

*Rotherham's*  
**Joint Strategic Needs Assessment**  
1st September 2011

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## Introduction

# Rotherham's Joint Strategic Needs Assessment( JSNA)

The Rotherham JSNA was developed and published in February 2009 in response to the duty placed on upper-tier local authorities and PCT's by 'The Local Government and Public Involvement in Health Act (2007)'.

Since then the Rotherham JSNA has played a key part in informing the various processes leading to reconfigurations, developments, commissioning and decommissioning of services both within the health and social care sector. More importantly the JSNA has promoted a joint approach to tackling Rotherham's Needs.

For the JSNA to remain a meaningful Needs assessment tool, its content must be periodically updated to accurately reflect Rotherham's demography. As such, partners in Rotherham have acknowledged the need to ensure that the Rotherham JSNA remains a continuous process.

The Joint Commissioning team; funded by both the Local Authority and NHS Rotherham, was tasked with undertaking the first refresh of Rotherham's JSNA. The Joint Commissioning team worked with partners in the Local Authority, Health services, Voluntary sector

services, wider community groups and users/carers in order to complete the refresh programme.

The revised JSNA is the result of a systematic approach adopted by the Joint Commissioning team in both updating and reflecting new areas of Need within Rotherham. To ensure consistency in structure and data quality, the refresh programme has been undertaken in line with the Department of Health (DoH) published Core Data set guidance. Local population needs have also been reflected through the addition of new assessments of need. It is expected that by adopting a combined approach that is iterative and thematic the Rotherham JSNA will continue to evolve over the coming years in line with changes to the Rotherham demography and health profile of the population. New information captured through this refresh programme will continue to assist towards the

investment and disinvestments whilst also ensuring the innovative targeting of resources to those in most need by partners.

## Introduction

### What is a Joint Strategic Needs Assessment (JSNA)?

Joint Strategic Needs Assessment (JSNA) is a process that identifies the current and future health and social care needs of a population, in light of existing services and informs future planning taking account evidence of effectiveness. It informs the priorities and targets leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities throughout the Borough.

The refreshed Rotherham's Joint Strategic Needs Assessment effectively identifies "the big picture" in terms of the health and wellbeing needs and inequalities of a local population.

## Introduction

### Why do we need a JSNA?

The Local Government and Public Involvement in Health Act (2007) places a duty on upper-tier local authorities and PCTs to undertake Joint Strategic Needs Assessment (JSNA). As such, since 1st April, 2008, Rotherham Metropolitan Borough Council and NHS Rotherham have been under a statutory duty to produce a Joint Strategic Needs Assessment (JSNA).

The Operating Framework for the NHS in England 2011/2012 refers to the importance of the JSNA in informing a Joint Health and Well-being Strategy across NHS, Public Health, Social Care and Children's Services.

The JSNA forms the basis of a duty to co-operate. This partnership duty involves a range of statutory and non-statutory partners, informing commissioning and the development of appropriate, sustainable and effective services.

### Pharmaceutical Needs Assessment (PNA)

To contribute to the JSNA and to meet the statutory duty laid down in NHS (Pharmaceutical Amendment) Regulations 2010, NHS Rotherham has published a separate PNA. This is to ensure that pharmacy and medicines management services play a key part in the development of health services in Rotherham.

The PNA can be downloaded by clicking the [HERE](#)

## Introduction Acknowledgements

All key contributors to the 2011 JSNA refresh document are greatly acknowledged.

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The JSNA refresh is a working document, designed for continuous adaptation and development as and when new information becomes available. With new governance structures imminent, such as the Health and Wellbeing Board in 2013 together with the transferring of Public Health functions to Local Authority, it is expected that the document be revised in the near future to ensure it is fit for purpose and best reflects the Needs of Rotherham's population.

This document has been designed and produced by NHS Rotherham Creative Media Services.

# Demographic Profile

## 1.1 Population Numbers

Rotherham is one of four metropolitan boroughs in South Yorkshire, covering an area of 118 square miles with a population of 253,900 (2009). The population of Rotherham has been rising by 1.0% (2,600) since 2004 and 1.8% (4,500) since 2002.

Population projections suggest that the population of Rotherham will increase by 5.1% to 266,900 by 2020 and by 9.8% to 278,900 by 2030. The projected increase is the result of rising life expectancy, natural increase (more births than deaths) and migration into the Borough.

The Borough is divided into 21 wards, grouped into 7 Area Assemblies as follows:

**Rother Valley South** – *Dinnington, Anston & Woodsetts and Wales*

**Rother Valley West** – *Brinsworth & Catcliffe, Holderness and Rother Vale*

**Rotherham North** – *Rotherham West, Keppel and Wingfield*

**Rotherham South** – *Boston Castle, Rotherham East and Sitwell*

**Wentworth North** – *Wath, Swinton and Hooper*

**Wentworth South** – *Rawmarsh, Silverwood and Valley*

**Wentworth Valley** – *Wickersley, Hellaby and Maltby*

About half of the population lives in and around the main urban area of Rotherham. The remainder live in a number of smaller towns such as Wath, Swinton, Dinnington and Maltby and in many villages.

Rotherham comprises a diverse and vibrant blend of people, cultures and communities. It is made up of a mix of urban areas and rural villages, interspersed with large areas of open countryside. About 70% of the Borough's land area is rural, but it is well connected to all areas of the country by its proximity to the motorway and rail networks. Rotherham developed around traditional industries of steel making and coal mining but these have largely given way to new industries. The local economy grew rapidly between 1995 and 2005 but has suffered heavy job losses since 2008.

# Demographic Profile

## 1.2 Age Profile

There are approximately 197,500 adults currently living in Rotherham (2009). 57,800 people are aged 60 and over (22.8%), 102,800 are aged 30 to 59 years (40.5%) and 37,000 are aged 18 to 29 years (14.6%). In addition, there are 56,400 (22.1%) children aged 0 to 17 years.

The age profile of the Borough population is shown in Figure 1.1.

Rotherham has more people aged over 50 (1 in 3 people) than people under 16 (1 in 5 people). Rotherham has 90,200 people aged 50 or over which equates to 35.5% of the total population and this proportion is rising.

### Ageing Population

The most significant demographic change occurring in Rotherham is the growth in the number of older people which is shown in Figure 1.2. The number of people over 65 is projected to increase by more than a half by 2028, from 41,500 to 61,400. The number of people over 85 will almost double (+96%) from 5,000 to 9,800 by 2028. Although people will tend to remain healthy for longer than they do now, healthy life expectancy is not rising as quickly as life expectancy overall. The rising numbers of older people, particularly those in the oldest groups will have major implications for health and adult social care services, informal care and all services used by older people.

Figure 1.1: Age Profile of Rotherham

Source: Mid Year Estimates 2009

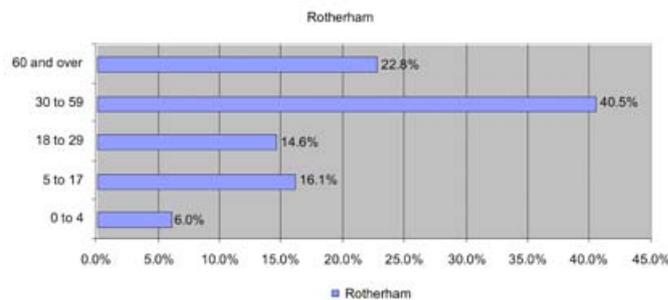
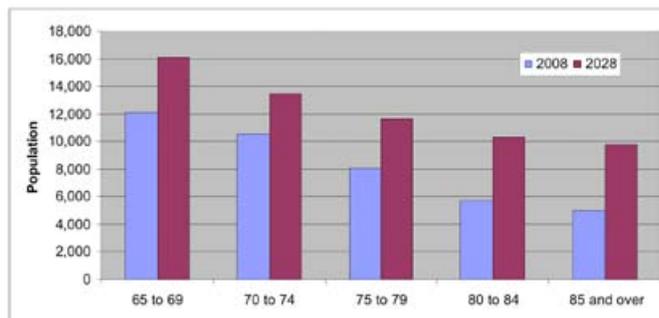


Figure 1.2: Projected Growth in the over 65 population from 2008 to 2028

Source: 2008 Population Projections



# Demographic Profile

## 1.2 Age Profile

The number of people aged over 65 years is projected to increase at a steady rate over the next twenty years. The number is projected to increase by almost 20,000 (48%) from 41,500 to 61,400.

The steady increase in the 65+ population hides a much faster rate of increase for the population aged over 85 years which is projected to increase by 96% between 2008 and 2028. The rate of increase is 2% per annum at present but this is projected to rise after 2014. The peak growth period will be between 2020 and 2025 when a 29% rise is projected, an annual average of 5.8% which is almost three times the current rate of increase.

Figure 1.3: Projected Growth in over 65 population from 2008 to 2028

Source: 2008 Population Projections

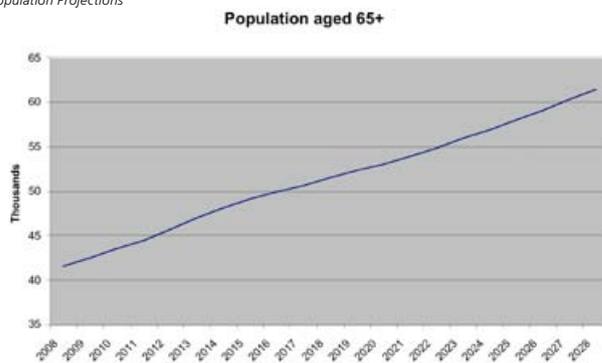
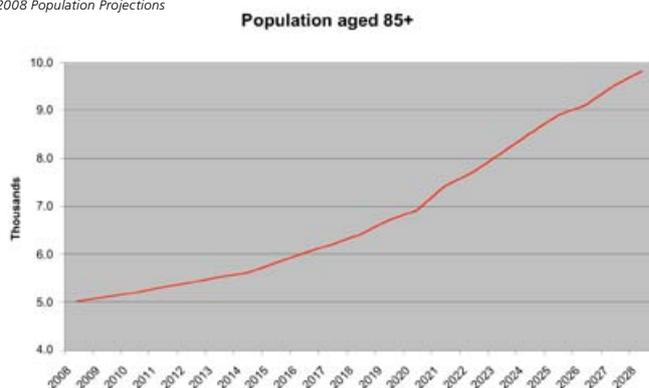


Figure 1.4: Projected Growth in over 85 population from 2008 to 2028

Source: 2008 Population Projections



# Demographic Profile

## 1.3 Gender Profile

In Rotherham, there are 129,400 (51%) females and 124,400 (49%) males, which is very similar to the national average. The age and gender distribution of Rotherham's population is similar to the national profile, although Rotherham has a slightly lower proportion of young adults (20-34). Figure 1.3 shows the age and gender structure of Rotherham compared to England and Wales in 2009.

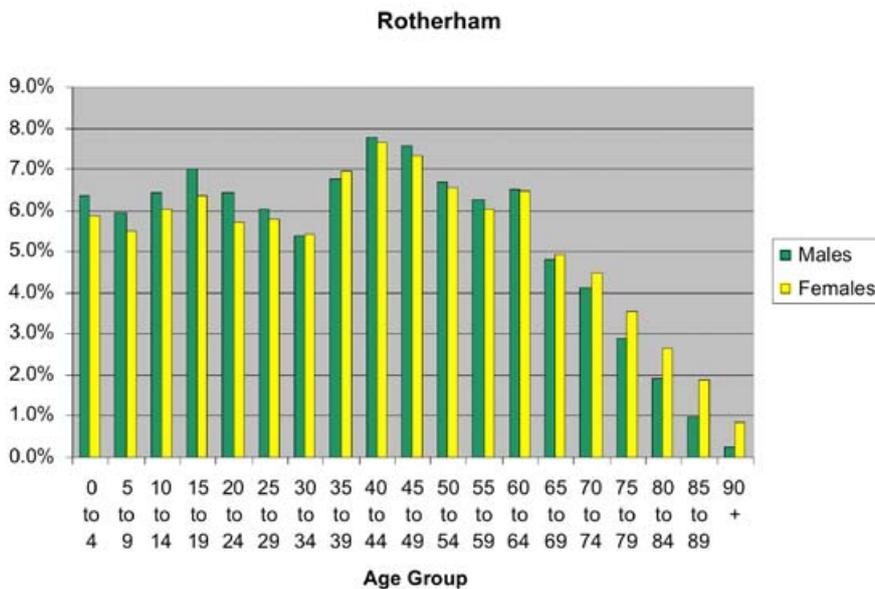
Office of National Statistics data illustrates that up to the age of 72 years the number of males and females are fairly equal. From the age of 73 years the proportion of females to males increases significantly<sup>2</sup>. 2.9% of the female population are over 85 years compared to 1.4% for men. There are 3.7 women for every man aged over 90 years. The rising population imbalance between males and females as old age progresses results from women's higher life expectancy.

62% of the entire population are of working age, of these 51.1% are under 40 years of age.

Figure 1.5 also shows a relatively low proportion of people aged 30-34 years which reflects the low birth rates from the mid to late 1970s. Likewise, the high proportion aged 40-45 reflects high birth rates in the early 1960s.

Figure 1.5: Age and gender profile Broken down by percentage of male/female population

Source: Mid Year Estimates 2009



# Demographic Profile

## 1.4 Birth Rate

The national birth rate fell during the 1990s but has been steadily increasing since 2002 (Figure 1.6). Live births in Rotherham followed a similar pattern, decreasing from over 3,700 in 1991 to 2,730 in 2001. The numbers of births has increased each year after 2001 to reach 3,300 in 2008 before dropping slightly in 2009 to 3,200. There has been an average increase of about 60 live births each year over the last eight years.

The Total Fertility Rate (TFR) for 2009 shows an average of 1.96 births per woman in England and Wales. This is a small decrease in fertility from 1.97 births in 2008, the first annual decrease since 2001 when the TFR was only 1.63. The TFR in 2008 and 2009 was at its highest point in 35 years which is reflected in growing numbers of young children. The

provisional General Fertility Rate (GFR) for 2009 was 63.7 live births per 1,000 women aged 15-44, a slight decrease compared with 63.8 in 2008.

In 2009, there were decreases in fertility rates for women aged under 30 and increases for women aged 35 and over, compared with 2008; fertility rates for women aged 30-34 remained unchanged. The largest percentage decrease (2.7 per cent) occurred among women aged under 20. For this age group the fertility rate fell from 26 live births per thousand women aged under 20 in 2008 to 25.3 in 2009. The standardised average (mean) age of women giving birth increased slightly to 29.4 in 2009 from 29.3 in 2008. The figure for 2009 is the highest on record indicating a gradual trend for women to

have children later in life. The sex ratio at birth for 2007 was 1,052 live males per 1,000 live females born which explains why there are slightly more boys than girls in the child population.

There was a continued rise in the proportion of births to mothers born outside the UK: 24.7 per cent in 2009 compared with 24.1 per cent in 2008. In 1999, 14.3 per cent of births were to non-UK born mothers.

Figure 1.6: Average Births per Woman 1959 to 2009

Source: Office of National Statistics 2010, Live Births



# Demographic Profile

## 1.5 Black and Minority Ethnic (BME) Population Profile

Rotherham’s Black and Minority Ethnic (BME) population is relatively small but has been growing and becoming increasingly diverse. Rotherham MBC estimates that there are 19,000 people from BME communities in 2009 which equates to 7.5% of the local population (5.6% are non-white), with 92.5% from the White British population<sup>3</sup>. By comparison in 2001, 4.1% of the population were from BME communities, suggesting that the number of BME residents has almost doubled over the last eight years.

BME residents are fairly evenly divided between those born in the UK and those born abroad, the latter being more likely to have limited English language skills.

In 2006, Yorkshire Futures produced population projections by ethnic group. Figure 1.7 illustrates the projection for Rotherham which suggests a 61% increase in the non-White

population between 2005 and 2030. Of the total of 17,600 non-white residents projected for 2030, about 11,400 would be Asians. However, the fact that Rotherham’s BME population more than doubled in the 13 year period 1991-2004, and that non-white residents already number about 14,000 suggests that this projection may underestimate the likely rate of growth.

Immigration and natural increase means that Rotherham’s black and minority ethnic population has continued to grow in recent years, reaching 19,000 people. The white minority population (mainly European) was estimated to have a population of about 3,000 in 2004, rising to 4,000 in 2006 and an estimated at 5,000 in 2009. Most minority ethnic groups have young populations, notably the Kashmiri and Pakistani. There is a growing mixed or dual heritage population, the majority

of who are children and young people. The Irish community is an exception, being much older than average. The largest BME community is that from Pakistan and Kashmir which constitutes 3.0% of the overall population, higher than the average of 1.5% in England and Wales. The Kashmiri and Pakistani community is well established in Rotherham following initial migration in the 1960s and 1970s. There are also much smaller established communities such as Chinese, Indian and Irish. The fastest growing population is the Black African community and other new communities, including migrant workers from Eastern Europe, have also settled in Rotherham which now has a Roma community of around 2,000 people.

Figure 1.9 shows the breakdown of the numbers of people from each BME community who are living in Rotherham. The largest

Figure 1.7: Projected BME Population Growth in Rotherham between 2005 and 2030

Source: BME Health Needs Assessment 2008, Black and Minority Ethnic Populations in Rotherham (page 12)

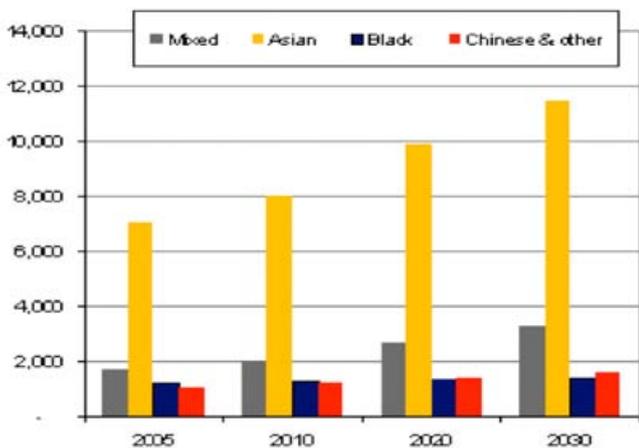
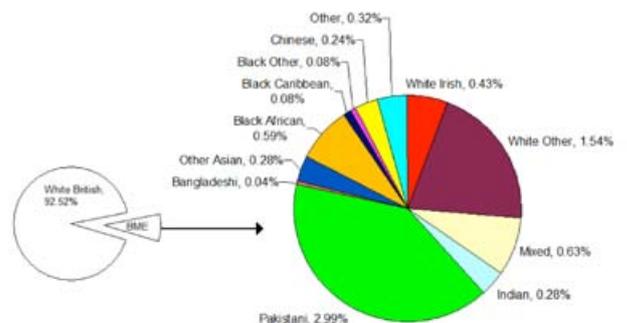


Figure 1.8: BME Population Breakdown in Rotherham – Mid-Year Estimates 2009

Source: Rotherham MBC Population Estimates by Ethnic Group 2009



## Demographic Profile

### 1.5 Black and Minority Ethnic (BME) Population Profile

number of people who are from minority ethnic groups are those from the Pakistani (and Kashmiri) community (7,600) which equates to 40% of the BME population in Rotherham. 3,900 people (20.5%) are from the White Other ethnic group which includes EU migrant workers from other European countries such as Poland and Slovakia. Further migration from European countries may result in continued growth in the years ahead.

Figure 1.10 provides a gender breakdown across all BME communities. It shows that white minority ethnic communities, Indian and Black groups have a larger number of men than women.

The Pakistani/Kashmiri community has a similar gender balance to the White British population, whilst the Chinese community has a higher proportion of women. The higher proportion of men amongst

certain BME groups in Rotherham is likely to reflect economic migration of men moving to Rotherham to find employment. This trend is more significant amongst more recent migrant worker groups where two thirds are often male.

Figure 1.11 provides an insight into the children to adults for each of Rotherham's BME population. Some BME communities have a significantly younger age profile than the general population of the Borough. The percentage of the Pakistani community under 15 years (1.18%) is around 60% of the adult population total and the Mixed community have more children than adults. This reflects a significantly higher birth rate for the Pakistani and Mixed ethnic groups. There is a big difference in the White British community where the adults outnumber the 0-15 population by approximately 5 to 1.

In contrast, the Mixed and Pakistani ethnic groups have a much smaller proportion of their population aged 65 and over (less than one seventh of the general population). The largest non-White British community is Pakistani with an estimated 550 elders (55 years of age+)<sup>4</sup>. BME communities have a younger age profile compared to the general population. Children and young people in Rotherham are far more ethnically diverse than older people.

Figure 1.12 provides a breakdown of the BME school pupils by Area Assembly in 2010 which shows that 52% of BME pupils live in Rotherham South. The distribution of pupils shows a similar pattern to the distribution of BME residents in the 2001 Census, 4,809 of who lived in the Rotherham South, 48% of the Borough's BME population. Only three wards – Rotherham East, Rotherham West and Boston Castle – have large minority

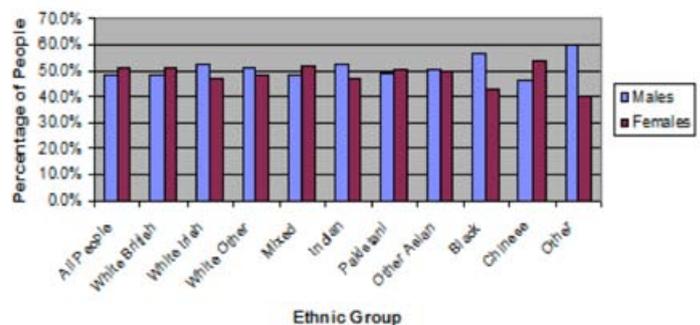
Figure 1.9: Number of People in each Ethnic Group in Rotherham in 2009

Source: Rotherham MBC Population Estimates by Ethnic Group 2009

Ethnic Group	No. of People
White British	234,900
White Irish	1,100
White Other	3,900
White and Black Caribbean	400
White and Black African	100
White and Asian	700
Other Mixed	400
Indian	700
Pakistani	7,600
Bangladeshi	100
Other Asian	700
Black Caribbean	200
Black African	1,500
Black Other	200
Chinese	600
Other Ethnic	800

Figure 1.10: Gender by Ethnic Origin of all Ethnic Groups in Rotherham in 2007

Source: BME Health Needs Assessment 2008, Black and Minority Ethnic Populations in Rotherham, p13



# Demographic Profile

## 1.5 Black and Minority Ethnic (BME) Population Profile

ethnic populations with 62% of Rotherham’s BME population and 82% of the Pakistani and Kashmiri population. Data on pupil ethnicity also shows that increasing numbers of BME families live in Sitwell ward. Rotherham North had the second largest BME population with 1,746 people (17%) in 2001. In comparison, there were 562 BME people (6%) living in Wentworth North which had the smallest BME population<sup>5</sup>.

Within Rotherham South, BME communities are particularly concentrated in Eastwood, Ferham, Masbrough, Wellgate and Broom Valley which are mainly deprived areas close to the town centre. These were the early settlement areas for the Kashmiri and Pakistani community. Since 2001, there has been some movement of the community into the suburban areas of Broom and Moorgate.

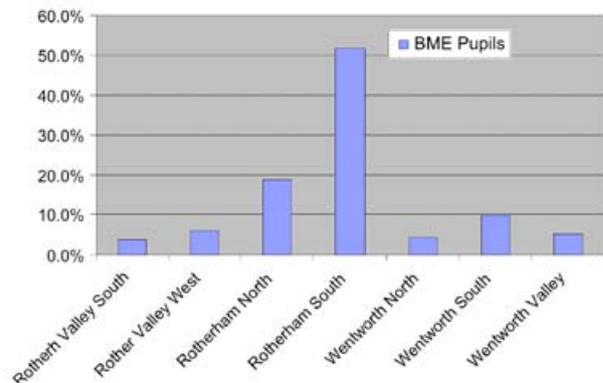
Figure 1.11: Population Structure of Different Ethnic Groups in Rotherham 2009

Source: Rotherham MBC Population Estimates by Ethnic Group 2009

Ethnic Group	Total Number	% Population aged 0-15	% Population aged 16+
Mixed	1,600	0.39%	0.28%
Pakistani	7,600	1.18%	1.81%
Other Asian	800	0.08%	0.24%
Chinese	600	0.04%	0.20%
Other	800	0.12%	0.20%
White British	234,900	16.86%	75.62%
Indian	700	0.04%	0.24%
Black	1,900	0.16%	0.59%
White Other	3,900	0.47%	1.06%
White Irish	1,100	0.04%	0.39%
<b>All People</b>	<b>253,900</b>	<b>19.38%</b>	<b>80.62%</b>

Figure 1.12: Percentage of BME pupils in each Area Assembly in Rotherham

Source: PLASC Data 2010



# Demographic Profile

## 1.6 Disability Profile

### Sensory Impairment – Blind/Partially Sighted

In 2008 there were 152,980 people in England and Wales registered blind. This is a slight increase of 525 people (0.3%) from March 2006. There were 10,300 new registrations in 2008, a fall of 5% compared to 2006<sup>6</sup>. There were approximately 156,285 people in England registered as partially sighted, an increase of 1,085 people since 2006. There were approximately 13,200 new registrations in 2008, a fall of 8% compared to 2006.

The leading cause of certifications for blindness is degeneration of the macula and posterior pole (57.2%) which largely comprises Age-related Muscular Degeneration (AMD). This is the leading cause of blindness amongst older people, in particular for the age group 75 years and over. Other common causes of certification are glaucoma

(10.9%), diabetic retinopathy (5.9%), optic atrophy (3.1%), hereditary retinal disorders (2.8%) and cerebrovascular disease/accidents (2.5%). Common causes of certification among partially sighted people are: degeneration of the macula and posterior pole (56%), glaucoma (10.2%), diabetic retinopathy (7.4%), cerebrovascular disease (4.9%), hereditary retinal disorders (2%), optic atrophy (1.9%), myopia (1.9%) and retinal vascular occlusions (2%)<sup>8</sup>.

Figure 1.13 provides a national breakdown by age of the number of people on the blind and partially blind registers.

Nationally the proportion of young people registered blind is increasing, in particular in the 18-49 age range. The number of blind people aged 75 and over is falling, with a 5% reduction in the last ten years from 69% to 64%.

However, the local picture is different to the national one. In Rotherham there were 860 people on the blind register in 2008, a reduction of 325 people since 2006. This reduction may be due to recent data cleansing of the local register. There are a total of 1,365 people who are on the partially sighted register, a decrease of 95 people since 2006<sup>9</sup>. Information for this register is obtained by the completion of SSDA902 returns by all Councils with Adult Social Services Responsibilities (CASSRs) on an annual basis to capture the number of people who are blind or partially sighted under Section 29 of the National Assistance Act, 1948.

Figure 1.14 provides an age profile of those who are registered blind or partially sighted in Rotherham. Approximately 63% of blind/partially sighted people in Rotherham are over 75 years of age. There has been an increase in

Figure 1.13: % of People on Blind or Partially Sighted (P/S) Register by Age Group in England 1994-2008

Source: National Statistics 2008, Council Tables - Blind and Partially Sighted, p6

Category	0-4		5-17		18-49		50-64		65-74		75 and Over	
	Blind	P/S	Blind	P/S								
1994	0	1	2	2	10	10	8	8	11	12	68	68
1997	1	1	2	2	10	10	8	8	10	12	69	68
2000	0	0	2	2	10	9	8	8	10	11	69	69
2003	0	0	2	3	11	10	9	8	10	11	67	68
2006	0	0	2	3	12	10	10	9	10	10	66	68
2008	1	0	3	3	13	11	10	9	10	10	64	68

Figure 1.14: Number of people registered blind/partially sighted by age group in Rotherham in 2008

Source: National Statistics 2008, Council Tables - Blind and Partially Sighted, pB1



6 National Statistics 2006 Registered Blind and Partially Sighted, p(i)  
7 National Statistics 2008 Council Tables - Blind and Partially Sighted, pPS1

8 Public Medical Health 2009 Research and Development, Leading Causes of Blindness  
9 National Statistics (2007), Deaf and Hard of Hearing, pPS1

# Demographic Profile

## 1.6 Disability Profile

the number of people registered blind in the 65 to 74 age group.

There has also been a reduction in the number of people registered blind between 18 and 49 years and 75 and over. In 2008 there were 95 new registrations for blind people compared to 85 new registrations in 2006. Of these 16% were between 50 and 64 years, 11% between 65 and 74 years and 63% who are 75 years and over. There has been a larger increase in the number of new registrations by people between 50 and 64 years<sup>10</sup>.

Figure 1.15 shows the predicted future prevalence rates of people with a serious visual impairment who will require help with daily activities. These prevalence rates have been derived from ONS population projections.

Projecting Adult Needs and Service Information System (PANSI) predicts that there are 102 people

with a serious visual impairment in Rotherham who require help with daily activities. It is predicted that this will slowly increase over the next 17 years, in particular in the age groups 55-64 age group.

Poor vision reduces postural stability and significantly increases the risk of falls and fractures in older people (Lord, Stephen R (2006). Visual risk factors for falls in older people. Age and Ageing 35-S2: ii42-ii45).

The black population has a greater risk of developing age related macular degeneration (AMD) compared to the white population aged under 60 where as the white population has a greater risk of developing AMD in the later years of life. Asian people have a greater risk of developing cataracts compared to the black population and white population.

Black and Asian populations have greater risk of developing

diabetic eye disease compared to the white population. The risk of glaucoma is much higher for the black population compared to the white population.

### Deaf or Hard of Hearing

There are approximately 9 million people who are deaf or hard of hearing in England. Around 688,000 people are severely or profoundly deaf<sup>11</sup>. More than 50% of people over the age of 60 years have some degree of hearing loss, but only one in three older people has an hearing aid<sup>12</sup>. The commonest cause of hearing loss is ageing and three quarters of people who are deaf are aged over 60. Men are more likely to become hard of hearing than women. However, the longer life expectancy of women means that they outnumber than men amongst people over the age of 80 who are deaf or hard of hearing.

Figure 1.15: No. of people projected to have a serious visual impairment and requiring help with daily living in Rotherham. 2010-2030

Source: PANSI 2008, People predicted to have a serious visual impairment projected to 2030

Ethnic Group	Total Number	% Population aged 0-15	% Population aged 16+
Mixed	1,600	0.39%	0.28%
Pakistani	7,600	1.18%	1.81%
Other Asian	800	0.08%	0.24%
Chinese	600	0.04%	0.20%
Other	800	0.12%	0.20%
White British	234,900	16.86%	75.62%
Indian	700	0.04%	0.24%
Black	1,900	0.16%	0.59%
White Other	3,900	0.47%	1.06%
White Irish	1,100	0.04%	0.39%
<b>All People</b>	<b>253,900</b>	<b>19.38%</b>	<b>80.62%</b>

Figure 1.16: Age profile of people registered as deaf or hard of hearing (HofH) in England from 1992 to 2010

Source: National Statistics 2010, Deaf and Hard of Hearing, p3

Category	All Ages		Under 18		18-64		65-74		75 or over	
	Deaf	H of H	Deaf	H of H	Deaf	H of H	Deaf	H of H	Deaf	H of H
Number of People										
1992	41,800	95,300	3,800	2,100	24,200	16,000	4,900	18,400	8,900	58,800
1995	45,500	125,900	4,400	3,500	26,000	21,900	5,000	23,800	10,100	76,700
1998	50,100	139,500	4,200	2,800	27,100	25,100	5,800	22,300	13,000	89,300
2001	50,300	144,600	4,000	2,900	27,200	25,400	6,400	24,700	12,600	91,300
2004	55,000	158,900	4,100	3,000	29,200	29,800	8,300	24,400	13,400	101,700
2007	54,500	164,600	3,400	4,100	28,700	30,500	6,400	23,100	16,000	106,500
2010	56,400	156,500	2,200	2,200	30,100	25,800	6,700	20,500	17,400	107,900
% of People										
1992	100	100	9	2	58	17	12	19	21	62
1995	100	100	10	3	57	17	11	19	22	61
1998	100	100	8	2	54	18	12	16	26	64
2001	100	100	8	2	54	18	13	17	25	63
2004	100	100	7	2	53	19	15	15	24	64
2007	100	100	6	2	53	19	12	14	29	65
2010	100	100	4	1	53	16	12	13	31	69

10 National Statistics 2007, Deaf and Hard of Hearing, pB2

11 RNID 2008, www.rnid.org.uk

12 Public Medical Health 2008, Research and Development, Leading Causes of Blindness

## Demographic Profile

### 1.6 Disability Profile

Common causes of deafness in adults and older people include; presbycusis (age-related hearing loss known as senile deafness), side-effects of medication, acoustic neuroma and Meniere's disease. Common causes of deafness in children include inherited conditions, infection during pregnancy, meningitis, head injury and glue ear.

In 2010 there were 56,400 people in England on the register of deaf people. Between March 2004 and March 2007 the number of people on the register has remained constant but there has been a rise in recent years<sup>13</sup>. During this same period the number of deaf people and the age profile of those on the register has changed significantly<sup>14</sup>. There are approximately 156,500 people in England on the register of hard of hearing. This is a decrease of around 8,000 (5%) since March 2007 but an increase of 24% since March 1995. The large increase since 1995 could be partially

attributed to improved systems of information capture or a failure to remove old registrations<sup>15</sup>.

Figure 1.16 provides a breakdown of the number registered as deaf and hard of hearing by age group.

In 2010 more than half (53%) of those on the deaf register were working age adults (18-64 years). The highest incidence of hearing loss occurred in the older age groups, particularly those over 75 years<sup>16</sup>.

In Rotherham there are currently 264 people on the deaf register. 66% are in the age range 18 to 64 years, 13% above the national average. There are currently only 8 children (3%) on the register<sup>17</sup>. The numbers registered suggest a level of under-reporting, especially in the older age groups.

There are a total of 1,006 people on the hard of hearing register. Almost two thirds (61%) are in

the age groups 75 years and over<sup>18</sup>. This is just under the national average of 65%. Figure 1.16 provides a local age profile of those who are registered deaf or hard of hearing. Information for this register is obtained by the completion of SSDA910 returns by all Councils with Adult Social Services Responsibilities (CASSRs) on an annual basis to capture the number of people who are deaf or hard of hearing under Section 29 of the National Assistance Act, 1948.

In 2006 there were 79,900 people registered blind or partially sighted with an additional disability in England. 24% of those registered as blind and had an additional disability were recorded as deaf or hard of hearing. 22% of those registered as partially sighted with an additional disability were recorded as deaf or hard of hearing<sup>19</sup>.

Figure 1.17: Number of people registered deaf/hard of hearing by age group in Rotherham in 2008

Source: National Statistics 2008, Council Tables - Blind and Partially Sighted, pB1

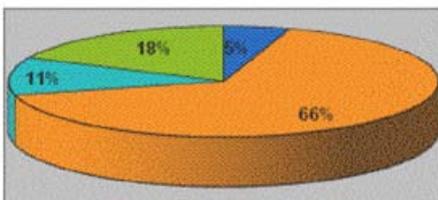


Figure 1.18: People registered as blind or partially sighted with a hearing impairment in 2006

Source: National Statistics 2007, Deaf and Hard of Hearing, p6

Category	Deaf with Speech	Deaf without Speech	Hard of Hearing
Blind	1,800	400	7,600
Partially Sighted	1,100	300	7,400

<sup>13</sup> National Statistics 2007 and 2010, Deaf and Hard of Hearing, p(iii)

<sup>14</sup> Office of National Statistics 2004, Religion in Rotherham, p(iii)

<sup>15</sup> National Statistics 2007, Deaf and Hard of Hearing, p3

<sup>16</sup> National Statistics (2007), Deaf and Hard of Hearing, p5

<sup>17</sup> Office of National Statistics 2004, Religion in Rotherham, p15

<sup>18</sup> Office of National Statistics 2004, Religion in Rotherham, p20

<sup>19</sup> Office of National Statistics 2004, Religion in Rotherham, p6

## Demographic Profile

### 1.7 Carers

In Rotherham 30,284 people, or 12.2% of the population, provided unpaid care in the 2001 Census, compared to 9.9% for England. Overall 3.0% of Rotherham's population provide 50 hours or more of unpaid care per week, compared to the English average of 2.0%. Whilst there are relatively high numbers of carers in Rotherham, they are not concentrated in deprived areas and are widely distributed across all areas of the Borough. The number of carers is growing and was estimated at 35,000 in 2010. A 19% increase in carers is projected by 2020 and a 36% rise by 2030. Most carers have traditionally been aged 45-64 but there are growing numbers aged 65+, now estimated at 5,300. The rise in older carers reflects the growing numbers of people who are caring for their spouse.

The number of carers is growing as the number of people requiring care increases. A report produced by the LSE (Pickard, 2007) concluded that over the next 30 years, care by spouses is likely to increase substantially. However, if current patterns of care remain the same, care by adult children will also need to increase by nearly 60% by 2031. Further research by the LSE (2008) concluded that the number of adult children providing care is only likely to rise by 25%, resulting in a widening "care gap" which will put pressure on formal care services and spouse carers.

## Demographic Profile

### 1.8 Population by Religious Group

The 2001 Census showed that 197,102 people (79.4%) of Rotherham's population described themselves as Christians. This is above the regional average of 73.1% and the national average of 71.7%, mainly because of the low proportion belonging to minority religions.

In 2001, 2.6% of Rotherham's population belonged to minority religions compared to 6% nationally. 10.2% of the local population have no religion compared to 14.6% nationally. The largest minority religious group in Rotherham in 2001 were Muslims with 2.2% of the population<sup>20</sup>.

A local estimate of the religious profile of Rotherham carried out in 2009 suggested that 4.2% of the local population now hold minority religious beliefs. There

are estimated to be 9,300 (3.7%) Muslims, 400 Hindus (0.2%), 300 Sikhs (0.1%), 200 Buddhists (0.1%), 40 Jews and 400 people (0.2%) who have other religious beliefs. There are estimated to be 25,700 people (10.2%) who have no religious beliefs<sup>20</sup>.

The influx of EU migrants, mainly from Poland and Slovakia, over recent years in Rotherham is likely to have impacted on the number of people from certain religious groups. For example, it is estimated that approximately 90% of Polish people are Roman Catholic with over 50% attending church regularly. The rest of the Polish population (10%) are mainly Eastern Orthodox, Protestants, Jehovah's Witness or have no religion<sup>21</sup>.

## Demographic Profile

### 1.9 Population by Migrant Status

The total number of National Insurance Number (NINo) registrations to adult overseas nationals in 2008/09 was 686,000, a decrease of 47,000 (6.4%) on the previous year. This is the first annual percentage decrease in the period for which figures are available. This overall fall in NINo registrations masks some significant variations by world area. Poland forms the largest nationality: 134,000 NINo registrations were made to Polish citizens in 2008/09 (a 36.2% decrease from the previous year).

163,000 NINos were registered to Asian and Middle Eastern nationals during 2008/09 - an increase of 8.8% on the previous year. Similarly registrations to African nationals and those from the Americas rose by 6.2% and 11.7% respectively. Registrations from Australasia and Oceania

fell by 11.5%. The average age is between 25 and 34 years<sup>22</sup>. The number of migrants entering Rotherham in 2008-09 was 1,330 which is 0.5% of the overall population. Since 2008, economic recession has meant that there are fewer migrants arriving in the UK. This trend has been particularly evident amongst EU migrants from the "A8" countries where a net inflow of 43,000 in 2007/08 turned into a net outflow 12,000 in 2008/09<sup>23</sup>.

According to the "Flag 4" Patient Registration Data System there were 567,500 people on the Patient Register Data System in England and Wales in 2006. The "Flag 4" system identifies those migrants who have registered with a GP. These figures suggest that there are 165,590 migrants (23%) who have not registered with their local GP.

In Rotherham there were 1,220 people registered with a NINo registration which suggests that 18% of migrants in Rotherham are not registered with a GP<sup>24</sup>.

<sup>22</sup> DWP NINo Registrations 2008-09

<sup>23</sup> Migration New Communities Briefing, Spring 2010

<sup>24</sup> 'Flag 4' Mid Year Estimates 2006, Patient Register Data System

# Demographic Profile

## 1.10 Number of Households

For the purpose of the JSNA a household is defined as comprising one person living alone or a group of people living at the same address sharing a living room or at least one meal a day. In 2001 there were 102,288 households in Rotherham. By 2009 there were nearly 107,695 households, an increase of nearly 6,000 over the last eight years. The number of households had increased faster over the last few years, whereas the number of properties has decreased slightly from 2008 with old properties being demolished. 3.3% of properties in Rotherham are vacant and 19.4% of the properties are council owned<sup>25</sup>.

Over two thirds of households in Rotherham have no children (68%), slightly below the national average. Lone parents with dependent children make up 6.8% of all households which is slightly above the national average of 6.5%. Almost one in seven households consists of a pensioner living alone (14.4%), equivalent to the national average<sup>26</sup>.

Figure 1.19 estimates the growth in the number of households in Rotherham by 2021.

It is predicted that the number of households is set to increase to 112,000 by 2011, 118,000 by 2016 and 122,000 by 2021. This is a total increase of 12,000 additional households over the next 13 years, an increase of 11%.

One family households account for over 68% of all households in Rotherham compared to the average of 63% for England and Wales. The number of one family pensioner households (9%), one family couple (49%) and one family lone parent (10%) is also above average compared to England and Wales but the number of one person households is below average at 27%<sup>27</sup>.

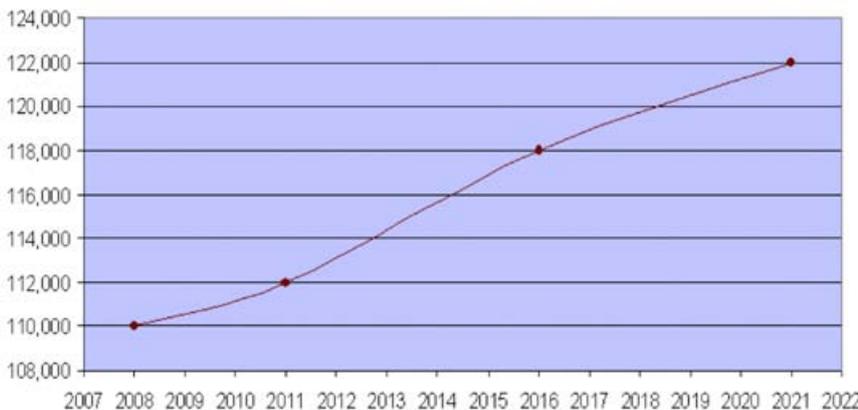
The average household size in Rotherham was 2.57 people in 1991, 2.41 in 2001 and 2.31 people in 2006. This trend is likely to continue in future years to 2.25 by 2011, 2.19 by 2016 and 2.14 by 2021. The decrease in the number of people per household is partly

attributable to an increase in one person households. This trend is reflected in national figures. The composition of households is expected to change over the next 13 years. There were 97,200 married couples in Rotherham in 2006. This is predicted to decrease to 95,200 by 2011, 94,400 by 2016 and 94,100 by 2021. This constitutes a 3.2% decrease in the number of married couples. There were 23,000 cohabiting couples in Rotherham in 2006. It is predicted that this will increase to 27,500 by 2011, 31,000 by 2016 and 33,600 by 2021. This constitutes a 35% increase in the next 13 years.

In 2006 there were 5,040,000 private households in the Yorkshire and Humber region. This is expected to rise to 5,172,000 by 2011, 5,308,000 by 2016 and by 5,442,000 by 2021. This is an additional 402,000 private households in the next 13 years, an increase of 8%.

Figure 1.19: Predicted Number of Households in Rotherham from 2008 to 2021

Source: Office of National Statistics 2006 Household Projections to 2029



25 Rotherham Properties List 2009

26 Rotherham State of the Borough (2008), A Statistical Portrait

27 Census 2004, Number of Households in Rotherham

# Demographic Profile

## 1.11 Deprivation

According to the Index of Multiple Deprivation (IMD 2010), Rotherham is the 53rd most deprived out of 326 English districts. Rotherham’s IMD rank improved from 63rd in 2004 to 68th in 2007 before deteriorating in 2010. The Indices of Deprivation 2010 domains most challenging for Rotherham are:

- Health and Disability
- Education, Training and Skills
- Employment

A third of Rotherham’s population live in areas which are amongst the most deprived 20% in England, which has not changed since 2004. However, the most deprived areas of Rotherham have seen deprivation increase the most between 2004 and 2007.

The key drivers of deprivation in Rotherham are: Health and

Disability (33% in English Top 10%), Education and Skills (24% in English Top 10%) and Employment (22% in English Top 10%). Rotherham has average or low levels of deprivation in other domains such as Crime (11% in English Top 10%) and Living Environment (3% in English Top 10%).

Figure 1.20 shows the IMD scores for Super Output Areas in Rotherham relative to England. In 2010, 33% of Rotherham’s population lived in the most deprived fifth of England whilst only 5% lived in the least deprived fifth of England<sup>28</sup>. Figure 1.20 shows that relative deprivation in Rotherham has deteriorated between 2004 and 2010 as well as polarisation within Rotherham. The proportion living in areas amongst the least deprived 40% of England increased from 16% to

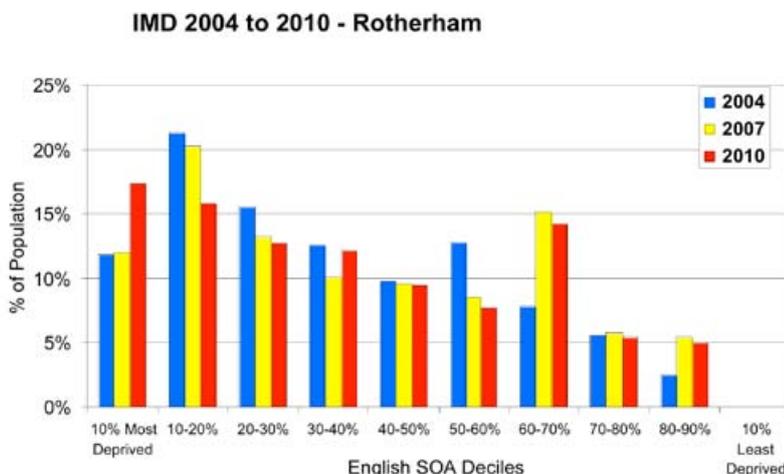
25%. However, the proportion of people living in areas amongst the most deprived 10% of England increased from 12% to 17%<sup>28</sup>.

Figure 1.21 shows the seven domains of the Indices of Deprivation 2010 and the proportion of Rotherham’s population in the most deprived areas of England. For example 24% of Rotherham’s population live in the 10% most deprived areas in terms of Education. If there was full equity in Rotherham, only 10% of the population should fall into this category.

Conversely 0% of the Rotherham population live in those areas where it is most difficult to access housing and services. The red shaded areas show domains where deprivation in Rotherham is high relative to the English average.

Figure 1.20: Percentage of Rotherham Residents Living in Index of Multiple Deprivation Deciles (2004, 2007 and 2010)

Source: Indices of Deprivation 2004, 2007 and 2010





# Demographic Profile

## 1.11 Deprivation

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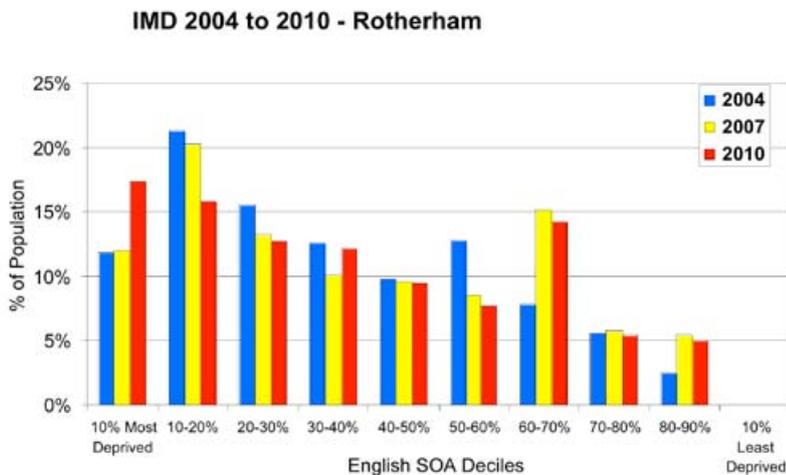
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Figure 1.20: Percentage of Rotherham Residents Living in Index of Multiple Deprivation Deciles (2004, 2007 and 2010)

Source: Indices of Deprivation 2004, 2007 and 2010



## Demographic Profile

### 1.12 Social Marketing Categories and Urban / Rural Classification

The 2001 ONS Classification and social marketing categories are used to group together geographic areas according to key characteristics common to the population in that grouping. Both the Social Marketing and Urban/Rural sections of the DH Core Dataset will be covered in more detail in Chapters 2 and 11 respectively. Around 70% of land in the Borough is classed as rural in nature and half of the land use is for agriculture. The majority of the Borough's population live in urban areas, around 50% in the Rotherham Urban Area area and 38% in smaller towns such as Wath, Swinton, Maltby and Dinnington. Rural areas, mainly in the south of the Borough contain 12% of the population.

## Demographic Profile

### 1.13 Sexuality

There are no statistics on the number of people in Rotherham who are Lesbian, Gay, Bisexual or Transgender (LGBT). Government estimates based on reliable survey evidence suggest that up to 6% of the UK population could be LGBT which would equate to 15,200 people in Rotherham or 11,800 adults. The Transgender population is estimated at 0.8% nationally which would translate into 2,000 people or 1,600 adults in Rotherham.

A local survey in 2010 found that 38% of LGBT respondents were Gay men, 35% were Lesbians and 12% were Bisexual. 10% lived in a different gender role to that assigned at birth including 6% who had changed gender. Survey evidence shows that LGBT people are more likely than average to be in employment. Discrimination remains an issue for LGBT communities with 40% having experienced harassment in the last 2 years and 73% felt unsafe in Rotherham.

# Demographic Profile

## 1.14 Key Messages

### Population projection:

Rotherham will see an increase in its population :

- of 5.1 % (266900) by 2020
- of 7.2 % (278900) by 2030
- Slightly higher concentration of the population are in the urban areas

Suggested rational for this are :

- Higher life expectancy
- Higher birth rate than death

### The over 65 and 85 years old population:

The steady increase in the 65+ population hides a much faster rate of increase for the population aged over 85 years which is projected to increase by 96% between 2008 and 2028.

- 22.8% of all population are over 60 years of age
- Projected growth for the 65+ over next 20years is 48%
- Projected growth for the 85+ over same period is 96%

### Gender:

Rotherham's population consist of 51% female and 49% male which is not too dissimilar to the national picture.

However this changes in the favour of the female gender group amongst the over 73 age bracket.

- 2.9 % of female are over the age of 73.

# Social and Environmental Needs Assessment

## 2.1 RMBC Strategic Housing Role

The Council's strategic housing role is central to delivering "sustainable communities and successful neighbourhoods where the quality and choice of housing underpins a buoyant economy and an improved quality of life". The role of the local authority in delivering strategic housing services was strengthened through the national regulatory and policy framework and looks set to continue via the emphasis on localism albeit with severely restrained resourcing and an increasing emphasis on making the most of existing opportunities and assets.

Rotherham Metropolitan Borough Council (RMBC) transferred responsibility for the delivery of housing management services to an arms length management organisation (ALMO) in 2005, which has allowed the Council to focus on its retained housing functions and its strategic place-shaping agenda.

This transfer is currently under review.

As strategic landlord the Council has a key role in ensuring housing is provided to households with specific needs. In particular:

- BME population
- Gypsies and travellers
- Vulnerable adults with a physical and/or sensory impairment, mental health problems or learning disabilities
- Extra care accommodation
- Floating support and move-on accommodation for teenage parents

# Social and Environmental Needs Assessment

## 2.2 Council Housing Stock

The Council's Arms Length Management Organisation (ALMO), 2010 Rotherham Ltd, was set up in May 2005 following a positive outcome to a tenant consultation and gave Rotherham the means to access some £218m towards the cost of delivering the decent homes standard across its 21,000 homes.

The original management contract was due to run until May 2010 but was extended to June 2011, in 2008/09, to allow completion of the decent homes programme and related environmental improvements.

2010 Rotherham Ltd has been successful in delivering 100% decent homes work (excluding refusals and no access) to timescale. However, now that the decent homes programme has come to a close the main reason the ALMO was created no longer exists.

In the summer of 2010, RMBC commissioned Price Waterhouse Cooper to carry out an independent appraisal on the options for the future management of Rotherham's

council housing. PWC recommended that the best available option for Rotherham was to return the management of its housing stock directly to the local authority. Direct management would:

- Minimise tenants' confusion around which organisation (2010 Rotherham or RMBC) is responsible for what service
- Promote greater accountability, through elected members
- Result in savings of around £1m per annum, excluding transfer costs

RMBC will resume the direct management of its housing stock on 1 July 2011.

The housing management services to transfer from the ALMO to the local authority include:

- Decent Homes works including environmental improvements
- Management of the repairs and maintenance contract
- Estate management
- Tenant empowerment/involvement

As well as accounting for the housing related changes outlined in the Localism Bill, a key piece of work is the creation and subsequent delivery of Rotherham's 30 Year Business Plan, prompted by Housing Revenue Account (HRA) reform. Priorities for the 30 Business Plan are:

- Maintenance of existing stock
- Climate change
- Environmental works
- Stock remodelling
- Big society/Localism
- Asset review
- Local authority new build
- Balancing neighbourhoods (buy-backs/acquisitions)
- Major structural repairs

2010 Rotherham Ltd submitted its local offers to the Tenant Services Authority in December 2010 and performance against those offers is being monitored by the same group of tenants who decided on Rotherham's local offers.

## Social and Environmental Needs Assessment

### 2.3 Private Sector

Rotherham's Private Sector housing interventions are aligned to support the priorities of the Community Strategy and Housing Strategy and will increase choice in the housing market and address decency standards in the private sector.

- The energy efficiency profile of private rented dwellings is poor when compared with other private sector dwellings in Rotherham (although good when compared with the national position).
- Around 67% of private rented stock would fail the Government's Decent Homes standard due to excessive cold.
- Almost half of the private rented stock would fail the Government's Decent Homes standard due to levels of disrepair.

It is anticipated that with the Government priority to rebalancing the economy increasing emphasis will be placed upon private householders to utilise the equity in their property to manage adaptation and modernisation. There will also be an increasing role for the private sector in addressing demands previously considered the domain of Registered Providers, particularly low cost housing provision and addressing the needs of vulnerable groups on a commercial basis.

## Social and Environmental Needs Assessment

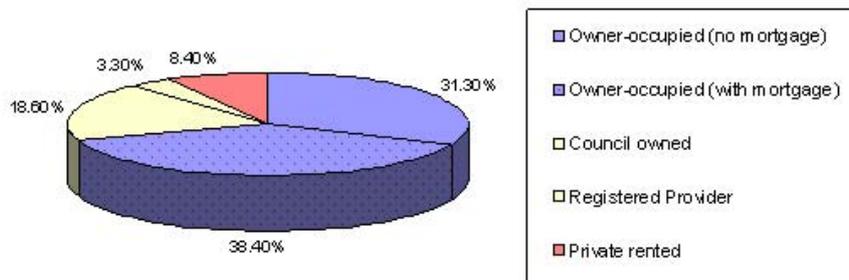
### 2.4 Housing Tenure

Rotherham has a population of around 253,900 people living in 111,822 households in 2010. Figure 2.1 illustrates that more than two thirds of people own their own homes in Rotherham and nearly a quarter of people socially rent from Local Authority and Housing Associations. Figure 2.1 shows a breakdown of household tenure in Rotherham.

69.7% of the local population are owner occupiers in Rotherham which is slightly above the national average of 67.9%. The proportion of the local population renting from the Local Authority or a Housing Association in Rotherham, which contributes toward the provision of affordable social housing, is 21.9%. This figure is higher than the national average of 17.8%.

**Figure 2.1: Breakdown of Household Tenure in Rotherham**

*Source: Census 2004, Mid Year Estimates – Household Tenure*



# Social and Environmental Needs Assessment

## 2.5 Ethnicity

The 2001 Census indicates that the proportion of the population in a Black or Minority Ethnic (BME) (non-White) group in Rotherham is quite low by national and regional standards at just 4.1%, compared to 7.7% in the region and 11.7% nationally.

Rotherham MBC estimates that there are 19,000 people from BME communities in 2009 which equates to 7.5% of the local population (5.6% are non-white), with 92.5% from the White British population<sup>1</sup>. By comparison in 2001, 4.1% of the population were from BME communities, suggesting that the number of BME residents has almost doubled over the last eight years (see chapter 1, section 1.5 for a further breakdown of the BME population in Rotherham).

Table 2.1, below, sets out the home ownership across the Ethnicity bands, which indicates

that a large proportion of White British people (68.2%) are owner occupiers, the same as the local average for all ethnic groups. The number of White British people who socially rent is equivalent to the national average at 24%. The proportion of the local population renting from private landlords is 6.1%, marginally lower than the national average of 18%. A small minority of the population live in communal accommodation (0.9%) such as hostels, bed and breakfast or staffing accommodation.

Home ownership within the BME population varies according to ethnic origin. Ownership ranges from 42.4% to 86.5%. BME groups are under-represented in the social rented sector but significantly over-represented in the private rented sector. People with mixed ethnicity are most likely to live in Council or Housing Association rented housing.

Members of the Black community are the least likely to be owner occupiers and have the highest proportion living in communal establishments. The increased prevalence in communal establishments is mainly due to Black Africans living in staff hospital accommodation.

**Table 2.1: Household Tenure and Communal Establishments**

Source: Census 2004, Mid Year Estimates – Household Tenure

Ethnicity	% Owner Occupied	% Social Rented	% Private Rented or Other	Communal Establishment
White British	68.2	24.2	6.7	0.9
White Other	59.1	23.4	16.7	0.8
White Irish	68.7	24.8	5.7	0.8
Mixed	53.3	32.1	14.1	0.5
Pakistani	73.0	13.9	13.0	0.1
Other	42.4	30.9	26.7	0
Chinese	86.5	5.9	7.6	0
Other Asian	65.7	13.1	21.2	0
Indian	77.9	10.9	11.2	0
Black	54.3	18.8	17.4	9.5
<b>All People</b>	<b>68.2</b>	<b>24.0</b>	<b>6.1</b>	<b>0.9</b>

# Social and Environmental Needs Assessment

## 2.6 Overcrowding

The government published a report, "Impact of Overcrowding on Health and Education", which demonstrates that overcrowding is either associated with or a casual factor in:

- Infant mortality.
- Respiratory conditions in children (although housing conditions themselves have a larger effect) and through into adulthood.
- Rates of serious infectious diseases such as meningitis and tuberculosis.
- Infections with *Helicobacter Pylori* which have implications for growth and diseases of the digestive system.
- Self-reported health status.
- Female mortality rates.
- Mental ill-health ranging from issues with self-esteem to psychiatric symptoms.

It is important to note that many of these effects are long-lasting.

Exposure to overcrowding in childhood can lead to poor health in adulthood, even when they no longer live in overcrowded accommodation.

Table 2.2 shows the number of overcrowded households in Rotherham. An overcrowded household is one where there are fewer habitable rooms than people. This can have some implications for health and well-being of the local population.

Generally, overcrowding is not a major issue for the local population, with 3.9% of households suffering overcrowding (3,997). Rotherham has lower overcrowding than both the regional average of 5.5% and national average of 7.1%.

Only 3.6% of the White British population live in overcrowded accommodation. However, BME groups are more affected,

with overcrowding ranging from 13.2% to 22.8% of the community's population. The proportion of BME households suffering overcrowding in the BME community is up to six times greater than the local average. There are 1 in 5 Pakistani/Kashmiri households who are overcrowded, compared to 1 in 25 for White British. More recent inward migrations of Eastern European Economic Migrants also experience high levels of overcrowding.

Whilst the Indian and Chinese communities tend to live in areas of low deprivation, many many have high levels of overcrowding, of 18.3% and 16.9% respectively.

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Other	42.4	30.9	26.7	0
Chinese	86.5	5.9	7.6	0
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Black	54.3	18.8	17.4	9.5
<b>All People</b>	<b>68.2</b>	<b>24.0</b>	<b>6.1</b>	<b>0.9</b>

# Social and Environmental Needs Assessment

## 2.7 Living Alone

Approximately one in seven local households consists of a pensioner living alone (14.4%). This equates to the regional and national average. Projecting Older People Population Information System (POPPI) estimates that there were 14,670 people over 64 years who were living alone in Rotherham in 2008. This is 5.8% of the local population. The gender breakdown of older people living on their own is 39.6% males and 60.4% females.

The Office of National Statistics estimates that there are 14,701 people living alone in Rotherham, 5.9% of the local population. This equates with POPPI estimates<sup>3</sup>.

POPPI predicts that the number of people over 64 years living alone in Rotherham is set to increase to 17,202 by 2015 and 21,234 by 2025. This is an anticipated

increase of 17% in the next 7 years and 45% in the next 17 years.

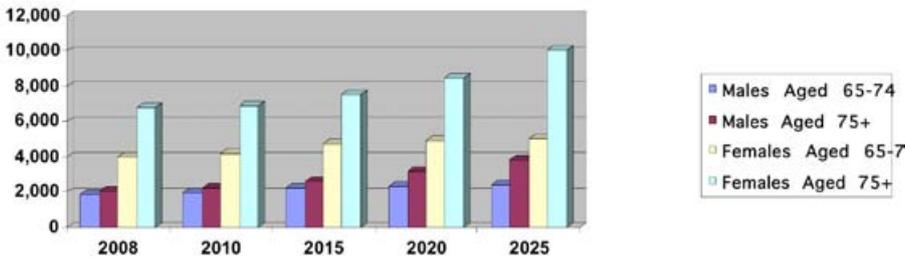
The most significant increase in population is males over 74 years. It is predicted that there will be an increase of 82% living alone by 2025 from 2,072 in 2008 to 3,808 in 2025. For females over 74 years it is predicted that there will be an increase of 48% by 2025 from 6,785 in 2008 to 10,030 in 2025. This significant increase in the population of older people living alone is due to a number of factors:

- Reduced impact of mining and heavy industry
- Increases in life expectancy particularly for men
- The ageing baby boomer population from the 1950s and early 1960s
- Intergenerational changes in family structure

People who are living alone tend to require more formal support from adult social care services, especially if their family or carers do not live in the local area and are unable to provide informal support. Therefore, the increasing number of people living alone is likely to have a significant impact on adult social care in the future.

Figure 2.2: Number of people over 64 years living alone in Rotherham in 2008

Source: POPPI 2008, Number of People over 65 years living alone



# Social and Environmental Needs Assessment

## 2.8 Summary of Housing Demand in Rotherham

Properties take an average 8.4 weeks to sell compared to the regional average of 11.2 weeks achieving. On average, 88.9% of their asking price compared to the regional average of 90.8%.

In 2008, there were 20,826 people on the Housing Register in Rotherham compared to 21,636 in 2002.

The most common house type is semi-detached (see table 4), of which there are 51,946,

representing 49% of all housing in the area.

The most common housing tenure is "owns mortgage with a loan" (see table 3) of which there are 39,588 representing 39% of all housing in the area.

Housing density is 4 dwellings per hectare<sup>d</sup>.

Rotherham Metropolitan Borough Council has a stock of 20,971 homes (as at April 2009). They

are managed and repaired by the arms length management organisation (ALMO), 2010 Rotherham Ltd.

There are currently 111,822 households in Rotherham, however statistical information related to tenure distribution is based on figures reported for April 2008 when there were 109,959 homes in Rotherham. The tenure distribution is set out in table 2.3.

**Table 2.3: Tenure of Rotherham's housing stock, April 2008**

Source: Hometrack

Tenure	Rotherham		Yorkshire & Humber		England	
	Count	%	Count	%	Count	%
LA dwelling stock	21,289	19.4	242,854	10.7	1,870,365	8.3
RSL dwelling stock	3,559	3.2	178,000	7.8	2,142,297	9.5
Other public sector dwelling stock	244	0.2	3,869	0.2	74,134	0.3
Owner occupied and private rented dwelling stock	84,867	77.2	1,854,154	81.4	18,407,061	81.8
<b>Total</b>	<b>109,959</b>	<b>100</b>	<b>2,278,877</b>	<b>100.1</b>	<b>22,493,857</b>	<b>99.9</b>

**Table 2.4: Size of homes in Rotherham**

Source: Census 2001

No of rooms	Rotherham		Doncaster		Barnsley		Sheffield	
	Count	%	Count	%	Count	%	Count	%
1 room	336	0.3	378	0.3	291	0.3	1,501	0.7
2 rooms	974	1.0	1,221	1.0	889	1.0	4,508	2.1
3 rooms	7,183	7	6,974	5.9	5,607	6.1	19,998	9.2
4 rooms	19,954	19.5	20,311	17.1	22,260	24.2	46,973	21.6
5 rooms	34,972	34.2	41,880	35.3	33,234	36.1	70,050	32.2
6 rooms	25,261	24.7	30,107	25.4	19,218	20.9	43,954	20.2
7 rooms	7,936	7.8	9,679	8.2	5,974	6.5	16,461	7.6
8 or more rooms	5,608	5.5	8,164	6.9	4,675	5.1	14,214	6.5

**Table 2.5: Property types in Rotherham**

Source: Hometrack, February 2010

Housing stock by property type	Rotherham	Doncaster	Barnsley	Sheffield
Detached	21,479	28,326	20,075	31,676
Semi-detached	51,946	55,374	45,023	84,075
Terraced	21,416	30,782	24,391	67,381
Flats - purpose built block	9,315	5,966	4,692	34,561
Flats - conversion	682	1,050	743	4,367
Flats - commercial building	694	894	727	2,258
Mobile or temporary structure	59	784	74	147
In a shared dwelling	315	256	137	756

## Social and Environmental Needs Assessment

### 2.9 Condition of Stock

The Private Sector Stock Condition Survey carried out in 2007 revealed that the average cost of repairs required were significantly higher in the private rented sector than the owner-occupier sector.

The Private Sector Stock Condition Survey revealed that the main reason for not attaining the Decent Home standard was thermal comfort. Groups with high levels of non-decency included; private rented, pre-1919 dwellings, converted flats and terraced houses. The households which showed high levels of non-decency included single pensioner, special needs and vulnerable households.

2010 Rotherham Ltd. manages 21,000 social homes on behalf of the Council and has completed the Decent Homes programme, achieving 100% decency with the exception of no access for repairs and refusals. 2010 Rotherham Ltd. are also working in partnership with RMBC to deliver a programme of environmental improvement works and the investment programme has secured the long term sustainability of Council housing by aligning with other major neighbourhood investments such as building schools for the future, Housing Market Renewal and Economic regeneration.

During the financial year 2009/2010 Rotherham Metropolitan Borough Council's Home Energy Advice Team has been able to improve the energy efficiency of council and privately owned housing stock through gaining access to over £3.5 million of funding from partners such as Warm Front and South Yorkshire Housing and Regeneration Partnership. Initiatives include installation of central heating systems to over 700 homes, replacing boilers in 68 homes, loft insulation and cavity wall insulation to 3,198 homes.

**Table 2.6: Overall repair costs in Rotherham private sector**

Source: RMBC Private Sector Stock Condition Survey 2007

Dwelling characteristic	Non decent	Category 1 Hazard	Fail disrepair	Fail modernisation	Fail thermal comfort
Owner occupied (no mortgage)	21.7%	10.5%	4.1%	5.9%	10.2%
Owner occupied (with mortgage)	15.6%	7.6%	3.2%	1.7%	7.0%
Private rented	44.9%	21.4%	14.2%	12.3%	28.2%
2010 stock	64.9%	4.6%*	79.7%	66.9%	13.4%

**Table 2.7: Non-decent homes and dwelling characteristics (2007 data)**

\*Statutory minimum standard

Repair category	Owner Occupied		Private Rented		All private sector dwellings	
	Total cost	Average cost per dwelling	Total cost	Average cost per dwelling	Total cost	Average cost per dwelling
Urgent repair	£77.2m	£1,011	£16.0m	£2,031	£93.2m	£1,106
Basic repair	£124.5m	£1,631m	£25.0m	£3,177	£149.6m	£1,775
Comprehensive Repair	£331.7m	£4,341	£48.2m	£6,125	£380.0m	£4,510
Standardised repair cost (/m <sup>2</sup> )		£19.5		£42.2		£21.6

## Social and Environmental Needs Assessment

### 2.10 Affordable Warmth and Fuel Poverty

Fuel poverty has a negative impact on a person's quality of life and health. Cold and damp homes are linked with health problems such as asthma, bronchitis, influenza, heart disease, strokes and exacerbation of arthritis. Periods of prolonged immobility can result, making it even more difficult for older people to keep warm. Research has shown that domestic accidents, including fatal accidents, are more common in cold homes in winter, resulting in costly hospital admissions and social care such as home care or residential care.

Rotherham Metropolitan Borough Council is currently working with Sheffield Hallam University, Chartered Institute of Marketing and Positive Sum Ltd. for a research project investigating the role of domestic renewable energy technologies in alleviating fuel poverty. The main aims of the project are to:

- Determine the extent to which the retrofitting of renewable energy technologies into existing homes can help to alleviate fuel poverty.
- Establish which renewable energy technologies offer the most cost effective means of alleviating fuel poverty.
- Identify factors that influence the effectiveness of such projects to enable optimum design of future fuel poverty alleviating schemes.

# Social and Environmental Needs Assessment

## 2.10.1 Keeping warm at home in later life (KWILLT)

This is a study to develop social marketing interventions that promote engagement of older people in keeping warm behaviour and access to anti-fuel poverty services.

Contracting NHS Organisation: NHS Rotherham  
 Project Duration: 26 months  
 Funding body: National Institute for Health research - Research for Patient Benefit

### Summary Background

It is a public health priority to reduce the health burden of individuals on the health service due to cold housing. Cold, damp housing and fuel poverty link to chronic health problems, excess winter deaths and impaired quality of life. 19.9% of Yorkshire and Humber households are fuel poor. This is due to an ageing population, barriers to accessing energy efficiency and increases in fuel costs. This translational study uses social marketing and lay epidemiology to explore the issue and develop interventions. Social marketing is an approach to promote healthy behaviour change (e.g. keeping warm) and overcome barriers to healthy behaviour e.g. tools to identify those at risk and increase access to services. Lay epidemiology (knowledge, beliefs and values) provides a theoretical framework.

### Summary Aims

This qualitative study aims to

- (i) examine older person's lay epidemiology, this is the network of empirical beliefs, values and non-rational factors that influence their health-affecting choices regarding keeping warm at home
- (ii) develop a package of social marketing products PCTs can adopt to promote keeping warm at home in later life that is informed by the lay epidemiology identified. These are:
  - Brief intervention training materials for health and social care staff.
  - A risk assessment and referral tool.
  - The insight required for PCTs to commission a social marketing public campaign.
  - The study results and user informed outputs can be readily adopted by PCTs. Their impact on patients and NHS efficiency can be measured using routine audit and evaluation.

This is currently work in progress and more details will be available in the next JSNA.

### Scientific Summary Plan of Investigation

A qualitative study using in-depth semi-structured individual, group interviews, social marketing and framework analysis techniques. The study has three stages. Triangulation of methods adds to the rigor of the findings:

- Individual interviews and room temperature measurement with 50 older people and interviews with 25 health and social care professionals to explore the lay epidemiology of older people regarding keeping warm at home.
- (ii) 6 focus groups with older people and professionals to verify, challenge and expand upon findings from the individual interviews.
- (iii) A structured social marketing consultation of up to 50 key stakeholders to examine the findings and shape the study outputs including education materials, an assessment/referral tool and social marketing insight.

# Social and Environmental Needs Assessment

## 2.11 Energy

Rotherham Metropolitan Borough Council's Private Sector Stock Condition Survey 2007 revealed the following information regarding energy efficiency and heating in private housing in Rotherham:

- It is estimated that 83.2% of private sector dwellings in Rotherham have cavity walls, of which 38% have no cavity insulation (around 27,000 dwellings). This provides considerable scope for improving energy efficiency through the insulation of unfilled cavities.
- It was found that dwellings in the private rented sector are noticeably less likely to have full double glazing rather than those in the owner-occupied sector.
- 79.5% of dwellings with insulation have 100mm or more of insulation whilst 12.6% were estimated to have over 200mm (2.1% do not have a loft).
- The main types of fuel used are gas (95.1%), solid fuel (2.3%), electric (2.1%) and oil (0.5%).
- The average SAP (Standard Assessment Procedure) rating for the private sector is 60. Older dwellings typically display lower SAP ratings.

- Households living in dwellings with particularly low SAP ratings also appear to show quite distinct characteristics with single pensioner households showing the lowest average SAP rating.

8.4% (6,873) of private sector households in Rotherham were found to be in fuel poverty.

The long term impacts of climate change are unknown but several localised flooding incidents in recent years underline the seriousness of the issue and the potential for adverse impact on the Rotherham community in years to come.

The Climate Change Act (November 2008) puts the UK in an international leadership role, setting the world's most ambitious national targets for emissions cuts: an 80% reduction in carbon dioxide and other greenhouse gas emissions by 2050 as compared with 1990.

The impact of climate change is likely to be greatest on the most disadvantaged measured in terms of the cost of heating and cooling poorly adapted homes.

The Government has set out its ambitious timetable for the progressive tightening of building regulations (Part L) in 2010 and

2013, with the aim of achieving zero carbon emissions in all new homes by 2016. This will be supported by the Code for Sustainable Homes, the Planning Policy Statement on Climate Change and stamp duty relief for zero carbon homes.

Although new private sector development is to have Zero Carbon emissions by 2016, Central Government wants social housing to reach this by 2013 by way of demonstrating the technologies and contributing to developing economies of scale, thereby bringing down the current additional development cost of a Code 6 Zero Carbon home of ca. £34,000.

Emissions related to the existing housing stock present the greatest challenge. Constructed in eras of cheap fuel, hence poor in energy efficiency, they are unsuited to a projected period of fuel scarcity. We are reaching 3,000 private households per year, mainly promoting cavity and loft insulation. Our strategy directs priority to this issue.

# Social and Environmental Needs Assessment

## 2.12 Empty Properties

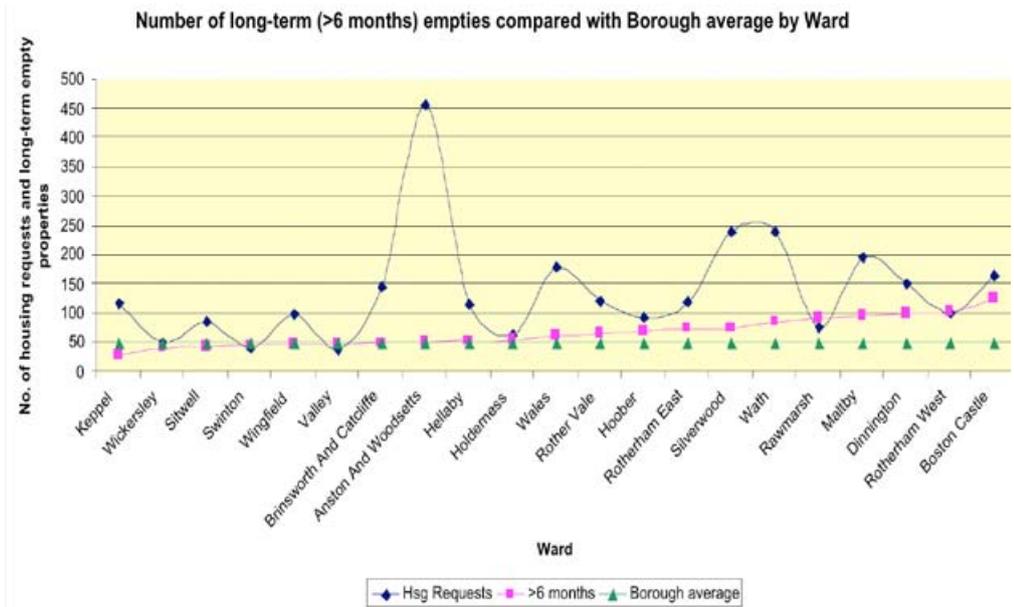
The number of empty properties across the district is recorded on an annual basis by the Housing Strategy Statistical Appendix (HSSA). A recent review of current statistics indicates that the empty homes picture for Rotherham is changing and that the mid year outturn for 2009/10 demonstrates that the number of empty properties in the Borough has reduced to 3,881 (3.53%) from 4,273 (3.88%). The figures include an amount of short term properties (less than 6 months) which are deemed vital to allow the housing market to function effectively and to facilitate both residential mobility and the improvement or redevelopment of the housing stock.

The table below identifies the wards where there has been high demand for housing based on Key Choices monitoring of Choice Based Letting requests and the wards where there are the highest numbers of empty properties and low demand.

As a result of direct council involvement 124 properties have been successfully returned back into use during 2008/09 - an increase of 45 properties compared to the number returned to use by the Council during 2007/08.

Figure 2.3: Empty properties in Rotherham

Source: Empty Property Update Report, March 2010



# Social and Environmental Needs Assessment

## 2.13 Affordability

Rotherham’s Strategic Housing Market Assessment 2007 suggested a target for 411 affordable homes, mainly to be delivered by the private sector but with some delivered via social housing grant. This study has been refreshed (December 2010) and the need for affordable homes has risen exponentially to over 1,000 per year. In August 2008, the Council adopted a new Interim Planning Policy as a basis for negotiation for 25% affordable housing inclusion on new build sites of 15 or more dwellings.

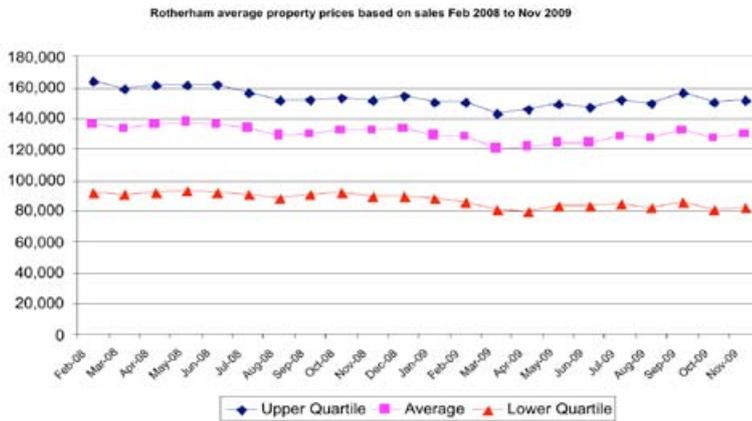
As a result of the economic downturn the Borough has experienced a decline in new build housing numbers, increased unemployment, leading to reduced demand for open market housing and increasing the number of repossessions.

The average house price in Rotherham as at November 2009 was £130,048, compared to £122,339 for the region and £152,898 for the whole of England and Wales. Following falls at the end of the 1990s,

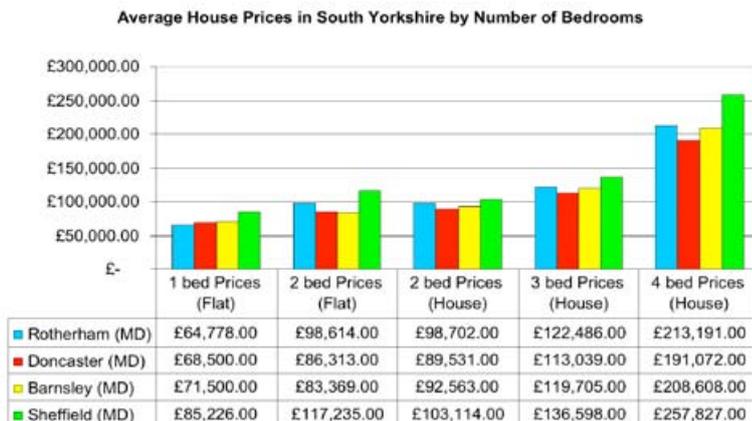
house prices in Rotherham have increased substantially since 2001 with annual rates of increase above 20% from 2003 to mid 2005. In the last year Rotherham has seen a fall in house prices of 11.3%, but this was less than the national fall of 16.2%.

Table 2.10 illustrates the average weekly cost of renting a home in Rotherham in August 2009.

**Figure 2.4: Rotherham average property prices Feb 2008 – Nov 2009**  
 Source: Land Registry, Hometrack



**Figure 2.5: Average house prices by number of bedrooms**  
 Source: Land Registry, Hometrack, February 2010



# Social and Environmental Needs Assessment

## 2.13 Affordability

Table 2.8: Lowest 10 Average House Prices by SOA in 2008

Source: Land Registry, Hometrack

Cross Tenure Affordability (wkly cost)	1 bed prop	2 bed prop	3 bed prop
Renting (Public)*	£53.99	£61.52	£75.85
Renting (HA)	£55.30	£59.70	£65.70
Renting (intermediate)	£73.00	£89.00	£101.00
Renting (Private)	£91.00	£111.00	£126.00
Buying a lower quartile re-sale	£73.00	£86.00	£104.00
Buying an average re-sale	£88.00	£109.00	£133.00
Buying a 40% new-build HomeBuy	£51.00	£78.00	£91.00
Buying a lower quartile new-build	n/a	n/a	£142.00
Buying an average new-build	n/a	n/a	£155.00

Table 2.9: Highest 10 Average House Prices by SOA in 2008

Source: Land Registry, Hometrack

LOCAL NAME	2008			
	Average House Price (current)	Average House Price Rank	No of Sales - 2008	Range £ k
Moorgate West	£370,000	166	10	150-200
Wath Central & Newhill	£365,000	165	7	80-300
Eastwood Village	£311,300	164	17	150-300
Canklow North	£275,000	163	14	100-300
Masbrough West	£266,900	162	29	120-600
Parkgate	£249,000	161	15	90-300
Eastwood Central	£237,500	160	19	70-200
Masbrough East	£225,100	159	16	80-600
Meadowbank	£214,100	158	7	80-200
Broom East	£205,000	157	14	120-200
Town Centre	£203,500	156	13	70-300

Table 2.10: Average rents by property size

\*Figures provided by 2010 Rotherham Ltd - August 2009

Source: Hometrack, RSR

LOCAL NAME	2008			
	Average House Price (current)	Average House Price Rank	No of Sales - 2008	Range £ k
Herringthorpe North	£40,000	1	14	50-150
Brinsworth North	£46,700	2	22	40-150
Brecks East	£58,360	3	13	20-400
Whiston South & Morthen	£58,500	4	15	50-150
Anston Greenlands	£60,000	5	55	40-150
Maltby West - Amory's Holt	£62,600	6	26	40-150
Swinton South East	£63,500	7	29	30-200
Aston South	£64,800	8	15	60-300
Bramley West	£65,500	9	11	60-300
Rawmarsh Victoria Park	£65,600	10	6	30-120

# Social and Environmental Needs Assessment

## 2.14 Household Income

The average hourly earnings (median for full time workers including overtime) in Rotherham in 2008 was £10.04, compared to £10.96 regionally, and £11.97 in the UK. This represents a fall of 1.2% from the 2007 figure in Rotherham, compared to a 4.6% rise seen regionally and a 4.4% rise in the UK<sup>5</sup>.

Housing remains far more affordable for first time buyers in Rotherham than nationally, or those looking to move up the property ladder in Rotherham<sup>6</sup>.

Table 2.11 shows the percentage of households priced out of the market in the area. The analysis differentiates between house types and whether or not the purchasers are first time buyers. This is a modelled figure which is derived from the house price and income assumptions. The figures displayed are simply derived from incomes and house prices and do not account for the existing tenures of local residents.

The Council has a key role in ensuring housing is provided to households with specific needs and we will;

- Encourage households to invest their own resources to fund repairs
- Target void and empty properties to be brought back into use
- Work with clients with particular needs to personalise housing choice
- Develop a Common Housing Register with Registered Providers to update and inform housing needs
- Work with housing developers to establish a viable supply of affordable low carbon housing from new planning permissions
- Build new council houses that have zero carbon emissions by 2013
- Continue to monitor need for Gypsy and Traveller accommodation

**Table 2.11: Income Ranking Report by Ward (2009)**

Source: Empty Property Update Report, March 2010

Affordability by income bands	3 x income	3.5 x income	4 x income
<b>Rotherham (MD)</b>			
Percent of households priced out of market			
FTB households – Flats	36.22%	36.22%	22.59%
FTB households - Terraced houses	36.22%	36.22%	22.59%
FTB households - Semi-detached houses	60.19%	49.11%	36.22%
FTB households - Detached houses	76.32%	69.20%	60.19%
Owner occupier – Flats	36.22%	22.59%	22.59%
Owner occupier – Terraced houses	36.22%	22.59%	22.59%
Owner occupier - Semi-detached houses	49.11%	36.22%	36.22%
Owner occupier - Detached houses	69.20%	60.19%	60.19%

**Figure 2.3: Empty properties in Rotherham**

Source: Empty Property Update Report, March 2010

Income Ranking Report 2009				
Ranking	Name	Total Households	Average Annual Household Income	Median Annual Household Income
1	Anston and Woodsetts	4,742	£31,865	£31,039
2	Wales	4,628	£30,280	£29,589
3	Dinnington	5,175	£30,169	£29,247
4	Holderness	5,096	£30,023	£28,362
5	Wickersley	5,572	£30,988	£28,122
6	Hellaby	4,883	£33,528	£27,860
7	Sitwell	4,921	£34,302	£27,813
8	Rother Vale	4,909	£28,616	£26,142
9	Brinsworth and Catcliffe	5,078	£29,035	£24,944
10	Keppel	5,215	£29,233	£24,638
11	Silverwood	4,671	£27,246	£24,478
12	Hooper	5,135	£25,954	£24,065
13	Wath	5,197	£23,098	£22,226
14	Rotherham West	5,571	£25,084	£21,460
15	Boston Castle	5,881	£28,712	£20,858
16	Swinton	5,386	£22,461	£18,733
17	Wingfield	5,771	£21,955	£17,762
18	Rawmarsh	5,714	£23,010	£17,759
19	Maltby	5,366	£21,050	£16,795
20	Valley	5,499	£23,484	£16,563
21	Rotherham East	5,747	£20,840	£14,555
	Whole of Rotherham	110,157	£27,017	£23,005

- Seek to improve standards in private rental housing by agreeing codes of practice and by enforcement using all available powers where necessary
- Work with private landlords to encourage voluntary improvements in decency standards of their property
- Demolish unsustainable stock subject to rigorous environmental assessment
- Tackle non-decent homes via our Home Improvement Agency

<sup>5</sup> data is workplace based, taken from the Annual Survey of Hours and Earnings (ASHE), which has been developed to replace the New Earnings Survey (NES).

<sup>6</sup> Rotherham In Focus – An Economic Assessment of Borough – April 2009

## Social and Environmental Needs Assessment

### 2.15 Central Heating

The 2001 Census shows that Rotherham has a lower number of households (4,260) lacking central heating (4.2%)<sup>7</sup> than both the regional average of 12.9% and national average of 8.4%. 6% of households living in the 10% most deprived areas of Rotherham have no central heating with 2.22% in the least 10% deprived areas<sup>7</sup>. People who live in the private rented sector are the most likely to be without central heating in their home.

POPPI estimates that there are 2,374 people over 64 years who have no central heating, 6.14% of the older population of Rotherham<sup>8</sup>. It is predicted

that these numbers will reduce as a result of the Decent Homes programme currently being delivered by Local Authorities.

There is evidence that households without central heating are more likely to adversely affect the health of people with conditions such as cardio-vascular disease or chronic obstructive pulmonary disorders. Approximately 13,300 people (5.2% of local population) live in fuel poverty.

# Social and Environmental Needs Assessment

## 2.16 Access to Car or Van

For the purpose of this section the term "car" is equivalent to "car or van". There were a total of 104,845 cars available to households in the Borough at the time of the Census in 2001<sup>9</sup>. There is approximately 1 car for every household in Rotherham with 30% of households (30,374) having no car. This is above the national average of 26.84% but below the regional average of 30.31%.

44% of households (45,009) have access to a car. This is similar to the regional (44.1%) and national (43.7%) averages. 21.7% of households (22,204)

have two cars, 3.6% (3,704) with three cars and 1.0% (988) with four or more cars.

According to the Office of National Statistics there are around 106,489 people of working age in Rotherham who regularly travel to work. Figure 2.6 shows a breakdown of the method of travel people use in order to attend work in Rotherham.

Over two thirds of people (69.3%) travel to work by car either as a driver or passenger. 12% of people travel by bus, minibus or coach and 8.2% travel by foot. A small

minority of people travel to work by other means of transport e.g. by bicycle or taxi. 6.9% of people work from home.

Figure 2.9 breaks down the distances that people travel into work. 22.5% of people travel 5km and 10km when going to work. 18.9% of people travel between 10km and 20km. 23.4% work from home, work abroad or have no fixed place of work. A small proportion of people (2.5%) commute to work and cover a distance of over 60 km.

Figure 2.6: Breakdown of Households who have Access to Car or Van

Source: Office of National Statistics 2007, Cars or Vans (KS17)

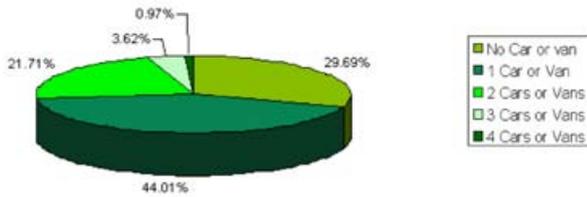


Figure 2.7: Breakdown of Methods of Travel to Work in Rotherham

Source: Office of National Statistics 2007, Method of Travel to Work – Resident Population (UV39)

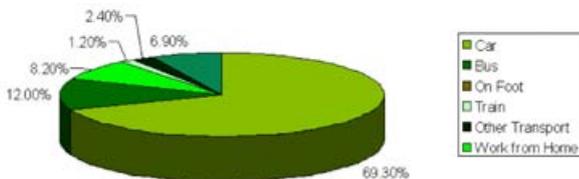
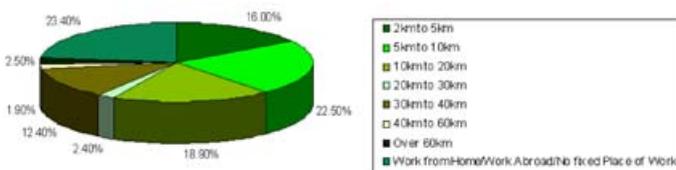


Figure 2.8: Breakdown of Distances Travelled to Work

Source: Office of National Statistics 2004, Distance Travelled to Work (UV35)



# Social and Environmental Needs Assessment

## 2.17 Overall Employment Rate

Rotherham's traditional industrial and mining industries have diminished during the last fifteen years. There was a long period of decline in employment during the 1980s and 1990s. However, new industries have developed and economic growth has boosted the employment rate. There has been a dramatic improvement in Rotherham's employment rate over the last ten years, an increase which has been faster than across England as a whole.

Overall, it would appear that Rotherham has significantly closed the gap in terms of employment<sup>10</sup>. This has been driven by a growing economy and associated job creation. Rotherham's employment rate began to increase strongly during 2001.

Between 1998 and 2006, the number of jobs located in Rotherham increased from

80,900 to 104,000, a 28.6% increase. This was the highest increase in the region and amongst the 20 highest increases nationally. Much of the rise is attributable to the development of large new employment sites such as Manvers<sup>11</sup>.

Between 2000 and 2006 there was a significant increase in job creation in Rotherham with 14,600 jobs being created which was well above the regional and national averages<sup>12</sup>. The employment rate continued to increase up to the end of 2006 when it reached the national average, but since then it has fallen back below the regional and national averages, falling particularly sharply since the start of the recession in mid-2008.

According to NOMIS Official Labour Market Statistics there are 123,100 people who are

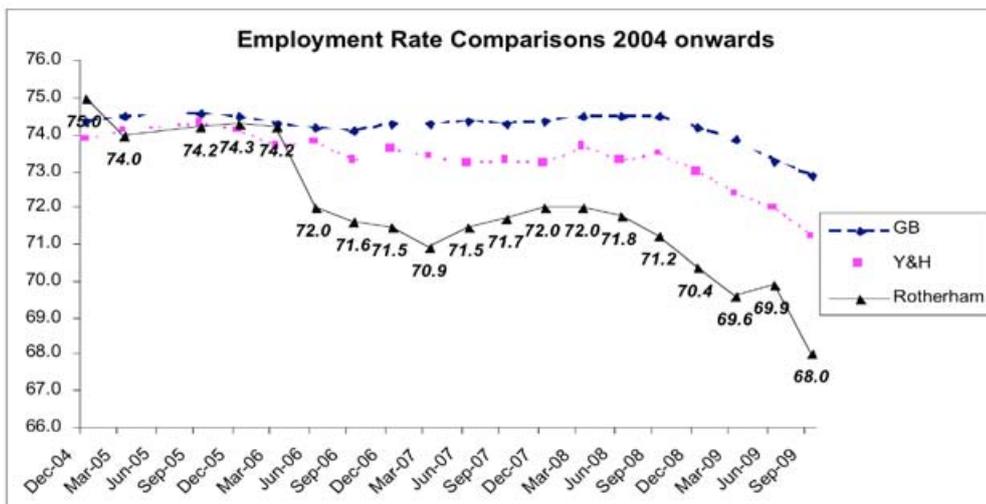
economically active, either in employment or unemployed and actively seeking a job. Of these, there are 107,900 people who are employed. This equates to 68.0% of the working age population, below the regional average of 71.2% and the national average of 72.9%<sup>13</sup>.

Breaking down the employment figures: 55,800 (52%) are males with 52,100 (48%) females. The difference is mainly attributable to the working age of females being 16-59 years and males being 16-64 years. 11,900 (7.6%) of people are self-employed which is below the regional average of 8.3% and national average of 9.1%. Males are more likely to be self-employed (11.5%) in comparison to females (3.2%)<sup>13</sup>.

The National Indicator (NI151) captures the number of people who are in employment according

Figure 2.9: Employment Rate in Rotherham from 2004-2009

Source: NI151 (2009) – Employment Rate in Rotherham



10 Rotherham State of the Borough 2008, A Statistical Portrait, p3

11 Rotherham State of the Borough 2008, A Statistical Portrait, p12

12 Rotherham State of the Borough 2008, A Statistical Portrait, p10

13 NOMIS Official Labour Market Statistics 2009, Labour Supply – Economically Active

## Social and Environmental Needs Assessment

### 2.17 Overall Employment Rate

to the International Labour Organisation (ILO). The working age population is classed as 16-59 years for women and 16 -64 years for men. Figure 2.10 illustrates the employment rate in Rotherham from 2004 to 2009.

In September 2009 68.0% of people who are of working age were in paid employment compared to the regional average of 71.2% and the national average of 72.9%.

Data for 2008 shows that public sector, financial/business services, manufacturing and distribution are the four largest employment sectors in Rotherham. In comparison with the UK, the biggest differences in employment were in financial/business sector and in manufacturing. Despite a decline in recent years 15.3% of Rotherham's working population work in manufacturing

compared to only 10.2% in the UK as a whole. The financial/business sector employs 17.6% of Rotherham's population (despite recent strong increases) compared to 22.0% in the UK<sup>14</sup>.

Figure 2.11 shows levels of economic activity across all ethnic groups in Rotherham. Highest economic activity is amongst the Indian (75.3%) and Black ethnic groups (68.1%). A high percentage of people from these ethnic groups are self-employed. Both have higher economic activity rates than White British people (64.4%).

Levels of economic activity are generally higher for the White British population but lower for BME groups. Lowest levels of economic activity occur in the Kashmiri/Pakistani community (44.2%) and people identified as "Other" ethnic origin (41.6%).

This is mainly due to particularly low levels of female economic activity and the role of women as carers.

Figure 2.11: Number of People who are Economically Active in Rotherham by Ethnicity

Source: Health Needs Assessment 2008, BME Populations in Rotherham, p17

Group	Population Aged 16-74	Economically Active	%	Unemployed	%
All People	178356	114116	64.0	7,041	6.2
White British	171723	110634	64.4	6,611	6.0
White Irish	867	447	51.6	29	6.5
White Other	996	568	57.0	46	8.1
Mixed	559	347	62.1	32	9.6
Indian	401	302	75.3	13	4.4
Pakistani	2815	1244	44.2	251	20.2
Other Asian	231	124	53.7	18	4.6
Black	329	224	68.1	23	7.4
Chinese	226	139	61.5	6	4.3
Other	209	87	41.6	18	20.0

# Social and Environmental Needs Assessment

## 2.18 Working Age People on Out-of-Work Benefits (NI 152)

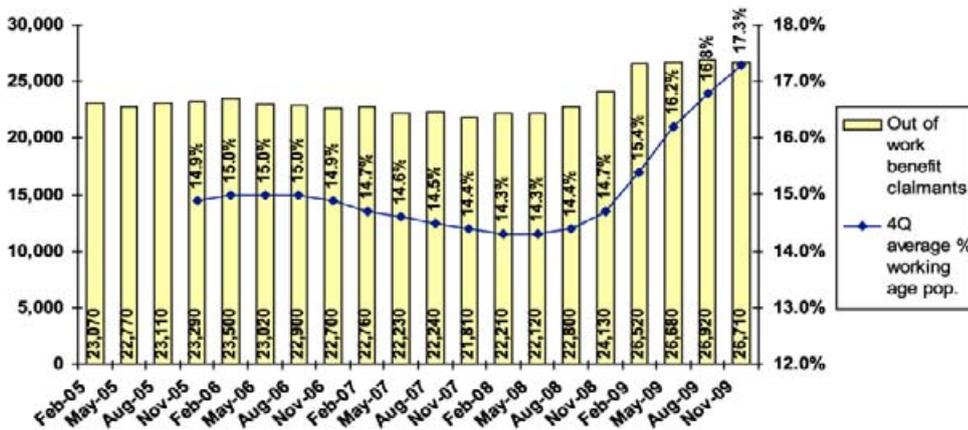
The National Indicator (NI152) measures the percentage of the working age population who are claiming out of work benefits. Out of work benefits include Job Seekers Allowance, Lone Parents on Income Support, Incapacity Benefit and other income related benefits. These benefits do not include carers, people who are disabled or people who have been recently bereaved.

declining from 23,290 people (14.9%) in November 2005 to 21,810 (14.4%) in November 2007. Since then the number of people on benefits has shown an increase, particularly since the economic downturn began in mid-2008. This is due to increasing numbers of Job Seeker Allowance claimants and at November 2009 there were 26,710 people (17.3%) on out of work benefits.

There are 154,400 people who are of working age population in Rotherham. Figure 2.12 shows that the total number of people on out of work benefits had been steadily

Figure 2.12: Rotherham people claiming out-of-work benefits from 2005-2009

Source: NI152 (2009), Working Age People on Out-of-Work Benefits



# Social and Environmental Needs Assessment

## 2.19 Number on Out-of-Work Benefits in Worst Performing Areas (NI153)

The National Indicator (NI153) captures the number of working age people who are claiming out-of-work benefits in the worst performing neighbourhoods in Rotherham. These neighbourhoods are defined as Lower Super Output Areas (LSOA) and made a benefit claim rate of 25% or more at the 2007 baseline. An average LSOA contains around 1,500 people.

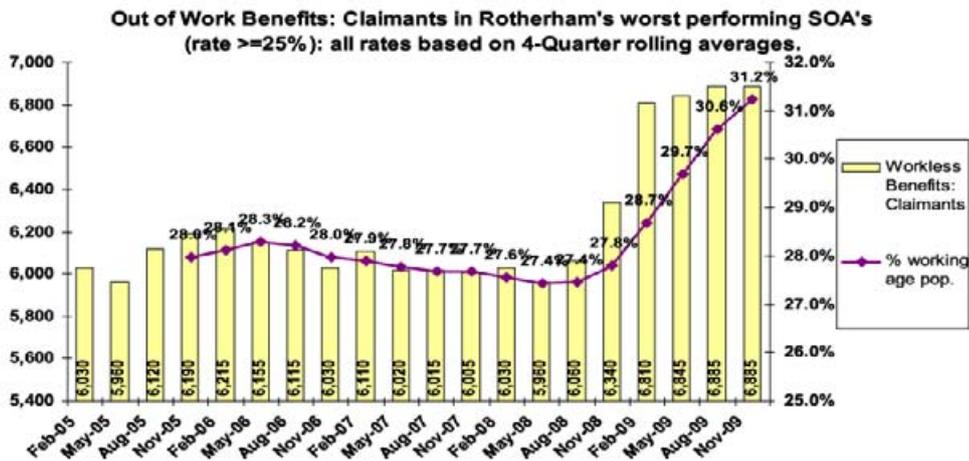
23 (13.9%) of Rotherham's 166 Super Output Areas (SOAs) had a claim rate of 25% at the 2007 baseline with an average claim rate across all 166 SOAs of 14.9%.

The average claim rate for SOAs, not including the LSOA rates (143 SOAs) was 12.7%.

The number of people who are claiming out-of-work benefits in the worst performing SOAs has increased from 5,960 in May 2008 to 6,885 people in November 2009, an increase of over 15%. The percentage of the working age population claiming out-of-work benefits had been falling slowly up to May 2008 but the recent recession has seen the rate increase to 31.2% in November 2009.

Figure 2.13: Working Age people claiming out-of-work benefits from 2005-2009 in the worst performing neighbourhoods

Source: NI153 (2009), Working Age People on Out-of-Work Benefits in Worst Performing Neighbourhoods



## Social and Environmental Needs Assessment

### 2.20 Contact with Mental Health Services whilst Employed (NI 150)

The National Indicator (NI 150) measures the percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in August 2010 this measured at 3.1%.

## Social and Environmental Needs Assessment

### 2.21 Unemployment Rate

Rotherham's unemployment rate at September 2009 was 10.2% which is above the national average of 7.4% and the regional rate of 8.2%. Rotherham had 12,300 people unemployed in 2009, including 430 from minority ethnic groups. 7.4% of the unemployed are therefore from the BME community. Unemployment had fallen dramatically from twice the national average to just below the national average by 2005 - the number unemployed in Rotherham peaked at 20,574 in September 1986 but, after falling to around 5,000, has increased again following the recession to reach 12,300 in September 2009.

Employment deprivation is one of the main drivers affecting Rotherham as measured by the Indices of Deprivation 2010. Although there have been some significant improvements since the mid-1980s Rotherham is still ranked as the 36th most deprived of 326 English Districts on the Employment Domain. This is an increase from 38th in 2007.

Employment deprivation has a distribution similar to overall deprivation levels, with the most deprived areas being East Herringthorpe, Thrybergh, Town Centre, Eastwood, Canklow, East Dene and East Maltby.

The main reason for high worklessness rates are the high levels of long-term sickness. These high numbers are a legacy from the old heavy and mining industries. Local regeneration has made a great impact in Rotherham in

recent years and the local economy has recovered strongly, creating jobs and prosperity, particular in the Manvers area. However, due to the impact of the recession overall unemployment has risen and there are still some neighbourhoods in Rotherham where unemployment remains very high.

There is substantial evidence that work leads to better physical, mental health and well-being. Conversely, worklessness can lead to poorer health, shorter life expectancy and loss of other health-related aspects of life such as daily routine, social contact and self-esteem. However, the nature of the work must be taken into consideration. Work can cause negative health impacts if, for example, it is stressful or performed in an unhealthy environment. Lack of secure and stable job opportunities cause anxiety through poor living standards and feeling deprived and isolated.

In Rotherham the rates of worklessness decreased over the period February 2001 to February 2008, with a 7% reduction and a fall of just over 2,000. This is made up of a reduction in the numbers on long-term sickness benefits (15,270 in 2001 reducing to 14,120 in 2008), and a larger fall in people on Job Seekers Allowance from 5,450 in 2001 to 3,910 in 2008. There has been progress in areas such as the Town Centre and Eastwood in reducing unemployment levels, but long-term sickness levels remain high in the most deprived areas of Rotherham<sup>15</sup>.

Since 2008 the position has worsened with worklessness increasing again. Whilst long-term sickness benefits have remained broadly similar the numbers on Job Seekers Allowance had risen to 7,498 by June 2010<sup>16</sup>.

People who are not working but seeking work are unemployed and unemployment rates are calculated as a percentage of the economically active population (those working or seeking work). The unemployment rate in 2001 averaged 6.2% for Rotherham as a whole but for BME groups overall, unemployment is twice as high. For non-White groups 14.4% were unemployed in 2001, rising to over 20% for people who originated from Kashmir/Pakistan. This contrasts with the below average levels of unemployment for Chinese and Indian people<sup>17</sup>.

Unemployment in 2001 was higher for men than women although this was not the case in every ethnic group. Although unemployment for Kashmiri and Pakistani men was high at 18.9%, women had an even higher rate of 23.2%. Men of "Other" ethnic groups and women of "Other Asian" groups also had unemployment rates over 20%. Chinese and Indian men had very low unemployment rates, as did Black women<sup>17</sup>.

<sup>15</sup> Rotherham State of the Borough 2008, A Statistical Portrait, p8

<sup>16</sup> NOMIS Official Labour Market Statistics (2009), Working Age Client Group - Benefit Claimants

<sup>17</sup> Health Needs Assessment 2008, BME Populations in Rotherham, p17

## Social and Environmental Needs Assessment

### 2.22 Claimant Count

The number unemployed at September 2009 was 8,838 according to the claimant count but, according to the Annual Population Survey (APS), was 12,300. The APS unemployment rate takes account of people not entitled to benefits. The APS unemployment rate for Rotherham in September was 10.2%, above the regional rate of 8.2% and national rate of 7.4%.

According to NOMIS Official Labour Market Statistics there were 7,498 people claiming Job Seekers Allowance in June 2010. 75.0% are males and 25.0%

are females. 55.0% of claimants are between the ages of 25-49, 31.5% between 18-24 and 13.3% aged 50 and over. 73.0% have been claiming this allowance up to 6 months with only 12.7% claiming over a 12 month period<sup>18</sup>.

Across Rotherham 28,450 people were receiving means-tested benefits - Income Support, Jobseekers Allowance or Pension Credit in 2008, which equates to 14% of all people aged over 16. This is made up mainly of Income Support claimants (10,270) and Pension Credit claimants (14,270). The numbers of people living

in income deprivation has been fairly static since 2001, with a fall in younger age groups being matched by a small rise in the older age groups.

# Social and Environmental Needs Assessment

## 2.23 Recent National Economic Down-Turn

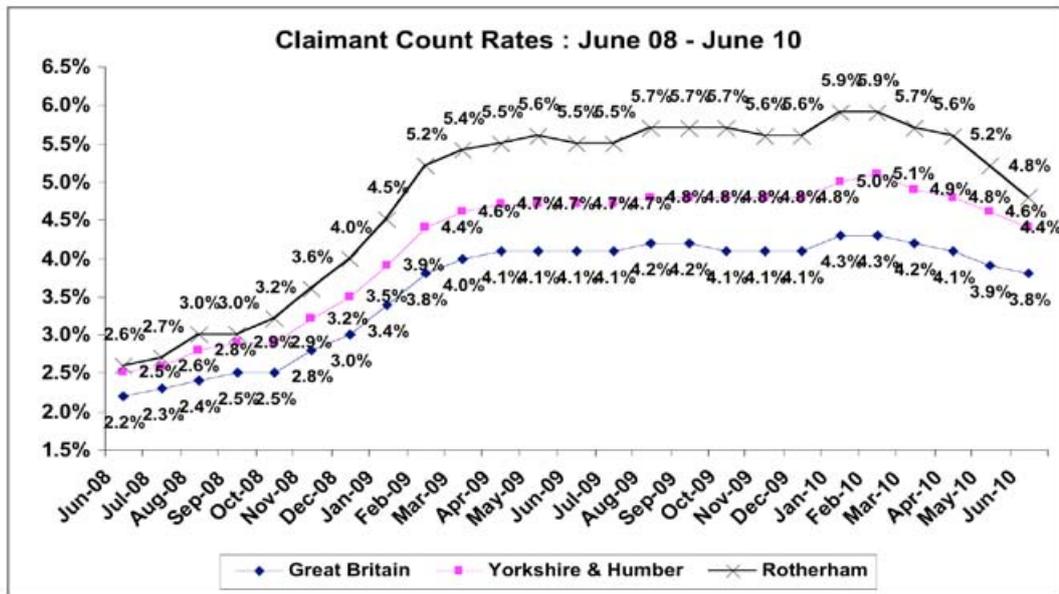
The UK economy is only just beginning to recover from the severe recession experienced since the middle of 2008. Rotherham has been severely impacted upon with significant job losses and increasing levels of unemployment. Most analysts expect the recovery to be slow with little significant improvement in employment numbers until 2011 at the earliest and employment numbers not getting back to pre-recession levels for a number of years.

The chart below shows how the claimant rate increased more quickly in Rotherham compared to regionally and nationally, although there have been some recent encouraging signs with falls in the claimant count locally in five of the first six months of 2010 and the overall rate falling faster than other areas.

In the long-term the latest forecasts from Yorkshire forward suggest that employment levels in Rotherham may not recover

to pre-recession levels until around 2020, particularly taking into account the expected job losses in the public sector over the next few years, but this will depend to a large extent on the speed/strength of recovery in the national economy.

Figure 2.14: Claimant Court Rates



## Social and Environmental Needs Assessment

### 2.24 Average Incomes

Levels of income deprivation across Rotherham are relatively high, with the Borough ranked 48th most deprived of the 326 English Districts. There is a close relationship between multiple deprivation and income deprivation. This is evident in parts of East Herringthorpe and Canklow where half the population are affected by income deprivation, whilst in the least deprived areas only 3% of people are similarly affected. 17.6% of Rotherham's population are defined as "deprived of income", slightly lower than in 2007.

Median average hourly earnings for full time workers (including overtime) in Rotherham were £11.24 in 2009, compared to £11.37 regionally and £12.43 in the UK. This represents a rise of 11.8% from the 2008 figure in

Rotherham, compared to a 3.6% rise in the region and a 3.8% rise in the UK. However, when comparing earning rates it should be noted that there is a lower cost of living in Rotherham.

In 2009, men earned an average of £11.40 per hour compared to £10.62 for women. Women's hourly pay was 93.2% of men's pay in Rotherham, slightly higher than the regional figure of 89.1% and the national figure of 87.1%. Weekly average full time earnings were £450.90 in Rotherham, compared to £490.20 nationally. Male earnings were 20.4% higher than female earnings, below the national figure of 25.1%<sup>19</sup>.

Historically the earnings of Rotherham's employed population have been above the level of the earnings of employees working

within Rotherham. People from Rotherham have taken advantage of higher earnings outside the borough, particularly Sheffield. This gap has shrunk over the last few years and work place/residence based earnings are now broadly at similar levels. This is an indication that higher paid jobs have been created in Rotherham<sup>20</sup>.

Average household income in Rotherham is estimated at £30,100 (2007), 88% of the national average of £34,166. Average household income varies greatly from £14,360 in the poorest 1% of the Borough, to £58,975 in the most affluent 1%, over four times higher<sup>20</sup>.

# Social and Environmental Needs Assessment

## 2.25 Access to Services

According to the Index of Multiple Deprivation (IMD 2010), Rotherham has relatively good access to housing and services with 58% of the population in the top 20% nationally. 0% of the Rotherham population live in areas where it is most difficult to access services.

Rotherham has excellent transport links to the rest of the country, being served by the M1 motorway which provides access to Leeds and Nottingham and the M18 which gives access to the Humber ports. There is an extensive network of rail and bus services, providing good links with Sheffield and other neighbouring towns.

The Department of Transport has produced a range of Core Accessibility Indicators which measures accessibility either by public transport, walking or cycling to primary schools, secondary schools, further education, GP surgeries, hospitals, supermarkets and employment. The findings from the indicators for Rotherham are as follows:

**Access to GP Surgeries** - 88.32% of households who do not have access to a car are able to access a GP surgery within 15 minutes. This is below the regional average of 92.29%. 100% of households with no car have access within 30 minutes in Rotherham<sup>21</sup>.

**Access to Hospital** - 88.56% of households who do not have access to a car are able to access a hospital within 30 minutes for routine appointments. This is above the regional average of 85.91%. 100% of households with no car have access within 60 minutes in Rotherham<sup>22</sup>.

**Access to Employment** - 95.2% of the local population can get to work by public transport within 20 minutes. This is above the regional average of 94.84%. 100% of the population have access within 40 minutes. 96.5% of Job Seekers can travel to work within 20 minutes, 100% within 40 minutes<sup>23</sup>.

**Access to Primary Schools** - 96.46% of target population have access to a local primary school within 15 minutes. This is above the regional average of 95.78%. 100% have access within 30 minutes<sup>24</sup>.

**Access to Secondary Schools** - 94.38% of target population have access to a secondary school within 20 minutes. This is above the regional average of 92.05%. 100% have access within 40 minutes<sup>25</sup>.

**Access to Further Education** - 99% of target population have access to Further Education facilities within 30 minutes. This is above

the regional average of 96.51%. 100% have access within 60 minutes<sup>26</sup>.

**Access to Supermarkets** - 92.63% of households who have a car can access a local supermarket within 15 minutes. 92.66% of households who do not have a car can access a local supermarket. This is below the regional average of 95.06%. 100% of households have access within 30 minutes<sup>27</sup>.

In summary, in comparison to other regional areas, Rotherham scored above average in 5 out of 7 areas for accessibility, in particular to primary and secondary schools, further education, hospitals and employment. This is as expected as Rotherham has low levels of deprivation in barriers to Housing and Access to Services.

The one area where accessibility rates were lower than the regional average was access to a local supermarket (2.43% below the regional average). Better transport links need to be established for some areas where access is difficult in remote areas such as Braithwell, Wentworth and Hooton Roberts. There may be more isolated communities who may not have access to a car.

21 Department of Transport 2005, GP Indicators

22 Department of Transport 2005, Hospital Indicators

23 Department of Transport 2005, Employment Indicators

24 Department of Transport 2005, Primary School Indicators

25 Department of Transport 2005, Secondary School Indicators

26 Department of Transport 2005, Further Education Indicators

27 Department of Transport 2005, Supermarket Indicators

## Social and Environmental Needs Assessment

### 2.26 Satisfaction of People Over 65 with Home & Neighbourhood (NI 138)

The National Indicator (NI138) measures the satisfaction of how people who are over 65 years within their home and their local neighbourhood. The biannual Place survey was sent out to a random sample of around 5,200 households (about 1 in 20) in Rotherham in the autumn of 2008 in order to capture their views. The results of the survey identified that 80% of Older People were satisfied with their home and local neighbourhood.

## Social and Environmental Needs Assessment

### 2.27 Summary of Chapter 2

What are the emerging needs within this section (a brief summary/conclusion drawn from this data):

- **Social Housing** - emphasis on localism albeit with severely restrained resourcing and an increasing emphasis on making the most of existing opportunities and assets
- **Private Housing** - emphasis will be placed upon private householders to utilise the equity in their property to manage adaptation and modernisation
- BME groups are under-represented in the social rented sector but significantly over-represented in the private rented sector
- The increasing number of people living alone is likely to have a significant impact on and increase the need for adult social care in the future
- There is a need to reduce the high levels of unemployment and worklessness in Rotherham

#### Key Issues:

##### For Social Housing:

- Maintenance of existing stock and major structural repairs
- Climate change and environmental works
- Big society/Localism
- Zero Carbon emissions by 2013
- Rapidly increasing BME population in Rotherham, many needing access to Social Housing
- Sharp increase in number of people aged over 64 living alone over the next 7 years
- High levels of unemployment due to the recession
- High levels of worklessness mainly due to long term sickness

#### What actions need to be taken:

- Work with private landlords to encourage voluntary improvements in decency standards of their property
- Encourage households to invest their own resources to fund repairs
- Work with housing developers to establish a viable supply of affordable low carbon housing from new planning permissions
- Build new council houses that have zero carbon emissions by 2013
- Continue to monitor need for BME, Gypsy and Traveller accommodation
- Structures in place to support people back into employment.

# Lifestyle and Risk Factors

## 3.1 Smoking

Smoking is a major contributor to ill health, particularly in relation to coronary heart disease and cancer.

Healthy Lives, Healthy People: A Tobacco Control Plan for England was published in March 2011. It contains three national ambitions: to reduce smoking prevalence among adults in England to 18.5% or less, among 15 year olds to 12% or less and during pregnancy to 11% or less by the end of 2015.

The 2009 General Lifestyle Survey (formally the General Household Survey (GHS)) shows that overall smoking prevalence in England has decreased from 39% of adults in 1980 to 21% in 2009. Reported prevalence was highest in the 20-24 age group (26%) and lowest (14%) for those aged 60+. 66% of current or former regular smokers state that they started before the age of 18 and 39% before the age of 16<sup>1</sup>.

Prevalence of smoking in England is slightly higher amongst men (22%) than women (20%), but the gap has decreased since 1980 when 42% of men reported smoking compared with 36% of women. The main reason for the decrease appears to be an increase in adults who have never or only occasionally smoked. This has risen from 42% in 1982 to 54% in 2009. The increase in those never smoking has been much larger amongst men than women, increasing from 32% in 1982 to 50% in 2009 for men, whereas the increase for women was from 51% to 57%.

Prevalence rates vary significantly with marital status. Co-habiting couples are most likely to smoke (33%) whilst those who are married are least likely to smoke (15%). In every age group, married people were less likely to smoke.

29% of those in manual employment groups are cigarette

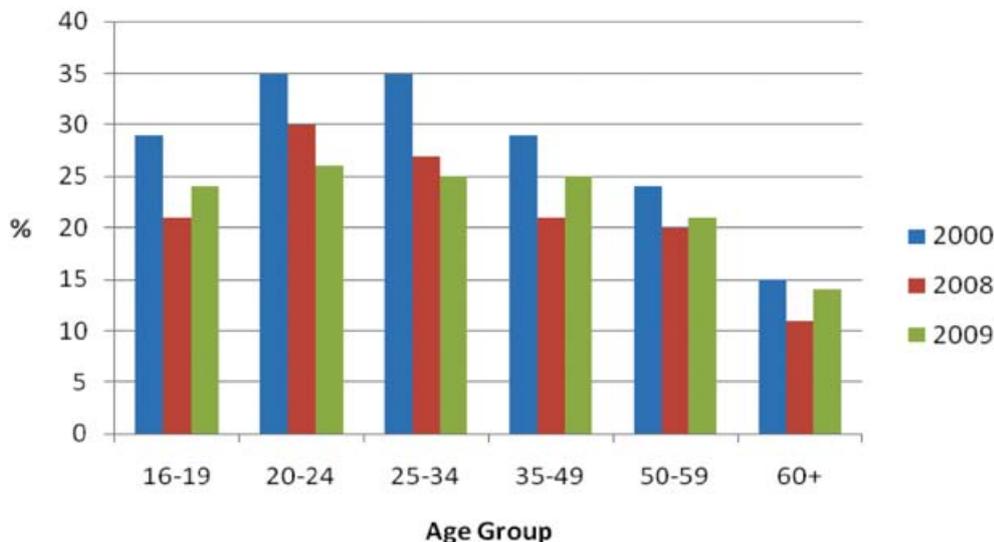
smokers, compared with 33% in 1998, confirming progress towards the targets. Routine and manual employment groups report the highest level of smoking. Those in managerial or professional households are the most likely to have never or only occasionally.

People who live in an area of deprivation are more likely to smoke. Rates of smoking also increase for men and women in households with low household income.

The Health Survey England (HSE) 2004 reported on the proportion of people from the Black and Minority Ethnic (BME) Community that smoked. This Survey reported on smoking prevalence among BME men. At that time 20% of Indian men smoke, 21% of black African, 21% Chinese and 40% of Bangladeshi men. Men in Bangladeshi and Irish groups were more likely to report smoking than men in the general population.

**Figure 3.1 Prevalence of smoking by age group for adults 2000, 2008 and 2009**

Source: General Lifestyle Survey 2009, GLS 2009 data



## Lifestyle and Risk Factors

### 3.1 Smoking

With the exception of Bangladeshi and Irish men, men from BME groups were more likely than those in the general population to report that they had never smoked. Chewing tobacco is quite widely used amongst specific BME groups<sup>2</sup>.

The reported pattern of smoking amongst ethnic minority groups was very different to that from women. The reported prevalence amongst women ranges from 2% of Bangladeshi women to 24% of Black Caribbean women and 26% of Irish women. This compares with 23% of the general female population<sup>2</sup>.

The latest data from the Integrated Household Survey (October 09-September 10) suggests that 22.5% of Rotherham residents are current smokers, higher than the England average of 21%<sup>3</sup>. Information is available from 22 Rotherham GP practices on the numbers of BME patients who smoke and this supports the national data that suggests a higher smoking prevalence particularly amongst Pakistani males and the Irish community.

During 2006-08 there were on average 481 deaths each year from smoking in Rotherham.

This equates to a directly age-standardised rate of 254.8 per 100,000 of the population aged 35+. This is above the national average of 206.8<sup>4</sup>.

The prevalence of smoking at the time of delivery in Rotherham during 2010-11 was 22.4%. This is well above the England average of 13.5%, the Y&H average of 16.9% but a significant reduction on the percentage smoking at delivery in 09/10 (26.3%). Rotherham has met the target of reducing the number of mothers whose smoking status is not known at delivery to less than 5%<sup>5</sup>.

There is evidence that younger mothers are more likely to smoke throughout pregnancy. 45% of mothers aged 20 or under reported smoking throughout pregnancy, compared with 9% of mothers aged 35 and over. Between 2000 and 2005 the proportion of mothers who smoked throughout pregnancy fell for all but the under 20 age group<sup>6</sup>.

There are wide variations in smoking rates across Rotherham<sup>7</sup>. Recorded smoking rates per GP practice vary from 15% to 56%. The rates at which people quit smoking varies dramatically according to the GP practice

patients are registered with. Some practices in high prevalence areas have high quit rates, other practices do not. Some of the variation is related to whether or not practices offer patients a locally enhanced service (LES) for smoking cessation. Another factor includes how accessible the NHS Rotherham Stop Smoking Service is to the local population.

Rotherham's Tobacco Control Alliance is working to deliver a revised action plan based upon the new Tobacco Control Plan for England. Work is based around six internationally recognised strands:

- Stopping the promotion of tobacco
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to second-hand smoke
- Effective communications for tobacco control

2,763 people achieved 4-week quit success in Rotherham in 2009/10. This exceeds the SHA target of 1,458 and the PCT stretch target of 2,550<sup>8</sup>.

<sup>2</sup> NHS Information Centre 2010, *Statistics on Smoking: England 2010*, p16  
<sup>3</sup> Association of Public Health Observatories 2010, *Health Profile Rotherham*  
<sup>4</sup> Department of Health: *Statistical release: Smoking at delivery - Quarter 4, 2010/11*  
<sup>5</sup> NHS Information Centre 2008, *Statistics on Smoking: England 2008*, p25  
<sup>6</sup> NHS Rotherham 2008, *Strategic Plan v 5 Annex A*  
<sup>7</sup> NHS Rotherham Stop Smoking Service  
<sup>8</sup> NHS Information Centre 2008, *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet: England January 08*

## Lifestyle and Risk Factors

### 3.2 Eating Habits

Poor diet and nutrition are major contributory factors to ill health and premature death. A significant proportion of the population are not eating the recommended daily intake of five or more fruit and vegetables a day although this is steadily increasing.

Research indicates that eating habits vary with gender and age. Men tend to eat larger quantities of most food groups and are more likely to consume fats, meat dishes, sugars, preserves, non-diet soft drinks and alcohol. Women are more likely to consume yogurts, fruit and diet soft drinks<sup>9</sup>.

Similar patterns have also been found among the low income population, with men from low income households being more likely to consume foods such as sausages, beer/lager and table sugar. Women are more likely to consume salad, vegetables, dairy desserts and fruit<sup>9</sup>.

Model-based estimates using HSE data for 2006-08 predicted that 28.7% of adults in England eat healthily. Rotherham had the third worst prediction for the region at 19.8% compared with a regional average of 24.5%.

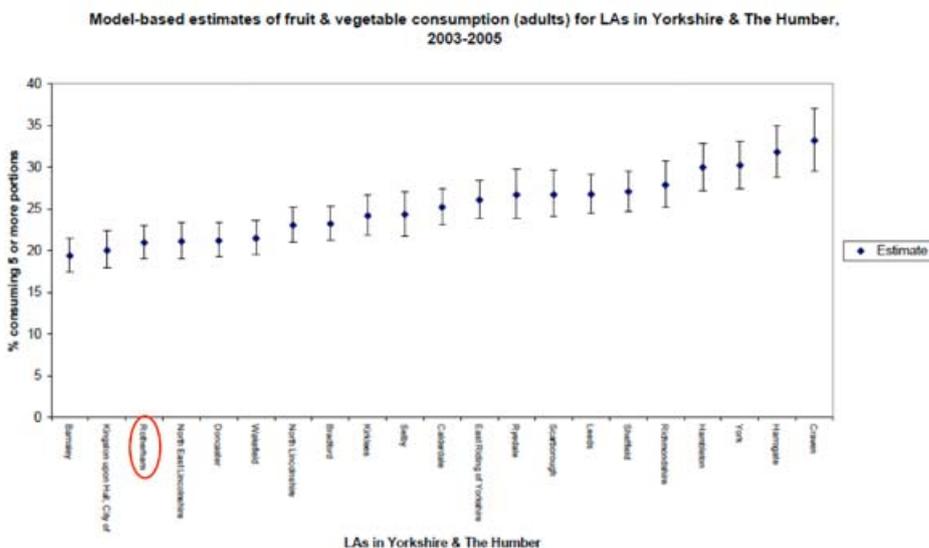
The HSE Survey (2008) reports that the proportion of men consuming 5 or more portions of fruit and vegetables a day has increased from 22% in 2001 to 25% in 2008 and for women from 25% to 29%. For both males and females, the number of portions of fruit and vegetables consumed per day was lowest in the 16-24 age group with an average of 2.9% (men) and 3.1% (women). This increases with age, peaking at an average of 4.0 portions per day for men aged 55-74 and 4.3 portions a day for women aged 55-64<sup>10</sup>.

There is a correlation between consumption of the recommended amounts of fruit and vegetables

and household income. In 2006 both men and women in the highest income quintile were more likely to consume 5 or more portions per day than those in the lowest income quintile<sup>11</sup>.

**Figure 3.2 Model-based estimates of fruit and vegetable consumption**

Source: NHS Information Centre 2008, Model Based Estimates of Fruit and Vegetable Consumption for PCOs in England 2003-5



9 NHS Information Centre (2009), Health Survey for England 2008 – Trend Tables

10 NHS Information Centre (2008), Health Survey for England 2008 Volume 1, Physical Activity and Fitness

11 Department of Health (2008), The cost of alcohol harm to the NHS in England

## Lifestyle and Risk Factors

### 3.3 Alcohol

The Alcohol Harm Reduction Strategy sets out the government's strategy for tackling the harms and costs of alcohol misuse in England. In 2008, the government produced a report that estimated alcohol misuse costs to NHS England at £2.7 billion in 2006/07 prices<sup>12</sup>, while the cost associated with alcohol-related crime and anti-social behaviour was estimated to be up to £7.3 billion each year. The strategy also estimated that workplace costs of alcohol misuse are as high as £6.4 billion per year through loss in productivity<sup>13</sup>.

Alcohol misuse can be directly related to deaths from certain types of conditions such as cirrhosis of the liver and stroke. The Alcohol Harm Reduction Strategy for England estimates that up to 22,000 premature deaths per year are associated in some way with alcohol misuse. The total number of deaths linked to alcohol consumption has increased each

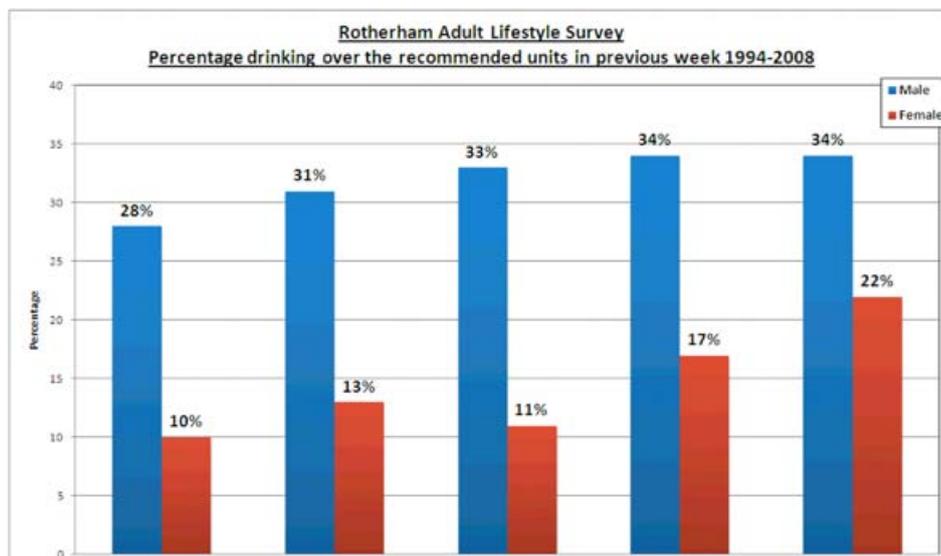
year since 2001. This is mainly due to the increase in the number of deaths from alcoholic liver disease in each year<sup>13</sup>.

In England, the directly standardised death rates from alcohol-specific conditions (all ages) per 100,000 of the population for 2005-07 were 12.7 for males and 5.9 for females and the regional averages were similar at 13.9 for males and 5.9 for females. The death rates in Rotherham were higher at 15.5 for males and 6.2 for females. Rotherham MBC is ranked 251 and 209 respectively on this indicator out of 326 Local Authorities. Figure 3.3 sets out a full profile of alcohol related indicators for Rotherham<sup>14</sup>. The most common cause of death directly related to alcohol is alcoholic liver disease; other main causes are fibrosis and cirrhosis of the liver and cognitive/behavioural disorders.

In Rotherham the death rates in 2007 for alcohol-attributable conditions are higher than the national average for both males at 51.1 compared with 36.1 and females at 19.0 compared with 15.2. The rate for both males and females was higher than the regional averages of 37.3 and 15.7 respectively. Rotherham MBC is ranked 310 on this indicator for males and 268 for females out of 326 local authorities<sup>14</sup>. Mortality from chronic liver disease (including cirrhosis) in Rotherham in 2006-08 was 18.3 for males and 5.8 for females. The rate for males is higher than for England (14.10) and Yorkshire and Humber (14.1). The rate for females is lower than national (7.3) and regional rates (7.3). Rotherham MBC is ranked 203 and 231 respectively on this indicator<sup>14</sup>.

There is evidence that men are more likely to exceed daily and weekly guidelines on alcohol

Figure 3.3



<sup>12</sup> NHS Information Centre 2008, *Lifestyles Statistics: Statistics on Alcohol England 2008*

<sup>13</sup> North West Public Health Observatory: *Local Alcohol Profiles England and Rotherham Alcohol Profile*

## Lifestyle and Risk Factors

### 3.3 Alcohol

consumption than women. Men and women who drink above the daily recommended guidelines also have a higher weekly consumption of alcohol. The youngest and oldest age groups are less likely to report drinking alcohol in the previous week, although older people reported drinking more frequently than younger people. There are some indications that consumption may be declining, particularly among men.

According to the Rotherham Lifestyle Survey 2008, 34% of males and 22% of females reported that they had exceeded the recommended number of units in the previous week. This is the same proportion as the previous survey in 2005 for males, but an increase of 5% for females. For females there have been increases of 8% in the percentage of females aged 16-34 and 55-70 reporting that they exceeded the guidelines. For males, the most significant

change was a decrease of 16% for the 16-34 age group.

Binge drinking is defined as drinking more than twice the daily recommendations, i.e. more than 8 units for men and 6 units for women. GHS reported that in 2008, 22% of men and 15% of women reported binge drinking on at least 1 day in the week<sup>15</sup>. The proportion was greatest amongst younger age groups with 32% of men aged 16-44 reporting binge drinking compared with 7% of those aged 65+<sup>15</sup>. In Rotherham the estimated prevalence of binge drinking is 27.8% of the adult population, which is significantly above both the regional average of 24.5% and the England average of 20.1%. 18% of male and 11% of female respondents to the 2008 Rotherham Lifestyle Survey

reported that they had drunk more than 6 units of alcohol more than 4 times in the previous month. This is a significant reduction for males since the last survey in 2005, when the results were 36% for males and 14% for females. Skilled manual workers and the unemployed were most likely to be in this category of respondents.

In 1995, in recognition of the dangers of excessive drinking in a single session, the sensible drinking message was changed to focus on daily guidelines. It suggests; a maximum intake 2-3 units per day for women and 3-4 for men, with 2 alcohol-free days after heavy drinking; continued alcohol consumption at the upper level is not advised<sup>14</sup>.

Alcohol dependence is defined as people drinking above sensible levels and experiencing harm and symptoms of dependence. In 2004 the overall prevalence of

<sup>14</sup> The reference for this is the National Alcohol Strategy for England

<sup>15</sup> Association of Public Health Observatories (2010), Rotherham Health Profile 2010

<sup>16</sup> Department of Health (2005), 2004 Alcohol Needs Assessment Research Project

# Lifestyle and Risk Factors

## 3.3 Alcohol

alcohol dependence in England was 3.6%, with 6% of men and 2% of women meeting the criteria equating to 1.1 million people. 2% of male and female respondents to the 2008 Rotherham Lifestyle Survey said they relied on alcohol compared with 2% and 1% respectively in the previous survey in 2005. Out of the English regions, Yorkshire and Humberside has the second largest gap between the number of alcohol dependent people and the number accessing treatment, with only 2.2% of the 'in need' population accessing

treatment compared with a national level of 5.6%<sup>17</sup>.

People from ethnic minority groups were found to have considerably lower prevalence of hazardous/harmful drinking use but a similar prevalence of alcohol dependence compared with the white population<sup>13</sup>.

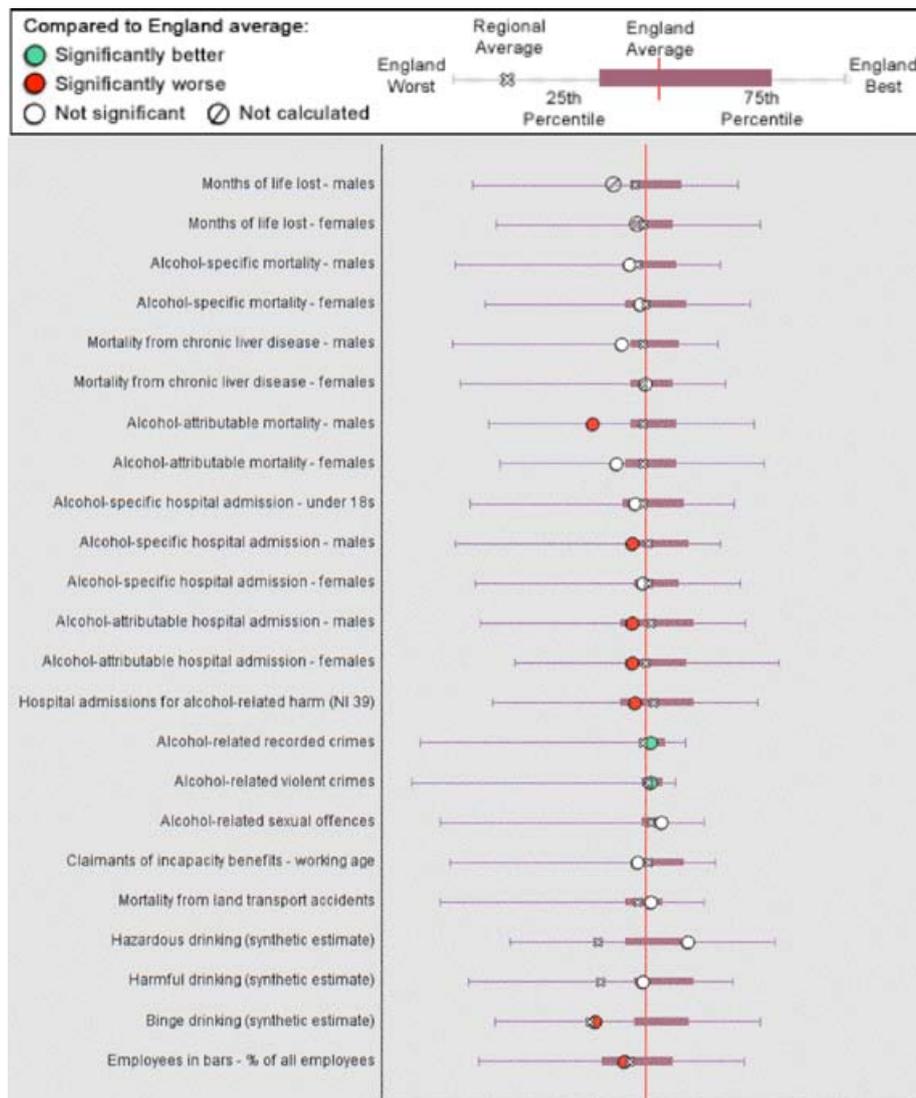
NI39 is a national indicator which measures alcohol-harm related hospital admission rates per 100,000 of the population. It measures all admissions that are

attributable to alcohol. In 2007-08 in Rotherham 1,552 admissions were reported, which is higher than the regional average of 1,413 and significantly worse than the national average of 1,473<sup>14</sup>.

There is evidence that drinking behaviour is affected by socio-demographic factors. People in employment are more likely to have drunk alcohol on five or more days in the previous week. They are also more likely to binge drink than unemployed people. Those in managerial and

Figure 3.4 Alcohol Profile Rotherham

Source: North West Public Health Observatory, Local Profiles England and Rotherham Alcohol Profile



17 Department of Health (2005), 2004 Alcohol Needs Assessment Research Project

## Lifestyle and Risk Factors

### 3.3 Alcohol

professional households are more likely to drink more frequently and drink above the daily recommendations than those in routine and manual households<sup>15</sup>.

Married adults (including those cohabiting) are more likely to have drunk alcohol in the previous week. They are also most likely to report drinking on five or more days in the previous week and single adults least likely. Single people are more likely to drink more than the recommended daily amount of units and to binge drink<sup>15</sup>.

Analysis shows that variation in drinking in the last week ranged from 4% to 5% of those of Bangladeshi or Pakistani origin to 67% to 68% of those recording their ethnicity as White British or White Other. Adults of mixed ethnicity were more likely to drink over the recommended daily limits on at least one day in the previous week as were the White British and the White Other ethnic groups. The same pattern is seen for binge drinking. It should be noted that this analysis was carried out using the original method of unit conversion and it is unclear whether or not the same patterns would emerge using the improved method<sup>13</sup>. Over half of pregnant women in the UK reported drinking during pregnancy in 2005, although this proportion has decreased from 66% in 1995 to 55% in 2005.

There has also been an increase in the percentage of mothers who gave up drinking when pregnant from 24% in 1995 to 34% in 2005. Older women are more likely to report drinking during pregnancy than younger women. The proportion who gave up drinking during pregnancy decreased with age while the proportion reporting they drank less increased with age<sup>13</sup>.

Overall a higher percentage of adults across all age groups in England reported Saturday as their heaviest drinking day (28%), followed by Sunday (23%) and Friday (14%). For 16 to 24 year olds however, 38% reported Saturday as their heaviest drinking day followed by Friday (23%) and Sunday (13%). Respondents over 65 were more likely to drink most on a Sunday (32%)<sup>15</sup>.

In 2009, there were 139,584 prescription items for drugs for the treatment of alcohol dependency prescribed in primary care settings and dispensed in the community in England. This is a big increase since 2003 when there were 93,241 prescription items. The Net Ingredient Cost (NIC) was £1.6 million in 2003 but has now increased to £2.4 million in 2009. The NIC per item has decreased from £17 in 2003 to £16 in 2009<sup>15</sup>.

These drugs are also prescribed in hospitals for dispensing in the

community, though in smaller numbers than those prescribed in primary care settings. In 2009, 10,861 prescription items were prescribed in hospitals. This has increased by over 10% since 2003 when there were 9,500 prescription items for the treatment of alcohol dependency<sup>15</sup>.

# Lifestyle and Risk Factors

## 3.3 Alcohol

Figure 3.5 Proportion of men and women in England consuming more than the recommended weekly guidelines by age

Source: NHS Information Centre (2008), *Lifestyles Statistics: Statistics on Alcohol England 2008*

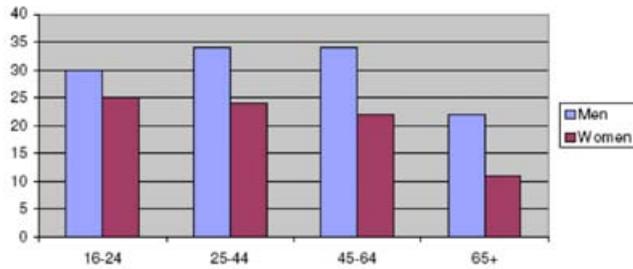


Figure 3.6 Percentage of people in England with an alcohol use disorder broken down by category of problem drinking and gender

Source: Department of Health (2005), *2004 Alcohol Needs Assessment Research Project*

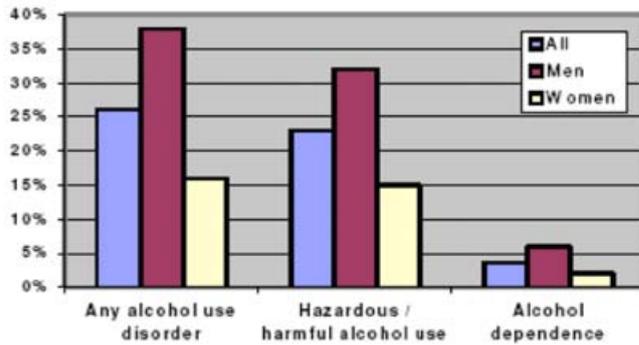
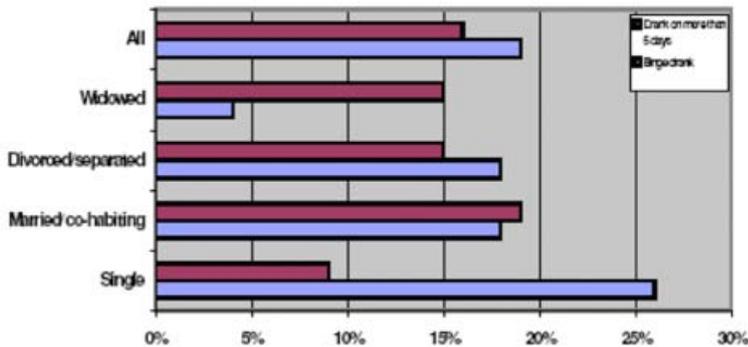


Figure 3.7 Adults who drank alcohol in the last week by marital status 2006

Source:



## Lifestyle and Risk Factors

### 3.4 Adult Drug Treatment

The Rotherham Adult Drug Treatment Needs Assessment undertaken in 2010/2011<sup>1</sup> identified the following key issues:

The National Treatment Agency for Substance Misuse (NTA) model indicates there was a significant increase statistically in Rotherham's treatment naïve population resulting in an increase of 142 Problematic Drug Users (PDUs) from 1,991 to 2,133, based on data from 2008/09<sup>2</sup>. Treatment naïve stands at 708 individuals that are either not known to structured drug treatment services or have not been known within the last 2 years (2008/09 – 2009/10)<sup>3</sup>. Local evidence pertaining to drug related deaths indicates that of 23 deaths that occurred, 9 were known to drug treatment services and just 4 (17%) were receiving treatment at the time of death indicating a growing trend of individuals not being in drug treatment at the time of death i.e. the treatment naïve population<sup>4</sup>.

25%(175) of the treatment naïve have been seen by the Drug Intervention Programme (DIP) (prison and communities) but not within structured treatment services, resulting in a reduction of 15% as seen in the previous needs assessment. DIP is therefore not as key a route of capturing treatment naïve individuals as previously seen, but still remains a key source

of contact for engaging with the drug using population.

In terms of DIP-community this figure reduces to 50 i.e. 7% of the treatment naïve population compared to 18% the previous year. Of this client group cocaine users have seen a significant reduction statistically from 117 in treatment 31st March 2009 to 35 in treatment 31st March 2010. Opiate and crack users have also seen a reduction.

The part of the treatment system with the highest numbers of individuals who were treatment naïve at presentation was the Central sector with 61 individuals (56% of all their referrals), this was followed by North sector and then South with 31 and 27 respectively. Central sector historically has more of a transient population and attracts a higher proportion of individuals which may influence planning for future activity to attract the treatment naïve population to drug treatment services.

The NTA's model shows that the estimated number of crack users in the borough has also increased which has had an increase in those being treatment naïve and crack users. Rotherham continues to have low figures of crack users accessing treatment and has significantly lower reported daily use than

regional and national averages. Statistically there are now 574 naïve with 12% (69) of these being within DIP (prison and community) tier 2, 2.6% (15) DIP (community) but not engaging with structured treatment services. DIP services need to continue to work closely with this client group drawing upon the specialism of the Stimulant Service. There is a reported increase of individuals in the treatment system reporting Crack use at review assessments and after more than 4 years in treatment.

Increase of community pharmacy needle exchange provision and hours of availability has expanded significantly with now 13 pharmacy sites providing this service covering 635 hours per week across the borough, two of which are 100 hour pharmacies. A further 4-5 are expected to open by the end of 2010/11 which should then provide sufficient coverage within the borough. By expanding this service area to more access points a wider drug misusing population will be reached to have a point of contact and access to drug treatment provision i.e. reaching the treatment naïve population as well as providing harm reduction interventions<sup>5</sup>.

Of those individuals (non steroid users) in contact with community pharmacy needle exchange it has

<sup>1</sup> Safer Rotherham Partnership – Adult Drug Treatment Needs Assessment 2010/11

<sup>2</sup> NTA Prevalence Estimates 2008/09

<sup>3</sup> National Drug Treatment Monitoring System - Restricted Statistics Needs Assessment 2010/11

<sup>4</sup> NHS Rotherham, 2009/10 Annual Drug Related Deaths Report

<sup>5</sup> NHS Rotherham, Alcohol & Drug Strategy Team

## Lifestyle and Risk Factors

### 3.4 Adult Drug Treatment

been estimated that 62% (841) are treatment naïve, however some of these may be steroid users due to missing information on the reporting system. This still provides pharmacy staff and specialist drug workers opportunities to engage with this population otherwise not contactable by drug services and encourage access to structured drug treatment.

Data quality needs to improve in order to fully understand the demographics of those individuals accessing needle exchange services. Work to collect a wider range of information is underway and will continue to improve data quality.

The number of steroid users accessing community needle exchange provision continues to be high with 202 steroid users recorded in a 12 month period, however anecdotal information confirms there are many more. Training to enhance knowledge and skills in this area is planned in year.

Overall 51% of individuals admitted to hospital for a drug related condition were in structured drug treatment which is a decrease on the previous year's figures of 5%, a further 11% were known but not in treatment at the time of admission and the remaining 38% were not known to service<sup>6</sup>. Improved communication methods between

the local acute hospital and drug treatment services remains an area requiring improvement.

Trends in relation to drug related deaths show that they are greater among males, people living alone, poly drug users and also not in treatment at the time of death. Reaching out to the treatment naïve population is always difficult and some targeted work has been undertaken this year including designing new publicity materials advertising the Single Point of Contact number, Family Friends and Support Service and also face to face contact 'selling' the services via other professional groups.

Rotherham has slightly more individuals in treatment 2-4 years and those in excess of 4 years than regional average, although the Yorkshire & Humber Region is higher than national. It was agreed with the NTA to undertake further investigation of prescribed interventions on the high levels of over 18s in treatment for longer than four years

Positive results can be seen in terms of planned exits. Overall out of the total number of treatment exits (296), only 11.5% were classed as 'dropped out' which compares extremely favourably to the regional performance of 23% i.e. less than half, the largest age group is 25-34 years,

presenting substance being opiates only, however 9% did report adjunctive alcohol use. The highest proportion of 'drop-outs' was those in treatment under 6 months at 47%. Improvements in planned exits were evident in the first half of 2010/11, in addition a piece of dedication outreach work was commissioned in year to target PDU clients across the treatment system focusing on those clients who have disengaged with structured treatment services or at risk of 'drop-out'.

The White British population is now almost fully representative of the population with the BME population still slightly under represented (0.5%) but has improved for access to structured drug treatment. Reporting of ethnicity data has improved and BME communities will continue to be a focus within the treatment system.

The number of individuals accessing structured drug treatment services with an injecting status recorded as current injectors has decreased by 9% over the last three years, and those with a status of 'previous injector' has increased by 9%. This seems to be in line with figures reported by the NTA. The NTA figure indicates that fewer people who inject drugs are entering treatment, which has dropped to its lowest level for five years<sup>7</sup>.

## Lifestyle and Risk Factors

### 3.4 Adult Drug Treatment

The percentage of individuals in treatment who have had a Hepatitis C Test has increased by 30% since 2007/08. The number of positive tests has not increased at the same rate and in 2009/10 was reported as 17% of the number screened compared to 33% in the previous year. Referrals for Hep C Treatment continue with 100% of those testing positive in year agreeing to a referral to treatment.

Alcohol plays a significant picture<sup>8</sup>: the number of individuals accessing drug treatment reporting alcohol use is nearly the same as for opiate clients; the number reporting initiating alcohol use at treatment reviews is significant; alcohol continues to be a prominent factor in terms of poly drug use and drug related deaths. Ensuring the workforce is competent to deal with significant alcohol use by drug using clients is crucial and additional specific training has already been planned to take place in year.

The percentage of individuals reported as being in paid work (1-28 days) was over 5% below that of the regional and national levels as was those in full time work (20 days or more). In context Rotherham as a borough has seen a rise in levels of unemployment of over 4,000 between 2008 and 2009 and is forecast to continue to

rise. Closer working arrangements have been in place locally within the last 12 months and will continue to be a focus with the new 'recovery' agenda.

There seems to be the early signs of a trend in terms of individuals particularly young males 22-27 years accessing services using mephedrone from the South sector of the borough. There is evidence of more sporadic referrals in North and Central sectors of the borough and this includes again young males aged 22-27. It appears at present Mephedrone and its derivatives are more available in the more affluent parts of Rotherham i.e., Wickersley and Bramley. Young Males assessed by the service described this as the new party drug in this area<sup>9</sup>.

Service User involvement and the Service User Rotherham Forum (SURF) group has moved on significantly in the last year with an expansion of service user meetings and sub meetings focusing on particular projects, attendance at key strategic planning and commissioning groups and direct service user consultation work. Service Users have also development two service user led DVDs – "*Promoting Needle Exchange Provision in Rotherham*" and "*Recovery*"<sup>10</sup>.

<sup>8</sup> NDTMS Restricted Statistics – Quarterly Outcomes Partnership Reports

<sup>9</sup> Rotherham Drug Treatment Services

<sup>10</sup> NHS Rotherham, Alcohol & Drug Strategy Team

# Lifestyle and Risk Factors

## 3.5 Physical Activity

Physical activity contributes to a wide range of health benefits and can reduce the incidence of many chronic conditions. Regular physical activity can improve health outcomes irrespective of whether individuals lose weight. Current recommendations are:

### Early Years (Under 5s):

1. Physical activity should be encouraged from birth, particularly through floor-based play and water based activities in safe environments.
2. Children of pre-school age who are capable of walking unaided should be physically active daily for at least 3 hours (180 minutes), spread throughout the day.
3. All under 5s should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).

### Children and Young People (5-18 years):

1. All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.
2. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days per week.
3. All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods.

### Adults (19 – 64 years):

1. Adults should aim to be active daily. Over a week, activity should add up to at least 2½ hours (150 minutes) of moderate intensity\* activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
2. Comparable benefits can be achieved by 1¼ hours (75 minutes) of vigorous intensity activity spread across the week or, a combination of moderate and vigorous intensity activity.
3. Adults should also undertake physical activity to improve muscle strength on at least 2 days per week.
4. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

### Older Adults (65+ years):

1. Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.
2. Older adults should aim to be active daily. Over a week, activity should add up to at least 2½ hours (150 minutes) of moderate intensity activity in bouts of 10 minutes or more

– one way to approach this is to do 30 minutes on at least 5 days a week.

3. Comparable benefits can be achieved by 1¼ hours (75 minutes) of vigorous intensity activity spread across the week or, a combination of moderate and vigorous intensity activity.
4. Older adults should also undertake physical activity to improve muscle strength on at least 2 days per week.
5. Older adults at risk of falls should incorporate physical activity to improve balance and coordination on at least 2 days a week.
5. Older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

The Health Survey England (HSE) indicates that for both men and women, the proportion achieving the physical activity recommendations has increased overall, from 32% in 1997 to 42% in 2008 for men and from 21% to 31% for women<sup>18</sup>. In 2006, for both men and women, the proportion meeting the guidelines decreased with age. For men, over 50% of 16 to 34 year olds met the guidelines compared to 9% for those aged 75 and over. The proportion of women meeting the guidelines remained stable for those between the ages of 16 and 54 (between 33% and 36%)

\* Moderate intensity activity will raise the heart rate and leave the individuals a little out of breath.

\*\* The 30 minutes target can be accumulated during the course of the day by undertaking a variety of activities in bouts of 10 minutes or more, these can include brisk walking and gardening<sup>18</sup>

## Lifestyle and Risk Factors

### 3.5 Physical Activity

and decreased thereafter to 4% among those aged 75 and over<sup>19</sup>. 52% of respondents to the 2008 Rotherham Lifestyle Survey reported doing no moderate or strenuous exercise compared with 50% in 2005, and only 9% reported an optimal activity level (as defined by the Allied Dunbar Survey) compared with 15% in 2005. 56% of respondents to the 2008 survey reported a total of 30 minutes or more energetic exercise per day compared with 58% in 2005. 65% of respondents said they would like to increase their activity and fitness levels compared with 70% in 2005. Of these 52% said they needed more time, 48% said they needed more willpower and 34% thought they needed better health.

In England between 41% and 42% of men in the 3 highest household income quintiles met the recommendations for physical activity in 2006, falling to 31% in the lowest income quintile. For women, 34% of those in the highest income quintile met the recommendations compared to 26% of those from the lowest income group. There is a clear trend in the prevalence of low activity levels for both men and women, with those in the lowest income quintile more likely to be low participators than those in the highest income quintile<sup>20</sup>. Results from the "Taking Part" household survey (TPS) show that those with the highest incomes were more likely to take part in active

sport. 89% of those earning over £50,000 had done so at least once in the previous twelve months compared with 61% of those with an income of less than £10,000<sup>21</sup>.

16.6% of the adult population in England (7 million people) takes part regularly in sport and active recreation (figures from the 12 month period up to April 2010)<sup>22</sup>. Regular participation in sport and recreation is defined as taking part in at least 3 days a week in moderate intensity sport and active recreation (at least 12 days in the last 4 weeks) for at least 30 minutes continuously in any one session<sup>23</sup>.

Results from the 2009-10 Active People survey show Rotherham to be in the bottom 25% of Local Authorities with 13.6% of adults taking part regularly in sport and active recreation<sup>24</sup>. For the active people 3 survey the rate was 19.2%. Participation is slightly higher for males with 21.9% participating compared with 16.6% of females. Participation is highest amongst individuals aged 35-54 at 26.8% and lowest amongst those over 55 at 9.2%<sup>25</sup>.

The HSE 2004 reported that within minority ethnic groups Irish (39%) and Black Caribbean (37%) men had the highest rates for meeting physical activity recommendations, similar to the proportion of men in the general population (37%). Black Caribbean, Black African and Irish women reported the highest

rates of meeting current physical activity guidelines (31%, 29% and 29% respectively), compared with 25% of women in the general population. Only 11% of Bangladeshi and 14% of Pakistani women did the recommended amounts of physical activity in the four weeks prior to interview<sup>21</sup>. In Rotherham, the Active People survey 3 indicated a higher percentage of non-white adults (47.1%) take part regularly in sport than the general population (19.2%)<sup>25</sup>.

The TPS indicated that adults living in single adult households with no children had significantly lower rates of participation (50%) in active sport than any other group in 2005-6. Adults living in households with adults and children had the highest rates with 82% reporting participation in at least one active sport in the last twelve months. The TPS also showed significant variations in participation in active sport between those with no formal qualifications (41%) and those with A-levels or above (83%)<sup>26</sup>. The TPS is used to monitor the Public Service Agreement 3 (PSA3). Part of this PSA is, by 2008, to increase the number who participate in active sport at least twelve times a year by 3%, among those in priority groups (black and minority ethnic group, limiting disability, lower socio-economic groups and women). Results from the TPS 2009-10 showed that 53.4% of all adults

19 NHS Information Centre (2008), *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet: England January 08* p53

20 NHS Information Centre (2008), *Health Survey for England 2008 Volume 1, Physical activity and fitness*, p46

21 NHS Information Centre (2008), *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet: England January 08* p55

22 Sport England, *Active People Survey 4 – 2009-10. Sports Participation Factsheet: Summary of results for England, Quarter 2, 2009/10*

23 Sport England, *Active People Survey 2005-6 Headline Results*

24 Sport England, *Active People Survey 4 – 2009-10. Sports Participation: England, regions, counties and districts. Quarter 2, 2009/10*

25 *Active People Survey 3 Results*

26 NHS Information Centre (2008), *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet: England January 08*, p56

## Lifestyle and Risk Factors

### 3.5 Physical Activity

participated at least once in active sport during the past 4 weeks. The report also states that men are more likely than women to have done active sport in the last 4 weeks (59.4% and 47.7% respectively). 60.7% of people without a long-term limiting illness or disability compared to 33.6% of people with a long-term limiting illness or disability reported to have done active sport in the last 4 weeks<sup>27</sup>. The proportion of those participating from all of the priority groups fell slightly between Year 1 and Year 2, with the largest decrease being in participation by females which fell by 1.5%<sup>28</sup>.

The second part of the PSA indicator relates to participation in moderate intensity level sport for at least 30 minutes on at least three separate days during the

past week. The TPS reported that overall the percentage of adults meeting this indicator increased from 20.9% in Year 1 to 21.5% in Year 2. The TPS 2009/10 reports that "between 2005/06 and 2009/10, the proportion of adults doing active sport in England for more than 30 minutes at a time increased from 49.9% to 52.9%"<sup>27</sup>. Participation from black and minority ethnic groups rose from 19.2% to 19.6% and from lower socio-economic groups from 15.2% to 15.3%. Participation by women fell from 18.5% to 18.3% and by those with a limiting disability from 9.5% to 9.4%<sup>28</sup>. In Rotherham only 11.8% of people with a limiting disability take part in sport compared with 21.1% of people with no limiting disability<sup>25</sup>.

## Lifestyle and Risk Factors

### 3.6 Obesity

The National Obesity Strategy "Healthy Weight, Healthy Lives" sets out measures to meet the challenge of excess weight in the population. In England almost two thirds of adults and a third of children are either overweight or obese and without effective action this could rise to almost nine in ten adults and two thirds of children by 2050. Overweight and obesity increase the risk of a wide range of diseases and illnesses, including coronary heart disease and stroke, type 2 diabetes, high blood pressure, metabolic syndrome, osteoarthritis and cancer. In 2007 it was estimated that the total annual cost to the NHS was 4.2 billion and to the wider economy 15.8 billion. By 2050 it has been estimated that overweight and obesity could cost the NHS 9.7 billion and the wider economy 49.9 billion (at 2007 prices)<sup>29</sup>.

NICE guidance currently states that assessment of health risks associated with overweight and obesity should be based on both Body Mass Index (BMI) and waist circumference<sup>30</sup>. Using both BMI and waist circumference to assess risk of health problems, in 2008 20% of men were estimated to be at increased risk, 14% at high risk and 21% at very high risk. Equivalent figures for women were 15% at increased risk, 17% at high risk and 24% at very high risk<sup>31</sup>. The proportion of both men and women at very high risk of the

health effects of obesity increased with age peaking in the 65 to 74 age group, where 30% of men and 34% of women were in this category<sup>30</sup>.

In 2008, 24% of men and 25% of women (over 16) in England were classified as obese (BMI>30)<sup>31</sup>. Women are more likely than men to be morbidly obese (3% compared with 1%). 37% of adults were overweight (BMI >25), with men more likely to be overweight than women (42% compared with 32%). Overall 66% of men and 57% of women were either overweight or obese in 2008<sup>31</sup>.

The estimated prevalence of obesity for adults in Rotherham, based on Health Survey England (HSE) - 2006-08, is 28.3%. This is slightly above the national estimate of 24.2% and the regional estimate of 26.3%<sup>32</sup>. QUEST and QOF data indicate that 32% of people in Rotherham with a recorded BMI are overweight, compared with 37% of people in the HSE 2005 and 23% are obese (HSE 24%). In Rotherham the number of people in the extreme BMI categories is of particular concern: 4,286 people are identified on GP practice registers with a BMI of over 40 (2.7% of the whole population compared with 1.8% in HSE 2005) and 614 of these have a BMI over 50 which equates to 0.3% of the

population. There are also likely to be more cases of extreme BMI in the 22% of the population that have not had their BMI recorded. It is predicted that by 2050 there will be 142,000 people who are obese which equates to 50% of the population<sup>33</sup>.

QOF estimated raw obesity prevalence for Rotherham for 2009/10 is 13.7%, calculated from an obesity register total of 28,463 for persons over 16<sup>34</sup>. The obesity prevalence in England in 2009/10 based on GP obesity registers was 9.9%. However, the HSE 2008 reported obesity in adults to be 24.5%<sup>31</sup>.

34% of respondents to the 2008 Rotherham Lifestyle Survey reported they were of normal weight, 38% overweight and 19% obese. This compares with 38%, 35% and 18% respectively to the 2005 survey. 57% of respondents in 2008 said they had tried to lose weight, but only 25% had been successful.

The HSE 2006 found overweight and obesity are more common in lower socioeconomic and socially disadvantaged groups, particularly among women. Women's obesity prevalence is far lower in managerial and professional households (18.7%) than in households with routine or semi-routine occupations (29.1%). The prevalence of morbid obesity (BMI

<sup>29</sup> National Heart Forum (2008), *Healthy Weight Healthy Lives*

<sup>30</sup> NHS Information Centre (2008), *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet: England January 08*, p5

<sup>31</sup> NHS Information Centre (2010), *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet, England February 2010*

<sup>32</sup> NHS Information Centre (2010): *Estimates of Obesity for PCOs in England 2006-8*

<sup>33</sup> NHS Information (2008): *Transformational Initiatives for Strategic Plan Obesity*

<sup>34</sup> NHS Information Centre (2010), *Quality and Outcomes framework (QOF) for April 2009-March 2010. Numbers on age-specific QOF disease registers and estimated raw prevalence rates by PCT*

## Lifestyle and Risk Factors

### 3.6 Obesity

over 40kg/m<sup>2</sup>) among women is also lower in managerial and professional households (1.6%) than in households with routine or semi-routine occupations (4.1%). However the proportion overweight was generally directly proportional to income in men<sup>35</sup>.

Among ethnic minority groups, obesity prevalence was highest among the Black Caribbean and Irish groups for men with 25% classified as obese in each ethnic group.

Bangladeshi and Chinese men had the lowest obesity prevalence at 6% each.

Obesity prevalence was highest in Black African (38%), Black Caribbean (32%) and Pakistani (28%) groups for women and lowest in Chinese women (8%)<sup>36</sup>.

There are also regional variations in obesity and it is estimated that incidence will generally be greater in the north of England

than the south-west. In Yorkshire and Humberside, obesity levels amongst women are predicted to reach 65% by 2050, compared with 7% in the southwest which is a reduction from the current 17%. Among men in Yorkshire and Humber, the West Midlands and north-east England obesity levels are predicted to reach 70% by 2050 compared with London where the predicted level is 38%<sup>37</sup>.

The HSE report 2003 showed that men who were co-habiting were most likely to be overweight or obese. Among women, those who were widowed were most likely to be overweight or obese. For both men and women, those who were single were least likely to be either obese or overweight<sup>38</sup>.

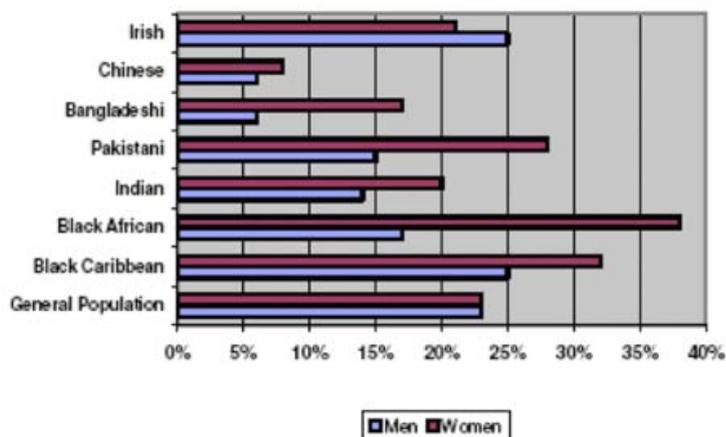
The proportion of men who were obese was higher among ex-regular smokers (31%) and non-smokers (21.2%) than current smokers (15.1%). Among women, those who were ex-regular

smokers showed the highest prevalence of obesity (29.1%), whereas the proportion of those who were obese was similar for current smokers (19.9%) and non-smokers (22.2%). The HSE report 2006 found that overall, amongst both men and women, the odds of a raised waist circumference were higher for ex-smokers than for non-smokers (odds ratio 1:6 in men and 1:2 in women)<sup>38</sup>.

The HSE report 2003 found that women who did not drink (61.3%) or drank within recommended limits (55.9%) during the week prior to interview had a higher prevalence of being overweight or obese than women who drank more than twice the recommended limits (48.8%)<sup>39</sup>.

Both men and women had a higher prevalence of obesity among those with low levels of activity than those with high activity levels. Adults with low physical activity levels were twice

Figure 3.8 Obesity Prevalence by Ethnic Group



35 NHS Information Centre (2008), *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet: England January 08*, p16

36 NHS Information Centre (2008), *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet: England January 08*, p6

37 National Heart Forum (2008), *Healthy Weight Healthy Lives*, p13

38 NHS Information Centre (2008), *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet: England January 08*, p7

39 NHS Information Centre (2008), *Lifestyles Statistics: Statistics on Obesity, Physical Activity and Diet: England January 08*, p8

## Lifestyle and Risk Factors

### 3.6 Obesity

as likely to have a raised waist circumference as those with high physical activity levels<sup>39</sup>.

Results from the HSE 2008 show that in England prevalence of both obesity and raised waist circumference has shown an overall increase since 1993, however overweight prevalence has remained relatively similar<sup>17</sup>.

Weight loss in overweight and obese people can improve physical, psychological and social health. Evidence suggests that a moderate weight loss of 5-10% of body weight is associated with important health benefits, particularly in a reduction in blood pressure and a reduced risk of developing type-2 diabetes and coronary heart disease. However, it is important to recognise that for very obese people, such changes will not necessarily bring them out of the "at-risk" category, but there are nevertheless worthwhile health gains. A continuous programme of weight reduction should be maintained to help continue to

reduce the risks<sup>40</sup>.

Rotherham PCT recognises being a healthy weight, healthy eating and physical activity are important to prevent overweight and obesity in the short and longer term. The PCT have invested in a range of obesity services including community weight management programmes, a Multi Disciplinary Team of health professionals and Bariatric surgery to support 2,000 adults 2009-2012 to have a healthier lifestyle and healthier future<sup>33</sup>.

The evidence from published papers on community weight management programmes (Tier 1) is consistent, reporting reduced incidence of Type 2 diabetes in the population of 58% compared to a control group. The local Yorkshire and Humber programmes, which follow the same proposed model, report an average of 5% body weight loss in those completing the programme and one could assume the well-documented health benefits this weight loss

infers. In addition to the physical health benefits, there are other less well-documented benefits, such as: increasing self-esteem and self-confidence; and beneficial knock on effects upon family members. These programmes also address other lifestyle issues such as: alcohol; smoking and issues of social support and social capital<sup>33</sup>.

Estimated annual costs to the NHS in Rotherham of diseases related to overweight and obesity are £72.2 million in 2007, rising to £74.9 million by 2010 and £80.1 million by 2015<sup>41</sup>. If the planned interventions prove successful the investment will pay for itself by preventing the ill health associated with overweight and obesity in the future.

## Lifestyle and Risk Factors

### 3.7 Summary of Chapter 3

The prevalence of smoking in Rotherham in Q1 2010-11 was 22.6%. This is well above the England average of 13.6%, the Y&H average of 17.4% and the national target for 2010 of below 15%. 2,763 people achieved 4-week quit success in Rotherham in 2009/10.

The Alcohol Harm Reduction Strategy sets out the government's strategy for tackling the harms and costs of alcohol misuse in England. In Rotherham the death rates in 2007 for alcohol-attributable conditions were higher than the national average for both males and females.

The estimated prevalence of obesity for adults in Rotherham is 27.7%. This is above the national prevalence of 23.6% and the regional prevalence of 24.1%. QOF data from obesity registers maintained by Rotherham GP practices for 2007-8 indicated an obesity prevalence of 10.1%, far below predicted levels and suggesting that a lot of obesity remains undiagnosed.

## Burden of Ill Health

### 4.1 General profile of burden of ill health

The Government has set Public Service Agreement (PSA) targets for life expectancy and infant mortality. The target to be achieved for average life expectancy in England by 2010 is 78.6 years for men and 82.5 years for women. The target for reduction in health inequalities is 10% by 2010, as measured by infant mortality and life expectancy. By 2010, PCTs are expected to reduce by at least 10% the gap in life expectancy between the 20% most deprived areas (the Spearhead Group) and the population as a whole. For children under one year, it is expected that there is a reduction of at least 10% in the gap in mortality between the "routine and manual" socioeconomic group and the population as a whole<sup>1</sup>.

## Burden of Ill Health

### 4.1.1 Mortality

All-age all-cause mortality rate is a national indicator which supports government targets on increasing life expectancy and decreasing health inequalities.

Over the last ten years, all-age all-cause mortality rates have decreased in Rotherham, but remain higher than the England average. The following charts compare the mortality rates in Rotherham against the national average for the

general population. They also compare mortality rates between males and females, using age-standardised rates based on the number of deaths from all causes per 100,000 of the population.

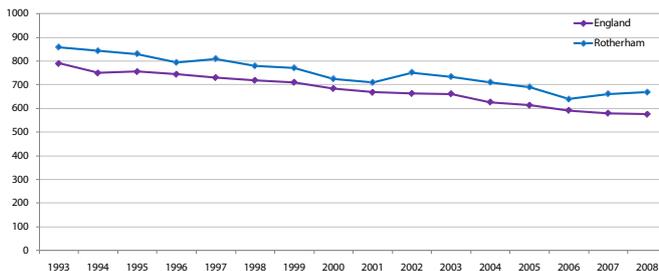
The mortality rate in Rotherham has generally been decreasing since 1993. However, since 2006 the mortality rate has increased. The gap in mortality rate between Rotherham and England is larger in 2008 than it was in 1993.

The Rotherham mortality rate for males has been on a general decreasing trend since 1993. However, since 2006 it appears to be levelling off. The gap between the local and national average remains much higher for males than females.

The mortality rate for Rotherham females fell in 2006 but has risen to higher rates again in 2007 and 2008. The gap between local and national rates is still prominent.

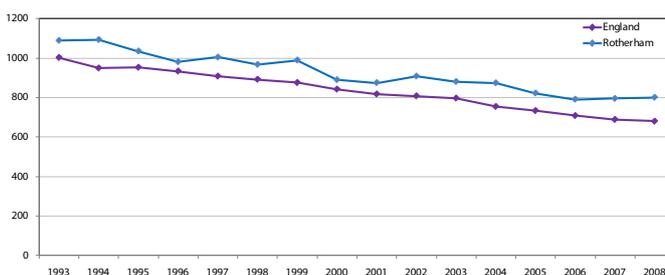
**Figure 4.1 All-Age All-Cause Mortality Rates Rotherham and England for all persons 1993-2008**

Source: NHS Information Centre (2009), *Compendium of Clinical and Health Indicators, Mortality from all Causes*



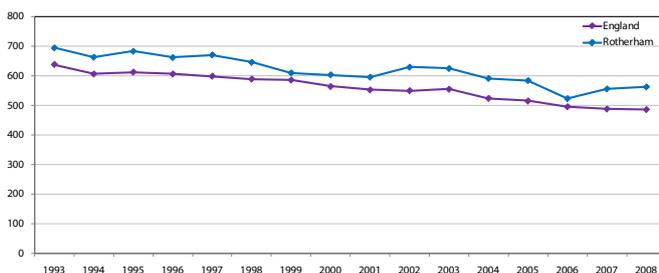
**Figure 4.2 All-Age All-Cause Mortality Rates for Males, Rotherham and England 1993-2008**

Source: NHS Information Centre (2009), *Compendium of Clinical and Health Indicators, Mortality from all Causes*



**Figure 4.3 All-Age All-Cause Mortality Rates for Females, Rotherham and England 1993-2008**

Source: NHS Information Centre (2009), *Compendium of Clinical and Health Indicators, Mortality from all Causes*



## Burden of Ill Health

### 4.1.2 Infant Mortality

Infant mortality rate is calculated from the number of deaths per 1,000 live births. Figures from the National Centre for Health Outcomes show that infant mortality rates in Rotherham for 2008 are above the national and regional averages<sup>2</sup>.

The infant mortality rate in England and Wales for the period 2007-09 was 4.7 per 100,000 based on 9,916 deaths overall. Although infant mortality rates are at an all time low, the government remains concerned that a gap remains between different social groups. Based on infant deaths successfully linked to their birth records for 2007-09 the IMR for routine and manual groups was 5.0 per 1,000 compared with 4.5 for all Socio-Economic groups combined. This confirms that whilst IMRs continue to be higher in routine and manual

(R&M) households, the gap has narrowed between this group and the population from 18% in 2002-04 to 12% in 2007-09<sup>3</sup>. Data from 2002-4 shows that infant mortality rates (IMR) were likely to be higher in "Spearhead Groups" indicating a correlation between infant mortality and deprivation. Rotherham was one of 43 Local Authorities identified with more than 20 infant deaths in the R&M group between 2002-04<sup>4</sup>.

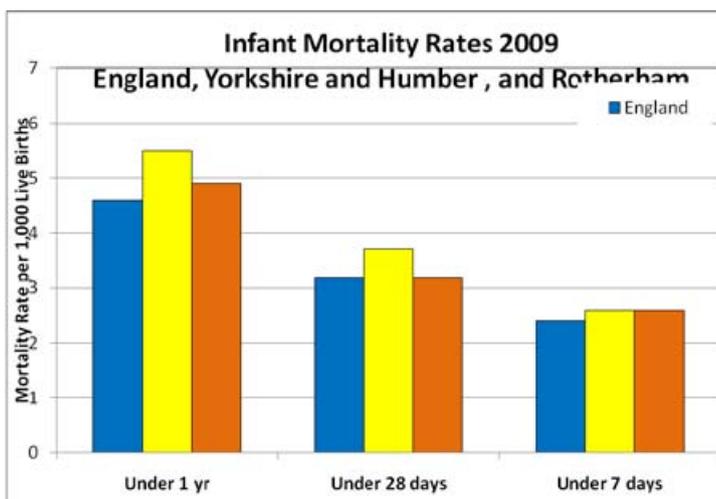
The Government target does not reflect other inequalities relating to infant mortality. During the period 2002-04 infant mortality for mothers born in Pakistan (10.2/1,000) was double the overall IMR. For mothers born in the Caribbean (8.3/1,000), the IMR was 63% above the national average. For mothers aged under 20 years (7.9/1,000), the IMR was 60% higher than for mothers aged

20-39<sup>5</sup>. In 2008 the IMR for sole registrations was 6.9 per 100,000 which is up on the previous two years' figures.

Tackling health inequalities relating to infant mortality at local level is complicated by the relatively small numbers of infant deaths. A research project has been undertaken in Rotherham to try and identify if infant mortality is higher in BME groups. It compared the percentage of live births with the percentage of infant deaths (under 1 year) for the years 2004 and 2005 combined. The analysis indicated that BME groups have a higher proportion of infant deaths than the general population. Even when it was assumed that non-declaration of ethnicity meant ethnic origin was White British this pattern still applied<sup>6</sup>.

Figure 4.4 Infant mortality rates 2008 for England, Yorkshire and Humber and Rotherham

Source: NHS Information Centre (2011), Clinical and Health Indicators, Infant Mortality



<sup>2</sup> NHS Information Centre (2009), Clinical and Health Indicators, Infant Mortality

<sup>3</sup> Department of Health (2009), Mortality Target Monitoring (Infant Mortality, Inequalities) update to include data for 2008

<sup>4</sup> Department of Health (2007), Review of the Health Inequalities Infant Mortality PSA Target, p14

<sup>5</sup> Department of Health (2007), Review of the Health Inequalities Infant Mortality PSA Target, p5

<sup>6</sup> UK Statistics Agency (2008), UK Snapshot, Life Expectancy at [www.ukstatistics.gov.uk](http://www.ukstatistics.gov.uk)

## Burden of Ill Health

### 4.1.2 Infant Mortality

Evidence about the effectiveness of interventions to reduce infant mortality is inconclusive, particularly interventions that will narrow the gap between the R&M group and the overall population. There are four potential strategies which could have an impact on infant mortality rates and for which predictive modelling exists;

- Reducing prevalence of obesity in the R&M population  
*2.8% reduction*
- Reducing smoking in pregnancy from 23% to 15% for R&M  
*2.0% reduction*
- Reducing no. of women in the R&M group who share a bed with their baby or put it to sleep on its front  
*1.4% reduction*
- Achievement of teenage pregnancy target<sup>7</sup>  
*1.0% reduction*

An Infant Mortality Summit was held in February 2007 and NHS Rotherham and Rotherham Foundation Trust have worked together to implement and refresh the action plan that was developed as a result. Recent data shows the 2008 rate as 7.7 deaths per 1,000, up on the previous figure of 5.9 although large fluctuations in rates are possible with low numbers. A Child Death Review Panel chaired by the Director for Public Health and a Designated Doctor for Death in Childhood are now in place to build upon existing strong SUDI arrangements.

## Burden of Ill Health

### 4.1.3 Life Expectancy

Life expectancy at birth in England has reached its highest level to date for both males and females. The latest ONS statistics for 2006-2008 are 77.9 for males and 82.0 for females. In Rotherham life expectancy is significantly lower for males and females at 76.5 and 80.7 respectively (see figure 4.5)<sup>8</sup>.

Females continue to live longer than males, but the gap has been closing. Although both sexes have shown annual improvements in life expectancy at birth, over the past 25 years the gap has narrowed from 6.0 years to 4.1 years nationally. The current gap regionally and in Rotherham is similar at 4.2 years<sup>9</sup>.

Life expectancy at 65 years is higher for women than for men. From 2006-08 a man aged 65 could expect to live another 17.7 years and a woman another 20.4 years<sup>9</sup>.

The relative gap in life expectancy from 2004-06 between the overall population and the 20% most deprived areas of England was wider than in the period 1995-97 for both males and females<sup>10</sup>. There is evidence that health improvements among higher socio-economic groups may have occurred at a faster rate than in other groups in the population. The result has been that the gap has not narrowed for life expectancy in disadvantaged areas; indeed, the gap has widened, particularly for women. This is a challenge for health inequality strategies when seeking to improve the relative health of disadvantaged groups. In Rotherham men in the least deprived areas have nearly 8 years longer life expectancy than those in the most deprived areas<sup>9</sup>.

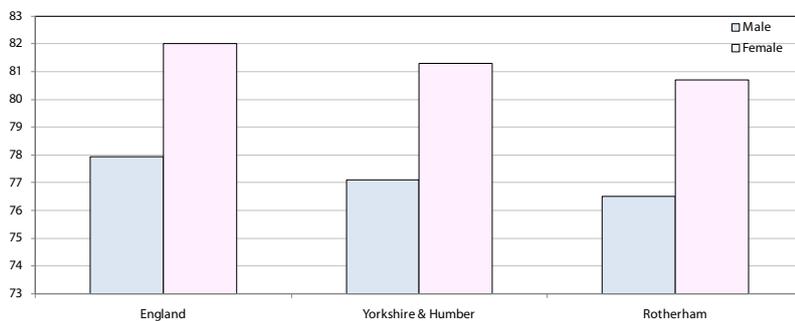
The latest data on life expectancy and ethnicity shows life expectancy for South Asians

in Rotherham between 2001 and 2005 was lower than that of the general population. Less than a quarter of South Asians lived beyond the age of 75 compared with two thirds of the general population. Average life expectancy for this period was 74.6 years compared with a Rotherham average of 77.4<sup>6</sup>.

The target for inequalities in life expectancy is to reduce the relative gap in life expectancy at birth between Spearhead Group and the England average by at least 10% by 2010. Life expectancy at birth in the Spearhead Group for 2006-2008 is 75.8 for males and 80.4 for females. Rotherham is part of the Spearhead Group but has above average life expectancies at birth than the average for this group<sup>11</sup>. Although life expectancy at birth has improved for both the Spearhead Group and for England as a whole, it has improved

**Figure 4.5 Rotherham Life Expectancy at Birth Compared with Regional and National Averages 2006-08**

Source: APHO 2010, Health Profile Rotherham 2010



<sup>8</sup> APHO 2010, Health Profile Rotherham 2010

<sup>9</sup> Department of Health (2008) Tackling Health Inequalities: 2007 Status Report on the Programme for Action

<sup>10</sup> Information Centre for Health and Social Care (2010), Compendium of Clinical and Health Indicators, p5

<sup>11</sup> Department of Health (2009) Mortality target monitoring (life expectancy and all-age all-cause mortality, overall and inequalities. Update to include data for 2008.

## Burden of Ill Health

### 4.1.3 Life Expectancy

more slowly in the Spearhead Group. As a result of this the gap in life expectancy has actually widened to 7% for males and 14% for females 14% in 2006-08 compared to at baseline in 1995-97<sup>12</sup>. There is a significant variation within the Spearhead Group of PCTs. In some areas life expectancy is increasing faster than average. If their trends were replicated in all Spearhead Areas the Government's life expectancy targets for 2010 would be met<sup>12</sup>. However, in general if current trends were to continue then 2010 targets will not be met<sup>12</sup>.

To meet the life expectancy target it is important to focus on preventing deaths from early middle age in Spearhead areas, including those at older ages. Deaths from CVD, cancer and respiratory disease account for approximately two-thirds of the gap between Spearhead Areas and the national average. There is substantial evidence that smoking reduction strategies will have an impact on the number of premature deaths from these conditions. Figures 4.6 and 4.7 predict the effect of interventions to narrow the life expectancy gap<sup>13</sup>.

# Burden of Ill Health

## 4.1.4 Main Causes of Death

Ranking leading causes of mortality can provide a useful picture of mortality patterns in England and Wales. The main causes of death should be viewed in the context of other indicators such as age, sex and cause-specific mortality rates. There are more deaths from cancer than from ischaemic heart disease (see Figure 4.8). However, no single cancer is a more common cause of death than ischaemic heart disease. In children, there are now more deaths from cancer than from accidents. Ranking leading causes of death is limited by the nature and quality of the information available through death registration<sup>14</sup>.

The figures illustrate the effects of the selected interventions to narrow the life expectancy gap.

Figure 4.6 Interventions Model for Males

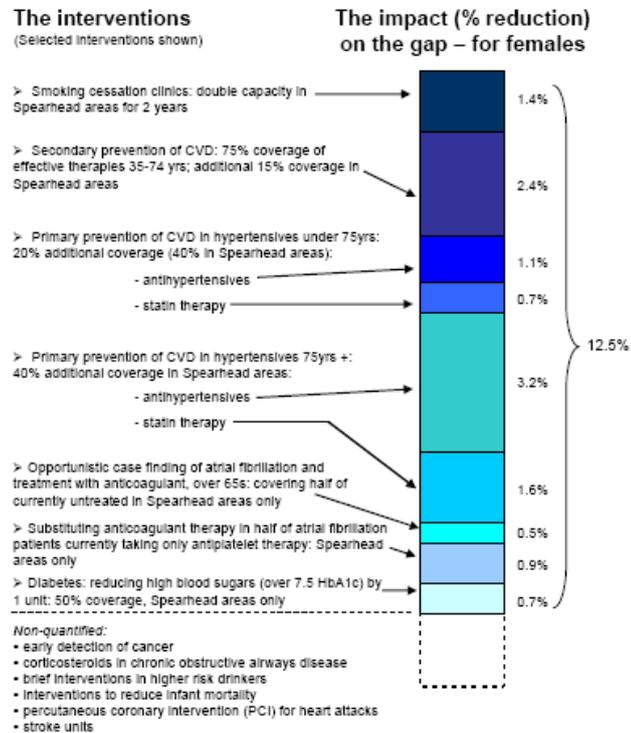
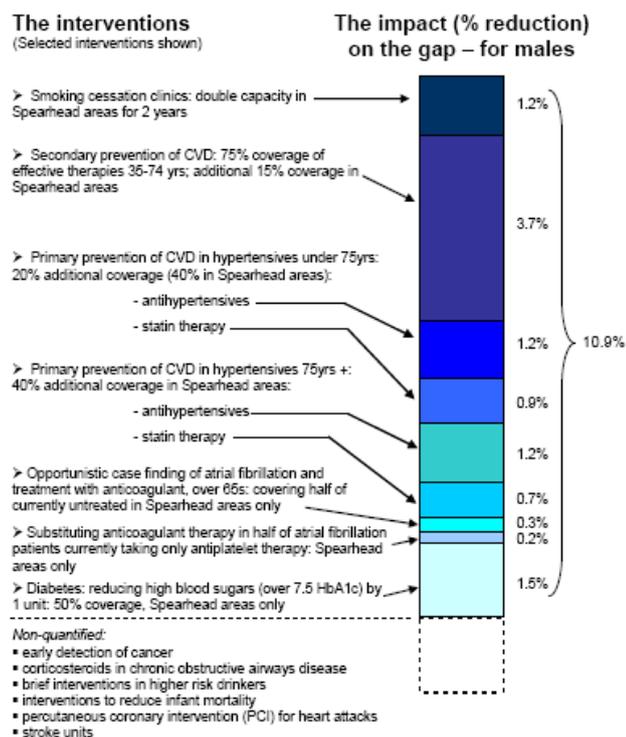


Figure 4.7 Interventions Model for Females



<sup>14</sup> Office for National Statistics (2005), Health Statistics Quarterly, Leading causes of death in England and Wales – how should we group causes?

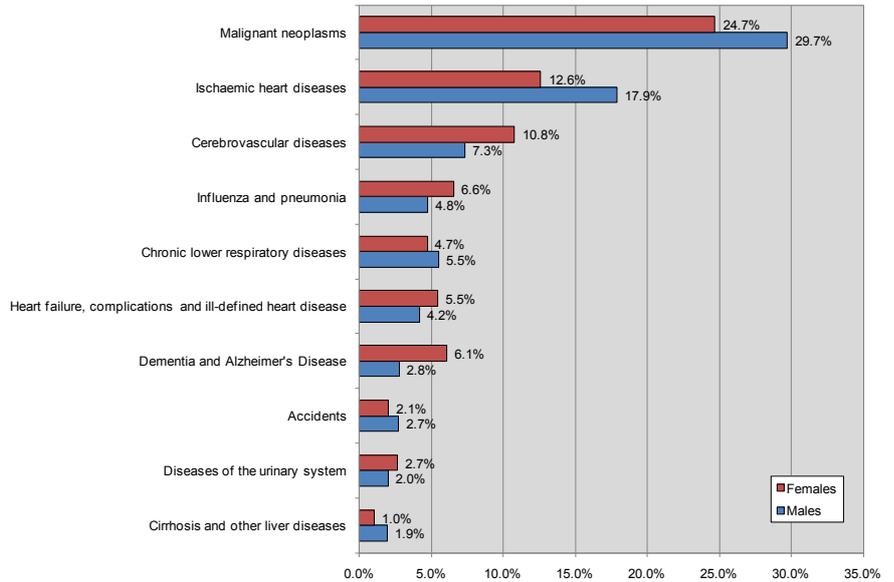
# Burden of Ill Health

## 4.1.4 Main Causes of Death

Figure 4.9 compares the causes of premature mortality in Rotherham with England and Wales for 2006-08 (3 years). It shows the number of years lost broken down by individual conditions and assumes that the timely age for death is 75 years. For example if one person dies of cancer at 65 this accounts for 10 years of life lost. The chart shows that overall there are more premature deaths in Rotherham than nationally. The three most significant causes of years of life lost are cancer, circulatory disease and diseases of the digestive system<sup>15</sup>.

**Figure 4.8 10 leading causes of death in England and Wales, by gender, all ages**

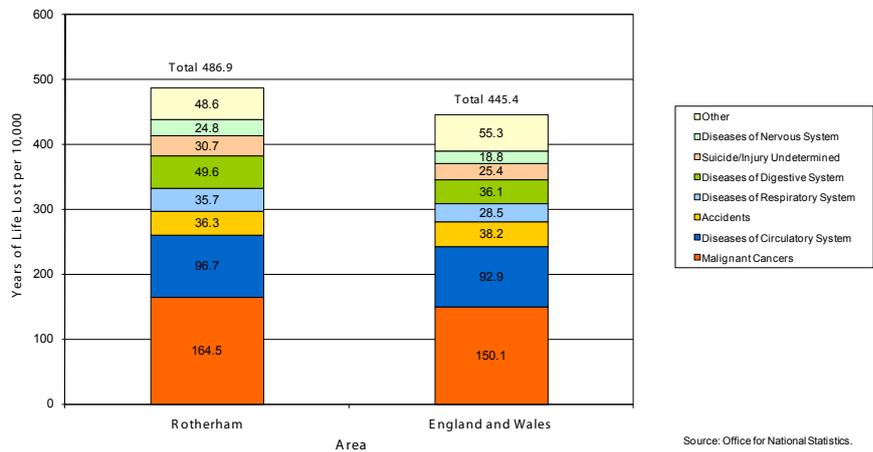
Source: London Health Observatories (2008), Health Inequalities Intervention Tool ([www.lho.org.uk](http://www.lho.org.uk))



**Figure 4.9 Years of life lost by conditions 2006-08 (3 years)**

Source: London Health Observatories (2008), Health Inequalities Intervention Tool ([www.lho.org.uk](http://www.lho.org.uk))

**Figure 4.9: Years of life lost by conditions 2006-08 (3 years)**



Source: Office for National Statistics.

# Burden of Ill Health

## 4.1.4 Main Causes of Death

Figure 4.10<sup>15</sup> looks at the difference in life expectancy between the most deprived 20% of Rotherham compared with the Rotherham average by cause of death. From 2003-05 cancer, accidents and circulatory disease have been the three conditions which have had the greatest impact on life expectancy gap. Since 2005 Rotherham's position with regard to circulatory disease has improved. The gap on circulatory disease mortality has virtually been eliminated. However this does not mean that circulatory disease should become less of a priority. Circulatory conditions are still a major contributor to premature mortality and there are cost effective interventions which, if made available to everyone at high risk, could have a substantial impact on life expectancy<sup>15</sup>.

Figure 4.10a: Breakdown of life expectancy gap between most deprived quintile in Rotherham and Rotherham average by cause of death

Source: London Health Observatories (2008), Health Inequalities Intervention Tool ([www.lho.org.uk](http://www.lho.org.uk))

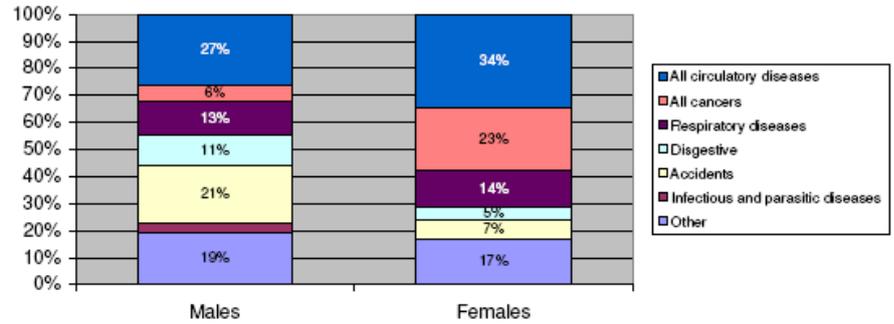
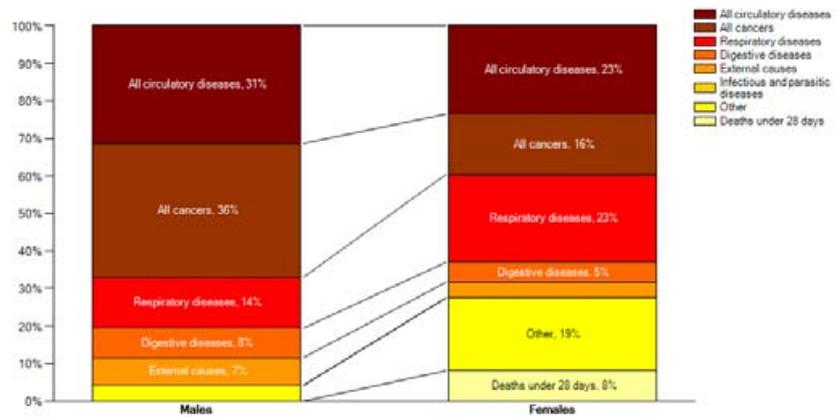


Figure 4.10b: Breakdown of life expectancy gap between Rotherham and England, by cause, 2006-08

Source: London Health Observatories (2008), Health Inequalities Intervention Tool ([www.lho.org.uk](http://www.lho.org.uk))



14 Office for National Statistics (2005), Health Statistics Quarterly, Leading causes of death in England and Wales – how should we group causes?

## Burden of Ill Health

### 4.1.5 Hospital Admissions

NHS Rotherham had the second highest rate of hospital admissions in the region in 2008-09. The rate was 278.9 admissions per 1,000 population, significantly higher than regional (237.3) and (218.6)<sup>16</sup> national averages. This suggests either a higher level of morbidity in the population, a lack of community care provision or reduced effectiveness in primary care.

The needs weighted total cost of acute admissions is higher than the regional and national rates. It is possible that the needs weighted adjustment under-compensates for actual need. Assuming that it does not, the possible causes of the relatively high needs weighted total cost could be due to; low provider admission threshold, lack of community care provision, high levels of inappropriate referrals, lack of post discharge community support and ineffective discharge planning<sup>17</sup>.

In 2008/09 Rotherham had a significantly higher rate of emergency hospital admission per 1,000 than the regional and national averages. The rate in Rotherham was the highest of all PCTs in the region. Rotherham also has a significantly higher rate of A&E emergency admissions per 1,000 than the regional and national averages. Rotherham had the second highest rate in the region<sup>17</sup>.

Rotherham has the 2nd highest rate of emergency admissions for ambulatory care conditions in the region. These 19 conditions have been identified as those which could be prevented by effective community care. The rate of admission for these conditions in Rotherham is significantly higher than regional and national rates. This could be due to factors such as higher levels of morbidity and a more complex case mix. However other factors could include; lack of appropriate

community care provision, post discharge support and effective discharge planning<sup>17</sup>.

Rotherham had the second highest regional percentage of emergency admissions discharged home with no overnight stay in 2009-10. This suggests low provider threshold for admissions, high level of inappropriate referrals and/or classification of A&E observation beds as inpatients<sup>17</sup>.

In 2009/10 the standardised cost rate for emergency admissions per 1,000 Rotherham was the 4th highest in the region and higher than the national and regional averages<sup>17</sup>.

## Burden of Ill Health

### 4.1.6 Self-Reported Measure of Health and Well-being

According to the Lifestyle Survey 2008 77% of respondents across Rotherham regard themselves as being in "good health". Only 7% consider themselves to be in "poor health". This compares with 65% and 11% of respondents in the most deprived areas<sup>18</sup>.

## Burden of Ill Health

### 4.1.7 Healthy Life Expectancy at 65

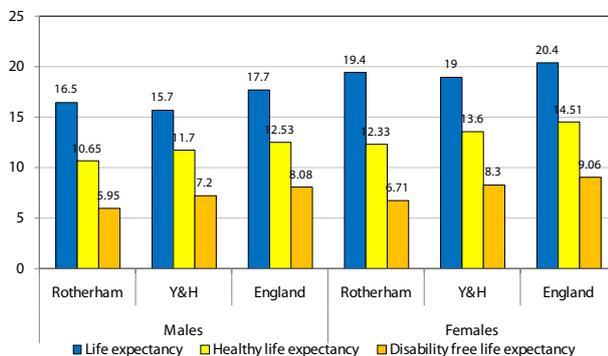
The UK population has been living longer over the last 20 years, but the additional years have not necessarily been in good health or free from disability or limiting illness. Healthy life expectancy (expected years of life in good or fairly good health) and disability free life expectancy (expected years of life free from disability or limiting illness) have all increased between 2000-02 and 2005-07<sup>19</sup>.

figures on health and disability free life expectancy for men and women 65+ are from 2001 but the latest figures on life expectancy at 65 are from 2006-08. Figure 4.11 below shows the difference between rates for Rotherham, Yorkshire and Humberside and England. The graph shows Rotherham rates to be lower than the regional or national averages<sup>20</sup>.

The gap in healthy life expectancy between men and women is smaller than for total life expectancy. In 2005-07, healthy life expectancy at birth was 68.4 years for men and 70.4 years for women, a gap of 2 years. The gap in disability-free life expectancy between men and women is also smaller than for total life expectancy and healthy life expectancy. In 2005-07, disability-free life expectancy at birth was 62.5 years for men and 63.7 years for women, a gap of 1.2 years<sup>19</sup>. The latest local comparative

**Figure 4.11 Life expectancy for people over 65 years**

Source: HM Government (2008), *National Indicators for Local Authorities and Local Authority Partnerships: Handbook of Definitions Annex 3*



<sup>19</sup> Office for National Statistics (2010), *Healthy life expectancy at birth 2000-02 to 2005-07 for England and Wales (experimental statistics)*

<sup>20</sup> HM Government (2008), *National Indicators for Local Authorities and Local Authority Partnerships: Handbook of Definitions Annex 3*

## Burden of Ill Health

### 4.1.8 Mortality Rate from Causes Considered Amenable to Health Care

Many determinants of health lie outside healthcare and therefore it can be difficult to measure the effectiveness of health care systems. Mortality data that is based on the concept that deaths from certain causes should not occur in the presence of timely and effective health care is one way of trying to measure health system effectiveness.

Amenable mortality, according to the Nolte and McKee definition<sup>20</sup>, is defined as deaths occurring before age 75 from causes that are considered amenable to medical intervention. Examples include: breast cancer, cancer of colon, leukaemia, gastric and duodenal ulcer and hypertensive diseases. Deaths from these causes may be avoidable through treatment of the condition after onset. Using this definition 43% of male and 47% of female deaths before age 75 were considered avoidable in 2005<sup>21</sup>.

The leading cause of amenable mortality for males in 2005 was ischaemic heart disease (IHD).

The picture was slightly more complex for females, where IHD was the largest contributor to amenable mortality based on age-standardised rates, but breast cancer was the largest contributor when standardised years of life lost were used. This indicates that, although mortality from both IHD and breast cancer increases with age, significant numbers of deaths from breast cancer begin to appear in women at younger ages than IHD<sup>21</sup>.

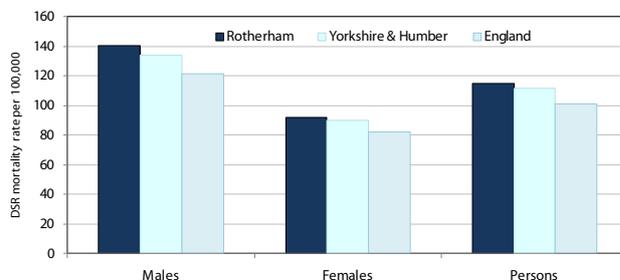
There have been considerable reductions in levels of avoidable mortality between 1993 and 2005. The age-standardised mortality rate for causes considered amenable to medical intervention fell by 43% for males and 38% for females in this period. Mortality from causes not considered avoidable decreased by 14 per cent and 8 per cent for males and females respectively over the same period. Results indicate that medical interventions are likely to have contributed positively to reductions in amenable mortality, since the decreases are unlikely to

be the result of a general decrease in mortality rates. The biggest reduction in amenable mortality has been deaths from IHD<sup>21</sup>.

Directly standardised mortality data from 2006-08 show that mortality rates for causes considered amenable to health care are higher in Rotherham than nationally and regionally. Mortality rates are higher for both males and females, but the difference is much narrower for females than males<sup>22</sup>. The ratio of deaths in Rotherham that are considered amenable to health care compared with those considered non-amenable to health care decreased faster than the national and regional averages between 1993 and 2006 and in 2006 was virtually the same (36% in Rotherham and regionally and 35% nationally). This suggests that differences in death rates are not related to variations in the quality of health care<sup>21</sup>.

Figure 4.12 Mortality rates for causes amenable to health care 2006-2008

Source:



21 Office for National Statistics (2007), *Health Statistics Quarterly issue 34*

22 Information Centre for Health and Social Care (2010), *Compendium of Clinical Health Indicators*

## Burden of Ill Health

### 4.1.9 Deaths attributable to smoking

*Please see under section 1 of Lifestyle and Risk Factors*

# Burden of Ill Health

## 4.1.10 Long Term Conditions/Physical Disability

It is estimated that in 2015 there will be 28,199 people over 65 in Rotherham with a limiting long-term condition. By 2025, it is estimated that the number will have risen to 33,831<sup>23</sup>.

Statistics from the Department of Work and Pensions show 10,540 people in Rotherham claimed Incapacity Benefit in February 2010 which equates to 6.5% of the working age population, compared with 5% nationally. Incapacity Benefit is generally claimed by adults of working age<sup>24</sup>.

The 2001 census shows that 22.4% of the population considered themselves to have a limiting long-term illness or disability compared with 17.9% nationally<sup>25</sup>. It is clear therefore that Rotherham has a higher prevalence of long-term conditions than the national average and this seems likely to increase as the population continues to age. Figure 4.13 shows the range of long term conditions experienced by working age adults in Rotherham,

Yorkshire and Humber and England, based on information relating to incapacity benefit claimants from 2007<sup>24</sup>.

Mental health disorders, although slightly lower than the England and regional averages, are still by far the highest cause of disability, followed by musculoskeletal problems. The 2008 Lifestyle Survey for Rotherham estimated that 35% of the population consider themselves to have a long term condition, an increase of 5% since the previous survey in 2005<sup>26</sup>. This increases to 39% of respondents in areas of deprivation, but this is a decrease of 3% since the last survey in 2005, which suggests that health is improving in NRS areas and the gap between NRS areas and the general population is decreasing .

PANSI estimates that 16,115 people in Rotherham aged 18-64 had a moderate or serious physical disability in 2010. This equates to 6.4% of the total population or 9.9% of the working age population. PANSI

predicts that by 2025 this number will have increased to 16,476<sup>27</sup>.

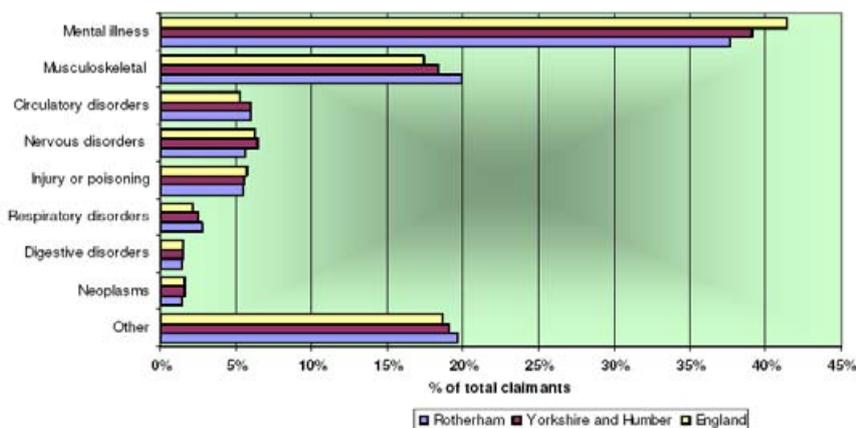
PANSI estimates that in 2010, 4,202 males and 2,585 females in Rotherham were permanently unable to work due to physical disability. This equates to 5.2% of working-age males and 3.2% of females. By 2025 the numbers in Rotherham are predicted to rise to 4,361 males and 2,610 females<sup>28</sup>.

Figure 4.14 shows predicted change in numbers of working-age adults in Rotherham who are permanently unable to work due to physical disability, broken down by age and gender. There is a significant decrease predicted in the number of people aged 45-54 years but increases in the number of people permanently out of work up to 2025 who are aged between 55 and 64 years<sup>28</sup>.

National Indicator NI124 measures the percentage of people with a long term condition who report that they have had enough support from local services or organisations to help

**Figure 4.13: Types of long term conditions using data on Incapacity Benefit Claimants-May 2007**

Source: Department of Work and Pensions tabulation tool



23 POPPI (2008) People aged 65 and over with a limiting long-term illness by age (65-74, 75-84, 85 and over) projected to 2025  
 24 Department of Work and Pensions tabulation tool  
 25 Census 2001 Table UV22  
 26 NHS Rotherham (2005), Rotherham Lifestyle Survey  
 27 PANSI (2008)  
 28 Health Care Commission (2008), Patient Survey Report 2008 Rotherham PCT

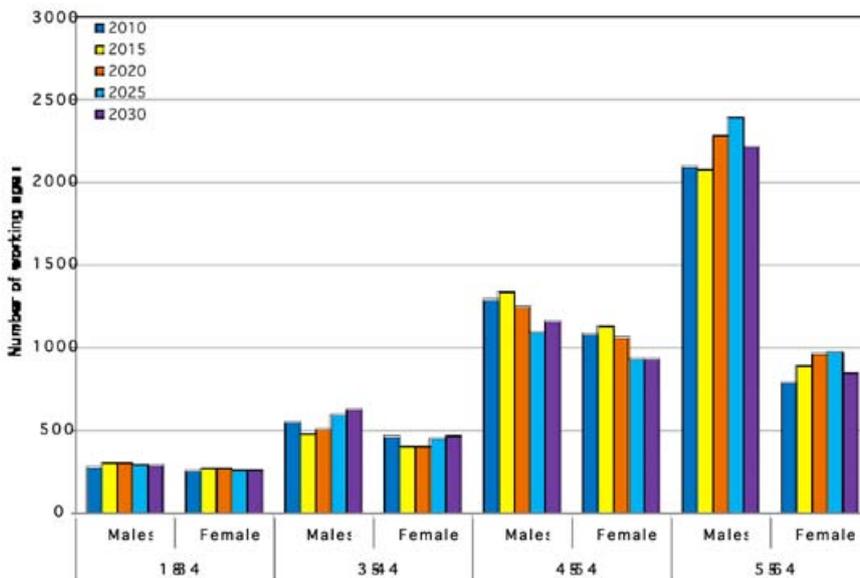
# Burden of Ill Health

## 4.1.10 Long Term Conditions/Physical Disability

manage their long-term health condition(s). This data is sourced from the Health Care Commission PCT patient survey which is a random sample of adults registered with GP practices in England. In 2008, 63% of the 115 Rotherham respondents to this question in the National Patient Survey reported they got enough support from local services and organisations to manage their long-term condition (includes health and social care services)<sup>29</sup>. This suggests services are working quite well together to support people with long term conditions but there is further improvement to be made.

Figure 4.14 Predicted numbers of working age adults permanently unable to work due to physical disability in Rotherham, 2010-2030

Source: PANSI (2008)



29 Quality and Outcomes framework (2010), PCT indicator group level summary of achievement submission detail, DM19

# Burden of Ill Health

## 4.1.11 Health at Work

ROHAS (Rotherham Occupational Health Advice Service) monitors incidents of work related ill health, taking referrals from across Rotherham via GPs. Work related ill health occurs across a wide range of industries and involves a wide range of conditions. Men are disproportionately represented as ROHAS patients compared to the proportion within the population. 60% of patients are male compared to just over 50% within the population.

Figure 4.14A ROHAS Patients by Industry

Source:

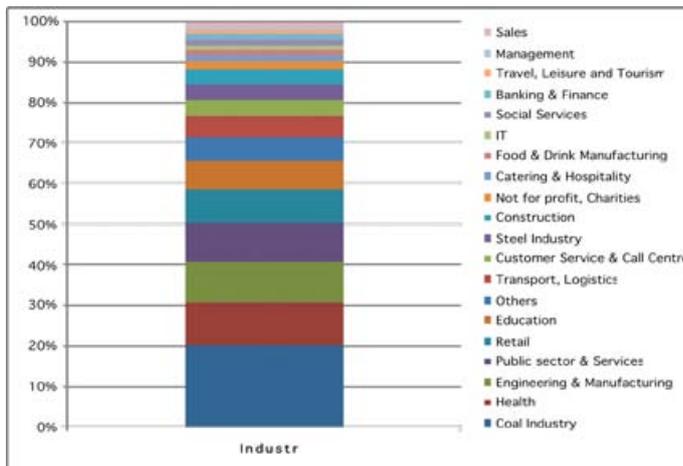
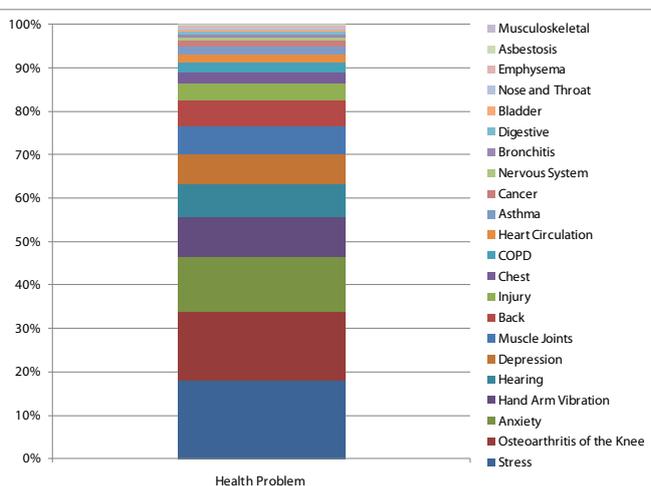


Figure 4.14A ROHAS Patients by Health Problem (note: more than one health problem can be assigned to a patient)

Source: Department of Work and Pensions tabulation tool



# Burden of Ill Health

## 4.2 Diabetes

According to the APHO Diabetes Prevalence Model there were an estimated 3.1 million people in England with diabetes in 2010, 7.4% of the population. 1 in 4 of these is estimated to be undiagnosed. The prevalence rate is predicted to rise to 4.6 million by 2030, 9.5% of the population<sup>30</sup>.

Life expectancy is reduced by at least fifteen years for someone with Type 1 diabetes. In Type 2 diabetes, which is preventable in two thirds of cases, life expectancy is reduced by up to 10 years<sup>31</sup>. It is estimated that around 90% of people with diabetes have type 2 diagnosis. Diabetes is the leading cause of blindness in people of working age in the UK<sup>31</sup>.

Diabetes prevalence increases sharply with age. The diabetes prevalence rate in persons aged 55-74 years and 75+ years was 14.3% and 16.5% respectively. By 2030, approximately half of the increase in diabetes prevalence

will be due to the changing and ethnic group structure of the population and about half will be due to the projected increase in obesity<sup>32</sup>. Assuming a continuing trend of rising obesity, the PBS prevalence model predicts that the number of people in Rotherham with diabetes will have risen to 18,164 by 2025 equating to 6.7% of the population<sup>33</sup>.

The main contributing factors to rising rates of diabetes are;

- Increases in population of older people
- Increases in rates of obesity

Figure 4.15 illustrates how much of the forecasted increase in diabetes is likely to be due to population change and how much is likely to be due to rising obesity levels. The graph summarises the diabetes prevalence rate and number that would occur under two different

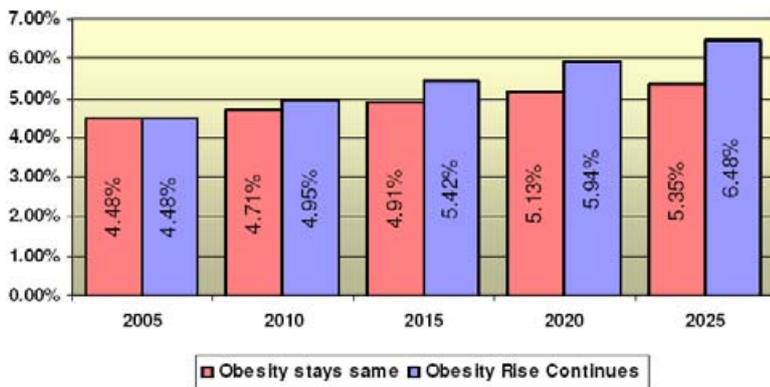
scenarios of obesity (both use the same ONS population projections). The first and most likely scenario is that the 1991-2006 obesity rise continues at the same rate. The second scenario is based on obesity being maintained at 2005 levels.

In Rotherham there were 11,084 patients registered with diabetes in Q4 2009/10<sup>29</sup>. This is equivalent to 4.6% of all Rotherham registered patients. Of these 1,004 are Type 1 and 10,080 are Type 2 which is 0.4% and 4.2% of Rotherham registered patients respectively. 15% of those diagnosed with Type 2 diabetes are prescribed insulin. 16% of diabetes patients are recorded as current smokers (of those with a smoking status ever recorded)<sup>34</sup>.

As mentioned above, the prevalence of diabetes is higher in older age groups. This is reflected in the Rotherham data. 9% of

**Figure 4.15: Diabetes prevalence forecast based on 2 scenarios of obesity levels**

Source: APHO Diabetes Prevalence Model: Key findings for England, June 2010 (2010), p1-3



30 APHO Diabetes Prevalence Model: Key findings for England, June 2010 (2010), p1  
 31 Diabetes UK (2007), Diabetes: State of the Nations 2006, p5  
 32 APHO Diabetes Prevalence Model: Key findings for England, June 2010 (2010), p2  
 33 NHS Rotherham (2008), Practice Based HNA: table of supporting data  
 34 NHS Rotherham (2010), QUEST diabetes data 2009/10 Q4

## Burden of Ill Health

### 4.2 Diabetes

registered patients over 40 have a diabetes diagnosis. Of these 85% are prescribed a statin for 6 months and 52% are prescribed an aspirin for 6 months<sup>34</sup>.

Prevalence and mortality rates for diabetes are greater in areas of deprivation and for people in lower socio-economic groups. One likely reason is that obesity prevalence is higher in areas of deprivation. In addition, people from BME communities are concentrated in areas of deprivation and African Caribbean and South Asian communities have a higher prevalence of Type 2 diabetes (4 times higher in African Caribbean and 6 times higher in South Asian). This is a result of genetic predisposition and lifestyle factors such as overweight or obesity and limited physical activity. Type 2 diabetes occurs at an earlier age in these communities and complications resulting from this

condition are more likely in this population. Several studies report inadequate quality of health care for Asian, Black African and Black Caribbean diabetics and poor treatment compliance, which may lead to higher than average hospital admissions<sup>6</sup>.

The all age all persons mortality rate from diabetes in Rotherham for 2006-08 was 5.9. This is slightly lower than regional and national rates which were 6.2 and 6.1 respectively. Locally, regionally and nationally the mortality rate from diabetes is higher in men than women. In Rotherham the rates for men and women are 8.0 and 4.1<sup>35</sup>.

Hospital admissions data shows levels of diabetes are higher in the Rotherham BME community. The data shows that 88.4 per cent of the 1,400 people admitted to hospital in Rotherham with diabetes were White British. Just under 2% (1.86 per cent)

reported being of Black or Minority Ethnic origin<sup>6</sup>. This latter figure seems low compared to the proportion of the population from BME groups (over 5 per cent). However, when the younger age structure of the BME population and the large number of people not stating their ethnicity are considered, diabetes may be more significant, particularly considering the high rates of obesity in some BME groups<sup>6</sup>.

Admissions due to diabetes amongst the Pakistani community increased from 87 in 2002/03 to 154 in 2006/07, an increase of approximately 77 per cent. The overall increase in admissions for all minority ethnic groups was 12% for the same period which suggests that other ethnic groups experience significantly lower rates of diabetes, moderating the overall increase for BME communities<sup>6</sup>.

Figure 4.16 shows the national

## Burden of Ill Health

### 4.2 Diabetes

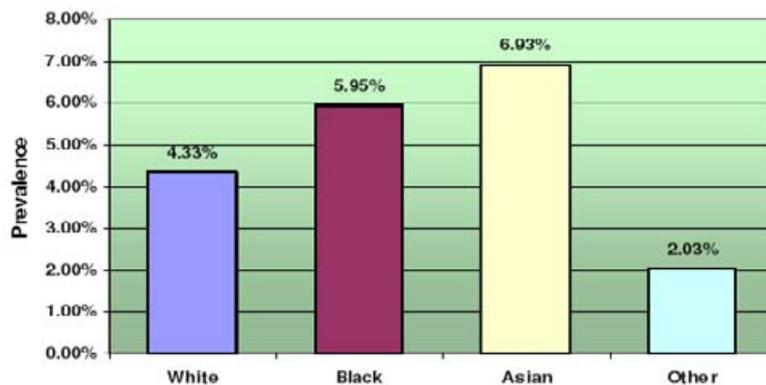
variation in prevalence by ethnic group. A comparison of the local authorities with the highest and lowest prevalence rates of diabetes shows that those with the highest rates had correspondingly higher rates either of people over 65 or ethnic minorities in their populations<sup>36</sup>.

People with diabetes have a higher risk of dying at all ages under 80. The relative increase in risk of death is higher for women than men. For example, women aged between 40 and 59 years with diabetes are 2.54 times more likely to die than women of the same age without diabetes, compared with 2.17 times for men<sup>37</sup>.

In England 26,300 deaths between the ages of 20 and 79 years in 2005 can be attributed to diabetes. This equates to 11.6% of all deaths in this age group. If current trends in diabetes prevalence and mortality rates continue, 12.2% of deaths between 20 and 79 years will be attributable to diabetes in 2010. The percentage of diabetes attributable deaths in 2005 varies from 17.08% to 9.25% between Local Authorities<sup>37</sup>. In Rotherham the proportion of diabetes attributable deaths was 11.57%, which is close to the national average<sup>38</sup>.

**Figure 4.16 Diabetes Prevalence by Ethnic Group**

Source: APHO Diabetes Prevalence Model: Key findings for England, June 2010 (2010), p1-2



<sup>36</sup> APHO Diabetes Prevalence Model: Key findings for England, June 2010 (2010), p1-2

<sup>37</sup> Yorkshire and Humber Public Health Observatory (2008), Diabetes Attributable Deaths

<sup>38</sup> Yorkshire and Humber Public Health Observatory (2008), Diabetes Attributable Deaths for Primary Care Trusts

## Burden of Ill Health

### 4.2.1 Diabetes - Impact on services

Nationally around 5% of total NHS spend is used for the care of people with diabetes. Up to 9% of hospital expenditure is used for the care of people with diabetes<sup>39</sup>. In Rotherham, during 2007/08, 0.5% of all A&E attendances were for diabetic related conditions<sup>40</sup>. 61% of these were by people aged 18-64 years<sup>41</sup>. There were 203 unplanned admissions where diabetes was the primary diagnosis and 2,680 unplanned admissions where diabetes was listed as a secondary diagnosis<sup>42</sup>.

Prescribing costs for diabetic drugs was £2.8 million, 7% of the total prescribing budget<sup>43</sup>. Rotherham has the highest prescribing costs for insulin in NE England and is well above the regional and national average<sup>43</sup>. Rotherham also has the third lowest costs for prescribing anti-diabetic drugs<sup>43</sup>.

<sup>39</sup> Diabetes UK (2007), *Diabetes: State of the Nations 2006*, p5

<sup>40</sup> NHS Rotherham (2008), *Diabetes A&E Attendances at All Providers (spreadsheet)*

<sup>41</sup> NHS Rotherham (2008), *A&E Attendances Patients aged 18+ 05-08 (spreadsheet)*

<sup>42</sup> NHS Rotherham (2008), *Diabetes Spells at all Providers (spreadsheet)*

<sup>43</sup> NHS Rotherham (2008), *07-08 Diabetes Expenditure NHS Rotherham*

# Burden of Ill Health

## 4.3.1 Circulatory Diseases - General

Circulatory disease is one of the main causes of premature death in England. It is therefore a significant condition when considering strategies for increasing life expectancy. The Department of Health has set the following PSA target:

*To substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole<sup>44</sup>.*

The Coronary Heart Disease (CHD) National Service Framework (NSF) Progress Report for 2008 stated that the Government target to reduce deaths from circulatory diseases by 40% for people under 75 had been met 5 years early.

Inequalities in the death rate for circulatory diseases among the under 75s have been narrowing and the absolute gap between the England average and the 20% most deprived areas of England has reduced by 32% since 1995-7<sup>45</sup>.

Deaths from cardiovascular diseases (CVD) in Rotherham have more than halved since 1991 and rates have been falling more than the national rates. It is expected that by 2010 mortality rates in Rotherham will have fallen to below the national average. Although mortality rates continue to be higher in NRS target areas, improvements have occurred at the same rate as for the rest of the population (see Figure 4.17 below)<sup>46</sup>.

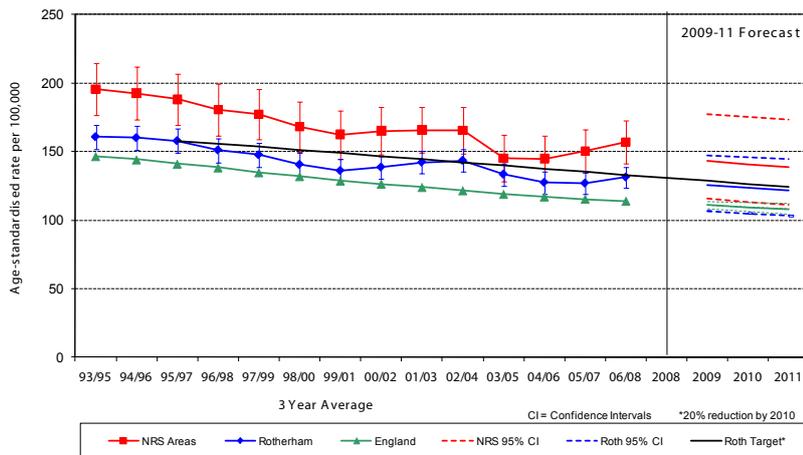
National Indicator NI121 measures the mortality rate from all

circulatory diseases per 100,000 of the population for people aged under 75<sup>44</sup>. Between 2006-08 the local mortality rate was 81.6, just below the regional rate of 82.8 but above the national rate of 74.8<sup>47</sup>.

Within the broad category of cardiovascular disease are a number of more specific health problems of which the two most important, in terms of causes of death, are Coronary Heart Disease (CHD, also known as Ischaemic Heart Disease - IHD) and Cerebrovascular Disease (stroke). Other significant conditions include angina and hypertension (high blood pressure). Cardiovascular disease is linked with other conditions, notably respiratory problems and diabetes. CVD is more common in men than women.

**Figure 4.17: Circulatory Diseases Mortality Rates 1993/5-2006/8: Persons Aged Under 75 Neighbourhood Renewal Strategy Areas Compared with Rotherham and England (+ 95% CIs)**

Source: London Health Observatories (2008), Health Inequalities Intervention Tool June 2010 (2010), p1-2



44 NHS Rotherham (2005), Lifestyle Survey – most deprived 20% of residents, p10  
 45 Department of Health (2008), The CHD National Service Framework Progress Report for 2007  
 46 NHS Rotherham (2007), Director of Public Health Annual Report 2006-7, p41  
 47 NHS Information Centre (2009), Compendium of Clinical and Health Indicators, Mortality from circulatory diseases (under 75, 2006-2008)

## Burden of Ill Health

### 4.3.2 CHD and Heart Failure

Mortality from CHD in the UK is declining but it remains the most common cause of death<sup>48</sup>. The mortality rate for CHD has decreased both in Rotherham and nationally between 1993 and 2007. Up to 2007, the mortality rate for CHD in Rotherham has been falling faster than the national and regional averages (Figure 4.18 below<sup>49</sup>). In 2008 the mortality rate for Rotherham increased slightly pushing Rotherham back above regional and national rates.

The national rate in premature death from coronary heart disease in people under 45, particularly women, was on a steady downward trend but has seen a recent increase since 2007. This is due to lifestyle factors such as young people smoking, low levels of exercise and an increase in obesity prevalence. The latest report from the British Heart Foundation suggests that unless these risk factors are tackled aggressively in the younger age

groups there is likely to be a reversal of the benefits achieved so far<sup>50</sup>.

More deaths from CHD occur in winter months than the rest of the year. Excess winter mortality is the increase in mortality over and above the rate of mortality in the rest of the year. For example in 2004-5 19% more deaths occurred in winter than would be expected based on the average mortality for the whole year. Excess winter mortality is more than double the rate for over 85s compared to those under 65s<sup>50</sup>.

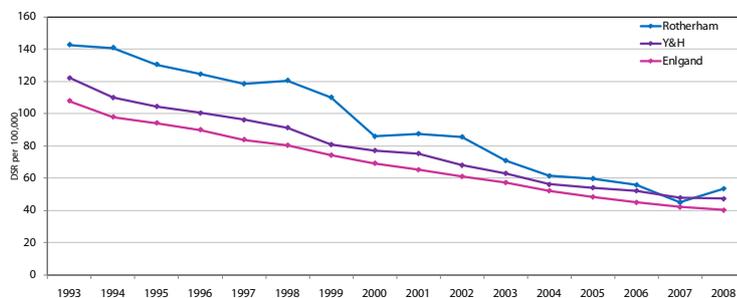
The CHD prevalence model estimates that in 2010 there are 6.4% of people all ages in Rotherham with CHD compared to 5.7% in England<sup>51</sup>. In July 2010 there were 11,301 patients on Rotherham GP registers with CHD. This is 4.4% of the registered population giving a difference of 2% between numbers on GP registers and estimated prevalence<sup>52</sup>. There were 2,086

patients on GP registers of all ages with heart failure which is 0.8% of registered patients<sup>52</sup>. It is estimated that the percentage of the Rotherham population with CHD will rise to 7.2 % by 2020 compared with 6.2% nationally<sup>53</sup>.

CHD is more prevalent among males than females. The CHD prevalence model estimates that in 2008 in England 6.8% of males and 4.5% of females have CHD. This compares with 7.6% and 5.0% respectively in Rotherham<sup>53</sup>. CHD is more prevalent amongst the white population in Rotherham at 6.4% in 2008, followed by the Asian population at 3.6% and the Black population at 1.4%. This compares with 5.9%, 3.9% and 2.1% respectively nationally. This suggests that CHD is less prevalent amongst ethnic minority groups in Rotherham than it is nationally, but this is likely to be due to the young age profile of BME groups in Rotherham and the prevalence is likely to increase as their average age increases<sup>54</sup>.

**Figure 4.18: CHD mortality rates between 1993 and 2008 for Rotherham, Yorkshire & Humberside and England. Persons Under 75**

Source: NHS Information Centre (2007), *Compendium of Clinical and Health Indicators, Mortality for coronary heart disease*



48 SEPHO (2009) *Coronary Heart Disease*

49 NHS Information Centre (2007), *Compendium of Clinical and Health Indicators*

50 British Heart Foundation (2008), *Heart Statistics 2008 - General*

51 Association of Public Health Observatories (2009), *CHD Model and Benchmarking Tool*

52 Quality and Outcomes framework (2010), *PCT indicator group level summary of achievement and submission detail, CHD1*

53 Yorkshire and Humber Public Health Observatory (2009), *CVD prevalence - observed and expected - spreadsheet*

# Burden of Ill Health

## 4.3.2 CHD and Heart Failure

Figure 4.19 compares the predicted trend in prevalence of CHD for different ethnic groups in Rotherham between 2008 and 2020. This suggests that CHD prevalence is likely to remain fairly stable among black, mixed and other ethnic groups and increase amongst white and Asian groups<sup>53</sup>.

Prevalence rates for CHD increase as people get older. In Rotherham in 2008 CHD rates were; 23.2% (75+ years), 17.0% (45-64) and 6.3% (all adults). The rates are higher than the estimated national prevalence for each group at 21.3%, 15.6% and 5.6% respectively. Figure 4.20 compares the predicted trend for CHD prevalence for different age groups in Rotherham and England between 2008 and 2020<sup>54</sup>.

CHD is more prevalent in areas of high deprivation for both men and women. Towards the end of the 1990s the premature death rate for female manual workers was 73% higher than for female non-manual workers. For males premature death rates were 50% higher. Since the introduction of inequalities targets there has been clear progress in reducing the gap between the most deprived areas and the nation as a whole.

NHS Rotherham has carried out a series of CVD equity audits focusing on ensuring that practices in deprived areas have maximised case finding. In the 1990s there was evidence that patients from deprived areas were less likely to receive specialist procedures such as coronary artery bypass grafts

even though they had much higher CVD mortality<sup>55</sup>. By 2005 this trend had been reversed and the use of specialised cardiac services by patients in deprived parts of Rotherham is now higher than the overall average. However it is likely that uptake is still not completely proportionate to the prevalence of disease<sup>55</sup>. Figure 4.2.2 below shows that the CHD mortality rates in the 20% most deprived areas are higher than the rest of Rotherham. However, the gap has narrowed since 1991.

National evidence has shown that South Asians living in the UK have a higher premature death rate from CHD than the population average. The rate is 46% higher for men and 51% higher for women (British Heart Foundation).

Figure 4.19: Predicted CHD prevalence in Rotherham by Ethnic Group between 2008–2020

Source: Yorkshire and Humber Public Health Observatory (2008), CVD prevalence – observed and expected - spreadsheet

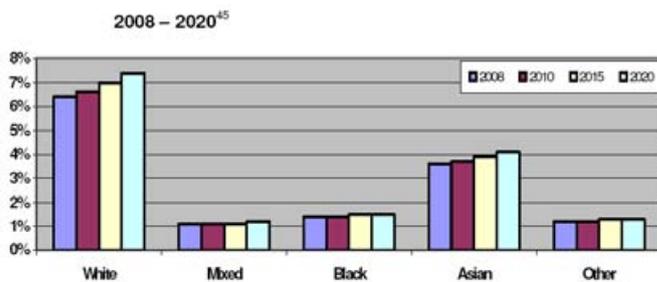
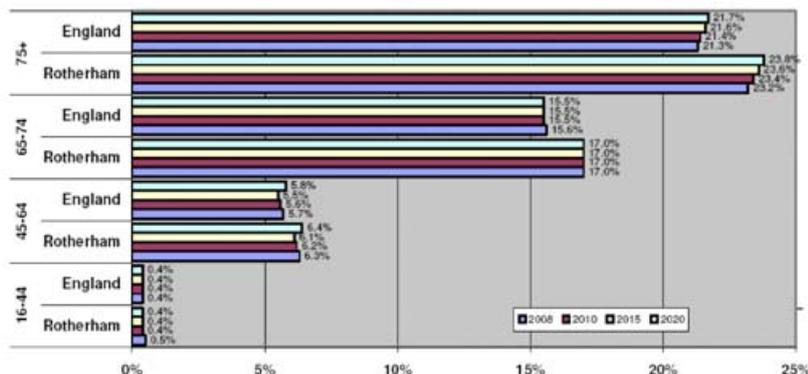


Figure 4.20a: Predicted prevalence of CHD in different age groups between 2008 and 2020 for Rotherham and England

Source: Association of Public Health Observatories (2008), CHD Model and Benchmarking Tool



54 NHS Rotherham (2007), CHD in South Asians Equity Audit  
 55 London Health Observatories (2008), Health Inequalities Intervention Tool, p23

## Burden of Ill Health

### 4.3.2 CHD and Heart Failure

There is also evidence that people from ethnic minorities have less access to these services as a result of language barriers and cultural differences etc<sup>54</sup>.

In Rotherham people of South Asian origin are more likely to be admitted to hospital with cardiac complaints and receive cardiac interventions (heart bypass and angioplasty) than the population average, once age differences in the populations are adjusted for. It indicates that the South Asian community has access to hospital services but it highlights the need for targeted health promotion and risk management for this population<sup>55</sup>.

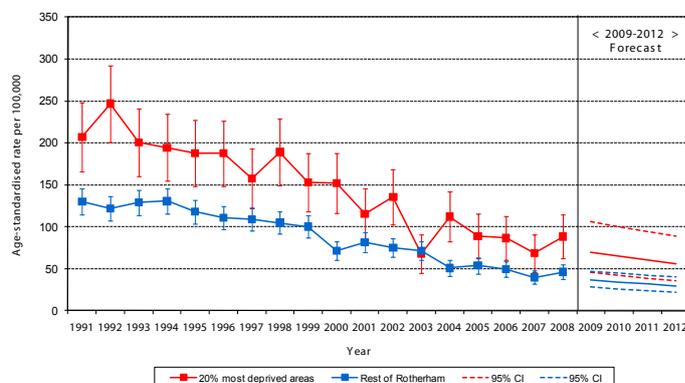
The South Asian population age profile is much younger than that of the general population. Over 50% of the South Asian population are under 25 years of age. As this population ages there is likely to be a sharp increase in the number of South Asians at risk of CHD<sup>56</sup>.

In Rotherham, South Asians appear to be admitted for treatment for CHD around 6-7 years earlier than the general population. A substantial proportion of South Asian secondary care admissions occur in the 45-54 age group. There is then a dip in the proportion of South Asian admissions between ages 55-64. This pattern is not seen in the general population where a gradual rise in admissions with age is observed<sup>57</sup>.

The BME community in Rotherham had twice the rate of hospital admissions for congestive heart failure (CHF) between 2000 and 2005 than for the general population. The Pakistani community had two and a half times the rate of hospital admissions for this condition compared to the general population. Consultation with BME groups suggests that raising awareness of the importance of taking medication to control the condition would be of benefit<sup>6</sup>.

Rotherham has one of the highest hospital admission rates for coronary heart disease. Rates are high for all types of admissions but especially for emergency admissions. In Rotherham 2007/08 there are 331 admissions per 100,000 population compared with 242 regionally and 222 nationally<sup>58</sup>. Although the prevalence rate in Rotherham is in the top 25%<sup>58</sup>, the level of hospital admissions is still much higher than other areas where there are high prevalence rates<sup>58</sup>. The number of emergency admissions for myocardial infarction (MI) in Rotherham in 2005-6 was 124.7 per 100,000 of population. This is higher than the regional rate of 106.7 and the national rate of 101 but the gap is less than for other types of heart conditions<sup>58</sup>. Further investigation may be required to look at the impact of avoidable admissions, hospital admission thresholds and availability of appropriate community based services.

Figure 4.20b: CHD mortality rates for Rotherham residents 1991-2008: Persons under 75, 20% most deprived areas compared with the rest of Rotherham (with 95% confidence intervals)



## Burden of Ill Health

### 4.3.2 CHD and Heart Failure

In Rotherham, the revascularisation rate in 2007/8 was 105.1 per 100,000 of the population. This is a big drop from the previous years which had a rate of around 140 per 100,000. Therefore for 2007/08 the Rotherham revascularisation rate is below regional and national rates of 129 and 136 per 100,000 population. 160 revascularisations were carried out in 2008/09 in persons 65 and over, which equates to a rate of 413.9 per 100,000 of population in this age group<sup>59</sup>.

The CHD National Service Framework recognises the importance of cardiac rehabilitation services in reducing mortality and morbidity and set a goal that in every hospital over 85% of people diagnosed with a primary diagnosis of heart attack or after cardiac revascularisation should be offered cardiac rehabilitation. The 2008 National Audit of Cardiac Rehabilitation reports that only 43% of people who suffer a heart attack in England are accessing treatment,

with major regional variations.

The report also reveals no cardiac rehabilitation programme meets minimum staffing levels set out for the NHS. Also, rehabilitation is also only routinely offered to 3 of the many diagnostic groups that could benefit and therefore only reaches a small proportion of the people who need to attend<sup>60</sup>.

## Burden of Ill Health

### 4.3.3 Hypertension

The APHO hypertension prevalence model estimates that 25.5% of the Rotherham population has hypertension compared with 24.2% in England. It is estimated that 10.2% of the Rotherham population is currently receiving treatment for hypertension compared with 9.8% nationally, which equates to 42% and 41.2% of hypertensives respectively. The model estimates that 18.9% of the hypertensives receiving treatment in Rotherham have the condition controlled compared to 18.6% nationally<sup>61</sup>.

38,666 patients on Rotherham GP registers were diagnosed with hypertension in March 2010, 32 compared with the expected prevalence of 65,027<sup>61</sup>. This equates to 15.2% of the population or 59.5% of expected prevalence. This indicates that NHS Rotherham is better at case finding than the prevalence model predicts.

## Burden of Ill Health

### 4.3.4 Stroke

Every year approximately 110,000 people in England have a stroke. It is the third largest cause of death in England. 25% of strokes occur in people who are under the age of 65. There are over 900,000 people living in England who have had a stroke and it is the single largest cause of adult disability. 300,000 people in England live with moderate to severe disability as a result of stroke<sup>62</sup>.

In March 2010 there were 5,474 patients on Rotherham GP registers with stroke and TIA. This is very close to the estimated prevalence of 5,420<sup>63</sup>. The average recorded incidence of stroke is approximately 530/year and of TIA approximately 150/year. This compares with estimated rates of 550 and 260 respectively, suggesting that TIAs may be under-diagnosed<sup>63</sup>. The National Stroke Strategy reports that too few people understand what a stroke is or that it needs to be treated as medical emergency when the symptoms occur. The strategy suggests that this is a likely reason for the discrepancy between actual and predicted incidence<sup>64</sup>.

It is estimated that 1,550 people in Rotherham have moderate or severe disability following a stroke and 201 deaths per year are due to stroke<sup>63</sup>. POPPI predicts that 986 people aged over 65 in Rotherham in 2010 had a long-standing health condition caused by stroke, and that this will have risen to 1,504 by 2030<sup>65</sup>. This represents a 53% increase.

PANSI estimates that in Rotherham 60 males and 99 females of working age require help with daily activities due to stroke. PANSI predicts these numbers will increase to 67 males and 108 females by 2025, an increase of 12% and 9% respectively<sup>27</sup>. Local data sources do not record actual numbers of people receiving assistance with daily living due to particular conditions, so it is currently hard to test how accurate these estimates are. Although the number of females disabled by stroke remains significantly higher than the number of males, the predicted increases in Rotherham follow the predicted national

pattern of higher increases in the number of males. Overall the predicted rate of increase is lower in Rotherham than the national average of 16% for males and 12% for females<sup>27</sup>.

More women who have strokes die from them compared with men. However, stroke is more common in men compared with women by the age of 75. People who are economically disadvantaged have a higher rate of stroke. People of African or Caribbean ethnicity are at higher risk of having a stroke, whilst people of South Asian origin are less likely to have hypertension managed. Incidence rates, adjusted for age and sex, are twice as high in black people as for white people. People who are overweight or obese, and who also suffer from hypertension, have a higher risk of stroke. Targeting prevention work at these groups is likely to yield significant results<sup>64</sup>.

In Rotherham between 2005-06 and 2009-10 2.6% of hospital

<sup>62</sup> Department of Health (2007), *National Stroke Strategy*, p31

<sup>63</sup> Department of Health (2007), *ASSET2 for Commissioners*

<sup>64</sup> Department of Health (2007), *National Stroke Strategy*

## Burden of Ill Health

### 4.3.4 Stroke

admissions for stroke were from the BME community (i.e. non-White British) although for about 7% ethnicity was not stated. People of Pakistani origin accounted for 0.8% of hospital admissions and data suggests that stroke is a significantly greater issue for BME groups than the general population<sup>6</sup>. Stroke is primarily a condition that affects older people and the low proportion of BME strokes in Rotherham reflects the younger age structure of the BME community. Stroke is likely to become a significant issue as these populations get older<sup>6</sup>.

Rotherham has a higher rate of emergency episodes for stroke for both males and females than the regional and national rates. In 2006-7 there were 115.4 episodes in Rotherham per 100,000 of the population compared with 97.4 regionally and 99.4 nationally<sup>58</sup>.

The Asset 2 model indicates that in 2007-08 67% of 382 acute hospital admissions due to stroke returned to their usual place of

residence. This is significantly higher than the national average of 52% and rates in the 90th to 95th centile nationally. 12% of stroke survivors were discharged to care homes or another hospital, significantly lower than the national average of 21%. Average length of stay was higher than the national average at 20.5 days compared with 18.1 days for people discharged to their usual place of residence, but lower at 28.2 days compared with 32.0 days for those discharged to residential care or another hospital. The high lengths of stay suggest a lack of early supported discharge services/community based rehabilitation, although they may contribute to the success in returning people to their usual place of residence. The model also highlights the lack of community based services in Rotherham for stroke survivors such as dysphasia or family and carer support services<sup>63</sup>.

## Burden of Ill Health

### 4.3.5 Impact on services

#### Rotherham resident hospital admissions 2009/10

- 3,169 (8%) non-elective admissions are due to cardiovascular illness<sup>66</sup>
- 5143 (9%) attendances at A&E (20% of attendances by people 65+)<sup>41</sup>
- 2,107 (5% ) elective admissions are due to cardiovascular illness<sup>67</sup>
- Prescribing costs were £8,814,822<sup>68</sup>
- CVD prescribing costs constitute 23% of the total prescribing costs for the PCT<sup>69</sup>.
- Programme budget costs for CVD in 2007-8 were £29,409,000<sup>70</sup>

The ASSET2<sup>63</sup> model suggests the following preventive measures which would reduce the incidence of CVD and the likely number of strokes prevented per year by the following amounts in Rotherham:

- Managing all individuals with hypertension to below 140mmHg systolic BP - 47
- Warfarin for all patients with atrial fibrillation - 50
- Statins for all people with >20% risk CVD in 10 years - 22
- Smoking cessation for all patients who have suffered a stroke or TIA – 10

<sup>66</sup> NHS Rotherham (2008), *Unplanned Hospital Admission 2007-08 (spreadsheet)*

<sup>67</sup> NHS Rotherham (2008), *All Elective Admissions 2007-08 (spreadsheet)*

<sup>68</sup> NHS Rotherham (2008), *Prescribing Costs CVD*

<sup>69</sup> NHS Rotherham (2008), *Total Prescribing Costs 2007-08*

<sup>70</sup> NHS Rotherham (2008), *Programme budget costs 2007-08*

## Burden of Ill Health

### 4.3.6 NHS Health Check in Rotherham

NHS Rotherham runs the national Health Check initiative across its GP practices. The purpose of the NHS Health Check is to identify an individual's risk of cardiovascular disease, for this risk to be communicated in a way that the individual understands, and for that risk to be managed by appropriate lifestyle advice, referral and clinical follow-up. As at December 2010 approximately 28% of the eligible population had been screened to identify risk of cardiovascular disease. Patients with a greater than 20% risk score are reviewed further for lifestyle intervention. In this group, 71% of patients are overweight or obese and 31% are current smokers.

## Burden of Ill Health

### 4.4.1 Cancer - Mortality

Cancer is one of the biggest killers in England – 1 in 3 people will be diagnosed with cancer in their lifetime and it is the cause of 1 in 4 deaths<sup>71</sup>. In 2008 there were approximately 128,800 cancer deaths equating to 172.2 deaths per 100,000 of the population<sup>72</sup>.

During the 1980s and 1990s the UK had one of the poorest cancer survival rates in Western Europe and patients often waited long periods for diagnosis and treatment. This led to the introduction of government targets to reduce mortality rates from cancer overall and within areas of deprivation<sup>73</sup>.

Between 1996 and 2008 cancer mortality in people under 75 fell by over 13%<sup>72</sup>. Since the implementation of the NHS Cancer Plan in 2000, there has been a significant fall in smoking rates, improved screening and faster diagnosis/treatment, all contributing to significant

progress on mortality rates<sup>74</sup>.

The Government target is to reduce cancer mortality in people under 75 by 20% by 2010 from the 1995/1997 rate (see figure 4.21)<sup>75</sup>. Considerable progress has been made towards this target and the latest data for 2006-08 shows a 19.3% fall in rates since 1995/97<sup>76</sup>. Survival rates for some cancers, such as colorectal and breast cancer, are improving year on year in line with other European countries<sup>77</sup>. In 2006 the UK ranked 9th out of 28 European countries for male cancer mortality (where first has lowest rate) and 22nd out of 28 for female mortality. The higher comparative mortality rate for females reflects higher smoking prevalence in the 1980s and 1990s compared with other European countries<sup>77</sup>.

In 2006, cancer accounted for 29% of all deaths in males and 25% in females<sup>72</sup>. Mortality rates

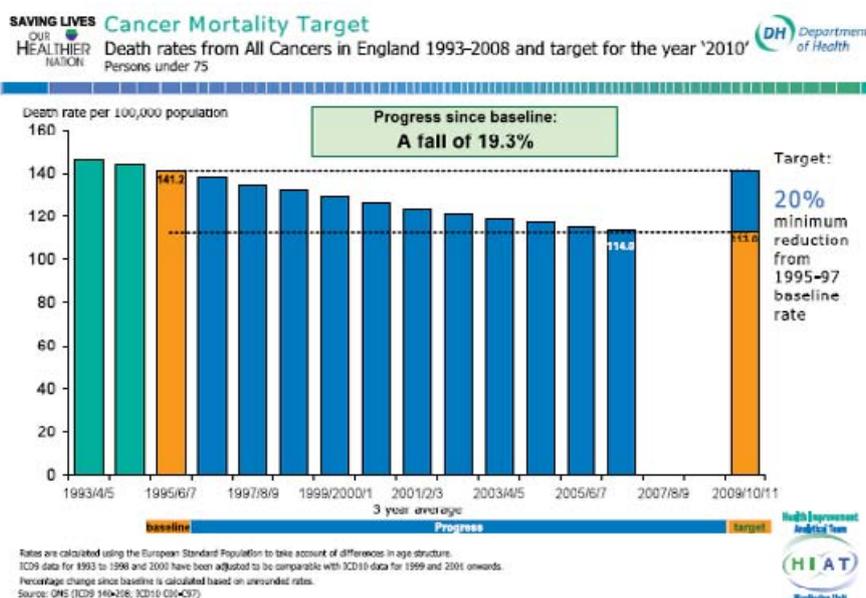
are higher for men than women although differences in mortality rates are not fully understood<sup>72</sup>. In some cases such as lung and oesophageal cancer, it may be due to high levels of smoking prevalence, later presentation, unidentified risk factors or biological predispositions<sup>78</sup>.

In 2008 Rotherham had an all age cancer mortality rate of 202.1 per 100,000. This is higher than the regional rate of 181.3 and England rate of 172.2<sup>72</sup>. The under 75 cancer mortality rate for Rotherham residents in 2006-08 was 131.5. This is above the national rate of 114.0. The rate of reduction in cancer mortality for people under 75 decreased faster than the national and regional averages between 2002 and 2006. This is mainly due to larger than average decreases in the female mortality rate (Figure 4.22)<sup>79</sup>.

Vital Sign VSB03 measures the

**Figure 4.21: Cancer mortality (persons under 75) from all cancers in England, 1993-2007**

Source: Department of Health, Cancer Reform Strategy – Achieving local implementation, Second Annual Report



71 UK Statistics Agency (2008)

72 NHS Information Centre (2009), Compendium of Clinical and Health Indicators, Mortality from all cancers

73 Department of Health (2007), Cancer Reform Strategy, p17

74 Department of Health (2007), Cancer Reform Strategy, p17-18

75 Department of Health (2008), Cancer Reform Strategy – First Annual Report 2008, p6

76 Department of Health (2009), Cancer Reform Strategy. Achieving Local Implementation Second Annual Report

77 Department of Health (2008), Cancer Reform Strategy – First Annual Report 2008, p18

78 Department of Health (2008), Cancer Reform Strategy – First Annual Report 2008, p90

79 Health Care Commission (2008), Data Set for the 2007-08 New National Targets

## Burden of Ill Health

### 4.4.1 Cancer - Mortality

age standardised mortality rate for all cancers for people under the age of 75 against the planned target for reducing mortality<sup>80</sup>. The most up-to-date performance report (2007-8) shows that NHS Rotherham has achieved its planned reductions in cancer mortality for the last 3 years. However, the data also shows that cancer death rates increased in 2006 and 2007 and NHS Rotherham may be struggling to reach their current target<sup>79</sup>.

Comparative data for 2003-5 suggests that Rotherham has

particularly high mortality rates for stomach cancer and cervical cancer when compared nationally, although they are comparable regionally<sup>58</sup>. Data from the Trent Cancer Registry does not indicate any significant statistical differences in age standardised cancer mortality rates for Rotherham, in comparison with other PCTs in the cancer network, between 2002-6 for any of the top 10 cancer sites<sup>81</sup>.

In 2006-08 there were 381 early deaths from cancer in Rotherham. This is a rate of 132 per 100,000,

significantly worse than the England average and in the worst quartile of regional local authorities.

Figure 4.22a: National, Regional and Rotherham age-standardised mortality rates for all cancers, all persons aged under 75, 2004-2008

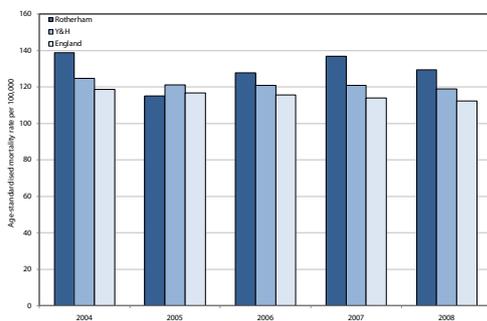
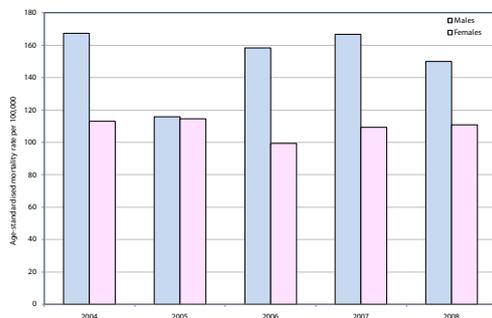


Figure 4.22b: Rotherham age-standardised mortality rates for under 75's, all cancers by sex, 2004-2008



80 Health Care Commission (2008), *New National Target Indicators for Primary Care Trusts 2007-08*

81 Trent Cancer Registry(2008), *Cancer Fact Sheet for Rotherham PCT*

## Burden of Ill Health

### 4.4.2 Cancer - Incidence

In 2007 there were 297,991 new cases of cancer in the UK, equating to an age standardised rate of 377 per 100,000 of the population<sup>82</sup>. The increase in the incidence between 2005 and 2006 for both males and females was less than 1%.

The incidence of new cases was higher in men at 409 per 100,000 compared to 357 per 100,000 in women. In the UK in 2007 the 3 most common sites for new cancer types in males were prostate, lung and colorectal and for females, breast, colorectal and lung<sup>83</sup>. Figure 4.23 shows the UK prevalence rates of the most common cancer types in 2007<sup>83</sup>.

Cancer incidence in Rotherham follows the national pattern for the most common cancer sites, but there are some significant

variations when compared regionally. Figure 4.24 shows the age standardised incidence rates for the most prevalent cancer sites in Rotherham for 2003-7 compared with the North Trent Cancer Network. The most significant exceptions to the regional averages are the lower rate of prostate cancer in Rotherham and the higher rate of bladder cancer in men<sup>84</sup>.

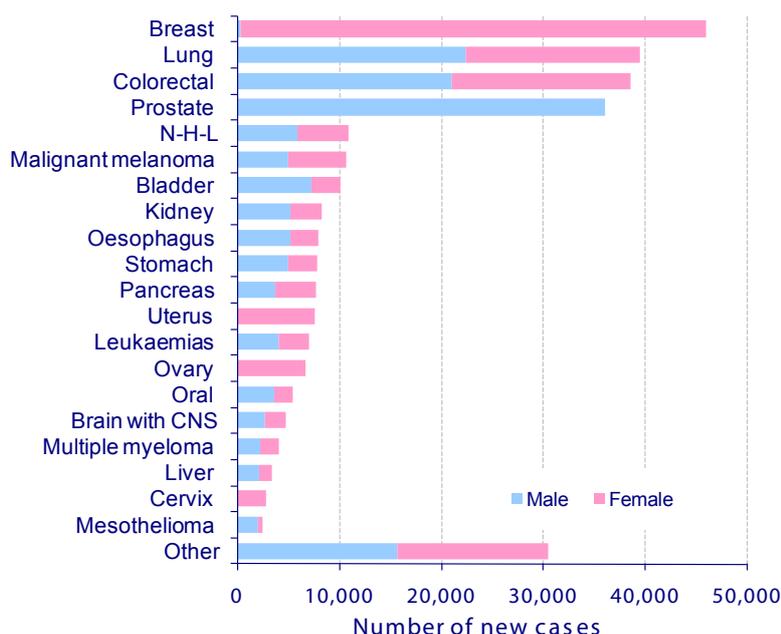
Approximately 1 in 10 cases of cancer occur in people aged 25–49 years. Breast cancer is the most common cancer in this age group accounting for over 30% of all cancers. Malignant melanoma, bowel, testicular and cervical cancers are the next most likely. There are almost twice as many females diagnosed with cancer than males in the 25–49 year group, while in the over 65s

the number of diagnoses is higher in males even though the female population is much larger<sup>84</sup>.

Cancer occurs predominantly in older people. Around two thirds of cancer deaths occur in people aged 65+ and more than one third (36%) in people 75+. Less than 1% of all newly diagnosed cases (0.5%) occur in children under 15, 1,400 new cases in 2004. The risk of a child in the UK being diagnosed with cancer under age 15 is approximately 1 in 500. Leukaemia is the most common form of childhood cancer, responsible for nearly one third of all cases, and tumours of the brain or central nervous system account for approximately one quarter.

Figure 4.23: The 20 most commonly diagnosed cancers (excluding non-melanoma skin cancer), UK 2007

Source: Source: Cancer Research UK – Cancer Stats Key Facts



82 NHS Information Centre for health and social care (2009), Incidence for all cancers 2006

83 UK Statistics Agency

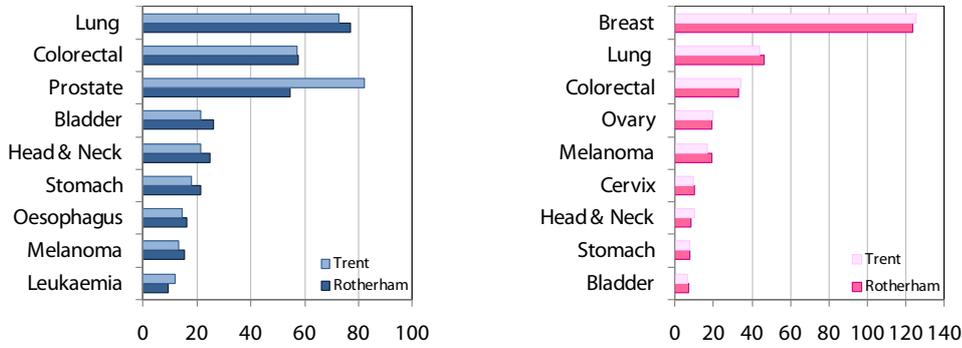
84 Cancer Research UK – Cancer Stats Key Facts

# Burden of Ill Health

## 4.4.2 Cancer - Incidence

Figure 4.24: Comparison of cancer incidence by site between Rotherham and North Trent Cancer Network for males and females, 2003-07

Source: Trent Cancer Registry (2010) Cancer Data. Local incidence, mortality and survival data by cancer site



## Burden of Ill Health

### 4.4.3 Cancer - Inequalities

Cancer incidence varies according to socioeconomic group. This is probably the result of environmental and lifestyle factors, differences in access to health care and health seeking behaviour. Evidence indicates that incidence of lung and cervical cancer is highest in patients from deprived backgrounds, whereas the opposite is true for malignant melanoma and breast cancer. The difference in incidence rates between the most and least deprived groups was higher for lung cancer patients aged under 65<sup>85</sup>.

The higher incidence of breast cancer in women from higher socioeconomic groups could be connected to increased likelihood of having a first child at a later age, having fewer children and increased take-up of hormone replacement therapy. Breast

cancer in post menopausal women is linked with obesity with the association particularly strong for women in more deprived areas<sup>85</sup>.

People in deprived areas, older people (particularly for breast cancer) and those from ethnic minority groups are more likely to delay seeking help. There is evidence that awareness of risk factors associated with cancer is particularly low in deprived groups<sup>85</sup>.

Incidence of cancer varies between different ethnic groups. Compared to the general population, prostate cancer incidence is higher in African Caribbean men. Mouth cancer has a higher incidence in the South Asian community and liver cancer is higher in the Bangladesh and Chinese communities.

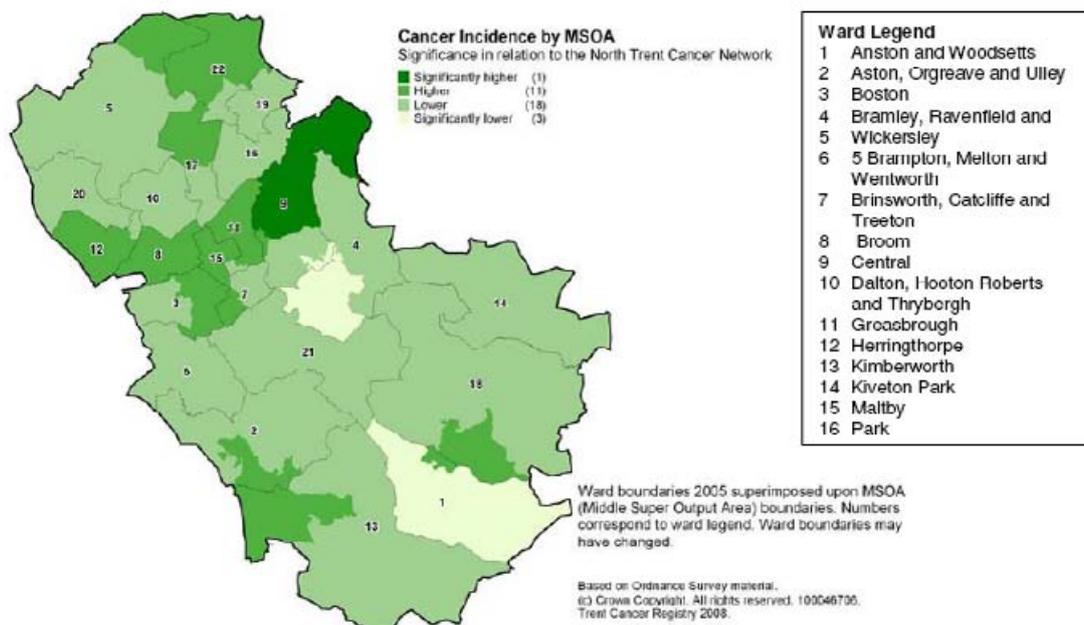
Some differences are due to lifestyle factors and exposure to infections. Others may be due to genetic factors<sup>85</sup>.

People with learning disabilities have the same overall risk of cancer as the general population, but a higher risk of some cancers such as gall bladder, thyroid and leukaemia. There is a lower risk of prostate, lung and urinary tract cancers<sup>85</sup>.

38% of lung cancer cases in women and 28% of cervical cancer cases. Incidence of breast cancer and melanoma was highest in the least deprived group. If all socioeconomic groups had incidence rates similar to the least deprived group it is estimated that the number of cases would increase by 7% for breast cancer, 27% for melanoma in men and

**Figure 4.25: Incidence of All Cancer in NHS Rotherham: by ward 2002-06**

Source: Source: Cancer Research UK – Cancer Stats Key Facts



<sup>85</sup> BMC Cancer (2008), variation in incidence of breast, lung and cervical cancer and malignant melanoma of skin by socioeconomic group in England

## Burden of Ill Health

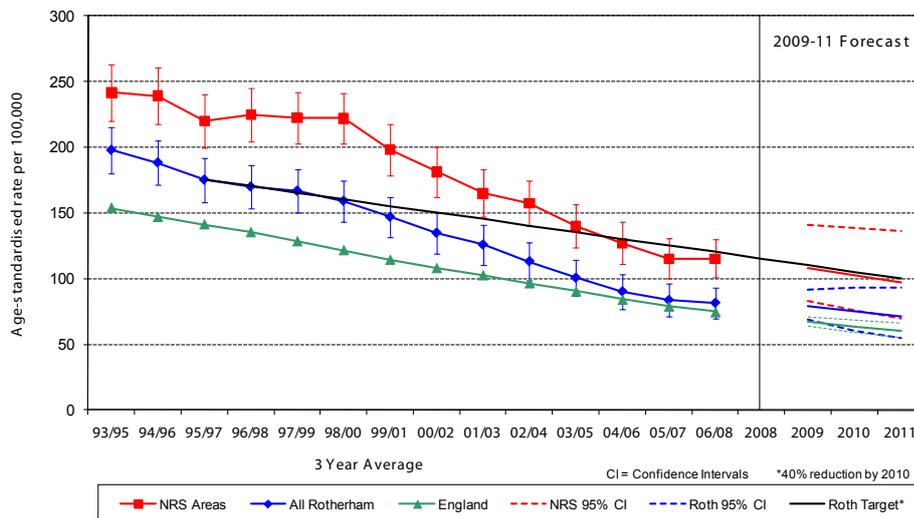
### 4.4.3 Cancer - Inequalities

29% for melanoma in women<sup>85</sup>.

Figure 4.25 shows that in Rotherham people in more affluent areas are almost as likely as those in more deprived areas to contract cancer. However they are less likely to die from cancer<sup>81</sup>. This is partly due to the fact that there are higher incidences of lung cancer in areas of deprivation, for which mortality rates are higher. Breast cancer, which is more common in affluent areas, has a lower mortality rate. Cancer mortality rates in Rotherham NRS areas are decreasing faster than the national average which indicates that targeted interventions are proving successful (see Figure 4.26)<sup>15</sup>.

**Figure 4.26: Malignant Cancer Mortality Rates 1993/1995-2006/08: Neighbourhood Renewal Strategy Areas Compared with Rotherham and England (+ 95% CIs)**

Source: NHS Rotherham (2007), Director of Public Health Annual Report 2006-07



## Burden of Ill Health

### 4.4.4 Cancer - Prevention

Over half of all cancers could be prevented by changes to lifestyle. Improving awareness and encouraging people to adopt healthy lifestyles is therefore a key factor in improving cancer outcomes.

Smoking is the single largest preventable risk factor, being a factor in a third of all cancer deaths and up to 90% of lung cancer cases. Differences in smoking rates between the most and least affluent groups account for around half of the inequalities gap in cancer mortality. Much of the improvement in cancer death rates can be attributed to reductions in smoking amongst adults. There is evidence that, since smoke free legislation was introduced in Scotland in March 2006, there has been a dramatic improvement in air quality in pubs, no increase in smoking in the home and

reduced tobacco consumption, particularly in disadvantaged communities. Smoking rates remain comparatively high in routine and manual workers, the North of England and in some very deprived groups.

Obesity increases the risk of many cancers including those of the uterus, kidney, gallbladder, colon and oesophagus. There is evidence that obesity is associated with breast cancer in post menopausal women. Obesity is now the most significant cancer risk factor besides smoking. There is evidence that for middle aged and older women in the UK, around 5% of cancers (6,000 per annum) are caused by being overweight or obese and 66% of these were cancers of the breast or womb.

Excess alcohol consumption is linked to the development of

several cancers, particularly the mouth, larynx, oesophagus, liver and breast. This risk is further increased when combined with smoking.

Melanoma is one of the fastest growing types of cancer, and although it is more common in women, the death rate is higher amongst men at 3.1 per 100,000 compared with 2.0 amongst women (2006-08 data). A particular concern is the use of cosmetic tanning salons with risks of excessive exposure amongst young people and lack of adequate health information provided to customers about health risks.

## Burden of Ill Health

### 4.4.5 Cancer - Treatment and survival

Evidence suggests that late diagnosis of cancer has been a major factor in the poorer survival rates in the UK compared with other countries in Europe. The Cancer Reform Strategy states that improving access to diagnostics was the single most important priority in primary care to improve outcomes in cancer treatment. There has been a significant improvement in diagnostics in recent years. In 2005, the DH set out milestones for the NHS to reduce waits for diagnostic tests to a maximum of 13 weeks by March 2007 and to 6 weeks by March 2008.

NHS Rotherham met the national target of having less than 2% of cases waiting more than 6 weeks for diagnostic tests by March 2008 with only 1.1% having to wait longer<sup>79</sup>. NHS Rotherham also significantly exceeded the national

targets for breast screening in 2007-8, with 83.4% (nat. target 70%) of women aged 53-64 being screened and 78.5% (nat. target 55%) aged 65-70. NHS Rotherham also met all the national targets in 2007/08 on waiting times between referral and diagnosis/treatment and on improving cancer services<sup>88</sup>.

The Radiotherapy Advisory Group suggests that demand is likely to grow over the next 10 years for radiotherapy services. On average 30,000 fractions are currently delivered per million population and it is anticipated that this will grow to 54,000 by 2016, requiring more staff and equipment, particularly if new Government targets are to be achieved<sup>87</sup>.

Nationally, there is a wide variation in radiotherapy activity, which cannot be explained by need

alone. The number of fractions delivered varies from between 17,000 and 48,000 per million population<sup>89</sup>. There is some evidence to show that older people are likely to receive less intensive treatment than younger people e.g. older women may not be offered radiotherapy for breast cancer. Also older people are less likely to be offered radical treatment for lung cancer and there is low screening uptake for people with learning disabilities<sup>90</sup>.

1 and 5 year survival rates for breast, colon, rectum and prostate cancer have shown big improvements since the publication of the Cancer Plan. The 5 year survival for breast cancer has risen from 80.6% in 2000 to 86.0% in 2007. For colon cancer the figures for men are 47.6% to 53.4% and for women 47.6% to 52.7%<sup>76</sup>.

<sup>87</sup> Department of Health (2007), *Cancer Reform Strategy*

<sup>88</sup> Health Care Commission (2008), *Data Set for 2007-08 Existing National Targets*

<sup>89</sup> Department of Health (2007), *Cancer Reform Strategy*, p60

<sup>90</sup> Department of Health (2007), *Cancer Reform Strategy*, p89-91

## Burden of Ill Health

### 4.4.6 Cancer - Trends

Nationally it is projected that there will be about 262,000 new cancer cases in 2011 and 283,000 in 2016. This represents increases of around 8% and 16% since 2006. For many types of cancer the projected increase to 2016 exceed 20%. However, the number of lung cancer and stomach cancer cases will remain broadly stable and the number of cases of cervical cancer is predicted to fall<sup>91</sup>.

Table 4.1 shows the predicted national increases in different types of cancer<sup>91</sup>. Figures 4.27 and 4.28 show how these trends will affect cancer incidence in Rotherham<sup>91</sup>.

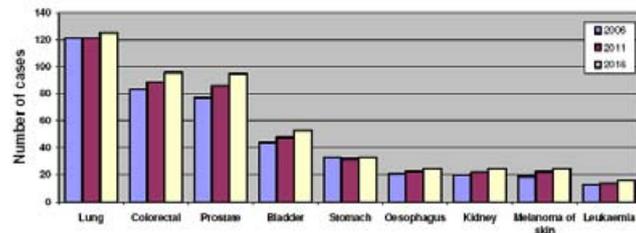
**Table 4.1: Predicted increase/decrease in incidence of the 10 key cancer sites for males and females nationally, 2006-2016**

Source: National Radiotherapy Advisory Group (2007), *Radiotherapy: Developing a World Class Service for England*, p13

Site description	Incidence 2006	Incidence 2011	% increase 2006-11	Incidence 2016	% increase 2006-2016
Bladder	9,605	10,468	9	11,551	20
Breast	44,074	48,671	10	52,878	20
Cervix	2,169	2,055	-5	2,045	-6
Colorectal	30,032	32,048	7	34,514	15
Kidney	5,277	5,909	12	6,488	23
Leukaemia	5,900	6,441	9	7,065	20
Lung	29,456	29,462	0	30,321	3
Melanoma of skin	7,484	8,823	18	9,893	32
NHL	9,152	10,381	13	11,537	26
Oesophagus	6,655	7,325	10	8,037	21
Ovary	5,946	6,284	6	6,620	11
Pancreas	6,162	6,592	7	7,176	16
Prostate	26,778	29,625	11	33,026	23
Stomach	6,814	6,678	-2	6,896	1

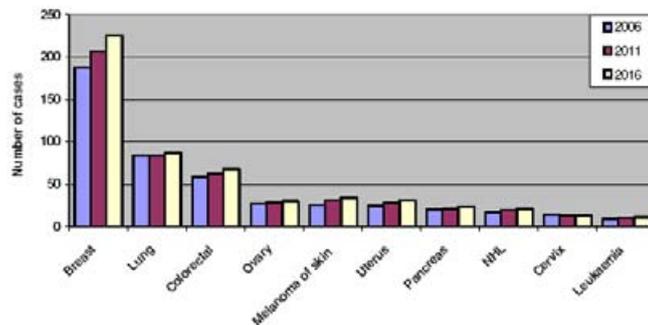
**Figure 4.27: Predicted increase in case numbers for top 10 cancer sites for Rotherham males 2006-2016**

Source: National Radiotherapy Advisory Group (2007), *Radiotherapy: Developing a World Class Service for England*, p13 and Trent Cancer Registry (2008) *Cancer Fact Sheet for Rotherham PCT*



**Figure 4.28: Predicted increase in case numbers for top 10 cancer sites for Rotherham females 2006-2016**

Source: National Radiotherapy Advisory Group (2007), *Radiotherapy: Developing a World Class Service for England*, p13 and Trent Cancer Registry (2008) *Cancer Fact Sheet for Rotherham PCT*



## Burden of Ill Health

### 4.4.7 Cancer - Costs

Expenditure on cancer care in England has risen by 27% over recent years and cancer is the third largest disease programme in the NHS behind mental health and circulatory diseases, costing the NHS £4.35 billion per year. Approximately 80% of this is spent on acute services (outpatients, diagnostics, treatment, and emergency care) and the other 20% is spent on community care (screening, GP consultations and palliative care). This estimate does not include preventative services, pre-diagnosis assessment and diagnostics and palliative care provided by the voluntary sector<sup>92</sup>. Expenditure per head of population is £80 compared with £121 in France and £143 in Germany. Figure 4.29 provides a breakdown of spend on cancer nationally.

Inpatient care for patients diagnosed with cancer accounts for around twelve percent of all inpatient bed days in England.

Cancer patients account for approximately 5.3 million bed days/year. This equates to approximately 14,550 cancer patients being in a hospital bed on any one day<sup>93</sup>.

From 2000-2008 inpatient admissions for cancer nationally have risen by 25% from 625,000 to 785,000 per annum. Bed days are rising by 1% each year. Much of the increase relates to emergency inpatient episodes, which have increased by 47% as opposed to elective inpatient episodes which have only increased by 8.6%. Over the same time period elective day case episodes have risen by 50% (from around 520,000 per annum to around 780,000 per annum)<sup>94</sup>.

Cancer incidence in England is projected to increase by 25% over the next 15 years, mostly due to the anticipated effects of population growth and ageing. Given the projected increase in the incidence of cancer within the population,

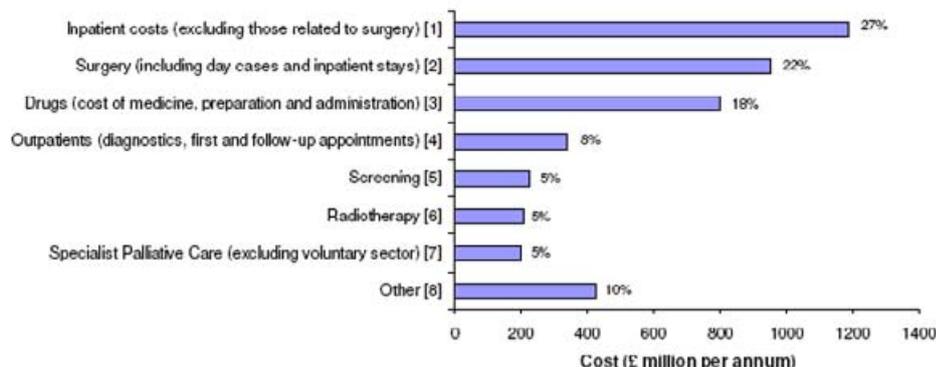
bed utilisation for cancer is likely to increase rapidly unless action is taken. Department of Health analysis suggests that, unless actions are taken to reduce lengths of stays and avoidable admissions, inpatient costs for cancer are expected to increase by 24% in the same period. The increase will differentially affect certain groups. For example, inpatient costs for the over 70s are expected to increase by 37% compared to 13% for the under 70s<sup>94</sup>.

To maintain inpatient costs at current levels, it is estimated that average length of stay would need to reduce by a third. Alternatively emergency admissions would need to reduce to 50% of current levels<sup>94</sup>.

The programme budget cost for NHS Rotherham for all cancers and tumours in 2007-8 was £23,722,000.

**Figure 4.29: Estimated Total NHS Spend on Cancer Care 2005-6**

Source: Department of Health (2007), *Cancer Reform Strategy*, p119



<sup>92</sup> Department of Health (2007), *Cancer Reform Strategy*, p118-120

<sup>93</sup> Department of Health (2007), *Cancer Reform Strategy*, p96

<sup>94</sup> Department of Health (2007), *Cancer Reform Strategy*, p97

## Burden of Ill Health

### 4.5 Chronic Obstructive Pulmonary Disease (COPD)

COPD is a chronic condition, which is usually symptomatic from middle age. 18% of male smokers and 14% of female smokers in the UK have COPD. It is a significant reason for hospital admissions and lost working days<sup>95</sup>. It is currently the 5th leading cause of death in the UK, with over 30,000 people dying each year from end stages of the disease. The direct cost to the NHS of COPD is almost £500 million per year and the estimated annual cost of treating a patient with severe COPD is £1,307<sup>96</sup>.

A recent American Lung Association survey revealed that 51% of all COPD patients say that their condition limits their ability to work. 70% are limited in normal physical exertion, 56% in household chores, 53% in social activities, 50% in sleeping and 46% in family activities<sup>95</sup>. Although the level of COPD in males appears to have peaked in the UK, it continues to rise in females. The cumulative effect of an ageing population and the higher smoking levels amongst women is likely to increase the present burden of COPD in the UK<sup>96</sup>.

In Rotherham 121 people died from COPD in 2008, which equates to an age standardised mortality rate of 28.7 deaths per

100,000 of the population. This was higher than the national rate of 27.2 but less than the regional rate of 31.1. Mortality rates are higher in men than women<sup>97</sup>.

There were 5,821 patients on Rotherham GP registers with COPD in July 2010. This is below the predicted prevalence of 7,355<sup>99</sup>. This indicates significant levels of under-reporting. The British Lung Foundation reports that there may be as many as 3.7 million people with the disease in the UK compared with the 900,000 on GP registers<sup>96</sup>. According to QOF data the recorded prevalence is 1.5% in England in 2008/09<sup>100</sup>, compared with an expected prevalence of 3.6% in adults over 16 years<sup>99</sup>.

In 2009/10 there were 1,509 hospital admissions from Rotherham registered patients. Of these 1,127 were emergency admissions. These figures equate to 4.2 and 3.1 per 1,000 patients<sup>101</sup>. Examination of data on hospital admissions for Rotherham from 2002-06 shows an increase in COPD admissions for BME groups. Hospital admissions from BME groups for COPD rose by 42% from 2002-06. The standardised admission ratio for BME groups in Rotherham was

113.2 (Rotherham = 100). For the Pakistani community this rises to 182.2 demonstrating that COPD is a significant risk for this group<sup>6</sup>.

The Disease Management Information Toolkit (DMIT)<sup>102</sup> indicates that the number of emergency bed days used in Rotherham was 118 per 100 people on the QOF COPD (2006-07). NHS Rotherham was ranked 96 out of 152 PCTs, which suggests Rotherham performs fairly poorly against other PCTs. The hospital admission rate in Rotherham was 15.8 per 100 people on the disease register, which is above the national average of 13.6. The average length of hospital stay in Rotherham was 7.7 days, slightly below the national average of 7.9 days. Rates of admission increased by 3.8% over the previous year compared with a national average decrease of -0.4%. DMIT estimates that a reduction in Rotherham's admission rate to the national average would save £213,367/year. The number of emergency bed days and length of stay are decreasing but at a rate that is 3-4% less than the national average.

95 DWP (2008), *Prevalence of COPD*

96 British Lung Foundation (2007), *Invisible Lives – COPD Finding the Missing Millions*

97 NHS Information Centre (2009), *Mortality from bronchitis, emphysema and other chronic obstructive pulmonary disease* ([www.nchod.nhs.uk](http://www.nchod.nhs.uk))

98 Quality and Outcomes Framework (2010) *COPD register size* ([www.qmas.nhs.uk](http://www.qmas.nhs.uk))

99 Eastern Region Public Health Observatory (2008) *Modelled estimated and projections of COPD for local authorities in England* (<http://www.erpho.org.uk/ViewResource.aspx?id=18024>)

100 NHS Information Centre, *QOF Disease Prevalence 2008-09* ([www.ic.nhs.uk](http://www.ic.nhs.uk))

101 Hospital Episode Statistics, *Inpatient Minimum Data Sets via Secondary Uses Services (SUS)* (2010)

102 Department of Health (2008), *Disease Management Information Toolkit*

## Burden of Ill Health

### 4.6.1 Infectious Diseases - Tuberculosis

Tuberculosis is the world's leading cause of death by a curable infectious disease. About 9 million new cases and 2 million deaths are estimated to occur around the world every year. Around 9,000 cases of TB are currently reported each year in the United Kingdom. Most cases occur in major cities, particularly in London<sup>103</sup>.

In 2009 in the UK, 9,153 TB cases were provisionally reported to enhanced national surveillance, a rate of 14.9 per 100,000 population. This represents a 5.5% increase compared with the number of cases provisionally reported in 2008.

In England, London continues to account for the largest proportion of cases reported (41%), followed by the West Midlands (12.3%). A rise in cases was seen in eight out of nine regions, with only the North East showing a decrease (-2%). 73% of cases were in persons who were born outside the UK, of whom the majority were from South Asia (55%) and sub-Saharan Africa (30%). Only

21% of non-UK born cases were diagnosed within two years of entering the UK. Individuals aged 15-44 years accounted for 60% of reported cases; 21% were 45-64 years old, 15% were 65 years and over and 5% of cases were aged under 15 years. Overall, 55% of cases were male, though females made up 54% of cases aged less than 15 years. 53% of cases were reported to have pulmonary disease. Of these, 57% had a reported smear result, of which 57% were sputum-smear positive<sup>104</sup>.

One of the biggest issues relating to tuberculosis treatment is the increase in drug resistant strains of the disease. Levels of drug resistance remain stable and resistance is more common amongst younger people and those born outside the UK.

In Rotherham there were 16 new cases of tuberculosis diagnosed in 2006-08 which equates to 6.0 cases per 100,000 of the population<sup>105</sup>.

<sup>103</sup> Tuberculosis, Health Protection Agency (2010)

<sup>104</sup> Tuberculosis Update, Health Protection Agency (2010)

<sup>105</sup> Table 2a, Three year average tuberculosis case reports and rates by Primary Care Trust, England 2006-2008. TB Tables and Figures

## Burden of Ill Health

### 4.6.2.1 Sexually Transmitted Infections & HIV - Overview

15 to 24 year olds, continue to be the group most affected by sexually transmitted infections (STIs) in the UK. Recent figures suggest a significant increase in the number of adults of working age who are also being affected by STI's. Further, evidence suggests that a high number of women from BME communities who migrate to the UK are also at risk.

In 2009 a total of 482,696 new STI diagnoses were reported to the agency from sexual health clinics across the UK and community based Chlamydia testing. This is almost 12,000 more cases than were reported in 2008 when there were 470,701 new diagnoses, continuing the steady upward trend we have seen over the past decade as illustrated in figure 1.

Last year around two thirds of new STI diagnoses in women were in those under 25. In women, 73% (3,955 out of 5,434) of all new gonorrhoea diagnoses and 66% (27,626 out of 42,095) of all new genital warts were in the under 25s. Of all women diagnosed with Chlamydia 88% (112,334 out of 127,741) were under 25 – this is in

part due to more sensitive tests and community based testing targeting the under 25's in England.

In men, over half of new STI diagnoses were in those aged under 25. They accounted for 41% (4,683 out of 11,541) of male gonorrhoea diagnoses, 47% (22,972 out of 49,105) of male genital warts and 69% (58,170 out of 84,863) of male Chlamydia diagnoses. High rates of STI diagnoses have also been found among men who have sex with men.

The peak age for an STI in women is between 19 and 20 years and in men between 20 and 23 years. Of all the 15-24 year olds diagnosed with an STI last year around one in ten of these will become re-infected within a year<sup>106</sup>.

Sexually Transmitted Infections (STIs) are diseases that can be transmitted through unprotected sex. Sexual health problems are more prevalent in low-income groups and those that are hard to reach. The most vulnerable groups include; asylum seekers and refugees, sex workers and their clients, homeless people

and young people in or who are leaving care. Other high risk groups include gay men, some black and minority ethnic groups and young people.

The latest overall UK-wide figures show:

- Chlamydia diagnoses increased by 7% (from 203,773 in 2008 to 217,570 in 2009)
- Gonorrhoea diagnoses increased by 6% (from 16,451 in 2008 to 17,385 in 2009)
- Genital herpes diagnoses increased by 5% (from 28,807 in 2008 to 30,126 in 2009)
- Genital warts diagnoses stabilised decreasing by just 0.3% (from 91,503 in 2008 to 91,257 in 2009)
- Syphilis diagnoses also stabilised decreasing by just 1% (from 3,309 in 2008 to 3,273 in 2009)<sup>106</sup>

In 2009 Rotherham saw a higher rate of diagnoses for all of the major STIs, with the exception of gonorrhoea, than England. The rate of Chlamydia diagnoses in the 15-24 age group was particularly high for Rotherham compared to the national average

Figure 30: Number of new STI episodes seen at genitourinary medicine clinics by gender: 2000-2009  
Source: STI Epidemiology in 2009 (England). STI Annual Data Tables. [Online] 2010.

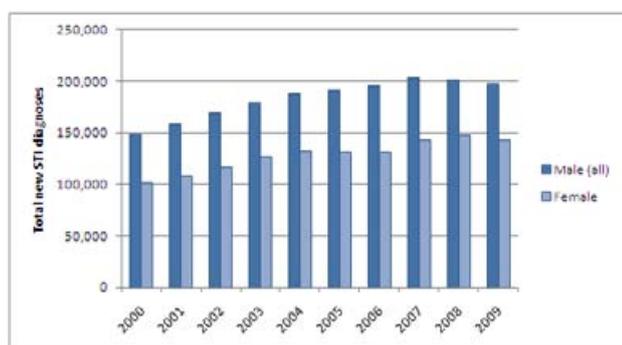
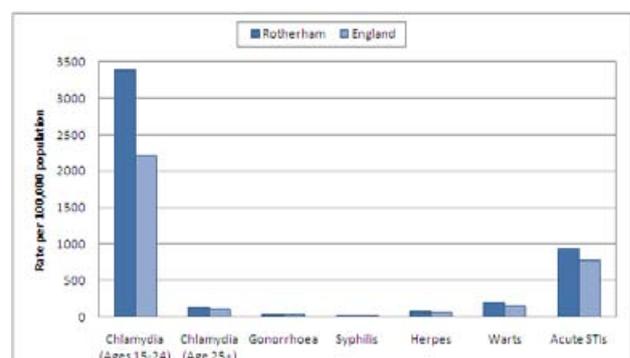


Figure 31: Rates of selected STI & acute STI diagnoses per 100,000 population for Rotherham and England (2009)  
Source: STI Epidemiology in 2009 (England). STI Annual Data Tables. [Online] 2010.



<sup>106</sup> Sexually transmitted infections reach almost half a million. Health Protection Agency. [Online] August 2010.

## Burden of Ill Health

### 4.6.2.2 Chlamydia

Genital Chlamydial infections were the most common form of STI diagnosed in GUM clinics in the UK in 2009. In Rotherham, the male group aged 20-24 has the highest number of diagnoses and lower numbers in the 16-19 and 35+ groups. There are higher numbers amongst younger women (16-19 and 20-24 year olds), with a sharp increase in these groups between 2006-07.

Approximately 50% men and 70% women with Chlamydia do not have any symptoms. If left untreated, genital Chlamydial infection can lead to pelvic inflammatory disease, ectopic pregnancy and infertility. Due to the high proportion of asymptomatic infection, the National Chlamydia Screening

Programme (NCSP) offers opportunistic screening for Chlamydia, with the aim of detecting asymptomatic infection in sexually active men and women under the age of 25 who would not otherwise access, or be offered a Chlamydia test. The Vital Signs Indicator, VSB13: Chlamydia Prevalence (Screening), measures the proportion of the 15-24 year old population tested for Chlamydia and for the first time will include screening that takes place outside GUM clinics. The Government has set a target for the 2008/09 period of screening 17% of the target population. In 2008/09 Rotherham achieved this target by screening 19.7% of the target population. In 2009/10 the percentage screened increased to 25.7%<sup>107</sup>.

Figure 32a: Numbers of diagnosis of uncomplicated genital chlamydial infection by sex (males) and age group in Rotherham (1995-2009)

Source: STI Epidemiology in 2009 (England). STI Annual Data Tables. [Online] 2010.

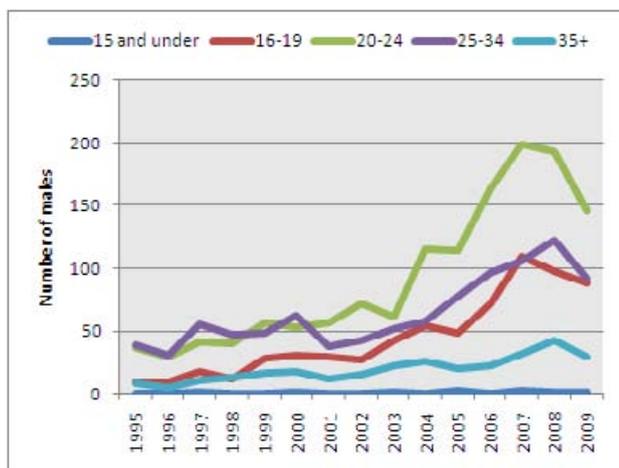
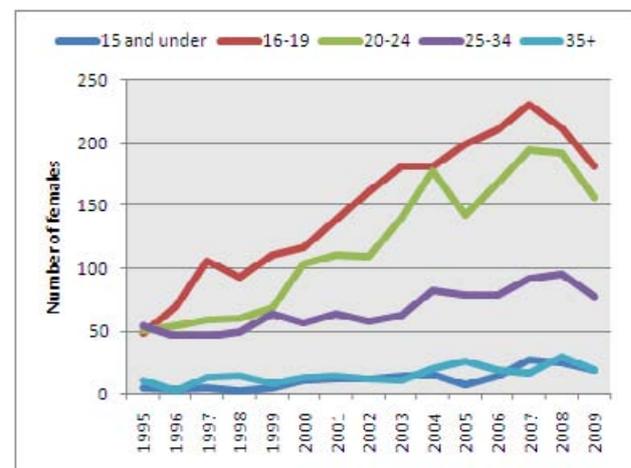


Figure 32b: Numbers of diagnosis of uncomplicated genital chlamydial infection by sex (females) and age group in Rotherham (1995-2009)

Source: STI Epidemiology in 2009 (England). STI Annual Data Tables. [Online] 2010.



## Burden of Ill Health

### 4.6.2.3 HIV

The number of people living with HIV in the UK continues to rise, with an estimated 83,000 infected at the end of 2008, of whom over a quarter (27%) were unaware of their infection. During 2008, there were 7,298 new diagnoses of HIV in the UK. This represents a slight decline on previous years, predominantly due to fewer diagnoses among black African women who acquired their infection abroad. New diagnoses among men who have sex with men remained high in 2008 and an estimated four out of every five acquired their infection in the UK.

New HIV diagnoses among those who acquired their infection heterosexually within the UK have risen, from an estimated 740 in 2004 to 1,130 in 2008.

The number of deaths among HIV-infected people has remained stable over the past decade and the number of AIDS diagnoses has continued to decline. A total of 525 people (387 men and 138 women) infected with HIV were reported to have died in 2008. Of these, 57% and 73% had been diagnosed with a CD4 cell count <200 and <350 per mm<sup>3</sup> within three months of diagnosis, respectively. This data highlights the importance of promoting testing to ensure earlier diagnosis and treatment<sup>108</sup>.

## Burden of Ill Health

### 4.7.1 Falls

Falls represent a significant cause of health problems particularly fractures and are a particular concern in individuals aged 55 and over. The number of admissions for falls for Rotherham residents over 55 has increased from 1,002 in 2002/2003 to 1,719 in 2009/2010, a 72% increase. The number of fragility fractures resulting from those falls has increased by 19% from 533 in 2002/2003 to 635 in 2009/10.

POPPI estimated that in 2008 there were 2,531 people attending A&E departments in Rotherham due to falls just among the over 65s and that this would increase to 3,839 by 2025, an increase of 52%. This compares with a national average increase for the same period of 46%.

POPPI also estimated for people over 65, admissions to hospital in Rotherham due to falls will increase by 61% from 2010 to 2030. This is in line with the national average increase over the same period.

## Burden of Ill Health

### 4.7.2 People Killed or Seriously Injured on Roads

In 2006-08 there were 103 road injuries and deaths on Rotherham roads. This equates to 40.6 per 100,000 population, significantly better than the England average rate. The Rotherham rate is also the lowest of all regional local authorities.

In 2009 there were 93 people in Rotherham who were killed or seriously injured (KSI) on the roads (8 were killed and 85 seriously injured) compared to 97 in 2008<sup>109</sup>.

In 2007 the overall casualty rate for people injured on Rotherham roads (includes slight injuries as well as KSI) was 532 per 100,000, significantly higher than the South Yorkshire average of 458 and the England average of 430. Casualty

rates in Rotherham for most types of road user were similar to the national and regional averages except for car drivers, where the rate was significantly higher at 378 per 100,000 compared to the South Yorkshire average of 297 and an England average of 278. There were 921 accidents in Rotherham 2007 and the rate of accidents was the highest in the region at 7.1 per 1,000 licensed vehicles, compared with the South Yorkshire average of 6.7 and the national average of 5.6.

Around 300 more casualties occurred in urban areas of Rotherham compared with rural areas in 2008. Two thirds of KSI accidents occurred in urban areas. The highest proportion of people who were killed in 2008 were

accidents on urban built up roads<sup>110</sup>.

In 2007 car drivers form the highest number of those killed or seriously injured, followed by pedestrians and motorcyclists. Casualties have been decreasing for most categories of road user except for motorcyclists which has shown an increase.

<sup>109</sup> Department for Transport (2010) Road Casualties in Great Britain, Main Results 2009.

<sup>110</sup> Department for Transport (2010) Road Casualties in Great Britain, Country and Unitary Authority Level Statistics 2007

## Burden of Ill Health

### 4.8.1 Arthritis

461 hip replacement operations were carried out in Rotherham in 2007-8. This equates to 129.6 per 100,000 of the population, higher than both the national rate of 116.3 and the Yorkshire and Humberside average of 125.1<sup>111</sup>. 31% of hip replacement operations were carried out on males and 69% on females. For males this equates to 94 operations per 100,000 of the population, lower than the regional rate of 105 but equal to the national rate of 93. For females the rate is 158 operations per 100,000, significantly higher than the national rate of 134 and the regional rate of 140<sup>111</sup>.

In Rotherham 61% of the hip replacement operations carried out in 2006-7 were on people under the age of 75 years and 39% on people over the age of 75 years. The rate of operations in people under 75 was 85.6 per 100,000, higher than the national rate of 75.2 but close to the regional rate of 86.6. 65%

of operations were carried out on females which equates to a directly age standardised rate of 108.2 per 100,000, significantly higher than the national average of 85.5 and the regional average of 95.9. 35% of operations were carried out on males, 61.5 per 100,000, compared to the England average of 64.1 and the regional rate of 76.5<sup>111</sup>.

The rate of operations in people over 75 in Rotherham for 2006-7 was 848 per 100,000 of the population, significantly lower than the national average of 969 and the regional average of 970.7. 82% of operations were carried out on females and 18% on males<sup>111</sup>. Trend data for hip operations for people over 75 shows that the number carried out in males fell significantly between 2004-5 and 2006-7, dropping from a directly age-standardised rate of 699 in 2004-5 to 415.6 in 2006-7, one of the lowest rates in the country. Operation rates for females

over 75 were more consistent between 2001-2 and 2006-7 but in comparison with other local authorities the quintile position has fallen from the top of third quintile in 2004-5, to top of the second quintile in 2006-7<sup>58</sup>. The trend data for hip operations for people under 75 shows that the number carried out in females rose sharply between 2005-6 and 2006-7. Rotherham was in the highest quintile for the rate of operations carried out on females under 75 in 2006-7 whereas in previous years it had been in the middle quintile. Rotherham was in the middle quintile for the rate of operations carried out in males under 75 in 2006-7, a significant fall since 2003-4 when Rotherham was in the highest quintile<sup>111</sup>.

## Burden of Ill Health

### 4.8.2 Knee operations

440 knee operations were carried out in Rotherham in 2007-8, 132.4 operations per 100,000 of the population. This is higher than both the regional rate of 107.3 and the national rate of 107.4. Although the rate of operations in Rotherham remained fairly constant over the 4 year period between 2003-4 and 2006-7 (fluctuating between 2nd lowest and 2nd highest quintile) Rotherham is now in the highest quintile in 2007-8 for rate of operations<sup>111</sup>.

71% of knee operations carried out in Rotherham in 2005-6 were on people under the age of 75 years. This equates to 62 operations per 100,000 of the population, below the regional rate of 679 and the national rate of 71. Although the rate of operations carried out has changed little between 2001-2 and 2005-6, NHS Rotherham was in the second lowest quintile when compared with other local authorities in 2005-6 for the rate of operations carried out, but the highest quintile in 2001-2<sup>111</sup>.

The number of operations carried out in 2005-6 in people under

75 years of age was split equally between males and females. The rate for males was 64.4 operations per 100,000, almost the same as the national average rate of 65 and the regional average rate of 65.6. Although the rate of operations carried out on males has changed little between 2001-2 and 2005-6, Rotherham was in the middle quintile for rate of operations when compared with other local authorities in 2005-6 whereas in 2001-2 it was in the highest quintile<sup>111</sup>.

For females under 75 years of age the directly age standardised rate of operations in 2005-6 was 59.8 per 100,000, significantly lower than the regional average of 68 and the national average of 76.5. The rate of operations puts Rotherham at the bottom of the second lowest quintile when compared with other PCTs in 2005-6 whereas in 2001-2 it was at the top of the middle quintile<sup>111</sup>.

In 2005-6 71 knee operations were carried out on people over 75 years of age. This equates to a directly age standardised rate of 403 per 100,000, significantly

lower than the regional average of 499 and the national average of 543. Rotherham is in the lowest quintile for rate of operations carried out on people under 75 when compared with other PCTs. 38% of the operations were carried out on males and 52% on females. The directly age standardised rate of operations carried out in males was 381 per 100,000, much lower than the regional rate of 492 and the national rate of 527. For females the rate was 430, significantly lower than the regional rate of 507 and the national rate of 557<sup>111</sup>.

Rotherham moved from being in the second highest quintile compared with other local authorities in 2001-2 to the bottom quintile in 2005-6. The rate of operations in females over 75 increased slightly between 2001-2 and 2005-6 but similarly Rotherham moved from being in the middle quintile compared with other local authorities in 2001-2 to the lowest quintile in 2005-6<sup>111</sup>.

## Burden of Ill Health - Trauma

### 4.9 Summary of Chapter 4

It is estimated that in 2015 there will be 28,199 people over 65 in Rotherham with a limiting long-term condition including respiratory, nervous and musculoskeletal disorders, neoplasm's and mental illness.

In Rotherham there were 11,084 patients registered with diabetes in Q4 2009/10. In Type 2 diabetes, which is preventable in two thirds of cases, life expectancy is reduced by up to 10 years.

Cancer is one of the biggest killers in England - 1 in 3 people will be diagnosed with cancer in their lifetime. In 2008 Rotherham had an all age cancer mortality rate of 202.1 per 100,000. This is higher than the regional rate of 181.3 and England rate of 172.2.

In 2009 there were 93 people in Rotherham who were killed or seriously injured (KSI) on the roads (8 were killed and 85 seriously injured). There were 921 accidents in Rotherham 2007

and the rate of accidents was the highest in the region at 7.1 per 1,000 licensed vehicles, compared with the South Yorkshire average of 6.7 and the national average of 5.6.

# Mental Health Needs Assessment

## 5.1 Introduction

Mental health is a significant health issue which affects all life stages from birth through to end of life (DH, 2011). It represents up to 23% of the total burden of ill health in the UK with costs expected to increase over the next 20 years (HM, 2011). In 2006 the Kings Fund commissioned work to estimate the future expenditure of mental health services. The findings showed that service costs and the proportion of service spend on dementia would increase. Common mental health problems are predicted to rise (DH, 2011) and mental health is one of three conditions accounting for over 70% of the burden on longstanding ill health (DH, 2011). The Department of Health predicts that by tackling poor mental health the overall disease burden could be reduced by nearly a quarter (DH, 2011). Mental ill health not only costs the health service, for example, the total cost to employers of mental health problems leading to lost productivity and sickness absence is approximately £30 billion a year (DH, 2011).

Mental health is something which everyone has, just like individuals all have physical health. Mental health is about how a person thinks and feels. Mental health affects how individuals cope with life events which might be sad ones like bereavement or happy events like having a baby

or retirement. A person's mental health affects how they learn and how they form, keep and end relationships.

'Good or positive mental health is more than the absence or management of mental health problems; it is the foundation for wellbeing and effective functioning both for individuals and for their communities' (HM, 2011)

Mental health problems are when there are disturbances in the way a person feels, thinks and behaves. Mental health problems are common and the section below details the extent to which individuals are affected.

Mental health problems are among the most common of health conditions and impact on individuals, families, communities and society as a whole. The National Service Framework for Mental Health (1999) was the first framework to be published and was developed to improve the quality of mental health services and reduce inequalities.

Mental health is linked to physical health. When mental health is improved then it has a positive impact on someone's physical health (HM, 2011) Having both physical and mental health problems delays recovery from both (HM 2011). Some of the

links between mental health and physical health are listed below:

- Depression increases the risk of mortality by 50%
- Depression doubles the risk of coronary heart disease
- People with diabetes, coronary artery disease and hypertension have double the rates of depression
- People with cerebrovascular disease and chronic obstructive pulmonary disease have three times the rate of depression (HM, 2011)

In 2011 the coalition Government launched the new mental health strategy called, 'No health without mental health'. This strategy takes the view that mental health is a collective responsibility requiring the action of individuals, families, communities, employers and educators. The strategy takes a life course approach addressing the mental health of all age groups.

This strategy has six outcomes which are shared between the Government and the partners listed above. These outcomes are:-

- More people will have good mental health  
*People of all ages will have better wellbeing and mental health and fewer people will develop mental health problems*
- More people with mental health

# Mental Health Needs Assessment

## 5.1 Introduction

problems will recover  
*For example more people will mental health problems will have a good quality of life, greater ability to manage their own lives, stronger social relationships, better employment and a sustainable and safe place to live*

- More people with mental health problems will have good physical health  
*Fewer people with mental health problems will die prematurely and more people will have good physical health*
- More people will have a positive experience of care and support  
*Care and support should be timely and evidenced based and people should be given greater choice and control over their lives*
- Fewer people will suffer avoidable harm  
*People should have confidence that the care and support they are being given is safe and of the highest quality*
- Fewer people will experience stigma and discrimination  
*The public will have a better understanding of mental health and negative attitudes and behaviour towards people with mental health problems will decrease.*

This strategy has a focus on improving mental health services and a strong emphasis on public mental health, which is;

*'The art and science of promoting wellbeing and equality and preventing mental ill health through population-based interventions to:-*

- reduce risk and promote protective, evidence-based interventions to improve physical and mental wellbeing; and
- create flourishing, connected individuals, families and communities

Another important policy document to emerge in the last few years was the Delivering Race Equality in Mental Health Care (DRE). This was a 5 years action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status, including those of Irish or Mediterranean origin and east European migrants.

The programme was based on three "building blocks", which are:

- **More appropriate and responsive services** - achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children;

- **Community engagement** - delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers; and
- **Better information** - from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services. This will include a new regular census of mental health patients.

The DRE finished March 2010 and the final report has not yet been published.

## Mental Health Needs Assessment

### 5.2.1 Stigma and Discrimination

People with mental health problems often experience worse life chances than other people. Some of this is due to their mental health condition but a large part is due to the stigma and discrimination they experience from family, friends, colleagues, employers and health professionals (DH, 2011) Tackling stigma and discrimination is one of the six shared objectives in the new mental health strategy, 'No health without mental health' (HM Government, 2011).

Stigma prevents people from seeking help in the first instance and hinders recovery. A recent survey by the Campaign Time to Change (2008) found that 9 out of 10 people reported on the negative impact that stigma and discrimination had had on their lives. Two thirds of the people interviewed said that they had stopped doing things because of stigma and discrimination. The survey found that there were certain groups which were more affected. These included; women, people living with severe mental illness, people who were gay, lesbian, bisexual, those with

additional disabilities and those middle aged service users.

In relation to employment there has been plenty of research to show that people with common mental health problems are more likely to be economically inactive and less than a quarter of people with long term mental health problems are in employment (SEU, 2004). There is a public health project which aims to improve employer's understanding of mental health and reduce stigma and discrimination.

The sixth outcome of the new mental health strategy (HM, 2011) was to reduce stigma and discrimination:

#### *Fewer people will experience stigma and discrimination*

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to people with mental health problems will decrease.

The mental health strategy outlines the responsibility individuals

have to tackle stigma and discrimination. There is also a role for mental health professionals. There is an acknowledgement that serious incidents involving mental health patients are rare but when they do occur they contribute to the stigma and discrimination. To mitigate against this the strategy calls for mental health trusts to look at risk management, appropriate sharing of information and learning lessons where serious incidents are concerned.

# Mental Health Needs Assessment

## 5.3 Local Picture

The population of Rotherham, according to the Office of National Statistics, is estimated to be 253,900 (in June 2009). The population has been relatively stable in recent years with only a 1% increase (2,600 cases) since 2004. Despite this, Rotherham has an ageing population with 36% aged 50 or above and there has been a 66% increase in the 75+ population and a 163% increase in the 85+ population since 1981. Rotherham has seen a decline in some of the young age groups; 10 to 14 (-29%) and 20 to 29 (-17%). The gender split in Rotherham is 51% female and 49% male which is comparable to national averages. Rotherham covers 109 square miles with most of the population living in urban areas and about 50% living in the central area of the town.

Rotherham is an area with high health needs, it has a history of deprivation and disadvantage being currently the 68th most deprived borough. One of the most striking health issues in Rotherham is the degree of inequality within the borough. The gap in overall life expectancy

between Rotherham and the national average is one and a half years but the gap in life expectancy between different parts of Rotherham is nearly seven years (males= 7 years, females= 6.5 years based on 2006-08 data). In recent years Rotherham has begun to see significant overall improvement, although the health and disability Index of Multiple Deprivation (IMD) domains have seen little change. This is particularly so for the most disadvantaged communities. It is an acknowledged fact that mental health problems are more common in areas of deprivation (Wanless 2004, Choosing Health 2005).

The following information has been split into two parts. Part one includes self reporting using the Rotherham Lifestyle data and predictions based on national prevalence rates.

Part two contains information based on the use of health and social care services in Rotherham.

# Mental Health Needs Assessment

## 5.3.1 Local Prevalence Rates - Part One

### Lifestyle survey

In 2008 a Lifestyle Survey was carried out in Rotherham. This was a self reporting survey which used questions from the Medical Outcomes Study 36 - item Short Form Health Survey, now known as SF-36. This was the sixth postal survey of its kind with the previous one taking place in 2005. The response rate for the survey was 47% which was slightly lower than the response rate for 2005. Caution must be taken when comparing 2005 to 2008 but some comparisons can be made. The 2005 figures appear in brackets:-

- Overall there has not been much change in the mean mental health score from 2005 to 2008 in women.
- The mean mental health score amongst men for all ages have decreased from 2005 to 2008. (The mean mental health scores are slightly lower in 2008 than in 2005 for both men and women.)
- Residents living in the 20% most deprived areas of Rotherham have lower mean mental health scores than Rotherham as a whole.

The following show figures for 2008 (in bold) compared to 2005 (in brackets).

**6%** (4%) of all respondents have no practical, problem solving or emotional support  
**62%** (64%) report that they are happy **21%** (16%) report being very happy. Common stress factors identified by respondents were money **38%** (34%), work **31%** (37%) and caring for family **24%** (23%). Stress was identified as an obstacle to health by **37%** (36%) of respondents.

It is of interest to see that the percentage of people expressing that money is a stress has risen from 2005 to 2008. There has been much discussion nationally and locally on the effect of the recession and unemployment on mental health. The unemployment rate was 7.8 per cent for three months to June 2009 which was up by 0.7% over the previous quarter (The NHS Confederation 2009). There are links between a person's employment status and mental health. People who are unemployed tend to have poorer mental health. If unemployment continues to rise Rotherham may experience more of a demand on local services. Anecdotally

the Primary Care Mental Health Service has seen an increase in the number of people attending stress control classes but it is too soon to say whether this will be the beginning of a trend which is in response to the recession.

As previously stated when taking the national prevalence rates, predictions can be made on the numbers expected in Rotherham. Based on national prevalence rates and using the ONS mid 2009 estimates for Rotherham the following can be calculated :-

- 1 in 6 people (adults aged 16+) will have a mental health problem at any one time (and for half of these people the problem will last longer than a year) (Office of National Statistics Psychiatric Morbidity Study)
- 34,138 adults will have a mental health problem at any one time and of these 17,069 will have the problem for longer than a year
- In any one year 1 in 4 adults will experience at least one mental disorder (Office of National Statistics Psychiatric Morbidity Study)

# Mental Health Needs Assessment

## 5.3.1 Local Prevalence Rates - Part One

- 51,208 adults will experience at least one mental disorder
- Depression - between 8% and 12% of the population will experience depression in any year. (Office of National Statistics Psychiatric Morbidity Study)
- Between 16,386 and 24,580 (people on depression registers at Rotherham practices as at end of 2009-10= 25,807 (QOF))
- 1 in 200 adults experience a probable psychotic disorder in the course of a year (Singleton N, Bumpstead R, et al, Psychiatric Morbidity Among Adults Living in Private Households, 2000, London, The Stationery Office)
- 1,024 adults will experience a probable psychotic disorder in the course of a year in Rotherham (Via QOF numbers registered with "schizophrenia, bipolar affective disorder and other psychoses" at Rotherham practices as at end of 2009-10 = 1,865)

### Disability Adjusted Life Years

Health conditions are often measured looking at mortality rates which for mental health is suicide rates. Whilst mortality rates are important they are not the only consideration to be made when deciding which clinical conditions are important. Mental health is not best measured by looking at mortality rates. Emphasis is placed on mental health when looking at Disability Adjusted Life Years (DALYs). DALYs are a measure developed by the World Health Organisation that takes into account conditions and risk factors which lead to morbidity (ill health) as well as mortality and provides a measure of the number of healthy life years lost. When considering DALYs, mental health is the leading cause of DALYs in Rotherham (NHS Rotherham, 2008). This is due to some people having recurrent and chronic mental health problems and suicide as a mortality measure only represents a small part of the disease picture for mental health.

# Mental Health Needs Assessment

## 5.3.2 Local Prevalence Rates - Part Two

This section will detail the information available on the numbers of people accessing services with various mental health problems and suicide rates for Rotherham.

### General Practice Data

The following information is data from Rotherham GP Practices (via the Quality and Outcomes Framework (QOF)). General Practices are required to have a disease register for mental health problems and the following table represents the recorded number of patients aged 18+ registered with Rotherham GPs with depression, dementia and severe long term mental health problems.

This data shows numbers on disease registers by mental health related domains (mental health, depression, dementia and learning disabilities) and by year. The domains of depression, dementia and learning disabilities were only introduced to QOF in 2006/07. Prior to this the definition was 'mental health', which covered severe long term mental health conditions and was open to interpretation. The register now includes all people with a diagnosis of schizophrenia, bipolar affective disorder and other

psychoses rather than a generic phrase that is open to variations in interpretation. This data highlights the increase in the numbers on the register, which could be due to more cases being indentified in line with the new definitions. It must be noted that data for mental health is not consistent across all years as the definition changed in 2006/07, so data for depression and dementia is missing for years 2004-2006. Table 1 also shows that in Rotherham the crude prevalence rates for depression are slightly above the national rate. (101 compared to 84).

The disease register for people with schizophrenia, bipolar affective disorder and other psychosis has been used within practices to review their physical health, offering patients an annual health check, health promotion and preventative advice. People with poor physical health are at a higher risk of experiencing a common mental health problem and people with mental health

problems are more likely to have poor physical health:-

- a person with schizophrenia will, on average, live for ten years less than someone without a mental health problem (National Institute for Mental Health in England 2004 cited in Halliwell, E. Main, L, & Richardson, C. 2007- The Fundamental Facts, Mental Health Foundation)
- people who experience persistent pain are four times more likely to have an anxiety or depressive disorder as the general population (The World Health Report, 2001 cited in Halliwell, E. Main, L, & Richardson, C. 2007- The Fundamental Facts, Mental Health Foundation)

Associations have been made between poor mental health and stroke, diabetes, cancer, HIV/ AIDS and asthma (Mental Health Foundation, 2010)

Patients on Rotherham Severe

**Table 1: Overall Disease Register Size, Crude Prevalence and Rotherham National Prevalence Ratio by Domain**

Domain	Total numbers of patients on Rotherham registers						2009-10		
	2004-5	2005-6	2006-7	2007-8	2008-9	2009-10	Crude Prevalence (Number per 1,000 List Size)		Rotherham/National Ratio
							Rotherham	National	
Mental health (1)	1,157	1,157	1,572	1,708	1,812	1,865	7	8	0.94
New in 2006/07:									
Dementia	N/A	N/A	1,135	1,223	1,320	1,461	6	5	1.26
Depression (2)	N/A	N/A	19,724	20,636	22,852	25,807	101	84	1.20
Learning Disabilities	N/A	N/A	767	803	920	1,074	4	3	1.28
Notes									
N/A= Introduced in 2006-7.									
1. Originally based on patients "with severe long-term mental health problems", but since 2006/07 based on patients "with schizophrenia, bipolar affective disorder and other psychoses".									
2. Data represents all patients aged 18+ on practice lists with a current diagnosis of depression.									
Source: NHS Information Centre (data for 2004-5 to 2008-9), QMAS for 2009-10.									

# Mental Health Needs Assessment

## 5.3.2 Local Prevalence Rates - Part Two

Mental Illness register are offered an annual health check because of the poor physical health people with long term mental health problems experience. The health check covers;

- smoking, alcohol and drug use,
- cholesterol check and blood pressure check,
- measurement of body mass index,
- check for development of diabetes,
- cervical screening,
- an enquiry about cough, sputum and wheeze.

In Rotherham in 2009/10 a total of 1,865 patients were on the register. Of this, 1,446 had a health review recorded in the 15 preceding months and had been offered health prevention and health promotion advice. A total of 69 patients who did not attend the practice for their annual health review were identified and followed up by the practice within 14 days of non attendance (Source: PCT Indicator Group Level Summary of Achievement Detail,

End of Year 2009-10 position).

In 2009 NHS Rotherham did a review to identify any health inequalities that may exist for this group of patients. They found that smoking rates were higher amongst this patient group compared to the rest of the practice population. However it was promising to see that patients on the registers were more likely to be given smoking cessation advice and be referred to the smoking cessation service, when compared to patients who smoked who were not on the register.

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- cholesterol check and blood pressure check,
- measurement of body mass index,
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SMI patients are on average, 2.12 times more likely to be diabetic than the non SMI patients within practices. Average for proportion

Table 2: Smoking rates, smoking cessation rates and referral to stop smoking service for patients on the SMI register and non SMI patient population

<b>Smoking status for...</b>
Non SMI practice population
SMI registered patients
<b>Smoking cessation advice</b>
Non SMI practice population
SMI registered patients
<b>Referred to smoking cessation</b>
Non SMI practice population
SMI registered patients

Table 3: Percentages of practice patients on the SMI register who are diabetic compared to non SMI practice patients

Patients who are diabetic:	Average
Non SMI practice population	4.69
SMI registered patients	9.97

# Mental Health Needs Assessment

## 5.3.2 Local Prevalence Rates - Part Two

of the patients who are diabetic who are either not on the SMI register or SMI registered patients is:

### Secondary Care Data

The data collected in Rotherham enables us to see the admissions to hospital for mental health problems either: seen under Mental Health specialties; or where the patient was diagnosed with a mental health related problem.

Table 4 and subsequent graphs show the mental health hospital admissions showing numbers and

age standardised rates. For the purposes of this document data based on diagnosis relates only to the primary diagnosis or the underlying reason for admission. The rates have also been combined into a table along with deprivation (based on the Index of Multiple Deprivation Scores 2007) to see whether there is any correlation between the number of hospital admissions and the place the person lives.

The data represented in table 4 and graph 1 show that hospital admissions tend to be higher

in the most deprived areas of Rotherham. Boston Castle is one of Rotherham's most deprived wards and has the most mental health admissions. Whereas Hellaby is Rotherham's second least deprived ward and has few mental health hospital admissions.

The Royal College of Psychiatrists refer to this correlation between deprivation and mental ill health:

*'Mental health problems, defined broadly, are more common among the poor than among the rich by about a quarter (the prevalence*

**Table 4 Mental Health Hospital Admissions by Ward and Area Assembly (2007/8 and 2009/10)**

Mental Health Hospital Admissions*				
Age Standardised Rates per 100,000 European Standard Population				
Rotherham Health District residents All Ages 2007/08 - 2009/10 (3 years)				
Area	2007/08 - 2009/10			
	Admissions	Rate per 100,000	Rank DSR (1=worst)	Significant?
<b>Ward (Area Assembly)</b>				
Anston and Woodsetts (RVS)	38	113.6	20	low
Boston Castle (RS)	277	577.9	1	high
Brinsworth And Catcliffe (RVW)	86	226.2	12	
Dinnington (RVS)	108	264.3	9	
Hellaby (WV)	30	70.8	21	low
Holderness (RVW)	117	275.4	8	
Hooper (WN)	62	162.1	17	low
Keppel (RN)	69	175.0	15	low
Maltby (WV)	121	299.9	6	
Rawmarsh (WS)	123	286.9	7	
Rother Vale (RVW)	69	167.1	16	low
Rotherham East (RS)	151	338.7	4	high
Rotherham West (RN)	156	389.9	2	high
Silverwood (WS)	57	147.0	19	low
Sitwell (RS)	82	197.0	14	low
Swinton (WN)	90	248.6	10	
Valley (WS)	127	330.7	5	high
Wales (RVS)	61	150.5	18	low
Wath (WN)	92	239.2	11	
Wickersley (WV)	93	226.0	13	
Wingfield (RN)	138	375.0	3	high
<b>Area Assembly</b>				
Rother Valley South	207	177.4	7	low
Rother Valley West	272	225.4	4	
Rotherham North	363	317.3	2	high
Rotherham South	510	382.5	1	high
Wentworth North	244	216.6	5	low
Wentworth South	307	257.4	3	
Wentworth Valley	244	205.9	6	low
<b>Rotherham HD</b>	<b>2,147</b>	<b>258.2</b>		
Sources				
Admissions: Secondary Uses Service, Office for National Statistics.				
Populations: Ward proportions by age and sex derived from Exeter System and scaled to fit ONS mid-year estimates.				
Notes				
*Mental Illness, Child and Adolescent Psychiatry, Psychotherapy and Old Age Psychiatry specialties.				
Significant? = Whether ward rate is significantly higher or lower than the Rotherham average (at 95% confidence level)				
Rank=Wards sorted into order of 1 for worst rate down to 21 for best rate (Area Assemblies 1 to 7)				

# Mental Health Needs Assessment

## 5.3.2 Local Prevalence Rates - Part Two

*of people with any type of mental health problems among the poorest 14% of the population is almost 30%). However, people with a diagnosis of psychosis are nine times more common among the poor than the rich' RC PSYCH, 2009: 9)*

The RC PSYCH explains the relation between deprivation and poverty as individuals lacking the material means to purchase the basic necessities like heating. If individuals feel like they do not have the resources to access these basic necessities and other social circumstances then this leads to an individuals experiencing a lack of control.

*'The experience of a lack of control over one's material and social circumstances may then act as a mediating factor between poverty and poor mental health'.(RC PSYCH, 2009:10)*

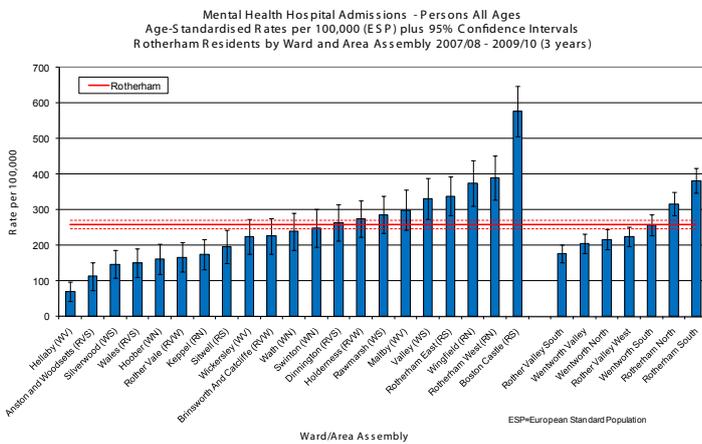
The following graphs (2,3,4,5) look at the hospital admissions where the primary diagnosis is mental health split into the different categories: depression, anxiety, dementia and schizophrenia. The data is presented by Ward and Area Assembly as age standardised rates.

Graph 2 illustrates that the wards with the least hospital admissions for depression (Hellaby, Silverwood

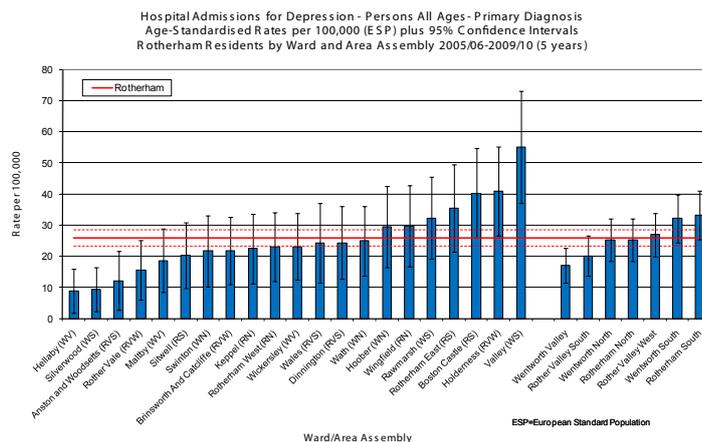
and Anston and Woodsetts) are in the top ten of the least deprived wards ranking 2, 9 and 3 respectively (where 1 is least deprived and 21 most deprived). This compares with wards with the highest number of admissions as a result of depression (Valley and Boston Castle) which are both in the top 10 most deprived wards, ranking 20, and 18 respectively. However, Holderness ward ranks 5 in relation to deprivation and has the second highest admission rates for depression. Valley ward is the only ward significantly above Rotherham average.

When looking at the admissions rates for anxiety the relationship

**Graph 1: All Mental Health Admissions by Ward and Area Assembly 2007/08-2009/10 (3 years)**



**Graph 2: Hospital Admissions for Depression by Ward and Area Assembly over a 5 year period**



# Mental Health Needs Assessment

## 5.3.2 Local Prevalence Rates - Part Two

between hospital admissions and deprivation (rank shown in brackets) Keppel ward (7), Anston and Woodsetts (3) and Brinsworth and Catcliffe (8) are the top three wards with the fewest hospital admissions. Hooper (13) Rawmarsh (15) and Maltby (17) are the top three wards with the most admissions. When looking at admissions overall, there are around half the admissions for anxiety than depression.

For hospital admissions for schizophrenia the wards with the lowest hospital admissions Anston and Woodsetts (3) Silverwood (9) and Sitwell (1) are amongst the

least deprived wards. However Holderness ranks 5 in relation to deprivation and is in the top 3 wards with high hospital admissions. Rotherham West, Boston Castle and Holderness have rates significantly above the Rotherham average.

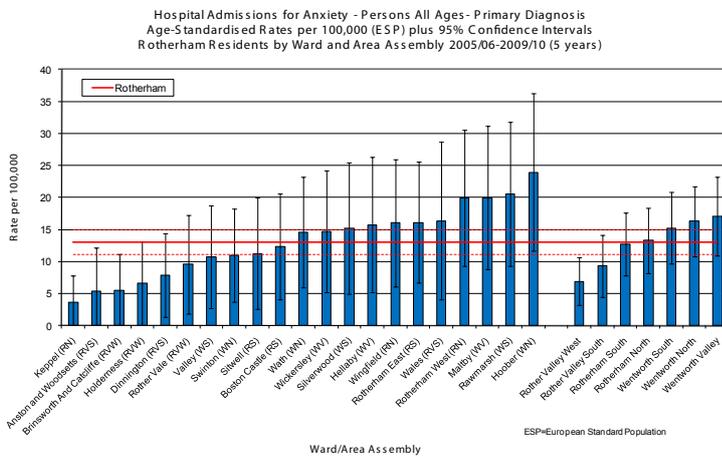
For dementia, Holderness is again significantly above the Rotherham average. There appears to be less of a direct correlation between admission rates and deprivation than with the other mental health conditions.

To assist with the analysis of this data the deprivation scores for the

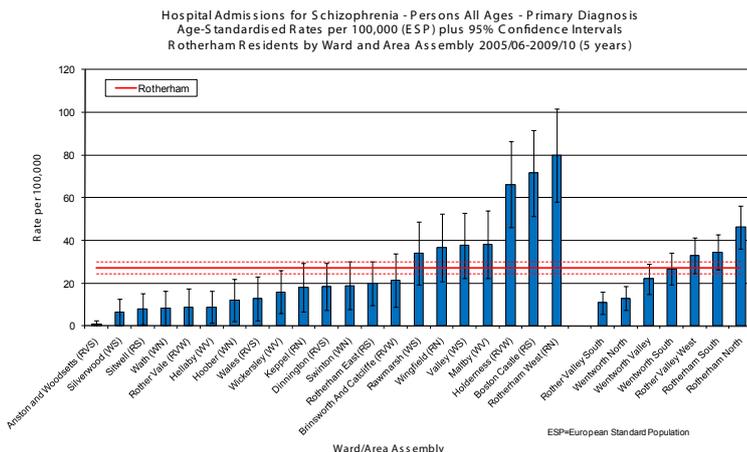
Wards and Area Assemblies can be found in Appendix 1. From this data the following summary can be made;

- Depression and schizophrenia have the largest number of admissions and anxiety has much less when looking at primary diagnosis only.
- Rates vary widely between wards and in the case of anxiety, depression and schizophrenia there appears to be some correlation between hospital admissions and deprivation. An exception seems to be

**Graph 3 Hospital Admissions for Anxiety by Ward and Area Assembly over a 5 year period**



**Graph 4: Hospital Admissions for Schizophrenia by Ward and Area Assembly over a 5 year period**



# Mental Health Needs Assessment

## 5.3.2 Local Prevalence Rates - Part Two

Holderness which appears in the top three wards for hospital admissions for depression and schizophrenia when the deprivation rank is only 5 (1 being the least deprived).

- In terms of age-standardised rates there is around a 4 times variation between best and worst wards for dementia and depression, whereas for schizophrenia, rates are over 20 times worse in Rotherham West than in Anston & Woodsetts.

Graph 5: Hospital Admissions for Dementia by Ward and Area Assembly over a 5 year period

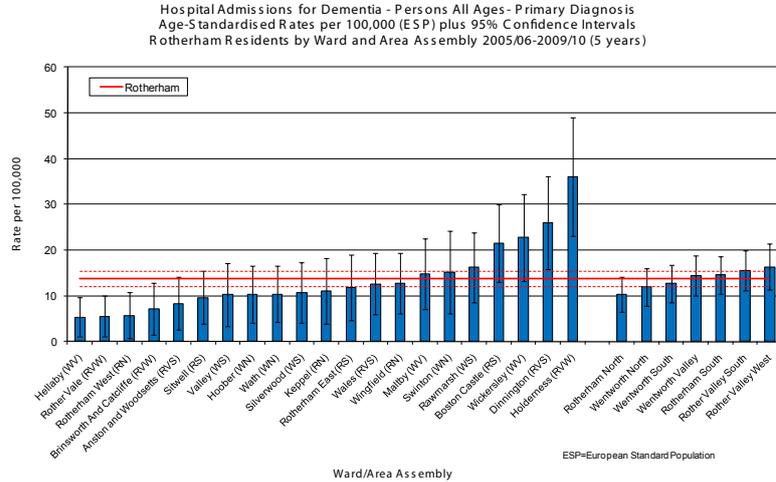


Table 5: Deprivation and Hospital Admissions for all mental health problems

Ward	IMD 2007	Hospital Admissions per 100,000 - 2005/06 - 2009/10				
		Mental Health (Unique)	Depression	Anxiety	Schizophrenia	Dementia
Sitwell (RS)	13.1	132.9	20.4	11.3	7.9	9.7
Hellaby (WV)	13.4	54.8	8.9	15.8	8.9	5.4
Anston and Woodsetts (RVS)	14.5	79.1	12.2	*	*	8.4
Wales (RVS)	15.3	83.5	24.2	16.4	12.7	12.6
Holderness (RVW)	19.1	161.2	41.0	*	66.3	36.0
Wickersley (WV)	19.4	166.3	23.1	14.7	16.0	22.8
Keppel (RN)	20.5	108.8	22.4	*	18.1	11.1
Brinsworth And Catcliffe (RVW)	22.3	129.1	21.8	*	21.5	7.2
Silverwood (WS)	24.5	97.1	9.4	15.3	*	10.7
Rother Vale (RVW)	24.6	126.1	15.6	9.6	*	5.6
Dinnington (RVS)	24.8	183.4	24.3	7.9	18.5	26.0
Wath (WN)	25.5	129.9	24.9	14.6	*	10.4
Hooper (WN)	25.8	110.7	29.5	23.9	12.2	10.3
Swinton (WN)	27.7	147.4	21.7	11.0	19.0	15.2
Rawmarsh (WS)	30.9	190.3	32.2	20.6	34.1	16.2
Wingfield (RN)	32.2	252.3	29.8	16.0	36.7	12.8
Maltby (WV)	33.7	234.6	18.6	20.0	38.2	14.9
Boston Castle (RS)	34.8	352.7	40.3	12.3	71.7	21.6
Rotherham West (RN)	39.2	256.2	23.0	19.9	79.9	5.8
Valley (WS)	40.9	223.3	55.1	10.7	37.7	10.3
Rotherham East (RS)	50.4	235.7	35.5	16.1	20.1	11.9
<b>Rotherham</b>	<b>26.7</b>	<b>169.6</b>	<b>25.8</b>	<b>13.0</b>	<b>27.2</b>	<b>13.7</b>

Sources  
 Admissions: Hospital episode datasets via Secondary Uses Service (SUS)  
 Populations: Derived from Exeter System (GP practice populations) and scaled to fit ONS mid-year estimates for Rotherham.  
 Deprivation Scores = Overall Index of Multiple Deprivation Scores, Department of Communities and Local Government  
 Hospital admissions for depression, anxiety, schizophrenia and dementia are based on admissions with a primary diagnosis (main reasons) o

Notes  
 Data has been arranged in order of rates and grouped into quintiles (fifths)

Highest fifth of rates (worst)  
 Lowest fifth of rates (best)

\* where the number of admission is below 5 and therefore has been blanked for confidentiality reasons

## Mental Health Needs Assessment

### 5.3.3 Suicides

All Primary Care Trusts have a responsibility to carry out suicide audits. In Rotherham there are systems in place so that the Clinical Audit Team within NHS Rotherham is informed of a suspicious death by the Coroner's Office as soon as possible. The Clinical Audit Team then work with the GP Practice Managers to complete a nationally agreed dataset. The dataset is designed to provide background information for district level analysis of suicide trends. NHS Rotherham Clinical Audit staff will also liaise with mental health services in Rotherham to establish whether the person has been accessing services. Rotherham, Doncaster and South Humber Mental Health Trust conduct their own audit.

There are around 20-25 suicides per year in Rotherham. In 1996 Rotherham was set a target of

reducing suicide rates by 20% - this was a challenging target because 1996 was, by chance, a relatively low year for suicide in Rotherham, this target finishes in 2011. Suicide is one of the proposed indicators in the Public Health Indicators framework which is out for consultation.

Most of the people who die by suicide in Rotherham are men, which is a similar trend found nationally.

In 2009 most of the people who died by suicide were aged 20 to 39. Nationally the age group with the highest suicide rates has been young men.

Suicide rates for Rotherham are not dissimilar to those of neighbouring districts. The latest information indicates that Rotherham's rates are lower than

those of Doncaster and in line with the average for England.

#### Method of Suicide

Hanging accounted for 9 (89%) of Rotherham suicides in the period from July 2008 - 2009 and 1 (11%) suicide via Suffocation. 50% of the suicides took place in the deceased's own home. The other suicides were predominantly in homes known to the individual or wooded areas. This collated information on suicides helps NHS Rotherham and other partners monitor any patterns and hotspots for suicide. A hotspot is a high risk place which is frequently used as a location for suicide. National recommendations are that a hotspot is where more than one suicide had taken place at that particular site. Often action to be taken at hotspots requires a multi agency response and there

**Table 6: Suicide Comparison from 2005**

Source: Office for National Statistics

Deaths from Intentional Self Harm (ICD-10: X60-X84) Rotherham Residents by Gender and Year 2005-20					
Gender	2005	2006	2007	2008	2009
Males	20	18	18	18	7
Females	1	2	6	3	1
Total	21	20	24	21	8

**Table 7- Age Variation**

Source: Office for National Statistics

Rotherham Residents by Age Group - 2009 Death Registrations							
	15-19	20-29	30-39	40-49	50-59	60-69	70+
Deaths	0	2	2	1	1	0	2
Percent	0	25%	25%	12.5%	12.5%	0	25%

Source: Office for National Statistics.

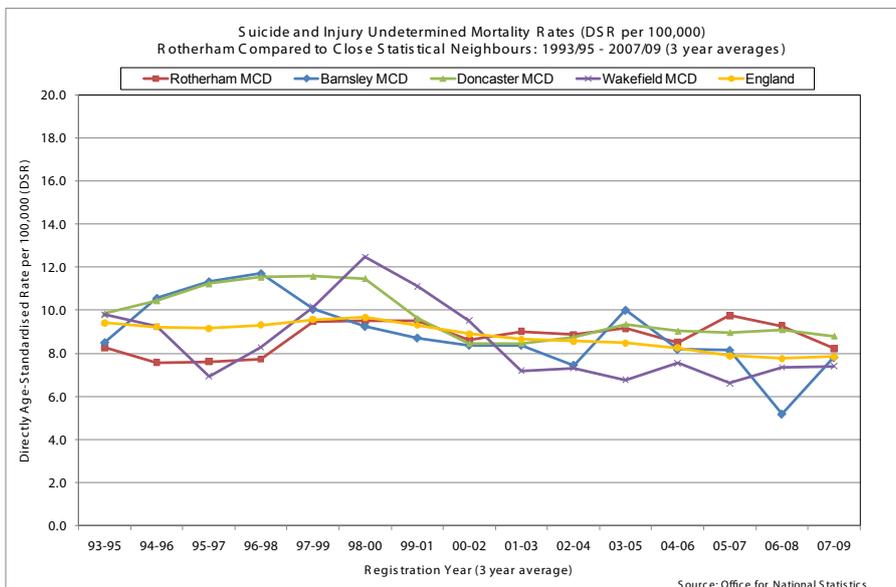
## Mental Health Needs Assessment

### 5.3.3 Suicides

is evidence from published studies on interventions which can save lives, impede or deter suicides. The fact that most suicides in Rotherham take place in a home environment makes it more problematic to do preventative work on hotspots. However, NHS Rotherham has worked with the Highways Agency, Samaritans and Rotherham Metropolitan Borough Council to install suicide preventative measures in one area in Rotherham.

In addition the Mental Health First Aid training for both adults and young people, trains workers to identify suicide warning signs in individuals and refers them to appropriate mental health services when they believe they are at risk.

**Graph 6: A comparison of Rotherham suicide rates with close statistical neighbours**



## Mental Health Needs Assessment

### 5.4 The impact of mental health problems on different community groups

Mental health problems are not equally distributed across all groups in society, there are differences. For example there are differences between men and women. Depression is more common amongst women than it is with men with 1 in 4 women requiring treatment for depression at some time compared to 1 in 10 men (NICE 2003). Other groups where there are differences in the extent of mental health problems are; black and minority ethnic groups, older people, prison population, people who provide substantial amounts of care to relatives, refugees, the deaf community and people with learning disabilities (Mental Health Foundation, 2007). For people with a learning disability the prevalence rates for psychiatric disorders are higher than in the general population (RC PSYCH, 2003)

The following section will explore some of these differences in more detail looking at:

- Black and Minority Ethnic Groups
- Maternal Mental Health
- Dual Diagnosis
- Deaf Community
- Older People

## Mental Health Needs Assessment

### 5.4.1 Black and Minority Ethnic Groups

Mental wellbeing is important for all sections of the community. During periods of mental illness it is important that individuals are able to access the services and help they need. There is a wealth of evidence which shows that black and minority ethnic groups suffer disparities and inequalities in rates of mental ill health, service experience and service outcome (NIMHE 2003:5 and HM, 2011).

*“There is discrimination, both direct and indirect, in mental health care.” Professor Kamlesh Patel OBE (DRE 2005: 9).*

The document ‘Delivering race equality in mental health’ (2009) indicates that individuals from some BME backgrounds are more likely to enter the mental health services through coercive means, through the criminal justice system for example. Once in care they are more likely to be highly medicated than their White counterparts and also more likely to suffer seclusion and/or restraint. On a local level there is no evidence to suggest this and in fact local data from mental health providers would suggest that BME communities are not

overrepresented in Rotherham’s mental health services.

In Rotherham there has been some needs assessment work with BME community groups to explore some of the issues they experience. In 2004, due to the small number of BME men accessing mental health services in Rotherham, Rotherham Primary Care Trust commissioned Rotherham Ethnic Minority Alliance (REMA) to look at the needs of men up to the age of 25 in relation to mental health and accessing of mental health services. Through questionnaires, interviews and workshops the young men expressed that ‘talking’ was their preferred means of receiving support to deal with their difficulties and problems. They expressed that this needed to happen with professionals who understood their difficulties and feelings within the context of their religious and cultural beliefs (REMA, 2004). Stigma and lack of awareness of services were some of the issues discussed by the young men indicating that awareness raising needed to take place within the community groups represented in Rotherham.

In 2008 Rotherham Primary Care Trust looked at the needs of Black and Minority Ethnic groups in relation to mental health services. The needs analysis, whilst looking predominantly at older people did interview some people from other age groups. The interviews and focus with members of Rotherham’s BME communities indicated that there were a variety of issues which commissioners and services needed to address. Some of the feedback included:-

- The stigma surrounding mental health which prevented people from accessing services
- A lack of understanding about mental health with older members of the communities sometimes seeing it as an inevitable part of getting older
- Little awareness of local services available for people to access
- Communication difficulties between health professionals and patients
- Lack of awareness from health professionals of cultural and religious issues

The new mental health strategy, ‘No health without mental health’ (HM, 2011) outlines three

# Mental Health Needs Assessment

## 5.4.1 Black and Minority Ethnic Groups

aspects to reduce mental health inequalities for groups including BME communities:

- tackling the inequalities that lead to poor mental health
- tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health;
- tackling the inequalities in service provision – in access, experience and outcomes.

There has been much evidence at a national and local level on how services can be improved for BME communities (DRE, 2005 & Rotherham Ethnic Minority Alliance, 2004, HM, 2011). It is about finding innovative ways of improving service for BME community groups which includes simple steps for improving access, for example:-

- offering variable lengths of appointment times
- an outreach approach,
- holding sessions in community centres (HM, 2011)

These factors need to be addressed in order to allow individuals to access treatment

as and when they need it. When looking at specific age groups within BME communities it is apparent that there are also a number of factors which are particularly pertinent to older people. These have been described as the “triple whammy” (Rait, 1996). They are:

- socio-economic deprivation - BME communities often live in the more deprived areas,
- ageing - illness, loss of mobility, bereavement are all factors more common to the older generation,
- immigrant status - the effects of the migration process, resettlement and transition cannot be underestimated; an alien environment, language and cultural barriers as well as discrimination and racism all impact on the mental health of individuals (Rait, 1996)

South Asians make up the largest BME group at approximately 2.54 % of the population as a whole. The demand on mental health services from this group is likely to grow as first generation immigrants from that region approach old age (there are larger numbers from the Asian ethnic

group in the 50-59 and the 60-74 age band compared to the over 75 age band, RMBC: 2006) and it could be anticipated that more people from BME communities would be accessing dementia services.

# Mental Health Needs Assessment

## 5.4.2 Maternal Mental Health

This section examines the specific needs of women both antenatally and postnatally in relation to mental health.

NICE guidance (Antenatal and Postnatal Mental Health, 2007) suggests 1 in 8 women will suffer a maternal mental health problem antenatally or postnatally – this equates to more than 500 women per year in Rotherham with young babies and between 500 and 700 pregnant women who require targeted support.

Women with maternal mental health problems will include women who experience depression or anxiety in pregnancy, women who have depression postnatally, women who experience the sudden onset of psychosis following delivery

(puerperal psychosis) and an important, but often forgotten, group of women who have an existing, diagnosed, enduring mental health problem - including schizophrenia or bipolar disorder – who become pregnant. There will also be some women with a past history of mental health problems, for example, depression, which re-occurs in pregnancy or in the postnatal period. Each of these groups of women will need different care and a different care pathway.

Suicide is the leading indirect cause of death for women up to a year after childbirth (Saving Mothers' Lives, 2003-2005, Confidential Enquiry into Maternal and Child Health). Rotherham has had 2 maternal suicides in the last ten years.

### Rotherham figures:

There are around 3,700 deliveries per year in Rotherham. Of these women up to 580 will experience mental health problems requiring some form of intervention postnatally (Royal College of Psychiatrists Perinatal Maternal Mental Health Services, 2000). In addition, 10-15% of women (up to 740) will experience psychiatric illness in the first trimester of pregnancy – mostly anxiety and depression (CEMACH, 2001)

Maternal mental ill health can produce adverse outcomes for babies and other children, with consequent long-term impacts, particularly for the child's development. There is robust evidence that babies of parents with mental disorder are more

**Table 8: Projected Incidence of Maternal Mental Health Problems (RCPsych 2000)**

Mental Health Problem	Percentage of women delivering	Annual Estimate for Rotherham	Numbers likely to present to services
Mild or minor depression	10%	370 Women	111-185 (30-50 per 1000)
Moderate to severe depression	3-5%	110-185 Women	110-185 Women
Of whom: Requiring referral (secondary care)	1.7%	63 Women	
Psychosis / severe depression / relapse of SMI - some requiring admission	Each 2 per 1000 women (around 3 per 1000 admitted)	22 Women	
Antenatal depression or anxiety	10-15% of pregnancies	490-740 Women (assuming 1:4 miscarry)	

# Mental Health Needs Assessment

## 5.4.2 Maternal Mental Health

likely to suffer from attachment disorders, also cognitive development deficits and increased likelihood of child psychiatric illness (NSF For Children, Young People and Maternity Services – Standard 11, 2004).

In 2009 the following gaps in service were identified:

- Training Referral pathways and clarity of responsibility is needed for existing services.
- Information for women, families and the wider public is required to reduce stigma and to encourage women and families to seek help.

During 2010, much work has been undertaken to address the identified gaps in service these include:

- Establishing a steering group for maternal mental health tasked with responding to the gaps in provision
- Mapping out the existing service provision and existing referral pathways
- Agreeing a universal screening tool to ensure consistency across all health professionals who see women antenatally and postnatally

- Utilising the information from the mapping event to inform the development of a clear referral pathway for all front line staff which meets the needs of Rotherham women with both existing mental health problems or mental health problems as a direct result of pregnancy
- A multiagency training package was developed for midwifery and health visiting services to aid the early detection of mental health problems and appropriate care and onward referral. This is still on-going
- Service specifications have been revised to ensure they reflect the new pathway
- New prescribing guidelines have been issued across primary care to ensure, preconceptionally, antenatally and postnatally women receive appropriate evidence based medicines in conjunction with pregnancy and breastfeeding.

### Next Steps

During 2011/12 we need have identified the following outcomes to be addressed:

- On -going training of midwifery and health visiting services
- Monitoring activity against the pathway

- Seek patient views on the introduction of the pathway
- Revision of the pathway in light of monitoring and feedback
- Awareness for women, families and the wider public is required to reduce stigma and to encourage women and families to seek help.
- Develop the books on prescription scheme to include maternal mental health books

Locally commissioned services include:-

- RDASH - Secondary Mental Health Services, Community teams Primary Care Mental Health Team and Health Visiting and CAMHS
- RFT - midwifery and obstetric services,
- Nottinghamshire Healthcare Trust for specialist in-patient beds
- Sure Start, children's centres
- RMBC for a range of parenting support
- GPs

## Mental Health Needs Assessment

### 5.4.3 Dual Diagnosis

Dual diagnosis is the term used to describe a person diagnosed with a mental health problem who uses alcohol and drugs (illegally produced drugs or illegally obtained prescription drugs). People with dual diagnosis represent a third of all Mental Health Service Users (Menezes et al. 1996) and half of all Substance Misuse Service Users (Weaver et al. 2001).

Alcohol and substance misuse can cause; the symptoms of the mental health problem to be worse, an acute illness relapse, self harm and in some instances violence towards others (DH, 2006, Dual Diagnosis in mental health inpatient and day hospital settings).

In addition individuals with a dual diagnosis often have multiple and complex needs (Gorry, A. and Todd, D., 2009) including physical health problems, social care issues, relationship difficulties,

housing problems and in some instances are in contact with the Criminal Justice system.

Despite the numbers of people with a dual diagnosis, mental health services have often been developed separately to drug and alcohol services (DH, 2006). Mental health services often find this group difficult to assess, treat and care for these patients safely and effectively (DH, 2006). There is a need within mental health services for clinicians to have the skills and knowledge to help these patients.

The new mental health strategy, 'No health without mental health (DH, 2001) states that fully integrated care should be provided for people with dual diagnosis. The Government makes a commitment to promote and support improvements in commissioning and service provision for this group, their families and carers (DH, 2001).

As the provider of both Mental Health and Substance Misuse Services RDASH are expected to have in place a robust strategy for dealing with clients with complex needs including those with a dual diagnosis of both mental health and substance misuse. The strategy to deal with dual diagnosis clients has previously been agreed, however there still needs to be more emphasis on its application in particular on monitoring the numbers of patients who are believed to fall into this category and documenting more effectively the outcomes of their treatment and this work is ongoing. It is expected that substance misuse and mental health should be equally prepared to collaborate to deliver an agreed care pathway and to build on previous training programmes which have been commissioned by NHS Rotherham to continue to develop staff skills in this area.

## Mental Health Needs Assessment

### 5.4.4 Deaf Community

There are almost 9 million people in living in the United Kingdom who are deaf and hard of hearing (RNID, 2005) and up to 40% of deaf and hard of hearing people will experience a mental health problem at some point in their lives (Hindley, 1994 in Sign, 2005). There has been little research on the mental health problems of people who are deaf and hard of hearing, with research tending to focus on the usage of mental health services (Sign, 2005). It appears that the degree of hearing impairment is not related to the severity of mental health problems. A person with some hearing impairment can struggle more with their identity living in the 'hearing world' (Hindley, 2000 in Sign, 2005). The report by Sign and the Mental Health Foundation

reinforced the levels of unmet need and lack of detection for deaf and hard of hearing people which could be due to the barriers people experience. There is also an overrepresentation of deaf and hard of hearing people in secure mental health settings (Sign, 2005). One of the biggest challenges to working with the deaf community is communication which mental health professionals rely on for assessments, diagnosis and treatment. Whilst many people within the deaf community have excellent communication skills, they may have obstacles communicating with services, making them more vulnerable and recovery slower (Sign, 2005).

The authors, Sign and Mental Health Foundation, state that the deaf and hard of hearing

communities require a different form of service commissioning and provision to other users of mental health services and that given the small numbers at local levels this would be better suited a regional level. However, local mental health services need to treat deaf and hard of hearing with dignity and respect. The Mental Health Foundation and Sign have produced an information pack which outlines the changes services can make to ensure that they are 'deaf-friendly'

## Mental Health Needs Assessment

### 5.4.5 Older People

Britain has an ageing population with a resulting impact on health services this trend is reflected locally. The ageing process has implications for mental health as well as other health areas. Depression is the most common mental illness found in older people and the second most common single underlying cause for all GP consultations for people over 70 years of age (Netdoctor: 2010). Generally the patterns of depression amongst older people are the same as younger people, however, events likely to cause depression are more common for older people. Research suggests that factors which can impact negatively on the mental health of older people are

- **Retirement** – possible consequences of this are feelings of a loss of role, isolation from work colleagues and friends, reduced social circle.
- **Poor health** – pain, reduced mobility
- **Bereavement** – loss of close family and friends.

BME older people have additional factors which can impact on their mental health such as language and cultural differences and the inappropriateness of support services to meet their needs increasing feelings of isolation.

Symptoms of depression in older people are often missed, being thought to be related to other causes, however, if recognised and treated the depression can be lifted and symptoms relieved.

#### Dementia

Dementia is one of the main causes of disability in later life. The World Health Organisation's Global Burden of Disease report accorded disability from dementia a higher weight than that for almost any other condition because it has a disproportionate impact on capacity for independent living.

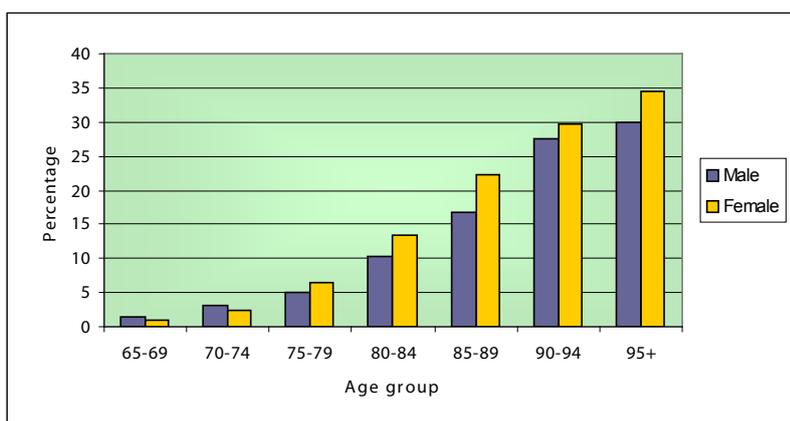
Dementia is a syndrome that can be caused by a number of progressive disorders that affect memory, thinking, behaviour and the ability to perform everyday

activities. Alzheimer's Disease is the most common form of dementia. Other types are vascular dementia, dementia with Lewy bodies and frontotemporal dementia.

The total estimated worldwide costs of dementia are £388 billion in 2010. About 70% of the costs occur in Western Europe and North America (Wimo & Prince, 2010). This includes the cost of social care, unpaid care by relatives and the medical bills for treating dementia. According to the World Alzheimer Report 2010 this figure is set to rise rapidly in coming years with the majority of governments woefully unprepared to deal with the impending challenge. Work in France, England and Australia has been singled out by the report for praise. The report recommends increased investment in research into the disease which lags behind investment into diseases such as heart disease and cancer.

Figure 5.1 breaks down the prevalence of dementia by age group. Young onset dementia is

Graph 7: Prevalence of dementia in men and women over 65 in the UK



## Mental Health Needs Assessment

### 5.4.5 Older People

comparatively rare, accounting for 2.2% of all people with dementia in the UK. It is estimated that there are now at least 15,034 people with young onset dementia and 668,563 people with late onset dementia. However, given that data on the numbers of young onset cases are based on referrals to services, this number is likely to be an underestimate (Dementia UK: 2007)

The number of people with dementia in the UK is forecast to increase to 940,110 by 2021 and 1,735,087 by 2051, an increase of 38% over the next 15 years and 154% over the next 45 years. This is mainly due to the increase in the number of older people in the population.

When considering the people with learning disabilities in relation to dementia the RC PSYCH (2009) found that:

- People with a learning disability have a higher risk of developing dementia compared to the general population

- There is a significantly increased risk for people with Down's syndrome and at a much earlier age
- Life expectancy of people with Down's syndrome has increased significantly
- The incidence and prevalence of Down's syndrome is not decreasing.

Local services will see increasingly more people with a learning disability living longer who need to be able to access mainstream dementia services.

The Memory Service in Rotherham supports the detection of dementia in primary care across the whole spectrum of the disease and provides prompt assessment and diagnosis. Referral to the Memory Service will be by GP and hospital consultant through the Single Point of Access currently located in the Community Mental Health Team for Older People. Once a patient is diagnosed and registered with the Memory Service that registration becomes permanent. Patients are then able to reactivate involvement

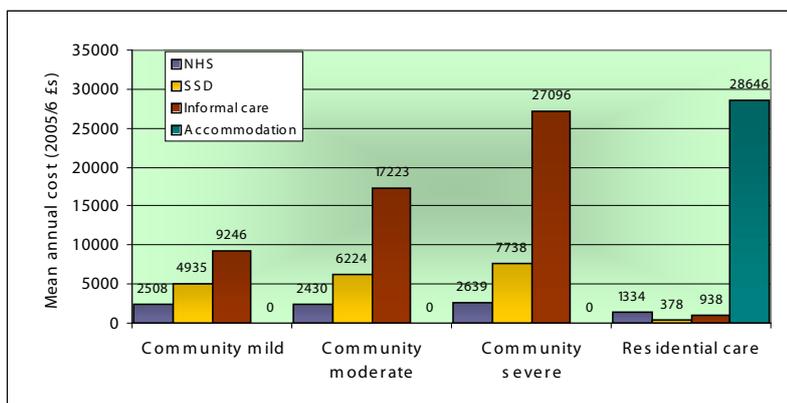
with the service through self-referral. Patients who have already received a diagnosis and been previously registered with the Memory Service will be able to self refer.

There are currently 1,152 people on GP dementia registers in Rotherham. This figure is likely to be an underrepresentation of the actual numbers of people with dementia. Early signs of the illness are often put down to natural symptoms of ageing and therefore help is not always sought. There is also proportionately an underrepresentation of BME communities accessing the Memory Service. Local research indicates that this is likely to be due to lack of understanding of mental health issues and services available in the BME communities.

It is estimated that by 2025 the number of people in Rotherham with dementia will have risen to 4,397, an increase of 54% from 2008.

Dementia UK suggests that the average annual cost of dementia

Graph 8: Annual cost of services used by people with late onset dementia by setting and severity 2005/6



## Mental Health Needs Assessment

### 5.4.5 Older People

care was £25,472/person (Figure 5.2). The report estimates the total annual cost of dementia care to be approximately £17 billion per annum. Residential care accounts for 41% of the total cost with 36% being met by informal care inputs. Included in the costs of informal care is the estimated £690 million in lost income for carers who have to give up employment or cut back their work hours.

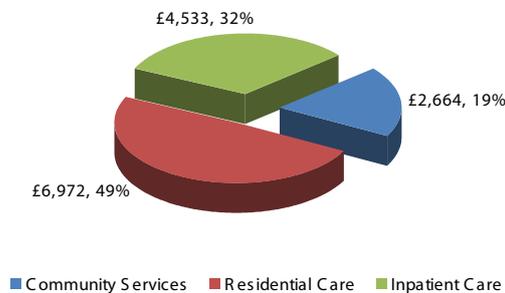
There is a disproportionate spend on residential care and a heavy reliance on informal carers to meet the needs of those with dementia.

Graph 9 shows the relative investment between residential, hospital and community support for Older People's Mental Health (OPMH) services in Rotherham. These are combined figures for both NHS Rotherham and Rotherham MBC and do not include expenditure within generic services. Excluding the cost of informal care, the amount spent in Rotherham on residential care is similar to the national average, but the proportion of costs spent on inpatient care is twice the national average and the proportion on community services much lower than the national average. The DMIT, however,

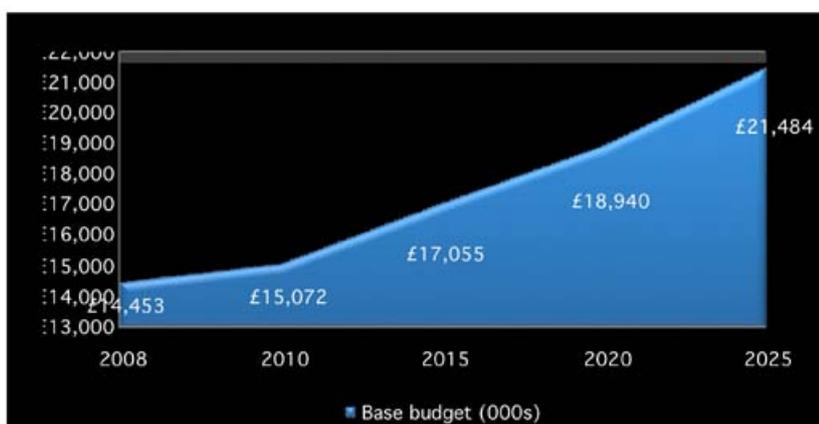
indicates that the number of emergency hospital admissions and average length of stay for dementia patients were below the national average.

Graph 10 sets out the potential impact that demographic changes could have on older people's mental health service costs in Rotherham. The baseline costs are taken from the supply mapping exercise completed in March 2007. This identifies the costs in 2006/07 of all specialist services for older people with mental health problems.

**Graph 9: Distribution of service costs for older people's mental health services in Rotherham 2006/7**



**Graph 10: Predicted service costs in Rotherham: 2008 – 2025**



# Mental Health Needs Assessment

## 5.5.1 Local Services - Promoting Public Mental Health

This section looks at what is happening in Rotherham at a preventative level through to inpatient care.

### Promoting Public Mental Health

This is a core aim of the new mental health strategy, 'No health without mental health'. Rotherham has a variety of public health initiatives which are detailed below.

The Rotherham Mental Health Promotion strategy covers a **whole population approach**, the settings of **schools, primary care and workplaces** and briefly refers to the work taking place on social inclusion for people with mental health problems.

In terms of outcomes, implementation of the Rotherham Mental Health Promotion Strategy would see:-

- Improvements in mental health literacy amongst frontline workers, in particular BME frontline workers, through initiatives like Mental Health First Aid.
- Earlier detection of mental health problems and poor mental health, with support and signposting, in particular targeting work with employers, carers and frontline workers.

- People with mental health problems having improved access to healthy lifestyle information and support and therefore improved physical health.
- Improved mental wellbeing of people and communities through targeted work with employers around promoting mental health in the workplace.
- People having a better understanding of how to look after their mental health, with examples of good practice with BME communities.
- Reduction of stigma and discrimination towards people with mental health problems

### Mental Health First Aid Training

During 2009-10 a nationally accredited training course called Mental Health First was run for frontline workers in Rotherham. A total of 220 frontline workers have been trained to recognise the symptoms of mental health problems, provide initial help and guide a person towards professional help. NHS is looking at options for sustaining this training including commissioning through mainstream services.

### Mind Your Own Business Project

Rotherham has a 5 year lottery funded workplace mental health project. The project aims to help employers improve the mental health of their staff, to work with and support staff who may be at risk of developing mental health problems and have a positive attitude towards employing people with a mental health problem. From April 2008 to August 2010 the project has worked with:-

- 1160 Direct Beneficiaries
- 106 businesses
- 448 have been trained as Mental Health First Aiders
- 139 people have attended the Managing Mental Health training
- 75 needs assessments have taken place with employers

The project has developed a Mental Wellbeing in the Workplace toolkit and a service directory for employers for working age adults.

In relation to mental health services, the last few years has seen a significant investment in mental health services in Rotherham.

## Mental Health Needs Assessment

### 5.5.2 Primary Care Mental Health Services

#### Improving Access to Psychological Therapies

The Rotherham Primary Care Mental Health Service provides a responsive and accessible service within primary care for people experiencing common mental health problems. The service is delivered in GP practices and community venues across Rotherham. The service has also developed a self-referral drop-in service which is being delivered at the Rotherham Community Health Centre on a Friday morning. In 2009 the service became a Yorkshire and Humber Strategic Health Authority Wave 2 Improving Access to Psychological Therapies service. In line with the Department of Health IAPT requirements, the service delivers a variety of treatment options to suit the patient's needs. It operates within the Improving Access to Psychological Therapies (IAPT) Framework and National Institute of Health and Clinical Excellence Guidelines. The service works with adults aged 18 upwards with no upper age limit. After assessment the patient is offered low or high intensity stepped care treatments.

The service works with many other partners including GPs, public health colleagues, Rotherham Occupational Health

Advisory Service (ROHAS), the voluntary sector and secondary care mental health services in particular the Community Therapies Team.

In addition to one to one appointments, the service offers a 'Books on Prescription Scheme and stress control classes.

The Books on Prescription scheme is for people experiencing mild to moderate mental health problems. Mental Health workers in GP practices can 'prescribe' a book or relaxation CD for patients, which can be borrowed free of charge from selected Rotherham Libraries, to help with recovery. There are books on most areas of mental health including anxiety, depression, improving self esteem, eating disorders and many more.

The books are also available to borrow without prescription from participating libraries. Rotherham libraries have also been busy supporting the mental health awareness programme with the Books on Prescription loans increasing to over 400 loans per month borough-wide. Stress Control is a free course suitable for anyone over 18 years

who experiences symptoms of stress, anxiety and panic. The course helps people to learn new skills to manage stress more confidently. The course is held over five weeks and people can self refer. Over the past year approximately 200 people have benefited from attendance at the Stress Control classes held in community venues across Rotherham. These have proved very popular and have evaluated well. Delivery of these classes will continue to be offered next year alongside other new initiatives such as the sleep-wise classes and the depression management group.

The service works very closely with ROHAS and between the two services they supported people 255 April 2010 to March 2011 to return to work.

The latest figures show in 2010/11 the service has been accessed by 4,972 people.

As stated previously the Primary Care Mental Health Service operates within the IAPT framework along with the secondary care Community Therapies Team. Patients can be stepped up to secondary care services if this is appropriate.

## Mental Health Needs Assessment

### 5.5.2 Primary Care Mental Health Services

#### Improving Access to Psychological Therapies

The latest IAPT key performance indicators for January 2011 to March 2011 for both these services can be found below:

In February 2011 the DH outlined its commitment to expanding psychological therapies by producing a 4 year action plan. The plan outlines specific action to roll out talking therapies to all people over the age of 65, introduce talking therapies for children and young people, broaden the benefits of talking therapies for people with long term physical health problems and finally expand services to people with long term mental ill health. The leadership and delivery of the expanded programme will be expected to come from local stakeholders.

**Graph 9: Distribution of service costs for older people's mental health services in Rotherham 2006/7**

	Number of people who have entered psychological therapies	Number of people who have completed treatment
Rotherham Primary Care Mental Health Service	<b>1023</b>	<b>1062</b>
Secondary care IAPT service	<b>16</b>	<b>9</b>

# Mental Health Needs Assessment

## 5.5.3 Secondary Care Mental Health Services

The main provider of mental health services is Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust (RDASH). Currently RDASH provides both inpatient and community services for Rotherham residents. Following a period of consultation with service users, carers, primary care, commissioners, local authorities and staff, RDaSH developed a new model for adult services which was implemented in Rotherham in February 2011. This model can be seen below:

Entrance to the service is via a single point of access. Whilst the previous model offered a good service, this change ensures that the right people provide the right treatment for services users at the right time. A brief description of the new teams is below:

Rotherham Borough Council also works in partnership with RDaSH and other Voluntary and Private Sector Organisations to provide Residential Care and Community Support services to Rotherham residents with Mental Health issues.

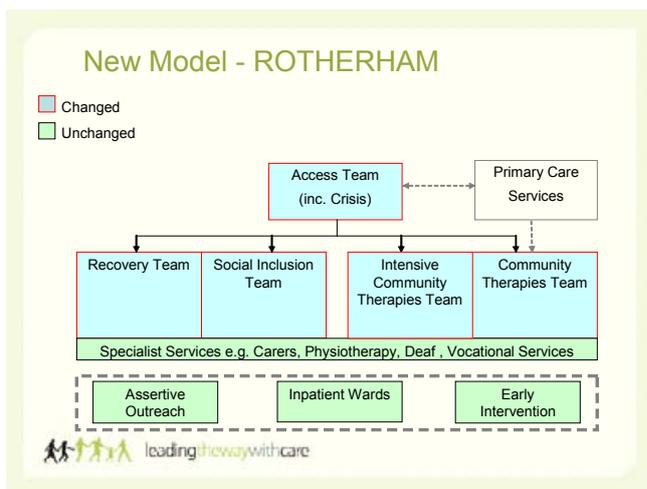


Table10: Rotherham Doncaster and South Humber NHS Foundation Trust- New Service Model

Team	Description
Access Team	A multi-disciplinary team providing initial assessment of secondary mental health referrals to identify individual need and the most appropriate service to meet that need
Recovery Team	A multi-disciplinary team providing interventions for service users who experience psychosis and have complex needs
Social Inclusion Team	A multi-disciplinary team providing interventions for service users who have experienced psychosis and require support to maintain well-being
Intensive Community Therapies Team	A multi-disciplinary team providing interventions for service users with severe depression and anxiety related disorders, personality disorder and obsessive compulsive disorder.
Community Therapies Team	A multi-disciplinary team providing interventions for service users with moderate depression and anxiety related disorders.

## Mental Health Needs Assessment

### 5.5.4 Mental Health Social Care

The following information provides an overview of how people of working age are supported in Rotherham via social care services. It gives a brief view of each service provided and concludes with a table showing the current social care expenditure and trends.

#### In-house Day Care (based in Central Rotherham and Dinnington)

Provide a range of Recovery Focussed Activities. The activities provided range from assisting people to better manage their finances, healthy diets, confidence building and graded exposure programmes, through to community based activities supporting people with mental health difficulties to access and use community facilities and services. Currently these services support 150 adults of working age. Referral to these services is via Community Mental Health Teams.

#### Voluntary Sector Day Care and Community Support Services (Rotherham Central)

This service provides similar services to those described above. Currently financed via a block contract this service is transition to become a service which can be accessed via

individual budgets, direct payments or by private individuals wishing to access its services. 17 people currently access this service via a Direct Payment/individual budget at a cost of £17.20 per session. Direct Payments are accessed via a Social Care assessment carried out by a community Mental Health team. The service also offers a free of charge drop in service twice a week to offer advice and signposting.

The provider also provides support to individuals in their own home and runs and manages two short term services which are accommodation based and provide short term accommodation to mental health service users who have experienced a mental health crisis and have homelessness issues or are engaged with early intervention in psychosis teams and have homelessness issues. The aim of this service is to assist service users to move into their own tenancies. These accommodation based services are supported by funding from Supporting People.

In total this service provides a service to 93 service users with mental health issues.

#### Voluntary Sector Day Care and Community Support (Rotherham North and South)

They provide community support services to service users with mental health difficulties throughout Rotherham. This service provides support to people in their own homes to enable them to access and use community facilities and services whilst moving towards independence. Of the current mental health population utilising the services of this provider 60% (63 people), engage with the service by means of an individual budget or direct payment, leaving 40% (42 people) supported under a contract arrangement with the local authority.

A service user led organisation providing peer support and guidance as well as some supported employment opportunities.

#### Supported Housing and Community Based Support

Provides accommodation based support to 28 service users in Rotherham. It provides 10 accommodation based supported places in Herringthorpe at Browning Court and 6 places at satellite units funded via

## Mental Health Needs Assessment

### 5.5.4 Mental Health Social Care

Supporting People. Burns Court in Maltby provides a further 10 places of accommodation and support funded directly under contract to the local authority.

The provider has also developed a personalisation team which provides floating support to mental health service users, which can be purchased by individual service users with an individual budget or direct payment. Currently this floating support service attracts 12 service users at a cost of £17.86 per hour.

#### Residential Care

RMBC supports 77 people with Mental Health difficulties to live in residential care. These places are either fully supported by the local authority or jointly funded by the local authority and our health partners. The cost to the local authority is £1,605,677 (gross expenditure).

#### General Direction of Travel of Social Care Support

As the Personalisation agenda gains pace the number of service users opting to have their support needs met by self Directed support via a Direct Payment or Individual Budget is increasing. Therefore there is a need for the services to restructure to allow service users greater choice and control over which services meet their needs over the last 5 years there has been a significant increase in the number of Mental health service users opting to take an individual budget or Direct Payment (see table below);

The significant increase shown during the current year reflects the change in commissioning activity where the local authority is currently incrementally reducing direct contract arrangements in favour of enabling service users to have greater choice and control whilst at the same time encouraging the growth of services available to meet the personalised needs of its service users. The growth of such services and innovation by these services has seen a reduction in

the number of people entering residential care and greater emphasis on care at home and in the community.

#### Supporting People

The supporting people programme is a grant funded programme for the provision of housing related support. Services for people with mental health problems funded through supporting people are preventative services that offer person centred support to enable people to maintain their independence.

This preventative programme works alongside adult social care to ensure the needs of this client group are met. The programme currently spends £786,815 (2010-11) per annum on mental health services from a current budget allocation of £7.56m. Services are provided through in-house and voluntary sector organisations for floating support and accommodation based services. The current split of funds is; £403,400 on accommodation based services which serve up to 45 clients at any one time and

**Table 11: Number of people with Individual budgets or Direct Payments from 2005-2010/11**

Year	2005	2006/07	2007/08	2008/09	2009/10	Current position 2010/11
Number of mental health Ind. Budgets/ Direct Payments	5	10	46	56	106	160

## Mental Health Needs Assessment

### 5.5.4 Mental Health Social Care

£383,415 on floating support service (support offered in the client's own home – Council or Private rented or home owner) which serve up to 60 clients at any one time.

Although there are capacities set on these services they tend to have a throughput within each service and in 2009-10 the number of leavers in all services was 93, so the services worked with over 186 people over the year.

Analysis of client profiles has been generated from submissions of client record forms for new starters 2009-10 and outcomes forms for all leavers in the same period. This is a snap shoot that will provide a guide to the age,

gender and ethnic origin of clients entering and leaving the mental health services funded through the programme. In 2009-10 only 2.1% of people accessing all housing related support services were from BME groups, the current BME population is 5.7%. This shows that the number of BME clients is lower than the population statistics.

The number of males and females accessing services has improved, current figures in 2009-10 show a fairly even split. 55% of clients are males and 45% are females. In 2009-10 there were 15 clients accessing the service that were under 20 years of age, 20 that were between the ages of 21 and 25 and 27 that were between 26

and 34. The number of clients accessing the service between the age of 45 and 64 doubles to 44 and 48 retrospectively. The number then declines slightly to 31 and only 1 person accessed the service that was over 65 in 2009-10.

## Mental Health Needs Assessment

### 5.6 Financial Costs – National Level

The social and financial costs of mental health problems to society have been estimated to be around £77 billion (New Horizons). In relation to health services costs, mental health services account for 13.8% of England's health budget.

The World Health Organisation ranks England's mental health services as the best resourced in Europe (World Health Organisation, 2008, Policies and practices for mental health in Europe: meeting the challenges cited in The NHS Confederation, Nov 2009, Key Facts and Trends in Mental Health). In 2006 the Kings Fund commissioned a review to estimate mental health expenditure in England from 2006 to 2026.

Some of the key findings highlighted that service costs are projected to increase to £32.6 billion based at 2007 prices. Of this total, dementia costs, which are already the highest service cost, are estimated to make up to 73% of all mental health service costs by 2026.

## Mental Health Needs Assessment

### 5.7 Financial Costs – Local Level

Local financial mapping on adult and older people mental health services can be found at Department of Health Autumn 2009 Monitoring - Results of Financial Mapping

The data enables Rotherham (Local Improvement Team, LIT) to compare its spend on mental health services for adults and older people to; the Strategic Health Authority area, Office for National Statistics (ONS) Cluster Group and England as a whole. The ONS cluster group classifies areas into one of 12 areas with broadly similar characteristics.

Graph 11 below shows spend on direct services in Rotherham followed graph 12 showing the overall investment per weighted

head of population. Direct service costs (primarily staffing costs) of adults' mental health are analysed into sixteen categories. Older people's direct services are analysed into thirteen categories. Additional costs such as indirect costs, overheads and capital have not been included here.

The percentage of spend Rotherham makes on direct costs for adult mental health is higher than other areas in the Strategic Health Authority, the NOS cluster group and England. However when it is weighted as an investment per head the amount is lower.

The table 12 below breaks down the spending into the different service categories (direct services).

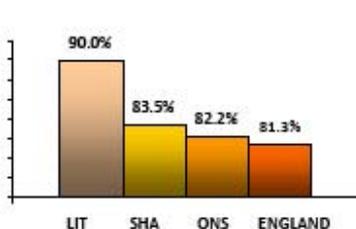
It shows how Rotherham compares to other areas in the same Strategic Health Authority area, the cluster group and England as a whole.

The graphs 13 and 14 below show the investment reported spend on direct services and overall investment per weighted head of population for older people's mental health services.

Rotherham's percentage spend on direct services for older people's mental health is lower than other areas in the Strategic Health Authority and England but slightly higher than similar areas in the ONS cluster group.

Graph 11

% Investment in Adult Direct Services



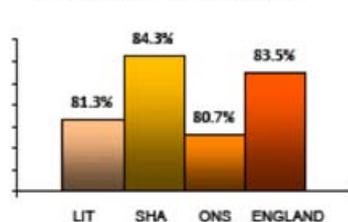
Graph 12

Adult Weighted Investment per Head



Graph 13

% Investment in OPMH Direct Services



Graph 14

OPMH Weighted Investment per Head



## Mental Health Needs Assessment

### 5.7 Financial Costs – Local Level

Table 12: Adult direct services percentage analysis (Year2009/10)

<u>LIT</u>	<u>St HA</u>	<u>ONS</u>			
<b>Rotherham</b>	NHS YORKSHIRE AND THE HUMBER	Manufacturing Towns			
Service Category	£'000s	Percentage		This ONS	English LITs
		This LIT	This SHA		
Access & Crisis Services	£2,947	12.7%	12.0%	10.4%	11.1%
Accommodation	£1,761	7.6%	6.7%	4.9%	9.5%
Carer's services	£132	0.6%	0.6%	0.4%	0.5%
Clinical Services	£3,198	13.7%	15.5%	16.6%	17.2%
Community Mental Health Teams	£4,112	17.7%	12.6%	13.4%	14.3%
Continuing Care	£2,257	9.7%	13.7%	16.4%	11.6%
Day Services	£699	3.0%	2.9%	3.2%	3.2%
Direct Payment	£469	2.0%	0.3%	0.5%	0.4%
Home Support Services	£139	0.6%	1.8%	1.1%	2.3%
Mental Health Promotion Services	£62	0.3%	0.1%	0.1%	0.1%
Other community and hospital professional teams/specialists	£1,188	5.1%	2.9%	1.5%	1.9%
Personality Disorder Services	£41	0.2%	0.4%	0.1%	0.6%
Psychological Therapy Services (IAPT)	£558	2.4%	2.2%	2.9%	2.5%
Psychological Therapy Services (Non IAPT)	£1,007	4.3%	3.9%	4.0%	3.5%
Secure and High Dependency Provision	£4,455	19.1%	22.1%	22.1%	18.9%
Services for Mentally	£90	0.4%	1.2%	1.1%	1.2%

# Mental Health Needs Assessment

## 5.7.1 Mental Health and Social Care Expenditure

Table 15: Expenditure for Mental Health and Social Care Expenditure 2010/11

Source: RMBC 2011

### **Mental Health budget 2010/11**

	Gross expenditure £	Income £	Net £
<b>Total budget</b>	5,996,627	-1,413,978	4,582,649
<b>Day Care</b>			
Inhouse	407,505	-105,129	302,376
<b>Voluntary sector</b>			
Day Care and Community Support	£400,265		
Service User led	£10,000		
<b>Total Voluntary Sector</b>	410,265	-21,016	389,249
<b>Residential Care</b>	1,605,677	-178,737	1,426,940
<b>Other</b>			
Assessment & Care Management	2,339,698	-739,512	1,600,186
MH Service Management	28,312	-24,995	3,317
Home Care in House	42,143	-31,396	10,747
Other Comm Services - Independent	162,414	-12,610	149,804
Homecare Independent Supported & Other Accommodation	398,749	-122,699	276,050
Advice & information - Independent	413,696	-108,372	305,324
Mgt & Admin Support	14,193	-12,610	1,583
<b>Total other</b>	3,573,180	-1,109,096	2,464,084

# Mental Health Needs Assessment

## 5.8 Emerging Patterns

As stated in the introduction of this chapter, mental health is a significant health issue affecting all stages of life (DH, 2011). The costs of mental health problems to this country are estimated to be about £105 billion (HM, 2011). Not only are there costs to society as a whole but there are incalculable costs to individuals, families and communities (HM, 2011). As discussed earlier mental health is strongly linked to physical health, in fact the new strategy embraces this in the title, 'No health without mental health' (HM, 2011).

Commissioning of health services is changing with GPs having an increasing role. Previous documents like 'The Commissioning Friend for Mental

Health Services' (NMH DU, 2009) outlines some challenges that commissioners of mental health services need to take note of, these are listed below:

- Personalisation and individual budgets
- Improving quality
- Reduced budgets
- Keeping mental health at the centre of commissioning
- Commissioning in partnership (health and social care)
- Engagement of service users and carers

This chapter has looked at some future predictions of demand on mental health services, which commissioners will need to consider. In particular the increase in number of older people and

the increasing number of people with a learning disability who are living longer and will be accessing older people's mental health services.

This chapter has also highlighted the needs of different groups in relation to mental health problems and access to services. The public sector has a duty to ensure that commissioned services comply with the Equalities Act, 2010 ensuring that they demonstrate how inclusion and equitable treatment of these groups is incorporated into services (HM, 2011).

The table 13 has used the available local data and national policy to outline themes and considerations for commissioners:

# Mental Health Needs Assessment

## 5.9 Summary of Chapter 5

More people will have good mental health  
Commissioning of services should focus on:-

- prevention
- early intervention
- wider determinants of health.

More people with mental health problems will recover  
Over the coming years commissioners should focus on services which are:-

- patient focused
- encourage equal and timely access
- appropriate
- evidence based
- recovery based

More people with mental health problems will have good physical health

Commissioners should ensure that mental health services encourage users to access mainstream healthy lifestyle services

Mental health services:-

- should develop public health strategies
- work with relevant partners to the wider determinants of health

More people will have a positive experience of care and support  
Commissioners should ensure that services:-

- offer choice, control and responsibility
- have improved mental health outcomes for all, whatever people's age, race, religion, gender, sexual orientation, disability, marital or civil partnership, pregnancy or maternity or gender reassignment status (Equality Act, 2010).
- promote equality of access and reduce inequalities
- are underpinned by an equality impact assessment
- work collaboratively with other health trusts to ensure that the best quality of care is provided for people with mental health problems in

Fewer people will suffer avoidable harm

Commissioners should ensure that patients have confidence that the services they are accessing are safe and of a high quality.

All mental health services should have the following

- clear clinical governance arrangements
- safe guarding policies
- risk assessments and risk management arrangements.

Fewer people will experience stigma and discrimination

Commissioners should commission services which:-

- refer patients into mainstream services wherever possible
- work closely with the communities in which they are based and with local partners
- work collaboratively to communicate messages which challenge stigma and discrimination
- involve service users in anti stigma and discrimination activities.

# Mental Health Needs Assessment

## 5.10 Appendix 1

Indices of Multiple Deprivation 2007		
Deprivation Scores by Rotherham Wards and Area Assemblies		
Ward	IMD 2007	Rank (1 = least deprived)
Anston and Woodsetts (RVS)	14.5	3
Boston Castle (RS)	34.8	18
Brinsworth And Catcliffe (RVW)	22.3	8
Dinnington (RVS)	24.8	11
Hellaby (WV)	13.4	2
Holderness (RVW)	19.1	5
Hooper (WN)	25.8	13
Keppel (RN)	20.5	7
Maltby (WV)	33.7	17
Rawmarsh (WS)	30.9	15
Rother Vale (RVW)	24.6	10
Rotherham East (RS)	50.4	21
Rotherham West (RN)	39.2	19
Silverwood (WS)	24.5	9
Sitwell (RS)	13.1	1
Swinton (WN)	27.7	14
Valley (WS)	40.9	20
Wales (RVS)	15.3	4
Wath (WN)	25.5	12
Wickersley (WV)	19.4	6
Wingfield (RN)	32.2	16
Area Assembly		
Rother Valley South	18.4	1
Rother Valley West	21.9	2
Rotherham North	30.9	5
Rotherham South	34.1	7
Wentworth North	26.3	4
Wentworth South	32.4	6
Wentworth Valley	22.6	3
Rotherham	26.7	
Data estimated by attributing scores by Lower Super Output Areas based on % each LSOA forms of total ward population (based on Exeter System data)		
Sources		
Deprivation Scores = Overall Index of Multiple Deprivation Scores, Department of Communities and Local Government		
Populations: Ward and Area Assembly proportions based on Exeter System populations.		
Notes		
Rank=Wards sorted into order of 1 for lowest/best score down to 21 for highest/worst score (Area Assemblies 1 to 7)		

# Mental Health Needs Assessment

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# Learning Disability Needs Assessment

## 6 Introduction

This section provides an analysis of the likely social and health care needs and service requirements for people with Learning Disabilities across Rotherham in the next 20 years. The section summarises the current demographic profile and projected changes across the area and likely future requirements for supporting people with learning disabilities. It provides information and analysis for future needs and services to support effective commissioning and service development.

# Learning Disability Needs Assessment

## 6.1 Numbers of People with a Learning Disability

The numbers of people with a mild, moderate or profound disability is increasing each year. In 2010, it is estimated that there were 971,182 people in England with a mild, moderate or profound learning disability, nearly 2% of the total general population<sup>1</sup>. This figure includes 828,000 adults (aged 18 or more). Of these adults it is estimated that 177,000 were known users of Learning Disability Services in England (equivalent to 0.47% of adult population).

The number of adults with learning disabilities is predicted to increase by 14% between 2010 and 2030 and 2021. This would raise the number of people in England aged 18 and above with learning disabilities to over one million by 2014 which is 7 years earlier than previously predicted. The number of adults with learning disabilities over 65 is predicted to increase by 52% between 2010 and 2030. This is an increase of 14% from previous predictions between 2001 and 2021<sup>1</sup>.

The 'Valuing People Now: From Progress to Transformation' sets out the priorities for the provision of services for people with a learning disability over the years 2008-11. Its focus is personalisation, what people do during the day, increasing health outcomes, and increasing access to housing.

The four main reasons for the increase in the number of people with a learning disability are:

- Increased life expectancy, especially among people with Down's Syndrome.
- Growing numbers of children and young people with complex and multiple disabilities who now survive into adulthood.
- A sharp rise in the reported numbers of school age children with autistic spectrum disorders, some of whom will have learning disabilities.
- Greater prevalence among some minority ethnic populations of South Asian origin.

## Learning Disability Needs Assessment

### 6.2 Expenditure for Learning Disabilities in Rotherham for 2009/10

The total budget for adult social care in Rotherham is £131.5 million for 2009/10. In comparison, the total budget for Learning Disability Services in Rotherham is £32 million. Therefore, 24.4% of the budget for adult social care is spent on people with learning disabilities, 3.4% above the national average of 21%<sup>2</sup>.

Budgets for adults with learning disabilities are under particular pressure, in part as these adults grow older and need greater care and as more young adults with learning disabilities are transferred from children's services.

Rotherham is currently spending 13% of the Learning Disability budget on nursing care which is above the national average of 3%. This suggests that there are a small number of people who are residing in institutionalised care for people who have a severe or profound learning disability in order to meet their complex nursing needs.

However, in comparison, Rotherham is spending 26.2% on residential care which is well below the national average of 48%. This suggests that people in Rotherham have more opportunity to live in alternative types of accommodation such as supported living schemes in order to maintain their independence in the community. This is evident as Rotherham is spending 20%, well above the national average of 7%, on supported living and other accommodation.

Rotherham currently spends 1.8% of their budget on direct payments which is slightly above the national average and this is expected to increase in the coming years as people are given the opportunity to purchase and organise their own care.

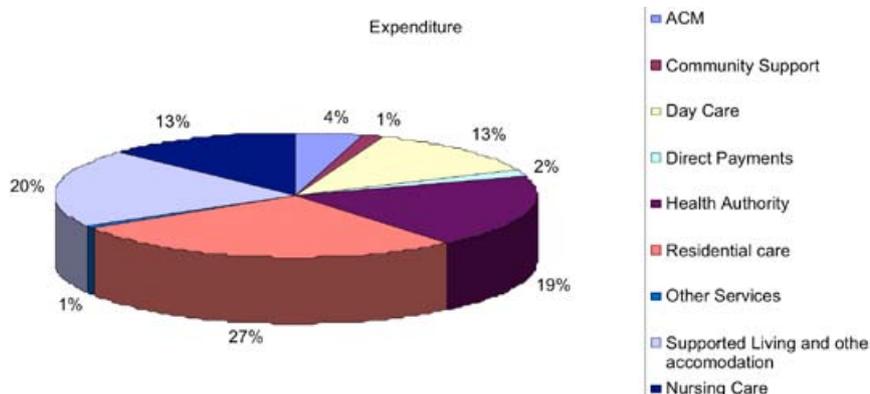
The average annual cost per person is £35,322 which is based on all services that are provided by the Learning Disability Services. This is an average of £679 per week per service user<sup>3</sup>. This is based on 904 adults known to

the service, an increase of 5% over the past 2 years with a corresponding increase in cost per person of 13.1%.

Not every person with autism will need services from health or social care, many such people have jobs and families of their own, but the National Autism Strategy makes it clear that each person should have the offer of diagnosis and an assessment of their needs for health and social care services, should they or their carer choose to access these.

**Figure 6.1: Expenditure Pattern for Learning Disabilities in Rotherham 2009/10**

Source: Report from Lancaster Council (2008), Issues to consider when planning services for the future



<sup>2</sup> Report from Lancaster Council (2008), Issues to consider when planning services for the future, p74  
<sup>3</sup> Report from Lancaster Council (2008), Issues to consider when planning services for the future

# Learning Disability Needs Assessment

## 6.3 Local Analysis

Several factors are likely to contribute to changes in the demographic profile of adults with learning disabilities in Rotherham over the coming years. These include changes to the demographic profile of the population of Rotherham and the effects of reduced mortality among people with learning disabilities. There is evidence to suggest marked increases in the rates of survival into adulthood of children with severe and complex disabilities.

Figure 6.2 sets out predictions for the number of people over 55 years who have a mild, moderate or severe learning disability in Rotherham from 2010.

Projecting Older People Population Information System (POPPI) and Projecting Adult Needs and Service Information System (PANSI) suggest that there

are 1,617<sup>4</sup> people aged over 55 years in Rotherham who have a mild, moderate or profound learning disability in Rotherham in 2010. This is set to increase to 1,729 by 2015, an increase of 7% in the next 15 years. By 2025 the figure will have increased by 17.3% to 2,027. An increase across all age groups is predicted but in particular people 85 years and over where there will be a rise of 77% in the next 10 years. This is mainly attributable to the life expectancy rate increasing and the mortality rates decreasing.

The above prediction rates have been applied to ONS population projections of the 55 and over population in the years 2010 and 2030 and prevalence rates which are based on the Estimating Future Need commissioned by Lancaster University in June 2004. However, these figures include a large proportion of people who

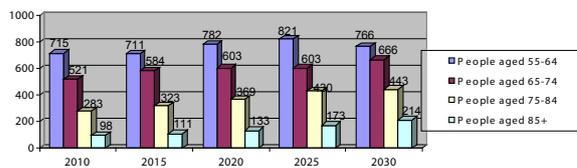
have a mild learning disability who are either not in contact with services or are in contact but not receiving assistance, support or treatment. These people will probably be receiving informal care from family members and carers or living independently.

Figure 6.3 predicts the number of adults aged 18 years and over who have a moderate or severe learning disability and are therefore likely to require services.

Projecting Adult Needs and Service Information System (PANSI) suggests in 2010 that there are 846<sup>5</sup> adults who are 18 years and over who have a moderate or severe disability in Rotherham and who are likely to be in receipt of services. This is predicted to increase to 851 people by 2015 and 878 people by 2025. It is anticipated that there will be a 12% reduction in

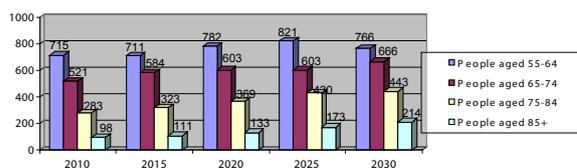
**Figure 6.2: No. of people aged 55 years and over with a mild, moderate or profound learning disability in Rotherham in 2010**

Source: POPPI (2010), People aged 55 and Over Predicted to have a Learning Disability



**Figure 6.3: No. of adults 18 years and over with a moderate or severe learning disability in Rotherham requiring services in 2010**

Source: PANSI (2010), Adults aged 18 years and over with a Learning Disability requiring Services



<sup>4</sup> POPPI (2010), People aged 55 and Over Predicted to have a Learning Disability  
<sup>5</sup> PANSI (2010), Adults aged 18 years and over with a Learning Disability requiring Services

# Learning Disability Needs Assessment

## 6.3 Local Analysis

the number of 18-24 year olds in 2025 with a moderate or severe learning disability but there will be a 40% increase in the number of people over 65 years old from 124 people in 2010 predicted to increase to 173 people in 2030. People with learning disabilities with complex needs are living longer. However there is a reduction in the number of children born with a moderate to profound learning disability.

The Rotherham Learning Disability Service currently knows 904 adults who are aged 18 years and over, most of whom have a moderate or severe disability. Up to 20 new young people are referred to the adult team each year and approximately the number of people dying is less than 5 each year. Using ONS predicted population profiles this would mean that by 2015 the Learning Disability Service in Rotherham will know

approximately 930 people and 1,030 people by 2025. This is an increase of 8% by 2015 and 20% by 2025<sup>6</sup>.

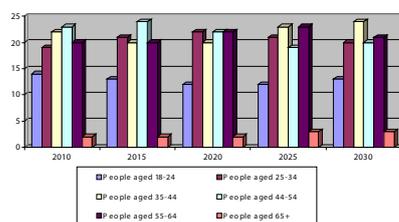
PANSI suggests that there are 108<sup>7</sup> adults aged 18 years and over who had Down's Syndrome/ Dementia in Rotherham in 2010. This is estimated to remain at 108 adults by 2015 and to 109 adults by 2025. It is predicted that there will be a slight increase in the number of people who are living longer with this condition as life expectancy has slowly increased. However, there will be a slight decrease in younger people aged 18 to 24 with this condition as screening and diagnostic tests undertaken at pregnancy reduce the number of children born with this condition. The increase in the older age groups who are over 55 years is predicted to increase from 22 people in 2010 to 24 people in 2025.

Prevalence rates are based on two studies which put the prevalence of Down's Syndrome at between 5.9 per 10,000 general population (Mantry et al) and 6.6 per 10,000 live births (the Clinical and Health Outcomes Knowledge Base). The mean of these rates (6.25%) has been used to calculate the prevalence rate. Recent research shows that there are more babies with Down's Syndrome being born. This may be attributable to the increasing age of women giving birth. The prevalence of dementia in people with Down's Syndrome is estimated at 25.6% in people aged 60 and over with Down's Syndrome.

PANSI suggests that there are 37<sup>8</sup> adults aged 18 -64 years and over who displayed challenging behaviour in Rotherham in 2010. This is estimated to remain the same by 2015 and to 38 adults by 2025. It is predicted that there will be very little movement in the

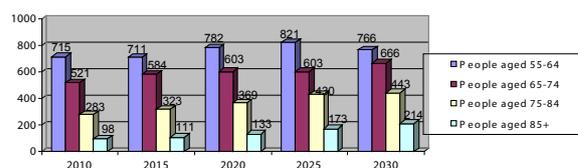
**Figure 6.4: No. of adults aged 18 years and over with Down's syndrome in Rotherham in 2010**

Source: PANSI (2010), Adults aged 18 years and Over with Down's Syndrome



**Figure 6.5: No. of adults aged 18 years and over with challenging behaviour in Rotherham in 2010**

Source: PANSI (2010), Adults aged 18 Years and Over with Challenging Behaviours



6 RAP Data (2010/11), BME Population of People with a Learning Disability

7 PANSI (2010), Adults aged 18 years and over with Down's Syndrome

8 PANSI (2010), Adults aged 18 Years and over with Challenging Behaviour

# Learning Disability Needs Assessment

## 6.3 Local Analysis

number of people with this type of behaviour in future years.

Prevalence rates for adults with a learning disability who present a serious challenge at any one time are 24 per 100,000<sup>8</sup> total population in England. The predictions include people with moderate and severe learning disabilities. These rates are based on Emerson E, Challenging behaviour: Analysis and Intervention in People with severe Intellectual Disability in 2001. Many people will move into and out of this group dependent upon changes in their behaviour characteristics and on how well services meet their needs over time.

PANSI suggests that there are 1,547<sup>9</sup> people in Rotherham who have an autistic spectrum disorder in Rotherham in 2010. This is an increase of 97% from 2008 predictions. The projected number of males with ASD is 1,391 and the number of females is 156 people with ASD. Estimates suggest 5

per 1,000 people have this type of disorder. 12% of these also have a learning disability. These prevalence rates have been applied to ONS population projections to give estimated numbers predicted to have this disorder by 2025.

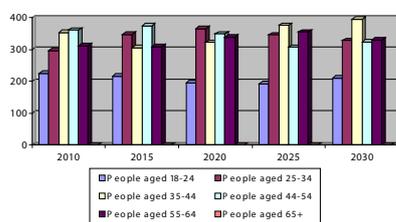
The National Autistic Society states that “estimates of the proportion of people with autism spectrum disorders (ASD) who have a learning disability (IQ less than 70) vary considerably and it is not possible to give an accurate figure. Some very able people with ASD may never come to the attention of services as having special needs, because they have learned strategies to overcome any difficulties with communication and social interaction and found fulfilling employment that is suitable to their particular talents. Other people with ASD may be able intellectually, but have need of support from services, because the degree of impairment they have of social interaction hampers their chances of employment and achieving independence”.

The information about Autism Spectrum Disorder (ASD) is based on ASD in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007 published by Health and Social Care Information Centre September 2009.

There are 99 adults aged 18 years and over who are known to have autistic spectrum disorder in 2010 with a learning disability in Rotherham. This is predicted to increase to 104 adults by 2015 and to 106 adults by 2025. It is estimated that there will be a steady increase in the number of people who are living longer with this type of disorder as life expectancy increases and mortality rates decrease.

**Figure 6.6: No. of adults with Autistic Spectrum Disorders in Rotherham in 2010**

Source: PANSI (2010), Adults aged 18 years and over with Autistic Spectrum Disorder



## Learning Disability Needs Assessment

### 6.4 BME Population – National Analysis

Nationally there has been a significant drive to enable people from BME communities to access services. Previous studies suggest that BME service users have been under-represented in learning disability services.

There is a higher prevalence of learning disabilities among younger people from Pakistani and Bangladeshi communities. It is estimated that between 2001 and 2021 there will be increases observed within the BME community<sup>10</sup>:

- 10% increase in the number of BME adults with learning disabilities known to services
- 36% increase in the number of BME adults with learning disabilities aged 60+

## Learning Disability Needs Assessment

### 6.5 BME Population - Rotherham in 2010

Information taken from RAP data for 2009/10 shows that there were 26 people (4.0%) who are aged between 18 to 64 years from a black or minority ethnic group who have a learning disability compared to 660 people from a White British or other white background. The number of people from the BME population who have a learning disability who receive a care managed service has increased by 60% since 2007/8.

In comparison to other client groups in Rotherham this suggests that the Learning Disability Service is closing the gap on representation of the BME population in learning disability services for people of working age. In comparison there are 5.5% of people with physical disabilities and 7.5% of people with mental health problems who are from the BME community.

Similarly for people 65 years and over there is no one receiving learning disability services

from the BME population. In comparison there is 0.9% of people with physical disabilities and 1.4% who have mental health problems.

Nationally there is a higher prevalence of people under 65 years with Pakistani origin who have a learning disability. This is reflected in Rotherham with 21 out of 26 people (80%) from the Pakistani community accessing services.

Rotherham is continuing to raise the profile of people with a learning disability from the BME population by developing a BME Engagement and Service Scoping Project in conjunction with Rotherham Advocacy Partnership to identify culturally acceptable and appropriate models for delivering support to BME people with Learning Disabilities and their families.

## Learning Disability Needs Assessment

### 6.6 Life Expectancy of People with Learning Disabilities

The life expectancy of people with learning disabilities is 67 years for men and 69 years for women. This is 10 years less for men and 12 years less for women in comparison to the general population. Older people with learning disabilities are now likely to have age related health problems such as strokes, heart disease and cancer<sup>11</sup>.

Studies have suggested that mortality rates are higher for all age groups of people with learning disability compared with the general population, but this difference has been reducing in recent years<sup>12</sup>.

There is a correlation between the severity of a learning disability and mortality in that people with profound disability and a significantly reduced life expectancy. There is also evidence that people with profound learning disabilities

are more likely to die as a result of respiratory diseases. There is a greater prevalence of heart disease amongst people with a learning disability. As life expectancy increases for people with learning disabilities so too does the risk of developing age-related cancers<sup>12</sup>. Risk factors connected to poor health and life expectancy include mobility problems, presence of epilepsy, poor nutrition and difficulties with verbal communication<sup>13</sup>. Although life expectancy has been rising it may well take a dip within 20 years, with the increase in the "pathologies of affluence" alcohol abuse, obesity and diabetes. People with learning disabilities are likely to be included in this.

Amniocentesis and other pregnancy screening are reducing the number of babies born early (23 or 24 weeks gestation) which are surviving into adulthood, with a higher likelihood of disability and

the likelihood of small numbers of severely disabled people. South Asian heritage people have a higher prevalence of learning disabilities and with continuing migration to the UK the population of people with learning disabilities is likely to increase<sup>3</sup>.

People with Down's Syndrome have a shorter life expectancy than other people with learning disabilities, although evidence shows that over the last two decades life expectancy for this group is increasing which is mainly due to improved medical intervention<sup>12</sup>.

# Learning Disability Needs Assessment

## 6.7 Health of People with Learning Disabilities in Rotherham

People with learning disabilities are 2.5 times more likely to have health problems than other people and 4 times as many people die of preventable diseases. They are more likely to have a long-term illness or another disability than other people<sup>14</sup>.

People with learning disabilities experience higher rates of ill-health than the general population. They are more likely to receive poor levels of health treatment as a result of “diagnostic overshadowing”, where people’s health needs are overlooked due to focusing on their learning disability<sup>17</sup>.

All people on the Local Authority register will be offered an Annual Health Check as 100% of Rotherham GP Practices have agreed to implement this health check. Over 350 staff have been trained in Learning Disability Awareness including GP Practices, Health Centres and Rotherham Foundation Trust which will improve service delivery. 50% of people have a Health Action Plan.

In 2010 a local Health Needs Assessment of People with Learning Disabilities was conducted with people who attended day services. The purpose was to collect information on the wider aspects of health and well being. The aim of the assessment was to gain an

insight into the health status of adults with a learning disability to inform and influence the commissioning of health services. In addition, the data collected during this assessment will form the baseline to monitor future outcomes and improvements.

Learning Disability is more prevalent among males, the young (due to mortality), poor people and South Asians. The risk of dying is 50-58 times that of the general population. Respiratory Disease is responsible for 50% of deaths (which is 3 times greater than the general population).

There are some conditions that disproportionately affect people with learning disabilities. The primary health conditions which affect people with learning disabilities are<sup>17</sup>:

### Respiratory Disease<sup>15</sup>

This is the leading cause of death for people with learning disabilities (52%). Aspiration and respiratory tract infections can be caused by congenital defects, vomiting, epilepsy, coughing, feeding, breathing and swallowing difficulties, regurgitation and gastroesophageal reflux.

### Screening

People with learning disabilities are often excluded from national screening programmes.

There is often a failure to screen for, identify and treat prevalent illnesses (e.g. thyroid dysfunction and congenital heart disease). Women with a learning disability are about 4 times less likely to undergo a cervical smear test than the general population (24% vs 82%). They are also less likely to have breast examinations or be invited to attend for a mammogram. The Rotherham Health Needs survey identified 74% of women respondents had never had a breast check and 84% had not received a smear test. The survey also identified that 77% of male respondents had not had a testicular examination<sup>15</sup>.

### Sensory Impairment

Approximately 30% of people with learning disabilities have a significant impairment of sight. Adults with Down’s Syndrome often present with cataracts, keratoconus and retinal pathology. Regular monitoring of vision is important for this group, as they rarely complain of poor vision.

40% of people with a learning disability have a hearing loss which is unidentified in 75% of cases.

<sup>14</sup> Disability Rights Commission (2006). *Equal Treatment: Closing The Gap*, p5

<sup>15</sup> *Valuing People (2001), A-Z of Health Issues Affecting People with a Learning Disability*

# Learning Disability Needs Assessment

## 6.7 Health of People with Learning Disabilities in Rotherham

### Oral Health

Poor oral health is one of the most frequent health problems in this population. One study found 86% of people with a learning disability had a dental disease. They have poor oral hygiene, untreated dental cavities and more extractions than the general population. However, the Rotherham Health Needs Assessment identified that the majority were registered with a dentist and 76% had visited a dentist in the last year<sup>16</sup>.

### Coronary Heart Disease (CHD)

Coronary Heart Disease is the second most common cause of death amongst people with learning disabilities (14% to 20%). Between 40% and 50% of people with Down's Syndrome are affected by congenital heart defects<sup>17</sup>. It is estimated that between 42 and 52 people with Down's Syndrome in Rotherham will have heart defects which may reduce life expectancy and increase mortality rates.

### Autistic Spectrum Disorder (ASD)

People with learning disabilities are more likely to have an Autistic Spectrum Disorder. In 2010, there were 1,547 people with this disorder in Rotherham, a projected increase of 96.5% from 2008, of which there were 99 people who had a learning disability. This equates to 12% of people with a

learning disability who had this type of disorder.

### Obesity

Around one person in three with a learning disability is obese compared to one in five of the general population. It is estimated that there are 284 people with learning disabilities who are obese in Rotherham. Studies suggest that 56% of men and 73% of women with a learning disability are obese. Obesity is a specific risk for adults with Down's Syndrome. Poverty, unemployment and social exclusion inhibit healthy lifestyle choices. Less than 10% of adults with learning disabilities eat a balanced diet. 80% of people with learning disabilities do less physical exercise than is recommended<sup>17</sup>. The Rotherham Health Needs Survey identified that 69% of people surveyed said they did no exercise. 9% exercised once per week<sup>16</sup>.

### Epilepsy

It is estimated that 22% of people with learning disabilities have epilepsy compared to 1% of the general population. This incidence rises to 30% in people with profound and multiple disabilities. In the Rotherham Health Needs survey 49% people listed epilepsy as a long term condition<sup>16</sup>.

### Mental Illness

Psychiatric disorders are more prevalent in people with learning

disabilities compared with the general population. Schizophrenia, depression, anxiety and pre-senile dementia are all more common in this group. 3% of people with learning disabilities compared to 1% of the general population have schizophrenia<sup>17</sup>. It is estimated that 26 people with learning disabilities in Rotherham also have schizophrenia.

People with learning disabilities are more likely to develop early dementia – 21% compared to 5.7% of the normal population. Prevalence rates are much higher for people with Down's Syndrome. Prevalence rates for dementia are between 40% to 50% which will mean that between 42 to 52 people with Down's Syndrome will develop early on-set dementia before the age of 50 years in Rotherham<sup>17</sup>.

### Mobility Problems

People with learning disabilities are more likely to have a physical disability than the general population. The majority of people with learning difficulties are unable to travel independently. A sample analysis of day service users showed that 90% of service users required assistance to attend those services<sup>17</sup>.

# Learning Disability Needs Assessment

## 6.8 Employment

It is estimated that around 17% of people with learning disabilities who are of working age have a paid job. Around 1 in 5 people with learning disabilities have an unpaid job<sup>17</sup>. 1 in 10 people with learning disabilities who access health and social care services are engaging in some form of paid work<sup>18</sup>.

Analysis of the first full year data collection (2009/10) for the National Indicator NI 146 which measures the percentage of adults with learning disabilities known to Adult Social Services in paid employment, shows Rotherham had 39 people in paid employment or 5.4%. This score is better and compares favourably against Rotherham's comparator group of authorities average score of 4.3%; but is not as good as the overall England average of 6.8% (although the actual gap is closer when compared to the true average for England of 6.4%).

Rotherham also has 34 people known (care managed) to Adult Social Services in voluntary employment.

These national figures indicate that in Rotherham there are more people with a learning disability

in employment than in most other comparable local authorities.

There are a number of organisations that employ people with a learning disability. Speak Up Self Advocacy Group currently employ 30 people and a further 31 people in a voluntary capacity (July 2010). MENCAP Pathways currently support paid work for 21 people and a further 15 people in voluntary placements with a learning disability.

The Local Authority supports a further 50+ service users through its various work experience/ employment projects (e.g. Project 400 and Ad pro)

Studies suggest that many people with learning disabilities would like to work and would be able to if they received good support. Employers often welcome advice and training in how best to help people with learning disabilities. Employers can help by making their application forms easy to read and only asking for qualifications that are relevant to the work on offer.

Local developments to improve employment possibilities for Rotherham people with learning

disabilities have included Jobcentre Plus, which is a member of the Learning Disability Partnership Board and "Access All Areas" (AAA), lead by RMBC with support from partner organisations.

The AAA has provided 30 day work placements for 38 people with a learning disability and for 7 people with Asperger's Syndrome and Autism. It aims to help individuals build their self esteem, confidence and stamina whilst providing real work experiences that can be described in job applications.

In addition to RMBC, the following strategic partners have offered placements:-

- NHS Rotherham
- Rotherham College
- Scope Day Services
- South Yorkshire Fire and Rescue Service
- South Yorkshire Police
- 2010 Rotherham Ltd

# Learning Disability Needs Assessment

## 6.9 Housing

Increased demand in the older age groups is of particular significance for the strategic planning of services since older adults with learning disabilities are significantly more likely than younger adults to rely on public funding for supported accommodation.

According to the Department of Health's "Valuing People" in 2001, it is estimated nationally that approximately 50% of adults with learning disabilities live with their families<sup>19</sup>. In comparison, Rotherham is well below the average. There are approximately 287 people (41%) who are known to the Learning Disability service who live with family members with greater numbers being supported to live independently in the community. This is mostly

due to active work undertaken with older carers to help them "let go", enabling their sons and daughters to move into supported living schemes. This helps the older carers to feel reassured about the future and to pass on valuable information to help the person with a learning disability settle into their new home.

Analysis of the first full year data collection (2009/10) for the National Indicator NI 145 which measures the percentage of adults with learning disabilities known to Adult Social Services who live in settled accommodation shows 519 (72.4%) people with a learning disability living in settled accommodation. This score is better than Rotherham's comparator group of authorities

average score of 64.3% and the overall England average of 61.7% (the actual gap is greater when compared to the true average for England of 61.0%).

Rotherham has an extensive supported living programme which promotes independence and admission to residential care before family carers become too frail to deliver care. There are 120 people currently residing in 40 supported living schemes in Rotherham. 97 people live at home with individually tailored community support ranging from 1 hour to 34 hours per week. Figure 6.7 shows the accommodation status of all those reviewed and recorded via the ASC-CAR return.

**Figure 6.7: Accommodation status of people with learning disability in Rotherham in 2010**

Source: ASC-CAR Adult Social Care Combined Activity Return 2010/11

Living Situation	Number	%
Living with family – informal support	287	41
Own home with formal support – supported living schemes, community support, Keyring, Direct Payments, home care	237	34
Registered care placement – residential or nursing care, shared lives scheme	171	25

## Learning Disability Needs Assessment

### 6.10 Residential and Nursing Care in Rotherham

Nationally it is predicted that there are approximately 33% of people living in residential care placements who are known to Learning Disability Services. Rotherham is well below the national average at 21% in 2010.

Nationally many people with learning disabilities who were formerly long-term patients in hospitals are now accommodated in care homes. In Rotherham 3 in 4 former residents are in a supported living scheme rather than living in a care home. However, the needs of those remaining in residential and nursing care are much greater. The cost of residential care for

people with learning disabilities has increased by 5% over the last two years<sup>20</sup>.

In 2010 there were 142 adults with learning disabilities supported by the Local Authority in residential care and 48 people in nursing care (190 supported in total). In 2010 there were 190 people in a registered care placement which is an increase of 23 people in long-term care over the last two years<sup>20</sup>.

NHS Rotherham's Continuing Care funding contributes to support costs of some of these residential placements. In 2010 there were 49 people with a learning disability in

receipt of continuing health care and placed in residential/nursing care/day care. This is an increase of 60% in the past two years. This is a reflection of the complex health needs of people with a learning disability particularly the young people transferring to adult services<sup>21</sup>.

# Learning Disability Needs Assessment

## 6.11 Community Based Services for People with Learning Disabilities

Community based services ensure that people with a learning disability are able to live at home independently for as long as possible, preventing or delaying admissions to long-term residential care.

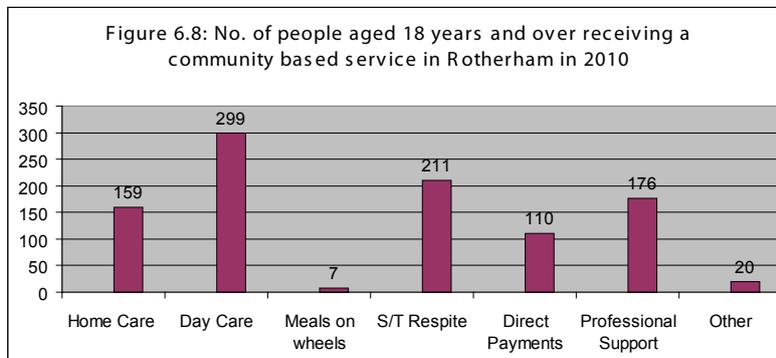
The number of service users receiving community based services taken from RAP data 2009/10 shows that the total number of learning disability clients in receipt of a community based service from learning disability services has decreased slightly over the last two years. In 2006/7 there were 522 people in receipt of community based

services, 507 people in 2007/8 and 506 in 2009/10<sup>22</sup>. The total number of community based services provided was 803 in 2006/7 and 835 in 2007/8 and 764 in 2009/10. This is a decrease of 8.5% in the last 2 years in comparison to a 10% increase from 2006-2008.

The number of people attending day care has remained the same and there has been a continued uptake of direct payments which have significantly increased by 100% in the last 2 years from 54 to 110 people. Previous increase from 2006-8 was 68%<sup>22</sup>. Another factor may be that people are

relying on family members and carers to provide informal support at home. There has been a 21% increase in the number of short-term respite care placements provided in Rotherham in the last two years compared to 9% in 2006-2008.

Figure 6.8: Number of people aged 18 years and over receiving a community based service in Rotherham in 2010



## Learning Disability Needs Assessment

### 6.12 Carers

The ageing profile of carers is likely to have a significant impact on health and adult social care services in the future as people who are currently cared for by family members will need support from learning disability services for formal support as their carer will no longer be able to provide informal care. People with learning disabilities are increasingly providing a caring role to their parents as they get older. However, people with learning disabilities are generally not perceived as being carers.

In 2010, there were 373 learning disability service users with a recorded carer. 31% of service users had a carer over retirement age compared to 23% in 2008 and 115 service users were known to have a carer over 65 years of age<sup>6</sup> and there are 24 single carers over the age of 80 years. In 2010 37 carers were assessed separately and 52 were assessed jointly there were 4 carers' assessments for carers over 65 years old. 12 carers received a service and 70 carers received advice and information.

# Learning Disability Needs Assessment

## 6.13 Summary of Chapter 6

### What are the emerging needs within this section:

- The number of individuals with learning disabilities continues to increase, and is predicted to reach 1 million people by 2014. There are also a significant number of adults with learning disabilities over the age of 65.
- 41% of adults living with a learning disability are living in an informal family setting. 115 of these carers are over the age of 65 years and a further 24 single carers over the age of 80 years.
- PANSI figures show an increase of 97% from 2008 figures of people in Rotherham who have Autistic Spectrum Disorder.
- Rotherham continues to spend well above the national average on supported living schemes enabling people to maintain their independence in the community.
- NI146 refers to the 5.4% of adults living with a learning disability who have a care managed service in paid employment.
- There has been a 100% increase in uptake of direct payments in the last 2 years and also an increase of 12% in demand for short term respite beds.

### Key Issues:

Life expectancy of people with learning disability is increasing year on year and also the number of age related problems EG Strokes, heart disease and cancer. The prevalence of early onset dementia for people with Down's Syndrome is 26% in people over the age of 60 years. There has been a sharp increase in the number of school age children with autistic spectrum disorders, some of whom have learning disabilities (12%). There is also a greater prevalence of learning disabilities among the S.E. Asian population and a growing number of children with complex and multiple disabilities who survive into adulthood.

### What actions need to be taken:

- It is important to recognise the age related health problems and the lack of preventative screening that has taken place with this group of people. There is a need for work to continue on the health agenda with acute services and primary health to improve access to these service areas. It is important for the Dementia Strategy to meet the needs of early onset dementia for people with Down's Syndrome.
- As stated in Valuing People Now there is a need to continue to improve employment opportunities for people with learning disabilities.
- There is a need to develop a greater awareness of the needs of older carers and develop appropriate plans for the future involving service users in person centred plans.

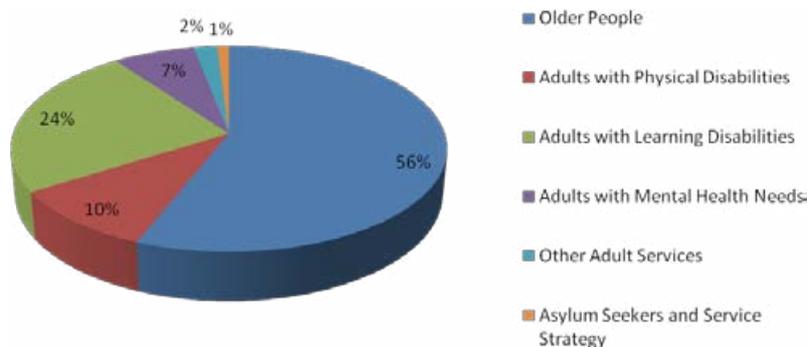
# Social Care Needs Assessment

## 7.1 National Profile of Need for Social Care

The “Personal Social Services Expenditure and Unit Costs” published by the NHS Information Centre highlights the gross expenditure by Local Authorities on adult social care services in England. There has been an increase in expenditure from £15.3 million in 2008-09 to £16.1 million in 2010/11<sup>1</sup>. This is approximately 5% in cash terms and 3% in real terms.

Figure 7.1 shows that services for older people accounted for 56% of the total gross adult social care expenditure. 24% of the allocated budget was spent on services for people with learning disabilities, 10% on physical disabilities, 7% on adults with mental health conditions and the remaining 3% on services for other adult services, asylum seekers and service strategy. Rotherham’s pattern of spending on adult social care is very similar to the national picture.

Figure 7.1: Client Group as a % of Gross Current Expenditure in 2010-11<sup>2</sup>



## Social Care Needs Assessment

### 7.2 Promoting Independence and Developing Community Support

Over the last five years there has been a national and local reduction of the number of people living in residential care who are financially supported by Local Authorities in England. This is consistent with Rotherham Council's strategic objectives to reduce the number of people admitted to institutionalised care by the provision of alternative places to live e.g. extra care housing, sheltered housing or adult placement schemes for those people with higher levels of need who are being supported for longer in community settings. Equipment, adaptations and assistive technology have also played a key role in preventing or prolonging the need for residential care, maximising independence and improving the quality of life for the local population.

It is a pivotal strategic objective for the Local Authority to delay the point at which people enter institutional care. There is evidence that developing care

and support services in the community reduces care costs further down the line. Achieving this objective requires transfer of resources from institutional care to the community. However, it also requires significant reconfiguration of existing community-based services.

Nationally and locally, there has been a reduction in the number of older people who are in receipt of traditional community support services such as home care, meals provision and day care services. These services have been replaced by personal budget schemes (direct payments and individual budgets) so that people are able to exercise their choice and control over any decisions about how their care needs can be met which are tailor-made to meet individual requirements. The unit costs for these types of schemes tend to be lower than traditional services which can maximise adult social care expenditure and provide value for money.

# Social Care Needs Assessment

## 7.3 Rotherham Profile of Need for Adult Social Care

The following analysis has been extracted from Strategic Needs Assessment for Long-Term Social Care for Older People (Planning4Care – 2010).<sup>3</sup>

The Strategic Needs Assessment uses the following social care needs definitions:

### Activities of Daily Living (ADL)

Getting in and out of a bed or chair, using toilet, get dressed and undressed, feed self, bath, shower or wash.

### Instrumental ADL (IADL)

Shopping, laundry, vacuuming, cooking a main meal and managing personal affairs.

### No Needs

Able to perform ADL and IADL tasks without difficulty or need for help.

### Low Needs

Difficulty in performing IADL tasks and/or has difficulty with bathing, showering or washing all over but not with other ADL tasks.

### Moderate Needs

Difficulty with one or more other ADL tasks.

### High or Very High Needs

Unable to perform one ADL task without help.

### Background

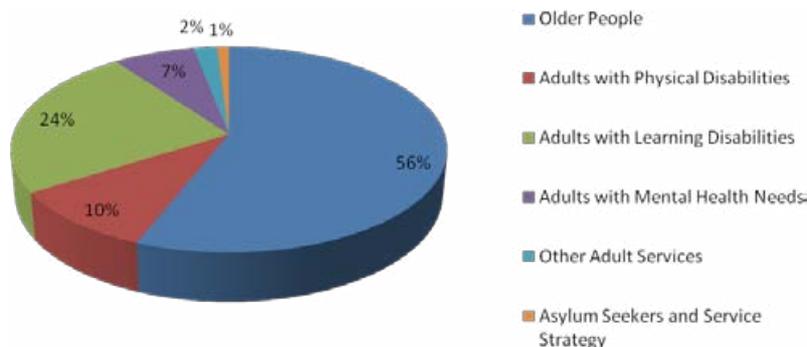
The Strategic Needs Assessment predicts that the number of older people in Rotherham is likely to increase by 51% over the next 20 years. This is slightly above the national average of 50%.<sup>3</sup>

It is estimated that there are currently 43,700 of people aged 65 years and over, of which 16,720 people (38%) in Rotherham have a formal social care need who are not well supported by informal carer(s) as they have no effective informal social support for main functional disablement problems or they receive support from a carer who does not live in the same household. Of these 8,770 (20%) are unable to perform

one or more ADL and therefore require direct support<sup>3</sup>. By the year 2030, the number of people aged 65 years and over who require formal care will increase to 26,190 (which equates to an additional 474 people requiring formal support from adult social care for each year).

There are currently 5,200 people in Rotherham who are 85 years and over. The population for this age group is projected to grow by 110% over the next 20 years to around 10,900 by the year 2030. This is significantly above the predicted national average growth of 50%. People who are 85 years and over are most likely to require formal support so this demographic is more relevant when projecting future service need<sup>3</sup>

Figure 7.1: Client Group as a % of Gross Current Expenditure in 2010-11<sup>2</sup>



# Social Care Needs Assessment

## 7.3 Rotherham Profile of Need for Adult Social Care

### Current Levels of Social Care Needs in Rotherham

Figure 7.2 illustrates the breakdown of social care needs for people aged 65 years and over in Rotherham in 2010-11. The pie chart illustrates that around 21% of older people have high or very high needs requiring formal social care support as they are unable to perform one ADL task without help and 13% having difficulty with one or more ADL task due to their long-term condition/physical disabilities.

This is higher than the regional and national averages as there are a higher prevalence of older people living with limiting long-term conditions in Rotherham. Therefore, Rotherham is likely to experience a proportionately higher level of demand for formal care services compared to other Local Authorities.

Figures 7.3 and 7.4 highlight the number of adults from the ages of 18 to 64 years who have a moderate or serious personal care disability in Rotherham and the increase in numbers, projected to the year 2030. The information is based on prevalence data on adults with physical disabilities requiring personal care.

In 2010/11, 12,394 adults (18 to 64 years) have a moderate physical disability and 3,720 with a serious physical disability. A moderate personal care disability means that tasks can be performed but with some difficulty, a severe personal care disability means that the task requires someone else to help.

Figure 7.2: Levels of Social Care Need for Older People (65 years and over) in Rotherham 2010/11<sup>3</sup>

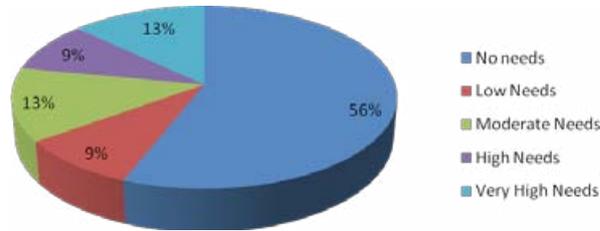


Figure 7.3: Adults (18 to 64 years) predicted to have a physical disability in Rotherham from 2010, projected to 2030<sup>4</sup>

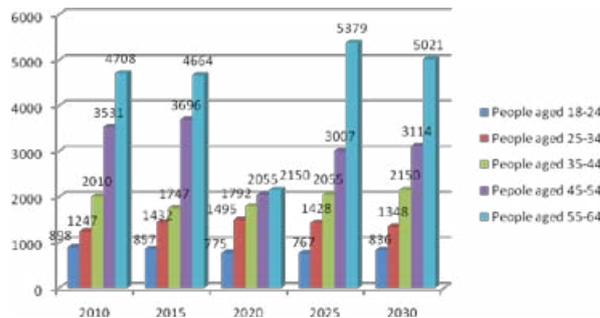
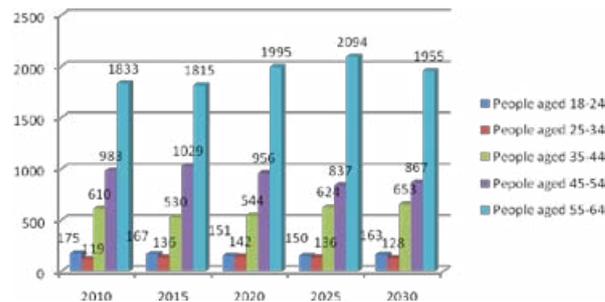


Figure 7.4: Adults (18 to 64 years) predicted to have a serious disability in Rotherham from 2010, projected to 2030<sup>5</sup>



<sup>4</sup> PANSI (2011), Adults Predicted to have a Moderate Physical Disability in Rotherham  
<sup>5</sup> PANSI (2011), Adults Predicted to have a Serious Physical Disability in Rotherham

# Social Care Needs Assessment

## 7.3 Rotherham Profile of Need for Adult Social Care

### Local Authority Funded Social Care Costs

Figure 7.5 illustrates the breakdown of publicly funded care costs by different types of service support package (according to PSS EX statistical returns).

60% of the allocated budget is spent on people living in 24 hour residential care in Rotherham. Home care is the main component of care packages for people living in their own homes (35%). Day care or other community support services is typically provided as a supplement to home care (5%).<sup>3</sup>

Developing more community-based services would significantly reduce care costs in the future and maintain older people in the community.

### Local Authority Funded Care for People with Very High Needs

Figure 7.6 illustrates the breakdown of publicly funded care costs by different types of service support package for people with very high needs (according to KIGS and ONS sub-national population projections).

Two thirds (67%) of expenditure is spent on people living in 24 hour residential care. In contrast, a third (33%) is spent on community care for people who receive care packages and support in their own homes through intensive home care packages, day care sessions or other community based services.

### Level of Social Care Need for Older People

Figure 7.7 illustrates the total number of older people with social care needs in Rotherham in 2010-11 (19,820). A total of 5,730 people fall into the very high needs category of which 4,510 as a result of a physical condition and 1,220 due to a cognitive/functional condition.

The numbers are predicted to significantly increase within the next 20 years to a total of 8,990 people resulting in an increase of 56% by the year 2030. There are 4,250 people in the high needs category which will increase to 6,680 by the year 2030, showing a similar increase of 57%.

Figure 7.5: Breakdown of Adult Social Care Costs for Older People in Rotherham in 2010/11<sup>3</sup>

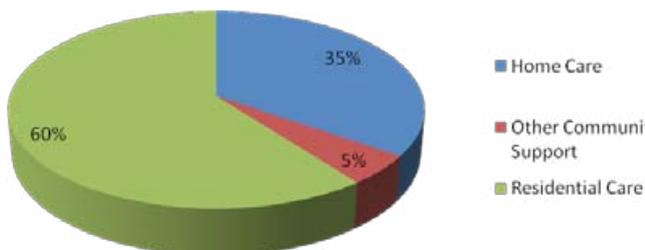


Figure 7.6: Breakdown of Residential and Community Care for People with Very High Needs in Rotherham 2010-11<sup>3</sup>

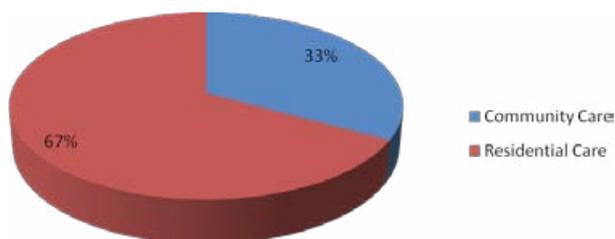
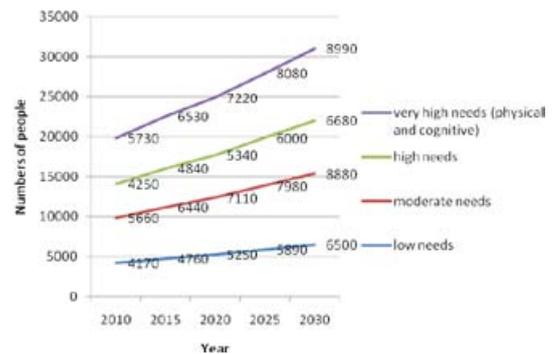


Figure 7.7: Number of Older People with Social Care Needs in Rotherham 2010/11<sup>7</sup>



# Social Care Needs Assessment

## 7.3 Rotherham Profile of Need for Adult Social Care

### Social Care Funded by the Local Authority

Figure 7.8 illustrates that there are a total number of 2,730 older people that are currently supported by adult social care in Rotherham (according to NASCIS data<sup>18</sup>). 56% of older people have very high needs, 30% with high needs and the remaining 14% with moderate needs<sup>3</sup>.

By the year 2020 the number of older people requiring support will increase by 25% to 3,440 and by the year 2030 by 58% to 4,290 which is above the national and regional averages of 23% and 53%. This increase will result in an additional 1,560 older people accessing adult social care support over the next 20 years, or an average increase of 78 older people per year.

### Projected Weekly Costs of Meeting Social Care Needs of Older People Receiving Publicly Funded Services

Figure 7.9 illustrates the total weekly cost of Local Authority commissioned care costs of £842,180 per week, totalling an overall spend of around £44 million per year (according to Unit Cost Summary, England). This includes home care, day care and residential care costs provided to older people.

It is predicted that the weekly cost will increase to £1,057,390, totalling an annual expenditure of £55 million by 2020 (an increase of 26%) and to £1,321,450 per week, totally an annual expenditure of £66 million (an increase of 57%). This is above the regional and

national average of 23% and 53% respectively.

### Number of Older People who are Potential Self-Funders

Figure 7.10 illustrates that there are a total number of 13,980 older people that are potential self-funders who are neither receiving publicly funded care nor well supported by informal care<sup>3</sup>.

By the year 2020 the number of potential self-funders will increase by 26% and the year 2030 by 57% which is above the national and regional averages of 23% and 54%. This increase will result in an additional 7,920 additional people or an average increase of 396 people per year who are self-funding their own care over the next 20 years.

Figure 7.8: Number of Older People Likely to Receive Care Funded by the Local Authority in Rotherham 2010-11<sup>3</sup>

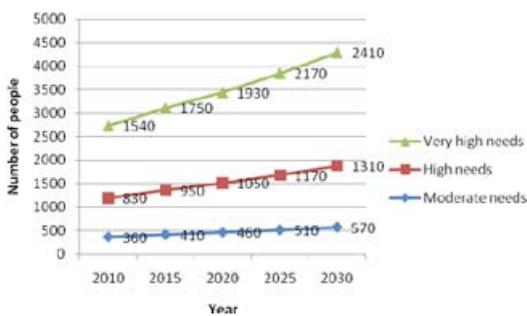


Figure 7.10: Number of Older People who are Potential Self-Funders in Rotherham 2010-11<sup>3</sup>

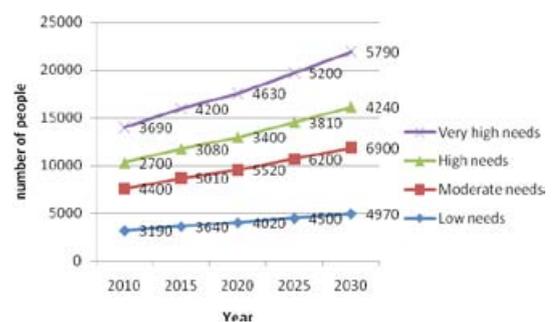
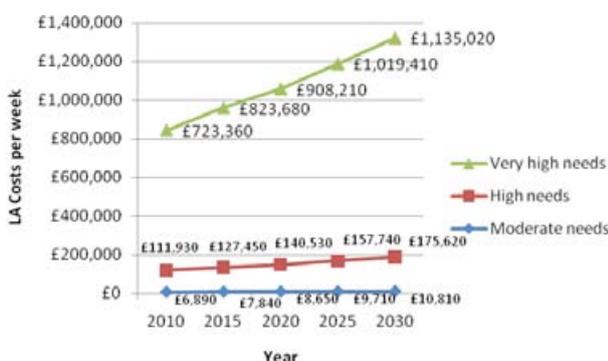


Figure 7.9: Weekly Cost to Local Authority to Meet Social Care Needs<sup>3</sup>



# Social Care Needs Assessment

## 7.3 Rotherham Profile of Need for Adult Social Care

However, a high proportion of older people who currently self-fund may require financial support from the Local Authority to fund their care costs due to smaller pension funds and increase in the cost of living which has risen considerably over the last five years.

### Number of Older People Potentially in Need of Formal Care

Figure 7.11 illustrates the total number of older people (16,720) who are requiring formal care but who are not well supported by informal carer(s) in Rotherham. An individual who is regarded as not well supported by informal care is if they have no effective informal social support for main functional disablement problem or receive support from a carer who does not live in the same household.

A total of 5,230 people fall into the very high needs category and 3,540 in the high needs category. The numbers are predicted to significantly increase within the next 20 years to a total of

8,200 and 5,550 respectively by the year 2030. This shows a significant increase of around 57% for both categories which is slightly above the national and regional rates of 54%.

### Informal Care Needs Analysis

In Rotherham there are an estimated 30,000 carers providing unpaid informal care. Carers UK have calculated this is one in eight adults<sup>11</sup>.

Nationally two recent reports by the Department of Health "The Survey of Carers in Households" and "The Personal Social Services Survey" showed that one fifth of carers care for over 50 hours a week.

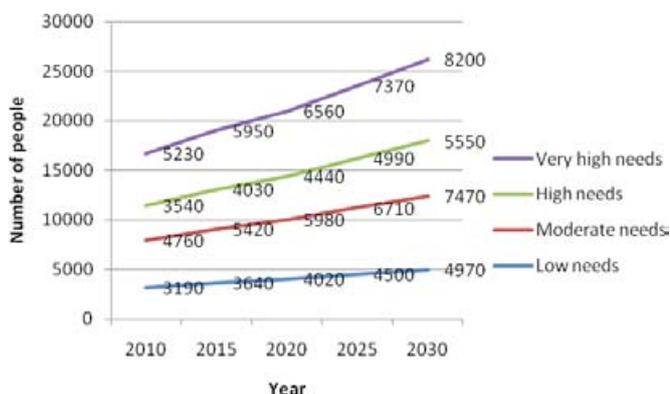
The reports also showed that carers known to Adult Social Services have more intense caring duties with almost half the number of carers spending over 50 hours a week caring and 30% of carers cared for more than 100 hours a week.

In Rotherham a local Carers Strategy has been developed which sets out an agenda for supporting carers over a three year period. The Action Plan aims to build on current good practice and makes the necessary changes to improve services. A Carers Strategy Implementation Group was established to set priorities and timescales.<sup>11</sup>

The following achievements have been made:

- carers are listened to and are at the centre of service development;
- carers are respected as expert care partners and have access to the integrated and personalised services they need to support them in their caring role;
- carers are able to have a life of their own alongside their caring role;
- carers will be supported to stay mentally and physically well and treated with dignity and respect

Figure 7.11: Number of Older People who are not well supported by informal carer(s) in Rotherham 2010-11<sup>3</sup>



# Social Care Needs Assessment

## 7.3 Rotherham Profile of Need for Adult Social Care

- children and young people are protected from inappropriate caring and have the support they need to learn, develop and thrive, to enjoy positive childhoods and to achieve against Every Child Matters outcome.

Special attention will be paid to the local demographic changes and reaching carers who are less likely to access our services.

### Number of Older People Well Supported by Informal Care

Figure 7.12 illustrates that there are a total number of 3,100 older people who have social care needs and receive help with their main care needs from informal carers who live in the same household<sup>2</sup>.

By the year 2020 the number of older people receiving informal care will increase by 26% and the year 2030 by 57% which is above the national and regional averages of 23% and 54%. This increase will result in an additional 1,270 additional people or an average

increase of 64 people per year who are receiving informal care over the next 20 years.

The number of minority ethnic elders is predicted to rise significantly over the next few years. Research by Age Concern predicts that the population is growing fast and expected to increase by 170% from 2005 to 2012.

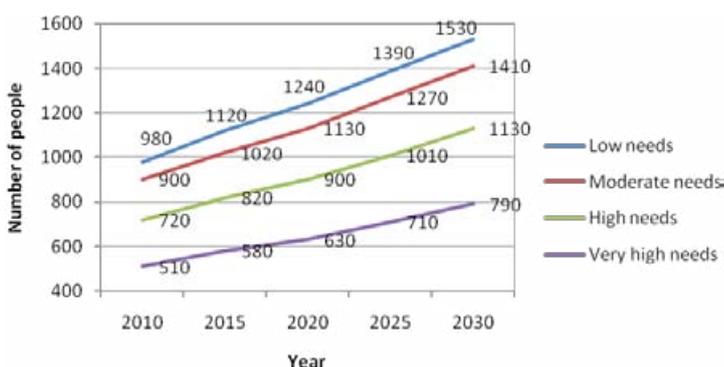
Currently there is a low take-up of community-based adult social care services from older people in BME communities. This indicates a heavy reliance on informal care, which is likely to come under pressure as the BME community experiences the same demographic changes as the overall population.

Research suggests that carers who are providing high levels of care are twice as likely to be permanently sick or disabled. Over 7,000 carers provide more than 50 hours of care per week and approximately 15,000 people combine care with work. Over 5,000 people care for more than one person<sup>17</sup>.

The "State of Social Care in England<sup>2</sup>" showed that two-thirds of new carers care for more than 20 hours per week. 41% support someone who is not receiving any services at all. 42% said the person they care for had not had their needs assessed. 41% did not know what services were available locally. Only 17% of new carers had received a carer's assessment and only 25% of working carers felt they had adequate support from formal services to enable them to combine work and care. Nearly half of carers said that a lack of flexibility and sensitivity in the delivery of services was hampering them.

The Joint Carers Strategy developed by the Local Authority and NHS Rotherham acknowledges that the shift to independent living and care at home, away from institutionalisation, is likely to place a greater burden on informal carers. Whilst the demands for informal care are increasing, societal and demographic changes are likely to reduce availability. Family networks are more dispersed, a larger proportion of women are working out of

Figure 7.12: Number of Older People who are well supported by informal care in Rotherham 2010-11<sup>3</sup>



## Social Care Needs Assessment

### 7.3 Rotherham Profile of Need for Adult Social Care

the home and there are a higher proportion of older people. Consequently there is a danger vulnerable people who were traditionally supported within the family will be left isolated with little or no support from family or friends.

Carers Carer opened in May 2010 and has supported over 4,000 people to provide advice, guidance, support, information and access to services such as welfare benefits, legal support, Alzheimers Society, Crossroads Emergency Scheme and Breakaway Scheme<sup>12</sup>.

Services jointly delivered through Carers Corner are Tasibee which is an organisation supporting carers from BME communities to learn new skills such as cooking, gardening, attending healthy eating sessions and walking groups<sup>12</sup>.

An increase in the volume of outreach work to support carers has resulted in a training programme developed jointly with carers to provide practical courses such as first aid training, handling and lifting, stress management and computer courses to 70 carers<sup>12</sup>.

# Social Care Needs Assessment

## 7.4 Carers Services Needs Assessments (NI 135)

In 2010/11, 2,300 carers (31.85%) received an assessment of their needs during the year and were provided with a carer service, information or advice, against a target of 30%. This has shown some improvement from 2009-10 where 1,973 carers received an assessment (29.61%) and 24.17% in 2008-09. This places Rotherham in the top 25% of Councils in England<sup>17</sup>. The national rate for this indicator is 25% of adults had received a community service who were offered an assessment or review.

### Projected Residential Care Placements Commissioned by the Local Authority

Figure 7.13 predicts future numbers of publicly funded residential placements per week required in Rotherham based on the growth in the older population. People in residential care are assumed in to be in the "very high" needs group.

Currently there are 1,406<sup>13</sup> older people in residential care and this is predicted to increase resulting

in an additional 366 placements will be required by the year 2020 and an additional 801 placements by the year 2030. However, the number could be decreased in future years, if additional community based services are available to support people within the community.

In 2010-11 there were 343 permanent admissions to residential care in comparison to 371 permanent admissions in 2009-10<sup>13</sup>, and a significant reduction from around 450 in 2005-2006. This shows that progress has been achieved as this has resulted in 28 less admissions to residential care from 2009-10.

However, although the number of people in long-term care has reduced over the last five years, the needs of people in the Homes are much greater. Older people are living at home for much longer and only move into residential care when their needs are much more significant and require more intensive support.

There are currently 144 people

(94 older people and 50 people under 65 years) placed in out-of-Authority placements and around 143 self-funders (140 older people and 3 people under 65 years) who are living in care homes in Rotherham<sup>14</sup>. However, people who currently self-fund their care may financially fall under the capital limits threshold which will place a further burden on Local Authorities to financially support these people in the coming years.

### Projected Weekly Costs of Meeting Publicly Funded Residential Care

Figure 7.14 illustrates the total weekly cost of Local Authority commissioned residential care costs and extra care housing placements of £511,530 per week for older people, totalling an overall spend of around £26 million per year (according to NASCIS).

It is predicted that the yearly cost will increase to £33 million by 2020 (increase of 26%) and to £42 million by the year 2030 (increase of 57%). This is above the regional

Figure 7.13: Predicted Need for Residential Care for Older People in Rotherham in 2010<sup>6</sup>

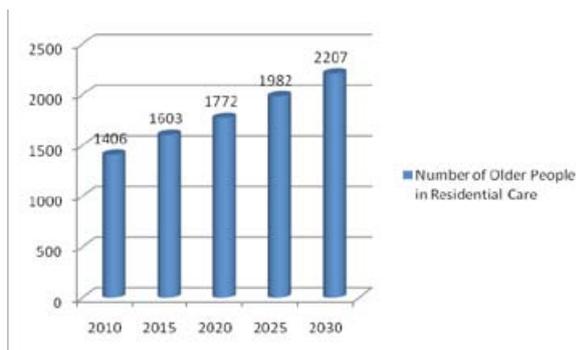
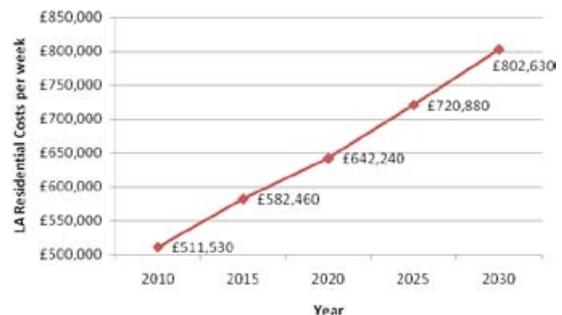


Figure 7.14: Weekly Cost of Providing Residential Care or Extra Care Housing Commissioned by the Local Authority for Older People in Rotherham in 2010-11<sup>3</sup>



13 ASC-CAR Returns (2009/10), Number of Residents Supported by Local Authority in Rotherham  
 14 SWIFT (2010), Data from Adult Services IT System

# Social Care Needs Assessment

## 7.4 Carers Services Needs Assessments (NI 135)

and national average of 23% and 54% respectively.

The average cost of residential care for older people is around £16,000 per person per year to the Local Authority. The additional cost of maintaining the current service model is estimated to be £7 million in real terms by 2020 and £16 million by the year 2030.

### Projected Home Care Hours per week Commissioned by the Local Authority

Figure 7.15 illustrates that there are a total average number of around 15,360 home care hours which are commissioned by the Local Authority per week (according to NASCIS data<sup>18</sup>). 10,390 hours (68%) provided are for older people with very high needs who are receiving 10 hours or more of home care a week. This is projected to increase by 28% by the year 2020 to 19,290 home care hours per week and

24,100 by the year 2030, showing an increase of 25% and 57% respectively.

For those with high needs (30%), there are a total of 4,620 home care hours provided who receive home care between 2 and 10 hours per week. This will increase by 26% by the year 2020 and 57% by the year 2030 which is above the regional and national averages of 23% and 54% respectively<sup>3</sup>.

However, the number of home care hours provided per week in Rotherham has decreased over the last two years with an average of 21,736 home care hours being provided in 2008/09 and an average of 16,957 home care hours per week in 2009/10.

The reasons for this reduction are as follows:

- People are relying on family members and carers to provide informal support at home

- Increase in direct payments and individual budgets enabling people to organise their own support

### Projected Weekly Costs of Meeting Publicly Funded Home Care

Figure 7.16 illustrates the total weekly cost of Local Authority commissioned home care costs of £291,840 per week for older people, totalling an overall spend of around £15 million per year. An average cost per person to the Local Authority is around £3,500 per annum.

It is predicted that the yearly cost will increase to £19 million by 2020 (an increase of 26%) and to £24 million by the year 2030 (an increase of 57%). This is above the regional and national average of 23% and 54% respectively.

Figure 7.15: Number of Home Care Hours per week for older people in Rotherham in 2010-11<sup>3</sup>

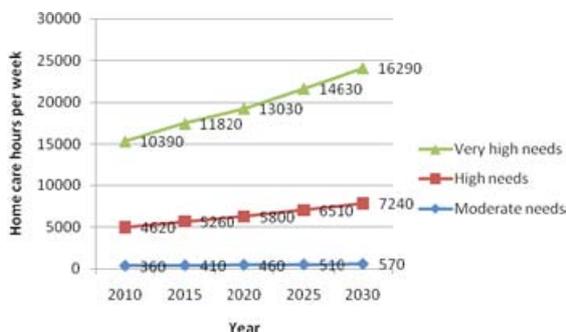
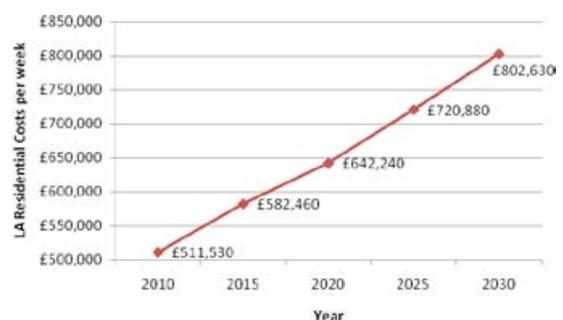


Figure 7.16: Weekly Cost of Providing Home Care Commissioned by the Local Authority to Meet Social Care Needs for Older People<sup>3</sup>



# Social Care Needs Assessment

## 7.4 Carers Services Needs Assessments (NI 135)

### Projected Requirements for Day Care Commissioned by the Local Authority

Figure 7.17 illustrates that there are a total average number of around 340 day care placements per week which are commissioned by the Local Authority provided to older people (according to NASCIS data<sup>18</sup>). 210 placements are provided for the very high needs group who have physical disabilities and 130 placements for the high needs group.

This is set to increase by 23% by the year 2020 for very high needs and 54% by the year 2030, which is very similar to the regional and national averages.

### Projected Weekly Costs of Meeting Publicly Funded Day Care

Figure 7.18 illustrates the total weekly cost of Local Authority commissioned community support costs of £38,810 per week for older people, totalling an overall spend of around £2 million per

year (according to Unit Costs Summary, England).

It is predicted that the yearly cost will increase to £2.5 million by 2020 (an increase of 26%) and to £3.2 million by the year 2030 (an increase of 57%). This is above the regional and national average of 23% and 54% respectively.

### Timeliness of Social Care Assessments (NI 132)

Local Authorities are subject to targets on timeliness of social care assessments. NI132 measures waiting times for assessments for new adult clients from the point of first contact to completion of assessment. This period should be less than or equal to four weeks (28 days)<sup>15</sup>.

In 2009/10 there were 1,761 people out of 2,182 people (80.71%) who received an assessment within the four week period, against a target of 80%. In 2010/11 there were 81.55% of people who received a timely assessment. This is a similar rate as the national average of 81%.

The indicator has shown significant improvement since 2008/09 where only 70.37% of people received a timely assessment. A service will be put in place in 2011-12 where all people will receive an assessment within 28 days.

In 2010-11 the number of people receiving a review of their services has increased by 689 additional reviews compared to 2009-10<sup>16</sup>.

In 2010-11, 95% of people receiving a package of care within 28 days following completion of their assessment (improved from 94% in 2009-10), rating Rotherham as the top 25% of Councils in England<sup>16</sup>.

Figure 7.17: Number of Day Care Placements per week in Rotherham 2010-11<sup>3</sup>

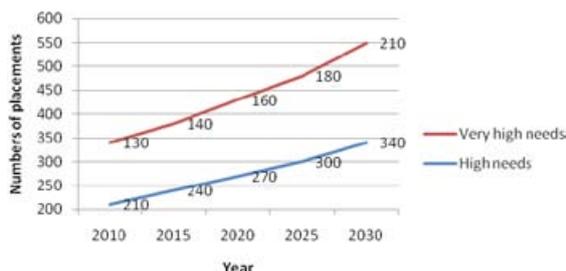
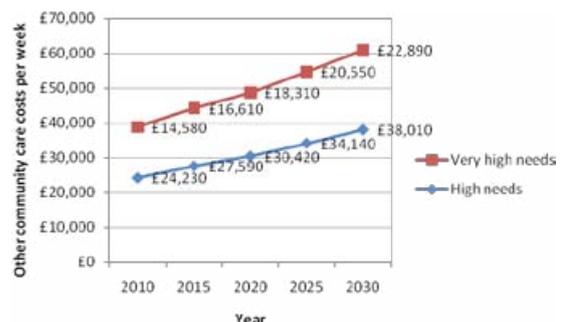


Figure 7.18: Weekly Cost of Providing Day Care Commissioned by the Local Authority to Meet Social Care Needs for Older People<sup>3</sup>



15 National Indicator 132 (NI 132) (2010-11), Timeliness of Social Care Assessments  
16 Annual Local Account (2010-11) – RMBC Adult Social Care Services

# Social Care Needs Assessment

## 7.5 Promoting Independence through Social Care (NI 136)

### Projected Requirements for Day Care Commissioned by the Local Authority

The National Indicator (NI136) measures the number of adults per 100,000 population that are assisted directly through social services assessed/care planned, funded support to live independently.

The Indicator includes those supported through organisations that receive social services grant funded services<sup>9</sup>.

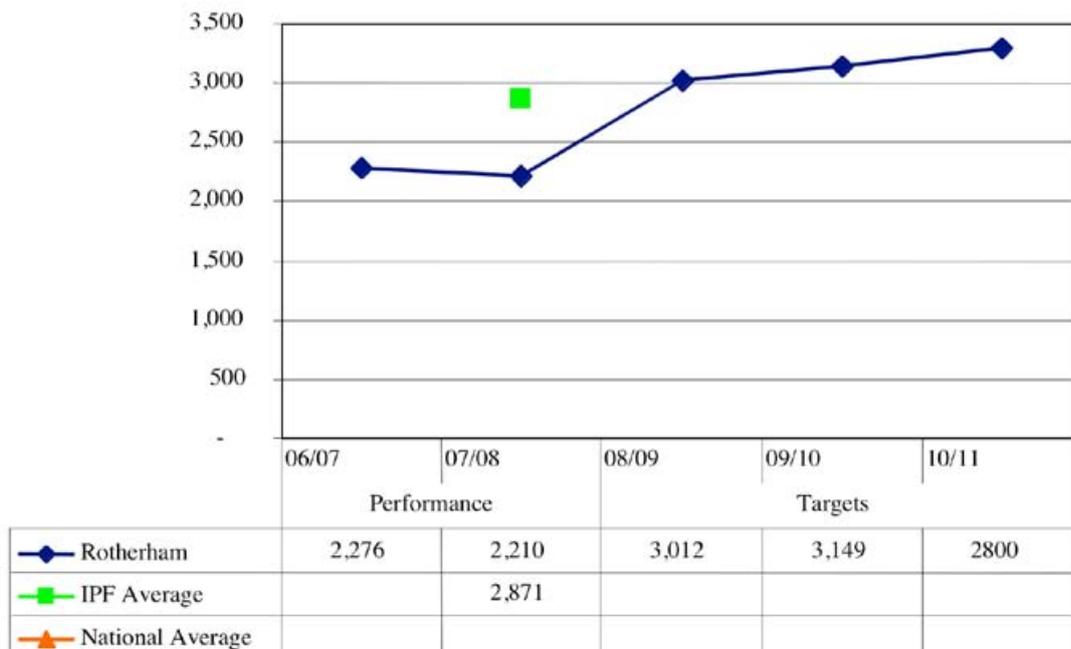
Figure 7.19 identifies the number of adults who are assisted through adult social services to live independently in Rotherham in 2010/11.

In 2010-11, the numbers of adults assisted directly through adult social services to live independently were 2,880, against a target of 2,800. This has shown significant improvement from 2008/09 of 2,351 adults and 2009-10 of 2,359 adults.

As at 31st March, 2011, 6,800 older people and adults were being supported by adult social care services to live in the community (an increase of 1,100 from 2009/10)<sup>17</sup>.

A newly commissioned service from January 2011 which is aimed at people with moderate or low level needs will aim to support people to remain independent as they take control of accessing universal preventative services <sup>17</sup>.

Figure 7.19: Number of Adults per 100,000 Assisted to Live Independently



## Social Care Needs Assessment

### 7.6 Direct Payments/Personal Budgets

Figure 7.20 illustrates that there were a total of 661 adults and older people who were in receipt of a direct payment in 2010-11, an increase of an additional 163 people organising their own support since 2009/10. This is a significant increase from 362 people in 2007-08. Expenditure on direct payments amounts to £82,888 per week, £4.3 million per year, averaging £6,520 per person or £125 per week.

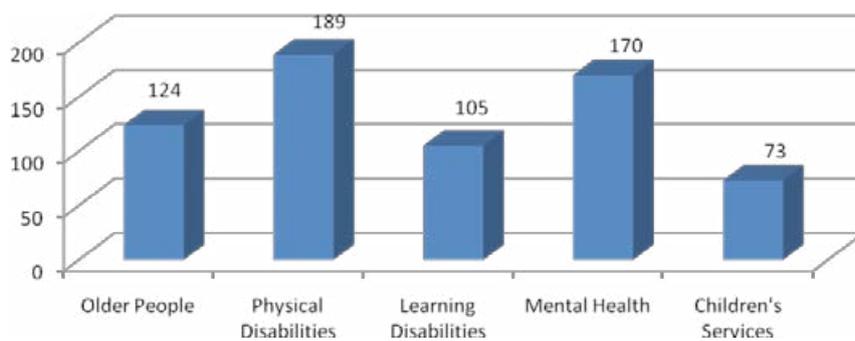
41% of direct payments are spent on people with physical disabilities, 20% on older people, 16% on learning disabilities, 17% for mental health and 6% on children.

The increasing trend in uptake of direct payments is apparent across all age and client groups as more

people are given more flexibility in how services are provided. This will affect the provision of adult social care, in particular home care and day care, as people will have greater choice and control over their lives and are able to make their own decisions about how their care is delivered.

In 2010-2011, 50% of people received their care via a personal budget. This has exceeded the national target of 30% set by Government for all Councils in England and will place Rotherham in the top 25% of Councils<sup>18</sup>.

Figure 7.20: No. of Adults receiving Direct Payments in Rotherham in 2010/11<sup>10</sup>



# Social Care Needs Assessment

## 7.7 Intermediate Care

### Intermediate Care Residential Rehabilitation

Currently in Rotherham there is an average of 300 people per year who are admitted to an intermediate care residential rehabilitation bed in order to receive a rehabilitation plan to maximise their independence and increase their quality of life<sup>19</sup>. There is clear evidence that the service reduces prolonged hospital stays, inappropriate admission to acute in-patient care, long-term residential care and reduces home care packages.

The majority of admissions to intermediate care are older people who have been discharged from hospital and are medically stable but require some form of rehabilitation before they are able to return to the community. The new service model is designed to provide rehabilitation for people who have experienced an acute exacerbation of their long-term condition which does not need to be managed in hospital. People who have experienced a recent change in their functional abilities

which could be improved by therapy intervention that is not appropriate within the home environment also benefit from the residential rehabilitation intermediate care service.

The average length of stay in 2010/11 in Rotherham is 28 days for general rehabilitation and 35 days for specialist rehabilitation for those people who have survived a recent stroke, have a neurological condition or are living with dementia who tend to require lengthier rehabilitation programmes to regain their independence<sup>19</sup>.

Intermediate care services can mean higher costs because of lower bed occupancy and the need for more staff to carry out intensive rehabilitation. However there is evidence that the extra short-term costs lead to savings further down the care pathway. Intermediate care has been identified as a service which can reduce service costs in home care, residential and hospital care.

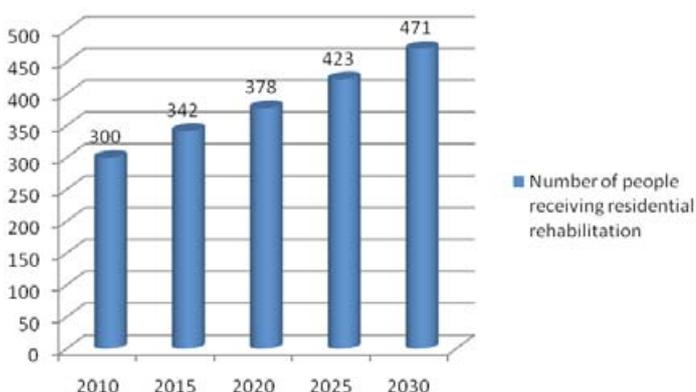
In 2010-11, the number of older

people who have been discharged from hospital who were surveyed who are still at home 3 months is 85% (NI125). This target has improved from 2009/-2010 from 84% placing Rotherham in the top 25% of comparable Councils and in the top 50% of all Councils in England. Only a small minority of people (3%) of people have moved into long-term residential care (previously 5% in 2008-09)<sup>20</sup>.

In 2010-11 the number of hospital preventions has increased from 312 in 2009-10 to 378 in 2010-11. Similarly the number of facilitating hospital discharges by providing effective rehabilitation programmes has improved from 288 in 2009-10 to 336 in 2010-11<sup>19</sup>.

The average age of the person who is admitted to intermediate care residential rehabilitation is 82 years. Approximately 68% of females and 32% of males use the intermediate care service. Around 89% of all admissions are from hospital, 10% from the community and 1% from residential care<sup>1</sup>.

Figure 7.21: Projected Need for Intermediate Care Residential Rehabilitation in Rotherham in 2010-11<sup>13</sup>



# Social Care Needs Assessment

## 7.7 Intermediate Care

Figure 7.21 sets out the projected need for intermediate care residential rehabilitation services in Rotherham over the next 20 years<sup>13</sup>.

Assuming service provision expands in line with the growth of the older population the number of intermediate care placements will increase by 14% to 342 by 2015, 26% to 378 by year 2020, 41% to 423 by 2025 and 57% increase by 471.

### Community Rehabilitation Service

Currently an average of 200 people each year receive short-term rehabilitation at home to optimise independence, maximise daily living skills, mobility, confidence and social skills.

There is clear evidence that this service reduces the need for high cost home care packages (savings of £500,000 per year on home care expenditure), inappropriate admission to hospital or long-term residential care.

Figure 7.22: Projected Need for Intermediate Care Community Rehabilitation<sup>13</sup>

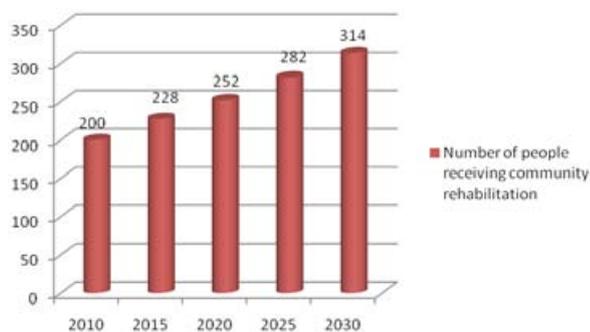


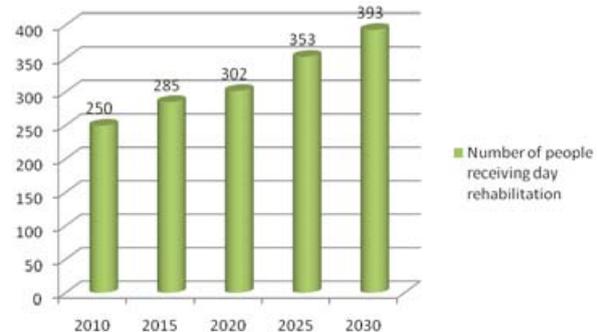
Figure 7.22 sets out the projected need for intermediate care community rehabilitation in Rotherham over the next 20 years. Assuming service provision expands in line with the growth of the older population the number of people requiring community rehabilitation will increase by 14% to 228 by the year 2015, 26% to 252 by the year 2020, 41% to 282 by the year 2025 and 57% to 314 by the year 2030.

### Day Rehabilitation Service

Currently an average of 250 people each year receive short-term rehabilitation in a day setting in order to increase and optimise physical functioning and ability to live safely at home, maintain physical well-being achieved through ongoing exercises and access to community services to prevent social isolation and promote good mental health.

Figure 7.23 sets out the projected need for intermediate care day rehabilitation in Rotherham over the next 20 years. Assuming

Figure 7.23: Projected Need for Intermediate Care Day Rehabilitation<sup>13</sup>



service provision expands in line with the growth of the older population the number of people requiring community rehabilitation will increase by 21% to 302 by 2020 and by 57% to 393 by the year 2030.

The overall budget for intermediate care services in Rotherham is approximately £3.6 million for 2010-11 in order to provide rehabilitation programmes for around 750 people in Rotherham.

In order to track the predicted demand, 1,178 people will require an intermediate care service by the year 2030, resulting in an additional investment of around £1.4 million.

However, these figures may be under-estimated as additional intermediate care rehabilitation placements may be required, as work is ongoing with the Rotherham Foundation Trust to implement Interqual, a mechanism to determine the appropriate level of care for people who are currently accessing hospital services.

# Social Care Needs Assessment

## 7.7 Intermediate Care

It is likely that some bed days that are currently provided at the acute hospital would be more appropriate in intermediate care, increasing the need for additional intermediate care rehabilitation placements in Rotherham within the next few years.

### Analysis of Community-Based Provision

#### Physical Disability

Community based services ensure that people with a physical disability (adults aged 18 to 64 years) are able to live at home independently for as long as possible and can prevent or prolong admissions to long-term residential and nursing care.

Figure 7.24 illustrates the number of adults with a physical disability who are in receipt of a community based service in Rotherham from 2008-09 to 2009-10.

There has been an increase in the number of community based services provided to people with physical disabilities from 763 adults in 2008-09 to 815 in 2009-10. The largest increase is the take-up of direct payments, professional support and other community based services.

#### Mental Health

Community based services ensure that people with a mental health problem are able to live at home independently for as long as possible and can prevent or delay admissions to long-term residential and nursing care.

Figure 7.25 illustrates the number of adults with a mental health problem who are in receipt of a community based service in Rotherham.

There has been an increase in the number of community based

services provided to people with mental health conditions from 1,694 adults in 2008-09 to 1,753 adults in 2009-10. The largest increase is the take-up of direct payments, professional support and other community based services.

Figure 7.24: No. of Adults with a Physical Disability in receipt of a community based service in Rotherham between 2008-10<sup>15,16</sup>

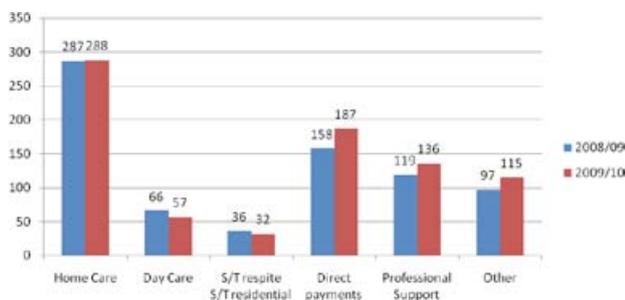
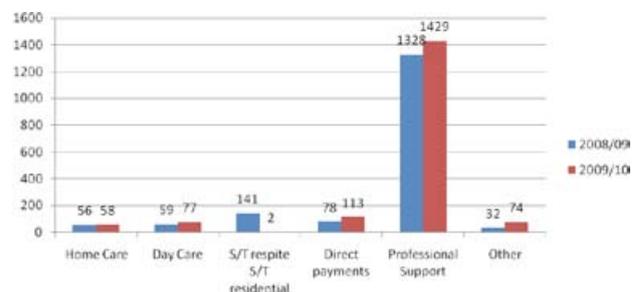


Figure 7.25: Adults with Mental Health Problems receiving Community Support in Rotherham between 2008-10<sup>15,16</sup>



## Social Care Needs Assessment

### 7.8 Assistive Technology

During 2010/11 around 2,232 new pieces of equipment were purchased and 1,326 items were issued to people in the community. This is an increase of 546 items from the previous year. The total expenditure was £293,986 in 2010-11.

An evaluation will be undertaken during 2011-12 of the impact this has had in maximising independence and increasing quality of life for the local population.

# Social Care Needs Assessment

## 7.9 Summary of Chapter 7

### Emerging Needs/Key Issues:

- An increase in the number of older people living in Rotherham, with a formal social care need (65 years and over).
- A significant increase in the numbers of older people (85 years and over) who are the most likely to receive formal support (110% in the next 20 years), which will have a major impact on the need for adult social care in the future.
- An increase in the number of adults (18 to 64 years) with serious and moderate physical disabilities and mental health conditions who are accessing community based services.
- An increasing number of older people not well supported by informal care.
- greater burden placed on informal carers to provide support, resulting in an increase in carers' needs assessments to provide better support, advice and guidance.
- An increase in numbers of people requiring rehabilitation and re-enablement services to provide earlier intervention in order to prevent heavy reliance on adult social care in the future.
- Rapidly increasing BME population in Rotherham, who will require support from formal adult social care.
- Currently there is a low take-up of community-based adult social care services from older people in BME communities.
- Increasing number of people accessing direct payments to commission their own support.

- Increasing number of people requiring a timely assessment and re-assessment of their needs.
- An increasing need for people accessing equipment, adaptations and assistive technology to maximise independence and improve quality of life.
- An increasing need for additional Extra Care Housing placements, sheltered housing or adult placement schemes.

### Actions to be Taken in 2011-12:

- Reconfiguration of existing community based services to meet future need.
- Develop more preventative services to provide earlier intervention.
- Assist more people to live at home through increased use of assistive technology and equipment.
- Develop a service for people to receive a re-ablement service within 24 hours of contact.
- Ensure people have access to an efficient, timely and effective Intermediate Care Service.
- Increase the number of people eligible for Continuing Healthcare.
- Reconfiguration of the Community Occupational Therapy service to provide a responsive service for people requiring an assessment for equipment.
- Reconfiguration of the Integrated Community Equipment Service to provide a responsive service for people requiring delivery of community equipment.

- Develop a service where all people who require an assessment receive this within 28 days.
- Develop a service where all people requiring a social care assessment in hospital will be seen within 24 hours.
- Develop a service that ensures all people whose needs have changed are re-assessed within 48 hours.
- Ensure that all people receive a review of their needs on an annual basis.
- Increase advice and guidance to meet all carers' needs through Rotherham's Carers Centre.
- Ensure the Resource Allocation System (RAS) is fit-for-purpose.
- Increase the number of people who have access to a personal budget.
- Improve and expand the range of information and advice which is available for adult social care services.
- Develop new Joint Commissioning arrangements, Health and Well-Being Board, and Public Health Structure.
- Develop the new Healthwatch body so that people can hold health and social care to account.
- Strengthen links between Children's Services and Adult Services in order to provide more support to younger carers.

## Access to Health Services

### 8.1 Early Access for Women to Maternity Services (NI 126)

All women are entitled to obtain a full health and social care assessment of needs, risks and choices within 12 completed weeks of their pregnancy. This gives the full benefit of personalised maternity care and improves outcomes for both mother and baby. Increasing early rates of access to maternity services through targeted outreach can reduce health inequalities and ensure choice in service provision.

Completion of the assessment supports women in making well informed decisions about their care throughout pregnancy, birth and post-natal care. The national choice guarantees: choice on how to access maternity care, the choice in type of antenatal care, choice of place of birth and choice of place of postnatal care.

Figure 8.1 shows that 93.26% of women who are pregnant had been given a health and social care assessment of need within 12 completed weeks of pregnancy. This is well above the local target of 75%. However, there are a small minority of women (121 or 6.74%) who are not accessing maternity services in the first six month period. It is estimated that a significant proportion of these women may be from BME communities.

**Figure 8.1: Number of Women Accessing Maternity Services in Rotherham in 2008 (Vital Sign BSB06)**

Source: PCT Health Improvement (2008-09), Vital Sign BSB06, Early Access for Women to Maternity Services, p1

	<b>2008-09 Target</b>	<b>Year to Date (April 08 to Oct. 08)</b>
Number of women in contact with the service who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy	<b>1,270</b>	<b>1,674</b>
Total number of women at 12 weeks of their pregnancy	<b>1,694</b>	<b>1,795</b>
% of women in contact with Maternity Services	<b>75.00%</b>	<b>93.26%</b>

# Access to Health Services

## 8.2 Number of People Accessing NHS Dentistry

Nationally the number of patients who have been seen by an NHS dentist has decreased in 2007-08 from the previous year. There were 26.9 million patients, equivalent to 52.7% of the population. In comparison, in 2005-06 there were 28.1 million patients, a decrease of 1.2 million patients (4.3%) over four years.

19.3 million adults (71.7% of all patients) were seen by an NHS dentist, equivalent to 48.3% of the adult population. This compares to 20.3 million adults seen the previous year and constitutes a 4.9% reduction. 7.6 million children (0 to 17 years) were seen by an NHS dentist, equivalent to 69% of the child population. This is a decrease of 209,800 on the 7.8 million children seen in the previous year.

There is a larger percentage of children (70.7%) accessing NHS dentistry compared to the adult population (51.6%). The rate of decrease in the number of adults accessing dentistry (3.4%) is more than double that of children (1.6%).

Reasons for the decrease in numbers include: trend towards adults choosing to visit a private dentist, free treatment for children and increase in dental costs, especially for those who live in low income households.

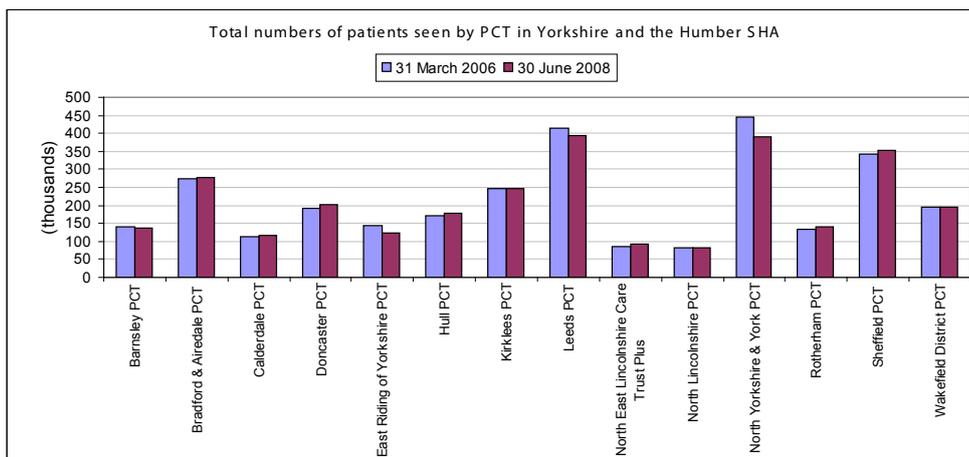
Figure 8.2 shows the total number of patients seen in the Yorkshire and Humber region in 2006 and 2008. This shows a different picture in comparison to national figures as there has been an increase in the number

of people accessing NHS dentistry in Rotherham over the last two years. In 2006 there were 132,978 patients seen by an NHS dentist (96,671 adults and 36,307 children). In comparison there were 141,609 patients seen (100,100 adults and 41,509 children) in 2008. This is an increase of 2.1% in the number of adults and 13.7% in the number of children accessing NHS dentistry over the last two years<sup>1</sup>.

Approximately 50.9% of adults and 73.4% of children regularly visit an NHS dentist in Rotherham. Rotherham is above the national average of 48.3% for adults and 69.0% for children. Rotherham is also above the regional average of 50.8% for adults and 71.0% for children<sup>2</sup>.

**Figure 8.2: Number of Patients seen by an NHS Dentist in Yorkshire and Humber**

Source: NHS Information Centre (2008), NHS Dental Statistics - Patients Seen by Primary Care Trust, p1



1 NHS Information Centre (2008), NHS Dental Statistics - Patients Seen within 24 Months, pD1  
 2 NHS Information Centre (2008), NHS Dental Statistics - Patients Seen within 24 Months, pD2

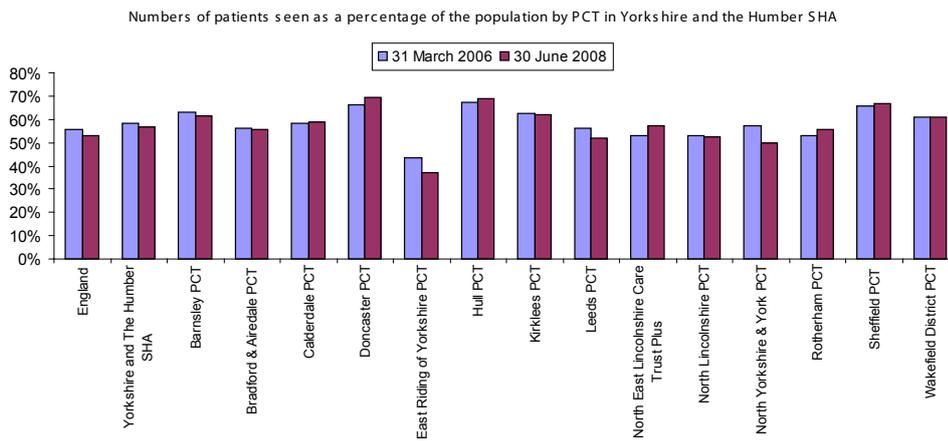
# Access to Health Services

## 8.2 Number of People Accessing NHS Dentistry

Figure 8.3 shows the number of patients seen as a percentage of the population in the Yorkshire and Humber region. This shows an increase in the proportion of the population accessing NHS Dentistry. There has been an overall increase of 3.3% in the proportion of the population seen by an NHS dentist from 52.6% in June 2006 to 55.9% in June 2008.

**Figure 8.3: Number of Patients seen as a % of the Population in Yorkshire & Humber**

Source: NHS Information Centre (2008), NHS Dental Statistics - Patients Seen by Primary Care Trust, p1



## Access to Health Services

### 8.3 Uptake Rates for Seasonal Flu Jab

An immunisation programme for people over 65 years against influenza was introduced in 2000. Historically the targeted risk groups for vaccination against seasonal influenza have been people over the age of 65 years, people under the age of 65 years in clinical high risk groups such as chronic heart disease, lung disease, neurological disease, renal disease or diabetes and those with immuno-suppression and poultry workers who carry out specific duties, although the Joint Committee for Vaccination and Immunisation suggest that the suggest there is little evidence to support this practice and so for the 2011/12 programme this group are no longer included on occupational grounds. As a result of the swine flu pandemic that occurred in 2009, the seasonal flu programme for 2010/11 was

extended to include pregnant women regardless of previous swine flu vaccination history. Pregnant women are now included as an eligible group as part of the routine programme

Influenza immunisation is also provided to those living in long-stay residential and nursing care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. Previously Influenza immunization has been given at the GP's discretion for those people who are in receipt of a carer's allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill, however for the 2011/12 programme carers are listed as main cohort.

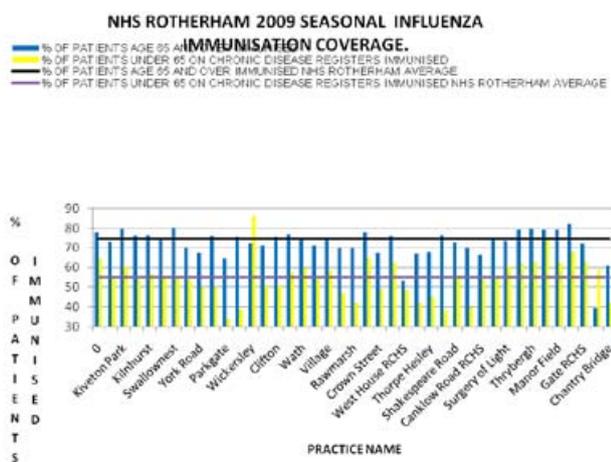
GPs should consider, on an individual basis, the clinical needs of their patients with regard to uptake of influenza immunization including individuals with multiple sclerosis or hereditary and degenerative diseases of the central nervous system.

The provision of seasonal flu vaccination to health and social care staff remains the responsibility of the employer.

In Rotherham the uptake for people who are aged 65 years and over was 74.4% in 2009/10, whilst this was slightly below the World Health Organisation 2010 target of 75% it was above the national average (72.4%) for the same group.

The table below shows uptake by individual practice.

Figure 8.4: Uptake of Seasonal and Swine flu Influenza Vaccine for all eligible groups in 2009/10



**Influenza Immunisation Uptake for NHS Rotherham 2010/11**

Year	Patients 65 and Over % Cover	National Average	Patients Under 65 at Risk % Cover	National Average	Pregnant Women NOT in clinical risk group	National Average	NHSR Staff	National Average
Sept.2007-Jan.2008	76.2		50.3					
Sept.2008-Jan.2009	76.1		51.2					
Sept.2009-Jan.2010	74.4	72.4	55.0	51.6			17.9	26.4
Sept.2010-6.Feb.11	74.9	72.8	50.8	50.3	38.2	37.7	52.7	unavailable

The target for uptake in the over 65's is 75% (WHO) whilst the target for the under 65's at risk for 2011/12 is 60% (no target previously) building towards 75% by 2014.

## Access to Health Services

### 8.4 Screening for Breast Cancer

Currently women who are aged 50 to 70 years of age are included in the breast screening programme. However, there are plans to extend this to include women who are aged between 47 to 73 years by 2012.

Over 1.6 million women aged 45 and over who are registered with a GP, including 1.3 million women aged between 50 to 70 years of age are screened within the programme, an increase of around 1% from 2005-06<sup>5</sup>. The last ten years have seen the programme grow by 48% from 1.1 million in 1996-07<sup>4</sup>.

Over 2.1 million women were invited for screening, an increase of 2.8% over the last year and 50% compared to ten years ago. There were 13,443 cases

of cancer diagnosed in women screened aged 45 and over, similar to the previous year (13,523), but more than double the number in 1996-97<sup>4</sup>.

Figure 8.5 shows that there has been little change in the number of women who have had breast screening in the age range 53 to 64 years over the last five years. In 2007, 76.0% were screened at least once in the previous three years compared to 75.9% in 2002.

In Rotherham 80% of women aged 50 to 64 years attended breast screening sessions in 2007, 4% above the national average and 2% above the regional average. There were 7.1 cancers detected per 1,000 women screened in this age group. In 1997 the rate was 5.3, but this has

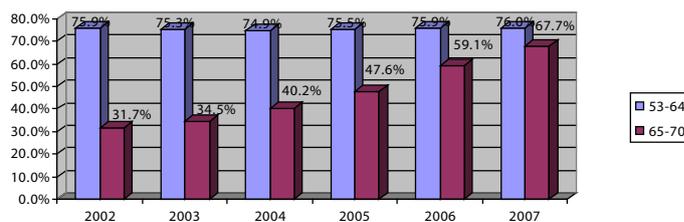
been rising steadily until the last four years where it has remained consistent at just over 7.04.

There has been a significant increase in the number of women aged 65 to 70 years who have been screened. The proportion of women in this age group has increased from 31.7% to 67.7%, a 36% increase in five years.

Figure 8.6 shows the proportion of women from 53-64 years who have received breast screening broken down by SHA. An average of 75.6% has received breast screening in 2007 in Yorkshire and Humber region. This is slightly below the national average of 76%.

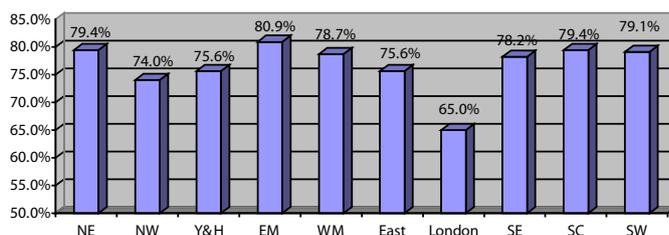
**Figure 8.5: Proportion of women who underwent breast screening**

Source: NHS Information Centre (2007), Breast Cancer Screening 2006-07, p8



**Figure 8.6: Percentage coverage of women aged 53-64 by SHA - 2007**

Source: NHS Information Centre (2007), Breast Cancer Screening 2006-07, p8



## Access to Health Services

### 8.5 Access to GUM services

20,007 people attended a Genito-Urinary Medicine (GUM) Clinic during a one-week audit in 2007, of which 18,986 questionnaires (94.8%) were included in the data analysis, which is the highest number of patients in any waiting times audit conducted by the Health Protection Agency to date.

During a one-week audit of GUM Clinics in 2007, 72% of all patients were seen within 48 hours in England. The regional rate was 62% which, although lower than the national average, was the highest rate achieved compared to previous years. The national rate has increased from 70% in 2007 and from 54% in the 2006 audit.

The May 2007 audit shows that 981 people (62%) in the Yorkshire

and Humber region were seen within 48 hours. 77% of people were offered an appointment within 48 hours<sup>6</sup>.

However, there have been significant improvements both at a local and regional level over the last twelve months in the numbers of people attending GUM clinics. An audit undertaken between April to June 2008 shows that 1,686 people were offered an appointment to be seen within 48 hours in Rotherham, which is 99.88% of all attendees. This is a significant improvement from the rate of 74% achieved in February 2007 and is slightly higher than the regional target of 99.71% achieved in the same period<sup>7</sup>.

The success rate improved further as another audit was undertaken

in July to September 2008 which showed that 1,855 people were offered an appointment to be seen within 48 hours, which is 100% of all attendees, which is slightly higher than the regional average of 99.19%<sup>8</sup>.

<sup>6</sup> Health Protection Agency (2007), GUM Clinic Waiting Times – May 2007 Audit, p2

<sup>7</sup> Health Protection Agency (2008), Local Sexual Health Profile, p33

<sup>8</sup> Health Protection Agency (2008), Local Sexual Health Profile, p34

## Access to Health Services

### 8.6 Long Acting Reversible Contraception Methods

Figure 8.7 shows the number of women who have used long acting contraceptive methods in Rotherham over the last two years.

There are six methods of long acting reversible contraceptive methods available in Rotherham. The most popular method is the depo provera injection method which constitutes 71.4% of usage. There has been a significant increase in the number of people using the implant method, (232 to 533 people). There has been a decline in the number of people using the Mirena coil method with a 45% decrease from 2007-09.

There were 4,147 long term contraception methods used in the specified seven month period in 2007 compared to 4,381 in

2008. This suggests that there has been an increase in uptake by 5.7% over the two year period. The increase in uptake may be attributable to greater numbers of younger people preferring the benefits of longer acting methods that are more reliable than oral contraceptive pills. These are known for their high failure rates if administered incorrectly. A 6 month social marketing campaign was launched during 2010/11 to promote the use of implanon as a more effective, easy and reliable method of contraception.

Overall for 2010, 38% of all contraceptives provided by GP's prescribing, CASH and TOPS were LARC methods. This is a 6% increase in LARC uptake from the previous year. The increase in LARC uptake can somewhat

be attributed to the success of the Social Marketing Campaign which ran throughout 2010 across the Rotherham Borough. The campaign aims to raise the profile of longer acting, more effective methods of contraception and has been advertised in Further Education colleges, on QTV in hospital and GP waiting areas and on Rotherham's bus fleet, on billboards and in bus stops.

**Figure 8.7: Number of Long Acting Contraception Methods used in Rotherham (During 7 month period)**

Source: PCT FACT Team (2008), Long Acting Contraception Methods, p1

Month	Implant		Injection		IUD		IUS		Mirena		Implanon Implant	
	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	07-08	08-09	08-09	08-09
April	22	40	473	502	12	9	25	15	25	15	8	10
May	25	34	545	494	4	5	15	20	15	20	7	7
June	47	41	519	495	5	5	24	28	24	28	11	12
July	33	46	477	530	11	12	18	15	18	15	7	15
Aug.	32	34	534	482	12	8	22	20	22	20	11	10
Sept.	39	46	479	463	11	7	16	19	16	19	9	23
Oct.	34	51	481	508	12	10	20	24	20	24	7	22
<b>Total</b>	<b>232</b>	<b>533</b>	<b>3508</b>	<b>3474</b>	<b>67</b>	<b>56</b>	<b>140</b>	<b>141</b>	<b>140</b>	<b>78</b>	<b>60</b>	<b>99</b>

## Access to Health Services

### 8.7 Access to NHS Funded Abortions before 10 weeks' Gestation

In 2007 the total number of legal induced abortions for women resident in England and Wales was 198,488, compared with 193,737 in 2006, a rise of 2.5%<sup>9</sup>. 90% of abortions were performed under 13 weeks gestation. In 2007 around 70% were under 10 weeks and a further 20% at 10 to 12 weeks. This shows a continued increase in the number of abortions that were performed under 10 weeks<sup>10</sup>.

In Rotherham 86% of abortions were performed under 13 weeks, 4% below the national average. 14% of abortions were over 13 weeks, significantly above the national average.

Figure 8.8 shows that there has been a significant increase (55%) in the number of abortions between 4 to 9 weeks gestation over the ten year period. This suggests there is more rapid

access to the terminations service. There has been a reduction in the number of abortions between 10-12 weeks gestation and the number of 13 weeks gestation and over has remained the same over a ten year period.

Evidence shows that the risk of experiencing complications increases the later the abortion is carried out. In 2001 the Government set a standard of a maximum waiting time of three weeks. Figure 8.9 shows that 68% of NHS funded abortions took place under 10 weeks in 2007, compared with 51% in 2002. This shows an improvement of 17% over the five year period.

The national age standardised abortion rate was 18.6 per 1,000 resident women aged 15 to 44 years, compared with 18.3 in 2006<sup>9</sup>. In Rotherham this is slightly lower at 17.0 per 1,000 .

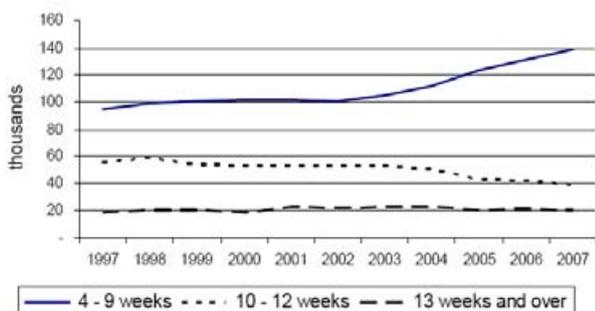
The abortion rate peaked at 15.5 in 1990, remained below 15 until 1995 but then rose to 17.2 in 1998. From 1999 to 2002 the rate remained level at just over 17 per 1,000. The rate then increased in 2007 to 18.6 which is the highest rate ever recorded.

The national abortion rate for women under 16 years of age in 2007 was 4.4 per 1,000 compared with 3.9 in 2006. The under 18 rate was 19.8 per 1,000 women compared to 18.2 in 2006<sup>9</sup>. In Rotherham this is slightly higher at 21 per 1,000 women<sup>11</sup>.

The national abortion rate in 2007 was highest at 36 per 1,000 for women who are aged 19 years. In Rotherham this is slightly higher at a rate of 38 per 1,000 women<sup>11</sup>. There were just over 1,170 abortions to women aged under 15 and about 730 to women aged

**Figure 8.8: Number of Abortions by Gestation Weeks – 1997 to 2007**

Source: Department of Health (2007), Abortion Statistics 2007, p5



**Figure 8.9: Percentage of all NHS Funded Abortions under 10 weeks from 2002 to 2007**

Source: Department of Health (2007), Abortion Statistics 2007, p5

Year	%
2002	51
2003	52
2004	56
2005	63
2006	65
2007	68

# Access to Health Services

## 8.7 Access to NHS Funded Abortions before 10 weeks' Gestation

45 and over, significantly higher than in 2006/9.

The national abortion rate for women who are over the age of 35 in 2007 was 6.9 per 1,000 compared to Rotherham's rate of 5.0 per 1,000<sup>11</sup>.

In Rotherham there were 806 legally induced abortions in 2007. The largest percentage of women (30.8%) was in the age range 20 to 24 years, above the national average of 28.7%. There has been an increase in the abortion

rate for all women aged under 24 years, most markedly for those aged under 18 years. 107 women (13.3%) had abortions under the age of 18 years, which is above the national average of 10.2%.

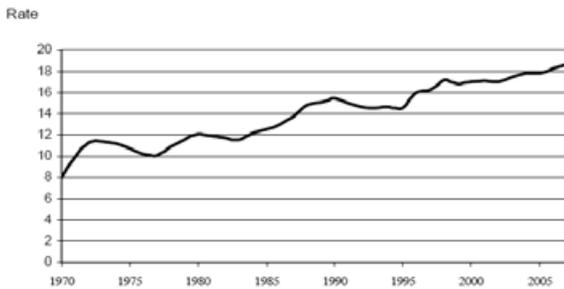
Figure 8.13 shows that 38% of legally induced abortions were performed in NHS hospitals in 2007 in comparison to 52% in 1997. 50% were performed in approved independent sector places under NHS contract (NHS Agency) which makes a total of 89% of abortions are funded by

the NHS nationally. The remaining 11% were privately funded.

In comparison in Rotherham 746 out of 806 abortions (93%) were funded by the NHS, with only 7% being privately funded. 54% of NHS funded abortions were under 10 weeks' gestation<sup>12</sup>.

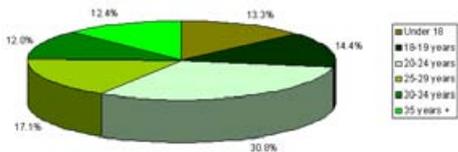
**Figure 8.10: Age-standardised abortion rate per 1,000 population aged 15 to 44 years from 1970 to 2007**

Source: Department of Health (2007), Abortion Statistics 2007, p2



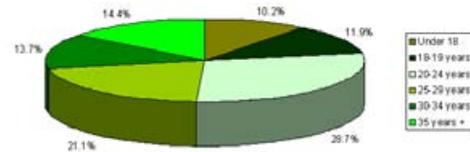
**Figure 8.11: Age Breakdown of Abortion Rate in Rotherham 2007**

Source: Department of Health (2007), Abortion Statistics 2007, p19



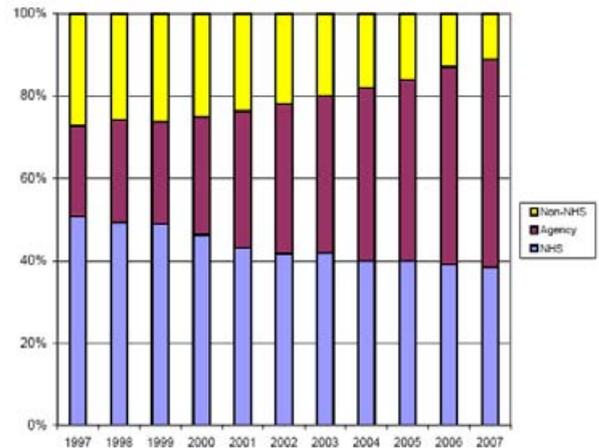
**Figure 8.12: Age Breakdown of Abortion Rate in England 2007**

Source: Department of Health (2007), Abortion Statistics 2007, p19



**Figure 8.13: Abortions by Purchaser – England and Wales – 1996 to 2007**

Source: Department of Health (2007), Abortion Statistics 2007, p3



## Access to Health Services

### 8.8 Summary of Chapter 8

In 2008/09, 93.26% of women who were pregnant were given a health and social care assessment of need within 12 completed weeks of pregnancy. This is well above the local target of 75%.

50.9% of adults and 73.4% of children regularly visit NHS dentists in Rotherham in 2007/08 which is well above the national average.

An immunization programme for over 65's was introduced in 2000. The target population also includes under 65's who may be at an increased risk due to chronic heart disease, lung disease, renal disease, diabetes and those with immune-suppression. In Rotherham, the uptake for people aged 65 and over was 74.4% in 2009/10 which was above the national average of 72.4%.

Overall for 2010, 38% of all contraceptives provided for Under 19's by GP's prescribing, the Contraception and Sexual Health service and the Terminations service were Long Acting Reversible Contraceptive (LARC) methods. This is a 6% increase in LARC uptake from the previous year.

The breast cancer screening programme is currently open to all women aged 50 to 70. In Rotherham in 2007, 80% of women aged 50-64 years received a screen. There were 7.1 cancers detected per 1,000 women screened in this age group.

## User Perspective on Social and Health Care Services

### 9.1 Support Older People Receive in order to Live Independently at Home

National Indicator (NI139) measures how far older people in a locality are getting the support and services they need to live independently at home and captures the views of those who are receiving services or potential future users. The results of the 2008 Place showed that only 32.9% of people believed that older people received the support and services they needed to live independently at home.

## User Perspective on Social and Health Care Services

### 9.2 Respect and Dignity in their Treatment (NI128)

National Indicator (NI128) and Vital Sign VSC32 measures whether service users and patients feel that they are receiving care that does not diminish their dignity, affect their modesty and respects their human rights. Dignity is measured both in health and social care settings and the measure therefore in Rotherham forms part of the monitoring work for both the Local Authority and Primary Care Trust in Rotherham. The results of the 2009/10 User Experience Survey of Adults Receiving Community Equipment of Minor Adaptations showed that 96.5% of people were happy with the way they had been treated by the service.

## User Perspective on Social and Health Care Services

### 9.3 User Perspective on Social and Health Care Services Neighbourhood and Adults Services (NAS) Research

Since January 2009 there have been three separate users experience surveys conducted of adult social care users including:

- Older People's Home Care
- Carers
- Community Equipment and Minor Adaptations

Neighbourhoods and Adults Services (NAS) have also participated in the voluntary extended study carried out by the Personal Social Services Research Unit (PSSRU) to better inform these surveys.

Each survey contains questions that form the Social Care Related Quality of Life (SCRQOL) measure developed by the PSSRU. The questions capture user perceptions on the following aspects of daily life:

- Control over daily life
- Personal care
- Meals
- Social situation
- Leisure time
- Safety
- Cleanliness and comfort

The surveys contain questions which capture user satisfaction and measure the quality of the service provided. We also capture our own local measures of user satisfaction with social care services through our own customer satisfaction testing mechanisms.

In addition, a wide-ranging consultation has been undertaken on the transformation of adult social care services through engaging with the programme of Personalisation. This has provided service users with an opportunity

to share their views about the future of adult social care service provision in Rotherham.

# User Perspective on Social and Health Care Services

## 9.3 User Perspective on Social and Health Care Services Neighbourhood and Adults Services (NAS) Research

### Research Results

#### Well-being

Enjoying a good quality of life is important to people. General well-being theme ran through all the discussions. Family and friendships important to people's sense of wellbeing.

Leisure pursuits key to well-being and positive self-esteem.

- Continue these for as long as possible.
- Would deteriorate physically and mentally without opportunities to 'get out and about'.

Retirement associated with loss of social links.

- Some had gone back to work for the companionship.
- Would like the choice of paid work but not to feel compelled to work because of financial hardship.

Having enough money to enjoy a quality of life important to well-being.

Would want influence concerning civic responsibility.

- Majority already feel invisible.

### Local Results, Comments

#### Older Peoples Home Care User Experience Survey - 2008/09 – PSSRU Extension Study

The findings of the PSSRU extension study of the User Experience Survey of Older People receiving home care demonstrated that quality of life of service users in Rotherham was significantly below the average of all authorities which took part in the study.

#### Older People's Home Care User Experience Survey - 2008/09

##### Control over daily life

- 14.7% of respondents said that they had no control over their daily life or not enough.

##### Personal care

- 13.7% of respondents said that they occasionally feel less clean that they would like or much less clean that they would like and are not able to wear what they want to

##### Meals

- 2.6% of respondents said that they were not able to eat the meals they liked when they wanted and felt there was a risk to their health

##### Social situation

- 43.6% of respondents said they sometimes felt lonely and cut off from others or they felt socially isolated and often lonely

##### Leisure time

- 69.6% of respondents aren't able to do the things that they want to do.

##### Feeling of safety

- 38.8% of respondents have some worries or are extremely worried about their personal safety

Overall in the study, Rotherham services users' perceptions of these outcomes were not significantly worse which suggest that quality of life in Rotherham is strongly influenced by all of these outcomes as well as the self-perceived health of service users.

User Experience Survey of Adults Receiving Community Equipment or Minor Adaptations – 2009/10

##### Control over daily life

- 13.1% of respondents said that they had no control over their daily life or not enough.

##### Personal care

- 9.5% of respondents said that they occasionally feel less clean than they would like or much less clean than they would like and are not able to wear what they want to

##### Meals

- 1.6% of respondents said that they were not able to eat the meals they liked when they wanted and felt there was a risk to their health

##### Social situation

- 32.0% of respondents said they sometimes felt lonely and cut off from others or they felt socially isolated and often lonely

##### Leisure time

- 35.6% of respondents aren't able to do the things that they want to do.

##### Feeling of safety

- 24.1% of respondents have some worries or are extremely worried about their personal safety

## User Perspective on Social and Health Care Services

### 9.3 User Perspective on Social and Health Care Services Neighbourhood and Adults Services (NAS) Research

#### Local Results, Comments

##### Carers Experience Survey – 2009

35.4% of carers rated their quality of life as good or better.

##### Control over daily life

- 13.1% of respondents said that they had no control over their daily life or not enough.

##### Personal care

- 36.2% of carers said that they sometimes weren't able to look after themselves or felt that they were neglecting themselves

##### Social situation

- 54.4% of carers said they didn't have enough or had little social contact with people

##### Personalisation

The broad views of people were that service users should have more choice and control over the services they received.

Many people referred to person-centred planning.

Many people felt that services should be structured around the service user's own outcomes and aspirations.

# User Perspective on Social and Health Care Services

## 9.3 User Perspective on Social and Health Care Services Neighbourhood and Adults Services (NAS) Research

### Research Results

#### Health and Ageing

Many initially have a positive attitude to health and ageing. Could adapt to a physical disability with support.

Maintaining independence paramount

- Expect services that facilitate this.
- Own definitions of independence should be accepted
- Wish to remain in control of their lives.
- After an illness, get "back to normal" as much as possible.
- Want information, guidance and support to live as independently as possible.

Many want six monthly/annual health checks at GP or Clinic

- Workers have occupational health for a healthy work force – continue for healthy retired citizens
- Information needed on health conditions, care pathways, referrals, alternative therapy etc.
- Need access to specialist knowledge and treatment of specific health conditions.

Huge concerns about dementia.

- Very negative images of dementia - 'nothing could be done for you when you're like that'
- Little recognition of the stages of dementia and no distinction between moderate and severe dementia,
- Concerned about managing risks in their own homes
- Would need care in an institution

### Local Results, Comments

#### Place Survey 2008

The National Indicator, NI 119, was previously used to capture self-reported measure of people's overall health and well-being.

With respect to self-assessed state of health, while 70.5% claim to be in a very good or good state of health, this ranges from 97% amongst 18-24 year olds to 46% amongst those aged 65 and over.

Women are also more likely to state that their health is good (74% v 66% men).

Amongst those living in social rented accommodation, 40% claim to be in good health, compared to 76% of home owners and 78% in private rented accommodation.

Assessment of health and well-being being very good or good is also higher for :

- White respondents (71% v 63% BME respondents)
- Those without a disability (90% v 32% with a disability)

Respondents from Rother Valley South Area Assembly are significantly more likely to rate their health as being good (79%). Conversely, those in Rotherham South Area Assembly and Wentworth North Area Assembly are less likely to assess their health to be good (both 64%).

The National Indicator, NI 139, previously measured how far

older people in a locality are getting the support and services they need to live independently at home. The score for this indicator, captured by the 2008 Place Survey, was 33% in Rotherham. However, amongst those people who were able to make a judgement on this indicator the score was 65%. This score was 75% for those in the 65+ age groups.

#### Older People's Home Care User Experience Survey - 2008/09 – PSSRU Extension Study

The findings of the PSSRU extension study of the User Experience Survey of Older People receiving home care demonstrated that the self-perceived health of service users in Rotherham was significantly worse than of other those in authorities. Only 20.5% of service users reported their health as good or very good.

In addition more service users were receiving other care and support services along with home care and more service users were receiving visits from a district nurse.

#### Carers' Experience Survey

9.3% of carers responded that their health was bad or very bad.

User Experience Survey of Adults Receiving Community Equipment or Minor Adaptations – 2009/10

# User Perspective on Social and Health Care Services

## 9.3 User Perspective on Social and Health Care Services Neighbourhood and Adults Services (NAS) Research

### Research Results

#### Support and care

Could come from family, friends, neighbours, social services and the NHS.

Do not want their grown up children looking after personal care needs

- Manage finances or do the shopping but little else.
- Do not want to be considered a burden
- Children should be left to get on with their own lives.
- Might call upon family for a temporary illness but not long term arrangement.

Friends and neighbours could “keep an eye out for you”, perhaps do your shopping but unfair to expect them to do anything else.

Would not mind partner providing personal care if they had a disability - but good support services to be available.

The bulk of care should be provided by professionals as opposed to family, friends and neighbours.

- Keenly felt by those currently living on their own.
- Care also to be available at night

### Local Results, Comments

#### Satisfaction

Satisfaction with all our services is 96% overall.

Satisfaction with ease of access to adult social care is 89%.

#### User Experience Survey of Adults Receiving Community Equipment or Minor Adaptations – 2009/10

The National Indicator, NI 128, self-reported experience of social care users, will be populated with data from the User Experience Survey of Adults Receiving Community Equipment or Minor Adaptations. The score for this indicator which records overall satisfaction with these services, in Rotherham is 77.0%. This has decreased from 79.4% which was the score last time this survey was undertaken in 2008.

The National Indicator, NI 127, respect and dignity in treatment, will be populated with data from the User Experience Survey of Adults Receiving Community Equipment or Minor Adaptations. The score for this indicator which records overall satisfaction with these services in Rotherham is 96.5%. This has been maintained from 96.6% which was the score last time this survey was undertaken in 2008.

#### Older People’s Home Care User Experience Survey – 2008/09

The findings of the 2008/09 Older People’s Home Care User Experience Survey tells us that 66.4% of service users received practical help in their own home

on a regular basis from someone living in another household. An additional 26.8% of service users receive help from someone living in the same household.

#### Carers’ Experience Survey - 2009

The results of the Carers’ Experience Survey showed that 61.2% of carers were caring for someone who lives with them. In 40.1% of cases they care for a spouse or partner and 34.9% of cases they care for a parent.

#### Personalisation

People felt that services should be simple and consistent. Most importantly they should be accessible to all – especially reaching out to the most vulnerable people who can’t speak up for themselves. Concern has been specifically expressed about information being made available to older people to enable them to make the right choices.

# User Perspective on Social and Health Care Services

## 9.3 User Perspective on Social and Health Care Services Neighbourhood and Adults Services (NAS) Research

### Research Results

#### Accommodation

Prefer to stay in their own homes as they aged  
Prepared to make adaptations to their lifestyle and environment.

- Houses need to have shower/ bathing facilities downstairs and/or a stair-lift - not willing to consider moving their bed downstairs.

For those living alone, housing is a preoccupation

- thinking of suitable accommodation - near families but not to move in with adult children - unless a 'granny annexe'.

Women living alone find problems managing gardens and general maintenance - cost and risk of rogue tradesmen.

Some have already downsized their accommodation.

- Concern that they could not afford a decent small property or bungalow.
- Moving to a smaller property not to a small property – do not want to be "living in a box".
- Want space to entertain family and friends and a second bedroom if partner becomes disabled or ill.
- Important to be near hospitals, shops, post office and bus stops - and community to be safe.

Mixed response to Extra Care Housing/ Retirement Villages.

- Like concepts of "home for life" allowing for independent living through to nursing care.
- A minority did not like living with just older people
  - Depressing if neighbours had dementia or challenging behaviour.
  - Prefer mixed communities not "segregation" - nice to be around younger people.

Great concern that they would not manage in their own homes with dementia - even with a high-level care package and Assistive Technology (AT).

- Limited knowledge of AT risk management at home
- Need a care home if they develop dementia
  - Would not want this but no alternative.
- Very pessimistic about care home standards.
- Want small specialist therapeutic environments where they could be "looked after properly".

### Local Results, Comments

#### Older Peoples Home Care User Experience Survey - 2008/09

Only 3.5% of service users responded that their home was totally inappropriate for their needs. 45.8% of service users responded that their home meets their needs very well.

#### User Experience Survey of Adults Receiving Community Equipment of Minor Adaptations – 2009/10

Only 1.2% of service users responded that their home was totally inappropriate for their needs. 51.8% of service users responded that their home meets their needs very well.

# User Perspective on Social and Health Care Services

## 9.3 User Perspective on Social and Health Care Services

### Neighbourhood and Adults Services (NAS) Research

#### Research Results

##### Finances

Would use assets to maintain quality of life - maybe by equity release - but others think it a 'con' – independent financial advice important as you age.

Unlikely that children would expect or get substantial inheritances.

- Assets and money should be used to look after yourself and not your children - but nobody wants to leave debt
- Would ask for financial help from their children only as a last resort

Pensions were not in line with the cost of living.

- Some worry about meeting basic demands such as running a car, the cost of food, bills and ever increasing council tax.
- Financial planning difficult as unable to judge future rises in utilities bills and taxes - expect to increase at a greater rate than pensions.
- Penalised unfairly if they saved as they were in the 'middle bracket' and did not get any financial help.

Benefits not sufficient but many feel they need to be more aware of benefits that may help towards the cost of care.

Resentment and anger about having to pay for care.

- They had paid taxes all their lives and now were not reaping the dividends.
- Best to spend money early and have care paid for when required.
- Little distinction between central and local government, central and local taxation, or between the NHS and social care as providers of support.
- Should not have to pay for nursing care (details of the Registered Nursing Care Contribution not known)
- Dementia care health related and should be free.

Debate around what people would be willing to pay for:

- Felt that their taxes not wisely spent by their Council
- Would pay if the services good quality and affordable.
- Equipment and adaptations should be funded publicly - less expensive for the public purse in the long run.

Most participants are pragmatic about spending money on care - they would use assets for personal/social care costs and most expect to fund their own 'well-being' services via equity release, selling their home and dipping into savings.

- Expect 'the government' to meet them half way through investment in preventative community and leisure facilities and higher thresholds for financial support, so people in 'middle bracket' not penalised.

#### Local Results, Comments

##### Consultation on Changes to Charging Arrangements for Day Care and Non-residential Services

The outcomes from this consultation were that there was broad agreement that in charging for care and support services people should only be asked to contribute what they can afford to pay. 40% of customers agreed that a charge should be based on ability to pay not a flat rate charge

There were mixed views on whether it was fair to ask people to pay more for services due to the rising costs of providing those services.

There was broad agreement that charging should be fairly applied across all care and support services.

##### Carers Experience Survey

31.6% of carers responded that caring had caused them some financial difficulties in the last 12 months

## User Perspective on Social and Health Care Services

### 9.4 Patients Survey Programme Findings for Local Institutions

The National Patient Survey Programme is co-ordinated by the Healthcare Commission on an annual basis which gathers feedback from patients on different aspects of their experience of care they have recently received across a variety of services and settings.

## User Perspective on Social and Health Care Services

### 9.5 Patient Survey of Local Community Mental Health Services

The national survey of Community Mental Health Services included 68 NHS Trusts that provide secondary mental health services to people in psychiatric outpatient clinics or through a local community mental health team.

Service users who took part in the annual survey were over 16 years of age and were in receipt of community mental health services. 14,355 service users completed the survey, a national response rate of 35%. In Rotherham there were 255 respondents to the survey that equates to a 41% response rate which is 6% above the national average.

In Rotherham 47% of respondents were male and 53% of respondents were female. 42% were in the age range 51 to 65 years, 37% in the 36-50 age group and 21% in the 16-34 age group. 97% of respondents were White British, 2% from Black or Black British and 1% from mixed minority ethnic group.

#### Key Findings in Rotherham

Rotherham scored well overall in the care they provided from Mental Health Services in Rotherham. A large percentage of service users (80%) said they

have confidence in mental health professionals, had enough say in decisions about their care and treatment and their diagnosis had been discussed with them.

A large percentage of service users (93%) felt that were treated with respect and dignity, 86% felt that health professionals listened carefully to them. 84% said that the purpose of their medication was explained to them and 62% were told about side-effects of any new medication. Nearly two-thirds of service users (64%) said they felt involved in decisions about their medication. This is above the national rate of 44%.

82% felt that counselling sessions provided met their requirements and 67% found that talking therapies were helpful.

82% said they knew who their care co-ordinator was and 88% would be able to contact their care co-ordinator if they had a problem. 58% had been offered a written copy of their care plan which is slightly below the national average of 59% but an increase from 49% in the previous year. 56% felt that they were involved in deciding what was in their care plan. 56% had a care review in the last 12 months, 75%

felt that the care review had been helpful and 88% were able to express their views freely.

71% felt that the activities provided at the day centre/ hospital were helpful, 62% had received information from local support groups, 55% had received help with finding work and 75% had received help with getting benefits.

69% had a contact number of someone from their local NHS mental health service to call out of hours. However, this is significantly above the national average of 55% in 2008. 68% had a family member or carer who had been given enough information which is above the national average of 58%.

#### Areas of Concern

There were no significant areas of concern identified within the Community Mental Health Survey as all scores were either in the intermediate 60% of trusts or best performing 20% of trusts category.

## User Perspective on Social and Health Care Services

### 9.6 Patient Survey of Local Community Health Services

The national survey of Local Health Services Survey helped Primary Care Trusts to improve services for the local population by capturing people's views and experiences on GP practices, health centres and access to dentistry. The survey of local health services involved 152 Primary Care Trusts in England.

Service users who took part in the survey were people aged over 16 years and were registered with their local GP. 69,470 patients completed the questionnaire, a national response rate of 40%. In Rotherham there were 485 respondents to the survey, equating to a 42% response rate (2% above the national average). In Rotherham 44% of respondents were male and 56% of respondents were female. 6% were in the age range 81 years and over, 21% who were 66-80 years, 32% who were 51 to 65 years, 21% who were 36-50 years and 20% in the 16-34 age group. 97% of respondents were White British, 1% from Asian or Asian British, 1% from Black or Black British and 1% unknown ethnic group.

#### Key Findings in Rotherham

GPs scored well above the average rate as 86% said their GP dealt with the main reason for their visit "completely" to their satisfaction which is 12% above the national average of 74%. 84% felt that the length of time to obtain an appointment with their doctor was reasonable and 76% being able to make an appointment three or more days in advance. 91% felt that their Doctor listened carefully to what they had to say, 87% were given enough time to discuss their

health or medical problem with the Doctor, 83% were involved in decisions about their care, 89% had confidence and trust in their doctor and 96% felt that they were treated with dignity and respect.

88% felt that they were given enough information about the purpose of their medication, 92% were given enough information about how to use their medicine and 89% have seen someone to check to see how they are getting on with their medication. 55% were offered a choice about which hospital they would like to be referred. 91% were satisfied with the length of time they waited for an appointment to see another GP or health centre. However, only 36% had received copies of letters sent between the specialist and their GP. 91% felt that the GP practice and/or health centre that they visited were in a clean and hygienic condition.

63% felt they were able to visit a dentist regularly as an NHS patient but patients wanted more access to NHS dentists. In comparison to national figures which suggest that 79% of those who did not receive NHS dentistry would like to be able to do so. 50% of respondents said they visited an NHS dentist regularly, while 24% did so as a non-NHS patient.

65% of people had their blood pressure taken within the last twelve months which is slightly below the national average of 66%. However, 66% of people had been given advice on sensible alcohol intake and 63% felt that they had enough support to manage their long-term condition.

#### Areas of Concern

Rotherham scored below the average rate of 60% of Trusts in the following areas:

- 57% of people had been given advice on their weight, which is below the national average of 64%. In order for Rotherham to become best performing 20% of Trusts a 67% response rate of advice given would need to be achieved. Information needs to be disseminated for weight management courses.
- 38% of people had been given advice on eating a healthy diet, which is below the national average of 44%. In order for Rotherham to become best performing 20% of Trusts a 46% response rate of advice given would need to be achieved.
- 35% of people had been given advice on getting enough exercise, which is below the national average of 41%. In order for Rotherham to become best performing 20% of Trusts a 44% response rate of advice given would need to be achieved.
- 9% of people had been given advice on giving up smoking, which is below the national average of 60%. In order for Rotherham to become best performing 20% of Trusts a 64% response rate of advice given would need to be achieved.

## User Perspective on Social and Health Care Services

### 9.7 Patient Survey of Local In-patient Services – Rotherham Foundation Trust (RFT)

The survey of the adult in-patient service involved 116 Acute and Specialist NHS Trusts in order to improve the quality of services that the NHS currently delivers. The Health Care Commission use national surveys to find out about the experience of patients when receiving care and treatment from local health care services.

Service users who took part in the annual survey were over 16 years of age, had at least one overnight stay and were not admitted to maternity or psychiatric units. 75,949 patients completed the survey, a national response rate of 56%. In Rotherham 850 recent in-patients from the Rotherham NHS Foundation Trust were sent a survey of which there were 449 respondents which equates to a 55% response rate, 1% below the national average.

In Rotherham 45% of respondents were male and 55% of respondents were female. 52% were in the age range 66 and over, 24% were in the age range 51-65, 15% in the age range 36-50 and 8% in the 16-34 age group. 93% of respondents were White British, 1% from Asian or Asian British and 5% from unknown ethnic group.

#### Key Findings in Rotherham

Rotherham scored well overall as the majority of respondents (79%) rated their overall care as an in-patient as "excellent", "very good" or "good".

79% felt that the doctors and nurses worked well together as a team which is in the category of best performing 20% of Trusts. 89% felt they had enough privacy when being examined in the A&E Department and were treated with respect and dignity while they were in the hospital. 84% felt that they had adequate information about their condition when they were in the A&E Department. 91% felt that the length of time was acceptable when they were on the waiting list to go into hospital for treatment. 85% felt that they did not have to wait a long time for a bed on a ward. 78% said the toilets and bathrooms were clean and 86% had seen doctors and nurses wash their hands between patient interactions.

90% felt they had confidence and trust in the treatment that was provided by Doctors and 88% in the care provided by nurses. 71% felt there were adequate numbers of nurses on duty in the hospital. 73% felt that they were involved in decisions about their care and 78% felt that they had been given adequate information about their condition or treatment. 86% felt that hospital staff did everything they could to help control pain. 93% felt that risks and benefits of operations were explained to them and 89% felt that staff answered any questions with regard to procedures undertaken. 86% felt that hospital staff had explained the purposes of the medicines that were to be taken home when

being discharged from hospital and 85% felt that they were given medication advice in a way that was easily understood. 80% were given clear written information about their medication on leaving hospital and 84% were given a contact number if they were worried about their condition.

#### Areas of Concern

Rotherham scored below the average rate of 60% of Trusts in the following areas:

- 48% said that they had to use the same bathroom or shower
- 76% had to share a sleeping area as patients of the opposite sex which suggests that more effort is required to provide single-sex facilities for patients
- 61% had their sleep disrupted by other patients
- 77% felt they were bothered by noise at night from hospital staff
- 18% of people felt that there was a lack of choice of food being provided at the hospital which is above the national average of 15%.

## User Perspective on Social and Health Care Services

### 9.8 Patient Survey on Access to Primary Care

The GP Patient Access Survey is conducted by the Department of Health. Almost two million people registered at GP practices in England responded to the annual questionnaire which asked how easy or difficult it is for them to see or speak to a doctor or access services at their practice.

Patients who took part in the annual survey were over 18 years of age and registered with their local GP. A total of 1,999,523 surveys were completed, a national response rate of 41% and a regional response rate of 42%. In Rotherham there were 22,018 surveys sent out to patients of which 9,498 responded. This equates to a 43% response rate, 2% above the national average and 1% above the regional average.

In Rotherham 44% of respondents were male and 56% of respondents were female. 30% were in the age range 65 and over, 22% in the age range 55-64, 33% in the 35-54 age group and 15% in the age group 18-34. 93% of respondents were White British, 1% from White Irish, 2% from Other White background, 2% Asian or Asian British and 1% from Black or Black British.

35% of respondents were in full-time paid work, 12% in part-time paid work and 53% in other category.

#### Key Findings in Rotherham

87% reported that they were satisfied with their ability to get through to their Doctor's Surgery on the telephone. 86% of patients who tried to get a quick appointment with their GP said they were able to do so within 48 hours. This is 1% below the national average of 87%. 79% of patients who wanted to book ahead for an appointment with a doctor reported that they were able to do so. This is 2% above the national average of 77%. 87% of patients who wanted an appointment with a particular doctor at their GP surgery reported that they could do this. This is 1% below the national average of 88%.

85% of patients said they were satisfied with the current opening hours of their practice. This is 3% above the national average of 82%. However, the main reasons for dissatisfaction with opening hours was not open enough in the evenings (40%) or on Saturdays (37%), not open early enough in the morning (7%) and not open around lunchtime (8%). 52% of patients who were referred by their GP to a hospital specialist reported that their GP discussed choice of hospital with them. This rate is the same as the national average.

#### Areas of Concern

69% can take time during the working hours to see a GP, whereas 31% of people are unable to do so due to work commitments. More flexible opening hours are required at some GP surgeries in order for patients to gain an appointment for medical advice.

Two new GP surgeries are currently being commissioned and will be fully operational by the Summer of 2009. The first one, located in the Wentworth North Area Assembly, will register patients from Wath, Swinton, Mexborough and Bolton-on-Dearne. The second, located in the Town Centre of Rotherham at the Community Health Centre, will take patients from across the borough. Both GP practices will be registering around 6,000 new patients and will be offering extended evening and weekend opening hours. This will improve accessibility rates for the local population, especially for those who are of a working age.

Although 87% of people were satisfied with being able to get through to someone on the telephone at their GP surgery in order to make an appointment there were two GP practices in Rotherham where only 51.2% and 54.9% of people were satisfied with access to their GP.

## User Perspective on Social and Health Care Services

### 9.9 Patient Survey of Choice to Primary Care

The GP Patient Choice Survey was conducted by the Department of Health. 283,400 surveys were completed by patients who were registered at GP practices in England which asked whether they were offered choice of which hospital they would like to go to receive treatment.

In Rotherham 1,724 surveys were completed, of which 1,614 (94%) said that they were offered choice which is 1% above the national average of 93% and 2% above the regional average of 94%. The percentage of people who were offered choice was slightly more in the younger age group between the ages of 18 to 35 (96%) in comparison to 92% in the over 65 age group.

## User Perspective on Social and Health Care Services

### 9.10 Black Minority Ethnic (BME) Mental Health Consultation Event

The BME Mental Health Consultation Event was held with the following key findings:

- Privacy and single sex wards – ideally separate rooms with en suite facilities
- Care provided by female Doctor for female patient
- Staff that are bi-lingual to be trained in providing care and support in
- Halal and tasty food should be provided
- Spiritual care and provision of prayer rooms
- Female spiritual care provision, not just Asian male Chaplain
- Staff to be culturally competent
- Separate space for patients at the end of their life
- Better monitoring of aggressive patients
- Gardens and relaxing spaces
- More information on raising awareness of mental health and challenging stigmatisation
- Early intervention, further community development and investment in communication
- Personal assessments and plans to reflect therapeutic interventions
- Better information on the ward and within the community

# User Perspective on Social and Health Care Services

## 9.11 Consultation with Focus Groups and Individual Interviews

A targeted consultation process was carried out as part of the development of the Joint Strategic Needs Assessment. This piece of work was carried in accordance with CSED's "Anticipating Future Needs Toolkit".

Three focus groups were held with service users and carers to inform the development of the JSNA and to form a picture of what services and support will be needed by older people in Rotherham in 10-15 years time. The Joint Commissioning Team also interviewed the two service user/carers representatives from the Adults Board to establish their views on future need.

### Characteristics of Focus Groups and interviewees

- The ages of the members of the focus groups ranged from 58 years to 86 years
- 33% of participants were men, 67% were women
- 67% were living with a partner, 33% were single
- 67% of people owned their own home and 33% were living in rented accommodation
- Of those that declared financial income, 55% had a private or employers pension
- Of those who declared financial income, 22% had savings over £20,000
- 67% had either cared for an older friend or relative for more than 5 hours per week

The first interviewee was male and 70 years of age from a Roman Catholic background. The gentleman lives with his spouse and owns his own home. He has a son who suffered a significant brain injury 14 years ago. The second interviewee was female and 58 years of age from a White Scottish, Catholic background. The lady is widowed but has a son living with her. She cared for her husband for ten years who survived a stroke and also suffered from dementia.

For the purpose of this report participants and individual interviewees will remain anonymous.

### Outcomes from the Focus Groups and Interviews

Below is a summary of the feedback from the focus groups on expectations, aspirations and fears:

#### Well-Being

All participants highlighted the importance of enjoying a good quality of life, keeping active and healthy for as long as possible. Family and friendships were identified as being important to a person's sense of well-being. Participants liked to take part in leisure pursuits in order to promote well-being, self-esteem and remain healthy e.g. walking, swimming and gardening, golf, table tennis, sequence dancing,

line dancing, woodwork, and keyboard. One participant still played squash to a high standard. Joining club and associations were regarded as important for social interaction and exercise. There was concern that there were no groups specifically for people with physical disabilities. Other interests included history and local heritage, family history and attending evening classes. There was support for organised outings to go to see shows, trips to sea-side etc. There was also support for further education courses being made more accessible to older people and those with physical disabilities. There was a desire to be able to continue these types of activities for as long as possible.

Participants felt that they would deteriorate physically and mentally without opportunities to "get out and about" in the community. Attendance at groups such as the Carers Forum and ROPES gave them a feeling of contributing to society. There was support for organised outings to go shopping, to the seaside or to visit stately homes. There was also interest in local attractions such as Magna, Castleton etc.

There was a strong desire to make links with younger people and engage them in leisure activities e.g. youth theatre groups. Also there was a role for visiting vulnerable older people who cannot get out themselves.

## User Perspective on Social and Health Care Services

### 9.11 Consultation with Focus Groups and Individual Interviews

One restriction to developing appropriate support networks was the availability of transport, especially in the evening when some participants felt they were effectively housebound. It was felt that these links needed to be improved so that people could access local amenities.

Participants were concerned that social links are diminishing as pubs are closing so there is nowhere to go to catch up with the local people. Some participants suggested an overhaul of Local Authority community centres so that they could organise social activities to engage the community and bring different generations together.

#### Health and Ageing

Participants attached high importance to maintaining independence and remaining in their own home for as long as possible. They recognised the importance of keeping fit and healthy for as long as possible also. Most members said that they could adapt to a physical disability with adaptations such as walk-in shower, stair-lift, having their bed downstairs. They felt there was a need for more information, guidance and support in order to look after the people they are caring for at home. Good, relevant information throughout health and

social care service provision is vital.

Some participants felt that people who have been diagnosed with dementia should go into residential care as soon as possible, rather than wait later on in life when their condition has significantly progressed.

There was a strong feeling that all staff should treat people with dignity and respect. They need to be treated in a holistic way and consulted with when decisions relating to their care are being made.

#### Support and Care

Participants believed that they would receive support from family, friends, neighbours, Social Services, NHS and the third sector as they got older. There was recognition that there will be an increased need for additional formal carers, especially if family members are unable to provide informal support as a result of work commitments or moving out of area. There was a call for better trained, more professional carers to make the job more attractive and improve care quality. There was concern at the limited home care time allocated to each person, with very little time for social interaction. There was support for a home care enabling service as this would

help to maximise independence. However, participants also felt that formal care was often awkward because they felt it was an invasion of privacy.

Focus groups were asked what services they thought were the most important as they grew older. Most participants said that they would like home care support to help with cleaning and shopping. There was a need for specialist transport especially for wheelchair users e.g. handybus to “getting out and about” in the community.

The focus groups felt strongly that there was a need to identify people who are lonely and that this group should be targeted for support. There is a need to identify people who could claim benefits but may have access problems in obtaining information due to their mobility needs.

Support for carers was a big issue. Some people felt too proud to ask for external support as they felt it was their “marital duty” to care for their spouse. There was support for the provision of a night sitting service to support carers and help them get sufficient rest. Respite care for carers was identified as important so that carers can have a break. There was support for an extended bathing service to help with this specific personal care task.

## User Perspective on Social and Health Care Services

### 9.11 Consultation with Focus Groups and Individual Interviews

There was support for the development of a hospital discharge service especially for people who have suffered falls or had an operation. Such a service could support people with personal care tasks, putting to bed, making meals etc straight after leaving hospital. Focus Group 2 believed that children should not have to look after their parents. There was also support for government policy on single-sex wards and respect for dignity in hospitals.

Participants supported the use of assistive technology especially for people with mild to moderate dementia. A number of participants raised the issue of early identification of dementia. They felt that GPs needed to make more referrals to the memory service to ensure early diagnosis. Additional dementia training needs to be provided to GP's in order for them to gain awareness of the condition and signpost people to relevant services.

Response times for social work assessment were highlighted as an issue. Group members felt that assessments should be completed within a maximum of two weeks, especially for those people with dementia. This should be followed by prompt implementation of care packages and then regular re-assessment. There was support

for tailor-made individual care packages so that people could choose what services they needed.

Participants supported the use of former local authority homes as day centres aimed at promoting community engagement. They wanted to see better pay, conditions and additional training for staff who work in independent sector homes to improve the quality of care provided.

Rothercare was highlighted as a great service for carers as it provide emergency cover when a carer leaves the house. Participants highlighted the Expert Patient Programme as a vehicle for self-management of long term conditions. However there is still a need for additional information on self- management of long term conditions. It was felt that GPs could provide better information on self-management. There was support for the wider availability of counselling services and end-of-life training for carers.

Some participants supported direct payments or individual budgets. Employing someone of their choice to provide personalised care was attractive to some but not others. There was general support for Direct Payments and the development of Individual budgets but Participants emphasised the need to protect people from the

extra pressure of co-ordinating their own care.

For participants who had cared for someone with a long term condition there was an emphasis on establishing clear care pathways with a structure in place for co-ordinated rehabilitation. There was a strong view that long-term rehabilitation should be available for people with a brain injury, stroke or another long term condition. Participants supported the development of a key worker role aimed at guiding someone with a long term condition through the care pathway and providing long term support. This role should be accompanied by additional support for families, appropriate respite care and opportunities for social activities.

There is a need to develop intermediate care services for people with neurological conditions and to provide a step-down provision from hospital or step-up provision form someone's own home.

Participants called for the development of appropriate day care for people who are under the age of 65. There was support for more preventive work around regular check-ups for blood pressure or monitoring to diagnose health conditions at an earlier stage.

## User Perspective on Social and Health Care Services

### 9.11 Consultation with Focus Groups and Individual Interviews

#### Where would you live?

All participants said that they would prefer to stay in their own homes but this would be dependant upon their needs and condition of health. They would prefer to have support from Social Services for as long as possible. There was no desire to move nearer to family or move in with family members if they required extra support. The majority of participants said they would prefer to stay in their homes and to remain living in Rotherham. A number of participants live in a privately owned house with a large garden. They have good transport links with buses, shops and families living nearby. They felt that over time they may need help with managing the garden, especially if they were left on their own. A number said that they would get to a stage where they were unable to manage the maintenance on their house and that that they would down-size. One member of the group had their house up for sale over the last two years but had been unable to find a buyer because of the state of the housing market. Some people would down-size their accommodation in order to be nearer their family. Some said they needed adequate accommodation in order for young grandchildren to stay over at the weekend.

There was a reluctance to consider moving into residential or nursing care as they felt that there is no privacy, they will lose their independence and lose their network of friends. Most carers would only consider residential care for their partner if they required double handling or had mental problems such as dementia. There was an acknowledgement that if someone had severe dementia they would require EMI residential care and the sooner they are admitted into this type of facility the better in order to meet their needs. Participants who were carers recognised that the burden of looking after someone with severe dementia was probably too great for any carer.

Many participants knew about and would consider Extra Care Housing. This would feel safer. They would have their own living accommodation and front door. All focus groups supported the development of this type of accommodation. A number of participants said that they would be interested in moving to Longfellow Drive where a community centre is available, as well as a hairdresser and computer access via the internet café. However there was some concern that the scheme was only available to people who are over 55 years of age.

Participants would also consider supported housing or sheltered accommodation where a warden or carer could come to visit on a daily basis to provide support. They would be prepared to have adaptations made to their home e.g. shower/bathing facilities, stairlift or bed downstairs. They would also be prepared to move into a specially designed bungalow or have doorways widened to accommodate wheelchair access. One participant suggested that a database be developed for specially adapted accommodation so that these can be designated to people with physical disabilities.

Participants were happy with the following tiered approach to addressing housing need:

- Use of assistive technology to stay at home
- Moving into specially adapted sheltered housing with some support
- Moving to Extra Care Housing when care needs becomes greater
- Final resort to go into residential or nursing care

#### Finances

Approximately 66% of participants had an occupational pension. 34% of people only have a state pension to rely on for income. The majority were comfortable with

## User Perspective on Social and Health Care Services

### 9.11 Consultation with Focus Groups and Individual Interviews

their present finances. However, in future this may become a problem if they had to pay for additional support when their needs are much greater.

There was concern that reductions in interest rates was impacting on income from savings. Participants said that they would consider down-sizing to release equity and enhance their quality of life. However, many felt that they should not have to use sell their house to pay for residential care and are hoping that Government policy changes this in the future. People were also concerned at the rise in fuel prices which have disproportionately affected older people. Participants said they would be prepared to move to a smaller property but not one that felt like you were "living in a box".

A number of participants said that they would not want to ask for help with finances as it would feel like we were "begging". Some participants were willing to pay for services such as physiotherapy, occupational therapy or speech and language therapy to help maintain their independence as everyone has some form of rehabilitation requirements. There was some resentment and anger about having to pay for residential and nursing care after having paid into the system all their lives and they felt they had been penalised unfairly if they had savings and assets.

## User Perspective on Social and Health Care Services

### 9.12 Consultation at Fair's Fayre – October 2010

52 questionnaires were completed at this event, of which 61% of respondents were female and 35% male (4% declined to answer).

12% of respondents were children (10 to 17 years), 73% were adults (18 to 64 years) and 15% were older people (65 years and over).

37% of respondents stated that they were living with a physical disability or limiting long-term condition. 52% stated that they were experiencing mobility problems, 37% had a sensory impairment, 37% had suffered a mental health problem, 42% had some forms of a learning disability and 32% had a long-standing limiting illness.

83% of respondents were from the White British population, with the remaining 17% from a Caribbean, Pakistani or Asian communities. 37% of respondents were Christian, 2% Baptist and 8% from an Islamic background. The remaining 53% did not state a religion or declined to answer. 75% of respondents were heterosexual and 25% declined to answer around their sexual orientation.

21% of respondents were caring for a close family member, friend or neighbour on a regular basis.

#### Key Issues in Rotherham

**Children and Young People** – 23% of respondents felt that alcohol and smoking were major health issues in Rotherham. However, only 2% of respondents were accessing services such as Turning Point or the Smoking Cessation Service to seek support, advice and guidance.

**Adults** – 37% of respondents felt that obesity was a major issue due to poor diet and lack of or limited physical activities being undertaken or available in Rotherham which is affecting the health of the local population. However, only 20% of people were using services such as leisure centres and weight management courses. 31% of respondents felt that smoking and 17% of respondents felt that binge drinking was a major factor in the health of the local population.

**Older People** – 19% of respondents felt that older people were suffering from long-term conditions as a result of stroke, dementia, COPD, diabetes which has a major impact on independence and heavier reliance on informal care from family members. 25% of respondents stated that older people with mobility problems has an impact on undertaking daily living tasks

such as personal and household duties. 17% of respondents stated that older people are more likely to have a hearing or visual impairment who may require specialist equipment to enhance their quality of life. 27% of respondents felt that older people are at a high risk of falling and resulting in a physical injury resulting in a prolonged hospital admission/stay.

**Access to Services** – 62% of respondents were regularly accessing libraries, 52% for leisure activities, 50% for education and transport, 39% for benefits/advice, 29% for housing, 27% were receiving support from carers, 23% from home care, 15% support from mental health services.

## User Perspective on Social and Health Care Services

### 9.13 Adding Quality, Adding Value; event report in 2010

This public and stakeholder conference considered how we improve Rotherham's health in the current challenging economic climate. Rotherham's significant achievements in:

- improving health services including better access to GPs
- reductions in levels of smoking
- new and innovative services for people with chronic breathing problems
- increased dental access
- lower waits for non-emergency outpatient treatment
- more services, support and information for people wanting to lose weight and make healthier lifestyle choices
- Need to ensure that the public are getting the very best possible value for money. Groups were asked to consider quality of health services in the Borough, gaps in service provision and any barriers to access. These themes were raised by a number of the groups:
- Improving awareness of and information about services was needed
- Using the voluntary and community sector better to add value to costly services, both to share skills and offer support;
- Providing information in formats people find understandable and accessible.

#### Outcomes:

##### Key Points around End of Life Care:

- Education and training for all staff and the public
- Consistent information around services available
- Better links between all services, and patient records kept in a way that supports people using a variety of services
- Equality of service – no matter where they are, home, hospice, hospital, everyone should experience choice and dignity in death.

##### Key Points around Obesity:

- Prevention work was felt to be important and of value, though there were concerns around low take up of services by those most in need
- We should better measure the value in terms of preventing obesity of various programmes (ie access to exercise), this includes ensuring that short term projects can run long enough to be properly evaluated
- Cost of and access to exercise facilities is a barrier
- Increased information and publicity around weight management services is needed, including better awareness and promotion from GPs

##### Key Points around Respiratory conditions:

- Awareness of conditions and smoking link in schools
- Better, and consistent information
- Using community champions / role models
- Better and consistent use of prescribing and medications
- More accessible and friendly smoking cessation services
- Health MOT / Lung Health checks in communities

##### Key Points around Dementia:

- Early Diagnosis and treatment (self referral) ensuring people access services quickly and easily
- Better GP awareness, including recognition of dementia and services available
- Addressing the stigma, and allaying fears
- More support for carers
- Integration of health & social care services, hospitals, community services, GP's, specialist services, and voluntary/community providers and support

##### Key Points around Diabetes:

- Better information and education around
- Awareness of the condition
- Prevention
- First signs and how to get help

## User Perspective on Social and Health Care Services

### 9.13 Adding Quality, Adding Value; event report in 2010

- Post diagnosis/ management
- Medicine management
- Avoiding duplication of care

Key Points around Prescribing:

- Waste
- Constant changes in appearance of medication
- Community pharmacy service good

#### Outcomes of open forum:

##### 1. Integrated services

Integrated work does take place within health and social care; we need to learn from the best examples and work together across health, social care and the independent sector.

##### 2. Up to date and accessible information

The need for information to be in date and easily readable was highlighted. Checking the information provided in practices could be picked up during annual practice review visits.

##### 3. Language and access barriers

GP practices are working with population groups, and we are looking to train staff to act as ethnic link workers

##### 4. Personalisation and care plans

The NHS does need to give greater emphasis to personalisation and focus on the needs of the individual. The Council for Care is aware of the personalisation agenda and interface with social care. Close work with social services and the local authority needs to happen in order to deliver effective care plans.

## User Perspective on Social and Health Care Services

### 9.14 Carer's Forum Consultation - 4th May 2011

The Carer's Forum are pulling together a constitution to clarify expected aims and outcomes of the group. During the session, the group identified that support services need to be promoted more effectively as there are many carers out in the community who are not aware of the health and social care services available to them.

The group established 4 main objectives including:

1. Relevant and flexible services are needed with increased access for all
2. Accurate information is to be received in a timely and preventative way
3. Improved communications are needed
4. The group will act as a key resource for carers and provide a support network

## User Perspective on Social and Health Care Services

### 9.15 Rotherham Older People's Experience of Service (ROPES) Consultation – 9th May 2011

#### Assessment Officer

Feb/March 2010

##### Successes

- “fabulous, provided all care that was needed”
- Good communication
- Good precautions provided by Social Care following a bad winter
- “NHS staff were very helpful and went out of their way to help”

##### Areas for Improvement

- Little support on discharge – waiting for 9 hours and much longer than necessary

#### Assessment Officer

In the past (20 years ago)

##### Successes

- “Really good service”
- “Support was provided when children were born, mortgage was provided through RMBC and housing support for our parents was good”
- Service provided is better than in other areas
- Warden service is vital
- Transport to hospital is good but the service needs to be utilised more efficiently i.e. better coordination and filling of buses

##### Areas for Improvement

- Length of time waiting for access to services i.e. a 90+ lady is waiting for home improvements

#### Assessment Officer

How the group felt about living in Rotherham

##### Successes

- Housing
- Safety
- Transport links
- Rothercare
- Neighbourhood/community support
- Shop Mobility Service

##### Areas for Improvement

- Services cannot always be accessed free of charge
- Need to find the most isolated populations
- Lack of community care and less community spirit
- Distribution of spend across health and social care should be reviewed and more people take responsibility for their own lifestyle
- ‘Form filling’ can be complex

#### Assessment Officer

Experiences of using Rotherham's Health and Social Care Services

##### Successes

- Services from access through to discharge plus continual care
- Equipment is now available upon discharge
- Breathing Space has excellent facilities
- Housing
- Appointments are on time
- Eye department – “staff are wonderful”
- Good experience in hospital – “I was treated really well, treatment was discussed and the outcome was really good”

#### Areas for Improvement

- Care in the community
- Availability of services all hours
- Lack of funding
- Neighbourhood support which would help ‘prop up’ services
- Lack of social workers at GP Practice
- Acute care is lacking – there is a need for more services in the home and community outreach
- Age Concern services cut – no longer are calls made to check okay
- Improve communications between Health and Social care
- More community transport is needed
- Involvement of too many agencies
- Identified the need of ‘key workers’
- Access to GP Practice can be difficult
- Private carers are expensive
- Drains blocked and streets not cleaned

Members noted several concerns for Rotherham in the future:

- People may only be able to access the services they can afford.
- The high unemployment rate amongst adults of working age and school/college leavers may add to existing financial concerns.
- Older adults are a proud generation who will often wait until crisis point before seeking help.
- Older people are being told by clinicians that their condition cannot be improved and putting it down to old age.

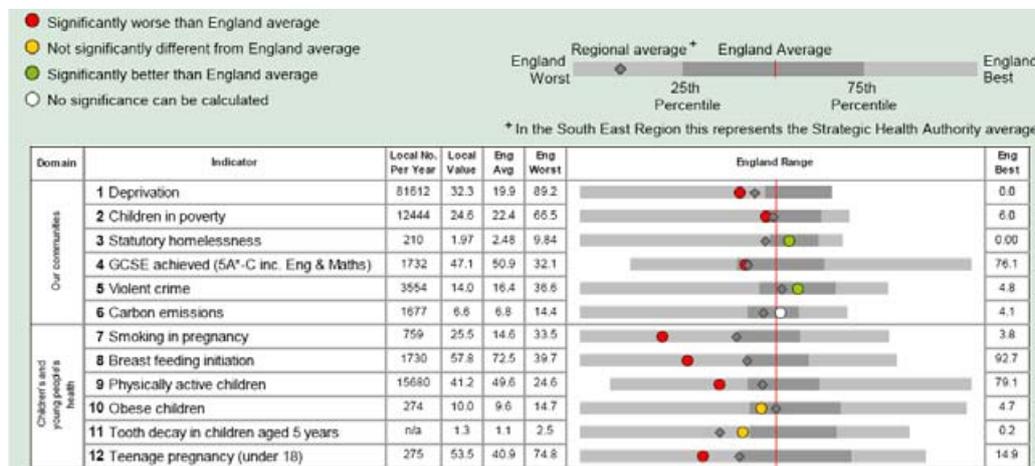
# Children and Young People's Needs Assessment

## 10.1 General Health<sup>1</sup>

The chart below (Figure 10.1) shows how children's health in Rotherham compares to other local authorities in England. The local result for each indicator is shown as a circle against the range of results for England which is shown as a bar. A green circle may still indicate an important public health problem.

The data shows that Rotherham fares poorly on most of the indicators compared with the national and regional averages, suggesting children in Rotherham are more likely to suffer from ill-health. Breastfeeding and smoking in pregnancy are the indicators where Rotherham is at the worst disadvantage.

Figure 10.1 Rotherham Health Profile 2010 – Indicators Relating to Children and Young People



### Indicator Notes

- 1 - % of people in this area living in 20% most deprived areas of England 2007
- 2 - % of children living in families receiving means-tested benefits 2007
- 3 - Crude rate per 1,000 households 2008/09
- 4 - % at Key Stage 4 2008/09
- 5 - Recorded violence against the person crimes crude rate per 1,000 population 2008/09
- 6 - Total end user CO2 emissions per capita (tonnes CO2 per resident) 2007
- 7 - % of mothers smoking in pregnancy where status is known 2008/09
- 8 - % of mothers initiating breast feeding where status is known 2008/09
- 9 - % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09
- 10 - % of school children in reception year 2008/09
- 11 - Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08
- 12 - Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional)

Source: APHO (2010), Health Profile Rotherham 2010

## Children and Young People's Needs Assessment

### 10.2 Proportion of Children in Poverty

Deprivation in Rotherham is now increasing according to Communities for Local Government. Rotherham ranked 68th most deprived district in England in the 2007 index and is now the 53rd in 2010 index. This demonstrates how deprivation has increased in Rotherham. Rotherham still ranks amongst the top 20% most deprived districts.

The key drivers of deprivation in Rotherham remain Education and Skills, Health and Disability and Employment although only relative Health and Disability has deteriorated since 2007. Improvements are most evident in Education and Skills, Living Environment and Employment. The greatest deterioration is in Crime although this is based on

changes between 2005 and 2008 and does not reflect the most recent trends. Deprivation tends to have reduced or stayed the same in the least deprived areas, whilst it has increased most in those areas with the highest deprivation. For Income, Health and Crime there is evidence of polarisation between the most deprived and least deprived, at least in relative terms. Children are more likely to be deprived than adults<sup>2</sup>.

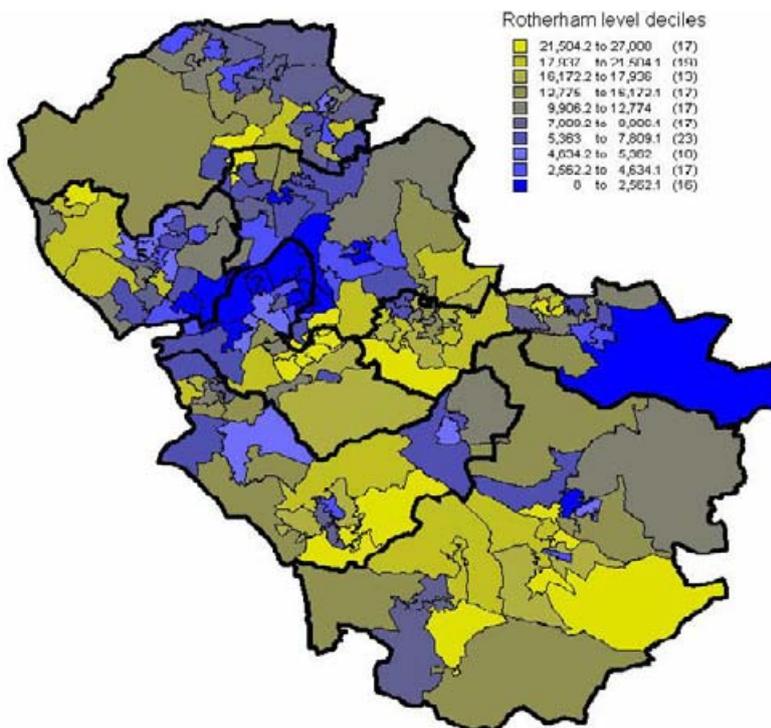
#### Income Deprivation Affecting Children Index (IDACI)

This is an index within the Income Domain which shows the proportion of children in households deprived of income

(using the percentage of children aged 0 to 15 living in households dependent on means tested benefits or receiving the highest rates of Child Tax Credit – applicable to very low waged parents).

Rotherham is still the above average percentage of children affected by income deprivation at 23.4% in 2010 and 24.6% in 2007. The level of polarisation within the Borough is even higher than with income deprivation as a whole, ranging from 61% in East Herringthorpe North to 0% in Whiston North.

Figure 10.2



# Children and Young People’s Needs Assessment

## 10.3 Prevalence of Breastfeeding at 6 to 8 Weeks from Birth

### Regional Data

Data quality has been an issue for many areas within the Yorkshire and Humber region. Breastfeeding rates at 6-8 weeks seem to differ across the region. There is also a difference between exclusive and partial breastfeeding rates. Figure 10.2 shows how rates in Rotherham compare with other areas in the region at Q4 2010/11.

### Local Data

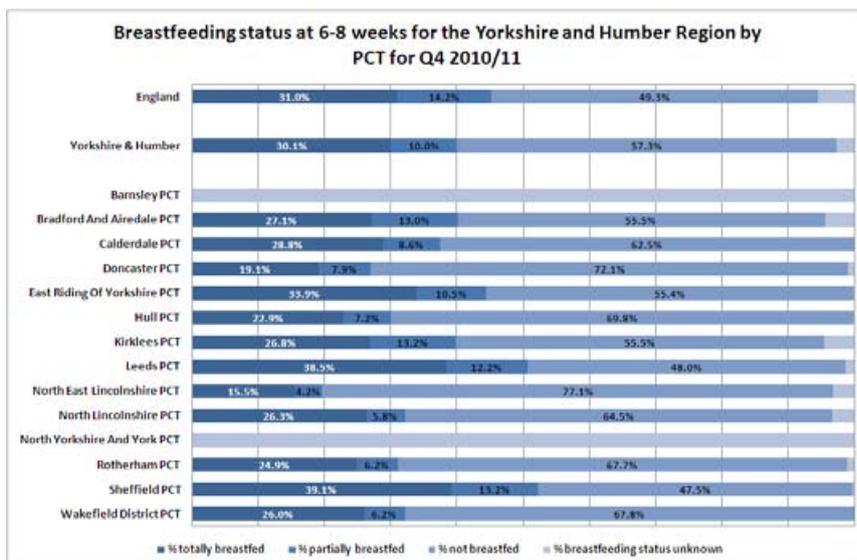
The Q4 2010-11 data shows that the percentage of babies that are totally breastfed has improved, but remains low within the region. The increase on the same quarter for last year (2009/10) is 4% (from 20.7% in 2009/10). The recording of breastfeeding has improved

significantly over the past two years and now the percentage where status is not known is consistently below 5%.

Rotherham is seeking to improve the breastfeeding initiation rate by 2% year on year level and achieved 61% in Q4 2010/11 (below the 62% end of year target). Initiation and continuation rates are significantly improving as a result of the ongoing implementation of the UNICEF Baby Friendly Initiative (BFI) in Hospital and the additional interventions delivered by Maternal Health Workers (at Rotherham Foundation Trust) and Breastfeeding Peer Supporters (RFT and RMBC). Improvements in initiation contribute to improved breastfeeding rates at 6-8 weeks.

Rotherham exceeded the 6-8 week breastfeeding target (set at 30%) at the end of 2010/11 achieving 31.1%. However, it must be recognised that Rotherham has significantly lower rates of breastfeeding than the England and Yorkshire and Humber average. This is likely to be due to Rotherham being one of the most deprived areas in England. NHS Rotherham has made a significant investment in breastfeeding to address and improve breastfeeding support across the borough. Current figures and those reported above suggest that a number of new local initiatives and the progress towards UNICEF BFI in community settings are starting to have an impact on the number of women breastfeeding at 6–8 weeks.

Figure 10.2



# Children and Young People's Needs Assessment

## 10.3 Prevalence of Breastfeeding at 6 to 8 Weeks from Birth

Figure 10.2

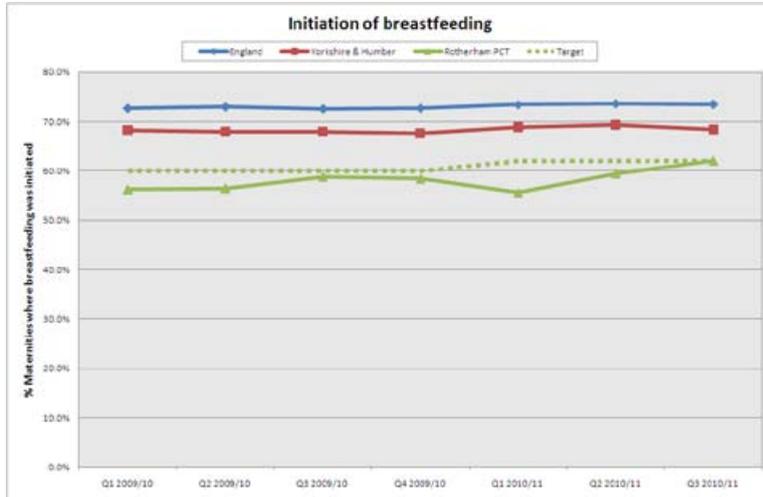
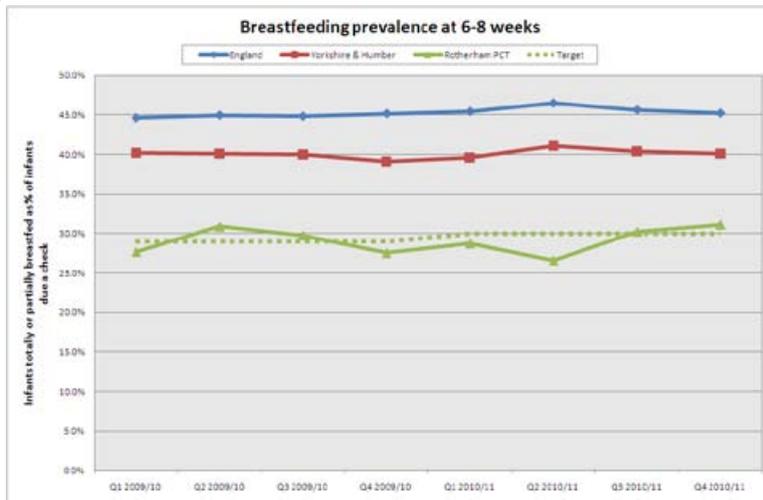


Figure 10.2



# Children and Young People's Needs Assessment

## 10.4 Teenage Pregnancy (Under 18 and Under 16 Conception rates)

The latest official annual under 18 conception data was made available in March 2011 for the year 2009. Rotherham failed to meet the national target of reducing Teenage conceptions by 50% by the end of the 10 year strategy. Official under 18 conception rates are provided by the Teenage Pregnancy Unit and ONS<sup>3</sup>.

Rotherham's Teenage Pregnancy Strategy was launched in 1998, in line with the national strategy, with the objective of achieving the following targets:

- To reduce by 50% the under 18 conception rate by 2010 from the 1998 baseline.
- To increase to 60% the proportion of teenage mothers in education employment and training.

Until 2005, the overall trajectory for under 18 conception rates for Rotherham was downward, with a final year rate of 49.5 (per 1,000 girls aged 15-17) and an overall rate reduction of 12%. This was comparable with the national rate reduction, and that of statistical neighbours<sup>3</sup>.

However, 2006 onwards saw an increase in numbers of conceptions, taking final yearly rate in 2008 to 55.8 and an overall rate reduction of less than 5%, taking Rotherham off its downward trajectory<sup>3</sup>.

In 2011, the 2009 rolling average for quarter 4 is the lowest since June 2003.

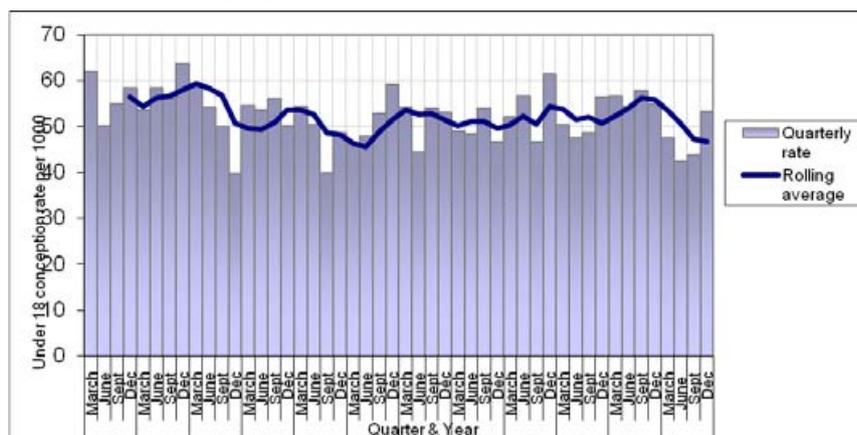
Following the disappointing 2008 figures with a slight increase on the 2007 numbers (leaving

a only a 1.4% reduction over the 1998 baseline). The 2009 figures proved more positive with a 17.7% reduction and a provisional Under 18 conception rate of 46.6. The national 10 year Teenage Pregnancy Strategy aimed for a 50% reduction over the baseline. Rotherham will be unlikely to achieve this but at least a reduction in numbers has been maintained. There was a decrease in the numbers of terminations to Under 18s in 2008, but provisional figures for 2009 show a rise again.

Rotherham's Teenage Pregnancy Strategy is currently being reviewed and a new local target will be set around reducing the number of teenage conceptions in Rotherham.

**Figure 10.3a: Rotherham under 18 conception rate Q4 2009**

Source: NHS Rotherham (2011), ONS, Teenage Pregnancy Unit, Under 18 Conception data for top-tier Local Authorities (LAD1), 1998-2008

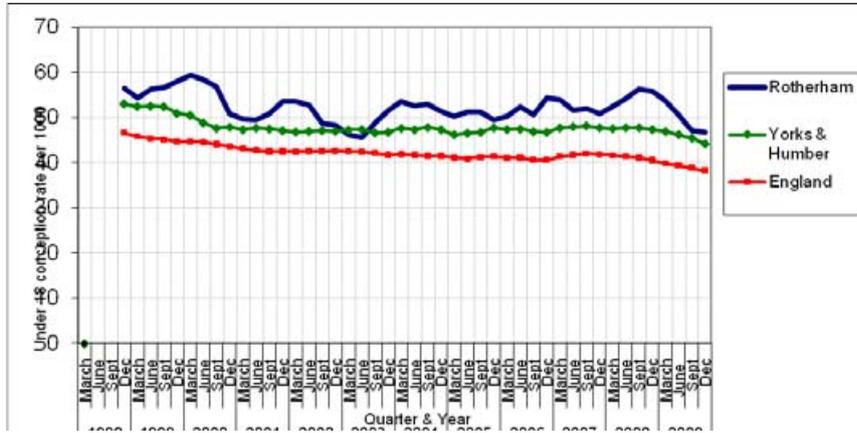


# Children and Young People's Needs Assessment

## 10.4 Teenage Pregnancy

### (Under 18 and Under 16 Conception rates)

Figure 10.3b Rotherham under 18 conception rate compared to regional and national rates Q4 2009  
 Source: NHS Rotherham (2010), ONS, Teenage Pregnancy Unit, Under 18 Conception data for top-tier Local Authorities (LAD1), 1998-2008



# Children and Young People's Needs Assessment

## 10.5 Obesity among Primary School Age Children in Reception Year and Year 6

The initial figures from the national weighing and measuring programme suggest we are halting the rise in obesity locally. Working with partner agencies, Rotherham now has in place a clear Young Person's Obesity Strategy, which has been implemented from 2008 onwards, along with significant additional funding. NHS Rotherham, working in partnership with a range of partners including RMBC, has developed a local strategy to tackle the problem of obesity in the town. This has resulted in the production of an award winning Healthy Weight Commissioning Framework. NHS Rotherham has invested £3.5m (excluding surgery costs) over a three year pilot period (until March 2012) in a range of services for children and adults. The aim of these services is to provide support for 2,000 adults and 2,000

children, young people and their families to have a healthier lifestyle and healthier future. For children, young people and families these services include (using a four tier system figure 10.4):

- Carnegie Clubs, delivered in the community in partnership with DC Leisure in venues across Rotherham
- Rotherham Institute of Obesity delivering support from multi-disciplinary teams to obese children who are registered with a Rotherham GP
- The Carnegie International Camp which is an intensive residential intervention for obese children<sup>4</sup>.

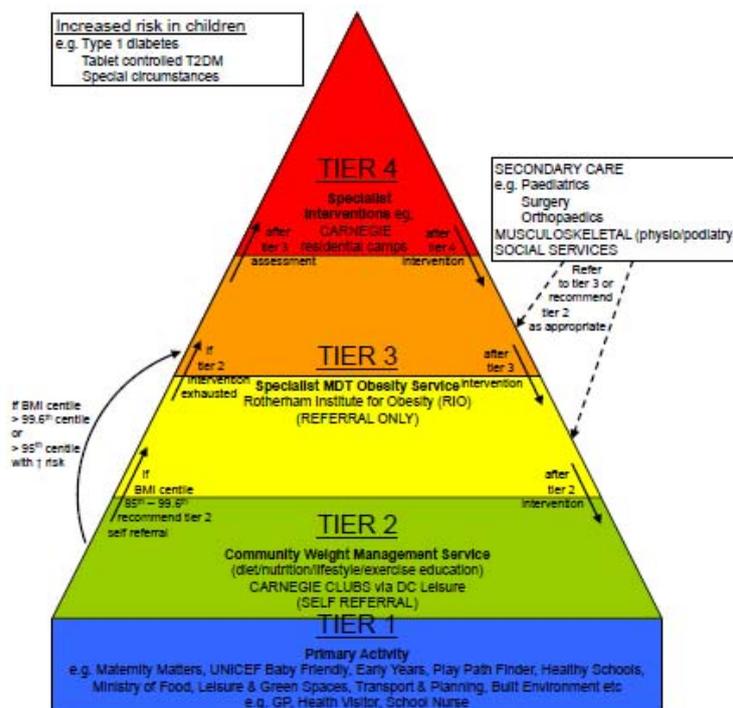
NCMP data for 2008/09 became available in December 2009 (see tables 10.2 below for comparisons with previous years and regional and national averages). The

prevalence of overweight and obesity in reception and year 6 children has remained around the same over the past 3 years. Participation coverage in year 6 children has increased around 10% since 2006/07<sup>5</sup>.

Rotherham has a higher participation rate in the programme than the regional and national averages. However, the prevalence of obesity in reception and year 6 children is higher than regionally and nationally. Prevalence of overweight is similar in reception and year 6 children but there is a higher level of obesity in year 6 compared to reception age children. A greater proportion of children are of a healthy weight in reception compared to year 6 nationally, regionally and in Rotherham.

Figure 10.4: NHS Rotherham Obesity Model: Children July 2009

Source: Rotherham Children and Young People's Plan 2010-2013



Any TIER 3 patient requiring pharmacotherapy will be treated in TIER 3, and this will be reflected in the GP prescribing data for whom the patient is registered  
NB if patients are considered unsuccessful at any given tier, they automatically progress to the next tier of intervention  
After intervention, patients progress down through the tiers and back to primary activity (TIER 1) of monitoring and education (every 6-12 months)

<sup>4</sup> Rotherham Children and Young People's Plan 2010-2013  
<sup>5</sup> NHS Information Centre, National Child Measurement Programme: England school year Tables for 2006/07, 2007/08 and 2008/09

# Children and Young People's Needs Assessment

## 10.5 Obesity among Primary School Age Children in Reception Year and Year 6

**Table 10.2a Results from the National Child Measurement Programme for Children in Reception and Year 6. Rotherham 2006/07-2008/09**

Source: NHS Information Centre, National Child Measurement Programme: England school year Tables for 2006/07, 2007/08 and 2008/09

	Reception				
	Participant	Underweight	Healthy Weight	Overweight	Obese
2008/09	94.1%	0.7%	75.0%	14.4%	10.0%
2007/08	90.0%	1.1%	73.7%	13.2%	12.0%
2006/07	91.0%			13.5%	10.3%

	Year 6				
	Participant	Underweight	Healthy Weight	Overweight	Obese
2008/09	90.8%	1.1%	65.6%	14.3%	19.0%
2007/08	88.0%	1.1%	61.9%	16.2%	20.8%
2006/07	78.6%			15.0%	18.4%

**Table 10.2b Results from the National Child Measurement Programme for Children in Reception and Year 6. Rotherham Compared to Yorkshire & Humber and England – 2008/09**

Source: NHS Information Centre, National Child Measurement Programme: England school year Tables for 2006/07, 2007/08 and 2008/09

	Reception				
	Participant	Underweight	Healthy Weight	Overweight	Obese
Rotherham	94.1%	0.7%	75.0%	14.4%	10.0%
Y&H	92.6%	1.1%	76.2%	13.1%	9.6%
England	91.2%	1.0%	76.2%	13.2%	9.6%

	Year 6				
	Participant	Underweight	Healthy Weight	Overweight	Obese
Rotherham	90.8%	1.1%	65.6%	14.3%	19.0%
Y&H	88.9%	1.4%	66.0%	14.0%	18.6%
England	89.1%	1.3%	66.1%	14.3%	18.3%

# Children and Young People's Needs Assessment

## 10.6 Infant Mortality

*See Chapter 4 The Burden of Ill Health Section 4.1.2*

## Children and Young People's Needs Assessment

### 10.7 Uptake of Chlamydia Screening in Under 25s

*See Chapter 4 Burden of Ill Health Section 4.6.2 Sexually Transmitted Infections (STI's)*

## Children and Young People's Needs Assessment

### 10.8 Percentage DMFT in 5 Year Olds

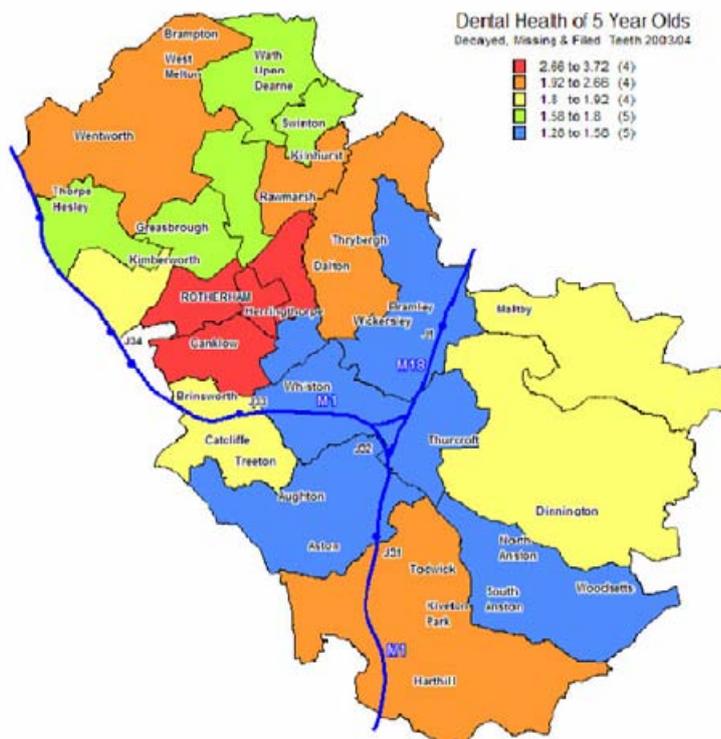
The Government target in 2003 was for all areas' 5 year olds to have an average Decayed Missing and Filled Teeth (DMFT) of 1.00. In 2007/08 the average DMFT in Rotherham was 1.34 which is a third over the National target. Rotherham DMFT was over the national average of 1.11 although below the Yorkshire and Humber figure of 1.51<sup>6</sup>. Figure 10.5 identifies the areas of most need in Rotherham, however all of Rotherham's wards are still above the Government DMFT 2003 target (please note data presented uses old ward boundaries)<sup>7</sup>.

Two Sure Start/Children's Centre areas in Rotherham have had targeted oral health promotion since 2000 (Rawmarsh and

Central). These have both seen modest to vast improvements in DMFT rates in young children. The rest of the borough is covered by one worker therefore some of the areas have little oral health promotion input for pre-fives other than via the health visiting service or dedicated pre-school groups. Specific areas of concern are the Park, Broom, East Dene and Herringthorpe areas that border Sure Start areas and where trends are showing a growth in dental disease. Dental health and medical statistics amongst looked after children is also monitored within Rotherham and between September 2004 and September 2005, 58% of looked after children had a dental health check and 61% had a medical<sup>7</sup>.

**Figure 10.5 Rotherham Areas with Highest Dental Need in 5 Year Olds**

Source: Rotherham Children and Young People's Services (2006), Audit of Need, Being Healthy Section



<sup>6</sup> NHS Information Centre for Health and Social Care (2010), *Compendium of Clinical and Health Indicators. Oral health in children – decayed/missing/filled teeth – aged 5 2007/08*

<sup>7</sup> Rotherham Children and Young People's Services (2006), *Audit of Need, Being Healthy Section*

# Children and Young People's Needs Assessment

## 10.9 Children Killed or Seriously Injured on Roads (persons under 16 years)

The Government has set a national casualty reduction target of reducing by 2010 the number of children (under 16 years of age) killed or seriously injured in road traffic accidents by 50%, compared with the average for 1994-1998.

Table 10.3 below compares 2006, 2007 and 2008 children's KSI numbers for Rotherham, South Yorkshire and England against the 1994-1998 baseline figure. The 2008 figure for Rotherham shows a decrease of 61% compared with the 1994-98 average which is above the Government target of 50% and the England average of 58%. If we compare the average figure for Rotherham for the period 2008 to nationally and

South Yorkshire, Rotherham has made the most improvement<sup>7</sup>.

Data shows that no children were killed in Rotherham in 2008 compared to 1 in 2007 and 13 were seriously injured in 2008 compared to 19 in 2007. Of the 13 that were seriously injured, 10 were pedestrians, 2 were car passengers and 1 was a motorcyclist<sup>7</sup>.

Data shows that 1 child was killed in Rotherham in 2007 and 19 were seriously injured. Of these 13 were pedestrians and 5 were riding pedal cycles, which suggests that interventions should be targeted at improving road safety awareness amongst children to reduce accidents<sup>8</sup>.

**Table 10.3 Comparison of Children's KSI Rates for Rotherham, South Yorkshire and England against the 1994-98 baseline figure**

Source: Department for Transport (2008), County and Unitary Authority Statistics, Road Casualties 2007

	1994-1998 average	2006	2007	2008	2008 % change on baseline
Rotherham	34	12	20	13	-61
South Yorkshire	146	96	77	72	-51
England	5729	2779	2671	2402	-58

#### Casualty Definitions

*Fatal* – casualties who sustain injuries which cause death less than 30 days after the accident.

*Serious* – an injury for which a person is detained in hospital as an 'in-patient'. Also includes certain injuries whether or not the casualty is detained in hospital such as concussion, fractures or burns. Fatal injuries which result in death 30 or more days after the collision are also classed as serious.

*Slight* – an injury of a minor nature which does not require the person to be detained in hospital as 'in-patient' and which is not judged to be severe. Also includes injuries not requiring medical treatment.

	1994-1998 average	2006	2007	2007 % change on baseline
Rotherham	34	12	20	-40%
S Yorkshire	146	96	77	-47%
England	5729	2779	2671	-53%

#### Casualty Definitions

*Fatal* – casualties who sustain injuries which cause death less than 30 days after the accident.

*Serious* – an injury for which a person is detained in hospital as an 'in-patient'. Also includes certain injuries whether or not the casualty is detained in hospital such as concussion, fractures or burns. Fatal injuries which result in death 30 or more days after the collision are also classed as serious.

*Slight* – an injury of a minor nature which does not require the person to be detained in hospital as 'in-patient' and which is not judged to be severe. Also includes injuries not requiring medical treatment.

# Children and Young People's Needs Assessment

## 10.9.1 Hospital Admissions Caused by Unintentional and Deliberate Injuries to Children and Young People Audit Commission website

The 1999 White Paper Saving Lives: Our Healthier Nation made injury prevention a priority, a theme that has not continued in subsequent health policy. The paper highlighted unintentional injury at the time as the greatest single threat to the lives of children, noting that it resulted in more children being admitted to hospital than any other cause. Whilst unintentional injury is no longer the single greatest threat to children's lives, it is still one of the leading causes of death and illness in children. Saving Lives set two targets: "to reduce the death rates from accidents (in all age groups) by at least one-fifth and to reduce the rate of serious injury from accidents by at least one tenth by 2010 – saving up to 12,000 in total"<sup>9</sup>.

Data from the DH show evidence of improvement in deaths for children under five, with a decrease of 19% from the 1995-97 baseline and also for the serious injury rate, which showed a

decrease of 31%. Recent data has shown a sharp decline in deaths from road traffic accidents, which may be a factor in the decline in overall rates of death from unintentional injury<sup>9</sup>.

However, each year there are approximately two million attendances by children at hospital accident and emergency (A&E) departments as the result of accidents that might have been prevented. This costs the NHS approximately £146 million per year and the most recent figures show that accidental injuries kill three children in every 100,000 each year – a similar rate to cancer<sup>9</sup>.

Injuries such as those caused by burns, falling down stairs at home, slipping on railway embankments and poisoning are a leading cause of death and illness in children aged 1-14, and account for approximately 120,000 admissions to hospital a year. However, understanding of the underlying causes of children's injury is patchy

and the actual number of injuries each year is unknown<sup>9</sup>.

Although the overall number of deaths has fallen, the Audit Commission report "Better Safe than Sorry" shows that there are persistent and widening differences between socio-economic groups. Children of parents who have never worked, or who have been unemployed for a long time, are 13 times more likely to die from unintentional injury than children of parents in higher managerial and professional occupations<sup>9</sup>.

The number of admissions for unintentional and deliberate injuries remained around the same for 2005/06-2007/08. However, the numbers of admissions of the last two years seems to indicate an emerging downward trend. This is reflected in the rates, which show a fairly large drop from 2008/09 to 2009/10.

**Table 10.4 Emergency Hospital Admissions for Persons under 19 for Unintentional and Deliberate Injuries, Rotherham 2005-6 – 2008-09**

Source: Hospital Episodes Statistics via SUS (2010)

Year	No. Admissions, persons 0-18	ONS Mid-Year Estimates Aged 0-18	Rate per 100,00
2005-6	812	60,751*	133.7
2006-7	806	60,406	133.4
2007-8	806	59,967	134.4

\* Latest figure from ONS has been revised upwards to 61,785

Year	Admissions persons 0-18	ONS MYE persons 0-18	Rate per 10,000
2005/06	812	60,723	133.7
2006/07	806	60,356	133.5
2007/08	814	59,931	135.8
2008/09	780	59,717	130.6
2009/10	684	59,489	115.0

## Children and Young People's Needs Assessment

### 10.10 Proportion of Children who Complete Immunisation by Recommended Ages

This national priority indicator for PCTs in 2008/9 reflects an area of national and international concern to end the transmission of preventable life-threatening infectious diseases. Vaccines prevent infectious disease and can dramatically reduce disease and complications in early childhood, as well as mortality rates. Pre-school immunisation for under 5 year olds in England enables the control of diseases such as diphtheria, tetanus, polio, pertussis, measles, rubella, haemophilus influenza type b (Hib), pneumococcal infection and meningitis C.

Although the coverage is relatively high for the majority of vaccines when England averages are considered, it is variable across trusts with some areas reporting particularly low immunisation rates. In addition, current World Health Organisation (WHO) immunisation recommendations state that at least 95% of children should receive three primary

doses of diphtheria, tetanus, polio and pertussis in the first year of life and a first dose of measles, mumps and rubella containing vaccine by 2 years of age. These recommended levels of coverage are in place to end the transmission of these vaccine-preventable life-threatening infectious diseases and is a public health priority for all trusts<sup>10</sup>.

Performance data for NHS Rotherham for Q2 2009/10 to Q1 2010/11 (see Table 10.5 below) shows progress towards the targets.

There has been improvement in the past year in coverage of all the immunisations tabled above. The biggest improvements have been seen in MMR and DTaP boosters at 5 years. DTaP at 1 year made the WHO 95% target in Q4 2009/10 and Q1 of this year. The MMR at 2 years is still below the WHO target, although coverage has increased by 3.3% in the past year.

**Table 10.5 Vaccination and Immunisation Coverage for all Rotherham GP Practices Q2 2009/10 to Q1 2010/11**

	DTaP at 1 year	Hib MenC booster at 2 years	Pneumococcal (PCV) booster at 2 years	MMR at 2 years	MMR booster at 5 years	DTaP booster at 5 years
2009/10 Q2	94.7%	94.1%	89.7%	87.8%	84.2%	85.8%
2009/10 Q3	94.8%	95.4%	91.1%	89.4%	85.0%	86.9%
2009/10 Q4	95.6%	96.0%	92.1%	90.1%	88.0%	89.3%
2010/11 Q1	95.4%	95.0%	92.0%	91.1%	89.6%	90.8%

# Children and Young People’s Needs Assessment

## 10.1 AHDC (Aiming High for Disabled Children) Results for Rotherham<sup>11</sup>

Aiming High for Disabled Children (AHDC)<sup>11</sup> is the Government’s strategy to improve the quality of services for disabled children and their families. One of its commitments was to measure performance and progress at a local level, by tracking parents’ perceptions. There were 214 questionnaires completed by parents with disabled children.

The overall score is based on an average of fifteen sub-indicators which each cover an element of the core offer in one of the three service sectors of health,

education and care & family support services. The five core offer standards are: information, assessment, transparency, participation and feedback. Parents rated the services received by their disabled child as 60 out of 100. Figure 10.6 shows the score that parents rated the service received by their disabled child.

### Information

Parents were asked to give their opinion about the information they received about health,

education and care & family support services. Those who had received information were asked how often the information was clear to understand, relevant and accurate.

Figure 10.7 shows the percentage of parents who agreed with each of the four statements that the information they received was always clear, always relevant or always accurate.

The information statements 2009-10 will be used as a baseline.

Figure 10.6 Rotherham score 2009-10

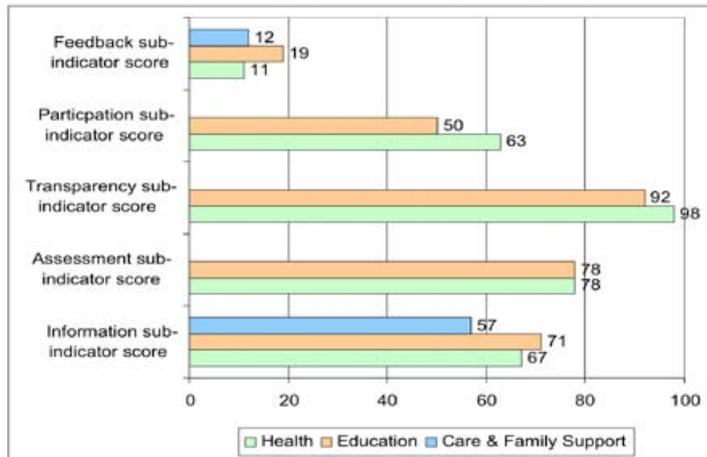
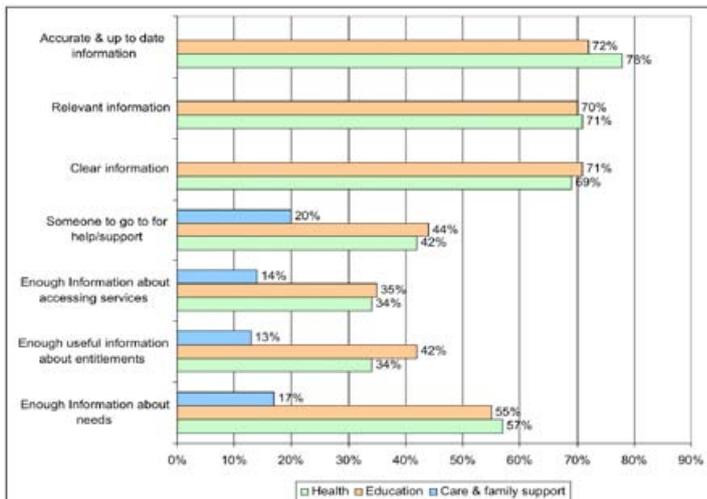


Figure 10.7 Information statements 2009-10



11 TNS-BMRB (2009), Aiming High for Disabled Children (AHDC) November 2009

# Children and Young People’s Needs Assessment 10.1 AHDC (Aiming High for Disabled Children) Results for Rotherham”

## Assessment

Parents were asked their opinion about the assessment process used for making decisions about the services their child would receive. Figure 10.8 shows the percentage of parents agreeing with each statement about the assessment process.

It should be noted that the agreement with “We/I had to give the same information several times” is a negative response.

## Transparency

Providing greater transparency about decisions is one of the elements of the core offer. To measure this element parents were asked how well they understood the decisions that were made about the services their child received. Figure 10.9 shows the percentage of parents that had chosen “very” or “fairly well”.

Figure 10.8 Assessment statements 2009-10

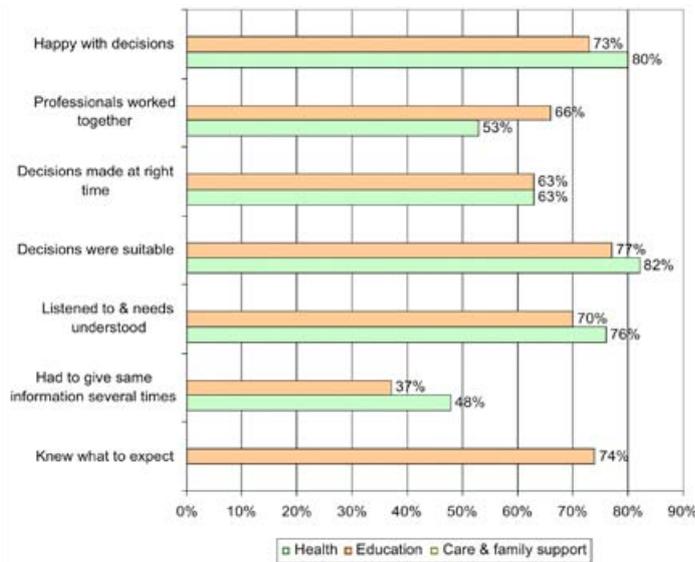
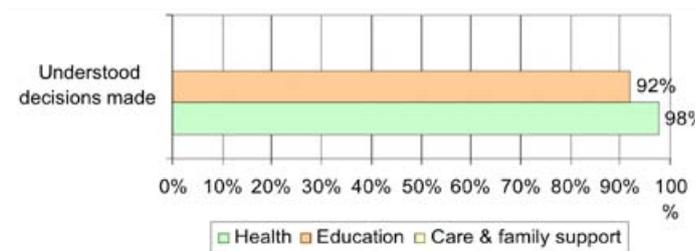


Figure 10.9 Transparency statement 2009-10



# Children and Young People's Needs Assessment

## 10.11 AHDC (Aiming High for Disabled Children)

### Results for Rotherham<sup>11</sup>

#### Participation

Participation is another element of the core offer and parents were therefore asked to what extent they felt they were consulted or asked for their opinions when decisions were being made about their child. Figure 10.10 shows the percentage of parents who felt they were consulted a lot when decisions were made about their child.

#### Feedback

Feedback shows that this indicator shows a low score. Parents were asked in the survey whether they or their children

were asked for their opinion or feedback about the services they received and if so whether they thought changes were made as a result of the feedback they gave. Figure 10.11 shows the percentage of parents that answered "Yes" at these questions.

Parents were also asked about the complaints process but so few parents had complained that there were not sufficient responses to analyse.

#### Short Breaks

In Rotherham a Needs Assessment Refresh was undertaken from October 09 to March 10 to provide an evidence base for identifying

service development priorities within Rotherham to inform a commissioning strategy to meet our obligations under the Aiming High for Disabled Children ("AHDC") Agenda and accompanying funding for short breaks<sup>12</sup>.

In order to prepare the 2010-11 Short Break Commissioning Strategy a review of current provision, its strengths and weaknesses and consultation with service users and stakeholders on their aspirations for future provision was carried out to fully understand need.

Figure 10.10 Participation Statement 2009-10

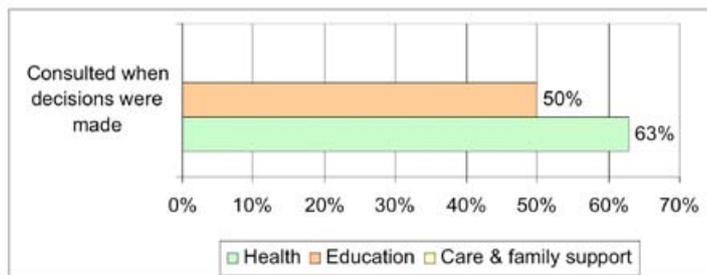
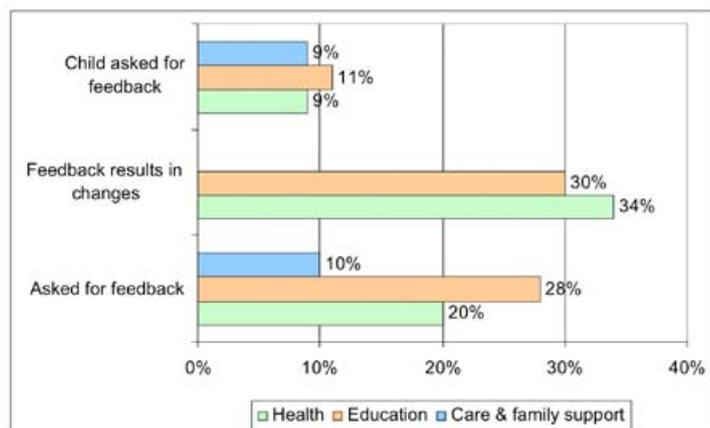


Figure 10.11 Feedback statements 2009-10



# Children and Young People's Needs Assessment

## 10.11 AHDC (Aiming High for Disabled Children)

### Results for Rotherham<sup>11</sup>

#### Parents/Carers Consultation

A parent and carer consultation event took place on the 17th March 2009 at the Holiday Inn Hotel in Rotherham to gain the views of parents and carers and to look at how they could assist local providers in shaping their services to enable more disabled children to access provision. Over 150 parent/carers attended the consultation event.

#### Summary of the key messages from parents/carers:

- Staff training and development – Parents expressed how they want to see providers meet their child's needs whilst ensuring quality recreational activities.
- School holidays, weekends and evening activities – The timing of activities was a concern as parents felt the need for more support when their children were away from school.

- Personalised and flexible provision – Families being able to go out together, to the coast, theme parks or places of interest with experienced and trained staff.
- Parental and family support – This was seen as crucial; not only for parent/carer support but for siblings too as parents felt they were often unintentionally overlooked.
- Provision for Under 8's - When talking to parents they have mentioned how there doesn't seem to be sufficient provision for under 8's whether it's out of school, weekend, or summer hols.
- Increased support after their child has been diagnosed – To include information pack (with details of support groups, services and financial support available), counselling service, parenting techniques and support group for siblings.

#### Disabled Children & Young People Consultation

This face-to-face consultation was done in partnership with the Voice and Influence Officer from RMBC (working with children age 0 to 13) and a qualified Youth Worker responsible for Voice and Influence for AHDC (age 13 to 19). A children and young people questionnaire was also included in the Exchange Newsletter which is sent out to families of disabled children and young people. The purpose of the consultation was to feedback what the children and young people said in the previous Needs Assessment consultation in 2008, what we have done as a result of this feedback in 2009/10 and what else the young people would like to see in 2010/11. The views of approximately 55 young people were captured.

## Children and Young People's Needs Assessment

### 10.12 Education and Skills

Overall levels of educational and skills in Rotherham follow patterns of deprivation and are lower than those nationally and our comparator statistical neighbours. This is a key priority highlighted within the Children and Young People's Plan within their priority to Transform Rotherham Learning.

The table below shows the three year trend against the three key assessments within mainstream education. Significant progress has been made in the early years foundation stage assessment where performance has improved from below to above national and statistical neighbour averages. Similarly GCSE outcomes have seen improvements at a higher rate than

National although performance is still below comparative data the gap is closing. However at Key Stage 2 performance has dropped and the gap continues to widen. Rotherham's traditionally low skilled workforce is gradually transforming. Currently (2008) 22% of the working age population are qualified to at least NVQ level 4, compared to less than 15% in 2001. Despite this improvement we are still behind regional and national averages.

6.6% of all 16-17 year olds in Rotherham are not currently in employment, education or training. This has dropped from just under 11% in 2006.

**Figure 10.12**

Source: DfE LAIT benchmarking tool April 2011

		2008	2009	2010	National Rank	Age at Assessment
78 points achieved across Foundation Stage with at least 6 points in each scale	<b>Rotherham</b>	44.0	50.0	57.0	56 [Quartile B]	5 years
	<b>Stat. Neighbours</b>	44.6	49.9	55.0		
	<b>National</b>	49.0	52.0	56.0		
% of pupils achieving Key Stage 2 Level 4+ English & Maths	<b>Rotherham</b>	68.0	68.0	66.0	138 [Quartile D]	11 years
	<b>Stat. Neighbours</b>	73.5	72.4	73.6		
	<b>National</b>	73	72	73		
5 or more A*-C grades at GCSE including English and Maths (End of Key Stage 4)	<b>Rotherham</b>	40.9	47.1	50.8	120 [Quartile D]	16 years
	<b>Stat. Neighbours</b>	43.1	46.7	52.1		
	<b>National</b>	47.6	49.8	53.4		

## Children and Young People's Needs Assessment

### 10.13 Care Leavers

The table below shows the five year trend data for numbers of Care Leaver for the authority taken from the SSD903 statistical return. Numbers are broadly stable and Rotherham's trend follows the same pattern as comparative data.

**Figure 10.13 Numbers of children aged 16 years and over who ceased to be looked after during the years ending 31 March**

Source: DfE SSDA903 Statistical Release

	2006	2007	2008	2009	2010
Rotherham	45	25	45	30	45
Yorkshire and The Humber	700	700	800	800	820
England	8,200	8,200	8,500	8,800	9,100

England totals have been rounded to the nearest 100 if they exceed 1000, and to the nearest 10 otherwise. Regional totals have been rounded to the nearest 10. Local authority numbers have been rounded to the nearest 5.

# Children and Young People's Needs Assessment

## 10.14 Children and Young People's Mental Health and Emotional Well Being

It is difficult to calculate the actual numbers of C&YP in Rotherham who have a diagnosable mental health disorder, as little whole service research and data collection has taken place. At a national level the Office of National statistics (ONS) have undertaken two studies, one in 1999 and more recently in 2004, which have specifically looked at mental health prevalence within Children and Young People. Both studies concluded that around 10% of the 5 -16 age group have a diagnosable Mental Health Disorder. The studies grouped different types of disorder and then created three main categories of mental health, which were then used for summarising the data, these are:

**Emotional disorders** include separation anxiety, specific phobias, social phobias, panic disorder, agoraphobia, post traumatic stress disorder, obsessive-compulsive disorder and depression.

**Conduct disorders** are characterised by aggressive, disruptive or antisocial behaviour.

**Hyperkinetic disorders** are characterised by hyperactive, impulsive and inattentive behaviours. This type of disorder is sometimes referred to as attention deficit hyperactivity disorder (ADHD), which is the name for a broader (and therefore commoner but milder) disorder defined by the American Psychiatric Association.

<http://www.statistics.gov.uk/pdfdir/cmd0805.pdf>

The study also evaluated the prevalence of less common disorders, which did not fit within the above categories, the key finding of the national study were:

- That 3.7% of children had an emotional disorder (anxiety or depression), 5.8% had a conduct disorder, 1.5% per cent had a hyperkinetic disorder, and 1.3% per cent had a less common disorder (including autism, tics, eating disorders and selective mutism). 2% per cent of children had more than one type of disorder.
- Boys were more likely than girls to have a mental disorder.

Among 5-10 year olds, 10.2% of boys and 5.1% cent of girls had a mental disorder. Among 11-16 year olds, the proportions were 12.6% for boys and 10.3% for girls.

The ONS study is a credible national study and as such we can use the prevalence evidence gathered and relate this to percentage rates to the 2001 population census data, this allows for estimates to be made around the numbers of Children and Young people in Rotherham who could be identified as having a mental health disorders. It is important to note at this point that vulnerable groups such as Looked After Children, Black or Minority Ethnic groups, Young Offenders, and those who have been abused (mentally, physically or verbally), have different prevalence rates.

In order to estimate the mental health prevalence numbers for Rotherham using the census 2001 census data set and the 2004 ONS survey, we have to acknowledge that due to the way in which the 2001 census data was collected, the age bandings can't be exactly

Figure 10.14 The breakdown of the identified disorders by age and gender taken from the 2004 ONS study.

	5 -10 year olds		11 – 16 year olds		All 5 -16 year olds
	Boys	Girls	Boys	Girls	
Emotional Disorders	2.2	2.5	4.0	6.1	3.7
Conduct Disorders	6.9	2.8	8.1	5.1	5.8
Hyperkinetic Disorders	2.7	0.4	2.4	0.4	1.5
Less Common Disorders	2.2	0.4	1.6	1.1	1.3
<b>Any Disorder</b>	<b>10.2</b>	<b>5.1</b>	<b>12.6</b>	<b>10.3</b>	<b>9.6</b>

Census 2001	2004 ONS Survey
5 -9 Year Olds	5 – 10 Year Old Prevalence Rates Used
10 – 14 Year Olds	11 – 16 Year Old Prevalence Rates used
15 -19 Year Olds	11 – 16 Year Old Prevalence Rates Used
5 – 19 Year Olds	5 – 16 Year Old Prevalence Rates Used

# Children and Young People's Needs Assessment

## 10.14 Children and Young People's Mental Health and Emotional Well Being

matched to those used for the 2004 ONS survey. The prevalence rates by age band used within the 2004 study will be applied to the following age bands from the census.

(Caution: Please note that due to the way in which data was collected within the ONS Survey we can not estimate numbers for the 0 – 5 age range)

Using the population information for 2001 we can estimate that there are 5000 Children and Young People aged 5 -19 with a diagnosable mental health disorder, 3000 with a conduct disorder, 2000 with an emotional disorder and 800 with a hyperkinetic disorder and 700 with a less common disorder.

From the way we have applied the ONS survey findings to Rotherham's 2001 census data, we know that certain age groups and genders will have higher prevalence rates than others due to higher populations of C&YP in Rotherham East, Valley, Rotherham West and Rawmarsh, Figure 15 below highlights the estimated prevalence by age and gender.

2010 / 11 Access to Child and Adolescent Mental Health Service (CAMHS) in Rotherham

At a local level professionals can refer directly into the CAMHS Single Point of Access team, information from this team gives the best picture of Children's mental health across the borough at any one time. During 2010/11 there were 1617

referrals into the CAMHS Single Point of Access team (SPA) of this total 59% were male and 41% female. The age range for Children and Young People requiring assessment is wide.

Figure 10.16 highlights the key reason for referral into the SPA during 2010/11 the main reasons' for referrals are related to behaviour and emotional problems. Diagnosis for Autism at a local level is undertaken by Paediatrician and Consultant Psychiatrists, recent work undertaken suggest that there are 934 C&YP up to the age of 18 current living within the Rotherham area with a diagnosis of Autism. Figure 10.17 gives a breakdown by age of those individuals referred into SPA, it is apparent to see from this data that

Figure 10.15 Prevalence of Mental Health Disorders by Age and Gender.

Referral Reason	Number
1. Behavioural	869
2. Developmental	25
3. Emotional	520
4. Depression	2
5. Mental Health Other	3
6. Query ASD	17
7. Query ADHD/Hyperkinetic	7
8. Query Attachment	0
1,2. Behavioural & Developmental	20
1,3 Behaviour and Emotional	42
1,4. Behavioural & Depression	5
1,7 Behaviour, Query ADHD/Hyperkinetic	3
1,2,3 Behaviour, developmental, emotional	1
Not Recorded	51
Not applicable	52

# Children and Young People's Needs Assessment

## 10.14 Children and Young People's Mental Health and Emotional Well Being

the numbers referred across the age range is consistent from 5 – through to 16.

Figure 10.18 below highlights the key wards in the Borough where referrals have been received from for a CAMHS assessment, this does not necessarily mean that this number of C&YP have a diagnosable mental health problem who reside in these areas, however it does highlight where professional

working with C&YPS have identified additional support being required with individuals emotional health and well being some of which will have a diagnosis upon further assessment.(It is worth noting that other areas in the borough that have had less than 10 referrals have not be included in this chart).

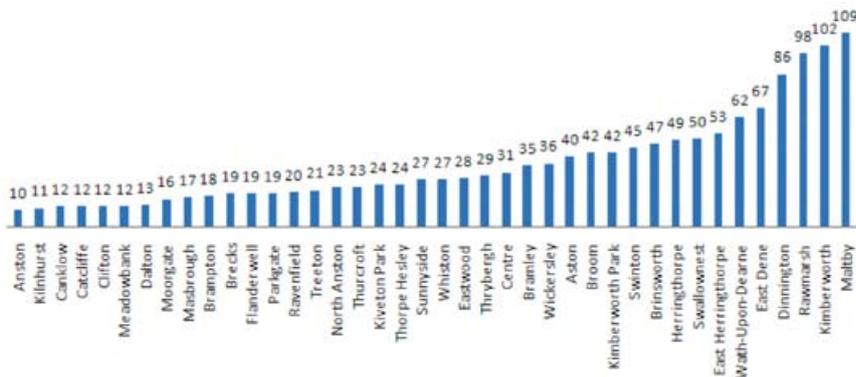
Figure 10.16

Referral Reason	Number
1. Behavioural	869
2. Developmental	25
3. Emotional	520
4. Depression	2
5. Mental Health Other	3
6. Query ASD	17
7. Query ADHD/Hyperkinetic	7
8. Query Attachment	0
1,2. Behavioural & Developmental	20
1,3 Behaviour and Emotional	42
1,4. Behavioural & Depression	5
1,7 Behaviour, Query ADHD/Hyperkinetic	3
1,2,3 Behaviour, developmental, emotional	1
Not Recorded	51
Not applicable	52

Figure 10.17

Age at Referral	Number
0	7
1	11
2	36
3	55
4	70
5	108
6	130
7	93
8	101
9	107
10	114
11	100
12	111
13	133
14	107
15	151
16	102
17	77
18	3

Figure 10.18 Number of referrals into CAMHS SPA by area 2010/11



# Children and Young People's Needs Assessment

## 10.15 Children and Young People

ONS population estimates (2010) show there were approximately 62,100 children and young people aged 0-19 living in Rotherham, representing 24.4% of the population. The gender split for children and young people is consistently 51% male and 49% female.

Rotherham, like many areas across the UK, has a significant number of children and young people living in deprived areas; 21.3% of Rotherham children live in areas which are within the 10% most deprived nationally and 23.4% of children are affected by Income Deprivation. 42% of Rotherham children in low income households

live in areas amongst the 10% most deprived in England.

There is a striking variation in vulnerability and life chances for a child who grows up in one of Rotherham's most deprived areas compared to one of the least deprived. As a hypothetical way to demonstrate the levels of inequality in the borough, Rotherham Children and Young People's Plan 2010 utilised the local concept of 500 babies, born and raised in Rotherham. These were separated into two groups, 317 who were born in the ten most deprived areas and 183 who were born in the ten least deprived areas. This pattern is based on the higher percentage of

babies born in the most deprived parts of the borough. (For the purposes of this illustration it is assumed that each baby experiences no significant change in background circumstances throughout the course of its life.)

This profile provides a lucid picture of the vulnerabilities and inequalities for children, young people and their families living in different circumstances. Evidence indicates that the children living in the most deprived areas of the borough are also more likely to be at risk of significant harm, requiring Child Protection Plans and are subsequently more likely to become Looked After Children.

Figure 10.19

Of the 500 babies	183 live in the least deprived areas	317 live in the most deprived areas
Are boys	93	161
Are girls	90	156
Are minority ethnic	10	105
Live in Christian families	144	198
Live in Muslim families	5	72
Are disabled	5	15
Live in a council house	1	122
Grow up in a lone parent family on Income Support	5	77
Will be classed as a 'Child in Need'	2	20
Grow up in a workless or very low waged household	10	178
Are eligible for free school meals	7	138
Gain at least 5 GCSEs A-C (including English and Maths)	113	75
Stay on at school or college after 16	152	159
Become NEETs (Not in Education, Employment or Training)	4	34
Live in a household where highest qualification is NVQ 4/5 or degree	33	23
Become a professional or manager	31	16
Earn £30k+	193	79
Claim housing / council tax benefit	15	159
Qualify for a means tested DWP benefit	9	143
Become pregnant before 18	3	11
Experience low birth weight or still birth	13	33
Can expect to live until age (males)	80.8	72.4
Can expect to live until age (females)	87.2	78.1
Will experience (annually)		
Violent crime	1	15
Deliberate fire	1	5
Anti-social behaviour	4	38

## Children and Young People's Needs Assessment

### 10.15 Children and Young People

#### Safeguarding Children and Young People

Children have the right to be protected from being hurt and mistreated, physically or mentally. Local authorities and their partners have a duty to ensure that children are properly cared for and protect them from violence, abuse and neglect by their parents or others who provide care or have significant contact with them.

In 2010/11 children's social care services were contacted 19,162 times by either professionals or members of the public regarding concerns over the welfare of a child, representing an increase

of 3,779 on the previous year. Of these 12,203 (64%) were regarding children not yet known to the service and 4,839 (25.3%) met thresholds for progression for further investigation by social care (known professionally as a 'referral').

There are a number of reasons for referrals into social care services. The two most common reasons in Rotherham are 'concerns regarding a child's health and development' which represented 16% of all referrals in 2010/11 (an increase on 13% in 2009/10), and 'Domestic Violence' which represented 15% (a decrease from the 20% in 2009/10). All other types of

referral each represent less than 5% of the total.

The table below summarises the number and proportion of referrals by originator (source). The highest proportion came from the Police which represent over a fifth of referrals.

Children in need are defined in law as children or young people aged under 18 who; need local services to achieve or maintain a reasonable standard of health or development or need services to prevent significant or further harm to health or development or are disabled. At March 2011 there were 2,584 children in need in

**Figure 10.20**  
Referrals by Source 2010/11

Referral Source	Number	% of Total
Cafcass	32	0.6%
Court	23	0.5%
Health & Hospital Services	602	12.2%
Local Authority (not Social Care)	347	7.0%
CYPS Social Care	524	10.6%
Community Health	368	7.5%
Police	1043	21.2%
Probation	133	2.7%
Members of public	397	8.1%
Schools, Colleges & Children Centres	664	13.5%
Voluntary Sector Organisations	166	3.4%
Youth Offending	31	0.6%
Other	246	5.0%
Not Recorded	351	7.1%
<b>Total</b>	<b>4927</b>	

**Figure 10.21**  
Child Protection Plans by category

Category	2009/10		2010/11	
	Number	% of total	Number	% of total
Emotional Abuse	38	13.6	39	11.8
Neglect	128	45.9	193	58.5
Physical Abuse	92	33.0	85	25.8
Sexual Abuse	15	5.4	13	3.9
Multiple	6	2.2	0	0.0
<b>Total</b>	<b>279</b>		<b>330</b>	

## Children and Young People's Needs Assessment

### 10.15 Children and Young People

Rotherham a 2.5% decrease on the previous year's figure of 2,649.

A child protection plan is the activity undertaken to protect a child who is deemed to be at risk of significant harm. It sets out in detail what work each of the professionals involved will do and the action members must take. Local children and young people subject to these plans have increased from 279 March 2010 to 330 in March 2011. The majority (58.5%) of these are connected to neglect issues. A breakdown by category is shown below;

'Looked after children' (LAC) means children in public care, who are placed with foster carers, in residential homes or with parents or other relatives. At the end of March 2011 there were 390 LAC in Rotherham, a drop on the previous year of 411. 171 of these children had newly entered care in the preceding 12 months.

The table below gives the latest benchmarking data and demonstrates that Rotherham is above our statistical neighbour and significantly higher than the national averages for LAC rate per 10,000 population aged under 18.

The table above shows that Rotherham has a higher proportion of LAC than the English average but is broadly in line with our statistical neighbour average. More deprived areas tend to have a higher proportion of LAC although the pattern is also affected by local policies and practices.

Rotherham's Local Safeguarding Children Board provides support and challenge. Its main objective is to ensure the effectiveness of all work done to safeguard and promote the welfare of children and young people in Rotherham. The Board works through a structure of sub groups that ensure the children and families

workforce have robust procedures and good quality training. The Board also undertakes serious case reviews where there is a need for professionals to examine and, crucially, learn from situations of abuse or neglect that have resulted in the death or serious harm to a child or young person.

In 2010/11 Rotherham Local Safeguarding Children Board has further developed and strengthened its constitution. All statutory and voluntary agencies within Rotherham have signed up to this and are currently implementing a robust process for monitoring the improvement of services. Copies of the updated constitution can be accessed via Rotherham Local Safeguarding Children Board website ([www.rscb.org.uk](http://www.rscb.org.uk)).

**Figure 10.22**  
Referrals by Source 2010/11

Statistical Neighbours	2008	2009	2010
Barnsley	53.0	54.0	50.0
Redcar and Cleveland	46.0	47.0	54.0
Wakefield	47.0	50.0	55.0
Telford and Wrekin	61.0	66.0	71.0
<b>Rotherham</b>	<b>61.0</b>	<b>72.0</b>	<b>73.0</b>
Tameside	64.0	68.0	73.0
Doncaster	63.0	66.0	74.0
Wigan	64.0	73.0	78.0
Hartlepool	72.0	73.0	81.0
St. Helens	81.0	84.0	93.0
Dudley	76.0	82.0	93.0
<b>Statistical Neighbour Average</b>	<b>62.7</b>	<b>66.3</b>	<b>72.2</b>
<b>England</b>	<b>54.0</b>	<b>55.0</b>	<b>58.0</b>

## Children and Young People's Needs Assessment

### 10.16 Summary of Chapter 10

Rotherham is ranked the 68th most deprived district in England in the 2007 index and is now the 53rd in 2010 index. The key drivers of deprivation in Rotherham remain Education and Skills, Health and Disability and Employment.

6.6% of all 16-17 year olds in Rotherham are not currently in employment, education or training.

During 2010/11 there were 1617 referrals into the Child and Adolescent Mental Health Service (CAMHS). Of these, 869 were for behavioral problems and 520 were emotional. Data collected for diagnosis by ward may be inconclusive due to discrepancies in the amount of partnership work that is being undertaken together with CAMHS to promote mental health assessment for children across the Borough.

There has been improvement in the past year in coverage of all immunizations provided for children.

# Area Assembly Needs Profile

## 11 Introduction

This chapter examines the needs profile of each of Rotherham's seven Area Assemblies, each of which combines three Borough wards. Each profile provides an overview of population, households, deprivation, life expectancy, health and social care needs and identifies where these needs appear to be greatest.

- Population data from ONS population estimates for wards 2007.
- Deprivation data from Indices of Deprivation 2010, CLG
- Neighbourhood Statistics from RMBC, SY Police and NHS Rotherham
- Housing Tenure estimated for 2010 by RMBC
- Ethnicity estimated for 2010 by RMBC
- Life expectancy taken from Rotherham Health Profile 2010, produced by the Association of Public Health Observatories

The social care needs assessment uses the service demand profile for 2007/08. It identifies the number of adults utilising the following services:

Home care:	No. of adults accessing in-house & independent home care by RMBC
Residential Care:	No. of adults placed in residential/nursing care by RMBC
Intermediate Care:	No. of adults admitted to the intermediate care assessment beds
Rothercare:	No. of adults using RMBC's community alarm system in July 2008
Sheltered Housing:	No. of households receiving warden service

# Area Assembly Needs Profile

## 11.1 Rotherham South

### Overview

Rotherham South Area Assembly covers the three wards of Boston Castle, Rotherham East and Sitwell located in the centre of the Borough covering an area of 9 square miles. Most of the area's population of 38,800 live in

central, southern and eastern parts of the Rotherham Urban Area. The north of the Area Assembly includes Rotherham Town Centre and the inner urban districts of Eastwood, Clifton, East Dene, Wellgate and Canklow. Further south, the Area Assembly covers a

large suburban area incorporating Broom, Moorgate and Whiston. Rotherham South encompasses a wide variety of urban environments and has the most ethnically diverse population of any Area Assembly.

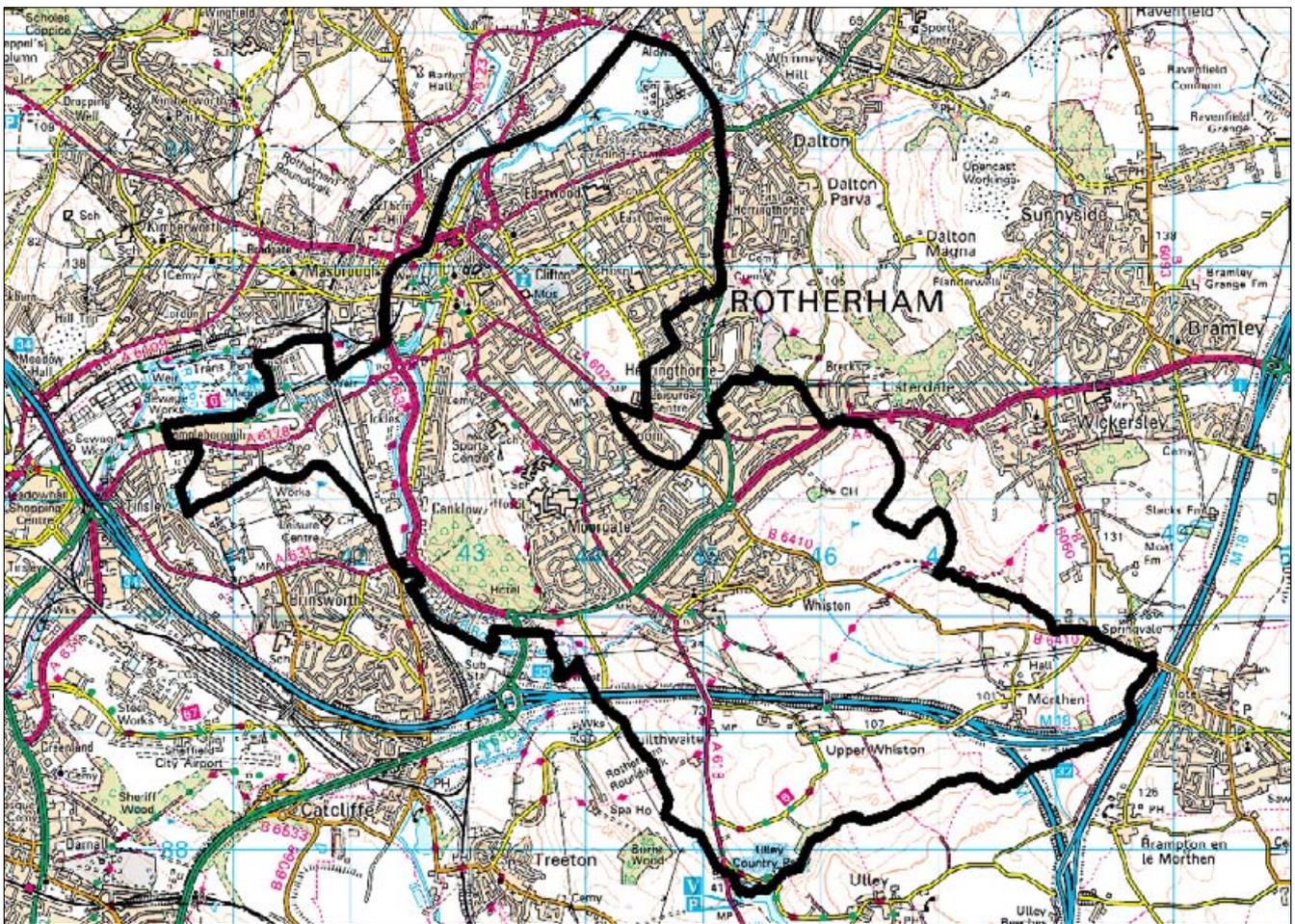


Figure 11.1

# Area Assembly Needs Profile

## 11.1 Rotherham South

### Population Estimates 2007

The graph below shows the total population of Rotherham South and estimated BME population. Rotherham South has a population of 38,800 which is the largest of any Area Assembly. An estimated 9,700 people (25.1%) are from Black & Minority Ethnic (BME) groups which is just over half the Borough's BME population and 36% of school age children (aged 4-15) are from BME communities. The largest BME groups are Pakistani & Kashmiri, Slovak & Czech Roma and Black African. Minority community languages used in Rotherham South include Punjabi (Mirpuri), Urdu, Arabic, Slovak, Polish and French. Based on Census definitions estimates the main religions in the area are Christianity 69% and Islam 17%.

The ethnicity of Rotherham South varies considerably with age and geographically. 21% of adults in Rotherham South are BME but the child population is quite different, with 40% from BME communities. This reflects the age structure of most ethnic minority communities which are much younger than average.

Within Rotherham South the tBME population lives mainly in the Town Centre, Wellgate, Eastwood, Broom, Broom Valley and Clifton. Whiston, Brecks and parts of East Dene have under 10% from BME communities.

The age structure of Rotherham South's population is unusual in that the area has above average proportions of children and young people but also those aged over 75. The projected population for Rotherham South in 2015 shows almost no change in the total although as in all areas, the population is ageing.

33.4% of pensioners in Rotherham South live alone which is slightly above the Rotherham average of 32%.

Figure 11.2

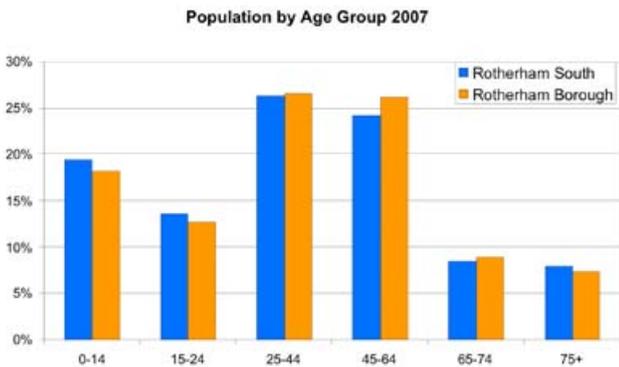
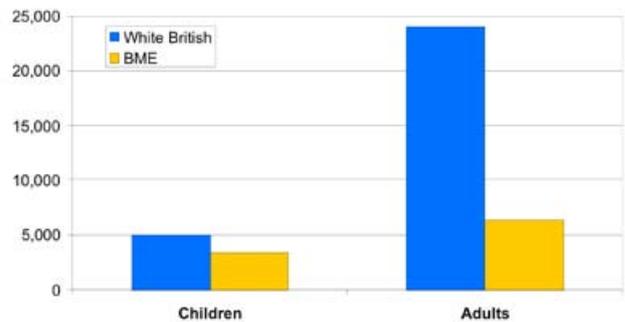


Figure 11.3



# Area Assembly Needs Profile

## 11.1 Rotherham South

### Deprivation

Rotherham South is the most deprived Area Assembly based on the Indices of Deprivation 2010 although this description hides a north – south divide within the area. Rotherham East and the northern half of Boston Castle have high levels of deprivation, mostly within the most deprived 10% of England (red areas on the map below). The most deprived neighbourhoods are Canklow, Town Centre, Eastwood, East Dene and Herringthorpe. Sitwell Ward and the Moorgate area of Boston Castle Ward have low deprivation, almost all below the English average (blue areas below).

Access to services is generally good in Rotherham South although the southern fringes of Canklow Meadows, Moorgate and Whiston are lacking in local service provision. However, most of these areas otherwise have very low deprivation.

Deprivation is illustrated by the 24.5% of working age adults who are on workless benefits, well above the Rotherham average of 20.9% and national average of 15.4%. 32.4% of households claim Council Tax or Housing Benefit, above the Borough average of 28.1%. 25.1% of school children are eligible for free school meals compared to 17.2% in Rotherham as a whole.

Figure 11.4

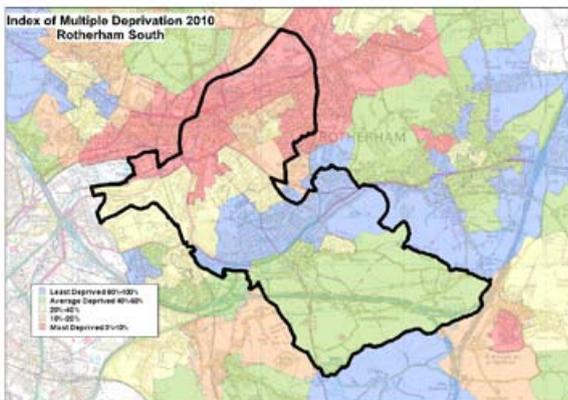
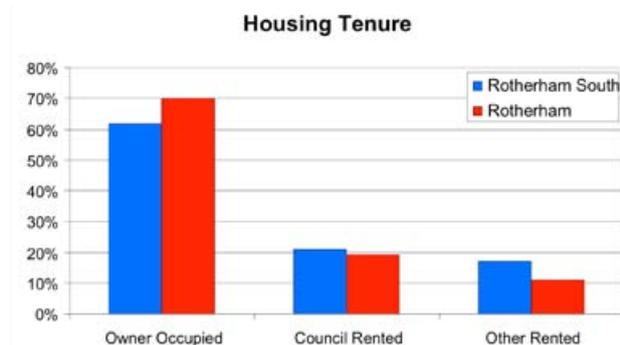


Figure 11.5



### Housing

Most homes in Rotherham South are owner occupied, the highest level being in Sitwell Ward. The proportion of council housing has fallen sharply from 31% to 21% since 2001 as a result of Right to Buy sales and demolitions. The other (mainly private) rented sector is significant at 17%, mainly in Boston Castle and Rotherham East, and for this reason, owner occupation is below the Borough average.

# Area Assembly Needs Profile

## 11.1 Rotherham South

### Qualifications

Qualification levels in Rotherham South are below average for Rotherham although there are wide variations within the Area Assembly. This variation is reflected in the percentage of households where at least one person has a degree which is above the Borough average at 14.3%. The percentage with no qualifications is also above average. The attainment of children and young people reflects a similar pattern to adults with 33.8% of 16 year olds gaining 5+ GCSE's A\*-C in 2009, well below the 41% in Rotherham as a whole and the English average of 47.6%. 14% of 16-18 year olds were Not in Education, Employment or Training (NEET).

On a positive note, 29% of young people stay on at school or college after the age of 16 which is above the Borough average of 25% but still well below the English average of 40%.

Figure 11.6 - Highest Qualification Level (aged 16 – 74)

(Source: 2001 Census Table KS13)



### General Health and Care Provision

Rotherham South has above average proportions of people who are not in good health and/or who have limiting long term illness.

Figure 11.7

General Health	Rotherham South	Rotherham	England
	% of Total Population	% of Total Population	% of Total Population
General Health 'Not Good'	13.0%	12.1%	9.0%
Limiting Long Term Illness (LLTI)	23.7%	22.4%	17.9%
People providing Unpaid Care	11.9%	12.2%	9.9%

1. General health refers to health over the 12 months prior to Census day.  
 2. Limiting long-term illness covers any long-term illness, health problem or disability, which limits daily activities or work.  
 3. A person is a provider of unpaid care if they give any help or support to family members, friends, neighbours or others because of long-term physical or mental health or disability, or problems related to old age.

### Life Expectancy

The graph below shows the current life expectancy of men and women in the Rotherham South area assembly. Life expectancy for men is below the local and national average although women are more average. Life expectancy in Rotherham East and Boston Castle is considerably lower than in Sitwell Ward.

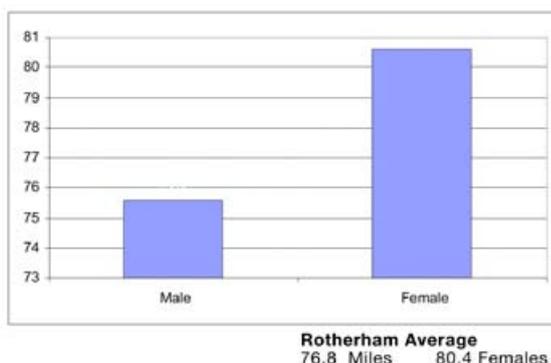


Figure 11.8 - Average life expectancy – years

# Area Assembly Needs Profile

## 11.1 Rotherham South

### Teenage Pregnancy

Conception rates for females aged 15-17 in Rotherham South are 5.8% which is above the Borough average of 5.1% and national average of 4.1%.

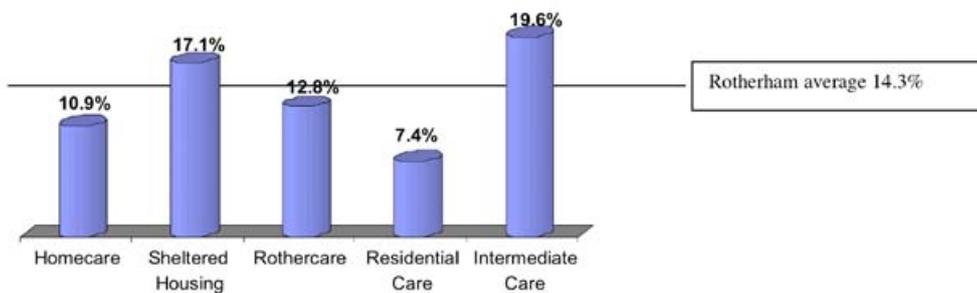
### Other Health Indicators

Hospital admissions for serious injury are 22.8 per 1,000 which is slightly above the Borough average. Low weight or still birth are above average at 9.5%. Smoking rates are also above average at 28.4%.

### Social Care Needs Assessment

The following graph shows the proportion of social care services received in Rotherham South in 2007/08. Despite indications that Rotherham South has the greatest need for social care services, analysis social data shows that actual service usage is relatively low. There is relatively high usage of preventive services such as intermediate care and warden support in sheltered housing. However service users in Rotherham South only use 10.9% of the borough's homecare provision, 3.4% below the local average. Also only 7.4% of residential placements were located in the area.

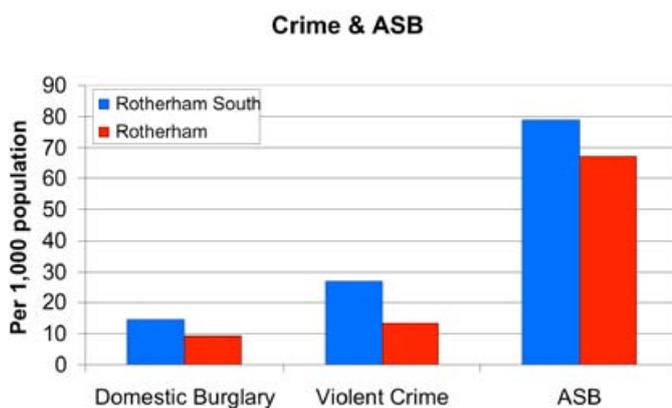
Figure 11.9 - Proportion of social care services delivered in Rotherham South



### Crime & Anti Social Behaviour

Crime and anti social behaviour in Rotherham South are generally higher than the Borough average which reflects relatively high rates in Boston Castle and Rotherham East, particularly in areas around the Town Centre. Sitwell has crime rates below the Borough average. Deliberate fires in Rotherham South are 7.2 per 1,000, above the Rotherham average of 6.3 per 1,000. The Vulnerable Localities Index 2010 shows that Canklow and Eastwood are amongst the 10 neighbourhoods most vulnerable to crime in Rotherham. The position of Canklow has deteriorated since the 2009 Index.

Figure 11.10



# Area Assembly Needs Profile

## 11.1 Rotherham South

### Rotherham South Priorities 2009/10

#### Community Priority: Community Safety

- Anti-social behaviour (ASB), causing a 'fear of crime' generally amongst parents, young people and the elderly remains the 'Number One' priority. This is a particular priority amongst people at the following locations: East Dene inside The Walk and around The Lanes and Longfellow Drive Eastwood Selborne Street shops Wellgate, Broom Valley and Moorgate outside Wellgate House Herringthorpe Playing Fields, Whiston outside Hungerhill Road shops and Howlett Close

#### Over the coming year we will work with partners, including local communities, to:

- Continue developing Action Plans to address issues at these locations
- Increase access to and awareness of local policing team
- Ensure that the projects being funded by the Area Assembly's Devolved Budget totalling £26,600 help to address this priority

#### Community Priority: Children and young people

- Improvements and increases in facilities for children and young people is the second most important priority. There is a perception that a lack of youth provision is linked with ASB.

#### Over the coming year we will:

- Work with internal and external partners to continue developing youth provision
- Promote positive images of young people

- Ensure that the projects being funded by the Area Assembly's Devolved Budget totalling £67,569 help to address this priority

#### Community Priority: Clean streets (including parks and open spaces)

- Maintaining the cleanliness of our streets and improving the appearance of our area, including parks and open spaces, emerged as the third most important priority. People asked for more bins, clean ups, regular street cleaning and road sweeps.
- Rotherham South is also home to Clifton Park and Herringthorpe playing fields, and a range of other historical sites and local parks and green spaces. The development of these sites and the quality of local parks and green spaces was highlighted as an issue.

#### Over the coming year we will work with partners, including local communities, to:

- Administer the Streetpride Devolved Budget
- Continue co-ordinating the response to Eastwood Village
- Receive progress reports regarding the Play Pathfinder, Eastwood Village
- Adventure Play Area and Boston Castle
- Ensure that the projects being funded by the Area Assembly's Devolved Budget totalling £39,068 help to address this priority

#### Community Priority: Road Safety

- Improving road safety, particularly in relation to pedestrians, emerged as a key issue at locations in Clifton, Wellgate and Moorgate, Whiston and Canklow.

Over the coming year we will work with partners, including local communities, to continue to try and resolve the situation at the following locations:

- Middle Lane, Clifton
- Queensway, Moorgate
- Worrygoose Lane, Whiston
- West Bawtry Road, Canklow

#### Community Priority: Community facilities, including services to disabled and elderly

- Whilst Rotherham South has distinct neighbourhoods, the whole area has a strong commitment to community involvement and a desire to see services delivered to some of our vulnerable communities. The Area Assembly has, as a result, allocated a proportion of its Area Assembly Devolved Budget to ensure communities remain strong and provide support to the most vulnerable.

#### Over the coming year we will work with partners, including local communities, to:

- Continue providing support to local groups
- Make available grants of up to £250 for community groups from an Area Assembly Small Grants Fund

#### Community Priority: Health Needs and Inequalities. Over the coming year we will work with partners, including local communities to:

- Monitor people's health needs and inequalities and respond to them
- Ensure that the projects being funded by the Area Assembly's Devolved Budget at a total cost of £8,806 help to address these priorities

## Area Assembly Needs Profile

### 11.2 Rotherham North

#### Overview

Rotherham North lies in the north west of the Borough and covers the smallest area of any Area Assembly at 2,049 hectares (16 square miles). Most of the areas 37,118 people live in the Rotherham urban area, ranging from the inner

terraces of Masbrough to peripheral council estates at Kimberworth Park and Wingfield, Rockingham and Munsbrough. There are also mixed and private suburban areas in Kimberworth and Greasbrough. The Area Assembly also covers a rural area around the local landmark

of Keppel's Column, beyond which is the village of Thorpe Hesley which has large amounts of modern private housing.

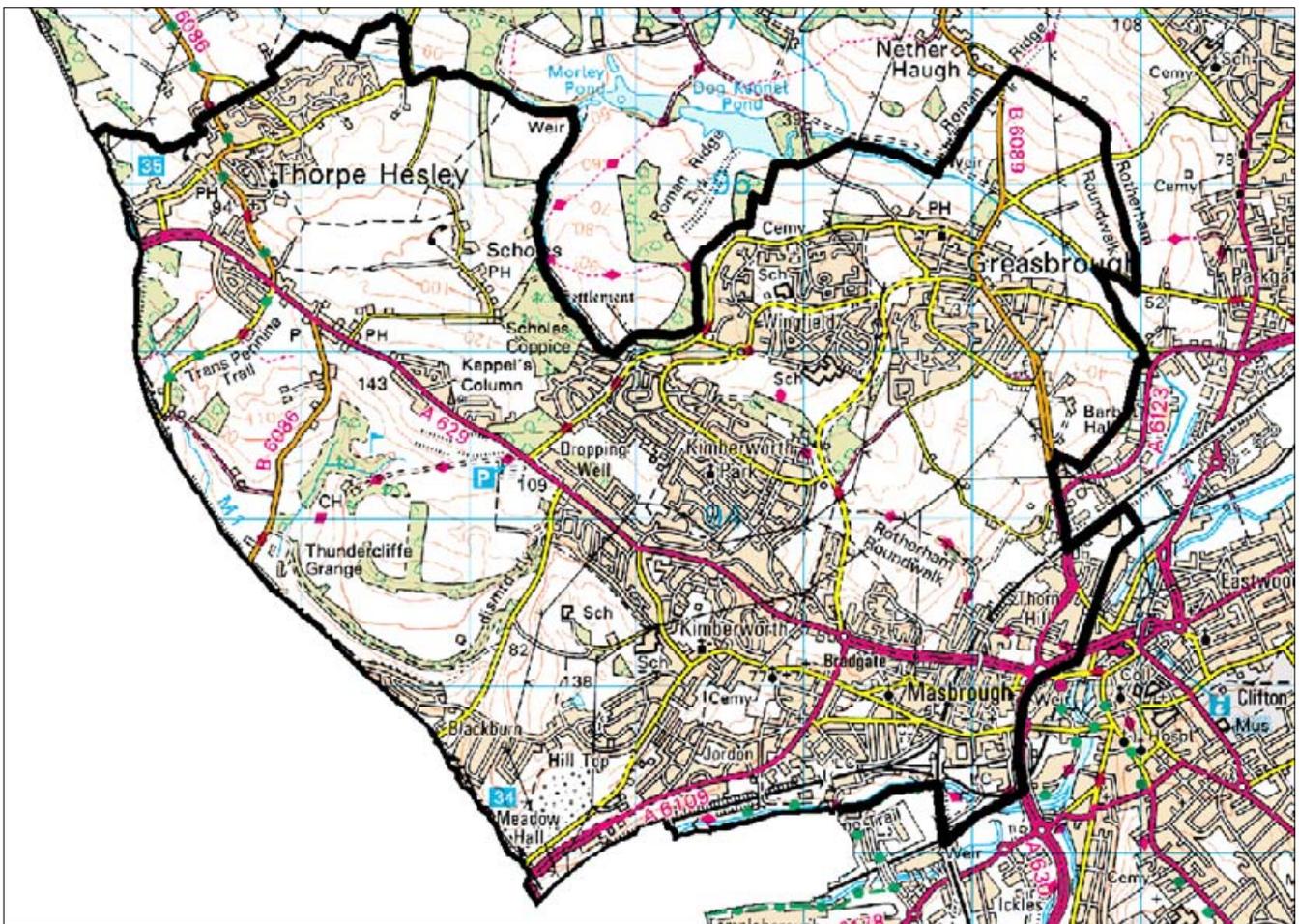


Figure 11.11

# Area Assembly Needs Profile

## 11.2 Rotherham North

### Population Estimates 2007

The graph below shows the total population of Rotherham North and estimated BME population. Rotherham North has a population of 37,000 which is the third largest of the Rotherham Area Assemblies. An estimated 3,309 people (8.9%) are from Black & Minority Ethnic (BME) groups and 15% of school age children (aged 4-15) are from BME communities. Based on Census definitions estimates the main religions in the area are Christianity 78% and Muslim 3%. The age structure of Rotherham North's population is similar to the Borough average however there is a slightly higher number of young people aged 15-24 in this Area Assembly. The projected population for Rotherham North in 2015 shows a slight increase in the total although as in all areas, the population is ageing. 34.3% of pensioners in Rotherham North live alone which is slightly above the Rotherham average of 32%.

Figure 11.12 - Population & Ethnicity of Rotherham North

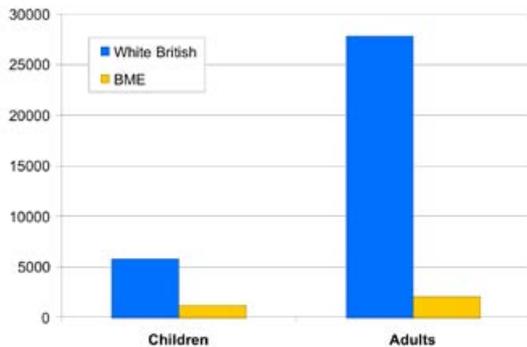
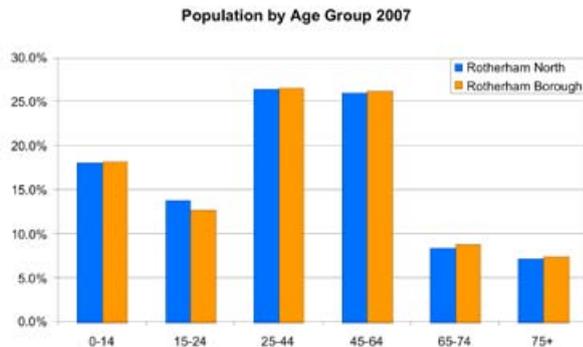


Figure 11.13 - Population by Age Group 2007

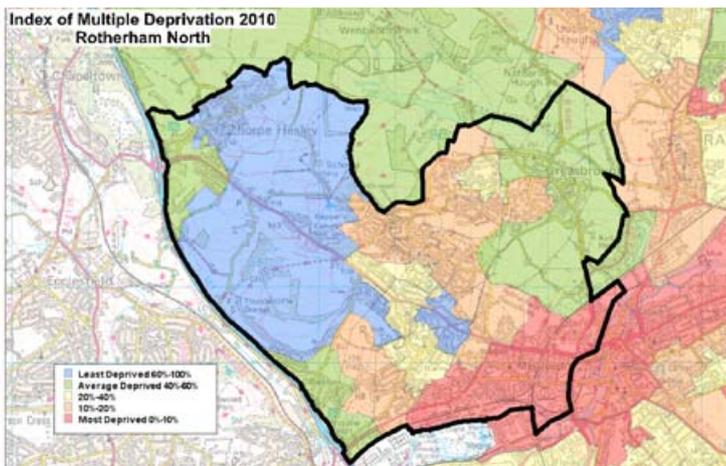


### Deprivation

Rotherham North is the third most deprived Area Assembly in Rotherham based on the Indices of Deprivation 2010. Masborough is the only area in Rotherham North that has high levels of deprivation (red area on the map below). Neighbourhoods in Rotherham North which fall in the least deprived 40% of England are Thorpe Hesley, Keppel and North East Kimberworth (blue areas below). Access to services is generally good in Rotherham North as in Rotherham as a whole. However, areas in Thorpe Hesley and Keppel (blue area on the top left of the map) are the most deprived in terms of access to services in Rotherham North which is mainly due to their semi-rural location.

Deprivation is illustrated by the 23% of working age adults who are on workless benefits, above the Rotherham average of 20.9% and national average of 15.4%. 32.7% of households claim Council Tax or Housing Benefit, above the Borough average of 28.1%. 20.4% of school children are eligible for free school meals compared to 17.2% in Rotherham as a whole.

Figure 11.14 -



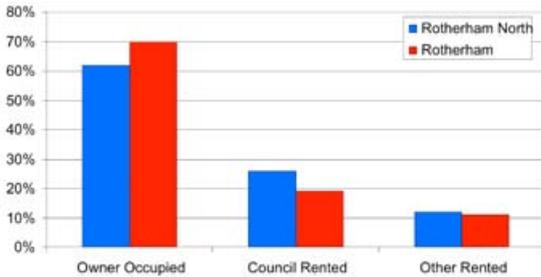
# Area Assembly Needs Profile

## 11.2 Rotherham North

### Housing

Most homes in Rotherham North are owner occupied, the highest level being in Keppel Ward. The proportion of council housing is above average but has fallen from 32% to 26% since 2001 as a result of Right to Buy sales. The other (mainly private) rented sector is about average for Rotherham although concentrated in Rotherham West.

Figure 11.15 - Housing Tenure



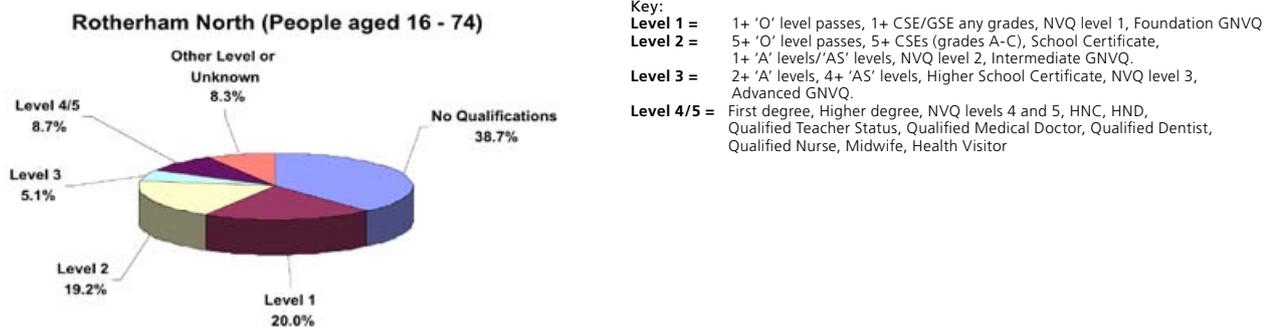
### Qualifications

Qualification levels in Rotherham North are similar to the average for Rotherham at levels 1 and 2 and below Rotherham averages for levels 3, 4 and 5. The percentage with no qualifications in Rotherham is 36.8%; the comparable figure for the Rotherham North Area Assembly is 38.7%. The attainment of children and young people reflects a similar pattern to adults with 37.9% of 16 year olds gaining 5+ GCSE's A\*-C in 2009, below the 41% in Rotherham as a whole and the English average of 47.6%. 7% of 16-18 year olds were Not in Education, Employment or Training (NEET).

19% of young people in Rotherham North stay on at school or college after the age of 16 which is well below both the Borough average of 25% and the English average of 40%.

Figure 11.16 - Highest Qualification Level (aged 16 – 74)

(Source: 2001 Census Table KS13)



- Key:
- Level 1 =** 1+ 'O' level passes, 1+ CSE/GSE any grades, NVQ level 1, Foundation GNVQ
  - Level 2 =** 5+ 'O' level passes, 5+ CSEs (grades A-C), School Certificate, 1+ 'A' levels/'AS' levels, NVQ level 2, Intermediate GNVQ.
  - Level 3 =** 2+ 'A' levels, 4+ 'AS' levels, Higher School Certificate, NVQ level 3, Advanced GNVQ.
  - Level 4/5 =** First degree, Higher degree, NVQ levels 4 and 5, HNC, HND, Qualified Teacher Status, Qualified Medical Doctor, Qualified Dentist, Qualified Nurse, Midwife, Health Visitor

### General Health and Care Provision

Rotherham North has above average proportions of people who are not in good health and people providing unpaid care. However, Rotherham North has a lower proportion of people who have limiting long term illness.

Figure 11.17

General Health	Rotherham North % of Total Population	Rotherham % of Total Population	England % of Total Population
General Health 'Not Good'	12.8%	12.1%	9.0%
Limiting Long Term Illness (LLTI)	21.4%	22.4%	17.9%
People providing Unpaid Care	12.8%	12.2%	9.9%

1. General health refers to health over the 12 months prior to Census day.  
 2. Limiting long-term illness covers any long-term illness, health problem or disability, which limits daily activities or work.  
 3. A person is a provider of unpaid care if they give any help or support to family members, friends, neighbours or others because of long-term physical or mental health or disability, or problems related to old age.

# Area Assembly Needs Profile

## 11.2 Rotherham North

### Life Expectancy

The graph below shows the current life expectancy of men and women in the Rotherham North area assembly. Life expectancy for men is below the local and national average although for women life expectancy is slightly above the Borough average but slightly below the national average.

Figure 11.18 - Average life expectancy – years

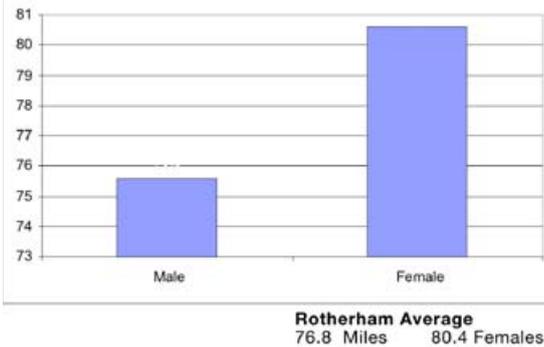
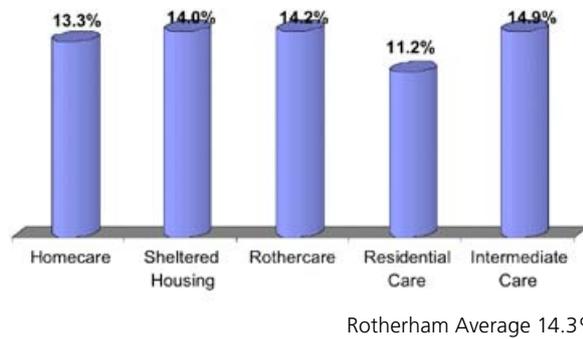


Figure 11.19 - Proportion of social care services delivered in Rotherham North



### Teenage Pregnancy

Conception rates for females aged 15-17 in Rotherham North are 3.8% which is below both the Borough average of 5.1% and national average of 4.1%.

### Other Health Indicators

Hospital admissions for serious injury are 21.4 per 1,000 which is slightly below the Borough average. Low weight or still birth is slightly above average at 8.4%. Smoking rates are also above average at 28.9%.

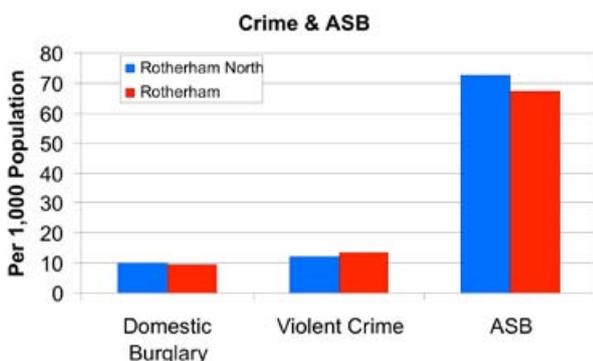
### Social Care Needs Assessment

Figure 11.19 shows the proportion of social care services received in Rotherham North in 2007/08. The low prevalence for long term conditions is reflected in demand for social care services during 2007/08. The proportion of homecare, Rothercare and intermediate care services were below the local average. Volume of sheltered accommodation and residential care placements are also lower than in other areas of Rotherham

### Crime & Anti Social Behaviour

Domestic Burglaries and Violent Crimes in Rotherham North are similar to the Borough average. However, anti-social behaviour is higher than the Borough average. Deliberate fires in Rotherham North are 7.0 per 1,000, above the Rotherham average of 6.3 per 1,000. The Vulnerable Localities Index 2010 shows that Ferham, Masborough, Bradgate and Meadowbank are amongst the 20 neighbourhoods most vulnerable to crime in Rotherham.

Figure 11.20



# Area Assembly Needs Profile

## 11.2 Rotherham North

### Rotherham North Priorities 2009/10

#### Community Priority: Activities for Teenagers and Children and Young People

- Through the Area Assembly Devolved Budget we will ensure that funding is prioritised for the following projects:
  - The employment of a Community Sports Coach for the area
  - Support a programme of Basketball delivery
  - The On 4 Wheels Drive Project promoting road safety and responsible driving
  - The Unique project working to raise the self-esteem and aspirations of young people
  - Development of a Young People's Community Leadership Project
  - Seating area for young people in Bradgate Park
  - The employment of a detached youth worker for St John's Green
  - A programme of gym instructor training
  - A Rotherham BMX club

#### Community Priority: Reduce the Level and Fear of Crime and Increase Community Safety

- Anti social behaviour (ASB), causes a 'fear of crime' generally amongst parents, young people and the elderly remains a key community priority.
- This is a particular priority in the following locations:
  - St Johns Green
  - Ferham
- Use the Neighbourhood Action Group process to identify hot spots within each neighbourhood using a range of methods and action plans to address issues raised
- Put in place monthly PACT (Partners and Communities Together) meetings
- Support South Yorkshire Police to deliver "Operation Staysafe" across the area to deter young people from underage drinking in public areas
- Support South Yorkshire Police to develop a Playstation club for young people across the area

#### Community Priority: Improve Standards of Roads and Pavements, Improve Facilities in Parks and Open Spaces and Cleaner Streets

- Deliver schemes utilising the Rotherham North Streetpride Devolved Budget
- Utilise "Grot Spot" Funding to clean areas of concern in Rotherham North
- Support Wingfield Horticulture Project to enhance their facilities and engage in projects in the wider community
- Develop stronger links with Greenspaces to provide up to date information for the residents of Rotherham North

#### Community Priority: Increase Community Activity

- The Area Assembly team will support a steering group responsible for organisation of Rotherham North Sports Festival and assist with delivery
- Support the development of Community groups via the Rotherham North Community Chest
- Host Rotherham North Community Achievement Awards

# Area Assembly Needs Profile

## 11.3 Rother Valley South

### Overview

Rother Valley South covers the south and south east of the Borough with the largest area of any Area Assembly, covering 9,325 hectares (36 square miles). The Area Assembly covers the three wards of Anston and Woodsetts,

Dinnington and Wales and within these 11 parishes and settlements include Dinnington, North and South Anston, Woodsetts, Wales, Kiveton Park, Harthill, and Todwick. The area population of 34,100 is concentrated in the Dinnington & Anston urban area (combined

parishes 18,800) and in Wales & Kiveton Park (5,850) but is otherwise quite dispersed. Rother Valley South is the most rural Area Assembly with most land in arable agricultural use. Recreation is also a feature at Rother Valley Country Park.

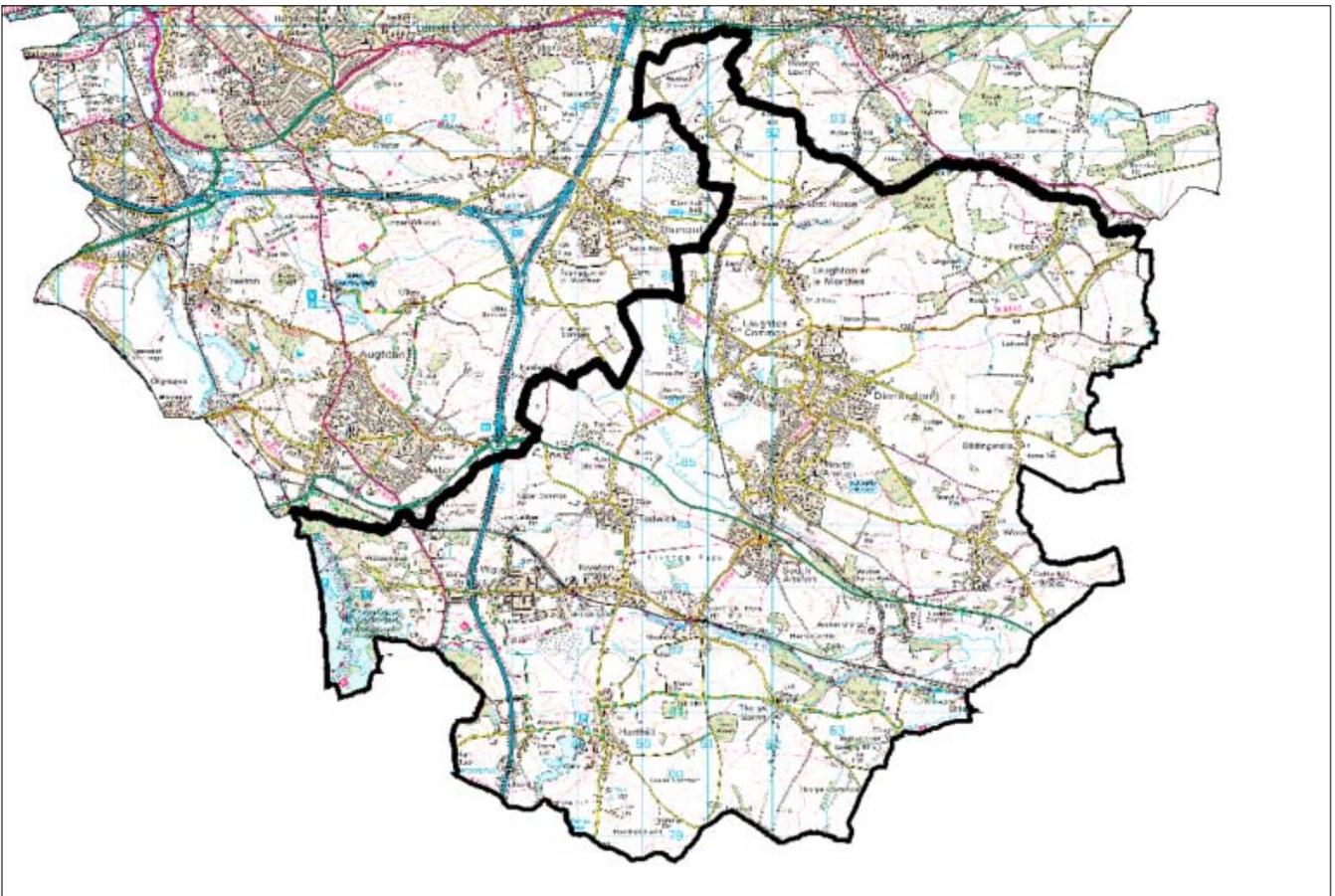


Figure 11.21

# Area Assembly Needs Profile

## 11.3 Rother Valley South

### Population Estimates 2007

The graph below shows the total population of Rother Valley South and estimated BME population. Rother Valley South has a population of 34,100 which is the smallest of any Area Assembly. An estimated 780 people (2.3%) are from Black & Minority Ethnic (BME) groups which is also the lowest BME population of any Area Assembly in the borough. 3.1% of school age children (aged 4-15) are from BME communities which is also the lowest in the Borough. Based on Census definitions estimates the main religion in the area is Christianity (80%).

Figure 11.22 - Population & Ethnicity of Rother Valley South

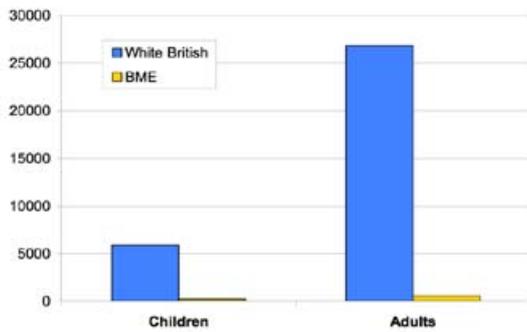
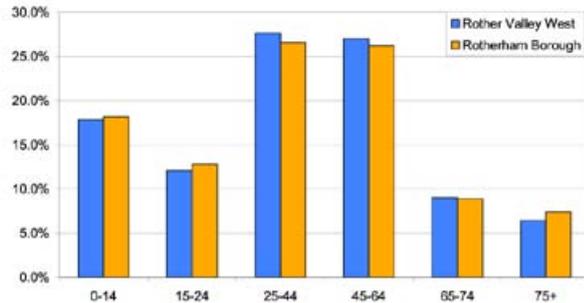


Figure 11.23 - Population by Age Group 2007



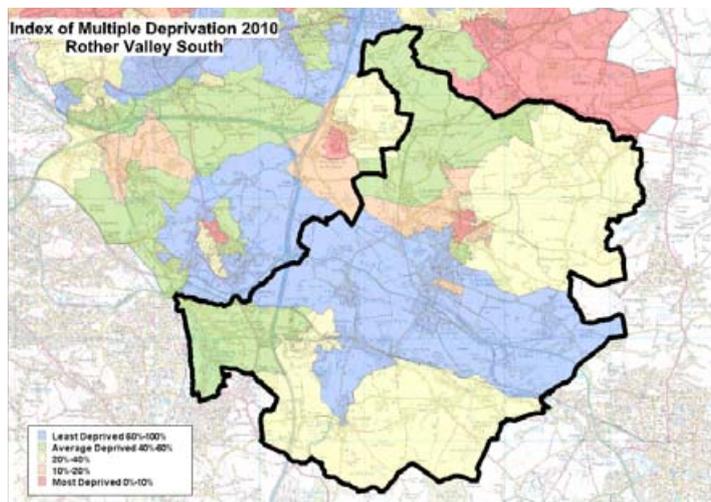
### Deprivation

Rother Valley West is the second least deprived Area Assembly in Rotherham based on the Indices of Deprivation 2010. Central Thurcroft and North West Aston are the only areas in Rother Valley West that have high levels of deprivation (red areas on the map below). Neighbourhoods in Rother Valley West which fall in the least deprived 40% of England are Swallownest and South Aston (blue areas below).

Access to services is generally good in Rother Valley West as in the whole of Rotherham with no areas falling below average deprivation.

Relatively low deprivation in Rother Valley West is illustrated by the fact that 18% of working age adults are on workless benefits, below the Rotherham average of 20.9%. 23.1% of households claim Council Tax or Housing Benefit, also below the Borough average of 28.1%. 14.2% of school children are eligible for free school meals compared to 17.2% in Rotherham as a whole.

Figure 11.24 -



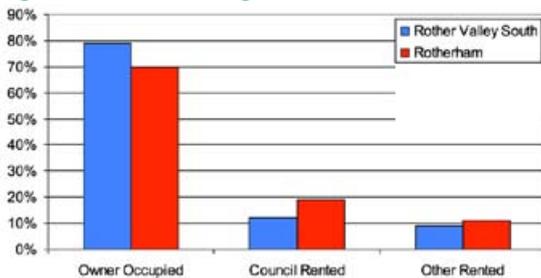
# Area Assembly Needs Profile

## 11.3 Rother Valley South

### Housing

Most homes in Rother Valley West are owner occupied (76%) which is higher than the figure for Rotherham as a whole (70%). The proportion of council housing in Rother Valley West has fallen from 14% to 15% since 2001 as a result of Right to Buy sales and demolitions. The number of council homes in Rother Valley West is lower than the Rotherham average (19%). The other (mainly private) rented sector figure is slightly lower than the Rotherham average.

Figure 11.25 - Housing Tenure

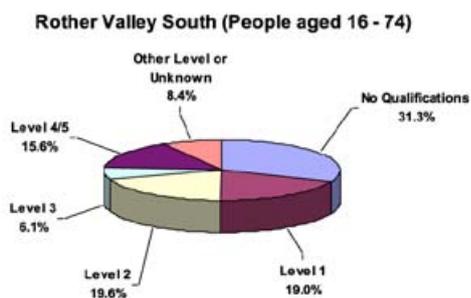


### Qualifications

Qualification levels in Rotherham North are similar to the average for Rotherham at levels 1 and 2 and below. Rotherham averages for levels 3, 4 and 5. The percentage with no qualifications in Rotherham is 36.8%; the comparable figure for the Rotherham North Area Assembly is 38.7%. The attainment of children and young people reflects a similar pattern to adults with 37.9% of 16 year olds gaining 5+ GCSE's A\*-C in 2009, below the 41% in Rotherham as a whole and the English average of 47.6%. 7% of 16-18 year olds were Not in Education, Employment or Training (NEET). 19% of young people in Rotherham North stay on at school or college after the age of 16 which is well below both the Borough average of 25% and the English average of 40%.

Figure 11.26 - Highest Qualification Level (aged 16 – 74)

(Source: 2001 Census Table KS13)



Key:

- Level 1 =** 1+ 'O' level passes, 1+ CSE/GSE any grades, NVQ level 1, Foundation GNVQ
- Level 2 =** 5+ 'O' level passes, 5+ CSEs (grades A-C), School Certificate, 1+ 'A' levels/'AS' levels, NVQ level 2, Intermediate GNVQ.
- Level 3 =** 2+ 'A' levels, 4+ 'AS' levels, Higher School Certificate, NVQ level 3, Advanced GNVQ.
- Level 4/5 =** First degree, Higher degree, NVQ levels 4 and 5, HNC, HND, Qualified Teacher Status, Qualified Medical Doctor, Qualified Dentist, Qualified Nurse, Midwife, Health Visitor

### General Health and Care Provision

Rother Valley South has below average proportions for Rotherham of people who are not in good health and/or who have limiting long term illness, however this is still above the England averages.

Figure 11.27

General Health	Rother Valley South	Rotherham	England
	% of Total Population	% of Total Population	% of Total Population
General Health 'Not Good'	10.3%	12.1%	9.0%
Limiting Long Term Illness (LLTI)	20.1%	22.4%	17.9%
People providing Unpaid Care	12.6%	12.2%	9.9%

1. General health refers to health over the 12 months prior to Census day.
2. Limiting long-term illness covers any long-term illness, health problem or disability, which limits daily activities or work.
3. A person is a provider of unpaid care if they give any help or support to family members, friends, neighbours or others because of long-term physical or mental health or disability, or problems related to old age.

# Area Assembly Needs Profile

## 11.3 Rother Valley South

### Life Expectancy

The graph below shows the current life expectancy of men and women in the Rother Valley South area assembly. Life expectancy for men is in line with the local average but just below the national average. For women life expectancy is above the local and national average.

Figure 11.28 - Average life expectancy – years

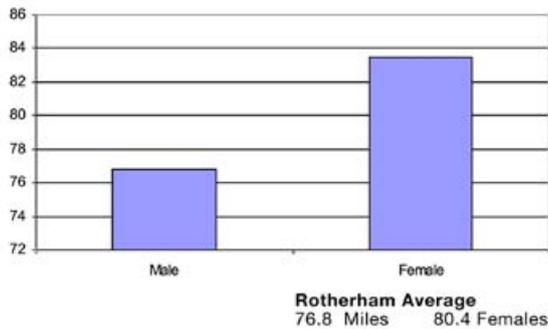
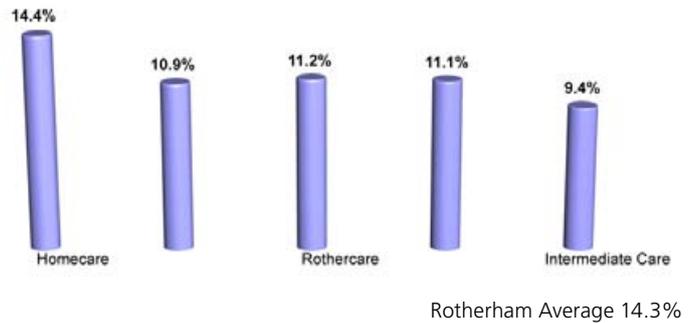


Figure 11.29 - Proportion of Social Care services delivered in Rother Valley South



### Teenage Pregnancy

Conception rates for females aged 15-17 in Rother Valley South are 4.9% which is below the Borough average of 5.1% but above the national average of 4.1%.

### Other Health Indicators

Hospital admissions for serious injury are 22.2 per 1,000 which is slightly above the Borough average. Low weight or still birth are also slightly above average at 8.1%. However smoking rates are below average at 18.6%.

### Social Care Needs Assessment

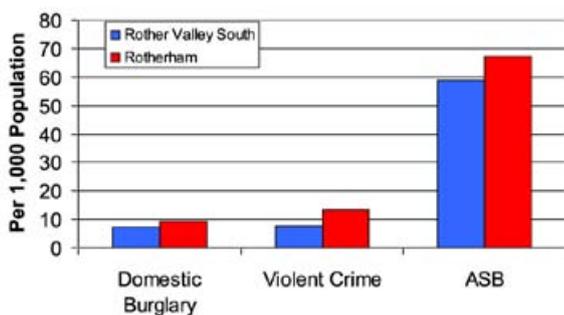
Figure 11.29 shows the proportion of social care services received in Rother Valley South in 2007/08. Rother Valley South has below average provision in all areas of social care except home care. Levels of home care provision are slightly above average for the borough.

### Crime & Anti Social Behaviour

Crime and anti social behaviour in Rother Valley South are generally lower than the Borough average.

Deliberate fires in Rother Valley South are 5.2 per 1,000, below the Rotherham average of 6.3 per 1,000. The Vulnerable Localities Index 2010 shows that Dinnington Central is amongst the 10 neighbourhoods most vulnerable to crime in Rotherham and Dinnington East is amongst the 20 most vulnerable areas.

Figure 11.30 - Crime & ASB



# Area Assembly Needs Profile

## 11.3 Rother Valley South

### Rother Valley South Priorities 2009/10

#### Community Priority: Increase activities for children and young people

- The Young Peoples Task Group will continue to meet to co-ordinate local activity and identify and deliver project ideas
- The Area Assembly Devolved Budget is funding a 9 month Detached Youth Work Project which will deliver two sessions a week in Anti-Social Behaviour "hot spot" areas
- A programme of sports activities including football, boxing and street-dance will be funded and delivered across the area
- Local sports clubs Brampton Dynamos under 10's Football, Dinnington Town FC and the Junior Cricket Club have also received funding to run local activities for young people

#### Community Priority: Improve local environments – roads and streets

- The Area Assembly Devolved Budget has funded the "Grot spot of the month project" which will ask members of the community to nominate and vote on a monthly "grot spot", Streetpride will then organise a clean up at the location
- The Area Assembly will support the delivery of the Streetpride Devolved Budget, which provides a pot of £20,000 to fund small scale projects which improve the street scene

#### Community Priority: Reduce crime and anti-social behaviour and the fear of crime

- The Area Assembly Devolved Budget is funding a range of diversionary activities for young people, including detached youth work, sports activities and additional sessions at the JADE Centre
- The Area Assembly Devolved Budget is also funding a range of projects to reduce crime and anti-social behaviour including, installing fencing at High Nook Play Area and purchasing Smartwater for Harthill with Woodall
- Neighbourhood Watch to distribute to vulnerable homes
- The Area Assembly will identify opportunities to raise awareness of appropriate reporting mechanisms, promote community safety and provide reassurance
- Funding has been secured to purchase two additional Mowcam CCTV cameras which will be linked into the mobile CCTV Camera Project where members of the community are asked to tell us where the cameras should be located
- The Area Assembly Team will continue to work with partners in the Safer Neighbourhood Team and Neighbourhood Action Group to reduce crime and anti-social behaviour in the community

#### Community Priority: Community facilities and activities

- The Area Assembly Devolved Budget is funding an outdoor gym for all ages which will be installed in summer 2009 next to the Dinnington Resource Centre
- Funding of £9,000 has been allocated to run a Community Chest Small Grants Fund so that local community groups and partner agencies can apply for up to £500 to fund equipment or community activities

#### Community Priority: Improve access to GP Services

- Rother Valley West Area Assembly will look at a range of information to identify key areas and target groups
- Arrange a meeting with key partners, NHS Rotherham, Rotherham Community Transport, Social Services and Voluntary and Community Sector partners to identify ways in which we can address this issue

## Area Assembly Needs Profile

### Overview

Rother Valley West is situated in the south west of the Borough, covering an area of 3,764 hectares (14.5 square miles). The Area Assembly covers 7 parishes and numerous settlements, the main urban areas being Aston, Aughton,

Swallowneast and Brinsworth. These and the smaller communities of Catcliffe, Treeton and Orgreave are close to Sheffield and are popular with commuters. Prominent features are the M1 and M18 motorways which enclose pleasant rural areas around Ulley. Beyond the

M18 in a rural setting is the former pit village of Thurcroft.

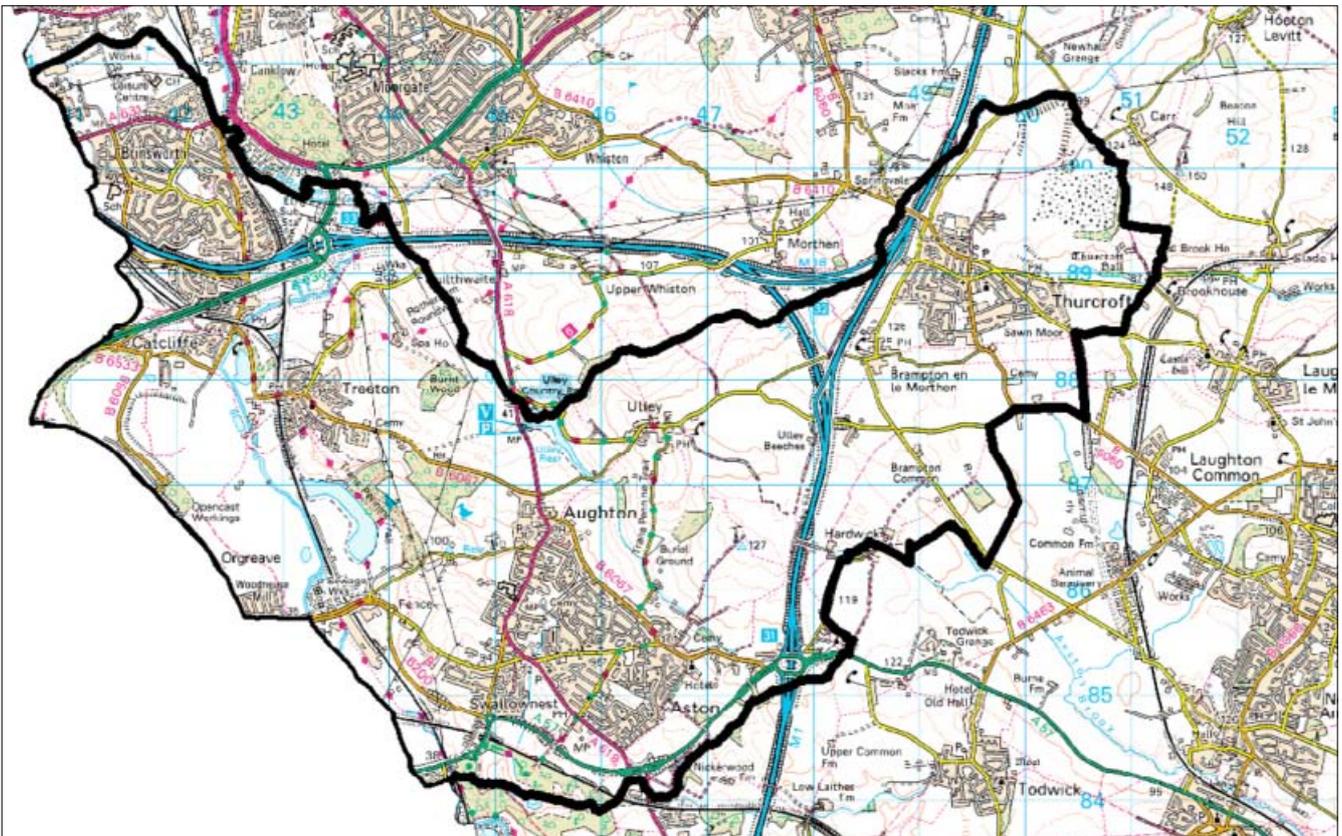


Figure 11.31

# Area Assembly Needs Profile

## 11.4 Rother Valley West

### Population Estimates 2007

The graph below shows the total population of Rother Valley West and estimated BME population. Rother Valley West has a population of 35,500 which is the third smallest of the seven Area Assemblies in Rotherham. An estimated 1182 people (3.3%) are from Black & Minority Ethnic (BME) groups and 5% of school age children (aged 4-15) are from BME communities. Based on Census definitions estimates the main religion in the area is Christianity (81%). The age structure of Rother Valley West's population shows that the area has slightly below average proportions of children and young people aged 0-24 and above average adults aged 25-64. The number of older people aged above 75 is also below the borough average. The projected population for Rother Valley West in 2015 shows a slight increase in the total and as in all areas, the population is ageing.

28.9% of pensioners in Rother Valley West live alone which is slightly below the Rotherham average of 32%.

Figure 11.32 - Population & Ethnicity of Rother Valley West

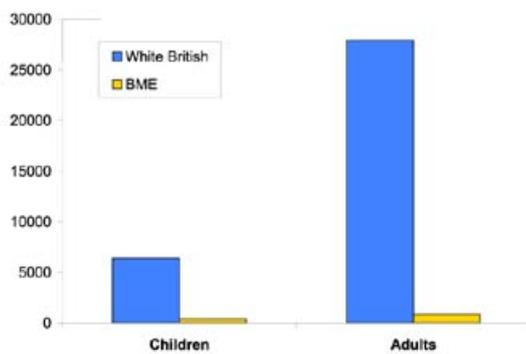
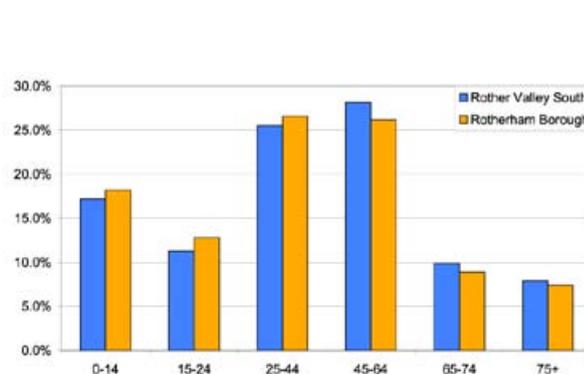


Figure 11.33 - Population by Age Group 2007

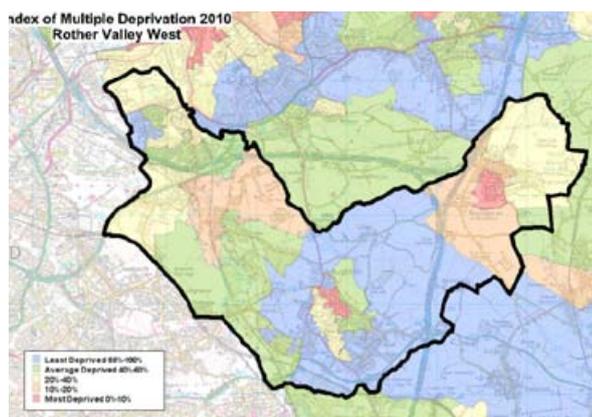


### Deprivation

Rother Valley South is the least deprived Area Assembly in Rotherham based on the Indices of Deprivation 2010. Central Dinnington is the only area in Rother Valley South that has a high level of deprivation (red area on the map below). Neighbourhoods in Rother Valley South which fall in the least deprived 40% of England are South Anston, Todwick Kiveton Park and Harthill (blue area below). Access to services is generally good in Rother Valley South as in the whole of Rotherham. However, north east Dinnington & Firbeck (yellow area on the top right of the map) is the most deprived area in Rotherham in terms of access to services which is mainly due to its rural location.

The relatively low deprivation in Rother Valley South is illustrated by the 16.7% of working age adults who are on workless benefits, well below the Rotherham average of 20.9%. 21.2% of households claim Council Tax or Housing Benefit, also well below the Borough average of 28.1%. 10.5% of school children are eligible for free school meals compared to 17.2% in Rotherham as a whole.

Figure 11.34 -



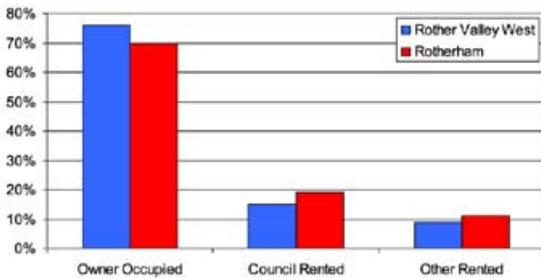
# Area Assembly Needs Profile

## 11.4 Rother Valley West

### Housing

Most homes in Rother Valley West are owner occupied (76%) which is higher than the figure for Rotherham as a whole (70%). The proportion of council housing in Rother Valley West has fallen from 14% to 15% since 2001 as a result of Right to Buy sales and demolitions. The number of council homes in Rother Valley West is lower than the Rotherham average (19%). The other (mainly private) rented sector figure is slightly lower than the Rotherham average.

Figure 11.35 - Housing Tenure

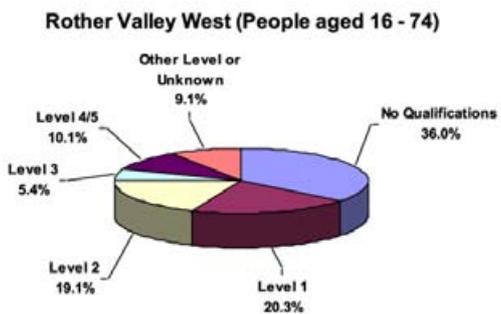


### Qualifications

Qualification levels in Rother Valley West are similar to the Rotherham average. The percentage with no qualifications in Rotherham is 36.8%; the comparable figure for the Rother Valley West Area Assembly is 36%. The attainment of children and young people in Rother Valley West stands at 44% of 16 year olds gaining 5+ GCSE's A\*-C in 2009. This is above the 41% average in Rotherham as a whole but still below the English average of 47.6%. 4.8% of 16-18 year olds in Rother Valley West were Not in Education, Employment or Training (NEET). 24% of young people stay on at school or college after the age of 16 which is just below the Borough average of 25%.

Figure 11.36 - Highest Qualification Level (aged 16 – 74)

(Source: 2001 Census Table KS13)



- Key:
- Level 1 =** 1+ 'O' level passes, 1+ CSE/GSE any grades, NVQ level 1, Foundation GNVQ
  - Level 2 =** 5+ 'O' level passes, 5+ CSEs (grades A-C), School Certificate, 1+ 'A' levels/'AS' levels, NVQ level 2, Intermediate GNVQ.
  - Level 3 =** 2+ 'A' levels, 4+ 'AS' levels, Higher School Certificate, NVQ level 3, Advanced GNVQ.
  - Level 4/5 =** First degree, Higher degree, NVQ levels 4 and 5, HNC, HND, Qualified Teacher Status, Qualified Medical Doctor, Qualified Dentist, Qualified Nurse, Midwife, Health Visitor

### General Health and Care Provision

Rother Valley West has just below average proportions for Rotherham of people who are not in good health and/or who have limiting long term illness, however this is still above the England averages.

Figure 11.37

General Health	Rother Valley West	Rotherham	England
	% of Total Population	% of Total Population	% of Total Population
General Health 'Not Good'	11.3%	12.1%	9.0%
Limiting Long Term Illness (LLTI)	21.0%	22.4%	17.9%
People providing Unpaid Care	12.4%	12.2%	9.9%

1. General health refers to health over the 12 months prior to Census day  
 2. Limiting long-term illness covers any long-term illness, health problem or disability, which limits daily activities or work  
 3. A person is a provider of unpaid care if they give any help or support to family members, friends, neighbours or others because of long-term physical or mental health or disability, or problems related to old age.

# Area Assembly Needs Profile

## 11.4 Rother Valley West

### Life Expectancy

The graph below shows the current life expectancy of men and women in the Rother Valley West area assembly. Life expectancy for women is in line with the local average but just below the national average. For men life expectancy is above the local average and just below the national average.

Figure 11.38 - Average life expectancy – years

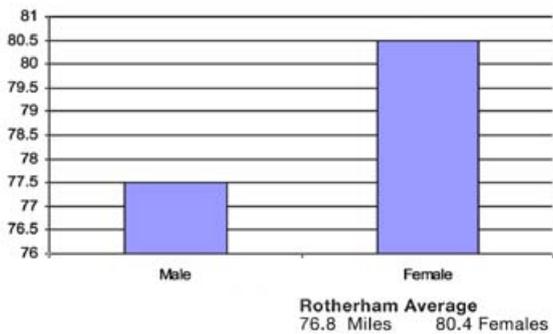
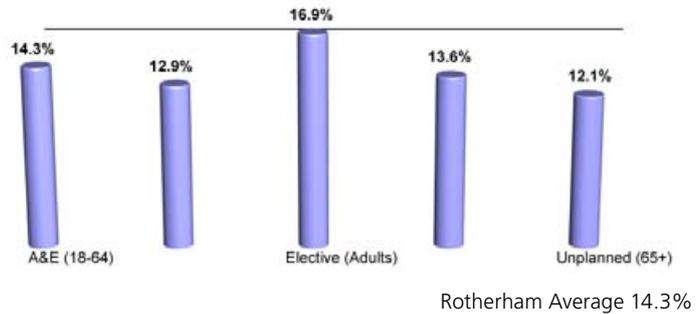


Figure 11.39 - Proportion of Social Care services delivered in Rother Valley South



### Teenage Pregnancy

Conception rates for females aged 15-17 in Rother Valley South are 4.9% which is below the Borough average of 5.1% but above the national average of 4.1%.

### Other Health Indicators

Hospital admissions for serious injury are 20.2 per 1,000 which is slightly below the Borough average. Low weight or still birth are also slightly below average at 6.9%. Smoking rates are below average at 23.6%.

### Social Care Needs Assessment

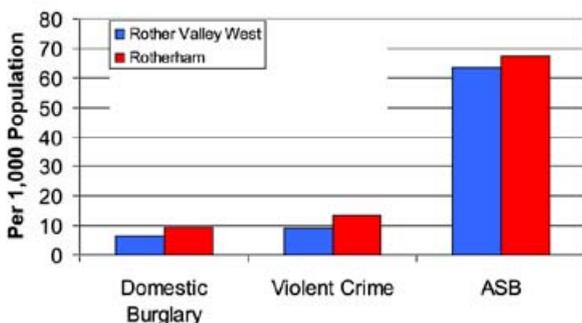
Figure 11.39 shows the proportion of social care services received in Rother Valley West in 2007/08. The figures for Rother Valley West show that A&E and unplanned admissions are on or below the Rotherham average. This is true for both working age and older adults. However the number of elective admissions is higher than the local average.

### Crime & Anti Social Behaviour

Crime and anti social behaviour in Rother Valley West are slightly lower than the Borough average.

Deliberate fires in Rother Valley West are 5.8 per 1,000, below the Rotherham average of 6.3 per 1,000. The Vulnerable Localities Index 2010 shows Aston Lodge as amongst the 20 neighbourhoods in Rotherham most vulnerable to crime and ASB.

Figure 11.40 - Crime & ASB



# Area Assembly Needs Profile

## 11.4 Rother Valley West

### Rother Valley South Priorities 2009/10

#### Community Priority: Crime and Community Safety

- Anti-social behaviour
- Criminal Damage
- Fear of Crime
- Drugs Misuse
- Motorcycle nuisance

Crime and community safety issues made up 5 of the top 10 priorities identified through consultation with Rother Valley West residents. Top of the list of concerns is anti-social behaviour by young people and the fear of crime this causes. Over the coming year we will:

- Work with partners to develop and strengthen multi-agency responses to crime and community safety "hot spots"
- Draw up action plans to tackle hot spots in partnership with communities
- Increase awareness in the community of Safer Neighbourhood Teams and the Neighbourhood Action Group
- Hold Partner and Community Together (PACT) meetings so local people can have their say on crime and community safety issues and receive feedback on the work carried out

#### Community Priority: Roads and Pavements

The condition of roads and pavements and clean streets are seen as important in Rother Valley West because a pleasant environment develops a sense of pride in the community. In order to make a difference in these areas we will:

- Improve access to information on reporting so that people know how they can get their issues addressed
- Monitor the service standards of Streetpride, particularly around roads and pavement repairs
- Work with partners and the community to develop a co-ordinated response to the issues communities raise

#### Community Priority: Facilities for Children and Young People

The increase and improvement of facilities, activities and services for our young people was an important concern in Rother Valley West across all age groups, genders and in all locations. There was a perception that anti-social behaviour is associated with a lack of youth provision. Lack of information on what is already available for young people was the biggest concern that came through

in the consultation both with adults and young people. In order to address these issues we will:

- Establish joint working arrangements with Children and Young People's Services to develop a multi-agency approach to developing services and access to information for young people and their families
- Work with partners to increase and improve facilities for children and young people by accessing funding opportunities
- Develop a programme of consultation with young people to get a better understanding of what young people want in their communities
- Encourage young people to become involved in active citizenship and local democracy

#### Community Priority: Opportunities for Access to learning new skills

Opportunities to access learning new skills is a new priority for 2009. People saw this as being particularly important in the current economic climate.

In order to begin to address this issue we will:

- Work with partner agencies to identify opportunities for people to access learning facilities within their own community

# Area Assembly Needs Profile

## 11.4 Rother Valley West

### Community Priority: Parks and Open Spaces

Rother Valley West is home to two Country Parks, Ulley and Rother Valley. It also has many Parish Council owned play areas. People told us through consultation, that parks and open spaces should be protected and improved to provide high quality provision. The damage caused to Ulley Reservoir during 2007 has been of great community concern and people are keen to see it back to full use as soon as possible. The quality of local play provision was also highlighted as a concern. To address these issues we will:

- Monitor the reinstatement of Ulley Country Park
- Monitor the Rother Play Pathfinder initiative

### Community Priority: Community Facilities and Activities

Rother Valley West is made up of seven distinct communities and each has a strong identity and proud heritage. "Community Spirit" is something that the people of Rother Valley West work hard to preserve. Information about how people can become more involved in community activity is seen as a key tool in promoting community cohesion.

We will:

- Work with communities to celebrate their areas so that people feel they belong to the community and get on well together
- Support community groups in the area to promote their activities and become more sustainable

# Area Assembly Needs Profile

## 11.5 Wentworth North

### Overview

Wentworth North lies in the north of the Borough, covering an area of 4,301 hectares (6.61 square miles). Most of the 34,800 residents in the Assembly area are concentrated on the eastern side, in the towns of Wath and Swinton and in

the parish of Brampton Bierlow, which are mixed communities, typical of Rotherham. North of Wath is the Manvers industrial & commercial area where many thousands of people work. The eastern side of the Area Assembly has a rural setting, including

villages of Wentworth, Harley and Upper Haugh, plus Wentworth Woodhouse. Upper Haugh, on the edge of Rawmarsh is also included.

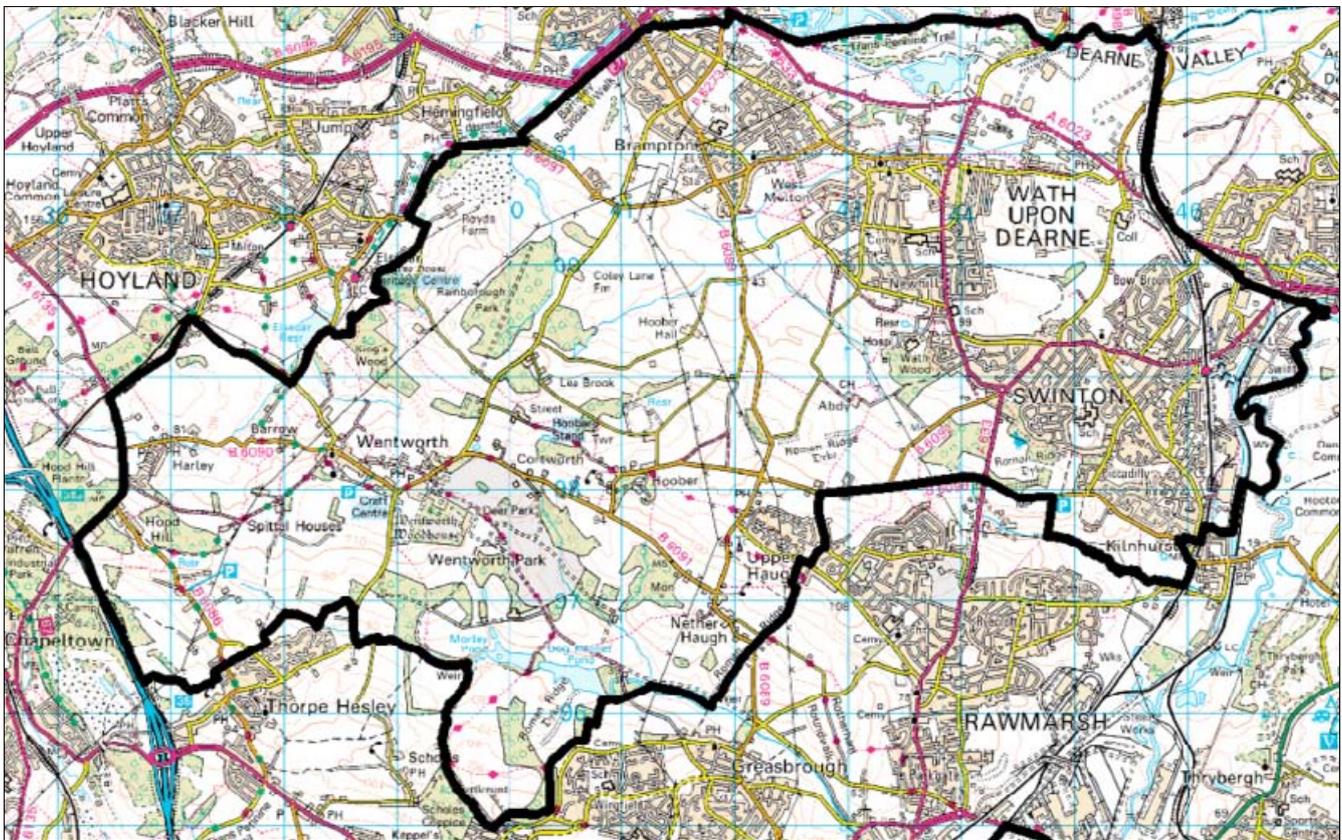


Figure 11.41

# Area Assembly Needs Profile

## 11.5 Wentworth North

### Population Estimates 2007

The graph below shows the total population of Wentworth North and estimated BME population. Wentworth North has a population of 34,800 which is the second smallest of the Rotherham Area Assemblies. An estimated 862 people (2.5%) are from Black & Minority Ethnic (BME) groups and 4% of school age children (aged 4-15) are from BME communities. Based on Census definitions estimates the main religion in the area is Christianity (84%).

The age structure of Wentworth North's population is similar to the Borough average however there are slightly higher numbers of adults aged 45-64 and over 75 in this Area Assembly. The projected population for Wentworth North in 2015 shows an increase of 2,200 people. As in all areas, the population is ageing.

34.3% of pensioners in Wentworth North live alone which is slightly above the Rotherham average of 32%.

Figure 11.42 - Population & Ethnicity of Wentworth North

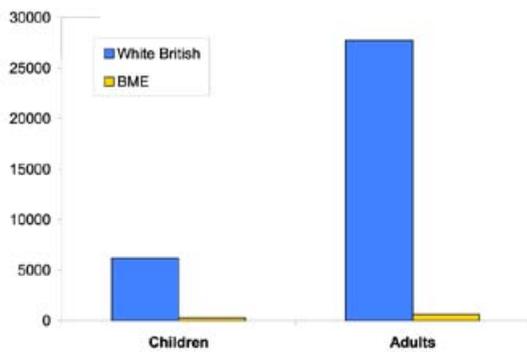
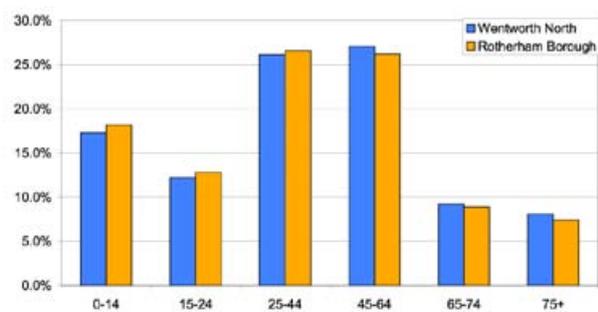


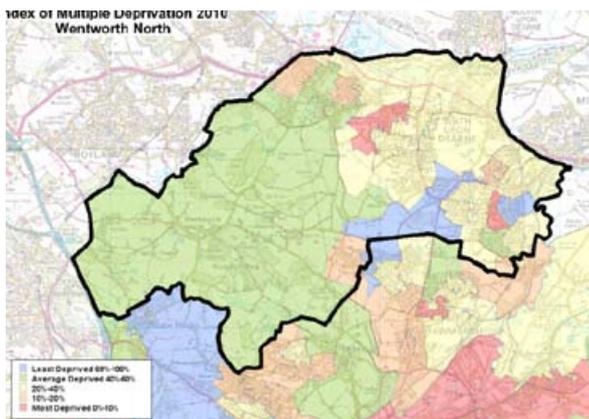
Figure 11.43 - Population by Age Group 2007



### Deprivation

Wentworth North is the fourth most deprived Area Assembly in Rotherham based on the Indices of Deprivation 2010. West Central Wath and South Swinton are the only areas in Wentworth North that have high levels of deprivation (red areas on the map below). Neighbourhoods in Wentworth North which fall in the least deprived 40% of England are the Warren Vale / Rockingham Road area and South East Swinton (blue areas below). Access to services is generally good in Wentworth North as in the whole of Rotherham. However, the Hooper area (large green area on the top left of the map) is the most deprived in terms of access to services which is mainly due to its semi-rural location. Deprivation is illustrated by the 21% of working age adults who are on workless benefits, above the Rotherham average of 20.9% and national average of 15.4%. 27.1% of households claim Council Tax or Housing Benefit, just below the Borough average of 28.1%. 15.2% of school children are eligible for free school meals compared to 17.2% in Rotherham as a whole.

Figure 11.44 -



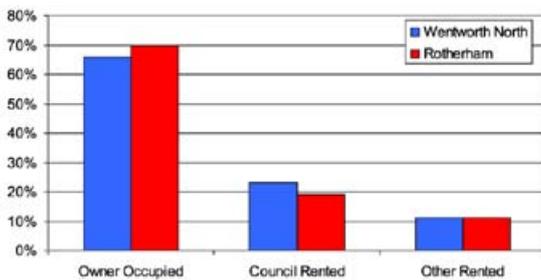
# Area Assembly Needs Profile

## 11.5 Wentworth North

### Housing

Most homes in Wentworth North are owner occupied although the proportion is slightly lower than the Rotherham average. The proportion of council housing has fallen from 28% to 23% since 2001 as a result of Right to Buy sales. The other (mainly private) rented sector is average for Rotherham. The pattern of housing tenure is very similar across the Hooper, Swinton and Wath wards.

Figure 11.45 - Housing Tenure



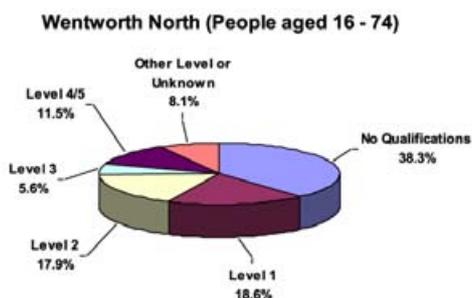
### Qualifications

Qualification levels in Wentworth North are similar to the average for Rotherham. The percentage with no qualifications in Rotherham is 36.8%; the comparable figure for the Wentworth North Area Assembly is 38.3%. The attainment of children and young people shows 44.8% of 16 year olds gaining 5+ GCSE's A\*-C in 2009, above the 41% in Rotherham as a whole but below the English average of 47.6%. 6% of 16-18 year olds were Not in Education, Employment or Training (NEET).

25% of young people in Wentworth North stay on at school or college after the age of 16 which is the same as the Borough average but below the English average of 40%.

Figure 11.46 - Highest Qualification Level (aged 16 – 74)

(Source: 2001 Census Table KS13)



Key:

**Level 1** = 1+ 'O' level passes, 1+ CSE/GSE any grades, NVQ level 1, Foundation GNVQ

**Level 2** = 5+ 'O' level passes, 5+ CSEs (grades A-C), School Certificate, 1+ 'A' levels/'AS' levels, NVQ level 2, Intermediate GNVQ.

**Level 3** = 2+ 'A' levels, 4+ 'AS' levels, Higher School Certificate, NVQ level 3, Advanced GNVQ.

**Level 4/5** = First degree, Higher degree, NVQ levels 4 and 5, HNC, HND, Qualified Teacher Status, Qualified Medical Doctor, Qualified Dentist, Qualified Nurse, Midwife, Health Visitor

### General Health and Care Provision

Wentworth North has above average proportions of people who are not in good health, people providing unpaid care and people with a limiting long term illness.

Figure 11.47

General Health	Wentworth North	Rotherham	England
	% of Total Population	% of Total Population	% of Total Population
General Health 'Not Good'	12.8%	12.1%	9.0%
Limiting Long Term Illness (LLTI)	24.1%	22.4%	17.9%
People providing Unpaid Care	12.8%	12.2%	9.9%

1. General health refers to health over the 12 months prior to Census day.

2. Limiting long-term illness covers any long-term illness, health problem or disability, which limits daily activities or work.

3. A person is a provider of unpaid care if they give any help or support to family members, friends, neighbours or others because of long-term physical or mental health or disability, or problems related to old age.

# Area Assembly Needs Profile

## 11.5 Wentworth North

### Life Expectancy

The graph below shows the current life expectancy of men and women in the Wentworth North area assembly. Life expectancy for men is below the local and national average although for women life expectancy is slightly above the Borough and national average. Despite indications that there Wentworth North has the lowest level of need, analysis of social care data shows that actual service usage is relatively high. There is high usage of homecare, warden support in sheltered accommodation and residential care. Preventive services such as intermediate care and Rothercare are below average usage.

Figure 11.48 - Average life expectancy – years

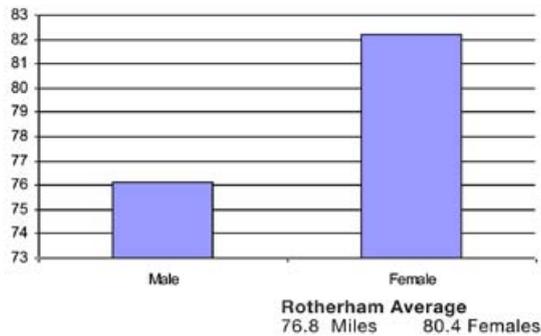
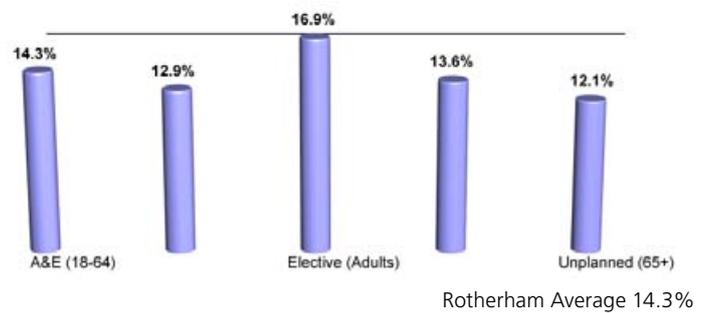


Figure 11.49 - Proportion of social care services delivered in Wentworth North



### Teenage Pregnancy

Conception rates for females aged 15-17 in Wentworth North are 6% which is above both the Borough average of 5.1% and national average of 4.1%.

### Other Health Indicators

Hospital admissions for serious injury are 23.5 per 1,000 which is slightly above the Borough average. Low weight or still birth is slightly above average at 8.8%. However smoking rates are below average at 22.6%.

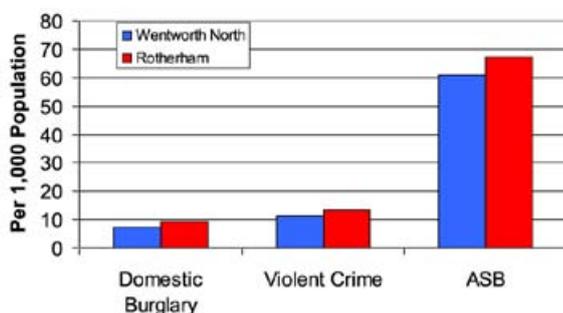
### Social Care Needs Assessment

Figure 11.49 shows the proportion of social care services received in Wentworth North in 2007/08. Despite indications that there Wentworth North has the lowest level of need, analysis of social care data shows that actual service usage is relatively high. There is high usage of homecare, warden support in sheltered accommodation and residential care. Preventive services such as intermediate care and Rothercare are below average usage.

### Crime & Anti Social Behaviour

Crime and anti-social behaviour is lower in Wentworth North than the Borough average. Deliberate fires in Wentworth North are 6.5 per 1,000, just above the Rotherham average of 6.3 per 1,000. West & Central Wath is identified as one of the 20 neighbourhoods most vulnerable to crime and ASB in the Vulnerable Localities Index 2010.

Figure 11.50 - Crime & ASB



# Area Assembly Needs Profile

## 11.5 Wentworth North

### Wentworth North Priorities 2009/10

#### Community Priority: Regeneration and Environment

- Promote the development of and provide information to the community about new and planned affordable housing
- Providing information to the community about the progress of the decent homes programme
- Receiving regular reports from the Neighbourhood Investment Service to promote public engagement and influence the work of the Housing
- Market Renewal Pathfinder process
- Supporting the consultation process and provide information about the Play Pathfinder Strategy in the communities around Strathmore Gardens, West Melton Park, Dunn Street, Horsefair Park and Brampton leisure centre site
- Representing the communities views about Swinton Community School
- Working in partnership with employers to provide opportunities and enhance skills to enable people to return to work

- Promoting projects and opportunities which improve skills and increase employability
- Supporting the development of healthy eating and food for free projects

#### Community Priority: Crime and Community Safety

This will result in key actions around the following priorities:

- Working with partners to holdstreet surgeries in priority areas which promote confidence, reduce fear of crime and support the management of estates
- Promoting the Safer Neighbourhood Team (SNT) and continue the work of the Neighbourhood Action Group (NAG)
- Put in place monthly PACT (Partners and Communities Together) meetings

#### Community Priority: Facilities and Activities for Children and Young People

- Work with Youth Services to engage young people about their involvement in future planning and signpost to existing activity

- Work with Children and Young Peoples Service to support services for families and young people
- Promote the work of the Extended Schools Service
- Work with partners to draw up action plans to tackle hot spots, address community concerns and plan for future development.

## Area Assembly Needs Profile

### 11.6 Wentworth South

#### Overview

Wentworth South lies in the north east of Rotherham, covering 3,541 hectares (13.7 square miles). The population of 38,200 is dispersed between several urban and rural areas. The Rawmarsh and Parkgate urban area lie in the west of the

Assembly area, next to the Corus steelworks at Aldwarke. East of the River Don, in the centre of the Area Assembly is the small urban community of Thrybergh, beyond which are the rural areas of Hooton Roberts and Ravenfield. The south and south east of the

Area Assembly covers the private suburban areas of Ravenfield Common and Brecks. These contrast with East Herringthorpe, Dalton and south Herringthorpe which are deprived, mainly council housing areas.

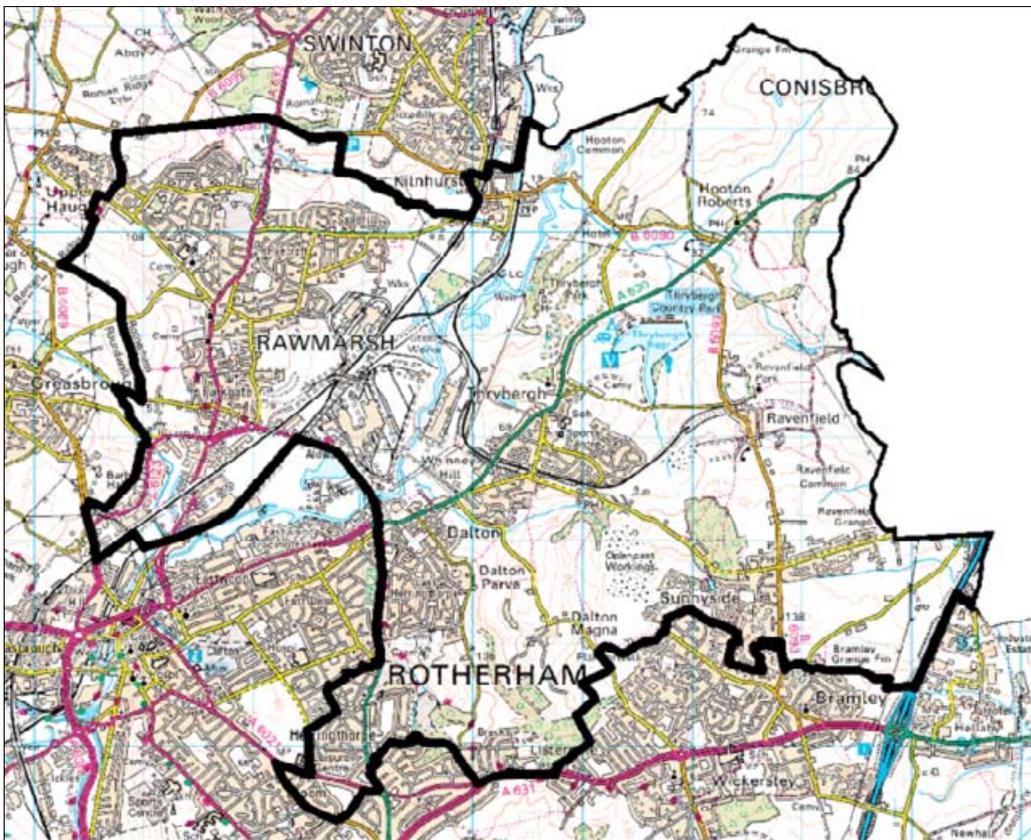


Figure 11.51

# Area Assembly Needs Profile

## 11.6 Wentworth South

### Population Estimates 2007

The graph below shows the total population of Wentworth South and estimated BME population. Wentworth South has a population of 38,200 which is the second largest of the Rotherham Area Assemblies. An estimated 1,461 people (3.8%) are from Black & Minority Ethnic (BME) groups and 6% of school age children (aged 4-15) are from BME communities. Based on Census definitions estimates the main religion in the area is Christianity (80%).

The age structure of Wentworth South’s population is similar to the Borough average however there are slightly higher numbers of people aged 0-44 and slightly lower numbers of people aged 45 and over in this Area Assembly. The projected population for Wentworth South in 2015 shows no change in the total although as in all areas, the population is ageing. 34.1% of pensioners in Wentworth South live alone which is slightly above the Rotherham average of 32%.

Figure 11.52 - Population & Ethnicity of Wentworth South

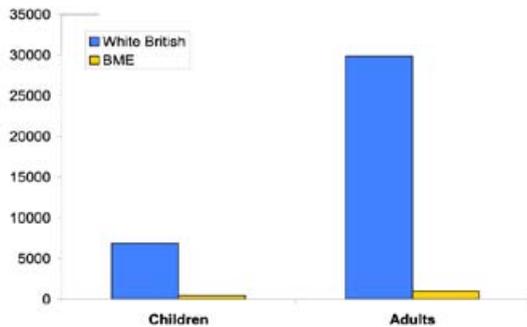
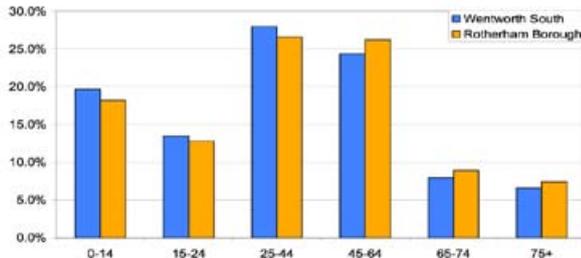


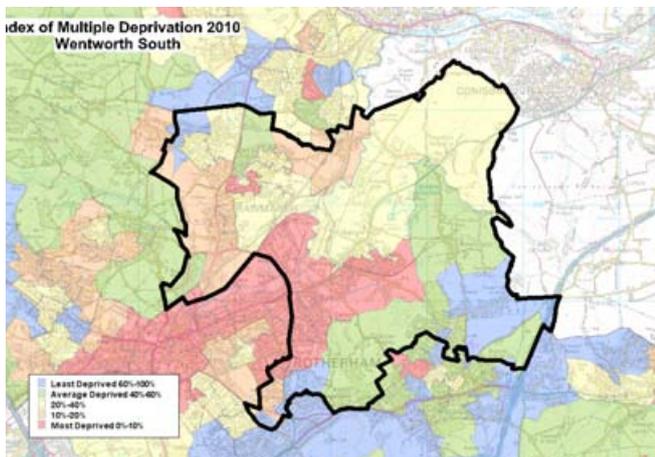
Figure 11.53 - Population by Age Group 2007



### Deprivation

Wentworth South is the second most deprived Area Assembly in Rotherham based on the Indices of Deprivation 2010. East Herringthorpe, Dalton, South Thrybergh and Central Rawmarsh are the areas in Wentworth South that have the highest levels of deprivation (red areas on the map below). The most deprived Super Output Area (SOA) in Rotherham is northern East Herringthorpe which was also the most deprived area in the Indices of Deprivation 2004 and 2007, and is amongst the most deprived 1% of England. Neighbourhoods in Wentworth South which fall in the least deprived 40% of England are Ravenfield Common, South Herringthorpe / Stag and the north western fringe of Rawmarsh (blue areas below).

Figure 11.54 -



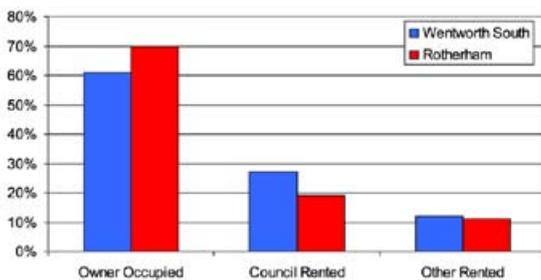
# Area Assembly Needs Profile

## 11.6 Wentworth South

### Housing

Most homes in Wentworth South are owner occupied although the proportion is below average for Rotherham. The proportion of council housing has fallen from 32% to 27% since 2001 as a result of Right to Buy sales but remains well above the Rotherham average, especially in Valley Ward. The other (mainly private) rented sector is similar to the Borough average.

Figure 11.55 - Housing Tenure



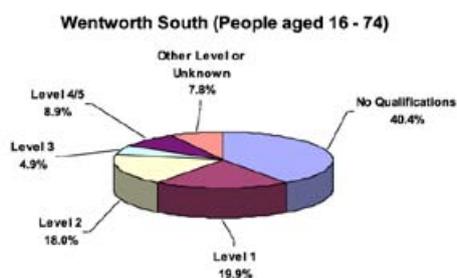
### Qualifications

Qualification levels in Wentworth South are similar to the average for Rotherham, however there are lower than average percentages of people with qualifications at Levels 3, 4 and 5. The percentage with no qualifications in Rotherham is 36.8%; the comparable figure for the Wentworth South Area Assembly is higher at 40.4%. The attainment of children and young people shows 39.3% of 16 year olds gaining 5+ GCSE's A\*-C in 2009, below the 41% in Rotherham as a whole and the English average of 47.6%. 8% of 16-18 year olds were Not in Education, Employment or Training (NEET).

19% of young people in Wentworth South stay on at school or college after the age of 16 which is below both the Borough average of 25% and the English average of 40%.

Figure 11.56 - Highest Qualification Level (aged 16 – 74)

(Source: 2001 Census Table KS13)



Key:

**Level 1** = 1+ 'O' level passes, 1+ CSE/GSE any grades, NVQ level 1, Foundation GNVQ

**Level 2** = 5+ 'O' level passes, 5+ CSEs (grades A-C), School Certificate, 1+ 'A' levels/'AS' levels, NVQ level 2, Intermediate GNVQ.

**Level 3** = 2+ 'A' levels, 4+ 'AS' levels, Higher School Certificate, NVQ level 3, Advanced GNVQ.

**Level 4/5** = First degree, Higher degree, NVQ levels 4 and 5, HNC, HND, Qualified Teacher Status, Qualified Medical Doctor, Qualified Dentist, Qualified Nurse, Midwife, Health Visitor

### General Health and Care Provision

Wentworth South has above average proportions of people who are not in good health and people with a limiting long term illness. The percentage of people providing unpaid care is in line with the Borough average.

Figure 11.57

General Health	Wentworth South	Rotherham	England
	% of Total Population	% of Total Population	% of Total Population
General Health 'Not Good'	13.0%	12.1%	9.0%
Limiting Long Term Illness (LLTI)	23.5%	22.4%	17.9%
People providing Unpaid Care	12.1%	12.2%	9.9%

1. General health refers to health over the 12 months prior to Census day.

2. Limiting long-term illness covers any long-term illness, health problem or disability, which limits daily activities or work.

3. A person is a provider of unpaid care if they give any help or support to family members, friends, neighbours or others because of long-term physical or mental health or disability, or problems related to old age.

# Area Assembly Needs Profile

## 11.6 Wentworth South

### Life Expectancy

The graph below shows the current life expectancy of men and women in the Wentworth South area assembly. Life expectancy for men is below the local and national average although for women life expectancy is slightly above the Borough average and just below the national average.

Figure 11.58 - Average life expectancy – years

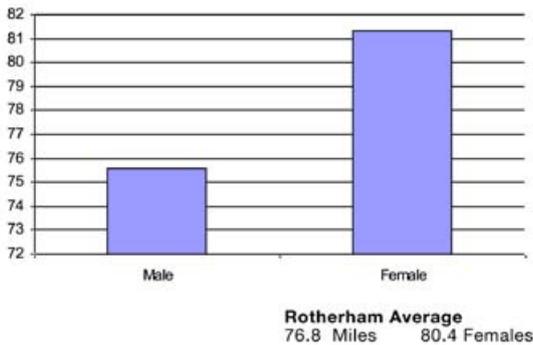
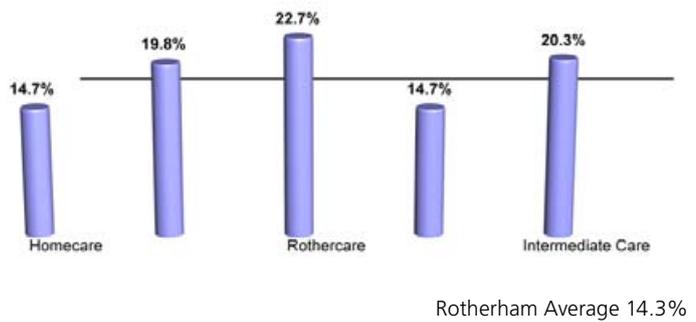


Figure 11.59 - Proportion of social care services delivered in Wentworth North



### Teenage Pregnancy

Conception rates for females aged 15-17 in Wentworth South are 6% which is above both the Borough average of 5.1% and national average of 4.1%.

### Other Health Indicators

Hospital admissions for serious injury are 21.4 per 1,000 which is slightly below the Borough average. Low weight or still birth is slightly above average at 8.3%. Smoking rates are also above average at 31.6% which are the highest of all the Area Assemblies.

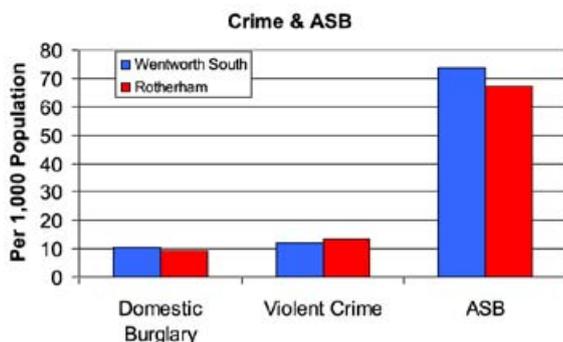
### Social Care Needs Assessment

Figure 11.59 shows the proportion of social care services received in Wentworth South in 2007/08. Wentworth South is a high-user of social care services compared to other assembly areas. It has the highest provision preventive services such as of warden support in sheltered housing and Rothercare. Wentworth South also has significantly higher levels of intermediate care provision compared to other areas.

### Crime & Anti Social Behaviour

Violent crime and Domestic Burglary is similar to the Borough average in Wentworth South. In contrast, anti-social behaviour is notably higher than the Borough average. Deliberate fires in Wentworth North are 6.8 per 1,000, just above the Rotherham average of 6.3 per 1,000. The Vulnerable Localities Index 2010 shows East Herringthorpe, south Thrybergh and part of Rawmarsh to be amongst the 10 most vulnerable neighbourhoods in Rotherham.

Figure 11.60 - Crime & ASB



# Area Assembly Needs Profile

## 11.6 Wentworth South

### Wentworth South Priorities 2009/10

#### Community Priority: Reducing the level and fear of crime and increase community safety

- Carry out additional motorcycle enforcement operations
- Engage young people who have been served by Acceptable Behaviour Contracts in positive activities to reduce re-offending rates
- Carry out test purchasing operations, to reduce under age alcohol sales
- Use the Neighbourhood Action Group (NAG) to identify hot spots within each neighbourhood and devise action plans to address the issues raised
- Put in place monthly PACT (Partners and Communities Together) meetings

#### Community Priority: Increasing facilities and activities for children and young people

- Create a Junior Warden Scheme which involves young people learning to look after their local area
- Provide "Out of Hours" youth provision (evenings, weekends and school holidays)
- Provide support for young people's sexual health
- Engage young people in challenging and stimulating activities

#### Community Priority: Improving standards of road and pavements and cleaner streets

- Clean up of "hot spot" areas
- Deliver "Grot Spot of the Month" clean-ups
- Implement works identified through the Streetpride Devolved Budget
- Hold an environmental themed Area Assembly meeting

#### Community Priority: Increasing employment opportunities and opportunities for access to learning new skills

- Work with local young unemployed people to gain a qualification whilst improving their environment
- Support a breakfast club to provide good quality, affordable childcare to enable parents to take up work
- Hold a Learning/Training Themed Area Assembly meeting

#### Community Priority: Increase community facilities and activities

- Provide weekly health trainer sessions
- Provide Active Always sessions – gentle exercise for over 50's
- Develop community plans to identify local priorities

## Area Assembly Needs Profile

### 11.7 Wentworth Valley

#### Overview

Wentworth Valley covers an elongated area in the east of the Borough covering 3,244 hectares (12.5 square miles). The population of 35,700 is concentrated in two urban areas. West of the M18 motorway are the parishes of

Wickersley and Bramley which form a single suburban area around the A631 Bawtry Road. Beyond the M18 is the small community of Hellaby and the town of Maltby. Maltby is a former mining community characterised by older social rented and private housing to

the east and modern private estates to the west. South of Maltby is the small village and parish of Hooton Levitt and a rural area including Roche Abbey.

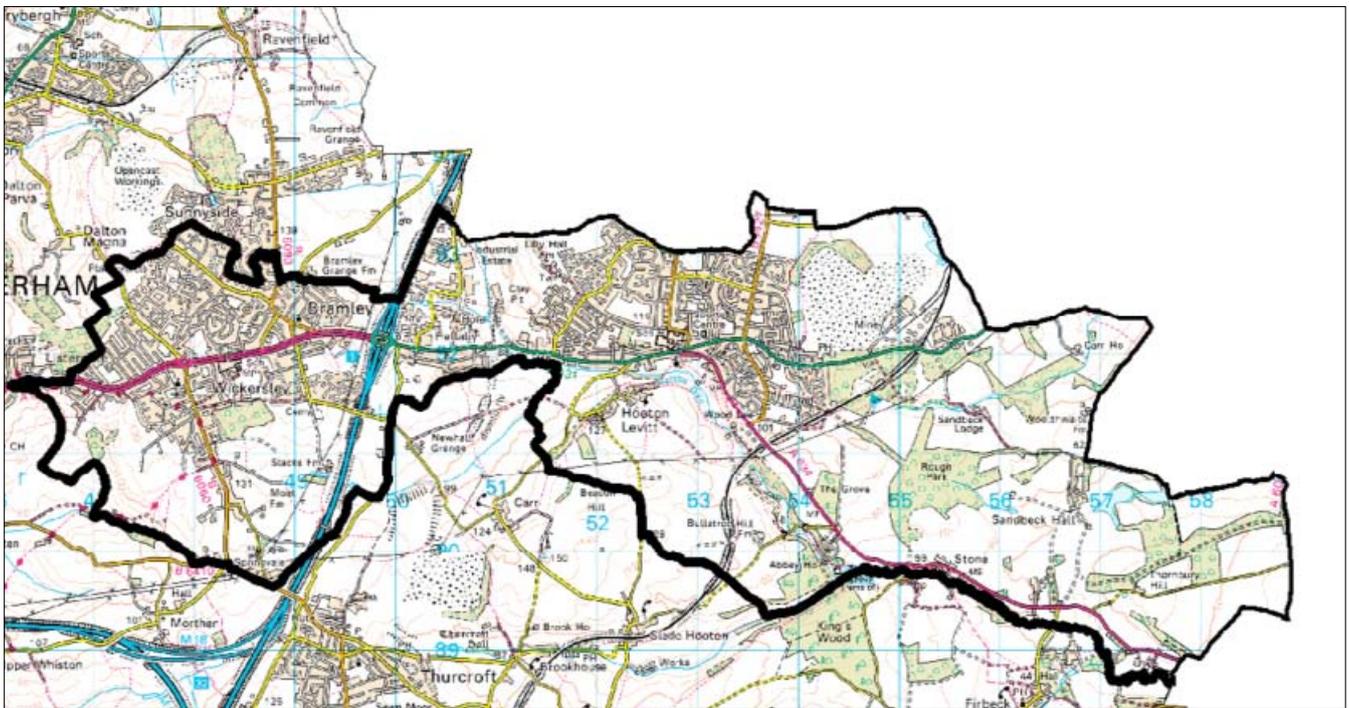


Figure 11.61

# Area Assembly Needs Profile

## 11.7 Wentworth Valley

### Population Estimates 2007

The graph below shows the total population of Wentworth Valley and estimated BME population. Wentworth Valley has a population of 35,700 which is the fourth largest of the Rotherham Area Assemblies. An estimated 1,102 people (3.1%) are from Black & Minority Ethnic (BME) groups and 5% of school age children (aged 4-15) are from BME communities. Based on Census definitions estimates the main religion in the area is Christianity (82%).

The age structure of Wentworth Valley's population is similar to the Borough average however there are slightly higher numbers of adults aged 45-64 and slightly lower numbers of children aged 0-14 and adults aged 25-44 in this Area Assembly. The projected population for Wentworth Valley in 2015 shows a slight decrease. As in all areas, the population is ageing. 30% of pensioners in Wentworth Valley live alone which is slightly below the Rotherham average of 32%.

Figure 11.62 - Population & Ethnicity of Wentworth South

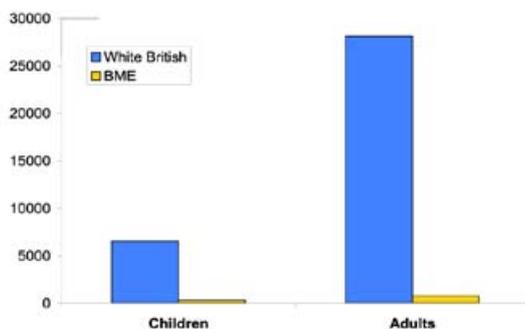
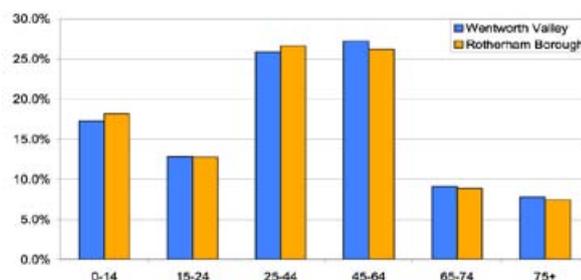


Figure 11.63 - Population by Age Group 2007

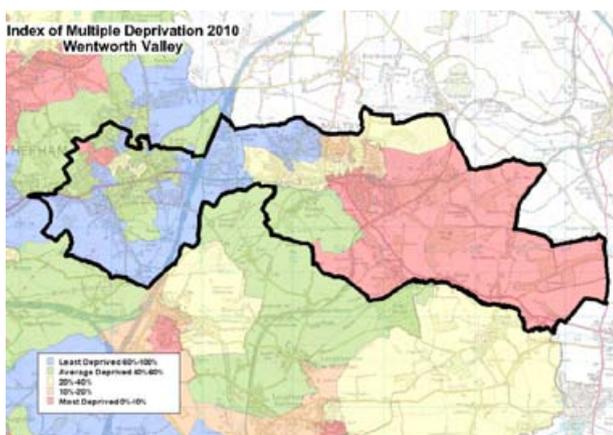


### Deprivation

Wentworth Valley is the fifth most deprived Area Assembly in Rotherham based on the Indices of Deprivation 2010. East Maltby and Flanderwell are the areas in Wentworth Valley that have high levels of deprivation (red areas on the map below). Neighbourhoods in Wentworth Valley which fall in the least deprived 40% of England are Hellaby, parts of Wickersley and Bramely, and north west Maltby (blue areas below).

Access to services is generally good in Wentworth Valley as in the whole of Rotherham. However, parts of the Hellaby and Maltby areas (yellow area on the top middle of the map) are the most deprived in terms of access to services which is mainly due to semi-rural locations. Deprivation is slightly below average as illustrated by the 19% of working age adults who are on workless benefits, below the Rotherham average of 20.9% and national average of 15.4%. 25.4% of households claim Council Tax or Housing Benefit, below the Borough average of 28.1%. 11.9% of school children are eligible for free school meals compared to 17.2% in Rotherham as a whole.

Figure 11.64 -



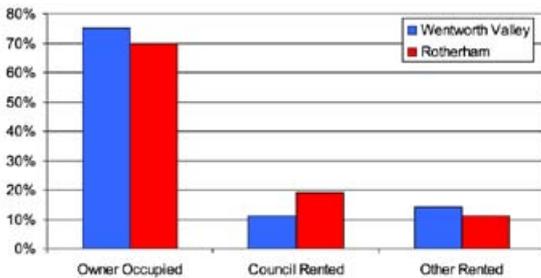
# Area Assembly Needs Profile

## 11.7 Wentworth Valley

### Housing

The great majority of homes in Wentworth Valley are owner occupied, the highest level being in Hellaby Ward. The proportion of council housing is below average and has fallen from 14% to 11% since 2001 as a result of Right to Buy sales. The other (mainly private) rented sector is above the Borough average, notably in Maltby.

Figure 11.65 - Housing Tenure



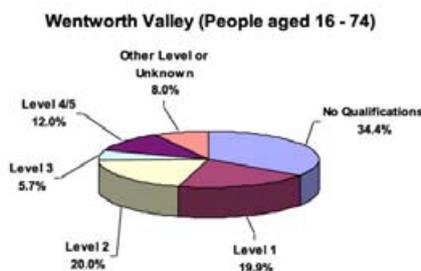
### Qualifications

Qualification levels in Wentworth Valley show higher than average numbers of people with Level 2 and Level 4/5 qualifications. The percentage with no qualifications in Rotherham is 36.8%; the comparable figure for the Wentworth Valley Area Assembly is 34.4%. The attainment of children and young people shows a similar pattern to adults with 47.2% of 16 year olds gaining 5+ GCSE's A\*-C in 2009, well above the 41% in Rotherham as a whole and just below the English average of 47.6%. 7% of 16-18 year olds were Not in Education, Employment or Training (NEET).

26% of young people in Wentworth North stay on at school or college after the age of 16 which is the higher than the Borough average but below the English average of 40%.

Figure 11.66 - Highest Qualification Level (aged 16 – 74)

(Source: 2001 Census Table KS13)



- Key:
- Level 1** = 1+ 'O' level passes, 1+ CSE/GSE any grades, NVQ level 1, Foundation GNVQ
  - Level 2** = 5+ 'O' level passes, 5+ CSEs (grades A-C), School Certificate, 1+ 'A' levels/'AS' levels, NVQ level 2, Intermediate GNVQ.
  - Level 3** = 2+ 'A' levels, 4+ 'AS' levels, Higher School Certificate, NVQ level 3, Advanced GNVQ.
  - Level 4/5** = First degree, Higher degree, NVQ levels 4 and 5, HNC, HND, Qualified Teacher Status, Qualified Medical Doctor, Qualified Dentist, Qualified Nurse, Midwife, Health Visitor

### General Health and Care Provision

Wentworth Valley has below the Borough average proportions of people who are not in good health, people providing unpaid care and people with a limiting long term illness.

Figure 11.67

General Health	Wentworth Valley % of Total Population	Rotherham % of Total Population	England % of Total Population
General Health 'Not Good'	11.3%	12.1%	9.0%
Limiting Long Term Illness (LLTI)	21.5%	22.4%	17.9%
People providing Unpaid Care	11.7%	12.2%	9.9%

1. General health refers to health over the 12 months prior to Census day.  
 2. Limiting long-term illness covers any long-term illness, health problem or disability, which limits daily activities or work.  
 3. A person is a provider of unpaid care if they give any help or support to family members, friends, neighbours or others because of long-term physical or mental health or disability, or problems related to old age.

# Area Assembly Needs Profile

## 11.7 Wentworth Valley

### Life Expectancy

The graph below shows the current life expectancy of men and women in the Wentworth Valley area assembly. Life expectancy for men is above the local average but slightly below the national average. For women life expectancy is above both the Borough and national average.

Figure 11.68 - Average life expectancy – years

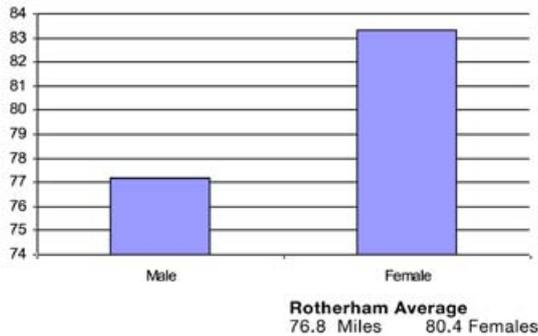
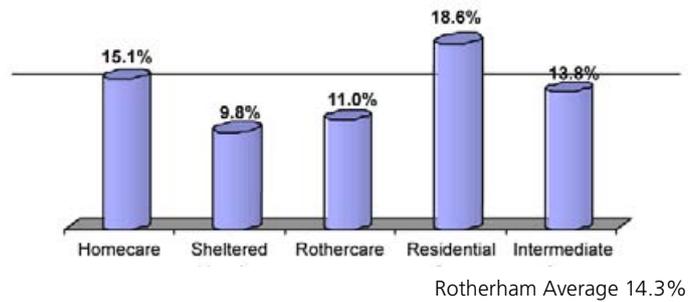


Figure 11.69 - Proportion of social care services delivered in Wentworth Valley



### Teenage Pregnancy

Conception rates for females aged 15-17 in Wentworth Valley are 5% which is in line with the Borough average of 5.1% but higher than the national average of 4.1%.

### Other Health Indicators

Hospital admissions for serious injury are 22.4 per 1,000 which is slightly above the Borough average. Low weight or still birth is below the Borough average at 7.5%. Smoking rates are in line with the Borough average at 25.3%.

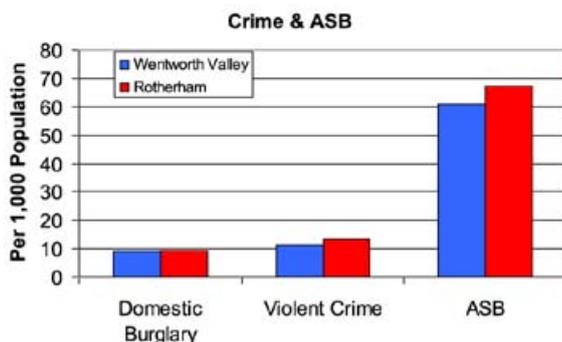
### Social Care Needs Assessment

Figure 11.69 shows the proportion of social care services received in Wentworth Valley in 2007/08. Wentworth Valley is a relatively low user of preventive social care services. It is however a higher user of direct social care compared to other assembly areas. It has the 3rd highest provision of homecare and the 2nd highest number of people living in residential care. Warden aided support in sheltered housing and Rothercare are 4.5% and 3.3% below the local average respectively.

### Crime & Anti Social Behaviour

Violent crime and Domestic Burglary is similar to the Borough average in Wentworth South. In contrast, anti-social behaviour is notably higher than the Borough average. Deliberate fires in Wentworth North are 6.8 per 1,000, just above the Rotherham average of 6.3 per 1,000. The Vulnerable Localities Index 2010 shows East Herringthorpe, south Thrybergh and part of Rawmarsh to be amongst the 10 most vulnerable neighbourhoods in Rotherham.

Figure 11.60 - Crime & ASB



# Area Assembly Needs Profile

## 11.7 Wentworth Valley

### Wentworth Valley Priorities 2009/10

#### Community Priority: Reducing crime and anti social behaviour and the fear of crime

- Increasing activities and facilities for young people
- Working with partners to develop multi-agency responses to crime and Anti Social Behaviour and increase awareness of the Safer Neighbourhood Team (SNT)
- Through the Neighbourhood Action Group (NAG) develop multi-agency action plans in hot spot areas.
- Hold monthly Partners and Communities Together (PACT) meetings to allow communities to have their say on what affects them

#### Community Priority: Increasing activities and facilities for young people

- Setting up a young people's working sub group to assist all young people's projects in the area
- Delivering a wide range of Area Assembly Devolved Budget projects Consulting with young people in hot spot areas to identify any gaps in provision
- Encouraging young people to become involved in the Young People's Area Assembly as well as active citizenship and local democracy
- Supporting the Play Pathfinder scheme to increase and improve play areas

#### Community Priority: Improving local environments – parks and open spaces, roads and streets

- Delivering the devolved budget 'Grot Spot of the month' projects where communities can identify and vote on where two clean ups per months will take place
- Improving access to information so that people know how they can get their issues addressed
- Working with partners and communities to develop a co-ordinated response to the issues communities raise
- Support delivery of the Streetpride devolved budget to fund small scale projects to improve local environments
- Support the delivery of the Play Pathfinder scheme to increase and improve play areas
- Offer an opportunity for community members to request a multi-agency walkabout in their area, to identify and address local problems

#### Community Priority: Employment opportunities and skill development

- Work with partner agencies to identify opportunities for people to access learning facilities within their own community
- Ensure opportunities for skill development are promoted within communities

#### Community Priority: Increase community activities and facilities

- Deliver Area Assembly Devolved Budget projects for a range of activities and facilities

- Introduce a £10,000 community chest small grant fund to enable local community groups to apply for a grant of up to £500
- Ensure events and activities are promoted through the Area Assembly Work with partners and communities to develop a co-ordinated response to the issues communities raise

# Glossary

Abbreviation	Definition	Abbreviation	Definition
<b>AAA</b>	Access All Areas	<b>DRE</b>	Delivering Race Equality
<b>ADL</b>	Adult Daily Living	<b>DWP</b>	Department of Works and Pensions
<b>AHDC</b>	Aiming High for Disabled Children	<b>GFR</b>	General Fertility Rate
<b>ALMO</b>	Arms Length Management Organisation	<b>GHS</b>	General Household Survey
<b>AMD</b>	Age-related Muscular Degeneration	<b>GLS</b>	General Lifestyle Survey
<b>APHO</b>	Association of Public Health Observatories	<b>GPs</b>	General Practitioners
<b>APS</b>	Annual Population Survey	<b>GUM</b>	Genito-Urinary Medicine
<b>ASC-CAR</b>	Adult Social Care Combined Activity Return	<b>HA</b>	Housing Association
<b>ASD</b>	Autism Spectrum Disorder	<b>HES</b>	Hospital Episode Statistics
<b>AT</b>	Assistive Technology	<b>HSE</b>	Health Survey England
<b>BME</b>	Black and Minority Ethnic Groups	<b>HSSA</b>	Housing Strategy Statistical Appendix
<b>BMI</b>	Body Mass Index	<b>IADL</b>	Instrumental Activities of Daily Living
<b>CAMHS</b>	Child and Adolescent Mental Health Service	<b>IAPT</b>	Improving Access to Psychological Therapies
<b>CASSRs</b>	Councils with Adult Social Services Responsibilities	<b>IHD</b>	Ischaemic Heart Disease
<b>CEMACH</b>	Confidential Enquiry into Maternal and Child Health	<b>ILO</b>	International Labour Organisation
<b>CHD</b>	Coronary Heart Disease	<b>IMD</b>	Index of Multiple Deprivation
<b>COPD</b>	Chronic Obstructive Pulmonary Disease	<b>IMR</b>	Infant Mortality Rate
<b>CSED</b>	Care Services Efficiency Delivery	<b>IPF</b>	Independent Property Forum
<b>CVD</b>	Cardio Vascular Disease	<b>JSNA</b>	Joint Strategic Needs Assessment
<b>DALYs</b>	Disability Adjusted Life Years	<b>KWILLT</b>	Keeping Warm In Later Life Project
<b>DCSF</b>	Department of Children, Schools and Families	<b>KSI</b>	Killed or Seriously Injured
<b>DH</b>	Department of Health	<b>LA</b>	Local Authority
<b>DMFT</b>	Decayed Missing and Filled Teeth	<b>LD</b>	Learning Disability
<b>DMIT</b>	Disease Management Information Toolkit	<b>LES</b>	Locally Enhanced Service
		<b>LGBT</b>	Lesbian, Gay, Bisexual, Transgender Communities
		<b>LINKs</b>	Local Involvement Networks
		<b>LIT</b>	Local Implementation Team
		<b>LSOA</b>	Lower Super Output Areas
		<b>NAS</b>	Neighbourhoods and Adult Services

# Glossary

Abbreviation	Definition	Abbreviation	Definition
<b>NCMP</b>	National Child Measurement Programme	<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>NCSP</b>	National Chlamydia Screening Programme	<b>QoF</b>	Quality Outcomes Framework
<b>NHS</b>	National Health Service	<b>QUEST</b>	Questionnaires in Standard Monitoring of Patients
<b>NI</b>	National Indicator	<b>RAP</b>	Referrals, Assessments and Packages data
<b>NIC</b>	Net Ingredient Cost	<b>RCHS</b>	Rotherham Community Health Service
		<b>RDASH</b>	Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
<b>NICE</b>	National Institute for Clinical Excellence	<b>RFT</b>	Rotherham Foundation Hospital Trust
<b>NIMH</b>	National Institute of Mental Health	<b>RMBC</b>	Rotherham Metropolitan Borough Council
<b>NINo</b>	National Insurance Number	<b>RNID</b>	The Royal National Institute for Deaf People
<b>NRS</b>	Neighbourhood Renewal Strategy	<b>RSL</b>	Registered Social Landlord
<b>NSF</b>	National Service Framework	<b>SAP</b>	Standard Assessment Procedure
<b>ONS</b>	Office of National Statistics	<b>SCRQOL</b>	Social Care Related Quality of Life
<b>PALS</b>	Patient Advice and Liaison Service	<b>SEPHO</b>	South East Public Health Observatory
<b>PANSI</b>	Projecting Adult Needs and Service Information System	<b>SHA</b>	Strategic Health Authority
<b>PCO</b>	Primary Care Organisation	<b>SMI</b>	Severe Mental Illness
<b>PCT</b>	Primary Care Trust	<b>SOA</b>	Super Output Area
<b>PD</b>	Personality Disorder	<b>STI</b>	Sexually Transmitted Infection
<b>PLASC</b>	Pupil Level Annual School Census	<b>SUDI</b>	Sudden, unexpected or unexplained death of an infant
<b>POPPI</b>	Projecting Older People Population Information System	<b>TFR</b>	Total Fertility Rate
<b>PPE</b>	Patient and Public Engagement	<b>TIA</b>	Transient Ischaemic Attack
<b>PSA</b>	Public Service Agreement	<b>TPS</b>	Taking Part Survey
<b>PSSRU</b>	Personal Social Services Research Unit	<b>WHO</b>	World Health Organisation

