCS Based Estimates and Forecasts

Local Authority	2006		2011		2016		2021		% change
	Number	% people 16-64	Number	% people 16-64	Number	% people 16-64	Number	% people 16-64	2006-2021
Cambridge	4,935	6%	5,779	6%	6,385	6%	6,458	6%	31%
East Cambridgeshire	3,825	8%	4,133	8%	4,147	8%	4,180	9%	9%
Fenland	4,371	8%	4,660	8%	4,770	8%	5,046	9%	15%
Huntingdonshire	8,240	8%	8,687	8%	8,414	8%	8,554	8%	4%
South Cambridgeshire	7,056	8%	7,627	8%	7,781	8%	8,173	8%	16%
Cambridgeshire	*28,428*	*7%*	*30,885*	*8%*	*31,497*	*8%*	*32,411*	*8%*	*14%*

Source: OPCS surveys of disability in Great Britain, Crown Copyright 1988; Cambridgeshire County Council Research Group, mid-2006 population estimates and forecasts.

Table 7: Census 2001 LLTI Based Estimates and Forecasts

Local Authority	2006		2011		2016		2021		% change
	Number	% people 16-64	Number	% people 16-64	Number	% people 16-64	Number	% people 16-64	2006-2021
Cambridge	8,074	10%	9,388	10%	10,391	10%	10,554	10%	31%
East Cambridgeshire	5,367	11%	5,764	11%	5,739	12%	5,720	12%	7%
Fenland	8,300	15%	8,733	15%	8,931	16%	9,375	16%	13%
Huntingdonshire	11,238	11%	11,870	11%	11,443	11%	11,517	11%	2%
South Cambridgeshire	8,326	9%	8,981	10%	9,155	10%	9,566	10%	15%
Cambridgeshire	*41,336*	*11%*	*44,791*	*11%*	*45,592*	*11%*	*46,512*	*11%*	*13%*

Source: Census 2001, Table S016, Crown Copyright 2003; Cambridgeshire County Council Research Group, mid-2006 population estimates and forecasts.

Table 8: 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%

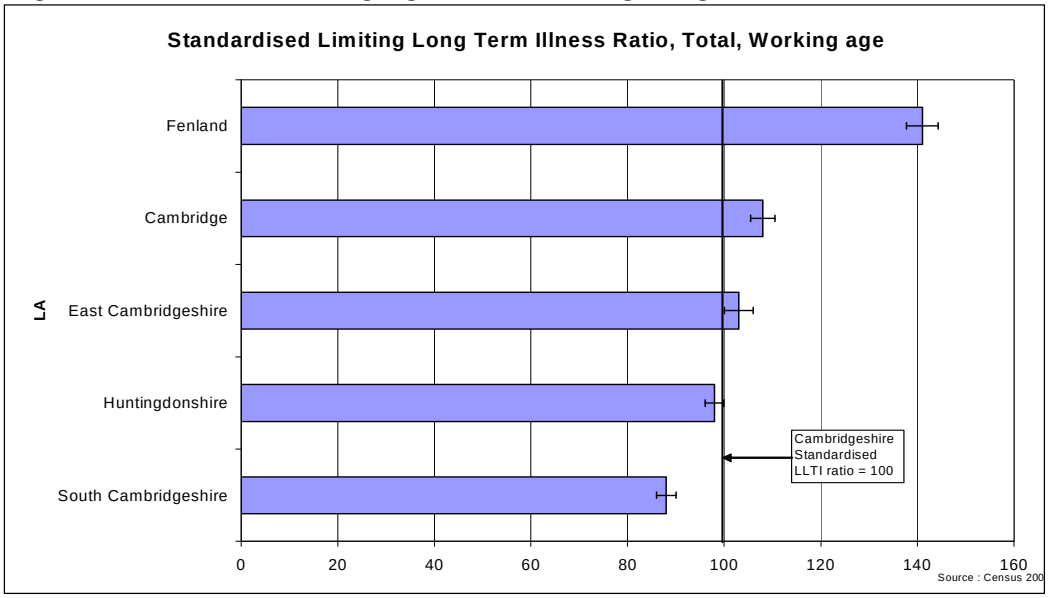
Source: OPCS surveys of disability in Great Britain, Crown Copyright 1988; Census 2001, Table S016, Crown Copyright 2003; Cambridgeshire County Council Research Group, mid-2006 population estimates and forecasts. [1],[2]

Differences across the districts may reflect:

- Differences in the age structure of the population (e.g. Cambridge City has a greater proportion of young people) and therefore there are differences in the proportion of 16-64 year olds with a disability across the districts.
- The extent of the increase in numbers reflects differences in population growth (see also Appendix 1), ranging from a predicted 31% increase in Cambridge City to an increase of only 4% in Huntingdonshire (OPCS disability estimates).

3.3 Limiting Long-Term Illness

Figure 1: Adults of Working Age with a Limiting Long-Term Illness



Source: Census 2001 © Crown Copyright 2003 and Cambridgeshire County Council Research Group

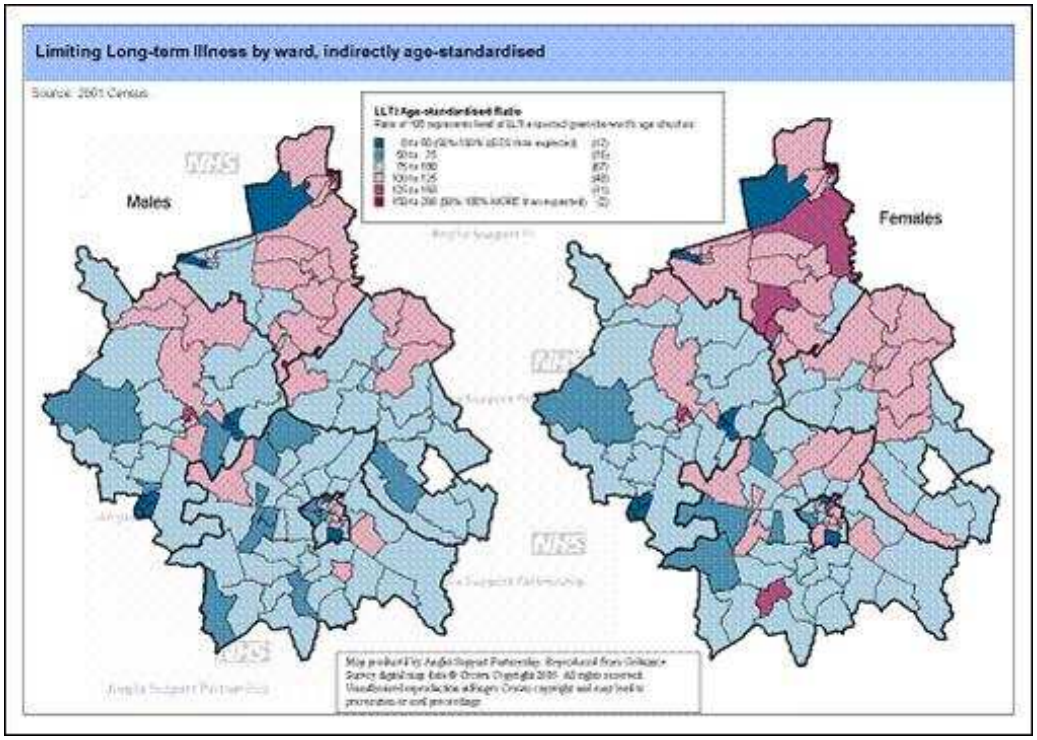
[1] **Assumptions and limitations**

For both Census LLTI and OPCS based forecasts it is assumed that the age-specific prevalence rates will remain stable over time – and does not allow for the fact that environmental/societal factors may impact on age specific rates. While the use of district level prevalence rates for census LLTI data mean that local factors that may impact on disability are accounted for to some degree, the application of national prevalence rates for OPCS data does not – eg links between disability, health and deprivation. The estimates and forecasts outlined in this section are crude. A more detailed piece of work, on projections of LLTI, is being completed by Alan Marshall at the Cathie Marsh Centre, in Manchester (as a PhD project).

[2] Based on: Estimating and forecasting the number of adults with a disability in Cambridgeshire. Brief report July 2007. Sarah Ball, Research Group, Cambridgeshire County Council.

The map shows the variation in self-reported health status across Cambridgeshire, taking the age and sex structure of the population into consideration. 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.

Map 1: Limiting Long-Term Illness by Ward, Indirectly Age-Standardised (All Ages)



Source: 2001 Census National Statistics. © Crown Copyright 2003

The Census question asks whether the person had any long-term illness, health problem or disability which limited their daily activities or the work they could do, including problems due to old age. Limiting long-term illness (LLTI) therefore covers any long-term illness, health problem or disability, which limits daily activities or work.

3.4 Indirect Estimates of Physical and Sensory Impairment

This section looks at benefits and other data which adds further information to the estimates of the number of people in Cambridgeshire who make up the population of physically and sensory impaired.

4. WORKING-AGE CLIENT GROUP - KEY BENEFIT CLAIMANTS

The 'disabled' claimants represent 0.8% of all resident working age people in Cambridgeshire (November 2007), similar to the national and regional average figure. In 2007, 2,860 people were in receipt of Disability Living Allowance (DLA).

Table 9: Working Age Client Group – Key Benefit Claimants

	Cambridgeshire (numbers)	Cambridgeshire (%)	East (%)	Great Britain (%)
Total claimants	31,190	8.3	10.7	13.9
Job seekers	4,160	1.1	1.5	2.0
Incapacity benefits	15,410	4.1	5.2	7.2
Lone parents	4,180	1.1	1.6	2.0
Carers	2,670	0.7	0.9	1.0
Others on income related benefits	1,020	0.3	0.4	0.5
Disabled	2,860	0.8	0.8	0.9
Bereaved	890	0.2	0.3	0.3

Source: DWP benefit claimants - working age client group

Note:% is a proportion of resident working age people

4.1 Disability Living Allowance (DLA)

There were 2,860 people receiving any benefits in the grouping 'disability' in the benefits data. Of these, 2,820 were receiving Disability Living Allowance.

Table 10: Disability Living Allowance Clients, Cambridgeshire November 2007

Agegroup	Any benefits	Disability Living Allowance (DLA) only	Total	% by agegroup (DLA)
<25 years	690	690	1,380	24%
25-34	360	360	720	13%
35-44	520	520	1,040	18%
45-54	680	670	1,350	24%
55-59	440	410	850	15%
60-64	180	180	360	6%
Total	2,860	2,820	5,680	100%

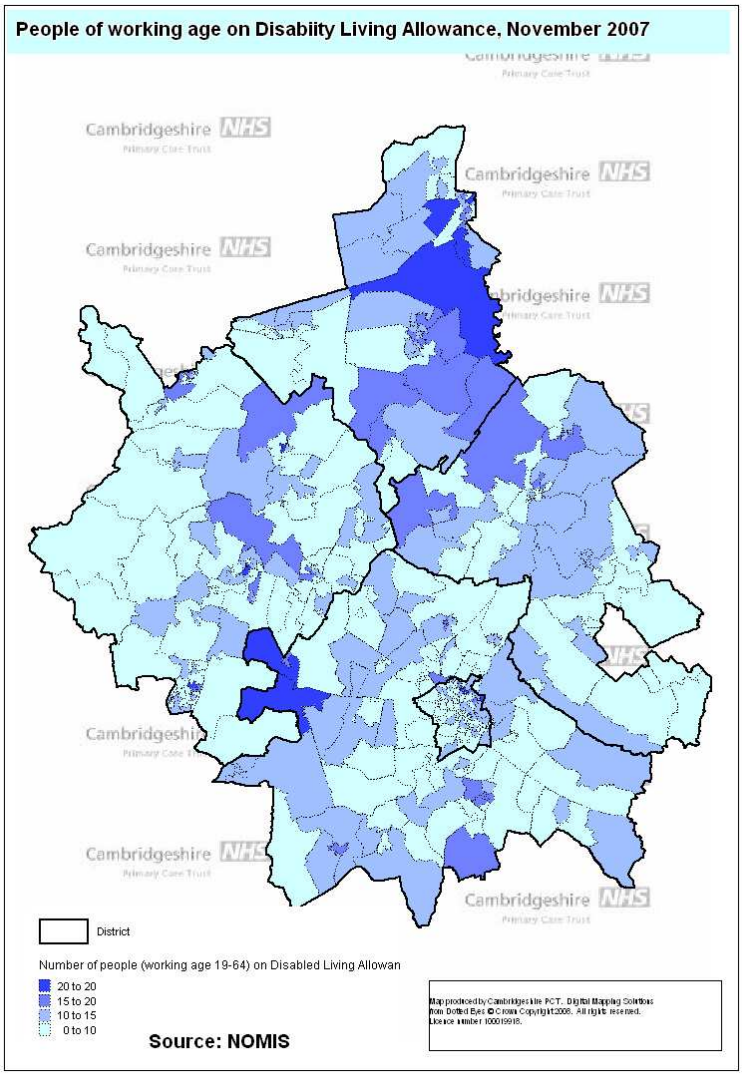
Source: ONS (Nomis)

Table 11: Disability Living Allowance by District and Duration of Claim

Disability Living Allowance clients only (all benefits)	Total	<6 mths	6 mths - 2 yrs	1-2 yrs	2-5 yrs	7 yrs+
East Cambridgeshire	350	30	30	20	70	190
Fenland	560	40	30	30	100	370
Huntingdonshire	820	50	40	70	160	500
South Cambridgeshire	660	30	30	50	130	430
Cambridge City	460	30	30	40	90	280
Total	2,850	180	160	210	550	1,770

Source: ONS (Nomis) numbers rounded

Map 2: People of Working Age on Disability Living Allowance November 2007



4.2 Blue Badges

The Blue Badge scheme provides a range of parking concessions for people with severe mobility problems who have difficulty using public transport. The scheme operates throughout the UK.

Estimates of the number of Blue Badges on issue in Cambridgeshire have been made for the 18-64 year old population. Over three years, 2,500 new badges were issued to 18 to 64 year olds and in total, over the same three year period there were over 10,500 badges on issue.

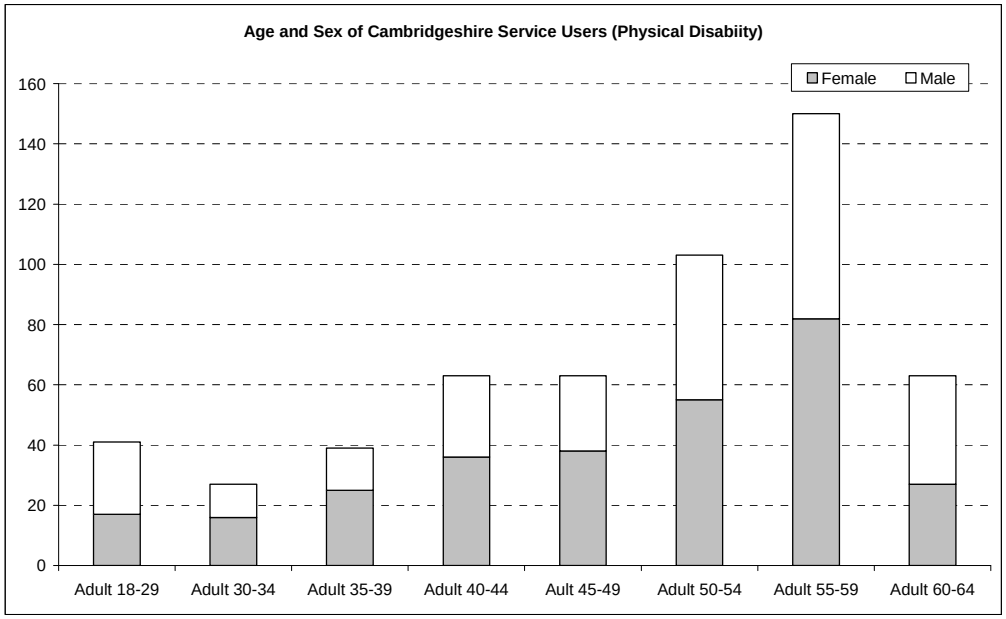
Table 12: Estimate of Blue Badges in Cambridgeshire, 2008

	Number of Blue Badges
Total number of blue badges on issue (all age groups)	39,286
Total number of blue badges on issue (over 3 years) to 18-64 yrs)	10,568
Number of new badges on issue (over 3 years) (18-64 yrs)	2,552
Number of renewed badges (over 3 years) (18-64 yrs)	8,016
Average number of new badges issued per month	135

Source: Cambridgeshire County Council

4.3 Demography of Cambridgeshire Service Users

Figure 2: Age and Sex Breakdown of Users of Cambridgeshire Physical Disability Services, 2008



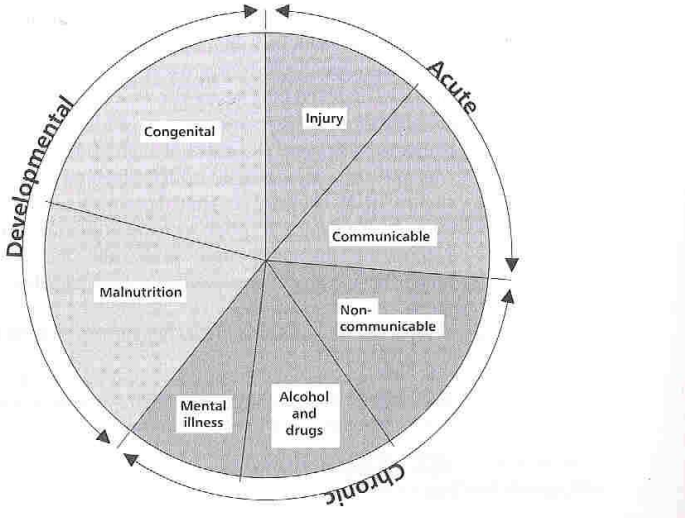
Source: Cambridgeshire County Council

4.4 Causes of Disability

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.

The major underlying causes of disability are consistent across a number of surveys. In examining population need locally, some insights into the size of the problem of disability can be derived by estimating the number of people with conditions such as stroke. This disease-based approach does not provide information on the full range of disability nor does it yield data on levels of incapacity amongst disabled people, the most important issue when assessing need and planning service responses.

Figure 3: Classes of Disorder Giving Rise to Disability in the World



Source: Wood P, Bradley E. The epidemiology of disablement. In: Goodwill C J, Chamberlain M A (Eds), Rehabilitation of the physically disabled adult. London: Croom Helm, 1988.

The most comprehensive information on the numbers of people with disability and the nature of their problem comes from a series of national surveys undertaken during the 1980s. Originally commissioned by the government in 1984, the Office of Population Censuses and surveys (OPCS) carried out four separate surveys between 1985 and 1988. In 1995 the Health Survey for England repeated major parts of the 1985 disability survey series using an adapted form of the World Health Organisation's question's for determining levels of disability.

The Health Survey covered private households in England and found that 18% of those aged 16 years and older had at least one type of disability out of the five covered. Overall, 4% of men and 5% of women were judged to have a serious disability. The prevalence of disability increased with age for both men and women with about three-quarters of men and women aged over 85 years having at least one disability.

The most commonly reported cause of disability was disease of the musculoskeletal system (in particular, arthritis). There was a strong relationship between disability and lower social class.

Table 13: Reported Causes of Disabilities Among Adults

Health Complaint	%
Diseases of the musculoskeletal system and connective tissue:	40%
• Arthritis	22%
• Others	18%
Disease of the ear and mastoid processes	7%
Disease of the circulatory system	13%
Diseases of the respiratory system	7%
Eye disorders	5%
Diseases of the nervous system (other than eye or ear)	5%
Injury and poisoning	9%
Endocrine, nutritional and metabolic diseases and immunity disorders	3%
Neoplasms	1%
Mental disorders	3%
Others	8%

Percentages add to more than 100 because some informants had more than one complaint.
Source: Health Survey for England 2001, London: The Stationary Office.

Because the nature of the services used vary from universal services to highly specialist services we have found clients with these conditions accessing the full range of services. The epidemiology of the long-term conditions and those with physical and sensory impairments is covered in section 5 on Improving Health and Wellbeing.

4.5 Cambridgeshire Service Users – Breakdown by 'Cause'

Clients with the most severe forms of physical and sensory impairment are eligible for social services support. For example the current case load illustrates this for Cambridgeshire County Council. In addition the services include services for people with HIV and AIDS. Multiple Sclerosis and Head Injury account for around 27% of the caseload.

Table 14: Type of Disability Amongst the People Eligible for Level 3 and Level 4 Support Provided by Cambridgeshire County Council

Disability	Number of people	%
Multiple Sclerosis	144	18.7%
Head Injury	70	9.1%
Cerebral Palsy	61	7.9%
Skeletal Trauma	73	9.5%
Arthritis	32	4.2%
Stroke	64	8.3%
Cancer	20	2.6%
Muscular Dystrophy	15	1.9%
ME	17	2.2%
Parkinsons	9	1.2%
Huntingtons	9	1.2%
Spina Bifida	12	1.6%
Obesity/Diabetes	17	2.2%
Heart and Respiratory	20	2.6%
Alcohol	13	1.7%
Epilsepsy	11	1.4%
Other	83	10.8%
Uncoded	100	13.0%
Total	770	100.0%

Source: Cambridgeshire County Council

4.6 Sensory Impairment

People with sensory disabilities are individuals with special needs within the disabled population. The three principal categories are people with blindness, those with deafness and those who are both deaf and blind.

4.6.1 Registered Blind and Partially Sighted People - Cambridgeshire

Table 15: Total Number of Blind and Partially Sighted People Registered with Councils by Age Group at 31 March 2006

Cambridgeshire	All ages	0 -4	5 -17	18 -49	50 -64	65 -74	75 or over
Blind	1,470	10	30	165	150	120	1,005
Partially sighted	1,005	-	15	145	100	95	655
Total	2,475	10	45	310	250	215	1,660

Source: National Statistics

Table 16: New Registrations: Blind and Partially Sighted People Registered with Councils by Age Group at 31 March 2006

Cambridgeshire	All ages	0 -4	5 -17	18 -49	50 -64	65 -74	75 or over
Blind	135	5	-	10	10	15	95
Partially sighted	110	-	0	10	15	10	75
Total	245	5	0	20	25	25	170

Source: National Statistics

Table 17: Number of Registered Blind and Partially Sighted People Registered with Councils with an Additional Disability at 31 March 2006

Cambridgeshire	Total	Mental illness only	Learning Disabilities only	Physical disabilities only	Deaf with speech	Deaf without speech	Hard of hearing
Blind	345	30	40	240	35	-	-
Partially sighted	230	25	15	175	15	-	-
Total	575	55	55	415	50	-	-

Source: National Statistics

Social services authorities are required to maintain registers of people in their areas who are blind or partially sighted. Individuals are not obliged to register in order to access social services, although some concessions provided by other agencies and not related to social services are available only to people who are registered.

Social services authorities are also required to maintain registers of people who are deaf or hard of hearing. The following table provides figures for Cambridgeshire.

Table 18: Cambridgeshire County Council: People Registered as Deaf or Hard of Hearing, Year Ending 31 March 2007

Condition	All Ages	0-17	18-64	65-74	75 or over
Deaf	435	25	195	45	175
Hard of hearing	1,075	10	205	160	700
Total	**1,510**	**35**	**400**	**205**	**875**

Source: Health and Social Care Information Centre http://www.ic.nhs.uk/statistics-and-data-collections/social-care/disability/people-registered-as-deaf-or-hard-of-hearing-year-ending-31-march-2007-england-ns,

The prevalence of hearing loss in the adult population in Britain is not available from routine data sources but can be derived from well designed surveys. People who are both deaf and blind are a particularly vulnerable group because they may be less likely to be able to access services on their own initiative.

5. IMPROVING HEALTH

5.1 Generic Patient Pathways

The Government's aim is to promote and spread across the NHS approaches that will lead to improved services and support for people with long-term health and social care needs – the specific aims being to produce better health outcomes and quality of life, slow disease progression and reduce disability. This in turn will result in improved quality of life, helping to relieve discomfort and stress and reduce the need for hospital admission.

People with long-term conditions have better lives when they are supported to take care of their conditions themselves. If people have a clear understanding of their condition and what they can do, they are more likely to take control themselves. One of the priorities from participants in the 'Your health, your care, your say' consultation was for services based around their needs which help them take control of their health, support their wellbeing; and enable them to lead an independent and fulfilling life.

'Our health, our care, our say: a new direction for community services (January 2006)' sets out a vision and package of proposals designed to address the expectations and outcomes that people want for themselves; maintaining a sense of wellbeing; and leading an independent life. There is solid evidence that care is less effective if people feel they are not in control.

Three themes run throughout the White Paper:

- Enabling and supporting health, independence and wellbeing.
- Rapid and conventional access to high quality, cost effective care.
- Putting people more in control of their own health.

Self care lies at the heart of putting people in control and plays a key role in improving the management of long-term conditions. Self care is "led, owned and done by people themselves. NHS and social care organisations cannot do self care to people, but what they can do is create the right environment where people feel supported to self care." This definition is taken from the self care guide for supporting people with long-term conditions that was published shortly after the White Paper.

The self care guide for supporting people with long-term conditions – 'Supporting people with long-term conditions to self care – a guide to developing local strategies and good practice' (published 24th February 2006), complements the proposals set out in the White Paper and both reinforce the existing programme of reform.

The document identifies key areas in which patients need support (skills; training, information, tools; devices and support networks) and gives examples of good practice together with the role of patients, professionals and PCTs/Trusts in supporting these areas.

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 www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/DH_4070951

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. There are a number of quality requirements.

Quality requirement 1: A person-centred service.
Quality requirement 2: Early recognition, prompt diagnosis and treatment.
Quality requirement 3: Emergency and acute management.
Quality requirement 4: Early and specialist rehabilitation.
Quality requirement 5: Community rehabilitation and support.
Quality requirement 6: Vocational rehabilitation.
Quality requirement 7: Providing equipment and accommodation.
Quality requirement 8: Personal care and support.
Quality requirement 9: Palliative care.
Quality requirement 10: Supporting families and carers.
Quality requirement 11: Caring for people with neurological conditions during admission.

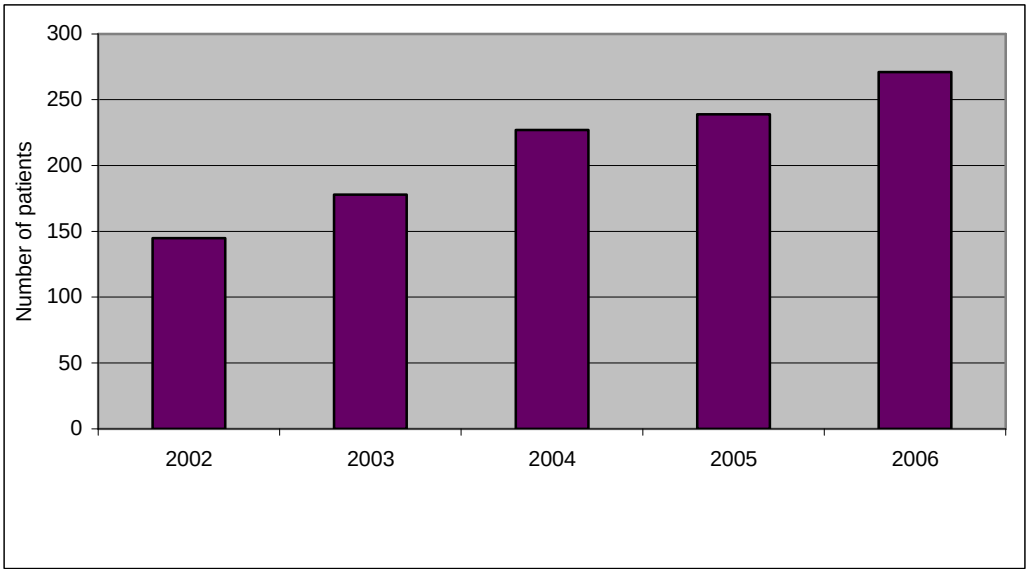
There is much common ground between the 'Long-Term Conditions Strategy' and the Long-Term (Neurological) Conditions NSF, for example around person-centred care planning, information and support, self care and case management. The strategy will be able to use neurological examples and case studies to illustrate how case management and self care can work. In turn it will rely on the NSF and all other NSF teams (e.g. renal, diabetes) to lead delivery of disease-specific issues under the broader long-term conditions work. However, it is important to ensure that NSF for Long-Term (Neurological) Conditions maintains its neurological focus and a discrete identity under this broader umbrella. 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.

5.2 Specific Patient Pathways

5.2.1 HIV and AIDS

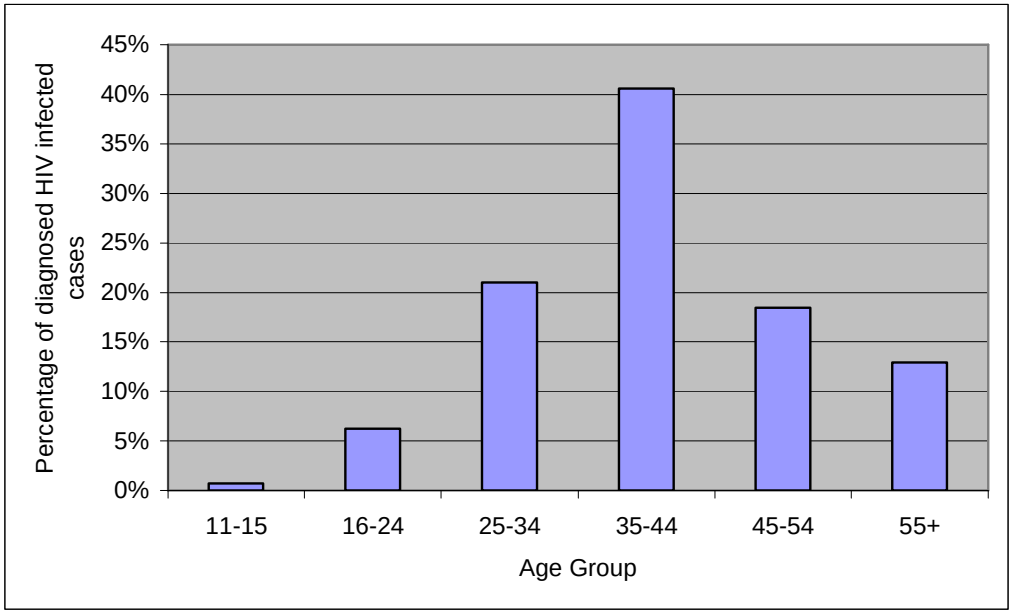
The incidence rate for HIV in the East of England was 12 per 100,000 compared with the national rate of 17 per 100,000. Data is available from SOPHID (Survey of Prevalent HIV Infections Diagnosed) data, which is collected and summarised clinical and epidemiological information on all cases with diagnosed HIV seeking statutory care in the year of reporting. Clinician reporting began in 2000. It should be noted when interpreting this data that under-estimation arises due to prevalent cases not seeking care during the year, sites of care not being included in the survey and incomplete data entry or reporting.

Figure 4: Numbers Patients Diagnosed with HIV Infection Seen for Statutory Medical HIV Related Care in Patients Resident in Cambridgeshire PCT



Source. SOPHID data. The figure shows that the number of patients resident in Cambridgeshire PCT with diagnosed HIV infection who attended for HIV related treatment, has increased on a year to year basis since 2002. In 2006, there were 271 cases in total.

Figure 5: Percentage Distribution of Age Groups of Diagnosed HIV-Infected Cases Last Seen for Care in 2006 in Cambridgeshire PCT Residents



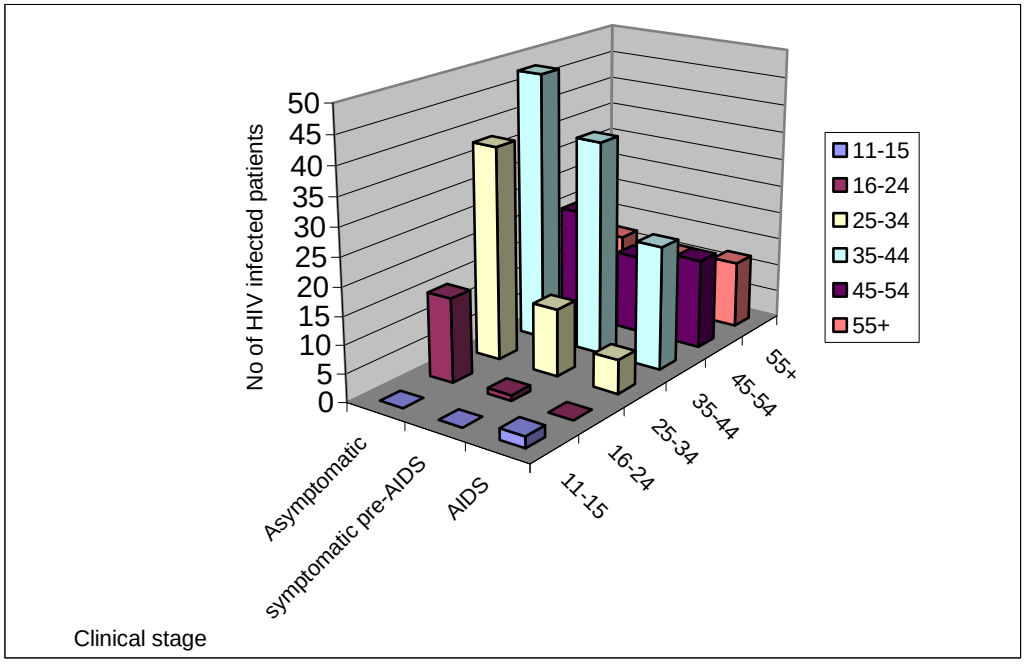
The figure shows the breakdown of the 271 patients in treatment by age and gender, 62% were men and 38% were women. The majority of men (70) and women (40) were in the 35-44 year age group.

The countywide 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. The social workers currently have an active case load of 32 service users.

There is a Service Level Agreement in place to support the local voluntary organisation – it is joint between the Local Authority and the Primary Care Trust.

The following figure shows the HIV diagnosed individuals by most advanced clinical stage and age group. This shows that the largest group of diagnosed HIV infected patients were in the age group 35-44 years and were asymptomatic.

Figure 6: Diagnosed HIV Infected Patients by Most Advanced Clinical Stage, and Age Group when Last Seen in Care in 2006



Source: SOPHID

5.2.2 Trauma and Head Injury

Head injury in England is common. Head injury incidence in England varies by a factor of 4.6 across Primary Care Trusts. Planning head injury related services at the local level thus needs to be based on local incidence figures rather than regional and national estimates. 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 2002/03, the hospitalised incidence rate was 229.4 per 100,000 all ages. This is similar to the incidence of stroke although the latter is experienced in predominantly older people. However, head injury affects a predominantly younger population and carried with it a high economic impact. About 4,700 people admitted in any one year in England out of 112,718, and who are considered to be economically active (aged 16 -74) and in employment at the time of their injury would be unable to return to their work at 6 weeks.

Table 19: Incidence of Admission to Hospital for Head Injury by PCT 2002-3. Estimated Rate Per 100,000; For Those Aged 0-15; 16-74; and 75 Years and Over, and in Total

PCT	Under 16	16-74	75+	All ages
Cambridge City	299.59	280.04	673.70	311.40
East Cambridgeshire and Fenland	355.18	176.74	606.06	247.33
Huntingdonshire	329.18	136.40	542.41	202.69
South Cambridgeshire	266.36	159.74	713.21	220.37

Source: http://www.dh.gov.uk/publicationsAndStatistics/Statistics/HospitalEpisodeStatistics

Table 20: Number of Hospital Admissions for Head Injury (ICD10 S00-S99) 2005/06 – 2007/08. Cambridgeshire PCT Residents.

PCT	2005/06	2006/07	2007/08	Total (3 years)
Hunts	345	326	302	973
City	475	412	402	1,289
South	241	224	207	672
ECF	403	378	355	1,136
Cambridgeshire	1,464	1,340	1,266	4,070

Source: ASP CDS

Table 21: Number of Hospital Admissions for Head Injury by Age Group (ICD10 S00-S99) 2005/06 – 2007/08. Cambridgeshire PCT Residents.

Age	2005/06	2006/07	2007/08	Total (3 years)	% of total (3 years)
00 - 04	125	129	118	372	9%
05 - 14	106	100	95	301	7%
15 - 24	274	235	229	738	18%
25 - 44	342	305	258	905	22%
45 - 64	165	175	155	495	12%
65 - 74	90	72	66	228	6%
Over 75	362	324	345	1,031	25%
All ages	1,464	1,340	1,266	4,070	100%
15-64	781	715	642	2,138	53%

Source: ASP CDS

Follow up studies imply that about 10% of people on follow up at one year have left with some form of physical or psychological impairment, after a head injury.

Table 22: Number of Hospital Admissions for Head Injury by Type of Injury (Primary Diagnosis) (ICD10 S00-S99) 2005/06 – 2007/08. Cambridgeshire PCT Residents

Age	2005/06	2006/07	2007/08	Total (3 years)	% of total (3 years)
Open wound of head	526	420	447	1,393	34%
Fracture of skull and facial bones	248	226	247	721	18%
Superficial injury of head	252	266	190	708	17%
Other and unspecified injuries of head	255	274	161	690	17%
Intracranial injury	140	110	189	439	11%
Injury of eye and orbit	27	37	26	90	2%
Other (minor)	9	<6	<6	19	0%
Other (major)	<6	<6	<6	9	0%
Total	1,464	1,340	1,266	4,070	100%

Source: ASP CDS

Much also needs to be done on prevention. Road traffic collisions, for example are high in some parts of Cambridgeshire. There are at least 70 people known to social services requiring Level 3 or Level 4 follow up care for severe physical disabilities following a head injury. A small number of people receive specialist holistic psychological rehabilitation, such as at the Oliver Zangwill Centre in Ely.

5.2.3 Chronic Obstructive Pulmonary Disease (COPD)

Health and Social Care aim to reduce the avoidable burden of respiratory problems in Cambridgeshire by a combination of prevention, early detection, rapid access to treatment, enhanced quality and length of life, and a well-managed terminal phase and death at the place of the patient's choosing that specifically includes:

- Reducing the prevalence of smoking.
- Comprehensive TB services and New Entrant Screening services.
- Reduce premature mortality from respiratory diseases (under age of 75 years).
- Promote pulmonary rehabilitation – restoration of maximum lung function and activities of daily living following bouts of respiratory illness.
- Support for carers.

Table 23: Quality and Outcomes for Chronic Obstructive Pulmonary Disease

	Disease Register COPD 2006/07	Unadjusted Recorded Prevalence (95% CI)	Range in GP Practices
East Cambridgeshire & Fenland	2,854	1.6% (1.6 - 1.7%)	0.9 - 2.6%
Greater Cambridge	2,406	0.9% (0.9 - 1.0%)	0.2 - 1.7%
Huntingdonshire	1,947	1.3% (1.2 - 1.3%)	0.5 - 1.9%
Cambridgeshire PCT	7,207	1.2% (1.2 - 1.3%)	0.2 - 2.6%

Quality and Outcomes Framework (QoF) is the system by which achievement against clinical and other outcome indicators for the new General Medical Services contract (nGMS) is measured. Since 2005, data have been published at GP practice level for a number of clinical, organisational, patient experience and additional service domains.

The data shown here are 'recorded prevalence' data at PCT area. The prevalence counts are unadjusted for age or sex (crude or raw prevalence) and are based on the counts of people (at all ages) forming the disease registers and on GP practice list sizes. There is no other demographic breakdown within QoF data as published.

It is generally recognised that these data are not yet of sufficient accuracy or completeness in many areas to be measuring actual prevalence of these conditions. Hence this is described in the tables as 'Recorded Prevalence'.

5.2.4 Diabetes

There are many published studies on the incidence and prevalence of diabetes in various parts of the UK. Most studies involve Caucasian populations and the results are not applicable to non-Caucasian populations. It is known that the prevalence of diabetes is higher in people of South Asian and Afro-Caribbean origin. When estimating local incidence or prevalence it is preferable, rather than extrapolating findings from elsewhere to use data from local studies if these are available. The incidence of type II diabetes is difficult to determine given the latency of the condition. The overall prevalence of clinically diagnosed diabetes in all ages in the UK is between 2 and 3%. For the population of Cambridgeshire this would mean an estimate of between 11,900 and 17,900 people having clinically diagnosed diabetes. The total number of people on the QoF register for diabetes in 2006/07 in Cambridgeshire GP practices is 19,579.

A draft Local Enhanced Service has been crafted by Practice Based Commissioners along with initial analyses partly using the diabetes commissioning toolkit. A PCT working group will scope the interface between primary and secondary care to ensure repatriation of patients for care in the most appropriate setting, by the most appropriate professionals, in the most appropriate place.

The diabetes information management will be improved using project management skills and involving the NPfIT team with a steering group. The diabetes network will expand to allow representation and contributions from neighbouring Huntingdonshire and East Cambridgeshire and Fenland. The findings will report to the PCT Clinical Services Redesign Board. The needs assessment will include adequate support for primary care, in terms of patient education, and the areas for improvements listed in the draft CATCH Local Enhanced Service. The savings will be monitored by the finance division of the Primary Care Trust.

5.2.5 Arthritis

For the majority of musculoskeletal conditions the aims are to help people with mobility, control of pain and symptoms and beneficially modifying the disease processes. Management plans need to be individualised according to the person's daily activity requirements, and work and recreational aspirations.

The wide variety of treatment approaches may require the expertise of a number of health professionals, necessitating a co-ordinated multidisciplinary team approach for some patients. The patient's symptoms will change with time, and require review and readjustment.

There are a number of approaches that can help people to cope better with, and to adjust to their chronic pain and disability.

There are over 200 types of musculoskeletal disease. 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.

5.2.6 Cancer

The epidemiology of cancer is part of the 'Cancer Strategy' which is being written by NHS Cambridgeshire.

5.2.7 Coronary Heart Disease

The estimated number of new cases of coronary heart disease in the community in Cambridgeshire per annum is 785 in men and 312 in women (total 1,097 with 95% confidence intervals from 982 to 1,222 cases). In people aged 65 to 74 years there are estimated to be 313 cases in men and 133 in women (total 446 with 95% confidence intervals from 378 to 512 cases).

Table 24: Estimated Number of New Cases Per Annum of Coronary Heart Disease in Men in the Community (Incidence)

Male	Exertional Angina	Unstable angina	Acute myocardial infarction	Sudden cardiac death	Total	95% CI LL	95% CI UL
25-34	0	0	2	0	2	0	10
35-44	9	2	25	2	38	23	14
45-54	51	18	49	12	130	101	166
55-64	162	35	85	42	324	270	384
65-74	118	46	95	53	313	267	364
25-74	326	100	252	108	785	709	868

Source: Wood D et al. Chapter 5 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Population: Exeter, April 2007. Incidence rates from Bromley Coronary Heart Disease Register. 95% confidence intervals available for individual disease categories but data not shown in these tables except for CHD Total).

Table 25: Estimated Number of New Cases Per Annum of Coronary Heart Disease in Women in the Community

Female	Exertional Angina	Unstable angina	Acute myocardial infarction	Sudden cardiac death	Total	95% CI LL	95% CI UL
25-34	0	0	1	0	1	0	1
35-44	3	0	1	1	6	2	15
45-54	20	7	5	2	35	23	50
55-64	82	17	22	9	129	103	160
65-74	59	15	35	24	133	111	148
25-74	163	40	68	40	312	273	354

Source: Wood D et al. Chapter 5 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Population: Exeter, April 2007. Incidence rates from Bromley Coronary Heart Disease Register. 95% confidence intervals available for individual disease categories but data not shown in these tables except for CHD Total).

The estimated number of new cases of heart failure per annum in men and women of 25 years and over in the community in Cambridgeshire is 3,477 in men and 3,101 in women.

Table 26: Estimated Number of New Cases (Incidence) Per Annum of Heart Failure in Men and Women In Cambridgeshire Aged 25 Years and Over in the Community

Age	Men	Women
25-34	0	2
35-44	8	8
45-54	10	3
55-64	61	24
65-74	88	54
75-84	133	105
85+	3,176	2,905
25 +	3,477	3,101

Source: Wood D et al. Chapter 5 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Population: Exeter, April 2007. Incidence rates from London Heart Failure Study II.

Table 27: Estimated Number of New Cases of Symptomatic Disease Per Annum in 25-74 Year Olds in Cambridgeshire

Age	All	Male	Female
Number of cases	541	175	99
Sudden cardiac death	31	26	9
Chest pain, cardiac in origin, no history of CHD	420	271	155
Exertional angina, no history of CHD	106	80	36
Non-fatal acute MI, no history of CHD	65	62	15
Unstable angina, no history of CHD	30	25	9

Source: Wood D Et Al. Chapter 5 In Health Care Needs Assessment Vol 1 (Eds Stevens A Et Al). Population: Exeter, April 2007. Incidence Rates From Bromley Coronary Heart Disease Register

5.2.8 Stroke

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.

Table 28: Estimated Number of First Strokes in Cambridgeshire PCT Local Areas

PCT area	Estimated number of first strokes	
	People of all ages	People aged 65+
Cambridge City	226	175
East Cambridgeshire and Fenland	379	299
Huntingdonshire	308	227
South Cambridgeshire	223	170
Cambridgeshire	1,136	872

Source: Mant J et al. Chapter 3 in Health Care Needs Assessment Vol 1 (Eds Stevens A et al). Calculations use age and sex specific incidence rates from Oxford Community Stroke Project (OCSP) and assume a 20% decline in age specific incidence since the time the study was performed (1981-1986.) Population: Exeter, April 2007.

Table 29: Summary of Epidemiology of Stroke and Risk Factors for Stroke in a Population of 100,000 and for a GP with a List Size of 2,000

Sub category	Expected number of new cases per year (incidence)		Expected number of existing cases (prevalence)	
	For a GP	For a PCT	For a GP	For a PCT
Risk factors for stroke				
Atrial fibrillation	7.0	330	22	1,100
Hypertension (BP > 140/90 mmHg)	-	-	680	34,000
Current smokers	-	-	560	28,000
Diabetes mellitus	-	-	40	2,000
Ischaemic heart disease	-	-	110	5,500
Transient ischaemic attack	0.7	35	-	-
Stroke			30	1,500
First stroke (excluding sub-arachnoid haemorrhage)	3.0	164	-	-
Recurrent stroke	1.0	57	-	-
People with moderate disability from stroke	-	-	20	1,000
Sub-arachnoid haemorrhage	0.2	10	-	

Source: Mant J et al. Chapter 3 in Health Care Needs Assessment Vol 1
(Eds Stevens A et al. Number of first strokes derived from assumption in preceding table.

One risk factor for stroke is atrial fibrillation of the heart. An estimate of the number of cases of atrial fibrillation in Cambridgeshire and local PCT areas is that there are 6,752 of which 81% (5,454) will be in people aged 65 and over and 51% (3,707) in people aged 75 and over.

Table 30: Estimate of Age-Specific Numbers of Cases of Atrial Fibrillation in Cambridgeshire and PCT Areas

Age group	Cambridge City	East Cambs & Fenland	Hunts	South Cambs	Cambridgeshire
40 - 44	10	13	14	9	47
45 - 49	24	36	39	25	125
50 - 54	36	54	55	36	182
55 - 59	55	92	92	60	299
60 - 64	91	163	159	103	515
65 - 69	132	250	225	145	752
70 - 74	192	377	288	205	1,062
75 - 79	239	456	321	246	1,262
80 - 84	281	457	323	260	1,320
85 - 89	179	249	193	154	775
90+	110	127	94	83	413
All ages	1,349	2,274	1,803	1,326	6,752
<40	2,293	2,044	2,102	1,336	7,775
65+	1,058	1,874	1,460	1,062	5,454
75+	783	1,277	918	729	3,707

Source: Mant J et al. Chapter 3 in Health Care Needs Assessment Vol 1
(Eds Stevens A et al). Population: Exeter, April 2007.

5.2.9 Neurological Conditions

The table overleaf shows the estimated number of people with selected long-term conditions, using study estimates from Annex A of the National Service Framework for Long-Term Conditions.

From Annex A - NSF for Long Term Conditions

	Incidence	Prevalence	Population: all ages	584,332	176,293	151,514	256,525	167,332
			Approximate number of people (prevalence)					
	per 100,000 per year	per 100,000 per year	**England**	**Cambs**	**ECF**	**Hunts**	**City & South**	**Pbro**
Cerebral palsy	N/k	186	110,000	1,087	328	282	477	311
Charcot-Marie-Tooth disorder	N/k	40	23,600	234	71	61	103	67
Dystonia[i]	N/k	65	38,000	380	115	98	167	109
Early onset dementia[ii]		N/k	18,000					
Epilepsy[iii]	24-58	430-1,000	182,750-425,000	2513-5843	758-1763	652-1515	1103-2565	720-1673
Essential tremor	N/k	850	500,000	4,967	1,498	1,288	2,180	1,422
Huntingdon's disease	N/k	13.5	6,000-10,000	79	24	20	35	23
Migraine[iv] (England)	400	15,000	8,000,000	87,650	26,444	22,727	38,479	25,100
Motor neurone disease	2	7	4,000	41	12	11	18	12
Multiple sclerosis[v]	03-Jul	100-120	52,000-62,000	584-701	176-212	152-182	257-308	167-201
Muscular dystrophy	N/k	50	30,000	292	88	76	128	84
Parkinson's disease	17	200	120,000	1,169	353	303	513	335
Post-polio syndrome	N/k	N/k	120,000					
Spinal cord injury[vi]	2[vii]	50	36,000	292	88	76	128	84
Spina bifida and congenital hydrocephalus	N/k	24	14,000	140	42	36	62	40
Young onset stroke[viii]	55[ix]	N/k	N/k					

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Population — Exeter registered population at April 2007

[i] Primary idiopathic, ie not associated with another condition.

[ii] For Alzheimer's disease/dementia, the incidence is 25,000 per 100,000 in over 65s,
prevalence 1,000 per 100,000 in the general population and approximate total numbers 700,000.
Alzheimer's disease and other dementias are covered in the National Service Framework (NSF)for Older People.

[iii] Figures for England and Wales from National Institute for Clinical Excellence (NICE) guidelines.

[iv] Steiner TJ et al. (1999) Epidemiology of migraine in England. *Cephalagia,* 19: 305-6.

[v] Figures from NICE guidelines for England and Wales.

[vi] Kurtzke JF (1978) Epidemiology of spinal cord injury. *Neurologia Neurocirugia Psiquiatria,* 18: 157-91.

[vii] The Spinal Injury Association gives 666 new patient admissions to spinal cord injury centres in the UK and Ireland in 2000 (equivalent to about 2 in 100,000).

[viii] For stroke in all ages the incidence is 204, prevalence 800, and approximate total numbers 300,000. Stroke is covered in the *NSF for Older People.*

[ix] Admissions to hospitals in England 2002/03.

5.3 Specific Conditions

5.3.1 Multiple Sclerosis

In the UK, the prevalence of multiple sclerosis is about 100-150/100,000. Most general practitioners care for two or more affected patients, of whom one or two require significant medical input. The peak incidence is in the third and fourth decades; new diagnoses of multiple sclerosis (MS) are uncommon after the age of 60. In the UK, the incidence of new cases is about 7/100,000 population per year. On average a GP is involved in a positive diagnosis of MS about once every 6 years.

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.

Compared with age-matched controls, 75% of MS patients are alive 35 years after diagnosis.

5.3.2 Cerebral Palsy

The incidence of cerebral palsy is about 2 per 1000 live births. Prevalence of cerebral palsy is best calculated around the school entry age of about six years and the prevalence is about 2.4 out of 1000 children. The ability to live independently varies widely depending on the severity of the disability. Some individuals will require personal assistant services for all activities of daily living. Others can live semi-independently, needing some support for certain activities.

5.3.3 Muscular Dystrophy

There is a group of inherited disorders characterised by progressive degeneration of groups of muscles. Onset is often in childhood, although some patients, especially those with myotonic dystrophy, may present in adults. Physiotherapy and occupational therapy help patients cope with their disability.

5.3.4 Myalgic Encephalomyelitis

Evidence suggests a diagnosed incidence of 0.04% and a population prevalence of 0.2% to 0.4% in the UK. People with severe myalgic encephalitis (ME) should be offered an individually tailored activity management programme as the core therapeutic strategy, which may be delivered at home, or using telephone or e-mail if appropriate and may incorporate the elements of activity management recommendations drawing on the principles of cognitive behavioural therapy and/or graded exercise therapy.

5.3.5 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. The diagnosis should be made by a specialist in Parkinson's disease. Parkinson's disease is estimated to affect 100 – 180 people per 100,000 of the population (or 6 – 11 people per 6000 which is the average GP list size in the UK). Some patients with Parkinson's disease have significant disability and handicap. The predicted number of new cases of parkinsonism and Parkinson's disease per year for the Cambridgeshire registered population can be measured form a Cambridge based study (CamPaIGN study). This is 133 with Parkinsonism (confidence interval 105 to 171) and for Parkinson's disease, 87 (confidence intervals 65 to 118). NICE guidance recommends that people with Parkinson's disease should have regular access to specialist nursing care (or other professional) who provide: clinical monitoring and medication support, a continuing point of contact for support including home visits, when appropriate, and a reliable source of information about clinical and social matters.

5.3.6 Spina Bifida

The features are invariably present at birth. There are symptoms including deformity and sensory loss in the legs. There are many other spinal disorders which interfere with the spinal cord and can occur in later life, often as a result of trauma.

5.3.7 Epilepsy

Epilepsy is defined as the tendency to have recurring, unprovoked seizures. Epilepsy is the most common serious neurological disease. The incidence is about 50/100,000 per year. About 1 in 200 individuals have active epilepsy. The difference between incidence and prevalence is mainly a result of remission of epilepsy. About one half of individuals who develop epilepsy do so before the age of 15 years. Active epilepsy is defined as the occurrence of a seizure during the previous 2 years and/or the taking of anti-epileptic drugs. The lifetime prevalence of a single non-febrile seizure is 2 – 5%. The occurrence of epilepsy is higher in those with learning difficulties.

5.3.8 Huntingdon's Disease

This is an inherited disorder with autosomal dominant transmission, affecting males and females, and usually starting in adult life. Symptoms usually begin in middle adult life with the development of chorea, which gradually worsens.

5.3.9 Alcohol

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.

Table 31: Interpolated National Figures Using CCCRG Mid-2006 Population Estimates, Cambridgeshire

	Age	%	*Source*	CC	EC	Fen	Hun	SC	County
Do not experience Problems	16 and over	90	ONS	87,333	55,100	65,481	115,371	99,651	422,936
Hazardous or harmful	men 16-64	32	ANARP	13,780	7,719	8,834	16,946	14,375	61,653
Hazardous or harmful	women 16-64	15	ANARP	6,029	3,667	4,167	7,876	6,646	28,385
Hazardous or harmful	all 16-64	23	ANARP	19,149	11,171	12,739	24,256	20,522	87,837
Dependent	men 16-64	6	ANARP	2,584	1,447	1,656	3,177	2,695	11,560
Dependent	women 16-64	2	ANARP	804	489	556	1,050	886	3,785
Dependent	all 16-64	3.6	ANARP	2,997	1,749	1,994	3,797	3,212	13,748
Binge drinkers	men 16-64	21	ANARP	9,043	5,066	5,797	11,121	9,433	40,460
Binge drinkers	women 16-64	9	ANARP	3,617	2,200	2,500	4,726	3,987	17,031
Alcohol use disorder	men 16-64	38	ANARP	16,364	9,166	10,490	20,123	17,070	73,213
Alcohol use disorder	women 16-64	16	ANARP	6,431	3,912	4,445	8,401	7,089	30,278
Alcohol use disorder	all 16-64	26	ANARP	21,647	12,628	14,400	27,420	23,199	99,295

Source: Office for National Statistics (ONS), Alcohol Needs Assessment Research Project (ANARP) 2004

5.3.10 Mental Health

Poor quality of life through physical illness is closely related to mental health problems. Limiting long-term illnesses impact upon an individuals ability to work and be economically active, which increases the risk to one's mental health.

6. SERVICE PROVISION

6.1 Provision of Services in Social Care

A range of services is commissioned to support people meeting eligibility criteria with a physical disability or sensory loss:

- Personal Care Support
- Day support
- Respite - Residential
- Nursing Home
- Permanent Nursing Home Placement
- Permanent Residential Placement
- Visual Impairment Rehabilitation
- Supported Living Housing Scheme
- (Local Authority run)

Direct Payments are provided to people meeting eligibility criteria who do not wish to access commissioned services.

Equipment is provided for services users with a visual and/or hearing impairment who meet eligibility, although this is currently not a commissioned service.

Grants to support people with a physical disability or sensory loss are provided to a number of organisations (third sector and health), regardless of eligibility criteria.

- Visual Impairment equipment demonstration and purchase – county wide.
- Hearing support services - City/South/East/Fenland.
- HIV/AIDS community services - county wide.
- Dual Sensory Loss, including transition from children to adult services - county wide.
- Co-ordinator role within Visual Impairment Clinic – Addenbrookes hospital.
- Co-ordinator role to provide hearing loss clinics – City/South/East.

Supporting people funding provides assistance to three Physical Disability housing schemes across the county and community support for people with visual impairment, hearing loss and HIV/AIDS.

6.2 Provision of Services in Health Care

Patients can access universal services in the National Health Service. Many people require physiotherapy, occupational therapy and speech therapy. A cornerstone of the health services' response to the problem of disability is the provision of quality rehabilitation services. The development of the services for the rehabilitation of people with spinal injuries, although a specialist field has done much to stimulate improvements in rehabilitation services generally.

Rehabilitation services have a number of functions. Firstly they must undertake a full assessment of the disabled person, ideally in their own home or other place of residence. This will enable functional capacity to be assessed and the scope for restoration of lost functions and acquisition of new skills to be identified. It will also identify the need for special equipment to be supplied or for adaptation to the person's day to day living environment. Secondly rehabilitation services will set out to establish a clear care plan, agreed with the person concerned and their carers (if any). Thirdly the service will set-in-hand measures and services to deliver the care plan. The circumstances vary greatly. In some cases rehabilitation will begin following an acute hospital admission; for example because of stroke or traumatic injury. In other cases rehabilitation services will be offered to someone who has a long-standing problem; for example, multiple sclerosis, but has never previously had help of this sort.

It is important to recognise that people with disabilities often have long-term care needs which will continue to benefit from rehabilitation services and the notion of rehabilitation as a single course of therapy is increasingly outmoded. This means that rehabilitation services will not be exclusively provided on a hospital site but will be delivered on a community basis. Local rehabilitation teams are multi-professional, using skills such as physiotherapy, occupational and speech therapy in addition to those of medicine and nursing.

Specialist services are also required for the rehabilitation of people with acute traumatic injury of the spinal cord and people who have sustained head injuries.

Many disabled people require specialist medical, surgical and nursing treatment to deal with locomotor and bladder problems. Close liaison is needed.

Specialist services can include the following:

- Disabled Living Centres
- Continence Services
- Stoma Care Services
- Pressure Sore Services
- Counselling Services
- Driving Assessment Services
- Prosthetics and Orthotics
- Wheelchair and Special Seating Services
- Communication Aids
- Technical Aids and Medical Physics Services
- Aid for Sensory Disabilities.

Finally universal primary care and community services are available for all clients. Some may require day care. Also support is needed for carers and families.

6.3 Transition In and Out of Client Groups

Transition to Older People Services

An estimate has been made of the number of people that the PSI services are currently working with and the time period (year and quarter) that these people will become aged 65 and over. These numbers will change as people come in and out of the service, however, at present it appears that around 30 people per year move into the age group at which Older People Services provide support.

Table 32: Number of People Currently Supported by CCC who will become 65 Years and Above and Transfer into Older Peoples Services

Financial year (Quarter)	2008 - 2009	2009 - 2010	2010 - 2011	2011 - 2012
Q1	10	11	8	8
Q2	4	1	12	6
Q3	9	5	4	7
Q4	5	8	5	5
Total	28	25	29	26

6.4 Supporting Carers

There are several initiatives around supporting carers and this is in the Local Area Agreement

6.5 Service Uptake Social Care

The following data are taken from Referrals and Assessment Packages (RAP) returns for 2006/07. Note that this refers to people over and above those receiving direct services as described in Section 4.5.

6.5.1 Assessments

Individuals may require regular reviews or reassessments. During 2006/2007 780 new people aged 16 to 64 years with physical disabilities had completed assessments. The table shows that over 70% of first assessments for new clients are for people with physical disability, frailty and/or temporary illness.

Table 33: Number of Completed Assessments for New Clients by Primary Client Type and Age Group 2006/2007

Client Type	16-64	65-74	75+	All ages
Physical disability, frailty and sensory impairment	780	383	2918	4081
Physical disability, frailty and/or temporary illness	627	252	2373	3252
Hearing/visual impairment or dual sensory loss	56	40	249	345
Mental health	78	51	273	402
Dementia	-	32	194	229
Vulnerable people	10	9	24	43
Learning disability	61	-	-	64
Substance misuse	-	-	-	6
Total	932	446	3218	4596

Note: '-' denotes where there are less than 5 individuals
Source: RAP return 2006/2007

The table shows that 86% of new clients with physical disabilities who have had an assessment have some or all services intended or services have already started. For 11% of new clients with physical disabilities who have had an assessment, no services were offered nor are intended to be provided. The proportion of new clients with physical disabilities who have had an assessment, 2% were offered services but declined or are subject to other sequel to assessment.

Table 34: Number of New Clients for Whom Assessments by Primary Client Type with Known or Anticipated Sequel to Assessment, Age Group 18-64, 01/04/06-31/03/07.

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	673	85	21	-
Physical disability, frailty and/or temporary illness	539	69	18	-
Hearing/visual impairment or dual sensory loss	52	-	-	-
Mental health	43	33	-	-
Dementia	-	-	-	-
Vulnerable people	7	-	-	-
Learning disability	42	15	-	-
Substance misuse	-	-	-	-
Total	768	136	26	2

Note: '-' denotes where there are less than 5 individuals
Source: RAP return 2006/2007

The table shows that the majority, or 96%, of people with physical disabilities are receiving community-based services in their own home. Note that a client may receive services from different service types simultaneously.

Table 35: Number of Clients Receiving Services During Period, Provided or Commissioned by the CSSR, by Primary Client Type, Service Type, Age Group 18-64, 01/04/06-31/03/07.

Client Type	Total of clients	Community-based services in own home	LA Residential Care	Independent sector residential care	Nursing care
Physical disability, frailty and sensory impairment	2025	1936	-	59	55
Physical disability, frailty and/or temporary illness	1377	1295	-	51	52
Hearing/visual impairment or dual sensory loss	273	250	-	9	7
Mental health	937	854	-	69	19
Dementia	19	13	-	3	5
Vulnerable people	58	58	-	-	-
Learning disability	1137	801	5	346	24
Substance misuse	29	25	-	-	-
Total	4186	3674	5	477	99

Note: '-' denotes where there are less than 5 individuals
Source: RAP return 2006/2007

The tables below show the breakdown of community based services by client type, aged years 18-64. Analysis of the breakdown of community based services by client type, aged years 18-64 shows that people with physical disabilities are most likely to receive day care services (10%), home care services (24%) and overnight respite outside their home (4%) and meals (2%). Note that each client may receive services from different service type simultaneously. 266 patients had direct payments, 193 required professional support and 1180 required equipment and adaptations.

Table 36: Number of Clients Receiving Community-Services During Period, Provided or Commissioned by the CSSR, by Components of Service, Primary Client Type, Age Group 18-64, 01/04/06-31/03/07.

Client Type	Total of clients	Home Care	Day Care	Meals	Overnight respite - not clients home
Physical disability, frailty and sensory impairment	1936	459	201	48	77
Physical disability, frailty and/or temporary illness	1295	411	164	18	74
Hearing/visual impairment or dual sensory loss	260	19	14	-	7
Mental health	854	176	643	-	-
Dementia	13	7	-	-	-
Vulnerable people	58	-	-	-	-
Learning disability	801	379	518	-	192
Substance misuse	25	5	6	-	-
Total	3674	1020	1368	52	272

Note: '-' denotes where there are less than 5 individuals
Source: RAP return 2006/2007

Table 37: Number of Clients Receiving Community-Services During Period, Provided or Commissioned by the CSSR, by Components of Service, Primary Client Type, Age Group 18-64, 01/04/06-31/03/07

Client Type	Short term residential not respite	Direct Payments	Professional support	Equipment & adaptations	Other
Physical disability, frailty and sensory impairment	-	266	193	1180	82
Physical disability, frailty and/or temporary illness	-	198	149	719	73
Hearing/visual impairment or dual sensory loss	-	14	34	223	9
Mental health	-	22	42	57	16
Dementia	-	-	-	-	-
Vulnerable people	-	32	-	24	-
Learning disability	9	100	-	62	97
Substance misuse	-	-	8	8	-
Total	9	421	248	1331	197

Note: '-' denotes where there are less than 5 individuals
Source: RAP return 2006/2007

6.5.2 Ethnicity

The table shows the number of people receiving services during 2006/2007 by ethnic group. Vast majority of people with physical disabilities receiving services belong to the white ethnic group or 98%.

Table 38: Number of Clients Receiving Services During the Period, Provided or Commissioned by the CSSR, by Ethnicity, Service Type, Primary Client Type And Age Group

Ethnic Groups	Physical disabiliity, frailty and sensory impairment	Learning Disability	Mental Health	Substance misuse	Vulnerable People
White	1904	1096	852	29	52
Mixed	14	10	-	-	-
Asian or Asian British	21	9	-	-	-
Black or Black British	43	8	10	-	-
Chinese or other ethnic group	10	5	-	-	-
Not stated	33	9	66	-	-

Note: '-' denotes where there are less than 5 individuals
Source: RAP return 2006/2007

6.5.3 Carers

Table 39: Number of Carers Receiving Different Types of Services Provided as an Outcome of an Assessment or Review, by Age Group of Carer, 01/04/06-31/03/07.

Age group of carer	Services including breaks for the carers' specific services	Information and advice only
Under 18	-	-
18-64	524	86
65-74	144	38
75 and over	638	56
Total	1308	180

Note: '-' denotes where there are less than 5 individuals
Source: RAP return 2006/2007

The table tells us that just under 60% of carers in Cambridgeshire are aged 65 or over.

Table 40: Number of Carers for Whom Assessments or Reviews were Completed During the Period, by Client Group and Age Group of Person Cared for by the Carer, 01/04/06-31/03/07.

Client group and age group of person cared for by the care	Number of carers assessed or reviewed separately	Number of carers assessed or reviewed jointly with the carer	Number of carers declining an assessment
Age 18-64			
Physical disability, frailty and sensory impairment	57	14	-
Mental health	-	21	-
Learning disability	109	31	-
Substance misuse	-	-	-
Vulnerable people	52	-	-
Total	222	66	-
Age 65 and over			
Physical disability, frailty and sensory impairment	524	39	10
Mental health	178	10	-
Learning disability	-	-	-
Substance misuse	-	-	-
Vulnerable people	616	-	568
Total	1321	49	579

Note: '-' denotes where there are less than 5 individuals
Source: RAP return 2006/2007

Table 41: Number of Carers Receiving Different Types of Services Provided as an Outcome of an Assessment or Review, by Client Group and Age Group of Person Cared For by the Carer, 01/04/06-31/03/07.

Client group and age group of person cared for by the care	Services including breaks for the carers' specific services	Information and advice only
Age 18-64		
Physical disability, frailty and sensory impairment	59	12
Mental health	-	6
Learning disability	107	31
Substance misuse	-	-
Vulnerable people	-	-
Total	170	51
Age 65 and over		
Physical disability, frailty and sensory impairment	519	33
Mental health	175	13
Learning disability	-	-
Substance misuse	-	-
Vulnerable people	441	83
Total	1138	129

Note: '-' denotes where there are less than 5 individuals
Source: RAP return 2006/2007

7 MORE CHOICE AND CONTROL

7.1 Personalisation

The Government's priority is " to put people first, through a radical reform of public services, enabling people to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual needs for independence, wellbeing and dignity." This wish to have as much choice and control as possible over their lives through advocacy and a person-centered approach is also the wish of people with learning disability and their families.

7.2 Direct Payments

Cambridgeshire already promotes access to Direct Payments enabling individuals to purchase the type of service they need.

7.3 Self Directed Support/Individualised Budgets

In addition to the growth of people using Direct Payments Cambridgeshire is also increasing the numbers of people using individualised budgets. The aim of self directed support or individual budgets is to give recipients of social care and associated services increased opportunities to design a package of services that meets their specific needs. Service users will be given a notional or cash sum of funding to use in developing their care package. This can be provided either as a direct payment or in the form of commissioned services. The principles of choice and control are critical to this policy development.

Individual Budgets can, in the longer term, include a variety of existing service and funding streams including Local Authority provided social care services, Supporting People, Independent Living Fund, Community Equipment Services, Access to Work and Disabled Facilities Grants. Cambridgeshire are currently introducing individual budgets.

7.4 Person Centred Planning

Person Centred planning must remain the key underpinning principle to gaining more choice and control. Whilst some resources have been allocated to enable people to access support to facilitate Person Centred planning the county is still behind some others. Recent initiatives have included:

- Grant funding independent voluntary groups.
- Appointment of PCP review staff to prioritise day service users.
- Appointment of Family Support Co-ordinators to support Individualised budget / self directed support.

7.5 Advocacy

Several advocacy initiatives are in place. The County Council hosts the Partnership Board for Physical and Sensory Impairments. There is national and local debate on User Led Organisations.

7.6 Communication and Information

Several studies have shown how physically disabled people's access to services is sometimes restricted due to a lack of understanding of the health problem itself or because of negative attitudes from the hospital or care staff. Some of the comments drawn from national research are summarised below:

- People with both physical impairment and mental health problems have difficulties accessing mental health services because of physical impairment.
- Inpatients comment that service providers have inaccessible physical environments.
- There is a lack of understanding of people's needs.
- There is no information on the potential effects of medication if several conditions are present.
- Unhelpful attitude of the staff or lack of communication with the staff. This is generally because the staff have limited understanding of the health problem.
- Support often is unrecognised.
- There should be more information on care, benefits and financial support.

Special groups in the population

Research supported by the JRF aimed at studying the needs of physical disabled people in refugee and asylum seekers (RAS) communities in Britain has found that RAS communities experience:

- Unmet personal care needs, unsuitable housing and lack of aids.
- Workers in 'reception assistant' organisations lack of knowledge on disability related entitlements and needs for RAS.
- There is a need for improved joint working between organisations.

7.7 Key Issues

- Housing is a major factor determining physically disabled people's health and wellbeing. It appears 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 deprived housing.
- Hospital and care staff often has negative attitudes towards physically disabled people mainly due to lack of knowledge of their requirements.

8. WELLBEING

In recent national consultations people have voiced their opinions about what matters most to them in the care and services they receive. A number of common themes and key messages have emerged.

People want services that will support them to remain independent and healthy and have increased choice. They want far more services to be delivered safely and effectively in the community or at home; and they want seamless, proactive and integrated services tailored to their needs.

These views have been taken into consideration to draw up high-level outcomes for people with long-term conditions:

- People have improved quality of life, health and wellbeing and are enabled to be more independent.
- People are supported and enabled to self care and have active involvement in decisions about their care and support.
- People have choice and control over their care and support so that services are built around the needs of individuals and carers.
- People can design their care around health and social care services which are integrated, flexible, proactive and responsive to individual needs.
- People are offered health and social care services which are high quality, efficient and sustainable.

8.1 Housing

The Papworth Trust has presented some national data on housing for disabled adults. There are 50 million people in 21 million households in England. Some 19.5 million (18.2%) have a disability. 1.5 million have a disability and need adapted accommodation (3%). 371,000 in need of adapted accommodation live in unsuitable housing (25% of those who need it). 97,000 of wheelchair users are estimated to be in unsuitable accommodation.

The draft Disability Housing Strategy was produced by the Disability Strategic Housing Network in February 2008[3]. 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.

[3] Reference this appropriately

- 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+).

8.2 Employment

The Welfare Reform Agenda has three distinct elements, and a new benefit employment and support allowance which will replace incapacity benefits. The Pathways to Work is the largest recent investment for access to work, and was piloted in 2003. This programme has increased this by 100% since 1997, and represents part of specialist disability services.

The Government has set an aspiration of moving one million people off incapacity benefit, and largely into work by 2015. Currently about 8% of the whole working age is currently on incapacity benefit. The Disability Discrimination Act has a definition of out of work.

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

- To start looking at work opportunities and aspirations with disabled young people at an earlier age (14+) to develop an expectation of work, and identify suitable support and training with a work focus.
- To develop appropriate capacity within Cambridgeshire (across day services, housing and support) to minimise the requirement for people to go out-of county, and to provide the opportunity for people currently out-of-county to return.
- To recognise the importance of continuity in provision and 'case management' in maintaining expectations and progression towards employment.
- To promote the use of a holistic person-centered approach to planning services, which is easily accessible to individuals and parents/carers, covering a wide range of support needs, and to review the roles, capacity and joint working among providers of information, advice and guidance to support this process.
- To ensure training and employment support is based around the vocational interests and aspirations of individuals.
- To clarify the role of social training enterprises and other work-based providers in supporting people to progress into work, and to be more explicit about the role of training activities where these are intended to develop skills for the workplace.
- To look at social firms, co-operatives and other models as a way of people progressing into paid work on a permanent or transitional basis.
- To increase access to job clubs and similar activities as a practical way of supporting people to move towards work.
- For Jobcentres, training providers and colleges to recognise and meet the differing support needs of people with different impairments (eg. people who are deaf or blind).
- To providing ongoing and adequate support to enable people with high support needs to maintain volunteering or paid work in the community.

- To clearly communicate with people about benefits issues and how people can work without being worse off (including in 'micro-jobs' of a few hours a week).
- To develop a transport strategy to minimise the impact of transport and/or location on people's ability to access training and employment opportunities.
- To promote positive attitudes and flexible practices among employers to maximise employment opportunities for disabled people.
- To support all stakeholders within the sector to share good practice, to look at opportunities for joint-working, and minimise unnecessary costs associated with funding and contract management.

8.3 Transport

A review, by the County Council, of passenger transport was completed in January 2008.[4] 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.

A sub-group of the Board has raised some specific issues in relation to transport:

- Satisfaction surveys and consultation exercises need to ensure that there is a focus on the needs of disabled people.
- Disabled people's perspectives need to be taken into account when planning the provision of public transport information, by the County Council and bus operators.
- The Real-Time Passenger Information project needs to ensure that displays are accessible for the visually impaired.
- Operators of public transport need to ensure that they comply with disability discrimination legislation and acknowledge their Disability Equality duty.
- Disabled people need to be fully involved in the forthcoming developments in relation to accessibility action plans prepared by the Local Strategic Partnership Transport and Access Groups in relation to rural transport.
- Those planning the implementation of the national concessionary fares scheme need to be aware of the issues for disabled people, particularly the constraints on travelling to work due to the 9.30 start time.
- There need to be links between road transport and rail services and the needs of disabled people.
- Disabled people need to be involved in the planning and design of the guided bus way including issues like level access and design of ticketing machines.

[4] Reference CCC review of transport

8.4 Overcoming Poverty

There is a strong relationship between physical disability and lower social class. In fact, the 'Social exclusion and the onset of disability' report (November 2003) supported by the JRF found that people in the poorest fifth of the income distribution are two-and-a-half times more likely to become disabled during a year than those in the top fifth. Moreover, disability, either caused by disease or accident, requires a considerable amount of medication and care, which can in turn lead to a sudden drop in the income level of a person. This can in the short term push a person into poverty. Implications of a decrease in the disposable income of a physically disabled person are:

- Rapid accumulation of debts. Physically disabled people accumulate debts to take care of their medical expenses and face housing issues. For those people who are recipients of benefits, it is very likely that most of these benefits are used to repay debts. As a consequence, care expenses are likely to be cut. Moreover, debts deteriorate mental and physical health.
- 84% of people with the least complex impairments retain their employment, while just over half of those with multiple impairments do so.
- Physical disability also affects members of the household. Research has found that amongst single earner couples, one in five leave employment, even if the earner is not the one who has become disabled. This is to take on new caring responsibilities.
- Liquidity constraints also impact on housing and the probability of living in a suitable accommodation.

8.5 Social inclusion

Housing is a major factor determining physically disabled people's health and wellbeing. Many disabled people still live in unsuitable accommodation. Physical disability also affects family members, as they often have to 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 deprived housing.

In September 2000 the day services for physical disability best value review was undertaken. All in-house service users of the Chrysalis and Cambridge Day Support Service were offered interviews. 75% took the opportunity to meet with an independent worker. Some of the results are summarised below :

- Acknowledging peoples need to socialise and get out of the house.
- Understanding the factors that impact satisfaction with day services.
- Informing people about other services.
- Understanding people's own abilities to develop groups and organisations.
- Facilitating people's wish to get out in their own and other communities and utilise mainstream facilities.
- Ensuring those people with personal care needs and declining health continue to be served and supported in what they wish to do.
- People's need for accessible flexible transport.

8.6 Protection of Vulnerable Adults from Abuse

Who is a vulnerable adult?

A vulnerable adult is a person who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to protect him or herself against significant harm or exploitation.

Abuse can happen in many different places:

- Someone's own home.
- A care home.
- A hospital.
- A day service.
- A public place.

Anyone could be an abuser and it is often someone who is known and trusted. It might be:

- A family member or partner.
- A neighbour.
- A health or social care worker.
- Another professional worker, for example a financial advisor or solicitor.
- A friend.
- A service user.

What do you need to do?

Recognise	Abuse comes in many forms and more than one type of abuse may be happening at the same time. The following are some examples of abuse.
Physical Abuse	Being hit or slapped, being given the wrong medication on purpose, being locked in or force-fed.
Psychological Abuse	Being threatened, not being given choices, being bullied or isolated from other people.
Financial Abuse	Having money or property stolen, being pressured into giving people money or changing a will, misuse of benefits, not being allowed access to money.
Neglect	Ignoring medical or physical care needs, withholding food or drink, not allowing access to appropriate health or social services, being left in wet or dirty clothes.
Sexual Abuse	Being touched or kissed when it is not wanted, being made to touch or kiss someone else, being raped, being made to listen to sexual comments or forced to look at sexual acts, or materials.
Discrimination	Ignoring spiritual or religious beliefs, comments or jokes about a person's disability, age, race, sexual orientation, or gender/gender identity, ignoring cultural needs, for example diet or clothing.
Lack of appropriate care / institutional abuse:	Lack of individual care, no flexibility of bedtimes or waking, deprived environment and lack of stimulation.

Concerns regarding a vulnerable adult should be reported to Cambridgeshire Direct.

9. PARTNERSHIP WORKING

Public Consultation

Phase 2 of the Joint Strategic Needs Assessments involves identifying work undertaken on the views of each of the client groups, on health and wellbeing to add to the information. We are collating public/local community views – particularly broad quality of life surveys, along with service user views and the needs of particular groups.

There are several useful websites including the Scottish Partnerships for Access to Health (PATH) project. Improving access to services for those with multiple and complex needs. http://www.pathproject.scot.nhs.uk

Key reviews have also been undertaken such as the review by the Leonard Cheshire Disability, 2008 on Disability Poverty in the UK.

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11. GLOSSARY

Self care
Self care and self management are more than giving people information about their condition. They are about acknowledging their central role in managing their own care and supporting them and their family and carers to manage their condition as effectively as possible. Self care is a well proven and highly effective means of improving Long-Term Condition care.

Disease management
Proactive disease management can make a real difference to people with a single condition or a range of problems that impact on their health and wellbeing. Implementation of the National Service Frameworks is already demonstrating that this approach can have a radical impact on outcomes for individuals. Good disease management involves identifying needs early and responding promptly with the right care and support. Personalised care planning actively supports this approach.

Case management
Some people have an intricate mix of health and social care needs and simple problems can cause their condition to deteriorate rapidly, putting them at risk of unplanned hospital admission. Evidence has shown that intensive, ongoing, personalised case management can improve quality of life and outcomes for such people. Case management, led by a community matron or a case manager, has been rolled out as part of the Long-Term Conditions strategy. PCTs have been encouraged to undertake local evaluation of this service.

Multidisciplinary teams
People with Long-Term Conditions, in particular those with a range of complex needs, often require care or support from a range of different professionals and agencies. Bringing these together into multidisciplinary teams is therefore critical as it underpins a co-ordinated, seamless approach to delivery of care and support, avoiding fragmentation, confusion and duplication of effort.

Self directed care
Individual budgets and direct payments can improve people's lives, giving them more choice and control over services. They can also give people more purchasing power by bringing different sources of funding and support together in one place. There are currently individual budget pilots in 13 local authorities.

12. APPENDICES

12.1 Appendix 1

Appendix 1 gives general demographic information for people of all ages. Population estimates and forecasts and a breakdown by ethnicity.

12.2 Demographic Trends, Cambridgeshire

Table 42: Population Estimates, Mid 2006, Local Authority

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	5,610	10,070	27,220	20,900	14,670	11,710	9,720	6,560	5,120	2,110	113,700
East Cambridgeshire	4,860	9,180	8,350	8,570	12,540	10,210	9,860	6,560	4,580	1,520	76,200
Fenland	4,700	11,370	9,780	10,530	13,040	11,620	11,480	9,070	6,370	1,930	89,900
Huntingdonshire	9,180	21,260	18,450	18,610	26,860	22,890	20,840	12,550	7,500	2,680	160,800
South Cambridgeshire	8,190	17,410	15,230	15,680	22,520	19,390	18,120	11,140	7,460	2,900	138,000
Cambridgeshire	32,540	69,300	79,020	74,290	89,620	75,810	70,020	45,880	31,020	11,130	578,600

Source: Cambridgeshire County Council Research Group. Totals may not add due to rounding.

The table above shows population estimates for 2006 by Local Authority in Cambridgeshire.

Table 43: Population Forecasts 2006 – 2021, All Ages, Local Authority

Year	2006	2011	2016	2021	% change 2006-2021	Absolute change 2006-2021
Cambridge	113,800	131,700	147,700	149,400	31.3%	+35,600
East Cambridgeshire	76,400	80,700	82,200	81,300	6.4%	+4,900
Fenland	89,800	91,700	95,400	99,700	11.0%	+9,900
Huntingdonshire	160,800	168,200	166,000	166,300	3.4%	+5,500
South Cambridgeshire	138,200	150,400	162,000	172,700	25.0%	+34,500
Cambridgeshire	579,000	622,700	653,300	669,400	15.6%	+90,400

Source: Cambridgeshire County Council Research Group 2005-based ward age-group forecasts. Rounded to the nearest hundred. Totals may not add due to rounding

The population forecasts for the county show an overall increase from 2006 to 2021 of about 16%, with significantly higher increases in Cambridge City and South Cambridgeshire.

12.3 Ethnicity

Table 44: Ethnicity, 2001, Local Authority

Percentage	England and Wales	Cambridge	East Cambridge-shire	Fenland	Huntingdon-shire	South Cambridge-shire
White	90.9	89.4	97.9	98.6	97.2	97.1
Mixed	1.3	2.0	0.7	0.6	0.9	0.9
Asian or Asian British	4.6	3.8	0.5	0.4	0.9	0.9
Indian	2.1	1.8	0.3	0.2	0.4	0.5
Pakistani	1.4	0.5	0.1	0.0	0.4	0.1
Bangladeshi	0.6	0.9	0.1	0.1	0.1	0.1
Other Asian	0.5	0.6	0.1	0.1	0.1	0.2
Black or Black British	2.1	1.3	0.3	0.2	0.5	0.4
Caribbean	1.1	0.5	0.1	0.1	0.2	0.2
African	1.0	0.7	0.1	0.1	0.1	0.2
Other Black	0.2	0.1	0.1	0.0	0.2	0.1
Chinese or Other Ethnic Group	0.9	3.5	0.7	0.3	0.5	0.8

Source: Census 2001 © Crown Copyright 2003 - Table KS06

The table above gives the ethnic composition in different districts of Cambridgeshire. Cambridge City has the highest proportion of people from a non-white ethnic group. The other districts have a significantly lower proportion of non-white ethnic group as compared with England and Wales.

Table 45: Ethnicity, Cambridgeshire 2001 And 2004. Persons, All Ages

	Number of people		% of population	
	2001	2004	2001	2004
White	531,600	544,500	95.8%	94.1%
White: British	504,100	511,100	90.9%	88.3%
White: Irish	4,900	5,300	0.9%	0.9%
White: Other White	22,600	28,100	4.1%	4.9%
Mixed	5,900	7,500	1.1%	1.3%
Asian or Asian British	7,700	11,400	1.4%	2.0%
Indian	3,700	5,600	0.7%	1.0%
Pakistani	1,400	2,300	0.3%	0.4%
Bangladeshi	1,400	1,700	0.3%	0.3%
Other Asian	1,200	1,800	0.2%	0.3%
Black or Black British	3,400	6,100	0.6%	1.1%
Black Caribbean	1,300	2,200	0.2%	0.4%
Black African	1,400	3,000	0.3%	0.5%
Other Black	700	900	0.1%	0.2%
Chinese or Other Ethnic group	6,400	9,500	1.2%	1.6%
Total	554,700	578,900	100.0%	100.0%

Source: ONS Census 2001 © Crown Copyright 2003 - Table KS06 and ONS Experimental Statistics (2006)

Table 46: Ethnic Population, Estimates for 2004 by District. People of Working Age (Men Aged 16 – 64 and Women Aged 16 – 59 Years)

	Cambs	Cambridge City	East Cambs	Fenland	Hunts	South Cambs
White	336,100	68,500	43,900	48,200	96,200	79,300
White: British	315,400	58,700	41,600	47,200	92,200	75,600
White: Irish	3,500	1,300	400	300	800	800
White: Other White	17,200	8,500	1,900	700	3,200	2,900
Mixed	3,000	1,300	300	300	700	600
Asian or Asian British	5,500	3,200	200	100	1,000	800
Indian	2,900	1,700	200	100	500	500
Pakistani	900	400	-	-	300	100
Bangladeshi	800	600	-	-	100	-
Other Asian	900	500	-	-	100	200
Black or Black British	2,600	1,200	200	100	700	500
Black Caribbean	1,000	400	100	100	300	200
Black African	1,100	700	-	-	200	200
Other Black	500	100	100	-	200	100
Chinese or Other Ethnic group	5,200	3,300	400	200	500	800
Total	352,400	77,500	45,000	48,900	99,100	82,000

Source: ONS Experimental Statistics (2006)

The tables show the number of people by ethnic group for 2001 and 2004 (Cambridgeshire) using information from the 2001 Census and 'experimental' statistics for 2004 produced by ONS. The estimated number of people is shown and the percentage of the total population. The latter table shows the experimental estimates for 2004 by Local Authority for people of working age.