**Execs Workshop for the Lancashire and Cumbria Health Equity Commission**

**15.00 – 16.50 Thursday 4th of November 2021**

**Key points:**

**Enabling action:**

* Currently held to an unhelpful standard when it comes to justifying preventative action – leaders need to be enabled/empowered to make decisions when there is broad consensus on what would work, or where past learning points to successful actions
* Currently a lack of strategic instruments, infrastructure and leadership roles within the system to engage in the kind of cross-sectoral project management that is needed for a whole system action on the wider determinants of health
* Governance arrangements feel like a burden when they should be designed to support leaders and free them up to do what is needed
* Funding/budgets should be devolved to whoever is positioned to make the biggest impact on the problems/priorities – to figure this out, there is a need to involve partners early and before the direction of travel is already decided

**Commissioning/funding:**

* Commissioning structures are oriented solely around delivery – they do not value the other essential work that enables collective action at a local level i.e. establishing long-standing relationships built upon trust with communities – recognition of this kind of work needs to be built into the commissioning system
* Need to move to long-term strategy for funding prevention recognising there will be short-term fall out for long-term gain (potentially separate and protected budgets needed for prevention otherwise funding will get sucked into acute/urgent priorities)
* Need to shift to integrated financial & operational planning across the system to enable broader preventative action

**Working together:**

* There are fundamental differences in governance and institutional structures which don’t align between partners and which pose persistent problems to working together and doing things differently
* There is a need to develop a better understanding of each other’s organisations in order to develop shared priorities and shared ways of working
* Essential to have equity *between* the partners – changes often oriented around the health system and their priorities without developing a shared agenda from the outset and understanding what the different partners can offer

**Relationships with the public:**

* Need greater transparency with the public and to generate more bottom-up pressure to reorient systems to prevention and equity – especially important when some of the problems discussed are not within the immediate remit of a single organisation
* Small interventions can make a big difference towards turning the ‘dial’ on health equity and public activation for change

**Language, communication, and messaging:**

* The ‘health’ in health equity/inequalities can tie the system in knots in terms of where people think the solution and responsibilities lie (i.e. health service)
* Media push simplistic narrative on inequalities which feeds into unhelpful perceptions
* Need to also deal with the public’s attachment to acute services and promote long-term strategy and importance of prevention

**Nearpod contributions**

**1.How do we make progress towards a system which better addresses the wider determinants of health and health inequalities in Lancashire and Cumbria?**

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| * We need to have more honest conversations about power and influence. It isn't always clear to the wider public who wields power, where it comes from and how they are accountable. This will be particularly important in creating social movements.
* Supporting people into work not only helps the economy, but more importantly is for good mental and physical health
* Ensure we understand the context locally - make a commitment as partners for greater working together to resolve - and understand each others unique and collective contributions
* aligned priorities, agendas, incentives, budgets
* We have to do things WITH people, not TO them to get buy in to changes that are needed in behaviour
* Most people think that the problem is the NHS, not individual responsibility and consequences of their behaviours - not blaming, but explaining and encouraging consequential thinking
* I agree with the points on governance but I also wonder about individual leaders and how we help them have the behaviours to support the governance
* focus on prevention as a matter of fairness and social justice
* use evidence for decision making such s allocative efficiency
* our region needs to move beyond equity projects to industrialise and at scale business as usual activity on equity
* The value of a session like this is that it creates a space for us to talk about what problem we are trying to solve, what works and how we need to change the way we work to achieve it. We need to create some more time for this.
* We need to stop describing the perceived problems in other organisations and identify some new ways of working together!
* I really liked the idea of being more transparent with the public about the state of health - to create accountability, behaviour change and action.
* What are the "seatbelts" (confident measures know will create improvement) to improve social determinants of health?
* Our region urgently needs to improve its connectivity of ongoing health equity projects
* invest in creating community voice and improving its vision into the Lancashire equity ecosystem
* Create a social movement in leadership for (health) equity
* Think Long term , you cant rely on short term interventions ..
* upstream our collective thinking to prevention and wellbeing and a strengths based community approach
* How we deploy resources is key. As has been said - if we keep the demand as it is then our hospitals will always need more & more resource. This is not sustainable so we need to focus some resource to prevent people going to hospital
* We need to step out of our institutional isolation that has been driven by austerity to a shared approach to solving shared problems. We shouldn't be afraid of taking leaps of faith that seek outcomes over periods of time that go - electoral cycles.
* How do we deal with the political position on investing in inequalities? The slide on expenditure in 2009/10 compared to current times says so much. This is one of the reasons we 'sell' the economic growth benefits of improving health outcomes.
* We should co-produce some health equity projects together
* seeking shared common purpose, unpacking that by identifying what shared, where we disagree and identifying and understanding what might contribute to both shared and different positions
* A shared approach about how as a system we facilitate and grow an empowering culture which promotes the basics of self care across communities and across life stages would be useful at some point
* The largest benefits will derive from improving personal & individual resilience, we need to focus on individuals not organisations, but we need delivery mechanisms which allow enhanced personal responsibility to overtake intervention
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**2.Which sectors should be involved in a health equity system? Who should be responsible and/or leading the regional system?**

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| * All sectors in partnership led by independent
* equity between partners too
* Housing must be a key part of preventative health strategies to address health equity
* what mechanism would underpin a cross sector partnership
* We Need to facilitate the Public to be driving us to do this
* Solutions need to come from an area or a population that makes sense to people and the way they live, I am not sure health structures are always a good starting point
* It wont work if you have a top down model .. is leading the right way as its all to remote from the problem
* I think there's plenty who will be willing to get involved but perhaps haven't seen health services working in such a wide reaching way before. Dominic pointed out that health to date has focused on hospital focused health.
* If you discount the role of central government, this all seems to be mainly about wider determinants of health and wellbeing, communities and economy - and not the NHS (although it has a certain role). What does this say?
* organisations need to find a reason for getting involved in health equity that makes sense for their core purpose
* helpful for leadership not to be top down but spring board up from communities that make sense to communities - this way will have local people as part of the leadership which is critical to get the right decisions and accountability
* Interested in idea of an independent leader for health equity. Think this might create a better balance between the sectors who need to be involved. We're good at critiquing other organisations and not being as objective about the probs in our orgs.
* NHS has missed a trick in relation to housing- housing associations have regular contact with individuals in everyday contexts and offer the entree into everyday concerns from the perspectives of tenants
* trust is a major challenge and if we learn anything from the Northern Ireland events, it is often a product of nurture rather than nature . We need to take these discussions much further up stream into school age environments
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**3. What are the obstacles to investing in prevention? How do we support leadership to shift priorities to spending on prevention and health equity?**

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| * There will always be difficult Choices; We need to make those decisions with our public through Participatory budgeting. All understanding the consequences
* We're back to nhs dominance across 'system' & associated finance. Resource will keep going to same old same old and so we need to change that to change our outcomes. Greater equity between partners needed
* Move talk to action
* While acute services are overstretched, resources will get sucked into them. Prevention needs separate and protected budgets.
* There also needs to be a big shift in culture. Particularly in relationship between NHS and third sector providers. Senior leaders get this but there's a raft of people below them with a different world view
* Immediate pressures on health care, as outlined earlier. Also, pressures on social care have knock-on effect for health care.
* Not all senior leaders get it [? In relation to the prevention/inequalities agenda]
* How about NHS committing 1% of its budget on an annual basis - to be spent through local government, VCFS - specifically for addressing social determinants. This, along with most of local gov budget could be turned into a funded plan for 10 years
* How about the whole system recognising existing public health expertise that has become fragmented in local government and build our system capacity to engage with all sectors and places?
* We need to be bold and make the shift to prevention. Health sector need to stop creating new partnerships and engage with existing partnerships. I like the idea of a percentage of H
* more confidence in allocative efficiency. Thinking about investment with pay back in longer term. thinking about investment across boundaries and payback in another sector e.g. investment in housing stock from projected savings in acute
* accountability with communities so changes in leadership, NHS or LA structures don't take system off the mission
* really hard to stop NHS doing things as sick people need care. it does need to be more efficient through. This is about allocating growth to prevention not to sickness and having a slower reduction in debt so prevention is invested in
* Whilst not wishing to offend, our health inequity could, as Sakthi often says, be viewed as an economic asset for which investment for innovation and business growth, could be charged with working with communities to address.
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**4. Where are our greatest opportunities for improvement?**

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| * Local Government
* local government reorganisation in Cumbria - an opportunity and a threat
* Greater Lancashire Plan
* Lancashire Enterprise Partnership (Health sector board)
* Ownership of this agenda by Lancashire (and Cumbria) leaders
* Community Equity Fund, contributed by all anchor institutions, supported by a dedicated health equity unit, to scale up what we know works (MM's 5 priorities)
* A concerted effort to be better advocates with the national government for Lancashire and Cumbria
* A 10 year plan (Equity 2030) that is part of a wider regional plan (? levelling up plan) - that is protected from distractions by short termisms
* an equity partnership that is driven to action and results
* shift to prevention and local level action - provide some small resource at a local level will see large advantage in hospitals & peoples health
* Community Equity Fund, contributed by all anchor institutions, supported by a dedicated health equity unit, to scale up what we know works (MM's 5 priorities)
* Investment fund for Community Health
* governance for health as Dom set out
* set up a equity partnership - cross sector and with senior leaders involved
* Our 'Better Care Fund' whilst currently poorly handled is a tool for future delivery of shared objectives on short and long term health equity
* Shift to integrated financial & operational planning across the system (Not just NHS) ; 3-5 year financial plans. Current system is geared to 6-12 month planning timescales in silos; no wonder no shifts and the existing models are perpetuated
* open our eyes and look, really look into the communities and listen to THEIR needs.
* Place based initiatives such as Healthier Fleetwood proving what can be done by local partnerships - achieving an awful lot with few resources. Give these initiatives some resources and watch what happens .... you'll like it
* Lincolnshire has a Housing Health and Care Delivery Group feeding in at high level at ICS level - it looks really effective
* bring in expertise to enable social movement for health
* commissioning organisations to deliver solutions like housing providers would mean you are investing in trusted organisations with a strong relationship with their customers
* If you want to innovate be prepared to take risk and have the occasional failure
* We need to be careful we don't just have a traditional view of communities- social networks/ communities are a key element for a significant percentage of our population that must be harnessed in this work
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**5. What single message would you send to the HEC that would make the greatest changes to improve health inequalities in Lancashire and Cumbria?**

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| * Step out of the institutional health box and trust partners to deliver solutions at a local level
* be prepared to take risks to innovate
* Move to action asap. Create a partnership and empower/resource local organsations to deliver a prevention agenda
* Be ambitious- Think differently and be brave! What's the worst can happen...
* Resource prevention
* Help with creating the culture of collective convergence and healthier mindset amongst leaders and towards each other in creating a fairer and sustainable future
* We will develop a shared vision of where we want to get to (in 10 years?); Can the HEC help us develop the Policy position and inform practice for financial re gearing strategy
* Children the well being and future is our most important asset. that should be the primary driver of our approach
* Resources need to be earmarked and protected. Targets must be set and leaders held to account for delivery.
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 **Attendees (minus Michael, Tammy, Jessica, Howerd, Naoimh)**

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