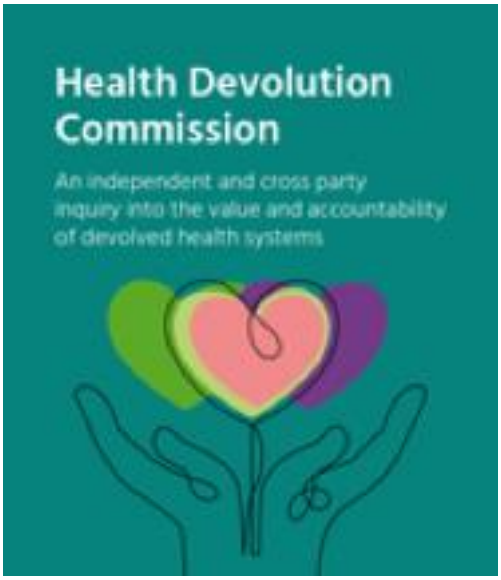

NON VERBATIM WRITE UP OF HEALTH DEVOLUTION COMMISSION ROUNDTABLE WITH NHSA

HELD BY ZOOM ON THURSDAY 21ST MAY

IN ATTENDANCE

- Dr Nav Ahluwalia, Executive Medical Director, Director of Research, Rotherham Doncaster and South Humber NHS Foundation Trust
- Dr Clare Morgan, Director of Strategy, Liverpool University Hospitals NHS Foundation Trust
- Professor Eileen Kaner Director of the National Institute Health Research (NIHR) Applied Research Collaboration for the North East and North Cumbria
- Rob Newton, Associate Director Policy & Partnerships, Leeds Teaching Hospitals NHS Trust
- Dr Liz Mear CEO Innovation Agency Academic Health Science Network North West Coast
- Dr Séamus O'Neill, CEO Northern Health Science Alliance
- Professor Wendy Baird, Director of NIHR Research Design Service Yorkshire and Humber, Faculty of Medicine Dentistry & Health Director of Research and Innovation University of Sheffield.
- Phil Hope, former Minister of State for Care Services and Health Devolution Commissioner
- Steve Barwick, Director of the Health Devolution Commissioner Secretariat
- Hannah Davies, Head of External and Public Affairs, Northern Health Science Alliance Ltd

ROUNDTABLE

PART ONE – GOOD HEALTH DEVOLUTION

Dr Seamus O'Neill warmly welcomed all attendees and Steve Barwick added his thanks to colleagues for giving up their valuable time as well as introducing the Health Devolution Commission which is a cross party, timely and important initiative.

Phil Hope, for the Commission, then introduced the first part of the roundtable – the inquiry into what good devolution looks like. A number of responses were given by participants including:

1. Interesting debate, and from public health perspective it is not possible to separate health and wealth (the economy).
2. Support for the idea of this paradigm shift in thinking and clear links between health strategies and local industrial strategies.
3. Shared projects are an important way of demonstrating the benefits of this way of thinking: from research through evaluation to implementation.
4. Local authorities are stretched in their infrastructure and capacity so need to be realistic regards the pace and scale of change that can be managed
5. It needs to be recognised just how difficult integration and collaboration can be especially if people are not genuinely committed to it
6. Covid 19 has revealed different experiences of "place-based working" which devolution aims to deliver
7. Devolution requires proper resourcing (capital, revenue and time) and a national 'psyche' – i.e. framework of working.
8. Health devolution in the broadest sense should encompass prevention, addressing inequalities and poverty, multi-morbidities, whole life course approaches and person-centred integrated care.
9. There are already movements towards aligning health to place – healthier communities are critical. The 'Total Place' approach.
10. Political consensus on any new framework will be needed for it to be acceptable and devolution could hard-wire best practice ways of working.
11. Focus should be on outcomes and what we want to achieve. Devolution may be an answer but not necessarily the only one
12. Health is critically dependent on education, training, housing, transport – it's not just biology
13. One should not get too focussed on organisational boundaries – also tension can be a good thing if it drives productive change.
14. It is not just about managing budgets, it is also about managing relationships
15. The digital agenda has been transformed by the Covid-19 experience
16. Link between health and wealth is at heart of Well North and for example the Wigan deal for health and wellness
17. Hospital debts are being written off during Covid-19 but council budgets have been cut to the bone: does this show where Government might direct future resources?
18. Working together – NHS and local authorities – is already happening and one way forward might for example by building on Joint Strategic Needs Assessments
19. There is loads of good practice out there and many barriers to integration have been reduced mainly through 'soft' initiatives
20. Health inequalities are stubborn as Wanless Report from 2002 highlighted – need long term approaches that build strong relations with the public and act upon the social determinants of ill-health (Marmot etc).
21. Subsidiarity – placing decision-making power to the lowest level possible should be a principle of health devolution.
22. GPs and councils are well placed to work together on social determinants of health but funding/ regulation/organisation of GPs in PCNs is becoming more centralised making this more difficult.
23. Universities as well as major hospitals and local authorities are 'anchor' institutions and key to place-based approaches. But to be successful, these anchor institutions need to have a culture of sharing, generosity and respect; and be good partners with local community-based organisations and voluntary groups.
24. Moving forward will require a joint national and local approach as there is some risk that less popular issues – prisoners etc – become overlooked at local level
25. The credibility of Government relies on looking at inequality highlighted by Covid-19 and moving forward focused on identity and inclusion

PART TWO – THE POLITICAL IMPLICATIONS

Steve Barwick, for the Commission, outlined a number of key questions that arise when one looks at the political implications of health devolution for example the question of whether new legislation is required, if there is a need for more visible leadership and democratic accountability, how should scrutiny be organised, and how workforce voices are to be factored in. Responses included the following:

1. The importance of public health, and how best to take forward, will need reflection after Covid-19
2. The performance of ICSs also requires further examination – good model but not proven to deliver better health outcomes
3. Difficult to be prescriptive regards health devolution – so not in favour of a 'blueprint' approach
4. Workforce should be appropriately represented in governance structures but be aware that clinicians are like taxi drivers: all know best!
5. Clarity on purpose essential – then do it well, do it once! Principles of change are: equitable leadership, properly resourced, proper representativeness
6. Support all MCAs having a clear responsibility to improve public health – but this not to be extended to ICSs at this time
7. National principles plus local flexibility please. But NB relationships at local level can drive innovation but can also block innovations sometimes!
8. Must also ask and then clarify what health devolution means for the public. In passing worth noting the north does citizen engagement better
9. Commitment to the 'levelling up' agenda must be at the heart of health devolution
10. If health devolution a good thing then must be good for all places so should not be presented as a north vs south issue.

CONCLUSION

The meeting ended with a request for further input to be sent directly to the Commission's Secretariat – steve@devoconnect.co.uk. All attendees were thanked for their invaluable contributions which would form part of the evidence base for the Health Devolution Commission and factored into the final report.