# Building Back Health and Prosperity

## Report of the Health Devolution Commission

***Authored by Phil Hope and Steve Barwick***

devo connect

# Contents



*Please note the authors of the report are Phil Hope, former Minister of State of Care Services and Associate of DevoConnect, and Steve Barwick, Director of DevoConnect*

devoconnect
Connect. Communicate. Change.

DevoConnect is a public affairs and thought leadership consultancy with a difference: it has a purpose - to help build more and better devolution across the UK. Working with public, private, and voluntary organisations it designs and delivers communications strategies and thought leadership, research and intelligence, training and event management, that help organisations communicate their ambitions and influence tomorrow's decision-making process today.


For more information please contact
**Chief Executive, Gill Morris**
**gill@devoconnect.co.uk**


# Foreword

Now is the time for true transformation and to build back a better NHS and social care service.

The Covid-19 pandemic has fundamentally changed our world. It has affected every child, adult, family and community in our country with the biggest impact on the most economically disadvantaged and those from Black, Asian and Minority Ethnic communities. It has put the severest pressure on our NHS, social care and public health services exposing in the starkest terms the divide - the lack of parity - between them. It has touched upon every aspect of our lives – the way we work, our enjoyment of sport and the arts, our leisure activities and holidays, and our family and relationships to name but a few. Crucial action to control the pandemic has had a catastrophic consequence for our economy and jobs that will be with us for years to come.

We began our work as a cross-party Commission before the pandemic hit. Our aim then was to scrutinise, illuminate and spread the potential of a novel approach, already underway in different parts of England, most visibly in Greater Manchester, to improve the health of communities and deliver better health and social care - health devolution.

That aim has changed. We believe we have to go further, faster. There has never been a more important time to think radically about the future. To be bold in the way we build back better health and prosperity, improve public services and tackle health inequalities within and between different parts of the country.

We believe we are at a crossroads. We have a choice between a future in which there is greater centralisation and control of the NHS and social care services, or a health devolution approach which incorporates national entitlements and targets but embeds the delivery of an integrated NHS, social care and public health service within broader, powerful, democratically led local partnerships.

Our report is clear. The pandemic has shown we cannot go back to the way things were. We need a 'new normal' and we believe that comprehensive health devolution is the only viable solution to the challenges the country now faces.

We thank the former Health Department Ministers from the three main political parties for their involvement and support. And we are hugely grateful to the many organisations and individuals who gave written submissions, spoke at our hearings, joined our roundtable discussions and actively participated in meetings of the Commission.

We thank too Phil Hope, former Minister of State for Care Services, and Steve Barwick, a director at DevoConnect, who between them managed our work as a Commission and authored our report analysing the many valuable contributions and developing our conclusions, recommendations and agenda for action.

We commend this report to you.

.

**The Rt Hon Andy Burnham, Mayor of Greater Manchester, and the Rt Hon Sir Norman Lamb**

*Co-Chairs, The Health Devolution Commission*

# Executive Summary

The Covid-19 pandemic has had a far-reaching and profound impact on the future of our health, social care, public health and economic landscape. The pandemic has had a disproportionate impact on economically disadvantaged and Black, Asian and Minority Ethnic communities. People living with particular conditions such as cancer, mental ill-health and dementia have been badly affected. Health inequalities are worsening, NHS and social care services are deeply divided, demand for care is increasing, the capacity of the system to respond is weaker, community institutions are struggling, and the prospects for the economy and jobs is alarming.

If ever there was a compelling 'burning deck' of circumstances that requires an urgent and radical response it is now.

We must not only integrate our NHS and social care services but also relocate the NHS within a new and comprehensive framework for rebuilding the health and prosperity of our communities and our nation.

***We cannot go back to where we were. There needs to be a 'new normal'.***

The cross-party Health Devolution Commission believes there is now a fundamental choice to be made: between greater centralisation of NHS and social care services or a comprehensive health devolution approach which incorporates national entitlements and targets but embeds the delivery of an integrated NHS, social care and public health service within broader, powerful, democratically led local partnerships.

We are clear about the case for change, submit this report as a formal contribution to that debate and call on the Government to build back healthy, resilient and prosperous communities through radical comprehensive health devolution that delivers the 'levelling up' of our economy. The Government should:

## Agenda for Action

### 1 Commit to the principle of comprehensive health devolution

Good health devolution should be comprehensive with the purpose of delivering better health and social care outcomes, improving public health and reducing health inequalities, integrating health, social care and public health services, and helping to build local economic prosperity through a local democratically led, place-based way of working.

### 2 Adopt comprehensive health devolution as the best way to reform social care

Comprehensive health devolution should be adopted as the most viable solution for radical reform of social care through integrating local social care and public health services with NHS (physical, mental and acute care health) services, and delivering a 'health in all policies' approach to other services such as housing, employment, transport, education, the environment and economic development.

### 3 Implement a rapid delivery programme for comprehensive health devolution across England

Comprehensive health devolution plans should be developed in all parts of England within 12 months through a new comprehensive health devolution mandate agreed jointly with locally elected leaders that reflects local boundaries and organisational footprints.

### 4 Accelerate integrated workforce planning and management

Comprehensive health devolution should be supported through integrating the planning and management of the health, social care and public health workforce within devolved areas, as part of a broader People Plan and in consultation with employers and trades unions, to meet local employment needs now and in the future.

### 5 Support parity of esteem within mental and physical health, and between health, social care and public health funding

Comprehensive health devolution should be enabled through an immediate increase in social care and public health funding together with a commitment to parity of esteem within and across NHS, social care and public health funding; the creation of single local NHS, social care and public health budgets; and a new, well-funded long-term settlement for social care that provides better support to more people in need.

### 6 Recognise the central importance of partnerships, engagement and involvement

Comprehensive health devolution should have at its core genuine and deep-rooted partnerships with key stakeholders and community-based networks including patient voice and carers organisations, clinicians, voluntary, community and social enterprises, and local employers and trades unions. At the heart of good health devolution should be close working relationships between clinical and civic leaders; community involvement and active citizenship; and parity of esteem between the public, private and voluntary sectors.

### 7 Implement the twelve specific recommendations of the Commission

Comprehensive health devolution should be taken forward through delivering the twelve detailed recommendations of the Commission: for taking early action to adopt and implement comprehensive health devolution; properly fund and integrate NHS, social care and public health services; establish new mechanisms for accountability and scrutiny; and give legislative support to the changes.

## Rationale

Health devolution is already underway in different ways and in different areas such as Greater Manchester, London, West Yorkshire and Harrogate, and Combined Authority Areas, as well as through different bodies such as Integrated Care Systems, Cancer Alliances and Health and Wellbeing Boards. However, there is no common, consistent or comprehensive understanding of what good heath devolution looks like, the benefits it brings or how it should be developed.

This was the starting point for the work of the Health Devolution Commission. Since then the Government has not only sought to implement the NHS long term plan, it has also published a Green Paper on prevention, put in place a task group on social care reform and published an NHS People Plan. The White Paper on Devolution remains eagerly awaited.

The Covid-19 pandemic began after the Commission started its work and has had a profound impact upon the health and social care landscape and the economy in England with key lessons to be learnt from the experience here and in other countries for the future.

It is clear that as the nation recovers we cannot afford to return to the previous ways of doing things. The pandemic has served to emphasise in the strongest possible terms the case for comprehensive health devolution as the most viable solution for delivering an integrated NHS, social care and public health service, improving public health, reducing health inequalities, re-building the economy, and being better prepared for any future pandemic.

## Comprehensive health devolution

Drawing on written submissions and oral evidence from over 30 organisations and individuals the Commission describes comprehensive health devolution as:

*The creation of healthy, resilient and prosperous communities through 'health in all policies', place-based, democratically led, local partnerships that explicitly aim to:*

- *improve patient health and social care outcomes*
- *improve the population's health and reduce health inequalities*
- *deliver a single local NHS, social care and public health service*
- *combine health improvement with economic prosperity*

The Commission believes that every area of England should be on a journey to comprehensive health devolution. This means developing new 'health and prosperity' organisational structures that reflect local boundaries to deliver these aims and support the nation's economic recovery and growth.

## Health, social care and public health integration

The Commission believes that comprehensive health devolution is the most viable route to integrate local NHS, social care and public health services in a single place-based service. This requires clear locally accountable leadership; a single NHS, social care and public health budget; and joint commissioning of local NHS (mental and physical health and acute care), social care and public health services.

Comprehensive health devolution is not about creating a set of local NHS services that lead to a 'postcode lottery' in health care. The 'N' in a devolved and integrated NHS is a national set of health, social care and public health outcomes and standards that every member of the public is entitled to expect. Comprehensive health devolution is about the local management and delivery of these outcomes in ways that are responsive to the needs of local populations with appropriate checks and balances, combined with locally determined ambitions and priorities for each area. Some highly specialised services such as the treatment of rare diseases would continue to be commissioned nationally.

## Reducing health inequalities and building healthier communities

The Commission believes that comprehensive health devolution is the most effective way of addressing the 'Marmot' social determinants of physical and mental ill-health such as poverty, poor housing, poor diet, poor environment, and job insecurity/unemployment in local communities. An understanding of the relationship between poor health, lower productivity, economic growth and a population's ability to participate in the local economy should underpin planning and action in devolved areas with the aim of building healthier communities, reducing health inequalities, supporting economic growth and managing the demand for health services.

## Funding

The Commission believes that comprehensive health devolution is dependent upon sufficient, equitable and sustainable funding of NHS, social care and public health services. There must be an immediate and substantial boost in the funding of social care and public health services; a move to parity of esteem within and between NHS care (physical, mental and acute), social care and public health funding in the medium term; and a new well-funded long-term settlement for social care that provides better support to more people in need. A new funding mechanism should support a place-based approach to integrated service commissioning and delivery, and the creation of locally led single NHS, social care and public health budgets.

## Leadership

The Commission believes that leadership of democratically accountable devolved health areas must be based on an agreed mandate with central Government and include robust structures for independent scrutiny. Specific health leadership roles should be identified for Metro Mayors, leaders of Combined Authorities (CAs) with no Metro Mayors including the Mayor of London and designated leaders in non-CA areas. There must be a strong and open partnership between civic and clinical leaders in devolved health areas.

A strategy for implementing comprehensive health devolution across England should be co-designed by Government and local partners that enables fast progress in some areas, and clearly identifies how Integrated Care Systems will play their part in new 'health and prosperity' strategies.

## Partnership working

The Commission believes that active community involvement, and personalised care are central to building personal resilience, promoting healthy behaviour and ensuring responsive public services. Citizen involvement and the voice of the patient and carers are core features that cannot be delivered from the centre.

The Voluntary, Community and Social Enterprise (VCSE) sector including patient voice and carers organisations plays a crucial role in linking together services and communities, harnessing the voice of communities in local debates and in delivering services to people and communities that other parts of the system find harder to engage with.

Integrated planning and management of the NHS, social care and public health workforce within devolved health areas in ways that involves employers and trades unions as part of a broader People Plan is key to accelerating the process of comprehensive health devolution as it is through the workforce that change will happen and be visible on the ground.

## Detailed Recommendations

The Commission calls upon the Government to:

### 1 Take early action to adopt and implement comprehensive health devolution

I. Develop comprehensive health devolution in every part of England through a new Common Framework and a rapid joint implementation programme that best reflects local boundaries and organisational footprints

II. Integrate NHS, social care and public health workforce planning and management to accelerate local joint working and service integration

III. Produce a new Partnership Compact for working with key stakeholders such as clinicians, patient voice and carers organisations, the VCSE sector, trades unions and health and social care providers in devolved areas

### 2 Fund and integrate health, social care and public health

I. Establish parity of esteem between physical and mental health funding within the NHS, and between the NHS, social care and public health funding in a new comprehensive health mandate.

II. Provide an immediate and very substantial increase to the funding of social care and public health services.

III. Create a new, well-funded long-term settlement for social care that provides better support to more people in need and supports a place-based approach to delivering integrated NHS, social care and public health services including a locally-led, single comprehensive care budget.

## 3 Establish new mechanisms of accountability and scrutiny

I. Establish an Annual Joint Mandate (AJM) between the Secretary of State for Health and Social Care and each devolved health area leader (Metro Mayors, leaders of Combined Authorities with no Metro Mayor and designated leaders in non-Combined Authority areas)

II. Give a formal health role to Metro Mayors, leaders of Combined Authorities with no Metro Mayor and designated leaders in non-Combined Authority areas

III. Establish new city region health and prosperity scrutiny committees and give a statutory role for Healthwatch in every devolved health area

## 4 Give legislative support to comprehensive health devolution

I. Give a statutory public health improvement role to Metro Mayors, leaders of Combined Authority areas with no Metro mayors and leaders of partnerships in non-Combined Authority areas

II. Create a permissive legislative framework that enables locally determined proposals for health devolution to be brought forward in Metro Mayor areas, Combined Authority areas with no Metro Mayors and non-Combined Authority areas

III. Ensure any stocktake and reformulation of the law governing the NHS, the outcomes from the social care task force, proposals arising from the prevention Green Paper, a future White Paper on devolution, and reform in response to the pandemic all support comprehensive health devolution

# The Health Devolution Commissioners

- **Rt Hon Andy Burnham,** Mayor of Greater Manchester and former Secretary of State for Health (Co-chair)
- **Rt Hon Sir Norman Lamb,** former Minister of State (Co-chair)
- **Rt Hon Alistair Burt,** former Minister of State for Community and Social Care
- **Rt Hon Stephen Dorrell,** former Secretary of State for Health
- **Phil Hope,** former Minister of State for Care Services
- **Sally Warren,** Director of Policy, the King's Fund
- **Dr Linda Patterson,** former Medical Director of CHI and Vice President of RCP
- **Liz Gaulton,** Director of Public Health and Wellbeing, Coventry City Council
- **Peter Hay,** former President ADASS
- **Michelle Mitchell,** Chief Executive, and **Shaun Walsh**, Head of Public Affairs and Campaigns, Cancer Research UK (advisory capacity)
- **Jon Restell,** Chief Executive, Managers in Partnership (advisory capacity)
- **Christina McAnea,** Assistant General Secretary, UNISON (advisory capacity)
- **Dick Sorabji,** Deputy Chief Executive, London Councils (advisory capacity)
- **Sophie Corlett,** Director of External Relations, and **Karen Mellanby**, Director of Networks and Communities, Mind (advisory capacity)

The Commission would like to record its gratitude to the following organisations without whose support this report would not have been possible.

The Health Devolution Commission is kindly supported by

LONDON COUNCILS mip CANCER RESEARCH UK

UNISON the public service union

mind for better mental health

# The Contributors

### National bodies and federations

- Public Health England
- Health Education England
- NHS Providers
- NHS Confederation
- Healthwatch
- **Local Government Association**
- General Medical Council
- Breaking Barriers Innovations

### Local bodies and partnerships

- **Greater Manchester Health and Care Partnership**
- West Yorkshire and Harrogate Health and Care Partnership
- Fleetwood Primary Care Network
- *Northern Health Science Alliance (seminar)*
- *Dr Tom Coffey, Senior Health Adviser to the London Mayor, Greater London Authority*
- *London Councils*

### Clinical and Workforce Representatives Bodies

- The Royal College of Occupational Therapists
- The Royal College of Radiologists
- The Association of Anaesthetists
- The Faculty of Sexual and Reproductive Healthcare
- *MiP*
- *UNISON*

### Charities, Social Enterprises and Businesses

- **Cancer Research UK**
- **Mind**
- Macmillan Cancer Support
- *Ageing Better*
- *Social Enterprise Mark (seminar)*
- Assura PLC
- Alzheimer's Society

### Think tanks, Academics and Individuals

- *Harry Quilter-Pinner, IPPR*
- *Professor Michael Marmot*
- Professor Mark Exworthy, Health Services Management Centre, University of Birmingham
- Dr Kimberley Lazo, University of Central Lancashire
- Chris Gibbon and Chris Brailey, independent management consultants
- Peter Hay, former DASS and former president of ADASS

NB: *Italics* indicates oral rather than written evidence; **bold** indicates both

# 1 Introduction

## 1 The Commission

The Health Devolution Commission is a high-level inquiry into potential reform of our health system. The Commission asked two primary questions about health devolution as a means of building successful places, developing healthier communities and transforming health and social care services:

- What does good health devolution look like?
- What are the implications for accountability, power and control?

The ten subsidiary questions asked by the Commission are given in Appendix 2.

This report is based on the evidence received in writing or in person at two commission hearings from 30 organisations and individuals including national bodies and federations, local bodies and partnerships, clinical representative bodies, charities and social enterprises, and academic studies and think tank reports. Two roundtables were also undertaken. All of the written submissions to the Commission are publicly available at www.healthdevolution.org.uk where the minutes of the evidence sessions can also be found.

The Commission began its work against the backdrop of the new Government's commitment to the 'levelling up' agenda and was well underway when the Covid-19 pandemic began. This context visibly influenced the nature of the evidence received in its later stages, and is reflected in our analysis of that evidence and our findings.

Based on these submissions and the impact of Covid-19 this report includes:

- An analysis of what good health devolution looks like
- An analysis of the political implications of health devolution
- A set of conclusions and detailed recommendations
- An executive summary with six calls to action

Summaries of the submissions to the Commission are attached as appendices.

We hope that the findings will be of value to policymakers at national, city region and local levels who are interested in understanding health devolution and considering its role in delivering better health and social care services, improving the health of local communities, reducing health inequalities and contributing to the nation's economic recovery.

## 2 The Policy Context

The NHS Long Term Plan outlines a fundamentally new direction of travel for the NHS based on the principle of collaboration rather than competition, and the introduction of new structures such as Integrated Care Systems, Integrated Care Providers and Primary Care Networks that bring together health and social care commissioners and providers in new partnerships to plan and deliver integrated and person-centred care. This is very welcome and much work is now underway to identify how this new approach can be made to work in practice.

The starting point for the Commission is however, that action must be taken to address the major drivers of physical and mental ill-health (in particular those linked to poverty such as poor housing, poor diet, smoking, poor environment, and job insecurity/unemployment in local communities) at the same time as addressing the challenges of service integration within the NHS and between the NHS and social care. Without this, the health service will always be subject to increasing demands and pressures with which it will struggle to cope.

In other words, the 'exam question' the Commission set itself, is whether the Long Term Plan, whilst welcome, is sufficient to achieve a financially sustainable health and social care system. The Commission therefore sought to understand the factors that drive successful places, the contribution that devolution overall may be able to make to address these, and the opportunities this might open up for creating both better community health and improved health and social care services.

The Commission's premise was that an understanding of the relationship between poor health, lower productivity, economic growth and a population's ability to participate in the local economy should underpin planning and action that seeks to prevent community ill-health, support economic growth and limit the otherwise ever-growing demand for health services. Action to transform the way that local health, social care and public health services and others are organised to deliver an integrated, person-centred system could then be built on much stronger foundations.

One new way of working in Greater Manchester that seeks to improve both a community's health and a community's health services is health devolution. The commission sought to test whether this approach does have the potential to embrace and address more of the circumstances and services that impact on the health and wellbeing of local communities, as well as improving the nature and quality of its health and social care services.

However, the Commission's other main premise was that a trend towards health devolution is not just to be seen in Greater Manchester. The Commission's goal was therefore to learn the key lessons from the wider experience of health devolution within England – the move towards Integrated Care Systems, Integrated Care Providers and Primary Care Networks as well as in other city region areas such as London and, to a lesser extent, the West Midlands. Health devolution is not just about redressing inequalities between north and south but should be a way of working that has benefits for every part of the country.

The Commission is very aware that every community has assets and strengths in its clinical and non-clinical workforces and in the local voluntary and community sector that can be identified, drawn upon and enhanced to help build healthier communities. Health devolution is cited by those involved as one way of opening up the possibility of integrating not just disparate services within the NHS, or even NHS and social care services in a locality, but bringing together in a combined strategy and structure all of the services, systems and partners in a community that have an impact upon the health of a local population and the care services to better meet their health needs.

The Commission is also very aware that there is a growing body of evidence and advice from the NHS and others about how the health and social care system can be better integrated, so its focus is wider: to bring to decision makers' and influencers' attention more understanding of the benefits that health devolution might bring in improving services, building healthier communities, tackling health inequalities and growing the local economy and bringing together a much wider range of services and partners that can improve people's health and care.

## 3 The Covid-19 pandemic

The Commission was launched in February 2020 with a call for evidence, and held its first evidence hearing in February 2020 with plans to publish its findings in the summer. But in March 2020 life for everyone changed. And that change will be felt for years to come.

The Covid-19 pandemic and the consequent lockdown has had tragic consequences for individuals and their families here in the UK and throughout the world. It is changing dramatically the way we live our lives, travel, do our work, run our economy, relate to our family and friends, enjoy our holidays and leisure pursuits, and improve our environment. It is having far-reaching and profound impacts on the future of our health, social care, public health and economic landscape that relate directly to debates about the nature and scope of greater health devolution.

The challenges presented by Covid-19 to the nation have included:

- providing equal respect and resources to the still separate NHS and social care sectors, including their workforces, despite years of moves towards integration
- identifying those at most risk and understanding why certain groups are more vulnerable;
- recognising the disproportionate impact of Covid-19 on economically disadvantaged and Black, Asian and Minority Ethnic (BAME) communities
- widening health inequalities
- changing people's personal behaviour profoundly through public health measures to stay safe and keep well and improve their health and wellbeing
- mobilising appropriate new acute health care at rapid pace and scale
- creating safe spaces for health services such as cancer diagnosis and treatment
- supplying protective equipment to health and social care workers at rapid pace and scale;
- delivering testing and tracking services at rapid pace and scale;
- maintaining access to other health and care services essential to people's health or wellbeing
- responding to the huge mental health impact of the pandemic, lockdown and economic downturn
- developing recovery plans that keep people safe and healthy, embed service transformation, and restore economic prosperity.

Covid-19 has shown that national leadership by the NHS and the Government can find and mobilise resources in an incredibly short time to organise and deliver vital extra clinical care in a few hundred hospitals and to deliver a single vital public health message.

It has also illustrated the essential role of grass-root community activity and the role of the VCSE sector in organising, delivering and overseeing activity within a local landscape. The sector in many places quickly mobilised action into communities where it was needed without 'waiting for permission' and for many isolated or trapped individuals were the first responders.

However, Covid-19 has also shone a very stark and sometimes harsh spotlight on key relationships for successfully tackling the challenges including the limitations of a command-and-control approach that divided into hospital/non-hospital, and health/social care support and co-ordination; and the variable quality of relationships between the centre and the local, between health and social care, between preventing ill-health and providing treatment, and between safeguarding a community's health and improving the state of the economy. Specific examples of concern relevant to health devolution include:

- Lack of consultation by the Government with local areas or Metro mayors about the location of testing centres
- Lack of early involvement of local authorities in developing and delivering the contact-tracing and isolation strategy
- Not releasing key regional data showing variations in needs and performance to inform local and national funding and policy decisions
- Not releasing to local councils person-level data on the results of test and trace activity
- Not including Metro Mayors in key national forums such as Cobra
- The absence of an integrated working between hospitals and social care providers
- The absence of extra resources, protective equipment or testing facilities for care homes and domiciliary care providers
- NHS debts being written off but social care pressures leading to worryingly high deficits for local councils
- The huge drop in income for the local VCSE sector from not being able to fundraise or trade

The Commission observed that, whilst it is not straightforward to make comparisons with other countries with devolved health systems such as Germany, there may nonetheless be important lessons to be learnt about the benefits of systems in other countries that are built on strong local/national partnerships to deliver better care, improve population health, reduce health inequalities and have the resilience to respond robustly in a crisis.

# 2 What does good health devolution look like?

### 1 The frame of reference or paradigm

There is much confusion about the term health devolution. Various submissions to the Commission use similar terms to mean different things. The academic submissions for example all refer to 'decentralisation' whilst the LGA outlines a continuum of models from 'a seat at the table' to 'fully devolved commissioning'.

However, the question is not just one of definition but rather understanding the mind-set of the contributor towards health devolution and what it embraces. The nature of the response to the overall question of what comprehensive health devolution looks like varies depending upon the frame of reference or paradigm of thought of each submission.

Many submissions also emphasise that health devolution should be a means to an end rather than an end in itself. The success or otherwise of health devolution is then judged on whether it has achieved the purpose, outcomes or 'end' it is seeking to achieve.

The determining factor underpinning each response is the lens through which they view health devolution. Our analysis is that four main paradigms exist among those making a submission:

- A **'Health Treatment'** paradigm of health devolution with a frame of reference that focuses solely on the better delivery of physical and mental health services.
- A **'Health Integration'** paradigm of health devolution with a frame of reference that focuses on the better delivery of integrated physical health, mental health and social care services.
- A **'Healthy Community'** paradigm of health devolution that focuses on prevention and public health measures to improve population health and wellbeing, tackle health inequalities, and address the wider determinants of ill-health such as poor housing, poverty, a poor start in life, low educational attainment or unemployment.
- A **'Health and Prosperity'** paradigm of health devolution with a focus on the development of prosperous local economies through an active two-way relationship between better health care, preventing ill health and economic development.

## 2 The impact of the organisation's paradigm on their views about health devolution

### 2.1 Submissions with a health treatment and/or health and social care integration paradigm

In broad terms, those submissions from clinically focused organisations such as the Royal College of Occupational of Radiologists, the Association of Anaesthetists, the Faculty of Sexual and Reproductive Healthcare and the GMC have a 'health treatment' or 'health integration' perspective. They see a benefit in devolving health inputs and processes to enable local responsiveness, joint working, reduced fragmentation of health and/or social care services, more innovation, and greater ownership and better leadership of shared services.

Other submissions emphasised the importance of the personal relationship between leaders of local authorities and GP leaders of clinical commissioning groups ('health mayors' as one person described them) in a co-terminous civic/clinical partnership for integrating and improving health and social care.

Their concerns about health devolution centre around the risks of a postcode lottery in health care; lack of NHS or council funding to support devolved services; and lack of national standards and targets to drive local performance improvement. They support limited forms of health devolution that lead to better integration and reduced fragmentation within and between health and social care services. But they wish to keep in place, and in some cases add to, key national outcomes and targets for particular areas of clinical concern such as cancer and mental health services.

The success of national leadership of the response to the pandemic has, however, only served to reveal the existing lack of integration between health and social care. Extra funding of services to respond to Covid-19 has largely flowed to the NHS, the extra equipment and PPE has flowed to the NHS, the hundreds of thousands of volunteers were recruited to support the NHS and the key metrics are all those of the NHS not social care. The national efforts, belatedly, to recognise and give support to domiciliary and residential care services have been clearly inadequate. They serve only to highlight the extent to which the ambition of successive Governments to integrate health and social services has failed.

The belated decision to consult, engage with and resource local authorities and local public health leaders to carry out the 'test, trace and isolate' system is an indication of the dawning realisation among national leaders that the vertical command and control structure of the NHS has not been successful in delivering some key outcomes outside of the acute hospital system in England. Instead it is now clear that the NHS must engage with, if not rely upon, local leaders to marshal the wider public services of social care, public health, the police, fire services and housing to help deliver a coherent and comprehensive response to the challenges presented by the pandemic that are tailored to the circumstances of local communities.

## 2.2 Submissions with a healthy community paradigm

Those submissions rooted in the healthy community paradigm are similarly concerned with improving health and social care services but also want to see a strong focus on preventing ill-health to achieve their aims of improving the quality of people's lives. They include national partners such as HEE and Healthwatch, umbrella bodies such as the LGA and NHS Providers, allied health professionals such as the Royal College of Occupational Therapists, local partnerships such as Healthier Fleetwood, and issue-based charities such as Cancer Research UK, Macmillan, Mind and Alzheimer's Society.

They believe that improving population health and resilience will, in the long term, reduce demand for and support the sustainability of health and social care services. One caveat to this for mental health is that due to the current scale of unmet demand, the overall costs of services are unlikely to go down, although investing in early intervention and recovery would significantly improve both cost-effectiveness and sustainability.

Some submissions emphasise that population health improvement should be a locally driven task rooted in an understanding of local population needs and demography, that requires joint funding and action by multiple organisations, strong local leadership, and freedom to deploy resources to meet locally determined needs and priorities. Delivering sustainable solutions to homelessness for example, is more possible with a devolved approach to health. Homelessness is often about more than having a roof over one's head, but about receiving appropriate health services – NHS and social care – and often skills training and work. In other words, homelessness will never be 'solved' with a piecemeal or siloed approach. It requires an integrated approach that addresses the wider social determinants of ill-health.

Others argue that a national oversight of certain policy areas such as workforce development, technology, data use and health literacy is needed to support and guide local initiatives. Many state that public health services that are largely the responsibility of local government have experienced significant reductions in funding in contrast to the 'flat-real' increase in resources for the NHS. For example, local authority spending in England on stop smoking services fell by £41.3m (30%) between 2014/15 and 2017/18.

So, for clearly pragmatic reasons, some of those supporting a prevention or healthy community approach to health devolution also want national standards and targets for public health services. They are concerned that the lack of national public health targets is a major reason for reduced national funding, an inconsistent approach, widening health inequalities and lack of accountability for local services that seek to prevent ill-health.

Whether for or against national standards and targets, most express a concern that health devolution without the funding necessary to deliver both health and social care services, and prevention services, could result in local decisions that shift resources to delivering front-line care at the expense of the funding of prevention services and activities that are less popular and have less immediate impacts.

In some cases where ICSs have explicitly included prevention as part of their remit, these new devolved NHS structures fit within the prevention or healthy community paradigm. However, some STPs that are yet to become ICSs may be narrowly focused on improving health services alone (the health treatment paradigm) or focused on improving and integrating health and social care services (the health integration paradigm).

Health and Wellbeing Boards (HWBs) when working well were cited as an existing vehicle for acting as the anchors of place with the most mature boards using their system-wide leadership as the glue across neighbourhoods, place and systems. The Joint Strategic Needs Assessment (JSNA) of an area is used by many HWBs to inform place-based planning. Covering a smaller geographical footprint than ICS/STPs, advanced HWBs working together are seen by some as being able to support system change at scale and provide stability in the increasingly fluid and complex landscape.

Cancer Alliances created by the Government at a regional level were given as an example of a devolved approach that was needed to integrate different elements of cancer care and prevention services. Cancer Alliances bring together clinical and managerial leaders from different hospital trusts and other health and social care organisations, to transform the diagnosis, treatment and care for cancer patients in their local area. These partnerships enable care to be more effectively planned across local cancer pathways.

Devolution also needs to reach local communities in order to harness their contribution and assets. The breadth of partnerships and alliances needed requires new ways of developing working relationships (for example Greater Manchester's 'power shifting' toolkit); new approaches to supporting local communities' initiatives and strengths (for example Somerset's community approach) and new ways of engaging with citizens and showing accountability (for example the Wigan Deal). Making a reality of devolution requires a sustained and persistent focus, but it draws upon the sense of interest and connectivity to communities that health devolution creates.

One example was given by Fleetwood in which the Primary Care Network (PCN) is rooted in a model of integrated care with Multi-Disciplinary Teams (MDTs) from many different health providers and social care. But it has gone beyond that and developed into a 'total neighbourhood' model that facilitates joint working across health, social care, education, housing and the local authority. This also includes a vibrant resident led social movement to create a healthier community for each and every resident. Taken together this has led to residents turning their lives around; health care professionals enjoying this way of working; fully staffed services and significant reductions in A&E attendances and emergency hospital admissions.

The public health component of the response to Covid-19 has been in two main parts: the importance of clear and consistent national public health messages in order to influence public behaviour; and undeniable recognition of the key social determinants of inequalities in ill-health and vulnerability already identified by Marmot and others including poverty, environmental health and ethnicity.

These are factors that vary locally and require locally tailored action across a range of public, private and third sector services to overcome, as well as national supportive action. The significance of obesity as a factor in the Covid-19 pandemic and the Government's drive to address it is a very recent and clear example of this. Similarly, CRUK has shown that there are an extra 15,000 cases of cancer in England each year due to socio-economic deprivation with smoking-related cancers having the largest difference between the least and most deprived populations.

## 2.3 Submissions with a health and prosperity paradigm

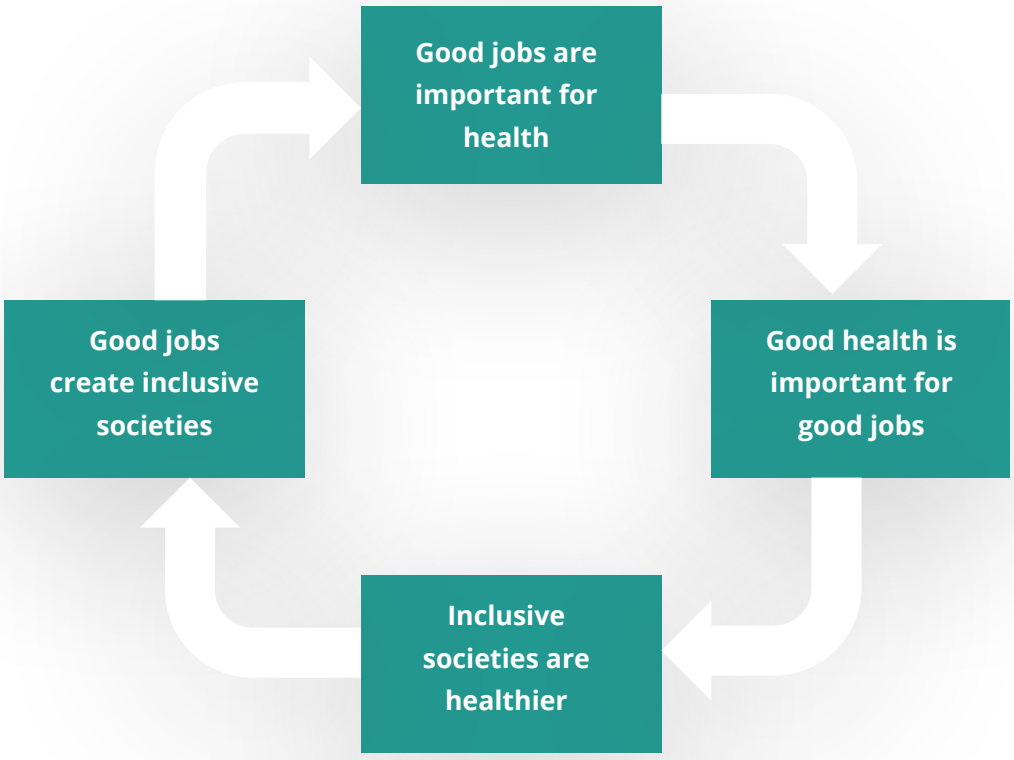
The submissions broadly rooted in the 'health and prosperity' paradigm of health devolution include significant stakeholders in the health and social care landscape including a statutory body - Public Health England, a broad umbrella body - the NHS Confederation, and geographical areas with experience of devolved arrangements such as Greater Manchester, and West Yorkshire and Harrogate.

These submissions suggest that health devolution should include responsibility for physical and mental health services, social care integration and community health improvement services; but they go much further to embrace the role that health care and prevention plays in the development of prosperous local economies.

This works both ways. Prosperous local economies with good jobs are seen as key in helping to prevent and reduce physical and mental ill-health, and this in turn reduces pressures on local health and social care services. The 'health in all policies' approach adopted by some Metro Mayors and local authorities reflect this holistic approach to health devolution. For example, the Mayor of London, as part of his work to tackle childhood obesity, has introduced restrictions on junk food marketing across the Transport for London estate.

The approach is rooted in an analysis of the local socio-economic drivers of ill-health and poor economic performance and how they are linked - *'there can be no economic growth without a healthy workforce'*. This was summed up in one submission as a 'virtuous circle' (figure 1 below) within a 'health means wealth means health' approach:

**Figure 1: Health and wealth**



Mind drew attention to other areas that have a major impact on mental health such as experience of abuse, neglect, violence, sexual violence, experience of a war zone, experience of crime, racism, and discrimination. Whilst these are likely to be more prevalent where there is poverty they are also to be found regardless of socio-economic status. Mind believes that responses to these problems and the provision of personally tailored services for people who have experienced them can be better delivered at a devolved level, particularly where it is possible to join together local VCSE services and statutory support. It may also require active 'community building' and early intervention support services as well as action to reduce poverty.

Tackling health inequalities in the community and inequalities within the health and social care system is also seen as a key task for comprehensive health devolution. Long standing concerns about race discrimination for example have been highlighted by the Covid-19 pandemic that has revealed huge differences in the vulnerability of particular groups such those from Black and Minority Ethnic (BAME) communities.

Submissions in this paradigm also placed a strong emphasis on the role of health and social care services, including hospitals, as key economic and social "anchor institutions being themselves large employers and consumers in a small local economy". This is some recognition for this in the recently published People Plan.

Covid -19 has been devastating in its impact on the personal lives of tens of thousands of families but its effect on 9 million people on furlough and on hundreds of thousands of businesses whose very existence is under threat has been a complete shock to everyone. The fundamental link between the health of a nation's people and the economic prosperity of that nation could not be demonstrated any more starkly or sharply. The recovery process cannot be a choice between health and prosperity. It has to be both, hand-in-hand, two sides of the same coin. And it is both a national task and a local one.

## 2.4 Cancer, mental health and dementia

The Commission also looked at the issues raised by devolution through the lens of three very different conditions: cancer, mental health and dementia.

### Focus on cancer

The advantages and disadvantages of health devolution in relation to cancer as a specific clinical condition is considered in detail by three submissions: Cancer Research UK (a sponsor of the Commission), Macmillan Cancer Support, and the Royal College of Radiologists. The main benefits of health devolution for cancer are two-fold:

- the ability of broader partnerships at a local level to address the primary causes of cancer such as smoking and obesity, and the wider social determinants of ill-health leading to cancer such as socioeconomic deprivation.
- more meaningful integration of health and social care services particularly in regard to an older population who are more likely to receive a cancer diagnosis and require more tailored care to prevent ill-health

Examples of this working in practice include the Making Smoking History programme and the Lung Health Check pilot in Greater Manchester (GM); and the Macmillan Local Authority Partnership Programme (MLAPP) that has councils taking a lead role in planning cancer support in the community.

The Cancer Alliances in Greater Manchester and in West Yorkshire and Harrogate are seen to have led to a compelling evidence-based case for a whole system approach to tobacco control, a groundswell of support to promote action across key local stakeholders, a new range of local champions and leaders, better consultation and greater innovation and integration of services and structures. Government support for regional Cancer Alliances across England has been crucial to their success.

One of the motivations for considering the benefits of health devolution for cancer survival in this country is the opportunity to address health inequalities across England and finding appropriate mechanisms for dealing with them. Smoking and obesity are the two biggest preventable causes of cancer in this country. Yet there is still great variation in prevalence and availability of services. Smoking prevalence has been reducing across the UK, but there is still a large gap in rates across local authorities. In London alone, there are huge differences borough by borough: in Richmond the smoking prevalence is just 8%, yet in Barking & Dagenham it is 18.1%.

Cancer Research UK estimate that there are an extra 15,000 cases of cancer in England each year due to socioeconomic deprivation with smoking related cancers showing the largest difference between the least and most deprived populations. There would be thousands fewer emergency presentations of cancer each year if the risk for all deprivation groups was the same as the least deprived. The impact of the pandemic on cancer has been significant with estimates that 2.4m people are now waiting for cancer screening, diagnosis or treatment. Early diagnosis is key to cancer survival so this will have a devastating impact on cancer survival in this country.

Metro Mayors are seen as having a key role in helping drive improvements in cancer prevention, diagnosis, treatment and survival across England as their personal mandate enables them to marshal a wide range of services and local partners on particular health needs. Examples of opportunities include committing to a smoke free strategy in partnership with others or setting up local childhood obesity taskforces committed to 'closing the gap' in childhood obesity rates. This local leadership is helping to minimise unhealthy influences, and address the wider determinants of poor health in local areas.

The new NHSE Integrated Care Systems (ICSs) that cover large geographical footprints are seen as a valuable way of ensuring integrated cancer services offer better value for money and better patient outcomes. However, there is some concern that the role of local authorities and HWBs in these new structures is not sufficiently recognised.

Examples of cancer care programmes in Scotland, Wales and Northern Ireland are seen as demonstrating the benefits of health devolution and integration with social care including Scotland's roll out of the Transforming Cancer Care programme, and the Northern Ireland Cancer Strategy 2020. The Wellbeing of Future Generations (Wales) Act is also welcomed as it creates a legal requirement for public bodies in Wales to think long-term and work better with people and communities to prevent persistent problems such as poverty, health inequalities and climate change.

The main concern about health devolution and cancer is the potential for exacerbating health inequalities and how national cancer targets can work if health is devolved. Variation in the provision of Stop Smoking Services between local authorities is an example of this concern where national funding reductions for local authorities has led to greater inequalities. Research from Cancer Research UK shows that among the local authorities that still had a budget for stop smoking services, 35% had cut the budget between 2018/19 and 2019/20. This was the fifth successive year in which more than a third of councils had cut their stop smoking service budgets. Tobacco control has been among the worst hit of all the areas of public health spending.

## Focus on mental health

Very few submissions to the Commission made specific reference to the impact of health devolution on mental health services or the mental health of the community. This in itself suggests that physical rather than mental health services are what is foremost in people's thinking, and that this lack of parity is an important challenge for devolved health areas to address.

The submission from Greater Manchester however, shows how (working across Trusts, Commissioners, Councils, the VCSE and the Greater Manchester Partnership) a focus on mental health over 3 years for a population of 2.8 million people led to mental health provision being pioneered as part of employment support; provided the country's largest emotionally friendly schools and colleges programme; introduced continuity of care in University mental health provision; and delivered major elements of the National Forward View for Mental Health ahead of schedule.

A significant contribution about mental health and health devolution was made by the mental health charity Mind. It believes that good devolution for mental health should enable people with mental health problems to receive timely and equal access to high quality services; have decisions about them made closer to home; experience person-centred care with choice and control; and be treated with dignity and respect.

To achieve these benefits, Mind believes that comprehensive health devolution should support organisations to work together as partners in multi-disciplinary approaches to the workforce; provide integrated care across the system; be more responsive to local needs; align policies within an area to tackle the wider determinants of mental ill-health; include sufficient accountability and reporting of performance to enable comparisons between different areas; support the involvement of the third sector and users in the design and delivery of services; support longer-term preventative approaches to tackling mental health and other health inequalities; and make savings for the system as a whole.

However, Mind is very concerned that health devolution could exacerbate local variation in the quality of mental health service particularly if there is poor leadership. It believes that strong national oversight is needed to avoid people with mental health problems being marginalised or stigmatised and for poor quality services going unchecked.

Mind believes that recent progress to improve mental health services has largely been driven from the centre such as the LTP, the 5 year forward view for mental health, IAPT and the mental health investment standard. Locally-driven progress performance has often relied on individual personalities or relationships that, on their own, are viewed as an unreliable way to achieve the national transformation required. National targets and standards are seen as very effective mechanisms to drive improvements and provide accountability for performance.

Mental health services have often been the junior partner within local health systems dominated by large acute hospitals. Funding mechanisms of block contracts when funding is cut has led to raised thresholds of access so two-thirds of people receive no treatment. Resources would need to follow any further moves to devolution.

Mind cite a report by the 'Centre for Mental Health' that ICSs offer three opportunities for mental health: preventing ill-health as mental illness contributes to physical ill-health; linking physical and mental health by ensuring that all physical ill-health interventions are equally accessible to people with mental health problems; and improving mental health services at a system level such as reducing 'out of area' placements or the overuse of long-term hospital placements.

However, as one submission suggested, comprehensive health devolution would be able to go further than an ICS strategy alone by including positive mental health as a precondition for educational and economic success. And that the level of positive mental wellbeing relies on a deep partnership with the VCSE sector for appropriate interventions as statutory services invariably stop at 'sub-clinical' thresholds.

Only a small proportion of people requiring mental health support will reach the clinical threshold for accessing mental health services within secondary care. Most require therapeutic options such as counselling, CBT or other talking therapies referred to from primary care, or more informal (but no less important) services such as befriending, peer support and self-care tuition and encouragement. These are activities provided, in the main, by the VCSE sector. The experience of health devolution in Greater Manchester has been that the process has helped lace together the many activities prevalent within a community. It has acted as catalyst, providing "permission" for different thinking and design. It has managed to disrupt the order of things, bringing to the fore services that are provided by VCSE organisations.

Mind also draw attention to the concerns that ICSs may not rise to the challenges for mental health in their area such as prioritising mental health, expanding the workforce, working in partnership with LAs and engaging with the third sector. Mind cite a report by the Royal College of Psychiatrists that says the ICSs have potential to improve mental health outcomes; integrate mental health services with the rest of the health and social care system; and develop system-wide incentives to improve mental health care.

National oversight combined with strong local leadership could however bring wider benefits such as investing in and co-ordinating population mental health programmes; aligning budgets across public services to achieve better mental health in the community; and investing more resources into primary care before people's mental health deteriorates.

### Focus on dementia

Alzheimer's Society (AS) believe that integrated health and social care is essential to the future of care and support for people with dementia. How dementia affects people is not simply due to the disease itself, but also as a consequence of how well they can access the care and support they need - too many people living with dementia face the condition alone, or they and their families struggle to access the services that they need, either because they are inadequate, or due to the fact that the current system that delivers that care and support is completely disjointed and overly complex. The complex nature of dementia and how it affects people means that care and support must also be provided in a highly personalised way that meets their individual needs.

People affected by dementia have highlighted that they often have to navigate through up to 20 different services to get the essential care and support they need. They depict a complex 'web' of people and services with whom they have to interact and navigate in order to get the care and support they need. This web encompasses the health and social care needs of the person with dementia and includes a range of services; from those directly related to day to day management and care, to managing direct payments, access to out of hours doctors, access to services regarding comorbidities or routine treatment, equipment services and other forms of support. Much of the support they need is through social care, resulting in them being disproportionately affected by failures in the current social care system; underfunded, uncoordinated or unavailable services, and an overburdened workforce that often lacks the appropriate knowledge and resources to meet their needs.

Poorly integrated care and the lack of community provision often means people with dementia do not receive sufficient support until their needs reach crisis point, at which point they are often admitted to hospital. Once there, extended length of stay can often negatively impact their dementia and cause more rapid deterioration. This results in people with dementia experiencing delayed transfer of care (delayed discharge) due to the fact that their needs may have changed, but that systems aren't coordinated well enough to get them where they need to be or provide the extra support they need. In addition to the impact on the person with dementia, this also has cost unnecessary cost implications for the NHS.

From a practical, service provision perspective, better integrated health and social care provides an opportunity to improve quality, reduce unnecessary duplication and wastage of resources and increase both staff and financial efficiency. The development of Dementia Friendly Communities has helped to address the challenges in the systems by stimulating community-led responses to support people living with dementia such as Dementia cafes, training of bus and taxi public transport providers, and creating dementia-friendly shopping areas and high streets.

From the perspective of people affected by dementia efficient, effective integrated systems will help to sustain and improve diagnosis and enable the delivery of comprehensive post diagnostic support and person-centred care. This will support people with dementia to remain in their own homes for longer, avoiding unnecessary admissions, and will reduce the length of stay and adverse outcomes from delayed transfer of care that we know people with dementia experience.

It is clear to Alzheimer's Society that devolution presents an opportunity to really drive integration forward, creating a modern health and social care system which is both cost-effective and tailored specifically to the needs of local communities. The devolution of Greater Manchester Health and Social Care has given AS a unique opportunity to create a joined up and consistent dementia pathway across the ten boroughs of Greater Manchester.

Dementia United and Alzheimer's Society agreed to formally work in partnership in January 2020, to develop programmes of work which aim to enhance the health and wellbeing of those living with or affected by dementia in Greater Manchester (GM), to benefit people across all ten boroughs. Through this collaboration they aim to achieve the shared ambition to transform structures, systems, support and representation of people affected by dementia in GM; together the partners will make GM the best place in the UK to live with dementia with sustainable and effective solutions.

This collaboration also offers the opportunity to develop new and wider partnerships with other key stakeholders, and to gather more information about the impact of dementia support on the lives of people living with dementia in the community. From diagnosis, people living with dementia find themselves having to navigate a range of services and professionals the aim of the partnership is to create a model of care provision that works and is consistent throughout diagnosis, treatment and appropriate care provision.

## 2.5 Core issues for health devolution

On the basis of this approach to analysing the evidence we heard, we have drawn the out the following observations and conclusions.

### 1 The scope of health devolution

The report identifies a range of health devolution paradigms from 'treatment' to 'health and prosperity'; and answers to key questions about measuring success, sufficient funding, national targets and co-terminous geographical footprints will very largely depend on the approach taken.

The level of shared ambition in central Government and among local partners will be the determining factor: the extent to which stakeholders are limiting their aims for health devolution to being a means of delivering better health care and more integrated health and social care services; or their desire to go further and use health devolution as a means of improving the health of the local community, or wider still to build a prosperous local economy.

It may be the case that local areas see themselves as being on a 'devolution trajectory' from being focused initially on treatment and integration, but with an aspiration to embracing prevention and population health improvement, and eventually seeking to improve the health and wealth of their locality.

Crucially, the impact of Covid-19 on health and social care services and on local economies may be shifting this debate from 'if' health devolution to city/regions should embrace the wider aim of improving health and prosperity to that of 'when' and 'how quickly'.

### 2 The depth of health devolution

It appears to be the case that the extent of devolution is directly related to the scope of devolution: the wider the scope, the greater the local freedoms from national targets and accountability. There is an important distinction between national quality standards for which accountability can be local, and national performance targets for which accountability is to the centre.

Cancer waiting times (CWT) is one example where national targets need to consider local context. Even though it is important for local areas to focus on improving their CWT performance, it is important not to penalise areas for poor performance when this may be caused by factors such as demographic factors and higher incidence rates of harder-to-diagnose cancers. The decision to stop the practice of making the award of transformation funding to Cancer Alliances conditional on 62-day wait performance reflects this approach.

However, it is to be expected that there will always be national performance targets for some defined elements of physical and mental health care, and thus some shared accountability to the centre with regard to some aspects of health services in all devolved health areas. In addition, there are and would continue to be, national quality standards for some aspects of devolved social care and public health services in which the management and accountability for those services is local.

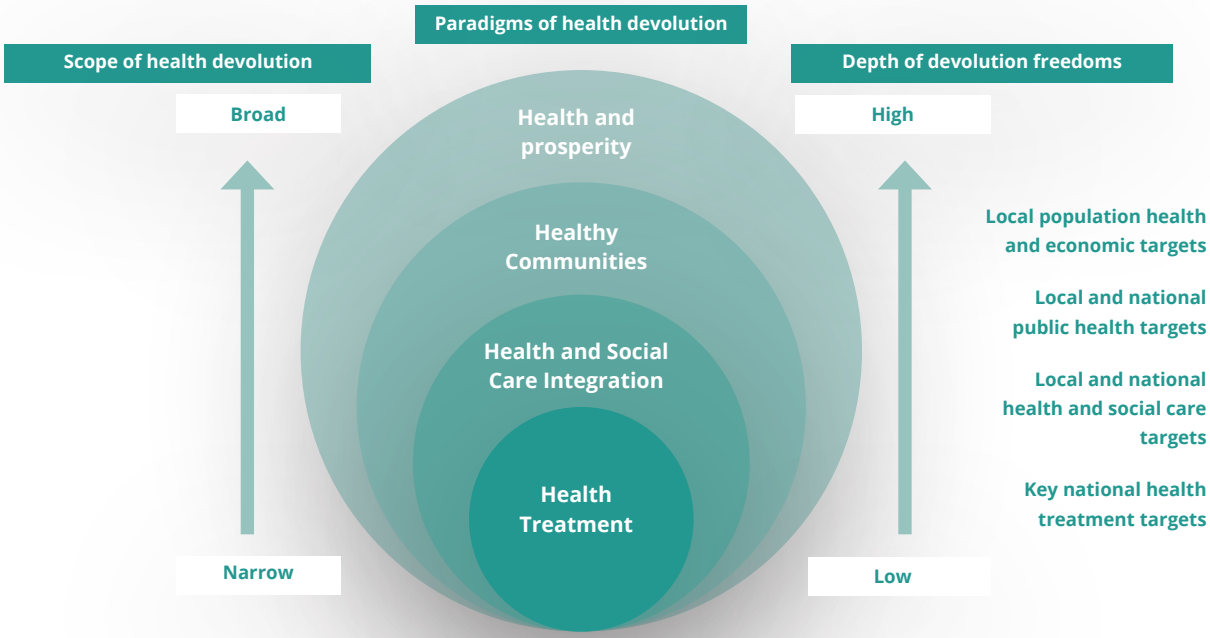
Consequently, the integration of health and social care in devolved areas will require a blend of:

- national health (physical and mental) targets for which there is both local and national accountability
- national quality standards for social care and public health
- local health (physical and mental), social care and public health ambitions relevant to the local population and landscape
- overarching 'health and prosperity' goals set locally

This suite of national and local targets, standards, ambitions and goals will form a unique dashboard of the measures of success for devolved health areas that will directly reflect the population needs, and health and social care landscape in each area. There may also need to be 'input' success measures relating to 'soft' factors such as trust and leadership, and 'hard' factors such as structures, memoranda of understanding and governance protocols.

The principle of subsidiarity in which decision making is located at the most immediate or lowest possible level consistent with their resolution should underpin the relationships in developed health areas both between the national and the 'local', and within local areas. The depth of health devolution may be pictured as a series of concentric circles with the smallest circle in the middle being the treatment paradigm where devolution is the most limited, surrounded by the integration paradigm circle, then the prevention paradigm circle and finally the health and prosperity circle where freedoms are greatest (figure 2 below):

**Figure 2: Paradigms of health devolution**



Covid -19 has revealed how success will be better achieved when there is a clear understanding of what is best done or led nationally, what is best done or led locally and how a joint approach combining the best of both approaches can be made to work in practice. Some submissions emphasise that it should be for local areas to choose whether to adopt a devolved approach and which structures or forms of devolution should be used. However, a key lesson from Covid-19 is that every area will need to have the resilience required for a future challenge of this kind as well as delivering better care when circumstances are more stable. All areas should prepare for comprehensive health devolution that has local support but recognising that some may need time than others to create an approach that works best for them.

A common framework for the implementation of health devolution would help to ensure best practice to meet local needs and reduce the risk of creating a postcode lottery of unfair or inappropriate health and social care services between different localities.

## 3 Funding of health devolution

A central concern of many submissions is that devolution of powers and responsibilities for health, social care and public health services without the resources to deliver them will lead to poorer health outcomes and poorer quality provision. The two main areas of concern are:

- The means-tested system for funding social care based on local council taxes and private fee payers is unfair and severely underfunded.
- The public health grant to local councils has substantially decreased and may not necessarily be spent on local public health measures.

There is a strong consensus that unless there is sustainable and sufficient funding for both social care and public health to match the funding agreement with the NHS then health devolution (in whatever form) will not be successful; and that there is a need to build in mechanisms that at least prevent the imbalance in funding getting worse. However, there is less consensus on what those funding solutions should look like. The options discussed include:

### NHS funding

- Maintaining or increasing if possible funding for the NHS
- Parity of esteem between mental health and physical health services in the NHS
- Parity of esteem between health, social care and public health funding
- A new duty on the NHS to spend its funds on services and locations that best deliver improved health for its population

## Social care funding

- Giving social care an immediate and substantial funding boost
- Extending the NHS funding principle (i.e. paid for by general taxation and free at the point of use) to embrace social care costs (excluding board and lodging) thereby ensuring 'parity' of funding between health care and social care.
- Creating a specific funding solution for social care that secures the principle of 'free at the point of use'
- Creating a mandatory social care insurance scheme to help pay for social care costs if needed
- Develop democratically accountable and fiscally progressive mechanisms for local areas to raise funds for improving health and prosperity
- Reforming the property-based council tax to be a progressive taxation system, and increasing the amount raised to make a significant contribution to social care costs
- Introducing a financial cap on the total amount that individuals pay for their assessed social care needs with the remaining costs funded through general taxation
- Reforming and devolving the funding of all local public services (other than the NHS) to local areas

## Public health funding

- Ensuring central Government provides sufficient funds to devolved areas to deliver their public health mandate using the principle of 'no unfunded burdens'.
- Enabling local areas to raise income in different ways
- Introducing new national levies to fund specific public health measures e.g. a levy on tobacco companies to fund local smoking cessation services

## New funding mechanisms

- Use of a new formula that locks in changes in core NHS spending to other spending on mental health, the public health grant and local social care funding
- Providing 10-year (not 1 year) capital allocations for the NHS to enable better local joint strategic planning of both the NHS and social care estate
- Creating a 'Year of Care' tariff through a capitated budget based on the needs of an identified population providing a per-person, average cost for a range of health and social care services over a fixed period of time.
- Ensuring the unique contribution of the VCSE sector is recognised and supported through the development of funding and commissioning frameworks

## 4 The role of integrated care systems

Integrated Care Systems (ICSs) and their predecessors (Sustainable Transformation Partnerships) could be viewed as a form of hidden devolution within the NHS, set out in the NHS Long Term Plan and being pursued at an increasing pace in some areas like London as a result of Covid-19.

However, in practice ICSs are a combination of hard delegation and local centralisation rather than true devolution as they do not embrace local democratic control, and accountability to the centre is hard-wired through a strong regional NHS tier of management and control. The Covid-19 pandemic has affected the way that some leaders of the ICS network view their role with more now supporting the system to become 'statutory integrated authorities' in order to take forward rapid transformations of their systems.

A few ICSs have ambitions that are broader in scope than the NHS alone but, in general, they are a relatively narrow structural solution to a set of internal NHS service integration and care pathway challenges. They do not appear to be a means of lifting horizons and addressing wider, deeper concerns such as the lack of integration of health and social care services or tackling the social determinants of ill-health in a local population.

If they are to be a cornerstone of the future transformation of the health and social care landscape their needs to be a thorough debate on their powers, resources, remit and accountability before being legislatively created.

The extent to which an ICS could be the vehicle for wider models of health devolution beyond NHS community and acute clinical services (i.e. integration with social care, delivery of community health or leading 'health and prosperity') depends on six primary aspects about the nature of each ICS:

| Theme | Key question | Comment |
|---|---|---|
| **Scope** | ***What are its areas of responsibility?***<br>NHS services<br>Social care services<br>Public health services<br>VCSE services<br>Economic prosperity services | The broader the scope of the ICS the more it could be a vehicle for health and prosperity devolution. |
| **Footprint** | ***How do the ICS boundaries relate to other NHS, local government and Metro Mayor boundaries?***<br>Co-terminous with one or more CCGs<br>Co-terminous with one or more top-tier local authorities<br>Co-terminous with one or more HWBs<br>One ICS among many within in a metro mayor footprint? | The more that the ICS is co-terminous with local government boundaries the more it could be a vehicle for health and prosperity devolution |
| **Budget controls** | ***What budgets does the ICS encompass and control?***<br>NHS community services<br>NHS acute services<br>Social care services<br>Public health services<br>VCSE grants and contracts<br>Economic development services | The wider the budgets it controls the more it can be a vehicle for health and prosperity devolution. |
| **Range of powers** | ***What powers agreed through MoUs or put into law does the ICS have?***<br>Service planning<br>Service commissioning<br>Service performance management<br>Income generation | The greater the powers it has the more it can be a vehicle for health and prosperity |
| **Local accountability** | ***To whom is the ICS accountable?***<br>NHSE<br>Its own board<br>Local government<br>The local electorate<br>A defined population<br>A combination of the above | The more accountable it is to local rather than national bodies the more it can be a vehicle for health and prosperity devolution. |
| **Leadership** | ***Who chairs the ICS board?***<br>A local NHS senior manager<br>An independent appointee<br>A council leader or Mayor | The more that ICS boards are chaired by democratically elected council leaders or mayors the more it can be a vehicle for health and prosperity |
| **Organisational structure** | ***What organisations are full members of the ICS?***<br>Acute trusts providers<br>Mental health trusts providers<br>CCGs<br>PCNs<br>Local authority social service leaders<br>Social care providers (residential and domiciliary)<br>Public health service leaders<br>VCSE sector organisations<br>Private sector organisations | The greater the range of organisations in full membership of the board the more it can be a vehicle for health and prosperity devolution. |

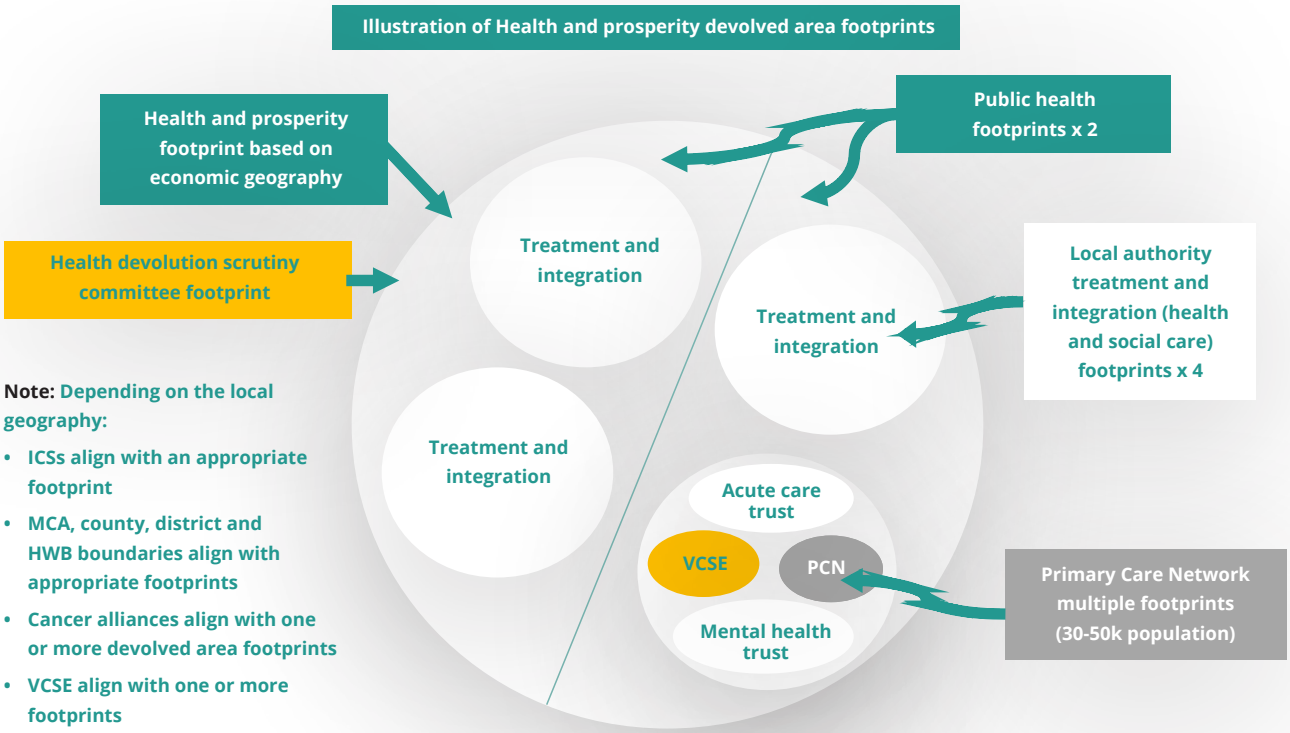
## 5 Geographical footprints

Geographical footprints in devolved areas may not be co-terminous with other health care structures such as ICSs, the NHS regions or the Cancer Alliances. And these in turn may not be co-terminous with local authority boundaries in two-tier areas or local economic development structures such as LEPs. This dilemma of mis-aligned geographical footprints is a significant barrier that can best be addressed on a case-by-case basis by local areas and agreed in collaboration with NHSE.

Covid -19 is accelerating the pace of change in this regard as, for example, the emergency systems and structures created in response for particular areas of London become the new normal. The concern is that these changes are still driven primarily by acute clinical considerations rather than the wider agendas of mental health, social care, public health and economic development. There may also be a need in London to create clearer connections between the health inequalities role of the Mayor and the public health and other policies of the London Boroughs.

Figure 3 below illustrates the potential geographical relationships between local organisations with different boundaries and footprints. The specific configuration of health devolution in any area will vary according to local history and circumstances.

### Figure 3 Health devolution footprints



## 6 Workforce integration

There are many different workforces within the health and social care landscape some of which have national systems for pay and conditions, and many of which are determined locally or by the service provider. The people involved in the system overall is much broader than clinicians and care workers and encompasses three broad layers:

- The paid staff working in formal health and social care settings employed by the public, private and voluntary sectors (e.g. hospitals, care homes, GP surgeries, community health services, and domiciliary care providers)
- The paid staff working in informal settings at home or in the community (e.g. personal assistants to individuals)
- The volunteers, friends and family that provide personal and community support to people with health and social care needs, and who can help to address issues such as loneliness and isolation

There are serious concerns about workforce shortages in the NHS both generally and for specific roles such as diagnostic posts where 1 in 10 are vacant. For many care workers the experience is one of low pay, and insecure and transient employment. Annual turnover of care staff is high (up to 40%), staff shortages are high and training is low level, all of which affect the quality and continuity of care for service users.

Some contributors argued strongly for a national social care workforce strategy to overcome these very real barriers to local workforce integration. There is a real concern that the NHS People Plan has focused on NHS staff in isolation from the social care workforce or public health staff. In the meantime, until national action is taken to address the lack of parity between the social care and the NHS workforce, devolved health areas will need to develop ways of working that allows integration of services being delivered by staff such as social care workers, NHS staff and GPs working with very different terms and conditions.

Working across large city/region footprints however, may offer an opportunity to bring together the care and the health workforce in a common and better workforce framework for that area. A place-based common framework based on parity of esteem for NHS and social care staff in relation to pay and conditions of work, recruitment, apprenticeships, and training and education could be developed in devolved health areas. This will require investment in the strategic and operational management capacity of devolved systems as it has been noted this is a key factor in successfully implementing visions for healthy and prosperous communities.

There may for example be immediate ways of integrating the training and education of the local health, social care and public health workforce. And joint approaches to workforce planning, training and education may help to accelerate service integration in a 'neutral' arena for bringing about new ways of working within devolved areas. Employers and trades unions should be directly involved in developing this approach.

The lessons for workforce integration from the experience of integrating health and social structures and services in devolved health areas could then inform the development of a common national framework and a fully integrated health and social care workforce in the long term.

## 7 Personalised care

The principle of personalised health and social care should be a core feature of the way care is provided in devolved areas. Personalisation may mean different things to health and social care services, with, for example, social care placing an emphasis on person-centred, strength based and community-oriented approaches.  It includes providing access to personal health and social care budgets for those that want them, and fully recognising and supporting the role of unpaid carers – family and friends – that are central to their care.

A recent Community Network project report (a collaboration of NHS Providers, the NHS Confederation, the National Association of Primary Care, the Association of Directors of Adult Social Services and Association of Ambulance Chief Executives) of six case studies reinforced this point in its conclusion that: "Partnering with organisations outside of the health and care sector is vital to ensure that the wider determinants of health and wellbeing are integral to the support people are offered."

## 8 Community involvement

Active community and citizen involvement (not just community and engagement and consultation) is essential in devolved health areas and cannot be delivered from the centre. This approach is key to building personal resilience, promoting healthy behaviours and ensuring responsive public services to local community needs.

The VCSE sector has a vital role to play in tackling health inequalities, and co-designing and delivering better services and outcomes in devolved health areas. Comprehensive health devolution has the potential to harness the leadership and assets in communities (community organisations, volunteers, carers, people with lived experience) to co-produce solutions and to fully own the vision as full partners in contributing towards outcomes.

## 9 Critical success factors

It is possible to identify from the various submissions a number of critical success factors for effective health devolution:

### Local success factors

- Clarity about purpose and scope
- Shared vision and a long-term commitment from the key stakeholders
- Shared values about ways of working with patients, carers, residents, services users and the community such as personalised care, active community involvement, digital ways of working, and better self-care
- A collaborative approach with shared leadership and robust structures for joint working
- Good personal relationships between local leaders
- Subsidiarity in decision-taking with clear accountabilities
- Integrated commissioning and single budgets
- Involvement of a wide range of public, private and VCSE sector partners appropriate to purpose from physical and mental health, social care, public health, environmental health, housing, education, economic development and academia
- Clear measures for success linked to purpose, vision and values
- A responsive and learning approach to local circumstances
- Action-led change
- Workforce flexibility and integration
- Innovation in local income generation and spending
- Independent scrutiny of structures, leadership and service delivery

### National success factors

- Agreed national mandate
- Clear statutory basis for structures, leadership and service delivery
- Sufficient agreed national funding
- Clear accountability framework
- Agree national targets to be met locally
- Tight/loose partnership on outcomes and outputs
- Co-design and collaborative approach to working together
- Shared national/local responsibilities for system/service regulation and inspection

# 3 What are the implications of health devolution for accountability, power and control in devolved health systems?

## 1 Complexity clouds clarity

Many organisations did not answer all the questions in section two of the call for evidence, some none at all. Of those that did only three made specific suggestions of reforms that should be considered. Public Health England advocated a statutory role for Mayoral Combined Authorities (MCAs) to improve public health; Healthwatch said if legislation is revisited to support the Long-Term Plan provision should be made for statutory underpinning of Healthwatch's remit at ICS/STP level; and the Royal College of Radiologists suggested a regional health and social care scrutiny committee.

This relative lack of input on questions of accountability, power and control is not surprising. If there is little consensus on what comprehensive health devolution looks like, then it is not surprising that there is a lack of clarity on the political implications – politics with a capital P and small. There are a further four reasons why answering the 'political implications' examination question is extremely difficult.

I. **Distributed leadership:** Despite accountability for current health services, or at least for the NHS, being ostensibly very straightforward – there is a Secretary of State for Health and Social Care – in reality they are extremely complicated. In truth, accountability and scrutiny of decision making across the vast health and social care sector takes place in very many different ways, at many spatial levels and involving a wide range of professional and elected leaders.

| Elected or professional leader | Accountable to: | Scrutinised by: |
|---|---|---|
| **Secretary of State for Health and Social Care** | Prime Minister, Parliament, the electorate | DHSC Select Committee |
| **Ministers of State/ Parliamentary Under Secretaries of State** | ***Secretary of State, Prime Minister, Parliament*** | DHSC Select Committee |
| **Chief Executive NHSE/I** | ***Secretary of State for Health and Social Care*** | DHSC Select Committee |
| **CCG accountable officers** | ***NHSE/I*** | Local Health and Wellbeing Boards, Local Authorities, Healthwatch |
| **NHS Trusts CEOs** | ***Local Board of governors, CCGs, NHSE/I Regional Offices and CEO*** | CQC |
| **GPs** | ***NHSE/I*** | GMC and CQC |
| **Public Health England CEO** | ***Secretary of State for Health and Social Care*** | DHSC Select Committee |
| **Local Public Health Directors** | Local Authority CEO | Public Health England, Local Health and Wellbeing Boards, Healthwatch |
| **Metro Mayors** | The local electorate | Secretary of State for MHCLG |
| **Council leaders** | Local Cabinet, the local electorate | Secretary of State for MHCLG, Local Health and Wellbeing Boards, Healthwatch |
| **Directors of Adult Social Care** | Local Authority CEOs | CQC, Local Health and Wellbeing Boards |
| **NHS Providers** | Provider boards and CCGs | CQC |
| **Social Care Providers** | Provider boards and LAs | CQC |

II. **Legal basis:** Current devolved political 'architecture' is evolving with some parts of the health and social care sector now working within the flexibility allowed by the 2012 Health and Social Care Act. In other areas Health and Wellbeing Boards, one of the 2012 Act's major changes, still play a leading role. The new tier of powerful ICSs has no legal status with different 'work arounds' being deployed such as merging CCGs that do have status in law being merged to match the new ICS footprint. The overall picture is extremely fragmented and complicated even if a direction of travel can be identified.

III. **Structural complexity:** In Greater Manchester emerging structures are not as straightforward as may be thought. For example, contrary to what many may believe, the Mayor of Greater Manchester is not "in charge" of NHS and social care services in Greater Manchester. The decision-making body is a partnership board bringing together a wide range of leaders, including - but not exclusively - politicians, and chaired by Cllr Sir Richard Leese., The main spatial unit at which NHS and local government services have been joined up has not been at the GMCA level but at the level of the ten local authorities some of which have one Accountable Officer holding both CCG and social care funding. These new Local Care Organisations (LCOs) have become the favoured vehicle for integrating provision. At the most local level – a population level of 30-50,000 – is integrated neighbourhood working connecting a range of public services partners and local VCSE organisations.

In London the emerging ideas for change include a focus on borough level integration of provision led by local government but consistent with NHS goals and rules; borough support for Primary Care Networks; ICS level strategies resulting from collaborative agreements built on borough level strategies; and pooled funding to support these changes.

III. **Unfinished business:** These fluid power relations in play reflect wider unfinished business relating to three wider and national public policy debates:

a) Whether the time has come for a statutory stocktake and reformulation of the law governing the NHS.

b) What is the future of social care? Covid-19 has revived longstanding calls for reform of the social care sector, including its funding.

c) How and when will devolution more widely be rolled out? A Devolution White Paper was promised by the incoming Government in 2019 but this is now not expected until the autumn of 2020.

Of course, the Health Devolution Commission has been established precisely because there is complexity and in order to ascertain if there is clarity and consensus regards moving forward. As the NHS Confederation have explained "NHS organisations have historically had very strong and clearly drawn lines of accountability to Whitehall and Parliament. Changes to national and regional structures and regulatory processes over the last decade have sought to weaken these links, for instance by creating a new arm's-length body, NHS England and NHS Improvement, and shifting much of the responsibility for national-level management of the NHS out of the Department of Health and Social Care. By contrast, there is a limited level of national oversight of local government."

At this stage the evidence would, however, suggest that seven key questions regarding power, accountability and control need to be addressed. These are discussed in more detail below.

## 2 Key issues for accountability, power and control

### 2.1 Should health devolution be possible in all areas?

If health devolution, in whatever form, is the right approach for transformation of the health and social care landscape, it must be the preferred outcome for all areas of the country in England. It may be an approach that is easiest to pursue initially in areas already covered by Metro Mayors where the main task is to broaden their remit, powers, budget controls, scrutiny and so on. But, if health devolution is the right approach for a successful post covid-19 health and economic recovery strategy, then its principles must be applicable to those areas without those structures or leadership roles yet in place.

Health devolution is not therefore about rebalancing a perceived north/south divide as it should for example apply in London as much as Greater Manchester; but it will be a significant way of reducing the Whitehall-centric thinking that often appears to inform much national policy making across a range of key issues not least the response to Covid-19. Comprehensive health devolution could play a critical role in the 'levelling-up' agenda and tackling health inequalities that are rooted in the unique circumstances of different local areas.

The application of the principles and critical success factors of health devolution in non-city/regions or non-Metro Mayor areas may, however, lead to a range of different structural solutions that best fit the circumstances of each geographical area. This might include options such as a county council-based model, a combined authority model, an ICS-based model, or a regional model.

The development of the best approach to take in each part of England should be an joint local/national undertaking, and discussions between the centre and local areas should be taken forward urgently in order to create the most appropriate model of health devolution (scope, depth, footprint, and so on) for each area.

### 2.2 Is there a case for statutory change regards the health and social care architecture?

The only specific legislative change recommended in the submissions received by the Health Devolution Commission were from Public Health England, which advocated a statutory role for MCAs to improve public health, and from Healthwatch regarding the statutory underpinning of Healthwatch operating at the ICS/STP/MCA level.

With regard to the first suggestion, this is similar to the statutory responsibility currently given to the Mayor of London who has a duty to produce a health inequalities strategy and to have regard to public health when producing his or her other six statutory strategy documents: transport, economic development, housing, spatial development (the London Plan), environment and culture.

MCAs would, presumably, be able to take on this public health improvement power as and when capable and desirous of doing so. There would need to be primary legislation - or an amendment to the Greater London Authority 2007 Act - followed by a Statutory Instrument for each MCA area, subject to a formal request and it passing competence tests.

If health devolution is to continue to take place at the ICS level then in areas with non-MCA ICSs, it would be consistent to place on them a similar duty to improve public health (subject to the previous caveats of competence). However, as ICSs are not legal entities that would not be currently possible.

That in itself raises the issue of whether in those areas where there is some degree of shared responsibility for the delivery of both NHS and social care, there is a need for other statutory change. As Healthwatch have intimated a more comprehensive review of all the legislative changes that may be required to reflect the Long Term Plan, and its principle of collaboration rather than the competition that was at the heart of the 2012 Act, is overdue. If this happened, the case for a statutory city region remit for Healthwatch, would seem appropriate to be part of that legislation.

## 2.3 Is there a case for clearer political leadership and accountability?

As we saw from the governance arrangements laid out by both Greater Manchester and West Yorkshire and Harrogate Health and Social Care Partnership, the structures created are complex, extremely nuanced and to "the man or woman in the street" it is not at all clear who is in charge. This does not, of course, make them unfit for purpose now. But, as more responsibility is accrued at a devolved level, the democratic principle of clarity in leadership – knowing who is making decisions so that they can be held to account – becomes more important.

There is therefore 'prima facie' a case for a Metro Mayor to have a more formal, individualised and statutory role for health services within their geography. Such a reform would be in line with the spirit of the wave of devolution launched in 2014 (Devo 2.0), which was in part driven by the objective to make accountability at the city region level clearer for the public. In moving to this arrangement, there could also be a statutory duty to consult partners through, for example, a partnership board structure as now, which the Commission notes has been highly successful in bringing together all parties and encouraging collaboration.

It should be acknowledged, however, that whilst the Secretary of State for Health and Social Care is responsible for the NHS a Mayor would only be "a second hand on the tiller" – in other words they would still not have exclusive control of NHS with, for example, targets still set nationally and major strategic decisions such as new hospital build likely to remain the ultimate responsibility of the Government. Nor would the Mayor be directly responsible for operational care services that would remain the responsibility of local authorities.

If "two hands on the tiller" is formally recognised, two further reforms should be considered in order to make this approach work in practice, both from an operational leadership perspective and from the lens of public accountability.

First, the Secretary of State for Health and Social Care should have an annual meeting with each MCA empowered Mayor to agree an Annual Joint Mandate (AJM). Second, all Mayors with a statutory city region health role should appear in front of the national Health and Social Care Select Committee once a year. Similar arrangements would need to be developed for areas without a Metro Mayor in order for health devolution to be pursued in every part of the country.

It is worth noting in passing that these suggestions could still be considered as necessary if the Chair of the Strategic Board is a Councillor, as is currently the case in Greater Manchester and West Yorkshire, and not an MCA Mayor.

## 2.4 Should there be better scrutiny at the city region level? And if so, how?

Local authority (upper tier and unitary) health scrutiny powers give them a strategic role in taking an overview of how well integration of health, public health and social care is working. It requires clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health and wellbeing boards and local Healthwatch.

Scrutiny arrangements at the MCA level may be viewed by some as currently somewhat opaque. There is therefore a case, as recommended by the Royal College of Radiologists for a more visible and higher profile method of democratic accountability for health devolution, which draws upon the democratic political and professional expertise and experience within the relevant MCA.

If City Region Health and Prosperity Scrutiny Committee CRH&PSCs are established, some indication of how these would operate and what the membership might look like is helpful. For example, such a body would need to be properly resourced to meet monthly and empowered to conduct inquiries as well as hold accountability sessions in public. Membership would need to the subject of further consideration and consultation but, for example, could include:

- 5 MPs (in proportion to the number of MPs from each party in the respective area)
- Local government nominee
- Healthwatch nominee
- Business sector nominee (a nominee from LEP Chairs)
- Social enterprise/charity nominee
- Workforce nominee (a nominee arranged through the TUC)
- Regional Public Health Director

Much of the detail regards these arrangements for enhanced scrutiny - such as which of the members had voting rights, where the CRH&PSC would meet and how each nominee would be selected - would need to be considered further.

The principle of more high profile and better resourced and more accountable scrutiny seems to be both necessary and a common-sense use of the democratic and other talent within specific health geographies. It would be important however to ensure that these proposals at the city region level do not cut across other scrutiny arrangements that operate at the local authority level through local authority's Health and Wellbeing Boards and oversight committees and, of course, local Healthwatch.

### 2.5 What specific measures are needed for engaging patient voice and carers organisations, clinicians, the VCSE sector (voluntary, community and social enterprises), trade unions, private health and care providers and the public?

It is very clear from the evidence that the expectation is that health devolution offers considerable and welcome opportunities for patient and carers organisations, clinicians, the VCSE sector, trade unions, private health and care providers, and the public to be "at the table". In both Greater Manchester and West Yorkshire there is tangible evidence of this already with various Memorandums of Understanding and direct involvement through new governance arrangements.

Emerging proposals for health devolution encourage 'best practice' engagement with patient voice and carers organisations, clinicians, the VCSE sector, trade unions, private health and care providers and the public. However, consideration should be given to other measures required to guarantee that the concerns of all stakeholders are acted upon as well as heard. For example, this might involve taking community engagement to a deeper level of co-production by statutory bodies with the VCSE sector as equal partners. Or, for example, reassuring clinicians that more partnership working at the devolved health level will not inappropriately extend into operational clinical matters.

Within Greater Manchester, the relationship with the VCSE sector has evolved beyond simply an invitation to be at the table and recognised in good governance. The VCSE sector has taken ownership of devolution and delivering the desired outcomes and aspirations. This is being achieved through taking on both Greater Manchester level leadership (co-ordinating activity and approaches) and also locality specific leadership. The VCSE sector has taken on not just a role of passive partner but has been a key collaborator and owner of the goals of devolution and a significant deliverer of services.

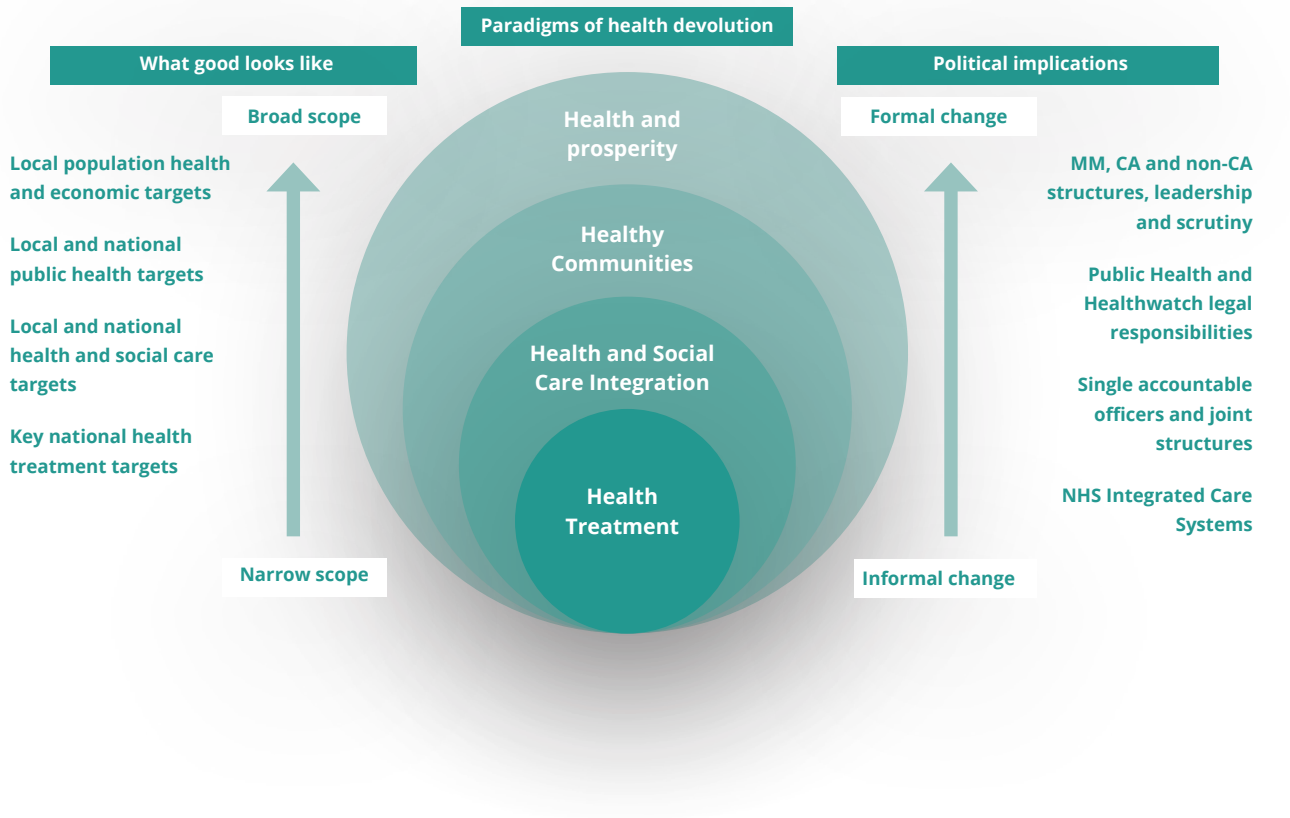
## 2.6 Should there be the evolution of devolution or a 'blueprint approach'?

The evidence shows that health devolution is evolving in different places in different ways and at different speeds. The overarching question the Commission faced is whether it is comfortable to support the evolution of devolution or whether it wishes to conclude that there is a need for a wholesale re-set of service configuration, in other words "a blueprint approach".

Those focused on 'better treatment' - paradigm one - wanted limited change, at most. Those who take the view that health devolution equals a 'health and wealth' approach were more likely to be advocates of statutory change. The consensus from our respondents would appear to be that an imposed blueprint is not the way forward but that a permissive approach based on a common framework may be appropriate.

Such an approach would be consistent with the recent Devo 3.0 Review report, published by the UK2070 Commission, which advocated a devolution continuum, showing "the range of current Government powers and funding suitable for devolving and which can be accessed as capacity and competence, as well as leadership and demand, becomes available at the devolved level." In other words, as a health devolution system moves through the different paradigms, different reforms become applicable. The precise statutory roles and responsibilities for different forms of health devolution is to be determined but figure 4 below illustrates how it might look:

**Figure 4: Statutory basis of different health devolution paradigms**



## 2.7 What are the implications for a national health and social care service?

The idea of merging together the NHS and the social care system to create a single National Health and Social Care Service is attracting much debate. But solving the challenges of integrating the 'free at point of use' vertical NHS that is funded through national taxation with horizontal means-tested social care services commissioned by local authorities, funded by local taxes and delivered by public, private and charity sector providers have so far proved insurmountable.

Some have suggested the solution lies in centralising responsibility for adult and children's social care away from local authority control and into the NHS, giving new Integrated Care Structures (accountable through NHS regional bodies to the centre) the statutory duties for those services and applying some of the means-test principles to the NHS to help financial sustainability. But this would remove local democratic accountability for social care services, undermine the founding principles of the NHS and create a new boundary between these merged services and other services such as housing and public health that are the responsibility of local authorities.

In contrast, comprehensive health devolution provides at least part of the answer to the challenge of merging the 'vertical' NHS with 'horizontal' local social care and public health services. Comprehensive health devolution ensures national health targets are delivered locally and for which there is a both local and national accountability. This 'two hands on the tiller' approach has been shown to work in areas like Greater Manchester where relationships are strong and appropriate structures are put in place.

Moreover, the existence of national quality standards for NHS, social care and public health services that have to be met in every area also avoids the development of a potential postcode lottery in care. Crucially, decision making about the delivery and management of those standards happens at a local level (not in Whitehall or Westminster) where a response to the particular landscape and demographics of that area can be best be made.

So, comprehensive health devolution is not about creating a set of local NHS services that could lead to a 'postcode lottery' in health care. The 'N' in a devolved and integrated NHS is a national set of health, social care and public health outcomes and standards that every member of the public is entitled to expect. Comprehensive health devolution is about the local management and delivery of these outcomes in ways that suit local circumstances with appropriate checks and balances, combined with locally determined ambitions and priorities for each area.

The one stumbling block that comprehensive health devolution cannot alone overcome is the level and nature of funding of social care and public health services. Whilst new funding mechanisms or formulae within the current system would help to build parity of funding; a new national funding settlement that makes social care free at the point of use would completely unlock the remaining barrier to comprehensive health devolution.

In that way we would have a single national health and social care service that is delivered through a devolved health system. The 'N' an integrated national health and social care service would be there for all through an agreed set of NHS targets, and through social care and public health standards that apply everywhere.

# 4 Conclusions and recommendations

### 1 The Covid-19 pandemic

The experience of the Covid-19 pandemic has revealed in the starkest terms that the economic prosperity of the country relies upon the health of the population; and that the lack of integration of health and social care services leaves the most vulnerable at most risk.

The response to Covid-19 has been overly centralised through a predominant culture of command-and-control from the centre. This approach has failed to marshal effectively local resources, leadership and organisations, to address the key challenges presented by Covid-19.

The post-Covid-19 world must be very different if any future pandemics are to be more successfully managed. A better balance of national and local leadership and decision making must involve the full integration of health, social care and public health services in local areas as well as place-based ways of working that embrace key services such as transport, education, housing and economic development.

### 2 Health devolution

Empowering communities is the purpose of devolution. Communities are most successful when they are able through local democratic structures, funding and powers, to determine their own future.

The purpose of comprehensive health devolution is to create healthy, resilient and prosperous communities through 'health in all policies', place-based, democratically led local partnerships that explicitly aim to:

- improve patient health and social care outcomes
- improve the population's health and reduce health inequalities
- deliver a single local NHS, social care and public health service
- combine health improvement with economic prosperity

Health devolution is already underway in different ways in different areas such as Greater Manchester, London, West Yorkshire and Harrogate, Combined Authority Areas; and through different bodies such as Integrated Care Systems, and Health and Wellbeing Boards. These disparate approaches could be built upon so that every area of England is on a journey to develop a comprehensive and consistent 'health and prosperity' approach to health devolution that embraces this purpose and aims.

## 3 Integration and subsidiarity

The principle of subsidiarity, by which decision making is located at the most immediate or lowest possible level consistent with their resolution, is key to comprehensive health devolution. Subsidiarity underpins the relationships within devolved health areas, and between national and local government.

Health devolution is the most viable route to integrate local health, social care and public health services in place-based ways of working. This requires moving towards joint leadership of the three services; a single health, social care and public health budget; and joint commissioning of all local health, social care and public health services including mental health and acute hospital care.

A broad approach to health devolution creates important opportunities to co-ordinate and join up a wider range of services to address the challenges faced by groups with complex need. People who are homeless for example require more than just a roof over their head but need to receive appropriate health and social care services alongside other forms of support such as skills training and work. Tackling homelessness effectively requires an integrated and devolved approach to a range of public services.

## 4 The role of the centre

Health devolution is not about creating a set of 'Local Health Services' that could lead to a 'postcode lottery' in health care. The 'N' in the NHS is a set of agreed health outcomes and priorities to be achieved in every area as well as entitlements and standards that every member of the public can expect but in ways that are determined locally to suit local circumstances.

Given the public and political 'national' expectations of the NHS, health in devolved areas will always have a combination of centrally determined targets and locally determined ambitions in a tight/loose national/local relationship.

Key national health targets (such as waiting times for A&E or cancer diagnosis) are best seen as part of a blended set of national priorities and locally determined ambitions that every devolved area should seek to achieve, can be compared upon and be held to account for.

The integration of health, social care and public health services in devolved areas is a blend of:

- A limited number of NHS (physical, mental and acute care) targets for which there is both local and national accountability
- A suite of national quality entitlements and standards for health, social care and public health and
- A set of locally accountable health, social care and public health ambitions relevant to the local population and landscape
- Local overarching 'health and prosperity' goals

Certain functions such as NICE guidance, and the regulation and inspection of health systems and services could continue to be delivered centrally in a devolved system. And provision of specific treatments for people who wrongly may be perceived as undeserving (such as alcohol or drug addiction services) will need some form of national 'protection'.

## 5 Funding of health devolution

Health devolution is dependent upon sufficient, equitable and sustainable funding of health, social care and public health services to be successful. In the short term it is clear that social care services (domiciliary care and residential care) are in urgent need of an immediate and very substantial increase to funding to ensure they are sufficient in volume and high enough in quality to provide adequate services for an ageing population.

In the longer term, a core principle of comprehensive health devolution should be parity of esteem within health (between physical and mental health) and between health, social care and public health services. Each needs to be properly funded to achieve their goals and maintain quality as each has a direct impact on the success of the other. Whilst the amount of funding for each service differs according to the population needs, parity of esteem ensures that one service is not given priority over the other in its importance, and that flexibility in the use of the budgets is not to the detriment of any other service.

The method for funding social care is for the Government to determine and outside the remit of the Health Devolution Commission, however a devolved health system will work best if it embraces four personal entitlements, namely that it provides:

- better social care to more people in need
- social care to people in their own home wherever possible
- the choice to receive their social care through a personal budget
- a mechanism for people to pay for some or all the elements of their social care if they choose to do so

Some commissioners were also strongly of the opinion that social care, like health care, should be free at the point of use as a principle and as a means to enable full integration with the NHS.

## 6 Funding mechanisms

The implementation of health devolution is easier if any new mechanism for the funding of social care supports:

- a place-based approach to planning and providing all public services
- services that are easy to understand by those using them
- involvement of people who use services in decisions about their services
- a direct element of local democratic accountability
- clinical and civic leaders participate in joint decision making
- partnership structures of health, social care and public health leaders to whom ACOs are accountable
- integration of health, social care and public health budgets in a single budget in devolved areas with a duty to spend on services and in places that ensures greatest health benefits
- joint commissioning of all health, social care and public health services in devolved areas
- flexibility in the use of funding to meet local priorities and achieve better outcomes
- single accountable officers (ACOs) for joint commissioning and integrated budgets
- capitated budget approaches to fund integrated services such as a 'Year of Care' tariff
- strong partnerships between health, social care and public health services; and partnerships with other services that affect health and prosperity in an area such as housing, transport, education and economic development

## 7 Leadership and accountability

Partnership governance structures in devolved health areas are complex but are necessary to manage the breadth of responsibilities held by different statutory bodies within their footprint. Accountability and scrutiny of decision making across the vast health and social care sector takes place in very many different ways, at many spatial levels and involving a wide range of professional leaders from different sectors and elected leaders.

Clarity of leadership in systems that have both local and national democratic accountabilities is thus important. There will always be an element of 'two hands on the tiller' as elected leaders of devolved health areas (Metro Mayor, leader of the CA or designated leader in non-CA areas) would not have exclusive control of the NHS or social care services. The leadership and accountability arrangements within a devolved health area should be endorsed by local democratic leaders and local health care managers with a presumption that ICS level policy is designed to align with local level plans and the ICS is chaired by a Metro Mayor or equivalent elected leader.

Ensuring clarity of leadership and proper democratic accountability requires explicit and agreed:

- mandates between Government and devolved health areas
- roles of elected leaders and healthcare managers at different spatial levels within devolved areas
- scrutiny structures aligned with devolved health areas

## 8 Principles of comprehensive health devolution

### Strong relationships

At the heart of comprehensive health devolution are strong relationships between the public and their services, between civic and clinical leaders, between the workforce and managers of different services, and between local and national tiers of government.

### Partnership working

Health devolution provides the opportunity for key stakeholders outside of statutory bodies to be 'at the table' at all stages planning, delivery and scrutiny in devolved health areas, and this includes clinicians, patient voice and carers organisations such as Healthwatch, the VCSE sector, trades unions and private health and social care providers. A real strength of the devolved approach is the active partnership working with sectors such as voluntary, community and social enterprise organisations that can harness the voice of local communities, deliver innovation and reach people that others find hard to engage with.

### Workforce integration

Health devolution can be accelerated through integration of health and social care workforce planning and management, and addressing key issues of low pay, insecure employment and low-level training standards for care workers. The people involved in a successful devolved and integrated health and social care system are much broader than clinicians and care workers, and a common workforce framework is best if it encompasses three broad layers:

- The paid staff working in formal health and social care settings employed by the public, private and VCSE sectors (e.g. hospitals, care homes, GP surgeries, community health services, and domiciliary care providers)
- The paid staff working in informal settings at home or in the community (e.g. personal assistants to individuals)
- The volunteers, friends and family that provide personal and community support to people with health and social care needs, and who can help to address issues such as loneliness and isolation

A place-based common framework based on parity of esteem for health and social care staff in relation to pay and conditions of work, recruitment, apprenticeships, and training and education could be developed in devolved health areas. This should be developed in consultation with employers and trades unions and could provide the basis for full integration of the health and social care workforce in the longer term. A broader People Plan for the NHS and the introduction of regional workforce boards could provide an opportunity that should not be missed to develop greater integration of the NHS, social care and public health workforce.

### Improving public health and reducing health inequalities

The aims of improving public health and reducing health inequalities are a core purpose of comprehensive health devolution. This requires robust and detailed population data at the level of the individual to plan and deliver the 'health in all policies' approach across a range of local services to tackle the wider social determinants of physical and mental ill-health such as poverty, poor housing, poor diet, negative lifestyle choices, poor environment, and job insecurity/unemployment in local communities

### Personalised care

A commitment to personalised care should be an essential element of health and social care services provided in devolved areas. This includes providing access to personal health and social care budgets for those that want them, and recognising the role that unpaid carers – family and friends – play in people's care. The principles of personalisation should be clearly articulated and used to inform the design and delivery of those services.

### Community involvement

Active community and citizen involvement (not just community engagement or consultation) helps to build personal resilience, promote healthy behaviour and ensure responsive public services. Community and citizen involvement is a core feature of comprehensive health devolution that cannot be delivered from the centre.

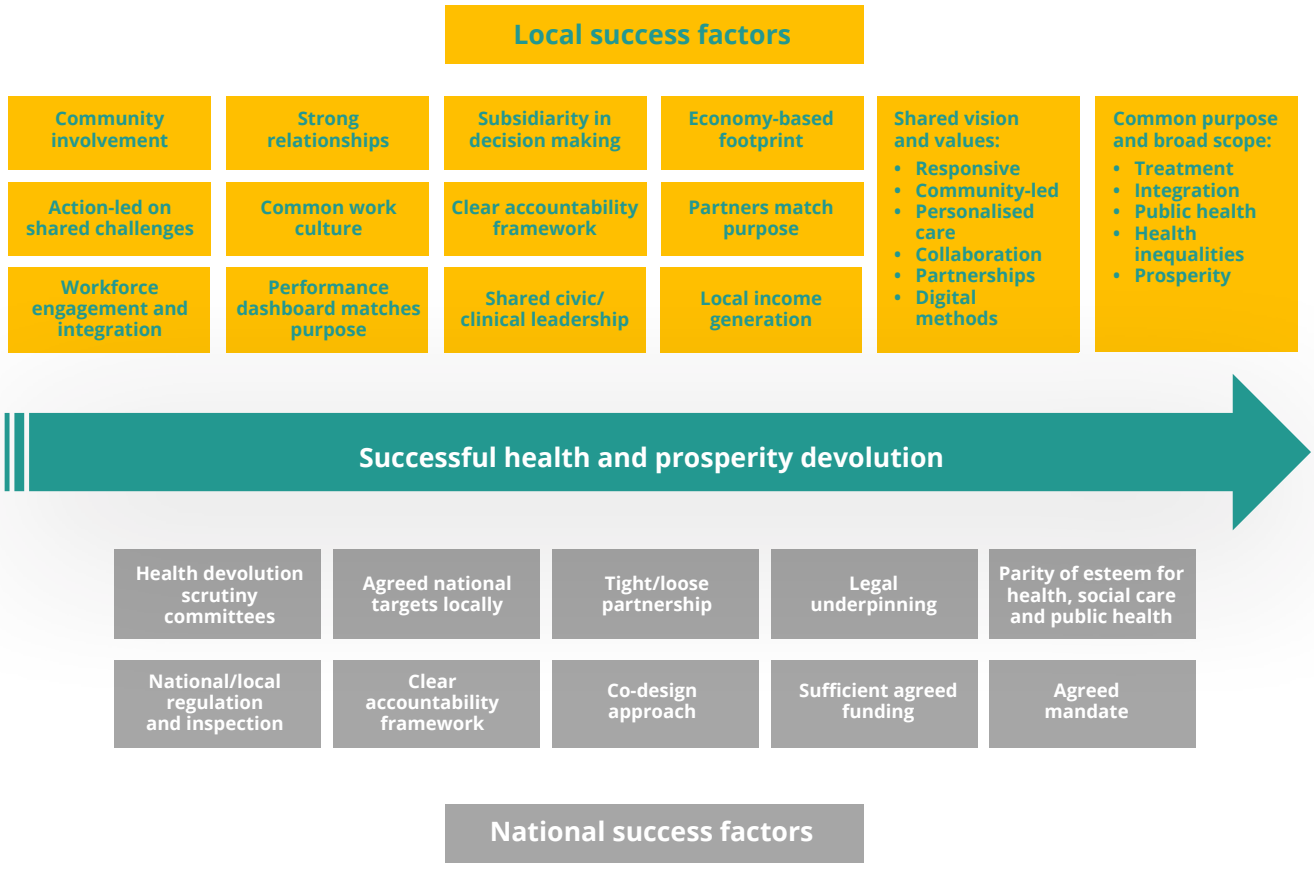
### Digital ways of working

The use of digital ways of working in integrated care records, the delivery of care, and the use of patient, carer and population data for planning care is a major enabler of ensuring better NHS, social care and public health integration, tackling health inequalities and delivering local health and prosperity.

### Success measures

The dashboard of outcome success measures in devolved areas should relate directly to the policy objectives of that area and, where necessary, include any centrally determined outcomes. Health and prosperity areas should have the widest range and number of Key Performance Indicators with varying periods for their assessment. Input success measures on themes such as community involvement, workforce integration and governance should be included within this approach. Figure 5 summarises the local and national critical success factors for comprehensive health devolution:

**Figure 5: Critical success factors for comprehensive health devolution**



## 9 Health devolution in every area of England

Health devolution is possible in every area of England that should be on a journey towards a new 'health and prosperity' approach to health devolution that integrates health, social care and public health services; and aims to improve the health of the population, reduce health inequalities and improve the economic and the economic prosperity of the community. The strategy for delivering health devolution is best if it is co-designed by national and local partners and recognises that:

- Health devolution may proceed more rapidly where appropriate devolved structures such as Metro Mayors and Mayoral Combined Authorities are already in place.
- New structures in areas without Metro Mayors or Combined Authorities (such as many rural areas) are best developed from the bottom up to provide the organisational vehicle and clarity of leadership required for successful health devolution.
- The absence of appropriate vehicles for health devolution in some areas is not be a barrier to progress in other areas that are ready to proceed.
- Integrated Care Systems (ICSs) are an integral part of devolved health systems but are unlikely to be the vehicle for health and prosperity devolution unless they broaden their scope to embrace social care, public health and economic development; and include clear local democratic accountability in their ways of working.
- The geographical footprints of devolved health areas are best determined locally and agreed nationally, and reflect relevant local government and NHS boundaries.
- Health devolution is not something to be 'earned' locally or awarded by the centre. The role of the centre is to support regions or areas to build healthy, resilient and prosperous communities through health devolution.

### Detailed Recommendations

The Commission calls upon the Government to:

#### 1 Take early action to adopt and implement comprehensive health devolution

I. Develop comprehensive health devolution in every part of England through a new Common Framework and a rapid joint implementation programme that best reflects local boundaries and organisational footprints

II. Integrate NHS, social care and public health workforce planning and management to accelerate local joint working and service integration

III. Produce a new Partnership Compact for working with key stakeholders such as clinicians, patient voice and carers organisations, the VCSE sector, trades unions and health and social care providers in devolved areas

#### 2 Fund and integrate health, social care and public health

I. Establish parity of esteem between physical and mental health funding within the NHS, and between the NHS, social care and public health funding in a new comprehensive health mandate.

II. Provide an immediate and very substantial increase to the funding of social care and public health services.

III. Create a new, well-funded long-term settlement for social care that provides better support to more people in need and supports a place-based approach to delivering integrated NHS, social care and public health services including a locally-led, single comprehensive care budget.

### 3 Establish new mechanisms of accountability and scrutiny

I. Establish an Annual Joint Mandate (AJM) between the Secretary of State for Health and Social Care and each devolved health area leader (Metro Mayors, leaders of Combined Authorities with no Metro Mayor and designated leaders in non-Combined Authority areas)

II. Give a formal health role to Metro Mayors, leaders of Combined Authorities with no Metro Mayor and designated leaders in non-Combined Authority areas

III. Establish new city region health and prosperity scrutiny committees and give a statutory role for Healthwatch in every devolved health area

### 4 Give legislative support to comprehensive health devolution

I. Give a statutory public health improvement role to Metro Mayors, leaders of Combined Authority areas with no Metro mayors and leaders of partnerships in non-Combined Authority areas

II. Create a permissive legislative framework that enables locally determined proposals for health devolution to be brought forward in Metro Mayor areas, Combined Authority areas with no Metro Mayors and non-Combined Authority areas

III. Ensure any stocktake and reformulation of the law governing the NHS, the outcomes from the social care task force, proposals arising from the prevention Green Paper, a future White Paper on devolution, and reform in response to the pandemic, all support comprehensive health devolution

# Appendices

## APPENDIX 1: KEY QUESTIONS IN THE CALL FOR EVIDENCE

### What does good health devolution look like?

- In what ways does health devolution enable the building of healthier communities and the prevention of ill-health?
- In what ways does health devolution enable the marshalling of a wide range of services and partners across local authorities and the NHS to address the wider drivers of ill-health in local communities?
- Are there any barriers to the potential benefits of health devolution being realised; and if so how could these be addressed?
- How does health devolution affect the outcomes and experience of care for people with specific conditions such as cancer or mental health, or specific population groups such as older people with health and social care needs such as dementia?
- To what extent does health devolution accelerate integration within the NHS and between health and social care services, and make the NHS Long Term Plan a reality?

### What are the implications of health devolution for accountability, power and control in devolved health systems?

- What is the relationship between central Government, NHSE and devolved health areas? In what way is the Secretary of State for Health and Social Care and NHSE held accountable for improving a community's health as well as NHS performance in devolved health and social care systems?
- How can local leaders in devolved health systems be held accountable locally and nationally at the same time for the performance of locally integrated services?
- What is the nature of the relationships between local clinical leaders and civic (professional and elected) leaders? What decisions are each responsible for in a devolved system?
- How do devolved health systems affect policies to empower individuals to have more control over their health and social care services and outcomes?
- What impact do devolved health systems have on the charity sector, social enterprises and the independent sector as providers and partners in health and social care structures?

## APPENDIX 2: WHAT DOES GOOD HEALTH DEVOLUTION LOOK LIKE?

### Summary of responses

### 1 In what ways does health devolution enable the building of healthier communities and the prevention of ill-health?

#### 1.1 National bodies and federations

**Public Health England** (PHE) describes devolution to Mayoral Combined Authorities (MCAs) an opportunity to develop and embed their 'health and wealth' approach to building healthier communities and preventing ill-health. MCAs are seen as having the potential to implement preventive policies at scale as they operate on a large geographical footprint corresponding to a functional local economic area.

**The NHS Confederation** is clear that ensuring a thriving, healthy, productive and prosperous place is a shared priority and responsibility. They emphasise that there is mutual benefit for health services and the local economy in aligning health with growth. Health is seen as central to Local Industrial Strategies. Devolution of economic policy levers and the NHS should be more closely aligned and co-designed. Two examples are cited: 'YHealth for Growth' is an initiative that focuses on the role of health and care in driving economic and inclusive growth strategies in in the Yorkshire and Humber regions; and the alignment of plans for health and care and the Local Industrial Strategy in West Yorkshire and Harrogate, and the Leeds city region.

**The Welsh NHS Confederation** describes how the law in Wales sets out how public bodies need to consider the long-term impact of their decisions, to work better with people, communities and each other to prevent persistent inequalities such as poverty, health inequalities and climate change.

**NHS Providers** (NHSP) believes that prevention goes beyond health services and public health functions given the wide range of factors which contribute to the health and wellbeing of a population. It says it is reasonable to suggest that devolving responsibility for health services to local areas, in alignment with local government responsibilities for public health may support greater alignment between the NHS and councils' local objectives for prevention. Devolved responsibilities and budgets may be one way of creating a tailored, locally driven approach to tackling the wider determinants of ill-health. HD gives more freedom to set a local vision for health, distribute funding in line with objectives, and empower all system partners to see themselves as part of the solution. As anchor institutions trusts are a key player in tackling the wider determinants of health and having a positive influence on local economic, social and environmental factors including employing a local workforce, purchasing goods and services locally with public money, and reducing its environmental impact. This in turn supports the health and wellbeing of the local population.

**Health Education England** (HEE) believe that workforce, education and training within devolved areas enables partners and providers across health and social care to better collaborate to meet population needs and deliver on priorities. Comprehensive health devolution will complement national planning and development initiatives and resources enabling devolved areas to maximise their investment and will display four main characteristics:

- Realising local workforce investments
- Maximising educational capacity
- Drawing on a data and digitally ready workforce
- Optimising evidence, data and knowledge
- Fully engaged, health literate citizens

Whilst national oversight of education, training, workforce planning and transformation for health and care is viewed as critical, HEE believes that education, training and workforce provide a neutral frame to allow partners to establish a common focus for local change.

**The Breaking Barriers** Innovation pilot projects on place and the social determinants of health suggest that god health devolution requires a focus on population health needs, including specific demographic variations; and workforce planning and transformation as part of wider system change.

**Healthwatch** believes that health devolution can put the focus on people and place rather than on an individual organisation. Consideration of the wider determinants of health and an understanding more broadly of what contributes to healthier communities is fundamental to success.

### 1.2 Local bodies and partnerships

**The West Yorkshire and Harrogate** (WYH) health and social care partnership believe their system includes many features associated with comprehensive health devolution. Their partnership enables them to tackle the drivers of ill-health in a holistic way going beyond the NHS into wider determinants of health and wellbeing focusing on education and skill, social mobility, housing and employment. They cite as examples: tackling inequalities being part of their 5-year strategy; rolling out the healthy hearts programme; work to support carers and neighbours to combat social isolation; and unlocking local talent through a wider approach to employment and skills.

**The Greater Manchester Health and Social Care Partnership** (GM) has been at the forefront of devolution generally for many years and health devolution in particular since 2016.GM has developed a clear set of health devolution principles and created a number of key objectives relating to a focus on prevention of ill-health and the promotion of wellbeing, and contributing to local economic growth.

**The Healthier Fleetwood and Fleetwood Primary Care Network** (PCN) has created a model of integrated care with Multi-Disciplinary Teams (MDTs) from many different health providers and social care. This has developed into a 'total neighbourhood' model that facilitates joint working across health, social care, education, housing and the local authority. This also includes a vibrant resident led social movement to create a healthier community for each and every resident. Taken together this has led to residents turning their lives around; health care professionals enjoying this way or working; fully staffed services and significant reductions in A&E attendances and emergency hospital admissions.

### 1.3 Clinical representative bodies

**The Royal College of Occupational Therapists** (RCOT) say that a national approach is needed that structures better services around people and that health devolution could assist the creation of such structures and ways of working that fully use health professionals like OTs.

**The Royal College of Radiologists** (RCOR) believe that Health Devolution (HD) allows decision making to be more responsive to varying local needs. However full devolution may be challenging due to potential for inequality of access and performance against national standards.

Th**e Association of Anaesthetists** (AoA) say good HD is agile and responsive to local demands whilst still accepting underpinning from the NHS strategy and framework. It allows funding to be directed to local health priorities and local solutions to be developed. This leads to increased ownership and outcomes; and for health education to be targeted at specific groups.

**The Faculty of Sexual and Reproductive Health** (FRSH) have a vision of comprehensive, holistic sexual and reproductive healthcare across the lifespan; and stress the importance of integration to create clear referral pathways between services. They believe HD can support their vision through the integration of healthcare services.

### 1.4 Charities and social enterprises

**Cancer Research UK** (CRUK) is encouraged by their experience in GM of Health Devolution (HD) being helpful in improving the prevention, diagnosis and treatment of cancer. HD is seen as being responsive to local needs and, when it is adequately resourced, of securing a coherent people-centred approach. Three programmes are cited as good examples: the GM Making Smoking History programme; the Yorkshire and Humber's Don't be the 1'; and the Cancer Vanguards. It believes that much can be done locally to prevent smoking and obesity through health devolution. HD, by placing the individual at the centre is well placed to deal with the rising challenge of health inequalities, and deprivation as one of its main causes.

**Macmillan Cancer Support** (Macmillan) has evidence that that when local authorities and the NHS collaborate around reducing inequalities and use their shared knowledge, power and resources it creates potential for greater investment, more targeted policies and better actions for deprived communities. It cites the 2018 London Health Inequalities Strategy that says that prevention and early diagnosis limits health inequalities in cancer. It says that although it is difficult to evidence the impact of a whole system population health approach, devolution allows for a stronger and more ambitious vision for health and social care, reinforcing collaborative working and ensuring that good practice, successful approaches and programmes are spread effectively through policy direction.

**Mind** believe that good devolution for mental health would enable people with mental health problems to receive timely and equal access to high quality services; person-centred care with choice and control; and to be treated with dignity and respect. To achieve that, good HD should support organisations to work together and provide integrated care across the system; include sufficient accountability and reporting of performance to enable comparisons between different areas; support the involvement of the third sector and users in design and delivery of services; and supports longer-term preventative approaches to tackling mental health and other health inequalities.

### 1.5 Academic studies

**Dr Lazo's** 2019 PhD study describes the power awarded to GM as an illusion because it is still subject to the NHS constitution and Mandate and operates through a series of Memoranda of Understanding (MoUs). It is a 'hands-off' mechanism allowing NHSE influence whilst giving the local partnership some level of autonomy. Key elements of GM's success are the political leadership partnership between the Mayor and the NHSE Chief Officer; the Partnership's response to barriers to devolution; the engagement and co-design of frameworks and networks at all stages; and a collective ambition and attitude of local ownership throughout.

Major barriers to devolution within the NHS are the culture of fragmented working, lines of accountability, competition, and resistance to collaboration, between different parts of the system. It concludes that with the right combination of leadership, trust, and collective intention to resolve joint problems, then it is possible to overcome the political barriers of devolution. GM are able to successfully craft, enforce, and monitor their own institutional arrangements to overcome the limitations of the formal rules and to use them as countermeasures to self-seeking behaviour.

All the other academic studies are about decentralisation rather than devolution and focus narrowly on the health services and the NHS. **The IJHPM 2019 research** comparing the impact of decentralisation in European countries says that many of the promises of decentralisation have proven difficult to materialise; that it is a policy that has spread without much empirical evidence; and that there is no clear evidence of the effects of it on health system performance.

**The NIHRSDO 2010 research** concludes that decentralisation is a means to an end, and that its policy objectives need to be clearly defined.

Decentralisation and centralisation usually exist together so clarification is needed about what is being decentralised – inputs and process as distinct from outcomes. The success of decentralisation depends on the nature of the local health economy particularly the quality of collaboration between local agencies. It concludes that decentralisation must be accompanied by regulation and performance management to prevent more local autonomy fragmenting health systems and ensure that system-wide objectives are met; but that these centralising processes need to be sensitive to local contexts. It warns that decentralisation cannot achieve specific outcomes always and everywhere so it will have mixed benefits and involves policy compromises say between equity and efficiency.

**The NCCSDO 2006 research** into decentralisation in health policy in England says that decentralisation is a problematic concept with significant problems of definition and links with other terms such as autonomy and localism that are also problematic. It says the debate about decentralisation lacks any maturity and sophistication and that assumptions about its effects have been incorporated into policy with reference to whether evidence or theory supports such an approach.

## 2 In what ways does health devolution enable the marshalling of a wide range of services and partners across local authorities and the NHS to address the wider drivers of ill-health in local communities?

### 2.1 National bodies and federations

**PHE** believe that MCAs can integrate public health into local economic and public service reform strategies, linking health improvement with improved productivity and more effective demand management for critically stretched statutory services.

**The NHS Confederation** have produced advice and information drawn from its members' experiences on the benefits and mechanisms for 'Letting Local Systems Lead' and 'Delivering Together' on partnership working, integration and relationships between local and central bodies. It has created a Health Economic Partnerships programme of work to focus on a range of policy areas that connect health and wealth locally including skills, innovation, population health, estates and finance.

**NHSP** say that whilst devolution may be one way to support closer working, the underpinning relationships remain crucial to developing an integrated approach to health and wellbeing. Devolution does not necessarily remove barriers related to cultural and organisational differences. The GM model is cited as a valuable example of how HD can bring system partners together and promote a preventive approach that in time improves population health.

**The LGA** is clear that health devolution is not an end in itself but is a means to secure local freedom, responsibility and accountability to achieve improved health and wellbeing outcomes, better health and care services and better use of resources. Local government delivers local solutions to national problems. The NHS and ICSs need a better understanding of what local government brings to the table and there should be parity between social care services and the NHS. It outlines a continuum of arrangements that exist under the health devolution banner; and identifies 7 health devolution areas but expresses scepticism about their delivery of such an ambition in practice. They believe resources are critical and must be sufficient to do the job.

**Healthwatch** stress the importance of involving people, patients and carers in the process of marshalling local resources to tackle the wider drivers of ill-health. Involving people means that solutions are more likely to be designed around what people actually need as opposed to what policy and decision makers think people need, which increases the likelihood of solutions working first time.

## 2.2 Local bodies and partnerships

**In WYG**, the Leeds City Region Local Economic Partnership operates on a similar footprint to the ICS that helps bring together the heath and equitable growth agenda. There is significant overlap between the 5-year strategy and the Local Industrial Strategy and a recent devolution deal for West Yorkshire in the 2020 budget will reinforce this.

**GM** has created a clear governance framework and architecture with a single commissioning system and new Local Care Organisations (LCOs) embracing health and social care. It has a vision of whole system public service reform to extend integration to create a GM Model of Unified Public Services. GM draws attention to the similarities of GM with plans for Integrated Care Systems (ICSs) in terms of their dual roles but highlights the relative narrowness of ICSs to GM with its whole public service partnership approach and the contribution to its goals from the whole of local government, police, fire, economic development, education, skills and housing.

## 2.3 Clinical representative bodies

**RCOT** says that Health devolution (HD) encourages closer collaboration between health and care and is an opportunity to better integrate health and housing as equal partners; and link with to community resources such as libraries. Scotland's integrated health and social care system is cited as an example of HD working which has also provided the opportunity to streamline key Scottish institutions such as CQC, NHSI, NHSS and Health Protection into one body.

**RCOR** say that health devolution should be a coming together of services; primary, secondary, third-sector and social care, to meet a central standard and better serve the needs of patients and carers in their locality through flexibility in how resources are used and finding local solutions.

**AoA** say HD offers an opportunity for health inequalities in an area to be addressed.

**FRSH** identify the greatest barriers to integrated SRH care as lack of funding for public health, fragmented commissioning of services and lack of accountability across the system. It says that HD can address these system barriers; and that to prevent ill-health it wants to see networks of care with common goals, clear leadership and cross institutional boundaries spanning health, public health and social care. PCNs are seen as a crucial new way of achieving these outcomes at a local level.

## 2.4 Charities and social enterprises

**CRUK** is interested in the role of Metro Mayors in helping to provide political will to address local health needs. They are great examples of local leaders being able to marshal a wide range of services and local partners on certain health needs. CRUK views Cancer Alliances (CAs) as health devolution on cancer in practice and are seen as strong examples of efforts to integrate care. CAs will align with ICSs as part of the LTP.

**Macmillan** cite GM as a good example of how devolution has boosted an already existing culture of collaboration at place and system-wide levels.

**Mind** believes that devolution for mental health has a range of benefits including decisions being made closer to home; more responsiveness to local needs; greater ownership and responsibility, closer partnership working; a more preventative approach to health; aligning policies within an area to tackle the determinants of good mental health; system savings that can be reinvested; multidisciplinary approach to the workforce; a stronger voice for the third sector; and community engagement.

But Mind are very concerned that HD could exacerbate local variation in the quality of mental health service particularly if there is poor leadership. And therefore strong national oversight is needed to avoid people

with mental health problems being marginalised or stigmatised; and poor quality services to go unchecked. However, Mind also describes a number of advantages of health devolution including investing in and co-ordinating population mental health programmes; aligning budgets across public services to achieve better mental health in the community; and investing more resources into primary care before people's mental health deteriorates.

**Mind** also believe that whilst poverty is a huge driver of ill health, so is discrimination, crime, domestic violence, poor childhood experiences, addiction – and these are not solely the preserve of the poor. These require a focus on community building, early intervention, addressing discrimination particularly race discrimination, as well as building prosperity in comprehensive health devolution.

**Alzheimer's Society** says the devolution of Greater Manchester Health and Social Care has given them a unique opportunity to create a joined up and consistent dementia pathway across the ten boroughs of Greater Manchester. Dementia United and Alzheimer's Society agreed to formally work in partnership in January 2020, to develop programmes of work which aim to enhance the health and wellbeing of those living with or affected by dementia in Greater Manchester (GM), to benefit people across all ten boroughs.

Through this collaboration they aim to achieve the shared ambition to transform structures, systems, support and representation of people affected by dementia in GM ; together the partners will make GM the best place in the UK to live with dementia with sustainable and effective solutions. This collaboration also offers the opportunity to develop new and wider partnerships with other key stakeholders, and to gather more information about the impact of dementia support on the lives of people living with dementia in the community.

From diagnosis, people living with dementia find themselves having to navigate a range of services and professionals the aim of the partnership is to create a model of care provision that works and is consistent throughout diagnosis, treatment and appropriate care provision. This plan aims to create the greatest and fastest possible improvement to integrated health and social care in Greater Manchester, aligned to the themes of the broader "Dementia United" transformational plan.

These themes are parallel to the NHS Well Pathway for dementia as well as underpinned by the NHS Long Term Plan ambition "We will go further in improving the care we provide to people with dementia and delirium, whether they are in hospital or at home."

## 3 Are there any barriers to the potential benefits of health devolution being realised; and if so how could these be addressed?

### 3.1 National bodies and federations

**PHE** identify the main barriers as being: system knowledge; lack of geographical alignment across system; national silos; and insufficient prevention funding and powers.

**The NHS Confederation** identifies two key barriers to HD being realised: the lack of a central narrative that connects Integrated Care Systems to the wider local growth and devolution agenda; and not having a greater level of 'place sensitivity' in the health and social care system around issues such as research and innovation, skills and anchor institution activity.

**NHSP** believes that in reality health devolution in its current form is really delegation of powers and funding as national standards must be met by both devolved and non-devolved areas, and transformation funding is accompanied by mandated programmes and services. It emphasises that it is crucial to deliver on the national constitutional standards first and foremost but recognises that this lack of flexibility can curb local autonomy to focus on local priorities tailored to population needs.

It puts it quite starkly - 'devolution would not be successful if local determination was allowed to put critical services at risk'. Other barriers they cite are lack of clarity about the freedom and flexibilities open to ICSs and the extra tier of performance management and accountability these create; poor relationships and differences in culture and accountability structures between NHS and local government; and lack of clarity in how county council chiefs and metro mayors will interact with ICSs in their footprint.

**The LGA** has a clear view that there is no one model or governance that is right for every area, and where greater accountability is needed it is for the area to develop its own proposals. It promotes the principle of subsidiarity in health and wellbeing namely that decisions should be taken as close as possible to the communities they affect and areas should have the freedom and flexibility to develop their own locally appropriate arrangements. On this basis, their focus is on relationships and decision-making within STPs and ICSs at a system level, Health and Wellbeing Boards (HWBs) at a place level and PCNs in neighbourhoods. The principle of subsidiarity however, should apply to devolution of powers and responsibilities from national government and arms-length bodies to more local levels of decision-making in the NHS and local government. The decision to propose health devolution is one for councils to make in partnership with their health partners.

**Healthwatch** identify a number of features of comprehensive health devolution that if not in place could be barriers to success including putting people at the very heart of services; reaching out to those who are typically under-served and seldom heard; focusing on individual and population outcomes not just clinical outcomes; is joined up across MHS, local authority and voluntary, community and social enterprises; considers the whole process of accessing care such as transport; has the patient, carer and public voice represented formally at all levels.

### 3.2 Local bodies and partnerships

**WYH** express concern that additional freedoms and flexibilities enable them to build on their effective partnership between health, local government, academia, business, the third sector and their local communities; and do not impose structures or ways of working not suited to local circumstances.

**GM** identifies the absence of a stable long-term financial settlement for social care is a source of significant pressure across the system. Other barriers include: partial regulatory delegation; statutory regulatory functions not easily sitting a part of the partnership; tension between accountability in the NHS and local democratic accountability; building trust and progress taking time; having too many priorities and spreading focus too thin so genuine ownership of the project not being deep enough in some places; and the constant challenge of choosing the right things to do at the right level.

**The GMC** are concerned that health devolution will have an unhelpful impact on the standardisation of data, as a major part of their work is intelligence gathering and analysing regionally sourced data to understand what doctors do.

### 3.3 Clinical representative bodies

**RCOT** emphasise that progress on HD will be faster in some areas than depending on the previous history of collaborative working in the area.

**RCOR** list a number of barriers to HD including political agendas, lack of funding, reduced LA budgets, interference form the centre, national approaches that don't lend themselves to local solutions, siloed funding, the long time it takes to see improvements in population health, local managerial and political commitment, lack of good data-based planning, resources and overarching strategy. HD would be helped by giving ICSs legislative power to organise care across providers and greater involvement of patients and carers.

**AoA** identify the main barriers to HD as centralised targets and demands, competing priorities, cost and lack of leadership. It says that there is a risk that HD could result in a post-code lottery and this needs to be avoided. Lines of responsibility need to be clearer and more flexibility introduced into the system.

**SRH** say Commissioning of SRH services is highly fragmented and split between CCGs, NHSE and local authorities creating confusion and barriers for women trying to access healthcare. These barriers to service integration must be overcome of HD is to be successful. Service fragmentation and the duty of competition on CCGs conflicts with the goals of collaboration and integration. Whilst prevention is the cornerstone of the LTP, clinicians cannot offer preventive care if they are not commissioned to do so. Through co-commissioning HD has the potential to remove arbitrary boundaries between service providers to deliver integrated services in a holistic way.

### 3.3 Charities and social enterprises

**CRUK** is concerned that the NHS is consistently failing to meet many of its core targets such as Cancer Waiting Times (CWT) and that devolved areas like GM as well as non-devolved areas are not meeting these targets. However, it recognises that local areas can act by focusing on issues that causing poor performance locally citing the Kent and Medway Cancer Alliance as a good example. Barriers to integration they cite include: complex funding flows and payment mechanisms within the NHS; misaligned incentives; and lack of statutory underpinning for a system approach to working.

**Macmillan** identify financial pressures and workforce challenges as significant barriers to the benefits of HD being realised. The accountability and transparency of the devolved system in GM has led to much greater engagement and acceptance from the public.

**Mind** says that successful programmes to tackle poor performance among mental health services have largely been top down such the LTP, the 5 year forward view for mental health, IAPT and the mental health investment standard. Local performance has often relied on personalities and relationships but this brings risks of more variation in quality. National targets and standards on the other hand can be very effective mechanisms to drive improvements and provide accountability for performance. Mental health services have often been the junior partner with within local health systems dominated by large acute hospitals. Funding mechanisms of block contracts when funding is cut has led to raised thresholds of access so two-thirds of people receive no appropriate treatment. Resources need to follow any further moves to devolution – devolution isn't a magic wand to improve services. Returning public health to local authorities without the funding to accompany has seen a catastrophic collapse in non-statutory services such as smoking cessation.

## 4 How does health devolution affect the outcomes and experience of care for people with specific conditions such as cancer or mental health, or specific population groups such as older people with health and social care needs such as dementia?

### 4.1 National bodies and federations

**NHSP** say people with long-term conditions and vulnerable may benefit from an approach in which all services consider the impact of their condition. And integration may help challenges in joining up such services. However, devolving funding will not automatically solve these problems if the amount of money is insufficient and could lead to diversion of funding away from these services.

### 4.2 Local bodies and partnerships

**WYH** give a number of examples including: taking shared accountability for cancer waiting times in the region led by their Cancer Alliance; making major service changes for Hyper Acute Stroke Unit; using new care models for adult eating disorders with measurable improvements for patient lives; and a preferred model for Assessment and Treatment Units for people with a learning disability.

**Achievements in GM** include improvements in smoking reduction; school readiness; cancer survival rates; support for people at risk of unemployment because of ill-health; activity rates in the population; babies born alive and well; people admitted to hospital for alcohol-related conditions; access to and quality of GP services; and the quality of care home beds and domiciliary care.

### 4.3 Clinical representative bodies

**RCOR** believe HD can help identify local challenges and target investment. However, it must not become 'multi-tiered' and geographically dependant; and ensure cancer patients will receive excellent treatment, and have equal access to imaging equipment and optimum cancer treatments no matter where they live.

**AoA** say HD can address the needs of specific groups because it can lead to highly personalised and local delivery of services. However, there could be losses of the benefits of centralisation especially variance reduction and economies of scale.

**FRSH** are critical that since 2015 2/3 of councils have reduced or frozen their SRH budgets; and that one in ten reduced the number of contracts with GPs on certain kinds of contraception for women. HD does not deal with what is primarily a funding shortage.

### 4.4 Charities and social enterprises

**CRUK** is concerned that stop smoking services and tobacco control have been badly affected by reductions to public health funding. It says that the link between local authorities and local NHS services needs to be readdressed as the current system is locked into a treatment approach and will be subject to increased demands and pressures. It is interested in the role of Metro Mayors in helping to provide political will to address local health needs.

**Macmillan** say that HD in GM has allowed their system work on cancer to be integrated into their population health planning. This has meant combining public health and prevention elements with measures to tackle the wider determinants of health as well as health inequalities after the point of diagnosis. The Macmillan experience in Scotland has shown how integration can improve care for everyone particularly the most socio-economically deprived.

**Mind** cite a report by the charity 'Centre for Mental Health' that ICSs offer three opportunities for mental health: preventing ill-health as mental illness contributes to physical ill-health; linking physical and mental health by ensuring that all physical ill-health interventions are equally accessible to people with mental health problems; and improving mental health services at a system level such as reducing 'out of area' placements or the overuse of long-term hospital placements. But Mind also draw attention to the concerns that ICs pose challenges for mental health such as prioritising mental health, expanding the workforce, working in partnership with LAs and engaging with the third sector. Mind also cites a report by the Royal College of Psychiatrists that says the ICSs have potential to improve mental health outcomes; integrate mental health services with the rest of the health and social care system; and develop system-wide incentives to improve mental health care.

**Alzheimer's Society** says that from accessing post diagnostic support that can help people to carry on living well and independently in their own home, through to putting more complex packages of care in place, the experiences of people affected by dementia have highlighted that they often have to navigate through up to 20 different services to get the essential care and support they need. They depict a complex 'web' of people and services with whom they have to interact and navigate in order to get the care and support they need. This web encompasses the health and social care needs of the person with dementia and includes a range of services; from those directly related to day to day management and care, to managing direct payments, access to out of hours doctors, access to services regarding comorbidities or routine treatment, equipment services and other forms of support.

## 5 To what extent does health devolution accelerate integration within the NHS and between health and social care services, and make the NHS Long Term Plan (LTP) a reality?

### 5.1 National bodies and federations

The NHS Confederation supports local systems to become Integrated Care partnerships and has established the Health and Care leaders Forum as part of this work. It recognises that PCNs are critical to delivery of the LTP and has established the PCN network to support and promote them.

**NHSP** say different models of HD have the potential to accelerate integration including pooling CCG and LA commissioning budgets and developing joint commissioning functions although these have been happening in non-devolved areas too. They raise a concern that whilst the GM model has helped to generate a social movement around the wider determinants of ill-health it has struggled to perform well against national standards such as the 4-hour A&E wait and DTOCs in some areas.

### 5.2 Local bodies and partnerships

**WYH** give a number of examples for this: a collaborative approach to financial planning and management has kept them within budgets and produced a balanced and credible five year financial plan; strong collaborative commissioning arrangements; digital ways of working; attracting capital funding; strong acute and mental health trust collaborative arrangements; apprenticeship flexibility; staff portability; Academic Health Science Network partnership; and diversity of leadership including BAME.

**In GM** health devolution has led to clear governance for delivering the LTP, a track record in managing transformation and system control, contract deals without recourse to national support or arbitration, undertaking CCG assurance and regulation, and regularly managing system level exceptions. New ways of working include: distributed leadership for key improvement areas such as cancer, elective care, and urgent and emergency care; standards agreed at GM level with clear governance for locality oversight; and GM-wide transformation projects that add value to local work such as mental health out of area placement. GM have ended each year of devolution with a financial surplus but concerns include: not securing the reliable delivery of NHS Constitutional Standards; too much variation in progress across localities within GM to reduce demand for acute services and in the development of robust LCOs; and insufficient workforce capacity.

### 5.3 Clinical representative bodies

**RCOR** says whilst there may be local integration, national services will remain fragmented. Need to shift power from GOP consortia and Foundation Trusts to ICSs. Need incentives for people to work together so people come out of silos to do the right thing for patients and carers.

**AoA** say there is no evidence that HD accelerates integration yet.

### 5.4 Charities and social enterprises

**Macmillan** acknowledge that integration of health and social care as a key factor in building healthier communities but that devolution is not a pre-requisite for integration. However, HD can provide political will, momentum, collaborative working and a whole system approach that makes integration easier to achieve. It believes the LTP played down the role of LAs and HWBs with ore power and control going to ICSs.

**Alzheimer's Society** says that integrated health and social care is essential to the future of care and support for people with dementia. It is clear to Alzheimer's Society that devolution presents an opportunity to really drive integration forward, creating a modern health and social care system which is both cost-effective and tailored specifically to the needs of local communities.

Poorly integrated care and the lack community provision often means people with dementia do not receive sufficient support until their needs reach crisis point, at which point they are often admitted to hospital. Once there, extended length of stay can often negatively impact their dementia and cause more rapid deterioration. This results in people with dementia experiencing delayed transfer of care (delayed discharge) due to the fact that their needs may have changed, but that systems aren't coordinated well enough to get them where they need to be or provide the extra support they need.

In addition to the impact on the person with dementia, this also has cost unnecessary cost implications for the NHS. From a practical, service provision perspective, better integrated health and social care provides an opportunity to improve quality, reduce unnecessary duplication and wastage of resources and increase both staff and financial efficiency. From the perspective of people affected by dementia efficient, effective integrated systems will help to sustain and improve diagnosis and enable the delivery of comprehensive post diagnostic support and person centred care. This will support people with dementia to remain in their own homes for longer, avoiding unnecessary admissions, and will reduce the length of stay and adverse outcomes from delayed transfer of care that we know people with dementia experience.

## 6 How do devolved health systems affect policies to empower individuals to have more control over their health and social care services and outcomes?

### 6.1 National bodies and federations

**Healthwatch** believe that devolution 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 people they love and care for) are made. All structures should 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.

### 6.2 Academics and individuals

**Peter Hay's** personal submission argues that the health and social care system should simultaneously develop both good person-centred care and community approaches to be effective. And that this requires a different approach to power, control and accountability. He describes comprehensive health devolution as being a way of working that:

- Recognises the uniqueness of communities
- Values outcomes
- Builds and keeps relationships over time
- Recognises that social care is about people as individuals who want 'a good life' within their communities and systems
- Works with choice and control from the person up

He identifies two fundamental principles that a devolved health system should incorporate: to be centred on people, their hopes and fears; and to support rights based social care. Drawing on the 'lens of social care' he goes on to identify four key features as key criteria in health devolution:

- The recognition and exercise of the legal powers to shape 'care markets' around people and communities
- The shaping of power with people and communities, so that the system is good for me and good for us
- New systems of measurement, accountability and learning
- Supporting new forms of collaborative leadership within a learning and adaptive system

### 6.3 Charities and social enterprises

**Alzheimer's Society** says that dementia turns lives upside-down, there is currently no cure and almost everyone knows someone who has been affected. How dementia affects people is not simply due to the disease itself, but also as a consequence of how well they can access the care and support they need - too many people living with dementia face the condition alone, or they and their families struggle to access the services that they need, either because they are inadequate, or due to the fact that the current system that delivers that care and support is completely disjointed and overly complex. The complex nature of dementia and how it affects people means that care and support must also be provided in a highly personalised way that meets their individual needs.

**Mind** strongly emphasises the critical role that the VCSE sector plays in building effective health devolution and indeed in building healthy communities. The VCSE acts as a conduit between services and communities, it can harness the voice of communities in to local debates, as well as delivering innovations, services and reach in to parts of the system it is harder to engage with. Robust engagement with the VSCE and funding and frameworks for commissioning the VCSE to be active partners in identifying and addressing health in the population is seen as very important. It says the real strengths of a devolved approach is the potential to better harness the leadership and assets in communities (community organisations, volunteers, activists, people with lived experience) to co-produce solutions and to fully own the vision as full partners in contributing towards outcomes.

## 7 Taking forward health devolution

PHE makes 5 recommendations for taking forward health devolution:

- Establish a clear role for MCAs in system leadership on health improvement
- Invest in prevention and account for it
- Put prevention and life cycle measure at the heart of local economic strategies
- Establish greater funding parity between investment in social infrastructure and physical infrastructure
- Each devolved area should develop its own prevention and health improvement plan

The NHS Confederation highlights the need to establish centrally a narrative that connects ICSs with wider local growth and devolution policies. It sees an opportunity for including health and wellbeing in the new 'levelling up' the economy agenda and inclusive growth approach. Health devolution is seen as a means to an end, that enables and empowers local leaders within geographical footprints to work together across sectors to develop healthy, prosperous and productive communities and economies.

GM identifies the key features of GM at present and identifies ways of taking it further including: leadership coming from the partners not just the CEO; more emphasis on 'if one fails, we all fail'; a collaborative approach to delivery of single control total and individual financial requirements; and more flexibility over the whole use of public service funding.

## APPENDIX 3: WHAT ARE THE IMPLICATIONS OF HEALTH DEVOLUTION FOR ACCOUNTABILITY, POWER AND CONTROL IN DEVOLVED HEALTH SYSTEMS?

### 1 What is the relationship between central Government, NHSE and devolved health areas? In what way is the Secretary of State for Health and Social Care and NHSE held accountable for improving a community's health as well as NHS performance in devolved health and social care systems?

#### 1.1 National bodies and federations

*The NHS Confederation advocated a positive, evolutionary approach:*

There needs to be a shift to a more mature oversight and regulatory relationship with systems driven by local needs and aspirations. This should take a broader-based approach beyond delivery of healthcare and be open to challenge about legitimate national aspirations for improving services. The NHS's national improvement goals should be developed much more closely with local systems to ensure their ambition is closely informed by local intelligence and thinking.

*The LGA in its oral evidence made a number of general relevant comments:*

- NHS is a nationally led with command and control system with accountability chiefly upwards; councils are first and foremost accountable to local electorate
- Local government delivers local solutions to national problems. However, resources are critical – they must be sufficient to do the job
- Centralised control approach has been beset by problems for example Covid 19 testing and PPE
- Local government has done well on public health despite a £700million cut in funding overall. Looking at 200 performance measures 80 went up which shows councils can do well.
- There needs to be parity between social care services and NHS. Problems during Covid-19 with social care often because NHS took precedence for example on PPE. Also, NHS debts have been written off but social care is creating worryingly high deficits for local councils.
- Devolution is not an end in itself – it is about what outcomes are achieved – but evidence shows local government can get the job done effectively: we need to build upwards allowing local leaders to take decisions

*Public Health England had a specific recommendation:*

MCAs (Mayoral Combined Authorities) have a critical role to play in providing system leadership on health improvement. This is about developing a shared strategy with partners, using the mayoral platform to communicate directly to the public, and marshalling resources to scale up the impact of local prevention initiatives. This could be supported by a new duty to improve public health by aligning resources and priorities to focus on achieving better health outcomes, with the aim of levelling up healthy life expectancy. MCAs could then act as the designated authority for receiving specific additional Government funding linked to this duty to support prevention, for example through establishing a radical prevention fund.

Fundamentally, this is a strategic enabling role, which would complement the delivery role of local government. Far from this being about taking powers from local authorities, this duty could enable MCAs to accelerate transformation and scale up projects developed by local authorities.

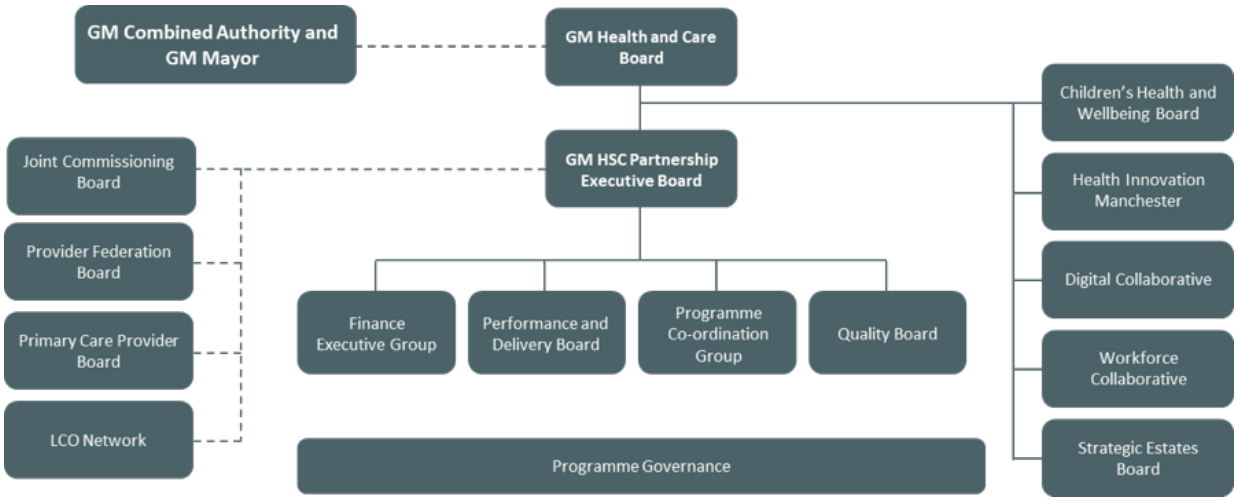
## 1.2 Local bodies and partnerships

*Greater Manchester has a complicated governance structure guided by the following principles*

- GM will still remain part of the NHS and social care system, uphold the national standards
- Decisions will be focussed on the interests and outcomes of patients and people in Greater Manchester, and organisations will collaborate to prioritise those interests;
- In creating new models of inclusive governance and decision-making, GM commissioners, providers, patients, carers and partners will shape the future of GM together
- Commissioning for health and social care will be undertaken at a GM level where the GM place-based approach is optimum for its residents, rather than at a regional or national level
- A principle of subsidiarity will apply within GM, ensuring decisions are made at the appropriate level

*The GM approach to Governance also seeks to deliver the following objectives:*

- Clearly set out what we are trying to achieve through the GM Health and Social Care governance, including the distinct responsibilities and accountabilities at each level
- Ensure governance facilitates leadership and participation across the whole system, and improves depth of engagement
- Ensure the whole system holds itself to account
- Reduce the amount of bureaucracy and duplication
- Locates GM Health and Social Care Partnership Team more clearly as a facilitator of the governance and a steward to the system
- Establish the right governance for the ongoing monitoring of the use of the GM HSC Transformation Fund and other similar GM funds
- Ensure all elements of the system and all localities have input into governance groups without requiring all organisations to be on all groups
- Consolidate and standardise assurance processes across the GM HSC system
- Pave the way for development of new GM Target Operating Model in the post-transformation phase



*West Yorkshire and Harrogate Health and Care Partnership advocated their own model of accountability:*

We already have a clear model of place-based mutual accountability, supported by an NHSE/I team that is fully integrated into the ICS. We believe that this model works and is replicable across other parts of the country. We [also] welcome place-based approaches to regulation and believe that they support our model of place-based mutual accountability.

A Partnership Board will be established to provide the formal leadership for the Partnership. The Partnership Board will be responsible for setting strategic direction and a forum to make decisions together as Partners on the range of matters highlighted in section 7 of this Memorandum, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

The Partnership Board is to be made up of the chairs and chief executives from all NHS organisations, elected member Chairs of Health and Wellbeing Boards, one other elected member, and chief executives from Councils and senior representatives of other relevant Partner organisations. The chair of the Partnership Board will be identified from among the chairs of Health and Wellbeing Boards, and the vice-chair will be nominated from among the chairs of NHS bodies. It will meet at least four times each year in public. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national bodies will increasingly be enacted through collaboration with our leadership. (From Memorandum of Understanding)

*The Northern Health Science Alliance (NHSA) made a number of relevant general points:*

- The importance of public health, and how best to take forward, will need reflection after Covid19
- The performance of ICSs also requires further examination – good model but not proven to deliver better health outcomes
- Difficult to be prescriptive regards health devolution – so not in favour of a 'blueprint' approach
- Support all MCAs having a clear responsibility to improve public health – but this not to be extended to ICSs at this time
- Commitment to the 'levelling up' agenda must be at the heart of health devolution
- A plea for national principles plus local flexibility.

### 1.3 Clinical representative bodies

*The Royal College of Radiologists expressed concerns especially regards the development of 'postcode lottery':*

Central Government and NHS bodies are responsible for funding allocation and determining the framework for delivery. The responsibility lies with the Secretary of State and his devolved agents. The Centre's role is to have a degree of oversight to ensure that patients receive core services no matter where they live and these are delivered to a high standard. Devolution must not be seen as the Centre 'washing its hands' of local issues and having easy scape-goats when things go wrong. There is a need for devolved health systems to remain an active part of UK health service development rather than passive recipients. Regional and local agencies should be held accountable with incorporated measures to check that those holding the devolved budget use it wisely and report to local service users. However, there also needs to be an acceptance centrally that it will take years to see some programmes through.

*The Association of Anaesthetists saw no reason to change the current status quo:*

The Secretary of State for Health and Social Care must retain overall accountability as the person who sets the agreed strategy and framework.

The Faculty of Sexual and Reproductive Health pointed out that 'fragmented services' need clearer lines of accountability:

Overarching accountability for sexual and reproductive health services has not been clearly established since the introduction of the Health and Social Care Act 2012, resulting in a lack of oversight of service quality and health outcomes. This has created a system where there are few incentives to work collaboratively, since the consequences of decreased access transfer to someone else's budget or balance sheet.

Clear lines of accountability must be established to ensure that both clinicians and patients understand healthcare service pathways. To avoid the challenges faced in Scotland and Wales, services must be fully-funded and consistently commissioned, and clear lines of accountability must be established.

### 1.4 Charities and social enterprises

*Mind thought the existing system needs a revamp:*

We still need national accountability to retain focus on mental health given the historic underinvestment and lack of priority given to mental health and how far behind it is in terms of the treatment gap. Whilst we have made great strides in awareness about mental health in recent years, there is still far too much local variation in both the availability and quality of services to relinquish national oversight and direction.

Mind does not take a view as to particular type of structure should be in place, as long as it works for people with mental health problems. There would, however, seem to be a democratic role for Government in setting the strategic direction of the NHS and we are disappointed that the Secretary of State is no longer using the Mandate to do this. Furthermore, the Mandate was initially envisaged as an annual set piece opportunity for the public and organisations that represent them to feed in and comment on the Government's priorities. There has been no form of consultation on the Mandate, however, for many years.

*Cancer Research UK were very positive about the role of Metro Mayors:*

Cancer Research UK believes Metro Mayors can have a key role in helping drive improvements in cancer prevention, diagnosis, treatment and survival across England. These improvements will bring not only health benefits but can also reduce demand on services and increase participation in the local economy. With 1 in 2 people in the UK diagnosed with cancer in their lifetime, action at city-region level has the potential to improve the lives of thousands of residents.

Metro Mayors are great examples of being able to marshal a wide range of services and local partners on certain health needs. The exact functions of combined authority and Metro Mayor vary across the conurbations depending on the content of the devolution deal reached with Government. Given their powers, they will be able to set smoke-free ambitions and bring local partners to deliver on these. Similarly, they can bring together local partners to reduce barriers to participation in cancer screening and pooling budgets for public awareness campaigns.

Metro Mayors represent millions of citizens. Their personal mandate is greater than any MP. Metro Mayors are influential and well-respected. They are often close to Government and in a position to influence change to improve the lives of the citizens they represent. Chairing combined authorities puts Metro Mayors in a position to 'influence down' to local authorities, cancer alliances and CCGS, bringing local stakeholders together and offering scrutiny of the whole system.

Sadiq Khan, Mayor of London, helped Cancer Research UK and partners to deliver a London based junk food marketing campaign across the Transport for London network. This included tube stations, tubes and bus stops and came into force from February 2019. Cancer Research UK hopes that Sadiq Khan and the Mayoral team can further build on this campaign and further tackle obesity in the city. This action could be replicated in other city regions thanks to devolved transport powers.

### 1.5 Academics/individuals

*Peter Hay concluded a debate about accountability is long overdue*:

What has been missing in this space for social care is accountability – a pinch point where someone 'owns' the issues and has the autonomy to enable longer term shaping of services and collaborations to influence outcomes. The case for a new form of accountability that supports learning, mistakes and collaboration is particularly strong and could make a major contribution to further improving health and care for all.

Of course, Government plays a role, not least as it has always 'owned' the national in NHS. Local government at a council level and importantly at the level of communities plays its role too. These layers however are not working fully effectively for the systems that people need and deserve for the challenges and opportunities that face us ahead. The debate about devolved systems and the role that they may play is overdue

## 2 How can local leaders in devolved health systems be held accountable locally and nationally at the same time for the performance of locally integrated services?

### 2.1 National bodies and federations

*The challenge this question presents was well set out by NHS Providers:*

There are important differences in culture and governance between the NHS and local government. A well-known challenge of the STP/ICS journey has been the impact of regulatory and governance tensions on the ability of systems to build strong relationships, implement collective decision-making, and collaborate to deliver shared objectives. Devolution is not simply a block transfer of accountabilities nor can it be overlaid onto existing local arrangements within STPs/ICSs.

There is an understandable public expectation of a degree of consistency of quality and access to services within the NHS. CCGs are accountable to NHS England. Trusts and foundation trusts remain statutorily accountable to regulators and commissioners for financial and operational performance. Trust boards remain accountable for the quality of care delivered by their trust. NHS foundation trusts are accountable to parliament and to local communities via their elected council of governors.

Local government is not tied in the same way to national mandates and is accountable to the local population, politically driven, and operates on a different funding model. Health and wellbeing boards (HWBs) have a statutory footing but to date have had variable impact and varied interaction with STPs/ICSs.

There is a risk that in a devolved health system, local council priorities sit at odds with NHS accountabilities for performance and delivery. There needs to be clarity around how NHS bodies, and trust boards, can conduct the requisite assurance, continue to deliver their statutory accountabilities upwards to the national bodies, and also be held accountable by local leaders in devolved health economies. This can become a trade-off between delivering on local objectives and national targets, as seen in GM in the form of deteriorating performance against key national NHS performance targets, in the context of improved outcomes across other measures like homelessness and school readiness.

In STPs/ICSs, strong relationships have enabled local partners to rally around a shared strategic vision and contribute to mutual objectives while maintaining their respective statutory accountabilities, in many areas through informal arrangements. Future devolution deals will need to take into account existing local arrangements and avoid destabilising progress.

The forthcoming NHS system oversight framework aims to clarify the role of systems in assurance and performance management. However, questions remain around how NHS bodies can be held to account by non-statutory partnerships without clear accountabilities.

Any new devolution deal must be clear how delegated accountabilities will interact with ICS and NHSEI regional oversight, particularly where such oversight relies on an underlying framework of metrics based on LTP commitments which trusts will be assessed against. There is also considerable diversity across the country in the role of the independent chair in an ICS which lacks any statutory footing.

*The NHS Confederation again promoted an evolutionary approach:*

Local accountability should be driven "from the ground up" within an ICS, incorporating a clear role for elected members of local authorities and accompanied by more acceptance of 'managed difference' of services if they are to be tailored to meet local need. Better internal accountability can be achieved through greater clarity about the function of ICSs, developing a clear set of outcomes to deliver collectively and by working through locally how the roles of the constituent organisations can fit together to deliver them. Local relationships and ways of working should be given time to develop further and this should be key to any future consideration of statutory change.

*The LGA were not in favour of any one solution:*

Our clear view is that there is no one model of governance that is right for every area, and where greater accountability is needed it is for the area to develop its own proposals… We will work with NHEI, DHSC, and MHCLG to ensure ICSs and STPs understand the importance of local government involvement in decision making structures…. Where greater accountability is needed it is for council and NHS leaders to determine their own arrangements for governance.  Regard the purpose and powers of health and wellbeing boards, an LGA review of 22 case studies provides important information about where they have made a strategic positive difference including in Wigan, Warwickshire, West Yorkshire and Nottinghamshire.

*Healthwatch were mindful of the potential desirability of some legislative change:*

Under current legislation local Healthwatch powers and activities are restricted to their local authority area. This can create challenges when local Healthwatch need to represent people's voices at a level that extends beyond their boundary – e.g. STP/ICS level – on issues that may have a significant impact locally. At the moment local Healthwatch work at the more regional level on a voluntary basis but this is becoming increasingly challenging…

Introducing more flexibility to create Healthwatch structures at different levels of the system would enable us to react effectively and more quickly to the sorts of structural changes being brought in by the NHS Long Term Plan (LTP) and general trends towards devolution. If the current health and care sector legislation is revisited to support the LTP, we would want it to make it possible for Healthwatch to operate at ICS/STP level on a systematic and consistent basis across the country. This will require additional resources for Healthwatch at this level.

*Breaking Barriers Innovations made the following observation:*

There are considerable differences between the NHS and local authorities in terms and conditions of employment, and to establish a truly integrated approach further work must be done to ensure that these are aligned closer… Alongside this, there is a need to develop a shared governance process that brings together lay members, non-executive directors and local councillors, into a single integrated framework for patient and public scrutiny and assurance. New ways of addressing accountability and governance must include the community and voluntary sector as equal partners.

## Local bodies and partnerships

*Dr Tom Coffey, the London Mayor's Senior Health Advisor made the following relevant points:*

- The Memorandum of understanding signed by London Councils, GLA and the Government has not delivered what we thought it would, for example delegated transformation funding has not happened.
- Most benefits of health devolution have been due to relationships between people not because of powers
- Unless there is the delegation of financial and legal powers then health devolution is just partnership working
- On estates there has been good progress as established London-wide business case approval board
- A ten-year capitation fund is needed in order to plan ahead for new hospitals – impossible to base investment on yearly income
- GLA introduced 'six tests' rule regards reconfiguration. GLA worked with the Kings Fund to develop the tests and this has allowed effective scrutiny of healthcare
- On public health GLA have been surprised how much they can do: as the mayor has other responsibilities, he has been able to link up action so for example no new fast food shops within 400 metres of schools; no fast food on the TfL estate
- This approach of Sadiq Khan is known as "health in all policies"
- There is more GLA would like to do and could do if it had more powers e.g. on gambling, taxes on sugar
- Devolution can be effective but without teeth it is partnership working

- The geographical footprint in London is either at the local authority level or London wide. ICSs' focus is hospital reconfiguration and possibly cancer services but they are not the right level of delivery for example of children's or mental health services where local footprint is better

- Public and charities can get involved in multi-level governance especially through local authority or Mayoral leaders. At a local CCG level, the GP chair is a mini-Mayor and there is evidence of good partnership working with elected council leaders

*West Yorkshire and Harrogate Health and Care Partnership again advocated its own accountability model:*

Our integrated governance arrangements are designed to support delivery and ensure that accountability is clear. Our Partnership Board gives strong, visible leadership. Health and Wellbeing Boards lead the place-based work that deliver on health and wellbeing outcomes locally. Additionally, we have system-level Programme Boards, with representation from all places that drive our joint priority areas. Our System Oversight and Assurance Group reviews progress against our agreed system objectives.

### 2.3 Clinical and workforce representative bodies

*The Faculty of Sexual and Reproductive Health called for reform as the existing structures are not working:*

We believe CCGs, NHSE and local authorities must work together and plan services based on patient and population need while embedding workforce planning in any service model. However, we believe that relying on voluntary initiatives for collaborative commissioning of SRH services alone will not suffice. Accountability mechanisms such as joint meetings to review population health outcomes and the performance of the local system against clearly designed objectives could be established to support accountability of local leaders. These meetings could bring together different commissioners, local authorities, Directors of Public Health and medical directors of health systems (PCNs medical directors, for instance), reporting to national commissioning leads/medical directors and DHSC.

*The Royal College of Radiologists made positive suggestions for reform:*

Central government could have a Health & Social Care Parliamentary committee that provides expert advice to the Secretary of State. Similar measures could be replicated at regional level. [However] accountability at both local and national levels might be difficult to monitor when there is an uneven playing field in terms of access and resources leading to differing outcomes. [But] they should have to report not only to central Government but also to those they serve.

*The Royal College of Occupational Therapists gave examples of models of governance in the devolved nations:*

Integrated Joint Boards (IJBs) in Scotland are not owned by either NHS boards or local authorities – therefore this gives them greater scope to work collaboratively to shift resources (as required) to community-based services. The IJB membership is broad: it includes councillors and NHS non-executive directors in all cases, plus other members (who do not have voting rights) including professional representatives and community and staff stakeholders. Each IJB has responsibility to appoint a chief officer to lead implementation of the strategic plan and an officer responsible for its financial administration. The chief officer has a direct line of accountability to the chief executives at the health board and the local authority and are now seen as the 'third seat at the table' to ensure that discussions aren't just about the NHS agenda or the social care agenda. (RCOT)

*The Association of Anaesthetists were firmly of the view that clinicians should lead outside Whitehall:*

We believe that the decision makers should be clinical, and community/patient representatives should be also involved in setting devolved healthcare priorities. Agreed and clear governance processes along with mutual respect between central and local systems can help overcome challenges.

### 2.4 Charities and social enterprises

*Mind were critical of existing structures:*

Within the Five Year Forward View for Mental Health and the NHS Long Term Plan, NHSE/I has set a national ambition and trajectory for what local areas are expected to deliver in terms of outcomes, but local areas have the freedom to determine the detail and how they go about meeting it. They will be held accountable nationally and will be offered intensive support by regional teams to achieve the national ambition. This has been effective in driving forward service improvements for those areas that are a priority within national plans, but can also lead to neglect of other important services not in the plan, and we know there is a degree of gaming of the data (e.g. hidden IAPT waits).

However, in most areas there has been a lack of local democratic accountability within health systems. Health and Wellbeing Boards have not had the impact that was initially envisaged for them as a place to bring together the NHS and local authorities and have been largely superseded by STPs/ICSs in terms of where the power lies. In some areas, local authorities have withdrawn from STPs, and thus the opportunity to have those cross-sector conversations has been lost. We have also heard anecdotally that there has been very little focus on public health and prevention within STPs/ICSs, a real missed opportunity.

The Mental Health Dashboard has been a useful tool to monitor progress at CCG, STP/ICS and national level across a range of key indicators. Local areas, whether devolved or not, should ensure they are collecting the data they need and investing in data analytics to understand patterns of service use, the demographics of those using their services and how best to target resources.

### 2.5 Academics/individuals

*Harry Quilter-Pinner, Fellow IPPR, made the following key points in oral evidence:*

- In 2017 IPPR undertook a comprehensive overview of the devolution of health policy to date, and the directions it could take in future, and its report presented early evidence for how 'devo-health' could allow integration within and beyond the NHS, and act as a catalyst to much-needed wider reform.
- Why devolve? There are two big benefits: overcome the fragmentation of the Lansley reforms and the fragmentation of public services more generally; it offers the opportunity to innovate.
- Current health devolution should go further: a bigger, bolder role for Mayors of Combined Authorities; some funding and revenue raising powers; concurrent changes to devolution so policy areas also highly relevant e.g. early years also devolved.
- True to say during pandemic there was a centralising tendency but there is another story: once national framework and tasks set, it has been for the local to get on and deliver.
- IPPR would rather have a national settlement for the funding of both NHS and social care services. Being taxpayer funded is what puts the N in NHS
- May be a case for some kind of revenue being able to be generated at the combined Authority level e.g. sin taxes on sugar but if want to fund properly need to fund nationally

*Chris Gibbon and Chris Bailey, Independent management consultants, discussed the inextricable link between resources and policy levers:*

Local structures must clearly be accountable to their constituencies. That accountability must include the power to raise and spend resources to achieve health (and indeed broader community) outcomes. Responsibility for outcomes without the ability to determine and fund programmes to achieve the outcomes or where the funding is determined elsewhere (i.e. nationally) fails a proper accountability test. Funding, however, can still have elements of a mixed economy model with some centrally determined resourcing and some locally determined e.g. the social care levy (UK) or local taxation (USA)

## 3 What is the nature of the relationships between local clinical leaders and civic (professional and elected) leaders? What decisions are each responsible for in a devolved system?

### 3.1 National bodies and federations

*The issues at the heart of this question were well laid out by NHS Providers:*

It is important to recognise the cultural differences between the NHS and local government. Whereas local government operates under local political direction, there is strong clinical leadership within the NHS and a history of NHS provider organisations working under board-led corporate governance locally. The NHS is accountable to a different legal and regulatory framework to local government, and there are fundamental differences in performance and funding regimes. Years of cuts to local government funding, and sustained pressure on NHS services despite the LTP funding settlement can create tension in local areas.

The quality of relationships between local clinical and civic leaders is crucial to effective system working. In GM, local authorities and health organisations have been working collaboratively for many years to deliver joined-up services. The developed nature of these relationships meant that there was a shared and coherent view of the challenges that the system faced and how these should be addressed, coupled with a high level of trust between colleagues and organisations, which enabled the region to develop and implement a single strategic plan.

While levels of engagement with councils vary across STPs/ICSs, much progress has been made since the original Sustainability and Transformation Plans (2015/16). Some trusts want to formalise this shared endeavour, but others are concerned the current momentum may be disrupted if the Government seek to legalise arrangements in the NHS LTP Bill.

There needs to be clear accountability within health and care systems, supported by robust governance arrangements. It must be clear what powers are delegated to whom in ICSs (and devolved health systems), how accountability for issues and decisions sits between ICSs and component organisations, and who ICSs and their component organisations are accountable to.

It is unclear what role HWBs will play in ICSs and how their accountability for health outcomes will interact with ICSs; they provide some scrutiny at place-level, and are often included in system governance arrangements, but their effectiveness varies considerably across the country. Where successful, they provide a key forum for local government to add a degree of democratic legitimacy to system working.

*NHS Confederation mentioned the workforce being increasingly organised at this level:*

Growing our own Future: a manifesto for defining the role of ICS in workforce, people and skills (https://www.nhsconfed.org/resources/2020/01/growing-our-own-future), published in January, called for ICSs to become the default level for future workforce decision making in health and care. This would enable increased autonomy over the development of local system architecture, responsibility for managing strategic external relationships and critically, control of dedicated funding streams.

To support this empowering of local leadership in workforce, the NHS Confederation published Knowing who to call: supporting ICSs to influence their local labour market in March. This report is intended to guide ICS leaders on how they can shape their local labour market to best determine and develop the future workforce.

Health Education England were clear, however, that national oversight of some functions remains critical:

In our view, from a policy and strategic perspective, national oversight of education, training, workforce planning and transformation for health and care is critical. Across this whole agenda, personalised care, cost-effectiveness, value for money and workforce productivity are key factors. Any devolution needs to be cognisant of these.

### 3.2 Local bodies and partnerships

*West Yorkshire and Harrogate Health and Care Partnership referred to the need to 'invest heavily' to bring clinical and civic leaders together:*

Successful Partnership working is based on trust and clear accountability. We have invested heavily in relationships, bringing clinical and civic leaders together to tackle system-wide issues at monthly leadership days. Most Partnership business takes place in system-wide, cross sector groups and builds on the strong relationships that we have established.

### 3.3 Clinical and workforce representative bodies

*The Association of Anaesthetists thought clinicians should be seen as the leaders at the devolved level:*

We believe that the decision makers should be clinical, and community/patient representatives should be also involved in setting devolved healthcare priorities. Agreed and clear governance processes along with mutual respect between central and local systems can help overcome challenges.

*The Royal College of Radiologists pointed to possible tensions between clinicians and civic leaders:*

Both groups have the patient's best interests at heart but may come at things from different angles. A respectful, courteous but challenging relationship, encouraging diverse views and backgrounds should be fostered. Elected leaders should not be able to exert undue pressure on commissioners and providers to make bad short-term decisions for the sake of re-election.

They should however be able to lobby Parliament on behalf of their constituents for resources etc. They should also be able to scrutinise the working of the devolved healthcare system to ensure that it is rigorously held to account on behalf of people living in the locality. If decision making is subject to individuals, national variation and fragmentation may increase.

*The Faculty of Sexual and Reproductive Health believe:*

In a devolved and integrated system, local clinical leaders work together with civic leaders to create a vision for what services should look like, and how they should be delivered. In Manchester, for example, a community-based medical gynaecology service has been developed to provide convenient access and safe services for women.

This service is consultant led, which has enabled an expansion of the range of services available, and has ensured that robust governance and training are in place. Close links and two-way communication between GPs and consultants have reduced the need for patients to travel to repeat appointments. There are also robust pathways into secondary and tertiary care.

The strong relationship between the service and their CCG commissioners has developed an excellent service. The service is monitored regularly against KPIs set out in the service specification. A collaborative, flexible approach means innovation is promoted and service developments implemented quickly.

*Managers in Partnership which represents 6,000 health service managers, most but not all of which are employed in the NHS, made the following relevant points:*

- There has been an amazing response from health service managers who in an extremely stressful and onerous situation have been exceptional at refocussing services and accelerating change. Question on many members' lips is whether we have now reached a point of reform change – reform that would dispense with distinction between health and social care and deliver real integration and devolution?
- Important to reflect that NHS England have 'taken over the running' of the NHS during the crisis so actually been more centralisation with little consultation. As crisis eases more consultation may be required on the changes introduced and which it is now deemed sensible to maintain
- Important to acknowledge the huge difference between social care sector and NHS: the former typified by mostly private providers with 15,000 care homes; the latter have 200 trusts. To allow dialogue a degree of devolution is needed.
- Most managers report positive relationships with local authority leaders but that may be due to a time of crisis: time will tell if old fears and anxieties return. There has been an appetite previously for a more devolved health system but undoubtedly the nationally focussed culture is strong in the NHS and has been reinforced during the pandemic response

*UNISON, the biggest trade union with 400,000 members in the NHS, 185,000 in social care and 450,000 elsewhere in local government and elsewhere, made the following relevant key points:*

- Covid-19 has demonstrated the differences between health and social care and made us question policies that have been around for years but clearly not delivering integration
- NHS is still a national service with national terms and conditions for staff and structures that deliver training and regulation. Meanwhile social care is delivered in a fragmented way with local authorities predominantly commissioners not providers. Terms and conditions vary massively, pay is low and training insignificant.
- UNISON embrace more local accountability and more local determination but does not want to see a postcode lottery for pay and conditions
- Health devolution must be delivered within a national framework – it can't be let a thousand flowers bloom
- Our key conclusions are that there needs to be a substantial funding boost for social care and there needs to be a workforce strategy for those in social care: it can't be left to devolution to deliver these or done on a piecemeal basis
- A Combined authority might offer some opportunity to mesh together the two workforce structures but would require a national framework

### 3.5 Academics

*Dr Kimberley Lazo gave examples of where clinical and civic leaders work together to benefit patients:*

The [GM] Partnership relied heavily on face-to-face dialogue to build up the relationships and as the collaborative process matures from the direction-setting to the implementation stage. The interviewees emphasised the aspect of strategic building as co-production and co-designing, where it particularly focuses on the level of involvement of the different stakeholders in the creation and development of the strategies and programmes. The Partnership made sure all levels of the governance structure have seen, read, engaged, and discussed all project proposals, strategic documents, etc prior to approval by the decision-making bodies.

## 4 How do devolved health systems affect policies to empower individuals to have more control over their health and social care services and outcomes?

### 4.1 Local bodies and partnerships

*West Yorkshire and Harrogate Health and Care Partnership emphasised this is one of their priorities*

Our approach is designed to put people at the centre of their health and wellbeing. Personalised Care is one of our WY&H priority programmes and we are exceeding all of the personalised care trajectories.

*Fleetwood Primary Care Network reported that Healthier Fleetwood, which it established, was a vibrant resident led social movement:*

The four key components of Healthier Fleetwood are:

1) Listening in order to understand what matters to residents
2) Connecting residents together in order to overcome social isolation
3) Increasing self-confidence, with residents becoming the doers and not the "done to".
4) Residents taking control of their own lives, their own health and their own community.

### 4.2 Clinical representative bodies

*The Association of Anaesthetists were very positive about the potential opportunities Health Devolution offered:*

If carried out correctly, it could further empower members of communities to engage in health care prevention activity and screening if they see it is for the benefit of their local people.

*The Royal College of Radiologists were similarly positive:*

Patients would benefit from care being more local and ancillary benefits such as not having to travel. Awareness among patients will increase through partnership working between patients and providers. It should also give people more power to help themselves, which could benefit from some incentives e.g. access to home tech for checking blood sugar/ blood pressure, if they comply with monitoring.

*The Royal College of Occupational Therapists warned against some perceived dangers:*

When creating devolved and integrated health systems we need to ensure that there is no disconnect between a person-centred care model and delivery. For example, when procuring services, organisations should be able to demonstrate values and behaviours that are person centred and have this assessed regularly. The role of occupational therapy in service commissioning, delivery and training staff would support a person-centred approach as well as supporting more occupational therapists into inspectorate and commissioning roles.

### 4.3 Charities and social enterprises

*Macmillan gave evidence that 'empowering individuals' was already happening:*

In the North West, Macmillan works with Greater Manchester Cancer to ensure the voices of people affected by cancer are at the heart of service improvements. Experiences can be shared by people with cancer, their family members, carers and friends. Greater Manchester has signed a User Involvement Charter to show their commitment to putting people affected by cancer at the heart of improving cancer services.

*Mind were also very positive:*

There is [currently] a very limited voice for local people and people using services. Healthwatch's remit only goes so far and some areas have resourced their local Healthwatch better than others. People with mental health problems tell us they find it difficult to find opportunities to influence services in their areas, and much public engagement is tokenistic and only takes place as a PR exercise after decisions have already been made. Devolved areas could choose to model high-quality public engagement in understanding how services are performing and where change is needed. Devolved areas would be able to invest in appropriate training for staff, support for people with mental health problems and in the types of support they want to give people greater control over their care.

The challenges to empowerment of people with mental health problems are not necessarily determined by local governance and commissioning structures. Funding for and availability of services (particularly non-clinical interventions), cultures within services and the skills of health professionals to take a person-centred approach to services and support are key factors in determining whether people are able to have choice and control over their own care.

*Macmillan also gave positive examples from devolved nations:*

To create the Northern Ireland Cancer Strategy 2020 the Department of Health have included people living with, or who have lived with, cancer and their carers. Training has been provided to these people about the Health and Social Care systems and structures, as well as the priorities and plans for the future, so they can better input into discussions on the proposed strategy. The coproduction of the strategy with professional cancer services staff, patients, cancer charities, commissioners, care providers and other key stakeholder groups will allow for the strategy to deliver the best standard of services and improvements of outcomes for people in Northern Ireland.

## 5 What impact do devolved health systems have on the charity sector, social enterprises and the independent sector as providers and partners in health and social care structures?

### 5.1 National bodies and federations

*Positive progress was noted by NHS Providers amongst many STPs/ICSs:*

STPs and ICSs are increasingly working collaboratively with their local voluntary, community and social enterprise (VCSE) sector and independent partners to plan and deliver health and care services. This engagement often takes place at neighbourhood and place-level. For example, Wigan (one of GM's LCOs) has a strong focus on asset-based community development.

### 5.2 Local bodies and partnerships

*West Yorkshire and Harrogate Health and Care Partnership highlighted how they engage:*

The third sector has an integral role in all parts of our Partnership. Three nominated representatives from the third sector sit on the Partnership Board, the third sector lead and manage a specialist priority programme – Harnessing the Power of Communities - and third sector representatives sit on all of our priority programme boards. In each of our places there are arrangements in place to ensure that the third sector is fully engaged. The independent sector [also] plays a vital role in providing care services to people across our Partnership. Local places already have arrangements in place for engagement with this disparate sector. We are in discussion with groups representing the independent sector about how we can ensure the effective involvement of the sector in our regional arrangements.

### 5.3 Clinical representative bodies

*The Association of Anaesthetists were very positive about the opportunities Health Devolution offered:*

These organisations should all be part of devolved health. Third sector and social enterprises are a useful barometer of success or failure and provide valuable insights into where needs may be.

*The Royal College of Radiologists were positive but also had some concerns:*

It gives them a stronger voice and opportunity for regular dialogue. This can also improve some local services although could also lead to more fragmentation. If private providers and charities provide NHS services, they should be held to account as the NHS is. 'Any qualified provider' must be rigorously monitored and the same audit processes applied to them as to NHS organisations so that patients are assured that they are receiving the same quality service whoever delivers it.

### 5.4 Charities and social enterprises

*Macmillan gave examples from devolved nations:*

Macmillan have worked closely with the Scottish Government to create the Transforming Cancer Care (TCC) programme. The £18m partnership makes Scotland the first country in the UK where cancer patients will be guaranteed wraparound support. Both the Scottish Government and Macmillan have invested £9m into the TCC Programme to ensure everyone with cancer is offered emotional, practical and financial help from a dedicated support worker. The TCC allows health, social care and third sector partners to accelerate the transformation of support available to people during and after their treatment from diagnosis onwards.

By 2023 all people in Scotland with a new cancer diagnosis will have the opportunity to access services to support and meet their needs and ensure people with cancer can have the best quality of life. Inequalities will be addressed by ensuring support is targeted to those who need it most and that is accessible to those who live in the most socially deprived areas of Scotland. There will be integration across health, social care and third sector, and an increase in the ability of partners to meet the needs of people with cancer. Co-production with users of cancer services will maximise impact.

*Mind cited specific progress in London:*

In London, 16 of the 19 local Minds have signed up to a collaboration at the London level and are also developing STP level alliances to allow them to respond to the changed NHS and devolved system in the city. Mind also sits on the London Mental Health Transformation Board. It is however the only charity partner on a board that hosts up to 30 stakeholders at a given meeting. The forum takes the form of programme updates and the opportunity to influence the direction of the Board's work is limited. Meanwhile the Healthy London Partnership and Thrive LDN bring partners together but whilst charities may be funded through their programmes for individual pieces of work, it is fair to say that charities are not as included in setting the agenda for work or strategy. It feels very much like a statutory partnership.

*Macmillan explained positive results from Greater Manchester*

In Greater Manchester, the Health and Social Care Partnership signed a MoU with the voluntary, community and social enterprise sector (VCSE). This sets out shared priorities between the two sectors, outlining work that is underpinned by £1.1m in funding to the sector until 2021. However, the GM VCSE Leadership Group has been contributing to health and social care activity since budgets were devolved. The MoU aims to get communities involved in co-designing health and social care to create a better system. The relationship between the VCSE and the Health and Social Care Partnership has been vital and have included working closely together to co-design, co-deliver and provide solutions, services and support so people can manage conditions at home and in the community.

### 5.5 Academics/individuals

*Peter Hay said there were four features of power control and accountability against which to consider devolution:*

1. The recognition and exercise of the legal powers to shape 'care markets' around people and communities
2. The shaping of power with people and communities, so that the system is good for me and good for us
3. New systems of measurement and in particular to take accountability for learning
4. Supporting new forms of collaborative leadership within a learning and adaptive system.

*August 2020*

**devoconnect.co.uk**