

**Minutes of the second meeting and first evidence session of the Health Devolution Commission**

**held on Friday 28th February 2020 at London Councils**

**1 Attendance**

Commissioners attending the meeting were:

* Norman Lamb (co-chair)
* Alastair Burt
* Stephen Dorrell
* Phil Hope
* Dr Linda Patterson
* Sally Warren, Kings Fund
* Dick Sorabji, London Councils (Advisory)
* Jon Restell MIP (Advisory)
* Warren Heppolette, Greater Manchester Health & Social Care Partnership (Advisory)\*
* Emma Greenwood, CRUK (Advisory)\*
* Sophie Corlett and Karen Mellanby, Mind (Advisory)\*

*\*Commissioners that presented evidence to the inquiry*

Also in attendance were:

* Steve Barwick, DevoConnect, Secretariat

Apologies were received from commissioners:

* Andy Burnham
* Peter Hay
* Liz Gaulton
* Sir David Behan

External contributors to the event were:

* Professor Michael Marmot, author of ‘Health Equity in England: The Marmot Review 10 Years On’ (February 2020)
* Andrew Travers, Chief Executive of Lambeth Council and lead for South East London Integrated Care System

**2 Business Items**

2.1 The Health devolution Commission website is now up and running, and the launch was successfully marked by articles in both the HSJ and the MJ. The call for evidence has now been issued and Commissioners were encouraged to draw attention to the inquiry through their own media and social media networks.

2.2 Following a discussion of the organisations invited to give evidence at the hearings of the commission the secretariat were asked to: a) approach ADASS with a request to agree to be interviewed if they were unable to attend any hearings; b) identify an appropriate social enterprise organisation to attend a hearing; c) seek to include evidence from the experience of devolution in Scotland, Wales and Northern Ireland; and internationally.

2.3 It was agreed to hold a third evidence session in May to give more organisations who have expressed an interest to present their views including UNISON who are now sponsors of the inquiry and an advisory member of the Commission. The Secretariat will consult on an appropriate date and location in London for a third hearing to be chaired by Norman Lamb.

2.4 It was agreed that the presentations and a summary of the discussion of the evidence session would made publicly available through the Health Devolution Commission website. Witnesses and Commissioners were advised to make clear at the time if any comments made by them were not to be recorded.

2.5 Dick Sorabji explained that London Councils was currently in discussions with NHS London on enhanced approaches to collaboration and so would not make a written submission at this time. Reflecting on past activity, he observed that the health and social care MoU for London in 2017 included 54 tangible components, but that most progress on joint working in London had been restricted and was mainly on the NHS estates strategy. Momentum for change has increased since the start of 2019, with the London Health Board considering these issues over the next few months.

**3 Evidence from witnesses**

**3.1 *Professor Michael Marmot***

Professor Marmot outlined the broad conclusions from his seminal report published earlier in the week on health equity in England. His main conclusion is that urgent action is now needed to address the social determinants of health, and that if there were additional resources for health now these should be directed at improving the public’s health rather than NHS health services.

His report makes clear that more resources for improving the public’s health are most needed in poorer areas of the country as low incomes and poor social and economic conditions are key social determinants of health. This however is a ‘funding allocation’ as distinct from a ‘health devolution’ question.

He observed that whilst he didn't have a prior view on health devolution it was the case that it is intrinsically more difficult to have national hands on the levers of those determinants of health that are local in nature. Local government is closer to the communities it serves, often works on a cross-party basis, and gets greater uptake on action to address the social determinants of health, However, for local action to be effective there has to be the right national funding and fiscal policy that provides resources and enhances rather than undermines locally determined population health improvement programmes.

Coventry was cited as an example of a ‘Marmot city’. Greater Manchester (GM) aspires to be a Marmot city region, and Chester and Gateshead are also considering taking forward this approach. There is some evidence that working across health, social care and other local authority sectors in GM is proving effective on social determinants of health such as smoking, the readiness of young children for school and the next steps for young people leaving school.

It is important that local and national stakeholders/government fully appreciate the distinction between improving a community’s health and improving a community’s health services. The quality of a community’s health – population health – is a fundamental indicator of the nature of society. If a community’s health is a government responsibility then action by government has, primarily, to be local in nature in order to engage and work with local communities. It is critical that communities are actively involved in the solutions that create the circumstances which allow people to lead meaningful lives.

It is very difficult to lay out which social determinants of health are the highest priority as they are all closely inter-linked. An alternative approach is to make a priority putting health equity at the core of all national and local decisions. The basis for measuring progress – the outcomes – might then be a limited number of the social determinants of health outlined in the Marmot report – child readiness for school, number of young people who are NEETs, housing quality, income levels, social isolation among older people, etc.

Integration of disparate health services and between health and social care services is the means to an end (better quality, person centred care) – rather than an end in itself. Similarly, health and health care devolution should be viewed as a means to an end – improvements to a population’s health and better, sustainable health care services for that population.

***3.2 Warren Heppolette (GM)***

In making the case for devolution it is important to start with an analysis of the drivers of successful places, what prevents people from participating in that success and the reasons why some areas punch below their economic potential. This shows that we should go beyond the conventional economic analysis (as GM did through the 2008/9 Independent Economic Review) of infrastructure investment levels to include also the social determinants of a successful local economy such as children’s development at 5 years old, educational attainment at 16 and the population’s health.

In planning a strategy to create a successful economy in a devolved system it helps to choose outcomes that cannot be achieved by a single player, or sector, such as school readiness among children, economic participation rates among school leavers, and physical activity levels. And it is important to clearly distinguish between and embrace both improving population health and improving health care services as the purpose of health devolution.

Experience is suggesting that full integration between health care services, and between health and social care services can take 3-5 years with the speed determined by the rate at which trust is developed between the key people involved.

The sustainability of NHS services is under pressure from the rise in demand for non-elective care so that interventions within a devolved system to improve services are ‘just keeping up’ rather than showing improvement from the baseline. Efforts to improve population health have however shown improvements in some areas such as smoking reduction and school readiness among children.

The GM health devolution deal was partial in nature with elements of ‘hard delegation’ or ‘managed devolution’ rather than full devolution and as such there is a permanent tension that has to be continually balanced between local and national accountability, and between local civic and clinical leadership.

Some lessons from GM such as the very local integration of disparate community health services and social care services have informed NHSE thinking and are now a central feature of the NHS long term plan. However, the way that this is now being rolled out through the Primary Care Networks and its associated contracts and funding is not congruent with the local GM approach, which has not always been helpful.

The role of acute hospitals within a health devolution area is important. Tameside Integrated Care Trust is a good example of a hospital that has seen its role as an anchor institution in the local community and re-shaped the way it works to provide more of its services in the community and outside of the institutional setting of the hospital campus.

Wales is similar in scale to GM health devolution and if it is agreed it is effective at this footprint/scale then applying it elsewhere - to places of similar population size – should be considered.

***3.3 Andrew Travers (Lambeth)***

When the original work to devolve health in London took place the NHS did not appear to be fully committed. Governance arrangements were awkward as the local government footprints of the GLA and 31 London boroughs did not match with those of the NHS CCGs and STPs in London.

There is, however, renewed interest and commitment by local government and NHS partners in London to joint working with a new London Vision being developed this year that is seeking to achieve greater London autonomy from NHSE nationally. Accountability still stays within the NHS ‘machine’ but local partners are seeking to build trust between each other, and develop new mechanisms for joint working and sharing budgets. In Lambeth for example there is now one person who is the budget holder for both the CCG budget and the adult social care budget.

There is now a good mental health partnership with a big shift away from institutional care to care in the community. Neighbourhood working within borough boundaries is developing and action is being taken to make ICS meetings meaningful and engaging, including the appointment of an independent chair. Lambeth councillors understand all this and want to manage well their relationships with NHS senior managers.

It is worth noting that, as Mayor of London, Boris Johnson developed a public health strategy based on improving health outcomes for Londoners.

The voluntary sector in London is mainly involved at neighbourhood level as well as being part of the Alliance contract. It might be more meaningful for them if health devolution was more real in nature.

A key lesson overall for all partners in all sectors has been to build relationships between people **before** building joint governance structures for those individuals.

***3.4 Sophie Corlett and Karen Mellanby (Mind)***

Mind is agnostic on issues of structures. Its primary concern is to see an improvement in mental health services to achieve better mental health outcomes so that people get well and stay well.

Health devolution presents both opportunities and dilemmas in mental health. Mind is itself a devolved organisation with 121 local independent charities. It is familiar with the dilemmas this brings for the national leadership in ensuring a desired level of service consistency and coverage, whilst knowing that local action is the key to reaching into local communities to co-design and co-deliver better mental health services. There are many social determinants of ill-health that vary from one location to another and Mind seeks to respond actively and appropriately to local needs and circumstances such as the major loss of jobs in an area like Teesside or a large-scale tragedy such as Grenfell.

Strong national standards or central targets of some type are, however, helpful to Mind as a campaigning and service delivery organisation as they provide a lever to put pressure on local areas to do more and better for people experiencing mental ill-health. Progress in mental health services and outcomes has been achieved through top-down drivers for change linked to transparent data that allows comparisons in performance between local areas to be made and used to create improvement.

Concerns about health devolution leading to a postcode lottery in health care are less relevant to mental health as the huge variations in spend on health mental services and outcomes between areas mean there is a massive postcode lottery already. Any charter or baseline for mental health in devolved areas could not be based on current metrics as the starting point would be unacceptably low. The lack of capital budgets for mental health projects in the various current ICS strategies is just one indicator of this fundamental problem.

Voluntary organisations need to be fully included at every level within devolved health systems if they are to play an effective part in both building healthier communities and delivering better health and social care services. This is very important in mental health, as they form a significant proportion of the overall mental healthcare system. This may require clear protocols such as a voluntary sector devolution compact.

***3.5 Emma Greenwood (CRUK)***

Cancer survival rates in England are poor in comparison to other countries and there are large variations within the country as well. CRUK is keen to focus on prevention of cancer and its causes such as smoking and obesity.

Growing awareness that influencing at the national level in Whitehall and Parliament is not enough to address the wider, social determinants of cancer. CRUK wishes to have influence and impact at a local level – councillors and NHS managers – in order to prevent reductions in spending on key services such as smoking cessation which are under threat from budget reductions in government support for local councils.

Regional cancer alliances are a key part of the health and social care landscape but they have their own unique footprint that is not co-terminous with any of those in local government, city regions or mayors. It is not clear how these would align with any new devolved health devolution footprints and this might not be helpful to achieving improvements in tackling the social determinants of cancer.

Action to help prevent cancer and increase early diagnosis rates in Greater Manchester has been very welcome. A new approach to lung checks for example was trialled in GM and is now being rolled out nationwide. However, as with PCNs, the approach being adopted for the roll out is slightly different to that trialled in GM which is in turn preventing GM to deliver the services as it would like.

The place-based approach which gets the right people around the table to focus on prevention has been good. Local leadership on these issues is important and Metro Mayors can be a real force for change. However, there have been national targets for various aspects of cancer services and these, like those in mental health, have been an important lever for change at a local level.

**4 General discussion**

During the short time left for general discussion a number of further observations and comments were made:

1. Health devolution must embrace both as its purpose improving population health and improving health and social care services.
2. The importance of improving the health of a community’s local workforce and the health and social care services they require should be more fully recognised as part of a health devolution strategy.
3. The health and social care workforce is a significant part of all local economies and improving their health and the services they receive could be a focus of action in devolved health areas.
4. Regulation of community health strategies and systems, as well health and social care services and systems, could be a lever for performance improvement. Responsibility for regulation of population health and health services/systems could also be devolved to devolved health areas through greater self-regulation. However, it is only possible to regulate services that exist already so this may not be a lever for allocating more resources into population health activities or for service areas such as mental health where services are so inadequate.
5. Public interest in and support for population health is much less than for the ‘traditional NHS’ and this does present challenges for local councillors who are accountable locally and who wish to address unpopular local public health issues.
6. Population health does not appear to be a priority for government at present as the drivers of ill-health are more complex, the time-lags between intervention and outcome are longer, and the accountabilities more diversified.
7. The geography of ill-health devolution is complex with a number of tiers of accountability within the NHS, within local government and between the NHS and local authorities. The location of power and accountability within this complexity can be unclear and this can hinder getting resources to the right place at the right time.
8. The relationship between national targets and drivers, and local leadership and accountability is complicated. Do national standards and direction fundamentally undermine devolution or provide a safety net to reduce the risks of too great a variation between local areas?