To be Fair

Evidence-led approaches to addressing health inequalities in Cambridgeshire and Peterborough.

DPH Annual Report 2022/23

Introduction

Health inequalities are unfair and avoidable differences in health between people or communities. The exposure and exacerbation of health inequalities through the Covid-19 pandemic has resulted in focused attention on health inequalities and renewed interest in addressing them. Yet our awareness of health inequalities and our desire to address them is not new. The Black report in 1980[1] exposed health inequalities and made clear statements about the broader determinants of health inequalities, such as education, income and housing. These inequalities start early in life and have sustained impact on all aspects of life including health and death. The Marmot review in 2010[2] made a clear articulation of the determinants of health inequalities and outlined actions that would address them.

There have been attempts by national government to reduce inequalities in health. However, ten years after the publication of his initial review Prof Marmot identified that inequalities in health had actually widened [3]. These widening disparities were in place long before the additional and unequal distribution of the impact of Covid-19[4], and now, two and a half years after the start of the pandemic, we are facing another threat to our residents' health which will once again have most of an impact on the most deprived households. This summer, our most deprived residents have already felt the effects of sharp increases in food, fuel and other costs of living, and the effects will worsen and be felt more widely as we enter the winter months. Stark choices for households are likely to result in poorer health for many especially those who are not able to absorb the additional costs.

There have also been multiple and ongoing attempts to reduce health inequalities at a local level in Cambridgeshire and Peterborough and yet health inequalities persist. Figure 1 shows the patterns for deaths under the age of 75 years where men in the most deprived fifth of areas have a considerably higher rate of premature death, and the gap between the most and least deprived fifths has remained relatively consistent. For women, this gap has potentially widened in recent years.

This report explores some of the reasons for why we have not been successful at reducing health inequalities and outlines some approaches, based on evidence and experience, that may materially improve outcomes for those who are experiencing inequalities and reduce inequalities.

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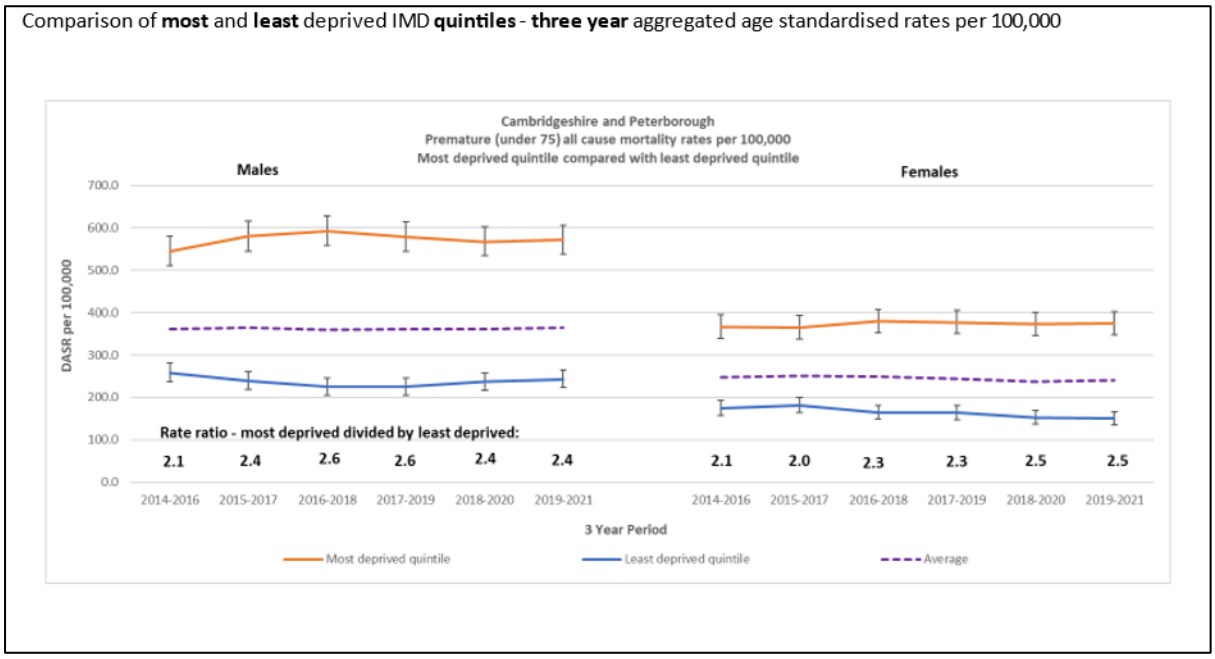
[1] The Black Report 1980 (sochealth.co.uk)
[2] Fair Society Healthy Lives, February 2010
[3] Health Equity in England: The Marmot Review 10 Years On - The Health Foundation, February 2020
[4] COVID-19: Review of emerging evidence of needs and impacts on Cambridgeshire & Peterborough, 2021/2022

Figure 1 All-cause mortality rates in those under 75 years between 2014 and 2021 by Indices of Multiple Deprivation (IMD)



The determinants of health inequalities

As made clear in both the Black report and the Marmot review, the causes of health inequalities lie predominantly in the wider determinants of health such as good housing, good education, good employment and income, healthy environments, a supportive community, and family. Many of the structural levers for addressing these lie outside local control, however this report will focus on what can be done at a local level to address health inequalities. If we are to be successful in tackling health inequalities now, we must learn from our experience to date and draw on the international evidence base of successful interventions.

Health inequalities are unfair and avoidable differences in health between people or communities. Our focus must be on reducing inequalities in health outcomes and to do this we must understand the determinants of those inequalities. These include education, income, gender, age, sexual orientation, disability, genetics, ethnicity and background, and access to services and treatment. Whilst many of these factors may predispose individuals to experience health inequalities, most of these factors should not inevitably lead to inequalities in health outcomes. It is how society responds to these different risk factors that should lead to a reduction in inequalities in outcomes.

Targeting by geographical groupings will miss most individuals that could benefit

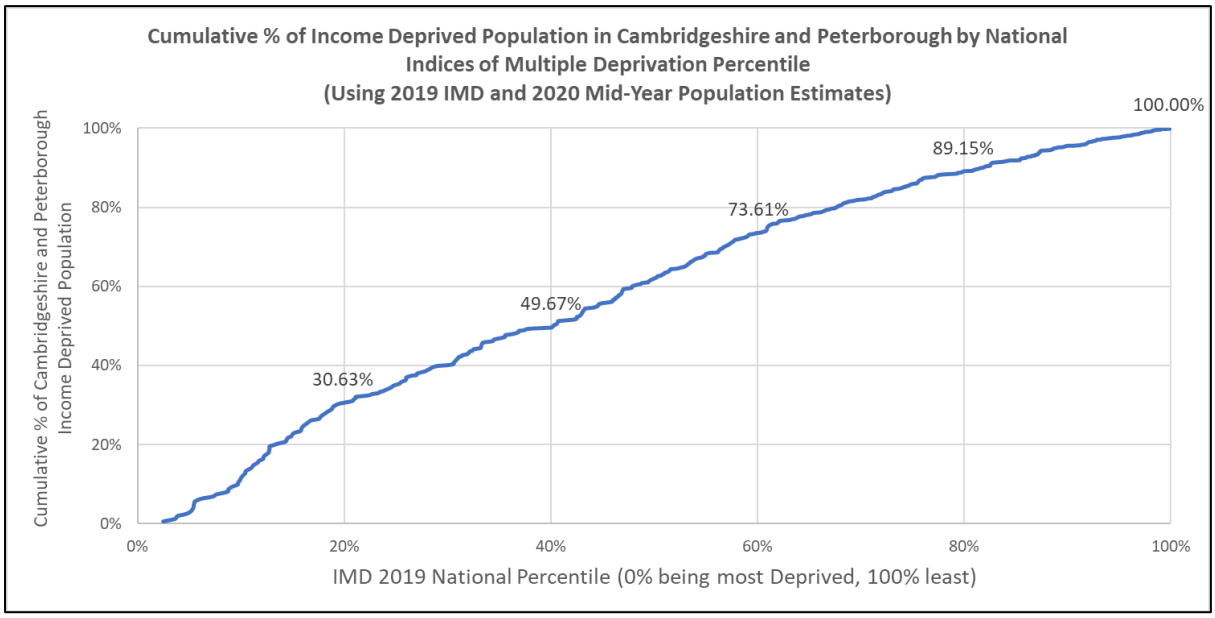
Inequalities in health are experienced by individuals, yet much of our analysis and data presentation is aggregated, hiding considerable variation. Information is often presented by geography, or the Indices of Multiple Deprivation (IMD) which itself is based on small area geographies.

Data presented by deprivation categories can highlight the health inequalities and the outcomes that need improving – but it doesn't necessarily inform the type of intervention that is going to be most effective. Sometimes, given the geographic clustering of deprived areas in Cambridgeshire and Peterborough, the presentation of data by deprivation can lead a focus on geographically based interventions. To the person with a hammer everything looks like a nail! Whereas we need to be rigorous and evidence-led in choosing the most effective intervention mechanism.

The factors that may predispose an individual to experience health inequalities are distributed widely across the county and not restricted within particular geographies. For example, a very important factor in health outcomes is income, and although low incomes are associated with some geographic areas, there remains a lot of variation.

Figure 2 shows the cumulative number of individuals who are income deprived across Cambridgeshire and Peterborough against IMD percentiles. Put simply, it's likely that all our areas, even the wealthiest, are home to people on low incomes. If we were to focus our attentions on the most deprived quintile, we would only reach 31% of individuals who are income deprived and miss the majority. Even the least deprived quintile contains 11% of the income deprived individuals across the county. Using food poverty as an example, whilst primary and secondary schools in the most deprived areas in Cambridgeshire and Peterborough are likely to have the highest proportions of children eligible for free school meals, the majority of children eligible for free school meals will be in the other quintiles and all primary and secondary schools in Cambridgeshire and Peterborough have some children eligible for free school meals.

Figure 2 The Cumulative percentage of income deprived population in Cambridgeshire and Peterborough by Indices of Multiple Deprivation



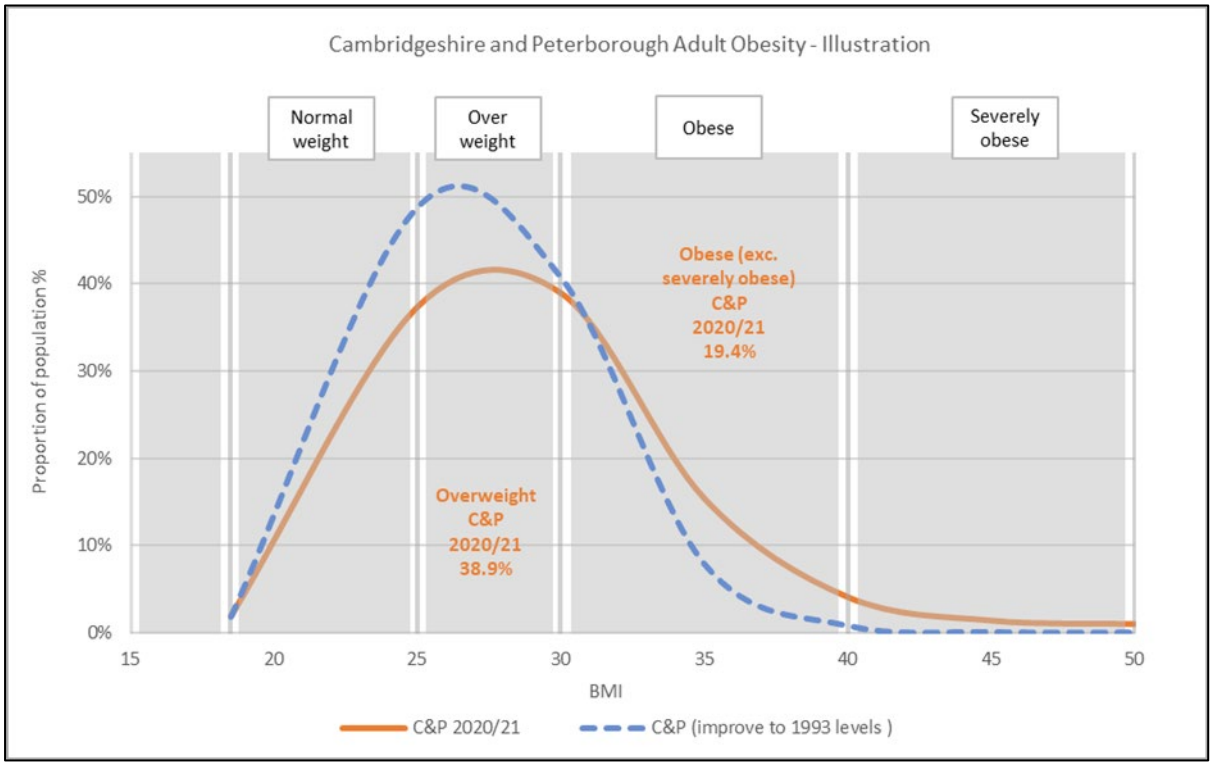
Apart from geographic targeting of interventions, the other approach that is often used is to target resources to the highest need individuals. This is an approach that is widely used by our health and social care sector, where need thresholds must be crossed before individuals can access care or support. Whilst of course this approach is required to protect limited resources and to ensure only those who are in need receive services, the limitation of this approach is that there are inequalities in healthcare-seeking behaviour and subsequent access to services can widen inequalities further[5]. Focusing resources at those in greatest need who are already unwell cannot result in a reduction of health inequalities as the determinants of those inequalities will already have had their impact. It is too late.

The case for universal approaches

As described above, when faced with a problem such as excess weight which impacts the health of the majority of the adult population, targeted approaches that focus on a relatively small number of people will not work at reducing overall risk in the population. Figure 3 illustrates the population distribution of those overweight and obese in Cambridgeshire and Peterborough and how that has shifted over the last 30 years, with many more of us now overweight and obese, something that need reversing.

[5] The Inverse Care Law, Lancet. Hart, J. T, 1971 Feb 27;1(7696):405-12

Figure 3 Illustration of the current distribution of those overweight and obese in Cambridgeshire and Peterborough compared to 1993[6]



However, if we focus on those who are overweight and living in the most deprived quintile, we will miss the majority of people who need to lose weight. Using a threshold approach, focusing on those who are obese or severely obese for example, we will miss the majority who are overweight and whose health is already at risk because of it and who could go on to be obese. Offering intensive individual level support to all of those who are overweight is unaffordable, impractical and not cost effective; universal measures are required to tackle a problem of this scale. Measures such as changing the environment to support people to walk or cycle by default or restricting advertising of fast foods are more cost effective. Of course, we will want to offer additional support and interventions to those who are obese, but this cannot be at the cost of universal approaches which have the potential to improve the risk levels of many more people.

Universal approaches can be very successful at both improving population health outcomes and reducing inequalities, without being stigmatising. For example, universal measures on smoking, such as the smoking ban in indoor public spaces, other smoking legislation and pricing measures have resulted in reduced overall population smoking prevalence, reduced inequalities in smoking initiation[7] and smoking prevalence between the most deprived and least deprived deciles, have

[6] Illustration based on point prevalence data for Cambridgeshire and Peterborough based on Active Lives Survey 2020/21 and England data from Health Survey for England 2019

[7] Impact of UK Tobacco Control Policies on Inequalities in Youth Smoking Uptake: A Natural Experiment Study | Nicotine & Tobacco Research | Oxford Academic (oup.com), May 2020

continued to reduce since the introduction of the ban[8]. Another such example is the addition of fluoride to drinking water, which can improve population oral health and reduce inequalities in dental caries[9]. If targeted approaches are used alone, the potential to improve population health outcomes, is missed.

Universal approaches are also essential when identifying those in greater need or at higher risk. For example, our health visiting services routinely visits all babies, providing systematic support to all new mothers but identifying and providing intensive and systematic support to any families with greater need. Without this universal intervention, it would be much harder to identify those who needed more help.

Even for something such as smoking in pregnancy, which on the face of it warrants a very targeted approach, without routine carbon monoxide checks, many pregnant smokers or those exposed to smoking in pregnancy, through household members smoking, would be missed and would not be offered support to stop smoking. Once identified, individuals can be offered the additional support they need.

Proportionate or progressive universalism

Combines the approach of improving health of all individuals as well focusing efforts on improving the health of the groups with the highest need.

For services, this means that there is a universal offer but one that is systematically planned and delivered to enable access and give support according to need – both at an individual level and at a neighbourhood level to ensure better outcomes for all.

The balance between a proportionate universal approach and a more targeted offer, and its impact on outcomes, has also played out in the approach to supporting families with the youngest children. The original Sure Start programme was funded to provide universal access to community-based support and health provision, but as funding changed a much more targeted approach needed to be offered which meant that it is more difficult to identify early signs of difficulties within families as they are no longer regularly attending universal sessions with their peer group. It also potentially impacted local community views on the purpose of Sure Start centres[10]. The new national approach for Family Hubs has recognised this gap and is moving towards a coordinated and universal Start for Life and family services as well as ensuring that there are additional targeted interventions to support vulnerable and under-served populations[11].

For all these reasons, universal approaches should be the first port of call.

[8] Smoking inequalities in England, 2016 - Office for National Statistics (ons.gov.uk)
[9] Health and Care Bill: water fluoridation - GOV.UK (www.gov.uk), March 2022
[10] Sure Start: voices of the 'hard-to-reach' (pdf - researchgate.net) October 2007
[11] Family hubs and start for life programme: local authority guide - GOV.UK (www.gov.uk), August 2022

The limitations of universal approaches

Universal approaches may sometimes fail to address inequalities. Some groups and communities are also more likely to experience challenges in accessing care, including preventative care – with issues such as the availability of services in their area, services opening times, digital exclusion, access to transport, access to child care, language and literacy, poor experiences in the past, misinformation and fear - all being highlighted by the NHS[12] as potential reason for differential access to care.

The Covid-19 vaccine is a universal offer that has been incredibly effective at reducing population harm from Covid-19, without this universal offer we would still be seeing many hospitalisations and deaths due to Covid-19. However, it has become increasingly clear, through the pandemic that this universal offer was not universal in reach. In fact, those who were most likely to need it due to being at higher risk through social factors, were least likely to take up the vaccine.

The offer of vaccination was systematic and there was considerable additional planning and engagement across geographies, ages, ethnicities and communities to address the issues such as opening times, transport, facilities, language, understanding and misinformation. However, there was clearly variable impact of vaccine initiatives, both nationally and locally, and there are still some local areas and communities with lower levels of Covid-19 vaccine uptake.

The complexity of addressing the underlying systemic issues and addressing individual concerns was highlighted throughout – with some real successes, but the continued lack of vaccine confidence in some areas despite considerable efforts highlights that there are still lessons to be learned to enable effective implementation and support to access this type of universal offer.

Interventions to improve uptake of such a universal offer may increase uptake for all, without reducing the inequalities across the population. For example, in Sweden[13] there was a randomised controlled trial of monetary incentives to undergo early Covid-19 vaccination, compared to other measures such as behavioural nudges or reminders. One group received a 200 Kr (£16) cash incentive if they were vaccinated within 30 days of becoming eligible for vaccination whereas the other groups received behavioural nudges. While some of the behavioural nudges significantly increased the intention of participants to be vaccinated, they did not significantly impact uptake, however the vaccine uptake rate in the monetary incentive group was 4 percentage points higher than the control.

Interestingly, financial incentivisation provided a similar boost to the rate of vaccination across all the demographic groups – thus improving uptake for all, but not reducing

[12] NHS England » What are healthcare inequalities?
[13] Monetary incentives increase COVID-19 vaccinations - PubMed (nih.gov) Campos-Mercade P etal. Science. 2021 Nov 12;374(6569):879-882

inequalities. This presents ethical questions of acceptability of improving absolute uptake overall and thereby preventing hospitalisations and deaths in those who are most vulnerable, yet not reducing inequalities.

There is obviously a trade-off between overall cost of an intervention program such as an incentive programme, the fairness with respect to who is eligible and this needs to be clearly and transparently balanced with the cost-effectiveness of the intervention. For vaccine incentives, it is fairer if the incentive is universal - offered to everyone, including groups who are likely to have high uptake or have already been vaccinated. This would mean the cost for each additional vaccinated person above the baseline would be much higher than for targeted incentives. However, the cost-effectiveness of such a program could still be positive if it reduces future pandemic costs sufficiently.

It is easier to target incentives when the need (and lack of need) can be clearly identified - such as in those smoking during pregnancy. Here, targeted monetary incentives have been shown to be highly effective at improving quit rates compared to normal care[14], with very clear benefits as to health outcomes for the mother and the child.

The ongoing debate of universal versus targeted support measures for energy costs this winter especially given the existing budget constraints highlights the complexity of these decisions and the need, if targeting, to identify all those in need or at risk of poor outcomes.

Care needs to be taken that interventions are based on true assessment of risk or need, rather than on the much easier to measure but crude demographic or geographic characteristics. Targeting to demographic or geographic groups assumes that the selected group is homogenous both in behaviour and health outcomes and also risks missing many people who are not in these groups but still in need. In addition, a service that is crudely targeted to a group can lead to a level of stigma and an unwillingness to use the service, which needs to be addressed in any successful targeted service.

Whatever form of targeting is used it is important that the identification of those at risk is carried out with the best data available, and the intervention has a strong evidence base of impact on outcomes.

[14] Cochrane Review (2019) Incentives for smoking cessation - PMC (nih.gov)

Table 1 Brief overview of types of targeting and the advantages and disadvantages

Targeted group for intervention	Advantages	Disadvantages
Risk group identified at an individual level	• Requires robust individual level data to enable risk scoring • Intervention can be targeted to those at need/risk and is likely to have more impact on outcomes	• Information to risk score is not always available • Requires system analytic capacity to identify risk groups • People below the cut-off for intervention may still have risks that can be reduced
Groups with key health or behavioural need e.g.	• Focused interventions such as incentives and peer support are possible • Some individuals with need will be known to services	• Often based on the individual or service identifying their need and accessing intervention – therefore groups may be missed leading to a widening of inequalities. • Need is not always easy to identify • Can be assumptions that group are similar in characteristics and a similar intervention is appropriate for all
Demographic group e.g. homeless, migrants, traveller communities, those on benefits	• Can be easy to identify • Often have high health needs	• Assumes a group is homogenous and have the same needs • Can lead to culture blaming and stigmatisation • Specific services can be perceived as poorer quality leading to issues with utilisation by the group • Focus can be on particular health conditions or support needs, neglecting broader health problems
Geographical/deprivation	• Requires no individual level data to identify target group • Need is proportionately higher in deprived areas	• Substantial proportion of health need is elsewhere.
Demographic e.g age, ethnicity	• Most services have age information	• Need is often higher in deprived individuals at an earlier age. • Age cut offs can therefore worsen inequalities if this isn't taken into account

Conclusions and Recommendations

The renewed interest and commitment to tackling health inequalities as a result of the pandemic, is very much welcomed. Historic approaches at tackling these inequalities have not been successful, in fact inequalities have widened.

The automatic response to tackling inequalities is to target, however, as demonstrated in this report, universal approaches can be far more effective at reducing inequalities, than targeted approaches. Universal approaches are also necessary in identifying those individuals who are in need of further intervention. Targeting has also often been carried out on geographical basis or using IMD quintiles, as argued in this report, this can often lead to the majority of individuals in need, being missed.

Targeting in the way that we have previously has not If we are

To be fair to our residents we need to successfully reduce inequalities in health outcomes. To be successful in this we must be more intelligence-led and evidence-based.

We need to:

- Keep a focus on universal interventions as a key way of improving outcomes, reducing inequalities in health in our population.
- Make sure that any universal offer is systematically planned and delivered to enable access to all and give additional support according to need.
- Start early (pregnancy and childhood) before inequalities become entrenched
- Ensure that any targeted intervention is
    - based on need, ideally through universal identification of need or risk rather than grouping by easily available information such demographics or geography
    - evidence-led as to approach
- Be transparent and explicit around considerations for interventions clearly articulating the proposed individual and population benefits, draw first on evidence based approaches with proven cost effectiveness and where evidence is not available, research and evaluate the impact of new and innovative approaches.

Cambridgeshire & Peterborough Integrated Care System

JOINT CAMBRIDGESHIRE & PETERBOROUGH OVERARCHING HEALTH AND WELLBEING STRATEGY 2022 -2030

1. BACKGROUND

1.1 Health and Wellbeing Boards are required, as stated in the Health and Social Care Act 2012, to produce Health and Wellbeing Strategies. The last two years have required the whole system to focus on tackling the challenges of the Covid-19 pandemic and whilst a Health and Wellbeing Strategy had previously been written and consulted upon, it was not launched due to the pandemic. Since then, much has changed and a new approach is needed

1.2 The direct and indirect impact of Covid-19 has brought threats and opportunities to our ways of working and our residents' health, which mean we must reconsider our priorities and actions. As the local and national response to the Covid-19 pandemic starts to wind down, it is time to rebalance our attention to other harms that have potential to cause great harm over the life course. There are clearly some real challenges ahead, and if we are to stand a chance of addressing these challenges, we must be ambitious and we must work together as a whole system, learning from our successes and prioritising our collective efforts and resources to where we can make the biggest difference to improving health and wellbeing

1.3 The Health and Wellbeing Strategy must be informed by Joint Strategic Needs Assessments. For the purpose of this particular strategy, the Covid-19 Impact Assessment fulfils the function of the JSNA, summarising the joint work we have done across local government, the NHS and partners to understand the emerging impact of Covid-19. In addition, the JSNA core data set provides understanding of health and wellbeing in Cambridgeshire and Peterborough residents.

2. PURPOSE

2.1 ***A new single approach for improving our residents' health and wellbeing***
The Covid-19 pandemic has positively changed the way we work together. All partners in Cambridgeshire and Peterborough have rallied to respond to the pandemic, each partner playing their part and delivering what was required, within very short time scales. We must not lose our collective learning from this.

2.2 There are also significant infrastructure changes such as the development of the Integrated Care System (ICS), which will support system partners to provide a more integrated approach and work more closely together. The Health and Wellbeing Boards in Cambridgeshire and Peterborough will work very closely with the emerging Integrated Care Partnership (ICP), and when we refer to 'joint' in this strategy this means jointly with the ICP, across geographies and with partners, communities and residents.

2.3 The Health and Wellbeing Boards and the Integrated Care Partnership (ICP) must remain separate legal entities with their own statutory responsibilities that cannot be delegated to each other. However, we intend to bring the HWBs and ICP much closer together with common membership and joint meetings as a combined HWB/ICP in practice, with many of the same individuals sitting on both the Board and the Partnership. All partners in the combined HWB/ICP commit to cooperative and supportive working as equal partners across organisations, with everyone putting aside organisational boundaries to be focused on improving health and wellbeing for the people they serve. We believe that working together as much as possible across organisations, pooling our data, our understanding, resources,

knowledge and experience, will result in better outcomes for our residents

2.4 We recognise there will be other priorities across the system. The Combined Authority, the Integrated Care Board, the Public Service Board, and district local authorities and other organisations will all have their own sets of priorities and plans. For example, the ICS has five strategic objectives which are partly focused on NHS workforce and services as well as including population health. Many of these priorities will undoubtedly lead to improvements in health and wellbeing through improving NHS care and also through improvements in the wider determinants of health – education, jobs, housing, income and the environment. However, the priorities and vision in this Health and Wellbeing Strategy should form the core of the system's commitment to improving health and wellbeing.

2.5 ***Developing the strategy and our joint approach for improving residents' health***

Before work on this strategy had started, our local developing Integrated Care System consulted and developed a mission statement for the 'system' (health, local authorities and other partners working together)

"All together for healthier futures"

Partners from across the NHS and the local authorities, and the wider public and voluntary sector, then came together in late 2021 and early 2022 several times to discuss the Health and Wellbeing Strategy and review the evidence on health in our area and the impact of Covid-19.

2.6 At a workshop held on 6th October 2021, all partners agreed in principle to a **single plan** and set of priorities across the Health and Wellbeing Board and the ICS. In addition, it was agreed that the ICS vision that had been consulted on and agreed by Cambridgeshire and Peterborough - "*All Together for Healthier Futures*" - should become the vision across the ICP and the HWB.

2.7 This means there will not be a separate overall long-term health and wellbeing strategy for local government, nor for the local NHS although there will however be Integrated Care Board plans for service delivery. This "One Plan" approach is a first for our area and demonstrates a commitment of all partners to working together towards shared goals, while retaining organisations' different areas of expertise and statutory responsibilities.

The workshop on 6th October 2021 was informed by our work assessing the impact of Covid-19

2.8 Key points from the impact assessment are:

- Covid-19 has exposed and exacerbated inequalities, as demonstrated by the differential impact of the pandemic on our black and ethnic minority communities and those living in our most deprived areas
- There are more people in poverty; this risks a long-term impact on health
- The mental health of our population has been impacted by the pandemic, particularly children and young people
- Obesity affects around a 1/3 of our year 6 children and up to 60% of adults and has been made worse by the pandemic
- Our health service is under pressure and the way that people access health care and preventative health care has changed
- There are risks and opportunities to our environment as result of the pandemic.

Three top-level overarching strategy goals and four key priorities for achieving these goals arose from discussions at this meeting on 6th October 2021. A subsequent development meeting on 17th January 2022 agreed, in principle, that these goals and priorities should form the core of the overarching Health and Wellbeing Strategy.

2.9 ***Health and Wellbeing Strategy for Cambridgeshire and Peterborough 2022-2030***

What will we focus on?

This 'overarching' strategic approach sets out our headline ambitions and the four priorities we will focus on to achieve these ambitions. We are aiming to work with our residents, patients and stakeholders to tackle some real challenges in improving the health and wellbeing of the people we serve, by reversing some of the health determinants and outcomes that were challenging before the pandemic and have worsened as a result of the pandemic. We also need to prioritise reducing the health inequalities which existed pre-pandemic but which were exacerbated and brought into sharper focus by Covid-19.

2.10 This will be an eight-year overarching strategy for the health and wellbeing of residents in Cambridgeshire and Peterborough.[1] It will provide a clear statement of what we intend to achieve together across the NHS and local government system and will set out how we intend to develop and achieve it in partnership with our residents, patients, and stakeholders. This strategy is also the high-level long-term plan and priorities for our local NHS Integrated Care System,[2] which oversees NHS services across Cambridgeshire and Peterborough.

2.11 Working jointly across the NHS and local government will mean that we can be more ambitious and more accountable in addressing these issues. By sharing more of our data, we can develop a better common understanding of our residents' health and needs as well as service use. Bringing all our collective resources, knowledge and experience together means we make best use of these resources to create measurable and meaningful impact.

What do we want to achieve?

2.12 Three overarching ambitions were agreed by consensus across local authority and NHS

[1] This strategy covers Cambridgeshire and Peterborough; the two local authorities have joint working relationships and have agreed to delegate authority to a single Health and Wellbeing Board to act on behalf of both areas.
2 The Integrated Care System is also developing NHS-focused plans describing priorities in commissioning and delivering healthcare

colleagues; reflecting the issues we know about in our population and the outcomes that are most important. Whilst these are recognised as ambitious, they are plausible, and all partners have committed to delivering these ambitions. This will require collective and organisation specific endeavours.

2.13 By 2030:

1. **We will increase the number of years that people spend in good health**

   Life expectancy is often used as a measure of societal progress, and although it is important, it does not take into account the fact that towards the end of life there is often a period, perhaps many years, which is spent in poor health. Healthy life expectancy, on the other hand, measures the average time we can expect to live in good health. It is clearly worthwhile to prevent conditions that cause disability and poor health over a long time, in order to increase the number of years that people spend in good health. We know that healthy life expectancy is also strongly linked to deprivation, with people living in less well-off areas more likely to experience a long time at the end of life in poor health. By 2030 we want to see healthy life expectancy increase by at least two years for men and women in Cambridgeshire and Peterborough.

2. **We will reduce inequalities in preventable deaths before the age of 75**

   Preventable premature mortality are deaths of people under 75, from causes of death that are largely or entirely preventable (for example, smoking related deaths, or deaths from vaccine-preventable disease). We know that there is a strong relationship between the wealth of an area and the rate of preventable premature mortality. Our most deprived areas see many more of these deaths than our least deprived areas. We will weaken this relationship between wealth and early preventable deaths so that people in our least well off areas are less likely to die young.

3. **We will achieve better outcomes for our children**

   Working with parents and communities we will achieve better outcomes for our children, recognising the holistic needs of our children. Health and wellbeing measures for children are broad and include determinants of health as well as health outcome measures. Investing in the health and wellbeing of our children, will pay dividends throughout their lives. In addition, investments in the early years are often the most cost effective[3]. This outcome would mean that on key measures of health and wellbeing for children, Cambridgeshire and Peterborough will be the best in a group of 'comparator' local authorities (those which are similar in size, wealth and some demographic factors). In other words, when it comes to our children and young people, we will be doing better than the other areas that we are most similar to us.

2.14 As part of our early workshops on this strategy, there was considerable discussion on how to set appropriate long-term goals for Cambridgeshire and Peterborough that would make a difference to the health of residents. The three overarching goals that were arrived at are intended to be stretching and ambitious, but also plausible and achievable. Together, the three goals will add up to a healthier and happier community, where the foundations for a good life are set in childhood, health inequalities are lessened, and wealth is less strongly linked to good health and wellbeing.

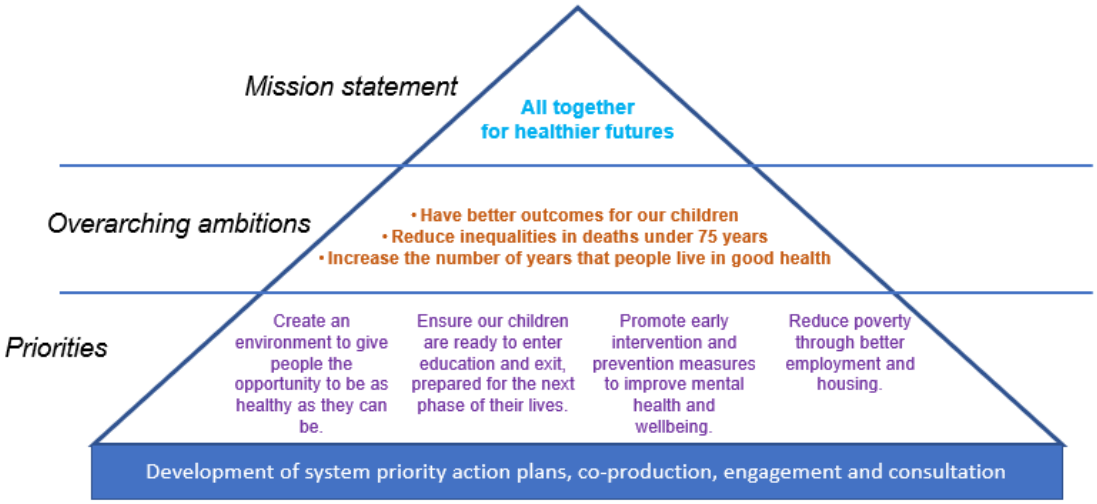
[3] The best start for life: a vision for the 1,001 critical days - GOV.UK (www.gov.uk)

2.15 The technical appendix C presents the best available evidence on the current situation for the three overarching goals. It is important to note that for some of the indicators used to measure progress towards these goals, the full impact of the Covid-19 pandemic is not yet showing up in the data. We may in fact be starting from a lower point than the most recent data suggests.

2.16 ***How we will achieve these ambitions***

Discussion at our system-wide workshops identified four priority areas where we know we need to do things differently in order to achieve our overarching ambitions.

The four priorities for the Health and Wellbeing Board and the Integrated Care System focus on children, our environment and opportunities for health, poverty, and mental health and wellbeing. Each of these priority areas will be developed into a chapter of the Health and Wellbeing Strategy. The four priorities are listed below.



2.17

1. **Ensure our children are ready to enter education and exit, prepared for the next phase of their lives**

    - This is not limited to children's educational attainment
    - Children's physical and mental health and wellbeing are essential for children to participate effectively in education

2. **Create an environment to give people the opportunities to be as healthy as they can be**

    - 'Environment' here is used in the widest sense, so includes wider determinants of health such as health behaviours, infrastructure, and socio-economic factors, as well as access to green spaces and clean air.

- This also includes the opportunities for better health which the NHS provides; partly healthcare, but also encouraging patients to take greater responsibility for their own health.

3. **Reduce poverty through better employment and better housing**

    - This especially recognises that the Health and Wellbeing Board / ICP partners are large employers within our local economy and the way we employ, treat our staff and commission services can have a big impact, as well as capturing work with wider partner organisations on the economy, employment and health.

    - Local and Combined authorities have a key role to play in improving housing across Cambridgeshire and Peterborough impacting health of residents

    - Better physical and mental health will improve employment for our residents

4. **Promote early intervention and prevention measures to improve mental health and wellbeing**

    - Work to improve wellbeing across the population, as well as intervening early when people experience mental ill-health, will have huge benefits for all our residents.

2.18 Senior staff from across the local public sector will work with partners and communities to take on development and leadership of the four strategy priorities, supported by evidence and data about our population. The work on these system-wide priorities – deciding what will change, what will cease and what new approaches are necessary will take place over the next six months. The longer timescale for developing this work is necessary to include and summarise much of the work that is already being done in these areas. It is also important to allow sufficient time for meaningful co-production, engagement and consultation to take place with service users, patients and residents, as well as ensuring relevance and support from partner organisations. The process and principles for developing the priority chapters, including engagement work, is laid out in the engagement plan and timeline in Appendix B

2.19 Health and Wellbeing Board and NHS partners will have different roles to play in each of these priorities; for example, the health system does not provide housing, and the local authority does not commission most mental health interventions. However, each of the four areas has scope for action for all key partners, plus there are additional benefits that should come from working on these agreed priorities together as a system.

2.20 All four priorities will need to consider what needs to be done around the cross-cutting themes and ambitions of improving children's outcomes, reducing health inequalities and improving years of life lived in good health.

3. CONCLUSION

3.1 We intend this Health and Wellbeing Strategy to shape work across the NHS and Cambridgeshire and Peterborough local authorities over the next eight years. We are starting from a challenging position given the impact of Covid-19 across our area, but we have set stretching but achievable ambitions. By working more closely across the NHS, the public sector, partners, communities and residents than we ever have before, we can achieve these ambitions and make a meaningful difference to the lives of our residents; happier and healthier children and young people, fewer early deaths in our more deprived areas, and more years spent in good health.

Joint Health and Wellbeing/ICP Strategy 2022-2030: Developing the Health and Wellbeing Strategy – timeline, co-production, engagement and consultation plan (Appendix B)

The overarching strategy was presented to the March meeting of the HWB for approval prior to public consultation. The initial development of the overarching strategy and targets has been done through two large stakeholder workshops on 6th October 2021 and 17th January 2022.

This paper sets out some more detailed information around the next steps for consultation and engagement for the overarching strategy and to enable the detailed development of the four priority chapters, their outcomes and action plans.

Timescales for development of overarching strategy

Date	
Oct 2021 – Feb 2022	Overarching strategy and targets developed based on system-wide workshops
Feb- March 2022	Socialised across system leads for comment and input
March 2022	Presented to whole system HWB sub-group formal meeting with request for approval around the engagement approach
May-June 2022	High level engagement activity underway within the integrated care system
May-June 2022	Senior Responsible Officers identified
Jul 2022	Engagement launched on the overarching strategy by the HWB/ICP. Engagement and consultation programme agreed
27th July 2022	Formal guidance on ICPs published
Sept 2022	Feedback from public engagement and Senior Responsible Officer (SRO)s received and analysed
Sept 2022	ICS launch public consultation on Integrated Care Strategy
14th Oct 2022	Final Overarching HWB Strategy submitted to Joint HWB/ICP for approval
20th Dec 2022	Joint HWB/ICP to receive the Integrated Care Strategy (incorporating the HWB Strategy)

Consultation and engagement for strategy priorities

We envisage that the bulk of the detailed co-production, engagement and consultation work on the HWB/ICP Strategy will be done on the content and direction of each priority chapter, key outcomes and action plans. Stakeholder groups and styles of engagement will vary with each topic and this will need careful consideration by topic leads to enable meaningful engagement and co-production.

Timescales for development of the four priorities

Date	
Oct 2021 – Mar 2022	Four priorities agreed and system leads identified
Mar 2022	As above, priorities presented to HWB/ICP formal meeting as part of the overarching strategy, with request for approval for public consultation on strategy
Apr-Nov 2022	Development and co-production of the four priorities by priority leads, partners and stakeholders with engagement as appropriate for each priority area.
Aug 2022-Dec 2022	Priority chapters of the strategy presented individually in detail to HWB/ICP formal meetings with request for approval for public consultation. Order to be determined.
Sep-Jan 2023	Formal consultation on priority chapters individually
March 2023	Formal approval of full overarching strategy with priority chapters by HWB/ICP.

Development of priority chapters

Each of the four priorities will have two senior responsible officer leads with experience of the relevant area. They will take account of relevant work that is already underway or in development across the system and consider how this fits together and how the system could work better to influence the three main overarching goals (children's outcomes, inequalities in premature mortality, and healthy life expectancy). The leads will also determine relevant indicators to monitor progress in each area.

A suggested structure for each of the four priority chapters:

- What is the scope for this priority and the overarching goal?
- Where are we now?
- What services and strategies are already in place (or development) across the system, including ICS work?
- What are we going to focus on (and how has this been decided)?
- Where can we get to with these areas of focus?
    - Bold ambitions for change that will prompt rethink of delivery and systems
    - How do these areas of focus contribute to overarching HWB priorities (healthy life expectancy, inequalities in premature mortality, and children's outcomes)?
- How can we get there – what will we do differently?
    - What will change?
    - Monitoring success - quick wins and ambitious medium and longer term targets

Principles for developing each chapter

Each of these four priorities is very wide-ranging with enormous scope. No strategy can be successful if it tries to improve everything all at once, so choices will be necessary while developing each of the four priorities. The senior leads for each priority will be making these decisions, but there are several principles that should be followed while these four priorities are being developed:

- We should use evidence-based approaches wherever possible, and embed evaluation and learning from new initiatives
- There should be an emphasis on prevention and early intervention
- The strategy must identify and tackle inequality in wellbeing across our places and by deprivation
- Given these principles above, where possible the choice of topics to focus on within each priority should be informed by stakeholder and service user and resident input on what is most important.
- It should be clear how actions and outcomes from each of the four priorities contribute to the three overarching goals of the strategy as a whole (improving outcomes for children, reducing inequalities in premature mortality, increasing years lived in good health), while having their own short and medium term goals.
- The goals within each priority should reflect different starting points for our different places, and also encourage reduction in inequalities by deprivation and ethnicity. Some short term ‘process’ outcomes may be necessary but medium (~5 yr) and long (~10 yr) outcomes should be clearly linked to the three overarching goals.
- Each priority should explicitly include children and young people.

Joint Health and Wellbeing/ICP Strategy 2022-2030: Setting the level of ambition (Appendix C)

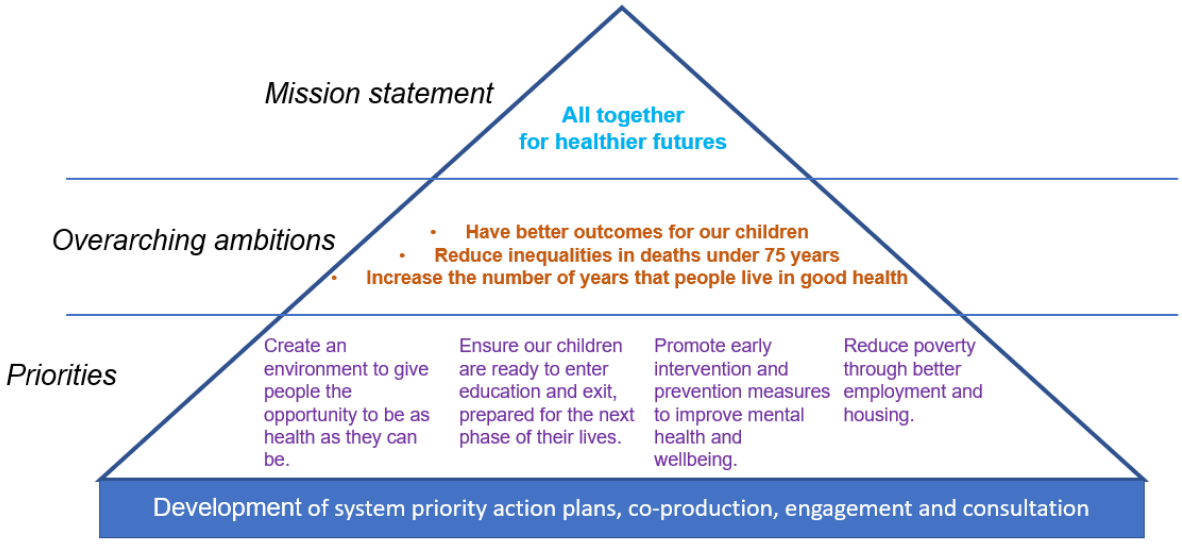
Introduction

The Health and Wellbeing Strategy overarching goals presented here are based on the system wide discussions held in October 2021 and January 2022. The January 2022 workshop specifically discussed the level of ambition for the Health and Wellbeing Strategy and highlighted that these goals should be stretching and ambitious while remaining plausible and achievable.

This technical appendix presents the best available evidence on the current situation for the three goals and proposes the level of ambition for each. It is important to note that the full impact of the Covid-19 pandemic is not yet showing up in the available data. We may in fact be starting from a lower point than the data below suggests; as such we suggest revisiting these targets once data is available that shows the full impact of the pandemic on our measures.

All the goals set out here are targets for the end of the strategy period in 2030.

All of the four priority areas (children, environment, poverty and mental health) will feed in to all three goals (image below), but some will have closer links than others. The priority areas will also develop their own targets which will include shorter-term metrics; these are yet to be determined but it will need to be clear how those targets feed in to these three overarching goals.



1. **We will increase the number of years that people spend in good health.**

   TARGET: We will increase healthy life expectancy by at least two years in Cambridgeshire and Peterborough, and we will reduce the gaps between men and women in our areas.

   What does healthy life expectancy mean?

   - For a particular area and time period, it is an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life.
   - Put simply, it is the number of years in good health that an average person can expect. It was chosen for one of our goals over life expectancy because life expectancy includes the years often spent at the end of life in poor health, and we do not seek to extend these. Healthy life expectancy has been described as 'adding life to years' rather than 'adding years to life.'

   Table 1 presents the latest data on healthy life expectancy for our area. At present Cambridgeshire residents have considerably higher healthy life expectancy than in Peterborough, for both men and women. Interestingly, in Peterborough women can expect fewer years in good health than men, while the reverse is true in Cambridgeshire. Therefore, we aim to see an increase of at least two years for women in Cambridgeshire and men in Peterborough, but to narrow the gap between the sexes we also want to see a larger increase for Cambridgeshire men and Peterborough women.

   The initial system wide workshops in October 2021 and January 2022 discussed a improvement levels of 10% for each target. For Healthy Life Expectancy this would be an unrealistic increase of at least six years which would take us beyond the current best in England.

Table 1 Healthy Life Expectancy in Cambridgeshire and Peterborough

	Cambridge-shire (2017-19)	**Cambridge-shire Plus 2 yrs**	**Peterborough (2017-19)**	**Peterborough Plus 2 years**	**Best in England (2017-19)**
Male healthy life expectancy	64.3	66.3	62.8	64.8	71.5
Female healthy life expectancy	66.2	68.2	59.9	61.9	71.4

We should also bear in mind that, as with most public health measures, healthy life expectancy is strongly linked to deprivation. Although figures for small areas are not

available to demonstrate the link in our local areas, national data shows clearly that people living in wealthier areas enjoy considerably more time in good health on average compared to residents of more deprived areas. We cannot set local targets to preferentially improve healthy life expectancy in our more deprived areas, but if this strategy includes a focus throughout on health inequalities we would expect healthy life expectancy to improve faster in these areas.

Healthy life expectancy was recently mentioned in the 'Levelling Up' White Paper[1] with one of the 'missions' described as: "*By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years."* This document refers to a forthcoming White Paper on health disparities that will set out the central governmental strategy for 'tackling the core drivers of inequalities in health outcomes. As such, we anticipate national policy support and action to facilitate this local target.

As with preventable premature mortality, increasing healthy life expectancy depends on core public health work and prevention and early intervention work delivered by the NHS. All four priorities will feed into increasing healthy life expectancy.

2. We will reduce inequalities in preventable deaths before the age of 75 years.

TARGET: We will reduce inequalities in preventable deaths before the age of 75 years by 20%.

Premature mortality here is defined as any death before 75 from causes considered preventable. It is presented as age-standardised rates per 100,000 rather than as absolute numbers.

Deaths are considered preventable if

- all or most deaths from the underlying cause could mainly be avoided through effective public health and primary prevention interventions.
- 'preventable' deaths include most infectious disease, some cancers, diabetes, cardiovascular disease, injuries and alcohol and drug-related deaths.[2]

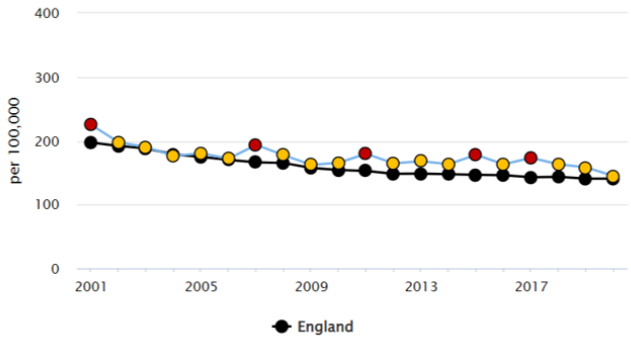
Preventable premature mortality rates are lower than the England average in Cambridgeshire but close to the England average in Peterborough (Figure 1). Rates have not changed much over the last ten years in either area, as the chart below shows. Comparing these two charts demonstrates an inequality between Cambridgeshire and Peterborough, which is probably a result of different levels of prosperity between these areas overall.

Figure 1 Preventable deaths under 75 per 100,000 in Cambridgeshire and Peterborough compared to England

[1] HM Government (2022) Levelling up the United Kingdom

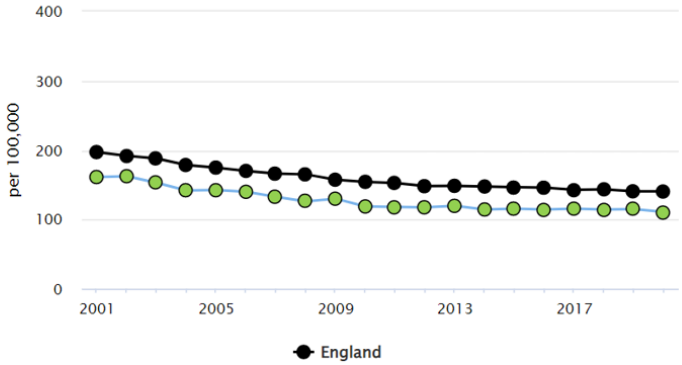
[2] For a full list of ICD-10 codes included in the definition of preventable deaths, see https://fingertips.phe.org.uk/mortality-profile#page/6/gid/1938133056/pat/15/ati/402/are/E10000003/iid/93721/age/163/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

Peterborough



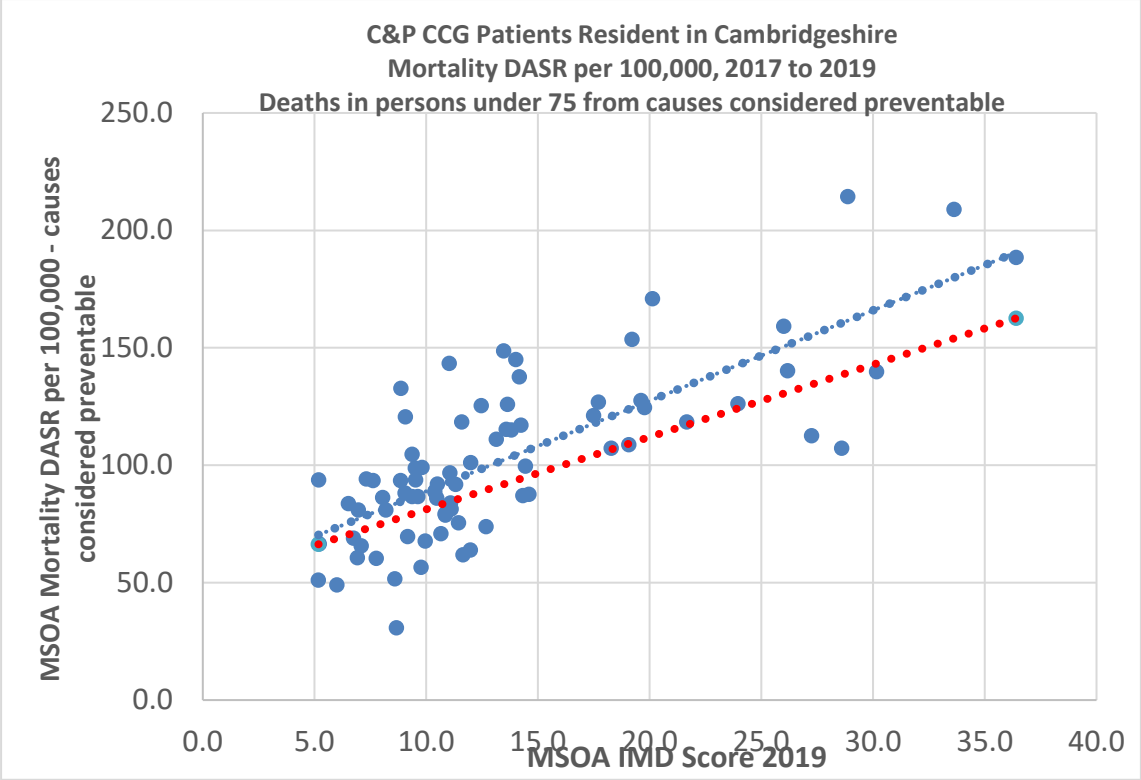
Period	Count	Rate
2010	210	165.6
2020	228	144.8

Cambridge



Period	Count	Rate
2010	587	118.8
2020	655	110.9

Preventable premature mortality rates also vary substantially by small areas (MSOA), with a clear link to deprivation. The chart below shows under-75 preventable mortality rates by Cambridgeshire MSOA (Peterborough not shown but a similar relationship exists). The blue line is the line of best fit for the current data (a regression line) which shows a strong relationship between increasing deprivation and increasing rates of preventable premature mortality. People in our some of our most deprived Cambridgeshire areas have a preventable mortality rate around four times higher than those in our least deprived areas; a substantial disparity. Please note that this data is the most recent available data and covers a three year period ending in 2019; as such the impact of the pandemic is not shown. At present the definition of premature preventable mortality data does not include deaths from Covid-19 (although it does include influenza deaths).



Reducing inequalities in premature mortality would require reducing the slope of this line to the red line shown above – our target. This is a 20% reduction in the slope of the line. This would have most benefit to those people in our most deprived communities but should also benefit people across the area; for instance, fairly well off areas (an IMD score between 10 and 20) also have some way to go to reduce their rates down to the red line.

The initial workshops discussed reducing targets by 10%. However, after considering what this would look like in practice, this has been considered as insufficiently ambitious and that in fact a 20% reduction was closer to the level of ambition discussed.

Reducing the slope of the line will also have the effect of reducing premature mortality overall. If the rates in the least deprived areas remain similar but the gradient reduces by 20%, we would have an overall preventable premature mortality rate of around 92 per 100,000 in Cambridgeshire, compared to 102 per 100,000 at present.[3] We will also have a target to reduce Peterborough's preventable mortality gradient by 20%

This target illustrates the principle of 'proportionate universalism'. To meet the target and reduce health inequalities, we need to work across our whole population, recognising there is room for improvement everywhere, but directing more efforts to those living in our most deprived areas where mortality is highest.

The work needed to reduce preventable premature mortality needs to take place largely in public health and in primary prevention. Improving health behaviour is key, as is early identification and intervention, including primary care and immunisation and

[3] Exact overall rate cannot be predicted.

screening. However, this target needs to also be seen in the context of the wider determinants of health and behaviour; the standard offers that reduce the risks of disease leading to premature mortality may not be sufficient (or may not be delivered to the same standard) in our most deprived areas. As such, each of the four priority areas has an important role to play in reducing premature mortality.

3. **We will have better outcomes for our children.**

TARGET: We will be the best of our comparators for core children and young people outcomes

Children and young people have been adversely affected by the pandemic across many areas of their lives, from loss of education, socialisation and jobs as well as increasing demand for mental health services from children and young people. Giving children the best start to life will pay dividends across the life course. Therefore, rather than a single outcome, the ambition is to improve across core children and young outcomes and be the best of our comparators. This priority is not limited to children's educational attainment; children's physical and mental health and wellbeing will be explicitly included.

Considerable work has already taken place on this topic and system-wide strategies currently already exist (or are in development) focusing on the main aspects of children and young people's lives. These strategies are led by the Children's and Maternity Collaborative who working across health, education and local authorities in Cambridgeshire and Peterborough. This has not been further defined at present because of the likely large overlap with the children and young People and mental health priority-specific targets. An important early step for these priorities will be to determine what outcomes should be included as overarching goals for the whole strategy and are likely to include the aspects below

- Best Start in Life (children 0-5 yrs)
- Strong Families Strong Communities (children and young people 5-25 yrs)
- Children and Young People's Mental Health
- Special Educational Needs and Disabilities including autism
- Autism

How are these goals linked?

These three overarching goals all interact. Improving child health will have significant effects on improving healthy life expectancy, because healthy life expectancy is strongly influenced by deaths in younger age groups. Reducing premature mortality will also affect healthy life expectancy, both by preventing death, but also because most of the conditions that contribute to premature mortality also cause substantial ill health for many people before death. If we are able to improve interventions to prevent these conditions in the first place then as well as preventing deaths, we will also prevent the associated ill health burden that reduces healthy life expectancy.

The focus on inequality means that we have to carefully consider how to do things differently – the 'easier' groups to influence are often those who are better off. Working with these better off groups would see overall rates decrease, but unless rates decrease faster for the more deprived then inequalities will worsen. Improving

outcomes for people at the most deprived end of the spectrum can be much harder, but it is also where there is most room for improvement.

The impact of Covid-19 on these metrics

Much of the full impact of the pandemic does not yet show up in these metrics. The healthy life expectancy data available at present only goes up to 2019, as do our small-area data on preventable premature mortality which allows us to see local inequalities in early deaths.

We know that overall life expectancy has shown a sharp downturn however in 2020, a pattern seen clearly in the charts below for men in Cambridgeshire and Peterborough though less apparent for women in our areas. Healthy life expectancy will have been similarly affected and so we will be starting from a lower base in 2022 than suggested by the figures above. We also know that Covid-19 has disproportionately affected our more deprived areas and communities, as is the case across the UK and beyond. As such, inequalities in healthy life expectancy and in premature mortality are likely to have worsened in the last two years.

We recommend revisiting the targets when data is available to give us a more accurate picture of our starting point at the beginning of 2022.