



Public  
Policy  
Projects

Public Policy Institute

# Addressing the National Syndemic:

Place-based problems and  
solutions to UK health inequality

A report by Public Policy Projects  
and the Institute of Health Equity



In partnership with  NOVARTIS  Cerner

State of the Nation 2021

# About Public Policy Projects

---

*Sponsorship for this programme of work has been provided by Cerner and Novartis. Public Policy Projects and the Institute of Health Equity has retained full editorial control of the content.*

Public Policy Projects (PPP) is a global policy institute offering practical analysis and development across a range of sectors, including health and social care. The institute is independent and cross-party, and brings together public and private sector leaders, investors, policymakers and commentators with a common interest in the future of public policy. PPP Chair, Rt Hon Stephen Dorrell and Deputy Chairs, Rt Hon Amber Rudd, Rt Hon Damian Green MP, Baroness Nicola Blackwood of North Oxford and Stephen Hammond MP, lead a truly unique policy institute that offers practical analysis and actionable insight around the world. Public Policy Projects publishes annual State of the Nation and State of the Globe reports in a series of policy areas, including integrated care, social care, genomics, rare diseases, women's health, antimicrobial resistance (AMR), health inequalities, diagnostics, economics, environment and energy, connectivity and 5G wireless technology, rail infrastructure and planning. All these programmes, and their corresponding events, publications and conferences, receive contributions from sector leaders from around the world.

# About IHE

---



---

The University College London (UCL) Institute of Health Equity (IHE) was established in 2011 and is led by Professor Sir Michael Marmot. It is the leading global institute on health inequalities and the social determinants of health. Its mission is a fairer, healthier society.

The aim of the institute is to develop and support work to improve health equity in the UK and globally. The approaches it advocates build on evidence from IHE's work, including the World Health Organization (WHO) Commission on Social Determinants of Health and Fair Society Healthy Lives (The Marmot Review).<sup>1,2</sup> More recently, IHE has published The Marmot Review 10 Years On report, which reviewed health equity in England in the decade 2010-2020, and the 2020 Build Back Fairer report, which assessed the inequality impacts of the Covid-19 pandemic.<sup>3,4</sup> IHE is working with regions and local authorities in England and advising WHO and governments globally.

Since 2010 IHE has worked with WHO to conduct major reviews in Europe, the Americas and the WHO's Eastern Mediterranean Region, and has supported countries and international organisations to take action.

# About Cerner

---



---

Technology provider Cerner believes in building positive, long-term partnerships that drive value across the health and care landscape. Its intelligent platforms and services connect people, information and care at more than 27,500 facilities of all sizes in over 35 countries and help manage the health of 223 million citizens across the globe. Together with clients and industry partners, Cerner is innovating for the future, integrating entire health and care systems to enable them to deliver smarter, value-based care, better outcomes, and proactively manage and improve the wellbeing of their populations. In the UK, its powerful, open and interoperable Cerner Millennium® electronic health record (EHR) platform is used by more than 144,000 health and care professionals across 24 NHS trusts to manage 1.5 million patients every month. Cerner's Health Information Exchange (HIE) is sharing over 19 million health records, while its population health intelligence platform HealthIntent® is contracted to help clients proactively manage and improve the health of over 9.5 million individuals.

# About Novartis

---





---

Novartis is reimagining medicine to improve and extend people's lives. As a leading global medicines company, Novartis uses innovative science and digital technologies to create transformative treatments in areas of great medical need. In its quest to find new medicines, Novartis consistently ranks among the world's top companies investing in research and development (R&D). Its products reach more than 800 million people globally and Novartis is finding innovative ways to expand access to its latest treatments. About 109,000 people of nearly 1400 nationalities work at Novartis around the world.

In the UK, Novartis employs approximately 1,300 people to serve healthcare needs across the whole of the country, as well as supporting the global operations of Novartis. In 2019, Novartis spent around £169m on research and development activities and infrastructure in the UK, and is a leading industry sponsor of clinical trials.



## Foreword:

# Professor Sir Michael Marmot

Director, Institute of Health Equity

**E**ven before Covid-19, the health picture in England was of great concern. At the UCL Institute of Health Equity, we published *Health Equity in England: the Marmot Review 10 Years On*, in February 2020, just before the pandemic engulfed the country.

Our findings showed that, in the decade from 2010, improvement in life expectancy had stalled, health inequalities had increased and life expectancy had declined for people in the most deprived 10 per cent of neighbourhoods outside London. In December 2020, we then published *Build Back Fairer: the Covid-19 Marmot Review* which showed that the pandemic and the societal response to it had exposed and amplified these underlying inequalities in health.

Plausibly, the state of health before and during the pandemic is a legacy of a decade of austerity pursued by national governments. Such disinvestment in public services, coming after decades of post-industrial decline in parts of the country, can induce some despair both in the people affected and those anxious to see actions to reduce health inequalities.

For people living in the most deprived areas outside London, the problems seem deep-rooted, almost intractable. The NHS provides a high standard of care all over the country – that is not the issue. Health inequalities, in large part, arise from the conditions in which people are born, grow, live, work and age. It is these social determinants of health that seem so difficult to address, and account for much of the social and geographic inequalities in health. The problem is not ignorance of what to do. Reports on social determinants of health, including the two cited in the previous paragraph, give evidence-based recommendations.

It is vital that national governments put equity of health and well-being at the heart of all national policy. But that is not where action should start or stop. Local and regional initiatives can be vitally important. Such is the conclusion of the series of seminars hosted by the Institute of Health Equity and Public Policy Projects, which gave rise to this report.

Even in the most difficult of circumstances, local initiatives can be found across the country. It is inspiring. The participants in the seminars were committed, enthusiastic, and making important impacts. This report captures part of that enthusiasm and shows examples of what can be done to address health inequalities: by the health and care system, local and regional government, the voluntary and community sector, and business, working with individuals and communities.

Levelling up will take investment of resources by national government, but actions taken locally and regionally will be vital to achieving greater health equity.



## Foreword: Rt Hon Stephen Dorrell

Chair, Public Policy Projects'

**T**his report addresses two central truths about health policy, one relatively well known, the other less so, but neither sufficiently well recognised by public policy.

It is well known that even the best healthcare cannot close a health inequality gap if social determinants such as employment, housing, and social context are neglected. Good public health is not the same as good healthcare and healthcare divorced from wider public health policy simply treats the consequences of policy failure.

What is less well recognised is that there is now a developing body of evidence – to which this report is a significant contribution – which demonstrates that the most effective health policy interventions are undertaken within local communities, and arise as a result of collaborations between local government, local public services (including but not confined to the NHS) and other partners including the commercial and VSCE sectors.

Good public health is the result of effective community action – not the result of excessive reliance on medicine – and community action relies crucially on local leadership.

It is not that there is no role for national government; it is simply that ministerial will power is not enough. Instead, national government should engage with local communities and recognise that improving public health, and reducing health inequalities, should be an objective of all public policy. At both local and national level.

Health inequality is not inevitable – it is a choice. This report provides evidence and testimonies from people all over the UK who know how to exercise that choice against health inequality and in favour of better public health.

It is a case which Professor Sir Michael Marmot has made his own, not just in UK but in many other countries around the world and his insights inform every page of this report; PPP has been pleased to work with him in preparing it – and we shall continue to look for opportunities to work with him to put these ideas into wider operation.

# Contents

---

---

<b>1.</b>	<b>Introduction</b>	<b>14</b>
<b>2.</b>	<b>Executive summary</b>	<b>16</b>
	a. Summary of Points of Agreement	17
<b>4.</b>	<b>Local government</b>	<b>20</b>
	a. Coventry City Council – A Marmot City	
	b. Gateshead Council – Good jobs, homes, health and friends	
<b>5.</b>	<b>Public services</b>	<b>23</b>
	a. Sunderland City Council – Healthy Places	
	b. Public Health and Policing Consensus Taskforce – Public health approaches to policing	
<b>6.</b>	<b>The health sector</b>	<b>27</b>
	a. Warm and Safe Wiltshire – partnering with the health sector	
	b. Ascension Trust – Beacon Project	
<b>7.</b>	<b>The voluntary, community and social enterprise (VCSE) sector</b>	<b>34</b>
	a. One Northern Devon	
	b. Be Buckfastleigh – Community action in rural places	
<b>8.</b>	<b>The business sector</b>	<b>39</b>
	a. IHE – How businesses can Build Back Fairer in Greater Manchester	
	b. Novartis UK – Partnering to deliver a new patient-centric approach to health inequalities	
	c. Cerner – Being a better neighbour	
<b>9.</b>	<b>Community partnerships</b>	<b>48</b>
	a. The Wigan Deal – ‘Working with’ rather than ‘doing to’	
	b. Wiltshire Council – Community engagement to address vaccine hesitancy	
<b>10.</b>	<b>Conclusion</b>	<b>53</b>
<b>11.</b>	<b>Case study list</b>	<b>54</b>
<b>12.</b>	<b>Acknowledgements</b>	<b>54</b>
<b>13.</b>	<b>References</b>	<b>55</b>

# 1. Introduction

In the UK, we had become accustomed to continually improving life expectancy and a sense that healthcare would continue to treat health conditions and that the health of the nation would improve. However, recent data shows that, even before the Covid-19 pandemic, life expectancy was stalling and declining for poorer people in most regions. Successive governments have failed to address the crisis of health inequality that Covid-19 has laid bare and worsened.

This report is a summary of workshops held over the first half of 2021. The workshops consisted of stakeholders discussing how to take effective action to reduce health inequalities. The report is titled Addressing the National Syndemic. A syndemic describes “two or more diseases” that synergise to make each other worse and include societal as well as biological drivers of poor health. Discrimination and disadvantage existed long before the coronavirus, yet the pandemic has clearly exposed how both result in poor health and drive health inequalities.

Studies indicate that only roughly 20 per cent of a person’s health is dependent on the healthcare they receive. The other 80 per cent is accounted for by the social determinants of health (SDH). Indeed, WHO states that “the social conditions in which people are born, live, and work are the single most important determinant of good health or ill health, of a long and productive life, or a short and miserable one”.<sup>5</sup> Social determinants of health include experience during the early years, education, working conditions, income, housing, communities and environment, and discrimination and exclusion. As former Public Health England (PHE) Chief Executive Duncan Selbie put it, giving people “jobs, homes, and friends” will make the biggest difference to their health outcomes.<sup>6</sup>

The case for SDH has long been made in the UK and beyond due to the groundbreaking work of Professor Sir Michael Marmot and his IHE team. IHE’s latest major report, Build Back Fairer, sets out policy recommendations to reduce inequalities in social, economic and health outcomes in the context of the impacts of Covid-19.<sup>7</sup>

Accountability for SDH and for health inequality is weak, and central government has not produced a national inequalities strategy since 2010. Action has been ineffective and piecemeal. Local authorities and public health departments have driven much of the action locally over the last 10 years, but require strengthened partnerships with public services, businesses and communities as well as much greater national resourcing and leadership.

The goal of the roundtable series summarised in this report has been to assess how effective local action and partnerships can be scaled up and how governance and accountability for health inequalities can be strengthened. Despite a lack of national action, there has been action locally, and this is accelerating in the context of the pandemic.





This report draws on existing literature, the four roundtables and many contributions (both written and verbal) from people around the UK who are making a difference. The scope of the report has been directed by Professor Sir Michael Marmot, who has worked over the last 40 years to demonstrate that health inequality is profoundly unjust and not inevitable. The moral argument has been supplemented by evidence showing that action can be highly impactful and cost effective.

This report demonstrates that when the private, public and voluntary, community and social enterprise (VCSE) sectors and communities work together, it is possible to create more equitable and healthy societies. It is not the responsibility of one person or system to reduce health inequality, but the collective and collaborative accountability of all.

---

## 2. Executive summary

This report, based on the testimonies of experts from a range of public services, local governments, businesses and charities, focuses on the prospect of networking whole-sector approaches to health inequality. While many organisations cross multiple sectors, for the sake of clarity, it breaks whole-sector approaches into six areas:

- Local government
- Other public services
- The health sector
- The VCSE sector
- The business sector
- The community

For over a decade, the UK Government has not prioritised action on health inequality and health inequalities have widened. However, local government has been working effectively to reduce health inequality, often in collaboration with other sectors. Where there has been action, there will be learning. The aim of this report is to disseminate the evidence of successful cross-sector working at local level, notwithstanding the pressing requirement for central government to take note and support action.

**Local government:** Local government action has been thriving and successful over the past decade, with local areas managing to reverse damaging health inequality trends. Most local government action happens with the close collaboration of other sectors, particularly the VCSE sector. With local government having the correct levers, partnerships and systems needed to influence other public services, implementing a cross-sector health inequality strategy is successful.

**Public services:** Critical to success in tackling health inequality is collaboration with public services. All public services cover areas that are essential for action on SDH and for reducing health inequalities. Broadly, any organisation that interacts with and serves the general population should have an interest in people's health. This is not simply a case of different sectors building health services into what they do, but recognising health has little to do with healthcare and much more to do with wider social, economic and environmental inequalities.

**The health sector:** Health and social care organisations have great potential to do more on SDH locally as well as nationally. The health sector, including the NHS, needs to be better at working with external stakeholders. When the NHS intervenes in the local community, it does so with substantially more resource than any other public service, and as a result the value of individual place may not be fully appreciated. The NHS must seek to work better in the context of place with local government, business and the community to succeed in tackling SDH.

**The VCSE sector:** The VCSE sector is a crucial ingredient of cross-sectoral approaches. While capacity for collaboration between the VCSE and other sectors can be limited due to restricted resources, support and advocacy on behalf of communities are essential components of work to improve health – even when the focus is not on health itself. The VCSE sector often provides the link between civic-led interventions and 'official' services and is crucial for co-production – an important indicator of success in reducing health inequality.



**The business sector:** The willingness of businesses to consider the social as well as economic impacts they have on health appears to have increased in the wake of the pandemic, yet collaboration between businesses and the public sector to improve conditions and support good health is fairly uncommon. There is great potential for businesses in the UK, including small and medium-sized enterprises (SMEs) to take further action to support health and advance positive social – as well as economic – progress. Businesses must begin to systemise their operational models in line with SDH, and understanding their role within a cross-sector approach can provide the direction many businesses are looking for.

**The community:** Local voices must always be central to conversations when decisions are being made that can either improve health or damage it. Cross-sector approaches that embed the lived experience of residents and local community voices at the heart of strategies are essential. Research and data that is given by those living in communities must be considered as valuable as routinely collected data.

## **A. SUMMARY OF POINTS OF AGREEMENT**

- 1.** Health inequalities are widening, and rapid development of place-based health systems is required involving local government, public services, health and care, the VCSE sector, businesses and communities.
- 2.** National government must urgently increase its involvement, investment and action on health inequalities. The Government's new body Office for Health Improvement and Disparities (OHID) is welcomed and must be at the forefront of action.
- 3.** Local government can lead cross-sector approaches to tackling health inequalities but needs strong partnerships with other sectors and communities to increase impact and effectiveness.
- 4.** Public services should strengthen their focus on reducing health inequality in partnerships with local government, businesses and communities.
- 5.** The NHS can have far greater impact on health inequalities by taking action on SDH. Each Integrated care systems (ICSs) and anchor institutions should develop an action plan on the social determinants, in partnerships with other sectors.
- 6.** VCSE organisations are often involved in work to improve SDH, but recognition for this role is underdeveloped and organisations and sectors leading health inequality work should partner with and invest more in the VCSE sector.
- 7.** Businesses have a profound impact on SDH as employers and advocates and through their social and economic impact on local areas. As such, businesses must invest in partnerships in the local areas they are based in. Larger businesses must look outside of London and the Southeast to increase their social and economic impact.
- 8.** Communities should be at the heart of partnerships to reduce health inequalities in place-based health systems.



## Making the case for whole-system approaches to health equity

The UK has been particularly guilty of suggesting that policy development and implementation lie in national solutions rather than communities that feel engaged in local solutions. While responses should be locally appropriate, it is also essential for national government to be involved. Strong governance, accountability and investment in health equity create conditions and capacity for local stakeholders to play their part.

Tackling SDH requires strong local and national leadership. In its review of the Wigan Deal, the King's Fund noted the quality and consistency of leadership in Wigan as a key ingredient of the council's success; the situation was similar in Coventry and in Greater Manchester.<sup>8,9</sup> The view expressed during the roundtable series by a stakeholder involved in the Wigan Deal was that leadership was "humble but bold". Another vital component recognised by the King's Fund evaluation of the Wigan Deal was "permission to work differently" with leadership backing. Allowing staff to know they would be supported by leadership in having the licence to develop new ideas and services based on their conversations with service users was a key performance indicator. Place-based approaches recognise the uniqueness of different demographics and localities in tackling health inequalities; one size does not fit all.

As health is mostly driven by conditions outside the healthcare sector, action to reduce health inequalities must involve a wide range of sectors. Broadly, any organisation that interacts with and serves the general population should have an interest in their health. This is not simply a case of different sectors building health services into what they do, but recognising health has much to do with wider social, economic and environmental inequalities. As well as healthcare, other public services, including education, youth services, adult education, the criminal justice system, parks and leisure, planning, employment services, transport and housing, all have highly significant effects on health and on SDH. Working alongside public services to reduce health inequalities through action on the social determinants is a prerequisite for effective local action. The VCSE sector also has enormous impact on SDH. While this is recognised, the capacity for collaboration between the VCSE and other sectors on the issue is usually limited due to restricted resources.

The significant role of businesses in affecting health has become even more evident during the pandemic, when conditions at work have been shown to damage health. The willingness of businesses to consider the social as well as economic impacts they have on health appears to have increased in the wake of the pandemic. The purpose of this report is to lay the groundwork to strengthen partnerships between different sectors. Improving health outcomes and tackling health inequality using SDH is not simply the responsibility of public health departments within local councils; it requires strong cross-sectoral partnerships.

Widening inequalities as a result of the Covid-19 pandemic further demonstrate that it is essential for central government to take widescale action on health inequalities. The pandemic has clearly shown the public and government that social, economic and environmental conditions influence health, and inequalities in those conditions result in health inequalities. Greater awareness and understanding that health is a collective endeavour have added momentum to action on SDH.

#### **POINTS OF AGREEMENT**

- 1.** Health inequalities are widening, and rapid development of place-based health systems is required involving local government, public services, health and care, the VCSE sector, businesses and communities.
- 2.** National government must urgently increase its involvement, investment and action on health inequalities. The Government's new body Office for Health Improvement and Disparities (OHID) is welcomed and must be at the forefront of action.

## 4. Local government

Local authorities are vital for action on health inequalities. They cover many of the sectors with direct influence over health, including but not limited to public health teams, education, planning, housing, sports and leisure, transport and social care, and have the local knowledge and mandate to design and deliver contextually specific health inequality interventions. While local government is an essential partner in tackling health inequalities, it cannot achieve wholesale reductions without broader partnerships with other sectors – communities, healthcare, businesses and nationally led public services. There are many examples of local authorities leading effective action on SDH, and plenty of them have worked closely with IHE. Over nearly 10 years, Coventry City Council has shown how fostering and developing those broad partnerships can lead to effective action on health inequalities.

### 4.A. CASE STUDY COVENTRY CITY COUNCIL – A MARMOT CITY

In 2013, Coventry had significant inequalities in health and healthy life expectancy between the areas of the city, related to levels of deprivation. That year, being aware of the high levels of local inequalities, and as it took on new public health duties, Coventry City Council decided to adopt the title of Marmot City and sought to apply its local powers and those of partner organisations to pursue the Marmot policy objectives. The city continues to be a Marmot City.<sup>10</sup> The Marmot brand has been important in influencing the various stakeholders and in gaining support across the local authority.

In an evaluation of Coventry as a Marmot City in 2020, it is evident tangible progress on reducing inequalities in SDH has been made.<sup>11</sup> Between 2015 and 2019 the number of Coventry neighbourhoods among the 10 per cent most deprived in England reduced from 18.5 per cent to 14.4 per cent, demonstrating that efforts to decrease the levels of inequalities have evidently been successful, despite austerity policies.

Being a Marmot City also positioned Coventry well in responding to the Covid-19 crisis. The areas where testing needed to be focused and where resources needed to be dedicated to vaccination uptake were well understood. Dealing with domestic abuse during the crisis was much easier than would have been.

The efforts implemented to reduce health inequalities in Coventry are important evidence for other areas.





#### **4.B. CASE STUDY GATESHEAD COUNCIL – GOOD JOBS, HOMES, HEALTH AND FRIENDS**

Public Health Gateshead's 2017 annual report points out that two babies born in Gateshead, a town in north east England, have as much as a 10-year difference in life expectancy because of the circumstances they are born into. Beyond Gateshead, those babies could have as much as a 15-year difference in life expectancy when compared with the most affluent area in Britain.<sup>12</sup>

Working closely with IHE, Gateshead Council overhauled its entire health and wellbeing strategy to tackle health inequalities. Working across local authorities, politicians and partners, the council implemented its health and wellbeing strategy, Good jobs, homes, health and friends, in 2020.<sup>13</sup>

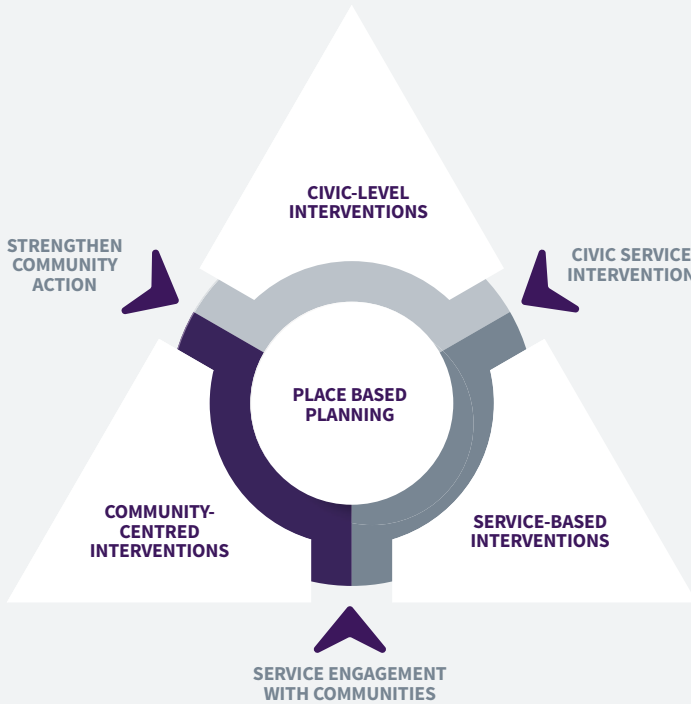
The strategy's title is representative of the approach. In Gateshead, health and wellbeing are not siloed to one part of the council but a fundamental part of its overarching strategy and everyone working in Gateshead Council works through the lens of health and wellbeing.

The council is committed to five pledges:

1. Put people and families at the heart of everything we do
2. Tackle inequalities so people have a fair chance
3. Support communities to support themselves and each other
4. Invest in the economy to provide sustainable opportunities for employment, innovation and growth across the borough
5. Work together to fight for a better future for Gateshead<sup>14</sup>



These pledges underpin the council's health and wellbeing strategy, which is based on the Marmot principles.<sup>15</sup> Delivering improvements at population level requires action at community, service and civic level. The council has adopted the 'population intervention triangle' (PIT) to illustrate how these differing elements fit together to make a holistic approach.<sup>16</sup>



- Civic-level interventions refer to a wide range of functions, across a range of public sector organisations, such as planning, broadband, water, housing, road infrastructure and schools.
- Service-based interventions refer to the range of public services, for example the NHS.
- Community-centred interventions recognise the vital contribution that communities themselves make to health and wellbeing.

By working with public sector organisations, local NHS trusts, NHS commissioning groups, charities and the community, Gateshead Council is fully committed to using a social determinants approach to health.

“Our Health and Wellbeing Strategy recognises that to deliver improvements at a population level we will need comprehensive action across the whole system of community, civic, and service interventions. We accept that approaches which are multifaceted and complementary are more likely to be successful in reducing inequalities and helping people in Gateshead thrive.”<sup>17</sup>

### POINTS OF AGREEMENT

3. Local government can lead cross-sector approaches to tackling health inequalities but needs strong partnerships with other sectors and communities to increase impact and effectiveness.

## 5. Public services

All public services cover areas that are essential for action on SDH and for reducing health inequalities. Local government has taken the lead on health inequalities in many areas but has to continue to forge close collaborations with public services, as shown in the case study on how Sunderland City Council works with schools to improve health and improve educational outcomes.

Collaborations between local government and public services can be undermined by capacity and resource issues, but the specific sectoral focus of public sector organisations can also mitigate against collaborative action on health inequalities. This applies to healthcare organisations, but also includes housing, education, the criminal justice system (as set out in case study 4.b. on the Public Health and Policing Consensus Taskforce), adult education and work services; all of these have profound impacts on SDH.

### 5.A. CASE STUDY SUNDERLAND CITY COUNCIL – HEALTHY PLACES

Healthy Places is an initiative set up as part of Sunderland City Council's public health implementation plan using a whole-system framework. The intention of Healthy Places is to influence the environment in which people learn.<sup>18</sup>

Organisations where people spend most of their time, such as schools, can have a significant influence on individuals' health and wellbeing, which makes them the ideal place to promote and deliver health improvement initiatives. The Healthy Places initiative is based on the 'settings approach', which means combining healthy policies and healthy environments with complementary education and wellbeing activities and initiatives.

The objectives are to:

- enhance students' readiness to learn
- contribute to improving students' educational attainment
- increase organisational capacity and resilience
- provide a strategic framework to plan and deliver the most effective course of action to address local health and wellbeing priorities
- demonstrate to Ofsted that schools adopt a systematic approach towards addressing health and wellbeing needs
- maximise schools' contributions to improving the health of students, staff and the local community, and
- support schools to achieve their core business objectives.

The place-based approach has facilitated multi-agency working in secondary schools. Examples include:

- links with sexual health services to facilitate monthly drop-in for students within schools in wards with high numbers of teenage pregnancies ➤



- funding secured by Sunderland Youth Offending Service to embed a restorative justice approach in one of the schools
- ‘nurture groups’ for transition students from primary to secondary school, delivered by the emotional resilience nurses within the 0-19 service
- peer education and support embedded in schools, with students delivering sessions to staff and facilitating workshops to young people from other secondary schools across the city and the colleges as part of a Sunderland Safeguarding Children Partnership young people’s event
- schools supporting work with alcohol information service Balance North East on alcohol-free childhood by feeding into the development of an alcohol-free school pledge to discourage alcohol as gifts for teachers and for raffle prizes at school events
- four schools engaging as early adopters for the compulsory relationships and sex education (RSE) curriculum, and
- facilitating school engagement in the Sunderland Mental Health Charter Mark.

This programme includes significant cross-sector working. Schools, colleges, Sunderland school nursing service, Sunderland’s youth drug and alcohol service, Change4Life Sunderland, Together for Children, Sunderland Sexual Health Service, Washington Mind and Sunderland Mind were all involved.



## **5.B. CASE STUDY**

### **PUBLIC HEALTH AND POLICING CONSENSUS TASKFORCE – PUBLIC HEALTH APPROACHES TO POLICING**

In 2018, the national policing, health and social care consensus statement was published to set out how the police service and health and social care services would work together to improve people's health and wellbeing, reduce crime and protect the most vulnerable people in England and Wales.<sup>19</sup> The Public Health and Policing Consensus Taskforce was established to oversee the delivery of the national consensus statement.

#### **The opportunity addressed**

SDH such as housing, education, work and income overlap with the social determinants of crime. Key risk factors for poor health align closely with risk factors for offending, and those who are at risk of offending are more likely to suffer from multiple and complex health issues, including mental and physical health problems, learning difficulties, substance misuse and increased risk of premature mortality.

#### **The successful model**

To consider these synergies, in 2019 the Public Health and Policing Consensus Taskforce produced a discussion paper on public health approaches to policing.<sup>20</sup> The paper highlighted the potential to apply an early intervention lens to crime prevention in a landscape review of policing and health collaboration in England and Wales.<sup>21</sup> The public health approach to policing offers the opportunity to simultaneously address the wider determinants of crime and health, improve population health and reduce crime.

The Public Health and Policing Consensus Taskforce brings together 12 organisations to provide a focus for the police service, health and social care services and VCSE sector to improve people's health and wellbeing, prevent crime and protect the most vulnerable people in England. The taskforce is responsible for using a collaborative approach to influence and support delivery of the consensus's following aspirations.

1. To move beyond single service-based practice to whole-place approaches to commissioning and delivering preventative services in response to assessments of threat, harm, risk and vulnerability.
2. To get better at identifying and supporting vulnerable people through the millions of interactions between community members, health and police services, and the taskforce's partners each year.
3. To enable the police service, public health teams and other partners to work better together to support families enrolled in the Government's Troubled Families Programme, domestic abuse victims and children subject to child protection plans, and to manage sexual and violent offenders and those with complex dependencies such as drugs, alcohol or mental health.
4. To identify and explore opportunities where national bodies can promote guidance and the sharing of information, support education and training needs, and share learning to improve local services.
5. To ensure staff have the skills and knowledge necessary to prevent crime, recognise risk factors earlier, protect the public, improve health and wellbeing, and secure public trust. ➤

6. To work together to use the taskforce's shared capabilities and resources more effectively to enhance the lives of those with complex needs and the people they interact with.
7. To offer an integrated approach through the better coordination, prevention and early intervention that will increase the reach and impact of all services.

Together, this whole-system public health approach to crime prevention provides an opportunity to address the significant challenges of police demand, health, social exclusion and inequalities.

The Public Health and Policing Consensus Taskforce addresses SDH by:

- supporting systems and networks that promote collaboration
- influencing the use of public health approaches, including primary prevention, and
- supporting workforce development in the policing sector.

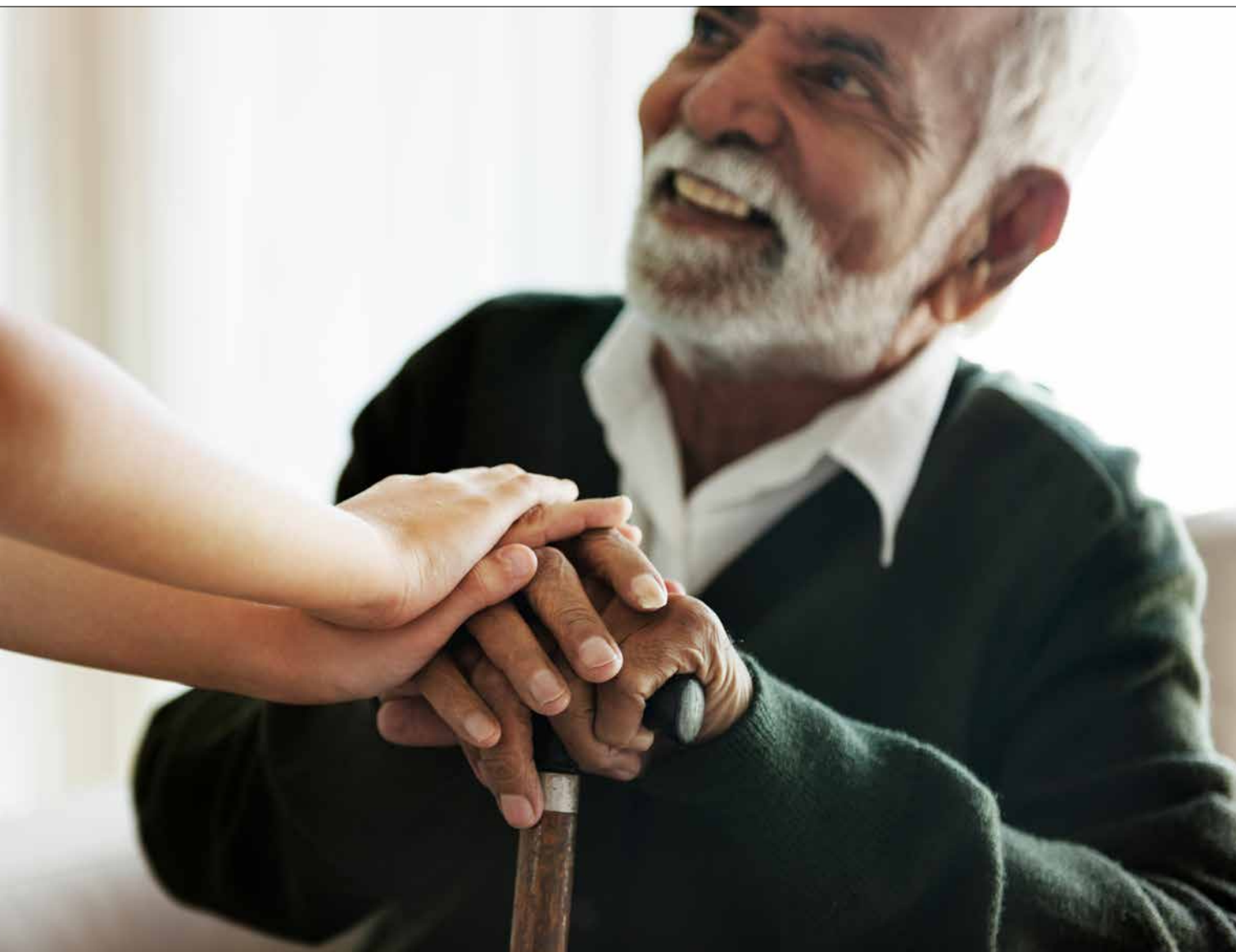
#### **A scalable model**

The Public Health and Policing Consensus Taskforce is intended to provide support to spread and scale examples of good practice via a specially created prevention leads network and webinar series. A knowledge hub is being developed to further allow the sharing of good practice and local examples by police forces across England. The knowledge hub is a digital platform that enables collaboration.

#### **POINTS OF AGREEMENT**

4. Public services should strengthen their focus on reducing health inequality in partnerships with local government, businesses and communities.





## 6. The health sector

To improve health and reduce health inequalities, the health sector needs to take action on SDH. While healthcare organisations have been focusing on ensuring equitable access to services, there are other ways that healthcare systems can help to reduce health inequalities. These include:

- incorporating social value in procurement and commissioning
- improving working conditions (including for contractors and across the supply chain)
- proactively working with communities to improve health
- incorporating action to improve social and economic conditions for the public, and
- working in collaboration with other sectors.

The role of the NHS is important, but the NHS must also strengthen its role within a wider network of whole-sector approaches in places that tackle SDH. The NHS must work with other public services, local government, business and the community to improve outcomes in SDH. IHE continues to work with the healthcare sector to support and extend its role in improving SDH.

## 6.A. CASE STUDY

### WARM AND SAFE WILTSHIRE – PARTNERING WITH THE HEALTH SECTOR

Warm and Safe Wiltshire is an initiative set up by Wiltshire Council, Swindon Borough Council, Dorset & Wiltshire Fire and Rescue Service and the Centre for Sustainable Energy (CSE) to help residents live in safer and healthier homes and combat fuel poverty.<sup>22</sup> It acts as a single point of contact for energy advice with the aim of reducing both fuel poverty in Wiltshire and the preventable excess winter death rates.

#### The problem

A household is understood to be in fuel poverty when it cannot afford to keep warm at a reasonable cost.<sup>23</sup> In 2015, Wiltshire's levels of fuel poverty were higher than levels in England and the south west. More than 10 per cent of households in Wiltshire were in Low Income, High Cost (LIHC) fuel poverty, and properties were 23 per cent less energy efficient than the national average.<sup>24</sup>

#### The solution

Warm and Safe Wiltshire is targeted at people with respiratory conditions, older people (aged 65 and over) and people on a low income. The service provides a varied holistic support service to people in fuel poverty who need help with their energy bills and keeping their home warm. Advisers offer home visits and ongoing casework to those in need of support. The service has access to funding for heating and insulation for some clients through third-party funds.

Warm and Safe Wiltshire has partnered with multiple organisations since April 2015, including Scottish and Southern Electricity Networks (SSEN), Wessex Water, Great Western Hospitals NHS Foundation Trust, NHS community health services and GP practices, Age UK Wiltshire and Salisbury NHS Foundation Trust.

As of July 2021, Warm and Safe Wiltshire had helped 6,993 households across the county. Of these, 71 per cent were fuel poor and 66 per cent identified as having a health condition. The service has collectively saved these households £889,000. The initiative has helped vulnerable communities to keep warm over winter rather than having to make a choice between heating their homes or buying food.

CSE has worked closely with the public health team at Wiltshire Council, which has introduced the Warm and Safe Wiltshire team to groups of healthcare workers in the area. The initiative takes a flexible approach to engaging new partners, based on partners' particular needs and opportunities that arise.

Most healthcare groups have been offered training for their team members. Training typically covers how to identify people in fuel poverty, how Warm and Safe Wiltshire can help and how to make a referral. Training is often delivered during regular team meetings, with a limited timeslot (allocations of five to 10 minutes), with an offer of a 30-minute e-learning module to reinforce understanding.



The project also benefits from a caseworker based at the Great Western Hospital in Swindon, originally funded by SSEN, and a caseworker at Salisbury District Hospital, originally funded by Wiltshire Council. After successful pilots, this has continued through project money allocated from the Energy Redress Scheme.<sup>25</sup> The hospital caseworkers work across discharge teams and wards, and with Age UK Wiltshire Home from Hospital coordinators, to provide advice and support to patients being discharged.

The Warm and Safe Wiltshire service and structure has enabled both the councils to obtain additional Covid-19 funding to support their most vulnerable communities during a time of crisis. Warm and Safe Wiltshire is able to provide both instant support and a short-term service over the next 12 months.

The importance of hospital and council-based discharge teams has taken on an added significance to ensure that bed space is readily available for patients hospitalised by Covid-19. It is important to recognise that when hospital services are under pressure to discharge patients back to their homes, this should not be undertaken in a way that compromises both hospital and council safeguarding duties, which must ensure that patients are not returned to a cold home.

The Better Care Fund allocation allows for a Warm and Safe Wiltshire adviser to be employed jointly by Wiltshire Council and CSE, with the position being linked to hospitals, council discharge services and GPs, providing support to clients across Wiltshire.<sup>26</sup>

### **A scalable project**

Although initial investment is required to set up the phone service and a sustainable funding source, the benefit to the population from minimal investment is significant.

Key learning for fuel poverty schemes partnering with the health sector and other service providers:

- Develop and use close working relationships between the fuel poverty service provider and local authority. Warm and Safe Wiltshire has demonstrated how working closely with local authorities and an advice provider enables specialist expertise to connect with a network that spans across numerous teams within the local authority and other service providers in the area. A lot of clients are referred into the service as a result.
- Present a clear offer to healthcare workers, with benefits both for patients and the health sector. Fuel poverty scheme providers need to set out clearly the available support and its benefits in the context of health professionals' perceptions of what is needed. The advice provider needs to persevere in helping health professionals develop a wider understanding of what type of support can make a difference to their patients. Creativity and persistence are needed to help health professionals recognise and value the benefits of less tangible forms of support that can result in patients being able to heat their home affordably on an ongoing basis. Communicating the benefits of the holistic support on offer – as illustrated by examples of patients successfully supported by the scheme – can help health professionals broaden their assumptions about which patients would benefit from an onward referral to the service.



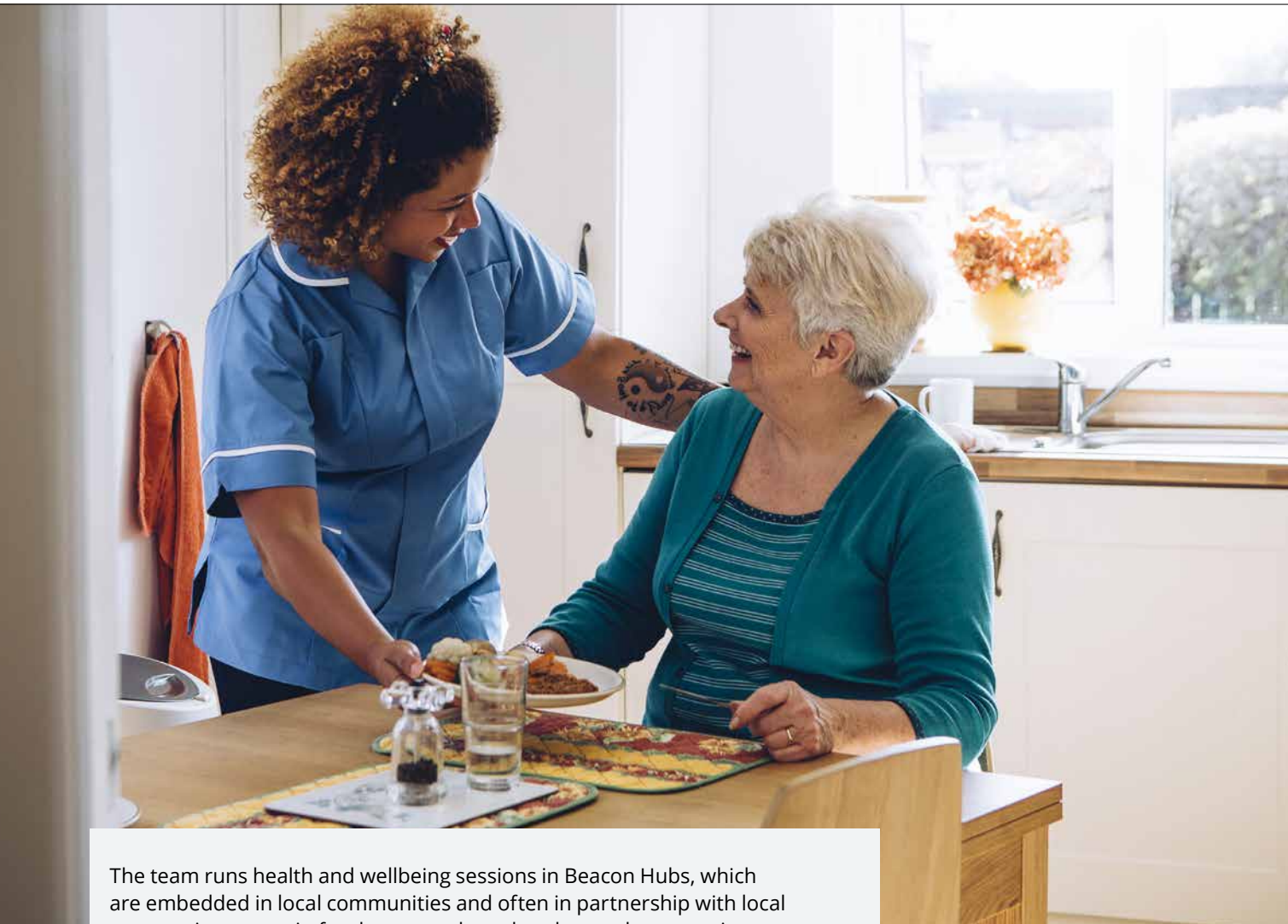
- Create a referral mechanism that is simple and quick to use. Referral routes should be as simple as possible. Having a single point of contact for fuel poverty services simplifies the process for those signposting or making onward referrals. The referral process must strike a balance between collecting just enough information to enable efficient triage to the right service and minimising the burden on the referral maker.
- Invest time in establishing and maintaining referral and delivery partnerships. Most health professionals engaged by Warm and Safe Wiltshire have extremely busy schedules with little to no capacity to fit in work that falls outside their main responsibilities. Making first contact with health professionals to set up referral partnerships can take multiple attempts and follow-ups by the advice service teams. Warm and Safe Wiltshire found that a friendly introduction from a contact at the local authority or another partner helped them get a ‘foot in the door’ to talk to potential referral partners. Continue to invest time in partnerships. Repeated reminders to health professionals about the caseworkers’ presence and the service offer are crucial to build familiarity with the service and confidence about where to direct people who require support.
- Engage the right people, both NHS leaders and frontline workers. Encouraging health professionals to consider fuel poverty as part of normal practice is likely to require support from leadership teams and frontline workers. Public health teams and NHS managers can provide access to frontline staff. Health managers set the expectations and procedures for onward referrals and engagement with third-party services. Frontline workers need to understand the value of the service to their patients and consider it part of their remit.

## 6.B. CASE STUDY

### ASCENSION TRUST – BEACON PROJECT

Ascension Trust (AT) is a Christian interdenominational organisation with a passion to mobilise the Church to make a positive contribution to society and to improve the quality of life of disadvantaged and vulnerable people. AT’s Beacon Project, commissioned by NHS South East London Clinical Commissioning Group, is ensuring knowledge gaps do not continue to expand between those who are engaged with the Covid-19 pandemic and vaccines, and those who are not.<sup>27</sup> The project is a 12-month initiative aimed at providing Caribbean and African communities in south east London with the ability to make informed choices, recognise myths and fake news, and ask the questions that will help them understand what is happening. The project is working with local faith communities in excluded areas.<sup>28</sup>

The AT Beacon Project engages and empowers communities and vulnerable groups to lead healthier lives. By working alongside communities, their families, and peers, as well as the places they live and spend their time, the AT Beacon Project creates safe spaces (Beacon Hubs) where people can gain access to trusted voices and sources on matters concerning health, wellbeing and vaccine confidence. Beacon Hubs also occur in virtual spaces and provide the opportunity for those wanting to access advice from trusted health and wellbeing experts at a more convenient time.



The team runs health and wellbeing sessions in Beacon Hubs, which are embedded in local communities and often in partnership with local community groups in focal areas such as churches and community centres. For example, in one of the Beacon Hubs, based in a south London church on a Friday afternoon, the AT Beacon Project team works alongside health ambassadors from Age UK and a local Eritrean group to co-produce the most suitable approach for that locality. The AT Beacon Project team also networks with local GP practices, borough-based practice nurse forums, local carers' hubs, and voluntary organisations. The team has also attended church services and mosques across south east London to speak to the attendees and congregations about issues relating to Covid-19 vaccines as well as health, mental health and wellbeing.

The AT Beacon Project develops strategic partnerships with faith leaders and VCSE sector stakeholders, promoting a culture of empowerment and co-creation with the aim acting as a bridge between these communities and the healthcare system. The project's culture is one of ongoing grass-roots, community-based engagement and networks, ensuring that it has a visible presence within these communities.

No Beacon Hub or event is the same, as the team adapts its programme to suit the needs of the community they are held in, and during these sessions the team speaks to and supports a diverse range of people, with various levels of knowledge and lived experience. The team also speaks to attendees about a range of health concerns, such as diabetes, hypertension healthy eating, prostate cancer, mental health and wellbeing and breast cancer, as well as vaccine confidence. The aim of these sessions is to encourage attendees to have the right information and to ensure that they are proactive about leading healthy, flourishing lives. ➤

---

The AT Beacon Project can be regarded as collaborative by nature and by design, and the team has shown a strong ability to connect with churches, faith groups and other likeminded groups for the purpose of envisioning, and equipping them for, cross-cultural engagement. The team is now also mobilising volunteers, such as nurses, clinicians and peer educators from Caribbean and African communities, to join and support the work of the AT Beacon Project.

The team is excited about this new way of collaborating with the NHS to reduce health inequalities across south east London. The aim is to make every contact count and to use these contacts as positive opportunities to help people improve their health.

Such efforts highlight that much more can and must be done to integrate health services into the wider tapestries of people's lives, irrespective of which communities they may be a part of and where they are located. It should not be the sole responsibility of charities to pick up the pieces where government-funded systems are failing to reach people. To ensure health systems can fully serve their communities, national government must first recognise the value and importance of community-led approaches.

NHS England and NHS Improvement are taking steps to set out a vision for tackling health inequalities with a focus on equitable access to healthcare services.

They have identified three core criteria that must be met to ensure quality healthcare is received by all:

1. Equitable access
2. Excellent experience
3. Optimal outcomes

While these are all important for equitable access to treatment and equitable outcomes during and after treatment, they do not prioritise tackling the causes of poor health.

However, NHS England and NHS Improvement's Health Inequalities Director Dr Bola Owolabi is placing more emphasis on incorporating tackling the social determinants into the role of the NHS. While the direct responsibility of the NHS is to tackle health inequalities within healthcare provision, the NHS recognises the role of multi-agency action to address the social determinants. Integrated Care Systems and Anchor Institutions are one way the NHS is embracing this wider role.

Integrated care systems (ICSs) have a clear mandate to improve health and health inequalities. To achieve this, they will need to act on SDH as well as deliver equitable healthcare. As well as supporting patients to improve the conditions in which they are born, grow, live work and age, healthcare organisations can form strong local cross-sectoral partnerships, using their purchasing power to strengthen local economic conditions and improve employment conditions for their workforce, including contractors.



## The NHS as an anchor institution

Many healthcare organisations are developing as anchor institutions to improve working and living conditions in the communities in which they are situated. An anchor institution usually refers to large, public-sector organisations. They are called anchors because they are 'anchored' in particular geographical areas and, as such, have significant influence on those areas. In the UK, some hospital trusts have developed as anchor institutions. The approach can also apply to organisations in other sectors and to businesses, discussed in the subsequent section.

Anchor institutions use their employment and spending power to improve outcomes in local areas, with the ambition to reduce deprivation and improve health. The US-based think tank Anchor Institutions Task Force (AITF) understands anchor institutions as sizeable organisations that are large employers and have significant purchasing power.<sup>29</sup>

The Health Foundation's 2019 report, *Building healthier communities: the role of the NHS as an anchor institution*, set out that: "Anchors have a mission to advance the welfare of the populations they serve. They tend to receive (or are significant stewards of) public resources, and often have a responsibility to meet certain standards on impact or value. These characteristics mean that the NHS, like other anchors, is well placed to have a powerful voice in where and how resources are spent locally."<sup>30</sup>

The report noted that while NHS organisations were already beginning to embrace the anchor mission, there is great potential for this approach to contribute to health improvement and reducing health inequalities. The NHS Long Term Plan references how NHS organisations can work as anchors, highlighting the need for the NHS to have wider social impact around its delivery of healthcare. It notes: "The national team is looking to work with any system delivering, or considering, initiatives with these ambitions so that we can map, test and spread action that will help tackle health inequalities and wider social determinants."<sup>31</sup>

### POINTS OF AGREEMENT

5. The NHS can have far greater impact on health inequalities by taking action on SDH. Each Integrated care systems (ICSs) and anchor institutions should develop an action plan on the social determinants, in partnerships with other sectors.

---

## 7. The VCSE sector

The VCSE sector (sometimes referred to as the third sector) is an essential partner in efforts to reduce health inequalities locally and nationally. The VCSE sector often works to support people who are most excluded and at risk of poor health, as well as having longstanding relationships with those communities. Support and advocacy on behalf of communities are essential components of work to improve health – even when the focus is not on health itself. The NHS Long Term Plan specifically calls out the increasing role of the VCSE sector in health and social care provision, stating an intention to “continue to commission, partner with and champion local charities, social enterprises and community interest companies providing services and support to vulnerable and at-risk groups”.

Taking a place-based approach requires the community within that place to be fully involved in co-producing the services they require. The VCSE sector often provides this link between civic-led interventions, ‘official’ services and the people those services are supposed to benefit. However, action and collaboration between the VCSE and other sectors to reduce health inequalities has been limited by lack of capacity and time and requirements to focus on the specific activity or services of individual VCSE organisations. Despite these constraints, there is a wealth of evidence of successful action by the VCSE sector to reduce health inequalities, and there is also clear evidence that work by the public sector and local authorities can be strengthened through collaboration with the VCSE sector.

### 7.A. CASE STUDY

#### ONE NORTHERN DEVON

One Northern Devon (OND) is a partnership of public services, businesses, voluntary and community groups.<sup>32</sup> It recognises that concerted, systematic action is needed across multiple fronts to address the causes of health and social inequalities and that systems need to work as one system to tackle the complex, multifaceted factors involved. OND believes there are problems solvable only by working across organisations and with, and within, communities.

The work of One Northern Devon sits under three pillars:

- Person-centred service
- Place-based action
- System coordination

OND was built from the ground up, starting in 2012 in Ilfracombe, which had one of the UK’s five per cent most deprived wards. OND has a ‘family’ of ‘One Communities’ that sit within its locality. It has invested in roles to develop the One Community infrastructure and systems, with the wider system recognising the expertise at every level.

## The problem

Public service policies were leading to 'poor help'. Residents described a puzzle of public services that were unsuitable, disconnected from other services, complex and overwhelming. The policies that were designed to help people were actually making their lives worse.<sup>33</sup>

Commissioners and providers wondered why the £82 million per year spent in Ilfracombe on public services was not making a difference. Despite investment, life expectancy was some 15 years less than in neighbouring communities and Ilfracombe continued to have the highest rate of alcohol-related hospital admissions and A&E self-harm attendances in the county. There was a sense of outrage that the most disadvantaged were being left further behind, which brought people living and working in Ilfracombe together to address the overarching issue – services did not meet the needs of individuals because they did not understand those needs in the context of the person's life. Local needs and assets were ignored in favour of centralised 'equal' provision; services worked in silos, competed with each other to meet targets, and created a complicated, incoherent and inaccessible service offer.

## The solution

OND was formed to address the issues that lead to the continuation of a cycle of deprivation and to poor health. Poor housing, low educational achievement, poor employment prospects, inadequate transport links, in-work poverty, poor mental health and addiction are interdependent factors that can only be properly addressed through a system approach and a joined-up strategy.

Having worked in communities and with people living with inequalities for the past nine years, OND believes that the important change required to tackle inequalities lies more in how service provision is approached rather than the interventions that are provided. Too many services have been parachuted into the most deprived communities by intelligent and well-meaning public servants who have never lived in those communities, faced the same circumstances, or experienced the same life events.

For interventions to work, they need to be easy to access locally and fit the needs and motivations of the individual. An assumption that achieving good health is a primary motivator for people experiencing poverty is often the first misconception, as well as the concept that providing something additional is better than helping people to cope with already overwhelming lives.

OND brought together all key stakeholders across local government, the NHS, social housing, education, business and the VCSE sector to create a 'system strategy' to address inequalities. Importantly, the OND partnership agreed on the following aims:

- For services to work towards becoming truly person-centred. This would necessarily involve understanding what mattered to the service user.
- For services to be commissioned and delivered in a place-based way, taking into account the individual needs and assets available in a place and supporting system infrastructure at community level. Just as context matters on an individual level, so it matters on a community level. ➤

- For organisations to work together and coordinate their activities so that people do not have to try and piece them together themselves.

OND has supported, through a dedicated One Community partnership development role, the development of One Communities in each of the six main towns in Northern Devon.

### **What is a One Community?**

- A group that brings together community, voluntary and statutory services, along with residents, with the aim of improving the wellbeing of residents.
- Each One Community engages with its residents to understand what matters to them and uses this engagement, alongside local data from public health, to create a community action plan.
- One Communities use existing local assets, including community groups and businesses, rather than commissioning something new, which can often destabilise small providers of valuable local services.
- One Communities have a direct voice to commissioners and providers of services in Devon through OND.
- One Communities have a louder voice together than they do separately, both in their individual towns and as the One Northern Devon Communities Group.

The OND model fits any geographical landscape by nature of the fact that it allows communities to define their 'place', assets and needs. In 2021 there are seven One Communities working across North Devon.

## **7.B. CASE STUDY**

### **BE BUCKFASTLEIGH – COMMUNITY ACTION IN RURAL PLACES**

Be Buckfastleigh is a community interest company (CIC) set up in October 2020 with the aim of tackling health, social and economic inequalities in Buckfastleigh, Devon, and other small rural towns, by involving communities in personal, social, economic and civic recovery from Covid-19. Its aim is to generate a fresh narrative to influence system change with rural decision and policy makers. Be Buckfastleigh provides activities and the strategic and delivery capacity for the town to develop new cross-cutting partnerships needed to ensure economic, social and community development in a cluster of nearby towns.

#### **The problem**

Around 20 per cent of the UK population live in rural places.<sup>34</sup> Much has been learnt from cities such as Wigan, Salford and Preston, but imposing city-based models in predominantly rural areas is misguided. Rural areas have distinct problems:

- highly seasonal, part-time, low-paid work, in sectors with early starts and late finishing times
- lack of available social housing, low standard social housing, and increasingly unaffordable and scarce private rented accommodation





- infrequent and high-cost public transport, which limits access to employment, education, training, health and leisure
- lack of affordable social and childcare that meets working patterns
- an absence of public sector services, facilities and interventions and community support services to respond to community needs, and
- small pockets of deep deprivation masked by general levels of affluence in surrounding areas, which results in structural inequalities and a concentration of services and VCSE focus on larger, higher-profile towns.

There is a distinct lack of data and evidence collected or used at Lower Layer Super Output Areas (LSOA) level. Combined with a complete lack of focus on rural communities by public bodies and the VCSE sector, there are significantly deep pockets of deprivation being overlooked by current public policy decision-makers.

One example of high deprivation combined with the lack of focus from public bodies on rural areas can be seen in the fact that it costs a young person from Buckfastleigh £937 a year to catch the bus to the nearest secondary school.

### **The opportunity addressed - humanising community services**

The ambition of Be Buckfastleigh is to demonstrate how a constellation or cluster of communities, organisations and businesses can work together to address the significant levels of deprivation and inequality hidden in small rural towns. Working in disadvantaged communities depends on building trust and creating hope that change is possible. This takes time. In Buckfastleigh, 10 years of local activism has developed that trust and a confidence in the town, galvanised public participation in decision making, and reconnected people ➤

to their vote, taxation and service levels. Be Buckfastleigh has generated funds to develop new services and activities to meet community priorities and used the positivity this has created to demonstrate new ways of lifting people out of poverty and dependency. The aim of Be Buckfastleigh is to humanise community services and create environments that attract and have empathy for those with least power, through themed activities designed to stimulate social, political and economic engagement connected to health, wellbeing and nature.

The approach is to tackle inequality by providing a range of free themed activities, services and interventions that create the entry point for engaging with the community. Community activities are self-selecting, infectious, simple, and inclusive gateways to participation and engagement. They encourage participation in decision making, building community collaboration, and strengthening networks. This approach is quite different from social prescribing via GPs and does not rely on contact with social or medical service practitioners.

There are several key principles that underpin the services Be Buckfastleigh develops.

- They are designed to meet the needs of the most disadvantaged in the community yet are free and open to all; they do not create stigma by simply targeting the poorest.
- They are focused on fun, health, community building, natural environment and creating a positive vibe to engage even the most disaffected and most marginalised.
- They target more complex problems and create a pathway out of dependence and into participation, engagement, volunteering and work by making people feel valued, appreciated, and respected.
- They create new networks of 'anchor' bodies – building on community strengths and identifying opportunities for economic growth, sustainability and resilience.
- They develop a network of communities, reducing competition for resources and providing a more sustainable scale for delivery.
- They create relationships with regional public and VCSE sector organisations, providing an effective gateway for engaging with rural communities.

### **A scalable approach**

Be Buckfastleigh is forging a distinctive model for addressing inequalities and hidden deprivation in small rural towns. By collaborating with similar towns in Dartmoor and south Devon, Be Buckfastleigh activities have become a showcase to other towns for what can be achieved and how they can shift public engagement and participation. Cross-cutting strategic capacity and wider networks will be needed to take the approach to scale. As Be Buckfastleigh matures, it will become clearer how wider system change can be facilitated in South Devon and in rural communities in other parts of the UK.

### **POINTS OF AGREEMENT**

6. VCSE organisations are often involved in work to improve SDH, but recognition for this role is underdeveloped and organisations and sectors leading health inequality work should partner and invest more in the VCSE sector.

## 8. The business sector

It cannot be the sole responsibility of the NHS, the public and the VCSE sector to carry the burden of reducing health inequality and societal inequity. The private sector has a responsibility not just for its employees, but also for their families and their local communities. Most of the UK workforce is employed in the private sector, and positive steps must be taken by industry to further support local communities and enhance positive social as well as economic impacts.

It has long been mentioned how important it is for the private sector to get involved in reducing health inequality. However, collaborations between businesses and the public sector to improve conditions and support good health are uncommon. The private sector has important roles in shaping SDH and health. Over 80 per cent of people who are employed in the UK are employed in the private sector, and the private sector shapes health through spending money in ways that do or do not benefit disadvantaged areas and communities, supply chains and the goods and services produced.<sup>35</sup> There is great potential for businesses in the UK, including SMEs, to take further action to support health and advance positive social – as well as economic – progress. IHE's recent report for Greater Manchester outlines the possible ways businesses can develop their roles, set out in the case study below.

### 8.A. CASE STUDY

#### IHE – HOW BUSINESSES CAN BUILD BACK FAIRER IN GREATER MANCHESTER

IHE has recommended that Greater Manchester adopt an ambitious framework to reduce inequities and “build back fairer” for future generations following the Covid-19 pandemic, including the part businesses can play.<sup>36</sup>

**Employers:** Good working conditions, fair progression, decent pay and security of work are vital to good health. Developing in-work training and extending apprenticeships and other training schemes are important ways to upskill the workforce at all ages, not just to contribute to reducing the numbers of young people not in education, employment or training (NEET), and to reduce unemployment in Greater Manchester.

**Services and products:** Businesses procure and deliver services and products. These services and products, and the related contracts, offer potential routes to greater health equity. Healthier products are important, but supply chains also need to support healthy living and working conditions, and businesses have an important role to play in scrutinising suppliers and contracts to ensure they protect health and equity in the supply chain. ➤

**Social value:** Businesses have great potential to add social value through their usual business practices, including the addition of social value in tenders and in contract awards – contracting social value.

**Investments and assets:** Businesses invest in, own and manage assets that can benefit or undermine good health and equity in SDH. Divesting from assets that undermine health and equity is a powerful lever for supporting change. Thriving businesses have an opportunity to fund and support essential services and assets for local communities. IHE suggests a regional investment fund to facilitate coordinated investment in Build Back Fairer.

**Business anchor institutions:** Anchor institution approaches have mainly been developed in the healthcare sector, with some additional developments in other public sector organisations such as universities. Businesses are also located in places and have an important place-shaping role. This includes, but extends beyond, their role as employers as they affect social, economic, cultural and environmental conditions within places. Their role includes social value contracting and ensuring that assets and investments support rather than undermine health equity.

**Wider partnerships:** Businesses should be closely involved with other organisations working to improve local conditions and foster healthier local areas. Hitherto, these collaborations have been weak, or one-offs, and more sustained collaborations between business, the VCSE sector, local authorities and public services would be highly beneficial to building back fairly.

**Workforce contributions:** Many businesses support their staff to volunteer their time and expertise to support local communities. We suggest this is extended so that staff who wish to are able to support their local communities, including those employed by SMEs.

**Advocacy:** Businesses can also be powerful advocates for greater health equity and equity in the social determinants, both nationally and locally.

Since the Covid-19 pandemic, the private sector has become more interested in reducing health inequality. IHE and Legal & General recently announced a partnership to build the Corporation's health equity impacts and to support a network of places taking action on health inequalities. The challenge to business included the question about how they use the considerable impact they have in society to improve health and reduce health inequality.

## 8.B. CASE STUDY

### NOVARTIS UK – PARTNERING TO DELIVER A PATIENT-CENTRIC APPROACH TO HEALTH INEQUALITIES

Out of the pandemic has come remarkable progress and unprecedented innovation, highlighting how working together across organisational boundaries can accelerate innovative approaches to healthcare delivery in the most challenging of times. However, the pandemic has also shone a light on the deep inequalities that exist in society. ➤







Health inequalities are not caused by one single issue, but by a complex mix of factors, including variable access to services, delayed diagnosis and a lack of early intervention, along with environmental and social factors that play out across local communities.<sup>37</sup> Those living with pre-existing health conditions, from ethnic minority backgrounds, and from the most deprived areas suffer both higher mortality and more severe illness.<sup>38</sup> To deliver improvements in outcomes at pace and scale the NHS will need to look at innovative ways to proactively engage those communities that are at the greatest risk.

### **The need for a new approach to tackle health inequalities**

Novartis UK's purpose is to reimagine medicine to improve and extend people's lives. To achieve this, it recognises that it has an important role to play in tackling health inequalities together with policymakers, healthcare systems and local communities.

A recurring feature of health inequalities is the challenge in identifying people at greatest risk, achieving early diagnosis and delivery of timely care. Within Novartis UK's diverse portfolio of treatments in multiple therapy areas, it focuses on targeting critical healthcare innovations to better meet the needs of those who are at greatest risk of ill health and poor health outcomes. However, for innovation to have the greatest impact in addressing ill health and reducing health inequalities, policy and system-change solutions are needed to help the NHS reduce the time it takes to get the right treatments to those who are at greatest risk. To realise this ambition, policymakers and healthcare systems, along with partners from across industry, need to work together to achieve the following. ➤

- Establish a proactive approach – A more proactive approach to tackling health inequalities is required that targets population groups at the greatest risk of ill health and poor health outcomes, in a way that they are best engaged. This approach needs to focus on better diagnosis and early intervention, enabled by strong cross-sector, multi-agency partnership working and targeted community engagement to better understand how different communities need to be engaged to improve health and wellbeing.
- Invest in innovative models of care – New models of care and innovative solutions are required to help reach those population groups at the greatest risk of ill health and poor health outcomes at every stage of the care pathway. This should include improved access to diagnostics, preventative interventions, digital solutions and health literacy support tailored to at-risk groups, working in partnership with other service providers, the VCSE sector and industry partners.
- Strengthen system leadership and capability – Local healthcare systems need to mobilise the strongest NHS assets and capabilities to lower the barriers to healthcare access for those populations at greatest risk of ill health and poor health outcomes. This needs to include the effective collection, measurement and intelligent use of data, strengthened local integration, and partnership between local institutions and the NHS to enable more coordinated approaches to reach at risk-groups.

### **The power of partnerships to address health inequalities**

Novartis UK has already helped improve patient outcomes at both a local and national level, develop new models of sustainable patient care and introduce innovative technologies into the NHS. These partnerships create new possibilities to improve and extend the lives of people in the UK, create better experiences for patients and find smarter ways of working together to build a healthcare system fit for the future.

Bold action is needed to address health inequalities at pace and scale. As an important contributor and partner to the UK healthcare ecosystem, Novartis UK is committed to playing its part in tackling health inequalities by leveraging innovative partnerships, such as population health management solutions in cardiovascular disease, health-tech challenges through the Novartis Biome digital innovation lab to identify solutions to support health literacy, and improving diversity, inclusion and patient experience in clinical trials and research.

In 2021 Novartis UK launched the Health Inequalities Pledge, a multi-year commitment to work in collaboration with partners from across the healthcare ecosystem to accelerate collective action on tackling health inequalities. This includes:

1. Improving access to healthcare: Using Novartis capabilities in data and research to help identify those population groups at the greatest risk of ill health and identify opportunities to improve early diagnosis and intervention.
2. Enabling innovative models of care: Co-creating solutions in collaboration with healthcare systems and Novartis partners to improve access to diagnostic and preventive interventions, digital solutions, and health literacy support for population groups at the greatest risk of ill health. ➤

3. Working with the UK research community to strengthen patient inclusion in clinical research: Working with Novartis partners across the research ecosystem to improve patient engagement, inclusion and access to clinical research so that patients from all backgrounds have the opportunity to participate in clinical research and thereby develop a better understanding of the needs of underserved populations.
4. Capability building and knowledge transfer: Upskilling people working for Novartis to ensure they are equipped with the knowledge, tools and insights to meaningfully engage and collaborate with healthcare systems and leaders to co-produce initiatives designed to tackle health inequalities at system and place levels.

### Looking to the future

Tackling health inequalities will depend on cross-sector collaboration, collective accountability and responsibility between partners across the private, public and VCSE sectors working together with local communities.

As the Government's 2021 Life Science Vision set out, by accelerating the adoption and spread of new treatments, and supporting the NHS transition to a population health system, innovative healthcare can make an important contribution to addressing the UK's underlying inequalities in health.<sup>39</sup> Moving forward, there is an opportunity, through the implementation of the Life Science Vision and the Health and Care Bill 2021–22, to create the right structures, incentives and metrics to drive action on health inequalities and facilitate the partnerships that could deliver real impact. By embedding this new approach, the NHS and its partners can make important steps towards levelling up health outcomes across society.<sup>40</sup>

UK | MLR 146652 | August 2021

*The State of the Nation: Addressing the National Syndemic project was sponsored by Novartis Pharmaceuticals UK.*

### Business anchor institutions

While the anchor institution approach has mostly related to public, non-profit organisations, the concept is applicable to businesses too. As described earlier, an anchor institution is a way of understanding the role that place-based institutions play in building healthy local communities and economies that reduce deprivation and encourage wider economic growth.<sup>41</sup> Both anchor institutions and businesses increasingly share the same mission or purpose in needing to build healthy local communities in order to be sustainable. Adopting environmental, social and governance policies is one way organisations can do this. According to Office for National Statistics (ONS) data from 2020, 83.4 per cent of the UK workforce is employed in the private sector and therefore simply by providing employment, the private sector has a role in – and a responsibility for – the health of the communities beyond their direct workforce.<sup>42</sup> However, with the usual definition of 'anchor institutions' referring to non-profit or public sector bodies tied to their locality by their presence and by their connection to the locality, it is an obvious step to examine how the private sector should also be challenged to think in the same way; creating a place-based embeddedness through engagement with the local population to optimise health outcomes and reduced health inequalities.

While there are local economies with a number of large businesses at their core, there are also places with huge inequalities where there is no big industry. SMEs are crucial stakeholders; they account for 99.9 per cent of the business population.<sup>43</sup> SMEs can form a part of anchor institutions and contribute to how all businesses work within the local communities they directly or indirectly serve, which is essential for improving place-based health.

## 8.C. CASE STUDY

### CERNER – BEING A BETTER NEIGHBOUR

The collective health and wellbeing of a community is built, in part, on secure paid employment in a workplace that is committed to physical and mental wellness. Global studies show ‘a clear relationship between employment and both life expectancy and healthy life expectancy’.<sup>44</sup>

Cerner is the world’s largest technology company solely focused on healthcare. Its headquarters are in the US, but it has offices and 27,000 employees globally, and been present in the UK for over 30 years. Cerner’s products and services are used across 30 NHS trusts in England, and increasingly connect together data and care pathways across care systems as they emerge under the ICS model, at a level where inequity in health and inequality in health provision become increasingly apparent.

Cerner has nearly 500 UK employees, most in commuting distance of its offices in Paddington, London, although there has been a move towards virtual working as a result of the Covid-19 pandemic. The company’s business in healthcare technology provides a natural affinity with health and wellbeing, and its employees are provided with a range of benefits that foster and encourage a healthier lifestyle for themselves and their families. Cerner has been present in Paddington since 2003, and there is a connection felt with the area as a base for the company and as a place where long-standing Cerner client Imperial College Healthcare NHS Trust is located.

NHS trusts in England make up most of the Cerner client base in the UK. Acute NHS trusts are a natural example of an anchor institution, being anchored in place physically, by their role in the local economy and in terms of scale and local connectedness. The direct connection with those institutions, the joint working between NHS and Cerner staff, and engagement with healthcare practices and data, provides a particular opportunity to engage with communities and provide a significant supporting role in the success of anchor institutions.

In the case of Cerner, it can divide this role and associated activities into three main areas:

**Charitable activities:** Since 2009, the UK arm of the Cerner Charitable Foundation (CCF) has provided financial and volunteer support to good causes relating to the health and wellbeing of the community surrounding Cerner and its employees.

Linked closely to our overarching mission to deliver a ‘seamless and connected world where everyone thrives’, within its UK branch CCF has a focus on supporting charities and organisations that seek to address areas of social ➤

and healthcare inequity. Organisations that regularly receive support from CCF include the Stephen Hawking School in Tower Hamlets, London, the North Paddington Food Bank and Hearts & Minds, a peer-support charity for young adults with mental health challenges. Charities CCF supports are local to Cerner's offices and most of its employees, encouraging and enabling greater levels of personal participation.

The charities CCF works with are selected and supported by our employees. CCF provides corporate and employee financial donations and Cerner allows paid time off for volunteer activities that can have an impact on the communities that are physically and emotionally close to its employees.

**Local employment:** Local hiring is mutually beneficial. By building a local workforce, reflective of the diversity of background and viewpoint, Cerner acquires knowledge of the communities served by its clients, a deeper connection to the societal challenges within the community, and a better applied knowledge of health and social care challenges.

Cerner's UK headquarters are in an area with a large disparity in wealth and health outcomes. Paddington is home to a notable immigrant population, greater incidence of deprivation and a lower median age when compared with national averages.

Employing from within the local community requires intervention from school age. Engagement with local seats of education can build an interest in the skills and expertise required by the business, for example through as coding clubs or school talks. This provides a link between learning and aspirational career prospects.

Cerner is an employer of skilled and relatively well-paid staff. The company has a responsibility to pay fairly and recognises the needs of its workforce by providing flexibility. Financial security is a key social determinant of health – it provides the ability to withstand financial shocks, which in turn securely helps to manage the building blocks of health, including the avoidance of food and housing insecurity, among other factors.

Hiring from within the local community supports the building of a diverse and representative workforce, offering opportunity, growth and training. Cerner encourages its employees and their families to live healthier lives and provides a range of support offers for those who need assistance. As an example, Cerner has engaged with the mental health charity Mind, which has encouraged more open dialogue about the challenges of mental health, building a greater understanding among the broader workforce. In addition, Cerner provides easy access to confidential counselling for those who may require direct support in times of need.

Many of the clients Cerner serves are anchor institutions, and they in turn require their suppliers to contribute to the community. During the pandemic, Cerner's clinically qualified and registered staff returned to the healthcare front line and were paid by Cerner – a practice that provided additional capacity to the health service, and also allowed Cerner teams to better connect with the needs of healthcare providers. Many returned to hospitals that they had previously practised in, including occasional cover for the NHS Nightingale Hospital established in East London. Incidentally, ➤

this facility also happened to use Cerner technology as an expansion of Barts Health NHS Trust.

**Conversations about data:** Cerner's systems are increasingly enabling the convergence of healthcare provision, which is being driven by the creation of ICSs and as described in the NHS Long Term Plan centrally, in addition to local place-based enablers to integration that have been building for some time. Redesign of systems will be informed by data, and the interpretation of that aggregated health and care data requires close cooperation between data scientists, technologists and those that have applied knowledge of health and social care. A broad spectrum of interests will make this work more effective.

Gathered data provides the opportunity for insight into healthcare inequalities and inequities, and Cerner employees increasingly need to provide not just the platform but the intelligence, the research capability and thought leadership that will unearth opportunities for systemic healthcare improvements. Cerner has a role in assisting its clients to bring together contributions from different viewpoints and sectors and will itself be more effective in building the subjects of research, and the hypotheses to be tested, by being able to walk the streets affected by the work it does. Cerner also brings to the conversation an academic rigour through its work with University College London (UCL).

The charities that CCF engages with are carefully chosen to relate to the work Cerner does, and by connecting those it supports with the work done, a potential platform is provided for those charities – a voice – as well as involvement in the strategic direction that Cerner follows with its product development. They too have the potential to become part of the network that benefits from the insights that the data provides.

There is a mutually supportive approach that Cerner looks to adopt. It is commercial in the way that it provides software, services and technology to its clients, yet it also learns from them and shares this learning with the broader community it engages with inside the UK and globally. That freedom to learn, share, volunteer and engage is something that helps everyone.

No single organisation has a monopoly on knowledge, and one of Cerner's major roles in the health and care community is to share learning and best practice to better serve the 19.5 million people its systems are connected to in the UK.

### **Private sector engagement is vital for progress**

As a natural progression of the engagement Cerner has with charities and local employment activities, it becomes a responsibility of the company to encourage the engagement of other stakeholders in conversations about the future of health and care. The three steps above help to provide Cerner with a better connection with the community in all aspects of its work, and in the success of the business.

The majority of the UK workforce is employed in the private sector, and positive steps must be taken by industry to provide support, access to healthcare, and the opportunity for learning and advancement – doing so will have a disproportionately positive effect on society. ➤

As noted earlier, the NHS Long Term Plan acknowledges the growing role of the VCSE sector in health and social care provision. The expanding network of voluntary organisations that Cerner works with provides an innovative way to realise and encourage their involvement beyond the simple provision of finance and volunteer services.

Over the past two years, health and care provision has been stressed and burdened in ways not previously encountered. Cerner's intrinsic connection with the providers of care and the data related to that care has challenged the company to think about the role it should play as an enabler of system and neighbourhood-based learning and data-driven care provision. As a private sector employer itself, Cerner has also learned of examples of best practice to reduce inequity and inequality in health and society through local intervention, localism in employment and procurement. It will be challenging itself to adopt some of that learning and look forward to positive engagement with others that have contributed to this report.

*The State of the Nation: Addressing the National Syndemic project was sponsored by Cerner.*

Health systems have mapped and understand which large, medium and small businesses exist within their geographies. They have a good understanding of their size, number of employees (including number drawn from the local population) and overview of products and services they provide, including how these may affect local health inequalities and the wider determinants of health, such as housing, education and employment.

Health systems actively collaborate with and involve business partners in the planning, development, measurement and evaluation of initiatives to tackle health inequalities. This is evidenced in local plans addressing health inequalities.

## **POINTS OF AGREEMENT**

- 7.** Businesses have a profound impact on SDH as employers and advocates and through their social and economic impact on local areas. As such, businesses must invest in partnerships in the local areas they are based in. Larger businesses must look outside of London and the Southeast to increase their social and economic impact.



## 9. Community partnerships

Evidence repeatedly demonstrates that actions to improve outcomes are most effective when undertaken in partnership with communities. This includes identification of the main local issues, the priorities for addressing those issues and efforts to implement actions; at every stage, strong community partnerships improve outcomes.

A view expressed during the roundtable series highlighted the fact that when services are delivered to people without their involvement, they rarely work. Weight management services often serve as an example of this. When such services exhort people to eat healthily, they rarely consider that the recipients of the message do not have access to healthy foods for various reasons – the principal one being expense. The Food Foundation highlights that if those in the bottom 20 per cent of household incomes followed PHE's Eatwell Guide, they would have to spend 42 per cent of their disposable income on food.<sup>45</sup> Many of the successful approaches outlined in this report have community involvement central to their design and implementation.





## 9.A. CASE STUDY

### THE WIGAN DEAL – ‘WORKING WITH’ RATHER THAN ‘DOING TO’

When austerity was introduced in 2010, the north west borough of Wigan was the third most affected local authority. Wigan Council experienced sizeable financial restrictions and was forced to devise novel ways to continue to provide and run services to support the local community. ‘The Wigan Deal’ is an informal agreement between the council and its residents to provide support and form collective efforts to improve the lives of citizens. It aims to reduce public service costs through active engagement and participation from the local community, shifting towards a community paradigm way of delivering public services in alignment with partners – ‘working with’ people rather than ‘doing to’ them.

When The Deal was first implemented, a social contract was signed between the local authority of Wigan and the local community, covering a series of partnerships between private and public sectors to create a whole-system, placed-based approach.

The Deal is based on a set of principles that seek to create a new relationship between all members of the community. The social agreement has transferred a sizeable amount of social responsibility to the individual citizen, whose role is to reduce pressure and impact on local services.

#### The main elements of The Deal

- The first measure was to freeze council tax for seven years, which saved around £500 per household over that period (2010–2017).
- Anthropology is used extensively. Analysing the ways in which people live their lives is used to shape and offer services. It is important to understand the people of Wigan people as assets to inform the council of how they want their services delivered. This way of working has been deployed in seven integrated teams around the neighbourhood. This creates a mutually beneficial quid pro quo relationship between the local authority and the community, with each benefiting from the efforts of the other.
- The Deal recognises the role of business in wealth building. An important aspect is working with local businesses to help ensure wealth created in the community goes to the community.

#### Replicating the Wigan Deal

The initiative started by Wigan Council is easily scalable across the entirety of the UK. Enabling and empowering local authorities to engage with local people to play a role in the betterment of the community can be replicated on both an individual and collective scale.

While the needs of authorities and communities will differ, the strength of this case study resides in its adaptability to differing circumstances. The Deal is not an overnight fix but became successful over a five-year period. ➤

A 2019 report by The King's Fund recognised that between 2008 and 2016, a period in which the national trend for community satisfaction was rapidly decreasing, the opposite had occurred in Wigan. Life expectancy has increased dramatically, despite the stagnation experienced across England as a whole.<sup>46</sup>

Implementing this initiative has saved Wigan Council at least £131 million since 2010.<sup>47</sup>

The Wigan Deal is a key example of how local government can work with local people to improve population health.

This report identifies co-production as a crucial ingredient for local governments seeking to tackle health inequality using the social determinants approach. Who designs a service is as important as what is being designed to ensure the service fits the user rather than the other way around.

In a 2020 report by financial experts Deloitte and public service think tank Reform, when 5,000 members of the public were asked how they felt about tax, spending and public service priorities during the pandemic, only 19 per cent of respondents felt public bodies listened to their preferences, and only 17 per cent felt they were offered a personalised public service.<sup>48</sup> It is essential that communities are involved in designing the services that are meant to help them.

The lived experience of people with poor social, economic and health outcomes often goes ignored when public services are being designed. A view expressed at a roundtable was that “until someone can say ‘no’ to you their ‘yes’ doesn’t mean anything”, which in this context means, if a person does not have a choice in designing a service that is meant for them, it cannot be said that it was their decision to participate in the service.

Confusing and hard-to-access services that are thrust upon people often do not work; they waste resources and can fail to benefit the people who need them. Broader approaches that imbed lived experience and local community voices at the heart of strategies are essential. Research and data that is given by those living in communities must be considered as valuable as routinely collected data.

Co-designing services with local communities empowers people to engage with them. Building trust is an essential element of this process and the VCSE sector plays an important role in facilitating relationships between employers, local authorities, public and voluntary services and the community.

One view expressed during a roundtable noted that co-production is often forgotten when organisations move into emergency situations, such as the recent pandemic. Successful approaches to increasing vaccine uptake involved going to venues like workplaces and faith centres, where people and community leaders were located, and working alongside them. As we move back into ‘business-as-usual’ settings, co-production must remain a core priority.





## 9.B. CASE STUDY

### **WILTSHIRE COUNCIL – COMMUNITY ENGAGEMENT TO ADDRESS VACCINE HESITANCY**

Wiltshire Council's public health team works to improve the wellbeing and quality of its population. It shapes services to meet local needs, influence wider SDH and tackle health inequalities in collaboration with national and local partners.

Wiltshire Public Health has a central role in protecting the population against Covid-19, and this case study relates to its response to the pandemic, particularly work done to challenge the impact of inverse care law (that those who most need healthcare are least likely to receive it) and encourage and enable Covid-19 vaccine uptake.

Wiltshire Public Health has a duty to ensure vaccine uptake is equitable. Although the county continues to see good levels of vaccination uptake across all cohorts, the public health team has taken additional steps to engage with key groups who might be less likely to access this service. ➤

Vaccine hesitancy can be based on a range of factors such as age, gender, religious and cultural variations, access to and experience of healthcare services, as well as beliefs and attitudes about health and disease prevention. This was reflected in local vaccine uptake data.

### **Wiltshire's 'vaccination bus'**

In collaboration with Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group BSW CCG, Wiltshire Council organised a 'vaccination bus' to visit the county's areas of highest need.<sup>49</sup> This gave residents the opportunity to talk to clinicians as well as be vaccinated (on the bus) should they wish. Bus locations were driven by data relating to geography and targeted areas where uptake was lower. In line with national trends, data suggested Wiltshire's most deprived areas required more support.

Compared to England, Wiltshire has few areas of high deprivation. However, evidence has highlighted that people in the most deprived 20 per cent of areas in Wiltshire have repeatedly poorer health outcomes than those living in the least deprived areas.

The project was co-produced and delivered according to the guidance of local communities and influencers such as faith leaders. Involving communities and listening to local voices in planning it played a key part in this project's success. Wiltshire Public Health used relationships and the trusted voice of those who know their communities best to decide where and how to place the bus, and communities and played an important part in the sensitive promotion required.

The specially adapted bus provided the coronavirus vaccine to people unable to travel to a vaccination centre and those who were hesitant about accepting a previous offer of vaccination. The bus created an opportunity for individuals to have extended conversations with clinicians and put forward their concerns. The project was not advertised publicly, and engagement was through ongoing outreach work with community leaders, faith groups and public health workers.

### **Co-production is scalable**

Co-production with the local community has been key to the success of this project. Engaging with communities using an asset-based approach requires little financial support, but it does take time. Having successfully built relationships with local partners and stakeholders across the community, Wiltshire Council plans to use the legacy of this work by continuing to co-produce services that engage residents with their health. The council is set to build on the model to ensure health interventions, such as screening programmes, support and advice, are available and equitable.

## **POINTS OF AGREEMENT**

- 8.** Communities should be at the heart of partnerships to reduce health inequalities in place-based health systems.

---

## 10. Conclusion

This report has demonstrated that when private, public and VCSE sectors and communities work together in local areas, developing more equitable and healthier societies is within reach. A clear precedent has been set for national government: to do more to improve the health of its most vulnerable people. The Department of Health and Social Care is launching the new Office for Health Improvement and Disparities (OHID) just days before this report is published.<sup>50</sup> OHID will be responsible for the prevention agenda across government, focusing on health inequalities. This is a welcome move; however, tangible action from national government must come in the form of supporting local, place-based solutions with community co-production at the centre.

This report, and the workshops and roundtables it was based on, shows that local authorities have worked effectively to tackle health inequality in a climate of austerity and unprecedented cuts to public funding. It has also demonstrated that other public services not specifically in the remit of health can have profound impacts on reducing inequalities within the social determinants, but that there is too much siloed working. Indeed, the health sector has an important role to play in ensuring equity of access and outcome when providing healthcare; yet it must also seek to work in partnership with local government, business and community to tackle the social determinants. The VCSE sector is a key player in facilitating methods of co-production, which as this report maintains, should be central to action on reducing health inequity. The willingness of business in the wake of the pandemic to recognise its impact on health is promising.

This project has been motivated by an issue that is fundamentally a matter of social justice: from the understanding that it is morally wrong that a child born in the most deprived area of the UK in 2021 will live fewer years than their wealthier counterpart due to circumstances that are entirely out of their control. The moral argument has been augmented with evidence that reducing health inequality will be cost effective and create a better society for everyone. Echoing what was said at the beginning of this report: it is not the responsibility of one person or system to reduce health inequality, but the collective and collaborative accountability of all.

---

## 11. Case Study List

- |      |   |      |   |
|------|---|------|---|
| 4.a. | Coventry City Council – A Marmot City   | 7.b. | Be Buckfastleigh – Community action in rural places                                   |
| 4.b. | Gateshead Council – Good jobs, homes, health and friends                              | 8.a. | IHE – How businesses can Build Back Fairer in Greater Manchester                      |
| 5.a. | Sunderland City Council – Healthy Places  | 8.b. | Novartis UK – Partnering to deliver a patient-centric approach to health inequalities |
| 5.b. | Public Health and Policing Consensus Taskforce – Public health approaches to policing | 8.c. | Cerner – Being a better neighbour   |
| 6.a. | Warm and Safe Wiltshire – Partnering with the health sector                           | 9.a. | The Wigan Deal – ‘Working with’ rather than ‘doing to’                                |
| 6.b. | Ascension Trust – Beacon Project  | 9.b. | Wiltshire Council – Community action to address vaccine hesitancy                     |
| 7.a. | One Northern Devon  |      |   |

*Should the reader wish to know more about any of the case studies listed here, please contact Public Policy Projects.*

## 12. Acknowledgements

This report was written following a series of roundtable conversations to which professionals from across the business, public and private sectors contributed. All these people are dedicated to making society fairer and healthier for all and gave their invaluable insights and time to these discussions. This report and its recommendations are a direct outcome of the concerns, suggestions and ideas generated in these sessions. This project of works was kindly sponsored by Novartis UK and Cerner. The work of Irfan Mohammed at Novartis UK and Matthew Pickett and Rani Viridi at Cerner has been critical in helping to deliver this report.

### **Institute of Health Equity**

This report is a collaboration between PPP and the Institute of Health Equity (IHE). Professor Sir Michael Marmot and Dr Jessica Allen at the IHE provided the vision, and gave their expertise and time to ensure it could be delivered.

### **Public Policy Projects**

This report was project managed and written by Lottie Moore, Policy Analyst. Other valuable contributions came from:

Dan Male, Former Policy and Publications Director

Lloyd Tingley, Policy and Partnerships Director

Vicky Burman, Subeditor

The report was designed by Joe Everley, 19-Ninety.com

## 13. References

1. <https://www.instituteofhealthequity.org/resources-reports/commission-on-social-determinants-of-health-closing-the-gap-in-a-generation> Accessed 14 September 2021.
2. <https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review> Accessed 14 September 2021.
3. <https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on> Accessed 14 September 2021.
4. <https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-the-covid-19-marmot-review> Accessed 14 September 2021.
5. <https://www.who.int/director-general/speeches/detail/launch-of-the-final-report-of-the-commission-on-social-determinants-of-health> Accessed 9 September 2021.
6. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60787-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60787-4/fulltext) Accessed 9 September 2021.
7. <https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review> Accessed 9 September 2021.
8. <https://www.instituteofhealthequity.org/about-our-work/latest-updates-from-the-institute/greater-manchester-a-marmot-city-region> Accessed 9 September 2021.
9. <https://www.instituteofhealthequity.org/resources-reports/coventry-marmot-city-evaluation-2020/coventry-marmot-city-evaluation-2020.pdf> Accessed 9 September 2021.
10. <https://www.instituteofhealthequity.org/resources-reports/coventry-marmot-city-evaluation-2020/coventry-marmot-city-evaluation-2020.pdf> Accessed 9 September 2021.
11. <https://www.instituteofhealthequity.org/resources-reports/coventry-marmot-city-evaluation-2020/coventry-marmot-city-evaluation-2020.pdf> Accessed 9 September 2021.
12. [https://www.gateshead.gov.uk/media/4234/Director-of-Public-Health-Annual-Report-2017-18/pdf/1419-PS-DPH\\_Annual\\_Report\\_Final\\_web\\_2017-18.pdf?m=636470405507200000](https://www.gateshead.gov.uk/media/4234/Director-of-Public-Health-Annual-Report-2017-18/pdf/1419-PS-DPH_Annual_Report_Final_web_2017-18.pdf?m=636470405507200000) Accessed 9 September 2021.
13. [https://www.gateshead.gov.uk/media/21507/2020-health-and-wellbeing-strategy/pdf/Health\\_and\\_wellbeing\\_strategy\\_2020.pdf?m=637323885643370000](https://www.gateshead.gov.uk/media/21507/2020-health-and-wellbeing-strategy/pdf/Health_and_wellbeing_strategy_2020.pdf?m=637323885643370000) Accessed 9 September 2021.
14. [https://www.gateshead.gov.uk/media/7200/Making-Gateshead-a-place-where-everyone-thrives/pdf/Making\\_Gateshead\\_a\\_Place\\_Where\\_Everyone\\_Thrives.pdf](https://www.gateshead.gov.uk/media/7200/Making-Gateshead-a-place-where-everyone-thrives/pdf/Making_Gateshead_a_Place_Where_Everyone_Thrives.pdf) Accessed 9 September 2021.
15. <https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review> Accessed 9 September 2021.
16. The PIT was originally developed by Professor Chris Bentley for Public Health England. <https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-and-nexes> Accessed 9 September 2021.
17. [https://www.gateshead.gov.uk/media/21507/2020-health-and-wellbeing-strategy/pdf/Health\\_and\\_wellbeing\\_strategy\\_2020.pdf?m=637323885643370000](https://www.gateshead.gov.uk/media/21507/2020-health-and-wellbeing-strategy/pdf/Health_and_wellbeing_strategy_2020.pdf?m=637323885643370000) Accessed 9 September 2021.
18. <https://www.sunderland.gov.uk/article/12114/Health-and-wellbeing> Accessed 22 September 2021.
19. <https://www.npcc.police.uk/Publication/NEW%20Policing%20Health%20and%20Social%20Care%20consensus%202018.pdf> Accessed 9 September 2021.
20. [https://cleph.com.au/application/files/7615/5917/9047/Public\\_Health\\_Approaches\\_in\\_Policing\\_2019\\_England.pdf](https://cleph.com.au/application/files/7615/5917/9047/Public_Health_Approaches_in_Policing_2019_England.pdf) Accessed 9 September 2021.
21. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/679391/Policing\\_Landscape\\_Review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/679391/Policing_Landscape_Review.pdf) Accessed 9 September 2021.
22. <https://www.warmandsafewiltshire.org.uk> Accessed 9 September 2021.
23. Fuel poverty is measured using the Low Income Low Energy Efficiency (LILEE) indicator. A household is fuel poor if they live in a property with a fuel poverty energy efficiency rating of band D or below and, when they spend the required amount to heat their home, they are left with a residual income below the official poverty line. <https://www.gov.uk/government/collections/fuel-poverty-statistics> Accessed 9 September 2021.
24. <https://fingertips.phe.org.uk/search/fuel%20poverty#page/4/gid/1/pat/6/par/E12000009/ati/102/are/E06000054/iid/90356/age/-1/sex/-1/cid/4/tbm/1/page-options/car-do-0> Accessed 9 September 2021.
25. <https://energyredress.org.uk/about-us> Accessed 9 September 2021.
26. <https://evolvingcommunities.co.uk/project/better-care-fund/> Accessed 9 September 2021.
27. <https://www.ascensiontrust.org.uk/at-beacon-project/> Accessed 9 September 2021.
28. <https://www.ascensiontrust.org.uk/about-us/mission-core-values/> Accessed 9 September 2021.
29. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/414390/Anchor\\_institutions\\_and\\_small\\_firms.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414390/Anchor_institutions_and_small_firms.pdf) Accessed 9 September 2021.
30. [https://www.health.org.uk/sites/default/files/upload/publications/2019/I02\\_Building%20healthier%20communities\\_WEB.pdf](https://www.health.org.uk/sites/default/files/upload/publications/2019/I02_Building%20healthier%20communities_WEB.pdf) Accessed 9 September 2021.
31. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf> Accessed 9 September 2021.
32. <https://onenortherndevo.co.uk> Accessed 9 September 2021.
33. <https://www.emerald.com/insight/content/doi/10.1108/JICA-10-2016-0038/full/html> Accessed 9 September 2021.
34. <https://www.statista.com/statistics/984702/urban-and-rural-population-of-the-uk/> Accessed 9 September 2021.
35. <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/timeseries/g9c2/lms> Accessed 9 September 2021.
36. [https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives\(p.11\)](https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives(p.11)) Accessed 16 September 2021.
37. <https://www.england.nhs.uk/ltphimenu/placed-based-approaches-to-reducing-health-inequalities/> Accessed 16 September 2021.
38. <https://www.health.org.uk/publications/long-reads/will-covid-19-be-a-watershed-moment-for-health-inequalities> Accessed 9 September 2021.
39. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1000030/life-sciences-vision.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1000030/life-sciences-vision.pdf) Accessed 9 September 2021.
40. <https://bills.parliament.uk/bills/3022> Accessed 22 September 2021.
41. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/414390/Anchor\\_institutions\\_and\\_small\\_firms.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414390/Anchor_institutions_and_small_firms.pdf) Accessed 9 September 2021.
42. <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/publicandprivatesectoremploymenttemp02> Accessed 9 September 2021.
43. <https://www.fsb.org.uk/uk-small-business-statistics.html> Accessed 9 September 2021.
44. <https://www.health.org.uk/news-and-comment/charts-and-infographics/unemployment> Accessed 9 September 2021.
45. [https://foodfoundation.org.uk/wp-content/uploads/2018/10/Affordability-of-the-Eat-well-Guide\\_Final\\_Web-Version.pdf](https://foodfoundation.org.uk/wp-content/uploads/2018/10/Affordability-of-the-Eat-well-Guide_Final_Web-Version.pdf) Accessed 9 September 2021.
46. <https://www.kingsfund.org.uk/sites/default/files/2019-07/A%20citizen-led%20report%20final%20%2819.6.19%29.pdf> Accessed 10 August 2021.
47. <https://www.wigan.gov.uk/Council/Performance-and-Spending/Annual-report.aspx> Accessed 9 September 2021.
48. <https://www2.deloitte.com/uk/en/pages/public-sector/articles/managing-citizen-demands.html> Accessed 9 September 2021.
49. <https://www.bswccg.nhs.uk/about-us> Accessed 10 August 2021.
50. <https://www.gov.uk/government/news/new-body-to-tackle-health-disparities-will-launch-1-october-co-headed-by-new-dcmo--2> Accessed 16 September 2021.

