



Office for Health
Improvement
& Disparities

The London Public Health Forum Presents:

From pandemic to syndemic: Working together to tackle health inequalities in London

Please use **#LondonPHForum** to live Tweet the event

22/06/2022

Welcome

Professor Kevin Fenton

Regional Director London, Office of Health Improvement and Disparities (OHID)

Objectives

This London Public Health Forum brings together public health leaders, practitioners and their teams from across London to:

- Reflect on progress on addressing health inequalities since the landmark study *Fair Society, Healthy Lives (The Marmot Review)*
- Identify levers and actions at regional and local level to reduce health inequalities as we emerge from the latest COVID-19 epidemic phase
- Be updated on the high priority actions being delivered by key regional partners including ADPHL, NHS, HEE, GLA and UKHSA to support a comprehensive approach to tackling health inequalities



House Keeping



Please stay on mute unless you are speaking.



Please turn your camera on if possible.



Please engage and ask questions by adding to the chat or raising your virtual hand. These will be answered at appropriate points.



This webinar will be recorded and slides will be shared after this event.



To turn your own live captions, select the three dots at top of your screen and click 'turn on live captions'

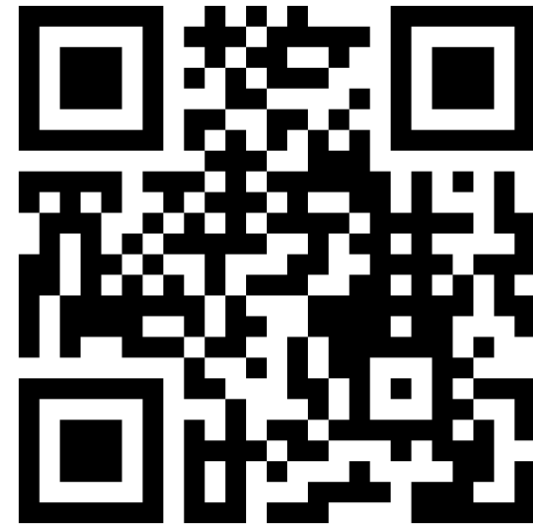
What do colleagues think public health should be doing to reduce health inequalities in the current context?

Where do we add the most value in our London systems?

Submit your answers via

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Or scan this QR code



Keynote: Sir Michael Marmot: Build back fairer

Sir Michael Marmot

Professor of Epidemiology and Public Health at University College London

Build Back Fairer

The Social Determinants of Health and Health Equity

Michael Marmot

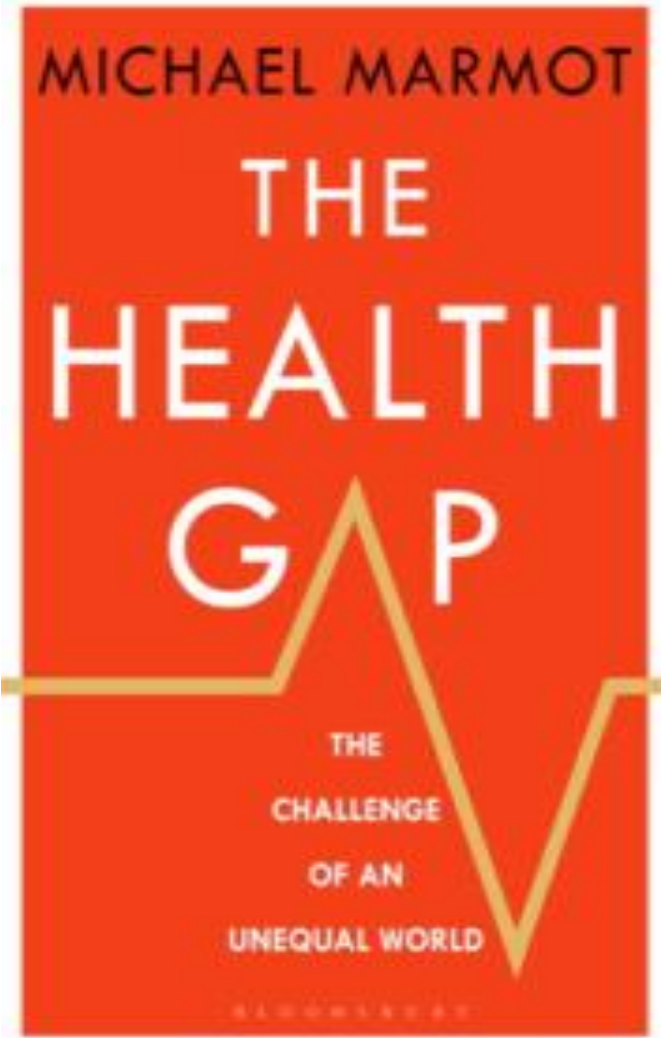
@MichaelMarmot

<http://www.instituteofhealthequity.org/about-our-work/latest-updates-from-the-institute/build-back-fairer>

The London Public Health Forum

June 2022

What good does it do to treat people and send them back to the conditions that made them sick?





Fair Society, Healthy Lives

The Marmot Review



Strategic Review of Health Inequalities
in England, post-2010

Fair Society, Healthy Lives:
6 Policy Objectives

- A. Give every child the best start in life**
- B. Enable all children, young people and adults to maximise their capabilities and have control over their lives**
- C. Create fair employment and good work for all**
- D. Ensure healthy standard of living for all**
- E. Create and develop healthy and sustainable places and communities**
- F. Strengthen the role and impact of ill health prevention**



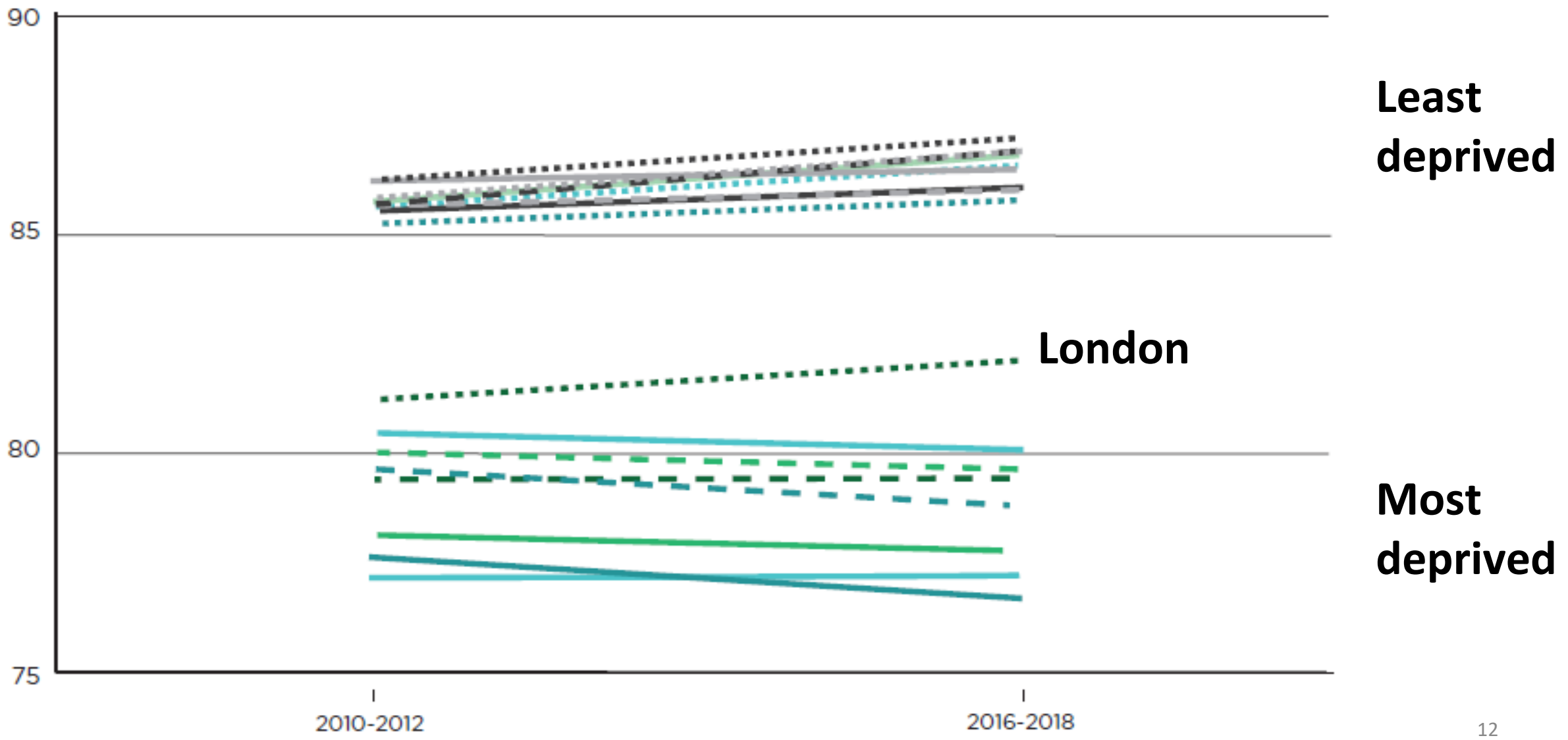


HEALTH EQUITY IN ENGLAND:
THE MARMOT REVIEW 10 YEARS ON

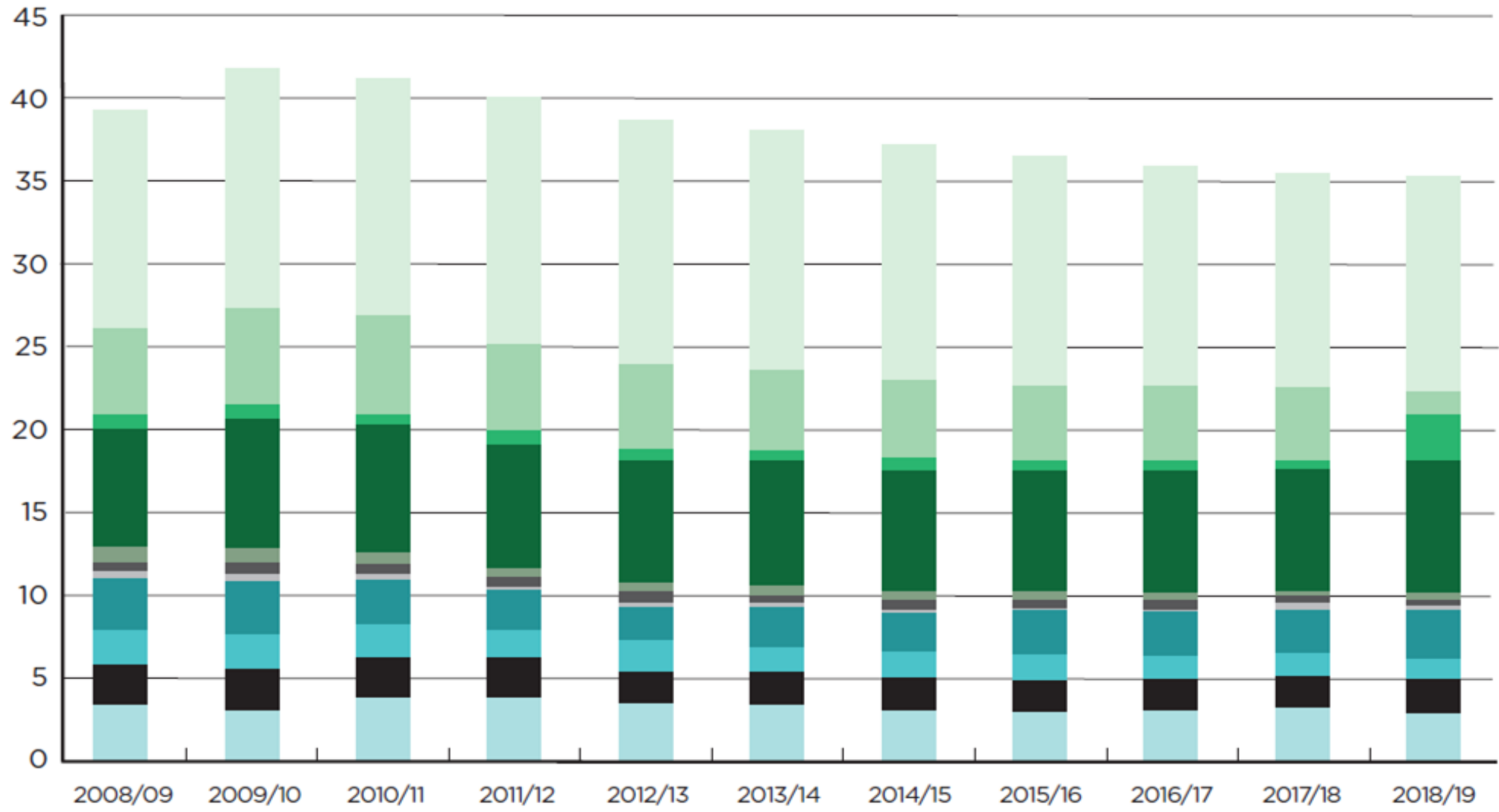
HEALTH EQUITY IN ENGLAND: THE MARMOT REVIEW 10 YEARS ON

Differences in life expectancy by deprivation widen in England's regions

Women



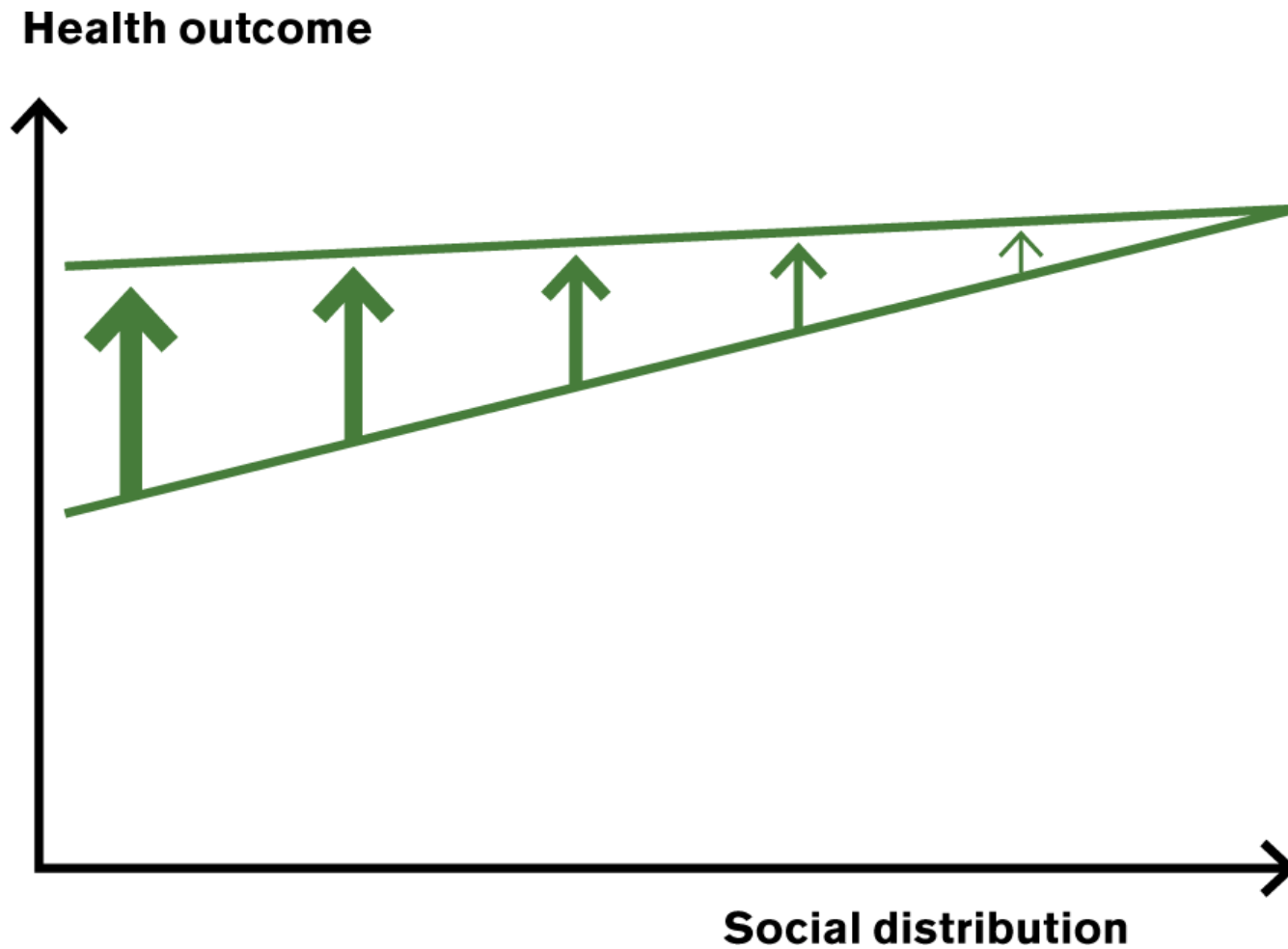
Public sector expenditure (% of GDP) declined in the UK



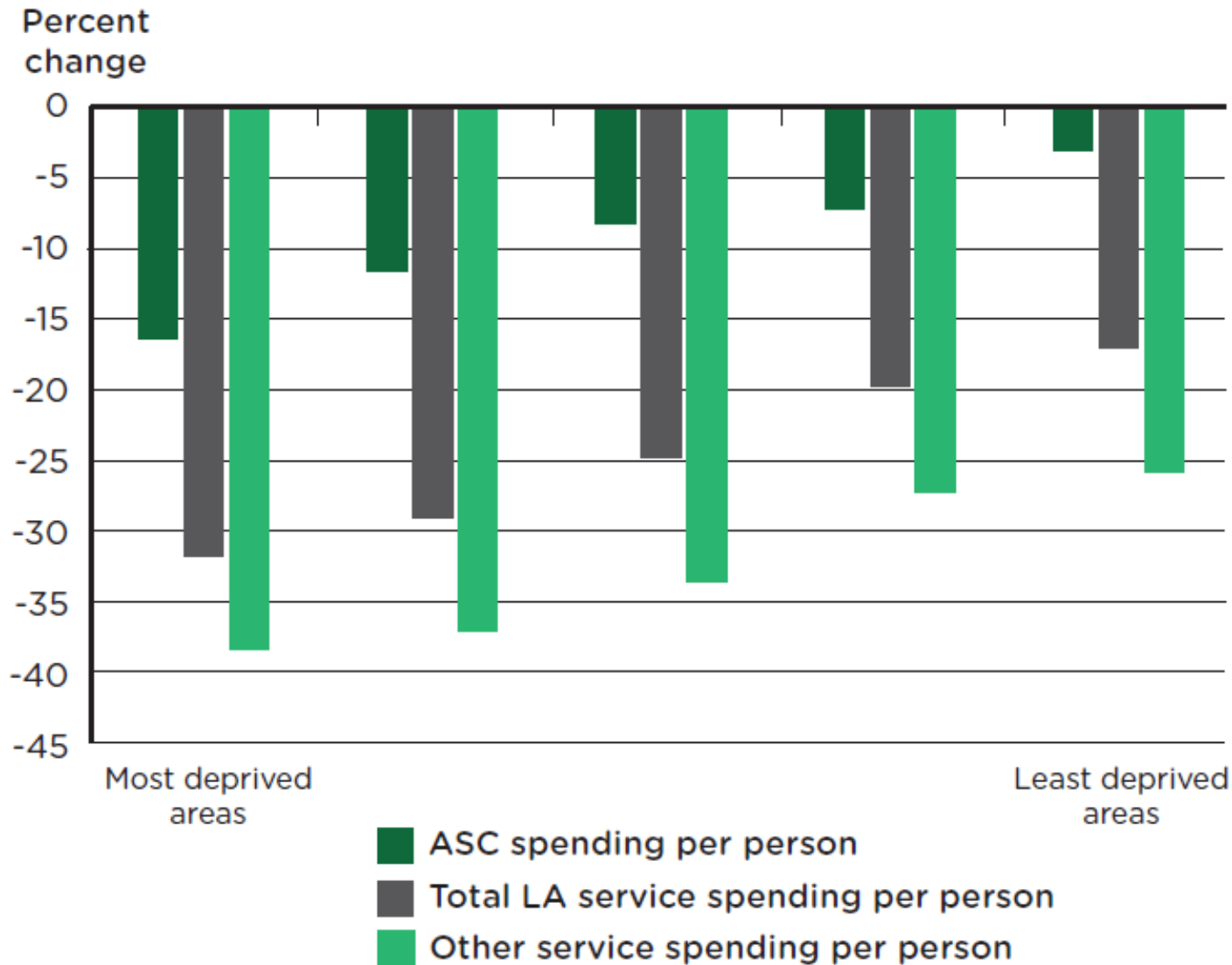
**Expenditure
by service**

Proportionate Universalism

Levelling-up the social gradient in health



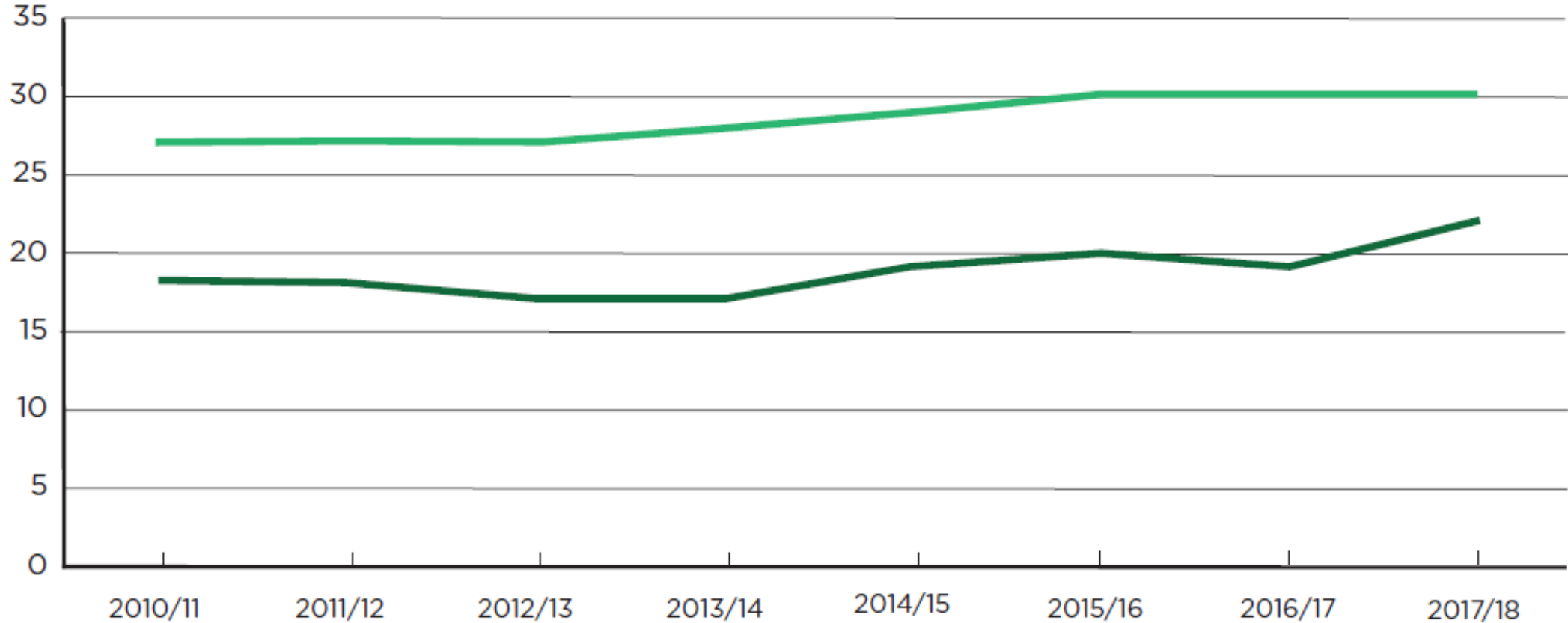
Council spending per person decreased the most in more deprived areas





Children living in poverty before and after housing costs in England

Percent of children



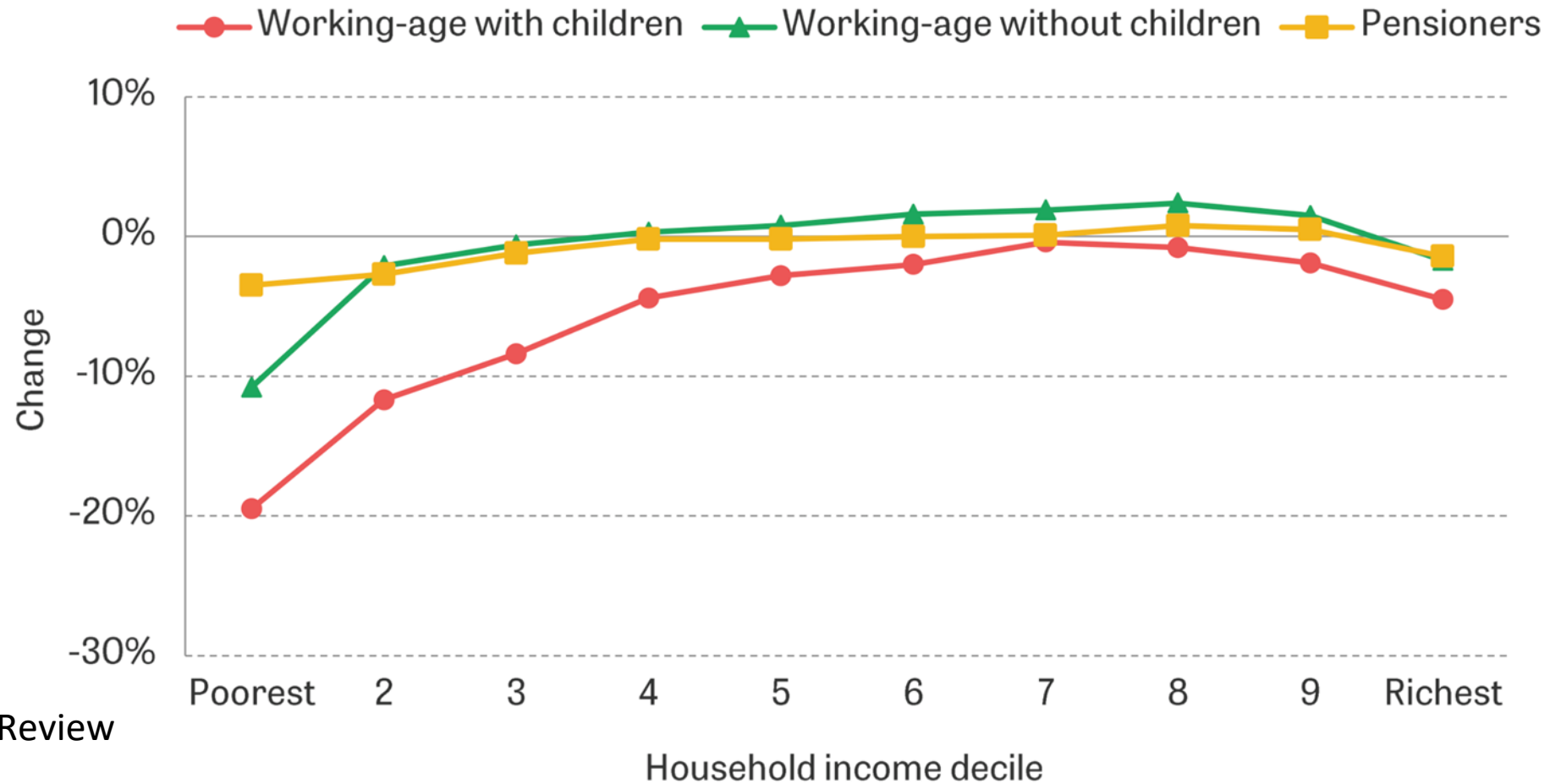
Years

After housing costs

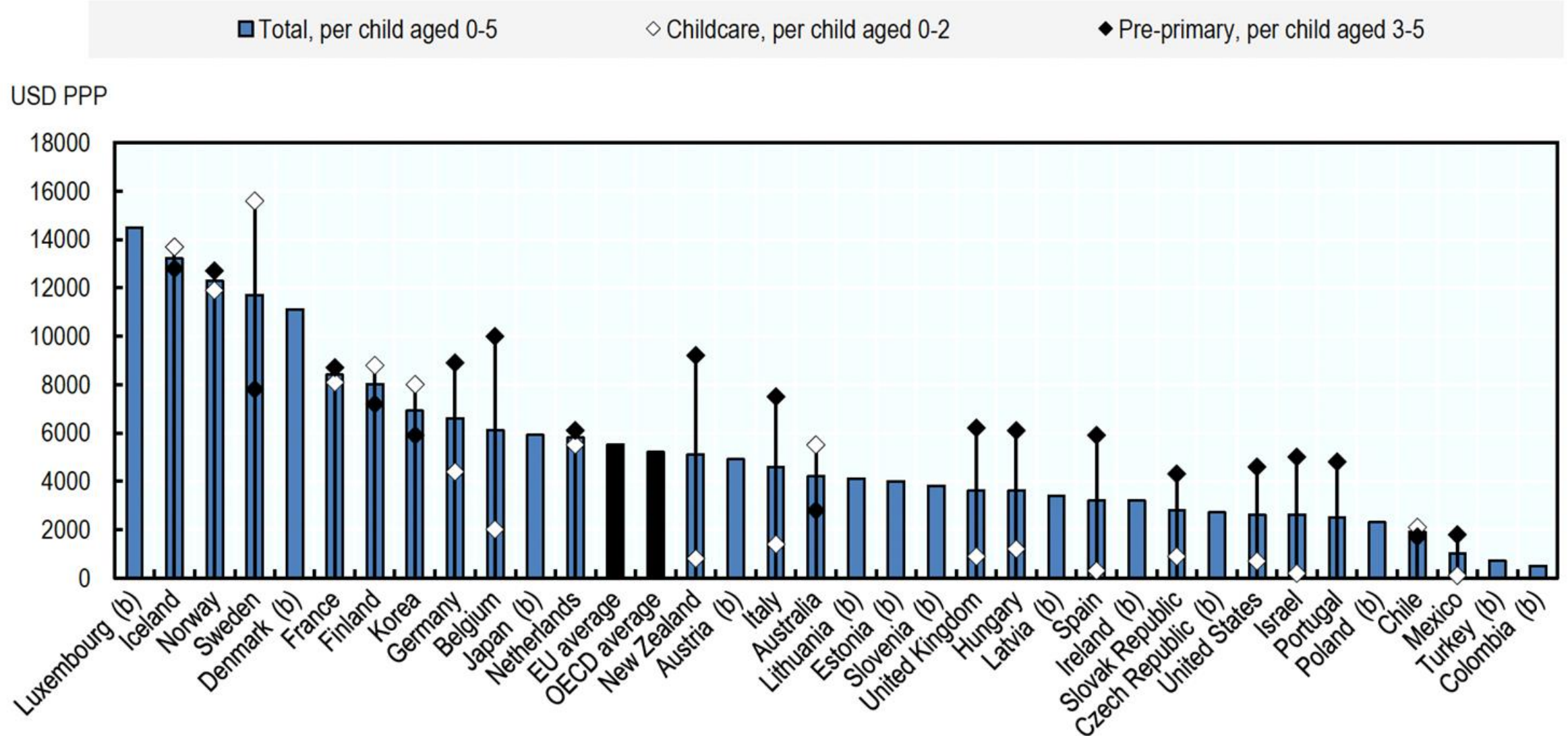
Before housing costs

The UK 2020: the poor poorer

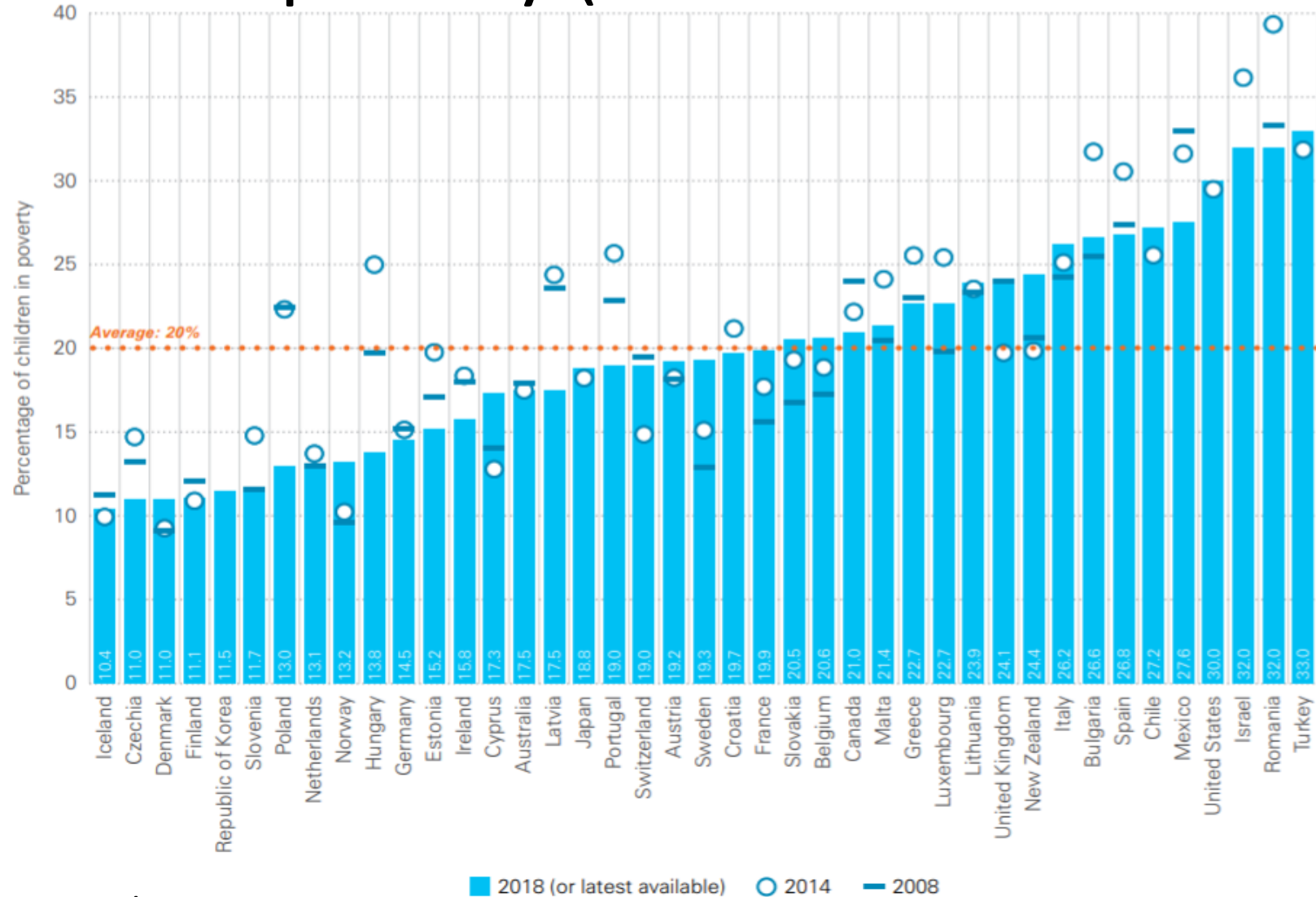
Figure 2. Change in net household incomes due to tax and benefit reforms, by income, 2010–19



Public spending early child education and care



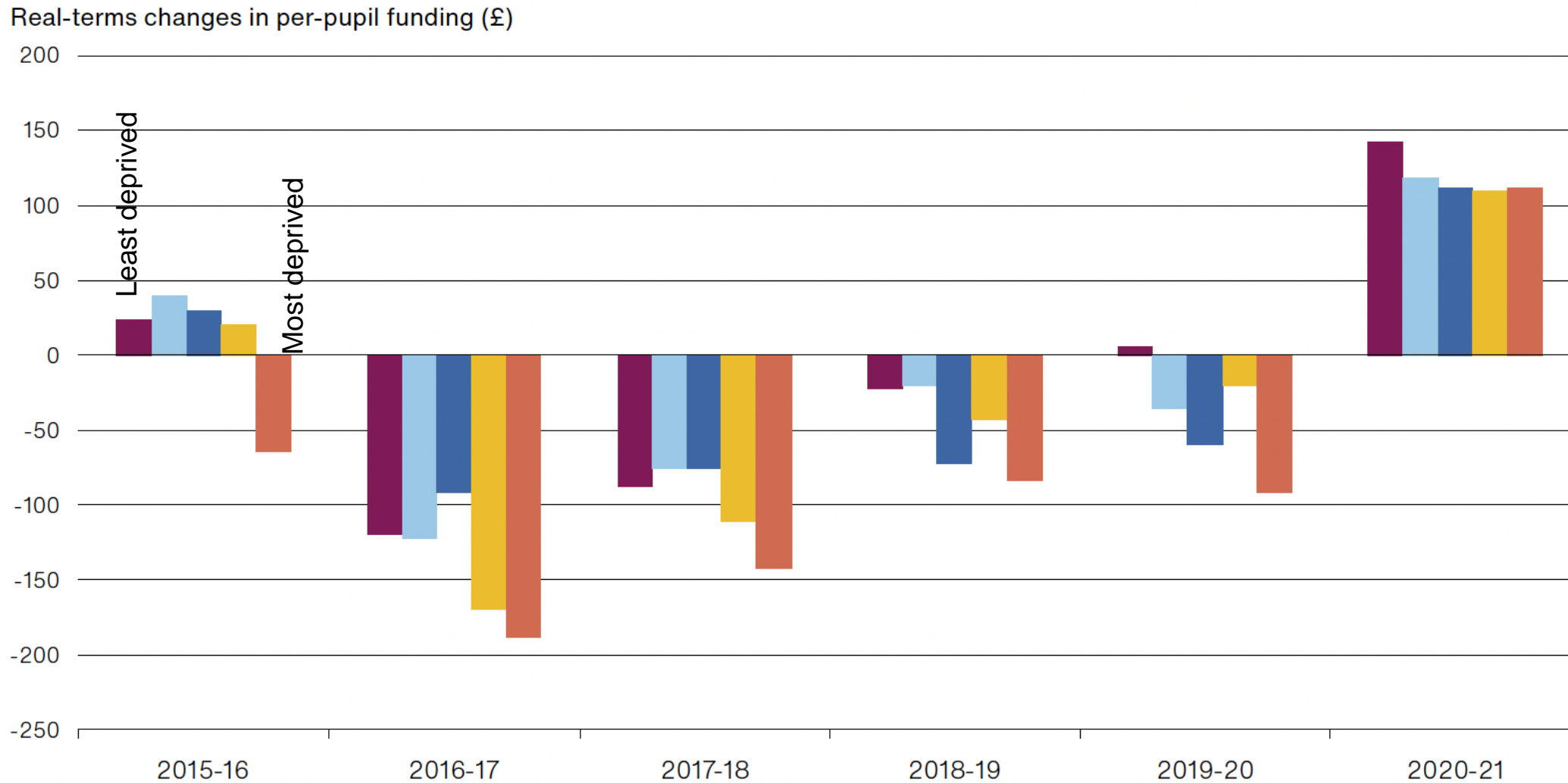
Child poverty (<60% median income)



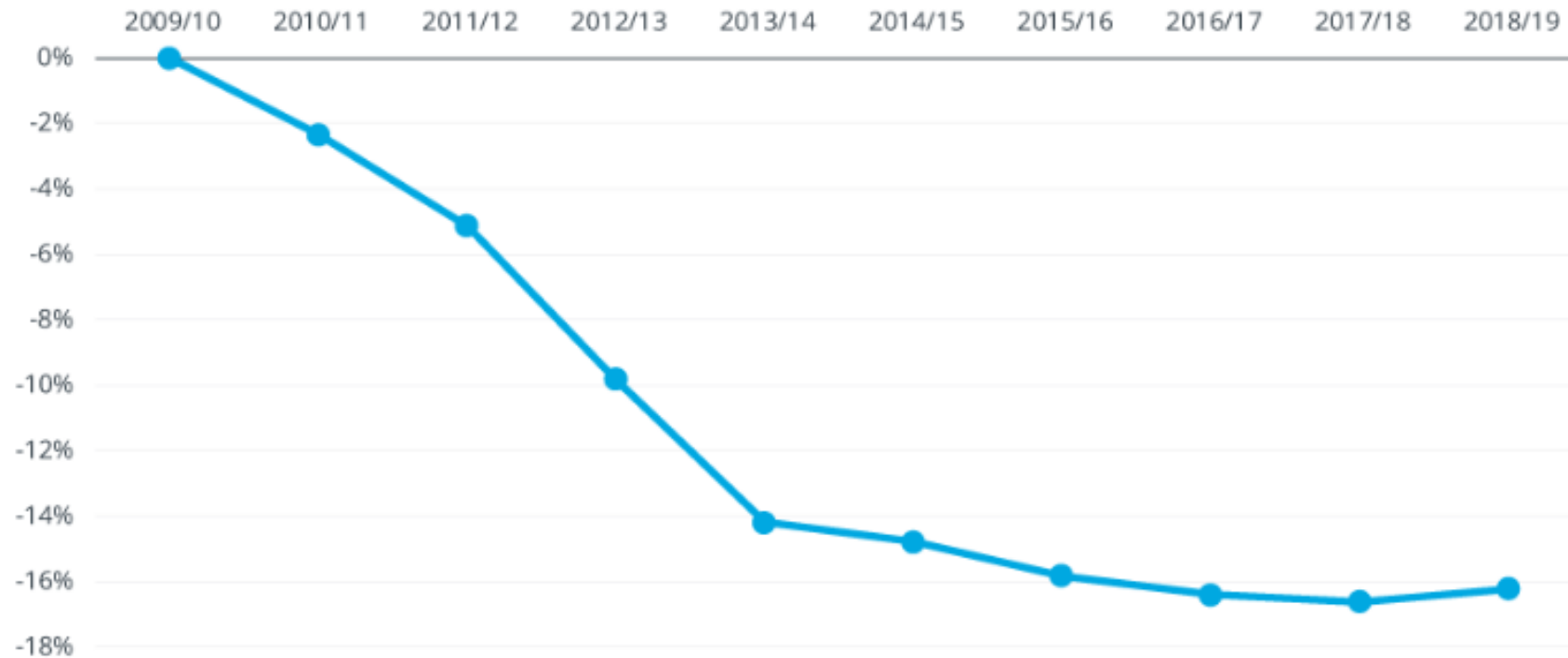
10 years of cuts to public services

Real-terms changes in per-pupil funding received by maintained schools and academy trusts, 2015-16 to 2020-21

On average, the most deprived schools had larger real-terms reductions in per-pupil funding than the least deprived schools



Change in day-to-day spending on police services in England and Wales

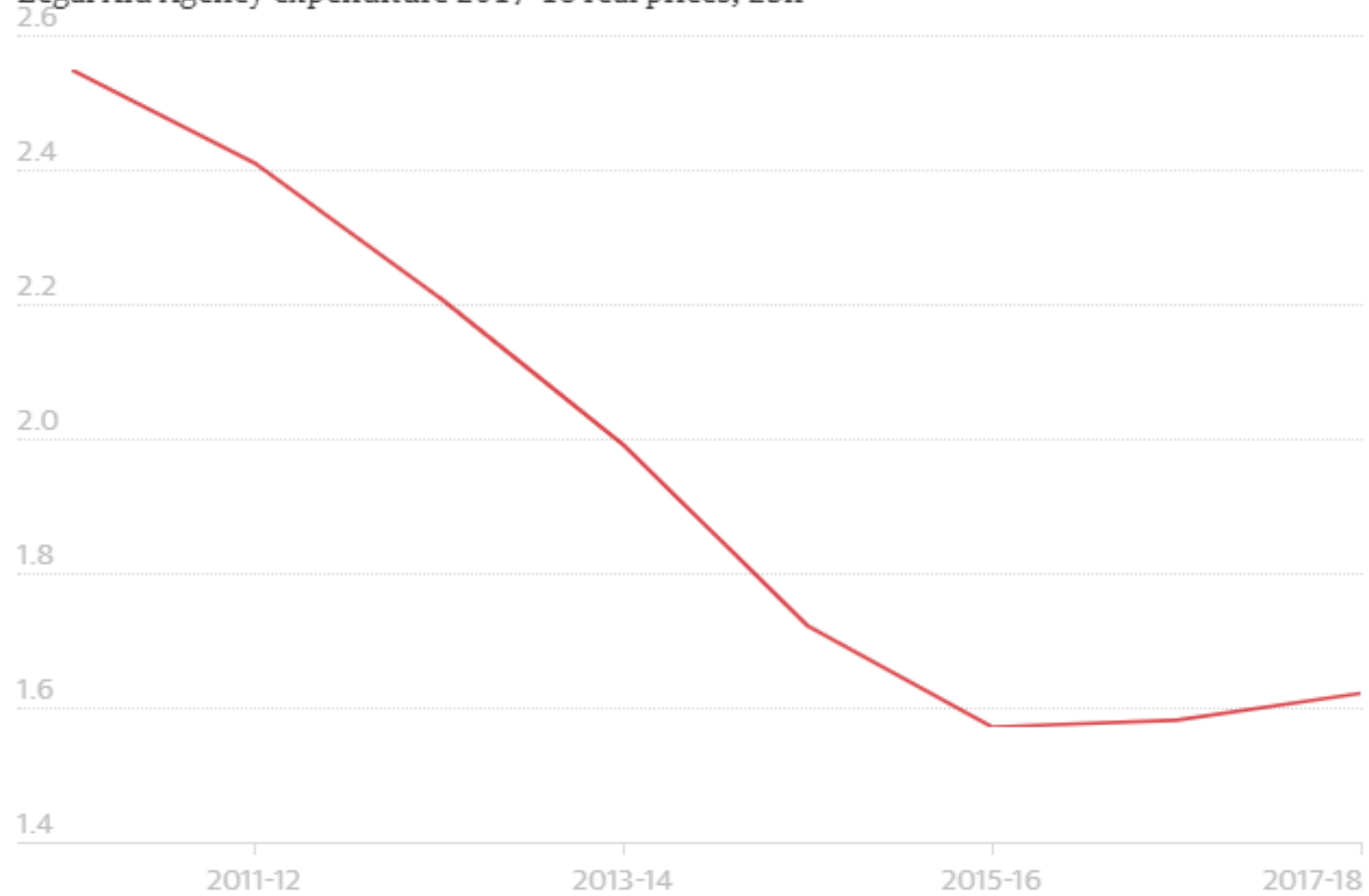



Source: Institute for Government analysis of Ministry of Housing, Communities, and Local Government, 'Local Authority Revenue Expenditure and Financing in England, individual local authority data - outturn: Revenue outturn central, protective and other services (RO6)'; StatsWales, 'Revenue outturn expenditure summary'.



Spending on legal aid fell by 37% between 2010-11 and 2017-18

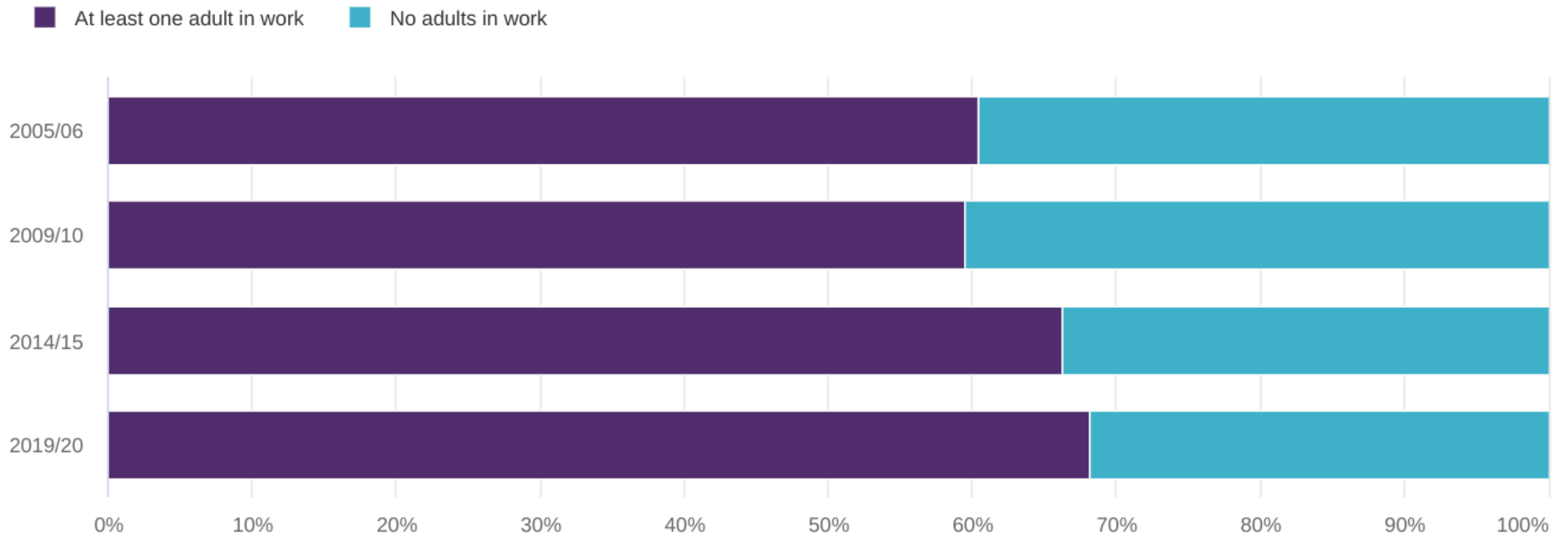
Legal Aid Agency expenditure 2017-18 real prices, £bn



Guardian Graphic | Source: House of Commons Library.

Working-age adults in working families in poverty

The percentage of working-age adults in working families in poverty is at its highest since records began

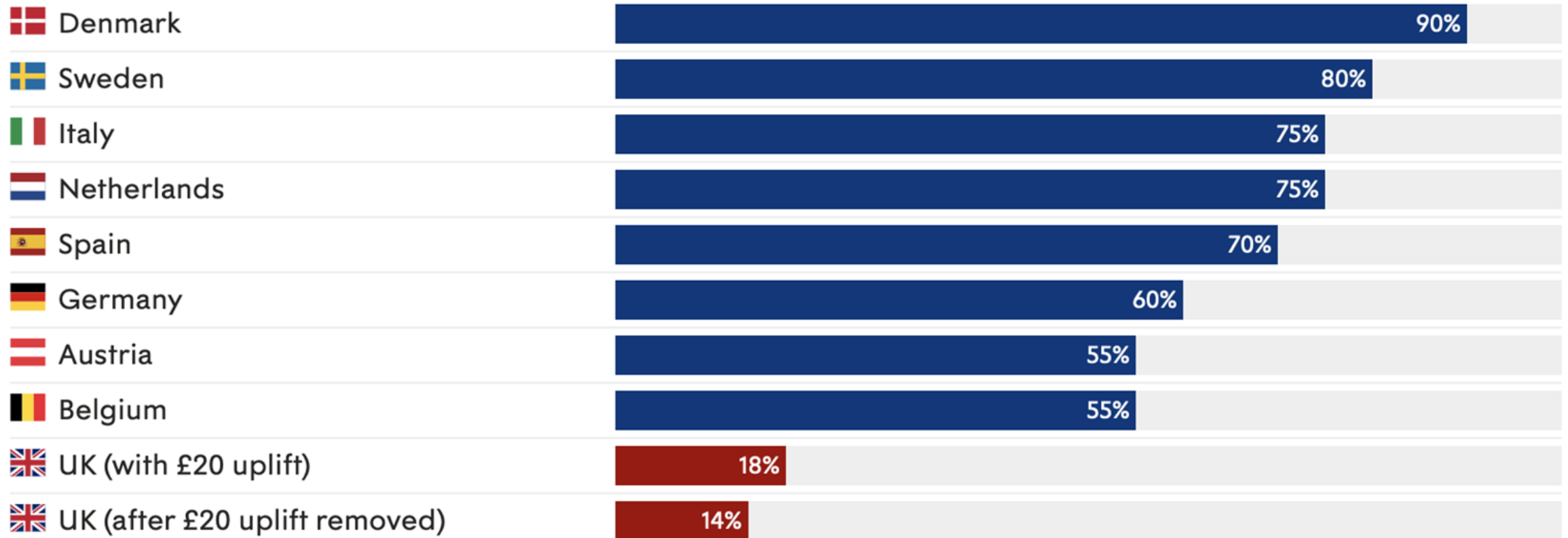


Source: *Households Below Average Income, 2019/20, DWP*

Unemployment benefits

Universal Credit is worth less than a fifth of average earnings, even with the uplift

Standard rate unemployment benefits for a single person, as a percentage of previous earning



Note: UK benefits are fixed amount, not proportional, so are shown as a percentage of average UK earnings.

Source: MISSOC • [Get the data](#)

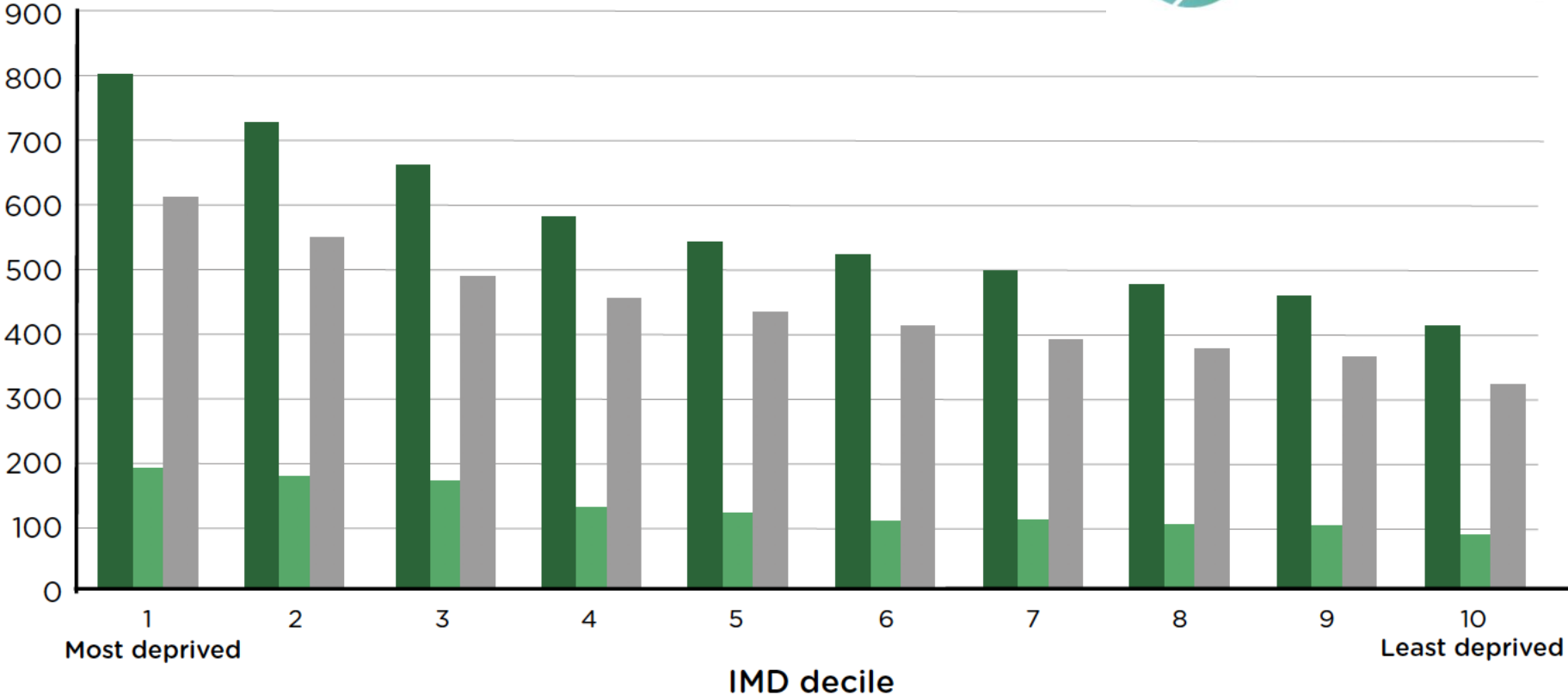
New Statesman 28 July 2021

BUILD BACK FAIRER: THE COVID-19 MARMOT REVIEW

The Pandemic,
Socioeconomic and Health
Inequalities in England



Male age-standardised mortality rates from all causes, COVID-19 and other causes (per 100,000), by deprivation deciles in England



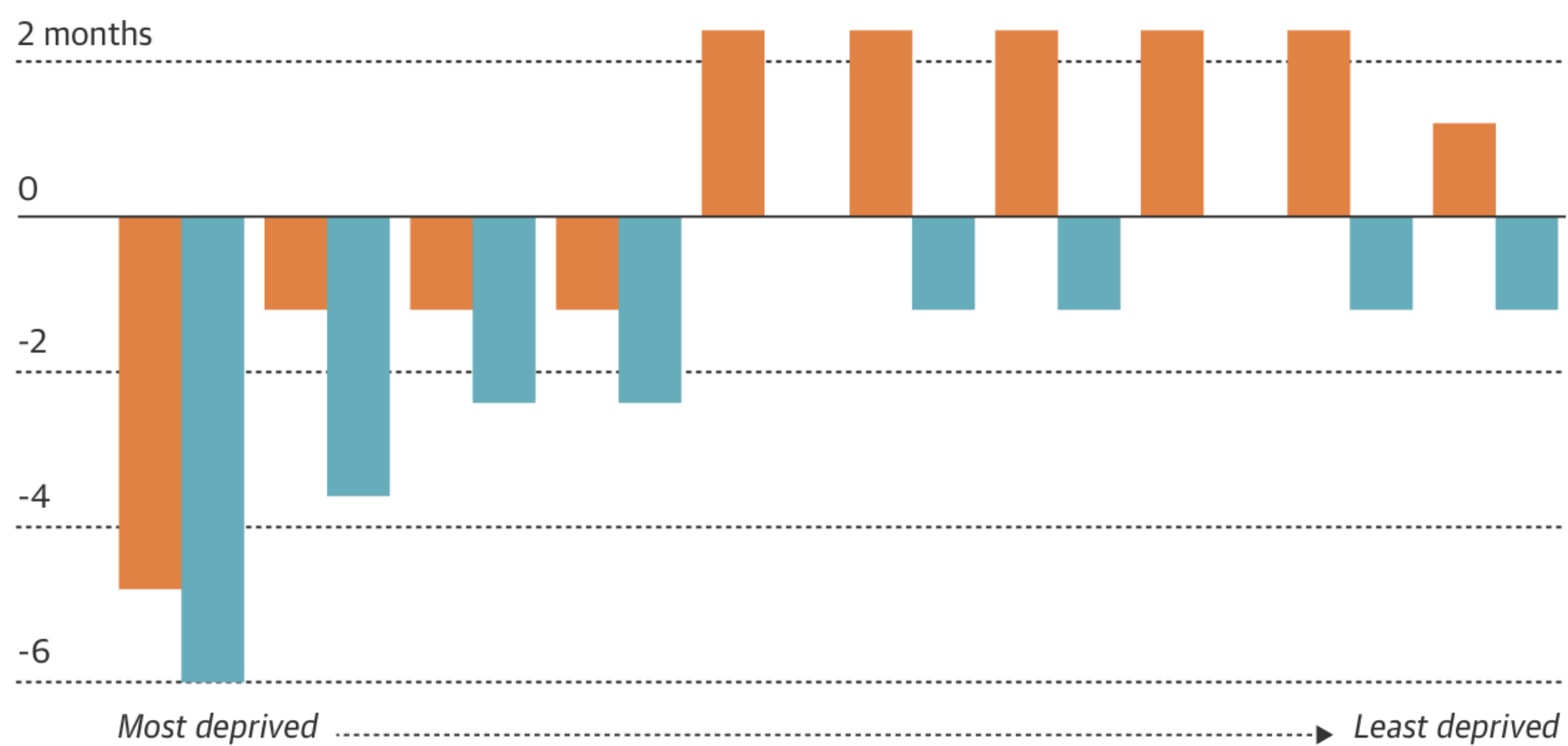
ONS. Deaths involving COVID-19 by local area and socioeconomic deprivation, 2020

■ All causes
 ■ COVID-19
 ■ Non-COVID-19

Life expectancy for men and women living in the most deprived areas of England fell significantly between 2015-17 and 2018-20

Change in life expectancy at birth

■ Females
 ■ Males

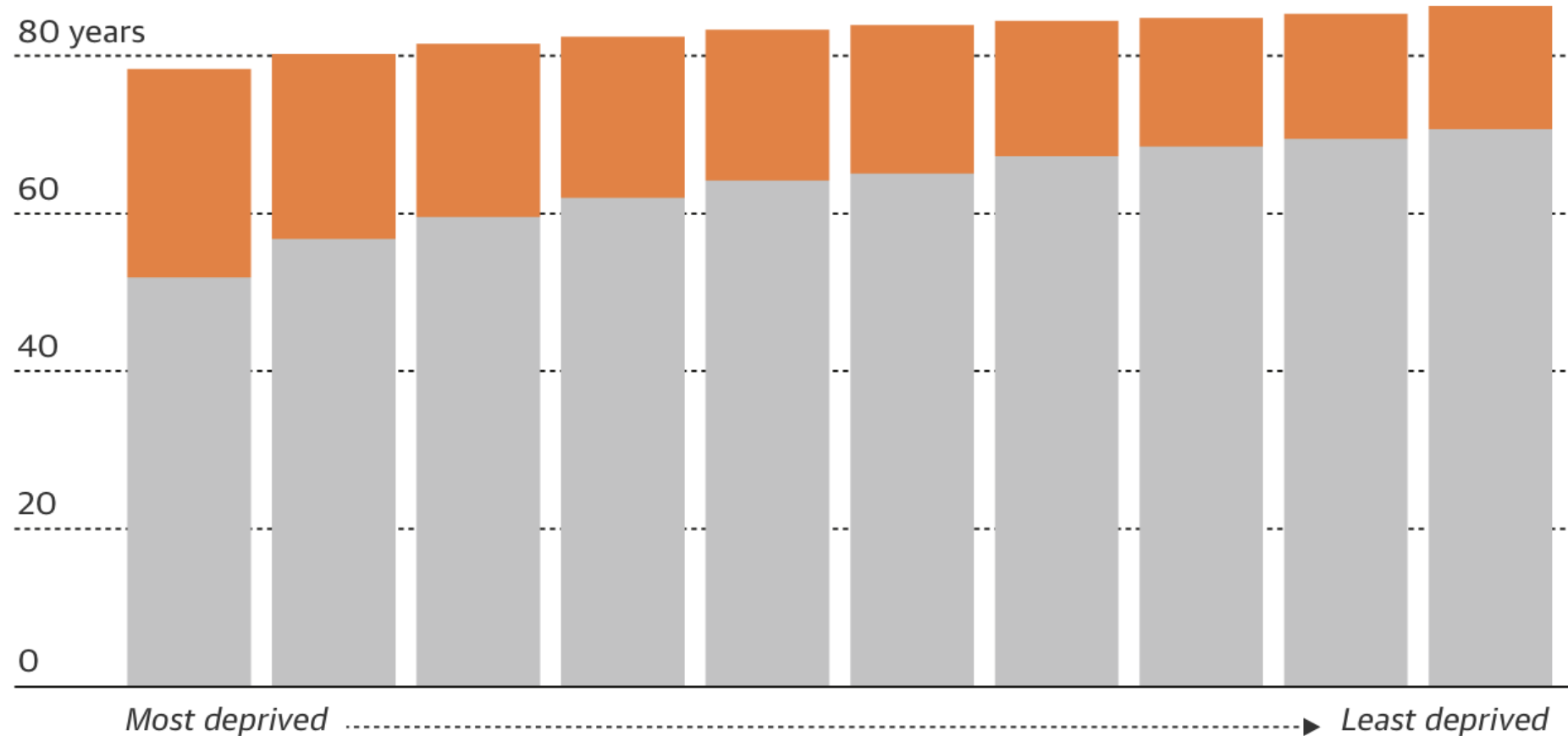


Guardian graphic. Source: ONS. Note: Deprivation deciles based on the Index of Multiple Deprivation 2019

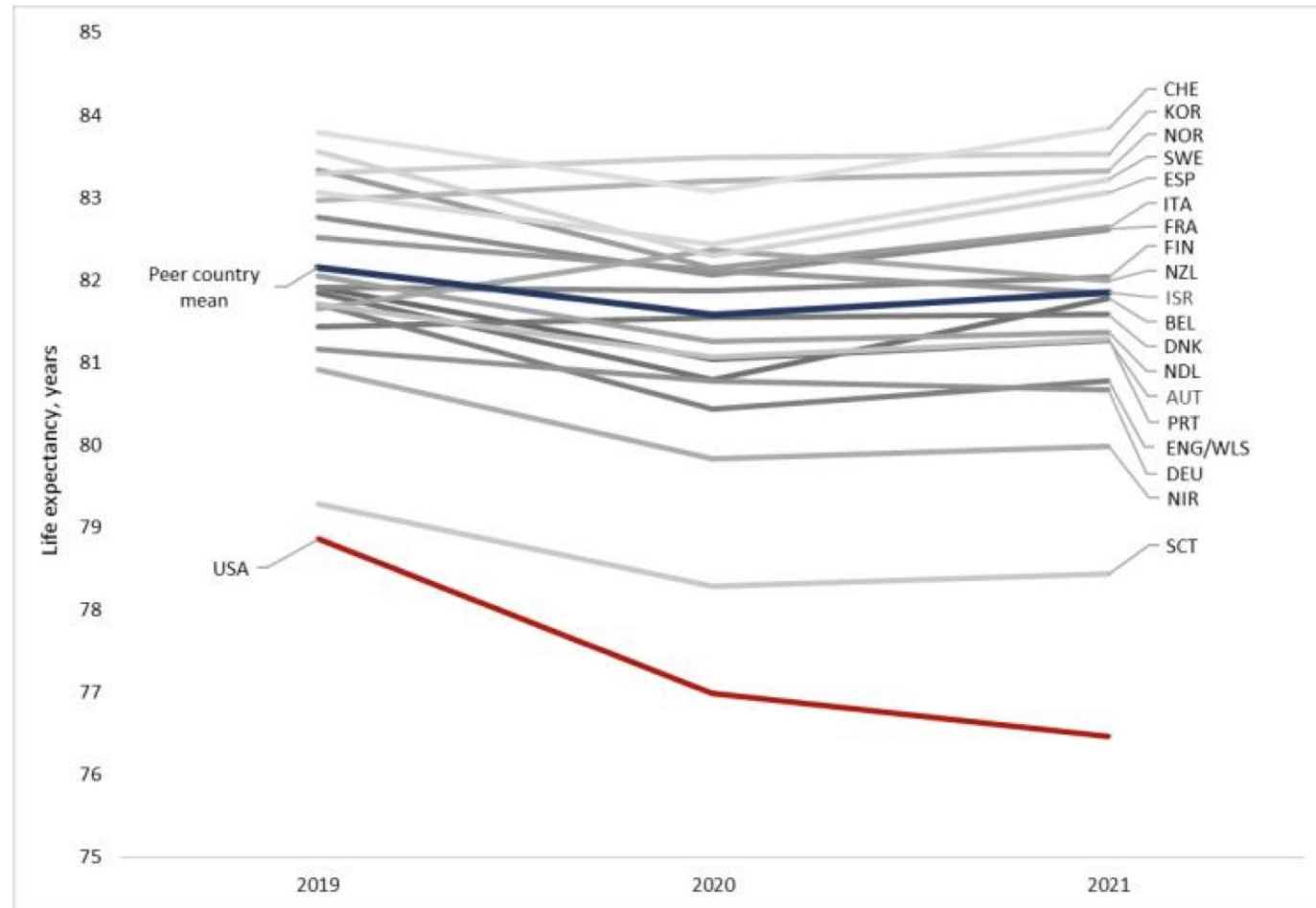
Women living in the most deprived areas of England are expected to live a third of their lives in poor general health

Healthy life expectancy at birth, England, 2018-2020

■ Good health ■ Poorer health



Change in LE, 2019-21, US and 19 peer countries



HEALTH AS A MEASURE OF SOCIETAL SUCCESS

Pre-Pandemic. LE stalling, inequalities increasing, LE for poorest people falling

Slow down in LE nearly slowest of rich countries.

Pandemic. Highest excess mortality

Link?

- Poor governance and political culture
- Social and economic inequalities increasing
- Reduction in spending on public services – we are ill-prepared
- England was unhealthy coming in to the pandemic

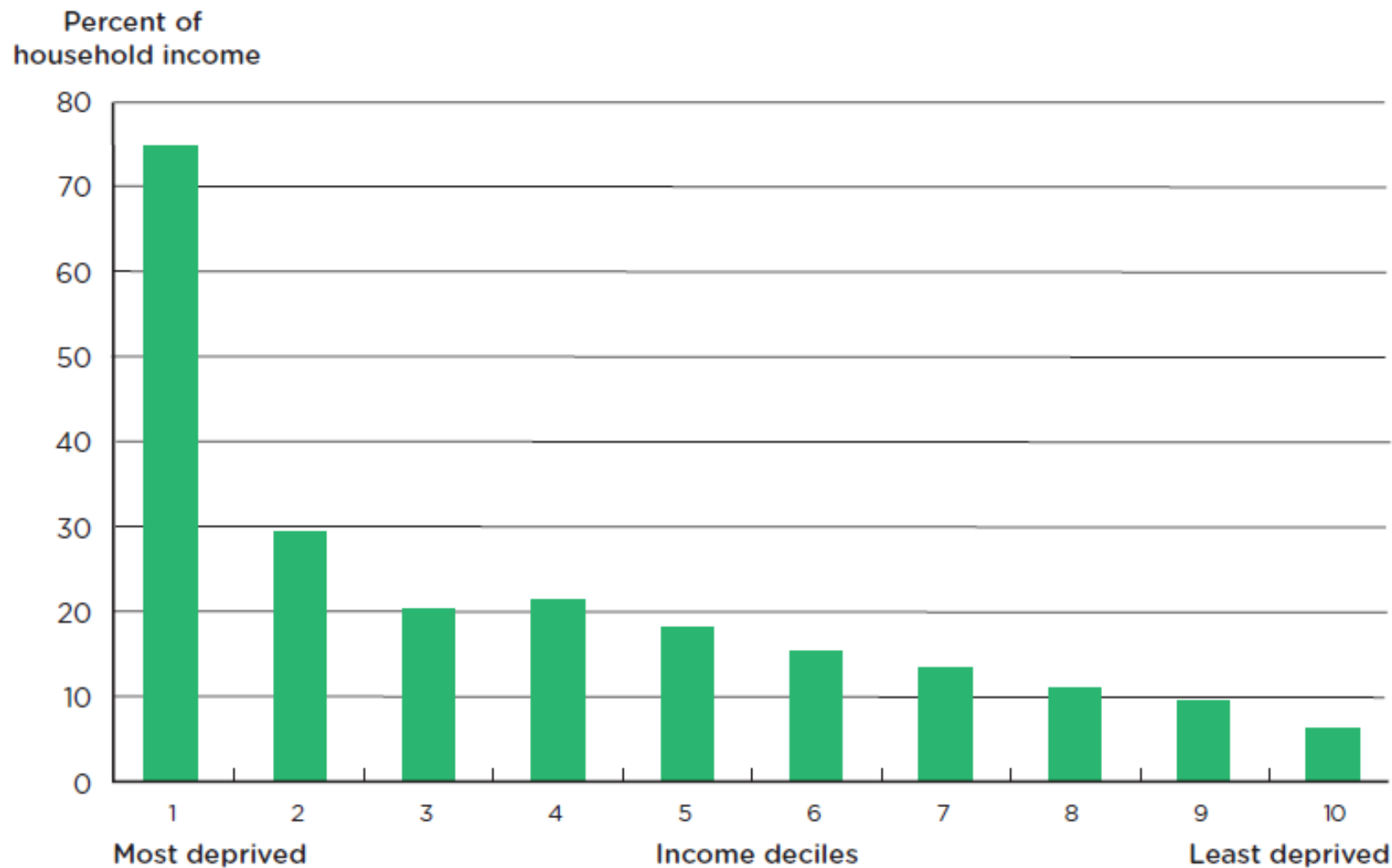
Cost of Living Crisis

- Humanitarian Calamity

Incomes 2021 to 2022 UK

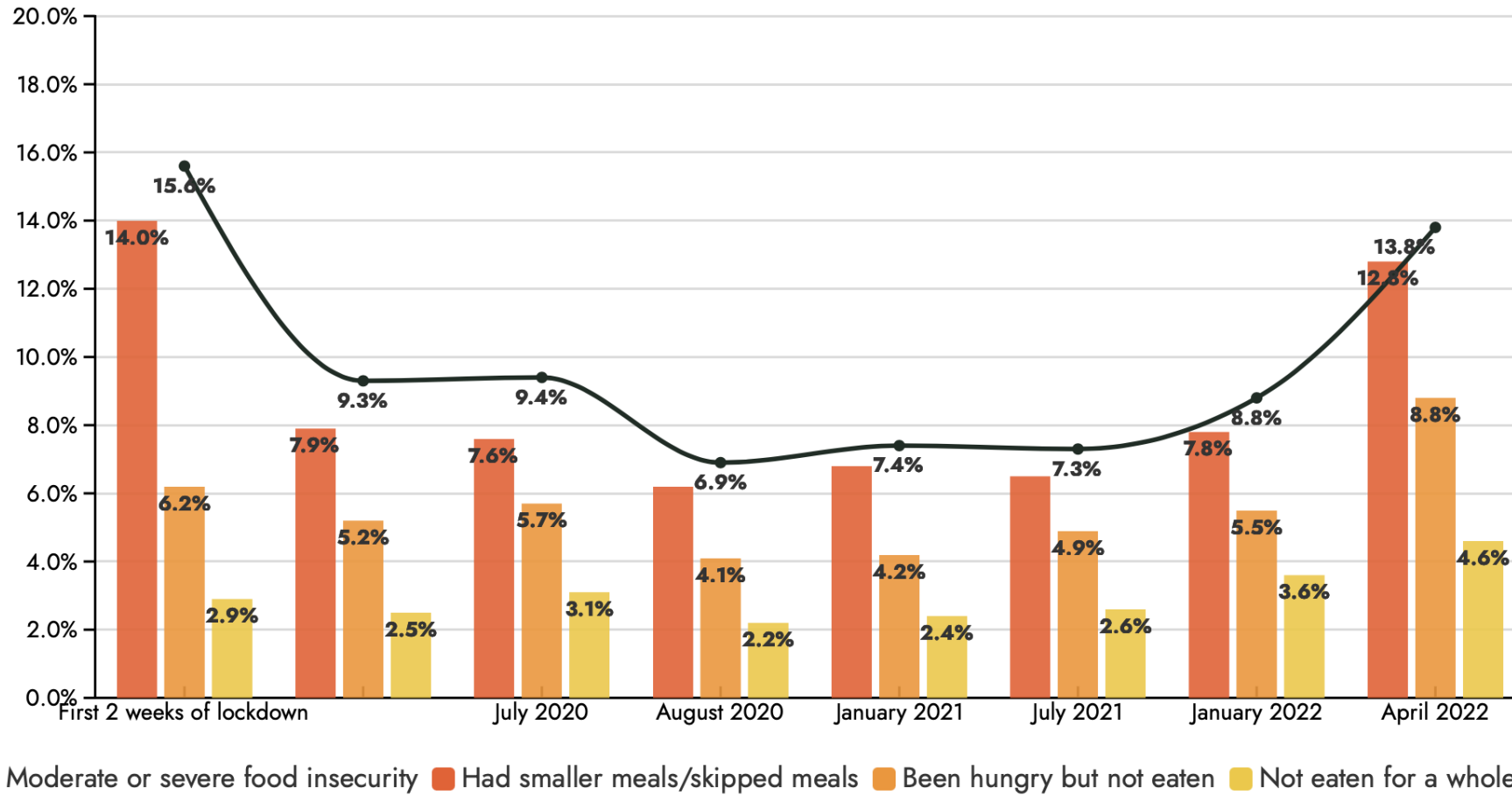
	Single person out of work	Single person, one child Working 20 hrs per week	Couple both working FT Median wage
Sept 2021 annual income	£9,054	£18,265	£38,065
End £20 p/w UC boost	-£1040	-£1040	£0
Cost of living to 09/22	-£557	-£1,198	-£2,648
Sept 2022 annual income	£7,718	£17,681	£37,672
Total real change in income	-£1,336	-£584	-£392
Total change %	-15%	-3%	-1%

The most deprived decile households would spend 75% of their disposable income to meet the NHS Eatwell Guide



13.8% of households (7.3 million adults) have experienced food insecurity in the past month

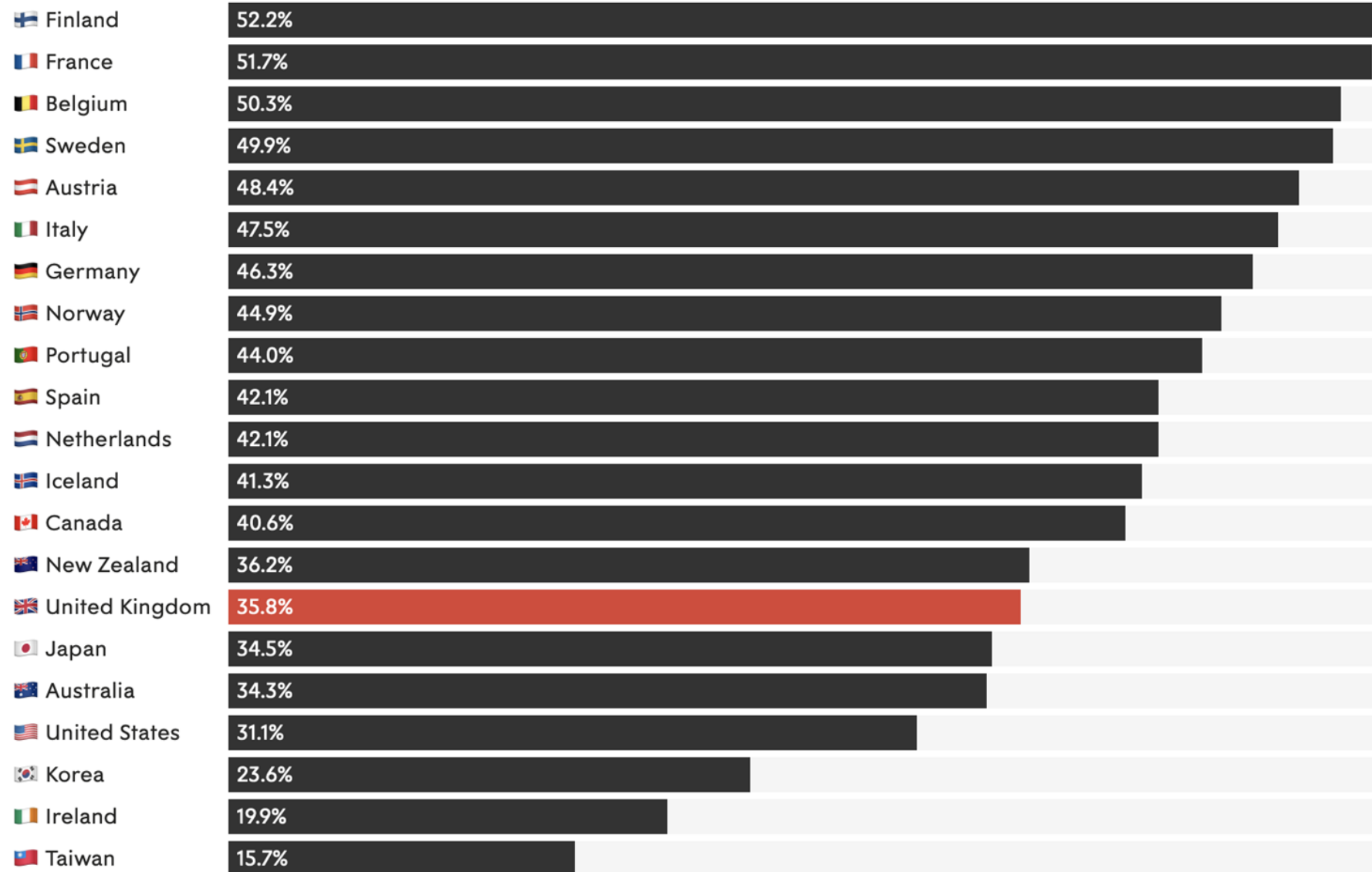
Percentage of households experiencing food insecurity*:



* 1-month recall period

Britain sits low in the league table for the tax burden

Government revenue as a percentage share of Gross Domestic Product (GDP).



‘Levelling up’ funding pales in comparison to local government austerity

- 2021 - Levelling Up Fund allocations:
 - £32 per person in the North
- 2010-2020 - Drop in annual council service spending:
 - £413 per person in the North
 - £388 per person in England

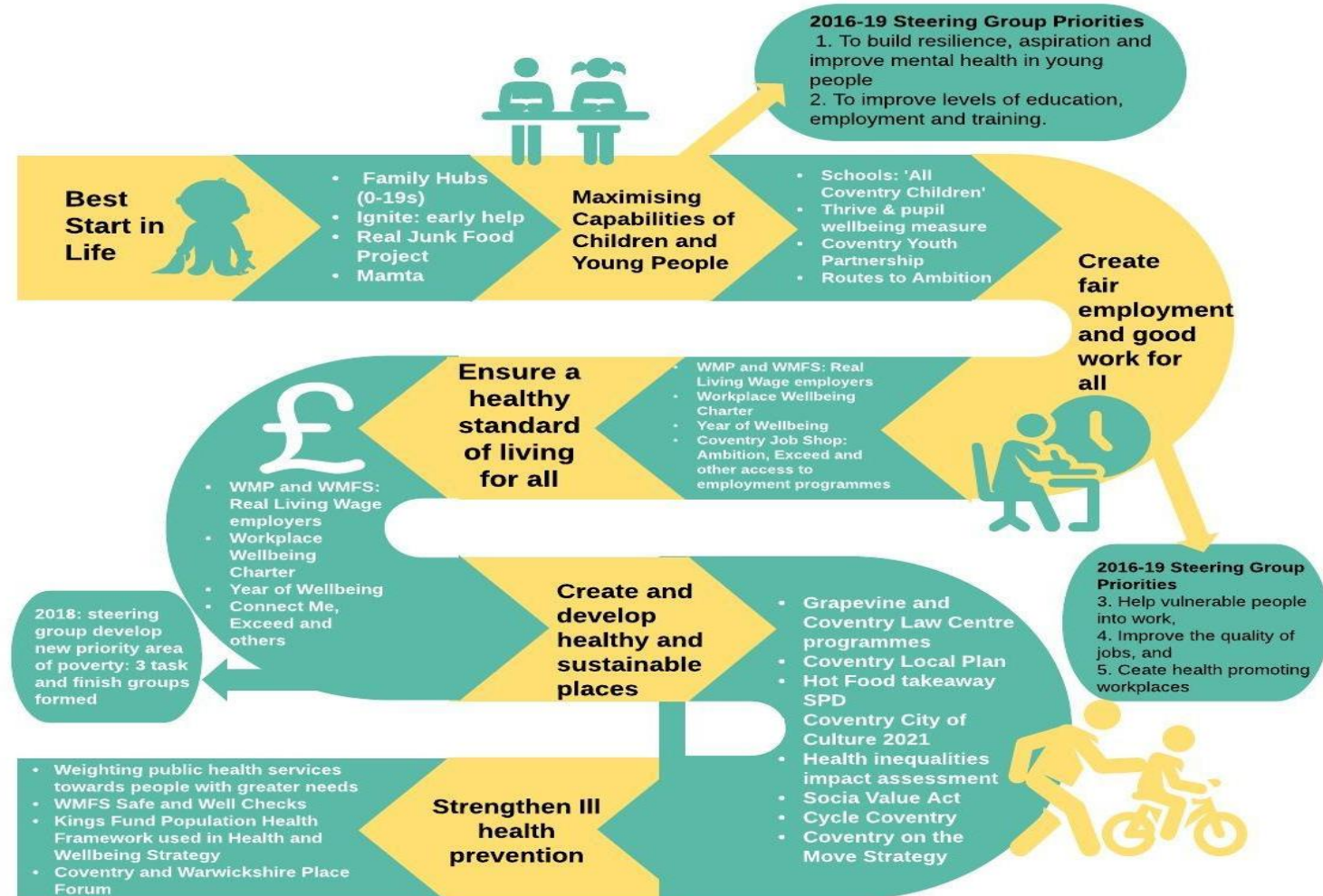


Source: IPPR North

Marmot Localities

- Coventry
- **Greater Manchester**
- Luton
- Waltham Forest
- Cheshire and Merseyside
- Lancashire and Cumbria
- Leeds
- North of Tyne
- Gwent

Coventry: A Marmot City



BUILD BACK FAIRER IN GREATER MANCHESTER: HEALTH EQUITY AND DIGNIFIED LIVES



BUILD BACK
FAIRER IN GREATER
MANCHESTER:
HEALTH EQUITY AND
DIGNIFIED LIVES

ALL TOGETHER FAIRER:
HEALTH EQUITY AND THE SOCIAL
DETERMINANTS OF HEALTH IN
CHESHIRE AND MERSEYSIDE



All together fairer

Professor Michael Marmot

@MichaelMarmot

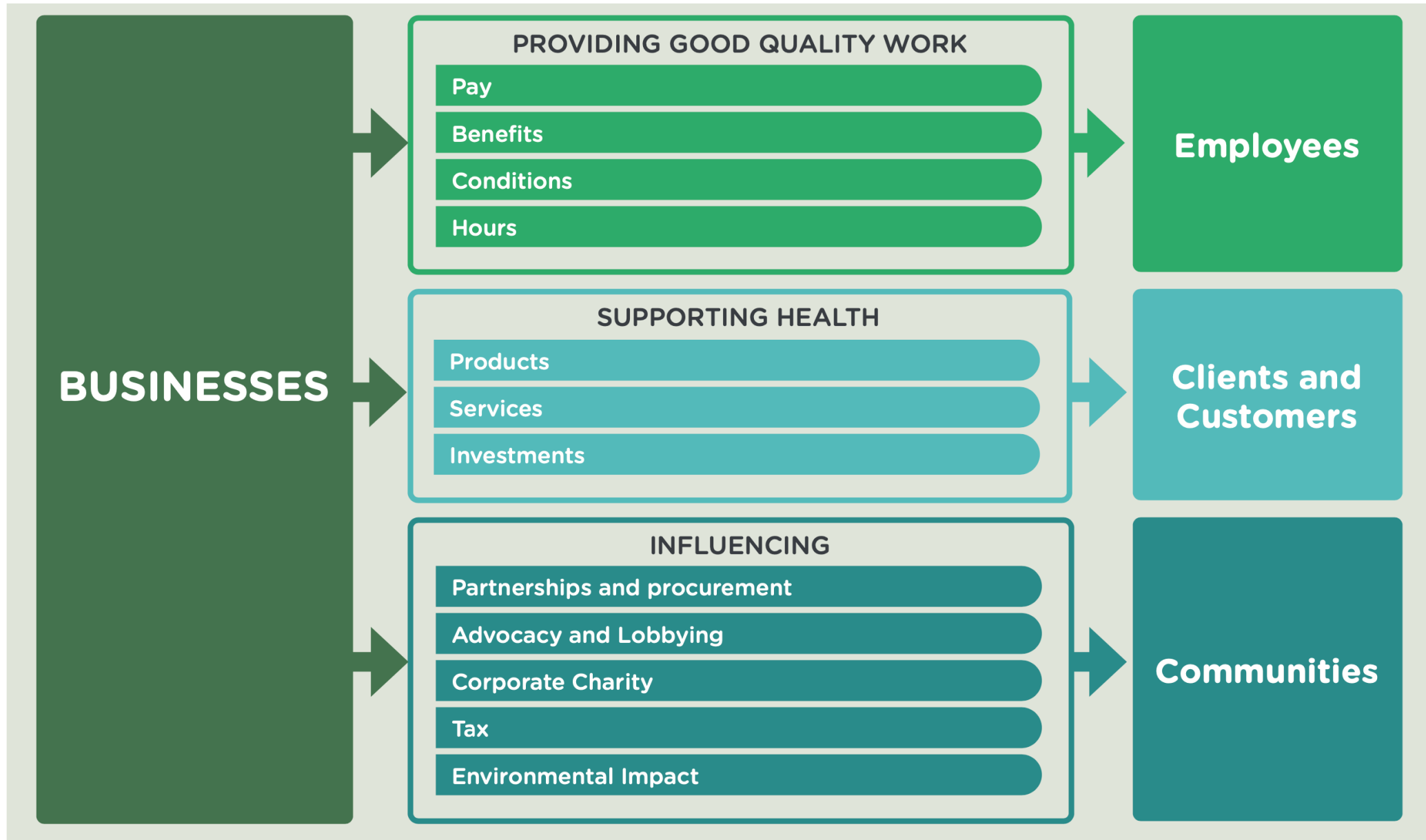
<http://www.instituteoftheequity.org>

May 2022



**THE BUSINESS OF HEALTH EQUITY:
THE MARMOT REVIEW FOR
INDUSTRY**

How businesses shape health: the IHE Framework



MARMOT PRINCIPLES

- 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**
- Tackle **discrimination, racism and their outcomes**
- Pursue **environmental sustainability and health equity together**

Recommendations

HEALTH AS A MEASURE OF SOCIETAL SUCCESS

- Poor governance and political culture
- Social and economic inequalities increasing
- Reduction in spending on public services – we are ill-prepared
- England was unhealthy coming in to the pandemic

PUT FAIR DISTRIBUTION OF HEALTH AND WELL BEING AT THE HEART OF GOVERNMENT POLICY

Question and comments from audience

Brief closing reflections



Dr Sandra Husbands
**ADPHL and DPH City of
London & London Borough
of Hackney**



Tom Rahilly
**Assistant Director for
Communities and Social
Policy, GLA**



Lizzie Smith
**Regional Director for HEE
London, National HEE EDI
Lead and NHS London
Anchor programme SRO**



Dr Shona Arora
**Interim Director of Health
Equity & Clinical
Governance, UKHSA**

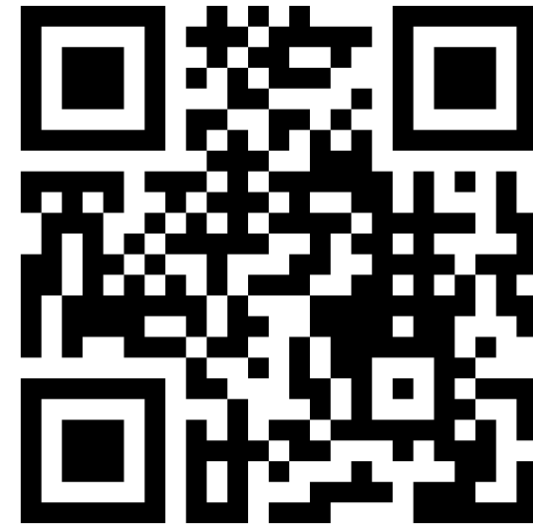
What do colleagues think public health should be doing to reduce health inequalities in the current context?

Where do we add the most value in our London systems?

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Menti Responses

(1) excellent data (2) the 'what to do' and 'how to do it' - supporting the system / ICBs with evidence and implementation support	To not be afraid to be able to talk about inequalities, to note there are disparities, and to influence stakeholders to adequately fund programmes to tackle inequalities	Focusing on a systematic response to the cost of living crisis as a significant driver of poor health
Building trust with our local communities	Listen to those affected	Use of data to target interventions and resources and in case finding
Tackle the root causes of poverty	To communicate to those who fall through gaps in terms of PH communications - we need more representatives from diverse communities in the workforce.	Collaborate with residents to find solutions to local issues.
System integration	Adding support to calls to ensure workers receive a living wage, particularly in settings where we have direct influence (e.g. NHS trusts)	Focus on addressing poverty and inequalities
Identify shared priorities across the system e.g. pre school years, racism, better use of public health workforce	Advocate for better social support - food, fuel and funds. Everything else is also important but London has the highest rates of child poverty - now up to 1 in 3 kids. 9 per classroom.	Support colleagues within LA and NHS to join up services where possible



Menti Responses (Cont.)

Address labour market inequality in london, including pay and “good work”	How can we continue to address inequalities within the context of the cost of living crisis?	Focus on the most modifiable factors in respect of health inequalities eg smoking
Engage with system-wide partners to improve joint working, identify common themes and approaches.	Be bolder and more creative in its collaboration with cross-sector partners. Could link its commissioning leverage, recruitment practice and social prescribing agenda to increase econ wellbeing	Quietly nudging NHSE back into public health so that the new system focuses / delivers PH priorities
Food co-ops, housebuilding, removing cars from our towns	Challenge the narrative of ‘selfish workers’ striking for a pay rise. Depression of wages is leading to increasing inequality and we must support legitimate industrial action	How we support people with long term conditions and disabilities
Influence our ICS partners	Have more diverse staff in senior position in organisation including UKHSA	Better cohesion of work between PH teams and academics
I think public health can reduce health inequalities by making the argument to maximise investment in early years/preventative services from the very start of life to close future inequalities	How can Public Health encourage our ICB and local CCG /PCNs invest more in a prevention approach delivered by our diverse voluntary, community and faith sector that reach the communities exp. Inequality	Addressing structural inequalities alongside ensuring sustainable and systemic interventions delivered at different levels of risk in the population and are deliver at scale
Collaboration is key both place based and at bigger footprints ie ICS and London level	Tougher stance on gambling issues	How we can support workplace health



Menti Responses (Cont.)

<p>The ICSs should be part of the conversation as they understand their own local context. Trust should be given to the VCS sector to help develop the solutions to tackle inequalities in partnership.</p>	<p>Ensure the twin challenges of health creation and service optimisation are recognised in ICS plans - especially for children and young people</p>	<p>We need a regular forum likes this to discuss the issues across PH, Local and national government and academia.</p>
<p>share what works in changing the social determinants that have most impact on health</p>	<p>Co-produce health initiatives with the community to include community voices and needs</p>	<p>Ensure that commercial determinants of health - big tobacco, food, alcohol, gambling, fossil fuels - are fully incorporated into our causal frameworks, strategies and policies</p>
<p>Providing a critical lens on commercial influences undermining public health, supporting stronger regulation e.g. advertising bans, scrutiny of partnerships with private sector in public services</p>	<p>System challenge- relentless focus on closing the gap</p>	<p>What need to be done to ensure everyone earn enough to live a healthy life</p>
<p>How we can support financial well-being for all</p>	<p>Talk to people. People are still, if not more, anxious, struggling with health issues or work concerns, energy/food bills</p>	<p>Focus on basics</p>
<p>Engage better with out social, education, environment and transport colleagues to ensure health is considered in all activities</p>	<p>Training on health protection for PH colleagues</p>	<p>Better engagement with our communities to find sustainable solutions.</p>
<p>Equal acces for all to all services</p>	<p>Joining up the dots eg impact of stigma on a number of PH challenges</p>	<p>Making every contact count</p>



Menti Responses (Cont.)

OHID to explicitly undertake to address modifying wider determinants in all its future strategies and to have cross party long term regular parliamentary accountability for these modifications.	Strengthening the links between health protection and improvement / prevention in the ICB footprint - rebuilding and improving what has been damaged	Ensure community leaders/gatekeepers are central to work and that people with a lived-experience have various routes to becoming community champions
support families and young people to understand the systems that support them - access to benefits, education, skills, literacy and numeracy.	Continue to use our voice and evidence to influence government and local government to tackle health inequalities cross-government on all the wider determinants	Ensure good data and provide quality insights across systems
Engage in dialogue with the public and listen to their responses. Develop a real understanding of the life circumstances of target gps & take action to address their health impacts.	Data - need v granular inequalities data triangulated with qualitative data - esp given the impact of gentrification on masking very local inequalities	Present reports that explain how resources are better spent to tackle those health inequalities in the form of an action plan for all levels of healthcare.
Applying pressure where possible to tackle poverty and I equalities	working with partners in the system (e.g. ICS) influencing. Advocating for population health approach	
Work better/more collaboratively with (and driving investment into) the voluntary and community sector	Challenge health and care services to look beyond equality of access	
Maximising every contact with best practiced data	Engaging with and supporting the CAVS.	



Session Close

Professor Kevin Fenton

Regional Director London, Office of Health Improvement and Disparities (OHID)

Please complete our evaluation form -

<https://forms.office.com/r/wKfuPvVTnv>





FACULTY OF
PUBLIC HEALTH

London Members Board Meeting of the Faculty of Public Health

22 June 2022

Dr Catherine Mbema

Director of Public Health Lewisham & FPH London Board Rep

www.fph.org.uk



FACULTY OF
PUBLIC HEALTH

Welcome from Prof. Kevin Fenton & Dr Catherine Mbema

What has worked well in your FPH members sessions to date?

What else would you like to see in these meetings going forward?

Submit your answers via

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FACULTY OF
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FPH Key Updates



FACULTY OF
PUBLIC HEALTH

Welcome by the President
Prof. Maggie Rae



FACULTY OF
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Changes to the FPH Continuous Professional Development (CPD) scheme

22 June 2022

Eva Hrobonova, FPH CPD Adviser - London

www.fph.org.uk

Previous CPD requirements and framework

- Submit CPD return through the online diary by 30 April each year
- Record CPD activities representing at least 50 hours of learning in each year regardless of full time / part time status
 - Requirement of 15 hours of CPD for practitioner members
- Provide structured reflection covering all those activities / hours logged
- 10% of submissions selected for audit, which might be multi-stage depending on the standard of the submission
- Selection for audit requires further documentation to be submitted
- All members reaching required standard deemed to be in good standing

Why is the CPD policy changing?



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PUBLIC HEALTH

The Faculty's CPD scheme was seen as good practice for many years with a good compliance from members. But CPD must be supportive and be seen to benefit not to burden members. Concerns raised about the current scheme included:

- Too much emphasis placed on counting credits (50 points seen as an arbitrary standard)
- Reflective notes often written to meet the credit requirement with no real benefit to members
- CPD audit perceived as a pass/fail assessment without support for members to improve
- The audit process placed unnecessary stress on members already under pressure
- Suspension of formal requirements during the pandemic –
a chance for the Faculty to reflect on CPD requirements

The new policy direction

The changes to the policy therefore focus on:

- Emphasising and supporting reflective learning and personal development - FPH has a responsibility to support and encourage the development of members as reflective practitioners
- More focus on writing good quality reflective notes that are linked to PDPs and therefore professional appraisal - a better standard for CPD than one based on a specific number of CPD credits
- Non-judgemental and supportive feedback to support the development of members as reflective practitioners

Development of new policy

- Drafting of framework by Faculty's CPD committee
- Consultation with local members through:
 - CPD advisers
 - Local Board Members
 - Faculty Advisers
- Engaging with members, Faculty Officers and Board



Summary of key changes to CPD

- ✓ Maintain a summary of personal development plan (PDP) in CPD diary (no change)
- ✓ Submission of annual CPD return by 30 April each year (no change)
- ✓ Submit a minimum of 3 and maximum of 6 reflective notes each year – no need to record credits
- ✓ Each reflective note submitted should be linked to one or more PDP objective (no change)
- ✓ The annual CPD audit is replaced by an ‘advisory review’ of randomly selected submissions
- ✓ The selected members will receive individual feedback on how they might improve
- ✓ There is no ‘pass or fail’ outcome, no need to provide any additional information
- ✓ All members can seek guidance/support from local CPD adviser (if they wish)
- ✓ **Members to focus on good quality reflection rather than points**

Timelines



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Milestone	Timing
Normal CPD expectations suspended	March 2020 – March 2022
Development of new CPD policy	August 2021 – January 2022
Launch of new CPD policy and CPD formally resumes	1 April 2022
Deadline for submitting CPD returns for current CPD cycle (2021/22)	30 April 2022
Development, testing and data migration of new CPD diary	September 2022 – February 2023
Launch of new CPD diary based within the Faculty members' portal	April 2023
Deadline for submitting CPD returns for upcoming CPD cycle (2022/23)	30 April 2023
New annual review process for members making CPD submissions	May 2023

Additionally.....



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- The new CPD policy and comprehensive FAQs page are available on the Faculty website CPD homepage [CPD – FPH](#)
- If you would like to get involved in testing the new CPD diary or have any queries, please email the CPD helpdesk cpd@fph.org.uk

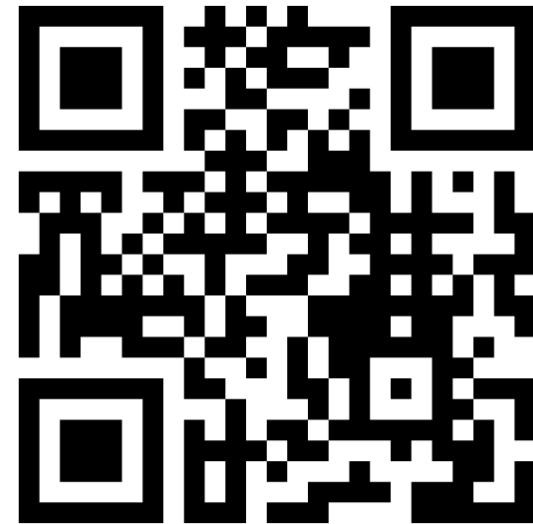
What areas of London FPH work would you like to be reflected back at the next FPH Board?

Are there any issues that you would like to be raised at the next FPH Board?

Submit your answers via

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Meeting Close

Dr Catherine Mbema