# Report of the Health Devolution Commission Roundtable on

## *Health Inequalities, Children, Mental Health and Learning Disabilities*

## Held 8th June 2022 by Zoom

**TWELVE EMERGING RECOMMENDATIONS**

**Reducing health inequalities**

1 ***Health in All Policies***: A 'Health in All Policies' approach must be adopted by ICSs to tackle the social determinants of ill-health if there is to be a significant reduction in health inequalities. This approach is being developed at every level - local, city, region, national and supra-national - as emerging evidence from Coventry and Greater Manchester shows that is works. But much more must be done nationally in the UK, underpinned by law, to reverse the last decade's shocking decline in health equality if ICSs are to succeed in this goal.

2 ***Hospitals as Community Anchors***: Large hospitals are increasingly recognising their role and impact as anchor institutions in local communities, and want to work in partnership with local government, the voluntary sector and local businesses to address health inequalities in the population as well as addressing inequalities in access to health services. ICSs should ensure that every hospital adopts this approach and develops their role as anchor institutions in the community

3 ***Equality and Quality***: The goal of equality as well as quality should be embedded in ICS and organisational codes of governance, and clear evidence shown that institutional resources are being shifted upstream towards prevention. The 'bottom-up' voice of communities and 'top down' action by system leaders should be combined to crack the challenge of improving the population's health and reducing health inequalities.

4 ***Whole System Approach***: To succeed will by not be easy as the public's expectation for the prioritisation of acute services – for example cancer treatments – will remain. But ICSs offer a chance to move beyond institutional and silo thinking, towards a whole system approach in which the NHS works in a joined-up way with a range of partners – local authorities, voluntary and community organisations, police, education, business - to deliver health improvement across a far wider agenda including air quality, regeneration, transport, housing, employment and skills.

**Improving the health and wellbeing of children and young people**

5 ***Mental Health First***: The key health challenge now for children's health is the major decline in their mental health. Recent excellent recommendations for reform of children's care services are in danger of being overwhelmed by the impact of this mental ill-health epidemic. It is simply wrong

that children in severe distress are now being put on a waiting list. ICSs must put children's mental health at the top of their agenda ensuring that all partners – NHS, local government and the voluntary sector - identify and act to reverse this situation.

6 ***National Leadership***: The landscape for children and young people is more complex for ICSs to manage as it includes education – schools and academies – as well as the NHS, local government and the voluntary sector. Effective data sharing is still not in place and there are no dedicated national funding streams for children's health as there are for conditions such as cancer. National cross-departmental leadership between health, social care and education is required to support integrated action at the level of the ICS, place and neighbourhood levels

7 ***ICS Policy Framework***: ICSs should develop a children and young people's policy framework based on a common set of design principles and containing clear indicators of success. Place-based partnerships should build on existing systems and structures, and clearly value the benefit for children and young people of accessing informal support in the community as well statutory services.

8 ***Avoid Over-medicalisation*****:** Care services for children and young people should not become medicalised but address the wider social, family, financial, educational and cultural factors influencing their growth and development. Schools must be fully engaged in the strategy and recognise their role as anchor institutions in local communities. The voice of children and young people is essential if change is to be successful.

**Mental health services and support for people with learning disabilities**

9 ***Mental Health Recovery Plan***: ICSs have a critical role to play in improving people's mental health, improving the services they rely on, reducing health inequalities and improving access to mental health services for marginalised groups in need. ICSs should be committed to parity of esteem between physical and mental health services and funding. As a priority, ICSs should enhance mental health services to better serve their local communities and help to tackle the existing shortfall in national provision, including the Improving Access to Psychological Therapies programme. ICSs should develop a fully funded post-covid mental health recovery plan for their area supported by a robust workforce development strategy.

10 ***Leadership*****:** Mental health services should be represented at every level in the ICS system with a full place on the ICS Board. There should be a process to allow the voice for mental health service users to be heard at every level - the ICS, place-based partnerships and Primary Care Networks

11 ***Learning Disability Action Plan*****:** As we heard directly from someone with a learning disability, providing the right extra support to ensure an active and full life is key to good health and wellbeing. ICSs should develop a learning disability action plan that includes driving up the numbers on the Learning Disability Register that is a passport to other services and benefits; exceeding their national target for Annual Health Checks; and ensuring GPs provide a Health Action Plan for all people with learning disabilities.

12 ***Leadership*****:** The Integrated Care Board member for Learning Disabilities and Autism should use their position to request regular reports on the delivery and impact of the Learning Disability Register, Annual Health Checks and Health Action Plans as a means of influencing the system.

## 1. INTRODUCTION

This is a summary of the opportunities, examples of best practice and challenges for Integrated Care Systems presented and discussed at the meeting of the Health Devolution Commission on 8th June 2022 chaired by the Rt Hon Andy Burnham, Mayor of Greater Manchester. A recording of the roundtable involving 42 participants is available here. A briefing paper was produced for the event and circulated in advance.

The roundtable was structured in three parts with presentations on and contributions by:

**Part One: Developing ICS best practice to address health inequalities**

- **Professor Michael Marmot**, Director, UCL Institute of Health Equity
- **Dame Jackie Daniel**, Shelford Group and Chief Executive of the Newcastle Upon Tyne Hospitals NHS Trust (with input from **Darren Banks**, Group Strategy Director for Manchester University NHS Foundation Trust and **Roland Sinker**, Chief Executive, Cambridge University Hospitals NHS Foundation Trust)

**Part Two: Developing ICS best practice and shared outcomes for children and young people's health, care and wellbeing**

- **Steve Crocker,** President, the Association of Directors of Children's Services
- **Russell Viner,** Professor of Adolescent Health at the UCL Great Ormond Institute of Child Health
- **Rukshana Kapasi,** Director of Health, Barnardo's

**Part Three: Developing ICS best practice in mental health services and support for people with learning disabilities**

- **David Weaver**, President, British Association for Counselling and Psychotherapy
- **Jackie O'Sullivan**, Director, and **Ciara Lawrence**, Big Plan Engagement Lead, Mencap
- **Claire Bruin**, Care and Health Improvement Adviser, LGA

## 2. DEVELOPING ICS BEST PRACTICE TO ADDRESS HEALTH INEQUALITIES

### 2.1 Health in All Policies

Michael Marmot described the background to his research since 1978 on the need to tackle the social determinants of ill-health to reduce health inequalities. A 'health in all policies' approach - in housing, the workplace, the community and the environment – is needed to improve the health of the population rather than focussing only on improving the performance of health and care systems.

This approach is now underway at local, city, region, national and supra-national levels within the UK and in other countries including examples of implementing the 'Marmot City' concept in Coventry and Greater Manchester, Hong Kong and the East Mediterranean. The evidence of growing health inequality in the UK since 2010 is of great concern and therefore, whilst local/regional action is important, it is vital that national government is not 'let off the hook' of the goal of reversing this decline.

Tackling health inequality is now a core business for Integrated Care Systems that provide the opportunity for establishing new local partnerships of the NHS, local authorities, the voluntary sector and businesses to tackle health inequalities in their area. Other local partners such as the police, the fire and rescue service, education and local businesses are also now expressing a strong interest in becoming a partner in this new approach. Individually and collectively local organisations can seek to improve people's health in their employment practices (wages and conditions), the nature of their goods and services, the qualities of their suppliers, and their impact on the environment and the local community.

Early evidence from Coventry and Greater Manchester is showing that this works. There is a need now to develop a monitoring framework using a limited number of 'beacon indicators' to measure the impact that ICSs are having on reducing health inequalities and improving the population's health.

### 2.2 Hospitals as Community Anchors

NHS organisations are viewed as anchor institutions in communities because of their organisational size, their roles as major purchasers and employers, and their long-term presence within local communities.

The Shelford Group is a collaboration between ten of the largest NHS Trusts in England with a combined annual turnover of £14bn, employing over 150,000 staff and delivering care to over 15 million people a year. The Shelford Group Strategy 2021-2025 'Improving Health Outcomes for All' includes hospitals as anchors in a stand-alone chapter, and is also a cross-cutting theme that recognises and seeks to address health inequalities within the communities that they serve.

The strategy includes a commitment to collaborative partnership working at local and national levels to affect the wider determinants of health and reduce health inequalities. It identifies opportunities for impact across a breadth of areas including employment, procurement, and sustainability.

Three detailed examples of what this means in practice from Newcastle upon Tyne, Cambridge and Manchester can be found in the presentation to the Health Devolution Commission here.

These include:

- Development of integrated care services
- Co-located staff and joint apprenticeships
- Joint system leadership
- Robust shared data and science analytics
- Wider impact beyond health and care
- Measuring social value and impact of spending
- Thought leadership and new services
- Key part of life sciences cluster and innovation ecosystem
- Supporting clinical networks with local hospitals other health providers
- Partnership working on housing and transport
- Pooling assets through civic and commercial partnerships
- Whole campus approach to capital investment and using capital to change lives
- Carbon reduction

### 2.3 Discussion Points

During discussion among the Commissioners about how ICSs can reduce health inequality, a number of key points emerged:

**Competing pressures**

- A fundamental concern is that the current pressure on Foundation Trusts (FTs) to give priority to reducing the Covid backlog will divert management time and attention from their good intentions to improve population health.
- A move from thinking about the performance of institutions to thinking about how well systems are performing is crucial to ensure that all partners – including large and powerful NHS bodies - focus on what is best for the health and wellbeing of whole populations.
- The Shelford Group Trusts have a key role in providing leadership to help ensure that reducing health inequalities is delivered as a priority throughout their systems; and to do so through a strong connection with local government and working with less recognised areas such as community services in disadvantaged areas or communities experiencing discrimination.
- Shelford Group members have shown that Trusts can deliver both high-end science to improve health outcomes **and,** through systems, deploy new developments to a much larger population across a bigger geographical footprint (for example, action on oesophageal cancer) with not just prevention, but also the broader determinants of health in mind.

**Evidence of a shift towards health equality**

- There needs to be clear evidence of a shift in hospital resources towards reducing health inequalities in the populations they serve (not just in ensuring greater equality in access to hospital services).
- The trend towards vertical integration of NHS services should make it easier to move resources ‘upstream’ towards prevention.
- Risk pooling among partners also helps promote this shift and to break down silos.

- The new tight financial "envelopes" will create challenges but new freedoms over how those resources are used will enable FTs to make spending choices that directly reflect the new priority task of reducing health inequalities.
- There needs to be a balance in the work of hospital clinicians between hospital-based services that some parts of the population may not readily access, and those provided in community locations that reach more people such as the use of scanners in public areas for early cancer diagnosis.

**Quality and equality in ICSs**

- One way of 'hardwiring' equality as well as quality into ICSs, provider collaboratives and individual institutions, could be through new requirements within their Code of Governance.
- Strong and practical relationships with local authorities must be a central task for hospitals as anchor institutions in the community if they are to help deliver the equality goals of an ICS.
- Trust and positive personal relationships between system leaders is an essential part of that 'hardwiring' that has to be built over time.
- The 'nutcracker' approach of both strong system leadership down **and** continuous pressure from the voices of people and community groups from the bottom up is needed to crack the 'tough nut' of reducing health inequalities.
- Shifting the curve to level up the population's heath to that of the top 10% will not be achieved by focussing only on the bottom 10%. The gradient of health inequality is what matters. Change requires action on the health inequalities of the bulk of people in the middle as well.
- Crucially, ICS population health data needs to be disaggregated to show the health of different populations and communities related to deprivation/poverty, race and ethnicity, gender, disability and location.
- A challenging question for ICS is how health equality can be achieved without reducing health service quality given we only have finite resources given that these two elements can be in tension.
- There is strong evidence that people from black and minority ethnic communities experience significantly worse health outcomes and this must be central to the task of reducing health inequalities.

## 2.4 Conclusions

In conclusion, ICSs offer a very real and unique opportunity for implementing the next chapter of reform in our health and social care system and one in which health inequalities are centre stage. There is genuine optimism 'on the ground 'and a strong support from NHS England and Improvement.

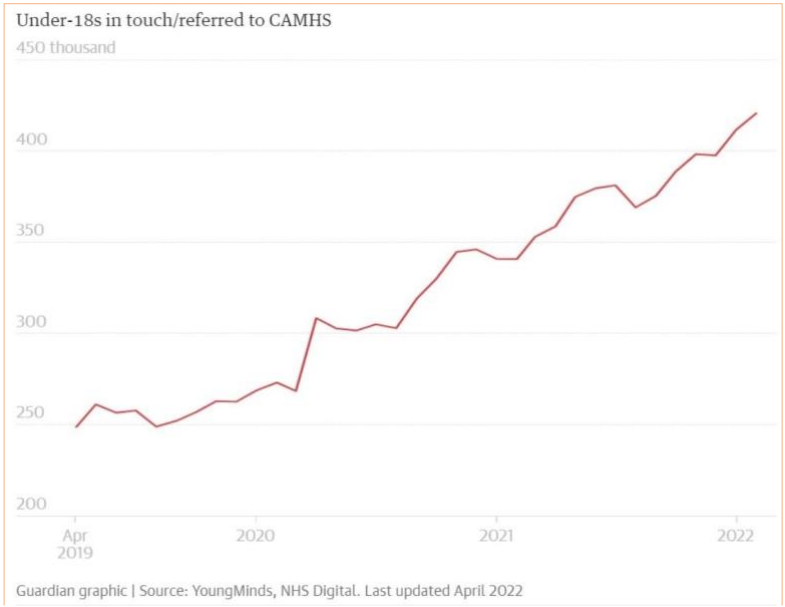
However good institutional architecture and better relationships between NHS local government and other partners, will only go so far. Supportive central Government action, including stemming growing inequality and poverty, is crucial. Making inroads on health inequality requires not only local collaboration but also central Government action.

## 3. DEVELOPING ICS BEST PRACTICE AND SHARED OUTCOMES FOR CHILDREN AND YOUNG PEOPLE'S HEALTH, CARE AND WELLBEING

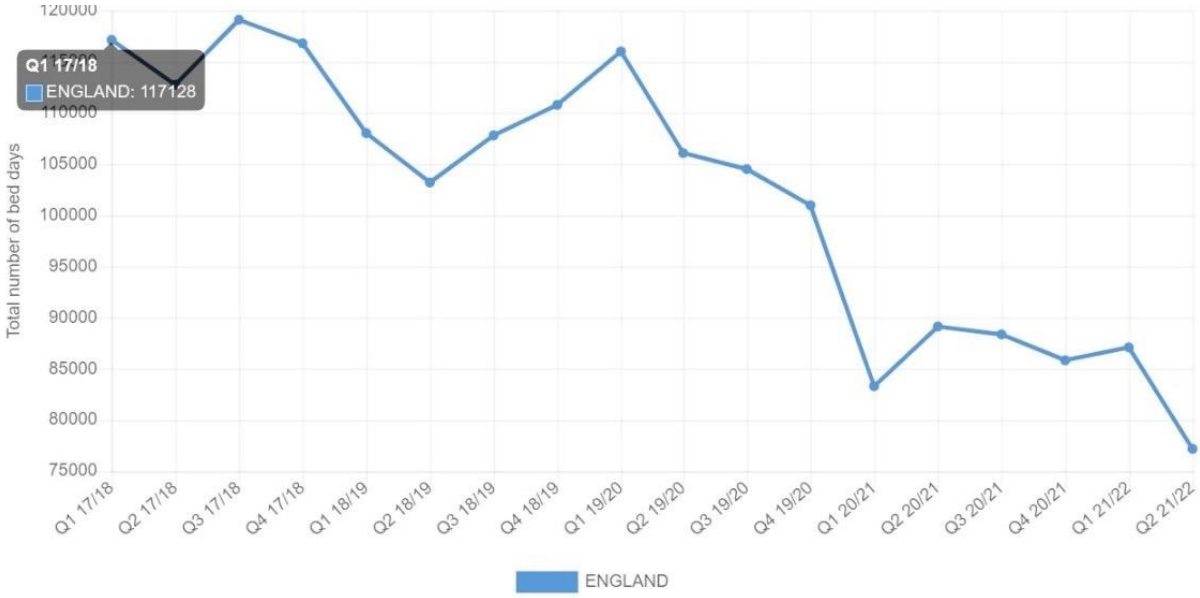
### 3.1 Mental health first

Steve Cocker identified the key challenge for the NHS and ICSs as being the major decline in children's mental health in the last few years. Demand for treatment and support during the pandemic has increased hugely whilst resources for children's mental health services are down, leading inevitably to long waiting times for treatment by children and families. The scale of this challenge is illustrated in the two graphs presented by below – also available here - and it is vital that wherever possible children are supported in the community rather than institutional settings:

**Under 18's in touch/referred to CAMHS – Young Minds UK**




**Number of Bed Days - RCP**



The recent independent review of children's social care services by Josh McAllister has a number of excellent recommendations for reform of children's health and care but is in danger of being overwhelmed in the face of this major mental health challenge. And it is of great concern that the government's targets for improving children's mental health services are so low – namely that 35% of schools should have a mental health team (suggesting it is OK that 65% won't) and that 35% of NHS diagnostic services for children's mental health should take place in the community when the aim should be for community-based diagnoses to be the norm.

It is simply wrong that a system for rationing treatment priorities for patients needing a hip operation should be applied to rationing services for children in great distress. There should not be NHS waiting lists for children experiencing poor mental health. It was pointed out that there are no waiting lists for children's social care.

An immediate response is required of the NHS and Local Government to address the mental health of children and young people that identifies what, together, they can do to address this growing challenge. Without good mental health, other health and care support and services will simply not work so this must be the priority for action.

Listening to children and young people – not just engaging but really listening and acting on what is said – is a central part of the solution as well.

### 3.2 Dealing with complexity

Russel Viner drew attention to the situation in which children and young people are 23% of the population but only receive 8-10% of NHS resources in England. In that context, ICSs represent a huge opportunity to re-shape and re-prioritise children's health and care given their new statutory role and requirement to identify a lead person for children and young people on the ICS Board.

Surveys of ICSs show that ICSs are developing their focus on children with the main issues of concern being mental health and childhood obesity. Whilst some are engaging with and giving a voice to children and young people the picture is patchy. And the involvement with schools varies greatly between areas.

There is optimism among ICSs about the future but a number of obstacles need to be overcome to make change happen in practice:

- There are no dedicated funding streams for children (unlike conditions such as cancer)
- There are tensions between national and local priorities for action.
- The institutional arena is more complex as improving children's health and wellbeing involves not just health and social care services, but also schools and academies, and the child's family and care circumstances.
- The capacity of ICSs to deal with this complexity needs to be recognised and addressed.
- Effective data sharing about children between key agencies is still not in place
- The future of highly specialised clinical services treating small numbers remains unclear and potentially puts them at risk.

### 3.3 Getting it right for children

Rukshana Kapasi presented Barnado's work across the UK and drew attention to the example of their work with Frimley ICS on engaging with children and young people at the level of system, place and neighbourhood. She briefly described two major initiatives: 'Solar' - an integrated local mental health offer at place, and LINKS - a social prescribing offer in neighbourhoods for children and young people.

Key actions that ICSs should take to get right what they do for children and young people are to:

- Start with a vision from perspective of children and young people
- Develop a clear set of principles for what it means to embed children and young people's voice in decision-making and programme development
- Define how system, place and neighbourhoods are meaningful to children and young people, how they need to interact and how strategic plans need to respond
- Give equal priority to the twin challenges of health creation and service integration and optimisation
- Determine priority shared outcomes for children and young people, and what this means for all partners
- Reflect on and seize unique opportunities that ICSs create

Suggestions for measures of success in delivering priority shared outcomes are levels of:

- School readiness
- Childhood obesity
- Young people reporting low mood and/or anxiety
- School attendance
- Young people not in education, employment or training
- Crisis interventions, or unplanned care e.g. asthma, diabetes, A&E attendances

The design principles for an ICS children and young people's policy framework could include:

- Comprehensive in scope (health, social care, education and family life)
- Reflect the life-course of children and young people (pre-conception to 25 years)
- Identify specific components to be addressed, and collective action of all partners
- Clear measures for assessing success and outcomes
- Equal weighting of health creation and service integration elements

Three simple but challenging questions that every ICS should seek to answer are:

- What are the top five things that matter to children and young people in this area?
- How would you justify your decisions to children and young people were they in the room today?
- What do you want to model to children and young people in the way in which you collaborate?

### 3.4 Discussion points

**Value both formal and informal support services**

- It is important for children and young people to have access to a balance of formal statutory mental and health and care services and informal engagement with non-statutory support provided by voluntary and community sector organisations.
- There is a need to ensure funding is available to the VCSE sector to provide this kind of support and appropriate partnership relationships with statutory services to ensure children get the right balance of support they need.

**Build on existing services, structures and place-based partnerships**

- It will be important for ICSs to know, through their place-based partnerships and neighbourhood networks, the map of existing services, structures, partnerships and relationships that work with children and young people.
- A children's services map may reveal areas where there is a gap in the appropriate range, and balance, of services and support; help to identify areas for service improvement; and locations of conditions where there may be unnecessary duplication or overlap.

**Avoid over-medicalisation**

- In working to identify and meet the needs of children and young people care should be taken to avoid over-medicalising the nature of the problems to be addressed and to consider other causes (and responses) that may have their roots in social, educational, financial, environmental or other aspects of the child's life.
- Engage fully with schools and academies in developing a new strategy to ensure a holistic and personalised approach is developed for individual children; and ensure that schools play their part as 'anchor' institutions for children and families in an integrated approach to improving the health and wellbeing of the child population.
- The impact of family life (or the care system for children in care) is central for children and young people so family support work must be part of the range of services on offer.

**Be clear and honest about priorities**

- As ICSs develop their role in overseeing the development of a more integrated health, care and education system to improve the health and wellbeing of children and young people they will need to establish a limited number of key priorities for action.
- These priorities should be determined locally based on robust data, engagement with children and young people, and thought-through cross-sector professional insight and expertise.

**National cross-departmental leadership**

- The late amendment to the Health and Care Act that children and young people will fall within the scope of ICSs has consequences nationally as well as locally. It will be important that the Department of Education works in full partnership with the Department of Health and Social

Care in reflecting a more integrated and person-centred approach to its own policies and procedures, particularly in relation to schools and academies.

- Ofsted is the regulator of children's care services as well as education and how it relates to the work of ICSs that now have a duty regarding children's health and wellbeing needs to be considered further. The relationship between Ofsted and the CQC where there is a joint interest in the performance of ICSs, place-based partnerships and service providers (health, social care and education), also needs further consideration.

### 3.5 Conclusions

In conclusion, action by the NHS and local government to address the growth in the mental ill-health of children and young people must be a top priority for ICSs developing their plans for improving the health and wellbeing of children and young people. The children's landscape is complex and ICSs must fully engage with schools and education to achieve their health and care goals for children.

This must be supported at a national level by new cross-departmental leadership between DfE and DHSC. Every ICS should develop a Children and Young People Policy Framework including shared outcomes and clear priorities for action based on a robust analysis of local needs that includes the voice of children and young people themselves.

ICSs must avoid the medicalisation of social care and mental health services; address the social determinants of mental ill-health; and ensure children and young people can access a balance of informal voluntary/community services and statutory services.

## 4 DEVELOPING ICS BEST PRACTICE IN MENTAL HEALTH SERVICES AND SUPPORT FOR PEOPLE WITH LEARNING DISABILITIES

### 4.1 ICSs and mental health services

**Mental health inequality**

- David Weaver suggested that ICSs have a critical role in improving people's mental health and the services they rely upon; in reducing population mental health inequalities for different groups experiencing discrimination, particularly those experiencing systemic racism; and improving equality of access to health services for marginalised groups.
- Change needs to be 'evolution at a pace' to both build consensus and achieve impact. This should include addressing structural problems within IAPT (Improving Access to Psychological Therapies) that is not adequately reaching or meeting the needs of people in black and minority ethnic communities and for other marginalised groups including older people and the LGBTQ+ community.
- The current system is unsustainable. Many third sector providers are receiving referrals for clients from IAPT services but are often not being paid to support these clients. As a result, they either join waiting lists or are discharged. Whilst IAPT undoubtedly has a place in the package of psychological therapy services available to the public their recovery rate targets (50% recovery) clearly show that it doesn't, and isn't designed to, meet the needs of all service users. Therefore, the necessity here is for systems to commission a broader range of mental health support to provide a much more holistic offering that meets the needs of a broader range of service users.
- ICSs can play an important role in developing mental health services to meet the gaps in IAPT with particular reference to the funding and support of voluntary and community organisations that are often more culturally accessible than statutory bodies.
- There is a need for direct representation of mental health services at every level – ICS, place-based partnerships and Primary Care Networks - and clear mechanisms for ensuring engagement and a voice for people with lived experience of care and the mental health system.
- ICS should play their part in moving towards parity of esteem between physical and mental health services and funding; and develop a fully funded mental health recovery plan for services in their area supported by a robust workforce development strategy

### 4.2 ICS support for people with learning disabilities

**Listen to us**

Ciara Lawrence has a learning disability and described her experiences growing up, how she now lives an independent life and her work for Mencap as the Big Plan Engagement Lead. She said how vital it is for all organisations to listen fully to people with learning disabilities – to their stories, their experiences, their feelings – and to really understand what matters to them and what they want. "We rely on you to make a big difference to our lives, so it is essential that you listen to us and support us to make our contribution".

**Some facts about us**

Mencap provide a wide range of services and support for people with learning disabilities across the country, and work in diverse partnerships with the NHS, local government, and other voluntary and community organisations. Jackie O'Sullivan, Director of Mencap, outlined the position of people living with a learning disability within which ICSs will do their work:

- There are 900,000 adults with a learning disability in England yet there are only 224,291 people (25%) on the Learning Disability Register
- Life expectancy is considerably lower – 27 years lower for women and 23 years lower for men
- There are 1,200 avoidable deaths every year
- The average age of death for Asian boys with a Profound and Multiple Learning Disability (PMLD) is 9
- The official employment rate among people with a learning disability is 5%
- 2,050 people are locked up in Assessment and Treatment Units (ATUs)
- A 2021 survey showed that 83% are lonely and 34% have a mental health issue

**National action to support us**

The NHS recognises that people with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying earlier than they should, many from things which could have been treated or prevented.

The learning from deaths of people with a learning disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities.

The Government have also introduced a requirement for CQC registered service providers to ensure their employees receive learning disability and autism training appropriate to their role. This is to ensure the health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability. This requirement is set out in the Health and Care Act 2022. The training is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training.

**What ICSs could do for us**

Jackie outlined some clear and achievable tasks that ICSs could undertake to rapidly improve the health, care and support that people with learning disabilities receive include:

- Drive up the numbers of people with a learning disability who are on the Learning Disability Register as this is their passport to a range of other services and benefits.
- Analyse the local LeDeR data and draw up an appropriate action plan to improve the health of people with a learning disability and reduce health inequalities.
- Roll out the Oliver McGowan Training for health and social care workers

- Identify and tackle co-morbidities that are common among many people with a learning disability
- Avoid the medicalisation of social care and properly value the contribution those with a Learning disability make.
- Transform care - homes not hospitals - for people with a learning disability
- Avoid the false economy of cutting small care packages and day care services

Claire Bruin from the LGA followed this with a presentation on the steps an ICS could take in an integrated approach to reduce health inequalities among people with a learning disability:

- Establish a shared outcome to improve health inequalities
- Consider how the National target for Annual Health Checks (AHCs) can support this – addressing quantity and **quality**
- Include expectations in Council contracts with providers that support people with learning disabilities to attend AHCs and other health appointments and identify reasonable adjustments
- Ensure providers commit to fulfil these expectations – monitored by Councils
- Provide specialist community health teams to support providers and people with learning disabilities and their families to recognise and communicate reasonable adjustments to other health staff e.g., GPs
- GPs to invite people for the AHC, make reasonable adjustments, if required and listen to the person and staff or family supporting them
- GPs to provide a **Health Action Plan** and make any follow up referrals to ensure health issues are explored and timely treatment can be given
- ICB Board member for Learning Disabilities and Autism could request regular reports to monitor the delivery and **impact** of AHCs and Health Action Plans

Claire Bruin summed up what she thought would help ICSs to deliver positive outcomes for people with a learning disability:

- Having a common purpose and vision developed with people with lived experience and their families and partner organisations
- Building mature relationships where partner organisations are prepared to work flexibly to progress the joint agenda including giving up some power
- Leaders of partner organisations demonstrating commitment to working collaboratively, focusing on strategic direction, operational implementation and practice of clinical, professional and other health and social care staff to ensure delivery

### 4.3 Discussion points

- Mental health is the defining issue of our time. It has to be a priority for every ICS not least because failure to make an impact on improving mental health will undermine the ability to achieve wider outcomes.
- People with learning disabilities are often overlooked so action to raise their profile within the ICS is urgently required. The suggestions for action by the ICB member for Learning Disabilities and Autism could be the key to unlocking a better future for this group in the population.

- There are important examples of best practice that the ICS network could consider in order to address issues around accessibility for racialised communities including an innovative service commissioned by the Greater Manchester Health and Social Care Partnership which offers culturally sensitive mental health support to ethnic minority communities across Greater Manchester. GMH&SCP have commissioned the delivery of this bespoke service from six third sector providers who represent a range of communities including the Manchester BME Network CIC, Yaran North West (which supports Middle Eastern communities), Jewish Action for Mental Health, Wai Yin Society (which supports Chinese communities) and the Caribbean and African Health Network.

### 4.4 Conclusions

In conclusion, as part of their commitment to parity of esteem for mental health, a key priority for ICSs is tackling mental health inequalities for different groups experiencing discrimination, particularly those experiencing systemic racism; and improving equality of access to health services for marginalised groups. A specific focus should be addressing structural problems within the IAPT programme including support for voluntary and community sector providers that can be more culturally accessible to groups experiencing discrimination.

There should be direct representation of mental health services and a voice for patients and services users at every level – the ICS, place-based partnerships and Primary Care Networks. Every ICS should develop a fully funded mental health recovery plan for services in their area supported by a robust workforce development strategy.

People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying earlier than they should, many from conditions which could have been treated or prevented. This should be formally recognised by ICSs and a plan developed to reverse this position.

An ICS learning disability action plan should include ambitious targets to drive up the number of people with a learning disability that are on the Learning Disability Register, have an Annual Health Check, and have a personal Health Action Plan. The ICB member for Learning Disabilities and Autism should request regular reports to the Board on progress in achieving these targets.

***Phil Hope and Steve Barwick, the Health Devolution Commission Secretariat***
***June 2022***

## APPENDIX 1 - ATTENDEES

| ***HEALTH DEVOLUTION COMMISSIONERS*** | |
|---|---|
| Rt Hon Andy Burnham | Co-chair HDC and former Secretary of State for Health |
| Rt Hon Alistair Burt | Former Minister for Community and Social Care |
| Cllr Izzi Seccombe | Leader of Warwick CC and Wellbeing Portfolio Holder, WMCA |
| Cedi Frederick | Chair Designate of Kent and Medway ICB |
| Nadra Ahmed | Executive Chair, National Care Association |
| Dr Linda Patterson | Former Medical Director of CHI and Vice President of RCP |
| Rt Hon Stephen Dorrell | Former Secretary of State for Health |
| Peter Hay | Former President, ADASS |
| Imelda Redmond | Former Chair, HealthWatch |
| Phil Hope | Former Minister of State for Care Services |
| ***ADVISORY COMMISSIONERS*** | ***PARTNER ORGANISATION*** |
| Cllr Rosemary Sexton | LGA |
| Alyson Morley | LGA |
| William Pett | NHS Confederation |
| Steve Mulligan | BACP |
| Ian Holmes | WYH&CP |
| Warren Heppolette | GMH&SCP |
| ***SPEAKERS*** | ***ORGANISATION*** |
| Professor Michael Marmot | Director, UCL Institute of Health Equity |
| Dame Jackie Daniel, Darren Banks and Roland Sinker | Shelford Group |
| Steve Crocker | President, Association of Directors of Children's Services |
| Russell Viner | Professor of Adolescent Health at the UCL Great Ormond Institute of Child Health |
| Rukshana Kapasi | Director of Health, Barnardo's |
| David Weaver | President, British Association for Counselling and Psychotherapy |
| Jackie O'Sullivan and Ciara Lawrence | Director, and Big Plan Engagement Lead, Mencap |
| Claire Bruin | Care and Health Improvement Adviser, LGA |
| ***OTHERS*** | ***ORGANISATION*** |
| Ed Jones and Lawrence Kent | NHS Confederation |
| Cheryl Davenport | EELGA |
| Hannah Shah | Norfolk ICS |
| Jane Moore | BSW ICS Partnership (Bath, Swindon, etc) |
| Katy Block | Association of Directors of Children's Services |
| Hazel Buchanan | Nottingham and Nottinghamshire ICS |
| Eleanor Wright | National Voices |
| Nathasha Owusu | Chartered Society of Physiotherapy |
| Will Warburton and Kathrine Badcock | Shelford Group |
| Ann McGuaran | Municipal Journal |
| Lawrence Dunhill | Health Service Journal |
| Joe McCormack | Shelford Group Secretariat |
| Steve Barwick | HDC Secretariat |