REVISITING THE HEALTH OF THE REGION

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Chapter 1: Introduction

The first Health of the Region (HOTR) report, published in November 2020, highlighted persistent and widening health inequalities within the WMCA region, and set us out on a journey of recovery intent on tackling these health inequalities through four priority challenges set alongside a series of more than 50 commitments to action made by WMCA and its partners[1]. Collectively, our priorities were focused on:

1. Improving outcomes for ethnic minority and vulnerable groups;
2. Tackling the wider determinants of health;
3. Widening access to health and care; and
4. Enabling people-powered health.

By articulating these challenges within a narrative that explicitly addressed the relationship between health and wealth, the HOTR 2020 report broke new ground for the Combined Authority and, together with its call to action, it facilitated a collective and committed approach to addressing and tackling health inequalities for the West Midlands region. This collaboration continues to be critical while it has become clear that we must learn to live with Covid-19, and we must do this in a changing institutional landscape and worsening context in terms of the day-to-day lives of our most vulnerable residents.

This report provides an update. Health data changes slowly and so it seemed pointless simply rehearsing a picture that has changed so little. Instead, this report does four things. First, it provides an update on the many commitments that partners made in our last report, celebrating some of the successes through special case studies. Second, it considers the remarkable work of the public health teams in our partner local authorities and the impacts they've had with their local communities. Thirdly, it explores the benefits of adopting a 'health-in-all-policies' (HIAP) approach. And finally, it unveils our new Health of the Region Data Hub.

When the HOTR report was compiled in mid-2020, few would have imagined that we would be continuing to fight Covid-19 in its various guises 18 months later. We understood from experts in the field that we would be facing an increasing frequency of such transmissible diseases[2] and would therefore need to improve our response and resilience to pandemics, but the duration and depth of Covid-19 through its several mutations, the multiple 'lockdowns' as well as the profound impacts on the economy and wider society were not yet broadly understood.

This update to the 2020 report provides a reflective pause – an opportunity to take stock of the aspirations and actions, set against the evolving wider picture. Whilst there may be widespread recognition that the issues we are grappling with will potentially take decades to shift at scale, it is important to revisit the commitments made and share our collective and individual resilience and success in the face of the pandemic. Countless individuals from multiple organisations across the West Midlands have put extraordinary levels of energy into their response, resilience and recovery efforts, and this must be captured and celebrated. This report is singularly focused on celebrating

[1] A full list of updates against each commitment is included in the appendix.

[2] Infectious diseases, particularly those with transmissions from animals to humans I.e. Zoonoses, are thought to be increasing due to the impact of climate change (e.g. Gibb et al., 2020 https://www.bmj.com/content/371/bmj.m3389; Rupasinghe et al., 2022 https://www.sciencedirect.com/science/article/pii/S0001706X21004034; WHO, 2003 https://www.who.int/globalchange/climate/en/chapter6.pdf)

these successes through case studies on the commitments that were made as well as highlighting how those commitments have been built on or adapted to changing needs and, indeed, how they have been exceeded in many ways, demonstrating some truly inspiring work in tackling demanding challenges. At this mid-point to the subsequent full edition of the HOTR report (planned for 2023), which we expect will include quantitative data that demonstrates the impact of Covid-19 on key health inequalities indicators, it is worthwhile in the interim to provide a snapshot of the current picture.

Following a relatively brief update on the current management of Covid-19 and its impacts to date, the first substantive section of this report showcases both the breadth and the depth of the work undertaken by a whole range of partners across the health and care landscape, from statutory public bodies to community delivery partners. A selection of case studies updating progress made against specific commitments aligned to the challenges previously set bring some of the work of these organisations to life. This section also reflects some of the ways in which partners have worked beyond those initial commitments, responding to the evolving scene and growing need in the region.

The following section moves the spotlight onto our local authority partners, whose public health teams have been at the frontline of dealing with wave after wave of Covid-19 variant and the impacts these have had on local communities. One of the key recommendations emerging from the influential PHE reports of 2020 which explored disparities in risks and outcomes of Covid-19 and the reasons behind the data, highlighted the importance of working in partnership with communities to tackle inequalities widening as a result of Covid-19[3]. We also know that community-centred approaches are critical in tackling health inequalities. Their success stories therefore take centre stage, reflecting their crucial role in, for example, managing local lockdown messaging and tailoring vaccination uptake campaigns – the key tools of reducing the spread and potentially the severity of Covid-19. Our seven local authority public health teams also here demonstrate innovations and continued good practice in their ongoing and longer-term work in supporting local health and wellbeing.

This report then presents updates from across the WMCA both against the commitments made and more widely on developments that have – or will eventually have – an impact on health outcomes. It reflects the renewed focus of the WMCA on the wider determinants of health and how, if we take a 'Health in All Policies' (HiAP) approach, we can steer workstreams across the WMCA to address health inequalities and ultimately help to close the gaps in health outcomes. Using the leverage that the WMCA has on some of the wider determinants of health could contribute significantly to the 'levelling up' agenda. Cumulatively, across its devolved responsibilities, the impact would be immeasurable.

Finally, this issue of measurability briefly takes centre stage as we unveil the HOTR data hub – an online space with updates on all the indicators previously presented in HOTR 2020. Developing this data hub into a functional tool for maximum utility with our partners is now a priority for ensuring that we drive our collective efforts in the most impactful ways to tackle health inequalities.

[3] "Disparities in the risk and outcomes of COVID-19" (2020) PHE https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

Chapter 2: A Snapshot of the Scene Since HOTR 2020

This snapshot provides a brief update of the overall context of Covid-19 (and related) since the publication of the HOTR 2020. It covers the introduction of the vaccine and the disparities that were again highlighted through roll-out of the national vaccine programme, followed by a focus on wider health issues – primarily mental health impacts – that have emerged over the duration of Covid-19 so far. Finally, in light of ongoing developments, we set out the evolution of the WMCA's sharpened focus in the health and wellbeing system, against a backdrop of other changes in the wider institutional landscape.

2.1. The roll-out of vaccines

The single most significant development in the fight against Covid-19 transpired within weeks of the publication of the HOTR 2020 report and it happened here in our region. On 8th December 2020 at University Hospital Coventry, the first ever Covid-19 vaccine was administered outside of clinical trial conditions, marking the start of the national roll-out programme. To date[4], approximately 9 in 10 individuals aged 12 and over have been vaccinated with at least one dose (43,513,915 people; 90.0% of the population across England).

Despite the huge successes of the vaccine programme, health and social inequalities have again been exposed and exacerbated. The roll-out was based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI) which prioritised primarily by age group. Some called this approach into question, recommending instead an approach prioritised according to the risk of spread of infection such as in areas of deprivation where relatively crowded multi-generational households are not uncommon or in certain occupational groups where working on site and exposure to the virus is required[5],[6]. In August 2020, our Interim Report exploring the West Midlands Health Impact of Covid-19 identified how the WMCA area has a slightly higher proportion of jobs within the health and social work sector (14%) compared with West Midlands Region (13.2%) or the national average (12.5%). Those in caring occupations have an increased health risk due to exposure to infection[7]. These scenarios often intersect with reliance on public transport[8].

These conditions correlate with being from a Black, Asian or minority ethnic background[9]and demonstrate what structural inequality, and structural racism, look like. It is multi-faceted and compounded across a life course, to impact upon several aspects of daily lived experience as more than a sum of its parts. Layer in generations of living in such conditions – and far worse – and we can begin to understand how layers of discrimination have solidified into deep and widespread – i.e. structural – inequalities. The HOTR 2020 report made a strong case for take a systemic approach to tackling the wider determinants of health and dealing with the structural inequalities we find in our

[4] As of 13th February 2022 – latest available data https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/02/COVID-19-weekly-announced-vaccinations-17-February-2022.pdf

[5] "Beyond the data: Understanding the impact of COVID-19 on BAME groups" (2020) PHE https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

[6] https://www.kingsfund.org.uk/sites/default/files/2022-01/The%20Covid-19%20Vaccination%20Programme%20online%20version_3.pdf

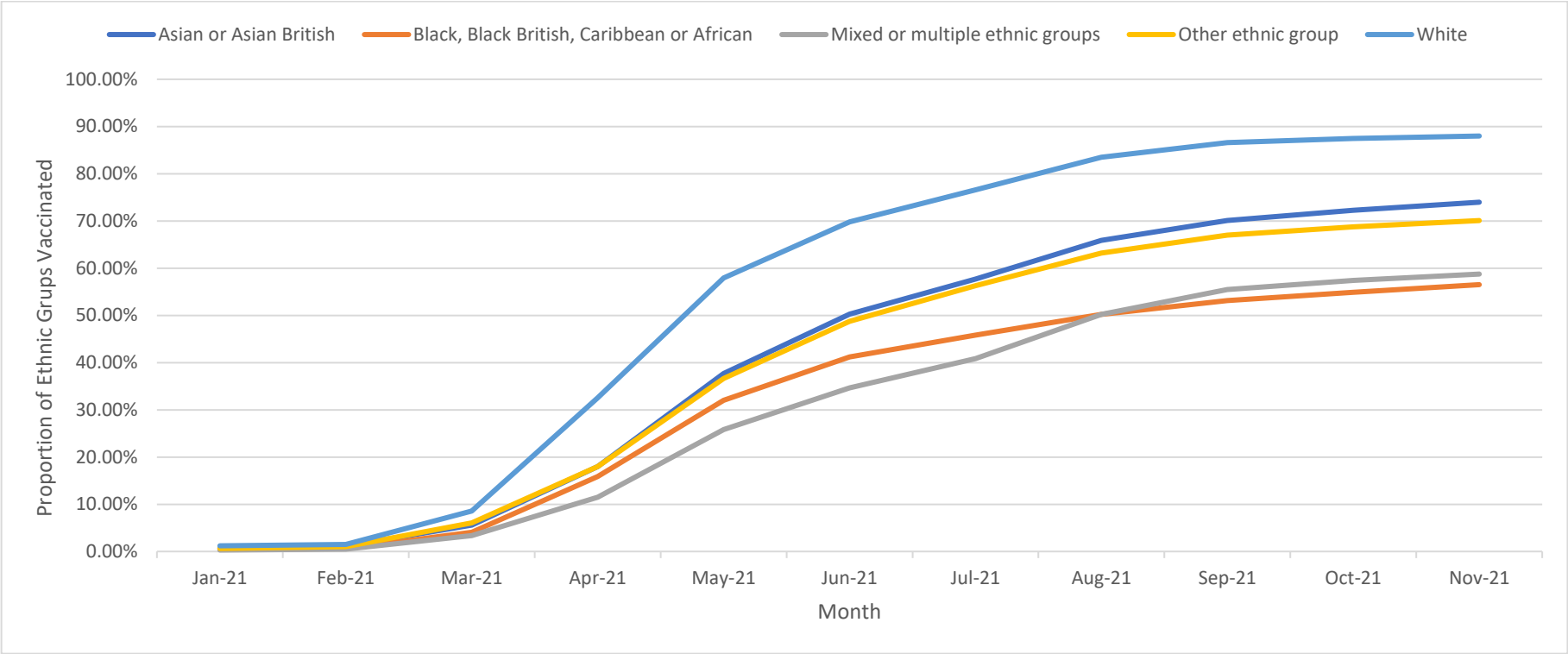
[7] https://www.wmca.org.uk/media/4122/regional-health-impact-of-covid19-v5.pdfThe

[8] https://www.wmca.org.uk/media/4122/regional-health-impact-of-covid19-v5.pdf

[9] This is by no means an exact and exclusive correlation, particularly with regards to white minorities, but it is notable; OHID Midlands LKIS' Disparity Report demonstrates that WM local authorities with the largest ethnic minority (excluding White minorities) populations have some of the highest levels of deprivation in the region.

economy, housing market, education, justice and transport systems. This will not be a quick fix; it will require sustained systemic and regional effort.

Figure 1: Proportion of Ethnic Group Vaccinated for West Midlands Region, from January 2021 to November 2021

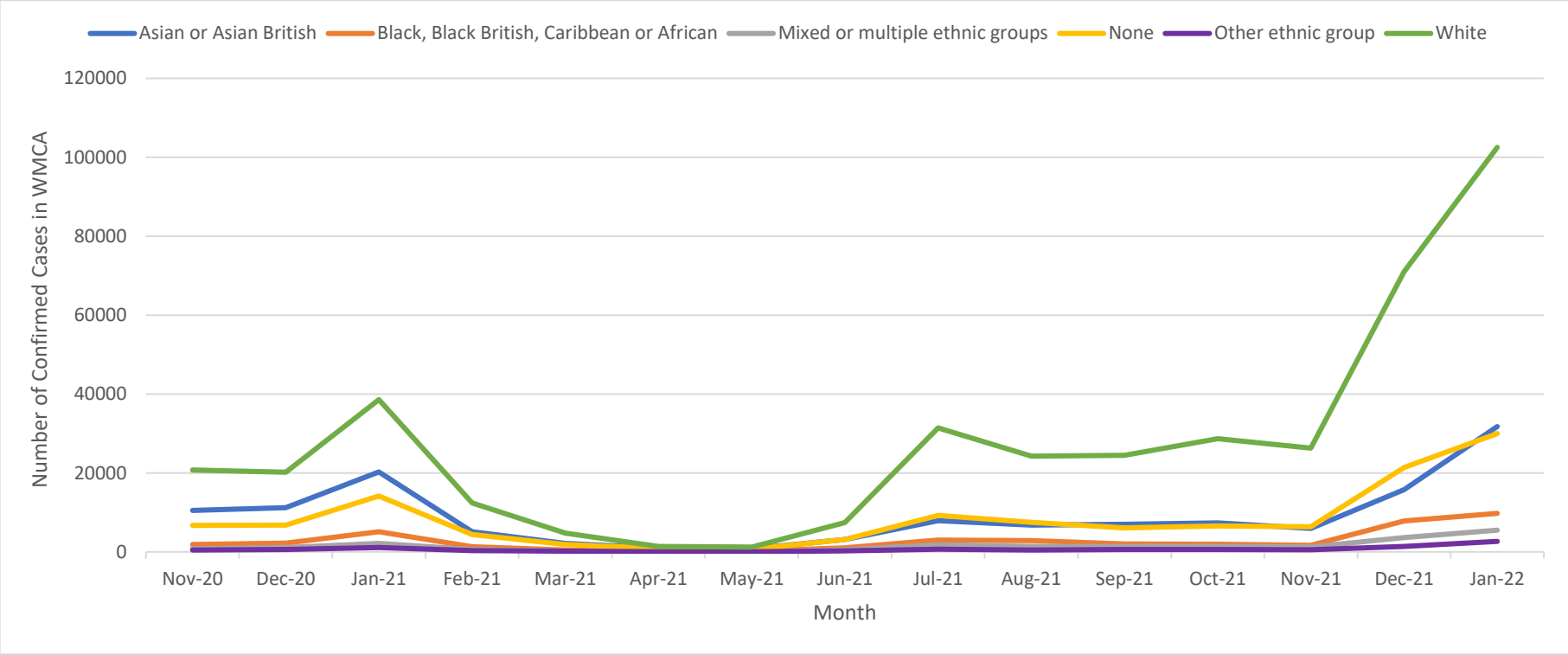


Source: OHID CHIME https://analytics.phe.gov.uk/apps/chime/

As of November 2021, 85% of adults in the West Midlands Region had received both their vaccinations. Figure 1 shows the proportion of double vaccinated population by five main ethnic groups in West Midlands region, from January 2021 to November 2021. We can see that vaccine uptake has increased for all five broad main ethnic groups over the period of January 2021 to November 2021. There is variation in vaccine uptake between White ethnic group and minority ethnic groups in West Midlands Region. Within the West Midlands region, the highest uptake has been amongst White British ethnic group between January 2021 and November 2021 and has been lowest in Mixed or multiple ethnic groups prior to August 2021. Black ethnic group was least likely to have the vaccination from September to November 2021. Differences in the vaccine uptake between adults of Asian or Asian British ethnic group and other ethnic groups have been narrow. Barriers to vaccine uptake include perception of risk, low confidence in the vaccine, distrust, access barriers, inconvenience, socio-demographic context and lack of endorsement, lack of vaccine offer or lack of communication from trusted providers and community

leaders[10]. In Chapter 2 and Chapter 3 we will explore some of the excellent work of our external partners and local authorities recognising their continued efforts to overcome these barriers to vaccine uptake.

Figure 2: Number of confirmed cases in WMCA from November 2020 to January 2022 per ethnic group



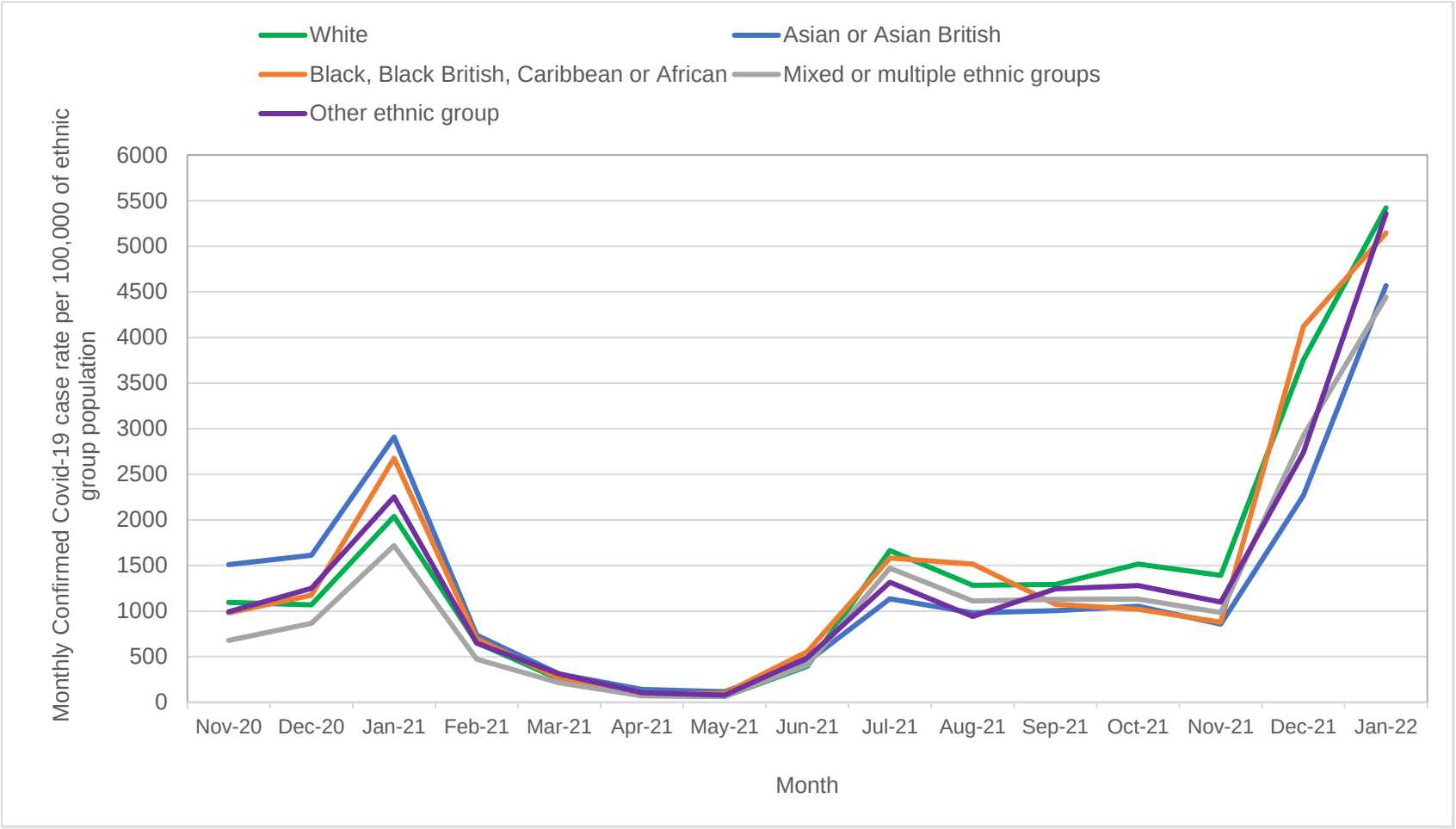
Source: Covid-19 Situational Awareness Explorer Dashboard.

[10] Factors influencing COVID-19 vaccine uptake among minority ethnic group (2020) ethnicity sub-group of the Scientific Advisory Group for Emergencies (SAGE) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf

The number of confirmed Covid-19 cases was highest in the month of January 2022 among White British ethnic group. Between November 2020 and January 2022, the WMCA saw a rate of 25,543 per 100,000 population confirmed cases[11]. This is similar to the national average case rate of 24,906 per 100,000 population during this period.

[11] Rate of Confirmed Covid-19 cases per 100,000 population is calculated by dividing confirmed cases from Covid-19 Situational Awareness Explorer Dashboard with ONS mid-year population estimates, 2020

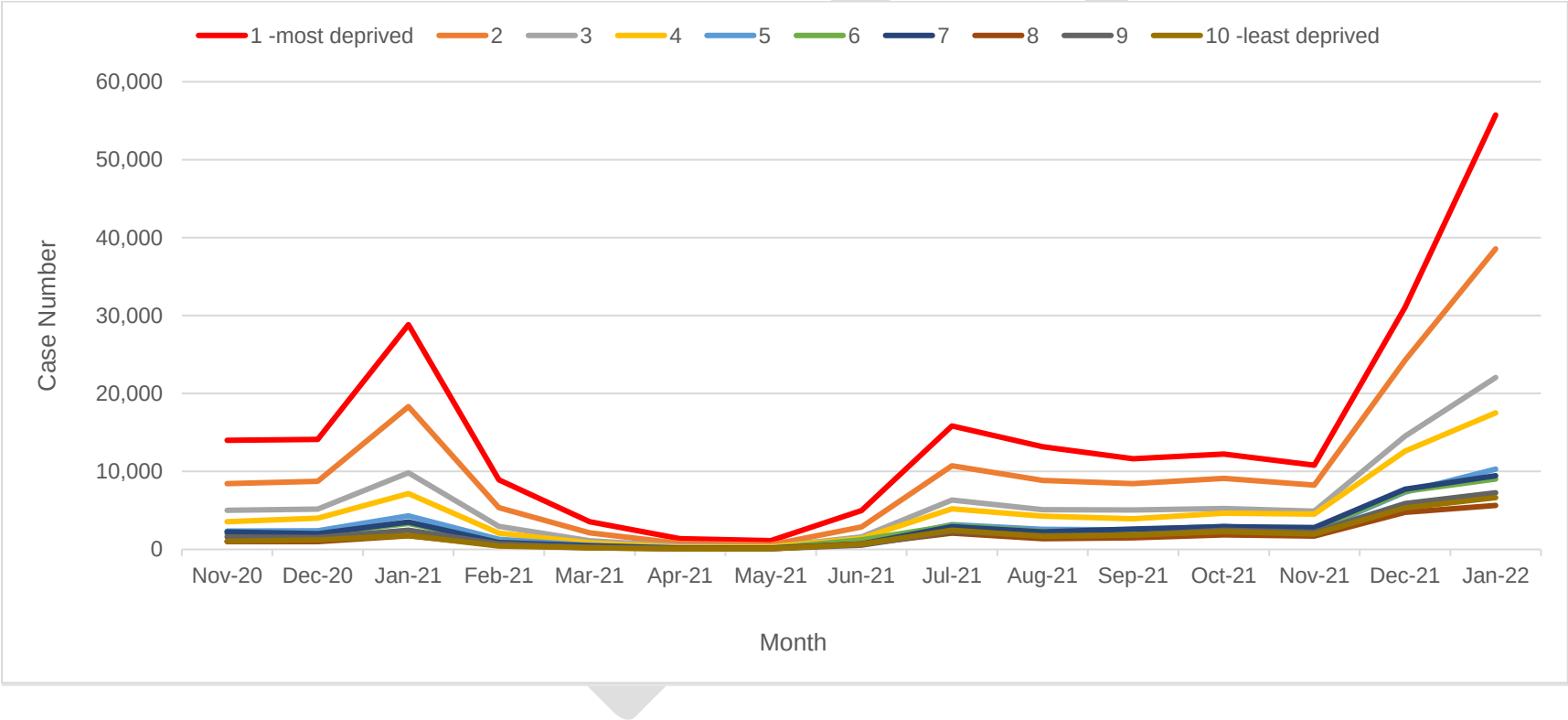
Figure 3: Monthly confirmed Covid-19 case rate per 100,000 ethnic group population for WMCA area from November 2020 to January 2022



Source: Covid-19 Situational Awareness Explorer Dashboard.

However, when population size of each ethnic group is adjusted for, case rates between ethnic groups start to differ[12]. From November 2020 to May 2021, monthly confirmed Covid-19 case rates were highest in Asian or Asian British ethnic group. During June, August and December 2021, monthly confirmed Covid-19 case rates were highest in Black, Black British, Caribbean or African ethnic group. Following the spread of Omicron variant from November 2021, cases rates peaked among White ethnic group.

Figure 4: Number of Covid-cases for WMCA area from November 2020 to January 2022 per deprivation decile

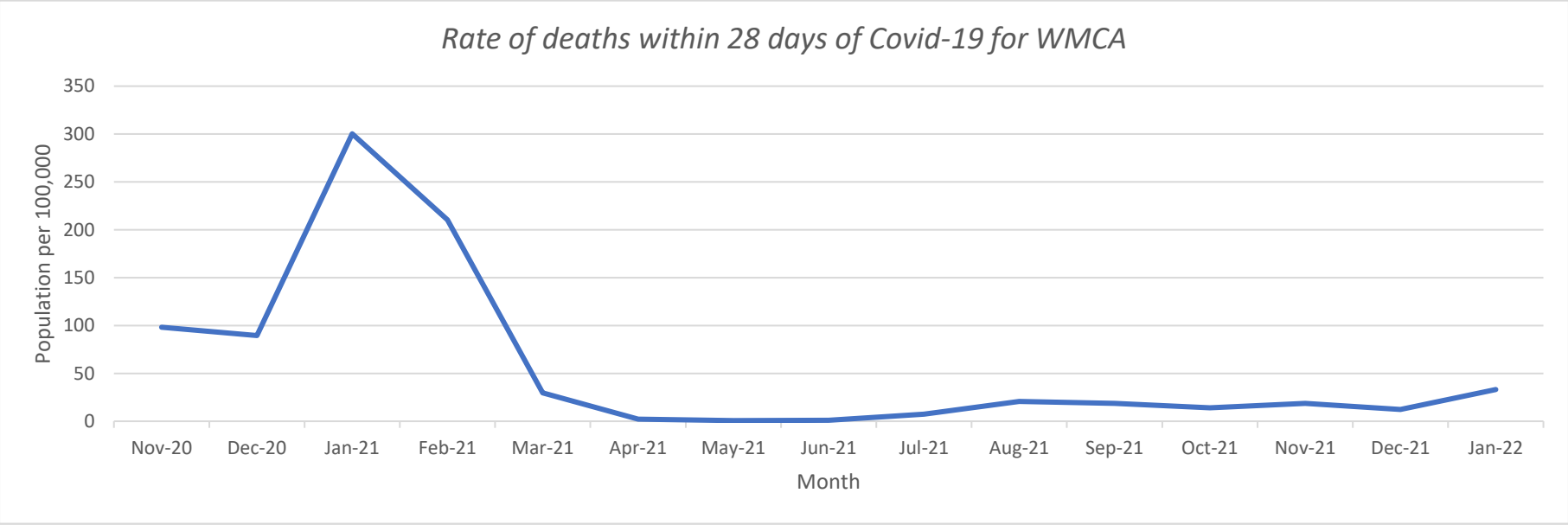


[12] Rate of monthly confirmed cases per 100,000 ethnic group population is calculated by dividing monthly number of cases for each ethnic group by total population estimate for each ethnic group 2020 modelled data. Source: ETHPOP projections which are used in the OHID CHIME tool. These were produced for OHID by Philip Rees and Paul Norman in the School of Geography, University of Leeds.

Source: Covid-19 Situational Awareness Explorer Dashboard.

The number of Covid-19 -cases for WMCA area from November 2020 to January 2022 has followed the pattern of deprivation. This means that areas with the highest levels of deprivation have also experienced the highest levels of Covid confirmed cases.

Figure 5: Covid-related death rate for WMCA area from November 2020 to January 2022



Source: Covid-19 Situational Awareness Explorer Dashboard

The Covid-19 related death rate reached its peak in January 2021 for WMCA. There were approximately 300.25 deaths in every 100,000 residents. There was a total rate of 295 Covid-related deaths per 100,000 population for WMCA between November 2020 and January 2022[13]. This was higher than the national average of 239 Covid-related deaths per 100,000 population during this period.

[13] Rate of Covid-19 related deaths: The number of deaths was from Covid-19 Situational Awareness Explorer Dashboard. The rate is calculated by dividing Covid-19 related deaths from Covid-19 Situational Awareness Explorer Dashboard with ONS mid-year population estimates, 2020

Whilst we have seen that vaccine uptake has increased across all broad main ethnic groups in West Midlands region, there has been variation in uptake between White ethnic group and Mixed or multiple and Black ethnic groups. We have seen a higher number of overall Covid-19 case rates in WMCA in White ethnic group from November 2020 to January 2021. However, during certain points during this period, Asian, Black and White ethnic groups have all seen higher case rates as a proportion of their ethnic group population. Demonstrating the changing picture of ethnic inequalities over the course of the pandemic, we have seen that the areas with the highest levels of deprivation within WMCA have experienced the highest levels of Covid-19 confirmed cases. We know that areas with higher levels of deprivation have a higher proportion of residents from an ethnic minority group and, in turn, face challenges around occupation, household composition, living arrangements, and pre-existing health conditions, which impact upon the risk of infection and adverse outcome of Covid-19[14]. Therefore, despite the pattern of ethnic inequalities being a moving picture over the various stages of the pandemic, the pattern of deprivation we saw at the beginning of the pandemic has persisted, even after vaccine success.

[14] "Ethnic differences in covid-19 death rates" (2022) BMJ 2022;376:o427 https://www.bmj.com/content/376/bmj.o427?fbclid=IwAR0EPwX1EWCly-9Ly-8uZP3MnEVYHDr6B9zFGo5MD1zF-fJgQ9c4TwKoUMs

2.2. The continued impact of Covid-19

As the HOTR report 2020 detailed, the wider impact of Covid-19 on mental health was profound, and it continues to be. Much of this emanates from the negative impact of Covid-19 on wider economic and social factors that, in turn, negatively impact mental health. It is pertinent to capture these emerging trends and issues, even if robust data reflecting this situation is itself still emerging, as set out below.

General trends in mental health

The Office of Health Improvement and Disparities (OHID) keep a running surveillance report on mental health and wellbeing from which we can detect trends that have emerged over the duration of Covid-19 so far, including how early responses and inclinations changed with Covid-19 developments i.e. new dominant waves and iterations or restrictions and lockdowns, or simply the length of time that this pandemic has persisted. There are undoubtedly time lags in the lived experience of these impacts as well as inevitable lags in capturing them in robust research, though we can extract the following from OHID's surveillance report[15]:

- Multiple studies revealed deteriorations in mental health and wellbeing between March and May 2020, followed by a period of improvement through July, August and September 2020 to a point where levels were comparable to before the pandemic. There was a second deterioration in population mental health and wellbeing between October 2020 and February 2021, followed by another period of recovery but not to pre-pandemic levels. The 'up and down' nature of these changes coincides with the periods of national lockdown and high COVID-19 cases followed by easing of lockdown and reducing number of cases.
- Studies looking at mental health trajectories for individuals suggest most of the population retained stable and good levels of mental health during the pandemic. However, some groups have been more likely to experience poor or deteriorating mental health during this period:
    - These include women, young adults (aged between 18 and 34, depending on the study), adults with pre-existing mental or physical health conditions, adults experiencing loss of income or employment, adults in deprived neighbourhoods, some ethnic minority populations and those who experienced local lockdowns.
    - In addition, those who felt lonely, felt a lack of control over their lives, who found uncertainty difficult or who were anxious about death were also more likely to experience worse or deteriorating mental health.
    - However, women and young people, people with lower levels of education and people living with children, following initial deterioration, also reported greater improvements and recoveries in mental health when case numbers had fallen and lockdowns were eased.
- Recent analysis of UK Household Longitudinal Study (UKHLS) data between April 2020 and May 2021 found a larger proportion of the population experienced psychological distress than previous estimates suggest.
    - Around two fifths of the population experienced severely elevated risks of distress during the pandemic, with 8% reporting an initial increase followed by a quick

[15] https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report; NB. findings have been selected from this national report based on: their pertinence to the West Midlands' population and circumstances; their explicit reference to changes over time, thereby providing additional insight to the scene set out in the HOTR 2020; and their relative robustness i.e. the multiplicity of studies supporting the headline findings.

recovery, 14.8% experiencing persistently elevated risks, and 24% experienced mildly elevated distress and then recovery in the first wave, then greater increases in the second wave.
    - This suggests that some groups may experience increasing mental distress from cumulative pandemic waves. Long-term distress was highest among younger people, women, people living without a partner, those who had no work or lost income, and those with previous health conditions or Covid-19 symptoms.
- Experiences of anxiety, depression, loneliness or mental distress may be linked with changes in lifestyle and adopting coping behaviours. Studies exploring these behaviours suggest some association between experiencing mental distress during the pandemic and changes in diet or eating behaviours, exercise, alcohol[16] use and sleep.
- Women were more likely to have made larger adjustments to manage housework and childcare during the first lockdown than men. These adjustments were associated with increased distress. Women also reported having more close friends and a larger subsequent increase in loneliness than men during the first national lockdown.
- There is mixed evidence about the impact of the pandemic on mental health and wellbeing by ethnicity. The associations between ethnicity and mental health during the pandemic are influenced by other factors, such as employment and income protection, community, gender and deprivation. Many population-based studies do not have sufficient ethnic minority respondents to enable a detailed look at experiences and outcomes of specific ethnic groups.

The impacts of wider determinants on mental health

The final point above and aspects of a number of the other findings point squarely to an increased impact of the wider determinants of health. The fact that a range of other, technically separate but intrinsically linked, factors play a profound role in health was comprehensively captured in the HOTR 2020 report, so it need not be repeated here. However, it is pertinent to explore developments across the wider determinants of health, particularly those innately linked to the economy, over the last 18 months of the pandemic. The restrictions and lockdowns that were put in place to manage the spread of infection had an immediate and direct impact on people's jobs and incomes. This was mitigated to some extent through the Government's Coronavirus Job Retention Scheme ('furlough') and a £20 per week 'top-up' to Universal Credit (UC)[17] while businesses were grappling with both the immediate impacts and wider, longer-term issues, which are now coming to the fore.

Although not yet encompassing the current picture, the (ongoing) Covid-19 mental health and wellbeing surveillance review has distilled that:

- Unemployed adults and those with lower incomes have reported higher levels of psychological distress, anxiety, depression and loneliness during the pandemic than adults with higher incomes (NB. there is mixed evidence about whether this gap has changed since before the pandemic).

[16] In its annual data release on the topic, the ONS reported a sharp rise - the sharpest, nationally - of alcohol-specific deaths in the West Midlands https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2020#factors-that-could-be-associated-with-the-2020-increase-in-alcohol-specific-deaths

[17] NB. The furlough scheme was brought to a close at the end of September 2021 and the UC top-up in October 2021.

- Loss of income and employment has been associated with worsening mental health during the pandemic. On average, any connection to a job or income (even if reduced compared to before the pandemic) has been better for mental health and wellbeing than none.
- Furlough has protected mental health among people with long-term insecure jobs. On average, furloughed workers in long-term insecure jobs before and during the first national lockdown reported no increase in mental distress, unlike counterparts who had not been furloughed.
- On the other hand, those who sought help from self-employment support schemes and Universal Credit to cover losses in income experienced comparably large and sustained increases in mental distress during the pandemic.

The furlough scheme was generally considered to be a success, having reportedly supported approximately 12 million jobs, and unemployment did not consequently reach the levels initially predicted[18]. Also unpredictable was a curious phenomenon now being labelled the 'Great Resignation' – despite the labour market having been relatively well protected, there are now record numbers of vacancies, meaning people are choosing not to work, and this is despite the highest wage rises for a decade. The intricacies of this trend as well as the potential future impact of this on mental health and overall health will be important to understand, as will the impact on health inequalities because it is likely to be an uneven picture across different socio-economic groups.

A snapshot of today's lived experience for significant sections of society, nationally, would show a 'cost of living crisis'. This follows what was reported as a 'supply chain crisis' in late 2021, which was an apparently global issue that resulted in a shorter supply of food[19] with a consequent rise in costs. Some commentators have drawn attention to this supply chain issue being related to or, at least exacerbated by, the UK's exit from the European Union and its ramifications on supply chains as well as labour shortages in the food and drink sectors (such as haulage, warehousing, hospitality and meat production). This increased cost of food has contributed to a significant rise in inflation; the official inflation rate has now reached 5.5% (January 2021), which is a 30-year high[20].

Combined with this, several emerging issues will likely impact mental and physical health in the immediate term:

- People claiming UC have been calculated to be five times more likely to experience food insecurity than those not claiming, which could be exacerbated by the withdrawal of the UC top-up[21].
- A nine-fold rise in wholesale energy costs coupled with a 12% increase to the level at which energy prices are capped is pushing significant numbers into 'fuel poverty' and also contributing to the rise in inflation[22].

[18] https://commonslibrary.parliament.uk/the-furlough-scheme-one-year-on/; https://commonslibrary.parliament.uk/examining-the-end-of-the-furlough-scheme/

[19] NB. There were other supply shortages, but food is particularly noteworthy with regards to health.

[20] It is noteworthy that the wage rises previously referred to are still below the level of inflation.

[21] https://foodfoundation.org.uk/press-release/new-data-shows-food-insecurity-major-challenge-levelling-agenda ; https://foodfoundation.org.uk/initiatives/food-insecurity-tracking

[22] https://lordslibrary.parliament.uk/rising-energy-costs-the-impact-on-households-pensioners-and-those-on-low-incomes/

- Having already seen a rise from 0.7% in 2019 to 1.5% in 2020, the number of households considered to be 'in destitution' has been projected to rise by 30% due to an increase in the rate of National Insurance alongside food insecurity and fuel poverty[23].

Evidently, beyond the fact of a highly infectious and potentially fatal pandemic itself being a source of anxiety, the circumstances around it can themselves evolve into health risks. Furthermore, each set of problematic circumstances are unlikely to transpire in isolation, especially for the most deprived segments of society. Issues compound one another, which exacerbates the overall impact. Correlate with this the impact of discrimination experienced – over generations – from being of Black, Asian or minority ethnic heritage, and potentially again layer onto this the experience of identifying with another characteristic protected under the Equality Act 2010 (or intersecting with multiple) and we begin to understand the cumulative impact of socio-economic deprivation and structural inequalities.

2.3. The institutional landscape

The brief insight presented here is a reminder that the significant health inequalities highlighted in the 2020 report have not dissipated and are, in fact, on a trajectory to widen. It is important then, that we as a region, and the WMCA as an institution, continue to work to address these inequalities.

Since the HOTR 2020 report, we have continued to work with health and care system partners by joining strategic conversations, Commissions and Boards as key stakeholders and to act as a regional voice on health inequalities. We have widened the WMCA Wellbeing Board to include representation from more system partners[24] alongside elected members from the WMCA's seven constituent local authorities. In addition, the HOTR Roundtable has evolved from a forum for engagement with the community that receives updates and gives opinions, to one that now has an independently led Core Group that acts as an operational sub-group that reports into the WMCA Wellbeing Board.

The HOTR 2020 report reset the narrative around the WMCA's role in the health and care system and, through the ongoing development of relationships within a wider context of institutional evolution, it has become clear that a sharpened focus on the second of the challenges set in the HOTR report – reducing health inequalities through tackling the wider determinants of health – is where the WMCA can best add value to the system and, ultimately, to the residents of the West Midlands.

We have therefore reshaped our strategy to focus on the following priorities:

- Using WMCA's core functions to galvanise action to ensure all economic investment in the region supports better health outcomes;
- Work with partners to attract funding from government and provide a regional voice on health inequalities;
- Work with partners to maximise the economic opportunities created by the West Midlands health and care economy;

[23] National Institute of Economic and Social Research (NIESR); "destitution" is based on the income components of the widely recognised JRF definition of destitution, which means going without the essentials that individuals need "to eat, stay warm and dry, and keep clean".

[24] The WMCA Wellbeing Board now includes representatives from all three ICSs, OHID, NHSE/I and Directors of Public Health.

- Champion specific issues and deliver grant-funded programmes where there is the clear support of the Combined Authority and its partners to do so.

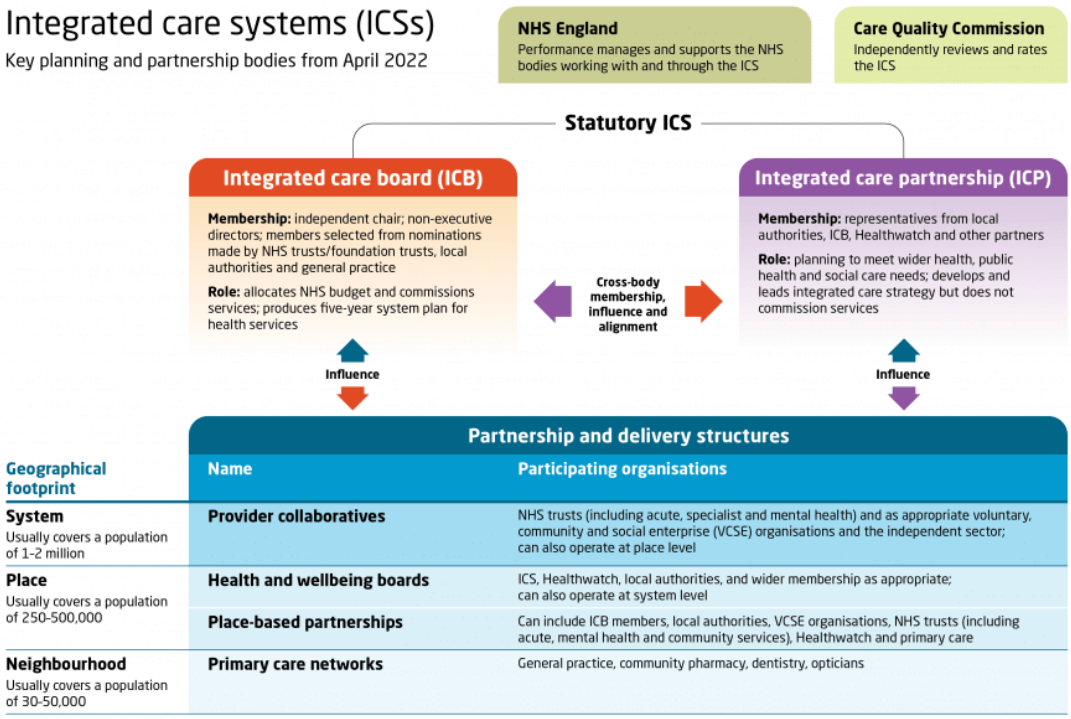
There is a clear emphasis on the economy; the key challenge now is how we shape the direction of economic recovery to align with improvements in health outcomes. Practically, that means using our leverage in areas of devolved responsibility to generate improvements through the wider determinants of health, which first means embedding an understanding of health in all policies. 'Health in All Policies' (HiAP) is defined as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful impacts in order to improve population health and health equity"[25]. Taking a HiAP approach will enable WMCA to put health inequalities at the heart of decision making across the wider determinants of health and enable progress on the priorities set out above.

In parallel with these developments, there has been large scale change in the wider health and care landscape. Public Health England ceased to exist on the 1st October 2021, and has been replaced with three distinct but inter-related Public Health functions:

- United Kingdom Health Security Agency (UKSHA), which will plan for the risk of future infectious disease pandemic and other major health threats;
- Department of Health and Social Care's Office of Health Improvement and Disparities (OHID), focusing on improving the nation's health so that everyone can expect to live more years of life in good health and on levelling up health disparities, working alongside the Chief Medical Officer; while
- the regional healthcare public health function is now part of NHS England and Improvement, continuing to place health inequalities and prevention at the forefront of decisions relating to NHS service delivery, design, and provision.

Significant change is also underway at a local level in terms of working together to improve health and social care through integration. The plans by the Department of Health and Social Care were accelerated as a result of the pandemic to support the system to recover and reform and included the formation of Integrated Care Systems (ICS). ICS's are governed by Integrated Care Partnerships (ICPs), which set system wide strategy, and Integrated Care Boards (ICBs), which are responsible for the NHS system performance (see image below). ICS's are partnerships between the organisations that meet health and care needs across an area to coordinate services and plan in a way that improves population health and reduces inequalities between different groups as part of a place-based approach with decisions affecting citizens being taking as close to the citizens as possible.

[25] WHO 2013



Source: The Kings Fund 2021

Furthermore, the long-awaited 'Levelling UP' White Paper was published on the 2nd February 2022, following a £4 billion Levelling Up Fund announced in the Government's November 2020 spending review and a longer-standing (pre-pandemic) narrative around mainly the inter-regional disparities in the UK. The Levelling Up White Paper has four policy objectives:

I. Boost productivity, pay, jobs and living standards by growing the private sector, especially in those places where they are lagging. Focus areas are living standards, research and development, transport and infrastructure, digital connectivity.
II. Spread opportunities and improve public services, especially in those places where they are the weakest. Focus areas include education, skills, health, and wellbeing.
III. Restore a sense of community, local pride and belonging, especially in those places where they have been lost. Focus areas include pride in place, housing, and crime.
IV. Empower local leaders and communities, especially in those places lacking local agency. The key focus area within this theme is local leadership.

Aligned to these are 12 missions, one specifically on health and another specifically on wellbeing. In terms of health, the paper sets out a headline metric of reducing the gap in Health Life Expectancy (HLE) between local areas by 2030 and raising HLE by five years by 2035, and it identifies a range of associated policies (not all of which are necessarily new). With regards to wellbeing, a reduced gap and an overall improvement are also set out as general aims, while the policies are yet to be defined. It is understood that a White Paper on Disparities, expected to focus on the prevention of disparities by ethnicity, socio-economic background and geography, will provide further details when it is published later in 2022.

Chapter 3: Action on Community-Centred Commitments from Across the Region

This section draws upon the activity of some of our partners within the health and care system who have been working hard to tackle the challenges impacting upon health inequalities in the region. The role of universities, the police, organisations taking community-centred approaches and NHS services will be reflected upon as an opportunity to bring to life and showcase the breadth of work in our region. This section will refer to the four key challenge areas for action identified in the HOTR 2020 report as touchpoints and also give mention to some of the commitments to action made in that report. Notably, there are range of key partner organisations that are not captured in this section but have been working hard to tackle health inequalities in the region. For example, NHSEI Midlands, the NHS Integrated Care Systems, Office for Health Improvement and Disparities, West Midlands Fire Service and many more. Our partners have worked above and beyond those initial commitments and have been responding to the evolving scene and growing need in the region. Please refer to the appendix for a progress update on the 50+ commitments made across our region's health and care/wellbeing system.

3.1. Aston University: Demonstrating the role that universities can play

As major institutions within the region, universities have a role to play in tackling the region's health inequalities, for example, by collaborating with public bodies, private and voluntary sector organisations on health improvement initiatives or improving their social value to support their local community's health and wellbeing through workforce development. Aston University is used here as a case study to bring to life some of this work in the region.

Aston University has been committed to improving the representation, progression and success of minority ethnic staff and students within higher education. By joining the Race Equality Charter, the University has been working through its framework to systematically identify and self-reflect on institutional and cultural barriers standing in the way of Black, Asian and minority ethnic staff and students. In response, the University has been developing initiatives and solutions for action. They are working towards obtaining their Bronze Race Equality Charter award.

The University has been exploring their role in widening access to health and care for the community that they sit within. They would like to develop a Health Hub at Aston that would be open to the local community and have been prioritising engaging with communities in the planning stage. They have been undertaking listening events to share local views and experiences of access to health and care in order to develop the Health Hub so that is serves the local community.

Aston University has been working in partnership with Aston Villa Foundation (and supported by Essilor) to go into local schools to deliver workshops about eye health, conduct eye screening and eye tests for those that need it in low-income communities. They collaborated with local organisation to listen to communities to understand barriers faced in relation to eye health and factored these into the Villa Vision programme. As of January 2022, they have been able to engage with around 4500 individuals in various capacities to help raise awareness around the importance of eye health. Within schools, this includes:

- Over 2200 children receiving the Villa Vision workshop across 30 schools
- Almost 1800 children having a vision and colour vision screening check in local primary schools

- Approximately 280 children (around 16%) being flagged for further investigation.
- Around 100 fully comprehensive eye tests being conducted at schools using the Villa Vision eyecare van
- Nearly 120 pairs of glasses being provided to children requiring them, helping to support both their educational and social development

Aston University and Aston Villa Foundation have also been working with children and parents on childhood eating habits to encourage healthy eating habits and enable healthy choices. The University has been exploring the role of food and health through its research, for example social media 'likes' are found to positively influence healthy food choices and children who watch smiling adults eat vegetables consume more than double the amount themselves. To explore and promote how a healthy food economy might operate in an area faced with multiple levels of inequalities, the University undertook research in partnership with Birmingham City Council on family food purchasing in East Birmingham[26]. The research identified opportunity barriers to healthy food purchasing but also the opportunities provided by healthy eating. The recommendations suggest that future interventions are not limited to educational and financial support but also focus upon motivational aspects of healthy food purchasing such as enjoyment, indulgence, and social bonding.

3.2. The WM Police and Crime Commissioner: Policing and tackling health inequalities

There is an established shared purpose for policing and health improvement[27], for example, by promoting proactive prevention, working with partner organisations to problem-solve, create cohesive communities, improve data-sharing, and promote evidence-based practice. Action led by the West Midlands Police and Crime Commissioner (PCC) shares this approach through their work on tackling health inequalities.

The WMPCC is prioritising building trust and strong relationships through working to look more like the people they serve with a target of recruiting 1,000 minority ethnic officers by 2025. Various initiatives have been taking place to increase the diversity of the Force and are already starting to see an increase in representation. Initiatives include data driven decision making, targeted advertising, intensive qualification support and maximising internal support. They have held successful recruitment events within specific locations to target underrepresented groups such as Perry Barr.

Supporting young people is critical to preventing and reducing crime through diverting young people away from crime and into employment[28,29]. As part of this work, the PCC continues to increase the number of police cadets to support young people and reduce inequalities they experience in tackling the wider determinants of health. The scheme fosters self-confidence and community engagement with policing. It gives children and young people valuable skills and experience, and some will be police officers of the future. The PCC has committed to increase the size of the West Midlands Police

[26] East Birmingham Family Food purchasing project: A qualitative analysis (2021) Aston University and Birmingham City Council

[27] World Health Organisation "Public Health Approaches to Policing in the UK" https://glepha.com/call-for-submissions-public-health-approaches-to-policing-in-the-united-kingdom/

[28] Police and Public Health Innovation in practice: an overview of collaboration across England (2016) Public Health England https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/567535/police_and_public_health_overview.pdf

[29] West Midlands Police and Crime Plan 2021-2025 https://www.westmidlands-pcc.gov.uk/wp-content/uploads/2021/10/The-West-Midlands-Police-and-Crime-Plan-2021-25.pdf?x52165

Cadets programme with an expectation the number of cadets will increase to 750- with measures for success in place.

Through collaborative working, the PCC are working towards early intervention and prevention to tackle the challenges faced by individuals and communities. This includes focusing on reducing harm caused by drugs, gangs and violence. For example, violence prevention through youth work, drugs strategy and prioritising those at risk through rolling out units in our most diverse and challenging areas, focusing on young people who need the most support.

3.3. The Ethnic Minority Council: Local infrastructure and equalities organisations in community-centred approaches

Local infrastructure and equalities organisations within the health and wellbeing system enable the voluntary, community and social enterprise (VCSE) sector alongside public bodies to take action on health inequalities. The Wolverhampton Ethnic Minority Council case study brings this to life through their collaboration within the regional system supporting ethnic minority and equality groups.

The Ethnic Minority Council undertook a raft of work to support the Covid-19 Community Champions work. Community champions are community members who promote health and wellbeing or improve conditions in their local community[30]. They utilise their networks and experience to address barriers to engagement and improve connections between services and disadvantaged communities. Community champions approaches provide rich learning for reducing health inequalities, they have been vital to supporting the local Covid-19 response.

The Ethnic Minority Council (EMC) facilitated engagement across community and equality groups focusing upon the take up of the Covid-19 vaccination, through which enhancing relations and partnership working between communities and public bodies. They worked to enable those who may usually be unable to take part due to barriers or needs including those with disabilities, ethnic minority and LGBT+ groups. Action included facilitating one-to-one consultation with Community Champions, Media and Marketing support, Wellness Activities, Q&A sessions, PPE Gifting, Community outreach videos, Community photo messages, and strategic social media campaigns.

Their Covid Champions activity provides helpful learning to understand different engagement techniques as they adapted their engagement approach to meet different needs. For example, specialist support sessions for Covid Awareness such as LGBT+, Punjabi and Urdu-speaking Ramadan. Q&A sessions included local specialist doctors and EMC Ambassador to discuss the Covid vaccine and myth busting with translated presentation slides. Another example was the use of wellness activity to provide Covid updates, Q&A, signposting and PPE. This meant holding events outdoors in community locations such as Silk Flower Arranging with the Sahali Group, Caribbean Tea Moments, Older Men's Hang-out & Covid Update, Children & Young People's Covid, Summer Samosas & Chai with Happy House. The focus on wellness over cultural food or activity encouraged discussions around the negative impact of Covid on mental wellbeing such as isolation which is damaging to both physical and mental health. The events were used to record community Covid messaging for social media with targeted distribution. This activity captures good practice for increasing the outreach and engagement of services to raise awareness and promote public health guidance and

[30] Community champions A rapid scoping review of community champion approaches for the pandemic response and recovery (2021) Public Health England

people-powered health and wellbeing within diverse range of resident groups within the West Midlands. EMC promoted community cohesion and a strong community spirit to help address health inequalities.

Through supportive and collaborative work, the Ethnic Minority Council works across equality grassroots groups and statutory bodies to promote the reduction of health inequalities and improvement of health and wellbeing.

3.4. Cysters: Specialist support from grassroots organisations in community-centred approaches

Across the Voluntary, Community and Faith sector, grassroots organisations provide specialist support for ethnic minority and vulnerable groups to tackle specific health and wellbeing issues which impact upon health inequalities. This case study looking at the work of Midlands-based Cysters charity helps to bring this vital part of the health and wellbeing system to life.

Cysters supports marginalised individuals and their communities with reproductive and mental health issues. Through their activity, they challenge the perception and narrative of marginalised people and their experience of illness which impacts upon the wider determinants of health such as education and identity. For example, Cysters partnered with the University of Birmingham in the Polycystic Ovaries Syndrome (PCOS) Leadership Programme and Study to improve experience of illness for women with PCOS. The research-based programme involves 1,000 women with a large proportion from an ethnic minority background to which Cysters provides support. Their grassroots activity contributes to the health and wellbeing of marginalised individuals and communities through addressing their experience and building control and resilience and, management of long-term illness[31].

They are committed to changing the narrative around accessing healthcare and offer peer-to-peer support and provide forums to discuss what may be useful when pursuing a diagnosis or asking for a referral. Cysters challenge the “hard to reach” narrative associated with people of colour and instead carve out a safe supportive space to engage with healthcare and services. They involve and empower marginalised individuals and communities to promote health and reduce the health inequalities they experience.

The charity works to tackle barriers around access to health and care services towards an inclusive healthcare system. To enable this, the charity has been developing bespoke training and workshops focused on the need for intersectionality for inclusive healthcare. [explain intersection]. They have been supporting healthcare research projects with the recruitment of diverse participants, bespoke inclusivity training programmes and shaping research to include lived experience. Cysters has been tackling the widening inequality of period poverty throughout the pandemic where 3 in 10 girls has struggled to afford or access sanitary wear during lockdown[32]. As an example, provided over 6000 menstrual products in one weekend and are supplying products to food banks, local support groups and the NHS. Cysters activity provides helpful examples for bottom-up grassroots activity to tackle health inequalities across the region.

[31] Health Matters: Community-centred approaches for health and wellbeing (2018) UK Health Security Agency https://ukhsa.blog.gov.uk/2018/02/28/health-matters-community-centred-approaches-for-health-and-wellbeing/

[32] Plan International (2020) https://plan-uk.org/period-poverty-in-lockdown

3.5. West Bromwich African Caribbean Resource Centre: Hearing voices of local communities in community-centred approaches

Community organisations are able to provide support at a community level to address factors that protect and create health and wellbeing. This case study looking at the West Bromwich African Caribbean Resource Centre helps to illustrate the role of community organisations with a focus on hearing voices of local communities.

The Centre undertook community-based research on the thoughts, feelings and impact of Covid-19 and the lockdown on Black African diaspora communities in Sandwell, West Birmingham and the wider West Midlands[33]. This type of research starts with the premise of listening and providing the time and means for participants to express themselves. This research is not only interested in the answers but the reasons behind the answers. The research independence challenges community research that is often "done to" Black African diaspora communities and places control with the community group to do its own research. The process is helpful learning for other community organisations to conduct their own research.

The research focused on the experience of Black African, African Caribbean, West Indian, Black British and dual heritage and other groups who have Black African lineage. Their work rejects and challenges the abbreviation for Black Asian Minority Ethnic (BAME) term. This is because it lessens individual experiences by amalgamating experiences together due to smaller numbers and less comparable social economic and political power. The research was prompted by emerging statistics throughout the pandemic that demonstrated racial disparities in those being hospitalised with Covid-19 and those dying from Covid-19 [insert reference]. As well as reported vaccine hesitancy amongst Black population. The research explored a better understanding of vaccine hesitancy and other matters relating to Covid-19 pandemic and lockdown.

Its findings challenge the portrayal of Black people being anti-vaxxers and identified successful vaccine promotion through Black doctors and health professionals providing information and answering queries. The findings also challenge the explanation of overcrowded housing for high infection rates within 'BAME' groups which may not apply to Black African Diaspora groups. The research identified underlying mistrust of the wider socioeconomic political system, which can be linked to negative experiences of racism which is evidenced by racial inequality. The lack of infrastructure investment into Black African Diaspora community groups was considered to be a contributing factor. The reporting of racial disparities in Covid-19 deaths was considered at times to lack sensitivity and served to exacerbate pre-existing fear and distrust. The research indicates that this perpetuated barriers to engaging with public health messaging and preventative actions. The findings and series of recommendations have been acknowledged by the Black Country & West Birmingham NHS Integrated Care System. They provide a helpful knowledge base for working to address health and wellbeing issues related to Covid-10 experienced by African Diaspora groups in the West Midlands.

[33] "Black, Covid and In Lockdown: In Our Own Words: The Findings" (2021) West Bromwich African Caribbean Resource Centre

3.6. The role of NHS in tackling health inequalities

As mentioned above (in section 2.3), NHS Integrated Care Systems and their Boards have a major role to play within the system to reduce inequalities between different groups and this is reflected in their statutory duty to do so in terms of access to and outcomes from health services[34]. NHS bodies have a core role to play in addressing health inequalities in the way that it provides services and supports an increased focus on prevention and early intervention[35]. Yet the role of the NHS goes beyond the direct provision of care to creating social value for local communities. For example, the NHS is a significant employer, purchaser and estate owner. The NHS can help shape a place through impacting local socio-economic conditions and tackle the underlying drivers of poor health. The NHS is able to recognise its role as an anchor institution and have an impact in areas of deprivation. In doing so, support the government's commitment to levelling up. Two case studies from within the region are drawn upon to illustrate the role of the NHS in tackling health inequalities.

The Dudley Group NHS Foundation Trust: Using workforce and service development to tackle health inequalities

The Dudley Group NHS Foundation Trust have been committed to supporting their workforce through their ethnic minority staff inclusion network which included a 12-month calendar of culturally appropriate health and wellbeing initiatives to support staff from a physical and mental wellbeing perspective. The network has been active with the members attending COVID vaccine walkabouts to promote uptake of the vaccination. Members took part in a Covid-19 mental health winter webinar. The network has invited external speakers to increase awareness of conditions that have a greater impact on people from the ethnic minority community and as a result highlight health inequalities. They have looked at lupus and prostate cancer and plan to raise awareness about sickle cell and thalassaemia.

The Trust has been working collaboratively with partners to explore how they can ensure more employment opportunities for local people, in particular those who have found it hard to get employment in the past. This work has meant 27 young people have received placements as part of the Kickstart programme, with 3 of these qualifying and being employed as phlebotomists. Two have secured posts as trainee Clinical Support Workers, with a further 3 starting apprenticeships with the Trust. The trust has signed up to the Care Covenant which is a national inclusion programme that supports care leavers aged 16-25 to live independently with opportunities and are in the process of recruiting to a cohort of care worker roles for care leavers. The Trust is in active discussions with partners about the proposed university centre in Dudley so that local people get the maximum benefit and the courses offered align with our current and future workforce needs.

Work is underway with colleagues in Dudley such as the local Council for Voluntary Service (CVS) to explore how to collectively make a difference to cancer outcomes, with a particular focus on parts of the Borough where outcomes are poorer. They organised a workshop in November 2021 for trust staff and local voluntary organisations to identify the barriers to accessing services. The trust is looking at what action can be taken quickly with a commitment to conduct deeper conversations in the future. This will include ensuring screening services provided by the Trust are delivered in a way

[34] House of Commons. Health and Care Bill Part 1 — Health service in England: integration, collaboration and other changes; 2021 (https://publications.parliament.uk/pa/bills/cbill/58-02/0140/210140.pdf

[35] Anchored in our community: The role of the NHS in addressing health inequalities (2020) NHS England https://www.england.nhs.uk/blog/anchored-in-our-community-the-role-of-the-nhs-in-addressing-health-inequalities/#:~:text=The%20NHS%20has%20a%20core,an%20increased%20focus%20on%20prevention.&text=The%20decisions%20the%20NHS%20takes,drivers%20of%20poor%20health%20development.

which encourages uptake from more vulnerable people and how cancer services are culturally sensitive and more person centred.

University Hospitals Birmingham Trust: Using digital transformation to tackle health inequalities

University Hospitals Birmingham Trust has been using digital transformation to reduce health inequalities by bringing care closer to communities. This has meant enabling people to access health care and information in a more accessible and a timely way through the creation of community-based diagnostic hubs in local neighbourhoods. The Trust has been working with the WMCA on an evidence-based approach to locate the diagnostic hubs in areas most accessible by the people most underserved and most in need of care. The programme has deployed a local non-medical workforce to help bridge the gap between services and the communities they serve whilst providing employment opportunities and career progression for local people.

The new model of care brings efficiency and personalised care is currently in place for dermatology and ophthalmology pathways, with ear and nose pathways due to go live in Spring 2022. There is a total 40 pathways planned for the future. The model allows for testing to be carried out remotely by non-medical workforce and escalated to clinicians for in-person care when needed. Data and intelligence from the patch is used to inform how the model operates across different setting and services. The model is currently focused on the Birmingham and Solihull NHS Integrated Care System patch with scope for wider scale across the region.

The Trust has also been using digital transformation towards early intervention in the community team supporting older people. For example, remote monitoring to support earlier return home for patients with respiratory conditions - initially for chronic obstructive pulmonary disease, now broadening to other conditions - following a stay in hospital. And, remote digital diagnostic equipment is being used between ambulance crews and hospital staff, to provide specialist care in people's homes which will soon to expand to community nursing staff.

An outpatient communication platform has been implemented to allow patients to specify how they would like to receive communications from the Trust relating to their care. This allows for patients to define how they wish to engage – whether that be on paper, by phone, or digitally.

Chapter 4: Local Authorities: Supporting Communities to Stay Well

In this section, our local authority partners provide examples of their Covid-19 response. Local Directors of Public Health and their public health teams had to innovate quickly to develop bespoke and tailored support to provide local health protection response, but also to keep their communities well. Support was wide ranging and included the communication of up to date lockdown messaging, encouragement for vaccination uptake as well as support to maintain mental, physical, and financial wellbeing, all in culturally appropriate ways. The teams have also worked to support businesses, schools and universities to be Covid-19 secure. They have reached out to those most at risk, working to reduce inequalities, and ensure the best possible outcomes for their communities during the pandemic. This section highlights some of the outstanding work lead by local authority Public Health Teams

4.1. Birmingham City Council: Authentic Conversations During Covid

It is well recognised that Covid-19 has disproportionately affected minority communities and in a global city like Birmingham this has been a core aspect of our response and it has required many authentic honest and open conversations over the last two years.

In April 2020, Councillor Paulette Hamilton, Chair of the Health and Wellbeing Board, called an emergency meeting of the Health and Wellbeing Board following concerns from local communities about the disproportionate impact on ethnic communities in the city. The question answered questions from the public about concerns and fears. It was broadcast live and at several points during the event the online coverage crashed due to overload. Since that meeting early in the first wave the Council has continued to develop and evolve our engagement with citizens and communities to respond to the challenge of the pandemic.

During the first wave the Council commissioned the first tranche of community engagement partners from local community organisations to help deeper engagement with specific communities of identity. This was particularly crucial for communities where English wasn't their first language. Working with partners like Birmingham Institute for the Deaf and Birmingham Chinese Community Centre we co-produced adaptions of the national messaging into culturally competent versions and collaborated on bi-lingual engagement events to allow citizens to ask questions in their first language and have them answered through a translator. As the pandemic continued to evolve, we worked with Aston University to develop this model of culturally competent translation further and it is now underpinning work to develop culturally competent physical activity guidelines as part of the Commonwealth Games Legacy.

We have worked throughout the pandemic with the faith leaders of the city. Bringing together on a weekly basis for most of the first two years leads from our Masjids and our Black-led churches and an interfaith group. Through these meetings we co-produced faith specific guidelines and advice and worked together to navigate the changing landscape of guidelines and information on safe worship. This was supported by the wider regional faith meetings hosted by the Combined Authority Mayor supported by the city's director of public health. This partnership with faith leaders has been particularly important as we moved into supporting the vaccination programme where their insight and position as key influencers in communities has been key.

Building on learning from Newham Council, in the Summer of 2020 the Council launched the Covid Champion programme which recruited volunteers across the city to support information dissemination through personal and professional networks. The Champions reflect the geography of the city with champions in every ward and we have worked hard over the year to increase the

diversity of the group to reflect the diversity of our city. In the Summer of 2021, we launched targeted youth champions and business champions to deepen our engagement with these different groups. The Champions have been supported through regular webinars as well as weekly data briefings and we have worked with them to reflect on how testing and later vaccination worked. We now have over 800 champions networked into our response.

Alongside this we have worked with regional and community radio and TV stations like BBC West Midlands, Unity FM, New Style Radio and the Sikh TV Channel, as well as supporting the wider community and voluntary sector through the Neighbourhood Network Scheme and Birmingham CVS to raise awareness and increase understanding. Our elected Members and local politicians have also been a key part of the information and engagement approach and have been fundamental to understanding the challenges of Covid in local communities across the City.

At the heart of our approach has been open authentic conversations. We recognised that information dissemination was only part of the solution and we needed to be actively listening and be in a two-way dialogue with communities. Putting our Director of Public Health, and our senior public health team, in direct engagement with citizens, whether to weekly radio phone-ins on BBC West Midlands or in translator facilitated webinars, giving citizens access to facts and information has been key. We have been honest when the science was unclear, we have been open about the difficult choices being made, and we have listened and changed direction when communities told us the approach wasn't working. We have worked as a City together to navigate the challenges of the pandemic and its inequalities.

But many of these inequalities existed before Covid and they remain a challenge in our City. Now as we move into a phase of living with Covid we are working with these partners to develop and evolve these relationships into on-going engagement approaches. These partnerships and collaborations will underpin the delivering of our Health and Wellbeing Board strategy to Create a Bolder Healthier Birmingham and help us move to a better future for all our citizens at every stage of life and in every community across Birmingham.

4.2. Coventry City Council: Community engagement the Coventry way

In summer 2020, Coventry City Council launched a community-led response to communications and messaging around Covid-19 that's seen the development of more than 320 community messengers across the city. They share information in the way they know works for their communities and neighbourhoods and provide feedback and intelligence about how it really feels on the ground in these extraordinary times. The programme secured further funding from the Ministry of Housing, Communities and Local Government to build on this approach and recruit organisations and community organisations to assist as community champions.

Community messengers were recruited through existing faith, voluntary and community networks in the city. A series of webinars were held to provide initial advice and training and focus groups were held with young people to help develop specific messaging.

A weekly news update is emailed to messengers to share with their networks. The email update is long and detailed, messengers pick and choose the items they would like to share. One messenger creates a weekly email for her neighbours and rewrites the information we provide into her style. Weekly webinars provide a forum for sharing and discussions for the messengers.

The network provides valuable feedback about what's really going on in neighbourhoods. They tell us about the latest false news and disinformation that's being shared on social media on things like the vaccine. It helps us make sure we're myth-busting when we need to.

When a walk-in test centre was set up in Foleshill, a ward with high levels of deprivation, it led to a backlash from the community. They thought we were stigmatising them. The decision to position a walk-in test centre was because of low levels of car ownership, but this hadn't been explained. The feedback helped us address the problem and to explain fully.

Alongside the messengers network, voluntary and community groups are working with the council to share communications. Webinars to brief community centres and places of worship are held when there's a change in guidance and they are provided with regular phone advice and weekly update emails.

This work is just as important as our engagement with community messengers. Community centres and places of worship are supporting people through these difficult times by providing social supermarkets and other crisis support and they're an excellent way to get stay safe messages out as they are hubs in their communities.

The true measure of success is that this is more than engagement. Our community messengers and the community and voluntary groups are not simply passing on messages. They are actively complaining to big business where they see failures, recruiting people in the network to help and the voluntary and community groups are peer supporting each other as well as working collectively with us. We hope these benefits will continue long after the pandemic is over.

4.3. Dudley MBC: Supporting Dudley residents to isolate

During the pandemic Dudley residents testing positive for Covid have been assisted through isolation with a package of support to enable them to isolate and remain well. All residents testing positive were contacted by either letter, email, text message or telephone call to inform them of support available. One of the key areas was to support residents and their households to be able to access the essential supplies needed to isolate. In order to do this, residents were encouraged to access supplies online, or via their networks of families and friends. Where residents were unable to access supplies by these methods, we worked with Black Country Foodbank, set up temporary food stores and established a business account with a local taxi firm to ensure that emergency food parcels were delivered quickly throughout the week.

Throughout the pandemic, processes were refined and improved to ensure support was available for all eventualities. For instance, on occasions where the contents of a standard foodbank parcel may not be appropriate, due to the need for specific items due to specific dietary requirements or items such as formula milk or nappies, alternative means of providing these items in a timely fashion were set up. This was achieved by creation of an Uber grocery delivery account that allowed members of the on-call team to be able to source a range of local providers and have the required items delivered in a timely fashion. These measures, underpinned by a 7 day a week on call team, ensured the offer of support was available to residents in a timely fashion.

Since April 2021 on average the monthly support provided to residents who were contacted by telephone call can broken down as:

- 113 residents called
- 30 supported with financial advice
- 5 referrals into mental health services

- 12 households supported with access to food supplies

4.4. Sandwell MBC: Creating an army of vaccine advocates

Sandwell Council were well placed to take action when the Government announced funding to support COVID champions. They had drawn on intelligence from local contact tracing and flu vaccination uptake and were aware of difficulties engaging some communities, particularly some ethnic minority communities. Armed with intelligence around digital exclusion, car ownership, language barriers and some cultural factors that meant myths circulate more strongly, the team knew they needed to act quickly and had already established a Community Vaccination Leadership Programme by the time the government initiative was launched.

They knew straight-away that they needed to harness trusted voices, it is not the Director of Public Health or council leader or even local doctors that are listened to, it is faith sector leaders, community group leaders, the local go-to guy who knows everyone in the neighbourhood. Leaders were recruited and trained, including faith leaders, representatives of Age UK, members of Sikh football team, someone form the local deaf community organisation and neighbourhood group members. The total number of vaccination leaders is currently 218 community members.

Online training was provided by one of the public health nurses with input from a behaviour change specialist. The sessions were live and interactive sessions so leaders can ask questions and the team could understand the issues on the ground. A key message in the training is to create positive behaviours and norms by leading by example, not about lecturing. Alongside providing training, the council has been providing support with promotional material, such as posters, while a vaccination uptake grant has been set up to help community groups run their own projects.

"*One thing this pandemic has shown me is how communities in Sandwell have come together to support one another*." Harmohinder Singha Bhatia

The Healthy Sandwell team, which normally does smoking cessation and weight management programmes are running a phone line and following up those who have not come forward for the jab. There may be practical reasons, such as not being able to read the letter or needing transport, which can then be arranged for them, while others may have concerns about the vaccine itself. One of the common concerns is that people are worried that the vaccines have been rushed. The team are able to provide reassurance by summarising the vaccine approval process and explaining the rigorous testing that all vaccines undergo.

Dr McNally is delighted with the efforts that are being made. "It is about getting everyone in the system playing to their strengths. We can make that happen – and I think have a significant impact on uptake. We are not seeing a big difference between uptake across ethnic groups at the moment, so it suggests we are having an impact."

4.5. Solihull MBC: Community outreach in Solihull

Ruth Tennant, Director of Public Health in Solihull, is typical when she says: We had been developing our outreach work throughout Covid. So when it came to the vaccine we could, pretty much at the drop of a hat, get together 200 community leaders of all sorts on a webinar, from people running playgroups and community centres to faith leaders, and tell them 'this is what we know about the vaccine, this is how it has been developed, and why it has been done so quickly' and do some early

myth-busting while encouraging them to use their networks to get the vaccine message out there and build trust. And that sort of infrastructure the NHS does not really have. When it came to extra clinics, local authorities and our teams are very good at knowing places and people and wards. So the potential locations that have high footfall, or to reach groups with low uptake, we could say 'you should open up something here', or for mobile vans knowing that you need to go in this car park if you want to get that group. So providing that sort of intelligence through to our NHS colleagues. People have recognised that there's a set of skills that you've got to bring together across NHS and local government.

4.6. Walsall MBC: Making Connections – A community centred approach

The Making Connections Walsall programme began in October 2017 to tackle loneliness and social isolation, improve health and wellbeing, and reduce preventable use of health services and social care among people aged 50+ in Walsall.

The service was co-produced by service users and community-based organisations having input into the design, delivery, and evaluation of the initiative. A set of workshops throughout the life of the project allowed it to be shaped because on local need. Manor Farm and other Community Associations were used to co-ordinate referral hubs based across Walsall who were responsible for supporting residents to access social activities. Social activities, for example gardening were also provided by community-based organisations including Goscote Green Acres.

As a result of Making Connections Walsall being trusted by residents as well as its reach into communities, the service has been used in response to the Covid-19 pandemic. It has provided support including the delivery of food packages and medication to some of the most vulnerable residents in Walsall. The hubs being embedded within communities and with support from key partners such as Walsall Housing Group, Walsall Fire Service, has ensured enough volunteers have come forward to support this work.

Suring the height of the pandemic the hubs were supporting over 1500 residents.

"It's good to know that it is not just my family who care but strangers have brought me friendship and I feel safe" A quote from one of the service users.

4.7. Wolverhampton: Wolverhampton's Local Support System

Wolverhampton's Local Support System was established during the COVID-19 Pandemic, and whilst difficult to measure, the system likely saved hundreds of lives.

To help protect vulnerable residents, the Council engaged with all GP surgeries in Wolverhampton to collate a list of 35,000 people identified as medically vulnerable. All were notified that they were at high risk of serious complications from coronavirus and that they could contact the 'Local Support System' for help.

Community Hub Contact Centre: Many Council employees, for example librarians, lifeguards and election staff were unable to fulfil their normal duties during the coronavirus lockdown and volunteered to work in the Community Hub Contact Centre as Customer Service Officers answering helpline calls rerouted through Microsoft Teams to corporate laptops and mobile phones.

The Community Hub Contact Centre provided important advice via telephone and email to 8,000 enquirers. Most callers required either a volunteer to call them regularly for a chat, as they were feeling alone, or a volunteer to collect their prescription or shopping. However, food shortages and limitations on supermarket deliveries caused by the implementation of the lockdown necessitated the creation of a new service area to provide food to potentially 35,000 people per week who could not access or afford food.

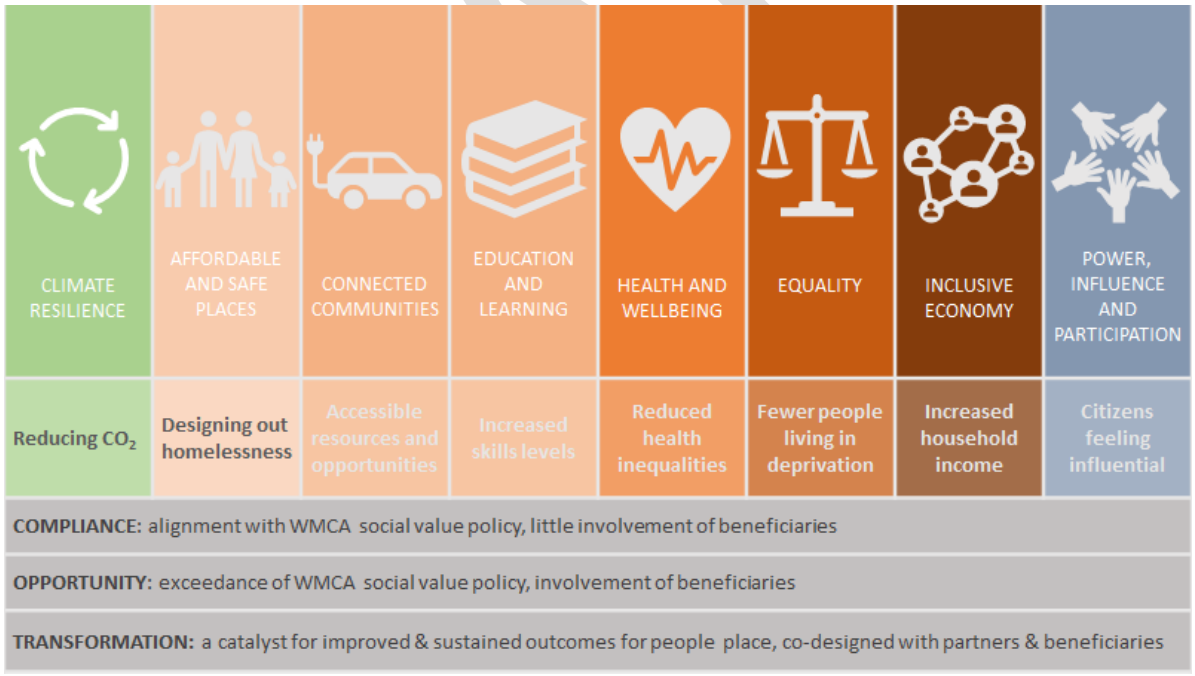
Food distribution: Aldersley Leisure Village was deep cleaned and redesignated as a food hall to assemble food packages. Within days, over one hundred Council employees had registered to volunteer at the Food Distribution Hub. The Council also drew on the mass of external volunteers in Wolverhampton, from full-time nurses to furloughed brewery drivers, who have helped build and deliver food parcels. In total, 250 people have been trained, with a roughly even split of delivery drivers and warehouse production operatives. Extensive infection control procedures were implemented for volunteers including hand sanitiser, PPE and staggered shift times and no known Covid-19 transmission occurred between people on site.

The Food Distribution Hub, which produced over 1,000,000 meals between April and June that were delivered to recipients shielding in their homes from coronavirus.

Chapter 5: Scope and scale: the WMCA's Focus on the Wider Determinants*This section explores actions taken across WMCA directorates and workstreams that contribute towards health outcomes. Much of this relates to commitments made in the HOTR 2020 report, though we move beyond these to demonstrate more broadly our now sharpened focus on the wider determinants of health and how there is ample opportunity to embed a HiAP approach.*

It is essential here to connect with the WMCA's work on inclusive growth and how this has developed since the HOTR 2020 report. Inclusive growth is defined as 'a more deliberate and socially purposeful model of economic growth – measured not only by how fast or aggressive it is; but also, by how well it is created and shared across the whole place, and by the social and environmental outcomes it realises for our people'. In terms of health, this is about recognising that not everyone will have or be able to work towards optimal health but should still be supported to maximise their potential and their quality of life, and recognising that a healthy and resilient population can be a foundation of creating and maintaining sustainable economic growth, contributing to a virtuous cycle. Inclusive growth, with an inclusive economy, actively seeks to reduce existing inequalities – of health and wider, as determinants of health – across the life course.

The WMCA's Inclusive Growth Framework is a tool that has been developed to measure how well our economy is performing specifically in terms of the more deliberate and socially purposeful model set, prioritising our people and our place. It captures a reduction in health inequalities, alongside a range of interconnected inequalities, as one of eight fundamentals to address in driving towards inclusive growth (see image below).



Some of the successes presented here are undoubtedly attributable to the Inclusive Growth Framework and the work that has happened to embed it within WMCA governance structures and related processes. We must now build on this to amplify the health and wellbeing fundamental, supporting colleagues across the WMCA with the arguments, evidence and tools they need to tackle health inequalities through their work, at pace and at scale.

5.1. Transport and active travel

The WMCA holds devolved responsibility over the region's transport infrastructure in its designation as the Local Transport Authority. This means it has a statutory role to co-ordinate investment to improve the region's transport infrastructure and create a fully integrated, safe and secure network. It is also responsible for assessing and planning for the region's future transport needs so the network can meet the demands of businesses and a growing population. Production, review and publication of the plan is a core statutory duty.

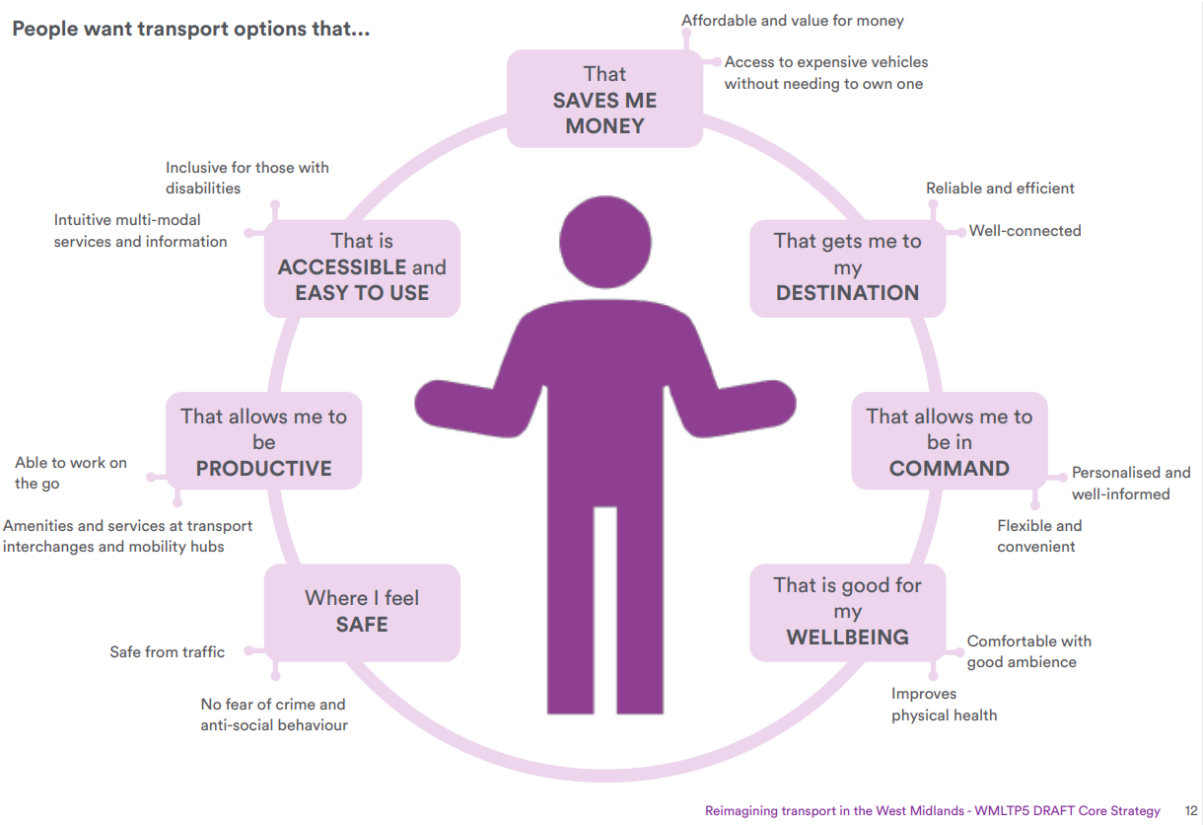
Prior to the outbreak of Covid-19, the region had been working to a 10-year strategic transport plan – 'Movement for Growth' – due to run to 2026, but the changing requirements of residents as a result of the pandemic instigated a review of this plan ahead of schedule, which highlights a pro-active and responsive commitment to people and their health-related needs. A new Local Transport Plan (LTP) – 'Reimagining Transport in the West Midlands' – is now being developed and its draft Core Strategy is currently open for consultation.

The LTP aims to balance the need to provide access with the harmful impacts that transport can have on people and places in order to develop a transport system that is fair for everyone. It ensures the region's transport infrastructure better supports residents' daily lives now as well as leaving a better legacy for the future. It proposes a new vision for travel in the West Midlands where people can thrive without having to drive or own a car.

As part of its explicit *Motives for Change*, the LTP includes several aspects that relate to health and the potential to address health inequalities in the long term:

- *Fair access* – improving social mobility by improving equity of access to opportunity by ensuring everyone, regardless of personal circumstance, has safe, usable and affordable travel choices that enable them to prosper
- *Fair impacts* – reducing the negative external effects of transport on people's health and wellbeing by improving road safety, reducing air pollution, and reducing noise.
- *Physically active* – enabling safe, convenient and accessible walking and cycling opportunities, to increase active travel for whole journeys or as part of journeys, which will improve the health, wellbeing and productivity of people today as well as leaving a healthy legacy for future generations

The LTP demonstrates a comprehensive understanding of citizens' needs:



While there is specific reference to wellbeing, every element drawn out in this infographic has an impact on an individual's overall health and wellbeing.

Health and wellbeing impacts has been assessed as part of the production of this LTP, namely through the Integrated Sustainability Appraisal (ISA), which includes or fulfils the requirements of a Health Impact Assessment (HIA) and an Equality Impact Assessment (EqIA) as well as a Community Safety Assessment (CSA) and a Sustainability Appraisal / Strategic Environmental Assessment (SA/SEA) though not a Habitats Regulation Assessment (HRA), which was undertaken and reported separately.

Evidently, it is tricky to balance a fully comprehensive and a fully integrated approach, and there are ongoing developments in this area. One such development is the Health Equity Assessment Tool (HEAT)[36], which focuses attention on health inequalities. It lifts the appreciation of health and equity, and it integrates these elements to reveal how there are systematic, avoidable and unjust differences in health and wellbeing between different groups of people (i.e. health inequalities). Refreshed by Public Health England (as it was then) during 2019-2020, HEAT is particularly pertinent in the context of Covid-19 as it enables system partners to consider which groups have been particularly affected by the pandemic and collaboratively mitigate against any negative impacts. The tool has been applied to NHS Integrated Care System's service and programme design in the region to account for and mitigate against the differential experience of access and delivery of services. The sustained use of HEAT has been supported by NHSEI Midlands Inequalities Board, Office for Health Improvements & Disparities and the NHS Commissioning Support Unit.

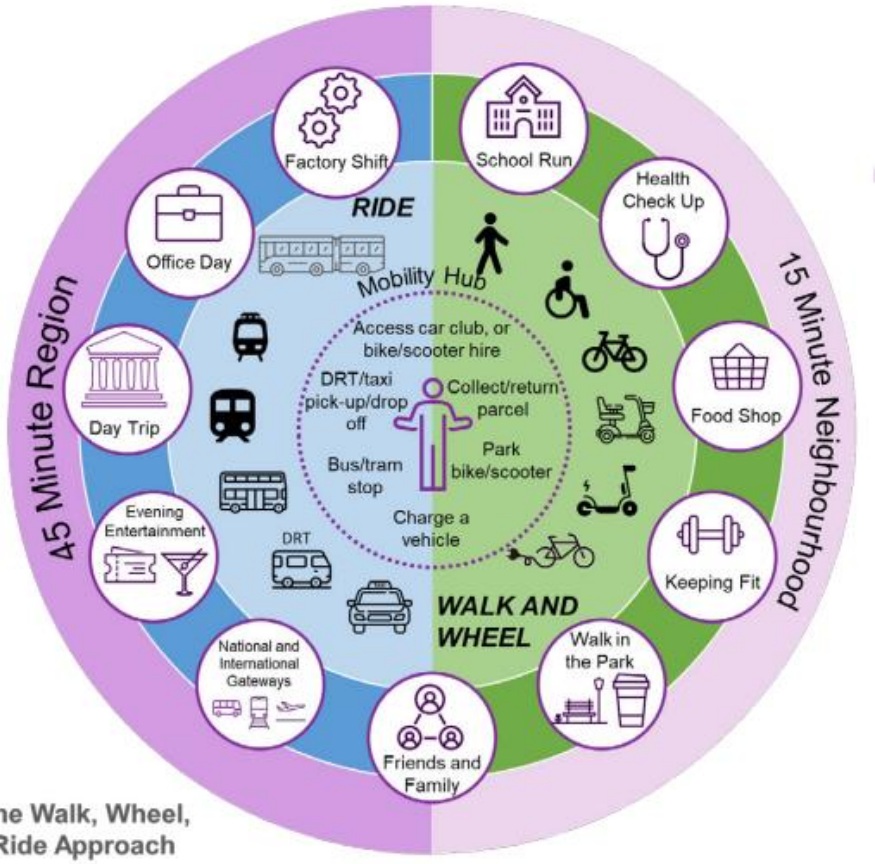
HEAT is now being piloted in a number of transport and transport-related projects as a way of objectively and tangibly testing its application. This is a hugely significant – and directly impactful –

[36] https://www.gov.uk/government/publications/health-equity-assessment-tool-heat

part of our commitment to start embedding a HiAP approach across the WMCA. This practical tool opens the way to a wider and deeper understanding of the interconnected elements of health and health inequalities, and it encourages strategizing to mitigate against health inequalities and also instigate preventative measures in the longer term.

- *Transport without Barriers*, funded jointly by the WMCA and Sport England, is a behaviour change trial testing whether a travel app will increase the confidence of disabled people and people with long term health conditions in using public transport
- *Cycling for Everyone* aims to enable those who would otherwise not benefit from the existing network and infrastructure investments to take advantage of interventions to support confidence-building and long-term behaviour change
- *Social Prescribing of Walking and Cycling*, focused on increasing patient referrals into walking and cycling activities, may be piloted in the region over a three-year period, funded by an award from the Department for Transport, depending on the results of a feasibility study, which is currently being developed collaboratively with HEAT centre-stage.

In HOTR 2020, the WMCA committed to increase cycling from 3% to 5% of mode share by 2023 through the delivery of the WM Cycling Charter and extending cycling and walking routes. Clearly, two of the projects piloting the implementation of the HEAT – Cycling for Everyone and the social prescribing of walking and cycling – are contributing towards this overall shift in mode share. Also, within the LTP, there is a clear commitment to active travel, with 'walk and wheel' approaches to travel hooked around the concept of a 15-minute neighbourhood (within a 45-minute region). By creating well-designed walkable and wheelable neighbourhoods with appropriate mixes of land uses, connected through high quality public transport, we can create more healthy, liveable communities.



There have already been several substantial achievements made towards making cycling a more accessible option and increasing the mode share of cycling:

- We have launched West Midlands Cycle Hire – a new cycle hire scheme that will help increase cycling in the region, with a target of making 1,500 bikes available (10% of which would be e-bikes) and 170 docking stations.
- We have launched the Starley Network – 500 miles of connected cycle routes across the region, named after the Starley family from Coventry, who were innovators of the modern cycle.

The WMCA is working hard to expand and improve these and related schemes, and also to increase investment for cycling across the region.

5.2. Housing and homelessness

Zero Carbon Homes Charter

The WMCA's Housing and Land team is responsible for over £10bn investable funds and has carved out a strategic role in turning challenging sites into development opportunities, particularly identifying land for new homes, creating better places to both live and work. Focused on regenerating brownfield land, hundreds of acres of which have already been brought back into use, their collaborative leadership here removes barriers to make sure land is being used for the public

benefit. People, and people connected into their communities, are at the heart of this – the WMCA, through several taskforces involving a range of partners, ensures new homes are built close to public transport services and encourages schemes to employ local people and businesses whilst also helping our local centres thrive again.

Sustainability is also a key driver behind work in this area, particularly through using new innovations to build sustainable homes and through reducing carbon emissions. There are implicit benefits to health aligned to these motivations and thus, for the HOTR 2020 report, a commitment was made around capturing tangible health outcomes in 'zero carbon' initiatives. The West Midlands' Zero Carbon Homes Charter has since been launched (in early 2021), setting out the WMCA and its partners' aspirations to deliver zero carbon homes as a long-term objective, driving zero carbon development and innovation, future-proofing the region's economy and enabling our communities to prosper for years to come.

This Charter sets out principles for designing and building homes fit for the future, including being:

- Climate responsive and resilient, maximising thermal comfort, health and wellbeing; and
- Designed for the life cycle, thereby multi-functional and flexible to residents' changing needs over their lifelong occupation.

The quality of the housing conditions described here would alone positively impact health and wellbeing. Overlay this with a previous achievement (in early 2020) on affordability – setting a localised definition of affordability at around 35% or less of the average gross earnings of the lowest quarter of wage earners in the local area (rather than the standard definition of around 80% of market value, which is still unaffordable for many) plus the stipulation that any development scheme receiving WMCA investment from its devolved funds must make at least 20% of the homes in their scheme affordable – and further social determinants of health come into play (income intersecting with housing or the built environment) and underline the cumulative health and wellbeing benefits.

Also embedded within the principles of this Charter is community engagement and stewardship, whereby communities are meaningfully engaged throughout a project lifecycle, community ownership is encouraged through co-design and community-led approaches, and communities benefit from a stake in decentralised energy systems. There are, again, easily appreciable health benefits – the reduced risk of fuel poverty from the latter, for example – while there are also profound and long-term benefits to wellbeing and to mitigating against health inequalities through the social capital of community.

The WMCA is already turning plans into reality, having recently agreed a multi-million-pound investment package into the next phase of Port Loop – an innovative housing scheme in central Birmingham that will see another six acres of derelict brownfield land turned into a new waterside district of low carbon, energy efficient, factory-built modular homes with public and communal green spaces, cultural hub 'Tubeworks' and new spaces for walking and cycling along the nearby Old Main Line Canal. This will enable us to take a stride towards achieving our net-zero ambition, while we will also ensure that at least 20% of which will be classed as affordable in line with the WMCA definition.

Commitment to Collaborate to Prevent and Relieve Homelessness

Successfully meeting its HOTR 2020 commitment, the Homelessness Taskforce and Team, in partnership with Birmingham Voluntary Service Council (BVSC), has developed a 'Commitment to Collaborate (C2C)' toolkit – a framework to help a wide range of organisations prevent and relieve homelessness.

Whilst the WMCA has no formal statutory duties, powers or resources around homelessness, the Homelessness Taskforce[37] convened by the WMCA uses its collective resources to 'design out' homelessness. We know that people are at an increased risk of homelessness when certain factors

[37] The WMCA Homelessness Taskforce was established in 2017 following the mayoral election, with the aim of designing out homelessness. Membership includes all seven constituent local authorities, representation from non-constituent local authorities, key public sector agencies, voluntary, private and charitable organisations, working together to prevent and relieve homelessness.

are broken or lost, including health, work, supportive relationships, and safe, affordable accommodation. By identifying and addressing gaps in policies, procedures, laws, structures, systems and relationships, we can tackle and design out the systemic inter-related issues that cause or fail to prevent homelessness.

The C2C toolkit includes information on homelessness in its widest sense and takes organisations through questions to consider around their contributions and omissions in designing out homelessness and then work through possible changes that they can make to prevent and relive homelessness, with examples of actions to take and blank templates to record progress. It has been designed to work through possible changes that could be made at the earliest opportunity, even when an issue is not directly linked to homelessness or easily identifiable as having a link to homelessness. It enables organisations to understand their contributions and omissions in designing out homelessness, through the angles of:

- Universal Prevention;
- Targeted Prevention;
- Crisis;
- Recovery;
- Move-on;
- and Settled Home.

The toolkit has been designed to provide practical help to not only specialist organisations and their partners but also those with no direct link to tackling homelessness. It will help them consider how they can support existing projects and programmes that provide people with a secure home, steady job and to stay safe and healthy. While health colleagues and access to health-related interventions are clearly part of this picture, it is the breadth of thinking and collaboration here that is the real success in terms of addressing health inequalities in the round.

5.3. Skills and employment

In our HOTR 2020 report, multiple commitments were made from across the WMCA around employment – from skills training for access into jobs, to employer support for workforce wellbeing. Employment and its related socio-economic status are seen as the main drivers of social gradients in health, meaning it can be a root cause of health inequality[38]. Furthermore, as stressed by Sir Michael Marmot in his original review:

> *"Being without work is rarely good for one's health, but while 'good work' is linked to positive health outcomes, jobs that are insecure, low-paid and that fail to protect employees from stress and danger make people ill"[39].*

The WMCA's collection of Thrive programmes, inspired by Stevenson and Farmer's 'Thriving at Work' review, together meet the brief of reducing health inequalities by supporting certain groups into work as well as supporting employers to support their employees' wellbeing. Given the impact of Covid-19 on both employers and employees, we committed to developing and amplifying these

38 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/356064/Review5_Employment_health_inequalities.pdf

39 Marmot et al., 2010: 68

programmes in response to the HOTR 2020 report's call for action, and have achieved significant successes over the past 18 months:

- Thrive at Work, our programme for employers improving their own wellbeing offer and thereby earning our accreditation, which marks them out as an employer of choice in the region, developed
    - 'Thrive at Home' as a rapid response to employees transitioning to homeworking due to Covid-19 restrictions and lockdowns[40]
    - Foundation level as a stepping stone towards accreditation at Bronze, reflecting the extra support employers were needing to start their journey towards accreditation
- Thrive into Work, our Individual Placement and Support (IPS) programme – a type of intensive employment support programme, integrated with the health system – developed and launched a series of specialist pathways focused on helping the following groups into employment
    - People who are homeless
    - People who are receiving treatment in lieu of a criminal conviction
    - Neuro-diverse people
    - People with a mild learning disability
- And, finally, in line with our commitment to develop a co-designed, targeted Thrive programme for Black, Asian and minority ethnic groups – now with a working title of 'Race to Thrive' – colleagues are
    - Undertaking a comprehensive mapping exercise to understand similar programmes
    - And have planned a series of stakeholder engagement workshops (over April).

Collectively, the Thrive programmes can be seen as an approach of 'proportionate universalism'[41], which is promoted as a way of addressing health inequalities. While Thrive at Work would set the (universal) bar for how employers should be supporting their staff, the Thrive into Work and Race to Thrive programmes would provide additional (proportionate) support for particular groups with relatively high need to meet if we are to address health inequalities and close the gaps in health outcomes.

Fundamental to employment and access to employment is skills, or the opportunity to gain skills. Improving skill levels and qualifications can have a positive economic impact – it has been estimated that the lifetime return on investment of Level 1 courses for those aged 19-24 is £21.60 for every £1 invested – and adult learning can itself have indirect health benefits by improving social capital and connectedness as well as general health behaviours[42]. There is therefore significant opportunity to improve health outcomes through the WMCA's role in adult education.

The WMCA holds devolved responsibility over the region's Adult Education Budget (AEB), amounting to approximately £130m per year. A smaller proportion of this budget is used to support Adult Community Learning (ACL) provision via our constituent local authorities, and the majority of

[40] This has since been retired as a separate 'product' given our collective transition to a 'new normal' and resources are being integrated into Thrive at Work's toolkit as revisions take account of the changing landscape.

[41] As set out in the HOTR 2020 report, proportionate universalism is fundamental to Marmot principles, balancing universal action on the wider determinants of health with targeted intervention to actively close the health and wealth gap and improve the health of the most disadvantaged fastest.

[42] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/356063/Review4_Adult_learning_health_inequalities.pdf

funding is used to commission provision from the Further Education (FE) sector against statutory obligations and regional priorities. The AEB funds residents' statutory entitlement, which includes basic English, maths and digital skills and a first full qualification at Level 2 or 3, as well as a range of provision aligned to regional priorities based on current skills gaps and projected future need in priority growth sectors[43][44].

The WMCA has taken strides in shaping AEB-funded provision to meet regional needs. And this skills provision is critical in addressing inequalities. Participation data regularly shows that a significant proportion – in fact, a majority (approximately 65%) – of those enrolled on AEB-funded courses are from a minority ethnic background. This reflects an 'over-representation' of this group, relative to the regional population. In turn, however, this also reflects structural inequalities more broadly as it demonstrates the over-representation of people from ethnic minority groups in the brackets of need for FE provision i.e. from *relatively* deprived backgrounds and with *relatively* low skills they want to enhance or with competing demands (jobs, childcare responsibilities) that means they need the flexibility of course delivery that colleges are particularly strong in providing.

As Covid-19 and the Black Lives Matter movement coincided to fully expose these structural issues, our colleagues in the Productivity and Skills team are examining why the relatively high representation of ethnic minority groups in AEB participation data does not translate into the labour market i.e. why ethnic minority groups then have lower employment rates. This disconnect itself further exposes the depth of structural inequalities. The learnings here will continuously inform and enhance the broad range of skills and employment programmes already in place that help to address inequalities, and consequently help to mitigate against health inequalities.

Specifically geared towards supporting access to jobs for under-represented groups in the workforce, and aligned to a priority sector projected for significant growth and therefore replete with opportunities for progression, our Productivity and Skills directorate have commissioned a range of digital bootcamps – intensive skills training programmes, mainly in higher levels skills and targeting specific groups, for example:

- Tech Talent – supporting women to get into tech roles
- Black Codher – addressing intersectionality by targeting Black women
- Ashley Housing Group – providing training for ethnic minorities
- Code Your Future – supporting refugees in particular
- Cauldwell Children – focused on training for learners with special educational needs

A skills and employment plan for the health and care sector has also been drawn up. Successfully launched in 2021, this directly responds to need in the sector, which has significant vacancy levels, as well as to indications that people were considering careers in this sector in response to Covid-19. The Health Science and Care Services Training Plan also makes direct reference to inequalities and the disproportionate impact of Covid-19 on ethnic minority groups; it includes a Black, Asian and

[43] https://www.wmca.org.uk/media/2274/regional-skills-plan.pdf?_ga=2.99898462.1712453289.1644860087-14288761.1539765837
[44] https://www.wmca.org.uk/media/4827/wm-local-skills-report.pdf?_ga=2.193368557.1712453289.1644860087-14288761.1539765837

Minority Ethnic Leadership Development programme as well as innovation around ESOL provision linked to vocational training for the care sector[45].

5.4. Energy and environment

The environment in which we are born, grow, live, work and age is a key wider determinant of health. By contributing towards improving the environment, the work of our colleagues in TfWM and Housing will benefit the health of the region, as has already been set out. A key driver behind the environmental imperative of that transport and housing work is 'WM2041' – our goal and strategy to reach net zero carbon emissions as a region by 2041. The target position has been broken down into a series of five-year tranches, and the first Five Year Plan (FYP), launched in 2021, sets out the measurable actions that need to be carried out in order to stay on track for meeting the overarching target. Various aspects of the supporting plans and programmes have direct links to health inequalities and health outcomes:

- The *Natural Environment Plan*, launched in 2021, seeks to protect, restore and enhance the region's natural environment so that everybody can enjoy the benefits of the natural environment – benefits that will include the profound effects the natural environment can have on both physical and mental health. Specifically, the plan aims to ensure the everybody can access high quality green space within a 300m walk of their home, and the work set out by the plan will support the creation of 200 jobs in natural capital by 2026 (intersecting with another wider determinant of health).
- The *Community Green Grants* programme was established following commission research that highlighted a considerable disparity between the amount of accessible green space per person across the region, from as much as 151 square meters per person in some areas and as little as 16 square meters in others (with a national average of 32.94 square meters per person). The Community Green Grants programme seeks to address this imbalance by providing grants totally £750,000 to regional organisations to support Natural Environment Plan outcomes on the ground over the next two years form its launch in early 2022.

These plans and programmes already demonstrate alignment with a HiAP approach and with further co-operation we can more fully capture and amplify the positive impacts of the successful implementation of these plans and programmes on improving health outcomes and, hopefully, contribute towards closing gaps in health outcomes.

Similar successes can be expected with regards to the WMCA's work on energy. In this space, the WMCA hosts Energy Capital – the West Midlands' smart energy innovation partnership exploring new models of regional energy governance and delivery. Energy Capital is made up of energy infrastructure providers, ambitious local authorities, academic experts and leading businesses and energy entrepreneurs who together work to make the West Midlands one of the most attractive locations to develop and deliver innovative clean energy systems and is the first point of contact for government, regulators, energy companies, funders and others interested in energy and decarbonisation across the West Midlands.

Programmes within this workstream with clear impacts on health and health inequalities include:

- *Retrofit:* As part of the FYP, we have set a regional target of delivering energy efficiency and low carbon heating measures into 280,000 homes by 2026 and up to 1.1 million homes by

[45] https://beta.wmca.org.uk/media/t4xngbob/dec21-health-science-and-care-services-brochure-v13.pdf

2041. Approximately £3m of the FYP delivery budget has been approved for use in retrofit and energy activity, and a further £3m has been brought into the region to support local authorities in tackling fuel poverty and retrofit scale-up. The WMCA, via Energy Capital, has used its convening role to support local authorities in accessing central government funding for domestic retrofit in low income, low energy performance homes and continues to support access into Sustainable Warmth and Social Housing Decarbonisation funding.

- *Net Zero Neighbourhood Demonstrators:* Working towards the WM2041 target, this programme aims to demonstrate how low carbon energy communities can offer residents and attractive place to live, work and play. This programme will work with each neighbourhood in turn, co-investing in retrofit and low carbon heating measures on a street-by-street or small area basis. It will take tailored approaches to community engagement that address householder concerns by co-designing a range of improvements and benefits for households and communities across tenure types.

Whilst it will inevitably take time for these programmes to be fully implemented and targets to be fully met, the eventual impacts will directly address some of the key issues that were set out regarding the current 'cost of living crisis'. Improving housing stock to ensure greater warmth for its residents will have a direct and immediate impact on physical health, whilst alleviating fuel poverty will undoubtedly provide relief from financial insecurity and associated anxiety.

Chapter 6: HOTR Data Hub to Support Our Next Steps

This final section focuses specifically on data and the need for a data-driven approach to comprehensively address health inequalities and our next steps in this space. As we launch our HOTR GIS dynamic data hub, we are keenly aware of the wider picture, and our need to collaborate and co-ordinate in order to ensure maximum utility for our overarching purpose – to tackle health inequalities.

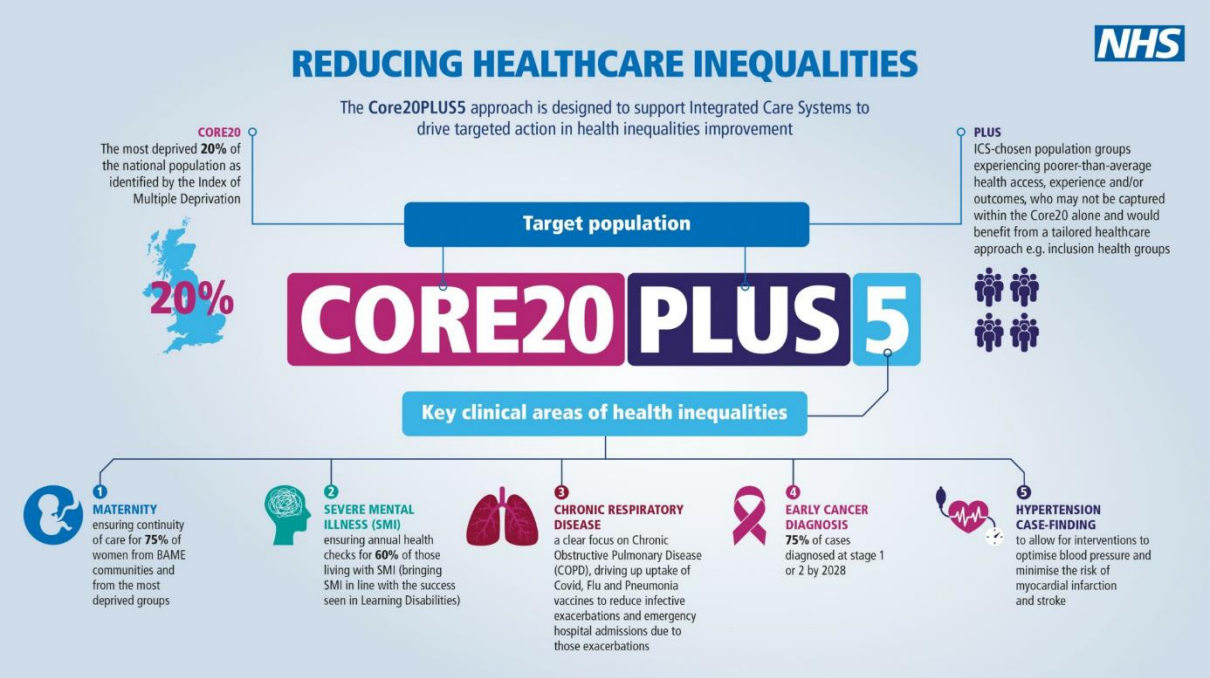
As was made clear at the outset, this interim report intended to capture the success stories of system partners in their work to address health inequalities over the past 18 months since the publication of the HOTR 2020 report, offering a picture of reality 'on the ground' rather than a comprehensive audit of the state of the region's health. This was partly driven by two main limitations: firstly, the frequency of updates across datasets varies considerably and a significant proportion of the indicators have not yet been updated; and secondly, even where updated data are available, the reference periods within which the data were collected mostly do not correlate with Covid-19 and so these do not yet adequately reflect the impact of the pandemic on the datasets most relevant to our work.

Clearly, both the richness of the case studies presented in this report as well as relevant, robust and timely quantitative data are pertinent for us to understand not only our impact, but also whether we are having the right impact in the right ways and in the right places to address deep-rooted structural inequalities. Others across the system are grappling with the same issues. NHS England and NHS Improvement (NHSEI) have in recent months developed the 'Core20PLUS5' initiative (see infographic below), whereby public health data is centrally held in a new NHS 'Health Inequalities Improvement Dashboard' (HIID) for data monitoring that supports efforts to reduce health inequalities[46]. The intention is that this data-focused approach will enable the prioritisation of energies and resources as they address health inequalities in the period 2021-2024 and contribute towards the Government's overall goal of increasing healthy life expectancy by five years by 2035[47]. The Department for Health and Social Care is also developing a strategy for the improved availability, quality and utility of health and care data in a safe, trusted and transparent way and makes clear reference to the digital transformation that we've witnessed through the pandemic[48].

[46] The most deprived 20% of the national population, as determined by the national Index of Multiple Deprivation (IMD), is the initiative's 'core' target population; 'plus' captures a local focus on local inequalities; and the final five refers to key clinical areas prioritised in the NHS Long Term Plan.

[47] https://www.england.nhs.uk/wp-content/uploads/2021/11/core20plus5-online-engage-survey-supporting-document-v1.pdf

[48] https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data-draft



In line with these developments, efforts have been channelled into the production of a dynamic data hub that will enable us to move away from a static report with a limited shelf-life. This is an online space, hosted by the WMCA, that collates data on all the indicators included in the original HOTR report, brought and automatically kept up to date. These data are geo-spatially plotted across the WMCA region and made available at different geographical levels, as the data allows. This tool effectively transforms the audience from report readers to interactive users that are enabled to develop data visualisations and potentially insightful correlations to assist their work.

This project is in its first stage. In this first iteration, the HOTR data hub presents an online, dynamic and interactive version of the HOTR 2020 report. With some basic functionality around additional data layering, it should support an evidence-based approach to targeting resources and programme interventions in a more agile, responsive and joined-up way. The HOTR 2020 report had collated data from different sources; this hub will allow the user to visualise all the data in one place in an interactive platform. It will also include links to original and other sources of data, allowing greater accessibility for users by having all resources in one place. The ambition then is to add various datasets that pertain to the wider determinants of health, thereby supporting a broader and deeper appreciation of the interconnectedness of factors, encouraging hypothetical pushing and pulling on the various levers available and facilitating the full utilisation of a HiAP approach.

Beyond this, the specification of datasets, the potential pooling of other evidence and the broader direction of travel will be determined through our ongoing stakeholder engagement around the development of this product. This process will ensure that the product is of maximum value to its users, that it balances the availability of a full range of relevant data (and any other resources) with its accessibility and operability, and that it becomes established as a uniquely placed tool that facilitates a comprehensive, visual understanding of the correlation of wider determinants that cumulatively impact the health outcomes of residents across the WMCA region.

Chapter 7: Conclusion

This report has sought to provide a record of relevant developments over the last 18 months since the publication of the HOTR 2020 report. Relevance, here, pertains to developments regarding Covid-19 as well as developments across the wider health and wellbeing system, with a focus on the significance of these developments for health inequalities.

Over those past 18 months, we, as a region, have taken a stride forward in the ongoing management of Covid-19 through the introduction of multiple vaccines and boosters. Coupled with the relatively agile response to new variants, it is evident that the majority of us can learn to live with Covid-19. However, there are significant differences of lived experience even within that majority and, as set out in Chapter 2, the ramifications of the processes to manage Covid-19 on an ongoing basis are different for different groups of people. The lower rate of vaccine uptake by ethnic minority groups again demonstrates and underlines structural inequalities, and the socio-economic impact of various risk-management strategies (e.g. lockdown, furlough etc.) again exposes how existing inequalities are being exacerbated. It is clear that the central points of the HOTR 2020 report were years in the making and will take years to resolve.

Towards this end, partners across the health and wellbeing system in the West Midlands are resourcing response, recovery and resilience efforts in ways that manifestly address health inequalities, and significant progress has been made to channel more concerted action into mitigating against health inequalities in the longer term. As evidenced in Chapter 3, major institutions as well as community-focused organisations in the region have put communities at the centre of their action on inequalities. . Chapter 4 demonstrated how local authorities continue to lead the frontline of response and translate all their efforts to be culturally appropriate and thereby maximise reach. The WMCA can add value by leveraging its devolved responsibilities related to the wider determinants to focus on long-term health improvements and prevention at scale, as set out in Chapter 5.

Together, this demonstrates not only the commitment across the system to address these long-standing issues, which we had already set out in the previous HOTR report, but we now have evidenced how much capacity there is to act, to adapt and respond, and to go above and beyond what was previously thought achievable even in the relatively short term. It is clear how powerful the system as a whole can be, and we need to continue to harness that power. If the component parts continue to play to their strengths and evolve together to co-ordinate efforts, then the system can develop its capability to take longer-term action and shift deeper-rooted issues.

The HOTR data hub presented in Chapter 6 aims to support this co-ordination effort, enabling a data-driven approach to programme planning across the health and wellbeing system with reference to the wider determinants of health. The ability to visualise data, correlate factors and potentially model outcomes would undoubtedly prove useful. The wider ambition here is to analyse were characteristics and factor intersect, demonstrating the multiplicity and depth of issues faced by the most vulnerable in the region. Using the data hub to understand more fully this cumulative impact of structural inequalities as well as the ways in which we can then use that understanding to sharpen strategy and target delivery is the key challenge to face in our next full Health of the Region Report due in late 2023.