Devon Communities Together

helping communities help themselves

Report from Cultural Awareness Project

The project was part of a Devon VCSE Contain Outbreak Management Fund (COMF) funded Health Inequalities insight programme led by Devon Communities Together.

Devon County Council

DeVA Devon Voluntary Action

A Devon-wide partnership building vibrant, healthy communities

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1. Introduction

The 2019 report 'Health Equity in England: The Marmot Review 10 years on'[i] highlights a lack of understanding amongst the public regarding the key drivers impacting upon health inequalities.

> *'The lack of public understanding of what drives health is a major obstacle to further progress in reducing health inequalities and increasing population health. Even though the health system and national government know the evidence that social determinants are largely responsible for the state of the nation's health and levels of health inequalities, they retain the focus on health care and continue to underfund action on social determinants. A 2017 survey by the British Social Attitudes Survey for the Health Foundation found that, "Consistent with political and media discourse, 96 percent of respondents considered 'free health care' to have a 'very large' or 'quite large' impact on health". 'Individual behaviours' were close behind (cited by 93 percent of respondents).'*[ii]

Whilst the VCSE sector have more understanding regarding social determinants of health, initial conversations for the project described below established that some community groups and organisations don't necessarily 'speak the language' of health inequalities, understand fully the link between their work and tackling health inequalities or know where to access relevant information and data.

In a report published by Public Policy Projects and the Institute of Health Equity (2021), Marmot further highlights the critical role the VCSE sector plays in addressing health inequalities[iii].

> '*The VCSE sector (sometimes referred to as the third sector) is an essential partner in efforts to reduce health inequalities ..... The VCSE sector often works to support people who are most excluded and at risk of poor health, as well as having longstanding relationships with those communities. Support and advocacy on behalf of communities are essential components of work to improve health – even when the focus is not on health itself.....*' (p34)

The report emphasises the importance of place-based approaches, co-production and links between statutory and VCSE providers.

> *'Taking a place-based approach requires the community within that place to be fully involved in co-producing the services they require. The VCSE sector often provides this link between civic-led interventions, 'official' services and the people those services are supposed to benefit'.*

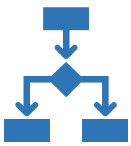
2. Programme Brief

Devon Communities Together, working with Devon Voluntary Action (DeVA) secured Contain Outbreak Management Fund (COMF) grant funding to lead on a Health Inequalities research and awareness raising project between December 2021 and March 2022. The project brief is outlined below:

DCT will develop a cultural awareness programme that describes a common understanding of why tackling health inequalities is important to our communities, to influence both public health & VCSE sector workforce and our population. There will be three programmes run, with ten people on each program. Delivery to be completed by 31st March 2022

Project objectives:

- To run three cultural awareness sessions with representatives from the VSCE sector/local communities and public health staff to enhance understanding of health inequalities, how this relates to the work and activities of specific organisations and communities and how to access/use relevant information and data.
- To gather information via a questionnaire regarding the VSCE's understanding of health inequalities and how it relates to the work they do.
- To feed back key information to public health and other relevant stakeholders regarding the VCSE sector's and local communities' understanding of health inequalities, any data gaps and relevant work/activities taking place to tackle health inequalities.



Short-term outcomes:

Participants have:

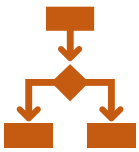
- Increased understanding regarding the importance of tackling health inequalities.
- Increased understanding regarding how tackling health inequalities relates to their work/activities.

- Increased understanding regarding how to access and use relevant data and information.
- Enhanced skills and information to enable organisations to attract funding to Devon to tackle health inequalities

Public Health have:

- Increased knowledge regarding any gaps in the VCSE's/local communities' understanding of health inequalities and data requirements.
- More knowledge regarding some of the relevant work/activities related to tackling health inequalities which is taking place in Devon

Long-term outcomes:



- Increased focus on tackling health inequalities amongst some VCSE organisations and communities.
- More funding attracted to Devon for VCSE organisations to be involved in work regarding tackling health inequalities.
- Improvement in data availability and accessibility for the VCSE sector and local communities where this is required.
- Improved links between participants from different sectors

3. Activities

Key activities for the project included desktop research, meetings with stakeholders, dissemination and analysis of a questionnaire, marketing, and delivery of three awareness sessions, analysis of themes generated in the sessions and contact with two projects undertaking place-based work.

4. Marketing

We marketed the workshops and the questionnaire in the following ways:

- A dedicated web page was created on DCT's website, which generated 305 page views
- 2 dedicated emails to selected VCSE contacts within DCT's databases (31st January and 15th February). The first was sent to 1,532 people and opened by 395; the second was sent to 1,990 people and opened by 327
- E-flyer (see appendix) was shared with an additional 13 newly researched contacts
- 17 contacts were direct messaged on LinkedIn, inviting them to the workshop

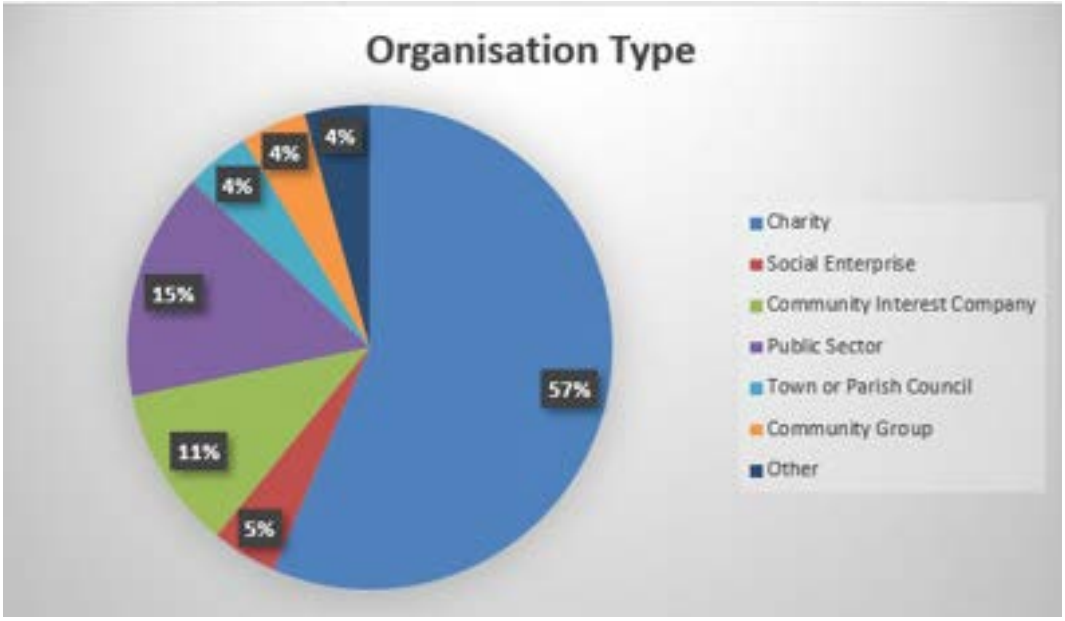
- We utilised DCT's Facebook, Twitter and LinkedIn channels to communicate messages, publishing 21 pieces of content

Below: section of DCT's web page. See appendix 1 for other publicity material.

5. Questionnaire and Quiz

5.1 Responses - type of Organisation

46 people completed the questionnaire as follows:



5.2 Questions and Responses

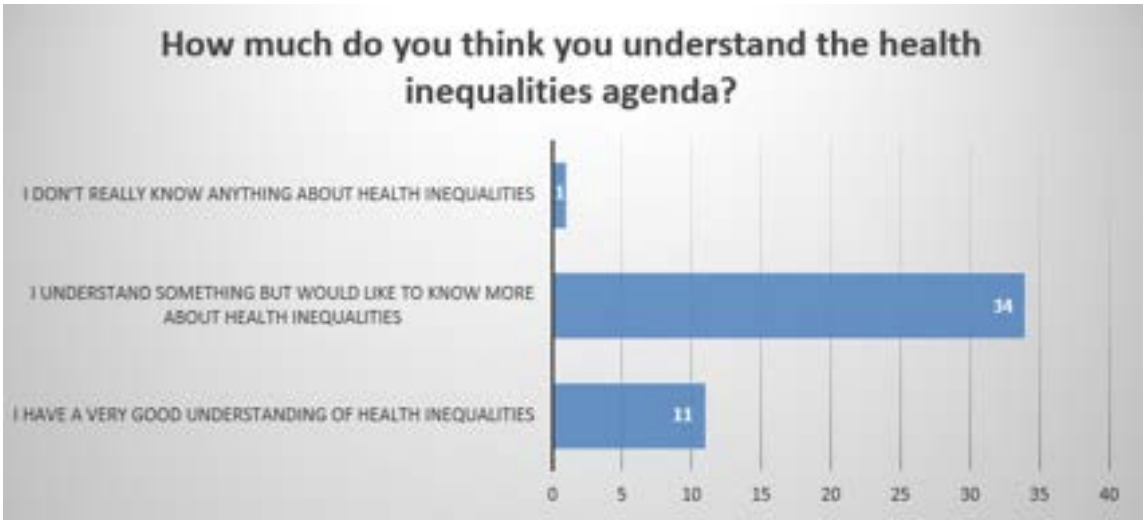
The questions and analysis of responses are outlined below:

Q1 Do you see a link between the work you do and tackling health inequalities?

Yes	45
No	0
Unsure	1

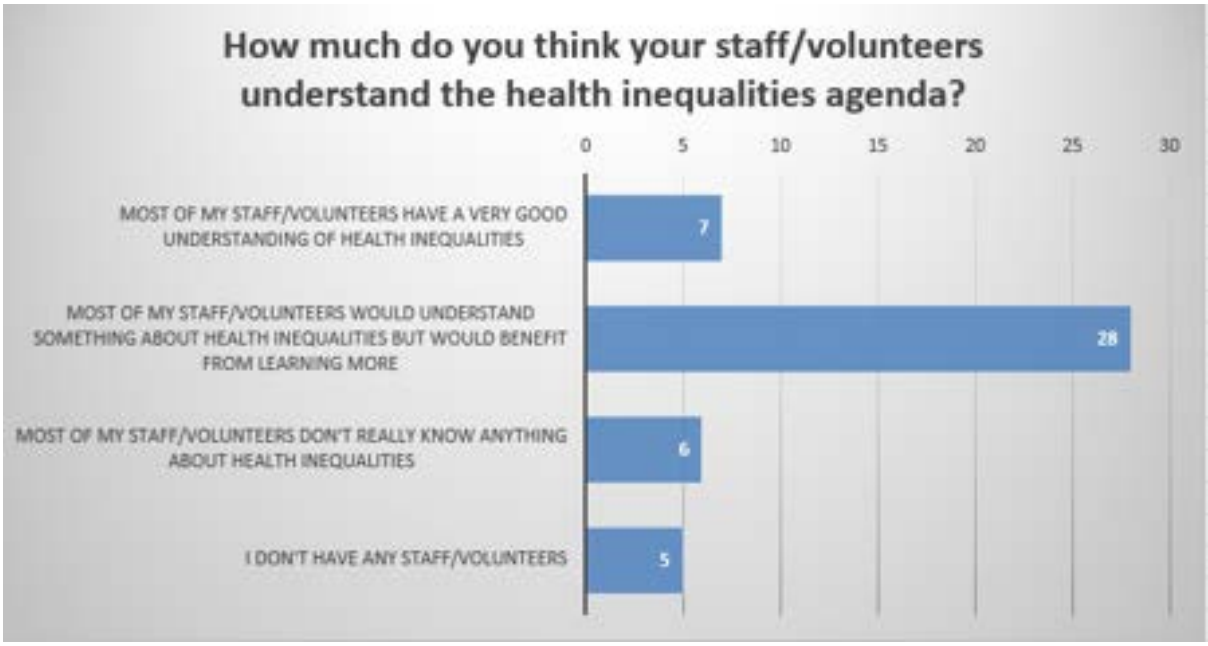
One unsure came from a VCSE support organisation.

Q2 How much do you think you understand the health inequalities agenda?

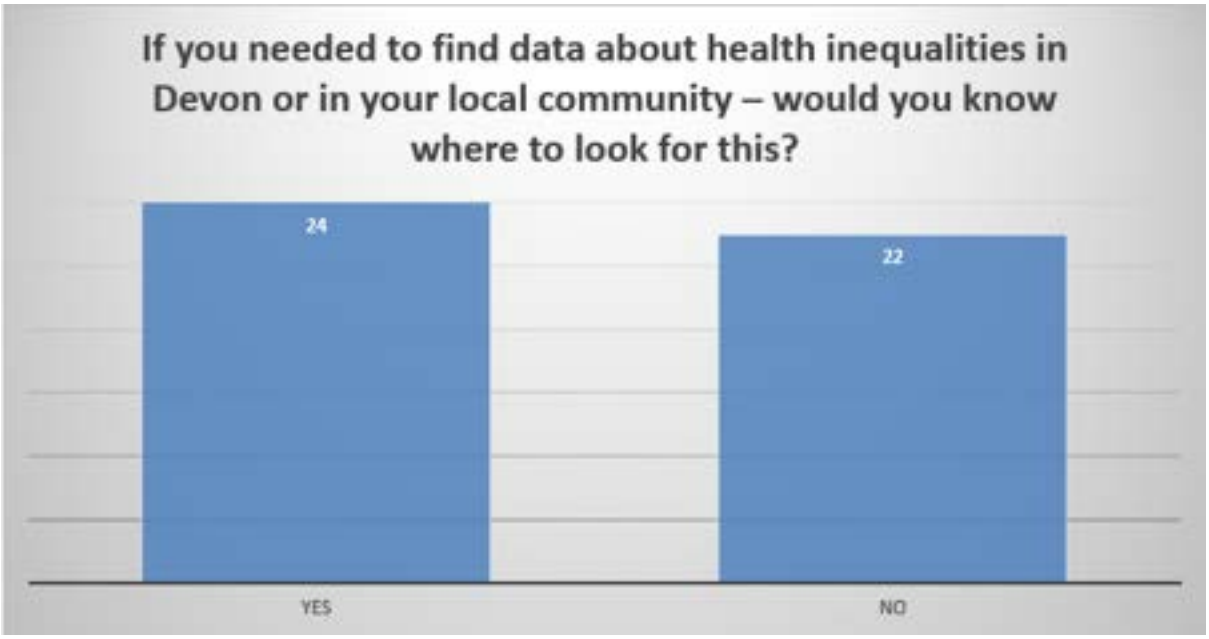


These responses were backed up by the responses to the quiz in the sessions, where there was clearly a good basic understanding of health inequalities (and the significant influence of the social determinants of health), but some things not all participants knew about.

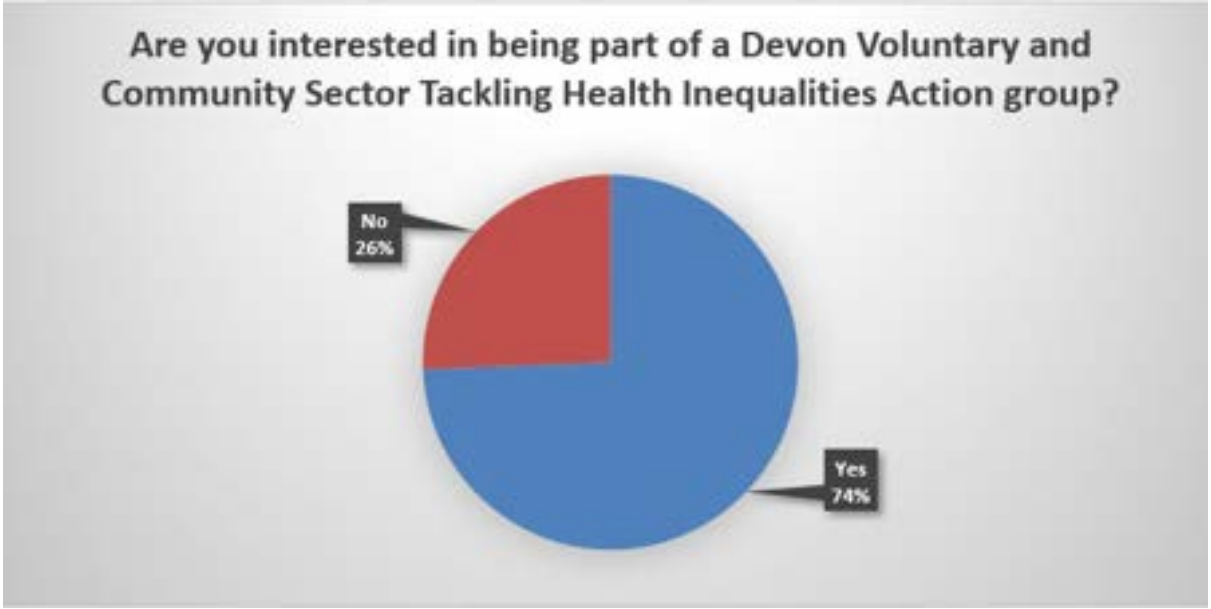
Q3 How much do you think your staff/volunteers understand the health inequalities agenda?



Q4 If you needed to find data about health inequalities in Devon or in your local community – would you know where to look for this?



Q5 Are you interested in being part of a Devon Voluntary and Community Sector Tackling Health Inequalities Action group?



Of those who would be 'interested in being part of a Devon Voluntary and Community Sector Tackling Health Inequalities Action group', 19 of the individuals were from charities, 2 from social enterprises, 4 from community interest companies, 4 from the public sector, 2 from community groups and 1 from other.

5.3 Quiz

The quiz (10 questions) was undertaken primarily to add variety to the session and help participants remember some useful facts. It wouldn't be appropriate to draw solid conclusions from the responses regarding the level of knowledge participants had at the beginning of the session. Analysis of the responses does, however, give something of a snapshot. The responses suggested that participants had a good understanding of the influence of social determinants upon health. For example, 91% of attendees responded correctly to the following question:

Which of the following will make the most difference to addressing health inequalities (single choice)?

Increased funding for the NHS
Tackling the social determinants of health (e.g. income, housing, education)
Individuals changing their health behaviour

Answer – Tackling the social determinants of health (e.g. income, housing, education).

Responses also suggested that there was a good understanding of the impact of particular determinants (e.g. loneliness) and a high level of understanding regarding the level of poverty in the UK. With some of the more specific questions regarding disparities between different groups, less attendees responded correctly to the questions as outlined below:[iv]

What percentage of ALL deaths in 2019 were caused by cardiovascular disease in black and minority ethnic groups?

7%
16%
24%

Answer – 24%. The percentage of attendees who got this answer right was 39%

What is the gap between life expectancy for a baby born in Ilfracombe Central and a baby born in Liverton?

5 yrs
10 yrs
15 yrs
20 yrs

Answer – 15 years. 30% of attendees got this answer right.

Please see Appendix 2 for all the quiz questions, answers and responses.

6. Sessions

6.1 Content and follow-up

The sessions were interactive online sessions, with a quiz, breakout rooms and discussions. They focused on the link between health inequalities and the work participants were engaged in, issues and proposed solutions. A presentation was delivered, covering basic definitions of health inequalities and the key influences, the issues/gaps faced by different groups of people and in different geographical areas, how inequalities have widened, the impact of covid, rural and coastal issues and the link between health inequalities and climate change. Some time was also spent during the sessions looking at the data from the Joint Strategic Needs Assessment using the interactive tools and seeking feedback from participants regarding the accessibility of the data. Following the sessions, participants were sent a link to data and information sources and the presentation slides. In response to requests/permissions, many participants shared their contact details with one another.

6.2 Attendees

37 people attended the three online sessions. 29 attendees worked in the VCSE sector, 4 were employees of Devon County Council (including 3 working for public health) and 2 were employees of West Devon Borough Council. 1 town councillor and 1 parish councillor attended. There was broad representation across the different Devon County Council geographical areas.

7. Summary of session discussions/themes

The following themes were focused on/emerged from the sessions:

7.1 Barriers to positive health outcomes

Many participants talked about types of barriers to positive health outcomes (these were primarily barriers to accessing healthcare services). Barriers included:

- **Previous negative experiences people may have had with services (creating fear of services)**
- **Language (including medical 'jargon')**
- **Digital exclusion**
- **Transport issues (urban and rural)**
- **Cultural differences**
- **The difficulty many people have in navigating the health service when they are already dealing with multiple pressures**
- **Barriers for specific communities (e.g. privacy requirements for women from refugee communities and people who are refugees not always having required documents to register for healthcare)**
- **Services often focused on 'men or women', and often not inclusive of those who do not identify as either**
- **Services not specifically focused on the LBGQT community.**
- **Lack of opportunities**
- **Low socioeconomic status (affordability) impacting on transport (especially in rural areas, where it can be expensive to travel to access healthcare services)**
- **Availability of/access to a range of services and deep pockets of deprivation in rural areas**
- **Navigating system changes (NB elderly people have found it harder to navigate recent changes in accessing healthcare services)**

- **Loneliness**
- **Access to information for all groups of people**
- **Poverty**
- **Centralisation of services is very difficult for many people**
- **Impact of reductions in funding for organisations who support people to overcome barriers**
- **Loneliness experienced by people who are working at home more/for the first time since the pandemic began**

It was highlighted that barriers can add to an already existing sense of isolation and exclusion. The systemic nature of inequality was discussed, and the way in which layers of barriers can impact upon whether people engage with services. It was pointed out that 'accessing' services is different to 'knowing about' services.

7.2 Digital Exclusion

Digital exclusion was discussed during the sessions, with input from the NHS X project, which Devon Communities Together and Wellmoor are undertaking (looking at rural health inequalities). People generally feel that the ability to access health online when living in a rural area is a good thing (resolves transport and parking issues), though many people have said that they prefer to have initial consultations online.

Above: social media graphic for the NHSX project

Access to the internet is not good in some areas and some people don't have the right equipment or skills. Most use friends and family (e.g. grandchildren) to help them. The NHS X project has undertaken a scoping exercise and identified that there are areas in the middle of the county where there is a high need (many people at risk of digital exclusion) and there are less support initiatives (e.g. parts of West Devon). Following completion of the scoping exercise, potential solutions will be explored.

There was discussion in the sessions regarding how digital healthcare can be both positive and negative. For example, many older people have the benefit of interacting with people when they go to a face-to-face appointment – but sitting at home and having an appointment via a computer can exacerbate isolation and loneliness. Local support (e.g. training digital befrienders and use of village halls) can be helpful to address the need for human contact. Digital changes have also given more people the opportunity to work from home – so is one potential resolution to rural challenges concerning employment. It was highlighted, however, that some people have experienced a deterioration in their mental wellbeing whilst primarily working from home.

More examples of addressing digital exclusion

The Chief Officer of Ottery Help Scheme (attendee) talked about work her organisation undertook with East Devon District Council to reach people who can't/don't want to access digital services. They produced an A5 flyer with local phone numbers on (food bank, fuel poverty, local anchor VCSE organisations). The local library fed back that this was very useful as many people were asking about services. Ottery Help Scheme also takes tablets

(ipads etc) into other services (e.g. memory café, friendship group, cognitive stimulation therapy for dementia support group) to try to integrate the use of digital equipment with all services, encouraging familiarity with equipment, to counter the fears some people may have.

7.3 The Role of the VCSE Sector

7.3.i Hidden populations and supporting access - It was raised that most services are very good at helping 'those who can' (those who are well resourced), and we need to move towards helping 'those who can't' (and who have less resources). Significant work goes on in the VCSE sector to identify and support people who aren't coming forward (hidden populations).

It was highlighted that much background work goes on at the community level to enable people to access services. This goes beyond ensuring basic information is available, as people often require considerable support and/or are very isolated. The importance of community activities (post-covid) was highlighted. Many organisations are currently spending a significant amount of time signposting people towards health support services, which is a change to the predominant activities of organisations prior to covid.

Community transport was discussed in the sessions – and seen as a lifeline to many people to enable them to attend medical appointments (although there are less trips since covid).

7.3.ii Building trusted relationships- The importance of building trusted relationships over time at a local level was emphasised by many participants. The role of the VCSE sector was seen as critical to this (*working with trusted people on the ground who understand communities*), but it was highlighted that funding needs to be more sustainable to support the sector's work. It was pointed out that it is difficult for statutory bodies to start conversations from

scratch and to go out and consult with a community if they have no relationship with that community. This was backed up by the experience of the public health outreach team, who have been making connections with community-based charities to build trust with communities to promote accessibility.

7.3.iii Asset-based approaches - Many participants talked about the importance of resourcing asset-based community development, an approach which focuses on supporting communities to recognise and build on the strengths they have. It was suggested that the value of investment in this approach needs to be better recognised as a potential solution to current challenges in health. Participants stressed the value of a sense of connection and belonging in communities. It was suggested that a 'medical model' gives away responsibility/a sense of control and that we need to support people to find their own sense of agency, making the transition from 'helping' to 'empowering' people, through initiatives which increase knowledge, skills, and capabilities. One participant talked about 'wellbeing capability' being delivered, recognising individuals within a family context and families within a community context. Participants discussed the importance of increasing awareness of/information about options/resources with regard to people improving their own health and making a range of options, including more holistic interventions, more accessible. It was suggested that accessible information needed to be at the heart of supporting self-help. Participants also thought it was important to understand better what would encourage people to be more interested in their own health. At the same time as 'building from the grassroots' and creating a sense of empowerment and connection, it was recognised that, in the short term, services such as food banks and debt advice were critical.

The importance of involving people 'with lived experience' was discussed.

7.3.iv Preventative, system focused and place-based work - It was pointed out that much of the work pre-covid/during covid has been about crisis intervention (dealing with people once they become ill) and there is a desire now to shift towards a more preventative approach. The importance of enabling information about wellbeing and preventative services to be more easily accessed was stressed. Participants talked about 'upstream' and 'downstream' work ('*should we put a gate at the top of the hill or have an ambulance at the bottom?*'). It was raised that we don't have sufficient people/resources to continually respond to crises. The transformational change needed is happening/will happen in the community, in the early intervention space where most of the VCSE sector sits.

It was suggested that there is a need to look at the challenges of health inequalities in different places and explore how we can resolve them *collectively*, as we still often work in silos. It was pointed out that the pandemic demonstrated how this can be done. It was suggested that an action plan and a place-based funding model would be needed to make this happen. One Northern Devon and Co-Lab were cited as great examples of collaboration.

7.3.v Volunteers - The changing nature of volunteering was discussed in one session. It was pointed out that, since the beginning of the pandemic, there have not been so many volunteer drivers, as many of the people who used to do this are older and may still be isolating. Newer mutual aid/volunteer groups have arisen. They undertook volunteering at the beginning of the pandemic (e.g. collecting prescriptions and shopping for people). The experience brought people together more in communities. One organisation noted that during the recent storms, younger working age people, who stepped up in the pandemic, came out again asking if there was something they could do. There's a significant culture change with regards to volunteering and many positive changes which we can build upon.

It was pointed out in one session that poorer communities often don't have capacity to volunteer and that we do also need paid roles.

7.3.vi Carers - There are many unpaid carers in Devon. A participant from a carer's organisation advised that prior to Covid unpaid carers saved the UK economy 132 billion. This has now increased to 193 billion! The participant pointed out that when people usually only identify themselves as carers when there is a crisis. They also raised the importance of language (e.g. carers have to do an assessment to be classed as a Devon carer. This can make services less accessible for some people, as they are wary of the term 'assessment' and what implications that might have for them).

One person suggested that we can get 'hung up on' people who are digitally excluded. They suggested that it could be more important to target carers for

digital upskilling rather than the people being cared for. If we can improve 'the lot' of carers – it will improve 'the lot' of those who are cared for as it will free up resource for those who are digitally excluded/lonely. There pointed out that there are many people who will help themselves and their families/people around them.

7.4 Rurality as a driver to health inequalities

The question was raised regarding how health inequality issues are different in rural as opposed to urban areas. It was pointed out that 'the bar has been raised' in terms of access to public services and services 'are on their knees' everywhere (NB mental health and youth services). Public transport and isolation can be issues in urban as well as rural places. How much is rurality the driving force? Several suggestions were put forward including the following:

7.4.i Digital and rural broadband - Where there is a small population, it can be harder to get help to that area? If people can't access face-to-face help, they may need to rely on digital solutions. This can be particularly hard in areas where connectivity is poor and other factors contribute to digital exclusion.

7.4.ii Transport and distance from services - The length of time it takes and the cost of getting to services is a significant issue for many

people living in rural areas (for example, a person may need to get 3 different buses to get to an appointment).

7.4.iii Experience of 'difference'/being in minority - One participant talked about an increased sense of isolation in rural areas where a person's neighbours are not 'like you' (as opposed to being in an area where there are many people experiencing similar challenges, such as on an urban estates). The sense of a support network can feel different in a rural area, and people facing challenges may be less visible.

7.4.iv Fuel Poverty - Fuel poverty is definitely worse in rural areas (e.g. non-mains gas) and costs of domestic fuel coupled with transport costs leads to an increased cost of living, currently exacerbated by rising energy costs.

7.4.v High housing costs and low wages - The differentials between wages and housing costs can be greater in rural areas. In Devon high housing costs have been exacerbated by people moving to Devon during the pandemic.

7.4.vi Hidden Deprivation - Deprivation in rural areas can be hidden by 'averages' across a district, whereas in urban areas the averages are likely to work better.

7.5 Solutions

Time was allocated in the sessions to explore some of the solutions to health inequalities. The proposals put forward are outlined below:

7.5.i Acknowledge the value of health and social care as a 'business and economic driver' - It was suggested in a couple of sessions that the health and social care sector should be flagged as one of the major industries in Devon and the South West. It was also flagged that there is evidence from the Women's Budget Group that investment in women's work in care has a bigger return on investment than investing in infrastructure. We have a care industry which we should be investing in as it provides a lot of the jobs in Devon. The Local Enterprise Partnership doesn't mention the care industry as an economic driver in their training and skills strategy for Devon.

It was proposed that there could be greater recognition from the public sector of what communities are doing for themselves and that there was a need to

engage with this on a system-wide basis. The Devon Recovery Plan (economic plan) document coming out of the pandemic talks about securing £56million of support for the 'hardest hit communities', including 6500 jobs and 5000 training opportunities. Tourism, food and drink, agriculture and retail and construction are identified as bedrock sectors. However, the 6000 organisations in the VCSE sector (employing 100,000 people, with a total turnover of £1 billion) are not recognised. It was suggested that there is a need to change this narrative and to shift from putting investment purely into growth to putting a proportion into sustainable wellbeing development

7.5.ii Tackling Isolation - Participants discussed social isolation, the impact of loneliness and the importance of people being able/having the opportunity to connect with others. It was stressed that we can't quantify the success of social interaction and sometimes we don't always understand sufficiently the importance of bringing people together.

7.5.iii Tackling housing issues and resolving policy contradictions - The challenge of living in houses when there are conservation restrictions on planning was raised, specifically where a house is difficult to heat, and it isn't possible to get double glazing. Participants talked about contradictory policies which needed to be resolved at a statutory level (i.e. conservation/heritage policies contradicting sustainability policies, which respond to the climate emergency). Participants were unclear what forums these challenges could be brought to.

Attendees also talked about the importance of tenants in social housing knowing their rights and having swift responses to difficulties. It was raised that it can be disempowering in social housing when repairs need to be done and tenants must chase the provider. Attendees also talked about people who can't afford to heat their houses and spend the day in bed as they are worried about contacting the council (some tenants fear they may be 'blacklisted' by the council).

7.5 iv Effective & affordable transport system - It was stressed that ***an effective, affordable transport solution does resolve a wide range of issues and enables people to access services.***

There was a lot of discussion about making service provision more mobile and bringing services *to* communities. It was recognised, however, that this is more expensive and it's harder to justify spending money on an area if the population of that area is so much smaller than more densely populated areas. It was recognised that the more viable option is to take people to services. Many attendees thought that transport and financial restrictions were the main barriers for people with low socioeconomic means.

7.5.v Other solutions which have been helpful - One thing which came out of Ottery Help Scheme taking people in East Devon to Exmouth for vaccinations was the realisation (following many requests) that people wanted to go past the seafront to see the sea. This highlighted a need for 'wellbeing trips.' People need more than just 'medical' help and we can do so much more than just taking them to their medical appointments. They need trips to the seaside and to greenspaces/cafes.

The importance of fun to help with healing for people who are/have been unwell was mentioned.

7.5.vi Improving access to services - The public health outreach team are undertaking a feasibility study for an outreach dental service and are looking at accessibility to healthcare for different groups of people. They are looking at different models currently being used. Teignbridge District Council, for example, work with stagecoach and provide vouchers to people who are homeless to access healthcare provision. There are new housing developments in Devon, where developers provide some sort of transport provision. There are pockets of accessibility plus lots of voluntary groups offering community transport. The team are looking at options so that they can present potential solutions.

7.5.vii Priorities - Participants were invited at the end of the sessions to write down which actions they thought were most important to tackle health inequalities (see google Jamboard and Zoom whiteboards below). The following were put forward as important actions to take:

Connecting with communities and asset-based approaches

- Connecting with people in marginalised communities to listen and develop relationships/trust
- Make sure marginalised groups are included in consultations
- Asset Based Community Development
- Supporting and resourcing organisations working with underserved communities
- Social prescribing needs to be more focused on connections

Reducing isolation

Sustainable funding targeted appropriately

- Many participants wanted to see more funding and a more consistent offer for children, families, and young people
- Funding holistic therapies was put forward in one session
- Longer-term funding for sustainable initiatives that work
- Core funding – not just project-based
- Funding – shift from silo'ed approach and to communal/place-based solutions
- Resources need to be used to get things done/make a difference – not just talk about it

Housing

We have declared a housing crisis. We need good quality, accessible housing

Transport

We need transport to feature in planning at an early stage, not as an add on

Place-based solutions and people-led change

- More localised health hubs (part of wider community hubs with post office, banking etc)
- More staff need to go out to communities (support public health teams). Do we spend money on the right sort of staffing in NHS (too many consultants?)?

- Co-design/co-production led by people with living/lived experience
- Informal access to social inclusion space

Do what Marmot said!

Linking of initiatives across Devon and sharing good practice
Development of the VCSE Assembly across Devon

Skills within VCSE to be more highly valued

Access to information

Establish a recognised and unified measure for Social Return on Investment value

Below are some resources created in the sessions:


Listen to the community groups, listening and feeding back up the chain.
reducing isolation
transport
More localised health hubs (part of wider community hubs with PO, banking, other services etc)
Inclusion of those from marganilsed groups via consult
supporting / resourcing organisations working with those who are underserved
Asset based community development
Do what Marmot said
indeed!
Connecting with people in marginalised communities and developing trust and relationships
FUNDING for services - youth, early years etc


Longer-term funding
Core funding, not just project-based
Informal access to social inclusion space
travel
access to information
My eCulture Solutions Digital Access to information Wellbeing Solution
Establishing a recognised and unified measure for social return on investment (SROI) value
Sharing best practise across areas
Development of the VCSE Assembly across Devon
Long-term funding for sustainable initiatives
Linking of initiatives across Devon
Place-based solutions; community health hubs
Funding shift from silo 'd approach to problem solving to communial / place making solutions
Longer term funding opportunities
co-design / co-production led by people with living / lived experience
People led change
Skills within the VCSE sector to be more highly valued!

8. Data

Part of each session was spent discussing data and looking at how to navigate the interactive tools for the Joint Strategic Needs Assessment. Participants talked about the importance of understanding data so that people who live in different areas know what is unique about their area, what the local health inequalities are and what they need to improve their area.

Many participants said they valued having the opportunity to see or be reminded of the data and interactive tools. Most felt they needed to spend time learning how to use the tools or seeing how to navigate things that had changed since they last looked at the data.

8.1 Data challenges for Devon

It was pointed out that Devon will very rarely meet the 20% 'most deprived' figure for the Core 20 plus 5, which health are prioritising, due to the disparate nature of inequalities across Devon. It was suggested that the Index of Multiple Deprivation (IMD) is a poor indicator of inequalities across Devon due to affluent areas masking and impacting on statistics. The IMD doesn't work as well for rural areas as it weights outdoor environment too highly and this is too skewed towards cities. This was seen as creating potential problems in terms of accessing funding.

District-level data doesn't tell the full story – e.g. Ashburton and Buckfastleigh are linked together as a 'District'. This does not show how Ashburton is more affluent and Buckfastleigh has a lot of inequalities. The picture which is painted can depend on who your community is matched with in the data.

What the data does show is that for those deprived areas who have been 'behind', the gap is getting bigger and growing more steeply.
Even Lower Layer Super Output Areas (LSOAs) can mask what is going on in one street or a cluster of dwellings. The averages can be very 'middling'.

Attendees questioned how they could get this conversation to people making decisions about how services are delivered, including policy makers, funders and those developing the new Integrated Care System (ICS).

8.2 Common sense and data

It was recognised that data doesn't tell us everything. It is useful for a 'birds eye view'. Participants thought it should be used as guidance rather than taking the figures as an 'exact science'. It was pointed out that if you live in a place, you have more insight regarding what the area is like. Some things can be slightly glossed over in data and particular pockets of extreme deprivation aren't shown. There is also a need to be sensitive about how data is used. It can be stigmatising to talk about an area as being 'deprived' and approaches needs to be more asset based. Some data may not include important features, for example strengths and weaknesses in a particular area, such as community interaction, whether people love living in a place, feel part of the neighbourhood, feel this is their home, are happy and doing things for themselves. It was pointed out that for some communities, where the data looks concerning, there may still be a strong sense of community and significant local support for people, which enhances that community's resilience. The importance of getting to know a community and find out what is really going on in an area was stressed.

There is more emphasis on qualitative information now and the importance of including case studies and real-life voices was stressed. It was highlighted that this is one of the ambitions of the Integrated Care System's (ICS) engagement with the new VCSE assembly – to bring lived experience into the design process and have a genuine co-produced approach to the development of new service models.

8.3 Suggestions to improve the data

One person raised that the data can be overwhelming, and it is up to the individual to look at the data and draw the conclusions. They said that previously a statistician would have done the work for you. It can be hard to interpret the data if you haven't got a statistical background.

It was queried how the information could be made more accessible for the VCSE sector. It was suggested that there could be more discussion with organisations about how the information matches up with what they are trying to do and how they are finding the data. One participant was interested to go away and ask groups more about what would be helpful to them, what their priorities are and how the information can be more accessible and relevant. It was discussed that any findings could be fed back to the Public Health Intelligence Team. It was queried whether there was a way to measure the impact the available information is having and who is using it?

One participant said that they would like to see a breakdown of where spending/investment happens in Devon and how that matches to deprived rural communities.

It was raised that the use of acronyms without sufficient explanation makes things very inaccessible. For example, several participants didn't know what an LSOA is. Some of the statistical terms were also confusing and one person highlighted that some information can be difficult to understand ('*Mood and anxiety disorders – the numbers don't mean anything to me*').

Data can be contradictory across multiple sources and it's not always obvious which data to refer to. It would be helpful to have some guidance. Looking at Chulmleigh as an example - the JSNA shows that it is not in the bottom decile. However, the Consumer Data Research Centre (CDRC) shows it to be in the bottom third.

8.4 Quantifying the solutions as well as the problems

The data is useful in that it explains the size of the issues and breaks things down into bitesize chunks - but it doesn't show the social value of addressing those issues. To get more resource we need to be able to explain the narrative of the value which we are delivering. It would be useful to apply a measure to solutions, so that we can demonstrate the value of investment in community/preventative activities. For example, self-harm costs over £9.5 million per year in Devon to address. Some is the direct cost on the NHS of hospital admissions. If we know the social and economic costs and we have a charity resolving self-harm, we can put a financial and social value on this.

9. Looking forward – what the VCSE sector could do

The following suggestions were made by session attendees and questionnaire respondents:

9.1 Strategy and representation

There was interest in producing a strategy and bringing a range of providers together to look at solutions for service delivery. It was pointed out that public services can't be delivered without the VCSE sector, who currently deliver a range of services which were previously delivered by the public sector. Participants thought that they should have more of a say in how things work in terms of service delivery across the region. Lots of communities don't have that say

It was suggested that we need a strong regional and national lobbying position with a good evidence base, comparing data with other national places to give a perspective. We need to have representation to regional funders in place to match delivery to places in need.

9.2 VCSE health inequality group

Many participants and respondents to the questionnaire were interested in a VCSE health inequality group. Attendees were keen to see a group which would do something meaningful (not just be a vehicle for more consultation). It was suggested that there would need to be clarity regarding how decisions will be arrived at and who will be representing the sector. Some attendees had concerns about any group becoming 'a tick box exercise', which didn't lead to anything and the difficulty of ensuring that everyone's voice is heard and given equal weight. Some attendees were concerned about the same voices being 'at the table', who are already engaged in the conversations. Including different sectors, 'under-served communities' and first-hand experiences to make decisions together would be a step in the right direction.

9.3 More action and less 'talk'

There was frustration expressed in the sessions regarding issues being discussed with lots of different people, but nothing getting done.

9.4 Joined-up approach

Participants in all sessions talked about the importance of having a more joined-up approach across the sector.

10. Specific challenges for smaller charities

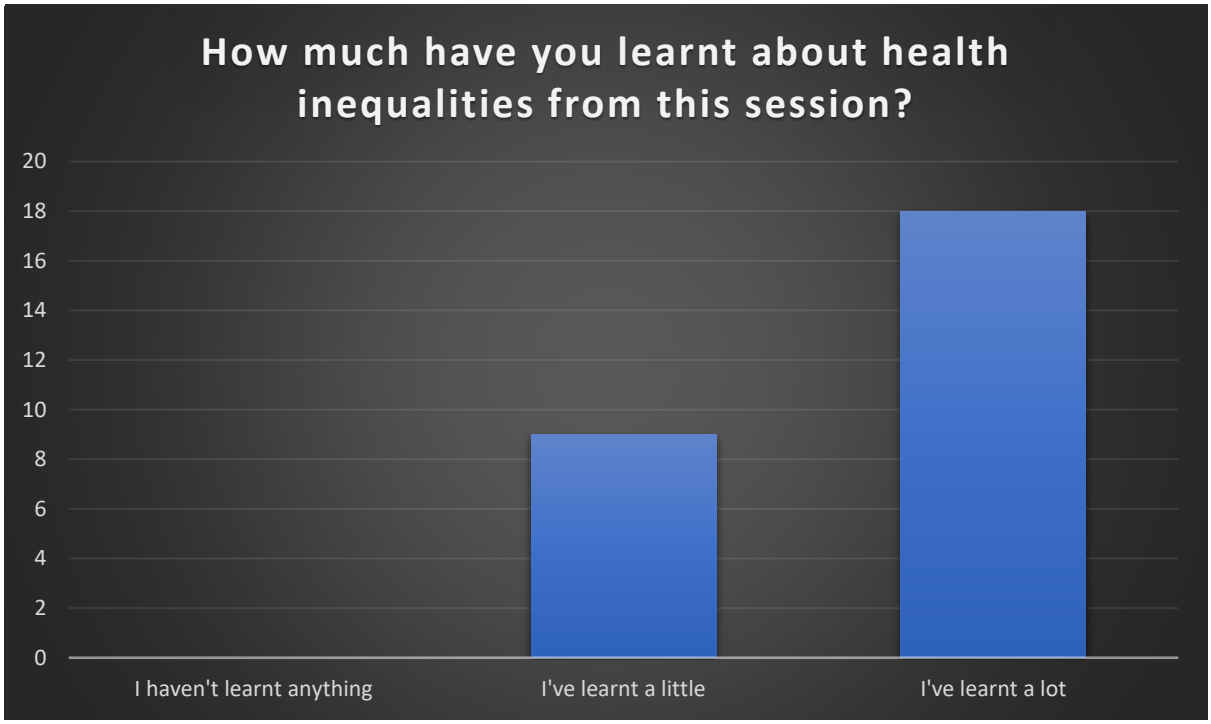
One of the sessions was delivered specifically for smaller charities. Attendees highlighted that there are many small charities delivering a huge amount of work, which are usually focussed on delivery and don't have the time to look at mapping, presentation, strategy, data, funding applications and evaluation of their services to demonstrate impact. It would be very helpful if there was a mechanism for the sector to enable these charities to link in and demonstrate what they do. Funding to support prevention is hard to come by. Most funding is short term crisis funding and it's harder to get long term funding where the outcomes are more difficult to record. This also presents a huge challenge to smaller organisations.

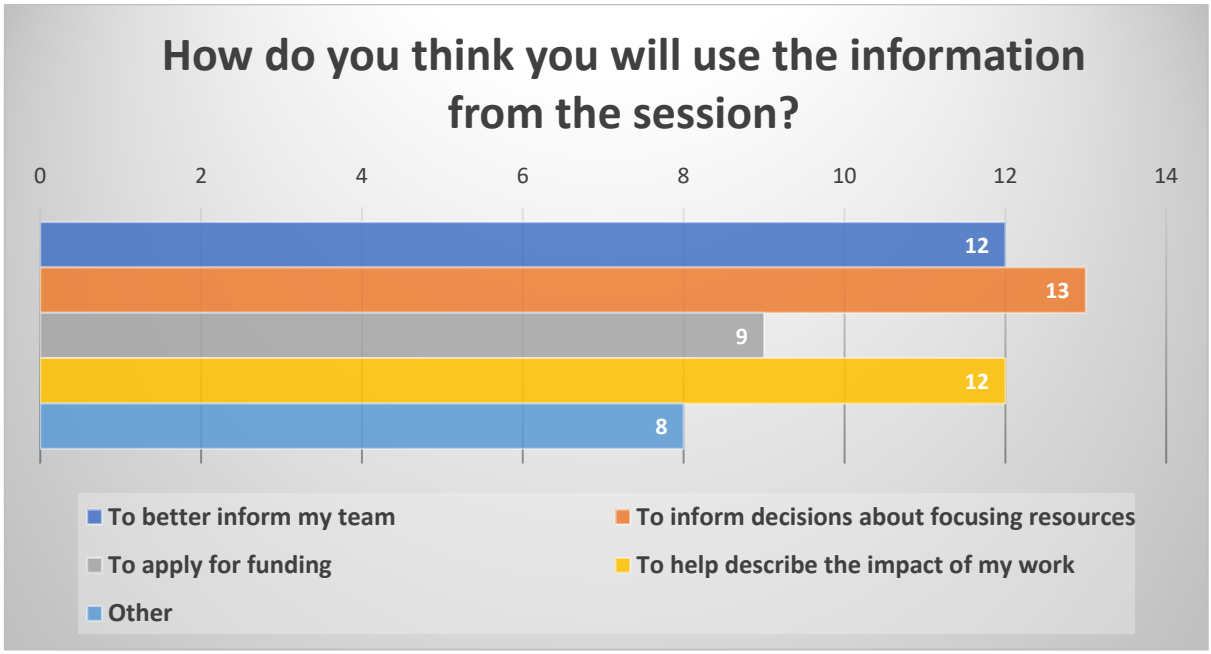
One attendee noted that co-design brilliant – but for a small organisation there is often very little capacity to do this and there are lots of people asking for time and input. There isn't sufficient infrastructure in small organisations to support those on the ground to free up time to do that. Another attendee said the VCSE assembly had been looking at how to address this with potential support to backfill positions

11. Session feedback

27 attendees completed a feedback form following the session. 22 said they'd found the session very useful and 6 said they'd found it quite useful. 18 said they'd learnt a lot and 9 said they'd learnt a little.

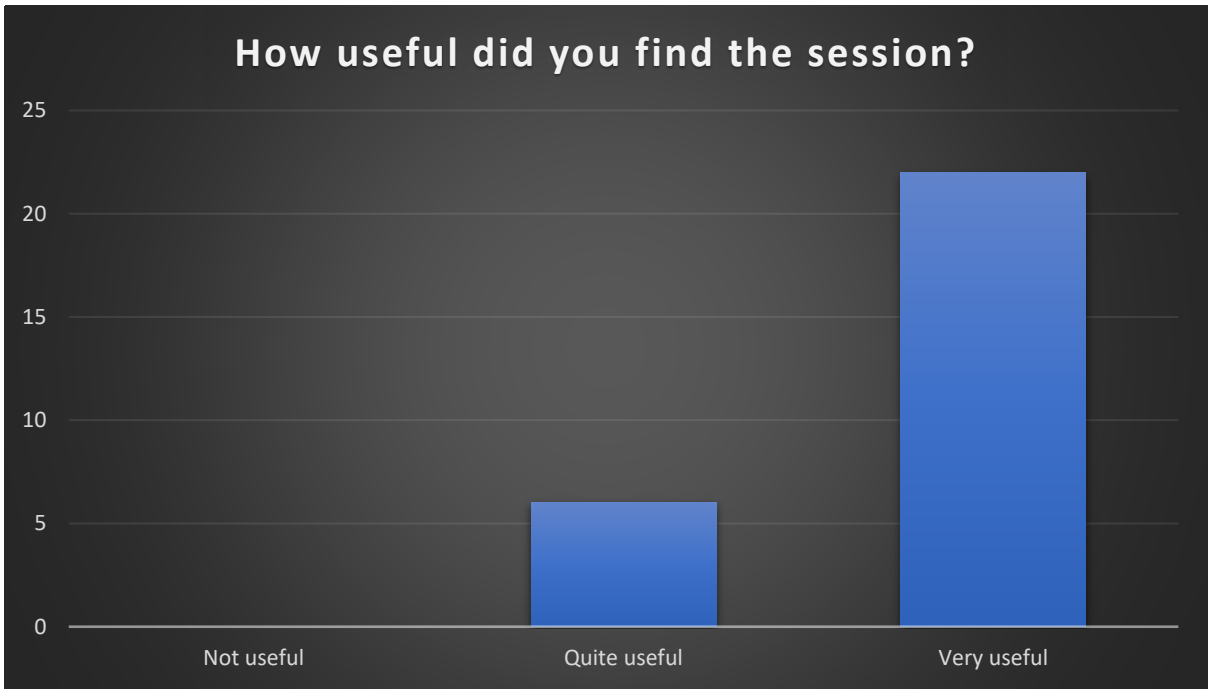
When asked how they would use the information from the session – 12 said it would be to inform their team, 13 said it would inform decisions about focusing resources, 12 said it would help them describe the impact of their work and 9 said it would help with applying for funding.





Other ways in which participants said they would use the information from the sessions were as follows:

- using the information to share learning with other organisations/groups
- to encourage a parish council to be more proactive in supporting residents to access healthcare
- to feedback to the VCSE Assembly development.



Some general feedback comments:

> *Wasn't sure what to expect, inequalities resonated when looked at the information as that is my remit. Wasn't sure how many diverse groups would be covered. Really good session. Got a lot from it. Being able to connect afterwards would be helpful. Learnt a lot from people. Greatly experienced people in the meeting.*

> *Astounded by all the work people are doing. Very useful.*

> *Interesting. Good diversity at this session. Good to consider what other voices we might need in the room as part of the conversation so that we ensure things are looked at holistically (e.g. include housing) and prevent silo'ed working*

> *Really insightful and really useful workshop.*

> *Complexity of everything that needs to be impacted – planning, health, and funders. Got such a far reach.*

> *I have taken so much. Wasn't aware of how huge the differences in health inequalities are. Learning about the impact of loneliness has helped me understand better the support that is needed to mitigate against loneliness and to empower people to help themselves more.*

> *The most powerful message was reinforcing the need to change. The session got these issues back on my radar.*

> *Really useful. Good connections. Helpful to hear what other people are doing and their ideas. Useful to be reminded of the data tools. Time is a big challenge for small organisations. There is work to be done to get the grassroots work going again and regenerate what we do following covid. Interested to talk to people more.*

Current interest and desire for action:

> *Just scratching the surface. There is a lot more and everyone has interest and appetite. Good timing to discuss this with commissioning changing (ICS/LCPs). There might be something valuable through Devon Communities Together linking to the board. Health inequalities getting more recognition. Time for all the talk to become action. There is some great traction coming from here.*

> *Would be useful to hear what has been drawn from all sessions and what you are going to do with it.*

Value of bringing people together:

> *Helpful to have wide spread of people and organisations. Biggest issue generally – so many people doing brilliant things/same things and not working together. Would like to see more working together and more joined up thinking. We could try to get more sustainable funding by working together.*

> *Good to have the chance to reflect more on the issues and the opportunities that are there and to draw out and connect more. It's an important subject for a lot of people – but we don't know where to start – so it's helpful to start by coming together.*

> *Good to meet people working on similar things – need to bring people together so we don't run the risk of duplication for communities as this will reduce impact of engagement.*

> *Connection is key, not only for the people we are supporting but also between ourselves. This is an important dialogue. Not sure we do it enough and people can feel isolated and work in silos. This is about building integration horizontally and vertically so that the voice of the grassroots comes to the surface and things are community led*

> *The session was extremely useful to make more connection with the living experience of people providing services and the challenge of being able to contribute towards the opportunity for effective change.*

12. Case Studies

In the report published by Public Policy Projects and the Institute of Health Equity (2021), the importance of place-based approaches, co-production and links between statutory and VCSE providers is emphasised.

'Taking a place-based approach requires the community within that place to be fully involved in co-producing the services they require. The VCSE sector often provides this link between civic-led interventions, 'official' services, and the people those services are supposed to benefit'.

Public Health England further recognises the value of working with communities:

> *Communities, both place-based and where people share a common identity or affinity, have a vital contribution to make to health and wellbeing. Community life, social connections, supportive relationships and having a voice in local decisions are all factors that underpin good health.....In order to build community contributions into a central role within place-based strategies to address health inequalities, it is important that all partners, including communities themselves, understand their potential. The assets within communities, such as the skills and knowledge, social networks, local groups and community organisations, are building blocks for good health.*

Place-based approached for reducing health inequalities: main report. September, 2021. Public Health England Click here

These benefits and the potential for transformation at this level were discussed in the sessions. There are many great examples of this type of work being undertaken by the VCSE sector across Devon. Two case studies are described below.

Case Study 1 – Buckfastleigh and Be Buckfastleigh

Buckfastleigh

Buckfastleigh is a rural town situated on the edge of Dartmoor, within the district council of Teignbridge. The town is adjacent to farms, woodlands and the River Dart, home to a rich variety of water birds and migratory salmon and sea trout. Buckfastleigh has a rich natural history, which includes otters, rare horseshoe bats, peregrine falcons, and the Pengelly caves, where you can travel back 350 million years, to see coral reefs and the remains of elephant, hippo, bison and hyena. The Abbey is the best-known building within Buckfastleigh. Hundreds of thousands of people come to visit it every year from around the world.

Much of the town we see today was shaped by the woollen industry; the workers' cottages, the mill buildings and the town hall and park. The town has been heavily impacted by the closure of Dartmoor's woollen industry, by the floods of 2012, by the years of austerity and cuts to public spending and by past planning developments, such as the A38, the main dual carriageway to the South West of England, built in the 1970s. The A38 created easier access to the South West for commuters and visitors, but it bypassed the town of Buckfastleigh, divided the parish physically and produces noise and air pollution for those who live nearby. Buckfastleigh's Steam Railway Station, from where tens of thousands of visitors each year take a riverside steam train journey to and from Totnes, was split from the town by the dual carriageway and few visitors to the station now come into the town. Indeed, the road system has been designed almost to bypass the town centre and its pretty and architecturally rich Fore Street, where many shops have closed and are continuing to do so.

Buckfastleigh is a typical example of an area in Devon where severe pockets of deprivation can easily be missed and masked by affluence, particularly where some data is looked at for Ashburton and Buckfastleigh together. Data from the Joint Strategic Needs Assessment (below) shows a number of socioeconomic indicators where areas in Buckfastleigh do not do well compared to Teignbridge and Devon as a whole.

	Devon	Teignbridge	Buckfastleigh North (LSOA E01020199)	Buckfastleigh South (LSOA E01020198)	Buckfast, Buckland in the moor and surrounding areas (E01020197)
Children with Special Educational Needs (2018)	17.2%	16.7%	19.9%	23.1%	
Child Poverty (2018/19)	12.2%	11.4%	17.2%	22.9%	
Houses classed as fuel poor (2019)	10.7%	9.9%	16%	15.1%	
NEET - Not in Employment, Education or Training (2020)	5%	4.9%		11.5%	10%
Healthy Life Expectancy		66.55yrs	63.24yrs	63.24yrs	63.24yrs

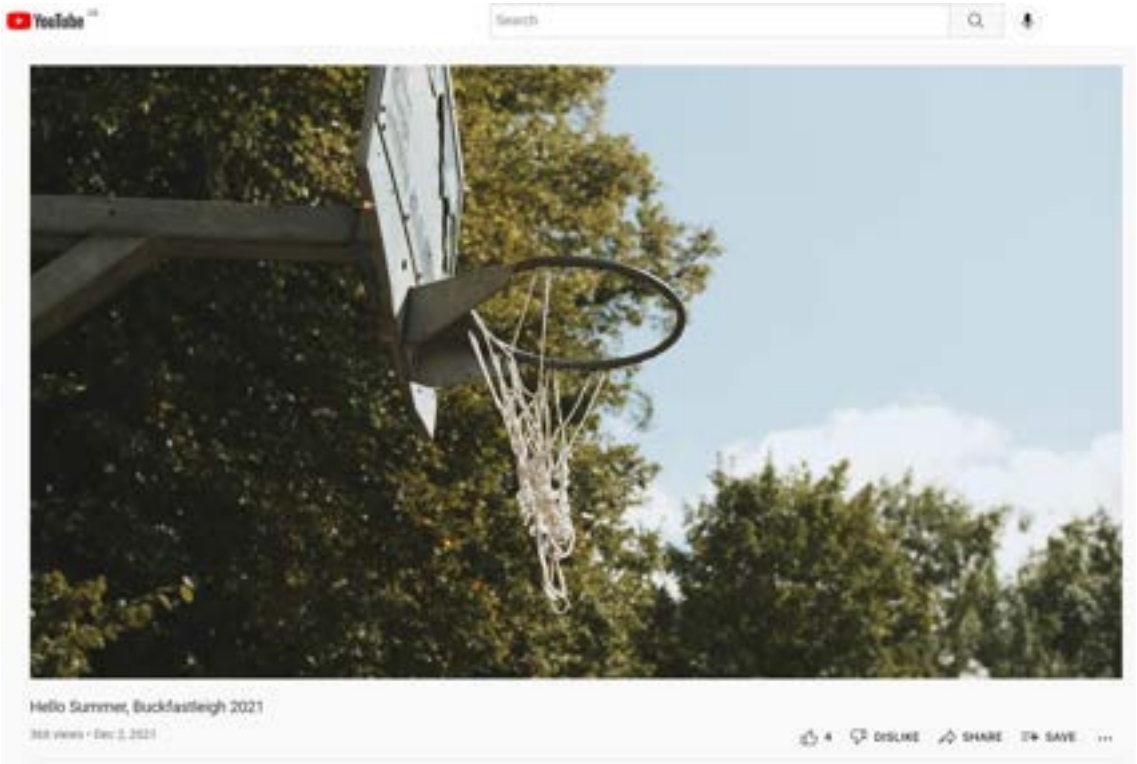
There is, however, more nuanced data, which can easily be missed by public bodies and a more 'top-down', urban-based model. A whole range of services are not available in Buckfastleigh itself, making them inaccessible to families who can't afford to travel. For example, it costs a young person from Buckfastleigh £937 a year to catch the bus to the nearest secondary school, which anecdotally has led some families (who can ill afford this price) to take

their children out of school. At the beginning of the pandemic, there was a national policy to distribute food vouchers to low-income families. However, the bus fare to the nearest supermarket rendered the vouchers almost worthless to families living in Buckfastleigh.

Be Buckfastleigh

Be Buckfastleigh is a community interest company (CIC), which has been established to tackle these health, social and economic inequalities in Buckfastleigh, and other small rural towns, using the basic principles of asset-based community development. Be Buckfastleigh supports a range of free community-led activities, services, and interventions. Activities are designed to meet the needs of people who are the most disadvantaged, yet they are free and open to all, so do not create stigma. They focus on fun, health, community building, the natural environment and creating a positive vibe to engage people who are the most disaffected. They also encourage participation in decision making, volunteering, and strengthening networks, by ensuring people are valued, appreciated and respected.

A great example of the activities supported by Be Buckfastleigh is the summer playscheme 'Hello Summer'. The short clip at the link below speaks for itself regarding the impact this has had for the local community. [Click here to watch the video: https://www.youtube.com/watch?app=desktop&v=ehGdYIbzQYo](https://www.youtube.com/watch?app=desktop&v=ehGdYIbzQYo)



In addition to working at this very local level, Be Buckfastleigh is taking a strategic approach to addressing rural health inequalities, building relationships with regional public and VCSE sector organisations and developing a fresh narrative with decision makers. It is developing networks of 'anchor' bodies – building on community strengths and identifying opportunities for economic growth, sustainability, and resilience. Be Buckfastleigh is forging a distinctive 'cluster' model for addressing inequalities and hidden deprivation in small rural towns by developing a network of communities in Devon, reducing competition for resources, and providing a more sustainable scale for delivery.

Be Buckfastleigh has attracted funding from the National Lottery and has been working with Michael Marmot, as part of a larger piece of work examining new models to address health inequalities

Case Study 2 – Interwoven Productions

A great example of truly asset-based community development is the work of Interwoven Productions CIC in and around Exeter. Whilst the project has no explicit goal of tackling health inequalities, the overriding emphasis is on connections - connecting people to people and people to place. The importance of these connections is increasingly recognised in the literature on health inequalities.

Interwoven Productions focuses on '*Squilometres*' – a (very roughly) square kilometre neighbourhood catchment. Within that catchment the *Squilometre* operates hyperlocally, street by street, around and around inside that landscape, ad infinitum. For each street project, the history, stories and

INTERWOVEN PRODUCTIONS CIC

landscape of that place are explored by the people living there, who also agree on events and activities to take place in and celebrate that street or feature, in depth, over a ten-month period.

This focus on place is led by the community. Street projects are nominated by residents who identify with that neighbourhood. Whichever street receives the most votes is the one that gets celebrated next. Staying with the activity, from project to project are volunteer 'Place Champions' – a local person who comes forward, wanting to learn about and connect more with the area and the people where they live. Interwoven Productions provides a 12-month flexible course of learning for them, including Oral History recording, reading the histories of the landscape and, of course, group facilitation. More than this the Place Champions are welcomed as Associates into the sociocratic governance framework of the company. In other words, they become one of the bosses and get to take what they're learning on the street, right into the heart of the organisation.

At the beginning of each year they reach out to the residents of the new street and set up a new 'Pod', a small group of local people, who will research the area, agree on and arrange activities and events. Past activities have included community stargazing, heritage trails and resident designed interpretation boards, street performance, intergenerational tea parties, flag and tile making to decorate the street, exhibitions and more. The Place Champion's role is to follow where they lead.

Interwoven Productions empowers local people who don't usually get involved in this type of activity. They are developed and continue to actively refine a methodology that they have termed Quiet Voice Animation. This ensures sure that people who may not have the social capital (confidence, resources, experience, qualifications, contacts etc) which others in the area may have, are supported to come forward and play an active part in the work of the Pod. The Place Champion is also supported and trained to lead the Pod.

Interwoven Productions CIC adheres to the principles of 'The Capability Approach', a way of measuring quality of life which has been adopted by successive international committees, including the United Nations. Underlying the approach is the belief that we should be taking full account of the capability of an individual to design, affect and determine their own change rather than prescribing what change we think is right for them.

Interwoven Productions started working in Heavitree in Exeter in early 2015. It has gone on to work in Burnthouse Lane, St Thomas, Beacon Heath and the West Quarter, as well as Littleham in Exmouth. At the end of each 10-month period, each street project 'pays forward' any surplus and resources which have been accumulated to next project within that *Squilometre*, supporting a new group of people to connect to their place and the people in that place. And so, the residents of a *Squilometre* neighbourhood maintain "ownership" of the overall activity and the *Squilometre* itself is not dependent upon large grant funding for sustainability. It belongs to its residents and continues, with no end date, via community perpetual motion.

Interwoven Productions has just started working in the Beacon Heath *Squilometre* with a project around Mile Lane, a Lane in Beacon Heath which comprises a mix of owner occupied and local authority housing. Emphasis is being placed on the relationship between residents of the Beacon Heath

estate and this ancient Lane. Mile Lane is in LSOA EO1019991, and whilst indicators of deprivation will be masked by the affluence in the area, the percentage of benefit claimants, houses classed as fuel poor, children with special educational needs and children in poverty compares less favourably to the Devon average. The conversations facilitated by Interwoven Productions are not about these indicators, however, but on the things which people want to celebrate – the history, the people, the landscape, and the stories. This sits at the core of a successful invitation to participation – particularly with the estate itself.

LSOA EO101991

	Devon	LSOA E0101991
% of children with Special Educational Needs (2018)	17.2%	22.1%
% of Children in Poverty (2018/19)	12.2%	15.9%
% of Houses classed as Fuel Poor (2019)	10.7%	12.1%
% of people claiming benefits (2020)	4.3%	6.6%

13. Summary and Recommendations

13.1 Summary

There is significant recognition at a national and local level of the importance of the VCSE sector in tackling health inequalities. Prior to the sessions the CE of Devon Communities Together and the project lead met with the Chair of the Executive Health Inequalities group in Devon, Dr Lincoln Sargeant. Dr Sargeant agreed that his recognition could be communicated to attendees using the following quote:

> *Addressing variations in health outcomes requires more than access to medicine or improvement in health-related behaviours. We need to recognise the community context in which people live their lives and the role the voluntary and community sector plays in bringing people together to tackle problems they cannot face on their own. A vibrant voluntary and community sector can boost individual and community resilience in the face of adversity but can also mobilise people to act collectively to improve the conditions in*

which they live and close the gap in the health outcomes they experience.

The significance of the VCSE sector in addressing health inequalities was reiterated by session participants, who stressed the importance of preventative, collaborative, asset-based and place-based approaches. Attendees highlighted the importance of building trusted relationships at a local level and the intense support required by many people to overcome the multiple layers of disadvantage and barriers impacting upon their health. Participants recognised the challenge which the health service faces in having sufficient resources for crisis intervention and it was suggested that transformation needed to happen within communities, with a significant focus on early intervention, prevention and enhancing strengths and resilience. Participants discussed the importance of ensuring that a range of options and information were available so that people can take care of their health. They highlighted that information alone was not enough. Support is often needed for people to access information and people need to be sufficiently empowered to take an interest in their health and available services.

The need for VCSE organisations to be sustainably funded was highlighted, with funding models supporting core funding, place-based, collaborative, and preventative approaches. Funding and support are also needed for smaller charities to undertake work beyond frontline delivery, especially to demonstrate their impact. The importance of carers and a new emerging group of volunteers were highlighted.

Whilst all except one of the organisations who responded to the questionnaire saw the link between the work they did and health inequalities, most organisations thought that they and their staff would benefit from learning more. All participants who completed the feedback form thought they had learnt something from the sessions and most people said they had learnt a lot. The quiz suggested that most participants understood the significant influence the social determinants of health had on health inequalities but didn't necessarily know the extent of the disparities between some areas and groups of people. Session attendees said they would use the information from the sessions to better inform their team, describe the impact of their work, apply for funding, and inform decisions about focusing the work that they do. Participants particularly valued meeting other people at the sessions and were keen to have more opportunities to come together for dialogue and to find ways to collaborate. Most questionnaire respondents were interested in a VCSE sector health inequalities group, but there was significant concern to

ensure diversity of representation/participation and tangible impact on decisions and positive action.

In addition to place and asset-based approaches, an affordable, accessible, effective transport system and tackling isolation were seen as some of the most important solutions to addressing health inequalities. Other solutions put forward were recognition of and investment in the care sector as an economic driver in the region, tackling housing issues, linking of initiatives, and establishing a recognised and unified measure for SROI (Social Return on Investment) so that the value of preventative work can be quantified.

The inequality drivers which are specific to rurality were discussed, including poor digital connectivity, transport, distance from services, hidden deprivation (masked by wealth), people facing challenges being in a 'minority', fuel poverty and high housing costs, coupled with low wages.

There was considerable discussion regarding digital healthcare, both in terms of the benefits and the nuances of digital exclusion. One participant talked about the ways in which her organisation was supporting people to be more familiar with digital options and there was input from the NHS X project, whose initial findings illustrate pockets in Devon where there are many people at risk of digital exclusion in areas where there are less support initiatives.

Participants were interested in current system changes and the potential for further collaboration between the VCSE sector and decision makers. They did, however express concerns regarding the lack of recognition for the care sector as an economic driver in the region, how to influence decision-makers so that action is taken on the challenges people face ('too much talk and not enough action'), the difficulty in ensuring under-served groups are genuinely involved in the dialogue/actions addressing health inequalities, the lack of sustainable funding for the sector and the difficulty for smaller organisations to find capacity to undertake activities beyond frontline delivery. Many participants were interested to know what the outcomes from this project would be.

Almost half the respondents from the questionnaire didn't know where to find data regarding health inequalities and most session participants said it was useful to spend time in the sessions looking at/re-visiting the data. There was significant discussion in the sessions regarding the limitations of the data for an area such as Devon, where deep pockets of deprivation can be masked by wealth. Participants talked about the importance of balancing quantitative data with qualitative data, including stories and getting to know a community and what the issues are (including all the positive experiences people in that area may have). Many suggestions were made regarding improving the accessibility

of the data and the kind of data which would be useful. These included ensuring acronyms and statistical terms are explained, further consultation with the VCSE sector regarding data requirements/in what way the data is currently being used and having data to illustrate how investment matches need and to illustrate the value of preventative work.

In conclusion, the project demonstrated that VCSE and public sector employees do benefit from coming together to learn more about health inequalities and to discuss what needs to happen to address them. Many participants felt strongly that they wanted to see 'action' and not just 'consultation', with clear channels for representation from a diverse group of people (who really understand what the issues are in their communities) to influence decision makers. Whilst there is more recognition of place-based, asset-based, co-produced, preventative, and collaborative approaches, many participants thought there was insufficient investment in the sector for the transformation required at a community level to take place. We agreed we would send this report to the participants who requested it and it would be valuable to be able to feed back to participants any actions arising from it.

13.2 Recommendations

Following the work of the project and the knowledge and suggestions which emerged from it, we would make the following recommendations.

Recommendation 1

There was significant interest and drive from participants to play a more significant and influential role in decision-making and the development of action plans regarding health inequalities. 74% of those who responded to the questionnaire and several session participants said they would be interested in being part of a Devon Voluntary and Community Sector Tackling Health Inequalities Action group. A number of session participants qualified their response with specific proposals for such a group. Given this our recommendation is as follows:

A health inequalities group is established. The group comprises representation from statutory and non-statutory bodies to ensure collaboration and dialogue and is led by the VCSE sector

- ***The group identifies how the VCSE sector can drive and/or play a significant role in agreeing priorities and taking action to address health inequalities (could be part of the emerging VCSE assembly structure)***

- ***The group looks at how to ensure representation from across the sector and genuine opportunities for under-served groups to engage in the dialogue***
- ***The group takes forward and builds upon the ideas and intelligence gathered from this and other relevant projects, identifying and progressing actions***

Recommendation 2

Given the project generated feedback and ideas from a range of organisations, our recommendation would be to:

Ensure findings from the project are shared and discussed with relevant bodies/decision makers, beginning with VCSE partners, to build upon intelligence and insight

Recommendation 3

The importance of the VCSE sector in tackling health inequalities is widely recognised. Session participants felt strongly that genuine recognition required sustainable funding. In response to this, we would recommend that:

The health inequalities group (see recommendation 1) promotes the significant role the VCSE sector plays in addressing health inequalities, identifying solutions and sustainable funding models

Recommendation 4

Participants raised the ongoing difficulty for smaller organisations and community groups to engage in activities beyond frontline delivery. A recommendation emerging from this is:

VCSE groups will incorporate into revenue generating activities additional funding to enable them to engage in work beyond frontline delivery and the public sector has a commitment to funding this sort of work (e.g. to engage in broader dialogue re health inequalities, co-produced activity and evaluating/demonstrating impact)

Recommendation 5

The sessions generated feedback and proposals from participants regarding the JSNA interactive tools. Given the information gathered, we would make the following recommendation:

Discuss with the Public Health Intelligence team the feedback regarding the JSNA interactive tools and consider further consultation with the VCSE sector (maybe via the delivery of further sessions) to ascertain the relevance and impact of the tools for VCSE organisations

Recommendation 6

In light of income and employment being major social determinants of health, several participants in two of the sessions highlighted a need for more recognition of the economic value of the health/social care and VCSE sector leading to the following recommendation:

Representation to be made to relevant bodies (e.g. LEP) with the aim of securing recognition of the economic value of the VCSE and health and social care sector as a significant economic driver in the region

Recommendation 8

The project demonstrated clear benefit to VCSE organisations who attended the sessions, and both the questionnaire and feedback/discussion from the sessions demonstrated the need for/value of learning more about health inequalities, linking initiatives and collaborating. Several participants said they hadn't known what to expect from the sessions and we would suggest many people working in the VCSE sector may still not see the relevance of sessions such as these to the work they do. Our recommendation would be to:

To expand upon, develop and have more conversations with the VCSE sector, partly via the delivery of further sessions, to promote learning, further collaboration and intelligence gathering (NB identify resource to do this and consider how to extend the reach of the sessions/conversations)

Appendices

Appendix 1 Marketing materials

1) E-flyer (also printed)
2) Graphic to accompany social media posts

Appendix 2 Quiz – questions, answers, and responses

- *Q1 Which of the following impact upon health (multiple choice)?*
- Income
- Education
- Healthcare
- Housing
- Employment
- Environment
- Food
- Transportation
- Gender
- Ethnicity

Answer – all of the above. 88% of attendees got this answer right

Q2 In 2016-18 what was the median age of death for people with learning difficulties?

- 44 yrs
- 59 yrs
- 63 yrs
- 69 yrs

Answer – 59 years. 58% of attendees got this answer right.

Q3 In 2016-18 what was the median age of death for people who were homeless?

- 44 yrs
- 59 yrs
- 63 yrs
- 69 yrs

Answer – 44 years. 70% of attendees got this answer right.

Q4 What is the gap between life expectancy for a baby born in Ilfracombe Central and a baby born in Liverton?

- 5 yrs
- 10 yrs
- 15 yrs
- 20 yrs

Answer – 15 years. 30% of attendees got this answer right.

Q5 Which of the following will make the most difference to addressing health inequalities (single choice)?

- Increased funding for the NHS
- Tackling the social determinants of health (e.g. income, housing, education)
- Individuals changing their health behaviour

Answer – Tackling the social determinants of health (e.g. income, housing, education). 91%

Q6 What percentage of people living in urban areas do not have access to their nearest hospital within an hour's travel?

- 8%
- 24%
- 33%
- 51%

Answer – 8%. The percentage of attendees who got this answer right was 48%

Q7 What percentage of people living in rural areas do not have access to their nearest hospital within an hour's travel (single choice)?

- 8%
- 24%
- 33%
- 51%

Answer – 51%. The percentage of attendees who got this answer right was 67%

Q8 Which of the following is associated with the biggest increase in mortality (single choice)?

- Obesity
- Loneliness
- Smoking 10 cigarettes a day

Answer – Loneliness. The percentage of attendees who got this answer right was 64%

Q9 What percentage of ALL deaths in 2019 were caused by cardiovascular disease in black and minority ethnic groups?

- 7%
- 16%
- 24%

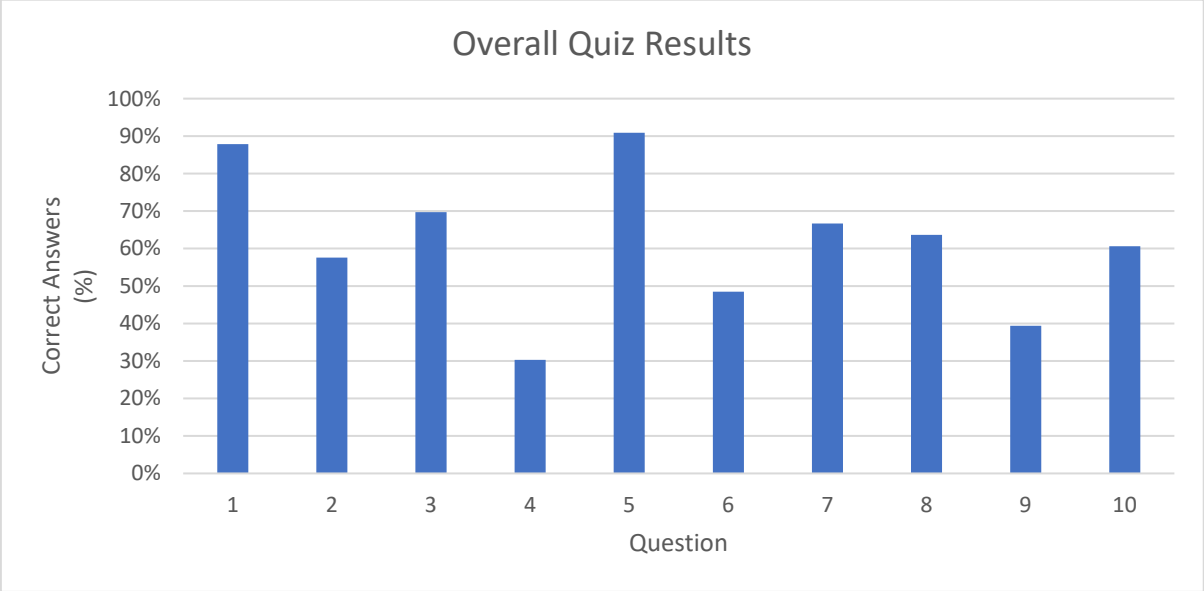
Answer – 24%. The percentage of attendees who got this answer right was 39%

Q10 What percentage of the UK population live in poverty?

- 7%
- 14%

- 22%

Answer – 22%. The percentage of attendees who got this answer right was 61%



[i] Health Equity in England: The Marmot Review 10 years on. Institute of Health Equity.
[ii] Holt-White E. Public opinion on the determinants of and responsibility for health. The Health Foundation. 2019.
[iii] Public Policy Projects and the Institute of Health Equity (2021). Addressing the National Syndemic. Place-based problems and solutions to health inequality.
[iv] Please note that it should be recognised these were multiple choice questions looking at exact figures/percentages. Attendees' responses do not necessarily suggest they did not understand that there is an issue.