Healthy Futures

A Regional Health Strategy for the East of England 2005-2010

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A Regional Health Strategy for the East of England 2005-2010

December 2005

east
of england
Regional Assembly
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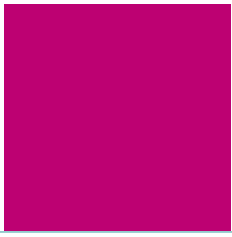# Contents

Preface

I am delighted to introduce **Healthy Futures** – the first Regional Health Strategy for the East of England. **Healthy Futures** has been developed over the past twelve months by the East of England Public Health Group (EEPHG) on behalf of the East of England Regional Assembly (EERA) and its partners, all of whom are committed to reducing health inequalities and improving the health of the Region's population.

Currently, our Region is not as healthy as it should be – and comparisons with other regions indicates considerable room for improvement. Even within the East of England the extent of health inequalities is large and growing. Evidence shows that people on lower incomes tend to have poorer health throughout their lives and die younger than their more affluent neighbours, and there is also substantial evidence that these inequalities are transmitted from one generation to the next.

Healthy Futures is not about health service delivery. Its analysis and proposed actions are based on the recognition that through their policies and actions, a great many agencies and organisations can individually and collectively have a major impact on people's health. It is by ensuring that these impacts have a positive rather than a detrimental effect that **Healthy Futures** will succeed.

The main priorities of the Strategy will provide a clear Vision to deliver improvements to health by raising awareness of health inequalities amongst key partners. The Strategy will be a vital tool in influencing regional policy making, demonstrating that the responsibility for the health of people in the East of England is, genuinely, a shared one. Having set out this Vision, we now look forward to our partners helping us to deliver real measurable improvements.

Alongside **Healthy Futures**, the Eastern Region Public Health Observatory and the Public Health Group have developed a Technical Supplement. The Technical Supplement provides background data and analysis to support the Strategy. It will also be a valuable resource in evaluating and reporting our progress.

I would like to take this opportunity to thank those who have participated in developing **Healthy Futures**. In particular I would like to extend my thanks to Dr Gina Radford, Regional Director of Public Health (Public Health Advisor to the Assembly), for leading on this Strategy on behalf of the Assembly.

Ermal Kirby

Ermal Kirby

Executive summary

Introduction and context

1 **Healthy Futures** is the East of England's first Regional Health Strategy. It is intended to improve the overall health of people in the East of England, and to reduce inequalities in health within the Region. Its focus is strongly on the underlying issues which determine people's health. Hence this Strategy is not concerned directly with the National Health Service (NHS), with health service delivery, or with the health and social care sector; these important issues need to be addressed within the Region but through other strategic processes.

2 Against this backdrop, **Healthy Futures** itself has three main purposes:

- To raise awareness of the issues surrounding the health of people in the East of England, and the extent of health inequalities

- To demonstrate that responsibility for the health of people in the East of England is, genuinely, a shared one

- To provide a basis for a meaningful dialogue – in both directions – between health care policy makers and professionals, and other public agencies and organisations operating in the East of England, in order to improve health within the East of England and to reduce health inequalities.

3 The policy context for **Healthy Futures** is defined along two principal dimensions. **Choosing Health** – the White Paper published by the Government in November 2004 – provides the national policy backdrop; this emphasises the need to make it easier for individuals to make healthier choices. A second key dimension is concerned with the regional context and, specifically, the priorities and aspirations set out in key regional strategies. During 2004/05, these were distilled into **Sustainable Futures**, the East of England's first Integrated Regional Strategy. This included a Vision of a better quality of life for everyone who lives or works in the East of England, and to this end it identified high level outcomes and a set of priorities for the Region. **Healthy Futures** has been developed in this context.

The health of people in the East of England

4 On most measures, people in the East of England are somewhat healthier than the national average: overall life expectancy is higher and the incidence of both cancer and Coronary Heart Disease (CHD) is lower. But within the Region, health inequalities are large and growing. The health of people in the East of England is also less good than in other European regions.

5 There is substantial evidence to suggest a strong – although complicated – relationship between people's health and levels of deprivation. For example, in 2002-03, 7% of people in social class I in the East of England were smokers compared to 33% in social class V, and cigarette smoking has been identified as one important reason for the observed gap in life expectancy between rich and poor. Within the East of England, these differences have a clear geography: areas such as Great Yarmouth, Luton, Tendring and Peterborough are characterised by a high incidence of deprivation, poor self-reported health and relatively low levels of life expectancy. However – as the Regional Social Strategy makes clear – there are people living in poverty throughout the Region: groups which are especially vulnerable include black and minority ethnic groups, disabled people, lone parents, older people, carers, asylum seekers, refugees and ex-offenders.

6   What actually determines the health of the population is a complicated question. Within the East of England, key factors include:

- Access to services, particularly for vulnerable groups within the population, recognising that this can be especially difficult in some rural areas

- Weak social and community networks, particularly among vulnerable groups and in those parts of the Region which are changing quickly

- Physical inactivity and increasing obesity

- Lifestyle factors such as smoking, drug abuse, alcohol consumption and sexual health

- Housing pressures (linked both to affordability and to the condition of housing) and wider issues around 'liveability'

- Relatively low levels of educational attainment, particularly in terms of progression to further and higher education, and continuing learning in adulthood

- A high incidence of employment in low paid jobs in sectors such as health and social care, tourism, and agriculture and food processing

- Stress at work, particularly amongst those aged 50 or more (which is a growing proportion of the workforce)

- A relatively large number of people of working age who are economically inactive: a proportion are long-term sick and deteriorating mental health can often be the issue.

Healthy Futures: a Regional Health Strategy for the East of England

7   The core of **Healthy Futures** is defined by a Vision that may be simply stated: **to improve the health of the population and to reduce health inequalities within the East of England.** In order to achieve this Vision, three broad Themes are identified, each of which embraces a number of distinct Strategic Priorities. There are important links across the nine Strategic Priorities.

Theme A: Health in Sustainable Communities

8   There are particular challenges in striving towards healthy sustainable communities across the East of England. In part, these simply reflect the pace of growth across much of the Region: the population of the East of England has grown more quickly than in any other region in the UK over the last two decades and further population growth is anticipated. In part, these reflect the challenges linked to resources; there are, for example, particular issues linked to water supply and issues relating to waste management. In part, they reflect an accumulated shortfall in investment in the surrounding infrastructures – both hard and soft. Within this context, three Strategic Priorities are identified:

- **Strategic Priority 1:** To ensure that the social, economic and environmental foundations of healthy lifestyles are designed creatively into new and existing communities in the East of England, recognising the range of factors that contribute to health outcomes

- **Strategic Priority 2:** To provide infrastructure and sustained support to build social capital, particularly among those communities (geographical communities, communities of interest and potentially vulnerable groups) which are experiencing poor health outcomes, recognising the key role of family and community relationships and the need to support them

- **Strategic Priority 3:** To make it possible for communities to 'choose health' positively and more easily, recognising the general importance of access, appropriate information and health literacy, but also harnessing the particular opportunities linked to the 2012 Olympics/Paralympics in encouraging healthy lifestyles.

Theme B: Health at Key Life Stages

9   People of different ages within the East of England are facing quite different issues with regard to their health and well-being. These need to be understood and addressed if the health of the population is to be improved and the extent of health inequalities reduced. Given the changing demography of the Region, three life stages are critical. Each of these provides the focus for a Strategic Priority within **Healthy Futures:**

- **Strategic Priority 4:** To ensure that children and young people in the East of England can get off to a healthy start in life, linking in with the National Service Framework for children, young people and maternity services, and recognising the five key outcomes set out in Every Child Matters (ECM)

- **Strategic Priority 5:** To encourage better health for people in the East of England throughout their working lives, recognising the links between people's health and the range of experiences relating to work and workplaces, and worklessness

- **Strategic Priority 6:** To support people in the East of England in 'active ageing' and adding life to years, linking in with the National Service Framework for older people, highlighting the needs and opportunities linked to an ageing population, and recognising and supporting the contribution made by older people to all aspects of life in the East of England.

Theme C: Health in a Connected Region

10   The third major Theme that defines **Healthy Futures** is concerned with the position of the East of England globally. The East of England is intrinsically – and increasingly – inter-connected. In this context, three major issues – all of which were identified in the Integrated Regional Strategy – are likely to have a significant bearing on the future health of the population and on health inequalities. These have been identified as three Strategic Priorities in moving forward:

- **Strategic Priority 7:** To recognise and respond to the practical implications of international gateways for health and health inequalities within the East of England, acknowledging the needs and opportunities linked to increasing international mobility

- **Strategic Priority 8:** To harness the East of England's international position to encourage learning, knowledge development and research and development (R&D) for health, recognising the opportunities to learn from elsewhere

- **Strategic Priority 9:** To understand and plan for the impacts of climate change and the more sustainable use of resources within the Region, in terms of health and health inequalities issues, embracing the imperative to formulate a clear regional response in terms of adaptation and mitigation, and linking, particularly, to Strategic Priority 1.

Delivering Healthy Futures

11   Given the focus on broad determinants of population health as they relate to the East of England, three groups of delivery processes should contribute substantively to advancing **Healthy Futures**. These relate to:

- Regional priorities set out in the Integrated Regional Strategy and in other 'premier league' regional strategies

- National priorities for population health set out in **Choosing Health**

- Local and sub-regional priorities, particularly those defined by Local Strategic Partnerships (LSPs) and being advanced – across much of the Region – through Local Area Agreements, and those services being influenced through Investing in Communities (IiC) partnership programmes.

12   In order to facilitate and inform these processes, a number of Actions have been defined in response to each Strategic Priority; these Actions – which will be subject to on-going development and review – are set out in Chapters 6-8.

13   For the most part, the Actions are modest in scale and scope: in keeping with the purposes of **Healthy Futures**, they are intended to support and influence other delivery processes, not replicate or replace them. Hence the Actions include, for example, the preparation of guidance and training materials, and the gathering and dissemination of data and intelligence. On their own, these will not deliver the Vision set out in **Healthy Futures**. But by influencing and supporting the three groups of processes set out above, significant progress ought to be possible.

14   Progress on delivering these Actions – and on achieving the overall Vision – will be reviewed regularly by EERA's Health and Social Inclusion Panel.

Figure 1: Healthy Futures – The Regional Health Strategy for the East of England

Vision: To improve the health of the population and reduce health inequalities in the East of England

Theme A: Health in Sustainable Communities

SP1: To ensure that the social, economic and environmental foundations of healthy lifestyles are deigned creatively into new and existing communities within the East of England

SP2: To provide infrastructure and sustainable support to build social capital, particularly among those communities (geographical communities, communities of interest and potentially vulnerable groups) which are experiencing poor health outcomes

SP3: To make it possible for communities to 'choose health' positively and more easily

Theme B: Health at Key Life Stages

SP4: To ensure that children and young people in the East of England can get off to a healthy start in life

SP5: To encourage better health for people in the East of England throughout their working lives

SP6: To support people in the East of England in 'active ageing' and adding life to years

Theme C: Health in a Connected Region

SP7: To recognise and respond to the practical implications of international gateways for health and health inequalities within the East of England

SP8: To harness the East of England's international position to encourage learning, knowledge development and R&D for health

SP9: To understand and plan for the impacts of climate change and the more sustainable use of resources within the Region in terms of health and health inequalities issues

National Priorities set out in the Choosing Health White Paper

Evidence and Analysis relating to the nature and extent of health and health inequalities issues

Priorities from Regional Strategies in the East of England

01 Introduction

Chapter summary

Healthy Futures is the East of England's first Regional Health Strategy. It is intended to improve the overall health of people in the East of England, and to reduce inequalities in health within the Region. Its focus is strongly on the underlying issues which determine people's health. Hence this Strategy is not concerned directly with the NHS, with health service delivery, or with the health and social care sector; these important issues need to be addressed within the Region but through other strategic processes.

Healthy Futures has three main purposes:

- To raise awareness of the issues surrounding the health of people in the East of England, and the extent of health inequalities

- To demonstrate that responsibility for the health of people in the East of England is, genuinely, a shared one

- To provide a basis for a meaningful dialogue – in both directions – between health care policy makers and professionals, and other public agencies and organisations operating in the East of England.

The World Health Organisation defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. It continues, 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.[1]

1.1   As the Region's Integrated Regional Strategy makes clear, on most key indicators, the health of people in the East of England is marginally better than the national average: for example, 21% of the Region's population report limiting long-standing illness compared to 23% across the UK, and the infant mortality rate is 4.4 deaths per 1,000 live births compared to a national average of 5.5.[2] Death rates from heart disease and cancer are slightly below the national average and life expectancy is slightly greater.

1.2   However, there is no room for complacency:

- Within the East of England, there is substantial intra-regional variation: most starkly, boys born today in Great Yarmouth can expect to live for over four years less than boys born in South Cambridgeshire

- Whilst the health of people in the East of England has improved over recent years, the extent of intra-regional health inequalities has increased

- On key indicators, the health of people in the East of England is less good than in comparable European regions.

1.3   Health inequalities and poor health outcomes matter for a number of reasons. Premature death and poor health are obviously tragic for the people concerned and for their immediate families; as one politician put it, 'What greater inequity can there be than to die younger and to suffer more illness throughout your life as a result of where you live, what job you do and how much your parents earned?'[3]

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1   Constitution of the World Health Organisation, available at http://policy.who.int
2   Region in Figures: East of England 8 (Summer 2004), National Statistics – data from Tables 7.14 and 7.15. Note that here – and throughout this document – Crown copyright material is reproduced with the permission of the Controller of HMSO and the Queen's Printer for Scotland.
3   Yvette Cooper – then Parliamentary Undersecretary of State for Public Health.

1.4 These same issues also have a substantial impact on the economy of the East of England. People in the East of England are, for example, less physically active than the national average. The National Audit Office (NAO) has estimated that the total cost of physical inactivity is £8.2bn per year (including 72,000 lost working days and 86,000 premature deaths)[4]. This excludes the contribution of inactivity to obesity which costs the wider economy (due largely to days of sickness relating to obesity) a further £3.5bn per annum.[5] It is estimated that alcohol misuse costs around £20bn a year in England, including alcohol-related health disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace, and problems for those who misuse alcohol and their families, including domestic violence.[6] The economic significance of people being unable to work due to mental illness is even greater; across England, output to the value of £23.1bn is lost as a result.[7]

The purposes of **Healthy Futures:** the Regional Health Strategy for the East of England

1.5 This document sets out a strategy to improve the overall health of people in the East of England, and to reduce inequalities in health outcomes within the Region. Within this overall context, **Healthy Futures** – the Regional Health Strategy for the East of England – has a number of purposes.

1.6 Raising awareness of the health of people in the East of England – and inequalities in their health – is a first key purpose. To fulfil this purpose, a comparative baseline providing key data and statistics is presented in Chapter 3, both to inform and underpin the Strategy, and to provide a benchmark against which progress might be monitored subsequently.[8]

1.7 From this foundation, the Strategy seeks to examine – and then to respond to – the factors which together determine the health of people in the East of England. These determinants are broad in character. They include the houses in which people live, the jobs in which they work, the leisure activities in which they engage, and the social and familial networks in which their everyday lives are structured. In the main, these 'determinants' exist outside the policy/organisational domain that is conventionally labelled 'health' or 'health care'. Policy decisions and prioritisation processes – led by organisations as diverse as Local Authorities, LSPs, Learning and Skills Councils, Jobcentre Plus, East of England Development Agency (EEDA), Government Office for the East of England (GO-East) and EERA – all combine together to impact on health outcomes. Hence a second purpose of the Strategy is to demonstrate that responsibility for the health of people in the East of England is – genuinely – a shared one; health is everyone's business.

1.8 A third key purpose is closely related to the second. It concerns the need for a fruitful and meaningful dialogue – in both directions – between health care policy makers and professionals, and other public agencies and organisations operating in the East of England. The intention is that this Strategy should be as relevant to economic development agencies and partnerships, LSPs and Local Authorities as it is to Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and the Department of Health (DH). If it is to succeed in effecting improvements in the health of people in the Region and reducing health inequalities, it needs to be genuinely cross-disciplinary, galvanising a range of perspectives, resources and decision-making powers behind a shared agenda for the Region. Facilitating such a dialogue as the basis for a joint endeavour is then a third key purpose for the Strategy as a whole.

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4   Physical Activity in the East of England Eastern Region Public Health Observatory (ERPHO) 2005.
5   Obesity in the East of England ERPHO 2004.
6   Alcohol Misuse Intervention: Guidance on Developing a Local Programme of Improvement, DH, 2005 (Crown copyright).
7   Economic and Social Costs of Mental Illness in England Sainsbury Centre for Mental Health, 2003.
8   A Technical Health Supplement for the East of England has been published alongside this strategy document. This presents a more comprehensive range of data of relevance to **Healthy Futures.**

What the Strategy does not address…

1.9   The focus of this Strategy is health and health inequalities within the East of England, not the NHS or health service delivery. From the outset it is important to be clear that the Strategy does not therefore focus on:

- Issues relating to employment, labour supply or working conditions in the health and social care sector specifically – whether that is part of the NHS, the private sector or the community/ voluntary sector [9]

- The performance, in economic terms, of the health and social care sector, or the scope for improving that performance [10]

- The actual or potential impacts of the NHS on the regional economy through, for example, procurement practices

- The nature or implications of changing arrangements with regard to the delivery of NHS services in the East of England.

1.10   All four of the issues raised above are important, and all four merit strategic consideration at a regional scale. However from the outset, the intention has been that **Healthy Futures** should focus solely on the health of people and inequalities in health within the East of England. Hence these allied issues are not addressed here although their significance is noted.

Structure of this document

1.11   In Chapter 2, we provide a summary statement of the policy context for **Healthy Futures**, drawing both on the range of strategies for the East of England and the national policy context. Key to this is the White Paper, **Choosing Health**, which was published by the DH in 2004.

1.12   Thereafter, the document is divided into three main sections, each of which is sub-divided into a number of chapters.

- **Section A** provides the backdrop to the Strategy by summarising the evidence base. It describes the health of people in the East of England (Chapter 3) and provides an analysis of the factors which are determining the health of people in the Region (Chapter 4)

- **Section B** sets out the Regional Health Strategy for the East of England. In Chapter 5, a Vision for the health of people in the East of England is presented and three high level Themes are introduced. These are examined in more detail in subsequent chapters, each of which outlines three Strategic Priorities and a number of accompanying Actions

- **Section C** explains the processes through which **Healthy Futures** will be delivered, linking with Local Area Agreements at a local level, through to the delivery structures for **Choosing Health** and for the priorities set out in the Integrated Regional Strategy at a regional scale. It also explains how the progress of the Strategy will be monitored over the years ahead.

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9   These issues are a concern: health and social care is a low paying sector and low pay is correlated with poor health. But low pay in the health and social care sector is no more of a focus for this Strategy than, for example, low pay and poor working conditions in the agricultural and tourism industries.

10   Health and social care is one of the largest sectors of the economy and it is growing quickly; it has been identified as a key sector in the Regional Economic Strategy.
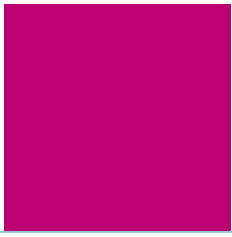
02 Policy context for Healthy Futures

Chapter summary

The policy context for **Healthy Futures** is defined along two distinctive dimensions. **Choosing Health** – the White Paper published by the Government in November 2004 – provides the national policy backdrop; this emphasises the need to make it easier for individuals to make healthier choices. A second key dimension is concerned with the regional context and, specifically, the priorities and aspirations set out in key regional strategies. During 2004/05, these were distilled into **Sustainable Futures**, the East of England's first Integrated Regional Strategy. This included a Vision of a better quality of life for everyone who lives or works in the East of England, and to this end it identified high level outcomes and a set of priorities for the Region.

2.1   The policy context for **Healthy Futures** is defined along two distinctive dimensions. The national policy context must be understood in terms of the Government's priorities for people's health nation-wide. But 'health' does not exist outside the environment in which people live and work. Hence as the foundation for a forward-looking Regional Health Strategy, Government's ambitions need to be interpreted through the prism of regional priorities for the East of England. In the paragraphs below we summarise both policy contexts.

National policy context

National policy for public health: **Choosing Health** and **Delivering Choosing Health**

2.2   **Choosing Health,** the Government's White Paper on public health, was published in November 2004 with a focus on health promotion and the reduction of health inequalities. The White Paper was followed in March 2005 by **Delivering Choosing Health,** which provided a cross-government programme for implementation.

2.3   The policies contained in **Choosing Health** were presented as radical and as representing the beginning of a new direction in public policy. In fact, there was a great deal of continuity with earlier public health policies: **Health of the Nation (1992)** and **Saving Lives: Our Healthier Nation (1999)**. This continuity lay in the definition of priority areas; the targets adopted; and the underlying view of the role of the state in promoting population health. In **Choosing Health**, the latter was defined in terms of making it easier for individuals to make healthier choices and this became the fundamental theme of the White Paper. There were, however, two important exceptions to this position. One concerned children and young people (where it was acknowledged that a more paternalistic approach was needed). The other was the protection of people's health from the adverse consequences of others' actions.

2.4   The White Paper stressed the economic arguments for improving population health. This followed the final Wanless Report in 2004.[11] Wanless modelled the national costs of health care going forwards to 2022/23 using three scenarios. The difference in future cost between the baseline scenario, which assumes no change in current trends, and the 'fully engaged scenario' is modelled at £30bn pa (2002/3 prices) or 1.9% of Gross Domestic Product (GDP). In the latter scenario the population is assumed to take more responsibility for the maintenance of its own health by adopting healthier lifestyles. The economic motivation to improve population health was explicitly acknowledged in the White Paper.

11   Securing Good Health for the Whole Population Final Report, Derek Wanless, HM Treasury/DH (Crown copyright), February 2004.

2.5   Against this backdrop, the White Paper sought to 'make it easier for individuals to make healthy choices'. In addressing health inequalities, the solution was to make it easier for individuals from disadvantaged groups to exercise healthier choices. From this position, three key principles were developed: **informed choice** (people want to make their own decisions about choices that will affect their health); **personalisation** (the support provided by government needs to recognise the different circumstances of particular groups, and specifically, the difficulties faced by disadvantaged groups); and **working together** (delivering the strategy will require effective partnerships across communities, involving local government, the NHS, advertisers, business, retailers, the voluntary sector, media, and faith groups). Six priorities were then identified as over-arching:

- Reducing the numbers of people who smoke

- Reducing obesity and improving diet and nutrition

- Increasing exercise

- Encouraging and supporting sensible drinking

- Improving sexual health

- Improving mental health.

2.6   In terms of implementation, key roles were identified at national, regional and local levels. In the context of a Regional Health Strategy, it is worth dwelling on the latter two:

- At a regional scale, Regional Public Health Groups were identified as having a key role in integrating and co-ordinating activities at the regional level, identifying regional issues and priorities for health and presenting information on health at the regional level. But alongside these, Government Offices for the Regions, Regional Assemblies and Regional Development Agencies were also recognised as playing an important part in shaping the social determinants of health through their influence over strategy on transport, employment, the environment and regeneration. At a regional scale, **Choosing Health** was therefore seen as a multi-disciplinary endeavour

- Similar arguments were made at a local level. **Choosing Health** identified that local authorities and PCTs share a responsibility to improve health and well-being by leading community partnerships; delivering on national targets; identifying local needs; and commissioning and delivering services. There are various structures for partnership working, including LSPs, Children's Trusts and Crime and Disorder Reduction Partnerships. Increasingly, Local Area Agreements will provide a key vehicle for delivery planning. These are structured around four functional blocks: children and young people; safer and stronger communities; healthier communities and older people; and economic development and enterprise. The read-across to **Healthy Futures** is considerable. Hence through Local Area Agreements, LSPs will have a key role in delivering this Strategy (see Chapter 9).

Frameworks/plans for public health in the East of England

2.7   In parallel with the emergence of **Choosing Health**, work has been underway on the production of various regional plans concerned with different priorities identified in the White Paper (although work on some of these regional documents preceded the White Paper's publication). With a focus on the broader determinants, **Healthy Futures** will complement and support their delivery. Three key documents are:

- **Smoke Free East:** A Tobacco Control Framework for the East of England 2005-2010, which has recently been completed[12]

- **Physical Activity Action Plan:** this has been developed by the Regional Physical Activity Forum

12   Available at www.go-east.gov.uk/goeast/public_health

- **Food and Health Action Plan:** the development of this Plan will be led by the East of England Public Health Group during 2006. It will link to the Obesity Framework which has recently been completed to support NHS delivery.

Other national strategies and policies

2.8 Alongside **Choosing Health** and its allied documents, **Healthy Futures** has been influenced and informed by various other national strategies that are concerned with health and well-being more generally. These include the National Strategy for Sustainable Development (published in 2005); the National Service Frameworks for Children, Young People and Maternity Services, and for Older People; the National Strategy for Neighbourhood Renewal (2001); and the Sustainable Communities Plan (2003). Reference to these and other national strategies and policies is made throughout this document.

Broader regional policy context

2.9 Within the East of England, the strategic context for **Healthy Futures** is set out in a suite of regional strategies. The most important – given the argument in Section A (which follows) – are the draft Regional Spatial Strategy **(East of England Plan)** which sets out priorities for spatial development Region-wide (including transport and housing provision) over the period to 2021; the Regional Economic Strategy which sets out the Region's ambitions for the future of its economy; and the Regional Social Strategy, which is concerned with addressing social exclusion in the East of England.[13]

2.10 During 2004/05, the East of England Regional Assembly (EERA) led an exercise to review these – and other – regional strategies, to draw out common themes (and identify potential tensions) and hence to present a single Vision, a set of high level outcomes, and a composite set of priorities for the East of England as it looks to the future. This process resulted in the production of **Sustainable Futures:** the Integrated Regional Strategy for the East of England. This provides the main regional policy context for **Healthy Futures** (see Figure 2.1, overleaf).

2.11 In preparing the Integrated Regional Strategy, the intention was that future regional strategies – such as **Healthy Futures** – should be developed in the context provided by the Integrated Regional Strategy, contributing to its overall Vision of a better quality of life for all who live or work in the Region. Beyond this, **Healthy Futures** will need to reflect and respond to the changing realities of the East of England as set out in the Integrated Regional Strategy. This identified **eight Crucial Regional Issues** for the East of England and – in developing the Regional Health Strategy – proper account needs to be taken of these. Hence there is a need to recognise fully the significance of the growth agenda, the tensions in terms of travel and transport, the dilemmas relating to the growth of the knowledge economy, the issues relating to the increasingly polarised labour market, continuing concerns around deprivation and social exclusion, rural issues and pressures on resource use, as well as what the Integrated Regional Strategy identified as **Crucial Regional Issue 6** – health and well-being.
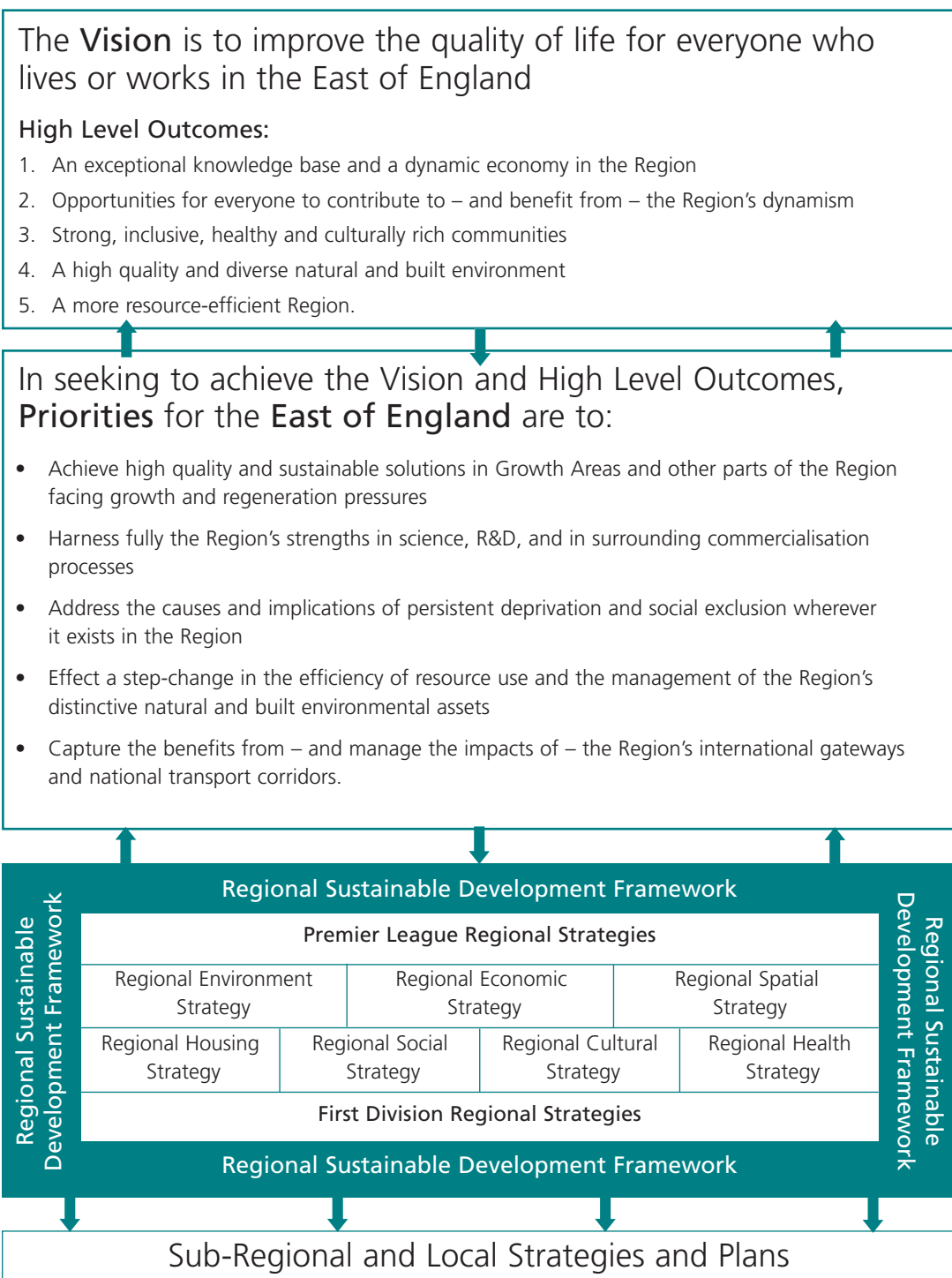
Conclusion

2.12 Drawing together the main themes set out in **Choosing Health** and the priorities identified through strategic processes in the East of England, it is clear that **Healthy Futures** needs to embrace the philosophy of **Choosing Health** – and equipping all people to do so effectively – but within the fast-changing and complex context that is the East of England. As the backdrop to the Strategy, these issues are examined in Section A.

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13   Note that the Regional Social Strategy includes within it a specific commitment to develop a regional strategy to address issues relating to public health.

Figure 2.1: Sustainable Futures: the Integrated Regional Strategy for the East of England

(including the high level objectives set out in the Regional Sustainable Development Framework)

The **Vision** is to improve the quality of life for everyone who lives or works in the East of England

High Level Outcomes:

1. An exceptional knowledge base and a dynamic economy in the Region
2. Opportunities for everyone to contribute to – and benefit from – the Region's dynamism
3. Strong, inclusive, healthy and culturally rich communities
4. A high quality and diverse natural and built environment
5. A more resource-efficient Region.

In seeking to achieve the Vision and High Level Outcomes, **Priorities** for the **East of England** are to:

- Achieve high quality and sustainable solutions in Growth Areas and other parts of the Region facing growth and regeneration pressures

- Harness fully the Region's strengths in science, R&D, and in surrounding commercialisation processes

- Address the causes and implications of persistent deprivation and social exclusion wherever it exists in the Region

- Effect a step-change in the efficiency of resource use and the management of the Region's distinctive natural and built environmental assets

- Capture the benefits from – and manage the impacts of – the Region's international gateways and national transport corridors.

Regional Sustainable Development Framework

Regional Sustainable Development Framework

Premier League Regional Strategies		
Regional Environment Strategy	Regional Economic Strategy	Regional Spatial Strategy

Regional Housing Strategy	Regional Social Strategy	Regional Cultural Strategy	Regional Health Strategy

First Division Regional Strategies

Regional Sustainable Development Framework

Sub-Regional and Local Strategies and Plans

Section A:
The health of people
in the East of England
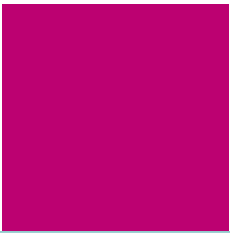
03 Describing the health of people in the East of England

Chapter summary

On most measures, people in the East of England are somewhat healthier than the national average: overall life expectancy is higher and the incidence of both cancer and CHD is lower. But within the Region, health inequalities are large and growing. The health of people in the East of England is also less good than in some European regions.

There is a strong – although complicated – relationship between people's health and levels of deprivation. For example, in 2002-03, 7% of people in social class I in the East of England were smokers compared to 33% in social class V, and cigarette smoking has been identified as one important reason for the observed gap in life expectancy between rich and poor.

Within the East of England, these differences have a clear geography: areas such as Great Yarmouth, Luton, Tendring and Peterborough are characterised by a high incidence of deprivation, poor self-reported health and relatively low levels of life expectancy. However there are people living in poverty throughout the Region. There is a need also to recognise the particular health issues facing key groups within the population. These include older people (who may be isolated and find access to services difficult), black and minority ethnic communities, people with disabilities, lone parents, carers, gypsies and travellers, refugees and asylum seekers, prisoners and ex-offenders, and some migrant workers.

3.1   On most measures, people in the East of England are somewhat healthier than the national average. But whilst the overall assessment is fairly positive, health inequalities within the Region are large and growing, and – on many measures – the health of people in this Region is less good than in comparable European Regions. In this chapter, we set out some of the key dimensions of health and health inequalities within the East of England.

Demography

3.2   The population of the East of England is currently about 5.4 million people. Over the last twenty years the Region's population has grown at a rate that is close to double the average for England as a whole and – as Figure 3.1 demonstrates – this trend is set to continue. It is explained partly by net in-migration and partly by population ageing.

Figure 3.1: Comparative projected population growth, 2003-2028 (2003 = 100)
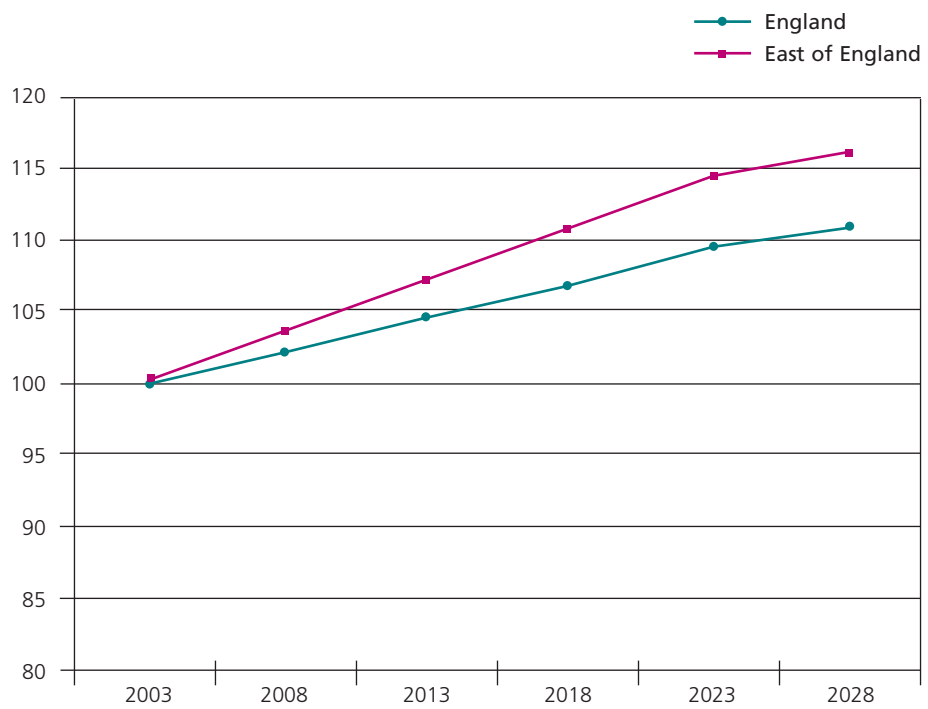

(Source: Office of National Statistics (ONS) 2003 sub-national population projections)

3.3   Over this period, there has been a marked change in the age structure of the Region's population and again, recent trends are set to continue. Projections suggest, for example, that between 2008 and 2013, the number of people aged 65 or more will overtake the number aged 16 or less. In addition, the number of 'very old' people (aged 85+) in the Region is growing rapidly; an increase of 24% was projected between 1998 and 2008.[14] As the backdrop to **Healthy Futures**, these demographic changes are extremely important.
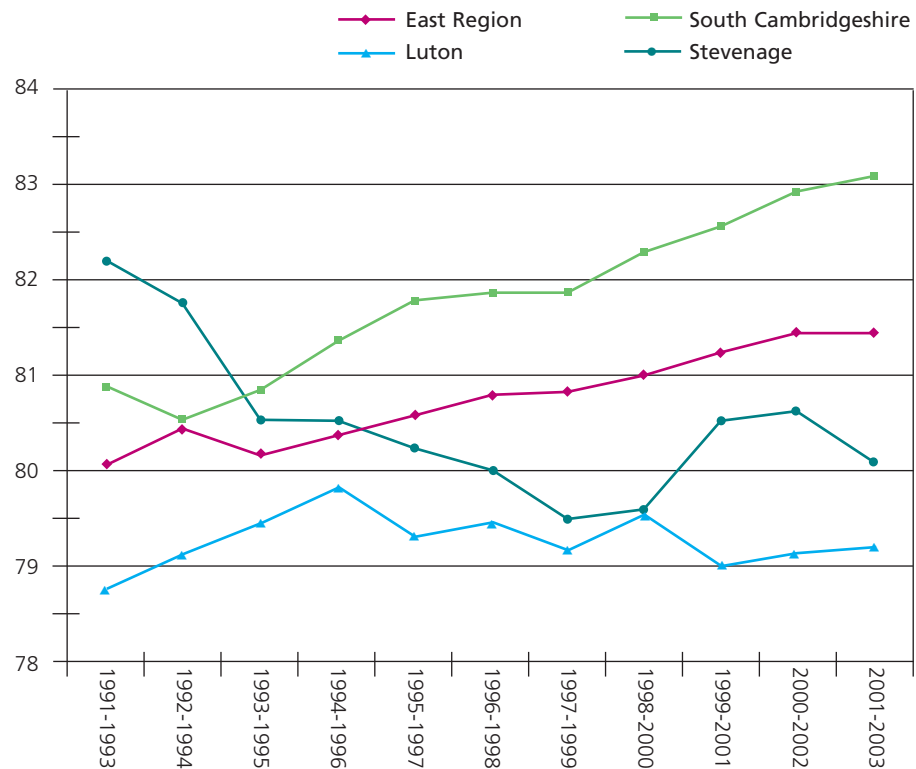
14   East in Focus: the East of England Health Profile, 2001 ERPHO.

Figure 3.2: Projected trends in older people and children, 2003-2028
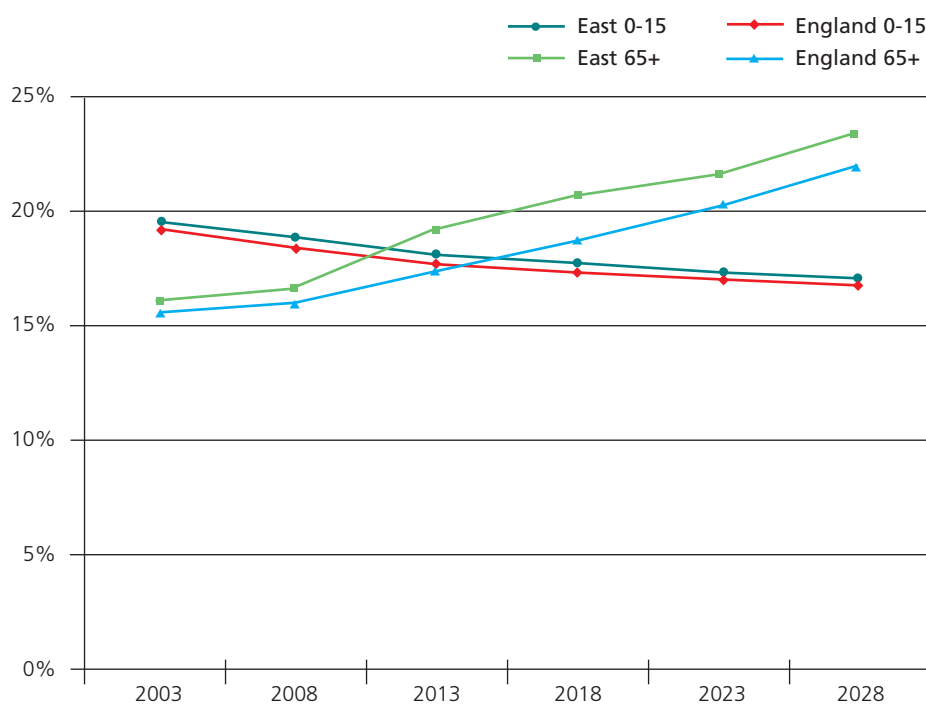
(Source: ONS 2003 sub-national population projections)

Figure 3.3: Trend in female life expectancy showing highest and lowest compared to regional average[15]

Source: Graph prepared by Eastern Region Public Health Observatory (ERPHO) based on data from ONS (Life expectancy at birth in the East of England, 1991-93 to 2001-03, National Statistics)
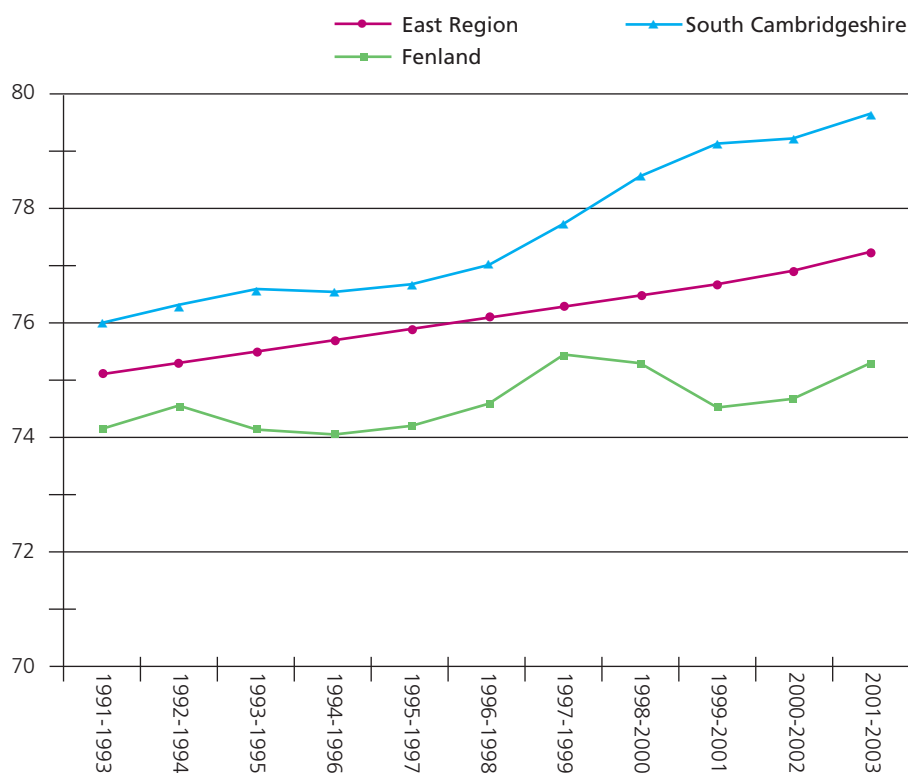
Life expectancy

3.4   Across the East of England, average life expectancy is about two years better than the national average. However as Figures 3.3 and 3.4 demonstrate, the gaps in life expectancy between the Local Authority Districts with the best and worst outcomes (Luton and South Cambridgeshire for females, and Fenland and South Cambridgeshire for males) are substantial and they have also increased over the last decade. Stevenage is one of the few Local Authority Districts in the country in which life expectancy (for females) actually declined throughout the 1990s.

15   Stevenage is shown to illustrate decline over the last decade.

Figure 3.4: Trend in male life expectancy showing highest and lowest compared to regional average

Legend: ●—● East Region ▲—▲ South Cambridgeshire ■—■ Fenland

Source: Graph prepared by ERPHO based on data from ONS (Life expectancy at birth in the East of England, 1991-93 to 2001-03, National Statistics)

Figure 3.5: Proportion of wards in each Local Authority District whose rate of poor health is significantly higher than the regional average (based on 2001 Census)

0% of wards	1-10% of wards	11-30% of wards	>31% of wards
South Cambridgeshire	Epping Forest	Mid-Bedfordshire	Great Yarmouth
Brentwood	Uttlesford	Maldon	Norwich
Chelmsford	East Cambridgeshire	Castle Point	Thurrock
Rochford	Three Rivers	Fenland	Peterborough
Broxbourne	Welwyn Hatfield	South Bedfordshire	Ipswich
East Hertfordshire	Breckland	Waveney	Southend-on-Sea
North Hertfordshire	Cambridge	Basildon	Luton
St. Albans	Colchester	Braintree	
Broadland	Dacorum	Harlow	
North Norfolk	Hertsmere	Tendring	
Babergh	Bedford	King's Lynn & W Norfolk	
Forest Heath	Stevenage		
Mid Suffolk	Watford		
St.Edmundsbury	South Norfolk		
Suffolk Coastal	Huntingdonshire		

(Source: Data prepared by ERPHO)

Poor health

3.5   The 2001 Census gathered information on self-reported health. Allowing for differences in the age structure, Figure 3.5 shows the proportion of wards in each Local Authority District in the East of England in which the age-adjusted rate of poor health is significantly higher than the regional average. These data suggest that the incidence of poor health is highest in the larger urban areas (Luton, Southend-on-Sea, Thurrock, Norwich, Ipswich, Peterborough and Great Yarmouth), some of the more remote rural areas (e.g. Fenland and Maldon), and some of the Districts dominated by new towns/ post-war settlements (e.g. Harlow, Basildon).

'Big killers'

3.6   In the East of England – as elsewhere – CHD and cancer are the 'big killers'. Key risk factors include smoking, obesity, physically inactive lifestyles, poor diet, excess salt, alcohol, diabetes and raised blood pressure.[16]

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16   The CHD National Service Framework: Leading the Way Progress Report 2005, DH (Crown copyright).

3.7 In 2001, the incidence of all cancers in the East of England (excluding non-melanoma skin cancer) was about 360 per 100,000 population for males and 320 per 100,000 population for females; this rate increased marginally during the 1990s although there is a suggestion of a slight decline more recently. Compared to the UK as a whole, the East of England has fewer cancers strongly associated with smoking and deprivation (e.g. lung, pancreas).[17]

3.8 The prevalence of CHD (CHD) is more difficult to estimate. In 2003, age-standardised mortality rates for circulatory diseases in the East of England were 288 per 100,000 population for males (compared to 322 in England and Wales) and 344 per 100,000 population for females (compared to 371 in England and Wales); all of these figures had improved during the preceding decade.[18]

3.9 With regard to the incidence of both cancer and CHD, there is evidence of substantial inequality due to deprivation.[19] This can be observed between wards within Local Authority Districts in the East of England. Overall, there are more Local Authority Districts with inequality in CHD than cancer, and the degree of inequality also tends to be greater for CHD.

Health and deprivation

3.10 At a District level, Figure 3.6 summarises the relationships between life expectancy, changes in life expectancy, poor health and socio-economic inequalities in CHD and cancer. This is accompanied by a series of maps (see pp 34 -37) which illustrate spatial patterns of deprivation, poor health and life expectancy across PCT areas within the East of England.

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17   Cancer Incidence in the East INpho Briefing papers on topical public health issues, published by ERPHO May 2004 Issue 10.
18   Region in Figures: East of England, National Statistics (Crown copyright) – Winter 2004/05 (No 9) Data from Table 7.14.
19   Based on a measure known as the Slope Index of Inequality: this quantifies the extent to which there is inequality due to deprivation between wards in each of the East of England Local Authority Districts.

Figure 3.6: Life expectancy, changes in life expectancy, poor health and socio-economic inequalities in CHD and cancer across Local Authority districts within the East of England

Local Authority District	Life expectancy significantly lower than regional average		Average % increase in Life Expectancy 1991-2003		% wards in LAD whose rate of poor health is significantly higher than EoE average	Socio-economic inequality in CHD	Socio-economic inequality in cancer
	Male	Female	Male	Female			
East of England			3.1	1.6	17%		
Peterborough	Yes	Yes	1.9	0.6	43%	Yes	Yes
Luton	Yes	Yes	2.6	0.6	53%	Yes	Yes
Southend-on-Sea	Yes	Yes	2.2	0.6	47%	Yes	Yes
Thurrock	Yes		4.0	1.9	40%	Yes	Yes
Mid Bedfordshire			4.0	3.5	12%	Yes	Yes
Bedford			3.5	1.5	8%	Yes	Yes
South Bedfordshire	Yes		2.1	2.3	17%	Yes	
Cambridge			2.7	0.4	7%	Yes	
East Cambridgeshire			2.1	3.8	5%		
Fenland	Yes	Yes	1.2	1.5	15%		
Huntingdonshire			3.1	1.2	10%	Yes	Yes
South Cambridgeshire			4.5	2.8	0%		
Basildon		Yes	3.5	0.9	19%	Yes	Yes
Braintree		Yes	2.4	0.0	20%		
Brentwood			6.1	3.0	0%	Yes	Yes
Castle Point			3.2	0.4	14%		
Chelmsford			2.0	2.5	0%		
Colchester			3.5	2.6	7%		Yes
Epping Forest			2.9	1.8	3%	Yes	
Harlow			2.8	3.4	27%	Yes	
Maldon			4.4	2.6	12%		
Rochford			4.9	2.8	0%		
Tendring	Yes		2.7	0.7	29%	Yes	
Uttlesford			3.9	2.0	4%		
Broxbourne			2.8	1.7	0%	Yes	

| Local Authority District	Life expectancy significantly lower than regional average		Average % increase in Life Expectancy 1991–2003		% wards in LAD whose rate of poor health is significantly higher than EoE average	Socio-economic inequality in CHD	Socio-economic inequality in cancer
	Male	Female	Male	Female			
Dacorum			3.3	1.0	7%		
East Hertfordshire			3.4	2.8	0%		
Hertsmere			3.6	2.1	7%	Yes	Yes
North Hertfordshire			2.4	1.8	0%		
St. Albans			4.0	3.1	0%	Yes	
Stevenage	Yes	Yes	2.4	-2.6	8%	Yes	
Three Rivers			3.2	1.5	5%	Yes	Yes
Watford	Yes	Yes	2.1	0.1	8%	Yes	
Welwyn Hatfield			3.5	1.5	6%	Yes	Yes
Breckland			2.4	1.6	6%		
Broadland			3.8	1.4	0%		
Great Yarmouth	Yes		3.3	1.9	35%	Yes	Yes
King's Lynn & W Norfolk			2.8	2.3	29%	Yes	Yes
North Norfolk			3.6	2.0	0%		
Norwich	Yes		3.7	1.0	38%	Yes	
South Norfolk			3.4	2.9	8%		
Babergh			3.6	2.4	0%		
Forest Heath			3.5	0.5	0%		
Ipswich			2.8	1.4	44%		
Mid Suffolk			3.0	3.0	0%		
St. Edmundsbury			3.3	2.1	0%		
Suffolk Coastal			2.2	2.0	0%		
Waveney			2.7	1.9	17%		

(Source: Data provided by ERPHO)

3.11   Looking together at Figure 3.6 and the six maps (which follow), several observations can be made:

- There are a number of PCT areas which score consistently poorly on every measure. These include Great Yarmouth, Peterborough, Luton and Tendring. In these areas, the link between poverty, deprivation and poor health appears to be strong. This observation is confirmed by the data in Figure 3.6: in the main, life expectancy has increased more slowly than the regional average and there is a high local incidence of socio-economic inequality in both CHD and cancer

- Conversely, there are several PCT areas which score consistently well on every measure: in South Cambridgeshire and St Albans and Harpenden, for example, the incidence of deprivation is low, people's self-reported health is typically good and life expectancy is high for both females and males. Figure 3.6 also suggests that in these areas, life expectancy has increased at a faster rate than the regional average

- There are other areas in which the picture is more mixed. Across much of the London fringe, for example, PCT areas score well in terms of measures from the Indices of Deprivation (ID) but these are not translated straightforwardly into good health outcomes. In part this may be explicable in terms of substantial local inequalities linked to the incidence of CHD and cancer. In Hertsmere and Three Rivers Local Authority Districts, for instance, Figure 3.6 suggests that the proportion of wards with a rate of poor health which is higher than the regional average is low but that there are sizeable socio-economic inequalities in both CHD and cancer. In both cases, rates of improvement in life expectancy have been close to the regional average.

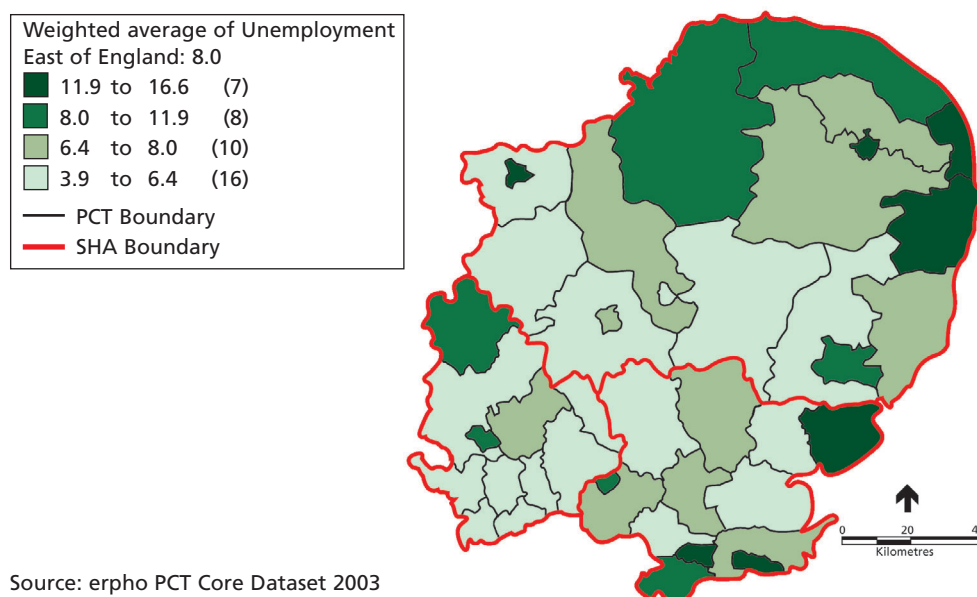## Figure 3.7: Child poverty Indices of Deprivation 2000 (ID 2000)

PCT Weighted average ID 2000 Child poverty domain
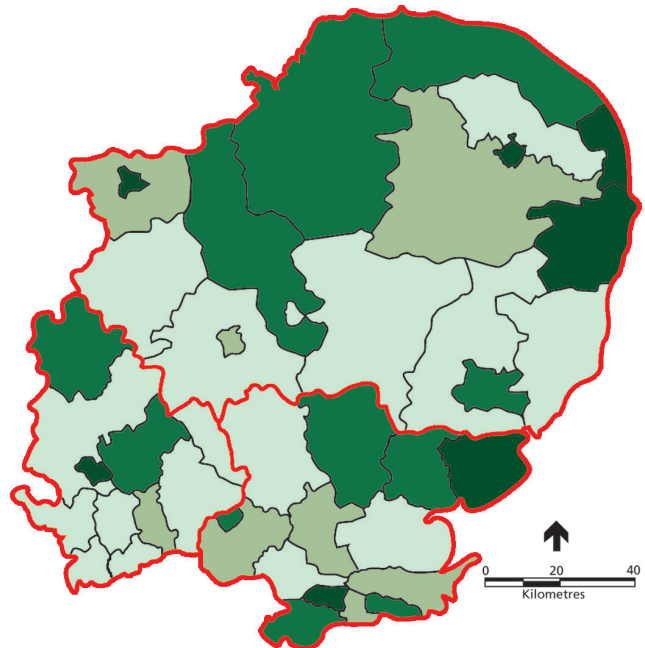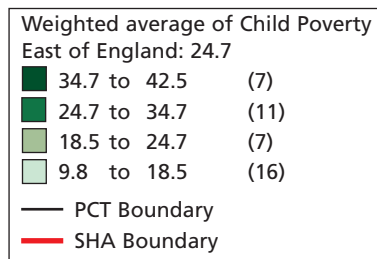
Source: erpho PCT Core Dataset 2003
Based on Ordnance Survey Material.
© Crown Copyright. All rights reserved. Erpho 100040338 2003

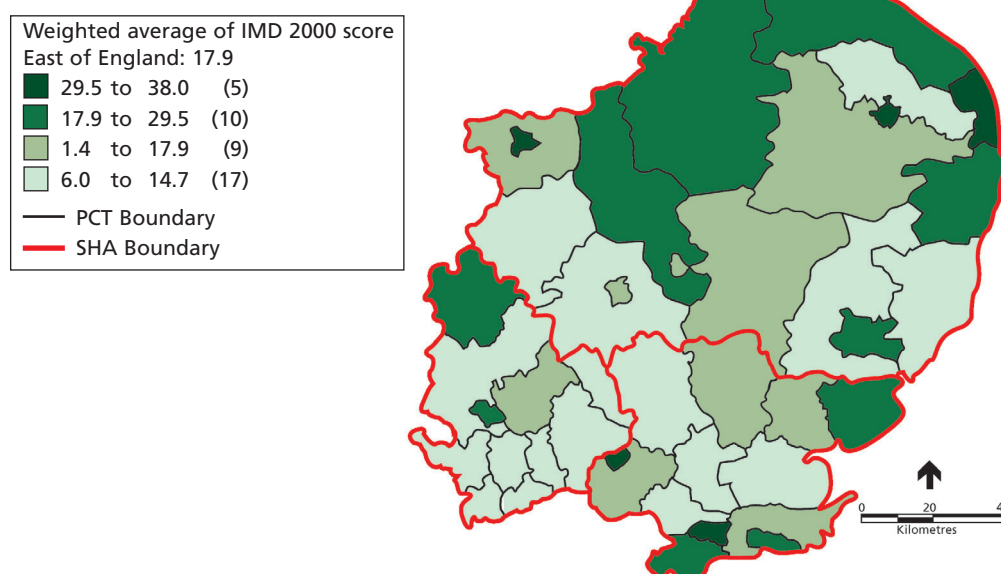## Figure 3.8: Unemployment Index of Multiple Deprivation (IMD 2000)

PCT Weighted average IMD unemployment domain

Weighted average of Unemployment
East of England: 8.0
- 11.9 to 16.6 (7)
- 8.0 to 11.9 (8)
- 6.4 to 8.0 (10)
- 3.9 to 6.4 (16)
- —— PCT Boundary
- —— SHA Boundary

Source: erpho PCT Core Dataset 2003
Based on Ordnance Survey Material.
© Crown Copyright. All rights reserved. Erpho 100040338 2003
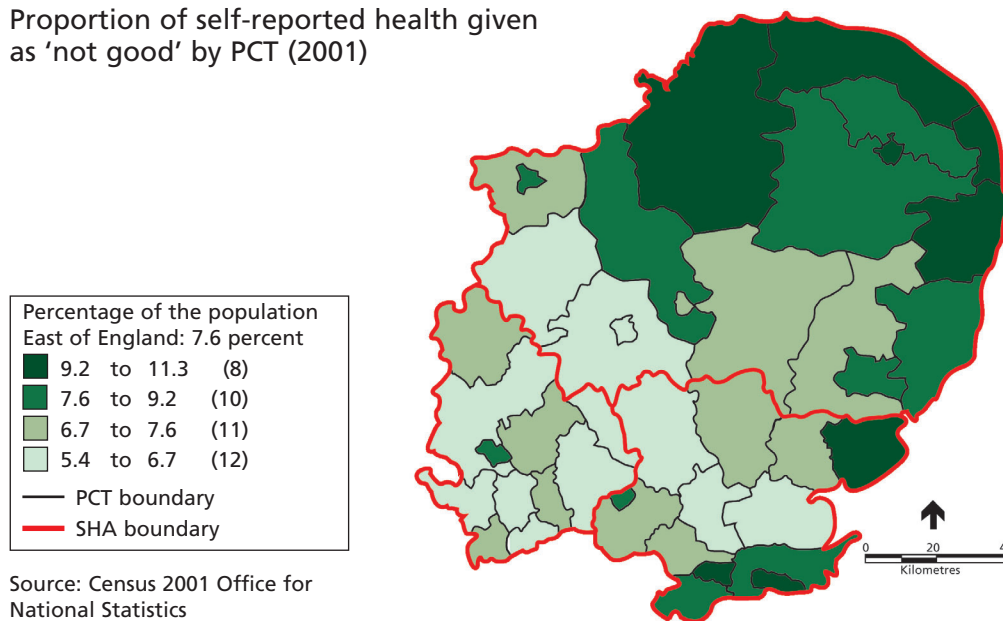
Figure 3.9: Multiple deprivation (IMD 2000)

PCT Weighted average IMD 2000 score

Weighted average of IMD 2000 score
East of England: 17.9
- 29.5 to 38.0 (5)
- 17.9 to 29.5 (10)
- 1.4 to 17.9 (9)
- 6.0 to 14.7 (17)
- —— PCT Boundary
- —— SHA Boundary

Source: erpho PCT Core Dataset 2003
Based on Ordnance Survey Material.
© Crown Copyright. All rights reserved. Erpho 100040338 2003
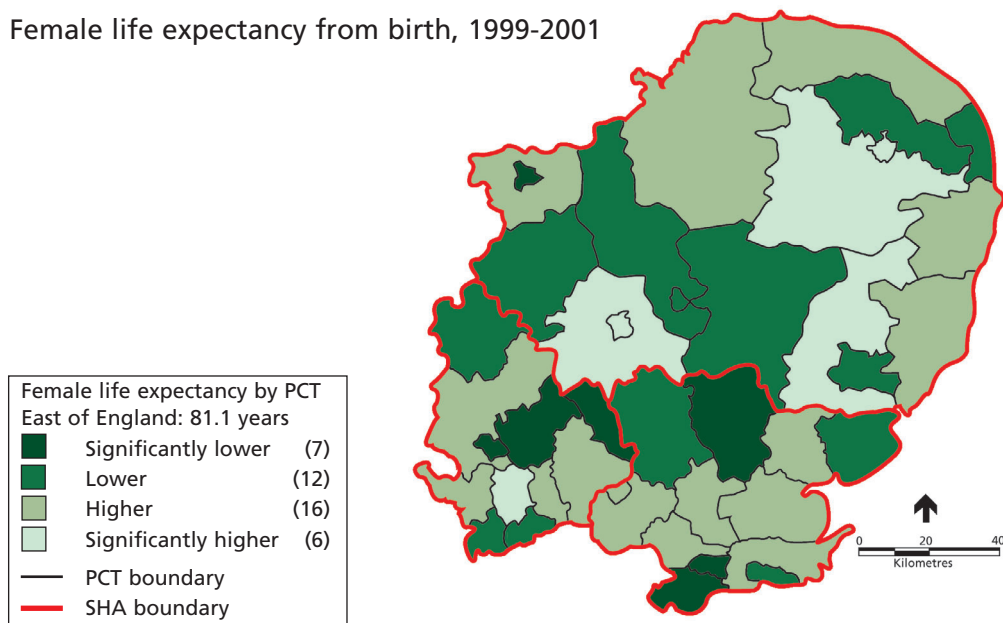
Figure 3.10: Self-reported health

Proportion of self-reported health given
as 'not good' by PCT (2001)

Percentage of the population
East of England: 7.6 percent

■	9.2	to	11.3	(8)
■	7.6	to	9.2	(10)
■	6.7	to	7.6	(11)
□	5.4	to	6.7	(12)

— PCT boundary
— SHA boundary

Figure 3.11: Female life expectancy

Female life expectancy from birth, 1999-2001

Female life expectancy by PCT
East of England: 81.1 years

■	Significantly lower	(7)
■	Lower	(12)
■	Higher	(16)
□	Significantly higher	(6)

— PCT boundary
— SHA boundary

Figure 3.12: Male life expectancy

Male life expectancy from birth, 1999-2001

Male life expectancy by PCT
East of England: 76.6 years

◼	Significantly Lower	(7)
◼	Lower	(12)
◼	Higher	(15)
◼	Significantly higher	(7)
—	PCT boundary	
—	SHA boundary	

Source: erpho PCT Core dataset 2003
Based on Ordnance Survey Material.
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Vulnerable groups within the population

3.12   The relationship between health and deprivation is strong and its geography is well established. But in addition, the particular issues faced by certain population groups must also be recognised; these groups may be dispersed within the overall population and hence largely invisible in terms of aggregate data. Within the East of England, the Regional Social Strategy has identified black and minority ethnic groups, people with disabilities, lone parents, older people, carers, asylum seekers, refugees and ex-offenders as especially vulnerable. In the paragraphs below we comment on key health issues relating to some of these groups.

3.13   Older people – particularly those that live alone – often face significant challenges; as argued above, the Region's demography is changing and older people comprise a growing proportion of the population. Isolation can be a problem and there are frequently major issues with regard to accessing services. In addition – nationally – 57% of the fuel poor are age 60 or over (reflecting the fact that properties in poor condition are disproportionately occupied by single older people) and poor housing design contributes to serious accidents, particularly among older people (who account for almost half of the deaths from accidents in the home).[20] [21]

3.14   People from black and minority ethnic (BME) communities face distinctive issues – although evidence suggests that BME groups are not uniformly at greater risk of poor health compared with whites. Nevertheless, many BME groups (with the exception of Chinese) are at much higher risk of diabetes mellitus than whites; Caribbeans and Pakistanis/Bangladeshis have a significantly higher risk of self reported poor or fair health than whites; and babies of Pakistani born mothers experience an infant

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20   The implications of an ageing population for the sustainable development of the East of England Study by Population Ageing Associates, for EERA, 2003.
21   See Chapter 7.

mortality rate which is more than twice the average. Overall the evidence suggests that many of the health inequalities experienced by BME groups are explicable in terms of material deprivation; and the correlation between areas of the Region in which the ethnic population is relatively large and levels of deprivation are acute (see Figure 3.9) is a strong one. In addition, however, BME groups experience inadequate access to quality health services and this is a further contributory factor to poor health outcomes.[22]

3.15   Prisoners, ex-offenders and young offenders are vulnerable in terms of health outcomes. Within the East of England there are 14 prisons – a significant proportion of the national estate. The prison population is growing and it has a very high incidence of mental ill health. Hence there are complicated and important dimensions, including those linked to the rehabilitation of offenders.

3.16   Another vulnerable group is Gypsy and Traveller communities such as English Romany Gypsies, Scottish and Welsh Travellers, Irish Heritage Travellers, Showpeople, New Travellers, Circus People and Bargees. A national study found that Gypsies and Travellers have significantly poorer health and more self-reported symptoms of ill-health than other UK-resident, BME groups and economically disadvantaged white UK residents.[23] Within this group, maternal health and infant health are especially problematic. Institutional barriers have been identified in terms of access to preventative health services, but these are compounded by a reluctance to engage with services, an anticipation of hostilities and a culture of self sufficiency.[24] Within the East of England, the Gypsy and Traveller population is relatively large.

3.17   Refugees and asylum seekers within the East of England face a further set of health issues. These people are inherently vulnerable, having been forced to leave their country of origin, frequently because of persecution. Once in the UK, many are living in poor accommodation with insufficient or limited access to services and in many neighbourhoods they are viewed with hostility, suspicion and prejudice. In seeking to improve the health of people within the East of England and to reduce health inequalities, the issues facing refugees and asylum seekers need to be taken into account fully.

3.18   Finally, it is important to comment on migrant workers. Migrant workers are defined by the Organisation for Economic Co-operation (OECD) as 'foreigners admitted by the receiving State for the specific purpose of exercising an economic activity remunerated from within the receiving country'. The term 'migrant workers' embraces a great variety of situations and hence the health issues faced by migrant workers will also vary substantially. That said, access to health (and other) services can be an issue and some migrant workers find themselves living in poor accommodation, working very long hours and facing isolation and exclusion.[25]

22   Ethnicity and Health Inequalities INpho Briefing papers on topical public health issues September 2002, Issue 2.
23   The Health Status of Gypsy and Travellers in England G Parry and P Van Cleemput (2004), University of Sheffield – for the DH.
24   Gypsy and Traveller Communities: Accommodation, Education, Health, Skills and Employment – An East of England Perspective Study completed by Camille Warrington and Sherry Peck, for EEDA (March 2005).
25   See, for example, http://www.gyros.org.uk

Conclusions

3.19   Across the East of England, patterns of health and well-being are complicated. There are substantial variations in health between Districts, but also within them. All of the data suggest a strong relationship between poor health and deprivation, but the relationship is not a simple one: we can observe poor health outcomes in relatively affluent areas, suggesting that local inequalities may be just as – and some would argue more – problematic than overall conditions. Hence although there are serious issues in those parts of the Region which are known to have relatively weak economies (e.g. Great Yarmouth and Fenland), there are also issues in some areas which are generally considered to be buoyant: for example, female life expectancy hardly changed in Cambridge, Braintree and Watford from 1991-2003 while in Stevenage it actually declined. In addition, it is important to acknowledge the particular issues faced by vulnerable groups and communities of interest which tend to be dispersed across the Region and hence largely invisible in terms of data.
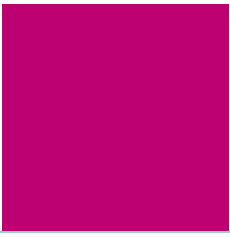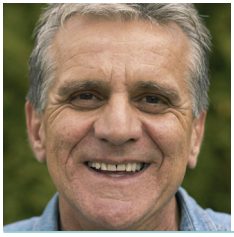
04 Understanding the health of people in the East of England

Chapter summary

What actually determines the health of the population is a complicated question. Within the East of England, key factors include:

- A high incidence of employment in low paid jobs in sectors such as health and social care, tourism, and agriculture and food processing

- Stress at work, particularly amongst those aged 50 or more (which is a growing proportion of the workforce)

- A relatively large number of people of working age who are economically inactive: a proportion are long-term sick and deteriorating mental health can often be the issue

- Relatively low levels of educational attainment, particularly in terms of progression to further and higher education and continuing learning in adulthood

- Housing pressures, linked both to affordability and to the condition of housing

- Poor access to services, particularly in rural areas and among some vulnerable groups

- Weak social and community networks

- Physical inactivity and increasing obesity

- Lifestyle factors such as smoking, drug abuse, alcohol consumption and sexual health.

Introduction

4.1 For any individual, issues relating to age, genes and other constitutional factors are primary determinants of health. Nevertheless – as Chapter 3 demonstrated – looking across the East of England, we can observe that people of similar age and gender experience very different health outcomes. In the East of England – as elsewhere[26] – health has improved over recent years, but on many measures, health inequalities have increased. These trends reflect a range of social, economic and environmental conditions and processes. It is these wider issues – and their relationship to health and inequalities in health in the East of England, and the wider implications that follow – that form the focus for this chapter.

4.2 Underpinning the discussions in this chapter are two theoretical approaches:

- The first relates to the **determinants** of health. Public health practitioners argue that these need to be understood at different scales, ranging from lifestyle choices, through social and community networks to broader living and working environments, and more general socio-economic, cultural and environmental conditions. The relationship between these factors is summarised in one well known model of health determinants which is presented in Figure 4.1

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26   Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson, published by the DH/The Stationery Office (Crown copyright), 1998.

Figure 4.1: The main determinants of health[27]

- The second is the **life course** approach. There is substantial evidence that health – both good and bad – is transmitted from one generation to the next through economic, social and developmental processes: babies born to poorer families are more likely to be born prematurely, are at greater risk of infant mortality and have a greater likelihood of poverty, impaired development and chronic disease in later life.[28] Against this backdrop, the life course approach focuses on the experience of health from conception through childhood and adolescence to adulthood and old age. It argues that there are critical points at the transition between life stages where an individual may move in the direction of advantages or disadvantages in health.[29]

4.3   The two approaches need to be regarded as cross-cutting: individual determinants are manifested in different ways at different life stages, and as an individual moves from one life stage to the next, the nature of the determinants will change.

4.4   In the paragraphs that follow, we examine each of the 'layers' within Figure 4.1, drawing on evidence and analysis from across the East of England to understand better the processes underpinning the data described in Chapter 3. As the strategy prepared by the Norfolk, Suffolk and Cambridgeshire SHA observes, around 15% of health differences are explicable in terms of genetic and biological factors,[30] the other influences on health – which are the focus for **Healthy Futures** – are explicable in terms of these broader determinants.

27   Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health Stockholm: Institute of Futures Studies, 1991 (Diagram reproduced with the publisher's permission).
28   Tackling Health Inequalities: 2002 Cross-Cutting Review HM Treasury (Crown copyright).
29   See, for example, 'Childhood disadvantage and adult health: a life course framework', Hilary Graham and Chris Power, Health Development Agency (HDA), 2004
30   Health Strategy 2005-2010 Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2005.

I: General socio-economic, cultural and environmental conditions

4.5   Chapter 3 demonstrated a strong correlation between poor health outcomes and deprivation. But what is it about weak economies and social exclusion that translates into poor health outcomes? There are many different dimensions and in the paragraphs that follow, we examine three key ones: the nature of work and employment, education and learning, and broad environmental conditions.

Work and employment in the East of England

4.6   In the East of England – as elsewhere – work and employment are key elements of a dynamic economy. Hence it is no coincidence that Goal One from the Regional Economic Strategy is concerned with building a skills base that can support a world class economy: skills, work, employment and economic prosperity are thoroughly intertwined.

Relationship between work and health

4.7   As well as being integral to the economy, work is a primary source of status; often it is the way in which people are defined, both by others and by themselves. At an individual level, work and employment provide purpose, social support, structure and a means of participating in society, as well as income.[31] For all of these reasons, people's experience of – and patterns of engagement in – work have important implications for their health. The links are well-established, but complicated:[32]

- Work which provides job satisfaction and allows individuals discretion, security and control over their working lives seems to confer considerable health benefits (and the reverse is also true). This appears to manifest itself during mid-life, a period during which social inequalities in health are especially apparent.

- An absence of work – in the form of unemployment – produces negative health effects. It impacts on psychological well-being, social participation and physical health. Impacts tend to be especially acute late into an individual's career. They are also problematic in the early years of employment; this in turn can have a substantial influence over the remainder of the life course.

- The threat of unemployment/redundancy is closely correlated to increased illness, health service use and hospital admissions.[33]

4.8   One influential and robust examination of the relationship between work experiences and health outcomes was based on a longitudinal study[34] of the English civil service. This demonstrated that stress at work results from an imbalance between the psychological demands of work on the one hand and the degree of control over work on the other. In seeking to improve health outcomes, it made the case for a better balance between effort and reward. The latter was measured in three different ways: esteem, career opportunities (including job security and promotion prospects) and financial remuneration.[35]

31   'The Future of Work-Life Balance' part of the Economic and Social Research Council (ESRC) 'Future of Work' Programme Seminar Series.
32   Work, non-work, job satisfaction and psychological health: Evidence Review HDA, March 2005.
33   Worklessness and health – what do we know about the causal relationship? HDA, March 2005.
34   A longitudinal study is one which focuses on the same group of people over a long time period.
35   Work, Stress, Health: The Whitehall II Study CCSU/Cabinet Office/UCL, 2004.

The changing experience of groups in the workforce

4.9 Over the recent past, there is evidence that the world of work has become less satisfying and more stressful with most people claiming that they are working harder than previously. In the East of England and elsewhere, older people are a key and growing part of the labour force. Evidence from the 'Working in Britain' survey[36] suggested growing issues for the over-50s at work – particularly a feeling of being under pressure but also undervalued.[37]

4.10 Women are another critical part of the labour force. The same survey found that women had seen a greater proportionate increase in working hours than men during the 1990s. Women in their 30s and 40s have seen the largest increases in the amount of time they spend working in paid jobs although they are at an age when family responsibilities are at their greatest.[38]

Low pay and inequalities in pay

4.11 In the East of England, the Regional Economic Strategy asserts that the Region has a 'strong economy supported by a weak skills base': across much of the Region, 'the economy is trapped in a spiral of low value-added, low skills and low wages'. In the main, the problem is not unemployment:[39] the Region has one of the highest employment rates in the UK. Instead, the challenge is low wage levels and poor quality employment. For example, in rural parts of the East of England, 400,000 people – close to a sixth of the population in rural areas – live in low income households but half of these people live in households where someone is working.[40] The problems of low pay are also found in urban areas where there are often high concentrations of poorly-paid service jobs in both the public and private sectors.

4.12 Within the Region, the 'low wage – low skills equilibrium' is especially problematic in some sectors: agriculture, health and social care, and tourism have all been identified in these terms and all of these sectors have above average proportions of low skilled workers.[41] In different ways, all three sectors are important for the regional economy and they are all cited in the Regional Economic Strategy.[42] But in all three, there are major challenges relating to the health of the workforce. As well as delivering benefits for the individuals concerned, their families and communities, addressing these challenges could reduce absenteeism, increase productivity and – hence – improve regional economic performance.

4.13 Across the Region, the problems of low pay are exacerbated by inequalities in pay. Within the East of England, the extent of inequality is substantial: evidence suggests that the range in average pay at a local authority level lies between 76% and 150% of the regional average,[43] and at local and neighbourhood levels, the differences are greater again.

36   Based on a survey undertaken during 2000 as part of 'The Future of Work', a £4m research Programme launched by the Economic and Social Research Council in October 1998 (see www.leeds.ac.uk/esrcfutureofwork/synopsis).
37   'Diversity in Britain's Labour Market' part of the ESRC 'Future of Work' Programme Seminar Series. Further evidence for declining job satisfaction among older workers was cited in HDA's evidence review 'Work, non-work, job satisfaction and psychological health' published March 2005.
38   'Diversity in Britain's Labour Market' part of the ESRC 'Future of Work' Programme Seminar Series.
39   There are exceptions within the Region, notably in some of the larger cities and coastal towns where levels of deprivation tend to be acute.
40   Poverty and Social Exclusion in Rural East of England Observatories Social Exclusion Partnership Report, 2004.
41   East of England 2004 Labour Market Assessment: Overview Report Prepared for EEDA by Step Ahead Research.
42   A Shared Vision: The Regional Economic Strategy for the East of England EEDA, 2004 page 104.
43   Health and Social Care and Sustainable Development in the East of England Centre for Public Services and the Nuffield Institute for Health, 2004 page 38.

Worklessness in the East of England

4.14   Over the last 10 years, unemployment rates have halved in the East of England. However the proportion of the working age population which is economically inactive has remained stable. Within the Region, there are about 155,000 people who are currently economically inactive but who would like to work.[44] Of these, around 71,000 are claiming Incapacity Benefit or Severe Disablement Allowance and/or have a work limiting illness lasting more than one year. Nationally, employment rates vary according to the type of sickness or disability and employer prejudices can be an issue: for people with diabetes the employment rate is over 60% while for those with mental health problems it is 17%. Analysis suggests that lone mothers and carers form a significant proportion of economically inactive women – and around a quarter of these report that they would like to be engaged in paid employment. A similar proportion of economically inactive people aged over 50 and below retirement age would like to work; here the main barriers are qualification and skills levels.[45]

4.15   Given the relationship between work and health, the issue of worklessness – which is seen most strongly in the East of England in terms of economic inactivity – raises important challenges for **Healthy Futures**; these are all the more important in the context of a region which reports labour shortages.

Work, health and future challenges in the East of England

4.16   In terms of the health of people in the East of England, issues relating to work and employment are posing challenges. In employment terms, the Region is set to grow significantly: the **East of England Plan** (draft Regional Spatial Strategy) makes provision for a projected net growth of 421,500 jobs in the period 2001-2021. If this is to contribute to an enhanced quality of life – including better health outcomes and reduced health inequalities – it is vital that quality jobs are created; these must provide people with meaningful work, good social interaction, prospects and income.

4.17   However areas that have grown quickly in the past – including some of the new towns – have tended to create large numbers of relatively poor quality jobs, often in retail, leisure/tourism and back office service functions, and there has been concern that they might have encouraged young people out of education and training at the age of 16/17 – a critical moment in the life course. If increased economic activity is to be linked to improved health and reduced health inequalities, the Region will need to do better. Interesting and fulfilling jobs must be created in which there is an appropriate 'effort-reward balance' across all occupations. Employment growth of this nature should serve the best interests of the employee, the employer and the Region as a whole. Consistent with this argument, it is important to note that promoting access to work, tackling low pay and improving conditions of work has been identified as one of eight Strategic Objectives within the Regional Social Strategy.

Education and learning

'Although the extent to which education has an independent effect on health status, and the mechanisms by which it does so are not fully understood, it does appear to have an important influence. This influence may be seen as both potentiating (providing the trigger for healthier lifestyles and behaviour) and protective (providing access to employment opportunities and life chances that can protect individuals from disadvantage in later life).'[46]

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44   Labour Market Statistics: June 2005 – East National Statistics (Crown copyright).
45   'Increasing Employment Rates in Disadvantaged Communities' Supporting document to the 2004 Labour Market Assessment for the East of England completed by Step Ahead Research for EEDA.
46   Independent inquiry into inequalities in health report, chaired by Sir Donald Acheson, published by the DH/The Stationery Office (Crown copyright), 1998 page 38.

4.18　There is a direct relationship between people's experience of education and learning; the opportunities available to them in the labour market; and, subsequently, their health outcomes. Currently, the Region's performance is mixed and there are some substantial variations within it:

- In 2003, the proportion of 15 year olds attaining five or more GCSEs at Grades A-C was 50.0% across the East of England compared to 52.9% across England as a whole. Within the Region it ranged from 46.1% in Bedfordshire and Luton to 58.1% in Hertfordshire[47]

- Rates of progression into higher education are lower than the UK average in seven of the ten county/unitary authority areas in the East of England: the proportion of young people (aged less than 21) entering higher education ranges from 16.6% in Thurrock to 47.5% in Hertfordshire[48]

- In terms of the skills of the resident population, Hertfordshire and Cambridgeshire have a lower proportion of low skilled residents than is found elsewhere in the Region and a higher proportion of high skilled residents[49]

- In 2003, survey evidence suggested that 44% of professionals had undertaken job related training in the previous 12 months compared to 16% of those working in skilled trades and 13% of those in elementary occupations.[50]

4.19　At a regional scale, the correlation between higher levels of skills and better health outcomes is a strong one – although the underlying processes are complicated. In Suffolk, for example, success rates at GCSE (Level 2) and A Level (Level 3) are relatively good, but there is a high incidence of low skilled workers in the county. In part this is explicable in terms of the sectoral and occupational mix and in part through the out-migration of more highly skilled younger people. As the regional data cited above demonstrates, employer funded job-related training tends to focus on the higher occupational groups. This all suggests that patterns of labour market inequality – which have important spatial dimensions in the East of England – are, if anything, deepening. For young people living in rural parts of Suffolk, the lack of learning and career opportunities appears to be shaping key life decisions which will have a bearing on health outcomes, both for those that leave and those that remain in the area; in considering the Region's medium-term health prospects, particularly in rural areas, the choices made by this cohort are extremely important. Arguments of this nature have underpinned the case for establishing a University Campus within the county and in time – accepting the links between low pay, unsatisfactory jobs and poor health – this ought to contribute to better health outcomes.

4.20　Within the East of England, there are some social groups that are particularly disadvantaged in educational terms. Gypsy and Traveller children are, for example, at particular risk. This is explained in terms of high levels of racism towards Gypsy and Traveller children within schools; enforced mobility impacting negatively on access to education; difficulties of the education system in accommodating nomadism; and a secondary curriculum which is seen to be culturally inappropriate or irrelevant.[51] The children of refugees are likely also to be disadvantaged.

Environmental factors

4.21　A wide range of environmental factors have a relationship to people's health. These include radiation levels, the presence of chemical toxins, air quality, the quality of water supply, extremes of temperature, noise and over-crowding. In the context of respiratory and infectious diseases reaching epidemic

47　Department for Education and Skills (DfES) School and College Performance Tables quoted in East of England 2004 Labour Market Assessment Overview Report prepared by Step Ahead Research for EEDA.
48　KPMG, HESA and CACI quoted in quoted in East of England 2004 Labour Market Assessment Overview Report prepared by Step Ahead Research for EEDA.
49　Census 2001, quoted in East of England 2004 Labour Market Assessment Overview Report prepared by Step Ahead Research for EEDA.
50　Data from LFS quoted in East of England 2004 Labour Market Assessment Overview Report prepared by Step Ahead Research for EEDA.
51　Gypsy and Traveller Communities: Accommodation, Education, Health, Skills and Employment – An East of England Perspective, Camille Warrington and Sherry Peck, for EEDA 2005.

proportions in recently urbanised populations after the industrial revolution, it was issues of this nature that dominated the earliest thinking with regard to public health.[52]

4.22　In the East of England in the 21st Century, determinants of health relating to the physical environment are evidenced in a less dramatic manner, but they are present nevertheless. Nationally, air pollution from particulate matter is linked to 8,100 premature deaths annually and sulphur dioxide to 3,500.[53] The Regional Environment Strategy highlights that a major source of air pollution in the Region is emissions from traffic. Within the Region, in 2002, some 36% of households had two or more cars/vans (compared to 29% across England) and there were almost 83,000 vehicles per day on every kilometre of motorway in the Region (compared to 78,000 across England).[54] Despite technological improvements, increases in road traffic are contributing to air pollution[55] which is known to have negative health impacts, particularly in areas which are in close proximity to the source of emissions. But there are other indirect consequences for people's health: within the East of England, the increasing use of motor vehicles, the increase in physical inactivity and the rising levels of obesity are causally inter-related.[56]

4.23　Noise is another environmental factor which has adverse impacts on population health. There is a body of evidence to suggest that chronic exposure to environmental noise leads to impaired cognitive function and health in children.[57] Noise from road traffic and air traffic are two key sources.

4.24　Looking to the future, climate change is likely to have a substantial effect on people's health. Nationally, an Expert Group on Climate Change and Health (formed at the request of Ministers at the Department of Health) has predicted that by the 2050s and as a result of climate change, heat-related deaths are likely to increase by about 2,000 cases per year; food poisoning will increase by 10,000 cases per year; there is likely to be a substantially increased risk of major disasters caused by severe winter gales and coastal flooding; and the incidence of skin cancer is likely to increase by 5,000 cases per year in the UK.[58] In the East of England, some areas are likely to be severely affected by the impacts of climate change: the low-lying Fens and Thames Gateway areas will be at greater risk of flooding and saline intrusion.[59] The report of the Expert Group on Climate Change and Health in the UK concluded by suggesting that the NHS ought to be able to cope. However there was one major exception – coastal flooding – and it is in this context that low lying parts of the East of England are vulnerable.

II: Living and working conditions

4.25　Nested underneath the broad social, economic and environmental factors which define the East of England – and caused in part by them – are the places/conditions in which people live, learn and work. These contribute to health outcomes. In seeking to improve the health of people within the East of England and reduce inequalities in health, it is important to understand this second 'layer' of determinants, both in terms of the current situation and future trends and drivers. The paragraphs that follow consider four elements: working and learning environments, housing, the design of settlements, and access to services.

52　'Issues in Health Development – Environment and Health' HDA, undated.
53　Making the case: Improving health through transport HDA, 2004.
54　Region in Figures – East of England, National Statistics (Crown copyright) No 9 Winter 2004/05.
55　This point is also made in the sustainability appraisal of the draft East of England Plan. See East of England Plan Non-Technical Summary of the Sustainability Appraisal, Levett-Therivel and Land Use Consultants, November 2004.
56　Obesity in the East of England ERPHO 2004.
57　See the World Health Organisation website on 'Noise and Health' http://www.euro.who.int
58　Health effects of climate change in the UK Authored by the Expert Group on Climate Change and Health in the UK. Department of Health (Crown copyright) 2001.
59　Living with Climate Change in the East of England Report to the East of England Regional Assembly and the Sustainable Development Round Table by LUC, CAG and SQW, 2003.

Working and learning environments

4.26   There is much evidence that the environments in which people work or study have important implications for their health; these are related to the broad 'conditions' described above – wage levels, the balance between effort and reward, etc. – but they are not reducible to them. The Whitehall II study found that 'good levels of social supports had a protective effect on mental health and reduced the risk of spells of sickness absence' while 'a poor work environment – including poor social support at work – was one of the main factors explaining the higher prevalence of depressive symptoms among participants in the lower employment grades'.[60]

4.27   **Choosing Health** – the health White Paper – flags the importance of promoting health in the workplace. It identifies smoke free work environments as a priority and the desire for this has been expressed strongly in the East of England: of the 7,882 people who took part in the Big Smoke Debate in the East of England in 2004, some 80% would back a law to make all workplaces smoke free.[61] In addition, health and safety at work remains an important consideration. The 1974 Health and Safety at Work Act placed duties on employers to protect the health and safety of their employees. Since the Act was passed, the nature of work – and work places – has changed significantly; there are many more small workplaces, women comprise a greater proportion of the workforce and the service sector has grown. Over this period, progress on safety issues has been substantial but traditional interventions have been less effective vis-à-vis health; in moving forward, this is recognised as a priority.[62]

4.28   Within this overall context, one group which is especially 'at risk' is migrant workers, as exemplified by the Morecambe Bay disaster. Within the East of England there is a high incidence of migrant workers, many of whom are employed on a casual and/or seasonal basis. Across all sectors, a responsible approach to migrant workers needs to be encouraged; employers could, for example, play an important role in signposting migrant workers to local health services.

4.29   Like working environments, learning environments are important for health. In this context, the National Healthy Schools Programme – which was launched in 1998 – is instructive; it encourages schools to work towards a healthy schools standard by investing in the health of their pupils and staff to help raise achievement and reduce health inequalities. Every Local Education Authority (LEA) in the UK is working in an accredited partnership with PCTs to manage their own local programme for the benefit of pupils, schools and local communities. Evidence from a review of Ofsted school inspection reports found that the Programme is contributing to raising pupil achievement and promoting social inclusion, and that it is having a greater impact in schools serving areas of socio-economic disadvantage.[63]

Housing

4.30   The housing in which people live has a strong – but complex – relationship to their health. Within the East of England, there are major issues relating to the affordability of housing. Across much of the Region, house prices have risen much faster than incomes, making housing unaffordable for many people.[64] Hence particularly for those working in low paid occupations and/or low paid sectors, there are substantial challenges relating to home ownership. One consequence has been an increasing incidence of homelessness although – as the Regional Housing Strategy makes clear – homelessness may often be the end result of other social and health-related problems. In this context, it has identified young people (aged 16-17) as especially vulnerable; young people are relatively excluded from advice on housing and homelessness at a critical moment in their life course.

60   Work, Stress, Health – The Whitehall II Study Cabinet Office/CCSU/UCL, 2004.
61   Big Smoke Debate: Results from the East of England published by ERPHO, September 2004.
62   A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond HSC, 2004.
63   http://www.wiredforhealth.gov.uk/
64   The Provision of Affordable Housing in the East of England 1996-2001 Report by Cambridge Centre for Housing and Planning Research for EERA, 2003.

4.31   The housing stock within the East of England is relatively modern; however much of the new town stock built in the 1940s and 1950s has reached the stage where serious modernisation is needed. By April 2002, there were 8,127 unfit local authority houses and 85,686 unfit private houses within the Region.[65] Poor housing has long been associated with a range of physical and mental health conditions. Evidence suggests that the effects of poor housing fall disproportionately on older people and children:

• Children living in poor housing conditions are more susceptible to higher rates of accidents, infectious and chronic disease. Evidence suggests a relationship between overcrowding and both respiratory conditions and meningitis in children, and – further – that living in overcrowded conditions during childhood results in poor self-rated health in adulthood[66]

• There is evidence to suggest that cold housing leads directly to hypothermia and may lead to the excess in winter deaths seen in older people.[67]

4.32   Within the East of England, housing conditions are close to the average for England: in the social sector, for example, the proportion of houses in the Region which are overcrowded is similar to the English average.[68] Within the Region, the proportion of households experiencing fuel poverty declined between 1998 and 2001; nevertheless 6.1% of households continue to experience fuel poverty and elderly people living in un-modernised homes are at particular risk.

4.33   With regard to housing needs within the Region, certain groups have been identified as being vulnerable. EEDA has recently investigated the accommodation needs of gypsy and traveller communities, concluding that a lack of secure accommodation is a major challenge and many gypsies and travellers are homeless.[69] EERA has examined the housing needs of refugees, recognising the particular challenges linked to integrating these people into the wider community.

Design and form of settlements

4.34   The design of settlements can have a substantial impact on the health of the people that live and work in them. In the context of the Sustainable Communities Plan, the East of England is facing substantial housing and population growth; the **East of England Plan** (draft Regional Spatial Strategy) makes provision for 478,000 net additional dwellings in the period to 2021. In this context, the design of settlements – both new and existing – is a major regional issue. In seeking to improve health and reduce health inequalities, two different dimensions need to be taken into account:

• First, it will be essential that appropriate levels of health service provision are 'planned into the design of new and existing settlements in the Region's three Growth Areas and elsewhere. Substantial work on this front is already underway[70]

• Second, it will be imperative that settlements are designed in a manner that encourages healthy lifestyles. This requires, for example, that provision is made for green spaces, that footpaths and cycleways link areas of housing and areas of employment and hence the scope for physical activity is 'designed in' rather than 'bolted on' as plans for development – in existing and new settlements – take shape.[71]

65   The implications of an ageing population for the sustainable development of the East of England Study by Population Ageing Associates, for EERA, 2003.
66   The Impact of Overcrowding on Health and Education: A Review of the Evidence and Literature Office of the Deputy Prime Minister (ODPM) (Crown copyright), 2004.
67   Independent inquiry into inequalities in health report, chaired by Sir Donald Acheson, published by the DH/The Stationery Office (Crown copyright), 1998 page 89.
68   The Impact of Overcrowding on Health and Education: A Review of the Evidence and Literature ODPM (Crown copyright), 2004.
69   Gypsy and Traveller Communities: Accommodation, Education, Health, Skills and Employment – An East of England Perspective, Camille Warrington and Sherry Peck, for EEDA 2005.
70   Creating Sustainable Communities Making it Happen – Thames Gateway and the Growth Areas ODPM (Crown copyright), 2004.
71   These issues are explored further in Chapter 6 in the context of Theme A.

Access to health care and other services

4.35   A fourth key element of 'living and working conditions' that has a material bearing on people's health experiences and health outcomes – and inequalities in both – relates to access to services. Poor access to services is a key cause of socio-economic exclusion. Nationally, it has been observed that 'lack of access to transport is experienced disproportionately by women, children, disabled people, people from minority ethnic groups, older people and people with low socio-economic status, especially those living in remote rural areas'.[72] Survey evidence suggests that 31% of people without a car have difficulties travelling to their local hospital compared to 17% of people with a car.[73] Within the East of England, the Regional Social Strategy identifies similar concerns. It reports that a third of the 50,000 lone parents and 60% of pensioners in rural districts of the East of England do not own a car and are therefore likely to be seriously disadvantaged in terms of access to services; older single women pensioners are identified as the group of greatest concern.

III: Social and community networks

4.36   Evidence suggests that people's experience of health and the actions they take to maintain good health are strongly influenced by their upbringing and family culture, peer groups, the media and health professionals. Typically, people with robust and diverse social networks have stronger immune systems, suffer less from heart disease, recover more quickly from emotional traumas such as bereavement, and seem to be more resistant to the debilitating effects of illness; this is explained in terms of social networks providing support and affirmation, including practical advice around health matters.[74]

4.37   Although there are exceptions,[75] high levels of social capital will generally contribute to enhancing people's health. 'Social capital' is defined as 'the networks, norms, relationships, values and informal sanctions that shape the quantity and co-operative quality of a society's social interactions;'[76] more simply, it can be considered as the ties that exist across families and communities and that help structure people's everyday lives. Whilst causality is difficult to prove, evidence suggests that where social capital is weak, support for families and investment in community development can contribute in important ways to improving health outcomes. The implication – as one report has put it – is that 'policies to reduce social inequalities and to promote social networks are part of a strategy to reduce inequalities in health in just the same way as action on economic inequalities or improvements in the material environment of disadvantaged communities.'[77]

4.38   In this context, the voluntary and community sector plays a key role. For an individual, the process of engaging in activities linked to the voluntary and community sector is itself indicative of some kind of network: people are largely recruited through word of mouth or knowing someone who is already involved. But the value of the voluntary and community sector goes further; much voluntary and community sector activity is linked – directly or indirectly – to the wider determinants of health through, for example, neighbourhood, sports and cultural associations.

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72   Independent inquiry into inequalities in health report, chaired by Sir Donald Acheson, published by the DH/The Stationery Office (Crown copyright), 1998 page 56.
73   Making the Connections: Final Report on Transport and Social Exclusion Report by the Social Exclusion Unit (Crown copyright), February 2003
74   'Community development and networking for health' Chapter by Alison Gilchrist in Public Health for the 21st Century edited by Orme et al (2003), Open University Press.
75   E.g. peer pressure and social activities are known to support unhealthy habits, particularly among young people, in relation to smoking, drug use, alcohol consumption, etc.
76   See Aldridge, S and Halpern, D 'Social Capital: A Discussion Paper' (2002), Cabinet Office: PIU.
77   Independent inquiry into inequalities in health report, chaired by Sir Donald Acheson, published by the DH/The Stationery Office (Crown copyright), 1998, page 17.

4.39   For the East of England, the implication is that those individuals and groups which are living in weak or fractured communities, and which are at risk of social exclusion, are likely also to be vulnerable in terms of poor health. Similarly, the breakdown of family relationships may also be a source of increased vulnerability to poor health outcomes.

IV: Lifestyle factors

4.40   In determining health outcomes, individual lifestyle factors are a fourth key consideration. Although these relate ultimately to decisions made by an individual, they are – in practice – difficult to divorce from the wider context in which they are made. Below, we consider key aspects of lifestyles in the East of England and their relationship to the more structural determinants described earlier.

Smoking

4.41   Smoking is the leading preventable cause of death in the East of England; it is estimated to have killed 8,300 people per year in the Region in the period 1998-2002. Most people start smoking between the ages of 15-18 years and very few start smoking after the age of 24; in life course terms, this highlights the great importance – in determining health outcomes – of the transition to adulthood. Moreover, cigarette smoking has been identified as the primary reason for the observed gap in life expectancy between rich and poor: in 2002-03, 7% of people in social class I in the East of England were smokers compared to 33% in social class V.[78]

4.42   Trying to explain why people smoke is immensely complicated. Ultimately it is an individual choice, but peer influence during teenage years is one key factor.[79] Other studies have shown, for example, that young mothers are well aware of the negative health consequences of smoking but they took the view that the short-term benefits of smoking as a stress reliever when coping with the care of young children in poor physical circumstances outweighed the longer term effects.[80]

4.43   In the East of England, **Smoke Free East:** A Tobacco Control Framework for the East of England, 2005-2010 has recently been completed.[81] This identifies five strategic priorities which aim to reduce exposure to secondhand smoke; reduce the uptake of smoking; promote smoking cessation; reduce inequalities caused by smoking; and strengthen community action for tobacco control.

Exercise

4.44   Government recommendations are that as a minimum, adults should undertake at least 30 minutes of moderate activity on at least five days a week (this can be accumulated in briefer episodes). Currently in the East of England, this minimum level is being achieved by 24% of women and 36% of men; both figures are below the English averages.

4.45   Barriers to physical activity exist across the four determinants of health; they include individual factors (e.g. time pressures, inconvenience and lack of enjoyment), social factors (e.g. cultural norms and fear of crime) and environmental issues (e.g. poor access to safe pedestrian and cycle routes; poor quality of parks and public spaces; cost of and distance to facilities; and lack of access to skilled support). A change in culture is required to tackle physical activity effectively. Significant changes are needed at many levels, from individuals' awareness of the potential benefits of physical activity and choosing to be more active, to changes in the physical environment to make it easier to be more active.[82]

78   Smoking in the East of England: An Update ERPHO March 2005.
79   'Community Development and Networking for Health' by Alison Gilchrist in Public Health in the 21st Century, Edited by Orme et al, 2003, Open University Press.
80   'The lay contribution to public health' by Pat Taylor, in Public Health in the 21st Century, Edited by Orme et al, 2003, Open University Press
81   See www.goeast.gov.uk
82   Physical Activity in the East of England ERPHO 2005.

Diet

'People in lower socio-economic groups tend to eat less fruit and vegetables, and less food which is rich in dietary fibre…. As a consequence, those in lower socio-economic groups tend to have low intakes of anti-oxidant and other vitamins, and some minerals, especially relative to intakes in higher socio-economic groups'.[83]

4.46   A great deal of work has been done to examine the reasons behind a poor diet. A report by the National Food Alliance challenged the presumption that anyone living in the UK could choose a healthy diet, arguing that to make good choices, people needed appropriate information, better access to appropriate sources of food and more money to spend on food.[84] Subsequently the Policy Commission on The Future of Farming and Food flagged the phenomenon of 'food deserts' asserting that 'there are places where low income consumers cannot access [healthy] food at reasonable prices, particularly fruit and vegetables. The major supermarkets do not operate there, and local shops do not provide fresh produce.'[85]

4.47   Food deserts are generally associated with inner urban areas. However the phenomenon is not exclusively urban. A study undertaken in Norfolk in 2002 estimated that only about a quarter of villages had a shop which sold any fruit and vegetables. It observed further that while village shops were used for 'top-up' shopping by most customers, a few residents – particularly older people – relied heavily   on them.[86] Hence for a potentially vulnerable group of people, there is evidence of food deserts in rural parts of the East of England.

Obesity

4.48   Obesity is caused when the amount of energy expended is less than energy intake. In the East of England, among adults (aged 16-64), the proportion of the population that is overweight or obese is 55% in social class I (professional) and 64% in social class V (unskilled manual). Spatially, levels of obesity are higher among sub-urban and rural populations than among people living in urban areas.[87]

Sexual Health

4.49   Trends in sexual behaviour in the East of England are similar to national patterns. Overall, more people are becoming sexually active at a younger age; however there is a strong socio-economic gradient and problems associated with becoming sexually active at a young age are closely correlated with poor levels of educational attainment, early school leaving age, family disruption and other forms of disadvantage. Hence the links to the broader determinants are again evident; for example, almost half of under-18 conceptions occur in the most deprived 20% of wards.[88] Across the Region, the incidence of sexually transmitted infections is increasing, especially among young people.[89]

83   Independent inquiry into inequalities in health report, chaired by Sir Donald Acheson, published by the DH/The Stationery Office (Crown copyright), 1998 page 63.
84   Myths About Food and Low Income - If They Don't Eat a Healthy Diet it's Their Own Fault! National Food Alliance (1997).
85   Farming and Food: A Sustainable Future Report of the Policy Commission on the Future of Farming and Food, 2002 (available from the Cabinet Office website www.cabinetoffice.gov.uk).
86   Food access and inequalities in rural Norfolk Report by Tully Wakeman, East Anglia Food Link, May 2002.
87   Obesity in the East of England ERPHO 2004.
88   This issue is considered further in Chapter 7.
89   Sexual Health in the East of England ERPHO INpho Briefing Papers on Topical Public Health Issues, October 2003 Issue 6.

Alcohol

4.50   Alcohol can cause significant physical, psychological and social harm if misused. Guidelines for sensible drinking state that regular consumption of up to 21 units per week for men and 14 for women does not accrue significant health risks[90] – equivalent daily limits are less than 3-4 units per day for men and less than 2-3 units per day for women (with two alcohol-free days after heavy drinking). Regular drinking, including binge drinking, above these levels is not recommended because of the progressive health risk this carries. In the East of England, the proportion of women consuming 21-35 units per week increased from 2% to 7% between 1993 and 2002; the proportion consuming more than 35 units per week increased from 2% to 4% over the same period.[91]

Conclusions

4.51   What determines the health of people in the East of England is, in practice, extremely complicated. Causal pathways are multi-dimensional and different layers of health determinants interact with each other – in different ways during an individual's life course – to determine health outcomes.

4.52   Looking across the four layers, we might summarise the different challenges in terms of different stages of the life course, recognising that considerations relating to gender, ethnicity, poverty and geography cut across each of these. A summary table which considers all of these dimensions is presented in Figure 4.2 overleaf.

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90   Sensible Drinking: the report of an inter-departmental working group. London: DH, 1995.
91   Alcohol Use in the East of England (draft): ERPHO, October 2005.

Figure 4.2: Summary table highlighting the relationship between different determinants of health as they relate to the East of England at key transitions in the life course

	General socio-economic, cultural and environmental conditions	Living and working conditions
Babies and young children (0-5 years) and their families	• Some 200,000 children are estimated to be living in poverty in the East of England. Factors associated with low income families include worklessness, single parenthood, disability, a head of household from an ethnic minority, and lower age of mother • There is some evidence that children within poorer families are badly affected by emissions from traffic as 'rat runs', etc. are close to their homes	• Poor housing has adverse impacts on the health of young children • Evidence suggests that early years learning can improve educational performance in later life and this has important implications for health • Young children need to have scope for an hour or more of physical activity every day. This means that playgrounds, etc., that are safe need to be provided
Young people (c.16-22 years)	• One challenge for the Region is to encourage young people to remain in education post-16: there are lots of low paid jobs available, particularly in those parts of the Region that are growing quickly and in rural areas • Many young people in the Region have high aspirations career-wise but end up in jobs which they consider to be disappointing; this is a cause of low self esteem and it can have adverse implications for their health • Many of the young people that do complete Further Education/Higher Education (FE/HE) courses have substantial debt. Particularly if they end up in relatively poorly paid employment, this can be problematic	• Evidence suggests that participation in physical activity drops off sharply – particularly for women – once it is not a compulsory school activity. 'Designing in' exercise is therefore likely to be especially important for this group • Homelessness can be a particular problem for young people and currently, access to relevant services is poor for this age group • The incidence of teenage pregnancies tends to cluster around particular schools suggesting that support from and through schools might have a significant impact on teenage conception rates. This in turn has long-term health implications
Older people	• People of older working age are coming under experiencing increased stress within the workplace and yet people within the Region are likely to need to work for longer	• Older people – many of whom are home owners – may be living in poor housing conditions. Particularly for older, single, women in isolated rural areas, this is a concern • Fear of crime tends to be especially acute among older people and this can limit access to services

Social and community networks	Lifestyle networks
• In the main, networks ought to be reasonably good for mothers and young children, other than the most disadvantaged	• Poor diet during the first five years of life can have long-term implications
• Networks are very influential in encouraging healthy or unhealthy behaviour: peer influence can result in very positive or very negative outcomes	• Most people who smoke, start smoking in their teenage years; this has long-term implications for people's health • Poor habits in terms of diet and cooking may begin as people leave home and these habits can be difficult to break later. It is important that this group of people knows how to handle food and make good food choices • Consumption of alcohol amongst this group can be excessive and this cohort is also prone to experimentation in illegal drugs • Sexual health issues were raised as a major issue in **Choosing Health** and it is likely that these are especially relevant for people in this age group
• As people approach retirement, one important source of social networks can disappear; this is a source of real vulnerability • Older people may become lonely and isolated following bereavement and this can make them extremely vulnerable; in the East of England there appears to be a particular problem facing elderly widows living alone in large, isolated houses which may also be falling into disrepair	• The transition to retirement is a major life change at which disposable income may fall significantly. This in turn will have implications for consumption decisions • It is important that older people are able to remain physically active; this has been shown to improve mental alertness

A Regional Health Strategy for the East of England

Section B: Healthy Futures: Regional Health Strategy for the East of England
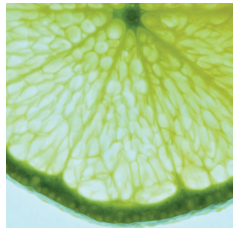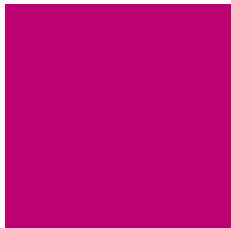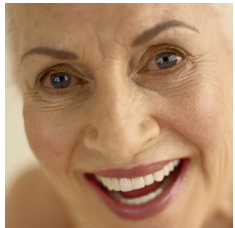
05 Healthy Futures: the strategy

Chapter summary

Taking into account the key determinants of health in the East of England, the policy context provided by the **Choosing Health** White Paper and the strategic context provided by the Integrated Regional Strategy, **Healthy Futures** has been developed. It focuses on issues which are especially important to the East of England and which can be influenced at a regional scale.

The core of **Healthy Futures** is defined by a Vision that may be simply stated: '**to improve the health of the population and to reduce health inequalities in the East of England**.' In order to achieve this Vision, three broad Themes are identified, each of which embraces a number of distinct Strategic Priorities:

- **Theme A: Health in Sustainable Communities**

- **Theme B: Health at Key Life Stages**

- **Theme C: Health in a Connected Region.**

Actions have been identified relating to each Strategic Priority. The Actions are intended to support and influence a range of much bigger regional and local strategic processes; working through these other delivery processes, progress towards the Vision ought to be achieved.

The Strategy's components

5.1 The analysis in Chapters 3 and 4 has painted a complex and dynamic picture of health and health inequalities in the East of England. The underlying causes relate to a range of factors – from broad regional conditions through social networks to the specific lifestyle choices that individuals make. Cutting across these, it is clear that particular groups in the population are affected in different ways and the needs of groups which are vulnerable should be recognised explicitly. A third important dimension surrounds Key Life Stages, recognising that there are specific (but cumulative) health-related opportunities and threats as people move from one life stage to the next.

5.2 **Healthy Futures** needs to make sense of this complexity in a manner that is specific and appropriate to the East of England. In addition, it must recognise what can – and what cannot – be achieved at the regional scale. Some issues are not in the Region's gift to determine: the Region cannot, for example, make regulatory or fiscal changes (although it may have some discretion in implementation). These considerations have been instrumental in shaping **Healthy Futures**.

5.3 In short, we have taken on board the factors that are determining the health of people in our Region; we have appraised these in the light both of regional priorities set out in the Integrated Regional Strategy, and national priorities articulated in **Choosing Health**; and then we have identified those priorities that we believe the Region, as a whole, can and must respond to. Our Strategy has been built up in this manner.

5.4   **Healthy Futures** has a number of different components: one Vision, three Themes, nine Strategic Priorities and accompanying regional Actions.[92] These Actions – which will be subject to on-going development and review – take a number of forms:

- **Targeted research and investigation**, contributing to the development of the regional evidence base

- Preparation of **guidance** and/or **training materials**, focusing especially on 'mainstreaming' key priorities from within **Healthy Futures** across a range of delivery processes

- Gathering and disseminating **good practice** (much of it generated locally) and **data/intelligence** to relevant partners across the Region

- **Raising awareness** of key issues and **influencing** the range of processes that can contribute to them

- **Influencing government**, particularly in response to issues that manifest themselves at a regional scale.

5.5   On their own, Actions of this nature are not going to deliver the Vision set out in **Healthy Futures**. However the Actions ought to be able to influence the three sets of delivery processes linked to: the Integrated Regional Strategy; **Choosing Health**; and local and sub-regional priorities (particularly those defined by LSPs and being advanced – across much of the Region – through Local Area Agreements, and those services being influenced by Investing in Communities (IiC) partnership programmes).[93] These in turn – and in combination – ought to be able to make a real difference to the health and well-being of people in the East of England.

Healthy Futures: the Strategy

Vision

5.6   The core of **Healthy Futures** is defined by a Vision that may be simply stated:

To improve the health of the population and to reduce health inequalities in the East of England.

5.7   The range of factors which are shaping the health of people in the East of England is enormous; achieving this Vision is not going to be easy, particularly given the intention both to improve overall health and to reduce inequalities in health. However we must – as a Region – address these issues. As Figure 5.1 demonstrates clearly, on key indicators – such as life expectancy (and the graph illustrates variations in male life expectancy) – inequalities across the Region are currently increasing; this is a trend that we need to reverse whilst seeking also to improve overall population health.

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92   In Chapters 6-8, Action Tables follow discussions of each Strategic Priority. These have been developed in consultation with partners and they will be subject to on-going development and review. The timescales set out in the Tables relate to the approximate period over which Actions will be completed; progress on all of the Actions needs to be achieved relatively quickly, including those that are described as 'long-term'. The expectation is that the Action Tables will be reviewed and refreshed on a regular basis.
93   The delivery of **Healthy Futures** is considered further in Chapter 9.

Figure 5.1: Male Life Expectancy in the East of England for the least and most deprived quintiles of Local Authorities
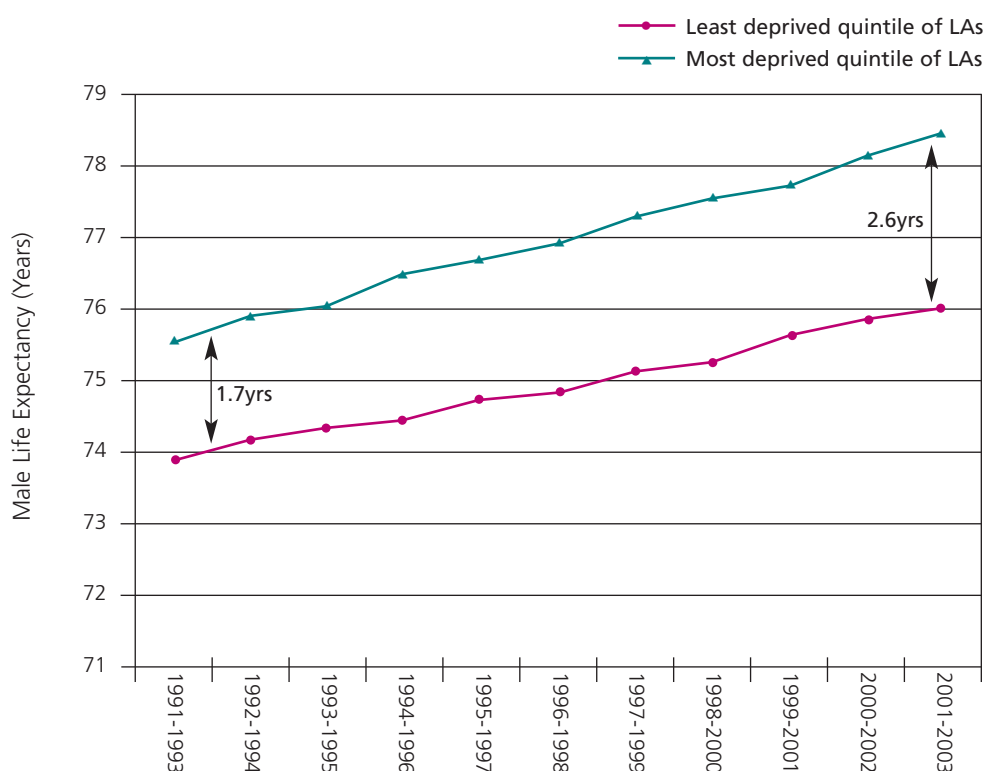
(Source: Data provided by ERPHO)

Themes and Strategic Priorities

5.8   Sitting beneath the Vision, we have identified three key Themes, each of which embraces distinct Strategic Priorities. These reflect the key determinants of health, but they do so in a way that is specific to the particular issues and challenges facing the East of England. They take account, for example, of the Sustainable Communities Plan and the fact that three of the four Growth Areas designated by government are partially within the East of England; the increasingly polarised labour market within the Region; the ageing population; and the growing role of the East of England in terms of international gateways. There is a great deal of read-across between the different Themes and Strategic Priorities; in delivery, they will complement each other in important ways. The three key Themes are introduced   in the paragraphs that follow.

Theme A: Health in Sustainable Communities

5.9   In the East of England, there are particular challenges in striving towards healthy, sustainable communities. These reflect, inter alia, the pace of growth; the challenges linked to resources such as water supply; and the accumulated shortfall in investment in the surrounding infrastructures – both hard and soft.

5.10   In response there is a need to ensure that new and existing communities are designed to be healthy; to build community cohesion and support the development of social capital, particularly for people experiencing disadvantage; and to take steps to ensure that all people within the Region are genuinely in a position to 'Choose Health'.
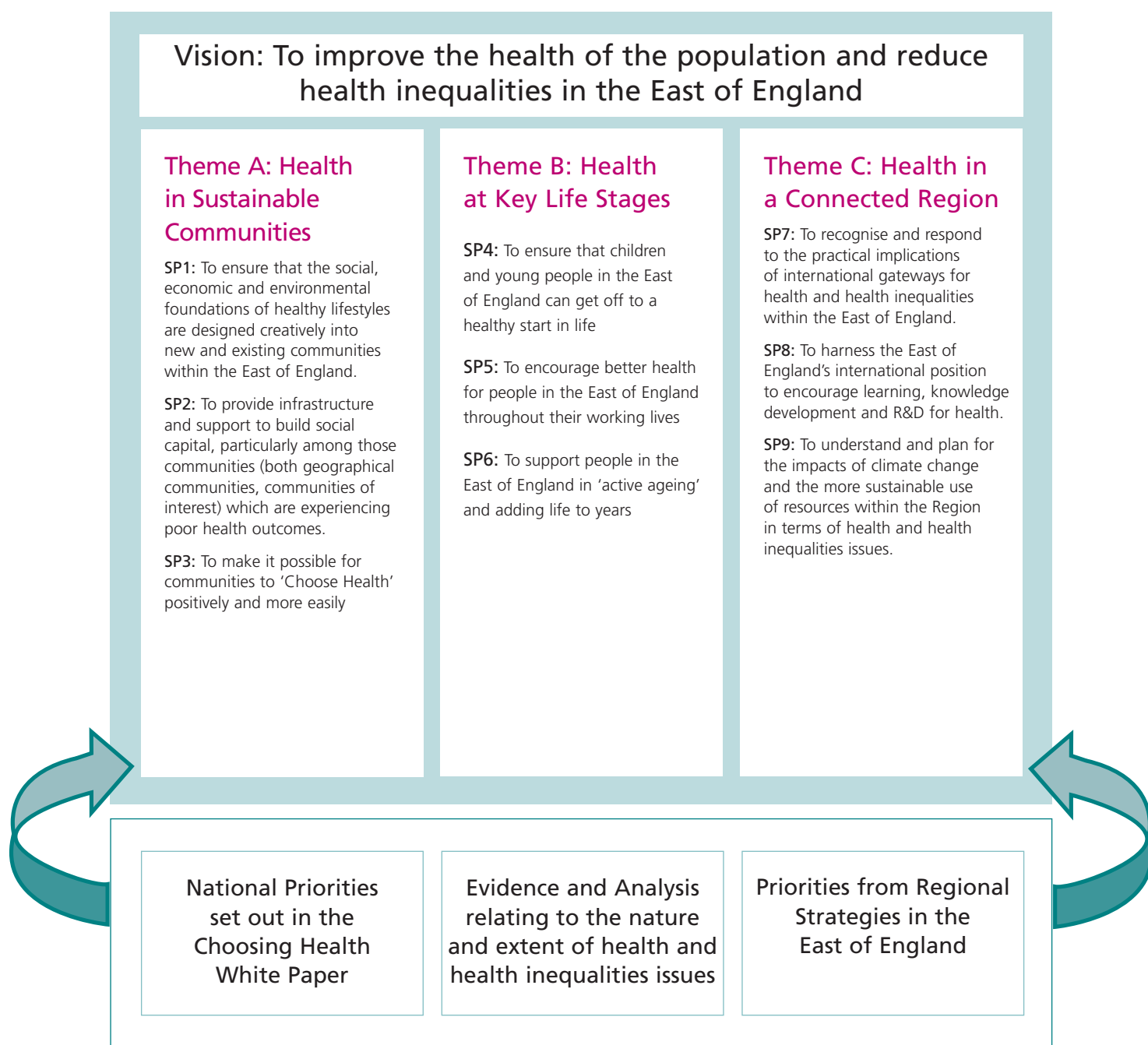
Theme B: Health at Key Life Stages

5.11   People of different ages within the East of England are facing quite different issues with regard to their health and well-being. These need to be understood and addressed if the health of the population is to be improved and the extent of health inequalities reduced:

- First, it is vital that we address the issues facing children and young people. The issues relating to young children and their families are very important while the transition into adulthood is a second key factor in terms of long-term health outcomes. The Region must support all its children and young people – and their families/carers – better

- Second, much can be done to improve the health of people of working age. For those in employment, work is a big part of life and depending on the nature and experience of work, it can contribute either positively or negatively to health. For those who are economically inactive, there is also a wide range of health issues. Sometimes poor health excludes people from work and this can be a particular source of isolation and vulnerability

- Third, given the Region's changing demography, it is vital to recognise the issues pertaining to older people. The concept of 'active ageing' needs to be embraced fully, encouraging full participation and both recognising and supporting the role that older people can and do play in communities throughout the East of England.

Theme C: Health in a Connected Region

5.12   The third major Theme that defines **Healthy Futures** is concerned with the position of the East of England globally. The East of England is intrinsically – and increasingly – inter-connected. In this context, three major issues – all of which were identified in the Integrated Regional Strategy – will have a significant bearing on the future health of the population and on health inequalities. All three need to be addressed in advancing the Strategy. Hence there is a need to recognise and respond to the practical implications of international gateways; to harness the East of England's international position to encourage learning, knowledge development and R&D for health; and to understand and plan for the impacts of climate change and the more sustainable use of resources within the Region, in terms of health and health inequalities issues.

5.13   The Vision and Themes – and the Strategic Priorities which follow – are summarised in Figure 5.2 and described in subsequent chapters. For each Strategic Priority a number of Actions are also identified.

Figure 5.2: Healthy Futures: the Regional Health Strategy for the East of England

Vision: To improve the health of the population and reduce health inequalities in the East of England

Theme A: Health in Sustainable Communities

SP1: To ensure that the social, economic and environmental foundations of healthy lifestyles are designed creatively into new and existing communities within the East of England.

SP2: To provide infrastructure and support to build social capital, particularly among those communities (both geographical communities, communities of interest) which are experiencing poor health outcomes.

SP3: To make it possible for communities to 'Choose Health' positively and more easily

Theme B: Health at Key Life Stages

SP4: To ensure that children and young people in the East of England can get off to a healthy start in life

SP5: To encourage better health for people in the East of England throughout their working lives

SP6: To support people in the East of England in 'active ageing' and adding life to years

Theme C: Health in a Connected Region

SP7: To recognise and respond to the practical implications of international gateways for health and health inequalities within the East of England.

SP8: To harness the East of England's international position to encourage learning, knowledge development and R&D for health.

SP9: To understand and plan for the impacts of climate change and the more sustainable use of resources within the Region in terms of health and health inequalities issues.

National Priorities set out in the Choosing Health White Paper

Evidence and Analysis relating to the nature and extent of health and health inequalities issues

Priorities from Regional Strategies in the East of England

06 Theme A: Health in Sustainable Communities

Chapter summary

Theme A is concerned with Health in sustainable communities. This is a particular challenge in the East of England given the pace of population growth and the pressure on resources. Three Strategic Priorities are identified, together with appropriate Actions:

- **Strategic Priority 1:** To ensure that the social, economic and environmental foundations of healthy lifestyles are designed creatively into new and existing communities in the East of England

- **Strategic Priority 2:** To provide infrastructure and sustained support to build social capital, particularly among those communities (geographical communities, communities of interest and potentially vulnerable groups) which are experiencing poor health outcomes

- **Strategic Priority 3:** To make it possible for communities to 'Choose Health' positively and more easily

6.1   Health is – or should be – an integral element of sustainable communities. The new UK Sustainable Development Strategy sets out some of the most important requirements of sustainable communities; these are summarised in Figure 6.1 below.

Figure 6.1: What makes Sustainable Communities?[94]

Sustainable communities are places where people want to live and work, now and in the future. They meet the diverse needs of existing and future residents, are sensitive to their environment, and contribute to a high quality of life. They are safe and inclusive, well planned, built and run, and offer equality of opportunity and good services for all.

Sustainable communities should be:

- Active, inclusive and safe – fair, tolerant and cohesive with a strong local culture and other shared community activities

- Well run – with effective and inclusive participation, representation and leadership

- Environmentally sensitive – providing places for people to live that are considerate of the environment

- Well designed and built – featuring a good quality built and natural environment

- Well connected – with good transport services and communication linking people to jobs, schools, health and other services

- Thriving – with a flourishing and diverse local economy

- Well served – with public, private, community and voluntary services that are appropriate to people's needs and accessible to all

- Fair for everyone – including those in other communities, now and in the future

94   Securing the Future: Delivering UK Sustainable Development Strategy, HM Government, 2005 (Crown copyright).

6.2   In the East of England, there are particular challenges – and opportunities – in striving towards healthy sustainable communities. The agenda is enormous and it extends far beyond the remit of **Healthy Futures**. However in seeking to deliver the Vision set out in Chapter 5, three elements are especially important and these have defined three Strategic Priorities.

Strategic Priority 1: To ensure that the social, economic and environmental foundations of healthy lifestyles are designed creatively into new and existing communities in the East of England

6.3   The manner in which settlements are planned and designed contributes significantly to the health of the people who live in them. Bad planning and design results in poor health outcomes; conversely, good planning and design can be positively health-enhancing. These arguments have long underpinned policy. The World Health Organisation, for example, has supported the concept of 'Healthy Cities' and Phase IV of the World Health Organisation's Healthy Cities Network in Europe (2003-2007) sets out two key priorities:

- **Healthy urban planning** – encouraging planners to integrate health considerations into planning strategies

- **Health impact assessment (HIAs)** – promoting HIAs to support inter-sectoral action for promoting health and reducing inequality.[95]

6.4   Although there are challenges linked to growth in the East of England – both in regeneration areas and areas which are already buoyant – there are also real opportunities. Settlements (both new and existing) that are being (re)designed need to contribute in a positive way to the health of the people who will live in them. New developments – whether residential, mixed use or town centre – need to be actively health promoting. In addition, appropriate health infrastructures need to be planned in anticipation of population and housing growth. More generally, account needs to be taken of changing lifestyles, expectations and aspirations, informed by the underlying determinants of population health described in Chapters 3 and 4 and the policy drivers set out in Chapter 2.[96] Hence there is a need to:

- Recognise that many people (particularly women) are juggling paid work with caring responsibilities: planning and design – in terms of the proximity and accessibility between places of employment, housing and the broader social infrastructure – can have a material bearing on the ability of people to cope

- Plan for population ageing: a range of housing types – including lifetime homes – ought to be planned from the outset and account ought to be taken of the need for closer proximity/easier access to services, reducing feelings of isolation and improving community safety

- Ensure that places are designed to minimise the risk and fear of crime

- Take into account the critical importance of accessible green space in urban and rural areas, recognising its significance in terms of recreation and amenities, the broader 'liveability' agenda,[97] and the clear links to physical and mental well-being

- Recognise the significance of building social capital and creating a real sense of community. Hence, designing in appropriate social infrastructures is imperative, including provision for a range of cultural, faith-based, sporting and leisure activities

95   Phase IV (2003-07) of the World Health Organisation's Healthy Cities Network in Europe, World Health Organisation (2003).
96   The recently published White Paper on healthcare outside hospitals 'Our Health, Our Care, Our Say' will also need to be taken into account.
97   The liveability agenda is about creating places where people choose to live and work. In 2003, ODPM launched a 'Liveability Fund' to support significant Local Authority projects to improve parks and public spaces.

- Acknowledge the potential links between health and the sustainable use of resources. Many different elements could be cited, including water resources and energy use. One further important component relates to the generation of waste; in this context it will be important to ensure that waste management is included within design criteria for new/existing settlements, following the principles set out in Planning Policy Statement 10 (Planning for Sustainable Waste Management).

6.5   In addition, it will be imperative that the links between healthy communities and transport planning are made fully and creatively.[98] In terms of health outcomes, transport – which includes walking and cycling as well as the use of private vehicles and public transport – is double-edged. Its health-promoting aspects can include access, recreation, exercise and economic development. However negative effects include: pollution; traffic injuries; noise; stress and anxiety; danger; land loss and planning blight; and community severance.[99] Moreover, evidence suggests that the negative impacts tend to be experienced primarily by more deprived communities, thereby exacerbating inequalities in health outcomes. All of these different dimensions need to be taken into account fully in planning for healthy sustainable communities across the East of England. Moving forward, the opportunities linked to 'active transport'[100] need to be explored in some detail.

6.6   Against this backdrop, Strategic Priority 1 is intended to ensure that the social, economic and environmental foundations of healthy lifestyles are designed creatively into new and existing communities in the East of England;[101] and in delivering this priority, the links to Strategic Priority 9[102] need to be clear and strong. Spatially, the focus will need to be on those parts of the Region which are growing quickly and/or undergoing significant regeneration.

6.7   In terms of the Actions that follow, the priorities identified by the World Health Organisation are relevant to much of the East of England – and across urban and rural areas alike. Hence it will be essential to continue to work closely with Inspire East (see Figure 6.2), planners and developers to ensure that health genuinely is 'designed in' as the Region seeks to respond both to the Regional Economic Strategy and – once it is finalised – to the **East of England Plan**. In addition, there is a need to support the intention – set out in the Regional Housing Strategy – for the Regional Housing Delivery Group to liaise with health professionals and to encourage better joint working and planning between housing authorities, PCTs and SHAs. Building on work already undertaken within the Region, it will be important to support health professionals as they seek to engage effectively with the new planning system.[103] Some specific Actions are set out in the Table on page 70.

Figure 6.2: Inspire East

Inspire East is one of the Regeneration Centres of Excellence across England which were set up in the context of the wider sustainable communities agenda. Inspire East is a regional body and it aims to drive up skills and knowledge in the related fields of regeneration and neighbourhood renewal. Its services are available to a wide range of people from the public and private sector including built environment professional, regeneration practitioners, people from the public and private sector including built environment professionals, regeneration practitioners, people working for local/regional government and community representatives.

Taken from Inspire East's website: **www.inspire-east.org.uk**

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98   This should build on the World Health Organisation Declaration on Transport, Environment and Health which commits governments to promote health in transport policies and was signed in June 1999.

99   Carrying out a health impact assessment of a transport policy: Guidance from the Transport and Health Study Group, Faculty of Health Medicine.

100   Defined as travel modes that involve physical activity.

101   There are close links between Strategic Priority 1 and Strategic Priority 9 (To understand and plan for the impacts of climate change and the more sustainable use of resources within the Region in terms of health and health inequalities issues).

102   Strategic Priority 9 focuses on climate change and the more sustainable use of resources; it is discussed in Chapter 8.

103   Reuniting Health and Planning: A Training Needs Analysis Report by Ben Cave Associates, Common Cause Consulting and InteREAM for ODPM and partners, May 2005.

Designing Health into Sustainable Communities – Cambridgeshire Horizons

The Cambridge Sub-Region has been identified by Government in the Sustainable Communities Plan as part of one of the four Growth Areas across the greater south east. Cambridgeshire Horizons is the local delivery vehicle (LDV) responsible for implementing the Structure Plan targets and sustainability standards for the Cambridge Sub-Region, including 47,500 new homes and 50,000 new jobs by 2016.

Within this context, Cambridgeshire Horizons is actively seeking to design health into sustainable communities. It has set up a Health Forum, the members of which are drawn from PCTs, the Strategic Health Authority, NHS Trusts and Local Authorities within the Cambridge Sub-Region. The Forum nominates a representative to sit on the overall Board of Cambridgeshire Horizons.

The purpose of the Forum is to ensure that healthcare organisations can inform and influence infrastructure development in the Cambridge sub-region in order to build health-promoting communities; and ensure appropriate health care infrastructure provision linked to new developments; and influence the planning and provision of other services, and the design of developments, to create healthy sustainable communities.

Within this context, the Forum is seeking to liaise with LSPs and other local agencies and organisations; identify health forecasting and planning work needs; and ensure health sector engagement with the planning processes linked to new developments.

Work undertaken by the Forum to date includes developing an approach to Health Impact Assessments (through which there has been a close dialogue with local authority planning officers) and work on the site specific requirements of the new settlement at Northstowe, including designing in infrastructure for health.

Case study provided by Cambridgeshire Horizons.

Sustainable transport and health – Travelchoice, Peterborough

In 2004, the Department for Transport (DfT) named Peterborough as one of three Sustainable Travel Demonstration Towns across England. Prior to this, sustainable travel played a role in the City Council's transport policy, however the £3.24 million funding associated with the award has allowed for a rapid extension in the provision of marketing materials and information including: improved public transport information, the development of an improved website, and mapping including walking, cycling and bus routes.

Locally branded as Travelchoice, the project aims to increase sustainable travel; walking, cycling, public transport and car sharing. Travelchoice in Peterborough is developing an integrated set of measures which are directed at changing travel behaviour among specific groups (such as school children and commuters) through better travel information and promotion of sustainable modes.

The project is made up of 18 schemes that are designed to produce a modal shift from the private car and promote healthier and more active forms of transport. These schemes include individualised travel marketing (packages of information tailored to individual household need and preference), travel behaviour research, walking and cycling reviews, route branding, business travel plans, real time passenger information and a car sharing website. In addition, there are a number of innovative projects being developed (e.g. text and go SMS service, a good going pledge card, and cycle revolution events).

Peterborough hosted the DfT Sustainable Towns Conference on the 5th April 2006. This conference, titled: **Getting active…getting there – making the links between transport and health**, covered areas such as forging partnerships to deliver healthier transport solutions and overcoming the barriers associated with achieving sustainable travel habits.

Case Study provided by Travelchoice, Peterborough City Council.

Strategic Priority 1: To ensure that the social, economic and environmental foundations of healthy lifestyles are designed creatively into new and existing communities in the East of England

Action Area	Actions	Milestones
Incorporating health considerations into Local Development Frameworks (LDFs)	1-1: Produce guidance to ensure that planning processes have full regard to the promotion of population health and the reduction of health inequalities in the East of England	• Task-and-finish group established • Draft guidance prepared and piloted • Guidance disseminated to Local Planning Bodies
Designing and (re)building communities for health in urban and rural areas	1-2: Raise awareness of the opportunities for creating healthier communities in existing and new settlements	• Identification of good/best practice case studies • Development of mechanisms for dissemination
	1-3: Contribute to reviews of sustainable development and other toolkits to ensure that they address health issues relevant to sustainable communities	• Relevant toolkit review cycles are identified and a programme of work is developed • Health inputs are made into review processes
	1-4: Ensure that the emerging Regional Design Champions Network and the Design Review Panel are equipped to encourage good health	• Emerging Networks/Panels give full consideration to the links between design and health
Developing approaches to mobility, access and transport which are aligned with healthy sustainable communities in both rural and urban areas	1-5: Support and influence Local Transport Plans so that more consideration is given to healthy options for travel e.g. through 'Active Transport'	• Review of planned approaches in the Region • Good practice from around the Region is identified • Findings are disseminated, linking with the Physical Activity Action Plan

Timescale	Suggested lead partner(s)	Outcomes
Short-term (0-2 years)	GO-East, EERA, EEPHG	Local Development Frameworks recognise and address issues relating to health and health inequalities
Short-term (0-2 years)	Inspire East	Steps are taken to make communities healthier in existing and new settlements across the East of England
Short-term (0-2 years)	EEPHG	As sustainable development and other toolkits are revised, refreshed and developed, they include guidance and measures for creating healthier communities
Short-term (0-2 years)	Inspire East, English Heritage	High quality design processes across the Region actively embrace opportunities to improve health outcomes
Short-term (0-2 years)	GO-East, Local Transport Authorities, EEPHG	Opportunities for – and uptake of – forms of mobility that have positive health outcomes are increased

Strategic Priority 2: To provide infrastructure and sustained support to build social capital, particularly among those communities (geographical communities, communities of interest and potentially vulnerable groups) which are experiencing poor health outcomes

6.8   Chapter 4 highlighted the relationship between the health of people on the one hand and the strength of social capital on the other. In general, the social norms and networks which structure relationships and – in broad terms – constitute social capital have a strong bearing on access to resources, information and opportunities both within (bonding) and between (bridging) communities. Hence the strength of relationships within families and communities matter greatly in terms of people's health.

6.9   Evidence from the British Social Attitudes Survey series showed an increase in social capital and social trust in the early 1990s, but it also suggested that this was concentrated in the middle classes. It suggested further that increasing disparities between socio-economic groups in the quantity or nature of social capital may go some way towards explaining increasing health inequalities: evidence pointed to a statistically significant relationship between perceived low levels of social support and poor mental health, and between a lack of engagement in organised activities and the incidence of smoking.[104] Empirically therefore, social capital matters and **Healthy Futures** ought to respond.

6.10   So where – and why – is social capital potentially weak in the East of England?

- First, irrespective of location, social capital will – de facto – be weak for people who are unable to participate fully in the networks and associations through which social capital itself functions.[105] Within the East of England, the Regional Social Strategy has identified black and minority ethnic groups, people with disabilities, lone parents, older people, carers, asylum seekers, refugees and ex-offenders as especially vulnerable; and to this list, we might add some migrant workers and people who have experienced major changes in family relationships (through bereavement, divorce, etc.). For these people, social capital may be very weak and poor health outcomes may follow.

- Second, it may be that social capital is weak and being eroded in areas which are changing quickly, either in terms of their economic base or the composition of the resident population. There is evidence that local populations may feel threatened by in-movers who bring with them different lifestyles and expectations, and this may be a particular issue in more rural areas; in this context, 'bridging' social capital (i.e. that which needs to exist between different groups) may be especially important.

- Third, new settlements are likely to be quite weak in terms of social capital, simply because many of their residents will – by definition – be new to the area and the soft infrastructure that helps communities to function – in the guise of clubs, societies, and informal institutions – is likely to be embryonic. Given the nature and pace of development, this dimension of sustainable communities needs to be embraced fully: so-called 'bonding' social capital (between people within a particular community) needs to be created.[106]

104   Social Capital and Health - Health Survey for England, 2000 (Published by The Stationery Office).

105   In this context, Skills for Life – the Government's strategy for improving the nation's skills in literacy, numeracy and English for speakers of other languages (ESOL) which was published by DfES in 2001 – is important. It focuses on priority groups with the greatest literacy and numeracy needs.

106   During the Action Planning Workshops undertaken in October 2005, the point was made that people who are new to an area tend to be heavy users of health services, presumably because social capital is weak. This may have more general implications in terms of resourcing within a fast-growing region.

6.11   Against this backdrop, there is a need to provide infrastructure and sustained support to build social capital, particularly among those communities and groups which are experiencing poor health outcomes. Looking ahead, there may be opportunities to engage the private sector in this context, encouraging businesses to consider the importance of building social capital as they exercise corporate social responsibility. But there will often also be a core role for both local authorities and the voluntary and community sector, recognising – as argued in Chapter 4 – that its contribution is certainly two-fold: both the **process** of engaging in voluntary and community sector activity and the **product** of that endeavour make a material contribution to the creation of social capital which in turn will have an important bearing on the Region's ability to achieve the Vision set out in **Healthy Futures**.[107] Beyond this, there is scope to build social capital across different generations (linking with **Theme B**).

6.12   In seeking to advance Strategic Priority 2, there are strong and clear links to the Regional Social Strategy and particularly to its eighth Strategic Objective, 'to develop social networks, community assets and promote community cohesion'. There are also important links to EEDA's IiC programme. The Actions identified in response to Strategic Priority 2 will need to be delivered in concert with initiatives of this type; the Actions are set out in the Table on page 76.

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107   This issue is also raised in the context of Strategic Priority 6 (see Chapter 7).

Support group for first generation Pakistani women over 40 – Raunak

A support group was set up in an area of Bedford that was targeted within the Social Regeneration Budget. The group was set up to support south Asian women over the age of 40 who were diagnosed as suffering from depression or who were identified as being at risk of mental health issues. Most of these women were first generation migrants and in most south Asian languages, there is no equivalent word to describe depression. However this particular group of women were targeted as there was a risk of isolation due to language barriers; some were caring for disabled/elderly spouses; and many were experiencing isolation due to children moving away from home.

The action that was taken was to set a support group called Raunak (joyous atmosphere) which was facilitated to provide a space for the women to relax, enjoy light exercise, enjoy healthy cooking and be introduced to specific health providers.

The group has helped many of the women make new friendships, participate in English for Speakers of Other Languages (ESOL) classes, eat more healthily, and take part in outdoor trips that are of mutual interest and social events.

Case Study provided by the Minority and Ethnic Network Eastern Region (MENTER).

Young people, volunteering, social capital: InterAct – Circles of Support Project

The Circles of Support project arose from a growing concern that, the fundamental needs for transition aged young people (16 -19) who have learning disabilities were not being adequately met by existing structures of support. Through in-depth discussions with the families and carers of learning disabled young people, it has been clearly identified that upon leaving special schools at the age of 16 many young people with learning disabilities become isolated in the community – yet they have the same dreams, goals and aspirations as other teenagers.

InterAct launched the Circles of Support project in June 2001 in Essex. Circles of Support enables young people with learning disabilities to take part in everyday activities, supported by peer group volunteers (aged 16-18). A Circle of Support is created for the disabled young person so that they are able to learn life skills that many of us take for granted such as money and time management skills. The Circle is led by the learning disabled young person, involves 3-4 young volunteers (usually local sixth formers) plus back up support from family and a mentor from InterAct. The circle of young people, led by the client, decides on the kind of skills they are going to gain from the activity. A trip to the cinema will help the Circles client to gain travel, time and money management skills plus develop their social interaction skills and self confidence.

Since 2001, the Circles of Support project has worked with over 150 young people in Essex, many of whom are now living independently, have some form of employment, have increased self confidence, feel part of their community and have developed long lasting friendships with their Circles volunteers.

Case study provided by InterAct.

Strategic Priority 2: To provide infrastructure and sustained support to build social capital, particularly among those communities (geographical communities, communities of interest and potentially vulnerable groups) which are experiencing poor health outcomes

Action Area	Actions	Milestones
Building social capital across the generations	2-1: Actions to better understand inter-generational relationships and their links to health outcomes	• Significance of inter-generational components of social capital and its links to determinants of health through the life course are codified • Strategic regional and sub-regional processes respond to this potential
Responding to the social determinants of health as they relate to key vulnerable groups within the Region	2-2: Identify and disseminate good and best practice in supporting the health needs of groups of people for whom exclusion from broad social networks is frequently a source of vulnerability (e.g. ex-offenders, children-as-carers, gypsies and travellers, isolated older people)	• Mechanism for effective and regular dialogue on the links between social determinants and key vulnerable groups is agreed • Expert insights are disseminated to regional and sub-regional agencies and organisations
Recognising the importance of the voluntary and community sector, and the contribution of volunteering to health and well-being	2-3: Identify the health benefits of volunteering and encourage greater participation in it to help build capacity across the voluntary and community sector, complementing Change-Up and other programmes	• Health benefits of volunteering are identified, codified and disseminated • Mechanisms for promoting volunteering are identified and used

Timescale	Suggested lead partner(s)	Outcomes
Long-term (>5 years)	Future East	The importance of nter-generational relationships is recognised (and hence supported) through regional and sub-regional strategies
Medium-term (3-5 years)	Health and Social Inclusion Panel, Observatories Social Exclusion Partnership	Agencies/organisations across the Region are able to respond better to the social determinants of poor health as they affect vulnerable and excluded groups within the population
Medium-term (3-5 years)	Future East and regional Voluntary and Community Sector (VCS) networks	The health benefits of volunteering are identified and participation in volunteering is increased

Strategic Priority 3: To make it possible for communities to 'Choose Health' positively and more easily

6.13   **Choosing Health** – the 2004 White Paper – identifies six over-arching priorities:

- Reducing the numbers of people who smoke

- Reducing obesity and improving diet and nutrition

- Increasing exercise

- Encouraging and supporting sensible drinking

- Improving sexual health

- Improving mental health.

6.14   Against this backdrop, the third Strategic Priority within the Theme of **Health in Sustainable Communities** is concerned with shaping and informing the choices that people make, recognising – as **Choosing Health** itself makes clear – that many of the decisions affecting our health are choices we make as consumers.

6.15   Consumption decisions are influenced by many factors, some of which are national or international in scope. The role of the media is, for example, substantial and there are, inevitably, limits as to what can be done at a regional scale in response.

6.16   Nevertheless, making it possible for communities to 'Choose Health' more actively and easily is a key Strategic Priority. At root, it links to the underlying determinants, and income and access are key factors: a national study found that financial problems (linked mainly to the costs of accessing transport) had restricted uptake for 23% of people seeking to use mental health services.[108] Hence building a strong economy – with opportunities for broad participation – ought to be a priority in advancing **Healthy Futures** and encouraging individuals and communities to 'Choose Health'.[109] In addition, there are clear links to the first two Strategic Priorities from **Healthy Futures**: individuals are far more likely to 'Choose Health' if their peers are doing likewise (Strategic Priority 2),[110] and, the design of settlements (Strategic Priority 1) must influence the ease with which good choices can be made.

6.17   Within this broad context, there are more immediate steps that also need to be taken. Making it possible for communities to 'Choose Health' more actively and easily means, for example, ensuring that all people who live and/or work within the East of England have **access to good and relevant information** in appropriate media. Hence in those parts of the Region which have communities of Portuguese migrant workers (for example), information in Portuguese may be needed. In addition, information must be provided in a way that is relevant and appropriate. Activities and initiatives aimed at **health promotion** and **health awareness** need to be tailored to the specific circumstances facing particular communities; for vulnerable groups within the Region, **improving health literacy**[111] must be a continuing priority. **'Making it possible for communities to 'Choose Health' more actively and easily'** also means that regional-level frameworks/action plans that have been (or are being) developed for food and health, tobacco control and physical activity must be implemented effectively.

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108   *Making the Connections: Final Report on Transport and Social Exclusion*, Report by the Social Exclusion Unit (Crown copyright), February 2003.
109   This links strongly with the Vision set out in the Regional Economic Strategy and the eight strategic goals that underpin it.
110   For example, there is a great deal of evidence that most people who smoke start smoking during their teenage years, a life stage during which the power of peer pressure is especially strong.
111   This is defined as the capacity of an individual to obtain, interpret, understand and use basic health information and services in ways which are health-enhancing.

6.18   In addition, there are real opportunities linked to the 2012 Olympics/Paralympics. In the course of London's winning pitch to the International Olympic Committee in Singapore in July 2005, the following comments were made: 'We can no longer take it for granted that young people will choose sport. Some may lack the facilities, or the coaches and role models to teach them. Others… may simply lack the desire. We are determined that a London Games will address that challenge'. For the East of England, the 2012 Olympics/Paralympics offer the prospect of greater interest in sport and physical activity – and this in itself should encourage people to 'Choose Health' positively. There is also the opportunity to capture elements of the Olympic legacy such that future generations benefit from better facilities and amenities. Third, there is the prospect of increased volunteering linked to sport which itself should contribute to building social capital and strengthening communities. Hence the 2012 Olympics/Paralympics ought to constitute a substantial and unique opportunity for the East of England in striving towards the Vision set out in **Healthy Futures**.

6.19   A series of regional-level Actions which have been identified in order to advance Strategic Priority 3 are set out in the Table overleaf.

Fifty and Beyond – Encouraging physical activity amongst older people

Organised and co-ordinated by the sports development team at Sportspace (Dacorum Sports Trust, which manages sports and leisure services for Dacorum Borough Council), the scheme provides over 50 sessions per week in community centres and village halls for easy access and to provide activities on a local level throughout the borough of Dacorum (Hertfordshire). The range of activities offered includes exercise to music; singing; yoga; swing, line, and ballroom dancing; short mat bowls and chair based exercise. There is also a comprehensive programme of rambles and health walks.

Current participation levels average 680 per week, with a 25,000 annual attendance in 2004/5. In addition to the community programme, there are also targeted activities within the borough's four sports centres. The programme operates with qualified instructors but is also reliant on approximately 70 volunteers.

Emerging from the co-ordinated programme has been the formation of a number of local self sufficient groups including 'Going Places' – which organises themed holidays including bowls holidays; 'Oasis' – Outings Shared Interests – which organises monthly guest speakers and outings; and an indoor bowls league.

The success of the programme has been reflected in the response of the local hospital's senior geriatrician who, in thanking the team for their work, commented that they are able to do more for older people than he can, recognising the programme's ability to keep people out of hospital, fit and healthy.

Case study taken from the Regional Physical Activity Framework.

Strategic Priority 3: To make it possible for communities to 'Choose Health' positively and more easily

Action Area	Actions	Milestones
Choosing Health in the East of England	3-1: Support the implementation of key plans which have been/are being developed: • Obesity framework • Tobacco control framework • Physical activity action plan • Food and health action plan	• Individual plans are completed and launched • Strategies led by organisations other than DH/NHS adopt complementary priorities and synergies are achieved
	3-2: Ensure that the build-up to the 2012 Olympics/Paralympics is used to encourage (a) increased participation in sport and physical activity amongst people of all ages (including those with disabilities); (b) increased participation in volunteering linked to sport; and (c) the full potential legacy to be captured	• Priority actions are identified in the East of England • Priority actions are delivered
Understanding the ways to help vulnerable people to 'Choose Health'	3-3: Draw together appropriate expertise and experience from within the Region concerned with improving the health of vulnerable groups and encouraging people to make positive choices for health	• Expertise and experience is assembled and disseminated e.g. through ERPHO's website
	3-4: Raise awareness of the range of available information relating to health and health inequalities issues in the East of England	• Appropriate dissemination mechanisms are identified • Appropriate health status indicators are identified consistent with an ageing population
Enhancing health literacy among vulnerable groups	3-5: Develop and disseminate training materials to improve health literacy among vulnerable groups	• A clear project plan is developed and DH funding is secured • Training materials are produced and used

Timescale	Suggested lead partner(s)	Outcomes
Short-term (0-2 years)	EEPHG, with relevant lead partners (e.g. Sport England / Regional Physical Activity Forum with regard to the physical activity action plan)	Progress is made in achieving the **Choosing Health** targets within the East of England
Long-term (>5 years)	Sport England East	Increased physical activity amongst people of all ages Increased participation in sport-related volunteering Strong Olympics/Paralympics legacy in the East of England
Medium-term (3-5 years)	ERPHO, Observatories Social Exclusion Partnership	Much better awareness Region-wide of problems and solutions
Short-term (0-2 years)	ERPHO, Observatories Social Exclusion Partnership	Organisations and agencies in the East of England are more aware of health and health inequalities issues across the Region
Short-term (0-2 years)	EEPHG	Improved health literacy among particularly vulnerable adults
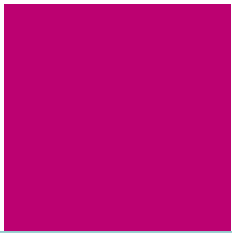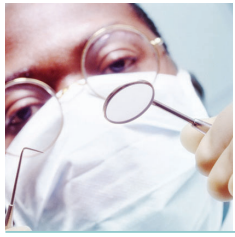
07 Theme B: Health at Key Life Stages

Chapter summary

Theme B is concerned with Health at Key Life Stages, recognising that people of different ages are facing different issues. Three Strategic Priorities are identified, together with appropriate Actions:

Strategic Priority 4: To ensure that children and young people in the East of England can get off to a healthy start in life

Strategic Priority 5: To encourage better health for people in the East of England throughout their working lives

Strategic Priority 6: To support people in the East of England in 'active ageing' and adding life to years

7.1   In order to achieve the Vision set out in **Healthy Futures**, it is important to recognise the changing demographics of the East of England (outlined in Chapter 3) and the different issues facing people of different ages within the East of England. These need to be understood and addressed if the health of the population is to be improved and the extent of health inequalities reduced. At the same time, it is essential to acknowledge the links across different stages of the life course: health outcomes in mid or later life are strongly influenced by events in childhood and even before birth.

Healthy pre-schools pilot in Cambridgeshire

Launched in March 2004, the Cambridgeshire Health Promoting Pre-School Programme (Foundation Stage) has been piloted with seven local pre school settings.

Through working with staff and members of the local community, pre-school settings chose a theme to work on over a period of two terms. Two pre-school groups chose healthy eating, two focussed on mental and emotional wellbeing, two opted for loss and change and one selected health related exercise.

As a consequence of the pre-school programme, the setting focussing on health related exercise introduced a Happy Hearts programme (which aimed to educate young children about the importance of physical activity through a range of fun activities). The setting looking at healthy eating involved parents in identifying changes that could be introduced to promote a balanced diet, replacing sweet biscuits with healthier snacks including yoghurt, dried fruit, fruit and vegetables. On the theme of mental and emotional wellbeing, one setting received some circle time and behaviour management training, provided by the Cambridgeshire Care and Education Partnership.

Nationally, the early years work in Cambridgeshire complements policies that direct the National Healthy School Programme. It contributes to four of the five criteria of ECM: being healthy, staying safe, enjoying and achieving, and making a positive contribution. It also contributes to priorities highlighted in the **Choosing Health** white paper.

An external evaluation, published in March 2005, found that the programme raises awareness about holistic health issues amongst children, staff and families, provides a vehicle to involve parents, opens up new channels of communication within the setting and beyond and maximises the work it is doing. The evaluation recommends that the pre-school programme should be extended to small cohorts of pre-schools on a rolling programme.

Case study provided by the National Healthy Schools Programme.

Strategic Priority 4: To ensure that children and young people in the East of England can get off to a healthy start in life

7.2   The wide range of issues relating to children and young people has been a strong policy focus in the UK and internationally. At a foundational level, the United Nations Charter on the Rights of the Child (UNCRC) provides an international human rights instrument setting out the basic rights of children, and the obligations of governments to fulfil those rights. A whole tranche of domestic policy has been developed from this basic premise.

7.3   In the UK, the importance of the early years for child development, the problems of multiple disadvantage for young children, the variation in the quality of services for children and families, and the need for community-based programmes of early intervention were highlighted in a key cross-government report.[112] This led to the launch of Sure Start, the aim of which was to work with parents and pre-school children to promote the physical, intellectual, social, and emotional development of young children, particularly those who are disadvantaged.

7.4   More recently, the publication in 2003 of the Green Paper **Every Child Matters: Change for Children** heralded a new inter-disciplinary approach to the well-being of children and young people from birth to the age of 19 years. The intention was that every child, whatever their background or their circumstances, should have the support they need to be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic well-being. In September 2004, the final elements of the National Service Framework (NSF) for children, young people and maternity services were launched to provide a key delivery mechanism to achieve (mainly) the 'be healthy' outcome described in ECM. The Children Act followed in November 2004, providing the legislative foundation for more effective and accessible services focused around the needs of children, young people and families. In July 2005, a Green Paper, **Youth Matters,** was published by Department for Education and Skills (DfES); this was based around the principle of integrating services around young people's needs thereby helping all teenagers – and particularly those that are disadvantaged – to achieve the five ECM outcomes to the greatest possible extent.

112   Department for Education and Employment. Sure Start: making a difference for children and families. London: DfEE, 1999.

7.5   Within this overall context – and focusing on those elements which relate most directly to health – we can cite some headline statistics for the East of England:[113]

- In 2000, 1.1% of babies born in the East of England weighed less than 1500g and 6.8% weighed less than 2500g. At a local authority district level, infant mortality rates were highest during the late 1990s in Cambridge, Luton, Fenland, Norwich and Peterborough[114]

- Some 200,000 children are estimated to be living in poverty in the East of England. Moreover, at the time of the 2001 census, over 150,000 dependent children within the Region lived in households in which no adult was working

- Issues relating to overweight and obese children have risen steadily over the recent past: in the East of England, 16% of boys and 21% of girls are overweight

- Although teenage conception rates are low in the East of England relative to the national average, UK figures are high relative to much of Western Europe.[115] Within the Region, almost half of under-18 conceptions occur in the most deprived 20% of wards. A national report by the Social Exclusion Unit suggested that the high incidence of teenage pregnancy in deprived areas is explicable in terms of young people seeing no reason not to get pregnant (in the context of low aspirations); lack of knowledge about contraception; and mixed messages from the media and from institutions (such as schools)[116]

- Some 76% of smokers in the East of England report that they started smoking between the ages of 11 and 18. In 2000, 34% of 15-year old girls and 25% of boys were found to be regular smokers

- In the East of England, the proportion of young men, aged 16-24 years, consuming more than 28 units of alcohol per week increased by 8% between 1993 and 2002. For young women aged 16-24 years, there was a 10% increase in those consuming more than 21 units of alcohol per week over this time.[117]

7.6   With regard to the long-term health prospects of the East of England, the experiences of the Region's children and young people are critical. Moreover, there are strong inter-generational elements: as the Regional Social Strategy explains, 'teenage mothers are less likely to finish their education, less likely to find a good job and more likely to end up as single parents bringing up their children in poverty. The children run a much greater risk of poor health and have a much higher chance of becoming teenage mothers themselves'. Enhancing the health of children and young people within the East of England is essential if this cycle of deprivation is to be broken, if health inequalities are to be reduced, and if the health of the Region's population is to be improved.

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113   Unless otherwise stated, data are taken from a paper on Child Health, prepared by ERPHO as an input into the development of the Regional Health Strategy.
114   East in Focus: East of England Health Profile 2001 ERPHO.
115   See http://www.nhsinherts.nhs.uk
116   Social Exclusion Unit report on Teenage Pregnancy, 1999 – cm4342.
117   Alcohol Use in the East of England (draft), October 2005, ERPHO.

7.7   The agenda with regard to children and young people is vast. In the East of England, a number of key dimensions might be highlighted, all of which have implications for the remainder of the life course:

- First, it is vital to acknowledge and respond to the number of children growing up in poverty within the Region. The numbers are substantial and there is evidence to suggest that being poor in a relatively rich area has more negative implications for health than being poor in a more generally deprived area; as one recent study put it, 'the prevalence of affluence and affluent images cause the socially excluded to suffer negative impacts upon their mental and physical health'[118] and, particularly for children and young people, this is a major issue

- Second, the issues relating to young children and their families need to be fully addressed. These include supporting families so that they are well informed, prepared and supported for birth and parenthood, and enabling children to develop so that they can meet their full emotional, social and physical potential. Within this context, it is especially important to recognise and respond to the needs of children with life-limiting conditions and their families and carers

- Third, it is imperative to recognise the roles played by schools. In this context, the National Healthy Schools Programme (which encourages a 'whole school' approach to exercise, sport, healthy eating and drinking) is an important venture. The opportunities linked to Extended Schools[119] – within the framework provided by ECM – also need to be recognised. At the same time, however, it is important to acknowledge that schools cannot be the only channel for health awareness and health promotion to children and young people; other mechanisms need to be found particularly in seeking to support those who are disengaged

- Fourth, it is important to emphasise the significance of the transition out of compulsory education. As Chapter 4 reported, rates of progression into further and higher education are low. Data from the 2001 Census show that in some districts in the East of England, the proportion of 17 year olds not in education or work is in excess of 15%. In the context of a generally buoyant economy, the transition out of compulsory education is a key one and it provides a defining moment with regard to the remainder of the life course.

7.8   Cutting across all of these dimensions, two further observations must be made. First, the crucial importance of family relationships needs to be flagged; this links strongly to the broader concept of social capital which formed the focus of Strategic Priority 2. Second, it is imperative to recognise the issues facing children and young people who may be particularly vulnerable for a host of different reasons; these may include life-limiting conditions, physical or sensory disabilities, abusive relationships, caring responsibilities (i.e. children-as-carers), discrimination (e.g. towards children and young people from Gypsy and Traveller communities). In all of these circumstances, children and young people need particular support such that the five ECM outcomes can be achieved irrespective of a child's/young person's background or circumstances; the issues facing vulnerable children and young people are reflected in Standards 6-10 of the National Service Framework (NSF).

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118   Health and Social Care and Sustainable Development in the East of England Report completed by the Centre for Public Services and the Nuffield Institute for Health, for the East of England Public Health Group, January 2004.
119   A package of support and funding for schools extending their services was launched in June 2005.

7.9 Taken as a whole, the NSF for children, young people and maternity services is the key delivery mechanism for the 'be healthy' outcome of ECM and within this context, PCTs and local authorities are playing key roles. In parallel, Local Area Agreements – which are being developed across much of the East of England – will also be contributing to the achievement of the ECM outcomes.

7.10 Through **Healthy Futures**, the intention is to influence and support these on-going processes and to do so in a way that addresses key regional issues and opportunities. In addition, there is a commitment to align regional processes such that they might contribute more effectively the pursuit of all five ECM outcomes. To these ends, a number of regional level Actions have been identified. These are set out in the table overleaf.

Strategic Priority 4: To ensure that children and young people in the East of England can get off to a healthy start in life

Action Area	Actions	Milestones
Ensuring that the voice of children and young people is heard and that the rights of children and young people are fully recognised	4-1: Led by the Regional Assembly, key regional agencies/organisations adopt the United Nations Convention on the Rights of the Child (UNCRC)	• EERA signs up to the UNCRC • Key regional agencies actively consider signing up to the UNCRC
Linking regional strategies and the health and well-being of children and young people	4-2: Ensure that regional strategies are aligned with the five key outcomes set out in ECM	• Issues relating to the health of children and young people – particularly those that are vulnerable and/or have health issues and/or disabilities – are taken into account
	4-3: Identify a clear 'children and young people's champion' on the Health and Social Inclusion Panel to promote the interests of all children and young people, particularly those who are vulnerable and/or have disabilities	• A clear 'children and young people's champion' is identified on the Health and Social Inclusion Panel
Supporting Under 5s and their families	4-4: Promote good practice in terms of the roll-out of childrens' centres, and forge connections to regional plans linked to the **Choosing Health** priorities and identified in Action 3-1 (SP3)	• Mechanisms to disseminate good practice are developed • Links to allied strategies are made
Supporting school-age children and young people	4-5: Ensure that the Healthy Schools Programme continues to respond to national targets, in a way that takes into account regional priorities	• Progress of the Healthy Schools Programme is actively monitored
	4-6: Encourage the application of principles from the Healthy Schools Programme in Further Education Colleges (FECs) and Higher Education Institutions (HEIs)	• Discussion with Association of Colleges Eastern Region (ACER) and the Association of Universities in the East of England (AUEE) takes place • Benefits of the Healthy Schools programme are captured in a form that is appropriate for FECs and HEIs

Timescale	Suggested lead partner(s)	Outcomes
Short-term (0-2 years)	EERA	The profile of children's and young people's rights is increased
Medium-term (3-5 years)	EERA	The needs of younger and future generations are recognised Contributions are made to the pursuit of the five key outcomes in ECM
Short-term (0-2 years)	EERA	Greater account of the issues relating to children and young people is taken in regional strategic processes
Medium-term (3-5 years)	GO-East	Cross-Agency links are made and progress is made in advancing regional priorities linked to **Choosing Health**
Short-term (0-2 years)	Regional Healthy Schools Coordinator, supported by DH/DfES	Principles underpinning the Healthy Schools Programme are strongly embedded
Long-term (>5 years)	ACER, AUEE, EEPHG	FECs and HEIs become learning environments that are more actively health promoting

Strategic Priority 5: To encourage better health for people in the East of England throughout their working lives

7.11   As Chapter 4 made clear, the processes surrounding work and employment provide purpose, social support, structure and a means of participating in society, as well as income.[120] People's experience of work – and workplaces – has a substantial bearing on their health. Chapter 4 highlighted the importance of structural issues concerned with the relationship between work and health including the incidence of employment in low pay sectors and the uptake of training and workforce development; the surrounding issues are addressed directly in both the Regional Social Strategy and the Regional Economic Strategy, and they are supported rather than replicated here. In **Healthy Futures**, the focus for Action is on the more immediate links between health, work and workplaces.

(i)   Vulnerable groups in the workforce, including those that are workless and experiencing poor mental health

7.12   A first key issue concerns groups which are – in some sense – vulnerable within the workforce. This includes both those who are currently in employment and those who are workless. In the East of England, the people who are prone to social exclusion are also likely to be vulnerable within the workforce. As set out in the Regional Social Strategy, this includes black and minority ethnic groups, disabled people, lone parents, older people, carers, asylum seekers, refugees and ex-offenders; all of these people are – in relative terms – more likely to find it difficult to secure employment. Some migrant workers are also vulnerable in labour market terms.

7.13   People with mental health problems comprise another vulnerable group; survey evidence – quoted in **Choosing Health** – suggests that most employers are unwilling to recruit people with any kind of mental health problem and the associated stigma for the individuals concerned is considerable.[121] Drawing on Census data, the Regional Social Strategy observes that 12.7% of the economically inactive population is sick or disabled and that these people constitute the biggest group among those who are economically inactive but want paid work. Other evidence suggests that just under half of all those classified as long-term sick or disabled are diagnosed with psychological ill health. There is, further, the suggestion that individuals (particularly men) drop out of the labour force as a result of worsening psychological health. There is no evidence that increasing numbers of school leavers enter the labour market in a poor state of health and hence, the implication is that a cause of the problem resulting in worklessness – and the vulnerability relating to it – is related to the experience of work; levels of job satisfaction relative to aspirations is one key issue.[122]

7.14   In a region with labour shortages, issues relating to the mental health of people in the workplace are a concern. Actions to improve job satisfaction – in the broadest sense – would appear to be a priority. For those that have become workless because of long-term sickness, appropriate routes back into employment should be beneficial both for the individual (in terms of their own health outcomes) and for the regional economy. In this context, the Intermediate Labour Market – which provides work, training and personal development opportunities for the long-term unemployed and economically inactive, in the charitable or not for profit sectors – may have much to offer as a bridge back into long-term employment.

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120   'The Future of Work-Life Balance' part of the ESRC 'Future of Work' Programme Seminar Series.
121   Choosing Health, DH (Crown copyright) 2004 – page 157.
122   'Work, non-work, job satisfaction and psychological health' published by HDA in March 2005.

(ii) Workplaces

7.15　The nature of workplaces impacts on the health of the people who work in them. Over the last thirty years, progress has been made in relation to safety at work but less attention has been paid to health.[123] Following the Health Bill, most workplaces ought, in the future, to be smoke-free environments.[124] However they ought, in addition, to be actively health promoting; this theme was highlighted in **Choosing Health**.

7.16　Within this context, steps could be taken by employers to promote health. Typically, larger corporations and some public sector bodies are able to provide some access to occupational health support, but for smaller companies – which are prevalent in the East of England – the challenges are significant. Nevertheless – as **Choosing Health** itself observes – there are no-cost/low-cost actions that can be taken and which ought to confer benefits on employee and employer alike. For example – although knowledge of the scheme is limited – Inland Revenue rules allow employers to help staff increase physical activity by cycling to work, including through tax-efficient bike purchase from salary. Steps are also being taken to develop a new healthy business assessment; the intention is that this should be incorporated in the Investors in People (IiP) Standard when it is next reviewed in 2007.[125] Within the East of England, there may be opportunities to work with small and micro-businesses such that more workplaces can be actively health promoting.

Supporting people with health problems returning to work – extract from an account from a customer on the Essex Pathways to Work Pilot

'I have moderate depression and severe anxiety, and although keen on the idea of working, I was very anxious just thinking about work. I was also worried about the financial implications.

Over several interviews my Jobcentre Adviser allayed all my fears, explaining that I did not have to work immediately. She helped me to look for part time work and also introduced me to a Job Broker.

When my Counsellor moved from the area I felt very isolated. My Adviser suggested that the Condition Management Programme would help me cope better with my depression and anxiety.

I found the Programme really helpful. When I was offered part-time jobs, a Work Benefit Calculation showed I would not be worse off – my Adviser also told me about all the other things available to me.

I was very nervous about starting work. But with In Work Support and continued counselling through the Programme, I am now excited at the prospect. Without the help of Pathways to Work and my adviser, I would not have considered applying for jobs. Now I'm waiting for a start date for one of the jobs and the other one is willing to wait and let me start at the same time'.

Case study provided by Jobcentre Plus.

123　A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond HSC, 2004.
124　The Health Bill – which was announced in parliament on 27th October 2005 – delivers the pledge in the Choosing Health White Paper to ban smoking in all enclosed public places apart from licensed premises that do not serve or prepare food and private members' clubs.
125　Choosing Health, DH (Crown copyright) 2004 – pages 165 and 166.

(iii) Issues relating to life-work balance

7.17   In terms of people's experience of work, there are challenges at both ends of the increasingly polarised labour market. For the 'work rich', working hours are increasing[126] and the 'long hours culture' is growing. Commuting (particularly to London) is absorbing more and more time, lifestyles are becoming more unhealthy (as people literally do not have time to prepare healthy food or take regular exercise), consumption of alcohol is increasing, and – for many – fundamental questions relating to life-work balance are being raised. **The East of England Plan for Sport** (produced by Sport England East, May 2004), for example, highlights the culture of long working days and argues that there is a need to influence work places to create a healthier and more active workforce.

(iv) Life-work transitions

7.18   Finally, consideration needs to be given to life-work transitions, including those linked to parenting, other caring responsibilities and – particularly – to the process of retirement.

7.19   Within the East of England, older workers are facing particular employment issues with adverse implications for their health. One study estimated that within the Region, around 50% of those aged between 50 and State Pension Age and not in work, would like to be working. The reasons for inactivity centred around long-term sickness (amongst men) and caring responsibilities (mainly amongst women). In terms of the latter, the greatest concentration of caring commitments among working age people is in the 50-64 age cohort; to date the focus on combining caring and work has been limited, certainly in relation to that on parenting and work, yet for older workers, this is a major issue.[127]

7.20   The fact of caring responsibilities is likely to be one reason for the observation – a report from the Performance and Innovation Unit observed that older workers are experiencing increasing stress in the workforce. Government itself has observed both the phenomenon and the consequences:

'Successive cohorts of older workers complain of increasing pressures and stress in working life. Many would welcome the opportunity to carry on working in less pressured jobs in the same organisation or elsewhere, or the chance to try something completely new. But this has rarely been on offer or culturally acceptable – for example, very few older people are working part time in organisations for which they once worked full time. Instead they face a cliff edge – the high-pressured job that they have always done, or nothing. Presented with such a 'choice', many older workers have felt compelled to retire'[128]

7.21   The transition out of employment into retirement can be a source of stress and anxiety and hence a cause of poor health. In this overall context, the attitudes of employers towards retirement are critical: a Green Paper from the Government highlighted the need to tackle barriers to flexible retirement to enable people to move from full-time to part-time work, or to less responsible positions, thus allowing them to make a more gradual transition from work to retirement.[129] In terms of the health of people in the East of England – a growing proportion of whom are of 'older working age' – these issues are important.

Action Areas and Actions linked to Strategic Priority 5

7.22   In order to advance Strategic Priority 5, six regional Actions (one of which is shared with Strategic Priority 6) have been identified. These are presented in the table on page 94.

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126   According to Regional Trends 38 (National Statistics (Crown copyright)), the average weekly hours (including overtime) for full-time male employees in the East of England are 41.4 hours per week compared to a UK average of 40.9 hours (data for 2002). Nationally, it is reported that 3.74 million workers clock up more than the 48-hour limit under the Working Time Directive. This is 423,000 more than in 1992 when there was no long hours protection (see Choosing Health: Making Healthy Choices Easier', DH, 2004 – page 161).
127   The Implications of an Ageing Population for the sustainable development of the East of England Population Associates, for EERA, July 2003.
128   Winning the Generation Game A Report by the Performance and Innovation Unit (Crown copyright), April 2000.
129   Simplicity, Security and Choice: Working and Saving for Retirement HM Treasury/DWP (Crown copyright), 2002.

Strategic Priority 5: To encourage better health for people in the East of England throughout their working lives

Action Area	Actions	Milestones
Reducing barriers to workforce participation linked to health, mental health and disabilities issues	5-1: Ensure that strategic regional level skills / business support partnerships are aware of (and promote) the links between work and health	• Meet with the Regional Skills and Competitiveness Partnership to discuss and agree a route forward • Business support / skills advisers on the ground are better equipped to recognise and address the links between work, health and disability issues
	5-2: Develop and support new and existing approaches to support people with health, mental health and disabilities issues in continuing in – or returning to – work	• Good practice resulting from the Essex Incapacity Benefit (IB) Reform Pilot (Pathways to Work) is shared and disseminated • Elements of Pathways to Work that can be tested and implemented within mainstream services elsewhere in the East of England are identified • Awareness amongst health providers of work-related support that is available to people with health issues is increased
Encouraging workplaces to contribute to people's health	5-3: Align the Health and Safety Executive's (HSE) national programmes for improving health at work to address regional issues	• HSE activity is reviewed in the light of the priorities identified in **Healthy Futures** • Steps are taken to increase levels of alignment
	5-4: Learn from the 'Health at Work' pilot and disseminate the findings to workplaces across the East of England	• Lessons from the pilot are captured • Lessons are disseminated
	5-5: Promote regional uptake of management standards for work-related stress	• Management standards for work-related stress are promoted amongst employers' groups within the East of England
Increasing flexibility in life-work transitions (Relates to both SP5 and SP6)	5-6/6-1: Support the adoption of 'age positive' and 'carer friendly' employment practices	• Identification and dissemination of good practice examples

Timescale	Suggested lead partner(s)	Outcomes
Medium-term (3-5 years)	Regional Skills and Competitiveness Partnership, EEDA	Greater awareness of the links between health, skills/training and work, particularly among regional agencies and organisations
Short-term (0-2 years)	Jobcentre Plus, SHAs	Improved rates of employment among people with health, mental health and disabilities issues
Medium-term (3-5 years)	HSE	HSE programmes are better aligned with regional priorities
Short-term (0-2 years)	Sport England/Business Link for Norfolk	More work places are actively promoting health
Short-term (0-2 years)	HSE	More employer organisations are aware of the issues linked to work-related stress
Medium-term (3-5 years)	Future East	Higher activity and employment rates, particularly among mid-life and older people, and people with caring responsibilities

Strategic Priority 6: To support people in the East of England in 'active ageing' and adding life to years

7.23   Between 1981 and 2003, the proportion of people aged 75 or over rose from 5.9% to 8% of the total in the East of England; this trend is projected to continue into the 2020s. Moreover, between 2008 and 2013, the number of people aged 65 and over is projected to overtake the number aged 16 and under in the Region. Within this overall context, the sixth Strategic Priority – identified in order to deliver the Vision of **Healthy Futures** – is concerned with 'active ageing', focusing especially on the issues facing the Region's older people.

Active ageing

7.24   'Active ageing' is defined by the World Health Organisation as 'the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age'. The concept embraces continuing participation in social, economic, cultural, spiritual and civic affairs, as well as the ability to be physically active and participate in the labour force.[130]

7.25   Active ageing is a process, not a milestone. Hence in terms of **Healthy Futures**, several Strategic Priorities have important contributions to make. There are close links with the three Strategic Priorities included within **Theme A – Health in Sustainable Communities**:

- The design of settlements (Strategic Priority 1) must have regard to the process of ageing in terms of individuals and the population as a whole

- The health and well-being of people of all ages is closely linked to all aspects of social capital (and inter-generational elements are important) (Strategic Priority 2)

- Access is a key consideration with regard to people's ability to 'Choose Health' (Strategic Priority 3) and population ageing ought to be considered in this context.

7.26   There are strong links to Strategic Priority 5, particularly in terms of life-work transitions. And health outcomes throughout the life course are influenced by events in childhood; Strategic Priority 4 is therefore also relevant.

Specific issues facing older people

7.27   Within this broad context, we must also focus on the more specific issues facing older people within the East of England, and their implications for health and well-being.

7.28   The discussion under Strategic Priority 5 highlighted the complex transition from work to retirement, and flagged the implications in terms of people's health. Against this backdrop, many older people engage in volunteering, thereby contributing greatly to the Region's life; nationally, the economic value of formal volunteering has been estimated to be £40bn per annum while the estimated value of volunteering for health and social services is around £7bn.[131] Particularly for the 'young old', the process of volunteering is also extremely important in terms of generating social capital and avoiding isolation and exclusion (see Strategic Priority 2).

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130   Active Ageing: A Policy Framework World Health Organisation (2002).
131   Taken from a factsheet to support delivery of the preventive aspects of the National Service Framework for Older People, produced by the HDA (available at www.futureeast.org.uk)

7.29   However, older people also face some quite specific challenges. Funding regimes are such that education and training opportunities may be simply unavailable and ageism in the workplace can also be a concern.[132] In addition, some 30% of pensioners (approximately 300,000 people) in the East of England live in households with below 50% mean income, after allowing for household costs; this is the second highest proportion across England. Moreover, within the Region, one third of pensioners live alone. For these people, there is an increasing risk of a lack of social cohesion, a greater likelihood of living in homes which are in disrepair and a higher risk of low income (compared to pensioner couples); lone pensioners may therefore be especially isolated and vulnerable.[133]

7.30   Across the East of England, the number of very old people (aged 85 or more) is projected to rise by 24% between 1998 and 2008; this rate of increase is faster than that for England as a whole.[134] Amongst 'older old' people, mortality from CHD and stroke is decreasing but morbidity is increasing and this in turn is placing considerable demands on health services. In addition, mental health problems are a serious concern; they are having substantial social and economic impacts on patients, their families and carers.

National Service Framework (NSF) for older people

7.31   Nationally – in response to issues of this type – the NSF for older people was published in March 2001. It sets standards across health and social services for all older people, whether they live at home, in residential care or are being looked after in hospital. The NSF includes eight Standards and it embraces plans to tackle age discrimination; ensure older people are supported by newly integrated services; address medical conditions which are particularly significant for older people (stroke, falls and mental health problems associated with older age); and promote the health and well-being of older people through co-ordinated actions across the NHS and local authorities.

Action Areas and Actions linked to Strategic Priority 6

7.32   The Actions identified within **Healthy Futures** in response to Strategic Priority 6 are intended to support the NSF for older people and the delivery processes linked to it, focusing on those issues which are especially important in the East of England. In delivery terms, this means ensuring that strategic regional and sub-regional processes are fully informed about the process of population ageing and the specific issues facing older people – and are able to respond to them. In advancing this element of **Healthy Futures**, Future East – the Regional Ageing Forum for the East of England – will have a key role to play (see Figure 7.1). Specific Actions are set out in the table on page 100.

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132   Subject to parliamentary approval, legislation to outlaw age discrimination in employment and vocational training will come into force in October 2006.
133   East in Focus: the East of England Health Profile, 2001 ERPHO.
134   East in Focus: the East of England Health Profile, 2001 ERPHO.

Town and Bridge Project: Improving health and well-being in Ipswich

The Town and Bridge (T&B) Project was developed following a report which showed that death rates amongst people under age 75 were 75% higher in Town ward and 54% higher in Bridge ward – two wards within Ipswich – than in Suffolk as a whole. Even more worryingly, death rates in these two wards increased over the 1990s, in marked contrast to a 10% decline across Ipswich. Further research revealed that the increase in death rates was due to higher rates of death amongst those aged 45-74 from heart disease, stroke, cancer and lung disease.

In response, five strands of work were identified during 2004:

- a campaign to increase the warmth of owner occupied housing and eliminate fuel poverty
- increasing the availability and accessibility of welfare benefits advice
- health promotion programmes embedded in a community development approach
- developing a Community Development Strategy
- improving street lighting in the project area

Subsequently, these different strands have been progressed. Achievements so far have included: securing £140k to improve fuel poverty within the area; the operation of a smoking cessation clinic which – during its first few months – resulted in a number of people quitting smoking; and upgrading street lighting to highways standard on the basis of £110k of 'liveability' money.

Case study provided by the Director of Public Health, Ipswich PCT.

Learning for Older People – Into IT in Norfolk

'Into IT in Norfolk' is a project run by Age Concern Norfolk in partnership with Norfolk Adult Social Services. Its purpose is to provide small grants to care homes, sheltered housing complexes and places such as day centres where older people meet regularly, to allow them to buy computers and then – with some training support – to encourage residents to use the computers.

A survey was undertaken of six venues within Norfolk which had taken part in the project. This suggested that most of the people engaging with the programme were aged 80 or more and that few had any previous experience of using computers. Following some initial training, all but three of the residents reported that they wished to continue using computers in the future in order to write letters and/or contact family and friends and/or browse the internet and/or play games. The majority of residents commented that the project had encouraged them to learn new skills. A number also commented that it had helped them to feel less isolated and/or changed their life for the better.

One gentleman from a care home, who had previously enjoyed visiting art galleries, found he was able to do this via the internet giving him back the opportunity to pursue a previous interest.

Case Study provided by Age Concern Norfolk.

Figure 7.1: Future East

Established in 2004, Future East is the Regional Ageing Forum for the East of England. The aim of Future East is to enable a strategic and joined-up approach to promoting and implementing change. The focus of the initiative is strategic, and also to provide a process to bring regional players together for action. This includes developing a mechanism for co-ordinated activity across the Region, bringing together organisations which can act to:

- 'Age-proof' all regional policy

- Increase employment and opportunity amongst the over-50s

- Develop innovative practice in service delivery, product design and infrastructure development

- Share best practice

- Help build a future which is fully inclusive across all generations

- Heighten awareness of the ageing dimension of sustainable development.

Future East will galvanise and enable member organisations to work together, acting as a dynamic platform for collaborative activity to meet the challenges of an ageing society.

Future East is supported by a strong partnership of organisations, including the East of England Regional Assembly, the EEDA and leading voluntary sector agencies.

Taken from Future East's website which may be found at **www.futureeast.org.uk**

Strategic Priority 6: To support people in the East of England in 'active ageing' and adding life to years

Action Area	Actions	Milestones
Increasing flexibility in life-work transitions (Relates to both SP5 and SP6)	5-6/6-1: Support the adoption of 'age positive' and 'carer friendly' employment practices	• Identification and dissemination of good practice examples
Accessing education and training	6-2: Improve access for older people to education and training	• Investigate the scope for bending mainstream funding for skills, education and training
Ensuring that older people can participate in all aspects of the Region's life, and that issues of isolation and access are addressed	6-3: Ensure that the health needs of older people are addressed through regional strategies, particularly those relating to isolation and access	• Relevant strategic regional and sub-regional processes are identified • Perspectives relating to the health and well-being of older people are mainstreamed within strategic processes

Timescale	Suggested lead partner(s)	Outcomes
Medium-term (3-5 years)	Future East	Higher activity and employment rates, particularly among mid-life and older people, and people with caring responsibilities
Medium-term (3-5 years)	Future East	Greater opportunities for older people to participate in education and learning
Short-term (0-2 years)	Future East, EERA	Health needs of older people are addressed and better outcomes are achieved

08 Theme C: Health in A Connected Region

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Chapter summary

The focus of Theme C is Health in a Connected Region, recognising that the East of England is facing some distinctive issues in this context. Three Strategic Priorities are identified, together with appropriate Actions:

- **Strategic Priority 7:** To recognise and respond to the practical implications of international gateways for health and health inequalities within the East of England

- **Strategic Priority 8:** To harness the East of England's international position to encourage learning, knowledge development and R&D for health

- **Strategic Priority 9:** To understand and plan for the impacts of climate change and the more sustainable use of resources within the Region, in terms of health and health inequalities issues

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8.1   The third major Theme within **Healthy Futures** is concerned with the position of the East of England globally. Three major issues – all of which were identified in the Integrated Regional Strategy – are likely to have a significant bearing on the health of the population and health inequalities. These are introduced briefly in the paragraphs which follow.

Strategic Priority 7: To recognise and respond to the practical implications of international gateways for health and health inequalities within the East of England

8.2   Our seventh Strategic Priority is concerned with the implications of increased physical movement – of both people and freight – into and out of the East of England. The Region's airports – particularly Stansted and Luton – are growing and there are expansion plans for the Haven and Thames Gateway Ports. All of this means that the East of England is increasingly globally inter-connected. This brings both pros and cons which – in seeking to improve the Region's health and reduce inequalities in health – need to be taken into account fully.

8.3   The fact of growing international gateway functions brings with it important issues with regard to health protection; substantial volumes of tobacco may, for example, be imported illegally while gateways can also provide a focus for low-cost alcohol sourced from continental Europe and further afield. More positively, the international gateways are expected to precipitate employment growth and this in turn needs to be harnessed – linking with Strategic Priority 5 – to provide better jobs for more people.

8.4   A further dimension of international gateways relates to the people entering the UK at ports and airports in the East of England. Some of these people are extremely vulnerable and it is important that appropriate health advice and support is provided.

8.5   Within the East of England there are currently around 600 dispersed asylum seekers, the majority of whom come from one of five countries (Turkey, Iran, Iraq, Eritrea and Sudan).[135] These people enter the UK seeking sanctuary because of persecution at home and they officially become refugees once their case has been investigated and it is proven that their fear of persecution is well-founded. Both

135   Asylum Seekers: The Facts Published by the EERA Consortium for Asylum and Refugee Integration, July 2005.

people seeking asylum and refugees are vulnerable in health terms and accessing health care can be difficult, not least because of language and cultural issues. A health sub-group of the East of England Consortium for Asylum and Refugee Integration has been investigating the surrounding issues,[136] **Healthy Futures** must lend support to this work.

8.6   Migrant workers constitute a second important group. These are much greater in number – a recent study has estimated that there are some 50,000-80,000 migrant workers in the East of England, and this number is growing. Migrant workers enter the Region in a great variety of circumstances and hence, making generalisations is both difficult and dangerous. However a proportion are working very long hours in low paid jobs and in poor (and sometimes dangerous) working conditions; particularly for these people, access to services (including, but not restricted to, healthcare) can be an issue and this may be exacerbated by issues relating to language and culture. In pure economic terms, it has been estimated that new migrant workers to the East of England contribute revenue in the order of £360m per annum.[137] Migrant workers are an important part of the way in which the Region works, and therefore recognising and responding to issues surrounding their health and well-being needs to be a priority within **Healthy Futures**.

8.7   The table below sets out a number of regional-level Actions which have been identified in response to Strategic Priority 7; these will be advanced alongside – and in support of – the range of on-going delivery processes.

Strategic Priority 7: To recognise and respond to the practical implications of international gateways for health and health inequalities within the East of England

Action Area	Actions	Milestones
Understanding the health needs of potentially vulnerable people entering the Region	7-1: Understand better the health needs of people entering the Region through networks of good practice, information and intelligence	• Appropriate mechanisms are established to capture and disseminate information and intelligence • Good practice is identified – for example from international gateways elsewhere in the UK and internationally
Recognising the impact of illicit imports of drugs/tobacco/alcohol	7-2: Highlight the extent and impact of illicit imports on health in different parts of the Region, and support the development of appropriate Actions	• Regional intelligence is gathered together and disseminated • Implementation of regional plans relating to tobacco control and alcohol is supported

136   East of England Consortium for Asylum and Refugee Integration: End of Year Report, 2003-04.
137   Migrant Workers in the East of England Report completed by Dr Sonia McKay and Dr Andrea Winkelmann-Gleed for EEDA, June 2005.

Norfolk Tobacco Alliance

Smoke Free Norfolk is aiming to implement a Tobacco Strategy for Norfolk and at present is in the consultation phase. It is working to five strategic priorities, one of which includes action to reduce the uptake of smoking.

The main projects actively in progress include a scheme to protect young children from second hand smoke exposure and work to encourage and enable young people to give up smoking. This incorporates smoke free homes initiatives and school-based programmes. The school-based programme is working with 5 secondary schools. It aims to offer support for effective preventative education, and smoking cessation. The project has trained a number of young people's workers, and has also trained 'stop smoking advisors' in how to work specifically with young people. Each school involved in the project has run up to 7 sessions with young people to support them in their efforts to stop smoking.

Other initiatives include partnership work with trading standards and HM Revenue and Customs. This work is aimed at reducing under age sales, eliminating tobacco promotion and reducing illicit tobacco trade. HM Revenue and Customs is a member of the Alliance's multi-agency group and its services are highlighted at Norwich Airport and sea ports.

Case Study provided by the DH Regional Tobacco Manager.

Timescale	Suggested lead partner(s)	Outcomes
Medium-term (3-5 years)	ERPHO, EERA, EEPHG	Regional partners are more aware of the health needs of people entering the Region
Medium-term (3-5 years)	Customs and Revenue, Trading Standards	Harm reduction and health improvements

Strategic Priority 8: To harness the East of England's international position to encourage learning, knowledge development and R&D for health

8.8   The East of England has substantial knowledge-based assets. Our proximity to the rest of Europe – and indeed further afield – ought to provide a basis for wider engagement and learning. And potentially, this could bring important health benefits to the Region. As a long-term priority within **Healthy Futures**, links of this nature ought to be harnessed.

8.9   One dimension concerns the health of people in the East of England in relation to international comparators. When considered on an international stage, the health of people in this Region is quite poor; health outcomes in parts of Scandinavia, for example, appear to be much better. There are data challenges linked to making robust assessments, both in terms of the units for data collection and the manner in which data are gathered. Hence statistical 'proof' is hard to come by. This should not however prevent the Region learning from elsewhere, particularly from areas that are comparable in socio-economic terms.

Strategic Priority 8: To harness the East of England's international position to encourage learning, knowledge development and R&D for health

Action Area	Actions	Milestones
Harnessing opportunities provided by the EU	8-1: Ensure that routine health data are published alongside European comparator information where this is available and appropriate	• ERPHO's work on EU comparators continues • The findings are disseminated to regional partners
	8-2: Explore opportunities to participate in health-related EU programmes linked to the pursuit of **Healthy Futures**	• Relevant programmes are identified • Regional agencies/organisations are encouraged to participate
Generating evidence-based policies and practice	8-3: Improve networking across public health research in the East of England to ensure that the research needs of the Region are met more efficiently	• Scoping meeting is completed, focusing on the priorities identified in **Healthy Futures** • Appropriate actions are identified
	8-4: Maximise the benefits of health-related research in the Region	• Scope of health-related research is better understood • Linkages are made more strongly to the benefit of the Region

8.10   Improving knowledge with regard to the Region's health also needs to have internal dimensions. Currently research into public health occurs in pockets across the Region: some is sponsored by the DH and occurs within NHS structures whilst other research takes place within universities and research institutes. More could be done to improve dialogue across these different domains and to ensure that the research needs of the Region – including those identified within **Healthy Futures** – are better aligned with the research activity that is taking place.

8.11   Finally, it is important to acknowledge the extent of health-related R&D that is taking place within the Region's research institutes, universities and some of its businesses. Much of this research is world class and its impacts – in terms of pharmaceuticals, medical devices and healthcare systems – will be seen worldwide. Although links to the health of people in the Region are indirect, population health (in the East of England and elsewhere) ought to be improved as a result of these specialisms and **Healthy Futures** needs to acknowledge and encourage them. Continuing support ought therefore to be given to Health Enterprise East and the various existing/planned Enterprise Hubs with links to health-related research.

8.12   A number of Actions which are linked to harnessing the Region's international position to encourage learning, knowledge development and R&D for health are set out in the table below.

Timescale	Suggested lead partner(s)	Outcomes
Medium-term (3-5 years)	ERPHO, EEPHG	Different agencies have a common view about how the Region's health compares with elsewhere in order to inform strategies for public health
Short-term (0-2 years)	EEPHG, Observatories Social Exclusion Partnership	Improved participation in EU programmes that contribute to public health practice and/or R&D strengths
Medium-term (3-5 years)	Academic Public Health Forum	Research in public health is better aligned to the priorities identified within **Healthy Futures**
Medium-term (3-5 years)	EEDA	Regional R&D strengths are used fully, maximising their economic contribution and impact on health services and systems, and ultimately on public health

Strategic Priority 9: To understand and plan for the impacts of climate change and the more sustainable use of resources within the Region, in terms of health and health inequalities issues

8.13   As a result of climate change, summers are becoming hotter and drier, while winters are milder and wetter; the expectation is that there will be more extreme climate events (very hot days and intense downpours of rain); and sea levels will rise, increasing the risk of coastal flooding and erosion. In the East of England, the impacts of climate change may be greater than elsewhere. As a report put it, 'as well as having large low-lying areas, the Region is also sinking very slowly due to geological processes, making it vulnerable to coastal inundation as sea levels rise. Greater intensity and frequency of winter rainfall may increase the risk of flooding from rivers, while drier summers may put additional pressure on water resources'.[138]

8.14   The impacts of climate change will be profound and wide ranging. The direct impacts on the health of people in the East of England are likely to include heat-related deaths and illness, increased incidence of food poisoning, increased injuries during storm events, increased health problems caused by air pollution (particularly in urban areas) and increased incidence of skin cancer. In addition, there is evidence that flooding – which is likely to increase in frequency as a result of climate change – has adverse consequences for mental health; this includes anxious anticipation of flood events, high levels of stress during the event, and depression in the aftermath.

8.15   The process of adapting to the impacts of climate change in order to improve health and reduce inequalities in health across the East of England must be a priority for **Healthy Futures**. Some of these impacts are negative – and there are clearly major issues relating to health protection in the context, for example, of increased concerns about food safety. However there are also positive effects: warmer weather may be conducive to greater participation in physical exercise, and changed growing conditions could improve the range of fruit and vegetables produced locally while warmer winters may make fuel poverty less of an issue. In seeking to achieve the Vision set out in **Healthy Futures**, it will be imperative that the issues relating to climate change adaptation are strongly on the agenda.

8.16   Under the auspices of **Healthy Futures**, a number of regional-level Actions are proposed in order to advance Strategic Priority 9. These are set out in the table on page 110.

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138   Living with Climate Change in the East of England: Summary Report (2003) Completed by Land Use Consultants, CAG Consultants and SQW Ltd for the East of England Regional Assembly and the Sustainable Development Round Table.

Climate change, health and the work of CRed (Community Carbon Reduction Project)

Perhaps the clearest recent example in the UK of the climate's impact on health occurred during the heat wave of August 2003, when there was a 16% increase in deaths in England and Wales (figures from Eurosurveillance July 2005). As temperatures are predicted to rise significantly in the next century, it is likely that scenarios akin to this will become more frequent in the East of England.

Domestic insulation, draught-proofing and passive solar mechanisms as a means of controlling thermal comfort (retaining heat during winter and a cool environment during summer) are examples of carbon reduction and energy bill reduction activities which are affordable to pensioners and those on low incomes. Encouraging people to leave the car at home and walk and or cycle more also has obvious environmental and health benefits, especially in an era where obesity is becoming a major cause for concern and road traffic emissions are being linked to respiratory diseases.

The Community Carbon Reduction Project's (CRed) promotion and use of sustainable resources endeavours to avert the worst effects of climate change and subsequent health implications. CRed's ambition is to reduce carbon dioxide emissions in the East of England by 60% by 2025. It has designed a network of pathways to help individuals and organisations to achieve this, highlighting the importance of energy efficiency measures and awareness of the issue and offering advice upon how they can make a personal commitment to combating climate change.

One aspect of carbon reduction is the promotion of reduced vehicle usage. 'Use the car less' is CRed's pledge which is frequently highlighted as a way to reduce emissions. CRed is just as quick to point out the health benefits of using alternative forms of transport. 'Before you jump into the car ask yourself if you could walk or cycle to your location. You can improve your health and save money by leaving your car at home and walking or cycling to the local shops' see CRed Transport http://www.cred-uk.org

Case Study provided by CRed (Community Carbon Reduction Project).

Strategic Priority 9: To understand and plan for the impacts of climate change and the more sustainable use of resources within the Region, in terms of health and health inequalities issues

Action Area	Actions	Milestones
Advancing the regional sustainable development framework (RSDF)	9-1: Ensure that regional agencies/organisations' commitment to sustainable development (through sign-up to the RSDF) takes on board fully the issues and opportunities relating to population health	• Health input is provided into reviews of the regional sustainable development framework
Anticipating and planning adaptation and mitigation required for health and climate change	9-2: Develop an appropriate strategy and action plan focusing on the links between health and climate change	• Scoping discussion takes place with the Climate Change Partnership • A strategy and action plan is prepared and launched

Timescale	Suggested lead partner(s)	Outcomes
Short-term (0-2 years)	EEPHG	Health is 'mainstreamed' as part of commitments to sustainable development
Medium-term (3-5 years)	Climate Change Partnership	The potential consequences of climate change in relation to the health of people in the East of England are better understood and appropriate responses are agreed

09 Delivering Healthy Futures
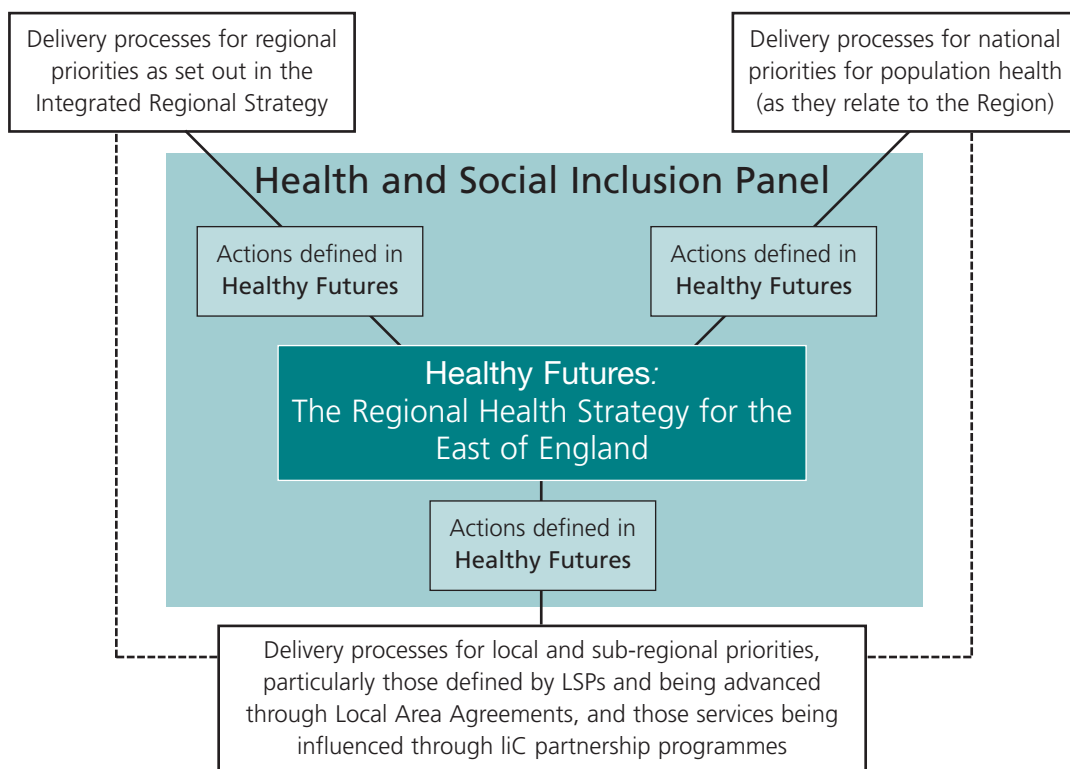
Chapter summary

The Actions identified in Chapters 6-8 will support and influence (rather than replicate or replace) three key groups of processes: it is these that will contribute substantively to the delivery of **Healthy Futures**. These delivery processes are those relating to:

- Regional priorities set out in the Integrated Regional Strategy and in other 'premier league' regional strategies

- National priorities for population health set out in **Choosing Health**

- Local and sub-regional priorities, particularly those defined by the LSPs and being advanced – across much of the Region – through Local Area Agreements, and those services being influenced by IiC partnership programmes.

Progress on delivering the Actions identified in **Healthy Futures** – and on achieving the overall Vision – will be reviewed regularly by EERA's Health and Social Inclusion Panel.

9.1   **Healthy Futures** has been developed from the premise that the health of people in the East of England is – literally – 'everyone's business'. Delivering **Healthy Futures** will therefore be a shared responsibility. The hope is that the wide range of partner organisations and agencies that have contributed to the development of this Strategy will be influenced by **Healthy Futures** in preparing their own corporate plans and making decisions about resource allocation.

9.2   Beyond this, the delivery of **Healthy Futures** will be ensconced within three groups of delivery processes (which are explained below). The intention is that these should be facilitated and supported by the Actions identified in this document. Progress in delivering these Actions will be overseen by the EERA's Health and Social Inclusion Panel. These different elements – and the relationships between them – are illustrated in Figure 9.1(overleaf) and described in the paragraphs that follow.

Figure 9.1: Delivering Healthy Futures


```
┌─────────────────────────────┐                    ┌─────────────────────────────┐
│ Delivery processes for      │                    │ Delivery processes for      │
│ regional priorities as set  │                    │ national priorities for     │
│ out in the Integrated       │                    │ population health (as they  │
│ Regional Strategy           │                    │ relate to the Region)       │
└─────────────────────────────┘                    └─────────────────────────────┘

        Health and Social Inclusion Panel

    ┌──────────────────┐          ┌──────────────────┐
    │ Actions defined  │          │ Actions defined  │
    │ in Healthy       │          │ in Healthy       │
    │ Futures          │          │ Futures          │
    └──────────────────┘          └──────────────────┘

              Healthy Futures:
      The Regional Health Strategy for the
                East of England

              ┌──────────────────┐
              │ Actions defined  │
              │ in Healthy       │
              │ Futures          │
              └──────────────────┘

┌───────────────────────────────────────────────────────┐
│ Delivery processes for local and sub-regional          │
│ priorities, particularly those defined by LSPs and     │
│ being advanced through Local Area Agreements, and      │
│ those services being influenced through liC            │
│ partnership programmes                                 │
└───────────────────────────────────────────────────────┘
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Key delivery processes

9.3   There are three key groups of delivery processes that will contribute substantively to the delivery of **Healthy Futures**. These are explained briefly below.

1)   Delivery processes relating to the Integrated Regional Strategy

9.4   **Healthy Futures** has been strongly influenced by the Vision, key outcomes and priorities set out in the Integrated Regional Strategy. Once finalised, **Healthy Futures** is one of the 'premier league' regional strategies for the East of England.[139] In advancing **Healthy Futures**, the delivery processes that are emerging for the Integrated Regional Strategy will play a role. A Regional Partnership Group has been formed to oversee the delivery of the Integrated Regional Strategy, providing a key interface between Central Government and regional agencies and organisations, and – more specifically – signing off regional advice to Government on the prioritisation of available resources. It will be important that the Regional Partnership Group – and any other regional delivery groups that are subsequently formed – take into account fully the priorities set out in **Healthy Futures** (alongside those included in other premier league strategies).

9.5   It will also be important that the bodies which are overseeing the delivery of other premier league strategies take note of **Healthy Futures** – both through the lens of the Integrated Regional Strategy and directly. As Figure 9.2 attempts to summarise, there is a strong level of read-across and significant complementarity. Hence the Regional Planning Panel (guardian of the **East of England Plan**) ought, for example, to be informed by the priorities set out in **Healthy Futures**, just as the Health and Social Inclusion Panel needs to be actively influenced by – and influencing – the priorities in the **East of England Plan**.

139   The other premier league regional strategies are shown in Figure 9.2.

Figure 9.2: Read-across between existing 'premier league' regional strategies and the Strategic Priorities identified in Healthy Futures[140]

Strategy	Regional Economic Strategy	Regional Spatial Strategy	Regional Social Strategy	Regional Environment Strategy	Regional Cultural Strategy	Regional Housing Strategy	Regional Sustainable Development Framework
Date published	2004	2004	2004	2003	2001	2005	2001
Theme A: Health in Sustainable Communities							
SP1: To ensure that the social, economic and environmental foundations of healthy lifestyles are designed creatively into new and existing communities in the East of England	✓	✓✓	✓✓	✓✓	✓	✓✓	✓
SP2: To provide infrastructure and sustained support to build social capital, particularly among those communities (geographical communities, communities of interest and potentially vulnerable groups) which are experiencing poor health outcomes	✓	✓	✓✓		✓	✓	✓
SP3: To make it possible for communities to 'Choose Health' positively and more easily			✓	✓	✓		✓
Theme B: Health at Key Life Stages							
SP4: To ensure that children and young people in the East of England can get off to a healthy start in life			✓✓		✓	✓	
SP5: To encourage better health for people in the East of England throughout their working lives	✓✓		✓✓		✓	✓	

140   The Table shows where priorities already identified in existing premier league strategies map onto those that have now been defined in **Healthy Futures**. The strength of the fit is shown by the number of ticks.

Strategy	Regional Economic Strategy	Regional Spatial Strategy	Regional Social Strategy	Regional Environment Strategy	Regional Cultural Strategy	Regional Housing Strategy	Regional Sustainable Development Framework
Date published	**2004**	**2004**	**2004**	**2003**	**2001**	**2005**	**2001**
SP6: To support people in the East of England in 'active ageing' and adding life to years			✓✓		✓	✓	
Theme C: Health in a Connected Region							
SP7: To recognise and respond to the practical implications of international gateways for health and health inequalities within the East of England	✓	✓	✓	✓			
SP8: To harness the East of England's international position to encourage learning, knowledge development and R&D for health	✓✓						
SP9: To understand and plan for the impacts of climate change and the more sustainable use of resources within the Region, in terms of health and health inequalities issues	✓	✓		✓✓			✓✓

2) Delivery processes relating to national priorities for population health (as they relate to the East of England)

9.6   **Healthy Futures** has been informed by the priorities set out in **Choosing Health** and its supporting documents. In the East of England, a number of multi-Agency **Choosing Health** delivery groups are in the process of being formed and the expectation is that these will be steered strongly in their work by the regional priorities set out in **Healthy Futures**, thereby contributing in important ways to its delivery.

9.7   Beyond this, there is also the question of the relationship between **Healthy Futures** and the NHS. Given current uncertainties regarding future NHS organisational structures, it is impossible to be definitive. However we will maximise the benefits from any future changes in NHS organisation. Our hope is that **Healthy Futures** will be seen to provide a medium-term statement of health issues in the East of England against which priorities for elements of public health and health service delivery may subsequently be assessed.

3) Delivery processes for local and sub-regional priorities

9.8 Finally, we envisage a number of local/sub-regional delivery processes playing important roles. LSPs and emerging Local Area Agreements are one key part of the delivery process at a local scale. Local Area Agreements are being advanced across much of the Region. They are structured across four funding blocks: children and young people, safer and stronger communities, economic development and enterprise, and healthier communities and older people. All four resonate with the Themes and Strategic Priorities identified in **Healthy Futures** and the read-across is, intentionally, strong. In addition, by influencing service delivery, Investing in Communities Partnerships will also form an important element of the delivery process at a sub-regional scale.

Health and Social Inclusion Panel, and Monitoring Progress

9.9 The East of England Regional Assembly's Health and Social Inclusion Panel will contribute to the delivery of **Healthy Futures** through its advocacy and influencing roles. It will be important that clear mechanisms are used to communicate with local and sub-regional partnerships. In seeking to disseminate the Strategy, it may want to consider producing a children-friendly version that can communicate effectively with children and their families.

9.10 The Health and Social Inclusion Panel will monitor progress with regard to the delivery of the Strategy. Monitoring will take place at two levels:

- First, progress on the delivery of individual Actions identified in the Strategy will be reviewed on a regular basis. Given the emphasis on influencing wider delivery processes, the precise impacts of individual Actions will be difficult to isolate. However, where relevant and appropriate, the effectiveness of Actions will be assessed, primarily in order to build up a body of evidence as to how and where regional interventions can add serious value

- Second, steps will be taken to monitor the changing state of the Region's health. The Strategy will have some – but very limited – influence on the headline indicators. Nevertheless, the Health and Social Inclusion Panel will want to be assured that the Strategy – and the Actions developed within it – is aligned with changing health needs.

The proposal is that the changing state of the Region's health will be monitored through an aggregation of Community Health Profiles. Provision for these was made in **Choosing Health**: the commitment was that Profiles should be prepared by Public Health Observatories on an annual basis using a common set of indicators for each Local Authority District. The first set of profiles will be published in 2006. It should be possible to aggregate the data for individual districts to derive an overall Health Profile of the Region and then to refresh this annually. This resource will be invaluable in terms of monitoring changes in the health of people across the East of England.

9.11 Overall – and through these different mechanisms – the Health and Social Inclusion Panel will want to be assured that Actions are being delivered and that wider processes are being influenced and supported in a way that contributes to achieving the Vision set out in **Healthy Futures** – namely, improvements in health and reductions in inequalities in health across the East of England over the period to 2010 and beyond.

Annex A:
Consultation process

Consultation process

Overview

Overseen by a Health Strategy Board[141] (with delegated authority from EERA) and with officer support from a Technical Advisory Group,[142] **Healthy Futures** has been developed in an iterative and consultative manner over a period of 18 months and involving well over 200 people. The consultation draft of **Healthy Futures** was posted on EERA's website on 22nd July 2005. In amending it subsequently, serious account has been taken of the comments and insights provided in response by a wide range of stakeholders.

Key elements of the various consultation processes are summarised below: the first of these informed the development of the consultation draft while the other three have been in response to the draft Strategy.

1) Early Stakeholder Workshop and Task Groups

An early Stakeholder Workshop was held in September 2004 and was well attended. This included a plenary session and then split into three Task Groups. In line with the 'life course' approach, these focused on children, young people and their families; people of working age; and older people. Each of the Task Groups met on two further occasions and considered the nature of key regional issues relating to particular stages in the life course and the opportunities for effective regional intervention.

2) Discussions on the consultation draft of Healthy Futures

Over the summer and early autumn 2005, officers from the East of England Public Health Group met with a range of regional and sub-regional partnerships and groups to present and discuss the consultation draft of **Healthy Futures**. Meetings were held, inter alia, with: the LSP Network, the Regional Health Forum, various Local Authority Health Scrutiny Committees, the Age Concern Regional Network, NHS public health networks, the Principal Youth Officers Network, the Regional Children's Leads, Future East, the Sustainable Development Round Table, Community and Voluntary Forum: East of England (COVER), MENTER, the East of England Faiths Council, and the Board of GO-East.

3) Written responses to the consultation draft of Healthy Futures

In addition, written responses were invited on the consultation draft. By the end of October 2005, 39 responses had been received. Of these, around a third came from NHS organisations (principally PCTs and SHAs) and two-thirds from a wide array of other agencies and organisations operating at regional and sub-regional scales.

In the main, the written comments provided broad support for the draft document. Elements which were identified as needing further development included: the action plan and arrangements for delivery (particularly in relation to LSPs and Local Area Agreements), the opportunities surrounding the 2012 Olympics/Paralympics, issues relating to travel and transport, the challenges of isolation (particularly among older people) and the issues relating to working age people outside of work/employment. In amending the draft Strategy, we have attempted to take into account the full range of perspectives that were set out in the consultation responses.

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141   The Health Strategy Board was set up as a 'task and finish' group to develop the Regional Health Strategy. In terms of membership, it has comprised several Non-Executive members of EERA, the Regional Director of Public Health, the director of ERPHO, a senior officer from HDA/NICE, and officers from EERA.

142   The Technical Advisory Group has supported the Strategy's development and it has included senior officers from Jobcentre Plus, Learning and Skills Council, East of England Public Health Group, ERPHO, HDA/NICE, EEDA, EERA and GO-East.

4) Action Planning Workshops

During October 2005, five workshops were organised; these were structured around **Theme A (Health in Sustainable Communities)**, **Theme C (Health in a Connected Region)** and the three Strategic Priorities from **Theme B** (focusing, respectively, on children and young people, adults of working age, and older people). The principal purpose of the workshops was to consider and advance the draft Action Plan. However they also provided an opportunity for stakeholders to comment on **Healthy Futures** as a whole. In total, the five workshops were attended by around 70 people drawn from the voluntary and community sector, local government, NHS organisations, private sector developers, and regional and sub-regional agencies, partnerships and organisations.

A Regional Health Strategy for the **East of England**

Annex B: Links between Healthy Futures and key PSA Targets

Links between Healthy Futures and key PSA Targets

Overview

The Public Service Agreement (PSA) Framework was first introduced in 1998 and it has become a central element of the Government's strategy for delivering high quality public services; the Framework is intended to ensure that key outcomes are delivered in return for resources. The latest set of PSA Targets was published as part of the 2004 Spending Review (SR2004) and relates to the period 2005-2008[1].

Three different groups of PSA Targets have been identified as especially relevant to the delivery of **Healthy Futures**. These are:

- Key DH PSA targets, focusing especially on the Department's priorities linked to improving health, reducing inequalities in health and tackling the determinants of ill health

- 'Linked' PSA Targets which belong to other Central Government Departments but were identified in 'Delivering Choosing Health'; this was published by the DH in March 2005

- Other PSA Targets which are relevant to **Healthy Futures**, given the three Themes and the nine Strategic Priorities that have been identified.

These three groups of PSA Targets are summarised below.

A: Key DH PSA Targets (from SR2004)

1) Substantially reduce mortality rates by 2010:

- From heart disease and stroke and related diseases (by at least 40% in people under 75 with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole)

- From cancer (by at least 20% in people under 75 with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole)

- From suicide and undetermined injury (by at least 20%).

2) Reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth.

3) Tackle the underlying determinants of ill health and health inequalities by:

- Reducing adult smoking rates to 21% or less by 2010 with a reduction in prevalence among routine and manual groups to 26% or less

- Halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole. **(Joint with DfES and DCMS)**

- Reducing the under-18 conception rate by 50% as part of a broader strategy to improve sexual health. **(Joint with DfES)**

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1   See http://www.hm-treasury.gov.uk/spending_review/spend_sr04/spend_sr04_index.cfm

B:	Other PSA Targets (from SR2004) from across Government identified in 'Delivering Choosing Health: Making Healthy Choices Easier' (DH, 2005) and relevant to Healthy Futures

1) Tackle social exclusion and deliver neighbourhood renewal, working with departments to help them meet their PSA floor targets, in particular narrowing the gap in health, education, crime, worklessness, housing and liveability outcomes between the most deprived areas and the rest of England, with measurable improvement by 2010. **ODPM**

2) Reduce the number of people killed or seriously injured in Great Britain in road accidents by 40% and the number of children killed or seriously injured by 50%, by 2010 compared with the average for 1994-98, with greater reductions in disadvantaged communities. **DfT**

3) Reduce the under-18 conception rate by 50% as part of a broader strategy to improve sexual health. **DfES/DH**

4) Improve children's communication, social and emotional development so that by 2008, 50% of children reach a good level of development at the end of the Foundation Stage and reduce inequalities between the level of development achieved by children in the 20% most disadvantaged areas and the rest of England. **DfES/Sure Start Unit/DWP**

5) Narrow the gap in educational achievement between looked-after children and that of their peers, and improve their educational support and the stability of their lives so that by 2008 80% of children under 16 who have been looked after for 2.5 or more years will have been living in the same placement for at least two years, or are placed for adoption. **DfES**

6) By 2010, bring all social housing into a decent condition with most of this improvement taking place in deprived areas, and for vulnerable households in the private sector, including families with children, increase the proportion who live in homes that are in decent condition. **ODPM**

7) Eliminate fuel poverty in vulnerable households in England by 2010 in line with the Government's Fuel Strategy objective. **DTI/Defra**

8) Reduce race inequalities and build social cohesion. **Home Office**

9) Demonstrate progress on increasing the employment rate. **DWP/HMT**

10) Increase the employment rates of disadvantaged groups (lone parents, ethnic minorities, people aged 50 and over, those with the lowest qualifications and those living in the local authority wards with the poorest initial labour market position). **DWP**

11) Significantly reduce the difference between the employment rates of the disadvantaged and the overall rate. **DWP**

12) By 2008, improve health and safety outcomes in Great Britain through the progressive improvement in the control of risks in the workplace. **DWP**

13) Promote sustainable development across government and in the UK [and internationally], as measured by: the achievement of positive trends in the Government's headline indicators of sustainable development. **Defra**

14) Reduce the gap in productivity between the least well performing quartile of rural areas and the English median by 2008 demonstrating progress by 2006, and improve the accessibility of services for people in rural areas. **Defra**

15) Increase the number of adults with the skills required for employability and progression to higher levels of training through:

- Improving the basic skill levels of 2.25 million adults between the launch of Skills for Life in 2001 and 2010, with a milestone of 1.5 million in 2007[2]. **DfES**

- Reducing by at least 40% the number of adults in the UK workforce who lack NVQ 2 or equivalent qualifications by 2010. Working towards this, 1 million adults in the workforce to achieve level 2 between 2003 and 2006. **DfES**

16) Improve air quality by meeting the Air Quality Strategy targets for carbon monoxide, lead, nitrogen dioxide, pesticides, sulphur dioxide, benzene and 1,3 butadiene. **Defra/DfT**

17) By 2007-08 reduce the illicit market share for cigarettes to no more than 13%. **HM Revenue and Customs**

18) By 2008, increase the take-up of cultural and sporting opportunities by adults and young people aged 16 and above from priority groups by: increasing the number who participate in active sports at least 12 times a year, by 3%; and increasing the number who engage in at least 30 minutes of moderate intensity level sport at least three times a week, by 3%. **DCMS**

19) Further enhance access to culture and sport for children and give them the opportunity to develop their talents to the full and enjoy the full benefits of participation by:

- Enhancing the take-up of sporting opportunities by 5 to 16 year-olds by increasing the percentage of schoolchildren who spend a minimum of two hours each week on high-quality PE and school sport within and beyond the curriculum, from 25% in 2002 to 75% by 2006 and 85% by 2008 in England, and at least 75% in each School Sport Partnership, by 2008. **DfES/DCMS**

20) Ensure people have decent places to live by improving the quality and sustainability of local environments and neighbourhoods, reviving brown field land, and improving the quality of housing

- Leading the delivery of cleaner, safer and greener public spaces and improvement of the quality of the built environment in deprived areas and across the country, with measurable improvement by 2008. **ODPM**

21) Improve the accessibility of services for people in England's rural areas (Success criteria – mental health – access to (i) crisis services and (ii) child and adolescent mental health services)[3] **Defra**

22) Reduce crime by 15% and further in high-crime areas, by 2007-08. **Home Office**

23) Improve levels of school attendance so that by 2008, school absence is reduced by 8% compared to 2003. **DfES**

24) By 2008, 60% of those aged 16 to achieve the equivalent of 5 GCSEs at grades A* to C; and in all schools at least 20% of pupils to achieve this standard by 2004, rising to 25% by 2006 and 30% by 2008. (This target may be reviewed in the light of recommendations in the Tomlinson report). **DfES**

25) Increase the proportion of 19-year-olds who achieve at least level 2 by 3 percentage points between 2004 and 2006, and a further 2 percentage points between 2006 and 2008, and increase the proportion of young people who achieve a level 3 qualification. **DfES**

26) Reduce the proportion of young people not in education, employment or training by 2 percentage points by 2010. **DfES**

27) Reduce the use of Class A drugs and the frequent use of any illicit drugs among all young people under the age of 25, especially by the most vulnerable young people[4]. **Home Office/DfES**

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2   Amended to be consistent with SR2004 targets
3   Part of Defra PSA4
4   This was included in Delivering Choosing Health but the wording of the target itself may be consistent with SR2002 (rather than SR2004)

28) Improve children's communication, social and emotional development so that by 2008, 50% of children reach a good level of development at the end of the Foundation Stage and reduce inequalities between the level of development achieved by children in the 20% most disadvantaged areas and the rest of England. **DfES/Sure Start Unit/DWP**

29) Narrow the gap in educational achievement between looked-after children and that of their peers, and improve their educational support and the stability of their lives so that by 2008, 80% of children under 16 who have been looked after for 2.5 or more years will have been living in the same placement for at least 2 years, or are placed for adoption. **DfES**

30) As a contribution to reducing the proportion of children living in households where no one is working, by 2008:

   • Increase the stock of Ofsted-registered childcare by 10%

   • Increase the take-up of formal childcare by lower income families by 50%

   • Introduce by April 2005, a successful light touch childcare approval scheme. **Sure Start Unit/DfES/DWP**

31) Further enhance access to culture and sport for children and give them the opportunity to develop their talents to the full and enjoy the full benefits of participation by:

   • Enhancing the take-up of sporting opportunities by 5- to 16-year-olds by increasing the percentage of schoolchildren who spend a minimum of two hours each week on high-quality PE and school sport within and beyond the curriculum, from 25% in 2002 to 75% by 2006 and 85% by 2008 in England, and at least 75% in each school Sport Partnership, by 2008. **DfES/DCMS**

32) By 2008, be paying Pensioner Credit to at least 3.2 million pensioner households while maintaining a focus on the most disadvantaged by ensuring that at least 2.2 million of these households are in receipt of the Guarantee Credit. **DWP**

33) Improve working age individuals' awareness of their retirement provision such that by 2007/08, 15.4 million individuals are regularly issued a pension forecast and 60,000 successful pension traces are undertaken a year. **DWP**

34) Eliminate fuel poverty in vulnerable households in England by 2010 in line with the Government's Fuel Strategy Objective. **DTI/Defra**

C: Other PSA Targets (from SR2004) from across Government that are relevant to Healthy Futures

Note: In the main, these relate to the broader determinants of health and health inequalities which were discussed in Chapter 4

1) Make sustainable improvements in the economic performance of all English regions by 2008, and over the long-term reduce the persistent gap in growth rates between the regions, demonstrating progress by 2006. **ODPM/DTI/HM Treasury**

2) By 2008, improve the effectiveness and efficiency of local government in leading and delivering services to all communities. **ODPM**

3) Achieve a better balance between housing availability and the demand for housing, including improving affordability, in all English regions while protecting valuable countryside around our towns, cities and in the green belt and the sustainability of towns and cities. **ODPM**

4) The planning system to deliver sustainable development outcomes at national, regional and local levels through efficient and high quality planning and development management processes, including through the achievement of best value standards for planning by 2008. **ODPM**

5) Improve the relative international performance of the UK research base and increase the overall innovation performance of the UK economy, making continued progress to 2008, including through effective knowledge transfer amongst universities, research institutions and business. **DTI**

6) Build an enterprise society in which small firms of all kinds thrive and achieve their potential with an increase in the number of people considering going into business; an improvement in the overall productivity of small firms; and more enterprise in disadvantaged communities. **DTI**

7) By 2008, working with other departments, bring about measurable improvements in gender equality across a range of indicators as part of the Government's objectives on equality and social inclusion. **DTI**

8) By 2008, promote ethnic diversity, co-operative employment relations and greater choice and commitment in the workplace, while maintaining a flexible labour market. **DTI**

9) Increase voluntary and community engagement, especially amongst those at risk of social exclusion. **Home Office**

10) As part of the wider objective of full employment in every region, over the three years to spring 2008, and taking account of the economic cycle, demonstrate progress on increasing the employment rate. **HM Treasury/DWP**

11) Halve the number of children in relative low income households between 1998-99 and 2010-11, on the way to eradicating child poverty by 2020. **HM Treasury/DWP**

12) By 2010, increase participation in higher education towards 50% of those aged 18-30 and also make significant progress year on year towards fair access, and bear down on rates on non-completion. **DfES**

13) By 2008, improve the productivity of the tourism, creative and leisure industries. **DCMS**

Annex C: Glossary

	Active ageing	This is defined by the World Health Organisation as 'the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age'
	Active transport	Travel modes that involve physical activity such as walking and cycling
BMI	Body Mass Index	This is calculated by dividing a person's weight (kg) by their height (m) squared. A BMI of 25-30 is considered overweight and a BMI of 30 or more is obese
CHD	Coronary Heart Disease	According to the DH, CHD is a preventable disease that preventable disease that kills more than 110,000 people in England every year. It is the biggest killer in the country
EEDA	East of England Development Agency	The Regional Development Agency for the East of England region which was set up following the 1998 Regional Development Agencies Act
EEPHG	East of England Public Health Group	The DH's regional presence, which is co-located with GO-East (the Government Office for the East of England)
EERA	East of England Regional Assembly	Voluntary partnership of elected representatives from the 54 local authorities in the East of England and appointed representatives from social, economic and environmental interests (Community Stakeholders)
ERPHO	Eastern Region Public Health Observatory	The ERPHO is part of a national network of Public Health Observatories. It was established as an NHS and DH partnership to promote better use of health-related information according to the roles set out in the Government White Paper 'Saving Lives: Our Healthier Nation' (Cm 4386, 1999)
	Fuel Poverty	The UK Fuel Poverty Strategy defines a fuel poor household as one that needs to spend in excess of 10% of household income on all fuel use in order to maintain a satisfactory heating regime
	Future East	Regional Ageing Forum for the East of England (see Figure 7.1)
GVA	Gross Value Added	GVA measures the contribution to the economy of each individual producer, industry or sector
	Inspire East	Inspire East is one of the Regeneration Centres of Excellence across England which was set up in the context of the wider sustainable communities agenda (see Figure 6.2)

IiC	Investing in Communities	A catalytic programme, developed by EEDA, provides a holistic approach to social inclusion, by supporting long-term strategic planning to tackle disadvantage and by encouraging the co-ordination of public sector resources and interventions to deliver agreed priorities
	Integrated Regional Strategy	A high level Strategy for the East of England which – drawing on other regional strategies – presents a Vision, high level outcomes, and priorities for the East of England
LAA	Local Area Agreement	Local Area Agreements are a new way of working to build a more flexible and responsive relationship between central government and a locality on the priority outcomes that need to be achieved at local level
LSP	Local Strategic Partnership	ODPM describes LSPs as single non-statutory, multi-agency bodies which match local authority boundaries, and aim to bring together at a local level the different parts of the public, private, community and voluntary sectors. LSPs are key to tackling deep seated, multi-faceted problems, requiring a range of responses from different bodies.
PCT	Primary Care Trust	PCTs have three main functions: improving the health of their community; developing primary care and community services; and commissioning hospital services for local people. Their performance and standards are monitored by the relevant Strategic Health Authority
PSA	Public Service Agreement	The Public Service Agreement (PSA) Framework was first introduced in 1998 and it has become a central element of the Government's strategy for delivering high quality public services; the Framework is intended to ensure that key outcomes are delivered in return for resources. The latest set of PSA Targets was published as part of the 2004 Spending Review (SR2004)
	Regional Economic Strategy	10-year Strategy developed by the East of England Development Agency (EEDA) setting out economic development priorities for the East of England
	Regional Spatial Strategy	Statutory framework for local authorities to produce more detailed development plans and local transport plans for their areas and to provide an overview of many issues that have implications across the Region

	Social Capital	Defined as 'the networks, norms, relationships, values and informal sanctions that shape the quantity and co-operative quality of a society's social interactions' see Aldridge, S and Halpern, D 'Social Capital: A Discussion Paper' (2002), Cabinet Office: PIU
SHA	Strategic Health Authority	SHAs were created in April 2002 Authority with the aim of ensuring high-quality performance in local NHS services. There were three SHAs in the East of England: Essex; Bedfordshire and Hertfordshire; and Norfolk, Suffolk and Cambridgeshire. From 1st of July 2006 there will be one SHA for the East of England
	Sure Start	Sure Start is a Government programme which aims to achieve better outcomes for children, parents and communities by: increasing the availability of childcare for all children; improving health and emotional development for young children; supporting parents as parents and in their aspirations towards employment
	Sustainable Communities plan	The Deputy Prime Minister launched **'Sustainable Communities:** Building for the Future' on 5 February 2003. The Plan sets out a long-term programme of action for delivering sustainable communities in both urban and rural areas. It aims to tackle housing supply issues in the greater south east, low demand in other parts of the country, and the quality of our public spaces

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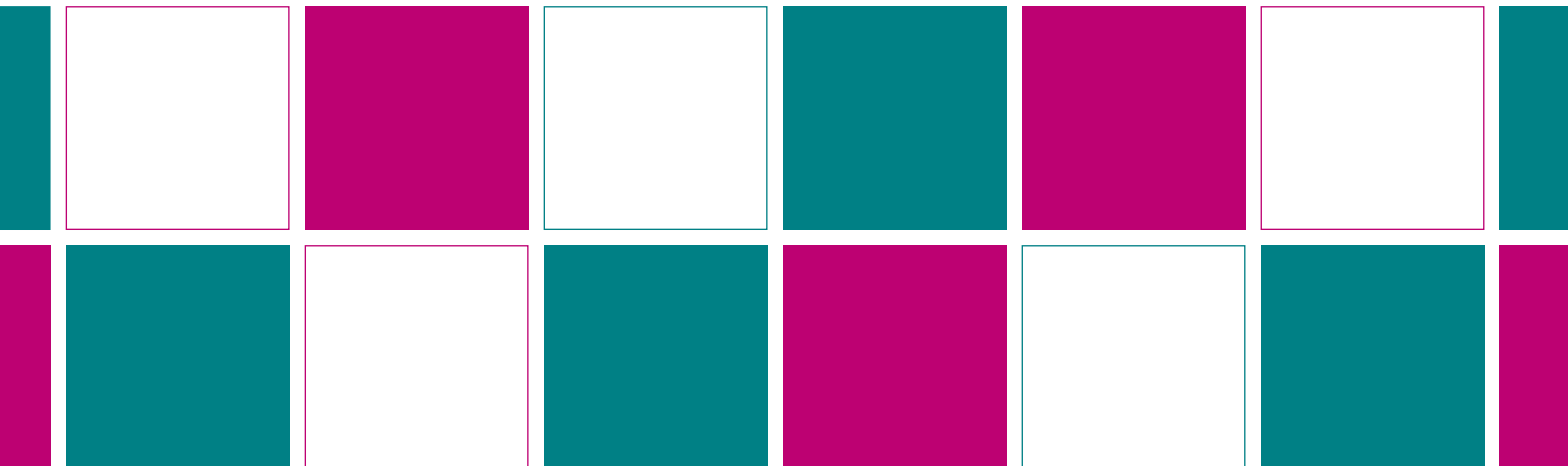
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