Cambridgeshire & Peterborough
Integrated Care System

Health Inequalities Information Statement Data Pack

2024/25

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Background

Information statement background

- Working through their Integrated Care Boards (ICB) and Integrated Care Partnerships (ICP), Integrated Care Systems (ICS) have four aims. **Tackling inequalities in outcomes, experience and access** is one of these four aims.
- In November 2023, NHS England published new guidance on how NHS bodies discharge their responsibility to report information on health inequalities:
    - NHS England » NHS England's statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006)
- The guidance reflects a proportionate and phased approach to gathering and making use of available information on health inequalities and recognises that this will evolve over time.
- NHSE also provided a list of indicators that NHS bodies should collect, analyse and publish on health inequalities.
    - NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)
- The Health Inequalities Information Statement Data Pack is supplementary to NHS Cambridgeshire and Peterborough ICB's annual report and should be read in conjunction with this.
- The pack has been created to highlight how Cambridgeshire and Peterborough ICB is delivering against NHS England's priorities and discharging its statutory duty to tackle inequalities in outcomes, experience and access.

Health Inequalities data and insights overview

NHS Cambridgeshire & Peterborough ICB continues to work closely with its ICS partners to strengthen its use of data and business intelligence to better understand population health needs and to identify and address healthcare inequalities.

The information contained within this pack has been compiled to support existing data and insights on health inequalities which include:

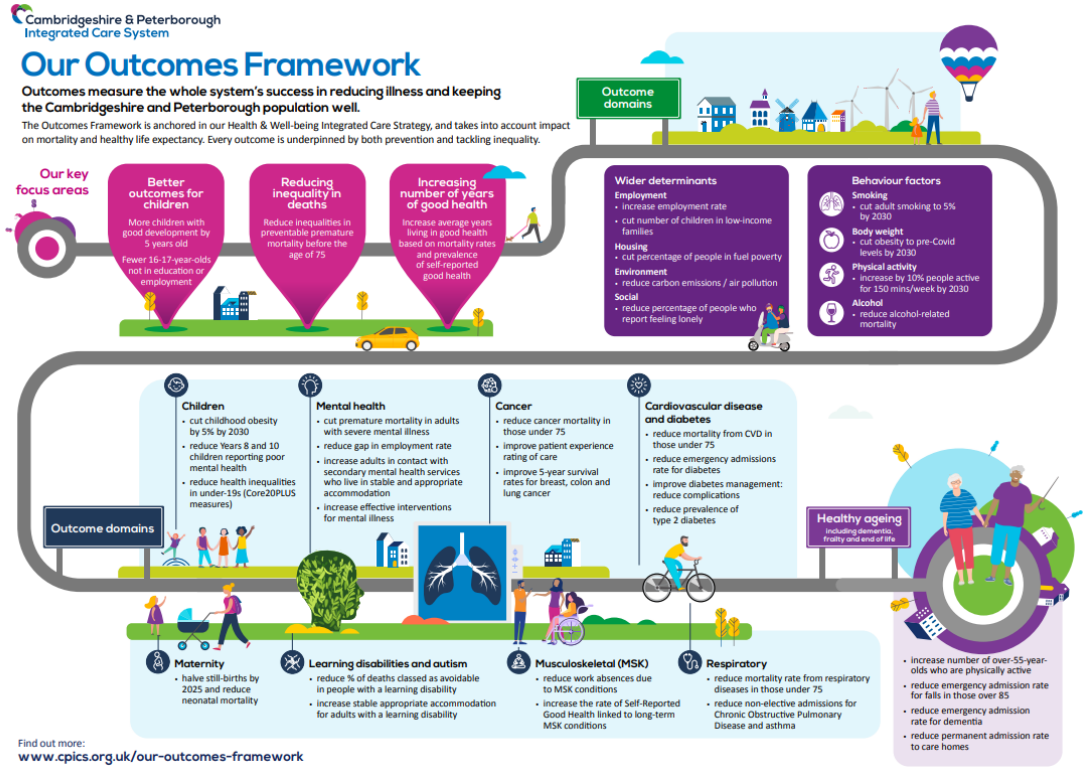
- The Cambridgeshire and Peterborough Outcomes Framework
- Local Authority Joint Strategic Needs Assessments
- Population Health Management (PHM) approaches and population segmentation reports that provide health insights at System, Place and Neighbourhood levels
- Core20PLUS analysis and insights
- Health Inequalities Improvement Dashboard (HIID) reports
- Equality and health inequality impact assessments (EHIAs)
- Reports developed which enable review by deprivation, ethnicity and other protected characteristics which help to inform priorities and resource distribution
- Community insight reports

What makes up the Cambridgeshire and Peterborough 'System', our two Places and our Neighbourhood teams

Cambridgeshire & Peterborough Insights

Outcomes Framework

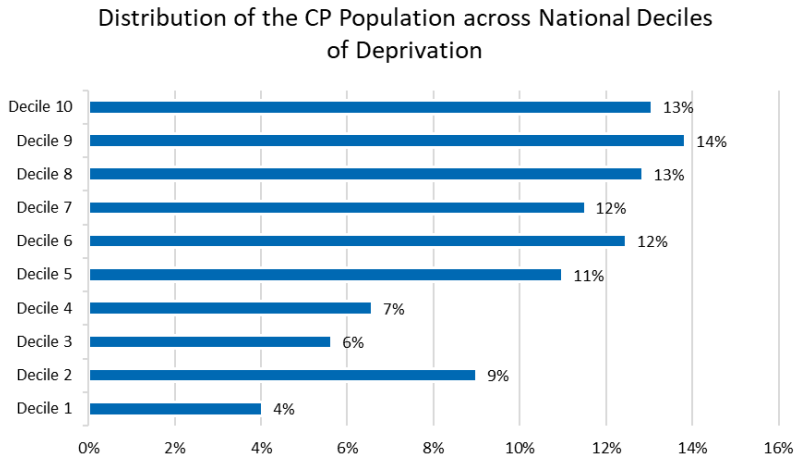
- Outcomes measure the whole system's success in reducing illness and keeping people who live across Cambridgeshire, Peterborough and Royston well. Outcomes are the 'things we know people care about', they are the result of the care, treatment and support we provide.



- Based on the core aims and priorities of our Health & Wellbeing Integrated Care Strategy, our Outcomes Framework sets out an agreed set of 'outcomes' that we want to achieve for our local population.
- It is supported by a set of indicators which enable us to track and monitor our progress so we can then identify opportunities to improve and work to reduce inequalities within our local area.
- The Outcomes Framework also supports the ICB's Joint Forward Plan and helps to guide the evolving delivery plans of our place-based partnerships.
- Cambridgeshire & Peterborough Outcomes Framework

Deprivation

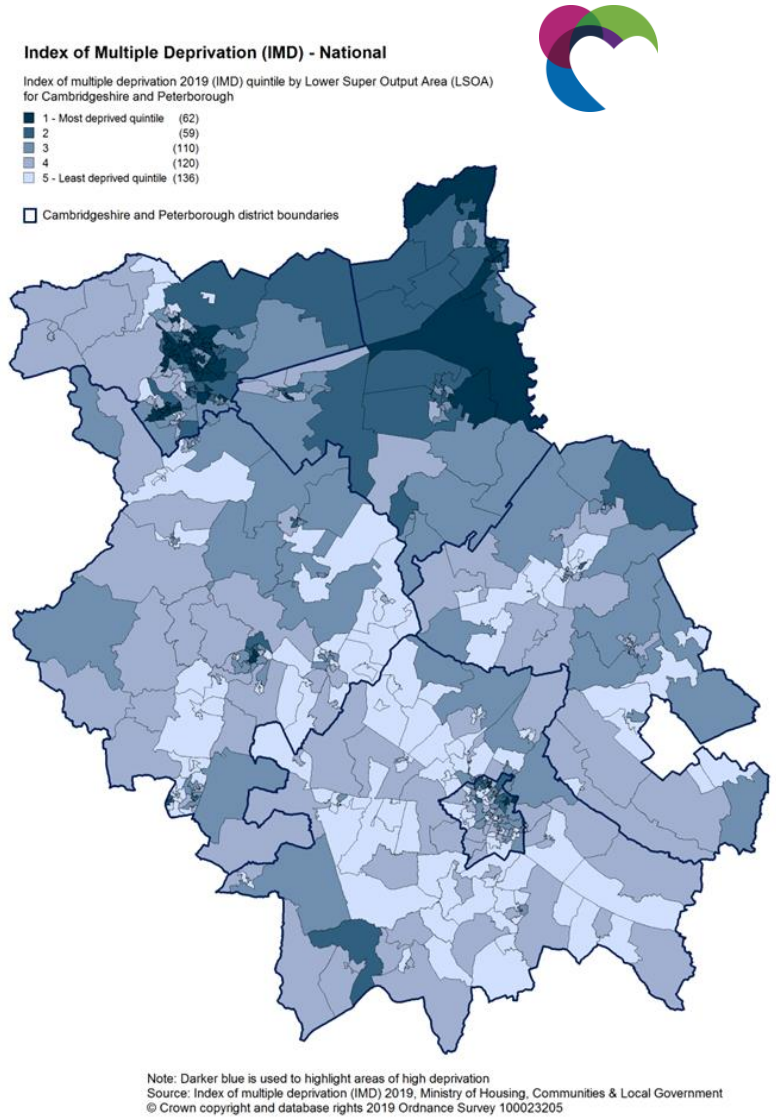
- Index of Multiple Deprivation (IMD) measures relative deprivation in small areas in England called lower-layer super output areas (LSOA).
- The image on the right shows the IMD quintile by LSOA for Cambridgeshire and Peterborough, where the darker blue is used to highlight areas of high deprivation.
- Cambridgeshire is relatively less deprived than Peterborough.
- There is variation in the level of deprivation across the Cambridgeshire districts with Fenland being most deprived (Score of 25.4).
- Cambridgeshire has an IMD Score of 13.9 and Peterborough has an IMD Score of 27.8.



In Cambridgeshire and Peterborough an estimated 112,000 people live in the 20% most deprived areas nationally ('Core20' – see slide 20).

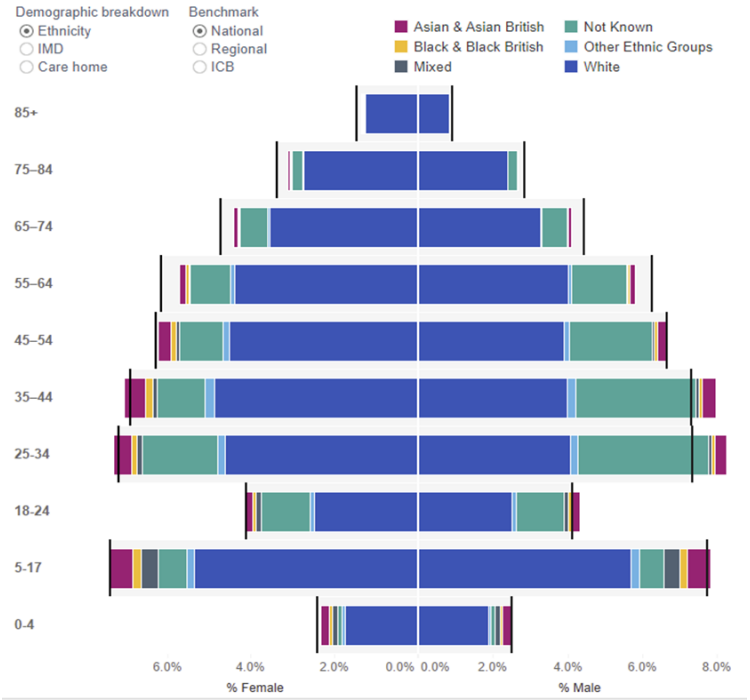
This equates to:

- 13% of the total Cambridgeshire and Peterborough population.
- 18% of the Fenland population (approx. 19,000 people).
- 41% of the Peterborough population (approx. 89,000 people).



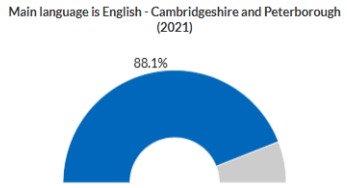
Population breakdown

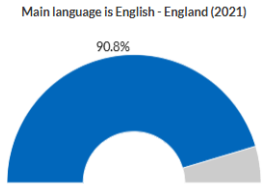
Cambridgeshire and Peterborough is an ethnically diverse area, but this diversity is most apparent in our cities and less so in more rural areas.

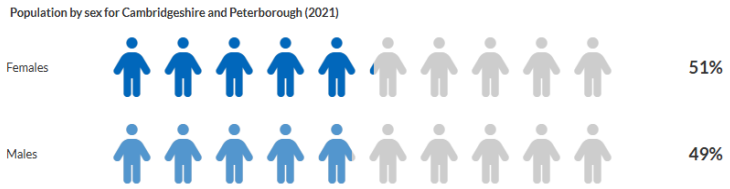


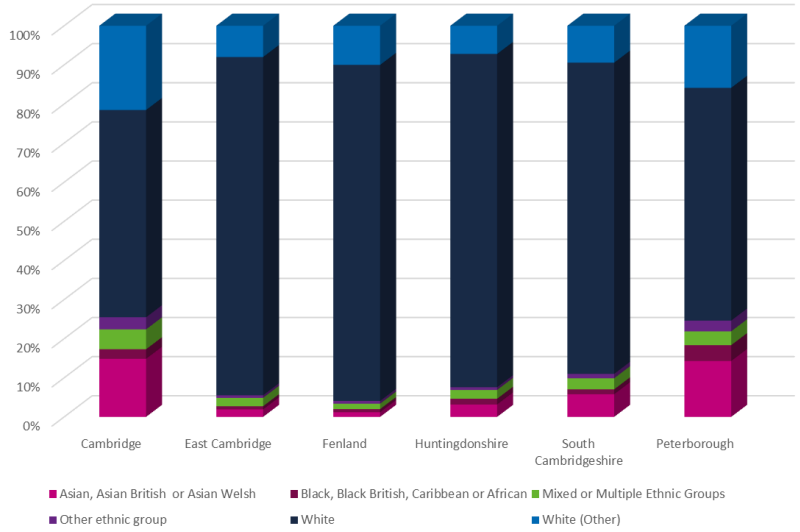
The above population pyramid shows ethnicity breakdown across age bands and between males and females

- 72.9% of the population describe their broad ethnic group as White, which is lower than England as a whole.
- 7.9% of the Cambridgeshire and Peterborough population are Asian or Asian British, although this is higher in Cambridge City (14.8%) and Peterborough (14.3%)







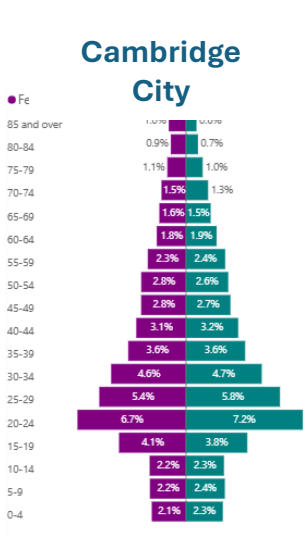


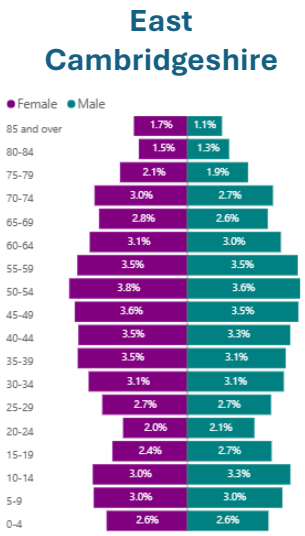
The proportions of the population in all high-level ethnic groups apart from “White” have increased since 2011.

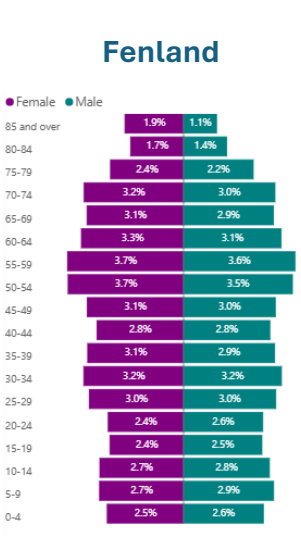
In Peterborough, the proportion of the population who identify as Asian, Asian British or Asian Welsh is notably higher than both the national and East of England averages.

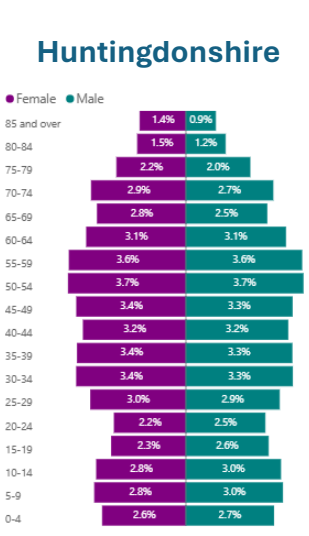
Sources: Population and Person Insight;
Census 2021; Cambridgeshire Insight

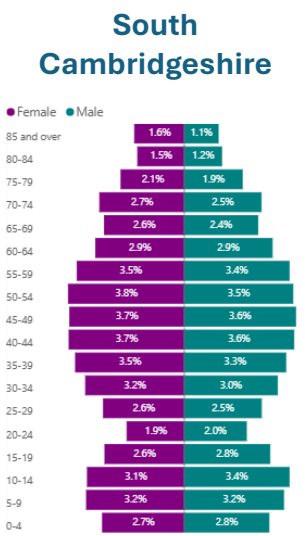
District population breakdown

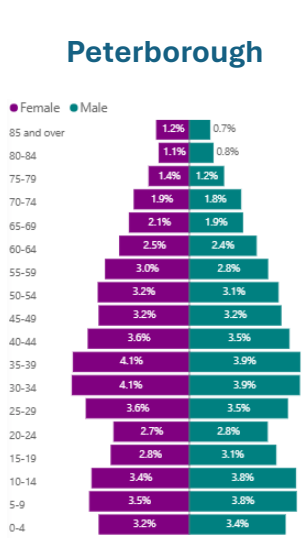












- There is variation in the shape of the population pyramids for each of our districts.
- Cambridge City has a ‘Christmas tree’ shape to its population pyramid, with a larger proportion in the younger adult age group, particularly young men, possibly reflecting the larger number of students residing in the city.
- Other areas in Cambridgeshire and Peterborough have a smaller percentage in the population pyramid in the younger adult age groups, perhaps reflecting population movement away from those areas to study or work elsewhere.

Health inequalities overview

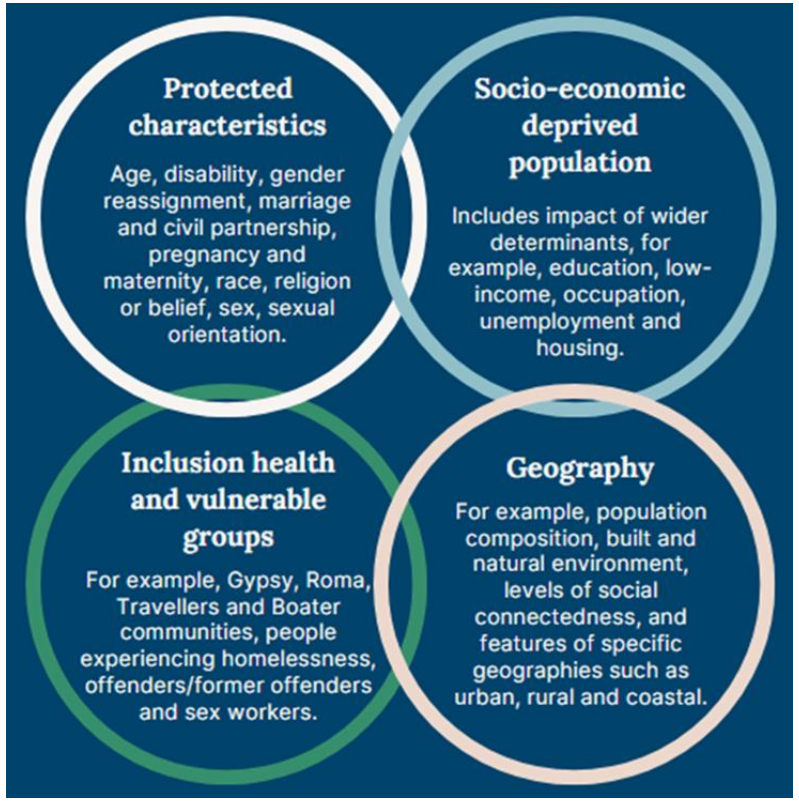
What are health and healthcare inequalities?

Health inequalities are systematic, avoidable and unfair differences in health outcomes that exist between different groups or populations. These inequalities arise from the unequal distribution of social, environmental, and economic conditions and can impact an individual's overall health and wellbeing.

Healthcare inequalities relate to inequalities in the access people have to healthcare services; in the experiences they have of using such services; and the outcomes they receive from healthcare services.

Health and healthcare inequalities are intrinsically linked and exist across the country. Within Cambridgeshire and Peterborough, there is no exception.

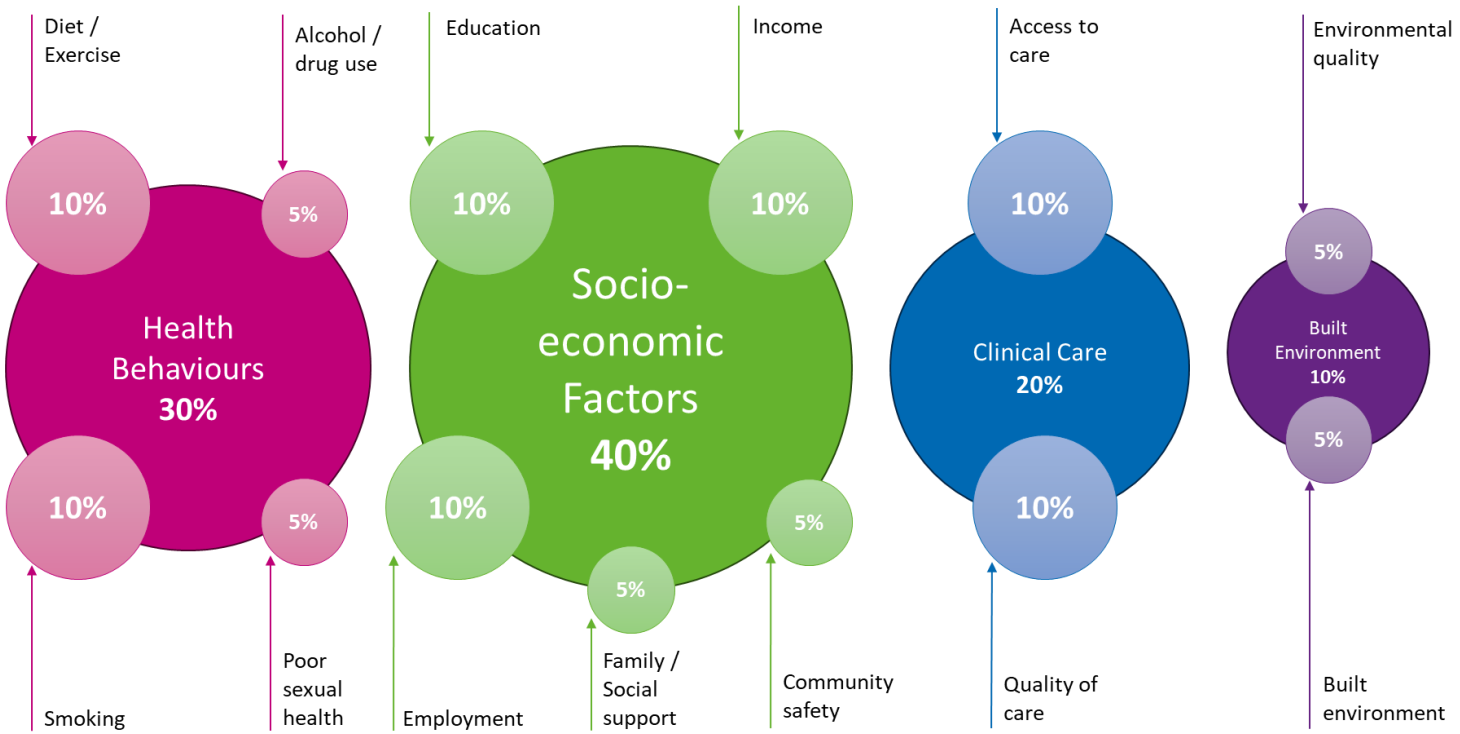
NHS Cambridgeshire & Peterborough is committed to reducing such inequalities, paying particular attention to groups or sections of society where health and life expectancy are not keeping pace with the rest of the local and national populations.



In England, health inequalities are often analysed and addressed by policy across four types of factors or domains as shown in the image above

Source: The King's Fund

Drivers of health outcomes



Where we live and work shapes our health by influencing our behaviours and the choices we make, our access to care and to our social conditions.

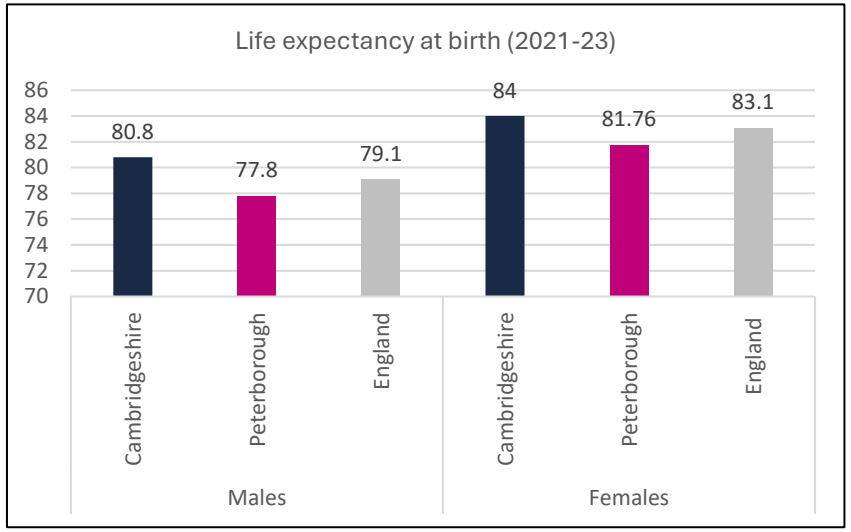
For example, safe neighbourhoods, stable jobs, quality education, and access to healthy food and recreation have a **positive impact** on encouraging **healthier choices**.

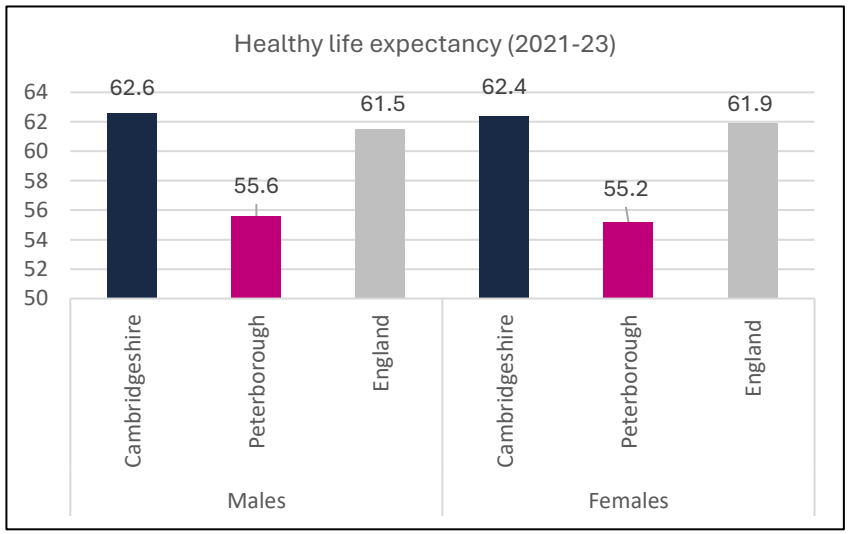
In contrast, limited resources, unsafe environments, and poor housing can lead to **negative health behaviours** and **poorer health outcomes**.

These disparities create health inequalities, where certain populations experience worse health due to social and economic disadvantages. **ICBs play a key role** in addressing these inequalities by **co-ordinating healthcare services**, **investing in prevention**, and **working with other partners**, including local authorities, to improve social determinants of health. By focussing on **early intervention** and **community-based solutions**, ICBs help create environments that support healthier choices and reduce disparities,

Source: Adapted from Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute's County Health Rankins Model

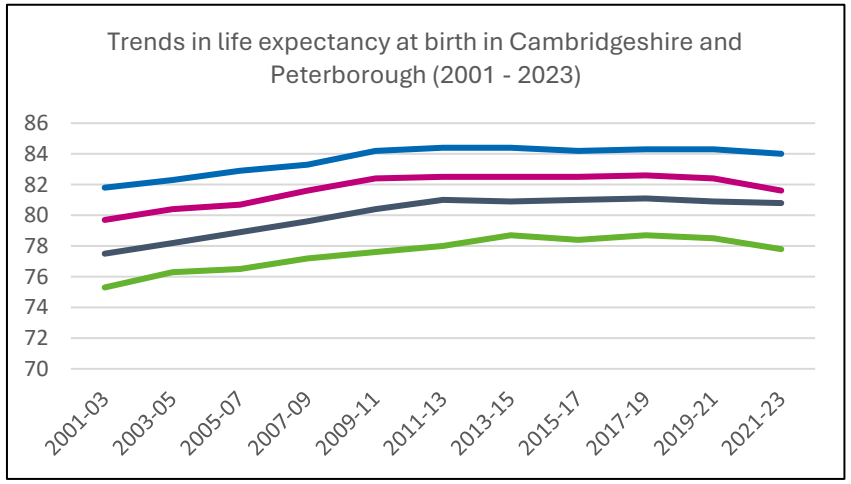
Life expectancy and healthy life expectancy

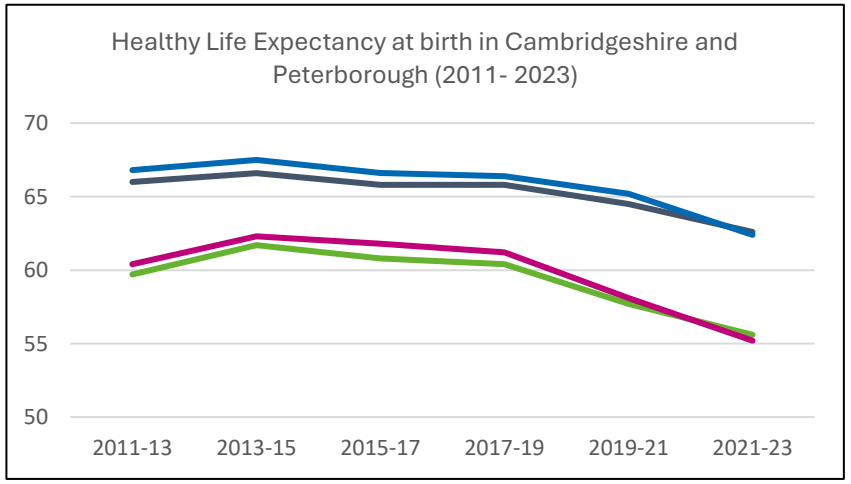




Key measures of inequality is life expectancy and health life expectancy.

Average **life expectancy** at birth is **lower in Peterborough** for both males and females than the England average and **higher in Cambridgeshire**. Increases in life expectancy stalled around 2010. More recently, life expectancy has started to **decline**, most notably in more deprived areas.





Average **healthy life expectancy** rates at birth are **higher in Cambridgeshire** than the England average, but **lower in Peterborough**.

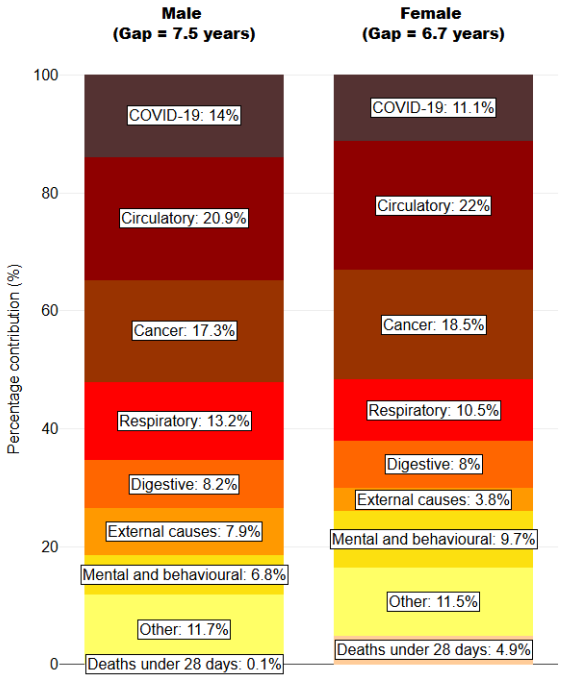
Healthy life expectancy rates have **declined** across Cambridgeshire and Peterborough since 2011, but these declines are more pronounced in Peterborough for both males and females.

Key

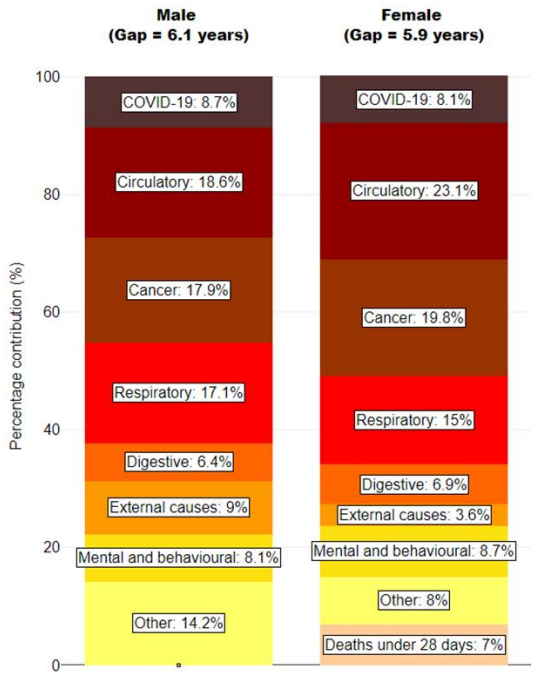
Cambridgeshire Males — Cambridgeshire Females — Peterborough Males — Peterborough Females

Source: Segment Tool (phe.gov.uk)

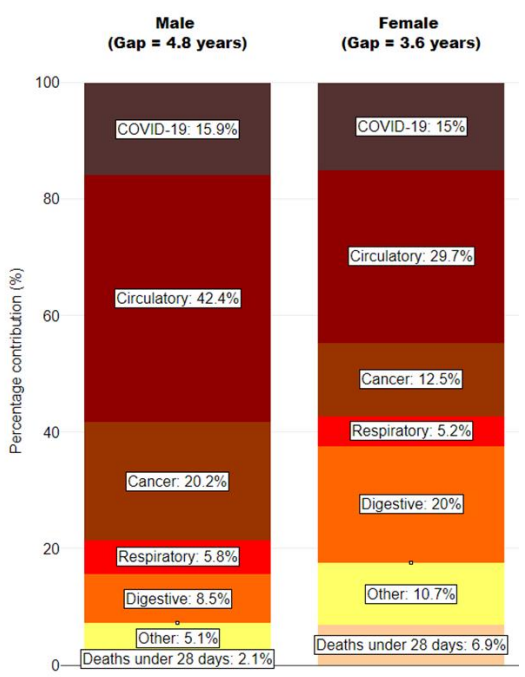
Variation in life expectancy



NHS Cambridgeshire & Peterborough (2020-21)



Cambridgeshire (2020-21)

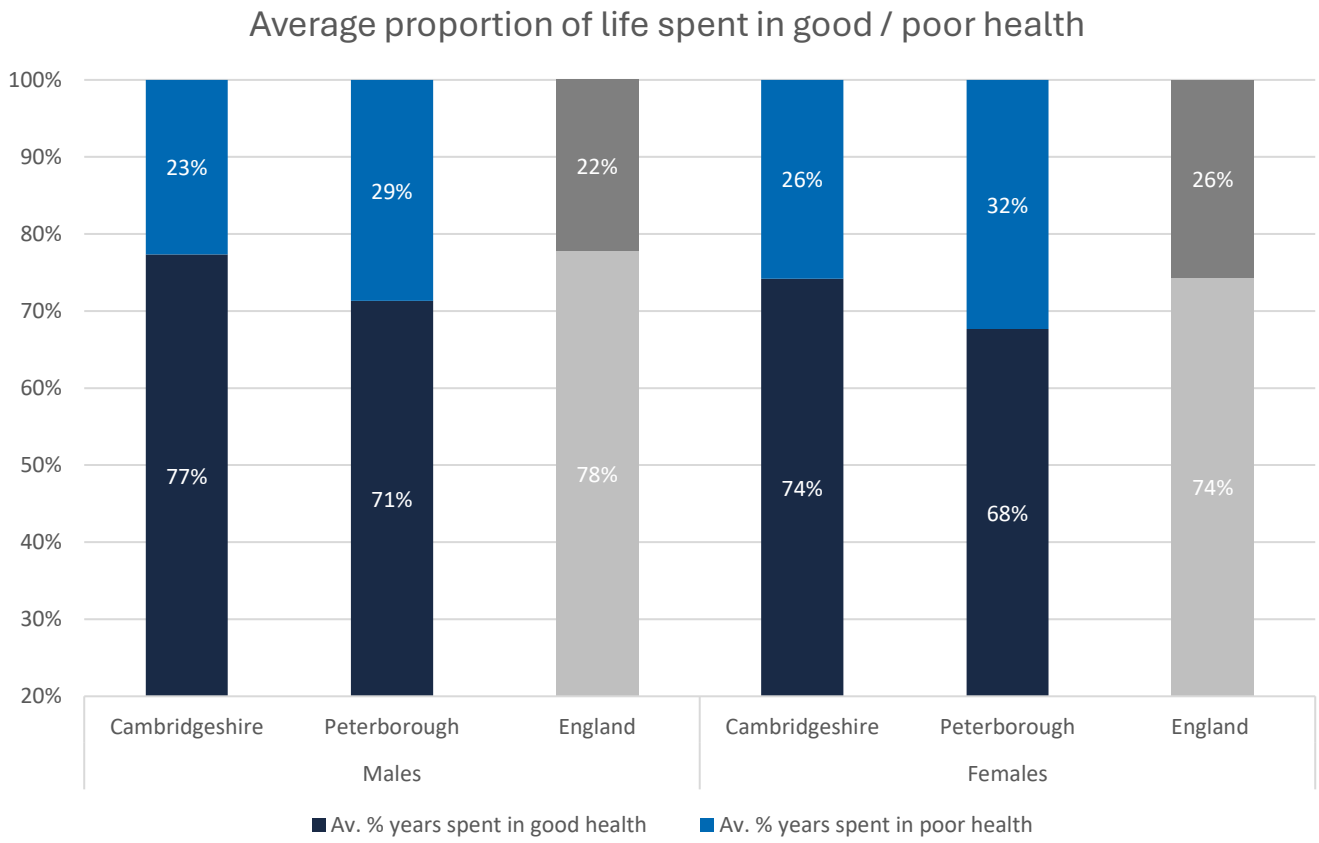


Peterborough (2020-21)

- The above ‘scarf’ charts show variations in the breakdown of the life expectancy gap between the most and least deprived quintiles by cause of death for NHS Cambridgeshire and Peterborough as a whole and for each of our local authorities.
- Across NHS Cambridgeshire and Peterborough, approximately 50% of the gap in life expectancy is driven by three main groups of conditions: circulatory, cancer and respiratory.
- In Peterborough, 42.4% of the gap in men is due to circulatory conditions, while digestive conditions, which include alcohol-related illnesses, contribute to an estimated 20% of the life expectancy gap for women.

Source: Segment Tool (phe.gov.uk)

Variation in years spent in good / poor health



There is considerable **variation in the proportion of years spent in good / poor health** across Cambridgeshire and Peterborough and between men and women.

A **female** who is born and lives in Peterborough has a life expectancy of 81.76 years but **can only expect to live 55.2 years (68%) in good health** on average.

This means they will spend approximately **one third** of their life (32%) **not in good health** compared to females born in Cambridgeshire who will spend around 26% of their lives in ill health.

For men in Peterborough the percentage of years spent not in good health is around 29%, compared to 23% in Cambridgeshire, both of which are worse than the England average.

Source: Department of Health & Social Care Public health profiles, February 2025

Governance, priorities and enablers

Healthcare inequalities governance in C&P

The ICB established a Population Health Improvement (PHI) Board with representation from partners across the ICS to drive an integrated approach in health improvement.

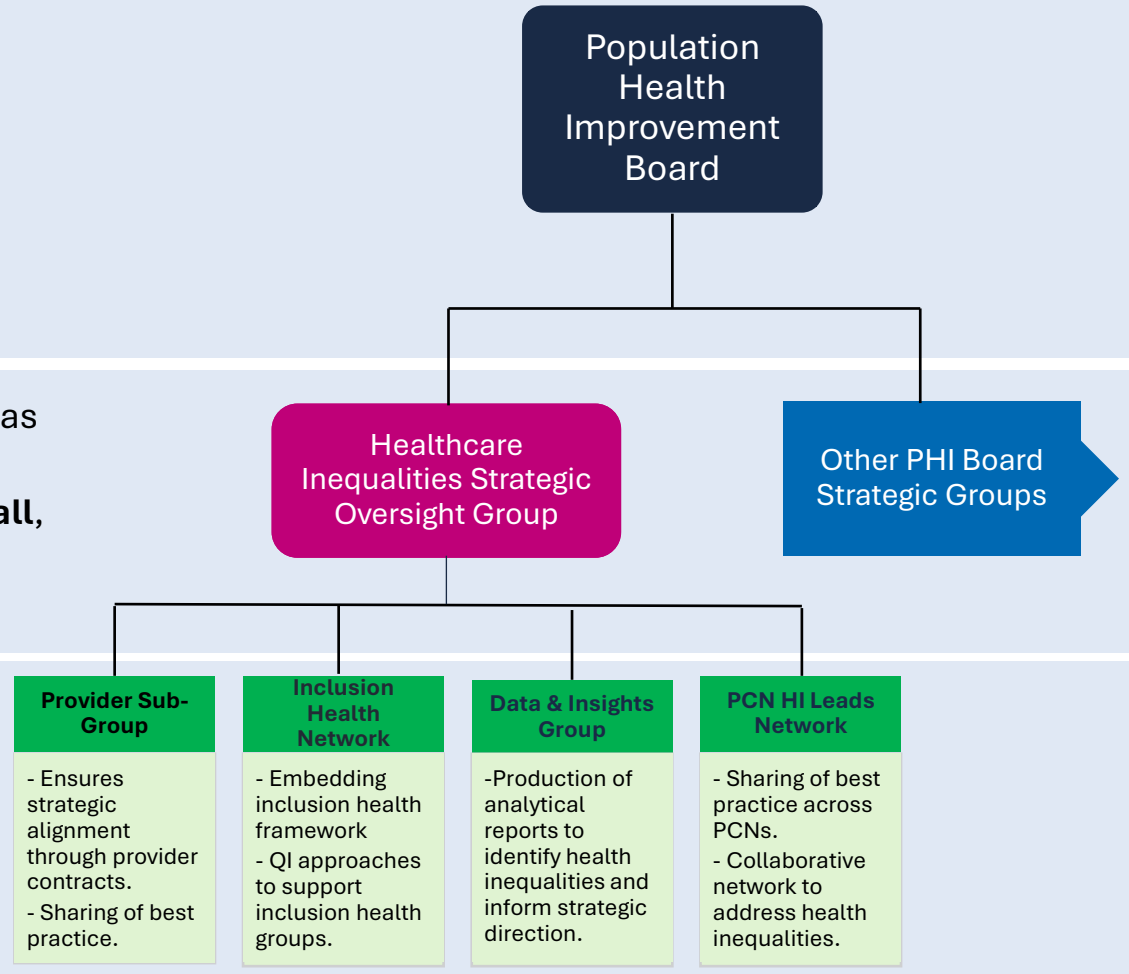
This Board brings together programmes of work across:

- Healthcare inequalities
- Population Health Management
- Prevention
- Innovation

The Healthcare Inequalities Strategic Oversight Group (HISOG) has oversight and co-ordinates the system's approach to deliver on NHSE's ambition of providing exceptional quality healthcare for **all**, ensuring equitable access, excellent experience, and optimal outcomes.

Delivery groups as sub-groups of our Health Inequalities Strategic Oversight Group.

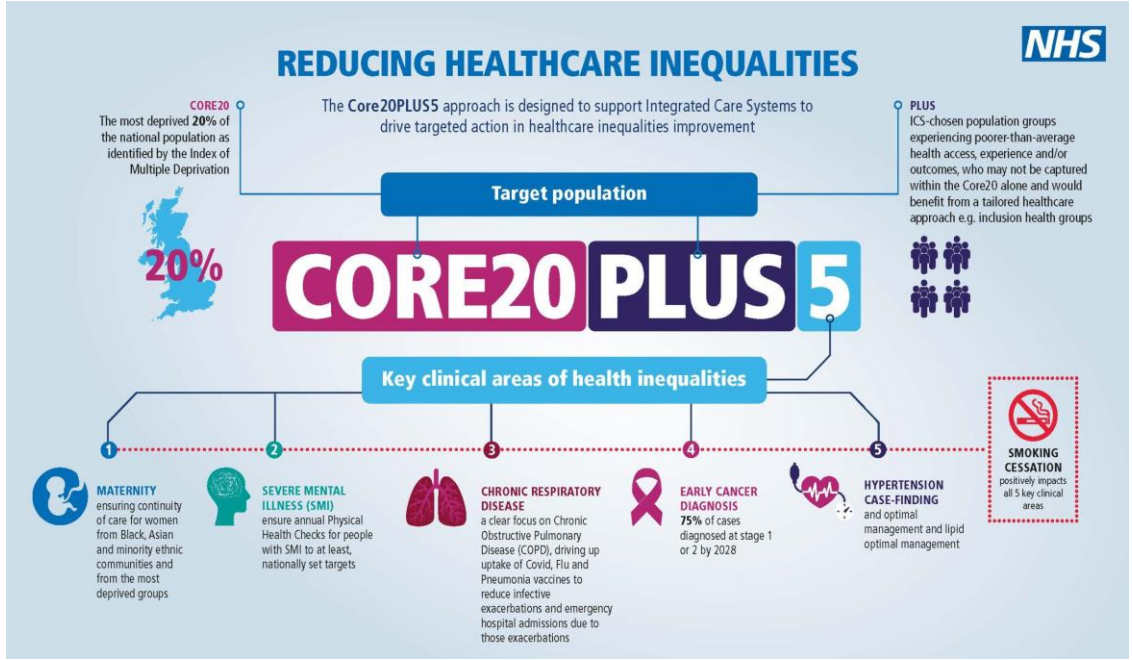
These sub-groups support delivery of the strategic priorities.



Healthcare inequalities strategic priorities

Priority	What	Action
Restore NHS services inclusively	• Utilise and monitor data efficiently, delineated by ethnicity, deprivation and other protected characteristics	• Analysis of elective waiting times completed at System and Provider level by deprivation and ethnicity • Waiting lists reduced from 10,188 people (April 2024) to 5,442 (December 2024)
Mitigate against digital exclusion	• Detailed analysis of who is accessing services and by what means, broken down by relevant protected characteristics and health inclusion groups	• Ongoing data collection to help identify disparities in accessing face to face, telephone, video consultations broken down by deprivation and ethnicity
Ensure datasets are complete and timely	• Improve collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning	• Achieved 96% ethnicity completeness rate across GP practices (June 2024) • Percentage of patients coded as Black, Asian or any other ethnic minority group increased from 13% (July 2022) to 16% (June 2024)
Accelerate preventative programmes	• Ongoing management of long-term conditions • Annual health checks for people with a learning disability and for people with a serious mental health • Implementation of continuity of carer for at least 35% of women from Black, Asian and other minority ethnic groups	• Launch of Your Healthier Future Programme focusing on lipid detection and optimisation and hypertension case finding. • Increased focus and funding in the Treating Tobacco Dependency (TTD) programme
Strengthen leadership and accountability	• Named leads for tackling health inequalities • Increased access to training and support	• Clear leadership, governance and accountability for health inequalities through the Health Inequalities Strategic Oversight Group, reporting to the Population Health Improvement Board. • Named exec lead within ICB, all NHS providers and PCNs

Core20PLUS5 frameworks



Core20PLUS5 is a national NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population (the 'Core20PLUS') and identifies '5' focus clinical areas requiring accelerated improvement.
The approach applies to both adults and children.

Core20

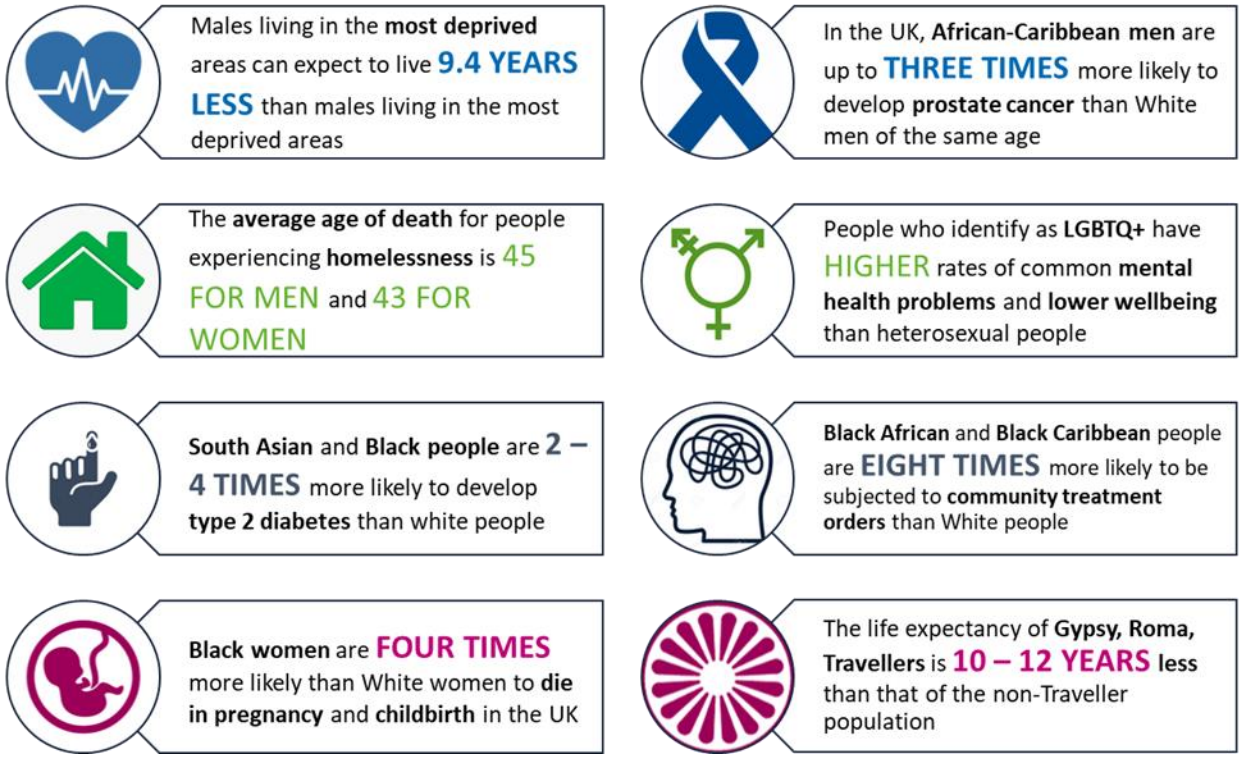
The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

'PLUS'

Population groups experiencing poorer than average health outcomes (e.g., people with a learning disability and autistic people, inclusion health groups, ethnic minority groups)

Source: NHS England: Core20PLUS5

Inequalities in our Core20PLUS populations



'PLUS' groups are ICS-determined population groups experiencing poorer than average health access, experience and outcomes, but not captured in the 'Core20' alone.

Gypsy, Roma, and Travellers (GRT) are one of the largest ethnic minority groups in Cambridgeshire and Peterborough, with approximately 7000+ living within the ICS footprint. GRT populations have **a life expectancy 10-12 years less** than that of the non-traveller population.

There are approximately between 1,500-1,700 people who are **homeless** within C&P. The average **life expectancy** for those experiencing homelessness is around **half that of the general population**.

C&P has a large **transient migrant population**, with influxes of migrant workers predominantly from Eastern Europe, most markedly in the Fenland and Peterborough areas. **Language barriers, cultural differences and health literacy** are identified as being key drivers of inequalities amongst such migrant and broader ethnic minority populations.

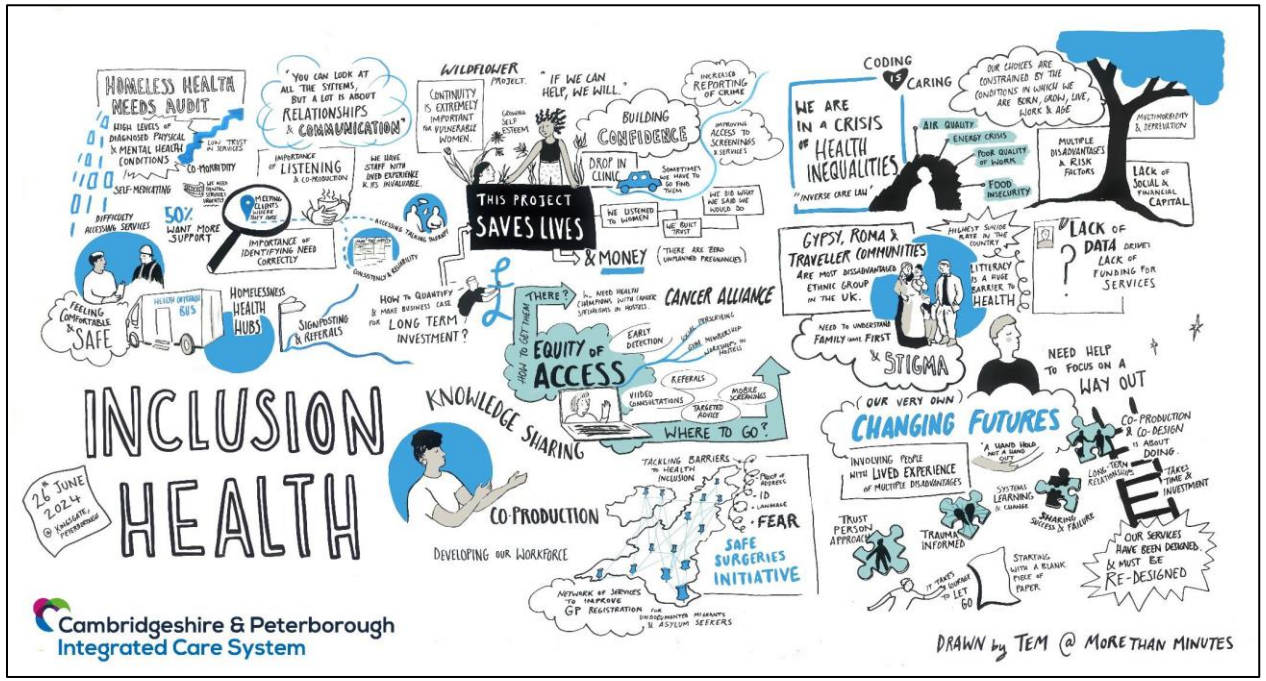
Inclusion Health

- Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma.
- This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.
- The ICB continues to work with system partners to embed NHSE's Inclusion Health Framework to support those within inclusion health groups overcome barriers to accessing healthcare services; to be more visible in data sets; to ensure services are not designed to exclude inclusion health groups; to help overcome digital exclusion; and to empower people to look after their health and wellbeing though personalised care and peer support approaches.

The 5 principles for action on inclusion health:

1) Commit to action
2) Understand the characteristics and needs
3) Develop the workforce
4) Deliver integrated services
5) Demonstrate impact and improvement

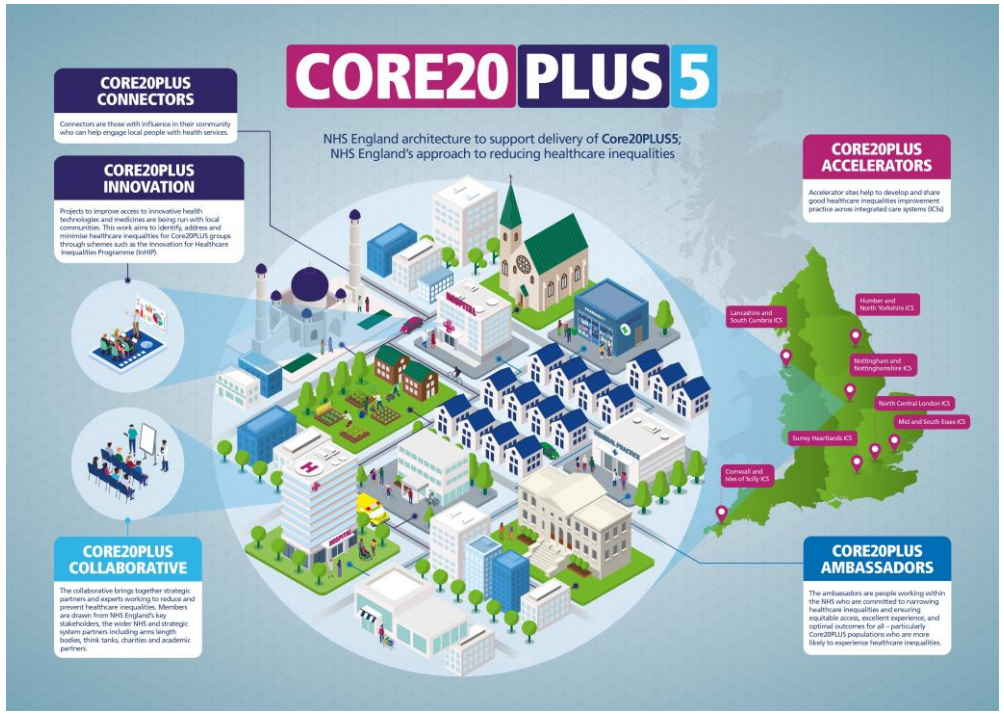
The below infographic summarises the discussions from a system-wide



Core20PLUS Architecture

Ambassador Programme

- Ambassadors are individuals working within the NHS and wider systems who are committed to narrowing healthcare inequalities and ensuring equitable access, excellent experience, and optimal outcomes for all, particularly amongst Core20PLUS populations who are more likely to experience healthcare inequalities. These include people living in areas of high deprivation, ethnic minority communities, and inclusion health groups.



- For cohort 3, Cambridgeshire & Peterborough ICB is providing ongoing support and strategic alignment with individual programmes of work. Ambassadors have been supported to enhance their knowledge, skills, and insights to tackle healthcare inequalities through the Core20PLUS approaches.
- Ambassadors have been offered platforms to actively develop their skills and to establish networking opportunities to champion healthcare inequality improvement.

Connector Programme

"It helps to discover yourself more and helps you to look inward and become more self-aware"

- The NHS England **Core20PLUS Connector Programme** funded place-based initiatives to recruit, mobilise and support influential community connectors to take practical action to improve health outcomes and reduce health inequalities.
- Connectors are those with **influence in their community** who can help engage local people with health services.
- Offering unique insight into the barriers people living in their communities' face, **connectors are ideally placed to advise local NHS services** on how these can be overcome and what makes a good service.
- In Cambridgeshire and Peterborough, the **ICB partnered with Barnardo's** to provide additional funding through the MUMMA Hub to help reduce maternal health inequalities, particularly focusing on women from Black, Asian, and Mixed Ethnicity backgrounds in Peterborough.

What is the MUMMA hub?
It is a culturally sensitive, free support service for Black, Asian and Mixed Heritage mums and families, supporting people through pregnancy up until the age of two.

Why was it set up?
Black women are four times more likely than White women to die in pregnancy or during childbirth. Women of mixed or Asian heritage are twice as likely to die.

What do we want to achieve?
Reduce maternal health inequalities; Providing support to families at risk of poorer maternal health outcomes; and to have a positive experience before, during and after pregnancy while helping to ensure good relationships with their babies and the community are established

How?
By providing the following:
- Story telling workshops (4-week course)
- Connecting Muslim Mums Wellbeing Course
- 1-to-1 support
- Coffee and Tea group sessions
- Providing advocacy support

"I am someone that would hardly talk to people, but the course has helped me to be able to open up more and able to hold longer conversations with people"

Mumma
SUPPORTING BLACK, ASIAN AND MIXED ETHNICITY FAMILIES THROUGH PREGNANCY AND BEYOND

Health inequalities and innovation

The Innovation Hub:

Plays a pivotal role in piloting and implementing innovations that extend the reach of system-wide health inequality programmes.

Case Example:

- A point-of-care (PoC) lipid testing pilot using the 5-lipid panel Poc Doc test allows at-home heart health checks, targeting populations who face barriers to traditional clinic-based screenings.
- This innovation directly supports our 'Your Healthier Future' programme by increasing population-level CVD risk factor data and enhancing engagement with under-represented groups.
- Citizen group engagement ensures implementation strategies are adaptable, improving equitable access and service uptake.

"What surprised me is the Hub's success in managing to convene people… It is that relationship stuff that we need to hold on to and not underestimate the amount of time and effort that takes "

The transition to ICBs and the creation of our Strategic Commissioning Unit (SCU) has created a system-wide opportunity to **drive innovation with a direct focus on reducing health inequalities**.

A structured **Multiple Criteria Decision Analysis (MCDA)** approach ensures innovation decisions are evidence-based, strategically aligned and weighted to consider their impact on health inequalities.

Embedding Innovation in System-Wide Decision-Making

- Innovation decisions are taken in collaboration with system partners, including healthcare providers, Health Innovation East, academic institutions, and citizens, ensuring that adopted innovations drive meaningful improvements in patient outcomes and service delivery.
- All innovation initiatives undergo an Impact Assessment to identify positive, negative, and unknown effects on populations, helping to ensure interventions contribute to equitable healthcare access and outcomes.

Voluntary sector network

VCSE work and links to health inequalities

We are committed to putting the **voices of people and communities** at the centre of decision-making and governance, at every level of the ICS. We know just how powerful working with our communities can be when it comes to tackling health inequalities and making improvements to services to ensure we best meet the needs of our local population.

Working with Voluntary, Community and Social Enterprise Sector (VCSE)

The Cambridgeshire and Peterborough ICS VCSE Strategy was approved in 2022. Significant progress has been made in strengthening relationships and collaboration with the VCSE sector. This has **enhanced prevention efforts**, **supported health promotion activities**, and **amplified community voices in decision-making**.

Following national directive in 2022, the Voluntary Sector Network was established, led locally by the three Councils for Voluntary Services (CVS), to amplify VCSE and community voices in ICB decision-making. The **Voluntary Sector Network (VSN)** has since grown to include **over 120 actively engaged VCSE organisations**, with reach via the CVSs to hundreds more, and is now a key strategic partnership within the ICS, enhancing resilience, partnerships and the sector's visibility and reputation. This captive and active forum has supported the socialisation of our strategic ICB work, bringing VCSE partners and the communities they support on the journey, ensuring their voices and ideas are heard.

Over the past year, substantial progress has been made to enhance the VSN's impact and influence within the ICS. This includes fostering **greater collaboration** and **integration** among members and **increasing the visibility** and **recognition** of the Network's contributions. 15 VSN members, all of whom are CEOs within local VCSE organisations, form our VSN Strategic Group and sit as VCSE representatives across all ICB Boards and committees.

Voluntary sector network

A three-year action plan to continue delivering the ICS VCSE Strategy was approved by the ICB Board in January 2025 and sets out how we continue to **build our partnerships** with the sector to amplify the voices of communities in our work and decision making.

Working in close partnership with VCSE organisations is vital in amplifying and understanding local people's needs, experiences and aspirations for health and care. The sector are experts in building relationships with previously underrepresented groups – including those affected by health inequalities. For example, health ambassadors have been recruited as part of a health project run by Cambridge Ethnic Community Forum to engage with their communities and be a trusteed source of health information. There are about 14 health ambassadors and currently they are working closely with CUH on use of the NHS app. These groups all feed into our Voluntary Sector Network and are useful conduits for engaging and hearing feedback from communities and people with lived experience.

Grant programmes

The ICB's £2million **Healthier Future's Fund** and smaller **community grants programmes**, are funding VCSE organisations to tackle health and wellbeing challenges in our communities, and address health inequalities. Since 2024 **over 30 projects** have been funded across the county linked to our strategic priorities.

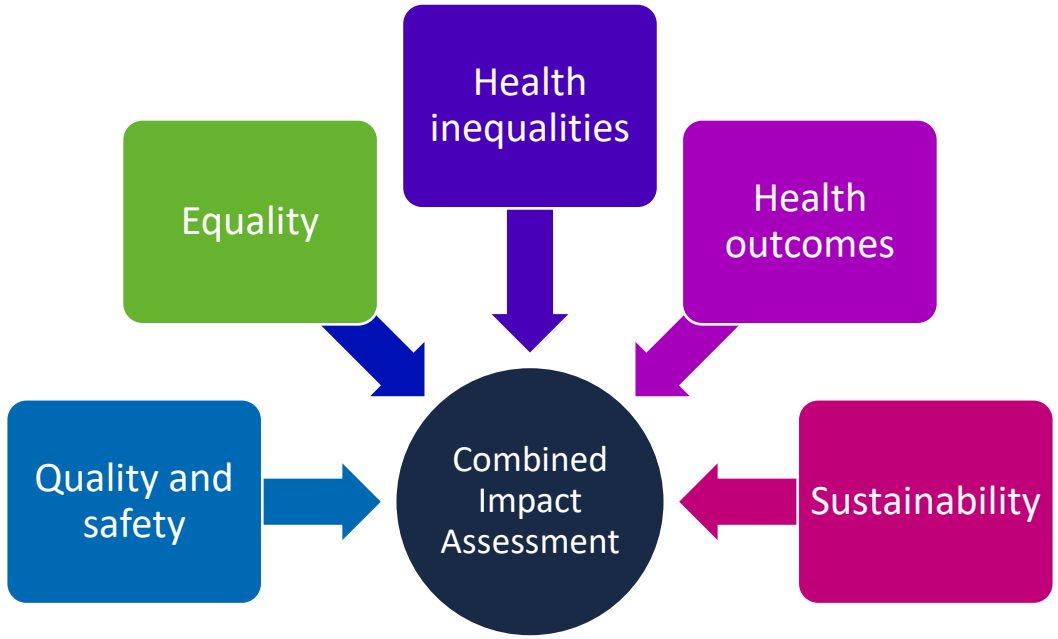
Faith research

Working in partnership with faith groups, as often trusted leaders within their communities, can be key to successfully engaging certain communities. Following funding from the ICB, Support Cambridgeshire, has conducted research into the faith communities' role within Cambridgeshire. The research included mapping faith organisations, how they are supporting and working with their communities and identifying how they wish to engage and collaborate with health and care in future.

Impact Assessment Process

- At the heart of the decision-making process within NHS Cambridgeshire and Peterborough ICB is our **impact assessment process** to ensure all decisions are assed against the domains as shown in the image.

- The process, managed by the Strategic Commissioning Unit (SCU), ensures every decision - whether about funding; changes to patient pathways; or the decommissioning of services - meets the ICB's statutory duty, under both the Health Care Act 2012 and the Equality Act 2010, and considers how it affects different groups of people, especially those who already face health inequalities.



- This approach is part of a broader effort to address health inequalities, as recommended in the Cambridgeshire and Peterborough Health Inequality Strategy. By thoroughly evaluating the potential effects of each decision, the ICB can ensure that healthcare services remain safe, high-quality, and fair for everyone. The process was developed over several months with input from a range of experts and community representatives to make sure it reflects the real needs of the population.

Cambridgeshire and Peterborough health inequalities data

Overview

The metrics on health inequalities as defined by NHS England within its Statement have been broken down into 11 domains:

1. Elective recovery
2. Urgent and Emergency Care (UEC)
3. Respiratory
4. Mental Health
5. Cancer
6. Cardiovascular disease
7. Diabetes
8. Smoking cessation
9. Oral health
10. Learning disability and autistic people
11. Maternity and Neonatal

The table on the next slide shows the 25 defined metrics and the level at which our analysis has been undertaken (i.e., whether at ICB or at NHS Trust level).

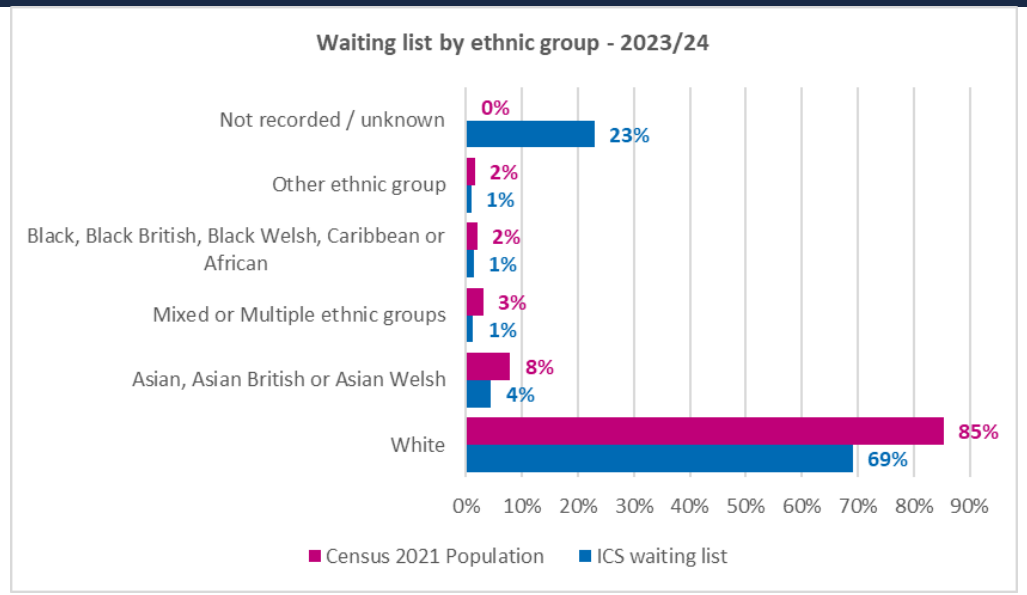
The table also shows the detail that the data was analysed at: Ethnicity (have used nationally defined NHS standard for definitions) and/or deprivation (either quintiles so 5 equal groups; or deciles, 10 equal groups of deprivation which will then be high to low).

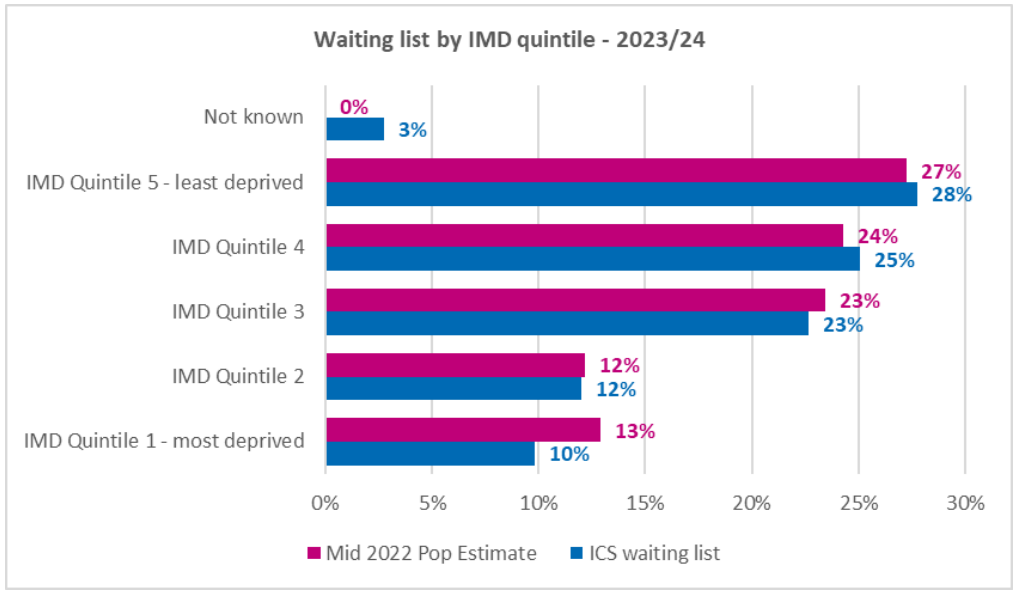
Finally, the table also shows whether there is an observed inequality or not within the data that has been analysed.

Analytical Report – Domains and Indicators

Domain	Indicator	Variables		Level	Observed Health Inequality
		Deprivation	Ethnicity	ICB	
Elective Recovery	Size and shape of waiting list, 18+, 52+ and 65+ weeks	Y	Y	Y	✓
	Age standardised activity rates with 95% confidence intervals for Elective, Daycase and outpatient attendances	Y	N	Y	✓
	Elective activity admissions for under 18s vs pre-pandemic levels	Y	N	Y	✗
Urgent and emergency care	Emergency admissions for under 18s vs pre pandemic levels	Y	N	Y	✓
	Age standardised activity rates with 95% confidence intervals for None-elective admission and A&E Attendances	Y	N	Y	✓
Respiratory	Uptake of COVID and flu vaccinations by socio demographic groups	Y	Y	Y	✓
Mental Health	Overall number of SMI physical health checks	N	N	Y	✗
	Rates of total Mental Health Act detentions	N	N	Y	✓
	NHS Talking Therapies (formerly IAPT) recovery	N	N	Y	✓
Cancer	Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex	N/A	N/A	Y	✗
Cardiovascular disease	Stroke rate of non-elective admissions (per 100,000 age and sex standardised)	Y	N/A	Y	✓
	Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)	Y	N/A	Y	✓
	CVDP007HYP: Per centage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold	Y	Y	Y	✓
	CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy	Y	Y	Y	✓
	CVDP002AF: % of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy	Y	N	Y	✓
Diabetes	Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes	N	N	Y	✓
Smoking cessation	Proportion of adult acute inpatient settings offering smoking cessation services	N/A	N/A	N	✗
	Proportion of maternity inpatient settings offering smoking cessation services	N/A	N/A	N	✗
Oral health	3.7 ii Tooth extractions dues to decay for children admitted as inpatients to hospital, aged 10 years and under	N	Y	Y	✓
Learning disability and autistic people	Learning Disability Annual Health Checks	N/A	N/A	Y	✗
	Adult mental health inpatient rates for people with a learning disability and autistic people	N/A	N/A	Y	✗
Maternity and neonatal	Preterm births under 37 weeks	Y	Y	Y	✓

Elective Recovery: Size and shape of waiting list, 18+, 52+ and 65+ weeks



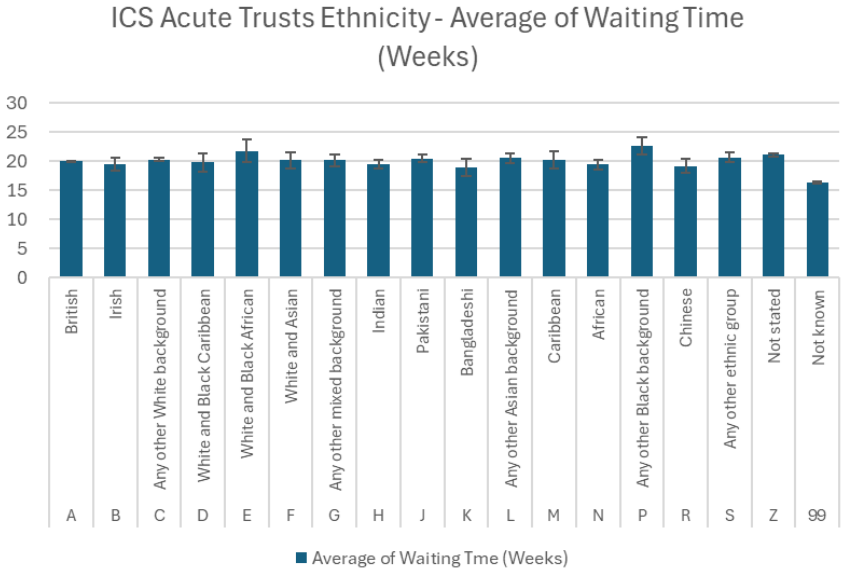


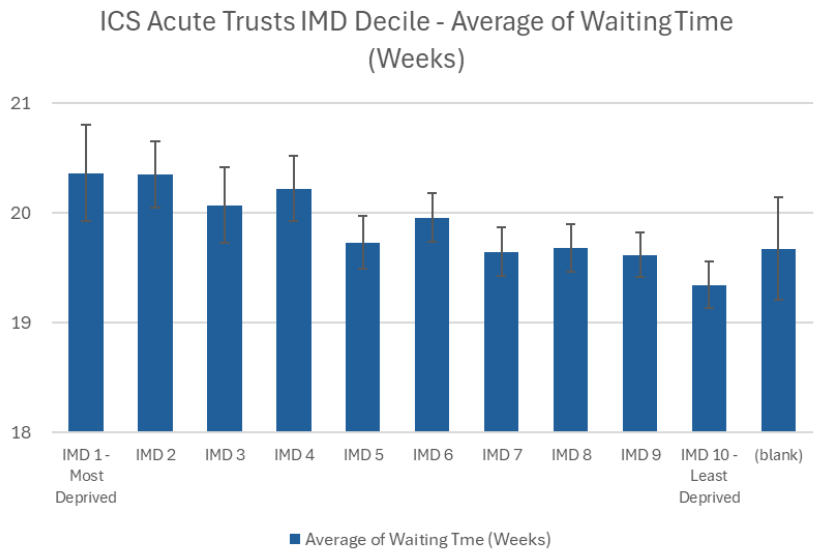
Observed health inequalities

- All ethnic groups are under-represented in the waiting list when compared to the census 2021 population.
- Ethnicity is not recorded for almost a quarter of those waiting and this makes it difficult to know for sure if there is under-representation.
- Based on those with a recorded ethnicity White ethnic group is over-represented and other ethnic groups are under-represented.
- Those living in the most deprived quintile are under-represented in the waiting list.

Source: Index of Multiple Deprivation (IMD) 2019

Domain: Elective Recovery Indicator: Size and shape of waiting list, 18+, 52+ and 62+ weeks (slide 1 of 3)

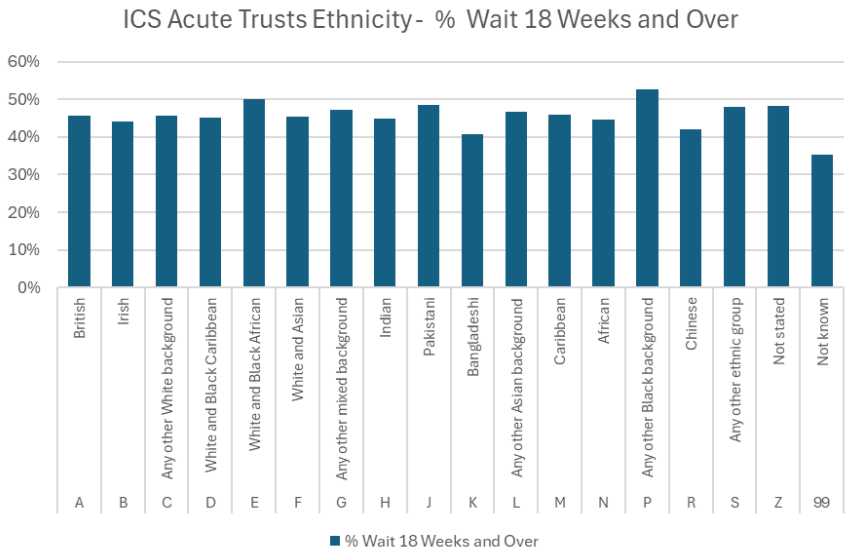


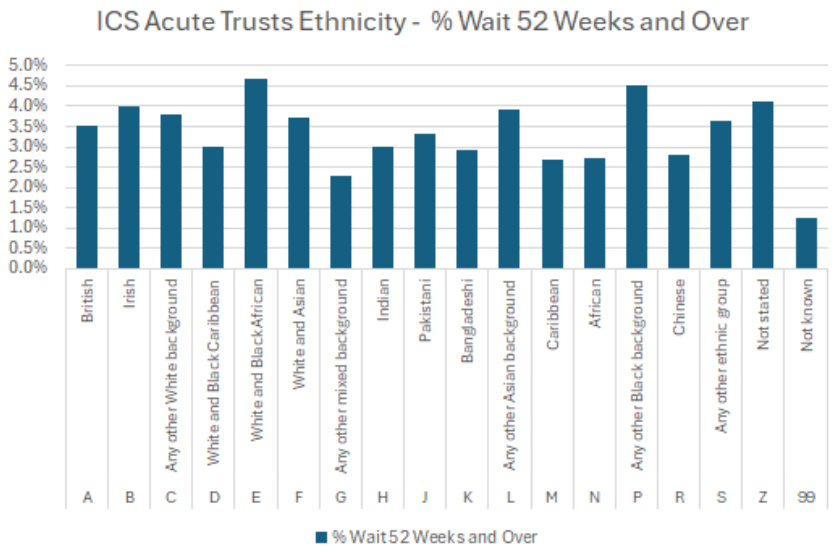


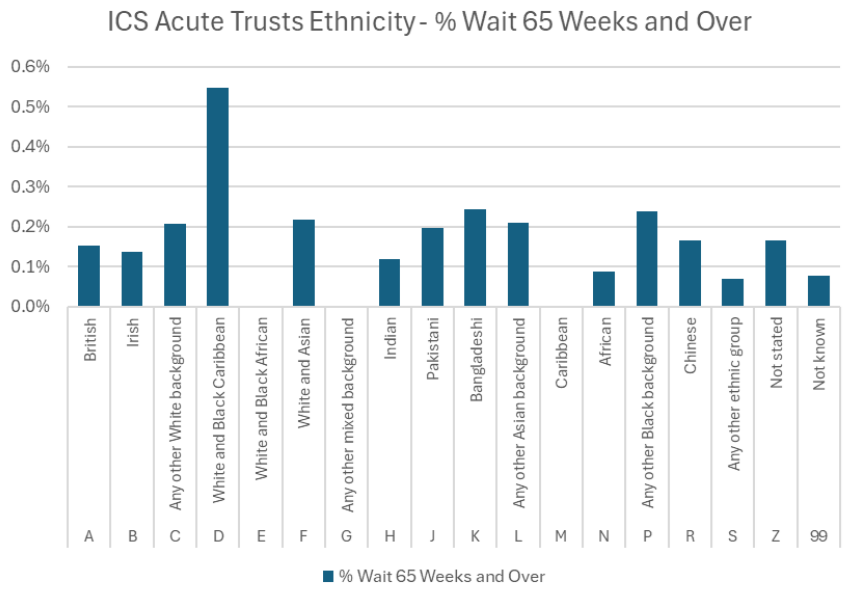
Observed health inequalities

- Average waiting times for different ethnic groups are disproportionate and this difference increases further for 52+ and 62+ week waits.
- Average waiting times increase as deprivation rises, i.e., those from the more deprived areas wait on average longer than those from the least deprived areas.
- Male and female average waiting times are similar, but there are a higher percentage of males waiting over 52+ and 62+ weeks.

Domain: Elective Recovery Indicator: Size and shape of waiting list, 18+, 52+ and 62+ weeks (slide 2 of 3)



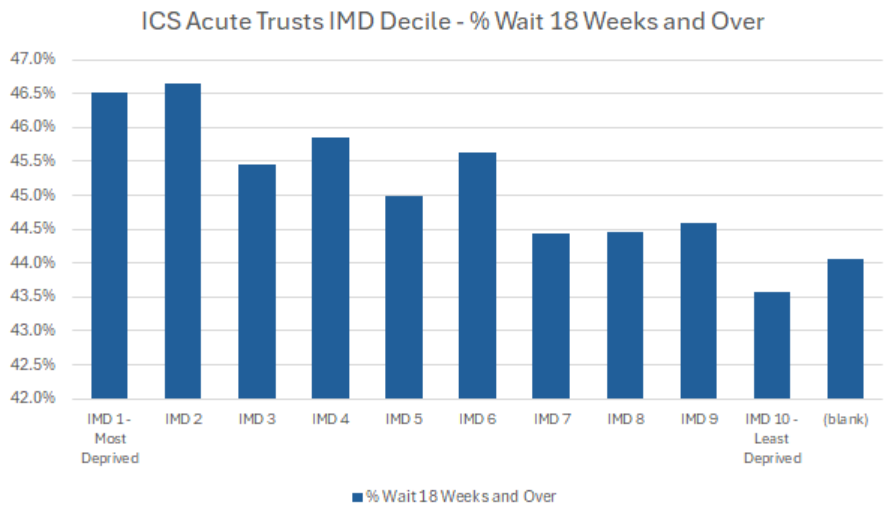


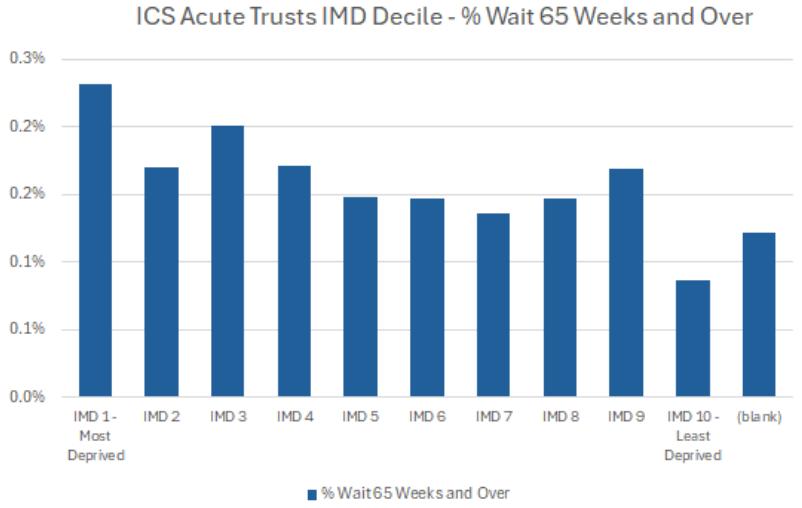


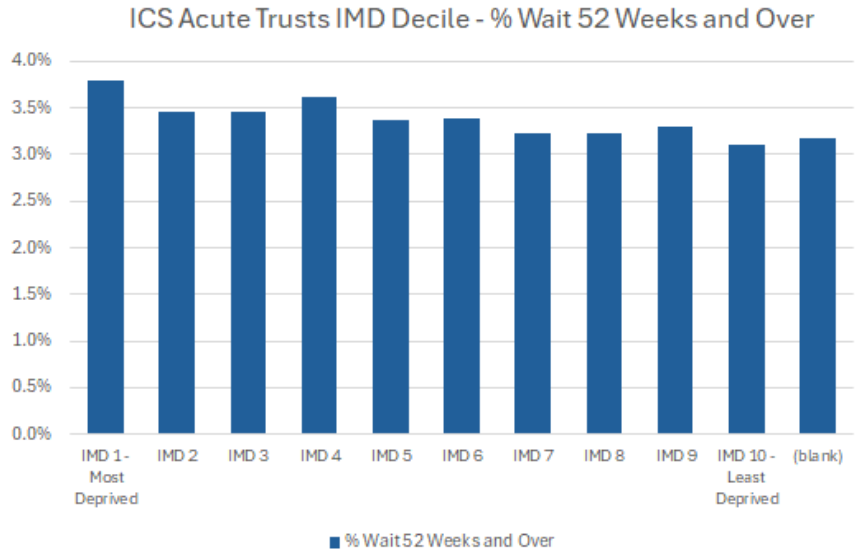
Observed health inequalities

- These graphs show the ICS average waiting times and percentage of patients waiting 18 weeks and over, 52 weeks and over and 65 weeks and over, split by ethnicity.
- These graphs show that the waiting times for different ethnicities is disproportionate.

Domain: Elective Recovery Indicator: Size and shape of waiting list, 18+, 52+ and 62+ weeks (slide 3 of 3)



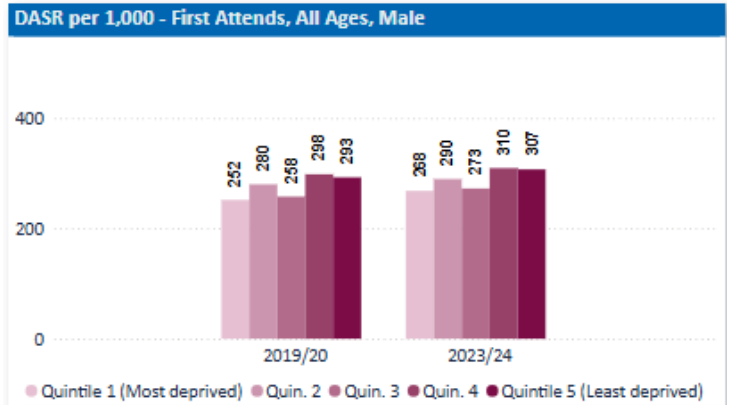




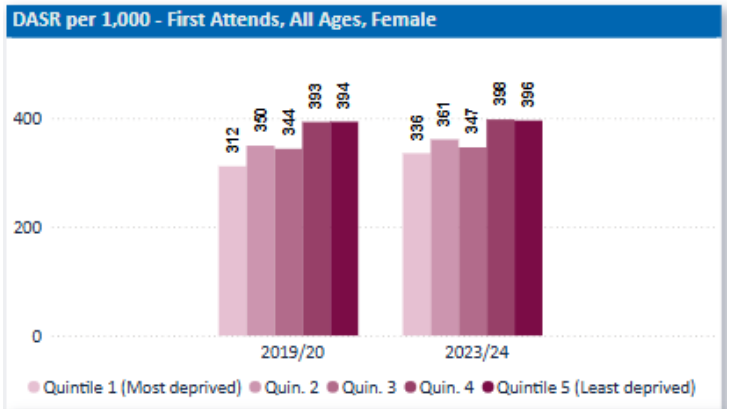
Observed health inequalities

- These graphs show the ICS average waiting times and percentage of patients waiting 18 weeks and over, split by deprivation according to where they live.
- The graphs show that the waiting times are longer for people living in more deprived areas.

Elective Recovery: Age standardised activity rates with 95% confidence intervals for Elective, Daycase and Outpatient attendances



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	252	249	255	293	290	296
2023/24	268	265	271	307	304	310



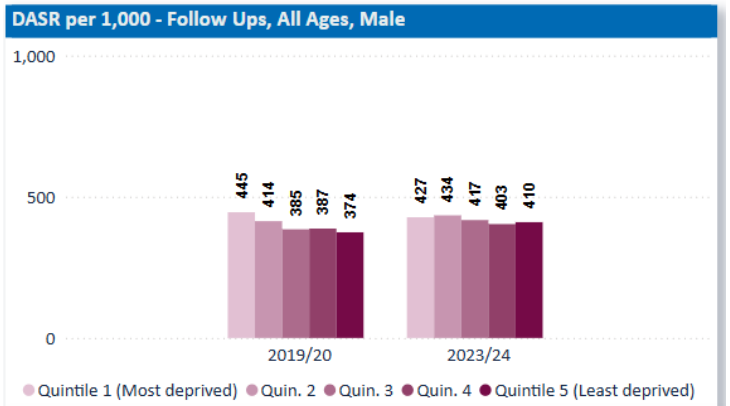
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	312	309	315	394	390	397
2023/24	336	332	339	396	392	400

Observed health inequalities

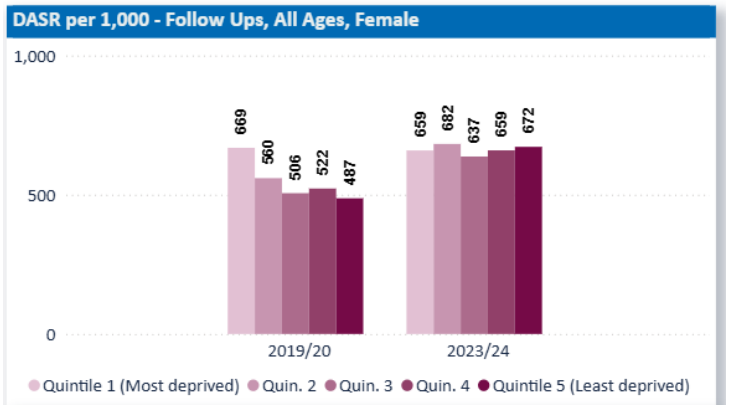
- These graphs show ICS consultant led, first outpatient attendance rates by gender and deprivation.
- In 2023/24 first outpatient attendance rates in the least deprived quintile are statistically significantly higher than those in the most deprived quintile for both males and females

Statistically significantly lower | Statistically similar | Statistically significantly higher

Source: DSCRO SUS_OP_All



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	445	441	449	374	370	378
2023/24	427	423	431	410	406	414



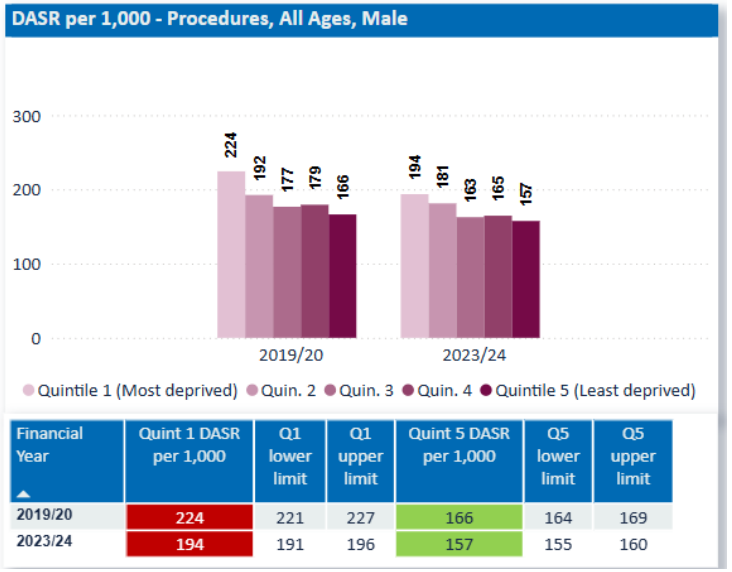
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	669	664	673	487	483	491
2023/24	659	654	663	672	667	677

Observed health inequalities

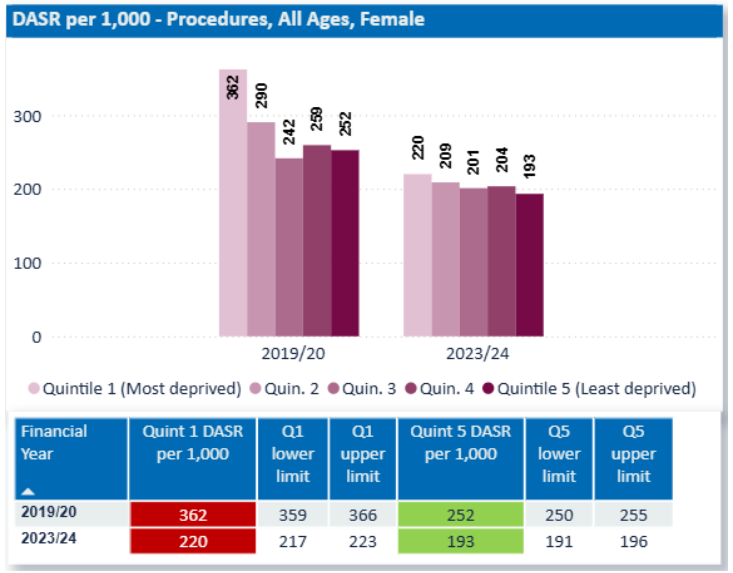
- These graphs show ICS consultant led, follow outpatient attendance rates by gender and deprivation.
- In 2023/24, consultant led, follow up outpatient attendance rates are statistically significantly higher in the most deprived quintile for males.
- For females, consultant led, follow up outpatient attendance rates are significantly higher in the least deprived quintile.

Statistically significantly lower | Statistically similar | Statistically significantly higher

Source: DSCRO SUS_OP_All



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	224	221	227	166	164	169
2023/24	194	191	196	157	155	160



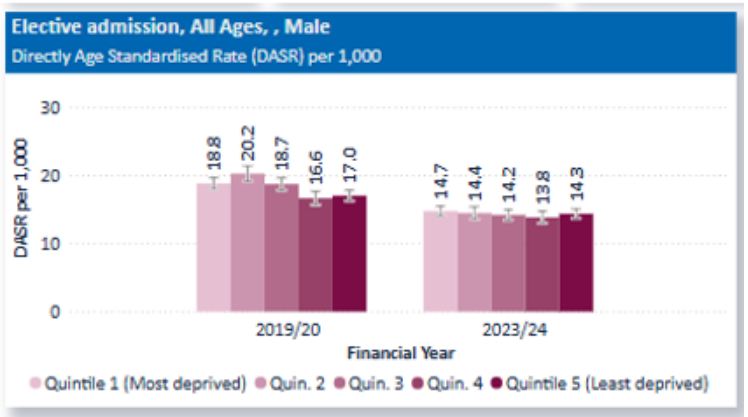
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	362	359	366	252	250	255
2023/24	220	217	223	193	191	196

Observed health inequalities

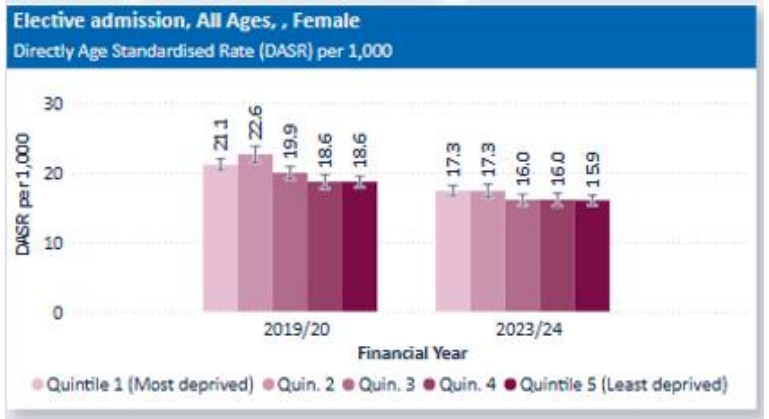
- These graphs show ICS consultant led, outpatient procedure rates by gender and deprivation.
- In 2023/24, consultant led, outpatient procedure rates are statistically significantly higher in the most deprived quintile for both males and females.

Statistically significantly lower | Statistically similar | Statistically significantly higher

Source: DSCRO SUS_OP_All



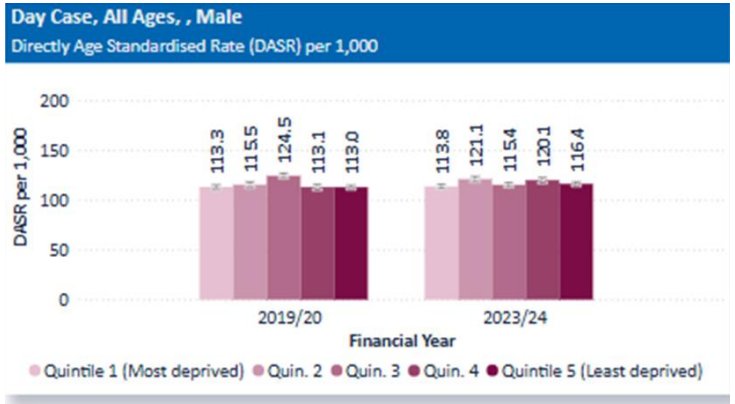
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	18.8	17.95	19.62	17.0	16.21	17.77
2023/24	14.7	14.00	15.44	14.3	13.65	15.03



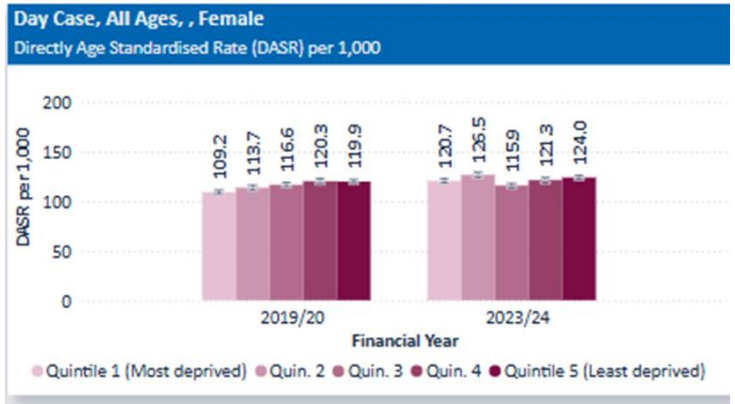
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	21.1	20.25	21.93	18.6	17.82	19.43
2023/24	17.3	16.57	18.06	15.9	15.24	16.67

Observed health inequalities

- These graphs show ICS elective admission rates by deprivation.
- In 2023/24 elective admission rates in the least deprived quintile are statistically similar to those in the most deprived quintile for both males and females



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	113.3	111.18	115.36	113.0	110.99	115.03
2023/24	113.8	111.78	115.85	116.4	114.42	118.34

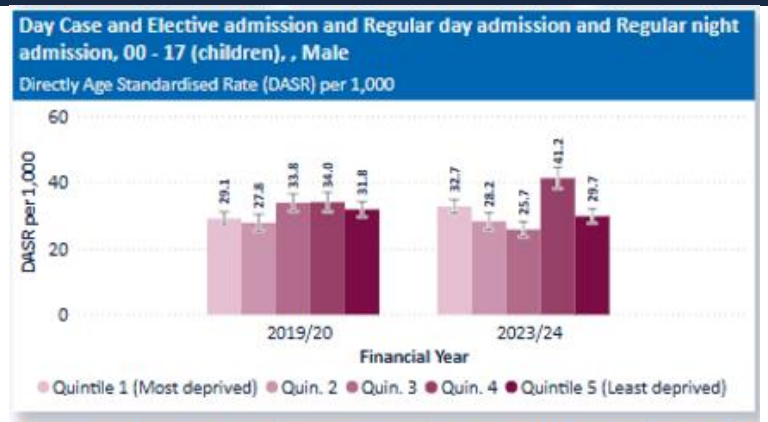


Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	109.2	107.29	111.18	119.9	117.86	121.94
2023/24	120.7	118.70	122.68	124.0	122.02	125.98

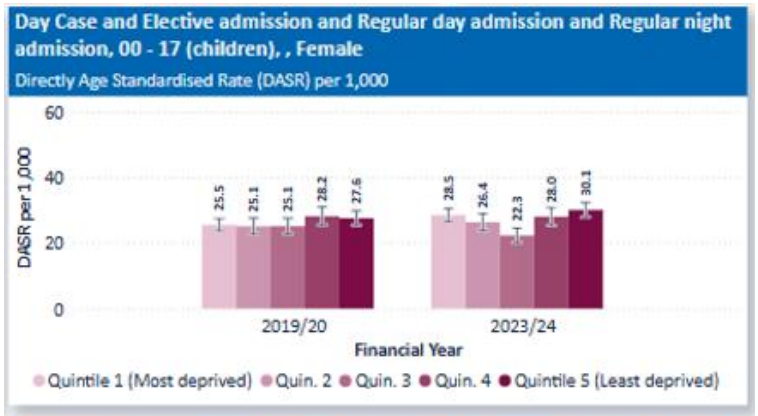
Observed health inequalities

- Day case rates in the least deprived quintile are statistically similar to those in the most deprived quintile for both males and females.
- Day case rates for females in the least deprived quintile were statistically significant in 2019/20 but this has changed in 2023/24.

Elective Recovery: Elective activity admissions for under 18s vs pre-pandemic levels



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	29.1	27.14	31.05	31.8	29.52	34.13
2023/24	32.7	30.65	34.77	29.7	27.58	31.93

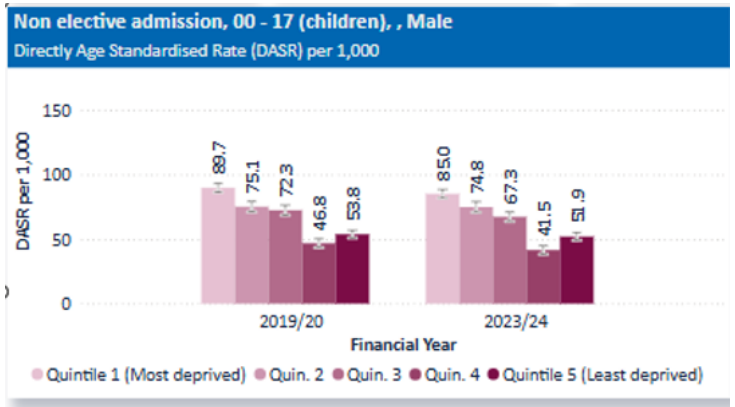


Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	25.5	23.66	27.47	27.6	25.40	29.82
2023/24	28.5	26.54	30.49	30.1	27.86	32.35

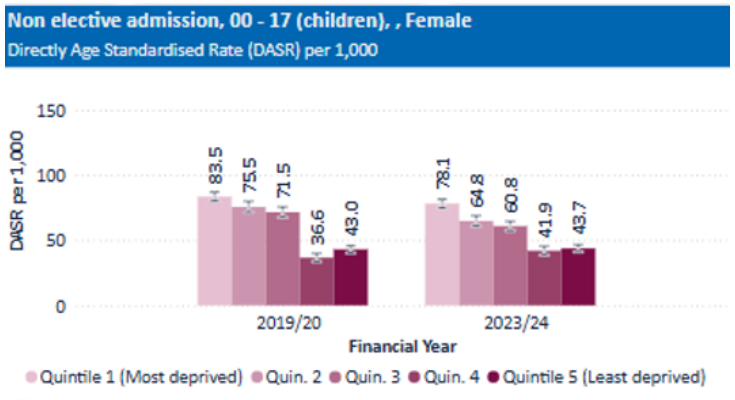
Observed health inequalities

- These graphs show ICS elective (day case and elective admissions inc. regular attenders) admission rates for under 18s by deprivation.
- Elective admission rates for children in the most deprived quintile are statistically similar to the rates in the least deprived quintile for both males and females in 2023/24.

Urgent and emergency care: Emergency admissions for under 18s vs pre pandemic levels



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	89.7	86.33	93.16	53.8	50.79	56.82
2023/24	85.0	81.71	88.44	51.9	49.04	54.93



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	83.5	80.09	86.96	43.0	40.26	45.79
2023/24	78.1	74.80	81.48	43.7	40.97	46.49

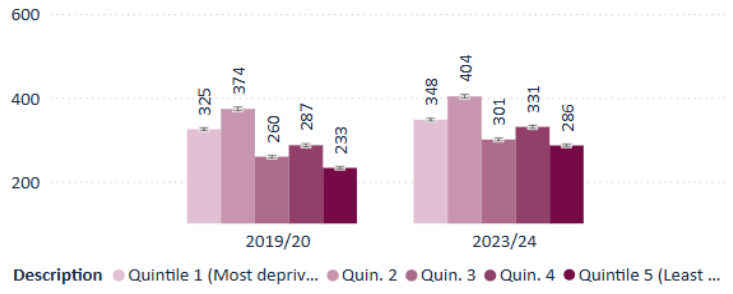
Observed health inequalities

- Non-elective admission rates for male and female children in the most deprived quintile are statistically significantly higher than the least deprived quintile in both 2019/20 and 2023/24.

Urgent and emergency care: Age standardised activity rates with 95% confidence intervals for Non-elective admission and A&E Attendances

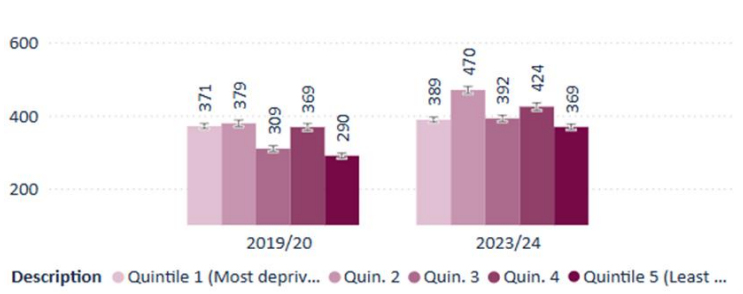
Domain: Urgent and Emergency Care — Indicator: A&E attendance rates

A&E Attendances, All A&E Dept Types, All Ages, Male, All Complaints
Directly Age Standardised Rates (DASR) per 1,000



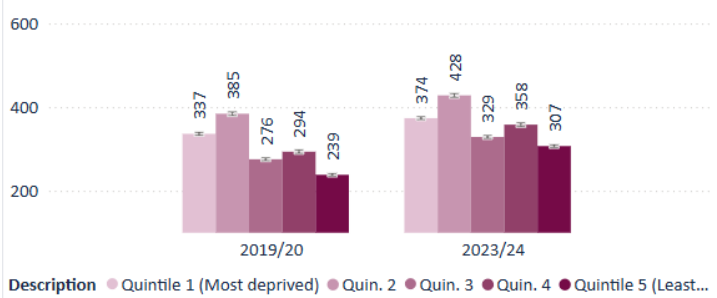
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	325.2	321.9	328.4	233.0	230.0	235.9
2023/24	348.1	344.8	351.4	286.5	283.3	289.6

A&E Attendances, All A&E Dept Types, 00 - 17 (children), Male, All Complaints
Directly Age Standardised Rates (DASR) per 1,000



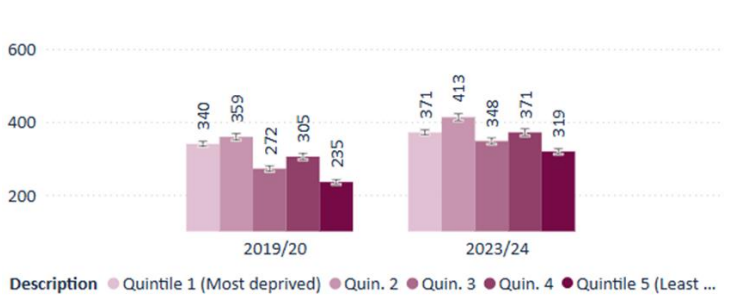
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	371.3	364.3	378.3	290.1	282.9	297.3
2023/24	388.8	381.7	395.9	369.0	361.0	377.0

A&E Attendances, All A&E Dept Types, All Ages, Female, All Complaints
Directly Age Standardised Rates (DASR) per 1,000



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	336.5	333.2	339.8	238.6	235.6	241.5
2023/24	374.0	370.6	377.3	307.2	304.0	310.4

A&E Attendances, All A&E Dept Types, 00 - 17 (children), Female, All Complaints
Directly Age Standardised Rates (DASR) per 1,000



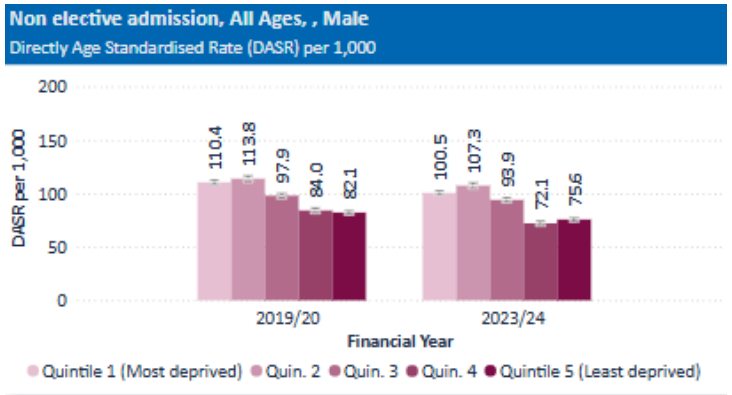
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	340.0	333.1	347.0	235.4	228.7	242.1
2023/24	371.4	364.3	378.6	319.2	311.6	326.9

Observed health inequalities

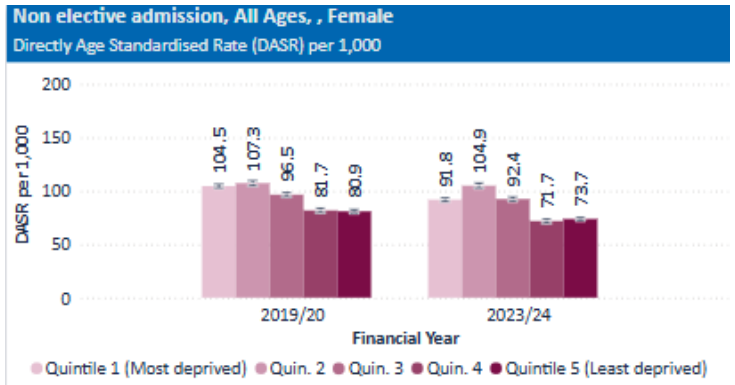
- Rates are statistically significantly higher in the most deprived quintile for both males and females.
- Rates for children are statistically significantly higher in the most deprived quintile for both males and females.

Action being taken

- Implementation of UEC Hubs to provide an urgent response where a person is at risk of admission (or re-admission) to hospital. We will continue to monitor the impact that UEC hubs have in addressing inequalities in activity.
- Operationalisation of Tier 1 HIU service to support frequent attenders to the A&Es who are coming for social or environmental reasons more than health reasons



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	110.4	108.36	112.41	82.1	80.38	83.85
2023/24	100.5	98.63	102.41	75.6	73.99	77.17



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	104.5	102.68	106.38	80.9	79.22	82.49
2023/24	91.8	90.09	93.48	73.7	72.22	75.22

Observed health inequalities

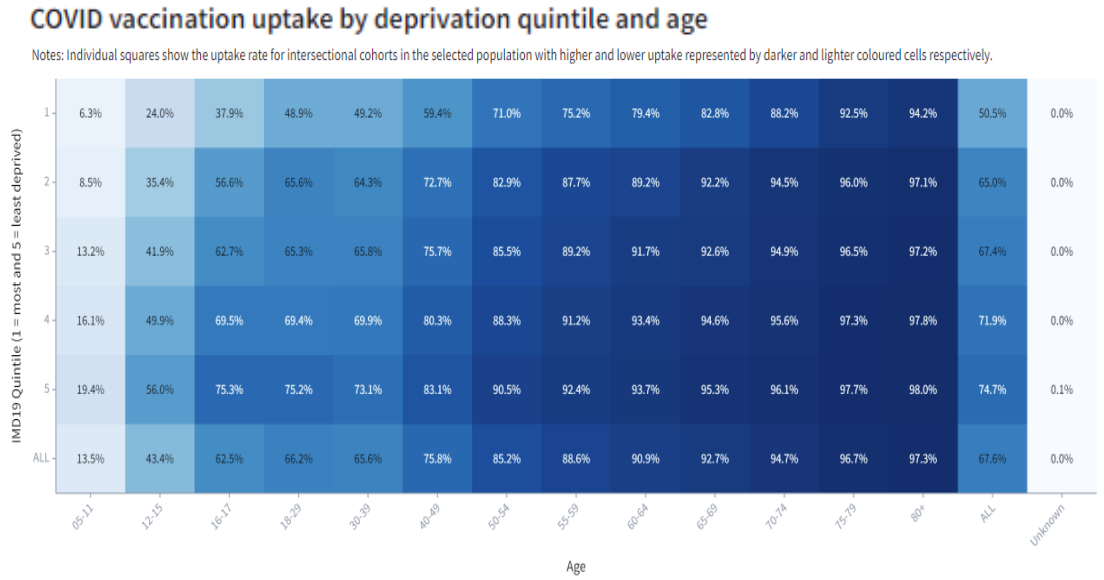
- Emergency admission rates for males and females in the most deprived quintile are statistically significantly higher than in the least deprived quintile.

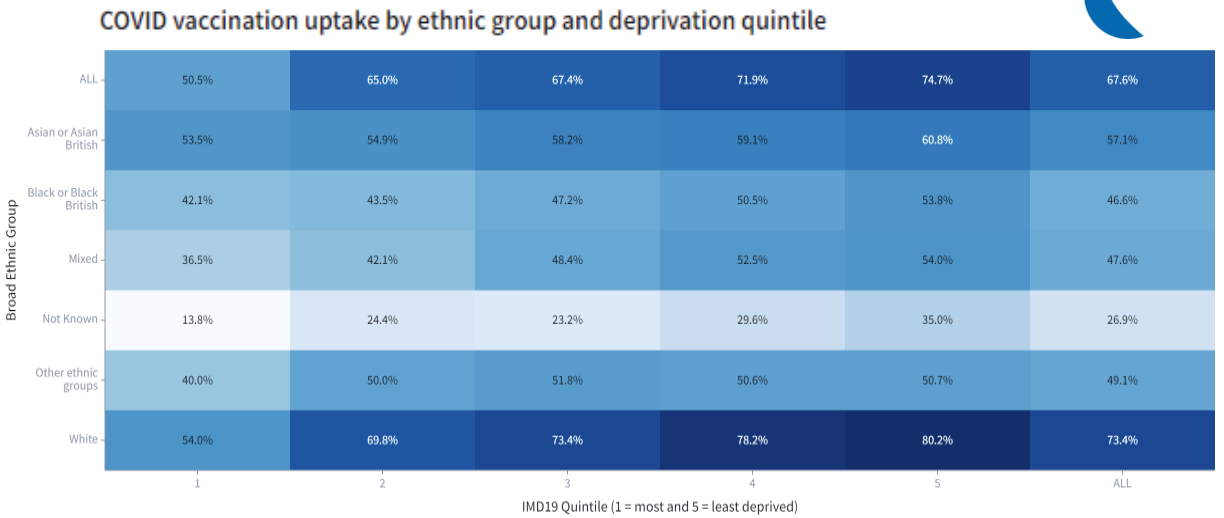
Action being taken

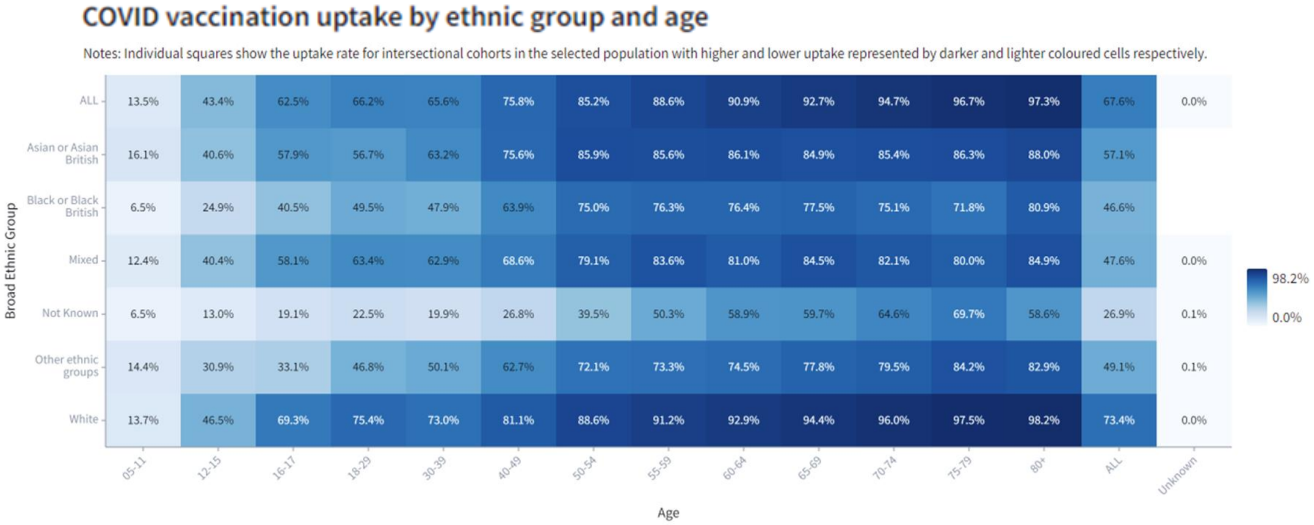
- Urgent Wrap Around Care (UWAC) delivers both a Urgent Community Response and also 5-day wrap around support to keep patients safe at home and avoid hospital admission.

Respiratory: Uptake of COVID and flu vaccinations by socio demographic groups

Domain: Respiratory Indicator: Uptake of COVID vaccinations by socio demographic groups



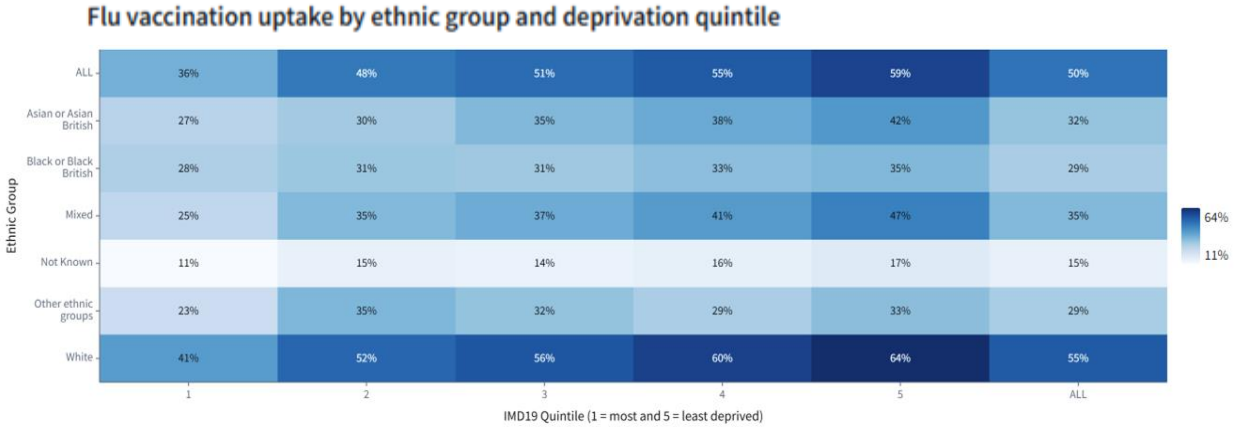


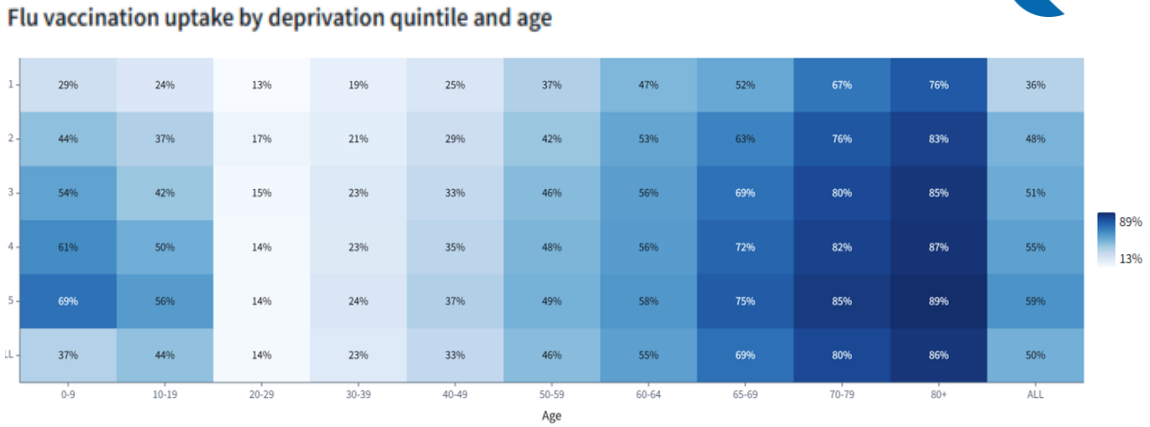


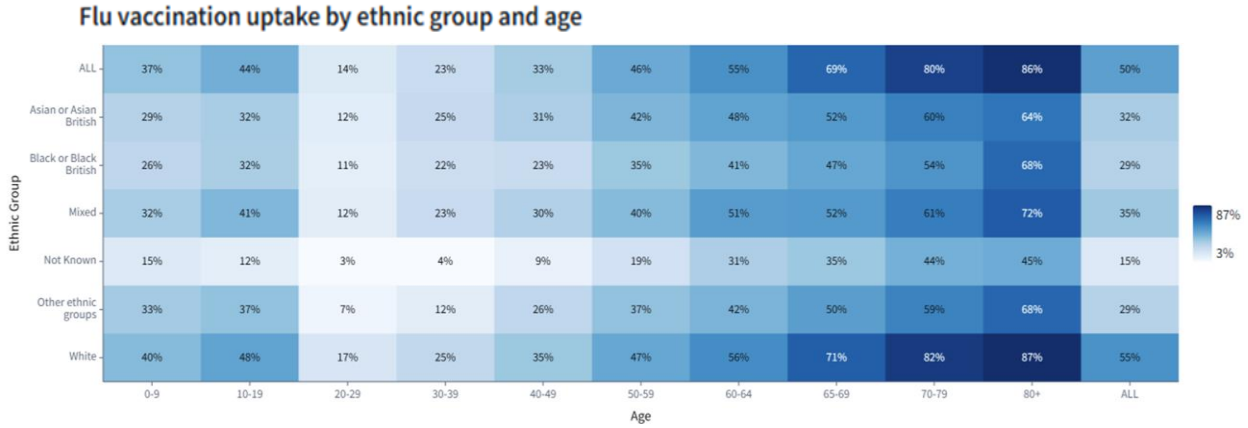
Observed health inequalities

- COVID vaccination uptake is highest amongst those living in the least deprived quintile and amongst older age groups.
- Ethnicity has an impact on relative rates of vaccination with White British having the higher levels of vaccination and mixed, black and unknown ethnicities having lower levels of uptake.
- The COVID vaccination uptake rate is highest amongst the white ethnic population living in the least deprived quintile.

Domain: Respiratory Indicator: Uptake of flu vaccinations by socio demographic groups







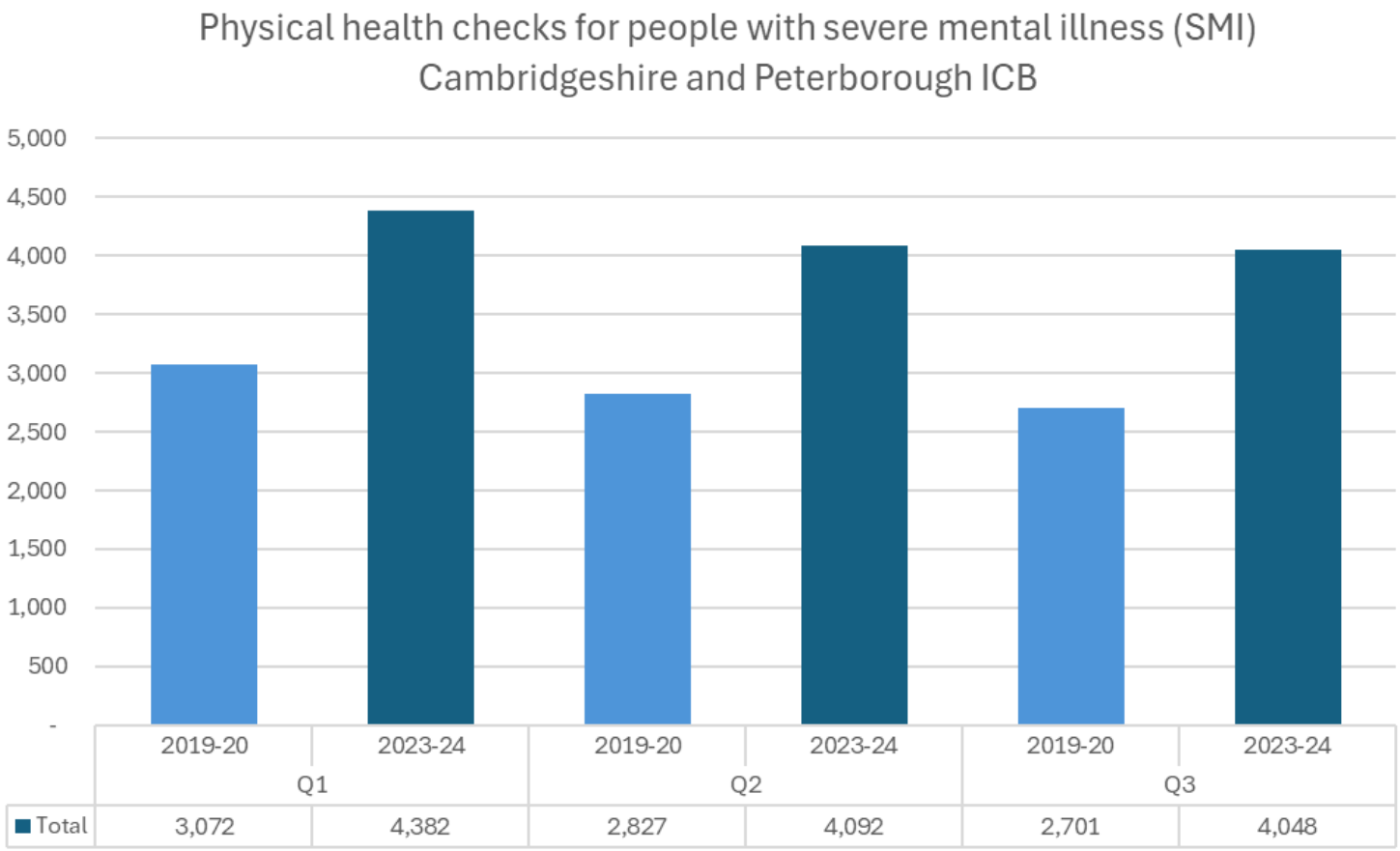
Observed health inequalities

- The flu vaccination uptake rate is highest for the white ethnic population living in the least deprived quintile.
- The flu vaccination uptake rate is highest for the older white ethnic population.
- The flu vaccination uptake rate is highest for the older population living in the least deprived quintile.

Action being taken

- Access & Inequalities Vaccine Project to improve uptake of childhood and respiratory immunisations for Core20PLUS5 population groups

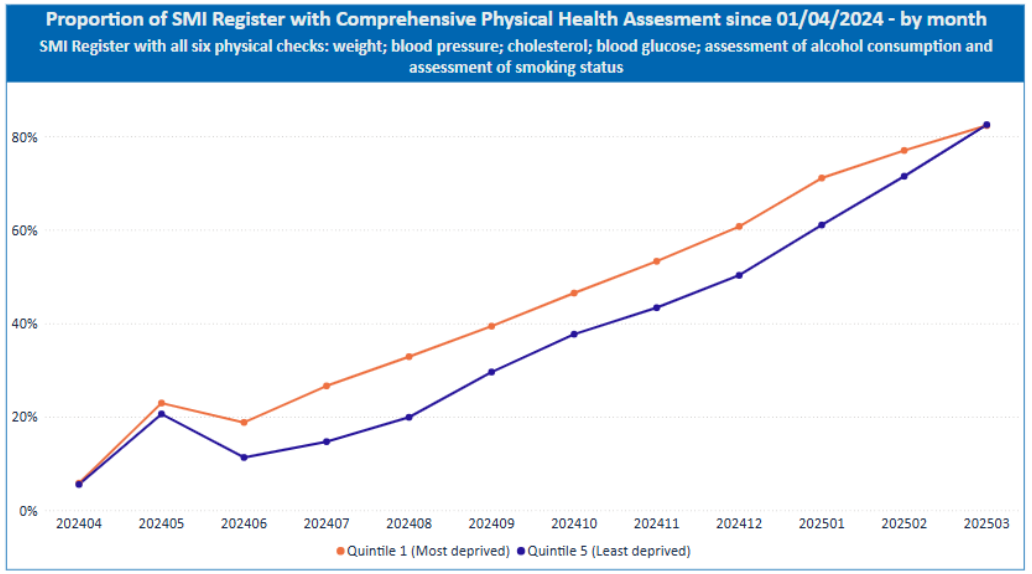
Mental Health

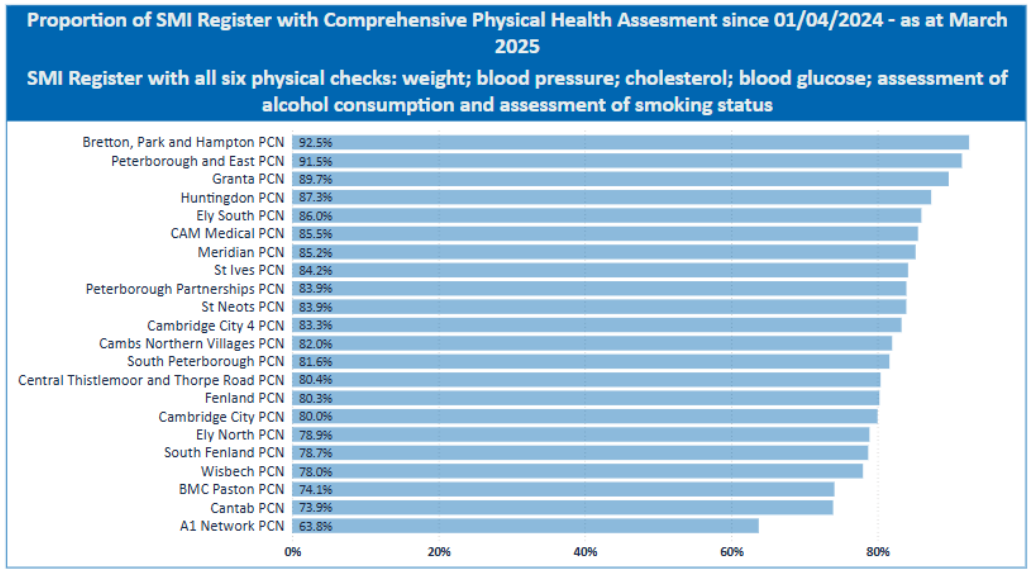


Observations

- There had been at least a 40% increase in physical health checks for people with serious mental illness for Cambridgeshire and Peterborough residents from pre-covid 2019/20 to 2023/24.

Domain: Mental Health Indicator: SMI Register with Comprehensive Physical Health Assessment





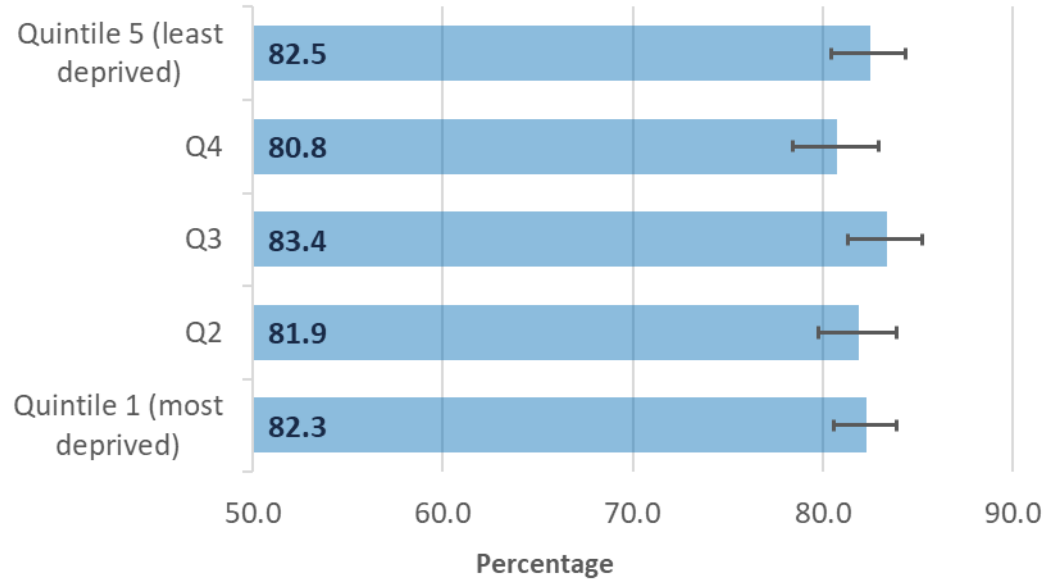
Observed health inequalities

- The proportion of those with SMI receiving a comprehensive physical health in the most deprived quintile of practices, exceeded those in the least deprived quintile until March 2025.
- In March 2025, the proportion with comprehensive physical health checks in the least deprived (82.5%) overtook the most deprived quintile (82.3%).
- There is wide variation across the PCNs – from 92.5% to 63.85.
- Top performing practice achieved 97.3% compared to worst performing practice 51.0%.

Source: Primary Care Information Systems

Domain: Mental Health Indicator: SMI Register with Comprehensive Physical Health Assessment

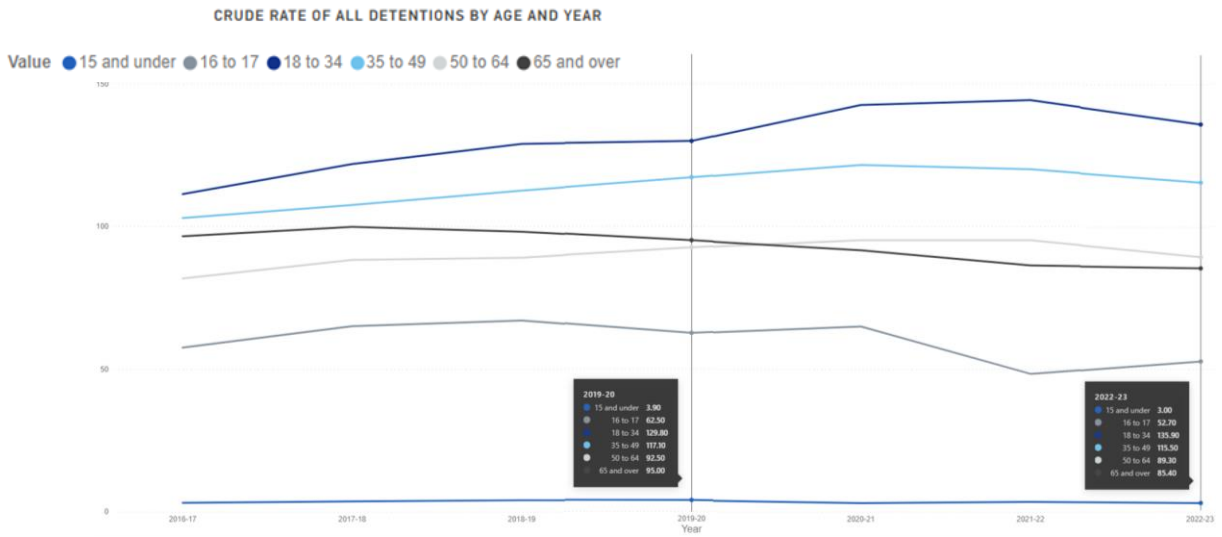
Proportion of SMI Register with Comprehensive Physical Health Assesment since 01/04/2024 - as at March 2025
All six physical checks: weight; blood pressure; cholesterol; blood glucose; assessment of alcohol consumption and assessment of smoking status

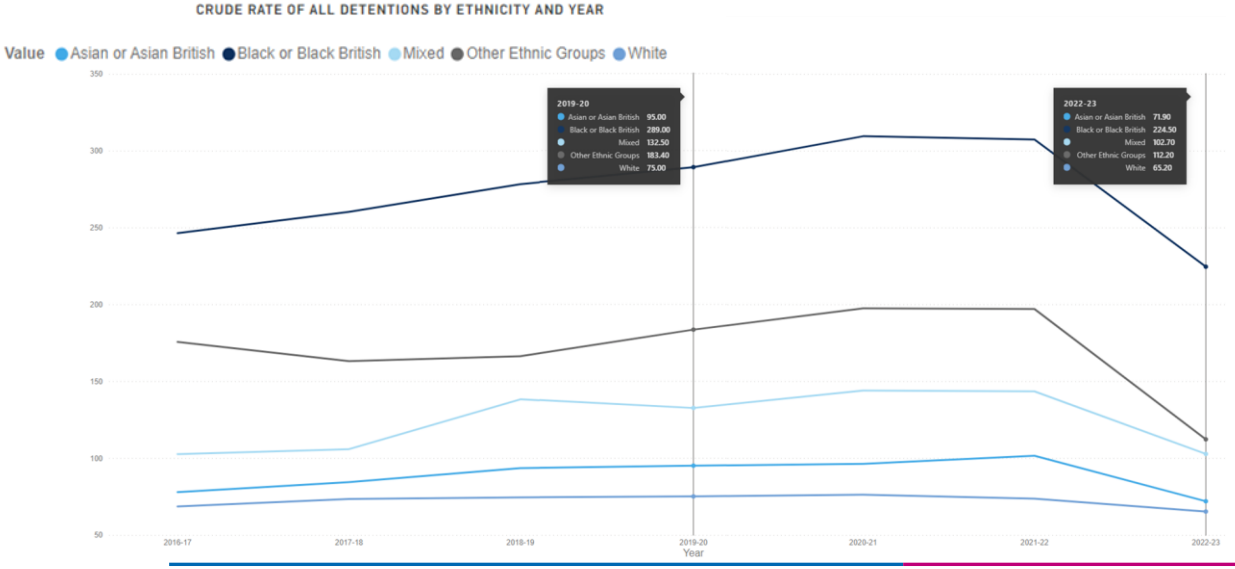


Observed health inequalities

- The proportion of those with SMI receiving a comprehensive physical health check was statistically similar across all deprivation quintiles in 2024/25.
- The second least deprived quintile (quintile 4) has the lowest proportion receiving all six health checks at 80.8%.
- The middle quintile (quintile 3) has the highest proportion at 83.4%.

Source: Primary Care Information Systems



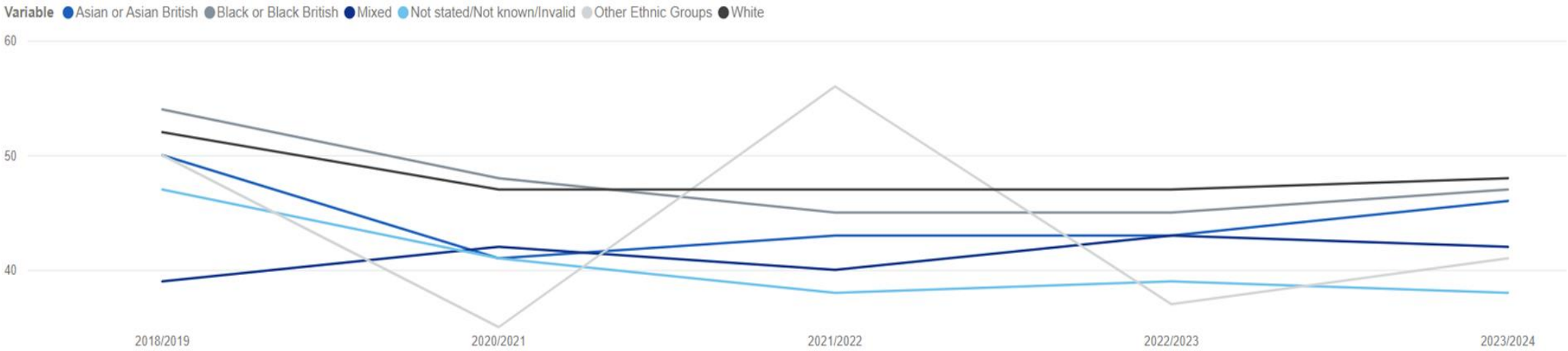


Observed health inequalities

- Analysis suggests higher rates of detentions for those aged between 18-34 and 35-49.
- Analysis suggests higher rates of detentions for Black and Black British and other ethnic groups.

Action being taken

- All-age review of the Mental Health Crisis Pathway with providers, those with lived experience and their carers.
- This review identified gaps in the provision and access of crisis alternatives for those in MH crisis and those from ethnic minorities and CYP populations. The ICB is now considering the options available to address these gaps.



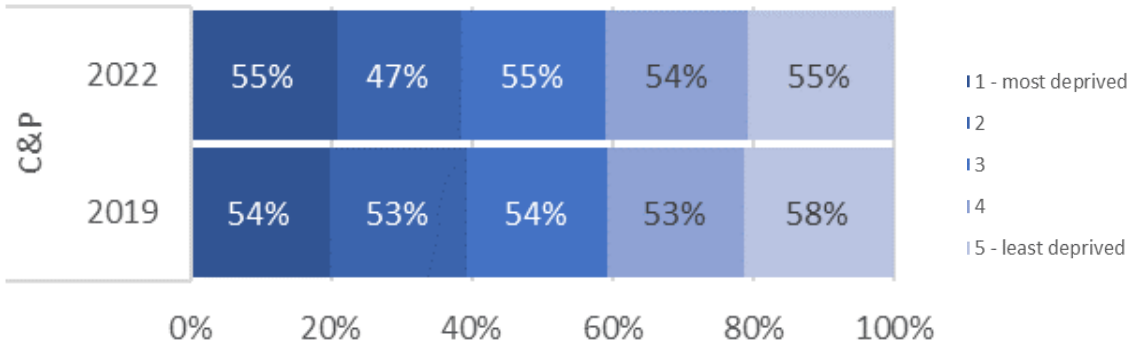
Year	Asian or Asian British	Black or Black British	Mixed	Not stated/Not known/Invalid	Other Ethnic Groups	White
2018/2019	50.00	54.00	39.00	47.00	50.00	52.00
2020/2021	41.00	48.00	42.00	41.00	35.00	47.00
2021/2022	43.00	45.00	40.00	38.00	56.00	47.00
2022/2023	43.00	45.00	43.00	39.00	37.00	47.00
2023/2024	46.00	47.00	42.00	38.00	41.00	48.00

Observed health inequalities

- Analysis suggests a higher reliable recovery rate for the White ethnic group compared with other ethnic groups.
- This rate has declined since pre-covid (2018/19).

Cancer: Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex

Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex.



Observed health inequalities

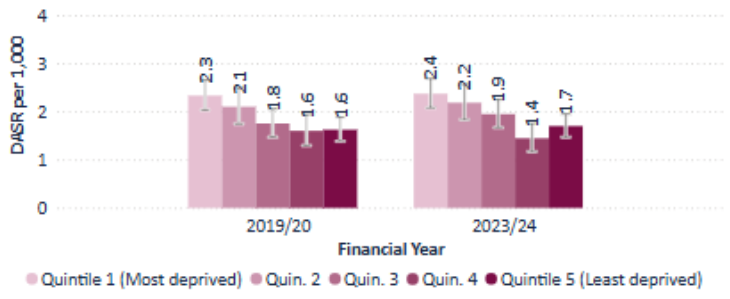
- Between 2019 and 2022, the overall percentage of cancers diagnosed at stage 1 and 2 has decreased for Cambridgeshire and Peterborough ICB

Action being taken

- Two key programmes to highlight the work taking place to increase the number of cancers identified at stage 1 or 2 to 75% are:
  - 1) **Targeted Lung Health Checks** – this is a national screening programme delivered by local systems to identify lung cancer at stage 1 or 2. it is targeted at populations where there are high levels of smoking, deprivation and poor lung cancer outcomes. Roll out will commence in the North which has the areas of higher deprivation and Core20PLUS groups.
  - 2) **Cervical Screening** – Neighbourhood programmes - targeted work is taking place through North and South Place to improve screening rates. North Place is focusing on practices with low uptakes in the Core20PLUS groups, and South Place is focusing on community events to promote the benefits of screening.

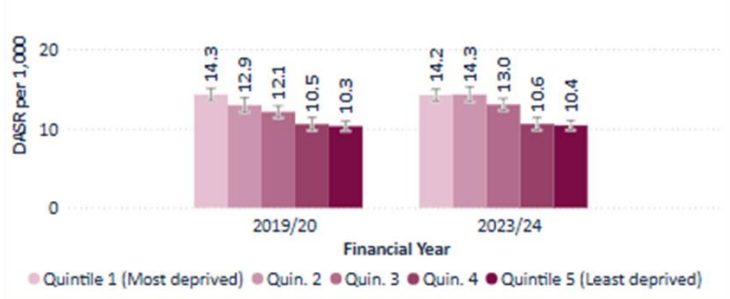
Cardiovascular Disease

Non elective admission, All Ages, Cardiovascular (CVD) Stroke, Male
Directly Age Standardised Rate (DASR) per 1,000



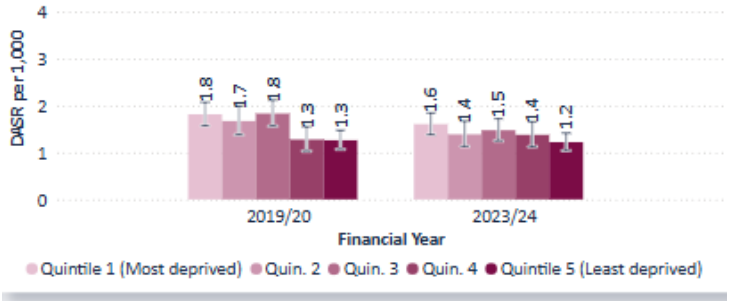
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	2.3	2.03	2.65	1.6	1.38	1.88
2023/24	2.4	2.08	2.69	1.7	1.47	1.95

Non elective admission, All Ages, Cardiovascular (CVD) , Male
Directly Age Standardised Rate (DASR) per 1,000



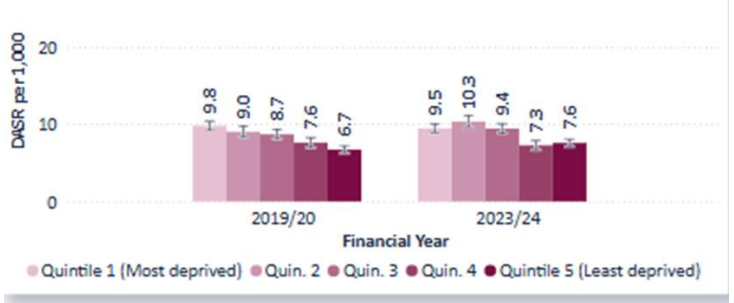
Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	14.3	13.52	15.05	10.3	9.67	10.92
2023/24	14.2	13.47	14.95	10.4	9.79	10.98

Non elective admission, All Ages, Cardiovascular (CVD) Stroke, Female
Directly Age Standardised Rate (DASR) per 1,000



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	1.8	1.57	2.07	1.3	1.06	1.47
2023/24	1.6	1.38	1.84	1.2	1.04	1.41

Non elective admission, All Ages, Cardiovascular (CVD) , Female
Directly Age Standardised Rate (DASR) per 1,000



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	9.8	9.20	10.36	6.7	6.23	7.17
2023/24	9.5	8.90	10.02	7.6	7.09	8.04

Observed health inequalities

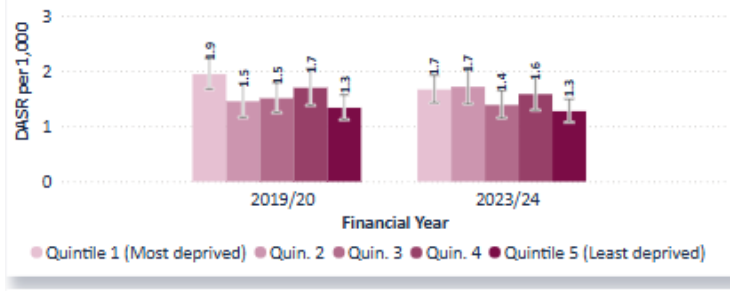
- Stroke rate of non-elective admissions:
  - Rates for females were statistically significantly higher in the most deprived quintile in 2019/20 but have fallen in 2023/24 and are statistically similar to the rates in the least deprived quintile.
  - Rates for males remain significantly higher in the most deprived quintile in 2023/24.
- Non-elective admission rates for CVD are statistically significantly higher in the most deprived quintile for both males and females in 2019/20 and 2023/24.

Domain: Cardiovascular Disease

Indicator: Emergency admission rates for myocardial infarction, all ages

Non elective admission, All Ages, Cardiovascular (CVD) Coronary Heart Disease (CHD), Male

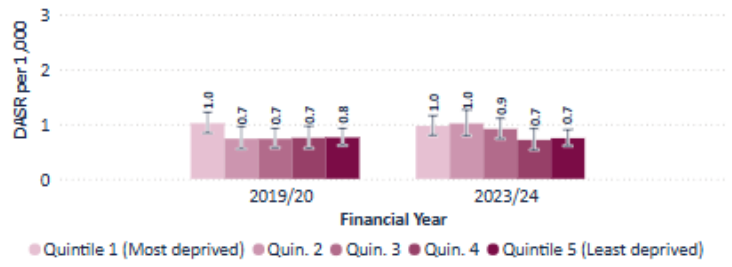
Directly Age Standardised Rate (DASR) per 1,000



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	1.9	1.67	2.23	1.3	1.12	1.57
2023/24	1.7	1.43	1.93	1.3	1.07	1.49

Non elective admission, All Ages, Cardiovascular (CVD) Coronary Heart Disease (CHD), Female

Directly Age Standardised Rate (DASR) per 1,000



Financial Year	Quint 1 DASR per 1,000	Q1 lower limit	Q1 upper limit	Quint 5 DASR per 1,000	Q5 lower limit	Q5 upper limit
2019/20	1.0	0.83	1.21	0.8	0.61	0.92
2023/24	1.0	0.79	1.15	0.7	0.60	0.90

Observed health inequalities

- These graphs show ICS non-elective admission rates for myocardial infarction (ICD10 code: I21 and I22) by deprivation.
- Myocardial infarction rate of non-elective admissions: Rates for males were statistically significantly higher in the most deprived quintile in 2019/20 but have fallen slightly in 2023/24 and are now statistically similar to the rates in the least deprived quintile. For females, the rates remain statistically similar in the most and least deprived quintiles.

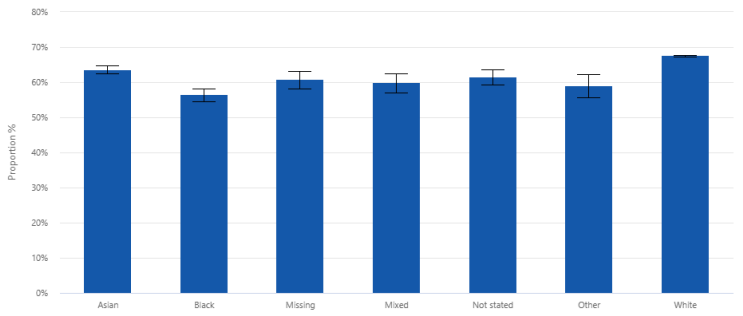
Action being taken

- The ‘Your Healthier Future’ (YHF) programme, launched by the ICB in conjunction with the Cambridgeshire and Peterborough public health teams, is a two-year programme which targets key clinical and behavioural risks associated with CVD.
- The programme risk stratifies people with a high or increasing risk of a major adverse cardiovascular events and enables GP practices to better support patients and reduce premature mortality.

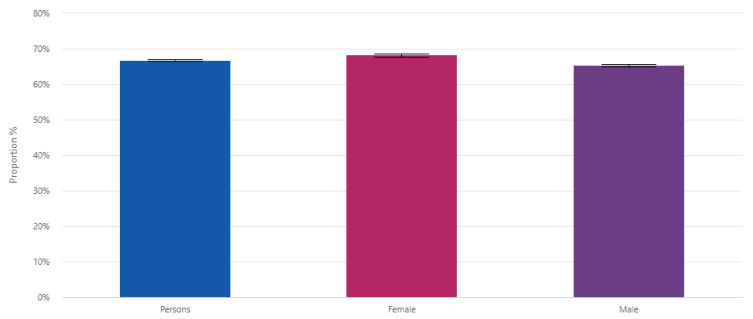
Domain: Cardiovascular Disease

Indicator: CVDP007HYP: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.

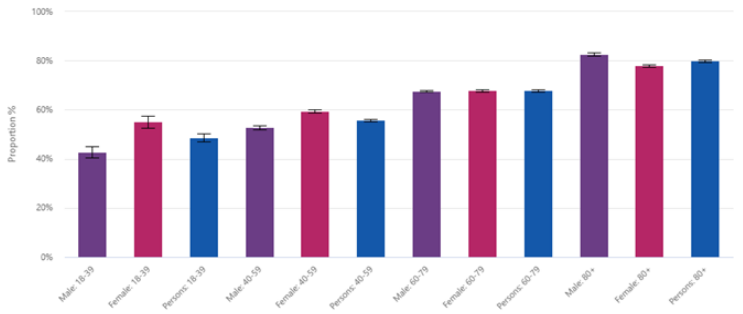
Ethnicity



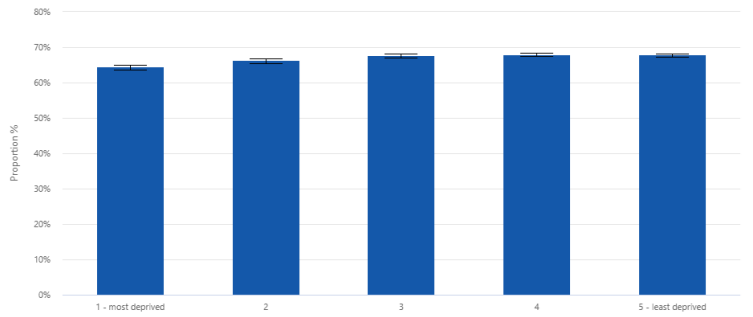
Sex



Age Group



Deprivation Quintile



Observed health inequalities

- Analysis suggests health inequalities for different ethnicities for those whose last blood pressure reading was in the last 12 months.
- Patients in the older age bands are more likely to have a blood pressure reading in the preceding 12 months

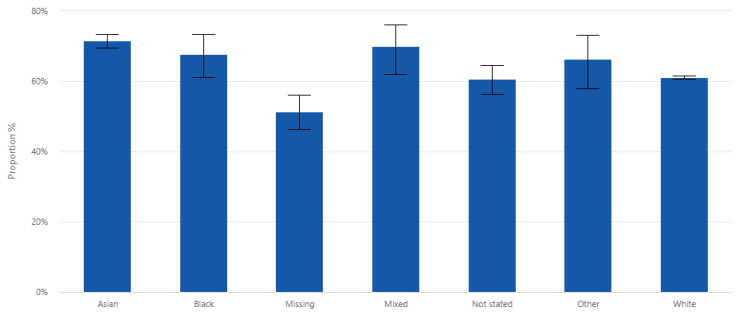
Action being taken

- The Your Healthier Futures programme recently launched its hypertension Detect and Perfect strands to improve the number of people identified as having hypertension and who are appropriately monitored and optimised.

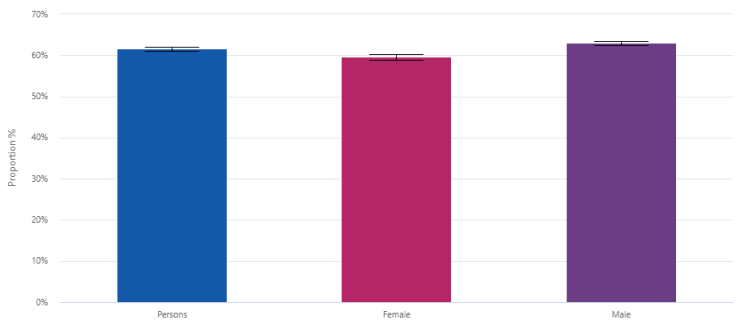
Domain: Cardiovascular Disease

Indicator: CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy.

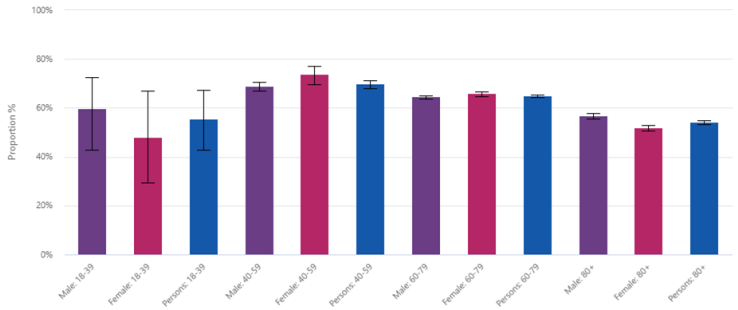
Ethnicity



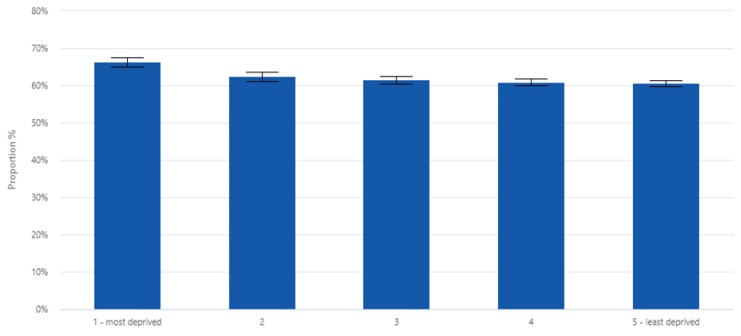
Sex



Age Group



Deprivation Quintile



Observed health inequalities

- Persons aged 40-59 are more likely to have no GP recorded CVD and a GP recorded QRISK score of 20% or more on lipid lowering therapy.

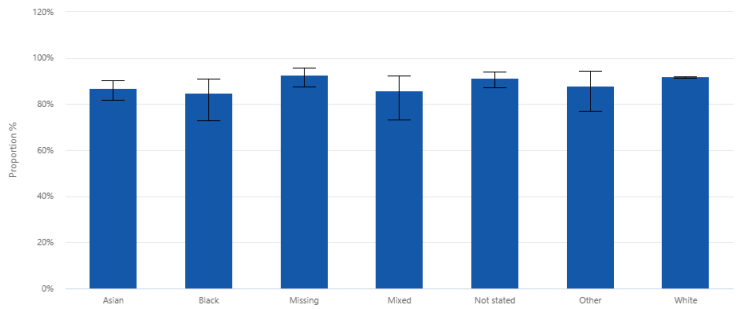
Action being taken

- Early indications from the Your Healthier Futures programme show that:
  - once contact is made with an individual, those from the most deprived two deciles (Core20) are more likely to take up a lipid lowering therapy than those from other deciles
  - For ethnic minority patient groups, mental health and learning disability groups, early results show the YHF programme is achieving proportionately higher uptake rates for lipid lowering therapies

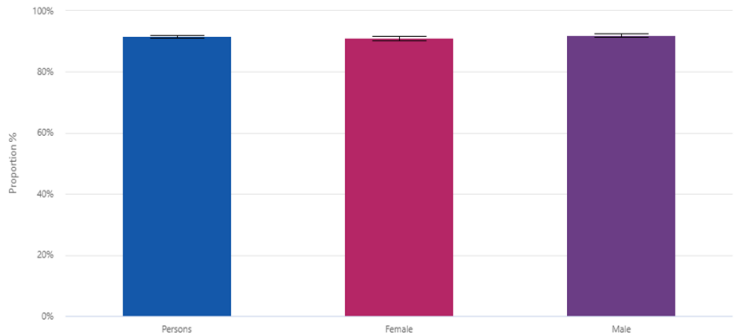
Domain: Cardiovascular Disease

Indicator: CVDP002AF: % of patients aged 18 and over with GP recorded atrial fibrillation and with a CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant.

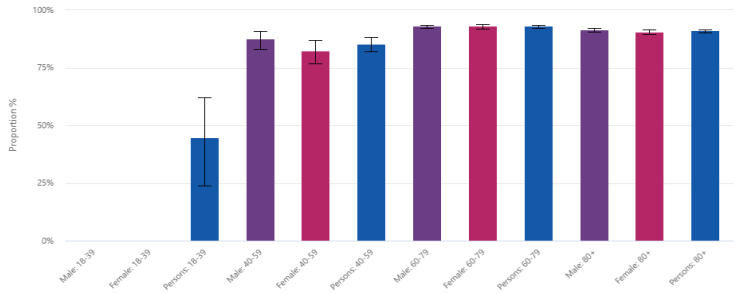
Ethnicity



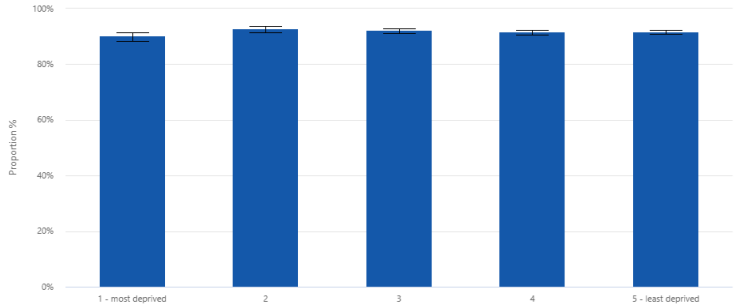
Sex



Age Group



Deprivation Quintile



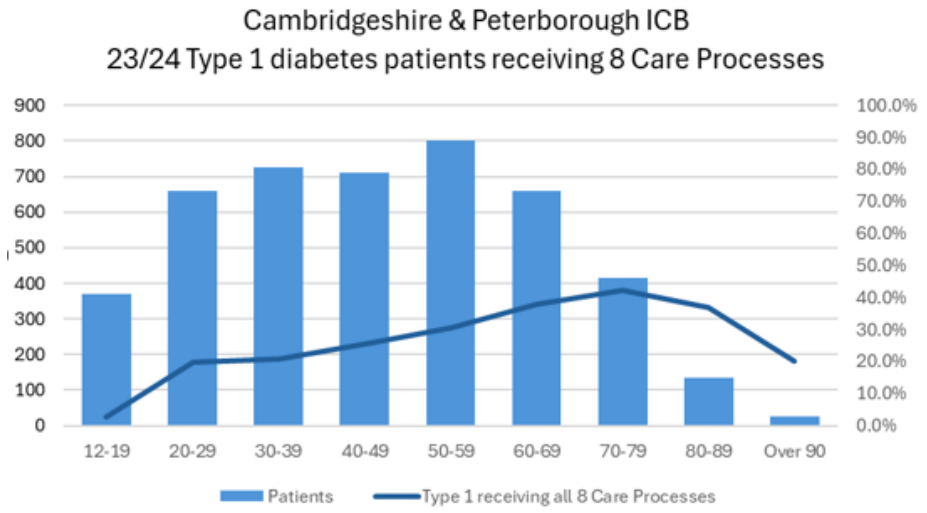
Observed health inequalities

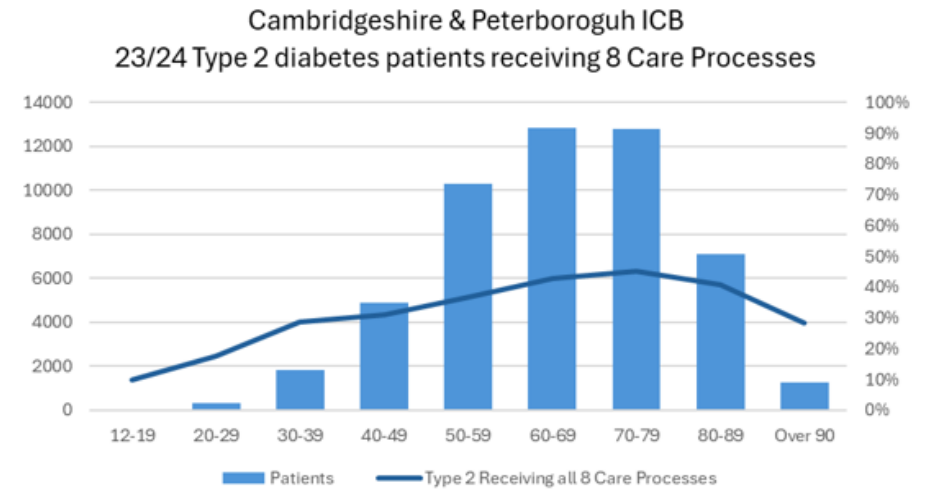
- Persons currently treated with any oral anticoagulant aged 18-39 are less likely to have GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more.

Diabetes: Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes

Domain: Diabetes

Indicator: Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes.





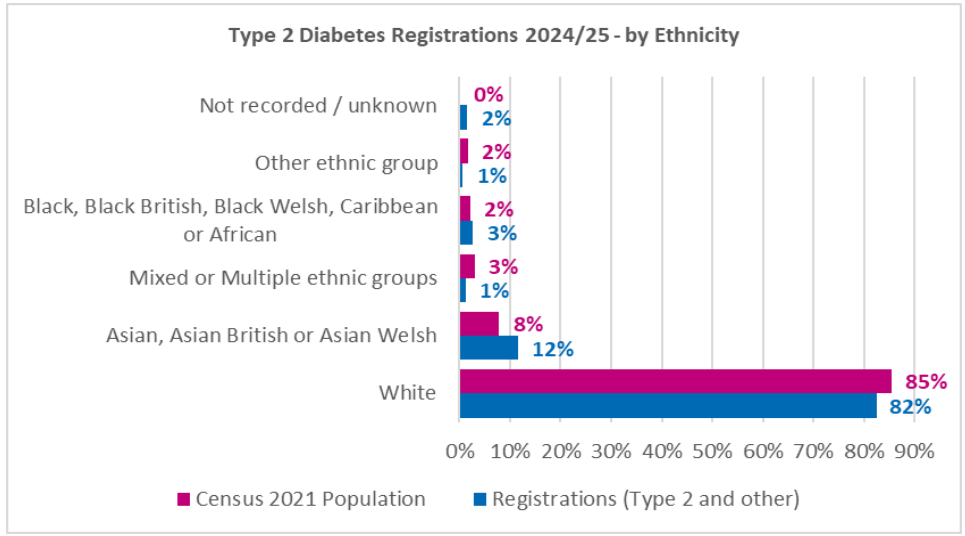
Observed health inequalities

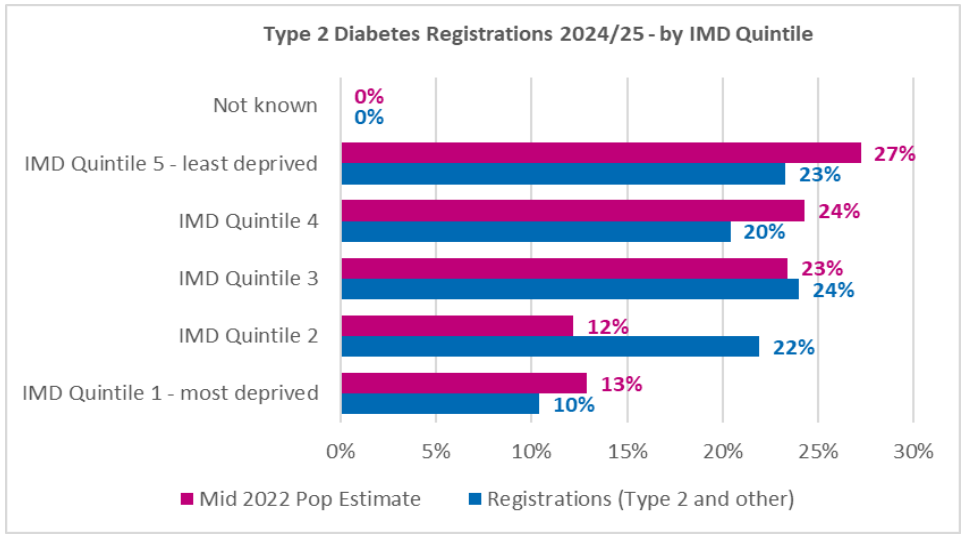
- There is variation in type 1 and 2 diabetes patients receiving the 8 care processes across different age bands.
- In 23/24, older patients with diabetes were more likely to receive all 8 care processes but drops down in the last 2 age groups.

Action being taken

- National GIRFT review and development of an ICB Children and Young Person (CYP) Diabetes Action Plan to ensure all CYP with type 2 diabetes receive the annual NICE recommended care processes.

Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile





Observed health inequalities

- The proportion of type 2 diabetes registrations from the Asian and Black ethnic groups is higher than the proportion of the census 2021 population from those ethnic groups.
- The proportion of type 2 diabetes registrations living in the most deprived quintile is lower than the mid 2022 population estimate of those living in the most deprived quintile. This may suggest that type 2 diabetes is under-diagnosed in this population.
- The proportion of type 2 diabetes registrations living in the second most deprived quintile is significantly higher than the mid-2022 population estimate.

Action being taken to address the inequalities

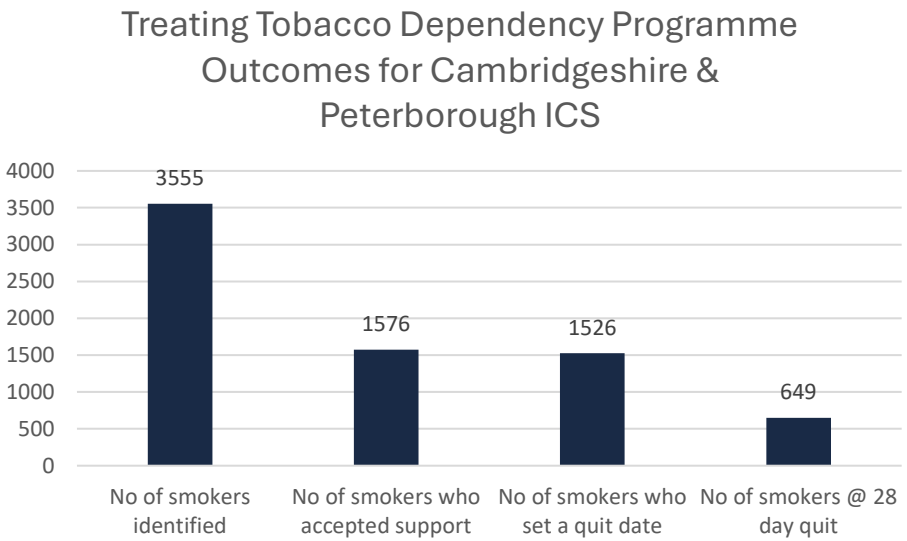
- National GIRFT review and development of an ICB Children and Young Person (CYP) Diabetes Action Plan to ensure all CYP with type 2 diabetes receive the annual NICE recommended care processes.

Source: National Diabetes Audit 2024-25

Smoking Cessation:

Domain: Smoking Cessation

Indicators: All adult acute inpatient settings offer smoking cessation services. All maternity inpatient settings offer smoking cessation services.



Observations

- 100% of adult acute inpatient settings offer smoking cessation services.
- 100% of maternity settings offer smoking cessation services.

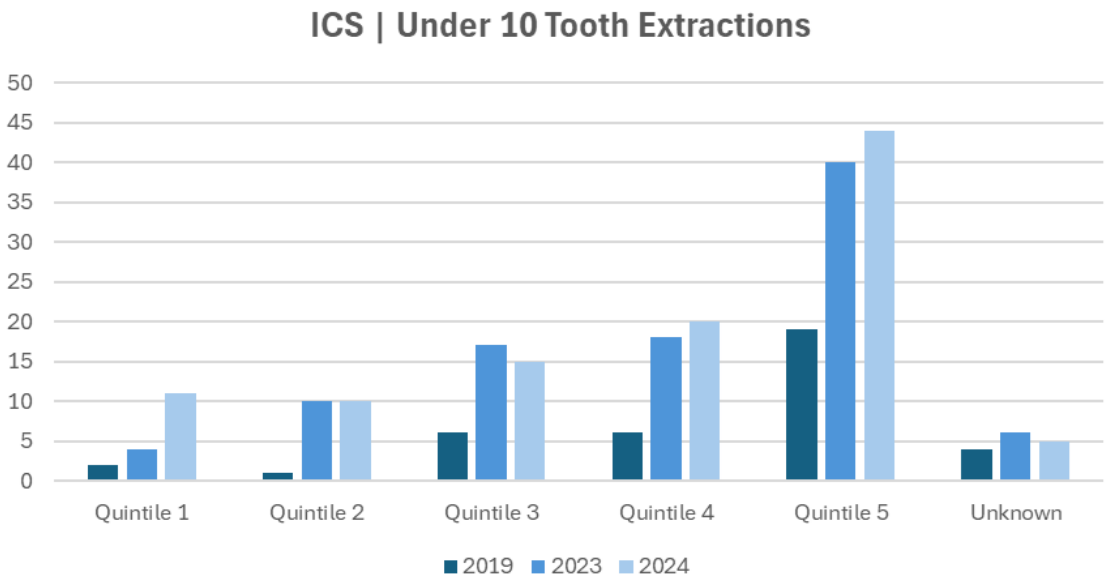
Action being taken

- The Treating Tobacco Dependency Programme (TTDP) has produced the following to date:
  - 3,555 smokers identified
  - 1,576 smokers (44%) accepted support from in-house smoking support services.
  - 1,526 smokers (97% of those accepting support) set a quit date.
  - 649 smokers (43% of those setting a quit date) sustained a quit attempt after 28 days.

Oral Health

Domain: Oral Health

Indicator: Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under.



Observed health inequalities

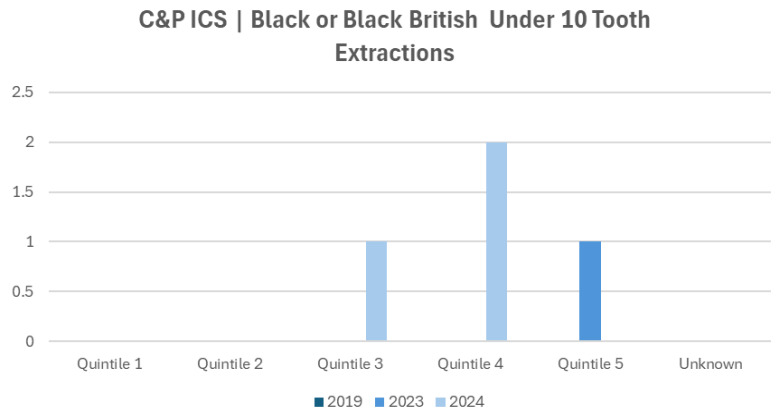
- During 2023 and 2024, the number of under 10 tooth extractions was higher in the more deprived quintiles.
- A similar trend in higher rates of under 10 tooth extractions in the more deprived areas is also observed across all ethnic minority groups, with the largest variations being amongst the Asian/Asian British (see next slide).

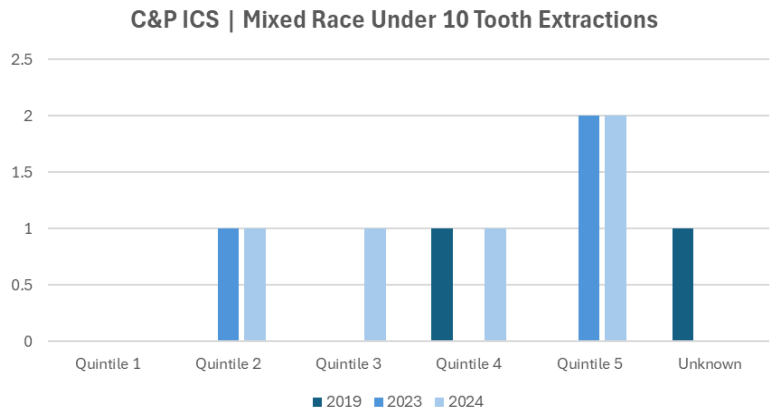
Action being taken

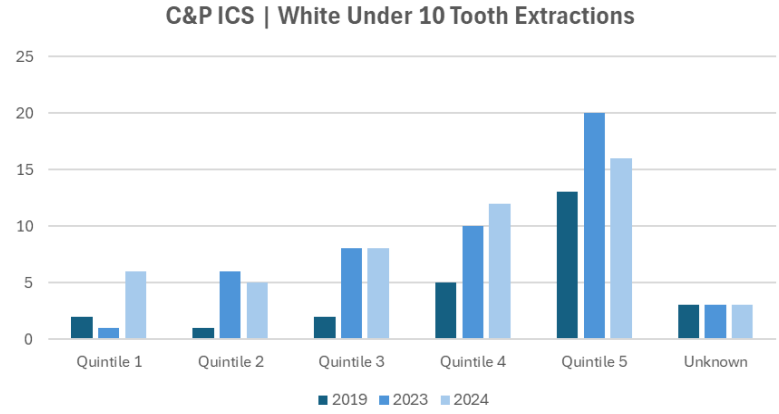
- System-wide paediatric dental pathway task and finish group was established in 2024 to develop initiatives that will be introduced to support access and earlier intervention. These include:
  - increased prevention initiatives
  - improved referral pathway to dental practices for routine check-up or treatment; and
  - the creation of Child Focused Dental Practices to reduce the number being referred to Special Care Dental Services and reduce the number requiring treatment under General Anaesthetic.

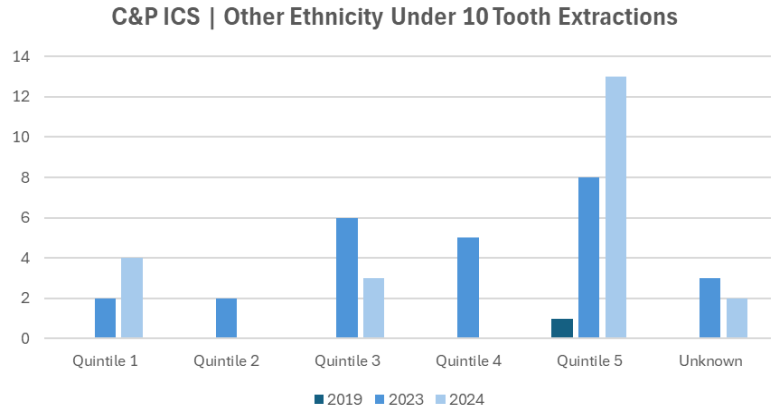
Domain: Oral Health

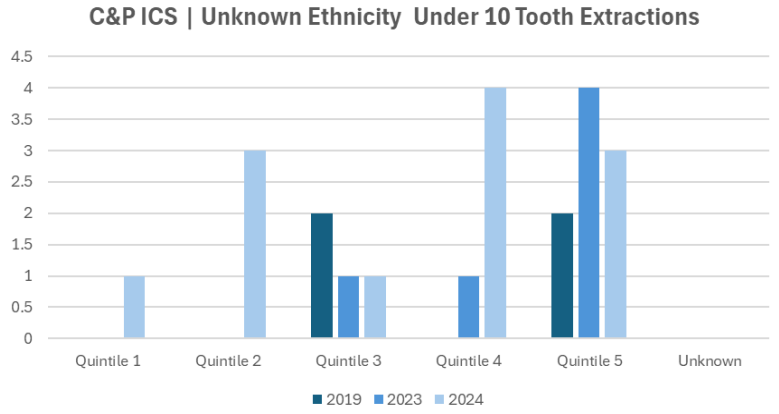
Indicator: Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under. (cont'd)

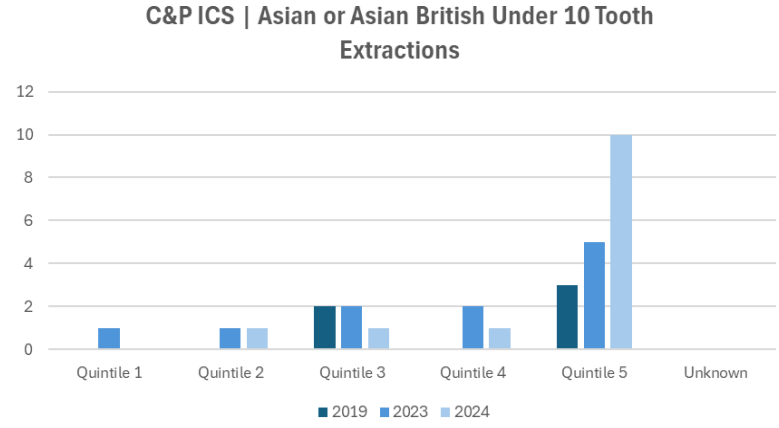




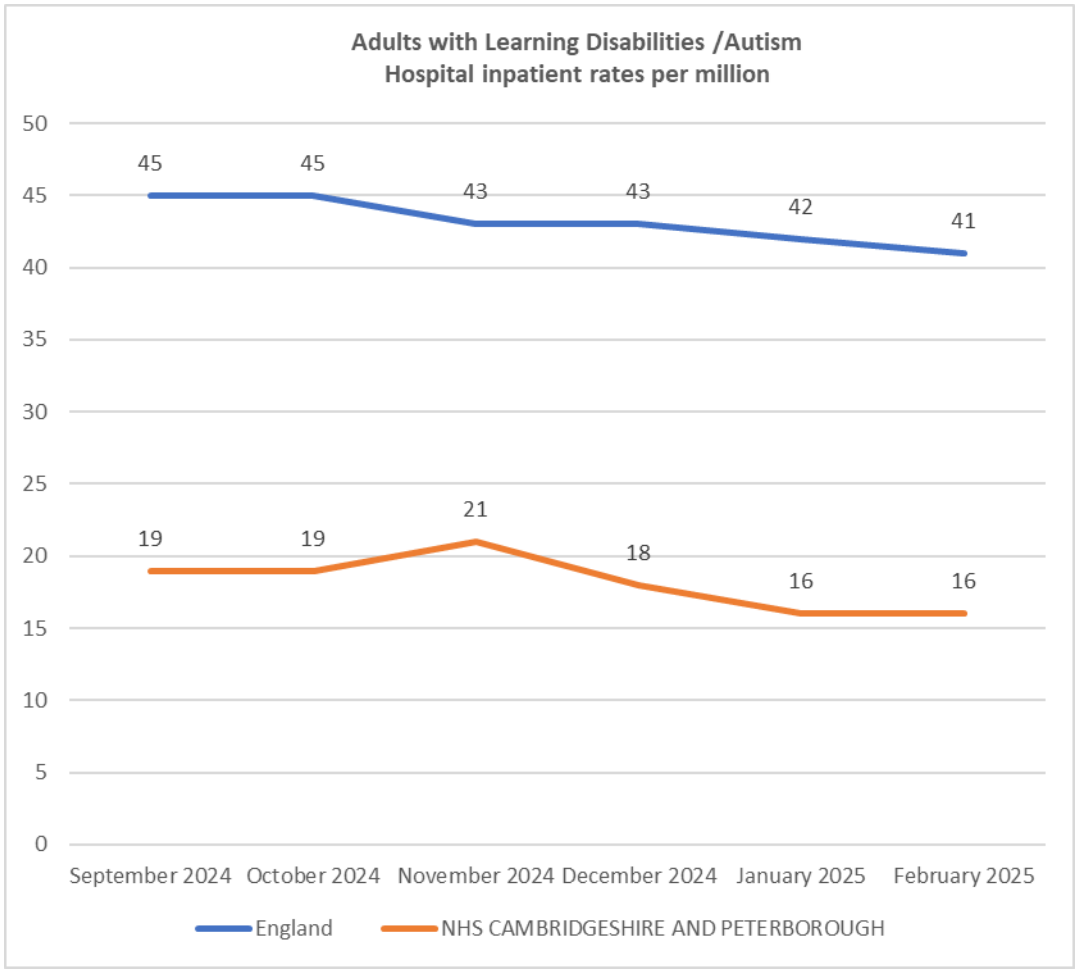








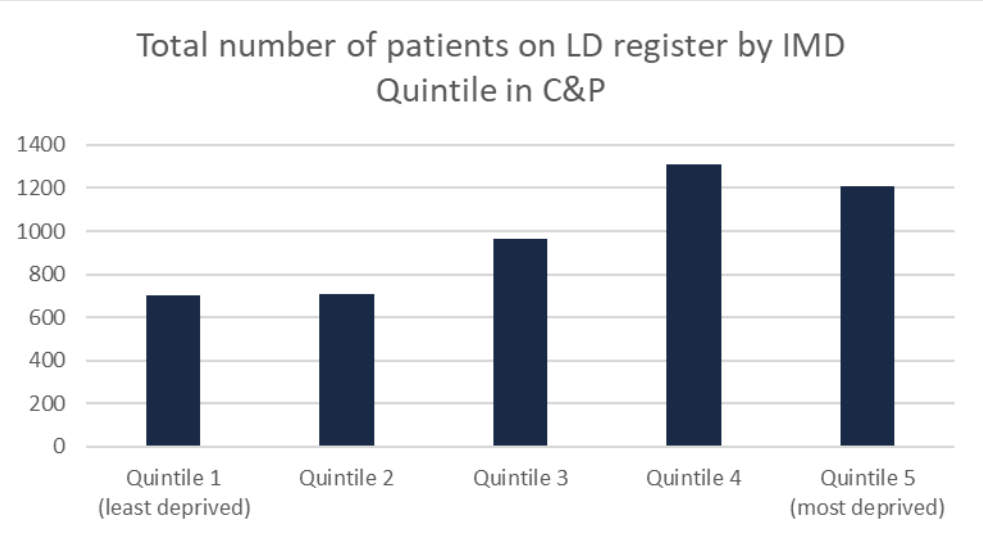
Learning disability and autistic people

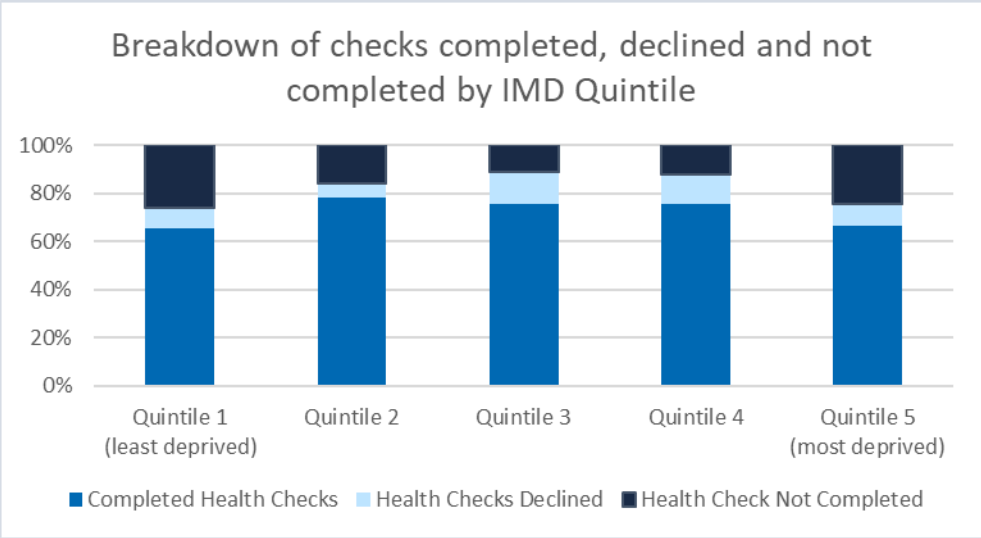


Observed health inequalities

- Inpatient rates for adults with learning disability / autism are lower for Cambridgeshire and Peterborough than England average.
- Inpatient rates have fallen slightly from 19 per million in September 2024 to 16 per million in February 2025.

Source: NHS England Assuring Transformation Dataset, February 2025

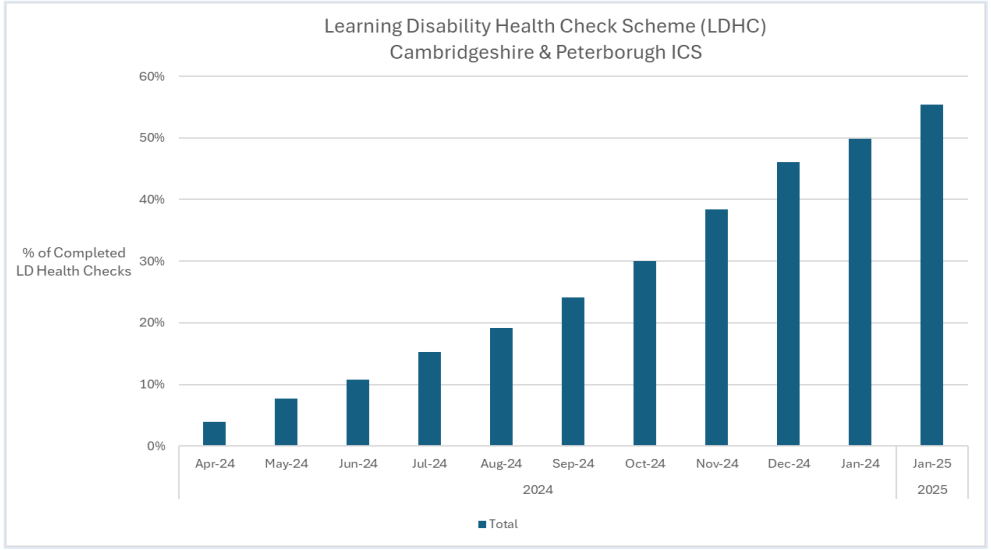




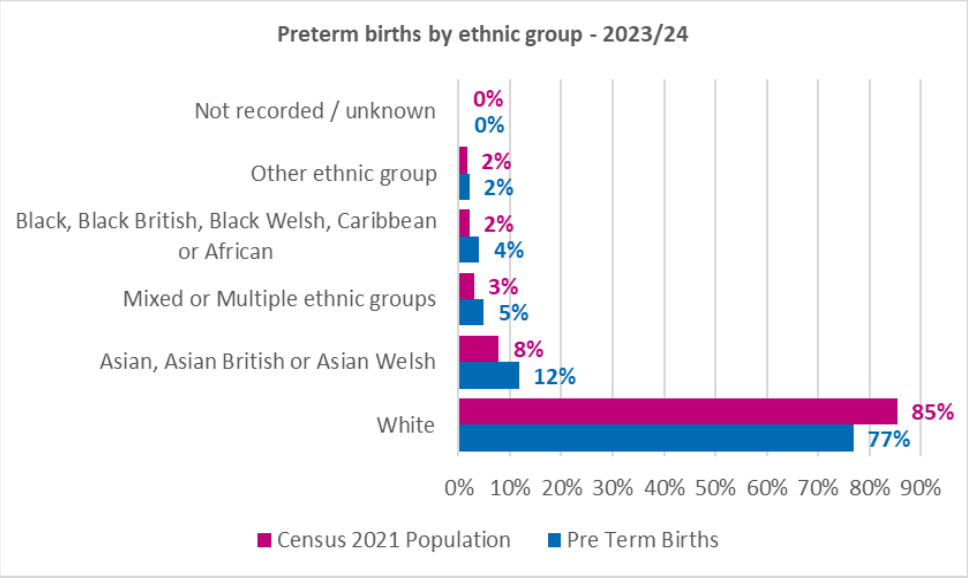
Observed health inequalities

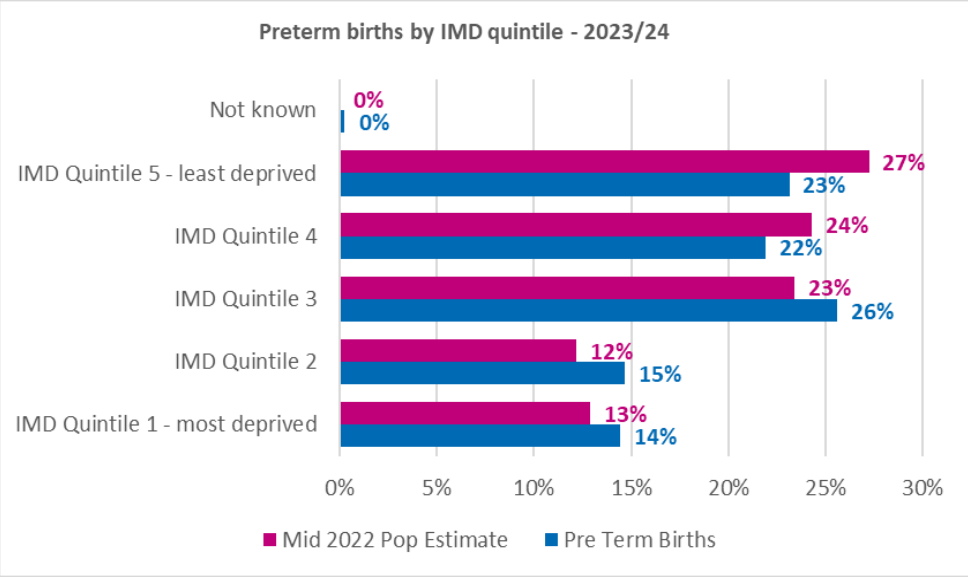
- Greater number patients on the LD register are registered with practices within IMD Quintile 4
- Practices in Quintile 1 (least deprived) and Quintile 5 (most deprived) have highest proportion of LD registered patients who have not had a health check completed compared with the other quintiles
- Highest percentage of patients declining a health check are registered at practices within quintile 3 and 4

The below graph shows % of LD health checks completed FY 2024-25



Maternity and Neonatal





Observed health inequalities

- The proportion of preterm births in ethnic minority groups is greater than expected, when compared to the census population.
- Those living in the three most deprived quintiles have more preterm births as a proportion of the total than expected, when compared to the latest population estimates.

Action being taken

- Senior midwifery advocate pilot role, hosted by NWAFT and supported by the Local Maternity and Neonatal System (LMNS) helps Black, Asian and Mixed ethnicity parents-to-be, new parents and families, to be listened to and heard by their maternity and neonatal care provider. This is a 12-month pilot which commenced in November 2024 to enhance the access, experience and outcomes for those who at risk of greatest inequalities.
- National NHS England Core20PLUS5 Connector programme (see slide 24) provided funding for Barnardo's to deliver their Mumma Hub to address and reduce maternal health inequalities, particularly focusing on women from Black, Asian, and Mixed Ethnicity backgrounds in Peterborough.

Source: Index of Multiple Deprivation (IMD) 2019

Summary

Analytical Report Summary Table (slide 1 of 4)

Domain	Indicator	Summary
Elective Recovery	Size and shape of waiting list, 18+, 52+ and 62+ weeks	• All ethnic groups are under-represented in the waiting list when compared to the census 2021 population. • Average waiting times for different ethnicities is disproportionate and this difference increases further for 52+ and 62+ week waits. • Average waiting times are longer for people living in more deprived areas. • Male and Female average waiting times are similar but there are a higher percentage of males waiting over 52+ and 62+ weeks.
Elective Recovery	Age standardised activity rates with 95% confidence intervals for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances	• In 2023/24, consultant led first outpatient attendance rates in the least deprived quintile are statistically significantly higher than those in the most deprived quintile for both males and females. • In 2023/24, consultant led, follow up outpatient attendance rates are statistically significantly higher in the most deprived quintile for males and in the least deprived quintile for females. • In 2023/24, consultant led, outpatient procedure rates are statistically significantly higher in the most deprived quintile for both males and females. • All age elective admission rates in the most deprived quintile are statistically similar to the rates in the least deprived quintile for both males and females in 2023/24.
Elective Recovery	Elective activity vs pre-pandemic levels for under 18s and over 18s	• Elective admission rates for children in the most deprived quintile are statistically similar to the rates in the least deprived quintile for both males and females in 2023/24.
Urgent and emergency care	Emergency admissions for under 18s	• Emergency admission rates for male and female children in the most deprived quintile are statistically significantly higher than in the least deprived quintile in both 2019/20 and 2023/24.
Urgent and emergency care	Age standardised activity rates with 95% confidence intervals for Non-elective admission and A&E Attendances	• A&E attendance rates are statistically significantly higher in the most deprived quintile for both males and females in 2019/20 and 2023/24. • A&E attendance rates for children are statistically significantly higher in the most deprived quintile for both males and females in 2019/20 and 2023/24. • Non-elective admission rates for males and females in the most deprived quintile are statistically significantly higher than in the least deprived quintile in both 2019/20 and 2023/24

Analytical Report Summary Table (slide 2 of 4)

Domain	Indicator	Summary
Cardiovascular disease	Stroke rate of non-elective admissions (per 100,000 age and sex standardised)	• Non elective admission rates for stroke for females were statistically significantly higher in the most deprived quintile in 2019/20 but have fallen in 2023/24 and are statistically similar to the rates in the least deprived quintile. Rates for males remain significantly higher in the most deprived quintile in 2023/24. • Non-elective admission rates for CVD are statistically significantly higher in the most deprived quintile for both males and females in 2019/20 and 2023/24.
Cardiovascular disease	Myocardial infarction – rate of non-elective admissions (per 100,000 age-sex standardised)	• Rates for males were statistically significantly higher in the most deprived quintile in 2019/20 but have fallen slightly in 2023/24 and are now statistically similar to the rates in the least deprived quintile. For females, the rates remain statistically similar in the most and least deprived quintiles. • Emergency admission rates for myocardial infarction are 1.3 times higher in the most deprived quintile for both males and females in 2023/24.
Cardiovascular disease	CVDP007HYP: Per centage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age-appropriate treatment threshold	• Percentage increases with age, no significant difference between Male and Female. Ethnic group 'Black' has the lowest percentage. All ethnic groups are significantly lower than ethnic group 'White'
Cardiovascular disease	CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy	• Persons aged 40-59 are more likely to have no score, women of this age group being the highest and is statistically significant. Percentage with no score increases as deprivation rises, this is statistically significant. By ethnicity, Asian and Black ethic groups show the highest percentage with no score.
Cardiovascular disease	CVDP002AF: % of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more who are currently treated with anticoagulation drug therapy	• There is no statistically significant difference across the deprivation quintiles. Percentage of patients has increased slightly over the last 4 years

Analytical Report Summary Table (slide 3 of 4)

Domain	Indicator	Summary
Diabetes	Variation between % of people with Type 1 and Type 2 diabetes receiving all 8 care processes	• The number of 8 care processes increases with age to a maximum of 70-79 and then tails off – this is similar profile for type 1 and type 2 diabetes: no significant difference between the types.
Diabetes	Variation between % of referrals from the most deprived quintile and % of Type 2 diabetes population from the most deprived quintile	• The proportion of type 2 diabetes registrations from the Asian and Black ethnic groups is higher than the proportion of the census 2021 population from those ethnic groups.
Smoking cessation	Proportion of adult acute inpatient settings offering smoking cessation services	• All Acute inpatient settings offer Smoking cessation services.
Smoking cessation	Proportion of maternity inpatient settings offering smoking cessation services	• All maternity inpatient settings offer Smoking cessation services.
Oral health	3.7 ii Tooth extractions dues to decay for children admitted as inpatients to hospital, aged 10 years and under	• Significant increase in extractions in 2023 and 2024 when compared to 2019. Extraction numbers increased as deprivation increased and is significant. • Tooth extractions in the most deprived quintiles were higher for Asian or Asian British and White ethnicity groups
Learning disability and autistic people	Learning Disability Annual Health Checks	• Health checks increasing through the year
Learning disability and autistic people	Adult mental health inpatient rates for people with a learning disability and autistic people	• Rate per million is falling in Cambridge and Peterborough
Maternity and neonatal	Preterm births under 37 weeks	• The proportion of preterm births in ethnic minority groups is greater than expected, when compared to the census population. • Those living in the three most deprived quintiles have more preterm births as a proportion of the total than expected, when compared to the latest population estimates.

Analytical Report Summary Table (slide 4 of 4)

Domain	Indicator	Summary
Respiratory	Uptake of COVID and flu vaccinations by socio-demographic groups	• COVID and flu vaccination uptake is highest amongst those living in the least deprived quintile and amongst older age groups. • Ethnicity has an impact of relative rates of vaccination with White British having the higher levels of vaccination and mixed, black and unknown ethnicities having lower levels of uptake.
Mental Health	Rates of total Mental Health Act detentions	• Higher rates of detentions for those aged between 18-34 and 35-49. • Higher rates of detentions for Black and Black British and other ethnic groups.
Mental Health	NHS Talking Therapies (formerly IAPT) recovery	• Higher reliable recovery rate for the White ethnic group compared with other ethnic groups. This rate has declined since pre-covid 2018/19.
Cancer	Percentage of cancers diagnosed at stage 1 and 2, case mix adjusted for cancer site, age at diagnosis, sex	• Between 2013 and 2021, the overall percentage of cancers diagnosed at stage 1 and 2 has decreased for Cambridgeshire and Peterborough ICB

In summary

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. NHS Cambridgeshire and Peterborough recognises **significant health inequalities exist** across the Integrated Care System. It remains committed to working with wider partners to help deliver exceptional quality healthcare for all; ensuring **equitable access, excellent experience** and **optimal outcomes**.

The information statement data pack reports the data, where available, in response to NHS England's Statement on Health Inequalities to highlight existing inequalities that exist. The purpose is to ensure NHS bodies and system partners are aware of existing inequalities in commissioned services so action can be taken to address them.

Significant work has gone into pulling this pack together, but we recognise this does not cover the full breadth of work that is taking place to address health and healthcare inequalities, nor does it cover all areas where inequalities in access, experience and access exist. The ICB will continue to develop its health inequalities reporting metrics in line with updated information statements and the evolution of the Cambridgeshire & Peterborough's Outcome Framework.

To tackle inequalities requires strategic collaboration amongst ICS partners to ensure alignment of efforts across healthcare, local authorities and community organisations. By sharing data, resources and expertise, the Cambridgeshire and Peterborough ICB and NHS bodies can target interventions that tackle health inequalities effectively, contribute to addressing social determinants of health, and ensure equitable access to care.

Contact & Further Information

Please note the information contained within this Health Inequalities Information Statement Data Pack should be read in conjunction with NHS Cambridgeshire and Peterborough ICB's 2025/26 annual report.

If there are any questions about the report or you would like to provide any feedback, please feel free to contact us at the following email address:

cpicb.inequalities@nhs.net

Thank you for taking the time to read this report