Public Health
England

Protecting and improving the nation's health

National Conversation on Health Inequalities

Report of event held on 25 June 2014

Mary Ward House, Tavistock Place, London

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by Lina Toleikyte, Health Equity and Place division.
For queries relating to this document, please contact: lina.toleikyte@phe.gov.uk or claire.laurent@phe.gov.uk

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Published September 2014
PHE publications gateway number: 2014345

Contents

About Public Health England 2
1. Introduction 4
Event attendance and programme 4
About this report 5
2. Summary of discussions 5
Morning session 5
Afternoon session 10
Appendix 1: full event programme 15
Appendix 2: summary of group discussions on the action to reduce health inequalities 17

1. Introduction

1.1 PHE's role is to protect and improve the public's health and reduce inequalities. In addition, action by PHE on inequalities in health is mandated through the new duty established in the Health and Social Care Act 2012 to 'have regard to the need to reduce inequalities between the people of England'. Inequalities in health are widespread across the country and can be entrenched for some parts of our society.

1.2 With the move of responsibility for public health from the NHS into local authorities there is a new opportunity for the public health system to work more effectively with local colleagues and leaders to act on those health inequalities.

1.3 To do this, the National Conversation on Health Inequalities is a programme by PHE to engage with the public in a dialogue about health inequalities and about solutions. Through this work, PHE aims to develop a common language and understanding around health inequalities and, with local partners, encourage and empower local communities to act on health inequalities.

1.4 PHE commissioned TNS-BMRB to undertake research with local communities to understand how the general public identify and describe health inequalities and to identify potential opportunities for innovation in communication and action. Further details about the research are available in section 2. The findings of the research were presented on the day of the event.

Event attendance and programme

1.5 On 25 June 2014 over 100 people attended an one-day event on the National Conversation. Participants were from a broad range of organisations including PHE, local authorities, the voluntary sector, academia and providers and commissioners of other local services (for example, the Fire and Rescue Service and clinical commissioning groups).

1.6 The full event programme is shown in Appendix 1. The event included a mixture of presentations, panel discussions, question and answer sessions and small group discussions.

About this report

1.7 This report provides the headlines from discussions at the event and a brief synopsis of each session. It is structured according to the programme. Links to presentations or key documents are provided within relevant sections.

2. Summary of discussions

Morning session

Welcome to the National Conversation – the vision: Professor Kevin Fenton, Director for Health and Wellbeing, PHE

2.1 Professor Kevin Fenton, the PHE Director for Health and Wellbeing, set the context for the day and shared PHE's commitment to address health inequalities. Health inequalities are the subject of longstanding debate and a priority for PHE.

2.2 Professor Fenton spoke about a range to work that PHE is doing to support work on health inequalities at national and local levels. He referred to the Public Health Outcomes Framework as tool to help us monitor progress on inequalities; forthcoming publications including a series of evidence reviews. Professor Fenton stressed the importance of moving the debate on health inequalities forward by strengthening partnership working between different stakeholders, followed by a debate and action at all levels informed by best practice and exchange of information.

National Conversation – first phase findings: Claire Laurent (PHE), and Ben Toombs and Daniel Clay (TNS-BMRB)

2.3 Colleagues from TNS-BMRB together with Claire Laurent (PHE) presented the findings from research that was used to initiate the National Conversation, followed by some powerful audio clips recorded at workshops with the public which illustrated individual perceptions on health inequalities.

2.4 The presentation opened with a description of the purpose of the National Conversation on health inequalities to understand the public's perception of health inequalities, to listen to their experiences and to learn what language is most useful in order to share knowledge. This would then be fed back into PHE's work and shared with colleagues and partners across the system.

About the process

2.5 TNS-BMRB had undertaken research with local communities to understand how the general public identify and describe health inequalities and to identify potential opportunities for innovation in communication and action.

2.6 Both public health stakeholders and members of the public were approached. The first stage of the research involved semi-structured qualitative interviews with 19 stakeholders – including directors of public health, lead councillors for health, and voluntary sector representatives – from across the country, focusing on five areas where TNS-BMRB held local dialogue sessions with members of the public. The areas – Hull, St Helens, Walsall, Hackney and Newquay – were selected following consultation with PHE regional centres and local authority representatives. A total of 87 members of the public took part in the process. There were also 130 respondents to a mailbox that was set up to allow other people to contribute ideas.

About the workshops

2.7 Local conversations took place in spring 2014, in the form of workshops where the same participants were invited to attend two workshops. As health inequalities are a complex issue it was decided that a deliberative approach[1] would be most appropriate for these local conversations.

2.8 In the first workshops the approach involved the facilitators providing information provision, discussion and activities in order to help participants recognise and then to describe health inequality in their local area. The information shared included intelligence on health inequality nationally and locally, information on the causes of health inequality and summarised recommendations from the 2010 Marmot review on health inequalities in England.[2]

2.9 The second workshops started with the key issues affecting communities identified in the first wave of workshops, which related to education, employment, the environment and housing, and working logically out from those to the health outcomes. Local stakeholders[3] were invited to actively

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1 Deliberative approaches offer an opportunity to discover more about a topic, consider evidence and discuss this with other people before presenting their views, as well as, allow more time for reflection, which is why deliberative approaches often involve reconvening people.
2 Fair Society, Healthy Lives (2010), the Marmot Review http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
3Stakeholder – local councillors, directors of public health, members of the clinical commissioning group and represenative from voluntary organisations.

participate and help facilitate discussion on ways in which assets could be harnessed to address some of the issues highlighted.

Summary of findings from local conversations

2.10 Through these workshops involving people from a wide variety of socioeconomic backgrounds, it was apparent that conversations around health inequality involve a number of challenges and opportunities. Participants linked the issue of inequality to income and employment rather than health and and viewed it largely as inequality of opportunity of areas affecting the quality of their lives – employment, education, and housing.

2.11 While health outcomes were linked to broader factors such as the environment and income, they were more commonly associated with unhealthy eating, levels of physical activity, smoking, alcohol and drug use. The role of the local physical and natural environment and community was the least obvious in its connection with health issues.

2.12 Inequality in relation to health was seen in terms of access and availability of health services within the community. Variations were acknowledged in the distribution of services but not in terms of inequality of health outcomes, for example local life expectancy and likelihood of people developing health conditions. Limited affordable housing and the quality and condition of available housing were believed to contribute to poor and unsafe living conditions, social isolation, lack of community integration and increased likelihood of anti-social behaviour.

2.13 There was very limited awareness of local assets (for example, support structures, local services, economic assets and cultural assets) and a lack of understanding of how these assets could be used to promote good health outcomes. The lack of a sense of community and concerns around social isolation were identified in all areas, and were a greater concern for most participants.

2.14 During the first wave of workshops TNS-BMRB provided members of the public with detail of the six actions recommended in the 2010 Marmot Review report Fair Society, Healthy Lives, to reduce the differences in outcomes between different sections of society. These included

- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
- ensure healthy standard of living for all

- create and develop healthy and sustainable places and communities
- strengthen the role and impact of ill-health prevention

2.15 For each action, TNS-BMRB shared examples (for example, giving every child the best start in life through investing in maternity services, parenting programmes, childcare and early years education), and facilitated discussion around which actions were deemed to be the most relevant to their local contexts in addressing health inequalities, taking into account preceding discussions on the causes of health and wellbeing issues.

2.16 In linking public priorities to the Marmot Review's policy objectives, there was a general consensus that health inequalities should be tackled through a combination of education and early intervention, fair employment opportunities and ensuring a healthy standard of living for all.

A Toolkit for Public Engagement on Health Inequalities: Dr Ann Marie Connolly, Director of Health Equity and Place division, PHE

2.17 Dr Ann Marie Connolly's presentation marked the launch of the National Conversation Toolkit. She described the toolkit and seven principles that are vital for public dialogue on health inequalities.

2.18 The challenge for public health colleagues is to support discussion around people's lived experiences. This means hearing about the issues that impact on people's quality of life and wellbeing, and helping people to make connections between these broader social issues and health issues in their community rather than describing health inequalities and hoping that the connections are obvious.

2.19 It is also vital to be clear about the purpose of the dialogue enabling people to consider a broad range of issues that impact (both directly and indirectly) on health and wellbeing and individual or collective ability to effect change. Stakeholders who organise, facilitate or support public dialogue can reinforce that decisions affecting health are taken at all levels, as well as, provide opportunities for inclusive processes to learn, discuss and debate as part of the dialogue. More information, including the summary of findings and the toolkit can be found on the website www.gov.uk/government/publications/health-inequalities-a-toolkit-to-support-local-conversations

2.20 PHE and TNS-BMRB have jointly produced a summary on guiding a conversation about health inequalities using seven principles of public dialogue around health inequalities in local areas.

Reflections by Professor Kevin Fenton

2.21 Professor Fenton drew together a number of themes that had emerged from the session and took initial reactions from the audience. He acknowledged the considerable amount of important work going on around public engagement. Regular and effective dialogue on health inequalities is particularly important because of the complex nature of issues involved and the differences that exist in understanding, experience, values and behaviours of people. A collaborative approach between public health, local authorities, and the voluntary and community sector is essential in continuing conversation and developing shared vision on tackling health inequalities.

2.22 The quotes from the audience illustrate some of the issues discussed and confirms continuous importance of addressing health inequalities:

“Health inequalities are not new, but the political and organisational environment that we are working within, and through, is. We have a much stronger potential to influence cross-government on a national and local level.We need to be able to understand and communicate what the overall goal is, and how each part of the wider system contributes to this (and then determine how we embed equity into each area of our work.”

“Stakeholders should be accountable for demonstrating how they proportionately/progressively invest their budget across the social gradient (Marmot's principles) for all spend.”

“Combined leadership and accountability are essential to establish what each agency or stakeholder can contribute and therefore, drive change in addressing health inequalities.”

2.23 Participants felt conversations about health inequalities with members of the public need messages that resonate with local communities and their concerns. Public dialogue should also be more actively used in local areas as part of the commissioning cycle to inform the improvements around service planning and provision and a major driver for service improvement especially among those with the greatest need.

Panel discussion

2.24 The panel was chaired by Poppy Jaman (chief executive of Mental Health First Aid England and non-executive board member, PHE). Panel members included a spread of individuals with different experiences of local public engagement including:

- Dr Helen Walters, Head of Health, Greater London Authority
- Cllr Brendan Sweeney, Barrow-in-Furness Borough Council
- Dr Michelle Harrison, CEO, TNS-BMRB
- Andrew Taylor, City Manager, Hull City Council

2.25 Questions to the panel related broadly to the need to integrate inequalities into wider agendas, harness the existing understanding of the needs and aspirations of communities and to address the challenge of competing priorities in and evolving policy climate. The panel acknowledged the shift in the political climate to focus towards individual responsibility, which can make debates on health inequalities more challenging. Despite that challenges and oppportunities to address health inequalities may be different between borough or districts councils and two-tier local authorities, colleagues at all levels should aim towards a shared vision of making health inequalities everyone's core business. Inequalities form an integral part in local strategies (at local authority level) and should be supported by local democratic processes that are transparent and adequate to ensure representation from all communities for example gypsies and travellers and other minority ethnic groups in England. Political activism at a local level could act as a key driver precipitating action on inequalities

Afternoon session

2.26 The afternoon session "Views from around the country" was chaired by Jeremy Taylor (chief executive, National Voices). There were four topic based presentations followed by a panel discussion. Facilitated discussions later in the afternoon explored the roles of the voluntary sector, local authority and PHE in taking forward the National Conversation. The panel consisted of the following speakers:

- Dr Jane Rossini (PHE centre director, Cumbria and Lancashire)
- Cllr Andy Hull (London Borough of Islington Council)
- Duncan Tree (Head of Policy, CSV)
- Professor Jennie Popay (Professor of Sociology and Public Health, University of Lancaster)

2.27 Dr Jane Rossini spoke about Health Equity North Independent Inquiry into health inequalities, which was working to identify actions to tackle or reduce long standing health inequalities experienced in the north of England , the results of which would be available later in the year. The aim of the inquiry had been to develop a range of recommendations to address the social determinants of inequalities in health. Health Equity North focused on the

experience of people living in the north of England but with recognition that the overarching impact of these inequalities and actions taken also apply to the rest of the country.

2.28 Cllr Andy Hull from Islington Borough Council presented about the Islington Fairness Commission – a commission to tackle poverty and inequality in Islington established in June 2010. The Fairness Commission provided Islington Council with an opportunity to set clarity and simplicity around poverty and inequalities agenda and enabled the council to exercise influence outside of council's authority. The commission produced a final report Closing The Gap (June 2011) with a set of 19 recommendations to make the borough a fairer place place by reducing poverty and inequality.

2.29 Duncan Tree, the head of policy at the CSV, spoke about the value of a voluntary and community sector in the current ever-changing public health climate, where he emphasised an important role CVS plays in addressing health inequalities through partnership working. Mr Tree touched on the challenges of the current economy and on adequacy of funding for CVS groups which can cause a sense of frustration and disempowerment among professionals working in this field. The presenter emphasised that voluntary and community sector should be a voice of a challenge and actively represent minority groups. He felt that a stronger collaborative approach between voluntary, community and public sector is required to deploy tools that draw on the assets that exist within communities in order to address inequalities and social change. He argued for the community and voluntary seizing opportunities to design and deliver public services and work in close partnership with public sector colleagues – but not losing their cutting edge and the very reasons that drive the sector to work with people and places that the private and public sector too often neglects.

National Conversation – the next wave

2.30 Jennie Popay (Professor of Sociology and Public Health (University of Lancaster) presented on in-depth academic research on lay understanding of health inequalities. She argued for the “wisdom of experience”, which was described as a complex responsiveness of ordinary people to the concrete situations they experience in their everyday lives. Professor Poppay stressed the importance of engaging people who experience health inequalities and whose wisdom has been neglected in reshaping problems and agenda setting. This could be achieved by improving health literacy levels among those who initiate these conversations or come into contact with people from the most disadvantaged communities. She also spoke about the creation of knowledge spaces to promote shared understanding of the health

inequalities "problem" that not only support enduring engagement, address the power imbalance between different understandings of health but also maximise opportunities for co-producing solutions.

Panel question and answer session chaired by Jeremy Taylor, chief executive of National Voices[4]

2.31 The panel agreed that developing a dialogue around social issues and health inequalities is important both at national and local levels if we are to understand people's lived experiences. Political leaders at all levels are accountable for their contributions to health inequalities agenda.

2.32 Delegates acknowledged the importance of continuing the debate and sought practical solutions to maintain and/or initiate conversations with communities. Practical tools and guidance to facilitate discussions (for example with patients or clients, local councillors and members of clinical commissioning groups) would help professionals to address inequalities in a more consistent way.

2.33 Empowering communities by involving them in meaningful conversations from the start and clearly outlining how their views will be taken into account could stimulate interest and encourage ongoing engagement. Where deliberative approaches are used, an honest discussion about resources and the issues to be decided would be helpful.

2.34 The opinions from the audience in quotes:

"This is not one conversation and they need to be different. It would be useful for PHE to reflect and segment its approach to this."

"This can be translated into action within political arena where politicians start to recognise that many of the issues the poor face are beyond their control."

Facilitated group discussions

2.35 In the afternoon the audience was divided into groups for facilitator-led discussions. The groups were asked to consider what action should be undertaken by PHE and by the voluntary and community sector nationally and by local authorities in their areas to reduce health inequalities. The discussion was structured around four core questions that are listed below

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4 National Voices is the national coalition of health and social care charities in England which focuses on strengthening the voice of patients, service users, carers, their families and the voluntary organisations that work for them.

together with the key points from the discussion. The following four questions were shared with the audience:

- who needs to be included in the conversation?
- what are the barriers that need to be overcome to achieve this action?
- continuing the National Conversation: what action is required at the local, regional and national level to take forward the conversation?
- what will success look like?

2.36 In summary, the participants felt that addressing health inequalities is everyone's responsibility and a genuine commitment to considering the health implications of a range of policies would encourage a wider range of people to understand that public health is everybody's business. Evidence based action is required at all levels of the public health system, and PHE as a systems leader and agent for change could strengthen its work with other government departments on inequalities, and challenge views where necessary. Additional discussion points are provided below:

- PHE might further develop strategic approach on reducing inequalities and outcomes
- the PHE national team and PHE centres were working to build their profile, increase their accessibility and responsiveness
- PHE and local authorities might encourage stronger links between commissioners and public health
- the independent voice of the director of public health is essential when tackling wider determinants of health
- the voluntary sector might engage commissioning support coupled with maximise local volunteering opportunities and support local champions
- the voluntary sector can be an important player in bringing people into conversations, creating social movement and providing advocacy
- strengthening the development of joint strategic needs assessments could help t to identify gaps and inform action on health inequalities
- lack of data sharing can be a barrier to joint work – PHE has a role to play with other government departments in tackling this issue across government
- PHE can promote the National Conversation in the media, strengthening the narrative on health inequalities
- good evaluation processes are necessary for capturing knowledge and experience that address health inequalities

2.37 A full summary of the group discussions is shown in Appendix 2.

2.38 Dr Ann Marie Connolly thanked the audience for a productive discussion and highlighted the value of continuing the National Conversation on health inequalities at different levels. She closed the event by thanking the delegates, speakers and members of her team for their active participation and contributions to this important agenda on health inequalities. Dr Connolly emphasised PHE's commitment to developing the next stage of National Conversation and encouraged delegates to express interest in contributing to this work.

Appendix 1: full event programme

10.15 - 10.25 Welcome and national conversation: The vision
Professor Kevin Fenton, Director of Health and Wellbeing, PHE

10.25 - 11.05 National conversation: First phase findings
Daniel Clay, Senior Associate Director, TNS-BMRB
Ben Toombs, Head of Behavioural Insight, TNS-BMRB
Claire Laurent, Public Health Manager, PHE

11.05 - 11.15 A toolkit for public engagement on health inequalities
Dr Ann Marie Connolly, Director Health Equity and Impact, PHE

11.15 - 11.25 Reflections
Professor Kevin Fenton, Director of Health and Wellbeing, PHE

11.25 - 11.40 Refreshments

11.40 - 12.15 Panel discussion
Chair: Poppy Jaman, CEO, Mental Health First Aid England; Non Executive Board Member PHE
Dr Helen Walters, Head of Health, Greater London Authority
Cllr Brendan Sweeney, Barrow-in-Furness Borough Council
Dr Michelle Harrison, CEO, TNS-BMRB
Julia Weldon, Director of Public Health, Hull City Council

12.15 - 13.00 Lunch and networking

Afternoon chair Jeremy Taylor, CEO, National Voices

13.00 - 13.35 Views from around the country
Health Equity North, Dr Jane Rossini, Centre Director, Cumbria and Lancashire, PHE
Islington Fairness Commission, Cllr Andy Hull, London Borough of Islington Council
Voluntary and community sector, Duncan Tree, Head of Policy, CSV

13.35 - 13.55 National conversation: The next wave
Prof Jennie Popay, Professor of Sociology and Public Health, University of Lancaster

13.55 - 14.20 Q&A panel session
Chair: Jeremy Taylor, CEO, National Voices
Dr Jane Rossini, Centre Director, Cumbria and Lancashire, PHE
Cllr Andy Hull, London Borough of Islington Council
Duncan Tree, Head of Policy, CSV
Prof Jennie Popay, Professor of Sociology and Public Health, University of Lancaster

14.20 - 14.35 Refreshments

14.35 - 15.30 Group discussions: Consultation on next steps
How do we take the conversation forward?
Who do we include?
What action do we need to take?
What will success look like?

15.30 - 15.50 Presentation of key points from group discussions
Dr Ann Marie Connolly, Director, Health Equity and Impact, PHE

15.50 - 16.00 Next steps and closing comments
Jeremy Taylor, CEO, National Voices
Dr Ann Marie Connolly, Director, Health Equity and Impact, PHE

Appendix 2: summary of group discussions on the action to reduce health inequalities

On 25 June 2014 PHE brought together colleagues from across public health, health services, local authority and voluntary and community sector to hear about the first phase of PHE's national conversation on health inequalities, to share learning across sectors and to consider how best to take forward the conversation in a way that could start to have an impact on health inequalities.

Groups were asked to consider what action should be taken by PHE and by the voluntary and community sector nationally and by local authorities in their areas to reduce health inequalities.

Summary of discussions

PHE is a systems leader and agent for change – for conversation and for action but it cannot do the job alone. A strategic approach with clear ambitions around inequalities would help to drive action. Nationally, it was thought that PHE might work with other government departments including Department of Health and use evidence both to highlight the impact of policy and to challenge policy where necessary. It might also consider implementing the legislation and guidance – for example the Social Values Act and the Equalities Duty to help reduce health inequalities. PHE has an important role to play in translating data and evidence for practical use – linking data to create narratives that work. There was a view that data could be more effectively translated into intelligence to enable local action. An economic case for policies that articulate the impact on the public spent would be a useful tool for professional communities.

There is a need to strengthen the links between commissioners and public health and PHE could support this work and help tie in commissioning for creative community action. Locally, it was felt that all organisations have a responsibility for public health. Strong corporate leadership is essential in driving change – fire and rescue and police all need to be involved as do small and medium enterprises (SME) and local chambers of commerce.

It was thought that PHE centres could build their profile to become more effective leaders and facilitators in the local public health system. A better engagement between voluntary sector and commissioning support would be welcomed, as well as, support for local champions and volunteering opportunities as appropriate. The importance of the joint strategic needs assessment (JSNA) in reducing health inequalities was highlighted as something that can be used to identify gaps at which public health can

direct resources or support. Delegates debated about an equity audit forming a part of the JSNA and a specific role on health inequalities for health and wellbeing boards.

What are the barriers that need to be overcome to achieve this action?

Strengthening organisational profile could help with driving actions. Ensuring that PHE centres are accessible, available and responsive for example to the voluntary sector would also help and as would smooth easy mechanisms for working with partners. The term public health does not resonate outside public health community – what about Health and Wellbeing England?

There was a view that funding is an issue across the system while plenty of resources are spent on councils and NHS. Moving out of "silo thinking" would facilitate better collaborative working among academia, professions and voluntary sector. Data sharing was identified as a barrier to reducing health inequalities and it was felt that a debate across government departments would generate solutions to this issue. A long term financial vision with mechanisms of shared or pooled budgets may contribute to improved commissioning and reduce anxiety among workforce. The VCS felt there was limited capacity to have a significant impact due to funding capacity, complexity and diversity.

Continuing the National Conversation

It is important to define PHE's remit on health inequalities and the purpose of the National Conversation. Nationally, PHE could work with the media to promote a national conversation on health inequalities, strengthening the narrative and using a range of media applications – You tube, Twitter, apps – to target audiences. PHE could facilitate conversations both at local public health system level and at a national level with emphasis on smaller groups that experience stark health inequalities. These might be resourced although finance should not restrict the engagement process.

The voluntary sector has a key role to play in advocacy, campaigning, creating social movement, listening to and representing local voices. When priorities are value based then the community should be involved in order to understand the potential trade offs that could be made. Good evaluation processes are necessary for capturing knowledge and experience that address health inequalities. The independent voice of the director of public health is vital when tackling the wider policies on health inequality. Accountability is important at all levels of the system including directors of public health and PHE.

What will success look like?

If there is a genuine commitment to considering the health implications of a range of policies across national and local government then this, together with a shared language across professional and departmental boundaries will give a clear sense that everyone regards public health as their business. If the media champions the need to reduce health inequalities and the natural focus is on the wider determinants that drive health inequalities then some progress will have been made.

It is also essential to have joined-up thinking about policy and leadership that provides stability and clarity with more inclusive and accountable ways for people in local areas, communities, and representative groups to influence local priorities.