



Cambridgeshire
County Council



Cambridgeshire

Cambridgeshire Joint Strategic Needs Assessment

Prevention of Ill Health in Adults of Working Age

2011

**FINAL v1
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The compilation of this report has taken several months. Data and organisations, such as clinical and local commissioning groups, may have been updated or changed composition. The JSNA website will be updated with revised data in due course.

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1. EXECUTIVE SUMMARY

1.1 Introduction

The Joint Strategic Needs Assessment (JSNA) Prevention of Ill Health in Adults of Working Age is based on a model where health is determined by a wide range of factors. These include the wider determinants of health such as the socio-economic factors, the health behaviours that individuals adopt and protective actions such as screening.

The JSNA includes information about a wide range of health and wellbeing indicators, the views of the local people and gives examples of good practice, along with identifying gaps and areas for development. It also includes some of the substantial evidence that indicates that prevention works, that it can provide cost benefits and importantly that it can make significant improvements to the health of the population, decrease health inequalities and effectively address health and social problems.

The development and production of the JSNA has been overseen by a very active and committed Steering Group with membership from a wide range of organisations. For the first time a bespoke community consultation process was developed and implemented for this JSNA. This involved the use of social media, an online survey and focus groups. A Stakeholder Event that was well attended by representatives from the statutory and voluntary sectors reviewed the JSNA and highlighted key issues and prevention priorities.

1.2 What Do We Know

The Wider Determinants of Health

- There is a clear negative downward trend across the socio-economic determinants of health. Although Cambridgeshire as a whole is relatively affluent, the patterns of inequality are mostly unchanged or worsened in some cases from previous years.
- Fenland and other areas in Huntingdonshire and Cambridge City continue to have higher levels of socio-economic deprivation than the rest of the county. There has been an increase however in all districts in the number unemployed between 2007 and 2010, though only Fenland was close to the national figure. Between August 2008 and 2010 the percentage of the population receiving benefits increased across all the districts with the highest proportion being in Fenland. In 2005-2009, the highest median household income was in South Cambridgeshire and the lowest was in Fenland.
- Nationally and locally demand for both affordable and market housing significantly outstrips supply. More detailed information is provided in the Strategic Housing Market Assessment (SHMA) (www.cambridgeshirehorizons.co.uk/shma). Private housing is particularly expensive in Cambridge City both to purchase and to rent. This has resulted in an increasing affordability gap between incomes and rents and house prices. In the past eight years, some 5,910 new affordable homes have been built across Cambridgeshire but the housing needs register for social rented properties has increased by around 10,000. There is widespread concern about planned changes and the effects of the Local Housing Allowance (LHA). These include unaffordable rents, leading to overcrowding, evictions and possible homelessness. The Supporting People Service helped around 2,000 people of working age in 2009/10 but there is inequity of provision.
- It was estimated that in 2008 there were 11.5% fuel poor households in Cambridgeshire compared to 6% in 2003. In addition there are Lower Super Output Areas where the proportion of the fuel poor households is above 20%. Most of those areas are in Fenland and East Cambridgeshire.

- Data from Cambridgeshire Citizens Advice Bureau has shown a steady and large increase in demand for advice on debt arrears especially in relation to fuel poverty, mortgage arrears and credit cards.
- Although there has been a reduction in deaths between 1998 and 2010 all the Cambridgeshire districts with the exception of Cambridge City have significantly higher death rates than England for road injuries and deaths. The greatest number of road traffic casualties occurs in the working age population with 17 to 25 year olds having the highest casualty rate per head of population. The highest mortality rate was in Fenland followed by Huntingdonshire. The evidence for prevention measures is strongest for environmental changes, such as area-wide traffic calming measures like speed bumps and cameras.
- Cambridgeshire has a number of Air Quality Management Areas (AQMAs). Areas of concern include the housing growth in the south of the county adjacent to existing AQMAs and the proximity of industrial pollutants to more deprived communities.
- Cambridgeshire is predominantly a rural county and access to all services is limited in many areas are especially in more deprived areas where car ownership is more limited. The full JSNA contains links to detailed maps that demonstrate the patterns and inequalities that are present in Cambridgeshire.
- In March 2011, 4.8% of 16-18 olds were Not in Education or Training (NEET). Localities with the highest proportion of people in the NEET group were in Wisbech (7.8%), Cambridge North (6.7%) and Cambridge South (6.5%). In 2009/10, more than 6,500 people (25-64 age group) were attending courses in Adult Learning in Cambridgeshire with an average 1.8% of people in the 19 - 64 age group. This was less than in the previous years. The proportion was smallest in Cambridge City and Fenland. Concerns for the future are the need to increase apprenticeship starts, the decline in other funded employee qualification routes, a lack of skilled workers and workers with sufficient employability skills.
- There is limited local data on employee health, occupational health services and prevention activities or opportunities in Cambridgeshire's workplaces. The available information gives an insight into the marked differences in reported workplace injury rates by district council area with higher rates in East Cambridgeshire and Fenland.

Lifestyles

- Surveys indicate that participation in physical activity decreases with age and that there has been an overall downward trend in participation rates with the exception of Huntingdonshire and South Cambridgeshire. Fenland has the lowest levels of participation in sport but scores highly on physical activity which is attributed to a high number of people in manual occupations. Participation in all groups is relatively low in Fenland and is generally lowest in the more deprived areas in each district, with the exception of East Cambridgeshire.
- Nationally the prevalence of obesity among adults has increased sharply in recent years. The estimated levels of obesity in Cambridgeshire (22.1%) are significantly lower than in England (24.2%). Fenland, with estimated obesity at 25.8%, is significantly higher than the county level (22.1%) but is not in comparison to the national levels (24.2%).
- Key factors for prevention of obesity are a healthy diet and physical activity. In Cambridgeshire 67.4% of the population is eating less than the recommended portions of fruit and vegetables a day.

- Tobacco use remains the leading cause of preventable morbidity and mortality worldwide. In Cambridgeshire nearly 20% of adults smoke. Although Cambridgeshire has relatively low smoking prevalence in comparison to national and regional figures this masks the range in smoking rates within Cambridgeshire. In Fenland the prevalence is 26.7% compared to the national figure of 21%. There are smaller areas that have rates higher than the national figure. Smoking prevalence is higher in more deprived populations and amongst the routine and manual group of workers.
- Overall the rate of Sexually Transmitted Infections (STIs) in Cambridgeshire has remained consistent between 2008 and 2010 with 575.5 cases per 100,000 in 2008 compared to 572.6 cases per 100,000 in 2010. There is a higher prevalence in the 15-24 age group. The number of people living with HIV in Cambridgeshire has increased since 2004 reflecting, to a large degree, better treatment methods. 28% of HIV-infected residents live in the most deprived 20% of areas (quintile) in Cambridgeshire. Over half are in the two most deprived quintiles. A third of HIV infected residents live in Cambridge City, with relatively high numbers also in Huntingdonshire (27%) and South Cambridgeshire (19%). Nationally there is also a concern with a high level of late HIV diagnoses which compromises treatment and potentially could increase the spread of the disease.
- The Cambridgeshire teenage conception rate has been consistently and significantly lower than the national and East of England rate with an overall downward trend over the past ten years. The rates vary across the county with Fenland having the highest rate and East Cambridgeshire the lowest in 2007-2009. Within districts there is variation in teenage conception rates.
- Cambridgeshire generally compares well to the national statistics on alcohol misuse but there are some concerns that are related to particular indicators and geographical areas where Cambridgeshire compares poorly to national figures. These include alcohol specific hospital admissions, alcohol-related harm, violent crime and binge drinking in Cambridge City.
- Although there are primary prevention interventions for drug misuse, most of these target young people and not those of working age. Prevention for the working age population is mostly secondary and occurs when individuals access the treatment service. Key issues for Cambridgeshire are that approximately one-third of the drug using population does not access any services.
- In 2004-06, 13% of the England population had a possible psychiatric disorder. The percentage was higher in Cambridgeshire (15%) but not significantly so. High suicide rates are found in Cambridge City and Fenland and in the homeless in Cambridge City. Current service provision is more focused on treating existing mental illness and further opportunities exist to invest in preventive interventions in a range of settings. Refer to the *Mental Health JSNA* www.cambridgeshirejsna.org.uk/mental-health-adults-working-age
- Local information about dental and oral health is routinely collected only at a regional level. The most recent adult data indicate that oral health is improving in adults of working age, particularly among the younger age group up to 45 years. However for those who do have decay or gum problems, disease can be very extensive and for many people in older middle age, dental needs can be very complex. The vulnerable and socio-economically disadvantaged groups are more likely to be at risk of poor dental and oral health. Adults who smoke, take drugs, binge drink or who are obese are more likely to suffer from gum disease and mouth cancer.

Other Areas of Prevention

- The screening programmes that are mostly accessed through general practices are well established and generally meet the targets to ensure that the population as whole is protected. However there is some inequity of service provision across the county and there is insufficient information about screening in vulnerable and hard to reach groups.
- Nationally there are estimated to be 15 million people living with one or more long term condition (LTC) with prevalence and severity being greater amongst the more deprived population. This will increase as the proportion of older people in the population becomes greater. Analysis at Local Commissioning Group (LCG) level in Cambridgeshire of five of the main LTCs indicates that there is higher prevalence in LCGs where there is known deprivation. Improving the health of those suffering from a long term condition can help stabilise conditions, reduce the need for health and social care and enhance the quality of life. There is a gap in secondary prevention services that could be incorporated into the long term condition pathways. The importance of secondary prevention is also considered for 14,000 estimated visually impaired people in Cambridgeshire.
- There has been a substantial increase in Domestic Violence in recent years. In the period 2005 – 2009, the number of incidents reported to the police has risen by more than 41.9%; subsequently the number of victims accessing services has risen dramatically. For example, the Independent Domestic Violence Advocacy Service received 324 high-risk referrals from the Constabulary in 2005. In 2008/09 that figure was 1536 (an increase of 377%). There is a higher level of domestic abuse in Fenland, amongst women from A8 (Central And Eastern European countries, Gypsy/Traveller/Roma and other Black Minority Ethnic communities), teenage mothers, Looked after Children (LAC) and children subject to a Child Protection Plan. Key issues include under reporting, a lack of services to support victims and prevent further incidences and involvement from a wider range of services.
- There were 740 sexual offences recorded in Cambridgeshire during 2008-2009 with 755 recorded sexual offences in Cambridgeshire in 2009-2010, representing a 2% increase year on year. The Cambridgeshire and Peterborough Sexual Assault Referral Centre opened in 2010 provided services to 330 people in its first year, of which 112 clients were from Cambridgeshire. This new service is anticipated to identify unmet demand through increased reporting.

Key Findings from the Community Consultation

In the survey responses and focus groups, it was clear prevention is valued and that there was support for prevention activities. There was an understanding that health is a complex concept that is a consequence of the inter-relationship between the wider determinants of health, lifestyle choice and the support that is available through different services.

Improving lifestyle was seen as a challenge that demanded individuals taking responsibility for their health but that it would not be achieved without supportive services. However, the most common theme was how the current economic climate is perceived as affecting people's health. Job loss, economic hardship, lack of housing and loss of motivation were seen as having a negative effect upon health.

There was an acknowledgement that there are prevention services that can be accessed across the county. However there are gaps in these services that to a large degree reflect personal financial constraints and service cuts creating an inability to meet demand. In terms of lifestyle services the gaps were mostly in terms of mental health and workplace schemes. General practice was found to be inaccessible to some groups and not fully effective at implementing prevention services. The services that target socio-economic issues were seen to be experiencing stress in the current financial climate. For example the Citizens Advice Bureau is not able to meet demand.

Overall there was shared expectation that the NHS and government had a responsibility to work with individuals and communities on the prevention agenda.

1.3 What is this Telling us?

The persistent theme in the JSNA is that the current economic climate has created conditions that are well evidenced as having a negative effect upon health. Raised unemployment, increased demand for benefits, lower incomes and increased debt have all increased in Cambridgeshire in recent years. There is a particular concern with the availability and affordability of housing, which is accompanied by increasing levels of fuel poverty. In Cambridgeshire there are long standing areas of deprivation amongst vulnerable groups. Poorer health is experienced in these areas and these areas are where the impact of the negative socio-economic factors is greatest.

Alongside the wider determinants of health are the lifestyles that affect health, such as levels of physical activity, smoking, healthy diet and alcohol consumption. These are reflected in such outcome measures of lifestyle as levels of obesity and indicators of mental health and wellbeing. There is a well evidenced inter-relationship between lifestyle and deprivation and this association can be found in many of the lifestyle indicators Cambridgeshire.

The JSNA also looks at the impact of programmes that protect the population from ill health, primary and secondary prevention of key long term conditions and domestic violence. The common factor is inequity in prevalence or service provision and the lack of client/patient pathways between organisations that would facilitate prevention interventions. The JSNA includes a brief summary of the prevention needs that have been identified in previous JSNA work in Cambridgeshire. The consistent factor common to these groups is inequalities in health. These reflect a wide inter-related range of issues that directly affect health and the complexity of prevention needs. Refer to www.cambridgeshirejsna.org.uk for relevant JSNAs for vulnerable groups

1.4 Taking Forward Prevention in Cambridgeshire

Each of the JSNA topics includes areas for development that have been identified through the data, local views, the Steering Group and at the Stakeholder Event. In addition, the following overall prevention priorities were identified from the JSNA.

- Socio-economic factors especially housing
- Lifestyle Issues
- Workplace Health
- Long-term Conditions
- Domestic Violence

The Steering Group expressed a wish to continue to work together to address prevention across Cambridgeshire and to facilitate further partnership working. It was thought that the lessons learnt from the JSNA could inform the overall further development of the prevention agenda. These include adopting a life-course approach to prevention, as so many of the determinants cut across age groups and settings. This includes expanding the analysis of the effect of the physical environment and social cohesion on health. Analysis of current services or assets that support prevention would provide a fuller understanding of needs. Comprehensive or robust data are not available but are necessary for a fuller understanding of the needs of workplaces and those related to dental and oral health.

2. INTRODUCTION

2.1 Context

Preventive intervention is key to improving the overall health of the population, and decreasing health inequalities.

Preventive intervention to improve public health has a long history that is not always recognised and acknowledged. It was not until the late 1940s that Hugh Leavell and E Gurney Clark from Harvard and Columbia University Schools of Public Health coined the phrase prevention using the terms primary, secondary and tertiary. The concept of working upstream to identify and prevent the root cause of illness emerged in the 1970s and 80s.

The publication of the *Wanless Reports* in 2002 and 2004 provided the backdrop for the Public Health White Paper *Choosing Health*. *Choosing Health* provided the impetus and support for organisations to shift their efforts more towards prevention and improving health. The focus on prevention has been maintained and is stated as a rationale found initially in the *Equity and Excellence, Liberating the NHS* White Paper (July 2010) and consolidated in the Health and Social Care Act 2011. These provide the legislative framework for the transfer of Public Health to local authorities with a ring fenced budget that would support a greater focus upon prevention and improving health. This policy was further expanded in the Public Health White Paper, *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (November 2010). It expresses a commitment to the principles found in *The Marmot Review Report (2010)* for tackling the wider determinants of health and enabling people to acquire the attributes and resilience to prevent ill health.

Social care policy found in *Putting People First* and the *Transforming Adults Social Care* firmly embedded prevention into ongoing reform and development of social services. It has resulted in a shift within adult social care towards delivering services that focus on prevention, health and wellbeing promotion and enabling or re-enabling people as part of maintaining and retaining their independence.

What is Health?

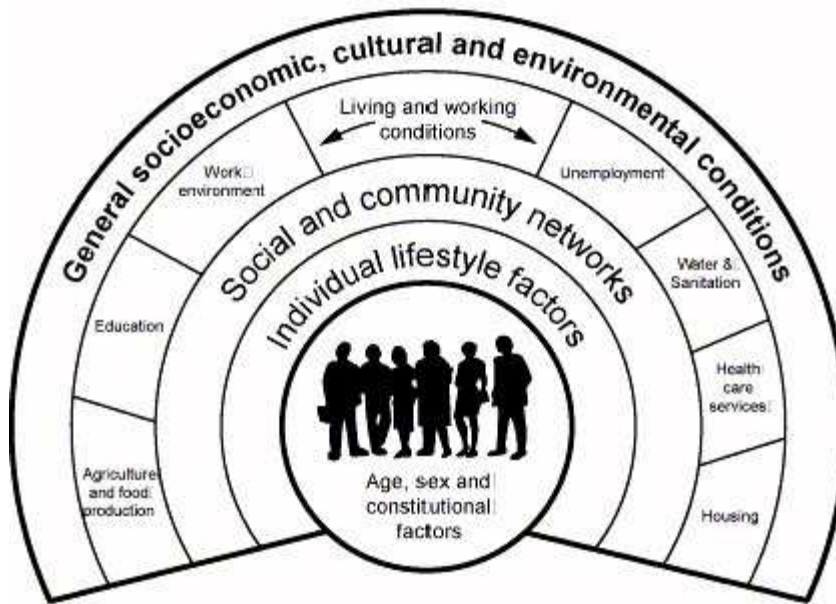
The concept of health is complex. The World Health Organisation (WHO) in 1984 described the key aspects of health as:

“a conception of ‘health’ as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and; on the other hand to change or cope with the environment. Health is, therefore, seen as resource for everyday living life not the objective of living; it is a positive concept emphasising social and personal resources as well as physical capacities”.¹

This definition of health captures the concept that health is more than individual health behaviours and environmental factors determine the health of the population. They are complex and inter-related with the health behaviours adopted by the population. The concept is captured in the following famous Dahlgren and Whitehead *Model of Health*.

¹ Health Promotion: a WHO discussion Document on the Concepts and Principles, World Health Organisation, 1984

Figure 1: Model of Health



Source: Dahlgren and Whitehead 1991.

What is Prevention?

Prevention is reducing the risk of disease, premature death, illness or disability or any other undesirable health event. It is categorised traditionally into three groups and it reflects a socio-economic model of health.

- Primary prevention seeks to actually prevent the onset of a disease. The ultimate goal being to alter some factor in the environment, to bring about a change in the status of a person, or to change behaviour so that disease is prevented from developing.
- Secondary prevention aims to halt the progression of disease once it is established. Early detection or early diagnosis followed by prompt effective treatment is critical.
- Tertiary prevention is concerned with the rehabilitation of people with an established disease to minimise residual disabilities and complications. It is aimed at improving the quality of life, even if the disease itself cannot be cured.

2.2 Data Sources

A wide range of data are used in this assessment from local and national sources. Users of the assessment are encouraged to read explanatory notes under tables and graphs. The notes refer to original sources of data where detailed information about the methodology used is available.

The section on demography uses local population estimates and forecasts by the Cambridgeshire County Council Research and Performance Team. Data users are strongly encouraged to read the "Introduction and notes" accompanying the data at <http://www.cambridgeshire.gov.uk/business/research/populationresearch/population/population/Researchgrouppopulationestimates.htm>

The section about wider determinants of health uses data from *The English Indices of Deprivation 2010*. A detailed report explaining results and the methodology used to combine the indicators is available from the Department of Communities and Local Government website at

<http://www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10/>

The wider determinants of health section quotes data from *NOMIS - Official Labour Market Statistics: unemployment, jobseeker's allowance claimants and key benefits claimants*. Detailed information about the data is available from the original source at

<https://www.nomisweb.co.uk/>

The section about lifestyles uses modelled estimates ('synthetic estimates') of healthy lifestyle behaviours. Modelled estimates have certain advantages but also limitations. Data users are therefore encouraged to read *Healthy Lifestyle Behaviours: Model Based Estimates for Middle Layer Super Output Areas (MSOAs) in England, 2006-2008*.

Methodology available at <http://www.apho.org.uk/resource/item.aspx?RID=96790>

2.3 Morbidity and Mortality

2.3.1 Introduction

This JSNA focuses upon prevention in the working age population. As an introduction this section provides an overview of the health of this population group. It presents data which include prevalence data, hospital admission data and mortality data. The analysis is presented, where possible, at county, local commissioning group (LCG) and local authority levels.

The second part describes the patterns of morbidity and mortality between the least and most deprived population groups and the changes that have occurred over time.

2.3.2 Prevalence by Local Commissioning Group (LCG)

The table below shows the recorded prevalence of diseases by LCG for 2009/10. It is important to note that these data relate to the whole population, in most cases, and do not cover solely the working age population. However, they have been presented to give an indication of the scale of these diseases in the population.

Table 1: Recorded Prevalence of Diseases, Local Commissioning Groups, 2009/10

Clinical Area	CATCH							
	Cambridge City	Cam Health	City	Granta	Herts	North Villages	South Villages	Total
Coronary Heart Disease	1.6%	2.7%	3.1%	1.7%	2.8%	2.7%	3.2%	2.5%
Cardiovascular Disease - Primary Prevention	0.3%	0.5%	0.6%	0.8%	0.6%	0.3%	1.0%	0.6%
Heart Failure	0.3%	0.8%	0.6%	0.4%	0.6%	0.5%	0.7%	0.6%
Heart Failure due to LVD	0.2%	0.5%	0.3%	0.2%	0.4%	0.3%	0.4%	0.3%
Stroke or Transient Ischaemic Attacks (TIA)	0.9%	1.5%	1.6%	0.9%	1.4%	1.3%	1.5%	1.3%
Hypertension	7.2%	11.7%	12.2%	7.3%	12.8%	11.9%	13.3%	10.6%
Diabetes Mellitus (Diabetes) (ages 17+)	2.3%	4.3%	4.3%	2.9%	4.3%	4.0%	4.5%	3.7%
Chronic Obstructive Pulmonary Disease	0.7%	1.3%	1.1%	1.0%	1.2%	1.2%	1.1%	1.1%
Epilepsy (ages 18+)	0.4%	0.7%	0.7%	0.6%	0.6%	0.7%	0.7%	0.6%
Hypothyroidism	1.9%	2.7%	3.2%	1.8%	3.4%	3.2%	3.4%	2.7%
Cancer	1.0%	1.4%	2.0%	1.2%	1.7%	1.7%	1.8%	1.5%
Palliative Care	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%	0.1%	0.1%
Mental Health	1.0%	1.0%	0.9%	1.2%	0.4%	0.6%	0.5%	0.8%
Asthma	4.9%	6.5%	6.0%	6.1%	7.3%	6.3%	7.1%	6.2%
Dementia	0.3%	0.7%	0.5%	0.2%	0.3%	0.3%	0.4%	0.4%
Depression (ages 18+)	8.8%	11.4%	9.5%	11.7%	13.1%	6.8%	9.1%	10.1%
Chronic Kidney Disease (ages 18+)	1.5%	3.3%	2.9%	2.5%	2.2%	2.2%	2.7%	2.5%
Atrial Fibrillation	0.9%	1.5%	1.7%	0.8%	1.3%	1.3%	1.6%	1.3%
Obesity (ages 16+)	4.5%	8.9%	6.0%	6.9%	10.1%	9.2%	6.7%	7.1%
Learning Disabilities (ages 18+)	0.3%	0.4%	0.3%	0.2%	0.2%	0.3%	0.3%	0.3%

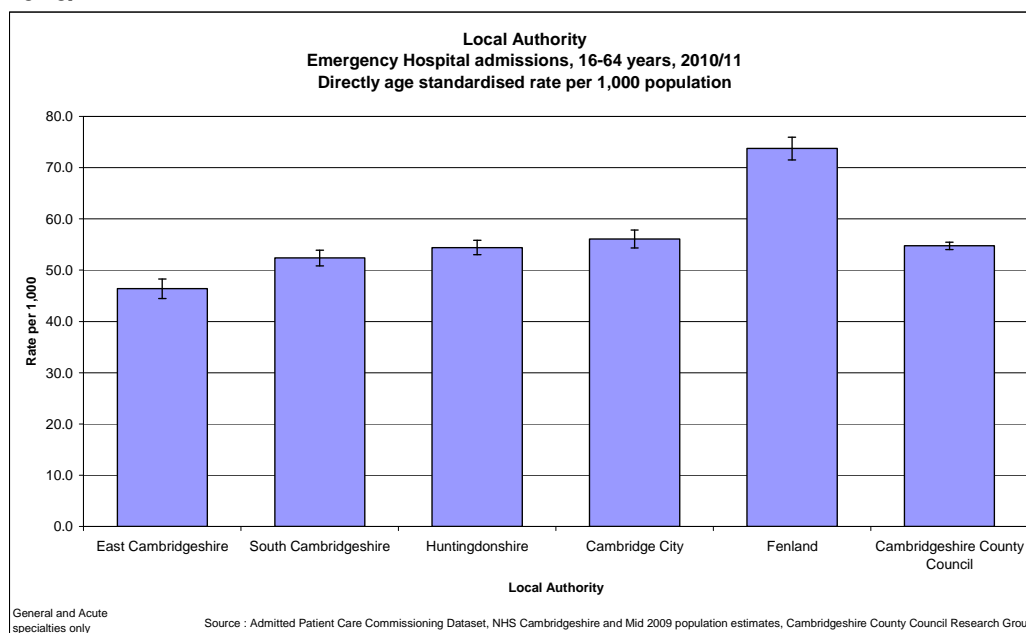
Clinical Area	Borderline	Hunts Care Partners	Hunts Health	Isle of Ely	Wisbech	Practices not in a cluster (as at 26 May 2011)	NHS Cambridgeshire
Coronary Heart Disease	3.2%	3.4%	3.2%	3.4%	4.1%	4.2%	3.1%
Cardiovascular Disease - Primary Prevention	0.6%	1.0%	0.9%	0.5%	1.0%	0.3%	0.7%
Heart Failure	0.8%	0.7%	0.7%	0.7%	1.0%	0.9%	0.7%
Heart Failure due to LVD	0.5%	0.4%	0.4%	0.4%	0.3%	0.4%	0.4%
Stroke or Transient Ischaemic Attacks (TIA)	1.6%	1.5%	1.6%	1.5%	2.0%	2.1%	1.5%
Hypertension	14.7%	13.6%	14.3%	12.8%	15.2%	17.1%	12.8%
Diabetes Mellitus (Diabetes) (ages 17+)	5.5%	5.4%	5.2%	5.7%	6.6%	6.6%	4.9%
Chronic Obstructive Pulmonary Disease	1.6%	1.4%	1.5%	1.5%	2.2%	2.0%	1.4%
Epilepsy (ages 18+)	0.8%	0.7%	0.8%	0.8%	0.9%	0.8%	0.7%
Hypothyroidism	3.2%	3.4%	3.3%	3.5%	3.2%	4.1%	3.1%
Cancer	1.5%	1.6%	1.6%	1.8%	1.8%	1.7%	1.6%
Palliative Care	0.2%	0.1%	0.2%	0.2%	0.1%	0.2%	0.1%
Mental Health	0.6%	0.6%	0.6%	0.5%	0.5%	1.0%	0.7%
Asthma	6.3%	7.2%	6.8%	6.9%	6.2%	8.7%	6.6%
Dementia	0.4%	0.4%	0.5%	0.4%	0.5%	0.5%	0.4%
Depression (ages 18+)	13.4%	13.0%	15.8%	13.4%	16.8%	15.1%	12.5%
Chronic Kidney Disease (ages 18+)	4.4%	4.5%	4.4%	4.5%	3.4%	4.9%	3.6%
Atrial Fibrillation	1.3%	1.6%	1.5%	1.5%	1.6%	1.9%	1.4%
Obesity (ages 16+)	10.7%	9.8%	11.3%	12.2%	12.2%	10.9%	9.5%
Learning Disabilities (ages 18+)	0.3%	0.4%	0.5%	0.3%	0.3%	0.6%	0.4%

Source: QOF 2009/2010, The Information Centre for Health and Social Care.

Emergency Admissions in People Aged Between 16 and 64 Years of Age

- In 2010/11 there were around 22,000 emergency hospital admissions in people aged between 16 and 64 years in Cambridgeshire. Fenland has an emergency hospital admission rate that is statistically significantly higher than Cambridgeshire, whilst East Cambridgeshire and South Cambridgeshire have statistically significantly low rates.

Figure 2: Emergency Hospital Admission Rates, 16-64 Years, Local Authority, 2010/11



Top 10 Main Reasons for an Emergency Admission by Age Band, 16 – 64 Years of Age

- The tables below show the top ten main reasons for an emergency admission by age band. These account for around 90% of all emergency admissions in each age band. As can be seen the reason for admissions change as age increases.

Table 2: Top Ten Emergency Hospital Admissions, 16-24 Years, 2010/11, Cambridgeshire

Main reason for admission	Number	% of total
Injury & poisoning	937	27.6%
Other Symptoms and signs	725	21.3%
Diseases of digestive system	384	11.3%
Genito-urinary	225	6.6%
Respiratory disease	222	6.5%
Pregnancy & childbirth	198	5.8%
Infectious & parasitic diseases	131	3.9%
Musculoskeletal	96	2.8%
Endocrine, nutritional & metabolic	95	2.8%
Skin & subcutaneous tissue	88	2.6%

Source: Admitted Patient Care Commissioning Data Set, Anglia Support Partnership

Table 3: Top 10 emergency hospital admissions, 25-49 years, Cambridgeshire

Main reason for admission	Number	% of total
Other Symptoms and signs	2223	21.3%
Injury & poisoning	2029	19.4%
Diseases of digestive system	1379	13.2%
Respiratory disease	732	7.0%
Genito-urinary	695	6.6%
Musculoskeletal	571	5.5%
Circulatory disease	546	5.2%
Pregnancy & childbirth	502	4.8%
Skin & subcutaneous tissue	358	3.4%
Diseases of nervous system	293	2.8%

Source: Admitted Patient Care Commissioning Data Set, Anglia Support Partnership

Table 4: Top Ten Emergency Hospital Admissions, 50-64 Years, Cambridgeshire

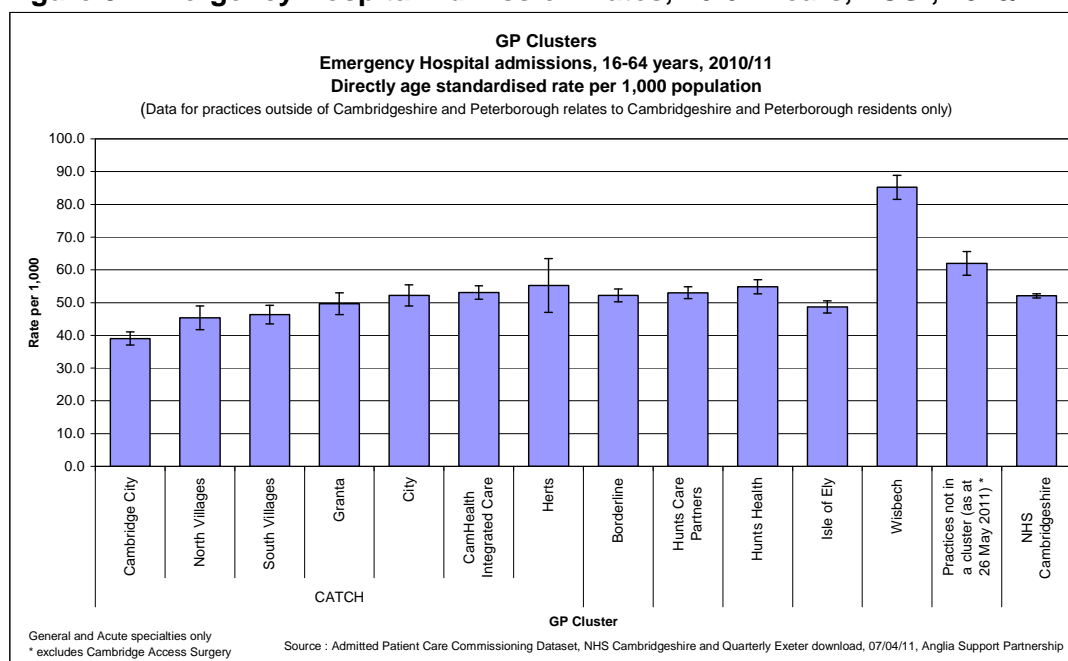
Main reason for admission	Number	% of total
Other Symptoms and signs	1608	20.4%
Circulatory disease	1132	14.4%
Diseases of digestive system	1021	13.0%
Injury & poisoning	1013	12.9%
Respiratory disease	765	9.7%
Neoplasms	440	5.6%
Musculoskeletal	410	5.2%
Genito-urinary	403	5.1%
Diseases of nervous system	240	3.0%
Skin & subcutaneous tissue	215	2.7%

Source: Admitted Patient Care Commissioning Data Set, Anglia Support Partnership

Emergency Hospital Admission Rate for Local Commissioning Groups in Cambridgeshire, 16-64 Years of Age

- The figure below shows the working age emergency hospital admission rate for the LCGs in Cambridgeshire. It is important to note that, due to current data collection methods, where practices are part of the Cluster but they are based outside of Cambridgeshire and Peterborough ie Hertfordshire and Northamptonshire practices then the data presented only relates to Cambridgeshire and Peterborough residents.
- As can be seen in the chart the Wisbech cluster has the largest emergency hospital admission rate for the working age population, with a rate that is statistically significantly higher than NHS Cambridgeshire. The combined rate for those practices currently not in a cluster and Hunts Health also have statistically significantly high rates compared to NHS Cambridgeshire.

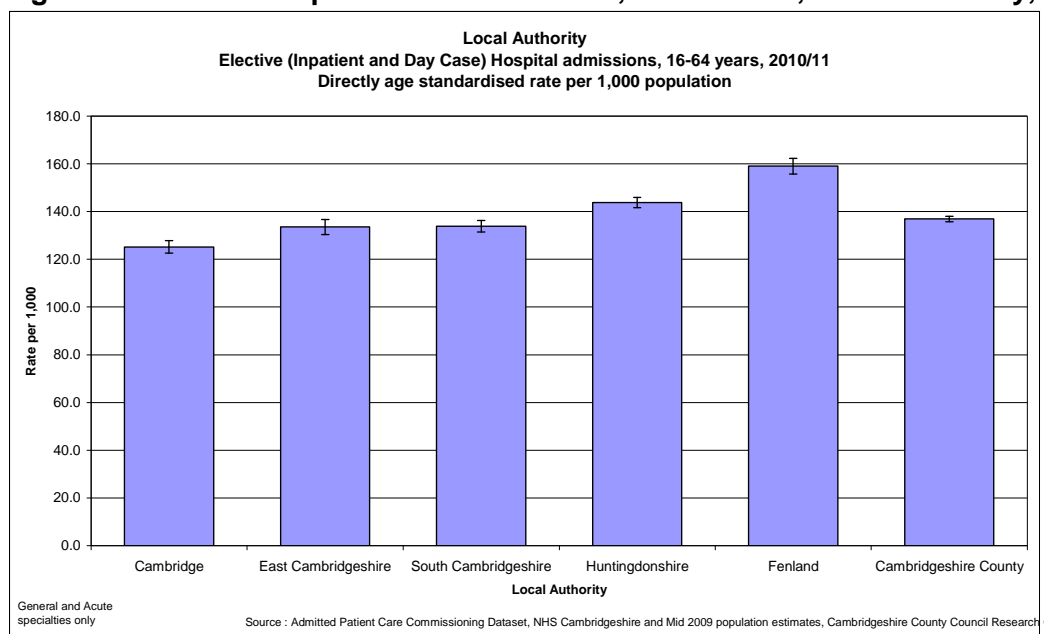
Figure 3: Emergency Hospital Admission Rates, 16-64 Years, LCG , 2010/11



Elective Hospital Admissions, 16-64 Years of Age

- In 2010/11 there were over 55,500 elective hospital admissions in Cambridgeshire for people of working age (16 to 64 years). Fenland and Huntingdonshire both have statistically significantly high elective hospital admission rates compared to Cambridgeshire.

Figure 4: Elective Hospital Admission Rates, 16-64 Years, Local Authority, 2010/11



- The tables below show the top ten main reasons for an elective admission by age band. These account for just under 90% of all elective admissions in each age band. The reason for admissions change as age increases.

Table 5: Top Ten Elective Hospital Admissions, 16-24 Years, Cambridgeshire

Main reason for admission	Number	% of total
Diseases of digestive system	928	22.1%
Genito-urinary	549	13.1%
Pregnancy & childbirth	526	12.5%
Neoplasms	424	10.1%
Musculoskeletal	339	8.1%
Respiratory disease	240	5.7%
Injury & poisoning	212	5.0%
Other symptoms and signs	188	4.5%
Diseases of nervous system	148	3.5%
Skin & subcutaneous tissue	142	3.4%

Source: Admitted Patient Care Commissioning Data Set, Anglia Support Partnership

Table 6: Top Ten Elective Hospital Admissions, 25-49 Years, Cambridgeshire

Main reason for admission	Number	% of total
Genito-urinary	5,257	22.6%
Diseases of digestive system	4,074	17.5%
Neoplasms	3,495	15.0%
Musculoskeletal	2,355	10.1%
Other symptoms and signs	1,181	5.1%
Factors influencing health status	898	3.9%
Diseases of nervous system	880	3.8%
Respiratory disease	853	3.7%
Pregnancy & childbirth	806	3.5%
Circulatory disease	640	2.7%

Source: Admitted Patient Care Commissioning Data Set, Anglia Support Partnership

Table 7: Top Ten Elective Hospital Admissions, 50-64 Years, Cambridgeshire

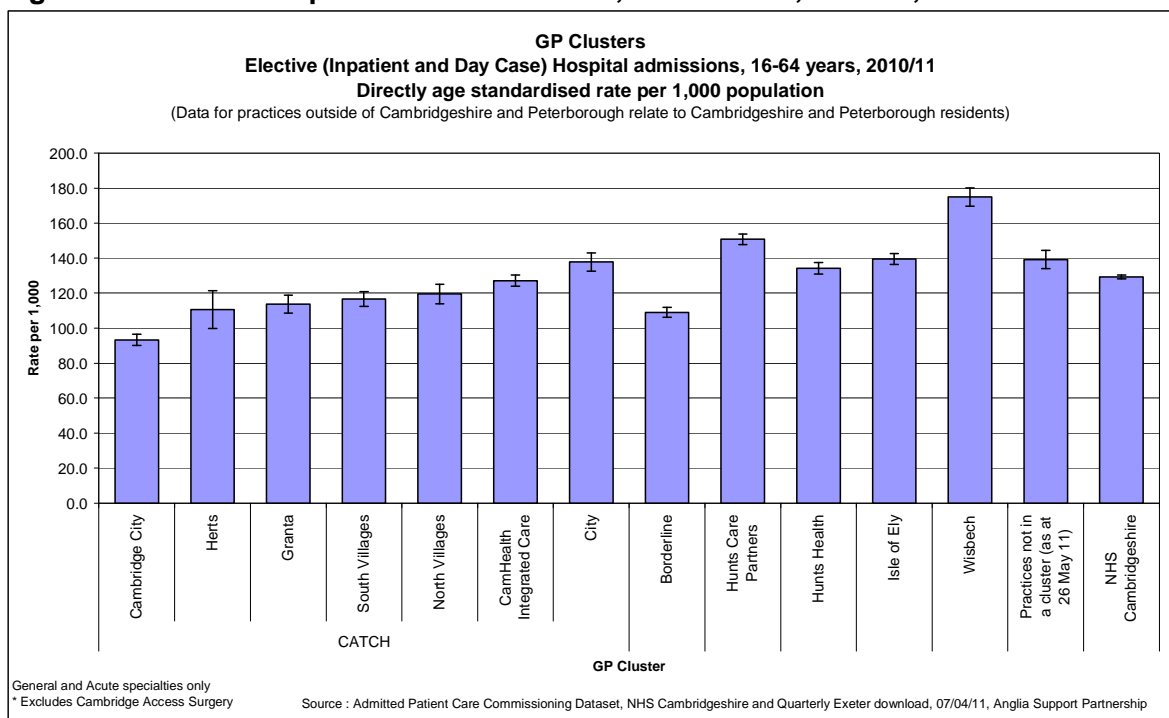
Main reason for admission	Number	% of total
Neoplasms	7,136	25.5%
Genito-urinary	6,298	22.5%
Diseases of digestive system	3,481	12.4%
Musculoskeletal	2,545	9.1%
Other symptoms and signs	1,479	5.3%
Circulatory disease	1,245	4.4%
Diseases of eye & adnexa	994	3.5%
Factors influencing health status	983	3.5%
Diseases of nervous system	953	3.4%
Respiratory disease	634	2.3%

Source: Admitted Patient Care Commissioning Data Set, Anglia Support Partnership

Elective Hospital Admission Rate for the Local Commissioning Groups in Cambridgeshire, 16-64 Years of Age

- The chart below shows the working age elective hospital admission rate for the LCGs in Cambridgeshire. It is important to note that, due to current data collection methods, where practices are part of a LCG but are based outside of Cambridgeshire and Peterborough (ie Hertfordshire and Northamptonshire practices) then the data presented only relates to Cambridgeshire and Peterborough residents.
- As can be seen in the chart below the Wisbech, Isle of Ely, Hunts Health, Hunts Care Partners and City LCGs have statistically significantly high elective hospital admission rates for their working age populations when compared to NHS Cambridgeshire.

Figure 5: Elective Hospital Admission Rates, 16-64 Years, Cluster, 2010/11



Mortality Rates, 16-64 Years of Age

- There are around 725 deaths a year in Cambridgeshire in people of working age (16 to 64 years), over half of which are aged 55 to 64 years. Fenland has a statistically significantly high rate compared to Cambridgeshire, with a rate that is almost a half higher than the Cambridgeshire average.

Table 8: Mortality Rates, 16-64 Years, Local Authority, April 2008 to March 2010, Directly Age Standardised Rate per 100,000

District	Average annual deaths	Rate per 100,000	95% CI
Cambridge City	118	180.9	(157.5 - 204.3)
East Cambridgeshire	98	169.5	(145.6 - 193.5)
Fenland	163	250.3	(222.9 - 277.8)
Huntingdonshire	189	159.5	(143.3 - 175.7)
South Cambridgeshire	159	153.6	(136.5 - 170.6)
Cambridgeshire	726	175.5	(166.4 - 184.5)

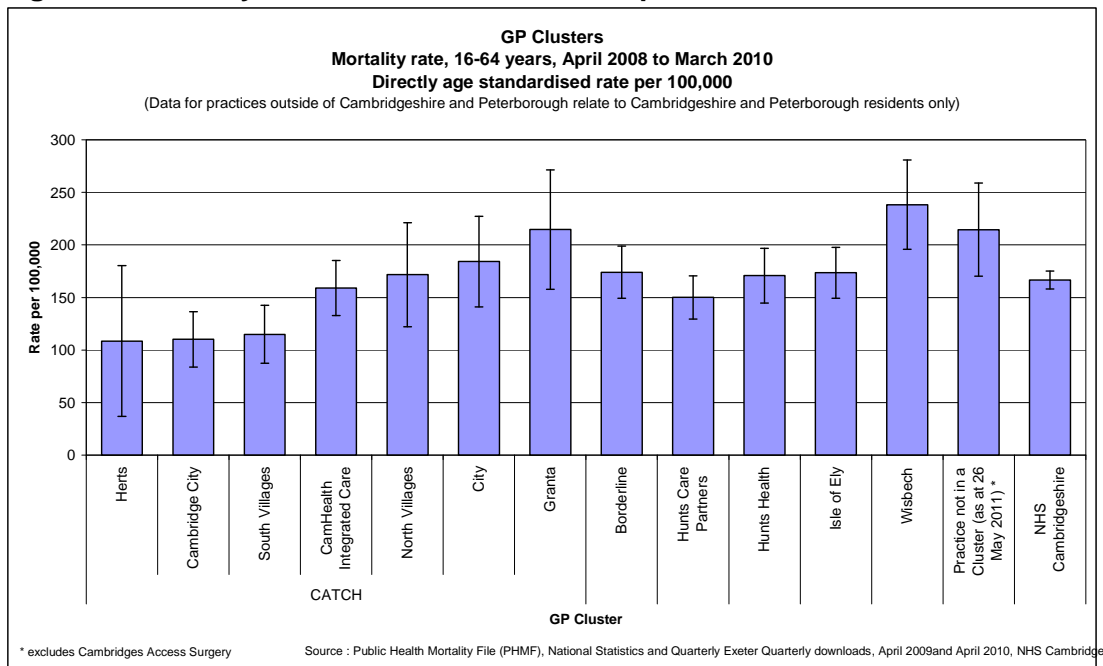
Source: Annual extract of deaths, Vital Statistics, National Statistics and Mid Year population estimates, Cambridgeshire County Council Research, Performance and Business Intelligence Team

- The main causes of death in people aged 16-24 years are transport accidents and intentional self harm. For people aged 25-49 years the main causes of death were cancers, circulatory disease, transport accidents and intentional self harm. Cancers, circulatory disease and diseases of the digestive system are the main cause of death in people aged 50-64 years.

Mortality rate for people by LCG, 16-64 Years of Age

- The chart below shows the mortality rate for people aged 16-64 years by LCG. It is important to note that these are based on relatively small numbers and are therefore prone to fluctuation. The Wisbech LCG has a statistically significantly high working age mortality rate compared to NHS Cambridgeshire.

Figure 6: Mortality Rates, 16-64 Years, LCG, April 2008 to March 2010



Mortality and Deprivation in Cambridgeshire, 2005 to 2009

- These data are taken from the health inequality profiles, which are published by the Eastern Region Public Health Observatory (erpho). The mortality data are sourced from National Statistics (ONS) and rates are calculated for deprivation quintiles based on the Index of Multiple Deprivation 2010 (IMD2010). Quintiles are fifths of the population, grouped according to their IMD2010 scores.

- Data are available for all age all cause deaths, for premature all cause mortality at ages under 75 years, for cancer deaths and for deaths from all circulatory diseases. These are provided below. Key issues are provided as bullet points to guide JSNA content.

All age all cause mortality by deprivation quintile, 2005 to 2009

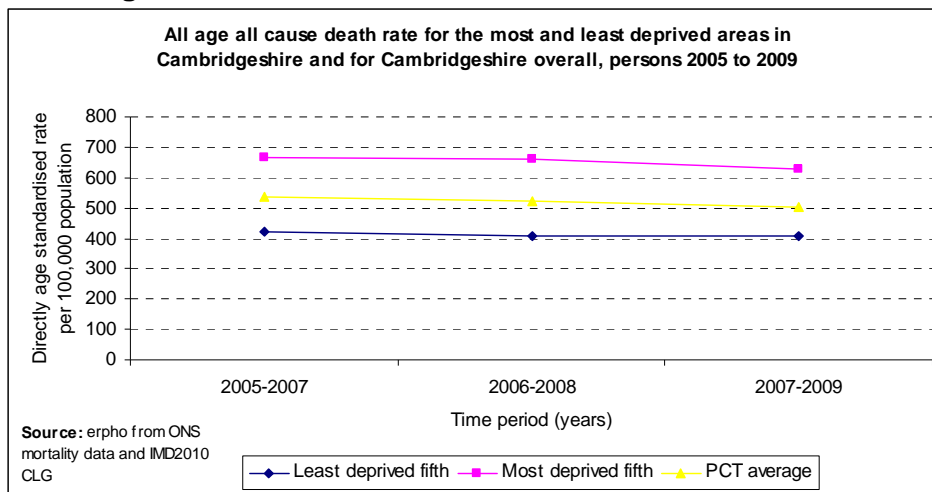
Table 9: All Age All Cause Mortality Rate by Quintile of Deprivation and for Cambridgeshire, 2005 to 2009 (Persons)

Area (IMD quintile) and PCT and years	DSR/100,000	95% CI lower	95% CI upper
2005-2007			
Least deprived fifth	421.1	402.9	440.0
Most deprived fifth	668.0	645.2	691.4
PCT average	535.3	526.2	544.5
2006-2008			
Least deprived fifth	409.5	391.9	427.7
Most deprived fifth	663.1	640.5	686.3
PCT average	522.8	513.9	531.8
2007-2009			
Least deprived fifth	406.7	389.4	424.6
Most deprived fifth	628.3	606.4	650.7
PCT average	505.1	496.4	513.8

Source: erpho from ONS mortality data and IMD2010 Department for Communities and Local Government

Note: DSR is a directly age standardised rate.

Figure 7: All Age All Cause Mortality Rate by Quintile of Deprivation and for Cambridgeshire, Persons 2005 to 2009



Source: erpho from ONS mortality data and IMD2010 Department for Communities and Local Government

Note: DSR is a directly age standardised rate.

Key points: All Age All Cause Mortality

- The rate of all age all cause mortality has fallen between 2005 and 2009 for the most and least deprived areas of Cambridgeshire and for Cambridgeshire overall.
- The death rate in the most deprived area is statistically significantly higher than in the least deprived area and in Cambridgeshire as a whole for the three time periods considered.
- The percentage change (decreasing) in the all age all cause death rate between 2005-2007 and 2007-2009 is greater in the most deprived area compared with the percentage changes in the least deprived area and Cambridgeshire as a whole.
- The absolute and relative gaps in all age all cause mortality between the most and least deprived area and the most deprived area and Cambridgeshire as a whole have reduced between 2005 and 2009. However, the absolute gaps increased in 2006-2008, before falling back below the earlier 2005-2007 levels in the latest 2007-2009 period. Thus the position over this period may not be definitive and future gaps will need to be monitored closely.

Premature all cause mortality at ages under 75 years by deprivation quintile, 2005-2009

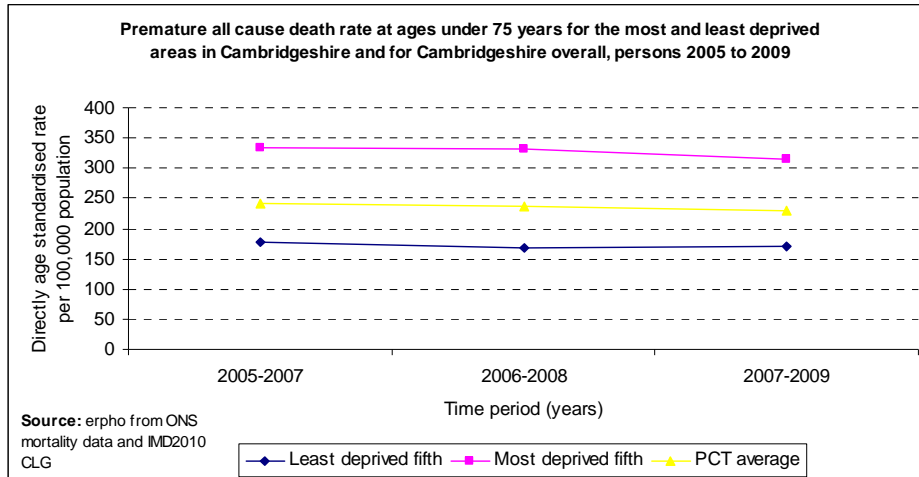
Table 10: Premature All Cause Mortality Rate at Ages Under 75 Years by Quintile of Deprivation and for Cambridgeshire, 2005-2009 (Persons)

Area (IMD quintile) and PCT and years	DSR/100,000	95% CI lower	95% CI upper
2005-2007			
Least deprived fifth	178.1	164.7	192.4
Most deprived fifth	333.9	315.5	353.1
PCT average	241.9	234.9	249.1
2006-2008			
Least deprived fifth	168.5	155.6	182.1
Most deprived fifth	332.1	313.9	351.2
PCT average	236.8	229.9	243.8
2007-2009			
Least deprived fifth	169.9	157.1	183.4
Most deprived fifth	314.0	296.2	332.4
PCT average	229.2	222.6	236.1

Source: erpho from ONS mortality data and IMD2010 Department for Communities and Local Government.

Note: DSR is a directly age standardised rate.

Figure 8: Premature All Cause Mortality Rate at Ages Under 75 years by Quintile of Deprivation and for Cambridgeshire, Persons 2005-2009



Source: erpho from ONS mortality data and IMD2010 Department for Communities and Local Government

Key points: premature all cause mortality at ages under 75 years

- The rate of premature all cause mortality has generally fallen between 2005 and 2009 for the most and least deprived areas of Cambridgeshire and for Cambridgeshire overall. However, the rate has increased negligibly in the least deprived area in 2007-2009 compared with 2006-2008.
- The premature death rate in the most deprived area is statistically significantly higher than in the least deprived area and in Cambridgeshire as a whole for the three time periods considered.
- The percentage change (decreasing) in the premature all cause death rate between 2005-2007 and 2007-2009 is greater in the most deprived area compared with the percentage changes in the least deprived area and Cambridgeshire as a whole.
- The absolute and relative gaps in premature all cause mortality between the most and least deprived area and the most deprived area and Cambridgeshire as a whole have reduced between 2005 and 2009. However, the relative and absolute gaps increased in 2006-2008, before falling back below the earlier 2005-2007 levels in the latest 2007-2009 period. Thus the position over this period may not be definitive and future gaps will need to be monitored closely.

Premature mortality from all circulatory diseases at ages under 75 years by deprivation quintile, 2005 to 2009

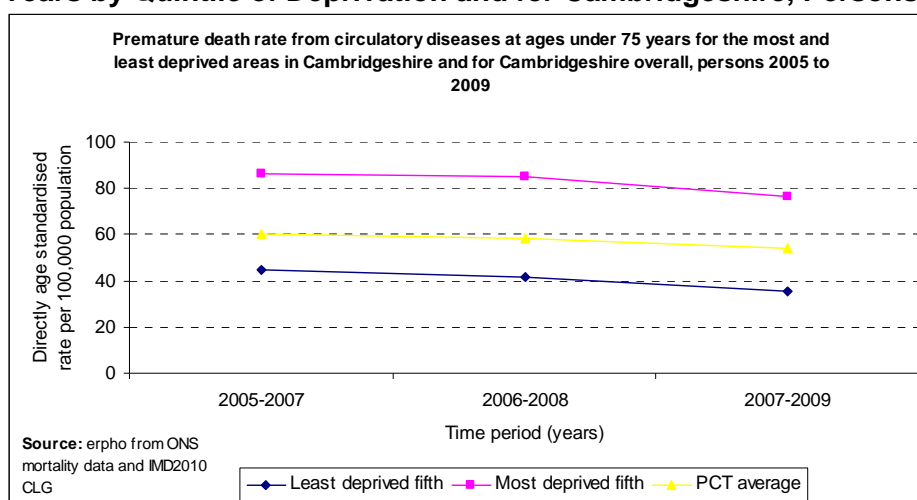
Table 11: Premature Mortality Rate from all Circulatory Diseases at Ages Under 75 Years by Quintile of Deprivation and for Cambridgeshire, 2005-2009 (Persons)

Area (IMD quintile) and PCT and years	DSR/100,000	95% CI lower	95% CI upper
2005-2007			
Least deprived fifth	44.9	38.4	52.2
Most deprived fifth	86.4	77.4	96.1
PCT average	60.0	56.6	63.5
2006-2008			
Least deprived fifth	41.5	35.3	48.3
Most deprived fifth	84.8	75.9	94.4
PCT average	58.3	54.9	61.7
2007-2009			
Least deprived fifth	35.1	29.5	41.4
Most deprived fifth	76.4	67.9	85.5
PCT average	54.3	51.1	57.6

Source: erpho from ONS mortality data and IMD2010 Department for Communities and Local Government.

Note: DSR is a directly age standardised rate.

Figure 9: Premature Mortality Rate from all Circulatory Diseases at Ages Under 75 Years by Quintile of Deprivation and for Cambridgeshire, Persons 2005-2009



Source: erpho from ONS mortality data and IMD2010 Department for Communities and Local Government.

Key points: premature mortality from all circulatory diseases at ages under 75 years

- The rate of premature mortality from circulatory disease has fallen between 2005 and 2009 for the most and least deprived areas of Cambridgeshire and for Cambridgeshire overall.
- The premature death rate in the most deprived area is statistically significantly higher than in the least deprived area and in Cambridgeshire as a whole for the three time periods considered.

- The percentage change (decreasing) in the premature circulatory disease death rate between 2005-2007 and 2007-2009 is greater in the least deprived area compared with the percentage changes in the most deprived area and Cambridgeshire as a whole. The percentage change in the death rate in the most deprived area is greater than the Cambridgeshire average.
- The absolute gap between the most and least deprived area is similar in 2007-2009 as in 2005-2007. However, the relative gap has increased. The absolute and relative gaps between the most deprived area and Cambridgeshire as a whole have decreased between 2005-2007 and 2007-2009 but the closing of these gaps is relatively small.

Premature cancer mortality in people aged under 75 years by deprivation quintile, 2005 to 2009

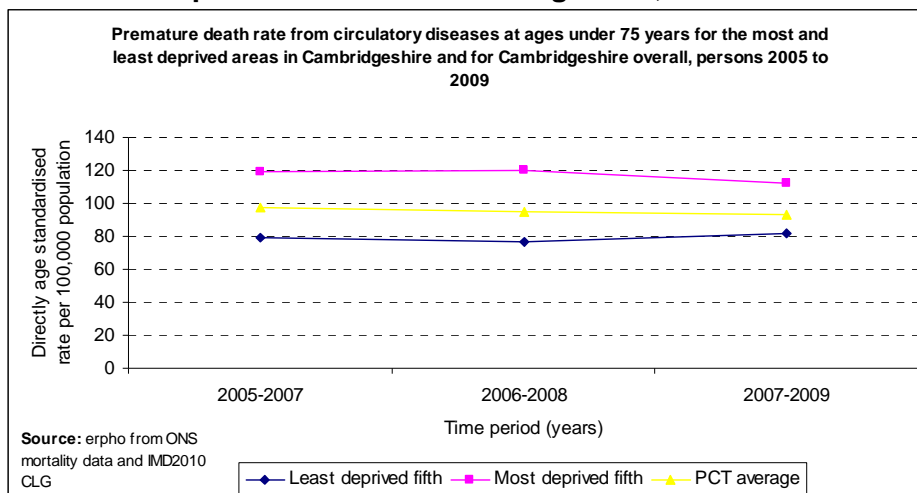
Table 12: Premature Mortality Rate from all Cancers at Ages Under 75 Years by Quintile of Deprivation and for Cambridgeshire, 2005-2009 (Persons)

Area (IMD quintile) and PCT and years	DSR/100,000	95% CI lower	95% CI upper
2005-2007			
Least deprived fifth	79.2	70.4	88.7
Most deprived fifth	118.9	108.1	130.4
PCT average	97.8	93.4	102.3
2006-2008			
Least deprived fifth	76.5	68.0	85.7
Most deprived fifth	120.1	109.3	131.6
PCT average	95.2	90.9	99.6
2007-2009			
Least deprived fifth	81.7	73.1	91.1
Most deprived fifth	112.5	102.1	123.7
PCT average	93.3	89.1	97.6

Source: erpho from ONS mortality data and IMD2010 Department for Communities and Local Government.

Note: DSR is a directly age standardised rate.

Figure 10: Premature Mortality Rate From all Cancers at Ages Under 75 Years by Quintile of Deprivation and for Cambridgeshire, Persons 2005 to 2009



Source: erpho from ONS mortality data and IMD2010 Department for Communities and Local Government

Key points: premature mortality from all cancers at ages under 75 years

- The trend in cancer mortality according to deprivation is harder to interpret than for all cause mortality or deaths from circulatory disease. Although mortality rates are higher in deprived areas, rates are improving in such areas whereas they may be stabilising or even worsening in relatively less deprived areas.
- Overall the Cambridgeshire premature death rate from cancer has fallen between 2005-2007 and 2007-2009. However, the rate in the least deprived area is slightly higher in 2007-2009 than in 2005-2007, although it fell in 2006-2008. In the most deprived area the latest 2007-2009 rate is lower than in 2005-2007 but there was a slight increase between 2005-2007 and 2006-2008.
- The premature death rate in the most deprived area is statistically significantly higher than in the least deprived area and in Cambridgeshire as a whole for the three time periods considered.
- The percentage change (decreasing) in the premature cancer death rate between 2005-2007 and 2007-2009 is greater in the most deprived area compared with the percentage changes in the most deprived area and Cambridgeshire as a whole. The percentage change in the death rate in the most deprived area is greater than the Cambridgeshire average. The percentage change in the least deprived area is positive meaning that the rate is higher in 2007-2009 compared with 2005-2007.
- Relative and absolute gaps in the most deprived area have decreased in 2007-2009 compared to 2005-2007 compared to both the PCT average and the rate in the least deprived area. However, the relative and absolute gaps increased in 2006-2008, before falling back below the earlier 2005-2007 levels in the latest 2007-2009 period. Thus the position over this period may not be definitive and future gaps will need to be monitored closely.

3. DEMOGRAPHY

3.1 Introduction

- It is estimated that there are 394,900 people of working age living in Cambridgeshire which accounts for nearly two-thirds of the total population. Huntingdonshire has the largest number of such population at almost 107,800 people. Cambridge City has the highest concentration of working age population at 73.0% of its total population. This is mainly due to the large student population living in the city. Cambridge has the highest proportion of its population aged 16-24 and 25-39 of all the districts.² Population estimates are calculated using the resident population of an area.

Table 13: Working Age Population Estimates, 16-64 years, Mid 2010

Local Authority	Age band (years)				% of total population
	16-24	25-49	50-64	Total (16-64)	
Cambridge	26,500	43,900	17,000	87,400	73.0%
East Cambridgeshire	7,800	27,200	16,000	51,000	63.1%
Fenland	9,500	29,700	18,700	57,900	61.4%
Huntingdonshire	17,200	57,600	33,100	107,800	65.2%
South Cambridgeshire	13,100	48,800	28,900	90,800	62.5%
Cambridgeshire	74,100	207,200	113,600	394,900	65.2%

Source: Cambridgeshire County Council Research, Performance and Business Intelligence Team, mid-2010 estimates.

Note: Figures are rounded to the nearest 100 hence totals may not add up.

3.2 Registered Population

- In April of 2011, there were 419,000 people of working age registered with a Cambridgeshire PCT general practice. This is an increase of 3.2% from January 2008 (13,000 people in total). These figures are based on the number of people registered with a general practice and regardless of where the patient lives.
- Since 2009, as part of Cambridgeshire's New Commissioning Model, general practices have formed 'clusters' ie commissioning groups.³ General practices may form commissioning groups beyond PCT boundaries, for example, in Borderline Commissioning Cluster, there are general practices based in Cambridgeshire, Peterborough and Northamptonshire. Data on the population registered with general practices in Cambridgeshire PCT are in Table 14.

² Cambridge City District Report 2011, Cambridgeshire County Council Research, Performance and Business Intelligence Team.

³ Clusters are accountable to the PCT, but have devolved authority to commission the pattern of services that best meets the needs of their specific population, within the resources available.

Table 14: Working Age Population, Cambridgeshire Local Commissioning Groups, May 2011

LCG	Age bands (years)				% of total population*	Total population*
	16-24	25-49	50-64	Total (16-64)		
Borderline	8,240	28,660	14,990	51,890	65.0%	79,800
Cambridge City	16,830	25,830	7,690	50,350	78.5%	64,120
Camhealth Integrated Care	10,990	27,900	11,740	50,630	68.4%	74,030
City	2,790	11,460	5,180	19,430	64.3%	30,210
Granta	3,950	13,370	3,370	20,690	71.4%	28,970
Herts	550	1,780	1,250	3,570	65.5%	5,450
Hunts Care Partners	9,530	32,510	18,830	60,870	64.6%	94,230
Hunts Health	7,680	25,900	14,490	48,070	65.4%	73,460
Isle of Ely	8,900	30,850	16,150	55,890	64.8%	86,200
North Villages	2,000	7,920	4,090	14,010	65.5%	21,390
South Villages	3,510	12,690	8,530	24,730	62.2%	39,730
Wisbech	4,990	14,870	8,960	28,810	63.3%	45,530
NOT IN LCG (as at 26 May 2011)	2,840	9,820	6,140	18,790	62.5%	30,040
Grand total	82,795	243,556	121,407	447,728	66.5%	673,165

Source: ASTROS April 2011 – patients resident in Cambridgeshire PCT and Peterborough PCT based practices; Exeter database for patients resident in Cambridgeshire PCT and Peterborough PCT registered with practices elsewhere (eg Herts).

Note (*): Table shows general practices in Cambridgeshire PCT and Peterborough PCT only. Data relates to Cambridgeshire and Peterborough residents. LCGs as at 26/05/2011.

- In the CATCH Commissioning group nearly 70% of patients registered with general practices in CATCH are in the working age group. Data are in Table 15.

Table 15: Working Age Population, Cambridgeshire Local Commissioning Groups, May 2011

GP Consortia	Age bands (years)				% of total population*	Total population*
	16-24	25-49	50-64	Total (16-64)		
CATCH	40,620	100,930	41,850	183,410	69.5%	263,900
Not in GP consortia	42,180	142,610	79,550	264,330	64.6%	409,260
Grand Total	82,800	243,540	121,400	447,740	66.5%	673,160

Source: ASTROS April 2011 – patients resident in Cambridgeshire PCT and Peterborough PCT based practices; Exeter database for patients resident in Cambridgeshire PCT and Peterborough PCT registered with practices elsewhere (eg Herts).

Note (*): Table shows general practices in Cambridgeshire PCT and Peterborough PCT only. Data relates to Cambridgeshire and Peterborough residents. LCGs as at 26/05/2011.

3.3 Population Forecasts

- The Cambridgeshire County Council Research, Performance and Business Intelligence Team forecast that between 2009 and 2031, the working age population in Cambridgeshire will increase by 4.5%.
- The largest actual and proportional increase is forecast in Cambridge City, with 15.1% more of such population by 2031 (13,000 people in total). East Cambridgeshire, Fenland and South Cambridgeshire districts are also forecast to see an increase in its working age population. Huntingdonshire is forecast to see a decline in this population over the same time period.

Table 16: Working Age Population Forecasts, Local Authority, 16-64 Years, Mid 2009

Local Authority	2009	2014	2019	2031	% change (2009-2031)
Cambridge	87,200	95,800	103,200	100,400	15.1%
East Cambridgeshire	51,000	49,100	49,300	54,900	7.7%
Fenland	57,400	58,000	60,100	61,300	6.7%
Huntingdonshire	107,700	107,800	108,400	99,700	-7.5%
South Cambridgeshire	90,900	88,500	94,900	96,000	5.6%
Cambridgeshire	394,100	399,300	415,900	412,000	4.5%

Source: Cambridgeshire County Council Research, Performance and Business Intelligence Team, mid-2009 forecasts.

<http://www.cambridgeshire.gov.uk/business/research/populationresearch/population/forecasts/>

Note: It is advised to use the 2009-based population forecasts in the knowledge of possible major revisions in future forecasts.

- Between 2009 and 2031, the largest proportional and actual increase in the working age population is forecast to be in the age ranges 50-64 at 11.6% (13,000 people in total) and in the 16-24 age group at 10.7% (7,900 people in total). In 25-49 age group a minimal decrease is forecast at 1.5%.

Table 17: Working Age Population Forecasts, Cambridgeshire, by Age Group

Age group	2009	2014	2019	2031	% change (2009-2031)
16 – 24	74,400	76,400	77,700	82,300	10.7%
25 – 49	207,500	204,900	208,800	204,400	-1.5%
50 – 64	112,300	118,000	129,400	125,300	11.6%
Total (16 – 64)	394,100	399,300	415,900	412,000	4.5%

Source: Cambridgeshire County Council Research, Performance and Business Intelligence Team, mid-2009 forecasts.

3.4 Ethnicity

- Cambridgeshire's ethnic diversity varies between the districts. On average, the proportion of people from 'White British' group in the county (83.5%) is estimated to be similar to the England average (81.8%).
- The most diverse district is Cambridge City with a high proportion of people from 'Other White' group and 'Chinese or Other Ethnic group'. Fenland has the highest proportion of people in 'White British' group (92.0%) and the lowest proportion of people from 'Other White' group (2.8%).

Table 18: Ethnicity of Working Age Population, Local Authority (16-64 Years Males, 16-59 Females), Mid 2007

Ethnicity		Cambridge	East Cambridge-Shire	Fenland	Huntingdon-shire	South Cambridge-shire	Cambridge-shire	England
White	British	69.3%	85.8%	92.0%	87.1%	87.0%	83.5%	81.8%
	Irish	1.3%	0.8%	0.6%	0.8%	1.0%	0.9%	1.0%
	Other White	11.4%	7.3%	2.8%	5.8%	4.9%	6.7%	4.3%
Mixed	White and Black Caribbean	0.5%	0.2%	0.2%	0.3%	0.2%	0.3%	0.4%
	White and Black African	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%
	White and Asian	0.8%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
	Other Mixed	0.7%	0.4%	0.2%	0.4%	0.4%	0.4%	0.4%
Asian or Asian British	Indian	3.7%	0.8%	0.7%	1.1%	1.2%	1.6%	3.0%
	Pakistani	1.0%	0.4%	0.4%	0.6%	0.5%	0.6%	1.8%
	Bangladeshi	0.9%	0.2%	0.2%	0.2%	0.2%	0.4%	0.7%
	Other Asian	1.0%	0.2%	0.4%	0.3%	0.5%	0.5%	0.8%
Black	Black Caribbean	0.9%	0.4%	0.4%	0.5%	0.6%	0.6%	1.3%
	Black African	1.7%	0.6%	0.6%	0.7%	0.8%	0.9%	1.6%
	Other Black	0.2%	0.2%	0.0%	0.5%	0.1%	0.3%	0.2%
Chinese or Other Ethnic Group	Chinese	3.9%	1.2%	0.4%	0.5%	1.0%	1.5%	1.0%
	Other	2.5%	0.8%	0.6%	0.9%	1.2%	1.3%	1.0%
Total population (16-59/64)		87,400	49,200	53,500	105,300	84,100	379,500	31,791,700

Source: Population Estimates by Ethnic Group Mid-2007 (experimental), ONS 2010.

- Note: Users should take careful note of the methodologies involved in constructing these estimates in order to be aware of their limitations. See website: <http://www.ons.gov.uk/ons/index.html>

4. WIDER DETERMINANTS OF HEALTH

4.1 Introduction

There is a wide range of broad social, economic and environmental factors including education, employment, income, housing and social support networks that influence health. These have an effect individually but also they are inter-connected and reinforce each other.

There is substantial evidence confirming how deprivation has a negative effect upon health when it impacts on these determinants. In 1980⁴ the *Black Report* clearly demonstrated the effect of deprivation on morbidity and mortality. The same conclusions were reached by the *Whitehead Report (1987)*⁵ and *Acheson Report (1998)*⁶. More recently *The Marmot Review Report: Fair Society, Healthy Lives (2010)*⁷ described the social gradient in health whereby the lower social position and the associated socio-economic deprivation results in poorer health.

Marmot identified key factors that start with the effect of deprivation on child development. Childhood deprivation can often determine the other key factors in adulthood, employment skills, opportunities and conditions, income, climate change and the quality of neighbourhoods where housing, fuel poverty, air quality and transport all impact on health. The analysis of the wider determinants of health that is found in Black and Marmot clearly demonstrates the effect they have on health and also the health inequalities that are created.

The Cambridgeshire data presented in this section provide the profile of the different determinants of health across the county.

4.2 Deprivation

What do we Know?

4.2.1 Introduction

This section presents information about the relationship between deprivation and health. Deprivation is measured by the English Indices of Multiple Deprivation using 38 indicators organised across seven domains. Each domain represents a distinct specific form of deprivation experienced by people and can be measured individually using a number of indicators. People may be counted in more than one domain.

They include:

- Income
- Employment
- Education Skills and Training Deprivation
- Health Deprivation and Disability
- Barriers to Housing and Services
- Living Environment Deprivation
- Crime

⁴ *The Black Report*, D. Black, Department of Health and Social Care, 10980

⁵ *Inequalities in Health: The Black Report and The Health Divide*, M. Whitehead 1987, Penguin

⁶ *Independent Inquiry into Inequalities in Health Report* 1998

⁷ *The Marmot Review Report, Fair Society, Healthy Lives*, M. Marmot. 2010

These can also be combined into an overall Index of Multiple Deprivation. These measures are calculated for every Lower Super Output Areas in the country (LSOAs). LSOAs are small areas of relatively even size. The Indices and Index can be used to rank every LSOA in the country according to their relative deprivation. Comparisons are often made between deciles of deprivation where the 32,482 LSOAs are split into ten groups of equal size. There is no definitive measure of deprivation, it is a continuous measure. It should also be noted that the statistics are not measures of affluence and to recognise that not every person living in a highly deprived area will themselves be deprived. Equally there will be people suffering the effects of deprivation living in the least deprived areas.

4.2.2 Figures and Trends

- Information about the levels of deprivation in Cambridgeshire in this section comes from *English Indices of Deprivation 2010 and English Indices of Multiple Deprivation 2010 Summary Report* compiled by Cambridgeshire County Council Research, Performance and Business Intelligence Team in April 2011.⁸
- In 2010, Fenland remains Cambridgeshire's most deprived district, followed by Cambridge City, East Cambridgeshire, Huntingdonshire then South Cambridgeshire.
- Compared to 2007, Fenland, Cambridge City and Huntingdonshire now rank as more deprived in national terms than previously, South Cambridgeshire has not changed, and East Cambridgeshire ranks as less deprived. Table 19 shows the average IMD rank change between 2007 and 2010.

Table 19: Average IMD Ranking – Change by District, 2007-2010

Local Authority	Average IMD Rank 2010	Average IMD rank 2007	% Rank 2010	% Rank 2007
Cambridge	188	234	58%	66%
East Cambridgeshire	269	278	83%	79%
Fenland	94	125	29%	35%
Huntingdonshire	276	311	85%	88%
South Cambridgeshire	321	350	98%	99%

Source: Department for Communities and Local Government, Indices of Deprivation 2010.

- In 2010, 11 of Cambridgeshire's 20 most deprived LSOAs were in Fenland, seven were in Cambridge City and two were in Huntingdonshire.
- Three LSOAs in Cambridgeshire fall within the most deprived 10% (Decile 1) of areas in England. All three are in Wisbech. This is the same as in 2007.
- A further six areas fall within the most deprived 20% of areas nationally. These are in Wisbech, March and King's Hedges (Cambridge City). All six were previously in the most deprived 30% nationally, suggesting that the local picture may have worsened slightly. The data are in Table 20.

⁸ <http://www.cambridgeshire.gov.uk/business/research/economylab/deprivation/>

Table 20: IMD2010 - 20 Most Deprived LSOAs in Cambridgeshire

Cams Rank 2010	LSOA Code	LSOA Name	Ward	LA Name	IMD Score	IMD Rank (National)	Decile	Quintile
1	E01018108	Fenland 002D	Waterlees	Fenland	53.36	1,643	1	1
2	E01018103	Fenland 003F	Staithe	Fenland	48.53	2,470	1	1
3	E01018107	Fenland 002C	Waterlees	Fenland	46.66	2,831	1	1
4	E01018089	Fenland 003D	Medworth	Fenland	36.85	5,558	2	1
5	E01017979	Cambridge 001E	King's Hedges	Cambridge	35.80	5,942	2	1
6	E01018078	Fenland 007B	March East	Fenland	35.59	6,006	2	1
7	E01018070	Fenland 003B	Hill	Fenland	35.47	6,052	2	1
8	E01017978	Cambridge 001D	King's Hedges	Cambridge	35.19	6,152	2	1
9	E01018071	Fenland 003C	Hill	Fenland	34.57	6,365	2	1
10	E01018063	Fenland 002A	Clarkson	Fenland	33.88	6,597	3	2
11	E01017948	Cambridge 006F	Abbey	Cambridge	33.41	6,769	3	2
12	E01017946	Cambridge 006D	Abbey	Cambridge	33.03	6,925	3	2
13	E01017975	Cambridge 001A	King's Hedges	Cambridge	32.55	7,111	3	2
14	E01018144	Huntingdonshire 008B	Huntingdon North	Huntingdonshire	32.36	7,187	3	2
15	E01018068	Fenland 004C	Elm and Christchurch	Fenland	32.10	7,300	3	2
16	E01018091	Fenland 004E	Parson Drove and Wisbech St Mary	Fenland	30.87	7,817	3	2
17	E01018143	Huntingdonshire 008A	Huntingdon East	Huntingdonshire	30.83	7,840	3	2
18	E01017971	Cambridge 003B	East Chesterton	Cambridge	30.55	7,949	3	2
19	E01017952	Cambridge 002D	Arbury	Cambridge	30.50	7,977	3	2
20	E01018066	Fenland 004A	Elm and Christchurch	Fenland	28.87	8,716	3	2

Source: IMD2010 Summary Briefing - Cambridgeshire County Council Research, Performance and Business Intelligence Team, CLG 2011.

Note: Decile = 10% groupings so 1 means among most deprived 10% in England, 2 means 20%, 3 means 30% etc; Quintile = 20% groupings.

- Based on IMD2010 proxy scores, the most deprived LCGs in Cambridgeshire are: Wisbech, Borderline and CamHealth Integrated Health. The score should be treated only as an indication. The data are in Table 21.

Table 21: IMD2010 Proxy Scores, Cambridgeshire PCT General Practice Clusters, May 2011

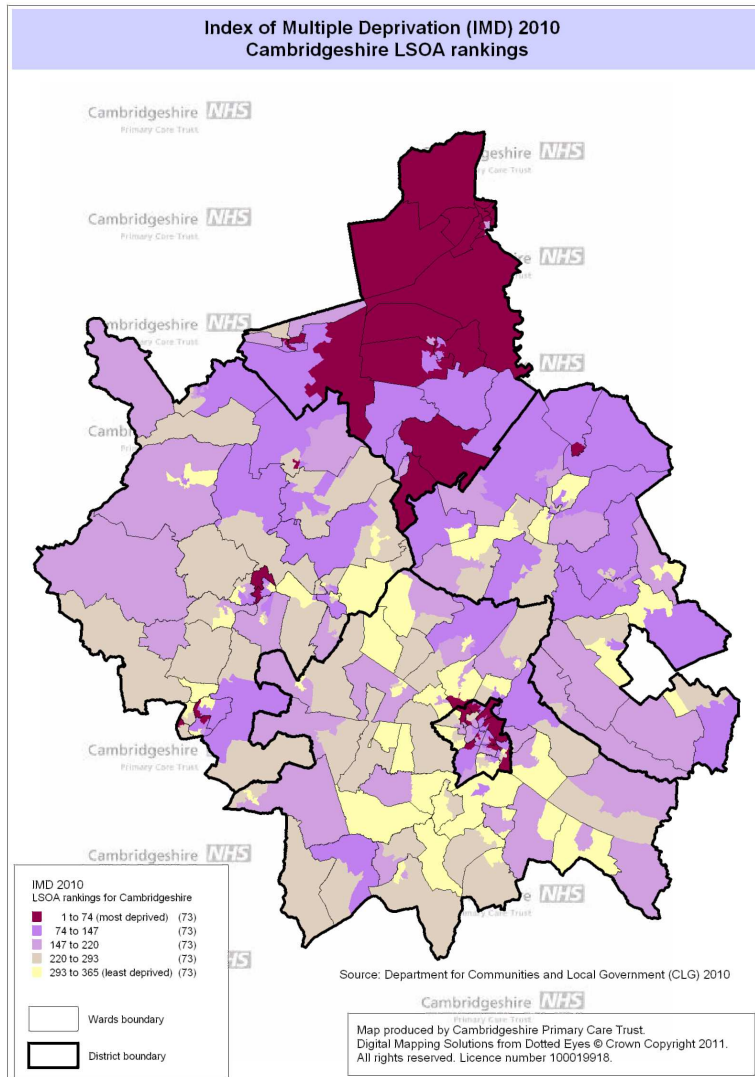
Cluster	Proxy IMD2010 score	Cluster deprivation rank (where 1 is the most deprived)
Borderline	17.4	2
Cambridge City	12.8	4
CamHealth Integrated Care	14.3	3
City	10.3	8
Granta	12.5	5
Herts	7.7	10
Hunts Care Partners	10.0	9
Hunts Health	12.4	6
Isle of Ely	11.7	7
North Villages	6.6	11
South Villages	6.3	12
Wisbech	29.9	1
Not in cluster	19.7	-

Source: erpho, IMD2010 scores at the Middle Super Output Area (MSOA) level; Exeter database for patients resident in Cambridgeshire PCT and Peterborough PCT registered with practices elsewhere (eg Herts); NHS Cambridgeshire Public Health Information, Cluster IMD2010 proxy scores.

Note: IMD2010 proxy scores for general practice clusters are calculated using the proportion of patients registered with general practice/general practice cluster and IMD score for MSOA they live in. The deprivation proxy scores for general practice Clusters should be treated as an indication and not compared with scores for LSOAs published by the Department of Communities and Local Government.

- The basic pattern of deprivation, as shown on Map 1, remains similar to previous years, with areas of greatest deprivation concentrated in Fenland, parts of the market towns in Huntingdonshire, and in northern and eastern parts of Cambridge City. The least deprived areas are mainly found in South Cambridgeshire and parts of East Cambridgeshire. East Cambridgeshire has a greater number of less deprived areas now than in 2007.⁹

Map 1: Cambridgeshire LSOA Rankings



Note: the darker colours indicate relatively more deprivation.

- A more detailed analysis of the trend across the IMD domains across the Districts and Boroughs can be found at www.cambridgeshirejsna.org.uk

4.2.3 Local Views

Huntingdonshire District Council has produced a local analysis of the Index of Multiple Deprivation 2010 that offers more detailed analysis. This can be found through the following link:

<http://www.huntingdonshire.gov.uk/Community%20and%20People/Facts%20and%20figures/Pages/Deprivation.aspx>

⁹ Ibid.

4.2.4 Evidence/Policy

Evidence/Policy is described in each of the domains included in this document.

4.2.5 What are we doing in Cambridgeshire - Examples of Good Practice?

Across Cambridgeshire there has been a range of interventions designed to address the different areas of deprivation. The Health Inequalities Strategy details the range of interventions that have been introduced to address many of the health inequalities that are linked to deprivation.

[http://www.cambridgeshirepct.nhs.uk/downloads/Your%20Health/OtherPublicHealthReports/Cambri
dgeshire%20Health%20Inequalities%20Strategy%202009-2011.pdf](http://www.cambridgeshirepct.nhs.uk/downloads/Your%20Health/OtherPublicHealthReports/Cambri
dgeshire%20Health%20Inequalities%20Strategy%202009-2011.pdf)

This also describes progress against a range of indicators.

What is this Telling us?

4.2.6 What are the Key linequalities?

- Although Cambridgeshire as a whole is relatively affluent there are areas of deprivation around the county. These can be small or can particularly affect vulnerable groups (see Vulnerable Groups Section).
- That overall there has been little change in the pattern of deprivation but Fenland, Cambridge City and Huntingdonshire now rank more deprived in national terms. East Cambridgeshire is less deprived and South Cambridgeshire has remained the same as in 2007.

4.2.7 What are the gaps in knowledge/services/areas for development?

- The IMD analysis describes deprivation at LSOA level but more information about smaller areas of deprivation is required.
- Individual domains in the IMD are described in more detail in The Wider Determinants of Health section of this document.

4.3 Economic

What do we Know?

4.3.1 Introduction

- Economic wellbeing is assessed primarily through indicators relating to employment (defined as the involuntary exclusion of the working age population from the labour market). The indicators below describe the allowances and benefits that are being claimed by those who are unemployed and reflect levels of income.
- Household income is another measure of economic deprivation and information is secured through PayCheck profiles. This is derived from UK postcodes using information from lifestyle surveys, census and market research.
- Access to Free School Meals (FSMs) is used as a proxy for economic wellbeing. Children are entitled to FSMs if their parents/carers receive any of benefits and if their income does not exceed a threshold.
- Level of debt is also regarded as an indicator of economic wellbeing. The Cambridgeshire Citizens Advice Bureau provided information for this JSNA.

- The affect of economic deprivation can be demonstrated across a range of poor health outcomes. *The Marmot Review Report (2010)*¹⁰ provides the evidence through an analysis of economic deprivation on morbidity and mortality. Unemployment, poorly paid employment and unhealthy working environments (see Workplace Health) are identified as being important economic variables for determining the health of populations. As a consequence of economic deprivation populations experience deprivation across a number of social variables.

4.3.2 Figures and Trends

Unemployment and Jobseeker's Allowance Claimants

- Between October 2009 and September 2010, the unemployment rate for economically active (working and seeking work) people aged 16 and over was estimated in Cambridgeshire at 5.1%, which was lower than the England average of 7.7%. Only one of the county's districts had an unemployment rate estimated as similar to the national average: Fenland at 7.6%. There has been an increase, however, in all districts in the number unemployed between 2007 and 2010.

Table 22: Unemployment Rate, Economically Active Resident Population Aged 16+

Area	Oct 2007-Sep 2008		Oct 2008-Sep2009		Oct 2009-Sep 2010	
	Number	%	Number	%	Number	%
Cambridge	2,800	4.5	3,100	4.7	3,700	5.3
East Cambridgeshire	1,400	2.9	2,100	4.7	2,200	4.9
Fenland	2,500	5.7	3,400	7.2	3,300	7.6
Huntingdonshire	3,200	3.4	4,900	5.5	5,200	6.0
South Cambridgeshire	2,200	2.9	3,000	3.8	3,200	4.1
Cambridgeshire	12,000	3.7	17,100	5.3	16,300	5.1
England	1,408,800	5.4	1,943,900	7.4	2,017,600	7.7

Source: Model-Based Estimates of Unemployment (for districts), Annual Population Survey, ONS, NOMIS.

Note: Rate – percentage of economically active population aged 16+.

- The number of people claiming Jobseeker's Allowance (JSA) is not an official measure of unemployment but it provides more up-to-date indicative figures of people who are seeking work. In March 2011, 2.2% of the working age population in Cambridgeshire were claiming JSA, which was at a lower level than the England average of 3.7% and lower than in 2009 when it was 2.5%. The claimant count rate was the highest in Fenland at 3.7%, equal to the national average. Between March 2009 and 2011, the claimant count rate in the county fell by 0.3 percentage points.

Table 23: Claimant Count, Resident Population Aged 16-64

Area	March 2009		March 2010		March 2011	
	Number	Rate	Number	Rate	Number	Rate
Cambridge	1,853	2.0	1,906	2.1	1,723	1.9
East Cambridgeshire	1,203	2.3	1,231	2.3	1,060	2.0
Fenland	2,211	3.9	2,297	4.1	2,072	3.7
Huntingdonshire	2,960	2.8	2,812	2.6	2,453	2.3
South Cambridgeshire	1,581	1.7	1,515	1.6	1,298	1.4
Cambridgeshire	9,808	2.5	9,761	2.4	8,606	2.2
England	1,272,858	3.8	1,333,659	4.0	1,246,554	3.7

Source: ONS, NOMIS.

Note: Rate – percentage of population aged 16-64. Rates for local authorities from 2010 onwards are calculated using the mid-2009 resident population aged 16-64.

¹⁰ *The Marmot Review Report, Fair Society, Healthy Lives*, M. Marmot. 2010

- In March 2011, the claimant count rates in Cambridgeshire were on average twice as high in the male population as in the female population: 2.9% and 1.4% respectively. Fenland had the highest rates in the county for both males and females. The data are in Table 24.

Table 24: Claimant Count by Sex, Resident Population Aged 16-64, March 2011

Area	Male		Female		Total	
	Number	Rate	Number	Rate	Number	Rate
Cambridge	1,219	2.5	504	1.2	1,723	1.9
East Cambridgeshire	735	2.8	325	1.2	1,060	2.0
Fenland	1,361	4.9	711	2.5	2,072	3.7
Huntingdonshire	1,682	3.1	771	1.5	2,453	2.3
South Cambridgeshire	880	1.9	418	0.9	1,298	1.4
Cambridgeshire	5,877	2.9	2,729	1.4	8,606	2.2

Source: ONS, NOMIS.

Note: Rate – Percentage of population aged 16-64. Rates for local authorities from 2010 onwards are calculated using the mid-2009 resident population aged 16-64.

- The claimant count rates are higher in 16-24 age group than in the other age groups: 3.2% compared with 2.2% in 25-49 group and 1.4% in 50-64 age group. In Fenland, the claimant count rate in the youngest age group is significantly higher than the county average at 7.7%.

Table 25: Claimant Count by Age Group, Resident Population Aged 16-64, March 2011

Area	Aged 16-24		Aged 25-49		Aged 50-64	
	Number	Rate	Number	Rate	Number	Rate
Cambridge	440	1.4	1,005	2.2	275	1.8
East Cambridgeshire	300	4.0	550	1.9	210	1.3
Fenland	685	7.7	1,080	3.8	305	1.6
Huntingdonshire	740	4.5	1,270	2.2	440	1.3
South Cambridgeshire	320	2.4	700	1.4	275	1.0
Cambridgeshire	2,485	3.2	4,605	2.2	1,510	1.4

Source: ONS, NOMIS.

Note: Rates for local authorities from 2010 onwards are calculated using the mid-2009 resident population aged 16-64.

- In March 2011, around a half of JSA claimants in Cambridgeshire were claiming for less than six months. Nearly 17% of claimants are in long-term unemployment, claiming benefits for over 12 months. Cambridge and Fenland both had higher proportions of claimants claiming for over six and 12 months.

Table 26: Claimant Count by Duration, Resident Population Aged 16-64, March 2011

Area	Claiming less than 6 months		Claiming for over 6 months and less than 12 months		Claiming for over 12 months	
	Number	% of claimants	Number	% of claimants	Number	% of claimants
Cambridge	775	45.0%	620	36.0%	330	19.2%
East Cambridgeshire	605	57.1%	305	28.8%	150	14.2%
Fenland	990	47.8%	690	33.3%	390	18.8%
Huntingdonshire	1,380	56.3%	695	28.3%	380	15.5%
South Cambridgeshire	745	57.4%	375	28.9%	180	13.9%
Cambridgeshire	4,485	52.1%	2,685	31.2%	1,435	16.7%

Source: ONS, NOMIS.

Note: Data rounded to nearest five.

Benefits

- In August 2010, 9.1% of the population aged 16-64 in Cambridgeshire were receiving key state benefits: Bereavement Benefit, Carer's Allowance, Disability Living Allowance, Incapacity Benefit, Severe Disablement Allowance, Income Support, Jobseeker's Allowance, Pension Credit and Widow's Benefit. The percentage of the population receiving benefits was the highest in Fenland at 15.7%, which was at a higher level than the England average of 14.3%.
- The percentage of people aged 16-64 claiming out-of-work benefits (includes the Jobseeker, ESA and Incapacity Benefits, Lone Parent and Others on income related benefit groups) was also highest in Fenland at 12.9%, above the national average of 12.0%, and lowest in South Cambridgeshire at 5.2%. Across Cambridgeshire 7.4% of people aged 16-64 were claiming out-of-work benefits in August 2010, down 0.4 percentage points from 7.8% in August 2009.

Table 27: Key Benefit Claimants - Working Age Client Group by Statistical Group, Local Authority, August 2010

Local Authority	Total number/ rate (proportion of population aged 16-64)	Statistical Group							
		Total Number	Job Seeker	ESA and Incapacity Benefits	Lone Parent	Carer	Others on Income Related Benefit	Disabled	Bereaved
Cambridge City	Number	7,100	1,720	3,450	790	330	220	480	110
	Rate	7.8	1.9	3.8	0.9	0.4	0.2	0.5	0.1
East Cambridgeshire	Number	4,390	990	1,880	500	390	160	380	100
	Rate	8.3	1.9	3.6	0.9	0.7	0.3	0.7	0.2
Fenland	Number	8,850	1,850	4,080	990	840	290	660	130
	Rate	15.7	3.3	7.3	1.8	1.5	0.5	1.2	0.2
Huntingdonshire	Number	9,890	2,230	4,210	1,040	910	360	890	230
	Rate	9.2	2.1	3.9	1.0	0.8	0.3	0.8	0.2
South Cambridgeshire	Number	6,280	1,180	2,810	670	540	170	740	190
	Rate	6.8	1.3	3.0	0.7	0.6	0.2	0.8	0.2
Cambridgeshire	Number	36,520	7,980	16,430	4,000	3,010	1,200	3,160	750
	Rate	9.1	2.0	4.1	1.0	0.8	0.3	0.8	0.2
England	Number	4,806,530	1,152,390	2,130,910	584,130	371,270	164,470	333,170	70,190
	Rate	14.3	3.4	6.3	1.7	1.1	0.5	1.0	0.2

Source: DWP Benefits, NOMIS.

Notes: Percentages of population receiving state benefits have been calculated using populations aged 16-64 for both men and women. Rates for local authorities from 2010 onwards are calculated using the mid-2009 resident population aged 16-64.

- Between August 2008 and 2010, the percentage of population receiving benefits increased by 0.9 percentage point in Cambridgeshire from 8.2% to 9.1%. The increase can be observed in all of the county's districts.

Table 28: Key Benefit Claimants - Working Age Client Group, Local Authority, August 2008-2010

Local Authority	August 2008		August 2009		August 2010	
	Number	Rate	Number	Rate	Number	Rate
Cambridge	6,570	7.4	7,310	8.1	7,100	7.8
East Cambridgeshire	3,770	7.2	4,490	8.5	4,390	8.3
Fenland	8,020	14.2	9,140	16.3	8,850	15.7
Huntingdonshire	8,510	7.9	10,240	9.5	9,890	9.2
South Cambridgeshire	5,490	6.0	6,480	7.0	6,280	6.8
Cambridgeshire	32,370	8.2	37,660	9.4	36,520	9.1
England	4,353,390	13.0	4,935,910	14.7	4,806,530	14.3

Source: DWP Benefits, NOMIS.

Notes: Percentages of population receiving state benefits have been calculated using populations aged 16-64 for both men and women. Rates for local authorities from 2010 onwards are calculated using the mid-2009 resident population aged 16-64.

- In August 2010, there were nearly 12,700 Incapacity Benefit or Severe Disablement Allowance working age claimants in Cambridgeshire. Fenland has the highest rate of such claimants, as can be seen in Table 29 below, and is higher than the England average.

Table 29: Incapacity Benefit/Severe Disablement Allowance, Working Age Client Group, August 2010

Area	Claimants	Population aged 16-64	Rate per 1,000
Cambridge	2,730	92,200	29.6
East Cambridgeshire	1,410	50,500	27.9
Fenland	3,200	52,700	60.7
Huntingdonshire	3,150	102,200	30.8
South Cambridgeshire	2,180	88,300	24.7
Cambridgeshire	12,670	385,900	32.8
England	1,661,740	32,256,500	51.5

Source: DWP Benefits, NOMIS, Mid-2010 population estimates: ONS.

Note: This data does not include claimants of Employment and Support Allowance (ESA). Working age restricts the analysis to males aged 16 to 64 and females aged 16 to 59.

- Between 2008 and 2010, both the numbers and rates of incapacity benefit claimants decreased in all of the county's districts, which was in line with the national trend.

Table 30: Incapacity Benefit/Severe Disablement Allowance, Working Age Client Group, Number and Rate Per 1,000 Working Age Population, August 2008 - August 2010

Local Authority	August 2008		August 2009		August 2010	
	Number	Rate per 1,000	Number	Rate per 1,000	Number	Rate per 1,000
Cambridge	3,420	39.6	3,030	34.3	2,730	29.6
East Cambridgeshire	1,760	35.3	1,560	31.1	1,410	27.9
Fenland	3,950	74.4	3,510	66.5	3,200	60.7
Huntingdonshire	3,800	37.2	3,430	33.7	3,150	30.8
South Cambridgeshire	2,590	29.7	2,370	27.0	2,180	24.7
Cambridgeshire	15,530	41.0	13,900	36.5	12,670	32.8
England	2,099,110	65.7	1,832,430	57.1	1,661,740	51.5

Source: DWP Benefits, NOMIS, Mid-2010 population estimates: ONS.

Note: This data does not include claimants of Employment and Support Allowance (ESA). Working age restricts the analysis to males aged 16 to 64 and females aged 16 to 59.

- Incapacity Benefit or Severe Disablement Allowance claimants diagnosed with mental and behavioural disorders account for 43% of the claimants in Cambridgeshire. This proportion is the highest in Cambridge at nearly 60% of claimants diagnosed with such disorders. Claimants diagnosed with diseases of the musculoskeletal system and connective tissue account for the second largest group at 16% of the claimants. This proportion is slightly higher in Fenland at 22% of the claimants. The data are in Table 31.

Table 31: Incapacity Benefit/Severe Disablement Allowance by Condition, Working Age Client Group, August 2010

Local Authority	Mental and behavioural disorders		Diseases of the musculoskeletal system and connective tissue		Diseases of the nervous system		Other conditions		Any condition/ Total	
	Number	% of total	Number	% of total	Number	% of total	Number	% of total	Number	% of total
Cambridge	1,590	58%	260	10%	200	7%	670	25%	2,730	100%
East Cambridgeshire	510	36%	240	17%	130	9%	530	38%	1,410	100%
Fenland	1,140	36%	700	22%	230	7%	1100	34%	3,200	100%
Huntingdonshire	1,210	38%	520	17%	300	10%	1110	35%	3,150	100%
South Cambridgeshire	940	43%	310	14%	200	9%	730	33%	2,180	100%
Cambridgeshire	5,400	43%	2,020	16%	1,060	8%	4200	33%	12,670	100%

Source: DWP Benefits, NOMIS.

Note: This data does not include claimants of Employment and Support Allowance (ESA).

Household Income

- The section looks at PayCheck data provided by CACI. It is an estimate of a household's income at postcode level. PayCheck models gross income before tax and covers income from every source, including investments, income support and welfare.
- The table below shows that in 2005-2009, the highest median household income was in South Cambridgeshire and the lowest was in Fenland. In 2009, the average median household income in England was £29,700. Map 2 shows Cambridgeshire wards by a percentage of households at the median household income below £20,000 in 2009. Fenland and Cambridge had more households with a gross income below £20,000.

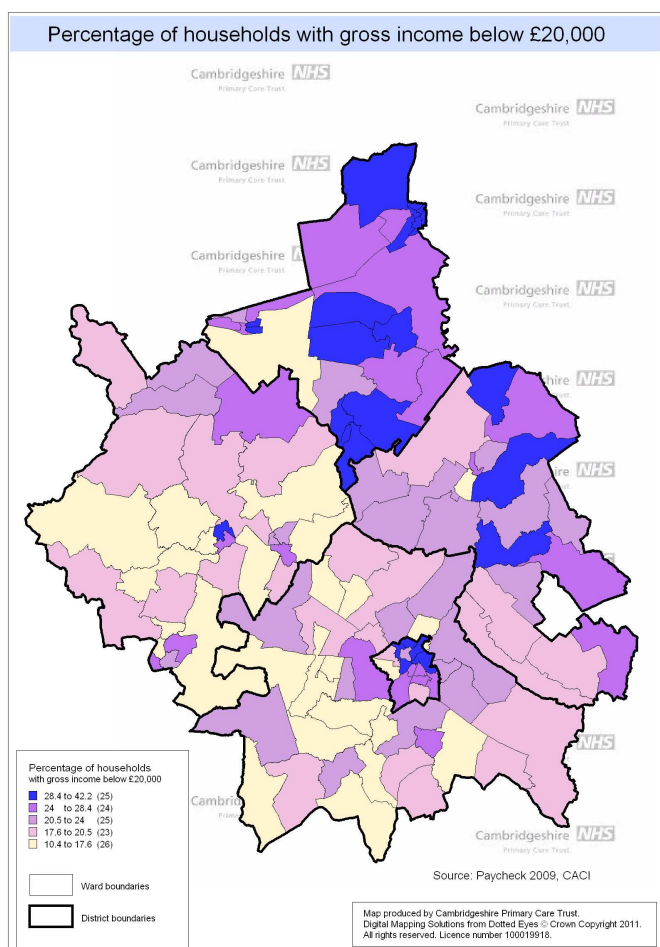
Table 32: Median Household Income, 2005-2009

Local Authority	2005	2006	2008	2009	
	Median income	Median income	Median income	Household (in total)	Median income
Cambridge	£27,600	£28,500	£29,700	48,554	£30,000
East Cambridgeshire	£29,300	£29,800	£31,900	35,576	£32,500
Fenland	£23,900	£25,300	£26,900	41,215	£27,500
Huntingdonshire	£31,100	£31,600	£34,000	72,742	£34,500
South Cambridgeshire	£33,500	£33,300	£35,400	58,439	£36,000
Cambridgeshire	£29,400	£30,000	£31,900	256,526	£32,500

Source: PayCheck 2009, CACI.

Note: The data are rounded to the nearest 100. 2007 data are not available.

Map 2: Cambridgeshire Wards – Percentage of Households with Gross Income Below £20,000.



Note: the darker colours show lower incomes.

Free School Meals (Proxy for Economic Deprivation)

- In January 2011, 10.4% of pupils' resident and learning in Cambridgeshire schools were eligible for Free School Meals (FSM). This was an increase of 1.7 percentage point in comparison to January 2009. Both the number and proportion of children eligible for FSM increased in all Cambridgeshire districts in the period.

Table 33: Pupils Living in Cambridgeshire who are on Roll at a Cambridgeshire School and Eligible for Free School Meals, 2009, 2010 and 2011 Pupil Level Annual School Census (PLASC)

Area	2009 PLASC			2010 PLASC			2011 PLASC		
	Total Number of Pupils	Number FSM Eligible	% FSM	Total Number of Pupils	Number FSM Eligible	% FSM	Total Number of Pupils	Number FSM Eligible	% FSM
Cambridge	10,597	1,413	13.3%	10,594	1,542	14.6%	10,732	1,508	14.1%
East Cambridgeshire	10,193	680	6.7%	10,355	860	8.3%	10,515	885	8.4%
Fenland	12,368	1,602	13.0%	12,283	1,833	14.9%	12,288	1,898	15.4%
Huntingdonshire	23,859	1,915	8.0%	23,819	2,288	9.6%	22,809	2,191	9.6%
South Cambridgeshire	18,745	960	5.1%	19,053	1,277	6.7%	19,259	1,369	7.1%
Cambridgeshire	75,762	6,570	8.7%	76,104	7,800	10.2%	75,603	7,851	10.4%

Source: Cambridgeshire County Council, LGSS, PLASC data.

Note: One Huntingdonshire school did not provide any data relating to their pupils in the January 2011 PLASC. This has an effect on numbers in Huntingdonshire in the 2011 sheet and thus on any comparisons with previous years figures.

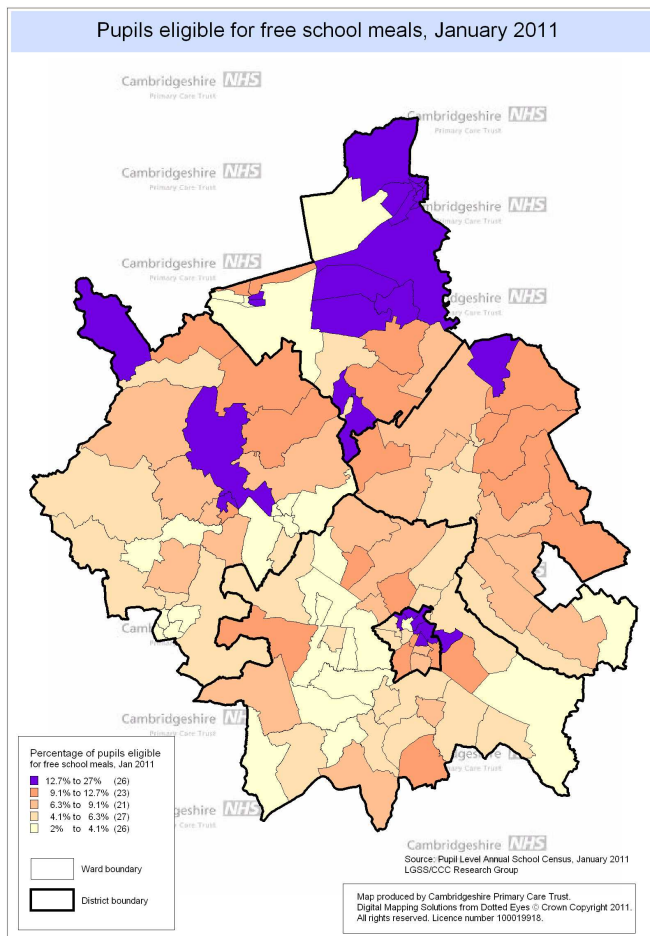
- In some of the county's wards the proportion of pupils eligible for Free School Meals was more than twice the county's average. Table 34 below shows wards where more than 20% of pupils were eligible for Free School Meals in January 2009, 2010 and 2011.

Table 34: Cambridgeshire Wards by Highest Percentage of Children Eligible for Free School Meals, 2009, 2010 and 2011 Pupil Level Annual School Census (PLASC)

2009 PLASC			2010 PLASC			2011 PLASC		
Ward	Number FSM Eligible	% Eligible	Ward	Number FSM Eligible	% Eligible	Ward	Number FSM Eligible	% Eligible
Waterlees	253	27.9%	Waterlees	271	29.8%	Staithe	88	26.9%
Huntingdon North	322	24.6%	Huntingdon North	369	28.0%	Huntingdon North	366	26.7%
East Chesterton	257	23.5%	Abbey	308	25.4%	Waterlees	232	26.6%
Abbey	279	23.2%	East Chesterton	278	25.1%	Abbey	302	24.4%
Staithe	74	21.6%	Elm and Christchurch	130	22.7%	Elm and Christchurch	138	24.0%
Clarkson	63	20.2%	King's Hedges	246	22.6%	King's Hedges	258	23.1%
			Staithe	76	22.6%	East Chesterton	241	21.7%

Source: Cambridgeshire County Council, LGSS, PLASC data.

Map 3: Cambridgeshire Wards - Pupils Eligible for Free School Meals, January 2011



Note: darker shading shows more pupils with free school meals.

Debt

- The following is information from the Cambridgeshire Citizens Advice Bureau (CAB). Increasing levels of debt is regarded as an indicator for increased economic deprivation.

Table 35: Number and Increase in Debt Issues Raised by Clients Between Q1 2008 and Q1 2009

	Q1 08/09	Q2 08/09	Q3 08/09	Q4 08/09	Q1 09/10	% increase between Q1 2008 and Q1 2009
Fuel debts	210	269	259	372	373	78%
Debt issues	5972	5996	6160	7557	7638	28%
Job Seekers Allowance	217	318	440	613	617	184%

Source: Citizens Advice Bureau

Table 35 indicates key areas of advice between Q1 2008 and Q2 2009 recorded for the four Cambridgeshire Bureaux. All demonstrate increases in demand for debt related advice.

Table 36: Key statistics from Cambridge CAB Specialist Debt workers - comparators of debt issues over a five year period

	2006/7	2007/8	2008/9	2009/10	2010/11
Benefit overpayment	£ 78,538.37	£ 73,653.00	£ 129,319.78	£ 192,825.32	£ 166,364.52
Business debt	£ 2,634.07	£ 36,788.30	£ 73,471.79	£ 100,070.60	£ 138,989.81
Cable/satellite/digital TV	£ 832.19	£ 1,589.95	£ 1,058.83	£ 11,281.26	£ 9,813.33
Cable/Satellite/Digital TV (essential)			£ 37.00	£ 72.00	
Catalogue/Mail Order	£ 85,273.87	£ 162,317.48	£ 149,029.92	£ 253,215.21	£ 170,254.44
Child Support/Maintenance arrears	£ 460.00	£ 7,711.77	£ 5,510.84	£ 62,655.97	£ 22,618.60
Council Tax arrears	£ 48,399.94	£ 114,751.40	£ 95,432.75	£ 224,372.01	£ 282,895.43
Credit card	£ 651,904.60	£ 1,794,708.40	£ 1,252,640.91	£ 3,350,308.78	£ 2,350,870.36
Credit union loan			£ 12,964.00	£ 51,874.09	£ 45,980.07
Debt secured by bill of sale					£ -
Debt to friends or relatives			£ 12,944.55	£ 76,890.00	£ 97,209.00
Electricity	£ 10,658.53	£ 25,175.43	£ 18,823.95	£ 63,211.92	£ 50,969.90
Former tenancy arrears			£ 12,127.09	£ 23,311.61	£ 34,673.03
Gas	£ 4,311.37	£ 17,035.57	£ 22,893.26	£ 43,237.82	£ 35,080.01
Hire purchase/Conditional Sale	£ 85,401.14	£ 120,415.17	£ 108,234.68	£ 94,516.20	£ 112,401.02
Income Tax/NI arrears	£ 30,250.43	£ 48,986.99	£ 42,966.50	£ 94,132.46	£ 202,701.10
Loan Shark debt				£ 3,208.00	£ 526.93
Magistrates Court fine	£ 4,159.63	£ 9,591.91	£ 18,627.90	£ 18,526.34	£ 19,009.70
Mobile Phone	£ 9,668.37	£ 14,230.61	£ 11,808.00	£ 43,307.18	£ 41,236.46
Mortgage arrears	£ 118,415.94	£ 530,994.02	£ 198,324.31	£ 859,138.82	£ 1,665,462.14
Mortgage shortfall debt	£ 16,624.74	£ -		£ 230,530.18	£ 1,225,535.81
Other	£ 67,693.97	£ 153,826.44	£ 207,540.67	£ 1,179,306.95	£ -
Overdraft			£ 117,231.40	£ 563,011.75	£ 493,838.05
Parking/traffic penalty charges	£ 95.00	£ 5,526.36	£ 4,806.60	£ 5,859.53	£ 6,630.63
Pawnbroker					£ 2,300.00
Rent arrears	£ 51,560.75	£ 75,257.54	£ 76,911.14	£ 172,410.07	£ 171,826.94
Secured loan arrears	£ 861,649.78	£ 61,849.71	£ 99,399.64	£ 400,475.16	£ 283,499.18
Social fund loan	£ 3,125.42	£ 5,825.36	£ 7,254.91	£ 4,881.87	£ 13,422.72
Store card	£ 78,387.09	£ 165,106.04	£ 52,552.36	£ 136,424.68	£ 134,870.59
Student loan company/fees	£ 5,330.17	£ 8,101.68	£ 20,197.37	£ 67,722.02	£ 59,665.45
Telecom packages (TV, phone and internet)			£ 2,054.05	£ 27,023.94	£ 29,110.13
Telecom packages (TV, phone, internet)			£ 1,014.00		£ -
Telephone	£ 15,305.38	£ 43,352.69	£ 30,204.32	£ 34,518.70	£ 30,052.06
Telephone (essential)			£ 124.98	£ 220.82	£ 1,199.40
Unsecured loan	£ 1,099,744.32	£ 2,290,094.07	£ 2,415,291.25	£ 4,191,986.81	£ 3,422,575.28
Water rates arrears	£ 20,891.13	£ 46,858.74	£ 43,023.38	£ 124,593.82	£ 114,920.53
Not Recorded	£ 551,034.00	£ 668,975.88	£ 1,057,659.25		£ -
	£ 3,902,350.20	£ 6,482,724.51	£ 6,301,481.38	£ 12,705,121.89	£ 11,436,502.62
	198	474	450	797	751

Source: Cambridge Citizens Advice Bureau.

- Table 36 indicates that whilst debt issues have risen rapidly over the five year period they have stopped rising in some areas over the last year, and currently they have plateaued out. This is in line with national trends. This is possibly because credit is harder to obtain.
- Certain types of debt that have increased significantly are council tax arrears, income tax/national insurance arrears, mortgage arrears and shortfall, rent arrears – all debts that can lead to homelessness and severe penalties. The impact of the increase in VAT, and fuel prices is yet to properly filter through.
- National CAB statistics indicate that Council Tax arrears is now the third highest debt recorded and fuel debts have overtaken mortgage arrears in the league table of recorded debts. Cambridgeshire is following the trend.
- A summary of the analysis of the CAB information focusing on those types of debt, which are directly relevant to the working age population (although they may also affect other people, especially children) identified the following key issues. Together these figures show an extremely large increase in the amount of money owed by those who go to Cambridge CAB for debt advice.
 - Credit card debt advice has increased from £651,904 in 2006/07 to £2,350,870 in 2010/11, an increase of 260%.
 - Electricity debt advice has increased from £10,658 in 2006/07 to £50,969 in 2010/11, an increase of 378%.

- Gas debt advice has increased from £4,311 in 2006/07 to £35,080 in 2010/11, an increase of 713%, though it has come down from a peak of £43,237 in 2009/10.
- Mortgage arrears debt advice has increased from £118,415 in 2006/07 to £1,665,462 in 2010/11, a tenfold increase (1,306%).
- Mortgage shortfall debt advice has increased from £16,693 in 2006/07 to £1,225,535 in 2010/11, a seventyfold increase of 7,241%.
- Overdraft debt advice has increased from £117,231 when it first appears in the figures in 2008/09 to £493,838 in 2010/11, an increase of 321%.
- Unsecured loan debt advice has increased from £1,099,744 in 2006/07 to £3,422,575 in 2010/11, an increase of 211%.
- Pawnbroker debt advice appears for the first time in 2010/11 figures.

4.3.3 Local Views

District and City Authorities undertake their own economic assessments which indicate the key economic potential and disadvantages. The following describes the key issues for some of the Cambridgeshire authorities.

South Cambridgeshire

South Cambridgeshire District Council referred to its commissioned economic assessment and strategy which identifies its economic infrastructure strengths:

- In March 2009, Public and Corporate Economic Consultants (PACEC) were commissioned by South Cambridgeshire District Council (SCDC) to produce an economic assessment of the district and develop a strategy for SCDC working with its partners up to 2015. The report of this work can be found through the following link. http://www.scambs.gov.uk/documents/retrieve.htm?pk_document=909415

East Cambridgeshire

East Cambridgeshire District Council has identified the following concerns relating to its economic development.

- There has been an overall increase in the benefits being claimed between 2007 and 2010. The rate of Job Seeker Allowance claimants in East Cambridgeshire increased from 2.9% in 2007 to 4.9% in 2010. Overall benefit claims in the area increased from 7.2% in 2008 to 8.3% in 2010.
- East Cambridgeshire's labour demand is not as high as its available workforce, with a jobs-to-working age population ratio of 0.66. This was identified in the 2007 Jobs Density figures.

Fenland

Fenland District Council has identified the following key issues for the area's economic development.

- The decline of retail is a threat to Fenland as this sector has expanded in recent years in other areas of the county.

- The poor infrastructure in Fenland and the high level of attention given to traffic congestion in the south of the county presents a threat; there is a risk that links between Fenland and the rest of the county will deteriorate – particularly as the new LEP concentrates on links between the south of the county and Peterborough.
- Fenland has a lower proportion of people employed in high value occupations, whereas the rest of the county has a higher proportion of people employed in these jobs – around 20% of the county's residents are employed in professional occupations, compared to only 8% in Fenland.
- Nearly a third of Fenland residents commute to Peterborough or Huntingdon to work. Analysis of workplace against residential earnings in Fenland suggests that workers commute out of the district to lower-paid, lower-value jobs, while higher value jobs are taken by people commuting into the district.
- Around a third of households in Fenland have an income below £20,000. The rate of increase in wages over the last five years has been slower in Fenland than elsewhere in the county, and females on average earn only two thirds of what males earn in the district.
- Inequalities in levels of pay are increasing between the north and south of the county – median weekly pay is around 50% higher in South Cambridgeshire than in Fenland, and the gap has doubled in size since 2002.
- In Cambridgeshire there is a greater disparity between the pay of men and women than nationally. This is most prominent in Fenland.
- Fenland has a large workless population, providing plenty of labour supply in the medium term, although generally the workless population in Fenland are low-skilled and, therefore, people looking for work generally do not have the skills required for businesses seeking to grow.
- Skill levels in Fenland have remained relatively consistent since 1999; levels in most other areas have risen. In national ranks, Cambridge City has the fifth highest proportion of people qualified to degree level (55%) and Fenland has the fourteenth lowest (16%). A higher proportion of people in Fenland have no qualifications than the national average, and fewer people are qualified to levels 2, 3 and 4 than seen regionally or nationally (see Education and Skills Section).
- The proportion of people in an area with access to more than 500 jobs by public transport, walking or cycling in a 'reasonable' period of time affects access to job markets. Only 76% (compared to 86% in Cambridge City and 79% across Cambridgeshire) are able to access employment in 500 or more jobs within a reasonable time by public transport. This is likely to have much more of an impact in Fenland than other rural areas in the county due to the higher proportions of people (~20%) who do not have access to their own transport.
- There are 2% fewer part-time jobs available in Cambridgeshire compared to national proportions, and the proportion of part-time jobs is particularly low in Fenland, which may make it difficult for those with personal commitments to enter the labour market, particularly women, parents and carers.
- Overall job growth in all Cambridgeshire districts has exceeded the national rate since 2000, although Fenland saw a considerable drop between 2006 and 2008, to fall to the lowest percentage change in the county.
- Fenland has only half the regional proportion of knowledge-intensive workers, at 6% (against 20% in Cambridge City). Creative, high technology and bio technology industries are seen as a key growth sector for the future – Cambridgeshire has a higher proportion of these types of industry, but the proportion is low in Fenland.

- In 2008, Fenland saw a greater number of business deaths than business births, with the lowest birth rate in the county and the highest death rate (note business births are defined as businesses registering for either VAT or PAYE). Fenland had the lowest rate of business births per 10,000 adults in 2008, at only 38.0, compared to over 60 in South Cambridgeshire and a county average of 50.2.

Huntingdonshire

Huntingdonshire District Council has identified the following issues for the area's economic development:

- Relatively high attainment levels, with higher than average proportions qualified to NVQ level 4 and above. However, there are areas of educational disadvantage and significant concentrations of young people not in education, employment or training. Nine of Huntingdonshire Lower Super Output areas are ranked as within the 20% most deprived in the country in terms of education.
- A relatively skilled workforce currently working within lower value industries. However, there is an Intermediate level skills shortage, particularly in technical and skilled trade occupations. In addition there is out commuting of higher skilled workers.
- Relatively high resident wages but with areas of low income in north Huntingdon and north of St Neots.
- A relatively large benefit claiming population reducing the overall economic activity rate in the district.
- Relatively poor accessibility to jobs reflects the district's rural nature.
- Unemployment generally low, yet the recession has reinforced disparities within the district.
- A diverse economy with significant hi-tech employment and industrial strengths in manufacturing and agriculture.
- Relatively high and increasing business density. Business population dominated by smaller businesses, however jobs growth is strong and jobs density is increasing.
- High levels of traffic congestion on the A14 and within Huntingdon town centre may have a significant impact on business productivity.
- Low likelihood of next generation broadband access could restrict future business growth and the ability of residents to work from home.

4.3.4 Evidence/Policy

Health and Socio-economic Status

*The Marmot Review Report, Fair Society, Healthy Lives (2010)*¹¹ provides clear evidence of the effect of economic deprivation upon health.

- Mortality in routine and manual socio-economic groups is more than three times higher than managerial and professional groups.
- People living in poorer areas will die on average seven years earlier than those living in richer areas.
- Limiting long term illness by age and socio-economic deprivation indicates that those in routine and semi-routine (more poorly paid) jobs have illness rates comparable to those aged 65 in the managerial and professional classes.

¹¹ *The Marmot Review Report, Fair Society, Healthy Lives*, M. Marmot. 2010

- Disability Free Life Expectancy (DFLE) refers to the number of years spent free from disability. People in lower socio-economic groups have shorter lives but they also spend more of their later years with disability.

Policy

Marmot's comprehensive evidence is complemented by some clear policy objectives and recommendations to address the employment and income issues that create economic deprivation. Good employment is identified as being protective of health and conversely unemployment or being poorly paid contributes to poor health.

Priority Objectives

The review identifies three priority objectives for employment and income.

<p>Employment</p> <ul style="list-style-type: none"> • To improve access to good jobs and reduce long term unemployment across the social gradient. • Make it easier for people who are disadvantaged in the labour market to obtain and keep work. • Improve quality of jobs across the social gradient.
--

<p>Income</p> <ul style="list-style-type: none"> • Establish a minimum income for healthy living for people of all ages. • Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies. • Reduce the cliff edges faced by people moving between benefits and work.

NB: The social gradient here describes the relationship between socio-economic characteristics and health outcomes. That is as socio economic status increases better health outcomes are observed. The gradient analysis can be applied to education, occupation and housing. Marmot summarises it as 'the higher one's social position the better one's health is likely to be'.

Recommendations

Marmot produced policy recommendations for employment and income for three separate time periods. The following apply for 2011-2015.

Employment

- Develop active labour market programmes to achieve timely interventions to reduce long term unemployment.
- Encourage, incentivise and, where appropriate, enforce the implementation of measures to improve the quality of work across the social gradient including
 - Ensuring that public and private sector employers adhere to equality guidance and legislation;
 - Implementing guidance on stress management and the effective promotion of wellbeing and physical and mental health at work.
- Develop greater security and flexibility in employment by
 - Improving flexibility of retirement age
 - Encouraging employers to create or adapt jobs that are suitable for one parent, carers and people with mental and physical problems.

Income

- Develop standards for minimum income for healthy living.
- Review the role of tax and benefit systems to facilitate adherence to minimum income for healthy living standards.
- Conduct a review of the systems of taxation, benefits, pensions and tax credits to achieve the reduction of “cliff edges” faced by those in and out of work and facilitate flexibility of employment.

What is this Telling Us?

4.3.5 What are the Key Inequalities?

- The economic indicators consistently identify Fenland as having higher levels of economic deprivation than the rest of the county. This is in terms of employment, income and across the range of benefits.
- This geographical inequality is reflected in the economic infrastructure and opportunities for development. This is particularly apparent in terms of education and skills, (refer to Lifelong Learning Section), business and transport.
- Within Fenland, men are more highly paid than women, creating another tier of inequality.
- Refer to Section on Vulnerable Groups for further population group inequalities.

4.3.6 What are the Gaps in Knowledge/Services/Areas for Development?

- More information is required about workplace health and the prevention and health improvement programmes that exist in workplaces across the county (see Workplace Health Section).
- A better understanding of the employment needs of vulnerable groups including carers, lone parents, marginalised groups and mental ill-health sufferers. This includes identifying the existing services that are in place to identify their needs and provide support.

4.4 Housing

What do we Know?

Please note the following:

- Housing data for specific population groups is not currently available.
- This section should be considered along with the *Homelessness and the at the risk of Homelessness and New Communities JSNA*.

4.4.1 Introduction

The effect of housing upon health is well documented. The key associated factors are: housing conditions (including fuel poverty), overcrowding and the availability of affordable housing. This section presents information on these aspects of housing and their relationship to health.

In Cambridgeshire, the housing function sits within the five district councils. This includes the management of the social rented housing needs register, providing housing options advice, discharging the homelessness duties, licensing houses in multiple occupancy (HMOs), working with local social and private landlords to address housing issues etc. Other district level functions of relevance to housing are environmental health (monitoring and addressing housing quality issues) and planning (negotiating with developers over the type of housing built within the district and the infrastructure which supports it).

Because housing markets are not contiguous with district boundaries, district councils in Cambridgeshire work together (along with Forest Heath District Council and St Edmundsbury Borough Council) on a number of housing issues. For example, a shared housing register and Strategic Housing Market Assessment.

www.cambridgeshirehorizons.co.uk/shma

This chapter refers to a number of assessment processes that provide information about the housing stock and housing needs. The following provides a guide to the assessments that are used in this document.

- Local House Condition Survey (LHCS)

These are carried out approximately every five years by each district authority and the results are used as a basis for the funding required to shape private sector housing strategies and policies. They are commissioned by local authorities.

- The English Housing Survey

Takes place every year, commissioned by the government, and is useful for looking at national trends in housing. Previously two reports, the Survey of English Housing and the English Home Condition Survey, it was combined in 2008/09 see

<http://www.communities.gov.uk/housing/housingresearch/housingsurveys/englishhousingsurvey/>

- Private Sector Housing

Private Sector Housing is housing not owned by the local authority, and includes housing owned by Registered Social Landlords (RSLs).

- Housing Health and Safety Rating System (HHSRS).

The Housing Health and Safety Rating System (HHSRS) is a risk based evaluation tool to help local authorities identify and protect against potential risks and hazards to health and safety from any deficiencies identified in dwellings. It was introduced under the Housing Act 2004 and came into effect in April 2006. It applies to residential properties in England.

The HHSRS assesses 29 categories of housing hazard, each hazard has a weighting which will help determine whether the property is rated as having Category 1 (serious) or Category 2 (other) hazards. The operating guidance can be found at <http://www.communities.gov.uk/publications/housing/hhsrsoperatingguidance>

- Decent Homes Standard

A property meets the Decent Homes Standard if it is free from Category 1 hazards, has a reasonable level of thermal comfort, is in a good state of repair and has reasonably modern facilities. Decent Homes Standard is usually applied to social that is, council and housing association - housing.

- Fuel Poverty

A household is classed as “fuel poor” if they are spending more than 10% of gross income to maintain a satisfactory heating regime (between 18 and 21°C). This definition is currently under review.

- Energy Efficiency

The Standard Assessment Procedure (SAP) is the UK Government's recommended method for measuring the energy rating of residential dwellings. Homes are assessed to establish whether they have effective heating and effective insulation and are rated against a scale which determines if there is a hazard from excess cold.

- Strategic Housing Market Assessment (SHMA)

The SHMA provide details on the local housing market, the need for new housing and the need for affordable housing. The Cambridge sub-regional SHMA (covering Cambridgeshire, Forest Heath and St Edmundsbury) is available at www.cambridgeshirehorizons.co.uk/shma. Government guidance relating to SHMAs is available at <http://www.communities.gov.uk/publications/planningandbuilding/strategichousingmarket>

4.4.2 Figures and Trends

Housing Standards in Private Sector Housing

- In 2009/10, Cambridge, East Cambridgeshire and Fenland had the highest rates of dwellings with Category 1 hazards under the HHSRS. Huntingdonshire had the highest rate of dwellings in the private sector made free from Category 1 hazards as a result of the authority's action.
- In terms of energy efficiency of private sector housing, Huntingdonshire had the lowest proportion of energy inefficient dwellings and the highest rate of Decent Homes Activity.

Condition of Dwelling Stock by Local Authority, April 2010

- In 2009/10, none of the dwellings owned by Cambridgeshire local authorities or those transferred to housing associations had Category 1 hazards under the HHSRS. Only Cambridge and South Cambridgeshire retain ownership of their housing stock. East Cambridgeshire, Fenland and Huntingdonshire have transferred stock to housing associations: Sanctuary Hereward in East Cambridgeshire; Roddons in Fenland and Luminus in Huntingdonshire.

- Overall, Cambridge had the highest number of dwellings (excluding local authority stock) with Category 1 hazards (9,000 in total). The rate per 1,000 homes was lowest in Huntingdonshire and South Cambridgeshire as shown in Table 37.

Table 37: Condition of Dwelling Stock by Local Authority, April 2010

Local Authority	Total number of dwellings owned by LA	Dwellings with Category 1 hazards	Total number of dwellings within LA area	Dwellings within LA area with Category 1 hazards	Rate per 1,000 dwellings
Cambridge	7,364	0	48,905	9,000	184.0
East Cambridgeshire	0	0	35,360	6,808	192.5
Fenland	0	0	42,286	7,227	170.9
Huntingdonshire	0	0	71,035	1,700	23.9
South Cambridgeshire	5,427	0	60,657	2,250	37.1

Source: Housing Strategy Statistical Appendix 2010.

Note: Dwellings not owned by the local authority includes those owned by: Registered Social Landlords (RSL), 'Other' Public sector or Private sector (non RSL).

Condition of Dwelling Stock in Private Sector Housing, April 2010

- Table 38 compares the estimated number of private dwellings with Category 1 hazards, which were made free from such hazards, between 1 April 2009 and 31 March 2010.
- In 2009/10, Huntingdonshire had the highest rate of private owned dwellings made free from Category 1 hazards as a direct result of the authority's action at 65.5 per 1,000 private dwellings. Cambridge and South Cambridgeshire had the lowest rates of such actions: 4.6 and 6.7 per 1,000 dwellings respectively.

Table 38: Dwellings with Category 1 Hazards Made Free From Those Hazards as a Direct Result of Action, Local Authority, April 2010

Local Authority	Private Dwellings (non RSL) within LA area with Category 1 Hazards	Private Dwellings made free from Category 1 Hazards	Rate per 1,000 Dwellings
Cambridge	9,000	41	4.6
East Cambridgeshire	6,808	232	34.1
Fenland	7,227	123	17.0
Huntingdonshire	1,100	72	65.5
South Cambridgeshire	2,250	15	6.7

Source: Housing Strategy Statistical Appendix 2010.

Decent Homes Activity for 2009/10

- In 2009/10, 317 homes classified as 'non-decent' in private housing received assistance to become decent or were cleared or demolished in Cambridgeshire. The average rate was 12 per 1,000 dwellings. The rate was markedly highest in Huntingdonshire (122.7 per 1,000 dwellings). It was the lowest in Fenland at 1.2 per 1,000 dwellings. It should be noted that much of the activity in this table is likely to relate to homes occupied by older people rather than those of working age.
- It should also be noted that this comparison does not reflect the different starting points. For example, the condition of much of Fenland's housing stock is poor due to long term lack of investment by owners, which reflects the deprivation in this area.

Table 39: Private Sector Housing (non RSL), Decent Homes Activity for 2009/10 by Local Authority, April 2010

Local Authority	Total number of dwellings improved	Total number of dwellings demolished	Grand total (dwellings improved and dwellings demolished)	Dwellings with Category 1 hazards in private sector housing	Rate per 1,000 dwellings
Cambridge	14	0	14	9,000	1.6
East Cambridgeshire	80	31	111	6,808	16.3
Fenland	9	0	9	7,227	1.2
Huntingdonshire	135	0	135	1,100	122.7
South Cambridgeshire	48	0	48	2,250	21.3

Source: Housing Strategy Statistical Appendix 2010.

Energy Efficiency

- In 2009/10 the average Standard Assessment Procedure (SAP) rating in private sector (non RSL) dwellings in Cambridgeshire was between 51 and 57. The proportion of dwellings with a SAP rating below 35 (on a scale 1 to 100), which indicates a low level of energy efficiency was highest in East Cambridgeshire at 18%. This proportion was lowest in Huntingdonshire at 6% of private sector dwellings.

Table 40: Energy Efficiency in Private Sector (non RSL) Housing, April 2010

Local Authority	Average SAP rating of the private sector (non RSL) dwellings	Percentage of private sector (non RSL) dwellings with a SAP rating below 35
Cambridge	51	12%
East Cambridgeshire	51	18%
Fenland	53	14%
Huntingdonshire	57	6%
South Cambridgeshire	54	14%

Source: Housing Strategy Statistical Appendix 2010.

Fuel Poverty

- Fuel poverty, where more than 10% of income is spent on heating, is linked to general poverty but is also affected by energy prices and energy efficiency. In 2003, a national report of fuel poverty was produced www.fuelpovertyindicator.co.uk. This map indicated that fuel poverty was generally more significant in the north of the country than in the south and East Anglia. It showed a low proportion of households in Cambridgeshire living in fuel poverty compared to other parts of the country with an estimated 13,154 households in fuel poverty based on full income or 6% of households. There were instances where fuel poverty was a significant issue, mostly in Fenland and Huntingdonshire.
- In 2010 Department of Energy and Climate Change (DECC) estimated that the national fuel poverty rate of 11.5% of households in 2006 had increased to 15.6% in 2008.¹² This is despite government targets and a range of initiatives aimed at reducing fuel poverty. Domestic energy prices have doubled over the same period. It was estimated that in 2008 there were 35,617 fuel poor households in Cambridgeshire (11.5%). Although the proportion of fuel poor households in Cambridgeshire is lower than across England (15.6%) there are areas in the county where this proportion is substantially higher.

¹² 2008 Sub-Regional Fuel Poverty Methodology and Documentation. Department of Energy and Climate Change (DECC) (2011)

- The levels of fuel poverty in the districts are found in Table 41 and the Lower Super Output Areas where a proportion of the fuel poor households is above 20% is provided in Table 42. Most of those areas are in Fenland and East Cambridgeshire.

Table 41: Percentage of Households in Fuel Poverty 2008

Local Authority	% Fuel Poverty
Cambridge City	11.7%
East Cambridgeshire	12.9%
Fenland	15.3%
Huntingdonshire	9.6%
South Cambridgeshire	10.7%
Cambridgeshire	11.5%

Source: Department of Energy and Climate Change (DECC).

http://www.decc.gov.uk/en/content/cms/statistics/fuelpov_stats/regional/regional.aspx

Table 42: Cambridgeshire LSOA with the Percentage of Households with Fuel Poverty Above 20%

LSOA Code	Ward Name	LA Name	Estimated number of households	Estimated number of households in fuel poverty	% of households fuel poor
E01018095	Roman Bank	Fenland	682	212	31.1%
E01018068	Elm and Christchurch	Fenland	570	158	27.7%
E01018090	Parson Drove and Wisbech St Mary	Fenland	693	185	26.7%
E01018092	Parson Drove and Wisbech St Mary	Fenland	681	179	26.3%
E01018196	Somersham	Huntingdonshire	485	126	26.0%
E01018091	Parson Drove and Wisbech St Mary	Fenland	532	137	25.8%
E01017982	Market	Cambridge	441	112	25.4%
E01018220	Balsham	South Cambridgeshire	550	138	25.1%
E01017981	Market	Cambridge	489	119	24.3%
E01018059	Benwick, Coates and Eastrea	Fenland	532	127	23.9%
E01018097	Roman Bank	Fenland	593	138	23.3%
E01018111	Wimblington	Fenland	878	201	22.9%
E01018247	Gamlingay	South Cambridgeshire	609	138	22.7%
E01018076	Manea	Fenland	815	181	22.2%
E01017986	Newnham	Cambridge	416	89	21.4%
E01018020	Downham Villages	East Cambridgeshire	579	124	21.4%
E01018157	Ramsey	Huntingdonshire	761	162	21.3%
E01018023	Dullingham Villages	East Cambridgeshire	878	186	21.2%
E01018024	Ely East	East Cambridgeshire	546	113	20.7%
E01018115	Brampton	Huntingdonshire	548	113	20.6%
E01018005	Trumpington	Cambridge	903	183	20.3%
E01018128	Elton and Folksworth	Huntingdonshire	521	105	20.2%

Source: Department of Energy and Climate Change (DECC),

http://www.decc.gov.uk/en/content/cms/statistics/fuelpov_stats/regional/regional.aspx

Note (after DECC): The results contained in this spreadsheet showing 2008 fuel poverty at detailed geographical areas are an estimated disaggregation of the (already published) 2008 national and regional fuel poverty levels. Users of the data are reminded that the sub-regional data is approximate, modelled based on a range of data sets and underlying assumptions.

- The most recent DECC report details changes in national figures and puts fuel poverty at 21%.¹³ Nationally, 49% of households are aged over 60 with the remainder being households containing children and people of working age. As fuel poverty is linked to economic wellbeing vulnerable groups, those on low incomes including the unemployed are particularly susceptible. The DECC report states that vulnerable group households experiencing fuel poverty had increased from 1 million in 2003 to 3.2 million in 2009.

Living Environment Deprivation

- This is part of the Index of Multiple Deprivation 2010. It looks at deprivation in relation to the indoor and outdoor living environment. The indoor living environment covers housing in poor condition and houses without central heating. The outdoors living environment covers air quality and road traffic accidents which involve injury to pedestrians and cyclists.
- None of Cambridgeshire's Lower Super Output Areas fall among the most deprived 10% nationally. Less than 3% of the county's LSOAs are in the 20% most deprived nationally (that is, ten out of 365 LSOAs in Cambridgeshire). Those ten areas are all in Cambridge and Fenland. It is estimated that 12.2% of all age population in Cambridge live in the 20% most deprived living environment areas in England (nearly 15,000 people in total). In Fenland this proportion is 4.3%. The data are shown in Table 43.

Table 43: Total Population Living in the 20% most deprived Living Environment Areas in Cambridgeshire

Local Authority	Total population living in the 20% most deprived nationally on the Living Environment Deprivation	Total population (all ages)	Proportion of population in each district that lives in 20% most deprived nationally
Cambridge	14,810	121,140	12.2%
East Cambridgeshire	0	83,910	0.0%
Fenland	3,920	91,670	4.3%
Huntingdonshire	0	165,760	0.0%
South Cambridgeshire	0	144,530	0.0%
Cambridgeshire	18,720	607,010	3.1%

Source: English Indices of Deprivation 2010. Barriers to Housing and Services Domain. ONS Mid-2009 Population Estimates for LSOAs.

Note: Figures were rounded to the nearest 10.

- Summarised data about the most deprived 20 LSOAs on the Living Environment domain in Cambridgeshire are in Table 44. In Cambridge, areas of deprivation are concentrated in Petersfield ward.

¹³ Annual Report on Fuel Poverty Statistics 2011. Department of Energy and Climate Change

Table 44: Most Deprived LSOAs on the Living Environment Domain in Cambridgeshire

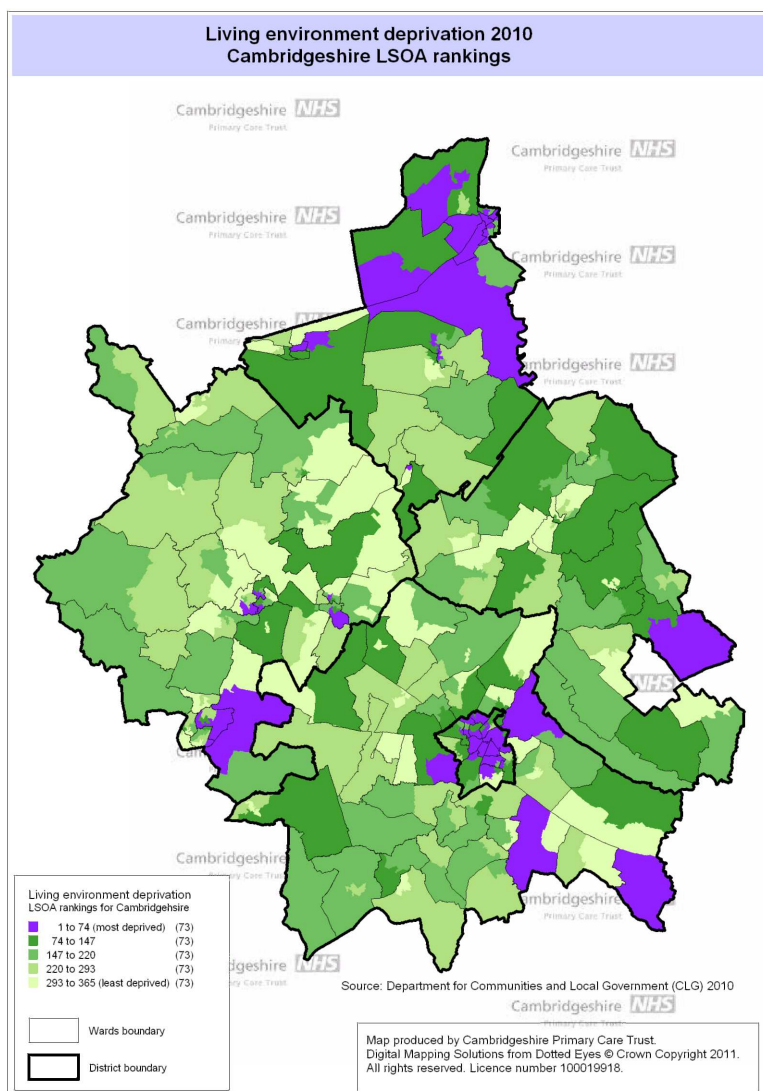
County Rank	LSOA Name	Ward	Score 2010	National Rank 2010*	% National Rank 2010	National Rank 2007	Change 2007-2010
1	Fenland 002C	Waterlees	45.92	3424	10.5%	5865	-2441
2	Cambridge 009E	Romsey	40.01	5000	15.4%	7515	-2515
3	Cambridge 008D	Petersfield	39.81	5061	15.6%	5724	-663
4	Cambridge 012D	Trumpington	39.67	5104	15.7%	5840	-736
5	Cambridge 007B	Market	38.93	5331	16.4%	6046	-715
6	Cambridge 008E	Petersfield	38.68	5408	16.6%	6244	-836
7	Cambridge 008C	Petersfield	38.50	5454	16.8%	6751	-1297
8	Cambridge 008A	Petersfield	36.83	5978	18.4%	7140	-1162
9	Fenland 002A	Clarkson	36.64	6033	18.6%	8381	-2348
10	Cambridge 008B	Petersfield	35.39	6462	19.9%	6146	316
11	Huntingdonshire 008C	Huntingdon North	34.23	6869	21.1%	15659	-8790
12	Cambridge 002B	Arbury	33.39	7169	22.1%	5103	2066
13	Cambridge 007A	Market	33.24	7230	22.3%	6186	1044
14	Cambridge 009B	Romsey	32.98	7328	22.6%	8327	-999
15	Cambridge 007C	Market	31.79	7792	24.0%	8230	-438
16	Fenland 004C	Elm and Christchurch	31.49	7918	24.4%	9010	-1092
17	Cambridge 004D	West Chesterton	31.10	8053	24.8%	5895	2158
18	Cambridge 006C	Abbey	30.38	8344	25.7%	7781	563
19	Cambridge 001F	King's Hedges	30.12	8454	26.0%	8126	328
20	Cambridge 009D	Romsey	29.77	8598	26.5%	7935	663

Source: English Indices of Deprivation 2010.

Note: Area ranked at one is relatively the most deprived.

- It should be noted that on the Barriers to Housing and Services and Living Environment Deprivation domains the more affluent areas of Cambridgeshire are relatively deprived. In terms of barriers to Housing and Services this reflects the link to affordability

Map 4: Living Environment Deprivation



Note: darker shading shows more living environment deprivation.

Housing Affordability and Access to Housing

This section looks at house price to income ratios, market rent levels, and the supply and demand for affordable housing. More detailed information about housing affordability, demand and supply are provided in the *Strategic Housing Market Assessment (SHMA)* www.cambridgeshirehorizons.co.uk/shma.

House Price to Income Ratio

The table shows the lower quartile, mean and median house price to income ratio for each district.

Table 45: House Price to Income Ratio

Local Authority	Lower quartile	Median	Mean
Cambridge	9.78	8.43	9.28
East Cambridgeshire	6.64	5.77	5.93
Fenland	5.69	4.91	4.83
Huntingdonshire	5.93	5.26	5.55
South Cambridgeshire	7.45	6.63	7.18
East of England	6.63	6.19	6.87

Source: Hometrack, June 2010-May 2011 downloaded July 2011.

- The average mean house price is around nine times mean household income in Cambridge City, seven times mean household income in South Cambridgeshire and between five and six times income in the other districts. Mortgage lenders typically lend up to four times income, so affordability for purchase is a significant issue in all districts.

Market Rents

- Market rents are also high in Cambridge City and South Cambridgeshire. The average rent for a one bed property in the city is £767 per month. Because of these high rental costs, there is a considerable market for shared housing in the City as it tends to be considerably cheaper. In most areas, the average rent per calendar month is equivalent to between 25% and 30% of median income. In Cambridge City, the average rent is equivalent to 44% of median household income.

Table 46: Rent per Calendar Month by Property Size and District

	1 bed	2 bed	3 bed	4 bed	All (inc. studios and 5+beds)	Median Gross Household income, 2009
Cambridge	£767	£1,026	£1,159	£1,557	£1,092	£30,000
East Cambridgeshire	£544	£642	£771	£973	£793	£32,500
Fenland	£409	£500	£626	£816	£583	£27,500
Huntingdonshire	£487	£621	£749	£985	£697	£34,500
South Cambridgeshire	£589	£734	£877	£1,137	£875	£36,000
Cambridgeshire	£550	£708	£822	£1,057	£796	£32,500

Source: LGSS Research and Performance Annual Review of Rents Jan 2011 and CACI 2009.

New Supply of Affordable Homes

- In the past eight years, some 5,910 new affordable homes have been built across Cambridgeshire. This includes social rented, shared ownership and intermediate rented homes.

Table 47: Additional Affordable Dwellings, 2002-2010

Local Authority	2002/3	2003/4	2004/5	2005/6	2006/7	2007/8	2008/9	2009/10	Total 2002/3 - 2009/10
Cambridge City	81	200	38	159	173	156	101	132	1,040
East Cambridgeshire	106	105	74	219	190	201	102	38	1,035
Fenland	34	67	89	91	76	111	58	103	629
Huntingdonshire	88	92	99	145	221	96	240	316	1,297
South Cambridgeshire	98	246	108	261	252	408	293	243	1,909
Cambridgeshire	407	710	408	875	912	972	794	832	5,910

Source: HSSA Section N.

Housing Need

- In the same period, the housing needs register for social rented properties has increased by around 10,000 which is consistent with national trends.

Table 48: Social Rented Housing Needs Register, 2002-2010

Local Authority	2002	2003	2004	2005	2006	2007	2008	2009	2010
Cambridge City	2,860	3,218	3,724	4,251	4,743	5,214	5,984	6,897	7,758
East Cambridgeshire	1,400	1,538	1,737	1,477	1,442	1,479	1,603	1,404	1,226
Fenland	1,185	1,248	1,439	2,226	2,032	1,971	1,802	2,481	2,147
Huntingdonshire	1,816	1,940	1,848	1,925	1,617	1,426	1,452	2,178	3,477
South Cambridgeshire	1,733	2,207	2,553	3,538	4,155	4,661	3,626	3,800	4,054
Cambridgeshire	8,994	10,151	11,301	13,417	13,989	14,751	14,467	16,760	18,662

- However, there are issues about these data which makes them more useful to identify general trends than specific numbers of households in need. For example, different districts have different review processes for keeping registers up to date. South Cambridgeshire's register decreased by around 1,000 in between 2007 and 2008 because the local authority contacted households asking if they still wished to remain on the register and a large number did not. In other areas there is a continual process of review. The number of duplicates (households registering with more than one local authority) has decreased since 2008 following the introduction of the shared register in 2007.
- Both nationally and locally, demand for both affordable and market housing significantly outstrips supply. Locally, particularly around Cambridge City, affordability is a problem for households wishing to buy or rent in the market because of high housing costs and limited mortgage finance, particularly when compared to pre-'credit crunch'.

4.4.3 Key Trends

- Housing affordability is a problem across Cambridgeshire. The number of home purchases has decreased, while house prices have increased. Although house prices are lower in Fenland, wages are also lower. A decrease in access to social housing and to first time buyers able to raise a deposit has led to an increase in the numbers of people renting privately.

- Private housing is particularly expensive in Cambridge City both to purchase and to rent. This has resulted in an increasing affordability gap between incomes and rents and house prices.
- Planned changes to the Local Housing Allowance (LHA) which supports peoples who cannot afford the full cost of their housing, will have a number of effects, including:
 - Strict limits on the Local Housing Allowance for new claimants is likely to lead to current rents becoming unaffordable, increasing overcrowding and leading to an increase in evictions and possibly homelessness.
 - The ability of some households claiming LHA, particularly young single households, to afford rented housing close to jobs due to the high cost of renting rooms and houses will be decreased. In Cambridge City this may result in people moving out of the City to live in villages some distance away that are more affordable. This will increase the costs of travel to local jobs and impact on air quality, and may also push up rents in those villages.
 - Claimants aged between 25 and 34 will no longer be entitled to claim at the single room rate, which is likely to impact on vulnerable people for whom sharing accommodation may be inappropriate for their needs.
- The cost of fuel for domestic use is rising at a greater rate than inflation. There may be an increase in the number of households slipping into fuel poverty from the estimated current 5,800. The inability to heat a house properly will impact on the health of vulnerable households.

4.4.4 Local Views

Huntingdonshire

Huntingdonshire District Council identified the following issues that arose from its 2010 Local House Condition Survey (LHCS).

- Average incomes - recent average incomes for heads of household and, where appropriate, their partner, were in Huntingdonshire, considerably lower than the averages for England. The owner occupied tenure group had average incomes that were 29% lower than the national average with the privately rented tenure group being 26% lower.
- Tenure Profile - in Huntingdonshire this differs from the national profile with the owner occupied stock at a higher level (75% compared with 68%). The privately rented sector was represented at a lower rate (11% compared with 14%). The overall proportion of social housing was lower at 14% compared with 18% nationally. The significance of income and tenure relates to privately rented accommodation which is associated with poorer conditions. In Huntingdonshire, households in this type of accommodation have lower incomes compared to national average.
- The rate of Category 1 Hazard failure is found in the privately rented stock at 25.7%, the majority relating to excess cold, falls on stairs and falls on the level.
- There is a high level of migrant workers in Huntingdonshire and many of these are in ad hoc agency work where income and employment is not regular. To reduce costs, these migrant workers share houses, often crowding together to reduce costs.
- There is no direct liaison between local health services and the local authority where information is passed on via the patient/tenant/client. Improvements are often able to be made to the accommodation by the local authority.

Cambridge City

Cambridge City Council has identified the following housing related issues:

- House prices and private rents are higher than elsewhere in the county, and there are a higher proportion of private rented homes than elsewhere in the county.
- The City has a high number of Houses in Multiple Occupation (HMOs) reflecting its universities and many private educational establishments resulting in many student halls and HMOs. It is estimated that 4,960 dwellings are in multiple occupation including an estimated 260 licensable HMO's.
- 21.8% of the privately occupied stock has Category 1 hazards of which the majority relate to excess cold. This reflects the age of the stock as there is a higher proportion of housing stock built pre 1919 and 1945 to 1964 with lower proportions built in other age bands.
- Cambridge City's 2009 Housing Condition Survey states that 12.5% of households in receipt of an income related benefit live in a dwelling with a SAP rating below 35, with a SAP below 35 being a proxy for fuel poverty. However 2009 and 2010 NI 187 surveys indicate it may be less than this at 6% and 9% respectively.
- Liaison with general practices could be improved as they may come across housing related health inequalities to which Cambridge City Council could respond. Improvements could be made particularly relating to excess cold related winter deaths and increases in childhood asthma and allergies.

South Cambridgeshire

South Cambridgeshire District Council has identified the following housing related issues:

- Private sector housing – 5% have serious hazards especially fuel poverty, damp and mould. The most vulnerable groups especially those on low incomes are particularly affected by poor housing conditions.
- The South Cambridgeshire Housing Strategy identified a need for more housing provision for Gypsies and Travellers in South Cambridgeshire.
- House prices in South Cambridgeshire have been higher than the national average over the past decade. They rose strongly in line with the local and national trend between 2000 and 2008; however, they dropped more rapidly in 2009 than in Cambridge and the rest of Cambridgeshire, the region, and the nation. This will particularly affect younger people on lower incomes. The 2006 Cambridgeshire Quality of Life Survey identified "affordability of housing" as the feature of local life that respondents in South Cambridgeshire were least satisfied about.

East Cambridgeshire

- Key concern for East Cambridgeshire District Council is the increase in house prices with more privately rented accommodation. This has led to an increase in tenants and in the number of Houses in Multiple Occupation. Also, privately rented accommodation is associated with poorer housing conditions.

Fenland

Fenland District Council identified the following housing related issues:

- The Fenland housing register for social housing at 1 April 2011 shows a total of 2,874 which represents a significant increase of over 30% from 2010.

- Fenland is characterised by high levels of multiple deprivation in a number of the district wards. It has LSOAs in the bottom 10% of LSOAs nationally for housing and access to services. Overall 57% of Fenland LSOAs performed among the lower percentiles (ie among the bottom 0-50% of LSOAs nationally).
- *The Living Costs and Food Survey* indicates that average household incomes in Fenland decreased between 2009 and 2008 (from £713.10 in 2008 to £682.60 in 2009). At the same time household expenditure also decreased (from £386.30 in 2008 to £383.10 in 2009). The largest areas of expenditure were for housing fuel and power followed by transport. Between 2008 and 2009 the proportion of weekly spending on housing fuel and power went up by 2%. The proportion of spend of household income on fuel and power is greater in poorer homes. The current and anticipated cost of fuel increases will disproportionately affect the poorer households.
- The majority of the district's housing stock is privately owned and there is concern about its condition. "Excess cold" was overwhelmingly the most common Category 1 hazard.
- Overall, the district has unique housing challenges including a large migrant population from the A8 (Central And Eastern European countries, Gypsy/Traveller/Roma and other Black Minority Ethnic communities) estimates suggest circa 4,000. There are currently 600 plus houses in multiple occupation (HMOs) in the district. The majority of these houses are being occupied by migrant workers, but there is also occupation by local people. A number of these HMOs present as poorly managed, some with overcrowding and health and safety related hazards and failings. The Council is currently assisted via government migrant impact funding to support an HMO officer post to assist in tackling poor conditions and improved neighbour relations and cohesion. The funding for this project will end at the end of September 2011. Linking with this the Council is still encountering evidence of rough sleeping. Also, unauthorised developments - conversions of sheds, outbuildings and the like for residential use.

4.4.5 Evidence/Policy

The Effect of Housing upon Health

There is a growing evidence base that confirms the impact of housing upon health. A comprehensive overview of the evidence can be found in the World Health Organization's Report *Environmental burden of disease associated with inadequate housing* (2011).¹⁴ <http://www.euro.who.int/en/what-we-do/health-topics/environment-and-health/Housing-and-health>

Some of the key areas described in the report are indicated below:

- Housing conditions that adversely affect health are identified as indoor dampness and pollutants associated with respiratory (breathing) problems and features that lead to physical injury.
- Indoor cold (fuel poverty) was estimated as causing 38,200 deaths across 11 European countries or 12.2 excess deaths per 100,000. It is linked to cardio-vascular (heart and circulation) health problems.
- Household overcrowding is associated with an increased risk of the spread of infections.
- The combination of factors associated with poor housing along with possible economic stressors has been identified as having an adverse effect on mental health.

¹⁴ *Environmental burden of disease associated with inadequate housing a method guide to the quantification of health effects of selected housing risks in the WHO region.* Braubach M., Jacobs D.E., Ormandy D. WHO Regional Office for Europe (2011)

Reducing the Negative Effect of Housing upon Health

- Poor housing is usually linked to poverty which means it is difficult to measure health gains from housing improvements alone. The WHO Report identifies evidence that interventions designed to increase energy efficiency, home improvements and wider neighbourhood renewal schemes have a positive effect upon health.

Economic Cost of Inadequate Housing

- There is a growing body of work that quantifies the cost of inadequate housing conditions upon health although there are some inherent difficulties. The Chartered Institute of Environmental Health (CIEH) toolkit found in *Good Housing Leads to Good Health* shows the cost benefit of rectifying defects within the home that can cause accidents and the cost of medical treatment following the occurrence of an accident.¹⁵
- Nicol et al produced a report (2010) on the development of methodology to quantify the annual cost of inadequate housing conditions on health compared with the one-off single cost of remediation. In England the cost is estimated to be £600 million per annum which is estimated to be 40% of the total cost to society as it excludes the effect of absence from education and work.¹⁶
- There are examples of where the collaboration of agencies has led to interventions to improve homes. For example Liverpool City Council and the local PCT jointly funded home improvements as an acknowledgement that poor housing conditions can influence the use of health services.

4.4.6 What we are doing in Cambridgeshire - Local Examples of Good Practice?

There are some examples of good local practice to address housing issues.

Case Study

Cambridge City Council

Various methods are used to identify vulnerable clients. Links with local General Practices has led to the identification of vulnerable clients at 'flu clinics'. Three area based promotional projects have helped to raise the profile of energy efficiency and the potential hazards to vulnerable residents. Establishing links within the City Council and beyond means a referral network is available to help vulnerable residents and maximise any contacts made. The Cambridgeshire Home Shield scheme is a example of where joint work has been effective.

Fenland District Council

Fenland District Council Housing Strategy sets out a commitment to work to reduce the number of vulnerable households living in private sector accommodation defined as non-decent. Between 2004 and 2008, the Council worked to bring approximately 200 homes up to Decent Homes standard. This has had particular effect upon the Houses of Multiple Occupation that are largely by used by migrant workers and other vulnerable groups. This meant rectifying housing conditions that had experienced years of very low investment reflecting the low incomes in the area.

¹⁵ *Good Housing Leads to Good Health*. Mason V. Chartered Institute of Environmental Health (2008)

¹⁶ *Quantifying the Cost of Poor Housing* Nicol S, Roys M, Davidson M, Summers C, Ormandy D, and Ambrose P (Watford, UK: IHS-BRE Press (2010)

Huntingdonshire District Council

Where vulnerable households qualify for energy efficiency works, an additional survey is carried out and where a Category 1 hazard is identified, additional aid is offered either in the form of a small grant or practical advice to reduce the hazard to an acceptable level.

What is this Telling us?

4.4.7 Key Inequalities

- Across the County there is variation in the rates of privately owned dwellings with Category 1 hazards and those made good by local authority. This is lowest in Huntingdonshire at 23.9/1000 dwellings which is a reflection of the action of the local authority. This compares with East Cambridgeshire at 192.5/1000 dwellings.
- There is inequity in relation to 'Decent Home Activity' in private housing. Huntingdonshire improved the greatest proportion of their houses classified as being 'non-decent' at 122.7/1000 with the lowest number of improvements being found in Fenland at 1.2/1000. As indicated above, this reflects the long term low levels of investment and consequent poorer housing conditions associated with more deprived areas. It should be noted that most of this work relates to older people.
- Access to decent housing is a reflection of affordability. Affordability of housing has an impact on health. It also creates inequalities with housing becoming unaffordable for low income households and vulnerable groups, increasing the risk of homelessness. In addition, low income households and vulnerable groups are the most likely to occupy poor standard homes with issues of overcrowding, fuel poverty, disrepair and damp and mould. Refer to the Supporting People Section and the *New Communities JSNA*.

4.4.8 Gaps in Knowledge/Services/Areas for Development

- Comparable data on housing conditions is not available across all the districts as data are collected at different times.
- The indications that the demand for affordable housing, the impact of the new housing benefit system and rising fuel prices will have a negative effect on housing and consequently health, requires further exploration and the establishment of a monitoring system.
- Greater awareness and involvement of health services in housing issues is an area for development. Health services are not always aware of the functions of local authority housing departments and their enforcement powers to remedy housing defects such as increasing energy efficiency. Cross-sector investment in housing as preventative intervention would support the good health of residents. The use of the CIEH toolkit might accentuate the cost benefit analysis of such action and deserves investigation.
- Category 1 hazards under the HHSRS are associated with poor health outcomes and should be reduced wherever possible in line with cost-effective recommendations found in the CIEH toolkit.

- Improving the energy efficiency of homes would help to improve living conditions and reduce fuel poverty, leading to better physical and mental health. A process is needed to co-ordinate current systems across the county for collecting information on fuel poverty with the aim of identifying households at risk of ill health through fuel poverty and local intelligence relating to fuel pricing/fuel co-operatives and fuel poverty is required.
- There is an indication that there are increasing numbers of people sharing houses to save costs, and this is likely to increase as Housing Benefit reforms are implemented. However there are few data available locally on overcrowding. A system is required for identifying adults of working age and their families who live in overcrowded conditions and those who are at risk.
- Currently there is no mechanism in place to monitor the success of any such interventions. There is a need to develop a mechanism that will allow any improvement to health attributable to improved housing to be explored.
- Other housing factors not considered here are the effects of housing with poor security or at risk of fire.

4.5 Supporting People

What do we Know?

4.5.1 Introduction

The Supporting People (SP) programme strategically commissions, monitors and reviews housing related support services to complement existing statutory services. The programme supports some of the most vulnerable and socially excluded members of our society. The primary purpose is to develop and sustain an individual's capacity to live independently in their accommodation. Examples include enabling individuals to access their correct benefit entitlement, ensuring they have the necessary skills to maintain a tenancy, advising on home improvements and accessing a community alarm service. Client groups include: single homeless, homeless families, rough sleepers; ex-offenders and those at risk of offending; physical and sensory disability; domestic violence; alcohol and drug problems; teenage parents; older people; young people at risk/leaving care; HIV and AIDS; learning difficulties; travellers; migrant workers, refugees and asylum seekers; mental health.

4.5.2 Figures and Trends

In 2009/10, Supporting People funded services helped around 2,000 clients in the working age group in Cambridgeshire. Client groups that accounted for the largest proportion of clients were: Single Homeless with Support Needs (25.6%), Young People at Risk (15.6%) and People with Mental Health Problems (14.6%). The data are shown in Table 49.

Table 49: Supporting People Clients of Working Age, Cambridgeshire – 2009/10

Primary Client Group	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire
Generic	-	-	25	25	-	50
Homeless Families with Support Needs	35	18	7	96	65	221
Offenders or People at risk of Offending	14	20	7	20	-	76
People with a Physical or Sensory Disability	36	-	11	24	127	198
People with Alcohol Problems	6	-	-	-	-	6
People with Drug Problems	-	-	10	20	-	30
People with HIV/Aids	8	-	-	-	-	8
People with Learning Disabilities	51	10	14	38	10	123
People with Mental Health Problems	254	-	-	20	18	292
Single Homeless with Support Needs	390	56	56	12	-	514
Teenage Parents	13	-	4	8	-	25
Gypsies and Travellers	-	-	66	20	-	86
Women at Risk of Domestic Violence	22	-	27	8	-	57
Young People at Risk	145	18	62	57	20	312
Young People Leaving Care	-	-	-	8	-	8
Grand total	974	122	289	356	240	2,006

Source: Cambridgeshire County Council, Community and Adult Services, Supporting People, May 2011.

4.5.3 Evidence/Policy

- The Supporting People programme saves money elsewhere by preventing or deferring the use of more costly alternatives eg hospitalisation, institutional care, committing/becoming a victim of crime or homelessness. It can also help the smooth transition to independent living from these alternatives.
- Evidence suggests that through investing in housing support it is possible to make savings elsewhere in public services. The evidence basis for this is demonstrated by the CLG Supporting People Financial Benefits Model. This shows that for every pound spent on housing support £1.78 is saved elsewhere in public services. Robust financial modelling by Capgemini (March 2009) has demonstrated a net financial benefit from the Supporting People programme of £3.41bn per annum, against an overall investment of £1.61bn.

What is this Telling us?

4.5.4 What are the Key Inequalities?

Based on information from *Supporting People Inclusive Forum* (September 2010), in comparison to East of England, Cambridgeshire's Supporting People services were:

- Weakest in helping socially excluded groups to participate in training and education.
- Second weakest on helping socially excluded groups to exercise choice and control.

- Weakest on helping socially excluded groups to manage mental health (NB excludes the client group mental health). Note: socially excluded groups are: single homeless, rough sleepers, people with drug and alcohol problems and offenders.

4.5.5 What are the Gaps in Knowledge/Services/Areas for Development?

- In May 2009 a Supporting People Needs Analysis was completed for the Supporting People programme in Cambridgeshire. This provides a theoretical picture of need across 21 different groups and concludes:
 - There is current capacity to support 2,100 adults of working age in Cambridgeshire.
 - A greater proportion of spend should be invested in floating support services.
 - Looking at individual groups in isolation gives a narrow understanding of need.
 - Some of the most vulnerable groups we support, eg Gypsies and Travellers, receive the least funding and should get more.
- There are disproportionately more services in some districts than others. Similarly, there are currently disproportionately more services for some client groups than others.
- Whilst the funded Supporting People Services are preventative some of the most vulnerable people who need support are not being supported. Services covering individual groups can give a narrow understanding of need. For example, an offender may have substance misuse and mental health issues and may present in a homeless service and be recorded as single homeless. This individual may have an array of support needs and require services set up to meet all those needs in a seamless single service.
- There is an opportunity to take partnership working to a new level with an increased focus on shared outcomes and joint commissioning. This could also include managing contracts jointly or on behalf of each other, which would mean less duplication and would be more efficient. The programme should increase social capital by working in partnership with families, carers, neighbours and the community, thereby building supportive networks.

4.6 Road Traffic Collisions

What do we Know?

4.6.1 Introduction

- This chapter is referred to as Road Traffic Collisions rather than Road Traffic Accidents. The rationale for this is that an 'accident' is often understood to be unpredictable and, therefore, unavoidable. However, most of these events and subsequent injuries are predictable and preventable. An editorial¹⁷ published in the BMJ in 2001 discusses this in detail and the term 'accidents' has been banned in the BMJ. However, in this chapter, the term accidents will still be found in places as information has been reported directly from other sources.

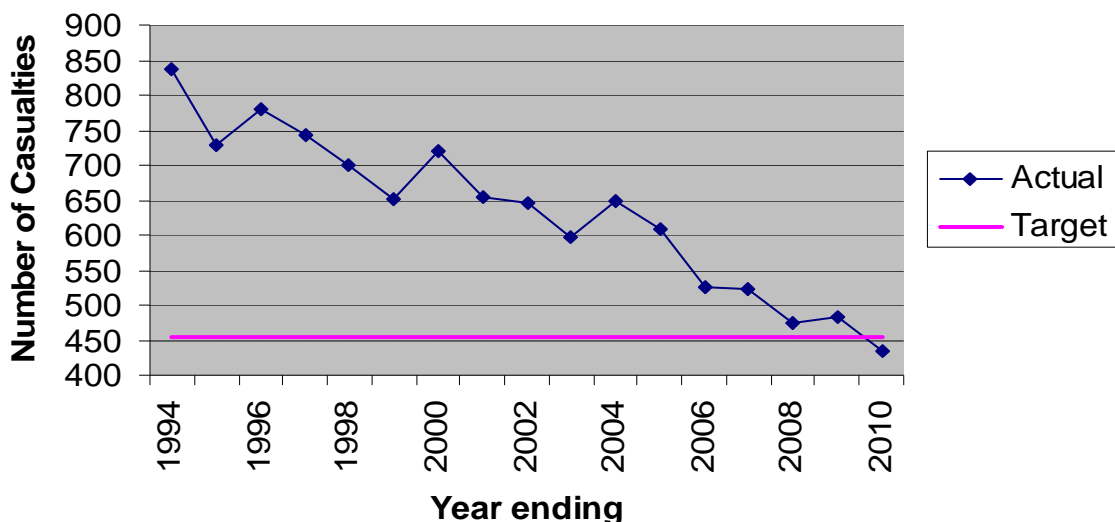
¹⁷ Davis RM, Pless P BMJ 322 (7298):1320 published June 2001 <http://www.bmj.com/content/322/7298/1320.full>

- Local data on road traffic collisions for Cambridgeshire and Peterborough is available both from police and health information systems. The data are captured in a joint annual road casualty report¹⁸ and this is particularly significant as it captures information both related to where the accident occurs (Police STATS 19 accident data) and information on accidents by residency in the county (health related data such as mortality and hospital data). Road safety activity and progress is captured in a supplementary monitoring report.¹⁹ These reports provide comprehensive information on road safety facts, figures and trends. Some of the key findings from the 2010 reports are summarised in the figures and trends section below.
- Injuries in Cambridgeshire and Peterborough cost £192 million annually.

4.6.2 Figures and Trends

- There were 434 people killed or seriously injured (KSI) on Cambridgeshire and Peterborough roads in 2010 (see Figure 11). This was 43% less than the 1994-98 average baseline, and the Government's challenging target of a 40% reduction was achieved. There were 22% fewer slight injuries.
- Reductions in deaths and injuries have been achieved despite traffic growth in Cambridgeshire.
- In 2010, 48% of all casualties, 57% of serious injuries and 95% of deaths occurred on rural roads (those having a speed limit of more than 40 mph). This reflects the fact that only 13% of the main road traffic in Cambridgeshire (6%) and Peterborough (38%) is urban.
- In 2010, 14% of accidents, 16% of casualties and 33% of deaths occurred on trunk roads.
- A Highways Agency Assessment²⁰ of the alternative proposals for upgrading the A14 in Cambridgeshire estimated these would result in an annual reduction of accidents of 3% in the study area with significant monetary savings.

Figure 11: KSI Casualties in Cambridgeshire and Peterborough



Source: The 2010 Joint Road Casualty Data Report

¹⁸ The 2010 Joint Road Casualty Data Report <http://www.cambridgeshire.gov.uk/transport/monitoring/joint+road+casualty+report.htm>

¹⁹ The 2010 Cambridgeshire County Council's Road Safety Monitoring Report <http://www.cambridgeshire.gov.uk/transport/monitoring/road+safety+monitoring.htm>

²⁰ Highways Agency Traffic and Economic Assessment 2005 <http://www.highways.gov.uk/roads/projects/6934.aspx>

- In people aged 16-24 years, transport accidents and intentional self harm are the main causes of death.
- The greatest number of road traffic casualties occurs in the working age population.
- 17 to 25 year olds have the highest casualty rate per head of population.

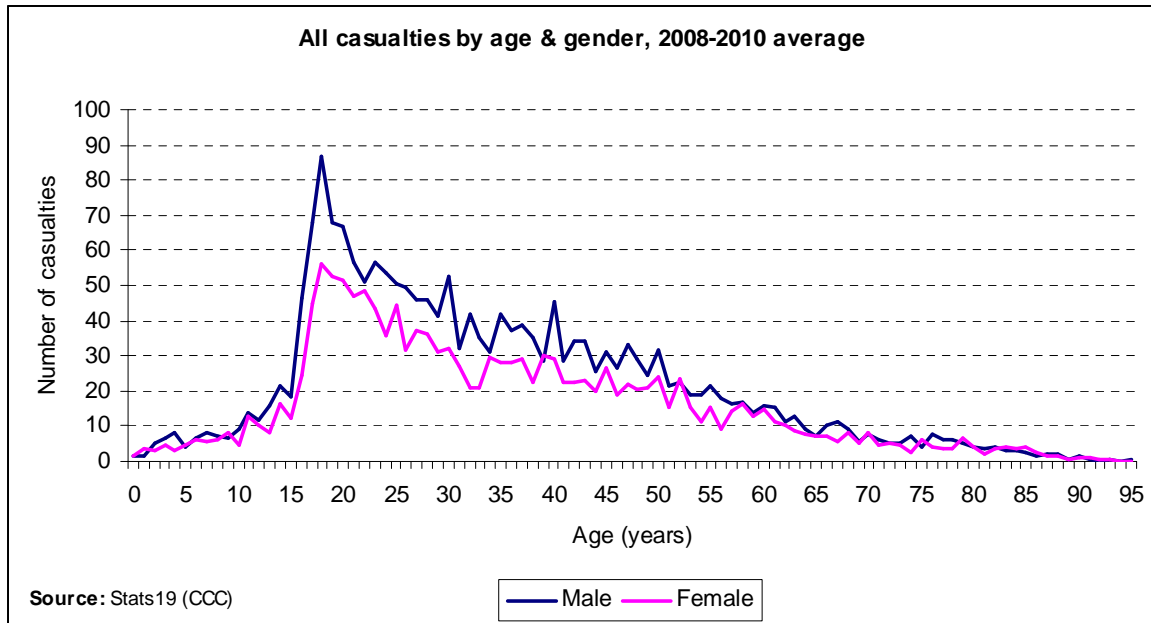
Table 50: Casualties by Age

Age group	Numer of casualties in Cambridgeshire and Peterborough 2010	ONS 2009 population estimates (Cams and Peterborough)	Casualty rate per thousand population	Casualty rate per thousand population Great Britain 2009
0-4	40	48,400	0.8	0.8
5-10	78	52,400	1.5	1.8
11-16	207	54,900	3.8	3.5
17-25	923	98,200	9.4	8.0
26-64	1,891	404,100	4.7	3.8
65+	233	120,200	1.9	1.7
Unknown	63	-	-	-
Total	3,435	778,200	4.4	

Source: 2010 Joint Road Casualty Data Report for Cambridgeshire and Peterborough.

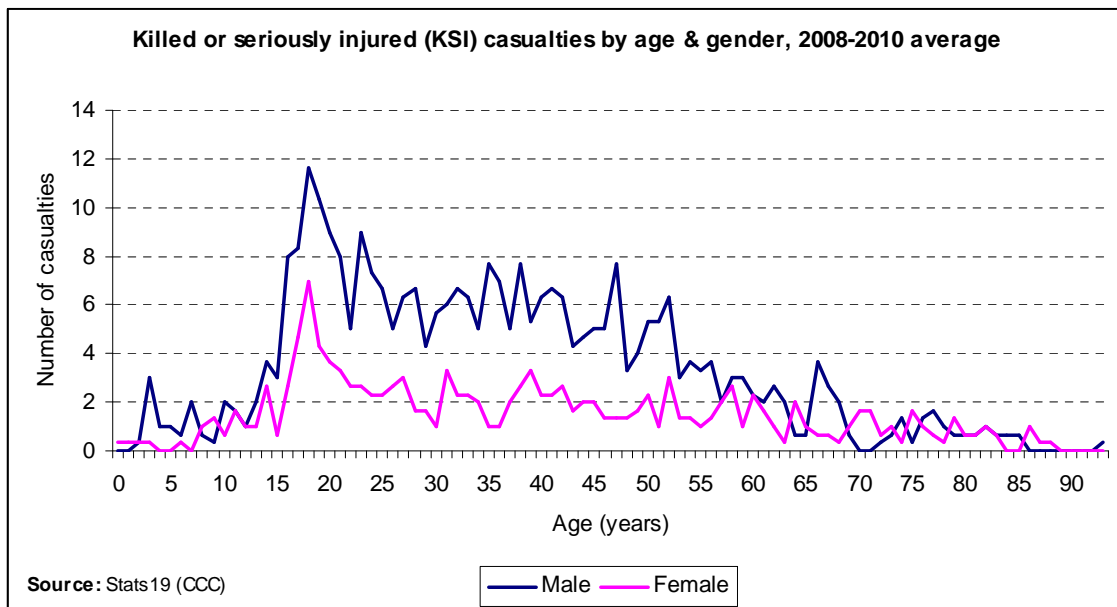
- The pattern is similar for casualties, killed or seriously injured. The peak age for casualties and those seriously injured or killed is 18. Nearly 70% of seriously injured and killed are males (see Figures 12 and 13).
- 54% of car driver casualties are male. The peak age is 18–19.
- 59% of car passenger casualties are female. For those aged over 50 this figure rises to 74%. The peak age is 18-20.
- 84% of two-wheel motor vehicle rider casualties are male. The peak age is 16-17. Since 2000 there has been a 54% reduction in two-wheel motor vehicle user casualties in the age group 25-34, a 24% reduction in casualties aged under 25, and a 5% reduction in casualties aged 35 and over.
- 14% of all casualties in Cambridgeshire and Peterborough are pedal cyclists. 49% of these are injured in Cambridge City, where pedal cycles were involved in 59% of all accidents last year.
- In cycle rider casualties, the peak age is 19-26 in Cambridge, reflecting the student population, whereas elsewhere the peak is between the ages of about 11 and 16.

Figure 12: Casualties by Age and Gender (2008-2010 Average)



Source: 2010 Joint Road Casualty Data Report for Cambridgeshire and Peterborough.

Figure 13: Killed or seriously injured by age and gender (2008-2010 average)



Source: 2010 Joint Road Casualty Data Report for Cambridgeshire and Peterborough.

- Over the 2010 Christmas period there were 121 arrests for drink-driving. 51% of the people failing breath tests were aged 26-45, 75% were aged less than 46 and 85% were male.
- In 2007-09, Cambridgeshire had a statistically significantly high land transport mortality rate for people under 75 years of age compared to England. Fenland had a rate significantly higher than both the county and England averages.
- Between 2004-06 and 2007-09, the rate of mortality from land transport accidents decreased in all areas of Cambridgeshire except Fenland. Because the numbers are small it should be noted that they can fluctuate by a relatively large amount from one time period to the next. The data are in Table 51.

Table 51: Land Transport Accident Mortality, Under 75 Years, Directly Age-Standardised Rates (DSR) per 100,000, 95% Confidence Intervals, 2004-06, 2007-09

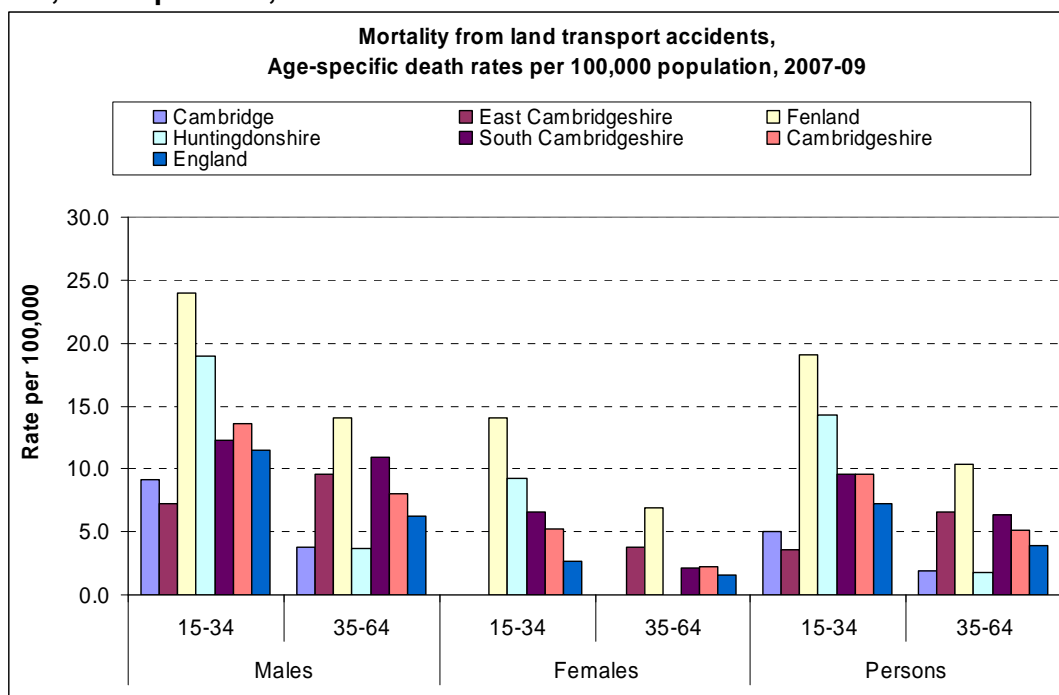
Local Authority	2004-06			2007-09		
	Annual average observed deaths	DSR	95% CIs	Annual average observed deaths	DSR	95% CIs
Cambridge City	-	3.2	(1.1-5.2)	4	2.9	(1.0-4.7)
East Cambridgeshire	7	9.9	(5.6-14.3)	3	4.1	(1.5-6.7)
Fenland	10	11.9	(7.6 -16.2)	10	12.3	(7.6-16.8)
Huntingdonshire	16	11.9	(8-14.4)	8	5.5	(3.2-7.7)
South Cambridgeshire	10	8.2	(5.1-11.2)	8	6.3	(3.8-8.9)
Cambridgeshire	46	8.2	(6.8-9.6)	33	5.7	(4.5-6.8)
England	2,392	5.0	(4.9-5.2)	2,019	4.2	(4.1-4.3)

Source: Compendium of Clinical and Health Indicators, March 2011. <http://www.nchod.nhs.uk/>

Note: (-) denotes less than five cases.

- In 2007-09, the highest mortality rate was for 15-34 year-old males in Fenland followed by 15-34 year-old males in Huntingdonshire. The data are in Figure 14.

Figure 14: Mortality from Land Transport Accidents, Age-Specific Death Rates Per 100,000 Population, 2007-2009



Source: Compendium of Clinical and Health Indicators, March 2011, <http://www.nchod.nhs.uk/>

- Work-related road casualties. About a third of collisions are related to driving for work either as part of commuting to work or for business purposes. As illustrated in Table 52, the proportions of drivers in each category have remained fairly constant over the past three years.

Table 52: Drivers/Riders (aged 17 or Over) Involved in Personal Injury Accidents, by Journey Purpose

	Journey as part of work	Commuting to/from work	Other	Total
2008	1,047 (23%)	651 (14%)	2,921 (63%)	4,619
2009	864 (20%)	527 (12%)	2,988 (68%)	4,379
2010	859 (21%)	558 (13%)	2,721 (66%)	4,138
Total	2,769 (21%)	1,736 (13%)	8,627 (66%)	13,132

Source: 2010 Joint Road Casualty Data Report, p5.

- Health Profiles 2011 published by erpho²¹ provide a summary overview of health issues by Local Authority area:
 - With the exception of Cambridge City, all districts in Cambridgeshire were highlighted as being significantly worse than England for road injuries and deaths. However these findings should be interpreted with caution as a local briefing²¹ states that the chosen indicator is known to be a poor measure, as it includes a mixture of area and resident based data.
 - When the data are examined by location of crash and district of residence,²² Fenland has the highest number of casualties who are also resident there. For example, between 2004 and 2009 there were 2,752 casualties in Fenland and of these 60% lived in Fenland. This is in contrast with South Cambridgeshire where only 36% were residents and 44% of the casualties were from out of county.

4.6.3 Local Views

- Police Neighbourhood Panels²³ give local residents an opportunity to engage with their local Policing Team at quarterly meetings, and set their own priorities for action. Panels across the county consistently report speeding drivers as one of their top three priorities, suggesting that road safety remains a major concern to the public. Concerned residents are given the opportunity to volunteer for a Speedwatch scheme, which has steadily grown in popularity over the past year and is now well-established.²⁴
- Cambridgeshire and Peterborough Road Safety Partnership (CPRSP) is currently considering options for how it will address the localism agenda. Within the next year CPRSP aspires to have systems in place empowering local people to have a say via consultation, potentially via District-based Community Safety Partnerships. This is work in progress, however, the value of engaging communities to have an active role in providing solutions to their problems is recognised as a credible paradigm as demonstrated by the Neighbourhood Policing model.²⁵
- As local road safety services move towards greater involvement with the public, it will be essential to have suitable systems for sharing casualty data at the local level to help inform decisions, and have clear processes of accountability in place.

²¹ Public Health Observatory Health Profiles 2011: briefing for NHS Cambridgeshire available at <http://www.cambridgeshirejsna.org.uk/other-assessments/cambshealthprofiles>

²² Cambridgeshire Research, Performance and Business Intelligence Team using MAST on line analysis

²³ http://www.cambs.police.uk/myneighbourhood/getting_involved.asp

²⁴ For more information please visit <http://www.cambs.police.uk/roadsafety>

²⁵ For more information please visit http://www.neighbourhoodpolicing.co.uk/files/np_and_np_partnerships.pdf

4.6.4 Evidence/Policy

- The Department of Transport's (DfT) new *Strategic Framework for Road Safety*²⁶ published in 2011 sets out a strategic framework for road safety and a package of policies to continue to reduce deaths and injuries on our roads. The policies are split between measures intended to be undertaken nationally and areas where the policy and delivery will reflect local priorities, circumstances and economic assessment. A key theme of the Strategic Framework is empowerment of local citizens. Funding has been decentralised to create more room for local flexibility and innovation.
- At national level the Government is required to provide leadership on road safety, delivering better driving standards and testing, enforcement, education, managing the strategic road infrastructure, and through research and the collation and provision of public information to support local delivery. Within this, the Government will contribute to developing better information for road safety professionals, identifying robust evaluated interventions and highlighting examples of successful case studies. There is a proposal to use a portal to bring information together more systematically.
- A review of the evidence on road traffic accidents²⁷ identified the following areas of successful or promising interventions to prevent road traffic accidents:
 - Adapting the environment: environmental changes such as implementing area-wide traffic calming measures (eg speed humps, 20 mph zones and speed cameras), marked pathways for cyclists, and school crossing patrols are effective in reducing road traffic accidents (RTAs) and associated injuries.
 - Safety education and skills training: there is some evidence that injuries from RTAs can be reduced through education and promotional interventions that encourage the use of safety equipment (often including the provision of discounted or free safety equipment). Less is known about the impacts of: safety education programmes for child pedestrians; driver education programmes; or road safety media campaigns on injuries. However, these interventions can improve knowledge and safety behaviours.
 - Addressing drink driving: bar server training programmes can improve server behaviours (eg refusing service to intoxicated patrons) and reduce customer intoxication levels when there is strong support from management. There is some evidence that they can also reduce night time RTAs.
 - Multi-component interventions: comprehensive programmes that combine strategies such as education and traffic calming measures can reduce the incidence of child pedestrian injury, particularly when a wide variety of organisations are involved.
 - Enforcement of legislation: speed enforcement detection devices can be effective in reducing RTAs and associated injuries. There is some evidence that increased policing for drink driving, including selective and random sobriety check points, can have a beneficial effect on road traffic fatalities and crashes.

²⁶ DfT *Strategic Framework for Road Safety 2011* <http://www.dft.gov.uk/publications/strategic-framework-for-road-safety/>

²⁷ Wood S Bellis MA Watkins S *Road traffic accidents: a review of evidence for prevention* <http://www.cph.org.uk/showPublication.aspx?pubid=665>

- Locally, the strategic approach for road safety is set by the Cambridgeshire and Peterborough Road Safety Partnership. The current priorities have been informed by analysis of the casualty data and comprise:
 - Young Drivers
 - Work-related Road Safety
 - Motorcycles
 - Speed
 - Migrant Road Users

4.6.5 What are we doing in Cambridgeshire - Local Examples of Good Practice?

Cambridgeshire has seen the introduction of a range of interventions to address Road Traffic Collisions. The following case study provides an example of a local intervention that has evaluated positively.

Case study: A14 Huntingdon to Cambridge Route Enforcement and Casualty Reduction Scheme using average speed enforcement cameras.

The A14 is the key strategic route between the Midlands and East Anglia. It operates at the national speed limit of 70 mph as a dual carriageway with central reserve and no hard shoulder. The average annual daily traffic figure is 74,000 and with no motorways or appropriate diversion routes along this corridor, journeys can be seriously delayed when congestion or collisions occur. To the East, the ports of Felixstowe and Harwich result in a high number of heavy goods vehicles; these having an impact on speed differentials and traffic flow.

There were a large number of collisions and casualties along this route, even after the installation of eight fixed 'spot speed' camera sites in 2001. To address ongoing public concerns about safety along the route, the Highways Agency decided to install average speed enforcement cameras (SPECS) between Spittals Interchange and Girton; a 22km control section. The cameras were operational in July 2007 and their launch was accompanied with road safety campaign. The positive outcomes are summarised below:

- £4.3m annual average saving to the economy.
- Improved journey reliability – non-recurrent delays reduced.
- 85th percentile speeds of 64.6 mph post installation.
- Only 404 Notices of Intended Prosecution issued in one year.
- Improvements seen along 22 km of road, not just at a collision hot-spot.

What is this Telling us?

4.6.6 What are the Key Inequalities?

- The data highlights that those most at risk of casualty from road traffic accidents are:
 - Young males (69% of those killed and seriously injured are males, the peak age is 18).
 - Residents of Fenland.
 - Two wheeled motor vehicle users (motor cyclists) followed by pedal cyclists and pedestrians (by kilometre travelled).
 - Car occupants (most journeys are by car).
 - Cambridge City has the highest number of pedal cycle injuries reflecting the above average number of cyclists. Pedal cyclists were involved in 59% of all accidents in Cambridge in 2010.

- The rates of death per head of population are highest in the rural areas of South Cambridgeshire and Fenland. This measure of casualty density reflects the cost to local health and emergency services of dealing with road traffic accidents, but, as it takes no account of traffic volume, is not a very good indicator of risk.
- Many of the people killed and injured in Cambridgeshire do not live in the county. Areas with busy trunk roads, for example, may well exhibit high casualty rates per head of resident population because they carry a lot of 'through' traffic.
- The following factors are relevant to the above average mortality rates for Fenland residents:
 - On average, people in rural areas drive further, thereby increasing the length of time that they are exposed to the risk of having an accident.
 - Impact speeds on rural roads are, on average, higher, and therefore, accidents are more serious.
 - Main roads in Fenland are primarily single carriageway 'A' roads. This type of road is less safe, on average, than dual carriageways, which are more predominant, for example, in Huntingdonshire and South Cambridgeshire.

4.6.7 What are the Gaps in Knowledge/Services/Areas for Development?

- Continue to apply the public health model of casualty prevention (as defined in the *Strategic Framework for Road Safety*²⁶) that is focused on prevention, based on science, and is collaborative by nature. Interventions should be evaluated and scaled up as appropriate.
- Continue to focus road safety work on the reduction of existing casualty problems and inequalities identified across the county. This will need to be taken into account when responding to the localism agenda.
- Particular consideration should be given to the provision of adequate information (such as casualty maps and evidence of effective interventions) to enable communities to consider appropriate solutions for their evidenced casualty problems.
- Explore what potential there may be for greater involvement by the health sector with regard to:
 - in-car safety messages such as seatbelt wearing;
 - informing patients about any side effects of prescription medication which may impair their driving/riding/cycling. Around 34% of road casualties are related to work related journeys. Ensure workplaces have access to sound information and training opportunities to put in place workplace policies.
- Address the level of under reporting associated with STATS 19 data, in particular single vehicle pedal cycle accidents, some of which may fall into the 'Serious' category.
- Drug driving is an emerging issue, which presents a number of challenges such as the wide range of illicit and prescription substances, which can impair safe driving in a variety of ways. The *Strategic Framework for Road Safety*²⁶ states that 'it can be just as dangerous for people to drive impaired by alcohol *or* drugs, and it is currently unbalanced in that it is easier to get away with one than the other.' It is indicated that central Government will be working to improve this situation by getting drug screening kits authorised for use in police stations and then on the road side and considering a new drug driving offence.
- According to data returned following the annual drink and drug driving campaign conducted by the Association of Chief Police Officers (ACPO) 1 December 2009 – 1 January 2010: Police conducted 223,423 breathalyser tests for alcohol – 3% were positive, failed or refused. In comparison, just 489 Field Impairment Tests were carried out for drug driving – with 18% arrested.

4.7 Air Quality

What do we Know?

4.7.1 Introduction

- Air quality is not a new issue in the UK. The first Clean Air Act enacted in 1953 was passed following serious winter smogs in London which resulted in many excess deaths amongst vulnerable members of the population. In the forties and fifties (and earlier) poor air quality was usually a visible phenomena resulting from sulphur dioxide and fine particles released by domestic and industrial coal burning. Today, air pollution remains a serious problem in the UK but, due to differences in pollution sources and the pollutants themselves, the problem tends to be invisible.
- Quantifying the health impacts of air pollution in the UK statistically is very complex and the derivation of figure depends on many assumptions and variables. Recent research²⁸ suggests that the impact can be described in a number of different ways:
 - 26,800 'attributable deaths' per year in England and Wales
 - 340,000 'lost life years' from the population
 - Up to 200,000 deaths with average loss of life of up to two years
- The research also stated, more generally, that "Outdoor air pollution at current levels makes a significant contribution to mortality in the UK today, in terms of total population survival time which has been estimated separately as a (substantially) greater burden than the mortality impacts of environmental tobacco smoke or road traffic accidents".
- The UK passed legislation on Air Quality in Part IV of the Environment Act 1995, transposing the EU Air Quality Directive into UK law. Various sets of regulations²⁹ have subsequently been made under this Act. This legislation requires district councils to review and assess their air quality and to report findings to Government on an annual basis in a process known as Local Air Quality Management (LAQM). Objective levels were set for seven air pollutants which apply where there are relevant receptors (people or ecosystems likely to be exposed for the averaging period of the objectives).
- The Air Quality Objectives are based on observable health effects ie the lowest concentration where there is an observable health impact. The exceptions to this approach are fine particles (PM₁₀ or PM_{2.5}) where there is no zero impact concentration.

4.7.2 Figures and Trends

- Of the seven key pollutants only three have been identified as being significant in Cambridgeshire; these are Nitrogen Dioxide (NO₂), sulphur dioxide (SO₂) and fine particles (PM₁₀).
- A total of ten Air Quality Management Areas (AQMAs) have been declared in Cambridgeshire at this time and they are listed in Table 53. There are different reasons for these declarations.

²⁸ *The Mortality Effects of Long-Term Exposure to Particulate Air Pollution in the UK*. QUARK Mortality Working Group (Part of COMEAP). (2010.)

²⁹ The Air Quality (England) Regulations 2000 (SI 2000/928) & The Air Quality Standards Regulations 2010 (SI 2010/1001)

See Appendix 1 for Cambridgeshire AQMA Maps

Table 53: AQMAs in Cambridgeshire

Location		Pollutant	AQMA declaration
Cambridge City	City Centre	NO ₂	2004
	Huntingdon	NO ₂	2005
	St Neots	NO ₂	2005
	Brampton	NO ₂	2006
	A14 Hemingford to Fenstanton	NO ₂	2006
	Wisbech	SO ₂	2001
	Wisbech	PM ₁₀	2001
	Wisbech	NO ₂	2006
	Whittlesey	SO ₂	2006
South Cambridgeshire	A14 Bar Hill to Milton	NO ₂ and PM ₁₀	2008

Source: Huntingdonshire District Council.

- All of the AQMAs that have been declared for NO₂ have significant contributions of oxides of nitrogen (NO_x) from road sources; either major trunk roads or congested urban streets.
- The PM₁₀ AQMA in South Cambridgeshire results from exceedences of the 24 hour mean objective, rather than the more commonly exceeded annual mean. It is thought that the 24 hour mean exceedences result during instances of queuing traffic on the A14. This PM₁₀ AQMA is encompassed in the NO₂ AQMA.
- The PM₁₀ and SO₂ AQMAs in Wisbech were declared due to the emissions from an antiquated coal fired boiler plant at a food processing factory in the north of the town.
- The SO₂ AQMA in Whittlesey was declared due to emissions from the two brickworks to the west of the town. This AQMA was declared due to exceedences of the 15-minute mean (which is a domestic objective rather than one in EU regulations).
- Since the inception of the LAQM regime there has been no significant trend of NO₂ concentrations. Due to the very significant effects of the weather, in any given year, on the dispersion of pollutants annual mean concentrations are unreliable for showing trends in concentrations. It is, therefore, common practice to base trend graphs on five-year rolling averages.
- There is significant housing growth in the south of Cambridgeshire with many developments taking place in or adjacent to existing AQMAs or close to heavily trafficked trunk roads. These developments effectively introduce more receptors (people) into areas of poor air quality resulting in increased exposure. Sometimes the developments themselves exasperate existing air quality problems by introducing more vehicles, roads and domestic emissions. The three district councils in the south of the county have all adopted (or are in the process of adopting) planning policies which attempt to minimise worsening air quality via new developments.

4.7.3 Local Views

- Following the declaration of an AQMA the responsible district council is then obliged to proceed to a Further Assessment that looks at the pollutant sources in more detail. Once this stage has been completed an Air Quality Action Plan must be developed to identify and encourage actions to reduce the concentration of the pollutant.

- In 2010, Cambridge City Council, Huntingdonshire District Council and South Cambridgeshire District Council produced a joint Air Quality Action Plan (AQAP). The Joint AQAP was accepted and commended by the Department for the Environment, Food and Rural Affairs (DEFRA) in August 2010. During the development of the AQAP three consultation workshops were organised for stakeholders and local residents where Officers explained the process of action planning and sought views on their proposals. About 100 proposals were floated and the most supported proposals survived to be included in the final AQAP. These included:
 - The rerouting of the A14 in Huntingdonshire away from population centres.
 - Network engineering measures to improve the traffic flow on the A14.
 - More efficient transportation of goods on the A14 (although most specific measures in this connection were considered to be impracticable).
 - Opening of the Cambridgeshire Guided Busway.
 - A more coordinated approach to delivering public transport.
 - Better transport planning for new developments.
 - Use of greener vehicles with the local councils leading by example.
 - Use of more flexible working practices to discourage unnecessary travel.
 - More generally it was noted that the general awareness of air quality issues amongst the local population was very low.

4.7.4 Evidence

- The LAQM regime is well established now and local councils have developed a fair amount of expertise in the subject over the last fifteen years. DEFRA's LAQM Policy and technical guidance³⁰ was reviewed in 2009 and a number of other guidance documents have been developed to complement these providing a comprehensive suite of guidance.
- There has, therefore, been a gradual improvement in the quality of the annual LAQM reporting to DEFRA. This reflects the review process that may involve a report being returned to its local authorities by DEFRA for further review and discussion. Local authorities are also expected to discuss any accepted report.
- Generally, local authorities have been perceived to be very good at Review and Assessment but far weaker at developing meaningful Action Plans in pursuit of the Air Quality objectives. It is thought that this is largely because district councils are not responsible for the roads or large industrial processes whose emissions make such significant contributions to pollutant concentrations in AQMAs.
- In Cambridgeshire, the three district councils in the south of the county collaborated to develop their Joint AQAP in conjunction with the County Council and other partner organisations. About 100 options for improving air quality were considered and, with the benefit of cost-benefit analysis and consultation with local residents and stakeholders, these options were coalesced down to four or five priority actions for each AQMA. The extensive work which underpinned the document was acknowledged by DEFRA and the three district councils were commended for their work.

³⁰ Local AQM Policy Guidance (PG09). February 2009. DEFRA & LAQM Technical Guidance (TG09). February 2009. DEFRA.

4.7.5 What are we doing - Local Examples of Good Practice?

Case Study

The process of Air Quality Review and Assessment is working well in terms of quantifying pollutant concentrations, and delineating the extent of exceedences and assessing source apportionment.

What is this Telling us?

4.7.6 What are the Key Inequalities?

- Cambridgeshire as in other areas have declared AQMAs when concentrations of key pollutants are higher in some areas and where exceedences of objectives have been identified or predicted.
- In Cambridgeshire all of the AQMAs are heavily influenced by road traffic sources or industrial emissions so residents close to such sources are exposed to higher concentrations of air pollutants. Property prices tend to reflect the proximity of such air pollution (and noise) sources and so, to a degree, there is greater exposure amongst less wealthy members of the population. This is particularly the case in the North Ward of Wisbech where some residents are exposed to high concentrations of SO₂ and PM₁₀ from an industrial source and NO₂ from road sources.
- In addition, an inequality lies with those who already suffer from respiratory illness (such as asthma and bronchitis). Poor air quality can lead to a worsening of the effects of these illnesses.

4.7.7 What are the Gaps in Knowledge/Services/Areas for Development?

- There is a perceived knowledge gap amongst the partner organisations whose involvement is essential if the Joint AQAP is going to deliver meaningful results.
- Over the last few years there have been significant contributions to the LAQM work by the County Council, specifically the Local Environment Section. This entire section is being dissolved due to budget cuts and the last officer is expected to leave by April 2012 which will effectively end the partnership.
- The Climate Change Section at the County Council is going to be dissolved by April 2012. This section was active in changing travel behaviour which is beneficial for both climate change and LAQM.
- Although it is early days in terms of implementing the AQAP there are already clear indications that some of the key proposed actions are unlikely to happen within the original timescales due to budgetary constraints. The cancellation/deferment of the A14 upgrade, the continuing delays to the opening of the guided bus way (St Ives – Cambridge) and the cancellation/deferment of some local highway improvements have significantly impacted on the delivery of the proposed improvements to air quality. Furthermore, decreases in Nitrous Oxide emissions from the vehicle fleet, long predicted by DEFRA have failed to materialise and the result is the continuation of numerous NO₂ AQMAs resulting from transportation emissions all over the UK.
- The implementation of the Joint AQAP is working less well as some of the key priority actions have already been cancelled or deferred due to budgetary constraints.

4.8 Lifelong Learning

4.8.1 Introduction

- Education is considered to be a major determinant of health and is one of the indices that form part of the Index of Multiple Deprivation. Learning that takes place in adulthood has the potential to impact on health in two ways. It provides the skills and qualifications for employment and progression in work and there is evidence that adult learning in itself impacts on health, wellbeing and outcomes.
- There has been a focus in education on the 18-25 year olds in recent decades with investment in higher education. Marmot³¹ presents evidence that gaps remain in the provision of vocational skills for other young people. The following describes the levels of adult learning and skills needs found in the 18 to 25 year olds and in older age groups.

Adult Learning 18-25 Year Olds

What do we Know?

4.8.2 Introduction

- Local authorities are responsible for supporting NEET (young people who are NOT in Education, Employment and Training) and encouraging them to remain in learning. NEET at this age is associated with negative outcomes in later life for individuals and society, including long term unemployment, low income, health issues and depression.
- The characteristics of young people who are NEET are diverse, although there are some groups who are at greater risk of becoming NEET. The most common factor, however, relates to young people with no or few qualifications and in Cambridgeshire this would account for 50% of the NEET cohort.
- Learning Difficulty and/or Disorder (LDD) is a classification including several disorders in which a person has difficulties learning in a typical manner, usually caused by an unknown factor or factors. This disorder can make it problematic for a person to learn as quickly or in the same way as someone who is not affected by a learning disability.
- The Common Assessment Framework (CAF) is a shared assessment tool for use across all Children's Services and all local areas in England. It aims to help early identification of need and promote co-ordinated service provision.
- The Young People's Learning Agency (YPLA) champions young people's learning by providing financial support to young learners; by funding Academies, general Further Education (FE) and sixth form colleges, and other 16 - 19 providers; and supporting local authorities to commission suitable education and training opportunities for all 16 - 19 year olds.

4.8.3 Figures and Trends

- In March 2011, there were 760 people who were NEET in the 16-18 year old population in Cambridgeshire. On average, 37 per 1,000 people in this age group are in the NEET group in the county. The rate is noticeably higher in Cambridge at nearly 58 per 1,000 population. The rate is the lowest in South Cambridgeshire at a half of the county average. The data are in the table below.

³¹ *The Marmot Review Report Fair Society Healthy Lives.* Marmot M. 2010

Table 54: Not in Education, Employment or Training (NEET), Local Authority, Crude Rate Per 1,000 Population 16-18 Year, March 2011

Local Authority	NEET group	Population 16-18 year old	Crude rate per 1,000 Population 16-18
Cambridge	190	3,300	57.6
East Cambridgeshire	100	2,710	36.9
Fenland	160	3,630	44.1
Huntingdonshire	230	6,110	37.6
South Cambridgeshire	90	4,860	18.5
Cambridgeshire	760	20,610	36.9

Source: Cambridgeshire County Council Connexions.

- On average, 4.8% of the total cohort in the 16-18 age group is not in education, employment or training in Cambridgeshire. Localities with the highest proportion of people in the NEET group are in Wisbech (7.8%), Cambridge North (6.7%) and Cambridge South (6.5%) and Cambridge City (6.6%).

Table 55: Not in Education, Employment or Training (NEET), Locality, March 2011

Local Authority Locality	NEET group	Cohort total	% NEET
Cambridge	190	2,880	6.6%
Cambridge North	90	1,330	6.7%
Cambridge South	100	1,550	6.5%
East Cambridgeshire	100	2,370	4.3%
Bottisham/Burwell/Soham	40	1,180	3.7%
Ely/Littleport/Witchford	60	1,190	4.9%
Fenland	160	2,710	6.0%
March and Chatteris	70	1,140	5.9%
Whittlesey	20	520	3.0%
Wisbech	80	1,050	7.8%
Huntingdonshire	230	4,840	4.8%
Huntingdon	70	1,410	5.4%
Ramsey/Sawtry/Yaxley	60	1,520	3.8%
St Ives	30	720	4.7%
St Neots	60	1,190	5.4%
South Cambridgeshire	90	3,270	2.8%
Bassingbourn/Melbourn/Comberton/Gamlingay	40	1,380	2.9%
Cottenham and Swavesey	30	1,060	3.2%
Sawston and Linton	20	830	2.2%
Cambridgeshire	760	16,070	4.8%

Source: Connexions, 2011. Figures are rounded to the nearest ten. Mid 2009 population estimates for people aged 16-18 years, Cambridgeshire County Council Research, Performance and Business Intelligence Team.

4.8.4 Evidence/Policy

- Marmot³² provides evidence that young people are most likely to be unemployed and be in low skilled jobs. It recommends that that young people receive individualised support to gain skills that start well before they leave school and maintaining the support through the transitional years from 16 to 25. The Report's evidence based policy recommendations for this age group for the period 2011-2015 are found in the box below.

³² The Marmot Review Report Report, Fair Society Healthy Lives Marmot M. 2010

- Developing school based workforce to build their skills in working across school home boundaries and addressing social and emotional development, physical, mental health and wellbeing.
- Increase lifelong learning opportunities across the gradient by:
 - Providing support and advice for 16-25 year olds on life skills, training and employment opportunities, delivered through centres that are easily accessible to young people.
 - Increasing opportunities for work based learning for young people, including apprenticeships and for those changing jobs/careers.

- NEET development work in Cambridgeshire follows evidence informed practice and national policy. Recent reports that relate to this area include: Against the Odds³³ (Re-engaging young people in education, employment or training) and What Works³⁴ (Re-engaging young people who are NEET).
- All stress the need for local authorities and their partners to understand the nature of the local NEET population and respond appropriately; get better outcomes by targeting their approaches and resources. Common success factors in getting young people into work or learning include: using information about young people to design responses appropriate to their circumstances; targeted pre-16 support for those at risk of becoming NEET and post 16 interventions tailored to individuals.

4.8.5 What are we doing in Cambridgeshire - Local Examples of Good Practice?

Case Study

Key NEET data has been used to inform the county commissioning statement for 16 – 19 provision in 2011/12. This ensures there is an appropriate spread of provision in learning funded by the YPLA to meet the needs of young people in the county. Currently, over 90% of young people remain in learning for one year post compulsory school leaving age.

What is this Telling us?

4.8.6 What are the Key Inequalities?

- Key inequalities are between Cambridge and South Cambridgeshire localities. There are also inequalities between localities within the Districts, as in Fenland, in Whittlesey (3.0%) and Wisbech (7.8%).
- Young people are more likely to become NEET if they:
 - Live in communities with high levels of deprivation
 - Have attendance and/or behaviour issues and at risk of or are excluded
 - Have low attainment
 - Are young parents

³³ Against the Odds – Audit Commission 2010

³⁴ What Works – Re-engaging young people who are NEET - DfE 2010

- Are engaging in risky behaviour including substance misuse and offending
- Have a Learning Difficulty and/or Disability (LDD)
- Are Looked After Children/Care Leavers
- Are Young Carers
- Are at risk of becoming homeless

4.8.7 What are the Gaps in Knowledge/Services/Areas for Development?

- No single organisation can reduce NEET levels. Collaboration is necessary to make the most effective use of scarce resources. As a starting point all partners should have access to the county NEET profile, greater integration of databases would enable earlier identification of young people at risk of NEET and more detailed reporting. There is a rich source of data in this area that could be used more effectively to inform planning and commissioning of services.
- The move to more targeted support for those young people at risk of NEET has reduced the capacity to offer universal services such as individual guidance and open access youth clubs. The challenge will be to ensure that young people do not slip through the net. Local commissioning and traded services may close this gap but variations in demand could lead to inequity in outcomes.
- Commissioning should take into account young people's views. Transport prevents a significant minority of young people from participating. Providers need to look at more creative ways of delivering learning if full participation is to be reached by 2015.
- Literacy and numeracy support at primary level would enable a more successful transition to secondary school curriculum and help prevent disengagement.
- Impartial, high quality Information, Advice and Guidance (IAG) is required to enable young people to make appropriate choices post 16. How this will be delivered to ensure all young people remain in learning needs to be considered at county level to prevent local variations in approach, which may result in inequality of opportunity for young people.
- The Common Assessment Framework (CAF) is the main mechanism to accessing individual support for young people across the county but has yet to be consistently applied.

Adult Learning - General

4.8.8 Introduction

- Adult learning is a broad concept. Participation in any form of learning has a range of potential benefits that may be beneficial to health. It may stimulate further personal development which may contribute to finding employment as well as other benefits. In practice, adult learning is taken forward through a range of services which reflects the concept that adult learning can encompass a very wide diverse range of activities.
- The Adult Learning and Skills Service provides learning, library learning and careers guidance opportunities for a very diverse population of learners across the whole of Cambridgeshire. A majority of the Informal Adult Learning is delivered by the community colleges. The accredited skills courses are delivered by a range of providers including further education colleges, private training providers, library learning services and voluntary sector organisations.

- The Adult Learning and Skills Service has a contract with the Skills Funding Agency (SFA) to provide adult and community learning and adult learner responsive courses that lead to qualifications. The SFA also secures contracts through University for Industry (UFI) for Learn Direct delivered through the Library Learning Centres. The SFA funds Information Careers Advice and Guidance (IAG) through Next Step via a regional contract managed by Suffolk County Council.

4.8.9 Figures and Trends

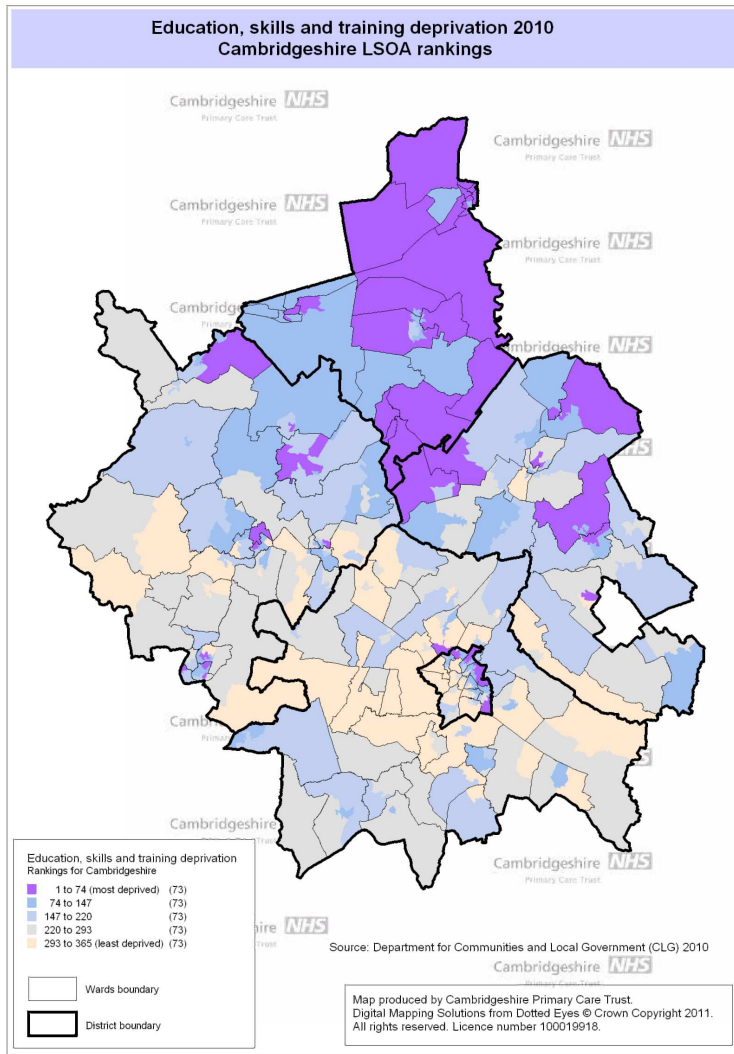
- The table below shows numbers of people in 19-64 age group engaged in Adult Learning in 2007/08–2009/10.
- In 2009/10, more than 6,500 people were attending courses in Adult Learning in Cambridgeshire at an average of 1.8% of people in the 19-64 age group. It was less than in the previous years. In 2007/08 more than 9,000 people in this age group were attending the courses at an average of 2.5% of the 19-64 population.
- In the whole period East Cambridgeshire, Huntingdonshire and South Cambridgeshire had higher proportions of adult learners in their 19-64 population. In Cambridge and Fenland this proportion was smaller and it was decreasing from 1.5% to 0.8% in Cambridge and from 2.1% to 1.1% in Fenland (2007/08 and 2009/10 data are used for comparison).

Table 56: Adult Learning, Local Authority, 2007/08–2009/10

Local Authority	2007/08		2008/09		2009/10	
	Number	% of population aged 19-64	Number	% of population aged 19-64	Number	% of population aged 19-64
Cambridge	1,182	1.5%	1,054	1.3%	642	0.8%
East Cambridgeshire	1,460	3.1%	1,392	2.9%	973	2.0%
Fenland	1,099	2.1%	905	1.7%	567	1.1%
Huntingdonshire	2,814	2.8%	2,485	2.5%	2,095	2.1%
South Cambridgeshire	2,614	3.0%	2,285	2.6%	2,285	2.7%
Cambridgeshire	9,169	2.5%	8,121	2.2%	6,562	1.8%

Source: Adult Learning & Skills (Lifelong Learning) from CCC Adult Learning Services 2011. Mid-2007, mid 2008 and mid 2009 population estimates from CCC/LGSS Research, Performance and Business Intelligence Team.

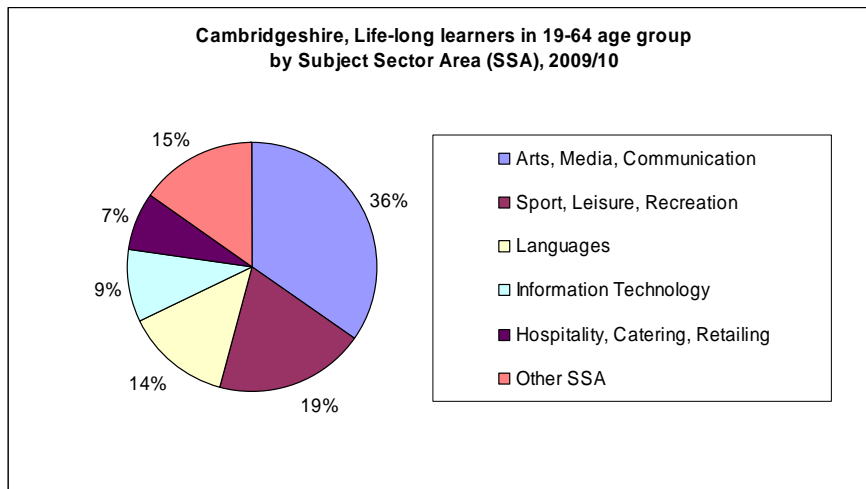
Map 5: Education, Skills and Training Deprivation 2010



Note: the darker colours indicate relatively more deprivation.

- In 2009/10, Adult Learners in the 19-64 age groups studied mostly Arts, Media and Communication (36%), Sport, Leisure, Recreation (19%) and modern languages (14%). The data is in the figure below.

Figure 15: Cambridgeshire, Adult Learners in 19-64 Age Group by Subject Sector Area, 2009/10



Source: Adult Learning & Skills (Lifelong Learning) from CCC Adult Learning Services 2011

- Data on age shows a consistent trend with around 40% of adult learners being over 55, 20% are over 65. Curriculum development in exercise classes is particularly designed to meet older learners' needs and to keep them safe. Evidence of the benefits is collected by learner questionnaire and course evaluation.
- The Cambridgeshire years highlighted in the data indicates a drop in enrolments reflecting the national picture in adult learning.
- The increase in numbers of learners on courses targeted at disadvantaged learners by Voluntary and Community Sector (VCS) groups is good.
- The Neighbourhood Learning in Deprived Communities (NLDC) and Development Fund Programmes (which specifically target disadvantaged communities) successfully recruit Black Minority Ethnic (BME) learners at 14% and 19% respectively (county population is 9%). Recruitment of males is good, 40% and 36% respectively (regional average 27%). Learners are unemployed, living in social housing, lone parents, in receipt of benefits, homeless, Travellers or adults with learning difficulties and/or disabilities. Curriculum is strongly focused on employability, practical skills and community development and learners frequently progress to employment, volunteering and further education.
- Increasing links with PCTs have good benefits for learners, for example Comberton Village College works with local general practices, who refer learners on to a fitness programme tailored to meet their needs. Evaluations of this course from learners and tutors show improved health.
- Family Learning is offered across Cambridgeshire in children's centres and schools. In Family Learning (FL), learners develop good confidence and parenting skills encouraging some to volunteer as parent helpers, to support children in school or to take a more active part in their local communities.
- Achievement and secondary benefits are good for learners on exercise classes, who report improvements to their muscular skeletal conditions and benefits to their physical, mental and social wellbeing.
- There has been good growth (21%) over three years in learners in food related courses. This area includes classes in cooking from across the world and food hygiene/safety taken to enhance employment.
- Programmes targeted at the disadvantaged are successful in engaging hard to reach learners. Overall numbers have increased over three years by 15%.

4.8.10 Local Views

- Within the Learner Involvement Strategy, an improving range of learner surveys, evaluations and learner focus groups produce a satisfactory sample of learner feedback. Local managers and front line staff regularly listen to verbal feedback and action is taken to improve resources and programmes. With the added support of District Managers, increasing numbers of learner focus groups are taking place and the recording of verbal feedback is improving. In 2010/11 learner surveys and focus groups, questions about social impact and community volunteering started to be used more widely to align with the Common Inspection Framework.
- An overview of the surveys undertaken in 2010/11 found that 90% of learners say they are very or extremely satisfied with all aspects of their experience.
- Learners on Development Fund and Neighbourhood Learning in Deprived Communities projects gave good evaluations on their progress and achievement, both in meeting the aims of the programme and in gaining confidence and improving skills. Many of these learners were from the hardest to reach groups in the counties communities.

4.8.11 Evidence/Policy

- There is a body of evidence that supports adult learning as being not only the route to employment but also to improvements in health.
- Non Vocational Qualifications (NVQ) has been shown to increase the likelihood of participating in further accredited learning.³⁵
- Other studies confirm an association that adult learning improves confidence³⁶ and self-efficacy.³⁷ These are associated with positive health behaviours.³⁸ It has been³⁹ estimated that taking one or two courses of any type between the ages of 33 and 42 can result in a 3.3% increase in the probability of giving up smoking.
- There is also a range of evidence of how adult learning impacts on preventative health as available on the Department for Business Innovation and Skills website.
<http://www.bis.gov.uk/policies/further-education-skills/learners/informal-adult-learning/ical-evidence-base/health-and-wellbeing>

Examples include:

- Four-fifths of learners aged 50–71 reported that learning has a positive impact on confidence, life satisfaction or their capacity to cope. <http://www.employment-studies.co.uk/pubs/summary.php?id=rr183>
- Exercise referral programmes have been shown to improve the physical and mental wellbeing of people experiencing poor mental health.⁴⁰
- An evaluation of a GENERAL PRACTICE prescribed exercise programme for patients with a diagnosis of depression found that 68% of those who accessed the programme had reached a non-clinical status three months later⁴¹ and after 16 weeks of treatment supervised exercise referral programs have been shown to be as effective as anti-depressant medication.⁴²
- Engagement in creative arts groups has been shown to lead to improved self esteem, feelings of empowerment and improved quality of life.^{43 44}
- In a survey of 2,000 adult learners, 89% reported that lifelong learning had a positive impact on their emotional wellbeing. Many felt that this was because they enjoyed their learning experience and that it had led to an increase in their self confidence.⁴⁵

³⁵ *The Value of Basic Skills in the British Labour Market* Vignoles A., De Coulin A., Marcenaro-Gutierrez DCSF (2008)

³⁶ *Adult literacy and numeracy, social capital, learner identities and self-confidence.* Tett L, Maclachlan K., *Studies in the Education of Adults* 39 (2) 150-167 (2007)

³⁷ *Are those that flourished at school healthier adults? What role for adult education?* Hammond C., Feinstein L London Centre for Research on the Wider Benefits of Learning (2006)

³⁸ *Self-Efficacy: The exercise of control.* Bandura A. New York Freeman (1997)

³⁹ *The contribution of adult learning to health and social capital, wider benefits of learning,* Feinstein I., Hammond C., Woods L., Preston J., Brynner J. Research Report. London Institute of Education (2003)

⁴⁰ Mental Health Foundation, 2009

⁴¹ Darbshire, Glenister, 1998

⁴² Blumenthal et al, 1999

⁴³ Huxley, 1997

⁴⁴ Secker et al, 2007

⁴⁵ Aldridge and Lavender, 2000

Policy

- *The Marmot Review Report*⁴⁶ recommends a number of policy drivers relating to adult education (see above for 16-25 year olds). For adults in general the review makes the following recommendations.

Increase access to and use of quality lifelong learning opportunities across the social gradient by increasing the availability on non-vocational life long learning across the life course.

There are more specific policy drivers that also lend support to adult education.

- The Department for Business Innovation and Skills (BIS) perspective is found in *Skills for Sustainable Growth* (November 2010)⁴⁷ where it is clearly stated that the aspirations for learning are not just about skills and employability, but the wider agenda of health and wellbeing.

“Learning is not just about developing skills for employment – learning also helps create a better society. There is a wealth of evidence that engaging in learning brings a wider range of benefits in enriching our lives and developing our communities. **It also brings health benefits and promotes wellbeing.**”

- The very recent Government document *New Challenges, New Chances for Adult Learning* (2011) is a consultation on proposals below that are of its ongoing reform of adult education.
 - Provide greater freedoms and flexibilities and further reduce the burden of bureaucracy on further education and skills providers.
 - Improve the quality of teaching and learning for adults.
 - Strengthen further education and skills providers’ capacity to offer training at higher education level.
 - Review and improve basic literacy and numeracy provision for adults.
 - Refocus Government support for informal adult and community learning.
 - Introduce loans from the 2013/14 academic year providing access to advanced and higher level courses.
 - Develop the further education landscape and shape of the sector.
 - It also provides support for Informal Adult and Community Learning (IACL) confirming its critical role in providing learning opportunities for everyone, regardless of age or background. The document states that it can offer life-changing experiences and help to develop new interests and new skills that can in time turn into new careers.

⁴⁶ *The Marmot Review Report: Fair Society Healthy Lives* Marmot M. (2010)

⁴⁷ Further Education-New Horizons. Investing in Skills for Sustainable Growth. Department for Business Innovation and Skills (2010)

4.8.12 What are we doing in Cambridgeshire - Local Examples of Good Practice?

Case Study

- The majority of learners in Informal Adult Learning (IAL) are over 46 years, and around 20% are over 65 years. The type of provision is attracting the target group of learners who may most benefit. They improve and maintain health and wellbeing through exercise, developing social contacts, and do creative work in art and craft. Evidence of the benefits is collected by learner questionnaires and evaluations.
- The spread of courses across Cambridgeshire means that provision is accessible to people in their local area.

What is this Telling us?

4.8.13 What are the Key Inequalities?

- The county's performance in improving skills to meet the needs of businesses improved before the recession. However, although the percentage of the working population with various qualification levels improved (although not at a sufficient rate to meet targets – 79% of the population to be qualified to level 2 by 2010-11, 56% to level 3 and 34% to level 4), this was largely driven by raising school age and higher education attainment filtering through to the adult population. However, since the recession and subsequent associated cuts in publicly funded programmes linked to skills, a number of indicators point to future concerns:
 - Apprenticeship starts need to increase to make up for the gap caused by the decline in other funded employee qualification routes such as 'Train to Gain'.
 - A lack of skilled workers and workers with sufficient employability, continues to be raised as an issue by manufacturing firms, even though labour market availability has increased.
 - The government is committing to the adult learning budget, but sees the fund being more targeted at those with the most need. (New Challenges, New Chances BIS August 2011)
 - Although having generally very high levels of skills, Cambridgeshire also demonstrates some of the highest levels of skills inequality with areas of skills deprivation evident in a number of communities.
 - Failure to invest in skills will increase demand for services.

4.8.14 What are the Gaps in Knowledge/Services/Areas for Development?

- Informal Adult Learning (IAL) learners are offered satisfactory support through induction, 'Support for You' leaflet to request learning support and a contact number on all prospectuses. However, there has been little take-up overall, with most support being given for hearing and sight impairment. There are few disability disclosures on enrolment forms. Absence of funding is also a barrier. Other than in further education funded courses (for qualifications only), specific funding for learner support is not provided for IAL.
- Growing awareness is producing an increase in Personal Emergency Evacuation Plans for disabled learners, taking courses at centres. However, not all learners realise that support is available and that can be a barrier to enrolment.

- Led by the adult service, Informal Learning Partnerships have developed with a focus on linking up the learning and a vision that they will provide a local planning opportunity. It is also envisioned that in the long term they will ensure, by undertaking needs analyses, that the local needs are met and that duplication and gaps are avoided. They will also form a significant part of the communication link through the Adult Learning and Skills Board to the Local Economic Partnership who will be the gatekeepers of the Cambridgeshire Skills Strategy.

4.9 Workplace Health

What do we Know?

4.9.1 Introduction

“Healthy Workplaces, designed to protect and promote health and wellbeing are key to preventing illness arising in the first place. It is important that employers provide and maintain them.”⁴⁸

Dame Carol Black 2008

- There is a positive link between employment and health. A recent review *Is work good for your health and wellbeing?* concluded that work was generally good for both physical and mental health.⁴⁹ For all age groups, work generally:
 - makes people healthier
 - helps people with a health condition get better
 - improves the health of people returning to work from unemployment
- Absence has further health implications too - the longer someone is out of work due to ill-health, the lower their chance of getting back into work:
 - the long-term unemployed or those who have never worked are two to three times more likely to have poor health than those in work
 - people are twice as likely to become psychologically distressed after going from work to unemployment
 - if you are off sick for six months, you have an 80% chance of being off for five years
 - 90% of people making a claim for incapacity benefits expect to return to work, but if you claim for two years or more, you are more likely to retire or die than return to work

Non-work related illness and injury is by far the most widespread driver of employee absence, followed by post-operative recovery time.

Mental health issues are the single biggest cause of long term absence followed by musco-skeletal orders, back pain and cancer treatment. Other factors contributing to absence include personal problems, caring responsibilities and misuse of sick pay provision by some employees.

Employment can protect a person’s mental health by boosting confidence and self-esteem; unemployment can be both a consequence and cause of mental health problems.⁵⁰ The issues related to employment and mental health have been looked at

⁴⁸ Black, C. *Review of the Health of Britain’s working age population: Working for a Healthier Tomorrow* (2008) <http://www.dwp.gov.uk/docs/hwwb-working-for-a-healthier-tomorrow.pdf>

⁴⁹ Waddell and Burton. *Is Work Good for your Health and Wellbeing?* The Stationery Office 2006 <http://www.dwp.gov.uk/health-work-and-well-being/about-us/>

⁵⁰ Burchardt T. *Employment Retention and the Onset of Sickness or Disability: Evidence from the Labour Force Survey (LFS) Longitudinal Data Sets*. Department for Work and Pensions. 2003.

in more detail in the *Mental Health JSNA* <http://www.cambridgeshirejsna.org.uk/mental-health-adults-working-age>

- The benefits of a healthy workplace can be summarised as:
 - Improved productivity and performance.
 - Reduced absenteeism and other costs associated with ill health.
 - Fewer injuries, accidents, and insurance and compensation claims.
 - Improved employee morale and staff retention.
 - Employees more receptive to and better able to cope with change.
 - Enhanced business reputation and corporate responsibility.

4.9.2 Figures and Trends

- Findings from the *Absence and Workplace Health Survey 2010*⁵¹ showed the average rate of absence in 2010 was 6.5 days per employee, only a marginal change from the record low of 6.4 days reached in 2009.⁵¹
- Absence from work results in 190 million lost working days, costing £17 billion a year in sickness absence⁵¹ (2010 figures). This includes over 2.7bn from 30.4 million days of non-genuine sickness absence.
- The above figures do not include the indirect costs of absence like lower customer service and lost productivity or the effects of 'presenteeism' – the loss of productivity that occurs.
- Viewed over the longer term, average annual employee absence levels have fallen by more than a quarter since the 1980s.
- Employees in the public sector take more sick days off than in the private sector, an average of 8.1 days a year compared with 5.9 day.⁵¹
- Long term absence accounts for almost half the days lost in the public sector and this is a much greater proportion than in the private sector where it accounts for 27% of days lost.
- Sickness absence figures have not improved in the first year following the launch of the 'fit' note – a new medical certificate that focuses on what people can do and is designed to aid returns to work and reduce absence costs. While a quarter (23%) of employers have found the fit note helpful to their rehabilitation policies, two thirds of firms (65%) say it has not moved things forward, with other employers undecided.
- Just one in eight employers (13%) have confidence that doctors have sufficient training to use the new fit notes differently to the old sick notes.
- In the last quarter of 2010, the percentage of all employees absent from work due to sickness or injury in England was estimated at 2.5%: 2.1% in males and 2.9% in females.⁵²
- Based on the above, the numbers of employees estimated to be absent from work in Cambridgeshire are set out in Table 57. It shows that nearly 6,500 employees might have been absent from work for at least one day due to sickness or injury in the last quarter of 2010.

⁵¹ CBI/Pfizer, Healthy Returns? Absence and Workplace Health Survey 2010. May 2011 <http://www.cbi.org.uk>

⁵² ONS, Absence from Work Statistics, 2011 <http://www.ons.gov.uk/ons/index.html>

Table 57: Absence from Work, Estimated Numbers of Employees 16+ Q4 2010

Local Authority	Males (2.1% of 16+ employees)	Females (2.9% of 16+ employees)	All people (2.5% of 16+ employees)
Cambridge	660	760	1,450
East Cambridgeshire	420	510	940
Fenland	380	490	880
Huntingdonshire	740	920	1,680
South Cambridgeshire	700	840	1,550
Cambridgeshire	2,900	3,530	6,490

Source: Employees 16+ population NOMIS, ONS Annual Population Survey.

Percentage of employees 16-64 absent from work due to sickness or injury. Absence from work statistics, ONS, 2011, <http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14424>

Note: ONS absence from work statistics are for 16-64 population; in local estimates the percentages were applied to 16+ population.

- Data on fatal and major injuries to employees in Cambridgeshire are available from the Health and Safety Executive (See Tables 58 and 59). Provisional data from 2008/09 shows that the:
 - rates of fatal and major injuries in East Cambridgeshire were more than twice as high as in England;
 - rate in Fenland was also significantly higher;
 - rates of injuries in Huntingdonshire and South Cambridgeshire were lower than those seen nationally;
 - rates of injuries where employee was absent from work for more than three days, were also markedly higher in Fenland and East Cambridgeshire.

Table 58: Fatal and Major Injuries to Employees and Rates of Injuries, 2006/07-2008/09p

Local Authority	Fatal and Major Injuries			Fatal and Major Rates per 100,000 employees		
	2006/07	2007/08	2008/09p	2006/07	2007/08	2008/09p
Cambridge City Council	71	81	89	81	96	105
East Cambridgeshire District Council	62	41	62	226	162	245
Fenland District Council	53	58	61	155	173	182
Huntingdonshire District Council	92	95	67	125	132	93
South Cambridgeshire District Council	58	48	47	90	76	74
Cambridgeshire	425	440	445	110	116	118
East of England	2,438	2,453	2,345	103	104	99
England	24,087	23,555	23,138	106	103	102

Source: Health and Safety Executive.

Notes: Excludes injuries reported to the Railways Inspectorate/ORR and records where the Local Authority location is not known. Rates based on employee numbers less than 10,000 are suppressed on grounds of reliability and to preserve confidentiality. NB 2007/08 employment data for Local Authorities has been used for the last two years as it is unavailable for 2008/09.
p = provisional

Table 59: Over Three Day Injuries to Employees and Rates of Injuries, 2006/07-2008/09

Local Authority	Over 3 day injuries			Over 3 day injuries rates per 100,000 employees		
	2006/07	2007/08	2008/09p	2006/07	2007/08	2008/09p
Cambridge City Council	330	326	338	376	385	400
East Cambridgeshire District Council	158	142	128	577	561	506
Fenland District Council	246	196	208	719	583	619
Huntingdonshire District Council	336	336	310	458	466	430
South Cambridgeshire District Council	201	144	176	310	227	278
Cambridgeshire	1,746	1,601	1,594	452	423	421
East of England	10,164	9,647	9,478	430	408	400
England	97,475	93,571	88,768	430	409	390

Source: Health and Safety Executive (HSE).

Notes: Excludes injuries reported to the Railways Inspectorate/ORR and records where the Local Authority location is not known. Rates based on employee numbers less than 10,000 are suppressed on grounds of reliability and to preserve confidentiality. NB 2007/08 employment data for Local Authorities has been used for the last two years as it is unavailable for 2008/09.

p = provisional

- 'Regional injury maps' show that East Cambridgeshire and Fenland are categorised in high risk groups for injury rates when compared to other local authorities (see Table 60)

Table 60: Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Injury Rates Per 100,000 Employees, 2009/10p

Local authority area	Injury rate per 100,000 employees	Risk Group
Cambridge	422.6	Average
East Cambridgeshire	647.8	High
Fenland	820.4	High
Huntingdonshire	511.9	Average
South Cambridgeshire	369.8	Low

Source: HSE, Regional injury maps 2009/10.

Note: Each local authority is categorised as high, medium or low risk according to how the injury rate compares to other local authority areas across Great Britain.

p = provisional

4.9.3 Local Views

We have found limited information on local views.

For the NHS, the Care Quality Commission runs annual staff surveys which provides robust information on NHS staff views and this is available for Trusts across Cambridgeshire at http://www.cqc.org.uk/aboutcqc/howwedoit/engagingwithproviders/nhsstaffsurveys/staffsurvey2010/nhsstaffsurvey2010.cfm?widCall1=customDocManager.generateatoz_show_1&civ_startletter=C

4.9.4 Evidence/Policy

- There is evidence that shows when organisations proactively improve their working environments by organising work in ways that promote health, all adverse health-related outcomes, including absence and injuries, decrease. This makes a strong business case for creating a healthy workplace.⁵³
- Evidence and good practice for workplace health have been set out in a number of national policy documents; most recently these include Dame Carol Black's *Review of the Health of Britain's Working Age Population, Working for a Healthier Tomorrow*⁵⁴ (2008) and subsequently, Dr Steven Boorman's *NHS Health and Wellbeing Review*⁵⁵ (2009). Important factors to consider include how work is organised and carried out, physical working conditions, employee consultation and involvement, and the organisation's policies, procedures and rules eg flexible working policies, avoidance of long hours culture, better design of the physical environment of the office and addressing travel.
- Leadership is the key to a healthy workplace and health promotion initiatives will only be effective under conducive managerial conditions, primarily those that stimulate employee job satisfaction. Line managers have a key role in ensuring the workplace is a setting that promotes good health and wellbeing. Good management can lead to good health, wellbeing and improved performance. The reverse can be true of bad management. Good health equals good business, and the line manager is a key agent of change⁵⁴.
- There is evidence that the following interventions are important for workplace health.⁵⁶
 - Getting the basics right – ie robust procedure for reporting absence, effective management of short and long term absence, timely occupational health support.
 - Robust business case and strategy in place – gaining senior manager support, managers leading by example.
 - Sustainability – mainstream initiatives as part of normal business.
 - Engage staff in what they think would improve their health and wellbeing and tailor interventions to suit staff. Health promotion activities in the workplace can be beneficial, but are more effective if they address the employees' expressed needs through an employer/employee partnership and especially if they involve increasing levels of physical activity.⁵⁷
 - Measure impact and progress – uptake, impact on staff attitudes, benchmarking the effectiveness of interventions.⁵⁸
- The Boorman Report highlighted the importance of good occupational health services and the need to modernise these within the NHS. Following this, a new report⁵⁹ - *Healthy Staff, Better Care for Patients: Realignment of Occupational Health Services to the NHS in England* has been published.

⁵³ Faculty of Public Health & Faculty of Occupational Health (2006) *Creating a Healthy Workplace* <http://www.fph.org.uk>

⁵⁴ Black, C. *Review of the Health of Britain's working age population: Working for a Healthier Tomorrow*⁵⁴ (2008) <http://www.dwp.gov.uk/docs/hwwb-working-for-a-healthier-tomorrow.pdf>

⁵⁵ Boorman, S *NHS Health and Wellbeing Review*⁵⁵ (2009) <http://www.nhshealthandwellbeing.org/>.

⁵⁶ PA Consulting (2008) *High Impact Healthy Workplace Interventions: Case Studies of Good Practice* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083381

⁵⁷ Hill et al (2007) *Review of the Health of Britain's Working Age Population, Institute for Employment Studies* http://www.employment-studies.co.uk/policy/resources/health_review_1207.pdf

⁵⁸ Boorman et al (2009) *Health and Wellbeing at Work in the UK*, DH <http://www.nhshealthandwellbeing.org/pdfs/Interim%20Report%20Appendices/Literature%20Review.pdf>

⁵⁹ Dept of Health *Healthy Staff, Better Care for Patients: Realignment of Occupational Health Services to the NHS in England*, July 2011 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128814.pdf

- In addition, examples of good practice, identified from case studies of different organisations include:
 - The use of multiple communication channels.
 - Empowering employees and line managers.
 - Employing a holistic approach to health and wellbeing.
 - Effectively branding and marketing the strategy – bringing initiatives together to ensure joined up working and marketing the strategy to the ‘end user’, the employees.
- Recent changes in legislation and initiatives such as Pathways to Work highlight the timely emphasis on rehabilitation and recruitment and retention of employees with disabilities and chronic illnesses (See the Department for Work and Pensions website www.dwp.gov.uk for initiatives which support people in getting into work).
- In England, NICE has developed four sets of guidance that specifically relate to the workplace. These include:
 - Managing long-term sickness absence and incapacity for work.⁶⁰
 - Promoting physical activity in the workplace.⁶¹
 - Promoting mental wellbeing through productive and healthy working conditions.⁶²
 - Workplace interventions to promote smoking cessation.⁶³

NICE guidance provides evidence on the benefits of a healthy workplace including: improved productivity and performance; reduced absenteeism and other costs associated with ill health; fewer injuries, accidents, and insurance and compensation claims; improved employee morale and staff retention; employees more receptive to and better able to cope with change; and enhanced business reputation and corporate responsibility.

- Two other sets of NICE guidance also contain recommendations that relate to the workplace:
 - Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children.⁶⁴
 - Promoting and creating built or natural environments that encourage and support physical activity.⁶⁵
- NICE guidance supports the business case for promoting a healthy workplace.⁶¹ For example promoting physical activity in the workplace may incur some costs but these are outweighed by benefits such as:
 - reduced sickness absence;
 - improved health and wellbeing of team;
 - improved employee satisfaction and staff retention;
 - improved productivity and reduced ‘presenteeism’ ;
 - improved team working;
 - enhanced company profile.
- In terms of smoking cessation⁶³, the evidence suggests that a person who smokes spends more time off sick than one who does not. Some evidence suggests that on average, a person who smokes will have 33 hours off sick, more per year than a non-smoker.

⁶⁰ NICE (2009) Long term sickness absence and incapacity for work www.nice.org.uk/PH19

⁶¹ NICE (2008) Promoting Physical Activity in the Workplace <http://guidance.nice.org.uk/PH13>

⁶² NICE (2009) Promoting mental wellbeing at work <http://guidance.nice.org.uk/PH22>

⁶³ NICE (2007) Workplace Interventions to promote smoking cessation <http://guidance.nice.org.uk/PH5>

⁶⁴ NICE. Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (CG43). London: NICE, 2006.

⁶⁵ NICE. Promoting and creating built or natural environments that encourage and support physical activity (PH8). London: NICE, 2008.

- Promoting the mental wellbeing⁶² of employees can have economic benefits by improving staff retention, productivity and performance, and reducing absenteeism. The costs associated with employees' mental health problems are significant in terms of lost productivity because of absence and early retirement, and increased staff turnover. Positive steps to improve the management of mental health in the workplace, including prevention and early identification of problems, should enable employers to save at least 30% of these costs.
- Business in the Community's *Healthy People = Healthy Profits Report*⁶⁶ showcases 20 examples of organisations that have developed outstanding employee health programmes which have benefited their employees and operations through productivity and cost savings.

What are we doing - Local Examples of Good Practice?

Case Study

A number of local and national programmes are in place that can provide support to health at work initiatives in Cambridgeshire. Among these is NHS East of England's Staying Healthy at Work (SHaW) programme that offers support to NHS employers and wider businesses, and offers an accreditation scheme as part of this. The programme is seeing encouraging progress and improvements in sickness absence within the organisations that have an active approach to employee health and wellbeing. The SHAW website provides a gateway to other initiatives and good practice. NHS Employers host the NHS wellbeing portal that brings together a comprehensive and continuously updated range of resources, including case studies of good practice.

What is this Telling us?

4.9.5 What are the Key Inequalities?

Cambridgeshire workplace injury data demonstrates that the:

- Rates of fatal and major injuries are higher in East Cambridgeshire (the rates are more than twice as high as in England).
- Rate in Fenland is also significantly higher than England.
- Rates of injuries in Huntingdonshire and South Cambridgeshire are lower than those seen nationally.
- Rates of injuries where an employee was absent from work for more than three days, were also markedly higher in Fenland and East Cambridgeshire.
- National data⁵¹ indicates:
 - There is a widening gap between the best and worst performing organisations in terms of average absence levels, showing the scope to raise performance.
 - Absence continues to be higher amongst manual employees than among non-manual staff but the gap is steadily narrowing.
 - While average absence levels remain higher in the public sector than in the private sector, 2010 saw the gap narrow.

⁶⁶ Business in the Community *Healthy People = Healthy Profits* Feb 2009 http://www.bitc.org.uk/resources/publications/healthy_people_.html

- Average levels of absence climb with organisation size. While SMEs average, under five days of absence per employee, larger employers average over seven days.
- Long term absence accounts for almost half the days lost in the public sector (47%) and this is a much greater proportion than in the private sector where it accounts for 27% of days lost.

4.9.6 What are the Gaps in Knowledge/Services/Areas for Development?

- There is a wide range of occupations across Cambridgeshire with many small and medium sized businesses in the county.⁶⁷ However, we have limited local data on employee health and occupational health services in Cambridgeshire's workplaces. The information we do have gives us an insight into the marked differences in reported workplace injury rates by district council area.
- The Richmond Fellowship provides services across Cambridgeshire that support people with mental health problems back into work including providing placements for work experience. The JSNA mental health 2010 <http://www.cambridgeshirejsna.org.uk/mental-health-adults-working-age/mh-adults> describes that more could be done with employers to find opportunities to find short term placements and voluntary work that provides the stepping stones into paid work.
- Based on the strong evidence base for the importance of workplace health on mental health and wellbeing, the *Mental Health JSNA 2010* recommended:
 - "NHS organisations and the Local Authority should take a lead role and work in partnership to promote a healthy workplace for their own and partner organisations."
 - In order to support the workplace recommendation made in the Mental Health JSNA 2010, it is recommended that further more detailed work is carried out.
- An assessment and better understanding of the health and wellbeing of employees across the range of organisations and businesses in Cambridgeshire is required. This should include an understanding of employers and employees views of the factors that influence their wellbeing and the measures that would support them.
- An understanding of the disparities in injury rates reported in the districts in Cambridgeshire, particularly the higher injury rates reported in East Cambridgeshire and Fenland is required.
- The learning from the 'Health at Work' Network⁶⁸ working groups needs to be shared. Areas of work include engaging Small and Medium Sized Enterprises (SMEs) in workplace health and wellbeing, guides for managing chronic conditions in the workplace, occupational health guidance and mental health.

⁶⁷ Cambridgeshire County Council Economic Assessment 2011 Business profile <http://www.cambridgeshire.gov.uk/NR/rdoonlyres/24E6AF41-201F-4E99-B430-461BED86CFE1/0/Business.pdf>

⁶⁸ This relates to the health at work pledge of the Public Health Responsibility Deal March 2011 <http://www.dh.gov.uk/en/Publichealth/Publichealthresponsibilitydeal/index.htm>

4.10 Access to Services

4.10.1 Access to Car or Van

The latest data available for car ownership are from the 2001 Census. This indicated that Cambridge City had the highest proportion of households without access to a car or van. This may be less of an issue within such an urban area due to public transport provision and the proximity to services. One in five households in Fenland did not have access to a car or a van.

Table 61: No Access to a Car or Van: Total Population, 2001

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

Source: 2001 Census

4.10.2 Accessibility Mapping

Access to a range of services and employment sites using public transport or walking have been mapped by Cambridgeshire County Council. These can be found on the JSNA website at www.cambridgeshirejsna.org.uk

The following is a summary of the key issues to emerge from the mapping.

Walking and Public Transport Accessibility to Nearest Area of Employment with 2000+ Employees

- This map shows the time it takes to travel from the centre point of each postcode area in Cambridgeshire to the nearest Area of Employment with 2000+ employees, travelling on a Tuesday 7 am - 9 am. The map shows that as the majority of these areas of employment are located in the major settlements in and around Cambridgeshire, so also travel times to the nearest area of employment are lowest in Cambridge and the larger market towns, typically within 15/30 minutes travel time.
- Outside of the market towns accessibility to areas of employment is far more mixed; some villages can access within 15/30 minutes whilst at the other end of the scale some have no accessibility at all. Areas of the county experiencing the worst accessibility to areas of employment, travel time over one hour or no accessibility include:
 - SW South Cambridgeshire: villages along and to the west of the A1198, such as Wendy, East Hatley.
 - SE East Cambridgeshire: villages to the southeast of Newmarket, such as Cheveley, Kirtling.
 - Huntingdonshire: villages to the north, northwest and west of Huntingdon, such as Kings Ripton, Hamerton, Bythorn.
 - Fenland: villages surrounding March not on A141 or B1101 corridor, such as Manea, Benwick, Christchurch.
 - Fenland: settlements to the north, west and southwest of Wisbech.

Walking and Public Transport Accessibility to Areas of Employment with 2000+ Employees: Number of Areas that can be Accessed Within 30 Minutes Travel Time, 8 am – 9 am

- This map shows, for each centre point of each postcode area, how many areas of employment with 2,000+ employees that can be accessed within 30 minutes travel time in the 8 am - 9 am window on a Tuesday.
- It shows that there is considerably more choice in and around Cambridge than elsewhere in the county to access areas of employment by walking and public transport. For example, it is possible to access ten plus areas in 30 minutes from much of Cambridge and to access seven plus areas from virtually all other parts of Cambridge. Similarly, in the first/second necklace of villages surrounding Cambridge it is possible to access either four to six or seven to nine areas of employment in many cases.
- Away from the Cambridge area, accessibility to areas of employment drops considerably - apart from in Huntingdon where most parts can access four to six areas. In the bigger market towns and surrounding villages, on bus routes, there is typically access to 1-3 areas of employment with 2,000+ employees.
- For large swathes of the county, however, it is not possible to access any areas of employment within 30 minutes travel time. For example, the area to the north of Huntingdon and St Ives, stretching as far north as Whittlesey and as far east as Littleport, have virtually no areas with access to areas of employment in 30 minutes. Areas with no accessibility to areas of employment within 30 minutes also exist in the villages surrounding Newmarket and in many of the villages on either side of the A1198 corridor.
- The biggest settlements with no access include Chatteris, Ramsey, Burwell and Cambourne.

Walking and Public Transport Accessibility to Nearest Sports/Leisure/Swimming Centre

- This map shows the time it takes to travel from the centre point of each postcode area in Cambridgeshire to the nearest sports centre, leisure centre or swimming pool, travelling on a Saturday 9 am -12 pm.
- The map shows that it is possible to access a leisure centre in 30 minutes from large parts of the county, not only Cambridge and all the market towns, but also a good number of villages. This is not only because each market town has at least one such centre but also because a number of villages also have a centre, often attached to the local village college.
- Areas of the county experiencing the worst accessibility to leisure centres, in terms of having a travel time exceeding one hour or no accessibility include:
 - Huntingdonshire: villages to the north, northwest and west of Huntingdon, such as Holme, Abbots Ripton, Winwick, Molesworth.
 - SW South Cambridgeshire: villages along and to the west of the A1198, such as Abington Piggots, Tadlow.
 - SE East Cambridgeshire: villages to the southeast of Newmarket, such as Brinkley, Woodditton.
 - Fenland: villages not on main public transport corridors, such as Murrow, Turves, Christchurch.

Walking and Public Transport Accessibility to Sports/Leisure/Swimming Centres: Number of Areas that can be Accessed Within 30 Minutes Travel Time, 10 am - 11 am

- This map shows, for each centre point of each postcode area, how many leisure centres can be accessed within 30 minutes travel time in the 10 am - 11 am window on a Saturday.
- It shows that there is considerably more choice in and around Cambridge than elsewhere in the county to access leisure centres by walking and public transport. It is possible to access 10+ leisure centres within 30 minutes from much of Cambridge and to access 7+ centres from virtually all other parts of Cambridge. Similarly, in the first/second necklace of villages surrounding Cambridge it is possible to access either four to six or seven to nine leisure centres in many cases.
- In some market towns – Huntingdon, St Ives, Ely, Soham, Whittlesey – it is possible to access up to three leisure centres within 30 minutes travel time whilst for the other market towns – St Neots, Littleport, Chatteris, Ramsey, March, Wisbech – it is only possible to access one such centre.
- Whilst it is possible to access one or more leisure centres from a number of larger villages within 30 minutes – such as Sawston, Melbourn, Burwell, Gamlingay, Yaxley – there are many settlements within the county for which it is not possible to access any leisure centres within 30 minutes. The greatest concentration of settlements with no access within 30 minutes is found in the following areas:
 - To the north, west and south of Huntingdon and St Ives.
 - To the south and north of Newmarket.
 - To the southwest of Cambridge, along A10/A603 corridors.
 - To the west and north of Ely.
 - To the north, west and southwest of Wisbech.
- The biggest villages with no access within 30 minutes include Cambourne, Brampton, Sawtry, Warboys, Somersham, Sutton, Fordham and Isleham.

Walking and Public Transport Accessibility to Nearest Hospital with Outpatients Facility

- This map shows the time it takes to travel from the centre point of each postcode area in Cambridgeshire to the nearest Hospital with an outpatients' facility, travelling on a Tuesday 9 am -12 pm. The map shows that travel times to the nearest hospital tend to be lowest in Cambridge, the larger market towns and those villages located on public transport corridors close to hospitals.
- The greatest concentration of areas with no accessibility to a hospital includes:
 - Huntingdonshire: villages to the north and west of Huntingdon, such as Abbots Ripton, Spaldwick, Perry.
 - SW South Cambridgeshire: villages along and to the west of the A1198, such as Wendy, East Hatley.
 - Fenland: villages to the west and east of March, such as Turves, Christchurch.
 - Fenland: settlements to the north, west and southwest of Wisbech.
- There are also a number of villages in the A1123/B1050/B1040 corridors for which it is not possible to access a hospital within one hour, such as Ramsey, Earith, Haddenham and Willingham.

Walking and Public Transport Accessibility to Nearest General Practice

- This map shows the time it takes to travel from the centre point of each postcode area in Cambridgeshire to the nearest general practice, travelling on a Tuesday 9 am -12 pm.
- This map shows that many – perhaps the majority of – settlements in Cambridgeshire can access a general practice within 15 minutes travel time. This is explained by the fact that many settlements in Cambridgeshire have their own general practice. That said there are still many smaller settlements that have no accessibility. The greatest concentration of villages and settlements with no accessibility can be found in the following areas:
 - South of South Cambridgeshire: villages such as Meldreth, Shrepreth, Fowlmere, Great Chishill.
 - SW South Cambridgeshire: villages along and to the west of the A1198, such as Wendy, East Hatley.
 - Huntingdonshire: villages to the north, northwest and west of Huntingdon, such as Kings Ripton, Great Gidding, Perry.
 - Fenland: villages to the east and west of March, such as Turves, Christchurch.
 - Fenland: settlements to the north, west and southwest of Wisbech.

Walking and Public Transport Accessibility to Nearest Large Scale Hospital

- This map shows the time it takes to travel from the centre point of each postcode area in Cambridgeshire to the nearest Hospital with an Accident and Emergency department (A & E), travelling on a Tuesday 9 am -12 pm.
- As the only large scale hospitals are located in Cambridge and Huntingdon it is not surprising that the settlements with the lowest travel times are those which are located on public transport routes in close proximity to these hospitals. Aside from Cambridge and Huntingdon themselves, villages to the south of these settlements tend to have the best accessibility, reflecting the fact that Addenbrooke's Hospital is located in the south of Cambridge and Hinchingsbrooke to the south of Huntingdon.
- Away from these areas of good accessibility, it can be seen that for the majority of settlements in the county it takes at least 45 minutes to access the nearest hospital. Indeed, in the northern half of the county the predominant colours are red and black, signifying that for most settlements in Fenland, North Huntingdonshire and East Cambridgeshire travel times are at least one hour, if it is possible to access a hospital at all.
- The parts of the county with greatest concentration of poor accessibility, travel times of over an hour or not accessible at all, are located in the following areas:
 - To the north and west of Huntingdon.
 - Villages to the west of the A1198 and south of A42.
 - Villages to the north, west and south of Newmarket.
 - Excluding parts of Wisbech and March, the whole of north Cambridgeshire to the east of Whittlesey, west of Ely and north of the A1123.

Walking and Public Transport Accessibility to Nearest Food Superstore

- This map shows the time it takes to travel from the centre point of each postcode area in Cambridgeshire to the nearest Food Superstore, travelling on a Saturday 9 am - 12 pm.
- It can be seen that many parts of the county are coloured green, signifying a travel time of either less than 15 or 30 minutes. This is explained not only by Cambridge and most market towns having more than one supermarket but also because some larger villages also have supermarkets, such as Cambourne, Bar Hill and Yaxley.
- Areas that do not have any access by walking or public transport to a supermarket include:
 - Villages to the north and west of Huntingdon.
 - Villages to the west of the A1198 in SW of South Cambridgeshire.
 - Villages to the south of Newmarket.
 - Settlements to the west and southeast of Littleport.
 - Settlements to the west, south and east of Chatteris.
 - Settlements to west and east of March.
 - Settlements to the north, west and southeast of Wisbech.

Public Transport Accessibility to Nearest Town Centre

- This map shows the time it takes to travel from the centre point of each postcode area in Cambridgeshire to the nearest town centre (as defined by district authorities), travelling on a Tuesday 7 am - 9 am.
- The map shows that travel times are lowest within Cambridge, the market towns and those villages closest to these towns. The largest villages with no accessibility at all to a town centre during this time period include:
 - Manea
 - Benwick
 - Highfields
 - Wicken
 - Fowlmere

5. LIFESTYLE

5.1 Introduction

Lifestyle and behaviour, especially habitual behaviour, can directly affect the health of an individual. The adverse effect of the misuse of alcohol and drugs, poor diet, low levels of physical activity and smoking upon health is well documented.

This section describes the prevalence, trends in the following lifestyle behaviours and outcomes.

- Physical Activity
- Obesity
- Nutrition and Healthy Eating
- Smoking
- Sexual Health
- Alcohol
- Drug Misuse
- Mental Health
- Dental and Oral Health

There is a strong reliance upon synthetic estimates in some of the areas (see Data Sources Section) as prevalence is difficult to capture outside of surveys. Synthetic estimates use modeling techniques based on surveys to produce the estimates.

Attention is directed to any associations between lifestyle behaviour and socio-economic or any other wider determinant of health.

5.2 Physical Activity

5.2.1 Introduction

‘Physical Activity’ includes all forms of activity, such as everyday walking or cycling, active play, work-related activity, active recreation, dancing, gardening and playing active games, as well as organised sport.⁶⁹

Physical inactivity is a significant, independent risk factor for a range of long-term health conditions. An active lifestyle:

- has a substantial impact on the risk of major non-communicable diseases, including Coronary Heart Disease (CHD), hypertension (high blood pressure), type 2 diabetes, chronic kidney disease and some cancers;
- can reduce the risk of stroke and vascular dementia.⁷⁰ Physical activity can be used to treat peripheral vascular disease and to modify cardiovascular disease (CVD) risk factors such as hypertension (high blood pressure) and adverse lipid profiles;
- protects against cancers of the colon, breast (post-menopause) and uterus (womb);
- reduces the risk of and helps manage musculoskeletal health conditions, including osteoporosis, back pain and osteoarthritis;

⁶⁹ Department of Health (2011). *Start Active, Stay Active: a report on physical activity for health from the four home countries' Chief Medical Officers*. London

⁷⁰ Personal Communication – Cambridge Community Services.

- reduces the risk of depression and promotes many other positive mental health benefits, including reducing state and trait anxiety; improves physical self-perceptions and self-esteem; and can help reduce physiological reactions to stress;
- has been found to be just as effective in the treatment of mental ill health as anti-depressant drugs and psychotherapy;
- supports weight management – physical activity by itself can result in modest weight loss of around 0.5–1kg per month;
- can prevent falls; people who are physically active are less likely to have problems with strength and balance in later life;⁷¹
- can prevent osteoporosis: physical activity (particularly strength training and weight bearing activities) will improve bone density and delay the onset of osteoporosis;⁷²

Physical inactivity cost PCTs in England more than £700 million in 2006/07. The total cost for Cambridgeshire PCT in five disease categories (cancer, bowel, breast cancer, diabetes, Coronary Heart Disease (CHD), cerebro-vascular disease) in 2006/07 was estimated to be nearly £7 million.⁷³

5.2.2 Figures and Trends

Active People 4 Survey: Cambridgeshire

- These data have been drawn from the Sport England Survey on Active People. There are segments of the population who are considered to be physically active who are not captured by this survey eg some manual workers who do not take part in active recreation but are nonetheless physically active through work. It is also worth noting that the sample size for each District area is small and may not be representative of the districts as a whole.
- The following tables present data from the fourth annual Active People Survey which was carried out between October 2009 and October 2010 on behalf of Sport England. The 'raw' data are currently unavailable and therefore the following charts and tables present the summarised data accessible from the Sport England website.
- The majority of the data relate to the former National Indicator 8 (NI8). NI8 is the percentage of the adult population in a local area who participate in sport and active recreation, at moderate intensity, for at least 30 minutes on at least 12 days out of the last four weeks (equivalent to 30 minutes on three or more days a week).
- Over the time period of the Active People Survey 4, 2,529 people were interviewed in Cambridgeshire, with around 500 in each district.

Trend

- Between October 2009 and October 2010 23.2% of people in Cambridgeshire participated in at least three days a week of 30 minutes moderate intensity participation in sport and active recreation. The table shows that there has been a slight increase at county level.

⁷¹ Personal Communication - Cambridge Community Services.

⁷² Personal Communication - Cambridge Community Services.

⁷³ Department of Health (2009). *Detailed local area costs of physical activity by disease category*. London.

Table 62: Trend in at Least Three Days a Week of 30 Minutes Moderate Participation in Sport and Active Recreation, Last Four Weeks in Cambridgeshire, October 2005-October 2010

District	APS1 (Oct 2005-Oct 2006)	APS2 (Oct 2007-Oct 2008)	APS3 (Oct 2008-Oct 2009)	APS4 (Oct 2009-Oct 2010)	Change between APS1 and APS4			
					%	95% CI		Significant
						LL	UL	
Cambridgeshire	22.2%	21.8%	22.3%	23.2%	1.0%	-1.0%	3.0%	No Change

Source: Sport England

- The table below shows the NI8 data by district. In general, there has been a downward trend in participation rates at district level since the beginning of the survey, with the exception of Huntingdonshire and South Cambridgeshire. Participation in South Cambridgeshire has statistically significantly increased over the time periods reported.

Table 63: Trend in at Least Three Days a Week of 30 Minutes Moderate Participation in Sport and Active Recreation, Last Four Weeks Districts, October 2005-October 2010

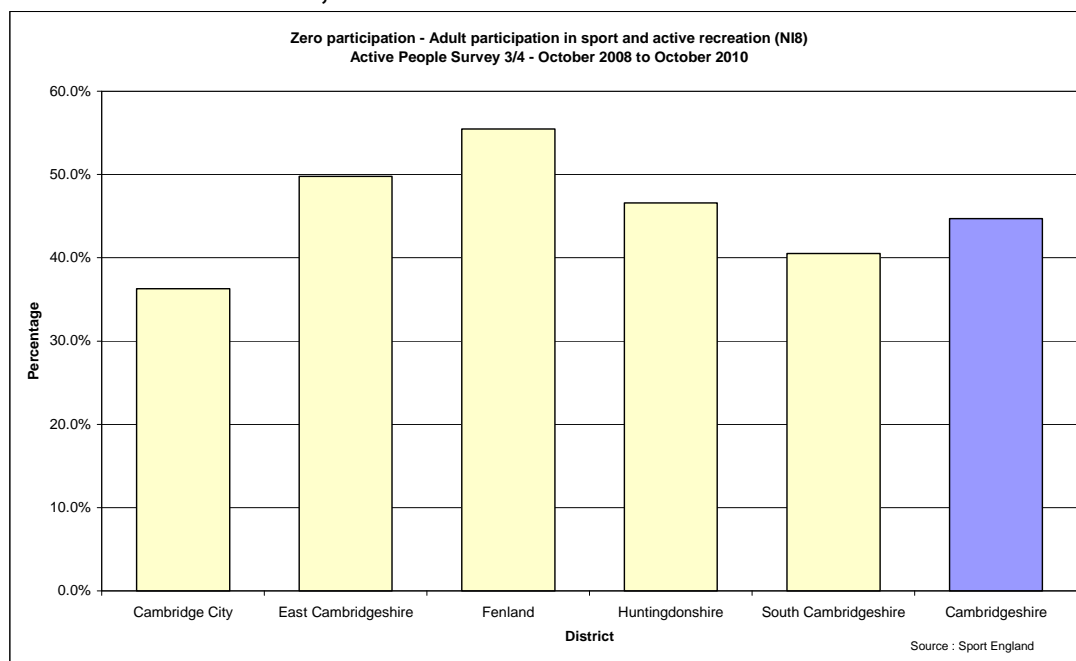
District	APS1 (Oct 2005 - Oct 2006) %	APS2 (Oct 2007 - Oct 2008) %	APS3/4 (Oct 2008 - Oct 2010) %	Change between APS1 and APS3/4			
				%	95% CI		Significant
					LL	UL	
Cambridge	26.8%	20.1%	23.7%	-3.1%	-6.9%	0.7%	No Change
East Cambridgeshire	21.5%	22.8%	20.8%	-0.7%	-4.3%	2.9%	No Change
Fenland	17.2%	17.4%	16.8%	-0.4%	-3.7%	2.9%	No Change
Huntingdonshire	23.5%	22.8%	25.2%	1.6%	-2.1%	5.4%	No Change
South Cambridgeshire	20.2%	24.8%	24.2%	4.1%	0.5%	7.6%	Increase

Source: Sport England

Zero Participation

- The chart below shows that Fenland had the highest proportion of adults (aged 16 years and over) who did not participate in any day participation of sport and active recreation within the previous 28 days of the survey.

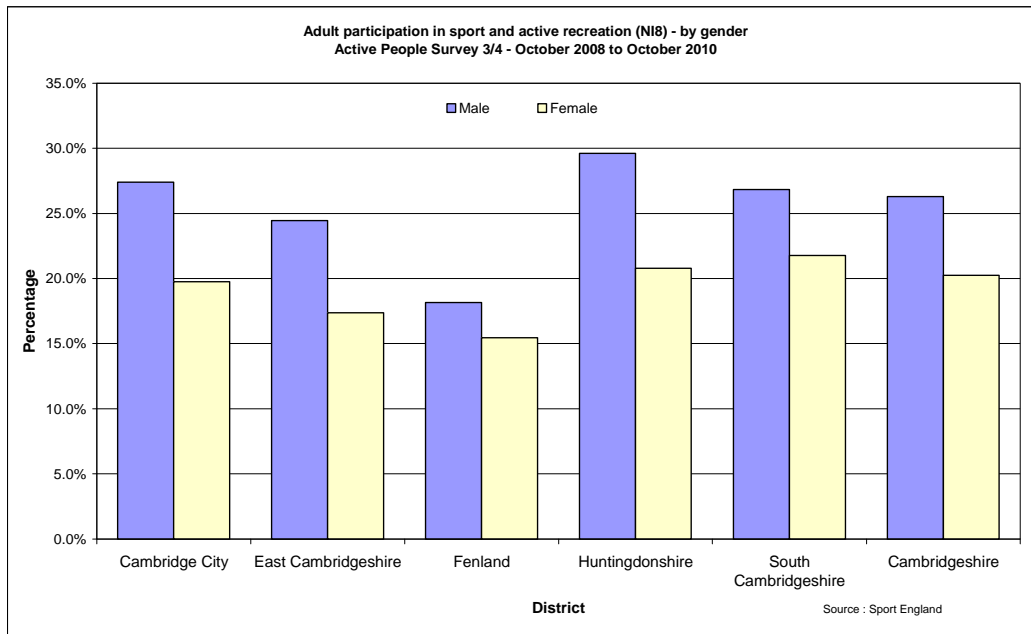
Figure 16: Zero Days Participation in the Last 28 Days, Adult Participation in Sport and Active Recreation , APS3 and APS4 Combined



Participation by Gender

It is apparent from the chart below that participation is higher in males than females, with Huntingdonshire having the highest male participation and South Cambridgeshire the highest female participation, closely followed by Huntingdonshire.

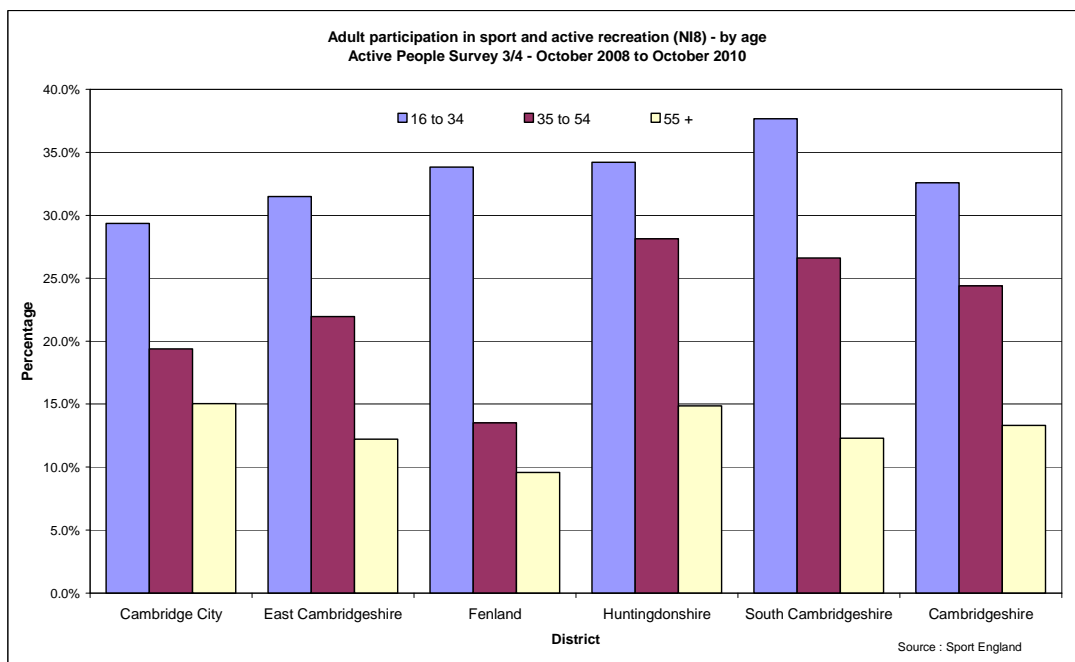
Figure 17: Adult Participation in Sport and Active Recreation, by Gender, APS3 and APS4 Combined



Participation by Age

- Participation rates decrease with age, and this is most notable in Fenland. The decrease between 16 to 34 years and 35 to 54 years is less notable in Huntingdonshire than the other districts.

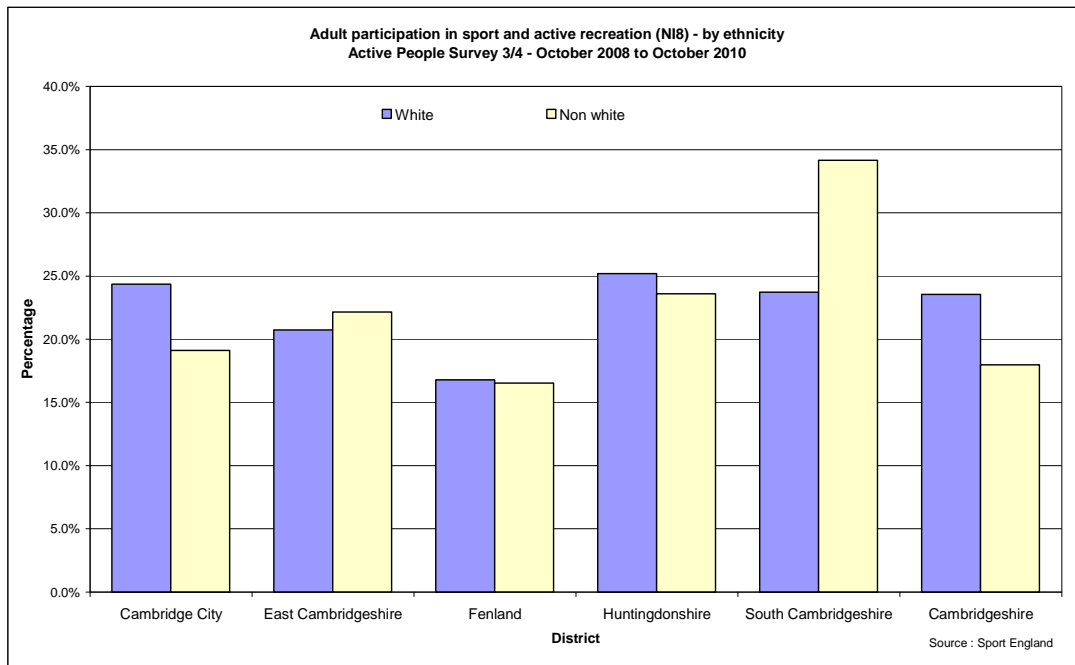
Figure 18: Adult Participation in Sport and Active Recreation, by Age, APS3 and APS4 Combined



Participation by Ethnicity

- In general white adults participate more in sport and active recreation than non-white adults at county level. This pattern is less marked in Fenland and Huntingdonshire, with the opposite being true in East Cambridgeshire and, more notably, in South Cambridgeshire.

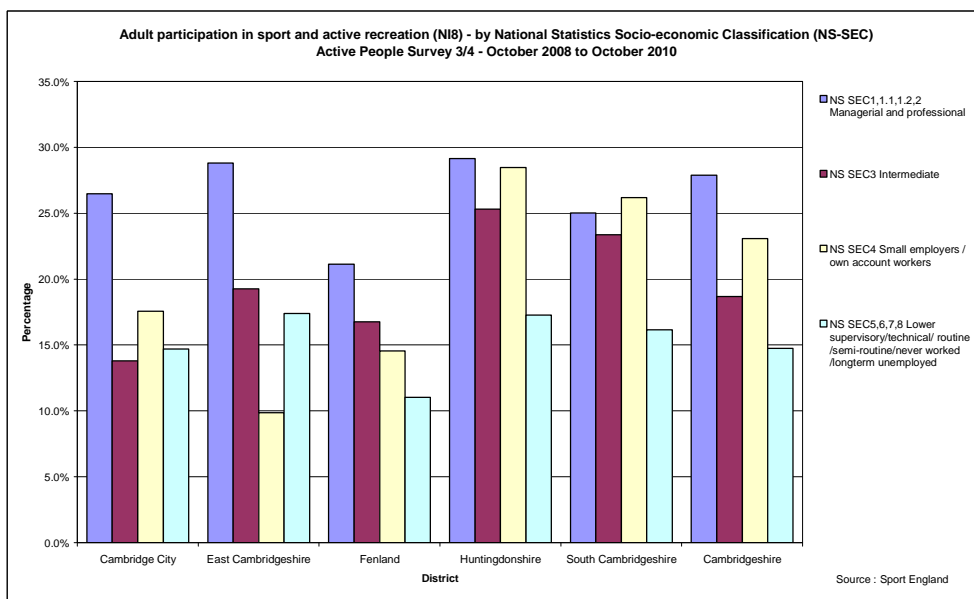
Figure 19: Adult Participation in Sport and Active Recreation by Ethnicity, APS3 and APS4 Combined



Participation by Socio-economic Group

- The difference between socio-economic group participation is most apparent in Cambridge City and East Cambridgeshire, with large decreases in participation rates between the highest NS-SEC group and the other groups. Participation in all groups is relatively low in Fenland and is generally lowest in the lowest NS-SEC group for each district, with the exception of East Cambridgeshire.

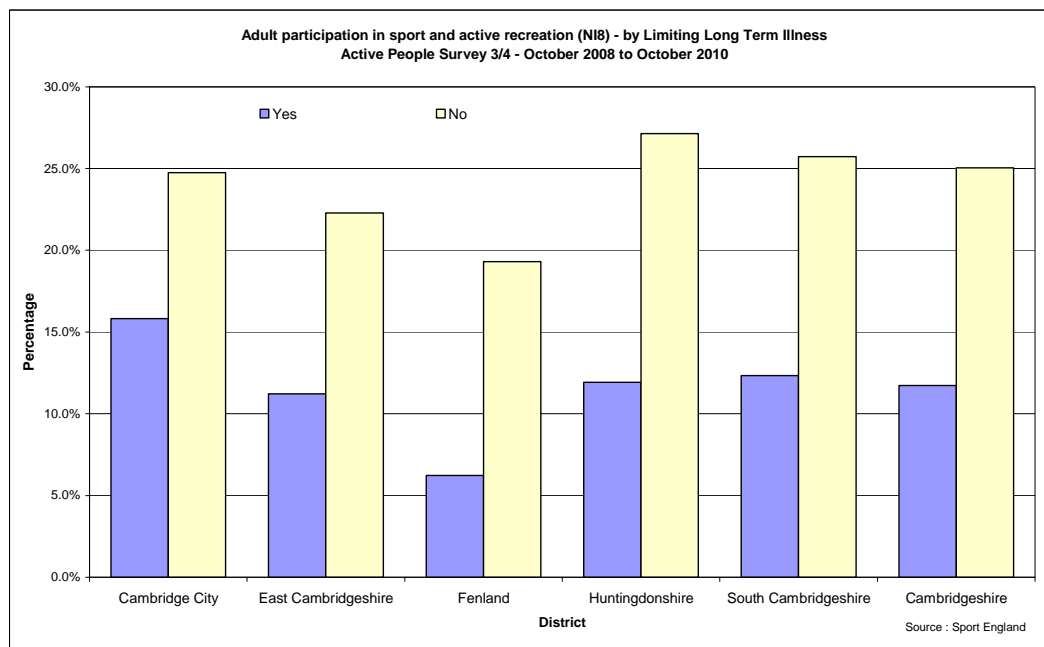
Figure 20: Adult Participation in Sport and Active Recreation, by NS-SEC, APS3 and APS4 Combined



Participation by Limiting Long Term Illness

- Participation is highest in all districts for people without a limiting long term illness. Cambridge City has the highest proportion of people participating and having a long term illness.

Figure 21: Adult Participation in Sport and Active Recreation, by Limiting Long Term Illness, APS3 and APS4 Combined



Quarterly surveys continue to be produced, and can be accessed at:

http://www.sportengland.org/research/active_people_survey/active_people_survey_5.aspx

Eastern Region Public Health Observatory: 2008 Lifestyle Survey

- In 2008, the Eastern Region Public Health Observatory undertook a Lifestyle Survey on behalf of NHS East of England and used a different measure of levels of physical activity.⁷⁴
- This survey concluded that in the Cambridgeshire PCT area, the percentage of men living in 20% most deprived populations achieving recommended levels of physical activity was significantly higher than the 80% least deprived. One possible reason could be that this reflects the higher proportion of manual workers living in more deprived communities. It should be noted the differing outcomes reflect the respective methodologies.

5.2.3 Local Views

- These will need to be summarised once data from the community engagement process has been collated and analysed.

⁷⁴ Eastern Region Public Health Observatory (2009). *2008 Lifestyle Survey: Cambridgeshire PCT*. Cambridge.

5.2.4 Evidence/Policy

- In July 2011, the Chief Medical Officers for the four home countries published new guidelines on the volume, duration, frequency and type of physical activity required across the life course to achieve general health benefits.⁷⁵
- The guidelines for adults apply to everyone, irrespective of gender, race or socio-economic status, but should be interpreted with consideration of individual physical and mental capabilities. There is substantially less research on the health benefits of physical activity for disabled people. Based on the evidence, the guidelines can be applied to people with disabilities, emphasising that they need to be adjusted for each individual, based on that person's exercise capacity and any special health or risk issues.

The guidelines for adults (19-64 years) are:

- Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of ten minutes or more. One way to approach this is for adults to do 30 minutes on at least five days a week.
- Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.
- Adults should also undertake physical activity to improve muscle strength on at least two days a week.
- All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Table 64: Examples of Activity

Type of Activity	Examples
Moderate intensity	Brisk walking, bike riding, dancing, swimming, active travel
Vigorous intensity	Running, playing sport, taking part in aerobic exercise classes, using cardiovascular gym equipment
Muscle strengthening	Weight training, working with resistance bands, carrying heavy loads, heavy gardening, push ups, sit ups

- An evidence base linking sedentary behaviour adversely and independently with all-cause and cardiovascular mortality, type 2 diabetes, some types of cancer and metabolic dysfunction, is growing rapidly. While adults aged 19–64 are a large and diverse population, the evidence demonstrates that engaging in physical activity has very low risks for most, while the risk of poor health from inactivity is very high.

⁷⁵ Department of Health (2011). *Start Active, Stay Active: a report on physical activity for health from the four home countries' Chief Medical Officers*. London.

- The National Institute for Health and Clinical Excellence (NICE) has reviewed the physical activity evidence base. Specific guidance with relevance to adults of working age can be found in the following documents:
 - Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling (2006).⁷⁶ During 2011, evidence and recommendations will be revised.
 - Physical activity and the environment (2008).⁷⁷
 - Promoting physical activity in the workplace (2008).⁷⁸
- A systematic review of interventions to promote walking was published in 2007⁷⁹ concluded that ‘interventions to promote walking could contribute substantially towards increasing the activity levels of the most sedentary’.
- Social marketing intelligence developed in relation to obesity, sport, active recreation and activities such as dance can be used to inform interventions. For example, Sport England is tasked with increasing adult participation in sport and active recreation. To achieve this, and to better understand the market, a segmentation model has been commissioned. This is made up of nineteen ‘sporting’ segments which offer an understanding of the attitudes, motivations and perceived barriers to sports participation. The segmentation model facilitates the development of tailored interventions, effective communications with target audiences and a better understanding of participation in the context of life-stage and lifecycles.⁸⁰

5.2.5 Cost-effectiveness

- The upper threshold applied by NICE when determining if an intervention is cost-effective is £30,000 per Quality Adjusted Life Year (QALY).
- NICE⁸¹ established that brief interventions for physical activity (when compared with no intervention) cost between £20 and £440 per QALY, better value for money than both the cost of smoking cessation (between £221 and £9,515 per QALY) and the cost of statins in secondary prevention (between £10,000 and £17,000 per QALY). The Department of Health economic analysis⁸² includes a projected lifetime QALY gain of between £91 and £288 depending on whether the brief intervention is delivered by a general practice, practice nurse or health care assistant.
- Return on Investment: NICE has calculated the likely costs of implementing its guidance on brief interventions in primary care. Brief interventions for physical activity in primary care⁸¹ demonstrated net costs saved per QALY gained of between £750 and £3,150.
- In 2009/10 the NHS East of England commissioned a review⁸³ to identify the cost-benefit impacts for the NHS in the region over the next five years. Physical inactivity was included as a modifiable risk factor for ill health and disease and concluded that the potential impact of health checks on physical activity in the East of England were highly cost-effective at £134 per QALY.

⁷⁶ National Institute for Health and Clinical Excellence (2006). *Four Commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling*. London.

⁷⁷ National Institute for Health and Clinical Excellence (2008). *Physical activity and the environment*. London.

⁷⁸ National Institute for Health and Clinical Excellence (2008). *Promoting physical activity in the workplace*. London.

⁷⁹ Ogilvie, D. et al (2007), *Interventions to promote walking: systematic review*. British Medical Journal. Vol 334: 1204-1207.

⁸⁰ Sport England. See: http://www.sportengland.org/research/market_segmentation.aspx

⁸¹ National Institute for Health and Clinical Excellence (2006). *Four Commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling*. London.

⁸² Department of Health (2009). *Let's Get Moving: Commissioning Guidance: Annex 2*. London.

⁸³ Mott McDonald on behalf of NHS East of England (March 2010) East of England: NHS Prevention

5.2.6 What are we doing - Examples of Good Local Practice?

- Physical activity interventions available to adults of working age across Cambridgeshire are predominantly funded and delivered by Local Authorities at district level and by organisations such as the County Sports Partnership (Living Sport)⁸⁴ with some limited funding from NHS Cambridgeshire. The range of programmes includes Exercise Referral Schemes, Walking for Health, Programmes for adults who would benefit from improved levels of physical activity, but who do not qualify for entry into an Exercise Referral Scheme, Cardiac Phase IV and Falls: primary prevention.
- Investments in infra-structure and programmes to promote sport and physical activity are also made by a range of organisations, for example Local Authorities, Age UK (BIG Lottery funding), Sport England, National Governing Bodies etc.
- The promotion of physical activity is undertaken in Cambridgeshire in partnership, wherever feasible. Sport, active recreation, training etc are promoted by many other organisations including Living Sport, National Governing Bodies, the voluntary sector and business organisations (including the private fitness industry). Initiatives are spread across many settings including the community where volunteering is growing demonstrated by the increase in the number of organised walk leaders.

Case Study

Cycle Cambridge is a partnership of Local Authorities working together to promote cycling in Cambridge and the surrounding area. Achievements to date have been:

- 12% increase in number of cycle trips in Cambridge.
- 21% of all journeys in Cambridge are made by bike.
- Eight new cycle routes installed, with improvements carried out on a further eight routes.
- 5.6% increase in cycling at Cambridge Science Park.
- Over 2,500 people have had Bikeability cycle training (adults and children).
- 900 secure cycle parking spaces installed at 21 schools.
- 600 cycle parking spaces installed including Addenbrooke's Hospital, Cambridge United Football Club and the city centre.

What is this Telling us?

5.2.7 What are the Key Inequalities?

- The *Active People Survey* indicates that people living in Fenland are most likely to be sedentary; this is based on an analysis of participation in sport and active recreation. The East of England Lifestyle survey, using a different measure of physical activity, indicates that men living in the 20% most deprived populations in Cambridgeshire are the most physically active. This makes any analysis of inequalities complex.

⁸⁴ For an explanation of the role of County Sports Partnerships see:
http://www.sportengland.org/support_advice/county_sports_partnerships.aspx

- The Chief Medical Officer's review of evidence of the impact of physical activity and its relationship to health identifies that sedentary behaviour should be minimised. Not all local people who are sedentary may live in areas of deprivation.

5.2.8 What are the Gaps in Knowledge/Services/Areas for Development?

- The development of cost-effective evaluation models and equality delivery systems for physical activity programmes that can be piloted with partners. NHS and partner organisations collect performance data identifying throughput and outputs from each scheme. Some providers are able to invest in user/customer feedback in order to improve the format and quality of the programmes they offer. Funding to invest in more formal evaluation remains scarce, especially at a time of diminishing resources. Partners who participated in the development of a grant application to formally evaluate the effectiveness of local Exercise Referral schemes indicated that time to collect robust, timely data demonstrating impact on the health of participants distracts from delivery.
- A process for identifying those who do not access physical activity programmes because of transport, time and financial barriers. This requires the development of an effective methodology.
- Brief interventions in primary care: identify if the Cambridgeshire NHS Health Check programme is effective in identifying adults of working age who are sedentary with a view to piloting a Cambridgeshire Health Check Physical Activity Pathway using the nationally accredited Let's Get Moving pathway.
- Increase the effectiveness of engagement of adults of working age through increasing the use of social marketing approaches, and targeting adults within their workplace.

5.3 Obesity

What do we Know?

5.3.1 Introduction

- Obesity is measured using the Body Mass Index (BMI). This is defined as the weight in kilograms divided by the square of the height in metres.

Table 65: Obesity Definitions⁸⁵

Classification	BMI (kg/m ²)
Healthy weight	18.5–24.9
Overweight	25–29.9
Obesity I	30–34.9
Obesity II	35–39.9
Obesity III	40 or more

The National Institute for Health & Clinical Excellence (NICE), Clinical Guideline No. 43 (2006)⁸⁵ (<http://guidance.nice.org.uk/CG43>) and its associated evidence base provides the core evidence base for the prevention and management of obesity. It should be noted that the Clinical Guidelines recommends that BMI is used in conjunction with waist circumference for measuring overweight and obesity and determining health risks.

⁸⁵ National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 43 Obesity Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children (2006) (refreshed 2010)

- Obesity occurs when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a prolonged period, resulting in the accumulation of excess body fat.
- NICE⁸⁵ identified many complex behavioural and societal factors that combine to contribute to the causes of obesity. The Foresight Report⁸⁶ referred to a "complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain". The report presented an obesity system map with energy balance at its centre. Around this, over 100 variables directly or indirectly influence energy balance. The Foresight map can be divided into seven cross-cutting predominant themes.
 - Biology: an individual's starting point - the influence of genetics and ill health.
 - Activity environment: the influence of the environment on an individual's activity behaviour, for example a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and showers.
 - Physical Activity: the type, frequency and intensity of activities an individual carries out, such as cycling vigorously to work every day.
 - Societal influences: the impact of society, for example the influence of the media, education, peer pressure or culture.
 - Individual psychology: for example a person's individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences.
- Being obese or overweight can increase the risk of developing a range of serious diseases with the risks rising with BMI. The 2004 Wanless Report 'Securing Good Health for the Whole Population'⁸⁷ likened obesity to smoking in terms of associated disease burden as a determinant of future health.

5.3.2 Figures and Trends

Nationally the adult obesity profile has the following key characteristics

- In 2009 61% of adults were estimated to be either overweight or obese aged 16 years or over 2% were underweight and 2% morbidly obese.
- Men and women have a similar prevalence but men are more likely to be overweight (44% to 33%).
- Many of those in the obese category have a BMI of well over 40. Women are more likely to have higher BMIs than men.⁸⁸

Obesity in Cambridgeshire (2006-2008)

- The estimated levels of obesity in Cambridgeshire (22.1%) are significantly lower than in England (24.2%).
- The same is true for Cambridge (17.2%), where the estimated levels of obesity are significantly lower than in any of the remaining Cambridgeshire districts: 22.9% in East Cambridgeshire, 25.8% in Fenland, 24% in Huntingdonshire and 21.4% South Cambridgeshire.
- Estimated obesity is not significantly higher than the England estimate in any of Cambridgeshire's districts.

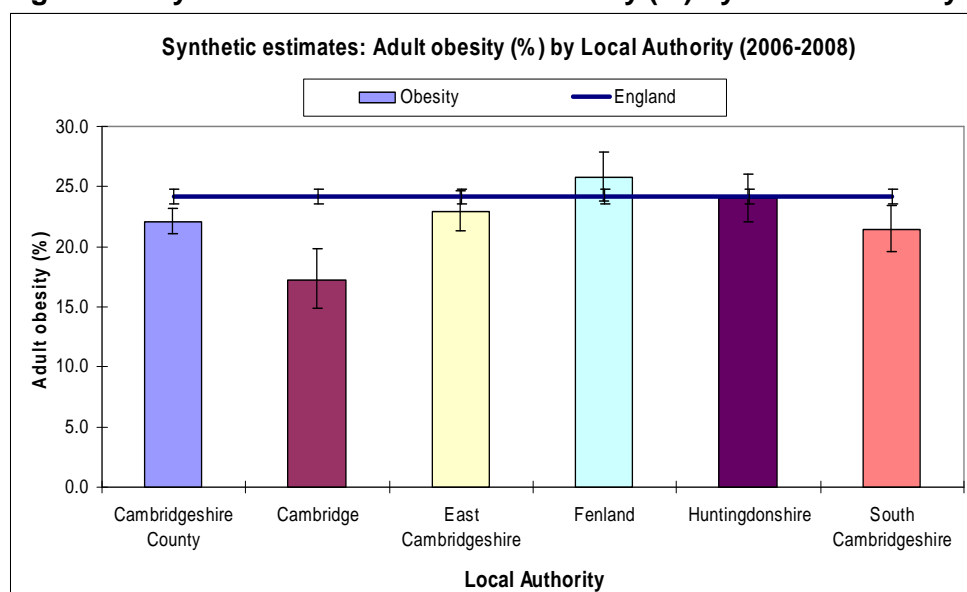
⁸⁶ Foresight - Tackling Obesity: Future Choices – Modelling Future Trends in Obesity & Their Impact on Health (2007) Government Office for Science <http://www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesity>

⁸⁷ Securing Good Health for the Whole Population (2004), Derek Wanless, The Treasury

⁸⁸ Health Survey for England (HSE) 2009

- Fenland, with estimated obesity at 25.8%, is significantly higher than the county level (22.1%) but is not in comparison to the national levels (24.2%).

Figure 22: Synthetic Estimates: Adult Obesity (%) by Local Authority (2006-2008)



Source: Association of Public Health Observatories © 2010

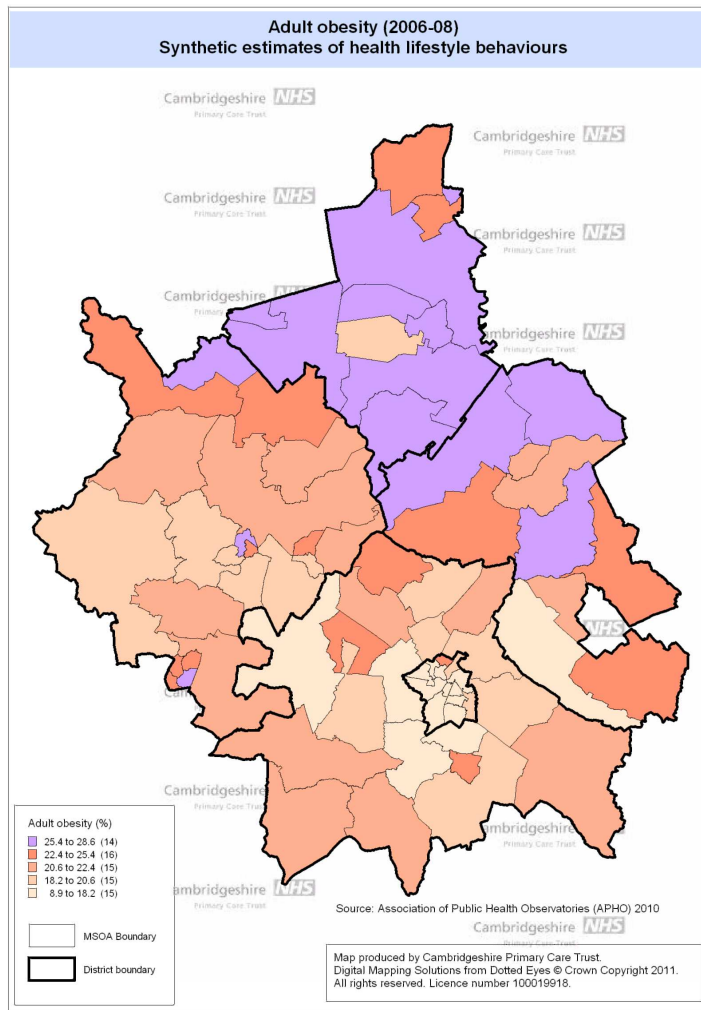
- In the following MSOAs the estimated obesity is higher than the national average although the difference is not statistically significant (Table 66).

Table 66: Cambridgeshire MSOAs: Estimated Obesity Levels Higher than the National Average (2006-2008)

MSOA Name	MSOA Description	Synthetic Estimate: Obesity (%)	95% Confidence Intervals	
			Lower Level	Upper Level
East Cambridgeshire 005	Haddenham and Stretham	24.6	18.3	32.2
East Cambridgeshire 002	Downham Villages and Sutton	25.7	19.1	33.4
East Cambridgeshire 006	Soham	25.9	19.3	33.7
East Cambridgeshire 001	Littleport	27.4	20.6	35.4
Fenland 003	South Wisbech	25.12	18.65	32.89
Fenland 004	Parson Drove and Wisbech St Mary and Elm and Christchurch	25.76	19.13	33.70
Fenland 008	Benwick Coates and Eastrea and Bassenhally	25.76	18.67	34.38
Fenland 005	March North	26.10	19.46	34.01
Fenland 011	Chatteris	26.14	19.50	34.06
Fenland 002	North Wisbech	26.80	19.99	34.88
Fenland 010	Wimblington, Doddington and Manea	26.90	20.16	34.89
Fenland 006	Whittlesey	27.78	20.88	35.89
Fenland 007	March East	28.58	21.47	36.89
Huntingdonshire 011	North St Ives	25.05	18.60	32.79
Huntingdonshire 003	Ramsey	25.35	18.90	33.07
Huntingdonshire 022	St Neots Eaton Socon	25.40	18.86	33.24
Huntingdonshire 021	St Neots Eynesbury	26.98	20.22	34.99
Huntingdonshire 008	Huntingdon North	27.07	20.17	35.25
Huntingdonshire 001	Yaxley and Farcet	27.71	20.80	35.84

Source: Association of Public Health Observatories © 2010.

Map 6: Adult Obesity (2006-08) Synthetic Estimates of Health Lifestyle Behaviours



Trends

- The prevalence of obesity in England has more than doubled in the last 25 years. Although this recent increase in the prevalence of obesity has been seen in virtually every country in the world, the rate of increase in England has been particularly high.⁸⁹
- The prevalence of obesity among adults has increased sharply in recent years. The proportion who were categorised as obese (BMI 30kg/m^2 or over) increased from 13% of men in 1993 to 22% in 2009 and from 16% of women in 1993 to 24% in 2009 (Health Survey for England).⁸⁸
- The Foresight Report (2007)⁸⁶ has estimated that by 2050 the prevalence of obesity is predicted to affect 60% of adult men, 50% of adult women and 25% of children.
- The obesity estimates for England collected through the annual Health Survey for England. The modelling becomes less robust in smaller areas as the estimates do not take account of particular local factors and they are not recommended for comparison between years.

⁸⁹ OECD Health Data 2011

5.3.3 Evidence/Policy

Policy Context

- The publication of the *Choosing Health White Paper*⁹⁰ established obesity as a public health priority and led to a range of national policy and strategic initiatives.
- The Government Public Health White Paper: *Healthy Lives, Healthy People: Our Strategy for Public Health in England*⁹¹ published in November 2010 confirms that addressing obesity would remain a priority policy objective. It indicates the national action for addressing obesity.
- Helping consumers to make healthier choices through the Change4Life campaign which is the marketing component of the Government's approach to obesity. It is a society-wide movement that aims to prevent people from becoming overweight by encouraging them to eat better and move more. The campaign aims to include everyone who has an interest in preventing obesity ie Government, business, healthcare professionals, charities, schools, families or individuals, can play their part. <http://www.nhs.uk/change4life/Pages/partners-supporters.aspx>
- Learning from the Healthy Towns movement which supports community led action in support of healthy lifestyles will be shared as good practice.
- The Public Health Responsibility Deal will seek to establish voluntary agreements with business to improve public health. This includes the re-formulation of food and better information for providers.
- The National Childhood Measurement Programme (NCMP) will be continued. This measures reception and year 6 school children annually. The results are fed back to parents with the aim of raising the profile of obesity with families and communities as well as informing commissioning decisions that will affect whole communities.

Evidence of Impact on Health

There is now good evidence to show that adult obesity is associated with a wide range of health problems. The National Obesity Observatory has reviewed the evidence and identified where risk of disease is increased with obesity.

- Musculoskeletal system - osteoarthritis, low back pain.
- Circulatory system – hypertension (raised blood pressure), coronary heart disease, stroke, deep vein thrombosis and pulmonary embolism (blood clots).
- Metabolic and endocrine systems – the risk of diabetes is substantially increased (by 80 times), high cholesterol.
- Cancers - several cancers including breast and colon (bowel) cancers.
- Reproductive and urological problems including risks for mother and child during pregnancy.
- Respiratory problems - sleep apnoea (interruptions to breathing while asleep) and other respiratory problems such as asthma.
- Gastrointestinal and liver disease.
- Psychological and social problems - stress, low self-esteem, social disadvantage, depression and reduced libido.

⁹⁰ *Choosing Health* (2004) Department of Health 2004

⁹¹ *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (2010) Department of Health

Costs of Obesity

- The National Obesity Forum⁹² identifies the estimated cost to the UK economy of overweight and obesity was at £15.8 billion per year in 2007, including £4.2 billion in costs to the NHS.
- *The Foresight Report (2007)*⁸⁶ estimates lost earnings attributable to obesity was £2.3 - 3.6 billion per year, accounting for an annual total of 45,000 lost working years. The Foresight Report also models increasing levels of BMI to 2050 and their effects on health and associated costs. Assuming costs remain constant a total cost per annum of £7.7 billion attributable to obesity would fall on the NHS. If the total wider costs of obesity are modelled these costs increase to £49.9 billion per annum.

Evidence/Policy for Preventing and Managing Obesity

- The NICE Clinical Guidelines⁸⁵ provide recommendations that are both strategic and operational. They reflect a broad and comprehensive approach that is based on inter-related public health and clinical prevention and management pathways. They emphasise that obesity is a complex problem. Its recommendations reflect this and target different audiences: public; professionals and those in responsible positions in the health services, local government, education, partnership organisations, the workplace and the voluntary sector.
- The recommendations encompass improving lifestyle through behavioural change, clinical interventions and address the 'obesogenic' (*Foresight Report 2007*⁸⁶) environment that supports unhealthy lifestyles. It includes evidence based recommendations for the NHS, local authorities, schools, early year providers, workplaces and also the public. This acknowledges that the prevention and management of obesity is complex that involves a wide range of organisations. Management of obesity is recommended not only as treatment but as secondary prevention intervention in terms of the poor health outcomes associated with obesity. They are both at a strategic and operational level.
- Recommendations for local authorities, schools and early years providers, workplaces and the public – key priorities for adult obesity. Although it should be noted that NICE recommends that interventions need to encompass communities and address children, adults and families to be effective.

Figure 23: NICE Recommendations for Local Authorities, Schools and Early Years Providers, Workplaces and the Public

- Local authorities and partners should work to create and manage more safe spaces for incidental and planned physical activity.
- Workplaces should provide opportunities for staff to eat a healthy diet and be physically active.
- Local authorities and primary care organisations should recommend to patients or consider endorsing self-help and community weight management programmes only if they follow best practice as recommended by NICE.

⁹² National Obesity Observatory (2011) <http://www.noo.org.uk>

Figure 24: NICE Recommendations for the NHS

- Interventions should take into account people's individual needs and preferences. Good communication and evidence based information will allow people to make informed choices.
- Public Health – managers and health professionals should ensure that preventing and managing obesity is priority at both strategic and implementation levels. Dedicated resources should be allocated for action.
- Clinical Care
 - Multi-component interventions that include behaviour change strategies to address physical activity and diet.
 - Any drug treatment should be fully discussed with the patient and should be offered along with support for lifestyle change.
 - Bariatric surgery – specific criteria for surgical interventions are recommended. Currently in the East of England the NHS Specialist Commissioning Group has applied modified criteria that commissioning organisations should adhere to when funding surgical interventions.

Evidence for Reducing the Cost of Obesity

- The Health Economics - Evidence Statements and Reviews that is included in the NICE Obesity Clinical Guidelines⁸⁵ provides an analysis of the cost-effectiveness of interventions. The analysis is separated into sections for non-pharmacological interventions, pharmacological interventions and surgery.

Cost-effectiveness of Non-pharmacological (Lifestyle) Interventions

NICE health economic analysis highlights the lack of good quality trials to assess the cost-effectiveness of lifestyle interventions for obesity management. This is flagged as a recommendation for further research. The NICE analysis concludes that the available research evidence supports the cost-effectiveness of non-pharmacological (lifestyle) interventions for obesity, although it does not provide definite proof.

- There is little evidence specifically on the cost-effectiveness of non-pharmacological interventions (diet, physical activity and behavioural treatment) in the treatment of obesity.
- The degree of cost-effectiveness of non-pharmacological interventions is highly sensitive to the duration of benefit.
- If weight loss relative to trend remains constant for five years post-intervention before returning to baseline, the cost per QALY in the best-performing non-pharmacological studies ranges from £174 to £9,971.

Cost-effectiveness of Pharmacological Interventions

Currently Orlistat is the only pharmacological intervention recommended for the treatment of obesity. It is judged to be cost-effective in the treatment of obesity, since the cost per QALY of providing Orlistat therapy in addition to non-pharmacological (lifestyle) interventions is below the NICE threshold of £30,000 per QALY.

- Orlistat is a cost-effective intervention in adults with a BMI greater than 30 (or 28 with co-morbidities) relative to non-pharmacological interventions.
- The most reliable published estimate of a cost per QALY under current licensing is £24,431 (range: £10,856 - £77,197).

Cost-effectiveness of Surgery

There is reasonably good research evidence that surgery for severe obesity is cost-effective.

- Evidence suggests that surgery in general is a cost-effective intervention relative to a limited non-surgical management option in a typical severely obese group.
- The most reliable cost per QALY estimate is £6,289 to £8,527.

Costs and Savings Analysis

The NICE Costing Report for CG43 assesses the overall costs and savings associated with implementation of the CG43 Obesity Guidelines. The focus is on a balance sheet of actual costs and savings to the health system.

- Main costs to the NHS of implementing the guidance – as shown (using national costs) in Table 67 only the most significant costs are included.

Table 67: Total Estimated Budget Impact

Recommendations with a significant resource impact	First year cost £000s
Recurrent costs	
Treatment of overweight/obese children with co morbidities	10,679
Bariatric surgery for obese adults with a BMI above 50 kg/m ²	28,756
Total recurrent costs	39,435
Non-recurrent costs	
Appropriate training in obesity management	23,880

- Table 68 describes the estimate of the annual costs and savings to the NHS in ten years time, assuming that full implementation of the guideline results in a 10% reduction in adult obesity over the period. Again, only the most significant costs are included – based on evidence of prescribing and GP visit levels for obese patients.

Table 68: Estimated Annual Cost Impact

Recommendations with a significant resource impact	Year 10 cost £000s
Recurrent costs	
Treatment of overweight/obese children with co morbidities	9,611
Bariatric surgery for obese adults with a BMI above 50 kg/m ²	25,878
Total estimated costs	35,489
Cash-releasing savings	
Reduced prescription costs in primary care	-13,992
Opportunity savings	
Reduced GP contacts	-41,636
Total estimated savings	-55,628

The overall cost impact analysis for year 10 shows a net saving of about £20 million per annum nationally, this is indicated as an incomplete analysis as it does not include the costs and savings associated with a reduction in obesity to non-NHS organisations. However, it is estimated that only about a quarter of the total societal cost of obesity is the result of NHS treatment costs. A fall in obesity levels would also result in significant savings outside the NHS.

What are we doing – Local Examples of Good Practice?

- The multi-agency Cambridgeshire Obesity Strategy 2008-11 (was developed by the multi-agency Obesity Strategy Group). It is in line with NICE guidance CG43 and emphasises action outside the NHS to support lifestyles which prevent obesity, as well as clinical interventions. Organisations outside the NHS which were involved in developing the Strategy included Cambridgeshire County Council, all local District and City Councils, a head teacher representative, Cambridgeshire ‘Living Sport’ and the Medical Research Council Epidemiology Unit.
<http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/OtherPublicHealthReports/Obesity%20Prevention%20and%20Management%20Strategy%202008-2011.pdf>
- It has directed the strategic direction of prevention and weight management pathway and supporting services. It has facilitated at county and local level partnership strategic collaboration and projects. Three local groups oversee local partnership initiatives and administer an annual small finding pot to pump prime initiatives. These have included for example, healthy eating and cooking projects at the community level.

Case Study Weight Management Programmes

- There is a range of weight management interventions across the county which include individual GP practice or community pharmacy interventions, commercial programmes and schemes specifically commissioned by NHS Cambridgeshire to address weight management programmes.
- Evaluations of the commissioned less intensive schemes which are provided in the primary healthcare setting are currently being reviewed. Initial analysis indicate that they meet the NICE recommendation of 5% of body weight over a three to six month period in around approximately 30% of individuals accessing the services. This is comparable to the most robustly evaluated primary care/community based schemes.

What is this Telling us?

5.3.4 What are the Key Inequalities?

National Picture

The National Obesity Observatory⁹² <http://www.noo.org.uk> identifies the following key inequalities nationally

- Age - The prevalence of obesity and overweight rise with age, in both men and women, from a relatively low level in the 16-24 age group to a peak at 65-74 (although obesity peaks slightly earlier in men). Older adults (aged 75+) have a lower prevalence of obesity.
- Social class - Adults in social class V (unskilled manual) have a higher prevalence of obesity than those in social class I (professional). The gap between the two is significant, and has widened since 1997 in both sexes.

- Ethnicity - Obesity prevalence varies between ethnic groups. Chinese and Bangladeshi groups have the lowest prevalence of obesity.

Local Inequalities

- The geographical inequalities are described above. Fenland, with estimated obesity at 25.8%, is significantly higher than the county level (22.1%) but is not in comparison to the national levels (24.2%).
- Analysis at MSOA level indicates some have estimated obesity which is higher than the national average although the difference is not statistically significant.
- Analysis of age, gender and ethnicity is not available at local level.

5.3.5 What are the Gaps in Knowledge/Services/Areas for Development?

- Adult obesity unlike childhood obesity (National Childhood Measurement Programme) relies upon synthetic estimates for prevalence information. This becomes less robust in smaller areas and does not allow analysis of the different inequalities.
- There are areas of prevention that require prioritisation for further development of workplace initiatives
 - physical activity – see relevant section
 - diet and nutrition – see relevant section
 - environmental planning
- Health economics – Robust academic research of the cost-effectiveness and cost-saving preventative and weight management interventions.
- Work towards developing services that reflect need and a reduction in any inequity of service provision especially in relation to weight management services.
- There is growing robust evidence for workplace interventions (see Workplace Health). The scoping of workplace opportunities and engagement of employers is required. This is a key setting to access adults of working age.

5.4 Nutrition and Healthy Eating

What do we Know?

5.4.1 Introduction

- A healthy diet is important in contributing to the prevention of nutrition-related ill-health and diseases such as obesity, Type 2 diabetes, coronary heart disease, stroke and cancer. In particular adequate intakes of fruit and vegetables, fibre and avoiding excessive intakes of salt, saturated fat and trans fats play a significant role.

- Low fruit and vegetable intake are among the top ten selected risk factors for global mortality. Worldwide, low intake of fruits and vegetables is estimated to cause about 19% of gastrointestinal cancer, about 31% of ischemic heart disease and 11% of stroke. There is convincing evidence that the intake of a minimum of 400 g of fruits and vegetables per day can lower the risk for Cardio Vascular Disease (CVD) and certain cancers⁹³ particularly cancers of the gastrointestinal tract.⁹⁴ For example, evidence suggests that the risk is higher among adults who eat more red and processed meats, but that a diet high in fibre, fresh fruit and vegetables may decrease that risk.⁹⁵ There is also convincing evidence that fruits and vegetables decrease the risk for obesity, and evidence that they probably decrease the risk of diabetes.
- There is now a large body of evidence, which draws an association between salt consumption and blood pressure. Habitual salt intake of the population raises the risk of high blood pressure, which in turn increases the risk of stroke and premature death from cardiovascular diseases.⁹⁶ For some time now there has been evidence that a reduction in saturated fatty acid (saturates) is recommended to reduce circulating cholesterol levels and minimise Coronary Heart Disease (CHD) risk.⁹⁷
- Industrially-produced trans fatty acids (IPTFAs) also constitute a significant health hazard and there is also now sufficient evidence upon which to base a risk estimate for trans FA and CHD.⁹⁸
- There are marked differences in diet and nutritional status associated with socio-economic status. Fruit and vegetable consumption is lower in those living in benefit households and those from manual social class groups than those in other socio-economic groups. Adults living in households in receipt of benefits were more likely to have intakes of vitamins and minerals below the Lower Reference Nutrient Intakes compared to those living in households not receiving benefits.⁹⁹ Poor diet has been proposed as a key area for interventions designed to improve the health of the most deprived population.¹⁰⁰

5.4.2 Figures and Trends

Fruit and Vegetable Consumption (2006-2008)

- It is estimated that in Cambridgeshire 32.6% of the adult population consumes five or more portions of fruit or vegetables a day, which is significantly higher than in England (28.7%) however this still leaves a significant percentage (67.4%) of the population eating less than recommended. In Cambridge (36.9%) and in South Cambridgeshire (33.6%), the estimated consumption of fruit and vegetable is also significantly higher than the national average. In East Cambridgeshire (31.7%), Fenland (29.9%) and Huntingdonshire (30.6%) levels of estimated fruit and vegetable consumption are similar to the national level.

⁹³ *Expert Report on Diet, Nutrition and the Prevention of Chronic Diseases*, Technical Report Series 916, 2003,WHO/FAO

⁹⁴ IARC, *Handbook on Fruit and Vegetable Consumption and Cancer Prevention*, forthcoming (end of 2003)

⁹⁵ World Cancer Research Fund (2007) *Food, Nutrition, Physical Activity and the Prevention of Cancer: A global perspective*

⁹⁶ NICE public health guidance 25: Prevention of cardiovascular disease at a population level

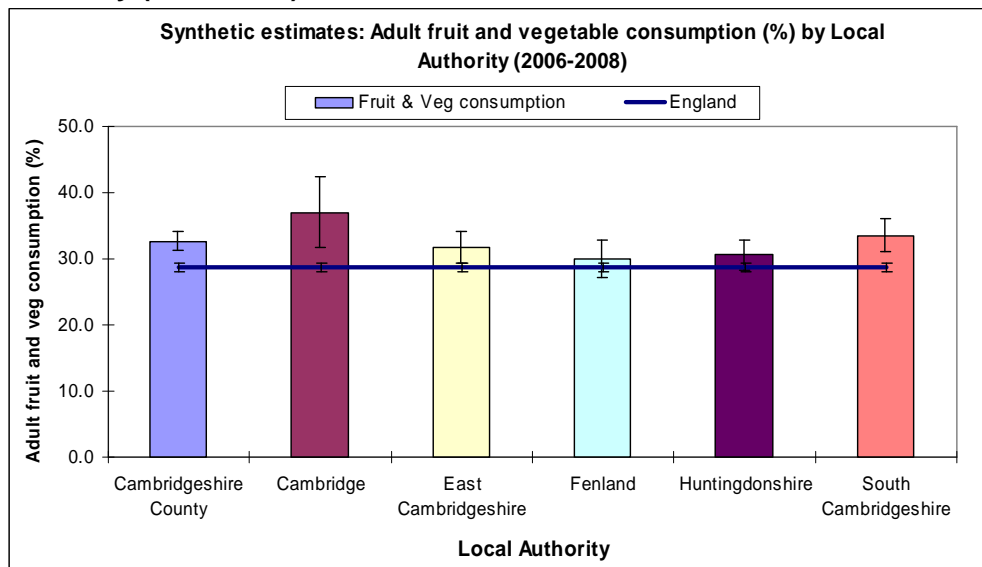
⁹⁷ COMA Committee on Medical aspects of Food Policy (1994) *Nutritional Aspects of Cardiovascular Disease*. Department of Health Report on Health and Social Subjects No 46. London HMSO

⁹⁸ Update on Trans Fatty Acids and Health Position statement from the scientific advisory Committee on Nutrition. London TSO 2007

⁹⁹ SACN position paper on the low income diet and nutrition survey (lidns) May 2009

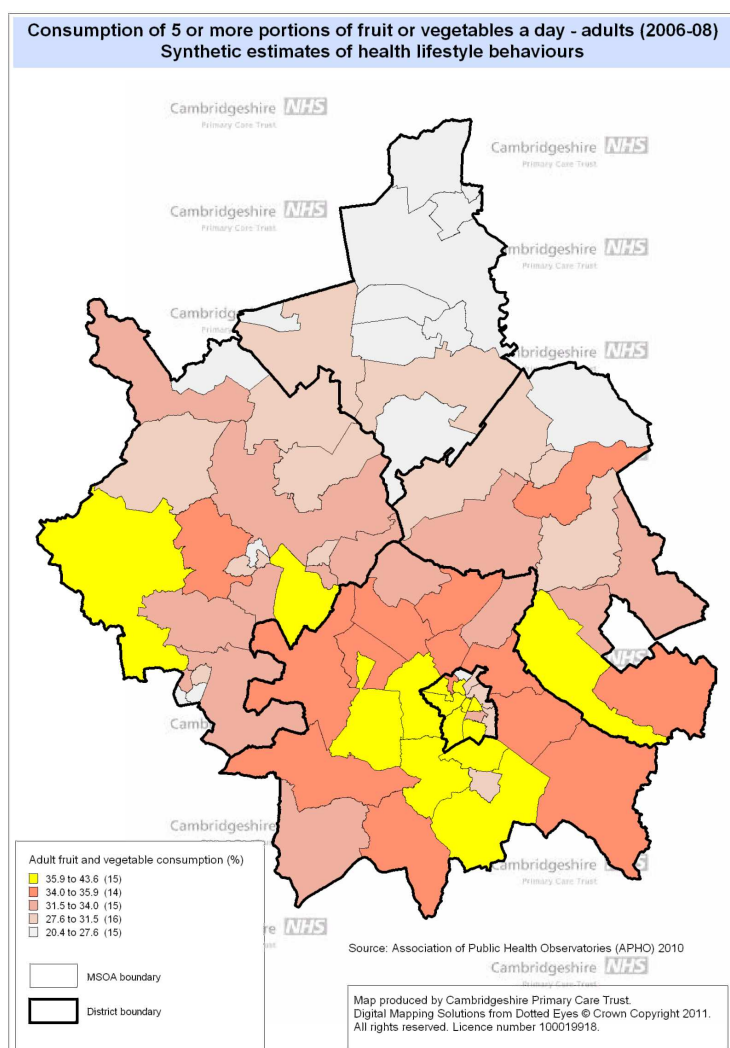
¹⁰⁰ Acheson D. *Report of the independent inquiry into inequalities in health*. London: The Stationery Office; 1998

Figure 25: Synthetic estimates: Adult fruit and vegetable consumption (%) by Local Authority (2006-2008)



Source: Association of Public Health Observatories © 2010

Map 7: Consumption of Five or More Portions of Fruit and Vegetables a Day



- There are no significant differences in the estimated consumption of five or more portions of fruit or vegetable at the MSOA level.

- Analysis of the results of the British National Diet and Nutrition Surveys (NDNS)¹⁰¹ indicates that intakes of fruit and vegetables are below with, 86% of adults between 19-64 years old consuming less than the recommendation of five portions a day. When looking only at 19-24 year olds almost all (98%) of young adults aged 19-24 years consumed less than the recommendation with a mean consumption of only 1.6 portions a day.

Salt, Fat and Trans Fatty Acids

- Local level data of salt and fat intake is not available however larger scale surveys suggest for adults between 19-64 years old intake of salt are increasing and now at 9.5g a day, well exceeding recommendations of 6g a day in the adult population.
- Although consumption levels of saturated fat are gradually moving towards the goal set by the Food Standards Agency, intake still exceed recommendations of 11% of food energy.¹⁰² However, certain sections of the population may be consuming a substantially higher amount of IPTFAs than average, particularly those who regularly eat fried fast-food.

5.4.3 Evidence/Policy

- An estimated 70,000 premature deaths in the UK could be prevented each year if diets matched nutritional guidelines. This is more than 10% of current annual mortality. The health benefits of meeting the national nutritional guidelines have been estimated to be as high as £20 billion each year.¹⁰³
- Over the past years there have been a number of national initiatives designed to improve diet including work with the food industry, to reduce levels of fat, salt and trans fatty acids in everyday foods.
- A further substantial reduction would greatly reduce CVD and deaths from CVD. Taking the example of Japan (where consumption of saturated fat is much lower than in the UK, halving the average intake (from 14% to 6–7% of total energy) might prevent approximately 30,000 CVD deaths annually. It would also prevent a corresponding number of new cases of CVD annually.
- In recent years many manufacturers and caterers have considerably reduced the amount of IPTFAs in their products. In some countries and regions (for instance, Denmark, Austria and New York), IPTFAs have been successfully banned. A study for the European Parliament recently recommended that it, too, should consider an EU-wide ban. In the meantime, some large UK caterers, retailers and producers have removed IPTFAs from their products. Further national policy recommendations which were made in relation to diet have recently been published.¹⁰⁴
- Dietary intervention can also have a significant role in the prevention of diabetes and recommendations suggest that working in partnership to develop cost-effective physical activity, dietary and weight management interventions. Interventions costing up to £10 per head would need to achieve an average weight loss of about 0.25 kg per head to be cost-effective. Those costing up to £100 per head would need to achieve an average weight loss of about 1 kg per head.¹⁰⁵

¹⁰¹ Nutritional Wellbeing of the British Population 2008 SACN

¹⁰² Nutritional Wellbeing of the British Population 2008 SACN

¹⁰³ In quality-adjusted life years, Department of Health estimate.

¹⁰⁴ NICE public health guidance 25: Prevention of cardiovascular disease at a population level

¹⁰⁵ NICE public health guidance 35: Preventing type 2 diabetes: population and community level interventions in high-risk groups and the general population

- Trials have shown that behavioural interventions help reduce the likelihood of type 2 diabetes developing among people with pre-diabetes. For example, The Finnish Diabetes Prevention Study¹⁰⁶ showed that the risk of these individuals developing type 2 diabetes is reduced if they achieve one or more of the following:
 - reduce their weight by more than 5%,
 - keep their fat intake below 30% of energy intake,
 - keep their saturated-fat intake below 10% of energy intake,
 - eat 15 g/1000 kcal of fibre or more,
 - are physically active for at least four hours per week.
- In addition, a population-based study¹⁰⁷ found an inverse relationship between the number of these goals achieved and the risk of type 2 diabetes developing among the general population. It concluded that interventions promoting these goals could significantly lower the risk of developing type 2 diabetes among people from lower socio-economic communities and from black and minority ethnic groups.
- In 2004, a comprehensive review of interventions to promote fruit and vegetable consumption was completed. The review included interventions in supermarkets, worksites, health care settings and the general population as well as interventions targeting specific groups (eg low income populations and people with pre-existing disease). They found that the largest increases in fruit and vegetable intake occurred with interventions targeting people with pre-existing disease or disease risk factors (ie those at highest risk), but increases of between 0.1 and 1.4 servings of fruits and vegetables per day were observed with interventions targeting the healthy adult population.¹⁰⁸ Consistent positive effects were seen in studies involving face-to-face education or counselling, but interventions using telephone contacts or computer-tailored information appeared to be a reasonable alternative. Community-based multi component interventions ie those that different types of interventions for example healthy eating, promoting access to healthy food, promoting and making physical activity easier, policy changes also had positive findings. This literature review suggests that small increases in fruit and vegetable intake are possible in population subgroups, and that these can be achieved by a variety of approaches.

5.4.4 What are we doing in Cambridgeshire – Local Examples of Good Practice?

- There is a wide ranging programme of evidence based interventions designed to increase healthy eating in Cambridgeshire. The national Change4Life obesity prevention campaign is being used to promote healthy lifestyle messages to adults and children. This includes messages to reduce fat and sugar and increase the intake of fruit and vegetables. There are now over 4,850 Cambridgeshire residents registered with Change4Life (August 2010 data). There are also schemes which aim to increase cooking skills and provide an affordable healthy diet.

¹⁰⁶ Tuomilehto J, Lindstrom J, Eriksson JG et al. (2001) *Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance*. New England Journal of Medicine 344: 1343–50

¹⁰⁷ Simmons RK, Harding AH, Jakes RW et al. (2006) *How much might achievement of diabetes prevention behaviour goals reduce the incidence of diabetes if implemented at the population level?* Diabetologia 49 (5): 905–11

¹⁰⁸ *Interventions Designed to Increase Adult Fruit and Vegetable Intake Can be Effective: A Systematic Review of the Literature* Joceline Pomerleau, Karen Lock, Cécile Knai, and Martin McKee. The Journal of Nutrition.

Community Based Prevention Projects

To support the prevention of obesity and promotion of healthy eating and physical activity in adults and children, local community groups and organisations are able to bid for funding from one of the three locality obesity strategy groups. In the last financial year 15 projects were funded ranging from dance classes for school aged children, physical activity programmes for the under fives, healthy eating and practical food education workshops such as cooking skills for young carers and Tips on Chips. Tips on Chips is a project to influence a change in the practice of frying to achieve a reduction of salt use and fat level in chips produced in catering businesses and hot food takeaways.

What is this Telling us?

5.4.5 What are the Key Inequalities?

- Although there have been positive changes in the diets of British adults over the last fifteen years (for example a fall in fat and saturated fat intake and an increase in fruit and vegetable consumption) many of the recommendations are still not being met. In Cambridgeshire, consumption of fruit and vegetables in the adult population compares well to the figure for England (see above) but there is still a significant percentage (67.4%) of the population eating less than the recommended level.
- Nationally the evidence and data also highlight the importance of recognising the nutritional needs of specific population groups identified as most at risk of poor dietary variety and low nutrient intake and disease risk. Those considered to be most at risk with relevance to this needs assessment are:
 - Young adults aged 19-24 years
 - Smokers
 - People in lower socio-economic groups

5.4.6 Gaps in Knowledge/Services/Areas for Development

- There are significant gaps in local level consumption data of saturated fat and salt levels, however, national data clearly indicates the inequalities existing in recommended intake.
- Gaps in evidence of cost-effective interventions also exist particularly in relation to interventions to increase fruit and vegetable intake. The impact of the intervention programmes is difficult to assess as behavioural change can be long term more evaluation of local programmes is required.
- There is also a need for a better assessment of the effectiveness and cost-effectiveness of large community based interventions and more investment in evaluating interventions that address the whole population, such as changing policies influencing price or availability of fruits and vegetables.
- The current dietary patterns of older children and young adults and people in lower socio-economic groups require attention and there is a need for action with these particular groups to ensure further improvements in the patterns of dietary intake.

- Wider policy action is required in order to further reduce levels of saturated fat and salt to levels that will have significant health impacts. Recommendations for local action to reduce the risks of CVD within the adult population of Cambridgeshire include:
 - Improvement in public sector food provision, ensuring that all food procured by, and provided for, people working in the public sector are low in salt and saturated fats, nutritional balanced in line with the eatwell plate and do not contain Industrially Produced Trans Fatty Acids (IPTFAs).
 - All food provided for people who use public services are low in salt and saturated fats, nutritional balanced in line with the eatwell plate and do not contain Industrially Produced Trans Fatty Acids (IPTFAs).
 - Using bye-laws to regulate numbers of and opening hours of takeaways and supporting owners to improve the nutritional quality of the food they provide.
 - Nutrition training for catering managers.

5.5 Smoking

What do we Know?

5.5.1 Introduction

- Tobacco use remains the leading cause of preventable morbidity and mortality worldwide. In England it accounted for 81,400 deaths in 2009 (Department of Health 2011¹⁰⁹). Smoking causes a range of illnesses, including respiratory disease, cancer, circulatory disease and diseases of the digestive system.
- Smoking is harmful not only to smokers but also to people around them. Infants of parents who smoke are more likely to suffer from serious respiratory infections.
- Smoking is a major cause of health inequalities. Smoking accounts for the biggest inequality in death between the richest and the poorest of our society. Indeed smoking prevalence is twice as high among people in routine and manual occupations compared to those in managerial and professional occupations. Additionally, babies born from less affluent backgrounds are more likely to be born to mothers who smoke. (DoH 2011¹⁰⁹)
- The Government in England continues to support tobacco control policies aimed at reducing the prevalence of smoking, such as removing point of sale displays and vending machines and preventing illegal tobacco sales (DoH 2011¹⁰⁹).
- Alongside this legislation is a commitment to continue to offer a network of smoking cessation services to assist the 67% of smokers who indicate they want to stop smoking (DoH 2011¹⁰⁹).

5.5.2 Figures and Trends

- Nationally, the prevalence of smoking has declined from 27% in 2000 to 21% in 2009 (*General Household Survey, 2010*), although this prevalence is higher for some social groups, especially those with low incomes. There has been no change (from 21%) over the last three years. In the East of England the decline has been greater from 25% in 2000 to 19% in 2009 – that is the lowest smoking prevalence amongst the English regions. Local prevalence data (county-wide) has only been available from a comparable source since March 2010 but this will now be available quarterly. To date there has been no statistically significant change but this can be monitored.

¹⁰⁹ Department of Health (2011) *Healthy Lives, Healthy People: A Tobacco Control Plan for England*. [Online] Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124960.pdf [Accessed 10 March 2011]

- A longitudinal study by Platt et al 2009¹¹⁰ exploring attitudes about smoking after the introduction of the smokefree legislation has found a growing perception of the personal, health and environmental benefits of smokefree.
- The table below shows the most recent estimates of smoking prevalence in Cambridgeshire by District in 2009/10. This comes from a new national survey, the *Integrated Household Survey* (IHS). Overall, smoking prevalence in Cambridgeshire is estimated to be 19.9% of the adult population aged 18 years and over, below that of England (21%). However there are marked differences in the prevalence across the county. The highest prevalence is in Fenland at 26.7% and the lowest in South Cambridgeshire at 16.2%.

Table 69: Smoking Prevalence, Adults (18+ years), 2009/10

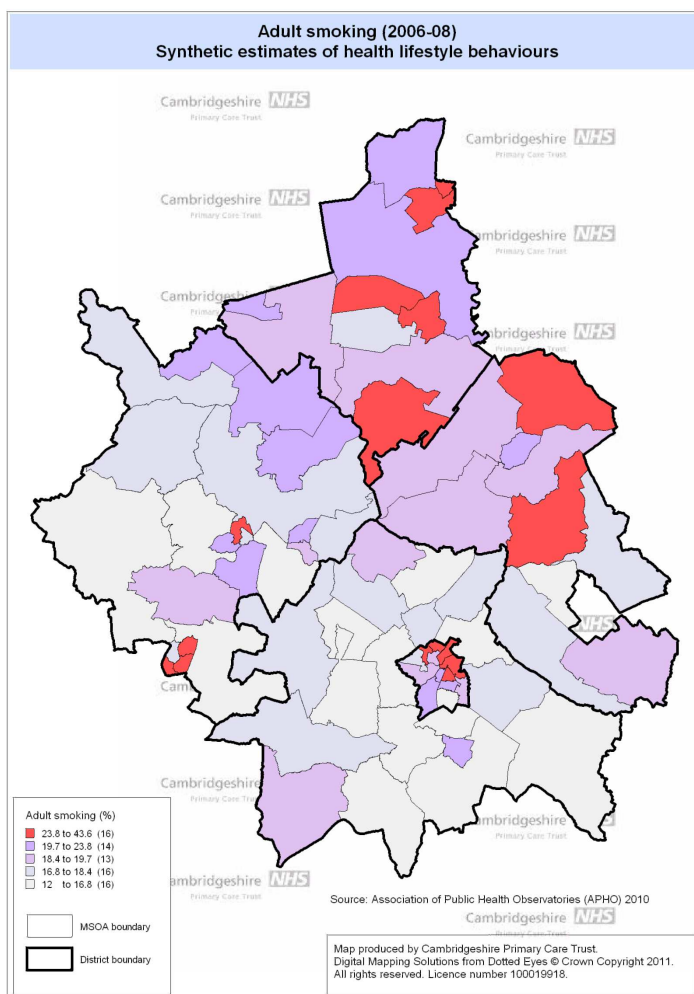
	October 2009 - September 2010				
	Sample size	Smoking Status			
		Current smoker	95% Confidence interval	Ex-smoker	Never smoked
England	258,380	21.0%	20.8% - 21.1%	33.5%	45.6%
East of England	25,067	19.9%	19.4% - 20.3%	34.9%	45.3%
Cambridgeshire	2,334	19.9%	18.2% - 21.5%	36.7%	43.5%
Cambridge	411	17.1%	13.5% - 20.8%	37.7%	45.2%
East Cambridgeshire	295	19.4%	14.9% - 24.0%	42.7%	37.9%
Fenland	360	26.7%	22.1% - 31.3%	30.3%	43.0%
Huntingdonshire	666	21.3%	18.2% - 24.4%	32.4%	46.3%
South Cambridgeshire	602	16.2%	13.3% - 19.1%	41.8%	42.0%

Source: Integrated Household Survey, ONS, Experimental Statistics (April 2011)

- Synthetic estimates of smoking prevalence provide a geographical breakdown of smoking prevalence across Cambridgeshire (Map 8). Estimated cigarette smoking is significantly higher than the national average in two of Cambridgeshire's MSOAs: Fenland 002 (North Wisbech) and Huntingdonshire 008 (Huntingdon North). Both MSOAs are in the 20% most deprived MSOAs in Cambridgeshire.

¹¹⁰ Platt S, Amos A Godfrey C, Martin C, Ritchie D, White M, Hargreaves K and Highet G (2009) Evaluation of Smokefree England: a Longitudinal, Qualitative Study. Report to the Department of Health. Public Health Research Consortium. Available Online www.york.ac.uk/phrc/projects_1.htm#a506

Map 8: Smoking Prevalence, Adults (18+ years), 2006-2008



Note: The darker shading indicates higher smoking prevalence in these areas.

- The prevalence of smoking varies markedly between socio-economic groups. Smoking prevalence is higher in more deprived populations and amongst the routine and manual group of workers. The IHS estimates that nationally prevalence in the routine and manual group is 29.4% and in Cambridgeshire 30.8%.
- Nationally the prevalence of smoking between men and women is roughly the same; 21% men and 20% women. Those aged 20-24 and 25-34 reported the highest prevalence of smoking 32% and 27% respectively, while those ages 60+ reported the lowest 12% (General Household Survey 2010).

5.5.3 Local Views

- A customer satisfaction postal survey conducted by Cambridgeshire's NHS stop smoking service (CAMQUIT) found that 69% (25) of respondents were satisfied with the service they received. Additionally the majority of respondents were happy with the accessibility of the service and the length of time they waited for an appointment. The majority of respondents heard about the service through their GP; these findings are similar to other studies (Friel 2010, Secker-Walker 2000, Thompson 2007¹¹¹).

¹¹¹ Secker-Walker R, Dana G, Solomon L, Flynn B, Geller D (2000) *The Role of Health Professionals in Community-Based Program to Help Women to Quit Smoking Preventative Medicine* Vol 30 pp 126-137 Thompson KA, Parahoo AK, Blair N (2007) *A nurse-led smoking cessation clinic – quit rate results and views of participants*, *Health Education Journal* Vol 66 pp 307-322 Freil M (2011) RE: Barriers to engagement with smoking cessation services beyond self initiated referral. Personal email to: E Nicholson 2 May.

- Qualitative research commissioned by NHS Cambridgeshire in 2008 found that the majority of the participants had thought about stopping smoking at least once, if not on a more regular basis. Additionally this research highlighted that these respondents (58) felt that they would be judged and not helped by a smoking cessation service; this is a similar finding to other studies with routine and manual workers (Department of Health 2009¹¹²). However, the majority of them were interested in using a stop smoking service and there was a split preference between group therapy programmes and one to one.

5.5.4 Evidence/Policy

- There is comprehensive evidence that the most effective tobacco control strategies involve a multi-faceted and comprehensive approach at both national and local level (DoH 2011¹⁰⁹). This includes stopping the promotion of tobacco, making tobacco less affordable, effectively regulating tobacco products, helping tobacco users to quit, reducing exposure to second hand smoke and gathering information and intelligence to stop the inflow of illegal tobacco products. The Department of Health recommends that a strong tobacco control alliance to support these broader issues that involves local council, business, schools and colleges, local councillors, NHS, Trading Standards, Environmental Health, HM Revenue & Customs, Police, Fire and civil society groups.
- Nationally in 2008/09 two thirds (67%) of current smokers reported wanting to give up smoking, with three quarters (75%) reporting having tried to give up smoking some point in the past. Research has shown that you are four times more likely to successfully quit smoking with a combination of support from an NHS stop smoking service and stop smoking medication (West et al 2000¹¹³). A systematic review examining the effectiveness of NHS smoking cessation services found that NHS treatment services are effective at helping people quit (Bauld et al 2009¹¹⁶). NHS stop smoking services use an evidence based approach to treating dependent smokers (West et al 2000¹¹³) which includes behavioural therapy, either in a one to one or group format, combined with smoking cessation medications such as Nicotine Replacement Therapy, Bupropion, Varenicline or Champix. Evidence has shown that a combination of behavioural support from a stop smoking service plus pharmacotherapy can increase a smoker's chance of stopping by up to four times. Group, one to one and telephone support have been identified as services that provide the best success rates (DoH 2009¹¹²).

Costs of Treating Smokers - Economic Modelling

- Treating smoking-related illnesses was estimated to have cost the NHS £2.7 billion in 2006/07, or over £50 million every week. In 2008/09, 463,000 hospital admissions in England among adults aged 35 and over were attributable to smoking. It is estimated that 300,000 general practice consultations and about 9,500 hospital admissions to the UK each year are for children who have been exposed to second-hand smoke (DoH 2011). However the costs of tobacco use extend beyond the NHS and the Department of Health suggests the overall economic burden of tobacco use is £13.74 billion every year (DoH 2011¹⁰⁹).

¹¹² Department of Health (2009) *NHS Stop Smoking Services – Service and monitoring guidance* 2010/11

¹¹³ West R, McNeill A, Raw M (2000) *Smoking Cessation guidelines for health professionals: an update* Thorax Vol 55 PP 987-999

Table 70: Directly Age-standardised Rate (DSR) of Smoking Attributable Deaths and DSR of Smoking Attributable Hospital Admissions Per 100,000 Population Aged 35 Years and Over. Costs of Smoking Attributable Hospital Admissions, in those Aged 35 Years and Over, Per Head of Population.

	Smoking attributable mortality (2006 - 2008)	Smoking attributable hospital admissions (2006 - 2008)	Cost of smoking attributable hospital admissions (2006 - 2008) £ per capita
England	206.8	1265.9	33.4
East of England	180.7	1147.1	30.9
Cambridgeshire	165.6	1219.3	30.2
Cambridge	172.4	1254.8	33.7
East Cambridgeshire	143.1	1092.3	30.4
Fenland	209.3	1532.1	37.0
Huntingdonshire	172.0	1299.8	28.6
South Cambridgeshire	135.6	1032.7	28.7

Source: Local Tobacco Control Profiles for England, Association of Public Health Observatories (APHO).

- In Cambridgeshire PCT, the rate of smoking attributable mortality is significantly lower than that of England and the East of England, except in Fenland district. Similarly, in Cambridgeshire PCT the rate of smoking attributable to hospital admissions is significantly lower than that of England but the rate is highest in Fenland which is significantly above that of the England average.
- A Department of Health funded study assessing the trends in key health outcomes after the introduction of the smokefree legislation found a statistically significant decline (–2.4%, 95% confidence interval –4.06% to –0.66%, P=0.007) in the number of people being admitted for Myocardial Infarction. This is equivalent to 1,200 fewer emergency admissions in the first year post legislation (Bauld L 2011¹¹⁴). Locally the Tobacco Control Alliance worked to successfully implement the workplace smoking ban across the county. In the months of June and July of that year over 400 more people accessed the local stop smoking service than in previous years.
- An economic model of smoking cessation and tobacco control was commissioned by the consultants¹¹⁵ Mott McDonald by the East of England. The modelling was based on the 2008 East of England lifestyle behaviour survey which found the Cambridgeshire smoking prevalence to be 15.6%. This indicated that there were about 77,000 smokers in Cambridgeshire. The modelling found that investment in smoking cessation and tobacco control over the five years 2010-2015 should lead to a net saving to the NHS of £1466k (commissioner costs). This is through avoidance of 288 coronary heart disease events, 16 cerebrovascular events and 423 other events over the period.

Improving Uptake of Smoking Cessation Services

A systematic review examining how to improve access to smoking cessation services for disadvantaged groups found very little effective evidence (Bauld et al 2009¹¹⁶). However, despite the quality of data key themes emerge from the evidence and include:

- GP and health professionals are key in referring to stop smoking services.
- Proactively targeting patients on general practice registers and routine screening is good practice.
- Delivering services in alternative (non-health) settings may be more appealing to some groups.

¹¹⁴ Bauld L (2011) *The Impact of Smokefree Legislation in England: Evidence Review* – University of Bath, Available Online http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124961

¹¹⁵ Mott McDonald, East of England 2009

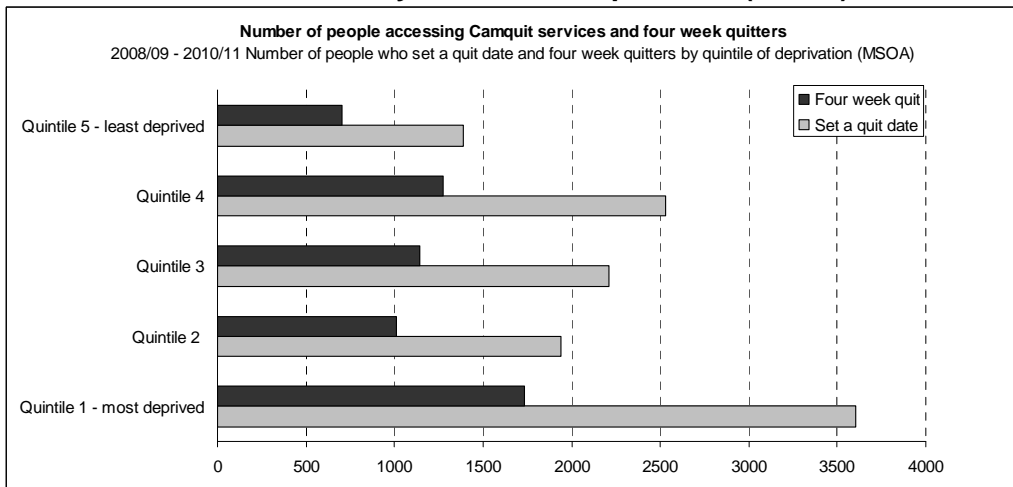
¹¹⁶ Bauld L, Bell K, McCulough L, Richardson L, Greaves L (2009) *The Effectiveness of NHS smoking cessation services: a systematic review* Journal of Public Health; Oxford University Press pp 1-12 (need volume)

- Effective marketing of stop smoking services to improve customer understanding of stop smoking services and to re-enforce positive messages about these services.

What are we doing in Cambridgeshire - Examples of Local Good Practice?

- In Cambridgeshire, the Tobacco Alliance achieved some success in promoting the opportunities afforded by the smokefree legislation (see above). The Alliance has subsequently reformed and is taking forward a number of initiatives focusing upon illegal sales and prevention of uptake of smoking amongst young people.
- Stop Smoking services are available in different settings across Cambridgeshire including primary care (general practices and pharmacies). The specialist service (CAMQUIT) also works across Cambridgeshire in a variety of settings. There has been some shift of activity in 2010/11 from general practices (reflecting the changes in primary care) with the specialist service and pharmacy now contributing an increasing proportion than in previous years.
 - In Cambridgeshire 2010/11 more people accessed the smoking cessation service than they have in previous years. This has increased from 4,500 per year in 2006/07 and 2007/08 to over 7,000 in 2009/10 and 2010/11.
 - Figure 26 shows the number of people accessing NHS Cambridgeshire’s Stop Smoking Service (CAMQUIT) over the last three years by quintile of deprivation. Between 2008/09 and 2010/11 31% of people using the service were from the 20% most deprived areas of Cambridgeshire and 30% of the people who successfully quit at four weeks.

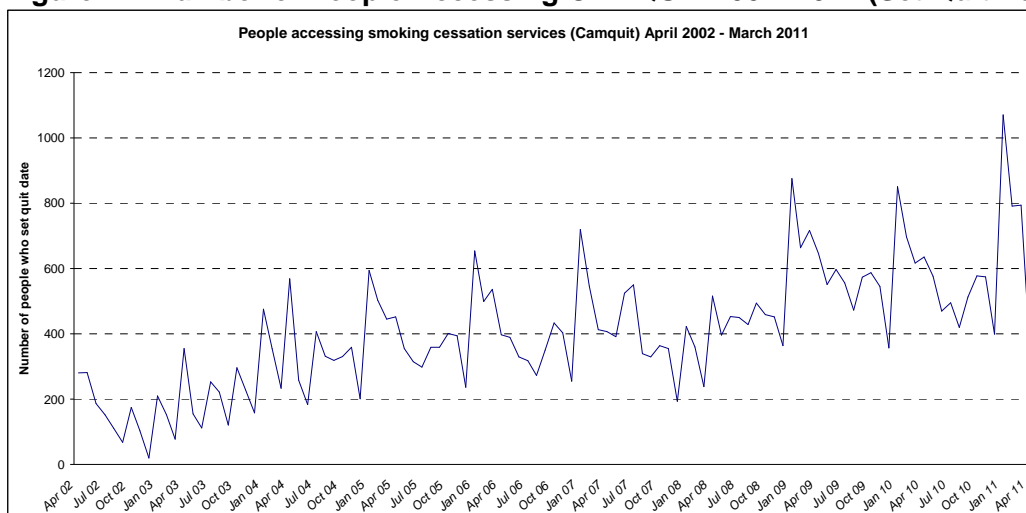
Figure 26: Number of People Accessing CAMQUIT Services and Four Week Quitters 2008/09 – 2010/11 by Quintile of Deprivation (MSOA)



Source: CAMQUIT

- Since 2002, over 44,000 people have used CAMQUIT services, of whom, 23,400 people quit at the four week stage. Each year since 2002 the service has been accessed by more people (Figure 27).

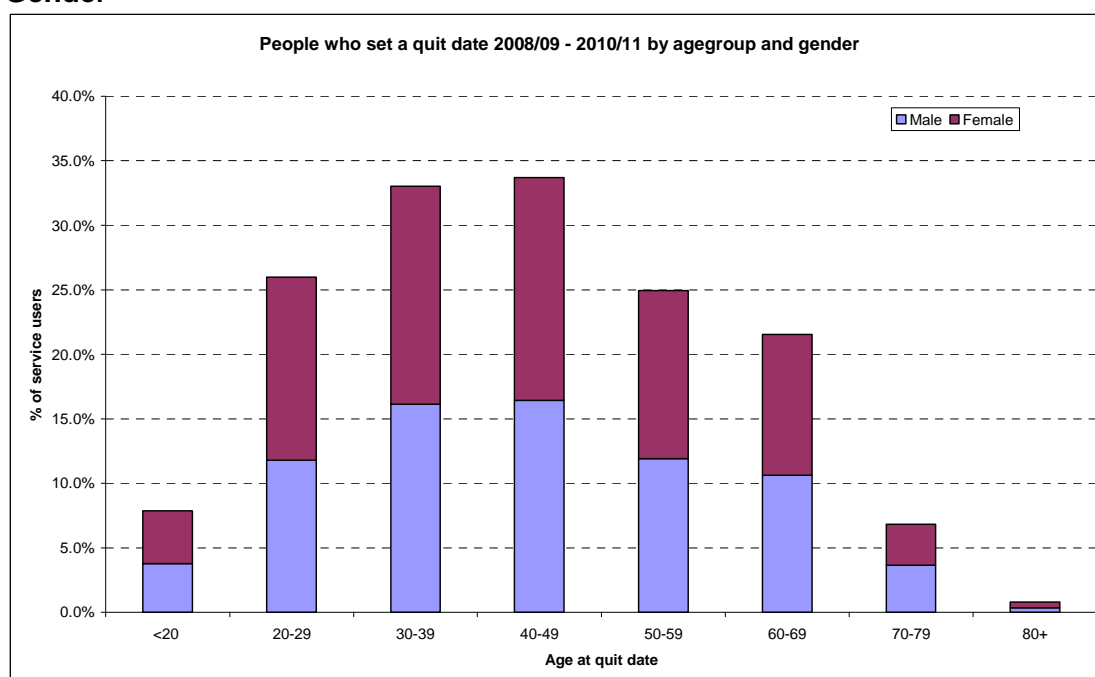
Figure 27: Number of People Accessing CAMQUIT 2002–2011 (Set Quit Date)



Source: CAMQUIT

Age/Gender using stop smoking services in Cambridgeshire

Figure 28: People Who Set a Quit Date 2008/09–2010/11 by Age Group and Gender



Source: CAMQUIT

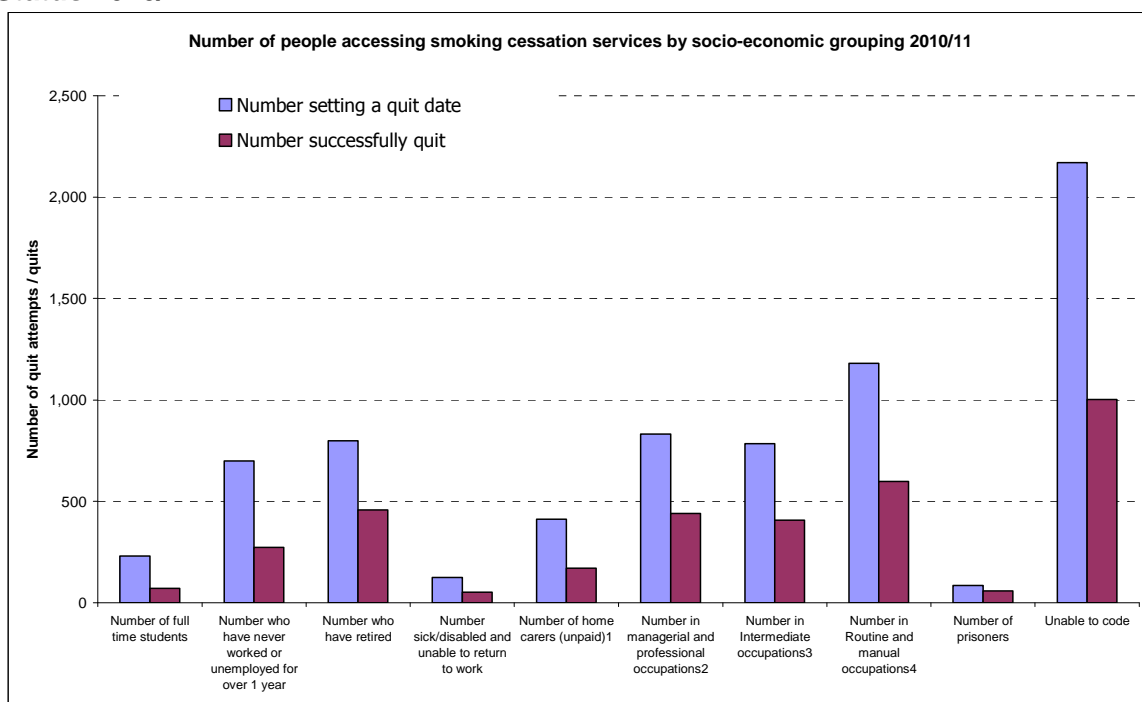
- Locally, a social marketing project was carried out in ten key locations identified by analysing smoking cessation data through the Health Acorn database. This project aimed to improve access to services, improve awareness of the service through localised promotion and target patients through general practice mail out.

What is this Telling us?

5.5.5 What are the Key Inequalities?

- Short Term Quit Rates - Nationally, younger smokers, females, pregnant smokers and more deprived smokers appear to have lower short term quit rates than other groups (Bauld et al 2009¹¹⁶). The desire to quit amongst these groups remains broadly the same, however levels of nicotine dependence does vary significantly as people from lower social groups take on more nicotine (Kotz and West 2009¹¹⁷). Combine this with the social aspects of smoking and communities where smoking is considered the normal thing to do, successfully quitting can be extremely hard.
- Routine and manual (R & M) workers - In 2009/10 smoking prevalence was twice as high in routine and manual occupations compared with professional type occupations. Nearly half of all smokers, more than four million people work in routine and manual type jobs (DoH 2011¹⁰⁹). Nearly 60% of this group are male and 42% are aged 25-44. There is a significant overlap between the R& M population and the C2D socio-economic grouping (DoH 2009¹¹²).
- R & M workers identify significant barriers to stopping smoking including a fear of failure, a fear of being judged, and a belief that stop smoking services will not be able to help them quit. This group also experiences wider life circumstances that reinforce smoking behaviour and make it harder to quit; including more members of their immediate family who smoke and they may also have higher levels of stress (Department of Health 2009¹¹²).
- In Cambridgeshire, the proportion of service users from routine and manual occupations has increased from 15% to 16% between 2009/10 and 2010/11 but generally the overall breakdown is consistent with previous years.

Figure 29: People Accessing Smoking Cessation Services by Socio-economic Status 2010/11

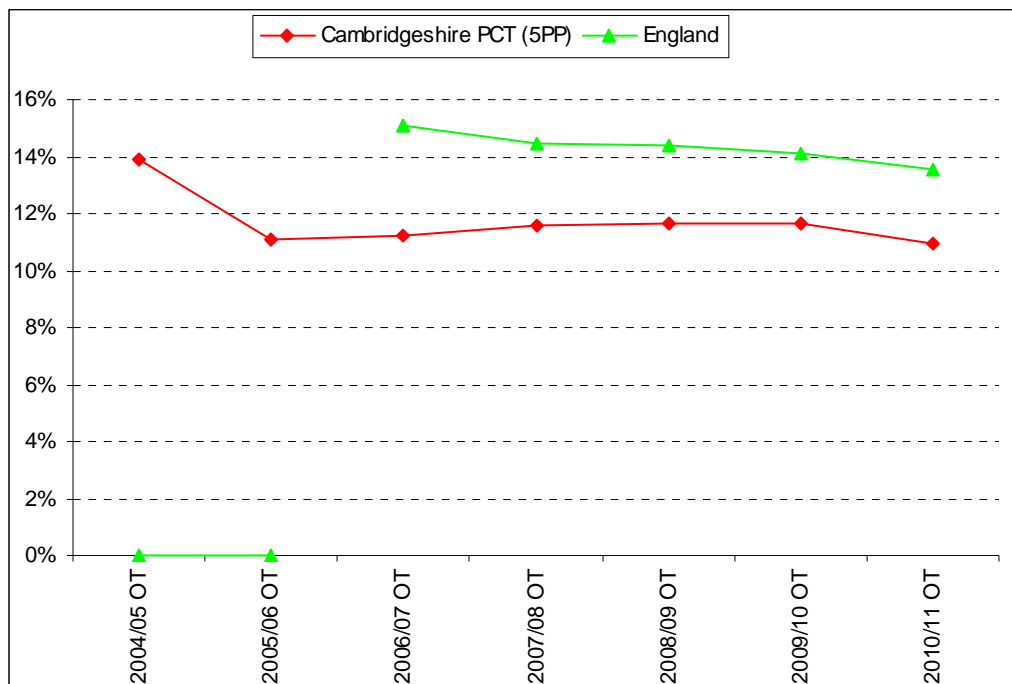


Source: CAMQUIT

¹¹⁷ Kotz D And West R (2009) *Explaining the social gradient in smoking cessation: it's not in the trying but in the succeeding* Tobacco Control 18:43-6

- Whilst there has been an improvement in the percentage of SE Status 'Unable to Code' (from 35% to 30%) this still remains an issue. Whilst 'Unable to Code' remains so high, this invalidates further analysis of the key groups.
- Pregnant Smokers - smoking is the single most modifiable risk factor for adverse outcomes in pregnancy. About one in seven (15%) of women who gave birth in 2008/09 reported smoking during their pregnancy. However the national average masks the regional inequalities; mothers in routine and manual occupations are more than four times as likely to have smoked throughout pregnancy as those in managerial and professional occupations (Department of Health 2009¹¹²). Prevalence in Cambridgeshire is below the national average, but more localised data is not available, so it is more difficult to ascertain the inequalities for this population subset.

Figure 30: Smokers as a Percentage of all Maternities 2004/05–2010/11



Source: Department of Health, NHS IC Omnibus © 2011

- The percentage of women known to be smoking at delivery (as a percent of all maternities) has reduced from 11.6% in the years 2007/08 to 2009/10 to 10.9% in 2010/11. Smoking status was known in 99.1% of maternities.
- Mental Health
 - Smoking tobacco is significantly associated with increased prevalence of all major psychiatric disorders (Department of Health 2011¹⁰⁹).
 - People with mental illnesses are likely to be heavier, more dependent smokers and to have smoked longer than smokers in the general population.
 - The highest levels of smoking occur within psychiatric inpatient settings, where up to 70% are smokers and 50% are heavy smokers (Department of Health 2009¹¹²).
 - It is believed that the health inequality experienced by people with mental illness will widen if investment in smoking cessation services for this group is not increased (DoH 2009¹¹²).

5.5.6 What are the Gaps in Knowledge/Services/Areas for Development?

- Following the implementation of the smokefree workplace legislation four years ago, there was a decrease in the activity of the Tobacco Alliance. To continue to make an impact on the prevalence of smoking and to reduce the health inequalities caused by smoking a stronger partnership approach is required involving organisations and communities. This needs to include the assessment of local perceptions of smokefree environments and pilot locally driven initiatives.
- An increasing number of people are accessing the stop smoking services in Cambridgeshire. However, there are certain population subsets including routine and manual workers, people with mental health concerns and pregnant woman where we could look to understand local barriers and improve service access. Innovative approaches need to be piloted that would explore how uptake of services by targeted groups could be increased.
- Routine and manual workers - accessing routine and manual workers will continue to be key to reducing the prevalence of smoking. Innovative partnerships with local businesses need to be established to provide an acceptable service for this target population. Innovative partnerships with local businesses need to be established to provide an acceptable service for workforces.
- The development of marketing strategies that improve customer understanding of stop smoking services and to re-enforce positive messages about these services.
- Types of services - currently recruitment to group programmes is low and in most cases non existent. Further assessment needs to be undertaken to understand what works to increase the uptake to group smoking cessation programmes as evidence suggests that quit rates are higher in a group format.

5.6 Sexual Health

What do we Know?

5.6.1 Introduction

Sexual health includes sexually transmitted infections (STI), contraception, abortion and reproductive health. Sexual health need requires a holistic understanding. For example if there is a high teenage conception rate then there is high risk of an increase in sexually transmitted infections and abortion.

There is also a clear link between sexual ill health, poverty, social exclusion and the disproportionate burden of STI infection on young people, men who have sex with men (MSM), and men and women from African and Caribbean communities.

5.6.2 Figures and Trends

Sexually Transmitted Infections (STI)

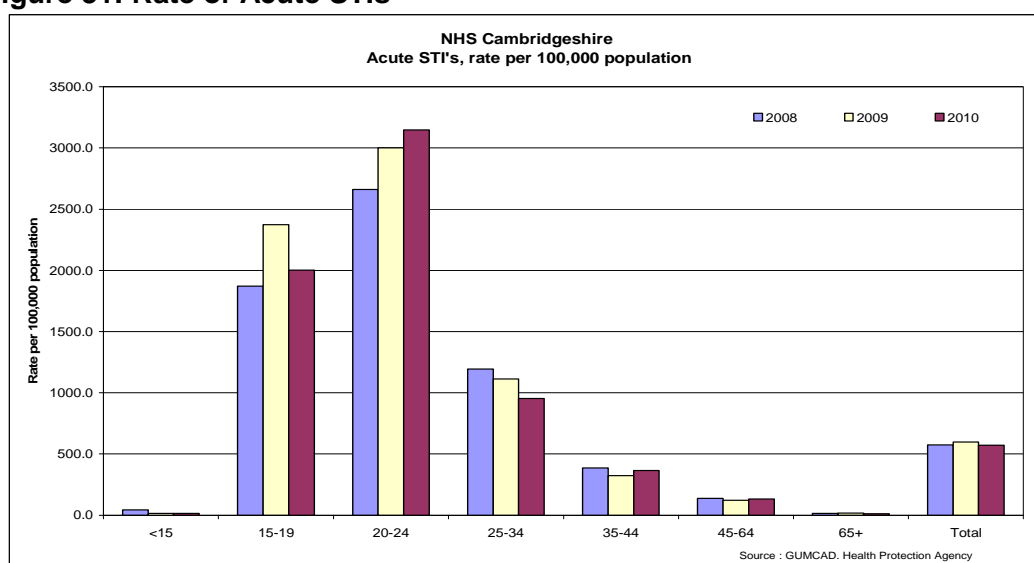
- Overall the rates of STIs in Cambridgeshire have remained consistent between 2008 with 575.5 cases per 100,000 compared to 2010 with 572.6 cases per 100,000.

Table 71: Rates of STI Diagnoses in Cambridgeshire (2008-2010)¹¹⁸

Acute STIs		Rates of diagnoses per 100,000 population							
		<15	15-19	20-24	25-34	35-44	45-64	65+	Total
2008	Male	0.0	1179.2	2588.5	1569.9	558.6	211.9	26.4	645.1
	Female	86.5	2619.4	2734.7	778.7	216.3	62.6	3.9	504.6
	Total	42.6	1871.8	2661.4	1194.1	386.6	136.5	13.9	575.0
2009	Male	14.0	1630.5	2926.0	1429.4	489.4	183.1	32.3	655.6
	Female	14.3	3189.9	3078.5	754.4	162.3	60.3	1.9	541.1
	Total	14.1	2374.6	3000.1	1112.4	324.0	121.1	15.6	598.3
2010	Male	0.0	1198.9	3007.1	1241.0	520.4	204.1	18.5	614.3
	Female	28.7	2879.8	3303.9	630.1	209.9	62.8	5.6	531.2
	Total	14.1	2001.0	3147.0	954.0	363.4	132.7	11.4	572.6

Notes: Acute STIs include: Chlamydia infection (uncomplicated and complicated), Gonorrhoea (uncomplicated and complicated), Primary, secondary and early latent syphilis, Genital Herpes simplex (first episode), Genital warts (first episode), Non-specific genital infection (uncomplicated and complicated), Chancroid/lymphogranuloma venerum (LGV)/Donovanosis, Molluscum contagiosum, Trichomoniasis, Scabies

Figure 31: Rate of Acute STIs¹¹⁹



Notes: Acute STIs include: Chlamydia infection (uncomplicated and complicated), Gonorrhoea (uncomplicated and complicated), Primary, secondary and early latent syphilis, Genital Herpes simplex (first episode), Genital warts (first episode), Non-specific genital infection (uncomplicated and complicated), Chancroid/lymphogranuloma venerum (LGV)/Donovanosis, Molluscum contagiosum, Trichomoniasis, Scabies.

¹¹⁸ GUMCAD Data 2008 to 2010, Health Protection Agency

¹¹⁹ GUMCAD Data 2008 to 2010, Health Protection Agency

Table 72: Number and Rates per 100,000 of STI Diagnoses in Cambridgeshire by STI (2008-2010)¹²⁰

Condition	Gender	Number of diagnoses			Rate of diagnoses		
		2008	2009	2010	2008	2009	2010
Chlamydia	Male	546	668	643	180.9	220.61	212.36
	Female	742	947	924	244.71	311.29	303.73
	Total	1,290	1,616	1,567	213.21	266.22	258.15
Gonorrhoea	Male	45	49	32	14.91	16.18	10.57
	Female	25	19	14	8.25	6.25	4.6
	Total	70	68	46	11.57	11.2	7.58
Syphilis	Male	-	-	-	3.98	1.98	1.65
	Female	-	-	-	0.33	-	0.33
	Total	-	-	-	2.15	0.99	0.99
Herpes	Male	81	82	83	26.84	27.08	27.41
	Female	108	112	121	35.62	36.82	39.77
	Total	189	194	204	31.24	31.96	33.61
Warts	Male	325	364	408	107.68	120.21	134.75
	Female	381	318	311	125.65	104.53	102.23
	Total	706	682	719	116.69	112.35	118.45
New STIs	Male	1,975	1,996	1,880	654.35	659.2	620.89
	Female	1,541	1,657	1,626	508.22	544.67	534.48
	Total	3,518	3,654	3,506	581.45	601.96	577.58
Other STIs	Male	450	450	462	149.09	148.62	152.58
	Female	306	304	279	100.92	99.93	91.71
	Total	756	754	741	124.95	124.21	122.07

Notes

- Total includes unknown gender.
- Figures for syphilis have been removed as there are less than 15 cases.
- Chlamydia data presented includes National Chlamydia Screening Program (NCSP) data and Non-NCSP and non-GUM returns from laboratories among 15-24 year olds only. Reporting of non-NCSP non-GUM returns began in April 2008, so there are no data available between January and March 2008.
- New STI's: (diagnoses) Chlamydia (uncomplicated and complicated), Gonorrhoea (uncomplicated and complicated), Non-specific genital infection (uncomplicated and complicated), Syphilis (primary, secondary and early latent), Lymphogranuloma venereum, Chancroid, Donovanosis, Genital herpes simplex (first episode), Genital warts (first episode), New HIV diagnosis, Molluscum contagiosum, Trichomoniasis, Scabies, Pediculus pubis.
- Other STIs: Congenital syphilis aged two or over and other acquired syphilis, Congenital syphilis, aged under two years, Ophthalmia neonatorum, Genital herpes simplex (recurrent episode), Recurrent and re-registered genital warts, Subsequent HIV presentations (including AIDS).

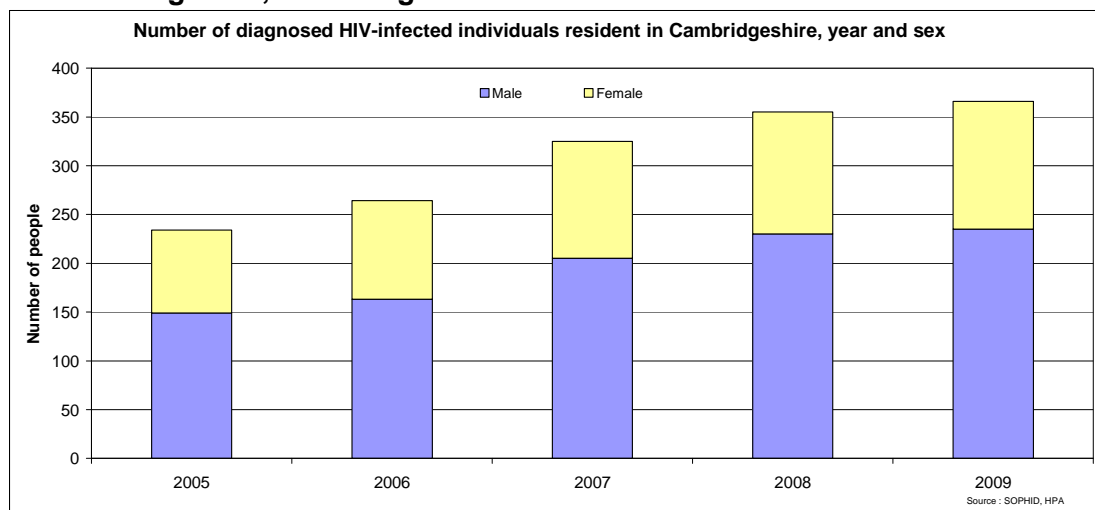
HIV/AIDS

- Nationally, it is estimated that by the end of 2009, 86,500 people in the UK live with HIV/AIDS, a quarter of whom had not been diagnosed. Since 2000 there has been a three-fold increase in the number of people living with HIV/AIDS in the UK accessing care and a four-fold increase among older (aged 50 years and over) individuals¹²¹.
- In Cambridgeshire, 366 people are living with HIV/AIDS and are accessing care (2009). The prevalence of HIV/AIDS in Cambridgeshire has been increasing since 2004 although the recorded prevalence is lower than both the national and regional figures.

¹²⁰ GUMCAD Data 2008 to 2010, Health Protection Agency

¹²¹ Source: HIV in the UK, 2010 report, Health Protection Agency (www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1287145367237)

Figure 32: HIV Diagnosis, Cambridgeshire 2005-2009



- The 2009 Survey of Prevalent HIV Infections Diagnosed (SOPHID) data highlighted the following local trends:
 - Just under two thirds (64%) were males. 138 (38%) were aged 35-44 years, 87 (24%) aged 45-54 years, 70 (19%) aged 25 to 24 years and 55 (15%) aged 55+ years.
 - 56% were from white ethnic groups, whilst 39% were Black Africans
 - A third of HIV infected residents live in Cambridge City, with relatively high numbers also in Huntingdonshire (27%) and South Cambridgeshire (19%).
 - 28% of HIV-infected residents live in the most deprived quintile in Cambridgeshire. Over half are in the top two most deprived quintiles.
 - The probable route of infection in over half (55%) of people was sex between men and women, with 91% of women being infected this way. Around 55% of infections in men were probably due to sex between men.
 - Half of HIV-infected residents were asymptomatic, 28% were symptomatic pre-AIDS and 21% had AIDS. Two people died.
 - Half were on triple anti-retroviral therapy and 31% were on quadruple therapy (mostly these latter patients' fourth drug was low dose Ritonavir as a boosting agent rather than for anti-retroviral activity).
- Of the 366 HIV-infected residents known to services 200 (55%) were seen at CUHFT, 84 (23%) were seen at Clinic 6, 17 (5%) at Queen Elizabeth Hospital, 13 (4%) at Peterborough District and 35 (10%) in London hospitals.

Chlamydia Trachomatis

- The number of cases of Chlamydia has continued to decrease in the UK although it remains the most common STI in under 25 year olds. In 2010-2011, there were 70,286 new diagnoses of uncomplicated genital Chlamydia in the UK compared to 123,018 in 2008-2009. In Cambridgeshire there were 762 cases of genital Chlamydia in 2010-2011 or 3.4% of the target population compared to 4.8% in 2009-2010 and 5.1% in 2008-2009.

Gonorrhoea

- In recent years the number of new diagnoses of Gonorrhoea in the UK has been on the decline. In 2008, there were 17,202 new cases of uncomplicated Gonorrhoea in the UK and 825 cases in the East of England. Unfortunately the local data available are not complete to confirm this trend for Cambridgeshire. Laboratory data shows that testing for Gonorrhoea has been increasing mainly in the GUM Clinic at Cambridge University Hospital Foundation Trust (CUHFT) and general practices between 2000 and 2008. The positivity rate was 0.3% in Health Protection Agency (HPA) CUHFT and lower in Peterborough and Queen Elizabeth Hospital in 2008.

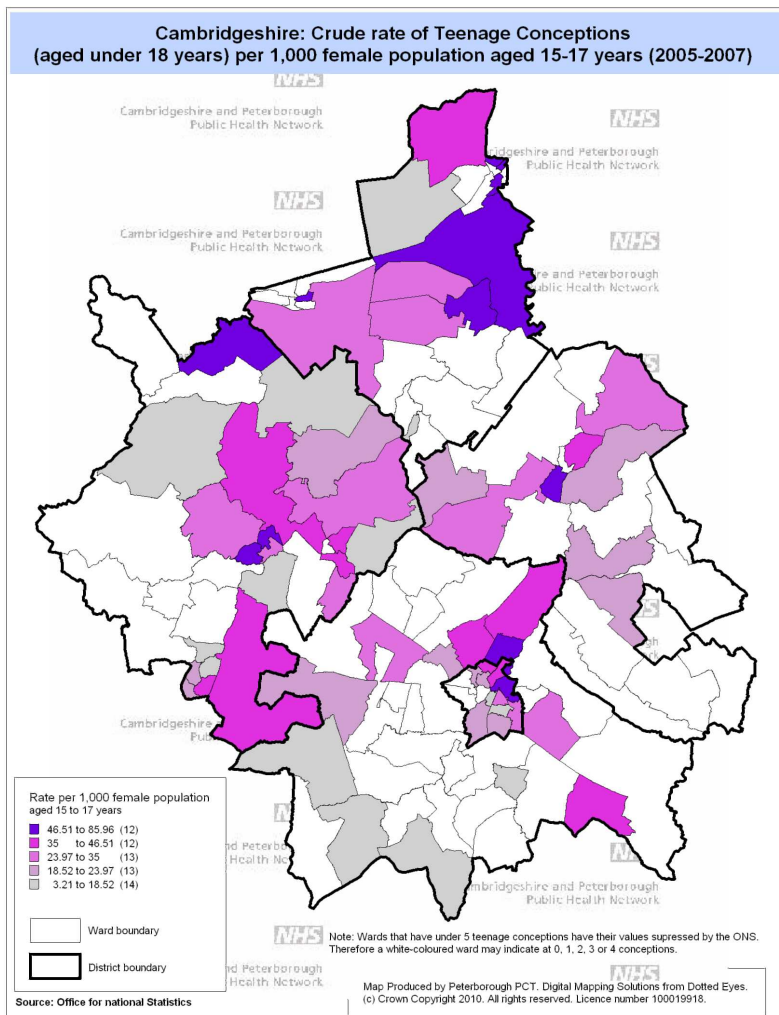
Syphilis

- Between 1997 and 2007, the number of diagnoses of infectious syphilis in the UK has increased 12 fold from 301 to 3,789. There has been a general upward trend in the number of new cases of Syphilis in Cambridgeshire between 1998 and 2007, although there were fluctuations year to year. Of the new cases between 2003 and 2007, 81% were male and 19% were female. The majority of cases were aged 25–34 years (35%), followed by 35-44 years (27%) and 20-24 years (21%). Females have higher proportions of cases in the younger age band than males. In 2008, the positivity rate varied between laboratories in Cambridgeshire, probably because some tests were covering a number of different diseases (1.5% HPA CUHFT, 2.2% Peterborough and 0.9% Queen Elizabeth Hospital).

Teenage Conceptions

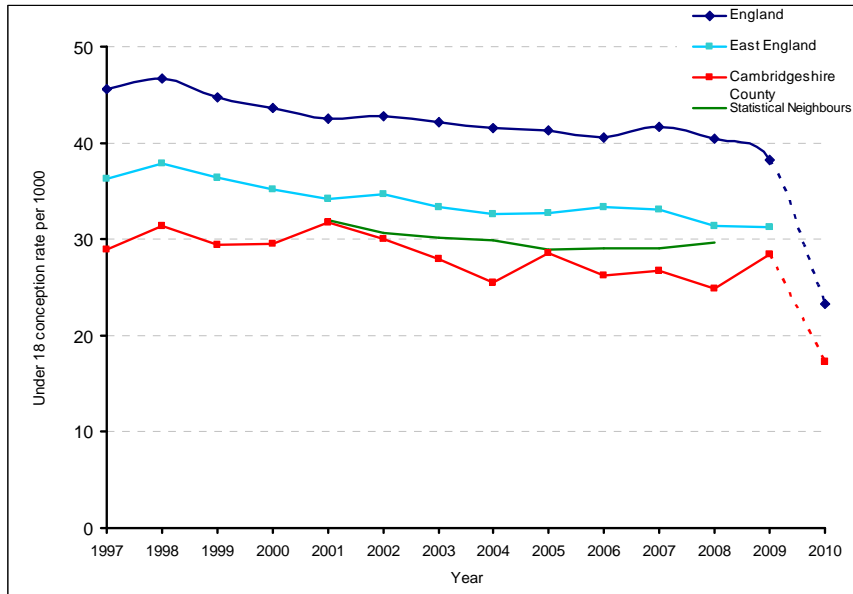
- The National Teenage Conception Rate in 2007-2009 was 40.2 per 1,000 females aged 15-17. The Cambridgeshire teenage conception rate has been consistently and significantly lower than the national and East of England rate since the launch of Teenage Pregnancy Strategy in 1999. There has been an overall improvement especially in Fenland, which was the only area in Cambridgeshire to be above the national average.
- In 2009, the teenage conception rate was 28.4 per 1,000 females aged 15-17 years (an increase from the 2008 rate of 24.8).
- In Cambridgeshire, the rates vary across the county with Fenland having the highest rate and East Cambridgeshire the lowest in 2007-2009. Within districts there is variation in teenage conception rates. The percentage of teenage conceptions leading to abortion increased slightly from 48% in 2006-2008 to 49% in 2007-2009.

Map 9: Crude Rate of Teenage Conceptions Mapped in Cambridgeshire 2005-2007



- The National Teenage Pregnancy Strategy set a goal of reducing teenage conceptions by 50% from 1997 to 2010. Chart 5 monitors the progress of Cambridgeshire against the National average. We are currently not on trajectory to meet the 2010 target.

Figure 33: Under 18 Conception Rate Per 1,000 in Cambridgeshire, East of England and Nationally



District and City Council Areas

- In general East Cambridgeshire, Fenland and Huntingdonshire experienced decreases in rates between 2006/08 and 2007/09, whilst there were increases in Cambridge City and South Cambridgeshire. The percentage that led to abortion increased in Cambridge City and slightly in South Cambridgeshire and decreased in all other areas.

Cambridge City

- 177 teenage conceptions in 2007/09 with a rate of 32.1 per 1000
- Increase from 28.3 in 2006/08
- % that led to abortion increased from 46% in 2006/08 to 50% in 2007/09
- 2.9% decrease in rates between 1998/00 and 2007/09

East Cambridgeshire

- 86 teenage conceptions in 2007/09 with a rate of 20.1 per 1000
- Decrease from 20.7 in 2006/08
- % that led to abortion decreased from 47% in 2006/08 to 45% in 2007/09
- 31.4% decrease in rates between 1998/00 and 2007/09

Fenland

- 182 teenage conceptions in 2007/09 with a rate of 36.7 per 1000
- Decrease from 38.2 in 2006/08
- % that led to abortion decreased from 37% in 2006/08 to 35% in 2007/09
- 30% decrease in rates between 1998/00 and 2007/09

Huntingdonshire

- 251 teenage conceptions in 2007/09 with a rate of 26.2 per 1000
- Decrease from 27.3 in 2006/08
- % that led to abortion decreased from 54% in 2006/08 to 52% in 2007/09
- 10.1% decrease in rates between 1998/00 and 2007/09

South Cambridgeshire

- 159 teenage conceptions in 2007/09 with a rate of 20.5 per 1000
- Increase from 17.6 in 2006/08
- % that led to abortion increased from 57% in 2006/08 to 58% in 2007/09
- 18.9% increase in rates between 1998/00 and 2007/09

Abortion

- The total number of abortions carried out in England and Wales in 2010 was 189,574, 8% more than in 2000 (175,542) indicating unintended pregnancy is not just a burden for young women but a negative health outcome for women of reproductive age.¹²²
- Cambridgeshire has a lower abortion rate than the regional and national figure, 10.7 per 1,000 women aged 15-44 in 2009 compared with 15.2 and 17.6, respectively. Between 2008 and 2009 there has been an increase of 2% in the number of abortions in Cambridgeshire whilst at the same time there was a 3% decrease in abortions in England and Wales. In 2009, roughly half of teenage conceptions in Cambridgeshire ended in abortion, although this varied from 35% in Fenland (which has the highest teenage conception rate) to 58% in South Cambridgeshire.
- In Cambridgeshire, 94% of abortions performed are funded by the NHS which comparatively is the same as the regional and national percentages. 73% of abortions in Cambridgeshire take place under ten weeks' gestational age which is slightly lower than the national and regional averages of 75%.

Emergency Contraception

- Emergency hormonal contraception (EHC) has long been recognised as a safe and effective method of preventing unintended pregnancy after unprotected sexual intercourse. It can be up to 95% effective within 24 hours of unprotected sexual intercourse and 75% effective within 72 hours.¹²³
- Despite increased availability, studies in the UK have shown that up to 40% of women do not know that EHC can be taken up to 72 hours after unprotected sexual intercourse.¹²⁴ Further research indicates that misconceptions, a lack of understanding of hormonal contraceptive methods and a general lack of knowledge that post-coital contraceptive options exist are still common-place (Wynn et al, 2005).¹²⁵
- EHC was prescribed in 397,000 occurrences by GPs and contraceptive clinics in England and Wales in 2010.¹²⁶ In 2010-2011, 3,427 prescriptions for EHC were filled by pharmacists in Cambridgeshire under the Patient Group Directive (PGD) a process that allows qualified pharmacists in Cambridgeshire to dispense the drug without a doctor's review to those who meet certain criteria. Issues with accreditation and overall numbers of pharmacists signed up to the PGD have resulted in patchy provision of services. Work is being undertaken, however, to ensure equitable and complete coverage throughout the county.

¹²² Great Britain. Department of Health (2011) *Abortion Statistics, England and Wales: 2010*. Department of Health. [online]. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127202.pdf [Accessed 28 May 2011].

¹²³ Trussell, J., Steward, F., Guest, F. and Hatcher, R. (1992) Emergency contraceptive pills: a simple proposal to reduce unintended pregnancies, *Family Planning Perspective*, 24, pp. 269-273.

¹²⁴ Schenk, K. (2003) Emergency contraception: lessons learned from the UK, *Journal of Family Planning and Reproductive Health Care*, 29(2), pp. 35-40.

¹²⁵ Wynn, L. and Trussell, J. (2005) The morning after on the internet: usage of and questions to the emergency contraceptive website, *Contraception*, 72, pp. 5-13.

¹²⁶ NHS Contraceptive Services: England, 2009-2010, Office of National Statistics

Sexual Assault

- There were 740 sexual offences recorded in Cambridgeshire during 2008-2009 with 755 recorded sexual offences in Cambridgeshire the following year (2009-2010) representing a 2% increase year on year. In 2009-2010, 131 cases were reported in Cambridgeshire with East Cambridgeshire having the lowest reported cases at 32. The Peterborough Unitary Authority figures are included in the Cambridgeshire totals and at 317, represented the highest number of reported crime in 2009-2010.¹²⁷
- The Cambridgeshire and Peterborough Sexual Assault Referral Centre provided services to 330 people in 2010 of which, 112 of those clients were from Cambridgeshire. Of the 330 referrals:
 - 82 were acute police referrals;
 - 13 were police referrals Independent Sexual Violence Advisor (ISVA) support;
 - 7 were acute self referrals;
 - 7 were self referrals for support;
 - 3 were professional referrals for support.

5.6.3 Local Views

- The burden of sexual ill health is weighted towards young people and there is ongoing consultation with this population group. Although school/college based surveys fall outside the remit of this JSNA they are important in terms of early prevention and also the 16 to 25 year old group.
- Specific groups of people are regularly consulted to inform sexual health service commissioning. A report commissioned from Brook in 2010, indicated that professionals in Huntingdonshire felt that there needed to be a focus on school-based sexual health service provider and the school is important in order to maximise the skills, abilities and the potential opportunities to capitalise on existing relationships with young people. The document outlined basic priorities for school-based sexual health services.
- In March 2010, a series of focus groups were held with young people and Lesbian, Gay, Bisexual and Transgender (LGBT) groups to gauge their feelings on sexual health services in Cambridgeshire. The summary report highlighted the need for community involvement in the promotion of services as well as in reducing stigma. Participants reinforced the need for services to be inclusive to all populations with regard to terminology, procedures and practice. Staff training, along with a concerted effort to make physical and emotional aspects of the service “friendly”, is paramount to quality services.

5.6.4 Evidence /Policy

National Policy

- *Better Prevention, Better Services, Better Sexual Health*¹²⁸ - The national strategy for sexual health and HIV (2001) set the context for the ensuing development of interventions to address sexual health. It had three main strands:
 - Prevention – calling for a shift in focus to prevention reflecting the massive increase in sexually transmitted infection over the previous decade.

¹²⁷ Crime in England and Wales: Local Authorities: Recorded crime for seven key offences, 2009-2010, Home Office, Research Development Statistics

¹²⁸ Better Prevention, Better Service, Better Sexual Health, Department of Health (2001)

- Better Services – this led to the establishment of the three levels of service that form the basis of current service delivery. Accessibility was a key theme and set the direction of travel for more integrated community-based services that were accessible to all and addressed any inequalities.
- Better Commissioning – the emphasised need for more partnership work and joint commissioning.
- Medical Foundation for AIDS and Sexual Health (MedFASH)'s Independent Advisory Group on sexual health and HIV (2008) reviewed the 2001 National Strategy and identified key priorities for action to include:¹²⁹
 - Commissioning for improved sexual health services (based on local needs assessment)
 - Improved IT systems to collect data
 - Explicit Service Level Agreements (SLAs)
 - Auditable services against robust standards
 - Equitable services
 - Investment in prevention including well-resourced health promotion
- In *High Quality Care for All* (Darzi) Review (2008)¹³⁰, included sexual health services that would benefit from service developments.
 - Wellbeing and prevention work should focus on six key goals which included improving sexual health. It was recommended that prevention work be scaled up to 'an industrial scale'.
 - New GP led health centres with more convenient opening hours, with access to a much broader range of services that included sexual health.
- The *Choosing Health White Paper*¹³¹ highlighted the importance of the modernisation of health services with fully integrated care pathways and new models of service delivery. It recommends delivery of coordinated programmes through Children's Trust involving NHS, Local Authority and schools with targeted delivery in the community.
- Recently updated guidance on clinical service standards has been launched including *Standards for HIV Clinical Care*¹³² and *Service Standards for Sexual Health Services* (Faculty of Family Planning and Reproductive Health Care, 2006).¹³³ These documents along with two guidance documents from National Institute for Health and Clinical Excellence (NICE) published in March 2011 focusing on increasing uptake of HIV testing among men who have sex with men (MSM)¹³⁴ and black African communities¹³⁵ provide a best practice for commissioning and delivery of services.

¹²⁹ Progress and priorities – working together for high quality sexual health: *Review of the National Strategy for Sexual Health and HIV*, Medical Foundation for AIDS and Sexual Health (MedFASH) (2008)

¹³⁰ High Quality Care for All, 2008, Department of Health

¹³¹ Choosing Health, making Healthier Choices Easier, White Paper, Department of Health (2004)

¹³² Standards for Clinical Care, British HIV Association (BHIVA) (2007)

¹³³ Service Standards for Clinical Care, Faculty of Family Planning and Reproductive Health (2006)

¹³⁴ Increasing the uptake of HIV testing among men who have sex with men, National Institute for Health and Clinical Excellence, 2011.

¹³⁵ Increasing the uptake of HIV testing among black Africans in England, National Institute for Health and Clinical Excellence, 2011.

- In *Increasing the uptake of HIV testing among men who have sex with men*, NICE provide the following advice:
 - planning services, including assessing local need and developing a strategy
 - promoting HIV testing among men who have sex with men, including outreach schemes and providing rapid point-of-care tests
 - offering and recommending an HIV test in primary care, secondary care and specialist sexual health services
 - repeat testing
 - HIV referral pathways
- In the second guidance, increasing the uptake of HIV testing among black Africans in England, recommendation include advice on:
 - community engagement and involvement
 - planning services, including assessing local need, developing a strategy and commissioning services in areas of identified need
 - promoting HIV testing and reducing barriers to testing among black African communities
 - offering and recommending an HIV test
 - HIV referral pathways
- Further NICE guidance on black African communities¹³⁶ and men who have sex with men¹³⁷ recommends the following points to professionals working in sexual health services including:
 - Assess people's risk of having a sexually transmitted infection (STI), when the opportunity arises.
 - Encourage earlier diagnosis by offering routine testing (ie at GP registration or annually to high-risk groups via their GP).
- NICE published guidance in 2005 that provided evidence base for the use of Long Acting Reversible Contraception (LARC)¹³⁸ methods to reduce unintended pregnancy as it is estimated that about 30% of pregnancies in the UK are unplanned. It also provided clear evidence that is cost-effective form of contraception and produced cost savings.¹³⁹ The effectiveness of the barrier method and oral contraceptive pills depends on their correct and consistent use but by contrast, the effectiveness of LARC methods does not depend on daily concordance. The uptake of LARC is low in Great Britain, at around 8% of women aged 16–49 in 2003–04, compared with 25% for the oral contraceptive pill and 23% for male condoms. Expert clinical opinion is that LARC methods may have a wider role in contraception.
- The Cambridgeshire Sexual Health Strategy was developed with partners from across the county. Its key strategic aims and objectives reflect the key national policies and strategies in the context of local need.

Strategic Aims

- To improve the sexual health of the population of Cambridgeshire.
- To reduce sexual health inequalities and inequalities of service provision.
- To commission, where appropriate with non-health partners, evidence based and cost-effective services in line with world class commissioning principles.

¹³⁶ Increasing the uptake of HIV testing among black Africans in England, National Institute for Health and Clinical Excellence 2011

¹³⁷ Increasing the uptake of HIV testing among men who have sex with men, National Institute for Health and Clinical Excellence 2011

¹³⁸ Long Acting Reversible Contraception, NICE Clinical Guideline 30 (2005)

¹³⁹ Long Acting Reversible Contraception, Costing Report, NICE Clinical Guideline 30 (2005)

Strategic Objectives

- Increase the range and number of preventative interventions to reduce the number of unintended teenage conceptions and Sexually Transmitted Infections (STIs).
- Commission high quality comprehensive cost-effective integrated sexual health services that reduce stigma and are supportive of sexual health wellbeing and are in line world class commissioning principles.
- To develop capacity to deliver modern high quality integrated sexual health services and appropriate knowledge and signposting in partner agencies.
- To improve access to integrated sexual health services with a focus on the rural areas where there are lower levels of service provision.
- Commission appropriate HIV services to improve health and social care for people living with HIV.

What are we doing in Cambridgeshire - Examples of Local Good Practice

- The multi-agency Countywide Sexual Health Forum along with the three area Sexual Health Forums (Cambridge City and South; East Cambridgeshire and Fenland; Huntingdonshire) oversee a range of initiatives in Cambridgeshire and aim to improve, protect and promote the sexual health and wellbeing of the population in Cambridgeshire. The group is responsible for the Cambridgeshire Sexual Health Strategy referred to above. Embodied in the approach of the group is a commitment to have more accessible community provided services. This work has been taking place since 2004, when the first services were transferred to the community and is still core to the current strategic direction of services.
- The rate of teenage conceptions has decreased by 9.5% between 1998 and 2009. Sexual Health Forums are addressing those wards in which teenage conception rates remain high.
- NICE clinical guidance encourages the uptake of Long-Acting Reversible Contraception (LARC) for pregnancy prevention among women of all ages. To increase the opportunity to women to access LARC methods, NHS Cambridgeshire commissioned a local training programme to train and accredited GPs to fit implants and IUD/IUS. Similar training is now being offered to Practice Nurses to further increase provision.
- A Sexual Assault Referral Centre was established which was due to extensive partnership working between NHS Cambridgeshire and Peterborough, Cambridgeshire County Constabulary, Cambridgeshire County Council and Peterborough Unitary Authority and a number of voluntary agencies. This has enabled victims of sexual assault to receive specialist treatment and follow up support.

Case Study

The National Chlamydia Screening Programme (NCSP) is a control and prevention programme targeted at sexually active young people under 25 in England. The NCSP aims to:

- prevent and control Chlamydia through early detection and treatment of asymptomatic infection;
- reduce onward transmission to sexual partners;
- prevent the consequences of untreated infection.

Locally, PCTs were required to screen 35% of the target population for 2010-2011 (a 10% rise from 2009-2010).

- The Cambridgeshire programme screened the largest total number of young people in the East of England which equates to 28,964 under 25s or 33.2% of the population group.
- The Cambridgeshire Screening Team successfully met the 25% target set in 2009-2010 by screening 27.3% of the population (23,670 screens) and ranking second in the region and 25th nationally. The Chlamydia Screening programme has raised the profile of STI screening and generally prevention and sexual health services.

What is this Telling us?

5.6.5 Key Inequalities

- Teenage pregnancy is associated with health inequalities including increased risk of poor social, economic and health outcomes for both mother and child and retains a high profile in health and social care policy. In Cambridgeshire there is higher rate of teenage pregnancy in the more deprived areas in the county.
- Inequalities in health repeat themselves as inequalities in sexual health (House of Common Health Committee, Third Report of Session 2002-2003)¹⁴⁰ It found that the highest burden of sexually transmitted disease is borne by women, commercial sex workers, gay men, men who have sex with men (MSM), teenagers, young adults and black and ethnic minorities (BME). A better understanding of the sexual health needs of these groups especially vulnerable populations is required.
- There is unequal provision of Sexual Health Services in Cambridgeshire. Although most general practices provide some level of contraceptive service, sexual health services and more complex contraceptive services are concentrated in the south of the county. The two level three consultant led services are located in Huntingdon and at Cambridge University Hospital Foundation Trust (CUHFT). This situation is also reflected in level 2 services which are also concentrated in the south of the county. East Cambridgeshire and Fenland have one extended session each per week. The rurality and limited transport links in these areas further disadvantages the local population accessing services.
- Other specific access inequalities relate to patchy provision of free Emergency Hormonal Contraception (EHC) across Cambridgeshire means that women in more rural areas may have to travel to obtain EHC within the pill's efficacy time frame. There are no targeted services for people with development or learning disabilities, who can be particularly at risk of unwanted pregnancy.

5.6.6 What are the Gaps in Knowledge/Services/Areas for Development?

- The National Chlamydia Screening Programme (NCSP) is a control and prevention programme targeted at sexually active young people under 25 in England. It initially required each area to screen a percentage of the target population. In 2010-2011, the programme objectives shifted from screening totals to a diagnosis target. There is some uncertainty about how to identify groups to target who will have higher positivity rates although a continued focus on some services such as remote testing and antenatal screening will ensure the first step to screening higher rates of positive patients.

¹⁴⁰ Health Inequalities, House of Commons Health Committee: Third Report of Session 2008-2009, Volume 1, 26 February 2009.

- Some key service gaps and development issues have been identified by providers and service users.
 - Contraceptive services have not been integrated with sexual health services in some areas with Genito-urinary Medicine (GUM).
 - IT capacity is an issue: most services are unable to collect data electronically which makes robust epidemiological understanding of need difficult.
 - Out of hours access to services ie services are not available on weekends or late evenings.
 - Psychosexual Services are not funded.
 - The Condom Distribution Scheme is not fully funded and there are concerns over its future development.
- Increasing access to prevention and treatment services for high risk and vulnerable groups including young people, young men who have sex with men (MSM), commercial sexual workers, looked after children, unaccompanied minors and young people not in school, migrant groups (including those for whom English is a second language) and those with disabilities.
- Continue working to ensure that access to sexual health services, including GUM, CASH and Termination of Pregnancy are appropriate and accessible to all populations in all areas of Cambridgeshire.
- HIV prevention and early diagnosis. The Government has announced that there will be new Sexual Health and HIV Strategy in 2011. This will have a focus on HIV especially on early diagnosis and treatment.

5.7 Alcohol

What do we Know?

5.7.1 Introduction

Hazardous drinking of alcohol is defined as a pattern of drinking which brings about the risk of physical or psychological harm. Harmful drinking is a subset of hazardous drinking and is described as a pattern of drinking that is likely to cause physical and psychological harm. Nationally over the last decade there are indications of an increase in adverse health outcomes associated with alcohol. In England alcohol-related hospital admissions doubled between 2002 and 2009. Deaths related to alcohol saw a 20% increase in the same period.¹⁴¹ Cambridgeshire generally compares well to the national statistics but there are some concerns that are related to particular geographical areas.

5.7.2 Figures and Trends

The most recent local alcohol profiles were published in September 2010. Compared to the England average, Cambridgeshire is significantly better on 16 out of 24 alcohol-related indicators, including:

- Alcohol-specific mortality for males and females, where the rate is 8.2 and 4.3 per 100,000 population respectively (directly standardised rate - DSR).
- Alcohol-attributable mortality for males at 28.5 per 100,000 (DSR).

¹⁴¹ Statistics on Alcohol, England 2011, Health and Social Care Information Centre. 2011

- Alcohol-attributable hospital admissions for males and females at 1,225 and 700 people per 100,000 population respectively (DSR).

Compared to the England average, Cambridge is significantly worse on seven out of 24 alcohol-related indicators; these are the following indicators:

- Alcohol-specific hospital admissions for under 18s at 88 per 100,000 population (crude rate).
- Alcohol-specific hospital admissions for males and females at 547 and 257 people per 100,000 population respectively (directly age standardised rate - DSR).
- Hospital admissions for alcohol-related harm (NI39) at 1,867 per 100,000 population (DSR).
- Alcohol-attributable recorded crimes at 9.3 per 1,000 population (crude rate).
- Alcohol-attributable violent crimes at 6.6 per 1,000 population (crude rate).
- Binge drinking at nearly 28% (synthetic estimate).

Cambridge is ranked among the 20% of local authorities with the worst results on the following indicators:

- Alcohol-specific hospital admission for males and females.
- Increasing risk drinking at 22.5% (synthetic estimate).
- Binge drinking at 28% (synthetic estimate).

Compared to the England average, Fenland is significantly worse on four out of 24 alcohol-related indicators:

- Alcohol-attributable hospital admissions for males and females at 1,486 and 826 per 100,000 population respectively (directly standardised rate - DSR).
- Hospital admissions for alcohol-related harm (NI39) at a rate of 1,932 per 100,000 population (DSR).
- Mortality from land transport accidents at 4.3 per 100,000 population (DSR).

Fenland is ranked among the 20% of PCTs with the worst results on the following indicators:

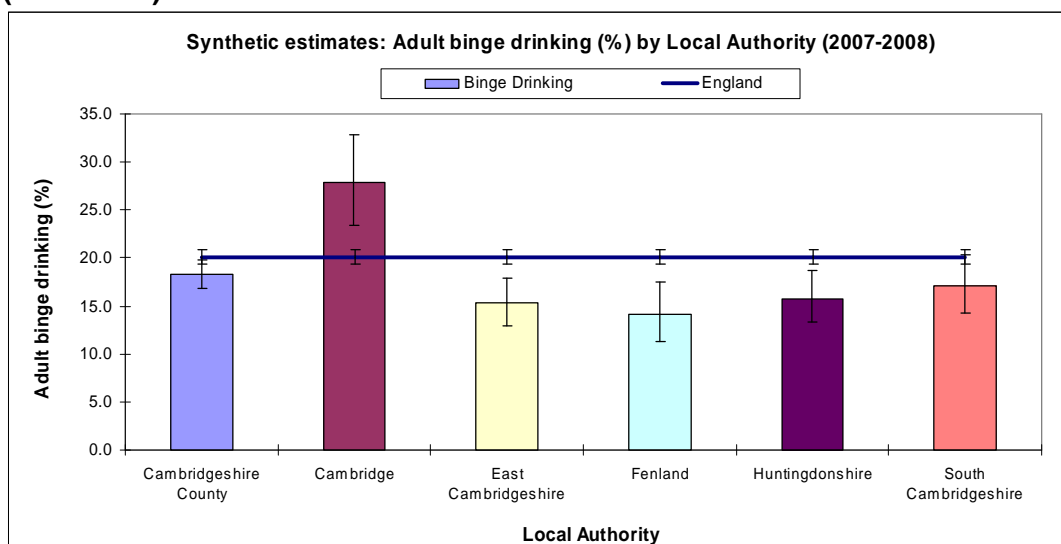
- Months of life lost – females.
- Alcohol-attributable mortality - both males and females.
- Hospital admissions for alcohol-related harm (NI39).

Binge Drinking (2007-2008)

- Binge drinking is defined separately for men and women in the Health Survey for England (HSE) which the synthetic estimates are based on. Men were defined as having indulged in binge drinking if they had consumed eight or more units of alcohol on the heaviest drinking day in the previous seven days; for women the cut-off was six or more units of alcohol.

- The prevalence of binge drinking in Cambridgeshire (18.3%) is similar to the national level (20.1%). It is estimated that nearly one in three people (27.9%) in Cambridge binge drink, which is significantly higher than in the county or in England. East Cambridgeshire (15.3%), Fenland (14.1%), Huntingdonshire (15.8%) and South Cambridgeshire (17.1%) are below the national level; except for South Cambridgeshire where the difference is significant.

Figure 34: Synthetic Estimates: Adult Binge Drinking (%) by Local Authority (2007-2008)



Source: Association of Public Health Observatories. © 2010

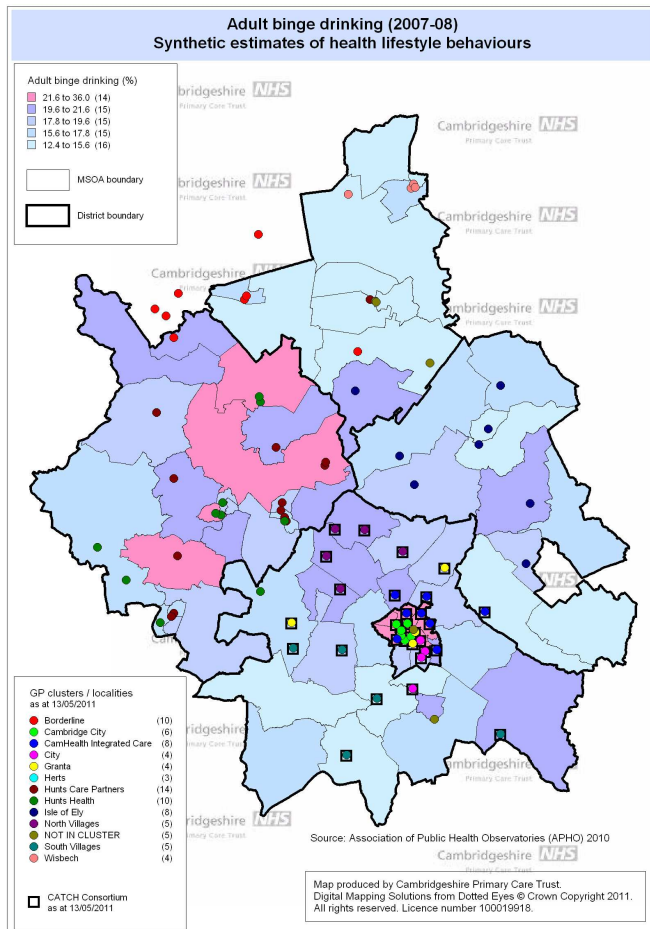
In the following MSOAs the estimated levels of binge drinking are higher than the national average, although the difference is not statistically significant (Table 73).

Table 73: Cambridgeshire MSOAs: Estimated Binge Drinking Levels Higher than the National Average (2006-2008)

MSOA Name	MSOA Description	Synthetic estimate: Binge drinking (%)	95% Confidence intervals	
			Lower level	Upper level
Cambridge 001	King's Hedges	22.0	12.2	36.7
Cambridge 010	Coleridge	23.8	13.3	39.3
Cambridge 003	East Chesterton	24.1	13.5	39.6
Cambridge 002	Arbury	24.7	13.8	40.6
Cambridge 006	Abbey	25.3	14.3	41.4
Cambridge 005	Castle	25.8	14.5	42.0
Cambridge 004	West Chesterton	27.2	15.4	44.0
Cambridge 007	Newnham	32.3	18.7	50.6
Cambridge 009	Romsey	34.0	19.8	52.6
Cambridge 008	Petersfield	36.0	21.1	55.0
East Cambridgeshire 006	Soham	21.4	11.8	36.0
Fenland 011	Chatteris	20.4	11.2	34.6
Huntingdonshire 001	Yaxley and Farcet	21.4	11.8	36.1
Huntingdonshire 006	Somersham, Upwood and The Raveleys	22.4	12.4	37.6
Huntingdonshire 012	Huntingdon West	23.1	12.8	38.3
Huntingdonshire 017	Buckden and the Offords	23.3	12.8	39.0
Huntingdonshire 003	Ramsey	23.8	13.1	39.6
South Cambridgeshire 015	Sawston	21.1	11.6	35.7
South Cambridgeshire 001	Willingham and Over	21.6	11.9	36.4

Source: Association of Public Health Observatories © 2010.

Map 10: Adult Binge Drinking, 2007-08



Hospital Admissions for Alcohol-related Harm (NI39)

- The former National Indicator NI39 provides a local measure of the rate of hospital admissions for alcohol-related harm for every 100,000 members of the population (standardised using the European age profile). They are derived from the Hospital Episode Statistics (HES) 2007/2008. NI39 data counts hospital admission episodes (not persons) attributable to alcohol.
- Alcohol indicators are either entirely related to alcohol (alcohol specific) or are influenced only in part by alcohol (alcohol attributable). In England, among younger age groups (<35 years) the majority of deaths occurred from the acute consequences of alcohol consumption, in particular self harm and road traffic accidents. Beyond the age of 35, the highest number of deaths occurred from chronic conditions partially attributable to alcohol consumption. In these age groups, alcoholic liver disease, cancer of the oesophagus and breast, and hypertensive disease were the most common cause of death attributable to alcohol.
- Acute admissions were mainly in the 16-24 category followed by 25-34 and chronic admissions increased in the older age groups.
- Absolute numbers of alcohol-related admissions increased steadily with age with the highest number occurring in those over 75 years old. This was because of the higher number of chronic conditions occurring in the elderly that are partly due to alcohol.

- There were relatively high numbers of acute admissions from people in their teens and early twenties in Cambridge City compared to the other districts. However, the age profile is different with relatively more young people living in the City compared to other districts. The only age category which appeared to be significantly higher than the England average was the acute admission rate of people in their early forties. There was a borderline difference for people in their late 30s in Cambridge City.
- The age specific acute admissions for Fenland showed that the highest rates of admissions were in the 30–34 year age group closely followed by the 35–44 year groups although none were significantly higher than the England average.
- The rate of NI39 admissions per 100,000 in England appears to be increasing steadily. Cambridge City had the highest rate of admissions per 100,000 of all the districts in Cambridgeshire in 2004/05 and the rate rose in the following year before the upward trajectory began levelling off in 2006/07. The gap between with the England rate now appears to be narrowing. Huntingdonshire started at a similar rate of admissions as England in 2004/05 but then followed a similar trajectory to Cambridge City. Rates are once again similar to the England average. In 2004/05, rates in Fenland were intermediate between Huntingdonshire and Cambridge City but unlike these districts the trajectory has continued increasing in line with the national trend.

5.7.3 Local Views

On 23 September 2010 the Safer and Stronger Communities Scrutiny Committee of Cambridgeshire County Council commissioned a Member Led Review on *Improving the Education and Training of Professionals to Help Alcohol Misusers*. The review group comprised Cllr Brooks-Gordon and Cllr Tierney who produced a report with 11 recommendations.

The full report can be found online at:

<http://www2.cambridgeshire.gov.uk/db/council2.nsf/af8076762df199c580256b14003ef043/555684707569b13e802578340052c1f6?OpenDocument>

Recommendation 1: The IBA training roll out is continued to ensure practitioners feel more confident addressing alcohol issues with clients.

Recommendation 2: There should be rigorous systematic and scientific evaluation of the IBA training.

Recommendation 3: Alcohol misuse training should be treated as a priority for Adult and Children’s Social Care.

Recommendation 4: Offer IBA training to people in the community as a qualification that can be used on cvs. People who gain the qualification can then spread the message within their own communities. It is suggested this is done as a pilot scheme, and this might be something other councils will look to as a future model.

Recommendation 5: Train volunteers to accompany alcohol misusers on journeys to detox clinics. This would be part of a “buddy” system.

Recommendation 6: It is recommended that a hard copy of alcohol services be provided to all practitioners so that services can be contacted immediately.

Recommendation 7: It is recommended that job shadowing opportunities are provided between Addaction and Social Care to increase understanding of each other’s roles.

Recommendation 8: Hinchingsbrooke Hospital to review its data sharing of A & E information with partner agencies.

Recommendation 9: Addaction to share more information with statutory professionals on clients’ progress where appropriate so that a risk assessment can be made (especially regarding children).

Recommendation 10: The co-chairs of this review strongly recommend that a separate member led review be taken into domestic violence in Cambridgeshire.

Recommendation 11: Coordination of training, following the departure of the Drug and Alcohol Action Team (DAAT) Alcohol Coordinator and DAAT's restructure, needs to be allocated as a role to an individual/individuals in the team.

Eight out of 11 recommendations were agreed by the County Council and an action plan was agreed for implementation of those recommendations. Recommendations 2, 4 and 9 were not accepted.

5.7.4 Evidence/Policy

Chief Medical Officer's Report

Consumption of alcohol causes a range of adverse impacts on health. In England the Chief Medical Officer has provided clear guidance on safe drinking limits and there is a wealth of evidence that shows that drinking more than the recommended safe limits (21 units per week for males and 14 units per week for females) is harmful. Effects of alcohol on health include:¹⁴²

- Above safe limits there is an increased risk of heart disease and stroke (small amounts may be protective).
- Any quantity gives an increased risk of cancers (liver, bowel, throat, mouth, larynx, breast and oesophagus). Risk increases with dose.
- Liver disease (eg cirrhosis) and the associated complications (oesophageal varices, GI bleed).
- Osteoporosis – leading to increased risk of fracture, especially hip, wrist and vertebrae.
- Reduced fertility.
- Increased risk of accidental and/or violent injury. Alcohol is a significant factor in approximately 25% of Accident and Emergency (A & E) attendances.
- Increased risk of miscarriage, stillbirth, premature birth and fetal alcohol syndrome.
- Impact on mental health and wellbeing, including that of family members – especially children.

The CMO estimates that the cost to the NHS from alcohol-related causes is £2.7 billion per year.

The Alcohol Ready Reckoner¹⁴³

This calculates the costs of implementing four High Impact Changes together with the benefits in terms of admissions avoided and subsequent cost savings. These High Impact Interventions are:

- Alcohol Specialist Nurses in A & E departments and acute hospital clinics working with non-dependent drinkers.
- Alcohol Health Workers in acute hospitals working with dependent drinkers.

¹⁴² CMO Annual Report 2008

¹⁴³ <http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/Datatools/?parent=5113&child=5109>

- Increasing the proportion of dependent drinkers treated with motivational or social network therapy.
- Screening and brief interventions in general practice.

NICE Guidance

There are three pieces of NICE guidance addressing alcohol-related problems:

- Alcohol-use disorders: preventing the development of hazardous and harmful drinking. [NICE public health guidance 24 \(2010\)](#) - public health guidance on the price, advertising and availability of alcohol, how best to detect alcohol misuse in and outside primary care, and brief interventions to manage it in these settings.
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. (see www.nice.org.uk/guidance/CG115/Guidance) - clinical guideline offers evidence-based advice on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10–17 years.
- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications. [NICE clinical guideline 100 \(2010\)](#) - clinical guideline covering acute unplanned alcohol withdrawal including delirium tremens, alcohol-related liver damage, alcohol-related pancreatitis and management of Wernicke's encephalopathy.

What is this Telling us?

5.7.5 What are the Key Inequalities?

- While Cambridgeshire has similar or better alcohol-related indicators compared to the England average, Cambridge City and Fenland are areas of inequality.
- Areas of concern for Cambridge City are alcohol-related crime, binge drinking and alcohol-related admissions. In Fenland, alcohol-related admissions and road traffic accidents are concerns.

5.8 Drug Misuse

What do we Know?

5.8.1 Introduction

- A drug is a chemical substance that acts on the brain and nervous system, changing a person's mood, emotion or state of consciousness. Drug misuse is when a person regularly takes one or more drugs to change their mood, emotion or state of consciousness. Their affect on health is well documented and recent studies have emphasised the diversity of effects and the impact of new drugs.¹⁴⁴
- Drugs are often classified by the effect they have. Stimulants, such as cocaine, make people feel full of energy. Depressants (or sedatives), such as heroin, make people feel relaxed. Hallucinogens, such as LSD, make people see, feel or hear things that are not real.
- One of the biggest risks of drug misuse is drug addiction. There are two main types of drug addition:-

¹⁴⁴ A Summary of the Health Harms of Drugs. Centre for Public Health, Faculty of Health and Applied Social Science, Liverpool John Moore's University for Department of Health and National treatment Agency for Substance Misuse.

- Physical addiction, when there are withdrawal symptoms, such as nausea, vomiting or cramping, if the supply is suddenly withdrawn.
- Psychological addiction, when there is a psychological compulsion or need to regularly use a drug. If a drug is withdrawn, there are no physical symptoms but there may be psychological symptoms, such as depression, anxiety and irritability.
- As well as the danger of addiction, drug misuse has serious health risks and is associated with a wide range of conditions and complications, both physical and psychological. For example, cocaine can cause heart failure and heroin can cause respiratory failure (loss of normal lung function), both of which can be fatal. In England and Wales, the number of deaths related to drug poisoning was 2,098 for males in 2009, an increase of 1% compared with 2008, and the highest number since 2001. The number of female deaths fell to 780 in 2009, a decrease of 9% compared with 2008. There has been no discernable trend in female drug-related deaths over the last 17 years.
- Drug use is linked with risks such as accidents while someone is intoxicated, overdose, or infection from sharing injecting equipment. If a person uses a needle to inject drugs, they have a high risk of catching a serious blood-borne infection, such as HIV or Hepatitis C.
- The Department of Health estimates that, in England, 90% of all cases of Hepatitis C and 6% of all HIV cases are caused by injecting drugs.
- Regular drug use is linked with social problems and can lead to criminal behaviour to pay for the drug habit.

5.8.2 Figures and Trends

- *The Drugs and Alcohol Action Team (DAAT) Needs Assessment 2010*¹⁴⁵ estimated that the number of Class A drug users in Cambridgeshire last year was 17,000, based on the British Crime 2009/10 estimates. That means in every 1,000 16-64 year old Cambridgeshire population, 44 people are Class A drug users.
- It is estimated that there are about 2,195 opiate and/or crack cocaine users (OCC) in Cambridgeshire, according to the Glasgow estimate for 2009/10. This makes a ratio of five OCCs per 1,000 16-64 general population.
- The bullseye data for opiate and/or crack cocaine users tells us that a quarter of the OCCs were not known to the treatment system. However, local treatment data suggested that more than 40% of the OCCs in Cambridgeshire were not in treatment.
- Nearly three quarters of clients were male and more than 90% were White British.
- Three quarters of clients were aged from 25 years to 44 years. However, data suggested that there has been a 5% increase in individuals in treatment aged 45 years and over.
- In terms of drug use, 77% (935) of clients presenting to treatment services in 2009/10 reported heroin as their primary drug issue. A further analysis shows that there has been a sharp increase among individuals arriving in treatment reporting cannabis use (+28% since 2008/09). This is particularly noticeable in the 18-24 age group with a 40% increase. This age group is also showing a 5% decrease in opiate and crack use. This mirrors national statistics. Overall, a slight (1%) reduction in clients presenting with Class A drugs has been noted.

¹⁴⁵ Data used for this JSNA is extracted from the DAAT Adult Needs Assessment 2011. For the full report, please visit the DAAT website at www.cambsdaat.org

- Criminal justice clients: probation data during 2009/10 showed that 384 of their clients indicated that drug use was linked to their offending. Of this cohort, 78 offenders reported daily cannabis use, 55 heroin use and 14 crack/cocaine use.
- In 2009/10, 30% of clients starting a new treatment journey reported that they were currently injecting. A further 25% had previously injected. This shows an increase in current injectors of 10% since last year.
- 51% of the interventions offered to clients last year were specialist prescribing. Residential rehabilitation and detox were only accounted for 0.6% of all modalities.
- For some years, a true picture of Hepatitis B and C treatment was unclear due to reporting issues. Whilst a continued problem is encouraging clients to take up the offer of treatment 2009/10 saw a significant progress in this area (32% accepted Hepatitis B treatment and 41% accepted and had a Hepatitis C test in 2009/10 compared with 13% and 26% in 2008/09).

5.8.3 Vulnerable Groups

- Criminal justice clients: Probation data during 2009/10 showed that of 384 of their clients indicated that drug use was linked to their offending. Of this cohort, 78 offenders reported daily cannabis use, 55 heroin use and 14 crack/cocaine use.
- For clients accessing rehabilitation, 100% of them were white British. For detox placements, all clients were white British except one was white other. This suggests that white British clients were over represented in Tier 4 treatment.
- In 2009/10, 397 clients engaged with the Cambridge Drug Intervention Programme (CDIP). Of these, 102 (26%) had a Drug Rehabilitation Requirement (DRR) order. It is noted that there are still issues with data discrepancy between Drug Intervention Programme (DIP) internal database and National Drug Treatment Monitoring System (NDTMS) data, which made it difficult for performance management. Breakdown of referrals to DIP from prisons shows that 72% of referrals were made from Peterborough prison. There have been no referrals from Whitemoor and only two referrals from Littlehey, which are two local HMPs. Drug Intervention Programmes (DIP) aim to get adult drug-misusing offenders who use specified Class A drugs (heroin and cocaine/crack cocaine) out of crime and into treatment. Many of the offenders who benefit from the DIP intervention are among the hardest-to reach and most problematic substance users, and are offenders who have not previously engaged with treatment in any meaningful way.

5.8.4 Local Views

A number of surveys have been undertaken by the DAAT to gather the evidence for its annual needs assessment. Below are summaries of two surveys conducted by the DAAT and one by the regional analyst team (MUSE).

DAAT Service User Survey

The DAAT carried out a service user consultation in November 2010 as part of the Needs Assessment process. The purpose of this survey is to examine the current delivery of treatment services from experience of service users. 217 current/ex-service users around the county were involved in the consultation process.

- Of all people with drug/alcohol problems, a third has never been or is no longer involved. The reasons for leaving were: the treatment service did not work, went to prison or orders finished, stopped using or moved out of the area.

- Overall the survey suggested that one third of the drug/alcohol misusing population does not currently access the treatment system with a high number of respondents admitting that they did not want to ask for help or were sceptical about the treatment.
- In general, people were happy with the needle exchange system.
- Of the 195 people who answered the question about accommodation, 90 (46%) stated that they were not happy with their current accommodation arrangements.
- Suggestions for service improvement included more service users/ex-service users involvement with services, more accommodation support, motivation for abstinence based outcomes, service need to be more approachable for young people, quicker prescription process.
- 91 out of 217 (42%) of people said they would like the chance to get their opinion about drug services heard more often and 68 provided their contact details as they were interested in being part of a service user group.

DAAT Professional Survey

The DAAT Professional consultation was open for one month from 23 November to 23 December 2010. The purpose of the consultation was to gather views from professionals working with substance misusers on the provision of adult drug treatment services in Cambridgeshire.

- In general, professionals who have experience working with substance misuse treatment services recognised the strength of the partnerships working to deliver a holistic approach to treatment, staff dedication and professionalism. The current referral pathway is working well, alongside the needle exchange service, therapeutics interventions, outreach work and after care.
- Respondents raised concerns was about lack of community support on reintegration for clients post treatment as well as the need to improve family and carer involvement.
- A suggestion for improvement was for an abstinence-based treatment system with intensive support and dedicated facility. This would provide joined drug and alcohol treatment for clients with both addictions, as well as residential detoxification, rehabilitation, training opportunity, employment and accommodation for service users and longer service contracts and more funding to enable long term investment from businesses.

MUSE Worker Survey

In the summer of 2010, the Monitoring Unit for Substances in the East (MUSE) carried out two surveys for service users and substance misuse workers in the East of England. The following are some key findings of the report:

- Housing support to ensure drug clients have stable accommodation both whilst in treatment and upon completing treatment is needed to help reduce unsuccessful completions and minimise the chance of relapse.
- Treatments under resourced include alcohol treatment, both as alcohol within poly-drug use and alcohol alone, stimulants (amphetamines, steroids, legal highs) and crack/cocaine treatment and abstinence based treatment (abstinence was stated as the goal for over half of clients in treatment).
- A lack of residential rehabilitation services that could help clients complete their treatment journey drug free.
- Transitions from a young person to an adult service can create barriers and anxieties which might impede a client's treatment journey. Raising the transition age, a gradual

handover and/or adopting a transition service would help to maintain the client's treatment journey.

- Abstinence was the goal for over half of clients in drug treatment. However there is a need for more abstinence-based services to meet this demand. Investment in the provision of residential rehabilitation services is also required to help clients end their treatment journey drug-free.

5.8.5 Evidence/Policy

- The prevention of drug misuse aims to change the personal, social or environmental factors in order to contribute to delaying or avoiding the onset of drug use and its progression to harmful or problematic misuse. This includes programmes, projects or initiatives that aim to make drug misuse less likely and help to promote health, healthy lifestyles and wellbeing among a certain group of people or the whole population in general.
- Because of the diverse nature and severity of problems that arise from substance use, prevention activity takes many forms, from brief interpersonal contact to broad national policies. It is recognised that prevention is challenging and, once established, substance abuse is persistent. It requires wide ranging approaches:
 - Information-based
 - Psychosocial
 - Environmental Focused
 - Alternative
 - School Management
 - Family-based
 - Community Norms
- In 2006, Hansen W et al¹⁴⁶ conducted an analysis of prevention programs listed on the American Registry of Effective Programs and Practices as of 2003. The analyses suggested there were seven distinguishable approaches that have been used in substance abuse prevention programs. These include:
 - changing access within the environment
 - promoting the development of personal and social skills
 - promoting positive affiliation
 - addressing social influences
 - providing social support and helping participants develop goals and alternatives
 - developing positive schools
 - enhancing motivation to avoid substance use.
- There is substantial research that emphasises the importance of early intervention and the need to focus upon young people. Gottfredson et al (2003)¹⁴⁷ for example carried out a study that highlighted the importance and effectiveness of school-based programmes.

¹⁴⁶ Hansen W, Dusenbury L, Bishop D and Derzon J (2006), Substance abuse prevention program content: systematizing the classification of what programs target for change, *Health Education Research*, Vol.22 no.3 2007, Pages 351–360, Advance Access publication 8 September 2006

¹⁴⁷ Gottfredson D, Wilson, D (2003) Characteristics of Effective School-based Substance Abuse Prevention, *Prevention Science*, Vol. 4, No. 1. March 2003

What are we doing in Cambridgeshire - Local Examples of Good Practice?

- The Cambridgeshire Drug and Alcohol Action Team (DAAT) which sits within Cambridgeshire County Council is responsible for commissioning a range of treatment services. Its agencies provide prevention work, such as training, advice and information and harm reduction. Consequently the DAAT is only able to provide very limited prevention data although its agencies do provide prevention work.
- Treatment services are an essential part of preventing further drug misuse. The DAAT and NHS Cambridgeshire commissions the following services, specialist drug treatment services for adults (18 and over), drug and alcohol treatment services for young people (under 18) and the adult alcohol treatment service. Addaction is commissioned by the DAAT to deliver adult drug treatment service in Cambridgeshire. Addaction offers a full range of services to those affected by their own or someone else's drug use including advice, information and support. Open access services are also available which include Needle Exchange, overdose prevention and other harm reduction advice and support. Additional services include dedicated outreach team, satellite surgeries and counselling sessions.

Case Study

- **Training, Information and Advice** - the DAAT provides drug and alcohol awareness training for professionals working with substance misusers, simple Information and Brief Advice (IBA) training. Addaction has provided drugs awareness training to partner agencies in order to promote harm reduction messages as well as the wider service. Service User involvement work involves training service users in overdose awareness and other harm reduction areas. Peer groups also support this activity across the county.
- **Harm Reduction Service** - harm reduction combines work aimed directly at reducing drug-related harm with wider goals of preventing drug misuse and of encouraging stabilisation in treatment and support for abstinence. In Cambridgeshire, harm reduction work includes the promotion of safer injection for drug users by providing a good needle exchange and disposal service, offer advice and support for the reduction of drug-related harm including drug-related death and overdose prevention to service users, carers and other professionals via key workers.

What is this Telling us?

5.8.6 What are the Key Inequalities?

Many of the inequalities are related to inequities of service provision but also there are groups that are particularly susceptible to drug misuse. These are:

- Victims of domestic violence: research suggested that women experiencing domestic violence are up to 15 times more likely to misuse alcohol and nine times more likely to misuse other drugs than women generally.
- Dual diagnosis clients: the term 'dual diagnosis' refers to people diagnosed with mental health problems, who also use alcohol or street drugs (illegally produced drugs or illegally obtained prescription medicines). It may, for instance, include someone diagnosed with a psychotic illness who uses cannabis; or someone who is depressed and drinking heavily or using stimulant drugs (such as amphetamine or cocaine) in order to feel more socially confident.

- In the UK it is estimated that a third of patients in mental health services have a substance misuse problem. At the same time, around half of patients in drug and alcohol services have a mental health problem (most commonly depression or personality disorder).¹⁴⁸ In a major study¹⁴⁹ of people involved in substance misuse treatment, one in five people reported recent psychiatric treatment. Prevalence amongst the prison population is high. A study¹⁵⁰ by the Office of National Statistics indicated that:
 - 10% of male remand prisoners had moderate dependency, 40% had severe dependency, 79% of male remand prisoners who were drug dependent had two additional mental disorders.
 - Locally, more than 4,200 people were registered with mental health disease at local Cambridgeshire GPs in 2008/09. The performance data submitted to the National Drug Treatment Monitoring System (NDTMS) in 2009/10 reported that in 6% (35 clients) of new treatment journeys dual diagnosis was recorded. This figure suggested that the mental health clients were under represented in the treatment system.
- Migrant Workers: the number of 'Other White' clients in treatment has been increased significantly in 2009/10 whilst the numbers of 'Others Ethnicity' have reduced. In Wisbech, 11% of those in treatment reported themselves as 'Other White', reflecting the migrant population in that area. This suggests that whilst access to treatment for migrant population is improving, work is needed to attract more minority ethnicities in the system.
- Overall, a local service user survey suggested that one third of the substance misusing population is not accessing treatment.

5.8.7 What are the Gaps in Knowledge/Services/Areas for Further Development?

- The most recent DAAT Treatment Service Plan identified the following areas where further work is required to secure improved outcomes.
 - More evidence based interventions to improve drug treatment and reduce length of treatment times.
 - Access to housing.
 - Family based approaches that involve parents – this would be both prevention and treatment.
 - Continue to develop processes and pathways for accelerating referrals management and treatment. Further exploration as to the level of joint working between substance misuse services and employment, training and further education services should take place. This should result in clear pathways being developed for drug and alcohol users to access the range of services available. This would include treatment services that are more community based with greater use of general practices, pharmacies, community centres, children's centres and home visiting – using discretion and outreach to hostels. This includes a greater focus on recovery. Active promotion and support of local, mutual, aid networks would be essential in order to achieve this aim.

¹⁴⁸ Dual Diagnosis Information Manual - Co-existing problems of Mental Disorder and Substance Misuse, The Royal College of Psychiatrists (2002)

¹⁴⁹ J. Marsden et al. *Psychiatric symptoms among clients seeking treatment for drug dependence*. Intake from the National Treatment Outcome Research Study, 176 Br, J. Psychiatry 285-289 (2000)

¹⁵⁰ Office of National Statistics (1999), Survey of psychiatric morbidity among prisoners in England and Wales in 1997.

- Further work is needed to establish the substance misuse treatment needs of all the vulnerable groups as mentioned earlier, particularly the gypsy and the travellers population and mental health population. Recent treatment data indicated that numbers currently accessing services are small but on the increase. The most significant barriers to accessing services for these groups were identified as language and lack of knowledge about what help is available.
- With 70% of individuals in treatment being male, there continues to be concern that women are not accessing services. Access to women only services or access to childcare could assist this situation.
- It has been identified that there are particular groups that are not accessing treatment, namely cannabis, crack cocaine, stimulant and alcohol users. The service users survey revealed that there is a perception that cannabis use is not treated as seriously as other substances and therefore young adults were reluctant to engage with the adult treatment system. Better promotion of the service would hopefully attract more clients, particular young adults with cannabis addiction.
- There is a need to improve services and support for dual diagnosis clients. The referral pathway between substance misuse service and mental health service need to be clear and effective.
- Exploration of the primary prevention needs of illegal drug misuse amongst the working age population.

5.9 Mental Health

5.9.1 Introduction

A JSNA for mental health of adults was prepared in 2010 as part of phase 4. For full details go to: <http://www.cambridgeshirejsna.org.uk/mental-health-adults-working-age>. The headlines are found below:

- Mental health is fundamental to good health, wellbeing and quality of life. It impacts on how we think, feel, communicate and understand. It enables us to manage our lives successfully and live to our full potential. We all have mental health needs irrespective of any diagnosis associated with mental health.
Wellbeing has been defined¹⁵¹ as "...a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community".
- It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Many of the risk factors for mental health and illness are linked to deprivation.
- Crime, particularly violent crime, is linked to mental health. They may have similar determinants such as drugs, alcohol and deprivation and victims of crime are more likely to suffer mental health problems such as depression. Those who suffer from mental illness are more likely to be victims of crime than commit crime, although violent crimes committed by people with mental illnesses are more frequently reported.

¹⁵¹ Foresight Review on Mental Capital and Wellbeing, Government Office for Science 2008, p10

- Smoking exacerbates stress, anxiety and sleep disorders; all of which will be detrimental to most mental health conditions. Smoking rates are much higher among people with mental health problems than among the general population, in some cases twice that of the general population. The smoking rates are higher in people with phobias and depressive illnesses, and relatively lower in neurotic illnesses. Over 70% of mental health inpatients with psychotic illness smoke.
- People with mental health problems are up to twice as likely to report experiencing a long-term illness or disability; over two thirds of people with a persistent mental health problem also have a long-term physical complaint.

5.9.2 Figures and Trends

- In 2004-06, 13% of the England population had a possible psychiatric disorder. The percentage was higher in Cambridgeshire (15%) but not significantly so.
- The prevalence of depression is significantly higher in the most deprived area of the PCT compared with the remaining less deprived area.

Table 74: Quality Outcomes Framework (QOF) 2008/09: Recorded Prevalence of Depression in Cambridgeshire for the Most and Least Deprived Areas Based on MSOA Level Proxy IMD 2007 Scores for General Practices

Area	Prevalence of depression		
	Prevalence %	Lower 95% CI %	Upper 95% CI %
Most deprived 20%	11.1%	11.0%	11.3%
Least deprived 80%	8.6%	8.5%	8.7%

Source: QOF 2008/09, Health and Social Care Information Centre. Cambridge Access Surgery is excluded from this analysis. MSOA – middle-layer super output area. IMD – Index of Multiple Deprivation.

- If Cambridgeshire residents experienced roughly the national average rate of mental health problems, there would be an estimated 41,000 people in Cambridgeshire that have mixed anxiety and depressive disorders, 15,000 people with generalised anxiety disorder and 11,500 with depressive disorders. Estimates for people with schizophrenia range from 580 to 2,890 and for people with affective psychosis from 1,160 to 2,890.
- The estimate for the number of people with early onset dementia (aged 30-64 years) in Cambridgeshire is 205 based on research done in 2003 by the Early-Onset Dementia Development Group.
- From 2006-2008, figures for mortality from suicide and injury undetermined indicate that the Cambridge City and Fenland rates are statistically significantly higher than the rate for England. The rates for Huntingdonshire and South Cambridgeshire are statistically significantly lower than the national rate.
- The Cambridge Access Surgery serves homeless people. According to QOF data for 2008/09, the recorded prevalence of mental illness at the surgery was 13.7% compared to the NHS Cambridgeshire average of 0.7%. The ratio of reported prevalence of depression to expected prevalence of depression in those aged 18 years and over was 3.24% for the Cambridge Access Surgery compared to a ratio of 1.38% for NHS Cambridgeshire.

5.9.3 Local Views

A range of local views from service users and providers were used to inform the JSNA Mental Health 2010. Local views were solicited from service users, gateway workers and from third sector providers including throughout the summer 2010, Service User Event, Lifecraft, Hunts MIND, Rethink, Richmond Fellowship, Making Space and Arts on Prescription.

5.9.4 Evidence/Policy

A summary of the evidence base is set out in the *Mental Health JSNA 2010*. A key reference for the findings was New Horizon's *Confident Communities 2010*¹⁵². Since that time, a more recent mental health outcomes strategy - *No Health without Mental Health*¹⁵³ and supporting document¹⁵⁴ have been published. (A series of more detailed public mental health evidence reviews and delivery document are awaited). 'No Health Without Mental Health' describes six shared objectives:

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

The rationale for a new outcomes strategy has been summarised:

- To build a healthier, more productive and fairer society in which difference is recognised there is a need to build resilience, promote mental health and wellbeing, and challenge health inequalities. To prevent mental ill health, early intervention and improvement in the quality of life of people with mental health problems and their families is needed.
- Improved mental health and wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include improved physical health and life expectancy, better educational achievement, increased skills, reduced health risk behaviours such as smoking and alcohol misuse, reduced risk of mental health problems and suicide, improved employment rates and productivity, reduced anti-social behaviour and criminality, and higher levels of social interaction and participation. (These issues will be further explored in a suite of public mental health evidence reviews to be published shortly by the Department of Health).
- The stigma attached to mental ill health and the social barriers that surround it amplify its direct effects and damage the life chances of people with mental health problems.
- There are indications that some problems are becoming more prevalent: for example, more young people have behavioural and emotional problems. The incidence of mental health problems – including in young people – can increase in times of economic and employment uncertainty, as can the rate of suicide. The number of older people in our population is growing, with a corresponding increase in the number of those at risk of dementia and depression.

¹⁵² New Horizons: *Confident Communities, Brighter Futures – A framework for developing wellbeing* Summary March 2010

¹⁵³ *No Health without Mental Health: a cross government mental health outcomes strategy for people of all ages*. HM Government February 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

¹⁵⁴ *No Health without Mental Health: Delivering better mental health outcomes for people of all ages*. HM Government February 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124057.pdf

Although this current JSNA focuses on prevention in adults of working age, it is clear that childhood and early adulthood are key periods in the development of personal resilience and educational and social skills that will provide the foundations for good mental health across the whole life course. *The Mental Health JSNA 2010* sets out a range of interventions that are known to be effective and many include childhood and family settings.

A specific section in this report covers evidence and cost-effectiveness of interventions in the workplace (see Workplace Health).

What is this Telling us?

The following is from the *Mental Health JSNA 2010*:

5.9.5 What are the Key Inequalities?

- The prevalence of mental ill health among the working age population is high in Cambridge City because of the demography, new growth, higher levels of crime, alcohol-related harm and suicide.
- Fenland also has a high prevalence of mental ill health due to the association between mental ill health and its determinants with deprivation. Suicide rates are high in Fenland.
- Travellers, homeless people, migrant workers, prisoners, people with substance misuse problems, people with learning disabilities and residents in new communities are at increased risk of mental ill health and may have difficulty accessing services and health promotion.

5.9.6 The Key Gaps in Knowledge/Services/Areas for Development

- There is a perceived need for more counselling services especially for those whose needs fell between the criteria for IAPT and secondary care.
- People making the transition into or out of adult mental health services need to be catered for. Young adults (17-22 years old) may find current local service models unattractive and people with young onset dementia often have very different needs to older people with dementia.
- NHS organisations and the Local Authority should take a lead role and work in partnership to promote a healthy workplace for their own and partner organisations.
- Review the availability of counselling services for groups where evidence shows greatest benefit.
- There is robust evidence for interventions that have the largest impact on improving mental health and wellbeing for the general population. Current service provision is more focused on mental illness and further opportunities exist to invest in 'preventive' interventions in a range of settings eg workplace health and through different providers
- Ensure equitable access to services and mental health promotion for vulnerable groups by:
 - Reviewing and implementing where appropriate the recommendations of the Bradley Report¹⁵⁵ to reduce inequalities experienced by prisoners.
 - Evaluating the effectiveness of alcohol pilots within A & E, homeless shelters and police stations in improving equitable access for vulnerable groups.
 - Explore best methods to engage with the travelling communities.

¹⁵⁵ Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

- In light of more recent organisational and policy changes at both local and national level and taking account of the life course implications and cross cutting nature of promoting mental health and wellbeing, an area for development is to ensure there is a mechanism in place such as the Health and Wellbeing Board to take a lead role in ensuring that the 'preventive' aspects of the mental health and wellbeing agenda are taken forward in an integrated way.

5.9.7 Recommendations from the Mental Health JSNA 2010

The following recommendations were made in the *Mental Health JSNA 2010*:

- The comprehensive evidence base¹⁵⁶ of what works to promote mental health and wellbeing in communities should be used by the range of partnerships that operate within the Local Strategic Partnerships and Cambridgeshire Together structures when developing and commissioning strategies and plans. Effective interventions for promoting mental health apply throughout the life-course and can be most effective in childhood because of the impact on a range of outcomes throughout life. The Mental Wellbeing Impact Assessment Tool¹⁵⁷ can be used to ensure that a programme maximises its positive impact.
- Strengthen and extend partnership working to promote mental health and wellbeing, and provide responsive services by:
 - Obtaining views of local stakeholders on all changes to mental health services to ensure they are patient-centred and socially inclusive.
 - Working with local GP commissioning groups to ensure equitable provision and targeting of mental health services based on needs assessments that identify the areas and populations at greatest need.

5.10 Dental and Oral Health

What do we Know?

5.10.1 Introduction

This section describes the dental and wider oral health needs of the population.

- The results of the most recent *Adult Dental Health Survey 2009 (ADHS)*,¹⁵⁸ published in March 2011 indicates that oral health is improving in adults of working age particularly among the younger age group up to 45 years. However for those who do have decay or gum problems, disease can be very extensive and for many people in older middle age, often called the heavy metal generation, because of their high number of fillings, dental needs can be very complex.
- Good health behaviours, such as regular brushing, are shown to be associated with better health and a greater proportion of dentate adults (have one or more natural teeth), than ever before, are engaging in these behaviours.
- Regular attendance at a dentist is also a key prevention action. The large majority of adults are also indicating that they are attending the dentist at least every two years, the maximum recommended interval.

¹⁵⁶ HM Government Confident Communities, Brighter Futures March 2010

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114774

¹⁵⁷ National Mental Health Development Unit, Improving Mental Wellbeing through Impact Assessment Sept 2009

<http://www.nmhd.org.uk/news/new-edition-of-the-mental-wellbeing-impact-assessment-toolkit/>

¹⁵⁸ Adult Dental Health Survey 2009, The Information Centre (2011)

5.10.2 Figures and Trends

Dental Decay

- Dental decay is one of the most common chronic diseases. It occurs when tooth tissue is demineralised by the acids formed by dental plaque in response to dietary sugars.

Gum (Periodontal) Disease

- Gum or periodontal disease is caused by inflammation of the gums and bone that support and anchor teeth. When severe, the bony support for teeth is extensively compromised causing otherwise healthy teeth to be lost.
- There are a number of gum (or periodontal) diseases, however, the disease with a public health implication is chronic periodontitis. This can lead to a number of conditions including tooth loss.¹⁵⁹ Prevalence tends to increase with age.
- In the East of England 96% of adults are dentate, 64% have 27 or more natural teeth and 89% have 21 or more. This compares with England figures of 61 and 87% respectively. Of these 57% have more than 18 sound and untreated teeth compared with 53% for England. There are marked differences however between age groups below and above 45 years.
- 22% of adults in the East of England had active dental decay and of these 7% had one or more teeth that was unrestorable.
- 36% had good periodontal health compared with an England average of 17%. 20% had excellent oral health, again compared with an England average of 10%.
- 30% had occasional or fairly frequent dental pain in the last twelve months and 10% reported current dental pain.

Obesity and Oral Health

- The Health Survey for England indicates that 22.1% Cambridgeshire are obese.¹⁶⁰ These adults are more likely suffer from the common dental diseases and are more likely to experience difficulty in accessing dental services than their counterparts whose weight is within the normal range. (See Obesity section for prevalence details and interventions)

Alcohol and Oral Health

- The Health Survey for England indicates that 18.3% of adults in Cambridgeshire are binge drinkers.¹⁶⁰ These adults are more likely to suffer from worse oral health, have an increased risk of mouth cancer and are more likely to experience facial injury as a result of their drinking habits.
- Alcohol increases the risk of accidental and/or violent injury. It is a significant factor in approximately 25% of A & E attendances. (Chief Medical Officer's Annual Report 2008)

¹⁵⁹ Corbet E 'Public Health Aspects of Oral Diseases and Disorders – Periodontal Diseases In Pine C, Harris R. Community Oral Health 2nd edition. 2007 Surrey: Quintessence

¹⁶⁰ APHO and Department of Health. Cambridgeshire Health Profile 2007. Available at URL http://www.communityhealthprofiles.info/profiles/hp2007/lo_res/12-HP2007.pdf.

- However there is little data currently available in Cambridgeshire to link episodes of care provided by the maxillofacial units of acute hospitals or A & E Departments with the causes of facial injury. Data currently collected on Cambridgeshire residents records the procedure carried out in hospital only. These figures may include for example patients attending with dental abscesses.
- It is not clear if information on assaults is shared with other agencies such as the police or crime prevention units.

Table 75 shows attendances at A & E departments over the last three years for maxillofacial problems.

Table 75: A & E Attendances for Maxillofacial Problems 2008-2011

Category	Attendances			Cost at 1011 Tariff		
	2008/2009	2009/2010	2010/2011	2008/2009	2009/2010	2010/2011
High Cost	22	26	34	£2,574	£3,042	£3,978
Standard Cost	73	69	73	£6,351	£6,003	£6,351
Minor	251	247	249	£14,809	£14,573	£14,691
Grand Total	347	343	358	£23,734	£23,618	£25,020

Source: Hospital Contract Data 2008-2011.

Smoking and Oral Health

- Adults who smoke are more likely to suffer from periodontal disease and mouth cancer. (See Smoking Section for prevalence and interventions)

Mouth Cancer

- Oral cancer is a generic term that is used to describe all malignancies of the oral cavity, oropharynx and hypopharynx (such as squamous cell carcinoma of the lip and tongue).
- Alcohol and tobacco use are strong risk factors for oral cancer. In Cambridgeshire there has been a slight increase in reported cases between 1999 and 2008. In 2008 the incidence of lip and oral cancer was slightly higher than the England average at 6.3 and 6.09 per 100,000 population respectively

Figure 35: NHS Cambridgeshire Incidence of Lip and Oral Cancer Per 100,000 Population 1999-2008

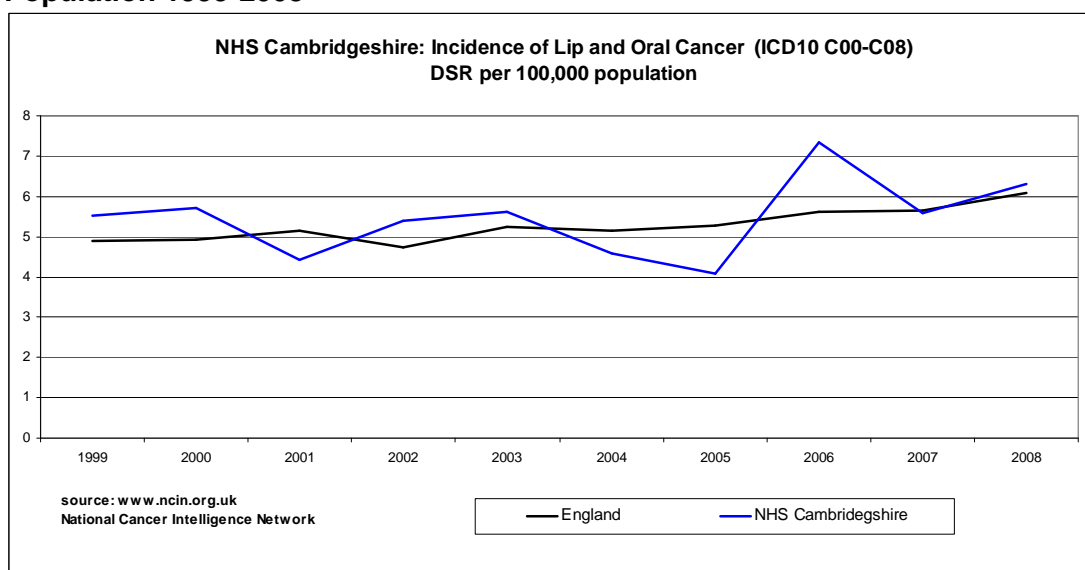


Table 76: NHS Cambridgeshire Incidence of Lip and Oral Cancer Per 100,000 1999-2008

Year	England	NHS Cambridgeshire
1999	4.9	5.52
2000	4.94	5.71
2001	5.16	4.43
2002	4.73	5.41
2003	5.23	5.61
2004	5.16	4.58
2005	5.27	4.09
2006	5.63	7.34
2007	5.65	5.59
2008	6.09	6.3

Source: National Cancer Intelligence Network.

Cardiovascular disease

- Poor oral hygiene is the major cause of periodontal disease, a chronic infection of the tissue surrounding the teeth. A recent study found that participants who brushed their teeth less often had a 70% increased risk of cardiovascular disease even when adjustments were made for age, sex, socio-economic group, smoking, visits to the dentists, BMI, family history of cardiovascular disease, hypertension and diagnosis of diabetes.¹⁶¹ These findings reflect earlier studies.

Health Behaviour and Prevention

- In the East of England¹⁵⁸ 98% of the adult population said they brushed their teeth one or more times a day. 78% used a fluoride toothpaste containing 1350-1500ppm. Nearly two-thirds reported that they also used other products such as mouthwashes, dental floss and electric toothbrushes and 82% reported that they had received advice on brushing. On clinical examination 42% had visible plaque on their teeth lower than an England average of 66%.
- 21% in the East of England reported smoking cigarettes compared with 22% for England and 9% in England said that they had received smoking cessation advice from their dentist at their last visit. Smoking was more common in adults up to the age of 54 and more common in those employed in routine and manual occupations.
- 55% of adults had a high sugar intake, ie they had cakes, biscuits, puddings or pastries, sweets or chocolate or fizzy drinks six or more times a week. This was slightly higher than the England average of 50% and was most marked in the 16-24 age group. There were no marked differences between social classes.
- In the East of England 62% reported that they attended the dentist regularly while 26% only attended when they had a problem; half said they visited a dentist every six months and 80% visited at least once every two years. 84% said they had good or very good general health and 70% said they had good or very good dental health. Reported dental attendance also appears to have an association with how often people brush their teeth and those who attended regularly appeared to brush more frequently
- When asked about the dental visit 14% were anxious or very anxious the day before the appointment and 30% were anxious or very anxious if a tooth was to be drilled.

¹⁶¹ De Oliveira C and Watt R (2010) *Toothbrushing, inflammation and risk of cardiovascular disease*. Results from Scottish Health Survey BMJ (compact) [0959-535X] vol:340 pg:c2451

- In England¹⁵⁸ at the last course of treatment 50% of adults reported having their teeth scaled and polished, 47% received advice on looking after their teeth, 9% received smoking advice and 1% had fluoride varnish applied.

5.10.3 Evidence/Policy

Common Oral Diseases and Their Causes

- For sustainable improvements in oral health and reductions in oral health inequalities in adults of working age, it is important to tackle the underlying causes of oral diseases. It is recognised that oral health is determined by a wide range of factors, from individual lifestyle choices (eg amount of sugar in diet), to national policy (eg smoke-free environments) A successful public health approach must focus on these wider determinants, as focusing on behaviour or lifestyle change has been shown to have a limited long-term effect.¹⁶²
- The provision of high quality dental services is one aspect but not all of the public health action needed to reduce oral health inequalities and improve oral health.

Dental Decay (Caries)

- A wealth of evidence has consistently shown that sugars are the most important factor in caries development.¹⁶³ The annual consumption of free sugars has increased since the 1970s.¹⁶⁴

Oral Cancer

- Almost all oral cancers are thought to be preventable. An estimated 80% are caused by tobacco (smoking or chewing), alcohol or a combination of the two. An estimated 10–15% of oral cancers may be caused by unhealthy diets.¹⁶⁵ (see relevant sections)
- Human papilloma virus (HPV) has been linked to mouth cancer through sexual transmission.¹⁶⁶ (See Sexual Health Section for interventions)
- Mouth cancers only account for about 1% of all new UK cancers per year but the incidence is rising and now accounts for approximately 800 deaths each year. Survival rates increase dramatically if the disease is diagnosed in the early stages

Common Risk Factors

- The most effective and efficient method of promoting oral health in adults of working age is to integrate oral health promotion with generic health promotion. The Common Risk Factor Approach emphasises the need to tackle the common risk factors and conditions that are shared by common chronic non-communicable diseases.¹⁶⁷ See Figure 36.

¹⁶² WHO (2003) *Diet, nutrition and the prevention of dental diseases* Public Health Nutrition:7 (1A) 201-226

¹⁶³ Moynihan P.J. *The role of diet and nutrition in the etiology and prevention of oral diseases*. Bulletin of the World Health Organization 2005; 83:694-699 Available at URL

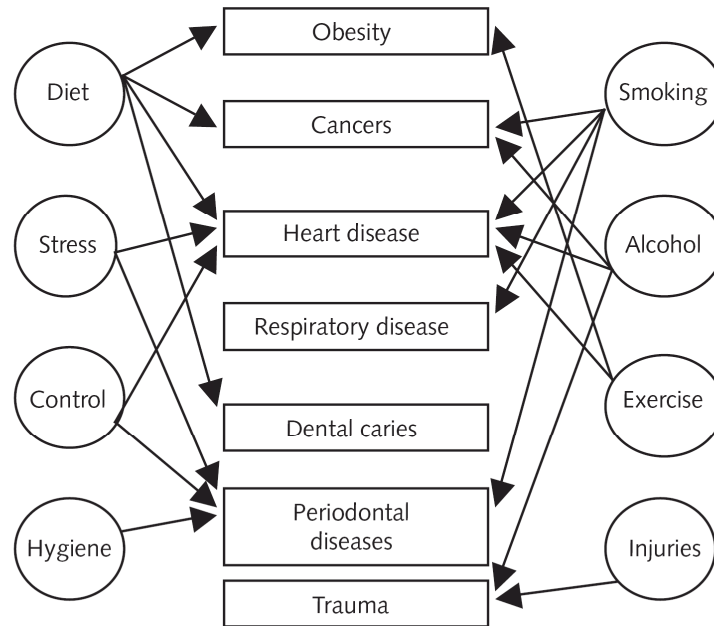
¹⁶⁴ Office of Public Management. 2005 *A futures study of dental decay in five and fifteen year olds in England*. Available at URL <http://www.opm.co.uk>

¹⁶⁵ Nuttall N et al. *A guide to the UK Adult Dental Health Survey 1998*. London: British Dental Association; 2001.

¹⁶⁶ Scully C. *Oral squamous cell carcinoma: from an hypothesis about a virus, to concern about possibly sexual transmission*. Oral Oncol. 2002 Apr;38(3); 227-34

¹⁶⁷ Watt RG. *Public Health Reviews. Strategies and approaches in oral disease prevention and health promotion*. Bull World Health Organ website 2005; 83(9):711-718. Available at URL www.who.int/bulletin/volumes/83/9/711.pdf.

Figure 36: The Common Risk Factor Approach



Source: Sheiham and Watt, 2000 in Department of Health Choosing Better Oral Health. An Oral Health Plan for England. 2005 Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123251

- These common risk factors include tobacco use, poor diet, stress, high alcohol consumption, poor hygiene, injuries and a sedentary lifestyle. Targeting these risk factors at a population level would simultaneously reduce the incidence of obesity, health disease, stroke, cancers, diabetes and mental illness, in addition to oral diseases. If the Common Risk Factor Approach is broadly adopted, it has the added advantage that all health professionals will communicate consistent health messages to the public. Strategic approaches to improving oral health will therefore be linked to other, more general, health promotion initiatives. (See smoking, obesity and alcohol sections for prevention interventions)

Trauma and Facial Injuries

- Injury to teeth can occur through accidental injury or violence, road traffic accidents or contact sports. Violent behaviour and associated facial trauma has a high association with alcohol use. Assault and alcohol consumption are the two major factors responsible for serious facial injuries in young adults of working age. One half of facial injuries in the 15-25 age group are sustained in assaults, usually in bars or streets and were associated with alcohol consumption by the victim or the assailant.^{168,169,170}

¹⁶⁸ *Alcohol, Violence and Injuries: The view from Accident and Emergency Departments* (Hutchinson I L, Magennis P, Shepherd JP and Brown A E (1998) 'BAOMs United Kingdom Survey of Facial Injuries Pt1: Aetiology and the Association with Alcohol Consumption', *British Journal of Maxillofacial Surgery*, Vol 36, pp 3-13.

¹⁶⁹ *Reducing alcohol misuse in trauma and other surgical patients – position statement*. Royal College of Surgeons 2010

¹⁷⁰ BMJ316:325 (Published 31 January 1998) Editorial. *Trends in facial injury: Increasing violence more than compensates for decreasing road trauma*. Magennis P, Shepherd J, Hutchinson I, Brown A

- A number of strategies have been found to prevent violence and reduce facial injuries. (See Alcohol section) These include:
 - Primary prevention: such as CCTV in violent hotspots.
 - Secondary prevention: brief alcohol interventions using motivational interviews with the victims of assaults has been shown to be effective in reducing alcohol consumption.
 - Multi agency prevention: where agencies such as the police, hospitals, crime prevention units work together and share information successes which has led to a reduction in alcohol-related incidents.

Health Behaviours

- Good oral hygiene helps prevent dental problems such as the accumulation of plaque and calculus that contribute to the development of gum disease and tooth decay. Evidence based guidance from the Department of Health recommends that people brush their teeth twice a day with a fluoride toothpaste.¹⁷¹

What are we doing in Cambridgeshire - Local Examples of Good Practice?

Case Study

- Access to dental services has increased in Cambridgeshire since 2009 through additional commissioning of dental services and social marketing initiatives such as local advertising and the dental helpline have also had an impact on this. The number of new patients attending the dentist has risen from 216,946 in September 2009 to 230,660 in March 2011 and increase of 2.4%¹⁵⁸.

What is this Telling us?

5.10.4 What are the Health Inequalities?

- In Cambridgeshire there is little local data available about the oral health of adults of working age. In the Adult Dental Health Survey this is reported only at SHA level. However evidence suggests that there are groups who are more likely to be at risk of poor oral health.
- However, the distribution of disease has become increasingly polarised and it is now concentrated in vulnerable and socio-economically disadvantaged groups. The inequalities exist in relation to both clinical diseases (tooth decay, gum disease, oral cancer) and subjective perceptions of oral health and quality of life.
- Obese adults are more likely suffer from the common dental diseases and are more likely to experience difficulty in accessing dental services than their counterparts whose weight is within the normal range.
- Binge drinkers are more likely to suffer from worse oral health, have an increased risk of mouth cancer and are more likely to experience facial injury as a result of their drinking habits.

¹⁷¹ Department of Health and The British Association for the study of Community Dentistry (2009) *Delivering Better Oral health* An evidence based toolkit for prevention-second edition

- Evidence also suggests that those most likely to seek NHS dental services are often those who need it least. Focusing solely on meeting demand therefore is likely to further increase oral health inequalities without improving oral health.

5.10.5 What are the Gaps in Knowledge/Services/Areas for Development?

- There is a wealth of data on how adults of working age access local dental services but these are largely treatment orientated services and give little indication about oral health status or preventative oral health behaviours of the adult population.
- Information is not routinely collected at a local level either through screening programmes, epidemiological surveys or self-reported questionnaires about the oral health status of adults other than through the decennial Adult Dental Health Survey which reports only at a regional level.
- The introduction of the common risk factor approach by health professionals to improve oral health should be considered.
- Oral health promotion undertaken by dental teams for patients attending for dental care in line with Delivering Better Oral Health Guidance¹⁷²
- Increase the number of dental care professionals providing brief interventions for smoking cessation.
- Consider rolling out IBA training for dental health professionals.^{173,174}
- Local monitoring of the oral health of adults should be considered.

¹⁷² Delivering Better Oral Health- An evidence based toolkit for prevention. Second edition July 2009 Gateway ref 12231

¹⁷³ Screening and brief interventions for hazardous and harmful alcohol use in primary care: a cluster randomised controlled trial protocol BMC Public Health 2009, 9:287.

¹⁷⁴ Current practices and intention to provide alcohol-related health advice in primary dental care. Dr Dent J 2011 Oct7:211(7) Shepherd S, Bonnetti D, Clarkson J E, Ogden G R, Young L

6. OTHER AREAS OF PREVENTION

6.1 Introduction

This section includes health protection interventions, as well as specific population groups where primary and secondary prevention is of particular importance. Lifestyles and the wider determinants of health are influences and are inter-related.

6.2 Communicable Diseases

6.2.1 Introduction

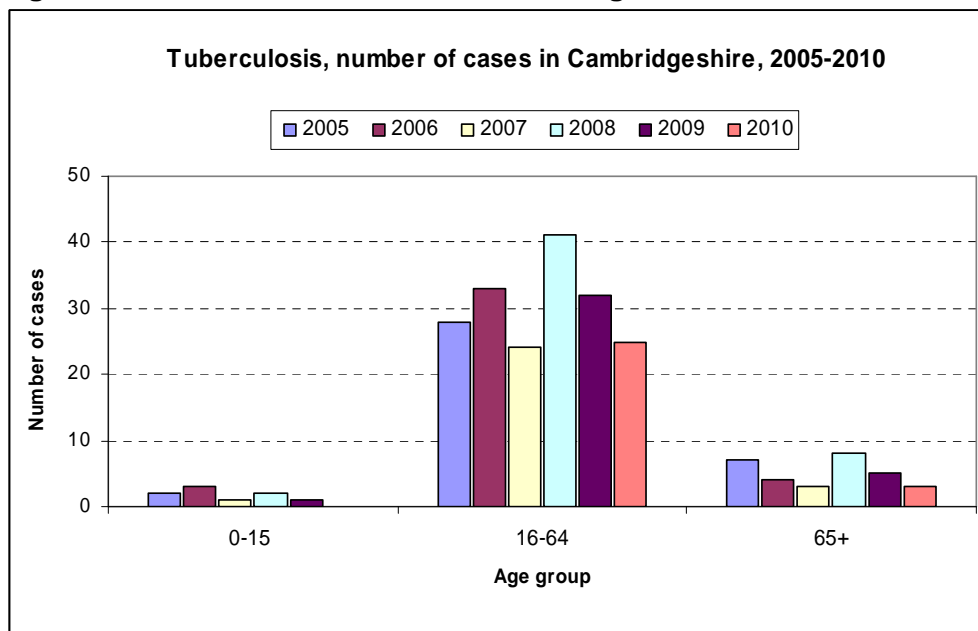
This section describes the three main areas that affect the working age population in terms of communicable diseases, namely, Tuberculosis (TB), Hepatitis and food poisoning. Communicable diseases are conceptualised as having three main components. First of all, the external agent is the organism that produces the infection. Secondly there is the “host” ie the individual affected by the organism. The host’s exposure, susceptibility and response is influenced by age, sex, socio-economic factors, lifestyle behaviour, genetic make-up, immunological status and psychological make. Thirdly extrinsic environmental factors affect the organism and opportunity for exposure, these include climate, physical surroundings, crowding and sanitation.

6.2.2 Figures and Trends

Tuberculosis

- Between 2005 and 2010, the total number of TB cases in Cambridgeshire decreased from 39 to 28 in all of the population. The most prevalent in TB cases was the 16-64 age group.

Figure 37: TB, Number of Cases in Cambridgeshire, 2005-2010



Source: Health Protection Agency 2011

Hepatitis B

- Between 2007 and 2010 there were 25 cases of acute Hepatitis B in Cambridgeshire PCT in the 16-64 age group.

Food Poisoning

- Campylobacter and Salmonella (non-typhoidal) species are the most common causes of food poisoning. In 2007-2010 there were 14 cases of confirmed laboratory notification of Hepatitis A in 16-64 age population in Cambridgeshire PCT. Data are in Table 77.

Table 77: Food Poisoning, Cambridgeshire PCT, 16-64 Age Group, 2007-2010

Year	Campylobacter	Salmonella non-typhoidal
2010	428	100
2009	419	103
2008	468	124
2007	489	103

Source: Health Protection Agency 2011. This is based on confirmed laboratory notifications.

6.2.3 Evidence/Policy

- In 2007 the Department of Health published a toolkit; *Tuberculosis prevention and treatment, a toolkit for planning, commissioning and delivering high quality services in England*. It sets out to offer commissioners of TB services a framework for assessing local need and for planning and commissioning high quality services in order to implement the TB action plan. It also contains models of best practice aimed at TB service providers, including laboratories and public health teams.
- NICE guidance on the clinical diagnosis and management of TB and measures for its prevention and control was updated in March 2011. NICE recommends that new entrant screening for Tuberculosis should be incorporated within larger health screening programmes for new entrants and linked to local services.
- An action plan from the Chief Medical Officer on Stopping Tuberculosis in England published in 2004 states that TB control is likely to be achieved if:
 - all patients with suspected pulmonary TB are seen by the TB team within two weeks of first presentation to healthcare;
 - at least 65% of adult patients with pulmonary TB have the diagnosis confirmed by laboratory culture of the organism;
 - all patients diagnosed with TB have the outcome of their treatment recorded, and at least 85% successfully complete their treatment.
- It is the policy in England to vaccinate only high risk groups against Hepatitis B. In countries where Hepatitis B is more prevalent universal vaccination is the policy. Those offered vaccination are:¹⁷⁵
 - babies born to infected mothers
 - close family and friends of infected people
 - patients who receive regular blood transfusions or blood products
 - people with any form of liver disease
 - people with chronic kidney disease

¹⁷⁵ <http://www.nhs.uk/Conditions/Hepatitis-B/Pages/Prevention.aspx>
Accessed 17/03/11

- people travelling to high-risk countries
 - sex workers
 - injecting drug users
 - people who change their sexual partners frequently or men who have sex with men
 - people whose work places them at risk, such as nurses, prison wardens, doctors, dentists and laboratory staff
 - prisoners
 - families adopting children from high-risk countries
- Most cases of food poisoning are sporadic or affect members of the same household. A general outbreak of food poisoning is an incident in which two or more people, from more than one household, or residents of an institution, thought to have a common exposure, experience a similar illness or proven infection (at least one of them having been ill). The environmental health officers and local Health Protection Unit are responsible for identifying and controlling outbreaks.

6.2.4 What are we doing in Cambridgeshire - Local Examples of Good Practice?

Case Study

- In 2009/10, 75% of clients accessing drug treatment services in Cambridgeshire were offered testing for Hepatitis C and 47% were tested. This represented an increase from 37% being offered in 2008/09 and 26% being tested.
- An audit undertaken at the Cambridge Access Surgery in March 2010 examined the uptake of Hepatitis B vaccination which is offered to all new patients who are current or previous intravenous drug users. Opportunistic testing and vaccination is also undertaken at nurse or doctor clinics. An accelerated course of a 0, 7 and 21 day Hepatitis B immunisation schedule with a booster at 12 months and post immunisation testing at 14 months is used.
- The audit revealed that 70% (n=188) of IVDU patients were immune to Hepatitis B (based on antibody results) or had been given at least three Hepatitis B injections (recorded). The majority of these (42%) had been coded as Hepatitis B immune.

What is this Telling us?

6.2.5 What are the Key Inequalities?

- Information on the overall prevalence of infection, derived from studies of low-risk and unselected populations, suggest that around 0.5% of the English population has antibody to Hepatitis C virus. However, the prevalence of Hepatitis C in injecting drug users in contact with health services is high at 47%.
- The largest influences on the number of cases of Hepatitis B in the population would be the prison population, number of intravenous drug users and men who have sex with men (MSM).
- National notification surveys have consistently shown that the highest rates of tuberculosis (TB) are in new entrants from countries with a high incidence of TB (TB incidence rate of at least 40/100,000). These cases of TB occur particularly within the first few years after initial entry into the UK.

6.2.6 What are the Gaps in Knowledge/Services/Areas for Development?

- The Unlinked Anonymous Prevalence Monitoring Programme in 2009, by the HPA, showed that 72% intravenous drug users in England and Wales have been imprisoned previously or currently. In prisons, at the present time, the pattern of Hepatitis C testing is variable and should be standardised. HMP/YOI Littlehey is taking part in a trial for Hepatitis C with Cambridge University Hospitals NHS Foundation Trust and people with Hepatitis C infection and mild to moderate liver disease are being treated medically under the hepatologists.
- The lead GP at Cambridge Access Surgery, a service primarily targeted at the homeless, conducted an audit in 2009 to investigate numbers of patients with Hepatitis C and possible reasons why treatment is not started or continued. The results of the audit were that although 67% were referred for treatment, 69% did not attend for their appointments and were subsequently discharged.

6.3 Screening

What do we Know?

6.3.1 Introduction

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.¹⁷⁶

For adults of working age there are currently three cancer (bowel, breast and cervical) and one non cancer (diabetic retinopathy) screening programmes offered to people in Cambridgeshire. Women who are pregnant are also offered antenatal and newborn screening for their baby.

6.3.2 Figures and Trends

Bowel Screening

- Men and women aged 60-69 years are invited every two years for bowel screening as part of a national screening programme to detect bowel cancer at an early stage. They are sent faecal occult blood (FOB) test kits and uptake is measured in terms of the number of kits returned.

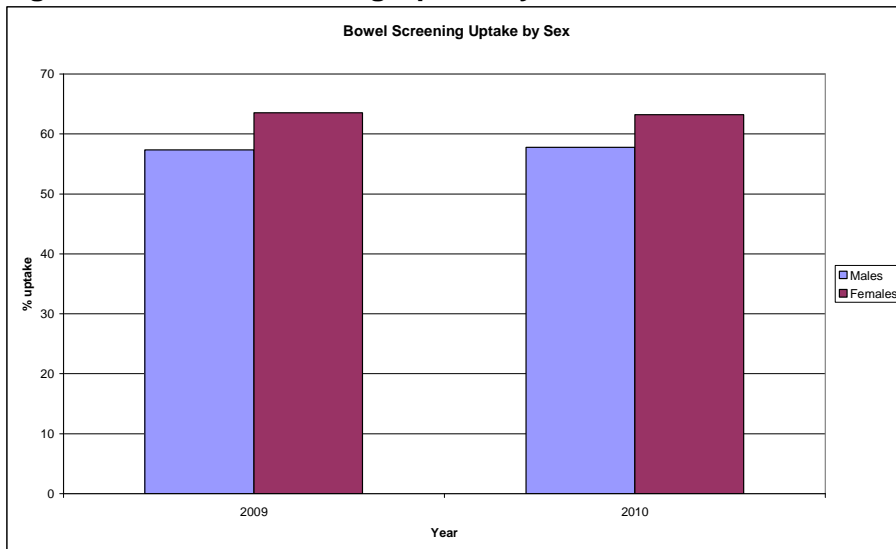
Table 78: Bowel Screening Uptake

	2009	2010
NHS Cambridgeshire	60.50%	60.56%
Eastern hub	56.88%	58.97%

- During 2010 uptake ranged from 49.52% to 73.36% at practice level. Uptake was highest in South Cambridgeshire with all practices achieving over 60%. There are also differences between uptake for males and females with uptake rates being higher for females, see below.

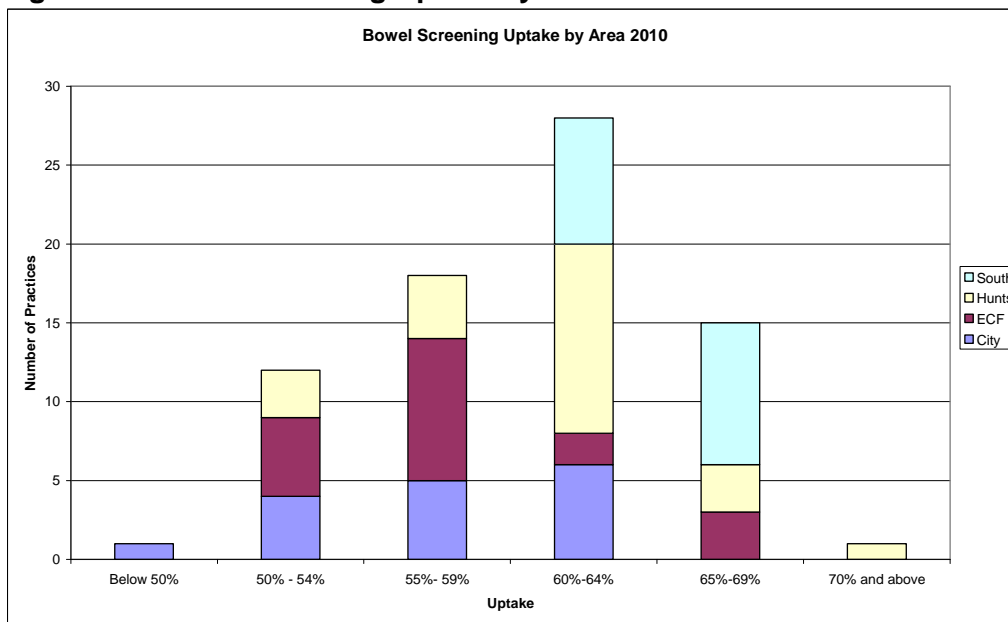
¹⁷⁶ National Screening Committee website <http://www.screening.nhs.uk/screening>

Figure 38: Bowel Screening Uptake by Sex



- The graph below shows the distribution of uptake by PCT area.

Figure 39: Bowel Screening Uptake by Areas 2010



Breast Screening

- Women between the ages of 50 and 70 are invited for regular breast screening (every three years) under a national programme. This is intended to detect breast cancer at an early stage.
- Coverage is defined as the percentage of women resident and eligible for screening at a particular point in time who had a test with a recorded result within the last three years. Currently coverage is best assessed using the 53-70 age group as women may be first called at any time between their 50th and 53rd birthdays.¹⁷⁷ NHS Cambridgeshire performance is shown below.

¹⁷⁷ Breast Screening Programme, England 2009-10. The NHS Information Centre, February 2011. http://www.ic.nhs.uk/webfiles/publications/008_Screening/Breastscrn0910/Breast_Screening_Publication_2010_Report.pdf

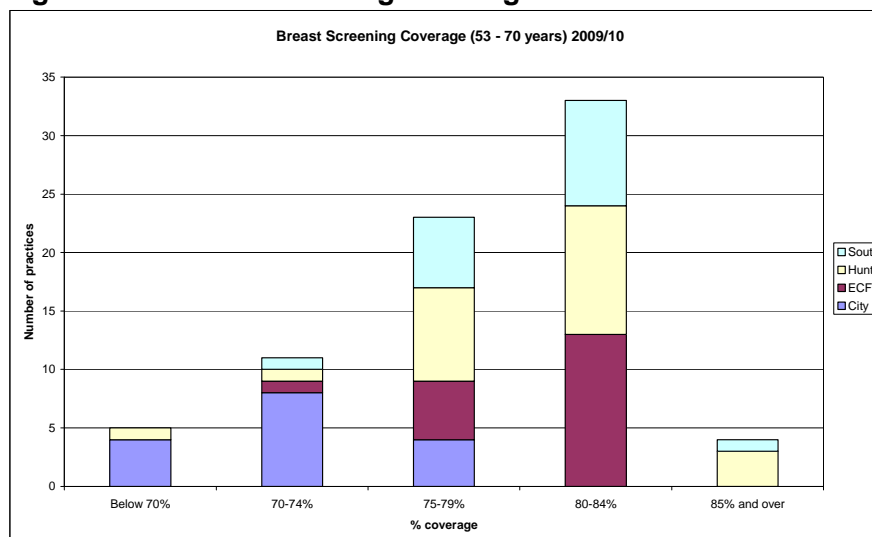
Table 79: Breast Screening Coverage of Women Aged 53-70 Years

	At 31 March 2009	At 31 March 2010
NHS Cambridgeshire	79.6%	79.5%
East of England	78.4%	78.6%
England	76.5%	76.9%

Source: NHS Information Centre 2011.¹⁷⁷

- During 2009/10 practice coverage ranged from 64.52% to 87.24%. Coverage is lowest in Cambridge City with none of the practices achieving 80% coverage.
- The graph below shows distribution of coverage by PCT area.

Figure 40: Breast Screening Coverage 2009/10



Source: NHS Information Centre 2011.

Cervical Screening

- Women between the ages of 25-64 are invited for regular cervical screening under a national Cervical Screening Programme. This is intended to detect abnormalities within the cervix that could, if untreated, develop into cancer. National policy is that women are offered screening every three years if aged 25-40 or five years if aged 50-64.
- Coverage is defined as the percentage of women in a population eligible for screening at a given point in time who were screened adequately within a specified period. For women aged 25-64 (the complete target age group) coverage is calculated as the number of women in this age group who have had an adequate screening test within the last five years as a percentage of the eligible population aged 25-64. The target for this is 80% and NHS Cambridgeshire performance is shown in the table below.

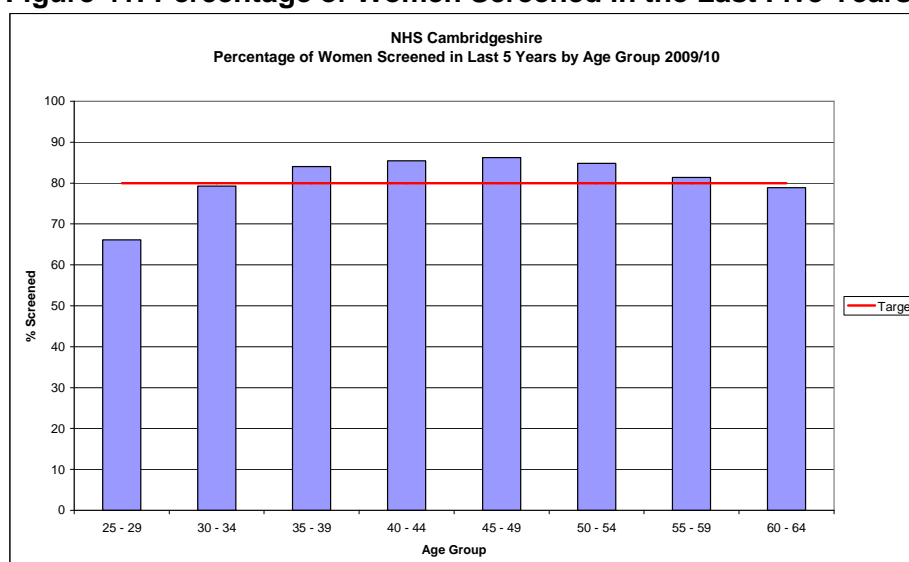
Table 80: Cervical Screening Coverage by Age Group

Coverage	Area	2008/09	2009/10
25-64 years (less than 5 years since last adequate test) (%)	NHS Cambridgeshire	81.1	80.7
	East of England	80.2	80.6
	England	78.9	78.9
25-49 years (less than 3.5 years since last adequate test) (%)	NHS Cambridgeshire	75.3	76.1
	East of England	74.9	76.4
	England	72.5	74.0
50-64 years (less than 5 years since last adequate test) (%)	NHS Cambridgeshire	83.5	81.9
	East of England	81.1	80.3
	England	80.0	78.9

Source: NHS Information Centre 2010.¹⁷⁸

- Although NHS Cambridgeshire is meeting the 80% standard for the complete age group, there are variations in coverage between age groups, with coverage being lowest in the 25-49 year age group. Further analysis by age group shows that coverage is particularly low in the 25-29 year age group (66% coverage in 2009/10).

Figure 41: Percentage of Women Screened in the Last Five Years 2009/10

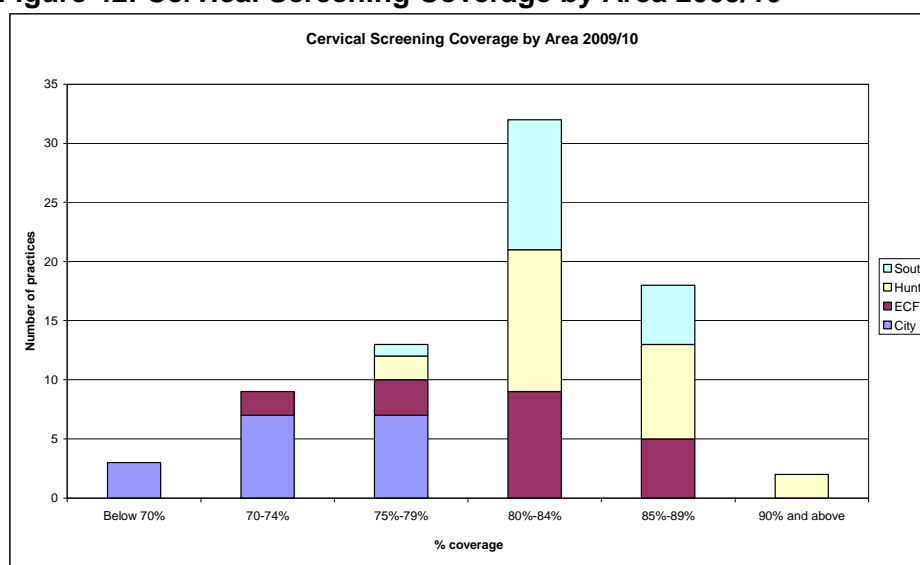


Source: NHS Information Centre 2010.

- There are also variations between localities with coverage during 2009/10 ranging from 64.5% to 91.7% across general practices and 25 practices not meeting the 80% standard. This is shown in the graph below. Coverage is lowest in Cambridge City, thought to be due to the high student population.

¹⁷⁸ Cervical Screening Programme, England 2009-10. The NHS Information Centre, October 2010. http://www.ic.nhs.uk/webfiles/publications/008_Screening/cervscreen0910/2009_10_Cervical_Bulletin_Final_Report_AI_v1F.pdf

Figure 42: Cervical Screening Coverage by Area 2009/10



Source: NHS Information Centre 2010.

Diabetic Retinopathy Screening

- Diabetic retinopathy screening is offered, on an annual basis, to all people aged 12 and over with diabetes. During 2009 a Health Equity Audit was carried out on Diabetic Retinopathy Screening Services in Cambridgeshire and Peterborough. This reviewed data from 1 September 2008 to 31 August 2009. This section outlines the findings from this audit for NHS Cambridgeshire.

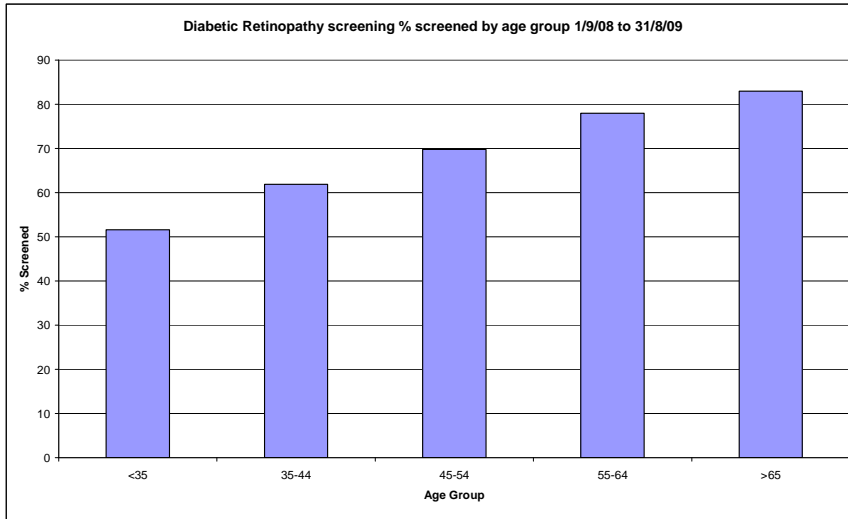
Table 81: Number and Percentage of Screened and Unscreened Population for Diabetic Retinopathy in NHS Cambridgeshire

Total number of patients on the DRSS register from 01/09/2008 to 31/08/2009	21,029
Total number screened between this period (percentage)	16,328 (77.6%)
Total number not screened (percentage)	4,701 (22.4%)

Source: Health Equity Audit, Diabetic Retinopathy Screening Services, NHS Cambridgeshire.

- The graph below shows the percentage screened by age group. The percentage screened aged under 35 years is noticeably lower than all other age groups. No notable differences were found in terms of gender with screening rates being very similar for males and females.

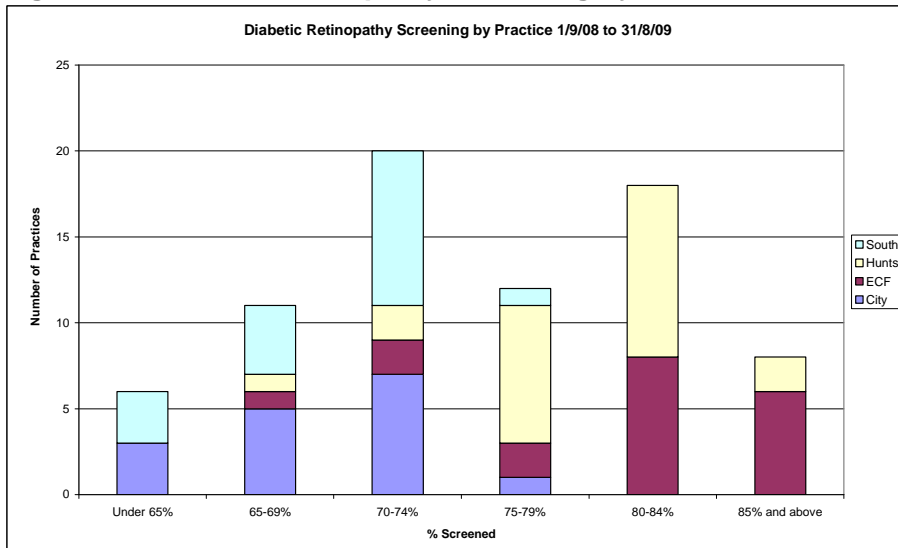
Figure 43: Diabetic Retinopathy Screening Percentage Screened by Age Group 01/9/08 to 31/08/09



Source: Health Equity Audit, Diabetic Retinopathy Screening Services, NHS Cambridgeshire.

- Differences were also found in terms of deprivation with screening rates being higher in the most deprived quintile than the least deprived quintile.
- The graph below shows distribution of coverage by PCT area. This shows that screening rates are higher in East Cambridgeshire and Fenland and Huntingdonshire practices, with no South Cambridgeshire or Cambridge City practices achieving 80%. This reflects the commissioning of a mobile screening service for those areas where the screening rates are higher.

Figure 44: Diabetic Retinopathy Screening by Practice 01/09/08 to 31/08/09



Source: Health Equity Audit, Diabetic Retinopathy Screening Services, NHS Cambridgeshire.

6.3.3 Local Views

- Locally each screening programme has a Programme Board, which is responsible for ensuring that the screening programme is meeting national standards and recommendations from quality assurance visits are addressed. Each of the Screening Programme Boards has representation from key stakeholders from each screening programme. Patient representatives currently sit on the Diabetic Retinopathy Screening Programme Board.

- The Anglia Cancer Network launched a 'Be clear on cancer' campaign in May 2011, which aims to raise awareness of the signs and symptoms of breast, bowel and lung cancer and encourage early awareness and diagnosis. The campaign ran during the summer and was aimed at people over 50 years of age. It engages with people on a one-to-one basis at a series of local events. It is hoped that this will also highlight the importance of regular screening.

6.3.4 Evidence/Policy

- The introduction of new screening programmes is managed by the National Screening Committee who appraise the viability, effectiveness and appropriateness of a potential screening programme before screening for a condition is introduced. There are a number of set criteria that need to be met before screening is introduced¹⁷⁹. National quality standards are in place for each screening programme and screening programmes are subject to external quality assurance visits.
- The following illustrates evidence of the effectiveness of screening:
 - Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16%.¹⁸⁰
 - The World Health Organisation's International Agency for Research on Cancer (IARC) concluded that mammography screening for breast cancer reduces mortality. The IARC working group determined that there is a 35% reduction in mortality from breast cancer among screened women aged 50-69 years old. This means that out of every 500 women screened, one life will be saved. In 2010, research demonstrated that the benefit of mammographic screening, in terms of lives saved, is greater than the harm in terms of overdiagnosis. Between two and two point five lives are saved for every overdiagnosed case.¹⁸¹
 - Cancer Research UK scientists estimate that up to 4,500 lives will be saved each year in England by cervical screening.¹⁸²
 - Untreated diabetic retinopathy is one of the most common causes of blindness in the working-age population.¹⁸³ Evidence has shown that early detection of retinopathy can prevent 260 new cases of blindness in England and Wales every year.¹⁸⁴
- Evidence on the effectiveness of interventions to improve uptake of screening is lacking. A Public Health Resource Unit report for the National Screening Committee¹⁸⁵ on reducing inequity and inequality in accessing national screening programmes reported that findings from the literature were often contradictory. However, the evidence that does exist suggests that interventions that actively engage the target audience were more likely to succeed than reminder letters. The report recommended that interventions to improve screening uptake should be based on existing evidence of effectiveness, trialled for a pilot period and the results shared widely.

¹⁷⁹ <http://www.screening.nhs.uk/criteria>

¹⁸⁰ <http://www.cancerscreening.nhs.uk/bowel/about-bowel-cancer-screening.html>

¹⁸¹ <http://www.cancerscreening.nhs.uk/breastscreen/save-lives.html>

¹⁸² Cervical Screening The facts, 2009. NHS Cancer Screening Programme. <http://www.cancerscreening.nhs.uk/cervical/publications/nhscsp-the-facts.pdf>

¹⁸³ Eye screening for people with diabetes – the facts. National Screening Programme for Diabetic Retinopathy. <http://www.retinalscreening.nhs.uk/userFiles/File/EyeScreeningForDiabetes.pdf>

¹⁸⁴ Rohan TE, Frost CD, Wald NJ. Prevention of Blindness by screening for diabetic retinopathy: a quantitative assessment. British Medical Journal 1989;299:1198-201.

¹⁸⁵ Interventions to reduce inequity and inequality in accessing national screening programmes, October 2008. Dr Tom Porter, Public Health Resource Unit.

What are we doing in Cambridgeshire - Local Examples of Good Practice?

- Screening programmes are continuously evolving as new technologies are introduced and more evidence on the effectiveness of screening is gathered. The introduction of flexible sigmoidoscopy in the bowel screening programme for men and women aged 55, along with age extensions for breast and bowel screening will make screening available to more of the population.
- Since September 2008 there has been a national programme to vaccinate girls aged 12 to 13 against the human papilloma virus (HPV), a major cause of cervical cancer, with catch up programmes running for girls aged up to 18. It is believed that it will be many years before an effect upon cervical cancer incidence is seen and so vaccinated women are advised to continue accepting their invitations for cervical screening as the vaccination will not prevent all types of cervical cancer. HPV testing for women with samples showing borderline nuclear change or mild dyskaryosis in the cervical screening programme is going to be rolled out nationally.
- Abdominal Aortic Aneurysm screening is being introduced across England for men in their 65th year. NHS Cambridgeshire is hoping to implement this programme in 2012.

What is this Telling us?

6.3.5 What are the Key Inequalities?

- Across all the screening programmes described above, uptake is lower in Cambridge City. Uptake is also lower in East Cambridgeshire and Fenland for bowel screening and South Cambridgeshire for diabetic retinopathy screening.
- For the screening programmes that cover a wide age range (cervical and diabetic retinopathy screening) uptake is lower in the younger age groups. There are also differences in uptake between males and females for bowel screening, with uptake being lower amongst the male population.
- The national screening programmes rely on people being registered with a general practice in order for them to be invited to screening. Hard to reach groups that may not be registered with a general practice such as Travellers and the homeless may therefore not be invited to screening.

6.3.6 What are the Gaps in Knowledge/Services/Areas for Development?

- Information on uptake for screening programmes is limited to age, postcode and gender. Other information such as ethnicity, homeless status, Traveller status, disability, etc are not collected and it is therefore not possible to determine the level of screening uptake in these particular groups.
- The national screening programmes are evidence based and screening, while not 100% reliable, has been shown to be effective in preventing and/or reducing the risk of disease. More needs to be done to ensure that the population of Cambridgeshire make use of the available screening programmes and is aware of the benefits and risks of screening. Focus interventions to improve screening on those areas identified as having low rates of screening ie Cambridge City (all screening), East Cambridgeshire (bowel screening), South Cambridgeshire (diabetic retinopathy) and younger age groups (cervical screening and diabetic retinopathy) is an area for development.
- Promote recording of wider demographic information by screening programmes, such as ethnic group, to allow uptake to be determined for specific groups and interventions targeted where appropriate.

6.4 Long Term Conditions

6.4.1 Introduction

There are around 15 million people in England with at least one long term condition (LTC) – a condition that can not be cured but can be managed through medication and/or therapy. There are a wide range of long term conditions that are described in the Adults with Physical or Sensory Impairment and/or Long Term Condition Needs Assessment. The focus in this section is on five conditions that respond to lifestyle interventions that aim 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. These lifestyle interventions also apply to primary prevention.

Although there are many LTCs this document addresses the following five conditions that reflect local priorities.

- Cancers
- Coronary Heart Disease (CHD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Stroke

Individual prevalence is described, but it is acknowledged that the evidence for prevention interventions is largely generic.

6.4.2 Figures and Trends

National Profile

The following factors are included in the national profile of LTCs¹⁸⁶ (Department of Health)

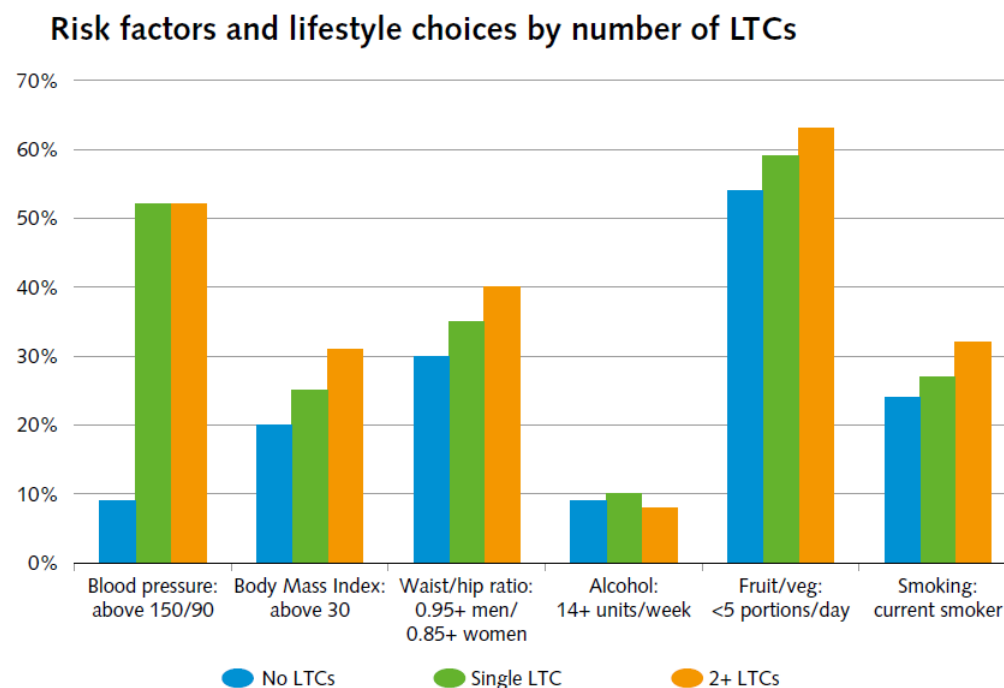
- While the number of people in England with a long term condition is likely to remain relatively steady, the number of people with comorbidities is expected to rise by a third in the next ten years.
- People with long term conditions are the most frequent users of healthcare services. Those with long term conditions account for 29% of the population, but use 50% of all GP appointments and 70% of all inpatient bed days.
- It is estimated that the treatment and care of those with long term conditions accounts for 70% of the primary and acute care budget in England. This means around one third of the population account for over two-thirds of the spend.
- The proportion of people with a limiting long term condition in work is a third lower than those who do not have a limiting long term condition.
- Long term conditions fall more heavily on the poorest in society: compared to social class I, people in social class V have 60% higher prevalence of long term conditions and 60% higher severity of conditions.
- Around 170,000 people die prematurely in England each year in total, with main causes being cancers and circulatory diseases. Those with long term conditions are likely to have a lower quality of life.

¹⁸⁶ <http://www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm>

Long Term Conditions and Prevention

LTCs are the main contributors to reduced life expectancy and are to a large degree preventable. Figure 45 indicates how those with one or multiple LTCs are more likely to be obese, have excessive alcohol consumption, an unhealthy diet and smoke. These factors are estimated to cause approximately 50% of Long Term Conditions.

Figure 45: Risk Factors and Lifestyle Choices by Number of LTCs



Source: Health Survey for England 2005 (age-adjusted rates).

http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_082067.pdf

Morbidity and Mortality

The following datasets describe hospital admissions and mortality for the five long term conditions. They are analysed by lower tier local authority area (districts) and by clinical commissioning group.

Data for practices outside of Cambridgeshire and Peterborough relate to Cambridgeshire and Peterborough residents only.

CANCERS

Over 250,000 people are diagnosed with cancer every year in England, 130,000 die and a further 1.8 million are living with and beyond a diagnosis.¹⁸⁷ The following data describes the impact cancer is having on the Cambridgeshire population. It includes all cancers.

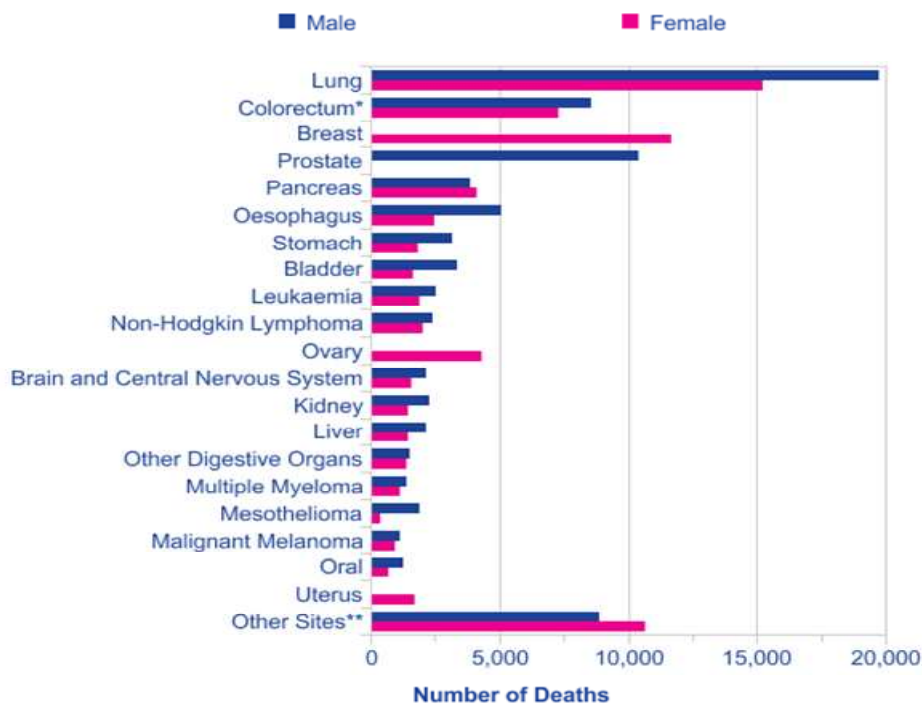
There were 156,090 cancer deaths in the UK in 2009.¹⁸⁸ Deaths from cancer of the lung, bowel, breast and prostate, together, account for 47% of all cancer deaths. The 20 most common causes of death from cancer are shown in Figure 46.¹⁸⁹

¹⁸⁷ Improving Outcomes A Strategy for Cancer Department for Health (2011)

¹⁸⁸ Cancer Research UK <http://www.cancerresearchuk.org/>

¹⁸⁹ Cancer Research UK <http://www.cancerresearchuk.org/>

Figure 46: The 20 Most Common Causes of Death from Cancer, UK, 2009



*Colorectum including anus (C18-C21)

** 8% of all female cancer deaths and 6% of all male cancer deaths are registered without specification of the primary site

Source: Cancer Research UK

Cancer in Cambridgeshire

Table 82: Cancer- Number of Hospital Admissions, 16-64 Years, 2010/11 by Local Authority

District	Number of admissions	Rate per 1,000	95%CI
Cambridge City	1,596	24.2	(23.0 – 25.4)
East Cambridgeshire	1,066	18.2	(17.1 – 19.3)
Fenland	1,238	19.0	(17.9 – 20.1)
Huntingdonshire	2,500	21.0	(20.2 – 21.9)
South Cambridgeshire	2,495	23.7	(22.7 – 24.6)
Cambridgeshire	8,895	21.3	(20.9 – 21.8)

Source: Acute Patient Care, Commissioning Data Set + Cambridgeshire County Council mid 2009 population estimate.

- Hospital admissions in Cambridge City and South Cambridgeshire are statistically significantly high compared to the Cambridgeshire County Council (CCC) area rate. East Cambridgeshire and Fenland are statistically significantly low compared to CCC and there is no difference in Huntingdonshire.

Table 83: Cambridgeshire - Number of Hospital Cancer Admissions, 16-64 Years, 2010/11 by Local Commissioning Group

LCG	Number of admissions	Rate per 1,000	95%CI
Borderline	853	15.4	(14.4 - 16.5)
CATCH = Cambridge City, CamHealth Integrated Care, City Suburb, Granta, North Villages and South Villages	4,323	13.4	(13.0 - 13.9)
Cambridge City	630	19.5	(18.0 - 21.1)
CamHealth Integrated Care	1,044	23.0	(21.6 - 24.4)
City	421	20.9	(18.9 - 22.9)
Granta	291	18.5	(16.2 - 20.7)
Hunts Healthcare Partnership	1,310	19.5	(18.4 - 20.5)
Herts	68	15.8	(12.0 - 19.5)
Hunts Health	1,104	22.1	(20.8 - 23.4)
Isle of Ely	1,153	19.6	(18.5 - 20.7)
North Villages	380	24.6	(22.1 - 27.0)
Practices not in a LCG (as 26/05/11)	665	30.4	(28.0 - 32.7)
South Villages	696	22.9	(21.2 - 24.7)
Wisbech	592	22.8	(20.9 - 24.6)
NHS Cambridgeshire	9,207	20.7	(20.2 - 21.1)

Source: Acute Patient Care, Commissioning Data Set + Cambridgeshire County Council mid 2009 population estimate.

- The Groups that are statistically significantly high compared to the NHS Cambridgeshire (NHSC) rate are four of CATCH sub-groups (CamHealth and North Villages, South Villages and Granta). The CATCH sub-group in Hertfordshire and Borderline is significantly low compared to NHSC. There is no statistically significant difference with any of the other groups.

Cancer Mortality

Table 84: Cancer Mortality in People Aged Under 65 years, 2007-2009 by District

District	Number of deaths	Rate	95% CI
Cambridge City	124	53.9	(44.3 - 63.4)
East Cambridgeshire	119	49.0	(40.1 - 57.9)
Fenland	186	66.7	(56.9 - 76.5)
Huntingdonshire	267	54.6	(48.0 - 61.3)
South Cambridgeshire	228	52.9	(46.0 - 59.8)
Cambridgeshire	924	54.8	(51.2 - 58.3)
England	89,526	62.7	(62.3 - 63.1)

Source: Compendium of Clinical and Health Indicators.

- Cambridgeshire as a whole has a cancer mortality rate that is statistically lower than England. There is no statistically significant difference between Cambridge City and Fenland from Cambridgeshire or England. East Cambridgeshire, Huntingdonshire and South Cambridgeshire are not statistically significantly different from Cambridgeshire but are low when compared with England.

CORONARY HEART DISEASE (CHD)

Coronary heart disease is the failure of the coronary circulation to supply adequate circulation to the cardiac heart muscle and surrounding tissue. Coronary heart disease is most commonly equated with coronary artery disease.

Coronary artery disease is a disease of the artery caused by the accumulation of atheromatous (fatty deposits) plaques within the walls of the arteries that supply the heart. Angina pectoris (chest pain) and myocardial infarction (heart attack) are symptoms of, and conditions caused by, coronary heart disease.

Table 85: Cambridgeshire Coronary Heart Disease - Number of Hospital Admissions, 16-64 Years, 2010/11 by District

District	Number of admissions	Rate per 1,000	95%CI
Cambridge City	126	2.0	(1.7 - 2.4)
East Cambridgeshire	124	2.1	(1.8 - 2.5)
Fenland	302	4.5	(4.0 - 5.0)
Huntingdonshire	386	3.2	(2.8 - 3.5)
South Cambridgeshire	210	2.0	(1.7 - 2.2)
Cambridgeshire	1,148	2.7	(2.6 - 2.9)

Source: Acute Patient Care, Commissioning Data Set + Cambridgeshire County Council mid 2009 population estimate.

- Cambridge City, East Cambridgeshire and South Cambridgeshire are all statistically significantly low compared to the Cambridgeshire area and there is no statistically significant difference in Huntingdonshire. Fenland is statistically high compared with Cambridgeshire.

Table 86: Cambridgeshire Coronary Heart Disease - Number of Hospital Admissions, 16-64 Years, 2010/11 by Local Commissioning Group

District	Number of admissions	Rate per 1,000	95%CI
Borderline	222	4.0	(3.5 - 4.5)
Cambridge City	48	1.6	(1.1 - 2.0)
CamHealth Integrated Care	81	1.8	(1.4 - 2.2)
City	45	2.3	(1.6 - 2.9)
Granta	35	2.4	(1.6 - 3.2)
HCP	218	3.1	(2.7 - 3.6)
Herts	9	2.0	(0.7 - 3.3)
Hunts Health	164	3.2	(2.7 - 3.7)
Isle of Ely	146	2.5	(2.1 - 2.9)
North Villages	27	1.8	(1.1 - 2.4)
Practices not in a cluster (as 26/05/11)	66	3.1	(2.3 - 3.8)
South Villages	56	1.8	(1.4 - 2.3)
Wisbech	127	4.7	(3.9 - 5.6)
NHS Cambridgeshire	1,244	2.8	(2.6 - 3.0)

Source: Acute Patient Care, Commissioning Data Set + Cambridgeshire County Council mid 2009 population estimate.

- Borderline and Wisbech have rates that are statistically high compared to NHSC. A number of CATCH's sub groups – CamHealth, Cambridge City, North Villages and South Villages are all statistically low compared to Cambridgeshire. There is no statistically significant difference with any of the other groups.

Coronary Heart Disease Mortality

Table 87: Mortality in People Aged Under 65 years, 2007-2009 by District

District	Number of deaths	Rate	95% CI
Cambridge City	27	11.9	(7.4 - 16.4)
East Cambridgeshire	35	14.5	(9.6 - 19.3)
Fenland	51	17.7	(12.8 - 22.7)
Huntingdonshire	60	12.0	(9.0 - 15.1)
South Cambridgeshire	66	15.1	(11.5 - 18.8)
Cambridgeshire	239	14.1	(12.3 - 15.9)
England	29,176	20.4	(20.2 - 20.7)

Source: Compendium of Clinical and Health Indicators.

- The Cambridgeshire mortality rate for CHD is statistically significantly lower than England. Fenland is the only district where there is no statistically significant difference to NHSC. The rest of the districts have rates that are not statistically significant to NHSC but are statistically significant low compared to England.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Chronic obstructive pulmonary disease (COPD) is the co-occurrence of chronic bronchitis and emphysema, a pair of commonly co-existing diseases of the lungs in which the airways become narrowed. This leads to a limitation of the flow of air to and from the lungs, causing shortness of breath. In clinical practice, COPD is defined by its characteristically low airflow on lung function tests. In contrast to asthma, this limitation is poorly reversible and usually gets progressively worse over time. In England, an estimated 842,100 of 50 million people have a diagnosis of COPD.

Table 88: Bronchitis, Emphysema and Other COPD Number of Hospital Admissions 16-64 Years, 2010/11 by District

District	Number of admissions	Rate per 1,000	95%CI
Cambridge	66	1.0	(0.8 - 1.3)
East Cambridgeshire	38	0.6	(0.4 - 0.8)
Fenland	76	1.1	(0.9 - 1.4)
Huntingdonshire	87	0.7	(0.6 - 0.8)
South Cambridgeshire	41	0.4	(0.3 - 0.5)
Cambridgeshire	308	0.7	(0.6 - 0.8)

Source: Acute Patient Care, Commissioning Data Set + Cambridgeshire County Council mid 2009 population estimate.

- Fenland's rate is statistically significantly high compared to Cambridgeshire County Council and South Cambridgeshire is statistically low compared to Cambridgeshire County Council.

Table 89: Bronchitis, Emphysema and other COPD – (some numbers are too small to publish) Number of Hospital Admissions 16-64 Years, 2010/11 by Local Commissioning Group

LCG	Number of admissions	Rate per 1,000	95%CI
Borderline	39	0.7	(0.5 – 0.9)
CATCH = Cambridge City, CamHealth, Integrated Care, City Suburb, Granta, North Villages and South Villages	166	0.4	(0.3 – 0.5)
Cambridge City	18	0.5	(0.3 – 0.8)
CamHealth Integrated Care	45	1.0	(0.7 – 1.3)
City	16	0.8	(0.4 – 1.2)
Granta	6	0.5	(0.1 – 0.8)
HCP	33	0.5	(0.3 – 0.6)
Herts	-	-	-
Hunts Health	50	1.0	(0.7 – 1.2)
Isle of Ely	47	0.8	(0.6 – 1.0)
North Villages	-	-	-
Practices not in a LCG (as 26/05/11)	27	1.2	(0.8 – 1.7)
South Villages	13	0.4	(0.2 – 0.6)
Wisbech	39	1.5	(1.0 – 1.9)
NHS Cambridgeshire	336	0.8	(0.7 – 0.8)

Source: Acute Patient Care, Commissioning Data Set + Cambridgeshire County Council mid 2009 population estimate.

Note: (-) denotes less than five cases.

- Wisbech is the only group that has a statistically high rate compared to NHSC. Hunts Care Partnership and the CATCH sub-groups – North Villages and South Villages are statistically significantly low compared to NHSC. There is no statistically significant difference between any of the others and NHSC.

Chronic Obstructive Pulmonary Disease Mortality

Table 90: Mortality from Bronchitis, Emphysema and Other COPD - Aged Under 75 Years by District

District	Number of deaths	Rate	95% CI
Cambridge City	23	8.4	(5.0 – 11.8)
East Cambridgeshire	10	3.4	(1.3 - 5.5)
Fenland	42	11.1	(7.7 – 14.6)
Huntingdonshire	49	8.6	(6.2 – 11.0)
South Cambridgeshire	29	5.8	(3.7 - 8.0)
Cambridgeshire	153	7.5	(6.3 - 8.7)
England	20,425	11.8	(11.7 – 12.0)

Source: Compendium of Clinical and Health Indicators.

CCC has a rate that is statistically significantly low when compared to England. Cambridge City and Fenland have rates that are not statistically significantly different from CCC or England. East Cambridgeshire is statistically significantly lower than CCC and England and in South Cambridgeshire there is no difference compared to CCC but there is when compared with England.

DIABETES

- Diabetes or Diabetes Mellitus, is a group of metabolic diseases. Metabolism is the process your body uses to get or make energy from proteins, carbohydrates and fats. A metabolic disorder occurs when abnormal chemical reactions in your body disrupt this process. With diabetes a person has high blood sugar, either because the body does not produce enough insulin, which is necessary to process sugars or because cells do not respond to the insulin that is produced. This results in progressive damage to body organs with a high risk of stroke, heart disease, blindness, kidney failure and range of other complications.
- There are three main types of diabetes:
 - Type 1 diabetes: results from the body's failure to produce insulin, and presently requires the person to inject insulin.
 - Type 2 diabetes: results from insulin resistance, a condition in which cells fail to use insulin properly. This type is associated with overweight and obesity
 - Gestational diabetes: is when pregnant women, who have never had diabetes before, have a high blood glucose level during pregnancy.
- All forms of diabetes are treatable with insulin medication. Both type 1 and 2 are chronic conditions that usually cannot be cured. Diabetes without proper treatments can cause many complications. Serious long-term complications include cardiovascular disease, chronic renal failure, retinal damage. Adequate treatment of diabetes is important, along with lifestyle factors such as smoking cessation and maintaining a healthy body weight.
- Nationally diabetes prevalence in England increased from 3.6% in 2005/06 to 4.3% in 2009/10¹⁹⁰ as recorded through GP Quality and Outcomes Framework (QOF) data. Estimates put it as high as 6.4% and projected to rise to 7.4% by 2020. The financial cost of diabetes care to the National Health Service is considerable. When the Diabetes National Service Framework Delivery strategy was published in 2003, 5% of all NHS expenditure and 9% of hospital expenditure was accounted for by the condition. A recent study in 2011 from the NHS Information Centre found that diabetes prescriptions now account for 8.4% of the entire NHS net bill for primary care drugs in England, an increase of 41.2% between 2005/06 and 2010/11.

¹⁹⁰ *Prescribing for Diabetes 2005/06 to 2010/11* NHS Information Centre (2011)

Table 91: NHS Cambridgeshire Quality Outcomes Framework Diabetes Mellitus Prevalence 2009/10 Ages 17+ Years

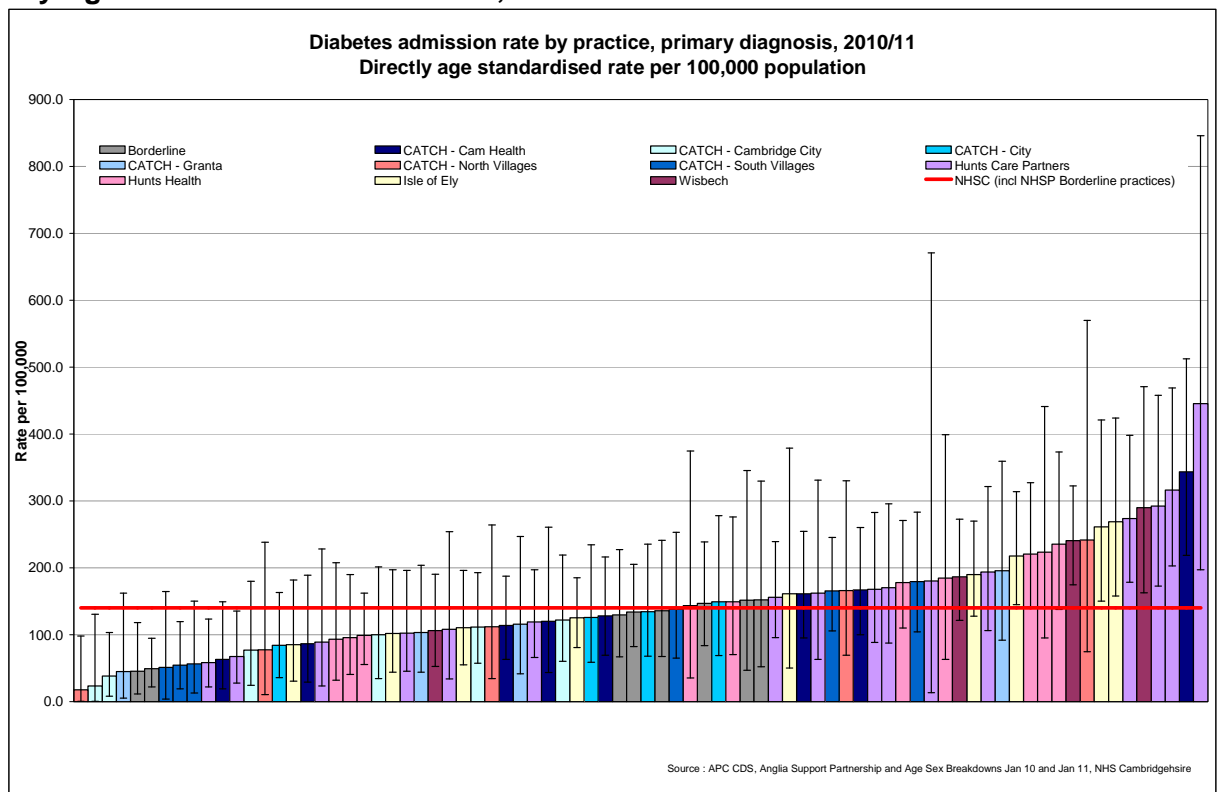
Local Commissioning Group	Diabetes Mellitus (Diabetes) (ages 17+)
Borderline	5.5%
CATCH - Cambridge City	2.3%
CATCH - Cam Health	4.3%
CATCH - City	4.3%
CATCH - Granta	2.9%
CATCH - Herts	4.3%
CATCH - North Villages	4.0%
CATCH - South Villages	4.8%
CATCH - Total	3.7%
Hunts Care Partnership	5.7%
Hunts Health	5.2%
Isle of Ely	5.7%
Wisbech	6.6%
NHS Cambridgeshire	4.9%
England	5.4%

Source: Information Centre.

Note: these percentages are not age standardised.

The highest prevalence is found in the Local Commissioning Groups in the north of the county and in Huntingdonshire.

Figure 47: Diabetes Admission Rates by Practice, Primary Diagnosis, 2010/11, Directly Age Standardised Rate Per 100,000



The chart above describes the spread of diabetes admissions as a primary diagnosis across practices and Local Commissioning Groups. As the numbers can be quite small it should be noted that there is potential for over interpretation.

STROKE

Stroke is one of the top three causes of death and the largest cause of adult disability in England, costing over £3 billion a year in direct care costs. More than one million people are living with the effects of stroke¹⁹¹

- Strokes are a blood clot (ischaemic) or bleed (haemorrhagic) in the brain that can leave lasting damage, affecting mobility, cognition, sight or communication. Typically 1.9 million neurons are lost each minute that it goes untreated, and in each hour in which treatment fails to occur, the brain loses as many neurons as it does in almost 3.6 years of normal ageing – “time is brain”.
- Every year approximately 110,000 people in England have a stroke. Most strokes are age related – more than 75% occur in people over the age of 65. However, one in four people who experience stroke are under 65, one in ten are under 55. Of those people who have a stroke, 20–30% die within a month, and approximately 30% are left with long-term disability, such as the loss of communication skills, physical disability, loss of cognitive skills, swallowing difficulties and mental health problems.
- In addition to full blown strokes, people may experience transient ischaemic attacks (TIAs) which occur when someone has symptoms similar to a stroke but they resolve within 24 hours. There is a 20% risk of a full stroke within the first four weeks after a TIA. There are also non-stroke conditions that present with similar symptoms, and these are known collectively as “stroke mimics”. International and UK studies suggest that the number of “strokes” seen that turn out to be mimics run at a rate of between 20% and 31%.

Table 92: Stroke: Number of Hospital Admissions 16-64 Years, 2010/11 by District

District	Number of admissions	Rate per 1,000	95%CI
Cambridge	38	0.6	(0.4 - 0.8)
East Cambridgeshire	31	0.5	(0.3 - 0.7)
Fenland	44	0.7	(0.5 - 0.9)
Huntingdonshire	51	0.4	(0.3 - 0.5)
South Cambridgeshire	35	0.3	(0.2 - 0.4)
Cambridgeshire	199	0.5	(0.4 - 0.5)

Source: Acute Patient Care, Commissioning Data Set + Cambridgeshire County Council mid 2009 population estimate.

None of the district rates are statistically significantly different from Cambridgeshire.

¹⁹¹ Department of Health (2007) *National Stroke Strategy*. London:DH

Table 93: Stroke: Number of Hospital Admissions 16-64 Years, 2010/11 by Local Commissioning Group

LCG	Number of admissions	Rate per 1,000	95%CI
Borderline	34	0.6	(0.4 - 0.8)
Cambridge City	14	0.4	(0.2 - 0.6)
CamHealth Integrated Care	17	0.4	(0.2 - 0.6)
City	-	-	-
Granta	9	0.6	(0.2 - 1.0)
HCP	30	0.5	(0.3 - 0.6)
Herts	-	-	-
Hunts Health	21	0.4	(0.2 - 0.6)
Isle of Ely	32	0.5	(0.4 - 0.7)
North Villages	11	0.7	(0.3 - 1.1)
Practices not in a LCG (as 26/05/11)	9	0.4	(0.1 - 0.6)
South Villages	9	0.3	(0.1 - 0.5)
Wisbech	19	0.7	(0.4 - 1.0)
NHS Cambridgeshire	210	0.5	(0.4 - 0.5)

Source: Acute Patient Care, Commissioning Data Set + Cambridgeshire County Council mid 2009 population estimate.

Note: (-) denotes less than five cases.

- CATCH as whole is statistically significantly low when compared to NHSC. There is no difference between NHSC and the other groups.

Stroke Mortality

Table 94: Mortality from a Stroke – Under 65 Years of Age by Local Authority, 2007-2009

District	Number of deaths	Rate	95% CI
Cambridge City	11	4.9	(2.0 - 7.7)
East Cambridgeshire	10	4.1	(1.6 - 6.7)
Fenland	11	4.0	(1.6 - 6.4)
Huntingdonshire	25	5.1	(3.1 - 7.1)
South Cambridgeshire	17	4.1	(2.1 - 6.1)
Cambridgeshire	74	4.4	(3.4 - 5.4)
England	8,719	6.2	(6.0 - 6.3)

Source: Compendium of Clinical and Health Indicators.

- Overall, Cambridgeshire is statistically significantly lower than England. There is no statistically significant difference amongst the rates of all the districts when compared with CCC and England.

6.4.3 Evidence/Policy

Policy

- There is a strong policy commitment to identifying and addressing the needs of people with a long term condition that is reflected in policy dating back several years.
- The policy aim is to ensure that the people lead a full and active role in society. *Improving the Life Chances of Disabled People* was published by the Department of Health in 2005. It expressed a commitment to achieving equality for disabled people by 2025. (The disabled terminology has been replaced by Long term Conditions)

- The Independent Living Strategy was published in 2007 by the Department of Health. It is aimed at ensuring that people with long term conditions, who need support to go about their daily lives, have greater control and choice over how that support is provided. This means working in partnership with people whose lives are affected by policies and by their implementation to ensure that people at the outset have the opportunity to influence and shape policy and the design, planning and delivery of services.
- More recently models of care have been developed to reflect this policy. The generic Long Term Conditions model published in 2010 by the Department of Health is committed to this model of care that is based on active participation of people with long term conditions in developing an individual structured and consistent approach to the management of their condition – matching care to need. Unplanned emergency admissions could be reduced by 20% by 2013-14 and length of stay by 25%¹⁸⁰. There are four key elements in the model that all aim to keep people active and involved in their care. Providing people with information and skills to make day to day decisions about the way they manage and maximise their health is fundamental to the model
- Locally the NHS Cambridgeshire QIPP (Quality, Innovation, Productivity and Prevention) and Reform Plan for 2010-2015 highlights the need to improve care for people living with long term conditions as a key priority area¹⁹² that is endorsed by its partners.

Evidence

This section should be cross referenced to the lifestyle section of the document for primary and secondary prevention interventions.

CARDIOVASCULAR DISEASE (CVD)

Primary Prevention

- In June 2010, the National Institute for Health and Clinical Excellence published its guidance on *Prevention of cardiovascular disease at the population level*¹⁹³. Policy areas for local work include:
 - ensure guidance for local transport plans supports physically active travel;
 - ensure publicly funded catering departments meet Food Standards Agency approved dietary guidelines;
 - encourage local planning authorities to restrict planning permission for take-aways and other food retail outlets in specific areas;
 - use population surveys and data from all relevant sources to monitor intake of nutrients for all population groups.
- Local CVD prevention programmes should:
 - comprise intense, multi-component interventions;
 - target the whole population;
 - complement initiatives for individuals at high risk;
 - be sustainable for a minimum of five years;
 - be allocated adequate time and resources.

¹⁹² NHS Cambridgeshire (2011). *QIPP and Reform Plan 2010-2015*. Cambridge.

¹⁹³ National Institute for Health and Clinical Excellence (2010). *Prevention of cardiovascular disease at population level*. London.

Secondary Prevention – Coronary Heart Disease

Myocardial Infarction:

A number of key priority recommendations have been identified by the National Institute of Health and Clinical Excellence (NICE)¹⁹⁴; these are listed below:

- After an acute myocardial infarction (MI), confirmation of the diagnosis of acute MI and results of investigations, future management plans and advice on secondary prevention should be part of every discharge summary.
- Patients should be advised to undertake regular physical activity sufficient to increase exercise capacity.
- Patients should be advised to be physically active for 20–30 minutes a day to the point of slight breathlessness. Patients who are not achieving this should be advised to increase their activity in a gradual, step-by-step way, aiming to increase their exercise capacity. They should start at a level that is comfortable, and increase the duration and intensity of activity as they gain fitness.
- All patients who smoke should be advised to quit and be offered assistance from a smoking cessation service in line with 'Brief interventions and referral for smoking cessation in primary care and other settings'¹⁹⁵ (NICE public health intervention guidance 1).
- Patients should be advised to eat a Mediterranean-style diet (more bread, fruit, vegetables and fish; less meat; and replace butter and cheese with products based on vegetable and plant oils).
- Cardiac rehabilitation should be equally accessible and relevant to all patients after an MI, particularly people from groups that are less likely to access this service. These include people from black and minority ethnic groups, older people, people from lower socio-economic groups, women, people from rural communities and people with mental and physical health co-morbidities.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Primary Prevention

The main cause of COPD is smoking. The likelihood of developing COPD increases the more people smoke and the longer they have been smoking.

Secondary Prevention

In NICE Guidance published in June 2010¹⁹⁶, a key priority for those diagnosed with COPD is encouraging patients still smoking, regardless of age, to stop. Help to stop smoking should be offered at every opportunity.

¹⁹⁴ National Institute for Health and Clinical Excellence (2007). *Myocardial Infarction: secondary prevention*. London.

¹⁹⁵ National Institute for Health and Clinical Excellence (2006). [Brief interventions and referral for smoking cessation: guidance](#) London.

¹⁹⁶ National Institute for Health and Clinical Excellence (2010). *Chronic Obstructive Pulmonary Disease: management in adults in primary and secondary care*. London.

DIABETES

Primary Prevention: Preventing Type 2 Diabetes - Population and Community Interventions

- In May 2011, NICE published its guidance on 'Preventing type 2 diabetes, focusing on population and community-level interventions in high risk groups and the general population'¹⁹⁷. Recommendations for local action include:
 - The use of the JSNA process to identify local communities at risk of developing type 2 diabetes.
 - The development of a local integrated plan for activities and programmes aimed at preventing type 2 diabetes and related non-communicable diseases (including cardiovascular disease).
 - Interventions for communities at high risk of type 2 diabetes including working in partnership to develop cost-effective physical activity, dietary and weight management programmes.
 - Conveying messages to the whole and local populations, ensuring that messages to prevent non-communicable diseases (including type 2 diabetes, cardiovascular disease and some cancers) are consistent, clear, culturally appropriate and integrated within other health promotion campaigns or interventions.
 - Training those involved in promoting healthy lifestyles (including local authority departments, voluntary sector, not for profit and non-governmental practitioners and the commercial sector).
 - Guiding principles include supporting behaviour change, helping people to achieve and maintain a healthy weight, provision of effective weight-loss programmes, helping people to achieve national physical activity levels and the provision of interventions which are culturally appropriate.

STROKE

Primary Prevention

- *The National Stroke Strategy* was published by the Department of Health in 2007¹⁹⁸. The main recommendations of Chapter 1 'Everyone's Challenge: Raising Awareness and Informing and Involving' can be summarised as follows.
 - Those at risk of a stroke and those who have had a stroke are assessed for and given information about risk factors and lifestyle management issues (exercise, smoking, diet, weight and alcohol), and are advised and supported in possible strategies to modify their lifestyle and risk factors.
 - Risk factors, including hypertension, obesity, high cholesterol, atrial fibrillation (irregular heartbeats) and diabetes, are managed according to clinical guidelines, and appropriate action is taken to reduce overall vascular risk.

¹⁹⁷ National Institute for Health and Clinical Excellence (2011). *Preventing type 2 diabetes: population and community-level interventions in high-risk groups and the general population*. London.

¹⁹⁸ Department of Health (2007). *National Stroke Strategy*. London

- The rationale behind these markers is that promoting healthy living is very important in helping to prevent strokes, particularly in disadvantaged areas and groups. Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke. It is estimated that 20,000 strokes a year could be avoided through preventive work on high blood pressure, irregular heartbeats, smoking cessation, and wider statin use. Preventing strokes does not only reduce the associated suffering, morbidity and mortality caused by strokes; it may also lead to NHS savings, as each stroke costs approximately £15,000 to treat over five years.

Secondary Prevention

For those who have already had a stroke or a transient ischaemic attacks (TIA), prevention advice is even more important. This means assessing individuals for their risk factors and giving them information about possible strategies to modify their lifestyle that can reduce their risk. General practitioners need to actively manage these conditions in line with national guidelines.

- Commissioners and providers use ASSET to establish a baseline and to ensure that there are systems in place locally for the following key prevention measures:
 - managing hypertension so systolic blood pressure is below 140 mmHg;
 - warfarin for individuals with atrial fibrillation;
 - statin therapy for all people with more than 20% risk of cardiovascular disease within ten years; and
 - smoking cessation for all individuals who have had a stroke or TIA.

6.4.4 What are we doing – Examples of Good Practices?

- As indicated above, evidence for primary prevention programmes is largely generic. In Cambridgeshire, existing evidence based primary prevention programmes are currently commissioned by NHS Cambridgeshire. Delivery is undertaken, often in partnership, with a range of organisations such as primary care, local authorities, schools, health trainer schemes, county sports partnership (Living Sport) etc.
- Details of lifestyle programmes relating to smoking, obesity, nutrition and healthy eating, physical activity, alcohol, mental health can be found in the Lifestyle section.

What is this Telling us?

6.4.5 What are the Key Inequalities?

Cancer

- The rate of hospital admissions (16-64 years) for 2010-11 by District is significantly higher in Cambridge City and South Cambridgeshire compared with the Cambridgeshire County Council area.
- The rate of hospital cancer admissions (16-64 years) for 2010-11 by Local Commissioning Group is higher in the four CATCH sub-groups (CamHealth and North Villages, South Villages and Granta).

Coronary Heart Disease

- The rate of hospital admissions (16-64 years) for 2010-11 by District is statistically higher in Fenland compared with the rest of the Cambridgeshire County Council area.
- The rate of emergency hospital admissions (16-64 years) for 2010-11 by Local Commissioning Group is higher in Borderline and Wisbech.

Chronic Obstructive Pulmonary Disease (COPD)

- The rate of emergency hospital admissions (16-64 years) for 2010-11 by District for bronchitis, emphysema and other COPD is significantly higher in Fenland.
- The rate of emergency hospital admissions (1-64 years) for 2010-11 by Local Commissioning Group for bronchitis, emphysema and other COPD is higher in Wisbech.

Diabetes

- There is variation between practices across the county. QOF data indicates higher rates in Huntingdonshire and the north of the county. Although this data is not age standardised.

Stroke

- The rates of hospital admissions (16-64 years) for 2010-11 by District are not significantly different from the Cambridgeshire County Council rate
- The rates of hospital admissions (16-64 years) for 2010-11 by Local Commissioning Group identifies that CATCH, as a whole, is significantly low when compared with the NHS Cambridgeshire area.

6.4.6 What are the Gaps in Knowledge/Services/Areas for Development?

- The extent to which primary prevention programmes are embedded in patient pathways for all five of the long term conditions highlighted in this section is unclear. *The Cambridgeshire Long Term Conditions Strategy (2008-11)* mapped pathways for a range of long term conditions and provides a template for ensuring evidence based primary prevention programmes front load LTC pathways. The following secondary prevention interventions require exploration.
 - Pathways between prevention programmes and health and social care services caring for people with LTCs.
 - The current secondary prevention model is adopted which includes (1) risk profiling (2) integrated care teams and (3) self-care/self management.
 - Adoption of the Working Together for Change model to ensure co-production of better health for people with long term conditions.
- The following primary prevention interventions provide opportunities for development.
 - Health Check programme is used to identify those at risk and entry into primary prevention programmes, where appropriate, facilitated.
 - Partnership approaches to promoting campaigns such as Be Clear on Cancer, FAST, Move More be developed using media, including social media, outlets already funded.
 - See Areas for Development – Lifestyles.
- Evidence is emerging on the links between physical activity and cancer¹⁹⁹. Emerging evidence shows that achieving sufficient activity levels can reduce the risk of dying from breast, bowel and prostate cancer and reduce the recurrence for breast and bowel. A review of this evidence base could lead to the inclusion of physical activity programmes in patient pathways for people who have cancer.

¹⁹⁹ MacMillan Cancer Support (2011). *Move More: physical activity, the underrated 'wonder drug'*. London

- NICE has published an evidence based guide for commissioning cardiac rehabilitation.²⁰⁰ A Cambridgeshire and Peterborough Coronary Heart Disease Equity Profile was completed in early 2007. The aspects of the patient pathway that showed greatest inequity were reported to include cardiac rehabilitation. It is unclear that these inequities have been identified and tackled across all phases of cardiac rehabilitation delivery, especially Phase IV. A new equity audit is required to identify current inequities in delivery of all phases of cardiac rehabilitation across Cambridgeshire.
- Other significant gaps in individual lifestyle programmes are identified in the Lifestyle section.

6.5 Skin Cancer

6.5.1 Introduction

- Skin cancer is not addressed separately in the Long Term Conditions section. It is included here, however, as it is a condition that highly susceptible to preventative interventions.
- In the UK 11,767 cases of malignant melanoma were diagnosed in 2008 and the incidence of melanoma has gone up by more than four times since the 1970s.
- Rates of melanoma have risen faster than for any other cancer in the UK, and if current trends continue, it is anticipated that there will be around 15,500 cases of malignant melanoma diagnosed per year within the next 15 years.
- Most skin cancer deaths, about 2,067 each year, are from malignant melanoma. In fact, there are more skin cancer deaths in the UK than in Australia, even though Australia has more cases of the disease. In 2002, it was estimated that skin cancer (malignant melanoma and other malignant neoplasms of skin) cost the NHS approximately £71 million.²⁰¹

6.5.2 Figures and Trends

Table 95: Malignant Melanoma, 2007-2009

District	Number of deaths	Rate	95% CI
Cambridge City	7	1.9	(0.4 - 3.4)
East Cambridgeshire	9	2.7	(0.9 - 4.4)
Fenland	13	3.3	(1.3 - 5.3)
Huntingdonshire	17	2.8	(1.4 - 4.2)
South Cambridgeshire	14	2.4	(1.1 - 3.7)
Cambridgeshire	60	2.6	(1.9 - 3.3)
England	5,162	2.6	(2.5 - 2.6)

Source: Compendium of Clinical and Health Indicators (nchod).

These rates are not significantly different to the England average. The number of deaths from skin cancers, other than malignant melanoma, is too small to report at district level. However, between 2007 and 2009 there were 16 such deaths in Cambridgeshire, with none of the districts having rates that differed to the national rate.

²⁰⁰ National Institute for Health and Clinical Excellence (2008). Cardiac rehabilitation service commissioning guide. London

²⁰¹ Cancer Research UK. Accessed Online 1/09/11 <http://www.cancerresearchuk.org/>

- Melanoma is one of the few cancers to affect young adults and is the second most common cancer amongst 15-34 year olds, however, a person's risk of developing melanoma increases with age. More women than men develop malignant melanoma. Cancer Research UK reports that there is a 60 -70% lower incidence among people from deprived areas compared with their more affluent peers. However people from more affluent areas are more likely to survive the condition. Additionally, it should be noted that sun-bed outlets are more prevalent in areas of socio-economic deprivation and that this could affect the rates in the future.

6.5.3 Evidence

- In general, multi-component public health interventions are often considered to be best practice and cost-effective. Combining national and local media campaigns, information resources, group education sessions, encouraging regular skin checkups and employee wellbeing initiatives. However, the evidence on multi-component interventions to prevent skin cancer is weak and very limited research has been based in the UK.²⁰²
- Health promotion initiatives should focus on groups who may be at higher risk, such as children, young people, outdoor workers, those who are immuno-suppressed, those with a family history of skin cancer and those who put themselves at risk by sunbathing.
- Employers and managers in schools, leisure facilities and other workplaces can play an important role in helping to raise awareness of the dangers of skin cancer by ensuring policies are in place and consistent messaging about covering up in the sun. The benefits of Vitamin D and physical activity need to be weighed up when considering reducing exposure to the sun.
- Providing shade structures in school grounds may help reduce UV exposure in children. However adding shade structures to the existing built environment is not considered cost-effective. Although, if the provision of shade was incorporated into the design and construction of buildings from the outset, then it was a cost-effective option.

What is this Telling us?

6.5.4 Health Inequalities

The numbers are too small to draw any conclusions about local inequalities. As indicated above, younger people are particularly affected.

6.5.5 What are Gaps in Services/Information/Areas for Development?

- There is a lack of local campaigns to increase awareness of the prevention of skin cancers.
- Workplace initiatives designed to increase awareness of the prevention of skin cancer.
- Explore with planning authorities how the provision of shade can be incorporated into the planning approval process.

²⁰² National Institute of Clinical Excellent Public Health Guidance No: 32 Skin Cancer: prevention using public information, sun protection resources and changes to the environment.

6.6 Visual Impairment

6.6.1 Introduction

This section considers the challenge of minimising visual loss in the population, and also the needs of blind and partially sighted people in Cambridgeshire. Sight is the sense most valued by the vast majority (86%) of the population.²⁰³ Sight loss is a life changing and disabling long term condition and failure to adapt to vision loss can lead to poorer physical and mental health, decreased independence and socio-economic deprivation.

In terms of prevention there is the primary need to reduce avoidable sight loss.

6.6.2 Facts and Figures

- In 2008 there were an estimated 1.8 million people living with sight loss in the UK.¹⁸⁰
- The number of people living with sight loss is increasing each year, and is set to double in size by 2050.
- Currently over 14,000 visually impaired people live in Cambridgeshire.²⁰⁴ Although there is no robust age breakdown that identifies younger age groups. Table 96 describes the breakdown across the county
- In 2008 there were an estimated 1.8 million people living with sight loss in the UK.²⁰⁵
- The number of people living with sight loss is increasing each year, and is set to double in size by 2050²⁰⁶

Table 96: Population Affected by Eye Conditions Within District, Includes Those With Impaired Vision, Low Vision and Severe Sight Impairment

Local Authority	Number Visually Impaired
Cambridge City	2,653
East Cambridgeshire	1,986
Fenland	2,617
Huntingdonshire	3,445
South Cambridgeshire	3,306

Source: National Eye Health Epidemiological Model 2008.

Visual Impairment and Health

- Mental health needs - immediate post diagnosis for emotional and practical support to avoid a potential drop in self-confidence. There is a longer term issue of depression with prevalence of depression in visually impaired people at 30-45%.²⁰⁷
- High risk of falls, other injuries and exclusion.²⁰⁸
- People with visual impairment are less physically active than their sighted peers.²⁰⁹
- 34% of visually impaired people are in employment, compared to 75% of population overall.²¹⁰

²⁰³ College of Optometrists, 2011. *Britain's Eye Health in Focus: A study of consumer attitudes and behaviour towards eye health.*

²⁰⁴ NEHEM model 2008

²⁰⁵ *Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population.* Access Economics RNIB. (2009)

²⁰⁶ College of Optometrists, Royal College of Ophthalmologists et al 2011. *Ophthalmic Public Health: The invisible public health time bomb.*

²⁰⁷ Tabrett & Latham, 2009

²⁰⁸ University of Reading, 2009

²⁰⁹ Rudman DL, Durdle M. Living with fear: the lived experience of community mobility among older adults with low vision. *J Aging Phys Act.* 2009;17(1):106-122.

- 24% of visually impaired people of working age have no qualifications, compared to 15% of working age population.²¹¹

Cost of Visual Impairment

In 2008 sight loss cost at least £6.5 billion, and this is likely to increase as the number of people with sight loss increases. This figure does not include the cost of sight loss in children.²¹²

This cost is made up of:

- £2.14 billion in direct health care costs, such as eye clinics, prescriptions and operations.
- £4.34 billion in indirect costs, such as unpaid carer costs and reduced employment rates.
- Wider economic cost on the UK, totalling an estimated £22 billion in 2008.

6.6.3 Evidence

Primary Prevention

Although sight loss is set to double by 2050, half of this is avoidable through early intervention and diagnosis. Even modest reductions in avoidable sight loss would result in significant health gains and savings in health expenditure by reducing physical frailty, lessening the impact of other illnesses and disabilities, reducing falls and preserving independence. There are conditions that are associated with sight loss that are amenable to prevention interventions.

Refractive error: 65% of adults between 18-60 years old and living in the UK wear some form of corrective eyewear.²¹³ However, a particularly startling research finding is that in 'developed countries', between 7% and 34% of older people have visual impairment that could simply be cured by appropriate spectacles.²¹⁴ Figures are not known for the working age adult population. With reference to drivers' vision, 13% of spectacle-wearers confess to have driven without their prescription glasses when they should have worn them.²¹⁵ A report was due to be published in September 2011 surveying the eyesight of business drivers.²¹⁶

Computer vision: more than 40% of adults now work with visual display units for more than five hours a day, yet only 28% of computer users know that they are entitled to an eye examination paid for by their employer.²¹⁷

There are conditions that are associated with sight loss that are amenable to prevention interventions:

²¹⁰ Network 1000: Douglas et al VICTAR/VISION 2020 UK, (2006)

²¹¹ *Functionality & the Needs of Blind and Partially Sighted Adults in the UK*, Pey, T et al. Guide Dogs, 2007

²¹² *Future Sight Loss UK 1: Economic Impact of Partial Sight and Blindness in the UK adult population*. Access Economics, RNIB. (2009)

²¹³ College of Optometrists, 2011. *Britain's Eye Health in Focus: A study of consumer attitudes and behaviour towards eye health*.

²¹⁴ Evans & Rowlands. *Correctable visual impairment in older people: a major unmet need*. *Ophthal. Physiol. Opt.* 2004 24: 161–180.

²¹⁵ College of Optometrists, 2011. *Britain's Eye Health in Focus: A study of consumer attitudes and behaviour towards eye health*.

²¹⁶ Eyecare Trust & Westfield Health. DRIVE campaign. http://www.eyecaretrust.org.uk/view.php?item_id=594

²¹⁷ College of Optometrists, 2011. *Britain's Eye Health in Focus: A study of consumer attitudes and behaviour towards eye health*.

Age-related macular degeneration (AMD)

- This rarely leads to complete sight loss because only the central vision is affected. At the moment, the exact cause of AMD is not known, however, a number of environmental factors have been identified²¹⁸ by NICE. This includes over-exposure to sunlight, nutrition deficiencies and smoking.

Diabetes-related sight loss

- Diabetes eye damage is the single largest cause of blindness before old age with a progressive incidence in people with type 2 diabetes.²¹⁹ Vision loss is not inevitable if certain steps are taken. According to NICE, recommendations for people with type 2 diabetes should closely follow those for type 1 diabetes. This includes good blood sugar level control and regular sight tests, ensuring good blood pressure and cholesterol control are also important. Also, encouraging a healthy lifestyle and giving up smoking, which increases blood pressure and raises blood sugar level, are also helpful in the prevention of sight loss. The Diabetic Retinopathy Screening Programme is key to the early identification or risk of visual impairment. (See Screening Section)
- People of Asian descent are at particular risk of developing diabetic retinopathy.

Glaucoma

- Research suggests that a form of glaucoma affects about two out of every 100 people in the UK who are over 40.²²⁰
- People of African-Caribbean descent are at particular risk.
- Although it is not possible to prevent glaucoma in most cases, early diagnosis and careful regular observation and treatment can keep damage to a minimum, meaning that good vision can be enjoyed indefinitely.²²¹

Regular Sight Tests for High Risk Groups

Vision loss in many cases can be prevented by regular eye examinations with an optometrist, in order to detect changes early on.²²² Eye examinations, which assess refractive correction and ocular health, are available through primary care optometry practices. Sight tests are paid for by the NHS for adults over 18 years on low income, with diabetes or glaucoma, if aged over 40 with a first degree relative with glaucoma, if registered as visually impaired, or if aged 60 years or over. All other adults pay privately for a sight test. A voucher towards the cost of spectacles is due to adults on low income.

However, nearly one in five people have either never been for a sight test or have not been to an optometrist in the last five years – equating to over 7 million people.²²³ Barriers to attending for an eye examination include lack of symptoms (50%) suggesting that people do not understand the health benefits of regular eye examinations. Additional barriers include concern about the cost of a sight test (20%), or of the cost of spectacles (17%). Only 23% of parents know that sight tests for children are paid for by the NHS.²²⁴

²¹⁸ Glaucoma: diagnosis and management of chronic open angle glaucoma and ocular hypertension. NICE, 2009 <http://www.nice.org.uk/CG85>

²¹⁹ Future sight loss UK (1): The economic impact of partial sight and blindness in the UK adult population RNIB, 2009

²²⁰ NICE, 2008. Guidance: Type 2 Diabetes, pp233-234. <http://www.nice.org.uk/nicemedia/pdf/CG66FullGuideline0509.pdf>

²²¹ RNIB, 2008b. Understanding Glaucoma.

²²² NICE, 2008. Guidance: Type 2 Diabetes, pp233-234. <http://www.nice.org.uk/nicemedia/pdf/CG66FullGuideline0509.pdf>

²²³ College of Optometrists, 2011. Britain's Eye Health in Focus: A study of consumer attitudes and behaviour towards eye health.

²²⁴ College of Optometrists, 2011. Britain's Eye Health in Focus: A study of consumer attitudes and behaviour towards eye health.

There is a need to raise awareness of particular issues that can affect the eyes, particularly amongst Asian and African-Caribbean groups, where there is a lack of awareness about their predisposition to certain eye conditions.²²⁵

Secondary Prevention Interventions

- People who are visually impaired should be supported to live healthy lifestyles that are adapted to their specific needs.
- Effective support services that will decrease the risk the risk of physical injury and decrease the risk of mental health issues.²²⁶
- Rehabilitation schemes that enable people to find employment, increase their independence and economic situation.

6.6.4 What are we doing - Examples of Local Good Practice?

- Cam Sight is a registered charity supporting 2,000 blind and partially sighted people within Cambridgeshire. Cam Sight works in partnership with a range of agencies including Cambridge University Hospital Foundation Trust, Cambridgeshire County Council; Cambridge City, South and East Cambridgeshire and Fenland District Councils; Anglia Ruskin University and local businesses. It represents visually impaired people on County Council bodies including those relating to training and of self-directed support. It provides countywide visual impairment services. Key services are:
 - Management of referrals from hospital to community services.
 - Provision of low vision aids aimed at increasing self – confidence and the prevention of injuries.
 - With the Supporting People Team, provide short term community support to increase client safety and avoid exclusion.
 - Rehabilitation work schemes.
 - Befriending schemes to decrease social isolation.
 - Braille training.
- The Supporting People Service helps individuals to meet a range of needs that contribute towards the retention of independence.

The following tables describe the outcomes of the Supporting People's Project that are overall positive.

Table 97: Figures as Percent Achieved of Supporting People's Initial Identified Capacity

	2008-2009	2009-2010
SPI 2 Utilisation levels	357.69	406.25
SPI 4 Throughput	562.50	206.25
NI141 Independence	100.00	103.03

Source: Cambridgeshire County Council performance monitoring workbooks.

²²⁵ College of Optometrists, 2011. *Britain's Eye Health in Focus: A study of consumer attitudes and behaviour towards eye health.*

²²⁶ University of Reading, 2009

Table 98: Percent of Those Who Achieved Positive Outcome of their Perceived Need

	2008-2009	2009-2010
Maximising income	96	93
Employment	50	50
Accessing education	34	67
Leisure	83	100
External groups/ family	69	85
Emotional Wellbeing	74	79
Assistive tech./aids	89	95
Housing	No need identified	No need identified
Choice & control	88	77

Source: Supporting People Programme.

What is this Telling us?

6.6.5 What are the Health Inequalities?

- People who have a visual impairment are more likely to experience socio-economic hardship associated with poorer health outcomes.
- Poor mental health, especially depression, is associated with people who become visually impaired.
- People who smoke and have a poor diet are more likely to compromise their vision

6.6.6 Gaps in Services/Knowledge/Areas of Development

- There are a range of services in Cambridgeshire that are designed to meet the specific needs of people with visual impairment. Of the estimated 14,000 people visually impaired in Cambridgeshire a clearer understanding of the numbers of people who are visually impaired, who are currently not receiving appropriate support is required ie the unmet needs. This needs to include accessibility especially for those living in rural areas.
- The proportion of the Cambridgeshire population who are visually impaired is not known because they are wearing inappropriate refractive correction.
- There is no robust knowledge of the proportion of Cambridgeshire adults that have not been for a sight test within the last five years (since these sight tests are largely private).
- The College of Optometrists and Royal College of Ophthalmologists are currently working on a project to help public health commissioners understand what outcomes are important in eye care and what services will provide the best results and value for money. Proposals will initially be published on glaucoma and minor eye condition services.

6.7 Domestic Violence

What do we Know?

6.7.1 Introduction

- The Home Office defines domestic violence as:

“Domestic violence is any incident of threatening behaviour, violence or abuse (physical, psychological, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.”²²⁷

- The Cambridgeshire Crime Research Team found that:

“Police recorded crime data is likely to be a gross underestimate of true levels of victimisation caused by domestic violence.”²²⁸

The document categorically states that all figures should be considered as under-estimates.

- Domestic violence can produce short and long term effects upon health. These include initial physical injuries and sexual problems and in the longer terms ongoing psycho-sexual, mental and emotional health problems. In addition it can create, for the victim, social and economic issues that in turn can have an adverse effect upon health.

6.7.2 Figures and Trends

- British Crime Survey data and Home Office estimates suggest that 15,173 women aged 16-59 were victims of domestic abuse in Cambridgeshire in 2010/11 – a figure considerably higher than the current number of individuals reporting to the police during the same period (7,718 reports).
- In the period 2005 – 2009, the number of incidents reported to the police rose by more than 41.9%;²²⁹ subsequently, the number of victims accessing services has risen dramatically. For example, the Independent Domestic Violence Advocacy Service received 324 high-risk referrals from the Constabulary in 2005. In 2008/09 that figure was 1,536 (an increase of 377%).
- A recent review (April 2011) of the data from the Independent Domestic Violence Advocacy Service continues to show an increase in reporting on domestic abuse to the Constabulary.
- The increase in reporting to police has also led to an increase in DV-related referrals to Children Services and an estimated increased reliance on health providers:
 - Between 01/07/2009 and 30/06/2010, the Children’s Services Contact Centre received 10,250 DV-related referrals for children and young people at risk.
 - It is estimated that between January 2008 and June 2009, 34.2% of all those children and young people subject to a child protection plan had domestic abuse as the primary issue.
 - It is further estimated that 31.7% of all Children’s Social Care contacts between September 2008 and August 2009 were for domestic-abuse related issues.²³⁰

²²⁷ Home Office, 2005.

²²⁸ Cambridgeshire Crime Research Team, *The Cost of Domestic Abuse in Cambridgeshire, 2005*.

²²⁹ Domestic Abuse Force Profile, Cambridgeshire Constabulary, 2009.

²³⁰ Cambridgeshire County Council, 2009.

- Recent research undertaken on behalf of the Cambridgeshire Adult Safeguarding Board has shown that domestic abuse is prevalent in 68% of referrals for violence to the Safeguarding of Vulnerable Adults process.
- Cambridge City Council also states that 14.28% of all statutory homeless applications in 2009 were caused by domestic abuse.²³¹
- Cambridgeshire's Multi-Agency Risk Assessment Conferences, which risk-assess and safety plan for those at most risk of homicide, heard 400 cases (involving 700 children) in 2009/10.
- 33% of respondents in the Year 8 and 10 Health Related Behaviour Survey in 2010 indicated the presence of domestic abuse issues in their home environment.
- 100% of the past ten LSCB Serious Case Reviews have identified domestic abuse as a key contributing factor.
- At least 75% of looked after children and 50% of children subject to a Child Protection Plan in Cambridgeshire have domestic abuse backgrounds.²³²

The Health and Financial Impact of Domestic Violence

Work has been undertaken nationally to show the effects and costs of domestic abuse to health agencies. These studies show that:

- In 2005, the cost of Domestic Violence to the NHS nationally was £1.2 billion.²³³
- 50% of women in contact with mental health services have suffered abuse/violence.²³⁴
- Domestic violence is the most common cause of depression in women.²³⁵
- Women in abusive relationships are admitted to hospital more frequently and are in receipt of more prescriptions than other women.²³⁶
- 64% of abused women suffer post-traumatic stress disorder against 1-2% of non-abused women.²³⁷
- Domestic violence is a factor in 49% of suicide attempts by Black, Minority, Ethnic (BME) women, and 22% of attempts from White communities.²³⁸
- More than 14% of maternal deaths occur in women who have disclosed DV to their health providers.²³⁹
- 40-60% of women experiencing DV are abused while pregnant.²⁴⁰
- At least 1% of all emergency department visits in the UK are attributable to domestic abuse.²⁴¹

6.7.3 Local Views

The Cambridgeshire Domestic Abuse Partnership works with Service User Sub-Groups (SUGS) facilitated by Voluntary Sector partner agencies (Cambridge Women's Aid and Refuge) to ensure that services are meeting need and that future planning is appropriate.

²³¹ Cambridge City Council, 2010.

²³² Cambridgeshire County Council/LSCB, 2010.

²³³ Department of Health, *Responding to Domestic Abuse (2005)*.

²³⁴ Greater London Domestic Violence Project, *Sane Responses (2008)*

²³⁵ Ibid.

²³⁶ Ibid.

²³⁷ Ibid.

²³⁸ Ibid.

²³⁹ Department of Health, *Responding to Domestic Abuse (2005)*.

²⁴⁰ Ibid.

²⁴¹ Boyle, Kirkbride and Jones, *Record Linkage of Domestic Abuse Assault Victims Between an Emergency Department and the Police (2005)*.

Community Safety Partnerships also use public consultations to determine priorities for their Districts, which frequently include addressing domestic abuse. The main findings from their consultations can be summarised as follows:

- agencies should promote positive images of survivors to encourage reporting;
- agencies should provide a range of referral/care pathways to encourage disclosures;
- agencies should sanction offenders outside of Criminal Justice System where appropriate;
- agencies should take learning from survivors to support the development of services and policy in the future;
- more specialist services are needed.

6.7.4 Evidence

Local and national evidence has proven that specialist interventions, such as those provided by the Independent Domestic Violence Advocacy (IDVA) Service, are an effective way to safeguard, reduce repeat victimisation and reduce both human and agency costs. Recent national research, delivered through Hestia <http://www.hestia.org/> supports the above assertion, and shows that IDVA intervention:

- Increases the safety of clients and decreases the likelihood of repeat victimisation.
- Increases the likelihood that perpetrators will desist in their abuse.
- Decreases costs to agencies, especially Police, Health and Housing.²⁴²
- On average, each IDVA costs less than £500 per victim supported.

6.7.5 What are we doing in Cambridgeshire - Examples of Good Practice?

Member agencies of the Cambridgeshire Domestic Abuse Partnership work to an internationally recognised model of intervention known as the 'Community Coordinated Response' model and the Partnership is responsible for implementing Central Government's 'End Violence Against Women and Girls (VAWG)' strategy through its multi-agency countywide strategy. Professionals from all disciplines are trained in addressing domestic abuse through a training strategy that is LSCB accredited.

Case Study

- Cambridgeshire's Independent Domestic Violence Advocates (IDVA) are trained to a professional Coordinated Action Against Domestic Abuse (CAADA) level.
- 6,928 incidents were recorded by police in Southern Sector in 2009/10, 984 were referred to the IDVA service in Cambridgeshire. Of these 984 referrals, 176 went on to become repeat victims in the same 12-month period. This means that for the 808 IDVA referrals where there was no repeat incident recorded by the police.
- Very recent research undertaken through the Emergency Department at Cambridge University Hospitals Foundation Trust Hospital, Cambridge, has shown a 38% reduction in repeat attendances at the Emergency Department following an IDVA intervention.

²⁴² Safety in Numbers: A Multi-Site Evaluation of IDVA Services, Hestia Fund, 2010.

6.7.6 What are the Key Inequalities?

Several key inequalities for those affected by domestic abuse are evident in Cambridgeshire. These are:

- Lack of appropriate and accessible services across the county for children and young people (both as victims and perpetrators) of domestic abuse.
- Lack of services for female victims of domestic abuse from A8 nations (Central And Eastern European countries, Gypsy/Traveller/Roma and other Black Minority Ethnic communities).
- Lack of services and appropriate access to services for those with no recourse to public funds across the county.
- Lack of appropriate support for victims and offenders through 'Health' providers across Cambridgeshire in comparison with other counties nationally.
- An increased likelihood of being a victim of a domestic abuse-related crime in Fenland as opposed to the other four Districts.
- Reduced access to a specialist intervention programme for those who use violence in their relationships for residents outside of Cambridge City.
- A disproportionate number of LAC and children subject to a Child Protection Plan have domestic abuse backgrounds.
- A disproportionate number of women from A8 background are victims of domestic abuse in Cambridgeshire.
- A disproportionate number of teenage mothers are victims of domestic abuse across the county.
- As the new 'End Violence Against Women and Girls' agenda progresses, and domestic abuse is recognised as a public health/wellbeing issue in addition to a criminal justice issue, more progressive partnership working will be required to address the above inequalities.

6.7.7 What are the Gaps in Knowledge/Services/Areas for Development?

- There are significant gaps in knowledge relating to domestic abuse in Cambridgeshire. Key agencies do not routinely record domestic abuse issues appropriately. It is difficult to assess the impact of addressing domestic abuse within these agencies. Data processes regarding the prevalence of domestic abuse require improvement across all agencies to establish a more accurate picture of the prevalence, risk and associated costs of addressing domestic abuse issues.
- Relying on police and IDVA/Multi-Agency Risk Assessment Conferences (MARAC) data alone is inadequate to address domestic abuse in the county effectively, as national and local research indicates that the majority of victims do not report their issues to the Constabulary.²⁴³
- A lack of local knowledge has also hindered the commissioning of services for:
 - Children and young people;
 - Those from A8 communities;
 - Those victims and perpetrators with additional health and social needs.

²⁴³ Cambridgeshire Crime Research Team, *The Cost of Domestic Abuse in Cambridgeshire* 2005 and House of Commons Library, *Domestic Violence Statistics* 2010.

- Cambridgeshire's domestic abuse services are mapped against the Local Government Framework for 'excellent' domestic abuse services. This has shown that, although Cambridgeshire is well on its way to achieving 'excellent' services for most adults, significant gaps remain around provision for children and young people, those from BME groups and those with no recourse to public funds.

7. VULNERABLE GROUPS

This section looks at the prevention needs of vulnerable groups. Key points have been extrapolated from existing JSNAs that have been undertaken for these groups and the commonalities are indicated. Please refer to the JSNA website for the full JSNA for these groups. (www.cambridgeshirejsna.org.uk)

7.1 Vulnerable Adults of Working Age

What do we Know?

7.1.1 Introduction

This section has collated information on four groups of vulnerable adults of working age. This following information has been sourced from the following JSNA documents which are accessible online (www.cambridgeshirejsna.org.uk):

- *Migrant Workers in Cambridge JSNA (2009)*
- *Homelessness and at risk of Homelessness JSNA (2010)*
- *Adults with Learning Disabilities JSNA (2007)*
- *Travellers JSNA*

Migrant workers are not a homogenous group. International migrants in Cambridgeshire come from all over the world with different socio-economic backgrounds. They provide much needed labour and skills for local business as well as vital public services. The migrant workers JSNA reports on those coming to the UK from the A8 states to take up work, as well as the greater availability of data relating to the working migrant population.

Homelessness describes a wide range of circumstances where people have no secure accommodation. Being at risk of homelessness can have wider implications for an individual's health, employment prospects and education. The JSNA recognises three overlapping groups of homeless people; 'single homeless and rough sleepers' (SHRS), 'statutory homeless' and the 'hidden homeless'. The JSNA has particularly focused on the SHRS population as this group have the poorest outcomes in Cambridgeshire.

Learning Disability is defined by The Department of Health as 'a state of arrested or incomplete development of mind that includes significant impairment of intelligence and social functioning'. People with learning disabilities are amongst the most vulnerable and marginalised people within Cambridgeshire. Few have jobs, live in their own homes or have control over their lives. The compounding impact of disability, health inequalities and social deprivation affects health, wellbeing, opportunity and outcomes for adults.

Gypsies and Travellers - the definition varies for housing, planning and education purposes. The Gypsies and Travellers living in the UK are made up of many different communities including Romany Gypsies, Irish Travellers, Scottish Travellers, Welsh Travellers, New Travellers, Travelling Showpeople, Bargees and Circus People. Romany Gypsies and Irish Travellers are recognised as ethnic groups, but the other groups are not.

Accurately identifying the Gypsy and Traveller population is difficult as this largely depends on self classification and there may be particular issues around the fear of being identified as a Gypsy or Traveller and negative consequences associated with this.

7.1.2 Figures and Trends

Overall

Each of the above vulnerable adult groups of working age have similar needs, namely; access to good quality housing and knowledge of and access to health, mental health and substance misuse services.

Although each of these population groups has heterogeneous features, they are at significant risk of marginalisation, social exclusion and poorer health outcomes compared to the general population in Cambridgeshire.

Migrant Workers

Cambridgeshire has among the highest number of migrant workers in the East of England. Within Cambridgeshire, Cambridge City has the highest number of work-related migrants overall while Fenland and East Cambridgeshire have particularly high numbers of migrants from the A8 countries (Central And Eastern European countries, Gypsy/Traveller/Roma and other Black Minority Ethnic communities).

The 2001 Census showed that 9% of Cambridgeshire's population were born outside of the UK, of which 34% were born in Western Europe, 24% were born in Asia and 20% were born in America. There was a rapid increase in migration from the A8 countries following EU expansion in 2004. The majority of A8 migrants are young adults with low numbers of dependents. International migration across Cambridgeshire is diverse reflecting seasonal employment opportunities and different sectors of work

Wider Determinants of Health

- Housing has an important influence on people's health. The housing report from the Migration Impacts Forum (2008) states that access to good quality and affordable accommodation is critical in providing stable circumstances for migrants to be economically active and in promoting community cohesion. The housing report indicates that the majority of migrants are living in privately rented or tied accommodation. The numbers of migrants living in houses in multiple occupation has also increased locally, especially in Fenland. This type of accommodation is often of low quality and overcrowded.
- The availability of English language provision is key. Evidence suggests that English language learning has a significant and positive impact on individuals, communities and the productivity and safety of workplaces with lack of fluency in the language condemning many to poverty.
- Although the impact of migrant workers has many positives, large social changes can occur which can alter community cohesion. There is little evidence of the increase in the number of migrants generally leading to problems with community safety or cohesion, but the perception of the indigenous community in some areas can be negative.
- Migrants that are employed as shift workers in these occupations, receiving relatively low earnings, are a group of migrants probably most likely to have limited access to healthy lifestyles or to experience socio-economic disadvantage and poor housing conditions. Poorly designed shift working arrangements and long working hours that do not balance the demands of work with time for rest and recovery can result in fatigue, accidents, injuries and ill health.

Morbidity and Mortality

- Registration at general practices is low amongst migrant workers, especially those from the A8 countries.
- Existing evidence suggests that foreign vehicles cause a disproportionate number of road accidents. Cross border driving rates were reported to be increasing.
- Risk of poor mental health for migrant workers largely depends on immigration conditions and UK living conditions. There are mental health conditions which are more common in non-UK populations and certain migrant groups. Barriers to diagnosing mental health conditions include cultural differences, language barriers and a lack of knowledge about services.
- Barriers to accessing substance misuse and alcohol services included language and lack of knowledge about what help is available. Other services in the East of England describe complex needs around drug misuse including racial discrimination, exploitation, poor working conditions, unemployment, social and economic exclusion, difficulty accessing services and language support, poor family backing and social networks and pre-conceptions of treatment.

Homelessness

The number of households accepted as homeless both in Cambridgeshire and nationally is dropping. However, the economy and state of the property market has led to increasing numbers of households being at risk of homelessness. The registered population of Cambridge Access Surgery is around 500 and the majority of people presenting to services for the homeless are white British males aged 26-49. Data on homelessness is collected by numerous service providers, therefore there is presently no robust way of identifying service users.

Wider Determinants of Health

- Homelessness is a complex issue and a number of interlinked personal and social factors can contribute; there is rarely a single explanation for someone becoming homeless.
- The need for housing is a common issue among the homeless client groups; most homeless people are initially assigned to live in temporary accommodation or live in poor quality housing.
- Homeless people generally experience difficulties with accessing health services; this poor access also impacts on their health status.
- The most common needs recorded for people accessing Supportive People services are stated as support to maximise income, support to maintain accommodation and avoid eviction, support to access external groups and services, and support to better manage substance misuse. The main reported reasons for these needs not being met are in relation to the client being unwilling or unable to engage or ceasing support before the outcome has been achieved.

Morbidity and Mortality

- Homeless people are much more likely to die prematurely than people who are not homeless; in Cambridgeshire the mean age of death is 44 (which is comparatively very poor compared to the rest of the Cambridgeshire population).
- Compared to the general population, homeless people experience poorer health outcomes. Physical health, drugs, alcohol, mental health and wellbeing have been recognised as priority health issues among the homeless.

Learning Disabilities

- Although the diagnosis of learning disabilities is not an exact science, across the total UK population 2% of adults are estimated to have some form of learning disability. In Cambridgeshire this corresponds to around 10,000 people aged 15 and above. It is estimated that 1,980 adults of working age with learning disabilities receive support or services through the County Council (assuming local service provision patterns reflect national patterns).
- Cambridgeshire's population is forecast to grow by around 16% between 2006 and 2021; the number of people with learning disabilities is expected to increase in line with this forecast. Although there will be an increase in people of all ages with learning disabilities, the greatest increase will be among those aged over 45.

Wider Determinants of Health

- 52% of service users are male, which correlates with the male gender bias estimates of adults with learning disabilities nationally.
- There is a notable high proportion of 20-24 year old service users with learning disabilities; this is a younger age profile compared to the overall Cambridgeshire population.
- Travellers represent the largest single ethnic minority group in Cambridgeshire making up about 1% of the population. There is a much higher than national prevalence of learning disability in the Traveller community
- The demand for quality housing and support is increasing
- People want the right to paid employment but need information, support, training and opportunity to achieve their goals. People with learning disabilities experience significant barriers in accessing paid work and numbers in paid employment are low

Morbidity and Mortality

- People with learning disabilities and their carers have experienced significant health inequalities, barriers to mainstream services, and have significant risk of major health problems.
- People with learning disabilities are more likely to experience significant health risks and health problems; particularly obesity and respiratory diseases.
- The age-specific prevalence rate of learning disability service users shows a general decline in prevalence as age increases, reflecting the lower life expectancy of people with some learning disabilities (such as Down's Syndrome).

Gypsies and Travellers

Gypsies and Travellers make up almost 1% of the population in Cambridgeshire representing the largest ethnic minority in the county. In Cambridgeshire it is estimated that approximately 70% are Romany Gypsies, 20% are Irish Travellers and 10% are others including Scottish and Welsh Travellers and an increasing number of Eastern European Gypsies.

The numbers of Gypsies and Travellers in the population is difficult to ascertain and there is often significant underreporting of service use and outcomes as organisations may not include Gypsies and Travellers in their ethnic monitoring, coupled with the need for the subjective definition of ethnicity and reluctance to declare ethnicity for fear of discrimination.

Wider Determinants of Health

- There is little research or consultation relating to Gypsies and Travellers and skills and employment. What existing research does suggest is that there is a strong preference for self employment among communities and there is a broad skill base that goes unrecognised. A reduction in some employment opportunities traditionally filled by Gypsies and Travellers has been highlighted and there is evidence of high levels of unemployment among those living on local authority sites.
- There is evidence of economic exclusion in the Gypsy and Traveller population and locally concern has been raised locally about access to affordable utilities. Other issues include problems with securing finance due to having no fixed abode or varied employment. In common with other vulnerable groups, lack of literacy and numeracy may impact on household budgeting skills and awareness of rights and benefits.
- In January 2009 there were 414 self-ascribed Gypsy/Roma and 88 self-ascribed Irish Traveller pupils in Cambridgeshire, comprising respectively 0.5% and 0.1% of the total school population compared with 0.2% nationally for both groups.
- In Cambridgeshire, data for 2009 across all phases (Foundation Stage, KS1, KS2 and KS4) shows performance of Gypsy, Roma and Traveller pupils as consistently trailing, with little evidence of narrowing the gap with the county average.
- Figures for Cambridgeshire in 2008/09 show that 81% of **all known** Gypsy, Roma and Traveller children and young people accessed education in county schools at some point during the year. There is a significant number of secondary school aged Gypsy, Roma and Traveller young people in Cambridgeshire, not accessing secondary school provision. Attendance figures are in line with those nationally for these groups but well below the national average for all pupils.
- Locally, there is experience that the Gypsy and Traveller community lack confidence and knowledge about how to access services such as health and social care and there is a tendency not to ask for external agency support.
- The Gypsy and Traveller community has different accommodation needs to the settled community, however, as with the settled community the type of need varies. Although travelling is recognised as part of their cultural heritage, not all Gypsies and Travellers actually travel.
- Many of the county's Gypsy Traveller population choose to live in housing. Whilst some live on authorised sites, which may be socially or privately rented/owned, others may live on unauthorised sites when authorised sites are not available. The 2005 Traveller Needs Assessment estimated that 58% of households live in caravans and 42% live in settled housing.
- Lack of secure accommodation is the biggest issue facing Gypsy and Traveller communities in the East of England and many are homeless. Eviction and enforced mobility are key factors preventing access to education, healthcare, training and work opportunities.
- Nationally it is reported that within the criminal justice system there is a process of accelerated criminalisation at a young age, leading rapidly to custody. Locally accurate figures of numbers of Gypsies and Travellers in the prison and youth offending populations are difficult to obtain due to the current method of ethnic monitoring. Therefore, assessing inequalities in comparison to the general population becomes difficult.

Morbidity and Mortality

- There is a wealth of local and national evidence which reports the poor health status of Gypsies and Travellers. A lower life expectancy, higher infant mortality rate, poorer health outcomes and poorer access to preventative care is found in the Gypsy and Traveller population compared to the general population and there is evidence that mental health problems are more widespread.
- There are issues around access to health services and lack of cultural awareness among healthcare staff impacts on this. There are particular issues around encouraging men to access health services. Male Gypsies and Travellers are reluctant to discuss personal issues with the women in their family network and will not access health services until the problem is severe
- Literacy problems may cause difficulties with reading communications such as hospital appointments/results and public health information.
- In Cambridgeshire, poor mental health is a particular concern. Lifestyle risk factors such as rates of smoking and obesity are higher in the Gypsy and Traveller community than the rest of the general population.

7.1.3 Local Views

Overall

A variety of methods were employed to engage the local views of migrant workers, the homeless and those with learning disabilities to produce their respective JSNAs. There are similarities across the JSNAs on migrant workers and learning disabilities. Both have reported local views and concerns regarding housing and working conditions. Parallels also exist between the homeless and learning disability JSNAs in regards to obtaining on-going support to achieve their goals (such as accommodation, training and employment).

Local Views of Migrant Workers

- In 2009 a longitudinal study of migrant workers in the East of England noted that many had experienced several changes of address in the region. Experiences of poor quality housing were relatively common and concerns exist about overcharging.
- The migrant workers JSNA noted in the East of England, one-third of employers felt migrant workers were at greater exposure to health and safety risks, whereas two-thirds felt that they faced the same risks. Risk was noted to be heightened by migrants who had difficulties with language, both to communicate with other workers and with supervisors. A Trade Union Survey agreed with the perception that migrants were at greater exposure to health and safety risks.
- The Institute for Public Policy Research (IPPR) identified that migrant workers are a highly diverse group in terms of their qualification and skills, yet almost all migrants interviewed identified better opportunities for employment and greater earnings potential as their reasons for migrating. Most migrants reported positive experiences of life in the East of England. However, many migrants reported being dissatisfied with their working conditions and held particular concerns about employment agencies.

Local Views of Homelessness

- Generally there appears to be limited involvement of the homeless population in developing and evaluating local services. The Cambridge City Homeless Strategy consultation involved current and former users of homelessness services. Key issues were the need for on-going support, especially around transition periods, communication and easier access to a range of accommodation, training and information.
- Other examples of obtaining views of the homeless population include:
 - Public consultation on the alcohol service specification for Cambridgeshire.
 - Winter Comfort engagement with the homeless regarding this service as well as frontline homeless service staff.
 - A patient and stakeholder survey undertaken by Cambridgeshire County Council Community and Adult Services (CAS), in 2007 which reported high levels of satisfaction with the service.

Local Views of Learning Disabilities

- Consultation with people with learning disabilities and their carers regarding their health indicated concerns exist about inadequate provision of advice and information, lack of facilities within and access to primary and acute care, and little awareness about the needs of people with learning disabilities. The views and experiences of local staff working have also been highlighted.
- Local consultation about housing with people with learning disabilities and national evidence agree that people want a secure and homely place to live, to live alone or with people whom they choose and like to be with, and want to have sufficient levels of support to live full lives in their local community.
- A Cambridgeshire Parliament noted that people with learning disabilities want the right to paid employment but need the information, support training and opportunity to achieve their goals. Furthermore, research in 2007 undertaken by the Papworth Trust highlighted that people with learning disabilities experienced significant barriers in accessing paid work and numbers in paid employment were low.

Local Views of Gypsies and Travellers

Over the last five years there has been extensive consultation with the Gypsy and Traveller communities in Cambridgeshire.

- A number of surveys have identified accommodation issues. There is a pressing need for more sites of all kinds and that the preference was for small, self-owned long-stay sites for family groups, preferably on the edge of a village, near established Gypsy and Traveller communities. Views were expressed about not being located immediately adjacent to existing housing to avoid potential problems between the two cultures. It was found that threat of repeated eviction was experienced by some children on unauthorised sites and contributed to children's insecurity and vulnerability.
- The main health and wellbeing issues expressed were difficulties obtaining permanent registration, a lack of awareness of Travellers on health issues and the health system, a lack of information in an appropriate format and a lack of awareness among health professionals on Traveller culture.
- A preference for self-employment amongst Gypsies and Travellers was expressed. A decline in traditional farm work and increased competition has made it increasingly difficult to make a living from traditional occupations, contributing to severe economic disadvantage and social exclusion.

- Some Gypsies and Travellers were motivated to ensure their children attend school to equip them for the future. However, a lack of interest in formal education was also expressed due to factors such as alienation at school, accommodation problems, negative experiences, concerns regarding the educational curriculum and cultural practices.
- It was identified that Gypsy and Traveller children valued opportunities for learning, but some children felt strongly that school wasn't always the best environment in which to learn. Concerns were expressed around racism and lack of representation within the school curriculum and learning resources.
- Children expressed concerns about their environment such as location, lack of safe play spaces/facilities and distance/isolation from local communities. Many Gypsy and Traveller children live without the levels of safety and security which most UK children take for granted.
- Racism has been identified as the single biggest problem Gypsy and Traveller children face. Misunderstanding about the nature of their identity and reluctance to reveal ethnicity for fear of bullying are particular concerns. Children expressed a constant expectation of racism and many had been exposed to racially motivated threats or attacks. It was found that Gypsy and Travellers have negative attitudes towards the police and a reluctance to report incidents to the police. Negative attitudes towards the media were also expressed.

7.1.4 Further Information

Further information regarding evidence, good practice, key inequalities and gaps in knowledge and services for migrant workers, the homeless, those with learning disabilities and the gypsy and traveller community are outlined in their respective JSNAs.

Please visit the website www.cambridgeshirejsna.org.uk to access these JSNAs and other relevant information.

Gaps in Information/Services/Areas for Development

The consistent factor common to these groups is the inequalities in health that these groups experience. These reflect a wide inter-related range of issues that directly affect their health and also their ability to adopt a healthy lifestyle. There are some good examples in Cambridgeshire of initiatives designed to meet their particular prevention needs. However there is a need to fully understand how these projects can be fully exploited not only to address the immediate health and social needs but also start to address prevention through education and skills building eg cookery courses or sex and relationship education for people with learning difficulties.

8. COMMUNITY CONSULTATION

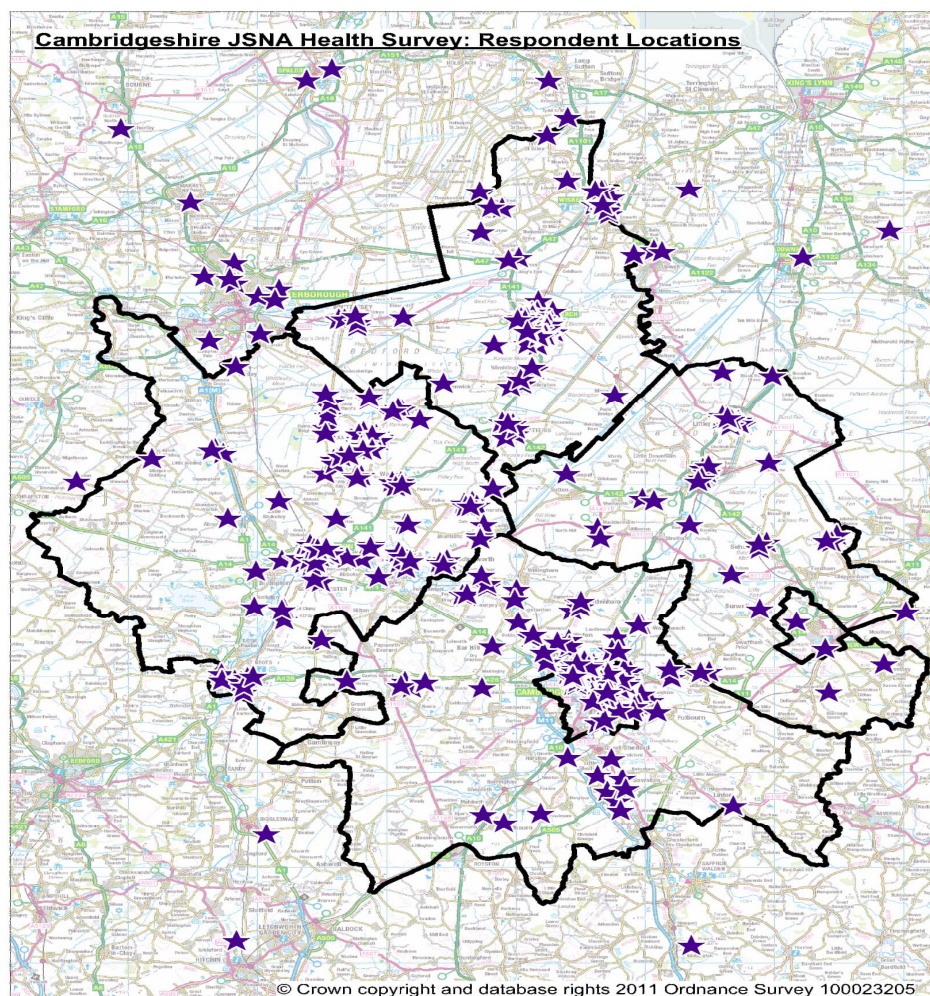
Summary of Community Consultation See Appendices

The Prevention of Ill Health in Adults of Working Age is the first JSNA that has used a bespoke process to secure the views of the population. This has involved collecting views in a number of different ways, for example through an online questionnaire and by attending neighbourhood panels.

The JSNA Survey was put online in early July 2011 and ran until the end of August 2011, and publicised across the county in neighbourhood panels, libraries, Patient Advice and Liaison Service (PALS) roadshows, and through the use of bespoke focus groups. In addition, paper versions of the survey were circulated to a number of locations. A total of 817 completed surveys were returned, of which 738 were paper-based.

Discounting those who chose not to complete the personal information section of the questionnaire, 69% were female, and 28% male. 82 respondents (10%) were aged under 25, with 322 (39%) falling into the 25-44 age group bracket, and 297 (36%) within 45-64 years of age. 93 (11%) were aged 65 or over. With regards to ethnic origin, 88% of respondents who chose to give their ethnicity recorded themselves as being white (British). Six respondents identified themselves as being a Gypsy or Irish Traveller. 666 respondents left an accurate postcode and their locations are outlined in the following map.

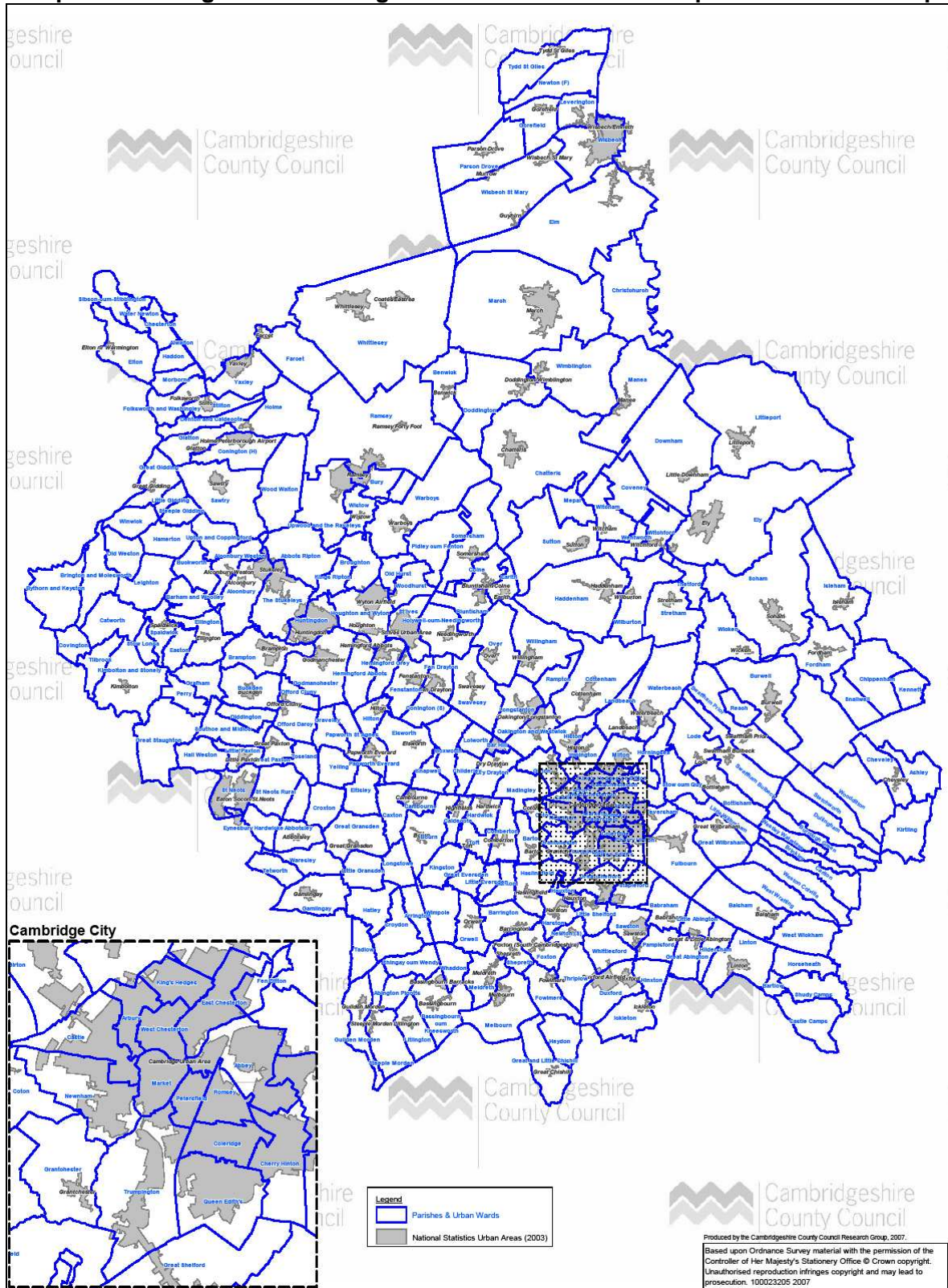
Map 11: Cambridgeshire JSNA Health Survey Respondent Locations



In addition Cambridgeshire Acre was commissioned to run four focus groups as a further mechanism for collecting community views. A total of four focus groups were run, two in Fulbourn and two at Wisbech during September 2011. A total of 37 people took part in the focus group split into 25 people participating in Fulbourn and 14 in Wisbech.

15 of those took part were male. There was a reasonable spread of ages with the category most represented being 45-64 age group (22 out of the 37), next was people aged 65 and over (10 participants), then those aged 25-44 (four participants) and also one participant in the 16-24 age group. All those who took part identified themselves as White British. The map below indicates the postcode location (red star) of those taking part.

Map 12: Map of Cambridgeshire Showing Home Postcodes of Participants in Focus Groups



Produced by the Cambridgeshire County Council Research Group, 2007.
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 prosecution. 100023205 2007.

The following provides an overview of the key issues and commonalities identified in both approaches. However it should be noticed that the focus group numbers were relatively small. The full reports of the Survey and Focus Groups can be found in Appendix 1 and 2.

Both the survey and focus groups demonstrated that communities have a good understanding of the range of factors that can influence people's health. Around 90% of participants in the survey and focus groups saw lifestyles as being critical factors in preventing ill health. Smoking, physical activity, type of food and alcohol are seen as the main influencers. However, stress and mental health and wellbeing were clearly seen as an important consideration. The underlying social and environmental pressures that create stress being the root causes.

Around two thirds of the survey respondents saw the wider determinants of health as contributing to health. The exception was homelessness, with 87% of the survey respondents seeing this as an important factor. The focus groups explored the relationship between the wider determinants of health and lifestyles in more depth. The economic climate was seen as creating many financial, employment and family worries and stress. It was suggested that the stress prevented people taking positive action to improve their health.

Access to prevention services might improve health but the initial challenge was to get people to use them. There was an acknowledgement that changing and maintaining behaviour is challenging due to self perceptions and requires support services. The family environment was seen as key for embedding healthy behaviours.

However, there was a strongly held view that healthy behaviours were inter linked and symptoms of wider factors. For example, homelessness could be a symptom of low educational attainment, followed by unemployment or low income, coupled with high rents.

Overall, there was general agreement that some ill health can be prevented. The focus groups expressed the viewpoint that people feel that they have the opportunity to make choices. However, the societal pressures of lack of education, lack of motivation and restricted income, were seen as factors affecting people's ability to take positive action.

From the Survey respondents, 45% strongly agreed that people should look after their own health, with a further 43% tending to agree with the statement. 545 of those 817 chose to elaborate further on their opinion, and for the most part it was emphasised that people had a responsibility to take care of themselves. Similarly, in the focus groups there a strong feeling that people should look after their own health with only one person disagreeing.

Just under 39% felt strongly that people should be helped and supported to remain healthy and to prevent illness. Only 2% - 19 people - disagreed with this concept. As highlighted above, it was felt that it was important for people to have the right information if they were to be able to help themselves. Concern was raised around the capacity of an individual to avoid illness or to look after themselves – many raised issues such as hereditary illnesses, disabilities, and age as factors that affected how far people could act independently. It was also felt that offering preventative support would motivate those less likely to take steps to improve their own health – *“Having support can make a huge difference as people do not always have the motivation to remain healthy or the means by which to do so.”* Many respondents referred to the importance of early education in schools.

All those who took part in the focus groups thought that support should be provided to help people to be and remain healthy. The provision of information and the promotion of healthy lifestyles by the Government and/or the NHS was seen as an important element of support to people when they are making choices.

Whilst it was felt that appropriate education and facilities would always need to be provided, there was a strong sense that *“improving health has to be a joint effort between the individual and the NHS”*, and as such it was the individuals’ responsibility to care for themselves, and to know when to seek help – and that money should not be “wasted” on those unwilling to follow advice. The focus groups acknowledged that some people do not want to and cannot be forced into looking after their own health and they cannot be forced into this.

The survey asked respondents about their awareness of local services and the importance they placed on them with regards to health benefits. The following services were listed:

- GPs and nurses
- Citizens Advice Bureau
- Local Housing Services
- Local Leisure Services that provide opportunities for physical or sporting activity
- Healthy eating and cooking programmes
- Adult Education Services
- Skills Development/Retraining Schemes
- Employment Services
- Weight loss Schemes
- Stress management/Schemes to improve mental wellbeing
- Other mental wellbeing services
- Stop Smoking services
- Alcohol Services
- Workplace schemes that support healthy lifestyles

The focus groups discussed the services that they identified. There was concern around funding that had been cut or insufficient to meet demand. Healthy eating and cooking programmes had been lost, there is a lack of prevention programmes for alcohol misuse. Services to address mental ill health were seen as essential in their role help people develop resilience against unhealthy behaviours such as drug and alcohol misuse. The Survey found other mental wellbeing services’ (52%) and stress management schemes (56%) were services that people were least aware of being provided.

Stop smoking services were well known but their success was thought to be a result of legislative and societal attitudes. A similar legislative approach to alcohol misuse was recommended.

There was concern about the cost of specific lifestyle services loss schemes were. Weight loss schemes were seen to be widely available but the commercial schemes were seen as being expensive and more concerned with weight loss than lifestyle change. Similarly leisure services were expensive even when exercise had been prescribed as part of GP referral scheme.

In the Survey, GP and nurse services were considered to be important by more people than others, with 680 people judging them to be of importance. Most Focus Group participants were aware that general practices offered prevention services such as screening. However, there was concern that this excluded those who were well or not registered with a practice. In addition, getting and short appointments along with fact that many participants felt that GPs were not giving advice in a manner that engaged their patients.

In the Survey, 406 people (less than half) felt that skills development and retraining schemes were important in preventing ill health. Early education was again mentioned as being an important service, with others discussing the importance of weight loss schemes as a preventative measure. There were concerns amongst the focus groups for the services that

support economic and social wellbeing. Considerable negativity was expressed about employment services and their ability to help people find employment. Adult education services were seen as focussing upon hobbies rather than skills for work. Local Housing Services were hampered by a shortage of housing, long waiting lists and too few new houses being built. The Citizens' Advice Bureau was seen as an excellent service but it is currently suffering acutely from being unable to meet demand.

In the Survey, the majority of people were least aware of 'workplace schemes that support healthy lifestyles' (50%). Participants in the Focus Groups thought that only large scale organisations would be able to provide this type of scheme. There was concern that in Cambridgeshire there is a high proportion of small-scale employers for whom workplace schemes would not be a priority of feasible. Public Sector employers have a good track record for providing workplace schemes. There was widely expressed view that in harder economic times these schemes are seen as less important by employers. Redundancies meant a smaller workforce and an increase in everyone's responsibilities.

A recurrent theme in the Focus Groups and Survey was that there were economic barriers to people accessing prevention services. In the Survey, the cost of services was judged to be the most significant barrier to services, with 80% considering it to have an effect (654 people). Less than half of respondents felt that having not used a service before might deter people from using it. 140 people went into further detail.

In the Survey, 70.4% of respondents saw weight related issues as being an area for effective prevention although issues around high blood pressure, heart problems, and smoking-related cancers and hearth and lung problems were raised. Just under 10% of respondents referred to mental health problems; these ranged across various issues such as depression, addictions, and stress.

The Focus Groups were asked to identify which contributed the most to prevention. The three services that attracted the most support were: mental wellbeing schemes, Citizens Advice Bureaux and local leisure services. These were followed closely by GPs and Nurses, healthy eating and cooking programmes. Weight Loss programmes received much less support amongst Focus Group participants.

Key Issues

In the Survey responses and messages from Focus Groups, it was clear that prevention is valued and that there was support for prevention activities. There was an understanding that health is a complex concept that is a consequence of the inter-relationship between the wider determinants of health, lifestyle choice and the support that is available through different services.

Improving lifestyle was seen as challenge that demanded individuals taking responsibility for their health, but that it would not be achieved without supportive services. Good mental health was generally held to be key factor as to whether an individual would take positive action to improve their health.

However, the most common theme was how the current economic climate is perceived as affecting people's health. Job loss, economic hardship, lack of housing and loss of motivation were seen as having a negative effect upon health.

However, there are gaps in these that, to a large degree, reflect the financial constraints that has led to service cuts and an inability to meet demand. In terms of lifestyle services, the gaps were mostly in terms of mental health, workplace schemes and general practice was found to be inaccessible to some groups and not fully effective at implementing prevention services.

The services that target socio-economic issues were, again, seen to be experiencing stress in the current situation and especially in the case of the Citizens' Advice Bureaux, an inability to meet demand.

Overall, there was shared expectation that the NHS and government had responsibility to work with individuals and communities on the prevention agenda.

9. PRIORITIES

Each of the JSNA topics includes areas for development that have been identified through the data, local views, the Steering Group and at the Stakeholder Event. In addition the following overall prevention priorities were identified from the JSNA.

- Socio-economic factors especially housing
- Lifestyle Issues
- Workplace Health
- Long-term Conditions
- Domestic Violence

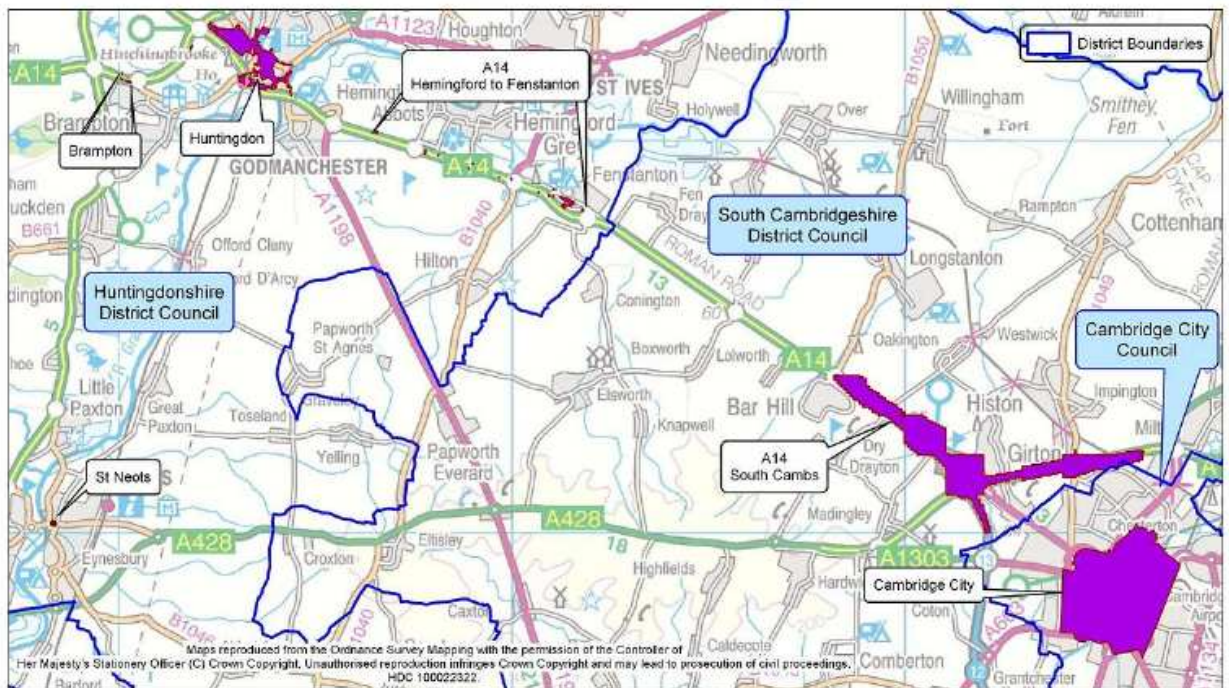
The Steering Group expressed a wish to continue to work together to address prevention across Cambridgeshire and to facilitate further partnership working. It is thought that the lessons learnt from the JSNA could inform the overall further development of the Prevention Agenda. These include adopting a life-course approach to prevention as so many of the determinants cut across age groups and settings. Inclusion of areas that play an important part in prevention, including analysis of the effect of the physical environment and social cohesion. Detailed information or analysis of current services or assets that support prevention would provide a fuller understanding of the needs. Comprehensive or robust data is not available, but is necessary for understanding the needs of workplaces and dental and oral health.

APPENDICES

APPENDIX 1: Maps of Air Quality Management Areas in Cambridgeshire

AQMAs in the South of Cambridgeshire

Figure 1.2 Air Quality Management Areas in the south of Cambridgeshire



Cambridge City AQMA

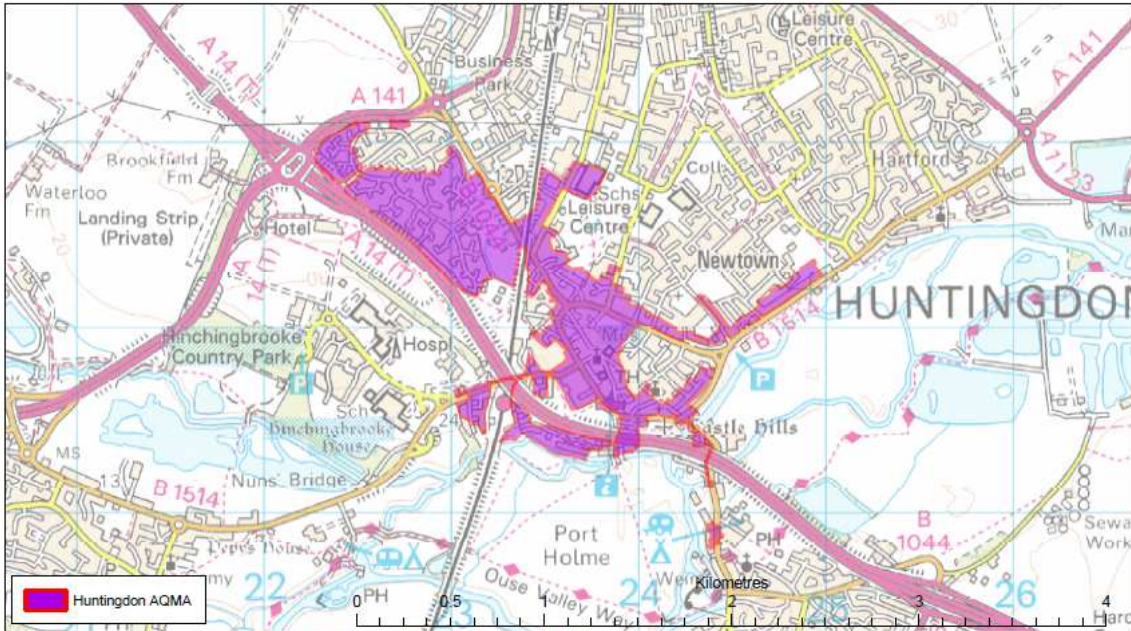
Cambridge City Council Air Quality Management Area 2004



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Huntingdon AQMA

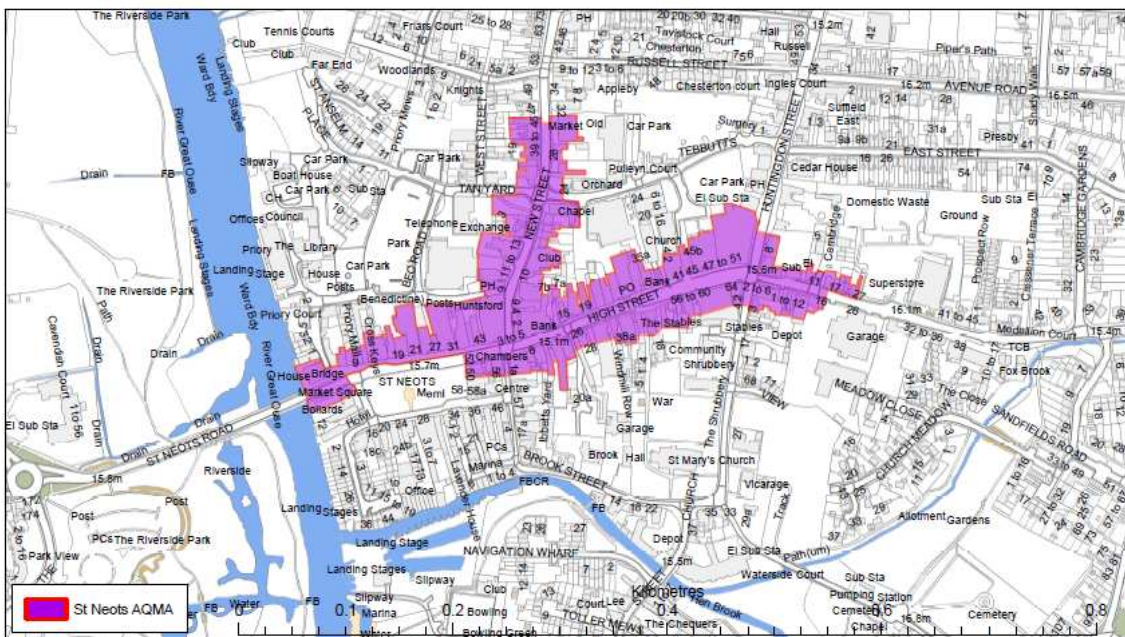
Huntingdonshire District Council Huntingdon AQMA (amended 2007)



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St Neots AQMA

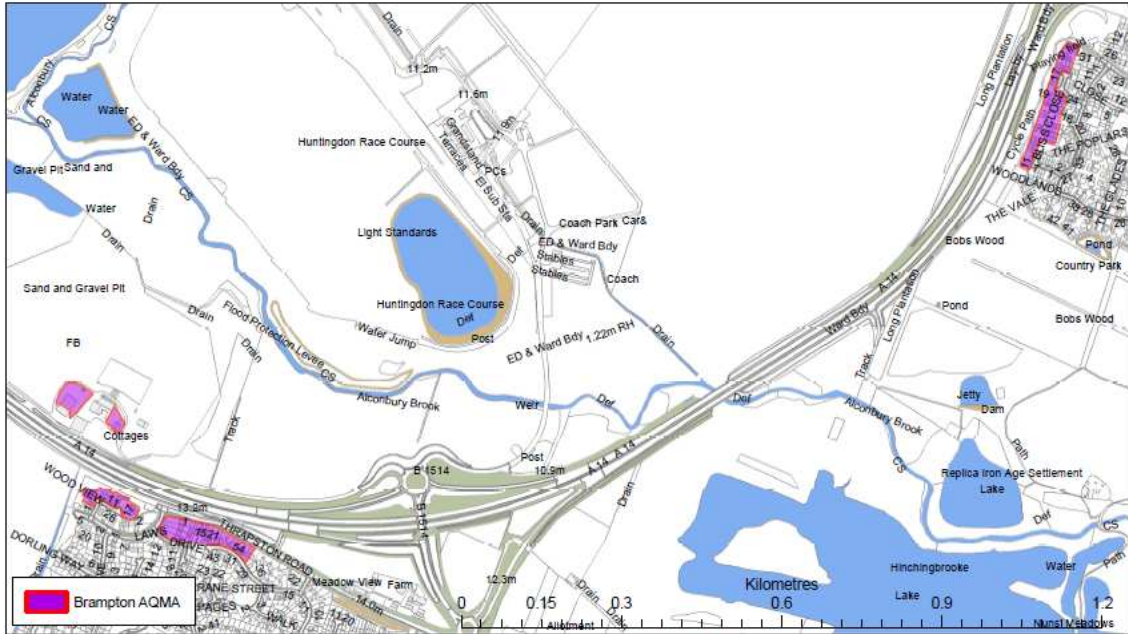
Huntingdonshire District Council St Neots AQMA (amended 2007)



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Brampton AQMA

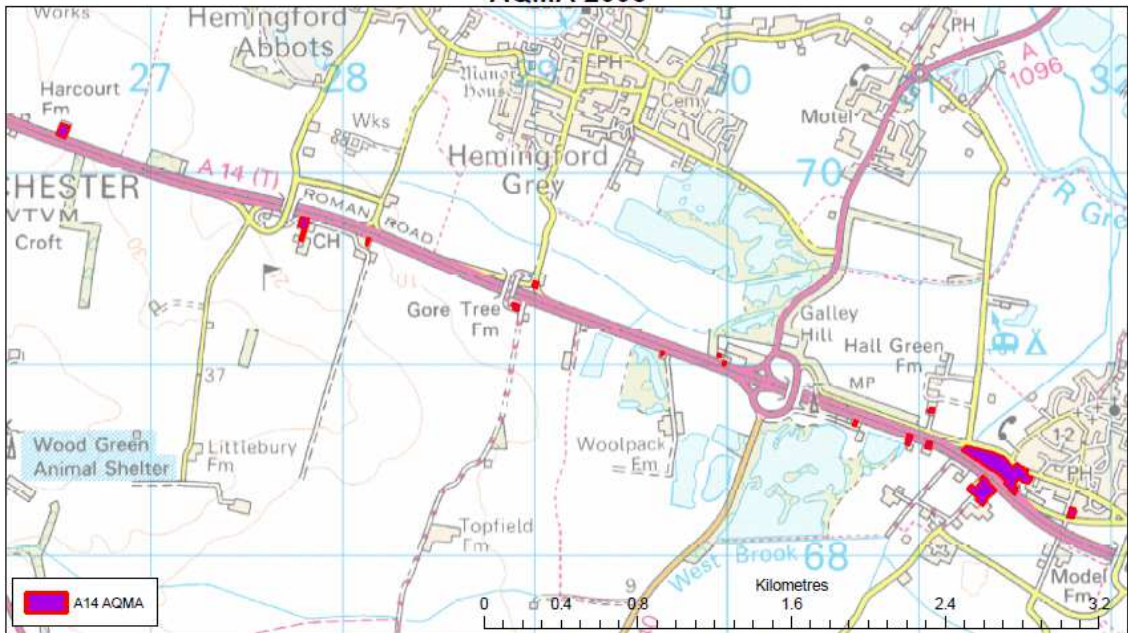
Huntingdonshire District Council Brampton AQMA (amended 2007)



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A14 Hemingford Gray to Fenstanton AQMA

Huntingdonshire District Council
A14 - Fenstanton to Hemingford
AQMA 2006



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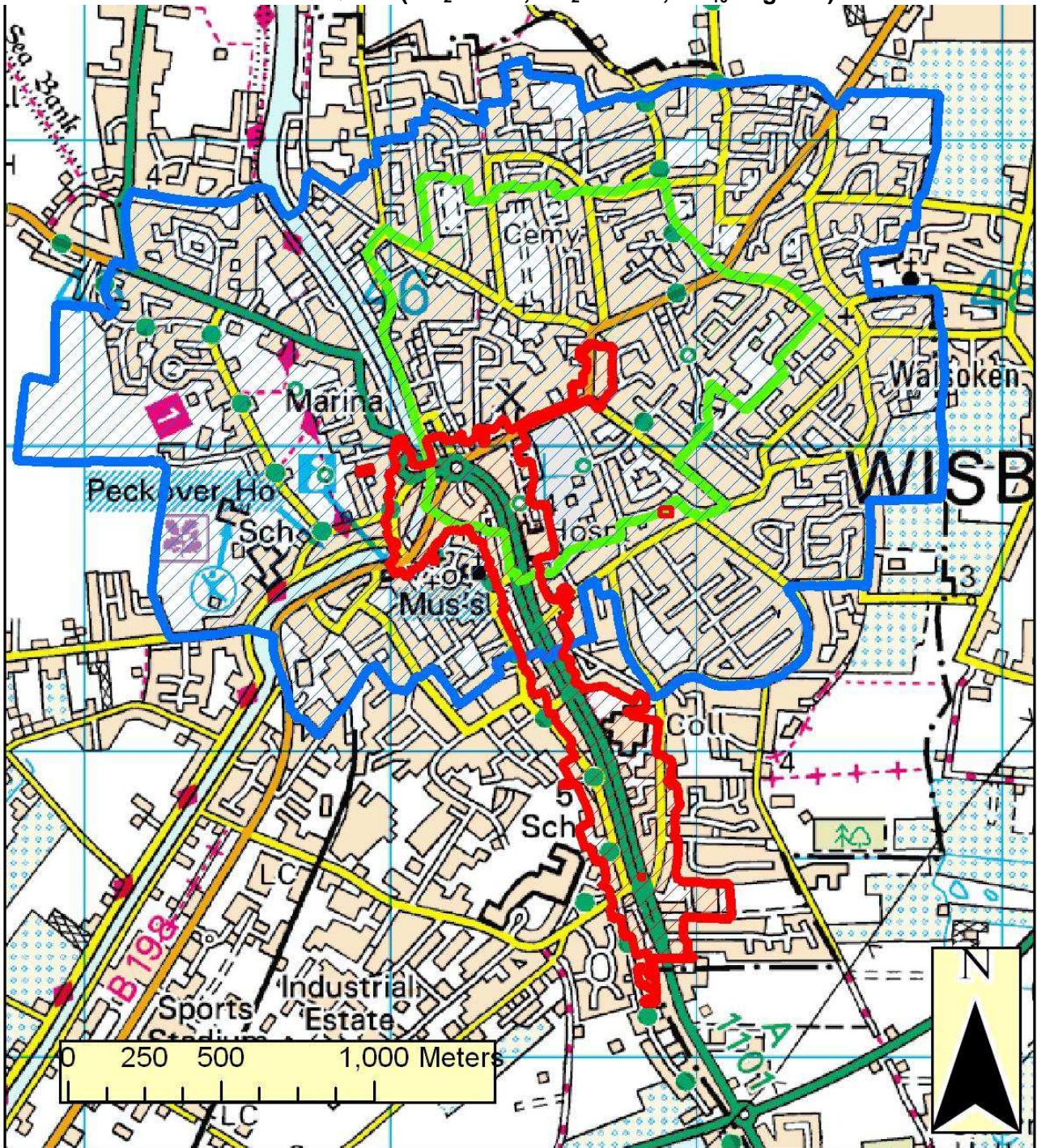
A14 Bar Hill to Milton AQMA

South Cambridgeshire District Council AQMA (amended 2008)



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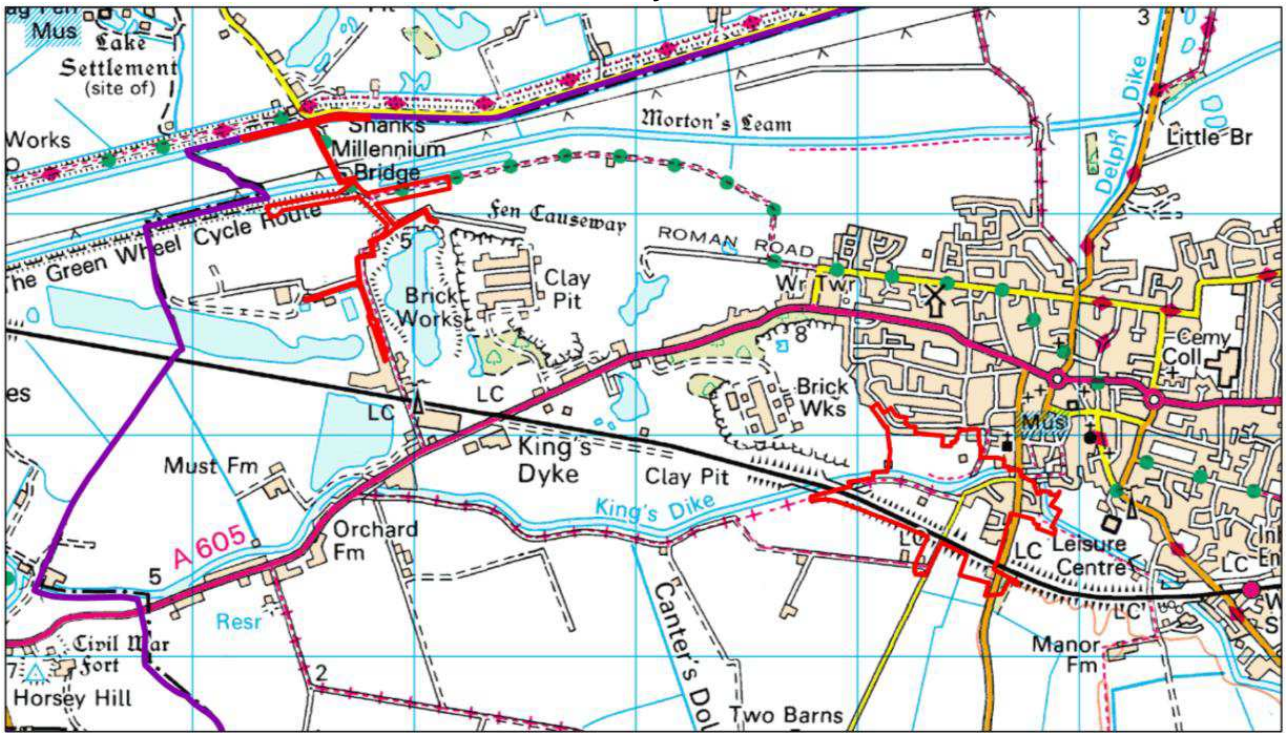
Wisbech AQMAs (NO₂ in red, SO₂ in blue, PM₁₀ in green)



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10023778, 2008



Whittlesey AQMA

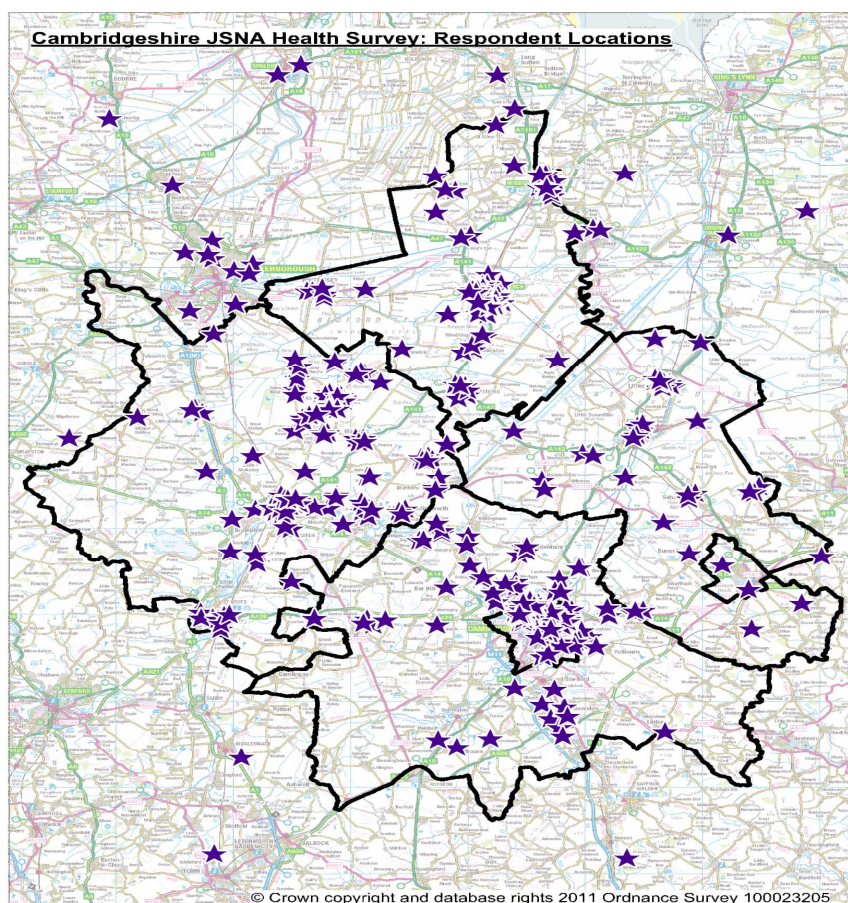


Appendix 2: Summary of Community Consultation Survey

The Prevention of Ill Health in Adults of Working Age is the first JSNA to use a bespoke process to secure the views of the population. This has involved collecting views in a number of different ways, for example through an online questionnaire and by attending neighbourhood panels.

The JSNA Survey was put online in early July 2011 and ran until the end of August 2011, and publicised across the county in neighbourhood panels, libraries, Patient Advice Liaison Service (PALS) roadshows, and through the use of bespoke focus groups. In addition, paper versions of the survey were circulated to a number of locations. A total of 817 completed surveys were returned, of which 738 were paper-based.

Discounting those who chose not to complete the personal information section of the questionnaire, 69% were female, and 28% male. 82 respondents (10%) were aged under 25, with 322 (39%) falling into the 25-44 age group bracket, and 297 (36%) within 45-64 years of age. 93 (11%) were aged 65 or over. With regards to ethnic origin, 88% of respondents who chose to give their ethnicity recorded themselves as being white (British). Six respondents identified themselves as being a Gypsy or Irish Traveller. 666 respondents left an accurate postcode and their locations are outlined in the following map:



In addition Cambridgeshire Acre was commissioned to run four focus groups as a further mechanism for collecting community views. A total of four focus groups were run, two in Fulbourn and two at Wisbech during September 2011. A total of 37 people took part in the focus group split into 25 people participating in Fulbourn and 14 in Wisbech.

15 of those who took part were male. There was a reasonable spread of ages with the category most represented being the 45-64 age group (22 out of the 37), next was people aged 65 and over (10 participants), then those aged 25-44 (4 participants) and also one participant in the 16-24 age group. All those who took part identified themselves as White British. The map below indicates the postcode location (red star) of those taking part.

The following provides an overview of the key issues and commonalities identified in both approaches. However, it should be noted that the focus group numbers were relatively small. The full reports of the Survey and Focus Groups can be found in the Appendices.

Both the survey and focus groups demonstrated that communities have a good understanding of the range of factors that can influence people's health. Around 90% of participants in the survey and focus groups saw lifestyles as being critical factors in preventing ill health. Smoking, physical activity, type of food and alcohol are seen as the main influencers. However, stress and mental health and wellbeing were clearly seen as an important consideration. The underlying social and environmental pressures that create stress being the root causes.

Around two-thirds of the survey respondents saw the wider determinants of health as contributing to health. The exception being homelessness with 87% of the survey respondents seeing this as an important factor. The focus groups explored the relationship between the wider determinants of health and lifestyles in more depth. The economic climate was seen as creating many financial, employment and family worries and stress. It was suggested that the stress prevented people taking positive action to improve their health.

Access to prevention services might improve health but the initial challenge was to get people to use them. There was an acknowledgement that changing and maintaining behaviour is challenging due to self-perceptions and requires support services. The family environment was seen as key for embedding healthy behaviours.

However, there was a strongly held view that healthy behaviours were inter-linked and symptoms of wider factors. For example, homelessness could be a symptom of low educational attainment, followed by unemployment or low income, coupled with high rents.

Overall there was general agreement that some ill health can be prevented. The focus groups expressed the viewpoint that people feel that they have the opportunity to make choices. However, the societal pressures of lack of education, lack of motivation and restricted income were seen as factors affecting people's ability to take positive action.

From the Survey respondents 45% strongly agreed that people should look after their own health, with a further 43% tending to agree with the statement. 545 of those 817 chose to elaborate further on their opinion, and for the most part it was emphasised that people had a responsibility to take care of themselves. Similarly in the focus groups there was a strong feeling that people should look after their own health with only one person disagreeing.

Just under 39% felt strongly that people should be helped and supported to remain healthy and to prevent illness. Only 2% - 19 people - disagreed with this concept. As highlighted above, it was felt that it was important for people to have the right information if they were to be able to help themselves. Concern was raised around the capacity of an individual to avoid illness or to look after themselves – many raised issues such as hereditary illnesses, disabilities, and age as factors that affected how far people could act independently. It was also felt that offering preventative support would motivate those less likely to take steps to improve their own health – *“Having support can make a huge difference as people do not always have the motivation to remain healthy or the means by which to do so.”* Many respondents referred to the importance of early education in schools.

All those who took part in the focus groups thought that support should be provided to help people to be and remain healthy. The provision of information and the promotion of healthy lifestyles by the Government and/or the NHS was seen as an important element of support to people when they are making choices.

Whilst it was felt that appropriate education and facilities would always need to be provided, there was a strong sense that *“improving health has to be a joint effort between the individual and the NHS”*, and as such it was the individuals’ responsibility to care for themselves, and to know when to seek help – and that money should not be “wasted” on those unwilling to follow advice. The focus groups acknowledged that some people do not want to and cannot be forced into looking after their own health and they cannot be forced into this.

The survey asked respondents about their awareness of local services and the importance they placed on them with regards to health benefits. The following services were listed:

- GPs and nurses
- Citizens Advice Bureau
- Local Housing Services
- Local Leisure Services that provide opportunities for physical or sporting activity
- Healthy eating and cooking programmes
- Adult Education Services
- Skills Development/Retraining Schemes
- Employment Services
- Weight loss Schemes
- Stress management/Schemes to improve mental wellbeing
- Other mental wellbeing services
- Stop Smoking services
- Alcohol Services
- Workplace schemes that support healthy lifestyles

The focus groups discussed the services that they identified. There was concern around funding that had been cut or insufficient to meet demand. Healthy eating and cooking programmes had been lost, there is a lack of prevention programmes for alcohol misuse. Services to address mental ill health were seen as essential in their role help people develop resilience against unhealthy behaviours such as drug and alcohol misuse. The Survey found other mental wellbeing services’ (52%) and stress management schemes (56%) were services that people were least aware of being provided.

Stop smoking services were well known but their success was thought to be a result of legislative and societal attitudes. A similar legislative approach to alcohol misuse was recommended.

There was concern about the cost of specific lifestyle services loss schemes. Weight loss schemes were seen to be widely available but the commercial schemes were seen as being expensive and more concerned with weight loss than lifestyle change. Similarly, leisure services were expensive even when exercise had been prescribed as part of GP referral scheme.

In the Survey, GP and nurse services were considered to be important by more people than others, with 680 people judging them to be of importance. Most Focus Group participants were aware that general practices offered prevention services such as screening. However, there was concern that this excluded those who were well or not registered with a practice. In addition obtaining appointments and short appointments, along with the fact that many participants felt that GPs were not giving advice in a manner that engaged their patients.

In the Survey 406 people (less than half) felt that skills development and retraining schemes were important in preventing ill health. Early education was again mentioned as being an important

service, with others discussing the importance of weight loss schemes as a preventative measure. There were concerns amongst the focus groups for the services that support economic and social wellbeing. Considerable negativity was expressed about employment services and their ability to help people find employment. Adult education services were seen as focussing upon hobbies rather than skills for work. Local Housing Services were hampered by a shortage of housing, long waiting lists and too few new houses being built. The Citizens' Advice Bureau was seen as an excellent service but it is currently suffering acutely from being unable to meet demand.

In the Survey the majority of people were least aware of 'workplace schemes that support healthy lifestyles' (50%). Participants in the Focus Groups thought that only large scale organisations would be able to provide this type of scheme. There was concern that in Cambridgeshire there is a high proportion of small-scale employers for whom workplace schemes would not be a priority of feasible. Public Sector employers have a good track record for providing workplace schemes. There was widely expressed view that in harder economic times these schemes are seen as less important by employers. Redundancies meant a smaller workforce and an increase in everyone's responsibilities.

A recurrent theme in the Focus Groups and Survey was that there were economic barriers to people accessing prevention services. In the Survey, the cost of services was judged to be the most significant barrier to services, with 80% considering it to have an effect (654 people). Less than half of respondents felt that having not used a service before might deter people from using it. 140 people went into further detail.

In the Survey, 70.4% of respondents saw weight related issues as being an area for effective prevention. Although issues around high blood pressure, heart problems, and smoking-related cancers and heart and lung problems were raised. Just under 10% respondents referred to mental health problems; these ranged across various issues such as depression, addictions, and stress.

The Focus Groups were asked to identify which contributed the most to prevention. The three services that attracted the most support were, mental wellbeing schemes, Citizens Advice Bureaux and local leisure services. These were followed closely by GPs and Nurses, healthy eating and cooking programmes. Weight Loss programmes received much less support amongst Focus Group participants.

Key Issues

In the Survey responses and messages from Focus Groups, it was clear prevention is valued and that there was support for prevention activities. There was an understanding that health is a complex concept that is a consequence of the inter-relationship between the wider determinants of health, lifestyle choice and the support that is available through different services.

Improving lifestyle was seen as challenge that demanded individuals taking responsibility for their health but that it would not be achieved without supportive services. Good mental health was generally held to be key factor as to whether an individual would take positive action to improve their health.

However, the most common theme was how the current economic climate is perceived as affecting people's health. Job loss, economic hardship, lack of housing and loss of motivation were seen as having a negative effect upon health.

There was acknowledgement that there are prevention services that can be accessed across the county. However, there are gaps in these that to a large degree reflect financial constraints that has led to service cuts and an inability to meet demand. In terms of lifestyle services, the gaps were mostly in terms of mental health, workplace schemes and general practice was found to be inaccessible to some groups and not fully effective at implementing prevention services.

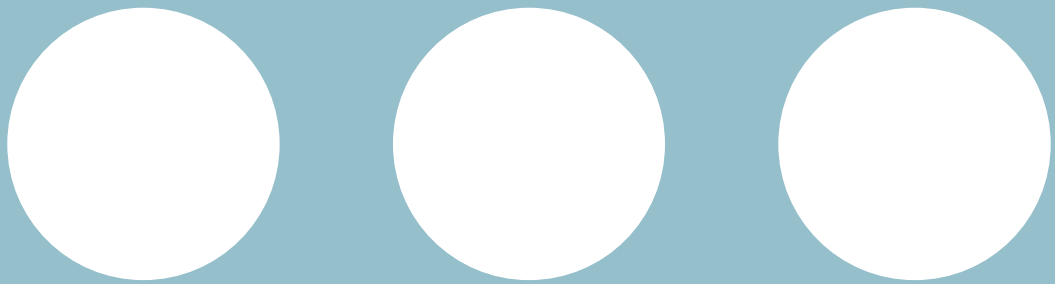
The services that target socio-economic issues were again seen to be experiencing stress in the current situation and especially in the case of the Citizens' Advice Bureaux, an inability to meet demand.

Overall there was shared expectation that the NHS and government had responsibility to work with individuals and communities on the prevention agenda.

Appendix 3: Summary of Community Consultation Focus Groups

Cambridgeshire ACRE

Prevention of ill health and promotion of good health amongst adults of working age Focus Group Report



Focus Groups undertaken on behalf of NHS Cambridgeshire
during September 2011



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INTRODUCTION

Background

NHS Cambridgeshire, Cambridgeshire County Council, district councils and other organisations in Cambridgeshire are looking at how ill health amongst adults aged 16-64 can be prevented and good health and wellbeing promoted.

This work is part of the Prevention Joint Strategic Needs Assessment (sometimes called a JSNA). Organisations will use the information found in the JSNA to plan services for the prevention of ill health in Cambridgeshire.

It is therefore important that they know and understand what people living in Cambridgeshire think about the prevention of ill health. For the first time, the JSNA has used a bespoke process to secure the views of the population. This has involved collecting views in a number of different ways, for example through an online questionnaire and by attending neighbourhood panels.

In addition, Cambridgeshire ACRE was commissioned to run four focus groups as a further mechanism for collecting community views. Following discussion with NHS Cambridgeshire, it was agreed that Cambridgeshire ACRE would run two focus groups in South Cambridgeshire and two in Fenland, as these were areas of the county where it had proved harder to engage with the wider public.

All information collected during these focus groups has been analysed in this report and will be fed back to NHS Cambridgeshire/Cambridgeshire County Council so that it might be taken into account when putting together the JSNA.

The views expressed in this document are those of the focus group participants only and do not necessarily reflect the views of Cambridgeshire ACRE.

Methodology

Cambridgeshire ACRE sent an email invitation to all those on its customer database, which spans parish councils, community groups, village hall management committees and individuals with no particular affiliation, seeking volunteers to take part in the four focus groups.

Each focus group would aim to reach 10 people and would last approximately one hour. Each would follow a similar format using a prescribed questionnaire as the basis for discussion. A number of short exercises were created to allow participants to consider their individual responses before group discussion took place.

The focus groups were facilitated by Kirsten Bennett (Chief Executive), Alison Brown (Head of Business Services) and Stuart Morris (Community Advisor).

FEEDBACK ON THOSE WHO TOOK PART

Background

Each person who took part was asked to complete a short monitoring information sheet. This enabled Cambridgeshire ACRE to collate demographic information on those who took part so that it could demonstrate that it had engaged with a diverse group of people.

Total attendees

A total of 37 people took part in the focus groups, split across the sessions as follows:

- Focus Group 1: Thursday 22 September, 6.30pm, Fulbourn – 11 attendees
- Focus Group 2: Thursday 22 September, 8.00pm, Fulbourn – 12 attendees
- Focus Group 3: Monday 26 September, 4.00pm, Wisbech – 9 attendees
- Focus Group 4: Monday 26 September, 6.00pm, Wisbech – 5 attendees

Gender

15 (41%) of those who took part were male with the remaining 22 (59%) being female.

Age

There was a reasonable spread of ages participating in the focus groups. The age category with the most representation was those aged 45 – 64 (22 out of 37 participants); next was people aged 65+ (10 participants); then those aged 25 – 44 (4 participants) and then the 16 – 24 age category (1 participant).

Ethnic Origin

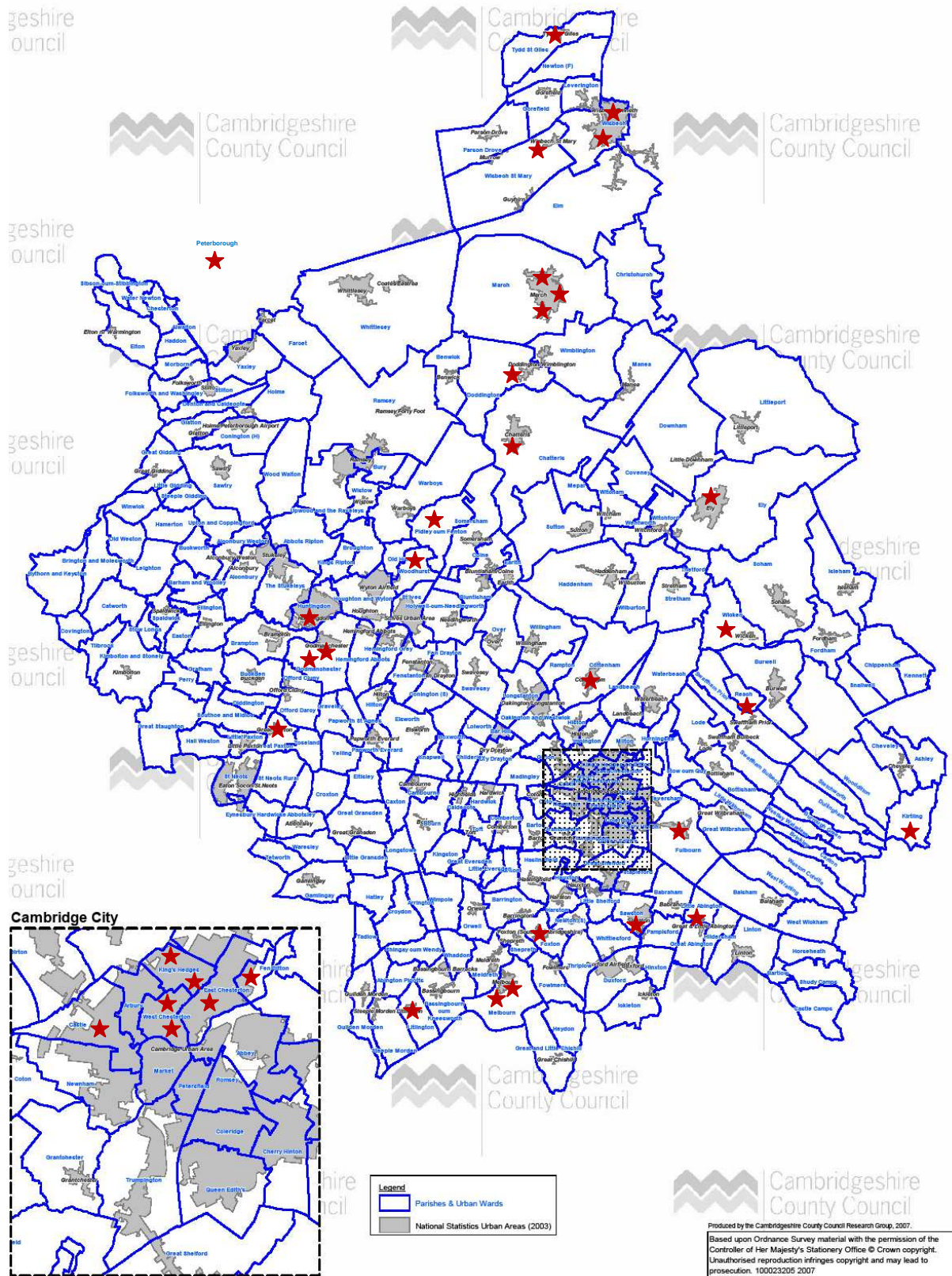
All those who took part identified themselves as 'White: British'.

Home Postcode

Respondents were asked to provide their home postcode so we might see from which geographic communities they came.

Figure 1 overleaf shows a map of Cambridgeshire displaying a red star to display this information pictorially for each participant.

Figure 1: Map of Cambridgeshire showing home postcodes of participants in focus groups



Reasons for wanting to take part in focus groups

To understand people's motivations for being involved, we asked why they had wanted to take part.

The full list of reasons is shown in Appendix 1, but most cited reasons of either personal or professional interest, a desire to 'make a difference' and help improve the Health Service.

FEEDBACK ON FOCUS GROUP EXERCISES

Exercise 1 – Contributing factors to ill health

Aim

To explore whether community members acknowledge that ill health can be prevented and to find out what they understand about the causes of ill health, i.e. do they see health as being influenced by wider determinants or are health services still seen as the main factor.

Our approach

Participants were given a handout showing a number of possible causes of ill health. They were given time to circle the three factors they thought contributed the most to ill health. Time was then spent talking about the choices people had made. Discussion also considered whether some ill health can be prevented.

Results

Following discussion it was clear that participants understood how all the factors presented could influence a person’s health but some were felt to have a greater influence than others. The top three factors chosen by participants were:

Factors	Number of votes received (out of a possible 111 votes)	% of the vote received
Physical inactivity	18	16%
Type of food	14	13%
Smoking	13	12%

Physical inactivity: There was general consensus that physical activity is an important factor for good health. People talked about how there is now not enough emphasis on walking and that people use their cars for very short trips such as for getting a newspaper and taking their children to school. It was recognised that physical activity can improve mental wellbeing and is generally rehabilitative for those who suffer ill health.

Type of food: Participants recognised that processed meals/refined foods provide poorer nutritional value than meals made ‘from scratch’. Busy lifestyles, misleading advertising, too much fast food and not knowing where food comes from were all seen as contributing factors for making poor food choices. Education on how to make the right nutritional choices is seen as key but there was a perception that there are now ‘lost’ generations who don’t know how to eat healthily and who are therefore condemning their children and grandchildren to making the same mistakes.

Smoking: General acknowledgement amongst participants that those who smoke put themselves at increased risk of a number of other illnesses.

These top three factors were followed by a further two factors that got a significant share of the vote:

Stress (12 votes, 11% of vote): Stress was seen to be a symptom with other root causes such as money worries, job pressures or family difficulties. The present economic climate was cited as a

major cause of stress, with redundancies leading to stress that then brings on other illnesses. It was suggested that stress is all-encompassing and stops people taking other positive action that might prevent illness; for example, if you are suffering from stress, you might be less inclined to take exercise or to eat well.

Access to services that support people to lead healthier lifestyles (10 votes, 9% of the vote): There was a general perception that having access to these services might help prevent ill health but there was an initial challenge in getting people to use them. It was suggested that changing people's behaviour can be very difficult as often their perceptions are skewed and they are not able to admit they have a problem. Individuals have to want to access services that will help them change their lifestyle. There is an additional challenge to get people to retain good habits once they have learned them. Support services are needed to achieve this. There was a concern that many of these services are provided privately and prohibitive costs can prevent people from using them.

An additional factor brought forward in discussion was the importance of family in preventing ill health. Strong family support was seen as important for the formation of good habits and values in children. There was recognition that no matter what schools do, unless the messages are backed up consistently at home, it will be hard for a child to take them on board for the longer term.

Participants also felt strongly that many of these 'factors' were closely inter-linked and were in fact symptoms rather than causes of ill health. For example, homelessness is a symptom that might be brought about by low educational attainment, followed by unemployment or low income coupled with high rent.

The full notes from the focus groups relating to each factor and the discussion around whether some ill health can be prevented can be found in Appendix 2a and Appendix 2b.

There was a general agreement that some ill health can be prevented. People feel they have the opportunity to make choices but societal pressures mean these aren't always the best ones for their health. Lack of education, lack of motivation and a restricted income are seen as factors affecting people's ability to take positive action for good health for themselves.

Exercise 2 - Responsibility for health

Aim

To explore the issue of whether or to what degree people should take responsibility for their own health and similarly whether they should be supported.

Our approach

Participants were given a handout with two statements set out on it:

- Statement A – People should look after their own health.
- Statement B – People should be helped and supported to remain healthy and to prevent illness.

For each statement there was the option to Strongly agree; Tend to agree; Neither agree or disagree; Tend to disagree; or Strongly disagree.

Participants were given time to circle the option that most closely reflected their own opinion on each statement. Time was then spent talking about the choices people had made.

Results

In respect of Statement A (People should look after their own health), the votes were cast as follows:

Factors	Number of votes received (out of a possible 37 votes)	% of the vote received
Strongly agree	24	65%
Tend to agree	12	32%
Neither agree or disagree	0	0%
Tend to disagree	1	3%
Strongly disagree	0	0%

There was a strong feeling that people should look after their own health, with all but one participant either tending to agree or strongly agreeing with this statement.

In the discussion that followed several people gave caveats to their response, acknowledging that some groups may need support in making the right choices (e.g. those with mental illness, the elderly, those with learning disabilities and children). It was also acknowledged that some people do not want to look after their own health and that people can't be forced into this.

It was seen as important that the Government / Health Service should provide information, education and help and continue to promote healthy options so that those who are capable of making their own choices are adequately informed to do so.

In respect of Statement B (People should be helped and supported to remain healthy and to prevent illness), the votes were cast as follows:

Factors	Number of votes received (out of a possible 37 votes)	% of the vote received
Strongly agree	26	70%
Tend to agree	11	30%
Neither agree or disagree	0	0%
Tend to disagree	0	0%
Strongly disagree	0	0%

All those who took part felt that support should be provided to people so they might remain healthy and to prevent illness. There was acknowledgement that prevention is better than cure, both in terms of people’s health outcomes and the cost of providing health care services once people have become ill.

The full notes from the focus group discussions around these statements can be found in Appendix 3.

Exercise 3 – Prevention Services

Aim

To identify whether people know of the support that is available (i.e. are services being promoted in a way that is capturing the attention of communities) and to understand whether people think they are relevant to preventing ill health and promoting good health. Also to identify the reasons why people might not use these services.

Our approach

Participants were shown a series of flashcards setting out the names of different prevention services. For each one, they were asked whether they were aware of its existence in their community, whether they thought the service was successful at preventing ill health and promoting good health and the barriers that prevent people from making use of these services.

Results

A short summary is given below for each prevention service discussed. The full notes from the focus group discussions can be found in Appendix 4.

Healthy eating and cooking programmes

Many participants knew of such schemes but there was a general consensus that many had been lost as a result of recent funding cuts and poor resourcing. Many cited the difficulties of getting those in most need to access this type of programme.

GPs and Nurses

Most of the participants in the focus groups were aware that their GP surgery offered prevention services such as health screening and monitoring, support groups and clinics.

Participants noted that you would probably need to be a regular visitor to your surgery to be fully aware of the prevention services offered. If you were generally fit and well then it is unlikely you would visit to become aware of what might be on offer. They were also concerned for those who are not registered with a GP.

Difficulty with getting appointments and short appointment times were seen as a problem and many felt that GPs do not give advice forcibly enough for people to take it on board.

Workplace schemes that support healthy lifestyles

Participants felt that only large organisations would be able to provide this type of scheme. Cambridgeshire has a high proportion of small-scale employers for whom these schemes would not be a priority or even feasible. Public sector employers have a good track record of provision of such schemes locally.

Many expressed the sentiment that in harder economic times these schemes are seen as less important by employers. Employees are expected to work harder and to take on duties previously undertaken by colleagues who have been made redundant, which is putting increased pressure on them.

Alcohol services

Participants knew of schemes that are available to help once someone has an acknowledged problem (e.g. Alcoholics Anonymous) but did not know of any schemes to prevent alcohol problems in the first place.

There was ready acknowledgement that alcohol is too cheap and too accessible. It was felt efforts should be put into preventing people drinking in the first place rather than seeking to provide a cure once someone is addicted.

Alcohol was seen as a coping mechanism for people with other problems and that if these could be solved then it would be less likely that people would turn to alcohol.

It was felt that tackling alcohol issues would need the same type of legislative support as was given to tackling smoking. Making it less socially acceptable, tightening up licensing laws and bringing in a minimum cost might begin to address the problem.

Stop Smoking services

There was a high level of awareness about the health problems related to smoking and the help accessible via GPs/supermarkets/chemists to stop smoking amongst focus group participants. They were fully aware of national awareness campaigns on this topic. It was felt that smoking has been successfully tackled to an extent but that success may have been as much about legislative changes and changes in societal attitudes than anything else.

Mental Wellbeing Services (including stress management)

There was very limited knowledge of mental wellbeing services but they were acknowledged as being vitally important in the prevention of ill health. It was understood that they would allow people to address the root causes of their problems and teach coping strategies that might prevent people turning to things like alcohol and drugs which would cause further ill health.

For those who did know about them, the feeling was that prevention services are limited, due to funding issues in Cambridgeshire, and that you have to be quite acutely ill before mental health services become available to you. Support is not well advertised, although organisations such as MIND and the Richmond Fellowship do good work. Waiting lists for free counselling and Cognitive Behavioural Therapy means that sufferers turn to other mechanisms for coping (e.g. alcohol, drugs, etc).

It was acknowledged that there is still a stigma attached to mental health issues and therefore getting people to admit they need help will be a barrier to access.

Weight loss schemes

Weight loss schemes were seen to be widely available. Private schemes such as Weight Watchers and Slimming World are well known and their methods of peer support are seen as useful. However, these are seen to be expensive and whilst they tell you how to lose weight they are less effective at teaching you how to eat healthily.

There was an understanding that 'comfort eating' is a coping mechanism and that people often need help with uncovering the trigger for their over-eating.

Employment Services

Whilst these services are reasonably well known there was a strong feeling that they do not do a very good job, particularly for those who have been made redundant from a professional level job. Participants used quite strong language when talking about the services provided by Job Centres such as 'useless' and suggested "they are not geared up for anything other than minimum wage jobs".

Amongst those who had experience of using them, there was a suggestion that there is a 'postcode lottery' with regards to job centres, with some staffed by temporary staff who don't know the 'rules of the system'. They also cited the length of the time you have to be unemployed before you are able to access courses and certain types of support.

Adult Education Services

There was high general awareness of these services but they are seen as being less aimed at skilling people for work and more about relaxation/hobbies. As people have to pay for such services, they are seen as mostly a service for people who are already educated and in work. People who access them don't really need them.

Local Leisure Services that provide opportunities for physical or sporting activity

Amongst participants there was a good understanding that this could take the form of formal, paid-for leisure activities or use of free options such as green, open spaces.

There was a clear belief that green spaces must be preserved for use by adults and children as they provide a vital space for exercise and play which are key to physical and mental health.

Participants expressed concern about the cost of formal leisure activities and noted that even when exercise had been prescribed as part of a GP referral, the cost might prove prohibitive for many.

Local Housing Services

Whilst participants were all aware of the local housing services provided by the District/City Councils, they believed there was a significant shortage in the amount of available social housing stock. They talked of long waiting lists and few new houses being built.

Citizens Advice Bureau

All participants were aware of the service provided by the CAB but knew they were suffering as a result of funding cuts. They believed there was a huge demand on the service with long waiting lists for appointments meaning people sometimes find their own solutions in the interim, like taking out high-interest loans. There was a suggestion that, in recent times, advice provided has become very formulaic and that a less subjective and less personal service is now being provided. This was seen as a shame as there was a strong belief the support they provide was excellent.

Exercise 4 – ‘Participatory budgeting’

Aim

To understand which services participants value the most and which they believe deliver the most benefit to health.

Our approach

The prevention service flashcards were laid out on the tables in front of participants and each participant was given three ‘money tokens’. Participants were then asked to spend their tokens on the services they believe contributed best to preventing ill health and promoting good health by placing them on the relevant card. Participants could place all their tokens on one service or divide them up as they saw fit.

Results

The votes were cast as follows:

Prevention Service	Votes received
Mental Wellbeing schemes	20
Citizens Advice Bureaux	14
Local Leisure Services	11
GPs and Nurses	10
Healthy eating and cooking programmes	10
Other - Preventative Screening ²⁴⁴	10
Alcohol services	9
Adult education services	7
Employment services	6
Local Housing Services	4
Other - Public Transport ¹	4
Workplace schemes	4
Weight loss schemes	2
Stop smoking services	0

The three services that received the most votes (Mental wellbeing schemes, Citizens Advice Bureaux and Local Leisure Services) were valued by focus group participants for the role they play in promoting good mental health and for allowing people to tackle issues or problems that might cause ill health in a positive way. The support of locally-based health professionals (GPs, nurses and preventative screening programmes) is seen as vital in maintaining good health and preventing ill health.

²⁴⁴ These ‘Other’ services were suggested by participants at one focus group as being important to preventing ill health.

APPENDIX 1

Reasons for participating in focus groups

- Important for faith groups to be consulted and more important for relevant information to reach them.
- As part of role as Community Officer at Wicken Fen.
- I work for Cambridgeshire Community Services. I am experiencing some health difficulties. I am also interested to know what a focus group will do.
- To promote the benefits of green space for healthy communities.
- Part wish to participate in democratic community focus process, part professional interest.
- Interest in social issues around health agenda.
- To help and improve systems/processes to enable a better and healthy community.
- Understanding and awareness of health issues.
- Worked as a volunteer at Addenbrookes for 20 years and been Oncology patient there for 5½ years.
- Opportunity to contribute and network with a sector that has great potential to make use of my employer's services.
- To put forward the case for health related subjects rather than illness related subjects.
- I am interested in health issues.
- I am the spokesperson for COPE, a forum of 2,891 individual members.
- Representing Royston Community Transport.
- I think that the value for health of participation in the cuts is underestimated.
- I have an interest in assisting local initiatives in improving health following work on the Melbourn Village Plan and a long association with the NHS.
- Developing online systems for mental health.
- Work-related.
- I chair Cambridgeshire Green Infrastructure Forum – planning and delivery of high quality green spaces and links across Cambridgeshire. Green space has a key role to play in promoting healthy lifestyles.
- Try to influence the NHS to make things better / improve preventative healthcare / increase life expectancy and quality of life for everyone – not just women as happens under current NHS priorities.
- I work within the third sector specialising in employment support for people with disabilities. Health is thus very important as is attitudes towards it. I am also interested in other people's views as I never see my GP or health centre.
- To provide a local authority perspective on the issues of fuel poverty.
- Because I feel it is important to find ways to improve the health and wellbeing of individuals.
- To help the NHS.
- Because I feel that there are opportunities to utilise adult education courses which include a wide range of keep fit and activity-based courses.
- To link in with other volunteering activity and maintain a personal involvement.
- Networking and general information.
- Interest – personal and professional. Need to make a difference somehow.
- I work for Cambridgeshire County Council Quality and Workforce Development. I am directly involved in work that relates to health promotion. I train with adults who have learning disabilities and staff teams across various settings.
- I have previously event managed and facilitated focus groups professionally and decided to participate as a delegate.

- To be part of innovative health services in the future due to the NHS reforms.
- Interested in promoting and enabling communities to access and participate in sports and physical activity for health benefits.
- Personal and professional interest in health and social care. Planning for the future. Concern for vulnerable adults who have difficulties accessing services.
- Present concerns.

APPENDIX 2A

Focus Group notes on contributing factors to ill health

Inherited health (family genetics)

- There was recognition that family genetics can predispose you to certain conditions and that some of this will be outside your control.

Level of education or training

- Some data shows that the level of health of an individual in a relationship depends upon the education of the other partner.
- However, some very highly educated people have problems with depression.
- In general, more educated people access services more.
- Low educational attainment can cause problems, for example not be literate enough to be able to read food nutrition labels will limit ability to make wise nutritional choices.

Income

- No comments made.

Type of job

- It was recognised that some jobs lead to physical inactivity and stress.
- It was noted that some people have seen colleagues made redundant and have then had to pick up some of their duties on top of their existing roles. Employee health is not seen as a priority for employers.

Unemployment

- Data shows that unemployment is another central factor in ill health.
- Jobcentre staff play as important a role as doctors.
- Seen as a big issue for this county with many of the public services making redundancies. The redundancy process can take a long time which can be stressful. It was noted that some families have both wage earners employed in the public sector meaning both jobs at risk.

Homelessness

- It was felt that once a person becomes homeless, they can then 'fall through the gaps' and find it harder to access other services.

Quality of housing

- No comments made.

Pollution

- Seen as more of an issue in bigger towns.

Smoking

- General acknowledgement that those who smoke put themselves at increased risk of a number of other illnesses.

Physical inactivity

- Agreement among contributors that physical activity is an important factor. Generally we don't do enough. There is not enough emphasis on walking. People use the car for very short trips such as for getting a newspaper.
- People now drive their children to schools and there are fewer school playing fields.
- It would be helpful if the hospital and leisure centre in Newmarket could link services. Some leisure centres are contracted to do this. Prescriptions for exercise would be good.
- Green space and Rights of Way provide opportunities for health.
- It was recognised that physical activity can improve mental wellbeing and is generally rehabilitative for those who suffer ill health.

Drinking alcohol

- Alcohol and drugs are both addictions of different types.
- Drinking alcohol (and other substance abuse) may lead to other mental health problems.

Type of food

- Processed meals/refined foods provide poor nutrition.
- Education on how to make the right nutritional choices is important.
- This is influenced by lifestyle factors. Children grow up being used to making unhealthy food choices.
- Busy lifestyles, too much fast food and not knowing where food comes from.
- People do not know how to make meals from scratch anymore.
- Misleading advertising was seen as important.
- It actually quite tricky to buy raw ingredients to make meals as opposed to processed foods.

Social interaction (physical)

- It was recognised that social interaction can improve mental wellbeing and reduce stress.
- Having good community support networks in place (i.e. social groups and clubs) is seen as being vital for wellbeing.

Social Interaction (online)

- No comments made.

Stress

- Divorce/bereavement and job worries are causes of stress. Stress is a symptom.
- The economic cuts were cited as a major cause of stress, with redundancies bring on stress than then leads to other illnesses. It was suggested that stress is all-encompassing and stops people taking other positive action that might prevent illness.

Safety and security in your community

- No comments made.

Access to services that support people to lead healthier lifestyles

- Individuals have to want to access services.
- There is a challenge to get people to retain good habits once they have tried them once. Support services are needed to achieve this.
- There are services which catch those visiting the sick, to inform them about their own health.
- It was suggested that changing people's behaviour can be very difficult as often their perceptions are skewed and they are not able to admit they have a problem.
- Prohibitive costs can prevent people from using services.

Access to health care services

- Poor access to health care services may lead to people ignoring symptoms.

Other factors

- Lack of self-control.
- Rising utility costs may limit people's ability to heat their homes which could exacerbate or allow illness to develop.
- Importance of strong family ties/support networks:
 - A particularly important factor missing from the options is that of family in the formation of habits and values in children. Keeping families together is very important.
 - Family break-up and poor parenting are the causes of most of this ill health.
 - Should we therefore spend most money on supporting families? Yes, but you need to have short medium and long term solutions. You have to address these current symptoms.
 - The system supporting families needs changing, in terms of benefits and incentives.
 - It was noted that it is not enough for schools to promote messages about good health unless these are backed up by parents at home.

Other key points raised

- Many factors can be inter-linked.
- You can link several of the factors listed here (e.g. unemployment can lead to alcohol abuse). The central question is where along the chain you tackle the problem.
- Some of the factors listed underpin all the others. Homelessness, for example, includes unemployment; social interaction is especially important in this geographical area (due to the rural characteristics of Cambridgeshire); stress is another factor that includes physical symptoms.
- The factors listed are symptoms not causes of ill health. It's more important to identify causes instead of symptoms. For example, homelessness is a symptom with possible causes of high rent, unemployment, benefits, low educational attainment, low income.

APPENDIX 2B

Focus Group notes on whether some ill health can be prevented

- Yes, through things such as smoking awareness, food labelling campaigns.
- There is a lack of emphasis on physical activity- we all know it's good for us, but do we do it?
- It is important to get children used to being outside. Parents are afraid of the risks of doing this.
- The secondary school routine is too tiring to enable children to have enough energy to go out after school.
- However, in places where children do go out we have seen riots in recent months.
- There are wider factors which prevent good health, such as the rise of Tesco in encouraging car use and removing local food options.
- There was a little disagreement with this last point - some stated that we all have a choice.
- Others responded that through such things as 2 for 1 deals, the bad option is always available.
- Perhaps the points being made are middle class views?
- You first need to define ill health and prevention.
- Anti smoking campaigns work.
- The proposed Health Bill includes preventative measures; public health is already on the agenda.
- The causes of ill health are located in childhood (before the age of 7?) - at home and at school is where to focus effort.
- Surestart supports single parents rather than families- but this scheme is better than what was there before.
- Parenting lessons are needed to set good habits for children. These can improve factors such as social interaction, low self esteem and mental health.
- Most medical money is spent on over 65s- but the working age group leads up to this age group, and so what support is provided for the working age group therefore affects the health of over 65s.
- It was agreed that generally people have good access to health care services in Cambridgeshire but lack of education, lack of motivation and a restricted income may affect people's ability to take action for themselves.
- Society provides mixed messages.

APPENDIX 3

Focus Group notes on statements regarding taking responsibility for your own health and the support that should be given

- Tend to disagree: some are not able to understand whether they are in good health.
- Some go online and buy inappropriate medicine.
- Some don't have online access to information.
- Suggestion that the question "Should...?" was badly worded. No one would disagree with the statement that people should, but it needs qualifying with the rider "within your own ability". People should try to look after their health.
- If you put too much pressure on people you will get a converse reaction.
- You need to entice not force people to change behaviours; help and support should be available.
- Some can't access help and support.
- Different people have different needs.
- There is a range of abilities to look after one's own health, rather than a strict divide of those that can and those that can't.
- For cost reasons alone it is important to focus on ill health prevention.
- Ideally yes - people should look after their own health. However, some people can't achieve this on their own.
- You need to provide information to support people in maintaining their own health. Often people have to go to the health service, rather than it coming to them.
- Emphasis must be on empowerment- information, education and help.
- Sometimes people don't want to know they are ill (e.g. prostate cancer).
- Some people are on a "suicide mission" and won't accept help.
- You have to give people self esteem and a reason to live, rather than just tackling medical issues.
- You need to provide capability and control to be healthy.
- There are perverse incentives in funding of support services. For example, City Council funds homeless shelters on the number of empty beds they have. There is therefore no incentive to move people on. Once people become homeless they are stuck in their situation.
- People should look after their own health but some groups may need support (e.g. those with mental illness, the elderly, those with learning disabilities and children).
- Hospitals should allow their patients to stand outside the entrance to the hospital smoking.
- GPs don't have time to give full and proper advice to their patients in the time allowed for routine appointments. Also they may not give message forcibly enough.
- Patients lose faith in support services that don't give them sufficient time.
- Immediacy of advice is important. If you have to wait for an appointment then you can lose heart.
- Government should promote healthier options for those able to take them for themselves.
- Good health care and support services enable early 'diagnosis' of problems before they become full-blown illnesses.

APPENDIX 4

Focus Group notes regarding Prevention Services

Healthy eating and cooking programmes

- Run by the public and voluntary sector, e.g. the National Trust.
- There was a perception that access to such services varies across the county.
- What is the cost for the users of these services? Cost could create inequality of access.
- Cambridge Health Improvement Programme (CHIP) exists, where doctors prescribe dietary improvements.
- Way to Go mentioned.
- Healthy eating information available includes Tesco healthy eating flyers.
- The group was more aware of national initiatives such as Change for Life rather than local initiatives, and was unclear what services existed.
- Children's tooth extractions in Cambridge City are much lower than in Wisbech.
- Some don't know of any such schemes.
- One contributor mentioned a Cambridge programme.
- Such schemes need to be targeted at those who need it most, but may also be unlikely to be attracted by such a programme.
- In one contributor's experience a basic cooking course was cancelled due to lack of interest.
- Jamie Oliver has highlighted that cooking skills are lacking nationally.
- Local Taste Buddies programme has had funding issues.
- Also an issue with 'fit for purpose' kitchens that are fit to be used for teaching purposes.
- Sure Start, Carry on Cooking
- People who access these problems may be people who don't really need them.
- Have been hit by funding cuts.

GPs and Nurses

- GPs do promote healthy eating.
- Natural England are doing some work with GPs to link medical services with wider services.
- GP consortia will now have the budgets to focus health provision.
- GP surgeries should have patient groups, although they are often poorly attended.
- GP services mentioned included: health monitoring for the over 40s, support for carers, Gateway (mental health) workers, self selected patient groups.
- You have to be in the surgery to know about such services.
- There is a stigma about people wasting the valuable time of GPs.
- Are there figures showing the number of people who don't go to the doctors?
- A wellbeing surgery was mentioned which screened healthy people and identified several diabetics.
- Many people are not registered.
- 75% of medical costs are spent on the last three years of people's life.
- Health lectures are put on, although only for people who will actively go to them.
- Engaging people who wouldn't otherwise see a GP is important- one example is a converted bus that stops in the city centre to catch shoppers.
- There is a choice to be made between offering the opportunity to access services, and going to see people in their everyday life.
- They deal with problems rather than prevent problems (you wouldn't get an appointment to prevent a problem).
- Contributors were not aware of GP prevention services.
- Drop in centres are needed.
- Getting appointments is difficult.
- NHS direct is useful.
- Dieticians work with GPs, but more could be done on this theme.
- GPs would ideally function as A&E outpatient clinics.

- The public need to know what's there in order to use it.
- At present you can only register with one GP. For commuters it would be helpful to be able to register with two (work vs. home access).
- Surgery hours can be unhelpful for employed people.
- Royston surgery has evening and Saturday sessions.
- Drop in sessions are well used in some places but not in others.
- Prevention services they provide like screening and health checks are seen as important.
- Lack of provision of NHS chiropody services.
- Lack of time in GP consultations is seen as a problem
- Importance of giving good, timely, forcible advice.
- Not everyone registering with a doctor.
- Do younger people go to the doctor – is it the right place to offer advice?
- Services need to be more joined up.

Workplace schemes that support healthy lifestyles

- Only large companies are able to do this.
- SMEs don't have the capacity; Cambridgeshire has a high proportion of smaller employers for whom this would not be a priority.
- Cambridgeshire County Council has lunchtime activities.
- National Trust jobs provide outdoor lifestyle type roles as a matter of course.
- Support needs to be given to employers to provide such schemes. Ideas included tax incentives, employee contributions, easy templates of what to do, cooperatives of companies could work together.
- It's easier to run awareness schemes when a company has a canteen.
- It is important to sell the benefits to companies, such as fewer sick days.
- Some new start-ups are very good at such schemes.
- There is no-one to look after farmers' health.
- CCC signposts officers to lunchtime walks, although it is questioned how much people use them.
- Employers have to fund them.
- This is another socio economic issue- only the affluent in large companies receive such benefits.
- Some people don't have time in their lunch break for exercise.
- Only already fit people use exercise opportunities.
- Some companies are innovative. e.g. one, based on the urban fringe, has allotments which staff use in their lunch hour.
- Workplace schemes need to be targeted where they are most needed.
- In Japan workplace health and exercise are part of their culture.
- Staggering the working hours of large companies could help with commuting and associated health problems, as could shared commuting arrangements between large companies.
- There needs to be a change of mindset in the workplace from time spent working to achievement.
- Do companies really just pay lip services to such ideals as work/life balance? Examples cited of eating lunch at desk, working additional hours, working at home.
- More pressure now – same jobs to be done but less people doing them.
- Public sector seems to provide good options like reduced gym memberships, counselling and chaplaincy services. Taster sessions for healthy living activities but these were only available to staff at main office site.
- Not practical for smaller companies due to resourcing issues.
- Individuals' attitudes are also important

Alcohol services

- Do prevention services exist, as well as organisations such as Alcoholics Anonymous?
- FLAG scheme mentioned.
- It is a particular problem among immigrant workers in the Fens.
- It is a hidden problem among all social groups.
- Alcohol is too cheap.

- There is not enough support available, especially in the villages.
- Licenses were given to village shops to sell alcohol. This though again raises the question of responsibility.
- There are different alcohol-related problems, i.e. binge drinking and long term alcoholism.
- The question of forcing vs enticing behaviour change is important in relation to alcohol.
- The drinking age should be increased from 18 to 21.
- People no longer need to go to a pub to drink.
- Alcohol services are available but not accessible.
- Alcohol trends show the changes in social customs; now drinking starts earlier and finishes later.
- Alcohol problems are a symptom rather than a cause of ill health.
- Licensing laws and supermarket prices are part of the problem.
- More important during a recession.
- Alcohol is too cheap and too accessible. Efforts should be put into preventing people drinking the first place rather than seeking to provide a cure once someone is addicted.
- People do not acknowledge they have a problem.
- Aware they exist.
- Reduced funding means fewer sessions being provided.
- Desire to the address the problem has to exist.
- What is the root cause of someone drinking.
- Drinking is socially acceptable.

Stop Smoking services

- There is lots of awareness about the health problems related to smoking.
- Help is accessible at GPs, but also supermarkets sell aids for stopping smoking.
- There have been well publicised national awareness campaigns.
- Alcohol should be priced higher in the same way as cigarettes are.
- Smoking has been successfully tackled.
- This success may be as much about a change in societal attitudes as well as prevention measures, although the publicity campaigns act as a part of this.
- Making smoking difficult (e.g. banning under 16s from buying them) makes it more attractive to young people.
- More girls smoke now than boys- possibly a link between smoking and the goal of suppressing the appetite in order to be slim.
- Attitudes have now changed towards smoking; the campaigns have succeeded.
- Schools campaigns are perhaps more effective than TVV advertising campaigns.
- Parental influence is important.
- These have been successful and seen a good take-up.
- Success has been backed up by changed legislation.
- Has become socially unacceptable – no longer ‘sexy’.

Mental Wellbeing Services (including stress management)

- Suffers from the title including the word “mental”.
- Questioned whether there is enough support available.
- Support is not well advertised, although organisations such as MIND and the Richmond Fellowship do good work.
- Getting round the social stigma is a problem.
- Large companies are better able to provide mental health support.
- Some people are unwilling to accept help.
- People without work lose social interaction and are at risk of mental health problems.
- Mental health services only engage with sufferers once they are seriously ill.
- These services, and prevention of mental health problems in particular, are underfunded.
- Cambridgeshire has low funding for Mental health services in comparison to the rest of England.
- Health walks are a cheap way of preventing mental health problems. The challenge is to get buy in from GPs.
- Know very little about them and wouldn’t know where to go to access them.
- There is a bit of stigma still and they need demystifying.
- Need to join up with other services so that root causes are treated.
- You have to be quite acutely ill before they become available to you.
- Waiting lists for free counselling and CBT means that sufferers turn to other mechanism for coping (e.g. alcohol, drugs, etc).

Weight loss schemes

- Weight loss schemes are widely available.
- There are not many available for men, who may find it humiliating to attend with a large number of women (separate men’s sessions do exist).
- BMI tests can make people feel depressed; they don’t always seem to accurately reflect someone’s health. Such tests and support should be more individually tailored.
- There are some successful Weight loss schemes.
- Prevention- through dietary advice- is central.
- Healthy eating is now taught in school.
- Weight watchers works for a particular social group.
- The main problem is that people spend their leisure time sitting down at home.
- Food manufacturers have a disproportionate amount of influence over people’s lives.

- Overweight parents influence children.
- There is now a second generation of people with poor cooking skills.
- Private schemes such as Weight Watchers and Slimming World are well known and their methods of peer support are seen as useful.
- Private schemes are expensive and whilst they tell you how to lose weight they are less effective at teaching you how to eat healthily.
- Issues with keeping weight off in the longer term.
- People often need help with uncovering the trigger for over-eating.

Employment Services

- Suggested that such services are useless.
- Employment services are not geared up for anything other than minimum wage jobs.
- Employment services should be independent not government led.
- Employment services should extend or link better to volunteering opportunities: Work experience can lead to a paid role.
- The training sessions involving CV writing are demoralising.
- It appears there is a postcode lottery with regarding to job centres, with staff are some who don't know the 'rules of the system'.
- Do not provide suitable help for those who have a professional background.
- Lack of progression in employment services.
- Accessing them is a problem but once you have, they are quite good.
- Job centre in March has been closed and accessing other job centres, when you have no income, is difficult.
- Length of the time you have to be unemployed before you are able to access courses.

Adult Education Services

- People have to pay for such services.
- It is mostly a service for people who are already educated.
- Excellent but not free.
- People who access them don't really need them.
- Lack of funding to supply courses at the right level.
- Less aimed at skilling people for work.

Local Leisure Services that provide opportunities for physical or sporting activity

- Green space is free, as opposed to gym membership.
- Health walks are available, but the people that use them are already fit. They should rather focus on attracting those that need the exercise most.
- Provision of green space is important to enable children's exercise. This is cheap to provide.
- There is too much emphasis on formal sport, and not enough on being outside playing.
- Recent housing developments have reduced the amount of green space available.
- Outside play encourages social skills and interaction.
- Secondary Schools are cutting PE lessons.
- Green space is not seen as safe places by parents.
- Cambridge green space is mostly owned by the university, and is concentrated in the north of the city.
- Beyond ensuring the existence of green space, it also needs to be used.
- Lack of Green space seen as an urban problem.
- Arts activities are undervalued- funding has been cut.
- In Parish and strategic plans arts are not mentioned. They are an important factor in wellbeing which do not require much money.
- The community should be encouraged to organise itself.
- There is a need to distinguish between urban and rural problems. In rural areas the main problem is lack of transport.

- There is a challenge to get those other than affluent, fit people to use facilities such as Parkside pool. Should GPs prescribe exercise? Is this already done? Could such medical support be more forceful and deny access to medical care unless patients exercise?
- Affordability and accessibility and issues are they are mostly found in towns not rural villages.
- FDC provided free 'give it a go' session for people aged 50+ which had a good take up but the cost to carrying on using the services was prohibitive.
- You still have to pay even with a GP referral.

Local Housing Services

- There is a long delay in assessing people for disability aids in their own homes.
- This is a different but important problem in both urban and rural areas.
- Cambridge has a waiting list of 7000, with 1000 on the highest priority category.
- The amount of accommodation needed is not available, due to underuse of accommodation, and high rents.
- New laws regarding housing benefit will exacerbate the problem.
- There is currently no private housing in Cambridge which is affordable to those on housing benefit.
- Family breakdown increases the need for housing- a split family ideally needs two family sized houses.
- All of the above services are patches rather than solutions.
- There is enough accommodation in terms of rooms- but nowadays people want to live in separate accommodation.
- Know that the service exists.
- Long waiting lists and few houses being built.
- Lack of social housing stock.
- Nightshelter provided exclusively for EU migrants and not indigenous population.

Citizens Advice Bureau

- Funding has been recently cut.
- Needs more funding.
- Some CABs are losing funding.
- CAB advisors have 1 day's training in mental health issues, but they use an extensive computer database to provide advice.
- Huge demand on services.
- Long waiting list for advice so people find their own solutions in the interim like taking out high-interest loans.
- Advice provided is now very formulaic. Less subjective and less personal service now being provided.

Other

- Most services listed require transport to access them. Money should be given to community transport initiatives.
- All the services listed are curative not preventative.
- Prostate screening for example is not covered here.
- Money should be given to small community groups rather than large organisations.