

Background

The [Cambridgeshire Annual Public Health Report 2013/14](#)¹ focused on the new national Public Health Outcomes Framework (PHOF) which provides detailed information on how well Cambridgeshire and districts is doing compared with other areas for a range of health outcomes, as well as the lifestyle and environmental factors which influence health. The PHOF is available on an interactive website which is updated quarterly, and is designed to be accessible and understandable for the general public as well as specialist staff: www.phoutcomes.info. Local information is also available at <http://www.cambridgeshireinsight.org.uk/health/phof>.

This report provides background to three indicators where Cambridge City has statistically significantly high rates compared with England as a whole:

- Fuel poverty
- Injuries due to falls in people aged 65 and over
- Hip fractures in people aged 65 and over

Further information will be presented to the meeting on October 23rd.

Fuel poverty

An understanding of fuel poverty is important because it can have negative effects on health and well-being; the 2012 Hills Review² suggested around 2,700 excess winter deaths caused by fuel poverty. It is strongly linked to general income poverty and deprivation, with households on below average incomes having to sometimes choose between heating their homes and other essentials such as food or accommodation costs, especially if they live in older, less well-insulated stock which uses more fuel to heat and increases carbon emissions.

Whether a household is in fuel poverty is determined by the interplay across three factors:

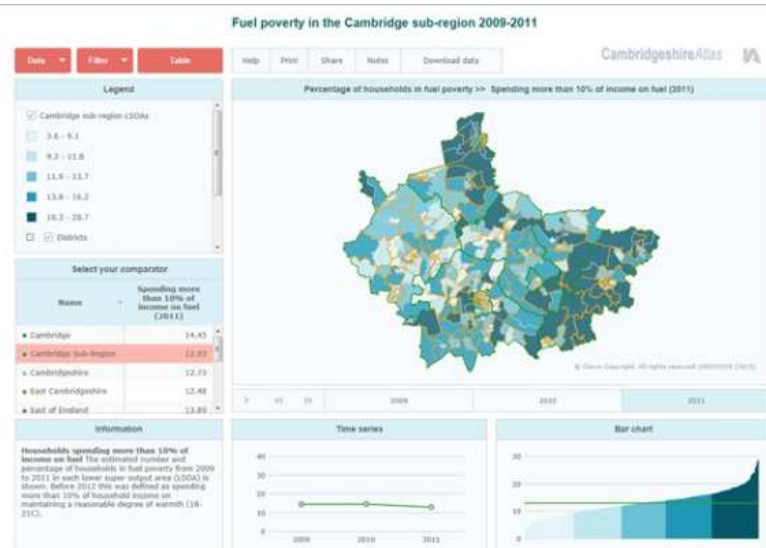
- The energy efficiency of the property;
- Energy costs;
- Household income.

Research about households in fuel poverty across the Cambridge housing sub-region is shown in the [Cambridgeshire Atlas™ | Fuel Poverty](#)³. This Atlas shows local data about fuel poverty. It looks at the number and percentage of households in fuel poverty at a detailed level (known as lower super output area or LSOA level). It compares these small areas with district, sub-region and country-wide data.

¹ http://www.cambridgeshire.gov.uk/download/downloads/id/2944/annual_public_health_report

² <https://www.gov.uk/government/publications/final-report-of-the-fuel-poverty-review>

³ <http://atlas.cambridgeshire.gov.uk/Housing/FuelPoverty/atlas.html>



What is fuel poverty?

The Atlas considers two definitions of fuel poverty. The 2009 to 2011 estimates are based on a household spending more than 10% of income on maintaining a reasonable degree of warmth (in England, between 18 and 21 degrees C). Based on this definition there were an estimated 7,493 households in Cambridge City (15.8%) in fuel poverty.

In 2012, the indicator for fuel poverty is based on a revised methodology (Low Income High Costs (LIHC)) based on households with below average incomes paying above average costs for fuel. This definition combines information on household income and energy costs to work out whether a household is fuel poor. Nationally the change in definition means around 800,000 fewer households estimated to be in fuel poverty; the previous definition possibly included some high income households with high (but affordable for them) fuel bills. This new definition emphasises urban fuel poverty whereas the previous definition tended to highlight fuel poverty in rural areas. In the Cambridge sub-region, the new definition shows more fuel poverty in areas such as Cambridge City and some of the market towns and less fuel poverty in more rural areas.

Fuel poverty in Cambridge City

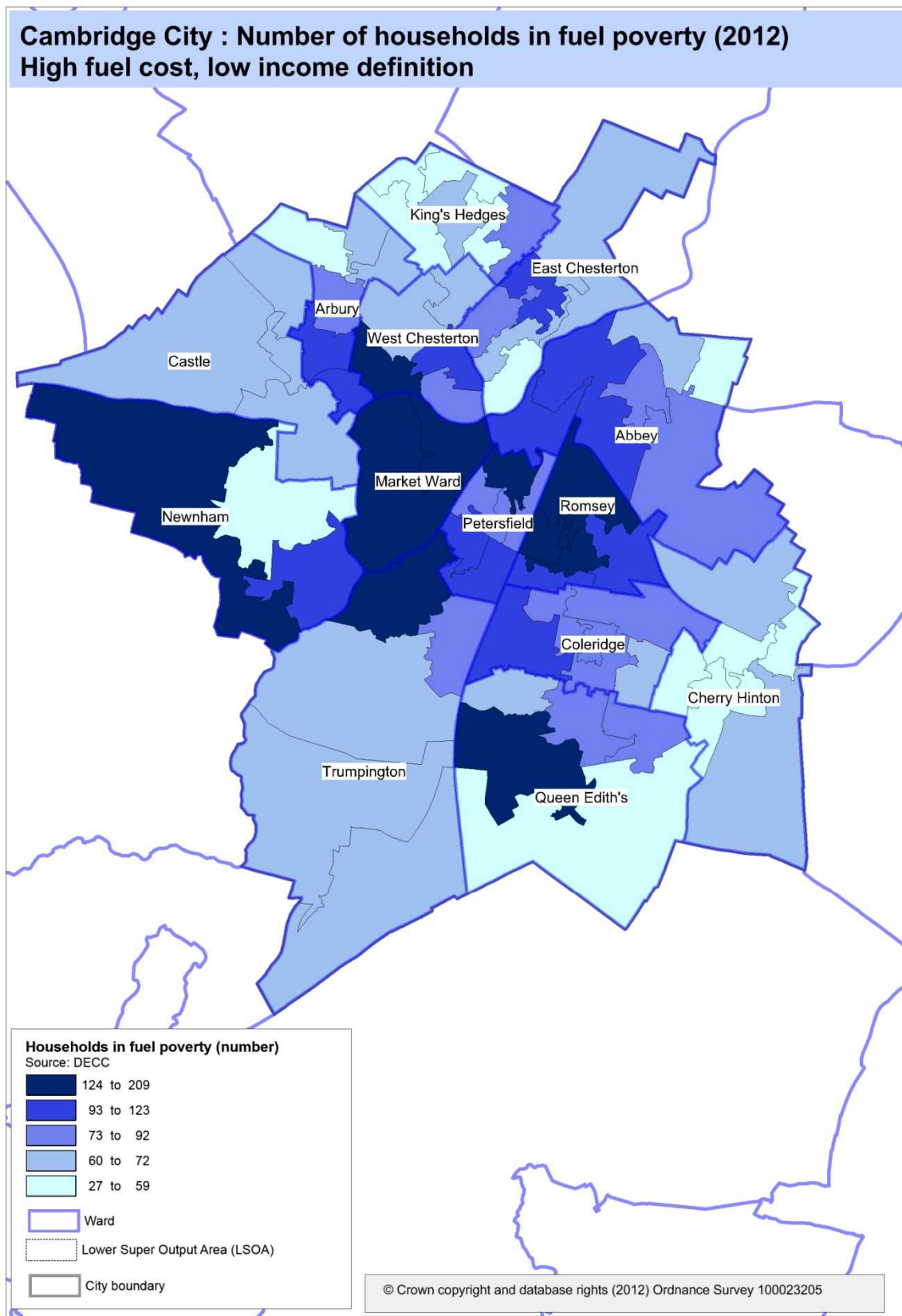
Cambridge City has a statistically significantly higher proportion of households in fuel poverty than England. In 2012, this equates to 6,087 households in Cambridge City, 13.5% of the total (95% Confidence Interval (CI) 12.9% to 13.5%). The value for England is 10.4%.⁴

The maps overleaf show the number (Map 1) and proportion (Map 2) of households in Cambridge City estimated to be in fuel poverty in 2012. Data are mapped to LSOAs within electoral wards and show the variation within the City.⁵

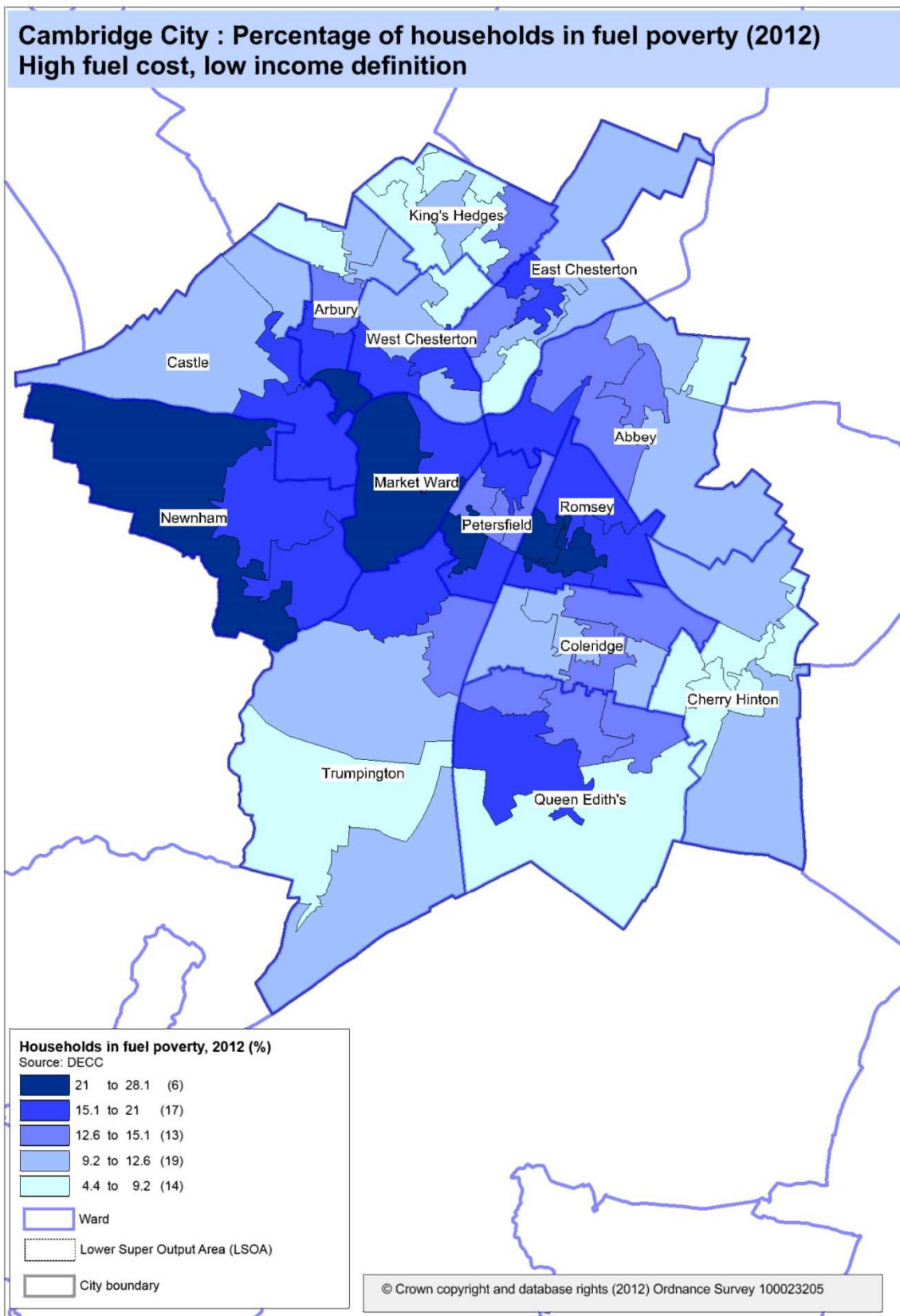
⁴ Estimates of households who are fuel poor are produced by the Department for Energy and Climate Change (DECC) and the full data spreadsheet for the country as a whole can be accessed at <https://www.gov.uk/government/collections/fuel-poverty-sub-regional-statistics>.

⁵ Fuel poverty data specifically for Cambridge City from the PHOF tool are available at: <http://www.phoutcomes.info/search/fuel%20poverty#gid/1/pat/6/ati/101/page/4/par/E12000006/are/E0700008>

Map 1



Map 2



See also Cambridgeshire Joint Strategic Needs Assessments (JSNA)

Housing and Health JSNA 2013 – Chapter 8 Improve standards in existing homes and encourage best use of all housing stock. Available at: <http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/housing-and-health-2013>

Further resources:

FUEL POVERTY: HOW TO IMPROVE HEALTH AND WELLBEING THROUGH ACTION ON AFFORDABLE WARMTH. A guide to delivering action on fuel poverty for public health professionals, health and wellbeing boards, and local authorities in England. UK Health Forum, April 2014. Available at: http://www.fph.org.uk/uploads/UKHF-HP_fuel%20poverty_report.pdf



Evidence review 7: fuel poverty and cold home-related health problems

Ref: PHE publications gateway number: 2014334
PDF, 641KB, 40 pages

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Evidence review 7: fuel poverty and cold home related health problems. UCL Institute of Health Equity. September 2014. Available at: <https://www.instituteofhealthequity.org/projects/fuel-poverty-and-cold-home-related-health-problems>

Briefing 7: fuel poverty and cold home related health problems. UCL Institute of Health Equity. September 2014. Available at: <https://www.instituteofhealthequity.org/projects/fuel-poverty-and-cold-home-related-health-problems>

Barnes M, McKnight A. [Understanding the behaviours of households in fuel poverty: a review of research evidence](#). DECC. July 2014.

The Health Impacts of Cold Homes and Fuel Poverty. Available at: <http://www.instituteofhealthequity.org/projects/the-health-impacts-of-cold-homes-and-fuel-poverty> Marmot review team. 2011.

Fall related Injuries in Older People

Falls are the leading cause of injury-related hospitalisation in older people and are a common reason for older people requiring long-term care in their home or a residential facility. Falls often lead to reduced functional ability and thus increased dependency on families, carers and services. They can often be a turning point or trigger for a deterioration in health or wellbeing, reducing independence and mobility and may lead to increased needs for both formal and informal support. Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.⁶ The prevention of falls can be categorised as primary (preventing a fall in those who have not yet had a fall) or secondary (reducing the likelihood of subsequent falls). Well organised services, based on national standards and evidence-based guidelines can prevent future falls, and reduce death and disability from fractures.⁶

The average age of a person with hip fracture is 84 years for men and 83 for women, with 76% of fractures occurring in women. There is emerging evidence that people with dementia and neurological disorders have an increased risk of falling.⁷ Only one in three sufferers of hip fracture return to their previous levels of independence and one in three move into long-term care.

Public Health Outcomes Framework indicators

Two indicators in the Public Health Outcomes Framework relate to falls and injury: the age and sex standardised rate of hospital admission for injury due to falls and the age and sex standardised rate of hip fractures⁸. Both indicators are for people aged 65 and over and have further sub-indicators broken down to those aged 65 to 79 years and those aged 80 years and over. This is because interventions for recently retired and active older people are likely to be different in provision and uptake to those for frailer older people.⁹

When a fall results in a hospital admission, the hospital codes the fall as a contributory factor to the reason for admission. The coding of falls is known to be variable between hospital Trusts but the new indicator improves upon this by restricting to where the primary reason for admission is an Injury code (International Classification of Disease (ICD 10).

Note that both indicators are calculated nationally based on the resident population.

Cambridge City

The rate in Cambridge City for both PHOF indicators related to falls injuries in older people aged 65 and over is significantly higher than the national average although for hip fracture this has varied from year to year. The rate of injury due to falls is higher in women than in men and in 2012/13, the rate was statistically significantly higher than England in both men and women though this has varied over time. (Figure 1) The average annual number of admissions over the period is 446, 130 in men and 300 in women.

⁶ Royal College of Physicians.(2011) 'Falling standards, broken promises. Report of the national audit of falls and bone health in older people 2010'. Available at: http://www.rcplondon.ac.uk/sites/default/files/national_report.pdf

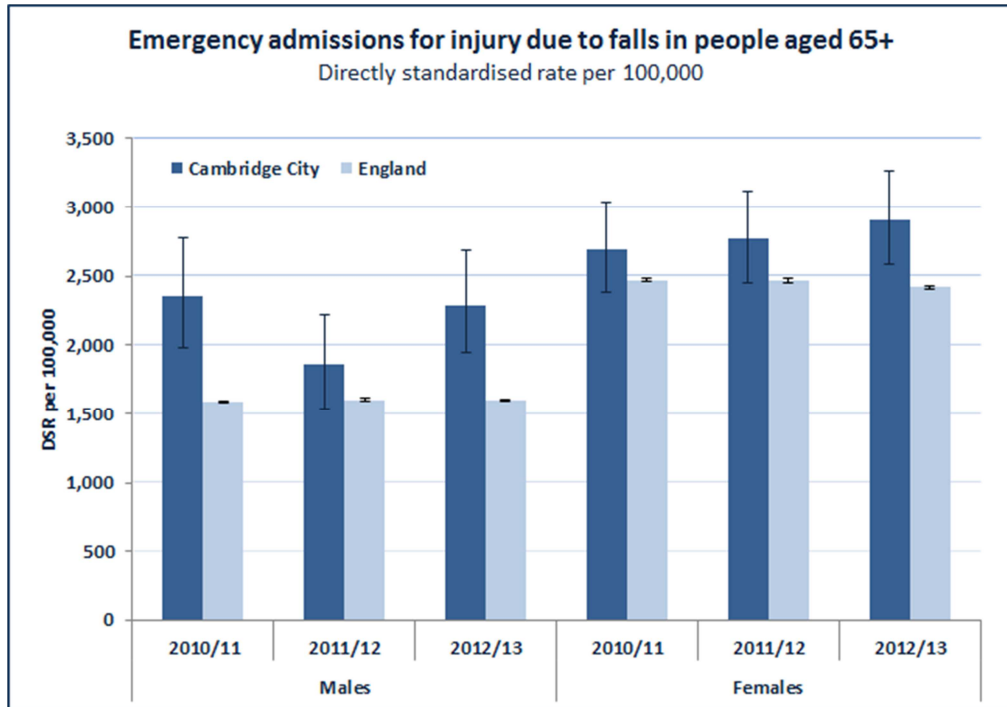
⁷ Allan LM, Ballard CG, Rowan EN, Kenny RA (2009) Incidence and Prediction of Falls in Dementia: A Prospective Study in Older People. *PLoS ONE* 4(5): e5521. doi:10.1371/journal.pone.0005521.

⁸ The standardisation method takes account of differing age and sex structures in the population.

⁹ Department of Health (2012). http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

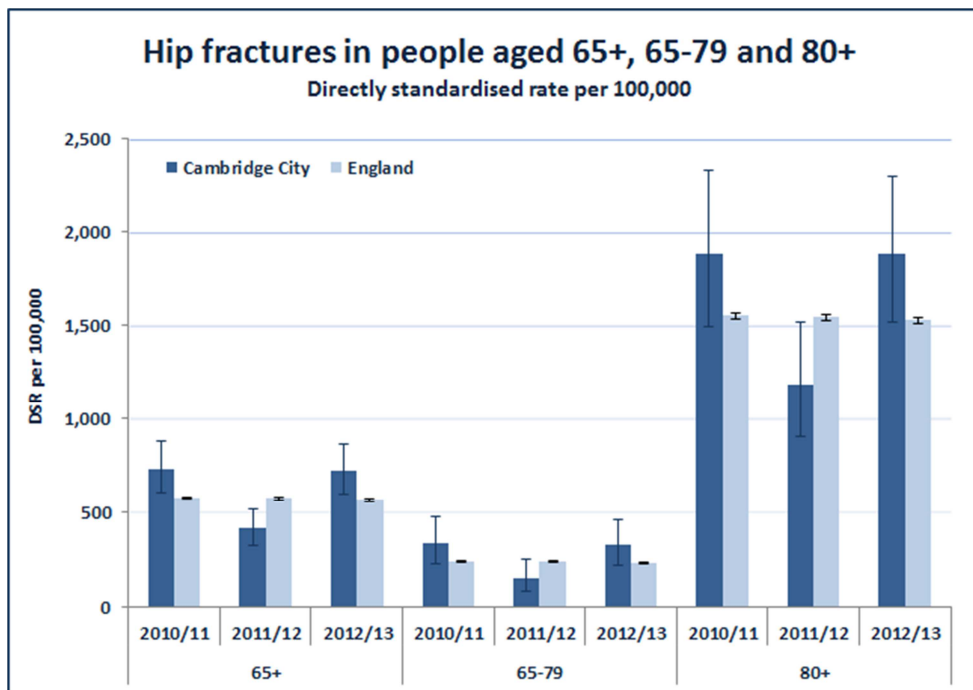
The rate of hip fracture in older people is highest in those aged 80 and above with over 75% of hip fractures occurring in that agegroup. (Figure 2) In 2012/13 there were 104 hip fractures in people aged 80 and over and 32 in those aged 65-79 years.

Figure 1



Source: Public Health England (PHE). Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (W00-W18) anywhere in diagnostic string.

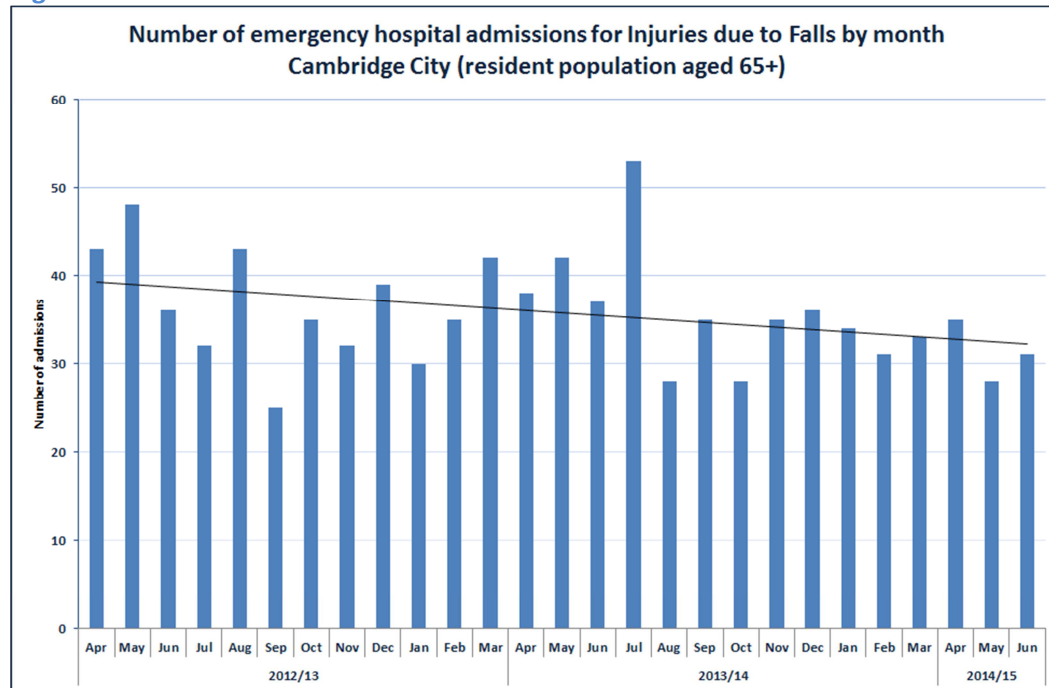
Figure 2



Source: Public Health England (PHE) Primary diagnosis ICD 10 S71.0, S71.1, S71.2.

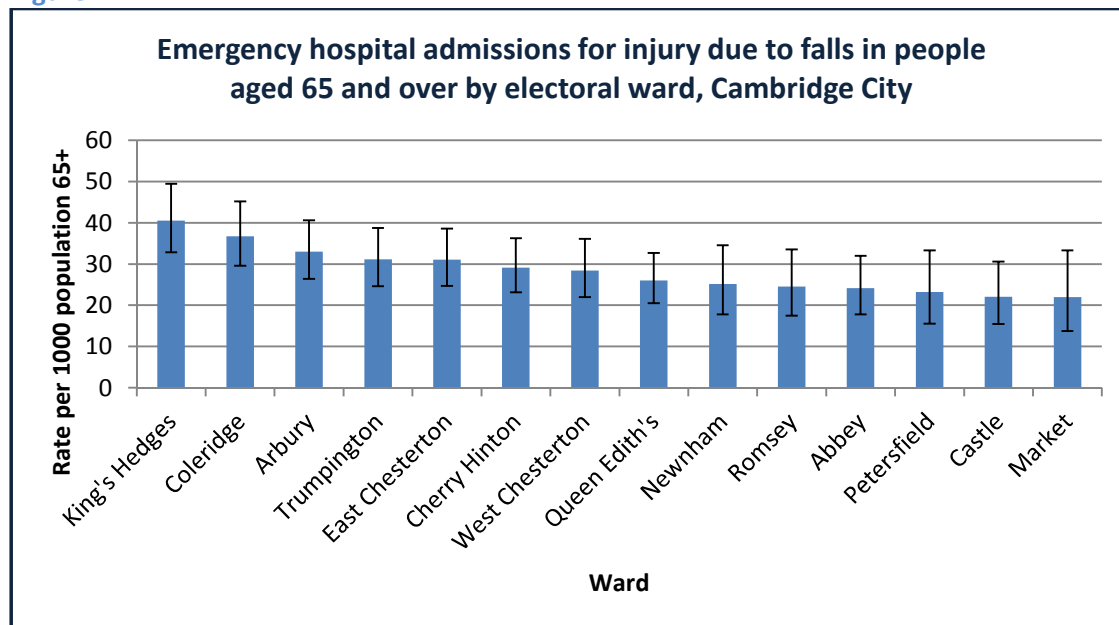
The following figures show the variation within Cambridge City over time (Figure 3) and by electoral ward (Figure 4).

Figure 3



Source: Inpatient Commissioning Data Set (CDS). Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (W00-W18) anywhere in diagnostic string. Note that there is little evidence of seasonal variation in these data although the trend over time appears to be downward.



Figure 4



Source: Inpatient Commissioning Data Set (CDS). Primary diagnosis code for Injury (ICD 10 S00-T19) with falls code (W00-W18) anywhere in diagnostic string. Error bars represent 95% confidence intervals (CI). Note that although there is variation between areas, the difference between electoral wards is not statistically significant.

See also *Cambridgeshire Joint Strategic Needs Assessments (JSNA)*

Older People and Prevention JSNA 2013 – Chapter 5: Falls Prevention.

 <p>Cambridgeshire County Council</p>  <p>NHS Cambridgeshire</p> <div data-bbox="229 607 695 958" style="background-color: #4a4a8a; color: white; padding: 20px; text-align: center;"><p>Cambridgeshire Joint Strategic Needs Assessment</p><p>Prevention of Ill Health in Older People</p><p>Full report</p></div>	<p>Contents</p> <p>Contributors 4</p> <p>Executive Summary 5</p> <p>1. Introduction 11</p> <p> 1.1 Purpose and aims of this JSNA 11</p> <p> 1.2 Prevention of Ill Health in Older People – a focus on early interventions 11</p> <p> 1.3 Community views and consultation 12</p> <p> 1.4 Further work 13</p> <p>2. Demography 14</p> <p> 2.1 Population of over 65s 14</p> <p> 2.2 Life Expectancy at age 65 years 14</p> <p>3. Preventing avoidable hospital admissions 16</p> <p> 3.1 Context 16</p> <p> 3.2 Emergency bed days in Cambridgeshire 16</p> <p> 3.3 Reducing emergency admissions for older people 18</p> <p> 3.4 Evidence for reducing unplanned admissions to hospital for those over 65 years 19</p> <p> 3.5 Integrated care for older people 21</p> <p> 3.6 Key findings 23</p> <p>4. Case management for 'frail' elderly people 24</p> <p> 4.1 Context 24</p> <p> 4.2 Local estimates of prevalence 24</p> <p> 4.3 Identifying those at risk of hospital admission 25</p> <p> 4.4 Causes of emergency admissions in over 65s in Cambridgeshire 28</p> <p> 4.5 Management of long term conditions and rehabilitation 29</p> <p> 4.6 Preventative interventions during an acute episode 30</p> <p> 4.7 Key findings 31</p> <p>5. Falls prevention 32</p> <p> 5.1 Context 32</p> <p> 5.2 Local data 33</p> <p> 5.3 National evidence base and recommendations 36</p> <p> 5.4 Local services and assets for falls prevention 42</p> <p> 5.5 Local views on falls services 43</p> <p> 5.6 Key findings 44</p> <p>6. Mental health 45</p> <p> 6.1 Context 45</p> <p> 6.2 Local data and trends 46</p> <p> 6.3 National evidence base and recommendations 50</p> <p> 6.4 Local services and preventative interventions 53</p>
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Available at:

<http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013>