Shared Intelligence

Action to address health inequalities in Greater London and the Mayoral combined authorities

A report by Shared Intelligence

August 2020

Contents

Foreword

Health inequalities between deprived and more affluent populations in England are stark, and in some cases widening. The publication of the Marmot Review 10 Year On report shines a spotlight on stalling improvements in life expectancy and healthy life expectancy for our most deprived communities, while the ongoing Covid19 pandemic has amplified these disparities in a most tragic manner.

Devolution provides opportunities for Combined Authority areas to approach and tackle the challenge of health inequalities in new and unique ways. As shown in this report, regional devolved administrations can work to enhance local action on health inequalities, bringing together local partners, shaping local activities, forging co-operation and leading improvements to the wider determinants of health that shape the health and wellbeing of our most deprived communities.

In February 2019, a partnership of the Greater London Authority, Greater Manchester Combined Authority and West Midlands Combined Authority was awarded grant funding from the Health Foundation to establish a project to accelerate efforts to tackle health inequalities in city regions.

From the outset, the partnership identified the limited collective awareness of the various powers, responsibilities and approaches in each of our Combined Authorities to address health inequalities. As a starting point for the project, the partnership commissioned Shared Intelligence to map the systems, approaches and powers for tackling health inequalities in each respective Combined Authority and GLA.

This policy mapping exercise explores similarities and differences in approaches, devolution agreements, priorities and partnership structures in each of the devolved English regions led by a directly elected Mayor. This report establishes the foundations in understanding the powers, drivers and approaches of each Combined Authority for tackling health inequalities in England's most high density and populous regions, supporting us to collectively learn and drive improvement.

The Covid19 pandemic has re-energised interest in health inequalities, re-energising interest and activity into addressing the disparities exposed so severely by the pandemic. While the research contained within this report was conducted prior to the pandemic, it provides an invaluable pre-Covid reference point for mapping the drivers and actions taken across English devolved regions.

We thank all those that participated in this valuable research from all devolved regions of England. We'd particularly like to thank the regions that agreed to be subjected to further in-depth enquiry, and to the researchers at Shared Intelligence, who's investigation has refined our collective understanding of the drivers and approaches that shape action to redress the disparities felt by our most vulnerable and health deprived communities in each of our devolved urban English regions.

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GREATER LONDON AUTHORITY

West Midlands Combined Authority

GMCA GREATER MANCHESTER COMBINED AUTHORITY

ADPH London

Funded by:
The Health Foundation

Executive Summary

Shared Intelligence was commissioned by the Greater London Authority (GLA), West Midlands Combined Authority, Greater Manchester Combined Authority and the Association of Directors of Public Health London to map the action being taken by the GLA and the eight English Mayoral Combined Authorities (MCAs) to address health inequalities. We carried out light touch research in all nine areas and more in-depth work in four: Greater London, Greater Manchester, Sheffield City Region and the West Midlands. The Tees Valley CA did not take part in this research.

The situation in each of the nine areas varies significantly. The GLA has statutory duties in relation to health inequalities and in Greater Manchester the Health and Social Care Partnership has responsibility for significant devolved powers and resources. Health in equalities do not feature in the devolution deals in the West Midlands or Liverpool City Region but significant action has been taken on the topic. Each of the other four MCAs covered by this research is developing a programme of activity on health inequalities.

We have identified three factors which have influenced the current position. They are:

History: including the length of time the authority has been in existence and the previous experience of collaboration in the area.

Organisation structures and boundaries: coterminosity helps to galvanise action on topics such as health inequalities. It is strongest in Greater London, Greater Manchester and Cambridgeshire and Peterborough. The position is more complicated in the other MCA areas.

Mayoral leadership: the use of the soft power and convening role of the "metro" Mayors is a significant factor.

We also identified three drivers of action by MCAs on health inequalities. They are:

Poor health as a barrier to work and productivity: given the economic focus of much of the MCAs activity, this is a particularly important driver of action on health inequalities.

Inclusive growth and public service reform: several MCAs are pursuing work streams on public service reform, often linked to inclusive economies, with action on health inequalities featuring as an important strand of this activity.

Health and care: in Greater Manchester action on population health, prevention, early intervention and health inequalities are important elements of the Health and Care Partnership's work programme.

Our research suggests that there are three ways in which the GLA and MCAs act on health inequalities. They are:

- Developing and adopting strategies, such as the GLA's Health Inequalities Strategy and Greater Manchester's population health plan;
- Pursuing specific initiatives, such as the air quality task force in Liverpool, action to address homelessness in Sheffield and the violence reduction unit in the West Midlands;
- Using the authorities' powers in relation to the economy, transport and regeneration to influence the wider determinants of health.

Finally, we have identified four ways in which the GLA and MCAs add value to work on health inequalities. First, the scale at which they operate enables them to adopt a genuinely strategic approach. Second, the powers they have, particularly transport, the economy, and in many cases housing, related directly to the wider determinants of health. The ability of these authorities to influence the wider determinants of health by taking health considerations into account in the exercise of these powers is significant. Third, the GLA and MCAs have capacity to supplement the capacity available in constituent councils to plan and mobilise action on health inequalities. Finally, as noted above, the hard and soft powers of the Mayor can be significant particularly in terms of convening discussions, shaping public opinion and highlighting the need for action on this subject.

1 Introduction and context

1.1 Shared Intelligence was commissioned by the Greater London Authority (GLA), West Midlands Combined Authority (WMCA), Greater Manchester Combined Authority (GMCA) and Association of Directors of Public Health (ADPH) London to map the action being taken by the GLA and the eight English Mayoral Combined Authorities (MCAs) to address health inequalities in their region.

1.2 Our research was undertaken in two phases. In the first phase we conducted interviews with officers from the GLA, the eight MCAs and with directors of public health (DsPH) from councils in the same regions. The interviews were supplemented by a light touch review of key documentation. The product of this stage was a pen portrait of the arrangements and activity to address health inequalities across the nine areas. We also identified a set of factors which were influencing action on health inequalities by the GLA and MCAs.

1.3 In the first phase we carried out interviews with a representation of the GLA or MCA in the following areas:

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

We also carried out interviews with one DPH from a council in each of the following areas:

- Greater London
- West Midlands
- Liverpool City Region
- Sheffield City Region
- West of England
- Cambridgeshire and Peterborough
- North of Tyne

The Tees Valley MCA did not take part in this research.

1.4 In the second phase we developed our understanding of the factors influencing action on health inequalities by the GLA and MCAs through more detailed discussions in four areas:

- **Greater London:** workshop with the GLA Executive Director (Communities and Skills) and Health team, ADPH London, PHE London Regional Director, three DsPH; and a public health consultant at Transport for London (TfL);
- **Sheffield City Region**: A discussion with the deputy chief executive and two other members of the executive team;
- **Greater Manchester Combined Authority:** A discussion with two members of the Health and Social Care Partnership's population health team, a DPH and a PHE regional official; and a discussion with members of the system leaders group;
- **West Midlands Combined Authority:** Interviews with two representatives from the MCA, an officer from Transport for the West Midlands and two DsPH.

1.5 We also held a wider sense-making session in Birmingham with representatives from ADPH, ADPH London, the Health Foundation and the GLA, WMCA and GMCA.

1.6 Section three contains the core of this report which provides a commentary on the factors we have identified as influencing action by the GLA and MCAs to address health inequalities. The pen portraits of each of the nine areas and the action they are taking are set out in the annex. The report also includes a summary of each of the nine areas (section two) and final reflections (section four).

1.7 The research was undertaken between October 2019 and January 2020. It therefore reflects the position before the Covid-19 pandemic and does not take into account any factors that may have arisen due to the pandemic.

Context

1.8 Health inequalities are avoidable, unfair and systematic differences in health between different groups of people[1]. They are avoidable differences in health between groups of people. The term also relates to the opportunities that people have to lead healthy lives. Inequality reflects a range of factors including geography, income, ethnicity, and gender, of which there are various ways to measure this inequality, such as through life expectancy, mortality rates, or mental ill health prevalence figures.

1.9 The wider determinants of health[2] are the social, cultural, political, economic, commercial and environmental factors which shape the conditions in which people live. This concept was originally developed by Dahlgren and Whitehead in 1991[3]. The wider determinants include, for example, employment and education opportunities, housing, social networks, and access to leisure and cultural opportunities. It is important that action to tackle health inequalities address these wider determinants. For example, those in lower paid employment or who are unemployed are more likely to be in poverty which is associated with lower life expectancy.

1.10 Two important documents have been published recently which set the scene for this piece of research. They are: Michael Marmot's Health Equity in England: The Marmot Review 10 Years On[4], and Lord

[1] The King's Fund: https://www.kingsfund.org.uk/publications/what-are-health-inequalities. More information on health inequalities and the wider determinants of health can be found here.
[2] Also referred to as the social determinants of health
[3] Dahlgren G, Whitehead M. 1991. Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies.
[4] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Heseltine's report, Empowering English Cities[5], which was commissioned by the West Midlands Combined Authority.

1.11 Professor Marmot's report follows his previous 2010 report, Fair Society Healthy Lives[6]. His latest research demonstrates the extent to which health inequalities persist in England. It highlights that life expectancy has stalled since 2010 and even reduced in some areas. The report demonstrates the amount of time people spend in poor health has increased since 2010. It demonstrates that life expectancy follows the social gradient and therefore that health issues are related to health and economic conditions. It shows that there are regional differences in life expectancy and in particular, differences between more and less deprived areas and that differences between areas have become starker. The report identifies how the cuts to public sector funding in the past 10 years have hindered local authority capacity to address the social determinants of health. The report does recognise, however, that despite these findings, some local authorities and communities have established effective approaches to tackling health inequalities through raising awareness, changing the debate, and establishing whole system approaches.

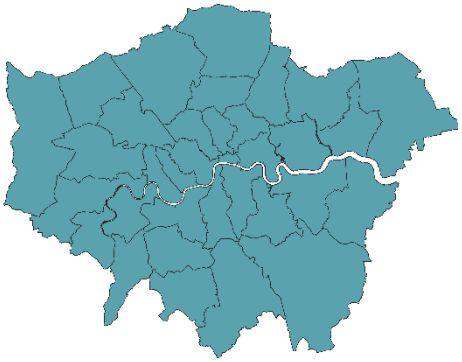
1.12 Lord Hesletine's Empowering English Cities calls for the MCAs to be given greater powers over housing, education and employment. It specifically recommends that "each mayor should commission and publish a condition of the people report analysing the social imbalances, the scale of health statistics and other indicators of relevant advantage or disadvantage upon which political priorities can be based".

5 https://englishcitiesmichaelheseltine.premediastudio.com/MichaelHeseltine/pubData/source/Empowering_English_Cities__Lord_Heseltine.pdf

6 http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

2 Summary of the Combined Authorities

Greater London Authority



Creation: 2000

Population: 8.96 million (2019)

Local authorities: 32 London Boroughs and City of London Corporation

Description: The formation of the GLA is the latest in a history of London-wide governance arrangements including the former London County Council and Greater London Council. Other bodies including Transport for London, the PHE Region and NHS England Region follow the same geography. London is a very diverse economy with some of the wealthiest neighbourhoods in the country alongside areas of deprivation – differences which are reflected in health inequalities.

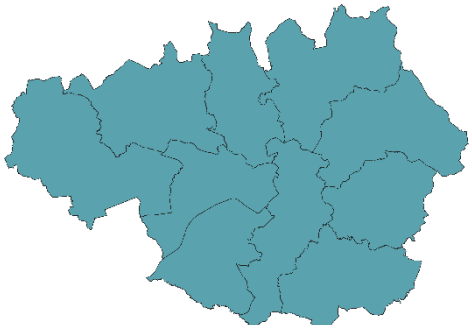
Greater Manchester Combined Authority

Creation: 2011

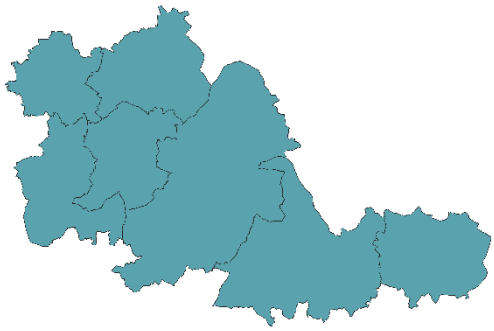
Population: 2.8 million (2019)

Local authorities: Bolton; Bury; Manchester City; Oldham; Rochdale; Salford; Stockport; Tameside; Trafford; Wigan.

Description: Greater Manchester has been economically significant since the 18th century and is widely seen to have led the development of the Northern Powerhouse. The Greater Manchester economy is bigger than that of Wales or Northern Ireland. It is a predominantly urban area but includes significant rural areas including part of the Peak District. The creation of the GMCA represents the latest stage in over three decades of collaboration since the abolition of the former metropolitan county council in 1986.



West Midlands Combined Authority



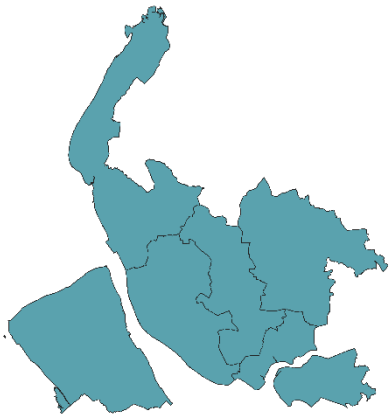
Creation: 2016

Population: 2.9 million (2019)

Local authorities: Birmingham; Coventry; Dudley; Sandwell; Solihull; Walsall; Wolverhampton.

Description: Birmingham is by far the largest council in the combined authority's area. Links with the wider West Midlands are reflected in the CA's associate members in Worcestershire, Warwickshire and Staffordshire. Arrangements for collaboration between the seven councils in the West Midlands conurbation have been in place since the abolition of the former county council in 1986. The Black Country councils also have a history of close collaboration and there are three Local Enterprise Partnerships (LEPs) in the CA area. Economic strengths of the region include advanced manufacturing, particularly in the automotive and aerospace industries.

Liverpool City Region



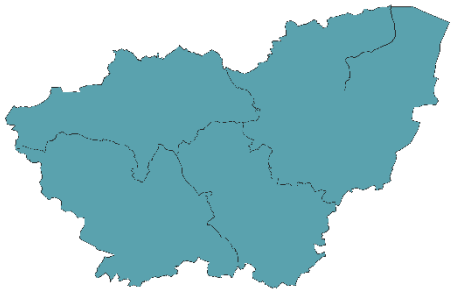
Creation: 2014

Population: 1.5 million (2019)

Local authorities: Liverpool; Halton; Knowsley; Sefton; St Helens; Wirral.

Description: LCR is predominantly urban and includes the internationall recognised waterfront. Economic strengths include advanced manufacturing health and life sciences, maritime and logistics and the visitor economy. Th councils in LCR have worked increasingly closely together since the abolition o the metropolitan county council in 1986. The directors of public healt collaborate across a slightly wider geography, which includes Cheshire, throug the Champs Public Health Collaborative.

Sheffield City Region



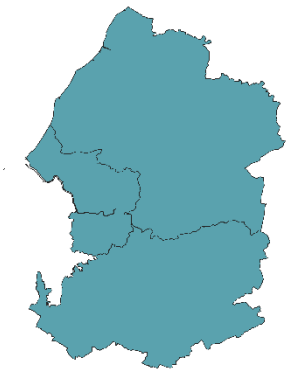
Creation: 2014 (devolution agreement not yet made)

Population: 1.4 million (2019)

Local authorities: Barnsley; Doncaster; Rotherham; Sheffield.

Description: The Sheffield City Region Mayoral Combined Authority comprises the four South Yorkshire council areas as full constituent areas with a less formal working relationship in place, with districts in Derbyshire and Nottinghamshire. After a long over reliance on the public sector the region is now experiencing strong private sector jobs growth and is increasingly well placed to benefit from its distinct economic strengths in engineering, advanced manufacturing and digital technologies. The city region is a well-established functional economic area with a history of collaboration. The formation of the LEP in 2011 and the creation of a Combined Authority in 2014 with the election of a Mayor in 2018 cements this close working.

West of England Combined Authority



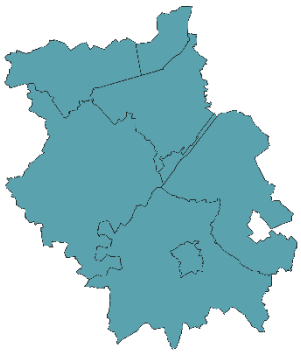
Creation: 2017

Population: 942,000 (2019)

Local authorities: Bath and North East Somerset; Bristol; South Gloucestershire.

Description: Bristol and Bath are located at the heart of the West of England Combined Authority. The region has a diverse economic base and high levels of employment. Of particular importance are the aerospace, financial & professional services sectors and the creative & digital sector. Collaboration across the area is complicated by the fact that the West of England LEP includes North Somerset Council, which is not part of the combined authority. The directors of public health also collaborate across the wider geography.

Cambridgeshire and Peterborough Combined Authority



Creation: 2016

Population: 856,000 (2019)

Local authorities: Peterborough (unitary); Cambridgeshire County; Cambridge City; East Cambridgeshire; Huntingdonshire; South Cambridgeshire; and Fenland.

Description: This is the only MCA in a non-urban area with two-tier local government. Greater Cambridge is an economically important location and forms part of the Oxford-Cambridge Arc which links the country's two leading universities and Milton Keynes. There is increasing collaboration across the geography with a single chief executive and officer structure for Cambridgeshire County Council and Peterborough City.

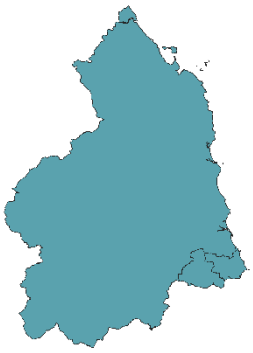
North of Tyne Combined Authority

Creation: 2018

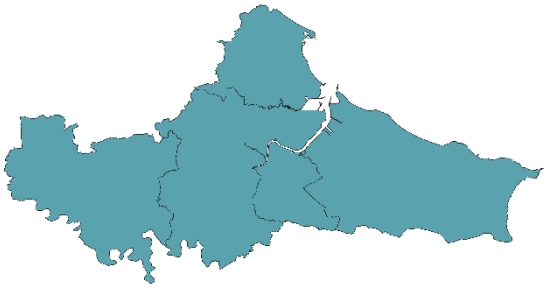
Population: 833,000 (2019)

Local authorities: Newcastle; North Tyneside; Northumberland.

Description: This is the most recently created combined authority. The urban area north of the Tyne includes part of Northumberland, but a large part of the combined authority is very rural. Economic strengths include offshore and clean energy, digital, and innovation in ageing. A joint transport committee has been established across a wider geography which includes the authorities south of the Tyne.



Tees Valley Combined Authority



Creation: 2016

Population: 675,000 (2019)

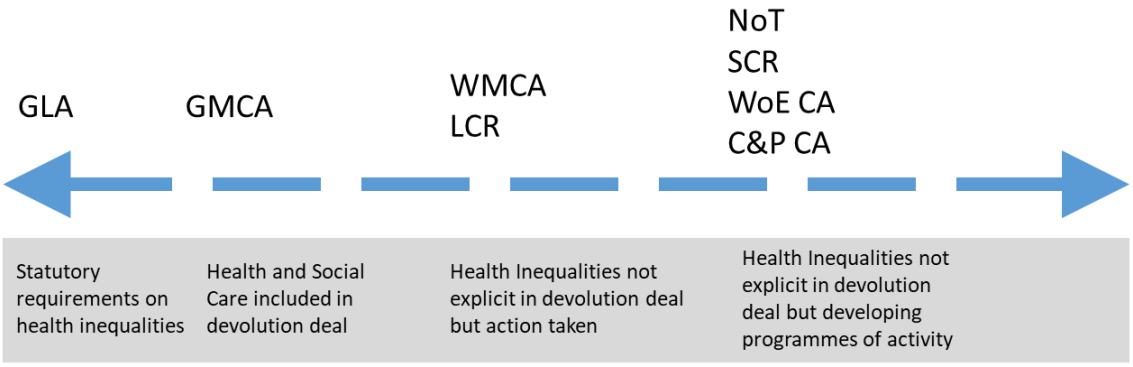
Local authorities: Darlington; Hartlepool; Middlesbrough; Redcar and Cleveland; Stockton-on-Tees.

Description: Its current economic strengths include chemicals, energy and advanced manufacturing. It also has an attractive coastline and a network of market towns. There has been a history of collaboration between the six councils that make up Tees Valley since the abolition of the former Cleveland County Council, which covered the same area, in 1996. There is no formal structure for collaboration of directors of public health across the area: the ADPH North East covers the wider North East region.

2.1 It is clear from these brief pen portraits that the position in each MCA varies significantly. The table below summarises the different powers and funding that have been devolved to each MCA. The table does not account for the variation within each devolved sector and therefore indicative of powers.

Combined Authority area	Population size (2019)	Year created	Devolved powers and funding														
			Business and economic growth	Transport (incl. strategic planning and bus franchising)	Fire	Policing and crime	Health and Social Care	Health Inequalities	Housing	Planning & Regeneration/infrastructure	Environmental improvement	Criminal justice	Arts and Culture	Education and youth	Adult education and skills	Waste disposal	Additional ad-hoc projects
Greater London Authority	8,961,989	2000	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	✓	
Greater Manchester CA	2,835,686	2011	✓	✓	✓	✓	✓		✓	✓		✓			✓	✓	Public Service Reform Pilot 100% retention of business rates
Liverpool City Region CA	1,559,320	2014	✓	✓						✓	✓				✓		Partnership on innovation, energy and National Museums. Pilot 100% retention of business rates
Sheffield City Region CA[7]	1,409,020	2014	✓	✓						✓					✓		Development of SCR Advanced Manufacturing Innovation District
West Midlands CA	2, 928,592	2016	✓	✓					✓						✓		
Tees Valley CA	675,944	2016	✓	✓						✓					✓		
West of England CA	941,752	2017	✓	✓											✓		Co-design National Work and Health Programme
Cambridgeshire and Peterborough CA	855,796	2017	✓	✓					✓	✓					✓		Work on the National Work and Health Programme
North of Tyne CA	833,167	2018	✓							✓					✓		

2.2 In order to help to understand this we have developed a spectrum which illustrates the position of each MCA and the GLA in terms of the development of their approach to tackling health inequalities. In the next section we explore the factors that explain these differences.



How are MCA's funded?

There is no simple explanation of how a Combined Authority is funded. Some funding is set out in devolution deals, and other funding is negotiated or raised outside of the deal. This could be through raising a council tax precept, taking part in specific projects, through transport levies, and from membership fees paid by their constituent local authorities. Typical examples of funding streams for the MCAs involved in this project include the following:

- Government grants, such as: Investment Fund Grant, Transport Grants, Adult Education Budget, Local Growth Fund.
- Specific projects, such as: Adult skills enhancement projects, Working Win pilot.
- Business rate retention pilots.

3 Key themes

3.1 In this section we set out our understanding of the factors which explain the differences between the approach to tackling health inequalities in the GLA and the MCAs. There are three parts to our analysis. First, we explore three factors which we conclude have influenced the current position: history; structures, including coterminosity (or the lack of it); and mayoral leadership. Then we discuss three drivers of action on health inequalities. Finally, we describe the three core activities which our research suggests the GLA and MCAs undertake in order to address health inequalities.

History

3.2 History is a significant factor in explaining the variation demonstrated in the previous section. The GLA was created in 1999 and was given specific duties in relation to health inequalities in 2007; Greater Manchester was the first combined authority to be established and negotiated the first devolution agreement. The North of the Tyne is the youngest combined authority. The Sheffield City Region Mayor was elected in 2018 and its devolution agreement was finalised in July 2020.

3.3 There is also a history of collaboration at the regional level in many of these areas which can provide a firm foundation for the new structures. This is particularly so in the case of Greater Manchester where the Association of Greater Manchester Authorities, which brought together all of the local authorities in the conurbation, had led joint working across the city region for more than three decades prior to the devolution deal. As a result there is a well-established city region identity there which does not exist to the same extent in many of the other MCA areas.

3.4 The fact that there is a far more sophisticated approach to health inequalities in Greater Manchester than in the other CA areas reflects the fact that health and social care was included in the Greater Manchester devolution deal, with the Greater Manchester Health and Social Care Partnership having responsibility for the £6 billion health and social care budget for the area. The partnership has adopted an approach which considers population health outcomes as a priority. Neither the West Midlands or Liverpool City Region MCAs have devolved responsibility for health and care, but both have significant programmes of work on health inequalities. At the time of writing, none of the other MCAs have specific powers or duties in health and care, but the Sheffield City Region, West of England, Cambridgeshire and Peterborough and North of the Tyne MCAs have all recognised the importance of this topic and are developing their roles in addressing health inequalities.

Organisational structures and boundaries

Coterminosity

3.5 There is no doubt that action on an issue such as health inequalities is significantly helped if all the organisations involved have the same or consistent boundaries. Greater Manchester is unique in that all the key players – health, local government, the CA, local enterprise partnership, police, fire and transport – cover the same geography.

3.6 In London, the GLA, PHE London, London Councils and NHS England and NHS Improvement London all adopt the same boundary, but the capital is split into five Sustainability and Transformation

Partnerships (STPs) and 32 Clinical Commissioning Groups[8] (CCGs). The STP boundaries mostly align with borough boundaries but they are not coterminous with local government's sub-regional partnerships which play an increasingly important role in joint working across wider geographies in London[9].

3.7 Cambridgeshire and Peterborough CA covers a far smaller area than most MCAs and is almost coterminous with the STP. It also covers the same area as the joint Cambridgeshire and Peterborough public health function, which is part of a set of joint officer arrangements between the two councils.

3.8 Elsewhere the situation is far more complicated. For example, the health organisations in the area of the North of Tyne CA cover a wider geography, as does the transport body. In the West Midlands CA area there are three local enterprise partnerships and three STPs. There are two CCGs in Birmingham alone. This geographical complexity makes the task of addressing health inequalities significantly more difficult.

3.9 London is also unique in that the regional network of the Association of Directors of Public Health is coterminous with the GLA. The Head of Health at the GLA, as well as being a joint role with Public Health England, is a member of ADPH London. Elsewhere, as with PHE regions, ADPH regions cover a larger geography than the MCA. In Greater Manchester, however, the DsPH work together across the MCA area. Work in Greater Manchester on population health[10] has been described as being led by three legs of a stool: the Health and Social Care Partnership; PHE; and the DsPH.

3.10 In the other areas, relationships are less formal and structured but there is joint working. In the West Midlands, for example, DsPH from the constituent councils are involved in projects being pursued by the combined authority.

Local governance arrangements

3.11 Our research has identified a number of examples where city region governance arrangements have been designed to take into account health inequalities. In London, the Mayor chairs a London Health Board, the membership of which includes NHS representatives, a number of council leaders and is supported by a group of borough chief executives[11]. In Greater Manchester, a Health and Social Care Partnership oversees the use of the devolved powers and resources. The partnership is made up of the Mayor, councils, local NHS organisations, NHS England and Improvement, emergency services, the voluntary sector, and Healthwatch. In the West Midlands, for example, two of the MCA's boards have an interest in health inequalities. These are the Public Service Reform Board and the Wellbeing Board.

Relationship with Public Health England

3.12 The relationship between Public Health England and the GLA and MCAs is important. Public Health England is divided into regions which cover a wider area than an MCA, but each MCA has a direct relationship with its corresponding regional director. The strength of these relationships varies from place to place. For example, the regional director in Greater Manchester works closely with the

[8] https://www.england.nhs.uk/london/ccg-trust/
[9] London is divided into the following sub regional partnerships: Central London Forward; South London Partnership; Local London; and West London Alliance.
[10] Population Health can be defined as, "an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national, population while reducing health inequalities."
[11] https://www.london.gov.uk/what-we-do/health/london-health-board

combined authority, and there is PHE collaboration on a number of projects in Liverpool City Region. Several MCAs have a public health consultant as a member of their team or seconded to it. West Midlands CA, for example, employs a consultant and works closely with the PHE intelligence hub.

3.13 London has a unique relationship with Public Health England with its Regional Director for London being the Mayor's statutory adviser on health. In practice, the statutory nature of this relationship is rarely exploited, but it reinforces the importance of the Mayor's role in this area and underpins close working relationships between the GLA and PHE.

Mayoral leadership

3.14 There is no doubt that the convening role and soft power of the London Mayor and many of the MCA Mayors has been critically important in driving action on health inequalities.

3.15 In London the Mayor's statutory duties are seen as being an important factor in bringing key players to the table, as are his use of his softer powers to convene discussions. In other places the soft power of the Mayor has been the sole factor used to convene discussions and instigate action on health inequalities in the absence of any statutory or devolved powers in this area. In the Sheffield City Region, for example, Mayor, Dan Jarvis, convened discussions on excess winter deaths and the Liverpool City Region Mayor, Steve Rotheram, has driven the CA's focus on poor health as a barrier to work and productivity.

3.16 Several of the CA Mayors have personally promoted active transport as a key element of their authorities' transport strategies. Organisational structures and powers on transport differ amongst the GLA and MCAs. Andy Burnham has brought his previous experience and knowledge as Secretary of State for Health to his role as Greater Manchester Mayor. He appointed Chris Boardman as Cycling and Walking Commissioner, and Dan Jarvis appointed Dame Sarah Storey as Active Travel Commissioner.

3.17 Wider system-wide leadership is also seen as being important in galvanising action on health inequalities. In Greater Manchester for example there is a determined effort to ensure that political, managerial, clinical and community leadership are around the table for key discussions and decisions. The convening power of the Mayor is key to delivering this and a number of chief executives, including those with joint council/CCG roles, also play important leadership roles.

Drivers of action

3.18 It is clear from our research that there are three significant drivers of action by MCAs on health inequalities. These are: poor health as a barrier to work and productivity; inclusive growth and public service reform; and health and social care reform. In several places more than one of these drivers have underpinned action.

Poor health as a barrier to work and productivity

3.19 The importance of the link between poor health, employment and productivity is best illustrated by the establishment of the Sheffield City Region CA. The need to address poor health as a barrier to work and productivity was one of the factors that prompted the establishment of this CA and featured prominently in its original draft devolution agreement. The CA subsequently led a national health and work pilot.

3.20 The link between health and productivity has also been central to the activities of Liverpool City Region CA. It commissioned the development of an evidence base on the impact of health on the economy. In

the case of both Greater Manchester and Cambridge and Peterborough economic and productivity assessments have highlighted the need for action on health to drive increased productivity and economic performance locally. In Greater Manchester the work concluded that almost a third of the productivity gap in the region was attributable to poor health.

3.21 In the West Midlands, the establishment of a mental health commission early on in the process of devolution and the creation of the combined authority put the link between health and work at the centre of the authority's priorities from the start.

3.22 In London the GLA runs the London Workplace Health Award to promote good practice in workplace health and wellbeing with employers, and more recently the Mayor has developed a Good Work Award for London to improve employment standards and work quality.

3.23 The economic benefits of the health sector also features in the work of the MCAs. Data driven health and life sciences has been identified as a new market opportunity in the West Midlands Local Industrial Strategy. Also, work is underway in Sheffield City Region to exploit the economic and health and wellbeing opportunities presented by a combination of elite sport infrastructure, university specialisms in health and care, businesses in the health and care sector and the Mayor's focus on physical activity.

Inclusive growth and public service reform

3.24 Several combined authorities are pursuing work streams on public service reform, often linked to action on inclusive economies. This underpins the case for an integrated approach with action on health inequalities featuring as an important strand of the wider activity.

3.25 This is very much the case in Greater Manchester where work on public sector reform has been underway for three years. It has informed the design of the city region systems architecture including the integrated commissioning function which is a key feature of the operation of the Health and Social Care Partnership. It has also informed the CA's approach to delivery with action at Greater Manchester, locality and neighbourhood levels. The authority's public service reform white paper includes a focus on prevention, new models of delivery and the design and delivery of better services. Actionable links are being made between, for example, health and the criminal justice system.

3.26 The approach adopted in the West Midlands has an outcomes focus. A toolkit has been developed in conjunction with PHE West Midlands through the CA's Inclusive Growth Unit, which is intended to ensure that considerations such as inclusive growth and health outcomes are taken into account in investment decisions. The authority's work on inclusive growth begins with developing an understanding of factors which might signify a local economy is doing well and how they might be measured. Rather than measuring GDP, trade etc. this leads to outcomes relating to, for example, healthy life expectancy, infant mortality, the mental health elements of the PHE outcomes framework and obesity.

3.27 The Cambridgeshire and Peterborough CA has commissioned an independent public services review, beginning with health care. In the West of England inclusive growth is central to the local industrial strategy with a particular focus on barriers to work.

Health and Care

3.28 Many of the CAs are clear that they are not seeking devolved powers and resources for health and social care, but do not see this as inconsistent with or a barrier to their commitment to acting on health inequalities. In Greater Manchester, however, work on health inequalities is an integral part of the work

of the Health and Social Care Partnership, particularly its work on population health. This reflects both the focus on prevention in the NHS Long Term Plan and the health and wellbeing strategies adopted by the councils in the area. The partnership's responsibility for making best use of the resources devolved to it is an important driver of its interest in population health, prevention, early intervention and health inequalities.

3.29 In London, while the Mayor has no powers over health and care, he is the chair of a non-statutory London Health Board, which facilitates close working with partners across London's health and care sector. In October 2019 London health and care partners published a shared vision for London and outlined how they will work together to deliver it.[12]

Action by the GLA and Mayoral Combined Authorities

3.30 There are three ways in which the GLA and MCAs can address health inequalities:

- Developing and adopting strategies;
- Pursuing specific initiatives;
- Ensuring that health considerations are taken into account in exercising their powers and responsibilities.

3.31 The London Mayor produces a statutory health inequalities strategy and the Greater Manchester Health and Social Care Partnership produces a Population Health Plan. The other MCAs address health inequalities to varying extents in other strategy documents, particularly their local industrial strategies.

3.32 The London strategy was published in 2018. It focuses on five key themes: healthy children; healthy minds; healthy places; healthy communities; and healthy living. The Greater Manchester Plan has five sets of objectives: person and community centred approaches; start well; live well; age well; and system reform.

3.33 In London, the strategy is seen as being an important mechanism to ensure that health considerations are taken into account in the GLA's other strategies and activities. It also provides a sense of direction for other organisations including the boroughs to follow. The strategy is underpinned by five key performance indicators reflecting mayoral led programmes, and progress in London is measured by 14 population health indicators and a baseline from which to report. It is also being used to open up areas in which health considerations can influence action, including violence reduction, planning and air quality. An example of how regional health inequalities policy in London has influenced borough plans is the Healthy Streets Approach[13], which originated in Transport for London (TfL). This approach has since been incorporated across a range of mayoral strategies, and has now been adopted in several boroughs' local plans.

3.34 In Greater Manchester the Mayor is also required to produce a report on the state of health and wellbeing in Manchester and it is anticipated that the first report will be produced later this year. The

[12] https://www.healthylondon.org/vision/
[13] https://tfl.gov.uk/corporate/about-tfl/how-we-work/planning-for-the-future/healthy-streets

CA is developing a health outcomes framework with key metrics which will be informed by the outputs of the Marmot Review.

3.35 Specific initiatives that are pursued by MCAs and the GLA relate to a number of areas. Active travel is a specific programme being pursued by several CAs, often with strong mayoral backing, including Greater Manchester, Sheffield City Region, and the West Midlands. Other examples of activity by MCAs include:

- An air quality taskforce in Liverpool City Region;
- Work on housing, health and regeneration with PHE in Liverpool City Region and the publication of a healthy housing design charter by the West Midlands CA.
- Action to convene partners to address homelessness in Sheffield City Region and West Midlands
- Action to address excess winter deaths in Sheffield City Region
- Violence reduction unit in West Midlands

The added value of combined authorities

3.36 On the basis of this research it is possible to identify at least four ways in which the GLA and mayoral combined authorities add value to work on health inequalities.

3.37 First, the benefit of **scale**. The geographical scale of most of the authorities, many of which comprise city regions, enables them to adopt a genuinely strategic approach. They also have the ability to adopt approaches which reflect the benefit of acting at different geographical levels: the city region, locality and neighbourhood. The scale of the GLA and MCAs also enables them to:

- Establish close links with other organisations that operate across similar geographies, most notably health, LEPs and the criminal justice system;
- Achieve economies of scale in the delivery of some health-related functions.

3.38 Second, the **powers** they have relate directly to the wider determinants of health, particularly transport, the economy, and in many cases, housing. The ability of these authorities to influence the wider determinants of health by taking health considerations into account in the exercise of these powers is significant.

3.39 Third, the GLA and MCAs have **capacity** to supplement available capacity in constituent councils to plan and mobilise action on health inequalities.

3.40 Finally, as noted earlier, the hard and soft powers of the Mayor can be significant particularly in terms of convening discussions, shaping public opinion and highlighting the need for action on this subject.

4 Reflections

4.1 The extent to which the GLA and MCAs are active on addressing health inequalities varies across the country. This variation is primarily a feature of the age of the authority and its legislative basis or devolution agreement. This research has identified a number of factors which influence and drive action on health inequalities and ultimately the added value that acting at the regional authority level brings.

4.2 Those factors are:

- Elected Mayors play a large role in driving action to address health inequalities through leadership, which is often influenced by personal interest and which often goes beyond the scope of the devolution agreements;
- Action on health inequalities often features in and/or is underpinned by a strategy document or framework, such as the Greater Manchester Health and Social Care Partnership Prospectus, or the West Midland Combined Authority Inclusive Growth Unit Tool. In some areas, the public service reform agenda enables a health in all policies approach ensuring that health inequalities are considered in the delivery of policies in transport, housing, planning etc.;
- The role of PHE's Regional Director in London as an adviser to the Mayor on Health is significant, as is the less formal relationship with the PHE regional directors in other areas. The involvement of PHE as an important voice along with DsPH and the Health and Social Care Partnership in GMCA is a driver of successful action;
- The inclusion of health and social care in GMCA devolution has provided a financial incentive to act on the wider determinants of health;
- Action on health inequalities often comes down to finding or crafting the opportunities for action. This often means linking in with other pressing policy areas such as inclusive growth, increasing productivity and public service reform. These links can maximise the opportunities for action on health inequalities;
- There is significant common ground between the wider determinants of health, inclusive growth and climate change and potential for links between these to be exploited.

5 Annex: Pen portraits

Greater London Authority

The Greater London Authority (GLA) was established by the Greater London Authority Act 1999, following a White Paper and a referendum. It comprises a Mayor and 25 Assembly members. The current Mayor is Sadiq Khan. The population of Greater London is 8.96 million (2019). The GLA's geography covers the 32 London Boroughs and the City of London Corporation.

The responsibilities the GLA has control over have evolved since 2000. It currently has responsibilities in the following areas:

- Arts and Culture
- Business and Economy
- Environment
- Transport
- Fire
- Health Inequalities
- Sport
- Volunteering
- Housing and Land
- Planning
- Regeneration
- Policing and Crime
- Education and Youth
- Adult Skills and education

There is a wider GLA group of organisations who are responsible for the delivery of different functions across London. These include Transport for London, the Mayor's Office for Policing and Crime, the London Fire and Emergency Planning Authority, the London Economic Action Partnership and the London Legacy Development Corporation.

The Greater London Act 2007 gave the GLA a statutory responsibility relating to health inequalities[14] including a requirement for the Mayor to produce a Health Inequalities strategy (HIS). This duty sits alongside the Mayor's responsibility to produce a range of other strategies including Transport, Economic Development, Housing, Spatial Development, Environment, and Culture.

Local authorities in London have established four sub-regional partnerships which work on a number of policy areas, most notably the economy. They are:

- Central London Forward[15] for the local authorities of Camden, the City of London, Hackney, Haringey, Islington, Kensington and Chelsea, Lambeth, Lewisham, Southwark, Tower Hamlets, Wandsworth, and Westminster;
- South London Partnership[16] for the local authorities of Croydon, Kingston upon Thames, Merton, Richmond upon Thames, and Sutton;

[14] http://www.legislation.gov.uk/ukpga/2007/24/contents
[15] https://centrallondonforward.gov.uk/
[16] http://southlondonpartnership.co.uk/

- West London Alliance[17] for the local authorities of Barnet, Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon and Hounslow; and
- Local London[18] for the local authorities of Barking and Dagenham, Bexley, Enfield, Havering, Greenwich, Newham, Redbridge, and Waltham Forest.

There are five STPs[19] in London, of which one, South East London, has matured into an Integrated Care System. Significantly, these structures do not adopt the same geography as the local authority sub-regions.

What action the Greater London Authority is taking explicitly on health inequalities

The current Health Inequalities strategy is a ten year strategy, published in 2018. This has five themes, with associated aims:

- Healthy Children including healthy early years and schools programmes and action on child obesity
- Healthy Minds; improving mental health and wellbeing, through the Thrive LDN programme, and action on suicide prevention
- Healthy Places; action on wider determinants of health such as housing and homelessness, low pay, skills and work quality, planning, green spaces and air quality
- Healthy Communities; including social prescribing, HIV/Fast Track Cities, Community safety and social integration
- Healthy Living, including active travel, food, and activity on smoking, alcohol and drug harms

A total of 14 key indicators on population health have been identified (mainly from the public health outcomes framework) and are being monitored and regularly reported on. These do not measure the impact of mayoral activity, but instead show the picture of health inequalities in London, with the anticipation that partnership action across the city could impact the trajectory. This strategy recognises the complexities in the health of the population of Greater London. It is a high level strategy setting an ambitious direction of travel but allowing delivery to reflect local needs and priorities. An annual report showing activity in the first year of the HIS was published in January 2020.

The London Assembly holds the Mayor to account in his delivery of the strategy. The London Assembly consider the Strategy before publication. The Health Committee of the London Assembly scrutinises the Mayor's activity against the Strategy as well as other elements of the Mayor's health programmes.

The delivery of the strategy is championed and overseen by the London Health Board, a non-statutory group chaired by the mayor and borough council leaders and representatives from the health sector. It champions and supports good practice, challenges partners to deliver improved health outcomes and services, supports health and care transformation and the delivery of the devolution memorandum of understanding. A unique feature of the London arrangements is the fact that the London Regional Director of Public Health England is the statutory adviser to the Mayor on health. This is an important

[17] https://wla.london/
[18] https://www.thisislocallondon.co.uk/
[19] https://www.england.nhs.uk/integratedcare/stps/view-stps/#london

back stop, highlights the importance of the Mayor's responsibilities on health inequalities and sets the context for collaboration between the GLA, PHE and the London Boroughs – including their directors of public health. It is also significant that the Head of Health at the GLA is a member of the London Association of Directors of Public Health network.

While the Mayor has some power relating to the wider determinants of health, addressing health inequalities necessitates activity beyond the Mayor's reach. The HIS is a partnership strategy, delivered working with a range of partners. This is indicated in the GLA Act 2007 which states that *"The strategy must— …..(d)describe the role to be performed by any relevant body or person for the purpose of implementing the strategy."*[20]

The extent to which the Greater London Authority is taking health into account in other responsibilities

The existence of the Health Inequalities Strategy has been instrumental in ensuring that health considerations feature strongly in the other strategies for which the Mayor and GLA are responsible.

Health considerations are particularly significant in relation to Transport for London which has public health consultants integrated in its workforce. Health factors feature strongly in the GLA's transport strategy. Relevant initiatives include the healthy streets programme through the funding of healthy streets officers, active travel, air quality and low carbon zones. Other priorities relating to health inequalities at TFL are not necessarily framed as public health issues, but which do have impacts on public health. For example, Vision Zero on tackling road traffic deaths, keeping fares low and improving accessibility to public transport for more Londoners.

Significant progress has also been made in embedding health considerations in the London Plan, housing and homelessness, and most recently in establishing the first Violence Reduction Unit in England founded on a public health approach.

Action taken by directors of public health across the geography

Significantly, the transfer of public health to local government took place six years after the introduction of the GLA's statutory duty for health inequalities. The directors of public health in the London boroughs have a very strong ADPH network and, as noted above, the head of the GLA Health Team is a member of that network. The network pursues London-wide activity on its own initiative and in collaboration with the GLA and individual DsPH work with the GLA team on particular initiatives.

Summary

The Mayor's duty to produce a health inequalities strategy is significant in its own right, as a hook to ensure that health considerations are taken into account in the GLA's other strategies and as a means of convening partners and driving action on health inequalities at a London-wide and local level. There are a number of important links between the GLA and the wider health system including the London Health Board, the role of the PHE London Regional Director and the GLA's representation on the London ADPH Network.

[20] http://www.legislation.gov.uk/ukpga/2007/24/part/4/crossheading/reduction-of-health-inequalities

Greater Manchester Combined Authority

Greater Manchester Combined Authority was established in 2011 and the first Mayor, Andy Burnham, was elected in 2017. It comprises the councils of Bolton, Bury, Manchester, Oldham, Rochdale, Salford, Stockport, Tameside, Trafford and Wigan. It has a population of 2.84million (2019).

There have been a total of six devolution deals between November 2014 and November 2017. The region currently has powers and controls over budgets relating to:

- Transport
- Housing Investment Fund
- The role of Police and Crime Commissioner
- Fire and Rescue responsibilities
- Business support
- Apprenticeship grants
- Working Well pilot
- Commissioner with DWP for the Work Programme
- Health and Social Care
- Creation of Greater Manchester Land Commission
- Collaboration on the Northern Powerhouse
- Economy and regeneration
- Employment and adult education
- Criminal Justice Devolution

The use of devolved powers and responsibilities in relation to health and social care is overseen by the Greater Manchester Health and Social Care Partnership (GMHSCP) which brings together the Mayor, local government, local health organisations, NHS England and NHS Improvement, the emergency services and the voluntary sector. There is a population health team within the partnership.

Devolution was underpinned by the long-standing history of collaboration between the councils of Greater Manchester Combined Authority.

What action the Combined Authority is taking explicitly on health inequalities

The inclusion of health and social care in the devolution deal has facilitated action on health inequalities. There are a number of important documents which have shaped the context within which action on health inequalities takes place. This has set the condition for public service reform at the GM, locality and neighbourhood levels and enabled population health to be embedded across the system. Documents include:

- Taking Charge of our Health and Social Care, 2015;
- The Greater Manchester Model White Paper on Unified Public Services;
- Population Health Plan, 2017;
- Local Industrial strategy, 2019;
- Independent Prosperity Review;
- Greater Manchester Health and Social Care Partnership Prospectus;

- Kings Fund Review of Population Health, 2020; and
- Work with Sir Michael Marmot to develop a proposition for reducing inequalities in Greater Manchester.

As a requirement to the devolution deal, the Mayor will be producing a report on public health which will pull together action to address health inequalities.

The Greater Manchester Health and Social Care Partnership, directors of public health and PHE work together to deliver action on population health. This partnership involves individuals in various positions which means that a common vision and narrative is shared.

The Mayor brings a wealth of experience and interest in addressing health inequalities.

The combined authority is coterminous with the ICS and the ADPH network. It is the only area, other than Greater London where the DsPH have a network that matches the CA geography.

The extent to which the authority is taking health into account in other responsibilities

An integrated place-based system which priorities population health is the key ambition. Population health is therefore becoming embedded across the responsibilities of the combined authority and features strongly in the documents set out above.

A Joint Commissioning Board has been created and is a core feature of the GM approach. It supports action to address the full spectrum of the social determinants of health. Similarly, at the locality level, they have single commissioning functions and single finance directors.

Some other examples of how population health is being taken into account in other responsibilities include:

- The Independent Prosperity Review which assessed the connections between good health and wealth. It provided evidence to substantiate that just under a third of the productivity gap in GMCA region was driven by poor health.
- Criminal Justice and Health board which has a particular focus on addressing health inequalities within the criminal justice system.

Action taken by directors of public health across the CA geography

The DsPH are a core group working together to embed action to address health inequalities in the system and in policy making. The DsPH are involved in all of the partnerships that exist. The long history of collaboration between local authorities in the Greater Manchester region has enabled collaboration at this level.

Summary

Greater Manchester Combined Authority is embedding action on health inequalities through an ambitious programme of public service reform. Having health and social care included in devolution provided weight to the inclusion of action on the wider determinants of health. The role provided by DsPH and their partnership with GMHSCP and PHE is crucial to achieving this. Having a long-standing history of collaboration between the districts meant that this level of collaboration has been possible.

West Midlands Combined Authority

The authorities in the West Midlands conurbation formally established a combined authority in 2016 having negotiated a devolution agreement in 2015. Some additions were made to the deal in 2017. Its Mayor, Andy Street, was elected in 2017. Its constituent authorities comprise Birmingham, Wolverhampton, Coventry, Dudley, Sandwell, Solihull, and Walsall councils. It has a population of 2.93 million (2019).

Its devolution deal includes the transfer of the following responsibilities:

- Transport budget;
- Bus services;
- Key Route Network; and
- Planning powers.

The Combined Authority received funding pots relating to:

- Driving growth;
- Adult skills funding;
- Employment support;
- Delivery of business support programmes
- HS2 Growth Strategy;
- Metro extensions;
- Roads investment strategy; and
- Public service Reform.

The regional structure of the West Midlands Combined authority is complex, which presents challenges for partnership working. There are multiple LEPs, 5 STPs and 2 CCGs in Birmingham alone.

What action the Combined Authority is taking explicitly

Work to address health inequalities has been a feature of the combined authority since 2015 and has taken shape through various phases. It first focused on mental health inequalities with the establishment of a Mental Health Commission to design and implement approaches to improving the life chances of "troubled individuals". This created a momentum which has driven subsequent action on health inequalities.

Work to tackle the wider determinants of health has a clear focus as being part of the combined authority's approach to inclusive growth.

The combined authority has undertaken explicit action on:

- Housing: they have developed a health housing design charter with local authorities, developers and housing representatives;
- Homelessness: they have a taskforce on addressing homelessness;
- Obesity and physical activity: linked into their transport responsibilities;
- Thrive at Work: for employers to support mental and physical health of workplace;
- Inclusive Growth Unit: supported by PHE and aims to better understand the local population and inequalities, particularly through the building of an evidence base for the Local Industrial Strategy, and to close the 'health and wealth' gap;
- West Midlands On the Move: physical activity programme;

- Commonwealth Games Legacy.

In some ways, the combined authority is exerting influence beyond its powers through undertaking action in areas which have not been included in devolution deals, but which has supported a Mayoral pledge, for example its action around homelessness.

The combined authority has employed a public health consultant who is an important member of their team and provides support on intelligence. They have also undertaken work with PHE through establishing a public health intelligence hub.

An important driver for action at the combined authority level is the value that working across this geography brings, which will depend on the sector/area of focus. For example, working across the combined authority area on violence reduction works well as the police works across the same geography as do NHS organisations which have data on violence.

Another important driver for action on health inequalities is the Mayor, who is interested in tackling health inequalities. In particular, the current Mayor, Andy Street, is interested in removing barriers to work and raising productivity. The Mayor's role enables a direct link into central government which is particularly powerful. It also brings a local profile and the use of softer powers to convene key local stakeholders.

The extent to which the authority is taking health into account in other responsibilities

The combined authority recognises that the powers which it has are relevant to the wider determinants of health and that addressing existing health inequalities is key to driving its inclusive growth agenda. Much of the work of the combined authority is driven by its focus on public service reform and therefore seeks to influence the whole system. While not explicitly driven by the need to address a particular determinant of health, health inequalities are addressed as part of the whole system approach.

The priority given to inclusive growth – ensuring that all communities in the region benefit from growth – means that health inequalities are intertwined in this approach and addressed at every level. The combined authority is working with PHE to test out an innovative approach to inclusive growth through a shift in the way that they measure their economy. Rather than use indicators relating to growth, jobs and trade, the region is moving to using a number of indicators relating to health inequalities as a measure of the economy.

A range of activity to address health inequalities has been undertaken in collaboration with West Midlands Transport. This is underpinned by evidence that demonstrates a high prevalence of obesity and inactivity linking to areas with bad air quality. Activity includes:

- A long term transport strategy;
- Improvements to air quality;
- Building of cycling networks and key walking zones;
- Work to join up activity and link transport with housing etc. particularly in the four priority corridors;
- Using the Better Streets Community Fund to develop an initiative on healthier streets; and

- West Midlands physical activity engagement.

The combined authority has provided the thinking space to focus and 'get things done'. The profile of the Mayor has enabled action to be prioritised.

Action taken by directors of public health across the CA geography

The combined authority has a close working relationship with the West Midlands Directors of Public Health individually and collectively. They have crafted a clear sense on where they need to work together to address health inequalities and where they need to work at the locality level. This has enabled them to work together towards a shared vision. Each of the area of work on health identified by the MCA involves a lead DPH.

Summary

West Midlands Combined Authority is leading a range of action to address health inequalities across its geography which has steadily grown in momentum since its inception. It recognises that addressing health inequalities is key to inclusive growth and that the wider determinants of health are inherent in each of its priorities, and is therefore in some ways acting beyond its powers. Action is jointly led by the combined authority and DsPH.

Liverpool City Region

Liverpool City Region Combined Authority was established in 2014 and comprises the councils of Liverpool, Halton, Knowsley, Sefton, St Helens and Wirral. Its first Mayor, Steve Rotheram, was elected in 2017. It has a population of 1.56 million (2019).

Devolution agreements were made in 2015 and revised in 2016 where additional powers were devolved. The deal includes:

- The appointment of a Mayor
- £900 million funding of priority areas
- Transport powers
- Piloting the 100% business rates retention approach
- Working in partnership with the Government on children's services, health, housing and justice.

The combined authority currently has priority areas on:

- Transport
- Energy and the environment
- Digital
- Skills and apprenticeships
- Culture
- Housing and spatial planning
- Homelessness

What action the Combined Authority is taking explicitly on health inequalities

The Liverpool City Region MCA is actively developing its work on health inequalities driven by the significance of poor health as a barrier to work and productivity. The combined authority aims to ensure that health inequalities are taken into account in its work on housing, transport, planning and the economy. LCR has therefore evolved to adopt a health in all policies approach to tackling health inequalities.

LCR has taken into account health inequalities within each of its priority areas, which are discussed below. The combined authority has also identified key areas and communities across the geography where health outcomes are at their worst.

The combined authority brings the benefits of scale and a strategic approach to tackling health inequalities. It enables common issues across the geography to be identified and addressed.

The Mayor has a personal interest in addressing health inequalities and increasing life chances. He has therefore brought focus and profile to the issue.

The extent to which the Combined Authority is taking health into account in other responsibilities

The combined authority is aiming to integrate health considerations across all of its priorities, in particular housing, planning, transport and the economy. It recognises that mental health is a particular contributor to low productivity, a particular challenge of the region. A public health speciality registrar has been placed in the CA for 12 months, to help identify how public health approaches can be embedded across its priorities. The intention is that the CA will become a regular placement for public health trainees.

The combined authority has undertaken a number of specific projects including:

- The Households into Work programme looking at the employability of individuals in disadvantaged households and supporting them into work.
- Work with PHE on the Wealth and Wellbeing Programme, which was jointly commissioned with councils across the geography, to develop an evidence base on the impact of poor health on the economy, and of the economy on health.
- Housing interventions in areas where health outcomes are particularly low, recognising the links between poor housing and poor health.
- Local Industrial Strategy which takes a person-centred approach and has made health, wellbeing and inclusive growth central aims.

Action taken by directors of public health across the geography

Councils across the geography collaborate on public health issues. They understand that the greatest impact on tackling health inequalities will be achieved when action is at scale and systematic across the geography.

There are a number of partnerships covering the geography such as:

- CHAMPs partnership, a sub-regional ADPH network
- The NHS Cheshire and Merseyside Healthcare Partnership

The combined authority is a partner in these collaborations and together have undertaken work on:

- Supporting homeless people with complex needs to live in their own home
- Addressing health reasons behind worklessness
- The link between health and care and inclusive growth

There are a number of challenges to working collaboratively. It is important that the collaborative work takes into account competing priorities and differing local agendas across the geography. These challenges are addressed by strong leadership, shared learning and continuous engagement.

Summary

An increasing amount of collaborative action is being undertaken across the geography by the combined authority and councils to address health inequalities and embed action to address them across all priority areas. The Mayor is a particular driving force for this as are the shared values across the geography about the importance of the work.

Sheffield City Region

Sheffield City Region formed in 2014 and comprises of the councils of Sheffield, Barnsley, Doncaster and Rotherham. It has a population of 1.4 million (2019). The City Region elected its first Mayor, Dan Jarvis, in 2018. Its devolution agreement was approved in July 2020, though yet to be published. It is likely to include control and powers relating to transport, economic growth, housing and employment and skills. The MCA has not sought devolved health powers, but action on the wider determinants of health has been a priority since the start.

What action the Combined Authority is taking explicitly on health inequalities

The link between heath and work was an early priority for the CA even before the election of the Mayor. The Working Win scheme, a pilot project with the Department for Health, was designed to re-integrate and support people who are on long term sickness for mental or physical health issues into employment. This pilot has brought together the CA, councils, CCGs and other stakeholders.

This pilot acted as a catalyst to an ambition for addressing health inequalities, and in particular the use of existing system architecture enabled action on health inequalities to be sustained.

The combined authority is developing an Innovation Plan which will connect deprived areas with benefits from the Olympic Legacy, elite sport, high quality research assets and physical space.

A Mayoral priority is on active travel and more widely encouraging a healthy and active lifestyle. This contributed to a bid for the Transforming Cities fund to improve facilities. Active travel requires a significant investment in infrastructure. Dame Sarah Storey has been appointed Active Travel Commissioner for the Sheffield City Region.

The combined authority is increasingly working with the CCGs, and together they are looking to form partnerships so that joined up solutions to tackling health inequalities can be developed. They recognise that no single organisation can tackle this issue on their own.

The Mayor has a personal interest in addressing health inequalities and therefore it has risen up the agenda. Despite not having any formal legal role or powers on health, the Mayor uses his softer powers to convene stakeholders and to drive forward the momentum on addressing health issues such as excessive winter deaths.

Working at a combined authority level brings the following opportunities:

- The opportunity to leverage additional funds;
- The opportunity to bring together and share best practice; and
- The opportunity to take forward a particular programme of activity at scale.

An important feature of the region is the similarity of the challenges faced by communities across the councils in the area. The combined authority is in a strong position to orchestrate multi-agency responses to these challenges.

The extent to which the authority is taking health into account in other responsibilities

The priority areas for the combined authority have begun to shift in the past 18 months, since the election of the Mayor. This reflects the fact that the economic situation has evolved since the evidence base that contributed to the original Strategic Economic Plan (SEP) which prioritised economic growth

and a reduction in unemployment. More recently, the combined authority is refreshing the SEP, and the emphasis is on inclusive growth and ensuring all communities benefit from economic growth. The new evidence base demonstrates the links between low wages, high poverty, low skills, and high health inequalities. As a result, the wider determinants of health are increasingly relevant to the MCA's economic priorities.

Action taken by directors of public health across the CA geography

There are no formal links between the MCA and the DsPH in its constituent councils. There is, however increasing collaboration as the combined authority develops its work programme. DsPH were involved in the work and health pilot and participated in the mayor's initiative on Winter deaths.

Summary

Strategic action to address health inequalities is work in progress in Sheffield City Region with current action taking the form of specific projects. A Mayor with an interest in addressing health inequalities combined with a refresh of the SEP evidence base is driving the agenda to integrate policies to address the wider determinants of health.

West of England

West of England Combined Authority was formed in 2017 with the Mayor, Tim Bowles, elected later that year. The combined authority comprises Bath and North East Somerset, Bristol and South Gloucestershire. It has a population of 941,752 people (2019).

It has powers on the region's transport, housing, and business support and skills. It aims to create healthy places where people want to live, work and move to. The combined authority's priorities, as set out in their 2018-19 annual report, focused on driving clean and inclusive economic growth. The region's Local Industrial Strategy sets out the ambition to cement the West of England as the place to develop and test innovation solutions to the challenges of the future. It has four key areas of focus that seek to raise the region's productivity and drive economic growth in a way that is sustainable and offers opportunity to all residents. The four key priority areas for action are:

- Cross sectoral innovation
- Inclusive growth
- Addressing the productivity challenge
- Innovation in infrastructure delivery

What action the Combined Authority is taking explicitly on health inequalities

The combined authority does not have a specific work strand on addressing health inequalities. Its Local Industrial Strategy focuses on driving an inclusive economy. It seeks to address the divide in opportunities that currently exist for lower skilled people. This divide is most apparent in particular communities across the wider geography and therefore working together at this scale is beneficial. It is envisaged that health inequalities will be addressed in the work that is being undertaken to deliver the Local Industrial Strategy. For example, Future Bright is a new project which aims to develop bespoke interventions to address the barriers to higher skilled employment faced by those in low paid employment.

There is an appetite to address health inequalities more explicitly at the combined authority level. There are informal plans to set up a partnership with councils, CCGs and the combined authority which will focus on addressing health inequalities.

The extent to which the Combined Authority is taking health into account in other responsibilities

Health inequalities are being taken into account on a project by project basis across the combined authority. For example, there is currently work underway to bid for funding, which, if successful, would aim to design desirable adaptations for bathrooms and kitchens to enable people to live in their homes for longer.

Action taken by directors of public health across the geography

Directors of public health across the geography have been the driving force behind setting up the partnership with the CCG to tackle health inequalities specifically. This was driven by the Public Health England toolkit and the need to focus on prevention from the STP.

Summary

While the focus of the combined authority in its first two years has been delivering against their initial priorities, work on addressing health inequalities is beginning to happen on a project by project basis. This is beginning to reflect the appetite amongst the combined authority and councils across the geography to drive forward a partnership agenda on reducing health inequalities.

Cambridgeshire and Peterborough

Cambridgeshire and Peterborough Combined Authority was established in March 2017, with its Mayor, James Palmer, elected in May of the same year. It comprises seven constituent councils Peterborough (a unitary council), Cambridgeshire County Council and five city and district councils including Cambridge, South Cambridgeshire, East Cambridgeshire, Huntingdon and Fenland. It has a population of 856,000 (2019).

The devolution deal includes powers and controls over transport, planning, skills and the economy. This includes the following:

- Responsibility for a multi-year, consolidated and, devolved transport budget;
- Responsibility for an identified Key Route Network of local authority roads that will be managed and maintained by the Combined Authority on behalf of the Mayor;
- Powers over strategic planning, control of a £100m housing and infrastructure fund the responsibility to create a non-statutory spatial framework for Cambridgeshire and Peterborough, to develop with Government a Land Commission, and to chair The Cambridgeshire and Peterborough Joint Assets Board for economic assets;
- Control of a new additional £20m million a year funding allocation over 30 years, to be invested to the Cambridgeshire and Peterborough Single Investment Fund;
- Responsibility for chairing an area-based review of 16+ skills provision;
- Joint responsibility with government and the single Employment and Skills Board covering the Cambridgeshire and Peterborough Combined Authority and the Norfolk and Suffolk Combined Authority to co-design the new National Work and Health Programme;
- More effective joint working with UKTI to boost trade and investment through agreement of a Joint Export Plan.

What action the Combined Authority is taking explicitly on health inequalities

The MCA commissioned an economic review which gave it a clear steer on the need to tackle health inequalities and a clear focus from which to develop a narrative. The inequalities that exist in the region are stark with significant wealth and poverty and differences between the urban and rural areas.

The economic review identified the potential role of the combined authority on prosperity and the closing of inequality gaps. Therefore, work to address health inequalities is driven by two economic objectives. The first is to support the continued economic growth of the region. The second is to raise productivity in the areas identified as having a higher proportion of residents with low skills and educational qualifications.

Public service reform is also on the agenda of the combined authority and has been the focus for around a year. This is being driven by the belief that if the systems are better joined up through public service reform, better outcomes will be achieved which will relieve longer-term financial pressures. While this is a broad remit, the CA decided to focus first on health and understanding how they can take a whole systems approach. The CA has commissioned an independent review of public services reform to review health and social care integration, which is in its early stages.

A key strand is the work the MCA is undertaking with PHE particularly around raising productivity in areas where educational outcomes are lower.

Coterminosity with the CCGs, Police and Fire authorities is an important driver to action, and particularly useful within a complex health and care system. A lot of the activity to date on health inequalities has been informal, but the Mayor is keen to do more to address the links between health, employment and productivity.

The extent to which the authority is taking health into account in other responsibilities

The CA has a representative from the NHS on its board. This is proving to be an effective way to incorporate decisions on health across the spectrum of work.

Action taken by directors of public health across the CA geography

There is a joint Director of Public health for Cambridgeshire and Peterborough, which is part of the extensive joint arrangements between the county and the unitary councils. This covers the same area as the combined authority.

Summary

The recently published economic review has been a catalyst to action on tackling health inequalities. The limited time since the creation of the combined authority and publication of the review means that action is in the early stages though ambition of the MCA is evident.

North of Tyne

North of Tyne Combined Authority was created in 2018 and its Mayor, Jamie Driscoll, was elected in May 2019. It comprises the councils of Newcastle, North Tyneside and Northumberland. The devolution deal aims to enable increased opportunities and living standards across the geography through inclusive growth and productivity improvements. It also aims to help drive the Northern Powerhouse. The deal included:

- The election of a Mayor
- Control of £20 million revenue funding over 30 years
- Adult Education budget
- Establishment of an Inclusive Growth Board
- Establishment of a Housing and Land Board
- Establishment of a joint committee with North of Tyne and North East Combined Authorities to exercise transport functions

Similar to West Midlands and Sheffield City Region, there is no public health duty in the devolution deal. The revenue funding mentioned above is an important feature of this deal and this brings additional flexibility and opportunities for creativity in its spending.

What action the Combined Authority is taking explicitly on health inequalities

This MCA is very new, though addressing health inequalities is considered essential to addressing population productivity and improving the wellbeing of its community.

Through the Investment Fund, the MCA is focusing on addressing the impact of poverty and an ageing society and is working with a number of partners to do so. One project is with the Housing Alarm Board and links wellbeing, climate and pro-ageing. The MCA is also working with the National Innovation Centre for Data based at Newcastle University to create opportunities using technology for those in poor health and poor wealth.

These projects recognise that health inequalities are embedded in everything that they do and therefore that inclusive growth is important.

The combined authority is also at the start of the journey of setting up principles on what good work looks like, which is similar to the work carried out in the West Midlands.

These actions are in recognition of the fact that the North East has some of the most extreme examples of the impact of poverty. Therefore, the health inequalities themselves are a key driver to this work. Supporting a healthier and productive workforce is also considered key, as there are issues locally around low pay and progression. Another driver for action is in recognition of the fact that the relationship between the high quality of health institutions and low health outcomes of some of the population is out of balance, and therefore the MCA sees partnership working with these institutions as being essential.

The extent to which the authority is taking health into account in other responsibilities

The increased flexibility from the Investment Programme provides a good opportunity to address health inequalities and integrate their priorities across the combined authority.

Action taken by directors of public health across the geography

The directors of public health from the three councils that make up this MCA are working together increasingly closely. One example of where they have begun to collaborate is on understanding what more can be done across the region on prevention.

Summary

Action to address health inequalities is considered central to the priorities of the combined authority. Though in early days as a combined authority, a number of projects to address specific issues linked to the wider determinants of health are already either in place or in the pipeline.

Tees Valley

Tees Valley Combined Authority created in 2016 and Mayor, Ben Houchen, was elected in 2017. The Combined Authority comprises Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees. It has a population of 767,000 (2019).

The devolution deal included the following powers and functions:

- Transport budget
- Creation of Mayoral Development corporations and leadership of a land commission
- Creation of Tees Valley Investment Fund
- Control of a new £15million a year for 30 years funding allocation to be included in the Tees Valley
- Redesign of the education, skills and employment support system
- Responsibility for business support

6 Appendices

Links to devolution agreements

- Cambridgeshire and Peterborough: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/600239/Cambridgeshire_and_Peterborough_Devolution_Deal.pdf
- Greater Manchester: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/369858/Greater_Manchester_Agreement_i.pdf
- Liverpool City Region: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/477385/Liverpool_devolution_deal_unsigned.pdf
- Greater London Authority: https://www.gov.uk/government/publications/london-health-devolution-agreement/london-health-devolution-agreement
- North of Tyne: https://static1.squarespace.com/static/5bbf08bdc2ff616708156a58/t/5cc83ca3085229bf2b1f2e72/1556626597305/North_of_Tyne_Deal.pdf
- Sheffield City Region: https://web.archive.org/web/20160607164028/https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403161/FINAL_Sheffield_City_Region_Devolution_Deal.pdf
- Tees Valley: https://teesvalley-ca.gov.uk/wp-content/uploads/2016/07/Devolution-Deal.pdf
- West of England: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/508112/160315_West_of_England_Devolution_Agreement_Draft_-_FINAL.pdf
- West Midlands: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/ile/477421/West_Midlands_devolution_deal_unsigned_final_web.pdf