Harry Quilter-Pinner
and Becca Antink

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DEVO—HEALTH

WHERE NEXT?

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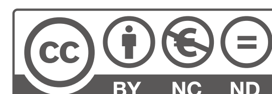


SUMMARY

1. **Devo-health is happening – but it is likely to happen slowly.** One of the biggest surprises in Greater Manchester's 'northern powerhouse' deal was the decentralisation of the region's £6 billion annual health and care budget. Other areas initially declared an interest in a 'formal' devo-health deal but have subsequently fallen away, with only London and potentially Birmingham likely to follow suit, albeit with different models on the ground, in the coming months and years.
2. **Devo-health has the potential to help local areas respond to gaps in quality and funding in health and care.** Specifically, devo-health may allow local areas to move towards place-based public services and population health systems, firstly by aligning and pooling budgets (and decision making power) at the local level, and, secondly, by empowering – and passing down accountability to – local leaders to drive forward with change.
3. **As yet decentralisation is more akin to deconcentration or delegation than devolution.** Devo-health areas have received new powers over commissioning and budget allocation, however, there has been little change in regulation, workforce or revenue raising and (at least on paper) accountability. Most importantly, in places like Greater Manchester, it will be the health secretary rather than the combined authority or mayor who is ultimately accountable for the NHS, and all organisational statutory responsibilities will still run upward to central government.
4. **This lack of real decentralisation might make it harder for local areas to unlock the potential benefits of devo-health.** In particular, the maintenance of existing accountability mechanisms may allow local leaders to pass difficult decisions back to the centre, or the centre could to continue to intervene unhelpfully in local decision making. These deficiencies may keep money locked within existing silos and limit change on the ground.
5. **A 'devo-health+' deal for areas that have demonstrated the ability to manage their existing devo-health powers might allow them to go further and faster in the future.** New powers would focus on the accountability mechanism, commissioning structures, regulatory functions and revenue raising and can be split into incremental and long-term changes.

POLICY RECOMMENDATIONS

Accountability

Incremental: Give metro mayors the power to develop strategic plans and outcome frameworks, alongside local health and care partners, and put a duty on others to comply with/deliver against them.

Long-term: Make the mayor and combined authority accountable for the NHS, including changes to organisational statutory accountabilities within the region.

Commissioning

Incremental: Amend existing national legislation – in particular Section 75 of the NHS Act 2006 – to better enable the pooling of budgets and commissioning functions locally.

Long-term: Create new national legislation to codify place-based health and care, soften emphasis on organisational silos, and move from competition to collaboration.

Regulation

Incremental: Allow devo-health areas to make joint appointments between NHS England and NHS Improvement in order to join up financial and quality regulation.

Incremental: Give devo-health areas a combined financial control total for providers – and between providers and commissioners – and fully delegate/devolve the management of their share of the national sustainability and transformation fund.

Long-term: Simplify the regulatory environment as part of new national legislation, including formally merging the regulatory functions of NHS England and NHS Improvement (and its component parts).

Revenue raising

Incremental: Allow areas with devo-health deals to test the use of minimum prices and 'sin taxes' on cigarettes, alcohol, and sugar and fat in order to discourage overconsumption.

Incremental: Give local areas greater fiscal devolution – with a focus on land taxes – to allow local government to properly fund existing services.

Long-term: Investigate the possibility of a wider fiscal devolution deal to allow local authorities to match-fund the NHS.

Which regions should receive these powers?

Incremental: Give existing devo-health areas (Greater Manchester and London) the 'devo-health+' powers set out above.

Incremental: Devo-health is still an experiment: pilot areas must demonstrate hard outcomes before devo-health is rolled out countrywide.

Incremental: Use learnings from the devo-health pilots to allow other areas to benefit from decentralisation but within the confines of the NHS (potentially through STPs or through changes to the national architecture).

Long-term: If devo-health delivers in pilot areas, allow other areas to follow suit, provided they meet clear and strict eligibility criteria.

1. DEVO-HEALTH

AN INTRODUCTION

THE STORY SO FAR

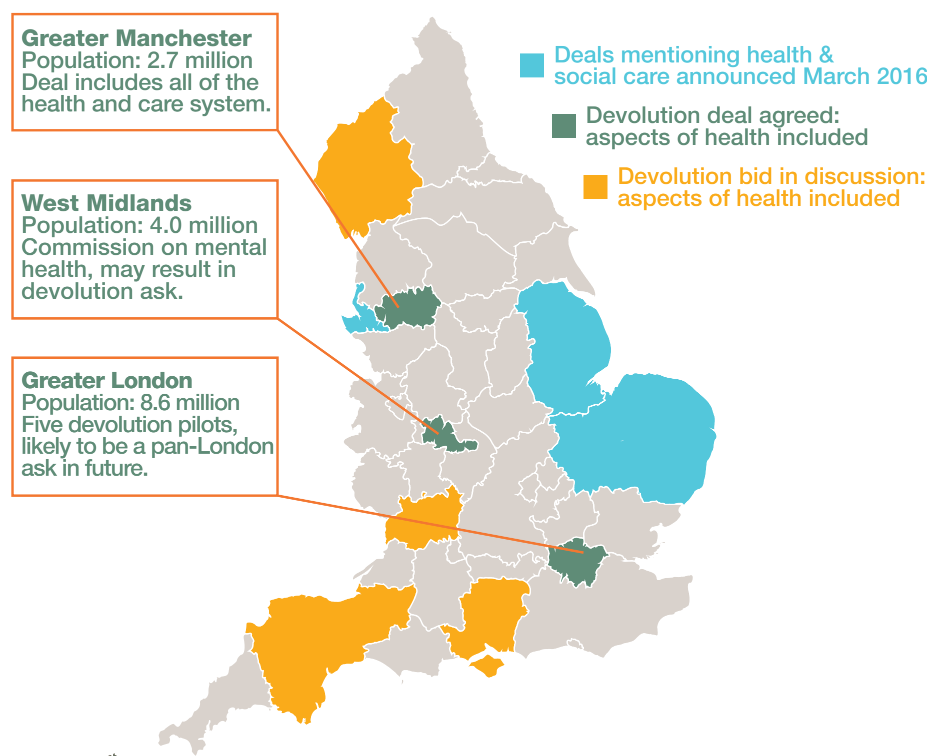
Over the last few decades, there has been a growing consensus behind the need to decentralise economic, public service and democratic power within England. This has culminated, in more recent times, in the northern powerhouse agenda, which saw the Coalition government pass down powers and budgets over a number of public functions to newly created combined authorities and metro mayors (Sandford 2016).

First in line for a devolution deal was Greater Manchester, gaining new powers over transport, housing, planning, policing, skills and employment support (HMT 2014). However, the most radical element of the regions deal was the inclusion of its £6 billion health and care budget (AGMA 2014). Up to this point it was widely believed that the NHS, as 'the nearest thing the English have to a religion', remained out of bounds.

FIGURE 1.1

A small number of areas have expressed interest in a devo-health deal

Map of actual and potential devo-health areas



Source: Dormon et al 2016 and IPPR analysis

A small number of other areas initially came forward with an interest in a devo-health deal, including Cornwall and the North East, but most have subsequently fallen away (see figure 1.1). This means devo-health will probably remain a slow burn, with only Greater London (HMT 2015, GLA 2015), and potentially Greater Birmingham, likely to follow Greater Manchester's lead in the coming months and years, albeit in a different form.

However, before devo-health takes hold as an established part of England's health system (albeit in just a few areas), many of the questions raised as a result of Greater Manchester's surprise devolution must be answered. How much power should be passed down to the local level? What are the benefits of devo-health? How can they be unlocked? What are the risks? How can they be managed? What should local areas do with their new health powers?

These are the questions which IPPR have been looking to answer as part of this programme of work over the last few months. Our introductory paper, 'Devo-Health: What and Why?' (Quilter-Pinner 2016) set out some initial answers to the questions above, but also raised a range of follow-up questions which require deeper investigation.

In particular, on 'why' we concluded that there were a range of potential benefits from devo-health, but that there was a risk that the form of decentralisation ('what') currently available to local areas – much more akin to delegation than devolution – might not place enough freedoms and power at the local level to unlock these benefits. This proposition is the focus of this research paper.

WHAT IS DEVO-HEALTH?

Devolution is the most complete type of decentralisation, meaning the transfer of power from a more national to a more local body. For example, since devolution to Scotland in 1998, the Scottish government has had complete control over its share of the NHS budget and is held to account by the Scottish population when it fails to deliver.

As it stands, this type of decentralisation, or anything close, is not available to regions across England. For example, devo-health in Greater Manchester is not devolution but more akin to deconcentration or delegation, a scenario whereby some powers are passed down either within an existing organisation or to a semi-autonomous body but ultimate accountability remains with central government.

This means that places like Greater Manchester are receiving some more freedoms, particularly over administrative functions, but through the so-called Warner amendment to the Cities and Local Government Devolution Act (2016), it will be Jeremy Hunt (as health secretary) and not the newly elected mayor or combined authority who is ultimately accountable for the NHS in the region. Likewise, all existing organisational statutory responsibilities – for example, from local organisations such as Clinical Commissioning Groups and foundation trusts to the centre – will be maintained.

TABLE 1.1

Types of decentralisation

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

Source: Based on typology developed by Saltman and Bankauskaite 2007

WHY DEVO-HEALTH?

Devo-health is a response to the challenges facing public services, and in particular the health and care system in the coming years. Notably, the health and care sector is facing a significant funding gap – a combined £20 billion by 2030/31 (Charlesworth et al 2015) – caused by low economic growth, a reluctance of politicians to increase taxes, and a combination of an ageing population and increasingly expensive new technologies in health and care.

TABLE 1.2

The potential benefits of devo-health

Potential benefit	Mechanism
1. Improved decision-making	better information due to increased proximity
	increased responsiveness due to better accountability
	leads to local innovation to solve local problems
2. Increased integration within health and between health, social care and other public services	more coordination between health and care system, and increased ability to move care into the community because of integrated governance, budgets, commissioning, and delivery across silos
	shift towards prevention and improvements in the social determinants of health through better 'non-health' policy because of aligned accountability and pooled budgets across public services
3. Increased pace and commitment to reform	empowers local leaders on the one hand, and gives them 'skin in the game' on the other
	leads to increased commitment to reform (vis-a-vis top-down model) and brings on partners more quickly/those who would not have joined in
4. Increased efficiency/ reduced cost	reduce demand more quickly and completely and release associated savings
	remove duplication and inefficiencies in the system and release savings

Source: Walshe et al 2016

The literature on public service decentralisation suggests that there are a number of channels through which decentralisation of health might address some of these challenges (Walshe et al 2016). These are listed

in full in table 1.2. However, for the purposes of this paper, two of these benefits in particular are worth focussing on. The first is centred on the type of reform that devo-health might enable, while the second concerns the pace of reform.

Benefit 1: devo-health may allow integration within and beyond the NHS

Devo-health may be able to help deliver place-based health and care (Ham et al 2015). This is a system in which leaders and organisations work together to improve health and care for the population they serve, moving away from organisational silos and 'fortress mentalities' towards collaboration and integration at the local level to manage the 'common-pool resources' available to them (Ostrom 2010).

In particular, it could help drive the creation of pooled budgets and commissioning functions for health and care, as well as moving towards population health management (Alderwick et al 2015) by also incorporating other health-related public services in these initiatives. This in turn could drive more integrated, preventative and coordinated provision which should drive both better efficiency and health outcomes.

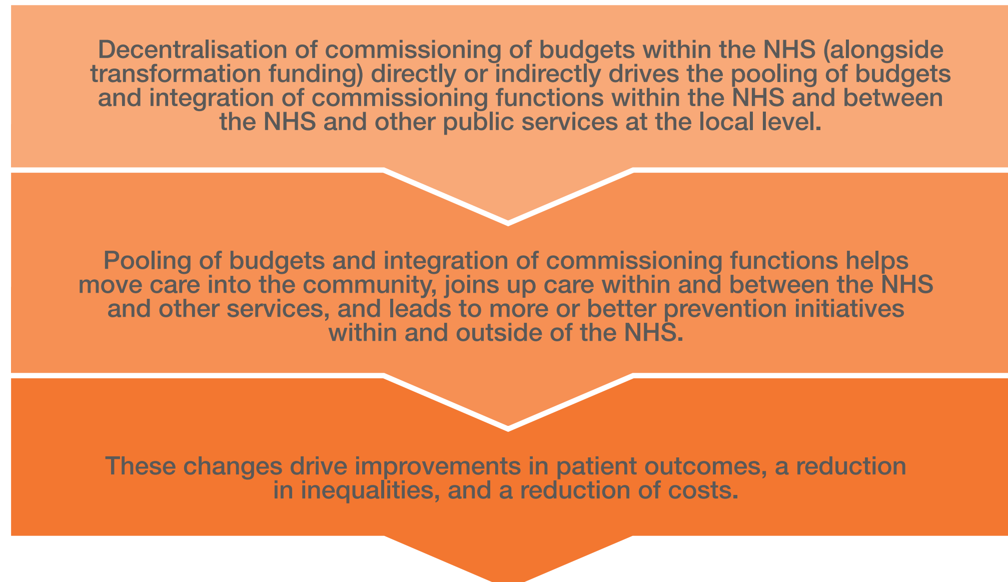
This logic (set out in figure 1.2) is also the justification behind many of the other reform initiatives currently being pursued including New Models of Care (Collins 2016), the Better Care Fund (DoH 2016, and Sustainability and Transformation Plans (Alderwick et al 2016). However, it is possible that devo-health could achieve this more completely by:

- aligning the responsibility, powers and funding for all areas of health care, social care and, crucially, other public services under one local body (see table 1.3 for a more detailed logic model)
- allowing local leaders to bypass top down ringfences, bureaucracy, or targets which they perceive to be a barrier to reform (such as payment mechanisms, competition and choice policy, four-hour wait performance target, NHS procurement and planning guidance).
- decentralising the commissioning of budgets within the NHS (alongside transformation funding) to drive the pooling of budgets and integration of commissioning functions within the NHS and between the NHS and other public services at the local level
- pooling budgets and integrating commissioning functions, helping to move care into the community, to join up care within and between the NHS and other services, and to lead to more or better prevention initiatives within and outside the NHS.

These changes drive improvements in patient outcomes, a reduction in inequalities, and a reduction of costs.

FIGURE 1.2

Devo-health may be able to help deliver place-based health and care
Devo-health, pooled budgets and commissioning logic model



Source: IPPR analysis

Benefit 2: devo-health could act as a catalyst to reform

Devo-health could also help increase the pace at which these reforms are delivered on the ground. This effect is likely to operate primarily through its effect on leadership, which is increasingly being recognised as a crucial, and underutilised, driver of change in the NHS (Timmins 2015).

In particular, since the abolition of strategic health authorities in 2013, there has been a growing concern about the absence of a designated system leader in the English NHS, leaving 'no one in charge'. Devo-health, focussed as it is at the regional level, can help correct for this by bringing together 'constellations of leaders' (Ham et al 2015) from across the health, care and public service sector at the local level and (crucially, given the emerging challenges faced by STPs) provide a governance and accountability framework around them.

This last point in particular is crucial, as by formalising decentralisation, it is likely that devo-health:

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

It is by creating these 'constellations of leadership' at the local level, and then both empowering them and making them accountable, that devo-health is likely to catalyse change within the system.

Emerging evidence from Manchester suggests that this may already be happening (such as an increase in the pooling of budgets, agreement to work together rather than compete between acute providers etc) (Quilter-Pinner 2016). Meanwhile the London Health and Care Devolution Programme reports significant improvements in collaboration between health and care partners in pilot areas in a few short months.[1]

Scotland, Northern Ireland and Wales: contradictory evidence?

Some commentators have argued that the evidence in favour of health devolution is slim based on the fact that NHS devolution to Scotland, Wales and Northern Ireland since 1999 has done little to improve relative outcomes or efficiency (Bevan et al 2014), 'it does not appear that the increasing divergence of policies since devolution has been associated with a matching divergence of performance'.

However, there are a number of reasons why this does not imply that devo-health within England cannot help deliver change:

1. NHS devolution to Scotland, Wales and Northern Ireland was not followed by decentralisation within those countries. The NHS in these countries largely remains a centrally controlled system, with orders coming from Edinburgh, Cardiff and Belfast, instead of from London.
2. NHS devolution to these countries was part of a much wider package of devolution which was about national identity and democratic control rather than public service reform. This has limited the amount of reform to the NHS with the inevitable result that outcomes have not radically improved. By contrast local areas such as Greater Manchester and London are receiving devo-health deals in the context of long term relationships and detailed health and care reform plans (GMHSC 2015a, London Health Commission 2014).
3. The limited reform which has taken place within the NHS in Scotland, Wales and Northern Ireland has focussed on more staff and free public entitlements, rather than new and better ways to deliver care.

POWER: HOW MUCH IS ENOUGH?

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

Will the retention of ultimate accountability to the centre allow local leaders to look to national government if the money runs out or if reform initiatives fail to deliver? Will it reduce their 'skin in the game' and therefore commitment to reform?

1 NHS Leader, London, focus group, October 2016.

Likewise, will the maintenance of existing statutory responsibilities act as a drag on integration? Will it keep money locked within existing silos (and in particular in the acute sector)? Will it ensure that 'devolved' systems system remain at the whim of central government targets and edicts?

England also remains one of the most fiscally centralised countries in the world with only 2.5% of tax revenue set locally (LFC 2013). Will this centralisation in the finances make it impossible for local areas to be held accountable for financial overspends? Will it inhibit their ability to create real place-based public services?

These are the issues that this research paper will look to tackle. In particular, we will ask three questions.

1. How much power do local areas have under current devo-health settlements?
2. What are local areas using their new powers for and do local areas need more power to unlock the potential benefits of devo-health?
3. What might a 'devo-health+' settlement look like?

2.
DEVO-HEALTH
PROGRESS TO DATE

CREATING A TYPOLOGY

To help us assess how much power is needed at the local level in order to maximise the benefits of devo-health we have set out a typology for decentralisation within health and care systems. This will allow us to 'measure' the extent of decentralisation in both current and potential future devo-health settlements.

Developing a typology for health and care decentralisation

This typology is largely based on the existing health and public service decentralisation literature, particularly contributions from Peckham et al (2005) and Saltman and Bankauskaite (2007). It looks at health and care centralisation along two main dimensions.

1. The degree of decentralisation

This is the extent to which power and accountability lies at lower tiers of government, with centralisation at one extreme, and full devolution at the other. However, it is worth noting that decentralisation settlements do not fit neatly into these models, and can fall anywhere on this spectrum.

FIGURE 2.1

A typology for health and care decentralisation allows 'measurement' of devo-health settlements

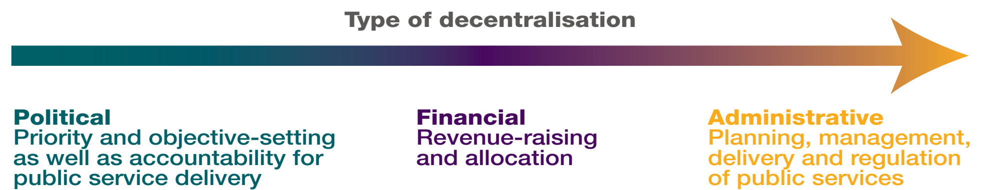
Source: IPPR analysis based on Peckham et al 2005 and Saltman and Bankauskaite 2007

2. The type of decentralisation

These are the functions that are being decentralised. They fall into three main categories: political, financial and administrative. Under each of these functions are a number of different elements of the system that could be included in a decentralisation.

FIGURE 2.2

The functions being decentralised fall into three main categories
Types of decentralisation



Source: IPPR analysis

To use our typology to set out different devo-health settlements we have combined these two dimensions to create a health and care decentralisation dashboard (see figure 2.3 and figure 2.4).

The focus of this chapter is on utilising this typology to answer the first of the key questions set out in the previous chapter: ‘How much power do local areas have under current devo-health settlements?’. We do this by setting out the status quo system and then comparing it to the devo-health settlement currently available to local areas (as exhibited by Greater Manchester).

THE STATUS QUO (CENTRALISATION)

To assess the amount of power passed down to the local level under existing devo-health deals we must first understand the degree of decentralisation in our existing ‘status quo’ system. At the highest level, the current system in England is a mix of centralisation, deconcentration and ‘weak’ delegation (see table 2.1).

TABLE 2.1

Summary: the status quo (centralisation)

Type	Degree
Political	Centralised
Financial	Centralised
Administrative	Deconcentrated/delegated

Source: IPPR analysis

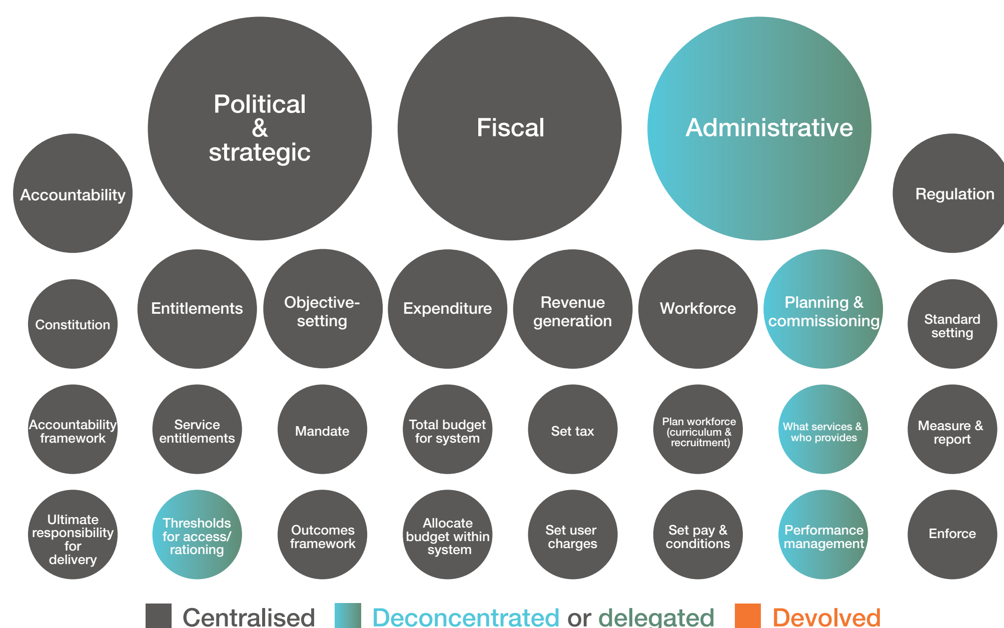
As it stands almost all political and strategic functions are centralised. Ultimate accountability rests at the centre with the health secretary and the chief executive of the NHS and the centre also prescribes the objectives and desired outcomes of the service via the Outcomes Framework, the NHS Mandate and strategic documents such as the Five Year Forward View (NHS 2014a).

These aims and objectives are then delivered administratively by a range of bodies that either benefit from a form of deconcentration (for example, NHS Regional Teams in the case of specialised commissioning or primary care commissioning) or a weak form of delegation (CCGs or foundation trusts in the case of acute and community commissioning or acute provision, for example). The only exception to this is regulation and workforce policy, which remains centralised.

Meanwhile, the service is almost completely centralised in terms of fiscal functions. All of the expenditure for the NHS is raised nationally.[2] CCG and NHS region allocations are determined centrally via a formula. These bodies then have some freedom on allocation of funding within these silos but this is limited in some cases by Mandate pledges (such as maintaining or increasing spend on mental health) and centrally determined tariffs and payment mechanisms (payment by results, for example).

FIGURE 2.3

Health and care decentralisation dashboard: the status quo (centralisation)



Source: IPPR analysis

DEVO-HEALTH AS IT STANDS (DECONCENTRATION/DELEGATION)

A delegated health and care system sees some powers transferred to a semi-autonomous body (such as a combined authority) but a degree of accountability to central government is retained (see table 2.2). This is essentially the arrangement agreed between Greater Manchester and Westminster on devo-health as it stands.

2 Historically, the majority of the money for social care in most local areas has also been raised nationally, although this has declined over time as central government grants for local authorities have been cut.

TABLE 2.2

Summary: deconcentration/delegation

Type	Degree
Political	Centralised/delegated
Financial	Delegated/deconcentrated
Administrative	Delegated

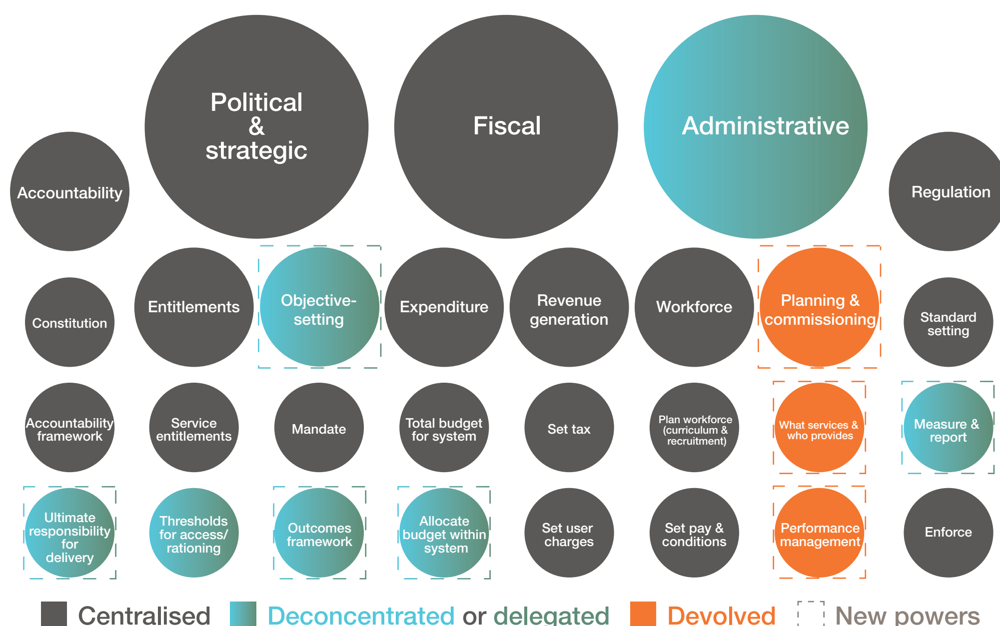
Source: IPPR analysis

Under delegation some political and strategic functions are passed down to the local level. For example, the local area might set out its own strategic plan and outcomes framework as Greater Manchester has done under their devo-health agreement (GMHSC 2015a). However, these would likely have a specific link to national plans and outcomes and would have to help deliver on them. Furthermore, as set out earlier, ultimate political accountability and organisational accountabilities for the NHS are still retained at the centre.

A delegated model sees significant powers passed down over administrative functions. Local areas such as Greater Manchester have near complete control over the way in which services are commissioned, what services are commissioned and how they are performance managed (although this responsibility is still split between CCGs, local authorities and the newly appointed Chief Officer). In particular, commissioning of primary care and around half of the region's specialised care has been passed down to the local level as part of Greater Manchester's devo-health deal.

FIGURE 2.4

Health and care decentralisation dashboard: deconcentration/delegation



Source: IPPR analysis

This model also sees a few extra freedoms given on the fiscal and monetary elements of the system. In particular there is more freedom over the allocation of money between healthcare silos. While local areas might already benefit from some fiscal devolution, which might cover social care and public health (such as business rates), the NHS is still funded nationally which is a significant limit on decentralisation under the current model.

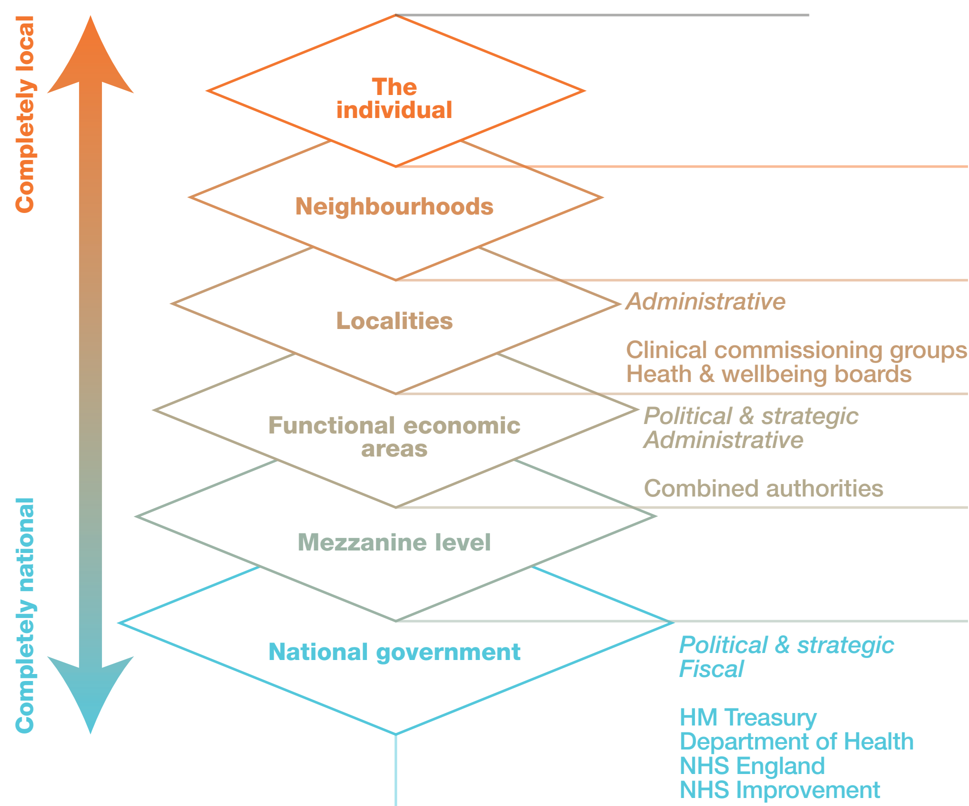
Level and breadth of decentralisation

There are two further dimensions of decentralisation that are worth considering including the level of government to which powers are being passed down, and the breadth of powers outside health and care included in the decentralisation agenda.

Under the status quo system the only health decentralisation initiatives pursued over the last decade or so have been to the organisational level (such as foundation trusts), with freedoms and finances given upon compliance with the national agenda (so-called 'earned autonomy'), or to the individual level (personal budgets for example).

FIGURE 2.5

Levels of decentralisation



Source: IPPR analysis

The current delegation model has moved the locus of power to the 'meso-level' of government, meaning regional or city-level government. This tier – formerly occupied by regional health authorities – had historically been hollowed out by the move towards 'earned autonomy'.

In terms of breadth, the reality is, pre-northern powerhouse, the majority of powers over functions beyond the NHS were centralised.[3] In theory this alignment should make integrating policy between areas easier but the scale and complexity of Whitehall has made this largely impossible. For example, as part of the 2010 Health and Social Care Act, Andrew Lansley set up the public health subcommittee (Buck 2012), a cross-government committee to champion the health initiatives across Whitehall, however very little progress was made and it was abandoned just two years later.

The current decentralisation agenda goes well beyond the NHS. There is a range of other public services and functions that are being devolved to the local level (see table 2.3). However, under a model where the NHS is only delegated, these powers would have separate accountability mechanisms (for example, the combined authority or mayor would be fully accountable for non-NHS powers) and be subject to different degrees of freedom.

TABLE 2.3

Breadth of decentralisation

Powers	London	Greater Manchester	West Midlands
Business support	Growth hub	Growth hub, manufacturing advice, export advice (UKTI)	Growth hub and export advice (UKTI)
Criminal justice	None	Commissioning local services, youth justice and prison budgets	Youth justice
Employment support	None	Work and health programme commissioning and pilot	Work and health programme commissioning
Further eduction & skills	Redesign of 16+ further education system 19+ skills funding	Redesign of 16+ further education system, 19+ skills funding, early years pilot and apprenticeship grant for employers	Redesign of 16+ further education system and 19+ funding
Health & social care	Health and social care commission and pilots	NHS and social care budget	Health and social care commission
Housing	Spatial planning, land disposal and utilisation, Mayoral Development Corporation, Housing Investment Fund	Spatial planning, land disposal and utilisation, Mayoral Development Corporation, Housing Investment Fund	Spatial planning, land disposal and utilisation, Mayoral Development Corporation, Housing Investment Fund
Police & fire	Police and fire services to mayor	Police and fire services to mayor	Police and fire services to mayor
Transport	Bus franchising, smart ticketing, rail and roads	Bus franchising, smart ticketing, rail and roads	Bus franchising, smart ticketing, rail and roads

Source: press cuttings and government press releases
Note: Orange = no powers; blue = partial powers; green = full powers
(relative to all devolution deals signed since the northern powerhouse speech.

3 The only notable exceptions are social care, public health and some planning laws.

CONCLUSIONS

Based on this analysis it is clear that while areas with a devo-health deal will have greater (though not absolute) power over some parts of the system – in particular planning and commissioning and funding allocation – there are many other parts of the system where local areas will still have to defer to national government.

Notably, existing regulatory and accountability mechanisms will remain on the whole in place (which will make setting different objectives and moving money around difficult in practice). There is no fiscal devolution, which will make managing the financial challenges facing public services more difficult (and ultimately ensure that accountability is retained at the centre).

3. DEVO-HEALTH

WHERE NEXT?

DEVO-HEALTH: RHETORIC OR REALITY?

The focus of this chapter is the second of the key questions set out in our opening chapter: 'What are local areas using their new powers for and do local areas need more power to unlock the potential benefits of devo-health?'

We have looked to answer this question by using our analysis from the previous chapters to identify four key areas of the health and care system where the current balance of power between local and national government warrants further attention. These are:

- the accountability mechanism
- commissioning structures
- regulatory functions
- the way in which revenue is raised.

These areas have been selected either because they are particularly important to the mechanism by which devo-health is supposed to drive improvements in health and care (commissioning structures for example) and/or because they have as yet been unaffected by the devo-health agenda and therefore remain largely centralised (such as revenue raising).[4]

For each of these key areas we have then examined in more detail any changes that have been made so far under devo-health, what these are delivering (if anything), what barriers to unlocking the benefits of devo-health remain, and by implication whether devo-health areas may require new powers in future to drive real change on the ground. These case studies are set out in the remainder of this chapter.

Research methodology

Our analysis is based on:

- a comprehensive literature review of relevant research papers and policy documentation including documentation published by the Greater Manchester Health and Care Devolution Programme and London Health and Care Devolution Programme
- over 100 semi-structured interviews with local and national policy makers and experts in the field including from Greater Manchester, London, Greater Birmingham,

4 It is worth noting that these are not the only areas of interest – for example, workforce probably remains overly centralised – however, we have focussed only on the immediate priorities.

the Department of Health, NHS England; HM Treasury; NHS Improvement; and CQC
- three roundtable discussions with policy makers and experts including one with leading figures in Greater Manchester and one with their equivalents from London
- Case study analysis of a number of other health and care systems from both within the UK (Scotland and Wales) and further afield (Finland, Denmark, Sweden, Spain and Italy).

CASE STUDY 1: ACCOUNTABILITY

As set out previously, at least formally, there has been limited change in the accountability mechanism (both ultimate political accountability and organisational accountabilities) under devo-health so far:

1. As per the Warner amendment to the Cities and Devolution Bill it will be the health secretary and not newly elected mayors or combined authorities that are ultimately accountable for health and care in regions with a devo-health deal.
2. Accordingly newly created Chief Officers (such as Jon Rouse in Greater Manchester (GMHSC 2016)) are still likely to be accountable to Paul Baumann, Chief Financial Officer of NHS England, and Simon Stevens, Chief Executive of NHS England, as well as or instead of the combined authority or the mayor.
3. Finally (and crucially) all existing organisational statutory responsibilities are likely to be retained, meaning CCGs and foundation trusts will still be accountable to Whitehall rather than their combined authority or mayor.

However, despite this, below the surface, devo-health has started to shift the dial towards the local level. Some of this change is formalised and tangible. For example, in Greater Manchester the Association of Greater Manchester Authorities (AGMA) are a key signatory of the memorandum of understanding (GMHSC 2016). Local government representatives sit on the GM Strategic Health and Social Care Partnership Board which oversees health and care across the region and there is a newly created Chief Officer position for health and care in the region with formally delegated powers and budgets.

Meanwhile, other elements of the change are more informal and relational. For example, strong relationships and trust among organisations in Greater Manchester have allowed them to create a Strategic Partnership Board,[5] Joint Commissioning Board[6] and Provider Trust Federation Board[7] where members voluntarily come together to make joint decisions about the future of health and care in the region in the interest of place rather organisational silos. Examples of such decisions include the creation of one acute provider in Central Manchester; the management of the Pennine Acute Trust crisis

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5 The SPB is tasked with setting strategic priorities and leading change across GM and is made up of GMCA, CCGs, NHS providers and NHSE as well as representatives from the four primary care provider groups (dental, GP, optometry and pharmacy).

6 The JCB is tasked with delivery of Commissioning for Reform (GM's commissioning strategy) and is made up of GMCA, NHSE, CCGs and local authorities.

7 The JPB brings together GM's 15 main providers to jointly manage financial and quality challenges across the region.

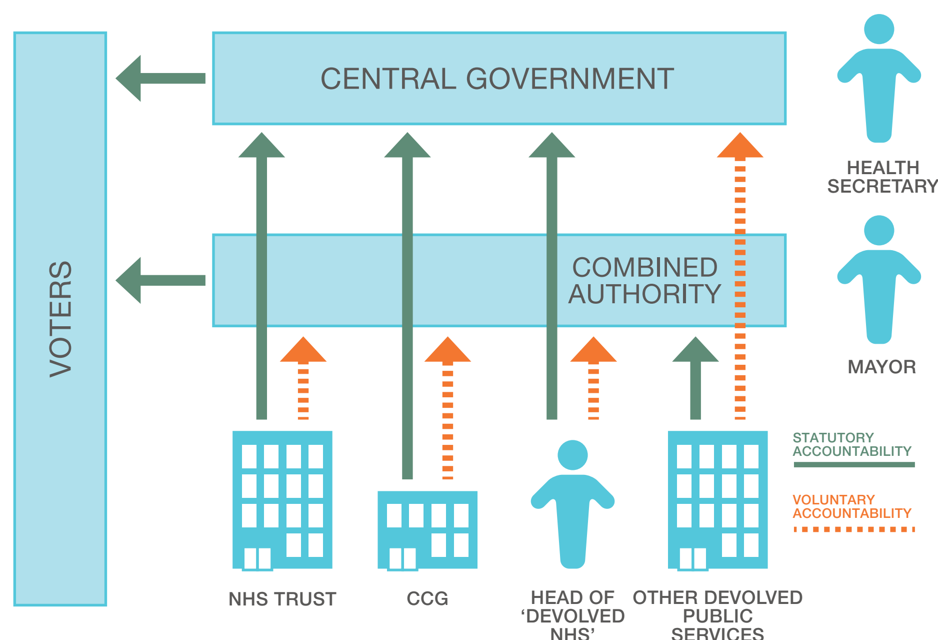
(GMCA 2016a) and the decisions to be taken at the Joint Commissioning Board. Similar shared decision making processes are also happening at local level in the form of newly created joint commissioning functions (discussed in more depth later).

These changes – which amount to the pooling of decision making responsibility and accountability at the regional and local level – in effect begin to create secondary non-statutory accountabilities at the local level (see figure 3.1) which in turn soften the hard, statutory accountabilities that have been maintained under the memorandum of understanding. This has resulted in public communications; decision making behaviours and the culture in Greater Manchester belying the continuity in accountability and accountabilities set out in the regions decentralisation deal (Dormon et al 2016). As one interviewee described it 'in Greater Manchester, both nothing has changed, and everything has changed'.[8]

FIGURE 3.1

Devo-health creates secondary non-statutory accountabilities at the local level

Accountability under delegation



Source: IPPR analysis

There are a number of strengths to this set up. There has long been a recognition that strong relationships and high quality leadership are as powerful as formal structures and accountabilities in driving change in health and care (Timmins 2015) (although, of course, not all areas will have the same history and culture of joint working as they do in Greater Manchester). Furthermore, it could be argued that the current arrangement, which retains formal accountability at the centre but gives local areas freedom to go beyond that, carefully protects the 'N in

8 NHS Leader, Greater Manchester, interview, November 2016.

NHS', something which is perceived to be important to the public, while maximising the degree of change delivered at the local level.

However, going forward, there are also a number of potential weaknesses with the current devo-health settlement available to local areas. In particular, it may have the following effects.

1. Reduce local leaders' 'skin in the game', allowing them to shirk or pass on difficult decisions (such as hospital closures) and responsibility during times of crisis (financial stress, for example) especially if local relationships breakdown or are put under too much strain.
2. Reduce the level of empowerment at the local level by allowing central bodies (NHSE, DoH, HMT, CQC, NHSI) to continue to intervene and override local decisions as well as reinforcing existing silos. This is especially concerning given the historical tendency of central governments to give up but then take back power (Peckham et al 2005).
3. Fail to increase the incentive and ability of local leaders to integrate across health and other public services through the maintenance of existing accountability mechanisms and cultures.

Our analysis therefore suggests that over time there may be a need (and/or a desire at the local level) to move more political accountability and organisational accountabilities to the local level, formalising some of the less tangible change that is already happening in places like Greater Manchester. Indeed, it likely that this impetus will grow as combined authorities gain more powers and metro mayors are elected in spring 2017.

CASE STUDY 2: COMMISSIONING STRUCTURES

As identified in chapter 1, reform to the commissioning structures within the NHS, as well as between the NHS and local government, is one of the primary mechanisms by which devo-health could help deliver improved health and care. Specifically, by passing commissioning budgets and decision making powers (so called 'spending decentralisation') down to the local level – alongside existing commissioning functions in the NHS and Local Authorities – devo-health should make pooling budgets and integrating commissioning easier and more effective (Ham and Alderwick 2015), which in turn should lead to more integrated delivery of health and care and therefore better outcomes.

This is reflected in the extent of change experienced in commissioning budgets under devo-health so far, as well as in the focus put on reform to commissioning structures by local areas (GMHSC 2015b). For example, as set out earlier, much of the specialised commissioning budget and the primary care commissioning budget have been passed down to the new Chief Officer in Greater Manchester under section 13z of the NHS Act (see table 3.1). Furthermore, all local CCGs have also received all general practice funding included in NHS England's co-commissioning programme (NHS 2014b).

This means that a significantly larger share of NHS funding – over £1.6 billion more per year – is now pooled locally, either at GM level or at CCG level, rather than being retained by NHS England (see table 3.1 for details). Furthermore, building on the back of initiatives such as Total Place (Humphries and Gregory 2010), devo-health areas such as Greater Manchester have complete freedom to allocate this funding across the health and care economy as they see fit (at least in theory). This 'spending decentralisation' essentially means that Greater Manchester has got a £6 billion annual control total for commissioning in the region.

TABLE 3.1

Commissioning decentralisation in Greater Manchester (£m) annually

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

Source: GMCA 2016b

However, as set out in detail later in this chapter, moving money around the system remains difficult because of the continuity in commissioning silos, governance, accountability mechanisms and regulatory regimes, as well as ongoing central planning guidance.[9] To help overcome some of these barriers – in particular the maintenance of existing commissioning silos and governance – local areas across the country are starting to use section 75 of the NHS Act and other provisions within the existing legislation to pool budgets at the local level in the form of joint commissioning functions and local care organisations (LCO).

To help increase the pace of this process at the local level and to enable double running of services in the short term, devo-health areas such as Greater Manchester have also benefitted from the delegation of its share of NHS England's Transformation Fund, worth around £450 million over five years (GMCA 2016b). This can be accessed by localities that demonstrate they are helping drive Greater Manchester's strategic objectives at the local level. This is helping to deliver some of the most advanced examples of pooled budgets and integrated commissioning

9 For example, the latest planning guidance puts a ringfence around mental health spend (it is unclear whether devolved areas will have to comply with this).

in England with significant progress in places like Tameside, Salford and Central Manchester.

Progress and obstacles in Tameside and Glossop

Tameside and Glossop Clinical Commissioning Group in Greater Manchester is at the vanguard in terms of pooling funding and commissioning functions. It has set itself the objective of creating a single commissioning function between health, social care and public health within its region worth nearly £500 million.

It has so far used existing legislation including Section 75 of the NHS Act to do this – and progress has been impressive. The region is now essentially operating as though it has a pooled fund through a single commissioning board.

However, because of the limitations created by the legislation, it has been unable to deliver this in its entirely and has to operate through workarounds of various kinds with governance arrangements that are unnecessarily complex (see below).

'Because of the restrictions in the legislation, we have had to create three distinct funding pots, managed directly or indirectly by a Single Commissioning Board.

- Pot A: Is made up of all the contracts which fall within the remit of Section 75 of the NHS Act
- Pot B: Is made up of functions which have been delegated to the CCG by NHS England and cannot be double-delegated, so need to be kept separate.
- Pot C: Is made up of anything which does not fall into Pot A or B (such as commissioning excluded from Section 75)

Decision making for Pot A can been formally delegated to the Single Commissioning Board and so truly operates as a pooled budget with an integrated commissioner. However, Pots B and C must be formally signed off by their 'accountable organisation' so the Single Commissioning Board has to make recommendations for these bodies to ratify instead.

The process has been really difficult and convoluted but we have found a solution. It is possible to achieve – but it's not ideal and could have been made much easier if the legislation was more conducive to place-based solutions. The next challenge will be including wider public service reform that impact on health within the tent.'[10]

However, our research shows that while devo-health makes it easier to deliver pooled budgets and integrated commissioning at the local level, going forward a number of challenges remain. These challenges are not isolated to devo-health areas – any region across the country attempting to pool budgets will face the same obstacles – however, it is likely that devo-health areas will continue to meet them first, as their reform agendas go further and faster than others.

10 NHS Leader, Greater Manchester, interview, November 2016.

1. Limits on pooling budgets under existing legislation
Under Section 75 of the NHS Act 2006, local authorities and NHS bodies can enter into partnership arrangements (that is, pool commissioning functions and budgets), where these arrangements are likely to lead to improvements in health and care. Currently urgent and emergency care, hospital care, rehabilitation, mental health services, community health and (following a recent amendment to the legislation [DoH 2015]) primary care services can all be included in these provisions. However, in talking to devo-health areas, it has become clear that a number of exemptions to these joint arrangements still exist including 'surgery, radiotherapy, termination of pregnancies, endoscopy, the use of class 4 laser treatments and other invasive treatments and emergency ambulance services' (NHS Bodies and Local Authorities Act 2012). This limits the ability of local areas to pool budgets at the local level and unduly complicates the process of integrating commissioning functions (see the boxed text on 'Progress and obstacles in Tameside and Glossop', later in this chapter).

Similar constraints exist in the Cities and Local Government Devolution Act 2016 which inserted a provision into the National Health Service Act 2006 (s.14Z3A) which enables CCGs to exercise their commissioning functions jointly with combined authorities, by way of a 'joint committee'. However, the provision does not contain the necessary flexibilities to enable this form of joint working at all spatial levels: it is limited to combined authorities, preventing, for example, a single local authority from forming a joint committee with a CCG. The provision also only applies to CCG functions: joint committees construed under this legislation would not be able to exercise the functions of local authorities. Finally, it is worth noting that the ability of local areas to engage in collaborative working is even more constrained in London as the definitions within the Devolution Act exclude London boroughs, and so prevent organisations in London from utilising s.14Z3A at all.

2. Lack of clarity around 'double and triple' delegation
Under some of the current arrangements in Greater Manchester, local areas are aiming to deliver 'double or triple delegation'. This is where the budget and responsibility for commissioning a service is passed between two or three organisations sequentially – using various sections of the existing legislation – before it reaches its final destination (usually a joint commissioning function between the NHS and local government at the local level). For example, in some areas in Greater Manchester, certain elements of primary care commissioning are being passed first from NHS England to the Chief Officer at Greater Manchester level, then from the Chief Officer to local CCGs, then all of the local CCG functions are being pooled at the local level within the Local Authority. This is technically possible under the existing legislation but it is confusing, time consuming and results in weak and opaque governance and accountability mechanisms.

3. Lack of a wider place-based settlement
So far efforts have focussed on pooling commissioning budgets at the local level between health and care. However, as devo-health areas achieve this, their sights will turn to a bigger prize: integrating commissioning and pooling budgets between health and care

and other public services to create real population health systems (Alderwick et al 2015) including transport, housing and the criminal justice system. While this is some way off, it is clear that further integration will pose a further challenge as the existing legislation is unclear as to how this can be done at the local level.

These findings suggest that the existing NHS legislation, while not an absolute barrier to change, is making it harder and slowing it down. Furthermore, as devo-health areas push on with reform, there will be a growing gap between the system that the legislation describes, and the one that exists on the ground.

CASE STUDY 3: REGULATION

There has been very limited decentralisation in regulation as part of the devo-health agenda so far. Indeed, the Warner Amendment in the Cities and Devolution Bill prevents the removal of regulatory functions from national bodies and ensures that transferred services adhere to existing accountabilities and national standards.

This makes a lot of sense in many ways: local areas should not be allowed to mark their own homework. Furthermore, financial efficiency and quality are in many ways universal and as much as possible standards should be consistent across the NHS.

However, it is clear that our existing regulatory system throws up a range of issues which, while experienced across England, are most acutely felt in devo-health areas as they drive forward with reform:

1. The NHS has a plethora of regulators (see the boxed text below), each focussing on different elements of the system. As a result there is a lack of joined up regulation, in particular between finance and quality. This leads to conflicting messages at the local level
2. Regulation still focusses on organisations and not the place or system as a whole. This reinforces organisational silos at the local level and is becoming increasingly ineffective as the system on the ground changes.

The regulators

The Care Quality Commission (CQC)

The CQC is the independent regulator for quality in health and social care in England (including private providers). It registers and inspects providers of health and care including hospitals, care homes, GP surgeries, dental practices and other healthcare services.

NHS Improvement (NHSI)

NHSI is an umbrella organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams. It focusses on the economic and financial regulation of providers in the acute sector.

NHS England (NHSE)
NHSE (formerly the NHS Commissioning Board) regulates Clinical Commissioning Groups (CCGs) across England focussing on both the quality of care and the efficient use of resources across an area.

Individual professional regulatory bodies
Including the General Medical Council, Nursing and Midwifery Council, General Dental Council and the Health and Care Professions Council. These regulate their relative professions focussing on setting and monitoring standards, qualifications, training and conduct.

Despite the continuity in regulatory functions ensured by the Cities and Devolution Bill local areas under devo-health deals have started to address some of these challenges. Both London and Greater Manchester report having 'more constructive conversations with the regulators'[11] about how regulation can be joined up more effectively, as well as take into account and embed local strategic objectives and reform initiatives into regulatory interventions.

Furthermore, both Greater Manchester and London have started creating joint appointments between NHSI and NHSE at the local level to better align regulatory functions. Without requiring legislation change, this has started to join up provider and commissioner oversight and ensures that Greater Manchester – the local place – has a greater influence in the regulatory process. The GMHSCP team has also agreed with NHSE that it will be consulted on all matters affecting individual organisational financial compliance including on financial control totals and access to the sustainability and transformation fund (GMCA 2016b) (see boxed text below).

Sustainability and transformation plans, funding and control totals

As part of its financial settlement in 2015, the NHS was given a large chunk of front-loaded investment. This has been placed into a £2.1 billion sustainability and transformation fund which will grow over time, reaching £3.4 billion by 2020/21 (McKenna et al 2016). For 2016/17, £1.8 billion of this will be used for sustainability (managing provider deficits) and will be allocated based on financial control totals (see below), while £340 million will be used for transformation and (from 2017) will be allocated on the basis of sustainability and transformation plans (see below).

From 2016 onwards, all NHS providers have to deliver an agreed financial control total. This is an individual organisational target for the size of deficit/surplus achieved at year end 2015/16 and 2016/17. This has been introduced to try to ensure that the provider sector achieves financial balance in 2016/17. These control totals have been calculated by NHSI on a trust-by-trust basis. If a provider's 2015/16 year-end position is worse than forecast at month six, it will need to deliver higher efficiencies in 2016/17 to meet its control total.

11 NHS Leader, Greater Manchester, interview, November 2016

Agreeing to deliver this control total is a condition for accessing the sustainability element of the sustainability and transformation fund.

Sustainability and transformation plans (STPs) will cover all areas of England and bring together local leaders and organisations from the NHS and local government to set out a five year strategic plan for financial and quality improvements across the local area. From 2017/18 onwards, STPs will 'become the single application and approval process for being accepted onto programmes with transformational funding' (NHS 2016a), with the most credible plans – judged on a number of criteria – securing the earliest funding.

National regulators themselves are also moving in the right direction. This began with the consolidation of Monitor and NHS Trust Development Authority into NHS Improvement, but has moved on to the promotion of place-based regulation such as CQC's place-based pilots (CQC 2016) and the creation of the NHS Success Regime (NHS 2015). The latter in particular is important as it sees national bodies come together with commissioners and providers in local areas facing deep-seated challenges to put in place a plan for improvement.

More recently, NHS England and NHSI have also confirmed that they will provide STP areas with an indicative control total for their local area. In theory, this will 'pool resources across organisations and make it easier to shift money to support care improvement and redesign'. However, given that STPs as yet have no formal governance these will likely be soft targets rather hard deliverables (NHS 2016a).

Going forward, these initiatives present a clear direction of travel towards consolidating the UK's many regulators across both quality and finance, as well as towards regulating a place and not just the individual organisations within. It is clear that progress is being made but as devo-health areas are highlighting, there is still a need for further change – both at the national and local level – as the system changes on the ground.

CASE STUDY 4: REVENUE RAISING

As highlighted earlier, there have been no major changes in the way in which revenue is raised for health and social care under devo-health so far. The NHS in places like Greater Manchester continues to receive the vast majority of its funding from centrally levied general taxation and national insurance with no new powers over patient charges (see figure 3.2), while local government has no funding responsibility for the NHS and limited new powers to raise revenues locally.[12]

There is no doubt that this lack of fiscal devolution will limit the degree to which local areas have real autonomy. In particular, it is worth noting the following.

1. Local services may be unable to decouple themselves from unhelpful conditions set by central government which might prevent the creation of real place-based commissioning.

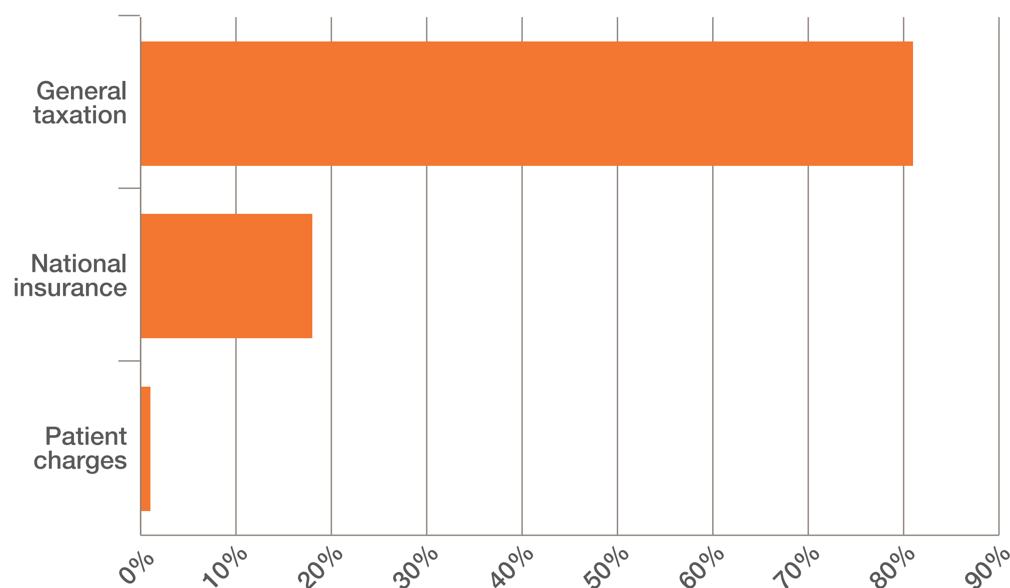
12 Local government does have a responsibility to fund social care, which will increasingly be linked to business rates retention.

2. Accountability may remain centralised because without revenue raising powers local leaders will not be able to hold financial risk at the local level (having to bail out failing hospitals, for example).[13]
3. The balance of power and accountability between the NHS and local government (as the main partners within health and care) may be skewed due to lack of shared funding, incentives and risk (Vize 2016).
4. A lack of fiscal devolution may reduce local control over the social determinants of health, in particular local growth and job creation, which may make it harder to reduce demand on health and care services in the longer term (McGough and Bessis 2015).

FIGURE 3.2

The NHS continues to receive most of its funding from centrally levied tax and NI

Sources of NHS funding



Source: ONS

Going forward, there is significant potential for local areas to gain greater revenue raising powers. Building on the newly obtained power to retain business rates at the local level (ibid) certain areas are lobbying for wider fiscal settlements (see the boxed text below). Notably, the mayor of London has recently reconvened the London Finance Commission (LFC 2013) to make the case for fiscal devolution to the capital, while the West Midlands is in advanced talks with HM Treasury on the same topic (Bounds 2016).

13 Accountability may also remain centralised because revenue raising powers could harm local democracy, see Travers (2003) https://www.policyexchange.org.uk/wp-content/uploads/2016/09/the-decline-and-fall-of-local-democracy-nov-03.pdf

Taxes on the table

A number of different types of revenue raising powers are on the table. These include the following.

Land taxes

Currently the fiscal devolution conversation is primarily focussed on property taxes, largely because these are anchored in a place and are the easiest to tax locally. Discussions have so far spanned council tax, business rates, stamp duty land tax, annual tax on enveloped dwellings and capital gains property development tax. Most international cities already have these fiscal powers according to the London Finance Commission (LFC 2013).

Labour taxes

The Scotland Act in 2012 allowed Scotland to set its own income tax rate. This has opened the door to similar arrangements in England and IPPR has recommended some retention of income tax at the local level (IPPR 2014). The London Finance Commission also flirted with this idea ‘especially as greater powers, for example in welfare, health or education, are devolved to London’ (LFC 2013). Many international cities derive income from a local income tax, including New York, Berlin, Madrid and Singapore.

Smaller taxes

There has long been a discussion about which smaller taxes and charges should be set at the local level. These may include things like hotel or occupancy taxes, but also health-related taxes and charges such as so-called sin taxes on sugar, fat, tobacco and alcohol. Local leaders in the US, in cities like New York, have the power to vary sin taxes locally.

Borrowing powers

Borrowing powers have been discussed as a further revenue raising method for local government but mainly in the context of capital rather than revenue spending. Currently local authorities have access to borrowing through the Prudential Code within certain limits.[14] Local authorities have been calling for these caps to be removed. As local areas gain more revenue raising powers locally it will also become possible for them to issue investment bonds or similar instruments.

However, the degree to which these new powers might be linked to the NHS is as yet unclear. [15] This is partly because as it stands fiscal devolution is largely seen as a way of driving economic growth at the local level, rather than a way of driving reform to public services. But it is also driven by fears that devolving revenue raising powers for the NHS will lead to a worsening of the postcode lottery, as different areas set different tax rates or because different areas have different tax bases. This fear is exacerbated by high-profile examples of the postcode lottery in other countries such as the US, Italy and Spain (Dormon et al 2016).

14 For example, there is a cap on Housing Revenue Account.
15 Although it is clear that they will be linked to social care.

However, it is worth noting that inequalities in these countries may well be driven more by other factors such as the role of co-payment and charges (Stubbs 2015). Furthermore, there are a number of measures that can be put in place to equalise funding between regions with larger and smaller tax bases (and more or fewer health needs). For example, Finland tops up the revenue of any local administration with less than 92 per cent of the national average, and reduces the budget of those authorities who have more than the average, while Sweden uses national grants, weighted by population factors, to ensure equity in financing between the counties (Anell et al 2012).

More health devolution, more fiscal devolution

- Sweden has 21 counties (regions) which deliver healthcare while the municipalities (locality) deliver social care. The majority of revenue for health and care comes from county council taxes. Indeed, Sweden's health system has one of the lowest levels of central funding in the Nordic countries.
- Finland is the most decentralised health system in Europe (Costa-Font and Greer 2013). There is no regional tier: municipalities (average population 17,000) are responsible for social care and the majority of health care, in addition to most other public services. The majority of health funding comes from local taxes, with municipalities relatively free to set taxes.
- Spain has been progressively devolving powers for health with regional government now responsible for the majority of health care and municipalities generally responsible for social care (García-Armesto et al 2010). Historically, funding for health and care was received in the form of centralised grants. However, more recently, regional ministries have been given power to raise more money by taxing gifts, inheritances, property and gambling.
- In Italy each of the 20 regions manages health and care via an elected council. Each regional council produces a regional health plan (and sets budgets for its local health authorities. Local health authorities deliver or commission care. Regions are able to raise their own revenue to fund health and care.

4. ‘DEVO-HEALTH+’

WHAT MIGHT IT LOOK LIKE?

OUR APPROACH

This chapter addresses the third and final key question set out in our opening chapter: ‘What might a ‘devo-health+’ settlement look like?’ Our policy suggestions in this chapter are based on the analysis set out in the previous chapters and as such focus on the four areas we have identified as warranting more attention: the accountability mechanism, commissioning structures, regulation, and revenue raising.

While looking to set out a bold ‘devo-health+’ deal we have recognised that this agenda is an experiment and that change is therefore happening slowly. Furthermore, it is clear that, while progress can be made on this agenda within the current legislative framework, real devolution of health and care would need structural reform. Despite increasing recognition that this might be necessary (PwC 2016) there is an understandable reticence to pursue further structural reorganisations so soon after the last.

As such, we have set out both incremental policy recommendations (which can be achieved under the existing legislative framework) as well as more radical long term policy recommendations (many of which require more fundamental NHS reform). This, we hope, allows a public debate about where we want the devo-health agenda to end up in the longer term as well as immediate steps to help us get there.

It is also worth noting that the recommendations set out below largely apply to those areas currently in receipt of, or pursuing, a devo-health deal (Greater Manchester, London and Greater Birmingham), rather than to all areas of the country. This is because we think we need ‘proof of concept’ before rolling out more widely and also because we recognise that many areas are not in a place to pursue a devo-health deal. We investigate this theme in more detail at the end of this chapter.

POLICY RECOMMENDATIONS

Accountability

> **Incremental:** Step 1: Give metro mayors and combined authorities a more direct role in the NHS.

Giving metro mayors and combined authorities a greater role in health could help move accountability to the local level; democratise decisions in the NHS; and integrate the NHS into wider place-based public services. Initially, this could be achieved by giving local mayors the power to develop strategic plans and outcome frameworks, alongside local health and care partners, and put a duty on others to comply with/deliver against them.

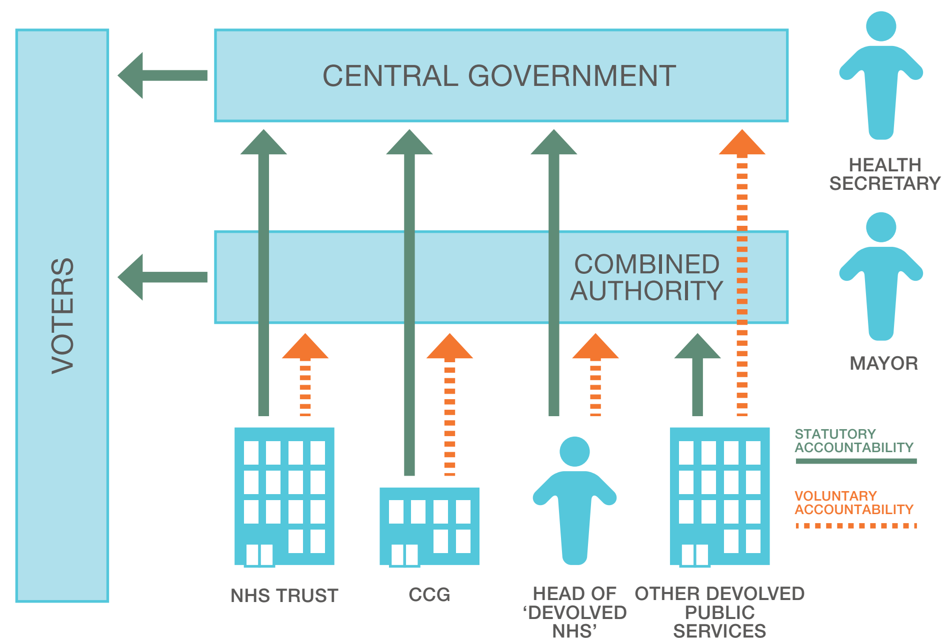
Long-term: Step 2: Make the mayor and combined authority accountable for health and care.

In the longer term, the government should pass more political accountability down to the local level in areas that have demonstrated they can manage devo-health powers. This would involve moving existing organisational statutory responsibilities and accountabilities down to local level so that they report to the combined authority and/or the local mayor rather than national government (see figure 4.1). Such a change could probably be achieved through a transfer order under the Cities and Local Government Devolution Act, although ideally it would be done through new and better legislation which would codify a more devolved system and set out the balance of power between local and national more clearly. Either way, mechanisms would have to be put in place to ensure that local areas adhere to certain core NHS principles including equality of access and free at the point of use.

FIGURE 4.1

Make the mayor and combined authority accountable for health and care

Recommended accountability under a 'devo-health+' settlement



Source: IPPR analysis

Commissioning

Step 1: Incremental changes to national legislation to enable easier pooling of budgets **(incremental)**.

The government should conduct a review to clarify what can and cannot be done in terms of pooling budgets at the local level under existing legislation. It should then take steps to amend existing legislation – in particular the NHS Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 – to enable the pooling of budgets and commissioning functions locally. Our research suggests that amendments are needed to

enable the pooling of functions currently exempt from Section 75 of the NHS Act 2006 as well as to enable easier and more transparent double or triple delegation to Section 132B of the same act, to name just two examples.

Step 2: More fundamental reform of national legislation to drive place-based health and care **(long-term)**.

In the longer term, as local areas move ahead with the integration of commissioning budgets and functions at the local level, the government should recognise the need for new and better legislation that closes the gap between the system that exists on the ground and the one described in legislation. This new legislation should recognise that top-down reforms are neither popular nor particularly effective at driving change. Rather than impose one new structure, the legislation should codify different place-based models (allowing for pluralism but ensuring that accountability and governance remains transparent). This legislation would also soften the emphasis on organisational silos and move from competition to collaboration.

Regulation

Step 1: More joined up place-based regulation at the local level **(incremental)**.

The government should encourage devo-health areas to make a series of joint appointments between NHS England and NHS Improvement at the managerial and working levels in order to join up financial and quality regulation at the local level. Over time these joint appointments could also include CQC. This approach would mimic the process undertaken in creating NHS Improvement at the national level.

Step 2: Move from organisational to place-based financial regulation **(incremental)**.

Allow devo-health areas to move from organisational financial control totals for providers (see the boxed text on 'sustainability and transformation' in chapter 3) to combined control total for providers – and between providers and commissioners – across a whole region. This would allow local areas to share financial risk and would discourage local providers from 'beggar thy neighbour' policies in order to reduce deficits. These would be managed by the local devo-health management board, which would also take over the administration of the local area's share of the sustainability and transformation fund.

Step 3: Simplify the regulatory environment as part of new national legislation **(long-term)**.

England is unique in having such a large number of national regulators as well as such a significant split between financial and quality regulation. New national legislation, as discussed earlier in the chapter, would also continue (and formalise the existing) consolidation of national regulation by merging the regulatory functions of NHS England with NHS Improvement (and its component parts).

Revenue raising

> **Step 1:** Give local areas greater fiscal devolution in order to enable them to prevent ill-health **(incremental)**.

Allow areas with devo-health deals to test the use of minimum prices and sin taxes on cigarettes, alcohol, sugar and fat in order to discourage overconsumption. This would see cities like Greater Manchester and London match powers obtained by local politicians in the US, such as the mayor of New York.

> **Step 2:** Give local areas greater fiscal devolution to raise more funding for health and social care **(incremental)**.

Social care is under severe strain and public health is also facing significant cuts. Local areas should have the power to retain and raise the rate of both council tax and business rates with full discretion to spend on social care (or indeed health) if they want. This would not entirely solve the funding problem – in many areas the tax base isn't deep enough to withstand big increases in tax for residents and/or local businesses – so national government would also need to give the whole health and care system a better financial settlement, but it may help to alleviate some of the immediate financial pressures.

> **Step 3:** Investigate the possibility of a wider fiscal deal to allow local authorities to part-fund health and care services **(long-term)**.

Central government should work with devo-health areas to investigate the potential for a wider fiscal settlement that would allow local government (mayor and/or combined authority) to match-fund the local NHS. This would involve a much wider fiscal settlement which would likely include the retention of a ring-fenced proportion of income tax and national insurance (see the boxed text below). Any settlement ultimately agreed would need to carefully protect the 'N in NHS' (so ensure that services remain free at the point of use) and include adjustment measures, such as exist in most foreign countries with fiscal devolution, to equalise budgets between different localities.

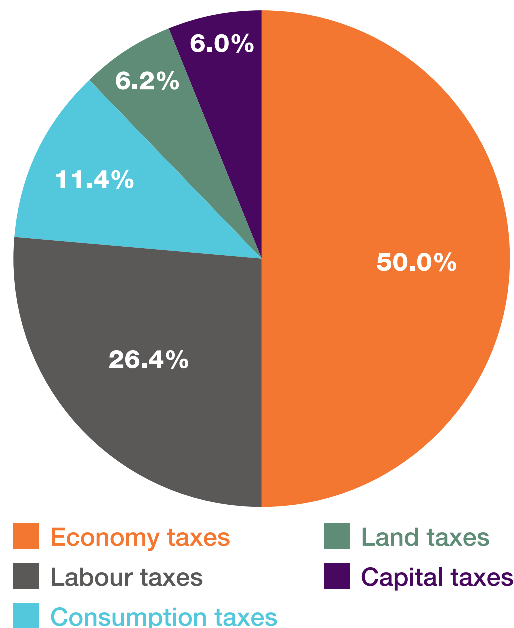
Tax and spend in Greater Manchester

Total public spending in Greater Manchester sits at around £22 billion (Cook 2014). Spending on health and care totals just under £6.5 billion. This means that to match-fund health and social care, £3.25 billion worth of tax revenue would have to be devolved to the local level.

Total tax revenue in Greater Manchester is estimated to sit at around £33 billion, of which half is derived from economy taxes, a quarter from labour taxes and the rest (in order of size) from consumption, land and capital taxes (see figure 4.2).

FIGURE 4.2

Estimated annual tax revenue in Greater Manchester, 2014



Economy taxes
Labour taxes
Consumption taxes
Land taxes
Capital taxes

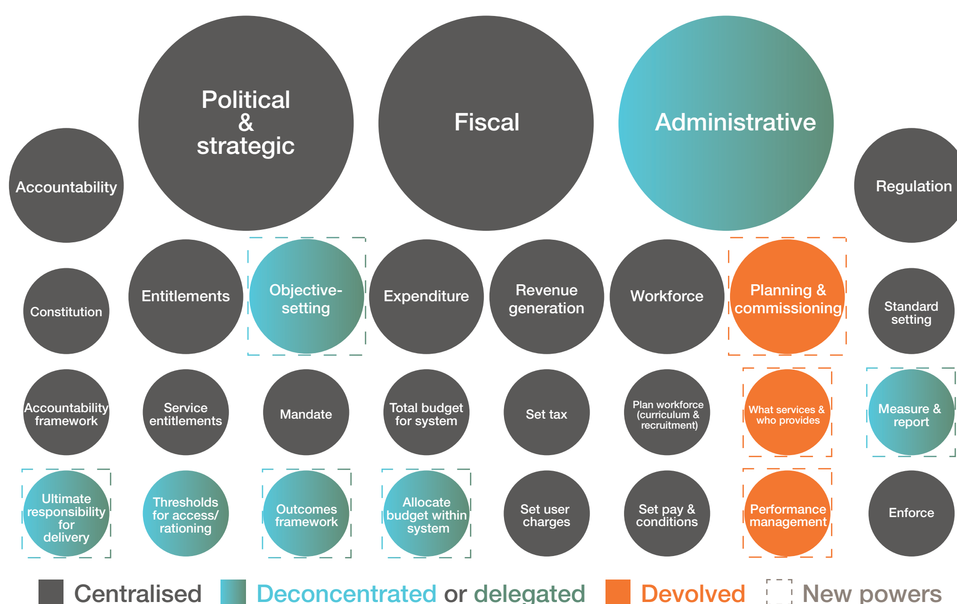
Source: Centre for Cities (2015)

This implies that Greater Manchester would need to have to retain around 37 per cent of income tax and national insurance receipts (labour taxes) in order for local government to be able to match-fund the NHS at the local level. It is worth noting that in other (less economically successful) areas income tax retention would have to be higher or central grants would have to replace locally raised revenue.

'Devo-health+': joining the dots

These recommendations allow us to set out where devo-health deals in Greater Manchester and London might end up in the future. The decentralisation dashboard in figure 4.3 shows what such a 'devo-health+' settlement would look like, with areas gaining significant new powers over accountability (and organisational accountabilities) as well as revenue raising, with changes in the national architecture enabling more complete place-based health and care, particularly regarding pooling budgets and commissioning functions and regulation.

FIGURE 4.3
Decentralisation dashboard
What a 'devo-health+' settlement would look like



Source: IPPR analysis

Which regions should receive these powers?

Step 1: Give existing devo-health areas (Greater Manchester and London) 'devo-health+' powers **(incremental)**.

Existing devo-health areas should move towards a 'devo-health+' deal and be given the additional powers set out above (as well as some powers in other areas outside the scope of this project, including those regarding the workforce).

Step 2: Devo-health is still an experiment: pilot areas must demonstrate hard outcomes before devo-health is rolled out countrywide **(incremental)**.

Devo-health is still an experiment. While initial progress in places like Greater Manchester is impressive we are yet to see hard outcomes in terms of health outcomes or greater efficiency. As such, we support the government's implicit policy of allowing a small number of areas – so far just Greater Manchester and Greater London – to demonstrate 'proof-of-concept' before other areas follow suit.

Step 3: Use learnings from the devo-health pilots to allow other areas to benefit from decentralisation but within the confines of the NHS **(incremental)**.

Devo-health areas are uncovering a number of ways in which central government policy and legislation prevents or slows down progress at the local level. Some of the powers that have been passed down to local areas under devo-health agreements can be given to other or all areas of the NHS – for example, primary care co-commissioning, combined financial control totals, amendments to NHS legislation – potentially

through the STP process or changes to the national architecture, without a formal devo-health deal.

Step 4: If devo-health delivers in pilot areas, allow other areas to follow suit **(long-term)**.

If it works, devo-health should not just be the preserve of the leading urban centres within England. Areas that meet a number of criteria (listed below) will have a stronger case for taking on devo-health powers in the future:

- a strong budgetary framework and strategic plan which details what local areas would do with newly decentralised powers
- clearly established geographic boundaries which work for both NHS patient flows and local government governance
- strong relationships and leadership within and between the NHS and local government
- developed local democracy potentially including a significant voter turnout, local media, and a metro mayor or high profile local government leadership
- a commitment to maintaining the core entitlements and characteristics contained within the 'N in NHS' (such as unwanted variation in processes and outcomes).

STPs are, in effect, trying to spread similarly collaborative strategic plans and decision making across the whole of England in order to improve care and deliver efficiencies. They could therefore be used as a way for local areas to develop the characteristics necessary to drive forward devo-health deals in their own areas over the coming months and years. One way for local areas to develop the necessary characteristics might be to adjust the existing geographies of their STP so that it is coterminous with likely devolution boundaries (NHS 2016b).

There should be little concern about health decentralisation being asymmetrical. In Spain the gradual transfer of responsibilities to the regional ministries occurred in two waves, with the first seven regions achieving devolution between eight and 20 years earlier than the remaining regions. This allowed more advanced regions to experiment with new approaches to delivering health services and encouraged 'second tier regions' to develop the structures and capacity needed to take control of the health system in their area (García-Armesto et al 2010). England could and should follow a similar model if it is decided to move toward a more decentralised health economy.

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