

Letting Go: How English devolution can help solve the NHS care and cash crisis

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Reform

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Introduction

In Spring 2014, we set out in a *Reform* publication some ideas for solving the NHS care and cash crisis. Amongst those ideas were greater integration of health and social care, an enlarged role for local government and less centralised control from Westminster and Whitehall. Since then, there has been widespread acceptance that, without substantial and sustained change, the NHS faces a significant funding gap by the end of the decade, probably of the order of £30 billion. The new Chief Executive of NHS England, Simon Stevens, has accepted that a figure of this order is indeed the challenge and, in October, published the NHS *Five Year Forward View* on how to tackle it.

This document represented a new direction of travel for the NHS with an explicit move away from central command and control. “England is too diverse for a ‘one size fits all’ care model to apply everywhere. But nor is the answer to let ‘a thousand flowers bloom’. Different local health communities will instead be supported by the NHS’ national leadership to choose from amongst a limited number of radical new care delivery options, and then be given the resources and support to implement them where that makes sense.”

This new approach came shortly after a hard-fought Scottish referendum campaign which in turn provoked more political and public debate about English devolution. In December 2014 the Government produced a command paper on *The Implications of Devolution for England*. With impeccable timing on the 800th anniversary of Magna Carta, ten core UK cities (excluding London) have been flexing their muscles on more devolution by publishing *A Modern Charter for Local Freedom*.

Across the political spectrum there seems to be a growing appetite to examine the scope for more devolution of responsibility to local areas and local government in England. The NHS has now been brought fully into this debate with the announcement on 27 February by the Chancellor of the Exchequer that the NHS bodies and ten local authorities in Greater Manchester were close to an agreement with NHS England to take responsibility for the £6 billion annual health and care budget for that area from April 2016.

We have been fortunate over the past few months in being able to speak with colleagues in Greater Manchester as they have shaped ambitious proposals for a reinvigorated NHS. We have also explored the implications for a *National* Health Service if other large areas in England follow in Greater Manchester's footsteps. Additionally, and as the starting point for this paper, we have examined what has happened in Scotland, Wales and Northern Ireland during the last 15 years, as responsibility for health and care services has been passed to devolved administrations.

On 10 March, NHS England announced 29 local areas that will share £200 million and be given flexibility to adapt payment systems to provide more co-ordinated local models of care of benefit to patients. The experience of these projects seems likely to drive further new local models of care in other areas. We have not attempted to bring these new projects into this document but they seem very much part of the devolution journey that England's NHS is now on, although they are not on the scale of Greater Manchester.

We hope that this short policy paper will stimulate discussion about how greater devolution of the NHS in England could help meet the challenges it faces for at least the next decade and beyond.

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Executive summary

Devolution can help rescue the NHS from its care and cash crisis

England's NHS is advancing towards major decentralisation, beginning in Greater Manchester. The process now seems inevitable given the impetus driving public sector devolution in England. This historic change will transform a centrally-controlled, command system that has underpinned the NHS since 1948. It can help cure the NHS's twin care and cash crises, namely a failing service model and a lack of affordability. This valuable prize is attainable without losing NHS core values.

Devolution in England reflects lessons from Scotland, Wales and Northern Ireland

English devolution is not the same as NHS devolution in Scotland, Wales and Northern Ireland. Crucially, it is about decentralisation. This has not occurred in the other devolutions. There, the NHS remains a centrally-controlled system, with orders coming from Edinburgh, Cardiff and Belfast, instead of from London.

“The terms of devolution in Greater Manchester highlight that the English NHS must, in exchange for resources and freedoms, be required to deliver clearly defined, better outcomes for patients and service users, as well as better value for taxpayers.”

We show in Section 2 that this first era of devolution focussed on more staff and free public entitlements, rather than new and better ways to deliver care. It has not delivered significantly better outcomes for patients than in England, despite more generous funding. The terms of devolution piloted in Greater Manchester are different. They highlight that the

English NHS must, in exchange for resources and freedoms, be required to deliver clearly defined, better outcomes for patients and service users, as well as better value for taxpayers.

Greater Manchester shows the opportunities offered by NHS decentralisation

Over the past few months, we have talked to colleagues in Greater Manchester as they have shaped ambitious proposals to transform the city's healthcare. The Government has agreed that, from April 2016, the conurbation's entire £6 billion health and social care budget, currently dispersed through more than 30 organisations, local and national, will be consolidated within a single partnership body which will define overall strategy. Executive powers will rest with a new Greater Manchester Joint Commissioning Board. Actual commissioning will be delegated, according to subsidiarity, to the most effective level.

UK's first devolved city region focussed on citizens' health

Greater Manchester is planning much more than a bureaucratic change. It aims to become the UK's first city to concentrate its assets – medical and non-medical – on improving the health of its citizens. To

“Greater Manchester is, for the first time in the 67 year history of the NHS, focussed on maintaining and improving the health of its entire population through a system-wide approach that rewards keeping people well, independent, at home and out of hospital.”

achieve this goal, it has developed a care model that focusses on maintaining and improving the health of its population through a system-wide approach that rewards keeping people well, independent, at home and out of hospital. Almost 600,000 (up to 20 per cent) of the city's three million people who have been identified as most at risk of disease progression and hospitalisation

will be offered an annualised care package. It will be personalised and directly targeted at the person's lifestyle and underlying conditions, with their GP as the accountable doctor. Greater Manchester's goal is to eliminate at least 60,000 hospital admissions per year. This is precisely the type of model for engaging citizens that we advocated in

Solving the NHS Care and Cash Crisis, published by *Reform* in 2014.¹

Crucially – and unlike devolution to Scotland, Wales and Northern Ireland – the changes in Greater Manchester decentralise power. They place all NHS decision-making at a more local level, aligning it with the authorities responsible for social care, thus facilitating vertical integration. Meanwhile, Westminster is also devolving to Greater Manchester other Whitehall-held responsibilities such as powers over work programmes, housing and infrastructural development. So, for the first time, the NHS can achieve horizontal integration with a wide range of services that are vital for maintaining community health, particularly among disadvantaged groups. The outcome will be a single local partnership controlling multiple levers for improving health – treatment and social care services as well as public health and all those non-medical services that make such a difference to health. We have given Greater Manchester the label “Healthopolis” – it is the UK’s first devolved city region to focus on citizens’ health.

Tackling the NHS cash crisis

“NHS devolution to Greater Manchester could halve the city region’s expected £500 million deficit in health and social care spending, reducing it by about £250 million through reduced admissions to hospital and the benefits of health and social care integration.”

Devolution promises to help tackle the NHS cash crisis. Greater Manchester anticipates that even after the most rigorous provider efficiency and productivity savings, it will still be left with a recurring annual budget deficit for health and social care of over £500 million by 2017-18. NHS devolution could halve that deficit, reducing it by about £250 million through reduced admissions to

hospital and the benefits of health and social care integration. Greater Manchester, like the rest of the NHS, will still need some extra funding, say managers. However, devolution could cut that requirement in half.

¹ Warner, N. and O’Sullivan, J. (2014), *Solving the NHS care and cash crisis: Routes to health and care renewal*, *Reform*.

Devolution in Greater Manchester and elsewhere in England should make the NHS more efficient, fair and sustainable. It places leadership plus responsibility for commissioning and service delivery all at the same, locally accountable level, thus resolving the fragmentation of planning and care delivery that undermines most

“The NHS should become more sustainable because maintaining health addresses key factors behind the NHS’s lack of affordability – interventions are typically episodic, infrequent and late. Treating people in the right way at the right time is cheaper.”

modern health systems. It shifts financial incentives and planning towards services that maintain health rather than simply treating sickness. This addresses the country’s core health inequality, namely that the less well-off suffer more ill-health than the better off, and, as a result, eventually die up to 19 years earlier.² The NHS should also become more sustainable because maintaining

health addresses a key cause of the NHS’s lack of affordability – interventions are typically episodic, infrequent and late. Treating people in the right way at the right time is cheaper. Greater Manchester, for example, estimates that shifting resources from acute to earlier community-based care will save £60-£70 million of the total £250 million annual savings expected from devolution.

Bringing responsibility for all these services closer to the individual should also support new partnerships between patients and care professionals, facilitating personalised care. It should release the untapped potential of “self-care” which is under-developed in traditional, hierarchical, professional-patient relationships.

2 Office for National Statistics (2014), “Inequality in Healthy Life Expectancy at Birth by National Deciles of Area Deprivation: England, 2010-12”, accessed March 2015, <http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/inequality-in-healthy-life-expectancy-at-birth-by-national-deciles-of-area-deprivation--england/2010-12/index.html>.

Devolution requires key powers

Devolution to Greater Manchester requires, say local leaders, decentralisation of key powers including: flexibility within longer than usual budgetary commitments from Whitehall; rights to reconfigure and develop capital assets; new workforce requirements for Health Education England; and more local control over the pricing, contracts and competition for services in order to incentivise a shift into fully integrated and expanded community, primary and social care delivery. The city also seeks a more flexible regulatory regime currently administered by national bodies such as Monitor, the Care Quality Commission and the Trust Development Authority, because its health priorities may differ from national policy.

Broad appetite for NHS decentralisation in England

Greater Manchester is just the beginning of NHS devolution in England. The NHS leadership appears drawn to devolution by its need for innovative solutions to deliver quality healthcare in a period of heavily constrained public expenditure. The *Five Year Forward View*, published by NHS England in October 2014, predicts that if it receives flat real

“We propose to fundamentally shift the balance of power and responsibility from a remote Westminster, Holyrood and Cardiff Bay to local people who know their places best.”

Core Cities

terms funding and achieves 1.5 per cent annual efficiency improvement for five years (double the historic rate), its funding gap will still be £16 billion by the end of the decade. New approaches are clearly needed.

“Today’s landmark agreement between NHS England, the local NHS and local government

leaders charts a path to the greatest integration and devolution of care funding since the creation of the NHS in 1948,” declared Simon Stevens, Chief Executive of NHS England, as he announced decentralisation of the NHS to Greater Manchester. “The eyes of the country will now be on what this new partnership can deliver.” Mr Stevens sounded remarkably like Sir Robert Peel, who once proudly

proclaimed: “What Manchester thinks today, the world does tomorrow.”

Westminster is also interested in English devolution beyond Greater Manchester. A command paper, *The Implications of Devolution for England* outlines “devolution on demand” where local areas with “genuine demand underpinned by popular support” could ask central government to transfer appropriate powers. It states: “There would be a presumption in favour of devolution, but checks in place would aim to ensure powers were not granted inappropriately.”

Local government is likewise enthusiastic. In February 2015, a group of “Core Cities” published *Modern Charter for Local Freedom*. The Core Cities, which include Glasgow and Cardiff, declared: “Devolution is more than passing powers from one centralising parliament to another. We propose to fundamentally shift the balance of power and responsibility from a remote Westminster, Holyrood and Cardiff Bay to local people who know their places best.”

How to protect core NHS values

Decentralisation can tackle NHS weaknesses caused by size and fragmentation, while retaining its strengths. Funding can remain largely through central taxation, with the NHS continuing to ensure comprehensive health coverage for every citizen and largely free at the point of delivery. Nevertheless, decentralisation to Greater Manchester does raise important questions if the NHS is to remain national, accountable, equitable, freely accessible, providing a high quality and comprehensive service.

Key national functions should be retained

Devolution in England must not be allowed to take the “National” out of the NHS. We envisage that decentralisation and its local flexibilities should be accompanied by national guarantees on access to a primary care physician and services as well as to specialist diagnosis and treatment, especially for “killer” diseases. This will require a national measurement system, ensuring local compliance and public transparency on performance.

Key national functions should remain. They are likely to include resource allocation and a system for ensuring fair population funding for the tasks an area is being asked to tackle; standard-setting and monitoring performance; some specification and oversight of those specialist services requiring large populations; research and development; and workforce planning and ensuring a reasonable

“Just as there are failures now, so there will be in a devolved system, and it will be crucial to clarify responsibility for service or financial failure in such a system when local services fall consistently below an acceptable level.”

geographical distribution of key staff such as doctors. However, this national role in workforce planning does not require slavish adherence to national pay bargaining and grading.

Perhaps some of the work of national regulators should be delegated locally. However, just as there are failures now, so there will

be in a devolved system. It will be crucial to clarify responsibility for service or financial failure in such a system when local services fall consistently below an acceptable level.

We recommend an independent review to examine the fairness of the system that currently allocates resources to different parts of the country. This is likely to mean a fair, weighted capitation budget, based on health need and accurate demographic and disease population profiles. Evaluation should be carried out independently of party political influence and the system should be reviewed regularly to take into account changing circumstances.

An agreed devolved budget for a devolved area should be related to an agreed five-year contract on what is to be delivered in outcomes for the local population and how the models of service delivery will change to achieve those outcomes. There should be agreement also on the capital implications of such a contract and how these would be addressed. We have not considered capital issues in this document. However, in principle, the devolved entity should be able to take decisions on better use of land and buildings that could lead to improved health and wellbeing for its population and better value for money.

It is possible to envisage that, after 5 years of successful local control and delivery, larger areas might be allowed to raise up to say 5 per cent of their budget for additional specific services if they had conducted a successful referendum. However, we would specifically rule out revenue-raising via any additional charges at the point of clinical need. We also suggest that there should be minimal local flexibility on revenue-raising until such issues have been considered more carefully.

Devolution should not necessarily be available to all areas – and should not be required of any particular area. To make applications, areas should have to demonstrate local appetite and support for their plans.

“Important principles of fair access, quality and equality of treatment as well as robust financial control have been at the core of NHS success and support since 1948. They must not – and need not – be lost amid the enthusiasm for an exciting vision.”

The centre might identify local processes such as referenda, citizen’s juries, public meetings, household leafleting, media campaigns and MP involvement that should take place to demonstrate local support.

Applicants should be required to have a credible budget-holding body and accounting officer system that could answer to a government department and

ultimately to Parliament. Given the sums of money involved in devolution to Greater Manchester, there will have to be robust, independent auditing and transparent public accountability for how money is spent and what is delivered in terms of public benefit.

Conclusion: Cautious enthusiasm

Our conclusion, therefore, about NHS devolution in England, particularly in the format proposed by Greater Manchester, is one of cautious enthusiasm. For the first time, a large city region has offered a model of healthcare in the UK that focusses on preserving and improving the health of all citizens rather than merely treating them when they are sick. It could provide a step change in health outcomes, particularly for the worst off. If successful in fixing the care model, this innovative approach could help make the NHS more financially sustainable, by controlling the numbers needing expensive acute care.

Nevertheless, we must protect all NHS values. Important principles of fair access, quality and equality of treatment as well as robust financial control have been at the core of NHS success and support since 1948. They must not – and need not – be lost amid the enthusiasm for an exciting vision.

1

The retreat from the centralised state

“Things fall apart; the centre cannot hold”

William Butler Yeats (1919), *The Second Coming*

After the Second World War, Britain, almost without thinking, shifted to greater centralisation of State functions. Public utilities were nationalised; a National Health Service was created with much more command and control from the centre; a national social security system was implemented; and, effectively, central government drove the house-building programme in war-damaged Britain. As Britain gave up its Empire, Whitehall and Westminster compensated for their loss of power by taking over many of the functions previously exercised by local government. Unsurprisingly, the political left wanted to protect its creation, the Welfare State, through central direction, but right of centre governments joined them in signing up for a more centralised State.

Yet, even with this centralising push, local government still retained some of its functions in the new NHS – for a while. Public health was a local government responsibility, with individual medical officers of health in each area. Local government built and managed health centres and ran district nursing and health visitor services until they were stripped of these responsibilities in the 1970s, along with their membership, as of right, on local health authorities.

“As Britain gave up its Empire, Whitehall and Westminster compensated for their loss of power by taking over many of the functions previously exercised by local government.”

But in the 1990s things started to change again. The Scots and, to a lesser extent the Welsh, began to rebel against being told by Westminster how to run affairs in their territories. Since the Good Friday agreement and the re-establishment of devolved government in Northern Ireland,

Belfast has joined in the argument over devolving more authority from London. In all these cases, however, there was still an expectation that Westminster would continue generous grant-aiding of the greater autonomy through Joel Barnett’s eponymous “temporary” formula, agreed in the 1970s, for distribution of UK public sector funding.

Over the last two decades we have seen substantial powers devolved to Scotland, Wales and Northern Ireland. In all three, the devolved administrations are now responsible for health, education, local government and agriculture; while Scotland and Northern Ireland are

also responsible for policing and criminal justice. In all these areas they can determine their own legislation, organisation of services and even some aspects of the funding arrangements.

London – itself the engine of the economic growth often providing the largesse for more devolution – has campaigned for more autonomy with its new mayoralty calling for more powers, including in the sphere of health. However, until recently, there has been no great wave of demands for more autonomy from other English regions apart from Manchester. Most referenda on mayors and regional assemblies have received a “thumbs down” from local electorates. Many of these engagements with local electorates have revealed a considerable distaste for another tier of elected politicians.

Successive governments have been reluctant to cede autonomy to local government in England. Indeed, in areas like schools and policing, local powers have been reduced. With the tightening of public expenditure since 2010, local government in England has seen

“Suddenly, there is great national political interest in English devolution hard on the heels of the Scottish referendum.”

its spending capability significantly reduced – in total by 28 per cent between 2010-11 and 2014-15.³

In the finance settlement for 2015-16, the Government appears to be imposing a further

cut of £2.6 billion. The Local Government Association claims that, by the end of this Parliament, English local authorities will have been required to make £20 billion of savings.⁴ (This contrasts with the protection of the NHS with real terms annual growth of 1-2 per cent.)

During this period of retrenchment, local government has been granted relatively little room for manoeuvre in terms of income generation or financial flexibilities apart from Local Enterprise Partnerships and the ability to spend growth money on capital investments for roads and buildings. But a game-changer has appeared – the Scottish independence referendum.

3 National Audit Office (2014), *The impact of funding reductions on local authorities*.

4 Local Government Association (2014), *Provisional Local Government Finance Settlement 2015-16*.

The Scottish referendum and English devolution

Suddenly, there is great national political interest in English devolution hard on the heels of the Scottish referendum, the growth of the Scottish National Party and the recent Smith Commission report on devolving more powers to Scotland. Increased attention to English devolution can only grow with the publication of draft clauses for legislation in the new Parliament that will deliver a substantial package of additional powers to the Scottish Parliament. Amongst other things, these powers will enable the Scottish Parliament to raise over 50 per cent of the money they spend and to decide what to spend it on.

Alongside this strengthening of devolution for Scotland, the Wales Act 2014, passed last December, provides for more devolved powers to Cardiff and the likelihood of growing demands for more control over tax revenues. It is not difficult to see why the big English cities are now arguing for a lot more freedom from Westminster control. Greater devolution to Scotland and Wales of revenue-raising powers, together with generous grant-aiding for key services provided by the Barnett formula, could spell serious trouble for many English cities.

Grants from central government to England's cities could well be cut further at a time of public expenditure austerity and their per capita spend on key public services, such as health and education, might well be substantially lower than their Scottish counterparts if there is no change to the Barnett formula. There is now a growing public suspicion that English taxes might be used to finance service improvements in devolved administrations. The political parties seem increasingly alert to the possibility that the English electorate may take the view that devolution sauce for the Scottish goose is also sauce for the English gander.

In December 2014 the Government recognised the issue of devolution fluttering in the English dovecotes and produced a command paper, *The Implications of Devolution for England*. Much of this document is preoccupied with the issue of MPs from constituencies in Scotland, Wales and Northern Ireland voting on legislation that relates only to England, which is not the subject of this document. However, there is a slim (two pages) chapter that briefly discusses greater devolution in

England. This chapter recognises that “local variation in the way services are run is a feature of devolution”. It also outlines the idea of a “devolution on demand” model.⁵

Under this model, local areas in which there is “genuine demand underpinned by popular support” would be able to ask central government to transfer appropriate powers locally. “There would be a presumption in favour of devolution but checks in place would aim to ensure powers were not granted inappropriately. This system could include giving local authorities more autonomy managing their budgets.” Although short on detail, this document is a clear recognition in the Westminster/Whitehall villages that they have to contemplate passing more power to local people. This seems to have stirred the big cities into life.⁶

The Core Cities Charter

The idea of city regions has been around for 50 years but, until recently, only in Greater Manchester has there been any serious and consistent effort to coordinate across a region the activities of groups of local authorities and interests to achieve infrastructure improvement and to drive economic regeneration. Now a group of “Core Cities” (including Glasgow and Cardiff, but not London) that have been

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meeting for about 20 years are seriously agitating for more autonomy. This February they published the *Modern Charter for Local Freedom*.⁷

This Charter argues that, internationally, cities and regions have more freedom to shape their localities than those in the UK and, as result, deliver more economic growth. It claims that “at a time of constrained budgets, localities

5 Leader of the House of Commons and the Cabinet Office (2014), *The Implications of Devolution for England*.

6 Ibid.

7 Core Cities (2015), *Modern Charter for Local Freedom*.

need the freedom to radically reform and improve public services and put them on a sustainable footing so that we can offer opportunities to everyone in our communities”. It suggests that the only way to restore confidence in politics and democracy is give people a greater stake in their own future, “trusting them to make the right choices for where they live”.

The Charter “calls for a different relationship between local and national governments and devolution based on clear practical outcomes for the people of Britain. Devolution is more than passing powers from one centralising parliament to another. We propose to fundamentally shift the balance of power and responsibility from a remote Westminster, Holyrood and Cardiff Bay to local people who know their places best, putting the principles of this Charter into new legislation with cross-party support.”

This is a very radical document in its calls for much more local freedom for making decisions; and using an independent body to receive proposals for the transfer of freedoms from the centre to local people based on publicly available criteria and to oversee that transfer. Places that achieve those levels of independence and meet the agreed criteria should be able to retain the proceeds from selected taxes, including property taxes and a percentage of income tax. “With more local control over resources, policies for growth can be linked to service reforms, strengthening economies, creating jobs and saving public money.”

“None of these nods to devolution included that national icon – the NHS. Now comes another game-changer.”

This Charter represents a real challenge to the idea of centralised state with its call to give more control over delivery of local services to those areas that want more responsibility and can

demonstrate the competence to use it. The service areas in it include skills and jobs; transport; business, trade and investment; housing numbers and funds; planning; policing; and public sector reform. This latter item includes “freedom to join up services at local level to deliver better outcomes including those for: early years, complex families, and health and social care integration”.

This radicalism is well-timed as all the main political parties recognise – sometimes reluctantly – that they have to pay serious attention to English devolution as Scotland, Wales and Northern Ireland assert their determination to break further from the control of Westminster and Whitehall. The Chancellor made an earlier nod in this direction in respect of Manchester and Sheffield, mainly in relation to infrastructure development. Labour has now gone further with a recent promise to hand over £30 billion in public funds to cities and counties to boost housing, transport, employment and skills.⁸ Under these proposals city and county regions that integrate in these areas would be able to keep all the extra business rates generated by economic growth. But none of these nods to devolution included that national icon – the NHS. Now comes another game-changer.

Greater Manchester and its NHS budget

The Government has now made a move that brings the NHS and its budget into the English devolution debate. On 27 February 2015, the

“Devolution now joins targets, choice, competition, commissioning and integration on the list of measures for reforming a reluctant NHS. If it won’t change because the centre says it must, then perhaps locally-driven reform should be tried.”

Chancellor announced a provisional deal between NHS England and Greater Manchester to entrust that region with £6 billion of annual expenditure on health and care. From April 2016 Greater Manchester will have budgetary control over public health, social care, GP services, mental health and acute and community health services. Much of the detail of this deal still remains to be worked out but as a

statement of intent on devolution, this is a seismic shift away from central control over the spending of a large chunk of public money in an English region with a population similar in size to Wales.

At this stage, we do not know how many other similar deals may be in the pipeline. We do know that NHS England has sought ideas from local areas for transforming their local health and care services

8 The Labour Party (2014), *Changing Britain Together*.

using new models of care set out in the *Five Year Forward View*. It wants these ideas quickly and for them to be implemented speedily in order to improve the sustainability of the NHS at a time of great public sector financial stringency. It will be surprising if there are no other proposals in the pipeline with similar levels of ambition to Greater Manchester.

The Chancellor's initiative can be seen as recognition at the centre that the NHS now requires shock therapy if it is to become sustainable. Devolution now joins targets, choice, competition, commissioning and integration on the list of measures for reforming a reluctant NHS. If it won't change because the centre says it must, then perhaps locally-driven reform should be tried. In Greater Manchester there seems to be appetite for this, including from the GP commissioners who already hold much of the health and care budget.

Some may find it surprising to see the Chancellor centre-stage on NHS reform. However, it is easier to understand when one recognises that health and social care is now costing the public purse £149 billion a year in England – double the combined budgets for defence and public order.⁹ Most of this budget is, in any case, already committed by a myriad of local decisions. So, why not let the locals take more responsibility for both controlling spend and securing the services that their local populations need?

“Greater Manchester has now stepped up to the plate and offered a local way forward for changing the NHS delivery model with integrated health and care and more emphasis on community-based services, especially prevention.”

For too long there has been a collective reluctance to confront the service delivery and funding realities facing the NHS and failure to produce a convincing methodology to change direction and address that reality. A revered national institution, the NHS assumed it would always be protected, whatever happens to other public services. Radical

change was unnecessary. The remedy was more money and a bit of tweaking here and there but nothing that might frighten the voters. However the mood music is changing, not least because our

9 HM Treasury (2014), *Budget 2014*.

television screens are showing on a daily basis the problems of a declining service using the wrong models of care.

There is now a growing public recognition that the NHS has to change if it is to be sustainable. Most people still want a NHS funded through general taxation and largely free at the point of use. But increasing numbers understand that simply pouring more public money into a defective system is not the answer. The missing element has been agreement on how to change direction confidently and at pace. In October 2014 the collective central NHS leadership seemed to have decided that enough is enough and publicly faced up to the unsustainability of the NHS as it currently operates, with its *Five Year Forward View*.

Greater Manchester has now stepped up to the plate and offered a local way forward for changing the NHS delivery model with integrated health and care and more emphasis on community-based services, especially prevention. It seems likely that they will be joined by others because momentum is building rapidly behind greater devolution to English local government. This makes it virtually impossible to insulate the NHS from devolution where there is local appetite and competence for taking on the health and care agenda.

Greater Manchester, with its history of local bodies working cooperatively together, has now done everybody a favour by identifying the role that devolution might play in making the NHS more sustainable. We now have to think through the conditions under which this paradigm shift in favour of English devolution could benefit the NHS whilst retaining a core framework of service access to all. A good starting point for this thinking is to learn from what we know and to clarify what we want devolution to achieve for health and care.

2

Learning from what we know

**“And always keep a hold of Nurse
For fear of finding something worse.”**

Hillaire Belloc (1940), *Cautionary Tales for Children*

What we can learn from NHS devolution so far

The UK already has four devolved NHSs, with separate systems in England, Scotland, Wales and Northern Ireland. The populations served by these different NHSs vary considerably. England has a population of about 57.5 million. Scotland's is the next largest at about 5.3 million. Then Wales at about 3 million; and the smallest is Northern Ireland with a population of about 1.8 million. London, with a population of 8.6 million, is bigger than Scotland and Wales combined. Several English regions are comparable with Scotland: Yorkshire and Humberside and the South West have populations of at least 5 million. The city region of Greater Manchester has a population nearly as large as that of Wales and larger, by over a million, than Northern Ireland's.

In little more than a decade, the divergence between these four systems has become striking. England has a quasi-market in healthcare with use of private providers. Patient choice and

“Despite all the political and public fears that a postcode lottery could develop in healthcare, the reality is that our legislators have already created such a lottery in today's Britain by passing responsibility for the NHS to devolved administrations.”

competition have been developed. Targets and sanctions for poor performance are an everyday fact of life; and there is a system of earned autonomy with Foundation Trusts having more financial freedoms than other trusts. Prescriptions and social care are means-tested, with the latter separate from the NHS. This system has recently been

subjected to an unpopular, costly and disruptive reorganisation which the other three territories escaped.

In Scotland things are very different. There is no quasi-market. Only since 2006-07 has it had tougher NHS performance targets and sanctions, more in line with those in England; but prescriptions are free. Local authorities administer social care, as in England, but there is a version of free personal care for over-65s which has turned out to be more expensive than the Scottish Government originally anticipated.

Wales has no quasi-market; means-tested social care as in England; but free prescriptions. Northern Ireland has pooled the budgets and management for health and social care in single organisations; but has no provider competition. It has retained means-testing for social care but abolished prescription charges.

Despite all the political and public fears that a postcode lottery could develop in healthcare, the reality is that our legislators have already created such a lottery in today's Britain by passing responsibility for the NHS to devolved administrations. On the borders of the different territories there are very different service offers within a few miles. For example, there are free prescriptions on one side of Offa's Dyke and the River Tweed but not on the English side. Yet, within England, we try to enforce a level of standardisation across different areas that may be larger than some or all of the populations under the devolved administrations.

Healthcare devolution and the patient experience

“It is difficult to see in the three devolved administrations any great appetite to use freedom from Westminster to try new ways of delivering health and care services. Their extra money seems to have gone on more staff and free public entitlements rather than on new and better ways of working.”

We have tried to establish what differences healthcare devolution has made in the three devolved administrations. In doing this we have drawn heavily on the work of the Nuffield Trust and the Health Foundation, particularly their April 2014 publication *The four health systems of the United Kingdom: how do they compare?*¹⁰ As the Trust acknowledges, there are limitations to these comparisons in terms of the data sets. However, it is possible to make some

meaningful comparisons on funding, staffing, access to services, patient outcomes and patient satisfaction. Our detailed interpretation of the Nuffield Trust data is in the Appendix. But we want to start first with the critical issue of differential funding.

¹⁰ Bevan, G. et al (2014), *The four health systems of the United Kingdom: how do they compare?*, The Health Foundation and The Nuffield Trust.

Follow the money

The Nuffield Trust has shown that, in 2000-01, England had lower total health spending per head than any of the devolved countries. By 2012-13 it was still the lowest at £1,945 per head per year; compared with £1,988 per head in Wales; £2,145 per head in Northern Ireland; and £2,151 per head in Scotland.¹¹ In crude financial terms, England has been, and continues to be, less favourably treated than the devolved administrations in the funding available per head of population to be spent on the NHS. England therefore spends 7.7 per cent less per head compared with the average for the three devolved administrations, and 10.6 per cent less compared with Scotland. All four countries had a rapid and historically steep rise in funding in the 15 years to the end of 2010-11. Since then, all have had reduced annual increases of about 1 per cent.

The differential funding between England and the devolved administrations is unlikely to change unless the Barnett formula is revised. That formula, started in the 1970s, is designed to give each of the devolved administrations a proportionate share, according to

“The relative generosity of funding to the devolved administrations has not shifted the gauge proportionately in terms of health outcomes. England, the least generously funded per head of population, continues to report the best health outcomes.”

population, of the increase in planned spending in England on comparable services. This means that any increase in NHS spending in England automatically triggers increases in allocations to the devolved administrations.

Devolved administration can decide to spend more of their total money on their NHS. In contrast, England can only choose within its

fixed budget to support some parts of its territory at the expense of others. It has favoured the North East which has a similar socio-economic profile to Scotland. Bearing in mind healthcare is highly labour-intensive, with about 60 per cent of the budget going on staff,

¹¹ The Nuffield Trust, “Health spending per head by country”, accessed in March 2015, <http://www.nuffieldtrust.org.uk/data-and-charts/health-spending-head-country>.

resource allocations have a significant impact on staff employed, especially doctors and nurses.¹²

Doctors and nurses

The data in the Appendix suggests a clearer relationship between levels of funding and nursing staff numbers than is the case for doctors. Providing more generous funding to the North East of England seems to have had a significant increase in nursing levels, pulling them well away from the English average and close to the devolved administrations. England seems in a better position on GPs than Wales and Northern Ireland but, without knowing more about whole-time equivalents (WTEs), it is difficult to be sure how much worse off it is than Scotland. On hospital doctors, England overall still lags behind Scotland (but not the other devolved administrations) and its rate of increase is slower. Overall higher funding levels in devolved administrations – especially Scotland – seem to have improved the availability of doctors and nurses.

Patient experience

In all four countries there have been improvements in ambulance response times since the late 1990s, but the devolved administrations have not yet achieved the same level of performance as England. Comparing waiting times is complicated, but England has had more ambitious targets and has consistently outperformed the other countries, with Scotland performing better than the other two devolved administrations. Wales appears to be going backwards on waiting times. On screening and immunisation/vaccinations the devolved administrations seem to be doing slightly better than England.

Since the early 1990s there have been improvements in life expectancy and reductions in amenable mortality in all four countries. However devolution has produced little change in the relative differences in amenable mortality between the countries. Scotland consistently has the highest amenable mortality rates and even the generosity of its Barnett formula funding seems not to have enabled it

12 NHS England (2013), *The NHS belongs to the people: A Call to Action – The Technical Annex*.

to close the relative gap. England has consistently performed better on reducing MRSA mortality rates; and the Nuffield Trust suggests that this is also true on stroke performance.

In all countries patients are more satisfied with their local doctors and GPs than they are with the NHS as a whole. Patient satisfaction in England is higher than in Wales though lower than that in Scotland.¹³

Conclusions on devolving the NHS to Scotland, Wales and Northern Ireland

It is difficult from the comparisons in the Appendix to see devolution on its own as an obvious “silver bullet” for performance improvements and better patient outcomes. Over the last fifteen years all four UK

“Before resources are passed down from the centre in England, there needs to be greater clarity about outcomes for patients and service users and better value for money for taxpayers. This is likely to mean stronger conditionality about what is required before money and freedom is handed over.”

NHSs have improved performance and patient experience and outcomes, but this seems primarily down to large increases in funding and staff everywhere. The relative generosity of funding to the devolved administrations has not shifted the gauge proportionately in terms of health outcomes. England, the least generously funded per head of population, continues to report the best health outcomes.

It is England that has set more ambitious access and other targets; and has been willing to experiment with the use of managed markets, more competition, greater diversity of providers and more patient choice. These different approaches look to have helped English health services improve more with lower funding.

It is difficult to see in the three devolved administrations any great appetite to use freedom from Westminster to try new ways of delivering health and care services. Their extra money seems to have gone on more staff and free public entitlements rather than on new and better ways of working. Indeed neither England nor the devolved

13 The King’s Fund (2015), *Public satisfaction with the NHS*.

administrations have succeeded in seriously shifting their health care systems away from expensive hospital-based care to more community care and prevention services.

We see little evidence from this experience that simply devolving accountability for NHS services on its own inevitably improves a population's health and care system. Devolution accompanied by large increases in funding seems to produce more of the same in terms of service delivery and little challenge to existing patterns of service delivery. The conclusion we draw from this experience is that before resources are passed down from the centre in England, there needs to be greater clarity about how they are going to be used to improve outcomes for patients and service users and better value for money for taxpayers. This is likely to mean stronger conditionality about what is required from devolution before money and freedom is handed over, particularly given the future that the NHS faces.

We know that the NHS has to change radically to be sustainable at a time when the public purse is shrinking and it faces major demography and disease challenges. It faces at least five years of constrained funding that is well short of the 3-4 per cent annual growth it has received for most of its life; and at a time when demand for its services is rising by about 3-4 per cent a year.¹⁴

The financial reality of a widely predicted £30 billion NHS funding gap by 2020-21 is accompanied by major disease and demography challenges, as well as rising public expectations. Across all four UK NHSs we have not used the years of funding plenty to change our public policies and business models for delivering health and care services. We have continued to pump money into expensive acute hospitals rather than develop cheaper and more effective community-based health and care services and public health. English devolution must make an effective contribution to tackle these realities and has to be judged against the effectiveness of that contribution.

14 NHS England (2013), *The NHS belongs to the people: A Call to Action – The Technical Annex*.

The case for decentralisation

More centralisation is not the answer to the crisis. The private sector has plenty of examples where success built on strong central control has turned out to be a hindrance when markets shift as a result of technology or changing customer needs and expectations. The

“A 67-year-old NHS in England is showing signs of becoming a public sector example of an organisation that sees itself as too big to fail but has also become too big to succeed.”

inability of a tone-deaf headquarters to listen to the people closer to customers can have serious consequences that might have been avoided if local people had been listened to more carefully. Retail banking is a good example of this, as are former technology companies such as

IBM. More currently, we are seeing Tesco going through this experience as its local outlets do what the centre tells them but the customers fail to comply with the centre’s view of the world.

A 67-year-old NHS in England is showing signs of becoming a public sector example of an organisation that sees itself as too big to fail but has also become too big to succeed. Although English NHS performance has been better than its smaller devolved counterparts, that may tell you more about the counterparts’ performance than about England’s NHS. There are plenty of day-to-day patient experiences that suggest the NHS in England has become too big for the kind of detailed command and control still exercised from Westminster.

Each day we see the reality of central decisions that produce the very behaviours by service users that the centre does not want. Governments decline to fund adult social care adequately for the best part of a decade and consistently favour acute hospital funding at the expense of community-based 24/7 health services such as GPs, district nurses and out-of-hours services. They then seem surprised when the public turn up in droves at the local A&E departments. It’s the public that is behaving rationally, not the central decision-makers, because their behaviour is forced upon them by the shortage of community-based alternatives to the hospital.

Now we have created a legislative structure that pretends to vest a lot of autonomy in over 200 clinical commissioning groups yet, in reality, the Health Secretary meets weekly with anxious officials to try to micro-manage struggling A&E Departments. We are perpetuating a

“We pretend to vest autonomy in over 200 clinical commissioning groups yet, in reality, the Health Secretary meets weekly with anxious officials to try to micro-manage struggling A&E Departments.”

public pretence that the Health Secretary is somehow accountable for what is going on daily in an English NHS employing about 1.3 billion people and spending more than £100 billion a year. The very CCGs that were supposed to produce more appropriate local services too often shrink from commissioning

different services because they doubt their authority to take tough decisions on behalf of their population, with the centre poised to intervene at the first whiff of controversy.

The time has come to find a better fit between the NHS centre and local institutions that can produce a more sustainable NHS in a world of shrinking budgets and major disease and demography challenges.

Changing direction

We consider that the NHS in England has reached a point where its sustainability requires a coherent programme of devolution that shifts much more decision-making and accountability away from the centre. This will undoubtedly produce cries of postcode lottery and the break-up of the NHS. Our response is that a postcode lottery already exists in terms of what you get locally and this can only get worse if we retain an over-centralised, financially unsustainable and unintegrated NHS that cannot meet variable local needs and with no effective local accountability. Judging by the *Five Year Forward View*, NHS central leadership seems to have come to a similar conclusion and is now looking at new models of service delivery and removing some of the central handcuffs.

At the same time, across England, a paradigm shift looks to be taking place in central/local accountability for public services with more

responsibility and freedom to act passing to the local level. This is bound to mean a greater role for local authorities and local bodies, or more likely, groups of local authorities and other bodies. This greater freedom will inevitably mean more financial autonomy. This change needs to be integrated with the shift of approach within the NHS to secure the maximum benefit for both local communities and central government. To exclude the NHS from this paradigm shift would be a serious missed opportunity given the challenges it faces.

This will require many in the NHS to rethink their attitude to local government and see it as part of the solution to their problems rather than part of the problem. They might want to reflect on the fact that,

“Some form of cross-government machinery will be required to ensure a successful integrated programme of local devolution embracing health, care and other public services.”

at the start of the NHS, local authorities had Medical Officers of Health with responsibility for their population’s health. Local authorities built and ran health centres; and provided district nursing and health visitor services as well as vaccination and immunisation programmes. Local

authorities were also represented on NHS bodies. All this only changed in the 1970s, a change that, with hindsight, may well not have been a wise one.

This means that some form of cross-government machinery will be required to ensure a successful integrated programme of local devolution embracing health, care and other public services. This change was accepted by the Core Cities when they envisaged legislation and an independent body to oversee the transfer of responsibilities to local authorities. Similarly, with the Government’s idea of “devolution on demand”, there was an expectation that those who wished to secure more local autonomy would have to demonstrate local appetite and competence.

We consider that a similar approach should be adopted to increasing NHS devolution. We certainly do not support imitating in England the kind of “condition-free ride” approach to NHS devolution adopted with the devolved administrations. The discussions between NHS England and Greater Manchester look to be pursuing a clear path

towards some kind of five year agreement on what will be delivered locally in return for the greater devolution of financial and service delivery autonomy.

“Discussions between NHS England and Greater Manchester look to be pursuing a five year agreement on what will be delivered locally in return for the greater devolution of financial and service delivery autonomy.”

We explore in the next section the work going on in Greater Manchester before moving to consider how to retain the “N” in the NHS within a cross-government programme of devolution that embraces health and care.

3

Greater Manchester's “Healthopolis” – a devolved city region focussed on people’s health

**“The age of ruins is past. Have you seen Manchester?
Manchester is as great a human exploit as Athens.”**

Benjamin Disraeli (1844), *Coningsby*

Introduction

Manchester has been one of England's sickest cities since the Industrial Revolution. After 200 years of growth, half a century of deindustrialisation and 67 years of the NHS, Mancunians are still typically less healthy than their English contemporaries. Friedrich Engels, who used Manchester as a backcloth for his 1844 work, *The Condition of the Working Class in England*, would recognise continuing, glaring health inequalities. They mean that a boy who is raised in Gorton, east Manchester can expect to die nearly 15 years sooner than his Chelsea-born peer. Mortality rates, adjusted for age, are so much higher than the national average that health officials equate them to a jumbo jet full of passengers crashing in Greater Manchester nearly every month. The voices we quote in this section are all from such healthcare officials who feel inspired to seek dramatic change for this city region.

Dickens' "Cottonopolis", which pioneered the steam engine, telephony and the computer, now has a compelling vision of itself as the world's first city to focus its assets around improving citizens' health. We call it "Healthopolis". In February 2015, the city's plan for

"Greater Manchester's 'Healthopolis' aligns all the levers for improving health at the same local level and offers an innovative cure for the fragmentation of planning, care delivery and leadership that undermines most modern health systems."

the industrialisation of good health persuaded Westminster, increasingly bereft of both funds and ways to transform the NHS for the 21st century, to cede control to Greater Manchester of the £6 billion spent annually on health and social care for the conurbation's population. From April 2016, a budget currently dispersed through more than 30 organisations, local and national,

will be consolidated within a single partnership body that merges health and social care and will define an overall strategy.

Responsibility for execution of that strategy will rest with a new Greater Manchester Joint Commissioning Board, with the actual commissioning delegated to the most effective level, under the principle of subsidiarity.

Meanwhile, under the "DevoManc" agreement, announced in November 2014, Greater Manchester is also poised to reclaim powers held by London over, for example, the local economy, employment supports, housing and infrastructure that are also each entwined with personal health and wellbeing. Additionally, it seeks to strike a deal with the city's five universities, building a new relationship between health research and practice, aimed at speeding up the identification and spread of innovation.

In this context, "Healthopolis" aligns all the levers for improving health at the same local level and offers an innovative cure for the fragmentation of planning, care delivery and leadership that undermines almost every modern health system. The hope is that, once again, as Sir Robert Peel proudly claimed: "What Manchester thinks today, the world does tomorrow."

At the heart of this initiative is an attempt to solve not only a care but also a cash crisis for the city. Greater Manchester is forecast to have an annual budgetary shortfall for health and social care of £1.075 billion by 2017-18, its share of England's £30 billion deficit by the end

"In the past few months, we have spoken with colleagues in Greater Manchester while they shaped their ambitious proposals to transform the city's health."

of the decade.¹⁵¹⁶ Greater Manchester's planners reckon that even the most rigorous provider efficiency and productivity gains will still leave a recurring annual budget deficit of £500 million. But they anticipate that NHS devolution could halve that deficit,

reducing it by about £250 million through reduced admissions to hospitals and through the benefits of health and social care integration. Greater Manchester, like the rest of the NHS, will still need some extra funding, say managers. However, devolution could cut that requirement in half.

Devolution is a radical proposal that aims to shift the city's health policy and practice away from crisis management, late intervention and reactive care. *The Memorandum of Understanding*, agreed with the Government in February, places devolution's first goals as being

15 Deloitte (2014), *Healthier Together: Financial Case for Change*.

16 NHS England (2014), *Five Year Forward View*.

“a focus on prevention of ill health and the promotion of wellbeing ... to move from having some of the worst health outcomes to having some of the best... to close the health inequalities gap within [Greater Manchester] and between [Greater Manchester] and the rest of the UK faster”.¹⁷

How will this be achieved? In the past few months, as plans have been developed, we have spoken with colleagues in Greater Manchester while they shaped their ambitious proposals to transform the city's health. Greater Manchester will merge health and social care at all levels. But the plan also involves a radical change in the

“Greater Manchester, like the rest of the NHS, will still need some extra funding, say managers. However, devolution could cut that requirement in half.”

prevailing NHS care model. It will target 600,000 of the city's 3 million people who are considered most at risk of disease progression and hospitalisation. They will be offered a special personalised care package, directly targeted at the person's

lifestyle and underlying conditions, with their GP as the accountable doctor. The goal will be to eliminate at least 60,000 hospital admissions per year (accounting for £60-70 million a year of the total £250 million anticipated savings from devolution and considerably improving patient experience). A more long-term ambition is to achieve reductions of 80,000-100,000 hospital admissions.

Could such a bold move at last put Mancunians' health where their football teams already are – near the top of the league table? How might Greater Manchester become a pilot for NHS devolution across other parts of England? Our examination of the conurbation's plans, some published and some still under discussion, begins by setting out ten key issues that currently underpin the problems that devolution is meant to address. These all relate to the fragmentation of Greater Manchester's health and social care planning, its care delivery and its leadership, as well as the health system's poor integration with the city's wider public sector. We conclude with an overview of what could be achieved, under the powers that Greater

17 NHS England, Association of Greater Manchester Authorities, and Greater Manchester Association of Clinical Commissioning Groups (2015), *Greater Manchester Health and Social Care Devolution: Memorandum of Understanding*.

Manchester will shortly gain. We sketch the path it might take up to April 2018 – during the first 1,000 days of the next Government.

10 chronic ailments of Greater Manchester's health economy

Care

Symptom: Every year, 60,000 more people are admitted to hospital in Greater Manchester than the English average would predict for long-term conditions such as asthma, diabetes and renal disease. If treated properly at the right time in the right place, these people could avoid hospitalisation. If Greater Manchester was as successful at reducing admissions as the top 10 per cent of areas in England, this figure could drop by 80,000-100,000.

1. Episodic delivery

Greater Manchester NHS, like most parts of the country, offers often confused, episodic and dislocated health support to individuals.

Health services tend to engage with people mainly when they are ill and then, once that problem is resolved, the NHS largely abandons them until they get sick again. On each such occasion, valuable chances to maximise longer term health are lost. This makes personalised healthcare more difficult and means that opportunities for supporting individual self-care are repeatedly missed. It's a problem that helps explain why Greater Manchester's

“A certain obesity level can trigger bariatric surgery for thousands of patients. But where are the triggers for more intensive primary care that would intervene much earlier and much more effectively for the person and the NHS?”
NHS manager in Greater Manchester

rate of admissions for ambulatory, care-sensitive conditions (conditions that could have been treated elsewhere) is more than 28 per cent higher than the England-wide average.¹⁸ A health manager described the odd priorities emerging from the system: “There's all this advice coming from NICE saying that when people hit a certain

¹⁸ Health and Social Care Information Centre (2014), “Admission rate (per 100,000 population) for ACS conditions by Area Team of residence - Jun13 to May-14”, accessed March 2015.

obesity level, it makes economic sense to give bariatric surgery to thousands of patients. But where are the triggers in the system for more intensive primary care that would intervene much earlier and much more effectively for the person and the NHS?"

2. Divided health and social care

The social care system is funded from Whitehall and run by ten local authorities while the health care system is nationally led and locally managed by a series of different bodies. People are treated by both health and social care services – sometimes simultaneously – and each system intricately affects the performance of the other. "We have the absurd situation," explained a health manager, "where district nurses or social workers are going into homes and you might have a social care bath that you pay for or a health care bath that you don't pay for". However, aligning the commissioning, management and delivery of these two sources of care is difficult under current arrangements. As one Greater Manchester official said: "Economic necessity has driven new thinking in local government in terms of sharing and decision-making at Greater Manchester levels. Sometimes the NHS can be intensely parochial, perhaps because it has not experienced anything like the financial challenge that local government has faced. I've told CCGs that the local authorities are showing them up."

3. Workforce misallocation

The divisions between primary and secondary care, as well as between health and social care, mean that staff are often not located where patients really need them or they may duplicate provision. For example, many geriatric consultants who might be employed more effectively, at least part of the time, in the community – helping elderly people stay out of hospital – are focussed on delivering care in a hospital environment. Another example would be different forms of nursing care – delivered by both the NHS and social care – that could be delivered more rationally if the two services were integrated and aligned.

Planning and budgets

Symptom: NHS services in Greater Manchester faces a structural overspend of £1.075 billion a year by 2017-18. The most rigorous provider efficiency and productivity savings would still leave a deficit of around £500 million. It is estimated that devolution could eliminate up to £250 million of this remaining £500 million by changing the care model, better local coordination plus the alignment of health and social care.

4. Division over commissioning

Fragmentation of healthcare commissioning between the local and the national NHS has long been a problem. However, this has worsened since the Lansley Reforms of 2012. Financial responsibility for a patient being treated for a single illness typically passes

“In Greater Manchester, we’ve had 10 or 12 years of national policy encouraging care closer to home, but there has been little improvement in the rebalancing of resources from acute to non-acute care. Indeed the balance has probably shifted a bit towards acute.”

NHS manager in Greater Manchester

repeatedly between different funders. This contributes to financial inefficiency and poor care. A manager detailed what can happen:

“A common cancer might be spotted in general practice, with care commissioned by NHS England at the area team level. The patient might then be referred into a specialist district hospital, the care commissioned by the clinical commissioning group at the locality level. There might be

secondary referral to a specialist cancer trust which would be provided again by NHS England but at a more regional level. The patient might then be routed back, in terms of rehabilitation and recovery, into services commissioned by NHS England or by some CCGs. This is a complicated commissioning process for a single illness, drawing down resources from three or four commissioners at different moments during perhaps an eight week period.”

5. Shifting care close to home

Fragmentation of responsibilities for commissioning additionally reduces incentives to focus care where it is most beneficial to the

patient and most cost-effective for the NHS and social care. So, for example, care organisations currently responsible for buying primary care (NHS England) are different from those buying hospital care (CCGs) and specialist care (NHS England). That damages incentives for a widely called-for shift of services to earlier interventions at GP level that are better for people (reducing their risk of serious illness) and are cheaper for the NHS (reducing the incidences of acute illness requiring treatment in more costly hospital environments). This adds to problems caused by existing divisions between health and social care. As one NHS manager said: "In Greater Manchester, we've had 10 or 12 years of national policy encouraging care closer to home, but there has been little improvement in the rebalancing of resources from acute to non-acute care. Indeed the balance has probably shifted a bit towards acute."

6. Pricing, incentives and contracting

The current "payment by results" regime rewards hospital activity. It provides too few incentives for a system-wide approach that would reward keeping people well, independent, at home and out of hospital. The overall approach to NHS services is not determined locally but according to annual instructions, decided centrally, such as the NHS Operating Framework. This is essentially a work plan for every NHS organisation involving little consultation with local partners. This top down, command health economy undermines local leadership that might otherwise develop some of the synergies detailed above.

7. Poor asset management

Strategic asset management is difficult currently in Greater Manchester as it is in many areas. The local NHS estate is owned and managed by different

"Nobody has the facility or duty to say: 'What shall we do with all of it?' That has to change if we are to leverage the city's estate efficiently to deliver system change."

NHS manager in Greater Manchester

organisations and there is little overall cooperation. Foundation trusts manage their assets. Primary care infrastructure is variously owned by GPs themselves, NHS Property Services and Community Health Partnerships (CHP), which have taken over the LIFT portfolio.

Meanwhile local authority property within Greater Manchester is owned by its ten constituent councils. As one official said: "Typically, a local council is looking after its buildings. The local clinical commissioning group has a relationship with NHS Property Services and CHP over its portion of the estate. And individual GPs are doing what they want with the bits that they own. But nobody has the facility or duty to say: 'What shall we do with all of it?' That has to change if we are to leverage the city's estate efficiently to deliver system change."

Leadership

Symptom: Change and management of health and social care in Greater Manchester currently can currently require decisions by, among others, 10 local authorities, 12 CCGs, NHS England at area team, regional and national levels, acute care providers, several national regulators and the Secretary of State for Health. Some of

"The existing system for strategic change is slow. Reducing Greater Manchester's obstetric units from 12 to 8 and down-sizing its smallest district general hospital in Trafford required a strategic levy from all 12 of Greater Manchester's CCGs to manage a transition that took 3 years."

NHS manager in Greater Manchester

these leaders are elected locally, some nationally and some are not elected at all, so accountability and responsibility is dispersed. Innovation is deterred.

8. Joint decision-making is difficult

Greater Manchester has attempted to make sense of a messy decision-making process that Westminster has provided. The Association of Greater Manchester Authorities (AGMA) was created in 1986 as a loose affiliation for cooperation between

the area's ten local authorities. They soon recognised that some city-wide functions needed to be planned, coordinated and funded across the ten councils. So they created the Greater Manchester Combined Authority (GMCA), a statutory body that can hold a budget and to which the ten councils have devolved upwards some funding and the running of some services, such as transport. Meanwhile,

Greater Manchester's 12 CCGs have created a joint committee. They have been working with the GMCA to start integrating care through the Healthier Together campaign.

Greater Manchester also has ten Health and Wellbeing Boards, nine of which are co-terminus with single CCGs and the tenth of which is co-terminus with three CCGs. They have powers to advise CCGs. The 10 come together in an 11th Greater Manchester Health and Wellbeing Board, but it has no individual powers at present.

The slowness of the existing process for strategic change is demonstrated by recent attempts at reconfiguration. A manager explained: "Greater Manchester has reduced its number of obstetric units from 12 to 8 and down-sized its smallest district general hospital in Trafford – it's A&E no longer operates after midnight. Achieving this change required a strategic levy from all 12 of Greater Manchester's CCGs to manage a transition that took 3 years. There are neither the funds nor the flexibility for the much larger challenge that a full reprioritisation of the Greater Manchester NHS would probably entail involving reconfiguration of its 8 district general hospitals and development of community and primary care services."

9. Fragmented regulation

The NHS in Greater Manchester is currently regulated by a number of national bodies such as Monitor, the Care Quality Commission and the Trust Development Authority. These bodies have multiple relationships with the city's 12 CCGs, 10 local authorities and providers. The level and complexity of regulation reflect both the multiplicity of organisations responsible for delivery of care and a lack of local accountability in the existing system. Fragmented regulation is another barrier to city-wide change and coordination. A local health manager explained: "It would be better to shift the focus of regulators towards improving the effective operation of the system rather than focussing simply on the statutory health of individual organisations."

Health and the wider public sector

Symptom: GPs who have some on-going responsibility for patient health have little knowledge of changes in their patients' lives, such as loss of job, problems with housing, or difficulties at school, that

evidence predicts can affect health. Nor do they have tools at their disposal to help tackle those non-medical determinants of health.

10. Lack of control over many causes of ill-health

There is a gulf between the medicalised NHS and almost everything else that keeps us well – work, income, leisure, education, housing, the environment and so on. Greater Manchester has begun to explore opportunities to link the two. For example, the GMCA is currently running, with the Government, a joint welfare-to-work programme,

“In Greater Manchester, despite the clamour around disinvestment in public services, actual total public spending has been fairly stable. Money has been taken out of public services, but it’s largely gone into the benefits system.”

Local government official in Manchester

Working Well, that recruits people who have already been through the centrally-run Work Programme but failed to secure jobs. Links with health and care services mean the programme can be more effective at tackling health-related causes of long-term joblessness. “Some 60 or 70 per cent of people on employment support allowance have an underlying mental health condition,” explained an official.

“One in five has a musculoskeletal condition. Yet traditional employment support fails to connect with the full blend of supports that the NHS can offer.” Another programme is exploring how fire prevention officers can support smoking cessation programmes during their visits to homes. A health manager explained: “We have great opportunity there to reach into parts of the community with which the NHS might have very little contact.”

A local government official set out the bigger financial picture. “In Greater Manchester, despite the clamour around disinvestment in public services, actual total public spending has been fairly stable. Money has been taken out of public services, but it’s largely gone into the benefits system.” The challenge, therefore, is to make that money work better for health and wellbeing. However, current divisions between health, social care and other public services have reduced incentives for initiatives that could be achieved by more joined up, decentralised government.

The first 1,000 days: May 2015 to April 2018

The goal of devolving powers – downwards from Whitehall and upwards from local authorities and CCGs – to Greater Manchester level is to resolve fragmentation of planning, care delivery and leadership, as well as overcoming disconnections between health and wider public sector policies on, for example, jobs and housing. The devolution and governance should be fully in place by 1 April 2016.

Fixing care delivery

“We want GPs effectively to have two prescription pads – one for medical prescriptions and one that can refer patients to supports around work, training, housing, exercise that might offer more long-term solutions than, say, anti-depressants.”
 NHS manager in Greater Manchester

The population of Greater Manchester will be risk stratified and pro-active care plans put in place for up to 600,000 people, the 20 per cent most at risk of disease progression or hospitalisation. Integration of health, social care and public health responsibilities within one umbrella organisation will provide care planners with a full range of tools to support this most vulnerable group and develop

approaches and incentives to prevent others coming into this “at risk” group. The goal is to reduce hospital admissions by 60,000 a year.

A key task in improving performance will be to drive out variation in primary care, which, in Greater Manchester as in most of England, is even greater than for secondary care. The process would build on the hospital-based Healthier Together programme which is currently implementing hundreds of clinical quality and safety standards across the acute sector to save 1,500 lives in Greater Manchester by April 2018. As one official said: “We’re applying standards to eliminate variations in hospital care. We’ve done that piece by piece – a bit on stroke a few years ago, a bit more on trauma and improvement on heart treatment as part of the National Service Framework. Now we are going to do it for primary care.”

Torbay Care Trust, created in December 2005 to integrate all adult health and social care (commissioning and provision), has demonstrated the potential for aligning, integrating and then transforming all health and social care in one place. The policy has delivered low emergency admission rates, the elimination of care transfer delays and excellent performance in use of hospital capacity as well as shifts in investment from acute to community services and the transfer of staff from acute to community provision. "We want to do what Torbay did," explained an official. "They targeted both ends and applied money where it was most needed. So they ended up taking acute resource and investing it in domiciliary care, because that stopped the crisis happening, and secondly in re-ablement and rehabilitation because that's the bit that helps get people out of hospital and keeps them out."

Links between medical care and other public sector services will offer GPs a variety of tools. As one official said: "We want GPs effectively to have two prescription pads – one for medical prescriptions and one that can refer them to a host of supports around work, training, housing, exercise etc that might help to identify the real factors that are making people ill and offer more long-term solutions to, for example, depression, than, say, anti-depressants."

Improving planning and commissioning

Devolving all NHS and social care commissioning to Greater Manchester will remove many perverse incentives in the system and provide opportunities to shift funding into more cost-effective treatments. "It might be easier to take difficult decisions at a local level," said one official. "It's easy for local politicians to attack policies when they are coming from a national level. But if they are being made locally, you've aligned responsibility and accountability."

Commissioning of primary care will be devolved from NHS England to CCGs, as will commissioning of specialist care, alongside the acute care responsibilities they already have. A shift of all health and social care commissioning to the local level – particularly bringing public health and primary care into the same budget pool as expensive drug therapies – might create an important debate about NHS equity. This

concerns what could be seen as a clear trade-off between the poor and ineffective preventive care often experienced by thousands of poorer Mancunians – many of whom die decades earlier than they might – and the costs of highly expensive drugs that often prolong lives for comparatively short lengths of time. A more locally accountable body might wish to alter the balance in health spending in favour of preventive care.

Although these issues are far from resolved in initial agreements, it seems that Greater Manchester will need devolved powers to create its own payments system so it could shift from the current “payment

“A whole system target might be to reduce blood pressure across Greater Manchester by 10 per cent. It has been estimated that achieving this goal could save 1,400 lives locally over 5 years. This would require better system working and incentivisation of each part of the system.”

NHS manager in Greater Manchester

by results” regime – which rewards hospital activity – to systems that are structured to reward keeping people well, independent, at home and out of hospital. Greater Manchester’s approach might, for example, include individual budgets pioneered by the Year of Care model to combine choice and more person-centred care. At city region level, weighted capitation might be used to fund the overall care of populations, offering those

responsible the freedom to develop care models that maximise health outcomes for those populations.

Contracts would require a new set of performance indicators related to keeping people well, independent, at home and out of hospital. To achieve the synergies of better integrated working, the devolved NHS would need to identify and implement measures that demonstrate contributions to whole system working. These might involve shifting from traditional performance measures, such as the four hour A&E target, which require excellence from a part of the system, but not whole system working. A local NHS manager explained: “For example, a whole system target might be to reduce blood pressure across Greater Manchester by 10 per cent. It has been estimated that achieving this goal could save 1,400 lives locally over 5 years. This

would require better system working and incentivisation of each part of the system.”

Well-coordinated care requires clear pathways and seamless service delivery. That might require some rethinking of competition rules. It would not require re-establishment of the old monopolies of care. But devolution of the rules of competition – the circumstances in which it

‘If we’ve got a person with diabetes and a heart problem and they’re recovering from cancer, we need a nurse who can take a more rounded view. Otherwise, we’re just going to crowd out their kitchen with different sorts of nurses.’

NHS manager in Greater Manchester

operates – might focus on competition around the provision of integrated care rather than competitive procurement of isolated elements of care. Some flexibility from Monitor might be required to ensure that competition served rather than undermined the integration of the health and social care system.

As one manager in Greater Manchester said: “It’s about creating the system that most patients think already exists. They don’t see the distinction that we make between primary and secondary care and don’t understand the split we have made between NHS and social care. We need the freedom to select competition that improves the logic of the system rather than the freedom not to apply competition at all.”

New care pathways will require a rethink of physical infrastructure. *The Memorandum of Understanding*, agreed with the Government in February, says: “A radical approach will be taken to optimising the use of NHS and social care estates.” Insiders explained: “We might seek devolution of the organisational authority that currently sits with NHS Property Services and CHP to allow Greater Manchester a unified estate approach.”

Changed service delivery patterns will also require new skills in the workforce. An integrated health and social care system, with a greater emphasis on primary and community care will need: more GPs and/or more advanced nurse practitioners as well as more district nurses, with generic skills. As one official said: “If we are offering holistic

treatment to patients with multiple morbidities, we will have to reverse past quite a lot of professionalisation of different nursing disciplines. If we've got a person with diabetes and a heart problem and they're recovering from cancer, we need a nurse who can take a more rounded view. Otherwise, we're just going to crowd out their kitchen with different sorts of nurses."

Additional workforce needs will be for social workers with enhanced healthcare skills, such as bandaging, so that nurses and social workers are not both visiting when one could do. Greater Manchester will require enhanced numbers of generally/geriatric skilled

"Why should Greater Manchester, the centre of the Industrial Revolution, not become the centre of the Information Revolution around healthcare, successfully managing the connection between life sciences, health, technology and engineering?"

Local government official in Manchester

consultants to work in community hubs for primary and social care.

"Otherwise," explained a local workforce planner, "there is a risk that England will continue creating many kinds of specialist doctors that would be unable to provide enough geriatric care than we need in Greater Manchester."

There might be a requirement for extended skills and responsibilities of pharmacies so better advantage can be taken of their already considerable role in the delivery of

primary care. For example, pharmacists might be trained to do blood tests. Such workforce changes could be achieved by Greater Manchester becoming a client of Health Education England (HEE), defining the city region's particular workforce needs that HEE would deliver.

Forging links between the city's health system and its five universities is also part of the package. Greater Manchester already has the north of England's only Academic Health Science Network. "We want to create in Greater Manchester a health system that is able to learn from its research base," said an official. "This is a great living lab for healthcare improvement. Why should Greater Manchester, the centre of the Industrial Revolution, not become the centre of the Information Revolution around healthcare, successfully managing the connection between life sciences, health, technology and engineering?"

Transforming leadership

Whitehall will devolve an array of non-NHS responsibilities to the GMCA, a statutory body that can hold a budget and to which the ten councils have already devolved upwards the funding and running of transport services and could further devolve powers, such as over

“An appendix to the agreement states: ‘The key objective of the agreement must be to create a Greater Manchester sub-regional focus for the regulatory and inspection functions, whilst maintaining proper consistency’.”

social care. In April 2015, the 10 leaders of Greater Manchester's district councils will appoint the first metro Mayor, who will be an 11th member of the GMCA.

However, Greater Manchester's Mayor will be unlike London's Mayor, who has a few discrete executive powers such as being the capital's Police and Crime

Commissioner, but has no working relationship with the 32 London councils. Greater Manchester's Mayor will have the capacity to work through the powerful GMCA 10-council strong cabinet.

Meanwhile, a Regulatory Reform Order will allow a combined committee of Greater Manchester's 12 CCGs to be created.

Decision-making powers for the NHS in Greater Manchester can then be devolved from Whitehall to the CCG Joint Committee. Under Section 75 of the Health and Social Care Act, 2006, it can then join with the GMCA to form Greater Manchester Joint Commissioning Board, which will be responsible for agreeing all Greater Manchester-wide spending on health and social care. Above this body will sit Greater Manchester Strategic Health and Social Care Partnership Board, which will be put on a statutory footing by the end of 2015-16. It will set Greater Manchester-wide strategies and priorities and allow system-wide management to assure they are achieved. Most of the actual commissioning will continue, according to subsidiarity, to take place at the appropriate level of CCGs or groups of CCGs.

Existing regulators – such as the Trust Development Authority and Monitor – will continue to regulate Greater Manchester NHS, but there is within Greater Manchester a desire to shift this role towards supporting transitional change, rather than simply ensuring the financial sustainability of individual providers. In an Appendix Letter,

signed on February 20 by Greater Manchester's acute providers, there are hints at changes that may be necessary. It states: "The key objective of the agreement must be to create a Greater Manchester sub-regional focus for the regulatory and inspection functions, whilst maintaining proper consistency."

The timetable is that by December 2015, in preparation for devolution, Greater Manchester and NHS England will have approved the details on the devolution of funds and supporting governance, and local authorities and CCGs will formally agree the integrated health and social care arrangements. By April 2016 full devolution would be in place, with the preferred governance arrangements established.

Rethinking finance and investment

It is extremely difficult to manage strategic reform on the basis of the current distribution of NHS funding – usually a one year allocation combined with an indication of funding for the following year. System safety typically demands the double running of services during transitions in service delivery, particularly when they involve reconfiguration of infrastructure. This will need either upfront investment above and beyond a yearly allocation or a capacity to draw down future years funding initially in order to stabilise the system in the long run. Details are not worked out, but it is clear that a devolved Greater Manchester NHS and social system will need funding certainty over perhaps five years plus either spending flexibility on a year by year basis or some capacity to raise capital for system change, perhaps securitised against future income.

The upfront investment costs, for example, of creating new delivery models in primary and community care, and covering stranded costs while double-running parts of the acute sector, are considerable, estimated at £300 million. Once complete, £165 million of extra spending is anticipated annually in the primary sector, shifted from the acute sector which would be expected to experience a reduction of about £225 million to £235 million in acute care spending, realising an annual saving of £60 million to £70 million. This means that investment costs could be earned back within five years. Together with planned integration and better coordination of health and social

care, total savings from devolution, once fully up and running, are estimated at about £250 million a year. This would cut in half the expected health and social care deficit of about £500 million that Greater Manchester expects to remain outstanding by 2017-18, even if it makes the most rigorous provider efficiency and productivity savings. So devolution does not eliminate the need for extra NHS funding, but it could cut it in half.

Securing devolution and accountability

Until very recently, the devolution discussion has been conducted largely in private between local leaders and central government, rather than with the people of Greater Manchester. However, the

“In the NHS, decisions at a local level have traditionally been taken by unelected professionals, albeit overseen by the elected Westminster government and its regulatory bodies. Healthcare professionals may be reluctant to surrender decision-making to local politicians and, ultimately, to a local electorate.”

history of devolution to Scotland, Wales and Northern Ireland is that it requires popular demand both to happen and to work.

In Greater Manchester, it is unlikely that the term “devolution” will, in itself, stir many Mancunians. Much more likely to stir citizens is consultation about the type of health system they want. Many already expect and believe, erroneously, that they have a unified NHS and are unhappy with the symptoms of disunity – poor care for elderly people and for

people with chronic ailments plus an over-stretched hospital and, in particular A&E system as well as a social care system that is deeply troubled by severe cutbacks in funding. Exploring these issues in Greater Manchester – and then the institutional change required to tackle them – may be the most likely route by which devolution of the NHS by people in Greater Manchester will be drawn into the programme of change.

A longer term issue for devolution of both the NHS and other Whitehall responsibilities is ensuring public accountability. Currently

non-NHS decisions in Greater Manchester are made by councillors, responsible to the electorate. Local authority officers play only an advisory role. In the NHS, decisions at a local level have traditionally been taken by unelected professionals, albeit overseen by the elected Westminster government and its regulatory bodies. Marrying these two cultures of governance into Greater Manchester Joint Commissioning Board and the framework-setting Greater Manchester Strategic Health and Social Care Partnership Board will be difficult. Healthcare professionals may be reluctant to surrender decision-making to local politicians and, ultimately, to a local electorate.

February's announcement detailed that a Chief Officer will be appointed to lead, manage and deliver the programme with appropriate staffing and be accountable for services. It will be vital that Whitehall also ensures that there is a robust process available to set things right should services fail to meet standards set either locally in Greater Manchester or by national regulators.

4

Retaining the “N” in the NHS

Maintaining a “national offer” for a devolved English NHS

However much health and care are part of a wider process of well-engineered devolution for public services in England, there will be a public expectation that certain features of the NHS should stay constant across the country, especially in the area of entitlements and charging. This does not mean giving ill-advised guarantees about no postcode lotteries – whatever that ill-defined term means. If everything is to stay the same everywhere, local people would be unable to deliver health and care in varying ways that best suit their needs. Devolution means much more local accountability and that is inconsistent with nationally uniform public services, including health services.

Moving to “devolution on demand” in England requires clarity about what has to remain universally standard to preserve some concept of an English National Health Service, particularly if the principles

“There has to be a convincing ‘national offer’ covering important access issues; service and treatment expectations; and what is free and what is not.”

underpinning the NHS Constitution are to be retained. There has to be a convincing “national offer” covering important access issues; service and treatment expectations; and what is free and what is not. It probably needs to cover means-tested

social care as well, as we move to more integrated health and social care. However this offer should aim to focus on defining the “what” and not elaborating the “how”.

Standardising the service offer

The service offer should not be so prescriptive that it thwarts local experimentation and denies citizens desirable and deliverable local advances. Settling the service offer may require that a body such as NICE identifies high volume or high cost treatments where some degree of standardisation is in everyone’s best interests. Where NICE cannot respond quickly to changing scientific and clinical knowledge, it may be necessary to accept some time-limited local variation – but

that is not very different from current practice. This should not mean NICE or any other national regulator over-zealously standardises treatments and price.

Similarly, there should be some national guarantees or indicators on service access to, for example, a primary care physician and services as well as to specialist diagnosis and treatment, especially for “killer” diseases. These national indicators should not be too numerous but should be measured consistently and comparably across England, for example using waiting times figures. The public values good access to services and will feel cheated if devolution damages such access.

This approach will require an agreed national measurement system; minimum local compliance requirements; and public transparency on performance. Equally it should not mean financial punishment for those whose performances exceed the “national offer” and the transfer of resources to those who under-perform, as happens too often now in the NHS. If Greater Manchester does better than their contractual requirements, it should be allowed to reinvest any surpluses and not find them diverted to prop up an under-performing part of the country. Devolved parts of the NHS should be able to build up reserves for future developments, as foundation trusts can now. This will incentivise the greater efficiency that the NHS so badly needs.

Central functions

Making the “national offer” work requires clarity about which functions remain at the centre to ensure critical national consistency. Some functions should also stay at the centre because they cannot be

“It is vital to avoid overzealous national regulators reintroducing standardisation by the backdoor in the name of patient safety.”

provided adequately or efficiently locally, even in an area as large as Greater Manchester.

We do not have the expertise to produce a prescriptive list of these functions. However, they are likely to include resource allocation and

a system for ensuring fair population funding for the tasks an area is being asked to tackle; standard-setting and monitoring performance; some specification and oversight of those specialist services requiring

large populations; research and development; and workforce planning and ensuring a reasonable geographical distribution of key staff such as doctors. However, this national role in workforce planning does not require slavish adherence to national pay bargaining and grading.

Thought should be given to how national regulators will operate in a more devolved English NHS and whether more of this work should be delegated locally. It is vital to avoid overzealous national regulators reintroducing standardisation by the backdoor in the name of patient safety. Just as there are failures now, so there will be in a devolved system, and it will be crucial to clarify responsibility for service or financial failure in such a system when local services fall consistently below an acceptable level.

Clearly, more work should be done on all these issues and related to modifications to the NHS Constitution so that it does not become a barrier to local innovation. We turn now to the potentially controversial issues of financial autonomy and accountability.

Financial autonomy and accountability

At the core of a more devolved NHS system is how the money flows from the centre and what discretion there is locally for using money differently, especially in the areas of capital assets, service transformation funding and borrowing against future income flows.

A starting point for what revenue funding could be delegated to a competent local body is to look at what is currently delegated to the clinical commissioning groups in the area of a devolved body, including their administrative allowances. To this might be added health and wellbeing board expenditure; any community mental health budgets not currently delegated; all public health and adult social care funding passed from central government to local government in the area; that area's share of the Public Health England budget; and the NHS England expenditure on primary care in the area. Much here depends on the scale of ambition in a local area devolution plan/contract. The final outcome of the Greater Manchester/NHS England agreement will provide some kind of benchmark.

However this approach alone does not address the issue of whether the current allocations are fair. In our view if “devolution on demand” is to be a continuing and significant feature of running England’s NHS in the future, there should be an independent review to examine the fairness of the system that currently allocates resources to different parts of the country. Devolution must be regarded as fair. This is likely to mean a weighted capitation budget, based on health need and accurate demographic and disease population profiles. Work on this should be carried out independently of party political influence but with a capacity to keep the system under review so that it can respond to changing circumstances.

An agreed devolved budget should be related to an agreed five year contract on what is to be delivered in terms of outcomes for the local population and how the models of service delivery would change to

“Given the sums of money involved in devolution to Greater Manchester, there will have to be robust, credible and transparent public accountability for how the money is spent and what it delivered in terms of public benefit.”

achieve those outcomes. There would have to be agreement also on the capital implications of such a contract and how these would be addressed. We have not considered capital issues in this document. However, in principle, it would seem right to allow the devolved entity to take decisions on better use of land and

buildings that could lead to improved health and wellbeing for its population and better value for money.

There are two other linked financial issues to be considered. The first is the ability of the devolved entity to merge all existing budgetary resources into a single budget over the duration of the contract. If best value and integrated services are to be achieved, this has to happen at some point, but we recognise that it may require legislative changes which we discuss below.

Given the sums of money involved in devolution to Greater Manchester, there will have to be robust, credible and transparent public accountability for how the money is spent and what it delivered in terms of public benefit. Initially, for a short interim period, this might be achieved through existing public bodies, but these are likely to be

increasingly unwieldy, difficult to understand and lacking clear accountability for performance. It will become difficult for Parliament to hold clearly identified public bodies and accounting officers to account for their actions.

Local revenue raising

The UK is highly centralised in the way it raises money for local services compared with other countries. According to *The Economist*, “its national government does 77 per cent of all public spending, compared with 58 per cent in America and 19 per cent in Germany. Even swaggering London, with its mayor and elected assembly, raises just 26 per cent of what it spends (by comparison, New York raised 69 per cent).”¹⁹ We have already seen that in the existing devolved administrations they have taken different views on what services should be free and what should be charged for. London has a bigger population than Scotland but cannot make this decision. We consider that if “devolution on demand” takes off in England it will be extremely difficult to hold the line for long that autonomous areas of a significant size should not be given some greater autonomy on revenue raising.

This will require careful thought, possibly a degree of experimentation and perhaps a wider independent review. It is possible to envisage, after five years of successful local control and delivery, larger areas being allowed to raise up to say 5 per cent of their budget for additional specific services if they had conducted a successful referendum. However, we suggest that revenue-raising by additional charges at the point of clinical need should be specifically ruled out. For the time being, we would also suggest minimal local flexibility on revenue-raising until this has been considered more carefully.

A system for “devolution on demand”

We support the approach to “devolution on demand” hinted at in the December 2014 command paper *The Implications of Devolution for England*. This would mean that the Government of the day would need to pass legislation paving the way for areas to come forward

¹⁹ *The Economist* (2015), “Decentralising health care: control yourself”, 28 February.

with plans and applications for devolution of functions and services and related budgets against certain criteria. Those criteria would need to include health and care functions if they were to be part of those applications and to meet the requirements of NHS England so that the essential NHS framework was protected.

“The next Government will need to address the implications of many more areas following in Greater Manchester’s footsteps. This means creating a credible and sound ‘devolution on demand’ process and framework for considering applications; and for ensuring that these protect the key principles of the NHS.”

To be able to make applications, areas would have to demonstrate local appetite and support for the plans that they were putting forward. So the centre might identify the kinds of local processes such as referenda, citizen’s juries, public meetings, household leafleting, media campaigns and MP involvement that would need to take place to demonstrate that a local support. Arrangements might have to combat strong professional

opposition to a devolution proposal that was clearly in the best interests of the local population.

All of this suggests that building a coalition of support for a wide-ranging package of devolution measures embracing health and care would require considerable political and organisational capability. It would also demand strong local conviction that local people and bodies could do a much better job for local people than the status quo and all its central controls and constraints.

In the longer term, for devolution on the scale being envisaged to be acceptable, it will be necessary for applicant areas to demonstrate the creation of a credible budget holding body and accounting officer system that can answer ultimately to Parliament. Such arrangements would probably need the backing of legislation eventually, following public and parliamentary debate and scrutiny. The existence of such arrangements would be necessary if there was to be high volume of “devolution on demand” applications.

Conclusions

There are strong signs of a groundswell of support in England for more local decision-making on the delivery of public services and more local autonomy over the spending of the money on those services. We think it highly likely that health and care services will be part of this paradigm shift; and that this could be beneficial to local people’s health and wellbeing. We have tried to outline the factors that would have to be taken into account to make a success of greater devolution of responsibility and accountability for integrated health and care services, whilst preserving the essential framework of the NHS.

We are much taken with the way people in Greater Manchester have come together to seize an opportunity to work with NHS England to tackle the looming NHS cash and care crisis within the essential framework of the NHS. We believe other cities and counties will follow their example. The next Government will need to address the implications of many more areas following in Greater Manchester’s footsteps. This means creating a credible and sound “devolution on demand” process and framework for considering applications; and for ensuring that these protect the key principles of the NHS.

In taking forward the devolution agenda, we hope the next government will heed advice from 50 years ago that we are sure Nye Bevan would have approved of.

Come senators, congressman, please heed the call

Don’t stand in the doorway, don’t block up the hall

For he that gets hurt will be he who has stalled

There’s a battle outside and it is ragin’

It’ll soon shake your windows and rattle your walls

For the times they are a-changin’

Bob Dylan (1963), *The Times They Are A-Changin’*

Appendix

Comparisons of Staffing and Patient Experience in the UK's NHSs

Doctors and nurses

General practitioners (GPs). There is comparable data for all four countries (but not by whole-time equivalents, WTEs); and this shows that in 2010 Scotland had more GPs than elsewhere, at 0.95 per 1,000 population. The figures for the other countries were 0.75 in England, 0.65 in Wales and 0.64 in Northern Ireland. These figures had not changed in Wales and Northern Ireland since 1996; but had increased in England and Scotland.²⁰

Hospital doctors. In 2011, the number of hospital doctors and dentists per 1,000 population were 2.3 in Scotland; 2.0 in Northern Ireland; and 1.9 in England and Wales. Even allowing for some definitional changes, all four counties have had rapid increases in the numbers of hospital doctors and dentists since the mid-1990s – probably a higher rate of increase than for any other staff group, with the rate of increase proportionately highest in England.²¹

Nurses. There are definitional problems about comparing numbers of nurses in all the four countries but, even so, there is a striking difference between England and the rest. In 2011 England had 5.8 nurses per 1,000 population compared with 7.9 in Scotland, 7.5 in Northern Ireland and 7.1 in Wales. The North East of England, with its favourable financial settlements, had nursing levels comparable to the devolved administrations rather than the English average – at 7.4 per 1,000 population. This may be because the North East is much more like the three devolved administrations in its low use of agency staff.²²

20 The Health Foundation and The Nuffield Trust, "Headcount rate of general practitioners", accessed February 2015, <http://www.nuffieldtrust.org.uk/data-and-charts/headcount-rate-general-practitioners>.

21 The Health Foundation and The Nuffield Trust, "Number of hospital doctors per 1,000 population", accessed March 2015, <http://www.nuffieldtrust.org.uk/data-and-charts/number-hospital-doctors-1000-population>.

22 Bevan, G. et al (2014), *The four health systems of the United Kingdom: how do they compare?*, The Health Foundation and The Nuffield Trust.

Patience experience

Has the variation in money and staff had much impact on the patient experience in the four countries?

Ambulance response times. Each country has set targets for ambulance response times for life-threatening emergency calls. These targets are more demanding in England and Scotland (75 per cent in 8 minutes) than in the other two countries, with Wales the least demanding at 65 per cent. There have been dramatic improvements in responding to Category A calls in all three devolved administrations since targets were set. Between 2006-7 and 2011-12, when the baseline was about 56 per cent, Scotland and Northern Ireland improved to 73 per cent and Wales to 68 per cent. Throughout that period, England, which had set targets earlier, continued at 75 per cent, with Wales lagging the field. This suggests that targets and management may have been at least as great an influence on service improvement as extra money.

Hospital waiting times. The four countries all have systems for measuring against targets waiting times for hospital inpatient admissions and outpatient appointments, although the targets vary. The Nuffield Trust have looked at performance in each country against their own targets as of March 2013.

- In England the targets were: for 95 per cent of outpatients to be seen and 90 per cent of inpatients to be admitted within 18 weeks. The achievement was 97 per cent and 92 per cent respectively.
- In Scotland the targets were: 90 per cent for both outpatient appointments and inpatient admissions. They achieved just over the target for both.
- In Wales the targets were: 95 per cent of inpatients and 100 per cent of outpatients should be seen/start treatment within 26 and 36 weeks respectively. 91.5 per cent of patients were admitted to hospital within 26 weeks; and 98.6 per cent of outpatients were seen within 36 weeks.

- In Northern Ireland the targets were: 50 per cent of outpatients to be seen within nine weeks and 100 per cent within 21 weeks. 50 per cent of inpatients were to be admitted within 13 weeks; and 100 per cent within 36 weeks.

Each country now has four-hour targets for waiting times in A&E departments but data is not available for a sufficient length of time in all countries to compare trends. It is clear that, despite more generous funding in Scotland, it is, like England, struggling to maintain its A&E performance. It is possible, however, to compare data on how long patients waited for treatment for several common procedures. For hip and knee replacements, it is possible to compare performance using the median point (where half the patients had waited less than the maximum time) and the 90th percentile (the point where 90 per cent of patients had waited less than the maximum time.) This reveals that, in 2012-13, patients in Wales waited on average about 170 days for a hip or knee replacement, compared with 70 days in England and Scotland. The median waiting times for a hip replacement in Wales increased by 69 days between 2009-10 and 2012-13, possibly because Wales seems not to have maintained its health service spending.

Amenable mortality. This is an indicator of health care performance that covers causes of death for under 75s that are regarded as responsive to health care. The Nuffield Trust has shown that, between 1990 and 2010, there were marked declines in the numbers of amenable deaths for under 75s in all four countries. The pace of decline in amenable deaths was faster in all four countries in the 2000s than in the 1990s (except for women in Scotland) which suggests that the higher spending on health care in that decade had an impact. However the relative gap between England (lower) and Scotland (higher) remains. In 2010, Scotland's amenable mortality rate per 100,000 population for under 75s was 76.8 for women and 97.2 for men, compared with 64.4 and 80.1 respectively for England.²³

23 The Health Foundation and The Nuffield Trust, "Trends in amenable mortality in the UK and North East England", accessed March 2015, <http://www.nuffieldtrust.org.uk/data-and-charts/trends-amenable-mortality-uk-and-north-east-england>.

MRSA mortality rates. MRSA rates are derived from deaths where MRSA infection is mentioned on the death certificate. Deaths linked to MRSA have fallen considerably since last decade's peak. In Northern Ireland, male mortality rates per million fell from a high of 43.2 in 2005 to 9.2 in 2012. Wales (28.3 to 7.6) and England (27.1 to 3.7) saw similarly large drop offs.²⁴ (Data by gender is unavailable for Scotland.)

Community services – screening, vaccination and immunisation. The take up of screening for breast cancer between the ages of 50 and 70 for 2010-11 was about 70 per cent in all four countries. Rates of childhood immunisation at age two in 2011-12 were similar in the devolved countries but lower in England. All four countries had vaccination rates for the MMR vaccine (measles, mumps and rubella) at over 90 per cent but still lower than the WHO recommended rate of 95 per cent. For the “five in one” vaccine (diphtheria, tetanus, whooping cough, polio and Hib) and for the meningitis C vaccine, the devolved countries all achieved over 95 per cent while England was just below 95 per cent.²⁵

Patient satisfaction. The 2014 British Social Attitudes survey provides data for all but Northern Ireland. In Wales, 51 per cent were very satisfied and quite satisfied, compared with 65 per cent for England and 75 per cent for Scotland. Dissatisfaction levels across the United Kingdom (15 per cent overall) are at an all-time low. While the most generously funded country, Scotland, tops this list, England outperforms a better funded Wales.²⁶

24 The Health Foundation and the Nuffield Trust, “Morality rates for deaths with MRSA”, accessed March 2015, <http://www.nuffieldtrust.org.uk/data-and-charts/mortality-rates-deaths-mrsa-1996-2012>.

25 Bevan, G. et al (2014), *The four health systems of the United Kingdom: how do they compare?*, The Health Foundation and The Nuffield Trust.

26 The King's Fund, “Who is satisfied with the NHS in 2014”, accessed March 2015, <http://www.kingsfund.org.uk/projects/bsa-survey-2014/who-satisfied-with-nhs>.

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