
**ENGLISH DEVOLUTION:
LOCAL SOLUTIONS FOR
A HEALTHY NATION**



FOREWORD Councillor Izzi Seccombe	3
WHERE WE LIVE IS THE BIGGEST SINGLE DETERMINANT OF OUR HEALTH Steve Pleasant Chief Executive, Thameside MBC	4
WE MUST STOP VIEWING PUBLIC HEALTH THROUGH THE LENS OF A SMALL CLINICAL SPECIALITY Kate Ardern Director of Public Health, Wigan Council	6
FOCUS ON GROWTH, REFORM AND PLACE HELPING TO BREAK CYCLE OF HEALTH INEQUALITIES David Regan Director of Public Health, Manchester	8
STRONG LEADERSHIP WILL BE NEEDED FOR THE COMPLEX CHALLENGES THAT LIE AHEAD Shirley Cramer Chief Executive, Royal Society of Public Health	10
EARLY WINS AND LONGER TERM SPADEWORK Dave Buck Senior Fellow, Public Health and Health Inequalities, Kings Fund	12
WHAT'S RIGHT FOR BIG CITIES WILL NOT WORK EVERYWHERE Maggie Rae Corporate Director, Wiltshire Council	14
DEVOLVING CONTROL OF SYSTEMS FOR BETTER HEALTH Jim McManus Director of Public Health, Hertfordshire County Council	16
SUCCESS LIES IN BUILDING STRONGER CO-PRODUCED RELATIONSHIPS WITH COMMUNITIES Mark Gamsu Visiting Professor, Leeds Beckett University	18
OPPORTUNITY TO TACKLE HEALTH INEQUALITIES SHOULD NOT BE WASTED Jessica Allen Deputy Director, Institute of Health Equity	20
PUBLIC HEALTH SPECIALISTS COULD DEVELOP AND TELL A POWERFUL STORY OF WHAT COULD BE Andrew Furber Director of Public Health, Wakefield MBC	22
FORM FOLLOWS FUNCTION: DOING THE RIGHT THING FOR USERS OF HEALTH AND CARE SERVICES Charlotte August Richmond Group Partnership Manager	24
SUPERLAMBANANA AND THE NEXT GENERATION INTEGRATION AGENDA Warren Escadale Chief Executive of Voluntary Sector North West	26
PUBLIC HEALTH MUST BE FRONT AND CENTRE Councillor Colin Noble Suffolk County Council	28

FOREWORD



In Victorian times, local government pioneered and introduced the provision of clean water, universal education, parks and open spaces, decent public housing, food inspection and the detection and treatment of infectious diseases. In the 21st century, we are building new partnerships and taking on a critical leadership role in improving the public's health.

The modern day health challenges are significant. One in five children in Year 6 is obese. Most people will reach a retirement age of 68 with a disability. Sick days cost our economy £14 billion a year. Long term conditions account for 70 per cent of hospital bed days. The country faces a rising tide of need, as people live longer but spend more of those years in ill-health, largely because of preventable chronic diseases.

I've heard first-hand from councillors and officers from across the country; they want to do more to tackle obesity, alcohol misuse, mental health and physical inactivity. They want youngsters to get the best start in life and older residents feel safe and connected. They also want to be empowered to make local decisions on fast food, alcohol, tobacco and other public health-related policy and regulatory decisions that go further and faster than national statutory frameworks.

Recent public health reforms have radically shifted power to local authorities, empowering them to invest and innovate to improve the health of their communities. The reforms reflect a confidence that local communities are best placed to respond to local needs, rather than central government.

The recent announcement of devolution in Greater Manchester places councils centre stage in the battle to improve population health and reduce inequalities. Devolving control of social care and health spending to Greater Manchester is good news for the people who live there and now needs to be replicated for people across the rest of the country.

With greater control over spending on hospitals, GP surgeries and drop-in centres, local areas can fully integrate their funding for health and social care to help people live independently at home longer into their older years and support people with long-term conditions. It is right that local areas should have the powers to make decisions that affect their residents at the most appropriate local level. This is vital to improving care and alleviating the wider pressures on the health service. But there is still more that can and should be done.

Crucially, true devolution to English local areas needs to be backed up by the promise of genuine financial freedoms for local government. It will be important that any transfer of funding from central to local government is free from counterproductive bureaucracy and Whitehall interference.

Councillor Izzi Seccombe

Chair of the Community Wellbeing Board, LGA

WHERE WE LIVE IS THE BIGGEST SINGLE DETERMINANT OF OUR HEALTH



Health and social care devolution in Greater Manchester sits as part of a much wider devolution of powers: skills, employment, transport and housing. It is the combination of these that offers the exciting prospect of deciding much more locally how to improve the public's health.

Where we live is the biggest single determinant of our health – not lifestyle choices or NHS treatments. Devolution will give Greater Manchester (GM) the powers to move to a place-based health system, one designed around local assets. The tools available in a devolved system include; rapid innovation; workforce development integrated with local skills and employment initiatives; and working with NHS to enhance their preventative role.

We are confident in GM of our ability to spot a good idea and use it to get better outcomes for local people (for example, the GM Working Well programme is successfully working with people who have not secured work through the national Work Programme, into work and volunteering).

But radical innovation in service delivery has often been constrained by the requirements of national frameworks.

Dividing workforce development responsibilities into different national agencies and professional bodies, has created a highly skilled public health workforce - but one that is not always in the right place with the right skills. Devolution provides us with an opportunity to think again about the skills required at all levels to protect and improve health, from service providers to directors of public health. So we can aspire to create a system that meets professional requirements but also equips individuals to adapt within new service models.

We also need to talk about the money. We must move beyond the perceived rights and wrongs of a ring fenced public health grant. The real issue is an assumption, still being made, that the grant can only be used to pay for public health services that look like those that transferred from the NHS. Local government must be confident, using the grant to support whole population interventions, shift societal norms, and improve the prospects for future generations.

The NHS five year plan has, significantly, acknowledged the role of the NHS in preventing ill health. Devolution will ensure that reform and redesign has prevention at the heart of our new models of care. Sometimes this work will be difficult and challenge our thinking about financial viability, service configuration and our workforce requirements. Those thorny issues, like smoking on hospital grounds or the sale of high calorie food in leisure centres will all need to be addressed if we are to normalise promoting good health rather than treating poor health.

There are risks and challenges. Foremost, that everyone agrees that visionary change is necessary – but then gets bogged down in sustaining the system. That would be to lose this fantastic opportunity to keep people healthier for longer. But from all we have achieved so far, I am confident that colleagues right across the Greater Manchester Health and Social Care system see devolution as much more than an exercise in preserving the status quo.

Steve Pleasant

Chief Executive
Tameside MBC

“Devolution will ensure that reform and redesign has prevention at the heart of our new models of care. Sometimes this work will be difficult and challenge our thinking about financial viability, service configuration and our workforce requirements.”

WE MUST STOP VIEWING PUBLIC HEALTH THROUGH THE LENS OF A SMALL CLINICAL SPECIALITY



Greater Manchester (12 NHS Clinical Commissioning Groups, 15 NHS providers and 10 local authorities) and NHS England's historic announcement of a Memorandum of Understanding to develop a framework for joint decision-making on integrated care bringing together health and social care budgets of £6bn represented a significant shift back to local determination of how resources, previously commissioned nationally or regionally, are most effectively deployed to work with local citizens to improve health and reduce long-standing health inequalities.

The welcome focus on well-being and prevention at the heart of the agreement and the current development of an MOU with Public Health England makes the potential realisation of both Derek Wanless' vision of the "fully engaged scenario" and Michael Marmot's "Fairer Society, Healthy Lives" recommendations integral to Greater Manchester's future economic success.

The agreement with NHS England affords the ability to pursue a whole system approach through local government's wider remit for civic leadership and greater freedom to pursue local objectives with a predominantly local, rather than national, performance regime.

The developing programme of work on well-being and prevention involving the Greater Manchester Directors of Public Health working in partnership with Public Health England harnesses the potential of the wider Greater Manchester devolution framework and Greater Manchester's well-established political and strategic governance to implement a place-based approach to public health leadership making Marmot's vision of addressing interlinked health determinants: employment, planning, housing, transport, skills, education and leisure as well as integration of health, social care and well-being services- a reality firmly embedding "health in every policy" and improving health outcomes at pace and scale through evidence-based transformation of core business, not small stand alone projects.

Greater Manchester devolution also provides a framework for bringing together strategies around health education and workforce.

Health and social care, fire services, police and housing staff are already working together in exciting new ways. However, they need time and expertise to shift their thinking from traditional service provision and ways of working. Delivering the agreement will require us to appoint staff with energy and motivation for change to support transformation.

Involvement of academic partners, Royal Colleges and professional bodies is vital in supporting Greater Manchester if we are to fulfil our key ambition of improving people's lives, moving from being one of the places where people have the worst health outcomes to becoming one of the best.

We need to rapidly make improving the public's health -so fundamental to system-wide transformation- everyone's business at the core of the wider workforces' practice and, crucially, empower citizens as equal partners in improving health building on programmes such as Healthy Living Pharmacy. This brings a specific challenge for public health professionals and other system leaders to stop viewing public health through the lens of a small clinical specialty and see it as a fully-integrated local government function influencing and supporting both the civic and the public's leadership at the core of public service reform.

Kate Ardern

Director of Public Health
Wigan Council

“Public health is fundamental to system-wide transformation but we need to rapidly make improving the public's health everyone's business at the core of the wider workforces' practice and, crucially, empower citizens as equal partners in improving health.”

FOCUS ON GROWTH, REFORM AND PLACE HELPING TO BREAK CYCLE OF HEALTH INEQUALITIES



February's historic devolution deal for health and social care integration represents a real opportunity for public health, as prevention and wellbeing feature strongly within the scope of the agreement.

However the greater public health prize will come from the alignment of health and social care integration, with the broader devolution agreement signed in November 2014. The focus of this agreement on growth, reform and place should create all of the necessary conditions to finally break the cycle of health inequalities that have been with us since Victorian times.

Now is the time to be really honest about the health issues we face, so that we can address them in a more focused way. Manchester for example, has the highest numbers of smoking-related deaths in England and women in Manchester die younger on average than anywhere else in the country. In Greater Manchester we have made some progress in narrowing the gap in relation to early deaths from cancer and cardiovascular disease – but we want accelerate closing that gap – and devolution is pivotal to it.

Prevention and early diagnosis of these conditions will not just save lives, but ensure

that our residents do not spend most of their later years in poor health. We need to find those people who may be at risk of developing cancer and heart disease and intervene at an early stage by working more effectively with primary care colleagues. If we do this well there will be a sea of change in health outcomes. Early diagnosis will mean that secondary care is more efficient and the whole system will work so much better.

But back to the wider determinants of health – and if I was going to choose one area that we should prioritise in the build up year for devolution it would be 'health and work'. Putting it simply, people live longer, healthier lives when they are in good, secure jobs. The evidence of this from a public health perspective is compelling. People of working age, who are out of work, are at a greater risk of poor physical health – they are more likely to be diagnosed with anxiety and depression and will experience higher rates of alcohol and tobacco consumption and lower rates of physical activity.

Maximum economic growth for Greater Manchester cannot be achieved without a healthy population, and similarly a strong economy is essential if we are to realise the potential that employment has to improve the health of the local population.

The challenge now will be to make good on the commitment contained in the NHS Five Year Forward View, which states very clearly that the NHS has a key role in supporting people to get and stay in employment. This obviously sits well with the rest of the devolution agenda. We can build on existing Greater Manchester programmes such as Working Well and use the expertise of our GP Leaders who now see work as a key health outcome. Also in line with the principles of Early Help, we need to do more to prevent people with various health conditions falling out of the labour market and never returning. Again, we have a number of successful, but small-scale programmes across Greater Manchester that are achieving results in partnership with primary care and could be expanded with the right level of upstream investment.

Finally, NHS hospital trusts are recognising their role in delivering local benefits under the provision of the Social Value Act. The NHS remains one of the largest employers in Greater Manchester and the recruitment of people with mental health problems to entry-level jobs for example, would demonstrate to others that we are doing what we say. Indeed we have much to learn from the private and community and voluntary sectors when it comes to innovative employment schemes.

There has never been a more exciting time to work in public health and along with my fellow directors and the wider public health workforce we will not waste this wonderful opportunity.

David Regan

Director of Public Health
Manchester City Council

“Preventative work and early diagnosis are, without doubt, the fundamental issues which will save lives and improve quality of health... If we do this well – there will be a sea change in health outcomes.”

STRONG LEADERSHIP WILL BE NEEDED FOR THE COMPLEX CHALLENGES THAT LIE AHEAD



Many of us have thought long and hard about how to improve the wellbeing of citizens across the country and about the balance that needs to be struck between national and local action. The UK is one of the most centralised of the developed nations and so the recent announcement that Greater Manchester, the 'northern powerhouse', will be responsible for a broad range of important issues including home building, planning, transport, business support, welfare to work programmes and critically health and social care, is extremely welcome.

There has been a plethora of comment and analysis over recent years about the need for the integration of health and social care, the rhetoric becoming more urgent by the week. With this one grand announcement devolving the funding and decision making to a city region, there is now the potential to do more than write and talk about whole system integration, but to do something about it.

The aim to give local government and local health leaders joint powers over public health, social care, primary care, mental health, acute and community care offers an extraordinary opportunity to make a difference to the lives of all the people in Greater Manchester. Of course there will be risks associated with an untested route but it cannot be worse than the dysfunctional health and social care system that we have at the moment. In addition the ten local authorities in Greater Manchester have been working together since 1986, they have experience and expertise in making productive and progressive decisions. They also have a trusted leadership team in the two Knights, Howard Bernstein and Richard Leese and it is certain that strong leadership will be needed for the complex challenges that lie ahead.

The NHS Five Year Forward View calls for a 'radical upgrade' in public health and integrating policies and plans across the region, with the golden thread of prevention running through everything could instigate the kind of changes we all want to see. System wide thinking with the potential of creating new effective models is appealing as is the opportunity of doing things differently.

A look at the work of the Manchester Fire Service and its role in improving and protecting the public's health should fill us with optimism for Devo Manc as fire fighters in the

region provide a broad range of healthcare advice and support on their home visits, a falls prevention service and are now responding to call outs from the Ambulance Service. The OECD reports that ‘good city governance is a critical factor in growth and wellbeing’ and we expect great things from the shared power across the region and measuring its success by its impact on health inequalities might be a good start too.

Shirley Cramer

Chief Executive
Royal Society for Public Health

“The UK is one of the most centralised of the developed nations and so the recent announcement that Greater Manchester, the ‘northern powerhouse’, will be responsible for a broad range of important issues including home building, planning, transport, business support, welfare to work programmes and critically health and social care, is extremely welcome.”

EARLY WINS AND LONGER TERM SPADEWORK



The Devo Manc deal on health took many of us, including me, by surprise, especially given the initial headlines in the Manchester Evening News and the BBC website, “Councils ‘to control £6bn NHS budget’.” More details quickly emerged including the MOU.

Whilst this is helpful, it still leaves many issues unresolved, particularly on where the various accountabilities end up settling. Manchester will indeed need the full shadow year to bottom much of this out.

On the surface, Devo Manc looks like it ticks many of the boxes that we and others have long been arguing for. But underneath the bonnet there are tricky questions to be addressed. Five inter-linked opportunities and challenges leap out for me: some early wins; the implications for local democracy, subsidiarity and accountability; the chance to make much more of the NHS; and underpinning all of this the leadership required from public health.

There are some welcome gains that will be easier to achieve under a more devolved system including the ability to stitch together pathways of care that reach beyond CCG

and LA boundaries and functions. An obvious example is sexual health services. Greater Manchester could move forward quickly on this, reshaping services that make much more sense to those who need them and gaining economies of scale to boot. I imagine this is where a lot of the operational spadework for public health colleagues will begin.

But beyond this, there are some deeper opportunities and challenges, which require thought and planning before picking up spades. First, how does this change the nature of local democracy? Already there have been concerns that Devo Manc has happened behind closed door without adequate public consultation. And whilst Devo Manc may lead to greater democratic participation and voting – which has happened elsewhere, for example in New Zealand – will that voting be about public health and its determinants, or just about saving the hospital down the road?

Related to this, what does the commitment to subsidiarity in the MOU really mean for public health? The LGA’s database of HWB priorities shows some clear synergies across HWB priorities for the 10 LAs – notably in the focus on the early years – but overall that there is more divergence than commonality. Greater Manchester needs to avoid the temptation to mistake more regional control for permission to tamper with local priority-

setting. Key decisions need to be made on where accountabilities are owned and how they are discharged, maintaining subsidiarity but avoiding a complex and impenetrable web of accountabilities between geographies and institutions.

One thing I will be definitely looking for from this devolution is a much greater realisation of the contribution of Greater Manchester's NHS to the wider determinants of health. Whilst many, including The King's Fund, have welcomed the NHS Five Year Forward View and its rediscovery of prevention there is an equally large prize to be had from making much more of the NHS' impact on poverty and the wider determinants of health. The way the NHS spends its budget, employs and connects with wider civil society are simultaneously under-valued (income inequalities would be 13% wider without the NHS) and under-challenged (much of the NHS has not heard of the Social Value Act, let alone it's implications). I look forward to a Greater Manchester that is proud of its future achievements in this area.

This is a great opportunity for Greater Manchester's public health leaders to think big and beyond the ring-fence, influencing everything Greater Manchester does, speaking where possible with a joint voice, and at every table – in short helping the shift to true population health systems. That means being wary of getting sidelined by the details, making the most of broader partnerships in Greater Manchester including with PHE, universities and third sector organisations and having the courage to stop things that don't work, and to decommission wisely, rather than through salami-slicing.

Finally, we mustn't forget that despite this agreement coming out of the blue, a lot of the spadework behind it has been going on for many years. Simply lifting and shifting this agreement elsewhere won't be possible or desirable. So, if things go well, Greater Manchester will be a beacon for other areas, but less of a template than many people may now think.

Dave Buck
Senior Fellow
Kings Fund

“One thing I will be looking for from this devolution is a much greater realisation of the contribution of Greater Manchester's NHS to the wider determinants of health.”

WHAT'S RIGHT FOR BIG CITIES WILL NOT WORK EVERYWHERE



Public health is primarily a population health speciality. So I think it's important to start with the question of what people want. Here in Wiltshire I know people want to see a joined-up system working for them in a seamless way. They want professionals to help and support them and aren't so concerned with what organisation we belong to.

So how are we doing? The Wiltshire Better Care Plan has been a useful vehicle to improve health and social care for the frail elderly. We were very pleased to be told we had one of the top plans in the country. But top-down performance management can be too focused on process rather than outcome.

Reprioritising investment can be a real challenge, partly due to the bureaucracy of reporting systems and the sheer weight of trying to manage frontline services. So further devolution, as with Manchester, can be part of the answer – with public health playing a critical role in bringing prevention to the fore.

Devolution is compelling as it enables integration and shifts the focus from acute to primary and community care and, in turn,

to prevention and population health. It allows the risks and rewards of investment to be shared locally. In Wiltshire, where we have good primary care, there is the opportunity for GPs to coordinate care at the neighbourhood level; and in time to move to commissioning on the basis of whole population health outcomes rather than a system which rewards increased contact.

Preventative activity should start at the beginning of life – so the impending transfer of commissioning responsibilities for 0-5yrs health from NHS England is welcome. However, devolution of other public health functions, such as screening and immunisation could be considered.

Simon Stevens, Chief Executive of NHS England, has the right approach and recognises that local authority leaders can be ambassadors for public health. We have embraced this in Wiltshire. Councillors have owned the principles of Joint Strategic Assessments which drive commissioning in the county. Wiltshire Council's Cabinet have received obesity, smoking and alcohol strategies – and commissioned sexual health services.

But there is still much to do. Using the 350 services provided through one council, and with strong resilient communities, the

fundamental challenges of loneliness, dementia, mental health, housing and lifestyle also need prioritising.

I was pleased to hear the Manchester model was not going to be imposed across the country. What's right for big cities will not work everywhere. The County Council Network have produced an excellent document which might be more relevant for areas like Wiltshire. We like to do things the Wiltshire way – which means doing the right thing for people living in a large county; supporting resilient communities and helping people to have a good quality of life.

Maggie Rae

Corporate Director
Wiltshire Council

“Devolution is compelling as it enables integration and shifts the focus from acute to primary and community care and, in turn, to prevention and population health.”

DEVOLVING CONTROL OF SYSTEMS FOR BETTER HEALTH



One of the continual debates in public health is whether to focus interventions on individuals or populations. Individual interventions focused on behaviour change are thought to be cheap, but as we learn more about human behaviour we realise they are more complex than we think. Population levels like legislative measures, fluoridation of water and so on have significant impact on health, but are often politically unpopular. Improving population health outcomes is often assumed to take decades. For some outcomes (the longevity of children in school now) it will, but there are quick wins. Local systems with devolution could decide on what measures are needed for their population, and put these in place, and allocate funding as one system.

But if devolution is to work for better health there is something we all have to get our heads round, and that's the fact that the evidence for changing a population's health means you can't focus just at the individual level or the legislative level. You have to think about the system, and invariably you need interventions at various levels and places. All the education on food choice in the world will not change obesity as much as we need it to if we can't make sure that the food environment doesn't make healthy choices easy and the built environment makes physical activity difficult.

So local devolution with the right powers would give us a chance to put the system to work in a way which can keep people healthier and more independent longer. How?

Let's take two examples to outline the opportunities:

Mental health – looking at how we create local areas that support resilience and good mental health is crucial. Quality of design (we've had this debate on fear of crime and planning), transport access, amenities and infrastructure, the quality of employment, responsible employers, schools which embed resilience and services which intervene early are all measures in preventing and reducing the growing epidemic of avoidable mental ill-health which results in expensive treatment.

Think like a system with local devolution and you could impact on the whole ecosystem which makes good mental health more likely. Some quick wins could be more prevention and early intervention in schools and workplace programmes. Longer term gains from planning and transport links to keep people connected could come later. A thriving economy is essential to this.

Obesity – Planning streets and buildings so physical activity becomes core for people of all abilities will help. Ensuring schools educate for healthy choices and make them available, and that our retail environment makes healthy choices the norm, so high fat high sugar processed foods are seen as treats, not for every meal, would be a good start. Working as a system to influence food choice, energy balance and culture at individual and population levels is surely something we could all see the value of.

You cannot isolate health outcomes from a good economy or having a good place to live. You need a systems approach. Local devolution would put local decision makers in charge of the system.

The challenges to this are our mindset, our ability to think in systems and having the right balance of powers and skills. But with careful thought this could be achieved. Some legal powers would be needed (health being a binding licensing consideration, for example; duty of all public agencies to collaborate, including schools.) But one way could be to see whether the general power of competence can be extended to include this.

Jim McManus

Director of Public Health
Hertfordshire County Council

“Local devolution with the right powers would give us a chance to put the system to work in a way which can keep people healthier and more independent longer.”

SUCCESS LIES IN BUILDING STRONGER CO-PRODUCED RELATIONSHIPS WITH COMMUNITIES



Like many I am concerned at the motives of the Government for Devo Manc and also of the absence of democratic process leading to the creation of a Mayor for Greater Manchester. However, my instinctive reaction is to see the intention to devolve the NHS budget to Greater Manchester as a positive step forward.

All the evidence, going right back to the Wanless report of 2002 and beyond points to the importance of stronger relationships with citizens and the need to have actions that address the social determinants of health if we are to improve wellbeing and in particular tackle inequalities.

Of the two forms of government we have in England it is local government through its elected members that is best placed to bring this engagement about. Local elected members rather than Westminster are the appropriate custodians to lead the long term multi-sectoral strategies that are required to improve wellbeing and tackle health inequalities.

This proposal represents our best chance yet. Having said this there are fundamental challenges – they include:

First, a well founded anxiety that government will pass the responsibility on and then start to reduce the budget, and specifically that this devolved NHS budget will be adversely affected by the further cuts that this government has promised to impose on local government.

Second, this is only a partial devolution it actually highlights the huge inconsistency in Government Policy which will continue to present challenge – from the libertarian centralism of the Department for Education and Skills (DfES), the apparent distrust that the Department for Communities and Local Government (DCLG) has of local government through to the workhouse values of the Department for Work and Pensions (DWP). This initiative will still have to work within the context of departments all with a varying commitment to tackling inequality, supporting communities, localism and local government.

Third, lets face it dabbling with the autonomy of local authorities and imposing city region mayors with no mandate to do so from the local population is not the best way to establish sustainable local democracies.

I don't think that there is a simple solution to any of the above, we are where we are. The best chance of success lies in building stronger co-produced relationships with communities. But, this has to go beyond the usual ambition to engage the population in the delivery and service design. It has to be about engaging with local people as allies who feel that they have a stake in local services and want to defend them – because history tells us that is what will be required the next time a health minister wants to close a hospital or another wants to punish people who are relying on benefit support for being unwell.

So, the biggest challenge is a cultural and local one – can local politicians deliver the leadership across the health and care system to continue the process of devolution of power in the communities and neighbourhoods they represent?

Mark Gamsu

Visiting Professor
Leeds Beckett University

“The biggest challenge is a cultural and local one – can local politicians deliver the leadership across the health and care system to continue the process of devolution of power in the communities and neighbourhoods they represent?”

OPPORTUNITY TO TACKLE HEALTH INEQUALITIES SHOULD NOT BE WASTED



Much of the evidence around how to deliver greater health equity points to the need for collaborative cross sector working and integration between health and other services. This is not surprising given that most of the drivers of health lie outside the health care system itself – and closely relate for instance to income, quality of housing and environments, levels of education, early years experiences, quality of employment and levels of unemployment all of which shape all of our health. To tackle inequalities in health therefore requires, at a minimum, far greater integration of all these social determinants of health and the health care system.

On the face of it therefore the plans for devolution of responsibilities for health and social care to Greater Manchester would seem to be a great opportunity to prevent unnecessary ill health, by acting on the social determinants of health – and the need is great.

There are widely divergent health outcomes across the ten authorities in the region. Manchester City, for instance had relatively low male life expectancy of 74.8 and female life expectancy of 79.5 in 2010-12 (compared with an English average of 79.2 – men and 83 for women) and people can only expect to live healthily only until about 55 in Manchester City, compared with an English average of just over 63 (men) and 64 (women); while in Trafford men could expect to live to 79.6 and women to 83.7 and to live healthily until 64.5, men and 63, women.

Most of the local authorities comprising the region have health outcomes below the national and regional average. There are also widespread inequalities within the local authorities – for instance within Bolton there is a just over 12 year gap in life expectancy and over 11 years in Oldham and Bury.

These unnecessary differences in health and length of life are simply unnecessary and unfair; literally a matter of life and death for the residents of Greater Manchester. Reducing them really should be a clear priority for the whole Greater Manchester Combined Authority. While there has been a welcome focus on integration to achieve ill health prevention and wellbeing, as well as savings, in the documents and rhetoric around

devolution – the question of greater equity, hasn't so far been sufficiently addressed.

This is worrying; reducing inequalities relies on strong political and system leadership and accountabilities; while it's entirely possible to reduce inequalities in health – it is hard and does require whole system focus and prioritisation. Integration across the public sector is necessary but not sufficient to bring greater health equity. There is potential in the plans for Manchester and it should not be wasted.

Jessica Allen

Deputy Director
UCL Institute of Health Equity

“While there has been a welcome focus on integration to achieve ill health prevention and wellbeing, as well as savings, in the documents and rhetoric around devolution – the question of greater equity, hasn't so far been sufficiently addressed”

PUBLIC HEALTH SPECIALISTS COULD DEVELOP AND TELL A POWERFUL STORY OF WHAT COULD BE



Greater Manchester has set out its ambition to ensure the ‘greatest and fastest possible improvement to the health and wellbeing’ of their 2.8 million citizens. Whether this proves to rhetoric or reality will depend on their ability to do things differently and in particular whether they can deliver better on the ‘prevention of ill health and the promotion of wellbeing’.

So how can this be done and specifically what contribution does public health have to make?

Firstly identify a small number of evidence-based priorities. Reducing smoking, promoting physical activity and a prevention programme (in its widest sense) for dementia might be my choices. The decision needs to be based on a Joint Strategic Needs Assessment for Greater Manchester, which needs to inform not only priorities for prevention but should also guide strategic decisions across the whole health and social care system.

Secondly a consensus needs to be developed around these priorities. The champions need to be GPs, council leaders, NHS chief executives and local resident representatives as much as directors of public health.

Thirdly the delivery of programmes to prevent ill health and promote wellbeing needs to be done by harnessing the power of existing structures. Getting what is there already to operate differently is more likely to result in success than creating a parallel system.

Fourthly nothing will change unless we radically innovate. There has already been lots of excellent public health work in Greater Manchester yet health outcomes remain amongst the worst in the country. The Troubled Families programme is perhaps an example of thinking differently, at least for its principles of integrating services around the needs of specific individuals to deliver measurable changes.

Finally evaluation needs embedding from the outset. This will allow programmes that are failing to be stopped early and resources redirected to work which is improving outcomes. Public health expertise around evaluation and health economics could be usefully be applied across the system, not just on preventative services.

All this needs formulating into a compelling narrative. Directors of public health have an opportunity to be amongst the leaders of the Greater Manchester health and social care system. Wearing their professional expertise lightly, public health specialists could develop and tell a powerful story of what could be.

Greater Manchester has much to be proud of in terms of what they have already done to improve health and wellbeing. Successes should be celebrated and shared as new opportunities are realised through these new arrangements. Delivering the greatest and fastest improvement to the health and wellbeing of our citizens is a challenge we all face.

Andrew Furber

President

Association of Directors of Public Health

“Getting what is there already to operate differently is more likely to result in success than creating a parallel system.”

FORM FOLLOWS FUNCTION: DOING THE RIGHT THING FOR USERS OF HEALTH AND CARE SERVICES



One of the things patient charities tend to be good at is to establish and understand the needs of the people they are aiming to serve. And it is clear to all of us that those needs aren't neatly compartmentalised into those that are about health and those that are about care.

Through our involvement with service improvement, innovation and redesign we also understand that bringing disparate parts of the system (such as primary and secondary care, or health and social care, or the NHS, public health and the third sector) together to improve joint working tends to be a critical success factor for improving service user experience and outcomes.

It is therefore principally welcome that organisations delivering public services to the people of Manchester, be they health, social care, housing or others, will be required and empowered to work together.

However, our experience on the ground has also taught us that there is no structure that automatically delivers great outcomes for people – and no structure that automatically prevents it.

Far more important than structural redesign are the relationships between people: Can information about service users flow between all those who need to know? Does everyone have access to the necessary expertise to make decisions that keep people supported? Is everyone aware of what the priorities and wishes of the service user are?

These are practical questions that can only be resolved locally, through configuring and strengthening teams of people that make it their business to holistically address the needs of those they are tasked with supporting.

Clearly, there are structural arrangements that are more or less helpful for enabling teams to perform this necessary coordination work, based on the views of service users. For example delays in sorting out social care, which is means tested, get in the way of people being able to spend the last weeks or days of their lives at home, instead ending up in hospital.

Each day 100 people with cancer die in hospital, who had said they wanted to die at home. Expensive hospital care that isn't wanted in the first place meets the very definition of waste. So merging budgets and accountabilities offers the hope of sorting out these dysfunctionalities.

Similarly, there is the hope that prevention, early diagnosis and intervention will become more reliably available where incentives align better across the NHS/ local authority divide. For example, early intervention services have shown to halve detentions of patients with psychosis under the Mental Health Act. Similarly, 80 per cent of amputations for diabetes patients could have been prevented with access to the right care and support.

It is clearly non-sensical that the incentives don't seem aligned across the current system to require and support all service providers and commissioners to do the right thing in the shape of upstream, preventative services that support independence and self care. But we mustn't kid ourselves that changes in budgets, reporting lines and organisational structures on their own will deliver the new ways of working, of listening to people and prioritising their needs that are required to make a real difference to the people of Manchester or elsewhere. A relentless focus on the needs of those who use services will be required to align new models of care in ways that radically change outcomes.

Charlotte August
Richmond Group
Partnership Manager

“A relentless focus on the needs of those who use services will be required to align new models of care in ways that radically change outcomes.”

SUPERLAMBANANA AND THE NEXT GENERATION INTEGRATION AGENDA



The Superlambanana, an eight-tonne bright yellow sculpture of a sheep-come-banana, is a familiar sight to many who have visited Liverpool. This unlikely symbol of integration has been replicated 125 times as part of a corridor of public art stretching across Merseyside. Each piece was personalised by the community organisations and businesses that backed the project, which is an iconic part of the region's culture.

Some of these near-sacred creations are austere, eerie mutations and some are beguiling and friendly.

Greater Manchester (GM) is now beginning its one-year conversation about what its integrated health and social care system should look like. The business cases and delivery models for a number of areas of integrated working have been meticulously developed over the last three years, originally with the direct support of central government staff placed in GM. Very much focused on growth and reform (reducing welfare bill).

There has been a strong focus on developing models that incorporate the best interventions, backed by a systematic approach to evidence, for the benefit of the people of GM. I don't know if the term "proportionate universalism" (actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. Marmot 2010) has been used, but it's certainly been embedded. The best interventions at the best time for the best impact.

There's a lot to like. And the deal is timely too. Austerity, according to GM evidence base, has not generated significant savings in GM. In 2008, public spend in GM was £22.93 billion and in 2013/14, it was £22.46 billion. £1.3 billion in cuts to councils has only reduced public spend by £0.47 billion. A lot of pain for little gain where cuts do not reduce welfare demand.

The two fundamental facts of public policy existence remain: social care demand is outstripping resources and health care demand is outstripping resources. Public service integration will help and my hope is that it will give us the most efficient public sector system there has ever been. But it won't be enough!!

The integration of supply side answers is commendable, necessary but insufficient.

My hope lies elsewhere. NHS England and Public Health England recently published: A guide to community-centred approaches in health and wellbeing. It's not particularly radical but it begins to pull together a framework for a fuller demand side answer that involves communities. For me, whatever we look to create over the next year, must include this. We have to start looking at the next curve in innovative integration and understand that community-centred approaches need to be half of the conversation.

No doubt there are scars, but this time we need to invest in the right approaches, develop the evidence and treat community involvement as a mainstream agenda - not a peripheral piece of side-lined and often singular experiment that we don't really believe in. Some of the bigger answers are interweaved into the report of the Inquiry into Health Equity, Due North, which connects health and economy, and my hope is that pilots like Well North can develop fuller evidence-based, methodical approaches to this eerie-for-some next-generation integration agenda.

The substantial integration agenda has to be about the best in public sector interventions with the best in supporting communities to shape answers and connect to opportunities. We need to develop this evidence base knowing that alternative business cases ultimately – no matter how efficient we get – will not stack up.

My hope is that Greater Manchester will take this opportunity to develop an effective and efficient answer that creates replicability, wellbeing and joy.

Warren Escadale

Chief Executive

Voluntary Sector North West (VSNW)

“We have to start looking at the next curve in innovative integration and understand that community-centred approaches need to be half of the conversation.”

PUBLIC HEALTH MUST BE FRONT AND CENTRE



Over the past few months myself and fellow councillors from across the political spectrum have travelled around the country from Durham to Taunton working alongside the LGA Systems Leadership Team delivering a programme of workshops for directors and senior public health professionals on some of the issues they face in their roles and about working in a political environment.

During this time the backdrop has been the ever changing world of health and wellbeing boards, the Better Care Fund, the public health ringfence and most recently the surprise announcement of the £6 billion NHS budget being devolved to the city region of Manchester. At the same time councils are having to grapple with ever reduced budgets and a growing demand for services.

Like most people I expect that the Manchester NHS budget deal will be the first of many as devolution takes a grip of the agenda for a new relationship between central and local government. Indeed it is a fairly logical step once an area or place, whatever size and shape is agreed to bid, for the debate to move from combined economic issues to combined

health ones. If the key word when looking at the economy of a place is 'growth' then the key word for the health economy must be 'prevention', and it is here that the public health teams must be front and centre.

To date much of the focus of public health professionals have been about how effectively they spend their budgets on the various things they are obligated to do and work they want to do. I would argue that in the coming debates about what devolution looks like, public health professionals must make sure they have a strong voice right from the start championing prevention so that, prevention is not achieved as the net result of the debate but the foundation stone of it.

Coming from health and now being a part of local government is what makes the enormity of this task a possibility in a way that would not have been possible in the old order.

Councillor Colin Noble

Suffolk County Council

DEVO NEXT



Local Government Association

Local Government House
Smith Square
London SW1P 3HZ

Telephone 020 7664 3000
Fax 020 7664 3030
Email info@local.gov.uk
www.local.gov.uk

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