Deloitte.

Tackling the gap:
Harnessing community assets to improve equity in public health outcomes

July 2022

Deloitte Centre *for* Health Solutions

Contents

Foreword 1

Utilising the strengths of local communities to tackle health inequalities 2

An asset-based approach to improving the resilience of communities 6

Strengthening the role of public health to reduce inequalities and deliver more equitable health outcomes 18

Glossary of terms 24

Endnotes 26

Contacts 29

Deloitte Centre *for*
Health Solutions

About the Centre for Health Solutions
Established in 2011, the Centre is the research arm of Deloitte's Life Sciences and Health Care practices operating in the UK and across our European member firms. Our aim is to be a trusted source of relevant, timely and reliable insights on emerging trends, challenges and solutions. We use our research to encourage collaboration across all stakeholders, from pharmaceuticals and medical technology companies to health and care providers and commissioners, to the patient and health and care consumer.

Foreword

Welcome to our report: *Tackling the gap: Harnessing community assets to improve equity in health outcomes*. This report is the final report in our Future of Public Health series and demonstrates the importance of asset-based, place-based solutions for improving public health and reducing health inequalities. While the broad objective is health protection and the prevention of ill health, the provision of services also needs to be equitable, creating opportunities for everyone to achieve their full potential. This requires positive actions to create sustainable and systemic change at a place level.

Over the past decade, improvements in life expectancy have stalled, health inequalities have increased, and life expectancy has declined, especially for people in the most deprived ten per cent of neighbourhoods. The Build Back Fairer report by Sir Michael Marmot in December 2020 demonstrated a clear correlation between health, social and economic factors and health inequalities, and found that the health of individuals and communities is much worse in deprived areas.

Failure to invest sufficiently in public services, especially following decades of post-industrial decline in parts of the country, undermines efforts to reduce health inequalities. For people living in the most deprived areas, the problems can seem deep-rooted and intractable. Expert opinion on public health emphasises the need to involve and empower local communities, particularly disadvantaged groups, and local and national public health strategies to promote health and wellbeing and mandate actions to reduce inequalities.

The UK government has acknowledged the need to put health equity and wellbeing at the heart of all national policy, but local and regional public health interventions remain vitally important. While there are numerous examples of what can be done to address health inequalities at the national, regional and local levels there are variations in good practice and a tendency to reject solutions as 'not invented here'. A crucial requirement is to find effective ways to involve all stakeholders in public health, including the voluntary and community sectors and businesses, working with individuals and communities to harness and optimise the use of community assets.

The Health and Care Act 2022 and the formal establishment of statutory integrated care systems in England has reinforced the call to tackle inequalities at a system level, through place-based partnerships and a focus on population health management. Public health has a crucial role to play in orchestrating the numerous stakeholders and bringing their local knowledge of place to bear. The government's levelling up agenda also creates an opportunity to act locally to achieve greater health equity for all.

As always, we welcome your feedback.

Karen Taylor
Director
UK Centre for Health Solutions

Dr Karen Kirkham
Partner
Deloitte Chief Medical Officer

Sara Siegel
Partner
UK Health and Social Care Sector Leader

Utilising the strengths of local communities to reduce health inequalities

Communities come in all shapes and sizes, but all have an important role to play in the health of their local population. They do this directly through the provision of health, education and housing services, green spaces, sports facilities, and active travel initiatives. Communities also do this indirectly, by supporting the development of social capital and through social cohesion and feelings of safety. To improve the economic, social, and public health of communities, the focus needs to be on utilising their strengths.

About this report

This is the final report in our series on 'The future of public health'.[1] Our research was conducted against the backdrop of an ongoing COVID-19 pandemic evidence of increasing health inequalities, and the introduction of wide-reaching statutory reforms of the NHS, social care, and public health. This report focuses mainly on England due to the statutory changes being introduced in the Health and Care Act 2022, but it draws on examples and experience in the devolved nations where integration was already more well-established. It is intended to provide insights into what is needed for an effective and sustainable future for public health.

Our findings for this report (and for the other reports in the series) are based on:

- responses from semi-structured interviews with 85 senior stakeholders across the health and care ecosystem, including directors of public health (DsPH), policy makers, individuals working in arm's length bodies, commissioners and funders, academics, voluntary sector organisations and employers. The core set of interviews were conducted between April and the end of July 2021. A sample of follow-up interviews were conducted between September 2021 and April 2022 to remain current and understand the impact of the passage through Parliament of the then Health and Social Care Bill

- an extensive literature review conducted between March 2021 and May 2022, including a review of the policies and practices driving public health transformation and an analysis of datasets across the UK to improve our understanding of key public health issues.

Further details of the methodology including the list of interviewees can be accessed in our overview report *Narrowing the gap: Establishing a fairer and more sustainable future for public health.*

Tackling health inequalities within and between communities

Health inequalities are pervasive, and there are systematic differences in health outcomes for different groups of people. These are avoidable, unfair and are often deep rooted. They are also increasing, resulting in earlier deaths and more years lost in ill health. Health inequalities within communities exist across the following overlapping dimensions:

- socio-economic groups

- deprivation (for example: vulnerable groups of society such as migrants, travellers, and homeless people)

- protected characteristics covered by the public sector Equality Duty to eliminate discrimination (for example age, sex, race, sexual orientation, and disability)

- geography (urban, rural, coastal).

In the specific context of health and social care services, the term 'community' can also be used to describe a group of people with similar health needs (for example, a group of people with diabetes or dementia), or a group receiving similar health services (for example, a group of patients receiving the same intervention for coronary heart disease or chronic obstructive pulmonary disease (COPD)). The local voluntary and community sectors and organisations linked to large local employers often support such communities, including providing funding and other resources to them.

While the context and causes of health inequalities and other trends impacting public health are explored in detail our report, *Identifying the gap: understanding the drivers of inequality in public health*,[2] the following have a particular impact on communities:

- the gap in life expectancy in England is increasing, with females in the most deprived parts of the country experiencing a decline in life expectancy (which ranges from 78.7 years in the most-deprived decile to 86.4 in the least deprived)

- health is not just about length of life, but also its quality. In 2014-2016 the gap in healthy life expectancy (HLE) between the most and least deprived deciles of England was around 19 years for both males and females

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

- the extra costs to the NHS of health inequalities were estimated in 2019 as £4.8 billion a year from the greater use of hospitals by people in deprived areas alone

- health inequalities reduce employment opportunities and restrict productivity: this has a direct cost for local economies

- acting on health inequalities is an investment for both the national and local economies, with the cost of inaction running into billions of pounds

- health inequalities are not caused by one single issue, but by a complex mix of environmental and social factors which play out in a local area, or 'place'. This means that local areas have an important role to play in reducing health inequalities

- addressing the wider determinants of health by considering each stage of the life course, from birth and childhood through to old age, is important in improving health at the population level, rather than at the individual level.[3]

Impact of the pandemic on communities and public health

The COVID-19 pandemic turned a spotlight on health inequalities and exposed the injustice of health outcomes being driven by where people live, the jobs they do and their ethnicity. The pandemic has also caused major shifts in public attitudes towards health, the NHS and social care. There is now a prevailing view that the government has responsibility for improving health. In a Health Foundation public poll in May 2020 the percentage of respondents feeling that government has either a 'great' or a 'fair' amount of responsibility for ensuring they stay healthy had increased, compared with two years previously, from 61 to 86 per cent for the national government and 55 to 76 per cent for local government.[4]

However, a balance is needed between government initiatives and local knowledge of where best to target support and interventions. This is where local public health teams have a crucial role to play. However, there are variations between communities in the authority of the Directors of Public Health (DsPH) and the size and composition of their teams within individual communities, reflecting both the priority and funding available within each local authority, as well as the ability to recruit and retain public health staff. Although the pandemic resulted in significant amounts of additional funding for local areas, which enabled public health teams to be strengthened, this level of funding is unlikely to continue.

The pandemic also enhanced the day-to-day relationships between the local DsPH and the government's Chief Medical Officer, which helped to reduce some of the longstanding barriers to relationships between the national and local levels. As the public health reforms move forward, maintaining and strengthening these relationships will be important for providing the critical connection between national and local organisations and understanding how national initiatives affect delivery of services at the local level.

Importantly, the pandemic raised the profile and standing of DsPHs and their teams within local communities. It demonstrated their ability to build relationships across sectors and to bring together people from different parts of the public health system. It also demonstrated how the understanding of DsPH and their teams about local places and resources, and their broader role in local authorities, helped put them at the centre of local decision-making on matters pertaining to public health. These strong, wide-ranging local relationships were critical responses to the pandemic, but will need continued investment of time and resources going forward.

Moreover, the pandemic has provided opportunities to create new partnerships across organisational boundaries, including joint working at the regional level together with a deepening of relationships across the community, particularly with charities voluntary and community sector (VCS) organisations. With the public profile of public health at an all time high, there is an opportunity to build on public health's enhanced standing to influence post-pandemic recovery plans.

"COVID-19 has had a levelling out effect and increased/restored the influence of public health professionals"

Local government leader

The ongoing challenges facing geographically disadvantaged communities

Despite growing awareness of the importance of public health in tackling health inequalities and providing equity of access to services at place level, many communities across the UK are facing pressure on their health and care services due to workforce shortages, delayed diagnoses and longer waiting times. Experience indicates that the more vulnerable in deprived communities are the hardest hit when there are financial and access problems affecting services. Improving their wellbeing will require strong advocacy from public health and for issues to be tackled locally, in neighbourhoods and communities.

The public health funding cuts across England have resulted in the most deprived areas facing the biggest cuts to their grants from central government, despite the government acknowledging that deprived areas have a greater need for some council services. Moreover, many councils are being forced to revisit their financial plans owing to the 'unprecedented' level of price rises as a result of energy and other inflationary pressures. The Local Government Association has estimated that inflation alone will add £800 million to costs in 2022-23. The combined impact of general inflation, energy costs and projected increases to the National Living Wage take the total to £2.4 billion, rising to an estimated £3.6 billion in 2024-25, creating a further threat to the provision of many local services.[5]

Reduction in budgets for public health and neighbourhood services

An impediment to action to draw on place-based assets for public health is the fact that in responding to austerity local authorities have concentrated their spending on statutory and demand-led services, such as homelessness and waste collection. Funding cuts and social care cost pressures have led local authorities to re-profile their budgets and reduce spending on preventative and 'universal' neighbourhood services such as children's centres, libraries, subsidised bus routes and independent living programmes. We discuss this issue at length in our report *Identifying the gap: understanding the drivers of inequality in public health*.

A May 2022 report by the Institute for Government (IfG), *Neighbourhood services under strain*, examined local government spending patterns in England since 2010. It highlighted increasingly serious funding challenges and concluded that while local authorities had managed financial pressures in the first half of the 2010s by delivering services more efficiently, this became a harder task as the decade progressed. Public health spending was excluded from this analysis because local authorities became responsible for public health services in 2013-14, but our research suggests that public health experienced similar patterns of funding cuts.[6]

Increasing demand for adult and children's social care has added to the overall pressure, and as a result of the combination of cuts in grants and the growing demand for social care, a range of local authorities have reduced their neighbourhood spending substantially.[7]

A critical finding by the Institute for Government (IfG) in their May 2022 report *'Neighbourhood services under strain'*, is that a lack of comprehensive and consistent data collection makes it difficult to understand fully the impact of funding cuts on non-statutory services. The IfG noted that spending performance indicators were only available for about a third of neighbourhood services, with little information available for the other two-thirds (totalling some £10 billion) of local authority spending in 2019-2020, making it impossible to judge the comparative performance of local authorities. While all authorities reduced their spending on neighbourhood services, the scale of the reductions varied hugely – from five per cent in East Sussex to 69 per cent in Barking and Dagenham.[8]

The February 2022 *Levelling Up the United Kingdom* white paper outlined proposals to improve healthy life expectancy, narrow the gap between geographical areas, and improve the consistency and completeness of local authority data to monitor progress and target interventions more efficiently. It identified the need to ensure that data is collected in a consistent and comprehensive manner and that any new datasets should have a wide enough scope for making evidence-based decisions and understanding the impact of funding cuts more effectively.[9]

However, the recent Spending Review failed to commit to a real-terms increase in the public health grant and soaring inflation rates (nine per cent at the time of writing) means that the Spending Review's commitments represent a significant funding cut in real terms.[10] As the economic outlook continues to deteriorate, driven by rising prices for gas, electricity, motor fuels and food, there will inevitably be increasing stresses on NHS and local government budgets, affecting their capacity to invest in initiatives aimed at reducing health inequalities.

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

The impact of the Health and Care Act 2022 on public health

The Health and Care Act 2022, which received Royal Assent in April 2022, establishes the legislative framework that supports collaboration and partnership-working aimed at integrating services for patients. It puts Integrated Care Systems (ICSs) at the centre of the legislative overhaul. England has been divided into 42 area-based statutory ICSs, each covering populations of around 500,000 to three million people. However, since there are variations in the size, geographical coverage, and maturity of ICSs, all ICSs will need to work with and devolve both decision-making and power to local places and neighbourhoods where the connection to community is stronger.

From an NHS perspective, there is an important role for primary care networks (PCNs), which are expected to work closely with communities, local government public health teams and others at the place and neighbourhood level. Working in partnership at the local level will be crucial not only for meeting the ambitions of the NHS LTP, but also in addressing wider issues and inequalities. With local authorities responsible for other services that contribute to population health, there is an opportunity for local systems, supported by public health teams, to work with PCNs to tackle health inequalities, address the wider determinants of health as part of a whole systems approach to prevention, and provide joined-up services.

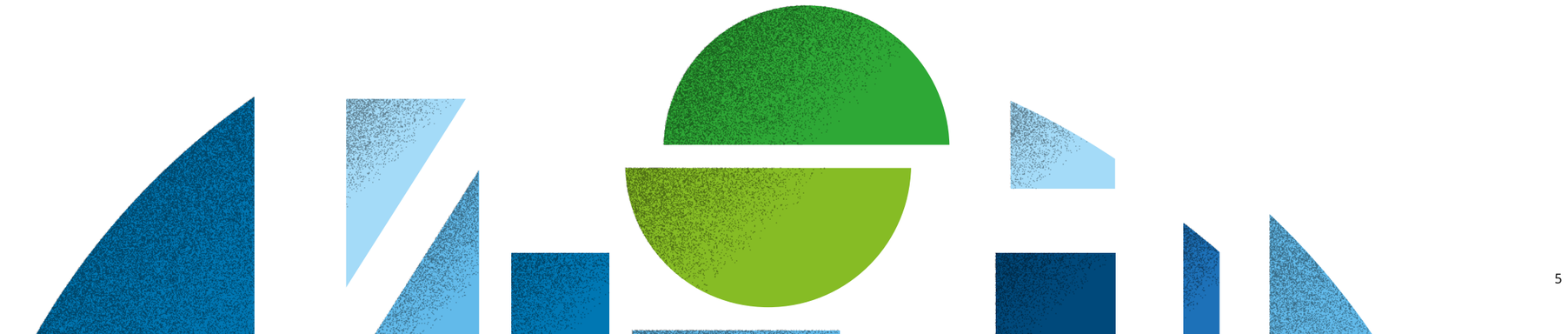
The Government's 'Levelling-up white paper' in February 2022 proposed a new statutory partnership between NHS, local government and wider partners to focus on tackling health inequalities and improving population health – alongside a duty to collaborate and promote the 'triple aim' of better care for all patients, better health for everyone, and sustainable use of NHS resources.[11] To help guide action, NHS England has developed an approach – known as 'Core20PLUS5' – that focuses on reducing inequalities by targeting efforts at people living in the 20 per cent most deprived areas (defined using the Index of Multiple Deprivation).[12]

The specific impact of the Health and Care Act reforms on public health include: the abolition of Public Health England and its replacement by the Office for Health Improvement and Disparities (OHID) and the establishment of the UK Health Security Agency (UKHSA), alongside plans for the fundamental reform of social care.

The interviews we conducted as part of our research for this report suggests that there are five key public health risks that will need to be managed overtly:

- the backlog in elective treatments and pressures on primary care are likely to dominate healthcare policy and priorities and consume a higher proportion of the healthcare budget than planned
- ICSs, and their Integrated Care Boards (ICBs) may have to focus attention and resources predominantly on maintaining NHS treatment services and have limited leeway to invest in initiatives to improve ill-health prevention and population health at place level
- the 'due regard' clauses in the legislation around local health and wellbeing strategies may not be implemented in a meaningful way and there is a risk that the connection between NHS services and public health may be weakened
- the voice of public health may be diluted or even ignored by ICSs, with health protection becoming increasingly a function of the UK Health Service Agency alone, and making local DsPH peripheral to health protection and without sufficient funding
- staffing is the issue keeping NHS leaders awake at night and which consumes around two-thirds of health provider spending. Workforce shortages are seriously affecting the NHS, they are also affecting social care and public health. While this risk was an issue pre-COVID-19, the pandemic intensified the pressures. Although the ICS structural changes may lead to new ways of working a shortage of the right people to do the job, could undermine improvement plans.[12]

Despite the above challenges and the likely impact on communities, the introduction of ICSs offers new opportunities for the specialist public health workforce to work as part of a whole system approach, focused on improving population health and wellbeing outcomes. DsPH and their teams can seize the opportunity to play a bridging and brokering role between public and private partners across the health system, to influence the shape of future population health and prevention programmes and activity.



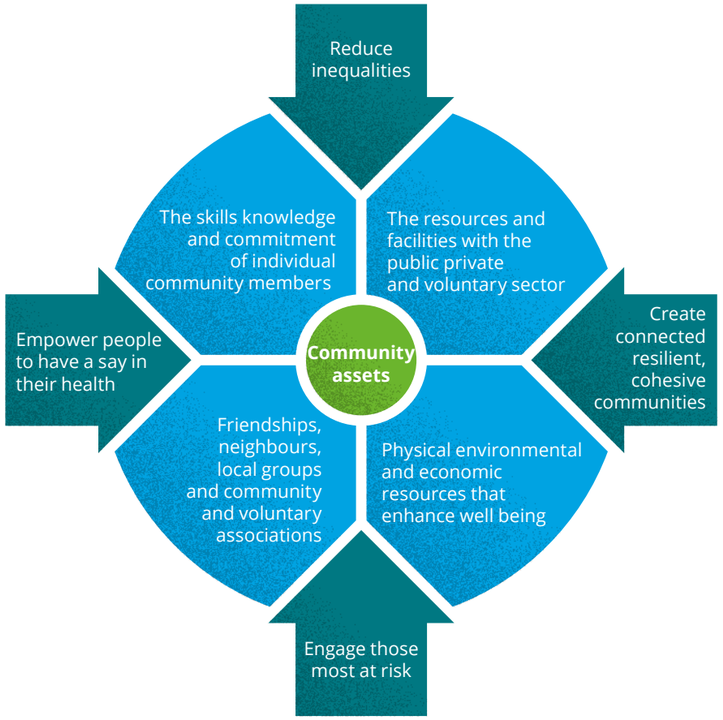
An asset-based approach to improving the resilience of communities

The Department of Health and Social Care (DHSC) and the new Office for Health Improvement and Disparities (OHID) have recognised the need for a place-based approach to reducing health inequalities and that action on health inequalities should aim to improve the lives of those with the worst health fastest.[13] The government's levelling-up white paper is aimed at ending geographical inequality and unfairness by giving everyone and every place an opportunity to flourish by improving economic dynamism and innovation across all parts of the country.[14] Changing the narrative from characterising neighbourhoods based on deprivation statistics to focusing instead on valuing and deploying community assets can help reduce the health gap and improve outcomes for all.

Harnessing community assets to reduce health inequalities

All communities have assets that contribute to the health and wellbeing of its members. These include the skills and knowledge of social networks, local groups, and community organisations, that together provide important building blocks for good health. A place-based community approach is a person-centred, bottom-up approach to meeting the unique needs of people in a community by working together and using the best available resources. Understanding the scale, extent and location of community health assets and deploying them effectively is a crucial task for public health teams (see Figure 1).

Figure 1. Optimising community assets to improve and empower individuals in creating resilient communities in public health



Source: Deloitte analysis.

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

Making use of community assets is essential for addressing health inequalities. This requires all stakeholders (including GPs who know their practice populations, public health teams who know the needs of their local population, and the communities themselves) to have knowledge and understanding of the assets available within their communities. They also need to use every opportunity to 'Make Every Contact Count', focusing on prevention where possible.

Some of the key assets at the heart of most communities are the services delivered by the VCS. However, several of our interviewees commented on how cuts in local authority funding have led to cuts in funding for VCS organisations, and this is compromising the activities of many and threatening their ability to deliver public health-related services. This view is supported by new research showing that the impact of the pandemic on voluntary organisations has been 'uneven and unpredictable' and warns of further declines in income and funding from all sources.[15]

The people we interviewed for our future of public health series of reports highlighted the role that an asset-based approach can have in changing the narrative from characterising neighbourhoods based on deprivation statistics to a focus instead on valuing and deploying community assets. An asset-based approach mobilises these resources and seeks to improve access to services for all members of the community. This contrasts with a reactive deficit-based approach which focuses more on treating problems when they occur.

Marmot's 'Build back fairer' cities: Utilising an asset-based approach to improve health outcomes

An asset-based approach is not new. For example, the first Marmot report in 2010 included a focus on place, wellbeing and cross-sectoral working based on an asset-based approach to tackling the social determinants of health. Moreover, it argued that reducing inequalities in health is a social good, and a matter of fairness and justice, which increases social cohesion and productivity. In Coventry these considerations influenced a decision by the city council in 2013 to become the first 'Marmot City'. *'All departments within Coventry Council have worked with partner organisations from the public sector and the voluntary, community and social enterprise sectors to draw on their collective strengths and assets to deliver an asset-based approach to tackling the social determinants of health'.*[16]

Since 2014, other cities and regions have become Marmot cities or regions. They include Stoke, Newcastle, Gateshead, Bristol and Somerset, Cheshire and Merseyside, and Cumbria and Lancashire have become Marmot cities or regions. They work with the UCL Institute of Health Equity, led by Sir Michael Marmot, to reduce health inequalities based on Marmot's eight principles (adapted from the six common goals in the 2010 report Fair Society Health Lives, see Figure 2).[17]

Figure 2. Marmot's Build Back Fairer Cities principles

1.	Give every child the best start in life
2.	Enable all children, young people and adults to maximise their capabilities and have control over their lives
3.	Create fair employment and good work and pay for all
4.	Ensure a healthy standard of living for all
5.	Create and develop healthy and sustainable places and communities
6.	Strengthen the role and impact of ill health prevention
7.	Tackle racism, discrimination and their outcomes
8.	Pursue environmental sustainability and health equity together.

Source: UCL Institute of Health Equity

In 2021, the Marmot report for Greater Manchester Health and Social Care Partnership, *Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives*, put forward bold and ambitious recommendations on how to reduce health inequities and build back in a fairer way for future generations, following the COVID-19 pandemic. It argued that 'equity of health and wellbeing must be at the heart of government and business strategy rather than narrow economic goals'.[18]

Rural and coastal areas: serious place-based challenges

Health inequalities also disproportionately affect most rural and coastal areas. For example, the Chief Medical Officer's 2021 annual report highlighted the substantially greater burden of physical and mental health conditions in coastal communities. In both rural and coastal areas a combination of deteriorating physical and mental health, ageing populations, high levels of social and economic deprivation and critical workforce shortages means that health and care services are facing serious challenges. Coastal communities have 14.6 per cent fewer postgraduate medical trainees, 15 per cent fewer consultants and 7.4 per cent fewer nurses per patient than the national average, despite higher healthcare needs.[19]

In February 2022, the findings of an extensive three-year parliamentary inquiry by the All-Party Parliamentary Group (APPG) for Rural Health and Care and the National Centre for Rural Health and Care identified the extent of the urban-rural divide in accessing health and social care. It found that around a fifth of England's population live in rural or coastal communities, and they have experienced poorer access to health and social care services than people in urban areas. Rural residents are older than the national average, often with complex co-morbidities, and they are comparatively disadvantaged throughout their life-course, despite the 'social duty to promote equality' embodied in the NHS Constitution. While the cost of social care is a national issue, rural local authorities spend a disproportionately larger share of their budget on these services and local council taxpayers are having to fund more costs than their urban counterparts.[20]

Alongside the funding challenges, people in health and social care jobs earn low wages, often face onerous travel times, and lack locally-based training. These conditions have led to high labour turnover and a shortage of nurses and care workers in rural areas. Poor broadband and network access and very poor public transport were highlighted as key drivers of rural healthcare inequalities, for both patients and staff. The lack of reliable and fast digital connectivity hinders the introduction into rural areas of alternative methods of health assessment and care, such as virtual appointments.

To address inequalities in these areas, new ways of working must be adopted, which are locally distributed, community embedded and build on greater collaboration across NHS local authorities, orchestrated by public health experts. Several initiatives have been launched to address some of the geographical inequality issues. For example:

- Health Education England (HEE) has a programme aimed at tackling health inequalities in rural and coastal areas based on the based on global evidence of the role that education, training and use of digital technology can play in delivering improvements. HEE aims to launch evidence-based pilots in selected ICSs that are having problems in attracting, recruiting, and retaining the required workforce. HEE recognise the need to develop residents' digital skills and confidence, to enable them to access advice, support and information, underpinning health literacy with digital skills. Several ICSs have already trialled innovative projects including training local residents to use online services and appointing Digital Ambassadors in the workforce and community[21]

- Lancashire and South Cumbria has been selected as one of 11 areas to launch NHS England and NHS Improvement's (NHSE&I's) new national Core20PLUS5 programme (for the 20 per cent of the population experiencing most deprivation, with 'PLUS' representing additional groups specific to each area that have poorer than average access to and outcomes from healthcare).[22] The programme is aimed at tackling health inequalities in five focus clinical areas (maternity, sever mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding). The focus is on how people access, experience and receive care and is seen as a starting point for levelling up healthcare by using local knowledge to prioritise and work with disadvantaged communities and tackle barriers preventing people from accessing care[23]

- NHSE&I has also launched the Healthcare Inequalities Improvement Dashboard, building on lessons from the COVID-19 pandemic around the importance of good quality data to drive improvements and reduce healthcare inequalities. Several individual tools exist, but the Healthcare Inequalities Improvement Dashboard provides, in one place, key strategic indicators relating to healthcare inequalities. It covers the five priority areas for narrowing healthcare inequalities in the 2021-22 planning guidance.[24] It also covers data relating to the five clinical areas in the Core20PLUS5 approach.[25] By providing data analysed by ethnicity and deprivation, the dashboard is intended to help the NHS to take concerted action to improve health inequalities.[26]

ICSs as statutory organisations: An opportunity for a fundamental shift in the way health and care are delivered

In 2019, the NHS LTP set out ambitions for the health service. It set out the role that the NHS could play in supporting healthier communities by using their sizeable assets to support local community wealth building and development through its procurement and spending power, workforce and training, and buildings and land. Furthermore, there is much experience and expertise in local government and the voluntary sector of working with communities to improve health, although the approaches that are used are often bespoke and are not applied in a co-ordinated or consistent way.

The NHS LTP also required all health and social care providers to form part of one of 42 statutory integrated care systems (ICSs), with the expectation that reducing health inequalities should be a central component of their activities. This expectation was formalised by NHS England in a 2020 white paper which identified the core purpose of ICSs: to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development.

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

These core purposes have been ratified in the Health and Care Act 2022, and by the unique step of establishing ICSs and their Integrated Care Boards (ICBs) as statutory bodies from 1 July 2022.[27] Figure 3 (developed by The King's Fund) illustrates how the different component organisations will contribute to working at system, place and neighbourhood levels. While many organisations will work across more than one level, the different sizes and maturity of development of ICSs mean that there will be variation in ways of working. This flexibility is an important feature of ensuring that ICSs work effectively to meet local needs.[28]

Given that so many causes of health inequalities sit outside the direct influence of health and care services, our interviewees saw the creation of ICSs as an opportunity to work more broadly and create an enabling infrastructure in which local communities can thrive. However, they also highlighted the need for public health to 'have a seat at the ICS table' and mentioned the importance for both public health and ICSs of having access to population health data to target interventions effectively. Most interviewees mentioned the difficulties public health experienced at the outset of the COVID pandemic due to problems accessing data, which undermined its ability to respond as effectively as would otherwise have been possible.

Figure 3. The key organisational components of Integrated Care Systems from July 2022

NHS England
Performance manages and supports the NHS bodies working with and through ICS

Care Quality Commission
Independently reviews and rates the ICS

Statutory ICS

Integrated care board (ICB)

Membership: independent chair; non-executive directors; members selected from nominations made by NHS trusts/foundation trusts, local authorities, general practice, an individual with expertise and knowledge of mental illness

Role: allocates NHS budget and commissions services; produces five-year system plan for health services

Cross-body membership, influence and alignment

Integrated care Partnership (ICP)

Membership: representatives from local authorities, ICB, Healthwatch and other partners

Role: planning to meet wider health, public health and social care needs; develops and leads integrated care strategy but does not commission services

Influence ↕ Influence

Partnership and delivery structures

Geographical footprint	Name	Participating organisations
System Usually covers a population of 1-2 million	**Provider collaboratives**	NHS trusts (including acute, specialist and mental health) and as appropriate voluntary, community and social enterprise (VCSE) organisations and the independent sector can also operate at place level
Place Usually covers a population of 250-500,000	**Health and wellbeing boards**	ICS, Healthwatch, local authorities, and wider membership as appropriate; can also operate at system level
	Place-based partnerships	Can include ICB members, local authorities, VCSE organisations, NHS trust (including acute, mental health and community services), Healthwatch and primary care
Neighbourhood Usually covers a population of 30-50,000	**Primary care networks**	General practice, community pharmacy, dentistry, opticians

Source: https://www.kingsfund.org.uk

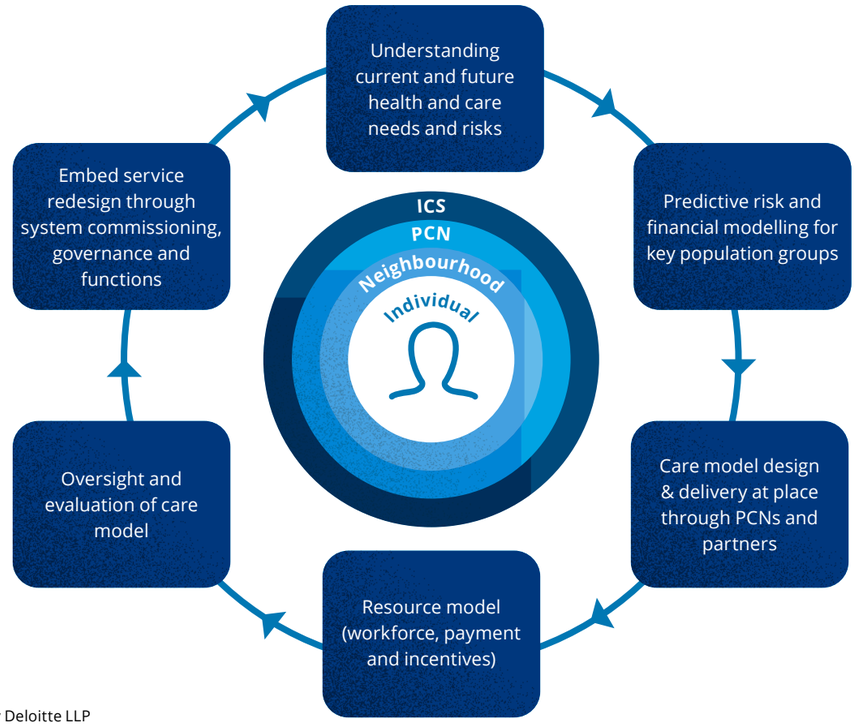
The crucial role of primary care networks

The establishment of primary care networks (PCNs) in 2019 was an important building block for integrating health and care. While prior to 2019 some GP practices had implemented new ways of working, for example in super-partnerships, federations, clusters and networks, the majority had remained as stand-alone independent practices.[29] PCNs were established as mostly geographically-based groups of general practices to enable primary care to operate at scale, improve the recruitment and retention of staff, manage financial pressures more effectively, and provide a wider range of services to patients.

The NHS LTP and the five-year framework for the GP contract, published in January 2019, put a more formal structure around working as part of a PCN, but without creating new statutory bodies. It introduced operational changes, including additional core practice funding, a care home premium to cover support for patients in care homes, a state-backed indemnity scheme for general practice staff and additional funding for IT to provide all patients with access to digital-first primary care.[30] Wales, Scotland and Northern Ireland had already implemented similar models.

PCNs work with a range of local providers (community services, public health, social care and the voluntary sector) to offer personalised, coordinated health and social care and improve the management of chronic conditions. By removing the historical divide between primary and community health services and establishing closer links with public health, the VCS and their local communities, PCNs have been given statutory responsibility for implementing a population health management (PHM) approach (see Figure 4). This is seen as indispensable to the success of ICSs.[31] A key responsibility is taking a proactive approach to managing population health and wellbeing, using disparate sources of data across multiple care and service settings.[32] This requires timely access to linked data sets, business analytic capabilities and the capacity to develop new data driven new care models. Crucial to the implementation of PHM is that ICSs should ensure that PCNs have sufficient capacity and capability to fulfil their role, which will be extremely challenging given the primary care workforce is already extremely stretched.

Figure 4. PHM is a core capability that needs to be supported at place
ICSs will need to delegate proportionate capacity and capability to PCNs to enable and empower them to take a PHM approach to joining up services and identifying proactive support around those that need it most.



Source: Adapted by Deloitte LLP

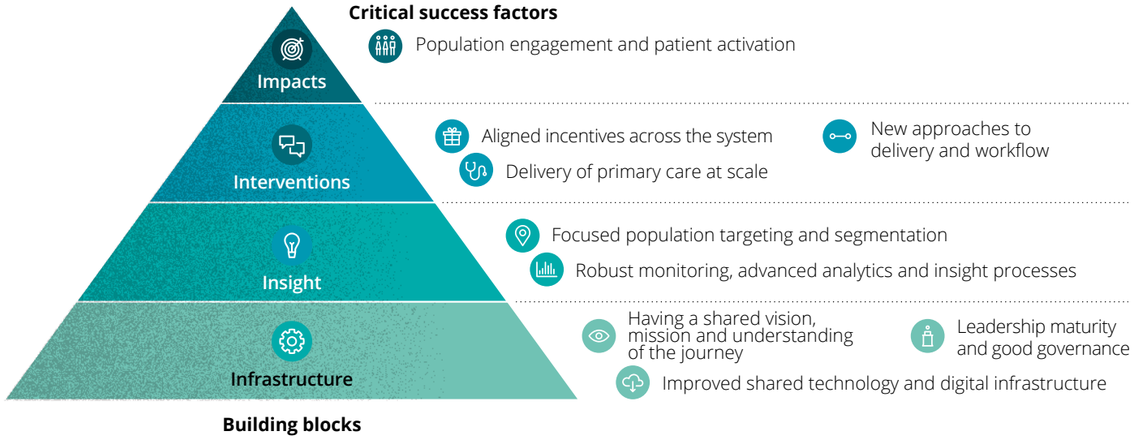
Tackling the gap: Harnessing community assets to improve equity in public health outcomes

Deloitte's 2019 report, *The transition to integrated care* identified how major advances in data analytics and machine learning are providing tools to make PHM a reality. These tools can help to identify risks and stratify patient populations to enable a predictive, participatory and personalised approach to care, and put in place measures to prevent illness.[33] PHM will require effective collaboration with public health teams and uninterrupted data flows across PCNs and ICSs.[34] Indeed, from April 2020 collaboration arrangements with other local care organisations were included in every PCN Network Agreement, using interoperable electronic health care record systems and advanced digital technologies such as AI and genomics.[35]

The Deloitte 2019 report also identified the main building blocks and critical success factors for PHM that will help to deliver measurable population health change and place-based working (see Figure 5).

> "PHM is being driven by the NHS – with ICSs relying on PCNs to pull population data together – but that is again something that should not be sitting just in the NHS but should be across the system. Public health is involved in PHM but we don't own it. Although in some areas there are good partnerships."
>
> **Managing Director, Public Health**

Figure 5. The four building blocks of PHM: Infrastructure, Insights, Impact and Intervention and the nine critical success factors enabling PHM
The policy shift towards integrated care and PHM sees Integrated Care System (ICSs) as the main organising principle for delivering a PHM approach.



Source: Deloitte LLP

PCNs collaborative place-based approach during the COVID-19 pandemic

Close collaboration between PCNs, including and public health teams proved invaluable during the pandemic, playing a vital role in the roll-out of the COVID-19 vaccination campaign and delivering the roll-out in record time. A survey of PCN clinical directors identified a shared purpose as instrumental in creating a sense of team, enabling staff to get to know each other and to build trust.[36]

The NHS Confederation's evaluation of the first two years of PCN operations identified progress across most PCNs in collaborative working, including reaching out to underserved communities, focusing more on prevention, and making headway in tackling health inequalities. While the pandemic created challenges, particularly in terms of workload and tensions between partners, many clinical directors cite the vaccination programme as a catalyst for collaboration and improvements. Going forward, three key principles will need to underpin the development of PCN policy: 'influence and autonomy, a recognition that one size does not fit all, and promoting integration in all areas'.[37]

"Vaccinations have been phenomenal. That kind of decentralised approach was successful – local teams activated local community systems such as churches, mosques, Hindu temples and hospital car parks – they really leveraged touchpoints, where the public want to come to deliver healthcare, whereas track and trace was centralised."

Director of Public Health

"Complex problems require teams."

Health Education England

The pandemic illustrated the power of new models of collaboration and service provision in reaching communities historically excluded from services, with over 2,000 groups listed on the mutual aid website established during the pandemic.[38] Greater recognition is needed of the role that communities can play in efforts to improve health and wellbeing, if there is to be a successful move to a PHM approach and a reduction in health inequalities.

Data sharing is central to PHM and tackling health inequalities effectively

Collecting accurate data and sharing it routinely is important for tackling health inequalities, stimulating action and enabling scrutiny by communities, health and wellbeing boards and regulators alike. This data helped raise awareness of health inequalities across the health and care system and also improved everyones understanding that inequality is a complex issue that is not always understood.

NHSE&I's Health Inequalities Improvement Dashboard (currently available only to public sector organisations) adds to an extensive body of data held by the Office for Health Improvement and Disparities, local government, and others.[39] Dashboard access is through the Equality and Health Inequalities Network – Future NHS Collaboration Platform.

Data sharing is central to population health management but there is work still to do to support PCNs, public health, primary care, social care and community teams to have visibility of common live datasets to direct their efforts. This sharing can take different forms, from peer support models (common in local government and public health) to nationally-led support used in the NHS.

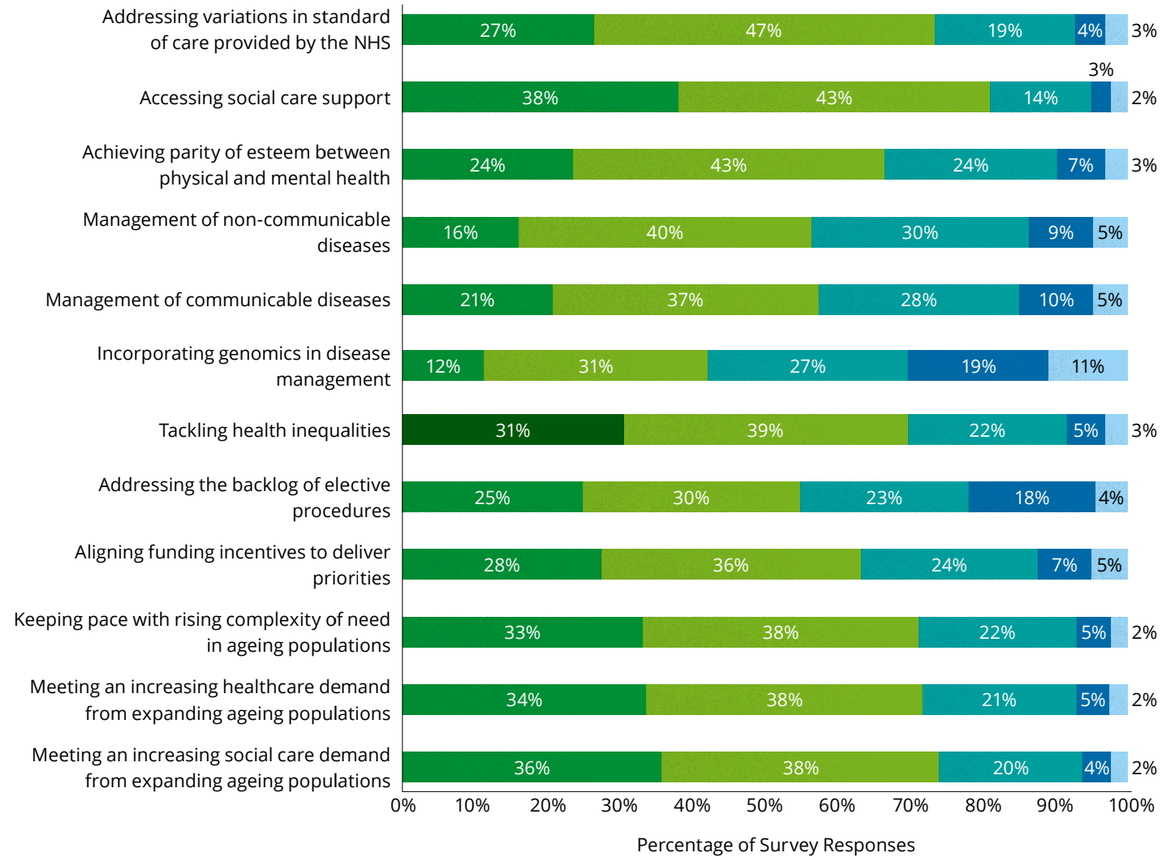
Tackling the gap: Harnessing community assets to improve equity in public health outcomes

How public health can lever the integration agenda to drive an asset-based approach

In our survey of clinicians working on the front line during 2021, we asked them to rate the extent to which the integration of services was likely to meet crucial public health challenges. Their views were generally encouraging: most clinicians considered that integration of services will help address public health challenges to a great or some extent. The areas where integration was seen as less effective were in incorporating genomics into disease management and addressing the backlog of elective procedures (see Figure 6). However, as previously noted, when asked a similar question our interviewees were almost unanimously concerned that tackling the day-to-day pressures of dealing with recovery from the COVID-19 pandemic, growing staff shortages, rising demand and funding constraints could seriously undermine the culture shift required to achieve the wider ambitions of the integration agenda.

Although the priorities of ICSs are expected to reflect the needs of the whole population, our interviewees felt particular attention should be paid to equity and diversity. Moreover, the involvement by PCNs in place-based partnerships and provider collaboratives will be instrumental in driving the integration agenda, while enhancing the skills and capabilities of the teams responsible for PHM. This in turn will create a link between neighbourhoods and systems, ensuring that ICS policies and objectives are grounded in an understanding of local needs. Essential components include a strong narrative, committed leadership at every level, a workforce culture willing to embrace change, and a different relationship with residents and communities, aimed at building self-reliance and independence based on a new model of contracting and community investment in market development.[40] The following case study illustrates how the ICS and PCN infrastructure can support existing public health-led place-based approaches.

Figure 6. To what extent will the integration of services across health and social care make the following public health challenges easier to address?



Source: Deloitte analysis of survey of 1,504 health care professionals conducted by M3 between 21st April – 28th April 2021.

Case study

Adopting an integrated place-based approach to improve citizen's lives in Wigan

Situation

In Wigan, a town in Greater Manchester with a population over 323,000, there are specific groups with severe public health-related problems. Nearly 100,000 people in the borough are in the most deprived quintile of the national population and 23 per cent have a long-term illness. Rates of both homelessness and obesity among adults and children are high. In 2010, Wigan council faced severe financial difficulties, and needed to reduce running costs by £160 million over the following ten years.

Actions

In 2010, the council introduced the Wigan Deal, freezing council taxes in return for improved health and wellbeing behaviours among the population. This involved a profound re-imagining of the relationship between citizen and state, including an understanding by the public of the costs of services. The council stopped things that didn't work and focused on supporting local groups and local clubs. The 'Be Wigan' experience is a place-based organisational development tool, re-thinking how citizens are viewed – not judging them but instead thinking how they can be helped. The two largest areas of expenditure are council services and the NHS – so the leadership reduced spending back to basics to 'get better value for the Wigan pound', wrapping services around citizens and engaging with community and voluntary organisations.[41]

In April 2018, the health and care partners made strides towards a fully integrated care model by signing the Healthier Wigan Partnership Alliance Agreement, committed to transforming local services and focusing initially on improving community-based out-of-hospital services. The Alliance Agreement includes a relationship based on 'Do with, not to'; and an asset-based approach that builds on the strengths of individuals, families and communities rather than focusing on the financial deficits. This place-based approach has redefined services, putting individuals, families and communities in control. Greater priority is given to wellbeing, prevention and early intervention. Staff are permitted to work differently and are enabled with technology to support new ways of working. Importantly, the Directors of Public Health agreed with GPs to form PCNs that were aligned to the seven council wards (with populations of 30,000 -50,000) driving all reforms on this basis. GPs and schools are designated as 'anchor institutions'.[42]

Outcomes

Following implementation of the Wigan Deal, by 2018 Wigan had one of best-performing hospital systems in England, had balanced its budgets for children and adults, and there was a seven-year increase in healthy life expectancy. Faced with austerity, Wigan Council had transformed its relationship with local residents and redesigned its services, whilst acknowledging that there was still more to do. By 2018 it had saved £130 million, with £30 million still to go). Wigan's 'Health Movement for Change' network now totals 23,000 citizens and currently includes 1,350 Health Champions, 495 Heart champions, 856 Cancer Champions, 10,000+ Dementia Friends, and 200+ Young Health Champions.

Measurable achievements

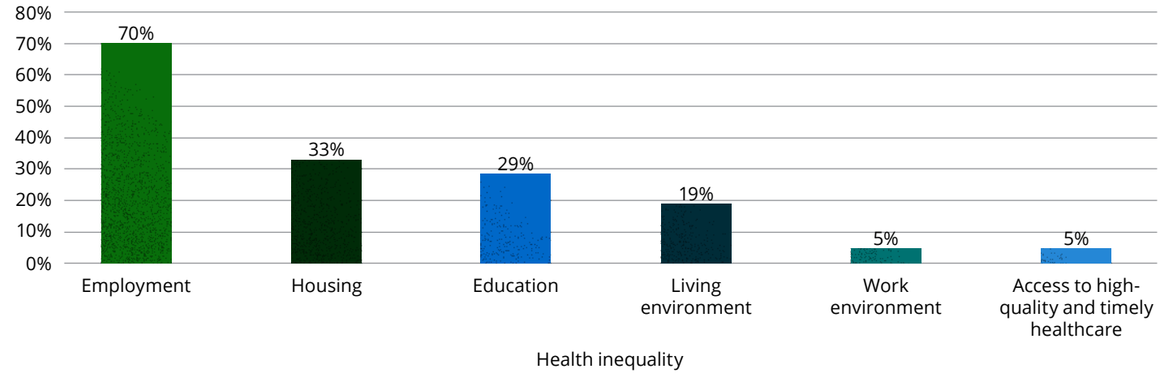
Since 2012, deaths attributed to cardiovascular disease (CVD) had reduced by 29% for males and 25% for females and early deaths attributed to cancer had fallen by 16% for males and 9% for females, bringing Wigan close to the average national rate. The proportion of adults who are physically active increased from 48% in 2012 to 63.4% in 2017. Over 15,000 children were doing a Daily Mile every day (extended to two-year olds via the 'Daily Toddle' in 20 nurseries), and 48.4% of 5-16 year-olds were meeting the CMO recommendations for physical activity. The proportion of smokers among manual workers, at 22.8%, were now below the England average (25.4%). Smoking among the population as a whole, had fallen from 16.7% in 2016 to 15.5% in 2018. Teenage pregnancy rates at 23.1 per 1,000 were now closer to the England average (20.8). All childhood vaccination programmes achieve 95% coverage – including for MMR and children in care.[43]

Community support networks, social connections, supportive relationships and having a voice in local decison making are all factors that help underpin feelings of good health and wellbeing. However, in the UK too many people experience the effects of social exclusion, or lack of social support, increasing the risk of health inequalities. It is important therefore, that all local partners, and the communities themseves, understand the full extent of the causes of inequalities in their local area.

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

Figure 7. Interviewees described employment as the greatest challenge the public health system faces in tackling health inequalities

What is the greatest challenge for the public health system in tackling health inequalities?



Rank	Health inequality	Comments and quotes
1	**Employment**	*Importance of income* *Importance of routine for maintaining wellbeing* *Some described a lack of support for workers from government during the pandemic.*
2	**Housing**	*Living in crowded housing compromised ability to shield/isolate during the pandemic.* *Concerns around homelessness during the pandemic.* *"Will there ever be public health housing"* *"You need National policy e.g. regulation on housing"* *"The conservative government stopped a programme that was helping large families to get larger houses."*
3	**Education**	*Importance of early start* *Skills training post 16 year old.* *Desire for health education (diet and lifestyle) to be included in curriculum.*
4	**Living environment**	*"In Maslow's hierarchy of needs, a safe and happy environment is the most basic and critical need before an individual can think about making changes to their life"* *"We need more scientific collaboration to help deal with pollution and climate change"* *"Living environment and housing are much more under the local authorities ability to influence than these other areas"*
5	**Work environment**	*Some mentioned the pandemic has highlighted safety at work issues (e.g. factory workers and higher outbreaks of COVID-19)* *"Work environment more than environment because its also the nature of the work – insecure work."*
6	**Access to high-quality and timely healthcare**	*"Ensuring equal healthcare access in deprived communities – it will take generations before its trusted again e.g. immigration services being informed if you come into the NHS"*
	Other	*"Immigration and advice"* *"Poverty...going to school hungry has a huge impact on children's educational attainment"*

Source: Deloitte analysis of interviews of public health stakeholders conducted between 6th April – 19th July 2021. with a sample of 12 interviewees followed up in April 2022 to see if still felt the same.

Question: COVID-19 has disproportionally affected those most vulnerable especially in deprived societies, in your view, what is the greatest challenge for the public health system in tackling health inequalities? 52% of interviewees answered this question..

We asked our interviewees what they saw as the greatest challenges that the public health system faced in tackling health inequalities (see Figure 7). Employment was rated as the biggest challenge, followed by housing and education. As we identified in our February 2022 report, *The role of employers in reducing the UK's public health gap*, pre-existing inequalities, such as low paid and poor quality work, housing conditions and access to financial support to self-isolate, fuelled wide disparities in people's experiences of the pandemic, their risks of infection, and likelihood of severe illness and death. It also found that even before the pandemic, low quality jobs were associated with people having poorer health. During the pandemic, the people employed in the highest risk job categories were less likely to be able to work from home, adding to the inequalities. Women and those from more deprived backgrounds appeared to be at particular risk of disrupted employment and reduced quality of life.

"Post COVID, housing will be a huge issue. We were able to rehouse homeless people during COVID to protect them and were also able to prevent evictions. We have to think about how to protect them moving forwards – e.g. landlords will be able to evict difficult tenants."

Director of Public Health

Understanding the range of community assets that can help improve public health

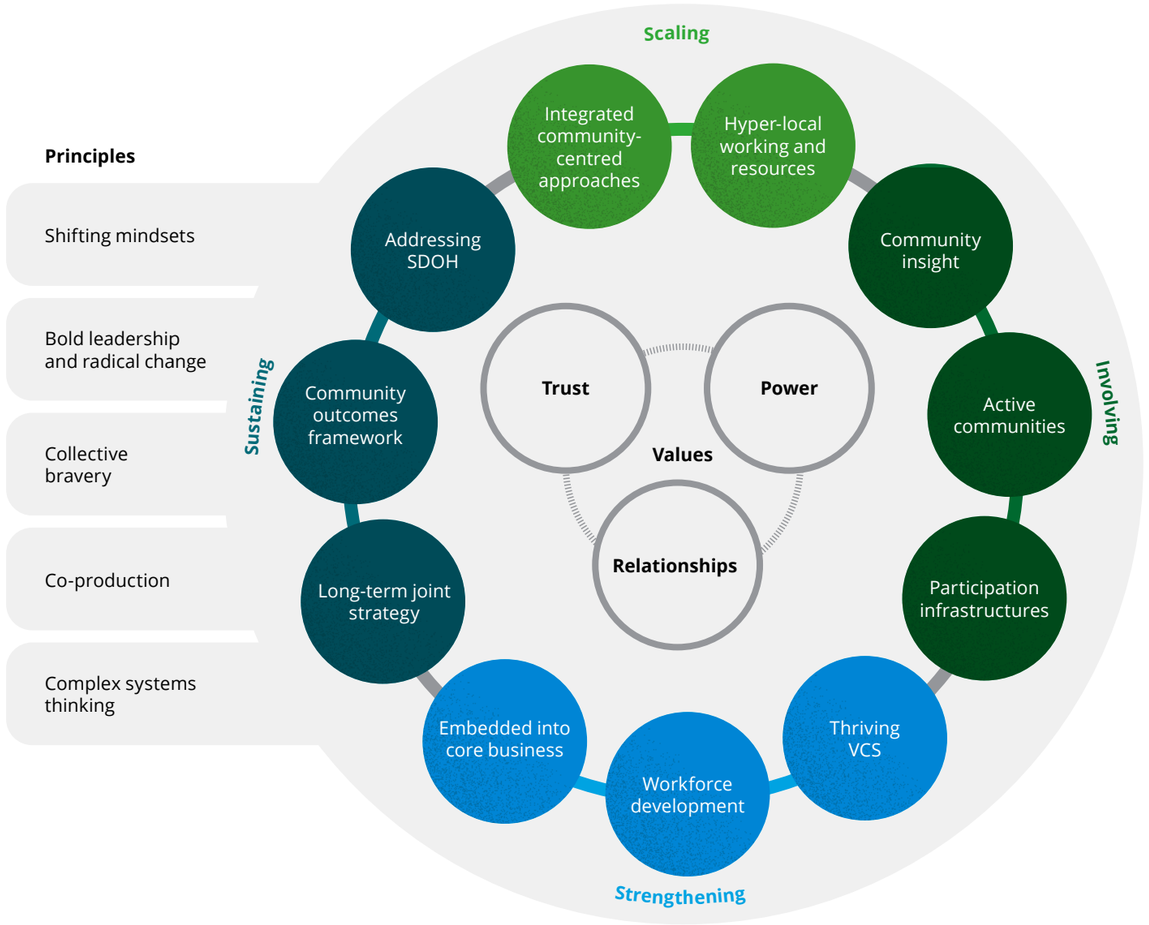
Assets within communities, such as skills and knowledge of individuals, social networks, local groups and community organisations, are building blocks for good health. Importantly, harnessing community-based assets helps mitigate the risk of leaving people behind and undermining attempts to improve the local populations' health. Specifically, a community-level, asset-based approach can mobilise all of the assets within a community, encourage equity and social inclusion and increase people's control over their lives and their health. Ideally an asset-based approach should:

- promote health and wellbeing or reduce health inequalities in a community setting, using non-clinical methods
- use participatory methods, where community members are actively involved in design, delivery and evaluation of any initiative
- include measures to identify and address barriers to engagement
- utilise and build on the local community assets in developing and delivering projects
- there are collaborations and partnerships with individuals and groups at most risk of poor health
- focus on changing the conditions that drive poor health, alongside individual factors
- increase people's control over their health and lives.

A briefing by Public Health England in January 2020 identified 11 key elements of change to a community-centred approach, underpinned by the core values of power, trust and relationships (see Figure 8).

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

Figure 8. Eleven elements of community-centred public health: a whole system approach



Source: Adapted from the UKHSA Library resources based on research by the Healthy Communities Team in 2019-20

Strengthening the role of public health to reduce inequalities and deliver more equitable outcomes

The COVID-19 pandemic has demonstrated the value that public health can bring to improving the health outcomes of local communities and clarified what is needed for a resilient public health system. Equipping public health teams with the authority and resources needed to enable them to tackle the existing stark inequities and resulting inequalities that exist, is essential. The emphasis needs to be on improving primary and secondary prevention through harnessing community assets to transform lifestyle behaviours. This will require funding and investment to strengthen public health teams, including ensuring they have a seat at the ICS table. The benefits are evident, including a reduction in the substantial costs of avoidable health inequalities and a more resilient and fairer public health system.

Deloitte's November 2020 report, *The future unmasked: Predicting the future of healthcare and life sciences in 2025* argued that "Better public health drives better productivity". It described the role of COVID-19 in exposing the failings of current public health systems and predicted that "public health will be a higher priority for governments everywhere, with a bigger proportion of funding devoted to it". Furthermore, "national statutory public health organisations will have clear and transparent responsibility for building and maintaining a robust and responsive public health infrastructure, and a diverse and well-qualified workforce and modern data systems". Our research identified what is needed for a robust public health system, where the focus needs to be, on what returns you can expect to get from this additional funding (see Figure 9).

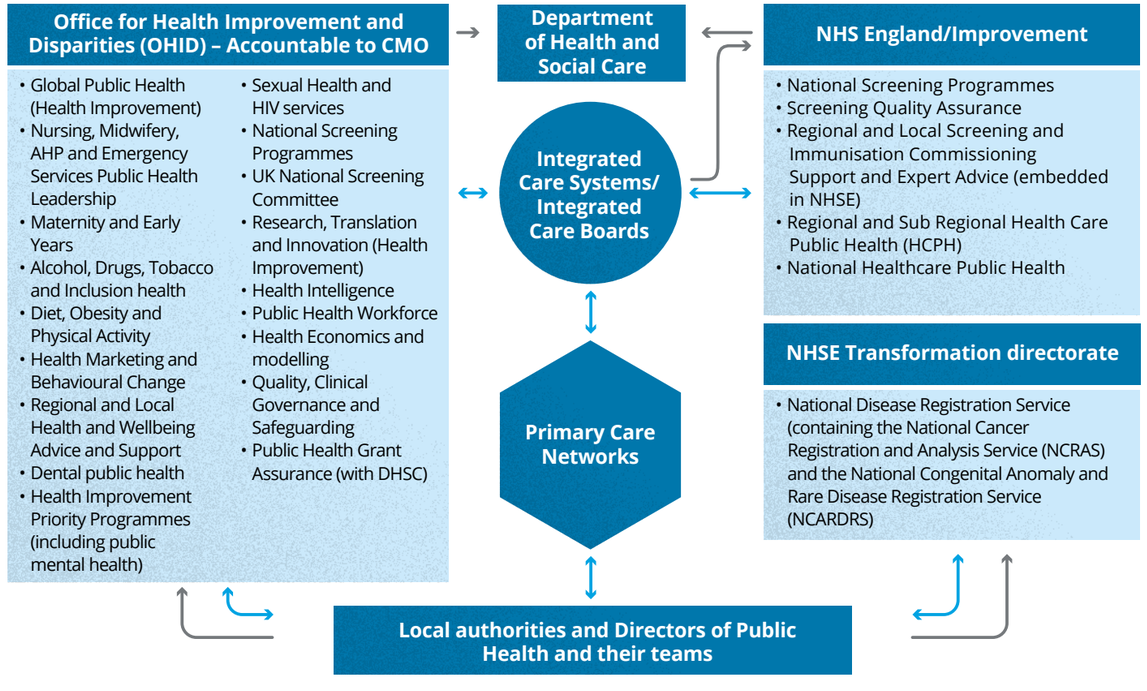
Figure 9. Realising a fairer and sustainable tomorrow: What good public health might look like in five years time

Source: Deloitte LLP

The UK's experience during the COVID-19 pandemic underlined the importance of an analytics-based population health approach to public health, to prevent disease and protect people and communities from threats to health. The pandemic demonstrated the need for a resilient and robust public health system and galvanised the government into establishing a major reform of public health. As we mentioned earlier, Public Health England's (PHE's) health improvement functions were transferred to DHSC and the newly created OHID, under the leadership of the Department's Chief Medical Officer, and the health protection elements become part of a new government agency the UKHSA.[44] Figure 10 details the organisation of public health functions at the national level.

In passing the Health and Care Act 2022, Parliament agreed that reducing health inequalities has to be a high priority for all public sector organisations, with specific responsibilities for everyone working across healthcare, social care and local authorities. For example, a crucial way of tackling inequalities in access, patient experience and health outcomes is by encouraging the adoption of innovative ways of working that will benefit the most disadvantaged people in communities alongside everyone else who need to access health and social care services. Innovative measures to tackle inequalities include offering in-house sexual health clinics to registered and non-registered patients, co-ordinating multi-disciplinary meetings with specialist consultants to review patients with complex needs, and improving methods of support for patients living in care homes.

Figure 10. The new organisational structure and responsibilities for public health from 1 October 2021 and the links to the wider public health system



Source: Deloitte analysis

The priorities for public going forwards?

Over the course of our research, we conducted a series of initial interviews and follow-up interviews to keep abreast of the changing public health landscape and increasing evidence of the impact of the pandemic. We asked our interviewees what three things they consider the new public health agencies should prioritise to help tackle the challenges facing public health (see Figure 11).

We also asked our interviewees what policy makers, public service providers, agencies and other stakeholders need to do to optimise future outcomes. Their answers can be summarised as follows:

- work collaboratively across sectoral boundaries and involve the wider public health system in taking joint decisions to achieve improved health outcomes
- open and transparent sharing of health data to enable both the planning and provision of services: however, service fragmentation and poor interoperability are impeding an integrated approach to disease prevention, care and cure
- provide appropriate levels of health and social care funding, based on economic evaluation of cost and benefits, and develop clear accountabilities for new models of integrated funding, with measurable performance indicators and aligned incentives across all parts of the system.

In order to understand the views of front line staff, we asked our survey respondents how effective key mechanisms identified by our research would be in helping to tackle the public health needs of their patients (see Figure 12). Views about the use of more innovative technologies and approaches were largely very positive, with access to patient data for digital technologies and point of care diagnostics considered the most effective.

We also asked both our survey respondents and interviewees what three words they hope will be used to describe the state of the public health system in five years' time. Their responses were almost entirely positive, demonstrating an ambition among most respondents to work together to deliver a more effective robust and resilient public health system. Among survey respondents, frequently mentioned words were Equitable, followed by Funded, Efficient, Improved, Accessible and Effective. Among interviewees the most frequently mentioned word, by far, was Integrated, followed by Funded, Resilient and Excellent (see Figure 13).

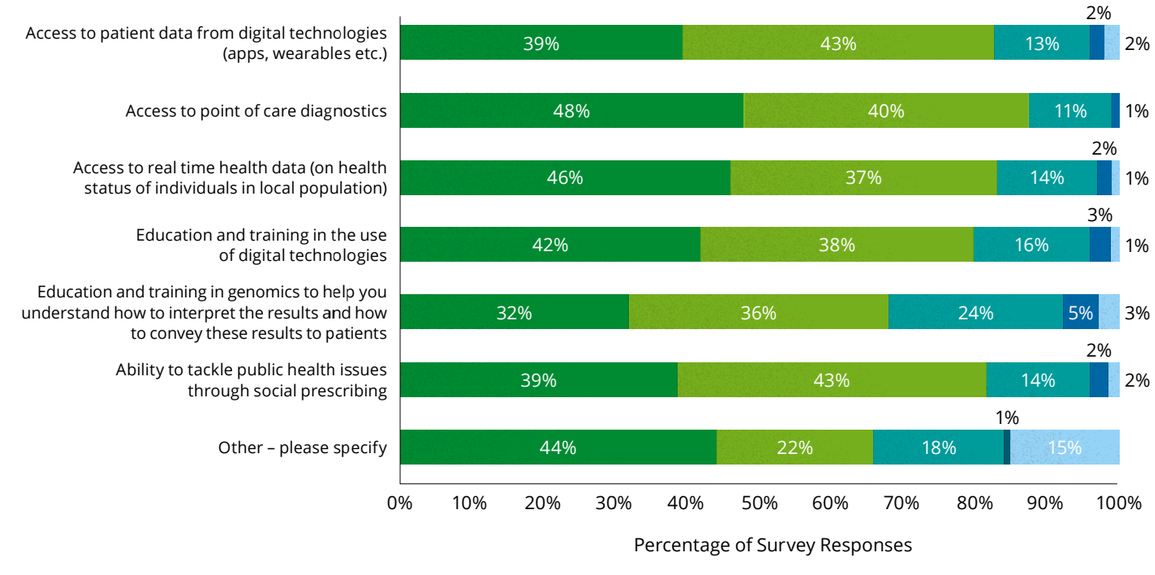
Figure 11. Which three things would you prioritise to help you tackle public health challenges?

Rank	%	Response
1	33%	**Funding/ resourcing: more imaginative use of resources is needed to obtain value for money** *"I'd prioritise funding so the right level of funding is targeted at the right groups of people at the right levels and the right initiatives."*
2	29%	**Workforce, skills and talent: need urgent attention to improve recruitment and retention** "There's an urgent and compelling need to make the clinical route into public health more attractive."
3	20%	**Inequalities and social determinants of health** *"Public health needs to be given the authority to influence the underlying social determinants including housing, employment, education, sport and leisure and environmental policies."*
4	13%	**Biosecurity and infection control** *"Preparing for future pandemics requires a robust and transparent pandemic response framework that shows how the lessons from COVID-19 have been applied."*
5	11%	**Prevention** *"There is an indisputable need to fund up-stream prevention, including ,behaviour coaches to provide nudges' and ,prevention at the point of birth and in first five yeas of life."*

Source: Deloitte analysis of interviews of public health stakeholders conducted between 6th April – 19th July 2021. Question: Which three things would you prioritise to help you tackle public health challenges? 69% of interviewees answered this question.

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

Figure 12. How effective would the following mechanisms be in helping you to tackle the public health needs of your patients?

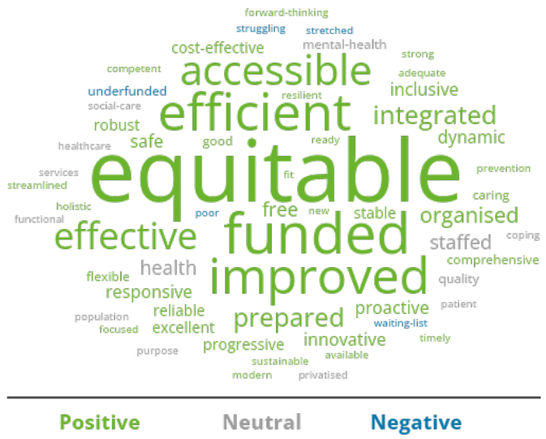


Source: Deloitte analysis of survey of 1,504 health care professionals conducted by M3 between 21st April – 28th April 2021.

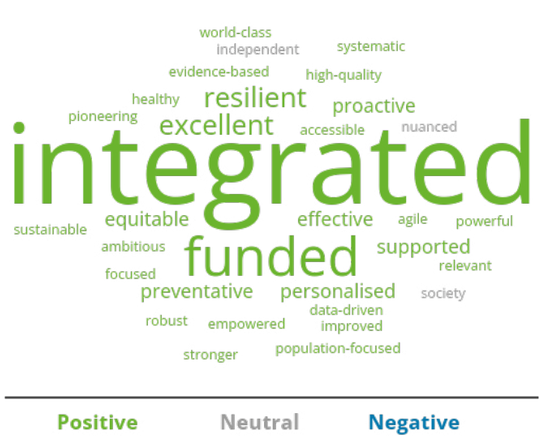
Note: For "Other – please specify" there were 120 responses, and for rest of the questions there were 1,504 responses

Figure 13. Thinking ahead five years, what three words would you hope will be used to describe the state of the public health system?

Survey respondents views



Interviewees views



Top 60 word view

Source: Deloitte analysis of survey of 1,504 health care professionals conducted by M3 between 21-28 April 2021.

Source: Deloitte analysis of responses from survey and interviewees.

Source: Deloitte analysis of interviews of public health stakeholders conducted between 6 April-19 July 2021.

The future role of digital transformation, data and analytics in public health

Public health services need access to health and care data, ideally through shared electronic health and care records, this would help drive a more cost-effective public health response. There is a need for standardisation in data sharing consent processes to improve consistency and familiarity for both clinicians and patients, as well as to facilitate interoperability between datasets. Patients and the public need to be confident that their health data is safe and is being used appropriately and responsibly.

New technologies such as genomics and artificial intelligence will help public health create new health protection and prevention models. Using data held by the NHS and generated by smart devices worn by individuals will help create an intelligent public health system, where everyone has access to their health information and many health interventions are personalised. Digital technologies can also empower individuals to take a greater role in co-creating approaches to improve their own health and wellbeing.

The UK's genomic infrastructure includes hundreds of specialist companies focused on genomics, a highly skilled workforce (across academia, charities, research institutes, the NHS and public diagnostics laboratories) and an impressive history of collaboration.[45] The UK's scientific strength in genomics enabled the UK public health system to be a leader in the early detection and monitoring of after of COVID-19 variants of (SARS-CoV-2) This scientific expertise should be harnessed to reduce health inequalities and improve the health of the whole population.

A resilient and sustainable public health workforce

DsPH need to play a leading role in driving the future of public health. Their training and expertise in population health, health protection and improvement, and infectious disease control, gives them a unique place for leading decision-making across local health and care systems and in influencing the wider public and private sectors in tackling the SDOH. But delivering the full benefits of public health will be dependent on having skilled and knowledgeable staff. This means prioritising the development of the public health education and training curricula, including ensuring that this includes training in genomics, artificial intelligence, and digital health.

The fragmentation of workforce planning needs to be resolved, through a more centralised but collaborative approach. There is also an ongoing requirement for public health to be built into education and training pathways for the entire healthcare workforce. Given the rapid expansion in knowledge, the approaches to improving and maintaining skills will need to be responsive and flexible. The establishment of statutory ICSs provide an opportunity to look at introducing more collaborative, innovative and forward looking training models that bring together the NHS, academia and local authorities.

Priority actions for a fairer, more equitable and sustainable future for public health

The COVID-19 pandemic has exposed deep and long-standing health inequalities and a lack of progress in addressing the SDoH. It has also highlighted the shortcomings in public health funding and the importance of place and harnessing community-based assets. Indeed, it has raised the public's understanding of the critical importance of public health and its crucial links to the health and wellbeing of local economies. While these developments have led to the adoption of innovative solutions and opportunities to work differently, adoption is fragmented and needs to be scaled up.

The power of digital and data has enabled staff to work outside of organisational silos and deliver more joined-up, user-centred care. This has helped ratify the case for integration, highlighting the importance of bringing together health data with local authority, voluntary sector to understand local population's experience of health and care, anticipate their future needs and identify the need for more focus on preventative care.

The UK government has committed to level up the country by boosting prosperity and widening opportunities in underserved communities. This provides a crucial opportunity to close the health inequality gap. Indeed, there is a general consensus that to 'build back fairer' from the pandemic, action from all levels of government, health and social care providers, employers, communities and society more generally, will be needed, including being held to account for 'tackling health inequalities in all policies'.

Actions for ICSs and PCNs to strengthen a community, asset-based approach

- Incentivising academia and industry to generate new evidence-based innovations and insights to support health protection, prevention and promotion initiatives.
- Using data and analytics and real-world evidence on the effectiveness of protection, prevention and health promotion interventions to encourage local adoption of best practice models of interventions.
- Standardising data protocols between NHS, social care, local authority and public health providers for collecting, recording and sharing public health data and monitoring performance aligned to the national deprivation index.
- Developing a robust, analytics based PHM approach to stratify and address population health needs.

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

Actions for public health directors and their teams

Public health directors and their teams should prioritise actions that support new patterns of collaborative working with the NHS, social care, and the private and CVS sectors through:

- Gaining a place at the ICS table and obtaining access to health and social care data as well as information on the social determinants, to improve the planning and provision of local public health services, overcome service fragmentation and poor data interoperability and establish an integrated approach to improving the health of local populations.
- Applying insights gained from social determinants of health scores and other predictive models to inform decision-making and proactive prescribing of evidence-based interventions.
- Using population health data and developing a range of health and wellbeing indicators at community level to ensure health protection is inclusive and proactively targets disadvantaged groups.
- Identifying individuals from across public health and community teams to act as navigators to available services and reduce the need for repetitive assessments of individuals and families with high levels of health, social and economic need.
- Focusing relentlessly on measurably improving health outcomes.

Other actions

Individuals and families should be encouraged to engage in the co-design and co-delivery of interventions, which are based on individual skills and capabilities, including access to initiatives to improve the health literacy of citizens. While this is generally easier for those less affected by social disadvantages, tailored interventions can help all individuals build the confidence to engage with their own health and wellbeing, especially in encouraging active participation in programmes developed by and available in local communities.

VCS and private sector organisations need to participate in sustainable relationships to support the use of social prescribing as well as to counteract consequences of poor living and working conditions on the health of local populations. VCS can work with community link- workers to build stronger relationships with local communities and PCNs. To be effective, VCS organisations need to negotiate long term settlements with the new ICB commissioners so that they can:

- Engage in sustainable business practices.
- Provide interventions that address the social determinants of health.

All stakeholders should consider the role of analytics and digital technology to help provide more efficient and cost-effective support across the range of interventions, including:

- Using financial modelling tools to assess fund flows and the return on investment of health and social care interventions.
- Establishing PHM analytics tools based on information sharing for addressing population health needs and problems more effectively.
- Integrating analytics and interoperable IT across all public services.
- Increasing transparency through data visualisation tools and dashboards that monitor system performance at a community place-based level and indicate high-risk areas in real time.
- Applying sophisticated machine learning and software models that predict risks at an aggregate population and individual level.
- Deploying data-driven triggers that automate communication with citizens, making use of behavioural insights and choice architecture to optimise citizen engagement.
- Developing digital platforms to make resources and knowledge more accessible, encouraging adoption of strategies that have worked elsewhere.
- Providing education and training to citizens in the use of digital technology.
- Providing a digital directory of community assets to help local populations to seek the right support from the right places.

Glossary of terms

Asset-based approaches – Asset-based approaches are concerned with identifying the protective factors that support health and wellbeing and enhance both the quality and longevity of life through focusing on the resources that promote the self-esteem and coping abilities of individuals and communities. Asset-based approaches can help redress the balance between meeting needs and nurturing the strengths and resources of people and communities. They are ways of valuing and building on the skills, successes and strengths of individuals and communities, which focus on the positive capacity of individuals and communities rather than solely on their needs, deficits and problems. These assets can act as the foundation from which to build a positive future. The identification and mobilisation of an individual's or a community's assets can help them overcome some of the challenges they face.

Community – Is a term for the relationships, bonds, identities, and interests that join people together or give them a shared stake in a place, service, culture, or activity. Communities can be place-based or communities of interests, and the strategies for engaging people will likely vary. Communities are also dynamic and complex, and people's identities and allegiances may shift over time and in different social circumstances.

Community resources – Are the businesses, public service institutions and charitable organizations that provide assistance and services to local residents. The range of services touches the lives of everyone who lives in a community.

Core20PLUS5 – A new initiative focused on driving targeted health inequalities improvements in the 20% most deprived populations, other priority population groups identified locally and in 5 key clinical areas of health inequalities – cancer diagnosis, hypertension, respiratory disease, annual health checks for people with serious mental illness, and contiunity of maternity care plans.

Health assets – Can be defined as any factor (or resource) which enhances the ability of individuals, groups, communities, populations, social systems and/or institutions to maintain health and wellbeing and to help to reduce health inequalities.

Health equity – Is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and wellbeing.

Health inequalities – Are unfair and avoidable differences in health acros the population, and between different groups of people both within and between countries. These inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions, or determinants, influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing. Factors associated with poorer health outcomes are complex, overlapping, and interact with one another.

Health resilience – Resilience in public health is the capacity for populations to endure, adapt and generate new ways of thinking and functioning in the context of change, uncertainty or adversity. Resilience occurs at the level of the individual, specific groups, communities, cities, regions or nations. Resilience refers to the ability of individuals, places and populations to withstand stress and challenge. Community cohesion, neighbourhood social capital and integration have been highlighted as key features of resilient places, while reduced social capital and cohesion can be seen as sources of vulnerability.

Place-based approach – Effective place-based action requires action on civic, service and community interventions, along with system leadership and planning. All local partners, including communities themselves, need to understand the potential of community contributions to reduce health inequalities (this includes the assets within communities, such as skills and knowledge, social networks, and community organisations, as building blocks for good health). Joint working between the civic, service and community sectors is needed to enable the whole to become more than the sum of its parts.

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

Public health – The art and science of preventing disease, prolonging life and promoting health through the organisaed efforts and informed choices of society, organisations, public and private communities and individuals.

Primary Care Networks (PCNs) comprise grouos of GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas to enable greater provision of proactive, personalised, cocordinated ad more integrated health and social care for people closer to home. Each of the 1,250 or so PCNs across England are based on GP registered lists, typically serving natural communities or between 30,000-50,000 people.

Social capital – Is the networks of relationships among people who live and work in a particular society, enabling that society to function effectively. It involves the effective functioning of social groups through interpersonal relationships, a shared sense of identity, a shared understanding, shared norms, shared values, trust, cooperation, and reciprocity. Social capital is a measure of the value of resources, both tangible (such as public spaces, private property) and intangible (such as information, innovative ideas, and financial support). Social capital also refers to bonds between individuals, both in intimate relationships (primary groups) and in voluntary associations (secondary groups) that make it possible for individuals and groups to achieve a variety of goals. Such bonds can have health promoting effects.

Social determinants – Are known as the 'Cause of the causes of ill health and encompass the inter-linked social, economic, cultural and political conditions that influence individual and group differences in health status. They are the health promoting factors found in one's living and working conditions (such as the distribution of income, wealth, influence, and power), rather than individual risk factors (such as behavioural risk factors or genetics) that influence the risk for a disease, or vulnerability to disease or injury. Poor social and economic circumstances affect health throughout life. People further down the social ladder usually run at least twice the risk of serious illness and premature death of those near the top. Between the top and bottom, health standards show a continuous social gradient.

Endnotes

1. The future of public health report series, Deloitte LLP, October-December 2021. See also: https://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/the-future-of-public-health.html
2. The future of public health report series, Deloitte LLP, October-December 2021. See also: https://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/the-future-of-public-health.html
3. Place-based approaches for reducing health inequalities: main report, Public Health England, 28 September 2021. See also: https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report
4. Public perceptions of health and social care in light of COVID-19, The Health Foundation, June 2020. See also: https://www.health.org.uk/publications/reports/public-perceptions-of-health-and-social-care-in-light-of-covid-19-may-2020
5. Spending Review 2021 Submission, Local Government Association, 05 October 2021. See also: https://local.gov.uk/publications/spending-review-2021-submission
6. Graham Atkins and Stuart Hoddinott, Neighbourhood services under strain, Institute for Government, May 2022. See also: https://www.instituteforgovernment.org.uk/sites/default/files/publications/neighbourhood-services-under-strain.pdf
7. Ibid.
8. Ibid.
9. Levelling Up the United Kingdom, Department for Levelling Up, Housing and Communities, 02 February 2022. See also: https://www.gov.uk/government/publications/levelling-up-the-united-kingdom
10. Autumn Budget and Spending Review 2021: what you need to know, NHS Confederation, 27 October 2021. See also: https://www.nhsconfed.org/publications/autumn-budget-and-spending-review-2021
11. Levelling up the United Kingdom, White paper, Department for Levelling Up, Housing and Communities, 02 February 2022. See also: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1052046/Executive_Summary.pdf
12. David Buck and Richard Murray, Public health and integrated care reform: doing the knitting, The King's Fund, 19 November 2021. See also: https://www.kingsfund.org.uk/publications/public-health-and-integrated-care-reform
13. Graham Atkins and Stuart Hoddinott, Neighbourhood services under strain, Institute for Government, May 2022. See also: https://www.instituteforgovernment.org.uk/sites/default/files/publications/neighbourhood-services-under-strain.pdf
14. Levelling up the United Kingdom, White paper, Department for Levelling Up, Housing and Communities, 02 February 2022. See also: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1052046/Executive_Summary.pdf
15. Pandemic impact on charities continues to be 'uneven' but funding challenges are on horizon, research shows, NCVO, 15 March 2021. See also: https://www.ncvo.org.uk/about-us/media-centre/press-releases/2793-pandemic-impact-on-charities-continues-to-be-uneven-but-funding-challenges-are-on-horizon-research-shows
16. ALL TOGETHER FAIRER: HEALTH EQUITY AND THE SOCIAL DETERMINANTS OF HEALTH IN CHESHIRE AND MERSEYSIDE, Institute of Health Equity, accessed 10 July 2022. See also: https://www.instituteofhealthequity.org/resources-reports/all-together-fairer-health-equity-and-the-social-determinants-of-health-in-cheshire-and-merseyside/executive-summary.pdf
17. Marmot M et al., Fair Society, Healthy Lives: The Marmot Review, Institute of Health Equity, February 2010, See also: https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review
18. Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives, Institute of Health Equity, June 2021. See also: https://www.instituteofhealthequity.org/resources-reports/build-back-fairer-in-greater-manchester-health-equity-and-dignified-lives/build-back-fairer-in-greater-manchester-executive-summary.pdf
19. Chief Medical Officer annual report 2021, Department of Health and Social Care, 21 July 2021. See also: https://www.gov.uk/government/news/chief-medical-officer-annual-report-2021
20. Professor Richard Parish CBE, APPG Rural Health & Care, National Centre for Rural Health and Care, February 2022. See also: https://rsnonline.org.uk/images/publications/RuralHealthandCareAPPGInquiryOve.pdf
21. HEE unveils programme to help tackle health inequalities in rural and coastal areas, Health Education England, 03 February 2022. See also: https://www.hee.nhs.uk/news-blogs-events/news/hee-unveils-programme-help-tackle-health-inequalities-rural-coastal-areas
22. https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/
23. New programme aimed at tackling health inequalities to launch in Lancashire and South Cumbria, Lancashire and South Cumbria Health and Care Partnership, 25 February 2022. See also: https://www.healthierlsc.co.uk/our-work/canceralliance/latest-news/new-programme-aimed-tackling-health-inequalities-launch-lancashire-and-south-cumbria
24. 2021/22 priorities and operational planning guidance, NHS, 25 March 2021. See also: https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-nhs-operational-planning-and-contracting-guidance.pdf
25. Core20PLUS5 – An approach to reducing health inequalities, NHS England, accessed 10 July 2022. See also: https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/
26. The Healthcare Inequalities Improvement Dashboard, NHS England, accessed 10 July 2022. See also: https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/hi-improvement-dashboard/
27. Integrated Care Boards, NHS Digital, accessed July 2022. See also: https://digital.nhs.uk/services/organisation-data-service/integrated-care-boards
28. Integrated care systems: how will they work under the Health and Care Act?, The King's Fund, 23 May 2022. See also: https://www.kingsfund.org.uk/audio-video/integrated-care-systems-health-and-care-act
29. Primary care today and tomorrow: Adapting to survive, Deloitte LLP, November 2016. See also: https://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/primary-care-today-and-tomorrow.html
30. GP Contract documentation 2019/20, NHS England, accessed 10 July 2022. See also: https://www.england.nhs.uk/gp/investment/gp-contract/gp-contract-documentation-2019-20/
31. GP Partnership review, Department of Health and Social Care, January 2019. See also: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf
32. What does population health management have to do with PCNs?, NHS Networks, accessed 10 July 2022. See also: https://www.networks.nhs.uk/news/what-does-population-health-management-have-to-do-with-pcns
33. https://www2.deloitte.com/uk/en/pages/public-sector/articles/population-health-management.html Karen Taylor, Cosima Pettinicchio and Maria Arvanitidou, The transition to integrated care: Population health management in England, Deloitte LLP, March 2019. See also: https://www2.deloitte.com/uk/en/pages/public-sector/articles/population-health-management.html
34. Primary Care Networks (PCNs), Pharmaceutical Services Negotiating Committee, 10 November 2018. See also: https://psnc.org.uk/the-healthcare-landscape/primary-care-networks-pcns/
35. Primary care networks: a quite revolution, The NHS Confederation and NHS Providers, July 2019. See also: https://nhsproviders.org/media/687950/primary-care-networks-a-quiet-revolution.pdf
36. Beccy Baird, Viewpoint: The COVID-19 vaccine rollout can help PCNs build cohesive primary care, GP Online, 11 March 2021. See also: https://www.gponline.com/viewpoint-covid-19-vaccine-rollout-help-pcns-build-cohesive-primary-care/article/1709554
37. Primary Care Networks (PCNs), Pharmaceutical Services Negotiating Committee, 10 November 2018. See also: https://psnc.org.uk/the-healthcare-landscape/primary-care-networks-pcns/
38. Jude Stansfield, Tom Mapplethorpe and Jane South, The community response to coronavirus (COVID-19), UK Health Security Agency, 01 June 2020. See also: https://ukhsa.blog.gov.uk/2020/06/01/the-community-response-to-coronavirus-covid-19/
39. Future NHS, NHS, accessed 10 July 2022. See also: https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FEHIME%2Fgrouphome
40. The Deal for Health and Wellness, Wigan Council, accessed 10 July 2022. See also: https://www.wigan.gov.uk/Council/The-Deal/Our-Deals/The-Deal-for-Health-and-Wellness.aspx
41. About us, Healthier Wigan Partnership, accessed 10 July 2022. See also: https://healthierwigan.nhs.uk/about-us/
42. Asset-based approaches in local authorities: the Wigan experience, Local Government Association, accessed 10 July 2022. See also: https://local.gov.uk/asset-based-approaches-local-authorities-wigan-experience
43. Transforming the public health system, Department of Health and Social Care, 29 March 2021. See also: https://www.gov.uk/government/publications/transforming-the-public-health-system

Tackling the gap: Harnessing community assets to improve equity in public health outcomes

Notes

Contacts

Authors

Karen Taylor
Director
UK Centre for Health Solutions
+44 7825 793729
kartaylor@deloitte.co.uk

Aiden Hannah
Research Analyst
UK Centre for Health Solutions
+44 7503 588555
ahannah@deloitte.co.uk

Industry Leadership

Sara Siegel
Partner
Public Sector Health and Care Leader, UK and North South Europe
+44 20 7007 7098
sarasiegel@deloitte.co.uk

Caroline Hope
Partner
Consulting
+44 121 696 8973
chope@deloitte.co.uk

Bill Hall
Partner
Public Sector Health
+44 121 695 5147
bhall@deloitte.co.uk

Stephanie Diller
Senior Manager
Monitor Deloitte
+44 77 6831 5865
sdiller@deloitte.co.uk

Karen Kirkham
Partner
UK Chief Medical Officer
Clinical Lead Partner for Integrated Care
UK Public Sector Health
+44 20 8071 0464
kkirkham@deloitte.co.uk

Catherine Skilton
Partner
Consulting
+44 20 7007 5490
cskilton@deloitte.co.uk

Frances Cousins
Partner
Risk Advisory
+44 20 7303 8316
fcousins@deloitte.co.uk

Cosima Pettinicchio
Partner
Consulting
+44 20 7303 2427
cpettinicchio@deloitte.co.uk

Gus Miah
Partner
Risk Advisory
+44 121 695 5349
gmiah@deloitte.co.uk

John Haughey
Partner
Global Consulting LSHC Industry Leader
+44 20 7303 7472
jhaughey@deloitte.co.uk

Hanno Ronte
Partner
Life Sciences and Healthcare
+44 20 7007 2540
hronte@deloitte.co.uk

Acknowledgements
Pratik Ahmad, Emily May, and Dylan Powell, Deloitte UK Centre for Health Solutions. With special thanks to the many people who gave their time to be interviewed, completed the survey or provided comment on the case studies to help us have a better understanding of the public health landscape during 2021 and 2022.

Contact information
To see more publications from the Deloitte UK Centre for Health Solutions, please visit: **www.deloitte.co.uk/centreforhealthsolutions**
Deloitte UK Centre for Health Solutions, 1 New Street Square, London, EC4A 3HQ

Deloitte.

Designed and produced by 368 at Deloitte. J21268_6