CLES
the national organisation
for local economies

The King's Fund
Bold thinking for better health

A new health duty for mayors and strategic authorities: *getting it right*

David Buck

Luca Tiratelli

Tom Lloyd Goodwin

About CLES

CLES is the national organisation for local economies. Established in 1986, we are an independent charity working towards a future where local economies benefit people, place and the planet. This will happen when wealth and power serve local people, rather than the other way around, enabling communities to flourish. We have an international reputation for our pioneering work on community wealth building and are recognised as the curators of the movement in the UK.

About The King's Fund

The King's Fund is an independent charity working to improve people's health. Our vision is a world where everyone can live a healthy life. Our mission is to inspire hope and build confidence for positive change. We achieve this through expert insights and original research, developing leaders and their organisations, convening, and strategic, collaborative partnerships.

About this essay

This is the first in a series of essays that will answer key questions about the effectiveness of devolution in addressing health inequalities. It is part of our joint programme of work funded by The Health Foundation.

June 2025

info@cles.org.uk | +44 (0) 161 832 7871
www.cles.org.uk | @CLESthinkdo
Registered charity no. 1089503

Supported by
The Health Foundation

1. Introduction

The Government's White Paper on devolution in England, released in December 2024, contained within it the commitment to furnish Strategic Authorities (SAs) with

> *"...a bespoke duty in relation to health improvement and health inequalities."*[1]

This duty will work alongside those that already exist for local governments and their partners, as well as helping to promote a "health in all policies" (HiAP) approach in SAs and across their partnerships with the health and care system and others.

But how will this work in practice?

To answer this question, we begin in section two by discussing briefly how a duty could help improve health inequalities. In section three, we review experiences to date with similar and related duties, drawing out strengths, limitations and lessons learned. Finally, drawing upon this analysis, in section four we set out what we consider are the key design features that the duty needs to cover in order to be effective in tackling health inequalities. Critical aspects of this design choice include: clarity of purpose, how a new duty adds to duties that already exist; the theory of change that drives the duties design, parameters and accountability; and, how the duty sits in a wider supportive policy environment – a duty in itself will not be sufficient on it's own.

2. How a duty on strategic authorities could help improve health inequalities

Over the last twelve months, we have been researching the opportunity for devolution to address health inequalities. In that time, one theme that has consistently emerged is that devolution is considered by central government to be, primarily, an economic policy lever.[2]

Since 2010, the raison d'etre of devolution as an agenda has been to generate economic growth in regions of the country that are falling behind. This ambition was stated overtly in the early years of the Coalition Government (in George Osborne's goal of a "Northern Powerhouse"), and was still front and centre a decade later when Boris Johnson's government was focussed on "levelling up" the English regions. Despite a change in

[1] The base level are: Foundation Strategic Authorities which will include non-mayoral combined authorities and combined county authorities automatically, and any local authority designated as a Strategic Authority without a Mayor. The next level will be Mayoral Strategic Authorities - the Greater London Authority, all Mayoral Combined Authorities and all Mayoral Combined County Authorities will automatically begin as Mayoral Strategic Authorities. Finally, those who meet specified eligibility criteria may be designated as Established Mayoral Strategic Authorities. This final stage unlocks further devolution, most notably an 'integrated settlement', much more control over funding streams from central government.

[2] TL Goodwin et al. (2024). Tackling health inequalities through English devolution: towards a new framework. CLES and The Kings Fund. Read

government, the rhetoric continues today, with the Deputy Prime Minister stating her aim for devolution to "ignite growth across our regions".

But there's a problem. In our conversations with people working in SAs, national policy makers, other parts of the public sector and academics we have been told – time and time again – that this framework for thinking about devolution is limiting. There is a need, they have told us, to

"challenge the growth agenda and the growth framing".

In particular, they say, there is a real risk that too narrow a focus on growth, and not enough on how its proceeds are distributed, could lead to a situation where health inequalities are either not improved or even worsened.[3]

In that light, the government's plan of placing a health duty on SAs is good news. It could help broaden the paradigm of how we think about devolution and open up a new conception of regional government, one which is about more than increasing the size of the economy. It could also be a vehicle for supporting the government's health mission to halve the healthy life expectancy gap between the richest and poorest regions of England (although it is striking that the Devolution White Paper did not directly allude to this: a missed opportunity).

Existing and future SAs already have significant powers in areas that affect the wider determinants of health, including housing, transport, green spaces and employment. A health duty would serve to recognise that addressing these wider determinants is crucial to addressing health inequalities and drive a (HiAP) approach. This could be a huge step forward.

The duty could also be seen as aligning with overall plans for SAs to have a greater and more consistent role in areas that drive health, such as housing, transport, skills and employment, aligning them better with upper tier local authorities.[4] The Bill which will introduce the duty also provides the opportunity to not just consolidate health as an important factor in the work of SAs, but to tailor this in a way that makes sense: distinguishing more clearly between the roles of upper tier local authorities and SAs.

What's more, a health duty could also clarify and deepen relationships between integrated care systems (ICSs) and local government. On the ICS front, this will be particularly important as budget cuts necessitate mergers.[5] This creates an opportunity to reimagine the geographies of ICSs and SAs in unison, and it will be important that large regional bodies work together on joint health agendas, which a duty could help catalyse. In the context of declining resources for ICSs, having SAs more formally bound in to the health system will be all the more important if the government is to meet its health mission.

[3] Ibid.

[4] Our next essay in this series will unpack in more detail the potential for SAs around their role in employment and health inequalities.

[5] D West. (2025). 'Big consolidation' of ICBs coming, says new NHSE chief exec. Health Service Journal. Read.

3. Lessons from similar duties: strengths and limitations

As set out above, there is a good case for a health duty, both for the direct benefits it will bring and, perhaps as importantly, for the signals it would send. But lessons of the past show us that duties also have limitations. The design features and the context in which they "'land", in particular, can affect their impact.

What already exists

Specific duties apply to the NHS and health bodies, both directly and indirectly, as well as legislation around equalities that apply to all public bodies, through the public sector equality duty, the Public Services (Social Value) Act (2012), the Procurement Act (2023) and a range of other duties.

There is also a raft of legislation, beginning with the Health and Social Care Act (2012) which introduced duties on key health bodies around health inequalities. These are "to give due regard" duties – meaning that the relevant bodies have to take into account the impact of health inequalities in their decision-making. The requirement to reduce health inequalities is also part of the rationale in legislation for integration (alongside improving quality of care). This was re-emphasised in the Health and Social Care Act (2022) which legislated for ICSs. A wide range of other legislation supports a focus on health and health inequalities (and their drivers and causes). For example, the public sector equality duty, the Public Services (Social Value) Act (2012), and the Procurement Act (2023) which apply to all public sector bodies and the Localism Act (2011) which applies to local authorities.

"...over time, mayors have developed a wider role, without additional duties, but within the scope of the Act."

Some areas, however, have gone beyond the requirements of national legislation and duties. The London mayor's duty was established through the Greater London Authority (GLA) Act (2007) and is primarily a duty to publish a health inequalities strategy for London and to employ certain advisers. The strategy and its implementation plan are periodically refreshed and this allows the Mayor to shift and adapt to changing circumstances. This gives great flexibility, and over time, London mayors have developed a wider role, without additional duties, but within the scope of the Act. For example, Sadiq Khan has set out six tests for major NHS reconfigurations in the capital as part of a wider range of health influencing activity including a focus on air pollution and junk food advertising restrictions on public transport. The Mayor is supported by the GLA Group Public Health Unit, whose mandate is to deliver HiAP in areas where the Mayor has responsibility (e.g. housing, transport, and skills).

Greater Manchester Combined Authority (GMCA) was the first SA to receive a major devolution deal, announced in November 2014. Connected to this was a unique deal around the NHS and social care which included the delegation of planning and decision-making for the £6bn health and social care budgets to a coalition of public agencies, brought together under the Health and Social Care Partnership, now the GM Integrated Health and Care System.

As a result, GMCA have been able to pursue a coherent approach to improving the health of the region's population. This has led to a positive change in life expectancy compared to what would have been anticipated.[6] As part of the 2014 deal, GMCA was granted concurrent powers with its constituent local authorities to take steps that it considered appropriate for improving the health of the people in its area, through what is known as the section 2B(1) local authority health improvement duty. More recently, the East Midlands Combined Authority (EMCA), was also conferred a duty through section 2B(1). The core duty is the same but differs in detail - for example, EMCA does not have the requirement to produce an annual report.

Both GMCA and the West Midlands Combined Authority have also considered where they require new or extended legislative duties to allow them to be more effective in improving the health of their populations.

There are also lessons to learn from outside of England. In Wales, the Well-being of Future Generations Act (2015) is a wide-reaching piece of legislation with the goal of improving the social, economic, environmental and cultural well-being of Wales through seven well-being goals. These apply to national and local governments, health boards and other public bodies and include "a healthier Wales" and "a more equal Wales". The Act is supported by a Future Generations Commissioner, indicators and regular reporting on progress. Alongside this, Wales has also enacted legislation that mandates Public Health Wales to assist other public bodies in undertaking health impact assessments (HIAs), and has set up an HIA unit. In Scotland, health is framed directly as a human right and it, too, has a national wellbeing framework.

How effective have these duties been?

Overall, it is questionable whether national duties have been successful in having a sustained, systematic and visible impact on health and health inequalities.

The Secretary of State's duty to report progress on health inequalities, introduced in the Health and Social Care Act (2012) was quickly relegated to a place deep in the Department of Health's annual accounts. Rarely, if ever, is the purpose of health inequality reduction in the legislation invoked or tested when health and care integration is debated. And there has only been one instance (that we are aware of) where the Act's duty on health inequalities has been tested through the courts – a reconfiguration of stroke services in Kent, that failed.[7] More broadly, five years after the Public Services (Social Value) Act (2012) was passed, only 13% of Clinical Commissioning Groups (CCGs) were actively pursuing social value in their commissioning decisions.[8]

This is not to say that in some areas and for some systems the legislation has not been helpful but it does tell us that having duties themselves are not sufficient, the wider context in which duties are enacted is as important for whether they actually bite and are implemented as the duties themselves. Up until 2010 there were no specific health

[6] D Buck and J Jabbal. (2024). Population health in Greater Manchester: The journey so far. The King's Fund. Read.

[7] A Moore. (2020). Campaigners lose legal battle against major reconfiguration. Health Service Journal. Read.

[8] J Butler and D Redding. (2017). Healthy commissioning: How the Social Value Act is being used by Clinical Commissioning Groups. Social Enterprise UK and National Voices. Read.

inequalities duties yet there was a coherent policy environment with explicit government targets, a strong multi-pronged support system,[9] and wider policy that was conducive to health inequalities reduction. It is this context that has been judged, in retrospect, to have reduced population level health inequalities on key indicators such as life expectancy by deprivation and inequalities in infant mortality.[10]

The Coalition Government introduced more legislation (see above) but the wider policy environment became correspondingly weaker, with targets and support systems dropped, and the policy emphasis on health inequalities narrowed. In this context, many measures of health inequalities and their drivers widened, despite the existence of new duties introduced by the Coalition.[11] The aftermath of the Covid-19 pandemic brought a refreshed focus, the development of England's core20plus5 approach for adults and children. Early assessments of ICSs, too, were optimistic that they were developing their capability and efforts on health inequalities.

"...the context for implementing policy locally is changing fast again"

Now, the environment for implementing health policy locally is changing fast again, with a national government that is developing a 10 year health plan, saying it will cut the gap in healthy life expectancy by half between regions of England, abolishing NHS England, cutting and changing the role of ICSs and proposing changes through the Devolution White Paper. To be successful, any duty will need to be resilient.

4. How should a new duty be designed

The duties already in place provide clear lessons for the development of a new one. Added to these, our conversations throughout this project suggest that the new duty:

- needs a clear purpose, which includes how it adds value to duties that already exist;
- needs to be connected to a clear theory of change and have accountability built in; and,
- will not be sufficient on its own – it will need a supportive policy environment.

Duties need to be robust, resilient and adaptable to change, remaining meaningful and useful in very different contexts. We set out our views below on how the duty therefore needs to be designed.

[9] For more on this including the role of targets, funding and a central national health inequalities support team see T Lewis et al. (2022). Equity and endurance: how can we tackle health inequalities this time? The King's Fund. Read.

[10] Ibid.

[11] M Marmot et al. (2020). Marmot Review 10 years on. University College London: Institute for Health Equity. Read.

A clear and explicit purpose

The Devolution White Paper does not set out what the specific purpose of the health duty is. In the context of devolution in England, there are five related purposes that we believe a health duty could achieve with respect to health and/or health inequalities:

1. As a corrective to a "growth at all costs" interpretation of devolution.[12] If economic growth is the only goal of devolution it can lead to inequality (and therefore health inequality). The duty could be designed with a specific emphasis on delivering "good growth", meaning growth that is well distributed and in alignment with social good and welfare, through health. A duty could help bind partners around co-aligned equitable growth and health goals,[13] accelerate existing initiatives such as the health and growth accelerators and unlock new ones.

2. To align key players around health. In many places, SAs will be relatively inexperienced or coming to the "health table" for the first time. A duty could be designed and used to help align SAs and other parties so that they "come to health" in a coherent way, for example through an explicit duty to co-operate. While this doesn't guarantee success itself, it would ensure parties actively work together. It could be a means of harnessing the functions (including employment, transport and housing), powers and resources that SAs have and directing them more purposefully towards the alleviation of health inequalities. This would align with the Health and Social Care Act (2022) that legally established ICSs and introduced duties on them to directly and indirectly (through integration with wider "health-related" services) seek to reduce health inequalities.

3. To provide a minimum floor on engagement or activity on health for SAs. A duty could also emphasise the minimum requirement expected from an SA to "raise the floor". This is particularly relevant to new SAs, or more established areas where there has been little focus on their role in health to date. This minimal expectation could therefore help accelerate progress and reduce inequalities in progress between areas. The government is moving fast to establish SAs, and the duty could act to bake in the expectation around health from the start.

4. To provide a springboard for those SAs that wish to go further. This would be particularly true for established combined authorities, such as Greater Manchester, with existing experience and expertise in their role in health. A duty could give them additional powers and abilities to go further still.

Finally, the language of the new health duty and how it is expressed needs to be carefully thought through. We have heard that there is a concern from upper tier local authorities that the language of "concurrent health duties" (as used above) can be unhelpful and cause some friction. In particular, the government needs to be clear that the new duty does not imply that SAs commission or take existing function from local authorities,

[12] TL Goodwin et al. (2024). Tackling health inequalities through English devolution: towards a new framework. CLES and The Kings Fund. Read here.
[13] Ibid.

unless of course it means to do so. At present there is a risk of friction and confusion: the government needs to be clearer and more direct about its intentions.

Our view...

A duty could conceivably be designed to promote all of the above purposes. However, in our view, the priorities should be that the duty ensures devolution promotes health and health inequality reduction and that it provides a minimum floor for what is expected of SAs. These are the biggest opportunities – and risks – in devolution as it progresses at pace. These should be pursued, if possible, in ways that promote alignment with existing legislation and bodies and provide space for those at the frontier to move faster, further.

Given the continuing poor performance in England on health inequalities, the powers and influence over the key drivers of health that sit at SA level and the need for economic growth to reach into the most needy communities, we believe the purpose of the duty should be focussed primarily on health inequalities, rather than a general health duty.

Well defined and connected to a theory of change

A duty will need to be specified and designed to play its part in a wider theory of change for how SAs and their partners can make a difference to health and health inequalities. This, in turn, relates to the direct and indirect functions and influence of SAs. The duty could be defined in one or more of the following ways.

1. Around the deployment of inputs, such as effort or resources. For example, a duty that specifies that SAs have a certain number of key roles and staff with a focus on health. Examples that already exist for this approach can be found in London – through the duty to have a number of key health advisers to the Mayor and a GLA public health team – and West Yorkshire, where a population health adviser is delivered as a joint post between the Combined Authority and the Integrated Care Board.

2. Around processes or outputs that relate to activities or functions. This could include, for example, a duty that specifies that SAs should have a health inequalities strategy (as London's Mayor does), or undertakes health or health inequality impact assessments on decisions of relevance.

3. Around outcomes, or the monitoring or frameworks around them. These could relate to the wider determinants of health or to health outcomes directly. For example, the Devolution White Paper includes plans for the development of outcomes frameworks. These could be mandated to include either direct health outcomes, or key drivers of health outcomes, or it could be specified that they need to be aligned and consistent with the outcomes of relevant ICS strategies or plans. This would help bind SA decision-making and focus closely to the health partnerships of which they are members.

There is a case for SAs, at least in the early years, to receive funding from government (for example a draw-down from the Department of Health and Social Care) to help set-

up and support the infrastructure to deliver the duty. This would give some "weight" to the duty, drive focus and raise expectations of SAs in the process. This should be time-limited funding, with a clear path to internalisation of the capacity and capability required over the medium term. To support this, SAs will require access to public health expertise, requiring an increase in national capacity coupled with bespoke models in local systems on how it is organised, as we know from wider research.[14]

Our view...

The duty needs to be designed so that it relates to a clear theory of change for how SAs are expected to act through their own functions, and through their partnerships. Each of the definitions we provide above can be seen as focussing on one part of the "production function" between the effort of SAs and the health outcomes that are ultimately required. A duty could, in principle, blend these in a way that ties in with SAs' direct and indirect impacts on health. We therefore propose that the duty has several specifications, including:

- to co-operate with partners such as ICSs (to demonstrate effort);
- to develop a health inequalities strategy (or similar process/output looking to the longer term);
- to have an internal health team (a function and a capability); and,
- to develop a co-owned outcomes framework for health which includes the SA's role in improving the wider determinants of health (a focus on outcomes and form of accountability).

We believe these "anchors" for a duty, alongside some initial funding, would help integrate how SAs function and help sustain a focus on health over time.

[14] D Buck et al (2024) Public health and population health: Leading together. London: The King's Fund. Read here.

An effective policy context

Duties do not exist in isolation. Experience has shown that they succeed or fail because of the context in which they sit and how resilient they are to that context changing.

Our view...

The government needs to pay as much attention to the context in which a duty will land, as to the duty itself. This means doing much more work preparing the ground for it than has been done to date, including clear roadmaps for:

- how English devolution will support the mission of halving the healthy life expectancy gap between regions;
- how the imminent 10-year health plan will connect with English devolution and the role of SAs.

Both of these must be underpinned by a strong narrative about the overall policy framework for action on the wider determinants of health at a national, regional and local level.

We also see this as an opportunity to reboot and refresh the overall narrative, accountability and support systems around the existing health and related duties which fall on partners of SAs, and will apply to them too. There needs to be clearer guidance and expectation associated with all these duties, including the new one on SAs, otherwise as a set they will not be effective. Ideally, all of the above would be connected as part of a wider national cross-government health inequalities strategy to cohere and signal that the policy context for health inequalities will remain key and stable over time.

Conclusion

"...the duty needs a clearly stated purpose, to be connected to a theory of change and to be robust enough to survive a changing policy environment"

The health duty proposed in the English Devolution White Paper aims to support SAs and mayors to improve health, through their own policies and in partnership with others, including integrated care systems.

This duty has the potential to significantly improve health outcomes and reduce health inequalities if – and only if – it enhances and sustains collaboration and action. For that to happen, the duty needs a clearly stated purpose, to be connected to a theory of change and to be robust enough to survive a changing policy environment. If designed and implemented effectively, this new health duty could play a crucial role in advancing health equality alongside economic growth.