

Poverty & Health

Potential opportunities to strengthen poverty reduction in neighbourhood health and care pathways in Cambridgeshire

Public Health

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1. Background to poverty & health

What is poverty?



Described as:

“Not being able to heat your home, pay your rent, or buy the essentials for your children. It means waking up every day facing insecurity, uncertainty, and impossible decisions about money. It means facing marginalisation, and even discrimination, because of your financial circumstances. The constant stress it causes can lead to problems that deprive people of the chance to play a full part in society.”

[Joseph Rowntree Foundation](#)

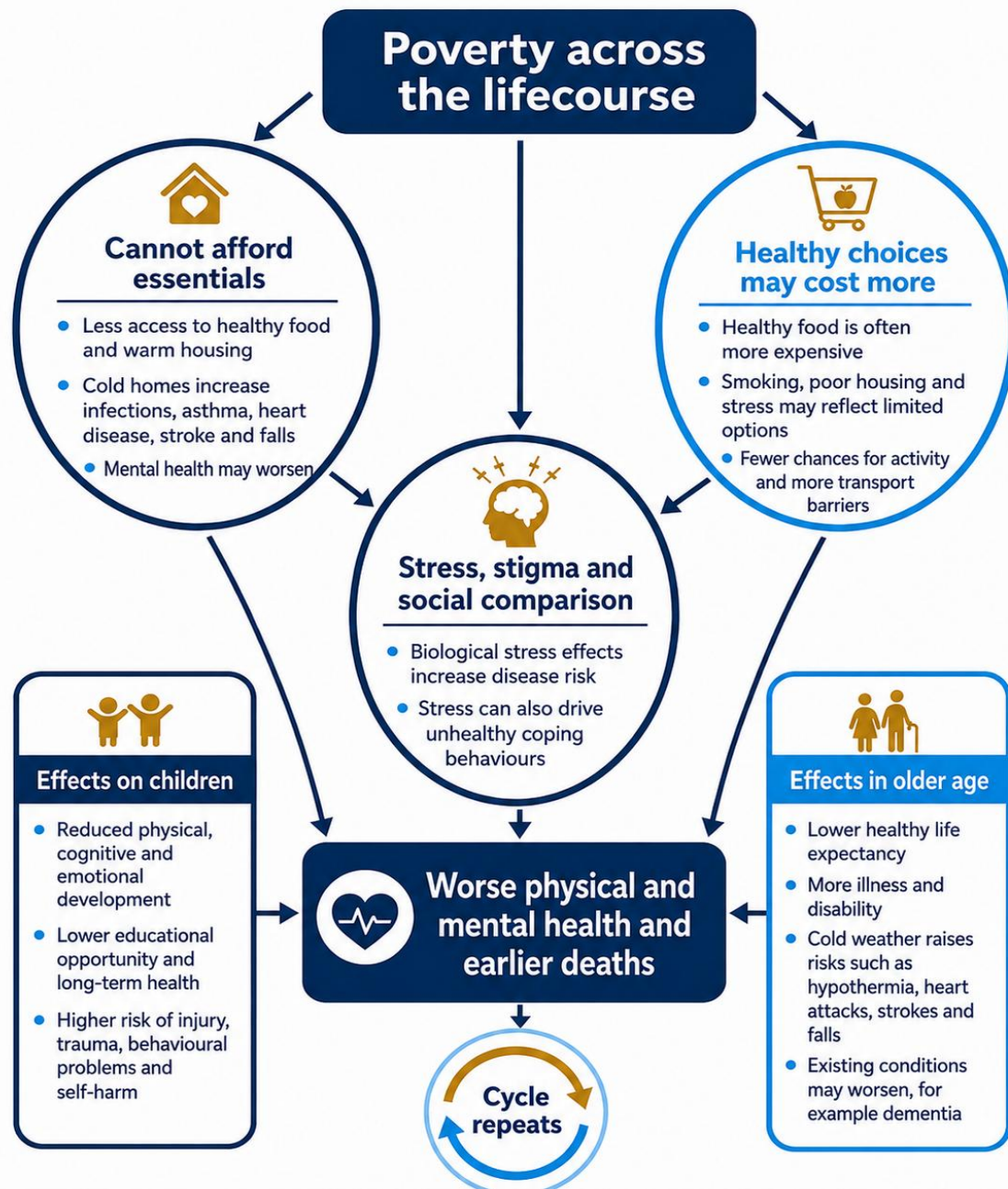
Measured as:

While poverty is not just about low income we have used the following statistics to look at poverty in Cambridgeshire & Peterborough because the data is available for small areas:

The proportion of the population in an area experiencing deprivation relating to low income. This includes people who are dependent upon the state for some form of means-tested benefit, and includes both those people that are out-of-work, and those that are in work but who have low earnings and are claiming a means tested benefit.

There are separate measures for children (up to 15 years) and older adults (60+).

This is all from the Index of Multiple Deprivation.



Poverty across the lifecycle



Living with low income and financial insecurity impacts health through multiple pathways, including:

Material impacts: Not being able to afford resources for good health such as nutritional food, adequate housing and being able to heat your home, resulting in people living in cold damp homes and going hungry.

Behavioural impacts: Creates barriers to adopting and maintain healthy behaviours. Increases risk of addictive behaviours (gambling, alcohol, tobacco).

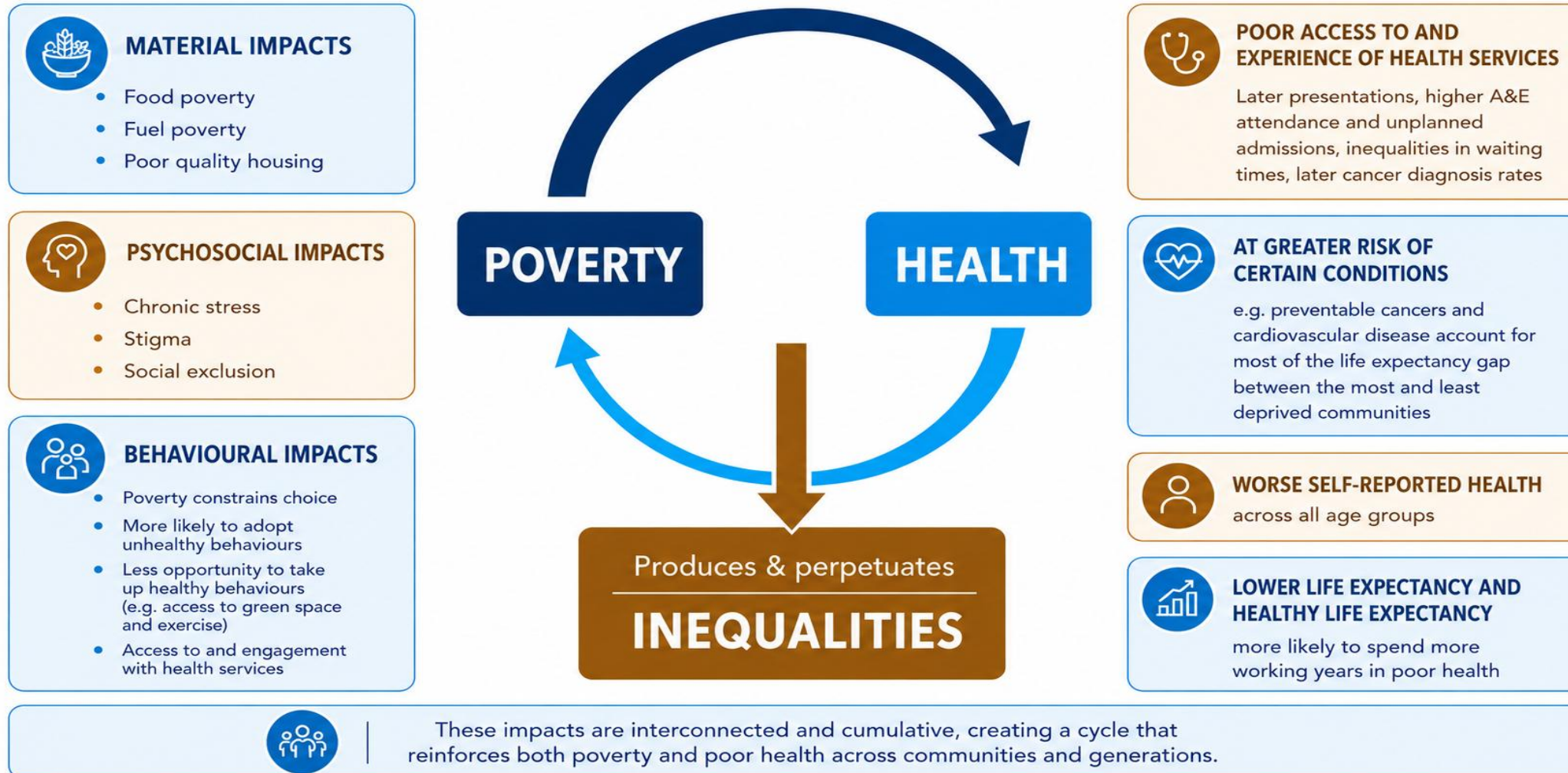
Psychosocial impacts: Living with financial insecurity including debt can cause chronic stress and exacerbate existing mental health problems, which increases the risk of poor health and certain diseases. It can also lead to social exclusion.

Access to health care: Creating barriers to accessing health care, such as not being able to afford to take time off work to attend appointments or not being able to afford to travel to appointments (public transport and car parking charges can both be an issue).

Educational: affects childhood cognitive development and impacts on access to and achievement in school

Social: poverty restricts social participation in leisure/recreational/social events and leads to isolation and loneliness

Poverty driving health inequalities



2. Patterns of poverty in Cambridgeshire

For place-based partnerships and integrated neighbourhoods, data below includes income deprivation data from the Index of Multiple Deprivation 2025 plus the supplementary data for children (IDACI) and older people (IDAOPI). Percentages have been applied to mid-year ONS population estimates for 2024.

Summary



- In total there are an estimated 204,100 people living in poverty in Cambridgeshire & Peterborough (19% of the population). This includes 55,400 children aged 0-15 years (30%) and 37,700 people aged 60+ (14%). Note that the rates and numbers of children living in poverty will be over-estimated as the two-child benefit cap was lifted in April.
- Patterns in poverty vary by place, locality and integrated neighbourhoods. Fenland and Peterborough have significantly higher proportions of their populations living in poverty across all age groups. The difference is particularly stark for 0-15 year olds with 40% of CYP in Fenland and 46% in Peterborough living in poverty. This is also reflected in total numbers across Cambridgeshire districts. Numbers are highest in Fenland (7,000) and Huntingdonshire (6,200) but large numbers of children also live in poverty in Cambridge City (5,900).
- This variable pattern is present in the patient population of primary care networks. Overall the North place has an estimated 145,000 (27%) patients living in poverty compared to 59,100 (13%) in the South Place.
- The percentage of patients in poverty varies greatly across the North Place from 12% of St Ives PCN (almost 6,000 low income patients) to 40% of Central Thistlemore and Thorpe Road PCN (almost 42,000 low income patients). The South Place has lower variation between PCNs (8-19%).

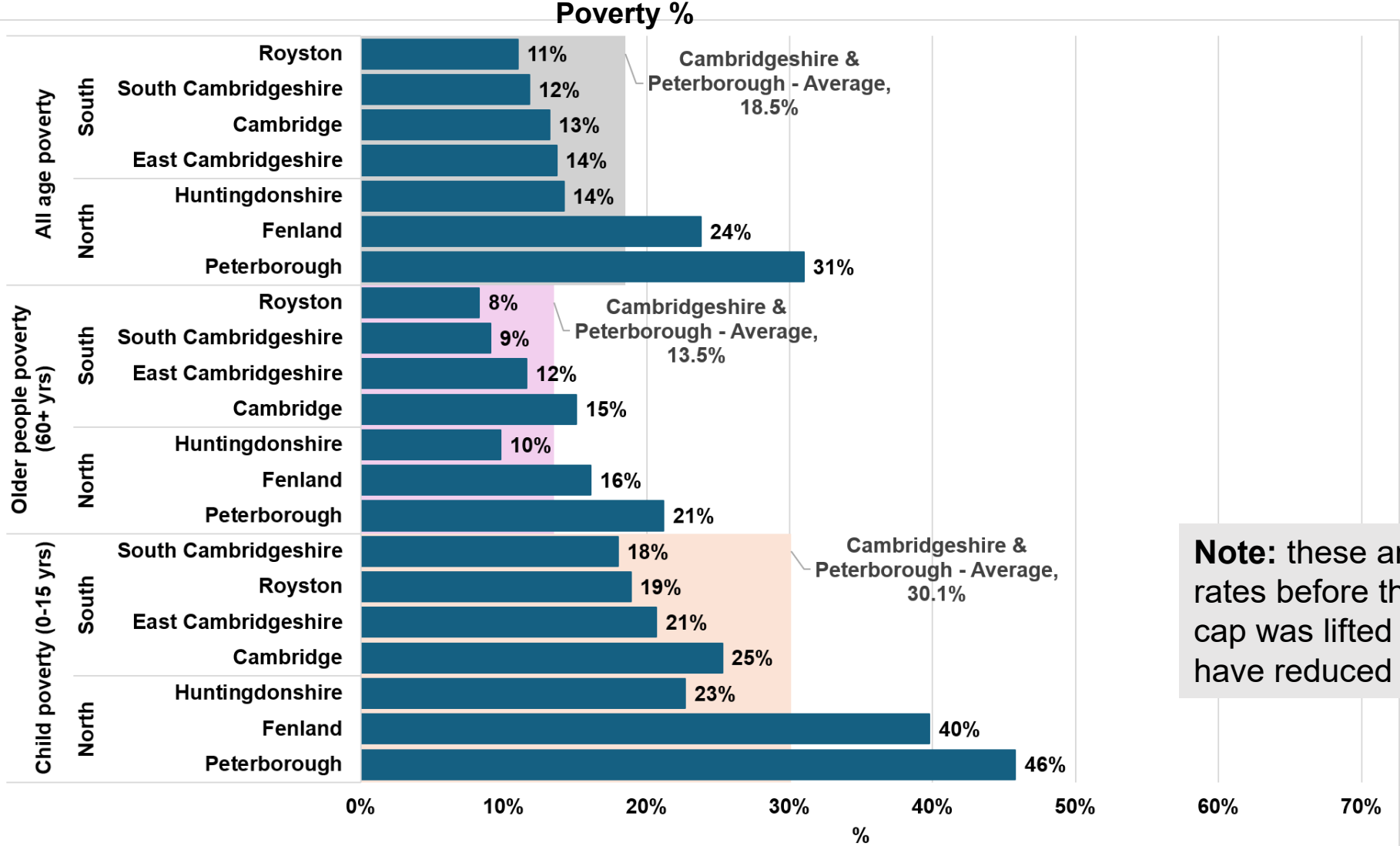
Poverty by place and locality



All age poverty

Older people poverty (60+ yrs)

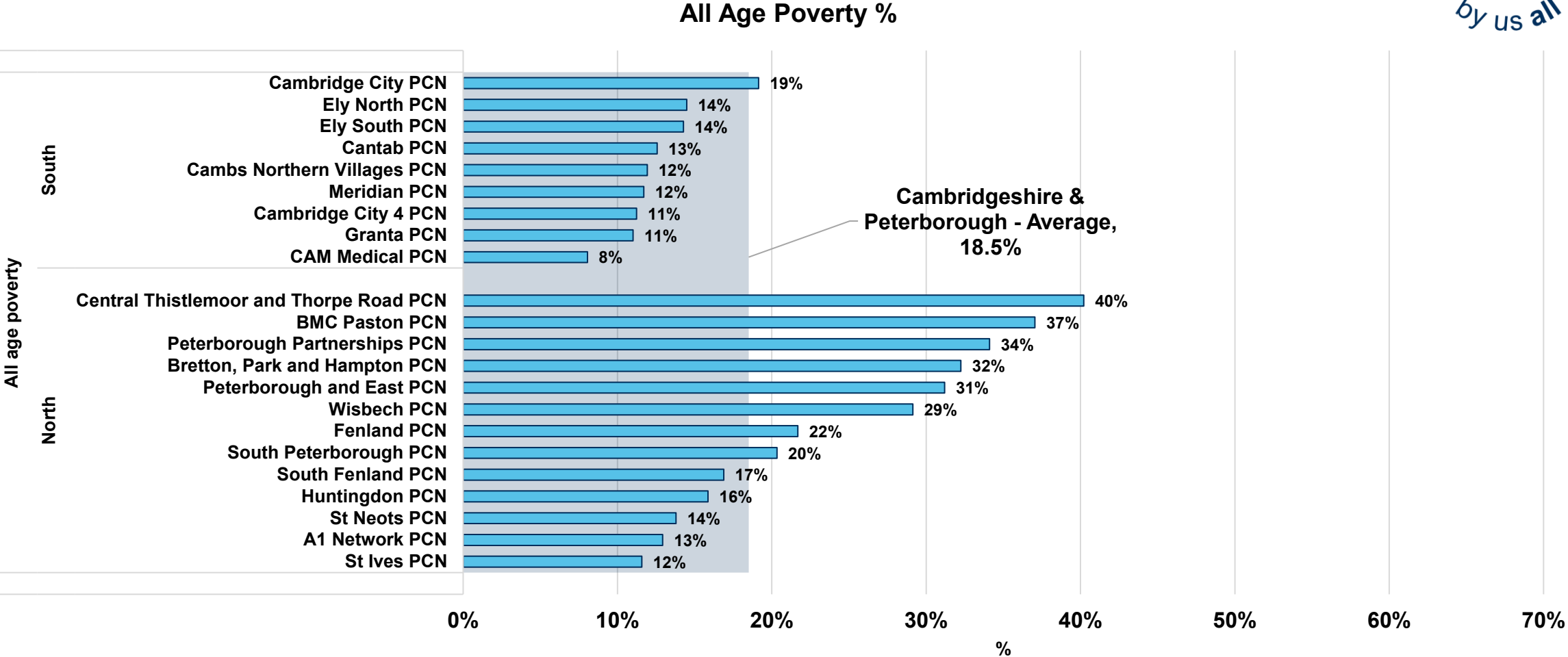
Child poverty (0-15 yrs)



Note: these are the child poverty rates before the two-child benefit cap was lifted in April – this will have reduced these rates.

Sources: [English indices of deprivation 2025 - GOV.UK](#) Child poverty (0-15 yrs): Income Deprivation Affecting Children Index (IDACI) Score (rate); Older people poverty (60+ yrs): Income Deprivation Affecting Older People (IDAOPI) Score (rate); All age poverty : Income Score (rate). PCN deprivation scores are modelled estimates based on the deprivation levels of the small

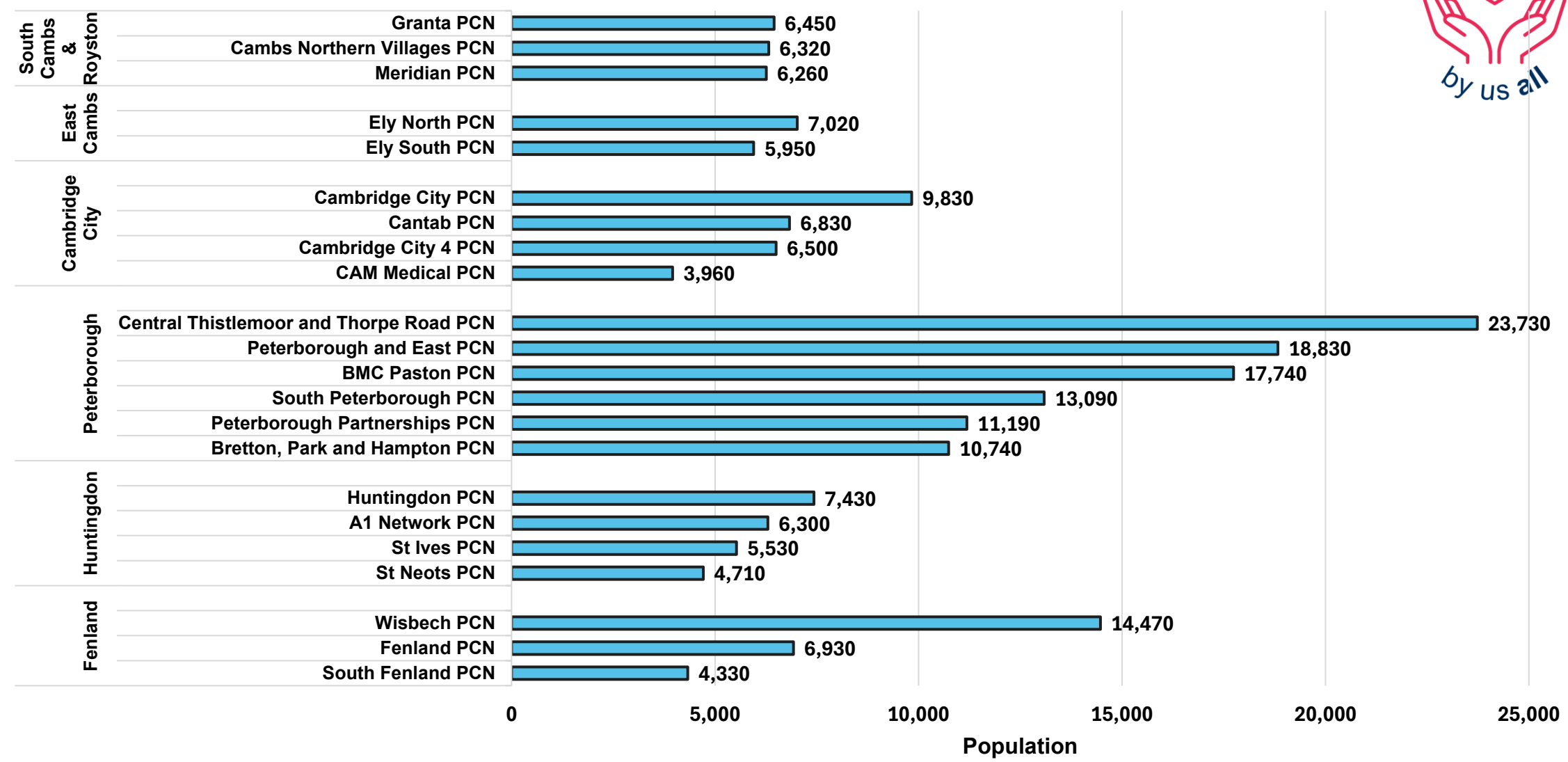
All Age Poverty by integrated neighbourhood



Sources: [English indices of deprivation 2025 - GOV.UK](#) and Local Insights – ONS Mid Year Population estimate 2024
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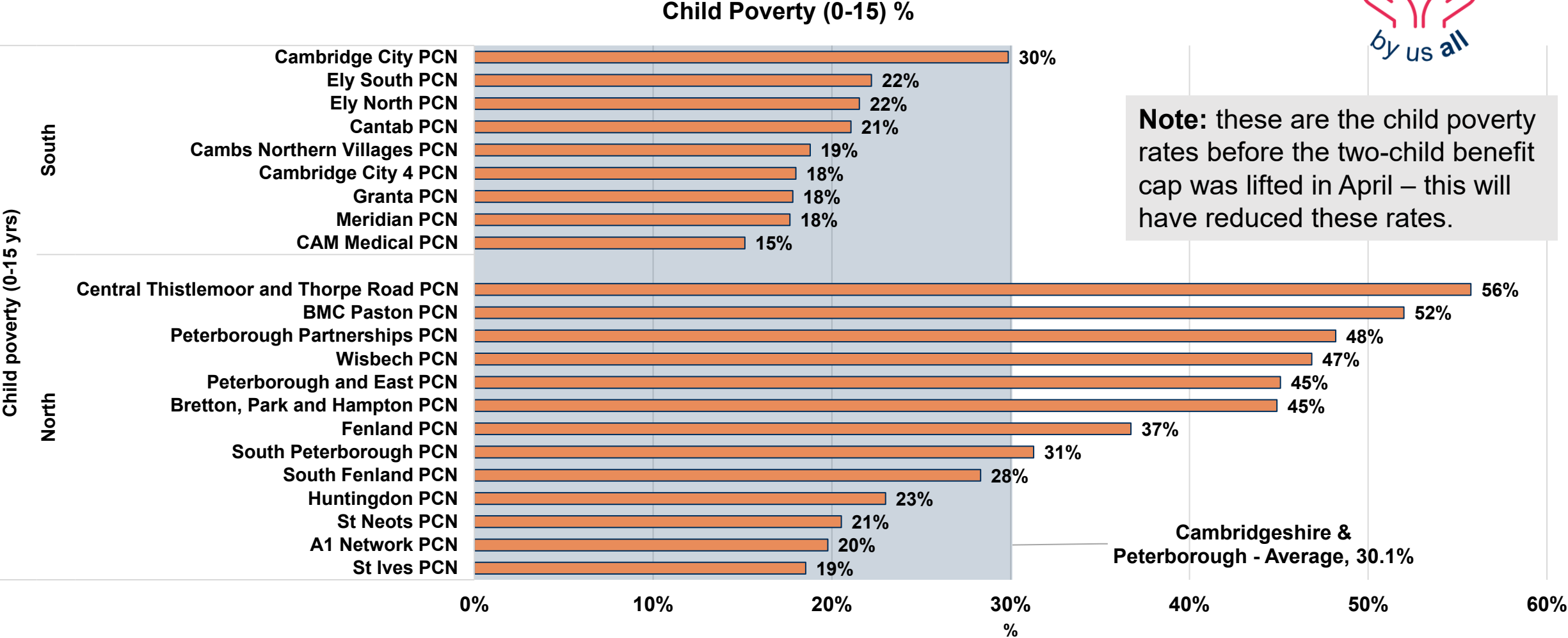


All Age Poverty estimate - based on registered population as at June 2026



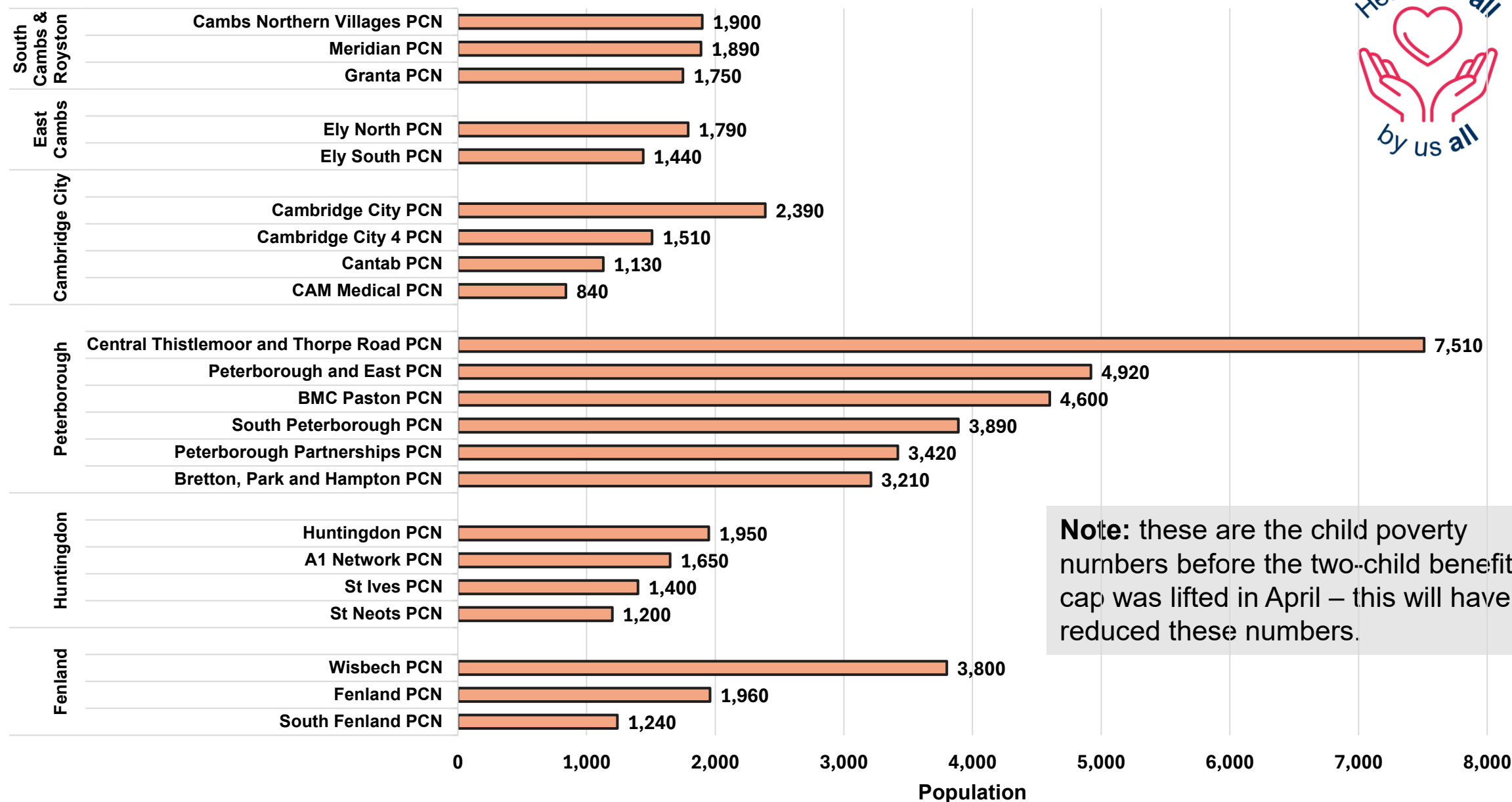
Sources: NHS Patients registered at GP practices June 2026 ([Patients Registered at a GP Practice, June 2026 - NHS England Digital](#)) and All age poverty : Income Score (rate) ([English indices of deprivation 2025 - GOV.UK](#)) downloaded from [Map | Local Insight](#) June 2026. Estimated counts are derived by applying modelled PCN rates to the registered population, providing an estimate of the number of registered patients

Poverty by integrated neighbourhood



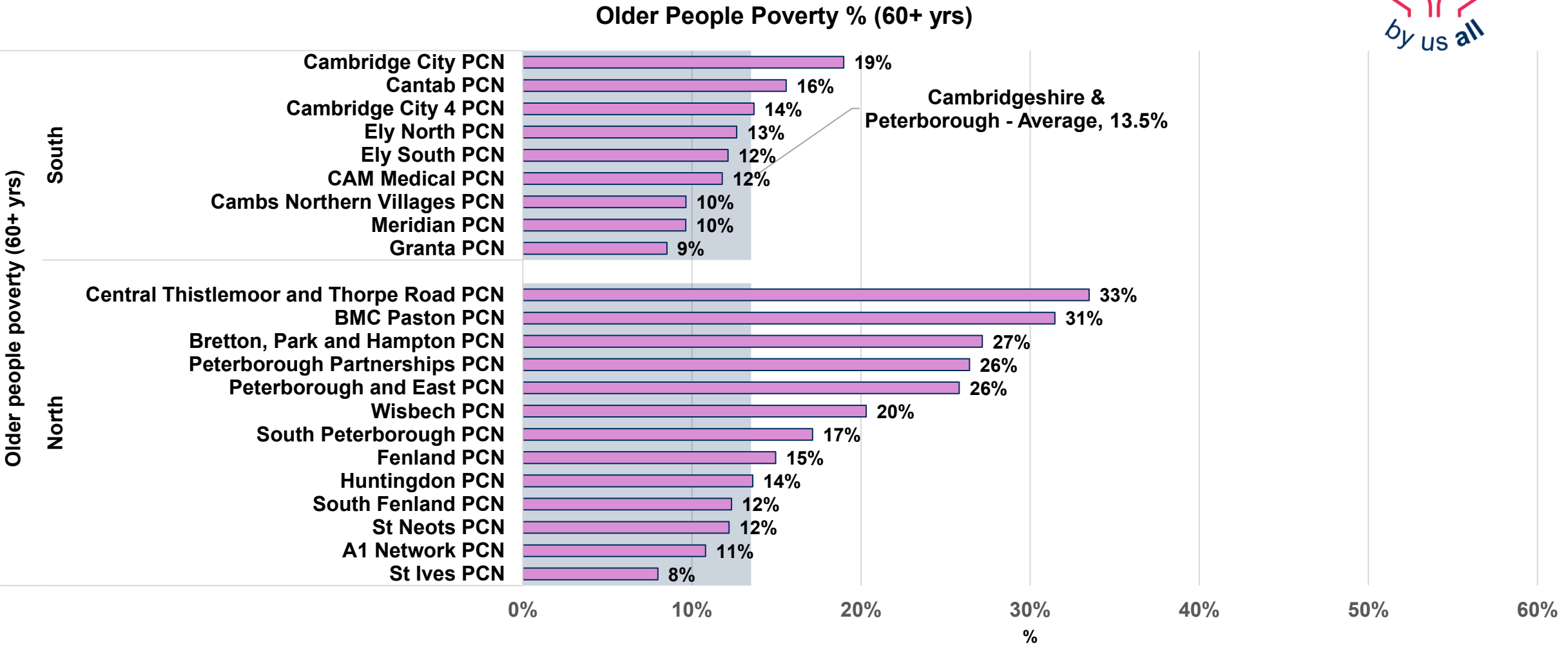
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Child Poverty (0-15 yrs) estimate - based on registered population as at June 2026



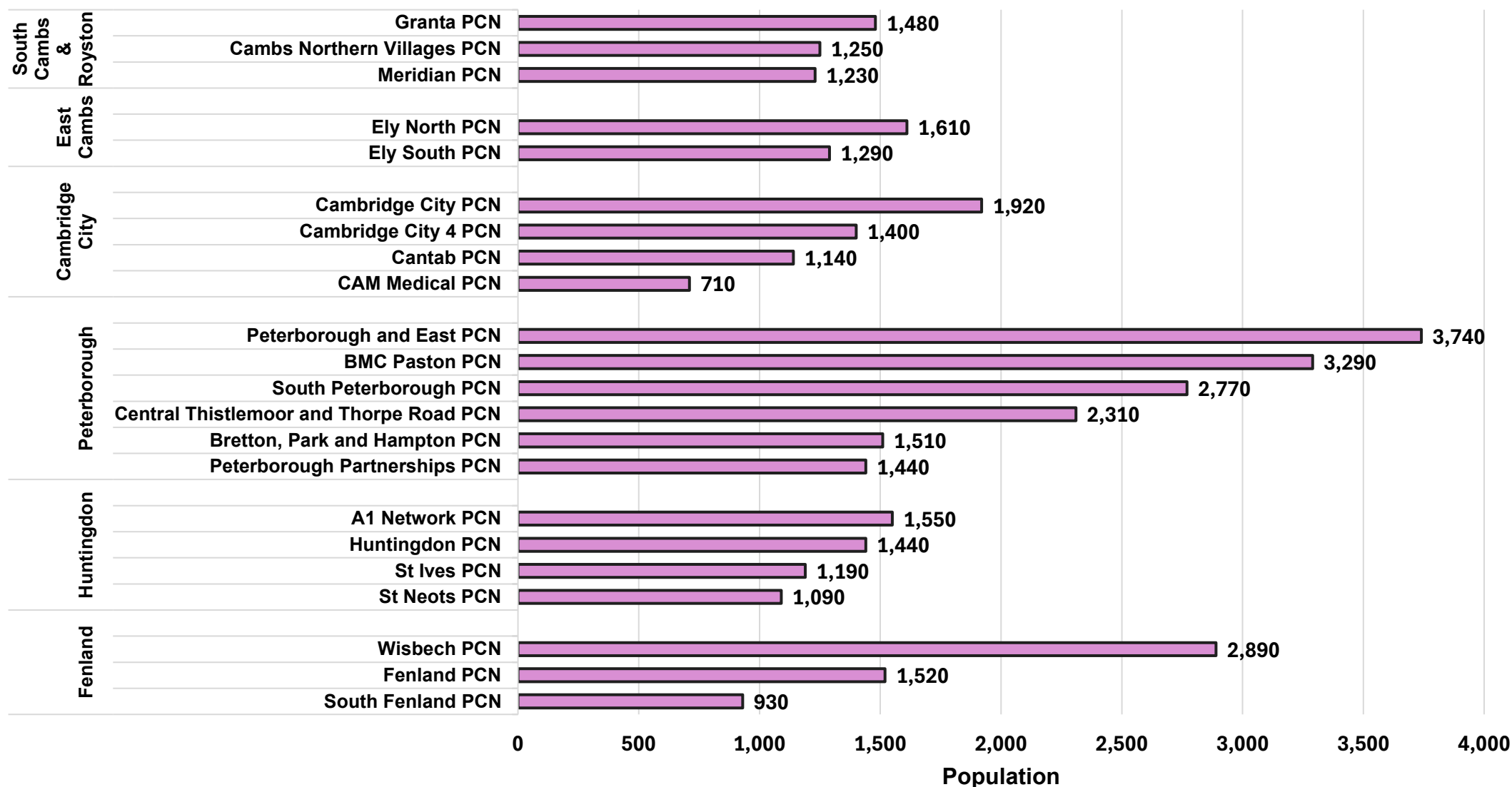
Sources: NHS GP Registered Population June 2026 ([Patients Registered at a GP Practice, June 2026 - NHS England Digital](#)) and IDACI score (Income Deprivation Affecting Children Index) ([English indices of deprivation 2025 - GOV.UK](#)) downloaded from [Map | Local Insight](#) June 2026. Estimated counts are derived by applying modelled PCN rates to the registered population, providing an estimate of the number of registered patients

Poverty by integrated neighbourhood



Sources: English [indices of deprivation 2025](#) - [GOV.UK](#) and Local Insights – ONS Mid Year Population estimate 2024
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Older People Poverty (60+) estimate - based on registered population as at June 2026

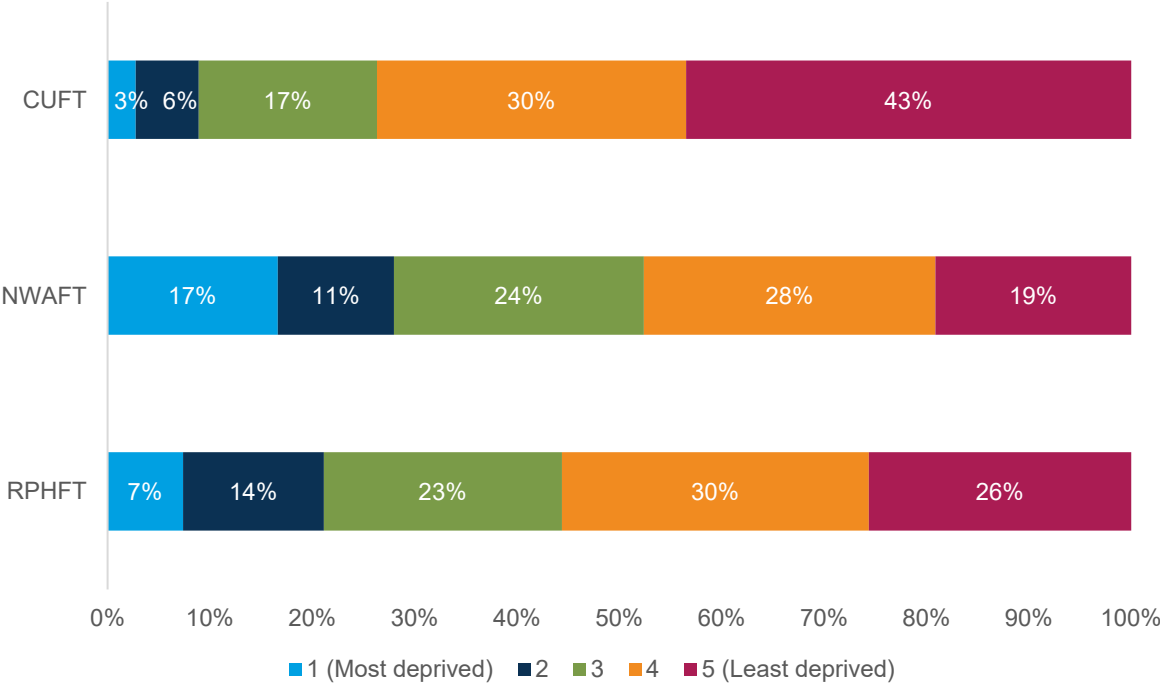


Sources: NHS GP Registered Population June 2026 ([Patients Registered at a GP Practice, June 2026 - NHS England Digital](#)) and IDAOPi score ([English indices of deprivation 2025 - GOV.UK](#)) downloaded from [Map | Local Insight](#) June 2026. Estimated counts are derived by applying modelled PCN rates to the registered population, providing an estimate of the number of registered patients. PCN deprivation scores are modelled estimates based on the deprivation levels of the small areas served by the PCN, weighted so that areas contributing more patients have a greater influence on the overall score.

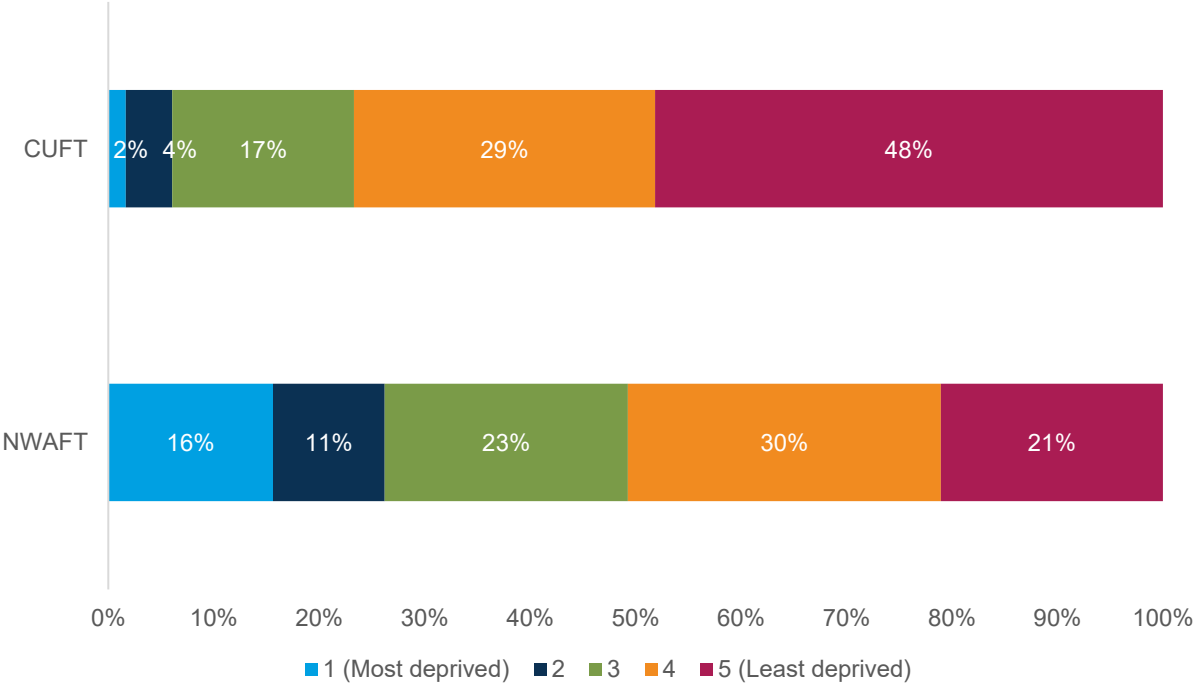
Poverty & acute trusts



Percentage of 2024/25 hospital catchment populations for elective admissions by trust and IMD quintile



Percentage of 2024/25 hospital catchment populations for emergency admissions by trust and IMD quintile



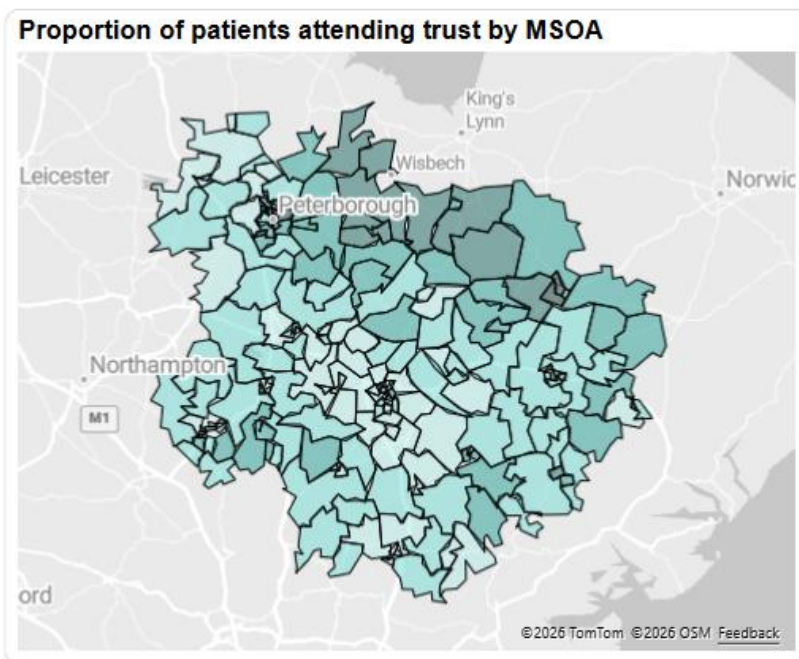
Source: NHS acute (hospital) trusts catchment populations dashboard. The Royal Papworth Hospital NHS Foundation Trust only has data presented for elective admissions. Note that deprivation is not just income deprivation – it is all of the domains from the Index of Multiple Deprivation.

Difference between elective and emergency admission catchments

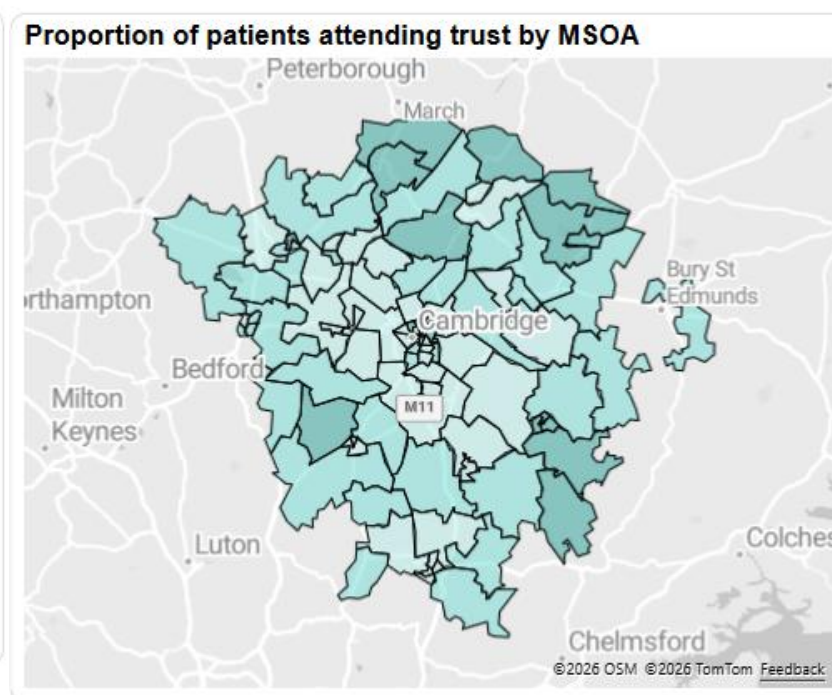
Cambridge University Hospitals



Elective admissions (2022/23 - 2024/25)



Emergency admissions (2022/23 - 2024/25)



More patients receiving elective care at CUH are from the more deprived areas of Cambridgeshire. Includes more than 2,250 patients from Fenland.

The map above shows MSOAs and the deprivation quintile of patients going to any hospital, that go to the selected trust. Proportions below 5% are not shown.

- Q1 - Most deprived
- Q2
- Q3
- Q4
- Q5 - Least deprived

Use the 'Trust MSOA view' selector to see only MSOAs where the majority of patients go to the selected trust (First past the post).

Source: NHS acute (hospital) trusts catchment populations dashboard.

Maps: Office for National Statistics licensed under the Open Government Licence v3.0. Contains OS data © Crown copyright and database right 2026.

3. “What works” to reduce poverty through health services

Strongest evidence

Welfare rights advice, Healthy Start and food/fuel-poverty support, removing direct cost barriers to care, NHS anchor institution employment and procurement practices.

More limited or mixed

Family Nurse Partnership, social prescribing impact.

Limitations

Most evidence from reviews, single-site evaluations or guidance rather than randomised control trials (RCTs).



Increasing income and reducing the cost of essentials



Welfare Rights Advice

Most consistently evidenced income-maximisation pathway. Advisers embedded in GP Practices, hospitals and mental health services. Average gains of £390 to £1,919 per person or family per year.

Healthy Start & Food Support

Vouchers and payment cards for low-income pregnant women and young families. A data-led campaign across three London boroughs increased uptake by 5.4%, generating £11 of value per £1 spent

Family Nurse Partnership

Intensive home visiting for first time adolescent mothers. Improved child development and school readiness, but costs around £1812 more per participant. Mixed evidence on primary health outcomes.

Fuel Poverty & Warm Homes

Boiler replacements, insulation and heating-on-prescription pilots. Reduced emergency admissions. Age UK identified £ 59 million in unclaimed benefits in 2023/24 through the associated benefits check.





Connecting to support and removing access barriers



Social Prescribing & Link Workers

Connect people to welfare, debt, housing and community support. Widely adopted but evidence on outcomes remains variable.

Poverty Proofing & Core20PLUS5

Audits and frameworks to identify barriers for the most deprived. Evidence of long-term impact on poverty, health outcomes or population-level inequality remains limited and still emerging

Debt and Financial Capability Support

Help manage arrears and reduce anxiety through welfare advice linked to health services. Evidence on long-term health and service-use outcomes remains limited.

Outreach & Community Hub Models

Outreach and community health worker models bring care closer to people facing transport, cost and navigation barriers; in Westminster, this was associated with 7% fewer unplanned GP appointments, 47% higher likelihood of vaccination, and 82% higher uptake of cancer screening and NHS Health Checks.

Removing Cost Barrier to Appointments

Travel, parking and prescription support. Community hubs and telehealth. North Lincolnshire CCG example reported up to 90% fewer missed appointments.

Digital Inclusion & Inclusive Design

Ensure patients are not excluded by lack of devices, data, transport, flexible appointments, clear communication or confidence using digital NHS routes. Improve access, attendance and patient experience. Evidence on long-term health and poverty outcomes remains limited



Addressing structural and housing-related drivers



Anchor Institutions

78%

25 of London's 32 NHS Trusts, had achieved London Living Wage accreditation, up from fewer than 10 in 2022.

Use local procurement, recruitment and pay policies to keep economic value within deprived communities. Greater Manchester: 41.7% local spend, 42.4% recruitment from the most deprived areas. Preston Community Wealth Building: 11% rise in median wages and 3% reduction in antidepressant prescribing

Hospital Discharge & Homelessness Support

89%

Oxford Health NHS Foundation Trust's co-located Housing Options Officer and step-down housing model reported an 89% reduction in delayed discharges, with estimated savings of £657,000.

Use the hospital stay to address health, housing and welfare needs together. Specialist pathways coordinate discharge planning with housing, benefits and GP registration. Bristol pilot: 24% fewer admissions, 85% decrease in patients lacking GP registration