NON-VERBATIM MINUTES

THIRD MEETING OF THE HEALTH DEVOLUTION COMMISSION ON THURSDAY 28th MAY (3pm-3.15pm) AND SECOND EVIDENCE SESSION (3.15pm-4.45pm)

HELD BY ZOOM WITH RT HON SIR NORMAN LAMB IN THE CHAIR

PART ONE - BUSINESS

1. **Welcome, introductions and minutes of meeting held on February 28th**

- *Norman Lamb welcomed all attendees and asked if there were any comments on, or amendments to, the minutes here. There were none so they were agreed.*

- *The chair reminded attendees that the meeting planned for March didn't take place because of Covid-19. He explained that the commission have received written submissions from some of those who were due to give their evidence in person.*

- *Norman Lamb said that the health and social care landscape has completely changed because of Covid-19 with for example ICSs being 'ramped up'; and that the Commission has to reflect this in its deliberations. The chair said that international comparisons, especially if there were any evidence that countries with greater levels of health devolution had lower levels of coronavirus incidence.*

2. **Update from Secretariat**

- *Steve Barwick reported that there will have been in the order of thirty contributions to the Health Devolution Commission (please see Appendix 2). All the evidence is available on the website and a summary of the written responses received so far has been drafted and circulated to attendees.*

- *Phil Hope had a blog published by the HSJ highlighting how Covid-19 has shone a very stark, sometimes harsh spotlight on key issues including relationships between the centre and the local, between health and social care, between preventing ill-health and providing treatment, and between a community's health and the state of the economy. Meanwhile Andy Burnham has offered to national Government that Greater Manchester pilots a fully integrated national NHS and social care service.*

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- *A first draft of the final report will be considered at the next meeting of the Commission to be chaired by Andy Burnham via Zoom on Wednesday June 17th from 3 to 4.30pm. A final decision regards when and how the final report should be launched will be taken at the conclusion of this meeting.*

PART TWO - ORAL EVIDENCE

- **Cllr Ian Hudspeth, Chair of the Community Wellbeing Board at the LGA ,made the following key points:**

- *Local government delivers local solutions to national problems*
- *Devolution is not an end in itself – it is about what outcomes are achieved*
- *Resources are critical – they must be sufficient to do the job*
- *All parties need to agree a shared vision of health devolution so welcome cross party approach*
- *In the wake of Covid19 the LGA will be reviewing its policy position on health devolution*
- *Regard the purpose and powers of health and wellbeing boards, an LGA review of 22 case studies provides important information about where they have made a strategic difference including in Wigan, Warwickshire, West Yorkshire and Nottinghamshire*
- *NHS is nationally led with command and control system and accountability chiefly upwards; councils are first and foremost accountable to local electorate*
- *Some national targets undermine local roles eg social prescribing targets*
- *Centralised control approach has been beset by problems for example Covid 19 testing and PPE*
- *Local government can get the job done effectively: we need to build upwards allowing local leaders to take decisions*

In the subsequent Q&A the following points were made:

- *NHS and ICSs need a better understanding of what local government brings to the table*
- *There needs to be better recognition of the importance of social care and local government as move on from Covid19*
- *National targets may avoid postcode lottery but they also stop using local understanding and meeting local needs*
- *There needs to be parity between social care services and NHS. Problems during Covid-19 with social care often because NHS took precedence for example on PPE. Also, NHS debts have been written off but social care is creating worryingly high deficits for local councils.*
- *Local government has done well on public health despite a £700million cut in funding overall. Looking at 200 performance measures 80 went up which shows councils can do well.*

- **Dr Tom Coffey, the London Mayor's Senior Health Advisor made the following key points:**

- *The Memorandum of understanding signed by London Councils, GLA and the government has not delivered what we thought it would, for example delegated transformation funding has not happened.*
- *Most benefits of health devolution have been due to relationships between people not because of powers*
- *Unless there is the delegation of financial and legal powers then health devolution is just partnership working*
- *On estates there has been good progress as established London-wide business case approval board*
- *A ten-year capitation fund is needed in order to plan ahead for new hospitals – impossible to base investment on yearly income*

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LONDON COUNCILS mip managers in partnership CANCER RESEARCH UK mind for better mental health UNISON the public service union

- *GLA introduced 'six tests' rule regards reconfiguration. GLA worked with the Kings Fund to develop the tests and this has allowed effective scrutiny of healthcare*
- *On public health GLA have been surprised how much they can do: as the mayor has other responsibilities he has been able to link up action so for example no new fast food shops within 400 metres of schools; no fast food on the TfL estate*
- *This approach of Sadiq Khan is known as "health in all policies"*
- *GLA were first to see knife crime as a public health issue and hence proposed investment in early years*
- *There is more GLA would like to do and could do if it had more powers eg on gambling, taxes on sugar*
- *Devolution can be effective but without teeth it is partnership working*

In the subsequent Q&A the following points were made:

- *Digital infrastructure has come on leaps and bounds during the covid19 crisis and it could be used to overcome one of the biggest barrier between NHS and social care which is the inability to share records*
- *The geographical footprint in London is either at the local authority level or London wide. ICSs' focus is hospital reconfiguration and possibly cancer services but they are not the right level of delivery for example of children's or mental health services where local footprint is better*
- *Public and charities can get involved in multi-level governance especially through local authority or Mayoral leaders. At a local CCG level the GP chair is a mini-Mayor and there is evidence of good partnership working with elected council leaders*

- **Jon Restell, Chief Executive, Managers in Partnership, made the following key points:**

- *MiP represents 6,000 health service managers most but not all of which are employed in the NHS. A significant number are in social care sector.*
- *There has been an amazing response from health service managers who in an extremely stressful and onerous situation have been exceptional at refocussing services and accelerating change, with for example urology outpatient appointments now on line!*
- *Question on many members' lips is whether we have now reached a point of reform change – reform that would dispense with distinction between health and social care and deliver real integration and devolution?*
- *Clearly the response to the pandemic has highlighted three things*
- *First the public realm has not been properly resourced over a number of years and therefore the public sector was unprepared for the pandemic as evidenced by fact track and trace only starting now*
- *Second, the response to Covid-19 is being borne by some of those with least resilience*
- *Third, it has exposed the brutal failure to deliver adequate social care and therefore the ringfence around the NHS is being questioned*
- *Also important to reflect that NHS England have 'taken over the running' of the NHS during the crisis so actually been more centralisation with little consultation. As crisis eases more consultation may be required on the changes introduced and which it is now deemed sensible to maintain*
- *Finally, MiP have three recommendations: reform social care; accountability of management is important; and the health service workforce is also part of the wider determinants of health*

In the subsequent Q&A the following points were made:

- *Important to acknowledge the huge difference between social care sector and NHS: the former typified by mostly private providers with 15,000 care homes; the latter have 200 trusts. To allow dialogue a degree of devolution is needed.*

- *Most managers report positive relationships with local authority leaders but that may be due to a time of crisis: time will tell if old fears and anxieties return. There have in the past been examples of fist fights between elected councillors regards the siting of a new dental practice!*
- *There has been an appetite previously for a more devolved health system but undoubtedly the nationally focussed culture is strong in the NHS and has been reinforced during the pandemic response*

- **Christina McAnea, Assistant General Secretary, UNISON, made the following key points:**

- *UNISON is the biggest trade union with 400,000 members in the NHS, 185,000 in social care and 450,000 elsewhere in local government and elsewhere*
- *Covid-19 has demonstrated the differences between health and social care and made us question policies that have been around for years but clearly not delivering integration*
- *NHS is still a national service with national terms and conditions for staff and structures that deliver training and regulation*
- *Social care is delivered in a fragmented way with local authorities predominantly commissioners not providers. Terms and conditions vary massively, pay is low and training insignificant*
- *When UNISON set up a hotline at the start of the crisis it had 4,000 calls in first few hours almost exclusively from workers in social care sector*
- *Health devolution must be delivered within a national framework – it can't be let a thousand flowers bloom*
- *Our key conclusions are that there needs to be a substantial funding boost for social care and there needs to be a workforce strategy for those in social care: it can't be left to devolution to deliver these or done on a piecemeal basis*

In the subsequent Q&A the following points were made:

- *UNISON embrace more local accountability and more local determination but does not want to see a postcode lottery for pay and conditions*
- *NHS is one of best employers despite occasional imperfections. Provides a structure and high job satisfaction which is a marked contrast to what is offer in social care sector*
- *A Combined authority might offer some opportunity to mesh together the two workforce structures but would require a national framework*

- **Harry Quilter-Pinner, Fellow IPPR, made the following key points:**

- *In 2017 IPPR undertook a comprehensive overview of the devolution of health policy to date, and the directions it could take in future, and its report presented early evidence for how 'devo-health' could allow integration within and beyond the NHS, and act as a catalyst to much-needed reform.*
- *Fair to point out that in England health devolution is currently delegation. In Scotland it is devolved.*
- *Why devolve? There are two big benefits: overcome the fragmentation of the Lansley reforms and the fragmentation of public services more generally; it offers the opportunity to innovate.*
- *Current health devolution should go further: a bigger, bolder role for Mayors of Combined Authorities; some funding and revenue raising powers; concurrent changes to devolution so policy areas also highly relevant e.g. early years also devolved.*
- *The momentum towards devolution has been lost but hopefully there is a new opportunity with the new government: levelling up means devolution.*
- *True to say during pandemic there was a centralising tendency but there is another story: once national framework and tasks set, it has been for the local to get on and deliver.*

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In the subsequent Q&A the following points were made:

- *IPPR would rather have a national settlement for the funding of both NHS and social care services. Being taxpayer funded is what puts the N in NHS*
- *May be a case for some kind of revenue being able to be generated at the combined Authority level e.g. sin taxes on sugar but if want to fund properly need to fund nationally*
- *There are some risks that devolved health could lead to domination by acute trusts*

3. General comments,

- *Health devolution means being able to link care with other policy areas e.g. transport, skills and housing. It therefore cannot be divorced from the other powers that are devolved to local and combined authorities.*
- *If there is to be more devolution safeguards need to be found to ensure funding for unpopular and/or historically neglected areas of healthcare e.g. mental health*
- *A key issue running through all evidence sessions is the question of funding for social care. Some want to widen the ringfence around health to include social care with full funding for both from the centre, others want to remove the ringfence and some would like to see a re-balance so more more devolved funding (although will always be some national element)*
- *In the margins of funding, taxes raised on 'polluter pays' principle could help e.g. levies on tobacco manufacturers could contribute to smoking cessation programmes*
- *International comparisons would be of interest*

The meeting ended at 5pm

APPENDIX 1 - COMMISSIONERS IN ATTENDANCE

- Norman Lamb (co-chair)
- Stephen Dorrell
- Phil Hope
- Alastair Burt
- Dr Linda Patterson
- Peter Hay, ex ADASS
- Jon Restell, MIP
- Dick Sorabji, London Councils
- Warren Heppolette, GMH&SCP (Advisory)
- Steve Barwick, DevoConnect, (Secretariat)
- Sophie Corlett, MIND (Advisory)
- Shaun Walsh, Cancer UK (Advisory)

APOLOGIES

- Andy Burnham, Mayor of GM
- Sally Warren, King's Fund
- Sir David Behan
- Liz Gaulton, Coventry Council

APPENDIX 2 – CONTRIBUTORS OF EVIDENCE

Please note *italics* indicates oral rather than written evidence; underline indicates both oral and written submissions.

National bodies and federations

- Public Health England
- Health Education England
- NHS Providers
- NHS Confederation
- Healthwatch
- Local Government Association
- General Medical Council
- Breaking Barriers Innovations
- ADASS (TBC)

Local bodies and partnerships

- West Yorkshire and Harrogate Health and Care Partnership
- Greater Manchester Health and Care Partnership
- Fleetwood Primary Care Network
- *Northern Health Science Alliance (seminar)*
- *Greater London Authority*
- *London Councils*

Clinical and Workforce Representatives Bodies

- The Royal College of Occupational Therapists
- The Royal College of Radiologists
- The Association of Anaesthetists
- The Faculty of Sexual and Reproductive Healthcare
- *UNISON*

Charities and Social Enterprises

- Cancer Research UK
- Mind
- Macmillan Cancer Support
- *Ageing Better*
- *Social Enterprise Mark (seminar)*

Think tanks and Academics/Individuals

- Health Foundation
- *IPPR*
- *Professor Michael Marmot*
- Professor Mark Exworthy, Health Services Management Centre, University of Birmingham
- Dr Kimberley Lazo, University of Central Lancashire
- Chris Gibbon and Chris Brailey, independent management consultants
- Peter Hay, former President of ADASS

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