HOUSE OF LORDS

Select Committee on Public Services

Oral evidence: “Levelling up” and public services

Wednesday 3 March 2021

3 pm

Watch the meeting

Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Bourne of Aberystwyth; Lord Davies of Gower; Lord Filkin; Lord Hogan-Howe; Lord Hunt of Kings Heath; Baroness Pinnock; Baroness Pitkeathley; Baroness Tyler of Enfield; Baroness Wyld; Lord Young of Cookham.

Evidence Session No. 2 Heard in Public Questions 9 - 16

Witnesses

I: Dr Jennifer Dixon, Chief Executive, the Health Foundation; Dr Stefan Speckesser, Associate Dean, Brighton Business School, University of Brighton, and NIESR Fellow and Node Leader, Centre for Vocational Education Research, London School of Economics; Richard Stubbs, Chief Executive Officer, Yorkshire and Humber Academic Health Science Network.

Examination of Witnesses

Dr Jennifer Dixon, Dr Stefan Speckesser and Richard Stubbs.

Q9 **The Chair:** Good afternoon, everyone. Welcome to this second session on levelling up and public services. I am very pleased to welcome three witnesses. Can I remind Members that they should declare any relevant interests before asking questions? We are very pleased that, despite the Budget, we have an interesting afternoon in front of us, with three witnesses who have all done work, in different ways, on levelling up, particularly on health, education and training. Jennifer Dixon is chief executive of the Health Foundation; Dr Stefan Speckesser is associate dean of Brighton Business School but also does some work at LSE; and Richard Stubbs is chief executive officer of the Yorkshire and Humber Academic Health Science Network.

Four questions are already allocated to members of this committee, but they like to come in on supplementaries. I will seek to call as many as I can. We will stick to around an hour, but, given we are now not having a second session today, it might go on a bit longer. We will wait and see. It means that there will be supplementaries that I cannot guarantee you have been warned about, but we are a friendly bunch really.

I will open the questioning. We are looking at levelling up from the perspective of a committee with responsibilities for public services, but we do not see much discussion, certainly from the Government, about public services and levelling up, or we have not as yet.

To what extent is the Government's ambition to level up with regard to the economic performance of regions dependent on increased investment in health and education services? As you each come in, can you say a bit about who you are and where you are from?

Dr Jennifer Dixon: Thank you very much to the committee for the question and for this opportunity to give evidence today. I suppose the first thing is pretty obvious. Levelling up is such a vague term, so before one gets into questions it will be critical for the committee to help to define what it is. I can say one or two sentences on that, if it helps.

The Chair: That is precisely what we want to do in this inquiry. We want to have an idea of what is realistic and relevant in terms of levelling up in order to help the Government to be clearer about what they might do.

Dr Jennifer Dixon: To be really basic here, it is important to be clear about the thing to be levelled up. Is it to do with social protection? Is it health, education, poverty, well-being, or is it more to do with economic growth, GDP, productivity, employment, good work? Are we talking about the thing being levelled up to an absolute level or a relative level—an inequality, if you like? That is the first thing that needs to be clear.

The second is the means by which the thing will be levelled up. Is this to do with an economic strategy? Is it to do with private enterprise, or is it really to do with the state and public spending? That also needs to be clarified in the absence of an economic strategy. After the thing to be

levelled up, what is the unit to be levelled up? What are we talking about? Are we talking about cities, regions, constituencies, NHS administrative areas or groups of people? That also needs to be clear.

The third thing is the timescale. There is the short-run recovery from the pandemic, which might be able to get results more quickly. There, you might go for cities, which are full of younger people and deprived groups. If you are going for longer-run levelling up, it might be aimed at more left-behind areas that have been subject to longer-run structural problems over the last 30 or 40 years; these are often coastal towns, often with older people—a different demographic. In some cases, there is overlap between those that have suffered in Covid and those that have suffered more long-term things. The IFS recently showed that there was some overlap between some coastal towns and some inner city areas—Liverpool, Glasgow, Dundee, Newcastle and Manchester, for example.

There are a couple of other things to say on the definition and clarity point. There is how likely it is that the rationale for whatever action you suggest will lead to levelling up—the theory of change.

Then there is the strategy and delivery mechanism and the accountability mechanism; I do not know about you, but at the moment, maybe because I am just sitting in health and not sitting cross-government, it is not clear to me whether this is a cross-government thing led by the Cabinet Office, or whether it is led by a department. MHCLG, BEIS and the Treasury seem to be very active in it. What is the role? Is this an add-on regeneration issue, or is this a real cross-government, whole-of-government-spending concept?

On the clarity, I suspect many would agree that you need to spend more public sector money on levelling up. If you raise extra money to pay for that, you need to make sure that it does not also penalise people in poorer areas, for example by pushing more on to local authorities that have to raise money through council tax, because that will disproportionately affect some deprived areas.

I am sorry to dwell on those points, but some clarity in those areas—I am sure you have come to the conclusion already—is necessary before you even begin to ask questions about the role of health or of local government in trying to level up.

I hope that is helpful and at least sets out my take on things. To go back to your precise question, was it about the role of the NHS or public spending on healthcare?

The Chair: Do you need increased investment in healthcare in order to tackle the inequalities that you have talked about, by whatever means?

Dr Jennifer Dixon: If you are talking about inequalities in health now—and it really does depend on which inequalities you are thinking about—the biggest effects on health are issues outside the NHS, social care and local authority public health system. There, you are talking about the

wider determinants of health of the type you all know about: housing, education, early life, poverty, stress, et cetera. Those are the things to focus on with regard to levelling up.

The NHS social care system has two major contributions. One is in its direct impact on helping people who are ill or frail—I think we know that—and some aspects of prevention. Secondly, social care and healthcare together are about £200 billion of spend. Each has about 1.4 million people employed. There are indirect effects on health of these two large industries sitting in England as an employer, a skills trainer, a procurer and an asset to generate business locally. There is a gearing impact, which has an indirect effect on health. That also needs to be considered. Investment in the NHS and social care for sure will help with direct care of people in ill health, but it will also have an indirect gearing effect through these assets that we have sitting in towns and cities, which employ lots of people.

One could then prioritise, within those two areas, what kinds of spend would have most bang for the buck in health and social care. I can go on to that if the committee would find that helpful.

The Chair: We may well come back to that.

Dr Stefan Speckesser: Thank you for inviting me today to this committee. To give you some context of why I am here and what I research, I am the associate dean at the Brighton Business School for research and enterprise. In my work as a researcher, I worked for many years on education investment and returns. That has implications for individual people's earnings, for firm productivity, and for community cohesion and wealth across the wider area, so it directly connects to the question of levelling up in a number of ways.

I have been given a brief to prepare myself for how I connect to this topic, but let me go back to what Jennifer raised in her first contribution. There was an element in the questions given to me about what criteria we look at to decide in which localities to focus additional investment, and what measures we then look at with regard to what is successful at achieving levelling up on a variety of indicators.

The measures are place-based, such as difference in life chances by locality. There is also a range of indicators when it comes to education. What are local measures of equality for young people? Labour market detachment is one of them, local unemployment rates is another. They are all engaging with the different narratives on social justice or productivity measures, which are at the very core of this agenda.

Education outcomes matter, because they are very highly correlated with well-being, health and economic outcomes. There are also composite measures to look at. Once you start to delve into this question about localities and focus, there are measures available that are repeatedly produced to help target investment. The most straightforward one is the index of multiple deprivation. This index is produced based on the 32,900

small output areas in England—the lower layer. There is a decile distribution of the most deprived and least deprived areas. In such composite indicators, you generally have representation of income, employment and education outcomes, as well as health. Income is measured in different ways. Then there are additional indicators concerning crime, barriers to housing and services, and the living environment.

All this matters, but, equally, there are measures repeatedly produced by the research community that you can connect to the topic we are talking about here.

That is as much as I wanted to say in engaging with what has just been said.

More narrowly on the topic of education, this is my key working area as a researcher. In this research, I focus largely on technical and occupational education—apprenticeships—but also higher education. Across all measures of education investment at the microeconomic level, you see huge benefits of continued education investment for businesses and workers: higher labour earnings, reduced poverty in households and locally improved income levels.

If you asked how much it matters for this agenda, I would say that it is central. It is also central because of the benefits of education investment for other outcomes such as crime, well-being and social cohesion. We have done research on this for every European country, and you can clearly derive the cost-benefit of investment in education from that point of view.

The greatest benefit is from high-level education investment. That covers degree studies in universities and technical education, but also higher vocational education such as higher national diplomas in technical subjects, which have huge benefits for the local economy, as well as for people who have invested in such education. In the levelling-up agenda, the most important point we can change is that education access and success is still largely driven by parental wealth. In areas where you see more deprivation, you also see relatively less education investment, in particular after the age of 16. There are pupil premiums in place in the compulsory education sector up to secondary education, which help to reduce the attainment gap, but in post-secondary and other adult education, such as retraining for people who have lost a job, there is no equivalent mechanism to counterbalance local inequalities by level of wealth, whatever measure you apply.

We can try to address this by resourcing place-based education investment based on measures such as local deprivation levels. Something like young people not in employment, education and training differs hugely across small geographies. In a research paper I did recently you see that it is not just a matter of how well people have achieved education; despite their education levels, there are still differences by parental wealth in labour market success.

These differences are more significant in the north than in the south or the south-east. There is a place-driven inequality in opportunity. It is driven by household wealth levels but equally by education success. If you want to change this, these three areas in education need to be tackled in a particular way in a small geography. I will pause here for a moment, because there may be more questions later about this.

***Richard Stubbs*:** Thank you to the committee for the opportunity to give evidence today. You asked for a bit about our backgrounds. As you mentioned, I am chief executive of the Yorkshire and Humber Academic Health Science Network. That is an organisation that works within the NHS but also with academia and industry to support the adoption and spread of innovation and to promote economic growth. In my spare time, I am a board member of Sheffield City Region Local Enterprise Partnership, sitting on the business, growth and resilience board. I am also a board director of an organisation called the Northern Health Science Alliance, which is a membership organisation across the north of England here, made up of the leading teaching hospitals, the universities and the academic health science networks themselves.

I agree with everything Jennifer said, particularly about levelling up being vague at the moment and requiring definition, but also about the importance of the wider social determinants of health when we are thinking about investment in health, rather than investment in healthcare. A lot of the work we have done on levelling up across Yorkshire and Humber has been about bringing our NHS colleagues towards this agenda through a stronger recognition of their influence as anchor institutions themselves. Jennifer talked about employment at the regional level, but also about their buying power as procurers. We should recognise that there are other rooms in local places where levers are there to be pulled, which will also have a fundamental impact on health outcomes, from the point of view of social determinants.

We know from our work, but also from other great research, that there are strong intrinsic links between health improvement and economic growth. Health inequalities are both a cause and an effect of income inequalities. Good health enables us to take part in society, hold down a job and generate income. It is a key economic asset to invest in. Current health inequalities, particularly those across the north, and their impact on productivity show us that, without investment in health—I stress in health rather than in healthcare, going back to the social determinants piece—I do not think the Government would be able to achieve their broad ambition. I think that is the heart of your question.

I have a few statistics to frame my logic. I am grateful to my colleagues at the Northern Health Science Alliance for this research. We know that 30% of the gap in productivity between the north and elsewhere in England is due to ill health. That equates to a cost to the UK of £13 billion each year in lost productivity, as a direct result of ill health from northern citizens. When we experience a spell of ill health in the north, we are 39% more likely to lose our jobs, compared to our counterparts in the

rest of England. If we go back to work, our wages are, on average, 66% lower. We also know that increasing by 3.5% the proportion of people in the north who have good health would reduce the employment gap between the north and the rest of England by 10%.

That was all pre-pandemic. Covid-19 has laid bare stark inequalities in our country. The north has felt the effects of this more than any other region. Mortality rates were higher in the north than in the rest of England, as I am sure we all know. The excess mortality that this caused will cost a potential £6.5 billion in lost productivity as a result. Poorer mental health outcomes in the north of England as a result of Covid-19 are estimated to be costing us around £5 billion in reduced productivity.

I mentioned that we need to recognise the distinction between the role of the NHS and the impact of the wider determinants of health when it comes to the cause of ill health. We have world-class NHS institutions across the north. I am sure that no chief exec would say no to further funding, but, when it comes to investment in health, in order to ensure that we reduce the productivity gap we need to look wider than health service delivery organisations, and consider well-being, housing, good work and education, as my colleagues have mentioned. Investment in longer-term lifestyle change and the prevention and alleviation of chronic ill health are part of the agenda. That looks like active travel, social prescribing and a whole host of interventions that do not necessarily sit within the NHS.

We also need to do more to restate the business case of well-being, particularly from a business perspective. Business benefits significantly from healthier, more productive workforces. In my view, health and the economy are bound tightly together. Interventions designed to improve health, inclusive growth and well-being are in the interests of all local, regional and national parties, partners, businesses and communities. It should be a shared priority and endeavour.

The Chair: One issue, it seems to me, is that there is so much. It is so wide an agenda. I think I have heard you say before, Jennifer, that for example 80% of improvement in health outcomes comes from outside healthcare. We need to get hold of what we think are the priorities in the areas we are working in. This committee has the joy of being able to work across the boundaries. Jennifer and Richard, I would like you to think about what, in health, you think would make a real difference. Stefan might want to say something about education, although I think he was beginning to tell us that anyway in his bit about the quality of education, particularly vocational education.

Dr Jennifer Dixon: I realise that I failed to introduce myself, so I apologise for that. I lead an independently endowed foundation, the Health Foundation. Before that I was at the Nuffield Trust and before that at the King’s Fund. My background is in medicine and public health. That is probably the main thing to know.

What aspects of public spending in the NHS and social care system are the best bets for improving health, which might then translate into a more flourishing workforce? The high priorities for me would be the following. Within the NHS itself, focusing on primary care is critical. We know that there is still an inverse care law in the distribution of GPs and, indeed, general practice staff around the country. The most impoverished areas have less access to primary care resource, so primary care investment is needed. For the last 20 years, hospitals have been invested in much more than primary care. That is one big area where a lot of the population are treated.

There are a couple of big risk factor areas that are stopping workers working effectively. I would invest in mental health and musculoskeletal services within the NHS, and some chronic disease management services. Those are the NHS areas that I would prioritise. In public health itself, where the public health grant that is spent in local authorities has been cut by a quarter since 2010, that needs to be restored. There is a lot of really excellent evidence of cost effectiveness of public health interventions, such as local authority investment in early years services, substance misuse treatment and, in particular, to keep up the pressure on tobacco, which is the biggest risk factor of all to health. I would be more proactive on national policy to tackle some of the big risk factors, in particular obesity. There is some evidence of that, but not enough. It is obviously socially patterned.

On social care, some of the big impact on health is in addressing the terms and conditions of the workforce in social care. We know 25% are on zero-hours contracts. Many are on the national living wage or less. That in turn will help to improve health.

If you look at the pattern of public sector spending across sectors, education, policing and the NHS, the NHS looks pretty good in terms of even spend geographically across the country. That is because we have a resource allocation formula based on need. It looks good, but that hides the fact that, in certain parts of the country, NHS assets have been withdrawn. For example, the number of hospitals has halved over the last 20 years. That has been done for good reasons—for efficiency, for better care and for quality—but the wider social impact on the towns in which the assets have been withdrawn is not factored in enough to reconfiguration decisions. I know that is quite a controversial issue; I can hear that.

If we are talking about the structurally left-behind areas—not the Covid-hurt areas that have short-run issues and are probably in cities—the fact that the NHS may no longer be the anchor in the area could be very significant. There are things that we could think about in the NHS, such as the criteria for reconfigurations and capital spend, that we do not necessarily think about if we feel happy with the overall resource allocation picture, which looks good. Those are some high-priority areas.

Then there are the geographical areas that have been particularly hurt over the last 10 or 20 years. My organisation commissioned and funded

the two Marmot reviews that you have seen in the last year. There, you see acutely hurting areas where life expectancy has stalled or reversed since 2010, particularly in the north-east. Not only is there a rich-poor gap between north and south, but there is a poor-poor gap opening up in health between the poor in the north and in the south-east. There needs to be some differential funding, perhaps, if one is talking about public spending. There, one might think about revisiting the inequalities supplement agenda between 1997 to 2000.

***Richard Stubbs*:** In the long term, if we are talking about funding directed at health services themselves, we should be looking at the current imbalance between investment in older people's health and the health of children and young people. Forty per cent of our population are under 24, but only 5% of our total research budget is spent on paediatric research, compared to 95% spent on adult acute services. We know a lot, and we do not need to rehearse it here, about the relative impact and value to a society of investing in our children and young people. If we had to spend on health services, that is where I would like to see the imbalance start to be reversed.

In terms of more short-term practical spend, I am minded to talk about a pilot that is running here in the South Yorkshire region called Working Win. It is focused on taking people with long-term health problems that have either stopped them working or prevented them being as productive at work as they could be, and giving them support, by healthcare teams, with talking to employers about workplace needs, et cetera. It gives them the knowledge that they need in order to sustain themselves in a working environment.

We are currently going through the evaluation of that work. I would be very surprised if, in a year's time, when the evaluation is complete, that does not show itself to be an incredibly effective way, in the very short term, of moving people either from low-paid work or from no work at all due to ill health into something much more productive for them and the economy. There is then the continued virtuous circle of the direct impact on their own healthcare.

The Chair: That is interesting.

Dr Stefan Speckesser: I largely agree with what has been said. This affects education in a similar way. If you look into how education spending has developed in the last 10 years—the Institute for Fiscal Studies does this quite regularly—in real terms, we are well below the levels observed 10 years ago for further education 16 to 18, as well as for school sixth forms. For further education, investment has gone down relatively more than for sixth forms. The adult education budget has gone even further. A decline in the adult education budget—that is classroom-based training for people who are 19-plus to participate in continuing education—has been observed probably for most of the last 20 years. That needs to be reversed.

The question, looking forward, is how you can make this work more clearly for a place-based agenda, if we settle on that. There have been developments in the adult education budget to devolve it in the larger cities—London, Manchester and other core cities that have devolved responsibilities. This is not a replacement for bringing funding levels up to some extent. A national skills fund was announced in the election manifesto in the year pre-dating Covid, but it was later decided that it would be £3 billion. That reverses some of the spending cuts. There was another announcement in the election manifesto about increasing funding for FT colleges, which has been in decline, with an investment fund to create institutes of technology. These activities are useful in trying to make a change.

A large impact will arise from how well these initiatives are managed and how successfully they adapt to local agendas. We can talk about this a little later. Who are the stakeholders involved in shaping the education offer at the local level—industries, chambers and the like? It comes back to the announcements from earlier today about apprenticeships. Apprenticeships are very important in trying to level up skills, in particular because they are owned by employers and operate to approved standards. Apprenticeships have also been used quite a lot for existing staff. Research that we undertook and published very recently shows that targeting this to labour-market entrants, to people who are new to the companies, has much more benefit. The announcement earlier today of a more significant subsidy to new hires in apprenticeships will be an important mechanism.

It is mixture of trying to increase spending in a sensible way and trying to level up by targeting where you can achieve the most significant benefit. In that, you should target people who are at the point of making significant transitions into the labour market, when they can make huge improvements in their productivity and incomes. That area is still not much talked about in the local agenda. That is something you can take away from my recommendations.

Q10 **Baroness Wyld:** This question is probably for Jennifer first and then Richard. I listened very carefully to your points about place-based solutions but also about the need for national strategy. It is the age-old conundrum, is it not? I sat on the seaside towns Select Committee before levelling up was officially a phrase. We saw some really excellent examples of place-based community health projects that had turned some of those complex issues around. I am thinking particularly of one in Fleetwood that was run by a local GP. I do not think we cracked how you then grip the system to scale those up and replicate proven success models around the country without cloning individuals. Any reflections you have on that would be most welcome.

The Chair: Can I ask Lord Hunt to ask his question as well? Then you can include both.

Q11 **Lord Hunt of Kings Heath:** Again, this question is about health. We have heard some very persuasive arguments about investment in

programmes in areas to improve people's health. I would have thought that one of the great lessons of the last year for the NHS concerns lack of capacity. That was identified this week by NHS Providers. If you make comparisons between the NHS and other healthcare systems, there are fewer doctors, nurses and beds in the NHS. Given that most interventions to improve people's health lie without the health service, would it be a mistake to think that we can shift resources from acute care into other areas? Do we not have to look rather more imaginatively at other ways of seeking to improve people's health?

***Richard Stubbs*:** Taking Baroness Wyld's question first, it is the common conundrum of national direction versus place-based devolved leadership, and the potential for one person's devolved economy to be another person's postcode lottery. How do you square that circle? It is an area I am fairly well versed in because, with a slightly different lens, it is the area in which we find ourselves when we talk about the adoption of innovation in the NHS, for example. The NHS is a national healthcare system, yet it has a largely devolved leadership and reinvents the wheel 600 times a week, rather than learning from itself.

Our lesson to learn there would be to say, "You have to recognise that there is not going to be an organic method of spreading good practice and learning". You have to create the vehicles that will allow that to happen. Bodies such as the NP11 can be a catalyst for lifting the excellent work that is done in a particular region and ensuring that it is adopted and spread elsewhere. That is always a challenge and it needs resource. You need not to assume that logic will win out and that good practice will organically spread; you need to put something behind that. It is also about leadership.

To Lord Hunt's question about capacity, it is a mistake to think that levelling up will be achieved by taking acute budgets and putting them into primary or community care, or into other people's budgets. It has to be "both/and". We have seen what happens in a pandemic. We need to retain the resilience of the healthcare system. This is not about shifting NHS resource. In fact, to the point Jennifer and I made about the social determinants, we have to stop putting the emphasis on the NHS to fix our health. By and large, the NHS is there for when we get ill. We need to start investing in the things that truly deliver genuine health. I do not think it is for us to take the NHS budget in order to fund that.

Dr Jennifer Dixon: On Baroness Wyld's question about scaling up, there is lots of good practice around the country. You all know that the factors impacting on the economy and on health in different places are so varied that it is very difficult to cut and paste and simply spread, push and roll out. That language has to be adapted. It does not happen by itself, which is what is behind the question.

There are two ways of trying to help here. In the past—I do not know whether it still exists; sorry, I should know this—local government had something called IDeA for best practice sharing. Indeed, I used to be the Audit Commission's longest serving board member, and we used to do

lots of value for money studies of local government and help to share good practice there. In the past, there have been national teams. There used to be something called the Health Inequalities National Support Team, which helped to share good practice between the local authorities and the most deprived communities with the most health problems. There should be a lot of horizontal learning, which may need to be facilitated. That is probably the simple answer to a complex problem.

I agree with the previous response to Philip Hunt's question. At the foundation, we fund a multimillion pound centre now. We set it up to be the OBR for health that did long-term projections for demand and supply. It is absolutely clear that we will need a lot more supply healthcare in future. I think you all know that, whether it is beds, doctors, capital or kit. We are underdoctored, undernursed, underbedded and underkitted compared to our European neighbours. It is "both/and", I am afraid.

That is why, if the levelling-up agenda is focused a lot on what public spending can do to increase social protection, whether in education or health, it has to be conjoined with some kind of economic overarching strategy to produce the money, quite frankly, that will pay for some of this. Put together, it strikes me that this is so complicated and complex that it may be worth thinking of these two things as separate but linked. That is just a thought.

The Chair: We have had a very comprehensive run-round there.

Q12 **Lord Davies of Gower:** Good afternoon. A lot of the answers so far have alluded to what I am about to ask. What role should educational well-being and health outcomes play in the criteria for deciding which localities will receive investment under the levelling-up agenda and measuring government success in left-behind areas? Richard, given the report that you co-authored, you might be well placed to answer this.

***Richard Stubbs*:** I will certainly have a go. The criteria are important in thinking about health outcomes. I am interested in us looking at the gain through investment in this. I have talked before about the deficit model. The Northern Health Science Alliance has produced statistics on the productivity deficit that exists because of ill health. When we are thinking about how we decide which localities would receive investment, it is really important to think about that not just as a cost but as a value—the value which the entire UK plc should gain as a result.

Inequalities are deep rooted and have been exacerbated by the pandemic. Health outcomes take an awfully long time to change. I have no doubt that the Government would wish to see progress made over the next three to four years. I struggle to see how a measure as well-being and health outcomes, which can take generations to shift, can be flexible and nimble enough to inform our funding on a year-by-year or other basis.

Dr Stefan Speckesser: I agree with that statement, to be honest. In targeting local investment, I believe that a range of indicators need to be

used, which have to be in focus to understand where spending should be improved. This is very difficult to decide, because you need to target a certain level of administration, such as a local authority. This might lead to a relative lack of support in some local areas, say in the south, where you see pockets of deprivation, but the overall wealth of the local authority means that they are not a focus for levelling up.

How far can you use the metrics longer term to understand the effectiveness of the intervention? Realistically, it is very difficult to make a good judgment about that at this point. You cannot anticipate what would be a counterfactual outcome without trying to change it. It would require you to model something and to understand how much of this is investment, and how much is immediately benefiting local income or poverty indicators by increasing, such as transfers.

As a German, I find the background of German unification helpful to understanding how long it can take to change local trajectories and whether you will be successful at scale. In the German example, we have huge transfers within the country into lower-productivity, lower-income areas. We are now at around €1.4 trillion of net transfers to the east. You see that income levels remain consistently at two-thirds. The answer is to frame the expectations, how long-term it will have to be and where you can actually achieve change. You need to use metrics that you can continue to monitor as you invest, but also where you can model what would have happened in its absence. Realistically, while it is very important for targeting and designing services, and making services consistently available where they are currently not, the outcomes and impacts of it will take a long time to come to fruition.

Dr Jennifer Dixon: A combination of measures could be an overall criterion for framing the levelling-up strategy. Some of you will know about the ONS well-being index, which brings together measures of social protection and economic development. There are 10 domains: personal well-being, economy, education and skills, the environment, personal finance and so on. That could be an overarching measure of a levelling-up strategy. One could then hold it to account.

Within that you want to make targeted progress in specific areas, be they education or health on the social protection side, or be it economic growth, GDP growth or productivity on the economic side. That could be used to help assess progress to specific targeted measures. You would want to do that within your overall levelling-up strategy. The ONS well-being index is very good.

A really good example of progress in the health area is a previous Government’s inequality strategy. That had a very specific target for levelling up: to reduce the gap in life expectancy by 10% for the fifth of local authorities that had the worst health and deprivation indicators, called the spearhead areas, and the wider population. That specific target was used to spawn a range of local authority activities on various themes and central government activities. Then the overall strategy was held to account on the basis of very specific target indicators.

The levelling-up agenda and the challenge for the country is so big that you cannot just reduce it to health, education or whatever. This overarching ONS well-being index might be one to consider when considering overall accountability in the short term but particularly the long term for a levelling-up strategy that unfortunately would span several Governments. Then you need to think about commitment devices might bind Governments across time. That is a very thorny issue, as you know.

Q13 **Lord Filkin:** Could I go back to Richard to start with? I found some of his framing potentially very helpful to us. Let me just test that I am not in danger of putting words into his mouth; I am paraphrasing and trying to compress. From what you said, I understood that economic growth, or improving economic growth in areas which we think are underperforming economically, whatever criteria we use, and that therefore link to their social performance, is pretty fundamental. The strong argument that we will get for investment in public services relevant to levelling up will be the extent to which we can demonstrate that there is a strong link between that investment in service A or B and economic growth.

If that is correct, the second point is that, unfortunately, practical politics also tells us that we are looking at evidential, political returns on investment within a shorter rather than a longer period. I am putting it rather crudely, but that is what I understood. If that is correct, it is incredibly helpful to us in thinking about how we argue for the contribution of public services to levelling up. We would all love lots more money for all public services, because evidentially they need it, but it is about that linkage. Am I putting words in your mouth?

***Richard Stubbs*:** Yes, very eloquently, but they are words I am happy to accept. That is what I am trying to say here. We need to stop looking at our public services as a cost and start looking at them as an investment—a wider investment than perhaps we perceive them to be in our more siloed thinking about the particular sector in which they exist.

Lord Filkin: That is true, but every public service bidder goes to the Treasury and says, "I don't think ours is a cost. We are really an investment". At that point, their eyes glaze over, do they not? Let me press you a little more specifically. You were essentially making the argument that we do not have much data on the table so far about the inequalities in health. By that I do not mean waiting list times or cancer success rates. I am talking about healthy life expectancy or even Covid mortality rates. There is some shocking data on how enormous the inequalities in health are, both socially and geographically.

Looking at that, because that is where you were, what would you do, using my focus of shorter term rather than longer term? What would your advice be to government to do, relevant to health, to improve the economic performance of these regions?

***Richard Stubbs*:** I agree with the analysis. Our Covid-19 mortality maps, deprivation maps or health outcome maps are the same map. We

can see the correlation there. In terms of what we could do, herein lies one of the opportunities. As I have outlined, we know that there are strong health inequalities felt by certain sections of our communities. I will shamelessly put the north at the head of the queue there, although I am willing to concede that there are other regions. That also gives us the testbed, with a population that has a level of sickness that is ripe for research and innovation.

An investment in our life sciences and health sector, for example, across the north of England would not only create infrastructure and jobs as a direct result of that investment, but put the right level of expertise, innovation and research with the population that needs it the most. Yorkshire and Humber, for example, have global capabilities in health technologies. There are 670 life science companies in my region, which is more than Oxford and Cambridge combined, and 22% of all digital health jobs in the country sit in Leeds.

The difference is investment. If we powered up our infrastructure across the north, it would become an opportunity not just to create high-value jobs in those sectors, but to have a step change in the research and innovation that will come as a result. That benefits all of UK plc but, perhaps most importantly for me, uses our local populations as the testbed patients who could benefit first from that innovation and research.

Q14 **Lord Filkin:** You have clearly had a nudge from the Chair, because you have cleverly answered the question I was meant to be asking, rather than the one I asked. Let us go on to that now. We would all agree that improving a region’s health, education and economic outcomes is vital. The question is what government can do—the answer might be nothing—to facilitate better collaboration between public services, academia and businesses in a region, so to improve the outcomes from health, education, activity and economic performance. Jennifer, could you have a go at that impossible question?

Dr Jennifer Dixon: I have a sentence on your previous question. The short-term thing you could do in healthcare investment would be to look at what is a drag on employment and on workers. It is mental health, it is musculoskeletal, it is the backlog of needed, planned surgery that will now result from Covid. It is caring responsibilities that take you out of the workforce when you should be in it, because you are caring for your older relative or disabled child. It is probably more primary care to give ongoing support. I would have thought that those are the immediate things that should be providing the lift for you in the NHS in the next two to three years. What was your real question about?

Lord Filkin: It is quite complicated. What could government do, if anything, to facilitate collaboration between sectors, public service, academia and business sectors, better to support improved public service outcomes and economic growth?

Dr Jennifer Dixon: Absent a devolution in England policy, the pathway that has been taken is to encourage places such as Greater Manchester, the northern powerhouse and so on to work together, have more autonomy across the city, forge the right kinds of economic links, link together public services and make more of the public pound. That should be continued. There we run into the sand, because we simply do not know what the English devolution policy will be. What is the future pathway for devolution in England?

Some of the lifting is being done by the NHS with the new White Paper and the move to integrated care systems, for example. They encourage local-based partnerships that can accelerate the kinds of links you are mentioning. At the moment, a proper structural policy on how we accelerate the early gains made by devolved areas is absent. This has caught up with local and national government strategy—what is it?—and therefore local government funding as a result. That is a big key to the way forward. I am hoping that the Government do not lose courage in pursuing that can and pushing it down the road.

Some of the interesting northern powerhouse suggestions coming out of the Covid Recovery Commission, led by John Allan, will be very helpful from the business side. Stronger local autonomy will help, possibly with well-targeted state aid coming out of the prosperity fund—that is still rather vague, is it not?—to insert into areas and kick-start where there is high potential for immediate gain. The biggest story for me will be the local government autonomy and flourishing, which still has a long way to go.

Dr Stefan Speckesser: I would not add too much here. Some of the initiatives that have been started by this Government are useful, such as setting up institutes of technology locally that can serve as a core. Some investment support for businesses could probably be linked more closely to it. In this enterprise zone way, there is a lack of aligning education investment into local strategies for business growth that are happening elsewhere, when you have other areas that are supported with business tax relief. Maybe setting up places such as the institutes of technology would help to create local knowledge and a local community, to try to shape this agenda more on a local basis.

That is probably just mirroring what Jennifer said earlier in the education field. In further and adult education, except for the devolved city budgets in adult education, it is largely a national agenda. Something probably needs to start shaping a potential localisation of this in the non-city areas.

Lord Filkin: Could I ask Richard for the data and sources he quoted on the link between economic performance and health? I am finalising a paper on levelling up health. It was very clearly put, so I would be grateful for that.

The Chair: There are always follow-up things that we can do after the committee. Lord Hogan-Howe, the respondents have touched on a bit of

your question, but it is still important.

Q15 **Lord Hogan-Howe:** The simple question we would like to address is whether there is a potential link between levelling up and the devolution agenda. If so, what is it? What are the opportunities? How might we maximise that link?

Dr Jennifer Dixon: We know that the solutions to local regeneration and economic growth are seen better locally. They cannot really be seen nationally, although there has to be a benign framework nationally. Therefore, the devolution agenda will be critical, plus the investment that follows that. It is about the funds local authorities have, as well as the freedoms they have to target investment in a way that only they can see, to improve the economy and improve health.

What I failed to say last time, which ought to be brought into the picture, is that, at the moment, the closest it seems we get to an economic strategy is the industrial strategy. Correct me if I am wrong. It strikes me that that is ripe for a reboot in the light of Covid. In particular, to what extent do the Government consider levelling up to be a whole-of-government approach, at national and local government level, that is normal business and therefore funded through funding of local government and more autonomy to local government? How far is it an add-on business, with pockets of regeneration funds—the shared prosperity fund, the towns fund, the coastal communities fund—that people bid for? It is more fragmented.

This is where the Government really need to join the dots. Is it an add-on, or is it part of the way Britain does business through a more considered, longer-term national to local government strategy, with funding attached? That is quite a crucial, strategic move. If it is an add-on, is it Michael Gove and the Cabinet Office? If it is the whole of government, is it somewhere else? Is it the Treasury? I do not know. How are they conceiving of it? Camilla Cavendish wrote a very nice piece in the *FT* at the weekend, saying that, if levelling up is really about, as she called it, "dribbling out regeneration money" from this or that pot, we are not going to get there. That is fairly critical.

Lord Hogan-Howe: You have reminded me to mention that I am a non-exec with the Cabinet Office, so thank you for that. Dr Speckesser, would you like to address the same question? I do not know whether it is relevant for German reunification and what is a federal state, but there may be lessons to be drawn there.

Dr Stefan Speckesser: I am not so sure about Germany as an example, because it looks very different from our system. Devolution has probably progressed most in the post-compulsory education sector in the adult education budget. You see the six or seven city areas in the country starting to draft skills strategies, such as for London or Greater Manchester. There is a lot of benefit in this activity, in that it can try to reflect the available local infrastructure more clearly than a national agenda. It can try to balance the offer more clearly between the relevant

institutions. It will help to shape it to become more effective and probably more efficient in how it is delivered. There is a huge benefit in setting devolution up in this way, as well as in further education.

What lessons can we learn from devolution in the adult education budget, looking forward across other areas? It is a bit early to say, but it has been happening recently. We need to see how effective it is in shaping the local offer. This is ongoing. The evidence will come post-Covid of how much more agile a system can become if it is more tailored to local supply and demand structures.

This is quite important and needs to be taken forward in order to see how it can benefit other areas. It will probably not be as devolved as London, because they will not have enough capacity to handle such a system, but a hybrid, with some elements of local offer included, so they can respond more clearly.

That is my summary of what I believe will happen in further and adult education. It should be supported by good evidence to see what the successes of devolution in adult education are.

***Richard Stubbs*:** We absolutely need to rely on place-based leadership. Whether that requires devolution is for individual regions to consider. Within Yorkshire, we have excellent examples of local political leadership through our devolved mayoral combined authority in Sheffield City Region. As I mentioned before, I am a member of that through the local enterprise partnership. I am also a part of and witness to similarly excellent collaboration within West Yorkshire, which at the moment does not have a metro mayor and is yet to have a devolution deal. The place-based leadership within that region has accelerated health/wealth policy, understanding and therefore interventions over the last two years or so.

I am less concerned with whether formal devolution is a requirement for levelling up. What is more important is the transfer of leadership and accountability from central government to a place, with genuine and recurrent transformational funding and, crucially, the levers to pull to make the right decisions for local communities and economies. We need to invest in, empower and, most importantly, trust our local leaders.

Q16 **Lord Hogan-Howe:** My follow-up question is not directly related to the first one. You have made me think about this, but it has come up at other times. You have all talked about how resources need to be applied appropriately and whether more need to be added because of a historical unevenness. I think Jennifer mentioned it in particular, but you have common good practice that you want people to apply and you need to know how to share that.

What no one tends to talk about in this debate is making things more efficient by managing performance with what they have. I lay that as a challenge for everybody. It does not get talked about often enough for me. That is not to blame the present managers. They may need help in understanding how to manage that, but I am surprised it does not

feature more often. Other countries with less resources sometimes achieve better results.

***Richard Stubbs*:** It is an interesting challenge. I view the productivity challenge in health as almost an internal managerial exercise. The levelling-up conversation is much more of a strategic leadership piece, which requires you to break out of the normal boundaries of health. I would want to stress that, just because we are not talking about that within this debate, it does not mean that it is not crucial or not happening.

From a levelling-up perspective, what does greater productivity mean? It means the place-based pound being spent in the best areas and within the best organisations. From an NHS perspective, it is much more about, I would guess, the business-as-usual approach of productivity and efficiency, the use of technology, resources and staff in the right place at the right time. It is a field that has a lot of emphasis and resource, and it is crucial, but it is not something I look at when I think about levelling up. For me, levelling up is more about the place-based pound, rather than the health pound or the education pound in a siloed sense.

Lord Hogan-Howe: I take that point. It just seems to me that the terrible coincidence of poor management and lack of resources could lead to terrible challenges. Better management could improve outcomes.

Dr Jennifer Dixon: It is a great point. The efficiency with which the public pound is spent across public services is critical. If you look at productivity changes in the NHS relative to the wider economy, it is very favourable. That does not mean to say that more could not be done, but it is a very good story to tell. We have seen that the NHS can move at speed with use of new technology through the pandemic, for example virtual consultations and digital developments. The horizon in the future is full of that kind of opportunity.

The question is how any available spend, particularly capital spend, can be used to get some good bets on technology that will be productivity enhancing. This is also about the opportunity in the future. The management that goes with a successful adoption of that is essential to the NHS's sustainability, so I agree with you.

My third point is where Richard finished. We must not forget that, when the NHS was set up, its hospitals, for example, had social objectives over economic objectives. The NHS cannot move, as a business can, to a place where demand and supply are in a better equilibrium. We should not forget that there is that social objective in the NHS, so it cannot be like a normal business in that respect.

Lord Hogan-Howe: Stefan, finally, can an improvement in efficiency overcome the challenges of inequality?

Dr Stefan Speckesser: This is a very important aspect that we have not talked much about. It probably requires a new session altogether. The

available indicators to monitor and assess the effectiveness of education provision are set up and have been around for quite a while. There are very successful metrics that we have looked at, such as progression in education, destinations of leavers from education or post-education earnings. They are coming together more and more, but I can see that there as not been much discussion as to how education institutions in particular places compare.

This is something we have not done too much research on. It was not really possible, given the data we used to have. There is now a lot of potential, using administrative data, to come to proper benchmarking across institutions, regions and localities as to how effective things are. This will give us a lot of learning from good practice. I believe strongly in management influence on effectiveness of education provision. When we start looking into this data at a more granular level and the particular areas of interest, to see how education success differs by management of institutions, there will be more lessons that we can learn about improving outcomes with available resources. This is a new point on our to-do list, to look into the data from this angle.

The Chair: We have overrun, but we were taking advantage of the fact that we did not have a second panel because of the Budget. Thank you to everybody. It has been fascinating. We really appreciate you giving up your time. You have given us things that we need to think about and work through. This is a fairly short, sharp inquiry, but we hope that we can come out with a bit of clarity at the end of the day about what the criteria for thinking about levelling up should be. Thanks very much indeed to all of you. I am sure we will see and hear from you again.