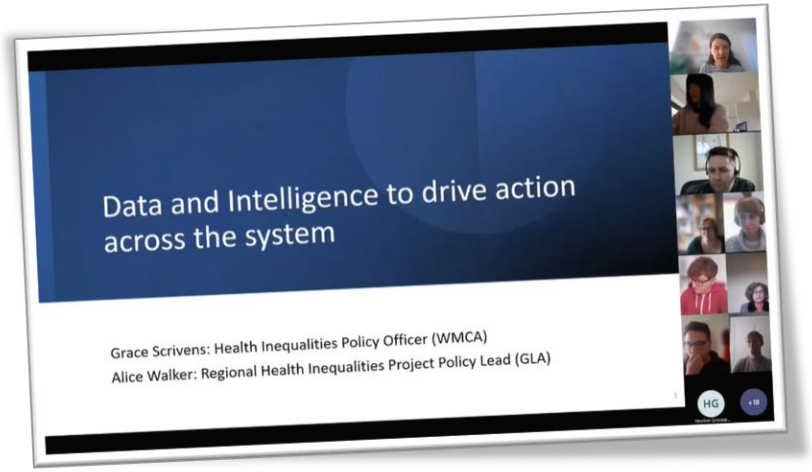
Cities Health Inequalities Project

Webinar series, session 3 - 5th November 2021

How best to use intelligence to guide, drive and monitor action on health inequalities at regional level



The Health Inequalities Project Policy Team

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You can view this webinar online at:

Using intelligence & data to understand and prioritise action on inequality at regional level - YouTube

Part 1: Setting the scene

- **Introduction to the Cities Inequalities Project**
- **Data as a part of the puzzle**
- **Key issues from previous webinars**

The Cities Inequalities Project

Vicky Hobart - Head of Health, Greater London Authority

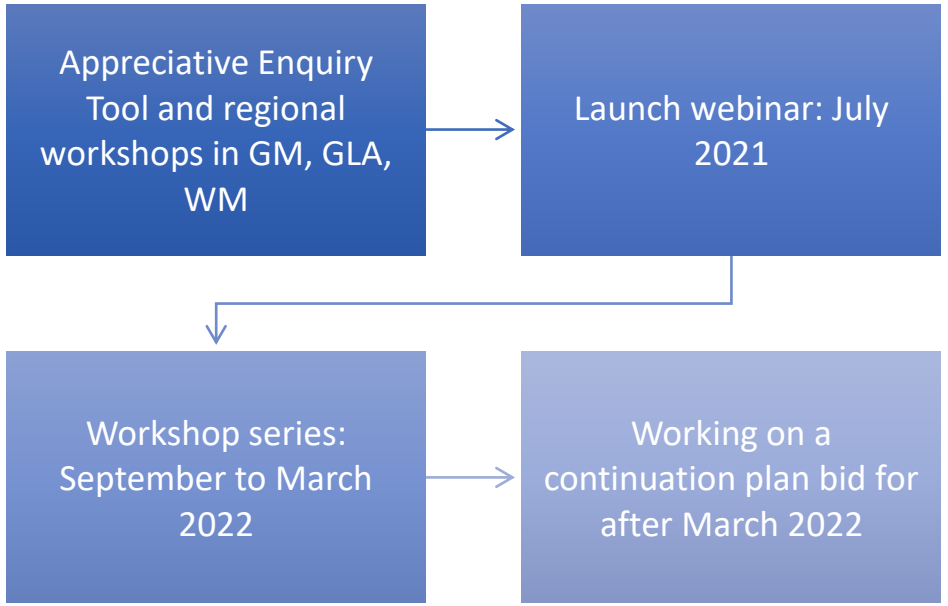
The **Health Inequalities Project** was launched in 2019 with the intent to bring together England's Regional Authorities to discuss and explore how devolved administrations can use their new powers to help accelerate action in tackling health inequalities.

This is the first in a series of multi-thematic workshops drawn from conversations taken place with various regions involved in the project to date.

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

The pandemic has increased attention on health inequalities supported by improved intelligence and data that highlights previously unseen patterns and new inequalities. We have a rich evidence base to draw on in designing policy and interventions. We're now using that evidence to shape our response to Covid. This project aims to address how we can use this evidence to create a tangible change and improvements.

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



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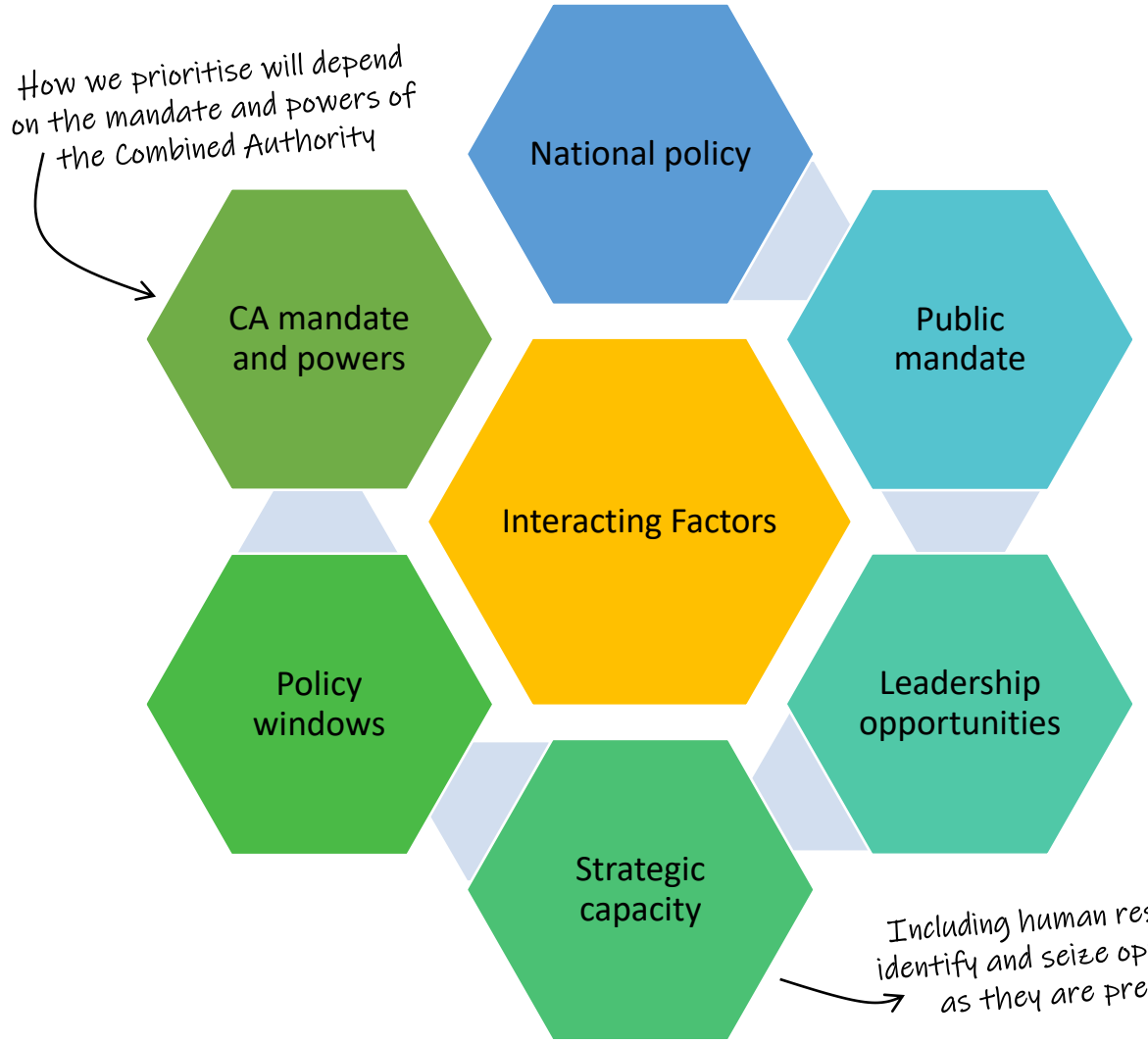
Data as a key part of the puzzle

Data is only one part of the puzzle
Even when we know where the main inequalities issues are, in order to translate insight into action there are a huge range of factors that interact that we can group into two elements:

- **Policy windows** – extrinsic things like the pandemic, public sector reform, devolution
- **Moments interact with availability of data** – not just about showing the need.

How we prioritise these factors depends on the mandated powers at the disposal of the Combined Authority in a particular region and the ability to make use of policy opportunities by having the strategic capacity. For example human resource to capitalise on opportunities and horizon scan.



Some key issues (from previous webinars):

What is the CAs role	• Within the data system – making the most of non health data at the CAs disposal • Access to regional-level data • How to structure intelligence and capacity function • How to work with other functions – LAs, NHS, Academia, Think Tanks, PHE/OHID
Prioritising action	• Resources we have • Powers and levers available • How to quantify the 'size of the prize' for action at regional level • Balancing limited resources, need, political appetite and policy windows
Data gaps	• What gets measured gets done • Information voids might affect what we do and don't do • Emerging issues such as furlough ending, universal credit changes and migration post-pandemic in big cities could change needs and the inequalities picture in our regions
Which disparities to measure at regional level	• Capturing intersectionality – going further than measuring disparities by protected characteristics

Part 2: Using data at regional level

1. Understanding inequalities at regional level

Outcomes are usually aggregated using these dimensions:

- Regional
- Subregional
- Ethnicity
- Socio-economic
- Gender
- Disability

Case studies from across the focus regions found three main ways inequalities were measured and understood. Each method way has specific value and uses:

Measure disparities in outcomes

- Good for bringing political attention to disparities in outcomes, galvanising action across the system as well as highlighting regional differences.
- Difficult to prioritise action using this method as it is measuring the 'final step' of multiple causal pathways.

We know what the problem is, but not how to address it or which outcomes to measure

- Need to consider what is missed in terms of intersectionality when we only look at protected characteristics. How we aggerate and at what level is important
- An example: *PHE disparities report*

Regional comparisons of outcomes could hide some of the smaller pockets if significant inequalities

Measure disparities in risk factors

- Access to health services, childhood obesity, smoking are typically used in monitoring frameworks as they usually address a specific health issue
- Often used in monitoring frameworks and as health sector indicators
- Focus on specific public health issues
- Good for uniting the system around a specific Public Health issue
- One of the issues with this method is the need to effect larger scale changes getting out of the health care sector.

How do we get out of the health sector to bring other in?

Measure disparities in determinants

- Most upstream way of thinking about health inequalities.
- Good for making use of non-health data making the case of ***Health in All Policies*** approaches because you are looking at issues outside health sector, enabling focus on action in a more systemic way.
- Helps with segregation factors because not looking at all inequality factors but those that are upstream; really focusing on wider determinants of health.
- In addition to measuring disparities, measure the drivers of disparities E.g., unemployment rate, AQ breaches, school readiness.
- E.g. Marmot Beacon Indicators are *'the causes of the causes of health inequality'*. Not just disparities and outcomes but measuring the systemic factors that lead to inequalities in the first place.

Downstream ← → Upstream

2. Using data and intelligence to strategise and drive action at a regional level

About the regional place - building in qualitative data that captures lived experience and local intelligence that understands the history and compounding factors that lead to inequalities in regions

Building a regional narrative

- Storytelling
- Combing mandate for regional action with policy window
- Shared agenda for a shared problem
- Value add of CA regional approach
- CA regulatory powers
- Mayoral soft powers and influence

Data can be a strong driver of political will and direction when combined with a compelling narrative or lived experiences

Political opportunity + data messaging = strong regional narrative for action

Cross-sectoral action

- CA levers for change (public services and funding)
- Identification of shared outcome indicator
- Working across sectors for shared goal

E.g. School readiness work in Greater Manchester

Examples of Using data and intelligence to strategise and drive action at a regional level

West Midlands Combined Authority

- The WM Health of the Region report told the narrative of existing health inequalities in the region and the impact of the pandemic on those inequalities.
- The report used quantitative data whilst telling the lived experience story of residents and communities during the pandemic and, actions by health system partners.
- Using this example the report built a picture of a real sense of place, which was used to mobilise the Mayor in city-region action and collaboration.

Greater London Authority

- Regional disparities in childhood obesity levels resulted in London being an outlier vs the rest of UK
- Building on combining political opportunity with data messaging created strong regional narrative for action, coinciding with the political opportunity in 2013 Public Health reform and Health & Care devolution.
- Branding of childhood obesity as a city-region wide problem requiring city-region action presented a leadership opportunity for the Mayor to step into that space.
- The Mayor played a role in creating momentum for a regional systems approach bringing together localities, NHS and other partners in regional action, e.g. seeing to the use of CA regulatory powers in bringing in the advertisement ban.

Greater Manchester Combined Authority

- Data and insight was used effectively to maximise opportunity of devolution deals through school readiness work across early years and health sectors
- High levels of child poverty in the city-region was recognised as a facilitating factor to below national average levels for 'Good Levels of Development'
- Rooted in vision of *'every child to have the best start in life'* a programme of work was devised to drive ambitious educational outcome improvements
- This was established as a priority across regional strategies with a 2-year funding allocation for action and a joint programme of work to accelerate Early Years improvements
- Data insight focused on improvements in outcomes for students eligible for Free School Meals bringing together Educational data and insight allowing for cross-sectional improvements

3. Strategic accountability and performance monitoring

How we use data to monitor action at regional level:

Using frameworks to hold city-regions to account around strategic focus for action.

Strategic accountability

Holding city-regions and CAs to account for high-level action and focus of attention.

Creation of an indicator framework that identifies areas for action

North of Tyne CA health**,** wealth & recovery work established a multi-sector workstream to bring to life what wellbeing should look like in their Covid19 recovery and renewal work. Collaboration, local consultation and pulling regional data into a framework of indicators.

Performance monitoring

Interventions

Integrating data

Demonstrate progress

Greater Manchester knew they wanted to focus on improving *Good Levels of Development* for those eligible for Free School Meals. To do so, they monitored Early Years interventions and harnessed inter-regional learning through collective action, integrating data and insight to demonstrate progress.

Part 3: Case study from Greater Manchester

Matt Hennessey - Chief Intelligence and Analytics Officer
Greater Manchester Health & Social Care Partnership

Case study: Greater Manchester CA and Marmot City Region

GM Marmot City Region work began in 2019 as idea to leverage the experience of the Marmot team in the support of the inequality challenge.

A move away from a programme approach towards population health system development, prevention and addressing the social determinants of health

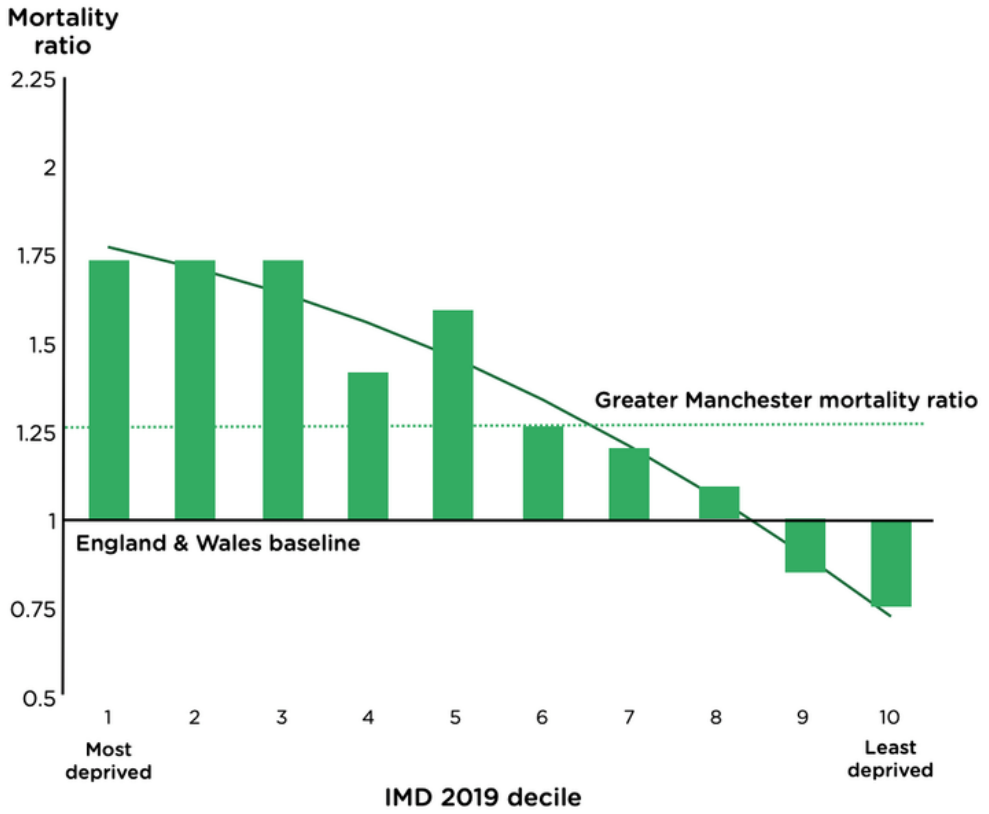
The Marmot City Region approach is central to making the most of the opportunities of health devolution:

New leadership, capacity, powers and a strong identity that enables action on health inequalities, with a focus on prevention, in ways that are not available in other parts of England.

GM reprofiled the work due to COVID-19. Work then ran alongside the recently established Inequalities Commission (chaired by Kate Pickett) which fit in nicely with the Marmot national teams 'building back fairer' work:

This work took stock of the state of social and demographic inequalities post COVID and the resurgence of the BLM movement, with a strong focus on business, public sector and VCS engagement

This led to the question of in Greater Manchester 'how do we know if we are building back fairer?' and 'to what extent are we building back fairer



COVID-19 mortality rates by deprivation decile (p27 of Marmot review). A value of 1 equals the average for England and Wales. The dotted line relates to the average for Greater Manchester, and the bars represent areas within Greater Manchester by level of deprivation. Values relate to the relative difference in mortality rates compared to the national average, accounting for the age profile of Greater Manchester, with values greater than 1 representing higher mortality rates. For example, a value of 1.25 suggests that mortality rates in Greater Manchester were 25% (or 1.25 times) higher) and a value of 0.75, 25% (or 0.75 times) lower. Institute of Health Equity

Case study: Greater Manchester CA and Marmot City Region

Process

- Overseen by multi-agency Steering Group
- Project team in GM to work alongside the Marmot Team
- Formal oversight from the Population Health Partnership Board

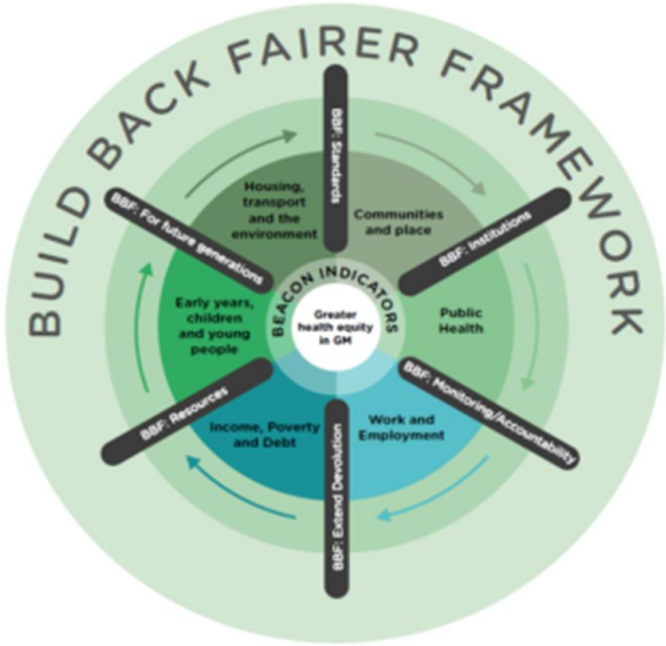
Outputs

1. Full analytical Report

- A complete analytical report on disproportionate impacts on drivers of HI (i.e., focusing on the 'causes of the causes' of ill health) presented as 6 policy areas as per the Marmot Framework Approach
- A set of recommendations (>100) and Build Back Fairer Charter

2. A Marmot Beacon Indicator set

- After a period of engagement with the Marmot team on how the data collated nationally can be used more locally, **GM Developed 24 outcome indicators in 6 categories** (Marmot framework)
- Each category of indicators reports and report directly to the 6-action area steering groups), as well as directly monitoring outcomes of interest



The Marmot team have been researching worldwide on measures of interest and factors that play a part in the direct consequences of Covid-19 and seeking to understand why some countries may fare better or worse than other countries in the long-term.

The international data set was presented to Marmot city regions. The challenge to Greater Manchester was how apply the data set and to achieve a greater level of granularity

Marmot Beacon Indicators

Throughout the early stages of the Covid pandemic, Greater Manchester found it didn't have access to the kinds of data needed to support decision making. The accessible data was often available only in a raw format and received too slowly to inform decision making.

The indicators developed by GMCA in partnership with the Marmot team and a way to measure attempts to *build back fairer*, so it is incumbent on GM as the local system the find the right metrics to support the indicators. These indicators are assessed at least twice a year alongside publishing a narrative assessment which feeds into governance, population and health boards etc.

An assessment group has been created to look at whether GM are indeed building back fairer using the indicators, which becomes the vehicle for the political imperative and getting behind something that the narrative is addressing.

The indicators are **not the end but a means to it.**

Key learning: All decisions result in some form of disinvestment somewhere in the system e.g. in money, focus or old ways of working. The Marmot narrative helps Greater Manchester make disinvestment decisions.

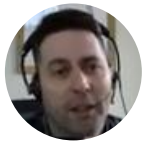
Early years, children and young people	Indicator 1: School readiness Indicator 2: Low wellbeing in secondary school children (#Beewell) Indicator 3: Pupil absences Indicator 4: Educational attainment by FSM eligibility
Work and employment	Indicator 5: NEETs at ages 18 to 24 Indicator 6: Unemployment rate Indicator 7: Low earning key workers Indicator 8: Proportion of employed in non-permanent employment
Income poverty and debt	Indicator 9: Children in low income households Indicator 10: Proportion of households with low income Indicator 11: Debt data from Citizens Advice
Housing, transport and the environment	Indicator 12: Ratio of house price to earnings Indicator 13: Households/persons/children in temporary accommodation Indicator 14: Average public transport payments per mile travelled Indicator 15: Air quality breaches
Communities and place	Indicator 16: Feelings of safety in local area Indicator 17: People with different backgrounds get on well together Indicator 18: Antisocial behaviour
Public health	Indicator 19: Low self-reported health Indicator 20: Low wellbeing in adults Indicator 21: Numbers on NHS waiting list for 18 weeks Indicator 22: Emergency readmissions for ambulatory sensitive conditions Indicator 23: Adults/children obese Indicator 24: Smoking prevalence

GM have been able to obtain Citizens Advice information for requests made for support e.g. debt, relationship, welfare, foodbank support etc.

Discussion & Feedback

Who are the experts that can look at this data (do they give options to decision makers?) and is there a live example of where the indicators have been used and what has been done differently as a result?

Matt Hennessey: During Covid we established expert assessment group made up of partners from across the system to help us to come up with a trustworthy interpretation of the huge amount of data we were receiving. This is being adapted to help give the narrative assessment of where GM are, how GM are doing, and the extent to which GM are building back fairer. It will be for the Population Health board to determine what the options are and feed that through to the other governance boards. The top levels of governance will be informed on what decisions are needed. Membership of the assessment group will be based on the domain knowledge e.g., CYP, children services etc.

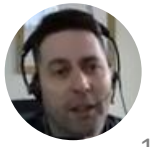


Q: How are you identifying the winners and losers of the 24 indicators?

Matt Hennessey: We want to do something related to allocative efficiency in a health economic sense. As a system we can be really good at **measuring whether we are doing things right and not whether we are doing the right things**. We need to start determining what has the greatest influence across the data set. In previous population health work GM would set out the top 2 or 3 things we could do and what they started to see is early years investment became quite critical. This was because if people became disenfranchised through the criminal justice system or teen pregnancy etc. they then become disenfranchised throughout the system for a long time and there is wide deviations to bring these people back into the system in later life. GM are trying to attach intrinsic value to the indicators which will change overtime as we identify the winners and losers in an indicator set

Are the public engaged in the data set? Could this help with some of the political messaging which may be tricky in terms of the headline actions?

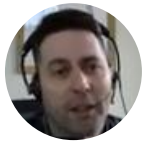
Matt Hennessey: The public aren't greatly involved in the data set and never have been. The financial challenges of trying to maintain Local Authority level surveys means we have lost some engagement. What GM have done is initiated a resident's perception of COVID19 survey. There is usually political aversion to surveys but with COVID19 this activity was embraced and provided lots of useful information which could be used to support to data



Discussion & Feedback Continued

Q: What is the granularity behind the 24 indicators for different characteristics and geography? How are you going to draw out the losers that we see consistently?

Matt Hennessey: This is a feature of the narrative assessment that we want to bring out. The indicators at the face of it are solicited and you draw a straight line between the obvious metrics. What you find is that usually reports don't go below LA level and are often produced quarterly or annually. The Marmot team accepted that their challenge to us was that we think this is a challenge or a domain which you need to think about and find your own data so this is likely to be a springboard for doing more qualitative and locally facilitated work. We want to look through the lenses of the IMD indicators and this blunts any nuance. I would like to unpick IMD and look at the double disadvantage through qualitative data and lived experience. The fact that GM are trying to create a narrative and not a dashboard is an opportunity to do that



Q: What was the reflection in the cultural shift from focusing on numbers to narrative?

Matt Hennessey: We had local chief governance officers which had trust in this work which helped as they were able to challenge their colleagues to trust in the expertise available so that they could focus on decision making and options. Each CA/city region has good expertise which we should utilise more often. The key is in trusting in the data and those who are interpreting the data so you can get back to discussing the options and making the decisions.

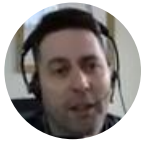
Q: Did you do any work with anchor organizations/institutions?

Matt Hennessey: GM are starting out in doing that. Anchor institutions and organisations are a big part of the GM strategy refresh as they will be part of the reinvigorated Population Health board. GMs devolution deal does not include a public health grant but includes business rate retention. Understanding the role of anchor organizations/institutions has huge potential"

Discussion & Feedback Continued

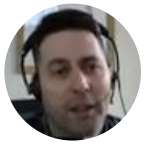
Given the data sets does the Population Health board inform and influence other GM boards and systems?

Matt Hennessey: Yes, we were keen that the Marmot process did not create parallel processes. The Population Health board is a system board that checks and challenges existing boards about their delivery



Given the overlaps in agenda in population, health inequalities etc. how have you managed this in terms of governance?

Matt Hennessey: One of the challenges was that we had two inequalities reports. The Marmot report looked at the wider determinants of health and inequalities and went to the Population Health board. The other report was a Kate Pickett report looking at inclusive growth. The tackling inequalities board sits on the back of this Inclusive Growth report and is a more politically led type of board, checking and challenging across components e.g., housing, economy and putting investment in the right place. The Population Health board and Inclusive Growth board will have to meet the new governance structure



Summary and key learning

***How best to use intelligence to guide, drive and monitor action on health inequalities at regional level* – key learning:**

This webinar focused on how best to use intelligence to guide, drive and monitor action on health inequalities at a combined authority regional level, setting out data as one part of the puzzle which when used effectively can bring together policy, CA mandate and powers. Some of the key learning

- Effective use of data and intelligence can **enable strategic capacity, open policy windows, and create leadership opportunities**
- Data can be harnessed to **drive action and accountability on both a strategic and political stage**
- Data can be used to **build a regional narrative that can build the foundations for storytelling**, combining the mandate for regional action with policy.
- **Combined Authorities can add value through the role of regulatory powers and Mayoral soft powers** to reduce health inequalities.
- Combined Authority **levers for change and identification of shared outcomes and indicators harness cross-sectorial action**
- **There are fundamental differences, limitations and opportunities attached to how we describe and measure inequalities in data terms at the regional level**. For example measuring disparities in outcomes has benefits in attracting political attention and galvanising action across the system.
- Whilst measuring disparities in risk factors can be effective in monitoring frameworks and uniting the system, **measuring the drivers of disparities is important for making the case for Health in All Policies approaches**.
- The Greater Manchester Marmot City Region work and Marmot Beacon Indicator set capitalises on the opportunities of health devolution and demonstrates a **shift from a programme approach towards the development of a population health system**, addressing the social determinants of health. The Greater Manchester approach creates opportunities for new leadership, capacity, additional powers and a strong identity that enables action to be taken on health inequalities in ways that are not available in other parts of England.

The recording of the webinar can be found here.

Please also see accompanying links Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives and Safely Managing Covid-19: Greater Manchester Population Survey results