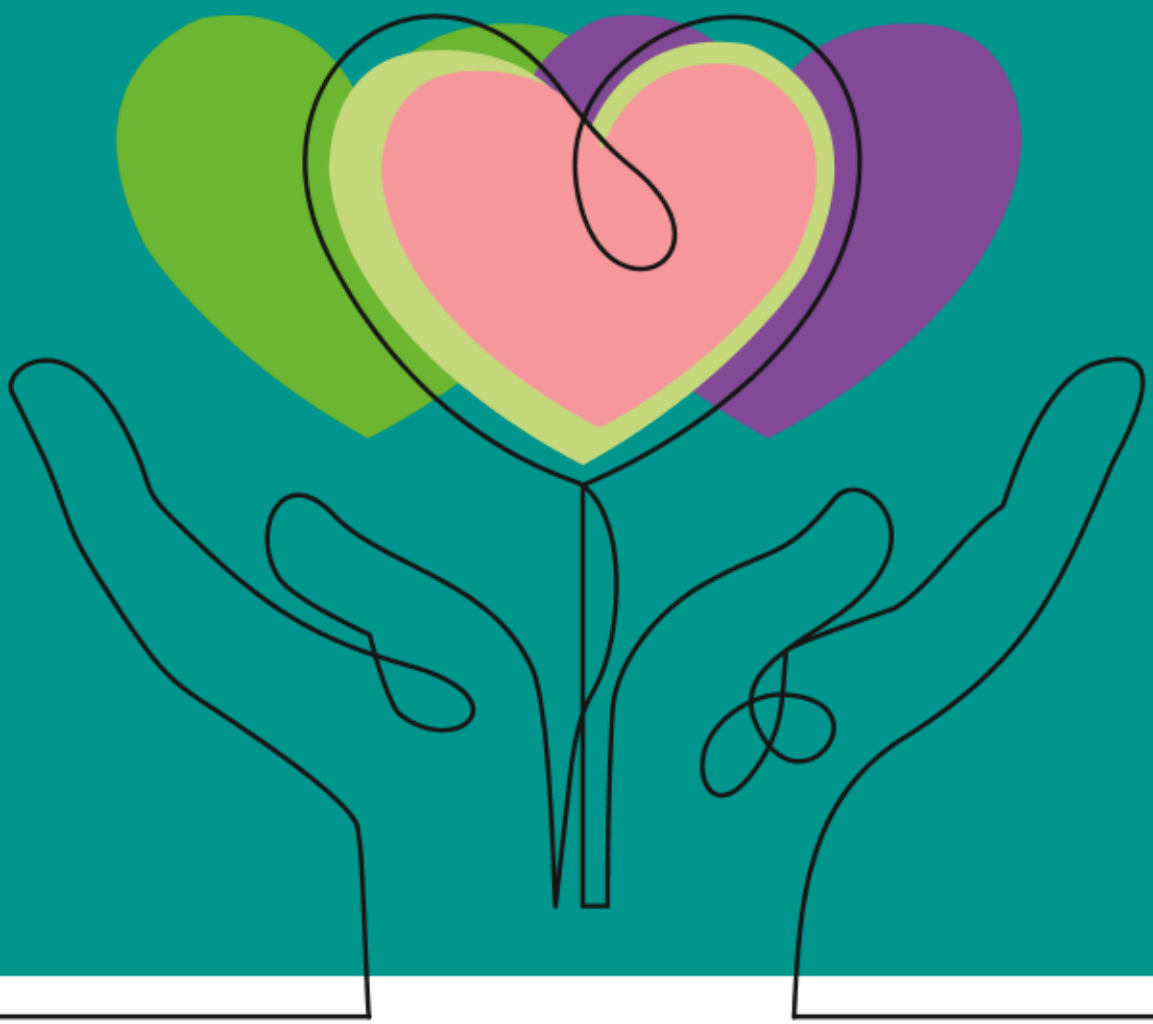
Is devolution the future of **health and social care**?



A collection of essays

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Foreword

Andy Burnham, Mayor of Greater Manchester

It is now three years since Greater Manchester took charge of health and care spending and decisions.

Since then, we have changed the way health and social care works, and how it connects with wider public services. Our approach is based on the shared recognition that you can only have good health with good housing, good education, good work, social, digital and transport connections, clean air, safe neighbourhoods and opportunities to be physically active.

Having put in place the building blocks, it is a good time to take stock and consider the challenges we have overcome and those we still face. This collection of essays therefore is an important contribution to the debate on how health devolution can enable the building of a population health system that meets, and indeed goes beyond, the ambitions in the NHS Long Term Plan.

By taking decisions locally, Greater Manchester has been able to begin to turn around the factors that mean people in our city-region die younger and suffer poor health earlier in their lives than elsewhere. We have increased the number of children who are *"school ready"*, helped 4,500 people, primarily out of work due to poor health or disability, back to work, and significantly improved access to mental health services.

Greater Manchester is using our unique devolution deal to do things differently. We are the first place in the country to publish waiting times data for children and young people's mental health service, we have introduced a job guarantee for our student nurses, and the NHS in Greater Manchester is investing in rough sleeper provision through our 'A Bed Every Night' initiative.

Despite being hampered by the lack of a long-term social care funding settlement, we have reduced delayed transfers of care and significantly increased the proportion of care homes rated as 'good' or 'outstanding'.

However, it is important to recognise that health devolution is a long-term project. Jennifer Dixon is right to describe it as a *"work in progress"* and to say that any assessment is best done over five years or longer. Many of the challenges we face – such as levels of smoking, obesity, morbidity – are endemic issues that will take more than a few years to address, and require solutions that sit outside the NHS.

As Warren Heppolette set outs in his essay, ***The Alchemy of Place***, the *"critical contributions"* needed to improve school readiness, tackle long-term worklessness or respond to the crisis of homelessness, often lie outside the control of any single government department. Warren argues that: *"Only devolution and local accountability can fit those pieces together"*.

Devolution may just also be our best means of addressing some of the economic, social and political concerns that fuelled Brexit. It is worth pointing out that much of the progress we have made locally in recent years has come at a time when Westminster has been unable to focus on or prioritise domestic issues.

As we move onto the next phase of our unique devolution journey, Harry-Quilter Pinner's essay, DevoHealth+, puts forward some powerful ideas for what a more radical deal could look like, and sets out how devolution or decentralisation can drive reform and improvement.

Finally, I want to thank all of the contributors to this collection of essays. They are some of our country's leading experts on health and social care, each with their own different perspective. This collection is a must read for anyone with an interest in how we can give public services, communities and individuals more control over the decisions which affect them at a local level.

Overview

Phil Hope, former Minister of State for Care Services
Steve Barwick, Director, DevoConnect

Is devolution the future for health and social care?

The NHS is continuing to change as it seeks to improve clinical outcomes and public health despite post-Brexit policy paralysis and the lack of the usual biennial health legislation. At the same time, the latest wave of devolution – the advent of Metro Mayors, nine of which now serve more than 20 million people – has quietly embedded itself into the body politic.

These two trends have come together most significantly in Greater Manchester, although *"health devolution"* is by no means confined to this geography. This collection of essays thus poses the timely question: is devolution the future for health and social care?

The NHS Long Term Plan

The NHS Long Term Plan has at its heart a philosophy of collaboration to improve patient care to be made real through new structures and processes to integrate community-based health services, join-up acute and community care pathways, and commission services jointly by health and social care partners. It is highly ambitious with aspirations to go even further in integrating, not just different types of community and acute health services but social care, as well leading to 'genuinely integrated teams of GPs, community health and social care staff'.

This wider ambition to integrate NHS and social care in England has been the goal of successive governments. Why? Because the benefits of doing so are clear.

Full integration will achieve better health and care outcomes for patients and service users, deliver a better experience of person-centred care, reduce unnecessary costs of delivering and managing siloed services in the system, and improve morale and motivation among staff and managers working together in multi-disciplinary teams and single organisational structures. Making this happen, however, has proven so far to be an insurmountable challenge, but does devolution solve the integration conundrum that Ministers and civil servants have struggled with?

The NHS Plan envisages the national health silo of power and money in England being broken down into 44 Integrated Care System commissioning bodies on new geographical footprints covering two or more Clinical Commissioning Group areas. It is a fundamentally new delegation from the national to the local in the system. And it is one that can go even further as NHSE is committed to supporting 'local approaches to blending health and social care budgets where councils and CCGs agree this makes sense'.

In addition, NHSE will reward successful ICS health commissioning bodies with greater autonomy giving a freedom, hitherto denied them, to go further if they wish and pursue genuine integration of local health and social care commissioning and delivery of services in new forms of joint civic and clinical leadership. The 'genuinely integrated teams of GPs, community health and social care staff' envisaged in the Health Plan can then operate with a single budget and one line of local management accountability.

Greater Manchester

Greater Manchester is at the forefront of this new approach. It is making it happen through pursuing a devolution approach on the ground, pushing at the limits of what current legislation permits. New Local Care Organisations to provide services have been created based on the ten council footprints within Greater Manchester. Alongside those are now place-based commissioning bodies combining civic and clinical leaders, and a single accountable officer responsible for the combined community health and social care budgets and services. Within these LCOs, as part of the neighbourhood model, sit the Primary Care Networks covering populations of 30-50k as envisaged in the NHS Plan that each have Multi-Disciplinary Teams of operational staff from both health and social care.

A combined civic/clinical management structure across the Greater Manchester area ensures there are lines of accountability to each other and to the Mayor, standardisation of hospital practice and processes across the area, new population-wide public health initiatives and a central commissioning hub.

Although technically a delegation of health resources and powers, all of the local partners - NHS and local authorities - are behaving as though it is fully devolution. This shift in culture has enabled civic and clinical leaders, managers and practitioners to make rapid progress on developing a shared vision and mutual accountability for the better health and social care outcomes they want to achieve from integrating their two organisations; on creating new structures for making decisions together and jointly managing their budgets; and on developing new ways of managing their services collaboratively within the existing legislative framework.

National perspectives

Three of the contributions to this collection of essays examine health devolution from a national perspective. Harry Quilter-Pinner, senior research fellow at IPPR considers whether a further step forward is needed – 'Devo Health+' – in Greater Manchester and elsewhere to truly unlock the benefits of decentralisation.

Sir David Behan and Ann Ford, Delivery Lead for the Care Quality Commission's Local Systems Reviews Programme explore what devolution means for developing a new model of health and social care system regulation.

Dr Jennifer Dixon, Chief Executive of the Health Foundation charged with evaluation of the Greater Manchester 'experiment' gives an interim response to the question of the impact health devolution is having and its value in enabling a positive process of system transformation. And Jon Restell, Chief Executive of the trade union MiP, reflects on what health devolution means for health service managers.

Local perspectives

Warren Heppolette, Executive Lead for Strategy and System development in the Greater Manchester Health and Social Care Partnership, sets out in his essay – the Alchemy of Place – the thinking behind the Greater Manchester approach. A combined civic/clinical management structure across the Greater Manchester area ensures there are lines of accountability to each other and to the Mayor, standardisation of hospital practice and processes across the area, new population-wide public health initiatives and a central commissioning hub.

In other areas such as the West Midlands where the Mayor already has wider aspirations for devolution as a means, for example of achieving economic growth and joining up public services, there is an opportunity to pursue health devolution and achieve ambitious health improvements for the population. Their approach may be more cautious than Greater Manchester but as the essay from Dr Henry Kippin, Director of Public Service Reform in the West Midlands Combined Authority and Councillor Izzi Seccombe, Leader of Warwickshire County Council and WMCA Wellbeing Board Chair, makes clear that does not mean there is a shortage of ambition.

Sector perspectives

Lynda Thomas, Chief Executive of Macmillan Cancer, explores the important topic of how devolved health offers a new opportunity to improve care and support for people living with cancer. And Imelda Redmond, National Director of Healthwatch, looks at the importance of ensuring that the patient voice is heard in a devolved health system..

Jonathan Murphy, Chief Executive of Assura, describes how health devolution could help to bring about a radical change to the local health and social care infrastructure with real benefits for improving patient care. And Michael Wood, Local Growth Advisor of the NHS Confederation, highlights the role that acute hospitals can play not just as local assets but as 'anchor institutions' in local communities.

Sally Bagwell, Deputy Head of Charities and Nathan Yeowell, Head of Policy and External Affairs, New Philanthropy Capital emphasises the important contribution that charities can play in devolved health areas as they are so often rooted in their sense of place and work across organisational boundaries.

A political perspective

The collection concludes with an analysis by Phil Hope, former Minister of State for Care Services, of the national and local politics of health devolution, how to avoid a postcode lottery in health care, and the fundamental reform of social care funding, if genuine integration and devolution of health and social care is to become a reality.

Conclusion

The Greater Manchester experience, taken together with the new delegated structures, philosophy of collaboration and emphasis on integration in the NHS Long Term Plan suggests that every local area could make rapid progress on fully integrating their health and social care systems, if they wanted to, through adopting the spirit of devolution.

There is no need to wait for permission from the centre, it is already there. And in ICS areas that earn greater autonomy over their health budgets the door is open to use that freedom to develop new integrated health and social care structures and services. Greater Manchester along with other ambitious ICS areas could become vanguards for this next phase of building a sustainable care system and to inform national policy and legislation.

Taken together, we hope these essays are an important contribution to a significant debate that is starting to happen. Now, in the lull before normal politics resumes, is the time to seriously consider the potential advantages and disadvantages of the decentralising approach now widespread in the NHS and in particular how this should be taken forward in the next chapter of health and social care. The goal is nothing less than a fully integrated community-based health and social care system that delivers the best possible health and wellbeing for every individual in need.

1 National perspectives

Devo-Health+

Harry Quilter-Pinner, Senior Research Fellow, IPPR

Introduction

"This has the potential to be the greatest act of devolution...in the history of the NHS." These are the words of Simon Stevens, Chief Executive of the NHS, back in 2015. He was describing George Osborne's announcement that, as part of his *"Northern Powerhouse"* agenda, Greater Manchester would receive new powers over, not just transport, housing, planning, policing, skills and employment support – all areas of policy which had long been part of the decentralisation debate – but also the region's £6bn health and care budget.

Up until this point, most believed that the NHS, as 'the nearest thing the English have to a religion', remained out of bounds in the ongoing devolution discussions. After all, the idea of equality of provision and outcomes – at least as an aspiration if not a reality - was built into the DNA of the NHS. As a result, the maintenance, indeed expansion, of central planning and control seemed inevitable. But, now it appeared, the rules were changing.

It's now almost five years on from this announcement. Greater Manchester is no-longer the only area benefiting from a devo-health deal, with Greater London and Surrey following suit. Moreover, the wider NHS reform agenda – notably the creation of Integrated Care Systems (ICSs) - has also embraced decentralisation as a lever with which to drive reform and improvement (potentially more in rhetoric than in reality). It is therefore the opportune moment to re-visit some of the big questions that the announcement raised, namely: what is health devolution, why might we want it and where will it end up?

What is health devolution?

The decentralisation debate in the NHS is not a new one: questions of how to reconcile the goals of a national service (fairness, efficient use of resources) with the benefits of devolved powers (democratic control, community integration) are as old as the NHS itself. But a consistent feature in this debate over the years has been a gap between rhetoric and reality. As the respected NHS historian Rudolph Klein has highlighted:

> *"In white paper after white paper the theme has been passing power down to the periphery. However, the same decades have seen an ever more assertive centre."*[1]

[1] https://www.ippr.org/files/2017-08/1502961603_devo-then-devo-now-august-2017.pdf

Figure 1: Types of decentralisation

Type of decentralisation	Definition	Example
Deconcentration	The centre prescribes the goal, the method and the running of services, but the latter is conducted through lower-tier actors or regional offices.	NHS England regional offices and specialised commissioning
Delegation	Responsibilities for setting policies and delivery are transferred to semi-autonomous entities but there is still a degree of accountability back to central government.	NHS 'devolution' to Greater Manchester
Devolution	Decision-making is completely transferred to a subnational body that is then held accountable from the bottom up rather than the top down.	The NHS in Scotland, Wales or Northern Ireland

Source: Quilter-Pinner and Antink, 2017.[2]

Health devolution in Greater Manchester

At first glance, devo-health – as embodied by Greater Manchester - appears to be no different. For, despite its title, what has happened up in Greater Manchester is not devolution - meaning the transfer of power from a more national to a more local body (for example, the NHS in Scotland) - but something closer to delegation. This is a scenario whereby some powers are passed down either within an existing organisation or to a semi-autonomous body, but ultimate accountability remains with central government.[3]

This means that, whilst Greater Manchester has received a range of new powers, in particular over commissioning of specialised care, primary care and transformation initiatives, it is still ultimately accountable to the Secretary of State for Health and Social Care, rather than the Mayor of Greater Manchester. Likewise, all existing organisational statutory responsibilities – for example, from local organisations such as Clinical Commissioning Groups and foundation trusts to the centre – have been maintained.

However, as Greater Manchester's new powers have 'bedded down', something more radical has begun to emerge. Notably, the strong relationships and trust built across the region over many years, have allowed it to behave as a more devolved administration would, even as its connections and obligations to the centre have remained. Notably, through newly created decision-making bodies (informal rather than empowered by legislation), organisations across Greater Manchester are now making shared decisions in the interest of the whole system, without intervention from central government, instead of working in organisational silos.[4]

[2] https://www.ippr.org/files/publications/pdf/devo-health-where-next_Mar2017.pdf
[3] ibid
[4] ibid

Figure 2: New commissioning powers received by Greater Manchester under devo-health

Commissioning decentralisation in Greater Manchester (£m) annually

Function	Budget	Decentralisation	
Acute, mental health & community	£3,861	-	CCG level
General practice co-commissioning	£388	⇩ Delegated under co-commissioning policy	To CCG level
Specialised commissioning (GM)	£904	⇩ Deconcentrated under 132B of the NHS Act	To chief officer GM
Primary care (dental, optometry, pharmacy)	£310	⇩ Deconcentrated under 132B of the NHS Act	To chief officer GM
Public health	£40	⇩ Devolved under Cities and Devolution Bill	To combined authority
Social care	£857	-	Local authority level
Other (including running costs)	£81	⇩ Deconcentrated under 132B of NHS Act	To chief officer GM

Source: Quilter-Pinner and Antink, 2017.[5]

Health devolution to deliver health reform

This shift in the way the system operates under devo-heath in Greater Manchester speaks to one of the key drivers behind the decentralisation agenda in health. Notably, devo-health – and its successors in the form of ICSs – come in the context of a health and care service facing significant challenges. With a growing and ageing population, and - even after the NHS's recent funding deal - a resource constrained environment, there is huge pressure for NHS leaders to deliver bold reform to make it more sustainable.

This reform agenda - first under the Five Year Forward View[6] and now under the NHS Long-Term Plan[7] - makes the integration of health and social care, shifting care out of hospital and into the community, and better prevention of ill-health, a priority for local health and care leaders across the country. However, whilst there are undoubtedly pockets of good practice, many areas have struggled to drive forward with reform. This is no surprise: delivering change in the NHS has always been a challenge. But, in the current context local leaders face some unusually formidable challenges.

Notably, the complexity and fragmentation created by the 2012 Health and Social Care Act – all of which was 'locked-in' using primary legislation – has made integration even harder. Devo-health may help undo some of this by aligning the responsibility, powers and funding for all areas of health care, social care and other public services under one local body which in turn allows local leaders to pool budgets and integrate commissioning functions within the NHS and between the NHS and other public services at the local level in order to drive integration (see figure 3 for a more detailed logic model). Put more simply: devo-health may enable the type of reform that can be delivered at the local level.

[5] *ibid*
[6] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[7] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

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Figure 3: The logic underpinning decentralisation in health

Source: Quilter-Pinner and Antink, 2017.[8]

Devolution to accelerate the pace of change

However, in addition devo-health may also drive up the pace of that reform by addressing some of the more timeless challenges in the NHS. Notably, because of the centralised nature of the system, local leaders in the NHS often feel disempowered and unable to take ownership of reform. Decentralisation – whether in the form of devo-health or ICSs – has been seen as a tool to address this concern. In particular, by handing power down to the local level it simultaneously:

- empowers local leaders to instigate and own reform, giving them the confidence to overcome barriers and do something different; and
- makes local leaders more accountable for their local health economy giving them 'skin in the game' which increases the cost to them of inaction.

Indeed, emerging evidence from Greater Manchester suggests that this has happened. Greater Manchester has some of the most advanced areas in terms of integrated commissioning, with places such as Tameside and Glossop now benefiting from a single commissioning function between health, social care and public health within its region worth nearly £500 million.[9] Likewise, the region has also gone further towards creating a place-based system, where organisations – in particular acute trusts - make decisions in the interest of the whole system rather than their individual organisation alone. This can be seen in the new agreements made between local acute providers to work together rather than compete (Quilter-Pinner 2016).[10]

[8] https://www.ippr.org/files/publications/pdf/devo-health-where-next_Mar2017.pdf
[9] ibid
[10] ibid

Where next for health devolution?

The question going forward for areas across England in receipt of, or considering, devo-health powers is whether the current devo-health settlements available to them pass down enough power (and in the right ways) to the local level in order to really unlock these benefits. Notably:

- Will the retention of ultimate accountability to the centre allow local leaders to look to national government if the money runs out or if reform initiatives fail to deliver? Will it reduce their 'skin in the game' and therefore commitment to reform?
- Likewise, will the maintenance of existing statutory responsibilities act as a drag on integration? Will it keep money locked within existing silos (and in particular in the acute sector)? Will it ensure that 'devolved' systems remain at the whim of central government targets and edicts?
- England also remains one of the most fiscally centralised countries in the world (LFC 2013). Will this centralisation in the finances make it impossible for local areas to be held accountable for financial overspends? Will it inhibit their ability to create real place-based public services?

At IPPR, we argue that on all-fronts devo-health may have to go further in order to truly unlock the benefits of decentralisation. In particular, there is evidence to suggest that the combination of maintaining statutory accountabilities of organisations to the centre will ultimately reduce local leaders' 'skin in the game', allowing them to pass on difficult decisions (such as hospital closures) and responsibility during times of crisis (financial stress, for example) as well as reduce the level of empowerment at the local level by allowing central bodies such as NHS England to continue to intervene and override local decisions as well as reinforce existing silos.

Likewise, there is no doubt that this lack of fiscal devolution will limit the degree to which local areas have real autonomy. In particular, local services may be unable to decouple themselves from unhelpful conditions set by central government, accountability may remain centralised because without revenue raising powers local leaders will not be able to hold financial risk at the local level (having to bail out failing hospitals, for example) and the balance of power and accountability between the NHS and local government (as the main partners within health and care) may be skewed due to lack of shared funding, incentives and risk.

Devo-health+

As a result, it can be argued that a next step in places like Greater Manchester, may be a more radical devolution deal – a 'devo-health+' deal – to allow them to go further.[11] Initially, this could involve giving local mayors the power to develop strategic plans and outcome frameworks, alongside local health and care partners, and putting a duty on others to comply with/deliver against them, as well giving them revenue raising powers over local 'sin taxes' to both drive an improvement in the social determinants of health and top up local funding streams for things like public health.

But in time, this could go further, for example by moving existing organisational statutory responsibilities and accountabilities down to local level so that local organisations report to the combined authority and/or the local mayor rather than national government (something that could truly enable place based health and care systems). Another step forward could include investigating the potential for a wider fiscal settlement that would allow local government (mayor and/or combined authority) to match-fund the local NHS (thus equalising the power balance between NHS and local government). This would need to ensure that funding across local areas remained fair and consistent but would allow that funding to be collected – and therefore some accountability to be retained – locally.

Conclusion

Any new 'devo-health+' deal would need to carefully protect the 'N in NHS'. However, the truth is, the NHS has never been a completely national service: there have always been variations at the local level (the 'postcode lottery'). Significant centralisation has not prevented this (though it has prevented reform at the local level at times). Instead, what is truly 'national' about the NHS – the deeply rooted idea of a health service free at the point of need for everyone when they need it most – comes not from a central dictat but from a public expectation of what the NHS and how it is run.[12] This will remain as true in decentralised systems such as Greater Manchester as it does anywhere else.

[11] *ibid*

[12] *https://www.ippr.org/files/2017-08/1502961603_devo-then-devo-now-august-2017.pdf*

A new model for regulating health and social care systems

Sir David Behan and Ann Ford, Delivery Lead Local Systems Reviews Programme, CQC

Introduction

Healthcare policy and delivery is shifting to emphasise the importance of the local health and care system. The development of health regulation must respond accordingly. This paper explores some of the issues such a shift raises for health devolution whilst maintaining the lessons of history.

The case for health regulation

"This must never be allowed to happen again" is a phrase that often follows incidents of abuse in the health and care system. Over the past 30 years numerous inquiries established by Governments of various political complexions have made recommendations to improve the quality and safety of services by strengthening the regulatory framework.

At the same time there has been an increasing focus from those delivering care on how to ensure that quality and safety are central to the delivery of care. The first approach is characterised by being reactive and extrinsic, and the other by being proactive and often intrinsic to services and professions.

A consistent theme has been where unacceptable standards of quality, safety and behaviour have become *"normalised"* and led to abuse. This raises the important question of why no one working in the services said *"this is not acceptable, it must stop now!"*? When such abuse occurs it leads to a break down in the public's trust in the system which appears to be incapable of self-regulating.

The sense of betrayal is further heightened when those who are abused or neglected are those who do not have capacity by virtue of learning disability or dementia. It is at this point that the call for the introduction of stronger regulation has arisen.

The job of the regulator is to provide independent assurance as to the quality and safety of the services in the interest of those who are receiving those services – the regulator is on the side of those people who use services and their independence is key. Often abuse takes place in *"closed systems"* and the role of the regulator is to *"speak truth to power"* and to intervene when standards are breached.

The new challenge is to ensure that such failures are prevented at the level of the system as well as the service.

From regulating services to regulating systems

Any discussion of health system regulation needs to be located in a broader context. Regulation is but one of five influences on the quality and safety of health and care services and systems:

1. Commissioners: How services are commissioned – the standards and outcomes that are specified.
2. Providers; How Provider Boards and Executive teams put in place quality standards.
3. Professionals: How registered professionals who have a personal responsibility to promote quality as part of their code of practice behave. Indeed, how the common standards of decency and respect for the dignity of others by all who work in health and care whether registered or otherwise.
4. Voice: How the voice of those who use services is heard and influences the standards of service they receive and, for those who are unable to express their view, how their advocates speak for them.
5. Regulators: Finally, how service, system, financial and professional regulators operate.

For sustainable quality to be present in services and in systems all five of these influences need to work together, in balance. If one influence is disproportionally stronger than the others then the risk is that quality and safety will not be sustainable.

This thinking influenced the redesign of the approach and methodologies of CQC in their role of regulating English health and social care services from 2012 onwards. CQC is uniquely placed amongst national organisations in England in that it has a remit for health care, primary care and social care. It is able to look across the range of provision in ways that others cannot.

The current focus of the health and care regulations is on individual services or organisations - for instance the care home, the general practice or the hospital trust. Yet with the development of the Five Year Forward View, the NHSE Long Term Plan and other policy developments such as the new Integrated Care System structure, competition is being replaced by collaboration as the organising principle of the NHS. That in turn will shape the future nature of regulation.

Regulating in different systems

The theory behind competition in health care was that it would drive up quality. It is debatable as to whether the NHS is a (perfect) market and therefore whether the anticipated and theoretical improvement has been achieved. There is a strong case that where there is a state monopsony (a market in which there is only one buyer) there is a need for an independent quality and safety regulator to ensure the interests of the individual citizens are being promoted.

In social care the market operates in a different way again. Like the NHS it is not a perfect market and has much greater pluralism with over 150 LAs and 220 CCGs acting as purchasers, and thousands of self funders who pay for their own care. In the pluralist market of social care an independent quality and safety regulator acting in the interests of the consumer is required.

One common feature of both the monopsony and the pluralist systems is there is an information asymmetry between those providing care and those receiving care as to the quality and safety of those services. How does the consumer know the quality of the services and can they trust the information that is available? An independent, trusted regulator is an essential design feature of health and care as a safety critical industry.

As the organising principles of the health and care system shifts from competition to collaboration there are two other significant shifts taking place.

Firstly, a shift of greater devolution from the national level to a regional and local level as evidenced by the programme in Greater Manchester and elsewhere. Secondly, much more emphasis on the way the system of health and care operates at the local level as distinct from the way individual organisations or services operate.

This focus on the system is, in part, an acknowledgment of the complex interdependencies between services at a local level, for instance how the number of admissions from care homes into hospital, is affected by the availability of primary care support to care homes.

Looking at the issue from the perspective of the person receiving care many people with complex co-morbid conditions experience care as being fragmented and fractured. The policy ambition of joined up and integrated care is not always delivered to those who require it. Their lived experience is very different to the policy ambition. For many people with complex conditions they will require care to be delivered by more than one individual and more than one professional. Their experience is shaped by the system.

Learning how to regulate systems

This move to looking at the way the health and care system operates was influential in informing the shift that CQC made in 2017 when it was asked by the then DH to carry out 20 local systems reviews to

> *"explore how well older people moved through the health and social care system, with a focus on the interface between acute, community, primary health care and social care, and what improvements could be made."*[13]

In many ways the request could have been interpreted as: *"design new methods for the regulation of a health and care system."*

To answer this question, CQC developed a co-produced methodology that involved people who used services and their families who are carers, as well as strategic partners, and national stakeholders. The reviews utilised data analytics, direct observation, case-tracking, interviews with system leaders, focus groups and questionnaire feedback tools.

The methodology focused on the planning, commissioning and the delivery of health and social care services. CQC reviewed how each local system worked within and across three key areas:

1. Maintaining people's wellbeing at home
2. Care and support when people experience a crisis
3. Step down, return to a person's usual residence, and/or admission to new residence

What does good look like?

The review findings demonstrate clearly that people experience the best care when people and organisations work together to overcome the fragmentation of the health and social care system and coordinate personalised care around individuals.

Although this was happening in some areas, wider findings indicated that for many people care was disjointed, and they were often cared for in the wrong place at the wrong time. In some cases, people's independence was squandered, and their aspirations compromised by a fragmented system unable to respond to need in a timely, coordinated and person-centred way.

Although there was a strong commitment within individual organisations to serve people well, there was often a culture where organisations prioritised their own goals rather than a system wide responsibility to meet a person needs. There was evidence of tensions in organisations influenced by system pressures (financial included) and accountability set against organisationally based performance measures rather than system-wide measures.

Organisations were also characterised by separate professions and practice cultures with limited evidence of interprofessional practice and cross boundary working. As collaboration and integration relied on clinical staff working better with colleagues in social care and the third sector this professional separation supported fragmentation.

The securing and sustaining of a skilled and competent workforce was also a major challenge identified in Beyond Barriers. However, there was limited evidence of a joint strategic approach to addressing workforce concerns.

The reviews programme concluded that such behaviours hindered a collaborative, integrated approach to service delivery.

[13] *Beyond Barriers, CQC, July 2018*

Better regulation of collaborative health and care systems

'Beyond Barriers' stated that changes were needed both nationally and locally to create a set of conditions that better enabled system performance, to deliver more integrated person-centred care:

- Opportunity for leaders to invest time and effort in developing positive relationships and changing competitive behaviors to support true collaboration and a system wide learning culture.
- A new type of leadership, where leaders are supported and encouraged to address system priorities collectively, through system-based, shared and well-understood performance measures and accountabilities.
- Common purpose based on assessed need to support aligned vision and values, open communication, improved joint funding and commissioning, better information sharing and the securing of a suitable workforce.
- Regulatory change including system level approaches.

Within the context of a rising demand for services, financial pressures, pressures to integrate at pace, coupled with policies and structures promoting competition and managing the workforce expectations, regulators have their part to play in creating the necessary conditions to support collaboration and integration.

Currently CQC has duties and obligations to inspect, monitor and rate health and social care at the provider level. This is an important role giving independent national insight into the state of health and care services in England to inform policy change as well as supporting people to make informed choices about their care.

However, as the landscape changes and becomes increasingly complex the challenge for CQC (and other regulators) is to develop regulatory models that use all available insight and intelligence to look more widely at the system's capacity and capability to respond, contribute and improve service design and delivery for the populations they serve. Regulators must also develop mechanisms that call system leaders as well as providers to account for service quality and secure on-going improvement.

A crucial step in taking forward this approach is for regulatory bodies to model the behaviors required for effective collaboration and lead this work by positive example.

Conclusion

The current model of regulation is one that was designed on the back of service failures such as Winterbourne View and Mid-Staffordshire NHS Trust. In the years that have passed since then, the policy and delivery agenda has shifted, and has developed and been shaped by the Five Year Forward View, Devolution and the Long-Term Plan.

The effective operation of the system as a whole and the collaboration between agencies and professionals as well as the integration of health and social care are key to these reforms. The future will see an emphasis on the way the system meets the needs of the population it serves. The pace of change across the country is very variable. Differential progress is evident in the way Integrated Care Systems are developing and that they operate at different levels of maturity.

In turn, the model of regulation will need to develop to keep pace with the changes in policy and delivery but it will also need to acknowledge that transformation will take place over a 5-10 year period. The regulatory challenge will be to continue to monitor, inspect and rate at provider level as well as to regulate the quality of the system as a whole.

The Local System Reviews have looked into the future and the approach has suggested some of the ways this could be done. In the short term it is possible to flex the current regulatory methodologies and, in addition, there is a real opportunity for collaboration between regulators – NHSE/I and CQC - to better align regulatory approaches and reduce the regulatory burden. Ultimately, however new legal powers will be required and any redesigned system of regulation will need to maintain an emphasis on *"encouraging improvement"*.

It is certainly true that *"what gets measured gets done"* so a system which incentivises organisations to work collaboratively to meet the needs of the population they serve must also hold the ambition of encouraging improvement in those services. Historically, regulation has lagged behind service innovation but, by preparing a model of regulation that looks at system effectiveness, regulation can incentivise the changes that will be required in the way that local health and care systems meet the needs of their populations.

Does health devolution work?

Dr Jennifer Dixon, Chief Executive, The Health Foundation

The need for change

Health and social care represents a growing share of government spend - in 2016/17 for every £1 the government spent 18.7p went on health and 2.6p on social care. If total government spending is to stay constant as a share of GDP, then on future projections the share of government spending in other areas such as education, the environment, welfare, will have to reduce further. So one of the biggest questions facing Britain today is how best to improve the quality of health and social care for the funding available and prevent avoidable ill health and dependency on services.

There are no simple solutions. In health care, the usual path of policy and management is to develop approaches incrementally, a set of pragmatic nudges here, a few initiatives with investment there, if you're lucky with an accompanying evaluation to help chart a further direction. Just occasionally, every couple of decades or so, there's a much bigger shift. The last in the NHS was the introduction of market-style incentives in 1991 to encourage better performance in clinical services. This was prompted largely by the prevailing currency of ideas at the time, and by some specific deficiencies in performance of the NHS – in particular long waiting times for planned treatment, starkly illustrated by the suffering of some individual patients waiting for surgery.

Health collaboration

Since around 2013 the tide has turned towards encouraging more collaboration across agencies to boost the quality of service. In part this is because the benefits of market-type incentives in clinical care had not been overwhelmingly demonstrated and the zeal for competition is cooler. In part it has been driven by low funding growth in health, cuts in social care, and the need to maximise impact for the public pound. In part it is down to a recognition that the key priority facing the NHS is no longer waiting times, but the care of the growing number of people with chronic ill health and frailty, and the increasing stock of the population with worrying risk factors for future ill health. Addressing these factors depends on action on the social determinants of health – for example, improving people's education, housing, and living conditions – which, in part, requires collaboration between services and sectors, such as the NHS, local government, schools and community groups.

Health devolution

Underlying this long run competition-collaboration axis to shaping care has also been a centralisation-devolution axis, where attempts to shift the balance of power from Whitehall to local areas have been accompanied by increased central regulatory oversight, or a subsequent reassertion of central control in the case of poor performance. The devo deals in England of the mid-2010's aimed, as outlined by George Osborne, to speed up economic development in northern cities by growing the private sector in particular technology start-ups, allowing councils more freedoms to do so and to pool their strengths under a clear accountable leader - a 'Metro Mayor'. There was an underpinning economic theory - clustering of enterprise and skills in the private and public sector would boost economic growth which would in turn benefit public services. Also, that leaders in cities were best-placed to see and grasp local opportunities. Manchester was held up to illustrate how this approach worked.

Each of the subsequent ten devo deals across England was different. Most conferred greater powers in the areas of transport, housing, adult training and education, the environment and justice. Several – Manchester, but also Liverpool and London – gave more freedoms with respect to health and social care. Of these the most developed deal is Greater Manchester, which is the most useful to explore with respect to assessing impact.

Health devolution in Greater Manchester

In February 2015 the government agreed that Greater Manchester, a city region covering 2.8 million people in 10 boroughs, could have 'devolved control' of the £6bn budget for health and social care. A new entity, the Greater Manchester Health and Social Care Partnership, was set up bringing together NHS organisations, local authorities and related stakeholders to achieve some key objectives. These were to improve health outcomes for the population, reduce inequalities in outcomes within the region and between the region and the rest of the UK, and to address the growing gap between demand and the resources for care. While the initial impetus for devolution in Manchester was to generate economic growth and productivity through greater clustering and enterprise, as applied in health and social care the concept was focused more on collaborating and sharing budgets to accelerate progress on health outcomes and efficiency.

In assessing the impact of devolution, the first question must be, what actually is devolution? One way of describing this is the exact powers and freedoms with respect to governance and finance that are different as a result of devolution. In Greater Manchester these are still developing. For example, with respect to health and social care, NHS bodies in Greater Manchester are still bound by the standards set out in national guidance, must meet statutory requirements and duties, including those of the NHS Constitution and Mandate, and remain accountable as before for performance (financial and quality of care) to NHS England and Improvement, and national regulatory bodies. As wider NHS policy changes, for example with respect to the subsequent Long Term Plan or related legislative developments, or the reintroduction of a regional tier of NHS management, Greater Manchester is likely to act in line.

Work in progress

As yet, devolution with respect to health and social care has no statutory basis and has been described as 'soft devolution'. But soft devolution has been powerful enough to encourage Greater Manchester to take a 'can do' initiative, galvanise more individual and collective energy, and do things differently. The main thrust to date of efforts in health and social care has been to encourage new and better partnerships between agencies, develop shared governance and decision-making processes, and pool budgets to achieve a clear set of mutually agreed outcomes by 2021 (shown below). New alliances and relationships at regional and local level have created energy and enthusiasm for an ambitious agenda to transform services in the medium term.

Goals for the Greater Manchester Partnership by 2021

Start well

- **270 more babies with healthier birth weights**
- **3,250 more five-year-olds being ready for school**
- **16,000 fewer children living in poverty**

Live well

- **1,300 fewer people dying from cancer**
- **600 fewer people dying from heart disease**
- **580 fewer people dying from lung disease**

Age well

- **2750 fewer older people suffering serious falls**

The key point then is that devolution itself in Greater Manchester is a changing concept, much of it at the moment being 'soft' (i.e. with no statutory footing) and affected by wider NHS policy. In fact, most of the policy agenda pursued in Greater Manchester in health and social care is similar to national priorities for these services, for example, the aim to develop more integrated care in the community. Across England different areas have some freedoms to pursue these priorities in different ways, regardless of a formal devolution agreement. In assessing the impact in Greater Manchester, it will be important to describe clearly what is distinctive about devolution, chart progress, and then assess what, if any, impact devolution has had on that progress relative to many other contextual factors such as changing wider NHS policy, investment in NHS and social care, changes to boost local management unrelated to devolution, and/or relative to a credible counterfactual. The impact should be assessed not only on the priorities that Greater Manchester has itself identified (as shown), but also on a wider set of issues that the health and social care system is meant to address. And given the time it takes to change health and care, the assessment is best done over not just two but also five years or longer. Maintaining the enthusiasm of the new over that period will be a challenge. Greater Manchester has set itself impact targets by 2021.

Evaluations of devolution

The Health Foundation has been and is still involved in many evaluations of complex changes, for example comparing performance of the NHS across the four UK countries post devolution in 1997, evaluations of many new service models of care such as integrated care pioneers, or NHS England's vanguards programme (with includes closer working across health and social care). The Foundation, with NHS R&D[14] has funded an evaluation of devolution in health and social care in Greater Manchester, involving a qualitative description of the changes occurring following 'soft devolution', and quantitative analysis on a range of indicators. The qualitative analysis (published in 2018)[15] followed the first 18 months of devolution, from December 2015 until September 2017. The report noted the challenges of rolling out devolution at the same time as balancing the requirements of the national NHS policy agenda.

According to the report, the Greater Manchester Health & Social Care Partnership invested considerable time and effort to build collaboration (and put in place governance structures) across multiple areas and organisations, before moving on to implementation. The quantitative analysis will be published later in 2019. It will assess whether devolution led to a deviation in policies implemented nationally (for example spending decisions), will measure a range of health and social care outcomes, and include assessment of inequalities in outcomes and variations in outcomes between health care providers. It will also try to assess how devolution might be impacting on outcomes, for example through changes to investment in capital infrastructure and the workforce.

Attributing the cause of impact

The history of evaluating similar complex interventions tells us that assessing the impact of devolution will be a difficult if not impossible task to do convincingly, not least because of the time it takes to begin implementing new initiatives and projects. Even if the performance and outcome of services in Greater Manchester is clearly head and shoulders different from the trend in other areas of England – for better or for worse – it can be hard to attribute changes to devolution, rather than other national policies. And if worse, expect stronger central direction to mitigate risk. For the other nine areas involved in devolution deals in England, the experience in Greater Manchester is likely to chart the course for whether devolution there is strengthened or not. As of now government enthusiasm for more devolution seems muted. Against this backdrop, it is crucial that evaluation continues over a long time-frame, and that absence of evidence of significant impact (whether positive or negative) is not used as a reason to curb efforts to generate an evidence base.

Conclusion

The enthusiasm, sense of rightness or emotional appeal of the approach by those advocating or implementing devolution are appealing and can create at least heady short-term impetus for change. But from experience of other complex interventions, such as integrated care, these three characteristics are necessary but not sufficient for lasting change and unfortunately have not been a reliable guide to eventual impact. Time will tell if the devo experiment in England gives more than a temporary fillip to the speed of change in the public sector. As for the future, long run policy direction along axes of collaboration-competition, central control-devolution remains in motion, influenced perhaps less directly by hard evidence and more as an intuitive abreaction to what has gone before.

[14] *National Institute for Health Research funded CLAHRC in Greater Manchester.*
[15] *Walshe K, Lorne C, Coleman A, McDonald R and Turner A (2018) Devolving health and social care: learning from Greater Manchester*

The role of health and social care managers in a devolved health system

Jon Restell, Chief Executive and Mercedes Broadbent, Policy and Communications Officer, Managers in Partnership

Introduction

"Devolution is, in my view, the only game in town."

David Cain, former NHS chief executive and Vice-Chair of MiP

Health and social care managers work at the coalface of health devolution. They are, at root, public servants delivering an excellent public service, who, if properly supported, could be the agents of health devolution, creating positive changes in the lives of millions of people. They have an excellent vantage point from which to judge whether devolution is successful, and are best placed to define the path devolution should take in the future. They are also aware of the pitfalls and advantages of the current framework, and have a good overview of workforce plans, which are an integral aspect of devolution, and important for the long-term success of any system. In short, health and social care managers know the lie of the land and what is possible to build upon it.

New structures for health devolution

It is important to note that we cannot only consider the role of healthcare managers, specifically NHS managers, in the future of health devolution. Health and social care are inextricably linked and both health and social care managers are key to the success of health devolution. One of the pitfalls of the current structures in England is the separation between social care and the NHS: devolution offers the possibility of dissolving this barrier, and it has been repeatedly called for by Andy Burnham, the Mayor of Greater Manchester.

Massive system change undoubtedly has significant potential for positive improvements, although this must be carefully planned and managed, and it is likely that legislative change would be necessary to enable some forms of integration. Jon Rouse, the chief executive of Manchester Health and Social Care Partnership, told MiP earlier this year that *"the things that slow us down are not in Greater Manchester: they are national processes which just have not evolved to reflect the changing landscape of integrated care systems."*

It is also crucial that management structures evolve to deliver capacity for integration and place-based planning, especially if legislative change is necessary. NHS England has made a cogent case for legislative changes to support the collaborative approach set out in the Long Term Plan, and MiP believes that health devolution is, in its own way, also a collaborative approach which needs to be supported. However, any such changes must be carefully translated into new structures, on the principle of form following function. Creating a system which generates high hopes but has little hope of success will not improve health outcomes, and will put added pressure on an already highly-pressurised workforce. An evidence-based approach is paramount.

System leadership and management

Manchester and London obviously provide the best evidence for how health devolution could develop in large urban areas in England, and also provide the best evidence of how integration of public services has produced positive results. Devolution and integration also gives scope for health and social care managers to view themselves as public servants in a wider sense, working together with leaders and managers in other sectors. Public servants have come under consistent external pressure in recent years, from both politicians and the media, and MiP considers health devolution an opportunity for a positive re-definition of 'public servant'.

> *"System leadership is going to be the order of the day; it's going to feel much more organic and networked and messy. And that requires a new mindset from managers. They'll have to work much more flexibly across the health and care spectrum: more proactively and creatively, and with an emphasis on agility and problem-solving.*
>
> *"Am I a great adaptive leader? Am I comfortable working with ambiguity? Am I okay in a space where I have to rely as much on influence and comradeship and solidarity as an instruction or a line report? That's the world we're heading into."*
>
> **Jon Rouse, Chief Officer, Manchester's Health and Social Care Partnership**

This re-definition must come with a true appreciation of the value of professional management in the delivery of quality public services, in terms of operational standards, service transformation and integration. This is also a question of putting one's money where one's mouth is — redesigning systems alone will not produce the results that political leaders want without additional funding. It is important to consider how we develop areas of management that have experienced under-investment, such as primary care and community services. Under-resourced managers in under-resourced areas do their best, but innovation is easier in systems that are not struggling with long-term neglect, and there is only so much that can be done with shrinking resources and increasing demand. Politicians will only see a healthcare revolution if they are willing to pay for a healthcare revolution.

Unintended consequences

It must be noted that devolution may lead to negative outcomes as well as positive ones, especially if mishandled, for example, through top down imposition of strategy or structure. Diversification of the system could lead to confusion and have negative impacts on transparency and clarity— creating an opportunity to 'pass the buck' and avoid taking responsibility. MiP is especially concerned that it could also lead to managers being blamed locally for national decisions that translate into less funding or less power than was expected regionally. And if health devolution is to be positive for the people who work in healthcare, it cannot sustain long-term problems such as the culture of bullying in the NHS.

There is also the additional possibility that if health devolution is a massive success, it could create a two-tier health system where health outcomes are better in some parts of the country than others, entrenching already-existent inequalities, especially across the urban vs rural divide. It is important that health devolution does not shore up existing inequalities and managers must be part of the process of ensuring this does not take place—there will already be great awareness within the system of where inequalities exist, and managers must be made part of forward planning to ensure that best practice can be shared in health systems outside of the devolved area.

Social care reform

There does, however, remain the great unanswered questions of social care— primarily how can social care managers work inside an integrated system when social care does not function like the NHS and is funded differently? Social care is a prime candidate for legislative change, and although MiP would require greater clarity before supporting reform, there is little doubt that the system of social care in England and its financing is unsustainable in its current form. So, what should the system look like?

> *"So what's needed? System leadership over population-wide health and care, provided by large-scale commissioners able to make unpalatable decisions about system change and investment. And financial flows that favour prevention, community services and care in the home, bridging the gap between health and social care.*
>
> *"That sounds like a mammoth task – but we've shown we can deliver disruptive, system-wide changes. In the 1980s we moved 100,000 people out of psychiatric hospitals into the community, shifting funding from the NHS to community provision, social care and benefits. If you point NHS staff in the right direction and give them the right incentives, levers and tools, they'll do amazing things."*
>
> **Sophia Christie, former NHS PCT chief executive**

Workforce changes

The secondary unanswered question on social care is: how should we restructure the workforce itself? The NHS and social care would not be simple to integrate, for myriad reasons—differing levels of training and qualifications, different system processes, and oversight by entirely different bodies.

> *"Where we start to integrate services along care pathways, we'll be bringing into close proximity staff on very different employment packages. There are big differences in what a care worker gets relative to even a low-paid NHS worker on an Agenda for Change contract – not just in pay, but also other conditions.*
>
> *"Where will that money come from? How will higher costs be funded? And how will the devolutionary organisations integrate staff on possibly very different employment packages?"*
>
> **Jon Restell, Chief Executive, MiP**

However, integration of employment packages would significantly aid recruitment and retention of social care staff —not only of care workers, but also of social care managers, who are paid much less than their NHS equivalents, and who usually have to cope with a constantly depleting workforce. Devolution offers the possibility of a more equitable and productive relationship between health and social care workforces, if politicians are brave enough to advocate for it.

Framework for accountability

It is integral to the future of health devolution that managers are at the heart of decision making and planning, as they know their systems best and have the insight, knowledge and skills to improve them. MiP supports devolution, if it is well planned, takes into account the views of those already in the system, and is adequately funded. There needs, however, to be a recognition that however successful devolution could be, that there are some issues that will best be addressed nationally.

Devolution does not mean full autonomy. Health devolution will exist as a system within a system, and cannot be allowed to become a separate system where there is a splitting of practice and regulation. Accountability of management also needs to be better balanced than it is now; current accountability mechanisms are overly punitive and lack clarity to such a degree that most people working within the system struggle to understand the regulations they operate under. Devolution represents an opportunity to create a more realistic framework, and a framework which is fairer for the people within the system.

Management workforce

There also needs to be a greater understanding of the role of managers in quality delivery and workforce experience, as well as the specialist skills required for organisational development and system transformation. There is already a huge shortage of leaders in the health and social care system, especially at senior levels. Chief executive roles often sit vacant for months, if not years, after multiple rounds of recruitment. No system will succeed without good management, and *enough* management. It will be vital that workforce plans include credible action on ensuring the supply of managers and leaders to local systems, which could include training offers, recruitment drive plans, and a credible pathway to ensure that diversity in the leadership reflects not only the diversity of the local area but of the system as a whole.

Conclusion

The most important aspect of the role of health and social care managers in healthcare devolution is this: it will not be successful without them. Managers know their systems, and they know what is already working well and what is already a problem. They need to be treated not merely as part of the system but as experts on their systems, who want nothing more than to see their systems excel. They need to be involved in every stage of planning, and a pipeline needs to be established at the start of any devolution process to ensure a supply of good managers in the future, which should include a greater focus on developing people at the very start of their careers. Managers are the great untapped resource of devolution, and a partnership must be established—between health and social care managers, politicians, local authorities and other public bodies, if the public are to be best served by devolution.

2 Local perspectives

The Alchemy of Place: Greater Manchester

Warren Heppolette, Executive Lead Strategy and System Development,

Greater Manchester Health and Social Care Partnership

Introduction

For those of us who have spent any time in healthcare, there is a calm, world weariness from having grown used to waves of top down reorganisation. Colleagues compare how many they've been through (I think survival through thirteen such changes was the record I'd picked up in one of those discussions).

At the same time, I recall the retirement speech of a Salford nurse who stood in front of an array of her identity badges with marginally different organisational titles and confirmed *"I've only ever worked for Eccles"*.

People in healthcare expect reorganisation and can spot when the last but three iteration comes back round again. They expect a new version of complexity and fragmentation to make sense of. Their partners in local government, and other sectors, do their best to make progress in improving the health and care of the population they serve during whatever brief brilliant period the affair is afforded before the next change.

There is an option to exchange that fragmentation and complexity for simplicity and permanence - a focus on place.

Focus on place

In Greater Manchester, almost the first principle during the earliest discussions on devolution for health and social care was the primacy focus on people and place. This was a deliberate antidote to any emergence of organisational self-interest. It was also a recognition of a key effect of devolution regardless of the service area, that the line of accountability no longer looks up to Whitehall and national bodies, but out and across to populations served.

I believe a focus on place can inspire participation, leadership, investment, coherence, stability and democratic relevance. Most importantly though, I believe it is the most effective starting point for the pre-eminent question people involved in healthcare should ask - how can we maximise the health potential of the population and who can help?

Connecting that question to a focus on people and place generates a number of key considerations relevant to our views on the leadership and coordination of public services.

Invitation to take part

The first is that its openness advertises an **invitation to participate**. This is critical if we accept the evidence that the most significant determinants of health lie outside the formal health and care system.

The response to a grand challenge on health outcomes and health inequalities brings an amazing array of participants along with their contribution. Our experience has been that, if we frame the challenge and the invitation to participate in this way, and if we break the traditional habit of seeking no more than external commentary on a published plan, the activists and participants come forward. The schools taking part in the Daily Mile and mental health pilots; the businesses supporting action on rough sleeping; the housing providers supporting hospital discharge and housing options for older people; the faith groups supporting local immunisation programmes and leadership on prevention; the voluntary and community organisations supporting mental health programmes and scaled social prescribing opportunities; the Park Run champions showing how physical activity need not leave anyone behind.

The examples are numberless. Taken together, they begin to take on the characteristics of a movement, rather than the response to a plan or programme. In some instances this reflection of a place based movement takes on its own momentum because it taps into habits of community action which have never gone away. Each of the proud towns in Greater Manchester know that they are carrying habits developed for 200 years. Public services have the opportunity to make themselves relevant to this and benefit from the ideas, capacity, energy and resources which flow from it.

Compulsion to integrate

The second aspect worth focussing on is the **compulsion to integrate** which comes from the accountability and clarity which devolution brings. Public Service silos set in Whitehall dissolve on contact with any logical interrogation the problems we are trying to solve together. There is no government department which can take an effective lead on improving school readiness, meeting the scale of our current mental health challenge, tackling long term worklessness or responding to the crisis of homelessness. That is because critical contributions lie outside the control of any single department. Only devolution and local accountability can fit those pieces together.

This means that we must act to overcome the information sharing, physical, cultural, and financial barriers which inhibit the integrated working required to stop the cyclical demand generated by an increasing number of often vulnerable individuals and families. We have a duty therefore, to pursue integration and contribute to each other's objectives. This means identifying employment as a health outcome; physical activity as a transport objective; homelessness as a health crisis; loneliness and social isolation as an early warning for declining health.

For Greater Manchester, making full use of our unique devolution settlement – the most advanced deal of any city-region in England – means changing the way in which our public services work to support people to achieve their full potential and ensure nobody is left behind. That means integrating services around people, neighbourhoods and their needs, focusing on prevention, developing new models of support and sharing information across the public sector to design and deliver better services.

This new model of public services is based on a new relationship with citizens and means freeing up the frontline, devolving power and allocating resources around need more effectively. Aligning geographies around these neighbourhood areas allows us to start with the person and start in the home. Each neighbourhood area will be served by an integrated place-based team with co-located professionals from all relevant public services working together. These teams will be supported by more specialist teams operating at a Locality, cluster or Greater Manchester level.

This will help to reduce pressure on crisis, acute and specialist services, allowing them to focus their resources on those that need it the most.

New models of public service leadership

The third key aspect of place based working is recognising the **challenge and change this brings to traditional models of public service leadership**. If, as we suggest above, an invitation to participation across the whole of civil society and a compulsion to integrate are 'make or break' competences for public service leaders, then we cannot and should not lead in traditional ways.

The breadth of contributions is more than any single public service, or sector can bear. The accountabilities must be shared and sovereignty pooled in the interests of common objectives. Leadership should be humble (recognising the limitations if its own contribution and the value of other's); and it should be entrepreneurial and curious (recognising that innovation may be discovered from any source).

This may therefore, feel more networked than hierarchical and not able to be drawn up through traditional structures but pushed out through new partnerships. This becomes possible when we recognise that we all work for the place and the people in it and that actually matters more than the terms of our individual contracts, or the functions of our individual organisations. This effort, of acting as if we worked for the place above or individual localities can be the source of the alchemy which transforms outcomes for residents.

That alchemy creates novel axes of leadership with immense potential. We have recognised and pursued an alignment of civic and clinical leadership where the trust and authority of clinical leaders rooted in local places allied to the focus of local democratic accountability truly strengthens the accountability of local public services. There is, I believe, a particular strength in the potential of the relationship between GPs and ward councillors with each often rooted in neighbourhoods with decades long connections.

One size does not fit all

There are, however related considerations which should be borne in mind and we have to avoid making the mistake of thinking this is a recipe which can be copied and pasted into any part of the country. There is no single right answer on the appropriate geography for a particular issue or potential partnership. It is deceptively attractive to think that there is and that this is an easily translatable model.

The truth is that, depending on the problem we are trying to solve, the geography, and the essential partners need bend and change. We act at the person, family and neighbourhood level to secure individually focussed care and support communities; we act at the whole district level to support those neighbourhoods and develop more specialist community-based services; we act at the city region level to progress our research and industry partnerships or support the resilience of specialist acute services or indeed, relate to Government and national bodies.

We must recognise, therefore that we have overlapping systems. The approach cannot be an endless search for the single geography which captures someone's view of the most relevant partnership of the moment. Instead we should recognise the challenge for public service leaders is to develop the adaptability to operate at multiple levels and the expertise to match the level with the opportunity or the problem.

Additionally, we should recognise that there will be occasions when the focus on 'place' is not the most appropriate. We should recognise the specific attention which may be needed to support communities of identity who may have highly specific needs which might be lost in a wider population view.

Challenges to national partners

Finally, we must observe that this doesn't only present challenges to local leaders, but also to national partners. A focus on place and local populations affirms an appropriate sense of accountability to a population served. This must be right, but we should recognise that the direction of accountability for many local services, and the NHS in particular, is actually away from the people and towards the regulators. There is an equal and opposite challenge therefore to national partners on the future of regulation and assurance which should feel less like functions discharged through national bodies, than debts owed to a defined population served.

Conclusion

Our experience of a focus on place is overwhelmingly positive. It is essential if we are to rise to the complexity of the challenges we face; it is the approach from which the benefits of devolution can be drawn; and it actively brings capacity and energy to public services which otherwise often feels locked out.

What could Health Devolution look like in the West Midlands?

Dr Henry Kippin, Director of Public Service Reform, West Midlands Combined Authority

and Councillor Izzi Seccombe, Leader of Warwickshire County Council and WMCA Wellbeing Board Chair

The importance of devolution

The West Midlands is a large, complex and fascinating region. It is home to three major cities – Wolverhampton, Birmingham and Coventry – and a population of over 4 million people across its entire geography. It is one of the youngest and most diverse city-regions in Europe, and over the next few years will play host to the City of Culture, the Commonwealth Games and a number of transport and infrastructure reforms (including HS2) that will transform its landscape.

As a region we have embraced devolution – sometimes enthusiastically; at other times reflecting the tricky relationships and mixed incentives which characterises every collaboration at one stage or another. But although the political landscape is diverse, we know that, fundamentally, the region is stronger together than pushing in separate directions at a time of great economic and social fragility.

Across transport, skills, housing and growth, the benefits of devolution are already obvious. The region's Strategic Economic Plan forecasts, for example, 500,000 new jobs and 214,000 new homes by 2031. The £80m devolution of adult education offers new opportunities to tailor skills provision and training to real local jobs. We are laying 35km of new Metro and our Local Industrial Strategy promotes a clean tech transport cluster and a manufacturing export sector that is already world leading. This is real added value in areas where the West Midlands has historically struggled to punch its weight.

Within public services, our job is to create the building blocks of true cross-regional collaboration that means everyone can see the benefit of this growth. Whitehall-designed policies have, in this sense, failed us. Inequality in the region has always been present, but is rising. Child poverty levels are above 35% in some urban areas, and wellbeing outcomes from cradle to grave are stagnating and already below the all-England average.

If William Beveridge were to assess the region today he would describe new 'giant evils' such as persistent in-work poverty; dysfunctional mental health outcomes; rising obesity and poor public health; and a link between economic progress and social change that has been fundamentally broken.

Health Collaboration in the West Midlands

Devolution is a means to address these issues together as a region, closing the gap between economic growth and economic inclusion. More collaborative health and public services are fundamental to achieving this. The West Midlands Combined Authority is not primarily a commissioning or delivery authority – but it represents a cross-regional collaboration that can enable massive positive change across our health economies. Strengthening this collaboration is our primary focus, and we are doing this in three ways:

- **Inclusive growth and wellbeing**

Each of the region's NHS Sustainable and Transformation Partnerships plans stress the relationship between health, wealth and the wider determinants of wellbeing, and our work as a Combined Authority prioritises this. For example, the region's Thrive Into Work programme provides wrap-around support for people with mental health problems to find work – with 150 people now into sustainable jobs over the last year. Thrive At Work supports businesses to get 'wellbeing ready' and support good mental and physical health in the workplace. Over 250 businesses – touching over 90,000 employees – are already signed up.

This is a cross-regional collaboration, with WMCA playing a catalytic role. We have also worked closely with Public Health England to set up the country's first embedded Inclusive Growth Unit within a combined authority – enabling us to build the evidence base and analytical tools for targeted interventions that support wellbeing outcomes across everything we do as a region.

- **Radical prevention**

Successive Secretaries of State for Health have counselled that 'prevention is better than cure'. Yet investment in prevention and early intervention – which has always been undervalued – is even harder at a time when community and civic capacity has been eroded by financial cuts. The region's fiscal gap is around £3.9 billion, which can only be closed by economic growth and public services acting in concert.

That is why we are developing a Radical Prevention Fund for the region – which will enable us to invest in innovative models of prevention that leverage our digital expertise and target those poor outcomes – such as school readiness, childhood obesity and physical inactivity – which create such misery for citizens in later life and increase demand on health and care services. The region is coming together to scale up a collective approach to violence prevention (in the face of rising knife crime) that will follow this collaborative ethos.

- **System collaboration and digital connectivity**

The West Midlands model of devolution will inevitably be bottom up and variable, spanning at least three Integrated Care Systems; seven urban councils (and several rural authorities); police, fire and emergency services with a cross-regional footprint; and civil society within our localities. Our priority is to put the building blocks in place that will allow the whole system to work together – a task that we are really just beginning.

Digital innovation is a key plank of this. The West Midlands is the UK's 5G test-bed, which means the region will play host to a dramatic shift in digital connectivity across its cities and places. So our devolution programme will prioritise the enabling of new models of connected health, remote care, and system collaboration enabled by faster, more reliable connectivity across public services.

New ways of working across health and social care

All of the above is, of course, a small part in a wider effort needed to shape public services that are fit for the future within the region. Across the system, health and care partners know they face a challenge of fundamental transformation in the face of changing patterns of demand. As the NHS Ten Year Plan makes clear, prevention must go hand in hand with further integration. There is some way to go in bringing together activity across different health and care settings, and to explore the potential of joint-commissioning in ways that leverage the potential of a combined authority.

As the region builds its 'West Midlands Model' we will test, trial and prototype new ways of working within our places. In town centres, growth corridors and with leading health providers like University Hospitals Birmingham we will support models of delivery that use devolved power and regional collaboration as the catalyst for change. We will maximise the benefit of our Industrial Strategy and the economic footprint of our anchor institutions. Over the coming months we will be drawing these threads together into a collective blueprint outlining the long-term relationship between public service partners within the region.

Conclusion

In response to the 'five giants' he observed in 1942, William Beveridge set out a blueprint for health and public services that has in many ways endured to this day. Our task today is to help our region to look to the future and address a climate of complexity and uncertainty by bravely doing the same.

3 Sector perspectives

Can health devolution improve cancer care?

Lynda Thomas, Chief Executive, Macmillan Cancer Support

Introduction

The devolution of health powers presents local health and care leaders with a significant opportunity to develop truly joined up, place-based care and support for their local communities, and to move away from 'one size fits all' services which are often no longer able to meet the unique needs of patients in the 21st century.

This is particularly important for complex illnesses, such as cancer, where increasing numbers of people are surviving or living with them for longer but with a range of unique care and support needs depending on their individual circumstances. A tailored response to these needs, or 'personalised care' as it is often referred to as, is therefore vital if they are to be effectively met. It is also clear that developing services with an understanding of the local area and its distinct factors (such as rurality, deprivation and transport links), will help to ensure they are as impactful and accessible as possible. Devolving health can help local health and care leaders in developing such support.

This is no simple task, however. Our experience at Macmillan Cancer Support highlights that the success of developing and delivering such services can hinge on how effectively local health and care leaders and their organisations collaborate, and devolution – whilst giving local areas the necessary powers to work as closely together as needed – cannot, in and of itself, provide this. As such, it is vital that local leaders are supported, alongside their local communities and health and care professionals, to develop meaningful shared visions around what devolution can deliver for health in their areas so that joined up working is in place from the outset and strong relationships are encouraged to grow.

Yet whilst truly joined up working at a local level requires time, effort and trust, the dividends this can pay when in place can be significant. In terms of those for people with cancer, Macmillan believes there are considerable opportunities in devolving health for the personalisation of care, as mentioned, as well as in improving patient experience and tackling health inequalities.

[16] *299,920 a year in England. 2001 - 2015 incidence figures from Office for National Statistics*

[17] *Maddams J, Utley M, Møller H. Projections of cancer prevalence in the United Kingdom, 2010-2040. Br J Cancer 2012; 107: 1195-1202. (Projections scenario 1). Macmillan analysis based on extrapolation of 2010 and 2020 projections that the number of people living with cancer hit an estimated overall 2.5 million in 2015*

Meeting the changing needs of people with cancer

Today, increasing numbers of people are being diagnosed with cancer,[16] and their care and support needs look very different to those seen in previous decades.

Every year nearly 300,000 people in England receive a life-changing diagnosis of cancer. [16] Furthermore, evidence tells us that, in the coming years, the number of people living with cancer in England will rise from two million today to 3.4 million by 2030.[17] Yet whilst there is an increase in prevalence, huge improvements in diagnosing and treating the illness means that more people are also now surviving cancer or living for longer with it and are now twice as likely to survive for ten years after a cancer diagnosis than they were 40 years ago.[18]

Increased survival is a hugely positive step forwards. But we know that surviving longer does not always mean living well. Many experience physical and emotional consequences of their cancer and its treatment, ranging from incontinence and fatigue, to depression and anxiety, and this can remain the case for many years after treatment has ended. For example, research tells us that one in three people (34%) are still struggling with their physical wellbeing up to two years after treatment ends, and a third of people (30%) who have completed treatment in the last two years report that their emotional wellbeing is still affected.[19] Those with a cancer diagnosis must, therefore, not only be provided with care and support to survive, but to survive with the best possible level of health and wellbeing and for as long as they need it.

This is complex, however. There are over 200 different kinds of cancer,[20] and treatment options depend on the type a person is diagnosed with and how advanced it is, along with other emerging factors in line with scientific advancements, like genetics. With so many variables, it is unsurprising that care and support needs differ between individuals, and so personalised care is vital if we are to meet their unique needs and support them to prepare for, and manage, their life through and after treatment and to work towards the best possible quality of life.

These changes with the cancer experience present the NHS with significant challenges on two fronts. First, in meeting the demand on its services from the increasing number of people with a known or suspected cancer diagnosis, and – importantly – in a quality way. Second, in delivering personalised care to each patient. Whilst this is a challenge for all local systems to meet, the devolution of health presents local health and care system leaders with a key opportunity to meet this head on through developing and delivering effective and joined up services for people with cancer and ensuring that the workforce that underpins this is in place and sustainable.

[18] *M Quaresma et al (2014) 40 year trends in an index of survival for all cancers combined and survival adjusted for age and sex for each cancer in England and Wales, 1971-2011: a population-based study The (Lancet 2014; 385) pp.1206-1218.*

[19] *Macmillan / YouGov online survey of 2067 people living with cancer in the UK. Fieldwork conducted 23 June – 6 July 2017.*

[20] *NHS, cancer, https://www.nhs.uk/conditions/cancer/ (accessed April 2019)*

The importance of personalised care for people with cancer

Personalised care not only improves experience but also improves outcomes, including by enabling early identification and diagnosis of side effects and consequences of treatment, as well as the recurrence of cancer. It can also help to reduce health inequalities.

Macmillan believes that personalised care must seek to meet the needs of an individual across all areas of their life so that everyone can continue to live as fully as possible. The first step is a conversation that explores what their support needs are through a holistic needs assessment that looks at both clinical and non-clinical matters (such as physical and emotional issues, and other factors, including financial wellbeing). This should be captured in a care plan and kept under review. Patients must also be given a treatment summary and support to navigate the health and care system, if needed. Again, this should be revisited throughout treatment and beyond.

For this to be successful, health services must be networked into other local services so that patients are able to access the full array of support they may need, such as housing, social care, and welfare advice. They must additionally look to ensure that personalised care is accessible to all through taking account of how people may access services differently depending on their age, cultural background or language. Devolution of health provides local leaders with the opportunity to design this into their systems or to prioritise a shift towards this approach, and with knowledge of the nuances of their local area.

For example, if there are pockets of non-English speakers within the community, health and care leaders could look to engage with these groups to ensure that personalised care is designed in a way that they can access and in a way that they can understand. For those with areas of deprivation, leaders may look to prioritise developing strong links between their organisations and welfare advice services in order to meet patient need.

In addition, devolution of health provides local leaders with the opportunity to build capacity into the local system, where it is needed, to deliver these personalised services through local workforce planning. Here, it is key that a clear picture is established as to where there are any gaps (in terms of posts and skills) and what steps are required to fill these; for example, creating new posts, recruiting to vacancies, effective retention policies and ensuring ongoing education and training support to develop a workforce that is fit for purpose.

Taking such action to deliver personalised cancer services will also support measures to tackle the health inequalities found in communities, as everyone – regardless of who they are or where they come from – will be enabled to find the care and support they need. This is important, as we know social determinants can impact on a person's whole experience of cancer and that purposeful and coordinated work is needed to address this.

As such, the devolution of health provides local leaders with a significant opportunity to transform local cancer care through providing quality, joined up services to everyone living with cancer in their communities, and through a workforce that is set up to deliver this.

Measuring the effectiveness of local care and support services

Whilst improving clinical outcomes are vital measures of cancer care, for example faster diagnosis and access to treatment, Macmillan believes it is equally important to improve patients' experience of their care and make sure it meets all their needs.

It is essential that local health and care leaders seek to measure the success of the services they put in place for patients, including through patient experience as well as clinical outcomes. Whilst the benefits of measuring the latter are obvious, patient experience is also key as it enables health and care leaders to improve and tailor the services they offer. In turn, fine tuning the support available results both in higher-quality care but also the system benefits of identifying and addressing needs at the earliest opportunity, therefore reducing escalation of need and greater demand on services later.

With regard to cancer, the National Cancer Patient Experience Survey in England enables us to do just this through exploring key questions with patients, including whether patients were: treated with dignity and respect; given good information; involved in decisions, and; had their views and preferences were listened to and taken into account. Results are available at a national and local level, which local health and care leaders can then use to review and improve their services.

The devolution of health provides an opportunity to local leaders to assess and continuously improve their services for people with cancer through using clinical and patient experience measures. It is vital they respond to this through a joined up response which includes engagement with the local community. For example, if local leaders believe the measure on whether those with cancer are getting the assistance they need from health or social services after their treatment had ended is too low, they could work to address this through joined up initiatives that ensure no one slips through the gaps.

Conclusion

Overall, it is clear that the devolution of health could provide people with cancer with tailored care and support that also takes into account the nuances of where they live, such as rurality. Benefits could additionally be realised in reducing health inequalities and being able to respond to clinical and patient experience measures in an agile way to deliver truly personalised and joined up local services. However, this hinges on the development of strong local working relationships between local leaders, and devolution can only enable, and not in itself, provide these, and local areas must be supported to build them.

How will patients have a voice in devolved health systems?

Imelda Redmond, National Director, Healthwatch England

The importance of devolution

One of the most frustrating aspects of my job as National Director of Healthwatch England is hearing the stories of people who have often not felt in control of their own care. People who have felt powerless as big decisions about their health were made by others, often by respected experts in their area of specialism, but with little regard to what those affected by the decisions felt was right for them. They were left with little choice in plans that would have an impact on the rest of their lives. When we examine the collective health and care experience of people, we find similar concerns about system wide change being made by managers and clinicians without involving the wider community.

Over the past thirty year we have experienced a shift to a more devolved and decentralised health and care system. Devolution, Sustainability and Transformation Partnerships and Integrated Care Systems, have all promised a more joined up experience for people and assigning more decision-making and control at local level for organisations operating at a regional area. The long road to integration has seen the increasing complexity of healthcare provision, the demands of a society that is living longer, often with one or more chronic conditions and an NHS under unprecedented operational and financial pressures.

So how can devolved or delegated systems meet the challenges of the 21st century and create a fit for purpose health and care system that truly delivers person-centred care?

Giving people a say

By giving people more of a say and ensuring their voice is heard and the information they share about their experience of care is acted upon. Devolved health areas must include people at every level.

#itstartswithyou is a Healthwatch initiative to encourage people to have their say about their health and care. This campaign is a grassroots approach to help people voice their ideas and views at a local level. Our aim is to hear from one million people each year and use their ideas to create a better health and social care system.

This means involving people in designing, commissioning, delivering and evaluating services. Listening to patients and their experience of health care, both good and less than good, is the very basis of person-centred care. We know real–time patient feedback is important, and necessary. But 'real involvement' of people is not merely the collection and analysis of feedback but the authentic, welcomed, and active involvement of people in the design of services, pathways and in the decision–making process itself.

It means ensuring that 'all level' system decision–making is grounded in the human experience perspective. We can go beyond the typical small 'user group' representation to systematically and comprehensively harnessing people's perception and experience of care within the system. This perspective can then be embedded in the decision-making process at all levels. The patient perspective becomes an integral part of how priorities are determined, where decisions are made, and how resources are directed to have the greatest impact on improving the health and wellbeing of the community.

Devolution – prioritising people and place over organisations

Devolution, by its very definition, should create an environment for people to have more of a say and to be more involved in their own health and wellbeing. People want to be informed and included in the how, when and why decisions that impact on their lives (and the lives of people they love and care for) are made.

Health devolution areas can put the focus on people and place and rather than on individual organisations. Consideration of the wider determinants of health and an understanding more broadly of what contributes to healthier communities is fundamental to success. So, it stands to reason that by involving people at all levels of the health and social care system, this will lead to better services and improved health outcomes for local people.

Healthwatch and the peoples' voice

Healthwatch England believes people need to be equal partners in determining the needs of their community, in how services are designed and delivered and in how limited resources can be used to achieve health equity. Our evidence and insight, which has been built over the past six years, makes people are heard and this data can inform all levels of the system.

When people tell Healthwatch about the issues that matter to them, they also mention the importance of shared decision making, collaboration and communication. But these qualities are, at times, considered by system leaders as valuable, but less important than other attributes such as performance targets.

The system's effort to measure quality has focused predominantly on the clinical aspects of care, rather than on systematically measuring and improving people's experience of care. This is indicative of the broader failure to acknowledge that a person's experience of good care can translate directly into improved clinical outcomes for patients, sometimes at a lower cost and with more efficient use of resources.

Given these dynamics, any new model of care designed without people's input can run the risk of being rejected because it has been designed without incorporating the views and ideas of the people who use the service. There is perhaps no better example of this than the initial backlash to Sustainability and Transformation Plans, where the 'if you build it, they will come' assumption backfired in a profound way because of the perception of STPs as 'secret NHS plans' to reduce services and/or to privatise the NHS. Now in 2019, we see the advancement of STPs to Integrated Care Systems. Will ICSs, with a focus on footprints and patches, replace all the promises of devolution, with prevention as a priority, the consideration of the wider determinants of health, and the understanding of the important of place in addressing the needs of our communities?

Engaging people: Healthwatch working with GM and Surrey Heartlands

Healthwatch has been a critical success factor in the Greater Manchester Health and Social Care Partnership (http://www.gmhsc.org.uk). This partnership is an example of how people's views have been incorporated into the devolution process. Ten local Healthwatch teams across Greater Manchester, engaged with over 21,000 residents in 2018 gaining insight of their experience of using health and social care services across the city.

From working with young carers in Bolton to seeking the views of people visiting A&E in Oldham, the issues identified by Healthwatch staff and volunteers have been used to shape key decisions about the city's hospitals, GP surgeries and council run care services.

An investment of £60,000 by Healthwatch England and the Greater Manchester Health and Social Care Partnership will enhance the research capacity and capability of the local teams. This programme will take local level insight and turn it into robust evidence which will inform decisions that affect the whole of the Greater Manchester area. Healthwatch has also been invited to sit on the Greater Manchester Reform Board.

Another example is the Surrey Heartlands Health and Care Partnership (http://surreyheartlands.uk/). Surrey Heartlands one of the more evolved Integrated Care Systems. It has placed a significant focus on listening to people and taking into account their views to inform future planning. Surrey Heartlands offers its population the opportunity to co-design health and social care service improvements through Citizen-led engagement and communications

Effective and co-ordinated engagement, supported by robust communications, is vital to the success of the Surrey Heartlands programme. Given the scale of the challenge and change required, the leadership must be committed to putting people at the centre of the new health and social care landscape. An innovative citizen-led approach forms the foundation of the work. Working with a representative cross-section of the population to gain greater understanding of local people's priorities for health and social care planning, leaders can test assumptions, and use the data to inform planning.

Engaging with people on significant change within these health and care systems resonated. People saw engagement as a mechanism to strengthen their voice in deciding what is best for them, and as a way for people to better understand their own health and wellbeing needs. People feel strongly about wanting a voice in decisions about their care and the care of loved ones. But they were more likely to see this as a right, rather than as a strategy for improving care.

Success factors

The devolving health areas, whether fully devolved, STP or ICS, need to encourage and support people to share their experiences and create easy ways for them to become better informed and active participants in their own health and wellbeing. This will require giving people better information; improving overall health literacy; and finding new and effective ways to facilitate shared decision making and problem solving between providers and the public.

Many of the things people say are important to them are expressed through online surveys of peoples' experience of care. We won't achieve a truly person-centered system unless we routinely and comprehensively integrate the use of this data into the standard practice of how care is delivered. Survey results should be used by providers to continuously improve care, and the public reporting of results can then better inform people's decision making at all levels.

Devolved systems will need to invest in the critical infrastructure upon which person-centered care depends. The effective use of secure health IT is essential to improve communication and coordination by facilitating sharing information electronically across organisations and in collaboration with patients. Supporting people to 'tell their story once'.

We should also continue to invest in advancing how we measure, report and improve care based on meaningful metrics that assess health outcomes; how care is coordinated and how effectively people transition through different parts of the system; measuring how person-centered and equitable is the care; and are we efficient in how we use the limited resources available.

Conclusion

Listening to people will support health and care systems to address the challenges that people themselves say most affect their health outcomes. If we do not make the 'people's voice' the focal point for transformation, then there is a high probability that people will see these new systems as ineffective at best, and contrary to their interests at worst.

If we take the opportunity presented to us now to create a true person-centered health and care system, working in partnership with people and communities, I have great confidence people will embrace it, benefit from it, and it will be a success.

An opportunity to improve local health and social care infrastructure

Jonathan Murphy, Chief Executive, Assura plc

Introduction

> *"Estates is a critical enabler of the GM health and social care transformation programme which must continue to be fully informed and led by frontline service strategy."*

The words of Greater Manchester's 'Taking Charge' plan back in 2015, highlighting the role that would need to be played by the NHS's bricks and mortar in delivering Greater Manchester's vision of health and social care with its devolution deal[21] - the physical infrastructure accommodating millions of appointments, tests and treatments every year across the city region.

It sat alongside issues such as the design of contracting and payment systems – cogs which make the wheels of the health service turn. Or, to put it another way, the things which can hinder change and progress if they fail to keep pace. As the plan went on:

> *"The estate varies significantly in terms of quality, condition and suitability. Some of the estate is in excellent condition providing state of the art facilities, whilst at the other end of the scale there are a lot of properties that are in very poor condition and no-longer fit for purpose."*

[21] *Taking Charge of our Health and Social Care in Manchester: Greater Manchester Combined Authority, 2015*

The impact of devolution on improving infrastructure

Since 2015, there have been new NHS buildings opening across the city region, ranging from The Christie's new outpatients department, The Curve mental health facility in Prestwich and primary care centres in places including Urmston and West Gorton, the latter using its building design to dramatically reduce energy use for the GP practice inside. Work on CityLabs 2.0 has begun, a joint venture between Manchester Science Partnerships and Manchester University NHS Foundation Trust underpinning Greater Manchester's new genomics campus.

Different types of project deliver different aspects of NHS services and research, but beyond individual schemes across the city region, has devolution made an impact for the strategic issue of the right spaces in the right places for patients and services? Has Greater Manchester's increased autonomy allowed it to accelerate improvement to its healthcare infrastructure?

In terms of what we can see on a map, you might conclude that it hasn't – yet. The city region's NHS estate hasn't seen a dramatic ratcheting up of investment, nor is there a huge swathe of innovative new health buildings to point to. But look more closely and there's progress to consider: the potential impact of better utilisation of existing NHS buildings across the city region; detailed estates planning work across the whole health economy to prioritise investment and seize opportunities; and making sure the NHS's physical infrastructure is considered in the city region's wider strategy work.

The 'Taking Charge' Plan stated that the initial tasks for transforming Greater Manchester's health estate were to bring together a Strategic Estates Planning Board, develop a framework for making investment decisions and to draft local strategic estates plans: take stock of the existing estate, assess how it was performing, how it could be improved or better used, and identify what needed to be completely replaced. The Greater Manchester Health and Social Care Partnership's annual report for 2016-17[22] marks these as complete – as well as the creation of a capital financing strategy and local ways of working with organisations such as NHS Property Services. The partnership reports that it has also been master planning for acute sites, working to improve the use of space in community health centres and, crucially, bringing together local working groups to *"drive the delivery of estates projects" and prioritise development needs.*[23]

[22] *GMHSC Partnership Annual Report 2016-17: Greater Manchester Combined Authority, 2018*

[23] *Greater Manchester Health and Care Board Estates Strategy, 2018*

Getting the infrastructure right

And while some may consider these the less inspiring aspects of estates planning and analysis, they are vital. As the Nuffield Trust's work on the challenges and opportunities of robust NHS estates strategies puts it:

> *"Effective estates planning is a pivotal requirement of delivering integrated care and financial sustainability. It needs to be positioned 'centre stage', along with financial and workforce planning, if the goal of integrated care is to be achieved.*
>
> *While the interdependencies between estates and finance are obvious, the relationship between estates and workforce are perhaps less so. Yet the location and design of facilities – especially technology – can help resolve some of the workforce pressure points being experienced by providers, just as shifts in the shape and functionality of the workforce can have a powerful and positive influence on the infrastructure required."*[24]

From our experience of working with CCGs, NHS Trusts and STPs all over the country, Greater Manchester is perhaps further ahead than many on embracing those principles. It has focused these first years of health devolution on analysing what's needed, and where; which estates projects must come first and which must wait longer. Whether that's an output of the devolution process, of organisational partnerships which are more mature in age than those elsewhere or simply a necessity for a city region facing such huge health inequalities and demographic pressures on its health system really doesn't matter: if Greater Manchester got a blank cheque in the post tomorrow to tackle its estate issues, it should have strong evidence and process in place to get started.

The wider impact of health infrastructure devolution

Strategically, we've seen health infrastructure considered in the consultation on Greater Manchester's Local Industrial Strategy, which will focus on pillars including our ageing population and cleaner growth.[25] Meanwhile, the city region's draft Spatial Framework described the opportunities for new and improved health facilities as part of new housing development, and to support the integration of health and social care.

But given Greater Manchester's unique health planning powers, its stated commitments to reduce health inequalities and the goal of being a zero carbon city by 2038,[26] are there opportunities to be even more ambitious for the potential role of improved NHS infrastructure in those wider strategic contexts?

The NHS is the biggest public sector contributor to climate change,[27] and is the service which deals with the health impacts and costs of environmental issues at the other end. Its buildings are fundamental to this and Greater Manchester has the opportunity to set the tone for the role NHS buildings can play in future carbon reduction through more sustainable design, choice of materials, methods of construction and energy-saving technology.

Eammon Boylan, Chief Executive of the Greater Manchester Combined Authority told a meeting of the All Party Parliamentary Group on Devolution in 2017: *"Devolution is not about more money but about better application of money."* The current health devolution deal doesn't change the government capital constraints in which all health services are operating — and these are challenging indeed, with a spending review due. So where there is still huge opportunity for Greater Manchester to think differently is in its capital financing strategy for NHS estate.

[24] *Delivering Robust Estates Strategies: Challenges and Opportunities; The Nuffield Trust, 2018*
[25] *Building the Greater Manchester Local Industrial Strategy; Greater Manchester Combined Authority, 2018*
[26] *https://secure.manchester.gov.uk/news/article/8076/ambitious_climate_change_target_proposed_for_manchester*

As the centre looks for new ideas to fund major infrastructure, Greater Manchester can be a fertile testing ground — as a place which others are watching for creative solutions to fund improved estate borne out of its integration of clinical services and focus. As GMCA's own review of progress puts it:

> *"Decisions are now taken in GM by organisations based in GM…The cultural change this has brought should not be underestimated".*[28]

Conclusion

Every new NHS building starts with solid foundations. The same principles apply to the estates strategy for the health and social care services of a whole city region. Devolution has not yet led to radical, visible change to the health estate in Greater Manchester, but all the signs are that it has laid foundations to do so: a shared vision of the patient experiences and outcomes Greater Manchester wants for everyone, and of the healthier, zero-carbon place it wants to be.

Devolution plans have always recognised the crucial role that the NHS's physical infrastructure will need to play in achieving those goals. Like everywhere, capital funding from the centre, processes for accessing it and awareness of other funding options continue to constrain the pace of change for the places and spaces from which many of Greater Manchester's GPs, nurses, physiotherapists, health visitors, pharmacists, mental health specialists and hospital teams deliver their work.

However, knowing what you want from your estate, where you want it to be and how you want it to work for the health services and people within are the first steps to making the case effectively and finding solutions — and that's where, compared with other parts of the country, devolution can make a difference for Greater Manchester.

[27] *Source: Sustainable Development Unit*

[28] *Greater Manchester: The Emerging Impact of Devolution: Greater Manchester Combined Authority, 2018*

A new 'community anchor' role for acute hospitals?

Michael Wood, Head of Health Economic Partnerships, NHS Confederation

Introduction

For many in England, the acid test of devolution lies in its local alignment between economic and social development. While HM Treasury may judge the success of localising power and finance through the prism of expected regional productivity and GDP/GVA gains, for the local population change needs to be felt on the ground in terms of improvements to the more mundane daily life experiences of jobs, transport, housing, health and public services and learning opportunities, for example. As the leaders of a given place ponder how to marry these twin aims and develop a local economy that spreads the benefits of economic growth more evenly across its communities, there are some very real questions for sectors such as the NHS that are more used to engaging in a national debate.

The development of Sustainability and Transformation Plans (STPs) and, more recently, Integrated Care Systems (ICSs) gives some clues as to how the NHS, and in particular its acute providers, can and should approach this 'place' question.

As we speak, these systems are prioritising their strategies for wider population health, ensuring a more proactive system-based approach that seeks to understand at the outset the links between the determinants of health, health behaviours and lifestyles, and the places and communities in which we live. And at the heart of this local system maturity is an understanding that our acute hospitals are critical assets in addressing these issues and have a clear and growing role to play.

Acute hospitals: from assets to anchors

This puzzle of how to unlock the full potential of our fixed local health and care assets within an emerging population health system is also analogous to devolution, which places asset growth at the centre of local economic and social development. Seen from the outside, the NHS certainly represents a significant local asset.

The language is important here. These assets are often referred to as 'anchor institutions', a term used to describe large, spatially fixed organisations with a social purpose that play a significant and recognised 'mooring' role in the local economy and community. Anchor institutions are what make a place distinctive, helping bring both an identity and a sense of belonging. They also play a critical role in creating economic and social benefits that stimulate local prosperity, given that they often pay higher than average wages, offer career progression, develop supply chains, invest and attract others. Businesses may come and go, investment may thrive or dry up - these anchors will remain.

Acute hospitals in England are increasingly understanding this concept and their role in place-shaping through aspects such as their workforce, purchasing power, investments, commercial potential and wider influence on the local surroundings. Devolution across a place gives this anchor understanding a wider local support network and fresh impetus for change.

A national perspective

First, let's look through the national lens. As an employer of 1.3million people, with an annual budget of £114billion in 2018/19, the English National Health Service is becoming more aware of the economic and social value it creates in its local communities. In its recently published Long Term Plan, which set out a 10-year vision to improve the quality of patient care and health outcomes, NHS England encouraged its hospitals to further develop the 'anchor institution' concept — highlighting that in many local areas across England the NHS is the biggest employer and one of the main procurers and land owners. Further to this, the NHS has a world class innovation reputation that drives important economic sectors such as life sciences, medTech and digital health and supports business competitiveness and productivity more generally through its population health plans.

While this certainly reflects progress in terms of the necessary thought leadership, we are still a long way off having the national metrics and culture needed to translate what acute providers routinely do into something that makes sense to their local communities and economies. For this reason, progress will likely be driven furthest and fastest at the local, devolved, level.

A local perspective: population health is population wealth

Locally, while the demands on our providers of health services show no signs of abating, there is an increased understanding in acute boardrooms of the need to influence the wider community outside the hospital's four walls. The drivers for this approach are multiple: for example, managing demand for services simply cannot be done from within (and nor can it be detached from the local economy); NHS workforce pressures (and challenging local labour market dynamics) now require much more innovative ways of encouraging local people into clinical and non-clinical health and care careers; a sustained lack of NHS capital funding means future estates plans increasingly involve wider local collaborations with other public and private partners; there is often a disconnect between hospitals and local industry innovation clusters despite the need for new system solutions focused on our data and patient reach; and last but not least, an important acknowledgement that engagement with communities has often been too reactive and legalistic, stifling the change that successive plans (local, regional and national) have stated are necessary.

The anchor role in practice

There are various ways in which these changes are being taken forward in practice. Some acute hospitals have appointed in-house public health teams to engage staff and patients on ways to prevent disease and promote and protect health and wellbeing. Other providers have their charitable trusts investing large sums in community-led solutions to urban health and care issues with a view to up-scaling successful projects throughout the organisation and beyond.

Acute providers are also reviewing their role in community-based provision, such as through implementing the popular Buurtzorg nurse-led model from the Netherlands. It can also be about partnerships too. Trust directors are increasingly seeking board positions with non-traditional NHS partners, such as Local Enterprise Partnerships (LEPs), for whom tackling local inequalities is fast becoming an economic priority. They are pleasantly surprised how welcome they are made too, which highlights a growing understanding from the outside of the economic and social role of the NHS.

Whereas in the past we have seen examples like this happen in isolation, the development of the population health agenda, coupled with a more devolved model of system leadership, is becoming a helpful framing tool for these discussions.

Turning challenge into opportunity

It may well be the case that the drivers for acute providers developing this greater out-of-hospital focus are seen in the first instance as challenges, but that would be to ignore the opportunities that such an approach can bring, particularly when part of a devolved system.

The economic context since the 2016 EU referendum is one where the biggest challenges to growing a local economy are social. To be blunt about it, the minds of our local leaders are focused on upskilling local people and getting them into work where they will pay tax and be happier and more productive, perhaps employing others and thus paying business rates, which are now directly financing local public service provision. They will certainly be less dependent on our public services and importantly an inspiration to their children and others who will want to follow their lead. Local people defining the future workforce, resilience and prosperity of their communities. This cycle explains why we are seeing the measure of local economic success moving from wealth to well-being.

With this will come opportunities for new funding, resources, partnerships and profile which, if they did exist previously, were perhaps not as open to acute providers and the wider NHS as they are now.

Health devolution and local industrial strategies

One example will be the development of LEPs – led by Mayoral Combined Authorities (MCAs) or Local Enterprise Partnerships and bringing together partners from the public, private and civic sectors to identify local priorities to, for example, improve skills, increase innovation and enhance infrastructure and growth. These strategies are intended to be long-term, collaborative and evidence-based and will likely guide the use of local funding streams and any spending from national government, as well as potentially outlining policy areas for future local devolution deals.

The economic success of the local NHS is and always will be closely connected to the economic success of the place, meaning these MCAs and LEPs are increasingly interested in how to support the NHS to successfully provide services but also to integrate them more into economic discussions around their Local Industrial Strategy. This presents a clear opportunity for the anchor institutions within the NHS to become much more influential in local decision-making processes and in turn address some of the societal and economic issues that drive their demand.

Conclusion

A critical part of the 'success' of a given place is its assets. This is particularly the case in any form of devolved system, where the joins between the local resourcing and provision of public services are so intricately linked — in short, places are now being challenged to stand on their own two feet.

It might not yet be a standard part of NHS language and behaviour but this approach to asset growth offers an insight into the future role of our hospitals in devolution and the opportunities that exist for the wider NHS as the place becomes the main unit of change.

When seen in isolation perhaps little of this is new. What has often been missing is the ability to focus so many minds locally on a common goal: making an area as prosperous as it can be. Devolution brings us that focus and the acute providers in the NHS should be at the forefront of leading the change.

A new opportunity for collaboration with charities

Sally Bagwell, Deputy Head of Charities and Nathan Yeowell, Head of Policy and External Affairs, New Philanthropy Capital

Place as the basic unit of social change

The places where we live and work define who we are and what we do. They determine the nature of our relationships with our fellow citizens and the communities we create together.

Shifting technological, political and social trends, triggered by austerity and global economic uncertainty, have led to calls for greater, more fundamental forms of devolution and the promise of more comprehensive, radical systems change at a local level. In response, interest in 'place' has shot up the public policy agenda.

At NPC, we're more and more convinced that place needs to be the basic unit of social change, and we're encouraging charities and funders to think more systematically and constructively about the opportunities that greater place-based activity might inspire.

Place and health

In a country with a nationalised health service (and hence a reasonably consistent level of provision), the wide regional variations we see in health outcomes are powerful evidence for the importance of places to people's health. There are national factors at work, but the fact the *"least deprived areas had the highest male life expectancy (83.1 years) while the most deprived areas had the lowest life expectancy (74.0 years)"* speaks volumes about the importance of places to our health.

Conversely, the success of efforts to address these unequal outcomes, such as the East London Clinical Effectiveness Group,[29] provide reassurance that locally driven activity can substantially impact the health of a place.

And health is an obvious area where greater local collaboration has the potential to improve outcomes. Together, charities and funders can design and deliver services that address local social determinants of health and barriers to stronger, collective community wellbeing.

Achieving this isn't easy. But more sustainable solutions, rooted in and tailored to the communities that need and use them, are a prize worth striving for. In this essay we're going to set out our basic thoughts on place-based approaches, make the case for greater engagement and integration of health charities in this and end with an example of a charity leading in this area.

[29] https://www.qmul.ac.uk/blizard/ceg/

What does 'place' look like for charities and the health service?

Place-based approaches are characterised by a shift away from centrally-dictated policy, operated in siloes, towards holistic solutions, defined, generated and delivered locally—generally determined by local authority boundaries or defined geographic units within them. In practice, this can usually be cut into three levels;

Community or people-focused work: this seeks to address the assets of the people in a geographic area to tackle and the factors that cause disadvantage there. Charity or health programmes with this focus might centre on exercise, ending isolation, community development or promoting self-help.

Systems or institution-focused work: tackles the potential causes of negative outcomes and/or the failure of local systems and services in a particular location, e.g. lack of coordination or responsiveness to local needs and cultural differences. Charities generally try to do this either through overt lobbying of institutions or by joining up services between themselves and, ideally, the other players in a place. In the health service these programmes tend to be government-led, focused on strategic partnership working and collaboration.

Structures or wider environment-focused work: this work asks how we react in a place when the potential causes of social problems are structural, resulting from macro trends in the economy or other major areas such as technology. Both charities and the health service try to tackle the national issue at a local level through things like economic and physical regeneration, smoking cessation or increasing access to mental health provision.

Place-based work on these different elements can have a major impact on an individual's health, even if it does not have an explicit 'health' focus and it is often the holistic benefit to an individual that a charity offers which can be of such importanct to their overall health.

What are the benefits to health of involving charities in place-based initiatives?

In the course of our research, frontline commissioners and health and care leaders we spoke to told us that charities can do certain things particularly well, often things that the health service is not equipped to do itself. Based on the findings of our 2016 report *Untapped potential: bringing the voluntary sector's strengths to health and care transformation,*[30] there are two ways we want to highlight where charities can add massive value to existing or emerging place based health initiatives.

1 Listening to patient voice and co-producing services:

Some charities are experts at integrating the views and concerns of the people they work with into their practice, what is sometimes referred to as 'user voice'. Some go further still and try to ensure that their services are designed with the people who are going to be using them. Charities are often good at understanding the patient experience, working bottom-up on problems, building on existing capabilities, sharing decision making and facilitating rather than delivering.

Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using their services, their families and their neighbours. This approach is often one used by many charities in their work.

> *"We needed a strategy shift from just treating ill health to helping people control their lives. It was driven by the goal of starting conversations with the patient—that's a key part of third sector expertise."*
>
> **Tracey Roose, Director of Transformation, NHS Kernow CCG**

[30] https://www.thinknpc.org/resource-hub/untapped-potential-bringing-the-voluntary-sectors-strengths-to-health-and-care-transformation/

2 Taking a holistic approach:

Charities are regulated but far more loosely than the health service. They have the freedom to set their own targets and approach issues from a range of angles which, in a health service rightly focused on outcomes, is not always possible. They are often better able to focus on whole person care, build relationships, give priority to wellbeing and address some of the social determinants of ill-health.

Charities also benefit from being embedded in communities. Whether at the charity shop, a community space or a regular event, charities interact with people in their day to day lives, outside of the setting of a hospital or a doctor's surgery.
They are therefore well placed to embed thinking about health into people's lives. They can adopt a non-specialist approach that takes account of more than a single, immediate condition and differing personal circumstances.

> *"The voluntary sector doesn't have the 'white coat effect', they don't have the ten-minute appointment, they have a chance to really engage with people and create in-depth relationships."*
>
> **Jeremy Bennett, Strategy and Planning Support Officer, Leicester City CCG**

3 Stitching together different services:

Charities often coordinate different aspects of emerging place-based systems—whether offering information or guidance on the most local services, assisting professionals from other sectors with information and referrals or helping patients to navigate between different parts of the system.

> *"What makes a third sector project stand out? The ability to co-ordinate public partners and the wider sector partners."*
>
> **Will Cleary Grey, Programme Director, Commissioners Working Together Group**

Our research with the Richmond Group of Charities in Somerset[31] demonstrates the power of charities playing a bridging role. The Group's programme managers were able to bridge gaps within and between the VCS and the statutory health and care sectors.

Previous research into cross-sector collaboration has shown how benefits stem from drawing synergy from the differences between organisations. The way that the local charity programme manager worked creatively across sectors meant that she was able to navigate those differences, open up conversations, and build relationships. Similar approaches have worked well in other areas.

But our work in Somerset also shows just how challenging it can be to achieve meaningful place-based, cross-sector collaboration. The dominant commissioning model means that charities are often competing for scarce resources, while the strict purchaser-provider split makes it harder to collaborate across sector boundaries. Successful place-based collaboration means overcoming or bypassing some of these tensions.

[31] https://www.thinknpc.org/resource-hub/tapping-the-potential/

Case study: Guy's & St. Thomas's Charity (GSTT)

GSTT is a place-based charity that works in the London boroughs of Lambeth and Southwark with the explicit aim of improving the health of local residents, focusing on a couple of complex issues at any one time. The current focus areas are tackling and reducing childhood obesity and improving health and care for people with multiple long-term conditions. Since 2017 their explicit place-based approach has combined data, evidence and insights from local people's lived experiences in order to shape programmes and build partnerships at different scales to help drive better health outcomes.

GSTT works on three geographic levels, both contributing to ideas and delivering services on the ground in partnership with other local bodies:

- At a neighbourhood or ward level to test and trial new solutions;
- At individual and combined borough levels to adopt and scale approaches that work;
- At a national level to influence social and policy changes — and encourage others to adopt approaches that work.

Their approach to tackling childhood obesity provides insight for other lifestyle-related health issues. Following a review of international evidence, they realised how much social and wider environmental factors shape the choices we make about what food we consume, and how we consume it, which in turn influenced their decision to focus efforts on promoting more informed and positive decisions about food consumption. As part of their current strategy they work with local supermarkets to promote healthy eating; with schools to reduce the visibility of unhealthy food; and with families to try to ensure that positive cultural changes extend to the home too.

Conclusion

In closing, we will quote Jon Siddell, Director of Funding at GSTT, who sets out what he believes are the fundamental merits of this whole approach. We believe in them, too.

> *"First, place-based working really allows you to get into the context of issues, and perhaps better understand the true nature of the national challenge. Second, there is a speed to place-based learning – working alongside residents, civic society, the public sector and businesses – that can shift understanding in a short space of time. Given the urgency of so many issues, this feels an approach we should be making much greater use of."* [32]

[32] https://www.gsttcharity.org.uk/get-involved/news-and-opinion/views/4-things-weve-learned-taking-place-based-approach-urban-health

4 A political perspective

The politics of health devolution, integration and social care funding

Phil Hope, former Minister of State for Care Services

Introduction

Over 70 years ago the founding father of the National Health Service, Nye Bevan, said 'the sound of a bedpan being dropped in Tredegar Hospital (in his Ebbw Vale constituency) will reverberate around the Palace of Westminster.'[33]

That national ambition at the birth of the NHS is no longer true today. Significant steps have been taken to decouple national political policy makers from local delivery decisions about NHS services including the creation of NHS England (NHSE) as an arms-length body separate from the Department of Health and Social Care (DHSC); and, within NHSE, the recent development of 44 local powerful joint Integrated Care System (ICS) bodies to run the NHS by 2021.

The first step was an overtly political decision intended to depoliticise the NHS which was always seen as a vote winner for Labour and, at best, a score-draw for the Conservatives. The second was a managerial decision intended to locate power and responsibility for health more closely at the frontline where the impact of change is most immediately felt.

[33] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf

National politics

These actions, however, have been only partially successful in reshaping the politics of health generally and the NHS in particular.

The new DHSC/NHSE divide has not removed Ministerial influence over the NHS but it may have changed the balance of power. There is now a comprehensive set of arrangements for information sharing, consultation, accountability and decision making at every level between the two, including regular meetings of the Health Secretary and the NHSE CEO. The personal style of the individuals in those posts is a key element in this new relationship and the political dynamics will change again when the people change.

It also remains the case that if local health policymakers propose a big change such as a difficult service reconfiguration then a Health Minister will be expected to answer a local MP's questions in Parliament and do something about it. This is why local health leaders take great care to engage actively with their local MPs on all major decisions and respond promptly to individual health casework.

More broadly, any future general election will undoubtedly feature the NHS centre stage, and the promise of more money for health was arguably a key political driver of support for Brexit in the 2016 referendum. It is not by chance that the NHS recently won a five year £20bn financial settlement entirely separately from all other government spending plans.

The public and MPs will always know that the Secretary of State for Health will have to stand at the despatch box to be held accountable for how £120bn of taxpayers' money is being spent.

The complete removal of politics from the NHS is an illusion but the creation of NHSE separate from the DHSC, and a new NHS Assembly has blurred the lines of political accountability for its performance and management.

Crucially, competition as an underlying principle of management of the NHS is the preferred Conservative alternative to Labour's perceived top-down style. However, the NHS Plan both rejects competition in favour of collaboration and promotes a local population-based approach based on evidence of what works from a series of vanguard projects. These major shifts suggest that the locus of power over the NHS in England has to a large extent shifted out of Whitehall. And whilst some have raised fears that this may open the door to privatisation of the NHS, there now appears to be a broad consensus between the main political parties in support of the new collaborative and localised strategy in the NHS plan.

Devolution or 'hard' delegation?

Devolution of public health has already happened through the transfer of responsibility and funding to local authorities. This has been a significant change enabling some areas to be highly creative and ambitious in their thinking about preventing ill-health for their local populations.

In contrast, whilst the new ICS structure and the new Primary Care Networks represent a significant delegation of power to local areas, NHS management accountability to the centre is still retained through regional offices of the NHS.

However, the idea in the NHS Plan of 'earned autonomy' for successful ICSs suggests this delegation could go further and there could be less command-and-control over local areas by the centre. Light touch monitoring rather than top-down management and intervention will become the new norm in many areas. This represents a second significant shift of power, this time from the centre to the local — 'hard' rather than 'soft' delegation if you like.

So, genuine devolution of health service commissioning power, money, service delivery and performance management of health to a locality has not happened. Greater Manchester which secured a unique health devolution deal (control of the GM health budget in return for a directly-elected mayor) as part of a wider transport-led devolution deal is, in reality, an example of 'hard' delegation and earned autonomy in practice.

This fact has not stopped the local health and social care partners in GM choosing to behave as though it was devolution. They have adopted a culture of devolution in the way they work together; and created a new, largely hidden, set of agreements and protocols to work around the legislative and organisational barriers to doing so. Social care, health and public health budgets have been pooled at Local Authority level with a single accountable officer for all revenue streams. By jointly taking an 'ask for forgiveness not permission' approach to local decisions they are, in effect, delivering health devolution including integration of disparate services within health, integration of health with social care and more ambitious public health programmes.

'Hard' delegation could open the door for more local partners to create local structures similar to Greater Manchester which bind together clinical and civic leaders in new joint organisations that have power that the centre will be less able to override, except perhaps in a crisis.

Local politics

'Hard' delegation and genuine devolution leading to genuine integration with social care in which local councillors have a real say in combined decision-making structures with the NHS, opens up the opportunity of delivering full health and social integration everywhere. But it also raises challenges about the role of local councillors in determining clinical priorities.

This works at a number of levels. First, devolution could simply add the local politicisation of health to the national political dynamics. Metro Mayors or council leaders seeking re-election could seek to gain electoral advantage from claiming better health and social care investment, services and outcomes in their area. And, of course, suffer politically if they are blamed for decisions on health services that their electorate does not like. It will be important that structural safeguards are created to avoid political rather than clinical criteria determining key decisions about what will deliver the best health care for a local community. With growing fears today about the rise of populism, the necessity of setting these protective parameters should not be underestimated.

Second, the key issues about what good looks like in the world of acute and high-tech health care may not be familiar to local councillors and Metro Mayors who may be better versed in social, community and public health care. Considerable time and effort will be needed to build knowledge and understanding of health issues among elected representatives and council officers, and to build open and trusting relationships between civic and clinical leaders in both the community and acute healthcare sectors.

Third, health devolution could create a new political dynamic between the policies and priorities of locally elected leaders and those of the government. As yet these tensions have not emerged but if devolution becomes the new future for health and social care they will need to be recognised and actively managed. A failure to do so would risk a national-local political divide that could at best be used for point scoring in local or national elections or at worst to a stalemate in progress to the detriment of local services and patients.

Postcode lottery

A different political challenge is how to manage the electorate's concerns of a 'postcode lottery' of health and social care in which the availability and quality of health care (such as waiting times for an operation or the availability of IVF treatment) vary for no defensible clinical reason.

Social care inherently varies significantly in the amount and nature of services it provides in different locations and among different families. This is because the assessment of a person's care needs that could be met by the state rightly takes into account the support that could be provided by their family; and because the organisations and facilities to support people with care needs inevitably vary hugely between different locations such as rural or urban communities.

Crucially, to avoid the sense that this is an unfair lottery based on location, social care seeks to ensure the care outcomes of the service (independence, dignity, control) are similar wherever people live. The pattern of care services may vary between places but the benefits they bring are the same for people with similar needs.

Arguably, the same is true of the NHS. Each geographical footprint area assesses the health needs of its population and commissions services to meet those needs. Those assessments and those services will inevitably vary according to local demographics, geography, industrial history, economic circumstances and so on. This is not a postcode lottery where health services vary because of poor performance and inadequate funding based on where people happen to live. Rather, it is a planned approach to achieving the best health outcomes for that particular population. The pattern of health services is different between one area and the next but the benefits seek to be the same for people with similar clinical needs.

So, combining health and social care services in new devolved structures and organisations will rightly lead to local variation between areas as long as they are based on achieving similar health and care outcomes no matter where people live. Local services can be designed in a bespoke manner to suit the specific health care needs in the area (such as higher incidence of conditions like lung cancer in a particular area) but not vary in their quality. Devolution is not and should not become a justification for unacceptable variation in key health measures of performance such as waiting times to be seen in A&E.

The challenges to integrating health and social care

The challenges to delivering the ambitious and worthy NHS Plan are huge, not least because the obstacles to full health and social care integration are profound: structural, financial and professional. Health care in England is free at the point of delivery, funded through general taxation, commissioned by a network of local commissioners accountable to NHSE through regional structures, and delivered by a mix of mainly public sector and some private sector providers. Although the goal is an NHS that successfully addresses local needs, the public expectation is that we will all get the same kind and quality of health care wherever we live.

Social care services, in contrast, are means tested such that people with savings and assets above a threshold have to fund their own care. Care is funded by local council taxes that vary between areas, services are commissioned by top-tier local councils, and care is delivered mainly by private sector and some public and charity sector providers. Unlike the NHS, public expectations about social care services are often confused, with people often unprepared for the reality of having to pay for it themselves or the variation that exists between different parts of the country.

However, despite these fundamental challenges, there has been a great deal of progress to join up the two systems at a local level. This success has been driven partly by a desire among local professionals to improve people's (particularly older people's) experience of the health and social care they receive; partly by the availability of ring-fenced Better Care funding for creating local integrated services in the community; and partly by the evidence of the financial benefit of investing in social care services that reduce health care costs such as reducing delayed transfers of care from hospital to home.

Experience in Greater Manchester and elsewhere[34] strongly suggests that greater integration of health with social care requires 'hard' delegation if not full devolution of health budgets — in this respect integration and devolution are two sides of the same coin. Without full delegation of health budgets to local levels the integration of health and social care services cannot happen. With full delegation or devolution, the door is open to achieve the long-held ambition for a fully integrated health and social care system.

[34] *Is devolution the future for health and social care? Phil Hope and Steve Barwick, DevoConnect, January 2019*

The politics of social care funding

This vision of health and social care integration through devolution cannot be fully achieved, however, as social care funding, provision and outcomes vary hugely between different parts of the country. This is due to the varying impact of significant reductions in government funding for different councils over the last ten years; the new council tax social care premium funding regime for care which varies hugely in the amount it raises between areas; and because social care is means tested so areas with higher numbers of people on low incomes will have more unmet demand for council funded care than wealthier areas.

Social care funding is thus the 'elephant in the room' in the politics of health and social care integration through devolution. It is not just the most significant barrier to the integration and devolution direction of travel, but also the biggest threat to the success of the NHS Plan.

That plan is based on the agreement that 'adult social care funding is such that it does not impose any additional pressure on the NHS over the coming five years'. This statement in the plan is not just the leadership of NHSE covering its back if the changes don't work. It means that the financial sustainability and operational success of the NHS Plan relies on getting social care funding and delivery right as well. So something has to change in the funding of adult social care if the NHS plan is to succeed, and our aspirations for an integrated, person-centred health and social care system are to be achieved.

In the short term, the Comprehensive Spending Review 2019 has been delayed until the financial implication of whatever Brexit deal (or no Brexit) has been established. It is unclear what councils might expect in ways of national financial support or permissions to increase local taxes to fund social care. The long-term settlement for social care funding in the Green Paper has also been delayed by Brexit and by the political nature of the challenge to raise additional resources in a fair and comprehensive way.

It is difficult not to be pessimistic. The policy of allowing local councils to raise a ring-fenced 2-3% care levy each year on top of the council tax to help fund social care services has enabled councils to raise money for care at a time when national financial support for councils has been steadily withdrawn. But this approach has a number of significant weaknesses making it an unsustainable approach for the long-term funding of social care.

Firstly, it simply does not raise enough money to pay for all social care needs even in a means tested system. In 2018/19, 148 out of 152 adult social care authorities used some or all of the 3% adult social care precept flexibility when setting their council tax but generated only £538m.[35] For 2019/20 the LGA has estimated that even if all councils used their council tax flexibilities to the maximum allowed, adult social care services still face a funding gap of at least £1 billion in 2019/20, just to maintain existing standards of care. This gap will rise to £3.6 billion by 2025.[36] Secondly, council tax is highly regressive in its impact on local tax payers with the poorest paying disproportionately more, so it is not a fair taxation system for funding social care for an ageing population. And thirdly the distribution of the income it raises varies massively between councils in different economic areas with the areas of most need raising least income.[37]

[35] *Council tax levels set by local authorities: England 2018-19 - revised*
[36] *Council tax will fail to protect adult social care services this year*
[37] *The end of formal social care*

A fair national alternative

A variety of proposals for raising more money, more fairly for social care have been floated by a wide range of think tanks, commissions, and inquiries over the years. These include proposals for payment thresholds and caps in the current means tested system; the introduction of National Insurance payments by older people; increasing the basic rate of income tax to fund free care; new voluntary insurance schemes for individuals to save and pay for their own care; and various voluntary equity release schemes. Each has its advantages and disadvantages in the amount of money they raise, the fairness in who pays and the impact each has on people's income, savings and assets. Ultimately, any new financially sustainable system that can meet the nation's growing social care needs will require some degree of compulsion to contribute in order to share the risk of costs to be met by any individual or their family.

My preferred option is a national care levy on property. The local care levy is a ring-fenced property tax to pay for adult social care. So, it does not seem such a great step to apply this approach to create a national ring-fenced levy on domestic property when someone dies which would create a national care fund to pay for social care for those who need it. The financial argument for this solution seems inescapable. The shrinking dependency ratio means fewer working adults paying income tax to fund the social care of a growing number of retired people who are living longer with increased care needs, and who have unearned and growing wealth in their housing assets.

Of course, a national care levy on property, like all other options, is open to political challenge. It was previously dubbed a 'death tax' by its opponents, and another alternative was dubbed a 'dementia tax'. Any substantive change that creates a fair, sufficient and sustainable funding solution for social care requires a national political consensus and would be politically challenging to make happen without cross-party support. The current climate for this does not look good but doing nothing is not an option.

Conclusion

There is a risk that health devolution could reduce the national leverage that the NHS currently has to secure resources and attention. Arguably, both social care and education have not been able to achieve the same degree of influence in Whitehall as the NHS because their local control gives national government a political way out of taking responsibility for the services and outcomes. However, the centrality of the NHS to our national political culture is so strong that this is unlikely to be the case.

A long-term, sustainable and fair means of funding free social care at the point of delivery would resolve the biggest structural obstacle to devolving and integrating health and social care services to ensure far better care for all.

Devolution in Scotland freed policymakers to introduce free personal and nursing care; and in Wales the means test threshold for paying for care is higher with a maximum weekly amount to pay for non-residential care. These country-based differences open up the question as to whether there is an option on resolving the funding of social care on a devolved basis within England. A devolved care levy on income or wealth would have huge implications for tax raising powers at a local level and the associated legislative framework but is worthy of further consideration.

In the meantime, the drive towards delegation and devolution of health combined with new approaches to integrating health with social care is gathering pace on the ground despite, rather than because of, national political leadership. Local civic and clinical leaders are getting on with making it happen by asking forgiveness rather than seeking permission, and presenting national policymakers with a 'fait accompli'.

Government Ministers should never be able to duck their accountability for the NHS but it could well be the case in future that the apocryphal dropped bed pan will soon be heard loudest in the town hall rather than Westminster.

Politics is changing and how you shape, inform and influence policy and decision making needs to change too. DevoConnect is a consultancy with a mission: to help make devolution work for communities, businesses and wider stakeholders. Our thought leadership, public affairs and communications services work to shape policy and influence decision making at the devolved level (sub-regionally and locally) as well as nationally.

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