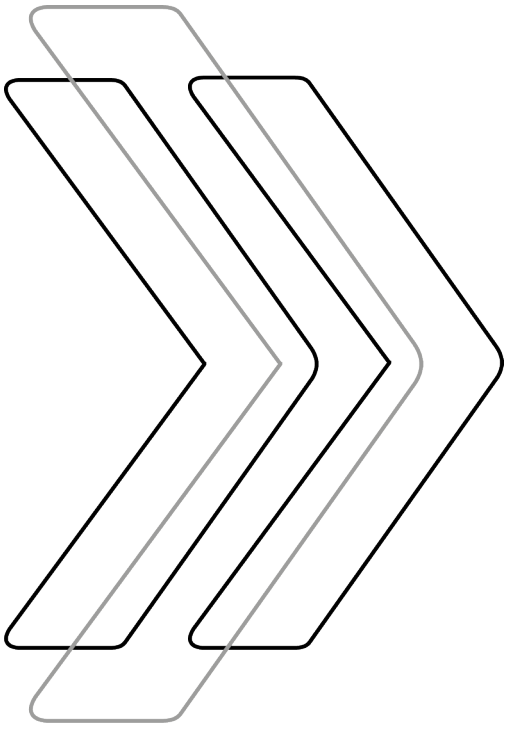
The King's Fund

Ideas that change health and care

West Midlands Combined Authority

Are further regional approaches to system leadership needed for health and wellbeing?



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1 Introduction

Using local leadership to unlock more preventive models of health and care has been the focus of a lot of policy development over recent years. The creation of integrated care systems (ICSs), and the emphasis on place within them, has established the local statutory partnerships to do this. Nationally, the development of a new operating model for NHS England has begun to develop a different set of relationships between the centre of the NHS and local bodies. This context creates an opportunity to turn our attention to a less explored, but potentially very significant set of questions, around the regional role in health, and the contribution to health that combined authorities can make.

Typically, combined authorities don't have formal powers around health policy. However, they do have powers in lots of areas that shape health outcomes and inequalities, such as transport, employment and housing, often by aligning public and private sector actors.

Through elected mayors, combined authorities also have significant 'soft' power within local areas, and an important role in convening and leading coalitions of public, private and voluntary sector organisations on particular issues. With devolution gathering pace across the political spectrum, and specific deals being discussed in the West Midlands, The King's Fund was invited to explore work on health and wellbeing.

In this report we consider both present and the future work on health and wellbeing by the West Midlands Combined Authority (WMCA). The King's Fund has worked recently with ICSs in the Midlands, and that work identified significant assets within the region, including relevant academic excellence and strong data analytics capability, and there is work to do to build on that excellence.

In exploring the role that the WMCA can play in improving health outcomes we ran a series of workshops exploring the following issues: inclusive growth and climate change, homelessness, inequalities and disability. Our goal was to uncover answers to a few key questions including:

1. What are the WMCA's core assets, and how can they be best used to improve health and wellbeing?
2. What can we learn from the what's already happening in areas such as disability, homelessness and inclusive growth to inform how the WMCA should approach its role in addressing health inequalities?

3. What do local partners want from the WMCA in this space? What gaps can it as a combined authority fill?

It is a coincidence that this report's submission to the WMCA is coinciding with the launch of the latest Trailblazer deal (Hill 2022). But this is a happy coincidence, because that deal creates growing expectations of delivery in return for investment. Other regional bodies, like the Office of Health Disparities (OHID), the Midlands Engine which brings together academe and commerce, and the integrated care board (ICB) who are leading NHS provision, may in differing ways look to the Combined Authority for leadership and partnership.

This report principally explores not *what* role in a specific health-related domain the WMCA might play, but, rather, *how* that role could be played differently for different circumstances: to the benefit of local communities, whose poor and unequal health outcomes must change if the region is to fulfil its potential. We argue that there is a range of approaches that the WMCA should now consider in health and wellbeing, which we present as a taxonomy in section 4.

2 Context

Health inequalities and the role of combined authorities

The West Midlands as a whole had the second largest regional fall in life expectancy in England in 2020. Inequality of life expectancy was 10.8 years between the most and least deprived males in the region, up 1.5 years compared to 2019, and 9.1 years for females in the region, up 1.8 years compared to 2019. Birmingham, Sandwell, Walsall and Wolverhampton, have the highest rates of infant mortality in the country (PHE 2021).

As up to 80 per cent of the determinants of health come from outside the health system (NHS Confederation 2022), many actors have a part to play in addressing this situation. Deprivation indices derived from the census suggest that two of the three ICSs within WMCA's geography are the two most deprived health partnerships in England. The West Midlands had significantly lower employment rates and in the first year of the pandemic (percentage for west midlands?), compared to England (75.1 per cent), and employment had downturned further to 73.7 per cent in 2021. In 2019, 17.5 per cent of households were living in fuel poverty, the highest figure across English regions (PHE 2021).

Local authorities are the lead local agency for public health in England. Recent reforms to the health system, such as the advent of integrated care systems, take the importance of local authorities in addressing ill-health as central in their design. In particular, integrated care partnerships (ICPs), which have responsibility for framing strategy for their respective ICBs, are expected to align the actions of statutory and the voluntary and community sector local bodies. Their visibility remains limited publicly, but 2023/24 will potentially see their role become more prominent.

While some profile has been attached to the work of Greater Manchester and to the health powers of the London Mayoralty, overall, the role of combined authorities (CAs) is not typically appreciated by health leaders. CAs as a tier do not have the history of involvement in health that local authorities do and, additionally, different CAs have different powers relating to particular policy areas (Health Foundation 2022), meaning that the precise role that each CA has to play varies across the country. This variability inhibits comparison and study.

While there are limited formal powers in health in any CA, it is important to emphasise that the situation is rapidly evolving. The economic opportunities of investment in both wealth through life sciences (Page 2021) and other enterprise, and in addressing poverty, through housing, mental health,

employment, and education, mean that picture is more nuanced than it could appear. Direct involvement supporting NHS provision is also growing (Liverpool City Region 2023), as is a role in assessing health delivery (Cambridgeshire and Peterborough Combined Authority 2022).

Combined authorities have a number of core assets that give them an inherently important role in health outcomes. The West Midlands Combined Authority, with its powers in areas including economic growth, transport, housing, skills and employment, has its hands on policy levers that control a great deal of the wider determinants of its residents' health. As previously discussed the WMCA also has considerable soft power, through the mayoral role. Emphasis on this mayoral role is apparent in successive governments' policies, and with some cross-party similarities: the role is well place to be a custodian of 'health in all policies' thinking.

Devolution of health powers in particular has been associated with improvements in outcomes in regions where it has been trialled (Britteon *et al* 2022), and regions that have had access to the extra resources that come with participation in programmes such as 'Marmot City Regions' have also shown positive results (Price *et al* 2020).

Levelling up

The publication of the Levelling Up White Paper in 2022 (Department of Levelling Up Housing and Communities 2022b) set out 12 missions for transformation by 2030. Two of these missions were directly health related, with a focus on wellbeing and a commitment to tackling healthy life expectancy. Unfortunately, subsequent political turbulence has created some confusion over the future of this policy agenda and the mechanisms for its delivery. Local data hubs and regional directors, two things vital for achieving these missions, remain undelivered at the time of writing.

The health of the workforce (CIPD 2020), and those leaving work, however, is receiving renewed focus. This reflects concern over unfilled job roles in the economy as well as a desire to improve growth and reduce welfare related costs, including in-work benefits for those who are lower paid. Haldane (Haldane 2022) argues that alongside rising mental health challenges among younger people and increased economic inactivity, greater participation among those over 50 has driven UK economic growth in the two decades prior to the pandemic. The reversal of this later trend now poses a challenge to future growth which requires a societal and governmental response.

Notwithstanding a lack of clarity, the context of levelling up has established policy interest both in the aggregate efforts of local public services acting together as a stimulus to inclusive growth, and an interest in the potential of devolution.

3 Where we are

With this context in mind, our major focus during this project has been to gain an understanding of the approaches currently being taken by the WMCA team in areas related to health and wellbeing. Our workshop series has taken us to territory where the WMCA has been extremely active over the long-term, as well as to areas where its work is in more of an embryonic phase, in view of the Trailblazer proposals.

The two principle approaches we have observed are direct delivery and convening.

Direct delivery

An example of direct delivery would be the WMCA sponsoring and supporting work with communities in employability and mental wellbeing. Similarly, the WMCA has developed projects in physical activity to seek to address the comparative inactivity of the citizens of the region when compared to peers. Evidence from before the Covid-19 pandemic supports the impact and effectiveness of this work. An ambition of the work was to stimulate related or similar work from other agencies acting more locally, creating a snowball effect. There is some research work to be done to establish whether such an impact can be seen, and what conditions are necessary for leadership from the WMCA to encourage action not inaction from peers and partners.

Convening

We have seen that the WMCA has created a variety of vehicles to boost the actions of others through commissions and reviews, with notable examples in homelessness and mental health. Those involved bring expertise and enthusiasm and connect through these programmes to grassroots and community groups. It is less apparent that these models have penetrated consistently into the local delivery architecture. Where personal connectivity is established, this can be surmised, but there is an absence of data to track local impact across the varied geographies of the authority.

In the health and care system, there is recognition for the value of these approaches, but also an awareness that the remit and role of the WMCA varies between policy areas. The funding authority given to the WMCA by any new deal, if not composed necessarily of new monies, will mark a moment of re-examination by many partners of how they can best work with the authority. Similarly, the WMCA needs to examine how it seeks to influence health-related organisations – not simply through integrated care systems, and at place

level. We explore what this might look like further in the taxonomy presented in the next section.

The ICSs created in the West Midlands are strikingly smaller in scale than those in much of the rest of England. Only the East Midlands and South-West have chosen to organise at equivalent scale. The forthcoming Hewitt Review for DHSC/HMT may cause some to wish to re-discuss these shapes, but at present, this configuration creates a distinctive opportunity for the combined authority to act as convenor.

We are aware that the six ICBs in the West Midlands as a whole (Townsend 2022) have sought to create capacity to act together at scale, for example over data or specialised commissioning work. These proposals are very early in their development. However, their existence recognises that, in addition to any efficiency gains from common services, there are situations where the scale provided by the West Midlands is the right scale at which to tackle common problems. This does not prevent collaboration among ICBs in the footprint of the WMCA.

Through the workshops conducted and through interviews with some stakeholders, we have sought to explore which approaches to WMCA involvement might benefit local communities and be acceptable to other agencies. Taking those contributions and insights together we note the following.

1. There is a prevalent concern about duplication of effort. Often local bodies contend that they are acting in a specific space, albeit that the scale and impact of that claimed work is not always recognised by others.
2. There is a common assumption that involvement at regional scale will be dominating or directing. Though few involved provided direct experience of this behaviour or approach and it seems to reflect assumptions unrelated to the WMCA itself.
3. There is a recognition of the scarcity of expertise and skills in key areas. The pandemic has exposed the stretch felt by local public health teams and the need to ensure that efforts are supported by best evidence and insight.
4. There is challenge, notably from voices representing community groups, to the variability of local efforts and a desire for successful interventions to spread. It was not apparent where in the current public services architecture such sharing can consistently occur.

In the next section, we explore how these challenges may be overcome, and describe where stakeholders want to get to. We then introduce a taxonomy of approaches that WMCA health and wellbeing may consider.

4 Where we could be

In this section we explore what we heard from participants in the workshops we held. Across the piece, some common themes included:

- how to secure local agencies' involvement and support, beyond those who attend or contribute to a specific discussion
- ensuring that co-creation and co-production form the essence of ideas and implementation, and increasingly evaluation
- defining more clearly the role that the WMCA wishes to play, in effect its offer to partners in a given space.

There is a risk that the role of WMCA can be conceptualised by partners with a bias towards initiation, often referred to as convening. In most of the areas that we explored thinking (among both the WMCA and its partners) has progressed towards an implementation or evaluative space, and there is a need to consider how the resources and talents of the CA can contribute throughout delivery.

Ambitions for specific policy areas

We have seen then that in its short history since being founded in 2016, the WMCA has already developed several distinct approaches to working with local partners and is already using them to achieve positive outcomes in policy areas related to health outcomes and inequalities.

In the workshops we ran as part of this project, we saw that people working in the WMCA and partner organisations were hugely ambitious about building on this and wanted to go further in ensuring the best possible outcomes for their communities. At every workshop, we asked participants to think about what they wanted to achieve in each of our discussion areas (inclusive growth, homelessness, health inequalities and disability), and were struck by the breadth and depth of what was proposed.

The ambitions that we heard have been summarised below and represent a map of what key stakeholders in different policy areas view as priorities and necessary changes of approach at the regional level.

Inclusive growth and the climate emergency

Our first workshop focused on inclusive growth, net zero and climate adaptation – with the latter concept being considered key (and often overlooked) for understanding the role of health services in the climate change space. The wider economy and climate change mitigation and adaptation both represent areas in

which the WMCA has established expertise and can make an offer to health services.

Potentially because of the wide-ranging nature of the subject matter, and perhaps because this was an initial workshop with senior leaders, the content reached beyond the specific into wider ranging ways of working across systems in the region.

When thinking about ambitions in these areas with respect to health, two key themes emerged.

- Structural issues: The first related to the way we conceive of these issues and think about challenges they bring. People were keen to see a renewed focus on the macro factors that underpin economic deprivation and thus poor health, such as racism and the legacies of previous economic policies. Health leaders in particular recognised the need to engage more fully and communicate more clearly the economic contribution of their long-term anchoring work and investment plans.
- Innovation: The other theme of our discussion at this session related to funding structures. In an emergent field like climate adaptation, there was a mismatch between the need to experiment and work with communities, and the ways in which funding flows are traditionally organised in statutory bodies. The potential to create more agile models was voiced as one potential suggestion.

Homelessness

Discussions in this workshop focused on how to translate targets into practical change, and on the experience of individuals when contacting services. The session drew heavily on the established coalition of community and institutional experts within the West Midlands Homelessness Taskforce, chaired by Jean Templeton. The taskforce has a commitment to bringing together a variety of regional resources and organisations to tackle homelessness, and represents a developed version of the WMCA taking on a convening role to help to solve complex issues.

There was a strong sense of the wider opportunity presented when someone from a highly marginalised group begins to engage with services, and how clinicians and professionals are supported to have time to respond to that contact.

- Accountability: Improving service user experience was one ambition that we heard about. For participants, this meant creating services that were better at listening to people they work with, and becoming more holistic, so that the breadth and depth of people's needs could be met, rather than systems working only within narrow silos. The challenge posed by this dialogue was

how systems could open themselves more fully to the judgement of those experiencing homelessness. The planned statutory duty to co-operate (Department of Levelling Up Housing and Communities 2022a), which may emerge during 2023, could create a space in which local agencies can cede some evaluative power.

- Exclusion: While there was a general recognition that health inequalities have been raised in profile, there was a concern that the stigmatised needs of inclusion health groups risk being submerged within that broader agenda. For example, digital exclusion was highlighted as a particular issue facing people experiencing homelessness. Discharge processes from health services were also raised as something that is vitally important to get right when it comes to people experiencing homelessness, and as something that also requires attention and improvement going forward. Given that the evidence on how to do make this transition better is well is validated by the National Institute for Health and Care Excellence (NICE), this could represent a clear opportunity to standardize and level up approaches across the region.

The workshop highlighted a continued appetite for the WMCA to move beyond initiation work, and to consider how best it could support others in the work of implementation and evaluation. As national policy develops in this field, there is scope for influence and impact via the WMCA – a feature of the devolution landscape that partners could consider how to rely upon and lean into.

Health inequalities

This workshop brought out two distinct ideas, one of which developed the idea of tobacco inequality and harm to examine how plans are developed and deployed – with the other relating to involvement and user voice. This latter issue is broader than health inequalities and is explored in our recommendations at the conclusion to this report.

- Involvement: There was an animated debate about how inequalities priorities have been developed locally and how community groups are included within delivery models as contributors. The discussion spoke to continued challenges in statutory bodies working meaningfully and fully with the voluntary sector and community groups. This included communities who felt that their scale was ignored (for example, those from specific eastern and central European backgrounds). These longstanding issues merit a more comprehensive and conclusive dialogue, because the workshop illustrated dissatisfaction and confusion with existing local arrangements. Neither health nor local authority current work was seen to wholly address the deficits raised at present.
- Tobacco: There was some confusion of role and some resultant gaps in effort. This could form a good system-thinking test case for contributors which might bring together: Local tailored services focusing on the groups public

services struggle to get to; statutory local action through regulatory services to check on illegal sales, pivoting Local Authority smoking money into this and ICB leadership to drive smoking cessation (and promoting effective use of vapes) through NHS service provision and staff, accelerating delivery through community pharmacy and general practice in areas of highest need, and setting ambition in this space as a system priority; together with regional support (potentially via the combined authority) to create data analysis/data linkage, maximise political leadership, moving beyond regional collaboration into regional delivery

Disability

In our disability workshop focused we posed the question 'What would it mean to be an "exemplar region" for disability'? As such, we discussed ambitions for what could be achieved in relation to disability across areas including transport, housing, employment and health. There was considerable energy and commitment to the intent of the exemplar, but also widespread concern that achievements might be project based and sporadic rather than systemic. Making sure this is not the case will likely mean multiple organisations, including but also beyond the WMCA, making leadership on the exemplar part of their own work. Plans for this were developed in outline but a vehicle to consider that further is now needed. The profile and potential impact of the exemplar appears to justify a bespoke approach to the governance, communication and delivery of the work.

- Mindset: Workshop attendees expressed a desire to create a region where active efforts were made across the area to identify and rectify the ways in which decisions we make can disable people. The goal was to create a culture where people are prepared to discuss uncomfortable and difficult questions that raise implications for how organisations are run and how people work on a day-to-day basis. The ambition here would be to change the mindset so that accessibility becomes the default.
- Adaptation: There was a focus on adaptability in new housing stock, and ensuring that environmental retro-fitting also takes account of feasible adjustments for access. Transport discussions argued for a more joined-up approach to the environment surrounding modes of transport. In education and health there was a dual concern that approaches remain paternalistic or medicalised, and that a more enduring approach to addressing this, including making visible what is not working, is now needed.

The ambitions we heard across the workshops represent specific changes that can be made in order to improve the efficacy of regional work in the specific topic areas. Common themes include thinking more about who is involved in

decision-making, both within and beyond the public sector, and being mindful of the causes and effects of particular types of exclusion relevant to each area.

However, our discussions about creating better futures were not limited to discussions in specific areas of policy. We also discussed questions of role, and of what partners wanted to see from each other in order to make ambitions realities. In particular, we explored these questions with respect to the WMCA itself. The view was that the 'disability exemplar' is not a programme but a combined obligation between communities and agencies and that this would require a new model of collaboration to those currently seen locally.

There is not a one-size-fits-all model for the future role of the WMCA in health and wellbeing. The offer from the WMCA will differ by subject matter. However, it will be important not to mis-learn from the experiences of the pandemic, and consider that all public health improvement work is highly localised. Somethings can be gained from work on a larger scale. Mutual aid but also shared expertise were a feature of the working practices of the Covid-19 response. Faced with the complex, often interdependent, challenges of poor health outcomes and inequity, a system of systems approach is often going to be needed beyond the boundaries of one local authority or integrated care board (ICB).

New approaches for the combined authority in health and wellbeing

Through the period of study, a wide range of views were expressed about the scope and role of the WMCA. Many views arose from concern about role boundaries, oversight or disruption. The trailblazer deal represents a moment with the potential to shift the dialogue to one of opportunity.

What it will take, however, to seize the possibilities created by the deal was another topic that we explored in the workshop series. The following three cross-cutting ideas put forward by stakeholders sketch out new ways of working that they felt to be key to unlocking best outcomes in the region.

Transparency

The landmark Health Of The Region report (West Midlands Combined Authority 2020) sets out the stark state of inequalities in the Midlands. Nonetheless, with the regional levelling up functions not (yet) in place, there is a lack of data on the health of residents of the West Midlands, and in particular a lack of data tracking commitments and objectives. Each integrated care partnership (ICP) will produce a five-year initial strategy, but guidance for these documents does not cover data accountability, or measures that can be observed over time against expected improvement.

Existing powers in London create a space through which the GLA can publish evaluative information on health outcomes. This visible data creates a public accountability which the current landscape of the region lacks.

This approach through publishing data publicly, could be explored within the current powers, remit, and resourcing of the WMCA. It would require scrutiny of ICP and ICB plans, and a related engagement with places' health and wellbeing board documents. But the aggregating of that analysis would offer an opportunity to local leaders. Specifically, it would allow health oversight and scrutiny committees to consider local progress against regional peers and support a focus across ICSs on the collective delivery of health gain.

Involvement

It's important that any emphasis on 'hard' data is accompanied by qualitative information. A major theme in our workshops was stakeholders seeking better engagement and more participation from and for community leaders and the voluntary sector. WMCA it was implied, relies on the efficacy of other more local public bodies' work to include and involve.

The question that arises is whether all work on community power and development has to be at that local level. There could be a regional role for the combined authority in this space?

There may be merit in curating better skills in community involvement and organising through the combined authority, or in supporting and developing local public bodies to develop excellence in this space. Either through investment and sponsorship or the development of skills and training, there is an intersectional role in supporting community resilience and participation. Such an approach would also allow prominence for communities that are locally small but regionally significant, and for those where geographical coherence matters less than salience across the whole West Midlands.

Expertise

Most public bodies that contributed to our discussions could identify areas of collective need where singular expertise might be deployed on behalf of a wider group of agencies. Digital transformation skills were widely cited as being intrinsic to the future of health and care, yet unevenly distributed across agencies, and often better developed among suppliers.

Common challenges, like the climate emergency or air quality, were raised as examples of emergent priority where both technical and procedural expertise might be drawn from a convening body.

In each domain, as in health and care, there is clearly distributed knowledge and expertise locally. The convening role is perhaps in stimulating discussions between local parties, and in drawing into the region expertise from elsewhere in the UK and abroad.

The combined authority may have to go beyond its current repertoire in terms of ways of working. Direct delivery in some areas will continue, but what could be important is to diversify and socialise a range of approaches to 'convening'. The suggested approaches are consistent with responsibility, delivery, and primacy remaining with other bodies. A taxonomy of what such a range of approaches could look like in practice is presented below.

Table 1 A range of approaches the WMCA health and wellbeing functions can take towards working with partners

	Characteristics	Examples
Type 1 – Hosting dialogue	Using the combined authority's position to bring people together and facilitate discussion, encouraging collaboration to solve problems.	Holding workshops or discussion forums.
Type 2 – Hosting expertise	Providing resources to assist other actors in the region to improve outcomes for residents.	Data and analysis, skills, capacity or leadership.
Type 3 – Incentivising and stimulating	Offering partners incentives to do or not do certain things in order to achieve agreed outcomes.	Financial incentives or public recognition.
Type 4 – Monitoring and evaluating	Using powers or leadership to hold partners to account for their actions in certain areas.	Monitoring systems to track outcomes or evaluating activities and programmes of work.
Type 5 – Influencing and brokering	Acting as a bridge between the West Midlands as a region and national government, either to establish bespoke arrangements or to pilot potential wider policy changes locally	Negotiating devolution settlements, or lobbying for particular policy changes.

These approaches would enable WMCA to move beyond a role that solely brings partners together. Consistent with the developing role of the WMCA, the

taxonomy invites partners to see the authority working in different ways within this space. This reflects dialogue initiated by partners that consistently through this engagement sought certain inputs, but lacked clarity on who these could be provided by. WMCA has the potential to offer reach geographically and to bridge between the public bodies most impactful in health outcomes, and therefore in tackling inequalities.

5 Conclusion and recommendations

The WMCA remains a young organisation. In this context, it is unsurprising that there is still scope for defining its precise role in different areas of policy, and that this process requires engagement and negotiation with other regional partners.

Health outcomes are determined by many things that go beyond what might be conventionally silo off as 'health policy' – and the WMCA has access to powerful levers in many of those determining areas. As such, even if no further powers are added its remit, the WMCA is already a major actor in terms of determining the health of its region.

Making sure that it plays this role as effectively as possible will require continual learning and adjustment. Over the course of this project, we have seen that already, in a wide variety of areas ranging from inclusive growth to homelessness, the WMCA is making a real difference through its ability to play a wide variety of roles in how it delivers for its communities.

However, there are opportunities to go further, and we hope that this document provides some options to consider in terms of how to better realise that potential. The King's Fund recommends that the following ideas are considered further. Each recommendation necessitates taking on at least one of the roles outlined in the taxonomy in Table 2 – precisely which is indicated in brackets in the list below.

1. Plans to mitigate climate change are well-developed and visible across many public bodies in the region. The economic opportunity from climate transition is well articulated. Health bodies have been required to develop green plans to a national template. It is clear that adaptation is less well advanced in some parts of public services. **The skills, data analysis and expertise apparent within the WMCA may usefully be shared with boards and teams working in other sectors** (type 2).
2. Tackling homelessness benefits from an expert commission and a real sense of local drive. But services remain often exclusionary for some. Even though the evidence of what works is clear, there is not transparency on how effective service offers are. **We heard a clear ask from those involved for the combined authority to hold a mirror**

with users up to services in different locations to test the equity of provision across the region (type 3, 4, 5).

3. Tobacco control represents an essential part of any health inequalities approach and the **alliance model** that is being developed could create a vehicle to level up across the West Midlands. **Agency engagement varies, and creating a sense of challenge from the combined authority may enable greater penetration by experts into changing policies and practice in each part of the region** (type 1, 4, 5).
4. Recognising the opportunity created by the disability exemplar region deal, there is a need to ensure that tangible, measurable results are defined rather than simply project areas for focus. **A commitment to a different future needs to be owned across partner agencies** (type 1, 4).
5. Routinely make available at WMCA and constituent authority level health outcome data, including data demonstrating inequalities, to illustrate the scale of challenge faced by the combined efforts of local public bodies. **This could become the groundwork for annual health of the region reporting, which would not only consider specific local projects, but also the overall performance curve of health as a contributory asset within the West Midlands** (type 4).
6. Explore the role the WMCA could play in developing expertise across local authorities and health in community leadership as applied to health improvement. **This could take the form of giving profile to local work or developing tools and knowledge which can then be used more locally** (type 2, 3).
7. Consider whether there are facets of health improvement expertise, including public health, where hosting within a regional body such as the WMCA could add value to locally led efforts. Such hosting would be on the basis of shared expertise rather than creating new domains of responsibility. **It is highly likely that this will require a dialogue with the Office for Health Improvement and Disparities and potentially The UK Health Security Agency, which hold statutory roles in this field** (type 2).

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Before joining The King's Fund, Luca worked for New Local, a local government think tank and membership organisation. While working there he conducted and led research into policy challenges facing councils across a range of areas, including health and social care. Prior to that he worked at NatCen Social Research in both research and communications roles. He holds a master's degree in public policy from King's College London.

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Before joining The King's Fund, Toby worked in the health services for more than 25 years at an operational level in mental health, primary care and hospital services. He has held director roles across University College London Hospital, Mid Yorkshire Hospitals NHS Trust, Bart's Health NHS Trust, and was Chief Executive of Sandwell and West Birmingham Hospitals until 2021. He worked in the Prime Minister's Delivery Unit from 2003–5, graduated from the Fund's Top Manager programme in 2004, and holds degrees from the University of Oxford and the University of London.