Cambridgeshire - Tackling Health Inequalities

Cambridgeshire Local Government and Health Economy

Audit 2007/08
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Background

National context

1 Health inequalities are differences in health experience and health outcomes between different population groups for example, by socio-economic status, geographical area, age, disability, gender or ethnic group. Health inequities are the differences in opportunity for different population groups that result in unequal life chances and unequal access to health services, a healthy diet, and decent housing for example.

2 Health and wellbeing is a key national focus for improvement. Narrowing the health gap between disadvantaged groups and the rest of the country is a top government priority. The single overarching target to reduce health inequalities is a national Public Sector Agreement (PSA) target. By 2010, inequalities in health outcomes have to be reduced by 10 per cent as measured by infant death and life expectancy at birth. It is one of the five top level priorities in the 2008/09 NHS Operating Framework.

3 The importance the Government is placing on reducing health inequalities is reflected in the fact that the Department of Health will be publishing a comprehensive strategy to help reduce health inequalities in 2008.

4 Tackling health inequalities is a new formal requirement both on local authorities and Primary Care Trusts (PCTs). The principal role is set out for PCTs in the Department of Health's 'Roles and Functions' statement in May 2006 as:

   'Improving the health status of its population and reducing health inequalities, in partnership with local authorities.'

5 The 2004 White Paper 'Choosing Health: making healthy choices easier' resulted in health inequalities targets being included in public service agreements (PSAs) for all government departments. 'Health Challenge England - next steps for choosing health 2007' sets out a new approach that aims to enable everybody to make a contribution to the nation's health. Further investment is expected to help in achieving sustained progress in improving the health of the whole population with a specific focus on health inequalities, smoking, obesity, alcohol and substance misuse, sexual health including teenage pregnancy and mental wellbeing.
The White Paper 'Strong and Prosperous Communities - Health and Wellbeing 2007', built on previous requirements, places the challenge of addressing health inequalities at the heart of changes. In particular: strengthening partnership working on the health inequalities agenda; strengthening scrutiny and overview arrangements; clear performance management; patient engagement and engagement with the voluntary sector; expectations of Directors of Public Health and annual reports; and a lead role for local authorities. The White Paper sets out four key areas for action:

- to ensure that all patients are able to voice their concerns on health and well-being issues in their area;
- to ensure there is more visible local leadership on health and well-being, particularly on public health issues such as childhood obesity, smoking rates and health inequalities;
- to build on the reforms set out in the Health Act (1999) and 'Our health, our care, our say' (2006), by engendering systematic partnership working between NHS bodies, local authorities and other partners, for example through greater use of joint appointments, pooled budgets and joint commissioning; and
- to ensure the priorities, reporting systems and performance management arrangements for public health and social care are joined up.

The document 'Commissioning framework for health and well-being' sets out the reform agenda for the health service. It emphasises the need for joint strategic needs assessment by councils, Primary Care Trusts (PCTs) and other relevant partners; and the sharing and using of information effectively. Lord Darzi's interim report references the intention of the Secretary of State to publish a national Health Inequalities Strategy.

**Cambridgeshire background**

At present there are significant levels of health inequality in some parts of the country. Certain groups of the population suffer from significantly greater ill-health (morbidity) and earlier death (mortality) than the average and other groups of the population. Understanding which groups of the population these are, and addressing the causes (targeting action), is the focus for addressing health inequalities.

Seeking to address health inequalities will have positive effects on the well-being and prosperity of the local population and investment is likely to provide significant long term benefit for the local communities of Cambridgeshire. Addressing such a large issue crosses organisational and service provision boundaries and therefore will require co-operation and shared vision.
The 2001 census showed that the county of Cambridgeshire (excluding Peterborough) was home to 553,000 people; of which 127,000 were aged 0 to 18. The structure of the resident population in Cambridgeshire was similar to the UK’s population profile. An influx of migrant workers (mainly from Eastern Europe) into both rural and urban areas in Cambridgeshire since the 2001 census means that these proportions may have changed in recent years.

Amongst children and young people, 89.9 per cent were born in the UK. Cambridge City had 17.8 per cent of dependent children born outside UK, whereas the figure for Fenland was just 3.2 per cent.

Cambridge City had the highest proportion (19.9 per cent) of dependent children with a language needs indicator. South Cambridgeshire (9.7 per cent) and Huntingdonshire (7.7 per cent) had higher proportions than East Cambridgeshire (5.9 per cent) and Fenland (3.8 per cent) with an indicator of likely need.

It is estimated that by 2021 there will be 90,000 more people living in Cambridgeshire than the estimated figure for 2006.

Table 1

<table>
<thead>
<tr>
<th>Local authority</th>
<th>2006 population forecast</th>
<th>2011 population forecast</th>
<th>2016 population forecast</th>
<th>2021 population forecast</th>
<th>% change 2006 to 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridge City</td>
<td>113,600</td>
<td>131,700</td>
<td>147,700</td>
<td>149,400</td>
<td>+31.5%</td>
</tr>
<tr>
<td>East Cambs</td>
<td>76,400</td>
<td>80,700</td>
<td>82,200</td>
<td>81,300</td>
<td>+6.4%</td>
</tr>
<tr>
<td>Fenland</td>
<td>89,800</td>
<td>91,700</td>
<td>95,400</td>
<td>99,700</td>
<td>+11.0%</td>
</tr>
<tr>
<td>Huntingdonshire</td>
<td>160,800</td>
<td>168,200</td>
<td>166,000</td>
<td>166,300</td>
<td>+3.4%</td>
</tr>
<tr>
<td>South Cambs</td>
<td>138,200</td>
<td>150,400</td>
<td>162,000</td>
<td>172,700</td>
<td>+25.0%</td>
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<tr>
<td>Cambridgeshire County</td>
<td>579,000</td>
<td>622,700</td>
<td>653,300</td>
<td>669,400</td>
<td>+15.6%</td>
</tr>
</tbody>
</table>

The biggest actual increases and also proportional increases are expected in South Cambridgeshire and Cambridge City. 23.6 per cent of the population in Cambridge city is 15 to 24 years old, compared to an average of 10.88 per cent for the other four districts. Fenland has a higher over-50 population than the rest.
Audit approach

This review is aimed at exploring how well local authorities in Cambridgeshire (excluding Peterborough) and the Cambridgeshire PCT are working in partnerships to:

- understand their local health inequalities;
- set objectives, targets and develop strategies, policies and actions to address local health inequalities;
- direct resources appropriately to narrow the health inequalities gap;
- have arrangements in place to challenge and review their actions; and
- know how well they are performing.

A list of organisations directly involved in the review is attached at Appendix 1.

The work involved:

- surveying partner organisations;
- document review;
- workshops;
- interviews; and
- focus groups.

The review was designed to examine two main issues:

- what evidence is there of local partners reducing health inequalities; and
- how partners are progressing action to achieve/improve on targets.

Following discussions with representatives of the key players, the theme of 'healthy living' was used to test how partners work together. This covered smoking; obesity; physical activity; sexual health; and alcohol and substance misuse and provided a useful focus as it was an area that both the county and district councils have a role as part of their day to day activities.

The outcome of the review is a joint performance report across local government and the health economy in Cambridgeshire, which identifies issues, based on identified areas of risk; makes high level recommendations; and shares notable practice to help improvement planning. An action plan is included in Appendix 2 to help partners move forward on reducing the health inequalities gap and address recommendations for improvement.
Main conclusions

Cambridgeshire faces a number of risks in its efforts to tackle health inequalities as follows.

• The lack of a countywide strategic approach has hindered the prospects of a structured approach to tackling health inequalities. Nevertheless, the opportunity for a more strategic countywide approach has been recognised following the creation of a single PCT and some work is underway to address the issue. Considerable effort has been invested in developing the Local Area Agreement and partnership arrangements necessary for tackling health inequalities. Supporting healthy lifestyles are being established.

• The full value of the possible input from the voluntary sector is not being embraced. Opportunities to share learning throughout the County are being lost.

• There is a lot of effort being made to tackle inequalities at a local level but the impact of this work is not effectively measured. Consequently, there is risk that activities may not be assessed and benefits realised.

• Capacity for tackling health inequalities robustly is variable. There are different approaches to championing health inequalities by the various partners and there is a lack of understanding of the term 'health inequalities' particularly at an operational level. Current governance arrangements also lack sufficient strategic focus to ensure an effective approach to reducing health inequalities.

What evidence is there of local partners reducing health inequalities

Health in Cambridgeshire is generally good in comparison to the national average. But there are some significant differences across the county in terms of life expectancy. For example between Fenland and South Cambridgeshire and differences between wards within Cambridge city. Life expectancy for people living in the most deprived wards can be up to four years lower than for those in the most affluent wards.

A countywide strategic approach has not been developed. There is consensus among stakeholders within Cambridgeshire on the role and shared responsibility of organisations to address health inequalities. There is some evidence of impact made by partnership working. The Fenland Spearhead Action Plan was developed to improve health and life expectancy in Fenland and to achieve the accelerated target trajectory for male life expectancy. This has been able to deliver its objectives through countywide partnerships such as the Children and Young People’s Strategic Partnership, as well as more local partnerships such as the Fenland Diversity Forum. Such action has been effective with improved life expectancy levels for males, as have various local initiatives on smoking cessation. However, the lack of a countywide strategic approach inhibits further development of this approach.
Information available at a district level relating to health inequalities is not consistently mapped across the full range of diverse groups, for example by gender, disability, sexual orientation, faith community and neighbourhoods. Consequently, there are gaps in knowledge about local patterns of health inequalities. It may not be possible to collect quantitative information about the full range of diverse groups, but qualitative information involving local feedback from these groups and relevant voluntary sector agencies can be collected. This means that partners do not have a complete picture of inequalities and risks across the county.

Data to provide a comprehensive picture of the health inequalities issues is being developed. But comprehensive data sets are not yet available for areas such as ethnicity monitoring of vulnerable groups such as travellers and for first language. This is partly dependent on the requirements of national data collection systems used by different agencies.

Initiatives in relation to smoking cessation and fitness promotion tend to last for a specific, concentrated period. This often means that, whilst the impact of a specific project is measured, there is no longer term evaluation of the outcomes. There is an absence of a concerted approach to securing data, once the profile of the particular promotion has diminished. For instance a failure to maximise opportunistic screening of service users to obtain data on lifestyles and offer appropriate advice.

How are partners progressing action to achieve/improve health inequalities

There is scope for more partnership working. There is evidence of successful action within Cambridgeshire to address health inequality issues, but partnership working is not use to its fullest potential. Partner organisations recognise that the establishment of a countywide PCT in late 2006 has provided an opportunity to more easily promote wider partnership working. The appointment of a joint PCT/County Director of Public Health and the establishment of a County Council public health management team has provided an improved focus on the public health functions. Within the various public sector organisations in the county there are many strategies that relate to health needs. It is accepted that these need to be pulled together more effectively. A county wide strategic approach is being developed by the PCT and County Council who are promoting and actively working on such an approach. Through the LAA they are scoping the role of a countywide health and well being partnership. There is a clear indication of a will to take a more strategic approach, which can only be of benefit to local people, and these approaches need to be co-ordinated further.
Cambridgeshire Local Government and Health Economy

27 Capacity to tackle health inequalities robustly is variable. District/city work is often associated with non-statutory service provision and can be dependent on external grant, the receipt of which is uncertain. Capacity is also hindered by the lack of full understanding of health inequalities. At an operational level, where health inequalities are being addressed, staff do not consistently understand the use of the term ‘health inequalities’ and its link to their service area or particular role. It is not always clear who is championing health inequalities issues at councils. Some councils have a specific member and/or officer champion whose remit is to promote the council's approach to dealing with health inequalities. In others the approach is less clear. Current governance arrangements also lack sufficient strategic focus to ensure an effective approach to reducing health inequalities.

28 The county lacks a methodology to assess the impact of actions taken to tackle health inequalities. There is a lack of SMART (specific, measurable, achievable, relevant, and trackable) targets relating to health inequalities. There are some measurable high level targets in the LAA, which are monitored on an annual basis. The lack of lower level SMART targets and the variability across different districts, makes it difficult to determine what progress is being made; effectively manage performance and gauge the impact of actions in this area. It is therefore difficult to assess how partners have improved health inequalities. For example, the voluntary sector tends to have targets that are a lot ‘softer’ and longer term than those of the statutory bodies. It would be beneficial if targets of the voluntary sector could be aligned with those of statutory organisations. This could also help the voluntary sector in funding applications and ultimately benefit residents of the county.

29 There is a vibrant voluntary sector in the county, with good examples of work that involves voluntary organisations. However, there is a concern that the PCT’s records on the voluntary agencies that work in Cambridgeshire are not complete and that the voluntary sector does not always receive key information. For example, information on practice based commissioning was not effectively communicated to voluntary sector groups. Given that GPs were often speaking with the clients of the voluntary sector, then it was unclear how GPs could effectively utilise the voluntary sector. The voluntary sector tends to have informal networks that could provide the PCT with more information on what its organisations can offer. The informality of these networks means that the knowledge is not shared within any strategic framework.

30 At this stage, it cannot be determined if Cambridgeshire achieves good value for money in its actions to reduce health inequalities. This is because of the lack of a strategic framework; variable performance management arrangements; the lack of resource focus and the inability to demonstrate outcomes which reduce health inequality gaps.
Recommendations

**Recommendation**

R1  A governance model be adopted to provide a countywide strategic focus for work on reducing health inequalities in Cambridgeshire in order to:

- ensure a strategic framework for tackling health inequalities is in place linked to the development of targeted work to address those areas most in need;
- enable maximum use to be made of the voluntary sector in dealing with health inequalities; and
- assist robust delivery of actions; accountability; performance management arrangements and evaluation across partners.

The expected benefits of this recommendation are:

- to provide a cohesive approach focused on areas and population groups most in need; and
- to provide greater value for money through a clear strategic focus and more targeted work.

The implementation of this recommendation will have high impact with low costs. This should be implemented by October 2008.

**Recommendation**

R2  Ensure that new public health and health inequalities data sets and tools allow:

- appropriate baselines to be set to accurately measure the impact of initiatives on reducing health inequalities;
- availability of information on local needs of the whole community to inform service delivery and health service access;
- action plans to be developed to address those residents most in need;
- data currently available, and the structures and process which collect it, to be mapped to identify gaps;
- gaps arising from the need to anonymise local data to be addressed, in order to ensure data confidentiality compliance;
- the identification of potential for shared working in areas of commonality across organisations to ensure value for money.
The expected benefit of this recommendation is:

- a more robust platform to tackle health inequalities in Cambridgeshire.

The implementation of this recommendation will have high impact with low costs. This should be implemented by October 2008.

**Recommendation**

<table>
<thead>
<tr>
<th>R3</th>
<th>Ensure robust performance management arrangements are in place to improve health inequalities in Cambridgeshire by:</th>
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<tr>
<td></td>
<td>- using intelligence appropriately to set SMART challenging targets which measure the impact of work undertaken;</td>
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<td>- sharing and seeking out best practice to inform future improvement;</td>
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<td></td>
<td>- setting appropriate milestones to improve health inequalities and judge improvement progress against;</td>
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<tr>
<td></td>
<td>- proactively and regularly managing performance through the new governance arrangements in place; and</td>
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<tr>
<td></td>
<td>- for neighbourhood based projects, develop a framework of potential assessment criteria in order to ensure that long term impact can be demonstrated.</td>
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</tbody>
</table>

The expected benefits of this recommendation are:

- To ensure the impact of outcomes towards addressing health inequalities are appropriately measured and improvement progress is robust.

The implementation of this recommendation will have high impact with medium costs. This should be implemented by March 2009.
Tackling health inequalities

What evidence is there of local partners reducing health inequalities?

Summary

There is some evidence that local partners are reducing health inequalities. Currently, there is an incomplete picture of the health inequalities across diverse groups in Cambridgeshire and variation in the priority given to addressing health inequality by district/city councils, although work is in hand to address this. There are few examples of organisations, either singly or jointly, being able to demonstrate a measurable reduction in health inequality as a result of a clear intervention on their part. However, in some cases, difficulties arise from data quality, a lack of data, or knowledge of what is available. In order to inform further development of a countywide strategy on health inequalities, a new public health and health inequalities dataset was commissioned through the County Council’s Research Unit, but it is too soon to assess whether this will have a demonstrable impact.

There are a number of national PSA targets to which the health economy and its partners are expected to contribute:

- increasing life expectancy at birth to 78.6 years (male) and 82.5 years (female)
- reducing mortality rates from circulatory diseases with a reduction in the inequalities gap;
- reducing mortality rates from cancer;
- reducing mortality from suicide and undetermined injury;
- reducing health inequalities as measured by infant mortality;
- reducing adult smoking rates;
- halting the rise in obesity among children; and
- reducing the under-18 conception rate.
Cambridgeshire is relatively prosperous with earnings in the county above the national average and this is reflected in many of its health profile indicators. Life expectancy for both males and females is significantly better than the average for England, as are the records of deaths from smoking, heart disease and stroke, cancer and infant deaths. But there are contrasts between parts of the county with pockets of significant deprivation. It is a predominantly rural county, with 74 per cent of the population living in the county’s market towns, villages and geographically isolated communities. Those rural areas that are most remote from the cities of Cambridge and Peterborough experience generally lower levels of skills and income and greater health inequalities than the rest of the rural urban economy. For example, life expectancy in Fenland is only at or around the national average, as are the records of deaths from smoking, heart disease and stroke, cancer and infant deaths.

Health inequalities are understood and addressed in some key services at a district level. There is evidence of some reduction in health inequalities. Some districts through their community strategies exhibit a broad understanding of health inequalities as they relate to their own populations. For example, Fenland local strategic partnership has a community strategy to 2010 which clearly recognises the issues faced within its area and the importance of dealing with health inequalities and the benefits of working in partnership. Action planning is well advanced and examples of joint working include its initiative with the PCT working on flu clinics and fuel poverty sessions. The Fenland Spearhead Action Plan, which was developed to improve health and life expectancy in Fenland and to achieve the accelerated target trajectory for male life expectancy, has been able to deliver its objectives, including a reduction in the number of deaths from road traffic accidents among 15 to 24 year olds (although the figures remains high in comparison to the average for the rest of England). South Cambridgeshire District Council has undertaken targeted initiatives towards travellers, which are the main minority group in the district, and there are targeted actions for the two most deprived wards in the district. Some GP practices in Cambridgeshire are doing well to ensure that those likely to be in most need are making greater use of the smoking cessation service. There is evidence of some improvement in health inequalities, with profiles indicate an improving trend in each of those areas mentioned above.

Targets have been agreed through the LAA process. These targets tend to be adopted by the individual councils and integrated into council strategies that have an impact on health. However, there are concerns among some districts that the LAA targets do not represent closely the inequalities that are specific to their area. There is a feeling that governance arrangements need to be strengthened and that work is needed to integrate local initiatives to countywide working in order to ensure that clear evidence can be provided of consistent reductions in health inequalities.
Data to provide a comprehensive picture of the health inequalities issues is being developed. But common data sets are not yet available for areas such as ethnicity and first language. Initiatives have been introduced locally in several parts of the county in relation to smoking cessation and fitness promotion. However, these promotions often tend to be for a concentrated, but limited period and this can mean that, whilst the impact of a specific project is measured, there is no longer term evaluation of the outcomes or evidence of a decline in performance level as a result of a promotion ceasing. There is no apparent attempt to maximise opportunities to ‘screen’ individuals when they come into contact with services, when such information could improve 'lifestyle data' or enable the service to be in a position to offer appropriate advice. There is a need to develop a responsive mechanism with a risk management focus which enables local services to recognise and escalate issues and information for further assessment.

There are a number of local schemes across the county which are improving access to health services for disadvantaged groups. But there is not always sound evidence of the measurable impact of such projects on reducing health inequalities. Examples of district wide initiatives include the following.

- South Cambridgeshire District Council has an ‘Active Sports’ development programme which highlights active communities as a key part of this programme. This is ‘designed to increase and sustain participation in sport and recreation by those individuals and groups who may be excluded from participating’, the priorities being;
  - communities in areas of social and economic deprivation;
  - ethnic minorities, women and girls, people with disabilities and people on low incomes; and
  - young people.
- Cambridge City Council operates a leisure card scheme and the active communities strategy has a target to increase participation in the use of leisure facilities by key groups.
- Huntingdonshire District Council’s smoking cessation initiative, including daily drop-in stop smoking clinics run by the Council’s smoke free implementation officer.
- The fitness suite at Witchford Village in the district of East Cambridgeshire is IFI accredited (Inclusive Fitness Initiative). This means that the equipment is highly accessible for use by wheelchair users and also for people with visual impairments. Also the instructors have received additional training to help people who may need extra assistance.
- Promotion of healthy living through leisure centres and outreach activities in rural areas, particularly in Fenland.
- The Neighbourhood Management Group healthy living initiatives in Ramsey, Eynesbury and Oxmoor.
In addition, there are a number of neighbourhood based projects focussing on specific areas of deprivation throughout the county. The impact of these activities both locally and on broader health outcomes and health inequalities can be difficult to assess. Without improved methods for assessing the impact of these schemes, partners cannot be clear that their efforts are contributing to local or countywide priorities. Also the timescale of some of these projects can be problematic eg annual or even three-year funding of a project may be insufficient to demonstrate any long term impacts.

Notwithstanding the fact that these initiatives are in place, more than half of the stakeholder representatives who responded to the Audit Commission's survey did not know which actions have had a measurable impact on reducing local health inequalities in the last two years, or that it could be shown that health inequalities have narrowed in the last two years in the area my organisation or service covers.

### How are partners progressing action to achieve/improve on targets?

**Summary**

39 *In the past, the lack of a countywide strategic approach has hindered the prospects for a structured approach to tackling health inequalities. Even so, there is a strong commitment to the principle of addressing health inequalities and there is widespread support for developing a countywide approach, particularly following the creation of a single PCT. Some work is underway to address the issue and the county is in state of managed transition towards the partnership arrangements necessary for tackling health inequalities and supporting healthy lifestyles. These partnership arrangements need to be taken forward at an early stage so that a more robust approach to health inequalities can be developed. The full value of the possible input from the voluntary sector is not being embraced and performance management arrangements and the lack of SMART targets to measure progress in addressing health inequalities are under-developed and therefore value for money cannot be demonstrated.*

40 There is acknowledgement of the importance of tackling health inequalities. Responsibility for action to address them is accepted as being shared across partner organisations in local government and the health economy. In the Audit Commission's survey to all partners as part of this study, all of the respondents recognised that councils have a community leadership role which includes promoting a healthier community and narrowing health inequalities. Eighty-eight per cent stated that their organisation's chief officers and councillors were committed to tackling health inequalities.
Existing governance arrangements do not provide a robust strategic framework to address health inequalities. This has been acknowledged by key players and the county is in a state of managed transition. Health inequalities and healthy lifestyles targets are agreed on a county-wide basis through the LAA and are implemented locally through the strategies and action plans, such as local health partnerships. Performance is monitored through the quarterly LAA monitoring process. Stakeholders consider the role of local strategic partnerships and sustainable community strategies to be a very important framework to maintain and that LAA targets have an important role to play, but the overriding need is identified as a county-wide strategic approach. The appointment of the joint PCT/County Director of Public Health is a useful catalyst to assist in driving forward a more robust county-wide framework.

The full value of the possible input from the voluntary sector is not being embraced. There is an active and willing voluntary sector in the county, with good examples of work that involves voluntary organisations. However, voluntary sector stakeholders are concerned that the PCT’s records on the voluntary agencies that work in Cambridgeshire are not complete and that the voluntary sector does not always receive key information on the latest developments that would impact on their organisations. For example, information on practice based commissioning was not effectively communicated to the group. GPs were often speaking with the clients of the voluntary sector, but were unclear how they could effectively utilise the voluntary sector. The voluntary sector tends to have informal networks that could provide more information on what organisations can offer. The informality of these networks means that the knowledge is not used strategically. The voluntary sector has targets that are a lot ‘softer’ and longer term than those of the statutory bodies. It would be beneficial if a county-wide strategic partnership group could help to align the targets of those in the voluntary sector with those of the other agencies.

The findings of the Commission’s survey confirmed a lack of joint training to reduce health inequalities, something from which the voluntary sector could benefit and could then better promote its organisations in areas that could help to address health inequalities.
Currently, there is limited dedicated capacity available to tackle health inequalities effectively across the county. For example, existing capacity within some districts to deal with health inequalities through physical activity is variable and activities are not necessarily linked to health inequality targets. In others there is an approach more focussed on physical activity which is being used to concentrate on improving health but not addressing health inequality. Capacity is also hindered by the lack of full understanding of the term 'health inequalities' at an operational level. Health inequalities are being addressed, but staff do not necessarily recognise it as such. It is not always clear who is championing health inequalities issues at councils. Some councils have a specific member and/or officer champion whose remit is to promote the council's approach to dealing with health inequalities, whereas others are less clear. The Commission's survey responses showed that only one half of those responding believed that there are effective mechanisms for enabling communities to participate in developing action on health inequalities.

Equally, additional financial resources are not always available to deliver actions in the LAA and the county community strategy; rather they have to be met through existing resources. Available resources have not necessarily been targeted at reducing health inequalities. This has an impact on the capacity of partners to deliver improvements to health inequalities in the short term and risks neglecting the potentially disadvantaged.

Overall, a lack of SMART targets in the various strategies and action plans makes the impact of local initiatives harder to assess and performance manage effectively. It is not clear from some documents who is accountable for delivery of the schemes or how progress is to be performance managed. Where targets have been set they focus on whole population health rather than on narrowing inequalities. It was a minority of responders to the survey who felt that the public sector partners can show that health inequalities have narrowed in the last two years in the area. As a result, there is limited evidence of improved delivery/outcomes through performance management arrangements.

Partners cannot demonstrate value for money in reducing health inequalities. For example, over the years the majority of sports facilities have been built in relatively affluent areas. Those most in need may not be benefiting from facilities which encourage physical activity a key determinant of health. A majority of participants in the survey acknowledged that cost benefit analysis of options for action had not been undertaken in the last two years, either singly or jointly. This means that it cannot be demonstrated that such projects have been effective in providing value for money because their impact on reducing health inequalities cannot be evidenced.
Appendix 1 – List of organisations involved in the review

The following organisations as key partners have been involved in the review.

- Cambridgeshire County Council
- Cambridgeshire PCT
- Cambridge City Council
- East Cambridgeshire District Council
- Fenland District Council
- Huntingdonshire District Council
- South Cambridgeshire District Council
- Cambridge and Peterborough MH Partnership NHS Trust

The following other partner organisations have been involved in the review.

- Age Concern
- Cambridgeshire ACRE
- Cambridgeshire ACRE Forum Support
- Hinchingbrooke NHS Trust
## Appendix 2 – Action plan

### Recommendations

**R1** A governance model be adopted to provide a countywide strategic focus for work on reducing health inequalities in Cambridgeshire in order to:

- ensure a strategic framework for tackling health inequalities is in place linked to the development of targeted work to address those areas most in need;
- enable maximum use to be made of the voluntary sector in dealing with health inequalities; and
- assist robust delivery of actions; accountability; performance management arrangements and evaluation across partners.

**R2** Ensure that new public health and health inequalities data sets and tools allow:

- appropriate baselines to be set to accurately measure the impact of initiatives on reducing health inequalities;
- availability of information on local needs of the whole community to inform service delivery and health service access;
- action plans to be developed to address those residents most in need;
- data currently available, and the structures and process which collect it, to be mapped to identify gaps;
- gaps arising from the need to anonymise local data to be addressed, in order to ensure data confidentiality compliance; and
- the identification of potential for shared working in areas of commonality across organisations to ensure value for money.

**R3** Ensure robust performance management arrangements are in place to improve health inequalities in Cambridgeshire by:

- using intelligence appropriately to set SMART challenging targets which measure the impact of work undertaken;
- sharing and seeking out best practice to inform future improvement;
- setting appropriate milestones to improve health inequalities and judge improvement progress against;
- proactively and regularly managing performance through the new governance arrangements in place; and
- for neighbourhood based projects, develop a framework of potential assessment criteria in order to ensure that long term impact can be demonstrated.