Cities Health Inequalities Project

Webinar series, session 1 – June 2021

Addressing Health Inequalities at Regional Level: Learning so far

Funded by:
The Health Foundation

Agenda

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- **Welcome and introductions**
- **Regional approaches to health inequalities, powers and responsibilities**
  (Phil Swann, Shared Intelligence)
- **Addressing health inequalities at regional level: learning so far** (Alice Walker and Grace Scrivens, Cities project policy team)
- **Wrap up and next steps**

To view the recording of this webinar please go to:
Cities Inequalities Project: Addressing Health Inequalities at Regional Level - YouTube

Project team

Project sponsors

- **Vicky Hobart** – Head of Health, Greater London Authority
- **Jane Pilkington** – Director of Population Health, Greater Manchester Health and Social Care Partnership
- **Jeanelle de Gruchy** – ADPH President, and Director of Population Health Tameside MBC
- **Mubasshir Ajaz** – Head of Wellbeing and Prevention, West Midlands Combined Authority

Project research team

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Project Manager and support

- **David McClory** – david.mcclory@adphlondon.org.uk

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Introduction – messages from the sponsors

Vicky Hobart, Head of Health, Greater London Authority

The Health Inequalities Project was launched in 2019 with the intent to bring together England's regional authorities to discuss and explore how devolved administrations can use their new powers to help accelerate action in tackling health inequalities.

This webinar celebrates the relaunch of this project following a hiatus from the pandemic.

The project aims to draw out our understanding of health inequalities both pre- and post-pandemic; exploring what we have learnt throughout the Covid pandemic, how devolved regions are working with their political and community driven mandates to address health inequalities.

We aim to engage and collaborate with all devolved regions in shaping this project, harnessing the ambition and energy of the Mayors in driving health inequalities action.

Local government has long had sector led improvement – this is a start of the journey for regional government.

Jeanelle de Gruchy, Director of Public Health, Tameside Council, Chair of Greater Manchester Directors of Public Health and ADPH President

We know Covid has shone a light on inequalities in our communities. It has exacerbated those inequalities, created new inequalities and impacted the most vulnerable.

We've had conversations about health and wealth, about the economies that makes people more vulnerable and how these effect the resilience and vulnerabilities of our communities. Covid has brought these questions to the fore, especially for cities. What can we learn from each other and challenge each other on?

Greater Manchester has just had the Marmot reports and an Equalities Commission report and a Mayor elected on a new manifesto. How do we priorities what we focus our efforts on?

It's the multi-disciplinary nature of the challenge we face. This has been especially important for Covid but is applicable to all health inequalities. How do we learn from each other so we can approach health inequalities better?

Mubasshir Ajaz, Head of Wellbeing and Prevention, West Midlands Combined Authority

Covid has had a huge role in shaping West Midlands response to health inequalities, shining a light on the Region's inequalities and what the Mayor and Combined Authority can do to tackle health inequalities.

West Midlands doesn't haven devolved powers around health or health inequalities, so this project has really helped shape the narrative around how the Combined Authority can address health inequalities. This has been especially important since health inequalities wasn't a focus of the Mayor or even his opposition prior to the pandemic. Now we are in a position to build the story working with our local Directors of Public Health in the Region and identifying the pockets where the combined authority can add value.

This project has been valuable to us in the West Midlands especially in learning from other Combined Authorities and wanting to share our learning with other regions.

Tackling health inequalities at a city region level

Highlights and learning from Shared Intelligence research

Phil Swann
Director, Shared Intelligence

SHARED INTELLIGENCE

Brief and methodology

This research was carried out in late 2018/early 2019, providing a unique snapshot of activities and thinking on Health Inequalities at a regional level right before the pandemic hit

Shared Intelligence were asked to map the action being taken by the GLA and the eight Mayoral Combined Authorities to address health inequalities in their regions

Two research phases:

1. Interviews with stakeholders in all nine areas
2. More in depth discussions in London, Greater Manchester, Sheffield City Region and the West Midlands

The GLA and Mayoral CAs

- Cambridgeshire and Peterborough
- Greater Manchester
- North of the Tyne
- Tees Valley
- West Midlands
- Greater London
- Liverpool City region
- Sheffield City Region
- West of England

Since our research was completed West Yorkshire became a Mayoral CA with the first election in May 2021

Significant differences between regional authorities:

- Legislative basis and scope and extent of devolved powers and resources;
- When the authorities were established: 2000 to 2010 to 2019;
- Variations in size, scale and geographical/boundary complexity;
- The timing of the transfer of Public Health to Local Government:
  - 13 years after the creation of the GLA;
  - Before first Mayoral elections in the MCA.

A spectrum of activity

Was developed in early 2019, prior to the pandemic

More activity on Health Inequalities

Less activity on Health Inequalities

Statutory requirements on health inequalities	Health and Social Care included in devolution deal	Health Inequalities not explicit in devolution deal but action taken	Health Inequalities not explicit in devolution deal but developing programmes of activity
Greater London Authority	Greater Manchester Combined Authority	• West Midlands Combined Authority • Liverpool City Region	• North of Tyne • Sheffield City Region • West of England CA • Cambridgeshire & Peterborough CA

Our findings: key themes

History

- The GLA was established in 1999 and was given responsibility for health inequalities in 2007
- The first Combined Authority (Greater Manchester) was created in 2011 and the first CA Mayoral elections took place in 2017
- The North of the Tyne CA was created in 2018 with the Mayoral election in 2019
- Many areas had a long history of collaboration across the CA geography

Structures and boundaries

- City region governance arrangements (most sophisticated in London and Greater Manchester)
- Relationship with Public Health England
- Relationship with constituent councils and Directors of Public Health
- Coterminosity (and the absence of it)

Drivers of action

Action on health inequalities by the MCAs has been driven by one or more of the following policy imperatives:

- Poor health as a barrier to work and productivity
- Inclusive growth and public service reform
- Health and social care

Leadership

The level of interest from mayors is a significant factor

- Mayors matter
  - Their convening role
  - Their policy priorities
- System wide leadership:
  - A three legged stool: the MCA, PHE and the DsPH
  - The role of Council Leaders and Chief Executives (including those with combined council and CCG roles)

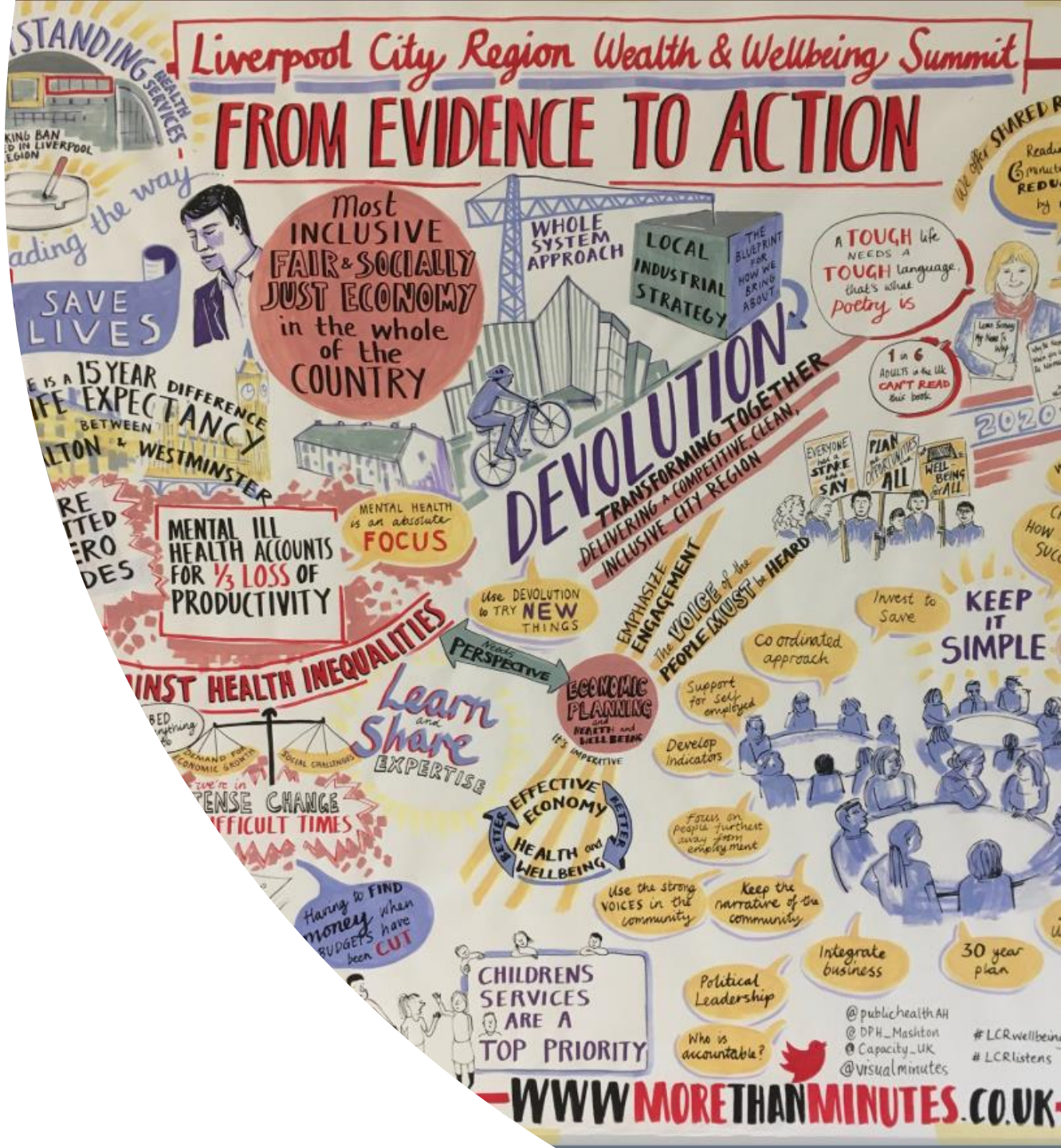
Action being taken

The GLA and MCAs are currently taking four types of action to address health inequalities:

- Developing and adopting strategies
- Convening partners and stakeholders
- Pursuing specific initiatives
- Taking health considerations into account in exercising their other powers

Reflections on tackling health inequalities at a city region level

- The remit, mandate and power of the Mayor ...and focus!
- The value of strategies as foundation and calling card
- The importance of the relationship with PHE
- The importance of the GM health and care role
- The significance of the drivers and action
- Links between action on health inequalities, responding to the climate emergency and the powers of the GLA and MCAs



Discussion and questions

We should be seeking much stronger relationships between the local authorities and the new regional health authorities. There are so many opportunities, especially around health and wealth that we can take up across all our organisations. The language may vary but the intention of what we are trying to achieve has great commonalities

Relationships with Council Leaders and the Mayor has totally transformed as a result of the pandemic, especially around having such an acute shared agenda around the health of our shared communities. This has brought about significant opportunities to initiate and shape conversations around inequalities and the role of our elected officials

The NHS focus on health inequalities and their role as a anchor institution has moved on significantly

With regards to the relationships with PHE, what was the value of that relationship that you identified and what parts of the relationship was so important?

Two things really stood out with regards to that relationship: Vicky Hobart's unique role in London as the organisational link between PHE and the GLA. This really helps to explain the depth of the relationship between *Health In All Policies* activities and Health Inequalities action. In Greater Manchester we described it as 'the three legs of the stool' created the environment for health inequalities action – The Combined Authority/Health and Social Care partnership, PHE and Directors of Public Health

On language and ownership, it's not right or reasonable for the NHS to be directing housing and environmental policy, they have enough on their plate, but they should be a part of the discussions and planning

The personal contribution of Mayors – their profile is greater now than they were when we carried out this project – how has that changed over the previous 18 months or so?

Are there any ongoing concerns or implications of the result of PHE disappearing?

The successor organisation should see the potential strength of a strong relationship with Combined Authorities, Council Leaders and Chief Executives in the area

We've never really capitalised on the collective political leadership and convening power of Mayors; there's so much opportunity around Mayors as a regional convener, using their leadership in creating unity. The pandemic has sped this up, for example mobilising and driving the vaccine rollout. There are certainly opportunities with this project in exploring and leading this. We have the Mayors' ear, we have the opportunity to help define the role the Mayor can play in regional health inequalities.

Addressing health inequalities at regional level: learning so far

Alice Walker and Grace Scrivens, Cities project policy team

Summary of work to date

- Regional approaches to health inequalities
- Appreciative Enquiry: Where are opportunities and how are we using them?
- Identifying shared challenges

How can this project support your work?

- What challenges resonate with you?
- Options for next steps

Regional approaches to Health Inequalities

Devolution context and mandate

- GM and health devolution in 2016/17
- Health Inequalities Strategy (GLA and WM)
- HI Strategy as a statutory responsibility Mayor as a Category 1 responder (GLA)

Strategic context

- Population Health Plan (GM) focussed on pump-priming transformational opportunities with a focus on early intervention and prevention (supported by cost-effectiveness analyses)
- Manifesto commitment to Health in All Policies (GLA)
- Mayors Roundtable and Wellbeing Board (WM) as mechanisms to progress action on Health Inequalities

Covid-19 recovery

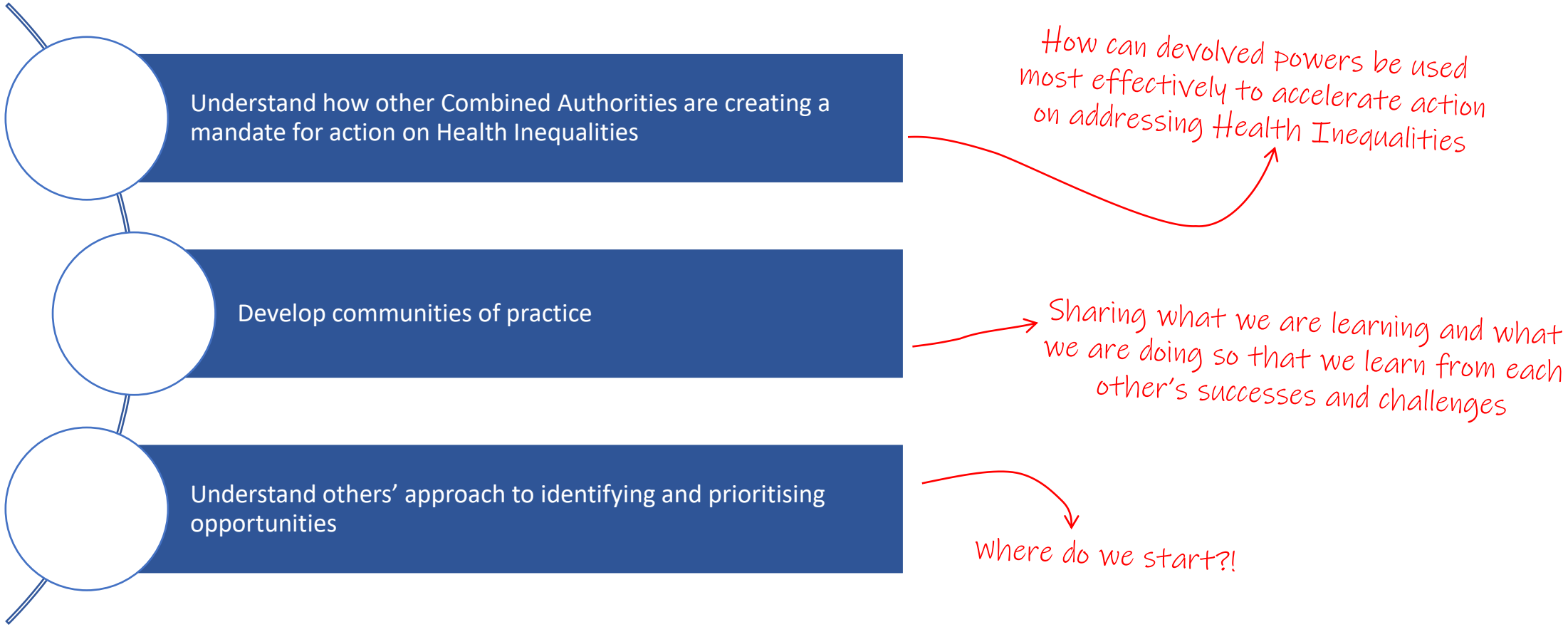
- Marmot City Region and Health Inequalities Commission (GM)
- Covid-19 and leverage into the Healthcare system (WM)
- London recovery programme (GLA)

Each sponsor region has its own unique context around **devolution**, strategic approach and covid recovery in approaching health inequalities. The project has used the Shared Intelligence policy mapping research as a foundation for ongoing project enquiries.

Strategic context to addressing Health Inequalities use a range of approaches from cost-effective analyses to galvanising transformational opportunities afforded by a specific devolution deal (such as in Greater Manchester), or utilise Mayoral and governance structures as convening mechanisms (such as in West Midlands), or focus on capitalising on devolved powers around WD (such as GLA)

Covid-19 and recovery has changed the Health Inequalities landscape for every region. In Greater Manchester this led to the commissioning of Michael Marmot and his team to produce a regional Build Back Fairer report to focus the system on an equitable recovery. In London the GLA has taken a leading role in advancing a system wide programme for Covid recovery, incorporating wider determinants in delivering and supporting health outcomes.

Sponsor perspectives on opportunities



2. Appreciative Enquiry framework

The Appreciative Enquiry framework was derived through an examination of case studies of health inequalities actions across the 3 sponsor regions (West Midlands, Greater Manchester and Greater London).

Themes were drawn from the case studies, which allowed for the creation of a set of questions that aims to bring out organisation learning on health inequalities.

This resulted in three sets of questions that were then used to conduct Appreciative Enquiry workshops in the three regional authorities with more active Health Inequalities programmes.

Where are the opportunities to address Health Inequalities at regional level, and how are we using them?

- **Identifying needs and prioritising action**
  - Public Health Intelligence
  - Strategic capacity to identify entry points
  - Responsivity to gaps in the rest of the system
- **Levers for change**
  - Devolved powers and functions
  - Political leadership and 'soft power'
  - Financial resources
- **Value-add of action at Combined Authority level**
  - Supporting collaboration and partnerships across sectors / agencies
  - Supporting work at locality level
  - Engaging residents and public mandate

Adding value to work already underway across the system

Policy leads at Combined Authority level can use the questions within the enquiry tool to draw out and reflect on learning from their own region as well as identifying opportunities for shared learning

Reflections from Appreciative Enquiry workshops

Identifying needs and prioritising action

How do we use data to effectively bring attention to what we need?

Role of CA within the regional system

- Political drivers and mandate
- Adding value to local work
- Co-terminosity and relationship to LAs, ICS
- Responsivity to gaps in the rest of the system

What do we want to prioritise? If we aren't best placed to deliver that, which partners do we need to work with?

Identifying entry points

- Strategic capacity
- Working across directorates
- Approaches for prioritisation and collaboration
- PHE restructure

What is the capacity within our organisations to spot new developments, challenges or opportunities? How do we work across departments? How do we prioritise actions in a robust way?

Public Health intelligence function

- Understanding regional needs and priorities for action
- Capturing and communicating impact of the pandemic on regional health inequalities
- Using data to drive action across system
- Strategic vs reactive function
- Performance monitoring vs accountability

Example: West Midlands CA embedded Public Health Intelligence team within Public Service Reform & Inclusive Growth Directorate and programme areas.

GM: Start Well Early Years Strategy work: school readiness was an indicator which galvanised action across sectors, regional below-England average as driver of action to close the gap / level-up

Reflections from Appreciative Enquiry workshops

Levers for Change

Leadership

- Drivers and mandate for action on HI
- Leadership without devolved powers
- Impact of pandemic
- Drivers of investment of political capital
- Navigating multiple leadership roles

Financial resources

- Investment shifting the balance between prevention and service delivery
  - **GM:** Invest-to-save thinking and transformational funding resources in Population Health Plan
- Pooling resources
- Leveraging resources for system wider work
  - **WM:** Using national funding to pilot evidence-based approaches (eg unemployment and health)

CA powers and functions

- Identifying opportunities to address HI through wider functions
  - **GLA:** Systematizing a Health in all Policies approach
- Use of policy/programmes and regulatory powers
  - **GLA:** TfL network Ad ban on junk food
- Universal proportionalism and inclusion
- Impact of new powers
- Use of data and evidence

The existing system wide childhood obesity strategy helped build momentum for the TfL network junk food ad ban.

What is the size of the prize for regional value add?

Reflections from Appreciative Enquiry workshops

Value add of CA regional approach

What is the offer of Combined Authority to the rest of the system?

How does the Combined Authority use mechanisms at their disposal to add value to work on HI in the rest of the system?

Regional convening and partnerships

- Who and how
- System bottleneck / gaps / silos
- Facilitators
- Leadership
- Structural factors
- Value

GLA: rough sleeping

How does the Combined Authority use its role as conveners to support collaboration and partnerships across sectors and agencies?

What are the facilitators, leadership and structural enablers that leads to successful partnership work?

Supporting work at locality level

- Technical support
- Innovation, piloting, data sharing
- Publicity
- Structural enabling
- Best practice
- VCFSE

GM: economy of scale for early years programme

How does the Combined Authority ensure they are adding value to the work of their localities?

Engaging residents and public mandate

- Prioritisation
- Issues
- Engagement approaches

WM:

- Framing priorities
- Measuring success
- Community decision-making

What is the value add of a Combined Authority in the regional approach to engaging residents and building the public mandate for action on Health Inequalities?

Shared Challenges

DATA AND INTELLIGENCE

- Ensuring a strategic, as well as reactive, intelligence function
- Using data to create a mandate for action at city level
- Quantifying the impact of HI policies at City level

BUILD THE MANDATE

- Issues with scope for significant HI impact, but little political appetite
- Engaging with citizens

BALANCING COLLABORATING, CONVENING AND LEADING

- Navigating multiple roles
- Adding value to work at local level

PRIORITISATION

- Existing and emerging opportunities to influence wider determinants as part of recovery

USE EXISTING NON-HEALTH POWERS

- Influence wider determinants through cross-directorate collaboration and influence
- Health in all policies

Shared challenges and learning

Shared Challenge	Examples of avenues for mutual learning
Ensuring a strategic (as well as reactive) intelligence function	**WM**: Embedded PHI team within Public Service Reform & Inclusive Growth Directorate and programme areas. Leads systematic regional analysis on HI for strategic prioritisation and identifies gaps, along with programme management support (e.g. demonstrating impact).
How to use **data to create a mandate for action** at city level How to **quantify the impact** of HI policies at City level	**GM:** Regional below-England average as driver of action to close the gap / level-up **GM:** ROI / invest to save thinking **WM**: logic models underpinning wellbeing indicator set (in development)
How to **build the mandate** for issues with scope for significant HI impact, but little political appetite	**GM:** Building a case for action around a marginalised population group at a multi-agency, system level (health and CJS collaboration) **WM**: community sentence mental health treatment – building mandate through Citizen Jury and Mental Health Commission
How to prioritise existing and emerging opportunities to influence wider determinants as part of recovery	**WM:** prioritisation Sprint work **GM:** prioritisation following Marmot City Region work **GLA**: Development of a prioritisation toolkit to map and prioritise current HIAP opportunities
How to capitalize on opportunities to influence wider determinants through cross-directorate collaboration and influence or HIAP approaches	**WM:** Cross departmental collaboration and shared measurement and accountability **GM:** Population health system work and Future Generations Thinking – focus on ROI, invest to save **GLA**: Current work to understand ways in which health in all polices approaches have been implemented in other regions, and previously in the GLA. Previous examples of how HIAP was supported (eg Healthy Streets) • Embedding PH consultants from health team into other departments (TFL, VRU, planning) to build relationships and drive action on wider determinants. • Bring initiatives together under specific strategy in order to build momentum / deploy regulatory powers for a specific high-profile issue (eg Ad ban on transport in London and Childhood Obesity strategy)
Convening and leadership: How to navigate multiple roles- convening and relationship building vs monitoring and 'holding to account'. How to highlight gaps without jeopardizing partnership relationships	
How to **add value to work of localities**	**GM:** learning from the implementation of the population health plan - collaboration with localities to build a case, test, learn, pilot, support common agendas
How to engage with citizens to build a mandate for action	**WM:** Value placed on residents framing priorities and 'what good looks like' (Citizen Jury framed 5 priorities at WMCAs creation, Citizen panel framed COVID-19 community recovery priorities, Citizen voice embedded measure in IG Framework indicators, Mayor's Roundtable brings together leaders from VCF & health system to progress HIS, Community decision-making 21/22 programme of work)

The West Midlands experience

Mubasshir Ajaz
Head of Wellbeing and Prevention
West Midlands Combined Authority

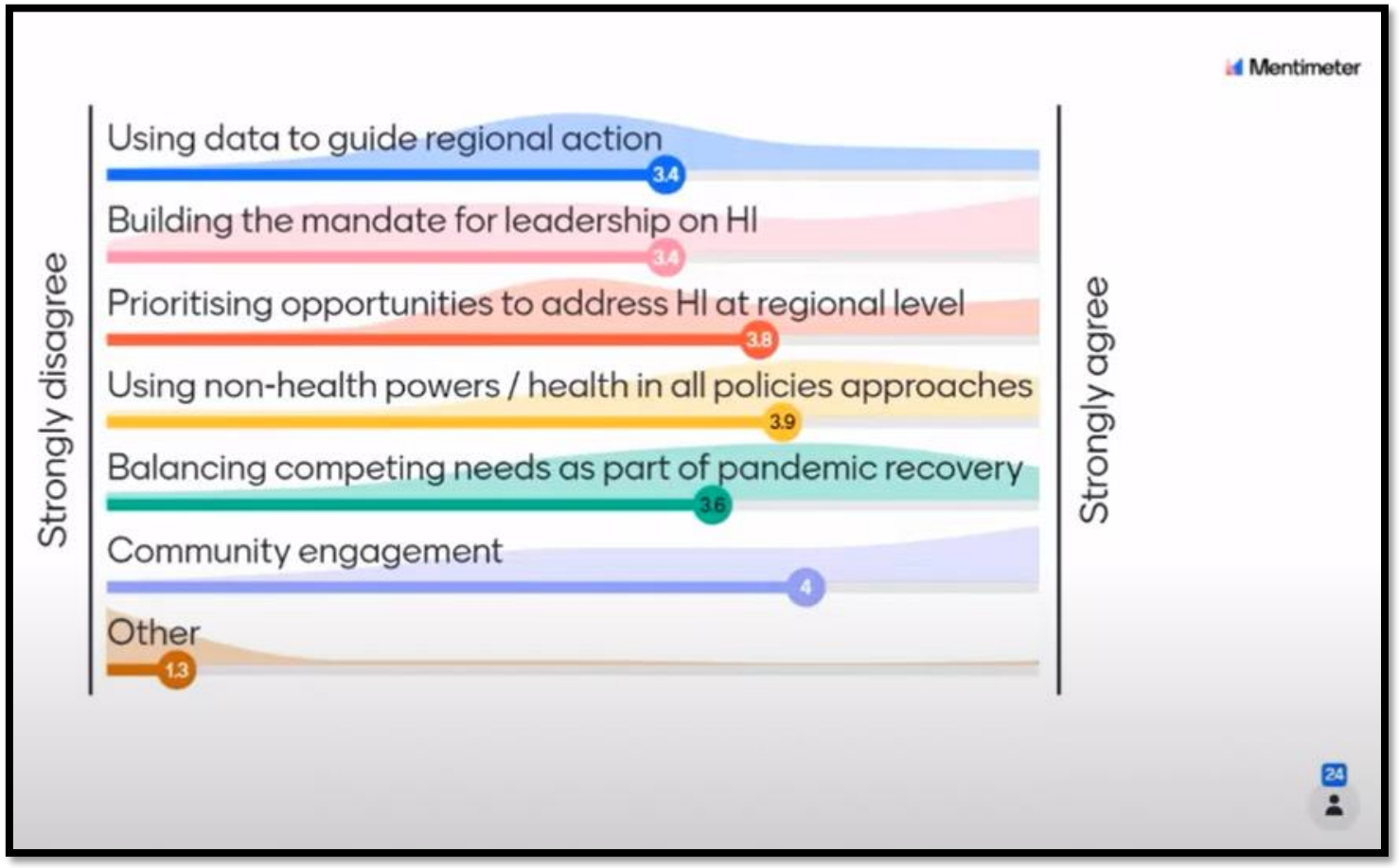
West Midlands has been a project sponsor since the start of the programme in 2019. For us, the project has been valuable especially in learning from other Combined Authorities and wanting to share our learning with other regions.

We've been fortunate to have had excellent support from Public Health England in establishing the role of the Combined Authority in the health inequalities space; this project allowed us to take that further.

Some of the outputs, especially the appreciative enquiry tools have helped to identify the gaps where the Combined Authority could step in to make a significant contribution. This is through working with our internal colleagues to understand the difference we can make in addressing health inequalities through the wider determinants of health.

There is a real desire and opportunity to learn from our colleagues across the country. There's huge potential in this project. We're going to keep using the appreciative enquiry gap analysis and share these with our partners in PHE and NHS, who are also taking part in this workshop, demonstrating how our partnerships have developed.

What are the challenges in addressing HI in your region?



Workshop participants were asked to vote on the top priorities for addressing health inequalities in their local region using a *mentimetre* poll.

The results of this poll were shared live as participants votes and would be used tio inform future project research and webinars over the next few months.

The results were quite consistent across the five options with the most popular 3 options being:

1. Community Engagement
2. Using non-health powers / health in all policies approaches
3. Prioritising opportunities to address health inequalities at regional level

The value of this project is its discursive opportunities between and within regions. The Health Foundation are looking to build on this work as an example tool and enabler for how we can work together in urban regions. There is lots of potential both in the remaining few months and as a legacy of this project.

Discussion and comments

Infrastructure to enable this will be important and getting the right people engaged and in the room. We are a room full of public health professionals at the moment, so are we right people to talk about this? How does this constituency talk to other constituents.

Getting the right people in the room

We need to get people into the room who are not already in the room, to see this through a different lens that we rely on to make this work

How do we bring people in who are living and experiencing this through their daily lives so we hear it and feel it through those people – how do they become engaged in our world so we have a mix of top down and bottom up perspectives?

Communities and bottom up perspectives

How do we bring in the citizen voice into what we are doing? Who is in the room is a really important conversation – using the Appreciative Enquiry workshop as a tool to bring together different directors and those wider determinants into a room to discuss this.

Capacity

We all have limited capacity in public health at the moment. If we do have to divvy up our capacity so that we can enact change and transform the way we do things, where do we put that capacity for greatest success?

Language

'When you put 'health' in front of something, we automatically start thinking about it in a certain way. How do we frame the potential solutions that help up to avoiding approaching this in a certain way and bring the right people into the room. Addressing 'inequalities in our covid recovery'

Lots of potential

Specific vs Broad

We need to be clear about where we want to land on this. Do we want a menu of specific health inequalities policies that we may want to enact or a broader scope of transforming the way we think and discuss this.

The nature of deprivation

We need to challenge the assumption that inequalities are homogenous, when we know from the Covid that this isn't the case and the nature of deprivation is different. Would it be better to work together as based on clusters of deprivation where the nature of deprivation is similar?

The 'Covid world' has brought together political power and opportunities for collaboration.

Covid-19

Once Covid is over our Mayors may not be able to work so closely together. There may not be a similar drive or ambition. Whereas Covid brought them together with a shared direction and ambition. After Covid, Mayors will have different priorities.

There's currently a common enemy for us to rally around. How do we play this out in this arena.

Activities so far and options for next steps

- Appreciative Enquiry workshops
- Conversations on shared challenges
- Mental health network
- Anything else?