16 March 2020

NHS Providers

NHS Providers response to the Health Devolution Commission's call for evidence

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

NHS Providers welcomes the opportunity to submit evidence to the Health Devolution Commission's inquiry into the value and accountability of devolved health systems. This inquiry is timely given the Government's commitment to 'levelling up' prosperity across the country, which seems to suggest that powers, responsibility and funding may increasingly be passed down from central government to local leaders to encourage regional economic growth. Given the precedent of devolution to Greater Manchester (GM) in February 2015, and subsequent examples in London and Surrey Heartlands, health and care could be included in future devolution agreements.

As national NHS policy accelerates towards system transformation and locally-driven integrated care, it is also timely to consider the benefits and limitations of different models of integrated care. NHS England and Improvement (NHSEI) are currently exploring what responsibilities could be delegated to the 28 Sustainability and Transformation Partnerships (STPs) and 14 Integrated Care Systems (ICSs), and this shift from national to system-level decision-making could build on the learning from devolved health systems.

NHS Providers supports the principle of subsidiarity and local leadership of public services. Trusts tell us that while they are keen to learn from each other, there is no 'one size fits all' approach which will serve the interest of all local populations. We are also keen to emphasise the need for comprehensive, long-term evaluation of the different arrangements already in place – across GM, London, Surrey Heartlands and other areas driving more innovative models of integration such as Frimley ICS, Northumbria or Croydon – as a means to effectively inform national policymaking. Our response is drawn from trusts' experience of devolution and focuses on the importance of clear accountability structures and the potential of population health management approaches.

What does good health devolution look like?

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

Prevention goes beyond health services and public health functions, given the wide range of factors which contribute to the health and wellbeing of populations including housing, transport, opportunities, the built environment, and social interaction.

Given the potential for fragmented responsibilities between local authorities and the NHS, and within the NHS itself, the leadership required to ensure a cohesive local approach to prevention risks not being clearly defined. It is therefore 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. In some areas it may also clarify different organisations' responsibilities around reducing health inequalities.

All factors which contribute to a place's capacity to make effective progress on prevention in its local communities must be taken into account. While 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. We have seen from the STP/ICS initiative that system maturity is varied and much of this relates to historical relationships.

The diversity of communities and their needs lends itself to a tailored, locally driven approach to tackling the wider determinants of health, enabling NHS services to play a proactive role in supporting communities across these areas. Devolved responsibilities and budgets may well be one way to support this, by affording local areas more freedom to set a local vision for health, distribute funding in line with what is needed to deliver objectives, and empower all system partners to see themselves as part of the solution. Evaluation of outcomes related to prevention should be robust and the argument for devolution improving people's health should be clear.

As anchor institutions, trusts are a key player in tackling the wider determinants of health which extend beyond the delivery of clinical preventative services. By employing a local workforce, purchasing goods and services locally with public money, and reducing its environmental impact, trusts can have a positive influence on the economic, social and environmental factors in their surrounding area. This, in turn, will support the health and wellbeing of the local population. Devolved health budgets may act as a cultural and financial lever enabling trusts to fulfil this role to its full potential.

2 **In what ways does health devolution enable the marshalling of a wide range of services and partners across local authorities, the NHS, community and charity bodies, and the private sector to address the wider drivers of ill-health in local communities?**

Devolving health and care responsibilities and budgets to local leaders may help address the wider determinants of health by enabling:

- local government – including social care, public health and other relevant services (e.g. housing, transport, schools) – to work more closely with the NHS while retaining a sense of local democratic accountability;
- the pooling of health and social care budgets; and
- a system-wide approach and shared purpose to planning and delivering services around specific population health needs.

The GM model is a valuable example of how health devolution can bring system partners together and promote a preventative approach that, in time, improves population health outcomes. In April 2016, control of GM's combined health and social care budget of £6bn was passed down to the GM Health and Social Care Partnership Board, which is made up of local NHS organisations and councils (including the voluntary sector and emergency services). Recent analysis undertaken by the Health Service Journal shows that although like other areas of the country GM has struggled to collectively maintain performance against the NHS constitutional targets (such as waiting times in A&E), the devolved area has outperformed other areas on key indicators such as increasing the number of deprived children who are school ready in comparison with the rest of the country. These measures remain relatively narrow and it is still too early to evaluate the GM model nor compare it to other approaches (including ICSs).

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

There are several barriers to realising the benefits of health devolution. The biggest issue is that funding and powers are, in reality, delegated rather than devolved. National standards must be met by devolved and non-devolved areas, and transformation funding is accompanied by a list of nationally mandated programmes and services. While it is crucial to deliver on the national constitutional standards first and foremost, this lack of flexibility around the national framework can curb the autonomy of devolved areas to focus on local priorities tailored to population needs. However, the *national* element of healthcare delivery remains important as it ensures a degree of consistency to access and quality of services across the country. Devolution would not be successful if local determination was allowed to put critical services at risk.

It remains unclear what freedoms and flexibilities will be afforded to ICSs as they develop and perform. The national NHS bodies are considering a dual role for ICSs: to drive transformation and collectively manage system performance. These two roles do not seem to be entirely compatible, and while we fully support the role of system-level partnerships in supporting and leading local transformation, we are cautious about the likely impact of creating an additional tier of performance management at system level. It is likely to be problematic for ICSs if NHSEI continue to oversee and monitor organisations, in line with legal and regulatory frameworks, as well as increase the number of information requests and performance management expectations of systems. Changes such as this will likely take years to embed and raise questions about how much autonomy systems are expected to hold.

The relationship between the NHS and local government can be a barrier to progress where local relationships are not strong and constructive. While there is widespread support for integration and collaboration across the health and care sector, it is important to recognise that the NHS and local government operate with different cultures and different accountability structures. There needs to be clarity from DHSC/NHSEI and MHCLG about how county council chiefs, metro mayors and their devolved responsibilities would interact with ICSs in their footprint, and how accountability and governance arrangements would support this interaction. Any risk of confused accountabilities needs to be managed, and appropriate representation on the partnership board carefully considered.

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

People living with long-term conditions and vulnerable groups face significant health inequalities, often come into contact with a wide range of services, and may benefit from an approach in which all of those services take into account the impact of their condition. Trusts are beginning to embed initiatives addressing the wider determinants into their services to ensure people with long-term conditions can access the support they need across all aspects of their lives.

Integrating budgets for health and social care may also help to address the challenges associated with joining up these services. However many of the existing challenges are exacerbated by an overall lack of investment in health and social care, and significant funding pressures mean the resources available do not match demand. Devolving funding will not automatically solve these problems if the amount of money available remains insufficient, and is likely to simply lead to diversion of funding away from other services. There are serious challenges related to access to social care, and national reform is needed to ensure people with social care needs are supported. Initiatives aimed at joining up funding for health and social care have not always delivered on their aim. For example, the Better Care Fund (BCF) and then the improved Better Care Fund (iBCF), were found by the Public Accounts Committee to be insufficient to support more integrated care, better services or significant financial savings. [1]

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

Different models of health devolution have the potential to accelerate integration between health and social care services. A key recent example has been the ability to pool CCG and local authority commissioning budgets for health and social care. For example, one of the Local Care Organisations (LCOs) in GM, Tameside and Glossop, has developed an integrated commissioner across the local authority and the CCG which uses pooled budgets to drive transformation. Other non-devolved areas are also

[1] https://publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/959/95902.htm

pooling health and social care funding, and developing joint commissioning functions with local government (e.g. Croydon), which suggests that devolution is only one means of accelerating integration.

Different forms of health devolution may help realise the ambitions in the NHS LTP by supporting the implementation of national priorities and fostering a shared focus on prevention. GM exemplifies how passing down powers and funding from central government to local leaders in one area can help generate a social movement around the wider determinants of health. However, the GM devolution model is not yet an unmitigated success as GM has struggled to perform well against some national standards, including the A&E four-hour target and (in some localities) DTOC performance has deteriorated.

How can challenges of accountability, power and control be addressed in devolved and integrated health systems?

7 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?

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.

8 What is the nature of the relationships between local clinical leaders (health commissioners and providers) and civic (professional and elected) leaders? What decisions are each responsible for in a devolved and integrated system?

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[2]. 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.[3] 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.

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[2] The King's Fund, *Devolution: what it means for health and social care in England,* (November 2015) https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/devolution-briefing-nov15.pdf

[3] https://nhsproviders.org/news-blogs/blogs/how-devolution-is-delivering-change-in-greater-manchester

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.

9 What impact does health devolution have on the charity sector, social enterprises and the independent sector as providers and partners in health and social care structures?

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. Some areas, including GM, have developed an MoU with the VCSE sector to help them organise at scale and develop strategic commissioning.

Summary

In summary, we fully support the principles of subsidiarity and local leadership. Different models of health devolution may well be a means to support constructive local relationships between partners and to achieve alignment behind the delivery of both national and local priorities. However the evaluation of the current models of devolution is limited, and there is a need to understand the health devolution agenda within the context of system working, and the developing role of ICSs.