Mayoral Regions Programme

Supported by: The Health Foundation

Lead delivery partner: West Midlands Combined Authority

Getting the foundations right

A practical guide for Strategic Authorities to take action on health inequalities

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Foreword

Strategic Authorities (SAs) are playing an increasingly important role in shaping the conditions that enable people and places to thrive. Recent devolution reforms, including the introduction of the new health duty, recognise the significant influence that SAs have over many of the building blocks of health. As evidence continues to demonstrate the close relationship between health, productivity and economic prosperity, there is a growing expectation that improving health and reducing inequalities should be considered alongside wider ambitions for inclusive growth and public service reform.

The Mayoral Regions Programme (MRP) is funded by the Health Foundation and delivered by the West Midlands Combined Authority in partnership with nine other Mayoral SAs. Through supporting capacity within Mayoral SAs, strengthening collaboration and peer learning, and building the evidence base on the role of devolved government in improving health, the MRP seeks to help regions make meaningful progress in tackling health inequalities. This guide has been produced as part of that ambition, bringing together emerging learning, evidence and practice from across England at a time of significant change for both the devolution and health landscapes.

Getting the Foundations Right: A Practical Guide for Strategic Authorities to Take Action on Health Inequalities has been developed to support both existing and emerging SAs in responding to the evolving policy and delivery context.

It is intended for mayors, elected members, senior leaders, and health and policy professionals working across regional government, the NHS and wider health-related services who are seeking to understand and strengthen the role of SAs in improving health and reducing inequalities.

The resource and supporting appendices focus on the practical considerations involved in delivering the health duty and making effective use of the wider powers, partnerships and levers available through devolution. Rather than prescribing a single approach, it brings together emerging practice, shared learning and illustrative examples from across England. Its purpose is to help SAs reflect on their current position, identify opportunities for action and develop approaches appropriate to their local context, priorities and ambition.

Foreword

Given the pace of change across devolution and health systems, this guide reflects the current policy context at the time of publication, while focusing on enduring principles that can support action regardless of future changes to governance arrangements or national policy. As new evidence, learning and practice emerge, future iterations will continue to evolve alongside the role of SAs.

We are grateful to the many colleagues and organisations across the MRP network, including the Programme's Governance Board and SAs, local government, the NHS, academia and wider partners who contributed their expertise, insight and experience to the development of this guide. We are also grateful to the Health Foundation for funding the MRP and supporting its work.

We hope this resource helps SAs seize this once-in-a-generation opportunity to harness devolution in service of local communities - improving health, reducing inequalities and creating the conditions for healthier, fairer and more prosperous regions across England.

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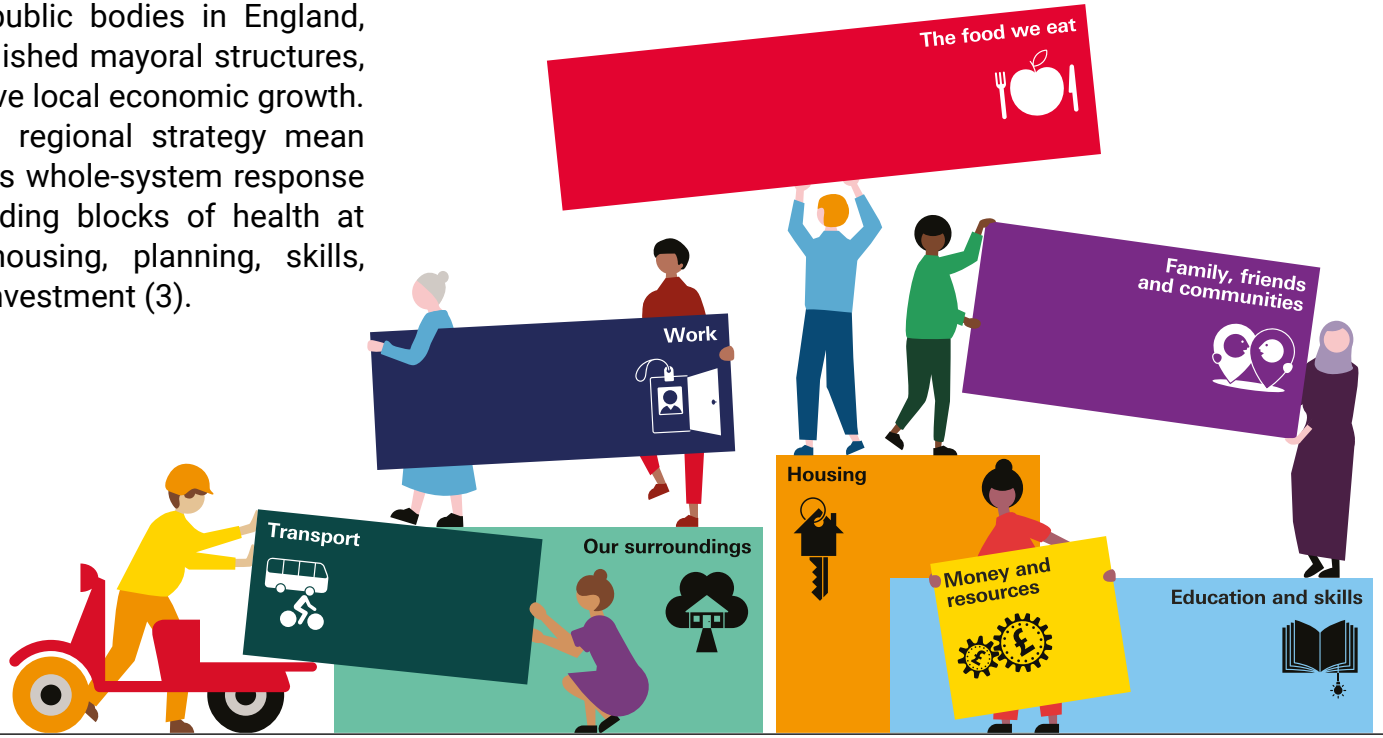
Introduction

There is growing consensus that improving health is not only essential for wellbeing, but also for economic prosperity and the sustainability of public services (1). National ambitions to reduce inequalities in healthy life expectancy as part of the '10 Year Health Plan' depend on effective collaboration between government, Local Authorities (LAs), the NHS, employers and regional leaders (2). Meaningful action to improve health and reduce inequalities also requires effective cross-sector coordination and recognition of health as both a social and an economic asset.

Strategic Authorities (SAs) are regional public bodies in England, comprising foundation, mayoral and established mayoral structures, created to receive devolved powers and drive local economic growth. Their position as bodies that coordinate regional strategy mean that they are uniquely positioned within this whole-system response because they influence many of the building blocks of health at a regional scale, including transport, housing, planning, skills, employment, economic development and investment (3).

SAs now have a new health duty, alongside a health, wellbeing and public service reform competence, new convening powers, with proposals for greater legislative support for joint working and pooled budgets across the public sector, and the option to appoint health commissioners, amongst other levers.

Taken together, these reforms position SAs as increasingly important place-shaping institutions with the potential to improve health and reduce inequalities at regional scale.



Introduction

Why this matters

Healthy life expectancy in England is falling, and health inequalities are widening (4). These outcomes are shaped largely by the conditions in which people are born, grow, live and work, including housing, employment, transport and the environment. These fundamental building blocks of health are central to the prevention agenda (5).

SAs influence many of these building blocks of health, meaning their decisions can play an important role in improving health and reducing inequalities. Population health and economic growth are mutually dependent; healthier populations support stronger economies, while inclusive economic growth helps create the conditions for better health. A strong economy generates the tax revenues necessary to improve living standards and fund healthcare (6). Therefore, investing in health should be viewed as an economic investment and necessity, as improved health supports labour market participation, productivity, inclusive growth and public service sustainability, while reducing the economic costs associated with ill-health and inactivity (7, 8).

For many SAs the case is already made that health is a core part of their role. The Mayoral Regions Programme (MRP) Health In All Policies (HiAP) Toolkit demonstrates many strong examples of SAs taking action and working with LAs, ICBs and other partners to drive improvements in the health and wellbeing of their populations.

The most significant opportunity may not be the duty alone, but the ability to use devolved powers, investment, commissioning, partnership and convening functions more intentionally in support of population health. However, in keeping with the principles of devolution, it will be for mayors and SAs to choose how to shape this role in line with local health need, context and ambition.

An overview of the current policy landscape

The English Devolution and Community Empowerment Act (2026) establishes a new health duty for SAs without existing health duties, requiring them to "have regard" to improving health and reducing health inequalities in their decision-making across areas of competence (9). This does not make SAs responsible for commissioning or delivering health services. Rather, it formalises their responsibility to consider how regional policy, investment and place-shaping decisions influence health and health inequalities. See **Figure 1** for a summary of SA areas of competence.

Figure 1. SA areas of competence

- **Transport and local infrastructure**
- **Skills and employment support**
- **Housing and strategic planning**
- **Economic development and regeneration**
- **Environment and climate change**
- **Health, wellbeing and public service reform**
- **Public safety**
- **Culture**
- **Rural affairs and coastal communities**

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An emerging role for Strategic Authorities in the broader health system

Guidance published alongside the English Devolution and Community Empowerment Act indicates that the intention of the health duty is (10):

1. To ensure SAs consider how their actions will impact wider health outcomes across their areas of competence.
2. To give SAs a stronger role as active leaders for health, supporting their engagement with wider health and care system partners.
3. To reinforce a Health in All Policies approach, embedding health considerations across all areas of competence, supporting the health mission in England to halve the gap in healthy life expectancy between the richest and poorest regions.

Alongside the duty, a health, wellbeing and public service reform competence has been introduced for SAs. This creates further opportunities for partnership working, convening, investment alignment and public service reform. These opportunities are strengthened by a wider set of devolution levers. These include new convening powers, greater legislative support for joint working and pooled budgets across the public sector, the option to appoint health commissioners, Integrated Settlements, and mechanisms such as the Right to Request additional devolved powers and funding.

These developments reflect a broader shift towards shared responsibility for health and health inequalities, and an expectation that all parts of the system prioritise effective prevention to help populations remain in good health. While LAs, the NHS and SAs have distinct functions and accountabilities, each has an important role to play in shaping the conditions for good health.

The **health and devolution policy appendix** gives further details of key legislative developments in devolution and health system reform and provides an interpretation of what they could mean for SAs *(N.B. some of these developments remain subject to change as the NHS Modernisation Bill (Health Bill) progresses through Parliament).*

An emerging role for Strategic Authorities in the broader health system

Equal and complementary roles in health system leadership

Change this sentence to: “The health duty and accompanying powers and levers for SAs are intended to complement, rather than replace, the existing statutory health responsibilities held by LAs, the NHS and ICBs (1).

Local Authorities influence health through their public health responsibilities and wider place-shaping functions that influence health and wellbeing, including planning, housing, transport and community services.

NHS organisations and ICBs influence health through healthcare planning, commissioning, service delivery and population health approaches.

Strategic Authorities influence health through regional policy, investment and partnership working across the building blocks of health.

SAs, LAs and NHS partners should develop a shared understanding of their respective roles to avoid duplication, support effective prevention and strengthen collaboration, whilst acknowledging that these roles may often be interconnected. **Figure 2** provides a simplified at-a-glance summary.

Figure 2. Summary of health system partner roles

Function	Local Authority	ICB	MSA
Improve population health	✔ Statutory duty	✔ (Population Health Role)	✔ Have regard
Reduce health inequalities	✔ Explicit	✔ Explicit	✔ Have regard
Public health delivery	✔	✘	✘
NHS commissioning	✘	✔	✘
Wider determinants	✔ (Place)	Limited	✔ (Regional)
Geographic Scale	Neighbourhood / place	Multi-place / system	Region

An emerging role for Strategic Authorities in the broader health system

SAs have an opportunity to uniquely influence the systems and structures that prevent ill-health and shape broader health and social outcomes. **Figure 3** below contains a summary of unique levers for SAs to add value in addressing regional health inequalities.

Figure 3. Unique levers for SAs

Regional-scale determinants

Taking action in areas such as transport connectivity, housing quality and pipelines, spatial planning frameworks, net zero, inclusive growth, skills and employment systems.

Cross-boundary working

Particularly where LA footprints and NHS "places" don't align neatly.

Investment-led activity

Capital programmes, transport schemes, regeneration, major procurement.

Convening-led activity

Brining partners together around shared outcomes. Mayoral convening powers strengthen this role and support development of a shared regional vision for health.

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Purpose of this guide

Principles

This guide aims to provide support to emerging, new and existing SAs during a period where each will need to consider how to meet its obligations under the health duty, and what shape its broader systems role on health and health inequalities will take.

As no further implementation guidance is expected from government, this document supports SAs in defining and operationalising their role. It aims to provide support to SAs at an early stage of development and those seeking to strengthen existing approaches when implementing the health duty and wider related powers and levers.

Given the evolving policy landscape and current pace of change, this guide is focused on enduring principles rather than the prescription of fixed arrangements. It also reflects the principles of devolution by recognising that implementation must be locally led and locally defined.

It highlights practical approaches that support meaningful action rather than compliance alone, and draws on shared learning, peer insight and collective leadership of the members of the (MRP), to:

- Articulate what effective implementation could look like
- Support proportionate progress across different starting points
- Contribute to wider national discussions on implementation and accountability

This guide also aims to offer insights to support both working within SAs and developing effective wider partnerships to drive health improvement.

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Purpose of this guide

Structure

It consists of the following sections:

Practical enablers and illustrative regional approaches (main document)

A summary of six key enablers that support SAs to improve health and reduce health inequalities, both within their own organisations and through collaborative work with system partners, with linked illustrative regional case studies of how these have been approached.

System maturity matrix (appendix A)

A quick-start tool designed to help SAs identify options for action, reflect on their current position, and apply the guide in ways that suit different local contexts and partnership journeys.

Regional health and devolution policy context (appendix B)

A more in-depth summary of key policy context regarding the health duty for SAs and other developments.

Emerging health system landscape (appendix C)

A high-level summary of the emerging health system alongside the current policy landscape.

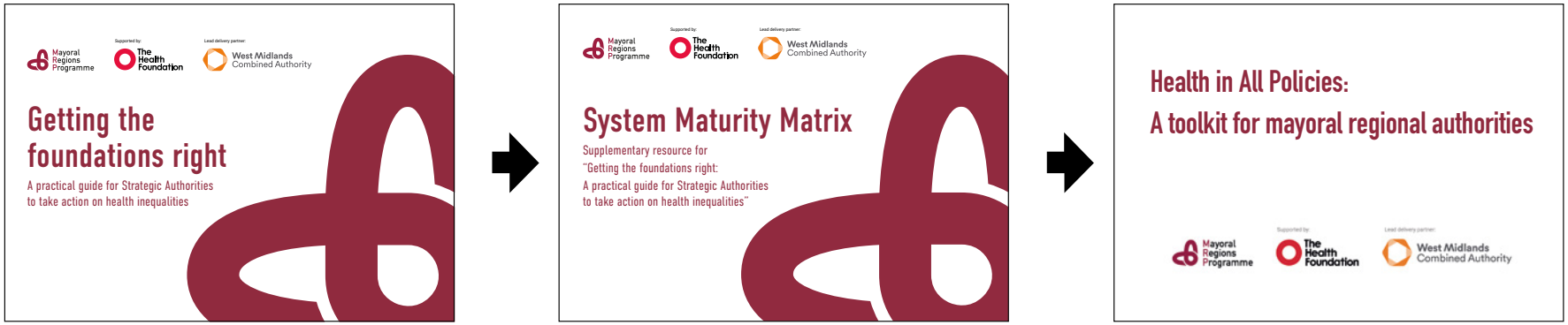
The focus within these resources is primarily on the "how" of implementation – for example, health need assessment, governance, collaboration, accountability, capability and investment – offering an entry point for developing and strengthening structures, systems and partnerships. For SAs wanting to progress to the "what" of improving health through policies and interventions, the MRP Health in All Policies Toolkit provides in-depth tools and case studies to support implementation.

Purpose of this guide

How to use the guide alongside other resources

Figure 4 below provides a summary how the MRP's resources, including this guide, can be used when developing strategic approaches to addressing regional health inequalities.

Figure 4. Summary of progressive MRP resources and how they can support a diversity of SA contexts to address health inequalities:



- Policy and health context
- Practical enablers
- Illustrative examples of practice

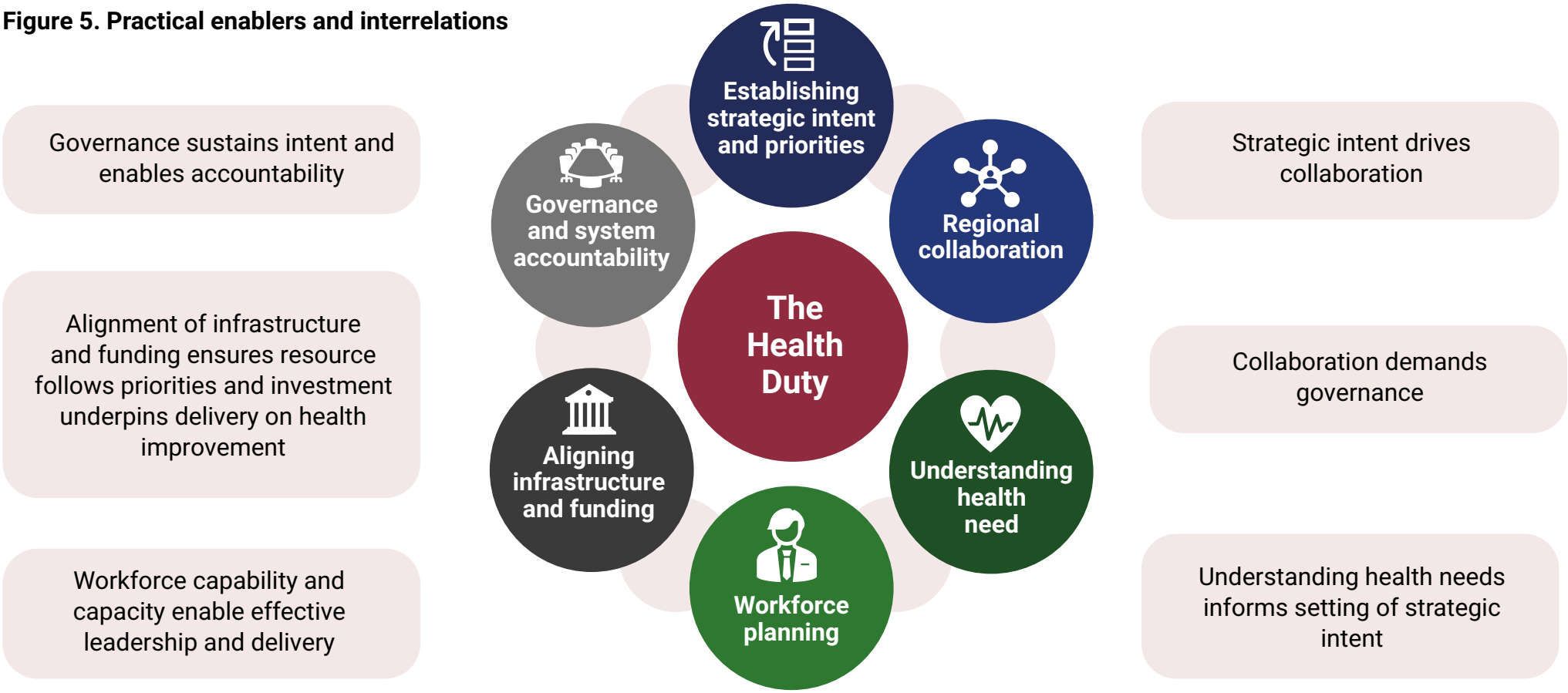
- Quick start matrix
- Use to assess local context for implementation
- Options for action in a diversity of contexts
- Reflective questions to support development
- Lists key resources for futher support

- Supports in depth strategic development for SA action on health
- Maps SA levers and functions against the building blocks of health
- Includes detailed implementation case studies
- Provides organisational self assessment tools for embedding a Health in All Policies approach

Creating the conditions for success – practical enablers

Following in-depth discussions and workshops with experienced senior leaders in a range of SAs, six practical enablers have been identified that can support implementation of the health duty and help to build effective partnerships to improve population health. These enablers are largely interrelated and operate both within SAs and across partner organisations; **Figure 5** below provides an overview of these enablers and their interrelations.

Figure 5. Practical enablers and interrelations



Governance and system accountability

This section sets out approaches for SAs to consider when thinking about accountability for the health duty, whilst recognising that SAs will start from different baselines and that action will develop over time. It describes how accountability can evolve from demonstrating basic considerations of health, through to embedding consistent practice and governance, to evidencing meaningful outcomes and impact.

Although described here in a linear process for simplicity, developing effective mechanisms for organisational and system wide governance of shared health ambitions is iterative, making use of both formal and informal routes to progress. SAs are likely to combine elements from across the spectrum of activity in ways that best suit their local context. The accompanying System Maturity Matrix appendix document can be used alongside this section as a practical tool to support reflection, self-assessment, and identification of next steps.

A starting point

A starting point for SAs is demonstrating accountability for meeting their health duty. The foundation of this is being able to evidence a proportionate and credible response, transparently showing how health and health inequalities are consciously and consistently considered in decision making across all SA competencies.

In practice this means SAs should strive to:

- Demonstrate that health impacts have been considered in functions through policy, strategy and investment decisions
- Draw on proportionate evidence, or professional advice, to inform considerations
- Explain how health has influenced options, trade-offs and final outcomes/decisions
- Record this transparently and consistently within existing documentation

This does not always require new standalone processes or additional bureaucracy. Instead, SAs can make health considerations visible within existing decision-making systems, such as business cases, strategy documents, or committee papers. This shows that health is recognised as a relevant and legitimate factor in decision-making, alongside other priorities. Establishing this minimum level of accountability creates the conditions for more systematic approaches to develop over time.

Governance and system accountability

Building accountability (within the SA)

SAs can embed health and inequalities more systematically within organisational processes, so that consideration becomes routine rather than dependent on individual initiative, with clear, replicable ways of demonstrating how decisions have taken account of their impacts on health and health inequalities.

To strengthen consistency, visibility and organisational learning, SAs may:

- Integrate health and inequalities into standard decision-making templates, ensuring that consideration is prompted consistently
- Align health with corporate priorities and strategic objectives, reinforcing its relevance and reciprocal 'win-wins' across policy areas
- Introduce regular reporting or reflection points, such as updates to senior leadership or inclusion in performance frameworks
- Assign clear responsibility or leadership, helping to coordinate activity and maintain momentum

Monitoring can also become more structured; rather than solely recording that health has been considered, SAs should begin to track patterns, identify gaps, and support continuous improvement. This may include reviewing how consistently health is reflected in decisions, where further evidence or capability is needed, and how effectively different parts of the organisation are engaging with the health duty.

This ensures that existing systems support more reliable and meaningful consideration of health impacts and signals a shift from basic transparency to organisational consistency and coordination.

Governance and system accountability

Strengthening governance (across the system)

As accountability becomes more consistently embedded within an SA, it is worth considering how to strengthen governance arrangements so that health and health inequalities are not only considered, but that action is also coordinated and sustained over time. This includes both internal SA governance and the wider cross-organisational partnership governance needed to support shared action.

As health outcomes are influenced by decisions and actions across multiple organisations, strong governance arrangements help ensure partners understand their respective contributions, monitor progress collectively and remain accountable for delivering on shared ambitions and outcomes.

SAs may adopt a range of approaches, including:

- Using existing boards, committees, and/or assurance routes to oversee how health and inequalities are being considered in decision-making
- Clarifying roles and responsibilities, including where leadership sits and how accountability is shared across teams
- Establishing routes for constructive challenge, ensuring that health impacts are meaningfully tested and discussed
- Aligning governance across organisational partnership settings, recognising the shared nature of improving population health

Some SAs use explicit governance arrangements, such as named leads, dedicated groups, or partnership forums. Others may continue to embed accountability within existing structures. Both approaches can be effective, provided they are clearly linked to decision-making and delivery, rather than operating as standalone forums.

The ability to balance flexibility with consistency creates a more resilient system for sustaining attention on health over time. Informal relationships, joint working, and collaboration can support responsiveness and pace, while formal governance can provide structure, continuity and legitimacy.

Strengthened governance will help to develop a more strategic and system-wide perspective that enables SAs to coordinate action across policy areas, support alignment with system partners (e.g., NHS and LAs) and optimise their role in shaping the building blocks of health. This represents a shift from organisational consistency to system leadership and shared accountability.

Governance and system accountability

Outcomes and impact

SAs can support a more intentional prevention and health improvement focus by being clear about the health outcomes they are seeking to improve and what levers or influence they have, to unlock improvements. This means not only assessing the health impacts of decisions but shaping proposed organisational decisions from early in their development, with improving health as a valued core outcome rather than marginal benefit.

SAs should be able to:

- Define the health and health inequalities outcomes they are seeking to influence
- Set out how their actions are expected to contribute to those outcomes
- Track progress using a mix of quantitative and qualitative evidence
- Explain their contribution alongside those of system partners

Demonstrating impact on health outcomes can be complex, as they are typically long-term, influenced by multiple factors, and shared across systems. Tools such as logic models or theories of change can help articulate rational explanatory links from decisions to outcomes, identifying short term indicators (or proxy measures) of success that will lead to long term impacts on health outcomes.

A proportionate approach to monitoring combines data with clear narrative and strategic intent. Accountability for this should support learning and continuous improvement, rather than compliance alone. It can also enable SAs to demonstrate how the health duty is contributing to wider priorities and delivering real benefits for communities.

Reflecting the collaborative nature of improving population health, some SAs are working with partners to develop shared outcomes frameworks, which align priorities and support collective measurement of progress across sectors.

Governance and system accountability

Local democratic versus national accountability

Importantly, many SAs have advocated for being held to account for fulfilling the health duty, recognising that clear expectations on accountability can help to focus action, build momentum and drive meaningful change. However, there is an understandable tension between a desire for visibility and priority to be given through national oversight, and the principles of devolution where local priorities should flow from local mandate and be democratically accountable.

SAs may establish such local accountability through visible commitments to health improvement made within strategy and policy, paired with transparent reporting of progress on achieving these commitments. SAs have also endorsed an approach that respects the spirit not just the letter of the law, through a focus on accountability for achieving meaningful health outcomes over time rather than on whether specific structures or processes have been adopted.

Governance and system accountability

Illustrative regional approaches

Leadership drives accountability

- Some SAs have identified named leads, cabinet members or board sponsors for health and inequalities. This can strengthen visibility, provide leadership and reinforce that the duty is a collective organisational responsibility.
- The Greater London Authority (GLA) has a deputy mayor with responsibility for health, providing visible political leadership across portfolios. In other areas, mayors or senior leaders play a prominent role in aligning health priorities across SA and system-level governance, with Greater Manchester a prime example.
- Both GLA and Liverpool City Region Combined Authority (LCRCA) highlight the importance of strong mayoral leadership in developing and implementing healthy advertising policies:

In ***GLA***, their healthier food advertising policy was introduced in 2018 as part of a wider mayoral commitment to address child obesity and health inequalities. Key impacts of the policy include:

- A 20% reduction in purchases of calories from confectionery
- 1,000 fewer calories purchased per household per week
- Stronger impacts in more deprived communities supporting reduction in inequalities.

In ***LCRCA*** a policy was developed in 2026 across transport assets to restrict advertising of food products high in fat, sugar, or salt (HFSS) and vaping, alongside a commitment to review inclusion of alcohol and gambling; Here, the CA integrated the policy within existing mayoral priorities and the health duty to drive it forward.

Governance and system accountability

Embedding health into decision making processes

West Midlands Combined Authority (WMCA) has embedded Health and Equity Impact Assessments (HEqIAs) within its Single Assurance Framework. This approach seeks to systematically guide decision-making by understanding health and equalities impacts and their distributions on different populations as an instrument for change. Responsibility for conducting HEqIAs is delegated across relevant policy or practice holders, with support available from the WMCA's Equalities Team. The WMCA is exploring the development of related training to help drive the embedding of HEqIAs at all stages of the policy lifecycle.

Additionally, the ***WMCA*** Health & Communities team has co-developed a series of logic models with non-health teams through a systematic process of formulating evidence-based assumptions. These have served as a foundational framework for articulating how activity across directorates influence the region's longer-term health and equity, providing a strong co-developed narrative for deliberate collective action on the building blocks of health.

Governance and system accountability

Defining outcomes and measuring impact

In ***Greater Manchester Combined Authority*** (GMCA), population health considerations are often evidenced through explicit alignment with existing strategies and partnership priorities, rather than through additional compliance processes. In tandem with the local NHS, they have utilised their established partnership with Professor Sir Michael Marmot and the Institute for Health Equity to develop a regional indicator set. This 'Marmot Beacon Indicator Set' utilises health intelligence to inform priorities for system-wide action and measure progress across the building blocks of health (housing, income, employment, environment and early years support). Focusing on fewer, more meaningful indicators has helped bring the system together and ensure accountability for monitoring and reprioritisation of joint goals.

East Midlands Combined County Authority (EMCCA) have developed an Outcomes Framework, which includes health, to translate the EMCCA's core mission and six long-term ambitions into actionable change. This is enabling EMCCA and its partners to align around common goals while tracking progress consistently. The framework strengthens accountability in policy and investment by requiring all programmes to explicitly demonstrate how their outputs contribute to one or more agreed outcomes, supported by proportionate scrutiny throughout the project lifecycle.

Governance and system accountability

Aligning with partnership governance structures
In some areas, health priorities are reflected within existing partnership governance arrangements, helping to align regional and system-level priorities.

WMCA have established a Strategic Health Partnership Board to provide leadership on improving health and reducing inequalities through the building blocks of health at a regional scale. The partnership acts as a strategic forum that brings together, under the mayor's Chairmanship, ICBs, LAs, Directors of Public Health, the Office for Health Improvement and Disparities and other key partners to align priorities and collective action. This provides a mechanism for embedding a health in all policies approach across regional policy and investment decisions while complementing, rather than duplicating, the statutory responsibilities of LAs and the NHS.

Greater Manchester Integrated Care Partnership (ICP) brings together GMCA, NHS organisations, LAs and Voluntary and Community Sector partners under a shared governance structure. By embedding population health within this system-wide forum, partners can align priorities, agree outcomes, coordinate action across sectors and hold collective accountability. For example, the ICP has enabled joined-up work on employment and health through the Get Greater Manchester Working Plan, tackling longstanding challenges around work, disability and inequalities.

West Yorkshire Combined Authority (WYCA) and ICB colleagues have aligned their governance structures to support joint delivery across shared priorities, including population health, economic opportunity and the climate emergency. Senior leaders from both organisations sit on each other's boards, supported by a formal partnership agreement and a jointly funded Associate Director for Improving Population Health role. This integrated governance model enables collaborative decision-making, strengthens accountability, and ensures coordinated implementation of initiatives across the region.

Establishing strategic intent and priorities

Establishing clear strategic intent sets organisational direction and provides a practical steer on what matters, where to focus, and how health should shape decision-making. Experience shows that SAs are better able to embed a health in all policies approach across functions when health and inequalities are framed not as a specialist concern, but as a cross-cutting outcome. In addition, progress is often strongest where strategic intent is clearly linked to existing priorities, programmes and decision-making processes.

Setting strategic intent and priorities can also be done jointly amongst partner organisations to align and drive progress on population health improvement. This includes developing a shared understanding of what health improvement means in practice and where SAs can have greatest impact.

Effective strategic intent

This is characterised by:

- A clear narrative linking health to wider organisational and political objectives
- Visible leadership, signalling that improving health and reducing health inequalities is a shared responsibility
- Clarity on priorities, focusing effort where SAs have the greatest influence
- A proportionate approach, recognising that not all decisions require the same level of analysis

Establishing strategic intent and priorities

Additionally, a clear and shared narrative is a key enabler to effective implementation. SAs that are further advanced in this area often describe a shared story or understanding across the organisation of the relationship between health and wider outcomes such as growth, employment and productivity. This helps shift the focus from justification to delivery.

A strong narrative can:

- Support alignment across teams and directorates
- Increase confidence among officers in applying the duty
- Reinforce shared purpose across system partners

For many SAs, building a shared understanding through narrative, leadership messaging and internal/external engagement is an important step, before introducing formal tools or assurance processes. This sequencing builds momentum and supports stronger buy-in over time.

Across SAs, there is growing recognition that articulating intent alone is insufficient. The key challenge is translating ambition into practice, particularly in fast-paced policy and delivery environments where time, capacity and competing priorities can limit depth of consideration. The other practical enablers described in this guide support this transition into action.

The health duty strengthens the mandate to act, shifting health from a “nice to do” to a “need to do” and its impact depends on how effectively intent is translated into everyday practice. Implementation will vary across SAs, depending on local priorities and political context. In some areas, leaders have made explicit commitments to improving health and reducing inequalities. In others, health is being framed through priorities such as inclusive growth, active travel or tackling poverty.

Establishing strategic intent and related priorities is therefore an ongoing process of aligning activity and ensuring health and health inequalities remain visible within decision-making.

Establishing strategic intent and priorities

Illustrative regional approaches

Developing a shared narrative

Some SAs are framing health improvement and reduced inequalities within a shared regional narrative linked to collective outcomes that cut across wider priorities such as economic growth, skills, transport and regeneration. This can help to embed the health duty across portfolios and positions health as a collective system goal rather than a standalone issue. Leadership forums and partnership approaches can support this by aligning expectations across organisations and creating a shared direction of travel.

In ***South Yorkshire***, the "Health is Wealth" report is a vision led, ambitious and bold 10-year strategy championed by the mayor to radically prevent ill health at its roots, tackle stark health inequalities, and increase life expectancy. Commissioned by the mayor and developed by a panel of health experts working alongside LAs, Directors of Public Health and the ICP, it sets out a four-part plan to improve health and wellbeing across the life course. The four areas of focus are; radical prevention, health equity in all policies, proportionate universalism and an inclusive economy.

Similarly, early work by the ***WMCA*** on a health and inclusive growth toolkit focused on working with key stakeholders to develop a common narrative across policy areas before formalising governance through an Inclusive Growth Implementation Toolkit, which is linked to the HEqIA process.

The mayor of ***LCRCA*** has confirmed LCR as a Marmot City Region, reinforcing a long-term commitment to improving health and reducing inequalities. As a Marmot City Region, the CA will embed the Marmot principles across its devolved responsibilities, demonstrating leadership in putting health at the heart of decisions. The commitment builds on the strong foundations already established across Cheshire and Merseyside through All Together Fairer – the shared programme led by the region's Directors of Public Health and the NHS Director of Population Health – to tackle health inequalities by putting the Marmot principles into practice.

Establishing strategic intent and priorities

North East Mayoral Strategic Authority (NEMSA) has developed a Statement of Intent on Public Service Reform to articulate a clear, shared narrative on improving health and reducing inequalities across the region. Co-produced with LAs and the ICB, the Statement sets out the NEMSA's commitment and role across the building blocks of health and is now shaping Work, Health and Skills partnership to tackle the high rates of economic inactivity in the region.

Embedding health within strategies and decision-making

The mayor of the ***GLA*** is required to publish a range of statutory strategies including the Health Inequalities Strategy, the Mayor's Transport Strategy, the London Housing Strategy, and the London Growth Plan. These strategies collectively reflect a HiAP approach, identifying health inequalities as a cross-cutting priority across all mayoral strategies, rather than confining it to a single policy area.

In the ***WMCA***, consideration of health and inequalities is embedded within governance investment processes. For example, Transport for West Midlands (TfWM) undertook a HEqIA as part of the production process of their Local Transport Plan, which assisted with identifying several features within the plan that could be utilised to address health inequalities, including fair access, fair impacts, and active travel.

Regional collaboration

The health duty reinforces the need for SAs to work with partners, rather than acting alone. This typically includes coordinated action across LAs, Directors of Public Health, ICBs, NHS providers, the voluntary, community, faith and social enterprise (VCFSE) sector and other organisations influencing the building blocks of health.

SAs should remain mindful of evolving local governance arrangements, including emerging neighbourhood and place-based structures, when designing partnership approaches. In some areas, system changes such as local government reorganisation or changes to ICPs may create coordination gaps, reinforcing the need for proactive regional collaboration. In this context, SAs can help create alignment around shared outcomes, strategies and investment decisions.

Clarifying roles across spatial levels

Effective collaboration depends on clarity about where action is best led. In practice this often reflects different spatial levels, including the following:

Regional	Large scale systems such as transport networks, labour markets and major investment
Place	Service integration, local economic development and delivery partnerships
Neighbour-hood	Community-level prevention, engagement and delivery

Clarity across these levels can help avoid duplication, support subsidiarity, and ensure that action is taken at the most appropriate scale. The role an SA chooses to play may vary depending on local context, mayoral priorities and the maturity of existing partnerships. SAs should work through and alongside existing local governance and neighbourhood arrangements wherever possible, ensuring that regional action complements place and neighbourhood leadership.

Regional collaboration

Approaches to collaboration

Across SAs, collaboration is developing in different ways. In practice, SAs may lead where regional levers are involved, convene where action spans multiple organisations, and support where issues are best addressed at place or neighbourhood level. Mission-driven approaches - for example on work and health, clean air or housing quality - can build on existing priorities, align with national policy agendas, and deliver tangible short-term outcomes.

For some SAs, these approaches provide a practical starting point for building relationships and confidence. More established organisations and partnerships may take a broader population health approach, aligning priorities and embedding health within wider regional strategies and investment decisions. Many SAs combine both approaches.

Developing shared ambitions

Some SAs are developing shared strategic plans with partners to improve health and reduce inequalities. Shared statements of intent can reinforce common goals, reduce duplication, support coherence during system change and demonstrate collective ambition.
Such arrangements are often informal but can be effective when supported by established partnership forums.

Using convening power and existing structures

A key contribution of SAs is their ability to convene partners around shared priorities, even where they do not directly control delivery. This can include bringing organisations together to focus on specific issues such as housing quality, air quality, employment or mental health.

In many cases, collaboration can be most effective when it builds on established arrangements such as Health and Wellbeing Boards, Director of Public Health networks, ICBs, Marmot partnerships and other regional forums. This is because this approach helps to reduce duplication and strengthens established partnerships. SAs can also use their convening role to support the integration of community voice into regional discussions and strengthen links between partners and those most affected by health inequalities.

Regional collaboration

Illustrative regional approaches

Partnership with ICB population health teams
In several regions, SAs have worked closely with ICB population health and prevention teams, particularly to inform regional approaches to inequalities, prevention and neighbourhood-based initiatives. In some cases, this has manifested in joint ICB-SA posts or mayoral representation on ICBs.

For example, ***Greater Manchester*** have a Tripartite Agreement, bringing together the Combined Authority, housing providers and the ICB (via the Health & Social Care Partnership). Established in 2021 and refreshed in 2025, this agreement aligns partners around common priorities (including improving health through better housing), shared outcomes and coordinated delivery, supported by locality-level frameworks to ensure flexibility. By pooling expertise, resources and influence across systems, the partnership has enabled more integrated, place-based action, improving housing quality and supply, reducing reliance on temporary accommodation and supporting more people to live independently. This demonstrates how formalised, trust and relationship-based collaboration with the ICB and other partners can drive system-wide impact.

In ***South Yorkshire***, a new Health Commissioner role is being piloted to shift local decision-making out of Whitehall. Under this model the ICB Chair will also serve as the mayor's Health Commissioner, creating a formal bridge between the two for regional collaboration. This dual role aligns accountability across the health system and devolved structures, with the Commissioner reporting to both NHS leadership and the mayor. By working closely with LAs, health providers, and community services, the role is designed to support more coordinated decision-making that reflects local priorities and needs. It may also enable a more integrated approach to tackling the building blocks of health.

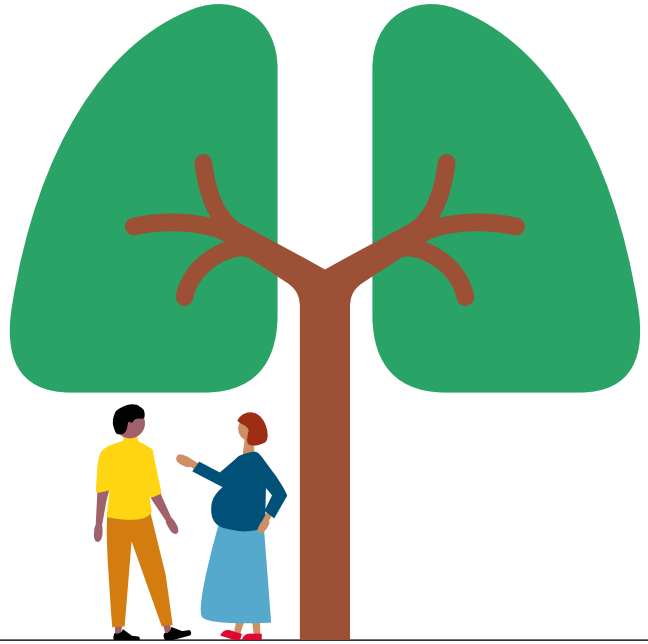
Regional collaboration

Bringing partners together around shared priorities

Some SAs are convening partners around specific issues, such as work and health, housing or air quality, to align activity and focus collective effort.

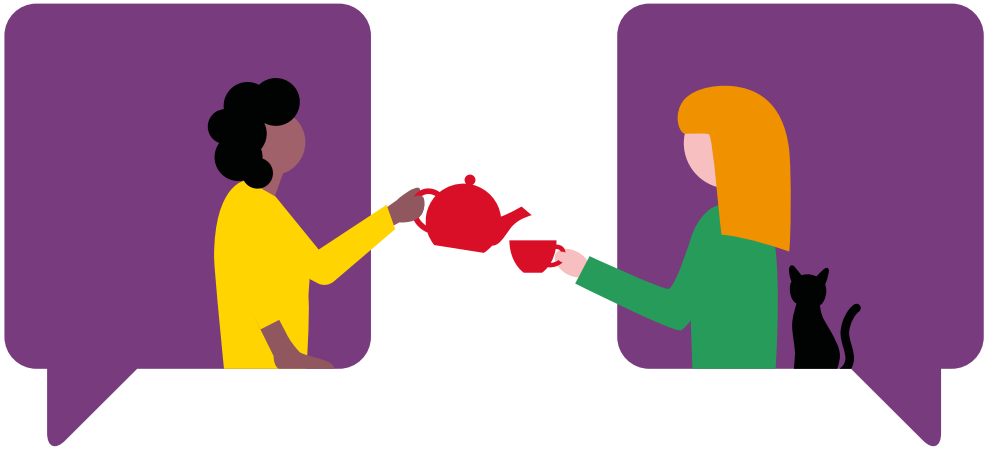
LCRCA have brought partners together around the shared priority of improving health through housing in developing their Housing Strategy. Led by the Lead Officer for Health Inequalities, LCRCA worked from the outset with the ICB, Directors of Public Health, Health and Wellbeing Boards and wider system partners to co-develop the strategy. This early and sustained collaboration created a shared understanding of housing as a key building block of health, enabling all partners to align around reducing health inequalities rather than treating health as a standalone issue. By coordinating input across six LAs and integrating health into every pillar of the strategy, the CA established a unified, cross-system approach that strengthened relationships, built shared ownership, and set the foundation for more joined-up, place-based action.

The ***WMCA*** have worked in partnership with key stakeholders across the region to develop the Air Quality Framework Implementation Plan, which sets regional goals to reduce unequal exposure to pollution. Local councils have supplemented this through localised Air Quality Supplementary Planning Documents (SPDs) that regulate emissions from new builds. Health outcomes, including direct improvement to human health and reduced health inequalities were key outcomes assessed during the process.



Regional collaboration

WMCA have exercised their role as system convenor to bring together education and wider system partners to establish a regional Mental Health Commission to consider the impact of the COVID-19 pandemic on mental health and inequalities and explore priority actions for the region. The emerging Thrive at College pilot programme saw the WMCA working with education providers and other relevant stakeholders to support schools and colleges to adopt a whole school approach to mental health and work towards zero exclusions.



Through a Climate and Ecological Strategy and the Placemaking Charter, the ***West of England CA*** (WoECA) has aligned partners around common priorities. This includes explicit references to the opportunities provided by action on the environment and built infrastructure to improve health and reduce inequalities. Working collaboratively with stakeholders across sectors, these documents provide a clear framework for coordinated action, from supporting businesses and residents to adapt to climate change, to embedding shared design and sustainability principles in development.

WYCA have a Healthy Working Life Board which is co-chaired by the mayor and the chief executive of West Yorkshire ICB, with representatives from charities, LAs, national government, and colleges. The Board oversees the delivery of the Healthy Working Life programme, which looks to break down longstanding barriers to good work by better integrating employment support services with health and care services, to offer holistic, person-centred support for those with health conditions and disabilities.

Understanding health need

Improving health and reducing inequalities requires a shared understanding of local need. For SAs, this means combining population health data with evidence on effective interventions to inform regional priorities, investment and policies supporting the prevention agenda. The main challenge with this can often be turning insight into action – i.e. translating evidence into priorities, linking it to investment decisions and avoiding repeated data collection without meaningful use.

Fortunately, SAs are not starting from scratch. Significant analytical capability already exists across LAs, ICBs, Office for Health Improvement and Disparities (OHID) regional teams and SA data teams. Joint Strategic Needs Assessments (JSNAs - a statutory requirement of LAs to produce, led by public health) provide an important foundation, including analysis of population health, inequalities and local priorities using both quantitative and qualitative evidence. Additionally, this work can be supported by organisations such as the Health Foundation and Local Government Association and related tools including the local authority dashboard (12) and Local Outcomes Framework (13).

However, despite the range of expertise and resources in this space, regional health intelligence is often fragmented across organisations and geographies.

Common challenges include:

- Non-coterminous boundaries between SAs, ICBs and LAs
- National datasets that do not align with regional geographies
- Limited availability of consistent SA-level data

Many SAs want more integrated data environments to bring together health, economic and wider building blocks of health data, alongside stronger use of lived experience and qualitative insight. There is also interest in greater availability of consistent SA-level data within validated health insight tools such as Fingertips (14).

Understanding health need

SAs are also increasingly identifying a regional role in understanding health issues linked to the building blocks of health that can complement locally led public health intelligence and support regional decision-making for population health. There is growing interest in developing shared regional population health priorities aligned with existing plans, including ICB Population Health Improvement Plans, Neighbourhood Health Plans and Health and Wellbeing Board priorities.

In practice, SAs are:

- Drawing on JSNAs and LA intelligence to build a regional evidence base
- Accessing ICB population health data to support prioritisation
- Using national datasets (e.g. ONS, Public Health Outcomes Framework) for benchmarking
- Combining quantitative analysis with lived experience insight

Overall, understanding health need is not a one-off analytical exercise, but an ongoing, system-wide function. SAs have an opportunity to bring together fragmented insight, develop a shared regional narrative, and use this to inform decisions across their core functions and levers for the building blocks of health.

Effective understanding of health need will also require meaningful engagement with communities and the VCFSE sector. Quantitative data can identify patterns and inequalities, but local insight can explain how this is experienced in everyday lives. As identified in a recently published report on delivering health equity through English devolution, engaging communities in shaping priorities and solutions can help to ensure that action is effectively planned and done with, rather than to, communities (15). In addition, coproduction with communities can be a means of health creation in itself, where individuals health and wellbeing is enhanced through creating the conditions for communities to take control and shape both services and their environment (16).

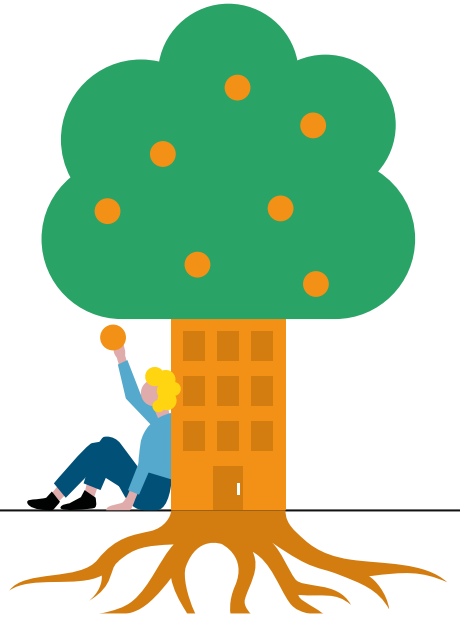
Understanding health need

Illustrative regional approaches

Using local and national data to build a shared evidence base
SAs are combining JSNAs, local dashboards and NHS data with national datasets to develop a regional understanding of need.

For example, ***LCRCA's*** Spatial Development Strategy demonstrates good practice by building a shared evidence base from both local and national health data to inform its report (An overview of health across the Liverpool City Region). This was commissioned early in the process to provide a clear, region-wide picture of health outcomes and inequalities ensuring all partners started with a common understanding of need. This was reinforced using wider technical evidence, public engagement, and a robust Integrated Impact Assessment that embedded health considerations into every stage of decision making. This made sure that health data was not only understood but actively used to shape priorities enabling informed and evidence led action.

The ***WoECA*** has developed a shared evidence base to inform action on climate and nature recovery, drawing on data from LAs, environmental partners, and national sources. Through its Climate and Ecological Strategy and Local Nature Recovery Strategy, the CA uses data on emissions, habitats, and environmental risks to identify priority areas and target interventions, including those concerning residents' health and wellbeing. Tools such as mapped "focus areas" and biodiversity datasets help partners align investment and action where it will have the greatest impact, supporting more coordinated, evidence-led decision-making across the region.



Understanding health need

Combining quantitative and qualitative intelligence
Alongside quantitative data, some SAs are placing increasing emphasis on qualitative insight, including lived experience and engagement with communities and the voluntary sector.

For example, the ***GLA*** has utilised mixed methods analysis, including lived experience insight, to better understand how inequalities are experienced and to shape more responsive policies. Through work with the Institute of Health Equity, both quantitative and qualitative evidence has been integrated to inform interventions on priorities such as anti-racism and skills. This approach is exemplified by the London Learner Survey, which captures both economic and social outcomes from adult education, including health, wellbeing, confidence, and social integration. By embedding these insights into the Adult Education Budget, the ***GLA*** has strengthened its evidence base - demonstrating how learning improves wellbeing alongside employment outcomes - and is using this combined intelligence to inform future skills policy and delivery.

Workforce planning – capability and capacity

Effective delivery on the health duty will require capability to apply a "health lens" across policy, investment and delivery, largely within existing resources. To build this capacity, SAs will need to ensure access to the right mix of expertise to support the following:

- Strategic leadership, governance and accountability
- Development of key insights on health need, inequalities and effective interventions
- Partnership working and system convening
- Policy and investment design, including health impact assessments and making the case for prevention

Across SAs, dedicated workforce capacity for health is often limited. Many rely on small teams or single policy-focussed roles with public health expertise accessed through partnerships, rather than embedded internally. In some areas, temporary or externally funded roles, such as public health registrars, are filling key gaps.

Colleagues across SAs have highlighted the importance of combining different forms of expertise to optimise action on health inequalities. Public health professionals bring technical and analytical expertise, while policy colleagues contribute knowledge of wider policy, systems and implementation in the regional landscape.

SA approaches to accessing relevant expertise broadly include:

- ✔ Using in-house health and/or policy roles or teams
- ✔ Drawing on LA public health, OHID or wider health system partner expertise
- ✔ Hybrid approaches combining both

Workforce planning – capability and capacity

Experience suggests that effectively embedding action on health inequalities depends on ensuring that health expertise has sufficient seniority, visibility and influence within organisational decision-making, alongside access to wider technical expertise needed to understand health need, inequalities and effective interventions.

At present, arrangements for accessing suitable expertise are often dependent on local relationships and can vary significantly between regions. There is growing recognition of the need for more systematic and sustainable approaches. Challenges are compounded by wider pressures, including reductions in public health capacity and uncertainty linked to local government reorganisation, raising questions about how workforce capability can be sustained in the future.

Importantly, delivery of the health duty cannot rely solely on specialist public health and health policy roles. Many SAs have highlighted the need to build baseline capability across the organisation so that teams working across the building blocks of health understand how their decisions affect health and inequalities. In some areas, this has been supported via dedicated training, guidance and cross-directorate/cross-regional communities of practice.

Success will be linked to how effectively regions can bring together existing expertise, strengthen partnerships, and build a broader organisational understanding of health. SAs are at different stages of this journey, but many share the view that more integrated, system-wide approaches to capability and capacity are needed.

Workforce planning – capability and capacity

Illustrative regional approaches

Building organisational capability for health

Both the GLA and WYCA have introduced training, guidance and cross-directorate communities of practice to build organisation-wide capability and embed a more consistent approach to implementing HiAP.

The ***GLA*** has built organisational capability for health through a structured approach to embedding HiAP; its Public Health Unit has developed a practical "Levers Framework" to help staff across departments understand, influence, and act on the building blocks of health within their roles. This has been supported by organisation-wide training, including webinars, masterclasses, and online learning modules, equipping staff with the knowledge and tools to apply HiAP in practice and drive health improvement through mainstream policy and delivery.

Developing in-house health capacity

Some SAs have developed in-house roles or teams focused on population health or health inequalities. In some cases, these include the explicit application of HiAP approaches, while in others these functions are embedded within broader strategy, policy or partnership roles.

For example, with support from the MRP, the ***GMCA***, ***NEMSA*** and ***LCRCA*** have recruited dedicated internal health-focused policy and strategy roles to build in-house capacity and leadership regarding action on health inequalities. This has helped with creating expertise and visibility that did not previously exist and enabled delivery of region-specific programmes, accelerating progress on key priorities such as health-related economic inactivity and health inequalities governance. They have also supported the development of practical tools, frameworks and datasets, alongside strengthening organisational processes and system partnership working to better embed health considerations across all sectors.

The ***GLA*** has bolstered their in-house health capacity by aligning public health expertise across its policy domains. Public health consultants are embedded within key functions such as transport, housing, policing, and skills, enabling closer collaboration with non-health colleagues. This model ensures that high-quality public health insight is consistently accessible across the organisation, supporting stronger cross-sector relationships and the integration of health considerations into a wide range of policy areas.

Aligning infrastructure and funding

The health duty requires SAs to consider how investment, infrastructure and funding decisions affect health and inequalities. In practice, this means applying health considerations to existing resources and aligning decisions across portfolios, rather than relying on new funding.

Integrated Settlements and mechanisms such as the Right to Request and place-based budgets create opportunities to support prevention and better align investment across the building blocks of health. The Autumn 2025 budget confirmed the launch of place-based budget pilots (17), allowing certain SAs to pool funding across services locally and shape integrated investment plans. This provides a framework for aligning or pooling resources across organisations within a place to support shared outcomes.

However, as the health duty is not accompanied by dedicated funding, progress will depend on how effectively existing resources are aligned and influenced across the system. Examples of this alignment may include:

- Reducing fragmentation between funding streams and supporting longer-term preventative approaches
- Aligning investment across transport, housing, skills and economic development to address the building blocks of health and support long-term improvements in health outcomes and inequalities
- Using place-based budgets to coordinate and align resources across organisations around shared health-related outcomes

Aligning infrastructure and funding

There is also growing recognition that health should be considered early in investment and infrastructure decisions, particularly in transport, housing and regeneration where investment choices can shape health outcomes and inequalities over the long term (18).

However, the ability to align funding varies between SAs. Those with Integrated Settlements generally have greater flexibility to align investment and support preventative approaches. These areas are also better placed to test place-based budgeting approaches, given their ability to coordinate funding across multiple policy areas. Newer or non-integrated SAs are often more constrained by fragmented funding streams and limited flexibility to shift resources between priorities. Even with Integrated Settlements, practical constraints remain around movement between funding areas and the scale of health-related funding.

Partnership working is therefore critical. Bringing partners together around shared priorities can help align, pool or sequence investment to support prevention and reduce health inequalities. Emerging regional approaches to this include:

- Applying a consistent 'health lens' across investment decisions
- Designing health outcomes into programmes from the outset
- Aligning funding across partners on shared priorities for prevention
- Developing place-based budget approaches to map, align or pool funding across organisations
- Using the Right to Request (for established mayoral SAs) to secure additional flexibilities or resources
- Using procurement and social value approaches to support health outcomes

Aligning infrastructure and funding

Illustrative regional approaches

Using flexible funding to support shared outcomes
Some SAs are using devolved or flexible funding arrangements to align investment with population health priorities.

For example, ***Greater Manchester*** has used devolved funding flexibilities to align investment across employment, skills and neighbourhoods with broader population health goals, demonstrating how pooled or flexible funding can support coordinated action. The pooling of resources from local government, healthcare and policing also allows leaders to redirect funds dynamically toward preventive services, housing and infrastructure instead of isolated departmental budgets

NEMSA has used targeted investment through its Child Poverty Prevention Programme to coordinate action across schools, employers, health services and LAs. With £2.7m funding, the programme supports families through school-based interventions, workplace action and early years support, demonstrating how devolved funding can enable cross-sector, preventative action on the building blocks of health.

Aligning infrastructure and funding

Using procurement to boost social value
WMCA has incorporated social value considerations (i.e. the extra economic, social, and environmental benefits created for a community beyond the basic delivery of a product or service) into investment and procurement decisions, linking economic activity with wider wellbeing outcomes through its Social Value Policy.

Aligning funding and investment with preventative approaches
In some areas, SAs are beginning to use investment frameworks and programme design processes to support longer-term, preventative approaches. This may include considering how investment contributes to reducing inequalities, improving access to opportunities, or supporting healthier environments over time. This approach reflects a shift towards embedding prevention within mainstream investment decisions rather than treating it as a separate funding stream.

For example, ***WYCA*** integrates economic strategy directly with health and equity through their health determinants and inclusion approach. Partnering with its regional ICB, the CA aligns economic development funding with health and wellbeing initiatives to tackle systemic health inequalities.

Conclusion

The health duty is an important opportunity for SAs to strengthen and formalise their contribution to improving health and reducing inequalities. This sits within a wider shift towards shared responsibility for preventing ill health and addressing health inequalities across the public sector. In addition, new powers and levers create opportunities for SAs to use their investment, commissioning, convening, partnership and system leadership functions in support of population health.

There is no single model for implementation and, in keeping with the principles of devolution, it will be for mayors and SAs to determine how best to respond to these opportunities in line with local need, context and ambition. For all SAs with the health duty, an essential starting point will be to demonstrate that health and health inequalities are consciously and consistently considered within existing functions and decision-making. For those with ambition to go further, this guide and the accompanying MRP HiAP toolkit provide practical examples of how SAs can use their distinctive regional levers, investment powers and convening role to shape the building blocks of health and support more upstream, preventative approaches.

The maturity matrix and reflective questions that supplement this guide are intended to support this journey, helping SAs and partners reflect on current practice, identify strengths, and consider priorities for future development. SAs may not be starting from the same place, but they are part of a growing network of places committed to action on health and health inequalities. By playing their part alongside the NHS, LAs and wider system partners, SAs can help build the conditions for healthier lives, fairer outcomes and more effective public services.

For further information from the MRP and the opportunity to connect with colleagues across English SA regions on health equity work,. Please contact Claire Humphries, MRP Delivery Manager at Claire.Humphries@wmca.org.uk, and join the MRP's Online Learning Network, which is hosted on the Health Equity Network. The network has been established to share updates, insights, and publications from the programme, as well as to facilitate ongoing discussion, peer learning, and collaboration amongst regional colleagues across multiple key health and inequality-related policy areas.

Mayoral Regions Programme

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The imagery used in this report was created by The Health Foundation. You can access this and the rest of the series on what builds good health aswell as top tips for embedding the building blocks of health narrative in your area here.

System Maturity Matrix

Supplementary resource for
"Getting the foundations right:
A practical guide for Strategic Authorities
to take action on health inequalities"

Mayoral Regions Programme

Introduction

This resource is intended to support reflection and development, rather than formal assessment or comparison between Strategic Authorities (SAs). It is designed to help SAs make the most of the opportunities created through devolution, including new powers, responsibilities and mechanisms such as the health duty, integrated settlements, convening powers and the Right to Request.

Different SA regions will operate at different stages of maturity across different domains depending on local context, relationships, devolution arrangements and capacity. The matrix is therefore designed to help SAs:

- Reflect on current approaches
- Identify practical next steps
- Support discussion with partners
- Recognise and build on existing strengths

It is intended as a quick-start tool for SAs and partners to undertake an initial reflection on system maturity, particularly in relation to the health duty and each of the related **strategic enablers** identified in the main document (Getting the foundations right: A practical guide for Strategic Authorities to take action on health inequalities).

It can be used to support system self-assessment, partnership discussions, priority-setting and action planning. Rather than being intended as a compliance tool, it instead provides a framework for reflecting on current practice and identifying next steps appropriate to local context.

It should also be noted that the matrix reflects the maturity of the wider regional system rather than SAs in isolation. Progress depends on the relationships, alignment, governance and collective action of SAs, local authorities (LAs), the NHS and wider partners.

For those seeking a more in-depth review of organisational approaches to implementing **Health in All Policies (HiAP)**, it is recommended to progress from this resource to the HiAP toolkit and self-assessment tools regarding the pillars for HiAP and prioritising areas for HiAP action.

The following sections have been created to facilitate self-assessment of, and next steps planning for, developing system maturity (from emerging to strengthening, and then to embedded) in relation to each of the **practical enablers** for implementing the health duty. Each section also provides reflective questions to support with self-assessment in relation to regional context and signposts to useful evidence/resources (with hyperlinks where available) to facilitate planning next steps for system development.

Governance and system accountability

System maturity:	Emerging	Strengthening	Embedded
Identifying factors:	• Health considerations are starting to be addressed within governance processes	• Health considerations are increasingly incorporated into routine governance and assurance arrangements	• Health is routinely considered across governance, investment and accountability systems • Shared accountability arrangements support delivery of agreed population health outcomes across partners
Possible actions:	• Introduce health and inequalities prompts into key papers/templates • Identify senior lead/s or sponsor/s to champion the health agenda • Begin documenting how health considerations inform decisions	• Establish proportionate reporting arrangements • Clarify routes for advice and challenge • Align with existing cross-cutting reporting processes	• Integrate health into mainstream governance and assurance processes • Use existing scrutiny/audit arrangements to support accountability • Monitor contribution to longer-term outcomes

Governance and system accountability

Reflective questions:

- Are health and health inequalities routinely considered within governance and decision-making processes?
- Is there proportionate documentation regarding impact of health considerations on decision-making processes?
- Are there clear routes for challenge/advice in relation to health and health inequalities considerations?
- How is accountability for considering health understood and demonstrated?
- Are health considerations embedded rather than operating as a parallel process?

Useful evidence/resources:

- Existing decision-making templates
- Health Impact Assessment (HIA) / Health Equity Impact Assessment (HEqIA) approaches
- Outcomes frameworks and theory of change models
- Existing scrutiny/audit structures
- Reporting templates used for equality/climate/social value

Establishing strategic intent and priorities

System maturity:	Emerging	Strengthening	Embedded
Identifying factors:	• Health recognised as relevant to SA priorities; largely led through individual teams or interests	• Shared narrative emerging, which links health, growth and wider regional priorities	• Health and inequalities are consistently embedded across strategies, investment and decision-making
Possible actions:	• Leadership discussions on implications of the health duty • Identify priority policy/delivery areas where SA has the strongest influence • Begin linking health to existing political priorities	• Develop shared narrative across portfolios • Use workshops/ briefings to build organisational understanding • Establish visible leadership/ sponsorship	• Embed health into corporate and investment frameworks • Align health objectives across regional strategies • Use outcomes frameworks and reporting to sustain focus, monitoring and accountability

Establishing strategic intent and priorities

Reflective questions

- How is health currently understood within wider regional priorities?
- Is there a clear shared narrative linking health, health inequalities and wider regional priorities?
- Where is health already being treated as a cross-cutting outcome?
- How are decisions made about where to focus effort on improving health and reducing inequalities?
- Is there visible political and/or senior officer sponsorship?
- Can staff articulate why health matters to their role?

Useful evidence/resources

- MRP HiAP toolkit and HiAP activity prioritisation self-assessment tool
- Existing mayoral SA strategies and corporate plans
- Existing SA regional inequalities strategies
- Institute of Health Equity – Marmot Places and 'eight principles' framework
- Health Foundation - Building blocks of health

Regional collaboration

System maturity:	Emerging	Strengthening	Embedded
Identifying factors:	• Collaboration occurs through existing relationships or individual programmes	• Structured collaboration on health and inequalities emerging around shared thematic priorities	• Shared regional approaches to improving population health and addressing health inequalities are embedded across partners and systems
Possible actions:	• Map key system partners and forums • Engage ICBs, local authorities and DPHs early • Focus initially on tractable mission-led priorities	• Develop shared priorities with partners • Use existing partnership structures rather than creating new ones • Clarify roles across regional/place levels	• Align strategies and investment decisions across organisations • Develop shared outcomes or regional ambitions • Coordinate action across multiple determinants of health • Uses mayoral convening powers to align partners around shared health outcomes and regional priorities • Uses joint working arrangements, pooled budgets or aligned investment approaches to support shared population health objectives

Regional collaboration

Reflective questions

- Are regional and local roles for addressing population health and health inequalities clearly understood?
- Are partners aligned around shared priorities?
- Are existing structures being used effectively rather than resulting in duplication and/or gaps?
- Is collaboration focused on areas where regional action adds value?
- Where can the SAs add most value as a) a convenor and b) a partner with levers relating to the building blocks of health?

Useful evidence/resources

- Existing partnership boards and forums
- Integrated Care Partnership (ICP) / Integrated Care Board (ICB) strategies and prevention plans
- Place-based partnership arrangements
- Reports from, and existing arrangements between, thematic partnerships (e.g. on work and health, clean air, etc.)
- Convening and partnership mapping exercises

Understanding health need

System maturity:	Emerging	Strengthening	Embedded
Identifying factors:	• Health intelligence is drawn mainly from existing LA or NHS sources	• The picture of regional evidence is developing across organisations and datasets	• Shared regional understanding of health need consistently informs strategic and investment priorities
Possible actions:	• Use Joint Strategic Needs Assessments (JSNAs) and existing public health intelligence • Identify gaps in regional insights • Build relationships with analytical partners	• Bring together regional data sources • Combine quantitative and qualitative/lived experience insights • Use evidence to support strategic prioritisation	• Use integrated evidence to shape strategic investment for addressing and preventing ill health • Develop shared regional narrative on health inequalities needs • Align evidence with regional outcomes frameworks

Understanding health need

Reflective questions

- What data and intelligence are currently used to inform regional decisions?
- Is there a shared regional understanding of health need?
- Are inequalities visible within the evidence base?
- Are qualitative and lived experience insights incorporated alongside quantitative data?
- Is there a clear pathway from data to insight, and from insight to action?
- How does evidence shape prioritisation, investment and regional action?

Useful evidence/resources

- LA JSNAs
- Public Health Outcomes Framework and Department of Health and Social Care Fingertips data
- ONS datasets
- ICB population health intelligence
- Local authority public health and SA analytical teams
- Lived experience and community engagement approaches
- SA regional dashboards and inequalities profiles

Workforce planning – capability and capacity

System maturity:	Emerging	Strengthening	Embedded
Identifying factors:	• Developing capability and capacity to take action on health and health inequalities within the SA	• Health expertise is increasingly connected to strategy and delivery functions across policy spaces	• Health capability is embedded across the SA and supported through strong mechanisms for accessing expertise and joint learning within the organisation and across system partners
Possible actions:	• Identify existing expertise across system partners • Access support from local authority/Office for Health Improvement and Disparities (OHID) /ICB partners • Build awareness of the health duty across SA policy spaces and teams	• Develop hybrid working between policy and health staff • Create joint roles, networks and/or communities of practice focussed on health improvement and addressing health inequalities • Provide internal guidance/training on health improvement and addressing health inequalities	• Build organisation-wide capability to apply a health inequalities lens to ways of working • Embed health capability across each SA policy and investment function

Workforce planning – capability and capacity

Reflective questions

- Where does health improvement and health inequalities expertise currently sit within the system? And how is it accessed by the SA?
- Is there scope to distribute health capability across SA and wider system policy areas?
- Do teams working across functions recognise their impact on the building blocks of health?
- Are teams confident in applying a “health/health inequalities lens” to their work?
- What expertise is needed internally within the SA, and what can be accessed externally from system partners?
- Are partnership arrangements for accessing health and health inequalities expertise suitable and sustainable?

Useful evidence/resources

- Public health specialist expertise
- OHID regional teams
- Workforce development and training programmes
- Communities of practice
- Joint appointments/joint teams
- Internal guidance and capability-building materials
- Academic partnerships/university collaborations

Aligning infrastructure and funding

System maturity:	Emerging	Strengthening	Embedded
Identifying factors:	• Health impacts are starting to be considered within investment and infrastructure decisions	• Health improvement and inequalities are increasingly considered upstream within investment and programme design	• Investment, infrastructure and funding decisions consistently support prevention of ill health and addressing health inequalities
Possible actions:	• Begin applying a “health lens” to investment decisions • Identify opportunities for alignment across policy and delivery spaces • Consider health inequalities impacts earlier in programme design • Understand opportunities presented through integrated settlements and devolved funding arrangements	• Align funding and investment around shared priorities • Use existing financial flexibilities to support approaches to preventing ill health • Strengthen links between infrastructure and health outcomes	• Include prevention and health inequalities considerations within investment frameworks • Use procurement and social value approaches to strategically address health challenges • Use the full range of devolved funding, commissioning, integrated settlement flexibilities and investment powers to improve population health and reduce inequalities • Coordinate investment approaches (including those that are place-based, pooled or aligned) across partners to maximise population health impact

Aligning infrastructure and funding

Reflective questions

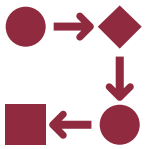
- Are health impacts considered upstream within investment and programme design?
- Is the prevention of ill health reflected within infrastructure and investment approaches?
- Are opportunities being taken to align or sequence funding to address regional health challenges alongside regional economic/ growth objectives?
- What existing investment processes could be adapted to better incorporate considerations for preventing ill health and addressing health inequalities?

Useful evidence/resources

- Integrated settlement guidance
- Investment frameworks/business case processes
- Procurement and social value frameworks
- Prevention and return on investment (ROI) evidence
- SA and LA infrastructure and regeneration strategies
- Health economic evidence
- Health Appraisal for Urban Systems Tool

Additional resources

Additional complementary resources to support SAs with addressing health inequalities:

Additional complementary resources:		
The University College London (UCL) Grand Challenges Team and Local Government Association (LGA) have recently published a report on how devolution can contribute to fairer, healthier places. The MRP was a member of the project team for this work alongside stakeholders across local and central government, academia, the NHS, the voluntary, community and social enterprise sector and policy organisations.		
The Kings Fund and Centre for Local Economic Strategies have been exploring the effectiveness of devolution in narrowing health inequalities in England via the following research essays:		
Tackling health inequalities through English devolution 	Strategic authorities and health inequalities: 10 actions for realistic progress 	Local growth plans and the building blocks of health 
Essay: Integrated care systems and strategic authorities 	Essay: Affordable infrastructure 	Essay: addressing health inequalities through employment 
Essay: getting it right 	Tackling health inequalities through English devolution 	 

Additional resources

The Health Foundation is the MRPs programme sponsor and has produced several leading resources in this space that have informed the development of this paper:

Introduction to the building blocks of health	How to talk about the building blocks of health toolk	Building blocks of health slide deck
Health at the heart of local growth briefing	Local Outcomes Framework: Priority outcomes and metrics | LG Inform	The Health Foundation

The Mayoral Authorities Creative Health Network (MACHN) is a coalition of MSAs working collectively to address health inequalities through culture, creativity, and cross-policy collaboration underpinned by a Health in All Policies approach. The MRP has provided grant funding to the MACHN to develop a Playbook and supporting resources for MSAs to facilitate the embedding of creative health approaches across regional policy and delivery (est. publication 30/09/26).

Health and Devolution Policy Appendix

Supplementary resource for "Getting the foundations right: A practical guide for Strategic Authorities to take action on health inequalities"

Introduction

This appendix sets out the policy and legislative context underpinning the evolving role of Strategic Authorities (SAs) in improving population health and reducing health inequalities. Please note that for consistency, this briefing will use the term SA to refer to mayoral SAs, Combined Authorities and County Combined Authorities. The aim of this appendix is to:

- Clarify how the new SA health duty sits alongside existing statutory responsibilities of Local Authorities (LAs), Integrated Care Boards (ICBs) and the NHS.
- Provide an overview of the key powers, levers and reforms that enable SAs to act on the building blocks of health (1).
- Explain how these changes collectively support a shift towards system-wide prevention and shared responsibility for health outcomes.
- Highlight the practical implications of this evolving landscape for the role of SAs within the broader health system.
- Consider emerging programmes and policy initiatives, including Place Based Budgets, prevention demonstrators, Health and Growth Accelerators and Regional Health Innovation Zones, where these may create opportunities for SAs to influence health improvement.

This analysis builds on work developed through the Mayoral Regions Programme's Health and Devolution Landscape (2025) policy briefing (2), exploring the implications of recent health system reforms for SA's. Please note that a summary of statutory health duties across the system has been included for reference at the end of this document.

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A shift towards prevention and system leadership

Recent reforms, including the *English Devolution and Community Empowerment Act 2026* (3), and the Fit for the Future: 10 Year Health Plan for England (4), signal a broader transformation in how health is understood and delivered. The SA health duty is intended to operate alongside, and reinforce, the ambitions of the NHS 10-Year Health Plan, which is framed around three strategic shifts: from hospital to community, from analogue to digital, and from sickness to prevention. Taken alongside wider devolution reforms, these changes create an opportunity for earlier intervention, stronger place-based approaches and more integrated system leadership. However, the extent to which these ambitions translate into new ways of working will depend on implementation and relationships between SAs, local government and NHS partners.

In this context, improving health is increasingly seen as a shared system outcome, requiring coordinated action across organisations and sectors. *Local Authorities*, the NHS and SAs each have distinct roles, but all contribute to shaping the conditions for good health. SAs have the potential to act as democratic, system level leaders who can align economic, social and environmental policy with health improvement through the building blocks of health (5).

This marks the shift of framing from “health as a sector” to “health as a system”. As set out by the Academy of Social Sciences (6), the devolution of health in England is not primarily about transferring responsibility for health services, but about reshaping power, accountability and leadership for improving population health and tackling health inequalities through the wider determinants.

SAs have a distinctive contribution within this system. Operating at a regional scale, they are uniquely positioned to:

- Support more coordinated and preventative approaches across local and national systems
- Influence the structural and spatial drivers of health inequalities
- Align policy, investment and delivery across sectors

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Strategic Authorities as enablers of prevention

The evolving role of SAs reflects a growing recognition that effective prevention requires action at scale, across the systems that shape people's everyday lives. Through their powers over transport, housing, skills, economic development, employment and skills and the environment, SAs can influence the conditions that prevent ill health and support wellbeing. Their role is not to replace existing public health or NHS functions, but to:

- Embed a Health in All Policies (HiAP) approach across regional governance
- Use policy and investment to address the root causes of poor health
- Convene partners to align action around shared prevention goals
- Support long-term, sustainable improvements in population health and economic outcomes

Delivering this role effectively requires not only statutory duties, but also fiscal flexibility, institutional capacity and strong partnerships. Mechanisms such as the Right to Request, Integrated Settlements, joint working arrangements and mayoral powers provide opportunities to strengthen this role in practice.

Alongside these, emerging programmes such as Place Based Budgets, Prevention Demonstrators and Health and Growth Accelerators provide practical opportunities to test more integrated and preventative approaches. Drawing on analysis by the King's Fund (2025) (7), the government contends that SAs can address a gap in regional-level policymaking, stating that key decisions can be most effective when taken at the scale of regional functional economies to drive economic growth.

Health duty and wider system developments

Clause 43 of the English Devolution and Community Empowerment Act - Health improvement and health inequalities duty - calls all SAs to "have regard" to the need to improve the health of persons in their area and reduce health inequalities between persons in their areas, when exercising their functions. It establishes SAs (except the Greater London Authority and certain authorities with existing health duties), with greater strategic oversight over the building blocks of health, working alongside LAs, ICBs and NHS partners. This duty does not create new responsibilities for the delivery of health services. Instead, it formalises and strengthens the role of SAs in shaping the social, economic and environmental conditions that drive health outcomes. In doing so, it reflects a broader shift towards prevention and action on the wider determinants of health, recognising that these factors have a greater influence on population health than healthcare services alone.

The Right to Request

The Right to Request is a separate devolution mechanism available to MSAs that enables submission of proposals to government for additional powers, funding arrangements or partnerships to be added to devolution arrangements. Government is required to consider and formally respond to the request, but the mechanism does not guarantee that the requested functions or resources will be transferred.

In relation to health, an MSA could use the mechanism to seek powers, flexibilities or partnerships that support upstream action, for example, greater alignment of employment, skills, housing or public-service funding around prevention; closer working with NHS bodies; or greater flexibility to pool and coordinate investment around defined population outcomes. The Right to Request therefore does not form part of the health duty, but may provide one route through which an Established Mayoral SA can strengthen its capacity to deliver against it.

Health duty and wider system developments

Health system reforms

While the health duty is an important statutory requirement, it should be understood as one part of a wider set of powers, levers and responsibilities that collectively enable SAs to influence health and wellbeing. Alongside the duty, SAs have access to a range of mechanisms that support a more proactive and preventative approach to population health, including the following:

Development	Implications for SAs
Proposed NHS reforms	The NHS Modernisation Bill (Health Bill) contains the following proposed changes to ICB governance and planning arrangements (please note that these measures remain subject to the parliamentary process and may be amended before enactment): • The mayor of each geographically overlapping SA nominate a member of the ICB (8). This would provide a formal route for SA priorities and perspectives to inform ICB discussions and strategic planning. Statutory accountability for NHS commissioning, resources and performance would remain with the ICB and wider NHS accountability structures. • A long term objective for ICB boundaries to align with SAs where feasible by 2035, supporting greater coherence between health systems and regional economic geographies. • The NHS 10 Year Health Plan sets out an ambition to shift more care from hospital into community and neighbourhood settings. This includes Neighbourhood Health Centres, integrated neighbourhood teams, neighbourhood-level planning and emerging contractual and organisational models, including Integrated Health Organisations. For SAs, neighbourhood health creates opportunities to connect healthcare transformation with housing, employment, skills, transport, community infrastructure and other building blocks of health. The models and governance arrangements remain in development and will vary between places. The 10 Year Health Plan and Health Bill envisage ICBs becoming more focused on strategic commissioning, alongside changes to their membership, planning responsibilities, operating costs and geographical footprints. This may increase the importance of SAs and LAs as convenors of action on the wider determinants, while also requiring new relationships with larger ICBs that may cover several places or overlap with more than one SA. • The statutory requirement to establish an Integrated Care Partnership is removed. If enacted, this could reduce the consistency of formal partnership arrangements across systems and increase the importance of locally agreed mechanisms connecting SAs, LAs, Health and Wellbeing Boards, ICBs and providers.

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Health duty and wider system developments

Development	Implications for SAs
Health, Wellbeing and Public Service Reform Competency	This area of competency positions SAs as place-shaping leaders with a remit to influence the building blocks of health and drive system-wide prevention and reform alongside economic growth.
Opportunities for joint working and pooled funding	Enables SAs to work jointly with NHS and local government, including through delegated functions, joint committees and pooled budgets, supporting more coordinated and preventative approaches to improving population health (9).
Powers to convene	Alongside the health duty, SAs have powers of competence to support delivery of the duty, which includes the power to convene. This provides SAs with the authority to bring partners together across sectors, strengthening their role as regional system leaders and coordinators of population health improvement alongside system partners. Success depends as much on relationships, alignment and influencing partners as on formal powers, particularly in a complex and evolving governance landscape.
Integrated settlements	Integrated settlements bring multiple funding streams together across a longer period, giving eligible SAs greater flexibility to align investment with regional priorities. Although they are not health budgets, they may support prevention by enabling coordinated investment across transport, housing, skills, employment and other building blocks of health.
Right to Request	Enables established mayoral SAs to propose additional powers, funding arrangements or partnerships to government. It may be used to seek arrangements that strengthen upstream action on health but does not itself confer additional functions or resources.

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Health duty and wider system developments

Development	Implications for SAs
Mayoral power to appoint Commissioners	Mayors may appoint commissioners to support leadership and delivery across the SA's areas of competence. A mayor could choose to appoint a commissioner with a health, wellbeing or public-service reform portfolio, although this is a local governance choice rather than a statutory requirement. Such a role could strengthen visibility, coordination and political accountability for health across SA functions, but would not transfer NHS or LA public health responsibilities to the commissioner.
Prevention Demonstrators and Growth Accelerators	Prevention demonstrators and Health and Growth Accelerators are emerging place-based mechanisms for testing how health improvement can be aligned with economic participation, employment and public-service reform. Although their scope and availability differ between areas, they may enable SAs to convene NHS, local government, employers and other partners around shared outcomes, test new delivery models and demonstrate the economic and service benefits of prevention.
Regional Health Innovation Zones	Government policy proposes Regional Health Innovation Zones to support large-scale development, adoption and evaluation of health innovation. These could bring together NHS organisations, SAs, local government, universities, industry and communities. For SAs, the opportunity is to connect innovation with regional economic development and population need, while ensuring that new technologies and models contribute to reducing rather than widening inequalities. The model, selection process, resources and freedoms attached to the Zones remain in development.

Ultimately, the value of the health duty lies not only in its statutory requirement, but in how it is interpreted and applied in practice. It encourages a shift from viewing health as the responsibility of individual organisations, to recognising it as a shared system outcome, requiring coordinated action across sectors and levels of governance.

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Health responsibilities across the system

The health duty for SAs sits alongside existing statutory responsibilities held by LAs, ICBs and NHS organisations. Taken together, these establish a shared but differentiated framework for improving health and reducing inequalities.

- **Local Authorities** operate primarily at place level and retain statutory responsibility for local public health functions. They also host and are the democratic anchor for Health and Wellbeing Boards (HWBs), which provide a statutory partnership forum for assessing local needs and agreeing joint health and wellbeing priorities. Proposed NHS planning reforms may give HWBs a more prominent role in connecting local priorities with neighbourhood health planning.
- **Integrated Care Boards** are statutory NHS commissioners operating across health system footprints. Their areas generally cover larger populations than individual local authorities, and planned mergers or clustering may further increase their scale. ICB and SA boundaries are not always coterminous: one SA may overlap with several ICBs, or an ICB may interact with more than one SA. This can create additional complexity for governance, planning and accountability.
- **NHS providers** deliver healthcare services across organisational footprints that may be local, system-wide or regional. Their role is distinct from the commissioning and strategic-planning role of ICBs.
- **Strategic Authorities** operate at regional or city-region scale. Their role is not to duplicate LA public health functions or NHS responsibilities, but to use their functions, investment decisions, partnerships and convening role to influence the wider conditions that shape health.

In this model, health improvement becomes a shared system outcome, with different organisations contributing through distinct but connected roles; the table on the next page provides a summary of these roles.

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Health responsibilities across the system

Function	LA	ICB	MSA
Improve population health	✔ Statutory duty	✔ (Population Health Role)	✔ Have regard
Reduce health inequalities	✔ Explicit	✔ Explicit	✔ Have regard
Public health delivery	✔	✘	✘
NHS commissioning	✘	✔	✘
Wider determinants	✔ (Place)	Limited	✔ (Regional)
Geographic Scale	Neighbourhood/place	Multi-place / system	Region

A high-level summary of the specific statutory duties held by SAs, LAs and ICBs has been provided in the appendix of this document.

Conclusion

The SA health duty is one part of a wider shift in the devolution and health landscape. It formalises the role of SAs in considering health and health inequalities through their existing functions, while leaving public health delivery and NHS service responsibilities with LAs, ICBs and NHS organisations.

The duty is therefore best understood as a mechanism for embedding health into regional decision-making, investment and system leadership. Its impact will depend on how SAs apply it in practice, how they work with partners, and how effectively wider powers and levers are used to support prevention and action on the building blocks of health.

There is no single model for how SAs should respond. In keeping with the principles of devolution, approaches will vary depending on local context, powers, partnerships and ambition. However, the wider policy and legislative landscape create important opportunities for SAs to strengthen their contribution to improving health, reducing inequalities and supporting more coordinated action across the public sector.

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Technical Appendix – Summary of statutory health duties across the system

This section provides a high-level summary of the statutory basis underpinning the roles described in this briefing. It is not exhaustive but highlights the key duties relevant to improving population health and reducing health inequalities.

Strategic Authorities (SAs)
The English Devolution and Community Empowerment Act (10) introduces new statutory responsibilities for SAs in relation to health.

Health Duty (Clause 43)
SAs must "have regard to the need to improve the health of persons in their area and to reduce health inequalities" when exercising their functions.

This duty applies across all areas of competence, including:
- Transport and local infrastructure;
- Skills and employment support;
- Housing and strategic planning;
- Economic development and regeneration;
- The environment and climate change;
- Health, well-being and public service reform;
- Public safety;
- Culture;
- Rural affairs and coastal communities.

These functions collectively shape the wider determinants of health at a regional scale.
Powers of Competence (Clauses 20–22)

SAs also have statutory powers that support delivery of the duty:
- **General Power of Competence:** enables action across their areas of competence
- **Power to Convene:** enables mayors to bring system partners together, with a duty to respond
- **Duty to Collaborate:** establishes formal expectations for cross-boundary working

Technical Appendix – Summary of statutory health duties across the system

Local Authorities (LAs)
LAs hold primary statutory responsibility for public health.

Under the Health and Social Care Act 2012, upper tier and unitary authorities must:
- Take steps to improve the health of their population
- Reduce health inequalities
- Deliver public health functions, including prevention and health protection

This includes mandated responsibilities under the NHS Act 2006 (Section 6C), such as:
- Health protection and emergency preparedness
- Sexual health services
- NHS Health Check and national screening programmes
- Public health advice to NHS commissioners

LAs also:
- Receive a ring-fenced Public Health Grant
- Appoint a Director of Public Health
- Lead Health and Wellbeing Boards to support integration

Integrated Care Boards (ICBs)
ICBs and NHS bodies have statutory duties to address health inequalities under the NHS Act 2006 (as amended by the Health and Care Act 2022) and the Equality Act 2010.

They must:
- Have regard to the need to reduce inequalities in access to services and health outcomes
- Consider the needs of the whole population, including those not currently using services
- Act to ensure integration between health services and wider health-related services where this improves outcomes or reduces inequalities

These duties apply across commissioning, service design, delivery and system leadership.

References

1.What builds good health? | The Health Foundation
2. MRP Briefing - Health Devo Landscape.pdf | Mayoral Regions Programme Learning Network
3. English Devolution and Community Empowerment Bill 2025
4. NHS England » Fit for the Future: 10 Year Health Plan for England
5. Not just a duty: unlocking the full potential of strategic authorities to tackle the wider determinants of health | The Health Foundation
6. The Devolution of Health in England – Academy of Social Sciences
7. English Devolution White Paper: Will It Be Good For Your Health? | The King's Fund
8. Health Bill: ICBs as strategic commissioners - fact sheet - GOV.UK
9. Existing legislative routes include joint working and delegation arrangements under section 65Z5 of the NHS Act 2006, which enable NHS bodies, local authorities and combined authorities to exercise functions jointly, establish joint committees and, where appropriate, pool funds. Further proposals to expand and simplify partnership arrangements have also been consulted on through reforms to section 75 arrangements.
10. English Devolution and Community Empowerment Act 2026

Health System Appendix

Supplementary resource for
"Getting the foundations right:
A practical guide for Strategic Authorities
to take action on health inequalities"

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Key system partners

Recent reforms set out in the Health Bill and wider devolution agenda envisage a stronger role for Strategic Authorities in health improvement and in relationships with NHS bodies. While SAs do not hold formal NHS commissioning responsibilities, their role has the potential to gain greater significance at regional scale, particularly in enabling prevention and improving population health through the wider determinants.

However, the reforms combine elements of devolution and partnership working with greater national direction and significant organisational change within the NHS. The proposed changes would alter national and system architecture, including the roles and arrangements of NHSE, ICBs and ICPs. Their implications for local autonomy, partnership working and system leadership will depend on the final legislation and its implementation. In this context, expectations for local and regional leadership, collaboration and place-based alignment are likely to increase. SAs are therefore emerging as key convenors and system leaders, working alongside Local Authorities, ICBs and NHS providers to support coordination.

Alongside this, proposed legislative changes would create new mechanisms for alignment between mayoral SAs and the NHS, including mayoral representation in ICB governance and changes to strategic planning arrangements. Other mechanisms, such as delegated functions, joint governance and pooled funding, may be available or developed locally but should not be presented as automatic consequences of the Health Bill.

While these reforms strengthen links between SAs and the NHS, the primary contribution of SAs remains their ability to shape the social, economic and environmental conditions that drive health outcomes, through regional policy, investment and place shaping functions.

This evolving framework places SAs in a position to better align upstream determinants (e.g. employment, housing, transport) with downstream health services. It reflects a wider shift towards shared responsibility for health outcomes, creating opportunities to embed prevention across policy areas and decision making. However, these changes also raise questions around accountability, coordination and capacity. The extent to which SAs can realise this potential will depend not only on governance arrangements, but also on their ability to align investment, use devolved powers effectively, and work collaboratively with system partners to deliver meaningful improvements in population health and reduce inequalities.

These developments position SAs as key actors in enabling system-wide prevention at regional scale, not by delivering health services directly, but by shaping the conditions that support healthier populations and more sustainable public services.

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Understanding the role of Strategic Authorities in an evolving regional health system

The health and care system in England is undergoing significant transformation and Strategic Authorities (SAs) are playing an increasingly important role in shaping population health outcomes through the wider determinants.

The NHS 10 Year Plan

NHS Modernisation Bill (Health Bill)

Devolution Act

These reforms signal intention to shift from:

- Centralised > devolved
- Organisational silos > system working
- Treatment > prevention

There is increased policy emphasis on:

- Neighbourhood health models
- Care in the community
- Population health as the organising principle

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Key system partners

National

NHS England (NHSE):
The government has announced its intention to abolish NHS England and bring its functions into DHSC. The Health Bill contains measures supporting the proposed new operating model. Subject to legislation and implementation, this would simplify national governance and strengthen direct ministerial accountability. The implications for the balance between national oversight and regional or local autonomy remain uncertain.

Department for Health and Social Care (DHSC): NHS England roles are to be combined with DHSC powers. It continues to define overarching health and care policy, agreeing NHS budget, and sponsoring the NHS and arms length bodies. It will absorb and deliver NHSE operational functions and determines national priorities.

Regional

Office for Health Improvement and Disparities (OHID): National leadership on prevention and health inequalities. Provides policy, evidence, and support (not delivery).

UK Health Security Agency (UKHSA): Leads health protection (prevention and reduction of harm caused by infectious disease, chemicals, radiation, climate change and environmental hazards).

Integrated Care Boards (ICBs): ICBs are statutory NHS bodies responsible for planning and commissioning NHS services and managing NHS resources across their areas. Government policy proposes refocusing them as strategic commissioners, alongside significant reductions in running costs and changes to their geographical footprints and operating arrangements. The Health Bill also proposes changes to ICB membership and planning duties, including closer alignment with SAs and mayoral representation. These changes remain subject to legislation and implementation. They may affect ICBs' wider role as system convenors and their capacity to support collaboration and population health improvement.

Key system partners

Integrated Care Partnerships (ICPs): The Health Bill proposes removing the statutory requirement for each area to establish an ICP and produce an integrated care strategy. If enacted, the reforms would replace elements of the current planning framework with ICB plans at neighbourhood and strategic level. Areas may retain non-statutory partnership arrangements, but their form and role are likely to vary.

Integrated Health Organisations (IHOs): The 10 Year Health Plan proposes developing IHO models in which selected NHS foundation trusts may hold responsibility for improving outcomes and managing healthcare resources for a defined population. The model is intended to strengthen incentives for prevention, integration and population health management. Its design, contractual basis, selection process and implementation timetable are still developing.

Local

Authorities and Public Health: Local Authority public health teams have statutory responsibilities to improve and protect the health of their populations and to commission prescribed public health services, including sexual health services, NHS Health Checks and elements of health protection. They must appoint a Director of Public Health jointly with the Secretary with of State, establish a Health and Wellbeing Board, and prepare a Joint Strategic Needs Assessment and Joint Local Health and Wellbeing Strategy with NHS partners.

The Director of Public Health is a statutory chief officer and principal adviser on the health of the local population, with responsibility for exercising the authority's public health functions and producing an independent annual report.

Community and Neighbourhood Health: The 10 Year Health Plan sets out an ambition to shift more care from hospitals into community and neighbourhood settings. This includes neighbourhood health centres, integrated neighbourhood teams and new contractual approaches intended to support more coordinated, proactive and preventative care. The precise models, providers and governance arrangements will vary by place and develop over time.

Primary Care Networks (PCNs): Coordinate/deliver primary care services at neighbourhood level.

Health and Wellbeing Boards (HWBs): Statutory local authority committees bringing together local government, NHS, public health and other partners. Local authorities and ICBs are responsible through these arrangements for producing Joint Strategic Needs Assessments and Joint Local Health and Wellbeing Strategies. The Health Bill's proposed changes to ICPs and NHS planning may increase the importance of HWBs in connecting neighbourhood, place and strategic planning, although the final arrangements remain subject to legislation and local implementation.

Key system partners

Place-Based Partnerships: Non-statutory collaborative arrangements bringing together organisations involved in health, care and the wider determinants. Their geography, membership, governance and functions vary considerably; many, but not all, operate across local authority footprints. They can provide a practical forum for coordinating services and action around the needs of a defined population.

Voluntary, Community, Faith and Social Enterprise (VCFSE) sector: These organisations improve health outcomes and tackle health inequalities not only by delivering services but also by shaping their design and advocating for, representing and amplifying the voice of service users, patients and carers. Their input is essential to a vibrant local health economy.

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Supported by:

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