Strategy to Tackle Health Inequalities In Cambridgeshire

A Framework for Action 2009-2011

Draft – February 2010

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- Community Wellbeing Partnership
- Children and Young People's Strategic Partnership
- Supporting People Partnership
- Adult Care and Transformation Group
- Health and Wellbeing Officer Group

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Narrowing the Health Inequalities Gap in Cambridgeshire : A Local Programme for Action

1. Introduction

1.1 The Cambridgeshire Health Inequality Strategy Challenges

The Cambridgeshire Health Inequality Strategy provides direction for addressing health inequalities across the county. There is already a range of existing strategies and plans in place at district and county levels that provide robust foundations for this Strategy It will be essential to ensure that there is an interface between these and the County Strategy that is visible, complementary and effective. The basis of this Strategy is that partners take a countywide view in tackling and responding to health inequalities. Avoiding duplication and conflicting initiatives will be a key objective for partners in order to effectively address inequalities within the current resource context.

1.2 Defining Health Inequalities

The Health Development Agency and Association of Public Health Observatories define health inequalities as:

"….differences between sections of the population which occur as a consequence of differences in social and educational opportunities, financial resources, housing conditions, nutrition, work patterns and conditions and unequal access to health services" (*Health inequality indicators: basket of local indicators: working draft.* 2003).

This definition is reflected in the aims and objectives found in this Strategy. They demonstrate that Cambridgeshire has a focussed collaborative approach and a commitment to addressing health inequalities.

1.3 Strategic Approach

To adopt a socio-environmental model of health is to ensure that the different layers of influence on health are recognised and addressed. Tackling health inequalities means tackling inequalities in these different areas. This approach was captured by the Health Development Agency (HDA, 2001: *Closing the gap: setting local targets to reduce health inequalities*.) in the following table. This lays out the dimensions to be considered if health inequalities are to be addressed and underlies this Strategy. The socio-environmental model has been reinforced more recently in Sir Michael Marmot's review 'Fair Society, Healthy Lives', together with the need to look at gradations in inequality across the board and promote social inclusion.

Table1: Examples of inequalities in health by level of health determinant, social parameter and key statutory influencer

Determinant of Health	Geography	Gender	Age	Ethnicity	Social Class
Natural environment	Geographical inequality in outdoor air pollution	Gender Inequality in safe use of green spaces	Inequality in accessibility of green spaces between age groups	Inequality in availability of green spaces between ethnic groups	Inequality in air pollution exposure between social classes
Socio-economic environment	Geographical inequality in housing tenure	Gender inequality in employment	Age inequality in job opportunities	Racial inequality in educational attainment	Social inequality in transport options
Lifestyles / health behaviour	Geographical inequality in access to fresh fruit and vegetables	Inequality in smoking rates between genders	Age inequality in opportunities for exercise	Racial inequality in smoking rates	Social inequality in alcoholism OR teenage conception
Access to effective services (health and social care)	Geographical inequality in access to primary care	Gender inequality in provision of surgical procedures	Age inequality in provision of surgical procedures	Racial inequality in access to appropriate health or social services	Social inequality in access to health information
Health outcomes	Geographical inequality in mortality rates	Gender Inequality in life expectancy OR morbidity	Age inequality in avoidable hospital admissions	Racial inequality in quality of life	Social inequality in oral health OR disability

1.4 Health Inequalities in Cambridgeshire

The Healthcare Commission and Audit Commission identified in their recent report, (*Are we Choosing Health,* 2008), that between 1997-2007 there is evidence of progress being made against the key national target. However there is a consensus that there remains a significant amount of work still to be done to both secure those gains and accelerate improvements against national targets.

In Cambridgeshire overall health and life expectancy are well above the national average but within this picture there are marked geographical and socio-environmental health inequalities in the county. These are closely linked with wider Index of Multiple Deprivation scores. Geographically the inequalities are present in both urban and rural areas, and are more concentrated in Fenland, the north and east of Cambridge city, North Huntingdon and the north of East Cambridgeshire, where lower levels of skills, income and greater health inequalities than the rest of the rural or urban economy are experienced. (Cambridgeshire's Vision 2007-2021). However specific vulnerable population groups such as Travellers, older people, people with disabilities, people who are on low incomes or unemployed, and homeless people are found across the county.

1.5 The Approach to Addressing Health Inequalities

This strategy is firmly based on an understanding of this local context, and the challenges faced in improving health and well being and addressing persistent health inequalities. Consequently the approach in Cambridgeshire is to target specific areas and population groups for improvement and includes the following elements.

Cambridgeshire's Approach to Addressing Health Inequalities

Understanding the problem:

- Using epidemiology, needs assessments, healthy equity audits and equality impact assessments with a focus on Joint Strategic Needs Assessment
- Using evidence of what works
- Ensuring that evaluation is undertaken where evidence does not exist

Joint Action:

- Ensuring that key county-wide and district strategies make an impact on health improvement and address health inequalities
- Making best use of existing resources evaluating the impact of new initiatives
- Ensuring commissioning plans and contracts are consistent with health inequalities objectives and targets.
- Using a community development approach to engage communities and families

Focus on what can be done and share best practice:

- Sharing learning between different areas in Cambridgeshire and between different organisations.

1.6 Structure of the Strategy

This document is divided into three sections.

Section One – Context and Evidence

- A description of the policy and wider strategic context of the Cambridgeshire Health Inequalities Strategy. It details the key national and local drivers to reduce health inequalities.

- Includes intelligence from Cambridgeshire's Joint Strategic Needs Assessment Phase 3 produced in December 2009, and earlier JSNA documents that have addressed the needs of particular population groups. This rich information and evidence is not fully reported and links can be found to the full documents.

Section Two – The Core Health Inequalities Strategy

- Strategic Aims:

Describes the strategic direction through the identification of four strategic aims.

- A Framework for Action:

    - Contains priority strategic objectives, key actions and partners. These represent a countywide collaborative approach to reducing health inequalities within the county. It also includes timelines for implementation from 2009-11.
    - The framework contains objectives, their key actions and interventions. These are the priorities that partners have agreed for reducing health inequalities. The key actions/interventions are divided into three categories to reflect their varying stages of development.

        - New collaborative interventions that are at early stage of discussion and development and have a **orange** timeline.
        - Agreed priority interventions that have been agreed and implementation has commenced and have an **yellow** timeline.
        - Agreed priority interventions that are well established and have a **green** timeline.

This is essentially a framework and beneath the aims and objectives there are or in development progress indicators and measurable outcomes.

Section Three – Existing Partner Strategies and Plans

This section details refers to the existing plans and strategies that support and provide a rich context to take forward the overarching Health Inequalities Strategy and Framework for Action. These are detailed documents and are continuously being updated and therefore only the electronic links to these are included.

Section 4 – Health Inequality Metrics

This section includes proposed metrics for health inequalities which will be used to monitor implementation of the Strategy. These metrics will need to be further tested and then embedded into governance and performance frameworks.

Section One: Context and Evidence

Section One – Context and Evidence

2. The Context of Health Inequalities

2.1 Policy Context

> WHO Europe target, 1999
>
> "By 2020 , the health-gap between socio-economic groups within countries should be reduced by at least one quarter in all member states by substantially improving the level of health of disadvantaged groups" [Target 2 Health 21 strategy]

There has been a long standing concern about those social and economic inequalities that lead to poorer health outcomes for some of our communities. The Black Report identified, nearly three decades ago, that an individual from the lowest social class is likely to have worse health through his or her life, and die younger, than someone better off (*Inequalities in health: report of a research working group* DHSS, 1980).

Subsequent inquiries (Acheson *Independent Inquiry into Inequalities in Health,* 1997) and White Papers (*Saving Lives: Our healthier nation 1999; Tackling Health Inequalities 2003; Choosing Health 2004*) have led to a greater focus on addressing health inequalities. Targets have been set to drive improvements, most particularly, focused on the concerns for life expectancy and premature mortality for those facing disadvantage.

In 2000, the *NHS Plan* (DH 2000) made explicit the commitment of Government to setting national health inequalities targets to improve services offered to the most deprived, women, children, and older people. By early 2001 the Government had announced two major health inequalities targets, designed to set the context in which local health inequalities strategies would be developed.

- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole.
- Starting with Health Authorities, by 2010 to reduce by at least 10 per cent the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole.

Tackling Health Inequalities: A Programme for Action, was published in July 2003 (DH) and was the first national health inequalities strategy. It established the foundations required to achieve the two national targets above.

A wide range of reports have supported the drive for improvement. These have given greater emphasis to public engagement and to the provision of support to encourage healthier lifestyles. These include:

The three Wanless reports, *Securing our Future Health: Taking a Long-term view,* (DH 2002) , *Securing Good Health for the Whole Population, (*DH 2004) and *Our Future Health Secured*? (Kings Fund 2007) covered the difference in health experienced by different parts of the community. The Wanless reports highlighted the need for a focus on prevention, improved access to services, and developing the evidence base for interventions and greater public engagement.

In 2004, the public health white paper *Choosing Health: Making Healthier Lifestyles Easier* was published. This White Paper set out the key principles for supporting the public to make healthier and more informed choices about their health. It proposed Government action to make information and practical support more freely available so that people are supported to improve their physical and emotional wellbeing.

Opportunity Age: Meeting the Challenges of Ageing in the 21st Century (HM Government, 2005) and *Don't Stop me Now* (Audit Commission 2008) emphasised the importance of tackling the wider determinants of health, particularly those relating to older people and their participation in their own health care and health improvement.

The social care Green Paper *Independence, Well-Being and Choice* (DoH 2005), emphasised the contribution older people can make to their own well-being, to their communities and to local and national economies. The White Paper *Our health, our care , our say* (DoH 2006) reinforced earlier messages and focused on the contribution people can make to staying healthy by adopting healthier life styles and understanding and managing their health when they are living with a long-term condition

The *Commissioning framework for health and well-being* (DoH 2007) proposed a framework that goes beyond traditional health and social care services to a focus on prevention and well being, together with community engagement in the commissioning process.

A number of other documents have subsequently described health inequality targets, or related health improvement targets These include *Tackling health inequalities: consultation on a plan for delivery* DH 2001 and *Tackling health inequalities: summary of the 2002 cross-cutting review* DH 2002. A series of 'Status Reports' have tracked progress on *Tackling Health Inequalities: A Programme for Action.* These 'Status Reports,' published in 2005 and 2007, both summarise the progress being made to deliver the health inequalities target and highlight the nature of the on-going challenge.

Most recently, '*Are we choosing health'* (Audit Commission/Healthcare Commission July, 2008) has reported on national polices that have sought to improve health and tackle inequalities over the period 1997 to 2007. The report argues for further progress to be made in achieving a healthier nation and more equal heath outcomes for all. This requires a renewed drive and focus by central government, local councils and healthcare organisations, the wider community and from individuals taking more responsibility for their own health.

Recommendations include :

- The requirement for clear, consistent ambitions and measurable objectives.
- The need for relevant, reliable and up-to-date information.
- A consistent focus across the NHS and Government.
- Putting the evidence of what works into practice.
- Providing sufficient capability and capacity.
- Commissioning for local need.
- Establishing clear accountabilities for commissioning and delivery.

Integral to the established policy framework is the importance attached to addressing equalities more generally and the development and provision of fair and equitable services which are responsive to the needs of the individual. Cambridgeshire is currently engaged in growth. An appreciation of spatial distribution and related issues of spatial equity is necessary to fully understand the potential for land use planning to impact on health inequalities. Concern has been expressed not to further inequalities, for example through transport policies and proposals. In developing planning policies there is an underlying commitment "to fairness so that all people can have a satisfying and healthy life".

In February 2010 the Marmot Strategic Review of Health Inequalities "Fair Society, Healthy Lives" was published. It acknowledged that health and life expectancy has improved for all, including those living in disadvantaged groups and areas. However narrowing the gap remains the key challenge. The Report emphasized the importance of reducing the social gradient of health and that action should focus upon all the determinants of health. A number of key policy objectives are identified and it was stressed that delivering these policy objectives will require action by central and local government, the NHS, the third and private sector and community groups. National policies will not be effective without local delivery systems focused upon health equity in all policies.

2.2 Strategic Context

The Cambridgeshire Health Inequalities Strategy has its foundations in the following partnership strategies and draft strategies:

- The Cambridgeshire Together Vision
- The Cambridgeshire Big Plan for Children and Young People
- The Sustainable Community Strategies for:
  - Cambridge City
  - East Cambridgeshire
  - Fenland
  - Huntingdonshire
  - South Cambridgeshire
- Rural Cambridgeshire: Ensuring a Vibrant Future
- The Cambridgeshire Alcohol Strategy
- Smoke Free Cambridgeshire and Peterborough Action Plan
- The Cambridgeshire Obesity Strategy

- The Cambridgeshire Teenage Pregnancy Strategy/Action Plan
- The Cambridgeshire Older People's Strategy
- The Supporting People Partnership Commissioning Strategy
- The Travellers' Health Strategy

There are also other strategies and plans that may impact on inequalities:

- Cambridgeshire Climate Change and Environment Strategy and Action Plan: Meeting the challenges in Cambridgeshire (2008)
  - Some actions will have relevant consequences, e.g. Action 9- .."shift towards more …healthy travel to school by March 2010" – this may prove easier to enact in urban areas and may widen the inequalities between rural and urban.
- Regional Social Strategy for the East of England: Action Plan 2007-2010
- East of England Implementation Plan (Economic) DRAFT April 2009
  - Some actions will have relevant consequences, e.g. affordable housing being included in growth areas, and transport structure deficit being addressed, specifically the A14. The A14 improvements may impact on road injuries and deaths.
- EEDA Business Plan 2007-2011: Investing in Communities in Cambridgeshire.
  - This has two significant strands: up-skilling and social enterprise both aimed at addressing barriers to employment for BME and those with limiting illness and those in most deprived communities e.g. Wisbech, North Huntingdon and areas in north and east Cambridge.
- Cambridgeshire Sub-region Housing Strategy 2004-9
  - Some actions will have relevant consequences, specifically those addressing homelessness, increasing affordable housing, supported housing and funding for grants for disabled facilities.
- Towards the Best Together : A Clinical Vision for the NHS in the East of England.
  - This has a focus on health inequalities, access to healthcare for marginalised groups in 'pledges' 8 and 9.

In addition, elements which will be key to addressing health inequalities are described in individual organisational strategies:

- The NHS Cambridgeshire Strategic Plan.
- The Cambridgeshire County Council Integrated Plan.
- Corporate Plans for District Councils. There is a particular emphasis on health inequalities in the Fenland Corporate Plan, which is the area in Cambridgeshire experiencing the highest level of inequalities.

3. Local Context Summary

3.1 Cambridgeshire Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment produced in 2009 gives a comprehensive overview of the demographics, health needs and health inequalities in Cambridgeshire The following describes some of the key health inequalities found in Cambridgeshire. These are fully described in the JSNA which can be found at
http://www.cambridgeshirepct.nhs.uk/documents/About%20Us/Public%20Health/Joint%20Strategic%20Needs%20Assessment%20for%20Cambridgeshire%20-%20Phase%203%20-%20January%202010.pdf?preventCache=12%2F01%2F2010+14%3A33
The mid-2008 estimate for the Cambridgeshire population was 595,600. The following table indicates how this is distributed across the districts.

Table 2: Cambridgeshire County Council demography of population:

Local Authority	Population
Cambridge City	117,700
East Cambridgeshire	79,400
Fenland	92,900
Huntingdonshire	163,100
South Cambridgeshire	142,500
Cambridgeshire	595,600

Source: Cambridgeshire County Council Research Group
Definition: Mid 2008 population estimates

The noticeable difference in age distribution within the districts is in Cambridge City which has a noticeably higher proportion of people aged 15-34 years. This is due to the high student population in the district. In general, most local authorities in Cambridgeshire have small proportions of minority ethnic residents. However, Cambridge City has higher proportions of minority ethnic groups than England and Wales, with a higher proportion of people from 'Chinese or Other Ethnic Groups'. The minority ethnic groups in Cambridge include a high proportion of students and professionals. Cambridgeshire also has considerable populations of Travellers and migrant workers.

The following table shows that Cambridgeshire county as a whole is among the 20% least deprived top tier local authorities in England. However at District Council level, there is considerable variation, with South Cambridgeshire and Huntingdonshire both being within the 20% least deprived second tier authorities nationally, while Fenland is in the 40% most deprived

Table 3: Indices of Deprivation 2007, Local Authority, average of LSOA scores

Local Authority	IMD 2007 score (average of LSOA scores)	LA rank (England)*
Fenland	20.50	139
Cambridge	13.87	236
East Cambridgeshire	10.84	285
Huntingdonshire	9.31	311
South Cambridgeshire	6.55	350
Cambridgeshire	11.49	135

NB: *LA rank (England): *the rank for 5 district authorities represents the relative rank within the 354 tier 2 local authorities in England where rank 1 is the most deprived authority and rank 354 the least deprived. The rank for Cambridgeshire represents the relative rank within the 149 tier 1 local authorities where rank 1 is the most deprived authority and rank 149 the least deprived.*

Source: The English Indices of Deprivation 2007, Department for Communities and Local Government (DCLG)

Definition: The English Indices of Deprivation 2007 include domains at lower super output area (LSOA) for income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services housing, living environment deprivation and crime. An average score has been calculated for each local authority district based on LSOA scores weighted according to their population. This measure takes into account the full range of scores across a district and averages the LSOA scores in each district after they have been population weighted.

These wards in the next table are the 20% of wards in Cambridgeshire with the highest deprivation score. The majority of wards are in Fenland, then Cambridge, although there are pockets of deprivation in all of the districts.

Table 4: Index of Multiple Deprivation, 2007 : fifth most deprived wards in Cambridgeshire

Local Authority	Ward name	IMD Score
Fenland	Waterlees	41.52
Fenland	Clarkson	32.83
Fenland	Medworth	32.01
Fenland	Staithe	31.21
Huntingdonshire	Huntingdon North	27.00
Fenland	Elm and Christchurch	25.73
Fenland	Parson Drove and Wisbech St Mary	25.39
Cambridge	King's Hedges	25.10
Fenland	Hill	24.41
Fenland	Kirkgate	24.36
Fenland	Kingsmoor	23.01
Cambridge	Abbey	21.93
Fenland	Roman Bank	21.24
Fenland	Peckover	20.42
Fenland	March East	20.08
Cambridge	East Chesterton	20.03
East Cambridgeshire	Littleport West	19.47
Cambridge	Arbury	18.97
Fenland	March North	17.83
Fenland	Lattersey	17.24
Fenland	Birch	16.78
Fenland	March West	16.49
East Cambridgeshire	Littleport East	16.48
Fenland	Wenneye	16.06
Fenland	Wimblington	15.55

Source: The English Indices of Deprivation 2007, Department for Communities and Local Government (DCLG)
Definition: The fifth most deprived wards in Cambridgeshire

Access to transport is of key importance in a rural county like Cambridgeshire. At the time of the 2001 census Cambridge City had the highest proportion of households without access to a car or van. This may be less of an issue within such an urban area due to public transport provision and the proximity to services. One in five households in Fenland did not have access to a car or a van.

3.1.1 Access and Economic Limiters

Table 5: No access to a car or van : total population, 2001

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

Source : Census 2001 © Crown Copyright 2003.
Definition: Number and proportion of all households living in households with no access to a car or van.

3.1.2 Education

Level of education is linked to health and well being outcomes. Educational achievement varies greatly within the districts of Cambridgeshire. In 2008, Fenland had a noticeably low percentage of pupils attaining five or more GCSE grades A*-C, with less than 53% of such pupils. This compares to over 75% of South Cambridgeshire pupils achieving these grades.

Table 6: Education : GCSE attainment, 5 or more A*-C, 2008

Area	No. of pupils achieving 5+ GCSE grades A*-C	% pupils achieving 5+ GCSE grades A*-C
Cambridge City	472	60.7
East Cambridgeshire	463	61.9
Fenland	509	52.4
Huntingdonshire	1,240	64.7
South Cambridgeshire	1,140	77.2
Cambridgeshire	**3,922**	**64.9**

Source: Children and Young People's Services, Cambridgeshire County Council.
Definiton: Percentage of pupils aged 15 and over who achieved five or more GCSE grades A-C, 2008.*

3.1.3 Life Expectancy

Life expectancy in the different areas of Cambridgeshire closely mirrors socio-economic circumstances, as indicated by IMD scores. Life expectancy for both males and females is lowest in Fenland and highest in South Cambridgeshire. Although, overall, life expectancy is better than the national average, female life expectancy in Fenland was significantly below the national average in 2006-08.

Life expectancy in the 20% of Middle Level Super Output Areas (MSOAs) in Cambridgeshire with the higher levels of deprivation is statistically significantly lower than all other groups of MSOAs (based on 2007 quintiles of deprivation) and the county and national average. Most of these MSOAs are in Fenland, but some are in north east Cambridge, Huntingdon and East Cambridgeshire. There is a similar picture for deaths aged under 75 from heart and circulatory disease, which are higher in the 20% more deprived areas.

3.1.4 Health Inequalities and Vulnerable Groups

Children and Young People

In Cambridgeshire, 8% of Reception pupils and 16% of Year 6 pupils are obese (NCMP 2008/09). 59% of Year 8 and 51% of Year 10 pupils in Cambridgeshire reported that they exercise hard at least 3 times a week in 2006. Around one in six boys and one in five girls aged 14-15 smokes occasionally or regularly (Health Related Behaviour Survey, Cambridgeshire 2008). Nearly a quarter of Year 8 children had had an alcoholic drink in the last week and nearly a half of Year 10 children (Ibid). About 290 under 18-year olds become pregnant every year (about one in 37 girls in the 15-17 age group). The teenage conception rate is highest in Fenland, Cambridge City and Huntingdonshire.

Vulnerable children include those who experience learning or physical disabilities, neglect and other adverse social environmental factors. They often experience multiple health issues e.g. mental health. These “children in need” are defined as those who need additional services in order to attain a reasonable standard of health and development. In Cambridgeshire there around 3,500 children who could have some form of disability. There is not at present robust data and it has been estimated that up to 50% of children with a learning difficulty experience emotional/mental health problems at some time in childhood.

Older People

There are an estimated 92,700 people aged 65 or over (16% of the total population) Fenland has the highest proportion of older people with over 19% of residents aged 65+. By 2021, the population aged 65+ in Cambridgeshire is forecast to increase by 54% (about 50,000 people). The population aged 75+ is forecast to increase by 54% between 2008 and 2021 and this increase is spread unevenly across districts, with a predicted 80% increase in South Cambridgeshire, 65% in Huntingdonshire, 47% in East Cambridgeshire, 33% in Fenland and 27% in Cambridge City in people aged 75 and over.

The pattern of income deprivation for older people is more dispersed than that for children and working age adults, with eight of the most affected small areas in Cambridge, seven in Fenland and five in Hunts – and more small areas of income deprivation in rural villages. The proportion of older people claiming benefits in Cambridgeshire is well below the national average. Cigarette smoking is implicated in eight of the top 14 causes of death for people aged 65 and over. The increase in the older population is creating a demand for accessible health, healthcare and social services that contribute to their health.

3.2 Other Vulnerable Groups

The JSNA and more recently specific needs assessment have identified inequalities in health amongst the following vulnerable groups that can be found throughout the county or concentrated in particular areas.

- People with disabilities (JSNA)
- Travellers
- Migrant populations
- People who are homeless
- Prisoners/Refugees/Immigrant populations

Morbidity and mortality rates indicate that these groups experience a range of health inequalities and also are affected by key socio-economic and access issues that determine these health outcomes.

3.3 Inequalities and Lifestyles – Regional and National Studies

Two recent studies provide information about inequalities in lifestyles that are key in determining health and well being

3.3.1 Health and Lifestyle Survey - Cambridgeshire Autumn 2008

The tables on the following two pages show the results for Cambridgeshire of a recent Health and Lifestyle Survey undertaken across the East of England SHA area. The results of the survey have been analysed to show differences in lifestyle factors between the 20% most deprived areas in Cambridgeshire and the rest of the county and key findings are as follows:

1. Social grade: 24% of the people surveyed from the 20% most deprived MSOAs * were unskilled or semi-skilled manual workers or on state benefit, compared with 12% in the rest of the county.

2. Long term limiting illness or disability: 17% of people surveyed in the 20% most deprived MSOAs had a long term limiting illness or disability, compared with 13% in the rest of the county.

3. Smoking: Smoking rates were 22% in the 20% most deprived areas compared with 14% in the rest of the county. This will have a significant health impact.

4. Obesity: Obesity rates were 17% for men and 19% for women in the 20% most deprived MSOAs compared with 11% for men and 12% for women in the rest of the county (note: people systematically underestimate their body mass in telephone/verbal surveys – therefore these figures will be lower than those that would be obtained in a survey which actually measured height and weight).

5. Eating fruit and vegetables: 42% of people surveyed in the 20% most deprived areas ate five pieces of fruit and vegetables 5-7 times a week, compared with 49% in the rest of the county.

6. Belonging to a black or minority ethnic group, unhealthy levels of alcohol consumption, and low physical activity levels were **not** more likely for people living in the 20% most deprived geographical areas.

* Super Output Areas. SOAs are a unit of geography used in the UK for statistical analysis. There are three layers of SOAs. Lower Super Output Area (LSOAs) - Minimum population 1000, mean population 1500. Middle Super Output Area (MSOAs) - Minimum population 5000, mean population 7200. Upper Super Output Area (USOA)

Table 7:Results of East of England Health and Lifestyle Survey in Cambridgeshire Autumn 2008

	Indicator	20% most deprived MSOAs	80% least deprived MSOAs	PCT	East of England
Ethnicity	White British	90.9% (88.4%, 92.9%)	88.1% (86.6%, 89.4%)	88.8% (87.5%, 89.9%)	90.7% (90.4%, 91.1%)
	White Other	6.5% (4.8%, 8.7%)	7.3% (6.3%, 8.6%)	7.2% (6.2%, 8.2%)	4.5% (4.3%, 4.8%)
	Black and minority ethnic groups (BME)	2.6% (1.6%, 4.2%)	4.5% (3.7%, 5.5%)	4.1% (3.4%, 4.9%)	4.7% (4.5%, 5.0%)
Social Grade	A/B - managerial and professional	18.7% (15.9%, 22.0%)	32.2% (30.2%, 34.2%)	29.1% (27.4%, 30.8%)	23.6% (23.1%, 24.1%)
	C - skilled manual workers, clerical and junior managerial and professional	54.7% (50.8%, 58.6%)	54.0% (51.8%, 56.2%)	54.2% (52.3%, 56.1%)	54.0% (53.4%, 54.6%)
	D/E - semi- and un-skilled manual workers and those on state benefit	24.1% (20.9%, 27.6%)	11.5% (10.2%, 13.0%)	14.4% (13.2%, 15.8%)	20.1% (19.7%, 20.6%)
Working Status	In full time employment	41.5% (37.6%, 45.4%)	44.5% (42.3%, 46.6%)	43.8% (41.9%, 45.7%)	42.9% (42.3%, 43.5%)
	In part time employment	13.9% (11.4%, 16.8%)	13.4% (12.0%, 14.9%)	13.5% (12.3%, 14.8%)	13.5% (13.1%, 14.0%)
	Retired	23.8% (20.6%, 27.3%)	21.0% (19.3%, 22.8%)	21.6% (20.1%, 23.2%)	24.0% (23.5%, 24.6%)
	Not working for any other reason (incl unemployed, student, disabled, carer)	20.8% (17.8%, 24.2%)	21.2% (19.4%, 23.0%)	21.1% (19.6%, 22.7%)	19.5% (19.0%, 20.0%)
Self perception of Health	Good	79.6% (76.2%, 82.6%)	79.8% (78.0%, 81.5%)	79.8% (78.2%, 81.3%)	77.2% (76.7%, 77.8%)
	Poor	5.1% (3.6%, 7.1%)	4.6% (3.8%, 5.6%)	4.7% (4.0%, 5.6%)	5.2% (4.9%, 5.4%)
LLTI	Has long-term limiting illness/disability	16.8% (14.1%, 20.0%)	12.7% (11.3%, 14.2%)	13.6% (12.4%, 15.0%)	16.3% (15.8%, 16.7%)
BMI	Male – overweight	32.9% (27.8%, 38.5%)	37.0% (34.1%, 40.0%)	36.1% (33.6%, 38.7%)	39.6% (38.8%, 40.5%)
	Male – obese	16.9% (13.1%, 21.6%)	11.1% (9.3%, 13.2%)	12.4% (10.7%, 14.3%)	14.2% (13.6%, 14.8%)
	Female – overweight	25.9% (21.5%, 31.0%)	24.2% (21.7%, 26.9%)	24.6% (22.4%, 27.0%)	27.0% (26.3%, 27.8%)
	Female – obese	18.8% (14.9%, 23.4%)	12.3% (10.4%, 14.4%)	13.8% (12.1%, 15.8%)	13.8% (13.2%, 14.4%)
Smoking	Smoking prevalence	21.8% (18.7%, 25.2%)	13.8% (12.4%, 15.3%)	15.6% (14.3%, 17.1%)	18.4% (18.0%, 18.9%)
	Proportion of current smokers who would like to quit	60.6% (52.1%, 68.4%)	63.6% (57.9%, 69.0%)	62.6% (57.9%, 67.2%)	65.4% (64.1%, 66.7%)
Alcohol	Male - Hazardous drinkers (22-50 units per week)	22.2% (17.8%, 27.3%)	23.0% (20.5%, 25.6%)	22.8% (20.6%, 25.1%)	20.2% (19.5%, 20.9%)

	Indicator	20% most deprived MSOAs	80% least deprived MSOAs	PCT	East of England
	Indicator	**20% most deprived MSOAs**	**80% least deprived MSOAs**	**PCT**	**East of England**
	Male - Harmful drinkers (51+ units per week)	5.8% (3.6%, 9.1%)	6.7% (5.4%, 8.4%)	6.5% (5.3%, 8.0%)	6.5% (6.1%, 6.9%)
	Female - Hazardous drinkers (15-35 units per week)	12.1% (9.0%, 16.2%)	12.4% (10.5%, 14.5%)	12.3% (10.7%, 14.2%)	12.3% (11.8%, 12.9%)
	Female - Harmful drinkers (36+ units per week)	1.8% (0.8%, 3.9%)	2.8% (2.0%, 4.0%)	2.6% (1.8%, 3.5%)	2.6% (2.3%, 2.8%)
5-a-day	Eats 5 portions of fruit or vegetables < 1 day per week	12.0% (9.7%, 14.8%)	12.3% (11.0%, 13.8%)	12.3% (11.1%, 13.6%)	14.4% (14.0%, 14.8%)
	Eats 5 portions of fruit or vegetables 5-7 days per week	41.8% (38.0%, 45.8%)	48.6% (46.4%, 50.7%)	47.0% (45.1%, 48.9%)	41.7% (41.1%, 42.3%)
Exercise	Male - doing the recommended amount of exercise	52.0% (46.3%, 57.7%)	44.8% (41.8%, 47.9%)	46.4% (43.8%, 49.1%)	46.7% (45.8%, 47.6%)
	Female - doing the recommended amount of exercise	43.6% (38.3%, 49.1%)	46.7% (43.6%, 49.7%)	45.9% (43.3%, 48.6%)	39.2% (38.4%, 40.0%)
Healthy Behaviour	Four healthy behaviours - non-smoker, moderate drinker, recommended exercise, 5-a-day	12.6% (10.2%, 15.5%)	15.9% (14.4%, 17.6%)	15.1% (13.8%, 16.6%)	11.1% (10.7%, 11.4%)

Highlighted when a significant inequality exists within the PCT

Key to PCT colouring
When high or low values cannot be interpreted as good or bad these colours are used:

Worse than East of England	Similar to East of England	Better than East of England
Lower than East of England	Similar to East of England	Higher than East of England

3.4 Other Local Evidence

In addition to the JSNA there have been other specific studies undertaken by a range of agencies. For example the Mapping Poverty Reporting that will be undertaken across the county will also be rich source of data.

4. Delivery and Governance

4.1 County-wide Governance

County-wide cross agency leadership for Cambridgeshire sits with the 'Cambridgeshire Together' Board which oversees the Local Area Agreement. The overall aims and objectives the CT Board are set out in the Cambridgeshire Vision. The Cambridgeshire Vision has five key themes of which one is Equality and Inclusion and tackling health inequalities sits within this theme.

The Cambridgeshire Together Board is supported by a sub-structure of county-wide Thematic Strategic Partnerships. Two Thematic Strategic Partnerships address the theme of Equality and Inclusion – the Community Wellbeing Partnership and the Children's Trust.

The **Community Wellbeing Partnership** consists of Local Authority Members from the County Council and each of the District Councils, together with Non-Executive Directors from NHS Cambridgeshire. Representation is also invited from the other organisations making up Cambridgeshire Together, including the Police, Fire Service, Voluntary Sector and Private Sector as well as the probation service.

The Community Wellbeing Partnership is supported by three officer groups:

- The Health and Wellbeing Officer Group, which has been leading on Health Inequalities including taking forward the response to the 2008 Audit Commission Report.
- The Adult Care and Transformation Group, which works on commissioning of health and social care for vulnerable adults and older people – this will shortly be merging with the Health and Wellbeing Officer Group
- The Supporting People Partnership (which is a joint member/officer group) which leads the commissioning of support for vulnerable people in housing.

The **Cambridgeshire Children's Trust** is the sum total of co-operative arrangements and partnerships between organisations with a role in improving outcomes for children and young people. The Cambridgeshire Children's Trust Board is the statutory group for ensuring that the Trust arrangments work in Cambridgeshire. The purpose of the Children's Trust Board is to set the strategic direction and commissioning of services in Cambridgeshire in order to improve outcomes for children and young people. The way this will be done is through the BigPlan2 and Children's Workforce Strategy.

Supporting the Board in delivering this work are:

- the Children's Trust Executive
- the Children & Young People's Area Partnerships

4.2 Local Strategic Partnership (District) Governance

Each district authority in Cambridgeshire has its own Local Strategic Partnership (LSP) with wide-ranging membership from public sector and independent sector organisations. Each LSP has its own Sustainable Community Strategy. The Sustainable Community Strategies in each district

include actions to address locally identified issues related to health, well-being and health inequalities .

Each LSP has its own Board and Executive and most have strategic groups that are arranged on themes. Health & well-being or Health Improvement are common themes. The LSPs from South Cambridgeshire and from Cambridge City are merging to form a joint LSP.

4.3 Local Area Agreement

Cambridgeshire's most recent Local Area Agreement (June, 2008) targets (2008/11) sets out the range of indicators covering specific commitments to equality and inclusion, covering several of the wider determinants of health, together with specific health improvement and health and care service targets. Delivery on these indicators is supported by the respective planning processes of partners.

Overview of delivery against LAA targets is carried out by the Partnership Structures sitting under the Cambridgeshire Together Board, as outlined under 4.1 and 4.2.

Cambridgeshire LAA targets which specifically address health issues which are more common in the 20% most deprived areas in Cambridgeshire or in vulnerable communities include (lead partnership in parentheses):

- Reducing all age all cause mortality in the 20% most socio-economically deprived areas in Cambridgeshire
- Under 18 conception rate
- Effectiveness of child and adolescent mental health services.
- Services for disabled children.
- Obesity among primary school children in year 6.
- Hospital admissions caused by unintentional and deliberate injuries to children and young people.
- 16+ current smoking prevalence (proxy: smoking quitter numbers).
- People killed or injured in road traffic accidents.
- Achieving independence for older people through rehabilitation and intermediate care.
- Carers receiving needs assessment or review and a specific carers service or advice and information.
- Number of vulnerable people achieving independent living.

4.4 Performance management

Effective performance management is critical to the delivery of this strategy. In developing our approach, we recognise that tackling health inequalities is a multi-agency effort that requires organisations to work together.

The performance management arrangements for this strategy recognise the important contributions made by individual organisations as well those made by the broader partnership. Specific arrangements for both the organisational and partnership approach are set out under the sub headers below:

4.5 Partnership arrangements

Through the Cambridgeshire Together board, Strategic Thematic Partnerships and their sub-groups, Local Strategic Partnerships and their thematic-groups, there are effective arrangements in place to performance manage partnership plans to tackle health inequalities in Cambridgeshire. A summary of these arrangements is set out below:

Cambridgeshire Together:

- maintain a strategic overview of LAA performance through regular performance reports with a focus on exception reporting;
- address issues referred by the thematic partnership boards through exception reports;
- are aware of issues of underperformance and to ensure that relevant steps are being taken to address these;
- have oversight of progress against the thematic priorities in the Cambridgeshire Together Vision.

Adult Equality and Inclusion – Community Wellbeing Partnership:

- take a strategic overview of health inequalities, including performance against the relevant LAA targets and regular review of the metrics outlined in this Strategy;
- identify opportunities for joint working and sharing of good practice to address priorities;
- address risks and obstacles.

Cambridgeshire Children's Trust Board

- Takes an overview of all issues which relate to the wellbeing of children and young people in the county, including health inequalities.

Local Strategic Partnerships:

- maintain a strategic overview of local performance through regular performance reports with a focus on exception reporting;
- are aware of local issues of underperformance and ensure that relevant steps are being taken to address these;
- have oversight of progress against the priorities in the LSP Sustainable Community Strategy, and local progress against the Cambridgeshire LAA targets.

Local Health Partnerships

- monitor performance against plans to address local aspects of health inequalities, and the relevant LAA targets;
- make local decisions about how best to work in partnership to address performance issues.

Organisational arrangements

Individual organisations have specific responsibilities to oversee and manage performance. A summary of these responsibilities is set out below:

- set ambitious and challenging targets in line with existing performance frameworks/ benchmarks;
- regularly monitor and challenge performance at officer and governance level;
- ensure that delivery/ service plans are in place for all indicators;
- assure the quality of data;
- report performance in line with the requirements of external regulation.

4.6 Performance Reporting Infrastructure

A web-based performance reporting system (CORVU) has been put in place, to be used by Cambridgeshire Together partners when performance reporting on LAA targets and National Indicators. This is now operational and involves performance officers from different organisations, who meet regularly.

Section Two: Cambridgeshire Health Inequalities Strategy: A Framework for Action

5. Cambridgeshire Health Inequalities Strategy and A Framework for Action 2009- 2011

5.1 Introduction

In Cambridgeshire there is a range of action plans and initiatives that have been drawn up to address health inequalities. The intrinsic importance of this Strategy is that it contains countywide collaborative strategic aims and objectives that are in addition to those found in existing strategies. They complement the vision that addressing health inequalities across the county demands that the LAA partners collectively agree the strategy, its aims and objectives and commit to collaborative interventions.

5.2 Strategic Aims

This document identifies four new overarching strategic aims that are underpinned by strategic objectives that have named lead partners and timelines

1. **To decrease the health inequalities and poverty found in the most socio-economically deprived areas in Cambridgeshire.** These are mostly found in the 20% most deprived Middle Super Output Areas (MSOAs) areas. These are predominantly in Fenland but also MSOAs in Huntingdonshire, East Cambridgeshire and Cambridge City. There are also smaller areas that experience socio-economic deprivation.

2. **To decrease access inequalities that impact on health and well being.** Table 1 (P2) indicates the range of socio-environment factors and identifies the impact of access across a number of domains. Cambridgeshire is predominantly a rural county and consequently is susceptible to experiencing health inequalities created by poor access to services and opportunities to a healthy lifestyle. Across the whole county, in some geographical areas, in vulnerable and certain population groups access factors are key in producing health inequalities.

3. **To decrease the health inequalities experienced by vulnerable groups that exist within the Cambridgeshire population.** These inequalities are shaped by a number of determinants including age and access issues. The JSNA identifies children and young people, older people and those with disabilities and mental health problems experiencing health inequalities. Subsequent needs assessments also identified travellers, migrant workers, prisoners and the homeless as groups experiencing health inequalities or inequity of service provision.

4. **To prevent the creation of new health inequalities.** The County is receiving funding to provide quality new homes and the necessary supporting services and facilities, which will assist the continued economic growth of the area to benefit both the existing and new communities. Planning policies require an underlying commitment to fairness so that all people, especially the vulnerable groups can access the services and opportunities needed for a satisfying and healthy life. The growth agenda is about more than just building new houses but it provides the opportunity to create environmentally sustainable developments and to provide infrastructure that supports healthy equitable communities. This includes creating environments that support physical activity, good social networks which have positive effect of physical and mental health, key services and facilities, including access to and appropriate provision of health services, and good transport links ensuring that all communities are able to access services and opportunities. Alongside these there needs to be an equitable distribution of economic prosperity and social opportunity with an increase in economic opportunities for disadvantaged communities and vulnerable groups.

5.3 A Framework for Action

- Contains priority strategic objectives, key actions and partners. These represent a countywide collaborative approach to reducing health inequalities within the county. It also includes timelines for implementation from 2009-11.
- The framework contains objectives, their key actions and interventions. These are the priorities that partners have agreed for reducing health inequalities. The key actions/interventions are divided into three categories to reflect their varying stages of development.

    - ❖ New collaborative interventions that are at early stage of discussion and development and have a **orange** timeline.
    - ❖ Agreed priority interventions that have been agreed and implementation has commenced and have an **yellow** timeline.
    - ❖ Agreed priority interventions that are well established and have a **green** timeline.

5.3 A Framework for Action

Strategic Objective 1: To decrease health inequalities found in the most socio-economically deprived areas in Cambridgeshire

No.	Outcome	Key Actions	Timeline	Partners Lead (L)
1.1	Health Inequalities in Fenland are fully addressed by the County Council	• Appointment of County Council Director with a specific role for ensuring that all County Council services are contributing to the reduction of inequalities in Fenland • Main Links with key partners to ensure effective joint working • Lead role in County Council for Community Engagement	2009 Appointment made	Cambs County Council (L) FDC
1.2	Improving outcomes for school age children in Fenland	• Building Schools for the Future Programme	2009 Commenced	EC& Fen Children & Young People's Area Partnership Children's Trust Fenland District Council NHS Cambs.
1.3	Further improvements in the 20% most deprived areas - Fenland - North Huntingdon - Littleport - North Cambridge	• Build on the improvements in the 20% most deprived areas. • Key actions to improve determinants of health locally include play strategy, leisure facilities, community development and engagement.	ongoing	FDC (L) ECDC (L) HDC.(L) CC (L) NHS Cambs
1.4	Secure economic regeneration and employment improvements	Economic regeneration and employment projects with a focus on areas and population groups experiencing higher deprivation:. • The Investing in Communities Cambridgeshire programme	Ongoing	Fenland District Council Greater Cambridge Partnership (L)

No.	Outcome	Key Actions	Timeline	Partners Lead (L)
		supports disadvantaged people in communities across the county to improve their confidence and skills to assist them to get a job or work for themselves. It is doing this by funding several projects in the county. • The Greater Cambridge Partnership delivers this programme on behalf of Cambridgeshire County Council and EEDA. Download: http://www.gcp.uk.net/downloads/IiC_EconP_Inv_Template.pdf More info on: http://www.gcp.uk.net/investing-communities.php		
1.5	Improvements through partnership working	• District Council Local Strategic Partnerships identified actions to address health inequalities in areas of socio-economic deprivation. (See local Sustainable Community Strategies, Health and Well Being thematic group plans found in Section 3). These are at different stages of development.	Ongoing	FDC, HDC, ECDC, SCDC, CC County Council NHS Cambridgeshire Police Fire Service Voluntary Sector Provider services
1.6	Improvements in community engagement and service developments in small areas of socio-economic deprivation	• Neighbourhood Management projects focussing on areas of higher deprivation in Fenland and North Huntingdon Neighbourhood Management • Extension of this approach to other areas of deprivation in - Huntingdonshire e.g. Eynesbury, St Neots and Ramsey. - East Cambridgeshire, Littleport	Ongoing	FDC, HDC, ECDC, SCDC, CC County Council

Strategic Objective 2: Decrease inequalities in access that impact on health inequalities

Across the whole of Cambridgeshire, in some geographical areas and certain population groups, especially the vulnerable groups identified in objective 3 health inequalities are experienced that are related to access to range of factors that can determine health. This includes

- Access to a healthy lifestyle
- Access to services
- Access to information

2.1: Access to a Healthy Lifestyle

The uptake of healthy lifestyles differs amongst different areas and different groups of people. This is manifested in obesity, high smoking rates, low levels of physical activity, unhealthy alcohol consumption

No.	Outcome Target	Key Actions	Timeline	Partners
2.1.1	Reduce childhood obesity in line with LAA district targets	• LPSA countywide Training Programme (increase access to prevention) • Jointly commission a countywide Child Weight Management Programme • Ensure that there are appropriate school lunch policies in place through the County Council commissioned school meals service	In place 2010/11	NHS Cambs. County Council FDC, HDC , ECDC, SCDC, CC School Sports Partnership Children's Trusts (Joint commissioning of weight management programme does not include all partners)
2.1.2	Establish a countywide adult weight management programme	• Jointly commission an adult weight management programme – includes - structured programme - healthy eating and physical activity schemes	In place 2012	NHS Cambs. FDC, HDC, ECDC, SCDC, CC, Children's Trust

No.	Outcome Target	Key Actions	Timeline	Partners
		in the community • Target areas/population groups/vulnerable groups (Lifestyle Surveys) across the county where rates are high		County Council (District Councils commission/provide physical activity interventions as part of the management)
2.1.3	Meet the LAA smoking cessation district targets	• All partner organisations actively referring to smoking cessation support services • Concentrate core NHS commissioned services in manual/routine worker communities (highest smoking rates) and any groups with smoking rates	2009/10	NHS Cambs. NHS Providers CCC FDC, HDC, ECDC, SCDC, CC County Council Workplaces Voluntary Organisations.
2.1.4	Decrease the number of people who smoke (prevalence - tbc)	• LPSA countywide programme targeting children and young people • Tobacco Alliance to target illicit sales in deprived areas	Programme commenced	NHS Cambs County Council Cambridgeshire Tobacco Control Alliance
2.1.5	Increase the number of people meet the criteria for undertaking the required amount of physical activity	• County Physical Activity Strategy currently in development	TBC	Living Sport (L) NHS Cambs. County Council FDC, HDC, ECDC, SCDC, CC Voluntary Organisations

No.	Outcome Target	Key Actions	Timeline	Partners
2.1.5	Increase the number of people who have access to healthy lifestyle interventions	• GP Practice Health Inequalities Project in 20% of areas in Cambridgeshire with higher deprivation levels (NHSC Pledges commenced 2009). Access to a range of healthy lifestyle interventions (healthy eating skills, increasing physical activity, weight, management, sexual health information and advice) • Health Trainer Programme supporting lifestyle behavioural change – covering 20% most deprived MSOAs in Cambridgeshire, and vulnerable population groups (NHSC WCC Strategy – Programme and tender developed in partnership with L.A.s and GP practices, • Vascular Health Checks and lifestyle intervention – For implementation across the county but out initially in the 20% most deprived MSOAs in Cambridgeshire.	2008 commenced Health Trainer tender successful. Programme recruited to and to start training Jan 29 2010 Vascular health Checks programme in development	NHS Cambs FDC, HDC, ECDC, SCDC, CC County Council
2.1.6	Increase access to prevention, early identification and treatment alcohol services	• Commission and provide core community based alcohol services offering equity and parity across the county consistent with modern best practice, to meet a diverse range of local need focused upon prevention and early intervention in line with Cambridgeshire Alcohol Strategy 2008-2011. and the Harm Reduction Strategy	2009-10 New Service currently being tendered	DAAT and partner agencies

2.2: Improve Access to Health and Social Care Services:

No.	Outcome Target	Key Actions	Timeline	Partners
2.2.1	Increase equity of NHS funding across the county	• Move towards fair shares funding of primary care providers/clusters	2010-13	NHS Cambs
2.2.2	Increase support to vulnerable families and children in the early years	• Needs based formula applied to allocation of funding for Children's Centres (2009 completed) • Work in partnership with Children's Centres in areas of designated health inequalities to deliver the early years promoting health framework • Develop the capacity and skills of Children's Centre staff to promote health with all children and families • Investment in midwife/health visitor support in areas of higher deprivation (NHSC Pledges commenced 2009) Current recruitment difficulties. • Investment in the Family Nurse Partnership project – evidence based, high levels of support levels to teenage parents (completed). • Provide dedicated nurse time for the Youth Offending Service to deliver dedicated health screening/support for young offenders (completed) • Increase joint commissioning for integrated		County Council Children's Trust NHS Cambs.

No.	Outcome Target	Key Actions	Timeline	Partners
		services for children with complex needs.		
2.2.3	Meet the teenage pregnancy district LAA target	• Implementation of joint Teenage Pregnancy Action Plan in localities where Teenage Pregnancy rate continues to be high or where there has not been sufficient improvement. • Jointly commission "one stop" outreach services, including schools, in high Teenage Pregnancy rate areas or where there has not been any improvement. Includes - Contraceptive services - Emotional and Mental Health Wellbeing - Drug and Alcohol - Smoking Cessation	2010/11	NHS Cambs. (L) County Council (L) Children's Trust Provider Services
2.2.4	Improve access to contraceptive and sexual health services	• Redesign of sexual health services to address inequity of service provision with a focus upon the north of Cambridgeshire (includes a focus upon Chlamydia screening in areas where uptake is low)	Planning in place first phase of service shift form April 2010	NHS Cambridgeshire (L) County Council
2.2.5	Improve access to services for people with long term conditions	• Investment in local NHS services to ensure equity across Cambridgeshire: for people with LTCs; cardiac rehabilitation; diabetes.	2009-11	NHS Cambs (L)
2.2.6	Improve access within the Supporting People Services	• Supporting People Partnership investment to ensure that all recipients are able to access their required services.		Supporting people Partnership

No.	Outcome Target	Key Actions	Timeline	Partners
2.2.7	Countywide joint strategy and action workforce plan for training staff to make appropriate behavioural interventions for a healthy lifestyle	• Scope existing training programmes and identify gaps. NHS Cambs lead. • Explore opportunities to commission training that encompasses all healthy behaviours.	2009-11	NHS Cambs. (L) County Council FDC, HDC, ECDC, SCDC, CC Voluntary Organisations
2.2.8	Improve access to health and other key services ensuring that there are consistent, reliable and reasonable journey times across the county.	• Refer to countywide transport plan • Target areas/populations where access to services is poor or limited. • To be identified following publication of the Cambridgeshire Local Transport Plan (3)	2009-11	County Transport Group

2.3: Improve access to information

Access to information about prevention, a healthy lifestyle or how to access services contributes to the health of the population. Easy to access, consistent appropriate and up to date information varies across different population groups. Vulnerable groups are more like to experience poverty of information.

No.	Outcome Target	Key Actions	Timeline	Partners
2.3.1	An evidence base of the information needs and appropriate interventions for targeting particular population groups	• Explore opportunities for joint commissioning of social marketing research to identify needs and strategies of meeting information needs of those experiencing health inequalities (geographical and vulnerable groups)	2010-11	NHS Cambs (L) County County FDC, HDC, ECDC, SCDC, CC
2.3.2	Countywide joint Information and Promotion Strategy and Action Plan in place	• Develop countywide collaboration and partnership for information and promotion • Identify and consider cost effective commissioning approaches for information and promotion including a central information.	2010-11	NHS Cambs County Council FDC, HDC, ECDC, SCDC, CC
2.3.3	Expand web-based and texting information and service appointment systems	• Expand the web based sexual health information and booking services to include contraceptive services. (Target group young people) • Centralised web-based smoking cessation services booking system and local telephone support service to improve access for smokers (NHS commissioned but includes referral pathways from non health partners)	2010-11 initial work commenced	NHS Cambs. (L) County Council FDC, HDC, ECDC, SCDC, CC

Strategic Objective 3: Decrease health inequalities amongst vulnerable groups
Please note the access interventions described in objective 2 will require targeting the vulnerable groups indicated in this section.

No.	Outcome Target	Key Actions	Timeline	Partners
3.1	Children and Young People	• Partnership work and joint commissioning approaches to support outcomes for vulnerable children and young people. • Children's Trust to develop a shared view of strategic commissioning and its implications for its future role and function • Mapping of meaningful and accessible management information to support effective strategic commissioning • Mapping the current deployment of resources and services in the system and how well these meet identified needs • Review the effectiveness of procurement/contracting and performance management arrangements between commissioners and providers • See access objectives for lifestyle and service interventions	2009-11	County Council NHS Cambs
3.2	Older people	Further develop a Preventive and Re-ablement Strategy for older people and adopt joint commissioning approaches to address three interacting dimensions that produces health	2009-10	County Council NHS Cambs

No.	Outcome Target	Key Actions	Timeline	Partners
		inequalities in older people - social and economic - access (see access objectives) - public involvement, decision making ageism		
3.3	Supporting people draft key outcomes (all vulnerable groups): -Greater availability of and accessibility to services: across all districts; across all vulnerable groups -High quality services -Improved personal outcomes for Cambridgeshire residents -Improved awareness of the services available to enable greater choice and control for individuals -Services that are more seamless from the individual's experience -Services that are more personalised and tailored to the needs of each individual -Best use of public resources in how services are commissioned, managed and delivered -Improved performance e.g.	Supporting People – draft key actions • Deliver more flexible and preventative services to improve the outcomes for the residents of Cambridgeshire • Improve the quality of services to ensure the market is developed and managed appropriately to improve the outcomes for the residents of Cambridgeshire • Develop stronger partnership working (including joint commissioning) to improve the outcomes for the residents of Cambridgeshire • Achieve a balanced budget within 3 years (i.e. by 2012) for the achievement of the above to be sustainable	2010-15 – draft key outcomes and actions awaiting approval.	Supporting People partners (County Council, NHS Cambs, FDC, HDC, ECDC, SCDC, CC, Probation); providers; residents and their carers; other stakeholder groups

No.	Outcome Target	Key Actions	Timeline	Partners
	reductions in: health inequalities; those not in education, employment or training; homelessness			
3.4	Disabilities (learning & Physical)	• Consider joint commissioning approaches for addressing the access to service issues that affect the different age groups with disabilities and integrated services	2011	County Council NHS Cambs FDC, HDC, ECDC, SCDC, CC
3.5	Travellers	• Refresh the Traveller Health Strategy and explore joint commissioning opportunities for integrated services • Establish a core team of dedicated advisors and workers (NHS – in place)	2011 2009	Travellers Partnership Group County Council NHS Cambs FDC, HDC, ECDC, SCDC, CC
3.6	Migrant workers	• Take forward the recommendations and action plan of the Joint Strategic Needs Assessment (JSNA) for Migrant Workers.	TBC	Cambridgeshire Migrant Workers Network (L) County Council NHS Cambs FDC, HDC, ECDC, SCDC, CC Voluntary Organisations
3.7	Homelessness	• Currently homelessness strategies in all districts. • Take forward the recommendations of the Homelessness JSNA. Action plan is being agreed.	2010-11	County Council NHS Cambs. FDC, HDC, ECDC, SCDC, CC Voluntary Organisations
3.8	Prisoners/refugees/immigrants	• Prison Steering Groups are continuing to take forward the recommendation of the	2009-11	Prison Steering Groups NHS Cambs

No.	Outcome Target	Key Actions	Timeline	Partners
		prison health needs assessments		
3.9	Improve access to employment, skill and enterprise for all vulnerable groups including those in contact with mental health services	• Cross reference to appropriate thematic groups. • Improving Access to Psychological Therapies programme (commenced) • Promotion of volunteering opportunities as a way to improve employability as well as education and training.	2009-11	County Council NHS Cambs. FDC, HDC, ECDC, SCDC, CC Voluntary Organisations

Objective 4: To prevent the creation of new health inequalities in new or existing communities through the growth process

No.	Outcome Target	Key Actions	Timeline	Partners
4.1	Any new housing/growth initiatives demonstrate that measures to prevent the creation of any new health inequalities	• Planning policies should ensure that assessment of health and health inequality impacts are embedded into the processes for managing new developments. This includes protecting and enhancing the environment in open spaces and the countryside for the benefit of people and wildlife and ensuring that the built environment is supportive of both physical activity and of the development of social capital. This requires a community infrastructure in the social as well as the physical sense. There should also be full consideration of access to, and appropriate provision of, health services within new communities.. Work should build on the principles already enshrined in the Quality Charter for Growth[1] and in the emerging Green Infrastructure Strategy.	2009-11	FDC, HDC, ECDC, SCDC, CC Cambridgeshire Horizons (L) County Council NHS Cambridgeshire
4.2	In existing communities increase opportunities for physical activity	• Increase the number of cycle paths, play areas and walking areas, as part of growth initiatives.		FDC, HDC, ECDC, SCDC, CC

[1] http://www.cambridgeshirehorizons.co.uk/about_horizons/how_we_do_it/quality_charter.aspx

Section Three:
Existing Plans and Strategies to Reduce Health Inequalities in Cambridgeshire

6. Sustainable Community Strategies and Other Plans in Cambridgeshire

The list of Strategies/Plans to be included in this section are:

1. Cambridgeshire's Vision: Countywide Sustainable Community Strategy: http://www.cambridgeshire.gov.uk/NR/rdonlyres/8707CA50-DEC9-4A7F-87E4-C8C108452C5D/0/CambsVision20072021.pdf

2. Cambridge County Council Integrated Plan: http://www.cambridgeshire.gov.uk/council/policies/integratedplanandpolicyframework.htm

3. NHS Cambridgeshire Strategy/ Operational Plan: http://www.cambridgeshire.nhs.uk/documents/Have%20Your%20Say/Consultations/Strategic%20Plan/Strategic_Plan_2010_to_2015_V5[1].pdf?preventCache=14%2F12%2F2009+11%3A53

4. Supporting People Commissioning Strategy (to 2010) http://www.cambridgeshire.gov.uk/social/supportingpeople/schsupstratrevs.htm

5. Sustainable Community Strategy and Action Plan for Cambridge City :http://www.cambridge.gov.uk/ccm/navigation/about-the-council/how-the-council-works/council-policies-and-plans/cambridge-local-strategic-partnership/

6. Sustainable Community Strategy and Action Plan for Huntingdonshire: http://www.huntingdonshire.gov.uk/Councils%20and%20Democracy/Council/Huntingdonshire%20Strategic%20Partnership/Pages/default.aspx

7. Sustainable Community Strategy and Action Plan for South Cambridgeshire: http://www.scambs.gov.uk/documents/retrieve.htm?pk_document=907058

8. Sustainable Community Strategy and Action Plan for Fenland: http://www.fenland.gov.uk/ccm/content/development-policy/ldf/evidencedocs/sustainable-community-strategy/sustainable-community-strategy.en

9.. Sustainable Community Strategy and Action Plan for East Cambridgeshire http://www.eastcambs.gov.uk/html/compages.asp?servid=53&title=Sustainable+Community+Strategy&hier=Community

Other useful `weblinks

National Institute of Clinical Excellence
http://www.nice.org.uk/

Department of Health
http://www.dh.gov.uk/en/index.htm

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SECTION 4
PROPOSED HEALTH INEQUALITY METRICS

Strategic Objective 1:

To decrease health inequalities found in the most socio-economically deprived areas in Cambridgeshire

No.	Outcome	Proposed metric	Level	Update	Source
1.1	Health Inequalities in Fenland fully addressed by the County Council	Life expectancy Economic measure eg average wage	District District	Annual Q'ly	ONS Paycheck
1.2	Improving outcomes for school age children in Fenland	GCSE % of pupils achieving 5+ A*-C/A*-G scores	District	Annual	CCC
1.3	Further improvements in the 20% most deprived areas	All Age All Cause mortality (AACM) Life expectancy (slope of inequality) Economic measure eg average wage	20%:countyave 20%:countyave MSOA 20:80	Annual Annual Annual	ONS ONS Paycheck
1.4	Secure economic regeneration and employment improvements	Unemployment rate (%)	Ward 20:80	Q'ly	NOMIS
1.5	Improvements through partnership working	n/a see existing District Plans	-	-	-
1.6	Improvements in community engagement and service developments in small areas of socio-economic deprivation	n/a see own Project metrics	-	-	-

Strategic Objective 2:

Decrease inequalities in access that impact on health inequalities (includes: access to a healthy lifestyle; access to services; access to information)

2.1: Access to a Healthy Lifestyle

No.	Outcome	Proposed metric	Level	Update	Source
2.1.1	Reduce childhood obesity in line with LAA district targets	Childhood obesity (Reception / Year 6)	MSOA 20:80	Annual	NCMP
2.1.2	Establish a countywide adult weight management programme	Adult obesity (male/female)	MSOA 20:80	Annual	EoE LS
2.1.3	Meet the LAA smoking cessation district targets	Smoking cessation: four week quitters	MSOA 20:80	Q'ly	CPCT
2.1.4	Decrease the number of people who smoke (prevalence)	Smoking prevalence	MSOA 20:80	Annual	EoE LS
2.1.5	Increase the number of people meet the criteria for undertaking the required amount of physical activity	Doing the recommended amount of exercise (m/f)	MSOA 20:80	Annual	EoE LS
2.1.5	Increase the number of people who have access to healthy lifestyle interventions	Health trainers % achieving goals Health checks - number of people seen last 5 yrs Four healthy behaviours - nonsmoker, moderate drinker, recommended exercise, 5 fruit/veg a day	GP Prac 20:80 GP Prac 20:80 MSOA 20:80	Q'ly Q'ly Q'ly	CPCT CPCT EoE LS
2.1.6	Increase access to prevention, early identification and treatment alcohol services	Alcohol specific hospital admissions	MSOA 20:80	Q'ly	CDS

2.2: Improve Access to Health and Social Care Services:

No.	Outcome	Proposed metric	Level	Update	Source
2.2.1	Increase equity of NHS funding across the county	Report on actions - may be able to develop metric in future	-	-	-
2.2.2	Increase support to vulnerable families and children in the early years	NI70 Childhood injury Breast feeding (initiation/at 6-8 weeks) Health visitor 1st visit within 14 days	MSOA 20:80 GP Prac 20:80	Q'ly Q'ly	CDS CCS/CPCT CCS/CPCT
2.2.3	Meet the teenage pregnancy district LAA target	Teenage pregnancy - rate per 1,000 girls 15-17	District/ward	Annual	TPU/ONS
2.2.4	Improve access to contraceptive and sexual health services	Report on actions - may be able to develop metric in future		-	-
2.2.5	Improve access to services for people with long term conditions	HbcA1 - Diabetes Elective admissions - all causes Elective admissions Coronary Heart Disease	GP Prac 20:80 MSOA 20:80 MSOA 20:80		QoF CDS CDS
2.2.6	Countywide joint strategy and action workforce plan for training staff to make appropriate behavioural interventions for a healthy lifestyle	Actions feedback	-	-	-
2.2.7	Improve access to health and other key services ensuring that there are consistent, reliable and reasonable journey times across the county.	Access by public transport			CCC

2.3: Improve access to information

Access to information about prevention, a healthy lifestyle or how to access services contributes to the health of the population

No.	Outcome	Proposed metric	Level	Update	Source
2.3.1	An evidence base of the information needs and appropriate interventions for targeting particular population groups	n/a Qualitiatively by report - progress on actions	-	-	-
2.3.2	Countywide joint Information and Promotion Strategy and Action Plan in place	n/a as above	-	-	-
2.3.3	Expand web-based and texting information and service appointment systems	n/a as above	-	-	-

Strategic Objective 3:

Decrease health inequalities amongst vulnerable groups

Please note the access interventions described in objective 2 will require targeting the vulnerable groups indicated in this section

No.	Outcome	Proposed metric	Level	Update	Source
3.1	Children and Young People	Looked after children: Educational achivement Monthly health action plan	County District	Annual Q'ly	CCC
3.2	Older people	Fuel poverty	Ward 20:80	Annual	
3.4	Disabilities (Learning & Physical)	Health Action Plans for people with learning disability	County	Q'ly	LDP
3.5	Travellers	Educational attainment: traveller children	County	Annual	CCC
3.6	Migrant workers	Actions feedback	-	-	-
3.7	Homelessness	Hospital admissions in homeless (emergency)	County	Q'ly	CPCT
3.8	Prisoners/refugees/immigrants	Actions feedback	-	-	-
3.9	Improve access to employment, skill and enterprise for all vulnerable groups including those in contact with mental health services	Mental and behavioural disorders incapacity benefit	District	Annual/Q'ly	NOMIS

Strategic Objective 4:

To prevent the creation of new health inequalities in new or existing communities through the growth process

No.	Outcome	Proposed metric	Level	Update	Source
4.1	Any new housing/growth initiatives demonstrate that measures to prevent the creation of any new health inequalities	n/a Qualitiatively by report - progress on actions	-	-	-
4.2	In existing communities increase opportunities for physical activity	Explore children travelling to school metric	District		CCC